2018 Annual Report of Suggested Improvement Ideas

Date: 4/4/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	2018 Annual Report of Suggested Improvement Ideas
Version:	0.1
Location:	
Owner:	DXC/Alabama Medicaid
Author:	DXC Team
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for Change	Changes (Section, Page(s) and Text Revised
4/4/2018	0.1		Initial draft	

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2 2010 ITB REQUIREMENT

The Request for Proposal (RFP) requires DXC to deliver a list of improvement ideas to the Agency on a yearly basis. The specific RFP requirement is documented below:

RFP Requirement
ITB Requirement 3.01.11 - The Vendor shall produce an annual report of suggested improvements with high-level estimates of effort for each subsystem. These reports will be submitted to the Agency before the end of the first quarter of the calendar year. A meeting will be scheduled with the Functional Process owner and Agency representatives one (1) week after delivery of the report.

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3 DXC IMPROVEMENT IDEAS

3.1 WEB GLOBAL MESSAGE PANEL

3.1.1 Proposed Solution

Use the Global Message panel (already exists in the Web Portal Admin accounts), along with the t_web_message table (which stores messages created in that panel), and add an HTML block above the login panel to display messages to users.

3.1.2 Benefits

This would allow us to add banner messages from the UI rather than altering code and it would provide DXC with a way to add start and end dates to those messages so they automatically start and stop displaying when needed. This would also eliminate issue of banner messages being overwritten on Production promotions, requiring UI resources to repost messages each promotion. Estimated amount of time saved every time a message is posted: 15 to 20 minutes

3.1.3 Estimate

SE: 60 hours
BA: 30 hours

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3.2 FEITH – MERGING SUPPORTING DOCUMENTATION

3.2.1 Proposed Solution

Merge new faxes with the existing digital submission allowing just one window to be open to see the faxes without having to use leaps. Workflow forms will be added as document comments rather than as new documents in file cabinets.

3.2.2 Benefits

This would benefit PA, Consent, and Enrollment Update immediately by improving user efficiency.

3.2.3 Estimate

SE: 0 hours
BA: 120 hours

Note: The Agency approved the creation of a CSR for this enhancement 1/25/2018, resulting in CSR EW2018012501 and the following COs:

CSR Type	ID	Defect Description	Reference CO	Subsystem	Grouping
CO	14727	Feith - Mother - Supporting Documentation Merging	EW2018012501	Feith	Operations CSR
CO	14728	Feith - Workflow - Dental PA Merge Fax	EW2018012501	Feith	Workflow
CO	14729	Feith - Workflow - Medical PA Merge Fax	EW2018012501	Feith	Workflow
CO	14736	Feith - Workflow - Dental PA Merge Workflow Forms	EW2018012501	Feith	Workflow
CO	14760	Feith - Workflow - CS1 Merge Faxes and WF Forms	EW2018012501	Feith	Workflow
CO	14774	Feith - WF - Rehab PA Merge Fax	EW2018012501	Feith	Workflow
CO	14776	Feith - WF - ERU Merge Faxes and Forms	EW2018012501	Feith	Workflow

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3.3 DRUG REBATE – INVOICING CYCLE AUTOMATION

3.3.1 Proposed Solution

As part of the Drug Rebate Invoicing Cycle, there are 5 SQL queries that pull data each quarter after the cycle is completed. This is currently a manual process that requires an SE to run the queries, export the data to an excel spreadsheet, place the spreadsheets on the shared drive, and notify this data is available for pick up. An automated solution would be to create the reports in DSS and update the Drug Rebate universe as necessary. The DSS reports will be stored in the Business Objects repository and will be available for the user to refresh after the Drug Rebate Invoicing Cycle has completed or when needed.

3.3.2 Benefits

Automating this process will result in better resource efficiency as manual steps will be eliminated.

3.3.3 Estimate

SE: 100 hours
BA: 200 hours

Note: The Agency approved the creation of a CSR for this enhancement 1/25/2018, resulting in CSR DR2018032901.

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3.4 CLAIMS – PANEL ENHANCEMENT

3.4.1 Proposed Solution

When researching claims for callers the EMC team is often asked the location and phone number of the provider that billed a duplicate claim. It would be beneficial to have a link on the claim that has the other providers contact information rather than having to search for the provider separately.

3.4.2 Benefits

Will reduce the amount of time callers need to be online with an agent, improving hold time targets.

3.4.3 Estimate

SE: 70 hours
BA: 35 hours

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3.5 PROVIDER - RE-ENROLLMENT FACSIMILE LETTER

3.5.1 Proposed Solution

Add detailed steps to the re-enrollment letter to assist individual providers with downloading the facsimile.

3.5.2 Benefits

Will reduce the number of calls EMC agents receive, especially during heavy re-enrollment periods. Less calls will result in lower hold times.

3.5.3 Estimate

SE: 30 hours
BA: 20 hours

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3.6 WEB PORTAL – UAT PIN LETTERS

3.6.1 Proposed Solution

Currently the UAT PIN letters generate the web address for production web portal. Update the letters to generate the UAT web address.

3.6.2 Benefits

Will reduce the number of calls EMC agents receive, resulting in lower hold times.

3.6.3 Estimate

SE: 24 hours
BA: 10 hours

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3.7 WEB PORTAL – IGNORE CASE SENSITIVITY

3.7.1 Proposed Solution

Ignore case sensitivity for Username.

3.7.2 Benefits

Removing case sensitivity for Username would cut down on a lot of user confusion and reduce the number of calls EMC agents receive. Case insensitive usernames seem to be pretty standard for web applications.

3.7.3 Estimate

SE: 80 hours
BA: 25 hours

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3.8 WEB PORTAL – PRODUCTION PIN LETTER GENERATION

3.8.1 Proposed Solution

Add functionality for password resets by the EMC help desk.

- Mandate two security questions. Answers will be case insensitive.
- Allow the EMC help desk to reset passwords and generate a one-time temporary password that can be faxed to the end user. The end user will be prompted to change the temporary password upon login.

If approved, further design discussion with the Agency will be needed.

3.8.2 Benefits

Improved user experience/functionality. End-user will be able to retain their same user ID instead of going through the registration process again.

3.8.3 Estimate

SE: 170 hours
BA: 35 hours

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MEMORANDUM

TO: Personnel Managers and Payroll Officers

FROM: Jackie Graham
State Personnel Director

DATE: September 14, 2018

SUBJECT: State Holidays for Calendar Year 2019

In order to assist you in planning for the calendar year ahead, we are sending a listing of Official State Holidays for 2019. For your convenience, this holiday schedule may also be found on our website at www.personnel.alabama.gov.

JG/jp

Enclosure

State of Alabama
2019
Official State Holidays

Holiday	Date in 2019
New Year's Day	January 1
Robert E. Lee Martin Luther King, Jr.'s Birthday	January 21
George Washington Thomas Jefferson's Birthday	February 18
Mardi Gras *	March 5
Confederate Memorial Day	April 22
National Memorial Day	May 27
Jefferson Davis' Birthday	June 3
Fourth day of July	July 4
Labor Day	September 2
Columbus Day Fraternal Day American Indian Heritage Day	October 14
Veterans' Day	November 11
Thanksgiving **	November 28
Mrs. Rosa L. Parks Day*** (Commemoration Only)	December 1
Christmas Day	December 25

* Mardi Gras is observed only in Baldwin and Mobile Counties. All other State employees are granted one personal leave day each year if in employment status on January 1.

** Upon designation by the Governor.

*** December 1 of each year is designated as Mrs. Rosa L. Parks Day to commemorate her accomplishments. Each resident of Alabama is encouraged to observe the day with suitable activities.

ALABAMA MEDICAID SPECIFICATIONS

NCPDP VERSION D.Ø
Document Version 1.7

ALABAMA SPECIFICS FOR PHARMACY

Note: *The information in this document is subject to change. The most recent version will be posted on the Alabama Medicaid website at:*
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

If referencing a downloaded copy, it is the responsibility of the reader to verify the correct version. Alabama Medicaid will track revision changes using a Change Summary Table.

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General Information and Requirements

Testing Procedures

Once a vendor has developed a program following the guidelines stated in this manual, they must test the program for approval. Test claims will be issued along with other necessary information for testing. The test claim results should be returned to HPES for review. Upon approval, instructions will be given for the submission of production claims. For more information, please call (334) 215-0111 or 1-800-456-1242.

Help Desk

The EMC Helpdesk is available to providers and vendors to answer questions, concerns, or to address any problems which may occur during transmission. The help desk can be reached at the following:

Phone	Writing	E-mail
(800) 456-1242 (334) 215-0111 (334) 215-4272 (fax)	Hewlett-Packard Enterprise Services Attn: EMC Helpdesk 301 Technacenter Drive Montgomery, AL 36117	AlabamaSystemsEMC@hp.com

Issues

The following paragraphs give specific information regarding the implementation of NCDPD Version D.Ø. Each of the following paragraphs gives information on specific issues regarding Alabama Medicaid transmissions.

Field Justification

Due to the variable format, field justification is not applicable. However, if you choose to pad each field, all alpha-numeric fields should be left justified and numeric fields should be right justified.

Data Element Usage

In NCPDP Version D.Ø, the field/data element usage is defined as:

M = Mandatory
R = Required
Q = Qualified Requirement
I = Informational Only
O = Optional

The Data Element Usage column listed per request/response segment is from the Telecommunication Standard Implementation Guide. Please reference the AL Requirements columns for any specific requirements for the selected field/data element.

Within a segment, situational or optional fields are submitted after the mandatory and required fields/data elements.

Some fields may be repeated or sent more than once. These fields are denoted with ***R***, in the Data Element Usage column. The number inside the ( ) represents the number of times the field can be repeated.

If the AL Requirements column is N/A, the value sent for the data element isn't used in processing the request. For example, the Processor Control Number (1Ø4-A4) in the Transaction Segment can be sent as all spaces to meet the mandatory requirement.

Co-Pay Exemption

The patient segment is an optional segment. There are two fields, also optional, that we will capture from this segment, if the segment is sent. Below is a table of these fields and the values we will default to if the segment and/or fields are not sent.

When the Place of Service indicates Long Term Care (LTC), the recipient will be considered exempt from co-pay. In version 5.1 the field was named Patient Location. For D.Ø, the field was renamed to Place of Service.

Field	**Segment**	**NCPDP Field #**	**Valid Values** (Valid values appear in ***bold***.)	**Default Value**	**AL Requirements**
PLACE OF SERVICE	Patient	3Ø7-C7	Refer to External Code List for values.	Blank	It will be assumed that the recipient is not in an LTC facility. Values of 31, 32, or 54 will indicate LTC.

A pregnancy indicator field (335-2C) exists in NCPDP D.Ø on the patient segment. A value of '2' in this field will indicate that the recipient is pregnant. When the Pregnancy Indicator is '2', the recipient will be considered exempt from co-pay. The table below shows the basic data for this field.

Field	**Segment**	**NCPDP Field #**	**Valid Values**	**Default Value**	**AL Requirements**
PREGNANCY INDICATOR	Patient	335-2C	Blank=Not Specified 1=Not pregnant 2=Pregnant	Blank	It will be assumed that the recipient is not pregnant.

The claim segment is mandatory for a B1 Billing request. A prior authorization field (461-EU) exists in NCPDP D.Ø on the claim segment. This field (461-EU) is optional. A value of '1' in this field will indicate a prior authorization number is contained in the 462-EV field. A value of '4' in 461-EU will indicate the client is exempt from co-payment. For additional information on exemption from copay, please reference the current Provider Manual for Pharmacy found at http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx.

Field	**Segment**	**NCPDP Field #**	**Valid Values**	**Default Value**	**AL Requirements**
PRIOR AUTHORIZA-TION TYPE CODE	Claim	461-EU	Blank=Not Specified 1=Prior Authorization 4= Exemption from Copay	Blank	It will be assumed that the recipient is not exempt from co-payment.

Other Insurance

NCPDP D.Ø allows the submission of up to 9 instances of other insurance information. We will sum those values up and the value will become the TPL amount. Due to the very rare nature of more than one insurance on a pharmacy claim, we will continue to accept only one other insurance amount. In the Other Payer Amount Paid Qualifier (342-HC) field, a value of "Ø7" (Drug Benefit) should be specified to denote the total amount paid by all other payers.

In addition, for the Other Payer-Patient Responsibility Amount Qualifier (NCPDP field 351-NP), only the value "Ø6" (Patient Pay) is captured by Alabama Medicaid. All other values in field 351-NP are ignored.

Compound Drugs

Compound drug billing is enhanced with version D.Ø to allow all NDC's that are part of a compound to be billed on the same transaction. As a reminder, a compound drug is identified when data element 4Ø6-D6 Compound Code is equal to "2".

- Alabama Medicaid will allow up to 25 NDC's/ingredients to be sent per claim.
- Alabama Medicaid will reject compound claims if one or more NDC's is "non-covered".
- For compound claims with one or more non-covered ingredients, a value of "8" should be submitted in field 42Ø -DK (Submission Clarification Code) to allow for payment on the remaining covered NDC's. Version 5.1 only allowed one occurrence for Submission Clarification Code. Version D.Ø allows a maximum of 3 occurrences. All three occurrences will be reviewed during processing of the claim. When at least one of the occurrences is "8" or "08", the claim will be processed for the approved ingredient(s).

.

Basis of Reimbursement Determination

Field 522-FM, *Basis of Reimbursement Determination* is an optional field that can be returned on a paid or duplicate billing transaction. This field explains how the drug ingredient cost was derived; whether DOJ, FUL, AWP (As of October 1, 2011, AWP pricing will no longer be available.), SMAC, WAC, or AAC. The table below shows how the basis of reimbursement values will be set in relation to the rate used in calculating the paid amount for the claim.

Value*	Price Type Used	Description
0		Not specified
1	**NA – this value will be returned when the billed amount is less than the calculated allowed amount**	**Ingredient Cost Paid as Submitted**
2		Ingredient Cost Reduced to AWP Pricing
3	**AWP**	Ingredient Cost Reduced to AWP Less X% Pricing
4		**Usual & Customary Paid as Submitted**
5		Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary
6	**SMAC or FUL**	**MAC Pricing Ingredient Cost Paid**
7		MAC Pricing Ingredient Cost Reduced to MAC
8		Contract Pricing
9	**DOJ, AAC**	**Acquisition Pricing**
1Ø		ASP (Average Sales Price)
11		AMP (Average Manufacturer Price)
12		34ØB/Disproportionate Share/Public Health Service Pricing
13	**WAC**	**WAC (Wholesale Acquisition Cost)**
14		**Other Payer-Patient Responsibility Amount**
15		Patient Pay Amount
16		Coupon Payment
17		Special Patient Reimbursement

***Valid values for Alabama appear in **Bold.**

Rejection Codes

A billing transaction (B1) can potentially be responded to with a rejected response, a duplicate response, or a paid response. The format of these response transactions will follow the variable requirements of the version D.Ø standard. For reject responses, Medicaid will return the corresponding four-digit internal error code for the NCPDP reject code in the Response Message Segment, field 5Ø4-F4 (Message). The error codes will be preceded by two digits indicating how many error codes are being returned. In addition, text descriptions for these error codes will be placed in the Response Status segment, field 526-FQ (Additional message information). These text descriptions will be separated by a semi-colon.

Reversal Request Format Changes

The claim reversal transaction, or B2 (value of field 1Ø3-A3 Transaction Code in NCPDP specs), is the transaction by which a provider will submit a reversal transaction. A maximum of four reversals on a single transmission can occur in version D.Ø, but is not mandated. However, Medicaid will continue to support only one reversal transaction per transmission to maintain the current billing practices supported.

The service provider ID, date of service, RX number and NDC (product/service ID) are also required to be sent on a reversal to further clarify that we have found the correct ICN to reverse. If the service provider ID, date of service, RX number and NDC do not match the paid claim exactly, the claim reversal request will be rejected accordingly.

Providers should contact their software vendor for issue(s) on processing a claim reversal.

Changes to the handling of Usual & Customary / Gross Amount Due fields

Effective April 13, 2010, for B1 transactions, the usual and customary (field 426-DQ) will be captured and compared to the amount submitted in the gross amount due (field 43Ø-DU). The lower of these fields will be used by the system to determine the final price to be paid by comparing the lowest submitted amount to the calculated price based on the Alabama Medicaid drug pricing file for the NDC submitted.

Billing Request Transaction (B1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		1Ø digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Patient Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø1 = Patient	Ø1 = Patient ID Segment is situational.
3Ø4-C4	DATE OF BIRTH	R	Date of birth of patient.	9(8)	8		
3Ø5-C5	PATIENT GENDER CODE	R	Code indicating the gender of the individual.	9(1)	1	Ø= Not Specified 1 = Male 2 = Female	
311-CB	PATIENT LAST NAME	R	Individual last name.	x(15)	15		
3Ø7-C7	PLACE OF SERVICE	Q	Code identifying the place where a drug or service is dispensed or administered.	9(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	31 = Skilled Nursing Facility 32 = Nursing Facility 54 = Intermediate Care Facility/Mentally Retarded 31, 32 and 54 will set LTC (long term care). If field not sent, default will be space.
335-2C	PREGNANCY INDICATOR	Q	Code indicating the patient as pregnant or non-pregnant.	x(1)	1	Blank=Not Specified 1= Not pregnant 2= Pregnant	If field not sent, default will be blank.
35Ø-HN	PATIENT E-MAIL ADDRESS	I	The E-Mail address of the patient (member).	x(8Ø)	8Ø		
384-4X	PATIENT RESIDENCE	Q	Code identifying the patient's place of residence.	9(2)	2	Ø = Not Specified. 1 = Home 2 = Skilled Nursing Facility 3 = Nursing Facility. 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 7 = Inpatient Psychiatric Facility 8 = Psychiatric Facility – Partial Hospitalization 9 = Intermediate Care Facility/Mentally Retarded 1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution	

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø4 = Insurance	Ø4 = Insurance Segment is mandatory.
3Ø2-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	x(2Ø)	2Ø		13 digit Medicaid ID number.
312-CC	CARDHOLDER FIRST NAME	Q	Individual first name.	x(12)	12		Required. Enter the recipient's first name. Alpha only.
313-CD	CARDHOLDER LAST NAME	Q	Individual last name.	x(15)	15		Required. Enter the recipient's last name. Alpha only.
359-2A	MEDIGAP ID	Q	Required, if known, when patient has Medigap coverage.	x(2Ø)	2Ø		
36Ø-2B	MEDICAID INDICATOR	Q	Required, if known, when patient has Medigap coverage.	X(2)	2	See Section II, Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR	Q	Required if necessary for state/federal/regulatory agency programs.	X(1)	1	Y = Assigned – Provider accepts assignment N = Not Assigned – Provider does not accept assignment	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Q	Required if specified in trading partner agreement.	X(1)	1	Y = Yes=CMS qualified facility N = No=Not a CMS qualified facility	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø7 = Claim	Ø7 = Claim Segment is mandatory.
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	2	See Appendix K - Product/Service Qualifier	Ø3=National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.
442-E7	QUANTITY DISPENSED	R	Quantity dispensed expressed in metric decimal units.	9(7)v999	1Ø		Required. Enter the ten digit metric decimal quantity of the drug dispensed in this field
4Ø3-D3	FILL NUMBER	R	The code indicating whether the prescription is an original or a refill.	9(2)	2	Ø = Original dispensing 1 to 99 = Refill number	Required. Alabama only allows value of ØØ thru 11 based on the NDC.
4Ø5-D5	DAYS SUPPLY	R	Estimated number of days the prescription will last.	9(3)	3		Required. Enter the estimated days supply of the drug dispensed. Alabama only allows value of <= 34.
4Ø6-D6	COMPOUND CODE	R	Code indicating whether or not the prescription is a compound.	9(1)	1	1 = Not a Compound 2 = Compound	Required.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	x(1)	1	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed-Patient Requested Product Dispensed 3 = Substitution Allowed-Pharmacist Selected Product Dispensed 4 = Substitution Allowed-Generic Drug Not in Stock 5 = Substitution Allowed-Brand Drug Dispensed as a Generic 6 = Override 7 = Substitution Not Allowed-Brand Drug Mandated by Law 8 = Substitution Allowed-Generic Drug Not Available in Marketplace 9 = Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed	Values Ø, 1, 3, 4, 5, 7, 8 and 9 are allowed. Values 2 and 6 are not allowed per state policy.
414-DE	DATE PRESCRIPTION WRITTEN	R	Date prescription was written.	9(8)	8		Required. Prescribe date in CCYYMMDD format.
419-DJ	PRESCRIPTION ORIGIN CODE	Q	Code indicating the origin of the prescription.	9(1)	1	Ø = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile	
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Q	Count of the 'Submission Clarification Code' (42Ø-DK) occurrences.	9(1)	1		Maximum count of 3.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
42Ø-DK	SUBMISSION CLARIFICATION CODE	Q***R***	Code indicating that the pharmacist is clarifying the submission.	9(2)	2	1 = No Override 2 = Other Override 3 = Vacation Supply 4 = Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound For Approved Ingredients 9 = Encounters 1Ø = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer-Recognized Emergency/Disaster Assistance Request 14 = Long Term Care Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Replacement box (kit) or automated dispensing machine 17 = Long Term Care Emergency supply reminder 18 = Long Term Care Patient Admit/Readmit Indicator 19 = Split Billing 99 = Other	8 or Ø8 as necessary to process approved compound ingredients. Otherwise N/A.
3Ø8-C8	OTHER COVERAGE CODE	Q	Code indicating whether or not the patient has other insurance coverage.	9(2)	2	ØØ = Not Specified Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists- claim not covered Ø4 = Other coverage exists-payment not collected Ø8 = Claim is billing for copay	Optional. Default to Ø1 if nothing entered. Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists-claim not covered Ø4 = Other coverage exists-payment not collected
418-DI	LEVEL OF SERVICE	Q	Coding indicating the type of service the provider rendered.	9(2)	2	Ø = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24 hour service 5 = Patient consultation regarding generic product selection 6 = In-Home Service	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
461-EU	PRIOR AUTHORIZATION TYPE CODE	Q	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	9(2)	2	Ø=Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from RX 6 = Family Planning Indicator 7 = TANF (Temporary Assistance for Needy Families) 8 = Payer Defined Exemption 9 = Emergency Preparedness	Value of '1' or 'Ø1' when applicable, to indicate Prior Authorization. Value of '4' or 'Ø4' when applicable, to indicate co-pay exemption.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Q	Number submitted by the provider to identify the prior authorization.	9(11)	11		Prior Authorization number when (461-EU) equals '1' or 'Ø1'
343-HD	DISPENSING STATUS	Q	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	x(1)	1	P = Partial Fill C = Completion of Partial Fill	
344-HF	QUANTITY INTENDED TO BE DISPENSED	Q	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(7)V999	1Ø		
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Q	Days supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(3)	3		

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
357-NV	DELAY REASON CODE	Q	Code to specify the reason that submission of the transactions has been delayed.	9(2)	2	1 = Proof of eligibility unknown or unavailable 2 = Litigation 3 = Authorization delays 4 = Delay in certifying provider 5 = Delay in supplying billing forms 6 = Delay in delivery of custom-made appliances 7 = Third party processing delay 8 = Delay in eligibility determination 9 = Original claims rejected or denied due to a reason unrelated to the billing limitation rules 1Ø = Administration delay in the prior approval process 11 = Other 12 = Received late with no exceptions 13 = Substantial damage by fire, etc to provide records 14 = Theft, sabotage/other willful acts by employee	
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)	Q	Code to indicate a patient's choice on assignment of benefits.	X(1)	1	Y = Patient assigns benefits – Patient has assigned benefits to another party N = Patient does not assign benefits – Patient has not assigned benefits to another party	
995-E2	ROUTE OF ADMINISTRATION	Q	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.	x(11)	11	Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
996-G1	COMPOUND TYPE	Q	Clarifies the type of compound.	X(2)	2	Ø1=Anti-infective Ø2= Ionotropic Ø3 =Chemotherapy Ø4= Pain management Ø5=TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6=Hydration Ø7=Ophthalmic 99=Other	
147-U7	PHARMACY SERVICE TYPE	Q	The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.	9(2)	2	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other	

Prescriber Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø3 = Prescriber	Ø3 = Prescriber Segment is mandatory.
466-EZ	PRESCRIBER ID QUALIFIER	Q	Code qualifying the 'Prescriber ID' (411-DB).	x(2)	2	Ø1 = National Provider Identifier (NPI) Ø2 = Blue Cross Ø3 = Blue Shield Ø4 = Medicare Ø5 = Medicaid Ø6 = UPIN Ø8 = State License Ø9 = CHAMPUS 1Ø = Health Industry Number (HIN) 11 = Federal Tax ID 12 = Drug Enforcement Administration (DEA) Number 13 = State Issued 14 = Plan Specific 15 = HC ID (HC IDea) 99 = Other	Required. Ø1 = National Provider Identifier (NPI) or Ø8 = State license number – Will continue to be accepted in place of the NPI number.
411-DB	PRESCRIBER ID	Q	ID assigned to the prescriber.	x(15)	15		Required. Based on the Prescriber ID Qualifier field, this reports either the 1Ø digit NPI Number or the state license number of the prescribing practitioner.
364-2J	PRESCRIBER FIRST NAME	Q	Individual first name.	x(12)	12		
365-2K	PRESCRIBER STREET ADDRESS	Q	Free form text for prescriber address information.	x(3Ø)	3Ø		
366-2M	PRESCRIBER CITY ADDRESS	Q	Free form text for prescriber city name.	x(2Ø)	2Ø		
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS	Q	Standard state /province code as defined by appropriate government agency.	X(2)	2		
368-2P	PRESCRIBER ZIP/POSTAL ZONE	Q	Code defining international postal zone excluding punctuation and blanks.	x(15)	15		

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø5 = Coordination of Benefits/Other Payments	Ø5 = Coordination of Benefits/Other Payments Segment is situational.
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Count of other payment occurrences.	9(1)	1		Only first occurrence will be used.
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	Code identifying the type of 'Other Payer ID' (34Ø-7C).	x(2)	2	Blank=Not Specified Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary Ø4 = Quaternary Ø5 = Quinary Ø6 = Senary Ø7 = Septenary Ø8 = Octonary Ø9 = Nonary	
339-6C	OTHER PAYER ID QUALIFIER	Q***R***	Code qualifying the 'Other Payer ID' (34Ø-7C).	x(2)	2	Ø1 = National Payer ID 1C = Medicare Number 1D = Medicaid Number Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Ø4 = National Association of Insurance Commissioners (NAIC) Ø5 = Medicare Carrier Number 99=Other	
34Ø-7C	OTHER PAYER ID	Q***R***	ID assigned to the payer.	x(1Ø)	1Ø		
443-E8	OTHER PAYER DATE	Q***R***	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	9(8)	8		Format = CCYYMMDD. Optional, will capture if sent.
993-A7	INTERNAL CONTROL NUMBER	Q***R***	Number assigned by the processor to identify an adjudicated claim when supplied in payer-to-payer coordination of benefits only.	X(3Ø)	3Ø		
341-HB	OTHER PAYER AMOUNT PAID COUNT	Q	Count of the payer amount paid occurrences.	9(1)	1		Only first occurrence will be used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Q***R***	Code qualifying the 'Other Payer Amount Paid' (431-DV).	x(2)	2	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit	Ø7, Drug Benefit, is the only value captured by Alabama Medicaid. All other values are ignored.

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
431-DV	OTHER PAYER AMOUNT PAID	Q***R***	Amount of any payment known by the pharmacy from other sources (including coupons).	s9(6)v99	8		Enter the total amount paid by all other insurers.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Q	Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences.	9(2)	2	Max of 25.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Q***R***	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	X(2)	2	Blank=Not Specified Ø1 = Amount Applied to Periodic Deductible Ø2 = Amount Attributed to Product Selection/Brand Drug Ø3 = Amount Attributed to Sales Tax Ø4 = Amount Exceeding Periodic Benefit Maximum Ø5 = Amount of Copay Ø6 = Patient Pay Amount Ø7 = Amount of Coinsurance Ø8 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection Ø9 = Amount Attributed to Health Plan Assistance Amount 1Ø = Amount Attributed to Provider Network Selection 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12 = Amount Attributed to Coverage Gap 13 = Amount Attributed to Processor Fee	Ø6, Patient Pay Amount is the only value captured by Alabama Medicaid. All other values are ignored.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	Q***R***	The patient's cost share from a previous payer.	s9(8)v99	1Ø		
392-MU	BENEFIT STAGE COUNT	Q	Count of 'Benefit Stage Amount' (394-MW) occurrences.	9(1)	1	Max count of 4.	

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
393-MV	BENEFIT STAGE QUALIFIER	Q***R***	Code qualifying the 'Benefit Stage Amount' (394-MW).	x(2)	2	Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap (donut hole) Ø4 = Catastrophic Coverage	
394-MW	BENEFIT STAGE AMOUNT	Q***R***	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	s9(6)v99	8		

Worker's Compensation Segment: Not Used

This segment will not be used in Alabama.

DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø8 = DUR/PPS	Ø8 = DUR/PPS Segment is situational.
473-7E	DUR/PPS CODE COUNTER	Q***R***	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		Only first occurrence of 439-E4, 44Ø-E5 and 441-E6 will be used in processing the claim.
439-E4	REASON FOR SERVICE CODE	Q***R***	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
44Ø-E5	PROFESSIONAL SERVICE CODE	Q***R***	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	ØØ = No intervention MØ = Prescriber consulted PØ = Patient consulted RØ = Pharmacist consulted other source
441-E6	RESULT OF SERVICE CODE	Q***R***	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	1A = Filled As is, False Positive 1B = Filled Prescription As is 1C = Filled, With Different Dose 1D = Filled, With Different Directions 1E = Filled, With Different Drug 1F = Filled, With Different Quantity 1G = Filled, With Prescriber Approval 1H = Brand-to-Generic Change 1K = Filled with Different Dosage Form 2A = Prescription Not Filled 2B = Not Filled, Directions Clarified

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	11 = Pricing	11 = Pricing Segment is mandatory.
4Ø9-D9	INGREDIENT COST SUBMITTED	R	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
438-E3	INCENTIVE AMOUNT SUBMITTED	Q	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
426-DQ	USUAL AND CUSTOMARY CHARGE	Q	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	s9(6)v99	8		Required. Format = $$$$$$cc If field 426-DQ is submitted, the lower of this field and the amount sent in 43Ø -DU (gross amt due) will be used as the amount billed by the submitter.

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
43Ø-DU	GROSS AMOUNT DUE	R	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted'(482-GE), 'Other Amount Claimed' (48Ø-H9).	s9(6)v99	8		Required. Format = $$$$$$cc.
423-DN	BASIS OF COST DETERMINATION	Q	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.	x(2)	2	ØØ = Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9=Other 1Ø=ASP (Average Sales Price) 11=AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	

Coupon Segment: Not Used

This segment will not be used in Alabama.

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	1Ø = Compound	1Ø = Compound Segment is situational.
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	Dosage form of the complete compound mixture.	x(2)	2	Blank=Not Specified Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	NCPDP standard product billing codes.	9(1)	1	1 = Each 2 = Grams 3 = Milliliters	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	9(2)	2		A count of 1 to 25 allowed.
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	Code qualifying the type of product dispensed.	x(2)	2	See Appendix K - Product/Service Qualifier	Ø3 One to twenty-five occurrences allowed.
489-TE	COMPOUND PRODUCT ID	M***R***	Product identification of an ingredient used in a compound.	x(19)	19		Enter the 11 digit NDC number. One to twenty-five occurrences allowed. Note: Prior Authorizations must be acquired prior to billing for compound.
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	Amount expressed in metric decimal units of the product included in the compound mixture.	9(7)v999	1Ø		Enter the metric decimal quantity of the drug dispensed. Field length of 1Ø One to twenty-five occurrences allowed.
449-EE	COMPOUND INGREDIENT DRUG COST	Q***R***	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	s9(6)v99	8		Enter the ingredient cost. One to twenty-five occurrences allowed.

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Q***R***	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	x(2)	2	ØØ =Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Q	Code indicating the number of Compound Ingredient Modifier Code (363-2H)	9(2)	2		
363-2H	COMPOUND INGREDIENT MODIFIER CODE	Q***R***	Identifies special circumstances related to the dispensing/payment of the product as identified in the Compound Product ID (498-TE).	X(2)	2	Reference: Healthcare Common Procedure Coding System (HCPCS) available at www.cms.hhs.gov/medicare/hcpcs/	

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	13 = Clinical	13 = Clinical Segment is situational.
491-VE	DIAGNOSIS CODE COUNT	Q	Count of diagnosis occurrences.	9(1)	1		Max count of 5.
492-WE	DIAGNOSIS CODE QUALIFIER	Q***R***	Code qualifying the 'Diagnosis Code' (424-DO).	x(2)	2	ØØ= Not Specified Ø1 = International Classification of Diseases (ICD9) Ø2 = International Classification of Diseases (ICD1Ø) Ø3 = National Criteria Care Institute (NCCI) Ø4 = The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) Ø5 = Common Dental Terminology (CDT) Ø6 = Medi-Span Product Line Diagnosis Code Ø7 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders(DSM IV) Ø8 = First DataBank Disease Code (FDBDX) Ø9 = First DataBank FML Disease Identifier (FDB DxID) 99 = Other	
424-DO	DIAGNOSIS CODE	Q***R***	Code identifying the diagnosis of the patient.	x(15)	15		1 occurrence allowed. Three to seven digit alpha/numeric code
493-XE	CLINICAL INFORMATION COUNTER	Q***R***	Counter number of clinical information measurement set/logical grouping.	9(1)	1		
494-ZE	MEASUREMENT DATE	Q***R***	Date clinical information was collected or measured.	9(8)	8		Format = CCYYMMDD
495-H1	MEASUREMENT TIME	Q***R***	Time clinical information was collected or measured.	9(4)	4		Format = HHMM

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
496-H2	MEASUREMENT DIMENSION	Q***R***	Code indicating the clinical domain of the observed value in 'Measurement Value' (499-H4).	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
497-H3	MEASUREMENT UNIT	Q***R***	Code indicating the metric or English units used with the clinical information.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
499-H4	MEASUREMENT VALUE	Q***R***	Actual value of clinical information.	x(15)	15	Blood pressure entered in XXX/YYY format in which XXX=systolic, /=divider, and YYY is diastolic. Temperature entered in XXX.X format always including decimal point.	

Billing Paid Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	P
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		13 digit ICN (internal control number) assigned to paid claim.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	Will be used to put EOB message concerning how the claim paid.

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
5Ø5-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay to be paid by the patient.
5Ø6-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	Total amount that will be paid for the drug dispensed.
5Ø7-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that will be paid for this claim (system generated).
5Ø9-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that will be paid to the provider for this claim.

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	9(2)	2	Ø = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient Cost Paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12= 34ØB/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value of Ø = DOJ Value of 1 = the billed amt was less than the allowed/calculated amt Value of 3 = paid the AWP price less X% Pricing Value of 4 = Usual & Customary Value of 6 = paid at MAC or FUL price Value of 9 = paid at DOJ or, AAC price Value of 13 = paid at WAC price Value of 14 = Other Payer-Patient Responsibility Amount
518-FI	AMOUNT OF COPAY	Q	Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay.	s9(6)v99	8		The value returned is the same as 5Ø5-F5 for the paid B1 claim.
566-J5	OTHER PAYER AMOUNT RECOGNIZED	Q	Claim Billing/Encounter: Required if this value is used to arrive at the final reimbursement. Required if Other Payer Amount Paid (431-DV) is greater than zero and Coordination of Benefits/Other Payments segment is supported.	S(9)6v99	8	Format 999999.99	This amount is to be included in instances where the TPL amount is greater than zero.

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Billing Rejected Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXXYYYYZZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	R
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		1 to 5
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3	See NCPDP D.Ø Data Dictionary.	The two digit NCPDP reject code.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		On multiple detail transactions, this field will reflect the detail number to which the reject code applies.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	This field will contain the text descriptions that correspond to the codes returned in the Response Message segment, field 5Ø4-F4. Each description will be no more than 4Ø bytes in length, and will be separated by a semi-colon.

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		1 - 3 allowed
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		Format = CCYYMMDD
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		Format = 9999999V999.
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	Blank = Not Specified 1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		1 - 3Ø characters.

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Billing Duplicate Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXXYYYYZZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	D
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		13 digit ICN (internal control number) assigned to previously paid claim.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	This will be a 4Ø byte message field indicating additional information. For a duplicate, a message indicating the transaction is a duplicate will appear in the 4Ø byte area, followed by the date the claim was submitted. If the pharmacy billing the transaction is different from the claim in history, a message indicating only the ICN will appear in the 4Ø byte area.

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
5Ø5-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay paid by the patient on the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
5Ø6-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	Total amount that was paid for the drug dispensed. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
5Ø7-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that was paid for this claim. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
5Ø9-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that was paid to the provider for the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	9(2)	2	Ø = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = 34ØB/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value is based on claim processing rules. 7/14 – Asked Gwen if she has some test data to see if this element is returned on a duplicate claim.

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	AlabamaRequirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø=Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Reversal Transaction (B2 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1 = One Occurrence (only one reversal will be permitted on a transmission)
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Insurance Segment: Not Used

This segment will not be used in Alabama.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø7 = Claim	Ø7
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 =Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/ SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	2	Ø3 = National Drug Code	Ø3
4Ø7-D7	PRODUCT/ SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.

DUR/PPS Segment: Not Used

This segment will not be used in Alabama.

Pricing Segment: Not Used

This segment will not be used in Alabama.

Coordination of Benefits/Other Payments Segment: Not Used

This segment will not be used in Alabama.

Reversal Approval Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B2 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	A = Approved
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		For a Claim Reversal, the authorization number will be the 13 digit voided ICN #.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 =Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	

Claim Response Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Reversal Rejection Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B2 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		Number of rejection codes set on the reversal txn.
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3		NCPDP two-digit rejection code that applies.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Eligibility Request Transaction (E1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	X(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1 = One Occurrence	1
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	X(1Ø)	1Ø		N/A

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	Ø4 = Insurance	Ø4
3Ø2-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	X(2Ø)	2Ø		Enter first12 digits of Medicaid ID number.

Patient Segment: Not Used

This segment will not be used in Alabama.

Pharmacy Provider Segment: Not Used

This segment will not be used in Alabama.

Prescriber Segment: Not Used

This segment will not be used in Alabama.

Additional Documentation Segment: Not Used

This segment will not be used in Alabama.

Eligibility Response Approved Transaction (E1 Response)

Response Header Segment– Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
5Ø1-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Response Message Segment: Not Used

This segment will not be used in Alabama.

Response Insurance Segment– Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	25 = Response Insurance	25
3Ø2-C2	CARDHOLDER ID	Q	Insurance ID assigned to the cardholder.	x(2Ø)	2Ø		Echo back from E1 request.

Response Insurance Additional Information Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment – Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	29 = Response Patient	29
31Ø-CA	PATIENT FIRST NAME	Q	Individual first name.	x(12)	12		
311-CB	PATIENT LAST NAME	Q	Individual last name.	x(15)	15		
3Ø4-C4	DATE OF BIRTH	Q	Date of birth of patient.	9(8)	8		

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATTION	M	Identifies the segment in the request and/or response.	X(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	X(1)	1	A = Approved	A
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free form text message.	x(1)-x(4Ø)	1-4Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Eligibility Response Rejected Transaction (E1 Response)

Response Header Segment – Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
5Ø1-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		
511-FB	REJECT CODE	R***R***	Code indicating the error encountered.	X(3)	3	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R***	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	1-4Ø		

Change Summary

This section details the changes between this version and the previous versions.

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
09/08/2011	1.0	Sarah Hataway		Agency approved
10/03/2011	1.1	Sarah Hataway	Added a new requirement on page 4. Added a new Value and updated the Alabama Requirements on page 9.	Origin Prescription Code Verbiage added. 419-DJ – Value 5 = Pharmacy added. Alabama Requirements updated to state this is required.
10/19/2011	1.2	James Barnett	Added new clarification in the Other Insurance section on page 3. Revised values allowed for field 308-C8 (other coverage code) on page 3. Clarification made regarding the number of COB segments that will be processed on page 15. Added note regarding field 342-HC.	Verbiage revised regarding allowed values in field 342-HC. Value '08' was removed as a valid value for field 308-C8. Revised statement to clarify that up to 9 occurrence of COB information will be processed. Change made on fields 337-4C and 341-HB. Value 09 (Compound Preparation Cost) was added as a valid value for field 342-HC, note was updated indicating that either 07 or 09 will be interpreted as TPL-AMT in the Alabama Medicaid system.
10/26/2011	1.3	James Barnett	Corrected Testing Procedures section on Page 1. Corrected reversal transaction information on Page 4.	Removed sentences referring to test claims being provided to testers. HP has never provided test claims to vendors wishing to test. Clarified that Alabama Medicaid will support only one B2 reversal transaction on a transmission. This matches the specifications for 109-A9 (transaction count) on Page 45.
12/08/2011	1.4	James Barnett	Clarified usage for field 436-E1 for B1 transactions on Page 8.	Added notes to specify that a ØØ = Unspecified code should be used for compound drug claims, and Ø3 – National Drug Code should be used for non-compounds.
12/20/2011	1.4	James Barnett	Clarified section "New Fields Related to COB Processing" on page 3.	Added notes regarding the usage and editing of the other coverage code field (3Ø8-C8).
03/08/2012	1.5	James Barnett	Added notes for Response COB segment – pages 5, 38-39.	Added notes for additional segment, Response COB, which will be returned on some rejected B1 response transactions.
10/23/2012	1.6	James	Added field 566-J5 in Response Pricing	Added new field to Response pricing segment, 566-J5, which will be returned on paid responses when the TPL amount is

Change Summary

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
		Barnett	segment – page 30.	greater than zero. Also corrected valid values for field 308-C8 to remove “08” as a valid code for Alabama Medicaid.
10/03/2014	1.7	James Barnett	Added clarification on page 3 under the Other Insurance section.	Added note concerning the usage of the NCPDP field 351-NP (other payer-patient responsibility amount). The only value captured by Alabama Medicaid in this field is “Ø6” (Patient Pay Amount). Also clarified the values accepted by Alabama Medicaid in fields 342-HC and 351-NP on pages 16-17.

Alabama Medicaid Vendor Interface Specifications

Standard Communications/Connectivity Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010
Interface Specifications Version Number: 1.4
Last Updated: March 24, 2017

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http://medicaid.alabama.gov/content/7.0_Providers/7.9_Vendor_Guides.aspx

If referencing a downloaded copy, it is the responsibility of the reader to verify the correct version.
Alabama Medicaid will track revision changes using a Change Summary Table.

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1 INTRODUCTION

PURPOSE

This document is intended for Software Vendors to use when developing applications to interact with the Alabama Medicaid Interactive Web site. This includes processes to upload and download Health Insurance Portability and Accountability Act (HIPAA) compliant transactions and National Council for Prescription Drug Programs (NCPDP) transactions via a secure Internet web site.

REFERENCES

Implementation Guides for all X12 transaction sets can be purchased from the publisher, Washington Publishing Company, at their website www.wpc-edi.com.

CONTACT

Alabama Medicaid in an effort to assist the community with their electronic data exchange needs have the following options available for either contacting a help desk or referencing a website for assistance.

Alabama Medicaid Website: http://www.medicaid.alabama.gov/

Electronic Media Claims (EMC) Help desk

Monday – Friday
7:00 a.m. – 8:00 p.m. CST
Saturday
9:00 a.m. – 5:00 p.m. CST
(800) 456-1242
Fax: (334) 215 – 4272
Email: AlabamaSystemsEMC@hp.com

Provider Relations Department (855) 523-9170

The Provider Relations Department is composed of field representatives who are committed to assisting Alabama Medicaid providers in the submission of claims and the resolution of claims processing concerns.

Provider Assistance Center (800) 688-7989

The Provider Assistance Center communication specialists are available to respond to written and telephone inquiries from providers on billing questions and procedures, claim status, form orders, adjustments, use of the Automated Voice Response System (AVRS), electronic claims submission and remittance advice (EOPs).

2 TRANSACTION PROCESSING

2.1 INTERACTIVE SUBMISSIONS

To submit an interactive NCPDP transaction, vendors must contract with a clearinghouse that has established a connection with the HPE data center. The following clearinghouses currently connect with the HPE data center:

Clearinghouse Name	Clearinghouse website
eRx	www.erxnetwork.com
Recondo	www.recondotech.com
Dorado	www.doradosystems.com
Relayhealth	www.relayhealth.com

The following transaction types may be submitted interactively by contracting with a clearinghouse:

Transaction	Request Transaction ID	Version Identifier	Response Transaction ID	Version Identifier
NCPDP Pharmacy Claim	B1	D.0		
NCPDP Pharmacy Claim Reversal	B2	D.0		
NCPDP Eligibility Verification	E1	D.0		

2.2 BATCH SUBMISSIONS

The following transaction types may be submitted in batches.

Transaction	Request Transaction ID	Version Identifier	Response Transaction ID	Version Identifier
Eligibility Verification	270	005010X279A1	271	005010X279A1
Claim Status	276	005010X212	277	005010X212
Prior Authorization	278	005010X217	278	005010X217
Healthcare Claim – Institutional	837I	005010X223A2		
Healthcare Claim – Professional	837P	005010X222A1		
Healthcare Claim – Dental	837D	005010X224A2		
Acknowledgement for Healthcare Insurance			999	005010X231A1
Acknowledgement for Healthcare Insurance	999	005010X231A1		
Batch Response File			BRF	Proprietary Flat File
Electronic Remittance Advice			835	005010X221A1
Unsolicited Claim Status Response			277U	003070X070
NCPDP Pharmacy Claim	B1	D.0		
NCPDP Pharmacy Claim Reversal	B2	D.0		
NCPDP Eligibility Verification	E1	D.0		
Long Term Care Acceptance Report – Response Only			LT1	
Long Term Care Rejected Report – Response Only			LT2	

2.3 Safe Harbor

Alabama Medicaid offers a “safe harbor” to submitters as an alternative submission method based on the guidelines set forth within the CAQH CORE operating rules. CAQH CORE described a specific set of web services which can be used over the Safe Harbor connection. Safe Harbor accepts both SSL v3.0 and TLS v1.0.

It is assumed that the trading partner has reviewed the CAQH CORE operating rules in regards to use of Safe Harbor. CAQH CORE guidelines can be found on the CAQH CORE website:
http://caqh.org/benefits.php/

Additional information regarding the Alabama Medicaid specific requirements for the use of safe harbor can be found within the companion guide published on the Medicaid website:
http://medicaid.alabama.gov/content/7.0_Providers/7.9_Vendor_Guides.aspx

2.4 NETWORK SECURITY

An EDI Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, etc.) that transmits electronic data to and receives electronic data from another entity. Alabama Medicaid requires all trading partners to complete EDI registration regardless of the trading partner type as defined below. Contact the EMC Helpdesk to register.

Trading Partner is an entity engaged in the exchange or transmission of electronic transactions.
Vendor is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.
Software Vendor is an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions.
Billing Service is a third party that prepares and/or submits claims for a provider.
Clearinghouse is a third party that submits and/or exchanges electronic transactions on behalf of a provider.

Before transactions can be processed through the Alabama Medicaid Interactive Web site, Trading Partners must obtain a Trading Partner ID and complete the Trading Partner Agreement. The Trading Partner Agreement form is readily available at the website listed.
http://medicaid.alabama.gov/content/7.0_Providers/7.9_Vendor_Guides.aspx

All Trading Partners are required to establish and set up an account on the Website, which includes a Web user name and password. Initial access for the new Web environments are granted by means of a Personal Identification Number (PIN) which is made available once a Trading Partner ID has been requested. In addition, each environment owns a unique security database; therefore, security maintenance must be performed within each environment that is used.
https://www.medicaid.alabamaservices.org/ALPortal/

2.5 TESTING REQUIREMENTS

All new Trading Partners are required to submit a test transaction and receive passing HIPAA compliance results prior to submitting files to production.

2.6 Web Interface

The Web interface is designed to support:

- batch file uploads and downloads
- interactive requests

There are two ways to use the batch upload and download interface. The first is to log on to the secure Website using a user name and password as described in Network Security. This Website has Web pages that allow users to upload and download files to and from directories within the user's personal computer (PC) or local area network (LAN). The second way is to use a software program that runs on a user's PC or server that connects to the secure Website. The user's site sends a request using the Secure Hypertext Transfer Protocol (HTTPS) containing parameters that include the Trading Partner user name, the associated password, and the request data. The request data can include a request for a listing of files available for download, a specific file name to download, or a file to upload. The files can be transferred in compressed format or in the American Standard Code for Information Interchange (ASCII) text format. All data is transferred using the Secure Socket Layer (SSL) that encrypts the data over the network.

2.6.1 Client Software for Web Communication

The client software can be written in any language that supports HTTPS for communicating with the web site. The request transactions are formatted in Extensible Markup Language (XML), but the data files transferred to and from the website are in the HIPAA standard format. The XML data is used to support the security and general interaction with the web site.

2.7 Use of the Alabama Medicaid RAS

Trading Partners who do not have a contract with an Internet Service Provider (ISP) can optionally use a modem to dial into Alabama Medicaid's Remote Access Server (RAS) to gain access to this website only. An Internet browser is also required to maintain a Trading Partner security ID and password. Please see section 17 "***Connecting through RAS"*** of the PES Software User Guide for details on setting up a network connection using the Alabama Medicaid RAS.
https://www.medicaid.alabamaservices.org/ALPortal/Tab/41/content/InformationLinks/InformationLinks.html.spage

3 WEB INTERFACE SPECIFICATIONS

3.1 Introduction to Requests

To successfully interface with the Interactive Website, all request pages must be prefixed with one of the Uniform Resource Locators (URLs) listed to form a valid request.

Environment	URL Prefix
Production	https://www.medicaid.alabamaservices.org/ALPortal
User Acceptance Test	https://www.alabama-uat.com/ALPortal/

The appropriate suffix listed that is to be attached to the prefix to complete the corresponding transaction.

Transaction	URL Suffix
Login	/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx
List Transaction Types	/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx
List Files	/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx
Get File	/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx
Send File	/DesktopModules/iC_Portal_BatchTransfer/BatchUpload.aspx

For all requests, any non-required element, attribute or node should not be sent if there is no value for it. For example, if the password is not being changed, then the logon request should not contain an attribute named new password.

3.2 Login

A successful login must be completed prior to processing any other requests. In the case of listTransactions, listFiles and getFiles, these requests can be sent together along with the login request. However, the request can also utilize a previously logged in session by sending the session cookie value in the request headers, which is required to successfully send a putFile request. The login response contains a Set-Cookie header to set session tracking cookies that can be used for subsequent transactions. The session tracking cookie can either be obtained from the Set-Cookie headers or it can be obtained from the content of the response to the login request.

3.2.1 XML structure of the request

XPath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/request[@requesttype="login"]		1 per parent	
/request[@requesttype="login"]/user		1 per parent	
/request[@requesttype="login"]/user/ @name	The username to use for login.	Required	At this time all user names should be upper case.
/request[@requesttype="login"]/user/ @password	The user's password.	Required	Please note that all passwords are case sensitive.
/request[@requesttype="login"]/user/ @newpassword	The password to which the user's login password should be changed.	Optional	Only send this attribute if changing the user's current password. If login return is successful, the user's password will be the value sent here. Please note that all passwords are case sensitive.
/request[@requesttype="login"]/user/ @provider	The provider's Medicaid ID.	Optional	If the user is the provider, this value will be ignored. If the user is classified as a clerk, this ID will become the currently selected provider for all following transactions.
/request[@requesttype="login"]/user/ @sakwebparent	The system assigned key (SAK) that uniquely identifies the provider.	Optional	Same as the provider attribute above.

XML sample:

```
<request requesttype="login">
<user name="USERABC" password="usersPassw0rd" provider="123456789A" />
</request>
```

3.2.2 Response Content

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content		1 per parent	Will contain any response content populated by the specific transaction request.
/content/provider		1 per parent	

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content/provider/@provider	The Medicaid ID of the current provider.		
/content/provider/@sakwebparent	The numeric SAK for the selected provider.		
/content/session		1 per parent	
/content/session/@cookieheadervalue	A string that can be appended to the HTTP request header's cookie to set the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.
/content/session/@cookiename	The name of the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.
/content/session/@cookievalue	The value for the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.

3.3 List Transaction Types

This transaction provides a list of all possible file types for transfer. The values from the response to the listTransactionTypes request must be used to identify the file type being transferred for a putFile request. It is common to combine this request with the login request to obtain both responses at once.

3.3.1 XML structure of the request

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/request[@requesttype="listTransactionTypes"]		1 per parent	

XML sample:

```
<request requesttype="listTransactionTypes" />
```

3.3.2 Response Content

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content		1 per parent	
/content/list		1 per parent	
/content/list/ttype/@cde_identification	The unique code value that identifies the transaction type.		
/content/list/ttype/@description	A long text description of the transaction type.		
/content/list/ttype/@map_tran	The American National Standards Institute (ANSI) transaction that the transaction maps to. This may be an empty string.		
/content/list/ttype/@sak_transaction_type	The unique SAK that identifies the transaction type.		
/content/list/ttype/@shortname	A short text description of the transaction. These values are not unique.		
/content/list/ttype/@direction	The value of this attribute will either be “UPLOAD” or “DOWNLOAD”.		Only Transaction Types that have a direction value of “Upload” can be used when sending us files. A Transaction Type could be listed twice, once with a direction attribute of “UPLOAD” and once with a direction attribute of “DOWNLOAD”.

3.4 List Files

The response to the listFiles request contains all of the files currently available for download based on the selected entity. These files may or may not have been previously downloaded. All files will continue to be returned as part of the response to the listFiles request until they have been purged from the Medicaid file system. It is common to combine this request with the login

request to obtain both responses at once. The sak_download value returned in the response to this request must be used to submit a getFile request.

3.4.1 XML structure of the request

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/request[@requesttype="listFiles"]		1 per parent	

XML sample:

```
<request requesttype="listFiles" />
```

3.4.2 Response Content

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content		1 per parent	
/responses/response[@requesttype="listfiles"]/content/files		1 per parent	
/responses/response[@requesttype="listfiles"]/content/files/file		0 or more per parent.	This entire element can be duplicated in the getFile request rather than creating a new element for the request.
/responses/response[@requesttype="listfiles"]/content/files/file/@cde_identification	The unique code that identifies the file type. This will match one of the elements returned by the listTransactionTypes request.		
/responses/response[@requesttype="listfiles"]/content/files/file/@checksum	The CRC32 checksum calculated for the file. This will be in lowercase hexadecimal form.		This value can be recalculated by the client when the file is received. The number calculated by the client should match the value reported here.
/responses/response[@requesttype="listfiles"]/content/files/file/@dte_available	The date the file was made available for download.		This will be in the MM/DD/YYYY HH:mm:SS ~hhxx format: 2 digit month, 2 digit day, 4 digit year, 2 digit hour (00-23), 2 digit minute, 2 digit second, followed by

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
			the time zone offset expressed as either plus (+) or minus (–) and a 2 digit hour followed by a 2 digit minute.
/responses/response[@requesttype="listfiles"]/content/files/file/@dte_downloaded	The date the file was downloaded by the provider or a representative of the provider.		This is the same time format as above. This value may not be present or it may be a very low date (01/01/1900) or a very high date (12/31/2299) for files that have not been downloaded. If searching for files that have yet to be downloaded, it is best to search for either missing values, values prior to 01/01/2007 or values after the current date.
/responses/response[@requesttype="listfiles"]/content/files/file/@filename	The name of the file.		
/responses/response[@requesttype="listfiles"]/content/files/file/@sak_download	The SAK that uniquely identifies this file.		This value must be used in the getFile request.

3.5 Get Files

The getFile request does not always return an XML response. If the request is successful, the response will contain the contents of the file requested. If the request cannot be processed, then the response will contain XML which consist of at least one error element to describe the nature of the failure.

For convenience, the request for login can be included with the request for getFile. In this case there is no need to pass the session tracking cookies because the login request will reset the session information. There will be no response for a successful login attempt because the body of the response will instead contain the contents of the file being requested. Since the element and attribute names match those returned by the listFiles request, the file element in the response to the listFiles request can be copied and sent as the file element of the getFile request.

3.5.1 XML structure of the request

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/request[@requesttype="getFile"]		1 per parent	

/request[@requesttype="getFile"]/file		1 per parent – Required	Rather than creating a new file element, it may be easier to copy the file element returned by the response to the listFiles request.
/request[@requesttype="getFile"]/file/ @sak_download	The sak_download value returned by the response to the listFiles request.	Required	

XML sample:

```
<request requesttype="getFile">
<file sak_download="123456789" />
</request>
```

3.5.2 Response Content

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content		0 or 1 per parent	If the request to getFile fails, the Content-Type of the response will be "text/xml" and this element will be present. There will also be at least one message element present to describe the reason for the failure. If the request to getFile succeeds, the Content-Type will not be "text/xml" and the body of the response will contain the file contents.

3.6 Send Files

The send file request cannot be combined with any other requests since the entire body of the request must contain the file contents and nothing else.
Prior to performing a putFile request, a login request must be performed. The session tracking cookie from the valid login response must be sent as a cookie header in the request to putFile.
Additionally the following custom HTTP request headers must be set:

- X-filename="" – must contain the name of the file which will help the sender track the progress of the file.
- X-checksum="" – must contain the CRC32 checksum value expressed as a 32bit hexadecimal number (a string length of 8).

The following HTTP request headers must also be set:

- X-cde_identification="" – must contain the cde_identification value obtained from the listTransactionTypes response that identifies the contents of the file being transferred.
- X-cde_industry="" – must contain the cde_industry value obtained from the listTransactionTypes response that identifies the version of the file being transferred. If the cde_industry value returned is blank then do not send anything in this field.
- X-sak_transaction_type="" – must contain the sak_transaction_type value obtained from the listTransactionTypes response that identifies the contents of the file being transferred. This request header is not required and is only provided as a convenience for those who would prefer to use the sak_transaciton_type rather than the cde_identification to identify the types of files. If this header is present, it is not necessary to send the X-cde_identification or X-cde_industry header.

The request body must contain nothing more than the contents of the file being transferred. When the response is created, the information from the headers is used to create an XML request, which is returned in the request element of the response.

3.6.1 XML structure of the request

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
Does not apply to this request.			

XML sample:

Not Applicable

3.6.2 Response Content

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/content		1 per parent	
/content/batch		1 per parent	
/content/batch/@batch_id	The SAK for the uploaded file.		This will be assigned after a successful transmission, but it may also be present for a failed transmission.

Appendix A Supported Documents

5010
If cde_industry is blank then do not submit.

CDE_INDUSTRY	CDE_TRANSACTION	CDE_IDENTIFICATION	DSC_SUPPORTED_DOC	DSC_SHORT_NAME
005010X279A1	270	270_X12_BATCH	Batch – X12 – Health Care Eligibility Benefit Inquiry – 5010	Eligibility Inquiry 5010
005010X279A1	270	270_X12_INTERACTIVE	Interactive – X12 – Health Care Eligibility Benefit Inquiry – 5010	Eligibility Inquiry 5010
005010X279A1	271	271_X12_BATCH	Batch – X12 – Health Care Eligibility Benefit Response – 5010	Eligibility Resp 5010
005010X279A1	271	271_X12_INTERACTIVE	Interactive – X12 – Health Care Eligibility Benefit Response – 5010	Eligibility Resp 5010
005010X212	276	276_X12_BATCH	Batch – X12 – Health Care Claim Status Request – 5010	Claim Status Rqst 5010
005010X212	276	276_X12_INTERACTIVE	Interactive – X12 – Health Care Claim Status Request – 5010	Claim Status Rqst 5010
005010X212	277	277_X12_BATCH	Batch – X12 – Health Care Claim Status Response – 5010	Claim Status Resp 5010
005010X212	277	277_X12_INTERACTIVE	Interactive – X12 – Health Care Claim Status Response – 5010	Claim Status Resp 5010
005010X224A2	837	837_D_X12_BATCH	Batch – X12 – Health Care Claim: Dental – 5010	Claim:Dental 5010
005010X223A2	837	837_I_X12_BATCH	Batch – X12 – Health Care Claim: Institutional – 5010	Claim:Institutional 5010
005010X222A1	837	837_P_X12_BATCH	Batch – X12 – Health Care Claim: Professional – 5010	Claim:Professional 5010
005010X220A1	834	834_X12_BATCH	Batch – X12 – Benefit Enrollment and Maintenance – 5010	Enrollment/Maint 5010
005010X218	820	820_X12_BATCH	Batch – X12 – Payroll Deducted and Other Group Premium Payment for Insurance Products – 5010	Group Premium Pymt 5010
005010X217	278	278_X12_BATCH	Batch – X12 – Health Care Services Response – 5010	Health Care Svc Rsp 5010
999ODBCT	999	999_X12_BATCH	Batch – X12 – Functional Acknowledgment – 999 – 5010	Functional Ack 5010
4010	TA1	TA1_X12_BATCH	Batch – X12 – Interchange Acknowledgment	Interchange Ack
	BRF	BRF_BATCH	Batch Response File for 837 submitted batches	Batch Response File
003070X070	277	277_U_X12_BATCH	Batch – X12 – Unsolicited Health Care Claim Status Response	Unsolicited Claim Status
005010X221A1	835	835_X12_BATCH	Batch – X12 – Health Care Claim Payment/Advice – 5010	Clm Payment/Advice 5010
1.2	B	B_NCPDP_BATCH	National Council for Prescription Drug Programs ? Batch Standard ? Billing/Reversal – 5010	NCPDP:E1, B1 and B2(1.2)
D.0	B1	B1_NCPDP_INTERACTIVE	National Council for Prescription Drug Programs – Telecommunication Standard – Billing – 5010	Billing (D.0)
D.0	B2	B2_NCPDP_INTERACTIVE	National Council for Prescription Drug Programs – Telecommunication Standard – Reversal – 5010	Reversal (D.0)
1.2	NCP	NCPDP_BATCH	National Council for Prescription Drug Programs ? Batch Standard	NCPDP:E1, B1 and B2(1.2)
1.2	E	E_NCPDP_BATCH	National Council for Prescription Drug Programs ? Batch Standard ? Eligibility	NCPDP:E1 (1.2)
D.0	E1	E1_NCPDP_INTERACTIVE	National Council for Prescription Drug Programs – Telecommunication Standard – Eligibility	Eligibility (D.0)
	LTC	LTC_BATCH	Batch – LTC Admissions	LTC Admissions
	LT1	LTC_ACCEPT_BATCH	Batch – LTC Response Accepted Admissions	Long Term Care Accepted
	LT2	LTC_REJECT_BATCH	Batch – LTC Response Rejected Admissions	Long Term Care Rejected

Appendix B Sample Transactions

This section provides examples of the entire HTTP request (header and body) and the entire HTTP response (header and body).

B.1. Login, List Transaction Type and Files Example

The following example includes the request with Login, listTransactionType and listFiles combined.

```
POST /ALPortal/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx HTTP/1.1
User-Agent: Java/1.4.2_10
Host: 10.7.200.159
Accept: text/html, image/gif, image/jpeg, *; q=.2, */*; q=.2
Proxy-Connection: keep-alive
Content-Type: application/x-www-form-urlencoded
Content-Length: 243
<?xml version="1.0" encoding="UTF-8"?>
<requests><request requesttype="login"><user name="UUUUUU" password="PPPPPPPPP"
provider="000000000A"/></request><request requesttype="listTransactionTypes"/><request
requesttype="listFiles"/></requests>
```

The following example includes the response to the above Login, listTransactionType and listFiles example.

```
HTTP/1.1 200 OK
Server: Microsoft-IIS/5.1
Date: Fri, 09 Dec 2011 01:55:12 GMT
X-Powered-By: ASP.NET
X-AspNet-Version: 2.0.50727
Set-Cookie: ASP.NET_SessionId=fzfd2255332kqv45xrusd345; path=/
Set-Cookie:
.iCPortal=CA296980AC7BD35E436F94FF921C55C644D81C8EE55BCAA29557478D7011EE7567AA9780C7
95FED1761C2B
4816AA50926E360E00B7A0B7FAB7E1B3D3E64E251F0D597EF1185F19D96C7BEEBEA03056495F80EE34
BCDE5A71; path=/;
HttpOnly
Set-Cookie: iCWindowID=0; path=/; HttpOnly
Set-Cookie: iCSessionWNDS=1; path=/; HttpOnly
Cache-Control: private
Content-Type: text/xml
Content-Length: 4385
<?xml version="1.0" encoding="utf-8"?><responses><response requesttype="login"
completedsuccessfully="true"><messages /><content><provider provider="000000000A" sakwebparent="5555"
/><session cookiename="ASP.NET_SessionId" cookievalue="fzfd2255332kqv45xrusd345"
cookieheadervalue="ASP.NET_SessionId=fzfd2255332kqv45xrusd345;" /></content><request
requesttype="login"><user name="UUUUUU" password="PPPPPPPPP" provider="100686679D"
/></request></response><response requesttype="listTransactionTypes"
completedsuccessfully="true"><messages /><content><list><ttype sak_transaction_type="24"
shortname="HIPAA (X12 or NCPDP)" cde_identification="B_NCPDP_BATCH"
cde_industry="D.0"description=" National Council for Prescription Drug Programs ? Batch Standard ?
Billing/Reversal – 5010" map_tran="" direction="UPLOAD" /><ttype sak_transaction_type="26"
shortname="LTC Admissions" cde_identification="LTC_BATCH" description="Batch – LTC Admissions"
map_tran="LTC" direction="UPLOAD" /><ttype sak_transaction_type="13" shortname="Clm Payment/Advice
– 5010"cde_identification="835_X12_BATCH" cde_industry="005010X221A1"description=" Batch – X12 –
Health Care Claim Payment/Advice – 5010" map_tran="835" direction="DOWNLOAD" /><ttype
sak_transaction_type="7" shortname="Claim Status Response" cde_identification="277_X12_BATCH"
```

cde_industry=”005010X212” description=” Batch – X12 – Health Care Claim Status Response – 5010” map_tran=”277” direction=”DOWNLOAD” /><ttype sak_transaction_type=”3” shortname=”Eligibility Resp 5010” cde_identification=”271_X12_BATCH” cde_industry=”005010X279A1” description=” Batch – X12 – Health Care Eligibility Benefit Response – 5010” map_tran=”271” direction=”DOWNLOAD” /><ttype sak_transaction_type=”15” shortname=”Functional Ack 5010” cde_identification=”999_X12_BATCH” cde_industry=”999ODBCT” description=” Batch – X12 – Functional Acknowledgment – 999 – 5010” map_tran=”999” direction=”DOWNLOAD” /><ttype sak_transaction_type=”30” shortname=”Health Care Svc Rsp 5010” cde_identification=”278_X12_BATCH” cde_industry=”005010X217” description=”Batch – X12 – Health Care Services Response – 5010” map_tran=”278” direction=”DOWNLOAD” /><ttype sak_transaction_type=”16” shortname=”Interchange Ack” cde_identification=”TA1_X12_BATCH” cde_industry=”004010” description=”Batch – X12 – Interchange Acknowledgment” map_tran=”TA1” direction=”DOWNLOAD” /><ttype sak_transaction_type=”27” shortname=”Long Term Care Accepted” cde_identification=”LTC_ACCEPT_BATCH” description=”Batch – LTC Response Accepted Admissions” map_tran=”LT1” direction=”DOWNLOAD” /><ttype sak_transaction_type=”28” shortname=”Long Term Care Rejected” cde_identification=”LTC_REJECT_BATCH” description=”Batch – LTC Response Rejected Admissions” map_tran=”LT2” direction=”DOWNLOAD” /><ttype sak_transaction_type=”31” shortname=”NCPDP:E1, B1 and B2(1.2)” cde_identification=”NCPDP_BATCH” cde_industry=”D.0”description=” National Council for Prescription Drug Programs ? Batch Standard” map_tran=”NCP” direction=”DOWNLOAD” /><ttype sak_transaction_type=”29” shortname=”Unsolicited Claim Status” cde_identification=”277U_X12_BATCH” cde_industry=” 003070X070” description=”Batch – X12 – Unsolicited Health Care Claim Status Response” map_tran=”277U” direction=”DOWNLOAD” /></list></content><request requesttype=”listTransactionTypes” /></response><response requesttype=”listFiles” completedsuccessfully=”true”><messages /><content><files><file sak_download=”251554” filename=”A100000009A_200701301951.txt” cde_identification=”EOP_BATCH” dte_available=”01/02/2011 19:02:29 -0600” dte_downloaded=”02/22/2011 16:15:47 -0600” checksum=” “ /><file sak_download=”9770” filename=”tax_intercept.txt” cde_identification=”CROCS_INTERCEPT_BATCH” dte_available=”10/08/2011 18:44:38 -0600” dte_downloaded=”02/22/2011 16:15:50 -0600” checksum=”da234e08” /><file sak_download=”251439” filename=”tax_intercept.txt” cde_identification=”CROCS_INTERCEPT_BATCH” dte_available=”01/09/2011 01:23:50 -0600” dte_downloaded=”02/22/2011 16:15:54 -0600” checksum=”da234e08” /><file sak_download=”251555” filename=”ELIGRSP13_271.txt” cde_identification=”271_X12_BATCH” dte_available=”01/29/2011 00:21:36 -0600” dte_downloaded=”02/22/2011 16:15:55 -0600” checksum=” “ /><file sak_download=”9769” filename=”BRADUPLOADTEST.txt” cde_identification=”270_X12_BATCH” dte_available=”10/08/2011 18:44:36 -0600” dte_downloaded=”02/22/2011 19:44:56 -0600” checksum=”da234e08” /><file sak_download=”251441” filename=”1234EOP_xyzProv.txt” cde_identification=”EOP_BATCH” dte_available=”01/18/2011 13:21:58 -0600” dte_downloaded=”02/05/2011 14:08:34 -0600” checksum=” “ /></files></content><request requesttype=”listFiles” /></response></responses>

B.2. GetFile Example

The following example includes the request to getFile.

POST /ALPortal/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx HTTP/1.1
Cookie: ASP.NET_SessionId=fzfd2255332kqv45xrusd345;
User-Agent: Java/1.4.2_10
Host: 10.7.200.159
Accept: text/html, image/gif, image/jpeg, *; q=.2, */*; q=.2
Proxy-Connection: keep-alive
Content-Type: application/x-www-form-urlencoded
Content-Length: 293
<?xml version=”1.0” encoding=”UTF-8”?>
<requests><request requesttype=”getFile”><file sak_download=”251555” filename=”ELIGRSP13_271.txt” cde_identification=”271_X12_BATCH” cde_industry=” 005010X279A1” dte_available=”01/29/2011 00:21:36 -0600”
dte_downloaded=”02/22/2011 16:15:55 -0600” checksum=” “/></request></requests>

The following example includes the response to the above getFile example.

```
HTTP/1.1 200 OK
Server: Microsoft-IIS/5.1
Date: Fri, 09 Dec 2011 01:55:27 GMT
X-Powered-By: ASP.NET
X-AspNet-Version: 2.0.50727
Content-Disposition: attachment; filename=ELIGRSP13_271.txt
Transfer-Encoding: chunked
Cache-Control: private
Content-Type: text/plain
a14
ISA*00*          *00*          *ZZ*752548221      *ZZ*200000390
*111212*1200*^*00501*000000008*0*P*:~GS*HB*752548221*200000390*20111212*120014*2*X*005010
X279A1~ST*271*000001*005010X279A1~BHT*0022*11*113451240*20111212*1200~HL*1**20*1~NM1*
PR*2*HP-ALABAMA-MEDICAID*****PI*752548221~HL*2*1*21*1~NM1*1P*2*CLASSIC OPTICAL
LABS*****XX*1234567890~REF*1D*123456~HL*3*2*22*0~TRN*1*113460000L*9-HP-
ALXIX*ELIGIBILITY
AUTHORIZATION~NM1*IL*1*LASTNAME*FIRSTNAME*M***MI*012345678901~REF*F6*0001112222
A~N4*DORA*AL*350624801~DMG*D8*19000101*F~DTP*472*RD8*20101231-
20101231~DTP*102*D8*20070113~EB*1*IND*30*MC*CNTY=64 AID-CAT=R3 Full Medicaid with QMB
Plus~DTP*307*RD8*20100101-20101231~EB*R*IND*30*MA*BUY-IN PART
A~DTP*307*RD8*20020401-22991231~EB*R*IND*30*MB*BUY-IN PART B~DTP*307*RD8*20020401-
22991231~EB*R*IND*30*OT*BUY-IN PART D~DTP*307*RD8*20071001-
20501231~EB*D*IND**MC*MAT WVR REGION=05~DTP*307*RD8*20020601-
20491231~LS*2120~NM1*1P*2*ALABAMA MATERNITY
INC~PER*IC**TE*2055587405~LE*2120~EB*F*IND*48*MC*Paid INPT
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*50*MC*Paid Outpat
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*98*MC*Paid Physician Office
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*44*MC*Paid Home Health
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*13*MC*Paid Ambulatory
Surgery~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*76*MC*Paid Dialysis
Services~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Paid Eye
Frames~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AO*MC*Paid Eye
Lens~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AL*MC*Paid Eye
Exam~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Paid Eye
Fitting~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*48*MC*Pend INPT
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*50*MC*Pend Outpat
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*98*MC*Pend Physician Office
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*44*MC*Pend Home Health
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*13*MC*Pend Ambulatory
Surgery~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*76*MC*Pend Dialysis
Services~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Pend Eye
Frames~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AO*MC*Pend Eye
Lens~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AL*MC*Pend Eye
Exam~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Pend Eye
Fitting~HSD*VS*0~DTP*636*D8*20111212~SE*90*000001~GE*1*2~IEA*1*000000008~
0
```

B.3. PutFile Example

The following example includes the request to putFile.

```
POST /ALPortal/DesktopModules/iC_Portal_BatchTransfer/BatchUpload.aspx HTTP/1.1
Cookie: ASP.NET_SessionId=fzfd2255332kqv45xrusd345;
X-filename: 271_X12_BATCH.251555.ELIGRSP13_271.txt
X-checksum: c9e1fc18
X-cde_identification: 271_X12_BATCH
X-cde_industry: 005010X279A1
User-Agent: Java/1.4.2_10
Host: 10.7.200.159
Accept: text/html, image/gif, image/jpeg, *; q=.2, */*; q=.2
Proxy-Connection: keep-alive
Content-Type: application/x-www-form-urlencoded
Content-Length: 2580
ISA*00*          *00*          *ZZ*752548221      *ZZ*200000390
*111212*1200*^*00501*000000008*0*P*:~GS*HB*752548221*200000390*20111212*120014*2*X*005010
X279A1~ST*271*000001*005010X279A1~BHT*0022*11*113451240*20111212*1200~HL*1**20*1~NM1*
PR*2*HP-ALABAMA-MEDICAID*****PI*752548221~HL*2*1*21*1~NM1*1P*2*CLASSIC OPTICAL
LABS*****XX*1234567890~REF*1D*123456~HL*3*2*22*0~TRN*1*113460000L*9-HP-
ALXIX*ELIGIBILITY
AUTHORIZATION~NM1*IL*1*LASTNAME*FIRSTNAME*M***MI*012345678901~REF*F6*0001112222
A~N4*DORA*AL*350624801~DMG*D8*19000101*F~DTP*472*RD8*20101231-
20101231~DTP*102*D8*20070113~EB*1*IND*30*MC*CNTY=64 AID-CAT=R3 Full Medicaid with QMB
Plus~DTP*307*RD8*20100101-20101231~EB*R*IND*30*MA*BUY-IN PART
A~DTP*307*RD8*20020401-22991231~EB*R*IND*30*MB*BUY-IN PART B~DTP*307*RD8*20020401-
22991231~EB*R*IND*30*OT*BUY-IN PART D~DTP*307*RD8*20071001-
20501231~EB*D*IND**MC*MAT WVR REGION=05~DTP*307*RD8*20020601-
20491231~LS*2120~NM1*1P*2*ALABAMA MATERNITY
INC~PER*IC**TE*2055587405~LE*2120~EB*F*IND*48*MC*Paid INPT
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*50*MC*Paid Outpat
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*98*MC*Paid Physician Office
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*44*MC*Paid Home Health
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*13*MC*Paid Ambulatory
Surgery~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*76*MC*Paid Dialysis
Services~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Paid Eye
Frames~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AO*MC*Paid Eye
Lens~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AL*MC*Paid Eye
Exam~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Paid Eye
Fitting~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*48*MC*Pend INPT
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*50*MC*Pend Outpat
Days~HSD*DY*0~DTP*636*D8*20111212~EB*F*IND*98*MC*Pend Physician Office
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*44*MC*Pend Home Health
Visits~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*13*MC*Pend Ambulatory
Surgery~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*76*MC*Pend Dialysis
Services~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Pend Eye
Frames~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AO*MC*Pend Eye
Lens~HSD*FL*0~DTP*636*D8*20111212~EB*F*IND*AL*MC*Pend Eye
Exam~HSD*VS*0~DTP*636*D8*20111212~EB*F*IND*AM*MC*Pend Eye
Fitting~HSD*VS*0~DTP*636*D8*20111212~SE*90*000001~GE*1*2~IEA*1*000000008~
```

The following example includes the response to the above putFile example.

```
HTTP/1.1 200 OK
Server: Microsoft-IIS/5.1
Date: Fri, 23 Feb 2007 01:55:38 GMT
X-Powered-By: ASP.NET
X-AspNet-Version: 2.0.50727
Set-Cookie: iCWindowID=0; path=/; HttpOnly
Set-Cookie: iCSessionWNDS=1; path=/; HttpOnly
Cache-Control: private
Content-Type: text/xml
Content-Length: 369
<?xml version="1.0" encoding="utf-8"?><responses><response requesttype="putFile"
completedsuccessfully="true"><messages /><content><batch batch_id="555" /></content><request
requesttype="putFile"><file filename="271_X12_BATCH.251555.ELIGRSP13_271.txt" checksum="c9e1fc18"
cde_identification="271_X12_BATCH" cde_industry="005010X279A1"sak_transaction_type=""
/></request></response></responses>
```

Appendix C XML Responses

This section shows the entire XML response for all transactions. The XML structure of all responses is described in the table below:

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/responses		1	
/responses/response		1 or more per parent	
/responses/response/@requesttype	"login", "listTransactionTypes" , "listFiles", "getFile", "putFile"		
/responses/response/@completedsuccessfully	"true" or "false"		"True" indicates the requested transaction succeeded. "False" indicates the requested transaction failed. All requests that return a value of "false" are guaranteed to have at least one element for /responses/response[completedsuccessfully="false"] /messages/ error
/responses/response/messages		0 or 1 per parent	
/responses/response/messages/error	Refer to the error messages table in Appendix C.	0 or more per parent	
/responses/response/messages/error/@code	Refer to the error messages table in Appendix C.		

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/responses/response/messages/error/@number	Refer to the error messages table in Appendix C.		
/responses/response/messages/error/@message	Refer to the error messages table in Appendix C.		
/responses/response/messages/error/detail		0 or more per parent	
/responses/response/messages/error/detail/text()	Free form text that provides more detail about the nature of the failure.	1 or more per parent	
/responses/response/messages/information		0 or more per parent	
/responses/response/messages/information/@code	Refer to the error messages table in Appendix C.		
/responses/response/messages/information/@number	Refer to the error messages table in Appendix C.		
/responses/response/messages/information/@message	Refer to the error messages table in Appendix C.		
/responses/response/content		1 per parent	Will contain any response content populated by the specific transaction request.
/responses/response[@requesttype="login"]/content/provider		1 per parent	
/responses/response[@requesttype="login"]/content/provider@provider	The Medicaid ID of the current provider.		
/responses/response[@requesttype="login"]/content/provider@sakwebparent	The numeric SAK for the selected provider.		
/responses/response[@requesttype="login"]/content/session		1 per parent	
/responses/response[@requesttype="login"]/content/session/@cookieheadervalue	A string that can be appended to the HTTP request header's cookie value to set the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.
/responses/response[@requesttype="login"]/content/session/@cookiename	The name of the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.
/responses/response[@requesttype="login"]/content/session/@cookievalue	The value for the session tracking cookie.		This value is only provided here for convenience. Therefore, it is not necessary.
/responses/response[@requesttype="listTransactionTypes"]/content/list		1 per parent	

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype		0 or more per parent	
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@cde_identification	The unique code value that identifies the transaction type.		
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@cde_industry	Identifies the HIPAA version.		
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@description	A long text description of the transaction type.		
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@map_tran	The ANSI transaction that the transaction maps to. This may be an empty string.		
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@sak_transaction_type	The unique SAK that identifies that transaction type.		
/responses/response[@requesttype="listTransactionTypes"]/content/list/ttype/@shortname	A short text description of the transaction. These values are not unique.		
/responses/response[@requesttype="listfiles"]/content/files		1 per parent	
/responses/response[@requesttype="listfiles"]/content/files/file		0 or more per parent	This entire element can be duplicated in the getFile request rather than creating a new element for the request.
/responses/response[@requesttype="listfiles"]/content/files/file/@cde_identification	The unique code that identifies the file type. This will match one of the elements returned by the listTransactionTypes request.		
/responses/response[@requesttype="listfiles"]/content/files/file/@cde_industry	Identifies the HIPAA version.		
/responses/response[@requesttype="listfiles"]/content/files/file/@sak_download	The SAK that uniquely identifies this file.		This value must be used in the getFile request.
/responses/response[@requesttype="getFile"]/content		0 or 1 per parent	If the request to getFile fails, the Content-Type of the response will be "text/xml" and this element will be present. If the request to getFile succeeds, the Content-Type will not be

Xpath http://www.w3.org/TR/xpath#path-abbrev	Value	Occurrences	Comments
			"text/xml" and the body of the response will contain the contents of the file.
/responses/response[@requesttype="putFile"]/content		1 per parent	
/responses/response[@requesttype="putFile"]/content/batch		1 per parent	
/responses/response[@requesttype="putFile"]/content/batch/@batch_id	The SAK for the file uploaded		This will be assigned after a successful transmission, but it may also be present for a failed transmission.
/responses/response/request		1 per parent	This will match the request submitted – in the case of putFile transaction a request element will be generated from the headers of the request.
/responses/response/request/@requesttype	"login", "listTransactionTypes" , "listFiles", "getFile", "putFile"		

Appendix D Messages

This section contains a list of all possible messages generated by a request. Please contact the EMC Helpdesk, as noted in Section 1, for additional assistance regarding any of the error messages listed below.

The error message codes and descriptions are listed in the table below.

Type	Message #	Code	Message	requestType	Detail
error	201	SERVER_FAILED	The server had an unexpected error.	Login, listTransaction Types, listFiles, getFile, putFile	Test node containing a failure message.
Error	202	NOT_AUTHENTICATED	The user has not been authenticated through the login process or the user's session has timed out. Please perform the login again.	Login, listTransaction Types, listFiles, getFile, putFile	
error	203	USER_NOT_AUTHORIZED	The logged in user has not been authorized by the selected provider to perform the requested action. Please contact the provider to get the appropriate authority or select a different provider.	listTransaction Types, listFiles, getFile, putFile	A text node containing the user name, the provider number and the required role.
Error	300	PASSWORD_EXPIRED	The password has expired. Change the password by logging in to the portal or by sending a new password with the login request.	Login	Please note that all passwords are case sensitive.

Type	Message #	Code	Message	requestType	Detail
Error	301	ACCOUNT_DISABLED	This account has been disabled.	Login	
error	302	ACCOUNT_LOCKED	This account has been temporarily locked out due to excessive failed login attempts. Please try again later.	Login	
error	303	BAD_LOGIN	Incorrect user ID or password. Please try again.	Login	Text node containing the status.
Information	304	PASSWORD_CHANGE_SUCCEEDED	The password has been successfully changed. Login continued using the new password.	Login	Please note that all passwords are case sensitive.
Error	305	PASSWORD_CHANGE_FAILED	The password could not be changed. Login will not be attempted.	Login	Please note that all passwords are case sensitive.
Error	306	CHANGE_PROVIDER_FAILED	The user was unable to select the passed in provider.	Login	Text node containing a more specific failure message.
Error	307	PROVIDER_NOT_FOUND	The user was unable to select the passed in provider because the provider ID could not be found.	Login	
error	308	PROVDER_NOT_VALID_FOR_USER	The provider ID request is not valid for the logged in user.	Login	

Type	Message #	Code	Message	requestType	Detail
error	309	NEW_PASSWORD_NOT_ACCEPTED	The new password could not be accepted.	Login	Text node containing a failure message.
Error	310	LOGIN_FAILURE	The server failed while attempting to log in.	login	Text node containing a failure message.
Error	311	INVALID_LOGIN_REQUEST	The login request was not valid. The request must be valid xml and must have exactly one element named user. The user element must have an attributed named name and an attribute named password.	Login	
error	312	INVALID_FILE_REQUEST	The request to get a file is invalid. The sak_download for the file could not be determined.	getFile	
error	313	FILE_RECORD_NOT_FOUND	The requested download file was not found. Check the sak_download value and try again.	getFile	
error	314	FILE_NOT_OWNED_BY_PROVIDER	The currently selected provider does not own the requested file.	getFile	

Type	Message #	Code	Message	requestType	Detail
error	315	INVALID_PUTFILE_REQUEST	The putFile request is not valid. The putFile request must contain the following headers: X-filename, X cde_transacti o n, X-cde_industry, X-checksum.	putFile	
error	316	INVALID_TRADING_PARTNER_ID	The trading partner associated with the selected provider is not valid.	putFile	
information	317	CHECKSUM_NOT_MATCHED	The checksum specified in the putFile request did not match the checksum calculated while receiving the file. The file will be forwarded for processing; however, it may fail processing due to an invalid checksum validation.	putFile	Text node containing the checksum value received from the request and the checksum value calculated during the file transfer.
Error	318	FILE_EXCEEDS_MAXIMUM_SIZE	Upload of this zip archive has failed. The file you are sending is larger than the maximum uploadable file size of 16MB or file	putFile	

Type	Message #	Code	Message	requestType	Detail
			size could not be determined.		
error	319	INVALID_ZIP_ARCHIVE	Upload of this file has failed. The zip archive is either corrupt or is an invalid format.	putFile	
error	320	ZIP_ARCHIVE_EMPTY	Upload of this file has failed. The zip archive contains no file. Zip archives must contain only one file.	putFile	
error	321	ZIP_ARCHIVE_TOO_MANY_FILES	Upload of this file has failed. The zip archive contains # files. Zip archives must contain only one file.	putFile	

Appendix E Sample Program

This sample demonstrates an entire sequence of transactions. It can be used as a starting point for automating the file transfer process.

Sample Java program ("com.eds.hcg.alxix.transfers.BatchTransfer.java"):

```
package com.eds.hcg.alxix.transfers;

import java.io.BufferedWriter;
import java.io.File;
import java.io.FileFilter;
import java.io.FileReader;
import java.io.FileWriter;
import java.io.IOException;
import java.io.InputStream;
import java.io.InputStreamReader;
import java.io.OutputStreamWriter;
import java.io.PrintWriter;
import java.io.Reader;
import java.io.Writer;
import java.net.Authenticator;
import java.net.HttpURLConnection;
import java.net.MalformedURLException;
import java.net.PasswordAuthentication;
import java.net.URL;
import java.net.URLConnection;
import java.text.ParseException;
import java.text.SimpleDateFormat;
import java.util.Calendar;
import java.util.Date;
import java.util.zip.CRC32;
import java.util.zip.Checksum;

import javax.xml.parsers.DocumentBuilderFactory;
import javax.xml.parsers.FactoryConfigurationError;
import javax.xml.parsers.ParserConfigurationException;
import javax.xml.transform.OutputKeys;
import javax.xml.transform.Transformer;
import javax.xml.transform.TransformerConfigurationException;
import javax.xml.transform.TransformerException;
import javax.xml.transform.TransformerFactory;
import javax.xml.transform.dom.DOMSource;
import javax.xml.transform.stream.StreamResult;
import org.w3c.dom.Document;
import org.w3c.dom.Element;
import org.w3c.dom.Node;
import org.w3c.dom.NodeList;
import org.xml.sax.SAXException;

/**
 * This class is used for file transfers into and out of interChange. It can be
 * started from the command line or accessed as an api by other programs. Refer
 * to the {@link #main(String[])} method for starting information on running
 * this from the command line.
 *
 * @author EDS
 *
 */
public class BatchTransfer {

  /**
   * This is the format of dates received from the batch transaction process.
   */
  public static SimpleDateFormat formatter = new SimpleDateFormat(
      "MM/dd/yyyy HH:mm:ss Z");

  /**
   * This Transformer will be used to format output for transmission to other
   * systems.
   */
  private static Transformer transmitTransformer = null;

  /**
   * The url suffix for general batch transactions
   */
  public static final String URL_SUFFIX_BATCH =
"/DesktopModules/iC_Portal_BatchTransfer/BatchTransactions.aspx";

  /**
   * The url suffix for uploading a file.
   */
  public static final String URL_SUFFIX_UPLOADFILE =
"/DesktopModules/iC_Portal_BatchTransfer/BatchUpload.aspx";

  /**
   * This will be the Transformer used to display xml nodes for visual output.
```

```
 */
private static Transformer visualTransformer = null;

/**
 * This method will create a request element to perform a transaction list.
 *
 * @param requestParent
 *          The parent Node of that the request xml element will be appended
 *          to.
 * @throws ParserConfigurationException
 *           Thrown if the XML parser cannot be used.
 */
public static void createFileListRequest(Node requestParent)
    throws ParserConfigurationException {

  // set up the login xml.
  Document doc = null;

  if (requestParent != null) {
    if (requestParent instanceof Document) {
      doc = (Document)requestParent;
    } else {
      doc = requestParent.getOwnerDocument();
    }
  }

  Element request = (Element)requestParent.appendChild(doc
      .createElement("request"));
  request.setAttribute("requesttype", "listFiles");
}

/**
 * This method will create the request element for a login request.
 *
 * @param requestParent
 *          The parent Node of that the request xml element will be appended
 *          to.
 * @param file
 *          The file element that needs to be added to the request.
 * @throws ParserConfigurationException
 *           Thrown if the XML parser cannot be used.
 */
public static void createGetFileRequest(Node requestParent, Node file)
    throws ParserConfigurationException {

  // set up the login xml.
  Document doc = null;

  if (requestParent != null) {
    if (requestParent instanceof Document) {
      doc = (Document)requestParent;
    } else {
      doc = requestParent.getOwnerDocument();
    }
  }

  Element request = (Element)requestParent.appendChild(doc
      .createElement("request"));
  request.setAttribute("requesttype", "getFile");

  request.appendChild(request.getOwnerDocument().importNode(file, true));
}

/**
 * This method will create the request element for a login request.
 *
 * @param requestParent
 *          The parent Node of that the request xml element will be appended
 *          to.
 * @param userId
 *          The userid to use for the login process.
 * @param password
 *          The password to user for the login process.
 * @param newPassword
 *          The new password to change the password to. This value should be
 *          null or empty if the password is not being changed.
 * @param providerId
 *          The provider id to select for all actions after login. This value
 *          should be null or empty if the provider should not be selected.
 * @param sakWebUser
```

```
 *          The SAK for the provider to select. This value should be null or
 *          empty if the provider is being selected by provider id or not
 *          being selected.
 * @throws ParserConfigurationException
 *           Thrown if the XML parser cannot be used.
 */
public static void createLoginRequest(Node requestParent, String userId,
    String password, String newPassword, String providerId, String sakWebUser)
    throws ParserConfigurationException {

  // set up the login xml.
  Document doc = null;

  if (requestParent != null) {
    if (requestParent instanceof Document) {
      doc = (Document)requestParent;
    } else {
      doc = requestParent.getOwnerDocument();
    }
  }

  Element element = null;
  Element request = (Element)requestParent.appendChild(doc
      .createElement("request"));
  request.setAttribute("requesttype", "login");

  element = (Element)request.appendChild(request.getOwnerDocument()
      .createElement("user"));
  element.setAttribute("name", userId);
  element.setAttribute("password", password);

  if ((newPassword != null) && (newPassword.length() > 0)) {
    element.setAttribute("newpassword", newPassword);
  }

  if ((providerId != null) && (providerId.length() > 0)) {
    element.setAttribute("provider", providerId);
  } else { // only attempt sakWebUser if providerId is NOT set.
    if ((sakWebUser != null) && (sakWebUser.length() > 0)) {
      element.setAttribute("sakwebuser", sakWebUser);
    }
  }
}

/**
 * This method will create a request element to perform a transaction list.
 *
 * @param requestParent
 *          The parent Node of that the request xml element will be appended
 *          to.
 * @throws ParserConfigurationException
 *           Thrown if the XML parser cannot be used.
 */
public static void createTransactionListRequest(Node requestParent)
    throws ParserConfigurationException {

  // set up the login xml.
  Document doc = null;

  if (requestParent != null) {
    if (requestParent instanceof Document) {
      doc = (Document)requestParent;
    } else {
      doc = requestParent.getOwnerDocument();
    }
  }

  Element request = (Element)requestParent.appendChild(doc
      .createElement("request"));
  request.setAttribute("requesttype", "listTransactionTypes");
}

/**
 * This method will send the passed in transaction to the server using the
 * connection passed in.
 *
 * @param connection
 *          A URLConnection that has not been opened yet.
 * @param request
 *          The XML Request. This value may be null in the case of a send file
```

```
 *          request.
 * @param response
 *          The XML to receive the response.
 * @param responseFile
 *          The Writer that will write out the file received. This should be
 *          null for every request except the getFile request.
 * @param checksum
 *          The Checksum to be calculated as the file is received. This should
 *          be null for every request except the getFile request.
 * @param requestFile
 *          The Reader from which the file contents will be read.
 * @throws IOException
 *           Thrown if there is an error sending the request or receiving the
 *           response or writing out the file.
 * @throws ParserConfigurationException
 *           Thrown if the request cannot be transformed for sending.
 * @throws SAXException
 *           Thrown if there is a problem with the request.
 * @throws TransformerException
 *           Thrown if there is a problem with the request.
 */
public static void getBatchResponse(URLConnection connection, Node request,
    Node response, Writer responseFile, Checksum checksum, Reader requestFile)
    throws IOException, ParserConfigurationException, SAXException,
    TransformerException {

  Node transResponse = null;
  HttpURLConnection http = null;
  Document responseDoc = null;
  if (response instanceof Document) {
    responseDoc = (Document)response;
  } else {
    responseDoc = response.getOwnerDocument();
  }

  connection.setAllowUserInteraction(true);
  connection.setDoInput(true);
  connection.setDoOutput(true);

  if (connection instanceof HttpURLConnection) {
    http = (HttpURLConnection)connection;
    http.setRequestMethod("POST");

    http.connect();

    if (requestFile != null) {
      Writer osw = null;
      try {
        osw = new OutputStreamWriter(http.getOutputStream());
        BatchTransfer.readToWriter(requestFile, osw, 4096, checksum);
      } finally {
        if (osw != null) {
          try {
            osw.flush();
          } catch (Throwable th) {
            // do nothing
          }

          try {
            osw.close();
          } catch (Throwable th) {
            // do nothing
          }
        }
      }
    } else { // not sending a file
      BatchTransfer.getTransmitTransformer().transform(
          new DOMSource(request), new StreamResult(http.getOutputStream()));
    }

    if (http.getContentType().equalsIgnoreCase("text/xml")) {
      InputStream is = http.getInputStream();
      // jvm 1.4 couldn't handle UTF-8 control characters.
      // a better check would be to also make sure that the stream has UTF-8
      // control characters, but this will work for now.
      if (System.getProperty("java.specification.version").equals("1.4")) {
        is.skip(3L);
      }
      transResponse = DocumentBuilderFactory.newInstance()
          .newDocumentBuilder().parse(is);
```

```
        response.appendChild(responseDoc.importNode(((Document)transResponse)
            .getDocumentElement(), true));
      } else if (responseFile != null) { // not an xml response, so check if
        // expecting a file.
        InputStreamReader isr = new InputStreamReader(http.getInputStream());
        BatchTransfer.readToWriter(isr, responseFile, 4096, checksum);
      }
    }
  }

  /**
   * This method will return the first element found that has the same name as
   * the elementName value passed in, has an attribute with the same name as the
   * attributeName passed in and has a value for that attribute that matches the
   * attributeValue passed in.
   *
   * @param parentNode
   *          The XML Node that is the desired element or a parent of the
   *          desired element.
   * @param elementName
   *          The element name to look for.
   * @param attributeName
   *          The attribute name to look for. This value may be null if
   *          attributes do not matter.
   * @param attributeValue
   *          The value to look for. This value may be null if the value is not
   *          important.
   * @return An Element that matches the passed in criteria.
   */
  protected static Element getElementWithAttributeValue(Node parentNode,
      String elementName, String attributeName, String attributeValue) {

    Element resultElement = null;
    NodeList elements = null;
    Element currentElement = null;

    if ((parentNode != null) && (elementName != null)) {
      if (parentNode instanceof Document) {
        elements = ((Document)parentNode).getElementsByTagName(elementName);
      } else if (parentNode instanceof Element) {
        if ((((Element)parentNode).getNodeName() != null)
            && ((Element)parentNode).getNodeName().equals(elementName)
            && ((attributeName == null) || ((currentElement
                .hasAttribute(attributeName)) && ((attributeValue == null) || attributeValue
                .equals(currentElement.getAttribute(attributeName)))))) {
          resultElement = (Element)parentNode;
        } else {
          elements = ((Element)parentNode).getElementsByTagName(elementName);
        }
      }
    }

    if (elements != null) {
      int count = 0;

      while ((resultElement == null) && (count < elements.getLength())) {
        currentElement = (Element)elements.item(count);
        if (currentElement.getNodeName().equals(elementName)) {
          if ((attributeName == null)
              || ((currentElement.hasAttribute(attributeName)) && ((attributeValue == null) ||
attributeValue
                  .equals(currentElement.getAttribute(attributeName))))) {

            resultElement = currentElement;
          }
        }
        count++;
      }
    }

    return resultElement;
  }

  /**
   * This method will set up the Transformer for sending xml to the server.
   *
   * @return the transmitTransformer
   */
  protected static Transformer getTransmitTransformer()
```

```
      throws TransformerConfigurationException {

    if (transmitTransformer == null) {
      transmitTransformer = TransformerFactory.newInstance().newTransformer();
      transmitTransformer.setOutputProperty(OutputKeys.METHOD, "xml");
      transmitTransformer.setOutputProperty(OutputKeys.INDENT, "no");
      transmitTransformer.setOutputProperty(OutputKeys.ENCODING, "UTF-8");
      transmitTransformer.setOutputProperty(OutputKeys.MEDIA_TYPE, "text/xml");
    }

    return transmitTransformer;
  }

  /**
   * This method will set up the Transformer for displaying the xml.
   *
   * @return the visualTransformer
   */
  protected static Transformer getVisualTransformer()
      throws TransformerConfigurationException {

    if (visualTransformer == null) {
      visualTransformer = TransformerFactory.newInstance().newTransformer();
      visualTransformer.setOutputProperty(OutputKeys.METHOD, "xml");
      visualTransformer.setOutputProperty(OutputKeys.OMIT_XML_DECLARATION,
          "yes");
      visualTransformer.setOutputProperty(OutputKeys.INDENT, "yes");
      visualTransformer.setOutputProperty(OutputKeys.MEDIA_TYPE, "text/xml");
    }

    return visualTransformer;
  }

  /**
   * This is the entry point for this program from the command line.
   *
   *
   * @param args
   *          This program requires 6 parameters:
   *          <ol>
   *          <li>the base url for accessing the server.</li>
   *          <li>the userid to log in with.</li>
   *          <li>the password to log in with.</li>
   *          <li>the new password to change to.</li>
   *          <li>the provider id to use for all actions.</li>
   *          <li>the SAK of the provider to use for all actions
   *          <li>
   *          <li>the local directory for saving downloaded files. Use an empty
   *          string if downloading is not desired.</li>
   *          <li>the date that should be used for finding files to download.
   *          Only files with dte_downloaded values after this date will be
   *          downloaded.</li>
   *          <li>the local directory for finding files to be uploaded. Use an
   *          empty string if uploading is not desired.</li>
   *          <li>a name to prefix to the filename when a file is successfully
   *          uploaded.</li>
   *          </ol>
   *
   */
  public static void main(String[] args) {
    BatchTransfer thisApp = new BatchTransfer();

    String urlPrefix = null;
    String userId = null;
    String password = null;
    String newPassword = null;
    String providerId = null;
    String sakWebUser = null;
    String downloadDir = null;
    String latestDownloadDate = null;
    String uploadDir = null;
    String archivePrefix = null;
    String proxyHost = null;
    String proxyPort = null;
    String proxyUser = null;
    String proxyPassword = null;

    if (args.length >= 3) {
      int lastArg = -1;
```

```
      urlPrefix = args[++lastArg];
      userId = args[++lastArg];
      password = args[++lastArg];

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        newPassword = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        providerId = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        sakWebUser = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        downloadDir = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        latestDownloadDate = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        uploadDir = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        archivePrefix = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        proxyHost = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        proxyPort = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        proxyUser = args[lastArg];
      }

      if ((args.length > ++lastArg) && (args[lastArg].length() > 0)
          && (!args[lastArg].equalsIgnoreCase("null"))) {

        proxyPassword = args[lastArg];
      }

      if (proxyHost != null) {
        if (urlPrefix.toLowerCase().startsWith("https")) {
          BatchTransfer.setupProxy(null, null, proxyHost, proxyPort, proxyUser,
              proxyPassword);
        } else {
          BatchTransfer.setupProxy(proxyHost, proxyPort, null, null, proxyUser,
              proxyPassword);
        }
      }
```

```
        thisApp.doEverything(urlPrefix, userId, password, newPassword,
            providerId, sakWebUser, downloadDir, latestDownloadDate, uploadDir,
            archivePrefix);
    } else {
        System.out.println("This application accepts 14 parameters:");
        System.out.println("The prefix portion of the URL to access the system.");
        System.out
            .println("The userid to use for logging in. All userids should be upper case.");
        System.out.println("The password assigned for the userid.");
        System.out
            .println("The password to change the user's password to. (null or empty quotes if not
changing the password)");
        System.out
            .println("The provider id of the provider to act as. (null or empty quotes if not
changing the password)");
        System.out
            .println("The sak for the provider to act as. (null or empty quotes if not changing the
password)");
        System.out
            .println("The directory to which available files should be downloaded.");
        System.out
            .print("The date used to find files for downloading. The format is ");
        System.out.print(BatchTransfer.formatter.toPattern());
        System.out.println(".");
        System.out
            .println("The directory in which files to be uploaded for the selected provider can be
found.");
        System.out
            .println("A name that should be prepended to files that have been successfully
uploaded.");
        System.out.println("The proxy server host.");
        System.out.println("The proxy server port.");
        System.out.println("The proxy server userid.");
        System.out.println("The proxy server password.");
        System.out.println();
        System.out.println();
        System.out.println("example:");
        System.out
            .print("java com.eds.hcg.alxix.transfers.BatchTransfer
\"http://medicaid.gov/Portal\"");
        System.out.print(" \"WEBUSER\"");
        System.out.print(" \"MyPassword77\"");
        System.out.print(" \"MyNewPasssowrd88\"");
        System.out.print(" \"123456789A\"");
        System.out.print(" \"\"");
        System.out.print(" \"D:\\DownloadedFiles\"");
        System.out.print(" \"");
        System.out.print(BatchTransfer.formatter.format(new Date()));
        System.out.print("\"");
        System.out.print(" \"D:\\FilesToUpload\"");
        System.out.print(" \"uploaded20070221.\"");
        System.out.print(" \"myproxy.mycompany.com\"");
        System.out.print(" \"8080\"");
        System.out.print(" \"myProxyUserid\"");
        System.out.print(" \"myProxyPassword\"");
    }
  }

  /**
   * This method will download all of the available files into the download
   * directory.
   *
   * @param requestTxnSite
   *          The url to send the request to.
   * @param downloadDirectory
   *          The directory that files should be downloaded into.
   * @param responseElement
   *          The element that responses will be appended to. Only files that
   *          fail retrieval will have responses.
   * @param loginResponse
   *          The response element from the login request.
   * @param availableFiles
   *          The response element from the getFileList request.
   * @param downloadedAfterDate
   *          The value to compare to the dte_downloaded attribe. Only files
   *          dated after this date will be downloaded. Files dated prior to the
   *          earliest acceptable date will also be downloaded. If this value is
   *          null or empty string, the current date will be used.
   * @throws FactoryConfigurationError
   *           Thrown when there is a problem creating XML documents.
```

```
 * @throws ParserConfigurationException
 *          Thrown when the parser used to create the request can't be
 *          configured.
 * @throws MalformedURLException
 *          Thrown when the url is invalid.
 * @throws IOException
 *          Thrown when the request can't be sent or the response can't be
 *          read.
 * @throws SAXException
 *          Thrown when there is a problem sending interpreting the xml.
 * @throws TransformerException
 *          Thrown when there is a problem interpreting the xml.
 * @throws TransformerConfigurationException
 *          Thrown when the xml transformer cannot be created properly.
 */
public static void performDownload(String requestTxnSite,
    String downloadDirectory, Element responseElement, Element loginResponse,
    Element availableFiles, String downloadedAfterDate)
    throws ParserConfigurationException, FactoryConfigurationError,
    IOException, MalformedURLException, SAXException, TransformerException,
    TransformerConfigurationException {

  Element requests;
  URL transactionUrl;
  URLConnection connection;
  Date downloaded = null;

  Calendar cal = Calendar.getInstance();
  cal.set(2007, Calendar.JANUARY, 1, 0, 0, 0);

  Date earliestValidDate = cal.getTime();
  Date latestValidDate = null;

  // check for specified compare date.
  if ((downloadedAfterDate != null) && (downloadedAfterDate.length() >= 19)) {
    try {
      latestValidDate = formatter.parse(downloadedAfterDate);
    } catch (ParseException e) {
      // ignore it.
    }
  }

  // set the compare date to the current time if it hasn't been set
  if (latestValidDate == null) {
    cal.setTimeInMillis(System.currentTimeMillis());
    latestValidDate = cal.getTime();
  }

  File newFileName = null;

  if ((downloadDirectory != null) && (downloadDirectory.length() > 0)
      && (availableFiles != null) && availableFiles.hasChildNodes()) {

    NodeList files = availableFiles.getElementsByTagName("file");
    Checksum checksum = new CRC32();
    Element currentFile = null;
    File sendThisFile = null;
    Writer fw = null;
    String expectedChecksum = null;
    StringBuffer fileName = new StringBuffer();
    Element downloadResponse = DocumentBuilderFactory.newInstance()
        .newDocumentBuilder().newDocument().createElement("myresponses");

    sendThisFile = new File(downloadDirectory);
    if (!sendThisFile.exists()) {
      sendThisFile.mkdirs();
    }

    for (int fileCount = 0; fileCount < files.getLength(); fileCount++) {
      currentFile = (Element)files.item(fileCount);

      fileName.setLength(0);
      fileName.append(downloadDirectory).append(File.separatorChar).append(
          currentFile.getAttribute("cde_identification")).append(".").append(
          currentFile.getAttribute("sak_download")).append(".").append(
          currentFile.getAttribute("filename"));

      expectedChecksum = currentFile.getAttribute("checksum");
      if (expectedChecksum != null) {
        expectedChecksum = expectedChecksum.trim().toLowerCase();
```

```
        }

        sendThisFile = new File(fileName.toString());

        // get date downloaded.
        if (currentFile.hasAttribute("dte_downloaded")) {
          try {
            downloaded = formatter.parse(currentFile
                .getAttribute("dte_downloaded"));
          } catch (ParseException pe) {
            downloaded = null;
          }
        } else {
          downloaded = null;
        }

        if (!sendThisFile.exists()
            && ((downloaded == null) || downloaded.after(latestValidDate) || downloaded
                .before(earliestValidDate))) {
          try {
            fw = new BufferedWriter(new FileWriter(sendThisFile));
            requests = DocumentBuilderFactory.newInstance()
                .newDocumentBuilder().newDocument().createElement("requests");

            createGetFileRequest(requests, currentFile);

            transactionUrl = new URL(requestTxnSite);

            connection = transactionUrl.openConnection();
            connection.addRequestProperty("Cookie", BatchTransfer
                .getElementWithAttributeValue(loginResponse, "session", null,
                    null).getAttribute("cookieheadervalue"));

            // set up connection and response holder.
            BatchTransfer.getBatchResponse(connection, requests,
                downloadResponse, fw, checksum, null);
          } finally {
            if (fw != null) {
              try {
                fw.flush();
              } catch (Throwable th) {
                // ignore it.
              }

              try {
                fw.close();
              } catch (Throwable th) {
                // ignore it.
              }

              fw = null;
              if (downloadResponse.hasChildNodes()) {

                System.err.println();
                getVisualTransformer().transform(new DOMSource(currentFile),
                    new StreamResult(System.err));
                System.err.println(sendThisFile.getName()
                    + " failed download attempt.");

                sendThisFile.delete();

                while (downloadResponse.hasChildNodes()) {
                  responseElement.appendChild(responseElement
                      .getOwnerDocument().importNode(
                          downloadResponse.getFirstChild().cloneNode(true),
                          true));

                  getVisualTransformer().transform(
                      new DOMSource(downloadResponse.getFirstChild()),
                      new StreamResult(System.err));

                  downloadResponse
                      .removeChild(downloadResponse.getFirstChild());
                }

              } else if ((expectedChecksum != null)
                  && (expectedChecksum.length() > 0)
                  && (!Long.toHexString(checksum.getValue()).trim()
                      .toLowerCase().equalsIgnoreCase(expectedChecksum))) {
```

```
                System.err.println();
                getVisualTransformer().transform(new DOMSource(currentFile),
                    new StreamResult(System.err));

                System.err.println(sendThisFile.getName()
                    + " failed checksum validation. Received: "
                    + Long.toHexString(checksum.getValue()).trim()
                        .toLowerCase() + " Expected: " + expectedChecksum);

                newFileName = new File(sendThisFile.getParent(),
                    "checksumerror.calc-"
                        + Long.toHexString(checksum.getValue()).trim()
                            .toLowerCase() + ".expc-" + expectedChecksum + "."
                        + sendThisFile.getName());
                sendThisFile.renameTo(newFileName);
              }
            }
          }
        } else { // file already exists
          if (sendThisFile.exists()) {
            System.err.println();
            getVisualTransformer().transform(new DOMSource(currentFile),
                new StreamResult(System.err));

            System.err.println(sendThisFile.getName()
                + " already exists and will not be downloaded again.");
          } else { // file doesn't exist but indicates it was already
            // downloaded
            System.out.println();
            getVisualTransformer().transform(new DOMSource(currentFile),
                new StreamResult(System.out));

            System.out
                .println(sendThisFile.getName()
                    + " has a downloaded time that indicates it was previously downloaded.");
          }
        }
      }

    }
  }

  /**
   * This method will perform send one request to login, get the list of
   * transaction types and get the list of available files for the selected
   * provider.
   *
   * @param requestTxnSite
   *          The url to send the request to.
   * @param userId
   *          The userid to use for the login process.
   * @param password
   *          The password to use for the login process.
   * @param newPassword
   *          The new password to change to.
   * @param providerId
   *          The providerID to act as.
   * @param sakWebUser
   *          The sakWebUser for the provider.
   * @param responseElement
   *          The XML Element to put the response into.
   * @param requests
   *          The XML Element to put the request into.
   * @throws ParserConfigurationException
   *           Thrown when the parser used to create the request can't be
   *           configured.
   * @throws MalformedURLException
   *           Thrown when the url is invalid.
   * @throws IOException
   *           Thrown when the request can't be sent or the response can't be
   *           read.
   * @throws SAXException
   *           Thrown when there is a problem sending interpreting the xml.
   * @throws TransformerException
   *           Thrown when there is a problem interpreting the xml.
   */
  public static void performLoginAndDataRequests(String requestTxnSite,
      String userId, String password, String newPassword, String providerId,
      String sakWebUser, Element responseElement, Element requests)
      throws ParserConfigurationException, MalformedURLException, IOException,
```

```
      SAXException, TransformerException {
    createLoginRequest(requests, userId, password, newPassword, providerId,
        sakWebUser);
    createTransactionListRequest(requests);
    createFileListRequest(requests);

    URL transactionUrl = new URL(requestTxnSite);

    URLConnection connection = transactionUrl.openConnection();

    BatchTransfer.getBatchResponse(connection, requests, responseElement, null,
        null, null);
  }

  /**
   * This method will attempt to upload all of the files in the passed in
   * uploadDirectory that have filenames that start with a valid transaction
   * type.
   *
   * @param requestTxnSite
   *          The url to send the request to.
   * @param uploadDirectory
   *          The directory containing the files to be uploaded.
   * @param responseElement
   *          The element that responses will be put into.
   * @param loginResponse
   *          The response to the login request.
   * @param transactionTypes
   *          The response to the getTransactionTypes request.
   * @param archivePrefix
   *          The value to prefix the filename with when the upload succeeds.
   *          This value may be null if the file should not be renamed.
   * @throws ParserConfigurationException
   *           Thrown when the parser used to create the request can't be
   *           configured.
   * @throws MalformedURLException
   *           Thrown when the url is invalid.
   * @throws IOException
   *           Thrown when the request can't be sent or the response can't be
   *           read.
   * @throws SAXException
   *           Thrown when there is a problem sending interpreting the xml.
   * @throws TransformerException
   *           Thrown when there is a problem interpreting the xml.
   */
  public static void performUpload(String requestTxnSite,
      String uploadDirectory, Element responseElement, Element loginResponse,
      Element transactionTypes, String archivePrefix) throws IOException,
      MalformedURLException, ParserConfigurationException, SAXException,
      TransformerException {

    URL transactionUrl;
    URLConnection connection;
    if ((uploadDirectory != null) && (uploadDirectory.length() > 0)
        && (transactionTypes != null)) {

      File upDir = new File(uploadDirectory);
      File currentFile = null;
      File newFileName = null;
      File[] fileList = null;

      String cde_identification = null;
      String filename = null;
      String checksum = null;
      Checksum check = new CRC32();
      Reader fileContents = null;
      boolean transferred = false;

      if (upDir.isDirectory()) {

        // skip files that already start with the archive prefix.
        final String skipFilePrefix = archivePrefix;
        fileList = upDir.listFiles(new FileFilter() {

          public boolean accept(File pathname) {

            // only return true for files and if the skipFilePrefix is set the
            // filename can't start with that value.
            return (pathname.isFile() && ((skipFilePrefix == null)
                || (skipFilePrefix.length() <= 0) || (!pathname.getName()
```

```
                .toLowerCase().startsWith(skipFilePrefix.toLowerCase()))));
            }
        });

        Element downloadResponse = DocumentBuilderFactory.newInstance()
            .newDocumentBuilder().newDocument().createElement("myresponses");

        for (int fileCounter = 0; fileCounter < fileList.length; fileCounter++) {

          transferred = false;

          currentFile = fileList[fileCounter];

          filename = currentFile.getName();
          check.reset();
          if (filename.indexOf('.') > 0) {
            cde_identification = filename.substring(0, currentFile.getName()
                .indexOf('.'));
          } else {
            cde_identification = "";
          }

          // only transfer files that are valid transactions
          if ((cde_identification != null)
              && (cde_identification.length() > 0)
              && (BatchTransfer.getElementWithAttributeValue(transactionTypes,
                  "ttype", "cde_identification", cde_identification) != null)) {

            try {
              fileContents = new FileReader(currentFile);
              BatchTransfer.readToWriter(fileContents, null, 4096, check);

              checksum = Long.toHexString(check.getValue()).toLowerCase();

              fileContents.close();
              fileContents = new FileReader(currentFile);

              transactionUrl = new URL(requestTxnSite);

              connection = transactionUrl.openConnection();
              connection.addRequestProperty("Cookie", BatchTransfer
                  .getElementWithAttributeValue(loginResponse, "session", null,
                      null).getAttribute("cookieheadervalue"));

              connection.addRequestProperty("X-filename", filename);
              connection.addRequestProperty("X-checksum", checksum);
              connection.addRequestProperty("X-cde_identification",
                  cde_identification);

              check.reset();
              BatchTransfer.getBatchResponse(connection, null,
                  downloadResponse, null, check, fileContents);
            } finally {
              if (fileContents != null) {
                try {
                  fileContents.close();
                } catch (Throwable th) {
                  // do nothing
                }

                fileContents = null;
              }

              if (downloadResponse.hasChildNodes()) {
                transferred = "true".equalsIgnoreCase(BatchTransfer
                    .getElementWithAttributeValue(downloadResponse, "response",
                        null, null).getAttribute("completedsuccessfully"));

                while (downloadResponse.hasChildNodes()) {
                  responseElement.appendChild(responseElement
                      .getOwnerDocument().importNode(
                          downloadResponse.getFirstChild().cloneNode(true),
                          true));

                  if (!transferred) {
                    getVisualTransformer().transform(
                        new DOMSource(downloadResponse.getFirstChild()),
                        new StreamResult(System.err));
                  }
```

```
                    downloadResponse
                        .removeChild(downloadResponse.getFirstChild());
                  }
                }

                if (transferred
                    && (checksum != null)
                    && (checksum.length() > 0)
                    && (!Long.toHexString(check.getValue()).trim()
                        .equalsIgnoreCase(checksum))) {

                  transferred = false;

                  System.err.println();
                  System.err.println(currentFile.getName()
                      + " failed checksum validation. Received: "
                      + Long.toHexString(check.getValue()).trim().toLowerCase()
                      + " Expected: " + checksum);
                }

                // rename the file after successful upload.
                if (transferred && (archivePrefix != null)
                    && (archivePrefix.length() > 0)) {

                  newFileName = currentFile;
                  while (newFileName.exists()) {
                    newFileName = new File(currentFile.getParentFile(),
                        archivePrefix + newFileName.getName());
                  }
                  currentFile.renameTo(newFileName);
                }
              }
            }
          }
        }
      }
    }

  /**
   * This method will read the reader and write its contents to the writer.
   *
   * @param reader
   *          Any java.io.Reader that has content.
   * @param writer
   *          Any java.io.Writer that can be written to. This may be null if the
   *          desired effect is to only read the input stream.
   * @param bufferSize
   *          The size of the buffer for each read.
   * @param checksum
   *          An implementation of the {@link java.util.zip.Checksum} interface
   *          that will be updated with the values read by the reader. This may
   *          be null if a checksum is not needed.
   * @throws IOException
   *           Thrown when there is a problem reading or writing.
   */
  protected static long readToWriter(Reader reader, Writer writer,
      int bufferSize, Checksum checksum) throws IOException {

    long totalChars = -1;
    int usableBufferSize = 4096;
    if (bufferSize > 0) {
      usableBufferSize = bufferSize;
    }
    char[] buffer = new char[usableBufferSize];
    int charsRead = reader.read(buffer);
    while (charsRead >= 0) {
      if (checksum != null) {
        checksum.update(String.valueOf(buffer, 0, charsRead).getBytes(), 0,
            charsRead);
      }
      if (writer != null) {
        writer.write(buffer, 0, charsRead);
      }

      totalChars += charsRead;
      charsRead = reader.read(buffer);
    }

    return totalChars;
  }
```

```
/**
 * This method will set all http and https requests to use the specified proxy
 * and authenticate using the userid and password provided.
 *
 * @param httpHost
 *          The proxy host through which http requests should be sent. If this
 *          value is null or empty string, the proxy will not be changed for
 *          https requests.
 * @param httpPort
 *          The port through which http requests should be proxied. If this
 *          value is null, no attempt will be made to set it.
 * @param httpsHost
 *          The proxy host through which https requests should be sent. If
 *          this value is null or empty string, the proxy will not be changed
 *          for https requests.
 * @param httpsPort
 *          The port through which https requests should be proxied. If this
 *          value is null, no attempt will be made to set it.
 * @param userid
 *          The userid to use on the proxy server. If this value is null or
 *          empty, then authentication will not be changed.
 * @param password
 *          The password to use for access through the proxy server.
 */
public static void setupProxy(final String httpHost, final String httpPort,
    final String httpsHost, final String httpsPort, final String userid,
    final String password) {

  if ((httpHost != null) && (httpHost.length() > 0)) {
    System.setProperty("http.proxySet", "true");
    System.setProperty("http.proxyHost", httpHost);

    if ((httpPort != null) && (httpPort.length() > 0)) {
      System.setProperty("http.proxyPort", httpPort);
    }
  }

  if ((httpsHost != null) && (httpsHost.length() > 0)) {
    System.setProperty("https.proxySet", "true");
    System.setProperty("https.proxyHost", httpsHost);

    if ((httpPort != null) && (httpPort.length() > 0)) {
      System.setProperty("https.proxyPort", httpsPort);
    }
  }

  if ((userid != null) && (userid.length() > 0) && (password != null)
      && (password.length() > 0)) {

    Authenticator auth = new Authenticator() {
      /*
       * (non-Javadoc)
       *
       * @see java.net.Authenticator#getPasswordAuthentication()
       */
      protected PasswordAuthentication getPasswordAuthentication() {
        return new PasswordAuthentication(userid, password.toCharArray());
      }
    };

    Authenticator.setDefault(auth);
  }
}

/**
 * This method will perform all of the functions available. It will log in,
 * then list transactions available, then list files available to be
 * downloaded. If the download directory is supplied, it will attempt to
 * download all files appearing in the list of available files. If the upload
 * directory is supplied, this will attempt to upload any files in
 * that directory with a hard coded transaction type of 2. This should be
 * changed to dynamically determine the transaction type based on either the
 * filename or directory name if it is also changed to look in subdirectories
 * of the download directory. Currently archiving of the successfully uploaded
 * files is not implemented.
 *
 * @param urlPrefix
 *          The prefix url for accessing the system.
 * @param userId
```

```
 *          The userid to use for the login process.
 * @param password
 *          The password to user for the login process.
 * @param newPassword
 *          The new password to which the users password should be changed.
 * @param providerId
 *          The providerId that all actions should be performed for.
 * @param sakWebUser
 *          The SAK of the provider that all functions should be performed as.
 * @param downloadDirectory
 *          The directory to which the files will be downloaded.
 * @param downloadedAfterDate
 *          The value to compare to the dte_downloaded attribe. Only files
 *          dated after this date will be downloaded. Files dated prior to the
 *          earliest acceptable date will also be downloaded. If this value is
 *          null or empty string, the current date will be used.
 * @param uploadDirectory
 *          The directory containing the files to be uploaded.
 * @param archivePrefix
 *          The value to prefix the filename with when the upload succeeds.
 *          This value may be null if the file should not be renamed.
 */
protected void doEverything(String urlPrefix, String userId, String password,
    String newPassword, String providerId, String sakWebUser,
    String downloadDirectory, String downloadedAfterDate,
    String uploadDirectory, String archivePrefix) {

  PrintWriter pw = null;
  Element responseElement = null;

  Element transactionTypesResponse = null;
  Element fileListResponse = null;
  Element loginResponse = null;
  Element transactionTypes = null;
  Element availableFiles = null;

  Element requests = null;

  try {
    pw = new PrintWriter(System.out);

    requests = DocumentBuilderFactory.newInstance().newDocumentBuilder()
        .newDocument().createElement("requests");

    responseElement = DocumentBuilderFactory.newInstance()
        .newDocumentBuilder().newDocument().createElement("myresponses");

    // get the login and data responses.
    BatchTransfer.performLoginAndDataRequests(urlPrefix + URL_SUFFIX_BATCH,
        userId, password, newPassword, providerId, sakWebUser,
        responseElement, requests);

    loginResponse = BatchTransfer.getElementWithAttributeValue(
        responseElement, "response", "requesttype", "login");

    transactionTypesResponse = BatchTransfer.getElementWithAttributeValue(
        responseElement, "response", "requesttype", "listTransactionTypes");

    if (transactionTypesResponse != null) {
      transactionTypes = BatchTransfer.getElementWithAttributeValue(
          transactionTypesResponse, "list", null, null);
    }
    fileListResponse = BatchTransfer.getElementWithAttributeValue(
        responseElement, "response", "requesttype", "listFiles");

    if (fileListResponse != null) {
      availableFiles = BatchTransfer.getElementWithAttributeValue(
          fileListResponse, "files", null, null);
    }

    // perform download
    BatchTransfer.performDownload(urlPrefix + URL_SUFFIX_BATCH,
        downloadDirectory, responseElement, loginResponse, availableFiles,
        downloadedAfterDate);

    // perform upload
    BatchTransfer.performUpload(urlPrefix + URL_SUFFIX_UPLOADFILE,
        uploadDirectory, responseElement, loginResponse, transactionTypes,
        archivePrefix);
```

```
        getVisualTransformer().transform(new DOMSource(responseElement),
            new StreamResult(pw));
    } catch (Throwable th) {
        th.printStackTrace(pw);
    } finally {
        if (pw != null) {
            try {
                pw.flush();
            } catch (Throwable th) {
                // do nothing
            }
        }
    }
```

4 CHANGE SUMMARY

This section details the changes between this version and the previous versions.

Date	Document Version	Author	Section/page	Description of change
01/09/2012	1.0	Sarah Viswambaran		Creation of Initial Document.
10/10/2012	1.1	Sarah Viswambaran	Appendix A Supported Documents, Page 16	Removal of the 4010 transaction table listing.
06/12/2014	1.2	Sarah Viswambaran	2.4 Testing Requirements	Removed link for a test tracking document which is no longer valid.
09/10/2015	1.3	Sarah Viswambaran	2.1 Interactive Submissions 2.2 Batch submission 2.3 Safe Harbor	2.1: Removed vendors and transactions from the table in relation to submitting X12 transactions. Only NCPDP may be submitted using this method. 2.2: Added inbound 999 transaction to the table within this section. 2.3: New section added concerning the option to use a safe harbor submission method.

Alabama Medicaid TPL Month-End Process Requirements

Post Payment Billing

Post payment recovery augments cost avoidance, allowing for recovery of payment for recipients where additional coverage is identified later or when the medical service is provided without cost avoidance based on exceptions for specific medical conditions. The AMMIS performs post payment recovery by comparing paid claim and third party client information to determine recovery activities.

SYNOPSIS OF BILLING JOBS

Pre-Production:

1. Extract the claims
2. Sort the claims (if necessary)
3. Run the claims through one of the billing programs to determine which claims meet the criteria for billing
4. Insert all claims into the TPL Prebill Claims table
5. Create all pre-production billing reports

Production:

1. Extract the claims from the TPL Prebill Claims table where the include/exclude indicator = N
2. Insert or update the TPL A/R Health and TPL A/R Disp records or insert Void Request transactions
3. Create the claim facsimiles, 837, or NCPDP records based on the carrier's media type
4. Create all production billing reports

The TPL billing programs are separated into three categories: Rebilling, Pay and Chase/Commercial, and Medicare. The following provides a summary of each billing job:

<u>Rebilling</u>

- No response has been received within 60 or 90 days from original bill date. The AR is inserted into the Prebill Claims table with an AR reason code = space but are not displayed on the Prebill panel.

- No response has been received within 12 months. The AR is closed with AR reason code = S. These are inserted into the Prebill Claims table with an AR reason code = S but are not displayed on the Prebill panel.

- The claim on the AR has been adjusted in the Claims Database with a Medicaid Paid Amount greater than zero, the full amount has not been recovered on the AR, and the adjusted claim is covered by the Matrix. If the AR is closed, the AR and adjusted claim is inserted into the Prebill Claims table with an AR reason code = X30. During the

production run, a new AR is created with the adjusted claim. If the AR is open, the AR and adjusted claim is inserted into the Prebill Claims table with an AR reason code = X. During the production run, the existing AR is closed with reason code = X and a new AR is created with the adjusted claim.

- The coverage codes have been updated and based on the Matrix the service is no longer covered. If the existing AR is active, the AR is inserted into the Prebill Claims table with an AR reason code = 46 but not displayed on the Prebill panel.

- The coverage dates have been updated and no longer cover the AR claim dates of service. If the existing AR is active, the AR is inserted into the Prebill Claims table with an AR reason code = 28 but not displayed on the Prebill panel.

- The policy number has been updated and the recovered amount on the AR is less than the billed amount. If the AR is already closed, the claim is inserted into the Prebill Claims table with an AR reason code = R61. If the AR is active, the AR is inserted into the Prebill Claims table with an AR reason code = R62 for rebilling.

- The suspect code on the policy has been changed to an invalid status or the policy record was deleted. If the AR is active, the AR is inserted into the Prebill Claims table with an AR reason code = 31 but not displayed on the Prebill panel.

- The rebill indicator has been manually set to Rebill. The AR is inserted into the Prebill Claims table with an AR reason code = 'R' but not displayed on the Prebill panel.

- The carrier code has changed and the recovered amount on the AR is less than the billed amount. If the AR is already closed, the claim is inserted into the Prebill Claims table with an AR reason code = R91. If the AR is active, the AR and claim are inserted into the Prebill Claims table with an AR reason code = C. During the production run, if the AR is active close with reason code = C and create a new AR.

- If an AR is active but the claim has been adjusted and paid zero or adjusted and denied or paid > zero but not covered by the Matrix, the AR is inserted into the Prebill Claims table with an AR reason code = 'W' but not displayed on the Prebill panel.

Pay and Chase:

- Extracts all paid claims where the cde_tpl_action = '4' (pay and chase) on the Claims TPL Resource table and all claims for a recipient meets the threshold. If the claims do not meet the threshold they are inserted into the TPL Threshold Summary table and are used as input into the Pay and Chase process for a 12 month period. Once the claims meet the threshold, they are deleted from the table and are processed for billing.

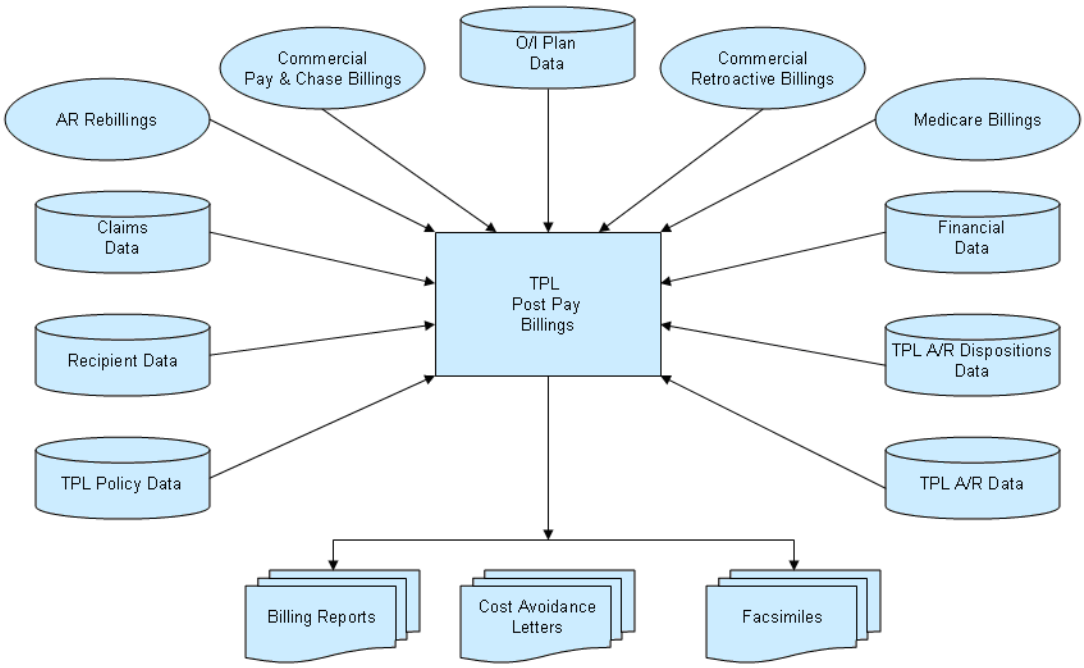
- Cancer Registry – If a paid pharmacy claim has a cde_tpl_action = '4' and the pharmacy claim was billed with a non-cancer related NDC and the recipient has coverage 13 (cancer), the recipient must be on the TPL Cancer Registry table to be processed.

Retroactive Commercial:

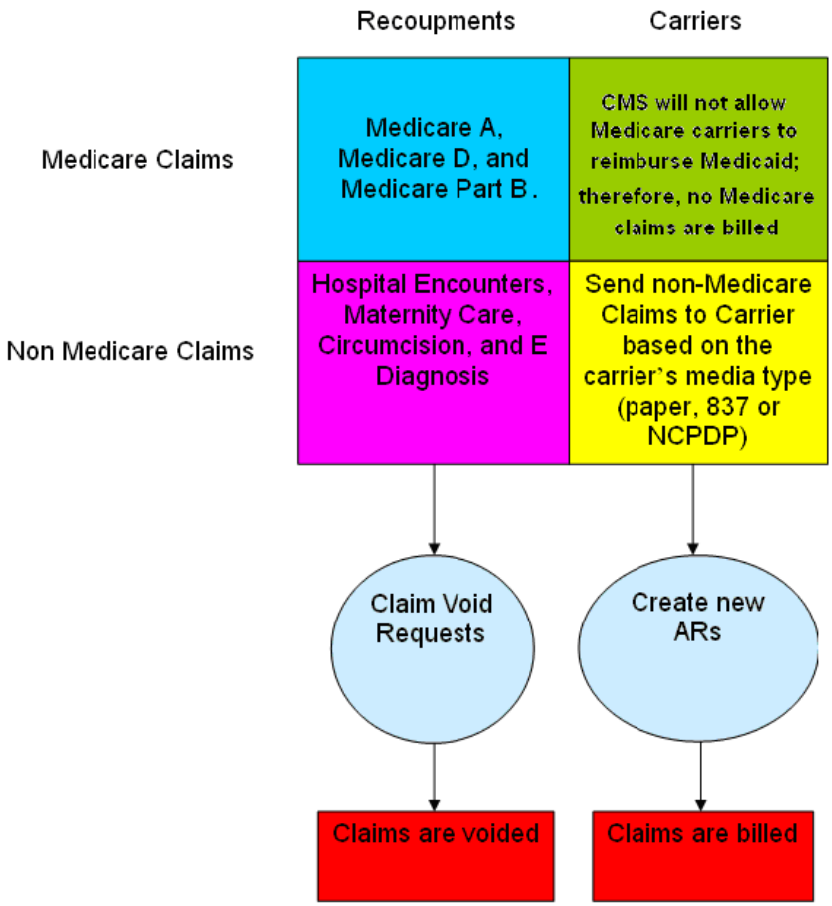
- Hospital Encounters – Paid claims with a managed care plan code = P00 through P14. These claims are recouped by inserting the claim into the Void Request table.
- Maternity Care – Paid claims where the provider type = 61. These claims are recouped by inserting the claim into the Void Request table.
- Circumcision – Paid claims where the procedure code = 54150 or 54160 and the recipient's gender = Female or Unknown. These claims are recouped by inserting the claim into the Void Request table. If the procedure code = 54150 or 54160 and the recipient's gender is Male, these are not recouped but billed to the carrier.
- E Diagnosis codes – Paid claims where the diagnosis code begins with the letter 'E'. These claims are recouped by inserting the claim into the Void Request table.
- Commercial billings – Paid claims that do not meet the above 4 conditions but are considered covered under the recipient's policy and have not been previously billed. These are billed to the carrier.

Medicare

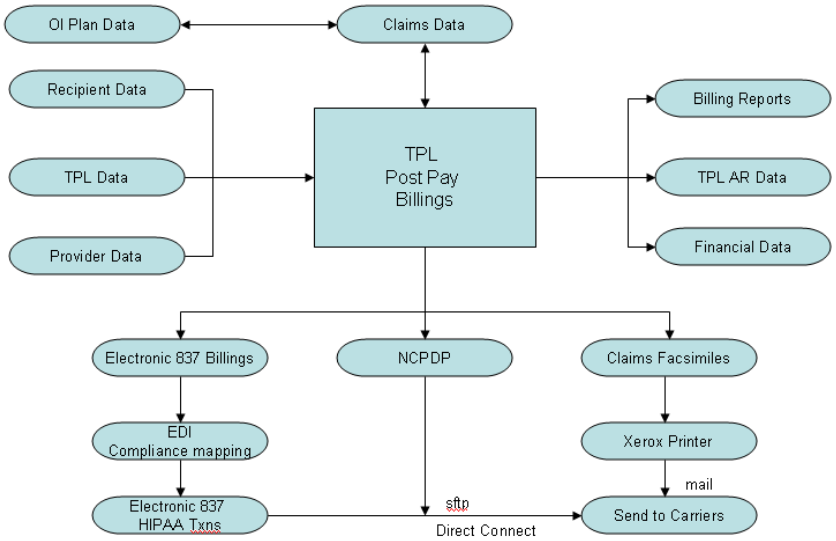
- Part A claims are recouped by inserting into the Void Request table.
- Part D claims are recouped by inserting into the Void Request table.
- Part B claims are recouped by inserting into the Void Request table.



Billing Types



High-Level Flow



Case Tracking

Case Tracking & Recovery occurs when other entities are suspected as being liable for claims Medicaid has paid. The Case Tracking section of the iC has been established to allow flexible creation of Cases which can then be classified as Estate Recovery, Accident Trauma (i.e., Personal Injury), Child Support, or any additional case type as needed by individual states.

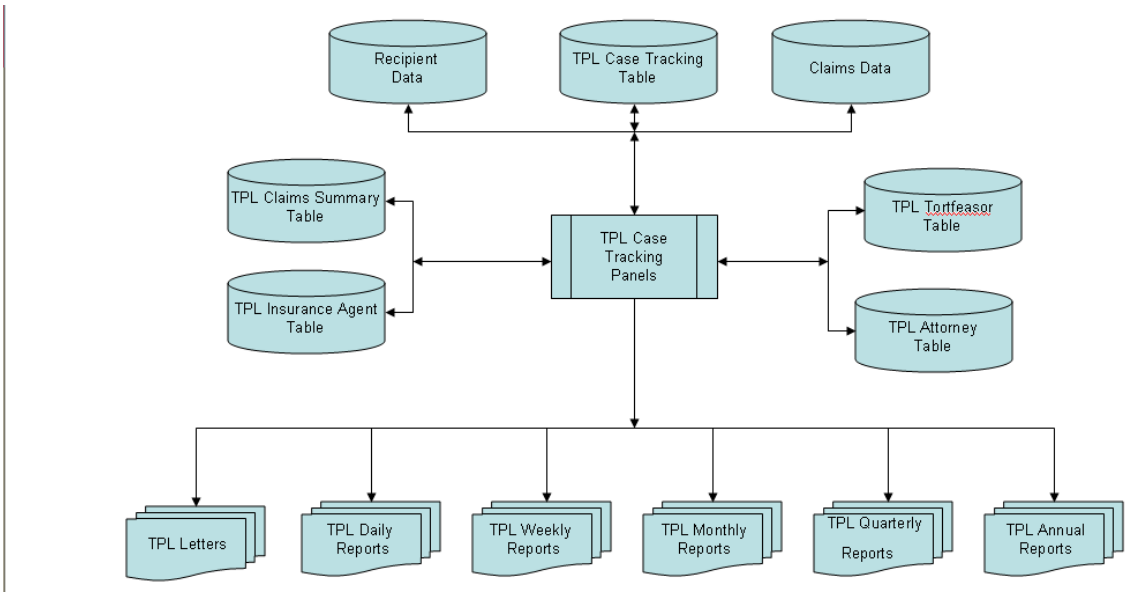
The basic information retained on a TPL Case includes case status, accident dates, case origin, case type, lien start and end dates, attorney information and fees, insurance agent information, tortfeasor settlement data, and any paid Medicaid claims being recovered against. All recoveries against the claims associated to a case are applied to the entire case, not individual claims. If there is a need to apply a recovery against an individual claim, an accounts receivable transaction (A/R) should be created. Any recovery made by Medicaid via A/Rs is included in the total recovery against a case.

The Personal Injury cases have automated batch processing to identify all accident claims paid by Medicaid throughout a specified time period. Provided the total claims for the recipient exceeds a pre-determined threshold, this processing automatically produce questionnaires to be sent to recipients to help determine if there is a necessity to create a new case.

Additional features the iC has are to allow the dynamic maintenance of thresholds and case types through online code table maintenance. Also, the iC TPL Case Tracking allows the user to enter free-form chronological notes to assist the analyst.

Diagram Abstract

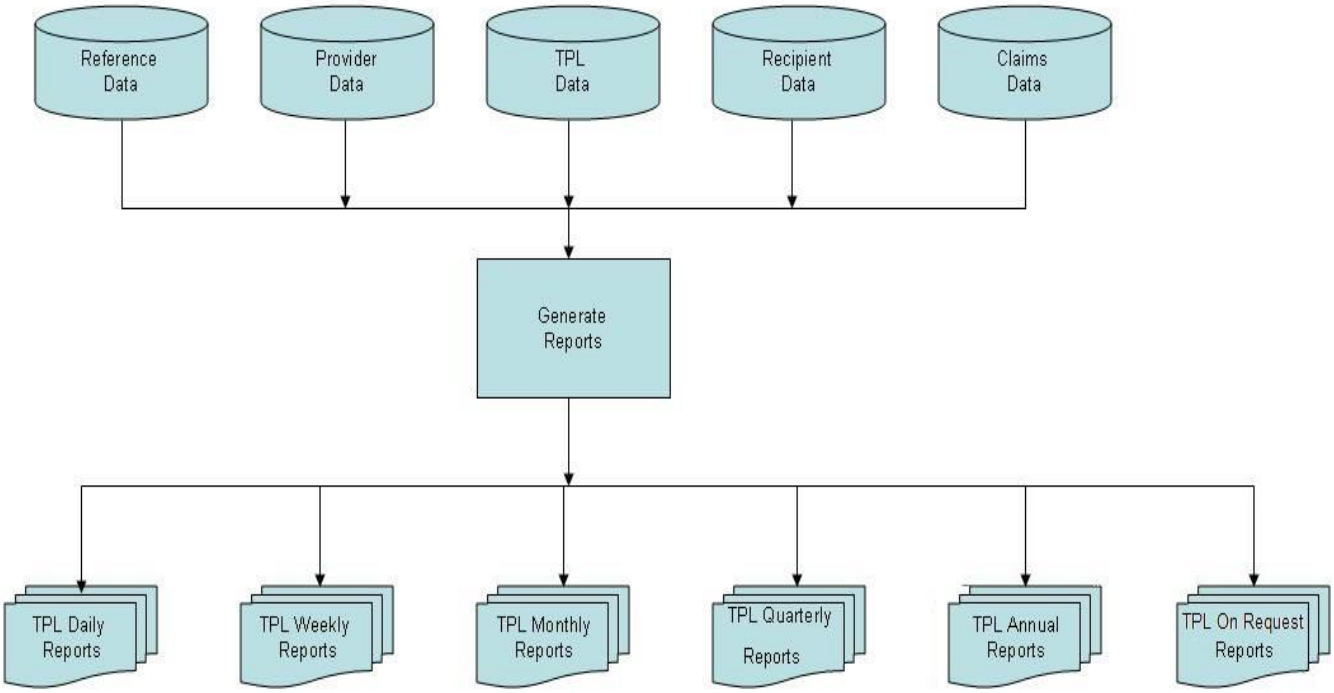
The process flow diagram below provides a visual representation of the case tracking process. Case tracking occurs when other entities are suspected as being liable for claims Medicaid has paid. Cases include: Estate Recovery, Accident/Trauma, and Liens, etc.



TPL Reports

Diagram Abstract

The process flow diagram below provides a visual representation of how the TPL reports are generated. All reports are stored and accessible through Feith. The TPL report data is extracted from the Recipient, Reference, Claims, Provider, and TPL Tables.



ID	Defect Description	CSR Type	Billable	Project	Create Date	Subsystem	Grouping	Severity	Date Last Status	Status	Due Date
14159	AVRS to speak and fax the hospice selection periods for a recipient	CO	Y	Operations CSR	2/22/2017	AVRS	Batch	Major - No Work Around (2)	11/16/2018 16:07	Const/Unit Test in Progress	3/28/2017
14278	IVR Migration to Contact Solutions Platform	CO	N	MNT	4/18/2017	AVRS	Batch	Major - No Work Around (2)	11/2/2018 11:19	Prod Verification	
15033	IVR - Post Go Live Changes for Verint	CO	N	MNT	6/22/2018	AVRS	Voice	Minor (4)	6/22/2018 9:26	Change Order Written	
15298	IVR - changes for prov payee household messages	CO	N	MNT	10/31/2018	AVRS	Voice	Minor (4)	10/31/2018 16:53	Change Order Written	
15278	Case Management initial implementation set up and meetings	Task	Y	ACHN	10/1/2018	Case Management	Install & Config	Internal (6)	10/14/2018 23:08	CO Work In Progress	
1078	Remove E1030-Ancillary Svc NotCov	CO	N	DDI	8/15/2006	Claims	Edits	Minor (4)	3/1/2007 9:54	Maintenance	
1111	Gender/Sex Limitations - Batch	CO	N	DDI	8/22/2006	Claims	Edits	Minor (4)	2/28/2007 12:12	Maintenance	
1112	Gender/Sex Limitations - Batch	CO	N	DDI	8/22/2006	Claims	Edits	Minor (4)	2/28/2007 12:08	Maintenance	
1113	Gender/Sex Limitations - DM	CO	N	DDI	8/22/2006	Claims	Edits	Minor (4)	2/28/2007 12:04	Maintenance	
2945	DM- Remove _MMIS tables	CO	N	DDI	5/22/2007	Claims	Data Model Change	Internal (6)	4/7/2017 16:25	MO Implementation	
6301	RTI Claims Month End Jobs	CO	N	MNT	10/15/2008	Claims	Extract Process	Internal (6)	3/10/2011 12:04	SE Assigned	
7013	Comprehensive Claims UI test plan	Task	N	MNT	7/20/2009	Claims	Documentation	Internal (6)	8/4/2009 17:01	Const/Unit Test in Progress	
7037	Add REOMB parameter table	CO	N	MNT	7/29/2009	Claims	Data Model Change	Major - With Work Around (3)	6/16/2010 17:54	SE Assigned	
7038	Create UI panel for REOMB parameters	CO	N	MNT	7/29/2009	Claims	UI	Major - With Work Around (3)	4/27/2016 11:59	Awaiting Further Definition	
7039	Modify REOMBs to automate parms	CO	N	MNT	7/29/2009	Claims	Batch	Major - With Work Around (3)	6/16/2010 17:55	SE Assigned	
7247	Create Weekly Suspense Rpts	CO	N	MNT	11/3/2009	Claims	Batch Reports	Major - With Work Around (3)	3/8/2010 15:13	Const/Unit Test in Progress	
7911	Process to balance Claims counts with Financial	CO	N	MNT	6/14/2010	Claims	Batch	Internal (6)	6/14/2010 9:49	Change Order Written	
7935	Claims audit trail maintenance	CO	N	MNT	6/25/2010	Claims	Batch	Internal (6)	6/25/2010 11:54	SE Assigned	
7986	Add index for the Benefit Limits Report	CO	N	MNT	7/17/2010	Claims	Data Model Change	Minor (4)	7/26/2010 0:13	Const/Unit Test in Progress	
8206	Research orphan records in claims history	Task	N	MNT	10/8/2010	Claims	Data Fix	Minor (4)	10/8/2010 11:39	Issue Identified	
8210	Optimize CLMPDER1 SQL	CO	N	MNT	10/12/2010	Claims	Batch Reports	Internal (6)	7/23/2015 10:42	Const/Unit Test in Progress	
9062	Claims ADJ panel creating invalid location records	CO	N	MNT	6/20/2011	Claims	UI	Major - No Work Around (2)	4/27/2016 12:01	Awaiting Further Definition	
9138	Pharmacy PA xref dtl nbr fix	CO	N	MNT	7/21/2011	Claims	Batch	Internal (6)	7/21/2011 16:32	Change Order Written	
10434	Correct PDAILY7_CLAIMS_PM2 to include PCLM_FAX_BAL	CO	N	MNT	6/27/2012	Claims	Batch	Minor (4)	6/29/2012 13:38	Const/Unit Test in Progress	
10609	Change to libhidclient.so for deadlock issue	CO	N	MNT	8/29/2012	Claims	Batch	Minor (4)	8/29/2012 17:09	SE Assigned	
10751	Modify edit dispositioning	CO	N	MNT	10/25/2012	Claims	Edits	Minor (4)	10/25/2012 8:01	Change Order Written	
10765	Promote Claims Extracts Override Members	CO	N	MNT	11/3/2012	Claims	Batch	Internal (6)	7/22/2015 13:04	SE Assigned	
11033	Task to identify and recreate incorrect facsimiles	Task	N	MNT	4/3/2013	Claims	Batch Reports	Major - No Work Around (2)	4/3/2013 17:05	Issue Identified	
11167	Recreate lost facsimiles	Task	N	MNT	5/31/2013	Claims	Batch Reports	Minor (4)	5/31/2013 12:50	Const/Unit Test in Progress	
11263	Change needed to hidsrvrd when unable to connect	CO	N	MNT	7/22/2013	Claims	Batch	Internal (6)	7/22/2013 12:40	SE Assigned	

11851	Monthly REOMBs RTI	CO	N	MNT	3/31/2014	Claims	Batch Reports	Minor (4)	3/31/2014 16:41	Change Order Written	
12121	Modify PA error message in clmsphrmWrite	CO	N	MNT	8/6/2014	Claims	Batch	Minor (4)	7/21/2015 16:49	Const/Unit Test in Progress	
12368	Pharmacy - timely refill additional message	CO	Y	CSR	12/2/2014	Claims	Batch	Minor (4)	12/2/2014 16:51	SE Assigned	
12369	Pharmacy - therapeutic dupe systemic drug bypass	CO	Y	CSR	12/2/2014	Claims	Batch	Minor (4)	11/16/2018 13:39	Const/Unit Test in Progress	
12466	Claims - Process TPL denial claims electronically	CO	Y	CSR	1/28/2015	Claims	Batch	Minor (4)	3/2/2016 9:36	Hold	
12468	Create benefit limit extract for NET	CO	Y	CSR	1/29/2015	Claims	Extract Process	Minor (4)	4/17/2018 11:55	Hold	
12536	Task to fix missing paper claim images	Task	N	MNT	3/1/2015	Claims	Reprocessing	Cosmetic (5)	3/1/2015 23:31	Issue Identified	
12754	Modify ESC 824 - UNBORN-NEWBORN edit	CO	Y	CSR	5/18/2015	Claims	Edits	Minor (4)	12/8/2015 4:52	Awaiting Further Definition	
12871	RTI CLMPM210	CO	N	MNT	8/5/2015	Claims	Batch	Minor (4)	8/5/2015 1:02	Change Order Written	
13019	Retro DOD Change	CO	Y	CSR	9/29/2015	Claims	Batch Reports	Minor (4)	2/26/2016 16:11	Prod Verification	
13114	RCO-CLMS-TASK DM PH2-R4 remove unused table	Task	N	Base RCO	10/1/2015	Claims	Data Model Change	Internal (6)	10/1/2015 13:42	Change Order Written	
13233	CLM- Hospice Retro Reporting	CO	Y	CSR	10/30/2015	Claims	Batch Reports	Minor (4)	11/6/2018 9:57	UAT Implementation	
13608	Retro DOD Exceptions and Performance Issue	CO	Y	Operations CSR	5/20/2016	Claims	Batch Reports	Major - With Work Around (3)	6/25/2018 15:16	Const/Unit Test in Progress	
13758	Claims ME - create conversion program	CO	Y	Base RCO	8/3/2016	Claims	Extract Process	Major - No Work Around (2)	5/15/2018 11:02	Ready for Const Wthru	######
13793	Claims adjustments - reject adjustments to unfinalized system adjustments	CO	N	MNT	8/19/2016	Claims	Batch	Internal (6)	8/19/2016 16:33	Change Order Written	
14140	DRG Grouper Annual update - Claims retro process	CO	N	MNT	2/9/2017	Claims	Batch	Minor (4)	2/9/2017 11:36	Issue Identified	
14454	RCO CD - Claims - Archive objects	Task	Y	Closedown	8/16/2017	Claims	Batch	Internal (6)	8/16/2017 11:01	Issue Identified	
14469	Claims - Pharmacy - Add MME criteria	CO	Y	Operations CSR	8/28/2017	Claims	Batch	Major - No Work Around (2)	7/12/2018 9:08	MO Implementation	
14546	Pharmacy Claims DM-Vaccine Administration fee	CO	Y	Operations CSR	10/3/2017	Claims	Data Model Change	Major - No Work Around (2)	10/3/2017 13:47	Change Order Written	7/1/2018
14547	Pharmacy Claims Batch-Vaccine Admin fee pricing changes	CO	Y	Operations CSR	10/3/2017	Claims	Batch	Major - No Work Around (2)	10/3/2017 13:54	Change Order Written	7/1/2018
14551	UI change - Pharmacy incentive amount-vaccine admin	CO	Y	Operations CSR	10/3/2017	Claims	UI	Major - No Work Around (2)	10/3/2017 15:48	Change Order Written	7/1/2018
14703	Claims - Modify the claims engine to handle re-used NDCs	CO	Y	Operations CSR	1/8/2018	Claims	Batch	Minor (4)	11/9/2018 12:37	Prod Verification	
14706	Claims ME - transmit 36 months to HMS	Task	Y	CSR	1/11/2018	Claims	Extract Process	Minor (4)	6/5/2018 11:45	CO Work In Progress	
14707	Edit 237 - Check for Recipient ID Valid Format	CO	N	MNT	1/11/2018	Claims	Edits	Minor (4)	2/2/2018 15:27	Const/Unit Test in Progress	2/28/2018
14810	reports	CO	Y	CSR	3/14/2018	Claims	Batch Reports	Minor (4)	5/23/2018 9:38	Prod Verification	
14891	Modify adjustment and data corrections panels for change to T_CLM_NDC_DTL	CO	Y	Operations CSR	4/11/2018	Claims	UI	Minor (4)	11/7/2018 15:36	Prod Verification	6/14/2018
14911	CLM Reprocessing - New Career Counseling Limit	Task	Y	Operations CSR	4/23/2018	Claims	Reprocessing	Major - No Work Around (2)	4/23/2018 15:41	Issue Identified	
14989	Claims - DM - new TPL Attachment database	CO	Y	CSR	5/31/2018	Claims	Data Model Change	Minor (4)	9/20/2018 10:50	Const/Unit Test in Progress	
14990	Claims - UI - TPL attachment panel	CO	Y	CSR	5/31/2018	Claims	UI	Minor (4)	5/31/2018 12:21	Change Order Written	
14994	Claims - Retro liability process defects	Defect	N	MNT	6/1/2018	Claims	Batch	Minor (4)	11/14/2018 10:15	**Ready for UAT Impl**	
15034	Claims - Batch - utility clm_manual_mass_adj	CO	N	MNT	6/26/2018	Claims	Batch	Internal (6)	11/1/2018 14:09	Ready for Const Wthru	

15045	Claims ME - add new MME fields to extract	CO	Y	Operations CSR	7/10/2018	Claims	Extract Process	Major - No Work Around (2)	11/6/2018 9:57	UAT Implementation	
15066	Claims - Phase 1 - New pricing indicator for zero paid services	CO	Y	Operations CSR	7/23/2018	Claims	Pricing	Major - No Work Around (2)	10/3/2018 10:45	**Ready for UAT Impl**	
15068	Claims - Pharmacy - Modify Timely Refill edit	CO	Y	Operations CSR	7/23/2018	Claims	Batch	Major - No Work Around (2)	7/23/2018 14:48	Change Order Written	
15139	Claims - UI - Related History panel change	CO	Y	Operations CSR	8/14/2018	Claims	UI	Major - No Work Around (2)	11/7/2018 8:33	Prod Verification	9/26/2018
15216	Claims - Batch - add recipient on review edit	CO	Y	Operations CSR	10/2/2018	Claims	Batch Reports	Major - No Work Around (2)	10/2/2018 13:45	Change Order Written	
15217	Claims - Batch reporting -recip on review	CO	Y	Operations CSR	10/2/2018	Claims	Batch Reports	Major - No Work Around (2)	10/2/2018 14:00	SE Assigned	
15257	Claims - Batch - CLMAOA02_90DCLM changes	CO	N	MNT	10/4/2018	Claims	Batch	Internal (6)	11/16/2018 16:27	Ready for Const Wthru	
15265	Apply SQL changes for RTI on job CLMJQ210- Retro dupe report	CO	N	MNT	10/9/2018	Claims	Batch	Minor (4)	11/13/2018 9:57	Const/Unit Test in Progress	
15281	Claims - Changes for LARC	CO	Y	Operations CSR	10/16/2018	Claims	Batch	Major - No Work Around (2)	11/14/2018 10:53	**Ready for UAT Impl**	
15282	Claims - Edits - new edit for date qualifier	CO	Y	CSR	10/16/2018	Claims	Edits	Minor (4)	11/13/2018 17:03	Ready for Const Wthru	
15317	T_CLM_NDC_DTL, display drug description based on sak_drug.	Defect	N	MNT	11/7/2018	Claims	UI	Cosmetic (5)	11/14/2018 14:19	SE Assigned	
15319	Claims - Pharmacy Oncology claims should be considered part of Naïve logic.	Defect	N	MNT	11/8/2018	Claims	Batch	Major - No Work Around (2)	11/14/2018 10:09	**Ready for UAT Impl**	
15336	Claims - Edits - edit for UB value code too large	CO	Y	Operations CSR	11/15/2018	Claims	Edits	Major - No Work Around (2)	11/19/2018 8:33	Const/Unit Test in Progress	
15339	Adjustment edit for claim in non-adjustable status	Defect	N	MNT	11/16/2018	Claims	Edits	Major - No Work Around (2)	11/19/2018 8:34	Const/Unit Test in Progress	
7407	DSS Research New Retro Elig Columns	CO	Y	CSR	1/15/2010	DSS	Universes	Minor (4)	4/27/2016 9:47	Hold	
10849	DSS - Purge Old DSS Data	CO	N	MNT	1/7/2013	DSS	Batch	Major - No Work Around (2)	1/8/2013 20:36	Const/Unit Test in Progress	
12442	Modify DSS purge to retain hospital claims	CO	Y	CSR	1/20/2015	DSS	Batch	Minor (4)	9/16/2017 12:37	SE Assigned	
14548	DSS - DM - Pharmacy-Vaccine Administration Incentive Amount	CO	Y	Operations CSR	10/3/2017	DSS	Data Model Change	Minor (4)	10/3/2017 14:11	Change Order Written	
14549	DSS - Batch - Pharmacy-Vaccine Administration Incentive Amount	CO	Y	Operations CSR	10/3/2017	DSS	Batch	Minor (4)	10/3/2017 14:19	Change Order Written	7/1/2018
14550	DSS - Universe - Pharmacy-Vaccine Administration Incentive Amount	CO	Y	Operations CSR	10/3/2017	DSS	Universes	Minor (4)	10/3/2017 14:23	Change Order Written	7/1/2018
14632	DSS - Convert Agency DSS Business Object Login IDs	CO	Y	Operations CSR	11/20/2017	DSS	Install & Config	Minor (4)	11/20/2017 14:45	Const/Unit Test in Progress	
14651	DSS/SUR - Send extracts to Agency SFTP	CO	Y	CSR	12/4/2017	DSS	Extract Process	Minor (4)	4/20/2018 14:52	Const/Unit Test in Progress	
14876	DSS - Producing Financial RA in Excel format	Task	Y	Operations CSR	4/4/2018	DSS	Business Objects Report	Major - With Work Around (3)	4/4/2018 10:49	SE Assigned	
14884	DSS - Change AdvanceMed extracts to CMS	CO	Y	CSR	4/9/2018	DSS	Batch	Minor (4)	6/15/2018 15:05	Under CCB Review	
14898	DSS - Batch updates for sak_drug on t_clm_ndc_dtl	CO	Y	CSR	4/11/2018	DSS	Batch	Minor (4)	4/12/2018 15:38	Const/Unit Test in Progress	
14899	DSS - Universe updates for sak_drug on t_clm_ndc_dtl	CO	Y	Operations CSR	4/11/2018	DSS	Universes	Minor (4)	11/16/2018 10:38	MO Testing Complete	
14954	DSS - Batch - populate new column on T_PR_ENROLL_INFO for Re-Enrollment Completion Date	CO	N	MNT	5/8/2018	DSS	Batch	Minor (4)	11/16/2018 10:29	Const/Unit Test in Progress	

14955	DSS - Universe - Add object for Re-Enrollment Completion Date on T_PR_ENROLL_INFO	CO	N	MNT	5/8/2018	DSS	Universes	Minor (4)	11/19/2018 9:49	Ready for Const Wthru	
15025	DSS - Batch - Optimize the DSS rekey process	CO	Y	CSR	6/15/2018	DSS	Batch	Minor (4)	11/7/2018 9:26	Prod Verification	
15092	DSS - Business Objects - Medical Services groups and folders	CO	Y	Operations CSR	7/31/2018	DSS	DSS Reports	Minor (4)	8/9/2018 12:10	UAT Implementation	
15177	DSS - Batch - Add referring provider ID to detail paid line items	CO	Y	Operations CSR	9/4/2018	DSS	Batch	Major - No Work Around (2)	11/7/2018 16:19	Prod Verification	
15178	DSS - Data fix - Update referring provider ID on detail paid line items	CO	Y	Operations CSR	9/4/2018	DSS	Data Fix	Major - No Work Around (2)	9/6/2018 16:16	Const/Unit Test in Progress	
15250	ICN Phase 2 - DSS - Batch - Load financial data on 1st business day	CO	Y	Operations CSR	10/3/2018	DSS	Batch	Minor (4)	10/30/2018 9:35	Const/Unit Test in Progress	
15260	DSS - Universe - County Inmate Project updates	CO	Y	CSR	10/8/2018	DSS	Universes	Minor (4)	10/8/2018 15:19	Change Order Written	
15262	DSS - Batch - Add fund code mapping for new target groups 10 and 11	CO	Y	Operations CSR	10/8/2018	DSS	Batch	Minor (4)	10/8/2018 15:32	Change Order Written	
15269	DSS - DM - Institutional Special Needs Plans (I-SNPs)	CO	Y	Operations CSR	10/10/2018	DSS	Data Model Change	Minor (4)	10/10/2018 12:34	Change Order Written	
15270	DSS - Batch - Institutional Special Needs Plans (I-SNPs)	CO	Y	Operations CSR	10/10/2018	DSS	Batch	Minor (4)	10/10/2018 12:41	Change Order Written	
15272	DSS - Universe - Institutional Special Needs Plans (I-SNPs)	CO	Y	Operations CSR	10/10/2018	DSS	Universes	Minor (4)	10/10/2018 12:57	Change Order Written	
15275	DSS - Universe changes for Reference Add remaining MME files	CO	Y	Operations CSR	10/11/2018	DSS	Universes	Minor (4)	11/13/2018 8:42	Prod Verification	
15279	DSS - Batch - Update T_PR_ADR_DN extract	CO	Y	CSR	10/15/2018	DSS	Batch	Minor (4)	10/15/2018 9:25	Change Order Written	
15285	DSS - Batch - Update the DSS rekey process for RTI and SUR Profiler	CO	Y	Operations CSR	10/22/2018	DSS	Batch	Minor (4)	10/23/2018 11:43	Const/Unit Test in Progress	
15287	DSS - Batch - Add new ESC group type tables	CO	Y	CSR	10/23/2018	DSS	Batch	Minor (4)	10/23/2018 10:46	Change Order Written	
15288	DSS - Universe - Add new ESC group type tables	CO	Y	CSR	10/23/2018	DSS	Universes	Minor (4)	10/23/2018 10:55	Change Order Written	
15293	DSS - Data fix - Update MME data in history	CO	Y	CSR	10/29/2018	DSS	Data Fix	Minor (4)	10/29/2018 10:49	Change Order Written	
15294	DSS - Batch - Send notification if check write box is running late	CO	N	MNT	10/29/2018	DSS	Batch	Minor (4)	10/29/2018 11:07	Change Order Written	
15295	DSS - DM - Remove partition on t_pf_recip_acg	CO	Y	CSR	10/29/2018	DSS	Data Model Change	Minor (4)	11/7/2018 9:45	Prod Verification	
15301	DSS - ACHN - Batch changes	CO	N	ACHN	11/1/2018	DSS	Batch	Minor (4)	11/1/2018 15:04	Change Order Written	
14879	Drug Rebate - Modify the drug rebate subsystem to handle re-used NDCs	CO	Y	Operations CSR	4/5/2018	Drug Rebate	Batch	Minor (4)	4/5/2018 16:28	Change Order Written	
14892	RTI - Remove unwanted files/factory methods from Drug Rebate subsystem	CO	N	MNT	4/11/2018	Drug Rebate	UI	Minor (4)	8/31/2018 17:18	Const/Unit Test in Progress	
14919	Drug Rebate - include recouped/adjusted claims in drug rebate process	CO	Y	Operations CSR	4/26/2018	Drug Rebate	Batch	Major - No Work Around (2)	9/10/2018 11:10	Const/Unit Test in Progress	
15070	Drug Rebate - update adjustment invoices	CO	Y	CSR	7/23/2018	Drug Rebate	Batch Reports	Minor (4)	7/23/2018 17:14	Change Order Written	
15171	Drug Rebate - Correct TPL amount being reported on RBT-2005-Q	Defect	N	MNT	8/29/2018	Drug Rebate	Batch	Minor (4)	10/10/2018 9:58	Prod Verification	
15211	Drug Rebate - Unit Conversion panel update	CO	Y	CSR	10/2/2018	Drug Rebate	UI	Minor (4)	10/2/2018 11:59	Change Order Written	
15212	Drug Rebate - Retroactive drug rebate invoice process	CO	Y	Operations CSR	10/2/2018	Drug Rebate	Batch	Minor (4)	10/2/2018 12:06	Change Order Written	
15213	Drug Rebate - Delinquent payments email change	CO	Y	CSR	10/2/2018	Drug Rebate	Batch	Minor (4)	10/2/2018 12:10	Change Order Written	

10137	XI_270 allow 13-digit RID; new gtwpintd version	CO	N	MNT	5/1/2012	EDI	Mapping	Major - No Work Around (2)	5/1/2012 16:34	Issue Identified	
10869	FTS - NCPDP translator change for diag qualifier	CO	N	MNT	1/23/2013	EDI	Install & Config	Cosmetic (5)	1/23/2013 11:26	Issue Identified	
12805	changes for increase in sak_event_tracking column	CO	N	MNT	6/19/2015	EDI	UI	Minor (4)	11/12/2015 12:16	SE Assigned	
14259	EDI -update FTS, NRM, ACA and Unix email from HPE to DXC	CO	N	NewCo	4/10/2017	EDI	Batch	Internal (6)	9/13/2018 15:46	Const/Unit Test in Progress	
14472	SFTP access for First Data to submit and receive files	Task	Y	CSR	8/28/2017	EDI	Install & Config	Minor (4)	10/11/2017 14:31	Const/Unit Test in Progress	
14554	OXi SaaS assessment for translator migration	Task	N	MNT	10/4/2017	EDI	Research	Internal (6)	10/4/2017 9:46	Issue Identified	
14893	RTI - Remove unwanted files/factory methods from EDI subsystem	CO	N	MNT	4/11/2018	EDI	UI	Minor (4)	10/10/2018 14:09	Const/Unit Test in Progress	
15031	XI_837D - Map adding blank clmDtp node for system generated details	Defect	N	MNT	6/21/2018	EDI	Mapping	Major - With Work Around (3)	6/21/2018 10:27	Issue Identified	
6202	Remove Obsolete EPSDT Tables from database	CO	N	MNT	8/26/2008	EPSDT	Data Model Change	Minor (4)	5/14/2010 14:02	Const/Unit Test in Progress	
13835	review evs service type -benefit plan coverage x-ref to determine if updates are needed	Task	N	MNT	9/12/2016	Eligibility Verification	Data Fix	Minor (4)	9/12/2016 12:40	Issue Identified	
14436	EVS - upd evselig for inactive recipients to return svc code 30- EB03	CO	N	MNT	8/8/2017	Eligibility Verification	Batch	Minor (4)	6/4/2018 15:19	Const/Unit Test in Progress	
14680	EVS-upd NDC queries to handle re-used NDCs	CO	Y	Operations CSR	12/27/2017	Eligibility Verification	Batch	Minor (4)	3/13/2018 16:38	SE Assigned	
15061	EVS - upd evselig to find dependent's DOB if ADPHTELC TP	CO	Y	Operations CSR	7/23/2018	Eligibility Verification	Batch	Minor (4)	9/13/2018 8:54	UAT Implementation	8/31/2018
12460	Feith - Forms - TPL Claims Attachment Web Form	CO	Y	Operations CSR	1/26/2015	Feith	Form	Major - No Work Around (2)	7/26/2018 10:00	Const/Unit Test in Progress	
12461	Feith - WF - TPL Claims Attachment	CO	Y	Operations CSR	1/26/2015	Feith	Workflow	Major - No Work Around (2)	7/26/2018 10:06	Const/Unit Test in Progress	
13456	Upgrade WebFDD to newest version	CO	N	MNT	3/28/2016	Feith	Install & Config	Internal (6)	3/28/2016 10:42	Change Order Written	
13939	Feith Workflow PH2-R5: CS001 ICN Julian Date Leap Year Correction	CO	N	MNT	11/1/2016	Feith	Form	Major - With Work Around (3)	11/1/2016 15:38	Issue Identified	
13940	Feith Workflow PH2-R5: PA001 and CS001 User Workflow Form Refresh Issue	CO	N	MNT	11/1/2016	Feith	Form	Major - With Work Around (3)	11/1/2016 15:42	Issue Identified	
14356	Feith - DM - Set up File Cabinet for Agency OPR	CO	N	MNT	6/7/2017	Feith	Workflow	Major - No Work Around (2)	2/8/2018 10:24	MO Testing Complete	
14534	Agency OPR Systems Team Workflow	CO	N	MNT	9/27/2017	Feith	Install & Config	Internal (6)	2/8/2018 10:25	MO Testing Complete	
14536	Add Workflow for Agency OPR Initial Review	CO	N	MNT	9/27/2017	Feith	Install & Config	Internal (6)	2/21/2018 14:23	MO Testing Complete	
14543	Agency OPR Financial Claims Team Workflow	CO	N	MNT	10/2/2017	Feith	Workflow	Internal (6)	2/8/2018 10:26	MO Testing Complete	
14555	Agency OPR Provider Enrollment Workflow	CO	N	MNT	10/4/2017	Feith	Workflow	Internal (6)	2/8/2018 10:26	MO Testing Complete	
14645	Agency OPR EMC Workflow	CO	N	MNT	11/30/2017	Feith	Workflow	Major - No Work Around (2)	2/8/2018 10:26	MO Testing Complete	
14727	Feith - Mother - Supporting Documentation Merging	CO	Y	Operations CSR	1/25/2018	Feith	Operations CSR	Major - No Work Around (2)	1/25/2018 16:15	Hold	
14729	Feith - Workflow - Medical PA Merge Fax	CO	Y	Operations CSR	1/26/2018	Feith	Workflow	Major - No Work Around (2)	3/5/2018 8:31	Ready for Prod	
14774	Feith - WF - Rehab PA Merge Fax	CO	Y	Operations CSR	2/26/2018	Feith	Workflow	Major - No Work Around (2)	3/5/2018 11:02	Ready for Prod	
14818	Feith - WF - PE Application Date Processed Change	CO	N	MNT	3/15/2018	Feith	Workflow	Internal (6)	7/27/2018 9:59	Const/Unit Test in Progress	

14844	Feith - DM - Add 'Excel' Field to iC_RA	CO	Y	Operations CSR	3/26/2018	Feith	Data Model Change	Major - No Work Around (2)	3/29/2018 9:15	MO Implementation	
14847	Feith - Config - Add CSV for RA	CO	Y	Operations CSR	3/26/2018	Feith	Install & Config	Major - No Work Around (2)	4/11/2018 12:02	MO Implementation	
14859	Feith - Config - Agency OPR Sweeper for UI PDFs	CO	N	MNT	3/28/2018	Feith	Install & Config	Major - No Work Around (2)	4/17/2018 15:19	MO Testing in Progress	
14860	Feith - WF - Agency OPR UI Workflow	CO	N	MNT	3/28/2018	Feith	Workflow	Major - No Work Around (2)	5/14/2018 11:08	MO Testing Complete	
14921	Feith - Batch - PE Report CSV to Feith	CO	N	MNT	4/26/2018	Feith	Batch Reports	Internal (6)	11/19/2018 8:57	UAT Implementation	
14922	Feith - Config - Update CSV Config for PE Report File	CO	N	MNT	4/26/2018	Feith	Install & Config	Major - No Work Around (2)	11/19/2018 9:00	UAT Implementation	
14923	Feith - DM - Update iC_Reports	CO	N	MNT	4/26/2018	Feith	Data Model Change	Major - No Work Around (2)	11/19/2018 9:21	UAT Implementation	
14944	Feith - WF - Reenrollment Staff Notification	CO	N	MNT	5/3/2018	Feith	Workflow	Internal (6)	5/3/2018 10:54	Awaiting Further Definition	
14964	Feith - Config - Create Feith Cabinet for SSN Unmasking Log	CO	Y	Operations CSR	5/15/2018	Feith	Install & Config	Major - No Work Around (2)	11/2/2018 15:12	UAT Implementation	
15056	Feith - DM - Add iC_TPL_Claims	CO	Y	Operations CSR	7/20/2018	Feith	Data Model Change	Major - No Work Around (2)	7/23/2018 9:45	MO Implementation	
15057	Feith - Form - TPL Claims Attachment Workflow Forms	CO	Y	Operations CSR	7/20/2018	Feith	Form	Major - No Work Around (2)	7/20/2018 17:47	Change Order Written	
15058	Feith - Config - TPL Claims Attachment Barcode Reader	CO	Y	Operations CSR	7/20/2018	Feith	Install & Config	Major - No Work Around (2)	7/20/2018 17:59	Change Order Written	
15081	Feith - WF - PAR01 Workflow	CO	Y	Operations CSR	7/30/2018	Feith	Workflow	Major - No Work Around (2)	7/31/2018 9:12	Const/Unit Test in Progress	
15082	Feith - WF - Dental Reconsideration Workflow	CO	Y	Operations CSR	7/30/2018	Feith	Workflow	Major - No Work Around (2)	8/9/2018 14:11	Const/Unit Test in Progress	
15083	Feith - WF - Update PA1 to Write to T_PA_Auth	CO	Y	Operations CSR	7/30/2018	Feith	Workflow	Major - No Work Around (2)	7/30/2018 15:59	Change Order Written	
15084	Feith - Config - Set up PAR Barcode in Sweeper	CO	Y	Operations CSR	7/30/2018	Feith	Install & Config	Major - No Work Around (2)	9/19/2018 13:21	MO Implementation	
15085	Feith - Form - PAR Web Portal Form w/Reverse Proxy	CO	Y	Operations CSR	7/30/2018	Feith	Form	Major - No Work Around (2)	8/27/2018 15:24	Const/Unit Test in Progress	
15086	Feith - DM - iC_Prod_PA_R	CO	Y	Operations CSR	7/30/2018	Feith	Data Model Change	Major - No Work Around (2)	8/2/2018 6:59	Const/Unit Test in Progress	
15087	Feith - DM - PA_Status Entry	Task	Y	CSR	7/30/2018	Feith	Data Model Change	Minor (4)	8/13/2018 9:17	MO Implementation	
15088	Feith - Form - Remove Checkbox from PA Forms	CO	Y	CSR	7/30/2018	Feith	Form	Minor (4)	7/30/2018 16:17	Change Order Written	
15144	Feith - Config - Update Config file for TY2018 1095s	CO	Y	Operations CSR	8/15/2018	Feith	Install & Config	Major - No Work Around (2)	9/28/2018 15:37	MO Implementation	
15160	ICN - Phase 2 - Feith - Config - MGM-7182-2	CO	Y	Operations CSR	8/24/2018	Feith	Install & Config	Major - No Work Around (2)	11/5/2018 8:53	UAT Implementation	
15167	Feith - DB - Update Access to MMIS Tables for PA Reconsideration	CO	Y	Operations CSR	8/29/2018	Feith	Data Model Change	Major - No Work Around (2)	8/29/2018 13:53	Change Order Written	
15180	ICN - Phase 2 - Feith - Config - MGM-A820-M	CO	Y	Operations CSR	9/6/2018	Feith	Install & Config	Major - No Work Around (2)	11/5/2018 9:10	UAT Implementation	
15186	Feith - Form - ABA PA	CO	Y	Operations CSR	9/18/2018	Feith	Form	Major - No Work Around (2)	10/9/2018 11:13	Prod Verification	
15187	Feith - WF - ABA PA	CO	Y	Operations CSR	9/18/2018	Feith	Workflow	Major - No Work Around (2)	10/9/2018 10:40	Prod Verification	

15191	Feith - Config - ABA PA Barcode	CO	Y	Operations CSR	9/19/2018	Feith	Install & Config	Major - No Work Around (2)	10/9/2018 11:47	Prod Verification	
15276	Feith - Form - Add Fax Number to LTC Barcode Cover Sheets	CO	N	MNT	10/12/2018	Feith	Form	Internal (6)	11/16/2018 13:28	**Ready for UAT Impl**	
15284	Feith - Workflow - Expand ABA PA Workflow	CO	Y	Operations CSR	10/22/2018	Feith	Workflow	Major - No Work Around (2)	11/2/2018 11:05	Const/Unit Test in Progress	
15333	ICN - Phase 2 - Feith - Config - MGD-0081-M	CO	Y	Operations CSR	11/15/2018	Feith	Install & Config	Major - No Work Around (2)	11/15/2018 12:47	MO Implementation	
14741	Individual Enrollment of Allied Mental Health	CO	Y	CSR	2/1/2018	Financial	Install & Config	Minor (4)	9/28/2018 8:22	Prod Verification	
14750	Fund codes needed are MU-SMD16-0003 EP and MU-SMD16-0003 EH	CO	Y	Operations CSR	2/5/2018	Financial	Install & Config	Major - With Work Around (3)	3/21/2018 9:30	Prod Verification	
14864	Financial RA in Excel Format	CO	Y	Operations CSR	3/29/2018	Financial	Batch Reports	Major - With Work Around (3)	4/5/2018 11:05	Const/Unit Test in Progress	
14895	RTI - Remove unwanted files/factory methods from Financial subsystem	CO	N	MNT	4/11/2018	Financial	UI	Minor (4)	10/5/2018 15:01	Ready for Const Wthru	
14948	Financial - Add new expediture and A/R reason codes for DSH for Public/Private	Task	Y	Operations CSR	5/4/2018	Financial	Data Fix	Major - No Work Around (2)	5/10/2018 12:14	Prod Verification	
15036	Add new fund codes for Targeted Case Management for Substance Abuse Services	CO	Y	Operations CSR	6/28/2018	Financial	Data Fix	Minor (4)	9/11/2018 16:17	Prod Verification	
15080	Financial - Phase 1 -New Fund Codes for ICN Project	CO	Y	CSR	7/30/2018	Financial	Install & Config	Minor (4)	9/28/2018 8:23	Prod Verification	
15105	Financial - Phase 2 -Add new Financial cycle for 1st business day of month for ICN CAPS/all CAPS	CO	Y	Operations CSR	8/2/2018	Financial	Batch	Major - No Work Around (2)	11/1/2018 8:44	UAT Implementation	
15174	835 Institutional Balancing issues	Defect	N	MNT	8/31/2018	Financial	Batch	Major - No Work Around (2)	9/5/2018 7:34	Awaiting Further Definition	
15271	11	CO	Y	CSR	10/10/2018	Financial	Install & Config	Minor (4)	11/15/2018 11:31	MO Testing in Progress	
15318	FIN - Update email distributions	CO	N	MNT	11/8/2018	Financial	Batch	Internal (6)	11/16/2018 10:54	Ready for Const Wthru	
7405	LTC Application Process -- Use Retro Information	CO	Y	CSR	1/15/2010	Long Term Care	Batch	Minor (4)	3/13/2013 12:00	Hold	
11364	LTC Hospice Transfer redefined	CO	Y	Operations CSR	9/6/2013	Long Term Care	Batch	Major - No Work Around (2)	9/6/2013 10:19	Change Order Written	
14245	Waiver Initial Assessment submitted via software not always written correctly	Defect	N	MNT	4/4/2017	Long Term Care	Batch	Major - No Work Around (2)	6/20/2018 13:56	Issue Identified	
14559	LTC Defects for overlap and transfers	Defect	N	MNT	10/5/2017	Long Term Care	Batch	Major - No Work Around (2)	10/5/2018 12:08	Ready for MO Implementation	
14591	LTC Admission Notification Software no longer require SSN	CO	Y	Operations CSR	11/2/2017	Long Term Care	Batch	Major - No Work Around (2)	5/29/2018 10:02	MO Testing in Progress	
14592	LTC Admission Notification Software no longer require SSN Batch changes	CO	Y	Operations CSR	11/2/2017	Long Term Care	Batch	Major - No Work Around (2)	5/29/2018 10:02	MO Testing in Progress	
14593	LTC Admission Notification Software no longer require SSN Report changes	CO	Y	Operations CSR	11/2/2017	Long Term Care	Batch Reports	Major - No Work Around (2)	5/29/2018 10:02	MO Testing in Progress	
14790	Report LTC/Waiver assignments where claims not received	CO	Y	Operations CSR	3/1/2018	Long Term Care	Batch	Major - No Work Around (2)	10/12/2018 10:07	Prod Verification	
15206	LTC - Software Change to add Admission Reasons	CO	Y	Operations CSR	10/1/2018	Long Term Care	Batch	Major - No Work Around (2)	10/1/2018 15:08	Change Order Written	
15207	LTC - Level of Care panel change to add Admission Reasons	CO	Y	Operations CSR	10/1/2018	Long Term Care	UI	Major - No Work Around (2)	10/1/2018 16:38	Change Order Written	
15209	LTC - I-SNPs - Confirm Pharmacy Lock-in panel not effected by change	CO	Y	Operations CSR	10/1/2018	Long Term Care	UI	Major - No Work Around (2)	10/1/2018 17:09	Change Order Written	
15210	LTC - I-SNPs - LTC AND WAIVER MONTHLY ACTIVITY REPORT, LTC-0007-M, changes	CO	Y	Operations CSR	10/1/2018	Long Term Care	Batch Reports	Major - No Work Around (2)	10/1/2018 17:17	Change Order Written	

15261	LTC Defect - to handle remaining issues effecting admissions and discharges	Defect	N	MNT	10/8/2018	Long Term Care	Batch	Major - No Work Around (2)	10/8/2018 15:33	SE Assigned	
13541	T-MSIS missing data elements - Eligibles short-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	5/20/2016 16:48	Const/Unit Test in Progress	
13544	T-MSIS missing data elements - CLAIMIP long-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	2/14/2017 8:56	Const/Unit Test in Progress	
13545	T-MSIS missing data elements - CLAIMLT long-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	2/14/2017 9:20	Const/Unit Test in Progress	
13546	T-MSIS missing data elements - CLAIMOT long-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	10/4/2016 8:04	Const/Unit Test in Progress	
13547	T-MSIS missing data elements - CLAIMRX long-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	2/14/2017 9:21	Const/Unit Test in Progress	
13548	T-MSIS missing data elements - Eligibles long-term	CO	Y	CSR	4/29/2016	MAR	Batch	Minor (4)	6/6/2016 9:12	Const/Unit Test in Progress	
14612	T-MSIS Reporting of Inactive Providers	CO	Y	CSR	11/13/2017	MAR	Batch	Minor (4)	12/4/2017 10:17	Const/Unit Test in Progress	3/6/2018
14756	T-MSIS Reporting of PCCM Providers	CO	Y	CSR	2/9/2018	MAR	Batch	Minor (4)	3/7/2018 9:28	Const/Unit Test in Progress	6/13/2018
14953	Supply Maternity Care data elements in T-MSIS	CO	Y	CSR	5/8/2018	MAR	Batch	Minor (4)	5/8/2018 10:21	Change Order Written	5/10/2019
14992	Add provider type 53 and specialty 590 to CMS 372 Reports	CO	Y	Operations CSR	5/31/2018	MAR	Data Fix	Minor (4)	11/2/2018 14:28	Prod Verification	8/22/2018
15024	Change MEDICARE-COMB-DED-IND from 8 fill to 0 for CRX File	CO	Y	Operations CSR	6/15/2018	MAR	Batch	Minor (4)	10/24/2018 9:21	Prod Verification	######
15079	Modification of health home chronic conditions logic	Defect	N	MNT	7/30/2018	MAR	Batch	Minor (4)	7/30/2018 10:57	SE Assigned	######
15102	Phase 2 - Modify EDW and ACW 372 waiver reports for ICN project	CO	Y	Operations CSR	8/1/2018	MAR	Batch Reports	Major - No Work Around (2)	11/5/2018 10:51	**Ready for UAT Impl**	
15103	Phase 2 - Modify T-MSIS for ICN project	CO	Y	Operations CSR	8/1/2018	MAR	Batch	Major - No Work Around (2)	8/31/2018 14:56	Const/Unit Test in Progress	
15128	Modify TMSIS for NET(non-emergency transportation) claims	CO	Y	Operations CSR	8/7/2018	MAR	Batch Reports	Major - No Work Around (2)	8/7/2018 20:02	Change Order Written	
15332	Add rows to T-MSIS tables based on new fund codes	CO	Y	CSR	11/15/2018	MAR	Batch	Minor (4)	11/15/2018 10:31	Change Order Written	
14653	Change MC SFTP delivery Method on Agency Files	CO	Y	CSR	12/4/2017	Managed Care	Extract Process	Minor (4)	12/4/2017 15:06	Change Order Written	
14843	Remove PHI PII info from Alabama Medicaid Managed Care User Manual	CO	N	MNT	3/26/2018	Managed Care	Documentation	Minor (4)	6/19/2018 11:40	**Ready for UAT Impl**	
14896	RTI - Remove unwanted files/factory methods from Managed Care subsystem	CO	N	MNT	4/11/2018	Managed Care	UI	Minor (4)	4/11/2018 12:43	Change Order Written	
14999	MC Batch Payment Suspension changes	CO	Y	Operations CSR	6/6/2018	Managed Care	Batch	Major - No Work Around (2)	8/22/2018 9:01	Prod Verification	
15000	MC UI Payment Suspension changes	CO	Y	CSR	6/6/2018	Managed Care	UI	Minor (4)	8/22/2018 8:18	Prod Verification	8/8/2018
15074	MC ICN High Level CO	CO	Y	Operations CSR	7/25/2018	Managed Care	High Level CO	Major - No Work Around (2)	7/25/2018 12:58	Change Order Written	
15095	ICN Phase 2 - Exclude ICN plans from PMP Assignment History and Case Panels	CO	Y	Operations CSR	8/1/2018	Managed Care	UI	Minor (4)	11/8/2018 15:42	MO Testing in Progress	8/24/2018
15096	ICN Phase 2 - Create new ICN Assignment History Panel	CO	Y	Operations CSR	8/1/2018	Managed Care	UI	Minor (4)	11/8/2018 15:42	MO Testing in Progress	9/11/2018
15097	ICN Phase 2 - Recipient MC Special Conditions panel	CO	Y	Operations CSR	8/1/2018	Managed Care	UI	Major - No Work Around (2)	11/8/2018 15:28	MO Testing in Progress	8/30/2018
15098	ICN Phase 2 - Update Managed Care Tables to support ICN Plans	Task	Y	Operations CSR	8/1/2018	Managed Care	Install & Config	Major - No Work Around (2)	11/1/2018 9:06	UAT Implementation	
15104	ICN Phase 2 - Create ICN Auto-assignment/disenrollment process	CO	Y	Operations CSR	8/2/2018	Managed Care	Batch	Major - No Work Around (2)	11/15/2018 9:48	MO Testing Complete	
15111	ICN Phase 2 - Update Panels to find contracts based on 1st three char of cde_pgm_health	CO	Y	Operations CSR	8/3/2018	Managed Care	UI	Major - No Work Around (2)	8/29/2018 8:48	Const Wthru Completed	8/22/2018

15112	ICN Phase 2 - Create ICN Prospective Caps process	CO	Y	Operations CSR	8/3/2018	Managed Care	Batch	Major - No Work Around (2)	11/13/2018 10:47	MO Testing Complete	
15113	ICN Phase 2 - Create ICN Recon Cap process	CO	Y	Operations CSR	8/3/2018	Managed Care	Batch	Major - No Work Around (2)	11/13/2018 10:48	MO Testing Complete	
15114	ICN Phase 2 - Changes to mgd_common to support ICN project	CO	Y	Operations CSR	8/3/2018	Managed Care	Batch	Major - No Work Around (2)	11/13/2018 10:48	MO Testing Complete	
15115	ICN Phase 2 - Create ICN version of mgd_prerecon	CO	Y	Operations CSR	8/3/2018	Managed Care	Batch	Major - With Work Around (3)	11/13/2018 10:49	MO Testing Complete	
15131	ACHN MC Design	CO	Y	ACHN	8/9/2018	Managed Care	High Level CO	Internal (6)	8/9/2018 8:21	Change Order Written	
15146	ICN Phase 2 - Modify RCO's MGD-A131-M report to work for ICN	CO	Y	Operations CSR	8/20/2018	Managed Care	Batch Reports	Minor (4)	11/13/2018 10:53	MO Testing Complete	
15159	ICN Phase 2 - Create MGD-0004-M rpt for ICN as well as MDADV	CO	Y	Operations CSR	8/24/2018	Managed Care	Batch Reports	Minor (4)	11/13/2018 10:50	MO Testing Complete	
15163	MC Batch Payment Suspension tied to ended PMPs	CO	Y	CSR	8/28/2018	Managed Care	Batch	Minor (4)	9/28/2018 10:05	MO Testing in Progress	
15214	ACHN MC Remediation	CO	N	ACHN	10/2/2018	Managed Care	High Level CO	Internal (6)	10/2/2018 13:39	Change Order Written	
15215	ACHN Phase 1 - Update Managed Care Tables to support ACHN Plan	CO	Y	ACHN	10/1/2018	Managed Care	Install & Config	Internal (6)	10/1/2018 13:50	Const/Unit Test in Progress	
15218	ACHN - Phase 1 - Add T_CAP_ACHN_ANNUAL_MAX	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Internal (6)	10/2/2018 13:57	Change Order Written	
15219	ACHN - Remove obsolete T_RE_RCO_ASSIGN	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Minor (4)	11/12/2018 20:13	Ready for Const Wthru	
15220	ACHN - Remove obsolete T_MC_RE_RCO_SEL	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Minor (4)	11/7/2018 8:44	Ready for MO Implementation	
15221	ACHN - Remove obsolete T_MC_EB_REJECTS	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Minor (4)	11/7/2018 8:45	Ready for MO Implementation	
15222	ACHN - Remove obsolete T_MC_RISK_LEVEL_CNTS	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Minor (4)	11/7/2018 8:45	Ready for MO Implementation	
15223	ACHN - Rename column on T_RE_PMP_REASON	CO	N	ACHN	10/2/2018	Managed Care	Data Model Change	Minor (4)	11/12/2018 20:14	Ready for Const Wthru	
15224	parm(s)	CO	N	ACHN	10/2/2018	Managed Care	Batch	Minor (4)	10/9/2018 8:59	Const/Unit Test in Progress	
15225	ACHN Phase 1 - Changes to mgd_common to support ACHN project	CO	Y	ACHN	10/2/2018	Managed Care	Batch	Minor (4)	10/3/2018 8:00	Const/Unit Test in Progress	
15226	ACHN Phase 1 - Create ACHN potentials program	CO	N	ACHN	10/2/2018	Managed Care	Batch	Minor (4)	10/12/2018 7:32	Const/Unit Test in Progress	
15227	ACHN Phase 1 - Create ACHN Auto-assign process	CO	N	ACHN	10/2/2018	Managed Care	Batch	Internal (6)	10/15/2018 7:32	Const/Unit Test in Progress	
15229	ACHN Phase 1 - Create ACHN daily Disenrollment pr	CO	N	ACHN	10/2/2018	Managed Care	Batch	Minor (4)	10/25/2018 12:13	Const/Unit Test in Progress	
15231	ACHN Phase 1 - Create ACHN monthly Disenrollment process	CO	N	ACHN	10/2/2018	Managed Care	Batch	Minor (4)	10/25/2018 9:54	Const/Unit Test in Progress	
15234	ACHN Phase 1 - Create ACHN Mass Disenrollment process	CO	N	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/4/2018 8:27	Const/Unit Test in Progress	
15235	ACHN - Phase 1 - Create ACHN Prerecon Process	CO	N	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/3/2018 8:18	Const/Unit Test in Progress	
15236	ACHN Phase 1 - Create ACHN PMPM Recon Cap process	CO	N	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/3/2018 8:38	Const/Unit Test in Progress	
15237	ACHN Phase 1 - Create ACHN PMPM Prospective Caps process	CO	N	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/3/2018 8:40	Const/Unit Test in Progress	
15238	ACHN Phase 1 - Update MNGCCHKA.sql for ACHN checks	CO	N	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/19/2018 8:41	Const/Unit Test in Progress	
15239	ACHN - Phase TBD - Stop Extracts to USACSHI	CO	N	ACHN	10/3/2018	Managed Care	Extract Process	Minor (4)	10/26/2018 12:42	Const/Unit Test in Progress	
15240	ACHN Phase 1 - Create ACHN Enrollment Roster Rpt	CO	N	ACHN	10/3/2018	Managed Care	Batch Reports	Minor (4)	10/4/2018 12:34	Const/Unit Test in Progress	

15241	ACHN Phase 1 - Create Quarterly ACHN Referral Report	CO	N	ACHN	10/3/2018	Managed Care	Batch Reports	Minor (4)	10/3/2018 9:07	Change Order Written	
15242	ACHN - Phase TBD - Create New ACHN Assignment History panel	CO	N	ACHN	10/3/2018	Managed Care	UI	Minor (4)	10/3/2018 9:22	Change Order Written	
15243	ACHN - Phase TBD - Create New ACHN Capitaton Limits panel	CO	N	ACHN	10/3/2018	Managed Care	UI	Minor (4)	10/3/2018 9:33	Change Order Written	
15244	ACHN - Phase TBD - Remove Patient 1st panels no longer needed	CO	N	ACHN	10/3/2018	Managed Care	UI	Minor (4)	10/3/2018 9:50	Change Order Written	
15249	ACHN - Phase 2 - Create 820 TXN process for ACHN	CO	Y	ACHN	10/3/2018	Managed Care	Batch	Minor (4)	10/3/2018 13:46	Change Order Written	
15251	ACHN - Phase TBD - Modify Region Enrollment Maintenance panel to support ACHN	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	10/4/2018 11:05	Change Order Written	
15252	ACHN - Phase TBD - Update PMP Assignment History panel for ACHN requirements	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	10/4/2018 11:27	Change Order Written	
15253	ACHN - Phase TBD - Modify MC Assignment Reason Panel	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	10/4/2018 11:35	Change Order Written	
15254	ACHN - Phase TBD - Modify Capitation Rate Override panel to support ACHN	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	10/4/2018 11:40	Change Order Written	
15255	ACHN - Phase TBD - Modify Recipient Special Condition Panel to support ACHN	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	10/4/2018 11:44	Change Order Written	
15256	ACHN - Phase TBD - Modify the PMP Maintenance panel to support ACHN	CO	N	ACHN	10/4/2018	Managed Care	UI	Minor (4)	11/1/2018 12:21	SE Assigned	
15328	ICN Phase 2 - Create new MGD-0081-M rpt for ICN	CO	Y	CSR	11/14/2018	Managed Care	Batch Reports	Minor (4)	11/15/2018 11:40	Ready for Const Wthru	
15338	Update MGD-A500-Q Report - text and field name	CO	Y	Operations CSR	11/16/2018	Managed Care	Batch Reports	Major - No Work Around (2)	11/16/2018 9:40	Change Order Written	
7708	CSR146 - Web Portal - Reconsideration for Denied P	CO	Y	Operations CSR	4/16/2010	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:34	CO Work In Progress	
8721	CSR274 - Send SOBRA Application fields from AMAES	CO	Y	Operations CSR	2/10/2011	Mother CO	Operations CSR	Major - No Work Around (2)	6/11/2018 9:45	CO Work In Progress	3/1/2011
10627	CSR447 - BNP - Modify ESC 5001	CO	Y	Operations CSR	9/10/2012	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:35	CO Work In Progress	11/1/2012
10746	CSR468 - BNP - LTC Software Change	CO	Y	Operations CSR	10/23/2012	Mother CO	Operations CSR	Major - No Work Around (2)	10/23/2012 8:30	Change Order Written	1/1/2013
11786	CSR597 - BNP - Smoking Cessation Counseling	CO	Y	Operations CSR	2/26/2014	Mother CO	Operations CSR	Major - No Work Around (2)	2/26/2014 15:56	Change Order Written	3/1/2014
12088	CSR622 - BNP - Maternity Care Encounter Claims	CO	Y	Operations CSR	7/17/2014	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:35	CO Work In Progress	11/1/2014
12366	CSR608 - Pharmacy Therapeutic Dup-Systemic Drugs	CO	Y	Operations CSR	12/2/2014	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:36	CO Work In Progress	7/1/2014
12367	CSR621 - Timely Refill Message	CO	Y	Operations CSR	12/2/2014	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:36	CO Work In Progress	10/1/2014
12438	CSR660 - Modify DSS purge to retain hospital claim	CO	Y	Operations CSR	1/16/2015	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:36	CO Work In Progress	2/28/2015
12453	CSR669 - Copy of Service Usage Panel Tables	CO	Y	Operations CSR	1/22/2015	Mother CO	Operations CSR	Major - No Work Around (2)	4/19/2018 7:40	Hold	3/15/2015
12750	CSR693 - BNP - ESC 824 Unborn Age Change	CO	Y	Operations CSR	5/14/2015	Mother CO	Operations CSR	Major - No Work Around (2)	5/14/2015 15:43	Change Order Written	7/1/2015
12780	CSR696 - ACA Minimum Essential Coverage Reporting	CO	Y	Operations CSR	6/5/2015	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:37	CO Work In Progress	7/1/2015
12870	CSR701 - TPL - Enhance Southland Data Match Report	CO	Y	Operations CSR	8/4/2015	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:37	CO Work In Progress	7/31/2015

13015	CSR713 - BNP - Retro DOD Change	CO	Y	Operations CSR	9/28/2015	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:37	CO Work In Progress	12/1/2015
13156	CSR714 - Recipient Portal Website Changes:	CO	Y	Operations CSR	10/7/2015	Mother CO	Operations CSR	Major - No Work Around (2)	10/7/2015 14:07	Change Order Written	1/1/2016
13199	CSR715 - BNP - Hospice Changes	CO	Y	Operations CSR	10/19/2015	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:38	CO Work In Progress	
13285	CSR723 - GP - Scope of Work Estimated ASC X12 275	CO	Y	Operations CSR	12/10/2015	Mother CO	Operations CSR	Major - No Work Around (2)	12/10/2015 11:33	Change Order Written	3/1/2016
13520	CSR742 - Dispensing Fee Reversion 2016	CO	Y	Operations CSR	4/22/2016	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:38	CO Work In Progress	5/1/2016
13560	CSR726 - swm-CRNP/PA procedure coverage	CO	Y	Operations CSR	5/6/2016	Mother CO	Operations CSR	Major - No Work Around (2)	5/6/2016 15:05	Change Order Written	1/18/2016
13727	CSR750 - Modify State Month-End file extracts and	CO	Y	Base RCO	7/21/2016	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:40	CO Work In Progress	######
13821	CSR756 - Recipient Telephone Numbers needed in MMI	CO	Y	Base RCO	9/1/2016	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:41	CO Work In Progress	1/1/2017
13981	CSR773 - FirstData EVVM changes	CO	Y	Operations CSR	11/29/2016	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:43	CO Work In Progress	1/1/2017
14118	CSR785 - BC-CMHC billing changes	CO	Y	Operations CSR	1/30/2017	Mother CO	Operations CSR	Major - No Work Around (2)	1/30/2017 10:51	Change Order Written	10/1/2017
14459	CSR818 - Pharmacy Add MME files	CO	Y	Operations CSR	8/21/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:51	CO Work In Progress	9/1/2017
14532	CSR829 - Pharmacy-Vaccine Administration	CO	Y	Operations CSR	9/26/2017	Mother CO	Operations CSR	Major - No Work Around (2)	9/26/2017 16:53	Change Order Written	7/1/2018
14600	CSR834 - Individual Enrollment of Allied Mental He	CO	Y	Operations CSR	11/6/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:49	CO Work In Progress	12/1/2017
14609	CSR841 - Patient First Exemption Changes	CO	Y	Operations CSR	11/9/2017	Mother CO	Operations CSR	Major - No Work Around (2)	11/9/2017 13:29	Change Order Written	
14630	CSR845 - Convert Agency DSS Business Object Login	CO	Y	Operations CSR	11/18/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:45	CO Work In Progress	
14633	CSR840 - 2018 HCPCS	CO	N	Operations CSR	11/21/2017	Mother CO	Operations CSR	Major - No Work Around (2)	11/21/2017 8:50	Change Order Written	1/1/2018
14643	CSR848 - Send extracts to Agency SFTP	CO	Y	Operations CSR	11/29/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:52	CO Work In Progress	3/1/2018
14670	CSR853 - Program Changes--prvGrpMbrDeactivate	CO	Y	Operations CSR	12/15/2017	Mother CO	Operations CSR	Major - No Work Around (2)	7/19/2018 14:32	CO Work In Progress	1/1/2018
14675	CSR858 - 2018 MITA	CO	Y	Operations CSR	12/20/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:52	CO Work In Progress	
14677	CSR857 - Pharmacy FDB Reuse NDC	CO	Y	Operations CSR	12/21/2017	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:51	CO Work In Progress	1/1/2019
14697	CSR859 - Surescripts Network Resiliency	CO	Y	Operations CSR	1/5/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:46	CO Work In Progress	
14734	CSR863 - SUR Indicator/Payment Suspension Issue	CO	Y	Operations CSR	1/29/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:50	CO Work In Progress	3/31/2018
14740	CSR864 - Add previous sanction indicator to facsim	CO	Y	Operations CSR	1/31/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:50	CO Work In Progress	3/31/2018
14745	CSR865 - Add fund codes for MU-SMD 16-0003 EP and	CO	Y	Operations CSR	2/5/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:47	CO Work In Progress	4/2/2018
14787	CSR872 - LTC Assignment Review	CO	Y	Operations CSR	2/28/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:48	CO Work In Progress	

14792	CSR873 - 2018 CDT/CPT licensing agreement copyrigh	CO	Y	Operations CSR	3/5/2018	Mother CO	Operations CSR	Major - No Work Around (2)	3/8/2018 15:51	CO Work In Progress	
14827	CSR879 - CSR for Rebate on audited claims	CO	Y	Operations CSR	3/22/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/22/2018 11:02	CO Work In Progress	4/2/2018
14831	CSR883 - Create paper RA in excel for Dept of Seni	CO	Y	Operations CSR	3/23/2018	Mother CO	Operations CSR	Major - No Work Around (2)	3/29/2018 19:13	CO Work In Progress	
14868	CSR884 - CSR for PAD Fee Schedule	CO	Y	Operations CSR	3/30/2018	Mother CO	Operations CSR	Major - No Work Around (2)	3/30/2018 7:27	Change Order Written	5/1/2018
14877	CSR885 - Change Medi-Medi Vendor	CO	Y	Operations CSR	4/4/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:53	CO Work In Progress	5/31/2018
14901	CSR887 - Limitation Audit Benefits and Career Coun	CO	Y	Operations CSR	4/16/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/14/2018 13:24	CO Work In Progress	6/15/2018
14924	CSR891 - TPL Mini Rekey Process	CO	Y	Operations CSR	4/30/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:54	CO Work In Progress	6/1/2018
14926	CSR893 - Split Large Plastic Card Files	CO	Y	Operations CSR	4/30/2018	Mother CO	Operations CSR	Major - No Work Around (2)	4/30/2018 10:42	Change Order Written	
14934	CSR894 - Targeted Case Management CSR	CO	Y	Operations CSR	5/1/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:50	CO Work In Progress	6/1/2018
14956	CSR895 - TA Personal Choices Claims	CO	Y	Operations CSR	5/8/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:48	CO Work In Progress	6/1/2018
14966	CSR901 - Modify Provider EFT and enrollment panels	CO	Y	Operations CSR	5/17/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/2/2018 11:40	CO Work In Progress	
14973	CSR900 - Add DME provider name	CO	Y	Operations CSR	5/21/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/15/2018 15:07	CO Work In Progress	6/12/2018
14981	CSR889 - Applied Behavior Analysis ABA Therapy	CO	Y	Operations CSR	5/23/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/8/2018 9:33	CO Work In Progress	10/1/2018
14982	CSR904 - Create a limitation audit and add modifie	CO	Y	Operations CSR	5/25/2018	Mother CO	Operations CSR	Major - No Work Around (2)	5/25/2018 7:12	Change Order Written	7/1/2018
14983	CSR903 - Create a limitation audit and add modifie	CO	Y	Operations CSR	5/25/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/14/2018 13:24	CO Work In Progress	7/1/2018
15017	CSR906 - ICN Encounter and PMPM	CO	Y	Operations CSR	6/13/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/25/2018 14:08	CO Work In Progress	10/1/2018
15021	CSR908 - Process Improvement: Change DSS Rekey Pro	CO	Y	Operations CSR	6/14/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/2/2018 9:30	CO Work In Progress	
15032	CSR909 - Pharmacy DUR-Opiod Experienced 90MME CSR	CO	Y	Operations CSR	6/21/2018	Mother CO	Operations CSR	Major - No Work Around (2)	6/21/2018 13:13	Change Order Written	2/1/2019
15037	CSR911 - Recipient Rekey Mod - TPL Policies	CO	Y	Operations CSR	6/29/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/2/2018 9:30	CO Work In Progress	
15049	CSR916 - Telcor SFTP Setup	CO	Y	Operations CSR	7/17/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/10/2018 16:35	CO Work In Progress	
15052	CSR918 - Drug Rebate Adjustment Invoices	CO	Y	Operations CSR	7/18/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/18/2018 7:02	Change Order Written	11/1/2018
15053	CSR915 - 85% Timely Refill	CO	Y	Operations CSR	7/18/2018	Mother CO	Operations CSR	Major - No Work Around (2)	7/18/2018 7:04	Change Order Written	#######
15054	CSR919 - Allow providers to download PA decision l	CO	Y	Operations CSR	7/18/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/16/2018 7:57	CO Work In Progress	8/17/2018
15078	CSR922 - Add Medical Services Div. InfoView Groups	CO	Y	Operations CSR	7/30/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/10/2018 16:34	CO Work In Progress	8/20/2018
15101	CSR920 - Enrollment of NET Transporters as Provide	CO	Y	Operations CSR	8/1/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/1/2018 15:30	Change Order Written	10/1/2018

15106	CSR924 - Medicaid Eligibility Linking Interface (M	CO	Y	Operations CSR	8/2/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/2/2018 13:43	Change Order Written	
15116	CSR925 - 2018 Process Improvement Ideas	CO	Y	Operations CSR	8/3/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/20/2018 10:42	CO Work In Progress	
15124	CSR926 - Alabama Coordinated Health Network (ACHN)	CO	Y	Operations CSR	8/7/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/9/2018 11:38	CO Work In Progress	
15130	CSR910 - AAC rate file layout change	CO	Y	Operations CSR	8/8/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/8/2018 14:44	Change Order Written	7/1/2018
15137	CSR928 - Create ADPH IRS 1095 for Tax year 2018	CO	Y	Operations CSR	8/14/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/16/2018 11:10	CO Work In Progress	
15138	CSR929 - Create Medicaid IRS 1095s - Tax year 2018	CO	Y	Operations CSR	8/14/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/20/2018 10:41	CO Work In Progress	
15156	CSR931 - OPR Enrollment Process	CO	Y	Operations CSR	8/24/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/12/2018 20:21	CO Work In Progress	
15158	CSR923 - Genetics Whole Exome sequencing codes	CO	Y	Operations CSR	8/24/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/24/2018 11:00	Change Order Written	8/21/2018
15162	CSR932 - Current physicians on file sent to eviCor	CO	Y	Operations CSR	8/27/2018	Mother CO	Operations CSR	Major - No Work Around (2)	8/27/2018 7:22	Change Order Written	9/1/2018
15166	CSR917 - System change for separate LARC reimburse	CO	Y	Operations CSR	8/29/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/26/2018 16:06	CO Work In Progress	10/1/2018
15176	CSR933 - Add referring provider ID to Detail pd li	CO	Y	Operations CSR	9/4/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/7/2018 16:50	CO Work In Progress	######
15184	CSR934 - Class code value addition	CO	Y	Operations CSR	9/14/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/14/2018 12:15	Change Order Written	2/28/2019
15196	CSR935 - County Inmate Project	CO	Y	Operations CSR	9/26/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/9/2018 11:42	CO Work In Progress	######
15199	CSR936 - Drug Rebate-Delinquent payments email	CO	Y	Operations CSR	9/27/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/27/2018 10:45	Change Order Written	2/1/2019
15200	CSR937 - Drug Rebate-Conversion factor panel updat	CO	Y	Operations CSR	9/27/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/27/2018 10:50	Change Order Written	2/1/2019
15201	CSR938 - Drug Rebate-Retroactive drug rebate invoi	CO	Y	Operations CSR	9/27/2018	Mother CO	Operations CSR	Major - No Work Around (2)	9/27/2018 10:51	Change Order Written	2/1/2019
15203	CSR939 - TCM 2018	CO	Y	Operations CSR	9/28/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/21/2018 20:41	CO Work In Progress	11/1/2018
15263	CSR940 - Fund Code Criteria Panel - Search Feature	CO	Y	Operations CSR	10/9/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/16/2018 11:47	CO Work In Progress	
15274	CSR941 - EPSDT CARES Extract Automation	CO	Y	Operations CSR	10/10/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/26/2018 16:08	CO Work In Progress	
15277	CSR942 - Add pipe (|) to end of T_PR_ADR_DN_Medica	CO	Y	Operations CSR	10/14/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/14/2018 13:40	Change Order Written	
15280	CSR943 - Add new edit: Fee-For-Service Maternity C	CO	Y	Operations CSR	10/16/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/26/2018 15:57	CO Work In Progress	
15289	CSR945 - Clinical Lab Fee Sched New File Format fo	CO	Y	Operations CSR	10/23/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/23/2018 11:36	Change Order Written	
15290	CSR944 - Plastic Card Report	CO	Y	Operations CSR	10/23/2018	Mother CO	Operations CSR	Major - No Work Around (2)	10/23/2018 12:47	Change Order Written	12/3/2018
15315	CSR946 - RDB - 2019 HCPCS	CO	N	Operations CSR	11/7/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/7/2018 8:51	Change Order Written	1/1/2019
15326	CSR947 - LICSW-FQHC	CO	Y	Operations CSR	11/13/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/13/2018 15:04	Change Order Written	12/1/2018

15335	CSR950 - Edit UB92 Birth Weight Field	CO	Y	Operations CSR	11/15/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/15/2018 13:40	Change Order Written	
15337	CSR949 - MGD-A500-A Report	CO	Y	Operations CSR	11/16/2018	Mother CO	Operations CSR	Major - No Work Around (2)	11/16/2018 8:51	Change Order Written	#######
10741	PES Provider List single error repeated	CO	N	MNT	10/19/2012	PES	Batch	Minor (4)	3/13/2013 8:26	SE Assigned	#######
12462	PES - Processing TPL Paper claims Electronically	CO	Y	CSR	1/27/2015	PES	Batch	Minor (4)	3/2/2016 9:36	Hold	
12620	PES - Read / Create 835 Report	CO	N	MNT	4/3/2015	PES	Batch	Minor (4)	4/3/2015 14:16	Change Order Written	
10256	PA Reconsideration report change to add new data	CO	Y	CSR	5/22/2012	Authorization	Batch Reports	Minor (4)	10/4/2018 10:07	UAT Implementation	
10257	PA - Auto denial for PAs in a Status of F- Denied nd Further doco	CO	Y	Operations CSR	5/22/2012	Prior Authorization	Batch	Minor (4)	11/16/2018 15:27	Ready for Const Wthru	
14701	Modify PA processes for re-used NDCs	CO	Y	Operations CSR	1/5/2018	Prior Authorization	Batch	Major - No Work Around (2)	10/24/2018 9:12	Prod Verification	
15119	PA - Report - Create a new version of the PAU-0002W report for Qualis	CO	Y	Operations CSR	8/6/2018	Prior Authorization	Batch Reports	Minor (4)	10/3/2018 11:04	SE Assigned	
15120	PA-Report- Update existing Quality reports to capture when a PA is changed to Status F and Status G	CO	Y	Operations CSR	8/6/2018	Prior Authorization	Batch Reports	Minor (4)	11/6/2018 10:46	UAT Implementation	
15123	PA UI - Update edit to require a reason code when PA line item status is changed to Status F	CO	Y	Operations CSR	8/7/2018	Prior Authorization	UI	Minor (4)	11/15/2018 8:15	UAT Implementation	#######
15172	PA UI - Add the two new reason codes for the Reconsideration process.	CO	Y	Operations CSR	8/30/2018	Prior Authorization	Install & Config	Minor (4)	9/12/2018 16:20	Ready for Const Wthru	
11000	iTRACE Maintenance	CO	N	MNT	3/26/2013	Project Workbook	High Level CO	Internal (6)	3/26/2013 12:02	Change Order Written	
14766	AMHP Allied Mental Health Providers Enrollment (Discontinue LCSW)	CO	Y	Operations CSR	2/21/2018	Prov Enroll Portal	Install & Config	Minor (4)	2/21/2018 11:02	Change Order Written	
14819	Modify Enrollment Portal to Accommodate Agency Review Column on T_PR_ENRL	CO	Y	Operations CSR	3/15/2018	Prov Enroll Portal	UI	Minor (4)	8/22/2018 12:36	Prod Verification	8/7/2018
14873	Provider Enrollment Portal UM PHI PII Redaction	CO	N	MNT	4/3/2018	Prov Enroll Portal	Documentation	Internal (6)	4/10/2018 9:57	CO Work In Progress	
14968	Modify Provider Enrollment Portal EFT Pages	CO	Y	CSR	5/17/2018	Prov Enroll Portal	UI	Minor (4)	10/24/2018 1:39	Prod Verification	10/5/2018
15099	Edit Specialty Selection for Type 31-To Select 175 339 Must Also Be Selected.	CO	Y	Operations CSR	8/1/2018	Prov Enroll Portal	UI	Minor (4)	11/14/2018 18:14	UAT Implementation	11/2/2018
15267	Filter Specialties for TCM 10	CO	Y	CSR	10/10/2018	Prov Enroll Portal	UI	Minor (4)	10/22/2018 10:47	Hold	
15306	ACHN - Filter New ACHN Type and Specialty from Enrollment Portal Drop Downs	CO	Y	ACHN	11/6/2018	Prov Enroll Portal	UI	Minor (4)	11/6/2018 13:35	Change Order Written	
11928	New Pharmacy Professional Svc Type and Specialty	CO	Y	CSR	5/15/2014	Provider	Install & Config	Minor (4)	10/26/2016 11:12	Hold	
14515	Add DRG Rates	Task	N	Base RCO	9/14/2017	Provider	Install & Config	Minor (4)	1/2/2018 12:59	Hold	
14608	VFC DME Short Term Solution	Task	Y	CSR	11/8/2017	Provider	Install & Config	Minor (4)	1/15/2018 12:50	Hold	
14687	prvGrpMbrDeactivate Modifications	CO	Y	CSR	1/2/2018	Provider	Batch	Minor (4)	9/18/2018 13:30	UAT Implementation	
14814	Update prv_sec_facs and Secondary Facsimiles to Include the Agency Review Indicator	CO	Y	Operations CSR	3/14/2018	Provider	Batch	Minor (4)	8/22/2018 8:58	Prod Verification	
14874	Create OPR Panel to upload OPR to the Feith.	CO	N	MNT	4/3/2018	Provider	UI	Minor (4)	10/2/2018 17:05	Ready for Const Wthru	5/3/2018
14887	Provider - Change AdvanceMed Extracts to CMS	CO	Y	CSR	4/10/2018	Provider	Extract Process	Minor (4)	4/10/2018 12:44	Change Order Written	
14950	Add Column to T_PR_ENROLL_INFO to Capture Re-Enrollment Completion Date	CO	N	MNT	5/7/2018	Provider	Data Model Change	Minor (4)	11/13/2018 12:52	MO Testing Complete	
14951	Add Field to Enrollment Info Panel to Capture Re-Enrollment Completion Date	CO	N	MNT	5/7/2018	Provider	UI	Minor (4)	11/8/2018 9:07	MO Implementation	#######

14952	Produce Provider Re-Enrollment Completion Notice	CO	N	MNT	5/7/2018	Provider	Letters	Minor (4)	11/13/2018 12:53	MO Testing Complete	
14958	Update Impacted Items Accommodate T_PR_ENROLL_INFO Completion Date	CO	N	MNT	5/11/2018	Provider	Batch	Minor (4)	5/11/2018 12:51	Change Order Written	
14980	Modify EFT Forms to Exclude the Withdrawal Acccount Option and Add Edits	Task	Y	Operations CSR	5/23/2018	Provider	Documentation	Minor (4)	5/23/2018 11:45	Change Order Written	
15149	Re-Enrollment Facsimile Process Improvement	CO	Y	CSR	8/20/2018	Provider	Letters	Minor (4)	8/20/2018 15:11	Change Order Written	
15168	Identify and Close OPR Enrollments with Full MCD Enrollments (prebatch)	Task	Y	Operations CSR	8/29/2018	Provider	Data Fix	Minor (4)	9/10/2018 16:18	CO Work In Progress	
15169	Batch Development - Identify and Close OPR Enrollments with Full MCD Enrollments	CO	Y	Operations CSR	8/29/2018	Provider	Batch	Minor (4)	11/1/2018 7:09	UAT Implementation	
15170	Modify current Evicore Provider Extract to Limit Data to Current Providers	CO	Y	Operations CSR	8/29/2018	Provider	Batch	Minor (4)	10/16/2018 12:18	Hold	
15179	Map sak_prov, Sak_prov_loc in ProviderFactory properly	Defect	N	MNT	9/6/2018	Provider	UI	Major - No Work Around (2)	10/10/2018 8:16	Prod Verification	9/19/2018
15188	Modify T_PR_RISK_GRP_XREF to Moderate for AMHP	Task	Y	Operations CSR	9/18/2018	Provider	Install & Config	Minor (4)	10/19/2018 14:15	Ready for Prod	
15193	Modify Screening Info Panel to Accommodate Risk Level for Type 07	CO	Y	Operations CSR	9/24/2018	Provider	UI	Minor (4)	10/29/2018 8:15	Prod Verification	10/8/2018
15194	Clean up Risk Level and Enrollment Frequency for Type 07 Enrollments	Task	Y	Operations CSR	9/24/2018	Provider	Data Fix	Minor (4)	9/24/2018 14:14	Issue Identified	
15245	AMHP Behavioral Health Re-Enrollment Frequency of 3 Yrs with Visit	CO	Y	Operations CSR	10/3/2018	Provider	Batch	Minor (4)	11/13/2018 13:27	Const/Unit Test in Progress	
15246	Behavioral Health 3 yr Visit Addition to Stats	CO	Y	CSR	10/3/2018	Provider	Batch Reports	Minor (4)	10/3/2018 12:21	Change Order Written	
15247	Modify Inserts to Account for New T_PR_ENROLL_INFO.DTE_COMPLETE Column	CO	N	Operations CSR	10/3/2018	Provider	Batch	Minor (4)	10/3/2018 13:13	Change Order Written	
15248	Modify Provider Enroll Info Code to Account for CDE_ENROLL_FREQ = 3	CO	Y	Operations CSR	10/3/2018	Provider	UI	Minor (4)	11/14/2018 16:20	**Ready for UAT Impl**	11/6/2018
15266	Create and Map New Specialties for TCM Group 10	CO	Y	CSR	10/10/2018	Provider	Install & Config	Minor (4)	11/9/2018 12:39	MO Implementation	
15268	Enroll Provider Files with TCM 10 Specialty 212	CO	Y	CSR	10/10/2018	Provider	Mapping	Minor (4)	10/10/2018 11:21	Change Order Written	
15286	Update prv_WPP_validation to Post Review Indicator of D to T_PR_ENRL for Denied App Facsimiles	CO	Y	Operations CSR	10/23/2018	Provider	Batch	Minor (4)	11/15/2018 12:35	Ready for MO Implementation	
15292	Change Criteria for Posting EFT Review Indicator on Provider Information Panel	Defect	N	MNT	10/25/2018	Provider	UI	Minor (4)	11/13/2018 14:53	Ready for MO Implementation	11/1/2018
15305	ACHN - Create and Map ACHN Type, Spec, Taxonomy and No Services Contract	CO	Y	ACHN	11/6/2018	Provider	Install & Config	Minor (4)	11/6/2018 13:33	Change Order Written	
15307	ACHN - Modify prvRenrlCntrct to set ACHN Enrollment Frequency and Disenroll Ind to X	CO	Y	ACHN	11/6/2018	Provider	Batch	Minor (4)	11/6/2018 13:38	Change Order Written	
15308	ACHN - Modify PIN Process to Generate ACHN Web ID	CO	Y	ACHN	11/6/2018	Provider	Batch	Minor (4)	11/6/2018 13:44	Change Order Written	
15309	ACHN - Create New Table to House Network Participation	CO	Y	ACHN	11/6/2018	Provider	Data Model Change	Minor (4)	11/6/2018 13:58	Change Order Written	
15310	ACHN - Create New Read-Only Panel to Show Network Participation	CO	Y	ACHN	11/6/2018	Provider	UI	Minor (4)	11/6/2018 14:00	Change Order Written	
15311	ACHN - Create Outgoing Extract of Data for ACHN	CO	Y	ACHN	11/6/2018	Provider	Batch	Minor (4)	11/6/2018 14:04	Change Order Written	
15312	ACHN - Process Incoming Data File from ACHN	CO	Y	ACHN	11/6/2018	Provider	Batch	Minor (4)	11/6/2018 14:06	Change Order Written	
15313	ACHN - Closure of Health Home Providers, Maternity District 61 and Patient 1st Contracts	Task	Y	ACHN	11/6/2018	Provider	Data Fix	Minor (4)	11/6/2018 14:09	Issue Identified	

15314	ACHN - DM for New Panel to Store Provider Agreement Data	CO	Y	ACHN	11/6/2018	Provider	Data Model Change	Minor (4)	11/6/2018 14:16	Change Order Written	
15316	ACHN - Create New Panel to Store Provider Agreement Data for ACHN	CO	Y	ACHN	11/7/2018	Provider	UI	Minor (4)	11/7/2018 13:02	Change Order Written	
15321	Task to Close Out Current Social Worker Files (outside of FQs)	Task	Y	Operations CSR	11/9/2018	Provider	Data Fix	Minor (4)	11/9/2018 9:37	Issue Identified	
15334	provider - update PPROV_WEEKLY_DEA to use filewatcher.	Task	N	MNT	11/15/2018	Provider	Install & Config	Minor (4)	11/15/2018 13:24	Issue Identified	
7402	Add More Retro Fields to Nightly Upd File	CO	Y	CSR	1/15/2010	Recipient	Batch	Minor (4)	3/13/2013 12:00	Hold	
7403	Add new fields to T_RE_RETRO_ELIG	CO	Y	CSR	1/15/2010	Recipient	Data Model Change	Minor (4)	3/13/2013 12:00	Hold	
7404	Retro Elig Panel -- add new fields	CO	Y	CSR	1/15/2010	Recipient	UI	Minor (4)	3/13/2013 12:00	Hold	5/12/2010
7406	Add new retro fields to mthly recip recon	CO	Y	CSR	1/15/2010	Recipient	Batch	Minor (4)	3/13/2013 12:01	Hold	
8076	Extract SOBRA Appl Status on Mthly Recon	CO	Y	CSR	8/26/2010	Recipient	Extract Process	Minor (4)	4/3/2013 13:49	Hold	
8336	Add Residence Addr to Monthly Recon	CO	Y	CSR	11/12/2010	Recipient	Extract Process	Minor (4)	3/13/2013 11:56	Hold	
8925	Expand Citizen Code -- Monthly Recon	CO	Y	CSR	3/31/2011	Recipient	Batch	Minor (4)	3/31/2011 8:19	Change Order Written	
9645	EIP #9 Dt of Change "Other Changes" Form 295	CO	N	MNT	12/8/2011	Recipient	Batch	Minor (4)	11/19/2014 17:40	MO Implementation	
9956	EIP#1 Reviewing vacant Recip addr against NCOA	CO	N	MNT	3/12/2012	Recipient	Batch	Minor (4)	3/12/2012 15:13	Change Order Written	
11144	E&E NCOA Updates	CO	Y	CSR	5/16/2013	Recipient	Batch	Minor (4)	4/27/2016 9:50	Hold	
11145	E&E Create Monthly Reconciliation	CO	Y	CSR	5/16/2013	Recipient	Batch	Minor (4)	5/20/2014 18:50	Prod Verification	
11199	E&E Recip Portal Email Updates	CO	Y	CSR	6/19/2013	Recipient	Extract Process	Minor (4)	1/8/2015 9:57	Prod Verification	
11200	E&E AMMIS to AMAES Extract	CO	Y	CSR	6/19/2013	Recipient	Extract Process	Minor (4)	5/12/2016 14:00	Change Order Written	
11499	Changes to Mnthly Recon for E&E	CO	Y	CSR	10/1/2013	Recipient	Batch	Minor (4)	4/27/2016 9:52	Hold	
12096	Nightly AMMIS to AMAES All Updated Recips	CO	Y	CSR	7/21/2014	Recipient	Extract Process	Minor (4)	5/12/2016 14:00	Change Order Written	
12244	RTI #2 Daily AMMIS to AMAES Extract	CO	N	MNT	9/30/2014	Recipient	Batch	Minor (4)	5/12/2016 14:00	Change Order Written	
12435	Extract for EDB Data Pull	CO	Y	CSR	1/16/2015	Recipient	Extract Process	Minor (4)	2/19/2018 14:30	Under CCB Review	
12992	Form 1095 RCC Requests	CO	Y	CSR	9/16/2015	Recipient	Batch	Minor (4)	4/27/2016 12:17	Awaiting Further Definition	
13209	Hospital Presumptive Elig Recip Changes	CO	Y	CSR	10/27/2015	Recipient	Batch	Minor (4)	10/27/2015 8:04	Change Order Written	
13241	Create Recipient IRS 1095 electronic transmission	CO	Y	Operations CSR	11/4/2015	Recipient	Batch	Major - No Work Around (2)	11/8/2015 11:11	SE Assigned	
13242	Capture recip IRS 1095 transmission receipt info	CO	Y	Operations CSR	11/4/2015	Recipient	Batch	Major - No Work Around (2)	4/27/2016 12:18	Awaiting Further Definition	
13275	Display Recip IRS 1095 information on UI panel	CO	Y	Operations CSR	12/3/2015	Recipient	UI	Major - No Work Around (2)	4/27/2016 12:19	Awaiting Further Definition	
13276	Add new recip UI panel for RCC to support 1095 upd	CO	Y	Operations CSR	12/3/2015	Recipient	UI	Major - No Work Around (2)	4/27/2016 12:19	Awaiting Further Definition	
13277	Add new recip table to capture RCC 1095 request	CO	Y	Operations CSR	12/3/2015	Recipient	Data Model Change	Major - No Work Around (2)	4/27/2016 12:19	Awaiting Further Definition	
13281	Form 1095 File to Printer by Household	CO	Y	Operations CSR	12/8/2015	Recipient	Batch	Major - No Work Around (2)	4/27/2016 12:20	Awaiting Further Definition	
13396	Remove Managed Care Items from Recip Cycles	Task	N	MNT	2/19/2016	Recipient	Batch	Minor (4)	2/19/2016 13:23	Issue Identified	
13413	Remove MedSol & CareCore Recip Files from syssftpoutfiles.ctl	CO	N	MNT	3/4/2016	Recipient	Batch	Minor (4)	3/4/2016 10:42	Change Order Written	

13741	DM - "Calculate" Race based on Indicators	CO	Y	CSR	7/28/2016	Recipient	Data Model Change	Minor (4)	7/28/2016 9:47	Change Order Written	
13743	Batch - Recipient monthly reconciliation extract	CO	Y	Operations CSR	7/28/2016	Recipient	Batch	Major - No Work Around (2)	7/28/2016 14:35	Change Order Written	
13744	Task - Data Clean up based on race indicator	Task	Y	Operations CSR	7/28/2016	Recipient	Batch	Major - No Work Around (2)	7/28/2016 14:58	Issue Identified	
13898	Remove obsolete EPSDT tables from Recipient	CO	N	MNT	10/14/2016	Recipient	Batch	Minor (4)	10/14/2016 9:34	Change Order Written	
14110	COBA Eligibles Extract and Report Changes (SSNRI/MBI)	CO	Y	Operations CSR	1/26/2017	Recipient	Extract Process	Minor (4)	10/19/2017 15:19	MO Testing Complete	
14197	T_RE_DEMOGRAPHIC Phone Number Changes	CO	Y	Base RCO	3/10/2017	Recipient	Data Model Change	Minor (4)	3/27/2017 10:50	Ready for Const Wthru	
14198	Changes to Nightly Recip Portal Demographic File to Agency	CO	Y	Base RCO	3/10/2017	Recipient	Batch	Minor (4)	3/10/2017 14:34	Change Order Written	
14240	Elig Issue with Current Month Updates	Defect	N	MNT	4/3/2017	Recipient	Batch	Minor (4)	8/2/2018 9:30	SE Assigned	
14308	Create Test Area for AMAES Transfer to CARES	Task	Y	CSR	5/1/2017	Recipient	Batch	Minor (4)	5/1/2017 15:10	Issue Identified	
14432	RCO CD - Recipient Update Schedule and Archive Code	CO	Y	RCO Closedown	8/4/2017	Recipient	Batch	Minor (4)	8/9/2017 13:01	Const/Unit Test in Progress	
14512	Drastic Elig should end date rows that begin prior to grant period	Defect	N	MNT	9/13/2017	Recipient	Batch	Minor (4)	8/2/2018 9:30	SE Assigned	
14561	SFTP COBA MBI File to Agency	CO	Y	CSR	10/5/2017	Recipient	Batch	Minor (4)	4/16/2018 11:19	**Ready for UAT Impl**	
14615	PCCM Exemptions Changes to Elig Update Processes	CO	Y	Operations CSR	11/14/2017	Recipient	Batch	Minor (4)	5/15/2018 12:47	CO Estimated	
14649	Change SFTP delivery Method on Agency Files	CO	Y	CSR	12/4/2017	Recipient	Extract Process	Minor (4)	11/16/2018 15:04	Const/Unit Test in Progress	
14709	ADPH - TY2017 - Monthly File Upload to IRS and Status Updates	Task	Y	Operations CSR	1/12/2018	Recipient	Documentation	Internal (6)	1/12/2018 11:28	Issue Identified	
14861	Support for CARES	Task	Y	CSR	3/28/2018	Recipient	Install & Config	Minor (4)	3/28/2018 13:33	Issue Identified	
14888	Current Month and Year Verified DOD not handled correctly	CO	N	MNT	4/10/2018	Recipient	Batch	Minor (4)	4/10/2018 16:17	Issue Identified	
14908	Move Parameter Update for ADPH 1095 Extract	Defect	N	MNT	4/19/2018	Recipient	Batch	Minor (4)	7/11/2018 14:41	Prod Verification	
14927	Limit Size of Plastic Card files	CO	Y	CSR	4/30/2018	Recipient	Batch	Minor (4)	4/30/2018 10:50	Change Order Written	
14931	New UI Panel to allow users to view the new "Mini Rekey" table	CO	Y	Operations CSR	4/30/2018	Recipient	UI	Minor (4)	10/24/2018 8:07	Prod Verification	7/17/2018
14932	New Batch Process to populate TPL "Mini Rekey" table	CO	Y	Operations CSR	4/30/2018	Recipient	Batch	Minor (4)	10/24/2018 9:30	Prod Verification	
15038	Change Rekey Process for TPL Policies	CO	Y	CSR	6/29/2018	Recipient	Batch	Minor (4)	7/26/2018 7:50	Prod Verification	
15040	Update Rekey Process to Remove Mini Rekeys	CO	Y	CSR	7/2/2018	Recipient	Batch	Minor (4)	10/24/2018 8:04	Prod Verification	
15050	ICN -- Phase 1 - Create 834 for the ICN Project	CO	Y	CSR	7/17/2018	Recipient	Batch	Minor (4)	10/10/2018 8:04	Prod Verification	
15071	Recipient - process new TPL attachment DB - move to master	CO	Y	Operations CSR	7/24/2018	Recipient	Batch	Major - No Work Around (2)	7/24/2018 16:07	Change Order Written	
15072	Recipient - rekey new TPL attachment DB	CO	Y	Operations CSR	7/24/2018	Recipient	Batch	Major - No Work Around (2)	7/24/2018 16:17	Change Order Written	
15109	Change to Support MELI (Medicaid Eligibility Linking Interface)	CO	Y	Operations CSR	8/2/2018	Recipient	Batch	Minor (4)	8/2/2018 17:12	Change Order Written	
15110	Support for MELI -- Medicaid Eligibility Linking Interface	Task	Y	Operations CSR	8/2/2018	Recipient	Documentation	Minor (4)	8/2/2018 17:18	Issue Identified	
15142	Create 1095s for Medicaid for Tax Year 2018	CO	Y	CSR	8/15/2018	Recipient	Batch	Minor (4)	9/19/2018 14:58	Const/Unit Test in Progress	
15143	Create 1095s for ADPH for Tax Year 2018	CO	Y	CSR	8/15/2018	Recipient	Batch	Minor (4)	10/15/2018 6:40	Const/Unit Test in Progress	

15145	ICN -- Phase 2 - Change 834 to be based upon ICN Assignment	CO	Y	Operations CSR	8/15/2018	Recipient	Batch	Minor (4)	11/15/2018 8:58	UAT Implementation	
15183	2018 1095 Java Program	CO	Y	CSR	9/13/2018	Recipient	Batch	Minor (4)	9/13/2018 15:52	Change Order Written	
15197	ICN 834 -- Blank Last Sponsor Name and Date on Termination	CO	Y	Operations CSR	9/27/2018	Recipient	Batch	Minor (4)	11/7/2018 8:06	Prod Verification	
15208	LTC - T_RE_ASSIGN_PLAN change to add Admission Reasons Field	CO	Y	Operations CSR	10/1/2018	Recipient	Data Model Change	Major - No Work Around (2)	10/1/2018 16:56	Change Order Written	
15232	Change T_RECIP_REVIEW to use for Inmate Project	CO	Y	CSR	10/2/2018	Recipient	Data Model Change	Minor (4)	10/2/2018 17:51	Change Order Written	
15233	Create Recipient Review Panel	CO	Y	CSR	10/2/2018	Recipient	UI	Minor (4)	10/2/2018 17:54	Change Order Written	
15259	Rekey changes for LTC table	CO	Y	CSR	10/6/2018	Recipient	Batch	Minor (4)	10/6/2018 13:54	Change Order Written	
15283	Schedule EPSDT Extract and Automate sftp of output file	CO	Y	Operations CSR	10/22/2018	Recipient	Batch	Minor (4)	11/14/2018 16:56	Ready for MO Implementation	
15296	Create New Report on Plastic Cards	CO	Y	CSR	10/29/2018	Recipient	Batch Reports	Minor (4)	10/29/2018 12:48	Change Order Written	
15320	Failed Link Requests Not Reported	Defect	N	MNT	11/8/2018	Recipient	Batch	Minor (4)	11/8/2018 16:27	Issue Identified	
15331	Convert non-editable drop down lists to read only label - Recipient	CO	N	MNT	11/15/2018	Recipient	UI	Minor (4)	11/15/2018 9:10	Const/Unit Test in Progress	
10461	Move HCP Users from ALPROAD to ALSECPROAD	CO	N	MNT	7/10/2012	Recipient Portal	Install & Config	Minor (4)	7/10/2012 10:55	SE Assigned	
11105	HCP Vault and Release process Setup	CO	N	MNT	4/25/2013	Recipient Portal	UI	Major - No Work Around (2)	4/25/2013 11:48	Const/Unit Test in Progress	6/30/2013
12470	Add HHP to Recip Portal for expand of PCNA SW	CO	Y	CSR	2/2/2015	Recipient Portal	UI	Minor (4)	10/22/2018 13:02	Ready for MO Implementation	5/31/2018
12991	Form 1095 Recip Portal Requests	CO	Y	CSR	9/16/2015	Recipient Portal	UI	Minor (4)	4/27/2016 12:16	Awaiting Further Definition	
13163	Recip Portal -- Refresh & Build App	CO	Y	CSR	10/8/2015	Recipient Portal	UI	Minor (4)	10/8/2015 10:10	Change Order Written	
13200	Recipient Web Portal -- Make an App	CO	Y	CSR	10/19/2015	Recipient Portal	UI	Minor (4)	10/19/2015 15:13	Change Order Written	
14202	Recip Web Portal -- Allow Recip to Submit Four Phone Numbers	CO	Y	Base RCO	3/13/2017	Recipient Portal	UI	Minor (4)	4/4/2017 10:15	Awaiting Further Definition	
15164	Recipient Portal - E-mail change to DXC.com	CO	N	MNT	8/28/2018	Recipient Portal	Data Fix	Cosmetic (5)	8/28/2018 11:17	Change Order Written	
2851	Remove unused t_asng tbls	CO	N	DDI	5/11/2007	Reference	Data Model Change	Minor (4)	4/7/2017 16:25	MO Implementation	8/27/2007
8005	Fix Provider Contracts for IRHC	Task	N	MNT	7/22/2010	Reference	Data Fix	Minor (4)	7/22/2010 12:58	Issue Identified	
9301	DM - Remove the unused benefit plan tables.	CO	N	MNT	8/25/2011	Reference	Data Model Change	Minor (4)	8/25/2011 15:07	Change Order Written	
9302	Batch - Remove the unused benefit plan tables.	CO	N	MNT	8/25/2011	Reference	Data Fix	Minor (4)	8/25/2011 16:13	Change Order Written	
11307	CSR447 - BNP - Ref - Modify ESC 5001 - Other Audit	CO	Y	Operations CSR	8/15/2013	Reference	Install & Config	Major - With Work Around (3)	4/27/2014 15:20	Change Order Written	
11308	CSR447 - BNP - Ref - Modify ESC 5001 - One/Day	CO	Y	Operations CSR	8/15/2013	Reference	Install & Config	Major - With Work Around (3)	10/2/2014 12:05	Const/Unit Test in Progress	
12051	New PT for Pharmacy Professional Services	CO	Y	Operations CSR	6/26/2014	Reference	Install & Config	Major - No Work Around (2)	9/27/2016 9:24	Awaiting Further Definition	
14505	REF - Process MME File from FDB	CO	Y	Operations CSR	9/12/2017	Reference	Batch	Major - No Work Around (2)	6/7/2018 15:52	Const/Unit Test in Progress	
14631	REF - HCPCS 2018	CO	N	Operations CSR	11/20/2017	Reference	Install & Config	Major - No Work Around (2)	11/20/2017 13:24	Change Order Written	
14705	Ref - Modify Reference Process to handle re-used NDCs	CO	Y	Operations CSR	1/10/2018	Reference	Batch	Major - No Work Around (2)	9/11/2018 15:04	Const/Unit Test in Progress	
14739	Modify Reference Panels to handle re-used NDCs - UI	CO	Y	Operations CSR	1/30/2018	Reference	UI	Major - No Work Around (2)	6/6/2018 7:47	Prod Verification	5/23/2018

14848	Remove PHI PII info from Alabama Medicaid Reference User Manual Part II	CO	N	MNT	3/26/2018	Reference	Documentation	Minor (4)	4/18/2018 9:06	MO Testing in Progress	
14885	Update reference programs to write upper case to generic drug table	CO	N	MNT	4/9/2018	Reference	Batch	Minor (4)	11/16/2018 16:27	Ready for MO Implementation	
14909	Improve response time of Reference Drug Search by integrating Covered and PA queries with main query	CO	N	MNT	4/23/2018	Reference	UI	Internal (6)	11/6/2018 8:16	Const/Unit Test in Progress	
14910	REF - Create New Limit for Career Counseling	CO	Y	Operations CSR	4/23/2018	Reference	Install & Config	Major - No Work Around (2)	11/12/2018 10:51	MO Testing in Progress	
14942	REF - Targeted Case Management Group 9	CO	Y	Operations CSR	5/2/2018	Reference	Install & Config	Major - No Work Around (2)	9/11/2018 9:33	Prod Verification	
14963	REF - Behavioral Health Contracts	CO	Y	Operations CSR	5/15/2018	Reference	Install & Config	Major - No Work Around (2)	11/6/2018 11:58	Prod Verification	
15013	REF - ABA Therapy Coverage Updates	CO	Y	Operations CSR	6/12/2018	Reference	Install & Config	Major - No Work Around (2)	10/15/2018 15:00	Prod Verification	
15014	REF - T2019 HW New limit Audit	CO	Y	Operations CSR	6/12/2018	Reference	Install & Config	Major - No Work Around (2)	6/12/2018 9:58	Change Order Written	
15015	REF - H2014 HW New Limit	CO	Y	Operations CSR	6/12/2018	Reference	Install & Config	Major - No Work Around (2)	11/12/2018 10:52	MO Testing in Progress	
15069	Reference - Phase 1 - Reimbursement Rules panel change	CO	Y	Operations CSR	7/23/2018	Reference	UI	Major - No Work Around (2)	9/19/2018 8:05	Prod Verification	9/19/2018
15077	REF - UI MME Remaining file panels	CO	Y	CSR	7/26/2018	Reference	UI	Minor (4)	11/8/2018 8:49	MO Testing in Progress	11/6/2018
15118	REF - ICD-10 2018 Code update effective 08/06/2018	Task	N	MNT	8/6/2018	Reference	Install & Config	Major - No Work Around (2)	9/7/2018 9:14	Prod Verification	
15198	Clinical Laboratory Fee Schedule New File Format for 2018	CO	Y	Operations CSR	9/27/2018	Reference	Batch	Major - No Work Around (2)	10/8/2018 10:02	CO Work In Progress	
15228	REF - DM - new ESC group type tables	CO	Y	Operations CSR	10/2/2018	Reference	Data Model Change	Major - No Work Around (2)	11/16/2018 10:57	Ready for Prod	
15230	REF - UI - ERROR GROUP PANELS	CO	Y	Operations CSR	10/2/2018	Reference	UI	Major - No Work Around (2)	10/23/2018 12:42	Const/Unit Test in Progress	
15264	Fund Code Criteria Panel - Search Feature	CO	Y	CSR	10/9/2018	Reference	UI	Minor (4)	11/13/2018 8:15	Ready for Prod	#######
15303	Convert non-editable drop down lists to read only label - Reference	CO	N	MNT	11/5/2018	Reference	UI	Minor (4)	11/14/2018 8:51	Ready for Const Wthru	#######
15324	REF - TCM Group 10	CO	Y	Operations CSR	11/12/2018	Reference	Install & Config	Major - No Work Around (2)	11/13/2018 10:17	MO Implementation	
15325	REF - HCPCS 2019	CO	N	Operations CSR	11/13/2018	Reference	Install & Config	Major - No Work Around (2)	11/13/2018 11:32	Change Order Written	
15327	update qty_refill on drug_limits for opioids to be a 1	CO	Y	Operations CSR	11/13/2018	Reference	Batch	Major - No Work Around (2)	11/13/2018 15:39	Const/Unit Test in Progress	
15330	REF - T1999 Create new waiver limit	CO	Y	Operations CSR	11/14/2018	Reference	Install & Config	Major - No Work Around (2)	11/14/2018 15:00	Change Order Written	
7253	SUR Case Tracking Panel Changes	CO	N	MNT	11/4/2009	SUR	UI	Internal (6)	4/27/2016 12:00	Awaiting Further Definition	
15299	ALDSST1 and ALDSSM1 - Add T_PF_RE_DECEASED	CO	N	MNT	11/1/2018	SUR	Data Model Change	Minor (4)	11/14/2018 10:40	Ready for MO Implementation	
6151	Retro Eligibility Program Codes	CO	Y	Operations CSR	8/4/2008	System Wide	Operations CSR	Major - No Work Around (2)	3/13/2013 11:57	Hold	
6759	Modify the limit on query execution time	CO	N	MNT	4/20/2009	System Wide	Data Model Change	Internal (6)	4/20/2009 15:53	Change Order Written	
7221	Query Parameter Datatype Correction CO	CO	N	MNT	10/20/2009	System Wide	UI	Minor (4)	10/20/2009 14:11	Change Order Written	
7965	MO/ACC route_rpt clean up job	CO	N	MNT	7/12/2010	System Wide	Batch	Internal (6)	7/12/2010 11:23	Change Order Written	

7989	SU Log review reporting	CO	N	MNT	7/19/2010	System Wide	Batch Reports	Internal (6)	7/19/2010 0:48	Change Order Written	
8012	Auto move release attachments to higher envmnts	CO	N	MNT	7/28/2010	System Wide	Documentation	Cosmetic (5)	6/21/2011 13:49	SE Assigned	
9021	EIP - ERX DM modifications	CO	N	MNT	5/26/2011	System Wide	Data Model Change	Minor (4)	10/29/2013 12:25	Ready for Const Wthru	#######
9023	EIP - ERX Panel Modifications	CO	N	MNT	5/26/2011	System Wide	UI	Major - With Work Around (3)	5/26/2011 12:13	Change Order Written	#######
9024	EIP - ERX Batch Modifications	CO	N	MNT	5/26/2011	System Wide	Batch	Major - With Work Around (3)	5/26/2011 12:40	Change Order Written	#######
9721	Update email in job copying reports to FEITH	CO	N	MNT	1/17/2012	System Wide	Batch	Minor (4)	1/17/2012 13:01	Change Order Written	
10051	Standardize table and field names for ICD	CO	N	MNT	4/10/2012	System Wide	Research	Minor (4)	4/10/2012 10:32	Change Order Written	
10074	Add search and result field to requirements search	CO	N	MNT	4/18/2012	System Wide	Documentation	Internal (6)	4/18/2012 1:11	Change Order Written	
10894	Add DBwatcher tool to itrace from Ohio's creation	CO	N	MNT	2/7/2013	System Wide	Install & Config	Internal (6)	2/7/2013 1:54	Change Order Written	
11139	Elig and Enrollment System Modifications	CO	Y	CSR	5/15/2013	System Wide	High Level CO	Minor (4)	6/11/2018 9:46	CO Work In Progress	
11314	Autosys updates for run history	CO	N	MNT	8/20/2013	System Wide	Install & Config	Minor (4)	8/20/2013 9:48	Change Order Written	
11519	Letter Generator Oracle 11g Conversion	CO	N	MNT	10/9/2013	System Wide	Letters	Minor (4)	10/9/2013 12:58	SE Assigned	
11732	Change from using lprcommon to lnpicomm	CO	N	MNT	1/23/2014	System Wide	Batch	Minor (4)	1/23/2014 14:20	Change Order Written	
11898	Monthly Recipient Reconciliation File Updates	CO	Y	CSR	4/30/2014	System Wide	Operations CSR	Minor (4)	4/30/2014 16:28	Hold	
12055	CAHPS Sampling	CO	Y	CSR	6/27/2014	System Wide	Operations CSR	Minor (4)	6/27/2014 9:53	Hold	
12297	alftp-clean up logs and chg log filename	CO	N	MNT	10/27/2014	System Wide	Batch	Minor (4)	10/27/2014 8:00	Change Order Written	
12430	Chgs required due to expansion of PCNA Statewide	CO	Y	CSR	1/13/2015	System Wide	Operations CSR	Minor (4)	7/5/2018 9:44	CO Work In Progress	3/1/2015
12440	Processing TPL Paper claims Electronically	CO	Y	CSR	1/20/2015	System Wide	Operations CSR	Minor (4)	10/26/2018 15:55	CO Work In Progress	
12571	SSN Masking & Inquiry Tracking	CO	N	CSR	3/11/2015	System Wide	Research	Minor (4)	3/11/2015 15:16	Change Order Written	
12876	CLM FIN Balancing Report Fixes	CO	N	MNT	8/6/2015	System Wide	Batch	Minor (4)	8/6/2015 7:47	Change Order Written	
13238	Create a process to notify OPS on large mailouts	CO	N	MNT	11/3/2015	System Wide	Batch	Minor (4)	11/3/2015 13:25	Change Order Written	
13278	Regression Testing - Windows 10/Microsoft Edge	CO	N	MNT	12/7/2015	System Wide	UI	Minor (4)	2/24/2017 16:21	Const/Unit Test in Progress	
13452	T-MSIS Addendum B - Missing Data Elements	CO	Y	Operations CSR	3/25/2016	System Wide	High Level CO	Major - No Work Around (2)	7/19/2018 14:03	CO Work In Progress	
13682	SSNRI CMS Project (Move from HICN to MBI -- Medicare Beneficiary ID)	CO	Y	Operations CSR	7/1/2016	System Wide	Operations CSR	Minor (4)	6/22/2018 10:58	CO Work In Progress	
13698	Recompile Libs/Pgms that reference $ORACLE_HOME/$ORAHOME	CO	N	MNT	7/8/2016	System Wide	Batch	Major - No Work Around (2)	7/8/2016 14:13	Change Order Written	
13887	Alabama Medicaid - Data Governance	CO	Y	CSR	10/12/2016	System Wide	Operations CSR	Minor (4)	10/12/2016 8:35	Change Order Written	
14031	SSN Masking - UI Inquiry Tracking	CO	Y	CSR	12/22/2016	System Wide	Operations CSR	Minor (4)	6/22/2018 10:59	CO Work In Progress	
14094	First Data Meetings and JAD session	CO	Y	CSR	1/19/2017	System Wide	High Level CO	Cosmetic (5)	1/19/2017 15:56	Change Order Written	
14114	NewCo Merger - HPE/CSC	CO	N	NewCo	1/26/2017	System Wide	High Level CO	Internal (6)	1/26/2017 17:32	Change Order Written	
14220	Audit Panel not displaying User Name (First Name + Last Name) in the data panel.	CO	N	MNT	3/21/2017	System Wide	UI	Minor (4)	10/11/2018 14:48	Ready for Prod	4/30/2018
14327	T-MSIS Operations & Maintenance (O&M) initiative	CO	Y	CSR	5/10/2017	System Wide	Operations CSR	Minor (4)	7/19/2018 14:04	CO Work In Progress	
14403	2018 ITB	Task	N	MNT	7/10/2017	System Wide	High Level CO	Catastrophic (1)	7/10/2017 13:43	Issue Identified	
14424	RCO Closedown - System Changes to Close Down RCO Project	CO	Y	RCO Closedown	8/1/2017	System Wide	High Level CO	Internal (6)	6/22/2018 11:00	CO Work In Progress	#######

14456	SSN Unmasking Log Report	CO	Y	CSR	8/18/2017	System Wide	Batch Reports	Minor (4)	11/12/2018 13:39	MO Testing in Progress	
14484	Fee Schedule Changes - Change to Quarterly, Only Produce if Change Has Occurred	CO	Y	Operations CSR	8/29/2017	System Wide	Operations CSR	Minor (4)	8/29/2017 14:59	Change Order Written	#######
14507	Modify Maternity Encounter claims processing	CO	Y	CSR	9/12/2017	System Wide	High Level CO	Minor (4)	6/22/2018 11:03	CO Work In Progress	
14535	Feith - Mother - Agency OPR	CO	N	MNT	9/27/2017	System Wide	High Level CO	Internal (6)	9/27/2017 10:15	Hold	
14586	Create ADPH IRS 1095 for Tax year 2017	CO	Y	Operations CSR	10/30/2017	System Wide	Operations CSR	Major - No Work Around (2)	6/22/2018 11:01	CO Work In Progress	#######
14594	LTC Process Improvement SSN changes	CO	Y	Operations CSR	11/3/2017	System Wide	Operations CSR	Major - No Work Around (2)	7/5/2018 9:46	CO Work In Progress	
14676	Portal Upgrade v4.0 to v5.0	CO	N	MNT	12/20/2017	System Wide	UI	Minor (4)	10/15/2018 10:14	Const/Unit Test in Progress	
14725	2018 Alabama DR drill activity	CO	N	MNT	1/24/2018	System Wide	High Level CO	Internal (6)	1/24/2018 12:57	Change Order Written	
14742	Review MMIS User Manual documentations and redact all PHI and PII information contained in the doco	CO	N	MNT	2/2/2018	System Wide	Documentation	Internal (6)	2/2/2018 9:51	Change Order Written	
14804	Cross Frame Scripting, Cookie Security not sent over SSL, System Information Leak: OPTIONS HTTP	CO	N	MNT	3/13/2018	System Wide	Install & Config	Major - No Work Around (2)	3/13/2018 8:55	Change Order Written	
14820	Blank size copied due to multiple filename match -	CO	N	MNT	3/15/2018	System Wide	Batch	Major - No Work Around (2)	3/15/2018 16:24	Change Order Written	
14905	System Wide - Report - Create Automated Weekly PE Report	CO	N	MNT	4/18/2018	System Wide	High Level CO	Major - No Work Around (2)	4/26/2018 15:05	CO Work In Progress	
14987	Non-Billable PE CAP Related Changes	CO	N	MNT	5/30/2018	System Wide	High Level CO	Minor (4)	5/30/2018 13:36	Change Order Written	
15039	SSAE18 Audit	Task	N	MNT	7/2/2018	System Wide	Audits	Minor (4)	7/2/2018 15:32	Issue Identified	
15044	2018 First MO Refresh	Task	N	MNT	7/6/2018	System Wide	Documentation	Internal (6)	7/6/2018 15:50	Issue Identified	
15125	ACHN Kickoff Meetings	Task	Y	Operations CSR	8/7/2018	System Wide	High Level CO	Major - No Work Around (2)	8/7/2018 10:48	Issue Identified	
15161	ICN - Phase 1 -- Set up sftp for 834 Count File	CO	Y	CSR	8/24/2018	System Wide	Batch	Minor (4)	10/10/2018 10:08	Prod Verification	
15195	2018 Second UAT Refresh	Task	N	MNT	9/24/2018	System Wide	Documentation	Internal (6)	9/24/2018 18:51	Issue Identified	
15205	LTC - Institutional Special Needs Plans (I-SNPs)	CO	Y	Operations CSR	10/1/2018	System Wide	Operations CSR	Major - No Work Around (2)	10/1/2018 11:15	Change Order Written	
8393	No information in iTrace for TTG link in TD	CO	N	MNT	12/2/2010	TTG	Documentation	Internal (6)	12/2/2010 16:47	Change Order Written	
7607	Chg TPL batch process to trim spaces before policy	CO	N	MNT	3/4/2010	Third Party Liability	Batch	Major - No Work Around (2)	3/4/2010 10:53	Change Order Written	
9134	TPL - Standardize job box names for BCBS 837 trans	CO	N	MNT	7/21/2011	Third Party Liability	Batch	Minor (4)	7/21/2011 10:07	Change Order Written	
9337	Modify DEERS script to update the new login info	CO	N	MNT	9/6/2011	Third Party Liability	Batch	Major - No Work Around (2)	10/2/2013 10:49	Change Order Written	9/30/2011
10292	TPL-9007-R Verification Letter and Questionnaire	CO	N	MNT	5/25/2012	Third Party Liability	Operations CSR	Major - No Work Around (2)	5/25/2012 10:48	Change Order Written	
11502	Modify DHR recipient xtrct SQL to use HINT for RTI	CO	N	MNT	10/2/2013	Third Party Liability	Batch	Minor (4)	10/2/2013 9:58	Change Order Written	
11537	TPL - Standardize names for .sql objects	CO	N	MNT	10/16/2013	Third Party Liability	Batch	Internal (6)	10/16/2013 16:13	Change Order Written	
12770	TPL A075 report	CO	N	MNT	6/1/2015	Third Party Liability	Batch Reports	Cosmetic (5)	6/1/2015 12:58	Issue Identified	
12890	CSR701 - TPL - Enhance Southland Data Match Report	CO	Y	Operations CSR	8/10/2015	Third Party Liability	Batch	Major - No Work Around (2)	12/22/2016 9:12	Prod Verification	

14935	TPL - Batch Mini Rekey Process	CO	Y	Operations CSR	5/1/2018	Third Party Liability	Batch	Major - No Work Around (2)	10/24/2018 9:54	Prod Verification	
14936	TPL - UI Mini Rekey Process	CO	Y	Operations CSR	5/1/2018	Third Party Liability	UI	Major - No Work Around (2)	10/24/2018 8:07	Prod Verification	8/28/2018
14945	TPL - Southland DM Issue with New Dates On Existing Coverage Segments	Defect	N	MNT	5/3/2018	Third Party Liability	Batch	Major - No Work Around (2)	7/25/2018 9:56	Prod Verification	
14957	TPL - Southland TPL-Q012 Report	CO	Y	Operations CSR	5/10/2018	Third Party Liability	Batch Reports	Major - No Work Around (2)	6/20/2018 9:45	Prod Verification	
15004	TPL - Policyholder ID issues found on TPLBaseEditPanel	Defect	N	MNT	6/7/2018	Third Party Liability	UI	Minor (4)	11/19/2018 10:20	Ready for Const Wthru	11/7/2018
15151	TPL - Verify Coverage Begin Date in HMS Data Matches	Defect	N	MNT	8/21/2018	Third Party Liability	Batch	Major - No Work Around (2)	10/24/2018 9:56	Prod Verification	
15300	TPL - Check Eligibility In Mini Rekey Process	CO	Y	Operations CSR	11/1/2018	Third Party Liability	Batch	Major - No Work Around (2)	11/16/2018 12:05	UAT Implementation	
15302	TPL - UI Mini Rekey Check Eligibility	CO	Y	Operations CSR	11/1/2018	Third Party Liability	UI	Major - No Work Around (2)	11/14/2018 16:29	Ready for Const Wthru	######
15323	TPL - BCBS Data Match Defect	Defect	N	MNT	11/12/2018	Third Party Liability	Batch	Major - No Work Around (2)	11/12/2018 11:57	Issue Identified	
7112	EDI professional claims unable to adjust on web	CO	N	MNT	8/24/2009	Web Portal	Batch	Major - No Work Around (2)	4/27/2016 11:59	Awaiting Further Definition	
7759	correct web portal panel doco and um	Task	N	MNT	5/7/2010	Web Portal	Documentation	Internal (6)	4/27/2016 12:00	Awaiting Further Definition	
9771	Update ERX letter name to WEB	CO	N	MNT	2/2/2012	Web Portal	Letters	Cosmetic (5)	4/27/2016 12:01	Awaiting Further Definition	
12493	Web Portal - Allow electronic TPL denial attachment records	CO	Y	Operations CSR	2/10/2015	Web Portal	UI	Major - No Work Around (2)	3/2/2016 9:37	Hold	
14022	Convert Web Portal to Function on Microsoft Edge	CO	N	MNT	12/15/2016	Web Portal	UI	Minor (4)	3/2/2017 6:36	Const/Unit Test in Progress	
14511	WEB Portal - changes for Maternity Encounters	CO	Y	CSR	9/12/2017	Web Portal	UI	Minor (4)	5/23/2018 8:36	Prod Verification	2/13/2018
14552	Web Portal-Pharmacy Vaccine Admin-add incentive amt	CO	Y	Operations CSR	10/3/2017	Web Portal	UI	Major - No Work Around (2)	10/3/2017 17:12	Change Order Written	7/1/2018
14754	Web Portal Drug Lookup - Account for Reuse of NDC numbers	CO	Y	Operations CSR	2/6/2018	Web Portal	UI	Major - No Work Around (2)	9/13/2018 13:19	MO Testing Complete	7/11/2018
14841	Update download panel to allow Excel files for RA	CO	Y	CSR	3/26/2018	Web Portal	UI	Minor (4)	5/14/2018 10:21	Const Wthu Prep in Progress	5/23/2018
15002	PA Search - Add DME provider name when searching for All Providers	CO	Y	Operations CSR	6/6/2018	Web Portal	UI	Cosmetic (5)	10/18/2018 8:42	UAT Implementation	######
15026	Web Portal User Manual - 2018 CDT/CPT licensing agreement footer	Task	Y	Operations CSR	6/18/2018	Web Portal	Documentation	Cosmetic (5)	6/18/2018 8:54	Issue Identified	
15029	Physician Claim Date Time Period Object Null checking	Defect	N	MNT	6/19/2018	Web Portal	UI	Major - No Work Around (2)	10/10/2018 8:19	Prod Verification	7/25/2018
15065	Web Portal Download Panel - Allow providers to download PA Decision Letter	CO	Y	Operations CSR	7/23/2018	Web Portal	UI	Minor (4)	10/24/2018 4:46	Prod Verification	8/22/2018
15122	Web - PAR - Add new PA Reconsideration form to Forms panel.	CO	Y	Operations CSR	8/7/2018	Web Portal	UI	Minor (4)	9/17/2018 10:03	CO Estimated	
15154	ICN - Phase 2 - Add new Security Level for ICN Provider	CO	Y	Operations CSR	8/22/2018	Web Portal	UI	Major - No Work Around (2)	11/12/2018 12:08	**Ready for UAT Impl**	9/5/2018
15173	Claim Level Detail Panel clocking for large sets of data	CO	N	MNT	8/31/2018	Web Portal	UI	Major - No Work Around (2)	10/4/2018 12:21	Ready for Const Wthru	10/4/2018
15185	Web Portal - Add Form for ABA Therapy PA	CO	Y	CSR	9/18/2018	Web Portal	UI	Minor (4)	10/10/2018 8:15	Prod Verification	######
15202	Web Portal PMP assignment through override of panel restriction fails for a recipient	Defect	N	MNT	9/27/2018	Web Portal	UI	Minor (4)	10/10/2018 12:16	Const/Unit Test in Progress	

15304	Web Portal - Update Search for Provider Re-Enrollment Facsimile to only return most recent document	CO	N	MNT	11/6/2018	Web Portal	UI	Minor (4)	11/6/2018 8:04	Change Order Written	
15329	ICN Phase 2 - Allow ICN Providers and Clerks to download ICN MGD reports	CO	Y	Operations CSR	11/14/2018	Web Portal	UI	Minor (4)	11/15/2018 10:13	CO Estimated	
14700	Modify ePrescribing formulary to handle re-used NDCs	CO	Y	Operations CSR	1/5/2018	ePrescribing	Batch	Major - No Work Around (2)	1/5/2018 11:51	Change Order Written	
14710	Surescripts Network Resiliency	CO	Y	CSR	1/12/2018	ePrescribing	Batch	Minor (4)	5/24/2018 15:07	Prod Verification	

DSC_TITLE	Technical Name
Online Adjustment Daily Report	CLM-0010-D
Clerk ID Recycle Claims Report	CLM-0011-D
EOB Listing	CLM-0012-D
Claims Processing Daily Summary	CLM-0016-D
Original Claims Processing Daily Summary	CLM-0017-D
Adjustment Credit Claims Processing Daily Summary	CLM-0018-D
Aged Detail Suspense Report	CLM-0020-D
Suspense Analysis by Exception Code	CLM-0021-D
Claim Exception Report	CLM-0023-D
Daily Exception Summary By Claim Type	CLM-0024-D
Services to be Clerically Denied	CLM-0025-D
Claims Paid Due To Force Report	CLM-0026-D
Transaction Register	CLM-0027-D
Claim Status Change and Exception Report	CLM-002-R
Weekly POS Activity	CLM-0048-W
Retro Adjustments due to Recipient RCO Assignment Changes	CLM-0050-A
Retro Adjustments due to DRG Provider Rate Changes - FFS	CLM-0050-D
Retro Hospice Claim Review Report	CLM-0050-H
Retro Adjustments due to Patient Liability Changes	CLM-0050-L
Retro Adjustments due to Provider Rate Changes	CLM-0050-P
Retro Adjustments due to Recipient Date of Death Changes	CLM-0050-R
Aged Detail Adjustment	CLM-0051-D
Edit Recycle Maintenance	CLM-0054-D
Daily Exception Summary By Claim Type Original Claims	CLM-0055-D
Daily Exception Summary By Claim Type Adjustments	CLM-0056-D
Suspense File Analysis By Claim Type 3	CLM-0060-D
Suspended Claims by Claim Type - Region	CLM-0064-W
Aged Suspended Report	CLM-0065-D
Daily ESC Error Counts Reports	CLM-0066-D
Claims Submission Statistics - Daily	CLM-0130-D
Claims Submission Statistics - Monthly	CLM-0130-M
Claims Submission Statistics - Weekly	CLM-0130-W
Encounters Submission Statistics - Daily	CLM-0132-D
Encounters Submission Statistics - Monthly	CLM-0132-M
ENCOUNTER CLAIMS SUBMISSION STATISTICS Report -Monthly	CLM-0134-M
ENCOUNTER CLAIMS SUBMISSION STATISTICS Report -Weekly	CLM-0134-W
Maternity Encounter Claims Submission Statistics - Daily	CLM-0136-D
Maternity Encounter Claims Submission Statistics - Monthly	CLM-0136-M
Maternity Encounter Claims Submission Statistics - Weekly	CLM-0136-W
Provider Rate Change Report	CLM-0210-M
DRG Provider Rate Change Report	CLM-0220-M
ICD VERSION EDIT FAILURES REPORT BY PROVIDER	CLM-0300-W
QUARTERLY PES CLAIMS SUBMISSION REPORT	CLM-0440-Q
ARRA Prompt Payment Monthly Report	CLM-0455-M
ARRA Prompt Payment Quarterly Report	CLM-0456-Q
Kick Payment Processing Report	CLM-0610-W

Random Sample ICN Report	CLM-0640-W
FEITH Images To Claims Balancing Report	CLM-0670-D
FEITH Images Missing Claims Report	CLM-0671-D
Claims Missing FEITH Images Report	CLM-0672-D
Feith Images To Encounter Claims Balancing Report	CLM-0675-D
Feith Images Missing Encounter Claims Report	CLM-0676-D
Encounter Claims Missing Feith Images Report	CLM-0677-D
Facsimiles Corrected Report	CLM-0690-O
CLAIMS RELEASE TESTING REPORT	CLM-0900-O
CLAIMS RELEASE TESTING REPORT - DIFFERENCE	CLM-0901-O
Claims Month-End Financial Balancing	CLM-1900-W
RECIPIENT DATA SHEET REQUEST PROCESS REPORT	CLM-2011-P
RECIPIENT DATA SHEETS	CLM-2011-R
Retro Dupe Report	CLM-2300-Q
Retro Dupe Summary Report	CLM-2400-Q
Exceeded Benefit Limits Report	CLM-2500-M
Encounters Retro Dupe Report	CLM-2800-Q
Encounters Retro Dupe Summary Report	CLM-2801-Q
DAILY BAD CLAIMS REPORT	CLM-3400-D
CLAIMS FAILED DEA REQUIREMENTS REPORT	CLM-4200-W
NCCI MEDICALLY UNLIKELY EDIT REPORTING	CLM-4301-W
NCCI PROCEDURE-TO-PROCEDURE REPORTING - PRACTITIONER - On-Request	CLM-4302-O
NCCI PROCEDURE-TO-PROCEDURE REPORTING - PRACTITIONER	CLM-4302-W
NCCI PROCEDURE-TO-PROCEDURE REPORTING - OUTPATIENT - On-Request	CLM-4303-O
NCCI PROCEDURE-TO-PROCEDURE REPORTING - OUTPATIENT	CLM-4303-W
NCCI PROCEDURE-TO-PROCEDURE REPORTING - DME - On-Request	CLM-4304-O
NCCI PROCEDURE-TO-PROCEDURE REPORTING - DME	CLM-4304-W
NCCI COST SAVINGS REPORTS - MUE - DME	CLM-4710-Q
NCCI COST SAVINGS REPORTS - MUE - OUTPATIENT HOSPITAL	CLM-4720-Q
NCCI COST SAVINGS REPORTS - MUE - PRACTITIONER AND ASC	CLM-4730-Q
NCCI COST SAVINGS REPORTS - P2P - DME	CLM-4760-Q
NCCI COST SAVINGS REPORTS - P2P - OUTPATIENT HOSPITAL	CLM-4770-Q
NCCI COST SAVINGS REPORTS - P2P - PRACTITIONER AND ASC	CLM-4780-Q
NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER	CLM-4810-Q
NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME	CLM-4820-Q
NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL	CLM-4830-Q
NCCI EDIT DEACTIVATION REPORT - P2P - DME	CLM-4860-Q
NCCI EDIT DEACTIVATION REPORT - P2P - OUTPATIENT HOSPITAL	CLM-4870-Q
NCCI EDIT DEACTIVATION REPORT - P2P - ASC AND PRACTITIONER	CLM-4880-Q
Maternity Care REOMB Letter	ELG-9001-A
Plan First REOMB Letter	ELG-9001-B
Patient First REOMB Letter	ELG-9001-C
LTC REOMB Letter	ELG-9001-L
Explanation of Medical Benefits	ELG-9001-M
Targeted REOMB Letter	ELG-9001-T
Maternity Care Recipient Listing	ELG-9002-A
Patient First Recipient Listing	ELG-9002-C

LTC Recipient Listing	ELG-9002-L
Summary of Recipient EOMB's	ELG-9002-M
Targeted Recipient Listing	ELG-9002-T
Maternity Care County Totals	ELG-9003-A
Patient First County Totals	ELG-9003-C
LTC County Totals	ELG-9003-L
Targeted County Totals	ELG-9003-T

Functional Area
Claims
Claims
Claims

Claims
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Claims

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Claims

DSC_TITLE	Technical Name
Drug Rebate Excluded Provider Listing	RBT-1001-Q
Drug Rebate Original Invoices	RBT-2000-Q (1-ORG)
Drug Rebate Adjustment Invoice	RBT-2000-Q (2-ADJ)
Drug Rebate Invoice Summary	RBT-2002-Q
Drug Rebate Invoice Summary Report	RBT-2002S
Drug Rebate Manufacturer Remittance Summary	RBT-2003-Q
Drug Rebate CMS Unit Discrepancy	RBT-2004-Q
Drug Rebate Amount Greater Than Reimbursement Amount	RBT-2005-Q
Drug Rebate Invoice $50 or Less	RBT-2006-Q
Drug Rebate CMS Rate Per Unit Discrepancy	RBT-2007-Q
Drug Rebate NDCS W2 Qtrs URA Equal to Zero	RBT-2008-Q
Drug Rebate NDCs Not on CMS	RBT-2010-Q
Drug Rebate Invoice Summary Activity	RBT-2011-Q
Drug Rebate CMSFDB File Update Report	RBT-2012-Q
DRUG REBATE NDCs URA Equals 0 With Paid Claims	RBT-2013-Q
Drug Rebate Address Update	RBT-2014-Q
Drug Rebate Participation by Labeler Code	RBT-2015-R
Drug Rebate CMSFDB File Update-Pharmacy Report	RBT-2016-Q
DRUG REBATE ELECTRONIC INVOICE FILE	RBT-2025-Q
Drug Rebate Accounts Receivable - By Labeler	RBT-3000-M
Drug Rebate Accounts Receivable - By Period	RBT-3001-M
Drug Rebate Cash Exception	RBT-3002-D
Drug Rebate Labeler Credit Due	RBT-3003-M
Invoice Disposition Exception Report	RBT-3004-D
Drug Rebate Labelers with Highest Dispute Amounts	RBT-3005-Q
Drug Rebate Delinquent Payments	RBT-3007-M
Drug Rebate Delinquent Payments	RBT-3007-Q
Drug Rebate Delinquent Payments Under Threshold	RBT-3008-Q
Drug Rebate Payments Received	RBT-3500-M
Drug Rebate Weekly Receipts by Quarter	RBT-3600-W
Drug Rebate Dispute Summary by Invoice Period	RBT-4000-M
Drug Rebate Amounts Billed and Adjusted and Collected	RBT-4001-M
Drug Rebate Aging	RBT-4002-Q
Drug Rebate Resolution Statement	RBT-5000-R
Drug Rebate Recoupment Detail	RBT-5003-W
Drug Rebate Recoupment Summary	RBT-5004-Q
Drug Rebate Letters GT 30 Days Old	RBT-5006-W
Drug Rebate Outstanding Balance Summary	RBT-9001-M

Functional Area
Drug Rebate
Drug Rebate
Drug Rebate

DSC_TITLE
ACA PCP Rates-Amounts Claims
Active Provider Listing By County Code and Provider Type
Patient 1st Provider Profile Report Card
AL - Profiler Provider Listing
Benchmark Query 1 From Date of Service
Benchmark Query 1 Paid Date
Benchmark Query 2 From Date of Service
Benchmark Query 2 Paid Date
Benchmark Query 3 From Date of Service
Benchmark Query 3 Paid Date
Benchmark Query 4 From Date of Service
Benchmark Query 4 Paid Date
Billing Provider Encounters (2016)
Billing Provider Encounters (including out of state) 2013
Billing Provider Encounters (including out of state) 2016
Billing Provider Encounters 2012
Billing Provider Encounters 2013
Business Objects Internal Audit Reports
Crossover Claim Listing For a Provider
Dental Claim Information Per Recipient
Dental Program Provider NPI Participation Analysis
District Office Cases Terminated for Death
District Office Certified Cases DC Code 82
District Office Terminated or Denied Cases
DO Certified Cases Liability Amount Not Updated
Immunization Registry Report
Total Eligibles Receiving Preventive Dental Services for FDOS (12B)
Total Eligibles Receiving Dental Treatment Services for FDOS (12C)
Fiscal Year Lead Test CMS Validation (14)
EPSDT Periodic Screens By FY Paid Date (9)
Total Eligibles Receiving Any Dental Service for FDOS (12A)
Total Eligibles Receiving a Sealant On a Permanent Molar for FDOS (12D)
Total Eligibles Receiving Dental Diagnostic Services for FDOS (12E)

Total Eligibles Receiving Any Oral Health Service By a Non-Dentist for FDOS (12F)
Total Eligibles Receiving Any Dental or Oral Health Services for FDOS (12G)
VFC Program-DPH Payment Report
Recipient Data Sheet Per Recipient
DSS Approved to Pay Detail Verification
Approved to Pay Summary Verification
Provider Payroll Summary Verification
Emergency Room Management Report
Medicare Eligibles Report
Lock-in Physician Report
Lock-in Recipients For All Counties
Active DO Recipients by LTC NPI Number
Active DO Recipients by County
Active DO Recipients by Reviewer
Pending DO Applications by Reviewer (all reviewers in the DO)
Active DO Recipients by Reviewer per Status Date
Active DO Recipients by Program Code (all DO program codes)
Active DO Couple Cases by Reviewer
Active DO Recipients by Income Type
Active DO Spousal Allocation Recipients by Reviewer
Active DO Family Allocation Recipients by Reviewer
Active DO Cases with Property by Reviewer
Active DO Cases with QITs by Reviewer
Active DO Cases with Burial Funds by Reviewer
Active DO Cases by Sponsor by Reviewer
Active DO Recipients by DO Number and County

Alert Codes Due by County
Active Cases by City
Active Cases by Worker County
Inactive SOBRA Cases
Reviews Due Report
Inactive SOBRA Cases by Review Date
Pending SOBRA Applications List by Region
Pending SOBRA Applications List by Worker
Active DO Recipients by Program Code
Invoice Details - Federal
Invoice Details - Supplemental
Meaningful Use Payments
Drug Claims Prescribed by License Number
Nursing Home Detail by Date of Service
Nursing Home Detail by Payment Date
OOS (Out of State) Hospital Rates Rpt for Provider Team
Performing Provider Encounters (2012)
Performing Provider Encounters (2013)
Performing Provider Encounters (2016)
Performing Provider Encounters Including Out of State (2016)
Performing Provider Encounters Out of State (2012)
Performing Provider Encounters Out of State (2013)
PHS Providers
Procedure Code - NDC Conversions
Provider Information
Provider Profiler Sharing Data Report
Provider Reenrollment Letters Info
Provider Reenrollment Letters Info No Response
Recipient Consent Form Information
Recipient DME Claims
SUR Controlled Substances Report
SUR Institutional
SUR Medical Dollars Paid
SUR Outpatient
SUR Pharmacy Report
SUR Professional
SUR Provider Information Report

Unit Conversions

Technical Name	Functional Area
ACA PCP Rates-Amounts Claims	DSS
Active Provider Listing By County Code and Provider Type	DSS
AL - FINAL PROVIDER MAILINGS	DSS
AL - Profiler Provider Listing	DSS
Benchmark Query 1 From Date of Service	DSS
Benchmark Query 1 Paid Date	DSS
Benchmark Query 2 From Date of Service	DSS
Benchmark Query 2 Paid Date	DSS
Benchmark Query 3 From Date of Service	DSS
Benchmark Query 3 Paid Date	DSS
Benchmark Query 4 From Date of Service	DSS
Benchmark Query 4 Paid Date	DSS
Billing Provider Encounters (2016)	DSS
Billing Provider Encounters (including out of state) 2013	DSS
Billing Provider Encounters (including out of state) 2016	DSS
Billing Provider Encounters 2012	DSS
Billing Provider Encounters 2013	DSS
Business Objects Internal Audit Reports	DSS
Crossover Claim Listing For a Provider	DSS
Dental Claim Information Per Recipient	DSS
Dental Program Provider NPI Participation Analysis	DSS
District Office Cases Terminated for Death	DSS
District Office Certified Cases DC Code 82	DSS
District Office Terminated or Denied Cases	DSS
DO Certified Cases Liability Amount Not Updated	DSS
EPS-3002-M Immunization Registry Report	DSS
EPS-4161-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4162-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4163-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4164-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4165-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4166-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4167-R - (a tab within DSS Report (CMS-416 Verification))	DSS

EPS-4168-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-4169-R - (a tab within DSS Report (CMS-416 Verification))	DSS
EPS-5002-Q VFC Program-DPH Payment Report	DSS
HMNCF33B Recipient Data Sheet Per Recipient	DSS
HMNFN01B Approved to Pay Detail Verification	DSS
HMNFN02B Approved to Pay Summary Verification	DSS
HMNFN03B Provider Payroll Summary Verification	DSS
HMNMC046 Emergency Room Management Report	DSS
HMNMC047 Medicare Eligibles Report	DSS
HMNRE004 Lock-in Physician Report	DSS
HMNRE005 Lock-in Recipients For All Counties	DSS
HMNRE006 Active DO Recipients by LTC NPI Number	DSS
HMNRE007 Active DO Recipients by County	DSS
HMNRE008 Active DO Recipients by Reviewer	DSS
HMNRE009 Pending DO Applications by Reviewer (all reviewers in the DO)	DSS
HMNRE010 Active DO Recipients by Reviewer per Status Date	DSS
HMNRE011 Active DO Recipients by Program Code (all DO program codes)	DSS
HMNRE012 Active DO Couple Cases by Reviewer	DSS
HMNRE013 Active DO Recipients by Income Type	DSS
HMNRE014 Active DO Spousal Allocation Recipients by Reviewer	DSS
HMNRE015 Active DO Family Allocation Recipients by Reviewer	DSS
HMNRE016 Active DO Cases with Property by Reviewer	DSS
HMNRE017 Active DO Cases with QITs by Reviewer	DSS
HMNRE018 Active DO Cases with Burial Funds by Reviewer	DSS
HMNRE019 Active DO Cases by Sponsor by Reviewer	DSS
HMNRE020 Active DO Recipients by DO Number and County	DSS

HMNRE021 Alert Codes Due by County	DSS
HMNRE022 Active Cases by City	DSS
HMNRE023 Active Cases by Worker County	DSS
HMNRE024 Inactive SOBRA Cases	DSS
HMNRE025 Reviews Due Report	DSS
HMNRE026 Inactive SOBRA Cases by Review Date	DSS
HMNRE027 Pending SOBRA Applications List by Region	DSS
HMNRE028 Pending SOBRA Applications List by Worker	DSS
HMNRE030 Active DO Recipients by Program Code	DSS
Invoice Details - Federal	DSS
Invoice Details - Supplemental	DSS
Meaningful Use Payments	DSS
MSSS710 Drug Claims Prescribed by License Number	DSS
Nursing Home Detail by Date of Service	DSS
Nursing Home Detail by Payment Date	DSS
OOS (Out of State) Hospital Rates Rpt for Provider Team	DSS
Performing Provider Encounters (2012)	DSS
Performing Provider Encounters (2013)	DSS
Performing Provider Encounters (2016)	DSS
Performing Provider Encounters Including Out of State (2016)	DSS
Performing Provider Encounters Out of State (2012)	DSS
Performing Provider Encounters Out of State (2013)	DSS
PHS Providers	DSS
Procedure Code - NDC Conversions	DSS
Provider Information	DSS
Provider Profiler Sharing Data Report	DSS
Provider Reenrollment Letters Info	DSS
Provider Reenrollment Letters Info No Response	DSS
Recipient Consent Form Information	DSS
Recipient DME Claims	DSS
SUR Controlled Substances Report	DSS
SUR Institutional	DSS
SUR Medical Dollars Paid	DSS
SUR Outpatient	DSS
SUR Pharmacy Report	DSS
SUR Professional	DSS
SUR Provider Information Report	DSS

Unit Conversions	DSS

DSC_TITLE	Technical Name
High Dosing Update Report	DUR-0001-M
Low Dosing Update Report	DUR-0002-M
Drug Pregnancy Update Report	DUR-0003-M
Adverse Drug Interaction Code Update Report	DUR-0004-M
Drug Age Update Report	DUR-0005-M
Under Utilization Update Report	DUR-0006-M
Over Utilization Update Report	DUR-0007-M
Therapeutic Duplication Update Report	DUR-0008-M
Contraindicated Disease Update	DUR-0009-M
Diagnosis to FDBDX Cross Reference Updates	DUR-0010-M
High Level Summary by DUR Alert Annual	DUR-0011-A
High Level Summary by DUR Alert Monthly	DUR-0011-M
Summary by Drug Involved in DUR Alerts Annual	DUR-0012-A
Summary by Drug Involved in DUR Alerts Monthly	DUR-0012-M
Prospective DUR Intervention Outcome Summary Annual	DUR-0013-A
Prospective DUR Intervention Outcome Summary Monthly	DUR-0013-M
Summary of Intervention and Outcome Overrides by DUR Alert Annual	DUR-0014-A
Summary of Intervention and Outcome Overrides by DUR Alert Monthly	DUR-0014-M
Summary by Drug Combinations in DUR Alerts Annual	DUR-0015-A
Summary by Drug Combinations in DUR Alerts Monthly	DUR-0015-M
Duration of Therapy Update Report	DUR-0016-M
Ingredient Duplication Update Report	DUR-0017-M
HIC Allergy Cross Reference Update	DUR-0018-M
Pediatric Dosing Update Report	DUR-0019-M
Geriatric Dosing Update Report	DUR-0020-M
GCN Sequence Number Update Report	DUR-0021-M
Annual ProDUR Cost Savings Report	DUR-0022-A
Monthly ProDUR Cost Savings Report	DUR-0022-M
Specific Therapeutic Class Update Report	DUR-0025-M
Inferred Disease Update	DUR-0026-M
Disease Update	DUR-0027-M

Functional Area
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DUR

DSC_TITLE	Technical Name	Functional Area
Interactive Inbound X12 Balancing - Daily	EDI-0004-D	EDI
Interactive X12 Balancing - All - Daily	EDI-0005-D	EDI
Interactive Activity by VAN - Daily	EDI-0100-D	EDI
Interactive Activity Time of Day by VAN - Daily	EDI-0110-D	EDI
Interactive Transaction Timing by VAN - Daily	EDI-0120-D	EDI
Interactive Activity for NCPDP - Daily	EDI-0300-D	EDI
Interactive Activity for NCPDP - Monthly	EDI-0300-M	EDI
Interactive Activity for NCPDP - Weekly	EDI-0300-W	EDI
Interactive Activity Time of Day for NCPDP - Daily	EDI-0310-D	EDI
Interactive Transaction Timing for NCPDP - Daily	EDI-0320-D	EDI
Interactive Transaction Timing for NCPDP - Monthly	EDI-0320-M	EDI
Interactive Transaction Timing for NCPDP - Weekly	EDI-0320-W	EDI
EDI outbound X12 balancing	EDI-0410-D	EDI
EDI outbound X12 balancing All	EDI-0411-D	EDI
EDI Data Errors	EDI-0551-D	EDI
Trading Partners Submitting Non-5010 Transactions	EDI-0600-W	EDI

DSC_TITLE	Technical Name	Functional Area
CMS-416 Annual EPSDT Participation Report	EPS-0011-A	EPSDT
CMS-416 Quarterly EPSDT Participation Report	EPS-0011-Q	EPSDT
Periodic Rescreen List	EPS-0500-M	EPSDT
EPSDT Periodic Screening List	EPS-0550-M	EPSDT
EPSDT Periodic Screening List Statistics	EPS-0560-M	EPSDT

DSC_TITLE	Technical Name
PHARMACY EPRESCRIBING NEEDED RULES FOR ALTERNATE THERAPY REPORT	ERX-0200-W

Functional Area
ePrescribing

DSC_TITLE	Technical Name
Enrollment Status Report	FTH-0001-W
Re-Enrollment Status Report	FTH-0002-W
Enrollment Update Status Report	FTH-0003-W

Functional Area
Feith
Feith
Feith

DSC_TITLE	Technical Name
Credit Balance Due	CRA-AL01-R
Remittance Advice - Banner Messages	CRA-BANN-R
Remittance Advice - Compound Drug Claim Adjustments	CRA-CDAD-R
Remittance Advice - Compound Drug Claims Denied	CRA-CDDN-R
Remittance Advice - Compound Drug Claims Paid	CRA-CDPD-R
Remittance Advice - Compound Drug Claims In Process	CRA-CDSU-R
Remittance Advice - Dental Claim Adjustments	CRA-DNAD-R
Remittance Advice - Dental Claims Denied	CRA-DNDN-R
Remittance Advice - Dental Claims Paid	CRA-DNPD-R
Remittance Advice - Dental Claims In Process	CRA-DNSU-R
Remittance Advice - Drug Claim Adjustments	CRA-DRAD-R
Remittance Advice - Drug Claims Denied	CRA-DRDN-R
Remittance Advice - Drug Claims Paid	CRA-DRPD-R
Remittance Advice - Drug Claims In Process	CRA-DRSU-R
Remittance Advice - Encounter Claim Adjustments	CRA-ENAD-R
Remittance Advice - Encounter Claims Denied	CRA-ENDN-R
Remittance Advice - Encounter Claims Paid	CRA-ENPD-R
Remittance Advice - Encounter Claims In Process	CRA-ENSU-R
Remittance Advice - EOB Code Descriptions	CRA-EOBM-R
Remittance Advice - Inpatient Claim Adjustments	CRA-IPAD-R
Remittance Advice - Inpatient Claims Denied	CRA-IPDN-R
Remittance Advice - Inpatient Claims Paid	CRA-IPPD-R
Remittance Advice - Inpatient Claims In Process	CRA-IPSU-R
Remittance Advice - Long Term Care Claim Adjustments	CRA-LTAD-R
Remittance Advice - Long Term Care Claims Denied	CRA-LTDN-R
Remittance Advice - Long Term Care Claims Paid	CRA-LTPD-R
Remittance Advice - Long Term Care Claims In Process	CRA-LTSU-R
Remittance Advice - Outpatient Claim Adjustments	CRA-OPAD-R
Remittance Advice - Outpatient Claims Denied	CRA-OPDN-R
Remittance Advice - Outpatient Claims Paid	CRA-OPPD-R
Remittance Advice - Outpatient Claims In Process	CRA-OPSU-R
Remittance Advice - CMS 1500 Claim Adjustments	CRA-PRAD-R
Remittance Advice - CMS 1500 Claims Denied	CRA-PRDN-R
Remittance Advice - CMS 1500 Claims Paid	CRA-PRPD-R
Remittance Advice - CMS 1500 Claims In Process	CRA-PRSU-R
Remittance Advice Summary	CRA-SUMM-R
Remittance Advice - TPL Information	CRA-TPLM-R
Remittance Advice - Financial Transactions	CRA-TRAN-R
Remittance Advice - Medicare Crossover Part A Claim Adjustments	CRA-XAAD-R
Remittance Advice - Medicare Crossover Part A Claims Denied	CRA-XADN-R
Remittance Advice - Medicare Crossover Part A Claims Paid	CRA-XAPD-R
Remittance Advice - Medicare Crossover Part A Claims in Process	CRA-XASU-R
Remittance Advice - Medicare Crossover Part B Claim Adjustments	CRA-XBAD-R
Remittance Advice - Medicare Crossover Part B Claims Denied	CRA-XBDN-R
Remittance Advice - Medicare Crossover Part B Claims Paid	CRA-XBPD-R
Remittance Advice - Medicare Crossover Part B Claims in Process	CRA-XBSU-R

Remittance Advice - Medicare Crossover Outpatient Claim Adjustments	CRA-XCAD-R
Remittance Advice - Medicare Crossover Outpatient Claims Denied	CRA-XCDN-R
Remittance Advice - Medicare Crossover Outpatient Claims Paid	CRA-XCPD-R
Remittance Advice - Medicare Crossover Outpatient Claims In Process	CRA-XCSU-R
Financial 1099s for Feith download	FIN-1099
Financial 1099s for Feith Download 2017	FIN-1099-2017
Credit Balance Aging	FIN-AL01-Q
Alabama Invoice	FIN-AL02-R
Electronic Invoices Transmitted	FIN-AL03-R
REQ Account Receivable Report	FIN-AL04-O
Accounts Receivable Summary	FIN-AR01-W
Provider Manually Recovered Accounts Receivable	FIN-AR04-W
Accounts Receivable - Aging by Provider	FIN-AR10-W
Accounts Receivable Recoupment Summary by Reason Code	FIN-AR20-M
Accounts Receivable - Weekly Activity	FIN-AR41-W
Accounts Receivable - Aging by Fund Code	FIN-AR42-W
Accounts Receivable - Weekly Activity - by RSN Code	FIN-AR43-W
835-EFT 3 Day Compliance Audit Report	FIN-AU01-M
EOB CARC RARC CROSS WALKING REPORT	FIN-AU02-R
Provider YTD Offset Balancing	FIN-BAAR-R
Provider YTD Check Balancing	FIN-BACH-R
Financial Balancing	FIN-BACY-R
Provider YTD Expenditure Balancing	FIN-BAEX-R
Financial Managed Care Balancing	FIN-BAMC-R
Provider YTD Refund Balancing	FIN-BARE-R
Provider YTD Void Balancing	FIN-BAVO-R
Financial Payment Xref Balancing	FIN-BAXR-R
Cash Dispositioned Not Posted	FIN-CR05-W
Cash Disposition Adjustment Postings Report	FIN-CR10-W
Cash Receipts Posted By Fund Code	FIN-CR11-M
Daily Cash Receipts Log by CCN	FIN-CR16-O
Daily Cash Receipts Log by Unit	FIN-CR17-O
Cash Control Balance Report	FIN-CR18-O
Daily Cash Deposit Log	FIN-CR19-O
Cash Receipts Posted by Unit	FIN-CR21-M
Cash Summary - by Reason	FIN-CR22-M
Refund Report	FIN-CR30-M
Financial Extractor Error Report	FIN-ERR-W
Expenditure Inquiry Report	FIN-EX10-O
Provider Lien Activity	FIN-LN01-R
Outpatient Voids	FIN-OPVO-R
Encounter Adjustments-Voids	FIN-PHPV-R
Payment Register by Benefit Plan	FIN-PR01-R
Payment Register by Fund Code	FIN-PR03-R
Payment Register by Provider Type	FIN-PR04-R
Payment Register by Provider Type to be Paid	FIN-PR05-R
Payment Register by Claim Type	FIN-PR06-R

Payment Summary	FIN-PR07-R
Payment Register	FIN-PR08-R
Payment Register - Summary of Counts	FIN-PR10-R
Payment Register by Fund Group	FIN-PR12-R
Payment Register by Fund Group Detail	FIN-PR13-R
Approved To Pay	FIN-PR30-R
Approved to Pay by Line	FIN-PR31-R
Approved To Pay Encounter Line Count	FIN-PR32-R
Issued Payments	FIN-PY01-M
Voided Payments by External Number	FIN-PY05-W
Stop Payment	FIN-PY10-M
Cleared Payments	FIN-PY11-M
Payments Staledated	FIN-PY12-M
Payments Staledated FY YTD	FIN-PY13-M
EFT Notice of Change	FIN-PY15-D
EFT Activity	FIN-PY16-R
Stoppay - Reissue Detail Weekly Activity	FIN-PY17-W
Payment Inquiry Online Report	FIN-PY50-O
Payment Transaction Inquiry Report	FIN-PY51-O
Payment Status Recon Report	FIN-PY60-O
Financial Transactions Input - Payouts	FIN-TI01-R
Financial Transactions Input - Provider Accounts Receivable	FIN-TI02-R
Financial Transactions Input - Payouts by Reason Code	FIN-TI04-R
1099 Payment Summary	FIN-TX05-Q
1099 Exception	FIN-TX06-Q
Missing Provider Information	FIN-TX10-Q
Paper 1099	PAPR1099

Functional Area
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DSC_TITLE	Technical Name
NOTIFICATIONS NOT ACCEPTED AND REASON NOT ACCEPTED	LTC-0005-M
NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE	LTC-0006-M
LTC AND WAIVER MONTHLY ACTIVITY REPORT	LTC-0007-M
LTC TRADING PARTNER ERROR ACTIVITY REPORT	LTC-0008-M
LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY REPORT	LTC-0011-M
LTC Weekly Discharge Explanation Report	LTC-0012-W
LTC SEGMENTS TERMINATED DUE TO PROVIDER CONTRACT CLOSED R	LTC-0014-M
LTC SEGMENTS TERMINATED DUE TO ELIGIBILITY LOST	LTC-0015-M
LTC SEGMENTS RECOMMENDED FOR TERMINATION DUE TO NO CLAIN	LTC-0016-M

Functional Area
Long Term Care
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Long Term Care

DSC_TITLE	Technical Name	Functional Area
MC Rpts and Feith	MC Rpts and Feith	Managed Care
Capitation Payment Listing	MGD-0004-M	Managed Care
Monthly PMP Enrollment Roster	MGD-0056-M	Managed Care
Monthly Managed Care Enrolled But Not Eligible	MGD-0070-M	Managed Care
Capitation Errors	MGD-0080-M	Managed Care
Capitation Errors for ICN	MGD-0081-M	Managed Care
Capitation Payment Listing Summary by Provider	MGD-0100-M	Managed Care
Capitation Summary by Program	MGD-0302-M	Managed Care
Medicare Advantage Enrollment Summary	MGD-A059-M	Managed Care
Capitation Payment Summary	MGD-A130-M	Managed Care
Capitation Payment Summary by Plan	MGD-A131-M	Managed Care
ACHN Referral Report	MGD-A501-Q	Managed Care
Monthly Medicare Advantage Enrollment and Errors	MGD-A810-M	Managed Care
Manual Override of EDB Information	MGD-A815-M	Managed Care
Monthly ICN Enrollment and Errors	MGD-A820-M	Managed Care
ICN Overlapping Special Conditions	MGD-A821-M	Managed Care
Capitation Reconciliation Report (Tab-delimited Format)	mgm71802.dat	Managed Care

DSC_TITLE
Errors By Claim Type
Payment Comparison By Category Of Service
Payment Comparison By Provider Type - Monthly
Payment Comparison By Provider Type
Error Code Analysis
Expenditure Analysis By Category of Service
Long Term Care Payments By Revenue Code
Medicare Participation Part A
Medicare Participation Part A and B
Medicare Participation Part B
Payment Statistics By State COS
Payment Statistics By Provider Type
Operational Performance Summary - Averages and Percents
Operational Performance Summary - Dollars
Operational Performance Summary - Provider
Place of Service Analysis
Provider Error Analysis
Provider Filing Analysis
Provider Participation Average
Provider Participation Total
Provider Ranking
Locality Participation Analysis By Aid Category
Locality Participation Analysis By State COS
Recipient Copayment By Aid Category
Recipient Ranking
Recipient Participation Summary By County
Third Party Payment Ranking
Claims Processing Throughput Analysis - DOR to DOA
Claims Processing Throughput Analysis - DOR to DOP
MAR Monthly Reconciliation
MAR Month-End Claims Processing Analysis Report
Expenditure By COS Report
Participation By COS Report
Annual Abortion Report
Monthly Abortion Detail Report
Annual Sterilization Report
Monthly Sterilization Detail Report
CMS 372 Annual Report On HCBS ID Waiver
CMS 372 Annual Report On HCBS ED Waiver
CMS 372 Annual Report On HCBS Living At Home Waiver (Long)
CMS 372 Annual Report On HCBS Living At Home Waiver
CMS 372 Annual Report On HCBS TA Waiver
CMS 372 Annual Report On HCBS SAIL Waiver
CMS 372 Annual Report On HCBS HIV - AIDS Waiver
CMS 372 Annual Report On HCBS ACT Waiver
TMSIS Medicaid Detailed Error Report

TMSIS BCBS-ADPH Detailed Error Report
TMSIS Summary Error Report
TMSIS CMS Medicaid Detailed Error Report
TMSIS CMS BCBS-ADPH Detailed Error Report

Technical Name	Functional Area
Errors By Claim Type	MAR
MAR.ComparisonByCOS.rdl	MAR
MAR.ComparisonByProvType.rdl	MAR
MAR.ComparisonByProvTypeRange.rdl	MAR
MAR.ErrorCode.rdl	MAR
MAR.ExpendituresByCOS.rdl	MAR
MAR.LongTermByRev.rdl	MAR
MAR.MedicarePartA.rdl	MAR
MAR.MedicarePartAB.rdl	MAR
MAR.MedicarePartB.rdl	MAR
MAR.PaymentByCOS.rdl	MAR
MAR.PaymentByProvType.rdl	MAR
MAR.PerformanceAvgPct.rdl	MAR
MAR.PerformanceDollars.rdl	MAR
MAR.PerformanceProvider.rdl	MAR
MAR.PlaceOfService.rdl	MAR
MAR.ProviderError.rdl	MAR
MAR.ProviderFiling.rdl	MAR
MAR.ProviderPrtcpAvg.rdl	MAR
MAR.ProviderPrtcpTotals.rdl	MAR
MAR.ProviderRanking.rdl	MAR
MAR.PrtcpByAidCategory.rdl	MAR
MAR.PrtcpByCOS.rdl	MAR
MAR.RecipientCopay.rdl	MAR
MAR.RecipientRanking.rdl	MAR
MAR.RecipPrtcpByCnty.rdl	MAR
MAR.ThirdPartyPayment.rdl	MAR
MAR.ThruputDORDOA.rdl	MAR
MAR.ThruputDORDOP.rdl	MAR
MAR-0111-M	MAR
MAR-018-M	MAR
MAR-0310-O	MAR
MAR-0320-O	MAR
MAR-2100-A	MAR
MAR-2100-M	MAR
MAR-2110-A	MAR
MAR-2110-M	MAR
MAR-4812-A	MAR
MAR-4822-A	MAR
MAR-4831-A	MAR
MAR-4832-A	MAR
MAR-4842-A	MAR
MAR-4852-A	MAR
MAR-4862-A	MAR
MAR-4872-A	MAR
MAR-8941-M	MAR

MAR-8942-M	MAR
MAR-8943-M	MAR
MAR-8951-M	MAR
MAR-8952-M	MAR

DSC_TITLE	Technical Name
Prior Authorization Notices - Recipient	PAU-0000-D
Prior Authorization Notices - Servicing Providers	PAU-0001-D
Prior Authorization 30 Day Aging Report	PAU-0002-D
Prior Authorization Reconsideration Report	PAU-0002-W
Prior Authorization Quality Review Report - Medicaid	PAU-0003-D
Prior Authorization Monthly Activity Report	PAU-0005-M
Prior Authorization Monthly Utilization Report	PAU-0008-M
Prior Authorization Monthly Utilization Report - Rqst Prov	PAU-0009-M
Prior Authorization Special Request Report	PAU-0010-R
Prior Authorization Analyst Activity Report	PAU-001A-M
Prior Authorization Electronic Activity Report	PAU-002A-D
Prior Authorization Quality Review Report - CHIP	PAU-003A-D
Prior Authorization Quality Review Report - ACA	PAU-003B-D
Prior Authorization Quality Review Report - Sobra and Non-Citizen	PAU-003C-D

Functional Area
Prior Authorization
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DSC_TITLE	Technical Name
Label Print Request Summary Information	PRV-0010-R
Provider Mailing Labels	PRV-0010-R 2
Provider DEA mismatch report	PRV-0015-D
Provider FEIN-SSN Cross Reference	PRV-0015-M
Provider License Number Cross Reference	PRV-0016-M
Provider CLIA Cross Reference	PRV-0017-M
Provider Pre-Notification	PRV-0032-W
Active Providers with invalid ABA Numbers	PRV-0100-W
Newly Enrolled Providers	PRV-0300-D
Provider Termination Report	PRV-0510-M
Provider Changes By Clerk ID Weekly Summary	PRV-0530-W
Institutional Rate Report	PRV-0540-Q
Provider Invalid Address report	PRV-0604-O
Provider Verification Review Report	PRV-0750-M
Provider Monthly Sanction file comparison report	PRV-0770-M
Provider OnRqst Sanction file Comparison report	PRV-0770-O
Provider CMS Medicaid Revocation Review	PRV-0771-O
Provider CMS Medicaid Termination Review	PRV-0772-O
Provider PDF RA End Date Forecast Report	PRV-0820-R
Physician board certification letter	PRV-1008-O
Primary Care Termination Notice	PRV-1009-A
Provider Welcome Letter	PRV-9008-R
OOS Participating Prov 45 Day Expiration Letter	PRV-A020-D
Newly Enrolled Web Providers	PRV-A030-D
Potential Provider Deactivation	PRV-A030-Q
Web Provider Welcome Letter	PRV-A030-R
Actual Providers Deactivated	PRV-A031-O
PROVIDER CLOSURE REPORT	PRV-A032-M
Notification of Alabama Medicaid Provider Number Closure Letter	PRV-A032-R
State Agencies Needing to Reenroll	PRV-A034-M
Provider Re-Enrollment Completion Letter	PRV-A035-D
Provider Reenrollment Facsimile	PRV-A035-M
Reenrollment Final Notice	PRV-A037-D
Annual Reenrollment Notice	PRV-A038-M
Proof of Enrollment Fee Payment Letter	PRV-A039-D
Reenrollment Statistics	PRV-A039-W
Reenrollment Statistics	PRV-A039-W
ERA Enrollment Letter	PRV-A040-O
Provider Fee Collection	PRV-A040-W
OOS Participating Prov 90 Day Expiration Report	PRV-A041-D
Provider B Notices Sent	PRV-A042-A
Provider B Notice Records Not Matched	PRV-A043-A
Provider B Notices Sent by Provider Id	PRV-A044-A
Provider Group Address Changes	PRV-A050-D
Providers Not Updated by Surety Bond Process	PRV-A060-D
Portal Performance	PRV-A070-M

Portal Statistics	PRV-A071-D
Provider Web App Facsimile - Facility	PRV-A072-D
Provider Web App Facsimile - Individual Within A Group	PRV-A073-D
Provider Web App Facsimile - Individual	PRV-A074-D
Provider Web App Secondary Facsimile - Facility	PRV-A075-D
Provider Web App Secondary Facsimile - Individual Within A Group	PRV-A076-D
Provider Web App Secondary Facsimile - Individual	PRV-A077-D
Provider Maintenance Facsimile	PRV-A078-D
Provider Web App Facsimile - Group	PRV-A079-D
Provider Web App Secondary Facsimile - Group	PRV-A080-D
Provider Web App Facsimile - OPR	PRV-A081-D
Provider Web App Secondary Facsimile - OPR	PRV-A082-D
Provider EFT Facsimile	PRV-A083-D
Provider ERA Facsimile	PRV-A084-D
Provider Customary Update Process	PRV-A098-A
Medicare Accreditation Bond Expiration Letter	PRV-AC01-D
Medicare Surety Bond Expiration Letter	PRV-MC01-D
Medicaid Surety Bond Expiration Letter	PRV-MD01-D

Functional Area
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DSC_TITLE	Technical Name
Total ID Card Counts by County	ELG-0001-D
ID Card Summary	ELG-0002-D
AMACL Daily Error Report	ELG-0003CL-D
AMAES Daily Error Report	ELG-0003-D
AMADR Daily Error Report	ELG-0003DR-D
AMACL Daily Transaction Count	ELG-0004CL-D
AMAES Daily Transaction Count	ELG-0004-D
AMADR Daily Transaction Count	ELG-0004DR-D
AMACL Daily Error Count	ELG-0007CL-D
AMAES Daily Error Count	ELG-0007-D
AMADR Daily Error Count	ELG-0007DR-D
Eligible ID Card Recipients	ELG-0009-D
Weekly Potential Duplicate Report	ELG-0011-W
Weekly Potential AMAES Duplicate Report	ELG-0012-W
AMAES PART A B Error Count Report	ELG-0014-D
Mini Rekey Records Removed Report	ELG-0015-W
AMAES PART A B Updates Error Report	ELG-0020-D
AMAES PART A B Transaction Count Report	ELG-0021-D
Consent Form Insert Error Report	ELG-0030-D
Link Requests Processed	ELG-0032-D
Unlink Requests Processed	ELG-0033-D
Automatic Unlink Warning Report	ELG-0036-D
Unlinking Transaction Count	ELG-0050-D
Unlinking Error Count	ELG-0052-D
Unlink Error	ELG-0055-D
Linking Transaction Count	ELG-0060-D
Linking Error Count	ELG-0062-D
Linking Error	ELG-0065-D
Recipient Portal Demographic Updates Daily Report -- Indexed	ELG-0070-D
Recipient Portal Demographic Updates Daily Report	ELG-0071-D
Plastic Card ID Updates	ELG-0072-D
Overlapping Patient Liability Report	ELG-0080-W
Monthly Date of Death Returned to Zero Report	ELG-0134-M
Lockin Eligibility Status	ELG-0135-M
Expired PharmacyPrescriber with Lockin Assignments	ELG-0136-M
Recipient with future date of birth	ELG-0137-M
EDB Processing Report	ELG-0151-M
Eligibility Error RID Report	ELG-0152-M
CHIP recipients with TPL or Medicare	ELG-0155-M
CMS Eligibility Error Report	ELG-0612-M
IRS 2015 1095-B Form	ELG-1095-M
IRS 2016 1095-B Form	ELG-1095-M-16
IRS 2017 1095-B Form	ELG-1095-M-17

Functional Area
Recipient
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Recipient

DSC_TITLE	Technical Name	Functional Area
Daily Recipient AR Reconciliation Report	RAR-1001-D	Recipient AR
On-Demand Recipient AR Reconciliation Report	RAR-1001-O	Recipient AR
Recipient AR Recipient Aging Report	RAR-2001-W	Recipient AR
Recipient AR Overpayment Notice Report	RAR-2002-W	Recipient AR
Recipient AR Promissory Notes Listing Report	RAR-2003-W	Recipient AR
Recipient AR Recipient Recoupment Report	RAR-3001-M	Recipient AR
Recipient AR Confirmed Claims Listing Report	RAR-3002-M	Recipient AR
Recipient AR Possible Claims Listing Report	RAR-3003-M	Recipient AR
Recipient AR Statements	RAR-3004-M	Recipient AR
Recipient AR Negative Balance Report	RAR-3005-M	Recipient AR
Recipient AR Active Overpayments Report	RAR-3006-M	Recipient AR
Recipient AR Recipient Aging Report	RAR-3007-M	Recipient AR
Recipient AR Tax Intercept Notice Listing Report	RAR-4001-Y	Recipient AR
Recipient AR Tax Intercept Notices	RAR-4002-Y	Recipient AR
Additional Notice Letter	RecipAR.AdditionalNoticeLetter	Recipient AR

DSC_TITLE
CMS HCPCS Update - Discontinued Procedure Codes
CMS HCPCS Update - Added Procedure Codes
CMS HCPCS Update - Added Modifier Codes
CMS HCPCS Update - Summary
CMS HCPCS Update - Error
EOB TO BUSC CARC RARC CAGC CROSS REFERENCE COMPLIANCE AUDIT
CMS HCPCS Update - Changed Procedure Codes For CCYY
CMS HCPCS Update - Changed Modifier Codes For CCYY
CMS HCPCS Update - Discontinued Modifier Codes
Error Listing Database Exceptions
Drug Pricing Update Summary Report
CMS NDC HCPCS Crosswalk Update - Activity Listing report
CMS NDC-HCPCS Crosswalk Activity Report
CMS NDC-HCPCS Crosswalk Error Report
MME LOADING UPDATE REPORT MED MASTER
MME LOADING UPDATE REPORT CF MME FACTOR
ICD-10 Annual Update - New Diagnosis Codes
ICD-10 Annual Update - Revised Diagnosis Codes
ICD-10 Annual Update - Discontinued Diagnosis Codes
ICD-10 Annual Update - Diagnosis Error Report
ICD-10 Annual Update - Diagnosis Summary Report
ICD-10 Annual Update - Diagnosis Benefit Category Groupings
ICD-10 Annual Update - Associated Groups For Discontinued Diagnosis Codes
Lab Fee Update Exceptions Report
Fee Schedule for Laboratory And Radiology For Physicians And Independent Labs And Independent Radiology Pro
Fee Schedule for Hospital Outpatient
Fee Schedule for Dental Codes
Fee Schedule for Physician Codes
Fee Schedule for Physician Drug
Fee Schedule for ASC
Fee Schedule for DME
Fee Schedule for EPSDT
Fee Schedule Manually Priced Procedures
Audit Criteria Report
ICD-10 Annual Update - New Procedure Codes
Limitation Audit Criteria Report
ICD-10 Annual Update - Revised Procedure Codes
Contra-Indicated Audit Criteria Report
ICD-10 Annual Update - Discontinued Procedure Codes
ICD-10 Annual Update - Procedure Error Report
ICD-10 Annual Update - Procedure Summary Report
ICD-10 Annual Update - Associated Groups For Discontinued Procedure Codes
Include-Exclude Audit Criteria Report
Procedure to Audit Cross Reference Report
Revenue Code to Audit Cross Reference Report
Quarterly Durable Medical Equipment NCCI Update Report

Quarterly Durable Medical Equipment NCCI Error Override Report
Quarterly Hospital NCCI Update Report
Quarterly Hospital NCCI Error Override Report
Quarterly Practitioner NCCI Update Report
Quarterly Practitioner NCCI Error Override Report
Quarterly Durable Medical Equipment MUE Update Report
Quarterly Durable Medical Equipment MUE Error Override Report
Quarterly Hospital MUE Update Report
Quarterly Hospital MUE Error Override Report
Quarterly Practitioner MUE Update Report
Quarterly Practitioner MUE Error Override Report
Weekly Drug Update Summary
Weekly Drug Update Error Listing
Weekly Drug Update Report
FDB Update Added Drugs Detail Report
FDB Update Updated Drugs Detail Report
FDB Update Rejected Drugs Added Report
Drug Pricing Add Detail Report
Drug Pricing Update Error Ignore Delete Report
Drug Pricing Update Error
Drug Pricing Update Detail Report
J Code (Injection Drug) Price Update - Summary Report
J Code (Injection Drug) Price Update - Error Report
J Code Injection Drug Price Update - Detail Report
CMS NDC-HCPCS Crosswalk Edit Error Report
Pharmacy Standard Classification Review Report
Pharmacy Part D Classification Review Report
Pharmacy Standard Classification Update Report
Pharmacy Part D Classification Update Report
Weekly AL SMAC Price Update Report
Daily PDL change report
GSN Generic Pricing Add Detail Report
GSN Generic Pricing Error Detail Report
GSN Generic Pricing Update Detail Report
GSN Brand Pricing Add Detail Report
GSN Brand Pricing Error Detail Report
GSN Brand Pricing Update Detail Report
CARC RARC Combinations Update Audit
Fund Code Assignment Criteria Report

Technical Name	Functional Area
REF-0001-A	Reference
REF-0002-A	Reference
REF-0003-A	Reference
REF-0004-A	Reference
REF-0005-A	Reference
REF-0005-O	Reference
REF-0007-A	Reference
REF-0009-A	Reference
REF-0011-A	Reference
REF0042E	Reference
REF-0044-W	Reference
REF0046A	Reference
REF-0046-A	Reference
REF-0046-E	Reference
REF-0071-W	Reference
REF-0072-W	Reference
REF-0101-A	Reference
REF-0102-A	Reference
REF-0103-A	Reference
REF-0104-A	Reference
REF-0105-A	Reference
REF-0106-A	Reference
REF-0107-A	Reference
REF-0120-A	Reference
REF-0126-Q	Reference
REF-0127-Q	Reference
REF-0128-Q	Reference
REF-0129-Q	Reference
REF-0130-Q	Reference
REF-0131-Q	Reference
REF-0132-Q	Reference
REF-0133-Q	Reference
REF-0134-Q	Reference
REF-0200-M	Reference
REF-0201-A	Reference
REF-0201-M	Reference
REF-0202-A	Reference
REF-0202-M	Reference
REF-0203-A	Reference
REF-0204-A	Reference
REF-0205-A	Reference
REF-0206-A	Reference
REF-0207-M	Reference
REF-0208-M	Reference
REF-0209-M	Reference
REF-0400D-C-Q	Reference

REF-0400D-E-Q	Reference
REF-0400O-C-Q	Reference
REF-0400O-E-Q	Reference
REF-0400P-C-Q	Reference
REF-0400P-E-Q	Reference
REF-0401D-C-Q	Reference
REF-0401D-E-Q	Reference
REF-0401O-C-Q	Reference
REF-0401O-E-Q	Reference
REF-0401P-C-Q	Reference
REF-0401P-E-Q	Reference
REF-04300-W	Reference
REF-04301-W	Reference
REF-04302-W	Reference
REF-04303-W	Reference
REF-04304-W	Reference
REF-04305-W	Reference
REF-044A-W	Reference
REF-044E2-W	Reference
REF-044E-W	Reference
REF-044U-W	Reference
REF-04500-Q	Reference
REF-04501-Q	Reference
REF-04502-Q	Reference
REF-048E-Q	Reference
REF-050A-W	Reference
REF-050B-W	Reference
REF-051A-W	Reference
REF-051B-W	Reference
REF-05501-W	Reference
REF-0580-D	Reference
REF-060A-W	Reference
REF-060E-W	Reference
REF-060U-W	Reference
REF-061A-W	Reference
REF-061E-W	Reference
REF-061U-W	Reference
REF-0900-O	Reference
REF-FCA-R	Reference

DSC_TITLE
Case Group Maintenance
Case Tracking - All Cases
Case Tracking - All Open Cases By Analysts
Case Tracking - Cases On Hold
Case Tracking - Contract Suspensions
Case Tracking - Open Closed Cases
Case Tracking - Open Working Cases
Case Tracking - Purge List
Case Tracking - Recipient Lockin (Monthly Review)
Case Tracking - Recipient Lockin for Open Cases
Case Type Maintenance
Dental Claim Details By Provider
Dental Claim Details By Provider Qtrly
Inpatient Case Type Comparison by Peer Group
Inpatient Case Type Comparison by Peer Group Qtrly
Inpatient Claim Details By Provider - FFS
Inpatient Claim Details By Provider Qtrly - FFS
Inpatient Disease Global View
Inpatient Disease Quick View
Inpatient Distribution Analysis
Inpatient Exception Quarterly
Inpatient Frequency Distribution
Inpatient Frequency Distribution Qtrly
Inpatient Provider Profile
Inpatient Provider Profile Qtrly
Inpatient Recip Case Type Comparison By Peer Group
Inpatient Recip Case Type Comparison By Peer Group Qtrly
Nursing Facility Case Type Comparison By Peer Group
Nursing Facility Case Type Comparison By Peer Group Qtrly
Nursing Facility Claim Details By Provider - FFS
Nursing Facility Claim Details By Provider Qtrly - FFS
Nursing Facility Disease Quick View
Nursing Facility Exception Quarterly
Nursing Facility Frequency Distribution
Nursing Facility Frequency Distribution Qtrly
Nursing Facility Provider Profile
Nursing Facility Provider Profile Qtrly
Nursing Facility Recip Case Type Comparison By Peer Group
Nursing Facility Recip Case Type Comparison By Peer Group Qtrly

Outpatient Case Type Comparison By Peer Group
Outpatient Case Type Comparison By Peer Group Qtrly
Outpatient Claim Details By Provider - FFS
Outpatient Claim Details By Provider Qtrly - FFS
Outpatient Disease Quick View
Outpatient Distribution Analysis
Outpatient Exception Quarterly
Outpatient Frequency Distribution
Outpatient Frequency Distribution Qtrly
Outpatient Provider Profile
Outpatient Provider Profile Qtrly
Outpatient Recip Case Type Comparison By Peer Group
Outpatient Recip Case Type Comparison By Peer Group Qtrly
Pharmacy Case Type Comparison By Peer Group
Pharmacy Case Type Comparison By Peer Group Qtrly
Pharmacy Claim Details By Provider
Pharmacy Claim Details By Provider Qtrly
Pharmacy Disease Quick View
Pharmacy Distribution Analysis
Pharmacy Exception Quarterly
Pharmacy Frequency Distribution
Pharmacy Frequency Distribution Qtrly
Pharmacy Provider Profile
Pharmacy Provider Profile Qtrly
Pharmacy Recip Case Type Comparison By Peer Group
Pharmacy Recip Case Type Comparison By Peer Group Qtrly
Professional Case Type Comparison By Peer Group
Professional Case Type Comparison By Peer Group Qtrly
Professional Claim Details By Provider - FFS
Professional Claim Details By Provider Qtrly - FFS
Professional Disease Global View
Professional Disease Quick View
Professional Distribution Analysis
Professional Exception Quarterly
Professional Frequency Distribution
Professional Frequency Distribution Qtrly
Professional Provider Profile
Professional Provider Profile Qtrly
Professional Recip Case Type Comparison By Peer Group

Professional Recip Case Type Comparison By Peer Group Qtrly
Professional Referral Case Type Comparison By Peer Group
Professional Referral Case Type Comparison By Peer Group Qtrly
Professional Referral Claim Details By Provider - FFS
Professional Referral Claim Details By Provider Qtrly- FFS
Professional Referral Distribution Analysis
Professional Referral Exception Quarterly
Professional Referral Frequency Distribution
Professional Referral Frequency Distribution Qtrly
Professional Referral Provider Profile
Professional Referral Provider Profile Qtrly
Provider Peer Group Comparison
Provider Peer Group Comparison Qtrly
Recipient Claim Details - FFS
Recipient Claim Details Qtrly - FFS
Recipient Exception Quarterly
Recipient Frequency Distribution
Recipient Frequency Distribution Qtrly
Recipient Peer Group Comparison
Recipient Peer Group Comparison Qtrly
Recipient Profile
Recipient Profile Qtrly
ETG Descriptions
ETG Details - FFS
ETG Distribution Analysis - FFS
ETG Episode Cross Reference - FFS
ETG Provider Comparison - FFS
ETG Provider Details - FFS
ETG Provider Summary - FFS
ETG Recipient Comparison - FFS
ETG Recipient Details - FFS
ETG Recipient Summary - FFS
ETG Summary - FFS
Peer Group Maintenance
Profiler Balancing Inpatient Quarterly
Profiler Balancing Inpatient Yearly
Profiler Balancing Nursing Home Quarterly
Profiler Balancing Nursing Home Yearly
Profiler Balancing Outpatient Quarterly
Profiler Balancing Outpatient Yearly
Profiler Balancing Pharmacy Quarterly
Profiler Balancing Pharmacy Yearly
Profiler Balancing Professional Quarterly

Profiler Balancing Professional Referral Quarterly
Profiler Balancing Professional Referral Yearly
Profiler Balancing Professional Yearly
TQ - Antibiotics 12 Months or Longer
TQ - Delayed Surgery Summary
TQ - Drug - Overspending Prescribers
TQ - Drug - Recipients w-mult Pharmacies-Prescribers
TQ - Emergency Room Visits
TQ - Facility Visits Exception
TQ - Home Hospital Conflict
TQ - Inpatient - Related Readmissions
TQ - Office Visits Exception
TQ - PT OT Daily Overbilling
TQ - Physician Office Visits
TQ - Physician Office Visits by Recipient

Technical Name	Functional Area
Case Group Maintenance	SUR
Case Tracking - All Cases	SUR
Case Tracking - All Open Cases By Analysts	SUR
Case Tracking - Cases On Hold	SUR
Case Tracking - Contract Suspensions	SUR
Case Tracking - Open Closed Cases	SUR
Case Tracking - Open Working Cases	SUR
Case Tracking - Purge List	SUR
Case Tracking - Recipient Lockin (Monthly Review)	SUR
Case Tracking - Recipient Lockin for Open Cases	SUR
Case Type Maintenance	SUR
DSSProfiler - Dental Claim Details By Provider	SUR
DSSProfiler - Dental Claim Details By Provider Qtrly	SUR
DSSProfiler - Inpatient Case Type Comparison by Peer Group	SUR
DSSProfiler - Inpatient Case Type Comparison by Peer Group Qtrly	SUR
DSSProfiler - Inpatient Claim Details By Provider - FFS	SUR
DSSProfiler - Inpatient Claim Details By Provider Qtrly - FFS	SUR
DSSProfiler - Inpatient Disease Global View	SUR
DSSProfiler - Inpatient Disease Quick View	SUR
DSSProfiler - Inpatient Distribution Analysis	SUR
DSSProfiler - Inpatient Exception Quarterly	SUR
DSSProfiler - Inpatient Frequency Distribution	SUR
DSSProfiler - Inpatient Frequency Distribution Qtrly	SUR
DSSProfiler - Inpatient Provider Profile	SUR
DSSProfiler - Inpatient Provider Profile Qtrly	SUR
DSSProfiler - Inpatient Recip Case Type Comparison By Peer Group	SUR
DSSProfiler - Inpatient Recip Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Nursing Facility Case Type Comparison By Peer Group	SUR
DSSProfiler - Nursing Facility Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Nursing Facility Claim Details By Provider - FFS	SUR
DSSProfiler - Nursing Facility Claim Details By Provider Qtrly - FFS	SUR
DSSProfiler - Nursing Facility Disease Quick View	SUR
DSSProfiler - Nursing Facility Exception Quarterly	SUR
DSSProfiler - Nursing Facility Frequency Distribution	SUR
DSSProfiler - Nursing Facility Frequency Distribution Qtrly	SUR
DSSProfiler - Nursing Facility Provider Profile	SUR
DSSProfiler - Nursing Facility Provider Profile Qtrly	SUR
DSSProfiler - Nursing Facility Recip Case Type Comparison By Peer Group	SUR
DSSProfiler - Nursing Facility Recip Case Type Comparison By Peer Group Qtrly	SUR

DSSProfiler - Outpatient Case Type Comparison By Peer Group	SUR
DSSProfiler - Outpatient Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Outpatient Claim Details By Provider - FFS	SUR
DSSProfiler - Outpatient Claim Details By Provider Qtrly - FFS	SUR
DSSProfiler - Outpatient Disease Quick View	SUR
DSSProfiler - Outpatient Distribution Analysis	SUR
DSSProfiler - Outpatient Exception Quarterly	SUR
DSSProfiler - Outpatient Frequency Distribution	SUR
DSSProfiler - Outpatient Frequency Distribution Qtrly	SUR
DSSProfiler - Outpatient Provider Profile	SUR
DSSProfiler - Outpatient Provider Profile Qtrly	SUR
DSSProfiler - Outpatient Recip Case Type Comparison By Peer Group	SUR
DSSProfiler - Outpatient Recip Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Pharmacy Case Type Comparison By Peer Group	SUR
DSSProfiler - Pharmacy Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Pharmacy Claim Details By Provider	SUR
DSSProfiler - Pharmacy Claim Details By Provider Qtrly	SUR
DSSProfiler - Pharmacy Disease Quick View	SUR
DSSProfiler - Pharmacy Distribution Analysis	SUR
DSSProfiler - Pharmacy Exception Quarterly	SUR
DSSProfiler - Pharmacy Frequency Distribution	SUR
DSSProfiler - Pharmacy Frequency Distribution Qtrly	SUR
DSSProfiler - Pharmacy Provider Profile	SUR
DSSProfiler - Pharmacy Provider Profile Qtrly	SUR
DSSProfiler - Pharmacy Recip Case Type Comparison By Peer Group	SUR
DSSProfiler - Pharmacy Recip Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Professional Case Type Comparison By Peer Group	SUR
DSSProfiler - Professional Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Professional Claim Details By Provider - FFS	SUR
DSSProfiler - Professional Claim Details By Provider Qtrly - FFS	SUR
DSSProfiler - Professional Disease Global View	SUR
DSSProfiler - Professional Disease Quick View	SUR
DSSProfiler - Professional Distribution Analysis	SUR
DSSProfiler - Professional Exception Quarterly	SUR
DSSProfiler - Professional Frequency Distribution	SUR
DSSProfiler - Professional Frequency Distribution Qtrly	SUR
DSSProfiler - Professional Provider Profile	SUR
DSSProfiler - Professional Provider Profile Qtrly	SUR
DSSProfiler - Professional Recip Case Type Comparison By Peer Group	SUR

DSSProfiler - Professional Recip Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Professional Referral Case Type Comparison By Peer Group	SUR
DSSProfiler - Professional Referral Case Type Comparison By Peer Group Qtrly	SUR
DSSProfiler - Professional Referral Claim Details By Provider - FFS	SUR
DSSProfiler - Professional Referral Claim Details By Provider Qtrly - FFS	SUR
DSSProfiler - Professional Referral Distribution Analysis	SUR
DSSProfiler - Professional Referral Exception Quarterly	SUR
DSSProfiler - Professional Referral Frequency Distribution	SUR
DSSProfiler - Professional Referral Frequency Distribution Qtrly	SUR
DSSProfiler - Professional Referral Provider Profile	SUR
DSSProfiler - Professional Referral Provider Profile Qtrly	SUR
DSSProfiler - Provider Peer Group Comparison	SUR
DSSProfiler - Provider Peer Group Comparison Qtrly	SUR
DSSProfiler - Recipient Claim Details - FFS	SUR
DSSProfiler - Recipient Claim Details Qtrly - FFS	SUR
DSSProfiler - Recipient Exception Quarterly	SUR
DSSProfiler - Recipient Frequency Distribution	SUR
DSSProfiler - Recipient Frequency Distribution Qtrly	SUR
DSSProfiler - Recipient Peer Group Comparison	SUR
DSSProfiler - Recipient Peer Group Comparison Qtrly	SUR
DSSProfiler - Recipient Profile	SUR
DSSProfiler - Recipient Profile Qtrly	SUR
ETG Descriptions	SUR
ETG Details - FFS	SUR
ETG Distribution Analysis - FFS	SUR
ETG Episode Cross Reference - FFS	SUR
ETG Provider Comparison - FFS	SUR
ETG Provider Details - FFS	SUR
ETG Provider Summary - FFS	SUR
ETG Recipient Comparison - FFS	SUR
ETG Recipient Details - FFS	SUR
ETG Recipient Summary - FFS	SUR
ETG Summary - FFS	SUR
Peer Group Maintenance	SUR
Profiler Balancing Inpatient Quarterly	SUR
Profiler Balancing Inpatient Yearly	SUR
Profiler Balancing Nursing Home Quarterly	SUR
Profiler Balancing Nursing Home Yearly	SUR
Profiler Balancing Outpatient Quarterly	SUR
Profiler Balancing Outpatient Yearly	SUR
Profiler Balancing Pharmacy Quarterly	SUR
Profiler Balancing Pharmacy Yearly	SUR
Profiler Balancing Professional Quarterly	SUR

Profiler Balancing Professional Referral Quarterly	SUR
Profiler Balancing Professional Referral Yearly	SUR
Profiler Balancing Professional Yearly	SUR
TQ - Antibiotics 12 Months or Longer	SUR
TQ - Delayed Surgery Summary	SUR
TQ - Drug - Overspending Prescribers	SUR
TQ - Drug - Recipients w-mult Pharmacies-Prescribers	SUR
TQ - Emergency Room Visits	SUR
TQ - Facility Visits Exception	SUR
TQ - Home Hospital Conflict	SUR
TQ - Inpatient - Related Readmissions	SUR
TQ - Office Visits Exception	SUR
TQ - PT OT Daily Overbilling	SUR
TQ - Physician Office Visits	SUR
TQ - Physician Office Visits by Recipient	SUR

cc

DSC_TITLE	Technical Name	Functional Area
Transactions in X Second Compliance	SYS-0100-M	System Wide
Transactions Response Variance	SYS-0101-M	System Wide
Web Portal Download Audit Report	SYS-0140-M	System Wide
Report Verification Error Listing Report	SYS-0500-D	System Wide
Report Verification - Confirmation Listing	SYS-0501-D	System Wide
Report Verification - Sent to Printer	SYS-0502-D	System Wide
Unmasking Log Report - Internal	SYS-0510-W	System Wide
Unmasking Log Report - Medicaid	SYS-0511-W	System Wide
Unmasking Log Report - Vendor	SYS-0512-W	System Wide
Unmasking Log Report - Non-Standard IDs	SYS-0513-W	System Wide

DSC_TITLE
CMS-1500 Billing Facsimile
Dental Billing Facsimile
UB-04 Billing Facsimile
DEERS Match - 271 Transaction
DEERS No Match - 271 Transaction
TPL Monthly Casualty Composite
TPL Case Activity Summary
TPL Monthly Case Review By Analyst
TPL Accident Trauma Report
BCBS Policy Not Identified-Needs Research
BCBS Policy Not Identified-Needs Research Pre-Production
BCBS Recipient Not Found Report
BCBS Recipient Not Found Report-Pre-production
BCBS Policy Add-Update Report
BCBS Policy Add-Update Report-Pre-production
BCBS Policy HIPP Update Report
BCBS Policy HIPP Update Report - Pre-Production
TPL Cost Avoidance
Carriers By Employer - online report
Employer By Carrier - online report
Recipients By Carrier - online report
Carrier By Recipient - online report
TPL Carrier Master File - Alpha
TPL Carrier Master File - Numeric
Potential TPL for Follow-Up
Verification Letter Follow-Up - online report
Billing Summary Reports
Pharmacy Billing Facsimile
TPL Casualty Collections
Case Tracking - Certificate of Authentication
Case Tracking - Case Detail
TPL Recovery Activity by Coverage Type - QTD
TPL Cost Avoidance Summary - CMS Calculation
TPL Cost Recovery Summary - CMS Calculation
Pay & Chase 90 Day Drugs Billing Summary Report
HIPP Monthly Payment Detail
HIPP Policyholders for Cost Effectiveness Review
HIPP Cost-Effectiveness - Quarterly Analysis
HIPP Policies For Follow-up
NCPDP Subrogation Response - Detail Status
NCPDP Subrogation Response - Summary
Pay & Chase 90 Day Drugs Recovery Summary Report
HIPP Policy Cost Effectiveness Summary
Questionnaires With No Response By Recip
Questionnaires With No Response By County
TPL 835 Checks Not Received

TPL Monthly Recoveries
Estate Lien Report
277CA Claims Acknowledgement Rejected Status Report
277CA Claims Acknowledgement Summary Report
HIPP Payments Processed
HIPP Rejected Payments
HIPP Remittance Advice
HIPP Premium Payment RA Register
HIPP Monthly Clerk Cost Effective Activity
HMS Monthly AR Aging Report
MONTHLY POLICIES CURRENTLY ON TPL FILE
QUARTERLY POLICIES CURRENTLY ON TPL FILE
MONTHLY POLICIES NOT FOUND ON THE TPL FILE
QUARTERLY POLICIES NOT FOUND ON THE TPL FILE
Weekly TPL SSA Policy not found report
TPL Refund Invoice List - BCBS
TPL Refund Invoice Errors - BCBS
TPL Refund Invoice List - HMS
TPL Refund Invoice Errors - HMS
HMS Case Extract Summary Report
HMS Case Extract Case Error Summary Report
HMS Claim Extract Summary report
HMS Claim Extract Error Summary Report
HMS Estate Cases Summary Report
HMS Estate Cases Error Summary Report
On Request - TPL Mass Claim Voids Submitted By Ext Entity
HIPP Duplicate Active Recipient ID Report
TPL Possible Medicare Eligibles
TPL Payment Integrity Report
TPL Billed ARs for Medicare Retroactive
TPL Medicare Claims Adjustment
TPL Actual Medicare Claims Adjustment
TPL Cash Receipt and Disposition
TPL Aged Detail Claims
TPL Input Output Code Report
TPL Trauma Detail Claims Listing
TPL UAIC Hits with no Policy Record Found
TPL UAIC Hits with no Match on Carrier
TPL UAIC Hits on Carrier no Match on Policy
TPL UAIC Hits on CarrierPolicy no Match on End Date
TPL UAIC Hits with Match on Carrier Policy and End Date
TPL RSA Insurance Policy Coverage
TPL DHR Absent Parent Military Service
TPL DHR Data
TPL DHR Transaction Error
TPL Electronic Remittance Summary Report
TPL Credit Balance

TPL Payments Received Not Posted
TPL Denials Posted - Needs Research
TPL Denials With Invalid AR Number - Not Posted
TPL AR Payments Posted Report
TPL Denials Posted
TPL RSA Policy Record not Added
TPL RSA Policy Record Added
TPL Collections By Invoice Category By Fiscal Year Report
TPL Hospital Encounter Claims Adjustment
TPL Maternity Care Claims Adjustment
TPL Circumcision Claims Adjustment
TPL E-Diagnosis Claims Adjustment
Daily HMS Active Add Report
Third Party Contractor Active Add Report
Third Party Contractor Active Add PreProduction Report
Third Party Contractor HIPP Records Add PreProd-Production Report
Third Party Contractor Inactive Add Report
Third Party Contractor Inactive Add PreProduction Report
Third Party Contractor Active Add Report - Update Records
Third Party Contractor Active Add PreProduction Report - Update Records
Third Party Contractor Inactive Add Report - Update Records
Third Party Contractor Inactive Add PreProduction Report - Update Records
Third Party Contractor Active Add Report - HMS Quarterly Records
Third Party Contractor Active Add PreProduction Report - HMS Quarterly Records
Third Party Contractor Inactive Add Report - HMS Quarterly Records
Third Party Contractor Inactive Add PreProduction Report - HMS Quarterly Records
Third Party Contractor Active Add Report - HIPP Update Records
Third Party Contractor Active Add PreProduction Report - HIPP Update Records
Third Party Contractor Inactive Add Report - HIPP Update Records
Third Party Contractor Inactive Add PreProduction Report - HIPP Update Records
Third Party Contractor Active Records Add Prod Report - Absent Parent Records
Third Party Contractor Active Add Report - Tricare Records
Third Party Contractor Active Add PreProduction Report - Tricare Records
Third Party Contractor Inactive Add Report - Tricare Records
Third Party Contractor Inactive Add PreProduction Report - Tricare Records
TPL Cash Receipts and ARs Created Through HMS Monthly Process
TPL ARs Sent By HMS Not Processed
THIRD PARTY CONTRACTOR ACTIVE ERROR PRODUCTION RPT
THIRD PARTY CONTRACTOR INACTIVE ERROR PRODUCTION RPT
Southland Policy Add-Update Report
Southland Policy Add-Update Pre Prod Report
Southland Not Identified - Needs Research Report
Southland Not Identified - Needs Research Pre Prod Report
Southland Recipient Not Found Report
Southland Recipient Not Found Pre Prod Report
Third Party Contractor Active PreProduction Error Report

Third Party Contractor Inactive PreProduction Error Report

Technical Name	Functional Area
HMT-R150-0	Third Party Liability
HMT-RADA-D	Third Party Liability
HMT-RUB0-4	Third Party Liability
TPL-0001-R	Third Party Liability
TPL-0002-R	Third Party Liability
TPL-0003-M	Third Party Liability
TPL-0004-M	Third Party Liability
TPL-0005-M	Third Party Liability
TPL-0009-W	Third Party Liability
TPL-0010-P	Third Party Liability
TPL-0010-T	Third Party Liability
TPL-0011-P	Third Party Liability
TPL-0011-T	Third Party Liability
TPL-0012-P	Third Party Liability
TPL-0012-T	Third Party Liability
TPL-0013-P	Third Party Liability
TPL-0013-T	Third Party Liability
TPL-0016-M	Third Party Liability
TPL-0017-R	Third Party Liability
TPL-0018-R	Third Party Liability
TPL-0019-R	Third Party Liability
TPL-0020-R	Third Party Liability
TPL-0021-Q	Third Party Liability
TPL-0022-Q	Third Party Liability
TPL-0023-W	Third Party Liability
TPL-0024-M	Third Party Liability
TPL-0025-R	Third Party Liability
TPL-0026-R	Third Party Liability
TPL-0027-M	Third Party Liability
TPL-0028-R	Third Party Liability
TPL-0029-R	Third Party Liability
TPL-0030-Q	Third Party Liability
TPL-0033-M	Third Party Liability
TPL-0034-M	Third Party Liability
TPL-0035-M	Third Party Liability
TPL-0038-M	Third Party Liability
TPL-0039-M	Third Party Liability
TPL-0042-Q	Third Party Liability
TPL-0044-W	Third Party Liability
TPL-0046-M	Third Party Liability
TPL-0047-M	Third Party Liability
TPL-0048-M	Third Party Liability
TPL-0050-D	Third Party Liability
TPL-0081-W	Third Party Liability
TPL-0082-W	Third Party Liability
TPL-0092-M	Third Party Liability

TPL-0101-M	Third Party Liability
TPL-0102-M	Third Party Liability
TPL-015R-D	Third Party Liability
TPL-015S-D	Third Party Liability
TPL-0250-W	Third Party Liability
TPL-0260-W	Third Party Liability
TPL-0270-W	Third Party Liability
TPL-0280-W	Third Party Liability
TPL-0290-M	Third Party Liability
TPL-0321-M	Third Party Liability
TPL-0350-M	Third Party Liability
TPL-0350-Q	Third Party Liability
TPL-0351-M	Third Party Liability
TPL-0351-Q	Third Party Liability
TPL-0352-W	Third Party Liability
TPL-0401-M	Third Party Liability
TPL-0402-M	Third Party Liability
TPL-0403-M	Third Party Liability
TPL-0404-M	Third Party Liability
TPL-0500-M	Third Party Liability
TPL-0510-M	Third Party Liability
TPL-0520-M	Third Party Liability
TPL-0530-M	Third Party Liability
TPL-0540-W	Third Party Liability
TPL-0541-W	Third Party Liability
TPL-0550-R	Third Party Liability
TPL-1185-D	Third Party Liability
TPL-3001-M	Third Party Liability
TPL-A001-M	Third Party Liability
TPL-A035-M	Third Party Liability
TPL-A036-M	Third Party Liability
TPL-A037-M	Third Party Liability
TPL-A038-R	Third Party Liability
TPL-A046-M	Third Party Liability
TPL-A047-R	Third Party Liability
TPL-A052-R	Third Party Liability
TPL-A056-R	Third Party Liability
TPL-A057-R	Third Party Liability
TPL-A058-R	Third Party Liability
TPL-A059-R	Third Party Liability
TPL-A060-R	Third Party Liability
TPL-A061-R	Third Party Liability
TPL-A070-R	Third Party Liability
TPL-A071-R	Third Party Liability
TPL-A073-R	Third Party Liability
TPL-A075-R	Third Party Liability
TPL-A076-R	Third Party Liability

TPL-A077-R	Third Party Liability
TPL-A078-R	Third Party Liability
TPL-A079-R	Third Party Liability
TPL-A080-R	Third Party Liability
TPL-A081-R	Third Party Liability
TPL-A088-R	Third Party Liability
TPL-A089-R	Third Party Liability
TPL-A090-R	Third Party Liability
TPL-A091-M	Third Party Liability
TPL-A092-M	Third Party Liability
TPL-A093-M	Third Party Liability
TPL-A094-M	Third Party Liability
TPL-A098-D	Third Party Liability
TPL-A098-R	Third Party Liability
TPL-A098-T	Third Party Liability
TPL-A098-W	Third Party Liability
TPL-A099-R	Third Party Liability
TPL-A099-T	Third Party Liability
TPL-A100-R	Third Party Liability
TPL-A100-T	Third Party Liability
TPL-A101-R	Third Party Liability
TPL-A101-T	Third Party Liability
TPL-A102-R	Third Party Liability
TPL-A102-T	Third Party Liability
TPL-A103-R	Third Party Liability
TPL-A103-T	Third Party Liability
TPL-A104-R	Third Party Liability
TPL-A104-T	Third Party Liability
TPL-A105-R	Third Party Liability
TPL-A105-T	Third Party Liability
TPL-A198-R	Third Party Liability
TPL-A328-R	Third Party Liability
TPL-A328-T	Third Party Liability
TPL-A329-R	Third Party Liability
TPL-A329-T	Third Party Liability
TPL-AR01-R	Third Party Liability
TPL-AR02-R	Third Party Liability
TPL-P098-E	Third Party Liability
TPL-P099-E	Third Party Liability
TPL-Q011-P	Third Party Liability
TPL-Q011-T	Third Party Liability
TPL-Q012-P	Third Party Liability
TPL-Q012-T	Third Party Liability
TPL-Q013-P	Third Party Liability
TPL-Q013-T	Third Party Liability
TPL-T098-E	Third Party Liability

TPL-T099-E	Third Party Liability

DSC_TITLE	Technical Name	Functional Area
Drug Manufacturer Pin letter	RBT-0001-Q	Web Portal
Internet Pin Letter	WEB-0001-D	Web Portal
Quarterly NDC Web Portal Search Report	WEB-0001-Q	Web Portal
Newly Enrolled Trading Partner Providers	WEB-0005-D	Web Portal

Server OS	Specifications	Tools
HP-UX B.11.31	HPUX SuperDome2 Blade with 2 CPUs/4 Cores each	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	HPUX SuperDome2 Blade with 2 CPUs/4 Cores each	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	HPUX SuperDome2 Blade with 2 CPUs/4 Cores each	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	HPUX SuperDome2 Blade with 2 CPUs/4 Cores each	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	HPUX SuperDome2 Blade with 2 CPUs/4 Cores each. This blade is shared with other accounts.	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	This is a HPUX SuperDome2 environment that is shared with other accounts. There are a total of 10 cores shared across the accounts.	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
Solaris 5.10	Leveraged across multiple accounts	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator

Solaris 5.10	Leveraged across multiple accounts	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
HP-UX B.11.31	2 - HPUX SuperDome2 Blade with 2 CPUs/4 Cores each	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
ESXi 5.5	6 - Proliant BL465c G7 2 CPUs per blade 12 cores per CPU 2.2 Ghz 128 Gb RAM	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator VMWare vSphere
ESXi 5.5	4 - Proliant BL465c G8 2 CPUs per blade 8 cores per CPU 2.6 Ghz 128 Gb RAM NOTE: These blades are shared across multiple accounts. Alabama uses 7 virtual machines on this cluster of blades.	Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator VMWare vSphere

Servers	Purpose	SAN Storage
8 cores supporting 2 Secure Resource Partitions in a single vPar.	Production MMIS and DSS Oracle Databases	19.6 Tb
8 cores supporting 2 Secure Resource Partitions in a single vPar.	Production MMIS and DSS Applications	4.1 Tb
8 cores supporting 3 vPars.	Production Document Repository and Database	7.4 Tb
8 cores supporting 3 Secure Resource Partitions in a single vPar.	User Acceptance Test Environment: MMIS and DSS Applications and Oracle Databases	10.7 Tb
4 cores supporting 3 Secure Resource Partitions in a single vPar.	Model Office Test Environment: MMIS and DSS Applications and Oracle Databases	5.4 Tb
Approximately 4 cores supporting 2Secure Resource Partitions in a single vPar.	Development Environment: MMIS Applications and Oracle Databases	2.6 Tb
4 CPUs supporting 2 child zones	SFTP	256 Gb

4 CPUs supporting 2 child zones	Translator	140 Gb
16 cores supporting 4 secure resource partitions in 2 vPars	Disaster Recovery	23.7 Tb
55 virtual machines (vm) running Windows 2008 R2 and 10 vms running Windows 2008	10 - Domain Controllers 5 - SQL Servers 21 - UI Servers 26 - Application Servers 3 - Tool Servers	6Tb
4 virtual machines (vm) running Windows 2008 R2 and 3 vms running Windows 2008	1 - SQL Production 1 - Application Production 1 - UAT Application and SQL 1 - MO Application and SQL 3 - Proxy Servers (1 for each environment)	750 Gb

OS Version	Detailed Usage
Windows 2008 Enterprise R2 x64	DHCP and DNS server
Windows 2008 Enterprise R2 x64	Print Server and DNS server
Windows 2008 Enterprise R2 x64	Windows File Server
Windows 2008 Enterprise R2 x64	Windows File Server
Windows 2008 Standard R2 x64	ArcSight Server
Windows 2008 Enterprise R2 x64	Mass Fax and Email Server
Windows 2008 Enterprise R2 x64	Feith Fax Server
Windows 2008 Enterprise R2 x64	CA Help Desk
Windows 2008 Enterprise R2 x64	Heat Server
Windows 2008 Standard R2 x64	Proxy
Windows 2008 Enterprise R2 x64	RRI
Windows 2008 Enterprise R2 x64	RRI
Windows 2008 Enterprise R2 x64	RRI
Windows 2008 Enterprise R2 x64	RRI Test
Windows 2008 Standard R2 x64	SiteScope/Nessus
Windows 2008 Enterprise R2 x64	Windows Update Server
Windows 2008 Enterprise R2 x64	Backup Server

CPU Type	Installed Memory	Manufacturer
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2048	Dell
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2048	Dell
Intel(R) Xeon(R) CPU E5-2650 v2 @ 2.60GHz	16350	Hewlett Packard
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell
AMD Opteron(tm) Processor 6136	10236	Hewlett Packard
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	8188	Dell
AMD Opteron(tm) Processor 6136	18428	Hewlett Packard
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell
AMD Opteron(tm) Processor 6136	10236	Hewlett Packard
AMD Opteron(tm) Processor 6136	10236	Hewlett Packard
AMD Opteron(tm) Processor 6136	10236	Hewlett Packard
AMD Opteron(tm) Processor 6136	10236	Hewlett Packard
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	8192	Dell
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell
Intel(R) Xeon(R) CPU 5150 @ 2.66GHz	2044	Dell

Number of logical CPUs	System Model	Physical Diskspace
2	POWEREDGE 2950	272
2	POWEREDGE 2950	68
2	POWEREDGE 2950	408
2	POWEREDGE 2950	339
16	PROLIANT DL360P GEN8	137
2	POWEREDGE 2950	340
8	PROLIANT DL385 G7	279
2	POWEREDGE 2950	272
8	PROLIANT DL385 G7	279
4	POWEREDGE 2950	135
8	PROLIANT DL385 G7	279
8	PROLIANT DL385 G7	279
8	PROLIANT DL385 G7	279
8	PROLIANT DL385 G7	279
4	POWEREDGE 2950	136
2	POWEREDGE 2950	135
2	POWEREDGE 2950	135

Tools
Hewlett Packard (HP) Server Automation HP Operations Management Nessus ArcSight HP Service Manager HP Onboard Adminstrator
same
same
same
same
same
same
same
same
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same
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same

Vendor
ANACAPA MICRO PRODUCTS INC
ANCHOR SOFTWARE LLC
DST HEALTH SOLUTIONS LLC
ENTERPRISE DISTRIBUTED
FEITH SYSTEMS & SOFTWARE INC.
FEITH SYSTEMS & SOFTWARE INC.
FEITH SYSTEMS & SOFTWARE INC.
FEITH SYSTEMS & SOFTWARE INC.
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FIRST DATABANK INC
FIRST DATABANK INC
FIRST DATABANK INC
GANSON ENGINEERING INC
HEAT SOFTWARE USA INC
IBM CORP
INFORMATICA
INFORMATICA
INFORMATICA
LEXISNEXIS
LYTROD SOFTWARE INC
MCAFEE LLC
MCAFEE LLC
OPEN TEXT INC

OPEN TEXT INC
OPEN TEXT INC
OPTUMINSIGHT INC
ORACLE AMERICA INC
ORACLE AMERICA INC
ORACLE AMERICA INC
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ORACLE AMERICA INC
ORACLE AMERICA INC
ORACLE AMERICA INC
ORACLE AMERICA INC
SAP PUBLIC SERVICES INC
SHI INTERNATIONAL CORP
SHI INTERNATIONAL CORP
SHI INTERNATIONAL CORP
SHI INTERNATIONAL CORP
SHI INTERNATIONAL CORP
SURESCRIPTS LLC
TRUVEN HEALTH ANALYTICS LLC
VERITAS TECHNOLOGIES LLC
MICROSOFT
MICROSOFT

Software	Quantity
Tenable Network Security, Inc. NESSUS PROFESSIONAL ONPREM-ANNUAL SUB (RENEW)	1
MAXCASS, MAXMOVER-LS PILOTPRO For use via SaaS license Fee	1
ACG LICENSE AND SUPPORT SERVICES	939,374 lives
edtFTPnet/PRO Team Developer License	1
Workflow iQ Named User 251	
Workflow iQ Named User 25 Maintenance	1
Feith Professional services for consent forms	100
FDD workflow 25 - user pack	1
FDD workflow Server Software	1
FDD Barcode Srvr w/Reader	1
FDD Form IQ designer	1
FDD Network Fax	1
additional COLD sweeper processes	1
FDD Job sweeper	1
FDD Workflow 25 User Pack	1
FDD Workflow Server Software	1
Additional Cold Sweeper processes	1
FDD Job Sweeper	1
FDD Object Cold Server	1
FDD Cold/Server Software	1
FDD Forms IQ designer	1
FDD Web Module	1
First Data Bank Medical Claims processing SOA LIC RW	1
First Data Bank drug rebate look ups	1
First Data Bank Annual License- up to 2 million claims/mth	1
CORPORATE EDITION-ANNUAL SUPPORT	
HEAT Classic Maint/Support	2
IBM Sterling Connect:Direct Premium Edition Processor Value Unit	100
Address Doctor Software Library per CPU-core Multi-core Multi-OS	1
United States Premium Address Cleansing Subscription	1
United States Geo Coding Cleansing Subscription	1
Healthcare/Medical Bundle- Monthly Minimum Users	19
Proform Designer Maintenance	1
MFE DataCntrSecS uiteServerLite	89
MFE Endpoint Protection Adv	98
Fax Gateway 304, Analog Fax Gateway, 4 FXO SIP/T.38 - North America Edition Maintenance	1

Fax Gateway 304, Analog Fax Gateway, 4 FXO SIP/T.38 - Advanced Replacement	1
RightFax Express CG 2 Channels Maintenance	1
Symmetry Episode Treatment Groups (ETGs) License	1
Oracle Database Enterprise Edition Processor	6
Oracle Partitioning Processor Perpetual	6
Oracle Programmer Named User Plus Perpetual	10
Oracle Database Enterprise Edition Processor Perp	9
Oracle Partitioning - Processor Perpetual	9
Oracle Diagnostics Pack - Processor Perpetual	15
Oracle Programmer for Rdb - Named User Plus Perpetual	1
Oracle Database Enterprise Edition - Processor Perpetual	6
Oracle Partitioning - Processor Perpetual	6
Oracle Programmer - Named User Plus Perpetual	10
Oracle Database Enterprise Edition - Processor Perpetual	9
Oracle Partitioning - Processor Perpetual	9
Oracle Diagnostics Pack - Processor Perpetual	15
Oracle Tuning Pack - Processor Perpetual	15
Oracle Advanced Compression - Processor Perpetual	1
SAP Maintenance and Support, Crystal Reports / BOE Pro	1
VMware vSphere Enterprise Plus - (v. 6) - license - 1 processor	1
VMware Support and Subscription Production - Technical support	1674
Cyfin 175 Users- renewal subscription license - Wavecrest	1
VMware vSphere Enterprise Plus Edition	10
VMware vCenter Server Standard for vSphere	1
Micromedex Clinical Lnowledge Suite (RedBook)	1
NETBACKUP ENT CLIENT WLS 1 SERVER LICENSE	6
Visual Studio	20
SQL Server (Micorsoft Reporting Services)	7

Alabama Medicaid Agency
Medicaid

Let's get to work!

Alabama interChange Project

Alabama interChange Claims Processing Operations Manual

01/04/2008

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04 January 2008

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1. Introduction

The Claims Processing functional area is the foundation for the Alabama Medicaid Management Information System (AMMIS). Claims Processing handles all provider claims by using a combination of manual and computerized functions and fulfills the essential requirements of making timely and accurate claim payments to eligible providers—on behalf of eligible recipients—for services covered under the Medicaid program.

1.1 Claims Processing Unit Functions

The primary functions for the Claims Processing area are as follows:

- Claims resolution
- Inventory management
- Paper claims data entry

1.2 Claims Processing Forms

All forms referenced in this document can be found in iTRACE. The table below documents the various forms and where to find them in iTRACE.

Forms	Location
CMS-1500 Billing Facsimile UB-04 Billing Facsimile Dental Billing Facsimile Pharmacy Billing Facsimile	https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Third%20Party%20Liability

1.3 Input, Processes, and Output

1.3.1 Input

The table below documents the inputs to the Claims Processing functional area.

Claims Processing Inputs

Input	Source	Purpose
Data corrections	Resolutions specialists	To correct information, override, edit, audit, or deny the claim or claim detail.
Electronic files - claims and encounters	Billing agencies Managed Care providers Providers	To input claims received via electronic media
Paper claims (including individual claim adjustments)	Providers	To input paper claims from providers

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Input	Source	Purpose
System-generated claims	AMMIS	To input data that is created by other *AMMIS* programs to pay managed care case management fees and capitated payments to eligible providers for enrolled recipients.

1.3.2 Processes

Processes accomplished in the Claims Processing functional unit include the following:

- Claims adjudication
- Claims history and extracts
- Claims payment and Claims operations
- Claims resolution
- Electronic claims management
- Inventory management
- Paper claims data entry
- Encounter claims processing

Claims Adjudication

Claims adjudication comprises three system processes that combine to accurately adjudicate Medicaid claims to a final disposition. These processes are as follows:

- Claims editing
- Claims pricing
- Claims auditing

Claims Editing

The first part of the claims processing cycle is the application of claim edits. Edits compare information on the current claim to other information on parts of the same claim or information on recipient, provider or reference files. The following provides a sample of the common edits:

- Procedure requires prior authorization and no prior authorization is on file.
- Provider number is not on the provider file.
- Recipient is eligible under the pregnant women and children's program for only pregnancy-related services and the diagnosis code is not pregnancy-related.

NOTE:

Edits can be very simple or very complex but they are all related only to data on the current claim.

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If a claim or claim detail fails an edit, an error status code (ESC) is posted to the claim record. Multiple error status codes can be posted to a claim or detail in a single claim cycle. This enables all identified errors to be resolved at one time, unless the errors are related to provider or recipient editing. In this case, no further editing can take place until the errors are resolved, as other edits are performed based on provider and recipient specifics.

Example: If the provider number is not on the provider file, the claim cannot be edited for valid provider type or specialty or for provider eligibility for the date of service. The claim will either deny or be returned to the provider, depending on the Agency's policy.

When edits are set on a claim, the edit disposition table is accessed for the system to determine the following:

- If the edit failure should suspend the claim for manual review and resolution.
- If the claim should be automatically denied.
- If processing should continue for the claim and report out for follow-up or tracking.

Claims that pass all of the system edits are passed on to claims pricing and claims auditing.

Claims Pricing

Each State Medicaid program determines the pricing method to be used to pay providers for services rendered. In Alabama, the pricing methods used include the following:

Pricing Method	Pricing Method Description
Average Wholesale Price (AWP) - 10% (EAC), State MAC (SMAC), Wholesale Acquisition Cost (WAC) + 9.2%, Federal Upper Limit (FUL) and Department of Justice (DOJ)	Price paid to pharmacy providers for drugs dispensed.
Customary Charge	A rate set by the State for a specific service and a specific provider that will be paid to the Medicaid provider who renders that service.
MAX Fee	A rate set by the State for a specific service that will be paid to the Medicaid provider who renders that service.
Per diem	A fixed amount paid per day for a set of services to hospital inpatient or nursing home providers.
Percent of charges	A fixed percent amount that is applied to the billed charges for designated services.

Each service on an incoming claim is priced based on the method designated by the Agency. The price is based on the prices found on the provider customary rate, provider outpatient rate, and provider NH/IP rate tables, the procedure code max fee table, and the drug code rate tables, as well as on the approved pricing logic that is coded in AMMIS. This portion of the pricing logic is referred to as preliminary pricing.

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After a claim has been through the audit process and is ready for final disposition, a process called final pricing occurs. In final pricing, the sum of all claim detail prices is calculated and then reduced by amounts previously paid by other insurance companies and amounts the recipient must pay for services, such as nursing home patient liability and co-payments. The final price becomes the amount that will be paid to the provider for the service(s) rendered.

After preliminary pricing, the claim moves to the claim auditing process.

Claim Auditing

Claim auditing is the process of comparing certain fields on the current claim to other fields on the same claim, to other claims currently in process, or to other paid claims that are already in claims history. The following describes the audit types:

Audit Type	Audit Description
Duplicate	Detect both exact duplicate claims and suspected duplicate claims. ***Examples***: If two claims from the same provider for the same recipient have the same date of service, same procedure code, same modifier, and the same billed amount, an exact duplicate audit may be set. If two different providers bill for the same service on the same day, a suspect duplicate audit may be set.
Hard-coded	Compare the current claim with past claims for certain conditions that are outside other audit criteria. ***Examples***: A non-standard time period may need to be coded for a limitation audit. A complex set of relationships may need to be determined across multiple time periods.
Limitation	Identify and restrict services that exceed established program and medical policy limits. ***Example***: Program policy limits office visits to 14 per calendar year. Medical policy limits tooth extractions to once per tooth in a lifetime.
Relationship	Restrict services that are defined as similar in purpose to other Medicaid services as defined by State Medicaid policy. ***Example***: If an office visit and an office surgery code are billed separately on the same day, but medical policy defines that the office visit charge should be included in the price for the surgery, a relationship audit will set.

Claims that have passed all edits and audits and have been priced are passed to AMMIS for financial processing. Those claims that fail edits and audits and whose disposition is set to suspend will be suspended until resolution occurs. Once resolution occurs, those claims will also be passed to AMMIS for financial processing.

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Claims History and Extracts

Claims history involves the processing and data management functions associated with creating and maintaining the large-scale finalized claims history files and databases and ensuring that a minimum of 36 months of full claims history is available in AMMIS. After each financial cycle, finalized claims are moved to the history database.

Claims Payment and Claims Operations

Payment and claims operations are the final processes in the claims processing cycle. During the financial cycle, a Remittance Advice (RA) is produced for each payee displaying their claims for that financial cycle.. The RA details the amount paid or the reasons for claim denial or suspense. Alabama specific Explanation of Benefit (EOB) codes will appear on paper RAs instead of the generic Health Insurance Portability and Accountability Act (HIPAA) standard codes.

Claim page sort order is by claim type, then by claim status as follows: Inpatient Crossover, Medical Crossover, Outpatient Crossover, Dental, Inpatient, Inpatient Encounter, Inpatient Nursing Home, Medical, Outpatient, Drug, Compound Drug. Second sort is by claim status: Adjustment, Denied, Paid, Suspended.

- Example: A doctor's RA sorts as: Crossovers, then Medicaid (each with the Adjusted, Denied, Paid, Suspended sort).
- Example: A hospital's RA sorts as: Inpatient Crossover, Outpatient Crossover, Inpatient, Inpatient Encounter, and Outpatient (each with the Adjusted, Denied, Paid, Suspended sort).

RAs are divided into the following primary sections:

Function	Function Description
Adjusted claims	Lists all claims that have been adjusted and the net financial result of the adjustment.
Credit Balance Due	"Letter" noting total amount due to Medicaid if account receivables are greater than payments.
Denied claims	An accounting of all claims denied in the financial cycle.
Explanation of Benefits	Lists EOB descriptions for header and detail EOBs posted on claims pages.
Financial items	Lists payouts (non-claim expenditures), refund checks received from the payee, and accounts receivables (both claim and non-claim).

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Function	Function Description
Financial summary	The total dollar amount paid during the current financial cycle, year-to-date and net payments amounts for the current cycle and year-to-date totals. ▪ The 'top' of the payment section displays the check or electronic funds transfer (EFT) amount. It will appear visually in the middle of the page as NET PAYMENT. If a credit balance is due to Medicaid, the NET PAYMENT is displayed as 0.00. The amount due appears on the CREDIT BALANCE DUE 'letter' that is the last page of the RA. ▪ If payee receives a Capitation Payment, it appears as a single line and amount in this 'top' section. ▪ The 'bottom' of the payment section displays any other financial data that may affect NET EARNINGS. ▪ If any of the payment is sent to the IRS, the deduction amount is noted in the 'bottom' section, and detailed in a message at the very bottom of the page. Additionally, this section reports the narrative descriptions for each EOB code that appears on the RA.
Paid claims	An accounting of all claims paid in the current financial cycle.
Suspended claims	An accounting of all claims still in process and the reason for the suspense.
Third Party Information	Lists the third party policy information for claims which denied for other insurance.

Providers use the RA to post and reconcile open accounts within their business practice. RAs are produced on paper and merged with paper checks, if applicable, after each financial cycle. RAs that contain payments sent to providers via EFT will be printed and mailed to providers beginning on the Monday following the financial cycle.

An example of each RA can be found on iTRACE at the following path:
https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Financial

Claims Resolution

Claims that fail edits and audits and have their dispositions set to suspend are viewed through the online data corrections panel. The claims resolution specialists will review and resolve suspended claims. Each edit and audit has defined resolution instructions that are approved by the Agency Medicaid program administrators.

Resolutions specialists identify the edit or audit that is set and utilize the approved resolution instructions to complete the following:

- Correct data entry errors.
- Deny the claim or claim detail.
- Override the edit or audit.

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- Return the claim to the provider for additional information.

All claims that are resolved are then sent back through the entire edit, pricing, and audit process until all errors are corrected, overridden, or denied so the claim will be ready for financial processing.

Electronic Claims Management

Electronic Media Claims (EMC)—also known as Electronic Claims Management (ECM)—is the core element in improving claims processing efficiencies and reducing time to process claims to their final disposition. Several common methods for providers to submit claims electronically are as follows:

- Public Internet to Alabama Medicaid Secured Web Portal.
- Dial-Up to Alabama Medicaid Secured Web Portal.
- From Alabama Medicaid Agency over private Multi-protocol Label switching (MPLS) circuits.
- Secured File Transfer Protocol (SFTP) (over public internet) from approved Contracted Vendors.
- Diskette/CD/DVD/Magnetic Tape.
- Interactive transmission and response from Clearinghouses with an approved site to site Virtual Private Network (VPN) connection.

Providers who use in-house computer systems or external billing service agencies can obtain electronic claim record specifications and program their systems to extract billing data in the required formats. The following list identifies the common format standards:

- Health Insurance Portability and Accountability Act (HIPAA).
- National Council for Prescription Drug Programs (NCPDP).

Software products enable providers to load programs on their personal computers (PCs) and enter billing information into pre-programmed and formatted claim entry screens to collect the required data. Many of the programs offer pre-editing of certain information to improve the accuracy of the data when it is submitted to AMMIS for processing.

The following modes of submission are available with the various software products:

Submission Type	Submission Description
Web Portal	The provider connects to the Alabama Medicaid Web Portal via a Secure Socket Layer (SSL) across the public internet for upload and download of claims transactions.
Dial-Up	A provider without an Internet Service Provider (ISP) may connect to the Web Portal via a dialup connection to a Cisco Universal Gateway. This allows a toll-free dial-up connection to the Alabama Medicaid Secured Web Portal.

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Submission Type	Submission Description
Diskette/CD/DVD/Magnetic Tape	The provider downloads the completed claim records to the selected media and mails it to EDS for processing.

Interactive transmissions and responses through clearinghouses enable providers to enter individual pharmacy claims or eligibility transactions using software loaded on a PC or point of service device (POS) provided by a third party vendor or clearinghouse. The interactive transaction is processed to final disposition, and receives an electronic response in a matter of seconds.

The Alabama Medicaid Secured Web Portal interface is designed to not only support batch file uploads and downloads but also to provide users the ability to perform interactive requests by completing the online claim submission, eligibility, claim status or prior authorization request forms.

> All providers who submit claims electronically must sign electronic billing agreements. The billing agreement is a substitute for provider signatures and documents provider accountability for each individual claim.

Regardless of the mode of electronic claim submission, all claims follow similar standards for processing. Every claim received is submitted to the AMMIS and is assigned a unique ICN, which begins the inventory control process for all claims.

Each authorized submitter receives a unique individual Trading Partner ID in addition to an individual provider number which produces a Personal Identification Number (PIN) for access to the Alabama Medicaid Secured Web Portal for security purposes. All magnetic media—tapes, diskettes, CD-ROM, or DVD —are delivered to Operations and the delivery is recorded in a log on the date of the receipt.

> All magnetic media claims are assigned a claim ICN within one business day of receipt.

Other electronic processing features include:

Feature	Feature Description
Automated Voice Response System (AVRS)	An automated system that allows providers to utilize a touch tone telephone to obtain information on check amounts, individual claim status (either paid or denied), individual prior authorization status, procedure code pricing, National Drug Code (NDC) pricing, household inquiry, recipient eligibility, third party coverage, and benefit limit status.
Electronic Funds Transfer (EFT)	The paying of providers for approved claims via electronic financial transfer of funds from EDS directly into the provider's bank account.

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Feature	Feature Description
Electronic Remittance Advice (RA)	Electronic Remittance Advice, a method for providers to obtain an electronic version of finalized claim accounting records from the Alabama Medicaid Secured Web Portal.

Inventory Management Processes

As each claim passes through the various processes, it is tracked within AMMIS for claims inventory management reporting. The total count of all claims input received from all sources—Alabama Medicaid Secure Web Portal, diskette, CD, DVD, magnetic tape, paper, or POS—are recorded as the claims beginning inventory. Each claim that suspends is assigned to a system control location that groups together comparable failures of edits or audits for common resolutions processing.

This common grouping enables easy reporting and rapid tracking of claims inventory problems and also allows claims to be located easily at any point during claims processing. All claims that are paid and denied are also counted and reported during each processing cycle. By balancing the number of claims received to the number of claims finalized and suspended, the claims manager can keep control of the location and timely processing of all claims and initiate immediate action to prevent and resolve claims inventory backlogs.

Paper Claims Data Entry Options

Paper claims are entered into AMMIS using optical character recognition (OCR) technology. In the OCR claims entry method, claim data is read electronically during the scanning process. If the OCR process reads the entire claim, the data is sent directly to the system for processing. If any character or field cannot be read through OCR, the claim is sent to a repair station. A data entry operator must then determine which character—or characters—must be corrected. Once the claim is corrected, the claim data is sent for processing. The entire batch must pass all keying rules before it is retired from the scanning process and sent to processing. After the batch is retired, the batch is processed in AMMIS in the same manner as electronic claim records.

1.3.3 Output

The table below documents the outputs from the Claims Processing functional area.

Claims Processing Outputs

Output	Source	Purpose
Payment records	Financial cycle	Records used to produce checks or EFT transactions.

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Output	Source	Purpose
Reports	AMMIS	Record action on claims that were processed. Monitors and tracks claim inventories. Summarizes dollars paid and reasons paid or denied. Provides claims history for research purposes.
Suspended claims	Edit or audit cycles	Claims that could not complete processing because they did not pass edits or audits and required resolution.
Updated claim records	AMMIS	Completed records of processed claims that are posted to history files and databases.

1.4 Functional Area Responsibilities

The following responsibilities for the Claims Processing functional unit were extracted from section 20.382 of the Invitation to Bid (ITB):

1. Operate the Claims/Encounter Processing component of the MMIS, including improvements as they are implemented.
2. Perform all data processing operations to support Claims/Encounter processing requirements, including:
   - Edit processing
   - Suspense resolution
   - Claim pricing
   - Adjudication processing
3. Execute claims/encounters processing cycles and generate outputs on a State-approved schedule, in accordance with the standards determined by the State.
4. Process UB-04, CMS-1500, and other State-approved claim/encounter forms.
5. Generate and process capitation payments for HMO and managed care providers.
6. Process and generate payments to Primary Medical Providers (PMP) and lock-in providers for case management fees.
7. Process Medicare coinsurance and deductible charges from providers on hard-copy and electronic media claims.
8. Provide on-line, real-time adjudication of claims submitted interactively through value-added networks (VANs) or PCs.
9. Review and process all claims and other transactions submitted (including both hard-copy and EMC claims) against the most current and appropriate files/database tables.

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10. Process "special" claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other State-defined situation, in accordance with State instructions.
11. Maintain a method to process for payment any specific claim(s) or claim type(s), as directed by the State, on an exception basis.
12. Edit all claims/encounters in accordance with State program policy, benefits, and limitations as defined by the State.
13. Price all claims in accordance with State program policy, benefits, and limitations as defined by the State.
14. Provide the State with on-line inquiry access to current claims/encounters status data.
15. Provide on-line access to the claims history file/database for both paid and denied claims.
16. Provide on-line access to suspended claims data and the exception control file defining the disposition of edits and audits.
17. Provide and maintain thirty-six (36) months of non-drug adjudicated claims history for all transactions processed to final disposition and for use in editing/auditing non-drug claims.
18. Maintain eighteen (18) months of history for use in processing drug claims.
19. Maintain all claim data elements defined by the state on claims history.
20. Maintain an adequately staffed claims/encounters resolution unit to resolve claims suspended for edits and audits designated by the State as a Contractor resolution responsibility.
21. Maintain a close working relationship between the claims resolution unit and the State to develop new edits and audits, write the claims resolution instructions, and resolve claims in accordance with program policy and procedures.
22. Manually and systematically review and resolve any claims/encounters that suspend for any of the edits and/or audits as determined by the State.
23. Verify that services billed are consistent with services previously billed to the recipient and that they comply with State policy and medical criteria.

    NOTE—This requirement was deleted during the GAP sessions.
24. Process, deny or recoup claims with potential third party liability or Medicare coverage as directed by the State. Supply the provider with instructions and third party information to facilitate billing the third party.
25. Process as encounters, claims with HMO covered services for HMO recipients as directed by the State.
26. Suspend for review by Contractor or State staff, as required by the State, those specific providers, procedure codes, or provider types placed on prepayment review by the State.
27. Ensure that suspended claims/encounters are resolved in accordance with State-approved procedures.
28. Process all claims, encounters and other claims-related transactions in accordance with the program policy, benefits, and limitations as defined and established by the State.
29. Provide an audit trail for all claims and adjustments from time of receipt to time of payment so a claim may be located at any time and so that all failed edits and edit dispositions can be identified.

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30. Implement and operate procedures to identify claims suspended as a result of data entry errors and correct such errors.
31. Resolve provider appeals on claim denials or cutbacks in accordance with State-approved procedures or refer to the State if unable to resolve.
32. Designate a staff person to serve as a contact point for the State who will coordinate the resolution of all exceptional claims submitted by the State.
33. Provide staffing as needed to resolve claims requiring PAs and/or attachments, such as TPL, sterilization, hysterectomy and abortion consent documents and Medicare attachments or medical review.
34. Maintain sufficient staff to manually price certain claims according to State-specified criteria.
35. Monitor the use of override codes during the claims resolution process to identify potential abuse, based on State-defined guidelines.
36. Maintain a system of Explanation of Payments (EOP) advice codes and messages for suspended and denied claims, adjustments, and certain paid claims. Obtain State approval for all new EOP messages developed by the Contractor. NOTE—The Explanation of Payments (EOPs) will be referenced as Remittance Advices (RAs) in the new system.
37. Maintain and update claims control, exception control, medical criteria, and other parameter files as required and in accordance with State change control procedures.
38. Liaison with the Medicare contractors to facilitate testing and processing of Medicare crossover claims.
39. Prepare and distribute operational and performance reports according to system requirements specified by the State.
40. Transmit a monthly file of adjudicated claims and encounter records to be used by the State for additional reporting and research. The file will be provided in a format approved by the State and will contain all fee for service and encounter claims adjudicated in the management reporting period.
41. Produce and submit to the State, on a timely basis, all required claims and encounter processing reports.
42. Make written recommendations on any area in which the Contractor thinks improvements can be made.
43. Receive and process all outpatient claims in the same format as they are submitted to Medicare. Medicare utilizes the Outpatient Prospective Payment System (OPPS) whereby providers may submit all procedure codes rendered for a date of service. This may require receiving and processing procedure codes that have a zero price. Accepting straight Medicaid claims utilizing the Medicare format will preclude providers from maintaining two (2) billing formats for outpatient claims.

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1.5 Performance Expectations

The following performance expectations for the Claims Processing functional unit were extracted from section 20.383 of the Invitation to Bid (ITB):

1. Meet all federal and State Processing Requirements.
2. Perform weekly edit/pricing cycles.
3. Perform at least one (1) audit processing cycle weekly.
4. Perform on-line, real-time adjudication of claims transmitted via electronic submissions twenty-one (21) hours a day, seven (7) days a week.
5. Process claims received according to the following standards:
   - Ninety percent (90%) within thirty (30) calendar days of receipt.
   - Ninety-nine percent (99%) within ninety (90) calendar days of receipt.
   - (Note: Processed claims are those claims adjudicated to final payment or denial status and ready for release to financial processing.)
6. Process all claims transactions suspended for reasons other than medical review to pay or deny status within twenty-five (25) calendar days of receipt.
7. Process provider adjustment requests and State initiated adjustments according to the following standards:
   - Ninety-five percent (95%) within thirty (30) calendar days of receipt.
   - Ninety-nine percent (99%) within ninety (90) calendar days of receipt.
8. Enter provider refunds within fifteen (15) business days of receipt.
9. Process to completion all adjustments resulting from system-caused or Contractor-caused errors within twenty-five (25) calendar days of identification of the error.
10. Deliver the monthly adjudicated claims file to the State within five (5) business days of the last payment cycle of the month.

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2. Paper Claims Data Entry

The Paper Claims Data Entry Unit consists of the data entry operators who enter information from scanned images into AMMIS. The unit is responsible for keying paper claims.

2.1 Paper Claims

Paper claims are entered into AMMIS using optical character recognition (OCR) technology. In the OCR claims entry method, claim data is read electronically during the scanning process. If the OCR process reads the entire claim without error, the data is sent directly to the system for processing. If the OCR cannot read any character or field, the claim is sent to a Recognition Research Incorporated (RRI) repair station. A data entry operator must then determine which character(s) must be corrected. Once the claim is corrected, the claim data is sent for processing. The entire batch must pass all keying rules before it is retired from the scanning process and sent to processing. After the batch is retired, the batch is processed in AMMIS in the same manner as electronic claim records.

If a scanned claim is identified as lacking critical claim information such as provider number or recipient number, the data entry operator can tag the claim as a Return to Provider (RTP) claim. After the scanning system retires the batch, a rework report is produced that identifies the claims to be returned. Each business day, the mailroom supervisor prints the rework report that identifies the claims to be returned. Using the report, a document control specialist pulls the paper claims from the original batch, attaches a cover sheet identifying the RTP reason and puts the claim and coversheet in an envelope to be mailed to the provider. A cover sheet on the batch is used to denote the claim(s) were returned to the provider.

NOTE:

Refer to the Data Entry Manual for specific instructions on the procedures for entering each claim type using RRI.

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3. Claims Resolutions

The Resolutions Unit consists of the specialists trained to review and resolve all claims that have been suspended. The claims resolution specialists are responsible for Agency-approved resolution procedures to resolve edit and audit failures on suspended claims.

In addition to these tasks, claims resolution specialists are responsible for recommending updates to resolution procedures, referring potential fraudulent claims for further investigation, and suggesting new edits or audits to improve claims processing efficiencies.

3.1 Performing Claims Resolution

AMMIS edits claims data for validity, presence, and relationship to other data on the same claim, and audits the current claims against other claims in history for service limitations, relationships, duplicates, and other data. Claims that do not pass the edits/audits and are set to suspend will appear on the data corrections panel. The panel containing the suspended claim will show all fields necessary for the specialist to determine whether final adjudication is to force, deny or correct the suspended item.

Claims resolution specialists apply Agency-approved procedures—documented in the Resolutions Manual—to resolve the edits or audits appearing on the suspended claim. This process enables the claim to complete its' processing. A resolution specialist completes the following procedures to resolve a suspended claim:

1. Review the suspended claim utilizing the data corrections panel.
2. Using the Resolutions Manual, locate the error that is causing the claim to fail.
3. Follow the directions in the Resolutions Manual to resolve the error.
4. Key the appropriate data correction(s) using the data corrections panel.
5. Release the claim for immediate re-verification of edits/audits.
6. Continue this process until the claim edits/audits have been resolved.

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4. Inventory Management

CMS requires that AMMIS operate at specified performance levels. For the claims processing area, this translates to the following:

- Ninety percent (90%) of clean claims must be processed within thirty (30) days.
- Ninety-nine percent (99%) of clean claims must be processed within ninety (90) days.
- All claims must be finalized within twelve (12) months from the date of receipt.

These performance requirements require that comprehensive and explicit claims inventory monitoring procedures be in place. The Claims Manager is responsible for the following tasks:

- Gathering daily inventory status reports from data entry, resolutions, and adjustment units.
- Gathering and reviewing AMMIS claims inventory management reports produced weekly through AMMIS.
- Taking action to prevent inventory backlogs.
- Implementing inventory reduction plans if backlogs occur.

4.1 Inventory Status Reports

The Claims Manager receives and reviews the following inventory status reports:

- Aged Suspended Report (CLM-0065-D)
- Claims Processing Daily Summary (CLM-0016-D)

Note: An example of these reports can be found on iTRACE at the following path:
https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Claims

4.1.1 Aged Suspended Report (CLM-0065-D)

- The Aged Suspended Report shows all suspended claims by location code. Within each location code, the report shows the number of claims that have been suspended within various aging buckets. Utilizing this report, the Claims Manager can quickly determine the status of suspended claims based on age and can alert the claims resolution specialists to concentrate on those claims greater than 30 days old.

4.1.2 Claims Processing Daily Summary (CLM-0016-D)

The Claims Processing Daily Summary report lists summary information by claim type for a claim adjudication cycle. For CMS 1500, an additional break out by provider type will be listed.

The report lists the following information:

- Total processed claims by claim type.
- Total claims approved for payment by claim type.
- Total number of denied claims by claim type.
- Total number of suspended claims by claim type.

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Utilizing the statistics provided in this report, the Claims Manager can divert resources to data entry needs or resolution problems.

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5. Glossary

The table below defines the terms used in the Claims Processing functional area:

Claims Processing Functional Area Terms

Term	Definition
Adjustment	A transaction to take back payment on a claim already paid and to reprocess and repay the claim correctly. Adjustments may be caused by an error in data entry, the reference file, or the automated system.
Audit	An error condition on a claim that is related to something on the current claim when compared to other historical claims or other lines within the same claim. ***Examples***: Duplicate service of a claim already paid. Service billed that exceeds benefit limitation for the number of allowed hospital days in a calendar year. Service billed that is included in another procedure already paid.
Claim	A paper document or electronic record sent by a provider to document services rendered and to request payment for those services.
Claim Cycle	A combination of system processes that take a claim from receipt through financial processing.
Claim Record	A combination of data elements from a submitted claim and auxiliary reference that defines everything needed and used to process a claim.
Control Location	An identifying code used in claims processing that is assigned to groups of similar edits or audits to track and manage claims inventory and to provide an audit trail of claims processing activity.
Data Correction	An action that a resolutions specialist performs on a suspended claim to correct information on the claim, override the edit or audit that set on the claim or deny the claim.
Disposition	The actions taken for each edit or audit on a claim. These actions include pay, suspend, manual deny, auto deny or return. Dispositions can typically be set differently for each claim type and submission media within a claim type. ***Examples***: An edit that sets when the recipient identification number is not on file may be set to auto deny for electronically submitted claims because the provider entered the claim information. An edit that suspends for claims submitted on paper to allow verification that no data entry error was made.

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Term	Definition
Edit	An error condition on a claim that is related to missing data, incorrect data or data that does not meet certain relationships on the current claim. ***Examples***: Recipient number not on the Recipient Eligibility File. Procedure code not allowed to be billed by the billing provider type. Diagnosis code that is missing from the claim.
Remittance Advice (RA)	A set of formatted reports that inform Medicaid providers of the payment status for each claim processed in AMMIS. The RA also provides a financial accounting of the provider's services with the Medicaid program.
Online Claim Adjudication/Resolution	A process to resolve suspended claims that uses formatted online screens to enter corrections to claims or to enter override or deny transactions to move the claim forward in processing.
Override	An action performed by a data correction specialist to bypass a claim edit or audit that has set on a suspended claim.
Recycle	A process that takes a single suspended claim, groups of suspended claims, or all suspended claims back through a claims cycle to be re-edited, re-priced, and re-audited.
Resolution Procedures	A defined set of instructions approved by the State that describes what to look for and what steps to take to resolve a suspended claim.
Return to Provider (RTP)	A manual letter that is attached to a non-processed claim. The letter and the claim are sent back to the provider to be corrected and resubmitted.

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AMMIS Claims User Manual

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1. Document Control

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1.1 Document Information Page

Required Information	Definition
Document Title	AMMIS Claims User Manual
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1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
20110810	1.1		EIP CO8123	Added the following reports: CLM-4710-Q, CLM-4720-Q, CLM-4760-Q, CLM-4770-Q, CLM-4810-Q, CLM-4820-Q, CLM-4830-Q, CLM-4860-Q, CLM-4870-Q
			EIP CO 8346	Added the following reports: CLM-4301-W, CLM-4302-W, CLM-4303-W, CLM-4302-O, CLM-4303-O
			EIP CO 8517	Revised the following panels: 6.58 Adjustment Request Panel 6.12 Physician Claim Panel 6.15 Physician Claim Navigation Panel 6.19 UB04 Navigation Panel 6.16UB04 Claim Panel
			EIP CO 8292	Added the following reports: CLM-2011-P and CLM-2011-R
			EIP CO 8658	Updated the following panels: 6.12 Physician Claim Panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				6.19 UB04 Navigation Panel Added the following new Panel: 6.46 NCCI Related History Panel
20110928	2.0		Agency approved	
20111107	2.1		Application of HIPAA EIP 5010 changes	CO 9018 – Added new fields:Medicare Copay Amount and Medicaid Late Filing Amount Medicare Information- Physician Panel (6.43.2, 6.43.3 and 6.43.4) Medicare Information – UB-04 Panel (6.44.2, 6.44.3, 6.44.4) CO 8788 – expand prescription number field from 7 to 12 characters. Pharmacy Data Correction Panel (6.69.1, 6.69.2, 6.69.3) CO 9027 - Increased Medical Record # from 30 to 50 characters. Physician Data Correction Panel (6.70.3) Physician Claim Panel (6.12.3) UB-04 Claim Panel (6.16.3) UB-04 Claim Correction Panel (6.71.3) **CO 9264 -** added “Other Payer Pat Resp Amt field. Pharmacy Claim Panel (6.8.3) - Pharmacy Data Correction Panel (6.69.2, 6.69.3) **CO 8634 –** expanded HIPAA value field from 30 to 50 characters. Claim Reference Detail Panel (6.22.2, 6.22.3) **CO 8675 –** Diagnosis Ind field – changed value from 1-8 to 1 to 12 for electronic claims. **Note:** Field displays the Maximum four Diagnosis Ind.) Physician Claim Detail Panel (6. 13.3) Physician Data Correction Panel (6.70.2, 6.70.3, 6.70.4) **CO 8687 –** changed last name length and size from 35 to 60 characters. Additional Claim Information Panel (6.29.2, 6.29.3)

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				NDC Details Panel (6.20.2, 6.20.3) NDC Details – Data Correction Panel (new) **CO 8831 -** ICD procedure code fields expanded from 4 to 7. ICD-9-CM Panel (6.41.3) **CO** - Dental Claim Correction Panel (6.67.2, 6.67.3) **CO 9151** - -Added Recipient Page Num) field CLM-2011-R - Recipient Data Sheet report (7.42.2, 7.42.3)
12/12/2011	3.0		Agency approved	
04/04/2013	4.0		Application of Production change orders	CO 8389 – (1.1) Dental Claim Navigation Panel, (1.2) Physician Claim Navigation Panel, (1.3) UB04 Claim Navigation Panel, (1.4) Pharmacy Claim Navigation Panel updated. (1.5) TPL Summary Information Panel added.
10/03/2013	5.0		Application of ICD-10 production change orders	CO 10196- Add new report CLM-0300-W CLM ICD Version Edit Failures by Provider (Section 7.42) CO 10200 – Update Section 6.19: UB04 Claim Navigation Panel Layout and field descriptions Update Section 6.42 ICD-9-CM Panel (now known as ICD Panel) layout and field descriptions. CO 10201 - Update Section 6.37 Diagnosis Panel Layout and Field Descriptions (Add ICD Ind) CO 10202 – Update section 6.61 Mass Adjustment Criteria panel layout and field descriptions. CO 10203 – Update section 6.37 Diagnosis Code panel layout and field descriptions. Add New Section 6.19 UB ICD Codes Panel layout and field descriptions. CO 10110 – 7.10 Combined Claim Exception Report removed from user manual.

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				CO 10195 – Update section 7.43 CLM-2011-R – Recipient Data Sheet Report layout and field descriptions
10/9/2013	6.0		Application of CO 8820 and 10896	6.17 UB 04 Claim Detail Panel- update layout, field descriptions and field edit error messages 6.13 Physican Claim Detail Panel- update panel layout, field descriptions and field edit error messages 6.8 Pharmacy Claim Panel – update layout and field descripitons 6.12 Physician Claim Panel – update layout and field descriptions 6.8 Pharmacy Claim Panel – update layout and field descriptions 6.16 UB 04 Claim Panel - update layout and field descriptions 6.4 Dental Claim Panel – update field descriptions and panel layout
10/23/2013	7.0		Application of CO 7545 and 11266	CO 7545 Update layout and field description to inlcude new field – “Image”. 6.4 Dental Claim Panel 6.8 Pharmacy Claim Panel 6.12 Physician Claim Panel 6.16 UB-04 Claim Panel CO 11266: Section 6.45 - Medicare Information- Physician Panel – update panel layout, field descripitons and field edit error messages Section 6.46 Medicare Infomation UB04 Physician panel - update panel layout, field descripitons and field edit error messages
02/26/2014	8.0		Application of producton change orders 11639 and 11248	CO 11639:615 Physician Claim Navigation Panel – layout and field description table updated. CO 11248: 6.58 Adjustment Information –Daughter or Mother panel – updated narrative, layout and field descriptions. CO 10670 – Add New Panel: Section 6.54 TPL Additional Panel. Add TPL Additional Information panel to Dental Claim Navigation panel,

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Physician Claim Navigation panel, UB04 Claim Navigation Panel,
04/15/2014	9.0		Application of CO 11508	6.4 Dental Claim panel – update panel layout and field descriptions 6.8 Pharmacy Claim panel– update panel layout and field descriptions 6.12 Physician Claim panel– update panel layout and field descriptions 6.16 UB-04 Claim panel– update panel layout and field descriptions
05/21/2014	10.0		Application of Production CO	CO 10830 6.1 – Claims SearchPanel – update layout and field descriptions. 6.73 Error List Panel – update layout, field descriptions, and field edit error messages. CO 11310 6.41 – Aadded new EOB List Panel
06/12/2014	11.0		Application of CO 11702	6.12 Physician Claim Panel – update layout and field descriptions 6.16 UB-04 Claim panel – update layout and field description.
09/10/2014	12.0		Application of CO 11201	Updated 6.3 Claims Mini Search panel layout and field descriptions. Updated 5.3.4 Mini Search layout
10/24/2014	13.0		Application of 12180	Updated 6.1 Claim Search Panel
07/15/2015	14.0		Application of ACA III production change orders and maintenance Change order.	CO 12130: The following panels/reports were updated to reflect a change in the descripiton of the “Date Paid” field as a result of the ACA III implementation: Claim Search Results panel, Dental Claim panel, Pharmacy Claim panel, Physician claim panel, UB-04 Claim Panel, Dental Claim Correction panel, Pharmay Data Correction panel, Physician Data Correction panel, UB-04 Data Correction panel, CLM-0035-M Report and CLM-2011-R report. In addiiton, the Dental Claim Panel, Professional Claim panel, Pharmacy Claim panel and Institutional Claim panel were updated to reflect the replacement of “Paid Date’ with ‘Checkwrite Date’ to the Claim Status

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Informaton section of the panel. Layout and field descriptions were updated. CO 10879 – Detail Health Program and Health Program
04/27/2016	15.0		Application of Production COs 12906, 13309, 12819	**CO 13132:** Add **7.8** CLM-002-R Claim Status Change And Exception Report **CO 12906:** Update 6.43.2 Health Program Panel layot and field descriptions CO 13309: Update 6.16 UB-04 Claim Panel Layout and Field Descriptions CO 12819: Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS
07/13/2016	16.0		Application of Production CO	CO 13495 6.16 UB04 Claim Panel - Update panel layout and field descriptions 6.77 UB04 Claim Correction Panel – Update panel layout and field descriptions
09/26/2016	17.0		Application of RCO COs	CO 13143 (implemented 6/6/16) 6.19 UB04 Claim Navigation Panel – update panel layout and field descriptions. 6.40 DRG Pricing Panel (New) CO 13137 6.15 Physician Claim Navigation Panel, 6.19 UB04 Claim Navigation Panel – updated panel layout and field descriptions 6.41 Encounter Summary PanelN (New) CO 13136 6.12 Physician Claim Panel, 6.13 Physician Claim Detail Panel, 6.16 UB04 Claim Panel, 6.17 UB04 Claim Detail Panel – updated panel layouts and field descriptions CO 13138 6.13 Physician Claim Detail Panel – modify panel layout and field

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				descriptions, 6.85 Related Data Other Panel – modify panel layout and field descriptions, 6.86 Related Data – Kick Panel (New), 6.87 Recoup Kick Payment Request Panel (New) CO 13140 7.43 CLM-0610-W Kick Payment Processing Report Layout (New) CO 13135 6.1 Claims Search Panel – modify panel layout, field descriptions and field edit error messages. DF 13745 6.40 DRG Pricing Panel – updated panel layout and field descriptions 6.87 Recoup Kick Payment Request Panel - updated panel layout and field descriptions CO 13210 – edited field edit error messages 6.7 Dental Claim Navigation Panel 6.10 Pharmacy Claim Navigation Panel 6.15 Physician Claim Navigation Panel 6.19 UB04 Claim Navigation Panel 6.66 Adjustment Request Panel
12/07/2016	18.0		Application of CO 13786, 13904	CO 13786 6.77 Pharmacy Data Correction Panel - panel layout and field description table updated. CO 13904 6.38 Diagnosis Codes Panel – Data Correction- panel layout and field description table updated.
04/18/2017	19.0		Application of CO 13785, 13701, 13848	CO 13701 6.59 Value Panel – update panel layout, field descriptions and field edit error messages. CO 13785 6.86 Related Data Kick Panel- updated panel layout and field descriptions

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				6.87 Kick Payment History Panel- add in place of Recoup Kick Payment Request CO 13848 6.26 Detail Error Panel – update layout 6.44 Error Panel – update layout 6.76 Error List Panel– update layout and Field Descriptions
05/31/2017	20.0		Application of CO 14058 as a result of the DRG Implementaiton that occurred on 5/31	DRG Pricing Panel
04/26/2018	21.0		Application of CO 14916	CO 14916: Redact all PHI/PII as well as non-public test data. Update screen layouts for: 5.3.3 Hot Links 5.3.5 Pop- Up Search 6.2.2 Claim Search Results Panel Layout 6.4.2 Dental Claim Panel Layout 6.5.2 Dental Claim Detail Panel Layout 6.8.2 Pharmacy Claim Panel Layout 6.13.2 Physician Claim Panel Layout 6.16.2 UB04 Claim Panel Layout 6.29.2 Detail Related History Panel Layout 6.30.2 Additional Claim Information Panel Layout 6.34.2 Check Panel Layout 6.41.2 Encounter Summary Panel Layout 6.46.2 ICN Recipient Link Panel Layout 6.52.2 NCCI Related History Panel Layout 6.57.2 TPL Additional Information Panel Layout 6.61.2 Adjustment Search Results Panel Layout 6.63.2 Adjsutment Information Panel Layout

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				6.64.2 Ajustment Information-Daughter or Mother Panel Layout 6.66.2 Adjustment Request Panel Layout 6.71.2 Mass Net Verification Panel Layout 6.72.2 Net Verification Panel Layout 6.73.2 Claims Suspense List Panel Layout 6.75.2 Dental Claim Correction Panel Layout 6.77.2 Pharmacy Data Correction Panel Layout 6.78.2 Physician Data Correction Panel Layout 6.79.2 UB04 Claim Correction Panel Layout 6.81.2 Claims Assignment Panel Layout 6.82.2 QA Review Criteria Panel Layout 6.83.2 Schedule Claims Panel Layout 6.84.2 Scheduling Criteria Panel Layout 6.87.2 Kick Payment History Layout

1.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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2. Claims Introduction

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Claims functional area.

This manual covers the following:

- Claims Overview
- Claims Review System Navigation
- System Wide Common Terminology and Layout
- Claims Pages/Panels
- Claims Reports

2.1 Claims User Manual Objective

The objective of the AMMIS Claims User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

This manual contains references to current AMMIS screens, when applicable. This information will be deleted after implementation training, and is identified in the narrative text in italics.

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3. Claims Overview

3.1 Introduction to Claims

Claims and Encounter processing functions ensure claims for eligible recipients, received from enrolled providers for covered services, are accurately processed and adjudicated in accordance with State and Federal requirements. The Claims processing function encompasses the tracking and processing of claim transactions up through adjudication. Data from Reference, Provider, Recipient, Service/Prior Authorization, Third-Party Liability (TPL), and Claims History is used in processing claims. The Encounter processing function encompasses the receipt, data validation, and processing of encounters. The data used in claims processing is also used for encounter validation.

The AMMIS provides a user-driven and maintainable claims processing environment. Data elements owned by the AMMIS are captured and stored with a single key name in one physical location within the database, and are accessed by all the other AMMIS processes. A majority of claims processing, such as edit and auditing, claims pricing, claims disposition, and claims adjudication, are completed in their logical entirety for each claim processed. These activities occur concurrently, with many claims processed simultaneously with continuous claims processing.

The AMMIS Claims Processing function includes:

- Claims Entry ensures the accuracy, reasonableness and integrity of AMMIS entered data.
- Claims Receipt and Control ensures all claim records are captured at the earliest possible time and in an accurate manner.
- Edit/Audit Processing ensures that claim records are processed in accordance with state policy.
- Claims Pricing calculates the payment amount for each service according to the rules and limitations applicable to each claim type, service, and provider type.
- Claims Resolution is to support the correction of suspended claims.
- Point Of Sale (POS)/Prospective Drug Utilization Review (ProDUR) provides for the on-line processing of pharmacy claims submitted in real-time by pharmacists and prevents the dispensing of inappropriate drugs through direct intervention.
- Adjustment Processing supports the adjustment of adjudicated claims.
- Claims Disposition provides information on how to set up dispositioning for edits and audits.
- Claims Reporting process is a comprehensive reporting function that supplies critical information for tracking, monitoring and managing all claims processing activities.

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4. Claims Review System Navigation

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 System Security

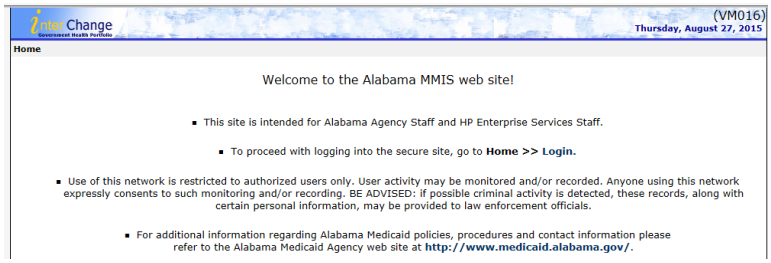
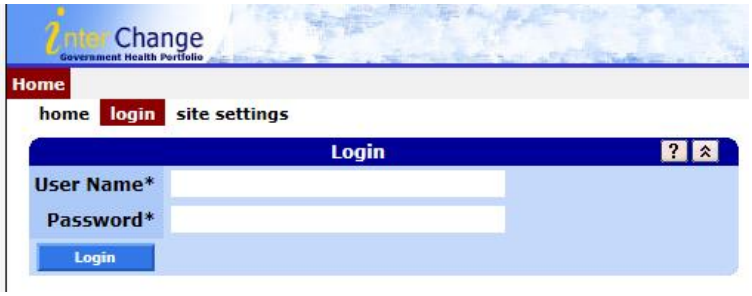
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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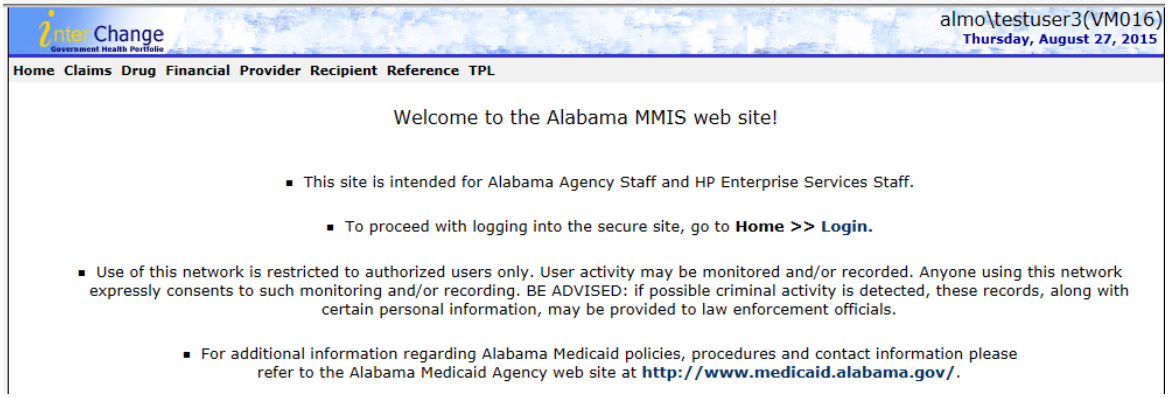
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	

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Step	Action	Response
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact the Assistant MMIS Coordinator.

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The following message displays if an invalid password is entered:

EDS Domain Password Manager

Error: Invalid username or password

Back

The following message displays upon successful password change:

iTRACE Password Manager

Password successfully changed.

" Back to "

4.5 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select View.	View menu displays.
3	Point to Text Size and click Smaller.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team recipients, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

Page

Page Header

Page Footer

Sub Menu

Shortcut Keys (ctrl + alt + letter)

Main Menu bar

Panel

Advanced Search

Mini Search panel

Hot Link

Information panel

Navigation panel

Task List panel

Title Bar Icons

Help Functionality

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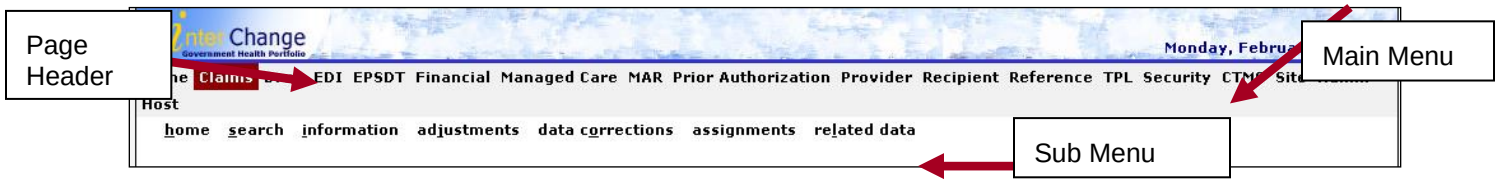
5.1 Page Layout

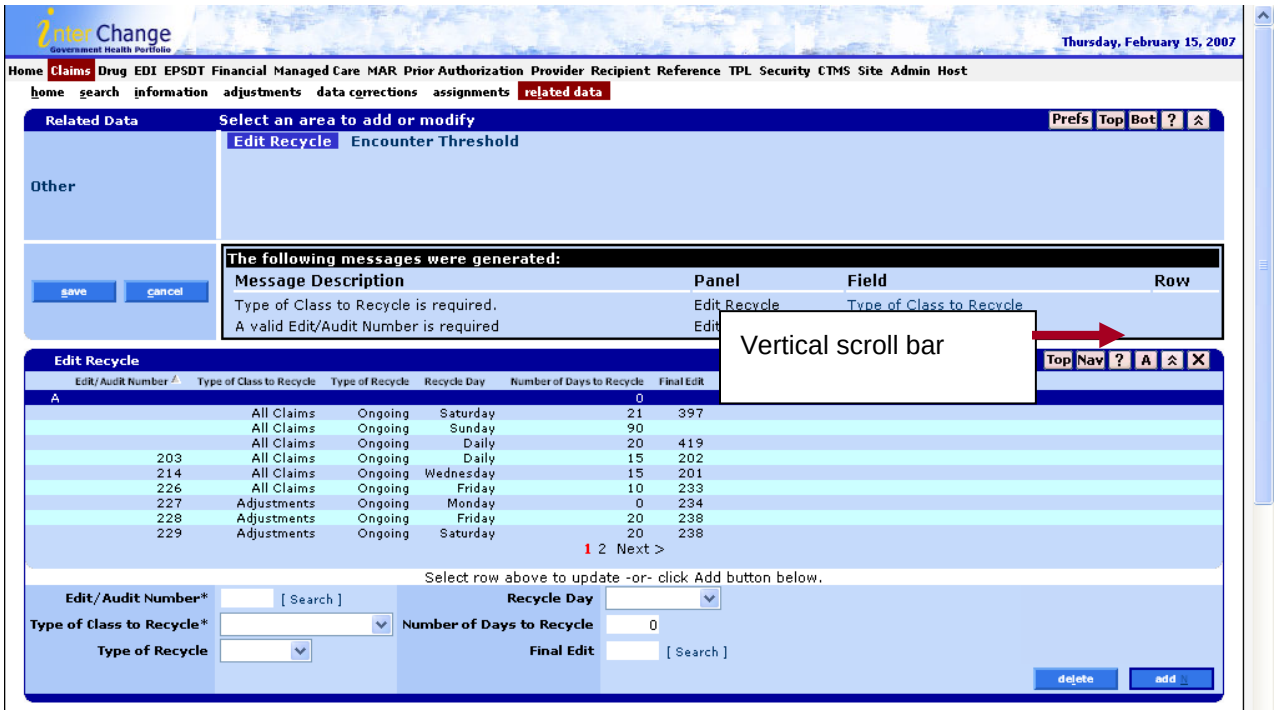
A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the HPE copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



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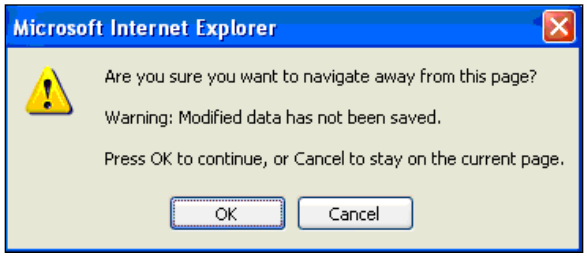
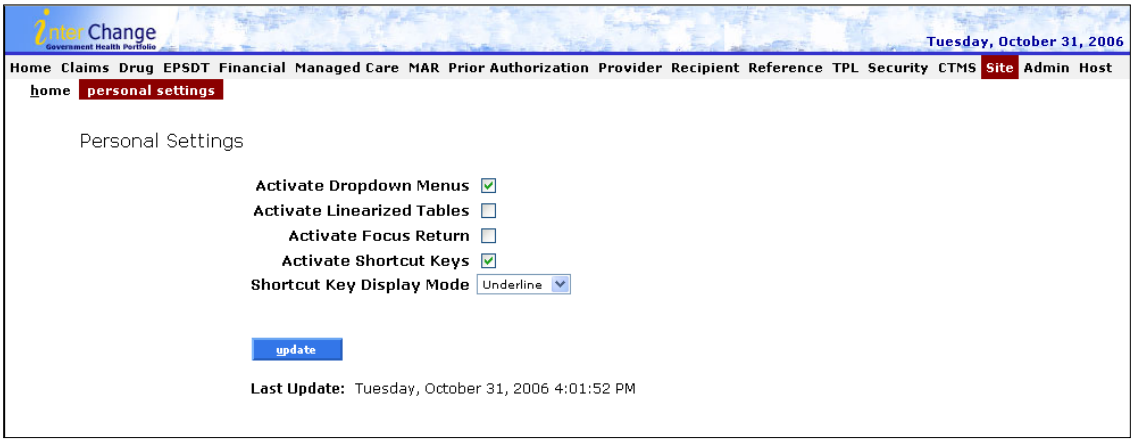
If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or canceling the changes, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 Shortcut Keys

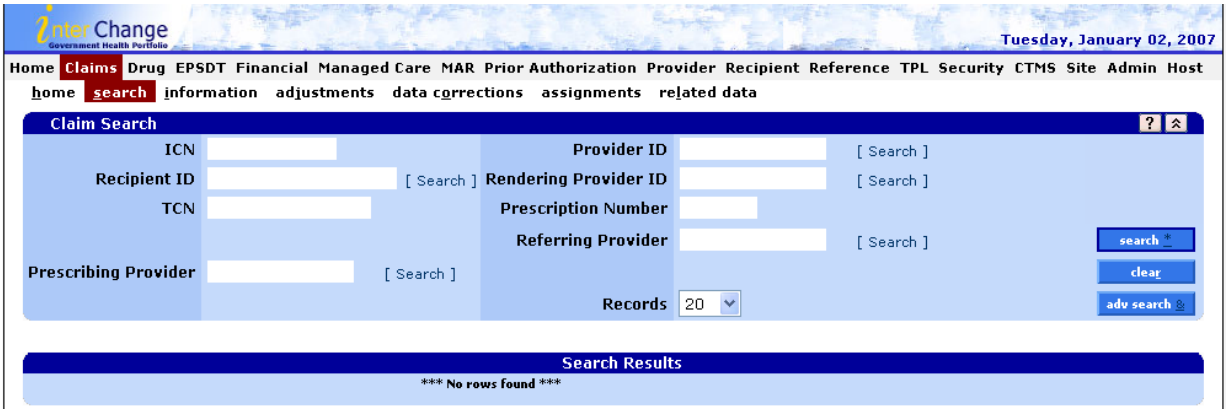
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + letter) to quickly open the associated page.

To activate the shortcut key, click on the Site link, select Personal Settings, check 'Activate Shortcut Keys' and click the blue 'Update' button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the Claims Sub Menu, the user can use the shortcut keys to quickly navigate from the Claims Search panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter 'L' is found within the horizontal bars on the Sub Menu related data link.



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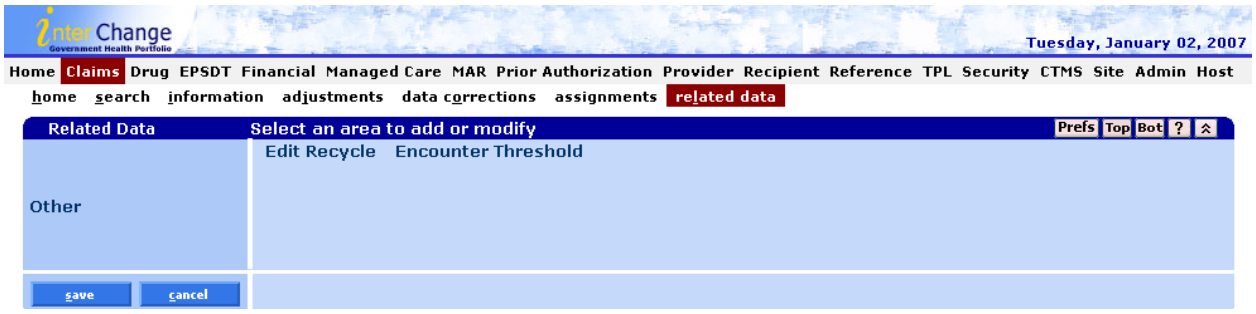


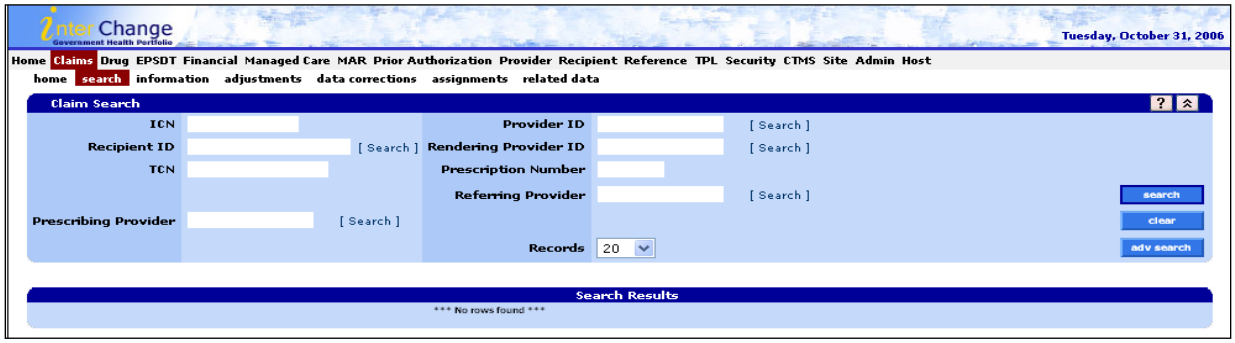
5.3 Search Options

There are several search options available within theAMMIS.

5.3.1 Search Panels

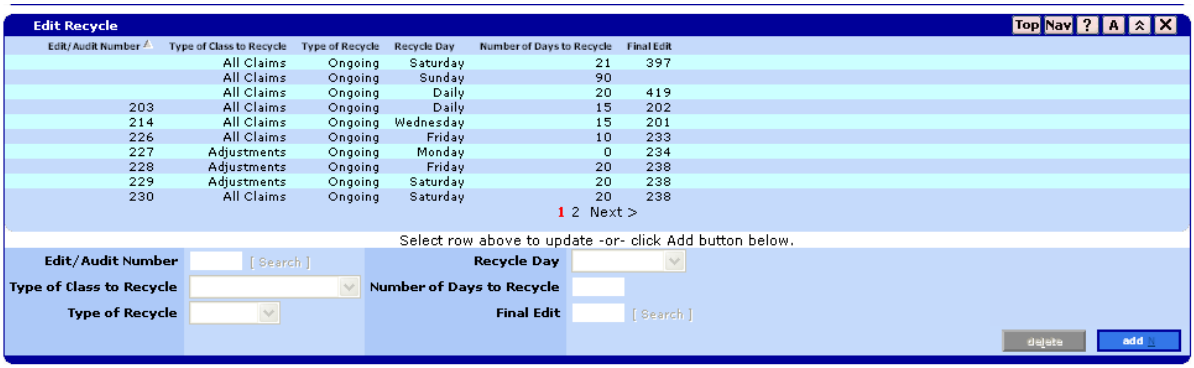
The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Claims subsystem contain a search panel without an advanced search button included on the panel, such as the image below.

The following is an example of the Claims Search panel with an advanced search button included on the panel:



5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



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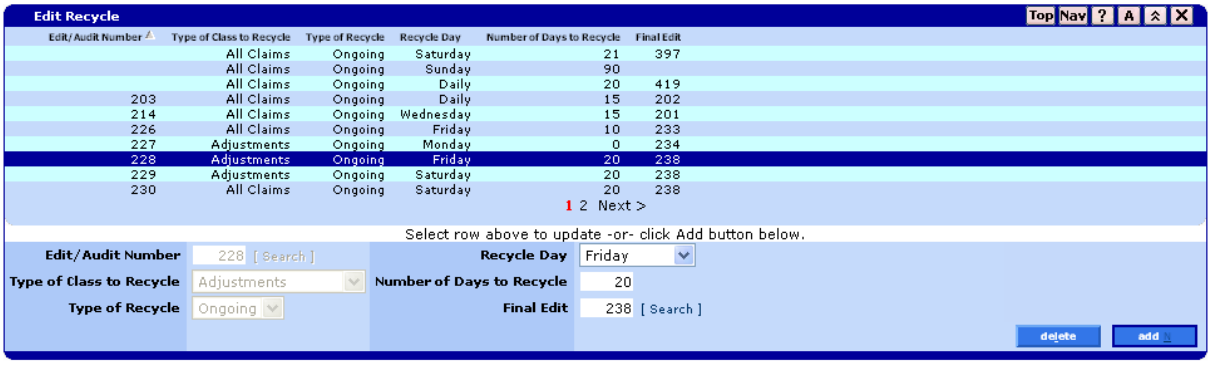
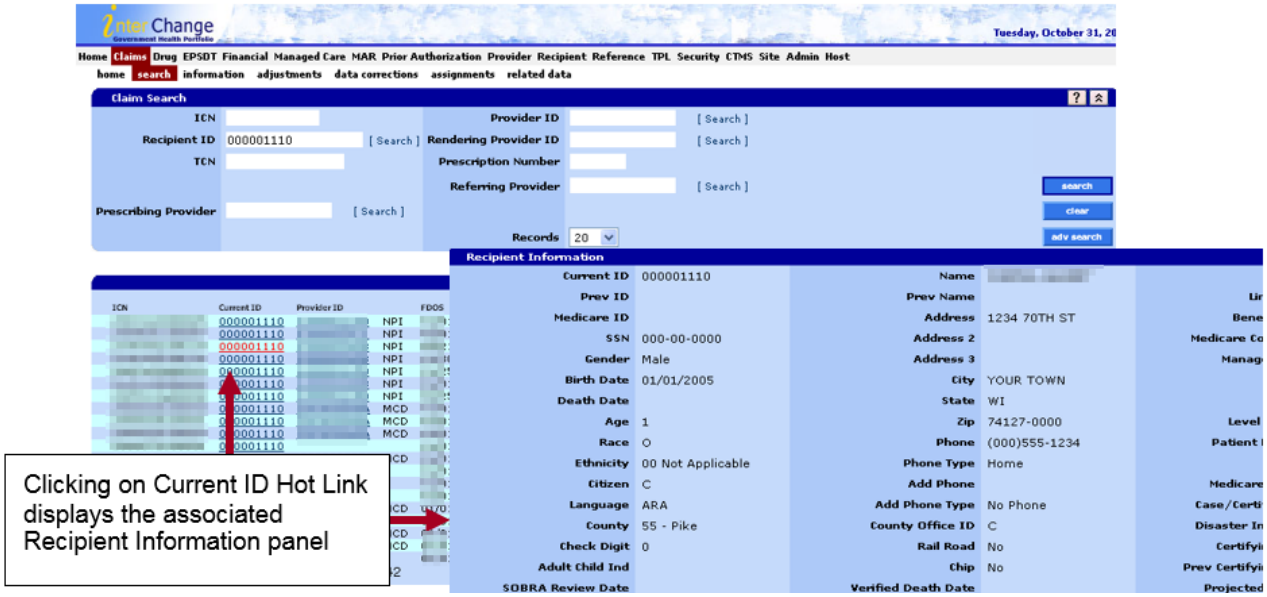
If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicks the eighth row of the Edit Recycle and detailed information is displayed at the bottom of the panel.



5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available.



5.3.4 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.

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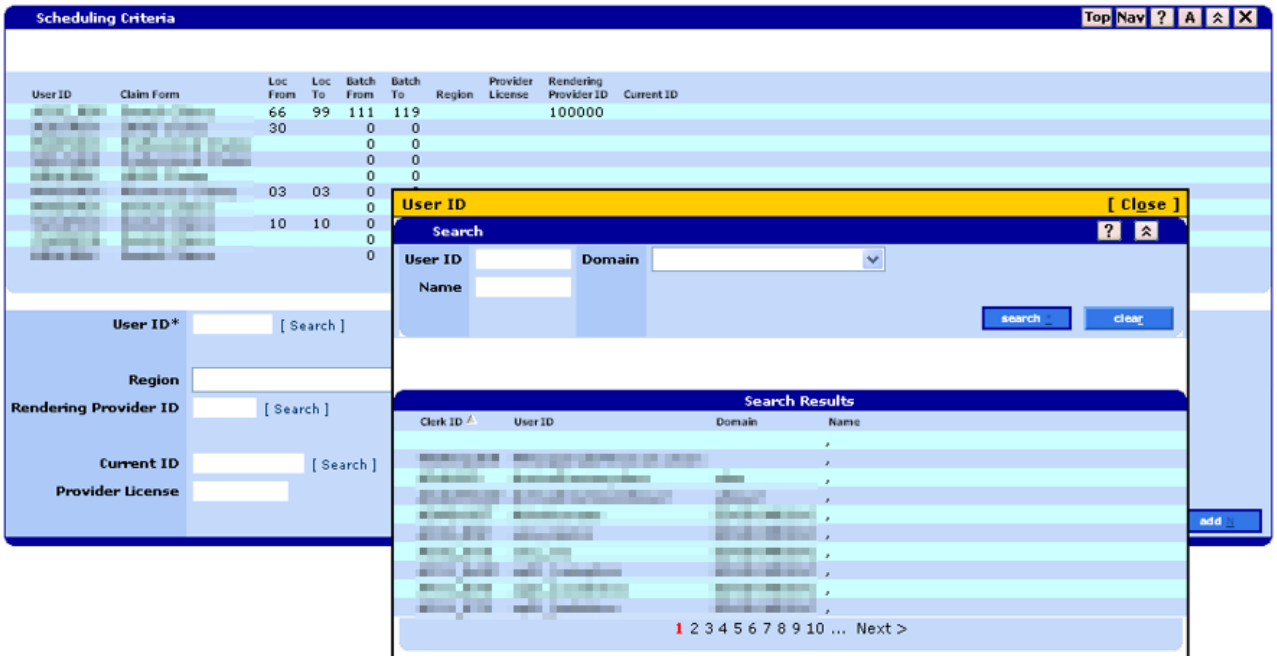
5.3.5 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.



5.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Preferences Button	Prefs	Allows user to place a checkmark next to each navigation panel they would like to see whenever they browse the Claims subsystem. To hide the boxes, click the checkbox a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.

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Name	Icon	Description
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a panel that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows a user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

Among the panel types are the following:

Maintenance Panel

Task List Panel

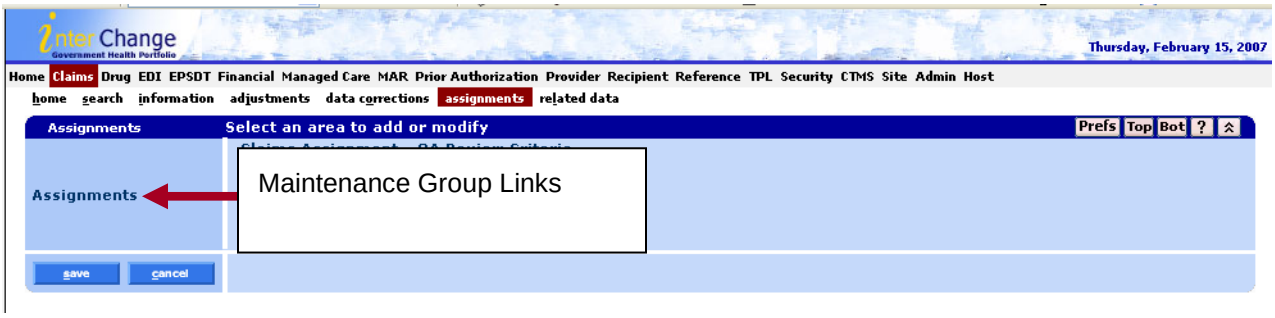
Maintenance Item Panel

Audit Panel

5.4.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page. The following image demonstrates Maintenance Group Links and the associated Maintenance Item links.



By clicking on a Maintenance Item Link (such as Claims Assignments), the associated panel opens.

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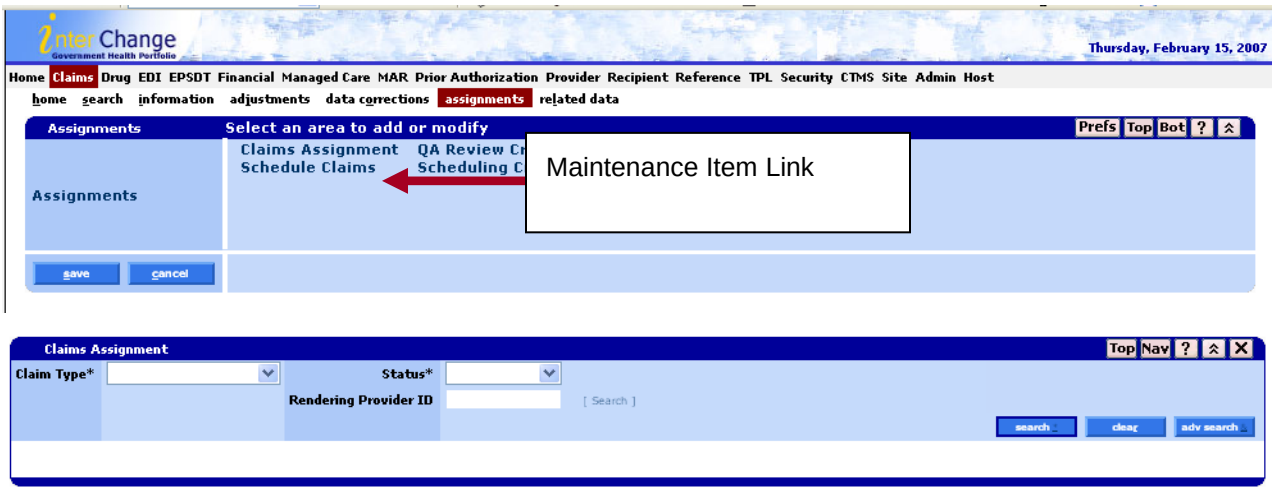
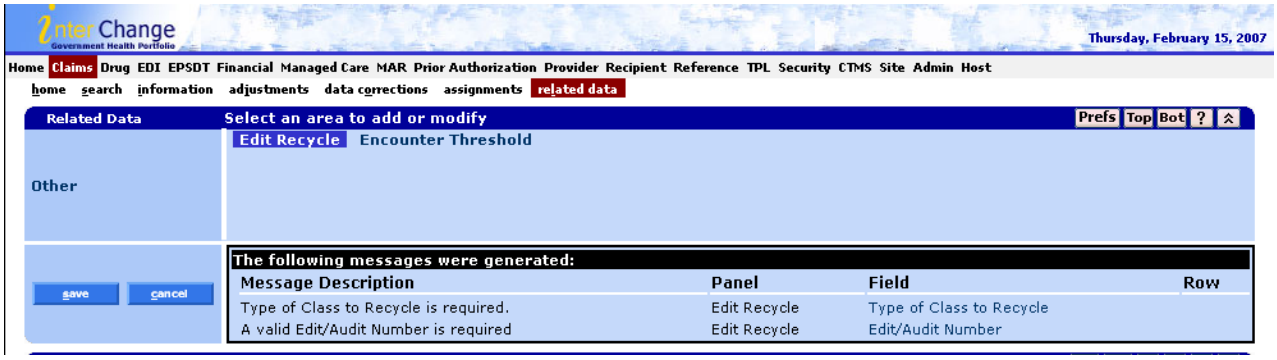


5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages.



The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

5.4.4 Maintenance Item Panel

A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All additions, deletions and updates must be followed by a Save before the transaction is permanent.

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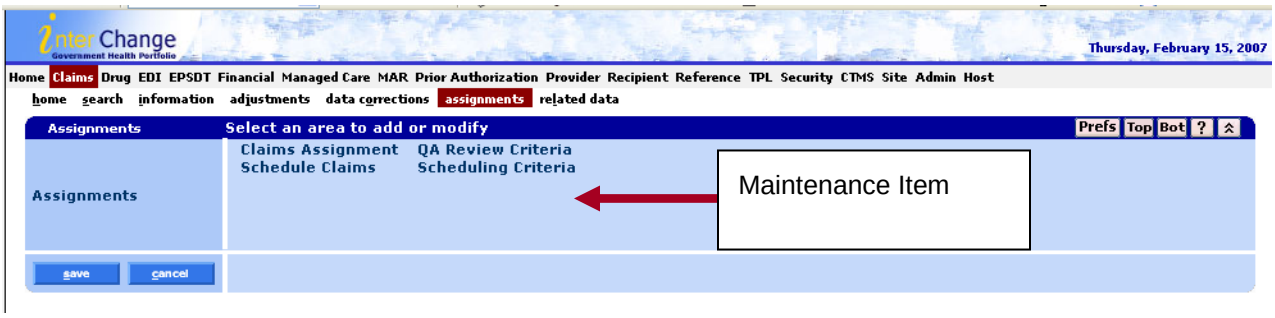
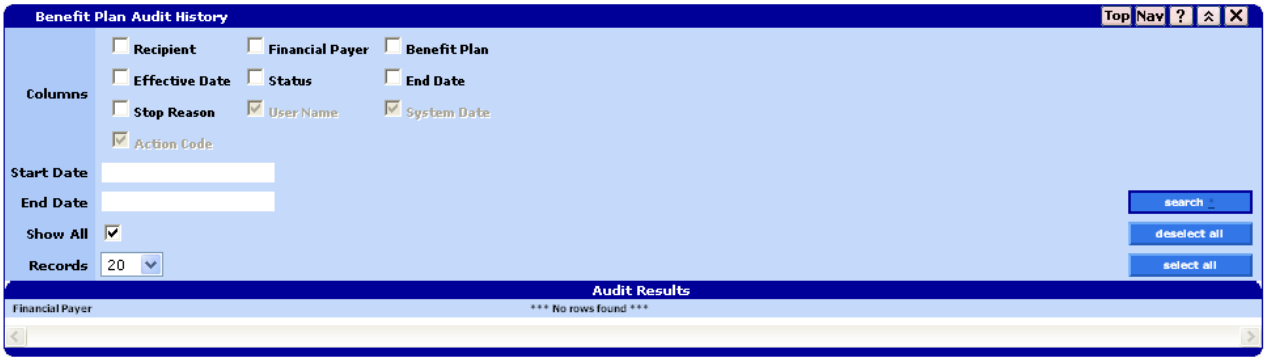


5.4.5 Audit Panel

Audit panels display data change history for a given Navigation Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a 'before' image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigation Item panel.



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5.5 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon ?

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate internet browser that contains information on the page/panel.

5.5.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the panel:

Edit Recycle

The Claims Edit Recycle panel allows select users to add and remove edits from the daily recycle parameter file.

Navigation Path: [Claims] – [Related Data] – [Edit Recycle]

Table: t_edit_recycle

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Add	Adds a new record.	Button	N/A	0
Delete	Deletes a record.	Button	N/A	0
Edit/Audit Number	The number of the edit or audit to be recycled.	Field	Number	4
Final Edit	The number of the edit that will be used to deny the claim once the number of days to recycle has been exceeded.	Field	Number	4
Number of Days to Recycle	The number of days that a claim recycles for the edit before it denies with the denial edit indicated.	Field	Number	4
Recycle Day	The day of the week that an edit should be recycled.	Field	Drop Down List Box	0
Type of Class to Recycle	The types of claims to recycle. This can be adjustments, all claims, all but adjustments, etc.	Field	Drop Down List Box	0
Type of Recycle	Indicates if this is a regular recycle request or an on-going request that eventually denies with a different edit number.	Field	Drop Down List Box	0

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The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the panel.

Field	Field Type	Error Code	Error Message	To Correct
Edit/Audit Number	Field	1	A valid Edit/Audit Number is required	Enter a valid value or select a value from the [Search] panel.
	Field	2	Edit/Audit number not exist	Enter a valid value or select a value from the [Search] panel.
Final Edit	Field	1	Final Edit has to be critical edit	The Edit number for the Final Edit must have a critical indicator set to Y on file.
	Field	2	Final Edit code not exist	The Edit number for the Final Edit must have a critical indicator set to Y on file.
Number of Days to Recycle	Field	100	Number of Days to Recycle must be less than or equal to 9999.	Enter a number between 1 - 9999.
Recycle Day	Field	1	Recycle Day must be greater than or equal to 1.	A Recycle Day must be selected from the drop down list.
Type of Class to Recycle	Field	1	Type of Class to Recycle is required.	Enter a valid Type of Class or select a valid value from the drop down list.
Type of Recycle	Field	100	Regular recycle must have 0 number of days to recycle and no final edit.	Recycle days must not be greater than 0 and Final Edit must be blank if the Type of Recycle is set to 'R' - Regular.

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the on the internet browser title bar.

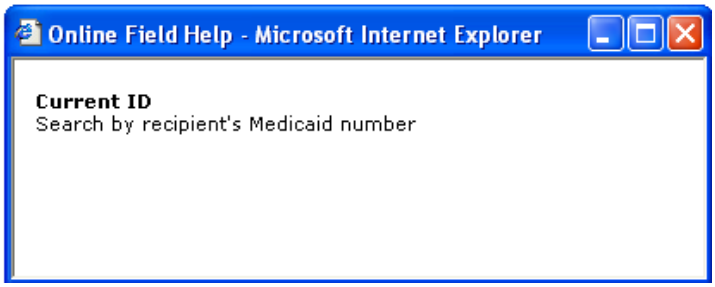
5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up panel that contains information on the field selected.

5.5.2.1 Field Level Help Description

Hovering the cursor over a field name, such as **Current ID**, a question mark will appear as part of the cursor.

Click once on the text area of the field and a pop-up panel appears with a description of the field, such as the one provided below:



To close out of the Field Level Help panel, click the in the Online Field Help title bar.

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6. Claim Pages/Panels

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The page/panels Field Description table is listed in order as they appear within the AMMIS.

Each panel covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 Claim Search Panel

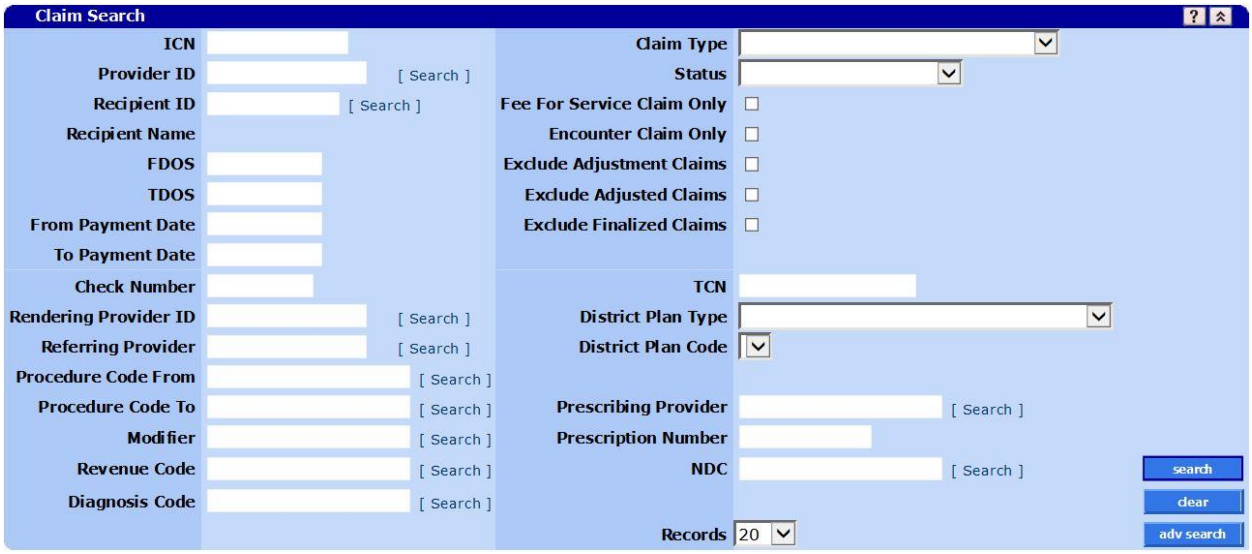
6.1.1 Claim Search Panel Narrative

The Claim Search panel has various select options which allow the user to view only the claims required. The primary selection items are Internal Control Number (ICN), Billing and Rendering Provider or Current identification number. The user may select claims by using one or all of the primary selection items. Additional search criteria include claim type, claim status, from date of service, to date of service and payment date. Once the user has entered the specific selection criteria, click on the search button to initiate the search. The system searches the database for all claims that meet the criteria and displays all the applicable ICN's on the Claim Search Results display panel.

This panel is inquiry only.

Navigation Path: [Claims] – [Search]

6.1.2 Claim Search Panel Layout



6.1.3 Claim Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Advanced Search Button, opens a panel with additional search criteria fields.	Button	N/A	0
Claim Type	Allows for the selection of a specific claim type to limit the data returned.	Combo Box	Drop Down List Box	0
Clear	Clears the previous search criteria from the search fields.	Button	N/A	0
Check Number	Check number search option.	Field	Number (Integer)	9
Diagnosis Code (Additional Search Criteria)	Diagnosis code search option.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
District Plan Code	Allows for the selection of a specific district code to limit the data returned.	Field	Drop Down List Box	0
District Plan Type	Allows for the selection of a specific district type to limit the data returned.	Field	Drop Down List Box	0
DRG	Diagnosis Related Group for UB04 claims. N/A for Alabama Medicaid.	Field	Character	3
Encounter Claims Only (Additional Search Criteria)	List only Encounter claims.	Combo Box	Check Box	0
Exclude Adjustment Claims (Additional Search Criteria)	Exclude Adjustment daughter Claims from the list.	Combo Box	Check Box	0
Exclude Adjusted Claims (Additional Search Criteria)	Exclude Adjusted Claims from the list.	Combo Box	Check Box	0
Exclude Finalized Claims	Exclude Finalized Claims from the list.	Combo Box	Check Box	0
FDOS (Additional Search Criteria)	Date of first service on the claim.	Field	Date (MM/DD/CCYY)	8
Fee for Service Claims Only (Additional Search Criteria)	List only fee for service claims.	Combo Box	Check Box	0
From Payment Date	Date of payment from which to begin the search.	Field	Date (MM/DD/CCYY)	8
ICN	Internal Control Number that uniquely identifies a claim.	Field	Character	13
Modifier	Modifier search option.	Field	Character	0
NDC (Additional Search Criteria)	National Drug Code search option.	Field	Number (Integer)	11
Prescribing Provider	License Number of the Prescribing Provider.	Field	Character	15
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Number (Integer)	7

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Field	Description	Field Type	Data Type	Length
Procedure Code From (Additional Search Criteria)	Beginning procedure code in a range selection option.	Field	Character	6
Procedure Code To (Additional Search Criteria)	Ending procedure code in range selection option.	Field	Character	6
Provider ID	Provider identification number that uniquely identifies the pay to provider.	Field	Character	15
Recipient ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Recipient Name	The name of the Recipient for the selected Recipient ID.	Field	Character	29
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Referring Provider	Provider Identification Number that uniquely identifies the Referring Provider.	Field	Character	15
Rendering Provider ID	Provider Identification Number that uniquely identifies the rendering provider and provider's service location.	Field	Character	15
Revenue Code (Additional Search Criteria)	Revenue Code search option.	Field	Number (Integer)	3
Search	Performs a query on the database and returns the data for the entered search criteria.	Button	N/A	0
Status	Allows for the selection of a specific claim status to limit the data returned.	Combo Box	Drop Down List Box	0
TCN	The transaction control number used to uniquely identify claims on the previous MMIS.	Field	Number (Integer)	17
TDOS (Additional Search Criteria)	Date of last service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
To Payment Date	Upper-bound value for the payment date range.	Field	Date (MM/DD/CCYY)	8
Check Number (Additional Search Criteria)	Check number search option.	Field	Number (Integer)	9

6.1.4 Claim Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
District Plan Code	Field	1	Please select District Plan Code.	Choose a District Plan Code from the dropdown.
FDOS (Additional Search Criteria)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter in MM/DD/CCYY format.
Fee for Service Claims Only (Additional Search Criteria)	Field	1	Choose Fee For Service Claim or Encounter Claim.	Only one, Fee for Service or Encounter Claims must be checked.
From Payment Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter valid date.
	Field	502	From Payment Date must be less than or equal To Payment Date.	Enter a From Payment Date which is earlier than the specified To Payment Date.
ICN	Field	1	ICN Must be at least 10 digits when it is the only primary search criteria used.	Either use at least the first 10 digits of the ICN or select more search criteria from the simple search panel.
	Field	2	ICN must be numeric.	Enter a valid ICN number.
Provider ID	Field	1	Provider Number must be valid. Enter the provider number then tab out of the field and allow the provider type to show up before pressing the search button.	Enter a valid provider id. When exiting the field, if there is more than one service location for the provider id, select the desired service location from the search results.
Rendering Provider ID (Additional Search Criteria)	Field	1	Rendering Provider Number must be valid. Enter the provider number then tab out of the field	Enter the provider number then tab out of the field and allow the provider type to show up before pressing the search button.

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Field	Field Type	Error Code	Error Message	To Correct
			and allow the provider type to show up before pressing the search button.	
Search	Button	1	Search requires additional primary search criteria.	Enter either ICN, Provider ID, Recipient ID, Claim Type, Claim Status, *FDOS, *TDOS, *From Payment Date, *To Payment Date, *Fee For Service Only, *Encounter Claims Only, *Exclude Adjusted Claims or *Exclude Finalized Claims. Fields with an asterisk (*) will require that you select at least one other criteria from the primary search criteria.
	Button	2	From Payment Date must be less than or equal to To Payment Date	Enter a valid From Payment Date.
	Button	3	FDOS must be less than or equal to TDOS	Enter a valid FDOS Date.
	Button	4	At least three primary search criteria must be used. If the field would not limit the search very well, more than one field will be required.	Add additional primary search criteria values.
	Button	5	At least one other primary search criteria must be used.	Select at least one more search criteria from the simple search panel.
	Button	6	The total number of claims that would be returned exceeds # which is the maximum number allowed. Please add additional search criteria that would limit the number of	Add more primary search criteria values until the count drops to acceptable levels.

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Field	Field Type	Error Code	Error Message	To Correct
			claims found. The total number of claims that would be returned is: # with a total billed amount of $#.## and a total paid amount of $#.##.	
	Button	7	Choose Fee For Service Claim or Encounter Claim.	This message displayed because both Fee For Service and Encounter Claim data were checked.
	Button	8	Search requires additional primary search criteria.	Add additional search criteria. This message displayed because the FDOS and TDOS were the only primary search values entered.
	Button	9	TDOS must be no more than ## days after the FDOS date.	
	Button	10	FDOS and TDOS are both required if the full ICN is not used. TDOS must be no more than ## days after the FDOS date.	
	Button	11	Field "Procedure Code From" cannot be included in search with the selected Claim Type.	Change Claim Type as B, C, D, L, M or O and then try again to search.
	Button	12	Field "Procedure Code To" cannot be included in search with the selected Claim Type.	Change Claim Type as B, C, D, L, M or O and then try again to search.
	Button	13	Field "Modifier" cannot be included in search with the selected Claim Type.	Change Claim Type as B, C, D, L, M or O and then try again to search.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	14	Field "Prescribing Provider" cannot be included in search with the selected Claim Type.	Change Claim Type as P, Q, or PQ and then try again to search.
	Button	15	Field "Prescription Number" cannot be included in search with the selected Claim Type.	Change Claim Type as P, Q, or PQ and then try again to search.
	Button	16	Field "NDC" cannot be included in search with the selected Claim Type.	Change Claim Type as P, Q, or PQ and then try again to search.
	Button	17	Field "Revenue Code" cannot be included in search with the selected Claim Type.	Change Claim Type as A, C, I or O and then try again to search.
	Button	18	Field "Diagnosis Code" cannot be included in search with the selected Claim Type.	Change Claim Type as A, B, C, D, I, L, M or O and than try again to search.
	Button	19	Field "Rendering Provider ID" cannot be included in search with the selected Claim Type.	Change Claim Type as A, B, C, D, I, L, M or O and than try again to search.
	Button	20	Field "Referring Provider" cannot be included in search with the selected Claim Type.	Change Claim Type as A, B, C, D, I, L, M or O and than try again to search.
TDOS (Additional Search Criteria)	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify date and re-enter
To Payment Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter valid date.
	Field	2	From Payment Date must be less than or equal To Payment Date.	Enter a From Payment Date which is earlier than the specified To Payment Date.

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6.1.5 Claim Search Panel Extra Features

Field	Field Type
The Claims Search Panel will produce results containing detail paid claims (such as dental, professional, pharmacy) as well as header paid claims (such as inpatient, etc) when the user searches using a single date in the FDOS and TDOS fields. This feature allows users to obtain results when the date entered matches the DOS on any detail of a detail paid claim as well as results where the DOS entered is within the range of a span dated claim.	

6.1.6 Claim Search Panel Accessibility

6.1.6.1 To Access the Claim Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claim Search panel displays.

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6.2 Claim Search Results Panel

6.2.1 Claim Search Results Panel Narrative

The Claim Search Results panel displays all the applicable ICNs from the database for all claims that meet the criteria user selected from Claim Search Panel.

This panel is display only. However, the user does have the ability to view detailed information on a Current ID or Provider ID by clicking on a hotlink.

Navigation Path: [Claims] – [Search] – [Enter at least one search field with or without Adv Search fields] – [Click Search]

6.2.2 Claim Search Results Panel Layout

Search Results

ICN	Current ID	Provider ID		FDOS	TDOS	Claim Type	Status	Derived Status	Date Paid	Amount Billed	Paid Amount
			NPI			DENTAL CLAIMS	PAID		0	$325.00	$261.00
			NPI			DENTAL CLAIMS	DENIED		0	$300.00	$0.00
			NPI			DENTAL CLAIMS	PAID		0	$46.00	$29.00
			NPI			DENTAL CLAIMS	PAID		0	$325.00	$261.00
			NPI			DENTAL CLAIMS	PAID		0	$600.00	$472.00
			NPI			DENTAL CLAIMS	PAID		0	$111.00	$83.00
			NPI			DENTAL CLAIMS	PAID		0	$46.00	$29.00
			NPI			DENTAL CLAIMS	DENIED		0	$300.00	$0.00
			NPI			DENTAL CLAIMS	PAID	A	06/06/2008	$300.00	$236.00
			NPI			DENTAL CLAIMS	PAID	A	06/06/2008	$325.00	$261.00
			NPI			DENTAL CLAIMS	PAID	A	06/06/2008	$600.00	$472.00
			NPI			DENTAL CLAIMS	PAID	A	04/04/2008	$46.00	$29.00
			NPI			DENTAL CLAIMS	PAID	A	05/16/2008	$111.00	$83.00
			NPI			DENTAL CLAIMS	SUSPENDED		0	$438.00	$0.00
			NPI			DENTAL CLAIMS	RESUBMIT		0	$156.00	$0.00
			NPI			DENTAL CLAIMS	PAID	A	02/08/2008	$156.00	$96.00
			NPI			DENTAL CLAIMS	DENIED		01/18/2008	$127.00	$0.00
			NPI			DENTAL CLAIMS	PAID		02/08/2008	$55.00	$29.00
			NPI			DENTAL CLAIMS	PAID		01/18/2008	$92.00	$61.00
			NPI			DENTAL CLAIMS	PAID		06/06/2008	$157.00	$79.00

Claim Count: 160

1 2 3 4 5 6 7 8 Next >

Pharmacy Claim Search Results Panel Layout

Pharmacy Claim Search Results

ICN	Current ID	Provider ID		FDOS	Claim Type	Status	Derived Status	Date Paid	Amount Billed	Label Name	Paid Amount
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		03/21/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		03/21/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		04/04/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		03/21/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		03/21/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00
			NPI	03/09/2008	PHARMACY CLAIMS	PAID		04/04/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$32.26
			NPI	03/09/2008	PHARMACY CLAIMS	DENIED		04/04/2008	$86.46	MIRTAZAPINE 15 MG TABLET	$0.00

Claim Count: 7

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6.2.3 Claim Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Billed	Amount billed for the claim.	Field	Number (Decimal)	9
Claim Count	Number of claims found for the selection criteria.	Field	Number (Integer)	5
Claim Type	Indicates the type of claim.	Field	Character	50
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Derived Status	Derived Status is populated with "A" if the claim has been adjusted.	Field	Character	1
FDOS	From Date of Service for the claim. Indicates the dispensed date on drug claim search results.	Field	Date (MM/DD/CCYY)	8
ICN	Internal control number which uniquely identifies a claim meeting the selection criteria.	Field	Character	13
Label Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product. Displays only on drug claim search results.	Field	Character	30
Paid Amount	Amount paid for the claim.	Field	Number(Decimal)	9
Provider ID	The provider identification number that uniquely identifies the pay to provider.	Field	Character	15
Status	Identifies the status of the claim within the system.	Field	Character	20
TDOS	To Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8
Total Billed	Total amount billed of the claims found for the selection criteria.	Field	Number (Decimal)	11

6.2.4 Claim Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.2.5 Claim Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.2.6 Claim Search Results Panel Accessibility

6.2.6.1 To Access the Claim Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claim Search panel displays.
3	Enter appropriate search criteria and click **Search.**	Claim Search Results Panel displays.

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6.3 Claim Mini-Search Panel

6.3.1 Claim Mini-Search Panel Narrative

The Claim Mini Search panel allows the user to search the database for all claims by specific ICN. This panel displays at the top of the Claim Information Page.

This panel is inquiry only.

Navigation Path: [Claims] – [Information]

6.3.2 Claim Mini-Search Panel Layout

6.3.3 Claim Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Advanced Search Button, opens the Claim Search panel with additional search criteria fields.	Button	N/A	0
Back Button	Return back to the Claims Search panel.	Button	N/A	0
Clear	Clears the previous search criteria from the search fields.	Button	N/A	0
ICN	Internal Control Number that uniquely identifies a claim.	Field	Number (Integer)	13
Search	Performs a query on the database and returns the data for the entered search criteria.	Button	N/A	0

6.3.4 Claim Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ICN	Field	1004	Must enter 13 digit numeric.	Enter 13 digit numeric Internal Control Number.

6.3.5 Claim Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Claim Mini-Search Panel Accessibility

6.3.6.1 To Access the Claim Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Mini-Search panel displays.

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6.4 Dental Claim Panel

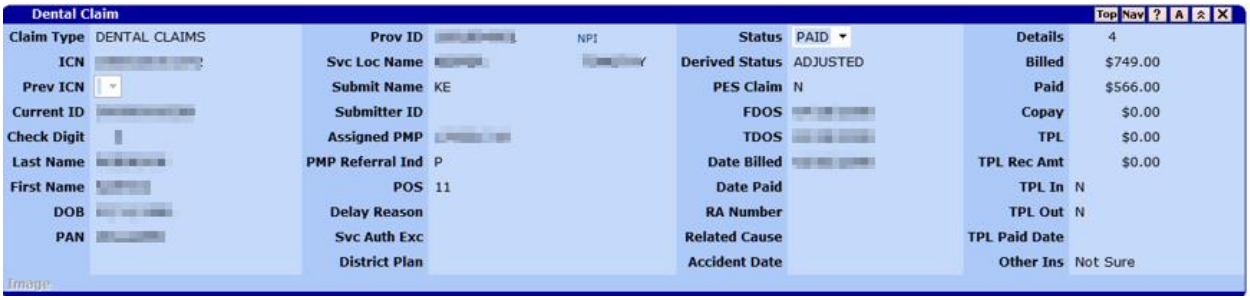
6.4.1 Dental Claim Panel Narrative

The Dental Claim panel displays the header information on a selected Dental claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Dental claim] – OR – [Claims] –[Search] – [Enter Criteria] – [Select a Dental claim]

6.4.2 Dental Claim Panel Layout



6.4.3 Dental Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date when accident occurred.	Field	Date (MM/DD/CCYY)	8
Assigned PMP	Provider ID of the current recipient's PMP from the dates of service.	Field	Character	15
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Check Digit	The 13th digit of an assigned number which uniquely identifies a recipient.	Field	Number	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	Total Copay amount. This is the amount the Recipient is response for.	Field	Number (Decimal)	9
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	A reason code for the delay in filing a claim.	Field	Alphanumeric	1
Derived Status	The displayed status of the claims processing status. Valid values include: Denied, Suspended or Paid.	Field	Character	20
Details	Indicates the number of detail service lines on the claim.	Field	Number (Integer)	9
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
FDOS	First Date of Service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Image	Allows user to open FEITH application and display appropriate Claims-related documents.	Button	N/A	0
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Other Ins	Indicates if another form of insurance was used.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
PAN	Identification for a recipient assigned by a provider. (Patient Account Number)	Field	Character	38
PES Claim	Indicates if a claim was submitted through PES by the billing provider. Valid values are Y - Yes and N - No.	Field	Character	1
POS	Place of Service where services were rendered.	Field	Character	2
Paid	Amount paid on claim.	Field	Number (Decimal)	8
PMP Referral Ind	Managed care referral indicator. N – Procedure does not require a referral. D – Dummy referring provider. E – Emergency. G – Grace Period. O – Edit was overridden. P – Billing or Performing provider is the PMP. A – Allowed provider as designated by the PMP or the group tables is the performing or billing provider. R – PMP is the referring provider. S – PMP designee is the referring provider.	Field	Character	1
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Drop Down List Box	0
Procedure Code description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition	Field	Character	40
Prov ID	The provider identification number that uniquely identifies the provider of services.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Related Cause	Accident related causes.	Field	Character	3
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submit Name	First two characters of providers last name or business.	Field	Alphanumeric	2
Submitter ID	Submitter of electronically submitted claims at the header level.	Field	Character	9
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location Name of the Provider.	Field	Character	30
TDOS	Date of last service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Third Party Liability. Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Date TPL paid the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

6.4.4 Dental Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.4.5 Dental Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Dental Claim Panel Accessibility

6.4.6.1 To Access the Dental Claim Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter a **Dental ICN** or an error message is displayed.	
4	Click **Search**.	Dental Claim Header, Maintenance and Claim Detail panels are displayed.

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6.5 Dental Claim Detail Panel

6.5.1 Dental Claim Detail Panel Narrative

The Dental Claim Detail panel allows the user to view the data entered on the detail portion of a Dental claim. When this panel is displayed in Data Correction mode, an Add button and a Delete button allows the user to add or remove details.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Dental claim] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Dental claim] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Dental claim from the list]

6.5.2 Dental Claim Detail Panel Layout

6.5.3 Dental Claim Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new claim detail. The button is visible only when viewing the claim on the Claims Data Corrections panel.	Button	N/A	0
Allowed Amt	Amount allowed by the specific program (Medicaid) for the procedure.	Field	Number (Decimal)	9
Billed Amt	Total billed amount.	Field	Number (Decimal)	9
Cancel	This allows the user to cancel any changes on the Dental Claim Detail panel.	Button	N/A	0
Delete	Allows a user to delete a claim detail. The button is visible only when viewing the claim on the Claims Data Corrections panel.	Button	N/A	0
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
DOS	Date of first service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Modifier 1	Code used to identify the Modifier 1 to the procedure code.	Field	Character	2
Modifier 2	Code used to identify the Modifier 2 to the procedure code.	Field	Character	2
Modifier 3	Code used to identify the Modifier 3 to the procedure code.	Field	Character	2
Modifier 4	Code used to identify the Modifier 4 to the procedure code.	Field	Character	2
POS	Place of Service where services were rendered.	Field	Character	2
Procedure Code	Code used to identify a Dental procedure.	Field	Character	6
Procedure Description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	40
Quadrant	The quadrant of the mouth that the procedure on the claim is related to.	Field	Character	2
Rendering Prov	The identifier for the performing provider.	Field	Character	15
Save	This allows the user to save a record on the Dental Claim Detail panel.	Button	N/A	0
Surface 1	Code which indicates the Tooth Surface of a particular tooth.	Combo Box	Drop Down List Box	0
Surface 2	Code which indicates the Tooth Surface of a particular tooth.	Combo Box	Drop Down List Box	0
Surface 3	Code which indicates the Tooth Surface of a particular tooth.	Combo Box	Drop Down List Box	0
Surface 4	Code which indicates the Tooth Surface of a particular tooth.	Combo Box	Drop Down List Box	0
Surface 5	Code which indicates the Tooth Surface of a particular tooth.	Combo Box	Drop Down List Box	0
System	System indicates bundling/unbundling system intervention. Values are Yes/No. N/A for Alabama Medicaid.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Tooth	The Tooth Number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.	Field	Character	2
Allowed Units	Number of units of service that is paid.	Field	Number (Integer)	6
Billed Units	The number of units billed by the provider.	Field	Number (Integer)	6

6.5.4 Dental Claim Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billed Amt	Field	1	Billed Amount not valid.	Billed Amount must be greater than or equal to 0.01.
	Field	2	Enter a valid value.	Enter a valid value greater than or equal to 0.01.
Billed Units	Field	1	Units billed not valid.	Units billed must be greater than or equal to 0.001.
DOS	Field	1	Invalid format. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	FDOS is required.	FDOS is required.
Modifier 1	Field	1	Invalid Modifier 1 code.	Enter a valid Modifier 1 code or select a value from the search [Search] panel.
Modifier 2	Field	1	Invalid Modifier 2 Code.	Enter a valid Modifier 2 Code or select a value from the [Search] Panel.
Modifier 3	Field	1	Invalid Modifier 3 Code.	Enter a valid Modifier 3 Code or select a value from the [Search] panel.
Modifier 4	Field	1	Invalid Modifier 4 Code.	Enter a valid Modifier 4 Code or select a value from the [Search] Panel.
POS	Field	1	Invalid Place of Service.	Enter a Valid Place of Service or select a value from the [Search] panel.
Procedure	Field	1	Invalid Procedure code.	Enter a valid procedure code or select a value from the [Search] field.
	Field	2	Procedure is required.	Procedure is required.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	A valid Procedure is required.	A valid Procedure is required.
Quadrant	Field	1	Invalid Tooth Quadrant.	Enter a valid Tooth Quadrant or select a value from the [Search] panel.
Rend Provider ID	Field	1	Invalid Rendering Provider ID.	Enter a valid Rendering Provider Id or select a value from the [Search] panel.
Tooth	Field	1	Invalid Tooth.	Enter a valid Tooth or select a value from the [Search] field.

6.5.5 Dental Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Dental Claim Detail Panel Accessibility

6.5.6.1 To Access the Dental Claim Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	Dental Claim Detail panel displays.
4	Click **Search**.	Dental Claim Header, Maintenance and **Claim Detail** panels are displayed.

6.5.6.2 To Add on the Dental Claim Detail Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a Dental claim.	Dental Claim Detail panel displays.
3	Select **Add** and update appropriate data.	
4	Click **Save**.	Dental Claim Detail data is saved.

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6.5.6.3 To Delete on the Dental Claim Detail Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a Dental claim.	Dental Claim Detail panel displays.
3	Select a detail to be deleted, select **Delete**.	
4	Click **Save**.	Dental Claim Detail data is saved.

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6.6 Dental Claim Detail Navigation Panel

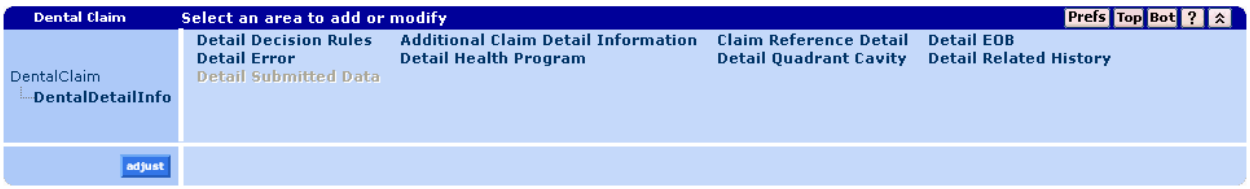
6.6.1 Dental Claim Detail Panel Narrative

The Dental Claim Detail Navigation panel provides access to the various panels through which Dental Claims detail information can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – (Enter an ICN for a Dental claim) – [DentalDetailInfo] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Dental claim] – [Dental Claim] – [DentalDetailInfo]

6.6.2 Dental Claim Detail Panel Layout



6.6.3 Dental Claim Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Detail Information	Link to the Additional Claim Detail Information panel.	Hyperlink	N/A	0
Claim Reference Detail	Link to the Claim Reference Detail panel.	Hyperlink	N/A	0
Detail Decision Rules	Link to the Detail Decision Rules panel.	Hyperlink	N/A	0
Detail EOB	Link to the Detail EOB panel.	Hyperlink	N/A	0
Detail Error	Link to the Detail Error panel.	Hyperlink	N/A	0
Detail Health Program	Link to the Detail Health Program panel.	Hyperlink	N/A	0
Detail Quadrant Cavity	Link to the Detail Quadrant Cavity panel.	Hyperlink	N/A	0
Detail Related History	Link to the Detail Related History panel.	Hyperlink	N/A	0
Detail Submitted Data	Link to the Detail Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0

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6.6.3.1 Dental Claim Detail Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.4 Dental Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.5 Dental Claim Detail Panel Accessibility

6.6.5.1 To Access the Dental Claim Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Dental Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **DentalDetailInfo** hyperlink.	Dental Claim Detail Navigation panel displays.

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6.7 Dental Claim Navigation Panel

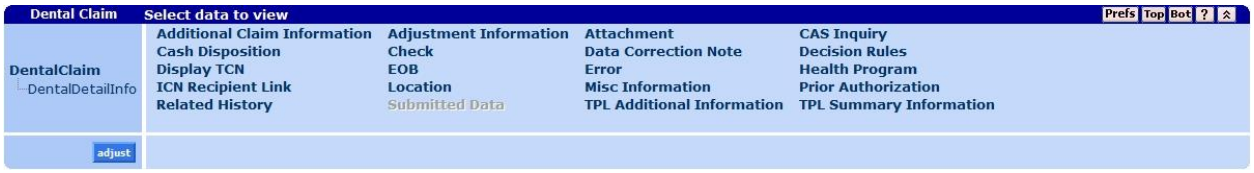
6.7.1 Dental Claim Navigation Panel Narrative

The Dental Claim Navigation provides access to the various panels through which Dental Claims data can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – (Enter an ICN for a Dental claim) – [DentalClaim] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Dental claim] – [DentalClaim]

6.7.2 Dental Claim Navigation Panel Layout



6.7.3 Dental Claim Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Information	Link to the Additional Claim panel.	Hyperlink	N/A	0
adjust	Opens the claim in the Claims Adjustment panel. The button is only visible for paid claims not already adjusted.	Button	N/A	0
Adjustment Information	Link to the Adjustment panel	Hyperlink	N/A	0
Attachment	Link to the Attachment panel.	Hyperlink	N/A	0
CAS Inquiry	Link to the Claim Adjustment Segment Inquiry panel.	Hyperlink	N/A	0
Cash Disposition	Link to the Cash Disposition panel.	Hyperlink	N/A	0
Check	Link to the Check panel.	Hyperlink	N/A	0
Data Correct	Opens the claim in the Claims Data Correction panel for updates. The button is visible only for suspended claims. Button is only displayed if the panel is in the corrections mode.	Button	N/A	0
Data Correction Note	Link to the Data Correction Note panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Display TCN	Link to the Display Transaction Control Number panel.	Hyperlink	N/A	0
EOB	Link to the Explanation Of Benefit panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Error	Link to the Error panel.	Hyperlink	N/A	0
Health Program	Link to the Health Program panel.	Hyperlink	N/A	0
ICN Recipient Link	Link to the ICN Recipient Link.	Hyperlink	N/A	0
Location	Link to the Location panel.	Hyperlink	N/A	0
Misc Information	Link to the Miscellaneous panel.	Hyperlink	N/A	0
Prior Authorization	Link to the Prior Authorization panel.	Hyperlink	N/A	0
Related History	Link to the Related History panel.	Hyperlink	N/A	0
Submitted Data	Link to the Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0
TPL Additional Information	Link to the TPL Additional Information panel.	Hyperlink	N/A	0
TPL Summary Information	Link to the TPL Summary Information panel.	Hyperlink	N/A	0

6.7.4 Dental Claim Navigation Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
adjust	Button	1	Online adjustments to encounter claims are not allowed	Enter an ICN number that do not start with 7 because 7 refers to encounter region

6.7.5 Dental Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Dental Claim Navigation Panel Accessibility

6.7.6.1 To Access the Dental Claim Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Dental Claim Header, Maintenance and Claim Detail panels are displayed.

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Step	Action	Response
5	Select the **DentalClaim** hyperlink.	Dental Claim Navigation panel displays.

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6.8 Pharmacy Claim Panel

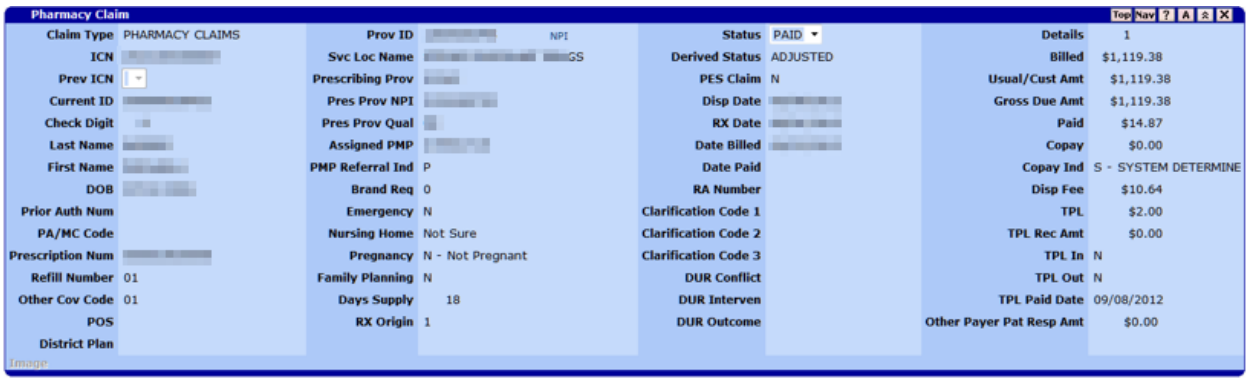
6.8.1 Pharmacy Claim Panel Narrative

The Pharmacy Claim panel displays the header information on a selected Pharmacy claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Pharmacy claim] – OR – [Claims -Search] – [Enter Criteria] – [Select a Pharmacy claim]

6.8.2 Pharmacy Claim Panel Layout



6.8.3 Pharmacy Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Assigned PMP	Provider ID of the current recipient's PMP from the dates of service.	Field	Character	15
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Brand Req	Indicates the reason, if any, that a brand name drug was dispensed (also referred to as DAW code).	Field	Character	1
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim. P - Pharmacy Claim - a one detail claim for a specific drug. Q - Compound Drug Claim - a multiple detail claim for pharmacists to bill all ingredients on a drug they mix.	Combo Box	Drop Down List Box	0
Clarification Code 1	The "Submission Clarification Code" - used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	ingredients. If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other			
Clarification Code 2	The "Submission Clarification Code" - used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients. If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other	Field	Character	2
Clarification Code 3	The "Submission Clarification Code" - used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients. If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other			
Copay	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	8
Copay Ind	System derived field indicating copay status of claim or detail.	Field	Character	25
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Derived Status	The displayed status resulting from specific criteria.	Field	Character	20
DOB	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	8
DUR Conflict	Reason for Service/Conflict Code used to override a Drug Utilization Review alert.	Field	Character	2
DUR Interven	The intervention response of the pharmacist to the Drug Utilization Review message.	Field	Character	2
DUR Outcome	The outcome response of the pharmacist to the Drug Utilization Review message.	Field	Character	2
Date Billed	The date on which a claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Days Supply	Number of days, written by the prescribing provider on the prescription, a prescribed drug should last a recipient.	Field	Number (Integer)	3
Details	The number of detail service lines on the claim.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
Disp Date	Date pharmacy dispensed the drug to the recipient.	Field	Date (MM/DD/CCYY)	8
Disp Fee	Amount of dispensing fee, if paid. Format 99999.99.	Field	Number (Decimal)	8
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
Emergency	Indicates whether service was provided as a result of an emergency situation.	Combo Box	Drop Down List Box	0
Family Planning	Indicates if the system determined this to be a family planning related claim based NDC therapeutic class.	Field	Character	1
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
Gross Due Amt	The value submitted by the provider in the gross amount due field (NCPDP field 430 –DU).	Field	Character	9
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Image	Allows user to open FEITH application and display appropriate Claims-related	Hyperlink	N/A	0
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	20
Nursing Home	Indicates whether the recipient is in a nursing home.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Other Cov Code	This field holds the value submitted from the NCPDP request located in NCPDP field 308-C8.	Field	Character	2
Other Payer Pat Resp Amt	The patient's cost share from a previous payer.	Field	Number(Decimal)	10
PA/MC Code	NCPDP 5.1 field 416-EU. Prior Authorization/Medical Code. Indicates prior authorization or medical certification occurred.	Field	Character	25
POS	Place Of Service.	Field	Character	2
Paid	Amount paid on claim.	Field	Number (Decimal)	8
PMP Referral Ind	Managed care referral indicator. N – Procedure does not require a referral. D – Dummy referring provider. E – Emergency. G – Grace Period. O – Edit was overridden. P – Billing or Performing provider is the PMP. A – Allowed provider as designated by the PMP or the group tables is the performing or billing provider. R – PMP is the referring provider. S – PMP designee is the referring provider.	Field	Character	1
PES Claim	Indicates if a claim was submitted through PES by the billing provider. Valid values are Y - Yes and N - No.	Field	Character	1
Prescription Num	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Character	7
Pregnancy	Indicates if this drug is pregnancy related.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Prescribing Prov	Provider License Number that uniquely identifies the Prescribing Provider.	Field	Character	15
Pres Prov NPI	National Provider Identifier for the prescribing provider.	Field	Number (Integer)	10
Pres Prov Qual	The prescribing provider qualifier tells whether the provider's state license or NPI is used.	Field	Character	2
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Dropdown Box	0
Prior Auth Num	Display the prior authorization number submitted by the provider on the pharmacy request.	Field	Character	10
Prov ID	The provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification that identifies a Remittance Advice.	Field	Number (Integer)	9
RX Date	Date the drug prescription (Rx) was written.	Field	Date (MM/DD/CCYY)	8
RX Origin	Prescription Origin Code.	Field	Character	1
Refill Number	Number of refills on the prescription.	Field	Character	2
Status	Identifies the status of the claim in the system.	Combo Box	Drop Down List Box	0
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Label	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Label	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Usual/Cust Amt	The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).	Field	Character	9

6.8.4 Pharmacy Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.8.5 Pharmacy Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Pharmacy Claim Panel Accessibility

6.8.6.1 To Access the Pharmacy Claim Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Pharmacy Claim Header, Maintenance and Claim Detail panels are displayed.

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6.9 Pharmacy Claim Detail Navigation Panel

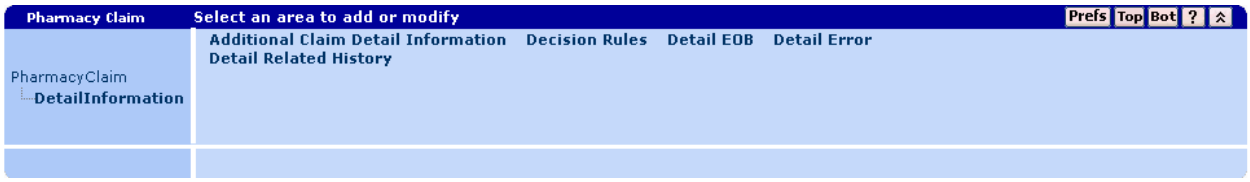
6.9.1 Pharmacy Claim Detail Navigation Panel Narrative

The Pharmacy Claim Detail Navigation panel provides access to the various panels through which Pharmacy Claims detail information can be viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – (Enter an ICN for a Pharmacy claim) – [DetailInformation] – OR – [Claims] – [Search] – (Enter Criteria) – [Select a Pharmacy claim] – [DetailInformation]

6.9.2 Pharmacy Claim Detail Navigation Panel Layout



6.9.3 Pharmacy Claim Detail Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Detail Information	Link to the Additional Claim Detail Information panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Detail EOB	Link to the Detail EOB panel.	Hyperlink	N/A	0
Detail Error	Link to the Detail Error panel.	Hyperlink	N/A	0
Detail Related History	Link to the Detail Related History panel.	Hyperlink	N/A	0

6.9.4 Pharmacy Claim Detail Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.9.5 Pharmacy Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Pharmacy Claim Detail Navigation Panel Accessibility

6.9.6.1 To Access the Pharmacy Claim Detail Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.

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Step	Action	Response
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **DetailInformation** hyperlink on the Pharmacy Claim Maintenance panel.	Pharmacy Claim Detail Navigation Panel displays.

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6.10 Pharmacy Claim Navigation Panel

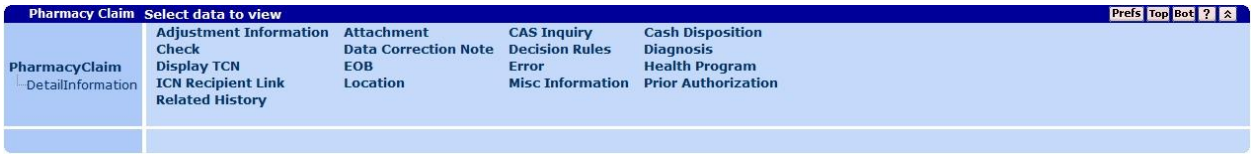
6.10.1 Pharmacy Claim Navigation Panel Narrative

The Pharmacy Claim Navigation panel provides access to the various panels through which Pharmacy Claims data can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – (Enter an ICN for a Pharmacy claim) – [PharmacyClaim] – OR – [Claims] – [Search] – (Enter Criteria) – [Select a Pharmacy claim] – [PharmacyClaim]

6.10.2 Pharmacy Claim Navigation Panel Layout



6.10.3 Pharmacy Claim Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Information	Link to the Adjustment Information panel.	Hyperlink	N/A	0
adjust	Opens the claim in the Claims Adjustment panel. The button is only visible for paid claims not already adjusted. Panel information is located in the Adjustments section of this manual.	Button	N/A	0
Attachment	Link to the Attachment panel.	Hyperlink	N/A	0
CAS Inquiry	Link to the CAS Inquiry panel.	Hyperlink	N/A	0
Cash Disposition	Link to the Cash Disposition panel.	Hyperlink	N/A	0
Check	Link to the Check panel.	Hyperlink	N/A	0
Data Correct	Opens the claim in the Claims Data Correction panel for updates. The button is visible only for suspended claims. Panel information is located in the Data Correction section of this manual.	Button	N/A	0
Data Correction Note	Link to the Data Correction Note panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Diagnosis	Link to the Diagnosis panel.	Hyperlink	N/A	0
Display TCN	Link to the Display TCN panel.	Hyperlink	N/A	0
EOB	Link to the EOB panel.	Hyperlink	N/A	0
Error	Link to the Error panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Health Program	Link to the Health Program panel.	Hyperlink	N/A	0
ICN Recipient Link	Link to the ICN Recipient Link.	Hyperlink	N/A	0
Location	Link to the Location panel.	Hyperlink	N/A	0
Misc Information	Link to the Misc Information panel.	Hyperlink	N/A	0
Prior Authorization	Link to the Prior Authorization panel.	Hyperlink	N/A	0
Related History	Link to the Related History panel.	Hyperlink	N/A	0

6.10.4 Pharmacy Claim Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
adjust	Button	1	Online adjustments to encounter claims are not allowed	Enter an ICN number that do not start with 7 because 7 refers to encounter region

6.10.5 Pharmacy Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Pharmacy Claim Navigation Panel Accessibility

6.10.6.1 To Access the Pharmacy Claim Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **PharmacyClaim** hyperlink on the Pharmacy Claim Maintenance panel.	Pharmacy Claim Navigation Panel displays.

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6.11 Pharmacy Claim Detail Panel

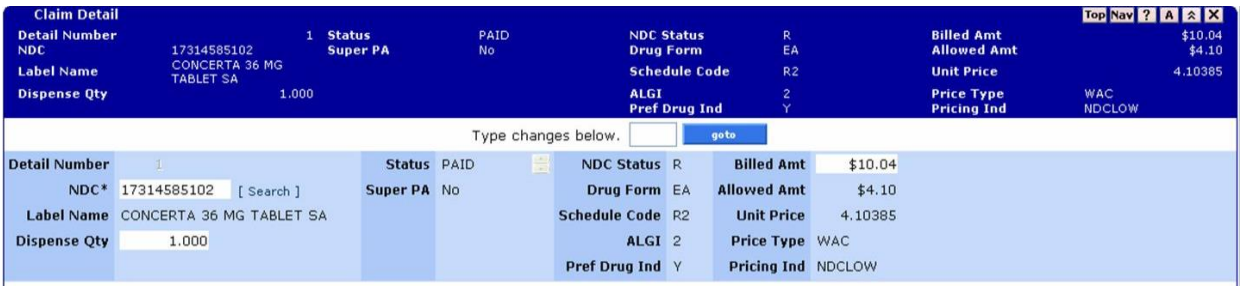
6.11.1 Pharmacy Claim Detail Panel Narrative

The Pharmacy Claim Detail panel allows the user to view the data entered on the detail portion of a Pharmacy claim. When this panel is displayed in Data Correction mode, an Add button and a Delete button displays allowing the user to add or remove details.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Pharmacy claim] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Pharmacy claim] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Pharmacy claim from the list]

6.11.2 Pharmacy Claim Detail Panel Layout



6.11.3 Pharmacy Claim Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ALGI	Alabama Generic Indicator, which indicates if the drug is brand or generic.	Field	Character	1
Allowed Amt	Indicates the computed allowable amount for the drug dispensed.	Field	Number (Decimal)	9
Billed Amt	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
Dispense Qty	Number of units of a drug dispensed to a recipient. The type of unit is expressed in Drug Form Code.	Field	Number (Decimal)	10
Drug Form	The basic drug measurement unit (each, milliliter, or grams) for performing price calculations.	Field	Character	2
goto	Allows user to view a specific detail.	Button	N/A	0
Label Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	30
NDC	National Drug Code is comprised of a 5 byte numeric labeler code, a 4 byte numeric product code, and a 2 byte numeric package code. It is used to uniquely	Field	Character	11

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Field	Description	Field Type	Data Type	Length
	identify a drug, its labeler, package size of a product for pricing, DUR, and prior authorization.			
NDC Status	Identifies the status of the National Drug Code in the system.	Field	Character	1
Pref Drug Ind	Indicates if a drug is preferred or not.	Field	Character	1
Price Type	Code used to identify the rate type use to pay the claim.	Label	N/A	0
Pricing Ind	Pricing information retained for audit trail.	Field	Character	6
Schedule Code	The unique 2 character code for the description of Alabama Schedule.	Field	Character	2
Status	This field displays the status of the claim.	Field	Character	12
Super PA	Indicates if a super PA was used to approve payment of this detail.	Field	Character	1
Unit Price	Rate amount used to price the claim.	Label	N/A	0

6.11.4 Pharmacy Claim Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Dispense Qty	Field	1	Enter a valid value.	Dispense Quantity must be numeric.
NDC	Field	1	Invalid NDC.	Enter a valid NDC or select a value from the [Search] field.

6.11.5 Pharmacy Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Pharmacy Claim Detail Panel Accessibility

6.11.6.1 To Access the Pharmacy Claim Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	

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Step	Action	Response
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

6.11.6.2 To Update the Pharmacy Claim Detail Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a Pharmacy claim.	Pharmacy Claim Information displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	Pharmacy Claim Detail data is saved.

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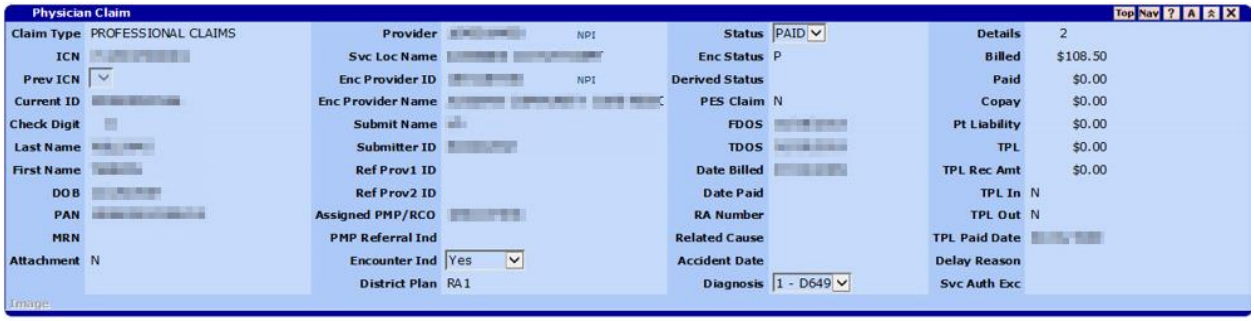
6.12 Physician Claim Panel

6.12.1 Physician Claim Panel Narrative

The Physician Claim panel displays the header information on a selected Physician (CMS-1500) claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Physician claim] – OR – [Claims –Search] – [Enter Criteria] – [Select a Physician claim]

6.12.2 Physician Claim Panel Layout



6.12.3 Physician Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date of accident.	Field	Date (MM/DD/CCYY)	8
Assigned PMP/RCO	This field displays the Provider Identification Number of the PMP or RCO to which a recipient is assigned as of the header first date of service.	Field	Character	15
Attachment	Indicates whether an attachment is present.	Combo Box	Drop Down List Box	0
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	The sum of all the detail co-pay amounts applicable to the claim. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date the claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	Code for delay.	Field	Number (Integer)	1
Derived Status	The displayed status of the claims processing status. Valid values include: Denied, Suspended or Paid or NCCI Non Adjustable.	Field	Character	20
Details	The number of detail service lines on the claim.	Field	Number (Integer)	4
Diagnosis	Code used to identify the primary or other diagnoses.	Combo Box	Drop Down List Box	0
District Plan	The district plan code indicates the system-assigned plan code (if any).	Field	Character	3
Enc Provider ID	This field displays the Provider Identification Number of the RCO that submitted the encounter claim.	Field	Character	15
Enc Provider Name	This field displays the name of the RCO that submitted the encounter claim.	Field	Alphanumeric	50
Enc Status	This field indicates the status of the claim had it been submitted as FFS.	Field	Character	1
Encounter Ind	A Y in this field indicates that this is an encounter claim.	Combo Box	Drop Down List Box	0
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Image	Allows user to open FEITH application and display appropriate Claims-related documents.	Button	N/A	0
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three	Field	Character	15

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Field	Description	Field Type	Data Type	Length
	characters of the last that was keyed is displayed.			
MC Ref Ind	Managed Care Referral Indicator.	Field	N/A	0
MRN	Code representing the Medical Record Number.	Field	Character	50
PAN	Patient Account Number. Patient's unique identification number assigned by the provider to track the patient's financial records.	Field	Character	38
PES Claim	Indicates if a claim was submitted through PES by the billing provider. Valid values are Y - Yes and N - No.	Field	Character	1
Paid	Amount paid on claim.	Field	Number (Decimal)	8
PMP Referral Ind	Managed care referral indicator. P-Referring = PMP	Field	Character	1
Prev ICN	Previous Internal Control Number. Allows the user to select a previous internal control number and to review the information, such as for a void or adjustment.	Combo Box	Drop Down List Box	0
Provider	The pay to provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Ref Prov1 ID	Provider Identification Number that uniquely identifies the referring provider.	Field	Character	15
Ref Prov2 ID	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Character	15
Related Cause	Related causes for accident.	Field	Character	3
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2

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Field	Description	Field Type	Data Type	Length
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location Name of the Provider or Business.	Field	Character	30
TDOS	To Date of Service. Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Third Party Liability. Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

6.12.4 Physician Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.12.5 Physician Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.12.6 Physician Claim Panel Accessibility

6.12.6.1 To Access the Physician Claim Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

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6.13 Physician Claim Detail Panel

6.13.1 Physician Claim Detail Panel Narrative

The Physician Claim Detail panel allows the user to view the data entered on the detail portion of a Physician claim. When this panel is displayed in Data Correction mode, an Add button and a Delete button displays allowing the user to add or remove details.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Physician claim] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Physician claim] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Physician claim from the list]

6.13.2 Physician Claim Detail Panel Layout

6.13.3 Physician Claim Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allowed Amt	Amount allowed that is paid.	Field	Number (Decimal)	9
Allowed Units	Number of units of service that is paid.	Field	Number (Decimal)	6
Billed Amt	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Billed Units	The number of units billed by the provider.	Field	Number (Decimal)	6
Copay Ind	System derived field indicating copay status of claim or detail.	Field	Character	25
Copay Status	Provider submitted copay status code indicates whether the provider deems the service to be detail exempt. 837 loop 2400 field SV115.	Field	Character	25

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Field	Description	Field Type	Data Type	Length
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
Diagnosis Ind	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims. (Field displays the Maximum four Diagnosis Ind.)	Field	Number (Integer)	2
EPSDT Ref	EPSDT referral/treatment information.	Combo Box	Drop Down List Box	0
Emergency Ind	Indicates whether the service was provided as result of emergency situation.	Combo Box	Drop Down List Box	0
Enc Status	This field indicates the status of the claim had it been submitted as FFS.	Field	Character	1
Family Plan (SUB)	Submitted Family Planning indicator. Mapped from field SV112 of the 837P transaction. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement. Paper claim: source field is 24H. In Alabama a "2" in this field indicates family planning and is mapped into the system as a "Y".	Field	Character	1
Family Plan (SYS)	Indicates if the system determined this to be a family planning related claim or detail based on procedure and diagnosis codes and the provider submitted family planning indicator (837 loop 2400 field SV112).	Field	Character	1
FDOS	Date service was first provided.	Field	Date (MM/DD/CCYY)	8
generate kick payment	Allows user to force the system to generate a kick payment for a claim detail.	Button	N/A	0
goto	Allows user to view a specific detail.	Button	N/A	0
KICK Ind	A Y in this field indicates that the claim meets the criteria for a KICK payment. It does not mean a KICK payment was made for this claim, only that it will be evaluated in the bi-weekly KICK program. Use the KICK panel link from Claims-Related Data to determine if a	Field	Character	1

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Field	Description	Field Type	Data Type	Length
	KICK payment was made based on this claim detail.			
Modifier 1	Code used to identify Modifier 1 connected to the procedure code.	Field	Character	2
Modifier 2	Code used to identify Modifier 2 connected to the procedure code.	Field	Character	2
Modifier 3	Code used to identify Modifier 3 connected to the procedure code.	Field	Character	2
Modifier 4	Code used to identify Modifier 4 connected to the procedure code.	Field	Character	2
POS	Place of Service. Place where services were rendered.	Field	Character	2
Procedure Code	A procedure code on a detail which indicates the service that was provided.	Field	Character	6
Procedure Description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	40
Pt Liability	Displays the total patient liability for all line items on the claim. Format 9999999.99.	Field	Number	10
Rendering Prov	The rendering provider identification number and location that uniquely identifies the provider of services.	Field	Character	15
Referring Prov1	Provider Identification Number that uniquely identifies the referring provider.	Field	Number (Integer)	15
Referring Prov2	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Number (Integer)	15
Status	Detail adjudication status.	Field	Character	1
System Added	Indicates whether detail was added by system during claim's processing.	Combo Box	Drop Down List Box	0
TDOS	Last service date.	Field	Date (MM/DD/CCYY)	8

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6.13.4 Physician Claim Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field error messages.				

6.13.5 Physician Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Physician Claim Detail Panel Accessibility

6.13.6.1 To Access the Physician Claim Detail Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

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6.14 Physician Claim Detail Navigation Panel

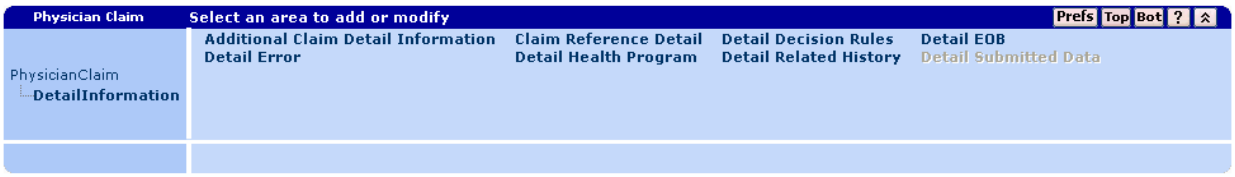
6.14.1 Physician Claim Detail Navigation Panel Narrative

The Physician Claim Detail Navigation panel provides access to the various panels through which Physician Claims detail information can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – (Enter an ICN for a Physician claim) – [DetailInformation] – OR – [Claims] – [Search] – (Enter Criteria) – [Select a Physician claim] – [DetailInformation] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Physician claim from the list] – [DetailInformation]

6.14.2 Physician Claim Detail Navigation Panel Layout



6.14.3 Physician Claim Detail Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Detail Information	Link to the Additional Claim Detail Information panel.	Hyperlink	N/A	0
Claim Reference Detail	Link to the Claim Reference Detail panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Detail EOB	Link to the Detail EOB panel.	Hyperlink	N/A	0
Detail Error	Link to the Detail Error panel.	Hyperlink	N/A	0
Detail Health Program	Link to the Detail Health Program panel.	Hyperlink	N/A	0
Detail Related History	Link to the Detail Related History panel.	Hyperlink	N/A	0
Detail Submitted Data	Link to the Detail Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0

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6.14.4 Physician Claim Detail Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.14.5 Physician Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Physician Claim Detail Navigation Panel Accessibility

6.14.6.1 To Access the Physician Claim Detail Navigation Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **DetailInformation** link from the Physician Claim Maintenance panel.	Physician Claim Detail Navigation panel displays.

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6.15 Physician Claim Navigation Panel

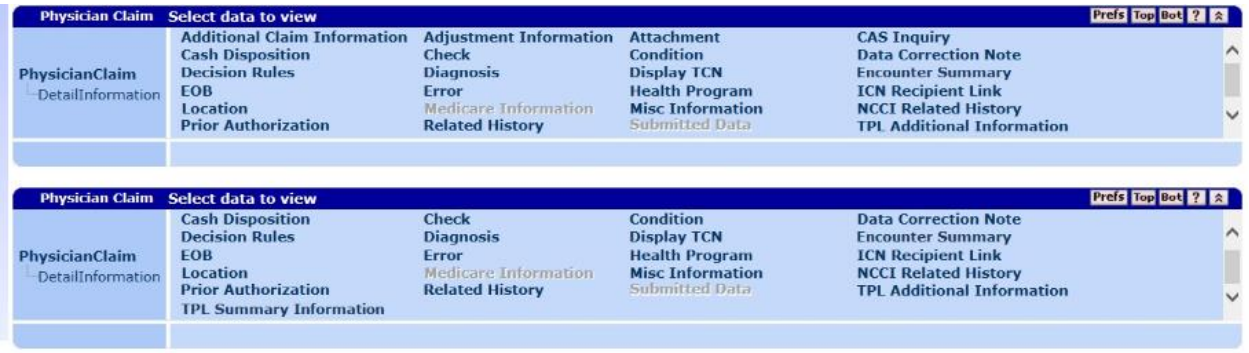
6.15.1 Physician Claim Navigation Panel Narrative

The Physician Claim Navigation panel provides access to the various panels through which Physician Claims data can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Physician claim] – [PhysicianClaim] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a Physician claim] [PhysicianClaim] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Physician claim from the list] – [PhysicianClaim]

6.15.2 Physician Claim Navigation Panel Layout



6.15.3 Physician Claim Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Information	Link to the Additional Claim Information panel.	Hyperlink	N/A	0
Adjustment Information	Link to the Adjustment Information panel.	Hyperlink	N/A	0
adjust	Button to request adjustment of the displayed claim.	Button	N/A	0
Attachment	Link to the Attachment panel.	Hyperlink	N/A	0
CAS Inquiry	Link to the Claim Adjustment Segment Inquiry panel.	Hyperlink	N/A	0
Cash Disposition	Link to the Cash Disposition panel.	Hyperlink	N/A	0
Check	Link to the Check panel.	Hyperlink	N/A	0
Condition	Link to Condition panel.	Hyperlink	N/A	0
Data Correction Note	Link to the Data Correction Note panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Diagnosis	Link to the Diagnosis panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Display TCN	Link to the Display TCN panel.	Hyperlink	N/A	0
Encounter Summary	Link to the Encounter Summary Panel	Hyperlink	N/A	0
EOB	Link to the EOB panel.	Hyperlink	N/A	0
Error	Link to the Error panel.	Hyperlink	N/A	0
Health Program	Link to the Health Program panel.	Hyperlink	N/A	0
ICN Recipient Link	Link to ICN Recipient Link panel	Hyperlink	N/A	0
Location	Link to the Location panel.	Hyperlink	N/A	0
Medicare Information	Link to the Medicare Information panel.	Hyperlink	N/A	0
Misc Information	Link to the Miscellaneous Information panel.	Hyperlink	N/A	0
NCCI Related History	Lint to the NCCI Related History panel.	Hyperlink	N/A	0
Prior Authorization	Link to the Prior Authorization panel.	Hyperlink	N/A	0
Related History	Link to the Related History panel.	Hyperlink	N/A	0
Submitted Data	Link to the Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0
TPL Additional Information	Link to the TPL Additional Information panel.	Hyperlink	N/A	0
TPL Summary Information	Link to the TPL Summary Information panel.	Hyperlink	N/A	0

6.15.4 Physician Claim Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
adjust	Button	1	Claim is in a NCCI non-adjustable status and permission from the Agency must be obtained in order to adjust the claim. If the user continues to want to adjust the claim, it should be allowed to adjust.	Check Ignore checkbox and click on Continue
adjust	Button	**2**	Online adjustments to encounter claims are not allowed.	Enter an ICN number that do not start with 7 because 7 refers to encounter region.

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6.15.5 Physician Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Physician Claim Navigation Panel Accessibility

6.15.6.1 To Access the Physician Claim Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claim Search panel displays.
3	Enter **ICN**.	
4	Click **Search**.	Physician Claim Navigation panel displays.

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6.16 UB04 Claim Panel

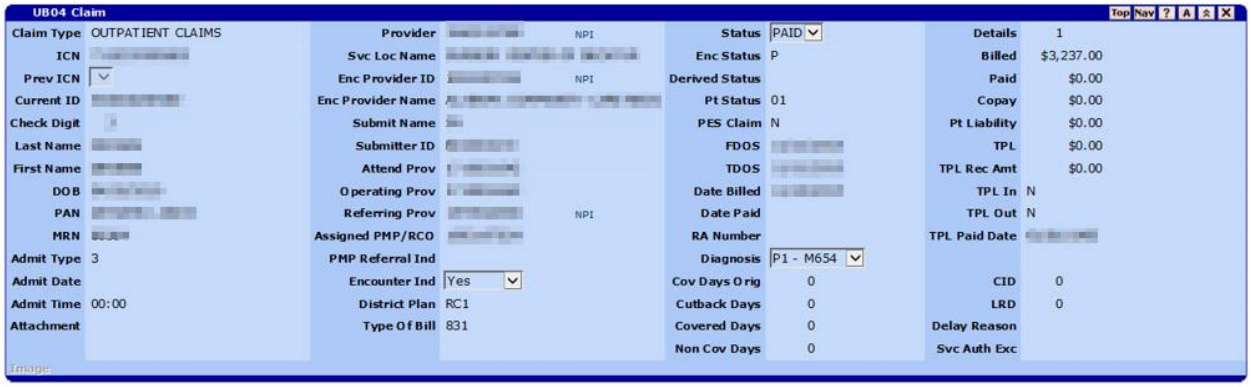
6.16.1 UB04 Claim Panel Narrative

The UB04 Claim panel displays UB04 claim header data.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select Submitted Data link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a UB04 claim] – [Select Submitted Data link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list] – [Select Submitted Data link from the displayed panel]

6.16.2 UB04 Claim Panel Layout



6.16.3 UB04 Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admit Date	The date the patient was admitted to the facility for care.	Field	Date (MM/DD/CCYY)	8
Admit Source	Displays the admit source for institutional claims.	Field	Character	36
Admit Time	The time that the recipient was admitted to the facility for care.	Field	Character	4
Admit Type	Code indicating the type of admission.	Combo Box	Drop Down List Box	0
Assigned PMP/RCO	This field displays the Provider Identification Number of the PMP or RCO to which a recipient is assigned as of the header first date of service.	Field	Character	15
Attachment	External Document submitted by the provider.	Field	Character	1
Attend Prov	Attending physician's NPI number.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
CID	Co-Insurance Days.	Field	Number (Integer)	3
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Combo Box	Drop Down List Box	0
Copay	The sum of all the detail co-pay amounts applicable to the claim. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	9
Cov Days Orig	Original number of covered days.	Field	Number (Integer)	3
Covered Days	Number of days covered by the primary payer.	Field	Number (Integer)	4
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Cov Days Orig	Original number of covered days.	Field	Number (Integer)	3
Covered Days	Number of days covered by the primary payer.	Field	Number (Integer)	4
Cutback Days	Cutback Days displayed is the difference between the total days billed and the total days covered.	Field	Number (Integer)	3
Date Billed	Date the claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Enc Provider ID	This field displays the Provider Identification Number of the RCO that submitted the encounter claim.	Field	Character	15
Enc Provider Name	This field displays the name of the RCO that submitted the encounter claim.	Field	Alphanumeric	50
Enc Status	This field indicates the status of the claim had it been submitted as FFS.	Field	Character	1
Encounter Ind	A Y in this field indicates that this is an encounter claim.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	The reason for the delay in filing a claim.	Field	Character	1
Derived Status	The displayed status of the claims processing status. Valid values include: Denied, Suspended, Paid or NCCI Non-Adjustable.	Field	Character	20
Details	The number of detail service lines on the claim.	Field	Number (Integer)	9
Diagnosis	Code used to identify the primary or other diagnosis.	Combo Box	Drop Down List Box	0
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Image	Allows user to open FEITH application and display appropriate Claims-related documents.	Button	N/A	Image
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
LRD	Lifetime Reserve Days.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
MRN	Code representing the Medical Record Number.	Field	Character	50
Non Cov Days	The number of days that were not covered.	Field	Number (Integer)	4
Operating Prov	The NPI number of the Operating physician.	Field	Character	10
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.	Field	Character	38
Paid	Amount paid on the claim.	Field	Number (Decimal)	8
PMP Referral Ind	Managed care referral indicator. P-Referring = PMP	Field	Character	1
PES Claim	Indicates if a claim was submitted through PES by the billing provider. Valid values are Y - Yes and N - No.	Field	Character	1
Pt Liability	Displays the total patient liability for all line items on the claim. Format 9999999.99.	Field	Number (Decimal)	9
Pt Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim.	Field	Character	2
Prev ICN	This field allows the user to select any of the claim's prior internal control numbers and obtain information on them.	Combo Box	Drop Down List Box	0
Provider	The pay to provider identification number that uniquely identifies the provider of services.	Field	Character	15
Pt Liability	Displays the total patient liability for all line items on the claim. Format 9999999.99.	Field	Number (Decimal)	9
Pt Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim.	Field	Character	2
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Referring Prov	The NPI number of the Referring physician.	Field	Character	10
Status	Identifies the status of the claim within the system.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Submit Name	First two characters of the last name of provider or business name.	Field	Alphanumeric	2
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location Name of the Provider.	Field	Character	30
TDOS	Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Type of Bill	A code indicating the specific type of bill.	Field	Character	3

6.16.4 UB04 Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.16.5 UB04 Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 UB04 Claim Panel Accessibility

6.16.6.1 To Access the UB04 Claim Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

6.16.6.2 To Update the UB04 Claim Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a UB04 claim.	UB04 Claim information panel displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	UB04 Claim data is saved.

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6.17 UB04 Claim Detail Panel

6.17.1 UB04 Claim Detail Panel Narrative

The UB04 Claim Detail panel allows the user to view the data entered on the detail portion of a UB04 claim. When this panel is displayed in Data Correction mode, an Add button and a Delete button displays allowing the user to add or remove details.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – OR – [Claims -Search] – [Enter Criteria] – [Select a UB04 claim] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list]

6.17.2 UB04 Claim Detail Panel Layout

6.17.3 UB04 Claim Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allowed Amt	Amount of money allowed for payment to a provider for services rendered.	Field	Number (Decimal)	9
Allowed Units	Number of units of service that is paid.	Field	Number (Decimal)	6
Billed Amt	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	9
Billed Units	Number of service units billed.	Field	Number (Decimal)	6
Copay Ind	System derived field indicating copay status of claim or detail.	Field	Character	25
Detail Number	The detail number of a claim record.	Field	Number (Integer)	4
Enc Status	This field indicates the status of the claim had it been submitted as FFS.	Field	Character	1
FDOS	Date service was first provided.	Field	Date (MM/DD/CCYY)	8
Family Planning	Indicates if the system determined this to be a family planning related claim or detail based on procedure, diagnosis, and condition codes.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
goto	Allows user to view a specific detail.	Button	N/A	0
Modifier 1	Original/Submitted Modifier 1 for procedure code.	Field	Character	2
Modifier 2	Original/Submitted Modifier 2 for procedure code.	Field	Character	2
Modifier 3	Original/Submitted Modifier 3 for procedure code.	Field	Character	2
Modifier 4	Original/Submitted Modifier 4 for procedure code.	Field	Character	2
Non-Covered Charge	Amount that is not covered.	Field	Number (Decimal)	9
Pt Liability	Amount of payment due by the recipient.	Field	Number (Decimal)	9
Procedure Code	A procedure code on a detail which indicates the service that was provided.	Field	Character	6
Procedure Description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	40
Revenue Code	A revenue code on a detail which indicates the service that was provided.	Field	Number (Integer)	4
Revenue Description	This describes a specific accommodation or ancillary service.	Field	Character	70
Status	Identifies the status of the claim within the system.	Field	Character	12
System	Indicates whether detail was added by system during claim's processing.	Combo Box	Drop Down List Box	0
TDOS	Date service was last provided.	Field	Date (MM/DD/CCYY)	8
Unit Rate	The rate per unit of associate revenue for hospital accommodation.	Field	Number (Decimal)	10

6.17.4 UB04 Claim Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field error messages.				

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6.17.5 UB04 Claim Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 UB04 Claim Detail Panel Accessibility

6.17.6.1 To Access the UB04 Claim Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

6.17.6.2 To Update the UB04 Claim Detail Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a UB04 claim.	UB04 Claim Detail panel displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	UB04 Claim Detail data is saved.

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6.18 UB04 Claim Detail Navigation Panel

6.18.1 UB04 Claim Detail Navigation Panel Narrative

The UB04 Claim Detail Navigation panel provides access to the various panels through which UB04 Claims detail information can be viewed.

This panel is inquiry only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [DetailInformation] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a UB04 claim] – [DetailInformation] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list] – [DetailInformation]

6.18.2 UB04 Claim Detail Navigation Panel Layout

6.18.3 UB04 Claim Detail Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Detail Information	Link to the Additional Claim Detail Information panel.	Hyperlink	N/A	0
Claim Reference Detail	Link to the Claim Reference Detail panel.	Hyperlink	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Detail EOB	Link to the Detail EOB panel.	Hyperlink	N/A	0
Detail Error	Link to the Detail Error panel.	Hyperlink	N/A	0
Detail Health Program	Link to the Detail Health Program panel.	Hyperlink	N/A	0
Detail Related History	Link to the Detail Related History panel.	Hyperlink	N/A	0
Detail Submitted Data	Link to the Detail Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0

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6.18.4 UB04 Claim Detail Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.18.5 UB04 Claim Detail Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 UB04 Claim Detail Navigation Panel Accessibility

6.18.6.1 To Access the UB04 Claim Detail Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **DetailInformation** link from the Claims Maintenance panel.	UB04 Claim Detail Navigation panel displays.

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6.19 UB04 Claim Navigation Panel

6.19.1 UB04 Claim Navigation Panel Narrative

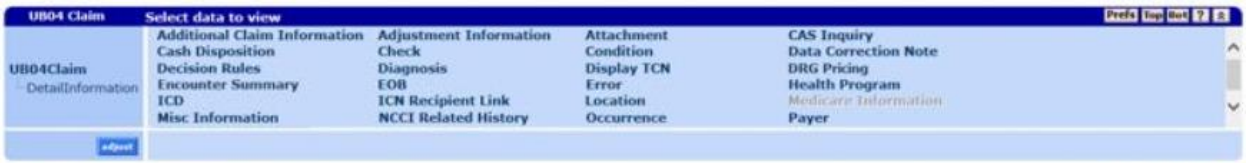
The UB04 Claim Navigation panel provides access to the various panels through which UB04 Claims data can be viewed and/or corrected.

This panel is inquiry only.

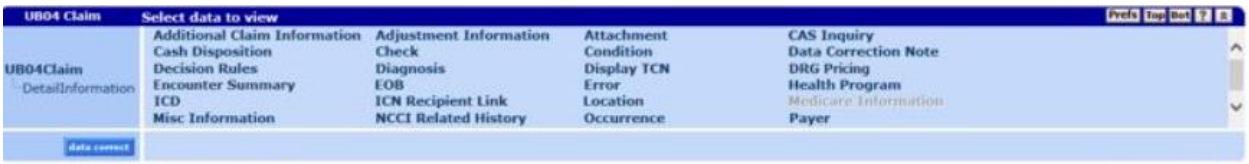
Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – OR – [Claims -Search] – [Enter Criteria] – [Select a UB04 claim]

6.19.2 UB04 Claim Navigation Panel Layout

Adjust



Data Correct



6.19.3 UB04 Claim Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Additional Claim Information	Link to the Additional Claim Information panel.	Hyperlink	N/A	0
adjust	Button to request adjustment of the displayed claim.	Button	N/A	0
Adjustment Information	Link to the Adjustment Information panel. Panel information is located in the Adjustment section of this manual.	Hyperlink	N/A	0
Attachment	Link to the Attachment panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
CAS Inquiry	Link to the CAS Inquiry panel.	Hyperlink	N/A	0
Cash Disposition	Link to the Cash Disposition panel.	Hyperlink	N/A	0
Check	Link to the Check panel.	Hyperlink	N/A	0
Condition	Link to the Condition panel.	Hyperlink	N/A	0
Data Correction Note	Link to the Data Correction Note panel. Panel information is located in the Data Correction section of this manual.	Hyperlink	N/A	0
Data Correct	Opens the claim in the Claims Data Correction panel for updates. The button is visible only for suspended claims. Panel information is located in the Data Correction section of this manual.	Button	N/A	0
Decision Rules	Link to the Decision Rules panel.	Hyperlink	N/A	0
Diagnosis	Link to the Diagnosis panel.	Hyperlink	N/A	0
Display TCN	Link to the Display TCN panel.	Hyperlink	N/A	0
Encounter Summary	Link to the Encounter Summary Panel	Hyperlink	N/A	0
DRG Pricing	Link to the DRG Pricing panel.	Hyperlink	N/A	0
EOB	Link to the EOB panel.	Hyperlink	N/A	0
Error	Link to the Error panel.	Hyperlink	N/A	0
Health Program	Link to the Health Program panel.	Hyperlink	N/A	0
ICD	Link to the ICD panel.	Hyperlink	N/A	0
ICN Recipient Link	Link to the ICN Recipient Link.	Hyperlink	N/A	0
Location	Link to the Location panel.	Hyperlink	N/A	0
Medicare Information	Link to the Medicare Information panel.	Hyperlink	N/A	0
Misc Information	Link to the Miscellaneous Information panel.	Hyperlink	N/A	0
NCCI Related History	Link to the NCCI Related History panel.	Hyperlink	N/A	0
Occurrence	Link to the Occurrence panel.	Hyperlink	N/A	0
Payer	Link to the Payer panel.	Hyperlink	N/A	0
Prior Authorization	Link to the Prior Authorization panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Related History	Link to the Related History panel.	Hyperlink	N/A	0
Submitted Data	Link to the Submitted Data panel. This panel is not utilized in Alabama.	Hyperlink	N/A	0
TPL Additional Information	Link to the TPL Additional Information panel.	Hyperlink	N/A	0
TPL Summary Information	Link to the TPL Summary Information panel.	Hyperlink	N/A	0
Value	Link to the Value panel.	Hyperlink	N/A	0

6.19.4 UB04 Claim Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
adjust	Button	1	Claim is in a NCCI non-adjustable status and permission from the Agency must be obtained in order to adjust the claim. If the user continues to want to adjust the claim, it should be allowed to adjust.	Check Ignore checkbox and click on Continue
		2	Online adjustments to encounter claims are not allowed.	Enter an ICN number that do not start with 7 because 7 refers to encounter region.

6.19.5 UB04 Claim Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 UB04 Claim Navigation Panel Accessibility

6.19.6.1 To Access the UB04 Claim Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Enter **ICN**.	
4	Click **Search**.	UB04 Claim Navigation panel displays.

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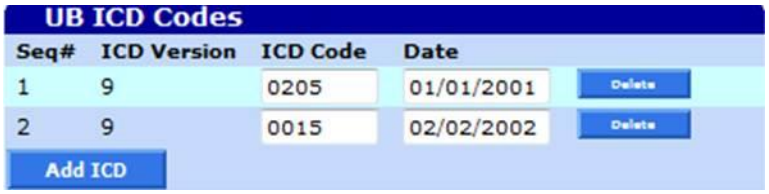
6.20 UB ICD Codes Panel – Data Correction

6.20.1 UB ICD Codes Panel Narrative

The UB ICD Codes panel displays the ICD Procedure Codes applicable to the claim. This panel includes both the principal and other ICD procedure codes. The principal procedure code is the ICD code that identifies the procedure performed during the period covered by this claim and the date on which the principal procedure was performed. The other procedure codes are the ICD codes that identify all significant procedures other than the principal procedure and the dates on which they were performed.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB claim from the list] – [Scroll to UB ICD Codes panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click on “Data Correct” button]

6.20.2 UB ICD Codes Panel Layout



6.20.3 UB ICD Codes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add ICD	Adds a new ICD record.	Button	N/A	0
Date	Date the ICD procedure was performed.	Field	Date (MM/DD/CCYY)	8
Delete	Deletes an ICD record.	Button	N/A	0
ICD Code	Code used to identify the surgical procedure code, principal or other.	Field	Alphanumeric	7
ICD Version	Code to denote which version of the ICD procedure code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Seq #	This column contains the sequence number of the surgical procedure code. The principal procedure will always be sequence 1.	Field	Number (Integer)	4

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6.20.4 UB ICD Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date	Field	1	Invalid Date. Format MM/DD/CCYY.	Enter the date in the correct format, MM/DD/CCYY.
ICD Code	Field	1	ICD Code #### not on file.	Enter a valid ICD Procedure code.
	Field	104	Exceed maximum number of ICD codes.	Verify there are no more than 24 ICD codes.

6.20.5 UB ICD Codes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 UB ICD Codes Panel Accessibility

6.20.6.1 To Access the UB ICD Codes Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **OK**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Click **data correct**	UB ICD Codes Panel displays.

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6.21 NDC Details Panel

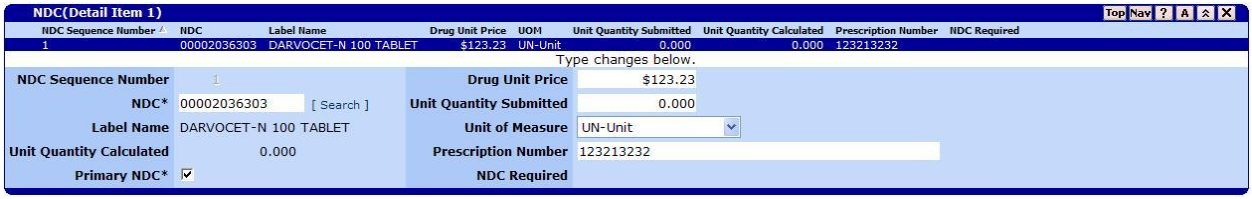
6.21.1 NDC Details Panel Narrative

The NDC Details Panel can be accessed from the paid, denied, or suspended claim panels. This panel displays the detail NDC applicable to the claim being viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – (Select a detail) – [Detail Information] – [NDC Details] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – (Select a detail) – [DetailInformation] – [NDC Details]

6.21.2 NDC Details Panel Layout



6.21.3 NDC Details Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Drug Unit Price	The price per unit of the product submitted on a claim.	Field	Number (Decimal)	17
Label Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	30
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	Field	Character	11
NDC Required	This field indicates whether an NDC is required for the HCPCS procedure code submitted.	Field	Character	1
NDC Sequence Number	The NDC Sequence Number.	Field	Number (Integer)	4
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Character	50
Primary NDC	Primary NDC Indicator.	Check Box	N/A	0
UOM	The Unit of Measure code specifying the units in which a value is being expressed.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Unit Quantity Calculated	This is the unit quantity calculated.	Field	Number (Decimal)	15
Unit Quantity Submitted	This is the unit count that the provider submitted. The Drug – not HCPCS – units. May be zero for a single NDC but must be filled in for every NDC if more than one NDC is billed for this detail.	Field	Number (Decimal)	15

6.21.4 NDC Details Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.21.5 NDC Details Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 NDC Details Panel Accessibility

6.21.6.1 To Access the NDC Details Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Detail Information** hyperlink.	Claim Detail Navigation panel displays.
6	Select the **NDC Details** hyperlink from the Claim Detail Navigation panel.	NDC Details panel displays below the Claim Detail panel.

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6.22 NDC Details – Data Correction Panel

6.22.1 NDC Details – Data Correction Panel

The NDC Details Panel for Data Correction is accessed for suspended claims. This panel displays the header and/or detail NDC applicable to the claim being viewed.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Scroll to the NDC Details panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click on “Data Correct” button]

Only authorized users are allowed to perform maintenance tasks.

6.22.2 NDC Details – Data Correction Panel

6.22.3 NDC Details – Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add NDC Detail	Add button to add a new NDC record.	Button	N/A	0
Delete	Delete button to remove any existing NDC record.	Button	N/A	0
Dtl#	Detail number of claim detail.	Combo Box	Number (Integer)	2
Primary NDC	Primary NDC Indicator.	Combo Box	Character	1
Unit of Measure	Code specifying the units in which a value is being expressed.	Combo Box	Character	2
Drug Unit Qty	This is the unit count that the provider submitted. The Drug – not HCPCS – units. May be zero for a single NDC but must be filled in for every NDC if more than one NDC is billed for this detail.	Field	Number (Integer)	15
NDC Code	The National Drug Code	Field	Character	16
Prescip. Num	The prescription number.	Field	Character	50
Seq. Num	Read only field Sequence number for the NDC record.	Field	Number (Integer)	2
Unit Price	Price per unit of product.	Field	Number (Decimal)	17
Unit of Measure (Raw DB Value)	Code specifying the units in which a value is being expressed.	Field	Character	2

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6.22.4 NDC Details – Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
NDC Code	Field	1	INFO : NDC ##### is not on file.	Informational message, saves data with incorrect NDC value.
	Field	2	Only 25 NDC segments per claim detail are allowed.	Enter NDC less than 25.

6.22.5 NDC Details – Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 NDC Details – Data Correction Panel Accessibility

6.22.7 To Access the NDC Details – Data Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.
3	Enter a **Clerk ID** and click **Search**.	
4	Select a row of data.	

6.22.8 To Add on the NDC Details – Data Correction Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate information.	
3	Click on **Save**.	Data Correction Note information is saved.

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6.23 Claim Reference Detail Panel

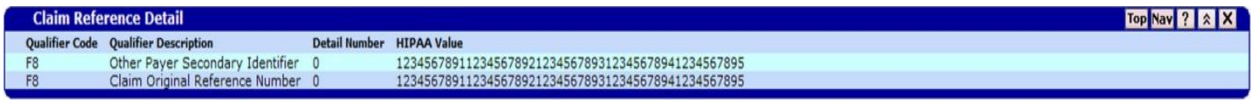
6.23.1 Claim Reference Detail Panel Narrative

Claim Reference Detail Panel. Displays all the claims (both header and detail) data received and stored in the T_CLM_REF table.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DetailInfo] – [Claim Reference Detail] – OR – [Claims] – [Search] – [Enter search criteria] – (Select claim) – [DetailInfo] – [Claim Reference Detail] - OR - [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [DetailInfo] – [Claim Reference Detail]

6.23.2 Claim Reference Detail Panel Layout



6.23.3 Claim Reference Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Detail Number	Applicable detail number. Header - 0.	Listview	Number (Integer)	4
HIPAA Value	HIPAA Value that was submitted.	Listview	Alphanumeric	50
Qualifier Code	Qualifier Code.	Listview	Character	3
Qualifier Description	Description of the Qualifier Code.	Listview	Alphanumeric	80

6.23.4 Claim Reference Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.23.5 Claim Reference Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.23.6 Claim Reference Detail Panel Accessibility

6.23.6.1 To Access the Claim Reference Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Claim Reference Detail** hyperlink from the Claim Detail Navigation panel.	Claim Reference Detail panel displays below the Claim Detail panel.

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6.24 Detail Decision Rules Panel

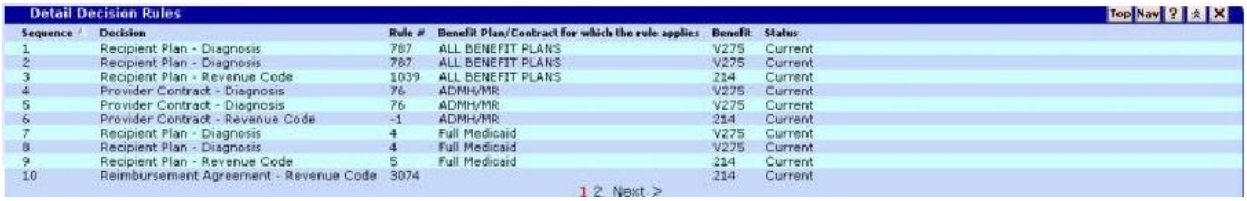
6.24.1 Detail Decision Rules Panel Narrative

The Detail Decision Rules panel displays Detail Decision Rules (Benefit Plan Rules, Assignment Plan Rules, Provider Contract Rules) used to process a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DetailInfo] – [Claim Reference Detail] – OR – [Claims] – [Search] – [Enter search criteria] – (Select claim) – [DetailInfo] – [Detail Decision Rules] - OR - [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [DetailInfo] – [Detail Decision Rules]

6.24.2 Detail Decision Rules Panel Layout



Detail Decision Rules

Sequence	Decision	Rule #	Benefit Plan/Contract for which the rule applies	Benefit	Status
1	Recipient Plan - Diagnosis	787	ALL BENEFIT PLANS	V275	Current
2	Recipient Plan - Diagnosis	787	ALL BENEFIT PLANS	V275	Current
3	Recipient Plan - Revenue Code	1039	ALL BENEFIT PLANS	214	Current
4	Provider Contract - Diagnosis	76	ADMH/MR	V275	Current
5	Provider Contract - Diagnosis	76	ADMH/MR	V275	Current
6	Provider Contract - Revenue Code	-1	ADMH/MR	214	Current
7	Recipient Plan - Diagnosis	4	Full Medicaid	V275	Current
8	Recipient Plan - Diagnosis	4	Full Medicaid	V275	Current
9	Recipient Plan - Revenue Code	5	Full Medicaid	214	Current
10	Reimbursement Agreement - Revenue Code	3074		214	Current

1 2 Next >

6.24.3 Detail Decision Rules Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit	Code used to uniquely identify a benefit. The benefit code may be a Procedure, Diagnosis, National Drug Code (NDC), Diagnosis Related Group (DRG), International Classification of Diseases, or Revenue code depending on the Decision.	Listview	Alphanumeric	11
Benefit Plan/Contract for which the rule applies	Code used to uniquely identify a Benefit Plan or Contract. This represents the Benefit Plan or Contract applicable to the Rule. This field may not always be present depending on the Decision (example Reimbursement Rules or Copay Rules).	Listview	Alphanumeric	50
Decision	Decision for which the rule applies. Examples are Recipient Benefit Plan - Procedure, Recipient Assignment Plan - Diagnosis, Provider Contract – Revenue.	Listview	Alphanumeric	80
Rule #	System assigned key used to uniquely identify a rule within a decision.	Listview	Number (Integer)	9
Sequence	The order in which the rule was applied to the claim.	Listview	Number (Integer)	4
Status	Code used to indicate if a rule on the claim is a current rule ('C') - a rule that was used in the most recent processing	Listview	Character	7

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Field	Description	Field Type	Data Type	Length
	of the claim, or an historical rule ('H') - a rule that was previously used when the claim previously processed.			

6.24.4 Detail Decision Rules Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.24.5 Detail Decision Rules Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Detail Decision Rules Panel Accessibility

6.24.6.1 To Access the Detail Decision Rules Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Detail Decision Rules** hyperlink from the Claim Detail Navigation panel.	Detail Decision Rules panel displays below the Claim Detail panel.

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6.25 Detail EOB Panel

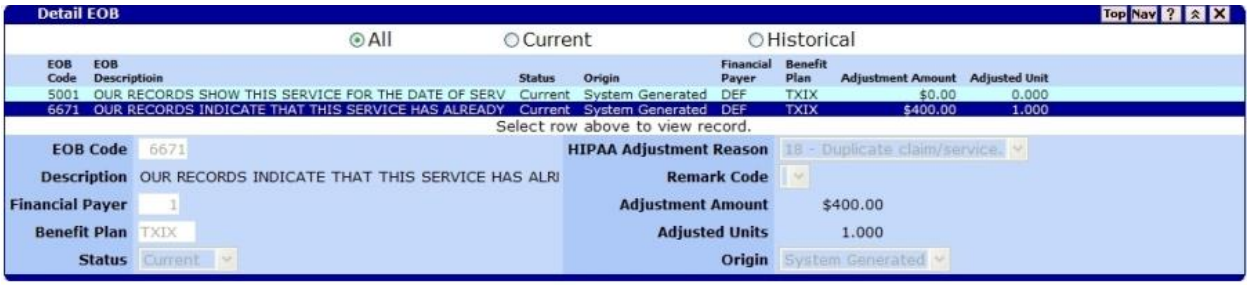
6.25.1 Detail EOB Panel Narrative

The Detail EOB panel is in view-only mode when accessed through Claims Inquiry. The panel is editable when accessed through Data Corrections. This panel displays the EOB codes and messages applicable to the claim that is in suspense. These codes and messages are generated to explain to the provider the reason that the claim is in suspense. In most cases, the same codes are generated to explain the denial of a claim.

This panel is display only.

Navigation Path:[Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail EOB] OR [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail EOB]

6.25.2 Detail EOB Panel Layout



6.25.3 Detail EOB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjusted Units	The quantity adjusted on the detail.	Field	Number (Decimal)	10
Adjustment Amount	The dollar amount adjusted on the detail.	Field	Number (Decimal)	9
All	Selected to display all current and historical EOB detail information.	Combo Boxc	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0
Description	First line of text description for explanation of benefit code.	Field	Character	79
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
HIPAA Adjustment Reason	The Health Insurance Portability and Accountability Act (HIPAA) code explaining why the service or claim paid differently from the billed amount.	Combo Box	Drop Down List Box	0
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Remark Code	HIPAA Remarks code.	Combo Box	Drop Down List Box	0
Status	Code used to indicate whether the explanation of benefit code on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.	Combo Box	Drop Down List Box	0

6.25.4 Detail EOB Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.25.5 Detail EOB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.25.6 Detail EOB Panel Accessibility

6.25.6.1 To Access the Detail EOB Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Detail EOB** hyperlink from the Claim Detail Navigation panel.	Detail EOB panel displays below the Claim Detail panel.

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6.26 Detail Error Panel

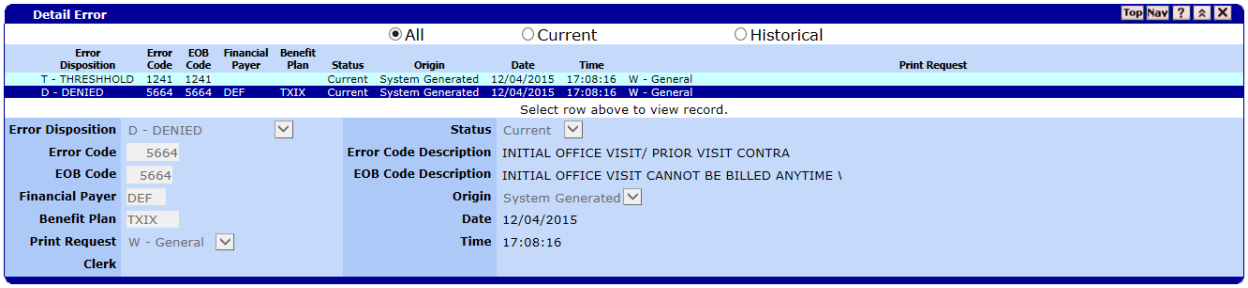
6.26.1 Detail Error Panel Narrative

The Detail Error panel is accessed from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Dental Claim] – [DentalDetailInfo or DetailInformation] – [Detail Error] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [Dental Claim] – [DentalDetailInfo or DetailInformation] – [Detail Error]

6.26.2 Detail Error Panel Layout



6.26.3 Detail Error Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Selected to display all current and historical EOB detail information.	Combo Box	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0
Date	Date of the error code.	Field	Date (MM/DD/CCYY)	8
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
EOB Code Description	Text description for the explanation of benefit code.	Field	Character	79
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Character	4
Error Code Description	Description of the error.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Error Disposition	Disposition of the error.	Combo Box	Drop Down List Box	0
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Print Request	The valid values for this indicator are Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.	Combo Box	Drop Down List Box	0
Status	Code used to indicate whether the explanation of benefit code on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.	Combo Box	Drop Down List Box	0
Time	Time of the error code.	Field	Number (Integer)	8

6.26.4 Detail Error Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.26.5 Detail Error Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Detail Error Panel Accessibility

6.26.6.1 To Access the Detail Error Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Detail Error** hyperlink from the Claim Detail Navigation panel.	Detail Error panel displays below the Claim Detail panel.

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6.27 Detail Health Program Panel

6.27.1 Detail Health Program Panel Narrative

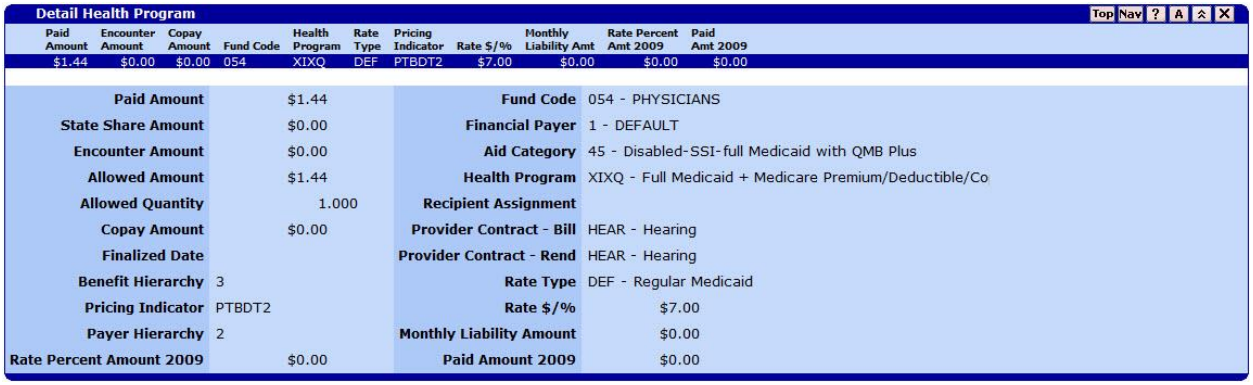
The Detail Health Program panel is applicable for all claim types and can be accessed from the paid, denied, or suspended claim panels. This panel displays the health program applicable to the claim detail being viewed.

This panel is display only.

To access Detail Health Program panel for Dental claims, select the DentalDetailInfo hyperlink from the maintenance window. For all other claim types, select the DetailInformation hyperlink.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail Health Program] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail Health Program]

6.27.2 Detail Health Program Panel Layout



6.27.3 Detail Health Program Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Aid Category for Medicaid coverage.	Field	Character	2
Allowed Amount	Amount allowed for payment on the claim.	Field	Number (Decimal)	9
Allowed Quantity	Number of units allowed under a financial payer/benefit plan.	Field	Number (Integer)	6
Benefit Hierarchy	This is the hierarchical order with which multiple, concurrent benefits assigned to a recipient are processed.	Field	Number (Integer)	9
Copay Amount	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7

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Field	Description	Field Type	Data Type	Length
Encounter Amount	Contains the amount for encounter services on the claim detail indicated by the detail number on table.	Field	Number (Decimal)	10
Finalized Date	Date that financial finalizes the claim for this payer.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Number (Integer)	9
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Listview	Number (Integer)	9
Funding Source	Indicates the budget category that the funds used to pay this claim/detail came from.	Field	Number (Integer)	9
Health Program	Identifies the medical assistance program that is supported in the system.	Field	Character	5
Monthly Liability Amount	The patient financial liability amount that must be paid by the recipient before Medicaid will make payment on the claim.	Field	Number (Decimal)	10
Paid Amount	The total amount paid on the claim.	Field	Number (Decimal)	10
Paid Amount 2009	This field indicates the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	10
Payable Benefit	Unique system assigned key that identifies each row on this table.	Field	Number (Integer)	9
Payer Hierarchy	Payer Hierarchy is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment plans for recipient's who are enrolled in multiple entities of any of these types.	Field	Number (Integer)	9
Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Provider Contract - Bill	Provider contract, under which the service was deemed covered, for the Billing Provider.	Field	Character	20
Provider Contract - Rend	Provider contract, under which the service was deemed covered, for the Rendering Provider.	Field	Character	20
Rate	A daily per diem rate or percentage of charge value depending on the pricing indicator.	Field	Number (Decimal)	9
Rate Percent Amount 2009	This field indicates the rate used to calculate the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	7
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Field	Character	3
Recipient Assignment	This describes the relationships between the Recipient and Provider for purposes of care. This information encompasses the Recipient level of care nursing home information, Provider lock-in information, hospice information, some Provider specific waiver information, and other benefit information that relates a Recipient to a Provider.	Field	Character	5
State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. N/A for Alabama Medicaid.	Field	Number (Decimal)	10

6.27.4 Detail Health Program Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.27.5 Detail Health Program Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.27.6 Detail Health Program Panel Accessibility

6.27.6.1 To Access the Detail Health Program Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Detail Health Program** hyperlink from the Claim Detail Navigation panel.	Detail Health Program panel displays below the Claim Detail panel.

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6.28 Detail Quadrant Cavity Panel

6.28.1 Detail Quadrant Cavity Panel Narrative

The Detail Quadrant Cavity panel displays the oral cavity codes for a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Dental Claim] – [DentalDetailInfo] – [Detail Quadrant Cavity] – OR – [Claims] – [Search] – [Enter search criteria] – (Select a claim) – [Dental Claim] – [DentalDetailInfo] – [Detail Quadrant Cavity]

6.28.2 Detail Quadrant Cavity Panel Layout

6.28.3 Detail Quadrant Cavity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Quadrant Code Cavity	First code identifying the area of the Oral Cavity in which service was rendered.	Combo Box	Drop Down List Box	0

6.28.4 Detail Quadrant Cavity Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.28.5 Detail Quadrant Cavity Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Detail Quadrant Cavity Panel Accessibility

6.28.6.1 To Access the Detail Quadrant Cavity Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **DentalDetailInfo** hyperlink.	Dental Claim Detail Navigation panel displays.

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Step	Action	Response
6	Select the **Detail Quadrant Cavity** hyperlink from the Dental Claim Detail Navigation panel.	Detail Quadrant Cavity panel displays below the Claim Detail panel.

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6.29 Detail Related History Panel

6.29.1 Detail Related History Panel Narrative

The Detail Related History panel is accessed from the paid, denied, or suspended claim panels. The panel displays the related history applicable to the claim detail being viewed.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [DentalDetailInfo or DetailInformation] – [Detail Related History] – OR – [Claims - Search] – [Enter search criteria] – (Select a claim) – [DentalDetailInfo or DetailInformation] – [Detail Related History]

6.29.2 Detail Related History Panel Layout

6.29.3 Detail Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system.	Listview	Number (Integer)	4
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	30
Related Detail	Related detail information to the history claim displayed.	Field	Number (Integer)	4
Related ICN	Internal Control Number of the related claim.	Field	Character	13

6.29.4 Detail Related History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.29.5 Detail Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Detail Related History Panel Accessibility

6.29.6.1 To Access the Detail Related History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the DentalDetailInfo or DetailInformation hyperlink.	Claim Detail Navigation panel displays.
6	Select the **Detail Related History** hyperlink from the Claim Detail Navigation panel.	Detail Related History panel displays below the Claim Detail panel..

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6.30 Additional Claim Information

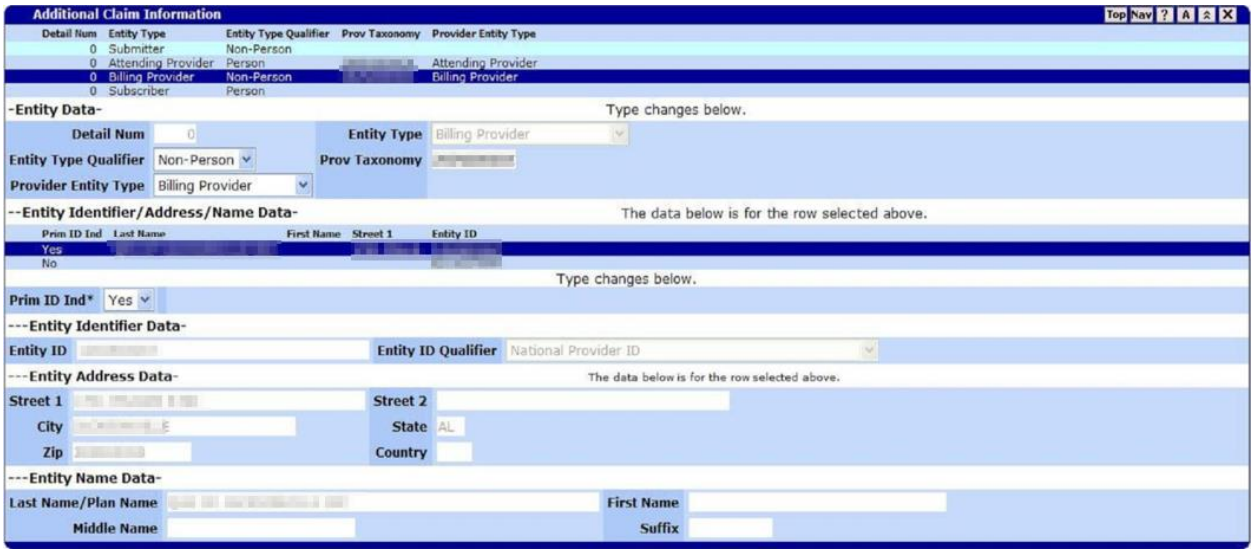
6.30.1 Additional Claim Information Panel Narrative

The Additional Claim Information panel allows the user to examine additional information submitted on the claim including information used to determine the correct service location assigned to a claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Additional Claim Information link] OR [Claims - Search] – [Enter Criteria] – [Select a Claim] – [Select Additional Claim Information link]

6.30.2 Additional Claim Information Panel Layout



6.30.3 Additional Claim Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
City	The city associated with the address for the Recipient/Provider.	Field	Alphanumeric	30
Country	The country associated with the address for the Recipient/Provider.	Listview	Character	3
Detail Num	Detail Number on the claim record (0 indicates Header).	Field	Number (Integer)	4
Entity ID	Entity's primary or secondary ID as specified by the ID qualifier.	Field	Alphanumeric	40
Entity ID Qualifier	The type of Entity ID Qualifier.	Combo Box	Character	2
Entity Type Qualifier	Indicates whether the entity is a person or a non-person.	Combo Box	Alphanumeric	2
First Name	First name of the recipient/provider.	Field	Alphanumeric	35

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Field	Description	Field Type	Data Type	Length
Last Name/Plan Name	Last name of the recipient/provider or the name of the organization.	Field	Alphanumeric	60
Middle Name	Middle name of the recipient/provider.	Field	Alphanumeric	25
Prim ID Ind	Indicates whether the ID is a primary (Y) or secondary (N) ID for the entity.	Combo Box	Character	1
Entity Type	Code that indicates if the information is for Recipient or Provider.	Listview	Character	3
Prov Taxonomy	The unique identifier for the entity type specified by the qualifier.	Field	Alphanumeric	30
Provider Entity Type	The type of practice for a provider.	Combo Box	Alphanumeric	3
State	The state associated with the address for the Recipient/Provider.	Field	Character	2
Street 1	The first address line of the recipient/provider.	Field	Alphanumeric	55
Street 2	The second address line of the recipient/provider.	Field	Alphanumeric	55
Suffix	Name suffix of the recipient/provider.	Field	Alphanumeric	10
Zip	The zip code associated with the address for the recipient/provider.	Field	Number (Integer)	15

6.30.4 Additional Claim Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 Additional Claim Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 Additional Claim Information Panel Accessibility

6.30.6.1 To Access the Additional Claim Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.

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Step	Action	Response
2	Point to **Claims** and click **Information**.	Claim Information Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Additional Claim Information** from the Claim Information Maintenance panel.	Additional Claim Information panel displays below the Claim Detail panel.

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6.31 Attachment Panel

6.31.1 Attachment Panel Narrative

The Attachment panel displays the Attachment Control Numbers (ACN) that are applicable to the claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Attachments link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Attachments link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Attachments link from the displayed panel]

6.31.2 Attachment Panel Layout

6.31.3 Attachment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ACN	The attachment control number associated with an attachment that is being sent by the provider for an electronically submitted claim.	Listview	Character	80
Attachment Indicator	Indicates if the attachment has been received.	Listview	Character	3
Detail Number	The detail number of a claim record.	Listview	Number (Integer)	4

6.31.4 Attachment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.31.5 Attachment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.31.6 Attachment Panel Accessibility

6.31.6.1 To Access the Attachment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Mini Search panel displays.
3	Enter **ICN** or an error message is displayed**.**	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Attachment** link from the maintenance item panel.	Attachment panel displays below the Claim Detail panel.

6.31.6.2 To Update the Attachment Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Attachment** from the Claim Information navigation panel.	Attachment panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click on **Save**.	Attachment data is saved.

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6.32 CAS Inquiry Panel

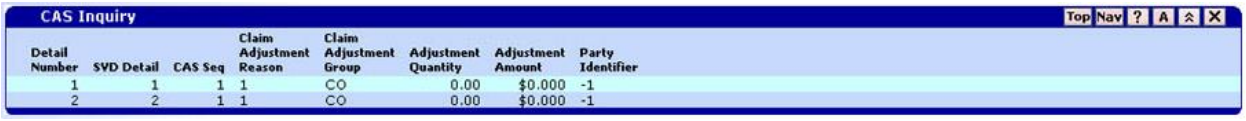
6.32.1 CAS Inquiry Panel Narrative

The CAS Inquiry Panel is used to view the Claim Level Adjustment Segments returned to the provider on the 835 transaction. The codes and amounts come directly from the 835 (RA) to report prior payers claim level adjustments which cause the paid amount to differ from the original paid amount.

This panel is display only.

Navigation Path: [Claims] - [Information] - (Enter ICN and click Search button) - [Physician/Dental/UB04 Claim] - [CAS Inquiry]

6.32.2 CAS Inquiry Panel Layout



CAS Inquiry

Detail Number	SVD Detail	CAS Seq	Claim Adjustment Reason	Claim Adjustment Group	Adjustment Quantity	Adjustment Amount	Party Identifier
1	1	1	1	CO	0.00	$0.000	-1
2	2	1	1	CO	0.00	$0.000	-1

6.32.3 CAS Inquiry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	Monetary amount of the adjustment. Format 9999999.99.	Field	Number (Decimal)	9
Adjustment Quantity	Number of units of service being adjusted. Format 999999.99.	Field	Number (Decimal)	8
CAS Seq	Identifies the iteration number for the Claim Level Adjustment Segments. A maximum of 99 Claim Level Adjustment Segments are allowed for a claim detail and 5 for the claim header.	Field	Number (Integer)	4
Claim Adjustment Group	Code identifying the general category of a payment adjustment.	Field	Character	2
Claim Adjustment Reason	Code identifying the detailed reason the adjustment was made.	Field	Character	2
Detail Number	Detail number on the claim record.	Field	Number (Integer)	4
Party Identifier	Unique identifier to identify a unique payer related to a claim.	Field	Character	80
SVD Detail	The SVD Detail (Service Line Adjudication) is the name of a segment sent in on a 837 claim file. It is returned on the CAS segment on the 835. The SVD on a claim will contain detail level adjustments.	Field	Number (Integer)	4

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6.32.4 CAS Inquiry Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.32.5 CAS Inquiry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 CAS Inquiry Panel Accessibility

6.32.6.1 To Access the Attachment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Mini Search panel displays.
3	Enter **ICN** or an error message is displayed**.**	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Attachment** link from the maintenance item panel.	Attachment panel displays below the Claim Detail panel.

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6.33 Cash Disposition Panel

6.33.1 Cash Disposition Panel Narrative

The Cash Disposition Panel is used to access cash-related information related to a particular adjustment. It displays the Cash Control Number (CCN), sequence number, and the refund (disposition) amount of the adjustment claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Cash Disposition link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Cash Disposition link from the displayed panel]

6.33.2 Cash Disposition Panel Layout

6.33.3 Cash Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	The Cash Control Number (CCN) associated with the adjustment transaction.	Listview	Character	11
Disposition Amount	The refund (disposition) amount for that line.	Listview	Number (Decimal)	10
Sequence	The disposition sequence number associated with the line. Each individual disposition to a check is given its own sequence number.	Listview	Number (Integer)	4

6.33.4 Cash Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 Cash Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 Cash Disposition Panel Accessibility

6.33.6.1 To Access the Cash Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Mini Search panel displays.
3	Enter **ICN** or an error message is displayed.	

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Step	Action	Response
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Cash Disposition** link from the maintenance item panel.	Cash Disposition panel displays below the Claim Detail panel.

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6.34 Check Panel

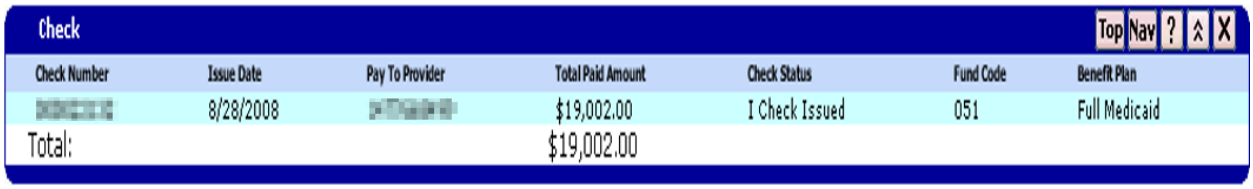
6.34.1 Check Panel Narrative

The Check panel allows the user to view the total amount paid from the current Remittance Advice (RA) for a specific claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Check link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Check link from the displayed panel]

6.34.2 Check Panel Layout



6.34.3 Check Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Listview	Character	30
Check Status	The status of the check.	Listview	Character	30
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Listview	Number (Integer)	9
Issue Date	The date when the check was issued or the electronic funds transfer was sent.	Listview	Date (MM/DD/CCYY)	8
Pay To Provider	The Provider who received the check or electronic funds transfer.	Listview	Character	10
Total Paid Amount	The total amount that was issued/paid to the provider.	Listview	Number (Decimal)	11
Check Number	This field displays the number of the check the provider received, or the number of the Electronic Funds Transfer.	Listview	Number (Integer)	9

6.34.4 Check Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.34.5 Check Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Check Panel Accessibility

6.34.6.1 To Access the Check Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Mini Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Check** link from the maintenance item panel.	Check Panel displays below the Claim Detail panel.

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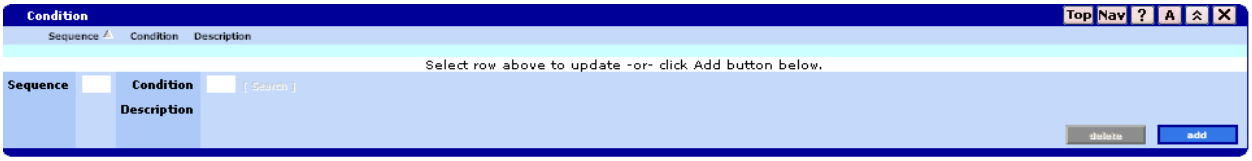
6.35 Condition Panel

6.35.1 Condition Panel Narrative

The Condition panel displays the Condition Codes applicable to the claim. These codes are generated to identify conditions relating to the claim that may affect payer processing. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select Condition link from the displayed panel] – OR – [Claims] –[Search] – [Enter Criteria] – [Select a UB04 claim] – [Select Condition link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list] – [Select Condition link from the displayed panel]

6.35.2 Condition Panel Layout



6.35.3 Condition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new Condition Code.	Button	N/A	0
Condition	A code used to identify conditions relating to the claim that may affect payer processing.	Field	Number (Integer)	2
Delete	Allows a user to delete a Condition Code.	Button	N/A	0
Description	Description of the condition.	Field	Character	50
Sequence	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	2

6.35.4 Condition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Condition	Field	1	A valid Condition Code is required.	Enter a valid Condition Code or select a valid value from the [Search] panel.
	Field	107	Exceed maximum number of condition codes.	The maximum number of condition codes is 24.
Sequence	Field	1	Sequence contains duplicates.	Please select a sequence number that has not already been used.

6.35.5 Condition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.35.6 Condition Panel Accessibility

6.35.6.1 To Access the Condition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter a **UB04 ICN** or an error message is displayed.	
4	Click **Search**.	UB04 Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Condition** from the maintenance panel.	Condition panel displays below the Claim Detail panel.

6.35.6.2 To Add on the Condition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate data.	
3	Click on **Save**.	Condition information saved.

6.35.6.3 To Delete on the Condition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.35.6.4 To Update the Condition Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Condition** from the Claim Information navigation panel.	Condition panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Condition data is saved.

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6.36 Data Correction Note Panel

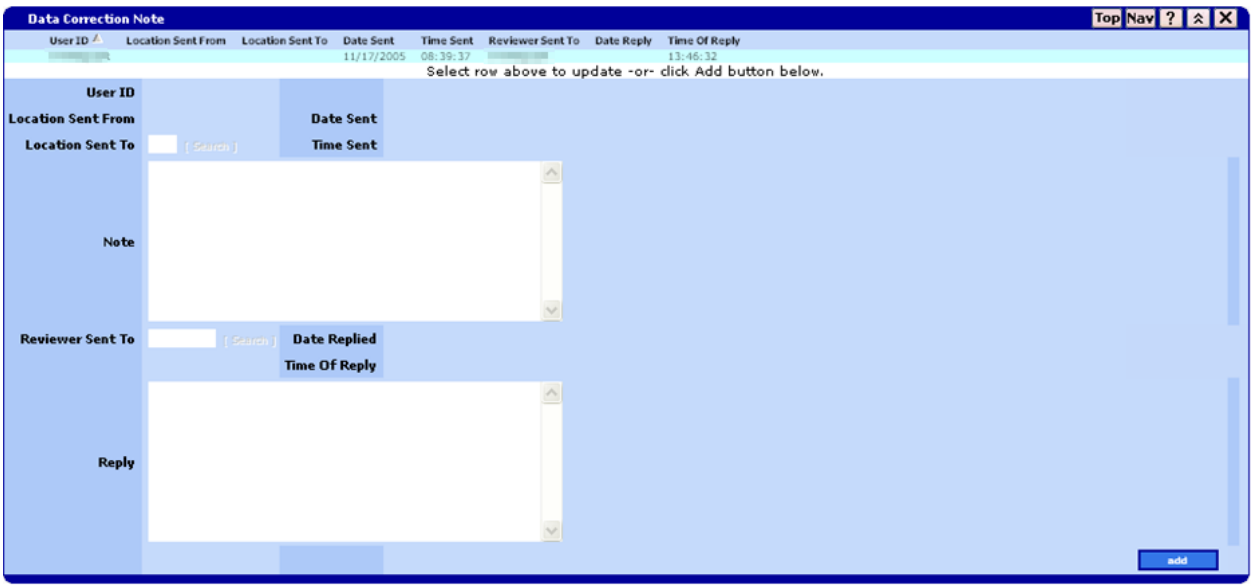
6.36.1 Data Correction Note Panel Narrative

The Data Correction Note panel is used by resolutions staff to forward questions to other people. Once the answer is received, the appropriate action can be taken by the note originator. When a note is sent, the claim is assigned to the location indicated on the note and reassigned to the new location the next time the claims scheduler is run to assign claims.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Data Correction Note link from the displayed panel]

6.36.2 Data Correction Note Panel Layout



6.36.3 Data Correction Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new location note.	Button	N/A	0
Date Replied	The date the reply is sent.	Field	Date (MM/DD/CCYY)	8
Date Sent	The date the note is sent.	Field	Date (MM/DD/CCYY)	8
Location Sent From	The location that the note originates from. The user is required to use the [Search] to select a value.	Field	N/A	0
Location Sent To	The location that the note is being sent to. The user is required to use the [Search] to select a value.	Field	N/A	0
Note	The note that is sent.	Field	Character	256

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Field	Description	Field Type	Data Type	Length
Reply	The note containing the reply.	Field	Character	256
Reviewer Sent To	The identification of the person who reviews the note. The user is required to use the [Search] to select a value.	Field	N/A	0
Time Of Reply	The time that the reply is sent.	Field	Character	6
Time Sent	The time that the note is sent.	Field	Character	6
User ID	The identification of the User (clerk) who originates the note.	Field	Character	8

6.36.4 Data Correction Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Location Sent To	Field	1	A valid Location Sent To is required	Select a value for the Location from the [Search] panel.
Note	Field	1	Note is required.	Enter text for the note description.
Reviewer Sent To	Field	1	A valid Reviewer Sent To is required.	Select a User ID from the [Search] panel.

6.36.5 Data Correction Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 Data Correction Note Panel Accessibility

6.36.6.1 To Access the Data Correction Note Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.
3	Enter a **Clerk ID** and click **Search**.	
4	Select a row of data.	

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Step	Action	Response
5	Select **Data Correction Note** from the Physician Claim maintenance panel.	Data Correction Note panel displays.

6.36.6.2 To Add on the Data Correction Note Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate information.	
3	Click on **Save**.	Data Correction Note information is saved.

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6.37 Decision Rules Panel

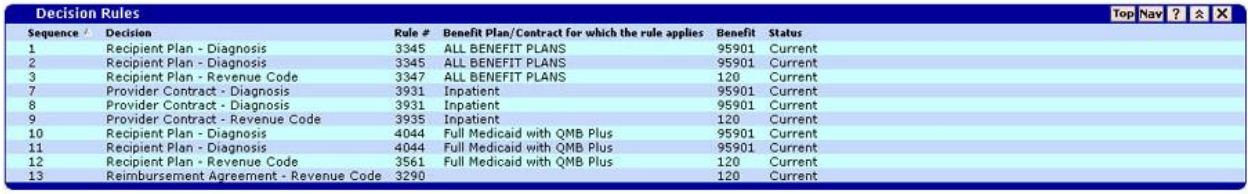
6.37.1 Decision Rules Panel Narrative

The Decision Rules panel displays Decision Rules (Benefit Plan Rules, Assignment Plan Rules, Provider Contract Rules) used to process a claim. *This panel is a new functionality and did not exist in the legacy system.*

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter ICN and click search button] – [Claim] – Decision Rules]

6.37.2 Decision Rules Panel Layout



Decision Rules

Sequence	Decision	Rule #	Benefit Plan/Contract for which the rule applies	Benefit	Status
1	Recipient Plan - Diagnosis	3345	ALL BENEFIT PLANS	95901	Current
2	Recipient Plan - Diagnosis	3345	ALL BENEFIT PLANS	95901	Current
3	Recipient Plan - Revenue Code	3347	ALL BENEFIT PLANS	120	Current
7	Provider Contract - Diagnosis	3931	Inpatient	95901	Current
8	Provider Contract - Diagnosis	3931	Inpatient	95901	Current
9	Provider Contract - Revenue Code	3935	Inpatient	120	Current
10	Recipient Plan - Diagnosis	4044	Full Medicaid with QMB Plus	95901	Current
11	Recipient Plan - Diagnosis	4044	Full Medicaid with QMB Plus	95901	Current
12	Recipient Plan - Revenue Code	3561	Full Medicaid with QMB Plus	120	Current
13	Reimbursement Agreement - Revenue Code	3290		120	Current

6.37.3 Decision Rules Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit	Code used to uniquely identify a benefit. The benefit code may be a Procedure, Diagnosis, National Drug Code (NDC), Diagnosis Related Group (DRG), International Classification of Diseases, or Revenue code depending on the Decision.	Listview	Alphanumeric	11
Benefit Plan/Contract for which the rule applies	Code used to uniquely identify a Benefit Plan or Contract. This represents the Benefit Plan or Contract applicable to the Rule. This field may not always be present depending on the Decision (example Reimbursement Rules or Copay Rules).	Listview	Alphanumeric	50
Decision	Decision for which the rule applies. Examples are Recipient Benefit Plan – Procedure, Recipient Assignment Plan – Diagnosis, Provider Contract – Revenue.	Listview	Alphanumeric	80
Rule #	System assigned key used to uniquely identify a rule within a decision.	Listview	Number (Integer)	9
Sequence	The order in which the rule was applied to the claim.	Listview	Number (Integer)	4
Status	Code used to indicate if a rule on the claim is a current rule ('C') – a rule that was used in the most recent processing	Listview	Character	7

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Field	Description	Field Type	Data Type	Length
	of the claim, or an historical rule ('H') – a rule that was previously used when the claim previously processed.			

6.37.4 Decision Rules Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.37.5 Decision Rules Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Decision Rules Panel Accessibility

6.37.6.1 To Access the Decision Rules Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select Decision Rules.	Decision Rules panel displays below the Claim Detail panel.

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6.38 Diagnosis Panel

6.38.1 Diagnosis Panel Narrative

The Diagnosis panel displays the diagnosis codes applicable to the claim. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Diagnosis link from the displayed panel] – OR – [Claims] –[Search] – [Enter Criteria] – [Select a claim] – [Select Diagnosis link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Diagnosis link from the displayed panel]

6.38.2 Diagnosis Panel Layout for Non-UB Claims

Diagnosis

Sequence	ICD Version	Diagnosis	Description
5	9	1234	DIPHYLLOBOTHRIASIS, INTESTINAL
3	9	2899	UNSPECIFIED DISEASES OF BLOOD AND BLOOD-
1	9	34540	PARTIAL EPILEPSY,W IMPAIRMENT OF CONSCIO
A	9	34540	PARTIAL EPILEPSY,W IMPAIRMENT OF CONSCIO
4	9	4011	BENIGN ESSENTIAL HYPERTENSION
2	9	9661	POISONING BY HYDANTOIN DERIVATIVES

6.38.2.1 Diagnosis Panel Layout for UB Claims

Diagnosis

Sequence	ICD Version	Diagnosis	Description	POA Indicator	POA Indicator Description
4	9	V270	MOTHER WITH SINGLE LIVEBORN	Y	DIAGNOSIS WAS PRESENT AT TIME OF INPATIENT ADMISSION
3	9	05410	GENITAL HERPES, UNSPECIFIED	N	DIAGNOSIS WAS NOT PRESENT AT TIME OF INPATIENT ADMISSION
2	9	64761	OTHER VIRAL DISEASES OF MOTHER, WITH DEL	1	EXEMPT FROM POA REPORTING.
1	9	64511	POST TERM PREGNANCY, OVER 40 WEEKS TO 42	U	DOCUMENTATION INSUFFICIENT TO DETERMINE IF CONDITION WAS PRESENT AT TIME OF INPATIENT ADMISSION
A	9	64511	POST TERM PREGNANCY, OVER 40 WEEKS TO 42	W	CLINICALLY UNDETERMINED IF THE CONDITION WAS PRESENT AT THE TIME OF INPATIENT ADMISSION

6.38.3 Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the Diagnosis Code, a short nomenclature for a medical condition.	Field	Character	50
Diagnosis	A code for the condition requiring medical attention. The medical classification of a disease or condition according to ICD.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
POA Indicator	The Present On Admission (POA) field indicates if a recipient's condition existed at the time of admission. It applies only to Inpatient hospital claims and is required for a specific set of diagnosis codes in order to be paid. Valid values are: Y - Diagnosis was present at time of inpatient admission. W - Clinically undetermined if the condition was present at the time of inpatient admission. N - Diagnosis was not present at time of inpatient admission. U - Documentation insufficient to determine if condition was present at time of inpatient admission. 1 - Exempt from POA reporting.	Field	Alphanumeric	1

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Field	Description	Field Type	Data Type	Length
	Blank - Exempt from POA reporting.			
POA Indicator Description	Describes the corresponding POA Indicator code.	Field	Character	100
Sequence	Sequential order of the Diagnosis Codes submitted on the claim.	Field	Number (Integer)	2

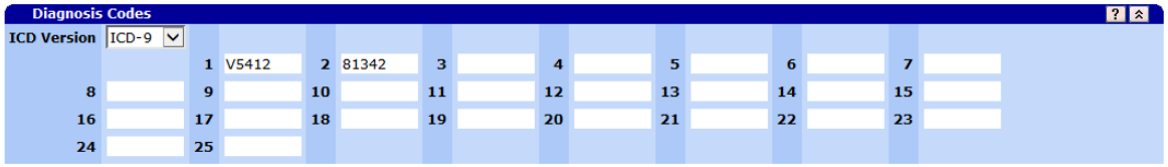
6.38.4 Diagnosis Codes – Data Correction Panel

The Diagnosis Codes panel displays the diagnosis codes applicable to the claim. Edits to diagnosis codes can be made via Data Correction.

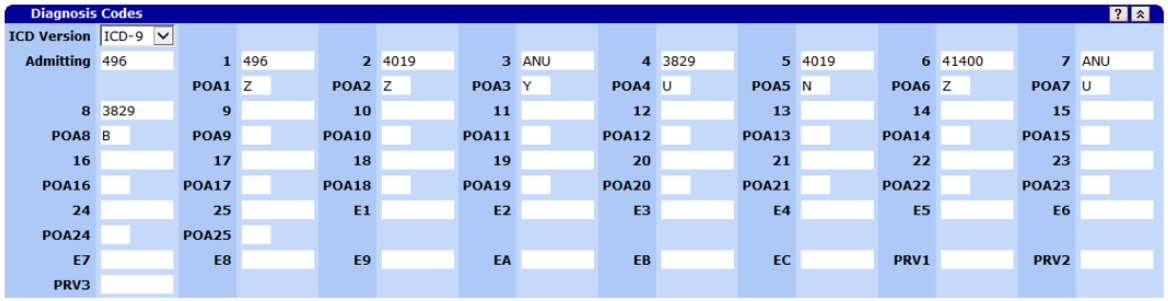
Navigation Path**:** [Claims**] –** [Data Correction] – [Enter Clerk ID**,** search then select a claim from the list] – [scroll down to Diagnosis panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click the "Data Correct" button]

6.38.5 Diagnosis Codes Panel Layout – Data Correction Panel

DC Panel for Non-UB Claim



DC Panel for UB Claim



6.38.6 Diagnosis Codes Panel Field Descriptions – Data Correction Panel

Field	Description	Field Type	Data Type	Length
Admitting	The admitting diagnosis code field.	Field	Character	7
Diagnosis 1, 2, 3, etc.	Sequence numbers for the related diagnosis code fields.	Field	Character	7
Emergency E1, E2, E3, etc.	The emergency diagnosis code field.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
POA 1,2,3, etc	POA1-POA25: Present On Admission (POA) indicator field displays the POA value for the related diagnosis code. Each diagnosis code has one present on admission indicator.	Field	Alphanumeric	1
PRV 1, 2 and 3.	PRV 1, 2, 3 codes for Patient Reason Visit fields.	Field	Character	7

6.38.7 Diagnosis Panel Field Edit Error Codes - Data Correction Panel

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis	Field	1	A valid Diagnosis is required.	Enter a valid Diagnosis Code.
	Field	2	Diagnosis must be less than or equal to 7.	Enter a valid Diagnosis Code.
POA 1,2,3, etc	Field	1	POA Indicator not on file.	Enter correct POA indicator or even can be left null.

6.38.8 Diagnosis Panel Extra Features - Data Correction Panel

Field	Field Type
No extra features found for this panel.	

6.38.9 Diagnosis Panel Accessibility- Data Correction Panel

Field	Field Type
No extra features found for this panel.	

6.38.10 To Access the Diagnosis Panel - Data Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

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Step	Action	Response
5	Select the **Diagnosis** hyperlink from the Claim Detail Navigation panel.	Diagnosis panel displays below the Claim Detail panel.

6.38.11 To Update the Diagnosis Panel - Data Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Diagnosis** from the Claim Information navigation panel.	Diagnosis panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Diagnosis data is saved.

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6.39 Display TCN Panel

6.39.1 Display TCN Panel Narrative

The Display TCN panel shows the transaction control number (TCN) number associated with the claim.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Display TCN link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Display TCN link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Display TCN link from the displayed panel]

6.39.2 Display TCN Panel Layout

6.39.3 Display TCN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
TCN	The transaction control number (TCN) used to uniquely identify claims on the previous MMIS.	Field	Character	17

6.39.4 Display TCN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.39.5 Display TCN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 Display TCN Panel Accessibility

6.39.6.1 To Access the TCN Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Display TCN** hyperlink from the Claim Detail Navigation panel.	Display TCN panel displays below the Claim Detail panel.

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6.39.6.2 To Update the TCN Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **TCN** from the Claim Information navigation panel.	TCN panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	TCN data is saved.

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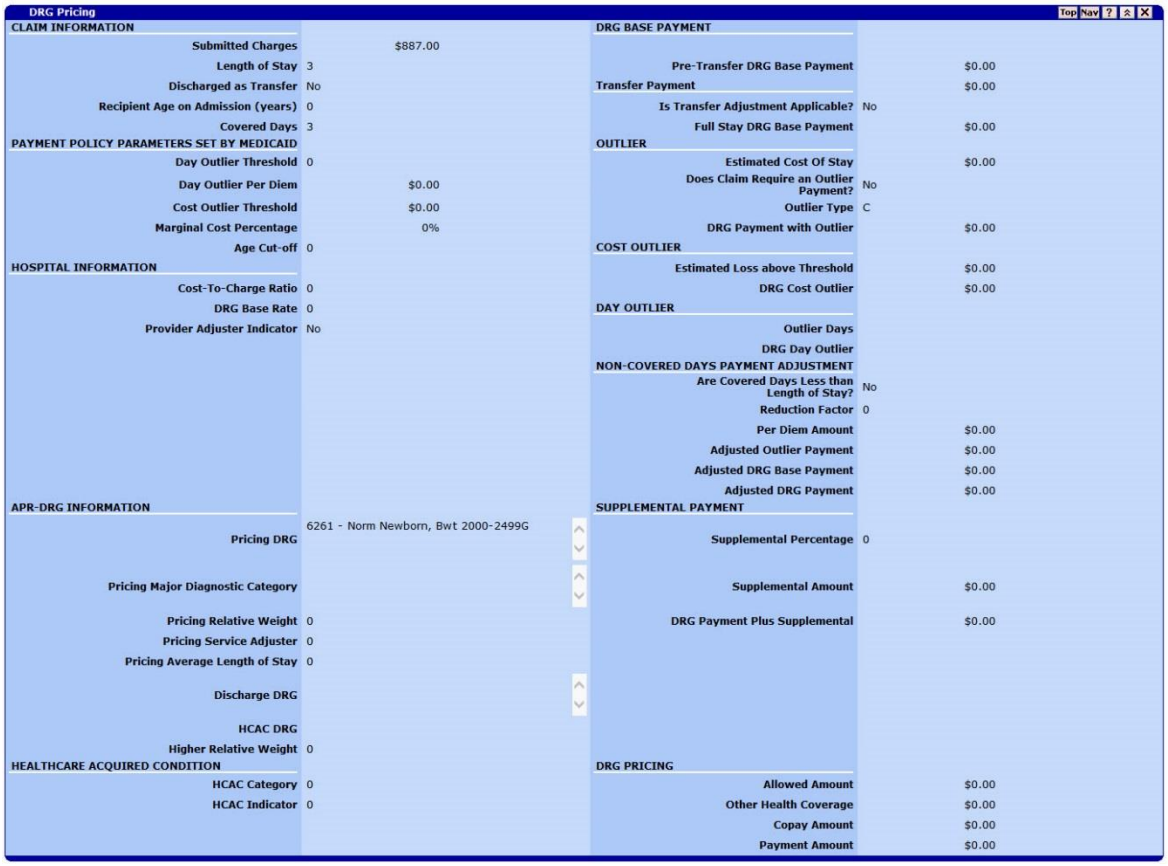
6.40 DRG Pricing Panel

6.40.1 DRG Pricing Panel Narrative

The Diagnosis Related Group (DRG) Assignment and Pricing panel displays DRG related data for an inpatient claim.

Navigation Path: [Claims] – [Search] – [Enter an ICN for a UB04 claim] – [Select DRG Pricing link from the UB04 Claim Navigation panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select DRG Pricing link from the UB04 Claim Navigation panel].

6.40.2 DRG Pricing Panel Layout



6.40.3 DRG Pricing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjusted DRG Base Payment	DRG base payment adjusted by the non-covered days. Excludes outlier.	Field	Number (Decimal)	9
Adjusted DRG Payment	DRG payment adjusted by the non-covered days. Includes outlier.	Field	Number (Decimal)	9
Adjusted Outlier Payment	Outlier payment adjusted by the non-covered days.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Age Cut-off	The age cutoff used in applying the adult or pediatric DRG service adjuster. If the recipient is less than the cutoff, the pediatric service adjuster will be applied; otherwise, the adult service adjuster will be applied.	Field	Number	3
Allowed Amount	Claim allowed amount.	Field	Number (Decimal)	9
Are Covered Days Less than Length of Stay?	Yes or No. Compare length of inpatient stay to the covered days.	Field	Character	3
Copay Amount	Claim copayment amount.	Field	Number (Decimal)	9
Cost Outlier Threshold	Dollar amount set by Medicaid as the threshold for a cost outlier payment.	Field	Number (Decimal)	9
Cost-To-Charge Ratio	Hospital cost to charge ratio used in calculating a cost outlier.	Field	Number (Decimal)	6
Covered Days	Number of covered days on the claim after non-covered days adjustment.	Field	Number (Integer)	4
Day Outlier Per Diem	This is the day outlier per diem amount.	Field	Number (Decimal)	9
Day Outlier Threshold	This is the day outlier threshold.	Field	Number (Integer)	4
Discharge DRG	DRG code assigned to the claim for non-HCAC diagnoses and procedures.	Field	Character	60
Discharged as Transfer	Is the patient status a transfer status? Yes or No.	Field	Character	3
Does Claim Require an Outlier Payment?	Length of inpatient stay in days.	Field	Number (Decimal)	4
DRG Base Rate	Hospital base rate amount.	Field	Number (Decimal)	9
DRG Cost Outlier	This is the outlier amount if the outlier type is ‘C’ for Cost.	Field	Number (Decimal)	4
DRG Day Outlier	This is the outlier amount if the outlier type is ‘D’ for Day. It is calculated as Outlier Days x Day Outlier Per Diem.	Field	Number (Decimal)	9
DRG Payment Plus Supplemental	Final DRG payment amount plus the supplemental amount.	Field	Number (Decimal)	9
DRG Payment with Outlier	DRG full stay payment plus the outlier amount.	Field	Number (Decimal)	4

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Field	Description	Field Type	Data Type	Length
Estimated Cost Of Stay	The estimated cost of stay for provider for the claim.	Field	Number (Decimal)	4
Estimated Loss above Threshold	Provider estimated cost – DRG full stay – outlier threshold.	Field	Number (Decimal)	4
Full Stay DRG Base Payment	DRG base payment after the transfer adjustment is applied.	Field	Number (Decimal)	4
HCAC Category	HCAC diagnosis category returned by the grouper.	Field	Character	2
HCAC DRG	DRG code assigned to the claim for HCAC diagnoses and procedures. HCAC = Health Care Acquired Condition.	Field	Character	60
HCAC Indicator	HCAC DRG code involvement to the claim. Values spaces = No HCAC found, 1 = HCAC found but DRG did not change, 2 = HCAC found and affected DRG assignment.	Field	Character	1
Higher Relative Weight	Relative weight assigned to the DRG with the highest relative weight if there are two DRGs.	Field	Number (Decimal)	7
Is Transfer Adjustment Applicable?	Yes if the claim is a transfer. No if the claim is not a transfer.	Field	Number (Decimal)	4
Length of Stay	Length of inpatient stay in days.	Field	Number	4
Marginal Cost Percentage	Percentage amount set by Medicaid to calculate the cost outlier.	Field	Number (Decimal)	9
Other Health Coverage	Claim TPL amount.	Field	Number (Decimal)	9
Outlier days	This contains the number of days used for the day outlier calculation. It is calculated as Length Of Stay – Day Outlier Threshold. Negative result will show as zero.	Field	Number (Integer)	9
Outlier Type	This is the outlier type. C = Cost, D = Day. C (cost) will be the default and will be set even if the claim has no outlier amount.	Field	Character	1
Payment Amount	Claim paid amount.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Per Diem Amount	The per deim amount of the DRG payment. This will be zero if there are no non-covered days.	Field	Number (Decimal)	9
Pre-Transfer DRG Base Payment	DRG base payment prior to any transfer adjustment.	Field	Number (Decimal)	4
Pricing Average Length of Stay	Average length of inpatient stay for the pricing DRG.	Field	Number (Decimal)	5
Pricing DRG	DRG code used to price the claim. If there are two DRG codes on the claim, this will be the lower weight DRG.	Field	Character	60
Pricing Major Diagnostic Category	Major Diagnostic Category of the pricing DRG.	Field	Character	42
Pricing Relative Weight	Relative weight associated to the pricing DRG.	Field	Number (Decimal)	7
Pricing Service Adjuster	Service adjuster associated to the pricing DRG and the age of the recipient on the admit date.	Field	Number (Decimal)	6
Provider Adjuster Indicator	The Provider Adjuster Indicator.	Field	Character	3
Recipient Age on Admission (years)	Recipient age in years as of the admission date of the claim.	Field	Number	3
Reduction Factor	The non-covered days reduction factor.	Field	Number (Decimal)	6
Submitted Charges	Claim total billed amount.	Field	Number (Decimal)	9
Supplemental Amount	Supplemental amount.	Field	Number (Decimal)	9
Supplemental Percentage	Supplemental percentage to be applied to the claim from the DRG payment.	Field	Number (Decimal)	7
Transfer Payment	Payment calculated for a transfer status claim. This will be zero if the claim is not a transfer.	Field	Number (Decimal)	4

6.40.4 DRG Pricing Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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60.40.5 DRG Pricing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 DRG Pricing Panel Accessibility

6.40.6.1 To Access the DRG Pricing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **DRG Pricing** hyperlink from the Claim Detail Navigation panel.	DRG Pricing panel displays below the Claim Detail panel.

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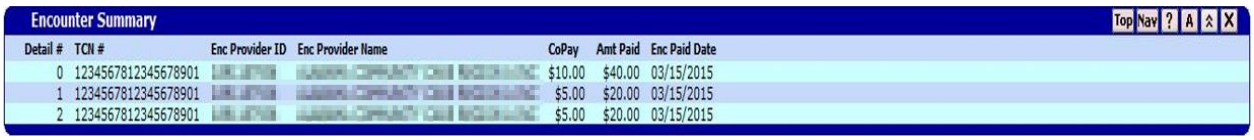
6.41 Encounter Summary Panel

6.41.1 Encounter Summary Panel Narrative

The Encounter Summary panel displays the Encounter information submitted on an encounter claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for an Encounter claim] – [Select Encounter Summary link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select an Encounter claim] – [Select Encounter Summary link from the displayed panel]

6.41.2 Encounter Summary Panel Layout



6.41.3 Encounter Summary Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amt Paid	This field displays the payment amount submitted by the Enc Provider Id.	Field	Number (Decimal)	9
CoPay	This field displays the amount of copay submitted by the Enc Provider Id.	Field	Number (Decimal)	9
Detail #	This field displays the claim detail number to which the data applies. A detail number of 0 (zero) indicates header data.	Field	Number (Integer)	4
Enc Paid Date	This field displays the date of payment submitted by the Enc Provider Id.	Field	Date (MM/DD/CCYY)	8
Enc Provider Id	This field displays the submitted Provider Identification Number.	Field	Character	60
Enc Provider Name	This field displays the name submitted by the Enc Provider Id.	Field	Character	60
TCN #	This field displays the transaction control number submitted by the Enc Provider Id.	Field	Character	15

6.41.4 Encounter Summary Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.41.5 Encounter Summary Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 Encounter Summary Panel Accessibility

6.41.6.1 To Access the Encounter Summary Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Navigation and Claim Detail panels are displayed.
5	Select the **Encounter Summary** hyperlink from the Claim Navigation panel.	**Encounter Summary** panel displays below the Claim Detail panel.

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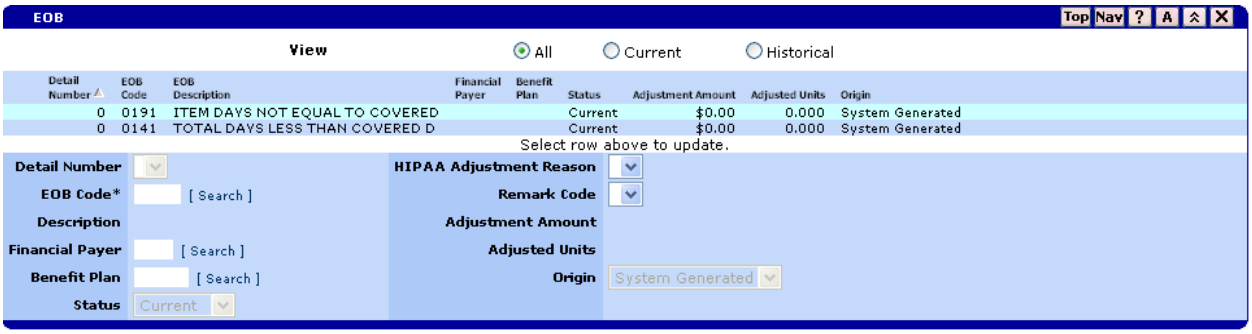
6.42 EOB Panel

6.42.1 EOB Panel Narrative

The EOB (Explanation of Benefit) panel is in view-only mode when accessed through Claims Inquiry. The panel is editable when accessed through Data Corrections. The Claim EOB Codes panel displays the EOB codes and messages applicable to the claim that is in suspense. These codes and messages are generated to explain to the provider the reason that the claim is in suspense. In most cases, the same codes are generated to explain the denial of a claim. Records may be added or deleted from this panel. The EOB Code and Detail number can be changed. Due to the data-relationship between EOB code and the HIPAA Adjustment Reason and Remarks Code fields, the latter 2 fields cannot be changed. Instead, when the EOB Code is changed, those other 2 fields are updated (they derive their value from the EOB Code and its Effective Date). If there are no corresponding HIPAA Adjustment Reasons or Remarks Codes for a given EOB Code, the panel displays those fields blank. The Adjustment Amt and Adjustment Units fields are updated in batch and are non-editable in the panel. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select EOB link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select EOB link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select EOB link from the displayed panel]

6.42.2 EOB Panel Layout



6.42.3 EOB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Selected to display all current and historical EOB detail information.	Combo Box	Radio Button	0
Adjusted Units	The quantity adjusted on the detail.	Field	Number (Decimal)	10
Adjustment Amount	The dollar amount adjusted on the detail.	Field	Number (Decimal)	9
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Current	Selected to display all current EOB detail information.	Combo Box	Radio Button	0

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Field	Description	Field Type	Data Type	Length
Detail Number	The detail number to which the Explanation of Benefit message is attached.	Field	Number (Integer)	4
EOB Code	Code number attached to an Explanation of Benefit message.	Field	Character	4
(EOB) Description	First line of text description for Explanation of Benefit code.	Field	Character	79
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
HIPAA Adjustment Reason	The Health Insurance Portability and Accountability Act (HIPAA) code explaining why the service or claim paid differently from the billed amount.	Combo Box	Drop Down List Box	0
Historical	Selected to display all historical EOB detail information.	Combo Box	Radio Button	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Remark Code	The code for the remarks.	Combo Box	Drop Down List Box	0
Status	Indicates whether the Explanation of Benefit is current or history.	Combo Box	Drop Down List Box	0

6.42.4 EOB Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select one from the [Search] panel.
EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
	Field	2	A valid EOB Code is required.	Enter a valid EOB Code or select a valid code from the [Search] panel.

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6.42.5 EOB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 EOB Panel Accessibility

6.42.6.1 To Access the EOB Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **EOB** hyperlink from the Claim Detail Navigation panel.	EOB panel displays below the Claim Detail panel.

6.42.6.2 To Update the EOB Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **EOB** from the Claim Information navigation panel.	EOB panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	EOB data is saved.

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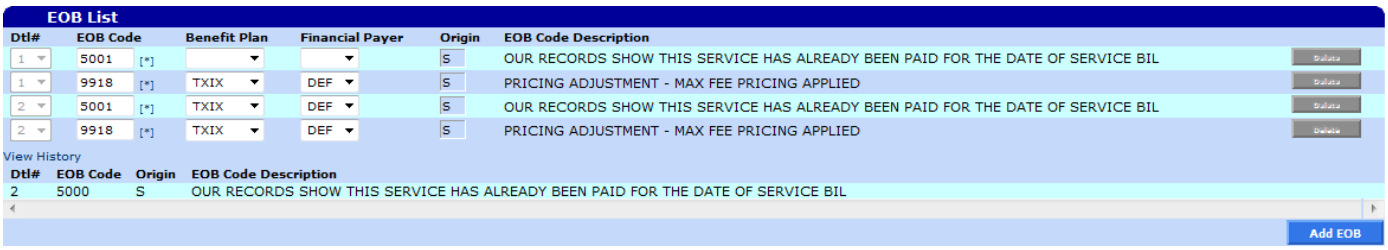
6.43 EOB List Panel

6.43.1 EOB List Panel Narrative

The EOB List panel for Data Correction is accessed for suspended claims. This panel displays the header and/or detail EOBs applicable to the claim being viewed.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Scroll to the EOB List panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click on “Data Correct” button]

6.43.2 EOB List Panel Layout



6.43.3 EOB List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add EOB	Adds a new EOB record.	Button	N/A	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Drop Down List Box	0
Delete	Deletes an EOB record.	Button	N/A	0
Dtl #	The number of the header or detail that contains an edit or an audit failure.	Field	Drop Down List Box	0
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4
EOB Code Description	Description of the explanation of benefit code.	Field	Character	79
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Drop Down List Box	0
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned.	Field	Character	1
View History	Displays all history records.	Hyperlink	N/A	0

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6.43.4 Error List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
EOB Code	Field	1	Invalid EOB code (####) for detail #.	Enter a valid EOB Code or select a valid code from the search link [*].

6.43.5 EOB List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 EOB List Panel Accessibility

6.43.6.1 To Access the EOB List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Enter appropriate search criteria for suspended claim and click **Search.**	Claim Search Results Panel displays.
4	Click required record in search result	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Click **data correct** button.	Claim Header, Maintenance, Claim detail list, Error list, EOB List, Data Correction Note, Manual Pricing, Diagnosis Codes, NDC Details, Related History, Payer Code, ICD9 Codes, Occurrence codes, value codes, condition codes and Medicare data panels are displayed for data correction.

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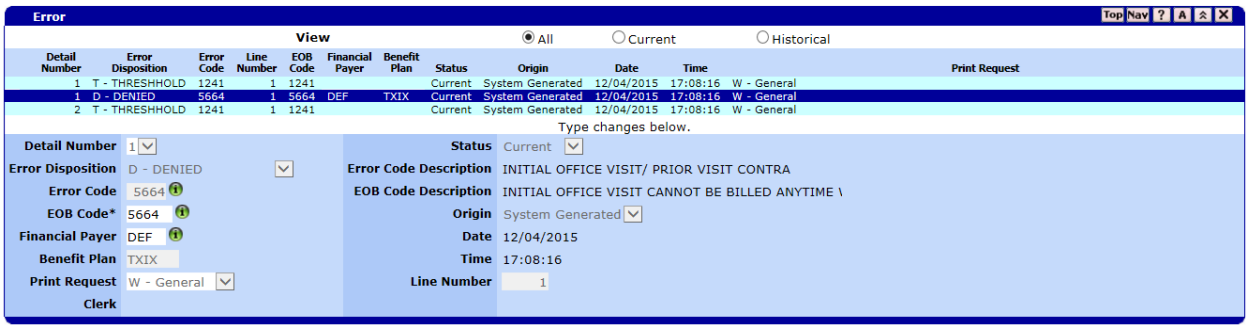
6.44 Error Panel

6.44.1 Error Panel Narrative

The Claim Error panel is accessed from the paid, denied, or suspended claim panels. This panel displays the header and/or detail errors applicable to the claim being viewed. Field edits and the Add/Delete buttons are for Data Correction only. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Error link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Error link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Error link from the displayed panel]

6.44.2 Error Panel Layout



6.44.3 Error Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
All	Selected to display all current and historical Error information.	Combo Boxc	Radio Button	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Current	Selected to display all current Error information.	Combo Box	Radio Button	0
Date	Date of the error code.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to delete a record.	Button	N/A	0
Detail Number	The number of the header or detail that contains an edit or an audit failure.	Combo Box	Drop Down List Box	0
EOB Code	This is the number assigned to an explanation of benefits description to uniquely identify it.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
EOB Code Description	Description of the explanation of benefit code.	Field	Character	79
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Number (Integer)	4
Error Code Description	Description of the error.	Field	Character	50
Error Disposition	Code that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).	Combo Box	Drop Down List Box	0
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	4
Historical	Selected to display all historical Error detail information.	Combo Box	Radio Button	0
Line Number	Represents the Error Disposition Key.	Field	Number (Integer)	4
Origin	Indicates how the EOB Code and message were generated: Valid values are 'S - System Generated' or 'U - User Assigned'.	Combo Box	Drop Down List Box	0
Print Request	The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.	Combo Box	Drop Down List Box	0
Save	This allows the user to save a record on the Error panel.	Button	N/A	0
Status	Indicates whether the Error is current or history.	Combo Box	Drop Down List Box	
Time	Time of the error code. Format HH:MM:SS.	Field	Number (Integer)	6

6.44.4 Error Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	Invalid Benefit Plan.	Enter a valid Benefit Plan or select a valid Benefit Plan from the [Search] panel.

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Field	Field Type	Error Code	Error Message	To Correct
EOB Code	Field	1	Invalid EOB.	Enter a valid EOB Code or select a valid code from the [Search] panel.
Error Code	Field	1	Invalid Error Code.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	2	Error Code XXXX cannot be overridden.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	3	Error Code XXXX cannot have the Error Disposition set to 'Deny'.	Enter a valid Error Code or select a valid code from the [Search] panel.
	Field	4	Invalid Error Code.	Invalid Error Code.
Financial Payer	Field	1	Invalid Financial Payer.	Enter a valid Financial Payer or select one from the [Search] panel.

6.44.5 Error Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.44.6 Error Panel Accessibility

6.44.6.1 To Access the Error Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Error** hyperlink from the Claim Detail Navigation panel.	Error panel displays below the Claim Detail panel.

6.44.6.2 To Update the Error Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim Information panel displays.
3	Select **Error** from the Claim Information navigation panel.	Error panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Error data is saved.

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6.45 Health Program Panel

6.45.1 Health Program Panel Narrative

The Health Program panel is used to display the program information for a claim. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Health Program link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Health Program link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Health Program link from the displayed panel]

6.45.2 Health Program Panel Layout

6.45.3 Health Program Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Aid Category for Medicaid coverage.	Field	Number (Integer)	9
Allowed Amount	Amount allowed for payment on the claim.	Field	Number (Decimal)	9
Allowed Quantity	Number of units allowed under a financial payer/benefit plan.	Field	Number (Integer)	6
Benefit Hierarchy	This is the hierarchical order with which multiple, concurrent benefits assigned to a recipient are processed.	Field	Number (Integer)	9
Copay Amount	This is the amount of copay that is subtracted from the allowed amount. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Detail Number	Number that indicates the claim detail line.	Combo Box	Drop Down List Box	0
Encounter Amount	This contains the amount for encounter services on the claim	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
	detail indicated by the detail number on the table.			
Finalized Date	Date that Financial finalizes the claim for this payer. This is when the claims are processed in Financial cycle and paid or denied, and RAs are produced.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	9
Fund Code	Indicates the budget category that the funds used to pay this claim/detail came from.	Field	Number (Integer)	9
Header/Detail Number	Number that indicates the header claim line. Number is 0 (zero) to indicate header level.	Field	Number (Integer)	3
Health Program	Name of program the header/detail was processed and/or paid under.	Field	Character	50
Paid Amount	The total amount paid on the claim.	Field	Number (Decimal)	10
Paid Amount 2009	This field indicates the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	10
Payer Hierarchy	Payer Hierarchy is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment plans for recipient's who are enrolled in multiple entities of any of these types.	Field	Character	9
Pricing Indicator	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	Field	Character	6
Primary Plan Indicator	Indicator identifies this entry as having the most payable plan for a given claim. If a claim has paid under this plan, it will be primary regardless of what type of eligibility. If a claim does not pay at all, first covered plans get priority, then non-covered plans. Within those	Field	Character	1

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Field	Description	Field Type	Data Type	Length
	categories, non-verified eligibility will get priority over verified eligibility. Values ('Y' – plan is marked primary, 'N' – plan is not marked primary)			
Provider Contract - Bill	Provider contract, under which the service was deemed covered, for the Billing Provider.	Field	Character	20
Provider Contract - Rend	Provider contract, under which the service was deemed covered, for the Rendering Provider.	Field	Character	20
Rate Percent Amount 2009	This field indicates the rate used to calculate the 2009 paid amount for claims paid using the Primary Care Provider rate. Claims not paid the PCP rate will have zero in this field.	Field	Number (Decimal)	7
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Field	Character	3
Recipient Assignment	This describes the relationships between the Recipient and Provider for purposes of care. This information encompasses the Recipient level of care nursing home information, Provider lock-in information, hospice information, some Provider specific waiver information, and other benefit information that relates a Recipient to a Provider.	Field	Character	9
State Share Amount	This is the amount of state share for this payment. The state share amount plus the amount Paid = Reimbursement amount. N/A for Alabama Medicaid.	Field	Number (Decimal)	10

6.45.4 Health Program Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Allowed Amount	Field	1	Enter a valid Value.	Verify allowed amount entered is less than billed amount on the detail for detail paid claims and less than the billed amount on the header for header paid claims.

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6.45.5 Health Program Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Health Program Panel Accessibility

6.45.6.1 To Access the Health Program Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Health Program** hyperlink from the Claim Detail Navigation panel.	Health Program panel displays below the Claim Detail panel.

6.45.6.2 To Update the Health Program Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Health Program** from the Claim Information navigation panel.	Health Program panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Health Program data is saved.

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6.46 ICN Recipient Link Panel

6.46.1 ICN Recipient Link Panel Narrative

The ICN Recipient Link panel displays the rekey history added to table t_clm_recip_hist by the new rekey process.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter ICN and click search button] – [Select Decision Rules link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select "ICN Recipient Link" from the displayed panel]

6.46.2 ICN Recipient Link Panel Layout

6.46.3 ICN Recipient Link Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the claim recipient was changed.	Field	Date (MM/DD/CCYY)	8
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
New Recipient DOB	Date of birth of the new recipient assigned to the claim.	Field	Number (Integer)	8
New Recipient Name	Name of the new recipient assigned to the claim.	Field	Character	36
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Old Recipient DOB	Date of birth of the recipient formerly assigned to the claim.	Field	Number (Integer)	8
Old Recipient Name	Name of the recipient formerly assigned to the claim.	Field	Character	36
Time	Time the claim recipient was changed.	Field	Number (HH:MM:SS)	8

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6.46.4 ICN Recipient Link Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.46.5 ICN Recipient Link Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 ICN Recipient Link Panel Accessibility

6.46.6.1 To Access the ICN Recipient Link Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select ICN Recipient Link.	ICN Recipient Link panel displays below the Claim Detail panel.

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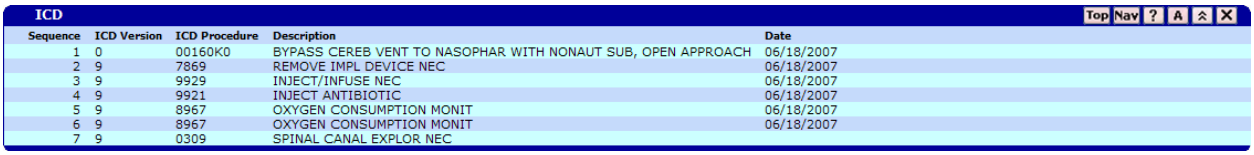
6.47 ICD Panel

6.47.1 ICD Panel Narrative

The ICD panel displays the ICD Procedure Codes applicable to the claim. This panel includes both the principal and other ICD procedure codes. The principal procedure code is the ICD code that identifies the procedure performed during the period covered by this claim and the date on which the principal procedure was performed. The other procedure codes are the ICD codes that identify all significant procedures other than the principal procedure and the dates on which they were performed.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select ICD link from the displayed panel] – OR – [Claims] - Search] – [Enter Criteria] – [Select a UB04 claim] – [Select ICD link from the displayed panel]

6.47.2 ICD Panel Layout



ICD

Sequence	ICD Version	ICD Procedure	Description	Date
1	0	00160K0	BYPASS CEREB VENT TO NASOPHAR WITH NONAUT SUB, OPEN APPROACH	06/18/2007
2	9	7869	REMOVE IMPL DEVICE NEC	06/18/2007
3	9	9929	INJECT/INFUSE NEC	06/18/2007
4	9	9921	INJECT ANTIBIOTIC	06/18/2007
5	9	8967	OXYGEN CONSUMPTION MONIT	06/18/2007
6	9	8967	OXYGEN CONSUMPTION MONIT	06/18/2007
7	9	0309	SPINAL CANAL EXPLOR NEC	

6.47.3 ICD Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the ICD procedure was performed.	Field	Date (MM/DD/CCYY)	8
Description	Description of the surgical procedure code.	Field	Character	60
ICD Procedure	Code used to identify the surgical procedure code, principal or other.	Field	Alphanumeric	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Sequence	This column contains the sequence number of the surgical procedure code. The principal procedure will always be sequence 1.	Field	Number (Integer)	4

6.47.4 ICD Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window				

6.47.5 ICD Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.47.6 ICD Panel Accessibility

6.47.6.1 To Access the ICD Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **ICD** hyperlink from the UB04 Claim Detail Navigation panel.	ICD panel displays below the Claim Detail panel.

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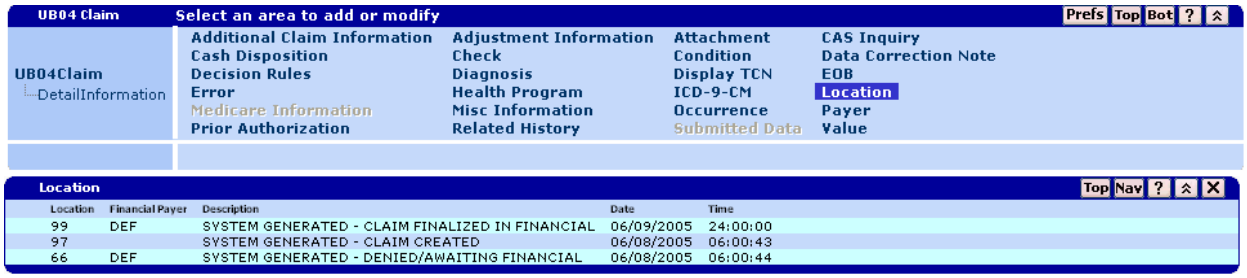
6.48 Location Panel

6.48.1 Location Panel Narrative

The Location panel displays claim location information. When opened from an inquiry panel, the Claim Location panel is not updateable. However, when opened from a Data Correction panel, the Add button is displayed allowing the user to add a location. This gives the user the ability to route the claim to another department for correction. This panel is shared by all claim types. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Location link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Location link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Location link from the displayed panel]

6.48.2 Location Panel Layout



6.48.3 Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	The date the claim went to this location.	Field	Date (MM/DD/CCYY)	8
Description	Description of the claim location within the claims processing system.	Field	Character	50
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	10
Location	Indicates claim location within the claims processing system.	Field	Character	2
Time	The time the claim went to this location.	Field	Number (Integer)	8

6.48.4 Location Field Panel Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Location	Field	1	Invalid Location Code.	Enter a valid Location Code or select a code from the [Search] panel.
	Field	2	A valid Claim Location is required.	Enter a valid Location Code before clicking the Save button.

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6.48.5 Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Location Panel Accessibility

6.48.6.1 To Access the Location Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
4	Select the **Location** hyperlink from the Claim Detail Navigation panel.	Location panel displays below the Claim Detail panel.

6.48.6.2 To Update the Location Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk id** and select a claim.	Claim information panel displays.
3	Select **Location** from the Claim Information navigation panel.	Location panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Location data is saved.

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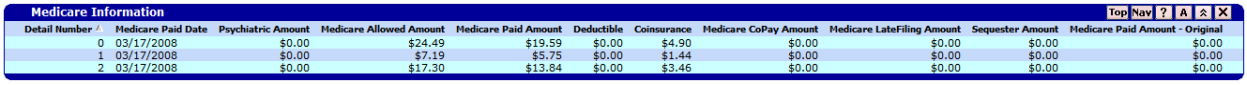
6.49 Medicare Information-Physician Panel

6.49.1 Medicare Information-Physician Panel Narrative

The Medicare Information panel displays the Medicare information applicable to the claim. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a Physician claim] – [Select Medicare Information link from the displayed panel] – OR – [Claims] –[Search] – [Enter Criteria] – [Select a Physician claim] – [Select Medicare Information link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Physician claim from the list] – [Select Medicare Information link from the displayed panel]

6.49.2 Medicare Information-Physician Panel Layout



Medicare Information

Detail Number	Medicare Paid Date	Psychiatric Amount	Medicare Allowed Amount	Medicare Paid Amount	Deductible	Coinsurance	Medicare CoPay Amount	Medicare LateFiling Amount	Sequester Amount	Medicare Paid Amount - Original
0	03/17/2008	$0.00	$24.49	$19.59	$0.00	$4.90	$0.00	$0.00	$0.00	$0.00
1	03/17/2008	$0.00	$7.19	$5.75	$0.00	$1.44	$0.00	$0.00	$0.00	$0.00
2	03/17/2008	$0.00	$17.30	$13.84	$0.00	$3.46	$0.00	$0.00	$0.00	$0.00

6.49.3 Medicare Information-Physician Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coinsurance	Amount which represents the recipient's coinsurance payment.	Field	Number (Decimal)	8
Deductible	The amount the recipient must pay before Medicare.	Field	Number (Decimal)	8
Detail Number	Indicates if the row pertains to the claim header or a claim detail line. The claim header is denoted by a zero.	Field	Number (Integer)	4
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services.	Field	Number (Decimal)	8
Medicare Copay Amount	Dollar amount which represents the recipient copayment.	Field	Number (Decimal)	8
Medicare Late Filing Amount	The amount Medicare has determined that a recipient must pay for late filing.	Field	Number (Decimal)	8
Medicare Paid Date	The date Medicare paid for the services.	Field	Date (MM/DD/CCYY)	8
Medicare Paid Amount	The dollar amount paid by Medicare for the services.	Field	Number (Decimal)	8
Medicare Paid Amount - Original	The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
Psychiatric Amount	The amount Medicare has determined that a recipient must pay for psychiatric services received. N/A for Alabama Medicaid.	Field	Number (Decimal)	8
Sequester Amount	The dollar amount of the 2% sequestration as required by the ACC.	Field	Number (Decimal)	8

6.49.4 Medicare Information-Physician Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Coinsurance Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Deductible Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Allowed Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Medicare Allowed Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Copay Amount	Field	1	Medicare Copay Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Copay Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Late Filing Amount	Field	1	Medicare Late Filing Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Late Filing Amount must be	Enter a numeric value less than or equal to 0

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Field	Field Type	Error Code	Error Message	To Correct
			greater than or equal to 0.	
Medicare Paid Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Medicare Paid Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Medicare Paid Amount – Original	Field	1	Enter a valid value.	Enter a numeric value. Format 99999999.99.
	Field	2	Medicare Paid Amount – Original must be less than or equal to 99999999.99.	Enter a value less than or equal to 99999999.99.
Medicare Paid Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY Format.
Psychiatric Amount	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Psychiatric Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.
Sequester Amount	Field	1	Enter a valid value	Enter a numeric value. Format 999999.99.
	Field	2	Sequester Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.

6.49.5 Medicare Information-Physician Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Medicare Information-Physician Panel Accessibility

6.49.6.1 To Access the Medicare Information-Physician Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	

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Step	Action	Response
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Medicare Information** hyperlink from the Physician Claim Information Navigation panel.	Medicare Information for Physician panel displays below the Claim Detail panel.

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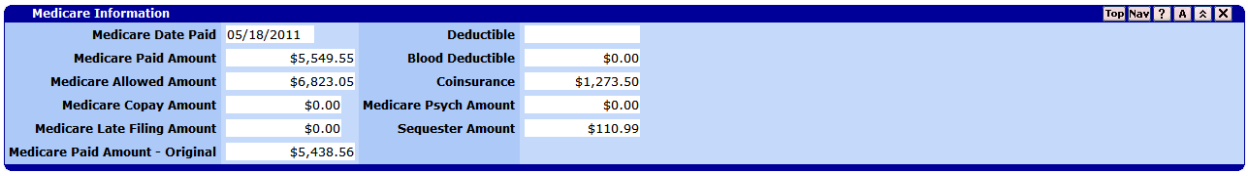
6.50 Medicare Information-UB04 Panel

6.50.1 Medicare Information-UB04 Panel Narrative

The Medicare Information panel displays the Medicare information applicable to the UB04 crossover claim. Field Edits are for Data correction only. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 Crossover claim] – [Select Medicare Information link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a UB04 Crossover claim] – [Select Medicare Information link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 Crossover claim from the list] – [Select Medicare Information link from the displayed panel]

6.50.2 Medicare Information-UB04 Panel Layout



6.50.3 Medicare Information-UB04 Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Blood Deductible	The amount Medicare has determined that a recipient must pay for blood procedures performed. N/A for Alabama Medicaid.	Field	Number (Decimal)	8
Coinsurance	Dollar amount which represents the recipient's coinsurance payment.	Field	Number (Decimal)	8
Deductible	The amount the recipient must pay before Medicare.	Field	Number (Decimal)	8
Medicare Allowed Amount	The dollar amount allowed by Medicare for the services.	Field	Number (Decimal)	8
Medicare Copay Amount	Dollar amount which represents the recipient copayment.	Field	Number (Decimal)	8
Medicare Date Paid	The date Medicare paid for the services.	Field	Date (MM/DD/CCYY)	8
Medicare Late Filing Amount	The amount Medicare has determined that a recipient must pay for late filing.	Field	Number (Decimal)	8
Medicare Paid Amount	The dollar amount paid by Medicare for the services. Format is 999999.99.	Field	Number (Decimal)	8

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Field	Description	Field Type	Data Type	Length
Medicare Paid Amount - Original	The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.	Field	Number (Decimal)	10
Medicare Psych Amount	The amount Medicare has determined that a recipient must pay for psychiatric services received.	Field	Number (Decimal)	8
Sequester Amount	The dollar amount of the 2% sequestration as required by the ACC.	Field	Number (Decimal)	8

6.50.4 Medicare Information-UB04 Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Blood Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Blood Deductible Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Coinsurance	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Coinsurance must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Deductible	Field	1	Enter a valid value.	Enter a numeric value. Format 999999.99.
	Field	2	Deductible must be greater than or equal 0.	Enter a numeric value greater than or equal to 0.
Medicare Allowed Amount	Field	1	Medicare Allowed Amount must be less than or equal to 999999.99.	Enter a numeric value less than or equal to 999999.99.
	Field	2	Medicare Allowed Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Medicare Copay Amount	Field	1	Medicare Copay Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Medicare Copay Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Date Paid	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
Medicare Late Filing Amount	Field	1	Medicare Late Filing Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Late Filing Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Medicare Paid Amount	Field	1	Medicare Paid Amount must be less than or equal to 999999.99.	Enter a numeric value less than or equal to 999999.99.
	Field	2	Medicare Paid Amount must be greater than or equal to 0.	Enter a numeric value greater than or equal to 0.
Medicare Paid Amount – Original	Field	1	Enter a valid value.	Enter a numeric value. Format 99999999.99.
	Field	2	Medicare Paid Amount – Original must be less than or equal to 99999999.99.	Enter a value less than or equal to 99999999.99.
Medicare Psych Amount	Field	1	Medicare Psych Amount must be less than or equal to 99999999.99	Enter a numeric value less than or equal to 99999999.99
	Field	2	Medicare Psych Amount must be greater than or equal to 0.	Enter a numeric value less than or equal to 0
Sequester Amount	Field	1	Enter a valid value	Enter a numeric value. Format 999999.99.
	Field	2	Sequester Amount must be less than or equal to 999999.99.	Enter a value less than or equal to 999999.99.

6.50.5 Medicare Information-UB04 Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.50.6 Medicare Information-UB04 Panel Accessibility

6.50.6.1 To Access the Medicare Information-UB04 Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Medicare Information** hyperlink from the UB04 Claim Information Navigation panel.	Medicare Information for UB04 panel displays below the Claim Detail panel.

6.50.6.2 To Update the Medicare Information-UB04 Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Medicare Information** from the Claim Information navigation panel.	Medicare Information panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Medicare information data is saved.

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6.51 Miscellaneous Information

6.51.1 Miscellaneous Information Panel Narrative

The panel displays Miscellaneous Information for a UB04 or Physician claim detail.

Navigation: [Claims] – [Information] – [Enter an ICN and click on Search button] – [Select Misc Information link from the displayed panel] OR [Claims] – [Search] – [Enter Criteria] – [Select Misc Information link from the displayed panel]

6.51.2 Miscellaneous Information Panel Layout

6.51.3 Miscellaneous Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a new record.	Button	N/A	0
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
Type Qualifier	This qualifier identifies the type of information under CDE_MISC.	Combo Box	Drop Down List Box	0
Value	A code used in claims processing.	Field	Character	11

6.51.4 Miscellaneous Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Detail Number	Field	0	Detail Number is required.	Select a Detail Number from the drop down box.
Type Qualifier	Field	0	Type Qualifier is a required field.	Select a Type Qualifier from the drop down box.
Value	Field	1	Value field is required.	Enter the Value.

6.51.5 Miscellaneous Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.51.6 Miscellaneous Information Panel Accessibility

6.51.6.1 To Access the Miscellaneous Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select the **Misc Information** hyperlink from the UB04 Claim Information Navigation panel.	Occurrence panel displays below the Claim Detail panel.

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6.52 NCCI Related History Panel

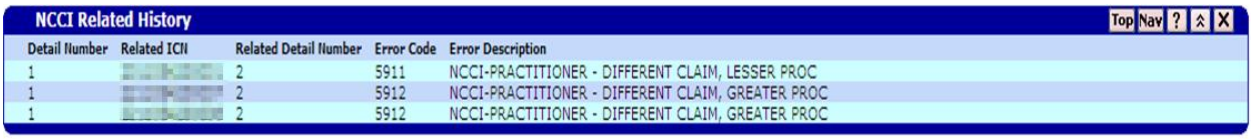
6.52.1 NCCI Related History Panel Narrative

The NCCI Related History panel displays the related claim detail and ESC description when an NCCI error is posted on a claim detail.

This panel is display only.

Navigation Path: [Claims] – [Search] – [Enter ICN and click search button] –[Select "NCCI Related History" from the listed links] – OR – [Claims] - [Information] - [Enter ICN and click search button] – [Select "NCCI Related History" from the listed links]

6.52.2 NCCI Related History Panel Layout



6.52.3 NCCI Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Detail Number	Displays the number of the detail on a claim record.	Field	Number	4
Error Code	Displays the code used to indicate an error was discovered on the claim during processing.	Field	Number	9
Error Description	Displays the description of the error which was discovered on the claim during processing.	Field	Character	50
Related Detail Number	Displays the detail number which relates to the detail of the history claim displayed.	Field	Number	4
Related ICN	Displays the Internal Control Number of the related claim.	Field	Number	13

6.52.4 NCCI Related History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.52.5 NCCI Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.52.6 NCCI Related History Panel Accessibility

6.52.6.1 To Access the NCCI Related History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN**	
4	Click **Search**.	Claim Header, Navigation and Claim Detail panels are displayed.
5	Select NCCI Related History Link.	NCCI Related History panel displays below the Claim Detail panel.

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6.53 Occurrence Panel

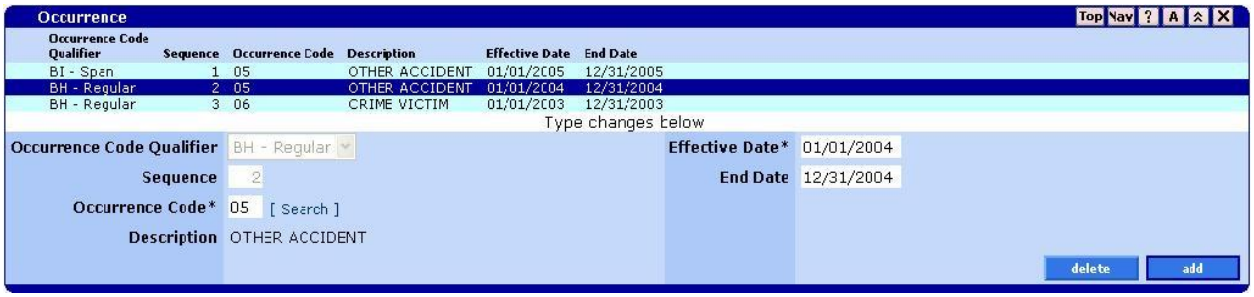
6.53.1 Occurrence Panel Narrative

The Occurrence panel displays the Occurrence Codes applicable to the claim. This panel includes the code and dates the event took place. Entries can be added and deleted from this panel. Field Edits are for Data Correction Only.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select Occurrence link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a UB04 claim] – [Select Occurrence link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list] – [Select Occurrence link from the displayed panel]

6.53.2 Occurrence Panel Layout



6.53.3 Occurrence Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Delete	Allows a user to delete a record.	Button	N/A	0
Description	Description of the Occurrence Code.	Field	Character	50
Effective Date	The date when the Occurrence Code began.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the Occurrence Code ended.	Field	Date (MM/DD/CCYY)	8
Occurrence Code	The code identifying a significant event relating to this claim that may affect payer processing.	Field	Character	2
Sequence	The sequence number as it appeared on the claim.	Field	Number (Integer)	4

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6.53.4 Occurrence Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid Date.	Enter a valid Effective Date.
	Field	3	Effective Date must be less than or equal to End Date.	Verify dates. Effective Date must be less than or equal to End Date.
End Date	Field	1	Invalid Date.	Enter the date in MM/DD/CCYY format.
	Field	2	Effective Date must be less than or equal to End Date.	Verify dates. End Date must be greater than or equal to Effective Date.
Occurrence Code	Field	1	A valid Occurrence is required.	Enter a valid Occurrence Code.
	Field	107	Exceed maximum number of occurrence codes.	Verify there are no more than 24 occurrence codes.
Occurrence Code Qualifier	Field	1	Qualifier Code List is required.	Select an Occurrence Code Qualifier from the drop down box.

6.53.5 Occurrence Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Occurrence Panel Accessibility

6.53.6.1 To Access the Occurrence Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information.**	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	.
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.

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Step	Action	Response
5	Select the **Occurrence** hyperlink from the UB04 Claim Information Navigation panel.	Occurrence panel displays below the Claim Detail panel.

6.53.6.2 To Add on the Occurrence Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate information.	
3	Click **Save**.	Occurrence information is saved.

6.53.6.3 To Delete on the Occurrence Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.53.6.4 To Update the Occurrence Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Occurrence** from the Claim Information navigation panel.	Occurrence panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Occurrence data is saved.

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6.54 Payer Panel

6.54.1 Payer Panel Narrative

The Claims Payer Information panel displays the payer information applicable to the claim. This panel includes the payer's code, prior payment amount, and the estimated amount due. This panel is specific to UB04 claims and does not display for any other claim type.

The panel is in view-only mode when accessed through Claims Information for inquiry.

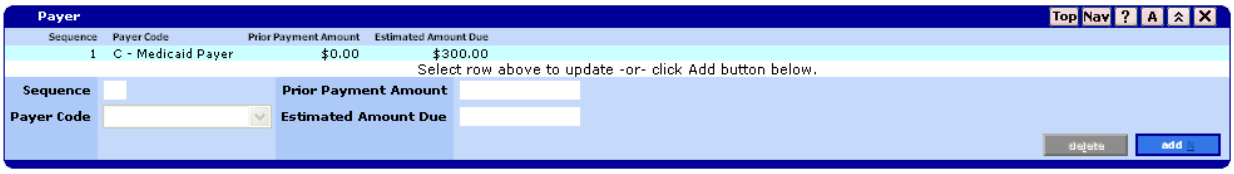
The panel is editable when accessed through Data Corrections.

Navigation Path:[Claims] – [Information] - [Enter a UB04 claim ICN] - [Select Payer link]

[Claims[- [Search] - [Enter criteria] - [Select a UB04 claim] - [Select Payer link]

[Claims]-[Data Correction] - [Enter clerk ID-search then select a UB04 claim from the list] - [Payer]

6.54.2 Payer Panel Layout



6.54.3 Payer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add. The button is visible only when viewing the claim on the Claims Data Corrections page.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete. The button is visible only when viewing the claim on the Claims Data Corrections page.	Button	N/A	0
Estimated Amount Due	The amount estimated by the hospital that is due from the payer. Format 9999999.99.	Field	Number (Decimal)	9
Payer Code	The code that identifies each organization from which the provider might expect some payment for the bill.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Prior Payment Amount	The amount the hospital has received toward payment of this bill prior to the billing date by the payer. Format 9999999.99.	Field	Number (Decimal)	9
Sequence	The sequence of the payer information as they appeared on the claim.	Field	Number (Integer)	4

6.54.4 Payer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Estimated Amount Due	Field	1	Enter a valid value.	Enter a numeric value.
Payer Code	Field	1	Payer Code is required.	Select a Payer Code from the drop down box.
	Field	108	Exceed maximum number of payer codes.	Select a Payer Code from the drop down box.
Prior Payment Amount	Field	1	Enter a Valid Value.	Enter a numeric value.

6.54.5 Payer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 Payer Panel Accessibility

6.54.6.1 To Access the Payer Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Payer** link from the Physician Claim Maintenance panel.	Payer panel displays.

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6.54.6.2 To Update the Payer Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Payer** from the Claim Information navigation panel.	Payer panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Payer data is saved.

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6.55 Prior Authorization Panel

6.55.1 Prior Authorization Panel Narrative

The Prior Authorization panel displays the prior authorization applicable to the claim. This panel includes the amount and units used in the claim. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Prior Authorization link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Prior Authorization link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Select Prior Authorization link from the displayed panel]

6.55.2 Prior Authorization Panel Layout

Prior Authorization

Detail Number	PA Number	Line Item	Financial Payer	Units Used	Amount Used	Status
0	5002162000	A	DEF	0.000	$0	A
0			DEF	0.000	$0.00	A

6.55.3 Prior Authorization Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Used	Prior Authorization amount applied to the claim.	Field	Number (Decimal)	9
Detail Number	Detail number which the Prior Authorization was applied.	Field	Number (Integer)	9
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	9
Line Item	Prior Authorization Line Item.	Field	Character	3
PA Number	Prior Authorization Number.	Field	Character	10
Status	Indicates the status of the claim within the system.	Field	Character	1
Units Used	Prior Authorization units applied to the claim.	Field	Number (Integer)	6

6.55.4 Prior Authorization Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.55.5 Prior Authorization Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.55.6 Prior Authorization Panel Accessibility

6.55.6.1 To Access the Prior Authorization Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Prior Authorization** link from the Physician Claim Maintenance panel.	Prior Authorization panel displays.

6.55.6.2 To Update the Prior Authorization Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Prior Authorization** from the Claim Information navigation panel.	Prior Authorization panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Prior Authorization data is saved.

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6.56 Related History Panel

6.56.1 Related History Panel Narrative

The Related History panel lists other claims that are related to the current claim. The panel is non-updateable and is shared by all claim types. This panel is used to validate medical policy audits, duplicate payment audits, umbrella audits, limitation audits, bundling and unbundling audits.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Related History link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Related History link from the displayed panel]

6.56.2 Related History Panel Layout

6.56.3 Related History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Character	5
Error Code	Displays the Error Code.	Field	Number (Integer)	9
Financial Payer	Description used to identify a unique payer related to a claim.	Field	Character	30
Related Detail	Related detail information to the history claim displayed.	Field	Number (Integer)	3
Related ICN	Internal control number related to the claim which caused the audit to post on this claim.	Field	Number (Integer)	13

6.56.4 Related History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.56.5 Related History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 Related History Panel Accessibility

6.56.6.1 To Access the Related History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Related History** link from the Claim Maintenance panel.	Related History panel displays.

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6.57 TPL Additional Information

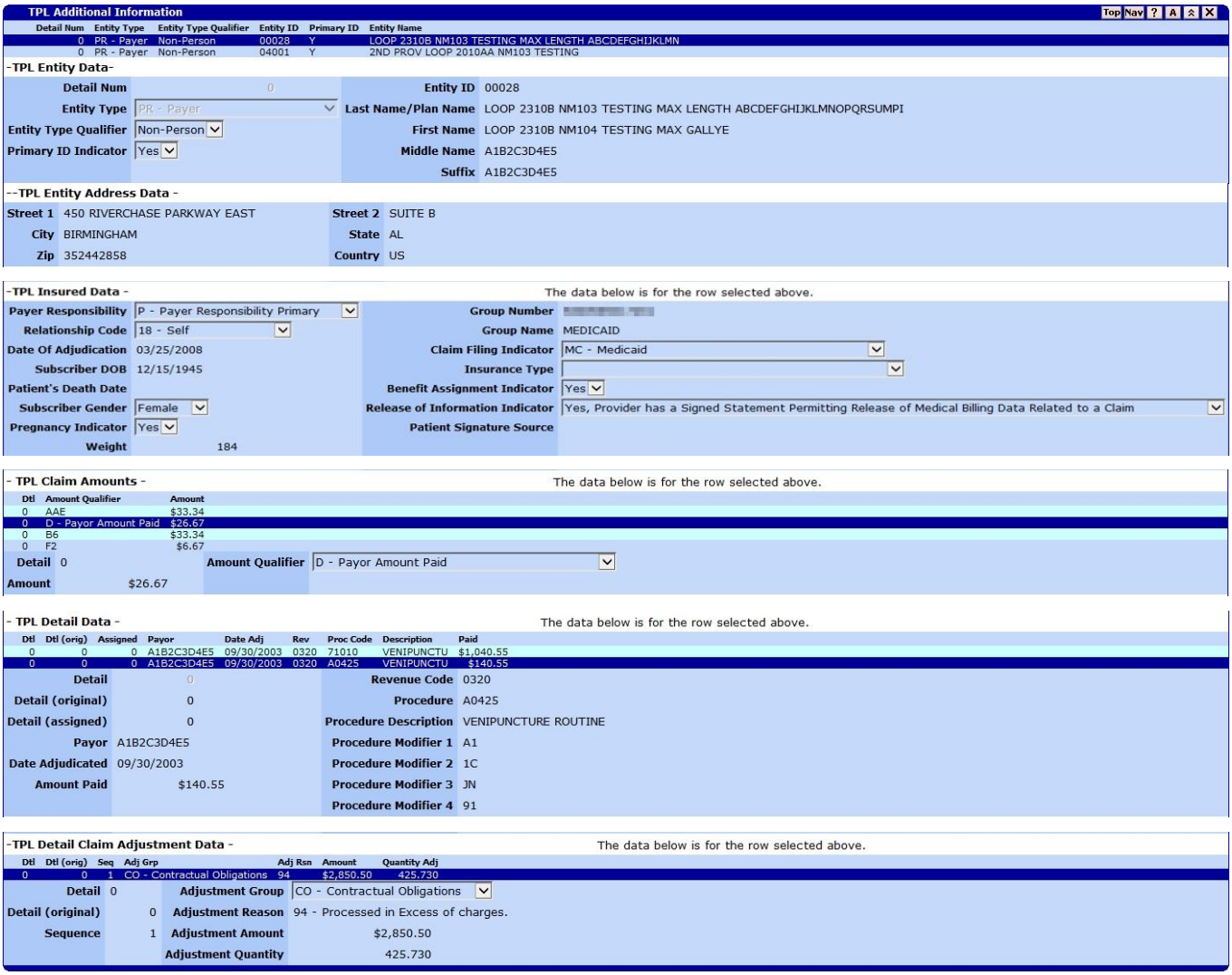
6.57.1 TPL Additional Information Panel Narrative

The TPL Additional Information panel allows the user to examine additional TPL information submitted on the claim including information about insurance, payments and additional TPL detail information.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select TPL Additional Information link] OR [Claims - Search] – [Enter Criteria] – [Select a Claim] – [Select TPL Additional Information link]

6.57.2 TPL Additional Information Panel Layout



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6.57.3 TPL Additional Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	Monetary Amount of the Adjustment.	Field	Number (Decimal)	9
Adjustment Group	Claim Adjustment Group Code.	Field	Character	2
Adjustment Quantity	Number of units of service being adjusted.	Field	Number (Decimal)	15
Adjustment Reason	Claim Adjustment Reason Code.	Field	Character	5
Amount	Payer Estimated Amount Due.	Field	Number (Decimal)	9
Amount Paid	Service line paid amount.	Field	Number (Decimal)	10
Amount Qualifier	Qualifier for Payer Estimated Amount Due.	Field	Character	3
Benefit Assignment Indicator	Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider. "N" indicates benefits have not been assigned to the provider. "W" indicates not applicable.	Field	Character	1
City	The city associated with the address for the recipient/provider.	Field	Alphanumeric	30
Claim Filling Indicator	Claim Filing Indicator Code.	Field	Character	2
Country	The country associated with the address for the Recipient/Provider.	Field	Character	3
Date Adjudicated	Service Adjudication Date.	Field	Date (MM/DD/CCYY)	8
Date of Adjudication	Date when this Payer adjudicated the claim.	Field	Date (MM/DD/CCYY)	8
Detail Num	Detail Number on the claim record (0 indicates Header).	Field	Number (Integer)	4
Detail (assigned)	The service line into which this service line was bundled.	Field	Number (Integer)	6
Detail (original)	This is the number of the SVD segment within a claim detail.	Field	Number (Integer)	4
Entity ID	Entity's primary or secondary ID as specified by the ID qualifier.	Field	Alphanumeric	40

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Field	Description	Field Type	Data Type	Length
Entity Type	Indicates the type of entity.	Field	Character	3
Entity Type Qualifier	Indicates whether the entity is a person or a non-person.	Field	Alphanumeric	2
First Name	First name of the recipient/provider.	Field	Alphanumeric	35
Group Name	Insured Group Name. AKA Plan Name.	Field	Alphanumeric	60
Group Number	Reference Identification. Insured Group or Policy Number.	Field	Alphanumeric	50
Insurance Type	Code identifying the type of insurance policy within a specific insurance program.	Field	Character	3
Last Name/Plan Name	Last name of the recipient/provider or the name of the organization.	Field	Alphanumeric	60
Middle Name	Middle name of the recipient/provider.	Field	Alphanumeric	25
Patient Signature Source	Code identifying how the patient or subscriber authorization signatures were obtained and retained by the provider.	Field	Character	1
Patient’s Death Date	Patient's date of death.	Field	Date (MM/DD/CCYY)	8
Payer Responsibility	Code identifying the insurance carrier's level of responsibility for payment of a claim.	Field	Character	1
Payor	It captures the other payer party identifier which help to identify the provider associated with the Medicare paid amounts.	Field	Alphanumeric	80
Pregnancy Indicator	Indicates whether drug is related to the condition of being pregnant.	Field	Character	1
Primary ID indicator	Entity represented by this row.	Field	Character	1
Procedure	Procedure Code identifying the service provided.	Field	Alphanumeric	48
Procedure Description	A free-form description to clarify the related data elements and their content.	Field	Alphanumeric	80
Procedure Modifiers	Code used to further define a procedure provided.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Relationship Code	Code identifying the relationship between two individuals or entities.	Field	Character	2
Release of Information Indicator	Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data to other organizations.	Field	Character	1
Revenue Code	This identifies a specific accommodation or ancillary service.	Field	Alphanumeric	48
Sequence	This identifies the iteration number for the adjustment segment.	Field	Number (Integer)	4
State	The state associated with the address for the recipient/provider.	Field	Character	2
Street 1	The first address line of the recipient/provider.	Field	Alphanumeric	55
Street 2	The second address line of the recipient/provider.	Field	Alphanumeric	55
Subscriber DOB	Subscriber Date of Birth (DOB). AKA Other Insured Date of Birth (DOB).	Field	Date (MM/DD/CCYY)	8
Subscriber Gender	Other Insured Gender Code. Valid values are F –Female, M – Male.	Field	Character	1
Suffix	Name suffix of the recipient/provider.	Field	Alphanumeric	10
Weight	Patient's weight.	Field	Number (Integer)	10
Zip	The zip code associated with the address for the recipient/provider.	Field	Number (Integer)	15

6.57.4 TPL Additional Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.57.5 TPL Additional Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.57.6 TPL Additional Information Panel Accessibility

6.57.6.1 To Access the TPL Additional Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claim Information Search panel displays.
3	Enter **ICN** or the sufficient search criteria.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select TPL **Additional Information** from the Claim Information Maintenance panel.	TPL Additional Information panel displays below the Claim Detail panel.

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6.58 TPL Summary Information Panel

6.58.1 TPL Summary Information Panel Narrative

The TPL Summary panel displays the information for each non-Medicare Third Party payer associated with a Claim or Claim detail.

This panel is applicable only to Dental, Professional, and Institutional Claims.

This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select TPL Summary Information link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select the "TPL Summary Information" link from the navigation panel].

6.58.2 TPL Summary Information Panel Layout

TPL Summary Information

Detail #	Sequence	Carrier Code	Payer Name	CoPay	CoInsurance	Deductible	TPL Paid	TPL Paid Date
0	1	9999888888	LOOP 2310B NM104 TESTING MAX GALLYE A1B2C3D4E5 LOOP 2310B NM103 TESTING MAX LENGTH ABCDEFGHIJKLMNOPQRSUMPI	$300.00	$200.00	$100.00	$500.00	08/17/2012
1	1	9999888888	LOOP 2310B NM104 TESTING MAX GALLYE A1B2C3D4E5 LOOP 2310B NM103 TESTING MAX LENGTH ABCDEFGHIJKLMNOPQRSUMPI	$800.00	$700.00	$600.00	$1,000.00	08/31/2012

6.58.3 TPL Summary Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Code	An unique identifier used to determine the type of carrier.	Field	Character	10
CoInsurance	Payer coinsurance amount.	Field	Number (Decimal)	9
CoPay	Payer copay amount.	Field	Number (Decimal)	9
Deductible	Payer deductible amount.	Field	Number (Decimal)	9
Detail #	Detail number on a claim record.	Field	Number (Integer)	4
Payer Name	Name of the Payer or the name of the Paying Organization.	Field	Character	60
Sequence	Payer hierarchy sequence.	Field	Number (Integer)	4
TPL Paid	Payer paid amount.	Field	Number (Decimal)	9
TPL Paid Date	Date adjudicated by the payer.	Field	Date (MM/DD/CCYY)	8

6.58.4 TPL Summary Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.58.5 TPL Summary Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.58.6 TPL Summary Information Panel Accessibility

6.58.6.1 To Access the Detail TPL Summary Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Navigation and Claim Detail panels are displayed.
5	Select the **TPL Summary Information** hyperlink from the Claim Navigation panel.	**TPL Summary Information** panel displays below the Claim Detail panel.

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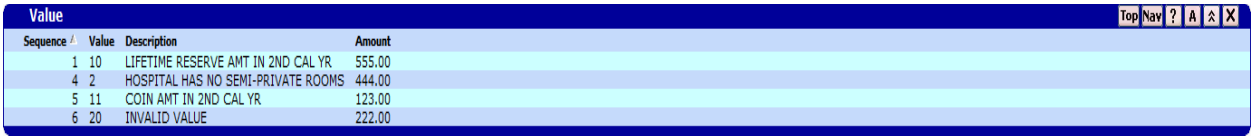
6.59 Value Panel

6.59.1 Value Panel Narrative

The Value panel displays the Value Codes applicable to the claim. This panel includes the value code and the amount of the value. Field Edits are for Data correction only. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Information] – [Enter an ICN for a UB04 claim] – [Select Value link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a UB04 claim] – [Select Value link from the displayed panel] – OR – [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list] – [Select Value link from the displayed panel]

6.59.2 Value Panel Layout



6.59.3 Value Panel Field Descriptions

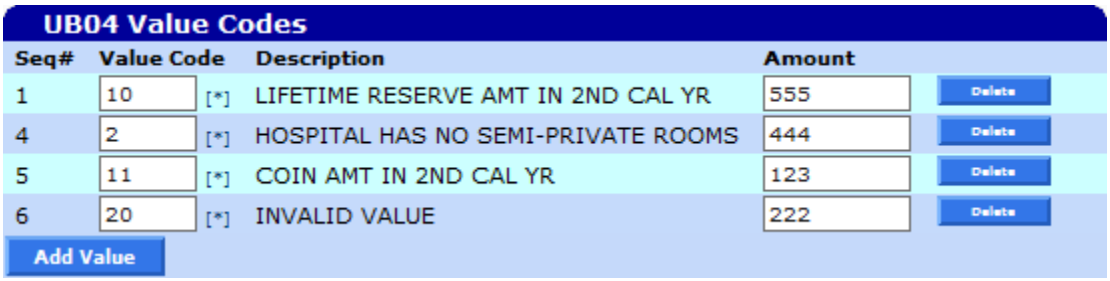
Field	Description	Field Type	Data Type	Length
Amount	The amount of the value code used to identify data elements that are necessary to process the claim.	Field	Number (Decimal)	9
Description	Description of the value.	Field	Character	50
Sequence	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	4
Value	A code that relates to the value used to identify data elements that are necessary to process the claim.	Field	Character	2

6.59.4 UB04 Value Codes Panel – Data Correction Panel

The UB04 Value Codes panel displays the Value Codes applicable to the claim. This panel includes the value code and the amount of the value. Field Edits are for Data correction only.

Navigation Path: [Claim] – [Data Correction] – [Enter Clerk ID, search than select a clam from the list] – [scroll down to UB04 Value Codes Panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click the “Data Correct” button]

6.59.5 UB04 Value Codes Panel Layout – Data Correction Panel



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6.59.6 UB04 Value Codes Panel Field Description – Data Correction Panel

Field	Description	Field Type	Data Type	Length
Add Value	Add a new record.	Button	N/A	0
Amount	The amount of the value code used to identify data elements that are necessary to process the claim.	Field	Number (Decimal)	9
Delete	Allows a user to delete a record.	Button	N/A	0
Description	Description of the value.	Field	Character	50
Seq #	Sequence numbers as they appeared on the claim.	Field	Number (Integer)	4
Value Code	A code that relates to the value used to identify data elements that are necessary to process the claim.	Field	Character	2

6.59.5 UB-04 Value Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Amount	Field	1	Enter a valid value.	Enter a numeric value in the Amount field.
	Field	2	Amount must be less than or equal to 9999999.99.	Enter an amount less than or equal to 9999999.99.
Sequence	Field	1	Sequence Contains Duplicates.	Please select a sequence number that has not already been used.
Value	Field	1	Enter Value Code.	Enter a Value Code or select a code from the [Search] panel.
	Field	2	A valid Value is required.	Enter a valid Value Code or select a code from the [Search] panel.
	Field	105	Exceeds maximum number of value codes.	Verify there are no more than 24 Value codes.
	Field	3	Value code ## not on file.	Enter a valid Value Code or select code from the [Search] panel.
	Field	4	Row with Seq # {0} cannot be saved without Value Code and Amount.	Enter a valid Value Code and Amount.

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6.59.6 Value Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.7 Value Panel Accessibility

6.59.7.1 To Access the Value Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Search panel displays.
3	Enter **ICN** or an error message is displayed.	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Value** link from the UB04 Claims Maintenance panel.	Value panel displays.

6.59.7.1.1 To Update on the Value Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a claim.	Claim information panel displays.
3	Select **Value** from the Claim Information navigation panel.	Value panel displays in edit mode.
4	Click **Add** and update appropriate data.	
5	Click **Save**.	Value data is saved.

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6.59.7.2 To Add on the Value Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Sequence.	
3	Enter **Value**.	
4	Enter Description.	
5	Click **Save**.	Value information is saved.

6.59.7.3 To Update on the Value Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Value information is saved.

6.59.7.4 To Delete on the Value Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.60 Adjustment Search Panel

6.60.1 Adjustment Search Panel Narrative

The Adjustment Search panel is used to search for claim adjustments. This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments]

6.60.2 Adjustment Search Panel Layout

6.60.3 Adjustment Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear data in the search fields.	Button	N/A	0
Date	The date of the adjustment request.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' - Processing, 'D' - Deleted, 'V' - Verified, or 'F' – Finalized.	Combo Box	Drop Down List Box	0
New Mass	Allows the user to create a new mass adjustment.	Button	N/A	0
New Single	Allows the user to create a new single adjustment.	Button	N/A	0
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Request Number	The request number to be associated with the adjustments for this batch. Format is RRYYDDDBBB; RR region, YYDDD Julian year and day, BBB batch number.	Field	Number (Integer)	10
Search	Returns the information for the entered search criteria.	Button	N/A	0
User ID	Identification number of the user who made the request.	Field	Character	8

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6.60.4 Adjustment Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.

6.60.5 Adjustment Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.60.6 Adjustment Search Panel Accessibility

6.60.6.1 To Access the Adjustment Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.

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6.61 Adjustment Search Results Panel

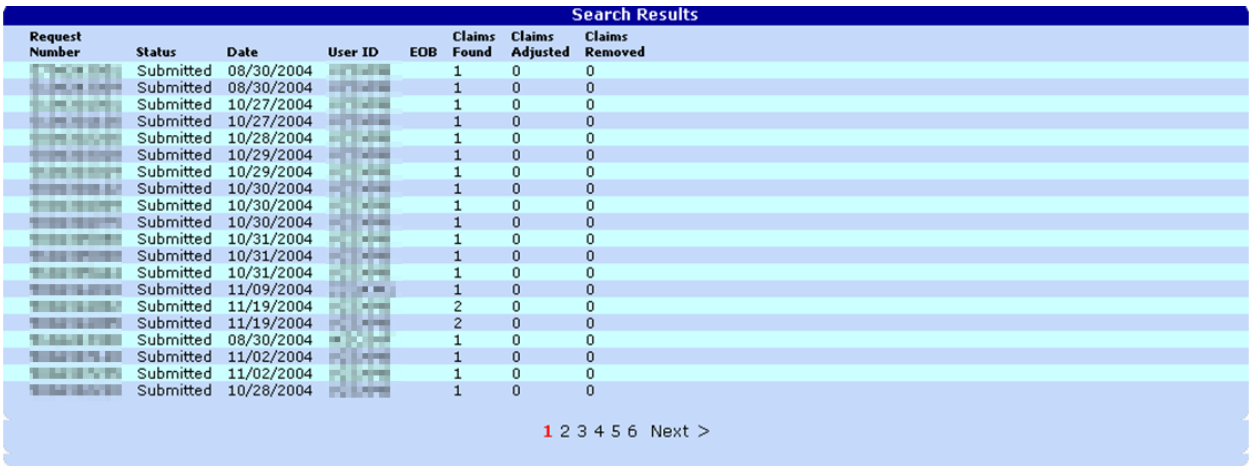
6.61.1 Adjustment Search Results Panel Narrative

The Adjustment Search Results panel displays the Claims Adjustment Search records returned by the search criteria.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Click Search]

6.61.2 Adjustment Search Results Panel Layout



Search Results

Request Number	Status	Date	User ID	EOB	Claims Found	Claims Adjusted	Claims Removed
	Submitted	08/30/2004			1	0	0
	Submitted	08/30/2004			1	0	0
	Submitted	10/27/2004			1	0	0
	Submitted	10/27/2004			1	0	0
	Submitted	10/28/2004			1	0	0
	Submitted	10/29/2004			1	0	0
	Submitted	10/29/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/30/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	10/31/2004			1	0	0
	Submitted	11/09/2004			1	0	0
	Submitted	11/19/2004			2	0	0
	Submitted	11/19/2004			2	0	0
	Submitted	08/30/2004			1	0	0
	Submitted	11/02/2004			1	0	0
	Submitted	11/02/2004			1	0	0
	Submitted	10/28/2004			1	0	0

1 2 3 4 5 6 Next >

6.61.3 Adjustment Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claims Adjusted	Total number of claims adjusted in this adjustment request.	Field	Number (Integer)	9
Claims Found	Total number of claims retrieved in this adjustment request.	Field	Number (Integer)	9
Claims Removed	Total number of claims removed from this adjustment request.	Field	Number (Integer)	9
Date	Adjustment request entry date to search.	Field	Date (MM/DD/CCYY)	8
EOB	Explanation of Benefit code used for an item meeting the search criteria.	Field	Character	4
Request Number	A unique number that identifies the mass adjustment request. Format: RRYYJJJBBB (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer)	10
Status	Status of the adjustment request to search.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
User ID	Clerk who entered the adjustment request.	Field	Character	8

6.61.4 Adjustment Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.61.5 Adjustment Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.61.6 Adjustment Search Results Panel Accessibility

6.61.6.1 To Access the Adjustment Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Enter applicable search criteria and/or click **Search**.	Adjustment Search Results displays.

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6.62 Adjustment Mini-Search Panel

6.62.1 Adjustment Mini-Search Panel Narrative

The Adjustment Mini-Search panel permits new searches from both the Adjustment Information and the Mass Adjustment Information panels without having to return to the Adjustment Search panel.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Click Search] – [select an adjustment request]

6.62.2 Adjustment Mini-Search Panel Layout

6.62.3 Adjustment Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Returns the full Adjustment Search panel.	Button	N/A	0
Clear	Clears the previous Adjustment Request Number from the search field.	Button	N/A	0
Request Number	A unique number that identifies the mass adjustment request. Format: RRYYJJJBBB (RR - Region, YYJJJ - Julian date, BBB - Batch number). It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer)	10
Search	Returns the information for the entered Request Number.	Button	N/A	0

6.62.4 Adjustment Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Request Number	Field	1	Enter a valid value.	Enter a numeric value in the Request Number field.
	Field	3	Record cannot be found for Request Number.	Enter a numeric value in the Request Number field.

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6.62.5 Adjustment Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.62.6 Adjustment Mini-Search Panel Accessibility

6.62.6.1 To Access the Adjustment Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Click **Search**.	
4	Select **Adjustment Request** from the results displayed.	Adjustment Information displays.

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6.63 Adjustment Information Panel

6.63.1 Adjustment Information Panel Narrative

The Adjustment Information panel displays information for a selected adjustment record. This panel is display only.

Navigation Path: [Claims] – [Adjustments] – [select an adjustment request for a single claim]

6.63.2 Adjustment Information Panel Layout

6.63.3 Adjustment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	The adjusted amount of the claim.	Field	Number (Decimal)	10
Claim Count	The number of claims found for the adjustment request.	Field	Number (Integer)	9
Entry Date	Adjustment request entry date.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' - Processing, 'D' - Deleted, 'V' - Verified, or 'F' - Finalized.	Field	Character	20
Net Amount	The amount by which the Original Amount was adjusted.	Field	Number (Decimal)	10
Original Amount	The original amount of the claim.	Field	Number (Decimal)	10
Request Number	A 10 byte unique number that identifies the mass adjustment request. Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.	Field	Number (Integer	10
User ID	Indicates a specific user of the system and can be used to identify who entered or last updated the Adjustment Request.	Field	Character	8

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6.63.4 Adjustment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.63.5 Adjustment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.63.6 Adjustment Information Panel Accessibility

6.63.6.1 To Access the Adjustment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Enter Request Number, Entry Status, Date or User ID.	
4	Click **Search**.	
5	Select a detail line from the results displayed.	Adjustment Information panel displays.

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6.64 Adjustment Information–Daughter or Mother Panel

6.64.1 Adjustment Information-Daughter or Mother Panel Narrative

The Adjustment Information panel displays information about adjustments to the current claim, including prior claims or adjustments and any subsequent adjustments. This panel is display only.

Navigation Path: [Claims] – [Information] – [Enter an ICN] – [Select Adjustment Information link from the displayed panel] – OR – [Claims] – [Search] – [Enter Criteria] – [Select a claim] – [Select Adjustment Information link from the displayed panel]

6.64.2 Adjustment Information-Daughter or Mother Panel Layout

6.64.3 Adjustment Information- Daughter or Mother Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Analyst Name	Name of the clerk that generated the adjustment request.	Field	Character	30
Adjustment Reason	Code identifying the detailed reason the adjustment was made.	Field	Character	4
Claim Status	The status of the claim, example ‘PAID‘.	Field	Character	10
Claims Status History Date	Date on which a claim was processed.	Field	Date (MM/DD/CCYY)	8
Date Adjusted	Date on which adjustment was made.	Field	Date (MM/DD/CCYY)	8
ICN	Internal control number which uniquely identifies a claim.	Field	Number (Integer)	13
Location	Location code of the claim.	Field	Character	2

6.64.4 Adjustment Information-Daughter or Mother Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.64.5 Adjustment Information-Daughter or Mother Panel Field Extra Features

Field	Field Type
No extra features found for this panel.	

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6.64.6 Adjustment Information-Daughter or Mother Panel Accessibility

6.64.6.1 To Access the Adjustment Information-Daughter or Mother Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Information**.	Claims Mini Search panel displays.
3	Enter **ICN** or an error message is displayed**.**	
4	Click **Search**.	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Select **Adjustment Information** link from the maintenance item panel.	Adjustment Information panel displays below the Claim Detail panel.

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6.65 Claim Adjustment Navigation Panel

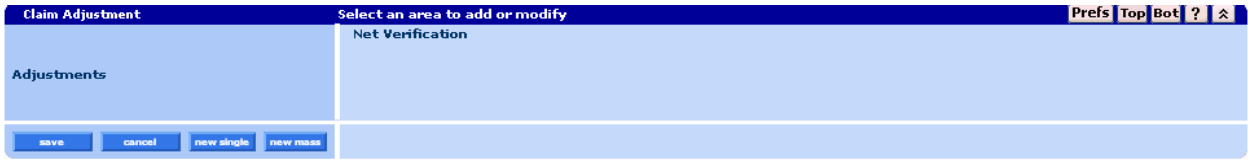
6.65.1 Claim Adjustment Navigation Panel Narrative

The Claim Adjustment Navigation panel allows the user to navigate to the Net Verification panel.

This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Enter Criteria] – [Click Search] – [Select a request]

6.65.2 Claim Adjustment Navigation Panel Layout



6.65.3 Claim Adjustment Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes made and close the panel.	Button	N/A	0
New Mass	Start a new mass adjustment.	Button	N/A	0
New Single	Start a new single adjustment.	Button	N/A	0
Save	Allows the user to save a record to the database.	Button	N/A	0
Net Verification	Activates the Net Verification display and update panel.	Hyperlink	N/A	0

6.65.4 Claim Adjustment Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.65.5 Claim Adjustment Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.65.6 Claim Adjustment Navigation Panel Accessibility

6.65.6.1 To Access the Claim Adjustment Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.

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Step	Action	Response
3	Enter applicable search criteria and click **Search**.	Adjustment Search Results displays.

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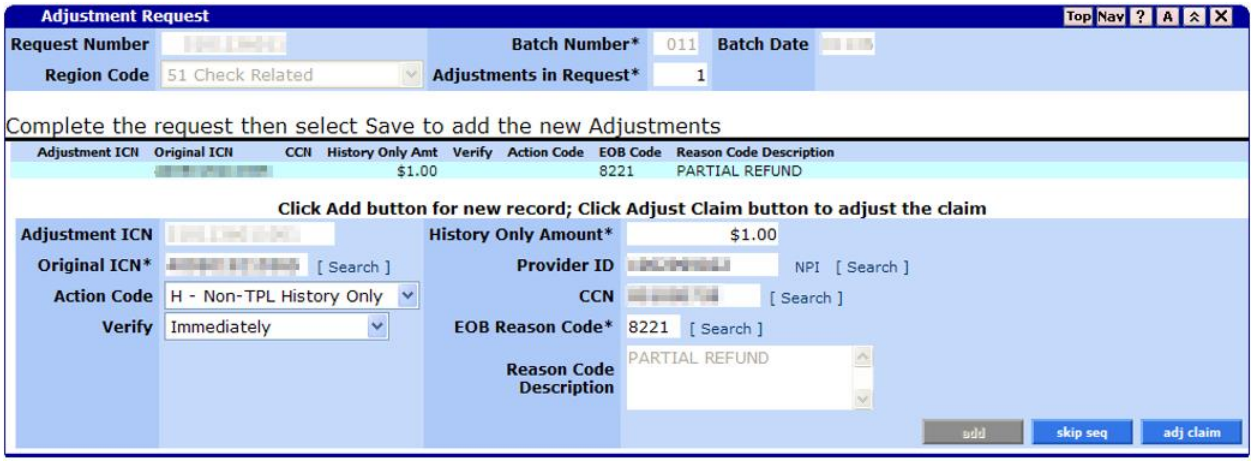
6.66 Adjustment Request Panel

6.66.1 Adjustment Request Panel Narrative

The Adjustment Request panel permits entry or update to single adjustment requests. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select an adjustment request]

6.66.2 Adjustment Request Panel Layout



6.66.3 Adjustment Request Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new record.	Button	N/A	0
Action Code	Field to add or change action to be taken for selected adjustment claim.	Combo Box	Character	30
Adj claim	Starts the claim adjustment process	Button	N/A	0
Adjustment ICN	Field to add or change an adjustment internal control number.	Field	Character	13
Adjustments in Request	The number of adjustments contained in the Adjustment Request.	Field	Character	3
Batch Date	Julian date entered to generate the request number. This value is not stored in any table in the database. It is used only by the User Interface to generate the request number. It has to be entered in Julian date format and should be less than or equal to the Julian date on the day it is being entered. Format YYJJJ.	Field	Date (YYJJJ)	5
Batch Number	The batch number of the record that was subject to the Adjustment Request.	Field	Character	5

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Field	Description	Field Type	Data Type	Length
CCN	Field to add or change an adjusted cash control number.	Field	Character	13
EOB Reason Code	Field to add or change explanation of benefit reason codes for an adjusted claim.	Field	Number (Integer)	4
History Only Amount	Field to add or change Third Party Liability amount for an adjusted claim.	Field	Character	6
Original ICN	Field to add more linked internal control numbers.	Field	Character	13
Provider ID	The Provider Identification Number of the provider for the claim selected for adjusting.	Field	Character	15
Reason Code Description	Reason code description field.	Field	Alphanumeric	25
Region Code	The Adjustment Request category.	Combo Box	Character	25
Request Number	The Adjustment Request number for which a search is being conducted.	Field	Character	15
skip seq	Advances Adjustment ICN, to the next available sequence within a batch. Note: skipped sequence cannot be recovered	Button	N/A	0
Verify	Field to add or change an adjustment Verify code.	Combo Box	Character	20

6.66.4 Adjustment Request Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Action Code	Field	1	Action code is required.	For single adjustments, Action Code is required.
adj claim	Button	1	Invalid request. PHP claim cannot be adjusted.	N/A
	Button	2	Invalid request. Service past the filing limit.	N/A
	Button	3	Original claim paid date is more than three years ago. Continue processing?	Click Ok if you want to continue with an adjustment, otherwise

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Field	Field Type	Error Code	Error Message	To Correct
				click cancel button.
	Button	4	Claim is in a NCCI non-adjustable status and permission from the Agency must be obtained in order to adjust the claim. If the user continues to want to adjust the claim, it should be allowed to adjust.	Check the ignore checkbox and click on continue.
Adjustment ICN	Field	1	Adjustment ICN is required	Enter a valid ICN.
	Field	2	Adjustment ICN cannot be found.	Enter a valid Adjustment ICN.
Adjustments in Request	Field	1	Adjustments in Request cannot be zero.	Enter a numeric value greater than 0.
	Field	91151	Adjustments in Request number cannot be less than the current number of adjustments."	Correct the number of Adjustments in Request
Batch Date	Field	1	Batch Date must be 5 character(s) in length.	Enter a 5 character valid Julian date
	Field	100	Invalid Julian date in columns 5-7.	Enter a valid Julian date
	Field	104	Not able to save a Mass Adjustment with this Mass Request Number.	Enter a valid Julian date - it forms part of the Request Number

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Field	Field Type	Error Code	Error Message	To Correct
	Field	105	Batch Date is required	Enter a Julian date less then or equal to current Julian date.
	Field	106	Enter Batch Date in YYJJJ	Enter a valid Julian date in YYJJJ format
	Field	107	Batch Date should be less than or equal to current Julian date.	Enter a Julian date less than or equal to current Julian date.
	Field	108	Enter only numeric values in Batch Date.	Enter only numeric values in the Batch Date field.
Batch Number	Field	104	Not able to save a Mass Adjustment with this Mass Request Number.	Enter a valid batch number - it forms part of the Request Number.
CCN	Field	1	CCN Provider Service location does not match claim Provider service location	Check the provider ID on the cash receipt to ensure it matches the claim's provider ID and service location.
	Field	6740	CCN balance is not greater than zero	Verify CCN. CCN must have a balance remaining for an adjustment to be applied
	Field	6741	CCN is not allowed on non-	CCN only allowed for region 51

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Field	Field Type	Error Code	Error Message	To Correct
			check related adjustment.	check-related adjustment. Correct region or clear CCN
	Field	91037	CCN is required.	Enter a valid CCN number.
EOB Reason Code	Field	1	A valid EOB Reason Code is required.	Enter an EOB Reason Code between 8200-8299. Must have a valid value for EOB Reason Code.
	Field	2	EOB Reason codes 8220 and 8221 are exclusive for Refunds (Region Code 51).	Please enter another EOB Reason code.
	Field	3	Check Related Adjustments have to use EOB Reason codes 8220 and 8221 exclusively.	Please enter another EOB Reason code.
	Field	4	EOB Reason Code number not found.	Please enter a valid EOB Reason Code.
	Field	401	EOB is required.	Enter an EOB Reason Code.
History Only Amount	Field	1	History only TPL amount is required.	Enter a numeric value in the History Only TPL Amt field.
	Field	6709	Full Refund amount must match the Claim's Paid Amount.	Enter the exact Paid Amount for the Mother Claim.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6710	Partial Refund amount must be less than the Claim's Paid Amount.	Enter an amount less than the Paid Amount of the Mmother Claim, but greater than zero.
Original ICN	Field	1	Cannot adjust a non-paid claim.	Only paid claims can be adjusted.
		2	Online adjustments to encounter claims are not allowed	Enter an ICN number that do not start with 7 because 7 refers to encounter region.
Provider ID	Field	1	Action code is required. Provider ID does not match.	Select an Action Code. Enter the Provider ID for this claim.
	Field	2	A valid Provider is required.	Enter a valid Provider ID.
Region Code	Field	1	Original claim paid date more than three years ago. Do you have Agency authorization to adjust this claim?	If Agency authorization is there, then click on ignore and continue to save the request. Else, click on cancel on the information page to cancel the entries
Request Number	Field	1	Request Number is a duplicate.	This Request Number already exists. Try changing the Batch Number to generate a

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Field	Field Type	Error Code	Error Message	To Correct
				new Request Number.
	Field	2	The request number must be in the format of RRYYJJJBBB.	Enter information for the request before clicking the Save button.

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6.66.5 Adjustment Request Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.66.6 Adjustment Request Panel Accessibility

6.66.6.1 To Access the Adjustment Request Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustments**.	Adjustment Search panel displays.
3	Click **Search**.	
4	Select **Adjustment Request** from the results displayed.	Adjustment Information displays.

6.66.6.2 To Add on the Adjustment Request Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate data.	
3	Click **Save**.	Adjustment Request information saved.

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6.67 Mass Adjustment Criteria Panel

6.67.1 Mass Adjustment Criteria Panel Narrative

The Mass Adjustment Criteria panel is a combined panel for adding and deleting Mass Adjustment criteria on new and existing mass adjustment request. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request] – [Mass Adjustment Criteria]

6.67.2 Mass Adjustment Criteria Panel Layout

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6.67.3 Mass Adjustment Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a segment.	Button	N/A	0
Age Max	The high age of the recipient age range.	Field	Number (Integer)	3
Age Min	The low age of the recipient age range.	Field	Number (Integer)	3
Aid Category	Displays the aid category entered as search criteria.	Field	Character	2
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient. Displays Current ID(s) entered as search criteria.	Field	Character	12
Delete	Allows the user remove a segment.	Button	N/A	0
Diagnosis	Displays diagnosis code(s) as search criteria.	Field	Character	7
ESC	Code to indicate an error was discovered on a claim during processing. This can be either an edit or an audit code, which is used as search criteria.	Field	Number (Integer)	4
Gender	The sex of the recipient.	Combo Box	Drop Down List Box	0
Health Program Selection	Medical Assistance Programs chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Combo Box	Character	1
Location	Provider service location(s) chosen as search criteria.	Field	Character	1
Modifier 1	First modifier to be used as search criteria.	Field	Alphanumeric	2
Modifier 2	Second modifier criteria.	Field	Alphanumeric	2
Modifier 3	Third modifier criteria.	Field	Alphanumeric	2

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Field	Description	Field Type	Data Type	Length
Modifier 4	Fourth modifier criteria.	Field	Alphanumeric	2
NDC	Displays NDC(s) found from the search criteria.	Field	Number (Integer)	11
Pgm	Medical Assistance Programs chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
Procedure Code	Field used to enter procedure code as search criteria.	Field	Character	6
Provider ID	Provider number(s) chosen as search criteria.	Field	Character	15
Provider Spec	Code used to identify the specialty of the provider.	Field	Number (Integer)	3
Provider Type	Code used to identify the type of the provider.	Field	Number (Integer)	2
Region	Region codes chosen from the list at the bottom of the panel.	Field	Number (Integer)	2
Revenue	Displays revenue code(s) as search criteria.	Field	Number (Integer)	3
Type (Claim Type)	Claim type chosen from the list at the bottom of the panel.	Combo Box	Drop Down List Box	0
Type (ESC)	Value that indicates if the edit or audit fails at detail, header or both.	Combo Box	Radio Button	0

6.67.4 Mass Adjustment Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Age Max	Field	1	Max is required.	Enter a max age.
Age Min	Field	2	Min is required.	Enter a min age.
Aid Category	Field	1	A valid Aid Category is required.	Enter a valid Aid Category or click on search and select one from the search results.
	Field	2	Invalid Aid Category Code.	Enter a valid Aid Category or click on search and select one from the search results.

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Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	1	Invalid Current ID.	Enter in a valid Current ID or click on search and select one from the search results.
Diagnosis	Field	1	A valid Diagnosis is required.	Enter in a valid Diagnosis or click on search and select one from the search results.
	Field	2	Invalid Diagnosis Code.	Enter in a valid Diagnosis or click on search and select one from the search results.
ESC	Field	2	Invalid ESC Code.	Enter a valid ESC Code or click on search and select one from the search results.
	Field	3	A valid Claim Error is required.	Enter a valid ESC Code or click on search and select one from the search results.
Gender	Field	3	Gender is required.	Select a gender from the drop down box.
Health Program Selection	Field	1	Health Program Code is required.	Select a Health Program from the list.
Modifier 1	Field	1	Modifiers MUST BE entered in order, starting with 1.	Verify entry and correct values in Modifiers.
	Field	2	Invalid modifier 1 code.	Enter a valid Modifier 1 Code or click on search and select one from the search results.
Modifier 2	Field	1	Invalid modifier 2 code.	Enter a valid Modifier 2 Code or click on search and select one from the search results.
Modifier 3	Field	1	Invalid modifier 3 code.	Enter a valid Modifier 3 Code or click on search and select one from the search results.
Modifier 4	Field	1	Invalid modifier 4 code.	Enter a valid Modifier 4 code or click on search

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Field	Field Type	Error Code	Error Message	To Correct
				and select one from the search results.
NDC	Field	1	Invalid NDC Code.	Enter a valid NDC Code or click on search and select one from the search results.
Procedure Code	Field	1	Procedure Code is required.	Enter a valid Procedure Code or click on search and select one from the search results.
Provider ID	Field	1	A valid Provider is required.	Enter a valid Provider ID or click on search and select one from the search results.
	Field	2	Both a Provider ID is needed.	Verify entries in Provider ID field correct or click on search and select one from the search results.
Provider Specialty	Field	1	A valid Provider Specialty is required.	Select a Provider Specialty from the list.
Region	Field	1	A valid Region is required.	Select a Region from the list.
Revenue	Field	1	A valid Revenue is required.	Enter in a valid Revenue Code or click on search and select one from the search results.
	Field	2	Invalid Revenue Code.	Enter in a valid Revenue Code or click on search and select one from the search results.
Type	Field	1	A valid Type is required.	Select a value from the drop down list box.

6.67.5 Mass Adjustment Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.67.6 Mass Adjustment Criteria Panel Accessibility

6.67.6.1 To Access the Mass Adjustment Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Adjustment panel displays.
4	Select **Mass Adjustment Criteria** hyperlink from the Adjustments Navigation panel.	Mass Adjustment Criteria panel displays.

6.67.6.2 To Add on the Mass Adjustment Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter appropriate data changes.	
3	Click **Save**.	Mass adjustment information is saved.

6.67.6.3 To Delete on the Mass Adjustment Criteria Panel

Step	Action	Response
1	Click **Delete** on the data fields that need to be removed.	
2	Click **Save**.	Mass Adjustment information is saved.

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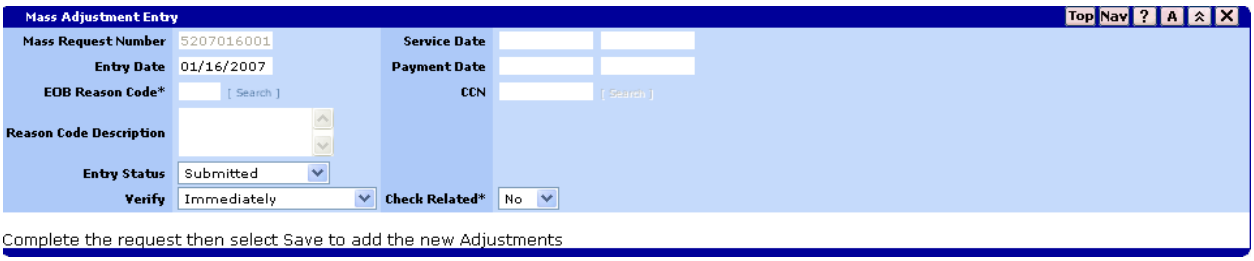
6.68 Mass Adjustment Entry Panel

6.68.1 Mass Adjustment Entry Panel Narrative

The Mass Adjustment Entry panel allows the adjustment analyst to enter a new mass adjustment request. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Adjustment - Search - {select one from list}] – [Click on New Mass Button] – OR – [Claims] – [Adjustment - New Single] – [Click on New Mass Button] – OR – [Claims] – [Adjustment - Click on New Mass Button]

6.68.2 Mass Adjustment Entry Panel Layout



6.68.3 Mass Adjustment Entry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash Control Number that refers to the cash receipt that is dispositioned against the adjustment.	Field	Character	11
Check Related	Indicates if the adjustment is related to a cash receipt.	Combo Box	Drop Down List Box	0
EOB Reason Code	The Explanation of Benefits (EOB) Reason identifies the reason for the request. The type of EOB also controls the processing action for editing and auditing purposes. Valid values: 8232 thru 8238, inclusive.	Field	Character	4
Entry Date	Indicates the date the request was entered, system assigned.	Field	Date (MM/DD/CCYY)	8
Entry Status	Indicates the current status of the request.	Combo Box	Drop Down List Box	0
Mass Request Number	The system assigned number for a Mass Adjustment Request.	Field	Number (Integer)	14
Payment Date (From)	Indicates the from payment date of the claims.	Field	Date (MM/DD/CCYY)	8
Payment Date (To)	Indicates the to payment date of the claims.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Reason Code Description	Explanation of the Explanation of Benefit Reason Code.	Field	Character	50
Service Date (From)	Indicates the beginning date of service.	Field	Date (MM/DD/CCYY)	8
Service Date (To)	Indicates the ending date of service.	Field	Date (MM/DD/CCYY)	8
Verify	Indicates the mass adjustment should suspend for review, the adjustment will process through the Claims Engine and will suspend for review at the end of processing. A – Suspend after running through the claims engine. B – Suspend before running through the claims engine. Immediately – Reprocess immediately, without a user's review and release.	Combo Box	Drop Down List Box	0

6.68.4 Mass Adjustment Entry Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CCN	Field	1	CCN number not found.	Enter a valid CCN number or select a valid number from the [Search] panel.
EOB Reason Code	Field	1	EOB Reason Code not found.	Enter an existing EOB reason or select a code from the [Search] panel.
	Field	2	Adjustment Reason Code must be 8232 - 8238.	Enter an existing EOB reason or select a code from the [Search] panel.
	Field	3	Adjustment Reason Code is required.	Enter an existing EOB reason or select a code from the [Search] panel.
Mass Request Number	Field	2	The request must have one of the following: 1) List of recipients; 2) List of provider ID's and service locations; 3) List of Error Codes; 4) List of Procedure Code and Modifiers; 5) List of NDC Codes; 6) Revenue Codes (UB04 Only).	Enter data into the panel before clicking the Save button.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	The mass adjustment request must have either one or both of the Service Date and Payment Date.	Enter a Service Date and/or Payment Date.
Payment Date (From)	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	The payment date cannot be greater than Today's date.	Enter a valid date in MM/DD/CCYY format.
	Field	3	First Payment Date is required for an entered Last Payment Date.	Enter a valid date in MM/DD/CCYY format.
Payment Date (To)	Field	1	Invalid Date.	Enter an ending Payment Date in MM/DD/CCYY format.
	Field	2	Payment From Date must be less than or equal to Payment To Date.	Enter an ending Payment Date in MM/DD/CCYY format.
Service Date (From)	Field	1	Invalid Date.	Enter a date in MM/DD/CCYY format.
	Field	2	First Service Date is required for an entered Last Service Date.	Enter a valid date in MM/DD/CCYY format.
	Field	3	Last Service Date is required for an entered First Service Date.	Enter a valid date in MM/DD/CCYY format.
Service Date (To)	Field	1	Invalid Date.	Enter an ending Service Date in the format: MM/DD/CCYY.
	Field	2	Service Date must be less than or equal to Service To Date.	Enter an ending Service Date in the format: MM/DD/CCYY.
	Field	3	The service date cannot be greater than Today's date.	Enter an ending Service Date in the format: MM/DD/CCYY.

6.68.5 Mass Adjustment Entry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.68.6 Mass Adjustment Entry Panel Accessibility

6.68.6.1 To Access the Mass Adjustment Entry Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Adjustment panel displays.
4	Select the **New Mass** button.	Mass Adjustment Entry panel displays.

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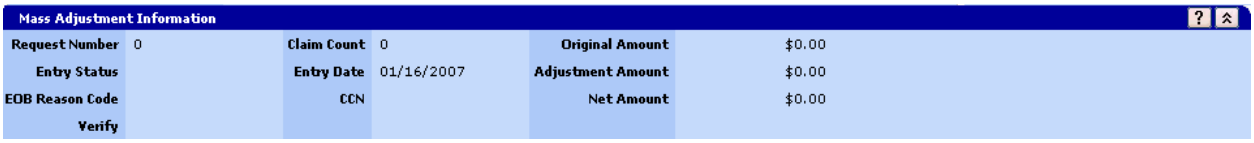
6.69 Mass Adjustment Information Panel

6.69.1 Mass Adjustment Information Panel Narrative

The Mass Adjustment Information panel displays information from a selected mass adjustment record. This panel is display only.

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request]

6.69.2 Mass Adjustment Information Panel Layout



6.69.3 Mass Adjustment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Amount	The adjusted amount of the claim.	Field	Number (Decimal)	10
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Number (Integer)	11
Claim Count	The sequence number of the selected claim in the search list.	Field	Number (Integer)	6
EOB Reason Code	Explanation of Benefit reason for the adjustment.	Field	Number (Integer)	4
Entry Date	The date the adjustment request was entered into the system.	Field	Date (MM/DD/CCYY)	8
Entry Status	Status of the adjustment request to search.	Field	Character	10
Net Amount	The amount by which the Original Amount was adjusted.	Field	Number (Decimal)	10
Original Amount	The original amount of the claim.	Field	Number (Decimal)	10
Request Number	A number that uniquely identifies the adjustment request. Format RRYYJJJBBB (RR – Region, YY – Year, JJJ – Julian date, BBB – Batch number).	Field	Number (Integer)	10
Verify	Indicates the mass adjustment should suspend for review, the adjustment will process through the Claims Engine and will suspend for review at the end of processing.	Field	Character	20

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Field	Description	Field Type	Data Type	Length
	A – Suspend after running through the claims engine. B – Suspend before running through the claims engine. Immediately – Reprocess immediately, without a user's review and release.			

6.69.4 Mass Adjustment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.69.5 Mass Adjustment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.69.6 Mass Adjustment Information Panel Accessibility

6.69.6.1 To Access the Mass Adjustment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment.**	Adjustment Search panel displays.
3	Enter an Adjustment Request.	Mass Adjustment Information panel displays.

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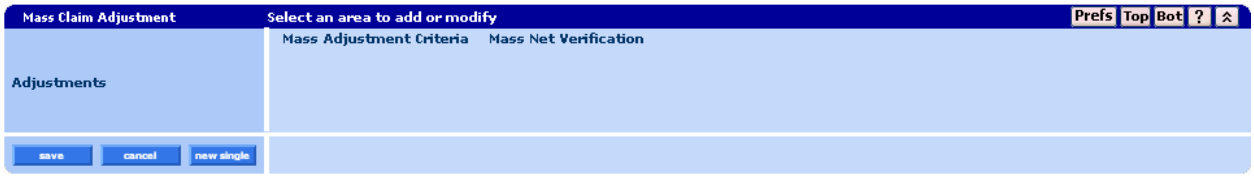
6.70 Mass Claim Adjustment Navigation Panel

6.70.1 Mass Claim Adjustment Navigation Panel Narrative

The Mass Claim Adjustment Navigation panel displays links to the Mass Net Verification panel and the Mass Adjustment Criteria panel. This panel is inquiry only.

Navigation Path: [Claims] – [Adjustments] – [Perform a search and select a mass adjustment request]

6.70.2 Mass Claim Adjustment Navigation Panel Layout



6.70.3 Mass Claim Adjustment Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancels any unsaved changes on the page.	Button	N/A	0
Mass Adjustment Criteria	Activates the Mass Adjustment Criteria search, display, and update panels.	Hyperlink	N/A	0
Mass Net Verification	Activates the Net Verification display and update panels.	Hyperlink	N/A	0
New Single	Starts a new single adjustment.	Button	N/A	0
Save	Causes the record to be saved to the database.	Button	N/A	0

6.70.4 Mass Claim Adjustment Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.70.5 Mass Claim Adjustment Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.70.6 Mass Claim Adjustment Navigation Panel Accessibility

6.70.6.1 To Access the Mass Claim Adjustment Navigation

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment.**	Adjustment Search panel displays.

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Step	Action	Response
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Mass Claim Adjustment Navigation panel displays.

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6.71 Mass Net Verification Panel

6.71.1 Mass Net Verification Panel Narrative

The Mass Net Verification panel permits the user to verify and update the financial changes made to mass adjustment claims. Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [select a mass adjustment request] – [Mass Net Verification]

6.71.2 Mass Net Verification Panel Layout

6.71.3 Mass Net Verification Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The action code determining how the adjustment is processed in batch.	Field	Character	5
Adjusted Amount	Adjusted amount for the displayed claim.	Field	Number (Decimal)	9
Adjusted Status	Indicates the status of the claim which is being adjusted.	Field	Character	10
Adjustment ICN	Field to add a new Internal Control Number for an adjusted claim. User changes the view to a different ICN, but not actually changing the ICN.	Field	Character	13
Adjustment Status	Field to add or update the status of a claim being adjusted.	Field	Character	10
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Character	11
Data Correct	Opens up the Corrections panel for the selected claim.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Delete All	Sets the Adjustment Status field to 'D' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0
Delete Selected	The user may select the checkboxes to the left of the claims and click this button to delete the selected claims.	Button	N/A	0
EOB	Indicates the Explanation of Benefits code entered for the claim.	Field	Number (Integer)	4
Net Amount	Net amount for the displayed claim.	Field	Number (Decimal)	9
New Claim Status	The status of the adjusted claim.	Field	Character	10
Original Amount	Original amount for the displayed claim.	Field	Number (Decimal)	9
Original ICN	Field to add or change original Internal Control Number of an adjusted claim.	Field	Character	13
Resubmit All	Sets the Adjustment Status field to 'R' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0
Resubmit Selected	The user may select the checkboxes to the left of the claims and click this button to set the Adjustment Status field to 'R' for the selected claims.	Button	N/A	0

6.71.4 Mass Net Verification Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Adjusted Status	Field	1	Cannot change Status.	The status cannot be changed based on the value of the current status.
First Service Date	Field	1	First Service Date is required.	Enter First Service Date.
Original ICN	Field	1	Adjustment ICN is required.	Must enter an Adjustment ICN.
Set Status	Field	1	Set Status is required.	Select Status from Set Status dropdown.
Super Suspend	Field	1	Super Suspend Status is required.	Select Status from Super Suspend dropdown.

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Field	Field Type	Error Code	Error Message	To Correct
Update	Combo Box	1	At least one row must be selected in the checkbox to update claim.	Select one row in the checkbox.

6.71.5 Mass Net Verification Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.71.6 Mass Net Verification Panel Accessibility

6.71.6.1 To Access the Mass Net Verification Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Mass Adjustment Navigation panel displays.
4	Select **Mass Net Verification** link from the Mass Adjustment Navigation panel.	Mass Net Verification panel displays.

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6.72 Net Verification Panel

6.72.1 Net Verification Panel Narrative

The Net Verification panel permits the user to verify and update the financial changes made to adjusted claims.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Adjustments] – [Enter Criteria] – [Click Search] – [Select a request] – [Net Verification]

6.72.2 Net Verification Panel Layout

6.72.3 Net Verification Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The action code determining how the adjustment is processed in batch. Values: 'A' - reprocess entire claim, 'P' - only reprocess claim details, 'H' - history only, do not edit, audit, or re-price.	Field	Character	5
Adjusted Amount	Adjusted amount for the displayed claim.	Field	Number (Decimal)	9
Adjustment ICN	Field to add or change new Internal Control Number of an adjusted claim.	Field	Character	13
Adjusted Status	Indicates the status of the claim being adjusted.	Field	Character	10
Adjustment Status	Field to add or update the status of a claim being adjusted.	Combo Box	Drop Down List Box	0
CCN	Cash or check receipt control number used in dispositioning the adjustment with the cash received.	Field	Character	11
Data Correct	Opens up the Corrections panel for the selected claim.	Button	N/A	0
Delete All	Sets the Adjustment Status field to ‘D’ for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
EOB	Explanation of Benefits Code, reason for the adjustment.	Field	Number (Integer)	4
Net Amount	Header total for net amount.	Field	Number (Decimal)	9
New Claim Status	The status of the adjusted claim.	Field	Character	10
Original Amount	Original amount for the displayed claim.	Field	Number (Decimal)	9
Original ICN	Field to add or change original Internal Control Number of an adjusted claim.	Field	Character	13
Resubmit All	Sets the Adjustment Status field to 'R' for all records. Clicking a 2nd time blanks out the adjustment status field.	Button	N/A	0

6.72.4 Net Verification Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.72.5 Net Verification Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.72.6 Net Verification Panel Accessibility

6.72.6.1 To Access the Net Verification Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Adjustment**.	Adjustment Search panel displays.
3	Enter an **Adjustment Request** or perform a **Search** and select from the list.	Adjustment Navigation panel displays.
4	Select **Net Verification** link from the Mass Adjustment Navigation panel.	Net Verification panel displays.

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6.72.6.2 To Delete on the Net Verification Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.72.6.3 To Update on the Net Verification Panel

Step	Action	Response
1	Click line item to be updated.	
2	Click **Resubmit All** or **Data Correct** and select Save.	Data is updated.

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6.73 Claims Suspense List Panel

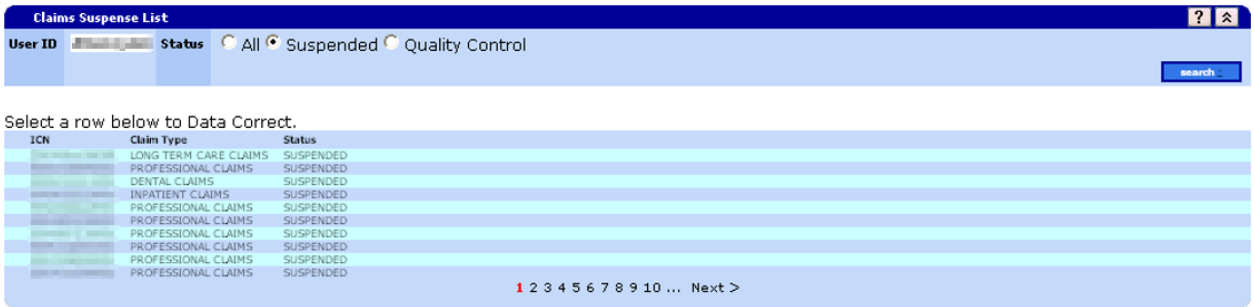
6.73.1 Claims Suspense List Panel Narrative

The Claims Suspense panel is used to list all claims that are in a suspended, or resubmit status. It only lists suspended claims for a given clerk, the clerk being the user who is currently logged onto the application. A user can make data corrections to a claim by selecting it from this listing.

This panel is inquiry only.

Navigation Path: [Claims] – [Data Corrections]

6.73.2 Claims Suspense List Panel Layout



6.73.3 Claims Suspense List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type	Displays the type of claim in suspense.	Field	Alphanumeric	30
ICN	Internal control number (ICN) which uniquely identifies a claim.	Field	Number (Integer)	13
Search	Allows a user to search by User ID and Status.	Button	N/A	0
Status (List)	The status of the claim within the system.	Field	Character	9
Status (Search)	The claims selected by the user depending on the status selected from ALL/Suspended /Quality Control.	Combo Box	Radio Button	0
User ID	The identification number of the user to whom the claims have been assigned.	Field	Character	8

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6.73.4 Claims Suspense List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.73.5 Claims Suspense List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.73.6 Claims Suspense List Panel Accessibility

6.73.6.1 To Access the Claims Suspense List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	Claims Suspense List panel displays.

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6.75 Dental Claim Correction Panel

6.75.1 Dental Claim Correction Panel Narrative

The Dental Data Correction panel is accessed by selecting suspended dental claims from the Claims Suspense List panel.

Only authorized users are allowed to perform maintenance tasks

Dental Claim Corrections are accomplished by changing the data in any of the following fields:

Accident Date

Billed

Current ID

Date Billed

FDOS

First Name

Other Ins

POS

Provider ID

TDOS

TPL

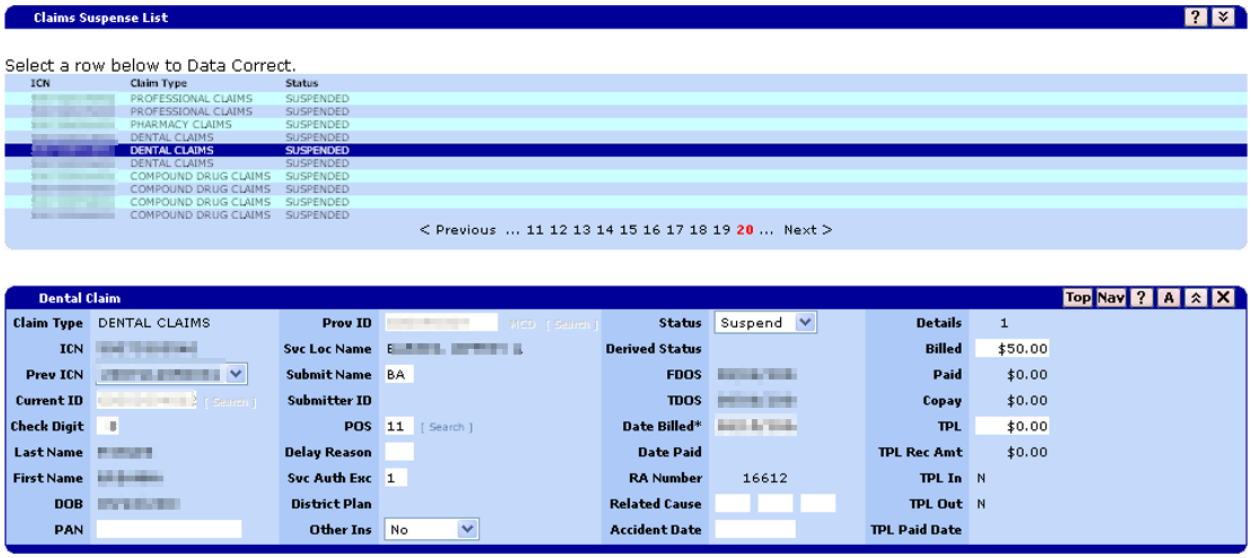
Status (Resubmit)

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted. *This information is currently housed on the WC screen to view and update suspended dental claims in the legacy system.*

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Dental claim from the list]

6.75.2 Dental Claim Correction Panel Layout



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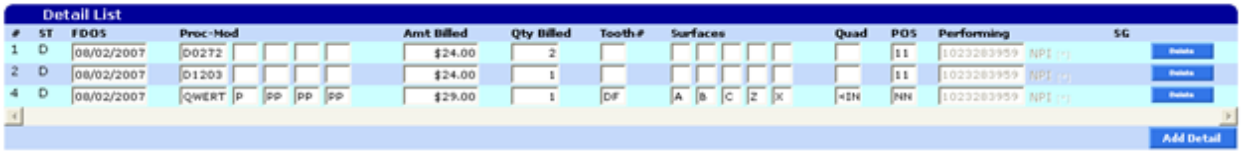

6.75.3 Dental Claim Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date of accident.	Field	Date (MM/DD/CCYY)	8
Add Detail	Adds a detail record.	Button	N/A	0
Amt Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	9
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Check Digit	The 13th digit of an assigned number which uniquely identifies a recipient.	Field	Number	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	Code for delay.	Field	Number (Integer)	1
Delete	Deletes a detail record.	Button	N/A	0
Details	Indicates the number of detail service lines on the claim.	Field	Number (Integer)	9
Derived Status	The displayed status resulting from specific criteria.	Field	Character	20
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the	Field	Character	3

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Field	Description	Field Type	Data Type	Length
	district within each program that controls payment for the claim.			
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Dtl # (#)	The number of the detail on the claim record.	Field	Number(Integer)	4
FDOS	Date of first service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies the claim being corrected.	Field	Number (Integer)	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Other Ins	Indicates if another form of insurance was used.	Combo Box	Drop Down List Box	0
Paid	Amount paid on claim.	Field	Number (Decimal)	9
PAN	Identification for a recipient assigned by a provider. (Patient Account Number)	Field	Character	38
Performing	The identifier for the performing provider. User can enter the provider number or click on the search link [*].	Field	Character	15
POS	Place of Service. Place where services were rendered.	Field	Character	2
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Drop Down List Box	0
Proc-Mod	Code used to identify a procedure and any corresponding modifiers to be billed (up to two); three separate fields.	Field	Character	6
Prov ID	The provider identification number and location that uniquely identifies the provider of services.	Field	Character	15
Quad	Displays the corresponding tooth quadrant code.	Field	Alphanumeric	3

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Field	Description	Field Type	Data Type	Length
Qty Billed	The number of units billed by the provider.	Field	Number (Integer)	6
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number	9
Related Cause	Related causes for accident.	Field	Character	3
SG	Indicates whether detail was added by system during claim's processing.	Field	Drop Down List Box	0
ST	Detail adjudication status.	Field	Character	10
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Surfaces	Code which indicates the Tooth Surface of a particular tooth (up to five).	Field	Character	4
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Date of last service on the claim.	Field	Date (MM/DD/CCYY)	8
Tooth #	The Tooth Number that identifies the tooth the provider rendered services on. An alpha indicates temporary teeth and numeric indicate permanent teeth.	Field	Character	2
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8

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Field	Description	Field Type	Data Type	Length
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

6.75.4 Dental Claim Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billed	Field	1	Enter a Valid Value.	Billed Amount must be numeric.
Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
FDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	FDOS must be less than or equal to the TDOS.	Enter a valid date in MM/DD/CCYY format.
TDOS	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
TPL	Field	1	Enter a valid Value.	TPL Amount must be numeric.

6.75.5 Dental Claim Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.75.6 Dental Claim Correction Panel Accessibility

6.75.6.1 To Access the Dental Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Dental Claim.	Dental Claim Correction panel displays.

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6.75.6.2 To Update the Dental Claim Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a Dental claim.	Dental Claim information displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	Dental Claim data is saved.

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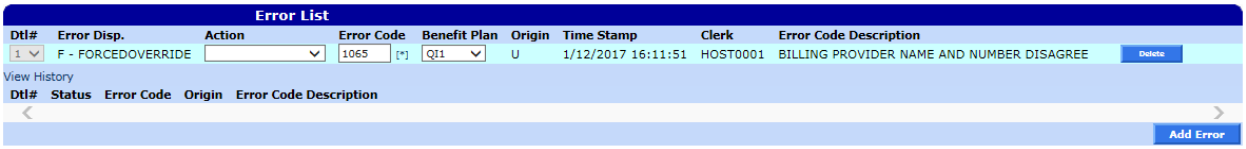
6.76 Error List Panel

6.76.1 Error List Panel Narrative

The Error List panel for Data Correction is accessed for suspended claims. This panel displays the header and/or detail errors applicable to the claim being viewed.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a claim from the list] – [Scroll to the Error List panel] --OR-- [Claims] – [Information] – [Enter ICN, Click on Search] – [Click on “Data Correct” button]

6.76.2 Error List Panel Layout



6.76.3 Error List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action	Action the user takes - either to 'Force Override' or 'Force Deny' the error code.	Field	Drop Down List Box	0
Add Error	Adds a new error record.	Button	N/A	0
Benefit Plan	The medical assistance program associated with the related ICN.	Field	Drop Down List Box	0
Clerk	Number used to identify the user who last updated the error record.	Field	Character	8
Delete	Deletes an error record.	Button	N/A	0
Dtll #	The number of the header or detail that contains an edit or an audit failure.	Field	Drop Down List Box	0
Error Code	Code used to indicate an error was discovered on a claim during processing in the base system. This can be either an edit or an audit.	Field	Number (Integer)	4
Error Code Description	Description of the error.	Field	Character	30
Error Disp.	Code and its description that represents the action that is taken on a claim at disposition time: pay (P), deny (D), suspend (S), force override (F), reject (J), or batch suspend (B).	Field	Drop Down List Box	0
Origin	Indicates how the EOB Code and message were generated: Valid values	Field	Character	1

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Field	Description	Field Type	Data Type	Length
	are 'S - System Generated' or 'U - User Assigned.			
Status	Indicates whether the Error is current or history.	Field	Drop Down List Box	0
Time Stamp	Date and Time of the error code.	Field	Number (Integer)	8
View History	Displays all history records.	Hyperlink	N/A	0

6.76.4 Error List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Action	Field	1	Action must be selected on Error List panel for detail number.	Select valid action from action dropdown.
Error Code	Field	1	A valid Error Code is required.	Enter a valid Error Code or select a valid code from the search link [*].
	Field	2	Error Code XXXX cannot be overridden.	Enter a valid Error Code or select a valid code from the search link [*].

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6.76.5 Error List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.76.6 Error List Panel Accessibility

6.76.6.1 To Access the Error List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Enter appropriate search criteria for suspended claim and click **Search.**	Claim Search Results Panel displays.
4	Click required record in search result	Claim Header, Maintenance and Claim Detail panels are displayed.
5	Click **data correct** button.	Claim Header, Maintenance, Claim detail list, Error list, Data Correction Note, Manual Pricing, Diagnosis Codes, NDC Details, Related History, Payer Code, ICD9 Codes, Occurrence codes, value codes, condition codes and Medicare data panels are displayed for data correction.

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6.77 Pharmacy Data Correction Panel

6.77.1 Pharmacy Data Correction Panel Narrative

The Pharmacy Data Correction panel is accessed by selecting suspended pharmacy claims from the Claims Suspense List panel. Claim corrections are accomplished by changing the data in any of the following fields:

RX Date
Prescrib Prov
Days Supply
Refill Number
Date Billed
TPL
Prescription Number
Emergency
NursingHome
Clarification Code 1
Clarification Code 2
Clarification Code 3
Copay Exemption
RX Origin
Other Cov Code
Brand Req
Disp Date
Billed
Usual/Cust Amt
Gross Due Amt
Pregnancy
Other Payer Pat Resp Amt

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a Pharmacy claim from the list]

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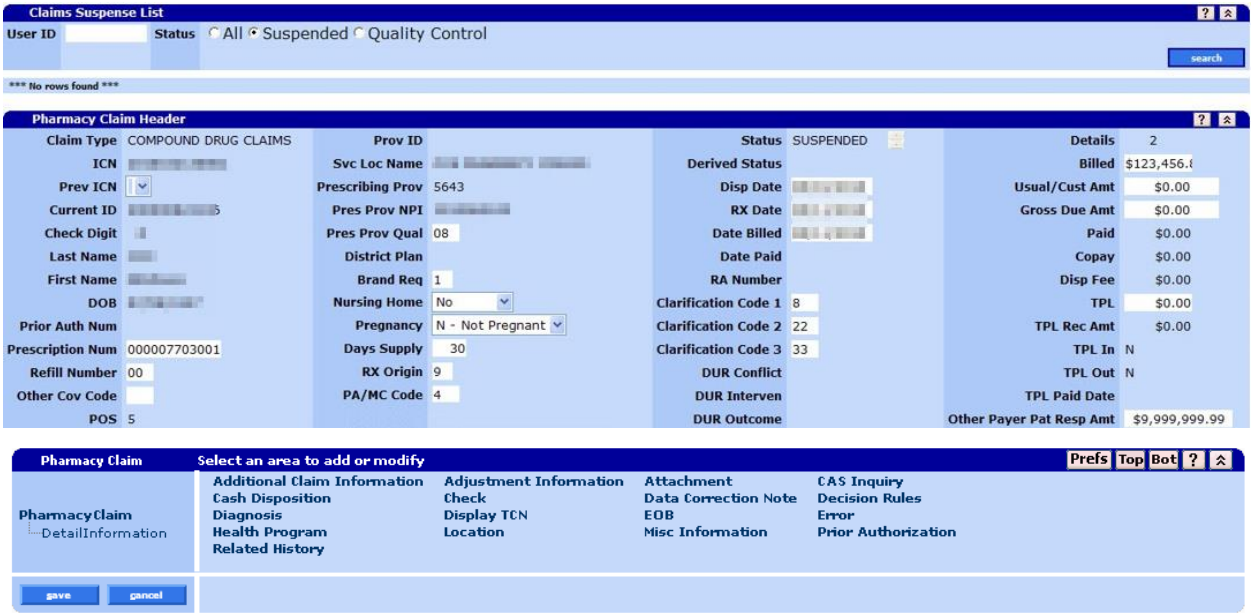
6.77.2 Pharmacy Data Correction Panel Layout



6.77.3 Pharmacy Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	8
Brand Req	Indicates the reason, if any, that a brand name drug was dispensed as written.	Field	Character	1
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Combo Box	Drop Down List Box	0
Clarification Code 1	The "Submission Clarification Code" is used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients.) If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other			
Clarification Code 2	The "Submission Clarification Code" is used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients.) If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other	Field	Character	2
Clarification Code 3	The "Submission Clarification Code" is used on compound pharmacy claims. Providers use it to indicate if they want payment for only the ingredients that are approved (payable) , this would be a value of "8" (process compound for approved ingredients.) If they give us any other value, then we reject the claim if one of more ingredients is not payable or sets some sort of edit. Valid Values include: 0=Not Specified 1=No Override 2=Other Override 3=Vacation Supply	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process Compound For Approved - this allows a compound claim to pay when one or more line items are not payable. 9=Encounters 99=Other			
Copay	Amount paid by recipient for services rendered. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Copay Exemption	Used to indicate if the claim is not subject to copayment. Valid values include: Y or blank.	Field	Character	2
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	8
DUR Conflict	Reason for Service/Conflict Code used to override a Drug Utilization Review alert.	Field	Character	2
DUR Interven	The intervention response of the pharmacist to the Drug Utilization Review message.	Field	Character	2
DUR Outcome	The outcome response of the pharmacist to the Drug Utilization Review message.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Date Billed	The date on which a claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Days Supply	Number of days a prescribed drug should last a recipient.	Field	Number (Integer)	9
Details	The number of detail service lines on the claim.	Field	Number (Integer)	9
Disp Date	Date pharmacy dispensed the drug to the recipient.	Field	Date (MM/DD/CCYY)	8
Disp Fee	Amount of dispensing fee, if paid.	Field	Number (Decimal)	7
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
Gross Due Amt	The value submitted by the provider in the gross amount due field (NCPDP field 430 –DU).	Field	Character	9
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Nursing Home	Indicates whether the recipient is in a nursing home.	Combo Box	Drop Down List Box	0
Other Cov Code	This field holds the value submitted from the NCPDP request located in NCPDP field 308-C8.	Field	Character	2
Other Payer Pat Resp Amt	The patient's cost share from a previous payer.	Field	Number(Decimal)	10
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Pregnancy	Indicates the claim is pregnancy related.	Combo Box	Drop Down List Box	0
POS	Place Of Service.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Prescribing Prov	Provider License Number that uniquely identifies the Prescribing Provider.	Field	Character	15
Prescription Num	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Character	12
Pres Prov NPI	National Provider Identifier for the prescribing provider.	Field	Number (Integer)	10
Pres Prov Qual	The prescribing provider qualifier tells whether the provider's state license or NPI is used.	Field	Character	2
Prev ICN	This field allows the user to select any of the other Previous internal control numbers for the claim and view that information.	Combo Box	Dropdown Box	0
Prior Auth Num	Display the prior authorization number submitted by the provider on the pharmacy request.	Field	Character	10
Prov ID	The provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
RX Date	The Date the drug prescription (Rx) was either filled or written.	Field	Date (MM/DD/CCYY)	8
RX Origin	Indicates the method used to submit a prescription to a pharmacy. Valid values include: 0 – Not specified 1 – Written 2 – Telephone 3 – Electronic 4 – Fax	Field	Character	1
Refill Number	Number of refills on the prescription.	Field	Character	2
Status	Identifies the status of the claim in the system.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Usual/Cust Amt	The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).	Field	Character	9

6.77.4 Pharmacy Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Billed	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
Disp Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	103	Dispense date must be prior to or equal to date billed.	Enter a valid date in MM/DD/CCYY format.
Gross Due Amt	Field	1	Gross Due Amt field must be equal to or greater than the Usual/Cust Amt field.	Verify the entry for fields Gross Due Amt and Usual/Cust Amt and correct it.
RX Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Rx Date is required.	Enter a valid date in MM/DD/CCYY format.
TPL	Field	1	Enter a valid value.	Enter a valid numeric value.

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6.77.5 Pharmacy Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.77.6 Pharmacy Data Correction Panel Accessibility

6.77.6.1 To Access the Pharmacy Data Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Pharmacy claim.	Pharmacy Claim panel displays.

6.77.6.2 To Update the Pharmacy Data Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a **Pharmacy** claim.	Pharmacy Claim information panel displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	Pharmacy Claim data is saved.

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6.78 Physician Data Correction Panel

6.78.1 Physician Data Correction Panel Narrative

The Physician Data Correction panel is opened by the system automatically from the first claim listed in the Claims Suspense List panel.

Only users with update authority are allowed to perform maintenance tasks.

Claim corrections can be accomplished by changing the data in any of the following fields:

Status

Current ID

Last Name

First Name

FDOS

TDOS

Refer Prov 1

Refer Prov 2

Attachment

Patient Acct Number

Date Billed

TPL Amount

Accident Date

After data correction is done, the user can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a physician claim from the list]

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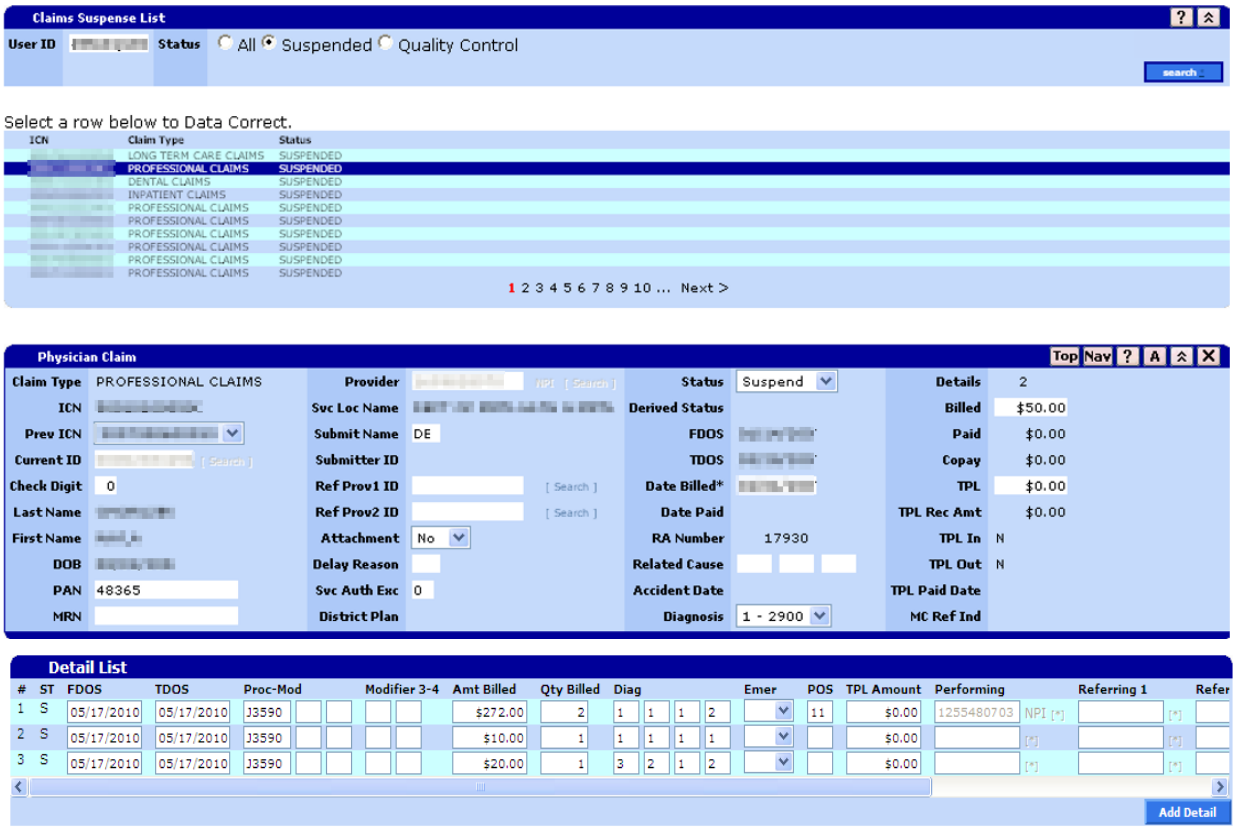
6.78.2 Physician Data Correction Panel Layout



6.78.3 Physician Data Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	Date of accident.	Field	Date (MM/DD/CCYY)	8
Add Detail	Adds a detail record.	Button	N/A	0
Amt Billed	Amount of money requested for payment by a provider for services rendered.	Field	Number (Decimal)	9
Attachment	Indicates whether an attachment is present.	Combo Box	Drop Down List Box	0
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Field	Character	50
Copay	The sum of all the detail co-pay amounts applicable to the claim. This	Field	Number (Decimal)	7

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Field	Description	Field Type	Data Type	Length
	is the amount the Recipient is responsible for.			
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid		Field	Date (MM/DD/CCYY)	8
Delay Reason	Code for delay.	Field	Number (Integer)	1
Delete	Deletes a detail record.	Button	N/A	0
Details	The number of detail service lines on the claim.	Field	Number (Integer)	4
Diag 1	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 2	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 3	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diag 4	Indicates which diagnosis or diagnoses applies to the service billed on a particular detail line. Valid values are 1 to 4 for paper claims and 1 to 12 for electronic claims.	Field	Number (Integer)	2
Diagnosis	Code used to identify the primary or other diagnoses.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Dtl # (#)	The number of the detail on the claim record.	Field	Number(Integer)	4
Emer	Indicates whether the service was provided as result of emergency situation.	Field	Drop Down List Box	0
EPSDT FP	Code from the CMS 1500 claim form, block 24 H, indicating EPSDT or Family Planning.	Field	Character	1
EPSDT Ref	EPSDT referral/treatment information.	Field	Drop Down List Box	0
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
MC Ref Ind	Managed Care Referral Indicator.	Field	N/A	0
Modifier 3-4	Third and Fourth modifier to the procedure code; two separate fields.	Field	Character	2
MRN	Code representing the Medical Record Number.	Field	Character	50
PAN	Patient’s unique identification number assigned by the provider to track the patient’s financial records.	Field	Character	38

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Field	Description	Field Type	Data Type	Length
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Performing	The rendering provider identification number and location that uniquely identifies the provider of services.	Field	Number (Integer)	10
POS	Place of Service where services were rendered.	Field	Character	2
Prev ICN	This field allows the user to select any of the claim's prior Internal Control Number and obtain information on them.	Combo Box	Drop Down List Box	0
Proc-Mod	Code used to identify a procedure and any corresponding modifiers to be billed (up to two); three separate fields.	Field	Character	6
Provider	The pay to provider identification number that uniquely identifies the provider of services.	Field	Character	15
Qty Billed	The number of units billed by the provider.	Field	Number (Integer)	6
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Ref Prov1 ID	The license number of the referring physician other than the attending physician.	Field	Character	9
Ref Prov2 ID	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Character	15
Referring Prov 1	Provider Identification Number that uniquely identifies the referring provider.	Field	Number (Integer)	10
Referring Prov 2	Provider Identification Number that uniquely identifies the referring provider. N/A for Alabama Medicaid.	Field	Number (Integer)	10
Related Cause	Related causes for accident.	Field	Character	3
SG	Indicates whether detail was added by system during claim's processing.	Field	Drop Down List Box	0
ST	Detail adjudication status.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Status	This field displays the status of the claim.	Combo Box	Drop Down List Box	0
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL Amount	Amount paid by third party for services (Not displayed in panel).	Field	Number (Decimal)	9
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Displays the TPL paid date.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9

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6.78.4 Physician Data Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billed	Field	1	Enter a valid value.	Enter a numeric value.
Date Billed	Field	1	Invalid Date.	Verify format and re-enter.
	Field	2	TDOS must be less than or equal to Billed Date.	Verify format and re-enter.
Diag2	Field	1	[Informational Message] INFO : Diagnosis indicator must be less than or equal to number of header diagnoses on the claim.Boxes must be completed left to right and cannot be skipped.At least one diagnosis indicator is required on each detail.	Verify the value and re-enter a value to reference the header diagnosis code codes to which the procedure is related.
	Field	2	[Informational Message] INFO :Diagnosis Code Pointer cannot contain duplicate values.	Verify the value and re-enter a value to reference the header diagnosis code codes to which the procedure is related.
FDOS	Field	1	Invalid Date.	Verify date and format and re-enter.
	Field	2	FDOS can not be greater than today's date.	Verify date and format and re-enter.
	Field	3	First Service Date is required.	Verify date and format and re-enter.
	Field	4	FDOS must be less than or equal to TDOS.	Verify date and format and re-enter.
TDOS	Field	1	Invalid Date.	Enter a valid date.
	Field	2	TDOS cannot be greater than today's date.	Enter a valid date.
TPL	Field	1	Enter a valid value.	Enter a numeric value.

6.78.5 Physician Data Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.78.6 Physician Data Correction Panel Accessibility

6.78.6.1 To Access the Physician Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Data Correction**.	Claims Suspense List panel displays.
3	Enter **Clerk ID** and click **Search**.	
4	Select a Physician claim.	Physician Claim panel displays.

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6.78.6.2 To Update the Physician Claim Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a Physician claim.	Physician Claim Information panel displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	Physician Claim data is saved.

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6.79 UB04 Claim Correction Panel

6.79.1 UB04 Claim Correction Panel Narrative

The UB04 Claims Correction UB04 Data Correction panel is accessed by selecting suspended Inpatient claims from the Claim Suspense Listing panel.

Only users with update authority are allowed to perform maintenance tasks.

UB04 Claim corrections are accomplished by changing the data in any of the following fields.

Type of Bill

Claim Status

Current ID

Last Name

First Name

Provider ID

FDOS

TDOS

Attend Prov

Cvd Days

Ncvd Days

Admit Date

Other Prov 1

Other Prov 2

Date Billed

Admit Source

Admit Time

Admit Type

Patient Status

MRN

PAN

After data correction is complete, the examiner can resubmit the claim. Claim resubmission allows the claim to go through the claims processing cycle, subjecting it again to the edits and audits. The claim enters the processing cycle as soon as it is resubmitted.

Navigation Path: [Claims] – [Data Correction] – [Enter Clerk ID, search then select a UB04 claim from the list]

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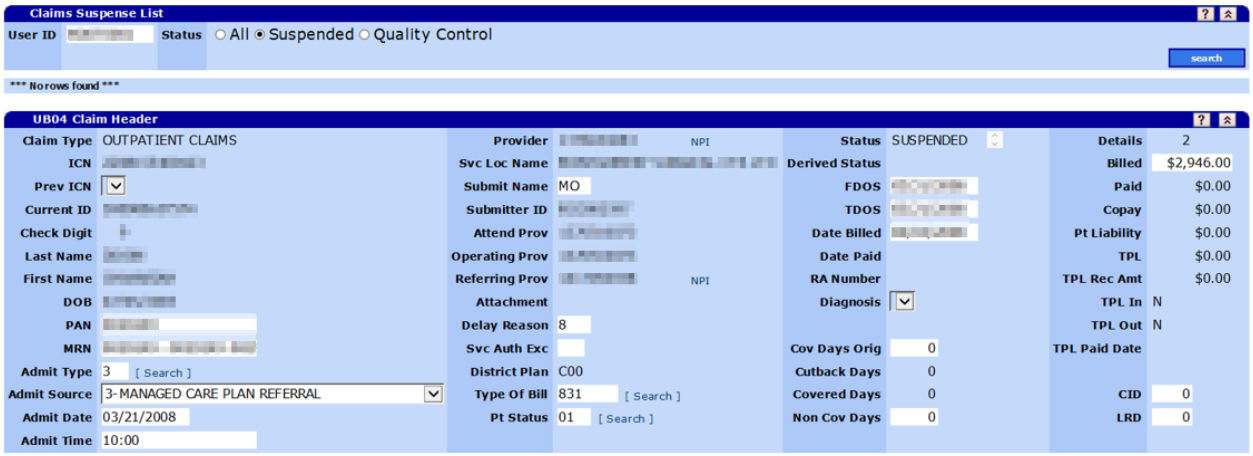
6.79.2 UB04 Claim Correction Panel Layout



6.79.3 UB04 Claim Correction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admit Date	The date the patient was admitted to the facility for care.	Field	Date (MM/DD/CCYY)	8
Admit Source	Displays the admit source for institutional claims.	Combo box	Drop Down List Box	0
Admit Time	The time that the recipient was admitted to the facility for care	Field	Number (HH:MM)	4
Admit Type	Code indicating the type of admission.	Field	Character	1
Attachment	Indicates whether an attachment is present.	Combo Box	Drop Down List Box	0
Attend Prov	Attending physician's NPI number.	Field	Character	10
Billed	Amount requested by the provider for services rendered.	Field	Number (Decimal)	8
CID	Co-insurance days.	Field	Number (Integer)	6
Check Digit	Check Digit for Medicaid ID.	Field	Character	1
Claim Type	Indicates the type of claim.	Field	Character	1
Copay	The sum of all the detail co-pay amounts applicable to the claim. This is the amount the Recipient is responsible for.	Field	Number (Decimal)	7
Cov Days Orig	Original number of covered days.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
Cutback Days	Days displayed will be the difference between total days and covered days.	Field	Number (Integer)	3
Current ID	The assigned number which uniquely identifies a recipient.	Field	Character	12
Covered Days	Number of days covered by the primary payer.	Field	Number (Integer)	4
District Plan	Partnership Hospital Program (PHP) code begins with 'H' and Maternity Waiver Program code begins with 'P'. The 2-digit number identifies the district within each program that controls payment for the claim.	Field	Character	3
DOB	Recipient date of birth.	Field	Date (MM/DD/CCYY)	8
Date Billed	Date on which claim was submitted for processing.	Field	Date (MM/DD/CCYY)	8
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	8
Delay Reason	A reason code for the delay in filing a claim.	Field	Alphanumeric	1
Details	The number of detail service lines on the claim.	Field	Number (Integer)	9
Diagnosis	Code used to identify the primary or other diagnoses.	Combo Box	Drop Down List Box	0
FDOS	Beginning date of service on the claim.	Field	Date (MM/DD/CCYY)	8
First Name	The first name of the recipient associated with the Current ID. If the first name and the Current ID don't match the first character of the first name that was keyed is displayed.	Field	Character	15
ICN	Internal control number which uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
LRD	Lifetime Reserve Days.	Field	Number (Integer)	6
MRN	Code representing the Medical Record Number.	Field	Character	50
Non Cov Days	The number of days that were not covered.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Operating Prov	The NPI number of the Operating physician.	Field	Character	10
PAN	Patient's unique identification number assigned by the provider to track the patient's financial records.	Field	Character	38
Paid	Amount paid on claim.	Field	Number (Decimal)	8
Pt Liability	The amount of patient liability that was used on the claim.	Field	Number (Decimal)	12
Pt Status	Codes indicating the patient's status as of the ending service date of the period covered on the claim.	Field	Character	2
Prev ICN	This field allows the user to select any of the claim's prior internal control numbers and obtain information on them.	Combo Box	Drop Down List Box	0
Provider	The provider identification number that uniquely identifies the provider of services.	Field	Character	15
RA Number	The unique identification number that identifies a Remittance Advice.	Field	Number (Integer)	9
Referring Prov	Provider Identification Number that uniquely identifies the Referring Provider.	Field	Character	15
Status	Identifies the status of the claim within the system.	Combo Box	Drop Down List Box	0
Submit Name	First two characters of the last name of provider or business.	Field	Alphanumeric	2
Submitter ID	Submitter of Electronically submitted claims at the header level.	Field	Character	9
Svc Auth Exc	Service Authorization Exception Code. Valid values include: 1 - Immediate/Urgent Care 2 – Services Rendered in a Retroactive Period 3 – Emergency Care 4 – Client as Temporary Medicaid 5 – Bypass Provider Contract Check 6 – Claim exempt from program edits 7 – Force into MAT Care Program	Field	Number (Integer)	1

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Field	Description	Field Type	Data Type	Length
Svc Loc Name	Service Location name of the provider.	Field	Character	30
TDOS	Ending date of service on the claim.	Field	Date (MM/DD/CCYY)	8
TPL	Amount paid by third party for services, at the claim header level.	Field	Number (Decimal)	8
TPL In	The code reflects the input of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Out	The code reflects the output of TPL edit in the claim processing system.	Field	Alphanumeric	2
TPL Paid Date	Date TPL paid the claim.	Field	Date (MM/DD/CCYY)	8
TPL Rec Amt	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	9
Type of Bill	A code indicating the specific type of bill.	Field	Character	3
User ID	Indicates the identification number of the user assigned to the claims.	Field	Character	8

6.79.4 UB04 Claim Correction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Admit Date	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Admit Date must be greater than or equal to 01/01/1990.	Enter an Admit Date greater than or equal to 01/01/1990.
Admit Time	Field	2	Admit Time contains an invalid value.	Admit time must be between 0000 and 2359.
Billed	Field	1	Enter a valid value.	Billed amount must be numeric.
Date Billed	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Date Billed must be greater than or equal to 01/01/1990.	Enter a Date Billed greater than or equal to 01/01/1990.
FDOS	Field	1	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	FDOS must be greater than or equal to 01/01/1990.	Enter a FDOS date greater than or equal to 01/01/1990.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	102	First date of service must be prior to or equal to the last date of service.	Enter a valid date in MM/DD/CCYY format.
Pt Status	Field	1	A valid Patient Status is required.	Enter a valid Patient Status or select a value from the [Search] panel.
TDOS	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
	Field	2	TDOS must be greater than or equal to 01/01/1990.	Enter a TDOS that is greater than or equal to 01/01/1990.

6.79.5 UB04 Claim Correction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.79.6 UB04 Claim Correction Panel Accessibility

6.79.6.1 To Access the UB04 Claim Correction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to Claims and click Data Corrections.	
3	Enter a **Clerk ID** and select a UB04 claim.	UB04 Claim panel displays.

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6.79.6.2 To Update the UB04 Claim Correction Panel

Step	Action	Response
1	Point to Claims and click Data Corrections.	Data Corrections search panel displays.
2	Enter a **Clerk ID** and select a **UB04** claim.	UB04 Claim information panel displays.
3	Click **Add** and update appropriate data.	
4	Click **Save**.	UB04 Claim data is saved.

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6.80 Assignments Navigation Panel

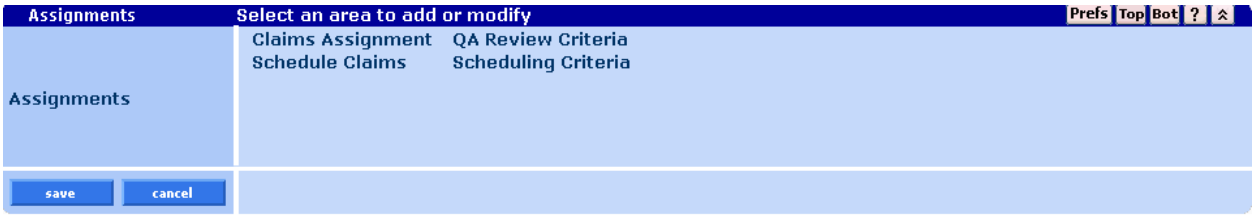
6.80.1 Assignments Navigation Panel Narrative

The Assignments Navigation panel contains links to the panels for Claims Assignment area.

This panel is inquiry only.

Navigation Path: [Claims] – [Assignments]

6.80.2 Assignments Navigation Panel Layout



6.80.3 Assignments Navigation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	This allows the user to cancel any changes on the Assignments panel.	Button	N/A	0
Claims Assignment	A link to the Claims Assignment panel.	Hyperlink	N/A	0
QA Review Criteria	A link to the QA Review Criteria panel.	Hyperlink	N/A	0
Save	This allows the user to save a record for Assignments.	Button	N/A	0
Schedule Claims	A link to the Schedule Claims panel.	Hyperlink	N/A	0
Scheduling Criteria	A link to the Scheduling Criteria panel.	Hyperlink	N/A	0

6.80.4 Assignments Navigation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.80.5 Assignments Navigation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.80.6 Assignments Navigation Panel Accessibility

6.80.6.1 To Access the Assignments Navigation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignement Navigation panel displays.

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6.81 Claims Assignment Panel

6.81.1 Claims Assignment Panel Narrative

The Claims Assignment panel allows the manager, or lead, to reassign claims to the user by changing the User ID associated with a claim. These claims can be assigned by claim type or claim status.

Only authorized users are allowed to perform maintenance tasks

Navigation Path: [Claims] – [Assignments] – [Claims Assignment]

6.81.2 Claims Assignment Panel Layout

6.81.3 Claims Assignment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Advanced Search Button, opens a panel with additional search criteria fields.	Button	N/A	0
Batch Range From	Batch Range From value that allows the manager to limit the selection of claims to a specific batch range.	Field	Character	3
Batch Range To	Batch Range To value that allows the manager to limit the selection of claims to a specific batch range.	Field	Character	3
Claim Type	Indicates the claim type assigned to the user.	Combo Box	Drop Down List Box	0
Clear	Clears the previous search criteria from the search fields.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Current ID	Allows the manager to limit the selection to a specific Recipient identification number.	Field	Character	12
Cycle Date	Allows the manager to limit the selection to a specific cycle date.	Field	Date (MM/DD/CCYY)	8
ICN	Allows the manager to limit the selection to a specific ICN (Internal Control Number) that uniquely identifies a claim.	Field	Number (Integer)	13
Location	Allows the manager to limit the selection of claims to a specific location.	Combo Box	Drop Down List Box	0
Region	Allows the manager to limit the selection of claims to a specific region.	Combo Box	Drop Down List Box	0
Rendering Provider ID	Allows the manager to limit the selection of claims to the individual provider number from the claims and provider.	Field	Character	15
Search	Performs a query on the database and returns the data for the entered search criteria.	Button	N/A	0
Status	Displays the claims selected by the user depending on the status selected.	Combo Box	Drop Down List Box	0
Update	Updates the claim assignment information.	Button	N/A	0
User ID	Indicates the identification number of the user assigned to the claims.	Field	Character	8

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6.81.4 Claims Assignment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Range From	Field	1	Batch Entry must be numeric.	Enter a numeric value.
	Field	2	Batch To must be less than or Equal to Batch From.	Enter a numeric value.
Batch Range To	Field	1	Batch Entry must be numeric.	Enter a numeric value.
	Field	2	Batch To must be less than or equal to Batch From.	Enter a numeric value.
Claim Type	Field	1	Must select a Claim Type and Status.	Select a value for claim type.
Current ID	Field	1	Current ID must be numeric.	Enter a numeric value.
	Field	2	Current ID must be numeric.	Enter a numeric value.
Cycle Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Verify format and re-enter.
ICN	Field	1	ICN must be numeric.	Enter a numeric value.
Status	Field	1	Must select a Claim Type and Status.	Select a valid Status from the drop down box.
Update	Button	1000	User ID is required.	Enter a valid User ID in the User ID data entry box.
	Button	1001	No Claim Assignments selected.	Select at least one claim assignment from the data list.

6.81.5 Claims Assignment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 Claims Assignment Panel Accessibility

6.81.6.1 To Access the Claims Assignment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Logi**n.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Maintenance panel displays.
3	Click Claims Assignment.	Claims Assignment panel displays.

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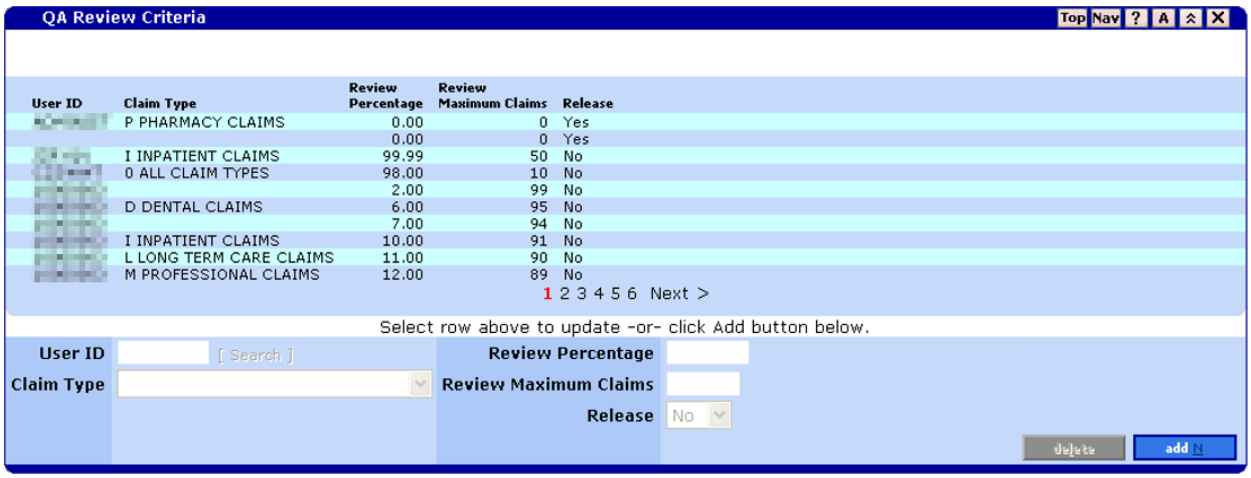
6.82 QA Review Criteria Panel

6.82.1 QA Review Criteria Panel Narrative

The QA Review Criteria panel allows the manager or lead, to set the number of claims for each user for quality review. These claims can be set by claim type. The percent and maximum number of claims needed for review can also be set. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Assignments] – [QA Review Criteria]

6.82.2 QA Review Criteria Panel Layout



6.82.3 QA Review Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Claim Type	Indicates the type of claim assigned to the user for review.	Combo Box	Drop Down List Box	0
Delete	Allows a user to delete a record.	Button	N/A	0
Release	Indicates if the claims assigned to the user are to be released at the end of the day or held until reviewed by the manager or lead.	Combo Box	Drop Down List Box	0
Review Maximum Claims	Maximum number of claims needed from the percentage to be checked for quality.	Field	Number (Integer)	5
Review Percentage	The percent of the user's claims per day to be quality checked.	Field	Numeric (Decimal)	4
User ID	Indicates the user the claims are assigned.	Field	Character	8

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6.82.4 QA Review Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required.	Select a Claim Type from the list.
Release	Field	1	Release Indicator is required.	Select a Release Indicator from the list.
Review Maximum Claims	Field	1	Enter a valid value.	Verify value entered is numeric and greater than or equal to 0.
	Field	2	Review Maximum Claims is required.	Enter a valid value.
	Field	3	Review Maximum Claims must be less than or equal to 99999.	Enter a value less than or equal to 99999.
Review Percentage	Field	1	Percentage must be greater than or equal to 0.	Enter a Percentage greater than or equal to 0.
	Field	2	Enter a valid value.	Verify Percentage entered is numeric.
	Field	3	Percentage is required.	Enter a Review Percentage.
	Field	4	Percentage must be less than or equal to 99.99.	Enter a Review Percentage less than or equal to 99.99.
User ID	Field	1	A valid User ID is required.	Enter a User ID or click on search and select one from the list.

6.82.5 QA Review Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.82.6 QA Review Criteria Panel Accessibility

6.82.6.1 To Access the QA Review Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Navigation panel displays.

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Step	Action	Response
3	Select QA Review Criteria.	QA Review Criteria panel displays.

6.82.6.2 To Add on the QA Review Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update appropriate data.	
3	Select **Save**.	QA Review information data saved.

6.82.6.3 To Delete on the QA Review Criteria Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.83 Schedule Claims Panel

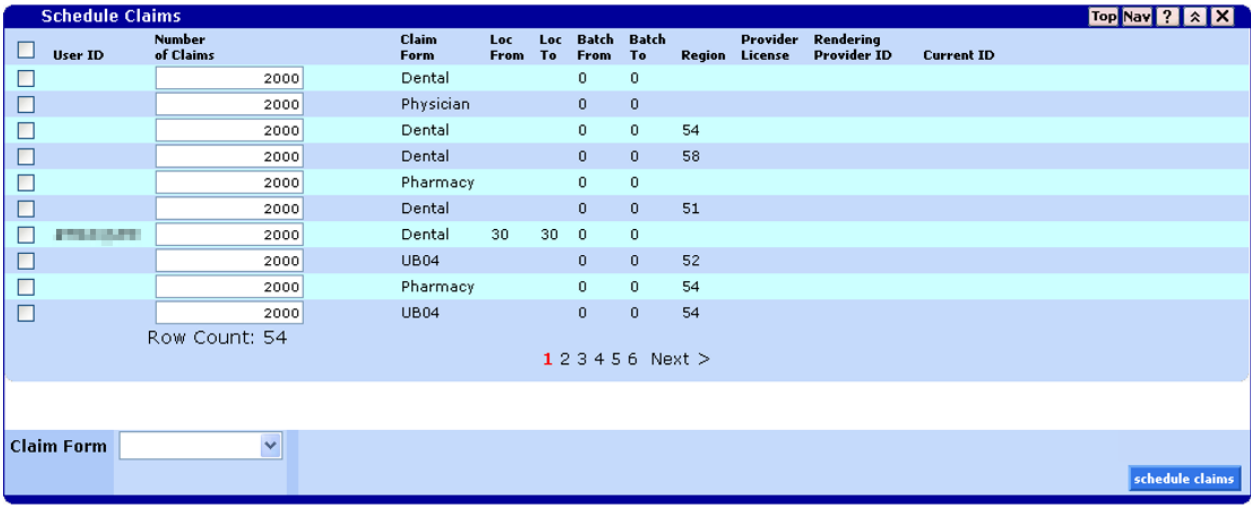
6.83.1 Schedule Claims Panel Narrative

The Schedule Claims panel allows the manager or lead, to distribute claims for the users on a daily basis. Claims can be assigned by claim type, or all claim types can be assigned at once.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Assignments] – [Schedule Claims]

6.83.2 Schedule Claims Panel Layout



6.83.3 Schedule Claims Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Batch From	The beginning batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Batch To	The ending batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Claim Form	Indicates the type of claim assigned to the user for review.	Combo Box	Drop Down List Box	0
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Number (Integer)	12
Loc From	The beginning location of the claims assigned to the user.	Field	Character	2
Loc To	The ending location of the claims assigned to the user.	Field	Character	2
Number of Claims	Number of claims found for the User.	Field	Number (Integer)	5
Provider License	License number of the provider of services.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
Region	The beginning region code of the claims assigned to the user.	Field	Character	2
Rendering Provider ID	The provider identification number that uniquely identifies the provider.	Field	Character	15
Schedule Claims	Runs the process to schedule suspended claims to Users based on the Claim Type [form] and rows checked.	Button	N/A	0
User ID	Indicates the user the claims are assigned.	Field	Character	8

6.83.4 Schedule Claims Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Form	Field	1	Claim Form was not specified.	Please choose a claim form.
User ID	Field	1	Select at least one user to schedule the claim.	Please choose a user ID.

6.83.5 Schedule Claims Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.6 Schedule Claims Panel Accessibility

6.83.6.1 To Access the Schedule Claims Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Navigation panel displays.
3	Select **Schedule Claims** link from the Assignments navigation panel.	Schedule Claims panel displays.

6.83.6.2 To Update the Schedule Claims Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Schedule Claims information is saved.

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6.84 Scheduling Criteria Panel

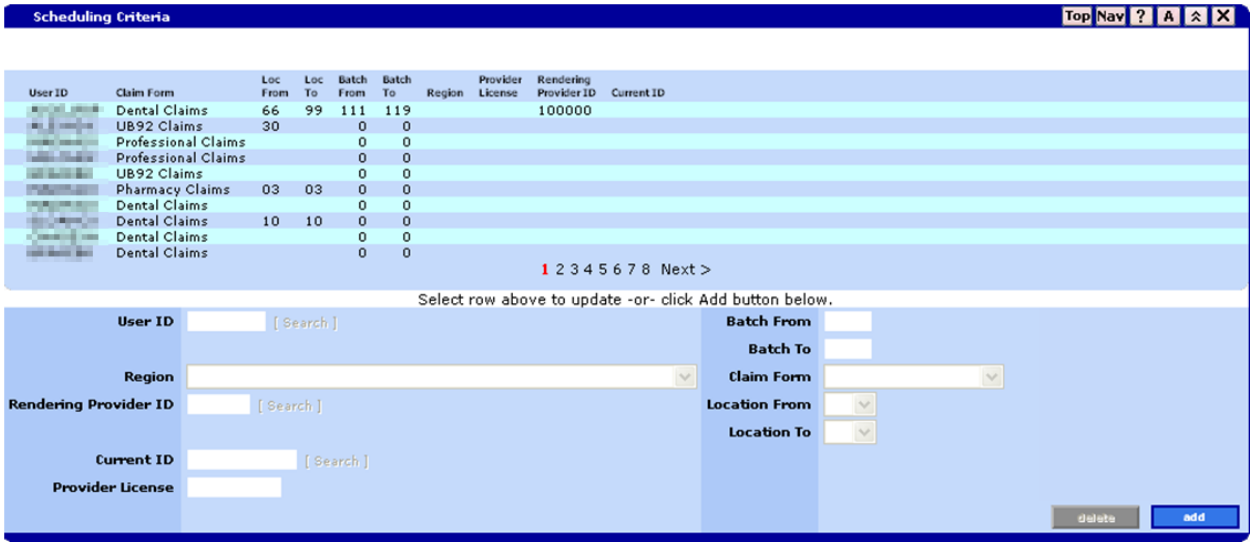
6.84.1 Scheduling Criteria Panel Narrative

The Scheduling Criteria Panel will allow assigning the user ID to a claim form, delete the already assigned user IDs and also change the criteria information for a user ID. Some of the fields on the Criteria Panel are optional. The Scheduling Criteria panel also allows the manager or lead to distribute claims for the users on a daily basis. Required criteria fields are User and Claim Type. Optional fields are Location Range, Batch Range, Region, Rendering Provider, and Current ID. Claims can be assigned by claim type, or all claim types can be assigned at once.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Assignments] – [Scheduling Criteria]

6.84.2 Scheduling Criteria Panel Layout



6.84.3 Scheduling Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Batch From	The beginning batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Batch To	The ending batch number used to identify the grouping of the claims.	Field	Number (Integer)	3
Claim Form	Indicates the claim form to assign.	Combo Box	Drop Down List Box	0
Current ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Number (Integer)	12

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Field	Description	Field Type	Data Type	Length
Delete	Allows the user to delete a record.	Button	N/A	0
Location From	The beginning location of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Location To	The ending location of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Provider License	License number of the provider of services.	Field	Character	9
Region	The beginning region code of the claims assigned to the user.	Combo Box	Drop Down List Box	0
Rendering Provider ID [Search]	The provider identification number that uniquely identifies the provider and provider's service location. Select a valid Provider identification number from the [Search] panel.	Hyperlink	N/A	0
User ID [Search]	Indicates the user the claims are assigned to. Select a valid User identification number from the [Search] panel.	Hyperlink	N/A	0

6.84.4 Scheduling Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch From	Field	102	Must enter valid Batch From and To numbers.	Only numeric values are accepted in this field.
	Field	103	Batch From number must be less than or equal Batch To number.	Only numeric values are accepted in this field.
Batch To	Field	102	Must enter valid Batch From and To numbers.	Only numeric values are accepted in this field.
Claim Form	Field	1	Claim Type is required.	Select a valid Claim Form Type.
Location From	Field	1	A valid Location From is required.	Select a valid Location From value.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	101	Must enter valid from and to claim locations.	If a From location is entered, a To location must also be entered.
	Field	104	From claim location must be less than or equal to claim location.	If a From location is entered, a To location must also be entered.
Location To	Field	1	A valid Location To is required.	Select a valid Location To value.
	Field	101	Must enter valid from and to claim locations.	If a To value is entered, a valid From value must also be entered.
	Field	104	From claim location must be less than or equal to claim location.	If a To value is entered, a valid From value must also be entered.
Provider License	Field	106	Only Pharmacy claims are allowed to have provider license numbers. All other claims require NPIs.	If the claim is not a Pharmacy, then a License number cannot be entered.
Rendering Provider ID [Search]	Hyperlink	105	Only CMS and Dental Claims are allowed to have rendering providers.	Enter provider criteria for all claims except pharmacy claims. Pharmacy claims do not have rendering providers.
User ID [Search]	Hyperlink	1	A valid User ID is required.	Enter a valid User ID.

6.84.5 Scheduling Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.84.6 Scheduling Criteria Panel Accessibility

6.84.6.1 To Access the Scheduling Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Assignments**.	Assignments Navigation panel displays.
3	Select **Scheduling Criteria** link from the Assignments navigation panel.	Scheduling Criteria panel displays.

6.84.6.2 To Add on the Scheduling Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update the appropriate data.	
3	Click **Save**.	Scheduling Criteria information saved.

6.84.6.3 To Delete on the Scheduling Criteria Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.85 Related Data-Other Panel

6.85.1 Related Data-Other Panel Narrative

The Claims Related Data Panel contains a link to the Edit Recycle and Encounter Threshold panels.

This panel is inquiry only.

Navigation Path: [Claims] – [Related Data]

6.85.2 Related Data-Other Panel Layout

6.85.3 Related Data-Other Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancel Button.	Button	N/A	0
Edit Recycle	A link to Edit Recycle panel.	Hyperlink	N/A	0
Encounter Threshold	A link to Encounter Threshold panel.	Hyperlink	N/A	0
Save	Saves a record.	Button	N/A	0

6.85.4 Related Data-Other Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.85.5 Related Data-Other Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.85.6 Related Data-Other Panel Accessibility

6.85.6.1 To Access the Related Data-Other Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.

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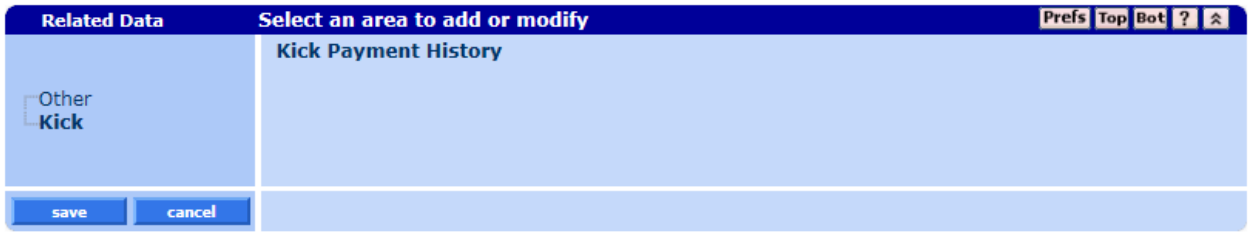
6.86 Related Data-Kick Panel

6.86.1 Related Data-Kick Panel Narrative

The Claims Related Data Panel – Kick contains a link to the Recoup KICK Payment Request panel.

Navigation Path: [Claims] – [Related Data] – [Kick].

6.86.2 Related Data-Kick Panel Layout



6.86.3 Related Data-Kick Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancel Button.	Button	N/A	0
Kick Payment History	A link to Kick Payment History panel.	Hyperlink	N/A	0
Save	Saves a record.	Button	N/A	0

6.86.4 Related Data-Kick Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.86.5 Related Data-Kick Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.86.6 Related Data-Kick Panel Accessibility

6.86.1.1 To Access the Related Data-Kick Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Click the **Kick** hyperlink located on the Related Data panel.	Related Data-Kick page displays.

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6.87 Kick Payment History Panel

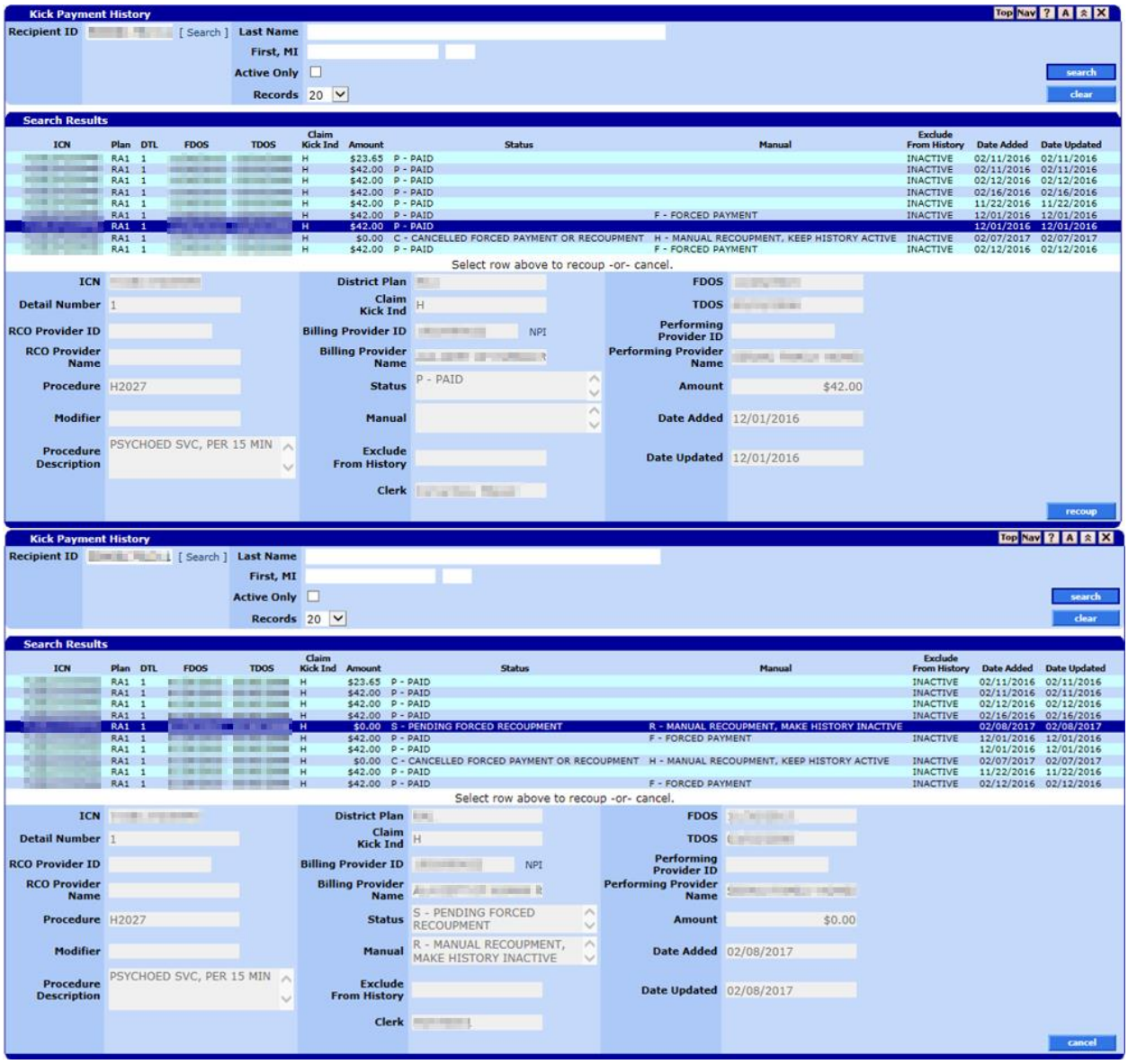
6.87.1 Kick Payment History Panel Narrative

The Kick Payment History panel allows the user to search for finalized Kick payments and FORCE a recoupment of the payment.

The panel allows the user to view prior Kick payments by Recipient ID. The user can then choose a Kick payment and select the RECOUP button to create a Kick payment recoupment request. The user will be prompted to indicate whether the record of the original payment should remain active in history for purpose of determining whether another Kick payment could be made for the recipient. The panel also allows users to view PENDING user-generated Kick payment requests or pending user-requested RECOUP request and CANCEL those requests.

Navigation Path: [Claims] – [Related Data] – [Kick] – [Kick Payment History].

6.87.2 Kick Payment History Layout



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6.87.3 Kick Payment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Only	Allows the user to determine whether to select all records or only active records.	Check Box	Check Box	0
Amount	Amount of payment. Format 9999999.99	Field	Number (Decimal)	10
Billing Provider ID	Provider identification number that uniquely identifies the pay to provider.	Field	Character	15
Billing Provider Name	Name of the Billing Provider.	Field	Character	30
Claim Kick Ind	Indicates the system determined the claim met the criteria for a KICK payment at the time the claim adjudicated. An L indicates the claim met the LOW risk criteria, an H indicates the claim met the HIGH risk criteria.	Field	Character	1
cancel	Button displays for pending generate payment or recoupment requests. When selected, panel cancels the selected request.	Button	N/A	0
clear	Clears the fields in the search criteria panel.	Button	N/A	0
Clerk	Identifies the user who updated record.	Field	Character	8
Date Added	Date the transaction was added.	Field	Date (MM/DD/CCYY)	8
Date Updated	Date the transaction was last updated.	Field	Date (MM/DD/CCYY)	8
Detail Number	The number of the detail on a claim record.	Field	Number (Integer)	4
District Plan	RCO plan codes begins with ‘R’.	Field	Character	3
FDOS	From Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8
First, MI	The first name and middle initial of the recipient associated with the Current ID. If the first name and the Current ID don't match the first	Field	Character	15

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Field	Description	Field Type	Data Type	Length
	character of the first name that was keyed is displayed.			
Exclude From History	Indicates if the record is active or historical. Valid values include: A = Historied. Spaces = Active	Field	Character	1
ICN	Internal Control Number that uniquely identifies a claim.	Field	Character	13
Last Name	The last name of the recipient associated with the Current ID. If the last name and the Current ID don't match the first three characters of the last that was keyed is displayed.	Field	Character	15
Manual	Indicates if the payment or recoupment was the result of a manual request. Valid values include: R= Manual recoup. H =Manual recoup – keep history.	Field	Character	1
Modifier	Code used to identify a procedure modifier.	Field	Character	2
Performing Provider ID	Provider identification number that uniquely identifies the performing provider.	Field	Character	15
Performing Provider Name	Name of the Performing Provider.	Field	Character	30
Procedure	Code used to identify a Medical procedure.	Field	Character	6
Procedure Description	A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	40
recoup	Button displays for an active Kick payment that can be recouped. When selected, panel creates a recoupment request.	Button	N/A	0
RCO Provider ID	Provider identification number that uniquely identifies the RCO Plan.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
RCO Provider Name	Name of the RCO Provider.	Field	Character	30
Recipient ID	The first 12-digits of an assigned number which uniquely identifies a recipient.	Field	Character	12
Records	Allows user to select the number or records in the datalist.	Combo Box	Drop Down List Box	0
search	Initiates the Search by entered Recipient ID.	Button	N/A	0
Status	Kick Capitation Status. Valid values include: P= Paid R= Recoup F= Pending force payment S= Pending force recoupment C= Cancelled force payment or recoupment E= Forced payment or recoupment that encountered an error in batch processing	Field	Character	1
TDOS	To Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8

6.87.4 Kick Payment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	1	Recipient not found	Correct Recipient ID keyed or key a valid Recipient ID
		2	Recipient ID must be numeric.	Enter a numeric ID.
Search	Button	1	Recipient ID should be entered for search criteria.	An entry is required to search for a recipient. Type in the Recipient ID.

6.87.5 Kick Payment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.87.6 Kick Payment History Panel Accessibility

6.87.6.1 To Access the Kick Payment History Panel

Step	Action	Response
1	Enter **Recipient ID** or an error message is displayed.	
2	Click **Search**.	All Kick payment transactions for the recipient are displayed.
3	Select a detail from the list.	Detail information populates to detail panel. If detail selected is an active Kick payment, RECOUP button displays. If detail selected is a pending recoupment or generated payment, CANCEL button is displayed.
4	Select CANCEL button -OR- Select RECOUP button	Cancel – panels cancels a pending request. Recoup – panel create a recoupment request.

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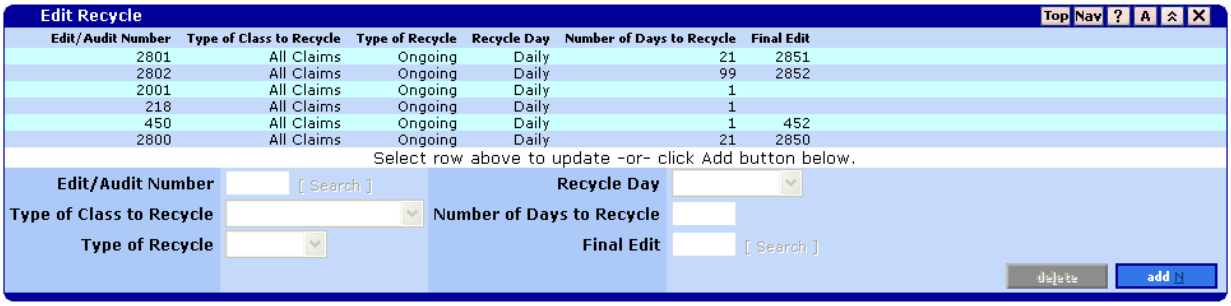
6.88 Edit Recycle Panel

6.88.1 Edit Recycle Panel Narrative

The Claims Edit Recycle panel allows select users to add and remove edits from the daily recycle parameter file. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Claims] – [Related Data] – [Edit Recycle]

6.88.2 Edit Recycle Panel Layout



6.88.3 Edit Recycle Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Record.	Button	N/A	0
Delete	Allows the user to delete a record.	Button	N/A	0
Edit/Audit Number	The number of the edit or audit to be recycled.	Field	Number (Integer)	4
Final Edit	The number of the edit used to deny the claim once the number of days to recycle has been exceeded.	Field	Number (Integer)	4
Number of Days to Recycle	The number of days that a claim recycles for the edit before it denies with the denial edit indicated.	Field	Number (Integer)	4
Recycle Day	The day of the week that an edit should be recycled.	Combo Box	Drop Down List Box	0
Type of Class to Recycle	The types of claims to recycle. This can be adjustments, all claims, all but adjustments, etc.	Combo Box	Drop Down List Box	0
Type of Recycle	Indicates if this is a regular recycle request or an on-going request that eventually denies with a different edit number.	Combo Box	Drop Down List Box	0

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6.88.4 Edit Panel Recycle Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Edit/Audit Number	Field	1	A valid Edit/Audit Number is required.	Enter a valid value or select a value from the [Search] panel.
	Field	2	Edit/Audit number not exist.	Enter a valid value or select a value from the [Search] panel.
Final Edit	Field	1	Final Edit has to be critical edit.	The Edit number for the Final Edit must have a Critical indicator set to Y on file.
	Field	2	Final Edit code does not exist.	The Edit number for the Final Edit must have a Critical indicator set to Y on file.
Recycle Day	Field	1	Recycle Day must be greater than or equal to 1.	A Recycle Day must be selected from the drop down list.
Type of Class to Recycle	Field	1	A valid Type of Class to Recycle is required.	Enter a valid Type of Class or select a valid value from the drop down list.
Type of Recycle	Field	100	Regular recycle must have 0 number of days to recycle and no final edit.	Recycle days must not be greater than 0 and Final Edit must be blank if the Type of Recycle is set to 'R' -Regular.

6.88.5 Edit Recycle Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.88.6 Edit Recycle Panel Accessibility

6.88.6.1 To Access the Edit Recycle Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Select the **Edit Recycle** hyperlink from the Other Navigation panel.	Edit Recycle panel displays.

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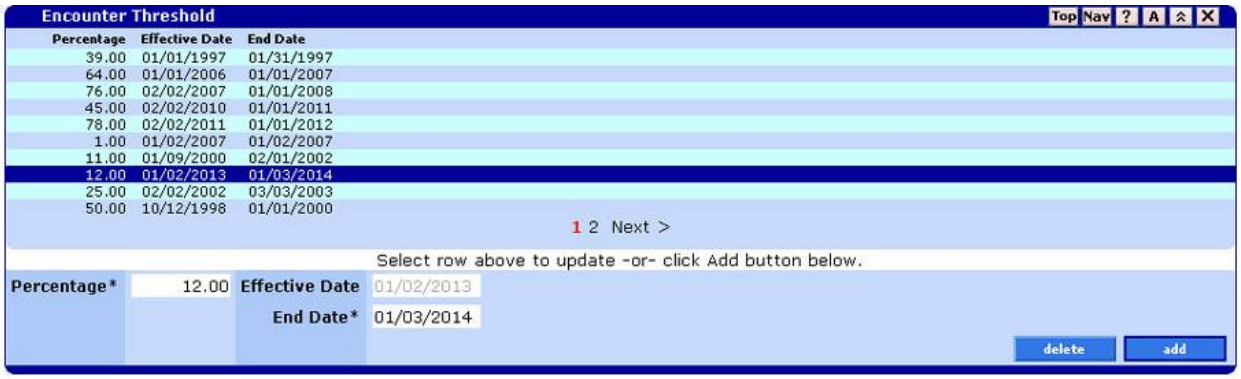
6.89 Encounter Threshold

The Claims Encounter Threshold Panel's information is used during encounter processing to determine if the batch is rejected or accepted. Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Claims] – [Related Data] – [Encounter Threshold]

6.89.1 Encounter Threshold Panel Layout



6.89.2 Encounter Threshold Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record.	Button	N/A	0
Delete	Allows a user to delete an existing record.	Button	N/A	0
End Date	End date for the associated Percentage.	Field	Date (MM/DD/CCYY)	8
Percentage	Percentage factor used during the encounter processing. The min. value is 0.00, Max is 100.00.	Field	Number (Decimal)	5
Start Date	Start date for the associated Percentage.	Field	Date (MM/DD/CCYY)	8

6.89.3 Encounter Threshold Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	Correction
Effective Date (Panel)	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	9057	Effective date must be less than or equal to End date.	Verify entry and re-enter a correct Date.
	Field	9060	Effective date and End date range overlap an existing entry.	Verify entry and re-enter a correct Date.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct Date.
End Date (Panel)	Field	1	End Date is required.	Enter a valid End Date.

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Field	Field Type	Error Code	Error Message	Correction
	Field	9060	Effective date and End date range overlap an existing record.	Verify entry and re-enter a correct Date span.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct Date.
Percentage (Panel)	Field	1	Threshold Percentage is Required.	Verify entry and re-enter a correct Percent.
	Field	2	Threshold Percentage must be greater than or equal to zero.	Verify entry and re-enter a correct Percent.
	Field	3	Threshold Percentage must be less than or equal to 100.00.	Verify entry and re-enter a correct Percent.

6.89.4 Encounter Threshold Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.89.5 Encounter Threshold Panel Accessibility

6.89.5.1 To Access the Encounter Threshold Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu panel displays.
2	Point to **Claims** and click **Related Data**.	Related Data panel displays.
3	Select Encounter Threshold.	Encounter Threshold panel displays.

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7. Reports

The Claims User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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7.1 CLM-0010-D -- Online Adjustment Daily Report

7.1.1 CLM-0010-D -- Online Adjustment Daily Report Narrative

The Online Adjustment Daily report is used to support the on-line updates made to the credit/adjustment data entry. This report is produced daily.

7.1.2 CLM-0010-D -- Online Adjustment Daily Report Layout

```
Report  : CLM-0010-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : CLMJD10D                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0010D                         ON-LINE DAILY ADJUSTMENT REPORT                                Page:       9999
-------------------------------------------------------------------------------------------------------------------------------


ICN           ICN TO CREDIT    ADJUSTMENT      PROVIDER ID          RECIPIENT ID    BEGIN DATE   END DATE     REASON   CLERK ID
                               REQUEST NUMBER                                                                  CODE
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXX  XXXXXXXXXXXXX  XXXXXXXXXX       XXX XXXXXXXXXXXXXXX   XXXXXXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXX      XXXXXXXX


                                                          END OF REPORT
                                                         NO DATA THIS RUN
```

7.1.3 CLM-0010-D -- Online Adjustment Daily Report Field Descriptions

Field	Description	Length	Data Type
Adjustment Request Number	Identifies the mass adjustment request.	10	Number (Integer)
Begin Date	First date of service.	10	Date (MM/DD/CCYY)
Clerk ID	On-line clerk identification.	8	Character
End Date	Last date of service.	10	Date (MM/DD/CCYY)
ICN	Internal control number.	13	Character
ICN To Credit	Internal control number to credit/adjust.	13	Character
Provider ID	Provider number.	15	Character

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Field	Description	Length	Data Type
Reason Code	Primary reason the adjustment is needed.	4	Character
Recipient ID	Identification number assigned to recipient.	12	Character

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7.2 CLM-0011-D -- Clerk ID Recycle Claims Report

7.2.1 CLM-0011-D -- Clerk ID Recycle Claims Report Narrative

The Clerk ID Recycle Claims report is used to determine the number of edits each clerk ID has worked in the Suspense Table. This report is produced daily.

7.2.2 CLM-0011-D -- Clerk ID Recycle Claims Report Layout

```
Report  : CLM-0011-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : CLMJD011                             MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MI:SS
Location: CLM0011D                               CLERK ID RECYCLED CLAIMS REPORT                               Page:       9999


                CLERK ID         DENIED          FORCED                  MANUALLY PRICED    OTHER          CLAIMS
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999
                XXXXXXXX         9999999         9999999                  9999999          9999999         9999999

                TOTALS           9999999         9999999                  9999999          9999999         9999999

***   END OF REPORT   ***

***   NO DATA THIS RUN   ***
```


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7.2.3 CLM-0011-D -- Clerk ID Recycle Claims Report Field Descriptions

Field	Description	Length	Data Type
Claims	Total number of claim records processed for clerk.	7	Number (Integer)
Clerk ID	On-line clerk identification field.	8	Character
Denied	Total number of denied edits for clerk.	7	Number (Integer)
Forced	Total number of forced edits for clerk.	7	Number (Integer)
Manually Priced	Total number of manually priced edits for clerk.	7	Number (Integer)
Other	Total number of other records processed for clerk.	7	Number (Integer)
Totals	Total for each subheading.	7	Number (Integer)

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7.3 CLM-0012-D -- EOB Listing Report

7.3.1 CLM-0012-D -- EOB Listing Report Narrative

The EOB Listing report lists each Explanation of Benefit (EOB) code and its description. This report is produced daily.

7.3.2 CLM-0012-D -- EOB Listing Report Layout

```
Report  : CLM-0012-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : CLMJD012                     MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: CLM0012D                                  EOB LISTING                                          Page:        999
-------------------------------------------------------------------------------------------------------------------------------
        EXCEPTION
        CODE                DESCRIPTION

-------------------------------------------------------------------------------------
9999              XXXX
```

7.3.3 CLM-0012-D -- EOB Listing Report Field Descriptions

Field	Description	Length	Data Type
Description (Line 1)	EOB description (first line).	79	Character
Description (Line 2)	EOB description (second line).	79	Character
EOB Code	The Explanation of Benefit Code.	4	Character

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7.4 CLM-0015-D-- Bundling Potential History to Adjust Report

7.4.1 CLM-0015-D-- Bundling Potential History to Adjust Report Narrative

This report contains claim detail lines audited by bundling, which can require adjustment if from paid history.

The information on this report refreshes on a daily basis and, therefore, does not reflect an accumulation of unadjusted bundled claim details. In order to view a previous day's activity, simply refer to that day's report.

7.4.2 CLM-0015-D-- Bundling Potential History to Adjust Report Layout

```
REPORT:   CLM-0015-D                                  ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS:  CLMJD015                                 REPORTING SYSTEM                                           RUN TIME: HH:MM:SS
LOCATION: CLM0015D                            BUNDLING POTENTIAL HISTORY TO ADJUST                                  PAGE: 99,999
                                             REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

HIST/CURR   ICN            PROVIDER         DATE        PROC     MODIFIERS     REPL                                      ALLOWED
                                            OF SVC      CODE     M1 M2 M3 M4   PROC    UNITS    BUNDLING AUDIT(S)          AMOUNT

ORIGINAL RECIPIENT ID:     999999999999                  BUNDLING CLAIM NUMBER:     9999999999999


HISTORY CLAIM LINES POTENTIALLY AFFECTED

  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX

OTHER CURRENT AND HISTORY CLAIM LINES

  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
  X         XXXXXXXXXXXXX  XXXXXXXXX        MM/DD/CCYY  XXXXXX   XX XX XX XX   XXXXXX   999    9999 9999 9999 9999 9999    XXXXXXXXXX
```

7.4.3 CLM-0015-D-- Bundling Potential History to Adjust Report Field Descriptions

Field	Description	Data Type	Length
Allowed Amount	This is the amount allowed.	Character	10
Bundling Audit(s)	This is the bundling audit number(s).	Number	4

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Field	Description	Data Type	Length
Bundling Claim Number	This is the ICN of the current claim.	Character	13
Date Of Svc	This is the date of service.	Character	10
Hist/Curr	This is a code indicating if the detail comes from history or the current claim.	Character	1
ICN	This is the Internal Control Number.	Character	13
Modifiers M1	This is the first procedure code modifier.	Character	2
Modifiers M2	This is the second procedure code modifier.	Character	2
Modifiers M3	This is the third procedure code modifier.	Character	2
Modifiers M4	This is the fourth procedure code modifier.	Character	2
Original Recipient ID	This is the original recipient ID.	Character	12
Proc Code	This is the procedure code that was on the original claim.	Character	6
Provider	This is the Provider number on the detail line.	Character	15
Repl Proc	This is the procedure code that should be added or bundled on the claim. This field can be blank or the same as the original procedure code.	Character	6
Units	This is the number of units billed.	Number	3

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7.5 CLM-0016-D -- Claims Processing Daily Summary Report

7.5.1 CLM-0016-D -- Claims Processing Daily Summary Report Narrative

The purpose of the Claims Processing Daily Summary report is to list summary information by claim type for a claim adjudication cycle. For CMS-1500 an additional break out by provider type is listed. This report is produced daily.

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7.5.2 CLM-0016-D -- Claims Processing Daily Summary Report Layout

```
Report  : CLM-0016-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD016                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0018D                                  CLAIMS PROCESSING DAILY SUMMARY                                    Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %    TOTAL AMT  AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------

MEDICAL
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

DENTAL
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

DRUG
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

COMPOUND
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

HOME HEALTH
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

LTC
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER A
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER B
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

XOVER C
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

INPATIENT
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

OUTPATIENT
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999



GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99




-------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0016-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
```


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```
Process : CLMJD016                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run Time:   HH:MM:SS
Location: CLM0016D                                 CLAIMS PROCESSING DAILY SUMMARY                                           Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %    TOTAL  AMT AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

PROV TYPE:  XX
       999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 999,999 9.99 999,999,999 9,999,999 99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                        * * * * * * *   End Of Report * * * * *
```

7.5.3 CLM-0016-D -- Claims Processing Daily Summary Report Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims for a specific claim type that have been denied.	4	Character
Approved For Denial-Avg Chg	Average charge of submitted claims for a specific claim type that have been denied.	10	Character
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	7	Character
Approved For Denial-Total Amt	Total charge of submitted claims for a specific claim type that have been denied.	11	Character
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Character
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Character
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Character
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Character
Claim Type	'English' name for a specific claim type.	11	Character
Grand Total For All Claim Types	Grand total for all columns.	84	Character

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Field	Description	Length	Data Type
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Character
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Character
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Character
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Character
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Character
Total Processed-Number	Total claims processed for a specified claim type.	6	Character
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Character

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7.6 CLM-0017-D -- Original Claims Processing Daily Summary Report

7.6.1 CLM-0017-D -- Original Claims Processing Daily Summary Report Narrative

The purpose of the Original Claims Processing Daily Summary report is to list summary information by claim type for original claims for a claim adjudication cycle. For CMS 1500, an additional break out by provider type is listed. This report is produced daily.

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7.6.2 CLM-0017-D -- Original Claims Processing Daily Summary Report Layout

```
Report  : CLM-0017-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD017                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0018D                                ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                                            Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------------
MEDICAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DENTAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DRUG
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

COMPOUND
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

HOME HEALTH
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

LTC
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER A
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER B
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER C
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

INPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

OUTPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99
```


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```
-----------------------------------------------------------------------------------------------------------------------------------------
Report  : CLM-0017-D                                        ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD017                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: CLM0017D                                  ORIGINAL CLAIMS PROCESSING DAILY SUMMARY                                     Page:       9999

-----------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   TOTAL CHG   AVG CHG   NUMBER %      TOTAL CHG AVG CHG
-----------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                                  * * * *   End Of Report * * *
```

7.6.3 CLM-0017-D -- Original Claims Processing Daily Summary Report Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims that have been denied for a specific claim type.	4	Character
Approved For Denial-Avg Chg	Average charge of submitted claims for a specific claim type that have been denied.	10	Character
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	5	Character
Approved For Denial-Tot Chg	Total charge of submitted claims for a specific claim type.	11	Character
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Character
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Character
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Character
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Character
Claim Type	'English' name for a specific claim type.	11	Character

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Field	Description	Length	Data Type
Grand Total For All Claim Types	Grand total for all columns.	84	Character
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Character
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Character
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Character
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Character
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Character
Total Processed-Number	Total claims processed for a specified claim type.	6	Character
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Character

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7.7 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02)

7.7.1 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02) Narrative

The purpose of the Adjustment Credit Claims Processing Daily Summary report is to list summary information by claim type for adjustments and credits for a claim adjudication cycle. This report is produced daily.

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7.7.2 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary Report (SAR - Part of M2500R02) Layout

```
Report  : CLM-0018-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD018                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: CLM0018D                              ADJUSTMENT/CREDIT CLAIMS PROCESSING DAILY SUMMARY                           Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------
CLAIM  *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   PAYMENT AMT AVG PMT   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------

MEDICAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DENTAL
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

DRUG
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

COMPOUND
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

HOME HEALTH
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

LTC
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER A
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER B
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

XOVER C
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

INPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

OUTPATIENT
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL CLAIM TYPES:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99
-------------------------------------------------------------------------------------------------------------------------------------------
```


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```
Report  : CLM-0018-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD018                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLM0018D                        ADJ/CREDIT CLAIM PROCESSING DAILY SUMMARY BY MEDICAL PROVIDER                            Page:       9999

-------------------------------------------------------------------------------------------------------------------------------------------------
PROV   *-----TOTAL PROCESSED-----*   *-----APPROVED FOR PAYMENT----*   *----APPROVED FOR DENIAL----*   *---------SUSPENDED---------*
TYPE  NUMBER  TOTAL CHG  AVG CHG   NUMBER %   PAYMENT AMT  AVG PMT  NUMBER %   PAYMENT AMT AVG PMT   NUMBER %      TOTAL CHG AVG CHG
-------------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

PROV TYPE:  XX
        999 999,999,999 9,999,999 99999 9.99 999,999,999  9,999,999 99999 9.99 999,999,999 9,999,999  99999 9.99 999,999,999 999,999

GRAND TOTAL FOR ALL PROVIDER TYPES PER 1500 CLAIM FORMS:
   99999999 999,999,999.99     99999999   999,999,999.99         99999999   999,999,999.99         99999999   999,999,999.99

                                                  * * * *   End Of Report * * *
```

7.7.3 CLM-0018-D -- Adjustment Credit Claims Processing Daily Summary (SAR - Part of M2500R02) Field Descriptions

Field	Description	Length	Data Type
Approved For Denial-%	Percentage of claims that have been denied for a specific claim type.	4	Number (Decimal)
Approved For Denial-Avg Pmt	Average charge of submitted claims for a specific claim type that have been denied.	10	Number (Decimal)
Approved For Denial-Number	Number of claims that have been denied for a specific claim type.	5	Number (Decimal)
Approved For Denial-Payment Amt	Total charge of submitted claims for a specific claim type that have been denied.	11	Number (Decimal)
Approved For Payment-%	Percentage of claims approved for payment for a specific claim type.	4	Number (Decimal)
Approved For Payment-Avg Pmt	Average payment amount approved for a specific claim type.	10	Number (Decimal)
Approved For Payment-Number	Number of claims approved for payment for a specific claim type.	5	Number (Decimal)
Approved For Payment-Payment Amt	Total amount approved for payment for a specific claim type.	11	Number (Decimal)

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Field	Description	Length	Data Type
Claim Type	'English' name for a specific claim type.	11	Character
Grand Total For All Claim Types	Grand total for all claim type columns.	84	Number (Decimal)
Grand Total For All Provider Types Per 1500 Claim Forms	Grand total for all columns.	84	Number (Decimal)
Prov Type	Code used to identify the type of the provider.	2	Character
Suspended Number	Total number of suspended claims for a specific claim type.	5	Number (Decimal)
Suspended-%	Percentage of claims suspended for a specific claim type.	4	Number (Decimal)
Suspended-Avg Chg	Average charge for suspended claims for a specific claim type.	7	Number (Decimal)
Suspended-Total Chg	Total charge for suspended claims for a specific claim type.	11	Number (Decimal)
Total Processed-Avg Chg	Average charge for processed claims for a specific claim type.	9	Number (Decimal)
Total Processed-Number	Total claims processed for a specific claim type.	6	Number (Decimal)
Total Processed-Total Chg	Total charge for processed claims for a specific claim type.	11	Number (Decimal)

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7.8 CLM-002-R Claim Status Change And Exception Report

7.8.1 CLM-002-R Claim Status Change And Exception Report Narrative

This report is results of processing update requests from the Agency SUR or unit other Agency-contracted company (such as HWT). Report will also be created for Ingenix.

7.8.2 CLM-002-R Claim Status Change And Exception Report Layout

```
Report  : CLM-002-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : CLMJO002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLMPO002                    CLAIM STATUS CHANGE AND EXCEPTION REPORT                            Page:       9999


      ICN           RECIP        PROV     CONTROL    ORIG      STATUS               REQST  CHANGE
                     MID          NBR        NBR     STAT   DESCRIPTION             BY...  RESULT
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXX   XXXXXXXXXXXX  XXXXXXXXXX XXXXXXXXX    X    XXXXXXXXXXXXXXXXXXXXX   XXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   *** END OF REPORT ***
                                                          or
                                                  *** NO DATA THIS RUN ***
```

7.8.3 CLM-002-R Claim Status Change And Exception Report Field Descriptions

Field	Description	Length	Data Type
CHANGE RESULT	Resulting change description. Reports if the status was changed.	30	Character
CONTROL NBR	Control number from the sent request.	10	Character
ICN	Internal Control Number (ICN) associated with the claim.	13	Character
ORIG STAT	Original claim status. If there is an ‘A’ in this field, then the ICN has already been adjusted. If there is an ‘E’ in this field, then the claim is an Encounter.	1	Character
PROV NBR	Provider NPI.	9	Character
RECIP MID	Recipient Medicaid Identification number.	12	Character
REQST BY	Agency requesting the change.	3	Character

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Field	Description	Length	Data Type
STATUS DESCRIPTION	Description of the Status.	21	Character

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7.9 CLM-0020-D -- Aged Detail Suspense Report (HCA)

7.9.1 CLM-0020-D -- Aged Detail Suspense Report (HCA) Narrative

The Aged Detail Suspense report displays a detail listing by claim type of claims that have been in the suspense file longer than a certain number of days specified by parameter. This report is produced daily.

7.9.2 CLM-0020-D -- Aged Detail Suspense Report (HCA) Layout

```
Report  : CLM-0020-D                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD020                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLM0020D                              AGED DETAIL SUSPENSE REPORT                                    Page:       9999

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                                 CLAIM TYPE: DENTAL CLAIMS

ICN                RECIPIENT        PROVIDER ID         LOCATION   EDITS                                                CLAIM-AGE
                                                                                                                         (DAYS)
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999
XXXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXX      99        XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX        999


*** END OF REPORT ***
```

7.9.3 CLM-0020-D -- Aged Detail Suspense Report (HCA) Field Descriptions

Field	Description	Length	Data Type
Claim Type	The claim type description.	60	Character
Claim-Age (Days)	Age of claim - number of days.	3	Number (Integer)
Edits	Edit codes - the claim failed. Note: There can be multiple occurrences of edits in this field.	4	Character
ICN	Internal control number of the claim.	13	Character
Location	Suspense location of the claim.	2	Number (Integer)
Provider ID	Provider Identification number.	15	Character
Recipient	Identification number of recipient.	13	Character

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7.10 CLM-0021-D -- Suspense Analysis by Exception Code Report

7.10.1 CLM-0021-D -- Suspense Analysis by Exception Code Report Narrative

The Suspense Analysis by Exception Code report is a list of the occurrences of each exception code in the suspense file. This report is produced daily.

7.10.2 CLM-0021-D -- Suspense Analysis by Exception Code Report Layout

```
Report  : CLM-0021-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD021                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0021D                    SUSPENSE FILE ANALYSIS BY EXCEPTION CODE                             Page:       9999
                                   START DATE:  MM/DD/CCYY   END DATE:  MM/DD/CCYY

CLAIM TYPE                    EXC         EXC DESCRIPTION                                        CURRENT              TOTAL
                              CODE                                                             OCCURRENCES         OCCURRENCES
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999
XXXXXXXXXXXXXXXXXXXXXXXXX     9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999999999            999999999

                                            ******   GRAND TOTAL BY EXC CODE   ******                 9999999999           9999999999
                                                        *** END OF REPORT ***
```

7.10.3 CLM-0021-D -- Suspense Analysis by Exception Code Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	25	Character
Current Occurrences	Number of current occurrences in suspense file.	9	Number (Integer)
Exc Code	The code for each claim type in suspense.	4	Number (Integer)
Exc Description	Description of each occurring exception.	50	Character
Grand Total By Exc Code	Grand total by exception code.	9	Number (Integer)
Total Occurrences	Total occurrences of each exception code.	9	Character

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7.11 CLM-0023-D -- Claim Exception Report

7.11.1 CLM-0023-D -- Claim Exception Report Narrative

The Claim Exception report is used by the Claims Resolution Unit as an inventory of claims to be resolved. Detailed Exception Reports by claim type are used by clerks to resolve claims. This report is produced daily.

7.11.2 CLM-0023-D -- Claim Exception Report Layout

```
Report  : CLM-0023-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD023                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:   HH:MM:SS
Location: CLM0023D                                      CLAIMS EXCEPTION REPORT                                              Page:      99999


     ICN       RECIPIENT ID  LOC   PROVIDER+LOC        PROV  PROV     DATES OF SERVICE       NET CLAIM   PAYMENT     EXCEP   CLAIM DISP       EXCEPTION
                                      NUMBER            SPEC  TYPE     FIRST       LAST       CHARGE      AMOUNT      CODE    PD SUSP DENY      FORCED
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X
9999999999999  999999999999  99    999999999999999      999   99      MM/DD/CCYY  MM/DD/CCYY  999999999   999999999   9999           X            X


                                                        *** END OF REPORT ***
```

7.11.3 CLM-0023-D -- Claim Exception Report Field Descriptions

Field	Description	Length	Data Type
Claim Disp-Pd Susp Deny	Status of claim.	1	Character
Dates Of Service First	First date of service on the claim	10	Date (MM/DD/CCYY)
Dates Of Service Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Excep Code	Code to uniquely identify an exception condition.	4	Number (Integer)
Exception Forced	Indicator designating if error was forced through the system.	1	Character
ICN	Internal control number used to uniquely identify a claim.	13	Character

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Field	Description	Length	Data Type
Loc	Current location of the claim.	2	Character
Net Claim Charge	Net claim charge after spend down, third party liability payments applied, etc.	9	Character
Payment Amount	Amount reimbursed to provider.	9	Character
Prov Spec	Provider specialty.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Provider +LOC Number	Provider identification number.	15	Character
Recipient ID	Recipient identification number.	12	Character

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7.12 CLM-0024-D -- Daily Exception Summary By Claim Type Report

7.12.1 CLM-0024-D -- Daily Exception Summary By Claim Type Report Narrative

The Daily Exception Summary by Claim Type report shows how many times each exception occurred by claim type. In addition, disposition of the exception is reported (super-suspend, deny, suspend, pay/report, or pay).

7.12.2 CLM-0024-D -- Daily Exception Summary By Claim Type Report Layout

```
Report  : CLM-0024-D                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJDER2                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:   HH:MM:SS
Location: CLMPER01                                DAILY EXCEPTION SUMMARY BY CLAIM TYPE                                      Page:        999

Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                      MM/DD/CCYY     MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY
CODE     EXCEPTION DESCRIPTION                            OCC.  CLAIMS   OCC.  CLAIMS    OCC.   CLAIMS   OCC.   CLAIMS   OCC.   CLAIMS

9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX
9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX     XXXX   XXXX

TOTALS BY CLAIM TYPE:
                                                         9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999    9,999  9,999

GRAND TOTAL:
                                                        99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999   99,999 99,999

                                                 **** END OF REPORT ****
```

7.12.3 CLM-0024-D -- Daily Exception Summary By Claim Type Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
Claims	Number of records or exception codes for each cycle.	4	Characters
Cycle Dates (OCC. and Claims)	The billing cycle dates by number of occurrences (OCC) and claims.	10	Date (MM/DD/CCYY)
Exception Description	Exception code description on the claim.	50	Character
Excp Code	Exception code on the claim.	4	Number (Integer)

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Field	Description	Length	Data Type
Grand Total	Total number of exception codes.	6	Number (Decimal)
OCC	Number of occurrences (OCC) of exception codes.	4	Characters
Totals By Claim Type	Total number of exception codes for each claim type.	5	Number (Decimal)

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7.13 CLM-0025-D -- Services to be Clerically Denied Report

7.13.1 CLM-0025-D -- Services to be Clerically Denied Report Narrative

The Services to be Clerically Denied report lists the claims that had services denied by a clerk, thereby enabling supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by denying exception codes. This report is produced daily.

7.13.2 CLM-0025-D -- Services to be Clerically Denied Report Layout

```
Report  : CLM-0025-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD25D                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0025D                               SERVICES TO BE CLERICALLY DENIED REPORT                             Page:        999


ICN             DETAIL  RECIPIENT ID   PROVIDER          PROV   PROVIDER     DATES OF SERVICE        NET  BILLED     DENIED    CLERK ID
                NUMBER                 ID                TYPE   SPECIALTY    FIRST       LAST        AMT             ERRORS
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX
XXXXXXXXXXXX    XXX     XXXXXXXXXXXX   XXXXXXXXXXXXXXX    XX    XXX          MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX     XXXX      XXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX

                                                 *** END OF REPORT ***
```

7.13.3 CLM-0025-D -- Services to be Clerically Denied Report Field Descriptions

Field	Description	Length	Data Type
Claim Count	Claim count per clerk.	7	Character
Clerk ID	On-line clerk identification number.	8	Character
Date Of Service-First	First date of service on the claim.	10	Date (MM/DD/CCYY)
Date Of Service-Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Denied Errors	Denied errors on claim.	4	Character
Detail Number	Detail that was clerically denied.	3	Character
ICN	Internal control number.	13	Character

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Field	Description	Length	Data Type
Net Billed Amount	Net billed amount.	11	Character
Provider ID	Provider identification number.	15	Character
Provider Specialty	Specialty code for the provider.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Recipient ID	Recipient identification number on claim.	12	Character

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7.14 CLM-0026-D -- Claims Paid Due To Force Report

7.14.1 CLM-0026-D -- Claims Paid Due To Force Report Narrative

The Claims Paid Due to Force report lists those claims that have exceptions that were clerically forced or overridden, thereby enabling supervisory personnel to identify those clerks who appear to resolve an inordinate number of suspended claims by forcing exception codes. This report is produced daily.

7.14.2 CLM-0026-D -- Claims Paid Due To Force Report Layout

```
Report  : CLM-0026-D                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJD26D                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLM0026D                             CLAIMS TO BE PAID DUE TO FORCE REPORT                                     Page:       999


ICN            DETAIL RECIPIENT ID   PROVIDER          PROV    PROV    DATES OF SERVICE        NET BILLED          PAYMENT       FORCED      CLERK ID
               NUMBER                NUMBER            TYPE    SPEC    FIRST       LAST        AMT                 AMOUNT        ERRORS
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX
XXXXXXXXXXXXX  XXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XX      XXX     MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX         XXXXXXXXXXX    XXXX       XXXXXXXX


*****CLERK ID RECAP*****
CLERK ID     CLAIM COUNT

XXXXXXXX       XXXXXXX
                                                      *** END OF REPORT ****
```

7.14.3 CLM-0026-D -- Claims Paid Due To Force Report Field Descriptions

Field	Description	Length	Data Type
Claim Count	Claim count per clerk.	7	Character
Clerk ID	Clerk identification number.	8	Character
Date Of Service First	First date of service on the claim.	10	Date (MM/DD/CCYY)
Date Of Service Last	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Detail Number	Detail that was clerically denied.	3	Character
Forced Errors	Total number of forced errors.	4	Character

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Field	Description	Length	Data Type
ICN	Internal control number.	13	Character
Net Billed Amt	Claim charge.	11	Character
Payment Amount	Amount due the provider.	11	Character
Provider Number	Provider identification number.	15	Character
Prov Spec	Specialty code for the provider.	3	Character
Prov Type	Code used to identify the type of the provider.	2	Character
Recipient ID	Recipient identification number.	12	Character

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7.15 CLM-0027-D -- Transaction Register Report

7.15.1 CLM-0027-D -- Transaction Register Report Narrative

The purpose of the Transaction Register report is to identify every claim processed in a daily claim adjudication cycle. Each claim is identified by ICN, Recipient ID Number, Provider Number, Transaction Code, Dates of Service, and Payment Amount. Additionally, this report displays any exception codes posted to the claim throughout the daily claim adjudication cycle. This report is produced daily.

7.15.2 CLM-0027-D -- Transaction Register Report Layout

```
Report  : CLM-0027-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD027                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0027D                                          TRANSACTION REGISTER                                                       Page:          1

ICN            RECIPIENT     PROVIDER ID       FROM             TO         REMIMBURSEMENT AMT  EXCEPTIONS
-------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX
XXXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXXXXXXXXX       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX



                                                                  *** END OF REPORT ***
```

7.15.3 CLM-0027-D -- Transaction Register Report Field Descriptions

Field	Description	Length	Data Type
From	First date of service on the claim.	10	Date (MM/DD/CCYY)
TO	Last date of service on the claim.	10	Date (MM/DD/CCYY)
Exception	Exception code posted to claim.	4	Character
ICN	Internal control number.	13	Character
Provider ID	Identification number of provider.	15	Character
Recipient	Recipient identification number.	12	Character
Reimbursement Amt	Reimbursement amount.	11	Character

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7.16 CLM-0029-W -- Title XIX - Adjudicated Claims Report

7.16.1 CLM-0029-W -- Title XIX - Adjudicated Claims Report Narrative

The purpose of Title XIX-Adjudicated Claims report is to show Family Planning Services by clinic in each county. In order for a claim to be included on the report, it must meet the following criteria. The criteria includes claims submitted by a provider with 'HF' as the state share agency code. The claim must have at least one detail line with a procedure code in the 'FAMPLNDH' procedure group. This report is produced weekly.

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7.16.2 CLM-0029-W -- Title XIX - Adjudicated Claims Report Layout

```
Report  : CLM-0029-W                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJW029                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLMR029W                              FAMILY PLANNING SERVICES ADJUDICATED CLAIMS                                Page:        999

COUNTY XX  CLINIC TYPE XXX
  (XXXXXXXXXXXXX)

RECIPIENT NAME                  RECIP ID/       DATE OF  SRVC   *--- CHARGES ---*  ERROR CODES
                                PATIENT #       SERVICE  RECVD  SUBMITTED ALLOWED  1    2    3    4    5    6    7    8    9    10

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                   9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX                                       9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                             MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX MM/DD/CCYY XXXXXX  XXXXXXXX XXXXXXXX  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                XXXXXXXXXXXX
WARRANT AMOUNT THIS CLAIM:  XXXXXXXXXXXX


TOTAL CHARGES SUBMITTED/ALLOWED THIS CLINIC TYPE:    XXXXXXXXXXXXX  XXXXXXXXXXXXX
TOTAL WARRANT AMOUNT THIS CLINIC TYPE:   XXXXXXXXXXXXXX
TOTAL CLAIMS THIS CLINIC TYPE:   XXXXXXX


TOTAL CHARGES SUBMITTED/ALLOWED THIS COUNTY:        XXXXXXXXXXXXXX XXXXXXXXXXXXXX
TOTAL WARRANT AMOUNT THIS COUNTY:      XXXXXXXXXXXXXXXX
TOTAL CLAIMS THIS COUNTY:      XXXXXXXXX

                                                  *** END OF REPORT ****
```


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7.16.3 CLM-0029-W -- Title XIX - Adjudicated Claims Report Field Descriptions

Field	Description	Length	Data Type
Charges Allowed	Allowed charges for payment.	8	Character
Charges Submitted	Submitted charges for service.	8	Character
Clinic Type	Clinic indicator. This translates to the pay to provider's specialty code.	3	Character
County	Code assigned to the county.	2	Character
County Description	County name (below county code and clinic code).	13	Character
Date Of Service	Date service was performed.	10	Date (MM/DD/CCYY)
Error Codes - 1,11	Exception code(s) 1 and 11 (if appropriate).	4	Number (Integer)
Error Codes - 10,20	Exception code(s) 10 and 20 (if appropriate).	4	Number (Integer)
Error Codes - 2,12	Exception code(s) 2 and 12 (if appropriate).	4	Number (Integer)
Error Codes - 3, 13	Exception code(s) 3 and 13 (if appropriate).	4	Number (Integer)
Error Codes - 4,14	Exception code(s) 4 and 14 (if appropriate).	4	Number (Integer)
Error Codes - 5, 15	Exception code(s) 5 and 15 (if appropriate).	4	Number (Integer)
Error Codes - 6, 16	Exception code(s) 6 and 16 (if appropriate).	4	Number (Integer)
Error Codes - 7, 17	Exception code(s) 7 and 17 (if appropriate).	4	Number (Integer)
Error Codes - 8, 18	Exception code(s) 8 and 18 (if appropriate).	4	Number (Integer)
Error Codes - 9, 19	Exception code(s) 9 and 19 (if appropriate).	4	Number (Integer)
Recip ID	Recipient identification number.	12	Character

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Field	Description	Length	Data Type
Patient #	Number assigned to the recipient by the provider for identification purposes.	12	Character
Recipient Name	Name of recipient covered.	31	Character
SRVC RECVD	Procedure code.	6	Character
Total Charges Allowed This Clinic Type	Total charges allowed for this clinic.	13	Character
Total Charges Allowed This County	Total charges allowed for this county.	14	Character
Total Charges Submitted This Clinic	Total charges submitted for this clinic.	13	Character
Total Charges Submitted This County	Total charges submitted for this county.	14	Character
Total Claims This Clinic Type	Total number of claims for this clinic.	7	Character
Total Claims This County	Total number of claims for this county.	9	Character
Total Warrant Amount This Clinic Type	Total warrant amount for this clinic.	14	Character
Total Warrant Amount This County	Total warrant amount for this county.	16	Character
Warrant Amount This Claim	This is the am_paid at the header level (num_dtl = 0) on the t_clm_pgm_xref table. This amount may not be equal to the sum of the allowed amounts at the detail level since any state share (N/A for Alabama Medicaid) deducted from the reimbursed amount. That is, the 'Warrant Amount This Claim' total will likely be less than the sum of the 'allowed' charges for the claim detail lines. This amt_paid on t_clm_pgm_xref is at the claim level so the actual check amount would equal the sum of all of the claims for the recipient during the weekly financial cycle.	12	Character

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7.17 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report

7.17.1 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report Narrative

The Pharmacy Report for Waiver Recipients report displays all pharmacy claims filled over the Title 19 limit of 3 when the recipient is Waiver type W1 -- W9, C1 or C2. (Combination of OHCA reports: M2885R01, M2885R02, M2885R03.) This report is only for adults with over 3 claims and is produced monthly.

7.17.2 CLM-0030-M -- Pharmacy Report for Waiver Recipients Report Layout

```
Report  : CLM-0030-M                                  ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM031                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                         Run Time:   HH:MM:SS
Location: CLMP0030                                 PHARMACY REPORT FOR WAIVER RECIPIENTS                                             Page:        999
                                            WITH MORE THAN 3 CLAIMS FOR PERIOD: MM/DD/CCYY - MM/DD/CCYY

BENEFIT PLAN: XX-XXXX
```

Field	Description	Length	Data Type
ICN	Internal control number.	13	Character
Prescribing Physician	Prescribing physician license number.	9	Character
Provider Number	Provider identification number.	15	Character
Recipient	Recipient identification number.	12	Character
Reimburse Amount	Amount given for reimbursement.	12	Character
Report Totals (Claims)	Total number of claims for the report.	6	Character
Report Totals (Reimbursed)	Total reimbursement amount for the report.	12	Character
Total Per Recipient	Total amount reimbursed per recipient.	13	Character

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7.18 CLM-0031-M -- Suspense File Analysis by Claim Type 2 v

7.18.1 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Narrative

The Suspense File Analysis by Claim Type 2 report prints a suspense file analysis by claim type of current and last fiscal years. The second page of the report is a break out by Provider type with CMS 1500. This report is produced monthly.

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7.18.2 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Layout

```
Report  : CLM-0031-M                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM031                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLM0031M                             SUSPENSE FILE ANALYSIS BY CLAIM TYPE                                                Page:        999

                                                         ***   X I X   ***
-------------------------------------------------------------------------------------------------------------------------------------------
 CLAIM                        FY   CCYY                                  PREVIOUS FY   CCYY
 TYPE                 NUMBER      DOLLAR VALUE                        NUMBER      DOLLAR VALUE
-------------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

XXXXXXXXXX            XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX

  TOTAL               XXXXXX    XXXXXXXXXXXXXX                        XXXXXX    XXXXXXXXXXXXXX
```


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```
Report  : CLM-0031-M                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJM031                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: CLM0031M                                SUSPENSE FILE ANALYSIS BY MEDICAL PROVIDER                                 Page:        999
-------------------------------------------------------------------------------------------------------------------------------------------
 PROV                          FY   CCYY                                  PREVIOUS FY   CCYY
 TYPE                 NUMBER      DOLLAR VALUE                          NUMBER      DOLLAR VALUE
-------------------------------------------------------------------------------------------------------------------------------------------
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX
PROV TYPE:  XX       XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX

  TOTAL              XXXXXX    XXXXXXXXXXXXXX                          XXXXXX    XXXXXXXXXXXXXX

                                                                 *** END OF REPORT ***
```

7.18.3 CLM-0031-M -- Suspense File Analysis by Claim Type 2 Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim code.	10	Character
FY CCYY Dollar Value	Fiscal year dollar value of reimbursement.	14	Character
FY CCYY Number	Fiscal year count of claims.	6	Character
Previous FY CCYY Dollar Value	Previous fiscal year reimbursement amount.	14	Character
Previous FY CCYY Number	Previous fiscal year count of claims.	6	Character
Prov Type	Identifies the type of provider (i.e. doctor, hospital, ACS, etc).	2	Character
Total Dollar Value	Total of each dollar value subheading.	14	Character
Total Number	Total of each number value subheading.	6	Character

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7.19 CLM-0035-M -- Advantage Waiver Recipient Report

7.19.1 CLM-0035-M -- Advantage Waiver Recipient Report Narrative

The Advantage Waiver Recipient report lists payments made to providers for Advantage Waiver recipient services. This report is produced monthly.

7.19.2 CLM-0035-M -- Advantage Waiver Recipient Layout

```
Report  : CLM-0035-M                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJM035                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0035M                                    ADVANTAGE WAIVER RECIPIENT                                      Page:        999

RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXX    RECIPIENT ID:  XXXXXXXXXXXX
                                                                                                   PROV
PROVIDER NAME           PROVIDER ID        SERV CODE      SERVICE DESCRIPTION         FDOS        LDOS     SPEC     DATE PAID   AMOUNT PAID

XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999
XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY  XXX     MM/DD/CCYY   99999999999


                                                                                 RECIP/PROVIDER TOTAL-  9999999999999
                                                                                 RECIPIENT TOTAL-       9999999999999
                                                   *** END OF REPORT ***
```

7.19.3 CLM-0035-M -- Advantage Waiver Recipient Report Field Descriptions

Field	Description	Length	Data Type
Amount Paid	Amount paid to claim.	11	Character
Date Paid	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	10	Date (MM/DD/CCYY)
FDOS	First date of service.	10	Date (MM/DD/CCYY)
LDOS	Last date of service.	10	Date (MM/DD/CCYY)
Provider ID	Provider identification number.	15	Character
Provider Name	Name of provider.	22	Character
Prov Spec	Provider specialty code.	3	Character

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Field	Description	Length	Data Type
Recip/Provider Total	Total amount paid to provider for the recipient.	13	Character
Recipient ID	Recipient identification number.	12	Character
Recipient Name	Name of recipient on claim.	31	Character
Recipient Total	Total amount paid for recipient.	13	Character
Serv Code	Procedure code.	14	Character
Service Description	Procedure name.	25	Character

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7.20 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report

7.20.1 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Narrative

The Claims with Excluded Provider Prescriber Numbers report lists claims with selected excluded provider prescriber numbers. This report is produced monthly.

7.20.2 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Layout

```
Report  : CLM-0036-M                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM036                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:      HH:MI
Location: CLM0036M                            CLAIMS WITH EXCLUDED PROVIDER PRESCRIBER NUMBERS                                         Page:          1

     ICN       PROVIDER        PRESCRIBER  PRESCRIBER                 PROGRAM   PROGRAM      FILED         FIRST DATE    REIMB
                               NUMBER      NAME                       CODE      END DATE      RID            OF SVC      AMOUNT
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99
XXXXXXXXXXXX  XXXXXXXXXXXXXXX 9999999999  XXXXXXXXXXXXXXXXXXXXXXXX   XXXXX     MM/DD/CCYY   XXXXXXXXXXXX  MM/DD/CCYY    99,999,999.99


                                                                  End Of Report
```

7.20.3 CLM-0036-M -- Claims With Excluded Provider Prescriber Numbers Report Field Descriptions

Field	Description	Length	Data Type
First Date of Service	First date of service.	10	Date (MM/DD/CCYY)
Filed RID	Filed recipient identification number.	12	Character
ICN	Internal control number.	13	Character
Prescriber Name	Name of the Prescriber.	25	Character
Prescriber Number	Prescriber license number.	10	Number (Integer)
Program Code	Program code that the provider was excluded from.	5	Character
Program End Date	The last day the provider was eligible for the program.	10	Date (MM/DD/CCYY)
Provider	Servicing provider identification number.	15	Character

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Field	Description	Length	Data Type
Reimb Amount	Reimbursement amount.	13	Number (Decimal)

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7.21 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report

7.21.1 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report Narrative

The purpose of the Potential Schedule 2 Narcotic Drug Abuse report is to summarize prescribing information relating to narcotic drugs. This report is produced monthly.

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7.21.2 CLM-0046-M -- Potential Schedule 2 Narcotic Drug Abuse Report Layout

```
Report  : CLM-0046-M                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJM046                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run Time:      HH:MM:SS
Location: CLMP046M                              POTENTIAL SCHEDULE 2 NARCOTIC DRUG ABUSE                                            Page:      99999
                                                         RECIPIENT NUMBER ORDER
                                                         MONTHNAME CCYY SERVICES

-------------------------------------------------------------------------------------------------------------------------------------------------------
RECIPIENT ID  RECIP NAME                                          PRESC
   PROVIDER NO PROVIDER NAME                                -     NUM-     ICN           DT SERV    DRUG CODE   DRUG NAME                    SUP  QTY
-------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999

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99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
99999.999
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX
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99999.999
```


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```
  XXXXXXXXXXXXXXX XXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
Recipient ID	Recipient identification number.	12	Character
Sup	Days supplied.	3	Character

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7.22 CLM-0048-W -- Weekly POS Activity Report

7.22.1 CLM-0048-W -- Weekly POS Activity Report Narrative

The Weekly POS Activity report provides a statistical summary of non-network originated transactions (Paper and EMC) and network originated transactions (POS) for the week.

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7.22.2 CLM-0048-W -- Weekly POS Activity Report Layout

```
Report  : CLM-0048-W                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : CLMJW048                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: CLM0048W                                              POINT OF SALE                                              Page:      99999
                                                          WEEKLY POINT OF SALE ACTIVITY

------------------- NON-NETWORK ORIGINATED TRANSACTIONS --------------

             CLAIMS      CLAIMS       CLAIMS       CLAIMS        CLAIMS  CLAIMS
TYPE         PROCESSED   SUSPENDED     PAID      PAID AMOUNT     DENIED  REJECTED

PAPER        999,999     999,999      999,999   99,999,999.99   999,999  999,999
EMC          999,999     999,999      999,999   99,999,999.99   999,999  999,999

-----------------------------------------------------NETWORK ORIGINATED TRANSACTIONS -------------------------------------------
                --------------- POINT OF SALE CLAIMS ----------------   ------------ OTHER TYPES OF POS TRANSACTIONS ------------

                CLAIMS    CLAIMS      CLAIMS        CLAIMS  AVG RESP   REVERSALS  REVERSALS RECIP.ELIG. POS COMM  PA      PA
HOURS RECEIVED  RECEIVED  PAID      PAID AMOUNT     DENIED    TIME     RECEIVED   REJECTED   INQUIRES   REJECTED  INQ     RQST

99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
99:99 - 99:99   999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999
                -------   -------   --------------  -------   ------   -------    -------   -------     -------   ------- -------
TOTAL           999,999   999,999   99,999,999.99-  999,999   99.999   999,999    999,999   999,999     999,999   999,999 999,999

                                                          *** END OF REPORT ****
```


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7.22.3 CLM-0048-W -- Weekly POS Activity Report Field Descriptions

Field	Description	Length	Data Type
Avg Resp Time	Average response time of point of service claims for each hour of the day.	6	Number (Decimal)
Claims Denied	Total point of service claims denied for each hour of the day.	7	Number (Decimal)
Claims Denied (Paper/EMC)	Total paper/EMC claims denied for the week.	7	Number (Decimal)
Claims Paid	Total number of point of service claims paid for each hour of the day.	7	Number (Decimal)
Claims Paid (Paper/EMC)	Total paper/EMC claims paid for the week.	7	Number (Decimal)
Claims Paid Amount	Total dollar amount of point of service claims paid for each hour of the day.	14	Number (Decimal)
Claims Paid Amount (Paper/EMC)	Total dollar amount of paper/EMC claims paid for the week.	14	Number (Decimal)
Claims Processed (Paper/EMC)	Total paper/EMC claims processed for the week.	7	Number (Decimal)
Claims Received	Total point of service claims received for each hour of the day.	7	Number (Decimal)
Claims Rejected	Total paper/EMC claims rejected for the week.	7	Number (Decimal)
Claims Suspended (Paper/EMC)	Total paper/EMC claims suspended for the week	7	Number (Decimal)
Hours Received	Hour of the day the point of service claim was received by the minicomputer.	11	Time (HH:MM)
PA Inq	Total number of prior authorization inquiries for the hour of the day.	7	Number (Decimal)

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Field	Description	Length	Data Type
PA Rqst	Total number of prior authorization requests for the hour of the day.	7	Number (Decimal)
POS Comm Rejected	Total point of service communication records rejected for each hour of the day.	7	Number (Decimal)
Recip Elig Inquiries	Total recipient eligibility inquiries received for each hour of the day.	7	Number (Decimal)
Reversals Received	Total point of service reversals received for each hour of the day.	7	Number (Decimal)
Reversals Rejected	Total point of service reversals rejected for each hour of the day.	7	Number (Decimal)
Total	Total of each subheading.	14	Number (Decimal)

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7.23 CLM-0050-L -- Retro Adjustments due to Patient Liability Changes Report

7.23.1 CLM-0050-L -- Retro Active Rate Adjustment Report Narrative

The Retro Active Rate Adjustment report lists the retroactive patient liability adjustments by provider. This report is produced monthly.

7.23.2 CLM-0050-L -- Retro Active Rate Adjustment Report Layout

```
Report  : CLM-0050-L                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJ050L                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0050M                           Retro Adjustments due to Patient Liability Changes                      Page:      99999
                                                        MM/DD/CCYY - MM/DD/CCYY

CL                                                  ----------------ORIGINAL----------------  -------------------ADJUSTMENT------------------
TY PROV NPI   PROVR MCD RECIP NO     FROM DOS   TO DOS      ICN                PAID AMT   PATLIAB AMT  ICN                PAID AMT   PATLIAB AMT  STAT

X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X

                                                        *** END OF REPORT ***
```

7.23.3 CLM-0050-L -- Retro Active Rate Adjustment Report Field Descriptions

Field	Description	Length	Data Type
Adjustment CLM STAT	Claim status of the adjustment claim.	1	Character
Adjustment ICN	ICN of the adjustment claim created.	13	Number (Integer)
Adjustment PAID AMT	Paid amount of the adjustment claim.	12	Number (Decimal)
Adjustment PATLIAB AMT	Patient Liability amount for the recipient when the adjustment claim paid.	12	Number (Decimal)
CL TY	Claim type of the current claim example 'O' for outpatient, 'I' for inpatient, etc.	2	Character
FROM DOS	Claim From Date of Service	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Original ICN	ICN of the claim that was adjusted.	13	Number (Integer)
Original PAID AMT	Paid amount of the claim that was adjusted.	12	Number (Decimal)
Original PATLIAB AMT	Patient Liability amount for the recipient when the original claim paid.	12	Number (Decimal)
PROV MCD	Provider Medicaid ID for provider on claim.	9	Character
PROV NPI	NPI Provider ID	10	Character
RECIP NO	Recipient ID	12	Character
TO DOS	Claim To Date of Service	10	Date (MM/DD/CCYY)

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7.24 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report

7.24.1 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Narrative

The Retro Active Rate Adjustment report lists the retroactive provider rate adjustments by provider. This report is produced monthly.

7.24.2 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Layout

```
Report  : CLM-0050-P                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJ050P                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLM0050M                            Retro Adjustments due to Provider Rate Changes                         Page:      99999
                                                        MM/DD/CCYY - MM/DD/CCYY

CL                                                   ----------------ORIGINAL----------------  -------------------ADJUSTMENT------------------
TY PROV NPI   PROV MCD  RECIP NO     FROM DOS   TO DOS      ICN                PAID AMT     PROV RATE  ICN                PAID AMT     PROV RATE  STAT

X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X
X  XXXXXXXXXX XXXXXXXX  XXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99  XXXXXXXXXXXXX  9,999,999.99  9,999,999.99   X

                                                        *** END OF REPORT ***
```

7.24.3 CLM-0050-P -- Retro Adjustments due to Provider Rate Changes Report Field Descriptions

Field	Description	Length	Data Type
Adjustment ICN	ICN of the adjustment claim created.	13	Number (Integer)
Adjustment PAID AMT	Paid amount of the adjustment claim.	12	Number (Decimal)
Adjustment PROV RATE	Provider rate of the adjustment claim.	12	Number (Decimal)
Adjustment STAT	Claim status of the adjustment claim.	1	Character

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Field	Description	Length	Data Type
CL TY	Claim type of the current claim example 'O' for outpatient, 'I' for inpatient, etc.	2	Character
FROM DOS	Claim From Date of Service	10	Date (MM/DD/CCYY)
Original ICN	ICN of the claim that was adjusted.	13	Number (Integer)
Original PAID AMT	Paid amount of the claim that was adjusted.	12	Number (Decimal)
Original PROV RATE	Provider rate of the claim that was adjusted.	12	Number (Decimal)
PROV MCD	Provider Medicaid number for provider on claim.	9	Character
PROV NPI	NPI Provider id.	16	Character
RECIP NO	Recipient Id	12	Character
TO DOS	Claim To Date of Service	10	Date (MM/DD/CCYY)

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7.25 CLM-0051-D -- Aged Detail Adjustment Report

7.25.1 CLM-0051-D -- Aged Detail Adjustment Report Narrative

The Aged Detail Adjustment report displays adjustments that have aged. This report is produced daily.

7.25.2 CLM-0051-D -- Aged Detail Adjustment Report Layout

```
Report  : CLM-0051-D                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD051                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0051D                                  AGED DETAIL ADJUSTMENT REPORT                                                  Page:       9999

THE FOLLOWING CLAIMS IN THE SYSTEM AT LEAST 999 DAYS                                                   CLAIM TYPE: DENTAL CLAIMS

ICN                RECIPIENT        PROVIDER ID         LOCATION     EDITS                                                   CLAIM-AGE
                                                                                                                               (DAYS)
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999
XXXXXXXXXXXXX     XXXXXXXXXXXX      XXXXXXXXXXXXXXX         99       XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX          999

                                                     *** END OF REPORT ****
```

7.25.3 CLM-0051-D -- Aged Detail Adjustment Report Field Descriptions

Field	Description	Length	Data Type
Claim Age (Days)	The number of days that an adjustment has been in process.	3	Number (Integer)
Claim Type	The claim type description.	60	Character
Edits	Code used to identify errors. Note: There can be multiple occurrences of edits in this field.	4	Character
ICN	Internal control number which uniquely identifies an adjustment.	13	Character
Location	Code which identifies the suspense location of the adjustment.	2	Number (Integer)
Provider ID	Provider identification number.	15	Character
Recipient	Recipient identification number which uniquely identifies the recipient.	12	Character

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7.26 CLM-0054-D -- Edit Recycle Maintenance Report

7.26.1 CLM-0054-D -- Edit Recycle Maintenance Report Narrative

The Edit Recycle Maintenance report lists each suspense transaction input to the system. It also prints appropriate error messages. This report is produced daily.

7.26.2 CLM-0054-D -- Edit Recycle Maintenance Report Layout

```
Report  : CLM-0054-D                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD054                              MEDICAID MANAGEMENT INFORMATION SYSTEM                             Run Time:   HH:MM:SS
Location: CLM0054D                                      EDIT RECYCLE PARAMETERS                                        Page:        999


EDIT/AUDIT          TYPE OF CLAIMS          TYPE OF                RECYCLE            # OF DAYS              FINAL
  NUMBER              TO RECYCLE            RECYCLE                  DAY             TO RECYCLE             EDIT

   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX
   XXXX               XXXXXXXXXX            XXXXXXXXXX             XXXXXXXXX            999                 XXXX

**** END OF REPORT ****
```

7.26.3 CLM-0054-D -- Edit Recycle Maintenance Report Field Descriptions

Field	Description	Length	Data Type
# Of Days To Recycle	Number of days for the recycle process.	3	Number (Integer)
Edit/Audit Number	Code used to identify errors.	4	Character
Final Edit	Final error code.	4	Character
Recycle Day	Day the claim is recycled.	9	Character
Type Of Claims To Recycle	Claim type needed to resubmit.	10	Character
Type Of Recycle	Type of resubmission.	10	Character

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7.27 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report

7.27.1 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Narrative

The Daily Exception Summary by Claim Type Original Claims report shows how many times each exception occurred by claim type for the last 5 cycles. This report is produced daily.

7.27.2 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Layout

```
Report  : CLM-0055-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLMPER01                        DAILY EXCEPTION SUMMARY BY CLAIM TYPE ORIGINAL CLAIMS                                       Page:        999
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

EXCP                                                        MM/DD/CCYY       MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                       OCC.     RECS     OCC      RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                           XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                          XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                           *** END OF REPORT ***
```

7.27.3 CLM-0055-D -- Daily Exception Summary By Claim Type Original Claims Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character
RECS (Cycle 5)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.28 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report

7.28.1 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Narrative

The Daily Exception Summary by Claim Type Adjustments report shows how many times each exception occurred by claim type for the last 5 cycles. This report is produced daily.

7.28.2 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Layout

```
Report  : CLM-0056-D                                ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                           Run Time:   HH:MM:SS
Location: CLMPER01                        DAILY EXCEPTION SUMMARY BY CLAIM TYPE ADJUSTMENTS                                       Page:        999
Claim
Type: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                       OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                          XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                         XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                         *** END OF REPORT ***
```

7.28.3 CLM-0056-D -- Daily Exception Summary By Claim Type Adjustments Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
RECS (Cycle 5)	Number of records recycled.	6	Character
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.29 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report

7.29.1 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Narrative

The Daily Exception Summary by Claim Type Capitated Plus report shows how many times each exception occurred by claim type. In addition, disposition of the exception is reported (super-suspend, deny, suspend, pay/report, or pay). This report is produced daily.

7.29.2 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Layout

```
Report  : CLM-0057-D                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJDER2                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLM0057D                            DAILY EXCEPTION SUMMARY BY CLAIM TYPE CAPITATED                                          Page:        999
Claim
Type:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


EXCP                                                      MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY
CODE EXC DESCRIPTION                                     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS     OCC.     RECS

XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX
XXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX   XXXXXX

TOTAL BY CLAIM TYPE
                                                         XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX  XXXXXXX

GRAND TOTAL
                                                       XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX XXXXXXXX

                                                                *** END OF REPORT ***
```

7.29.3 CLM-0057-D -- Daily Exception Summary By Claim Type Capitated Plus Report Field Descriptions

Field	Description	Length	Data Type
Claim Type	Type of claim.	50	Character
RECS (Cycle 1)	Number of records recycled.	6	Character
RECS (Cycle 2)	Number of records recycled.	6	Character
RECS (Cycle 3)	Number of records recycled.	6	Character
RECS (Cycle 4)	Number of records recycled.	6	Character
RECS (Cycle 5)	Number of records recycled.	6	Character

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Field	Description	Length	Data Type
Cycle 1 Dates	Date that cycle 1 ran.	10	Date (MM/DD/CCYY)
Cycle 2 Dates	Date that cycle 2 ran.	10	Date (MM/DD/CCYY)
Cycle 3 Dates	Date that cycle 3 ran.	10	Date (MM/DD/CCYY)
Cycle 4 Dates	Date that cycle 4 ran.	10	Date (MM/DD/CCYY)
Cycle 5 Dates	Date that cycle 5 ran.	10	Date (MM/DD/CCYY)
Exc Description	Description of the exception code.	50	Character
Excp Code	Edit or audit number.	4	Character
Grand Total	Grand total of all occurrences.	6	Character
Occ (Cycle 1)	Edit Occurrences.	6	Character
Occ (Cycle 2)	Edit Occurrences.	6	Character
Occ (Cycle 3)	Edit Occurrences.	6	Character
Occ (Cycle 4)	Edit Occurrences.	6	Character
Occ (Cycle 5)	Edit Occurrences.	6	Character
Total By Claim Type	Total of occurrences per cycle by claim type.	5	Character

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7.30 CLM-0059-D -- Alabama EOB Report

7.30.1 CLM-0059-D -- Alabama EOB Report Narrative

The Alabama EOB report lists EOB numbers, status and descriptions for Alabama. This report is produced daily.

7.30.2 CLM-0059-D -- Alabama EOB Report Layout

```
Report  : CLM-0059-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJD059                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLM0059D                                ALABAMA EOB REPORT                                         Page:        999
-------------------------------------------------------------------------------------------------------------------------------
     EXCEPTION
     CODE            STATUS            DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------

     9999              X              XXXX
```

Field	Description	Length	Data Type
Status	Status code for the claim.	1	Character

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7.31 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report

7.31.1 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Narrative

The Suspense File Analysis by Claim Type 3 report lists the number and dollar value totals of the various claim types that are currently in the suspense file. It also includes the same totals for claims that are 1 to 30 days old, 31 to 60 days old, 61 to 90 days old and over 90 days old, as well as totals for each of the above. This report is produced daily.

7.31.2 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Layout

```
Report  : CLM-0060-D                                  ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD060                               MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: CLM0060D                                SUSPENSE FILE ANALYSIS BY CLAIM TYPE                                               Page:        999
-------------------------------------------------------------------------------------------------------------------------------------------------
CLAIM        *------CURRENT------*  *---01 TO 30 DAYS---*  *---31 TO 60 DAYS---*  *---61 TO 90 DAYS---*  *---OVER 90 DAYS---*    AVG
TYPE         NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE   NUMBER  DOLLAR VALUE    DAY
-------------------------------------------------------------------------------------------------------------------------------------------------

MEDICAL      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

DENTAL       XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

DRUG         XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

COMPOUND     XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

HOME HEALTH  XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

LTC          XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER A      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER B      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

XOVER C      XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

INPATIENT    XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

OUTPATIENT   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

TOTAL        XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX   XXXXXXX  XXXXXXXXXXX    XXX

                                                   *** END OF REPORT ***
```


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7.31.3 CLM-0060-D -- Suspense File Analysis By Claim Type 3 Report Field Descriptions

Field	Description	Length	Data Type
01 To 30 Days Dollar Value	Total value of claim type in past 1 to 30 days.	11	Character
01 To 30 Days Dollar Value Total	Total value of claims in past 1 to 30 days.	11	Character
01 To 30 Days Number	Number of claims in past 1 to 30 days.	7	Character
01 To 30 Days Number Total	Total number of claims in past 1 to 30 days.	7	Character
31 To 60 Days Dollar Value	Total value of claim type in past 31 to 60 days.	11	Character
31 To 60 Days Dollar Value Total	Total value of claims in past 31 to 60 days	11	Character
31 To 60 Days Number	Number of claims in past 31 to 60 days.	7	Character
31 To 60 Days Number Total	Total number of claims in past 31 to 60 days.	7	Character
61 To 90 Days Dollar Value	Total value of claim type in past 61 to 90 days	11	Character
61 To 90 Days Dollar Value Total	Total value of claims in past 61 to 90 days.	11	Character
61 To 90 Days Number	Number of claims in past 61 to 90 days.	7	Character
61 To 90 Days Number Total	Total number of claims in past 61 to 90 days.	7	Character
Avg Day	Average claims per day.	3	Character
Claim Type	Name of the claim type identified in report.	11	Character
Current Dollar Value	Total value of claim type in current day.	11	Character
Current Dollar Value Total	Total value of claims on current day.	11	Character
Current Number	Number of claim type in current day.	7	Character
Current Number Total	Total number of claims on current day.	7	Character

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Field	Description	Length	Data Type
Over 90 Days Dollar Value	Total value of claim type over 90 days.	11	Character
Over 90 Days Dollar Value Total	Total value of claims over 90 days.	11	Character
Over 90 Days Number	Number of claims over 90 days.	7	Character
Over 90 Days Number Total	Total number of claims over 90 days.	7	Character

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7.32 CLM-0064-W -- Suspended Claims by Claim Type – Region Report

7.32.1 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Narrative

The Suspended Claims by Claim Type-Region report identifies the number of suspended claims by region and claim type. This report is produced weekly.

7.32.2 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Layout

```
Report:   CLM-0064-W                                ALABAMA MEDICAID AGENCY                                                  Run Date: MM/DD/CCYY
Process:  CLMJW064                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                      Run Time:   HH:MM:SS
Location: CLMPW064                             SUSPENDED CLAIMS BY CLAIM TYPE / REGION                                    Page    :        999


                            A-UB   B-1500  C-UB OP  D-DENTAL  H-HOME  I-INPAT  L-LTC  M-1500  O-OUTPAT  P-RX   Q-CMPND  TOTALS  %
                            XOVER  XOVER   XOVER                                                            POS      RX

99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%
99-XXXXXXXXXXXXXXXXXXXXXXXX 99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999  99,999 999.9%

TOTAL                      99,999  99,999  99,999    99,999   99,999   99,999  99,999 99,999  99,999   99,999  99,999 999,999
                            99.9%   99.9% 99.9%     99.9%    99.9%    99.9%   99.9%  99.9%   99.9%    99.9%   99.9%
** END OF REPORT **
```

7.32.3 CLM-0064-W -- Suspended Claims by Claim Type - Region Report Field Descriptions

Field	Description	Length	Data Type
A-UB XOVER	Number of UB crossover claims that have suspended.	5	Number (Integer)
B-1500 XOVER	Number of CMS crossover claims that have suspended.	5	Number (Integer)
C-UB OP XOVER	Number of UB Outpatient crossover claims that have suspended.	5	Number (Integer)

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Field	Description	Length	Data Type
D-DENTAL	Number of Dental claims that have suspended.	5	Number (Integer)
H-HOME	Number of Home health claims that have suspended. N/A for Alabama.	5	Number (Integer)
I-INPAT	Number of Inpatient claims that have suspended.	5	Number (Integer)
L-LTC	Number of Long Term Care claims that have suspended.	5	Number (Integer)
M-1500	Number of CMS claims that have suspended.	5	Number (Integer)
O-OUTPAT	Number of Outpatient claims that have suspended.	5	Number (Integer)
P-RX POS	Number of Pharmacy Point of Sale claims that have suspended.	5	Number (Integer)
Q-CMPND RX	Number of Compound Pharmacy claims that have suspended.	5	Number (Integer)
Region	The two byte code that represents the claim type and region.	2	Number (Integer)
Region Description	Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.	25	Character
TOTALS %	Total percent of suspended claims by region.	4	Number (Decimal)
TOTAL	Total number of claims suspended by claim type.	5	Number (Integer)
TOTAL (percent)	Total percent of claims suspended by claim type.	3	Number (Decimal)

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7.33 CLM-0065-D -- Aged Suspended Report

7.33.1 CLM-0065-D -- Aged Suspended Report Narrative

The Aged Suspended report shows the number of claims suspended by location code for a period of time ranging from current to over 99,999 days. This report is produced daily.

7.33.2 CLM-0065-D -- Aged Suspended Report Layout

```
Report  : CLM-0065-D                          ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : CLMJD065                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                            Run Time:   HH:MM:SS
Location: CLM0065D                    AGED SUSPENDED CLAIMS BY LOCATION REPORT                                               Page:          1
```

Location Code	Current to 30 days	Aged > 30 days	Aged > 60 days	Aged > 90 days	Total of all Aged
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999
99	99,999	99,999	99,999	99,999	99,999

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```
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|        99        |          99,999        |         99,999        |          99,999        |          99,999        |            99,999      |
-------------------------------------------------------------------------------------------------------------------------------------------
|      TOTAL       |         999,999        |        999,999        |         999,999        |         999,999        |           999,999      |
-------------------------------------------------------------------------------------------------------------------------------------------

                                                    END OF REPORT
```

7.33.3 CLM-0065-D -- Aged Suspended Report Field Descriptions

Field	Description	Length	Data Type
Aged > 30 Days	Total number of days claims have been suspended.	9	Number (Decimal)
Aged > 60 Days	Total number of days claims have been suspended.	9	Number (Decimal)
Aged > 90 days	Total number of days claims have been suspended.	9	Number (Decimal)
Current to 30 days	Total number of days claims have been suspended.	9	Number (Decimal)
Location Code	The location of the suspended claim.	2	Number (Integer)
Total	Total of each subheading.	9	Number (Decimal)
Total of all Aged	Total number of claims that are aged.	9	Number (Decimal)

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7.33 CLM-0610-W Kick Payment Processing Report

7.33.1 CLM-0610-W Kick Payment Processing Report Narrative

This report contains the processing kick payment data that is run after each financial. The Report is organized by RCOs in alphabetical order. For each RCO we will report the sum of all capitations and recoupments. At the end of the report, we will provide a capitations Grand total that is a sum of all capitations and recoupments for all RCOs.

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7.33.2 CLM-0610-W Kick Payment Processing Report Layout

```
Report  : CLM-0610-W                                  ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJW610                              MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPW610                                       KICK PAYMENT PROCESSING                                 Page:            XXX
                                                 REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


RCO RECIPIENT ID    RECIPIENT NAME    ORIG:  ICN     DTL  ST    DOS           AMOUNT        ACTION/MESSAGE
                                      NEW :

RA1 999999999999 ABCDEFGHIJKLMNOPQRST 7116240001001  999   P  MM/DD/YY  99,999,999.99   1234567890123456789012345678901234567890123456789 0
                                      7116259001001  999   P  MM/DD/YY  99,999,999.99   1234567890123456789012345678901234567890123456789 0

RA1 999999999999 LAST, FIRST          7116240001001  999   P  MM/DD/YY  99,999,999.99   CAPITATION GENERATED

RA1 999999999999 LAST, FIRST          7116240001002  999   P  MM/DD/YY  99,999,999.99   CAPITATION GENERATED - FORCED

RA1 - CAPITATIONS TOTAL:                                               99,999,999.99


RA2 999999999999 LAST, FIRST          7116240001003  999   P  MM/DD/YY          0.00   CAPITATION NOT GENERATED - ALREADY PAID

RA2 - CAPITATIONS TOTAL:                                               99,999,999.99


RB1 999999999999 LAST, FIRST          7116240001004  999   P  MM/DD/YY          0.00   CAPITATION NOT GENERATED - TOO SOON

RB1 - CAPITATIONS TOTAL:                                               99,999,999.99


RB2 999999999999 12345678901234567890 7116240001005  999   P  MM/DD/YY  99,999,999.99   TRACKING UPDATED - ICN REPLACED
                                      7716272001043  999   P  MM/DD/YY  99,999,999.99

RB2 999999999999 12345678901234567890 7116240001006  999   P  MM/DD/YY  99,999,999.99   CAPITATION RECOUPED - DENIED ADJUSTMENT
                                      7716275001016  999   D  MM/DD/YY          0.00

RB2 999999999999 LAST, FIRST          7116240001007  999   P  MM/DD/YY  99,999,999.99   CAPITATION PAID - FORCED

RB2 - CAPITATIONS TOTAL:                                               99,999,999.99


CAPITATIONS GRAND TOTAL:                                               99,999,999.99


                                                   *** END OF REPORT ***
                                                            or
                                                 *** NO DATA THIS RUN ***
```


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7.33.3 CLM-0610-W Kick Payment Processing Report Field Descriptions

Field	Description	Length	Data Type
Action/Message	Text indicating whether a capitation or recoupment was generated along with a message explaining the action.	50	Character
Amount	Amount the kick payment processed. If this field is negative, then the kick payment was recouped. If the field is positive, a capitation was paid.	12	Number (Decimal)
Capitations Grand Total	Sum of all capitations and recoupments for all RCOs.	12	Number (Decimal)
DOS	Date of service of the respective claim.	8	Date (MM/DD/YY)
DTL	Detail number with the Kick Payment Indicator.	3	Number (Integer)
ICN	Internal control number of the claim.	13	Number (Integer)
RCO	RCO of the recipient during the date of service.	3	Character
RCO-ID – Capitation Total	Total sum of the RCO-ID's capitation and recoupments.	12	Number (Decimal)
Recipient ID	Medicaid identification number of the recipient.	12	Character
Recipient Name	First and last name of the recipient. This field is truncated at 20 characters.	20	Character
ST	Status (paid or denied) of the respective claim.	1	Character

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7.34 CLM-0640-W Random Sample ICN Report

7.34.1 CLM-0640-W Random Sample ICN Balancing Report Narrative

The Random Sample ICN Report lists two ICNs per region per claim type. This report is produced every Friday for claims processed through the system Saturday through Friday.

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7.34.2 CLM-0640-W Random Sample ICN Balancing Report Layout

```
Report:   CLM-0640-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process:  CLMJW640                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: CLMPW640                          RANDOM SAMPLE ICN REPORT                                       Page:     XXX

FOR: MM/DD/YYY    THRU   MM/DD/YYYY

RGN CT        ICN
10  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

11  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

90  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

91  IX            9999999999999             9999999999999
    OX            9999999999999             9999999999999
    MX            9999999999999             9999999999999
    IP            9999999999999             9999999999999
    OP            9999999999999             9999999999999
    LT            9999999999999             9999999999999
    HC            9999999999999             9999999999999
    DE            9999999999999             9999999999999
    PH            9999999999999             9999999999999
    PC            9999999999999             9999999999999

                                                   ***END OF REPORT ***
```


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7.34.3 CLM-0640-W Random Sample ICN Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range from which ICNs are being reported.	10	Character
Thru MM/DD/YYYY	The ending date range from which ICNs are being reported	10	Character
RGN	Region of the claim (excludes converted regions 40 – 48 and encounters 70)	2	Number (Integer)
CT	Claim types IX – Inpatient Crossover OX – Outpatient Crossover MX – Medical Crossover IP - Inpatient OP – Outpatient HC – Medical LT – Long Term Care DE – Dental PH - Pharmacy PC – Pharmacy Compound	2	Character
ICN	Random ICN for that claim type and region. 2 occurrences	13	Number (Integer)

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7.35 CLM-0670-D FEITH Images to Claims Balancing Report

7.35.1 CLM-0670-D FEITH Images to Claims Balancing Report Narrative

The FEITH Images to Claims Balancing Report lists the number the electronic and paper claims accepted into the MMIS and the number of electronic and paper claims images residing in FEITH. This report is produced daily.

7.35.2 CLM-0670-D FEITH Images to Claims Balancing Report Layout

```
                                CLAIMS ACCEPTED     PAPER PHARM DTLS*   CLAIM IMAGES        CLAIMS MISSING      IMAGES MISSING

     ELECTRONIC                    999999                                    9                                 999999
999999                          999999

     PAPER                                999999                              999999                              999999
999999                          999999

     TOTAL                               9999999                                                                    9999999

     *  This number represents the number of additional claims created when there are multiple details on a paper pharmacy form.

                                                   *** END OF REPORT ***
```

7.35.3 CLM-0670-D FEITH Image to Claims Balancing Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Electronic Claims Accepted	Total number of electronic claims accepted into the MMIS for the date given	4	Number (Integer)
Paper Claims Accepted	Total number of paper claims accepted into the MMIS for the date given	4	Number (Integer)
Total Claims Accepted	Total number of paper and electronic claims accepted into the MMIS for the date given	5	Number (Integer)

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Field	Description	Length	Data Type
Paper Pharm Details	A paper pharmacy form has up to three details which creates three claims in MMIS while FEITH only has one image. This number represents the additional claims created in MMIS that will not have an individual image in FEITH.	4	Number (Integer)
Electronic Claim Images	Total number of electronic claim facsimiles residing in FEITH for the date given	6	Number (Integer)
Paper Claim Images	Total number of paper claims images residing in FEITH for the date given	6	Number (Integer)
Total Claims Images	Total number of paper and electronic claims images residing in FEITH for the date given	7	Number (Integer)
Electronic Claims Missing	Number of electronic images that are missing claims	6	Number (Integer)
Paper Claims Missing	Number of paper images that are missing claims	6	Number (Integer)
Electronic Images Missing	Number of electronic claims that are missing facsimiles	6	Number (Integer)
Paper Images Missing	Number of paper claims that are missing images	6	Number (Integer)

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7.36 CLM-0671-D Images Missing Claims Report

7.36.1 CLM-0671-D Images Missing Claims Report Narrative

The Images Missing Claims Report is broken in two parts – the Summary Report which lists the number of electronic and paper images that do not have a corresponding claim in the MMIS. The Detail Report lists the specific ICNs that are missing a claim in the MMIS. An email is sent to the Claims team with the ICNs for them to research the ICN and take corrective action. This report is produced daily.

7.36.2 CLM-0671-D Images Missing Claims Report Layout

```
Report :  CLM-0671-D                                          ALABAMA MEDICAID
AGENCY                                                          Run Date: MM/DD/YYYY
Process : CLMJD670                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                               IMAGES MISSING CLAIMS SUMMARY
REPORT                                             Page:          X

FOR: MM/DD/YYY   THRU   MM/DD/YYYY

                      NUMBER OF IMAGESS MISSING CLAIMS
   ELECTRONIC                        9999
   PAPER                             9999
   TOTAL                                99999

                                                                          *** END OF REPORT ***
Report  :  CLM-0671-D                                        ALABAMA MEDICAID
AGENCY                                                          Run Date: MM/DD/YYYY
Process : CLMJD671                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                              IMAGES MISSING CLAIMS DETAIL
REPORT                                             Page:          X

                                   FOR: MM/DD/YYY THRU   MM/DD/YYYY

THE FOLLOWING IMAGES WILL BE RESEARCHED TO DETERMINE WHY CLAIMS ARE MISSING.

ICN                           DATE RECEIVED
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
                                                            *** END OF REPORT ***
```


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7.36.3 CLM-0671-D Images Missing Claims Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Summary Report			
Electronic Number of images missing	Total number of electronic facsimiles missing claims for the date given	4	Number (Integer)
Paper Number of images missing	Total number of paper images missing claims for the date given	4	Number (Integer)
Total Number of imagesmissing	Total number of paper and electronic images missing claims for the date given	5	Number (Integer)
Detail Report			
ICN	Specific ICN of the image missing a claim	13	Number (Integer)
Date Received	Date image was received into the system	10	Character

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7.37 CLM-0672-D Claims Missing Images Report

7.37.1 CLM-0672-D Claims Missing Images Report Narrative

The Claims Missing Images Report is broken into two parts – the Summary Report which lists the number of electronic and paper claims that do not have a corresponding image in FEITH. The Detail Report lists the specific ICNs that are missing an image in FEITH. An email is sent to the Claims team with the ICNs for them to research the ICN and take corrective action. This report is produced daily.

7.37.2 CLM-0672-D Claims Missing Images Report Layout

```
Report  :  CLM-0672-D                                          ALABAMA MEDICAID
AGENCY                                                           Run Date: MM/DD/YYYY
Process : CLMJD670                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                                 CLAIMS MISSING IMAGES SUMMARY
REPORT                                        Page:          X

                                                   FOR: MM/DD/YYY    THRU   MM/DD/YYYY

                      NUMBER OF CLAIMS MISSING IMAGES
   ELECTRONIC                         9999
   PAPER                              9999
   TOTAL                                 99999

                                                                                  *** END OF REPORT ***
Report  :  CLM-0672-D                                          ALABAMA MEDICAID
AGENCY                                                           Run Date: MM/DD/YYYY
Process : CLMJD670                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALRPT                                 CLAIMS MISSING IMAGES DETAIL
REPORT                                           Page:          X

                                     FOR: MM/DD/YYY THRU   MM/DD/YYYY

IMAGES WILL BE SYSTEMATICALLY GENERATED FOR THE FOLLOWING CLAIMS:

ICN                           DATE RECEIVED
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY
9999999999999          MM/DD/YYYY

                                                                 *** END OF REPORT ***
```


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7.37.3 CLM-0672-D Claims Missing Images Report Field Descriptions

Field	Description	Length	Data Type
For MM/DD/YYYY	The beginning date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Thru MM/DD/YYYY	The ending date range being reported. Date determined by value in t_system_parms where nam_program=CLMPBAL	10	Character
Summary Report			
Electronic Number of claims missing images	Total number of electronic claims missing facsimiles for the date given	4	Number (Integer)
Paper Number of claims missing images	Total number of paper claims missing images for the date given	4	Number (Integer)
Total Number of claims missing images	Total number of paper and electronic claims missing images for the date given	5	Number (Integer)
Detail Report			
ICN	Specific ICN of the claim missing an image	13	Number (Integer)
Date Received	Date claim was received into the system	10	Character

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7.38 CLM-0690-O Facsimiles Corrected Report

7.38.1 CLM-0690-O Facsimiles Corrected Report Narrative

The Facsimiles Corrected Report is broken in two parts – the Summary Report which lists the number of facsimiles that the action taken to ensure that every claim in the MMIS has a facsimile was verified. The Detail Report lists the specific ICNs that have been verified as having been corrected and the action taken for that ICN. This report is produced on request.

7.38.2 CLM-0690-O Claims Missing Facsimiles Report Layout

```
Report  :  CLM-0690-D                                        ALABAMA MEDICAID
AGENCY                                                         Run Date: MM/DD/YYYY
Process : CLMJD690                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                        Run
Time:   HH:MM:SS
Location:  CLMPBALVER                           FACSIMILES CORRECTED SUMMARY
REPORT                                                 Page:          X


                     NUMBER OF FACSIMILES CORRECTED

   DELETED                           9999

   ADDED                      9999

   TOTAL                         99999


                                                                        *** END OF REPORT ***
```


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```
Report  : CLM-0690-D                          ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/YYYY
Process : CLMJD690                     MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: CLMPBALVER                     FACSIMILES CORRECTED DETAIL REPORT                            Page:          X
THE FOLLOWING FACSIMILES HAVE BEEN CORRECTED AND VERIFIED:
        ICN                  DATE CORRECTED       DATE VERIFIED     ACTION
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
        9999999999999     MM/DD/YYYY             MM/DD/YYYY        XXXXXXXX
*** END OF REPORT ***
```

7.38.3 CLM-0690-O Facsimiles Corrected Report Field Descriptions

Field	Description	Length	Data Type
Summary Report			
Number of facsimiles corrected - deleted	Total number of facsimiles that were deleted from FEITH.	4	Number (Integer)
Number of facsimiles corrected - added	Total number of facsimile that were added to FEITH.	4	Number (Integer)
Total number of facsimiles that have been corrected.	Total number of facsimiles for which corrective action was taken.	5	Number (Integer)
Detail Report			

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Field	Description	Length	Data Type
ICN	Specific ICN of the facsimile corrected	13	Number (Integer)
Date Corrected	Date claim was corrected in FEITH.	10	Character
Date Verified	Date claim was confirmed as being corrected in FEITH.	10	Character
Action	The specific action taken and verified for this ICN. Added – indicates a facsimile was generated for the claim. Deleted means there was not a claim for the facsimile and therefore, the facsimile was deleted from FEITH.	9	Character

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7.39 CLM-0130-D -- CLM Claims Submission Statistics – Daily Report

7.39.1 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Narrative

The CLM Claims Submission Statistics Daily report provides summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It lists the information at the summary level, and at the submitter level. Does not report paper claims. This report is produced daily.

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7.39.2 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Layout

```
Report  : CLM-0130-D                  ALABAMA MCLMCAID AGENCY                  Run Date:  MM/DD/CCYY
Process : CLMJD130           MCLMCAID MANAGEMENT INFORMATION SYSTEM            Run Time:    HH:MM:SS
Location: CLM0130D          CLM CLAIMS SUBMISSION STATISTICS - DAILY           Page:            9999

Submission Type
Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied

NCPDP             999,999,999      999,999,999      999,999,999      999,999,999
xxxxxxxx           999,999          999,999          999,999          999,999
xxxxxxxx          999,999           999,999          999,999          999,999
xxxxxxxx          999,999           999,999          999,999          999,999

WEB DDE           999,999,999      999,999,999      999,999,999      999,999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999

ASC X12           999,999,999      999,999,999      999,999,999      999,999,999
Xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999
xxxxxxxx          999,999          999,999          999,999          999,999

System Totals     999,999,999      999,999,999      999,999,999      999,999,999



Summitter 1   Submission Type: NCPDP

Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999


Totals                999,999           999,999          999,999           999,999


Summitter 2   Submission Type: WEB DDE

Claim Type        Accepted Claims  Claims Suspended Claims Paid      Claims Denied
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999
xxxxxxxx              999,999          999,999          999,999          999,999


Totals                999,999           999,999          999,999           999,999
```


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```
Summitter 3   Submission Type: ASC X12

Claim Type       Accepted Claims  Claims Suspended Claims Paid      Claims Denied
Xxxxxxxx         999,999          999,999          999,999          999,999
Xxxxxxxx         999,999          999,999          999,999          999,999
Xxxxxxxx         999,999          999,999          999,999          999,999

Totals           999,999          999,999          999,999          999,999

                                        *** END OF REPORT ***
```

7.39.3 CLM-0130-D -- CLM Claims Submission Statistics - Daily Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Decimal)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12)	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.40 CLM-0130-M -- CLM Claims Submission Statistics – Monthly Report

7.40.1 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Report Narrative

The CLM (Electronic Data Interchange) Claims Submission Statistics report is a monthly summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It is reported at the summary level, and at the submitter level. Does not report paper claims. This report is produced monthly.

7.40.2 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Layout Report

```
Report  : CLM-0130-M                  ALABAMA MEDICAID AGENCY                  Run Date:  MM/DD/CCYY
Process : CLMJM130           MCLMCAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130M          CLM CLAIMS SUBMISSION STATISTICS - DAILY          Page:            9999

 Submission    Claim Type    Accepted Claims   Claims Suspended   Claims Paid      Claims
 Type                                                                            Denied
 NCPDP                       999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 WEB DDE                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 ASC X12                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 System                      999,999,999       999,999,999        999,999,999      999,999,999
 Totals
Summitter 1   Submission Type: NCPDP
 Claim Type       Accepted       Claims           Claims Paid      Claims Denied
                  Claims         Suspended
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999

 Totals           999,999        999,999          999,999          999,999
 Summitter 2   Submission Type: WEB DDE
 Claim Type       Accepted       Claims           Claims Paid      Claims Denied
                  Claims         Suspended
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999
 xxxxxxxx         999,999        999,999          999,999          999,999

 Totals           999,999        999,999          999,999          999,999
 Summitter 3   Submission Type: ASC X12
```


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```
Claim Type        Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended
Xxxxxxxx          999,999        999,999         999,999          999,999
Xxxxxxxx          999,999        999,999         999,999          999,999
Xxxxxxxx          999,999        999,999         999,999          999,999

Totals            999,999        999,999         999,999          999,999
                                          *** END OF REPORT ***
```

7.40.3 CLM-0130-M -- CLM Claims Submission Statistics - Monthly Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Integer)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12).	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.41 CLM-0130-W -- CLM Claims Submission Statistics – Weekly Report

7.41.1 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Narrative

The CLM Claims Submission Statistics report is a weekly summary of CLM claim counts sent to the claims engine by submission type (NCPDP, WEB DDE, ASC x12). It provides information at the summary level, and at the submitter level. Does not report paper claims.

7.41.2 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Layout

```
Report  : CLM-0130-W                ALABAMA MCLMCAID AGENCY                    Run Date:  MM/DD/CCYY
Process : CLMJW130           MCLMCAID MANAGEMENT INFORMATION SYSTEM           Run Time:    HH:MM:SS
Location: CLM0130W          CLM CLAIMS SUBMISSION STATISTICS - WEEKLY          Page:            9999
 Submission    Claim Type    Accepted Claims   Claims Suspended   Claims Paid      Claims Denied
 Type
 NCPDP                       999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 WEB DDE                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
 ASC X12                     999,999,999       999,999,999        999,999,999      999,999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999
               xxxxxxxx      999,999           999,999            999,999          999,999

 System                      999,999,999       999,999,999        999,999,999      999,999,999
 Totals
Summitter 1   Submission Type: NCPDP
 Claim Type       Accepted Claims    Claims            Claims Paid      Claims Denied
                                     Suspended
 xxxxxxxx         999,999            999,999           999,999          999,999
 xxxxxxxx         999,999            999,999           999,999          999,999
 xxxxxxxx         999,999            999,999           999,999          999,999

 Totals           999,999            999,999           999,999          999,999
```


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```
Summitter 2   Submission Type: WEB DDE


 Claim Type       Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended

 xxxxxxxx         999,999        999,999         999,999          999,999

 xxxxxxxx         999,999        999,999         999,999          999,999

 xxxxxxxx         999,999        999,999         999,999          999,999


 Totals           999,999        999,999         999,999          999,999

 Summitter 3   Submission Type: ASC X12


 Claim Type       Accepted       Claims          Claims Paid      Claims Denied
                  Claims         Suspended

 Xxxxxxxx         999,999        999,999         999,999          999,999

 Xxxxxxxx         999,999        999,999         999,999          999,999

 Xxxxxxxx         999,999        999,999         999,999          999,999


 Totals           999,999        999,999         999,999          999,999

                                  *** END OF REPORT ***
```

7.41.3 CLM-0130-W -- CLM Claims Submission Statistics - Weekly Report Field Descriptions

Field	Description	Length	Data Type
Accepted Claims	Total count of CLM claims submitted by indicated submission type and sent to the claims engine. This total should equal the count of suspended, paid, and denied claims in this report.	6	Number (Integer)
Claim Type	MMIS Claim Type.	15	Character
Claims Denied	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and denied by the claims engine.	6	Number (Integer)

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Field	Description	Length	Data Type
Claims Paid	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and paid by the claims engine.	6	Number (Integer)
Claims Suspended	Total count of CLM claims submitted by indicated submission type, sent to the claims engine, and suspended by the claims engine.	6	Number (Integer)
Submission Type	Origination of transmission (NCPDP, WEB DDE, ASC X12).	15	Character
Submitter	The submitter code for the claim.	50	Character
System Totals	The total number of accepted, denied, paid and suspended claims submitted for all claim types.	11	Number (Integer)
Totals	The total number of accepted, denied, paid, and suspended claims per claim type.	7	Number (Integer)

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7.42 CLM-0300-W -- CLM ICD Version Edit Failures by Provider – Weekly Report

7.42.1 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Narrative

The CLM ICD Version Edit Failures by Provider report is a weekly list of the claims failing edit 309 or 310 for incorrect version of ICD procedure (309) or diagnosis (310). This weekly report will be used to monitor ICD-10 compliance and to contact providers as needed. There are two sections to the report: 1) Detail section sorted by provider, ICN, and Edit number that lists the diagnosis codes and/or ICD procedure codes on the claim. 2) Summary section sorted by the total claims failing these edits in descending order and listing the Provider summary counts and contact information.

7.42.2 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Layout

```
REPORT  : CLM-0300-W                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS : CLMJW300                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     RUN TIME:   HH:MM:SS
LOCATION: CLMP0300                      ICD VERSION EDIT FAILURES REPORT BY PROVIDER - DETAIL                PAGE:    999,999
                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

                         C                                 --------------- ICD PROCEDURE (309) OR DIAGNOSIS (310) ----------------
PROVIDER    ICN          T FDOS/DISCH  PAID DATE  ICD  EDT  QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX QLF PROC/DX
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
            XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
            XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        310  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
XXXXXXXXXX  XXXXXXXXXXXXX X MM/DD/CCYY  MM/DD/CCYY  X   309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX
                                                        309  XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX XXX XXXXXXX

REPORT  : CLM-0300-W                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
```


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```
PROCESS : CLMJW300                          MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME:   HH:MM:SS
LOCATION: CLMP0300                    ICD VERSION EDIT FAILURES REPORT BY PROVIDER - SUMMARY                  PAGE:    999,999
                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

PROVIDER   CONTACT NAME                       CONTACT PHONE   EXT       TOT CLAIMS FAILING      COUNT EDIT 309       COUNT EDIT 310
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999
XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999) 999-9999  9999        999,999,999            999,999,999          999,999,999

GRAND TOTALS:                                                           999,999,999            999,999,999          999,999,999

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```

7.42.3 CLM-0300-W -- CLM ICD Version Edit Failures by Provider - Weekly Report Field Descriptions

Field	Description	Length	Data Type
Contact Name	The name of the contact person on file for this provider.	35	Character
Contact Phone	The phone number of the contact person on file for this provider.	14	Character
Count Edit 309	Calculated count of the number of claims reported as failing edit 309.	9	Number (Integer)
Count Edit 310	Calculated count of the number of claims reported as failing edit 310.	9	Number (Integer)
CT	The claim type for the claim being reported.	1	Character
EDT	This is the edit associated with the report line. Value will be either 309 for ICD Procedure codes or 310 for Diagnosis codes.	3	Character
EXT	The phone extension of the contact person on file for this provider.	4	Character

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Field	Description	Length	Data Type
FDOS/DISCH	For inpatient claims this will be the Last Date of Service (discharge date). For all other claim types it will be the First Date of Service from the header. This is the date that the system uses to determine the correct ICD version that should be on the claim.	10	Date (MM/DD/CCYY)
Grand Totals	Calculated grand total count of the three numbers being reported on the summary section of the report.	9	Number (Integer)
ICD	The ICD version that should have been used for this claim. Calculated using the Claim Type and either the From Date of Service for non-Inpatient claims or the Through Date of Service (Discharge Date) for Inpatient claims. Values are: '9' = ICD-9, '0' = ICD-10.	1	Character
ICN	Claim internal control number	13	Character
Paid Date	The date on which the claim was denied	10	Date (MM/DD/CCYY)
PROC/DX	If EDT is 309, this will be the ICD procedure code. If EDT is 310, this will be the diagnosis code. T_CLM_DIAG_XREF or T_UB92_HDR_DIAG_X for diagnosis codes, or T_UB92_HDR_ICD9CM for procedure codes.	7	Character
Provider	The Billing Provider Location Medicaid Number: CDE_PROV_ID_TYPE = 'MCD'.	10	Character
QLF	The diagnosis or procedure qualifier associated with the code. T_CLM_DIAG_XREF or T_UB92_HDR_DIAG_X for diagnosis codes, or T_UB92_HDR_ICD9CM for procedure codes. ICD-10 qualifiers will be 3 characters and ICD qualifiers will be 2 bytes long.	3	Character
Report Period	This is a weekly report. The report period will be displayed in the headings.	10	Date (MM/DD/CCYY)
Tot Claims Failing	Calculated count of the number of claims reported as failing either edit 309 or 310.	9	Number (Integer)

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7.43 CLM-2011-P -- RECIPIENT DATA SHEET REQUEST PROCESS REPORT

7.43.1 CLM-2011-P – Recipient Data Sheet Request Process Report Narrative

Reports of Datasheet requests received and processed including any errors encountered.

7.43.2 CLM-2011-P – Recipient Data Sheet Request Process Report Layout

```
REPORT  : CLM-2011-P                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                       MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                    RECIPIENT DATA SHEET REQUEST PROCESS REPORT                  PAGE:    999,999


          REVIEW                                        CLAIMS       ERROR
REQUESTOR NUMBER SEQ  RECIPIENT       REQUEST DATES     REQUESTED    MESSAGES

   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXX    XXXXX  999 XXXXXXXXXXXXX  XXXXXXXX XXXXXXXX   XXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                        .....  END OF REPORT  .....
```


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7.43.3 CLM-2011-P – Recipient Data Sheet Request Process Report Field Descriptions

Field	Description	Length	Data Type
Claims Requested	REQUESTOR indicates the claims to report in this field. The REQUESTOR may indicate ALL for all claim types, or ALLXzzzz to report all claims types "except" those indicated (the zzzz) values. The REQUESTOR may also indicate the specific claim types to include using the 1-character interchange claim type codes (REFERENCE > RELATED DATA > > Codes > Claim Type).	8	Character
Error Messages	Issues or errors encountered while processing the Recipient Data Sheet requests are reported in this field.	60	Character
Recipient	A 12-digit number that uniquely identifies an individual eligible for Medicaid benefits.	12	Character
Request Dates	Two ten character date fields (MM/DD/CCYY) indicating the from and through dates of service of claims for this request. These fields are optional. If not provided, the default is to report the past 37 months of data.	20	Character
Requestor	Identifier submitted on the request to identify the source of the request.	3	Character
Review Number	This field is submitted on the request to identify a specific review to the REQUESTOR. This field is optional.	5	Number (Integer)
SEQ	Displays the total number of providers that have invalid Account Routing Numbers.	3	Number (Integer)

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7.44 CLM-2011-R -- RECIPIENT DATA SHEET REPORT

7.44.1 CLM-2011-R – Recipient Data Sheet Report Narrative

Lists claims data for recipients and dates requested.

7.44.2 CLM-2011-R – Recipient Data Sheet Reports Layout

```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                         RECIPIENT DATA SHEET                            PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: DENTAL

    ICN       BILLING NPI SPC FROM DOS   THRU  DOS  PAID DATE  BILLED AMT   ALLOWED     TPL  AMT   PAID AMT    POS  T P  ESC1 F S
  ADJ ICN     CS DERIVED STAT                                                                                        I A  ESC2 F S
XXXXXXXXXXXXX XXXXXXXXXX  XXX MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY 9999999.99  9999999.99  9999999.99  9999999.99  XX   X X  XXXX X X
XXXXXXXXXXXXX X  XXXXXXXXXXXX                                                                                          XXXX X X

     DT S SERVICE DT  PERF PROV   SPC  PROC  TN OC SFSFSFSF  UNITS BLLD    BILLED AMT  ALLOWD AMT  PAID AMT     ESC1 F S ESC2 F S
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
     99 X MM/DD/CCYY  XXXXXXXXXX  XXX  XXXXX XX X  X X X X   999999.999    9999999.99  9999999.99  9999999.99   XXXX X X XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

P R O C E D U R E   C O D E   S U M M A R Y

CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y

CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: INPATIENT AND INPATIENT CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS  ADMIT  DT  PAID DATE   BILLED AMT  COPAY  AMT TOB  C F E T S E C M P Q ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING   ATTENDING  DISCHARGE  PAID AMT    ALLOWED     TPL  AMT   CDYS T P P I V C P E A M ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY MM/DD/CCYY MM/DD/CCYY  9999999.99    99999.99 XXX  X X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX  XXXXXXXXXX MM/DD/CCYY 9999999.99  9999999.99  9999999.99 XXXX                    XXXX X X

DIAGNOSIS: XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX

MEDICARE  ALLWD:9999999.99  COINS:9999999.99  DED:9999999.99  PAID:999999999.99  PD DT:MM/DD/CCYY   LTR:999   CID:999

SURG CODES:    X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX  X-XXXXXXX

             DTL S FROM DOS   THRU DOS    REV   UNITS BLLD  SUBM RATE  BILLED AMT  ALLOWD AMT                 ESC1 F S  ESC2 F S
             999 X MM/DD/CCYY MM/DD/CCYY  XXXX  999999.999  999999.99  9999999.99  9999999.99                 XXXX X X  XXXX X X
             999 X MM/DD/CCYY MM/DD/CCYY  XXXX  999999.999  999999.99  9999999.99  9999999.99                 XXXX X X  XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

R E V E N U E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

S U R G E R Y   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: OUTPATIENT AND OUTPATIENT CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS             PAID DATE   BILLED AMT  COPAY  AMT  TOB  C F E T S E C M P ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING                         PAID AMT    ALLOWED     TPL  AMT    PAT  T P P I V C P E A ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY            MM/DD/CCYY  9999999.99    99999.99  XXX  X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX                        9999999.99  9999999.99  9999999.99  XX                     XXXX X X

DIAGNOSIS: XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX
           XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX   XX-X-XXXXXXX

MEDICARE  ALLWD:9999999.99  COINS:9999999.99  DED:9999999.99  PAID:999999999.99  PD DT:MM/DD/CCYY

  DTL S FROM DOS   THRU DOS    REV  PROC  M1 M2 M3 M4 UNITS BLLD UNITS ALLW BILLED AMT  ALLOWD AMT  PAID  AMT  Q ESC1 F S  ESC2 F S
  999 X MM/DD/CCYY MM/DD/CCYY  XXXX XXXXX XX XX XX XX 999999.999 999999.999 9999999.99  9999999.99  9999999.99 X XXXX X X  XXXX X X
  999 X MM/DD/CCYY MM/DD/CCYY  XXXX XXXXX XX XX XX XX 999999.999 999999.999 9999999.99  9999999.99  9999999.99 X XXXX X X  XXXX X X
TOTAL PAID AMOUNT:999,999,999,999.99

R E V E N U E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O C E D U R E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: PHARMACY AND COMPOUND PHARMACY

    ICN       BILLING NPI SPC PRESCRIBER DISPENSED  PAID DATE   BILLED AMT   DISP FEE     TPL  AMT    DAYS  C F P T C P E B
  ADJ ICN     CS DERIVED STAT PRSCRB NPI PRESCRIBED SCRIPNO RF  ALLOWED      COPAY        PAID AMT          T P G I P A M R
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX MM/DD/CCYY MM/DD/CCYY  9999999.99   99999.99    9999999.99   9999  X X X X X X X X
XXXXXXXXXXXXX X  XXXXXXXXXXXX XXXXXXXXXX MM/DD/CCYY XXXXXXX XX  9999999.99   99999.99    9999999.99

     DT S NDC          ALGI  PREF  SC    CLASS     PACKAGE  SIZE   QTY DISP       UNIT RATE    RATE  BILLED AMT  ESC1 F S
          DESCRIPTION                               STRENGTH                                        ALLOWD AMT  ESC2 F S
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X
     99 X 99999999999   X     X    XX  XXXXXXXXX  99999999999.999  9999999.999  9999999.99999  XXXX  9999999.99  XXXX X X
          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      9999999.99  XXXX X X


TOTAL PAID AMOUNT:999,999,999,999.99


P R O V I D E R   S U M M A R Y

NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX


E S C   S U M M A R Y

CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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```
REPORT  : CLM-2011-R                                    ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : CLMJO201                                 MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:   HH:MM:SS
LOCATION: CLMPO201                                          RECIPIENT DATA SHEET                           PAGE:    999,999

                                                                                                 RECIPIENT PAGE NUM:    999,999

RECIPIENT: XXXXXXXXXXX  LASTXXXXXXXXXXXXXXXXX, FIRSTXXXXXXXXXX M  REQUESTOR:XXX REVIEW XXXXX SEQ:999 DATES:MM/DD/CCYY TO MM/DD/CCYY

CLAIM SECTION: PROFESSIONAL AND PROFESSIONAL CROSSOVERS

    ICN       CS DERIVED STAT FROM DOS    THRU  DOS            PAID DATE   BILLED AMT  COPAY  AMT  TOB  C F E T S E C M P ESC1 F S
  ADJ ICN     BILLING NPI SPC REFERRING                        PAID AMT    ALLOWED     TPL  AMT    PAT  T P P I V C P E A ESC2 F S
XXXXXXXXXXXXX X  XXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY           MM/DD/CCYY  9999999.99    99999.99  XXX  X X X X X X X X X XXXX X X
XXXXXXXXXXXXX XXXXXXXXXX  XXX XXXXXXXXXX                       9999999.99  9999999.99  9999999.99  XX                    XXXX X X

DIAGNOSIS: XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX
           XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX  XX-X-XXXXXXX

     DT S FROM DOS    PERF PROV  SPC PROC  M1    UNITS BD    UNTS ALW  BILLED AMT  ALLOWD AMT   PAID  AMT      ESC1 F S  ESC2 F S
        Q THRU DOS    REFERRING  POS M2 M3 M4  MC PAID DT    MC COINS  MC DEDUCT   MC ALLOWED   MC PD AMT
     99 X MM/DD/CCYY  XXXXXXXXXX XXX XXXXX XX    9999.999    9999.999  9999999.99  9999999.99  9999999.99      XXXX X X  XXXX X X
        X MM/DD/CCYY  XXXXXXXXXX XXX XX XX XX  MM/DD/CCYY  9999999.99  9999999.99  9999999.99  9999999.99
     99 X MM/DD/CCYY  XXXXXXXXXX XXX XXXXX XX    9999.999    9999.999  9999999.99  9999999.99  9999999.99      XXXX X X  XXXX X X
        X MM/DD/CCYY  XXXXXXXXXX XXX XX XX XX  MM/DD/CCYY  9999999.99  9999999.99  9999999.99  9999999.99
TOTAL PAID AMOUNT:999,999,999,999.99

P R O C E D U R E   C O D E   S U M M A R Y
CODE   DESCRIPTION
XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

D I A G N O S I S   C O D E   S U M M A R Y
ICD CODE     DESCRIPTION
 X  XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

P R O V I D E R   S U M M A R Y
NPI NUMBER  MEDICAID   NAME
XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

XXXXXXXXXX  XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TYPE: XX-XXXXXXXXXX
SPECIALTIES: XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX  XXX-XXXXXXXXXX

E S C   S U M M A R Y
CODE  DESCRIPTION
XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  .....  END OF REPORT  .....
```


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7.44.3 CLM-2011-R – Recipient Datasheets Report Field Descriptions

Field	Description	Length	Data Type
ADJ ICN	Adjusted Internal control number	13	Character
ADMIT DT	The admit date on the claim.	10	Date (MM/DD/CCYY)
ALGI	Alabama Generic Indicator – 1 is a generic or over the counter drug, 2 is a name brand drug and 0 is a bulk chemical	1	Number
ALLOWD AMT	The allowed amount on the claim	10	Number (Decimal)
ALLOWED	The allowed amount on the claim	10	Number (Decimal)
ATTENDING	The license number of the attending physician on the claim.	10	Character
BILLED AMT	Detail record amount submitted for services.	10	Number (Decimal)
BILLING NPI	The billing providers npi #.	10	Number
CID	Coinsurance Days	3	Number (Integer)
CLAIM SECTION	Name of claim section displayed on this page	50	
CLASS	The therapeutic class code.	10	Character
COINS	The Medicare coinsurance amount which is subject to payment by Medicaid.	10	Number (Decimal)
COPAY	The copay amount.	8	Number (Decimal)
COPAY AMT	The copay amount.	8	Number (Decimal)
CP	Copay indicator.	2	Character

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Field	Description	Length	Data Type
CS	Claim Status D=Denied, P=Paid, S=Suspended, V=Voided	1	Character
CT	Claim type indicator.	2	Character
DAY SUP	Number of days supply.	4	Number (Integer)
DAYS	Number of covered days on claim.	4	Character
DED	The header Medicare deductible amount.	10	Number (Decimal)
DERIVED STAT	Derived Status of the claim.	12	Character
DIAGNOSIS	The diagnosis will be displayed in the format ss-v-ddddddd where ss is the sequence, v is the icd version, and ddddddd is the diagnosis code.	12	Character
DIAGNOSIS DESCRIPTION	The description for all of the detail diagnosis codes on the claims.	60	Character
DISCHARGE DATE	The date of discharge on the claim.	10	Date (MM/DD/CCYY)
DISP FEE	The dispensed fee for the drug on the claim.	8	Number (Decimal)
DISPENSED Date	The date upon which the drug was dispensed to the recipient	10	Date (MM/DD/CCYY)
DT	The detail number on the claim.	2	Number (Integer)
DTL NUM	The detail number on the claim.	3	Number (Integer)
EC	Encounter claim indicator	2	Character
EI	Emergency indicator.	2	Character
EP	EPSDT Referral.	2	Character

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Field	Description	Length	Data Type
ESC 1	First error status code on the claim.	4	Number
ESC 2	Second error status code on the claim.	4	Number
FI	Forced code indicator.	2	Character
FP	Family Planning Indicator	2	Character
FROM DOS	From Date of service on claim	10	Date (MM/DD/CCYY)
First Date Requested	First Date of Service in range requested	10	Date (MM/DD/CCYY)
ICD	ICD Version of a Diagnosis code or a Surgical Procedure Code. Value is '9' for ICD-9 and '0' for ICD-10.	1	Character
ICN	Internal control number.	13	Number (Integer)
LTR	Lifetime Reserve Days	3	Character
Last Date Requested	Last Date of Service in range requested	10	Date (MM/DD/CCYY)
M1	Modifier 1 on the claim.	2	Character
M2	Modifier 2 on the claim.	2	Character
M3	Modifier 3 on the claim.	2	Character
M4	Modifier 4 on the claim.	2	Character
MC ALLOWED	Medicare allowed amount on claim.	10	Number (Decimal)
MC COINS	Medicare coinsurance amount on claim.	10	Number (Decimal)
MC DEDUCT	Medicare deductible amount on claim.	10	Number (Decimal)
MC PAID DT	Medicare paid date on claim.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
MC PD AMT	Medicare paid amount on claim.	10	Number (Decimal)
MEDICARE ALLWD	Medicare allowed amount on claim.	10	Number (Decimal)
NDC	The National Drug Code on the claim	11	Number (Integer)
NDC DESCRIPTION	The National Drug Code Description on the claim.	30	Character
OC	Tooth Quadrant on the claim.	2	Character
PA	Prior Authorization indicator.	2	Character
PACKAGE SIZE	Package Size - The metric quantity used to drive a unit price; the usual labeled quantify form which the pharmacist dispenses (for example, 100 tablets).	15	Number (Integer)
PAID AMOUNT	Provider reimbursement amount.	12	Number (Decimal)
PAID AMT	The header paid amount on the claim.	15	Number (Decimal)
PAID DATE	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	10	Date (MM/DD/CCYY)
PAT	Patient Status on the claim.	2	Character
PD DT	Date the claim paid.	10	Date (MM/DD/CCYY)
PERF PROV	Performing providers name on the claim	10	Character
PI	Pricing indicator.	2	Character
POS	The place of service code.	3	Character
PRESCRIBER	Prescribing providers name on the claim.	10	Character
PROC	The procedure code on the claim.	5	Character

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Field	Description	Length	Data Type
PROC CODE	The procedure code on the claim.	5	Character
PROCEDURE CODE DESCRIPTION	The description for all of the procedure codes profiled on the report.	60	Character
PRSB PHY	Prescribing physician's license number.	10	Character
PRSCRB NPI	Prescribing providers NPI number on the claim	10	Number (Integer)
Q	QMB (Qualified Medicare Beneficiary) indicator.	1	Character
QI	QMB (Qualified Medicare Beneficiary) indicator.	2	Character
QTY DISP	Quantity or units of drugs dispensed.	5	Number (Integer)
RATE	Code used to identify the rate type use to pay the claim. Allowable values are: AWP=Average Wholesale Price, SMAC=State MAC, WAC=Wholesale Acquisition Cost, FUL=Federal Upper Limit, DOJ=Department of Justice.	4	Character
RECIPIENT	A 12-digit number that uniquely identifies an individual eligible for Medicaid benefits. (Only one base number is issued per recipient and remains constant; Recipient Current ID can change frequently). Also, the recipient name is included in the format as LAST, FIRST M	54	Number (Integer)
RECIPIENT PAGE NUM	Recipient page number. This number is reset with each recipient printed. This is addition to the main page number printed at the top of each page of the report.	9	Number (Integer)
REF NO	Number of refills.	1	Number
REFERRING	The referring provider's name on the claim.	10	Character
REV	Revenue Code on the claim.	4	Number (Integer)

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Field	Description	Length	Data Type
RLCD	First Detail EOB code.	3	Character
S	The status for that detail. D=Denied, P=Paid, S=Suspended, V=Voided	1	Character
SC	The unique two character code for the description of the Alabama Schedule.	2	Character
SCRIPNO	Prescription number.	10	Character
SERVICE DATES FIRST	The first date of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE DATES LAST	The last date of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE FIRST	The First dates of services on the claim.	10	Date (MM/DD/CCYY)
SERVICE LAST	The last dates of services on the claim.	10	Date (MM/DD/CCYY)
SF	Tooth Surface on the claim.	1	Character
SPC	The billing provider specialty code.	3	Character
STRENGTH	Recommended dosage.	20	Character
SUBM RATE	Submitted Rate on the claim	10	Number (Decimal)
SURG CODES	Surgical Procedure Code	7	Character
SURG CODE DESCRIPTION	Surgical Procedure Code Description	60	Character
SVCD	The revenue code.	4	Number
Sum	Sum of Paid Amount column	5	Number (Decimal)
THRU DOS	Thru Date of service on claim	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
TI	Third party indicator.	2	Character
TN	Tooth Number on the claim.	2	Character
TOB	The type of bill.	3	Number (Integer)
TOT DAY	The number of Medicaid covered days.	3	Number (Integer)
TOTAL BILLED	The total billed by the provider.	12	Number (Decimal)
TOTAL PAID AMOUNT	Sum of the Paid Amount Column	18	Number (Decimal)
TPL AMT	Third party liability amount.	9	Number (Decimal)
UNIT RATE	The detailed billed amount divided by the quantity billed code	13	Number (Integer)
UNIT RATE	Rate amount used to price the claim.	13	Number (Decimal)
UNITS	The quantity billed count.	5	Number (Integer)
UNITS ALLW	Units Allowed on the claim.	10	Number (Integer)
UNITS BD	Units Billed on the claim.	10	Number (Integer)
UNITS BLLD	Units Billed on the claim.	10	Number (Integer)

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7.45 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting

7.45.1 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Narrative

The CLM NCCI Medically Unlikely Edit (MUE) report has three sections.

The first section is a single line displaying the total number of claims that received the MUE Error Status Code during the reporting period.

The second section is a list of procedure codes and a count of claim details for each procedure code. The list includes up to 50 procedure codes with the highest number of claim details that received the MUE Error Status Code during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure codes listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure codes and, within a particular procedure code, the claim details are in random order.

Each of the three sections is produced twice on this report, once for professional claims and once for outpatient claims. The order of the sections as listed on the report is: Totals by ESC for Professional, Procedures/Counts for Professional, Totals by ESC for Outpatient, Procedures/Counts for Outpatient, Claim Details for Professional, Claim Details for Outpatient.

This report is run bi-weekly toward the end of the Financial cycle.

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7.45.2 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Layout

```
Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Total Claims for MUE ESC 5900 - Professional:  999,999,999

  Top 50 Procedures for Professional Claims

  Procedure            Procedure Description              Count
    XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999
  ** End of Top 50 Procedures for Professional Claims **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Total Claims for MUE ESC 5900 - Outpatient:  999,999,999

  Top 50 Procedures for Outpatient Claims

  Procedure            Procedure Description              Count
    XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999
  ** End of Top 50 Procedures for Outpatient Claims **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Claim Details - Professional

       ICN        DTL   PT   Procedure            Procedure Description             M1   M2   M3   M4     CLM QTY        MUE QTY
  9999999999999  9999   99     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XX   XX   XX   XX  999,999,999.99     99999
  ** End of Claim Details - Professional **

Report  : CLM-4301-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   99:99:99
Location: CLMPW430                    NCCI MEDICALLY UNLIKELY EDIT (MUE) REPORTING                           Page:          9
                                        REPORTING PERIOD: 99/99/9999 - 99/99/9999
  Claim Details - Outpatient

       ICN        DTL   PT   Procedure            Procedure Description             M1   M2   M3   M4     CLM QTY        MUE QTY
  9999999999999  9999   99     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XX   XX   XX   XX  999,999,999.99     99999
  ** End of Claim Details - Outpatient **
                                                 ** END OF REPORT **
```


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7.45.3 CLM-4301-W -- CLM NCCI Medically Unlikely Edit (MUE) Reporting - Report Field Descriptions

Field	Description	Length	Data Type
Reporting Period MM/DD/YYYY – MM/DD/YYYY	The date range being reported. Dates determined by the values in t_system_parms where nam_program is NCCIRPTW.	23	Character
Report Section 1			
Total Claims for MUE ESC 5900	Total count of claim details that received the MUE Error Status Code during the reporting period.	9	Number (Decimal)
Report Section 2			
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
Count	Total count of claim details for a Procedure Code that received the MUE Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
CLM QTY	Quantity of units billed on a claim.	11	Number (Decimal)
MUE QTY	Maximum quantity of units for a procedure code on the CCI MUE table.	5	Number (Integer)

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7.46 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims

7.46.1 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Practitioner Claims report is an on-request report. The request to run this report must include 1 to 3 pairs of procedure codes and set of dates to be the reporting period. For each procedure pair, the report will display all claims that received any of the P2P Error Status Codes during the reporting period.

7.46.2 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Layout

```
Report  : CLM-4302-O                          ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJO430                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   99:99:99
Location: CLMPO430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - PRACTITIONER                        Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details

                                                                                                                      NCCI
                     Prov                                                                                           Modifier
      ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                   ** END OF REPORT **
```

7.46.3 CLM-4302-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner Claims - Report Field Descriptions

Field	Description	Length	Data Type
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
Prov Type	Provider Type.	2	Character
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.47 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner

7.47.1 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Practitioner report has three sections.

The first section is a list of the total number of Practitioner claims that received each of the P2P Error Status Codes.

The second section is a list of procedure code pairs and a count of claim details for each procedure code. The list includes up to 50 procedure code pairs with the highest number of claim details that received one of the P2P Error Status Codes during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure code pairs listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code pair is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure code pairs and, within a particular procedure code pair, the claim details are in random order.

This report is run bi-weekly toward the end of the Financial cycle.

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7.47.2 CLM-4302-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Practitioner - Report Layout

```
Report  : CLM-4302-W                          ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJW430                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   99:99:99
Location: CLMPW430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - PRACTITIONER                         Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Edit        Count        Edit Description

  5910     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5911     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5912     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Top 50 Procedure-To-Procedure Edit Count by Procedure Pair and Provider Type

                                                                                                   Modifier  Provider
  Procedure          Procedure Description           Procedure          Procedure Description      Indicator   Type    Count

    XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX   XXXXXXXXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
Report Section 1			
Edit	Procedure-To-Procedure (P2P) Error Status Code	4	Number (Integer)
Count	Total count of claim details that received the P2P Error Status Code during the reporting period.	9	Number (Decimal)
Edit Description	Description of the Procedure-To_Procedure (P2P) Error Status Code.	50	Character
Report Section 2			
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character
Prov Type	Provider Type.	2	Character
Count	Total count of claim details for a Procedure Code pair that received a P2P Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number	13	Number (Integer)
DTL	Claim detail number	4	Number (Integer)
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character

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Field	Description	Length	Data Type
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.48 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims

7.48.1 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Outpatient Claims report is an on-request report. The request to run this report must include 1 to 3 pairs of procedure codes and set of dates to be the reporting period. For each procedure pair, the report will display all claims that received any of the P2P Error Status Codes during the reporting period.

7.48.2 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient Claims - Report Layout

```
Report  : CLM-4303-O                          ALABAMA MEDICAID AGENCY                                          Run Date: 99/99/9999
Process : CLMJO430                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   99:99:99
Location: CLMPO430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                          Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details

                                                                                                                      NCCI
                     Prov                                                                                           Modifier
      ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                   ** END OF REPORT **
```

7.48.3 CLM-4303-O -- CLM NCCI Procedure-To-Procedure (P2P) Reporting – Outpatient Claims - Report Field Descriptions

Field	Description	Length	Data Type
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)
Prov Type	Provider Type.	2	Character
Proc	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character

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Field	Description	Length	Data Type
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.49 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient

7.49.1 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Narrative

The CLM NCCI Procedure-To-Procedure (P2P) - Outpatient report has three sections.

The first section is a list of the total number of Outpatient claims that received each of the P2P Error Status Codes.

The second section is a list of procedure code pairs and a count of claim details for each procedure code. The list includes up to 50 procedure code pairs with the highest number of claim details that received one of the P2P Error Status Codes during the reporting period. The list is in descending order by number of claim details.

The third section is a list of 10 to 20 claim details for each of the top 50 procedure code pairs listed in the second section of the report. The list includes up to 20 claim details if the count for the procedure code pair is greater than 100 and up to 10 claim details otherwise. The list is in the same order as the top 50 procedure code pairs and, within a particular procedure code pair, the claim details are in random order.

This report is run bi-weekly toward the end of the Financial cycle.

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7.49.2 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Layout

```
Report  : CLM-4302-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   99:99:99
Location: CLMPW430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                     Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Edit        Count        Edit Description

  5910     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5911     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  5912     999,999,999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Top 50 Procedure-To-Procedure Edit Count by Procedure Pair and Provider Type

                                                                                                  Modifier  Provider
  Procedure          Procedure Description           Procedure          Procedure Description     Indicator   Type    Count

    XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X        XX    999,999

  ** End of Top 50 Procedure Pairs **

Report  : CLM-4302-W                          ALABAMA MEDICAID AGENCY                                    Run Date: 99/99/9999
Process : CLMJW430                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   99:99:99
Location: CLMPW430              NCCI PROCEDURE-TO-PROCEDURE (P2P) REPORTING - OUTPATIENT                     Page:          9
                                         REPORTING PERIOD: 99/99/9999 - 99/99/9999

  Procedure-To-Procedure Edit Occurrence - Claim Details
                                                                                                                   NCCI
                     Prov                                                                                        Modifier
      ICN       DTL Type Proc   Procedure Description  M1  M2  M3  M4  Proc   Procedure Description  M1  M2  M3  M4  Indicator

  9999999999999 9999  XX  XXXXX  XXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX  XXXXX  XXXXXXXXXXXXXXXXXXXX  XX  XX  XX  XX      X

  ** End of Procedure-To-Procedure Edit Occurrence - Claim Details **

                                                 ** END OF REPORT **
```


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7.49.3 CLM-4303-W -- CLM NCCI Procedure-To-Procedure (P2P) Reporting - Outpatient - Report Field Descriptions

Field	Description	Length	Data Type
Reporting Period MM/DD/YYYY – MM/DD/YYYY	The date range being reported. Dates determined by the values in t_system_parms where nam_program is NCCIRPTW.	23	Character
Report Section 1			
Edit	Procedure-To-Procedure (P2P) Error Status Code.	4	Number (Integer)
Count	Total count of claim details that received the P2P Error Status Code during the reporting period.	9	Number (Decimal)
Edit Description	Description of the Procedure-To_Procedure (P2P) Error Status Code.	50	Character
Report Section 2			
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	40	Character
Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character
Provider Type	Provider Type.	2	Character
Count	Total count of claim details for a Procedure Code pair that received a P2P Error Status Code during the reporting period.	5	Number (Decimal)
Report Section 3			
ICN	Claim Internal Control Number.	13	Number (Integer)
DTL	Claim detail number.	4	Number (Integer)

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Field	Description	Length	Data Type
PT	Provider Type.	2	Character
Procedure	Procedure Code.	5	Character
Procedure Description	Procedure Code Description.	21	Character
M1	First procedure code modifier.	2	Character
M2	Second procedure code modifier.	2	Character
M3	Third procedure code modifier.	2	Character
M4	Fourth procedure code modifier.	2	Character
NCCI Modifier Indicator	The NCCI Modifier Indicator for the Procedure Code pair.	1	Character

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7.50 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL

7.50.1 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI MUE edits for professional claims.

7.50.2 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Layout

```
Report  : CLM-4710-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ471                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ471                          NCCI COST SAVINGS REPORT - MUE                                   Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Medically Unlikely Edits - Professional

 PROCEDURE             PROCEDURE DESCRIPTION                          COUNT          SAVINGS
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99

            TOTALS FOR MUE - Professional  =================>      9999999    9999999999.99

                                                ** End of Report **

                                             ** No Data This Report **
```

7.50.3 CLM-4710-Q - NCCI COST SAVINGS REPORTS - MUE - PROFESSIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR MUE – Professional (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7

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Field	Description	Data Type	Length
TOTALS FOR MUE – Professional (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.51 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL

7.51.1 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI MUE edits for institutional claims.

7.51.2 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Layout

```
Report  : CLM-4720-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ472                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ472                          NCCI COST SAVINGS REPORT - MUE                                   Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Medically Unlikely Edits - Outpatient

 PROCEDURE             PROCEDURE DESCRIPTION                          COUNT          SAVINGS
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99
   XXXXXX              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999      99999999.99

            TOTALS FOR MUE - Outpatient    ================>      9999999    9999999999.99

                                                 ** End of Report **

                                              ** No Data This Report **
```

7.51.3 CLM-4720-Q - NCCI COST SAVINGS REPORTS - MUE - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR MUE – Outpatient (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7
TOTALS FOR MUE – Outpatient (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.52 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL

7.52.1 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for professional claims.

7.52.2 CLM-4760-Q - NCCI COST SAVINGS REPORTS - P2P - PROFESSIONAL Layout

```
Report  : CLM-4760-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : CLMJQ476                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ476                          NCCI COST SAVINGS REPORT - P2P                                  Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Procedure-to-Procedure Edits - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                          COUNT         SAVINGS
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99

                                 TOTALS FOR PROCEDURE TO PROCEDURE - Professional  ================>       9999999   9999999999.99

                                                   ** End of Report **

                                                 ** No Data This Report **
```

7.52.3 CLM-4760-Q - Quarterly CCI Professional Cost Saving Report Field Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR PROCEDURE TO PROCEDURE – Professional (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7
TOTALS FOR PROCEDURE TO PROCEDURE – Professional (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.53 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL

7.53.1 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.53.2 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Layout

```
Report  : CLM-4760-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ476                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ476                           NCCI COST SAVINGS REPORT - P2P                                  Page:    999,999
                                      REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Procedure-to-Procedure Edits - Outpatient

 PROCEDURE  PROCEDURE DESCRIPTION                      PROCEDURE PROCEDURE DESCRIPTION                          COUNT         SAVINGS
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99999     99999999.99

                                 TOTALS FOR PROCEDURE TO PROCEDURE - Outpatient  ================>       9999999   9999999999.99

                                                   ** End of Report **

                                                 ** No Data This Report **
```

7.53.3 CLM-4770-Q - NCCI COST SAVINGS REPORTS - P2P - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
COUNT	Number of claims counted for a particular procedure.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
SAVINGS	Amount saved for a particular procedure.	Number (Decimal)	11
TOTALS FOR PROCEDURE TO PROCEDURE – Outpatient (COUNT)	It represents the total claims counted during the report run period.	Number (Integer)	7

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Field	Description	Data Type	Length
TOTALS FOR PROCEDURE TO PROCEDURE – Outpatient (SAVINGS)	It represents the total amount saved during the report run period.	Number (Integer)	13

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7.54 CLM-4810-Q – NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER

7.54.1 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Narrative

Summary of services paid due to NCCI MUE edit deactivation - professional practitioner claims.

7.54.2 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Layout

```
Report  : CLM-4810-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ481                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ481                       NCCI DEACTIVATED EDITS REPORT - MUE                               Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Deactivated or Overridden - Practitioner - Professional

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - Practitioner - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for Practitioner Professional        :   9999999        9999999999.99
       Totals Providers                            :   9999999

                                                     ** End of Report **
                                                  ** No Data This Report **
```

7.54.3 CLM-4810-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - PRACTITIONER Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals for Practitioner Professional (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Practitioner Professional (COUNTS)	It represents the total claims counted during the report run period.	Number (Integer)	7
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7

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7.55 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME

7.55.1 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.55.2 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Layout

```
Report  : CLM-4820-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : CLMJQ482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: CLMPQ482                        NCCI DEACTIVATED EDITS REPORT - MUE                              Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Deactivated or Overridden - DME - Professional

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - DME - Professional

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for DME Professional                 :   9999999        9999999999.99
       Totals Providers                            :   9999999

                                                     ** End of Report **

                                                   ** No Data This Report **
```

7.55.3 CLM-4820-Q - NCCI EDIT DEACTIVATION REPORT - MUE - PROFESSIONAL - DME Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for DME Professional (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for DME Professional (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.56 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL

7.56.1 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.56.2 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Layout

```
Report  : CLM-4830-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ483                        NCCI DEACTIVATED EDITS REPORT - MUE                                Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY


 Deactivated or Overridden - Medically Unlikely Edits - Outpatient

 PROCEDURE  PROCEDURE                                EFFECTIVE      END      MAX         CLEID        LAST         RECORD
            DESCRIPTION                              DATE           DATE     QUANTITY                 UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   99999    XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX

 Claims PAID as a result of deactivation or override - Medically Unlikely Edits - Outpatient

 PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS          AMOUNT PAID

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999          99999999.99

       Totals for Outpatient MUE                  :   9999999        9999999999.99
       Totals Providers                           :   9999999

                                                    ** End of Report **

                                                  ** No Data This Report **
```


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7.56.3 CLM-4830-Q - NCCI EDIT DEACTIVATION REPORT - MUE - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number	Character	12
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
MAX QUANTITY	Quantity of units allowed.	Number (Integer)	5
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Outpatient MUE (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Outpatient MUE (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.57 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL

7.57.1 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.57.2 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Layout

```
Report  : CLM-4860-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : CLMJQ486                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: CLMPQ486                        NCCI DEACTIVATED EDITS REPORT - P2P                                Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

 Deactivated or Overridden - Procedure to Procedure Edits - Practitioner - Professional

 PROC_1 /   GREATER PROCEDURE DESCRIPTION /          EFFECTIVE      END       MOD      CLEID        DATE LAST    RECORD
 PROC_2     LESSER PROCEDURE DESCRIPTION             DATE           DATE      IND                   UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 Claims PAID as a result of deactivation or override - Procedure to Procedure Edits - Practitioner - Professional

 PROCEDURE PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS    AMOUNT PAID
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99

                                                          Totals for Proc to Proc Practitioner :      9999999  9999999999.99
                                                          Totals Providers                     :      9999999

                                                     ** End of Report **

                                                  ** No Data This Report **
```

7.57.3 CLM-4860-Q - NCCI EDIT DEACTIVATION REPORT - P2P - PROFESSIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
DATE LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
GREATER PROCEDURE DESCRIPTION	Brief description about the greater procedure code.	Character	40
LESSER PROCEDURE DESCRIPTION	Brief description about the lesser procedure code.	Character	40
MOD IND	Modifier indicator.	Character	1
PROC 1	Greater procedure code.	Character	6
PROC 2	Lesser procedure code.	Character	6
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Proc to Proc Practitioner (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Proc to Proc Practitioner (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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7.58 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL

7.58.1 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Narrative

Summarizes cost savings attributable to NCCI P2P (procedure-to-procedure) edits for institutional claims.

7.58.2 CLM-4870-Q - NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Layout

```
Report  : CLM-4870-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : CLMJQ487                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: CLMPQ487                        NCCI DEACTIVATED EDITS REPORT - P2P                               Page:    999,999
                                     REPORTING PERIOD: MM/DD/CCYY  -  MM/DD/CCYY

Deactivated or Overridden - Procedure to Procedure Edits - Outpatient

 PROC_1 /   GREATER PROCEDURE DESCRIPTION /          EFFECTIVE      END       MOD      CLEID        DATE LAST    RECORD
 PROC_2     LESSER PROCEDURE DESCRIPTION             DATE           DATE      IND                   UPDATE       TYPE

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY   MM/DD/CCYY   X      XXXXXXXXXXXX  MM/DD/CCYY   XXXXXXXX
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 Claims PAID as a result of deactivation or override - Procedure to Procedure Edits - Outpatient

 PROCEDURE PROCEDURE DESCRIPTION                     PROCEDURE  PROCEDURE DESCRIPTION                      COUNTS    AMOUNT PAID
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99
  XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999    99999999.99

                                                           Totals for Proc to Proc Outpatient   :      9999999  9999999999.99
                                                           Totals Providers                     :      9999999

                                                     ** End of Report **

                                                  ** No Data This Report **
```

7.58.3 CLM-4870-Q – NCCI EDIT DEACTIVATION REPORT - P2P - INSTITUTIONAL Descriptions

Field	Description	Data Type	Length
AMOUNT PAID	Total amount paid for a particular procedure due to deactivation.	Number (Decimal)	11
CLEID	Correspondence Language Example Identification Number.	Character	12

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Field	Description	Data Type	Length
COUNTS	Number of claims that were paid for a particular procedure due to deactivation.	Number (Integer)	5
EFFECTIVE DATE	Begin date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
END DATE	End date for the procedure related NCCI edit.	Date (MM/DD/CCYY)	10
DATE LAST UPDATE	The latest date for which the record is updated.	Date (MM/DD/CCYY)	10
GREATER PROCEDURE DESCRIPTION	Brief description about the greater procedure code.	Character	40
LESSER PROCEDURE DESCRIPTION	Brief description about the lesser procedure code.	Character	40
MOD IND	Modifier indicator.	Character	1
PROC 1	Greater procedure code.	Character	6
PROC 2	Lesser procedure code.	Character	6
PROCEDURE	Procedure code.	Character	6
PROCEDURE DESCRIPTION	Brief description about the procedure code.	Character	40
RECORD TYPE	Identifies the record type. BASE – CMS record. OVERRIDE – Override record for the CMS record. AUDIT – The Override records that were deleted during the report period.	Character	8
Totals Providers (COUNTS)	The total number of providers counted during the run period.	Number (Integer)	7
Totals for Proc to Proc Outpatient (AMOUNT PAID)	It represents the whole total amount paid during the report run period due to deactivation.	Number (Decimal)	13
Totals for Proc to Proc Outpatient (COUNTS)	It represents the total claims that were paid for a particular procedure due to deactivation.	Number (Integer)	7

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1. Document Control

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1.1 Document Information Page

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1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
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4/04/2018	5.0		Application of CO 14833	Update entire User Manual to remove PHI information

1.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

2. Drug Rebate Introduction

2.1 Drug Rebate User Manual Overview

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Drug Rebate functional area.

This manual covers the following:

- Drug Rebate Overview
- Drug Rebate System Navigation
- Drug Rebate Pages/Panels
- Drug Rebate Reports

2.2 Drug Rebate User Manual Objective

This section explains that the objective of the AMMIS Drug Rebate User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

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3. Drug Rebate Overview

3.1 Introduction to Drug Rebate

The Federal Drug Rebate program requires that drug manufacturers have a National Rebate Agreement in place with Centers for Medicare and Medicaid Services (CMS) in order for a drug to be covered by Medicaid. For each of their National Drug Codes (NDC), participating manufacturers are required to submit Best Price (BP) and Average Manufacturer's Price (AMP) information to CMS within 30 days of the end of each quarter. CMS uses this data to calculate the Unit Rebate Amount (URA), which is then sent to Medicaid on a quarterly tape. The Unit Rebate Amounts are used by Medicaid to generate invoices. The manufacturer is required to pay the invoice, less any disputed amount, within 38 calendar days from the postmark date of the invoice. The Medicaid Drug Rebate Subsystem is responsible for ensuring rebates are invoiced and for tracking the payment of the invoices. If any amounts due are disputed, Medicaid must proceed with collection activity to resolve the disputes. Medicaid must also ensure that collected amounts are reported to CMS and posted accurately.

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4. Drug Rebate Getting Started

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 System Security

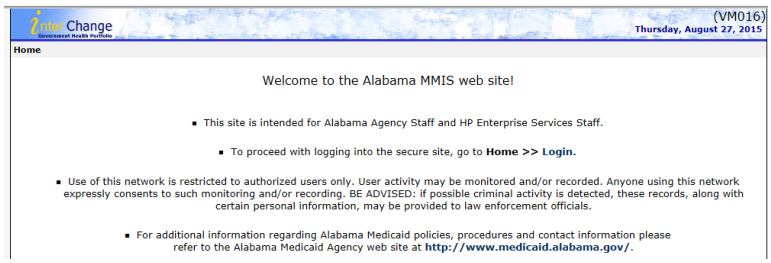
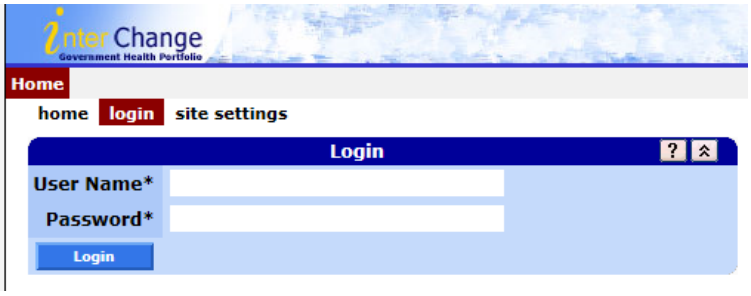
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

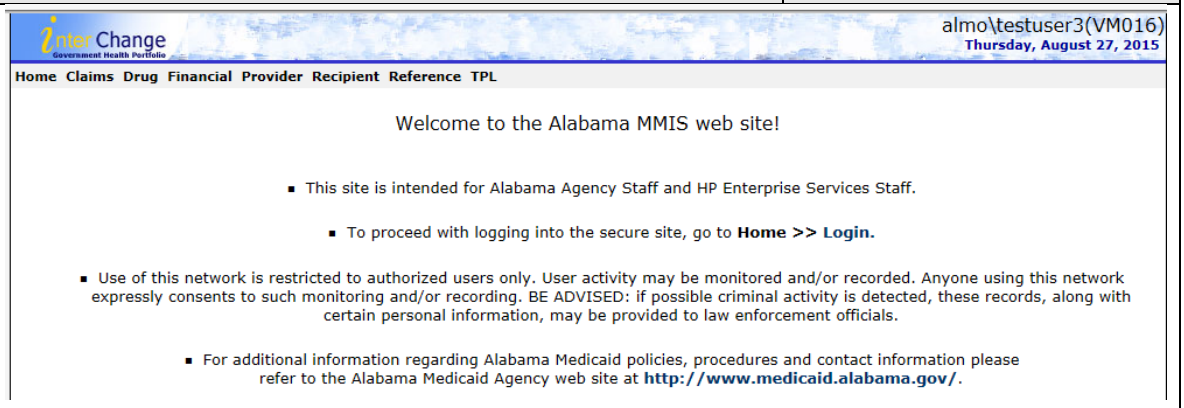
4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 Changing Passwords

Users are prompted to change their password every thirty (30) days. The password must be seven characters in length and contain alpha/numeric values. The Password Manager panel displays when it is time to enter a new password.

Note: The Account ID is automatically populated when the panel displays.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Old password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm new password field.
5	Confirm new password by entering it again.	
6	Click **OK**.	Password successfully changed. Note: If a user enters an invalid password the system

Step	Action	Response
		displays an error message.

The following message displays upon successful password change:

4.5 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Sub Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Hot Link
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

5.1 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header area with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the HP Enterprise Services copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options and the Sub Menu links are spelled the same as the Main Menu pull down options.

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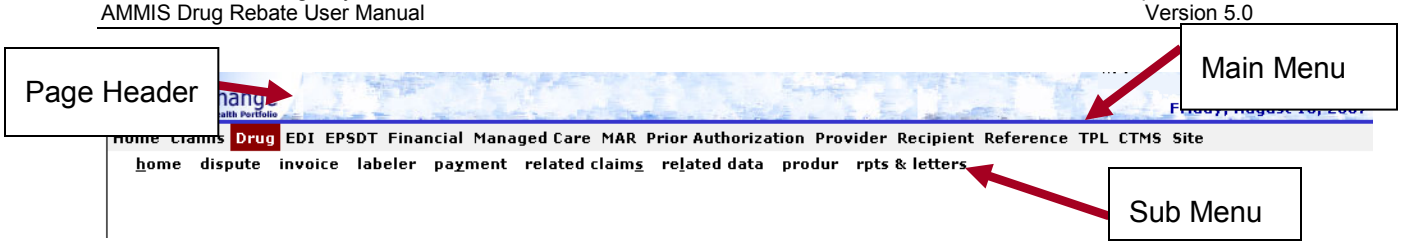
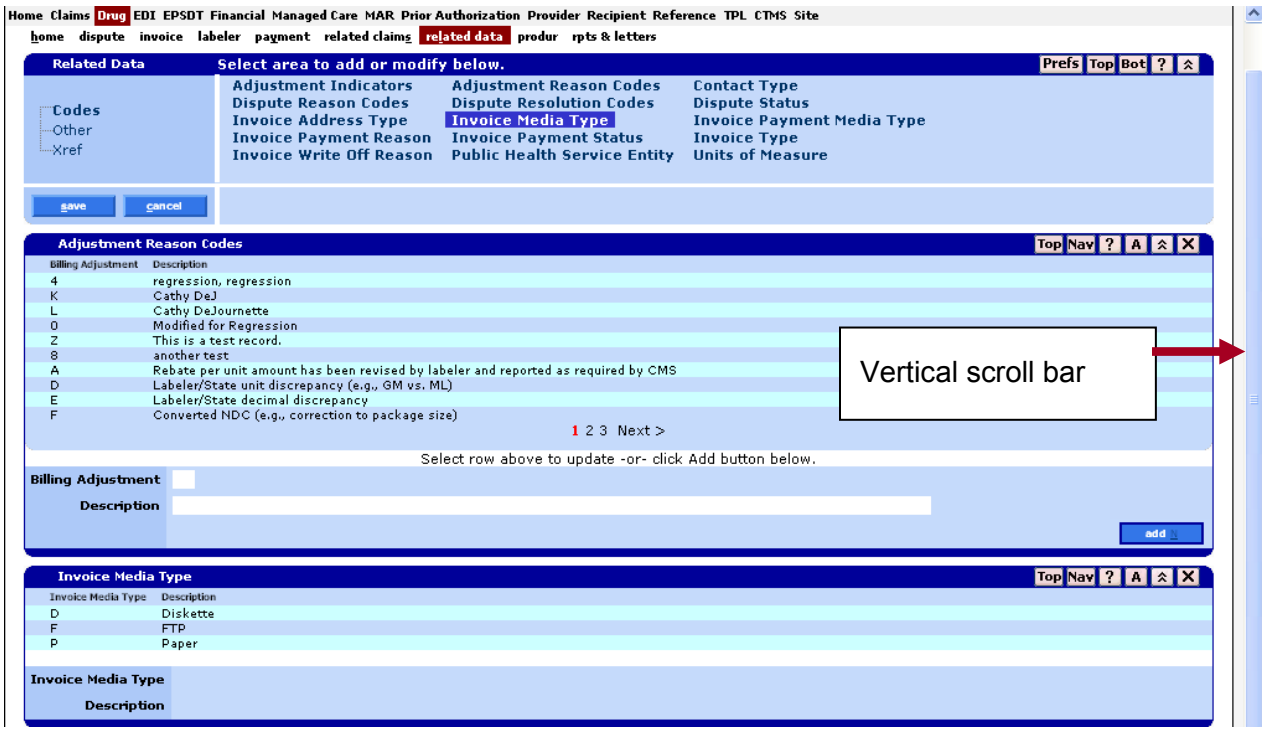
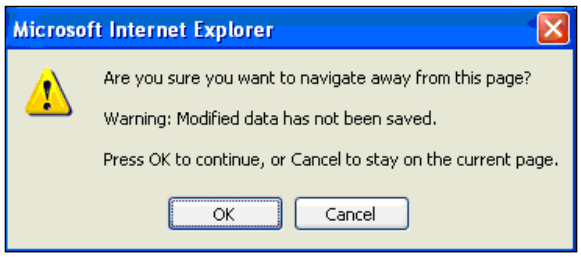


In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or canceling the transaction, the system prompts the user with a pop-up window message.

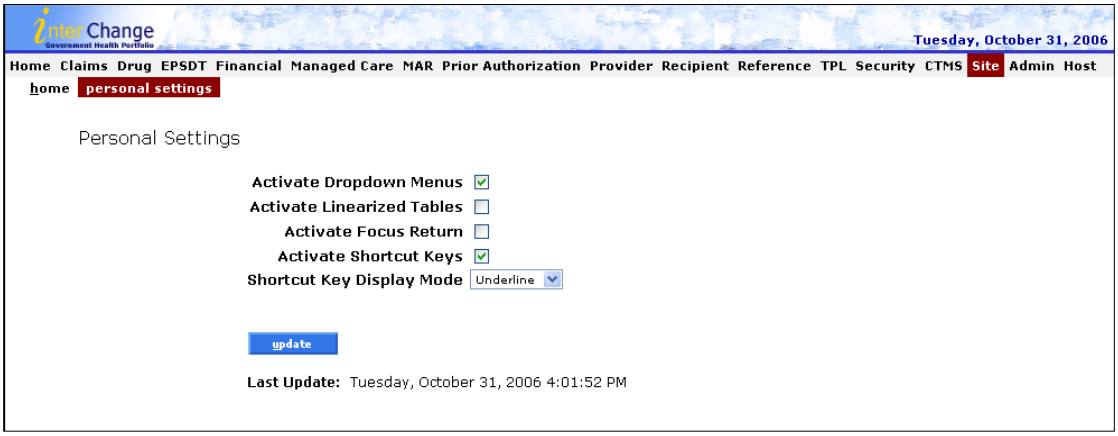
When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 Shortcut Keys

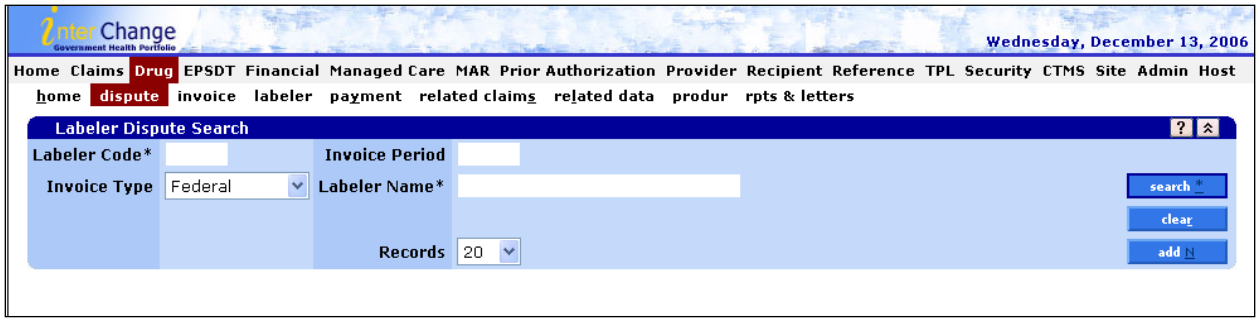
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated page.

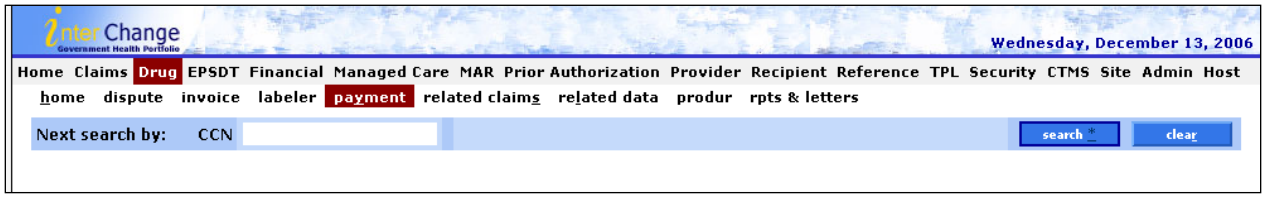
To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the Drug Rebate Sub Menu, the user can use the shortcut keys to quickly navigate from the Drug Rebate Dispute Search panel to the Payment panel by using the following shortcut key combination: (Ctrl + Alt + Y) since the letter “Y” is found within the horizontal bars on the Sub Menu payment link.



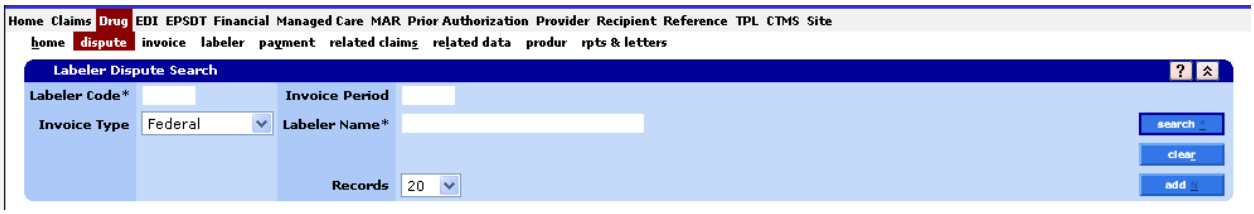


5.3 Search Options

There are several search options available within the AMMIS.

5.3.1 Search Panels

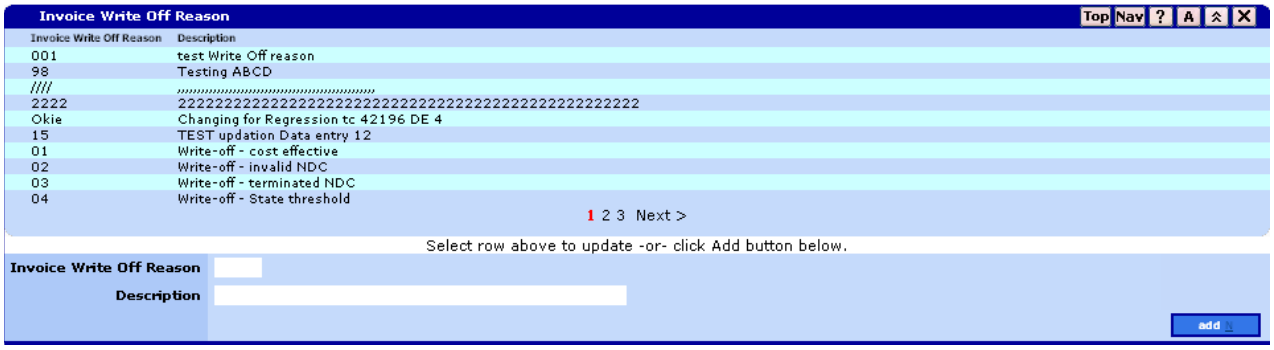
The AMMIS contains more than one type of search panel: Search and Advanced Search. The following is an example of a Drug Rebate panel that contains a search button.



The following is an example of the Invoice Mini Search panel with an advanced search button included on the panel:

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.


Invoice Write Off Reason
Top Nav
Invoice Write Off Reason Description
001 test Write Off reason
98 Testing ABCD
//// ,,,

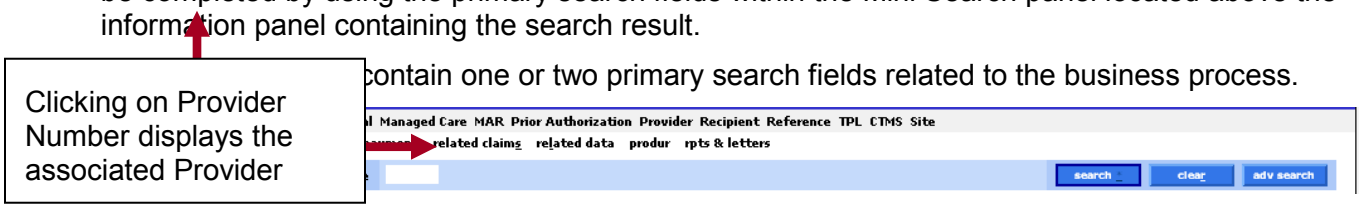
5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available.

5.3.4 Mini Search

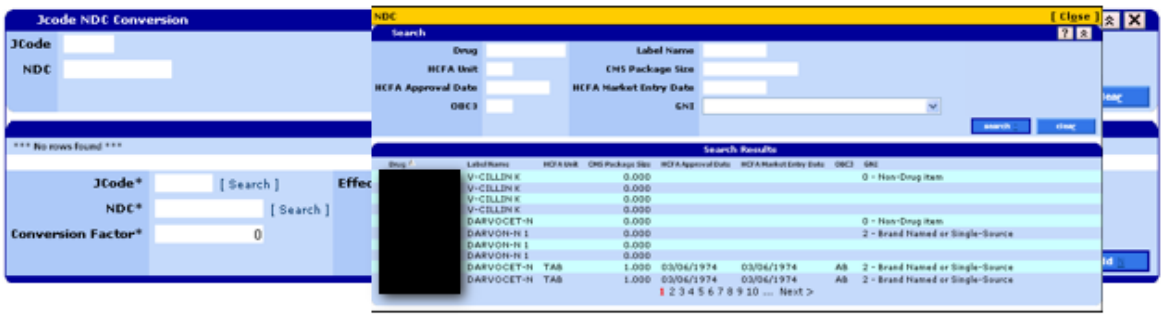
After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

contain one or two primary search fields related to the business process.



5.3.5 Pop-Up Search

Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.



5.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Maintain Button	maintain	Maintains a selected data record.
Preferences Button	Prefs	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
Navigation Button	Nav	Allows a user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.

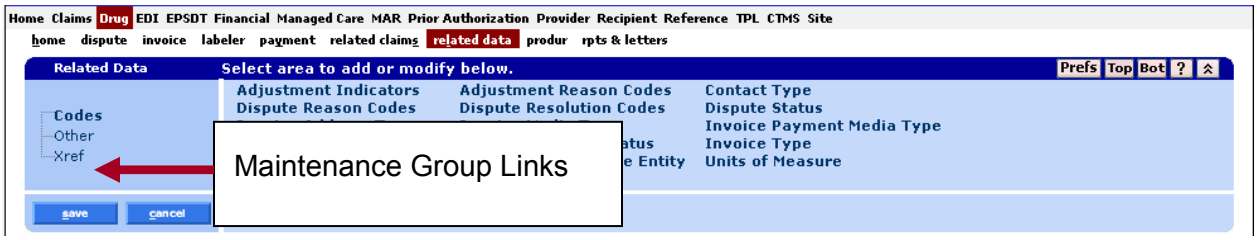
Among the panel types are the following:

- Maintenance panel
- Task List panel
- Maintenance Item panel
- Audit panel

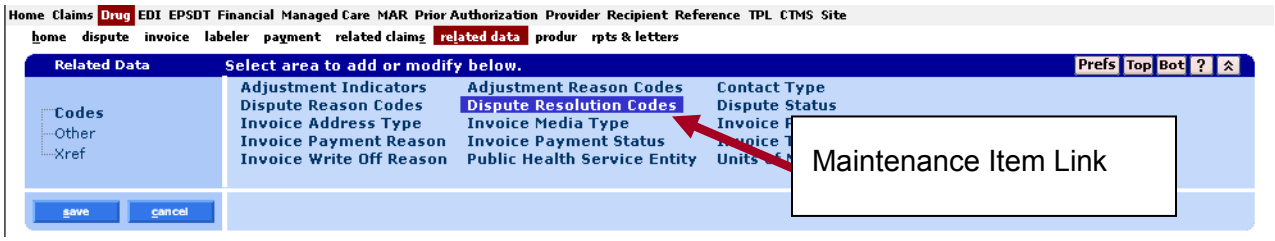
5.4.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page. The following image demonstrates Maintenance Group Links (Codes, Other and Xref) and the associated Maintenance Item links.



By clicking on a Maintenance Item Link (such as Dispute Resolution Codes), the associated panel opens.



5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

The following messages were generated:

Message Description	Panel	Field	Row
Description is required.	Dispute Resolution Codes	Description	1
Dispute Resolution is required.	Dispute Resolution Codes	Dispute Resolution	1

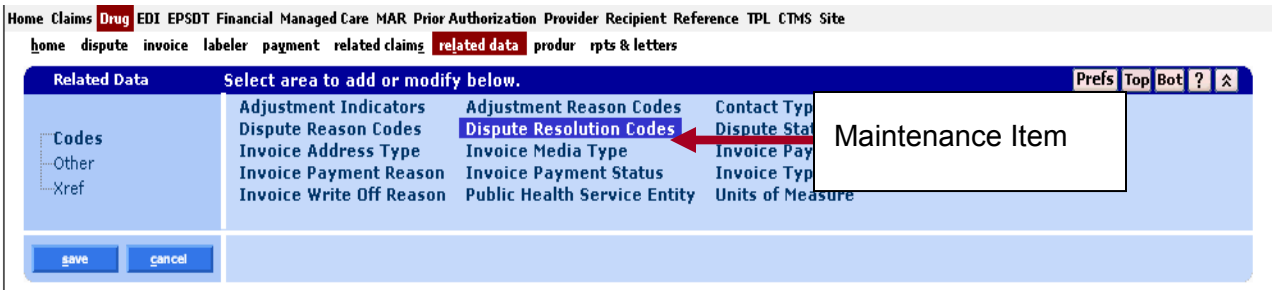
The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

5.4.4 Maintenance Item Panel

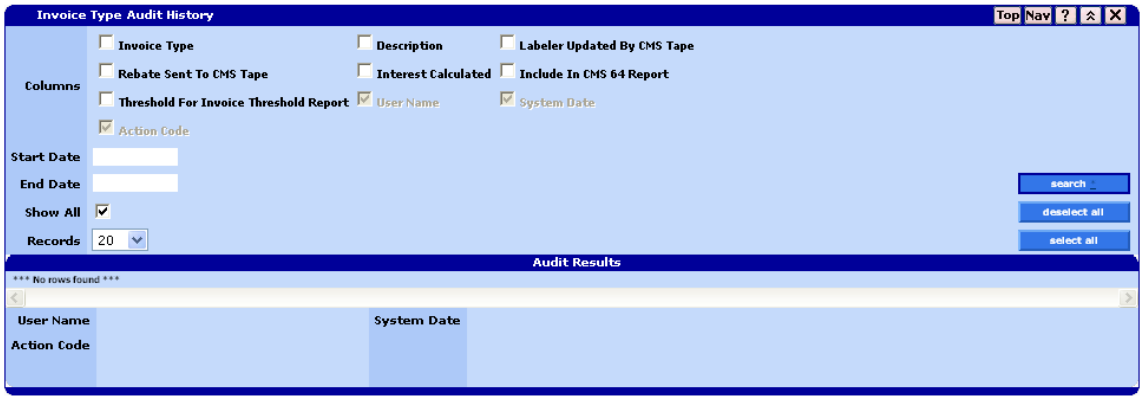
A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.4.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



5.5 Help Functionality

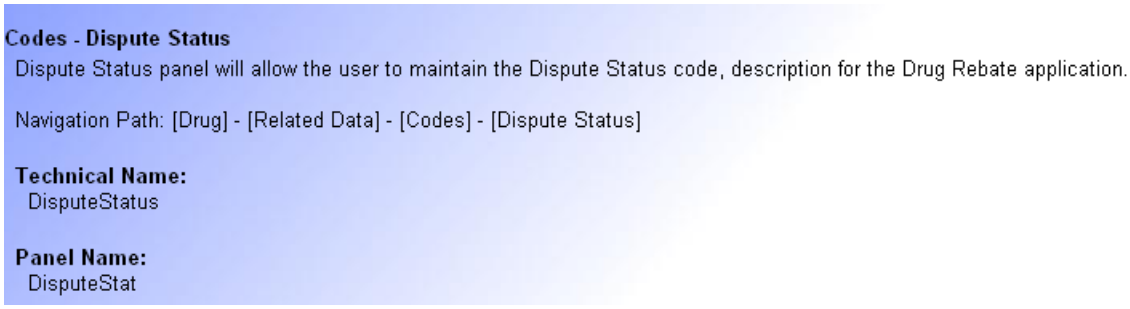
The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon ?

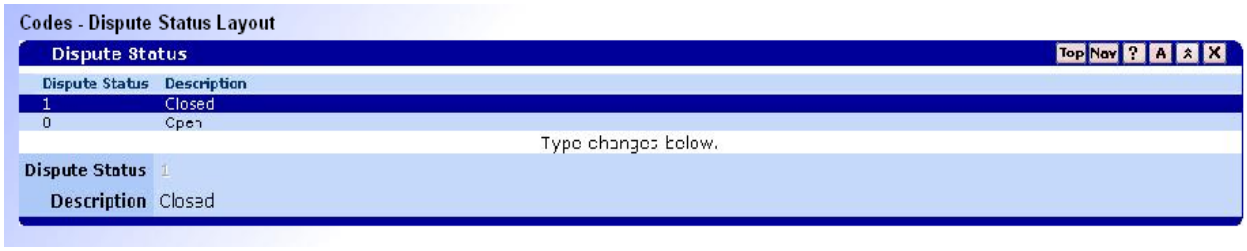
The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.5.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



The second item displayed is the **Panel Layout**:



The third item displayed is the **Field Description** information related to the panel:

Field Descriptions

Field	Description	Field Type	Data Type	Length
Description [Detail]	Dispute Status Code Description	Field	Character	100
Description [List]	Dispute Status Code Description	Field	Character	100
Dispute Status Code [Detail]	Dispute Status Code	Field	Character	1
Dispute Status Code [List]	Dispute Status Code	Field	Character	1

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window				

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any Associated documentation that relates to a panel.

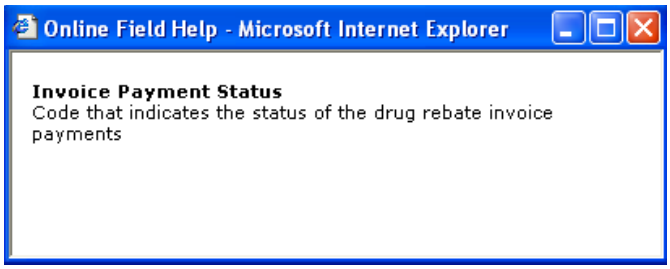
To close out of the Help panel, click the in the browser title bar.

5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.5.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **Invoice Payment Status**, a question mark appears as part of the cursor. Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

6. Drug Rebate Pages/Panels

This section gives a brief description of each page/panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each page or panel covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Codes
- Page/Panel Extra Features
- Page/Panel Accessibility

6.1 Labeler Dispute Search Panel Overview

6.1.1 Labeler Dispute Search Panel Narrative

The Labeler Dispute Search panel is used to search for disputes based upon Labeler Code, Invoice Period and Invoice Type or Labeler name. It is useful when researching disputes.

This panel is for inquiry only, but allows the user to add a record to the Dispute Base Information panel.

Navigation Path: [Drug] - [Dispute Search]

6.1.2 Labeler Dispute Search Panel Layout

6.1.3 Labeler Dispute Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add labeler code information.	Button	N/A	0
Clear	Allows the user to clear any changes on the Labeler Dispute Search panel.	Button	N/A	0
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Program type of the invoice. Valid values include Federal or Supplemental.	Combo Box	Drop Down List Box	0
Labeler Code	Code used to identify the labeler invoiced.	Field	Character	5
Labeler Name	The name of the drug labeler.	Field	Character	30
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates search by Labeler Code, Invoice Period, Invoice Type or Labeler Name.	Button	N/A	0

6.1.4 Labeler Dispute Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Period (Q/CCYY)	Field	1	Invoice Period must be 5 digits if entered.	Enter in a valid year with a quarter.
	Field	8188	Enter a valid value.	Re-enter valid quarter and year.
Labeler Code	Field	1	A Labeler Code or Labeler	Enter in a valid Labeler

Field	Field Type	Error Code	Error Message	To Correct
			Name is required.	Code.
	Field	91059	Labeler Code must be 5 digits if entered.	Re-enter 5 numeric characters.
	Field	91080	A Labeler Code or Labeler Name is required.	Enter a valid Labeler Code.
Labeler Name	Field	91080	A Labeler Code or Labeler Name is required.	Enter a valid Labeler Name.

6.1.5 Labeler Dispute Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Labeler Dispute Search Panel Accessibility

6.1.6.1 To Access the Labeler Dispute Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Dispute Search**.	Labeler Dispute Search panel displays.

6.1.6.2 To Add on the Labeler Dispute Search Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Labeler Code.	
3	Enter Date Received.	
4	Enter Invoice Type.	
5	Enter Analyst Assigned.	
6	Click **Save**.	Labeler Dispute information is saved.

6.2 Labeler Dispute Search Results Panel Overview

6.2.1 Labeler Dispute Search Results Panel Narrative

The Labeler Dispute Search Results panel displays the Labeler Dispute Search Results based upon Labeler Code, Invoice Period and Invoice Type or Labeler name.

This panel is display only.

Navigation Path: [Drug] - [Dispute Search] - (Click on [Search]) - [Search Results])

6.2.2 Labeler Dispute Search Results Panel Layout

Search Results

Labeler Code	Labeler Name	Invoice Period	Invoice Type	Amount in Dispute	Units in Dispute	Dispute Status	NDCs in Dispute	Received Date	Last All Closed Date	Analyst Assigned
[redacted]		20001	Federal	$0.00	0.000	Open	0	11/15/2005	0	AP21_BAM
		19981	Federal	$0.00	0.000	Closed	0	10/01/2005	11/15/2005	XXX
		20013	Federal	$0.00	0.000	Closed	0	09/06/2002	07/17/2003	CMS
		20012	Federal	$342.00	456.230	Open	1	07/17/2003	0	AP21_RUL
		20001	Federal	$0.00	0.000	Open	0	01/01/2005	0	AICE_SOS
		19991	Federal	($61,093.41)	50.000	Open	1	11/08/2005	11/08/2005	XXX
Totals: 6				($60,751.41)	506.230					

6.2.3 Labeler Dispute Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount in Dispute	Sum of the balance due for disputed details for the specified invoice.	Field	Number (Decimal)	11
Analyst Assigned	Identifies the individual who entered dispute data by capturing the logon Identification number.	Field	Character	8
Dispute Status	Contains the header status of Open or Closed.	Field	Character	6
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Program type of the invoice. Valid values are Federal or Supplemental.	Field	Character	30
Labeler Code	Code used to identify the labeler invoiced.	Field	Number (Integer)	5
Labeler Name	Name of the drug labeler.	Field	Character	39
Last All Closed Date	Displays the date all disputes were closed.	Field	Date (MM/DD/CCYY)	8
NDCs in Dispute	Total number of National Drug Codes (NDC) in dispute for the specified invoice.	Field	Number (Integer)	4
Received Date	Date the check was received at the state.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Totals (Amount in Dispute)	Total of the dispute amount paid column.	Field	Number (Decimal)	11
Totals (Units in Dispute)	Total of the dispute units column.	Field	Number (Integer)	13
Totals (Number of dispute rows)	Total number of dispute National Drug Codes (NDC).	Field	Number (Decimal)	5
Units in Dispute	Total number of units in dispute as identified by the labeler for the specified invoice. Difference between the units invoiced and units paid.	Field	Number (Decimal)	13

6.2.4 Labeler Dispute Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Labeler Dispute Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Labeler Dispute Search Results Panel Accessibility

6.2.6.1 To Access the Labeler Dispute Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Dispute Search**.	Labeler Dispute Search panel displays.
3	Enter search criteria.	Labeler Dispute Search Results panel displays.
4	Click on a record to display.	Labeler Dispute information displays.

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6.3 Dispute Mini Search Panel Overview

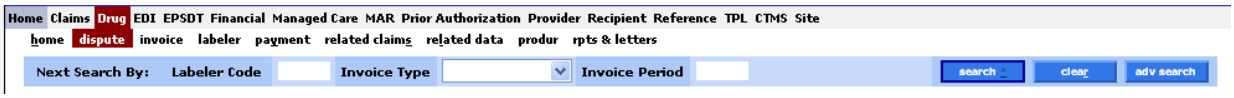
6.3.1 Dispute Mini Search Panel Narrative

The Dispute Mini-Search panel is used for the Drug Rebate Dispute/Labeler search functionality to search the disputes for a labeler.

This panel is for inquiry only.

Navigation Path: [Drug] - [Dispute Search] - (Enter 5 Digit [Labeler Code] and click on [Search]) - (Select a row from search results)

6.3.2 Dispute Mini Search Panel Layout



6.3.3 Dispute Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Allows the user to access the Advanced Search panel.	Button	N/A	0
Clear	Allows the user to clear any changes on the Dispute Mini-Search panel.	Button	N/A	0
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Search by the Invoice Type. Valid values included: Federal or Supplemental.	Combo Box	Drop Down List Box	0
Labeler Code	Five-digit code used to identify a labeler(s).	Field	Number (Integer)	5
Search	Initiates the Search by Labeler Code, Invoice Type or Invoice Period.	Button	N/A	0

6.3.4 Dispute Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Labeler Code	Field	1	Labeler Code must be numeric.	Labeler Code must be numeric.
Invoice Period	Field	2	Enter a valid value.	Enter the quarter and year of the invoice (Q/CCYY).

6.3.5 Dispute Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.3.6 Dispute Mini Search Panel Accessibility

6.3.6.1 To Access the Dispute Mini-Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Dispute Search**.	Dispute Mini Search panel displays.

6.3.6.2 To Navigate the Dispute Mini-Search Panel

Step	Action	Response
1	Enter a Labeler Code, Invoice Type or Invoice Period and click Searcb.	List of Labeler Dispute Information displays.
2	Click to highlight the row to be viewed.	Dispute Information displays.

6.4 Dispute Information Panel Overview

6.4.1 Dispute Information Panel Narrative

The Dispute Information panel displays information for a particular dispute.

This panel is display only.

Navigation Path: [Drug] - [Dispute Search] - (Enter 5 Digit [Labeler Code] and click on [Search]) - (Select a row from search results)

6.4.2 Dispute Information Panel Layout

6.4.3 Dispute Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount in Dispute	Dollar amount of dispute.	Field	Number (Decimal)	11
Analyst Assigned	Identifies the individual who entered dispute data by capturing the logon Identification number.	Field	Character	8
Date Received	The month, day and year of the postmark date the invoice was mailed to the labeler.	Field	Date (MM/DD/CCYY)	8
Dispute Status	Contains the header status of Open or Closed.	Field	Character	6
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	This value represents the description of the type of the invoice.	Field	Character	30
Labeler Code	Five-digit code used to identify a labeler(s) that matched the search criteria.	Field	Character	5
Labeler Name	Name of the labeler(s) that matched the search criteria.	Field	Character	15
Last All Closed Date	Date status marked to close.	Field	Date (MM/DD/CCYY)	8
NDCs in Dispute	Number of disputed National Drug Codes (NDC).	Field	Number (Integer)	6
Units in Dispute	Number of units disputed.	Field	Number (Integer)	6

6.4.4 Dispute Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.4.5 Dispute Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Dispute Information Panel Accessibility

6.4.6.1 To Access the Dispute Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Dispute Search**.	Labeler Dispute Search panel displays.
3	Enter Labeler Code; Click Search.	Labeler Dispute Search Results panel displays.
4	Click to select a row to be viewed.	Dispute Information panel displays.

6.5 Dispute Maintenance Panel Overview

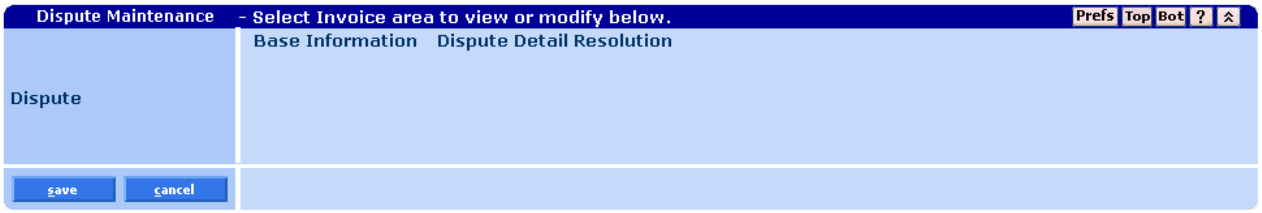
6.5.1 Dispute Maintenance Panel Narrative

The Dispute Maintenance page displays the read-only Dispute information and offers panel options for the Dispute Base Information and Detail Resolution.

This panel is inquiry only.

Navigation Path: [Drug] - [Dispute Search] - (Enter 5 Digit [Labeler Code] and click on [Search]) - (Select a row from search results)

6.5.2 Dispute Maintenance Panel Layout



6.5.3 Dispute Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Dispute Maintenance panel.	Button	N/A	0
Dispute Detail Resolution	Link to the Dispute Detail Resolution panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Dispute Maintenance panel.	Button	N/A	0

6.5.4 Dispute Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.5.5 Dispute Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.5.6 Dispute Maintenance Panel Accessibility

6.5.6.1 To Access the Dispute Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Dispute Search**.	Labeler Dispute Search panel displays.
3	Enter Labeler Code; Click Search.	Labeler Dispute Search Results panel displays.
4	Click to select a row to be viewed.	Dispute Information panel displays.

6.5.6.2 To Navigate the Dispute Maintenance Panel

Step	Action	Response
1	Enter **Labeler Code** and Click **Search**.	Dispute Information and Dispute Maintenance displays.

6.6 Dispute Base Information Panel Overview

6.6.1 Dispute Base Information Panel Narrative

The Dispute Base Information panel allows the user to add/change invoice dispute information. All information in the Dispute Base Information panel, except for the Analyst Assigned field and Date Received are read-only when updating an existing Dispute. If creating a new Dispute, all fields can be edited until the user enters a Labeler Code, Invoice Period and Invoice Type that matches an existing Invoice, and then these fields become read only.

There are two other ways to create a dispute header:

Created from the Payment CCNs panel by using a reason code of '06' (Disputed NDC), and the analyst assigned field is populated with 'XXX'

Created from the Dispute Detail Resolution panel in Payment.

This panel is inquiry only.

Navigation Path: [Drug] - [Dispute Search] - (Enter 5 Digit [Labeler Code] and click [Search]) - (Click on a record) - [Dispute Maintenance] - [Dispute] - [Base Information]

6.6.2 Dispute Base Information Panel Layout

6.6.3 Dispute Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Analyst Assigned	Identifies the individual who entered dispute data by capturing the logon Identification number.	Field	Character	8
Date Received	Displays the date the drug rebate invoice dispute was received/opened.	Field	Date (MM/DD/CCYY)	8
Invoice Period	Represents the quarter the claims billed on the invoice were paid. The date is in the format Q/CCYY where Q indicates the quarter. Valid values for the quarter are 1-4. 1 = Jan. – March 2 = April - June 3 = July - Sept 4 = Oct. - Dec	Field	Date (Q/CCYY)	5
Invoice Type	Represents the code and description of the type of the invoice. Valid values included: Federal and Supplemental.	Combo Box	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Labeler Code	Five-digit code used to identify a labeler.	Field	Number (Integer)	5
Labeler Name	Displays the name of the labeler.	Field	Character	15

6.6.4 Dispute Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.5 Dispute Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 Dispute Base Information Panel Accessibility

6.6.6.1 To Access the Dispute Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Dispute Search**.	Labeler Dispute Search panel displays.
3	Enter Labeler Code; Click Search.	Labeler Dispute Search Results panel displays.
4	Click to select a row to be viewed.	Dispute Maintenance panel displays.
5	Click Base Information.	Dispute Base Information panel displays.

6.7 Dispute Detail Resolution Panel Overview

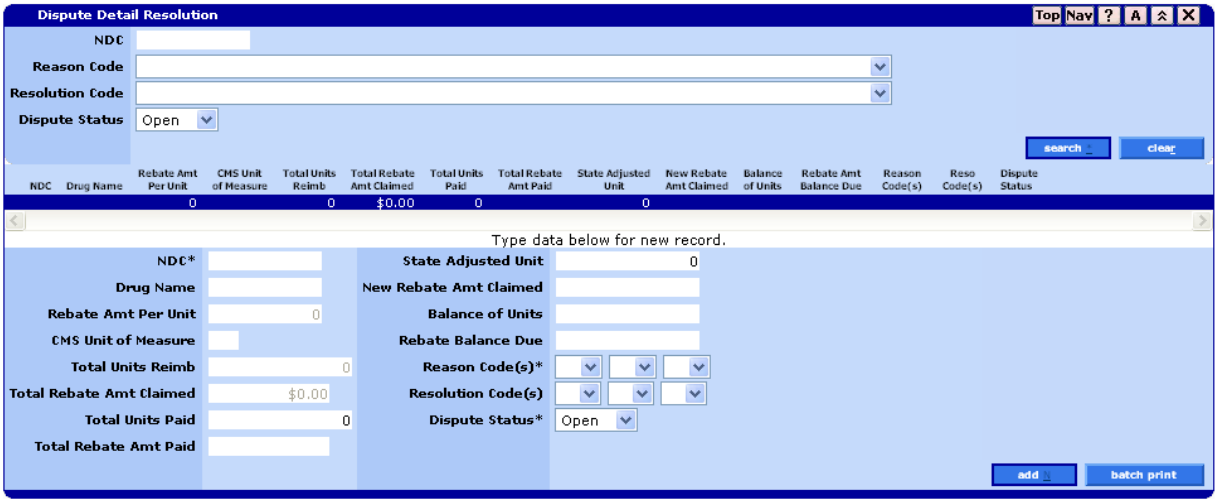
6.7.1 Dispute Detail Resolution Panel Narrative

The Dispute Detail Resolution panel allows users to enter or inquire on Dispute Detail information. The user may enter dispute information when a payment is received. If the labeler identifies disputes through written correspondence or pays $0 on all or a portion of details, the user keys the dispute information into this panel. This panel searches on disputed line item/National Drug Code (NDC) disputes based upon the search criteria.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path from Dispute Maintenance: [Drug] - [Dispute Search] - (Enter search info, click on search, and select row from search results) - [Dispute Maintenance] - [Dispute] - [Dispute Detail Resolution]

6.7.2 Dispute Detail Resolution Panel Layout



6.7.3 Dispute Detail Resolution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add dispute detail resolution information.	Button	N/A	0
Balance of Units	Displays the number of units due from a labeler for a specific National Drug Code (NDC) drug rebate claim.	Field	Number (Decimal)	14
Batch Print	Allows the user to send disputes to the printer.	Button	N/A	0
Clear	Allows the user to clear any changes on the Dispute Detail Resolution panel.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
CMS Unit of Measure	Basic measurement that represents the smallest unit by which the drug is measured. The rebate amount is calculated per unit.	Field	Character	3
Dispute Status	Identifies the status of the dispute. Valid values include: Open or Closed.	Combo Box	Drop Down List Box	0
Drug Name	Displays the drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Medicaid programs.	Field	Character	10
NDC	Represents the National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
New Rebate Amt Claimed	Displays the new calculated rebate amount due from the manufacturer.	Field	Number (Decimal)	14
Reason Code + Reason Code Description	Represents the labeler explanation of the disputes for a specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Reason Code 1	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 2	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 3	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Rebate Amt Balance Due	Totals re-calculated amount due after subtracting any previous payment. Balance due = balance of units due multiplied by the current rebate amount per unit.	Field	Number (Decimal)	14

Field	Description	Field Type	Data Type	Length
Rebate Amt Per Unit	Indicates the rebate amount per unit supplied by Centers for Medicare and Medicaid Services (CMS) on a quarterly basis for the calculation of the drug rebate amount for each National Drug Code (NDC) in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.	Field	Number (Decimal)	11
Resolution Code + Description	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 1	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 2	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 3	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by NDC, Reason Code, Resolution Code or Dispute Status.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
State Adjusted Unit	Represents the new total number of units after the state has resolved the dispute for a specific National Drug Code (NDC). This would not be an adjusted difference but the total adjusted amount. i.e., if current total units are 300, total paid are 250, and the adjusted decision is 275. 275 would be entered into this field.	Field	Number (Decimal)	14
Total Rebate Amt Claimed	Result of multiplying the "rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Paid	Result of multiplying the rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Units Paid	Indicates the number of units paid.	Field	Number (Decimal)	13
Total Units Reimb	Indicates the total units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	13

6.7.4 Dispute Detail Resolution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
NDC	Field	91029	Enter a value.	Enter a valid 11 numeric character NDC.
	Field	91080	A valid NDC is required.	Enter a valid 11 numeric character NDC.
NDC [Search]	Field	91029	Enter a valid value.	Enter a valid 11 numeric character NDC.
Reason Code 1	Combo Box	1	A valid Reason Code (1) is required.	Enter a dispute reason.

Field	Field Type	Error Code	Error Message	To Correct
	Combo Box	2	Reason Code is used more than once.	Enter each code only once.
Resolution Code	Combo Box	1	Resolution Code cannot be used on open dispute.	Enter a resolution code only when the dispute status is closed.
	Combo Box	2	A valid Resolution Code (1) is required.	Enter a Resolution Code.
	Combo Box	3	Resolution Code is used more than once.	Enter each code only once.
State Adjusted Unit	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	State Adjusted Unit must be less than or equal to 999999999.999.	Enter an adjusted unit's amount than is less than 10,000,000,000.00.
	Field	91115	State Adjusted Unit must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.
Total Units Paid	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	Total Units Paid must be less than or equal to 9999999999.999.	Enter a Total Units Paid amount that is less than 10,000,000,000.00.
	Field	91115	Total Units Paid must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.

6.7.5 Dispute Detail Resolution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Dispute Detail Resolution Panel Accessibility

6.7.6.1 To Access the Dispute Detail Resolution Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Dispute Search**.	Labeler Dispute Search panel displays.
3	Enter Labeler Code; Click Search.	Labeler Dispute Search Results panel displays.
4	Click to select a row to be viewed.	Dispute Maintenance panel displays.
5	Click Dispute Detail Resolution.	Dispute Detail Resolution panel displays.

6.7.6.2 To Navigate the Dispute Detail Resolution Panel

Step	Action	Response
1	Enter **NDC**.	
2	Select **Reason Code** from drop down list box.	
3	Select **Resolution** from drop down list box.	
4	Select **Dispute Status** from the drop down list box.	
5	Click **Search**.	Dispute Detail Resolution Search results display.

6.7.6.3 To Add on the Dispute Detail Resolution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **NDC**.	
3	Enter Drug Name.	
4	Enter Rebate Amount Per Unit.	
5	Enter CMS Unit of Measure.	
6	Enter Total Units Reimbursed.	
7	Enter Total Rebate Amount Claimed.	
8	Enter Total Units Paid.	
9	Enter Total Rebate Amount Paid.	
10	Enter State Adjusted Unit.	
11	Enter New Rebate Amount Claimed.	
12	Enter Balance of Units.	
13	Enter Rebate Balance Due.	
14	Select **Reason Code** from drop down list box.	
15	Select **Resolution** from drop down list box.	
16	Select **Dispute Status** from the drop down list box.	
17	Click **Save**.	Dispute Detail Resolution information is saved.

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6.7.6.4 To Update the Dispute Detail Resolution Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Dispute Detail Resolution information is updated.

6.8 Invoice by Labeler Search Panel Overview

6.8.1 Invoice by Labeler Search Panel Narrative

The Invoice by Labeler Search panel allows the user to retrieve invoices and invoice totals for a labeler. The user can enter any or all of the search fields. Totals are accessed by checking the Check for Totals box.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search]

6.8.2 Invoice by Labeler Search Panel Layout

6.8.3 Invoice by Labeler Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Check for Totals	Indicates if the search needs to check for totals.	Combo Box	Check Box	0
Clear	Allows the user to clear any changes on the Invoice by Labeler Search panel.	Button	N/A	0
Invoice Period	One digit quarter followed by the four-digit year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Program type of the invoice. Valid values are Federal or Supplemental.	Combo Box	Drop Down List Box	0
Labeler Code	Five-digit code used to identify a labeler(s) that matched the search criteria.	Field	Number (Integer)	5
Labeler Name	Name of the labeler(s) that matched the search criteria.	Field	Character	39
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Labeler Code, Labeler Name, Invoice Period or Invoice Type.	Button	N/A	0
Search by NDC	Initiates a search by National Drug Code (NDC).	Button	N/A	0

6.8.4 Invoice by Labeler Serch Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Period (Search)	Field	23	Invoice Period must be 5 digits if entered and Quarter must be 1, 2, 3, or 4.	Re-enter the invoice period using 5 numeric characters and/or re-enter a valid quarter and year.
	Field	9670	The invoice period must be in the format Q/CCYY.	Re-enter a valid year and quarter in Q/CCYY format.
Labeler Code	Field	1	Labeler Code or Labeler Name is required.	Must enter a Labeler Code.
	Field	2	Labeler Code must be 5 digits if entered.	Re-enter 5 numeric characters.
	Field	3	Labeler Code must be numeric.	Enter a valid Labeler Code.

6.8.5 Invoice by Labeler Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Invoice by Labeler Search Panel Accessibility

6.8.6.1 To Access the Invoice by Labeler Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.

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6.9 Invoice by Labeler Search Results Panel Overview

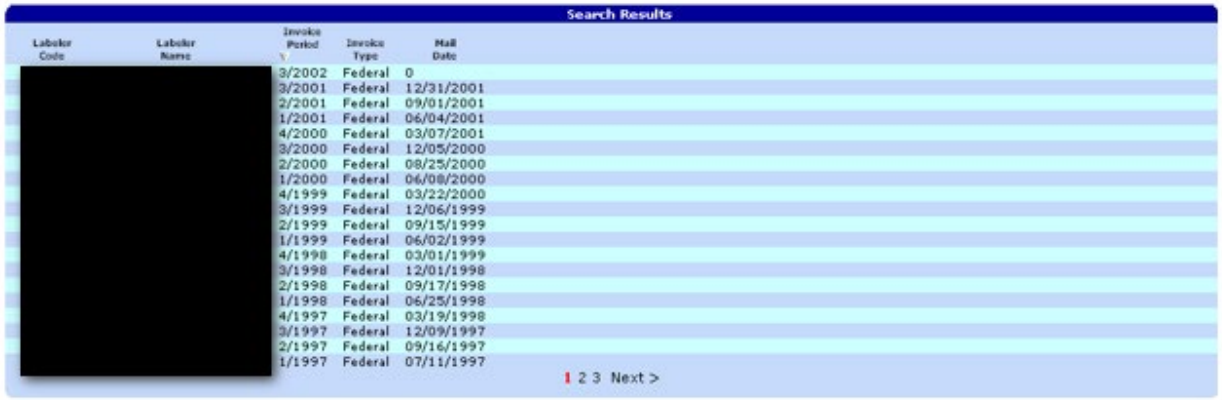
6.9.1 Invoice by Labeler Search Results Panel Narrative

The Invoice by Labeler Search Results panel is accessed from the Main Menu by selecting Drug and clicking on Invoice Search. Default data list displays: Labeler Code, Labeler Name, Invoice Period, Invoice Type and Mail Date.

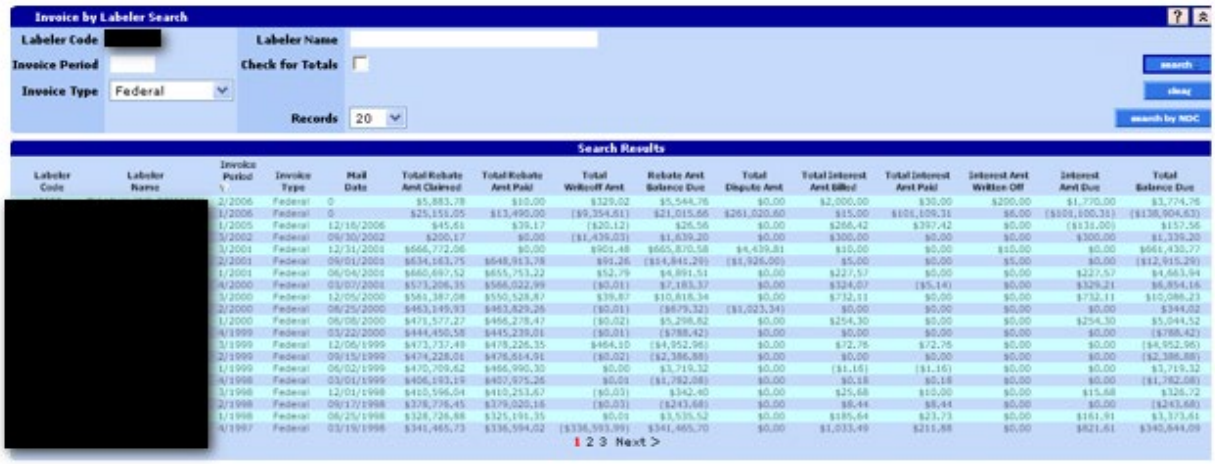
This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search])

6.9.2 Invoice by Labeler Search Results Panel Layout



Search Results when Check for Totals is checked:



6.9.3 Invoice by Labeler Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Interest Amt Due	The incremental amount of interest that is due for this invoice.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Interest Amt Written Off	The incremental amount of interest that has been written off for this invoice.	Field	Number (Decimal)	11
Invoice Period	Quarter the claims billed on the invoice were paid. The date is in the format Q/CCYY where Q indicates the quarter. Valid values for the quarter are 1-4. 1 = Jan. - March, 2 = April - June, 3 = July - Sept, 4 = Oct. - Dec.	Field	Date (Q/CCYY)	5
Invoice Type	Description of the invoice type - used in report headings. Valid values are Federal or Supplemental.	Field	Character	32
Labeler Code	Used to uniquely identify the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first 5 characters of the labeler's National Drug Code (NDC).	Field	Number (Integer)	5
Labeler Name	Name of the drug labeler.	Field	Character	39
Mail Date	Date the invoices for the quarter were mailed. This attribute should correspond to the postmark date on the invoices and is used in late payment and interest determination.	Field	Date (MM/DD/CCYY	8
Rebate Amt Balance Due	Rebate amount balance due for the invoice.	Field	Number (Decimal)	25
Total Balance Due	Total balance due for the invoice.	Field	Number (Decimal)	25
Total Dispute Amt	Total disputed amount for the invoice.	Field	Number (Decimal)	25
Total Interest Amt Billed	The amount of interest that has been billed for this invoice.	Field	Number (Decimal)	25

Field	Description	Field Type	Data Type	Length
Total Interest Amt Paid	Total interest amount paid for the invoice.	Field	Number (Decimal)	25
Total Rebate Amt Claimed	Total rebate amount claimed for the invoice.	Field	Number (Decimal)	25
Total Rebate Amt Paid	Total interest amount paid for the invoice.	Field	Number (Decimal)	25
Total Writeoff Amt	Total amount written off for the invoice.	Field	Number (Decimal)	25

6.9.4 Invoice by Labeler Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.9.5 Invoice by Labeler Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Invoice by Labeler Search Results Panel Accessibility

6.9.6.1 To Access the Invoice by Labeler Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5 digit **Labeler Code**.	
4	Click **Search**.	Invoice by Labeler Search Results panel displays.

6.10 Invoice by NDC Search Panel Overview

6.10.1 Invoice by NDC Search Panel Narrative

The Invoice by NDC panel is used to view the historical transaction of a rebate NDC.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - [click on Search by NDC button] - [Invoice by NDC Search]

6.10.2 Invoice by NDC Search Panel Layout

6.10.3 Invoice by NDC Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Invoice by Invoice by NDC Search panel.	Button	N/A	0
Invoice Period	Four-digit year followed by one digit quarter for the invoice period.	Field	Date (Q/CCYY)	5
Invoice Type	Invoice Type code followed by description. Valid values include Federal and Supplemental.	Combo Box	Drop Down List Box	0
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code and the two-digit package size code.	Field	Number (Integer)	11
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by NDC, Invoice Period or Invoice Type.	Button	N/A	0
Search by labeler	Allows the user to search by a labeler.	Button	N/A	0

6.10.4 Invoice by NDC Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Period	Field	8188	Quarter must be 1,2,3, or 4.	Re-enter quarter of 1,2,3, or 4.

Field	Field Type	Error Code	Error Message	To Correct
	Field	91029	Invoice Period must be numeric.	Re-enter 5 numeric characters.
	Field	91059	Invoice Period must be 5 digits if entered.	Re-enter 5 numeric characters.
NDC	Field	91029	National Drug Code must be numeric.	Re-enter 11 numeric characters.
	Field	91080	An 11 digit National Drug Code is required.	Enter a valid NDC.

6.10.5 Invoice by NDC Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Invoice by NDC Search Panel Accessibility

6.10.6.1 To Access the Invoice by NDC Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Click on **Search by NDC** button.	Invoice by NDC Search panel displays.

6.11 Invoice by NDC Search Results Panel Overview

6.11.1 Invoice by NDC Search Results Panel Narrative

The Invoice by NDC Search Results panel is used to view all the historical transactions of a rebate NDC. It is useful when doing a comparative analysis of several different quarters.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Click on [Search by NDC]) - (Enter [NDC] and click on [Search])

6.11.2 Invoice by NDC Search Results Panel Layout

Search Results

NDC	Drug Name	Invoice Period	Invoice Type	Rebate Amt Per Unit	CMS Unit	Total Units Reimbursed	Total Rebate Amt Claimed	Total Rebate Amt Paid	Total Writeoff Amt	Rebate Amt Balance Due	Number of Scripts	Total Prov Reimbursement
[redacted]		3/2002	Federal	$0.151900	TAB	30.000	$4.56	$0.00	$4.56	$0.00	1	$3.97
		3/2001	Federal	$0.246400	XXX	9,295.000	$2,290.29	$0.00	($628.79)	$2,919.08	92	$1,890.76
		2/2001	Federal	$10,000.000000	XXX	10.000	$100,000.00	$699.90	$0.00	$99,300.10	98	$2,062.92
		1/2001	Federal	$0.151980	XXX	2,788.000	$423.72	$423.34	$0.00	$0.38	70	$1,277.54
		4/2000	Federal	$0.140987	XXX	3,101.000	$437.20	$437.20	$0.00	$0.00	75	$1,377.45
		3/2000	Federal	$0.139241	XXX	3,819.000	$531.76	$531.76	$0.00	$0.00	106	$1,761.65
		1/2000	Federal	$0.127297	XXX	2,900.000	$369.16	$369.16	$0.00	$0.00	68	$1,218.97
		4/1999	Federal	$0.122133	XXX	2,790.000	$340.75	$340.76	$0.00	($0.01)	69	$1,159.23
		3/1999	Federal	$0.113205	XXX	3,104.000	$351.39	$351.39	$0.00	$0.00	65	$1,192.69
		2/1999	Federal	$0.114726	XXX	2,007.000	$230.25	$230.25	($0.01)	$0.01	51	$817.36
		1/1999	Federal	$0.100335	XXX	2,035.000	$204.18	$204.18	$0.00	$0.00	47	$789.93
		4/1998	Federal	$0.100912	XXX	2,981.000	$300.82	$0.00	$0.00	$300.82	53	$1,101.03
		3/1998	Federal	$0.101674	XXX	2,385.000	$242.49	$0.00	$0.00	$242.49	53	$908.53
		2/1998	Federal	$0.102919	XXX	1,875.000	$192.97	$0.00	$0.00	$192.97	45	$732.56
		1/1998	Federal	$0.099345	XXX	2,112.000	$209.82	$0.00	$0.00	$209.82	50	$775.64
		4/1997	Federal	$0.089182	XXX	2,876.000	$256.49	$0.00	$0.00	$256.49	75	$1,107.35
		3/1997	Federal	$0.090347	XXX	2,799.000	$252.88	$0.00	$0.00	$252.88	64	$1,044.48
		2/1997	Federal	$0.090742	EA	2,360.000	$214.15	$0.00	$0.00	$214.15	63	$902.29
		1/1997	Federal	$0.258534	XXX	2,730.000	$705.80	$0.00	$0.00	$705.80	74	$1,047.33
		4/1996	Federal	$0.224760	XXX	2,464.000	$553.81	$0.00	$0.00	$553.81	71	$935.15

1 2 3 Next >

6.11.3 Invoice by NDC Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CMS Unit	Basic measurement that represents the smallest unit by which the drug is measured. The rebate amount is calculated per unit.	Field	Character	3
Drug Name	First 10 characters of the product Federal Drug Agency (FDA) registration name.	Field	Character	10
Invoice Period	Four-digit year followed by one digit quarter of invoice period.	Field	Date (Q/CCYY)	5
Invoice Type	Invoice type followed by type description. Valid values included Federal and Supplemental.	Field	Character	32
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and the two-digit package size code.	Field	Number (Integer)	11
Number of Scripts	Number of claims for a specific	Field	Number (Integer)	6

Field	Description	Field Type	Data Type	Length
	National Drug Code (NDC) and invoice period.			
Rebate Amt Balance Due	Contains the rebate amount balance due.	Field	Number (Decimal)	25
Rebate Amt Per Unit	Centers for Medicare and Medicaid Services (CMS) calculated rebate amount per unit.	Field	Number (Decimal)	15
Total Prov Reimbursement	Total Medicaid dollars reimbursed to providers, including dispensing fees. This field is informational only and is not used in calculating the rebate amount claimed.	Field	Number (Decimal)	20
Total Rebate Amt Claimed	Contains the total rebate amount claimed.	Field	Number (Decimal)	25
Total Rebate Amt Paid	Contains the total rebate amount paid.	Field	Number (Decimal)	25
Total Units Reimbursed	Contains the total units reimbursed.	Field	Number (Decimal)	20
Total Writeoff Amt	Total dollar amount written off for a given invoice.	Field	Number (Decimal)	25

6.11.4 Invoice by NDC Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.11.5 Invoice by NDC Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Invoice by NDC Search Results Panel Accessibility

6.11.6.1 To Access the Invoice by NDC Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter **NDC**. User many enter Invoice Period or	

	Invoice Type to narrow the search.	
4	Click **Search**.	Invoice by NDC Search Results display.

6.12 Invoice Mini Search Panel Overview

6.12.1 Invoice Mini Search Panel Narrative

The Invoice Mini-Search panel is used to search the transaction history of a labeler. The panel is accessed from the Main Menu by selecting Drug, clicking on Invoice Search, conducting a Search by Labeler, then selecting a single record from the data list.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results)

6.12.2 Invoice Mini Search Panel Layout

6.12.3 Invoice Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Opens the Invoice by Labeler Search panel.	Button	N/A	0
Clear	Allows the user to clear any changes on the Invoice Mini Search panel.	Button	N/A	0
Invoice Type	Allows a user to search by Invoice Type. Valid values include: Federal and Supplemental.	Combo Box	Drop Down List Box	0
Labeler/ Year/ Qtr	Labeler Code/Year/Quarter. Entry length must be 12 including fore slashes. The format is: 5-digit labeler code, followed by a fore slash, followed by a 4-digit year followed by a forward slash, followed by a 1-digit quarter. The field is not required, so searching without any entry is allowed, but if any character is entered the field is edited for length, numeric validity, and valid quarter number.	Field	Number (Integer)	12
Search	Initiates the Search by Labeler/Year/Qtr or Invoice Type.	Button	N/A	0

6.12.4 Invoice Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Labeler Year Qtr	Field	8188	Quarter must be 1, 2, 3, or 4.	Re-enter a valid quarter and year.

Field	Field Type	Error Code	Error Message	To Correct
	Field	91029	Labeler Codes must be 5 digits if entered.	Re-enter 5 numeric characters.
	Field	91059	Entry must be in 99999/9999/9 format.	Re-enter 12 numeric characters with appropriate fore slashes.
	Field	91060	Labeler Code must be numeric.	Re-enter numeric Labeler Code.
	Field	91061	Invoice Period must be 5 digits if entered.	Re-enter 5 digit Invoice Period.
	Field	91062	Quarter Date must be numeric.	Re-enter numeric Quarter Date.
	Field	91063	Quarter must be entered when Year entered.	Enter a Quarter.
	Field	91064	Labeler Code must be 5 digits if entered.	Enter a valid Labeler Code.
	Field	91065	Year must be 4 digits if entered.	Enter a valid year in CCYY format.

6.12.5 Invoice Mini Search Panel Extra Features

Search results yielding a single record clears the fields on the mini search panel and update fields on the Invoice Information by Labeler Panel. Search results yielding more than a single record or no records returns to the Invoice Search by Labeler panel which are pre-filled with the criteria entered on the mini panel. Records meeting the criteria, if any, are displayed on the data list.

6.12.6 Invoice Mini Search Panel Accessibility

6.12.6.1 To Access the Invoice Mini-Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Mini Search panel displays.

6.13 Invoice Information Panel Overview

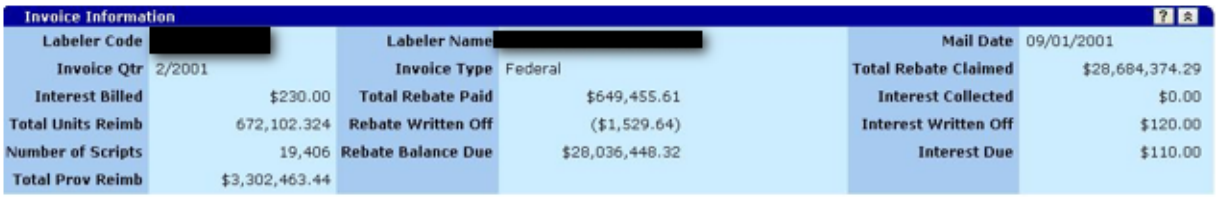
6.13.1 Invoice Information Panel Narrative

This panel displays invoice information for a particular labeler.

This panel is display only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results

6.13.2 Invoice Information Panel Layout



Invoice Information

Labeler Code	[redacted]	Labeler Name	[redacted]	Mail Date	09/01/2001
Invoice Qtr	2/2001	Invoice Type	Federal	Total Rebate Claimed	$28,684,374.29
Interest Billed	$230.00	Total Rebate Paid	$649,455.61	Interest Collected	$0.00
Total Units Reimb	672,102.324	Rebate Written Off	($1,529.64)	Interest Written Off	$120.00
Number of Scripts	19,406	Rebate Balance Due	$28,036,448.32	Interest Due	$110.00
Total Prov Reimb	$3,302,463.44				

6.13.3 Invoice Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Interest Billed	Dollar amount the labeler has been billed in interest for overdue payment.	Field	Number (Decimal)	11
Interest Collected	Dollar amount the labeler has paid in interest for an invoice.	Field	Number (Decimal)	11
Interest Due	Interest amount still outstanding for an invoice.	Field	Number (Decimal)	11
Interest Written Off	Interest amount written off.	Field	Number (Decimal)	11
Invoice Qtr	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Value represents the description of the type of the invoice. Valid values include Federal and Supplemental.	Field	Character	30
Labeler Code	Five-digit code used to identify a labeler(s) that matched the search criteria.	Field	Number (Integer)	5
Labeler Name	Name of the labeler(s) that matched the search criteria.	Field	Character	39
Mail Date	Displays the month, day, and year of the postmark date the invoice was mailed to the labeler.	Field	Date (MM/DD/CCYY)	8
Number of Scripts	Number of claims for a specific National Drug Code (NDC) and	Field	Number (Decimal)	6

Field	Description	Field Type	Data Type	Length
	invoice period.			
Rebate Balance Due	Total rebate amount due for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Rebate Written Off	Displays the rebate amount written off.	Field	Number (Decimal)	11
Total Prov Reimb	Total dollars paid to providers for a specific National Drug Code (NDC) and invoice period.	Field	Number (Decimal)	11
Total Rebate Claimed	Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for a National Drug Code (NDC)for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Paid	Total rebate paid for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Total Units Reimb	Number of units invoiced for a specific invoice period to a labeler for a National Drug Code (NDC).	Field	Number (Decimal)	13

6.13.4 Invoice Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Qtr	Field	1	Valid Quarters are 1, 2, 3, or 4.	Re-enter a valid quarter and year.

6.13.5 Invoice Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Invoice Information Panel Accessibility

6.13.6.1 To Access the Invoice Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.

Step	Action	Response
5	Click on a record from search results.	Invoice Information displays.

6.14 Invoice Maintenance Panel Overview

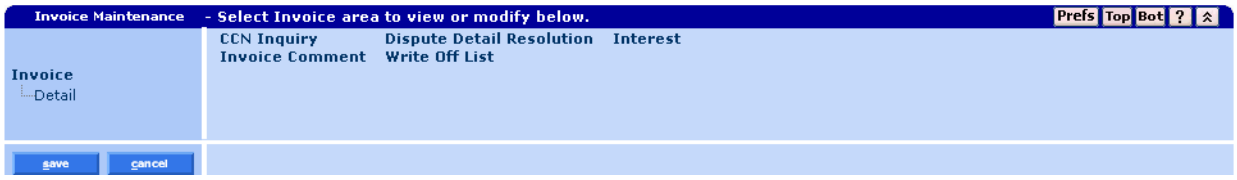
6.14.1 Invoice Maintenance Panel Narrative

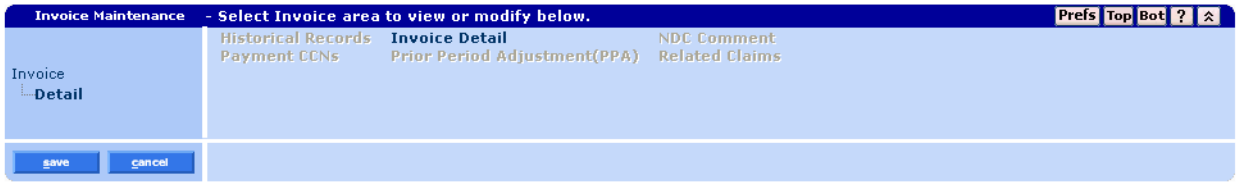
The Invoice Maintenance panel allows the user access to invoice areas to view or modify.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Detail]

6.14.2 Invoice Maintenance Panel Layout





6.14.3 Invoice Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Invoice Maintenance panel.	Button	N/A	0
CCN Inquiry	Link to the CCN Inquiry panel.	Hyperlink	N/A	0
Dispute Detail Resolution	Link to the Dispute Detail Resolution panel.	Hyperlink	N/A	0
Interest	Link to the Interest panel.	Hyperlink	N/A	0
Invoice Comment	Link to the Invoice Comment panel.	Hyperlink	N/A	0
Invoice Detail	Link to the Invoice Detail panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Invoice Maintenance panel.	Button	N/A	0
Write Off List	Link to the Write Off List panel.	Hyperlink	N/A	0

6.14.4 Invoice Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.14.5 Invoice Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Invoice Maintenance Panel Accessibility

6.14.6.1 To Access the Invoice Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Maintenance panel displays.

6.15 CCN Inquiry Panel Overview

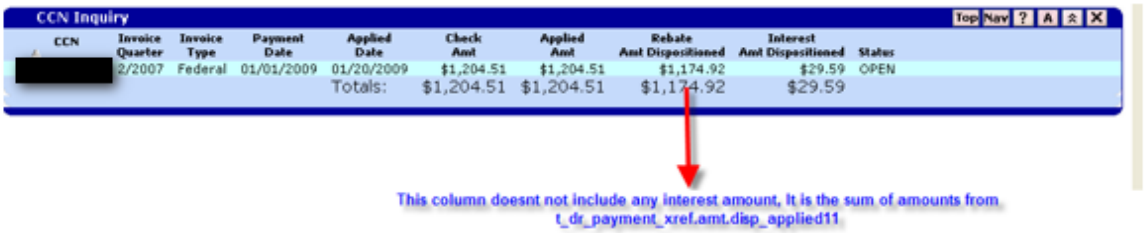
6.15.1 CCN Inquiry Panel Narrative

The CCN Inquiry panel allows the user to view all payment dispositions made to an invoice detail. Multiple checks can be applied to an invoice. The panel displays the Cash Control Number (CCN), check amount, postmark date of the check, dollars applied to the invoice, amount dispositioned and the payment reason code. If no data appears in the panel, payments have not been dispositioned for this invoice detail.

This panel is display only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [CCN Inquiry]

6.15.2 CCN Inquiry Panel Layout



6.15.3 CCN Inquiry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Applied Amt	Amount of money that has been applied to the invoice by this cash control number (CCN).	Field	Number (Decimal)	11
Applied Date	Date on which money was applied to the invoice.	Field	Date (MM/DD/CCYY)	8
CCN	Cash control number (CCN) associated with the cash receipt received for this accounts receivable disposition.	Field	Number (Integer)	11
Check Amt	Dollar amount of the check for an invoice sent by a drug labeler.	Field	Number (Decimal)	11
Deposit Date	Date on which the check was deposited.	Field	Date (MM/DD/CCYY)	8
Interest Amt Dispositioned	Interest payment amount that is being applied from the current check.	Field	Number (Decimal)	11
Invoice Quarter	Quarter and year of the invoice.	Field	Date (QCCYY)	5

Field	Description	Field Type	Data Type	Length
Invoice Type	This value represents the type of the invoice. Valid values include Federal or Supplemental.	Field	Character	35
Rebate Amt Dispositioned	Amount of money that has been dispositioned to the National Drug Code (NDC) detail for this invoice from this cash control number.	Field	Number (Decimal)	11
Status	Status for this cash control number (CCN) associated with the cash receipt received for this accounts receivable disposition. Valid values are Open and Closed.	Field	Character	50
Total Applied Amt (footer)	Total amount of money that has been applied to the invoice by all cash control numbers (CCN).	Field	Number (Decimal)	15
Total Check Amt (footer)	Total dollar amount of all checks for an invoice sent by a drug labeler.	Field	Number (Decimal)	15
Total Dispositioned Amt (footer)	Total amount of money that has been dispositioned to the National Drug Code (NDC) detail for this invoice for all cash control numbers.	Field	Number (Decimal)	15
Total Interest Applied Amt (footer)	Total interest payment amount that is being applied for all the checks.	Field	Number (Decimal)	15

6.15.4 CCN Inquiry Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.15.5 CCN Inquiry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 CCN Inquiry Panel Accessibility

6.15.6.1 To Access the CCN Inquiry Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice**	Invoice by Labeler Search panel displays.

Step	Action	Response
	Search.	
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Invoice** from the Invoice Maintenance panel.	List of maintenance areas to view or modify are displayed.
7	Click on CCN Inquiry.	CCN Inquiry panel displays.

6.16 Invoice Dispute Detail Resolution Panel Overview

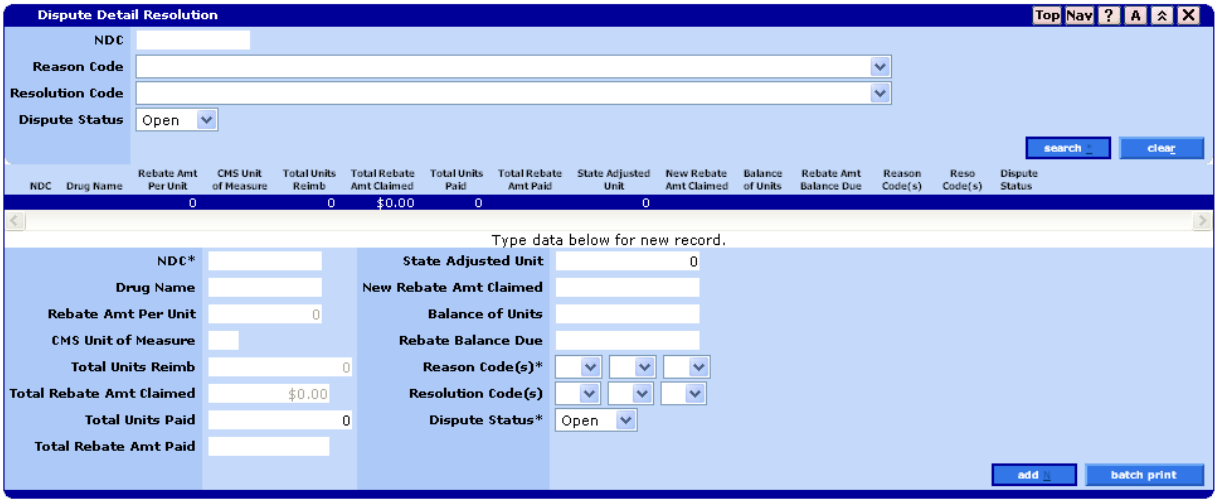
6.16.1 Invoice Dispute Detail Resolution Panel Narrative

The Invoice Dispute Detail Resolution panel allows users to enter or inquire on dispute detail information. The user may enter dispute information when a payment is received. If the labeler identifies disputes through written correspondence or pays $0 on all or a portion of details, the user keys the dispute information into this panel. This panel searches on disputed line item/NDC disputes based upon the search criteria.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path from Invoice Maintenance: [Drug] - [Invoice Search] - (Enter a labeler code) - (Enter search info, click on search, and select row from search results) - [Invoice Maintenance] - [Invoice] - [Dispute Detail Resolution]

6.16.2 Invoice Dispute Detail Resolution Panel Layout



6.16.3 Invoice Dispute Detail Resolution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add dispute detail resolution information.	Button	N/A	0
Balance of Units	Displays the number of units due from a labeler for a specific National Drug Code (NDC) drug rebate claim.	Field	Number (Decimal)	14
Batch Print	Allows the user to send disputes to the printer.	Button	N/A	0
Clear	Allows the user to clear any changes on the Dispute Detail Resolution panel.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
CMS Unit of Measure	Basic measurement that represents the smallest unit by which the drug is measured. The rebate amount is calculated per unit.	Field	Character	3
Dispute Status	Identifies the status of the dispute. Valid values include: Open or Closed.	Combo Box	Drop Down List Box	0
Drug Name	Displays the drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Medicaid programs.	Field	Character	10
NDC	Represents the National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
New Rebate Amt Claimed	Displays the new calculated rebate amount due from the manufacturer.	Field	Number (Decimal)	14
Reason Code + Reason Code Description	Represents the labeler explanation of the disputes for a specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Reason Code 1	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 2	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 3	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Rebate (Amt) Balance Due	Totals re-calculated amount due after subtracting any previous payment. Balance due = balance of units due multiplied by the current rebate amount per unit.	Field	Number (Decimal)	14

Field	Description	Field Type	Data Type	Length
Rebate Amt Per Unit	Indicates the rebate amount per unit supplied by Centers for Medicare and Medicaid Services (CMS) on a quarterly basis for the calculation of the drug rebate amount for each National Drug Code (NDC) in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.	Field	Number (Decimal)	11
Resolution Code + Description	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 1	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 2	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 3	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by NDC, Reason Code, Resolution Code or Dispute Status.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
State Adjusted Unit	Represents the new total number of units after the state has resolved the dispute for a specific National Drug Code (NDC). This would not be an adjusted difference but the total adjusted amount. i.e., if current total units are 300, total paid are 250, and the adjusted decision is 275. 275 would be entered into this field.	Field	Number (Decimal)	14
Total Rebate Amt Claimed	Result of multiplying the "rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Paid	Result of multiplying the rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Units Paid	Indicates the number of units paid.	Field	Number (Decimal)	13
Total Units Reimb	Indicates the total units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	13

6.16.4 Invoice Dispute Detail Resolution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Reason Code 1	Combo Box	1	A valid Reason Code (1) is required.	Enter a dispute reason.
	Combo Box	2	Reason Code is used more than once.	Enter each code only once.
Resolution Code 1	Combo Box	1	Resolution Code cannot be used on open dispute.	Enter a Resolution Code only when the dispute status is closed.
	Combo Box	2	A valid Resolution Code (1) is required.	Enter a Resolution Code.

Field	Field Type	Error Code	Error Message	To Correct
	Combo Box	3	Resolution Code is used more than once.	Enter each code only once.
NDC	Field	91029	Enter a value.	Enter a valid 11 numeric character NDC.
	Field	91080	A valid NDC is required.	Enter a valid 11 numeric character NDC.
State Adjusted Unit	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	State Adjusted Unit must be less than or equal to 999999999.999.	Enter an adjusted unit's amount that is less than 10,000,000,000.00.
	Field	91115	State Adjusted Unit must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.
Total Units Paid	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	Total Units Paid must be less than or equal to 9999999999.999.	Enter a Total Units Paid amount that is less than 10,000,000,000.00.
	Field	91115	Total Units Paid must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.

6.16.5 Invoice Dispute Detail Resolution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Invoice Dispute Detail Resolution Panel Accessibility

6.16.6.1 To Access the Invoice Dispute Detail Resolution Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Invoice** from the Invoice Maintenance panel.	List of maintenance areas to view or modify are displayed.

Step	Action	Response
7	Click on Dispute Detail Resolution.	Invoice Dispute Detail Resolution panel displays.

6.16.6.2 To Navigate the Invoice Dispute Detail Resolution Panel

Step	Action	Response
1	Enter **NDC**.	
2	Select **Reason Code** from drop down list box.	
3	Select **Resolution** from drop down list box.	
4	Select **Dispute Status** from the drop down list box.	
5	Click **Search**.	Invoice Dispute Detail Resolution Search results display.

6.16.6.3 To Add on the Invoice Dispute Detail Resolution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **NDC**.	
3	Enter Drug Name.	
4	Enter Rebate Amount Per Unit.	
5	Enter CMS Unit of Measure.	
6	Enter Total Units Reimbursed.	
7	Enter Total Rebate Amount Claimed.	
8	Enter Total Units Paid.	
9	Enter Total Rebate Amount Paid.	
10	Enter State Adjusted Unit.	
11	Enter New Rebate Amount Claimed.	
12	Enter Balance of Units.	
13	Enter Rebate Balance Due.	
14	Select **Reason Code** from drop down list box.	
15	Select **Resolution** from drop down list box.	
16	Select **Dispute Status** from the drop down list box.	

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Step	Action	Response
17	Click **Save**.	Invoice Dispute Detail Resolution information is saved.

6.16.6.4 To Update the Invoice Dispute Detail Resolution Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Invoice Dispute Detail Resolution information is updated.

6.17 Interest Panel Overview

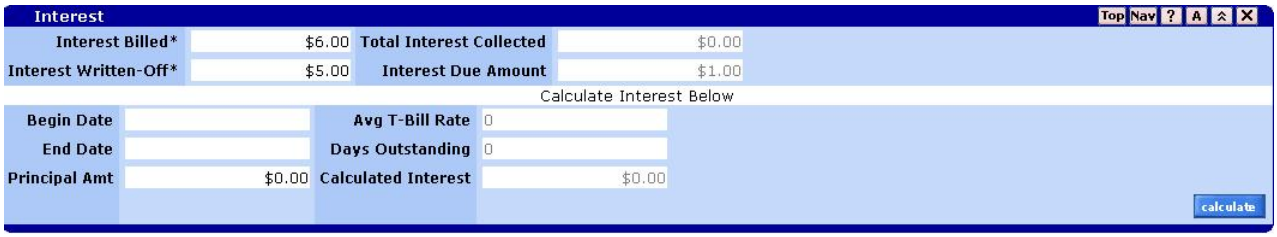
6.17.1 Interest Panel Narrative

The Interest panel allows the user to view the amount for interest billed, collected and written-off for a specific time frame.

This panel is inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Interest]

6.17.2 Interest Panel Layout



6.17.3 Interest Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Avg T-Bill Rate	Displays the average t-bill rate for the interest period.	Field	Number (Decimal)	10
Begin Date	Allows the user to enter the beginning date of the interest period. This date is 38 days after the postmark date on the invoice.	Field	Date (MM/DD/CCYY)	8
Calculate	Calculate interest based on user input.	Button	N/A	0
Calculated Interest	Calculated interest, based on the dates and balance that were input.	Field	Number (Decimal)	10
Days Outstanding	Number of days for which interest is calculated.	Field	Number (Integer)	10
End Date	Allows the user to enter the ending date of the interest period. This is the postmark date of the manufacturer's payment.	Field	Date (MM/DD/CCYY)	8
Interest Billed	Allows the user to enter a dollar amount the labeler has been billed in interest for overdue payment.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Interest Due Amount	Interest amount still outstanding for an invoice.	Field	Number (Decimal)	11
Interest Written-Off	Allows the user to enter the amount of interest that has been written off.	Field	Number (Decimal)	11
Principal Amt	Allows the user to enter the principal amount used to calculate the interest.	Field	Number (Decimal)	10
Total Interest Collected	Dollar amount the labeler has paid in interest for an invoice.	Field	Number (Decimal)	11

6.17.4 Interest Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Date	Field	91080	Begin Date is required.	Enter a date.
	Field	91163	There is no record of t-bill rates before MM/DD/CCYY.	Verify date and re-enter.
End Date	Field	91080	End Date is required.	Enter a date.
	Field	91136	End Date must be greater than Begin Date.	Verify date and re-enter.
Interest Billed	Field	1	Enter a valid value.	Verify the input data.
	Field	91115	Interest Billed Amount must be greater than or equal to 0.00.	Re-enter amount greater than zero.
	Field	91150	Interest Billed Amount must be less than or equal to 999999999.99.	Re-enter an amount less than 10,000,000,000.00.
Interest Written-Off	Field	1	Enter a valid value.	Verify the input data.
	Field	91115	Interest Written Off Amount must be greater than or equal to 0.00.	Enter a write-off amount >= zero.
	Field	91150	Interest Written Off Amount must be less than or equal to 999999999.99.	Enter a write-off amount less than $999999999.99.
Principal Amt	Field	1	Principal Amt is required.	Enter an amount.
	Field	91080	Principal Amt is required.	Enter an amount.

6.17.5 Interest Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 Interest Panel Accessibility

6.17.6.1 To Access the Interest Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search Results pane displays.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Invoice** from the Invoice Maintenance panel.	List of invoice maintenance links to view or modify are displayed.
7	Click on **Interest**.	Interest panel displays.

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6.18 Invoice Comment Panel Overview

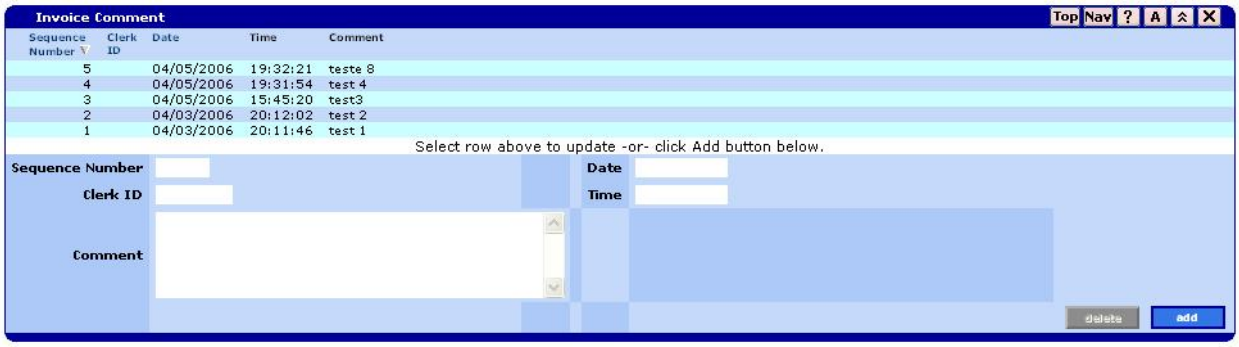
6.18.1 Invoice Comment Panel Narrative

The Invoice Comment panel is used to enter comments relating to a specific invoice. All notes pertaining to verbal or written correspondence for a specific labeler and invoice period are entered in this panel.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path: [Drug] – [Invoice Search] - [Click on Search] - [click on record in Search Results] - [Invoice Maintenance]-[Invoice Comment]

6.18.2 Invoice Comment Panel Layout



6.18.3 Invoice Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add invoice comment information.	Button	N/A	0
Clerk ID	Identification number of the user that added the comment.	Field	Character	8
Comment	Allows the user to enter comments about the invoice, payment or dispute.	Field	Character	50
Date	Date on which a particular comment was added.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove invoice comment information.	Button	N/A	0
Sequence Number	System assigned key that is used in conjunction with sak_invoice and sak_drug to uniquely identify a comment.	Field	Number (Integer)	4
Time	Time the comment was added.	Field	Number (Decimal)	8

6.18.4 Invoice Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	91080	Comment is required.	Enter some text comment.

6.18.5 Invoice Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 Invoice Comment Panel Accessibility

6.18.6.1 To Access the Invoice Comment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Invoice** from the Invoice Maintenance panel.	List of maintenance links to view or modify are displayed.
7	Click Invoice Comment.	Invoice Comment panel displays.

6.18.6.2 To Navigate the Invoice Comment Panel

Step	Action	Response
1	Click to highlight the row to be viewed.	Data is populated in fields.

6.18.6.3 To Add on the Invoice Comment Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	Invoice Comment information is saved.

6.18.6.4 To Update on the Invoice Comment Panel

Step	Action	Response
1	Click to highlight the row to be updated	Data is populated in fields
2	Click in **Comment** field to update and perform update.	
3	Click **Save**.	Invoice Comment information is updated.

6.18.6.5 To Delete on the Invoice Comment Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.19 Write Off List Panel Overview

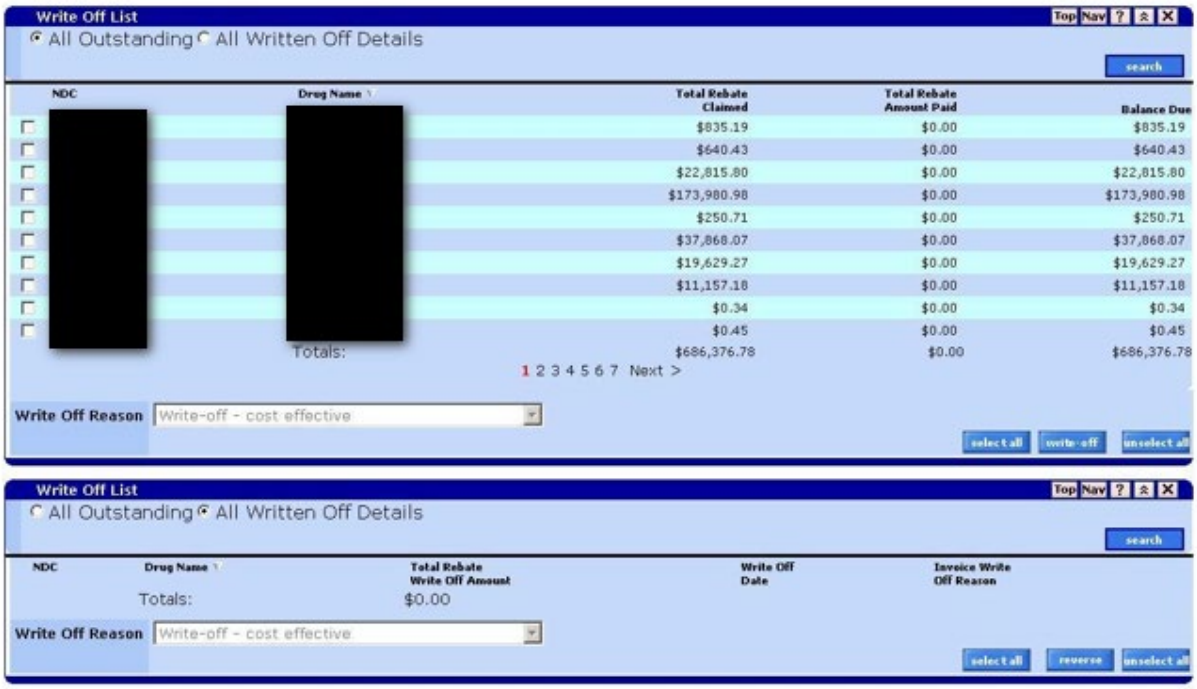
6.19.1 Write Off List Panel Narrative

The Write Off List panel provides quarterly drug utilization data and estimated rebate amounts owed by the manufacturer of a drug that is in the drug rebate program. On a quarterly basis, a drug rebate invoice is generated for each participating manufacturer, listing this data for all their NDCs.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search]) - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Write Off List]

6.19.2 Write Off List Panel Layout



6.19.3 Write Off List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All Outstanding (Search)	Allows the user to search by All Outstanding.	Combo Box	Radio Button	0
All Written Off Details	Allows the user to search by All Written Off Details.	Combo Box	Radio Button	0
Balance Due	Displays the Total Rebate Claim Amount – Total Rebate Paid Amount.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Drug Name	Name of the drug as assigned by the Food and Drug Administration (FDA) as reported to Office of Health Care Access (OHCA) by Centers for Medicare and Medicaid Services (CMS) as part of the quarterly drug rebate information. This name is printed on the drug invoices.	Field	Character	10
Invoice Write Off Reason	A description of the write off reason.	Field	Character	50
NDC	National Drug Code (NDC) is comprised of a 5-byte numeric labeler code, 4-byte numeric product code and a 2-byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and prior authorization.	Field	Number (Integer)	11
Reverse	Allows the user to reverse a write-off.	Button	N/A	0
Search	Initiates the Search by All Outstanding or All Written Off Details.	Button	N/A	0
Select All	Allows the user to select all records to be written off.	Button	N/A	0
Total Rebate Amount Paid	Total rebate amount paid by the drug labeler for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Claimed	Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Write Off Amount	Dollar amount that was written off for a specific invoice detail.	Field	Number (Decimal)	11
Unselect All	Allows the user to unselect records to be written off.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Write Off Date	Date the invoice detail was written off.	Field	Date (MM/DD/CCYY)	8
Write Off Reason	Description of the 'cde_reason_four' field.	Combo Box	Drop Down List Box	0

6.19.4 Write Off List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.19.5 Write Off List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 Write Off List Panel Accessibility

6.19.6.1 To Access the Write Off List Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Invoice** from the Invoice Maintenance panel.	List of maintenance links to view or modify are displayed.
7	Click on Write Off List.	Write Off List panel displays.

6.19.6.2 To Navigate the Write Off List Panel

Step	Action	Response
1	Check the record/s to write off.	
2	Select **Write Off Reason** from drop down menu.	
3	Click on **Write-Off**.	Records selected for Write-Off are written off.

6.20 Invoice Detail Panel Overview

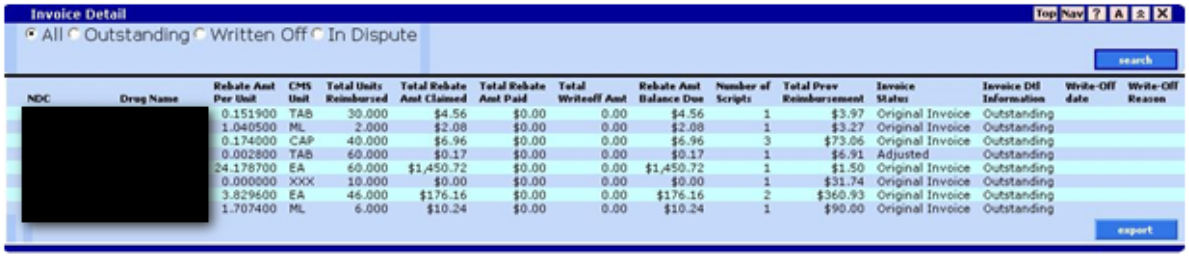
6.20.1 Invoice Detail Panel Narrative

The Invoice Detail panel allows the user to view the most current invoice detail information at a NDC level for a specific invoice period. The user has the ability to search for an invoice by entering the labeler code and invoice period. Once a valid invoice is displayed, all invoice details display. The user is able to filter the detail list by using the search so that only selected invoice details display.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Detail] - [Invoice Detail]

6.20.2 Invoice Detail Panel Layout



NDC	Drug Name	Rebate Amt Per Unit	CMS Unit	Total Units Reimbursed	Total Rebate Amt Claimed	Total Rebate Amt Paid	Total Writeoff Amt	Rebate Amt Balance Due	Number of Scripts	Total Prev Reimbursement	Invoice Status	Invoice Dtl Information	Write-Off date	Write-Off Reason
[redacted]		0.151900	TAB	30.000	$4.56	$0.00	0.00	$4.56	1	$3.97	Original Invoice	Outstanding		
		1.040500	ML	2.000	$2.08	$0.00	0.00	$2.08	1	$3.27	Original Invoice	Outstanding		
		0.174000	CAP	40.000	$6.96	$0.00	0.00	$6.96	3	$73.06	Original Invoice	Outstanding		
		0.002800	TAB	60.000	$0.17	$0.00	0.00	$0.17	1	$6.91	Adjusted	Outstanding		
		24.178700	EA	60.000	$1,450.72	$0.00	0.00	$1,450.72	1	$1.50	Original Invoice	Outstanding		
		0.000000	XXX	10.000	$0.00	$0.00	0.00	$0.00	1	$31.74	Original Invoice	Outstanding		
		3.829600	EA	46.000	$176.16	$0.00	0.00	$176.16	2	$360.93	Original Invoice	Outstanding		
		1.707400	ML	6.000	$10.24	$0.00	0.00	$10.24	1	$90.00	Original Invoice	Outstanding		

6.20.3 Invoice Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Allows the user to select all records to retrieve in a search.	Combo Box	Radio Button	0
CMS Unit	Code indicating the unit of measure used by Centers for Medicare and Medicaid Services (CMS). This unit of measure should match the unit of measure being billed by the provider and the unit of measure being used in drug pricing.	Field	Character	3
Drug Name	The name of the drug as assigned by the Food and Drug Administration (FDA) as reported to Office of Health Care Access (OHCA) by Centers for Medicare and Medicaid Services (CMS) as part of the quarterly drug rebate information. This	Field	Character	20

Field	Description	Field Type	Data Type	Length
	name is printed on the drug invoices.			
Export	Allows the user to export the detail information to an Excel file.	Button	N/A	0
In Dispute	Allows the user to select in dispute records in a search.	Combo Box	Radio Button	0
Invoice Dtl Information	Identifies if a correction has been made to the National Drug Code's (NDC) rebate information for a given quarter. Values are "0" (Original Invoice), "1" (In Dispute), and "2" (Written Off).	Field	Character	1
Invoice Status	Field used to identify the status of an invoice detail. Values are "0" (Original Invoice), and "1" (Adjusted).	Field	Character	1
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code and the two-digit package size code.	Field	Number (Integer)	11
Number of Scripts	Total number of prescriptions for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Integer)	6
Outstanding	Allows the user to select outstanding records in a search.	Combo Box	Radio Button	0
Rebate Amt Balance Due	Total rebate amount due for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Rebate Amt Per Unit	Rebate amount per unit supplied by Centers for Medicare and Medicaid Services (CMS) on a quarterly basis for the calculation of the drug rebate	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
	amount for each National Drug Code (NDC) in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.			
Search	Initiates the Search by All, Outstanding, Written Off or In Dispute.	Button	N/A	0
Total Prov Reimbursement	Total dollars reimbursed to providers for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Claimed	Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Paid	Total rebate amount paid by the drug labeler for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Units Reimbursed	Total units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	13
Total Write-off Amt	The dollar amount that was written off for a specific invoice detail.	Field	Number (Decimal)	11
Write-Off Date	Date the invoice detail was written off.	Field	Date (MM/DD/CCYY)	8
Write-Off Reason	Description why a drug rebate detail was written off.	Field	Character	50
Written Off	Allows the user to select written off records in a search.	Combo Box	Radio Button	0

6.20.4 Invoice Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.20.5 Invoice Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Invoice Detail Panel Accessibility

6.20.6.1 To Access the Invoice Detail Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter a Labeler Code; Click Search.	Invoice by Labeler Search Results panel displays.
4	Click on a record from search results.	Invoice Maintenance and Invoice Detail panels display.
5	Click on **Detail**.	Invoice Detail panel displays.
6	Click on Invoice Detail.	List of maintenance links to view or modify are displayed.

6.21 Invoice Detail Historical Records Panel Overview

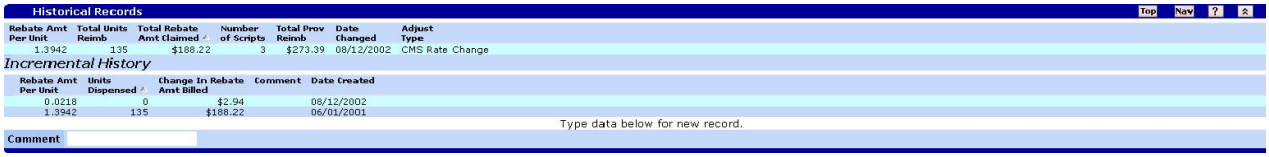
6.21.1 Invoice Detail Historical Records Panel Narrative

The Invoice Detail Historical Records panel contains the data for all Prior Period Adjustments (PPA) for a previous quarters NDC. The PPA adjusts the rebate amount due from the labeler. The Drug Rebate PPA Invoice Detail contains invoice detail information as it appeared before the PPA was received.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Detail] - [Invoice Detail] - (Select one detail records) - (Select [Historical Records] in [Invoice Maintenance])

6.21.2 Invoice Detail Historical Records Panel Layout



6.21.3 Invoice Detail Historical Records Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjust Type	A description of the 'ind' field.	Field	Character	50
Comment	Comments about the invoice, payment or dispute.	Field	Character	20
Date Changed	Date the Prior Period Adjustment (PPA) was received.	Field	Date (MM/DD/CCYY)	8
Number of Scripts	Total number of prescriptions for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Integer)	6
Rebate Amt Per Unit	Rebate amount per unit supplied by on a quarterly basis for the calculation of the drug rebate amount for each National Drug Code (NDC) in the program. The rebate amount per unit is determined by the manufacturer and forwarded to Centers for Medicare and Medicaid Services (CMS), who then forwards it to the State Medicaid Agencies.	Field	Number (Decimal)	11
Total Prov Reimb	Total dollars reimbursed to providers for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Total Rebate Amt Claimed	Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Units Reimb	Total units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Integer)	13

6.21.4 Invoice Detail Historical Records Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.21.5 Invoice Detail Historical Records Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Invoice Detail Historical Records Panel Accessibility

6.21.6.1 To Access the Invoice Detail Historical Records Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter a **Labeler Code**; Click **Search**.	List of Invoice Information displays.
4	Click on a record from search results.	Invoice Information and Maintenance panels display.
5	Click **Detail** from the Invoice Maintenance panel.	List of invoice detail areas to view or modify are displayed.
6	Click Invoice Detail.	Invoice Detail panel displays.
7	Click on a record from search results.	Record displays.
8	Click Historical Records.	Invoice Detail Historical Records panel displays.

6.21.6.2 To Update the Invoice Detail Historical Records Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in **Comment** field to update and	

Step	Action	Response
	perform update.	
3	Click **Save**.	Invoice Detail Historical Records information is updated.

6.22 Incremental Adjustment Information Panel Overview

6.22.1 Incremental Adjustment Information Panel Narrative

The Incremental Adjustment Information panel is used to view the detailed adjustment activity for an invoice detail. The three possible adjustment types are rebate amount per unit, provider utilization and dispute resolutions. When an invoice detail is modified by one of these activities, the "change" is captured on this panel. This panel also shows the payment information for this invoice detail. Users are only capable of changing the comment field on the adjustments.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Detail] - [Invoice Detail] - (Select one detail records) - (Select [Historical Records] in [Invoice Maintenance])

6.22.2 Incremental Adjustment Information Panel Layout

6.22.3 Incremental Adjustment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Change in Rebate Amt Billed	Incremental change in rebate amount billed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Comment	Free-form text box for entering comments about the incremental adjustment.	Field	Character	20
Date Created	Date the incremental change was created.	Field	Date (MM/DD/CCYY)	8
Rebate Amt Per Unit	Change in the rebate amount per unit billed to the labeler for a specific National Drug Code (NDC).	Field	Number (Decimal)	12
Units Dispensed	Incremental units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Integer)	9

6.22.4 Incremental Adjustment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Text Comments are required.	Text Comments are required.

6.22.5 Incremental Adjustment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 Incremental Adjustment Information Panel Accessibility

6.22.6.1 To Access the Incremental Adjustment Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by Labeler Search panel displays.
3	Enter a **Labeler Code** and Click **Search**.	List of Invoice Information displays.
4	Click on a record from search results.	Invoice Maintenance and Invoice Detail panels display.
5	Point to **Invoice Detail** on the Invoice Maintenance panel.	A list of Invoice panels display.
6	Click on a record from search results; Click **Historical Records**.	Historical Records panel displays.

6.22.6.2 To Navigate the Incremental Adjustment Information Panel

Step	Action	Response
1	Click on a record from search results.	
2	Enter **Comment**.	
3	Click **Save**.	Incremental Adjustments information is saved.

6.23 Invoice Detail NDC Comment Panel Overview

6.23.1 Invoice Detail NDC Comment Panel Narrative

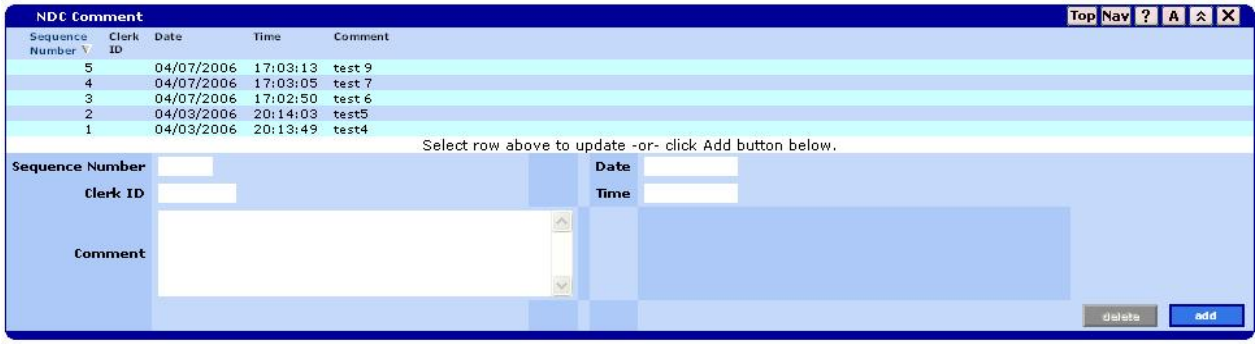
The Invoice Detail NDC Comment panel is used to enter comments relating to a specific invoice detail. All notes pertaining to verbal or written correspondence for a specific invoice detail are entered in this panel. This panel can also be accessed through the Payment function as indicated in the navigation path below.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path via Invoice function: [Drug] - [Invoice Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Detail] - [Invoice Detail] - (Select a row from [Invoice Detail]) - (Click on [NDC Comment] in [Invoice Maintenance])

Navigation Path via Payment function: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - (Click on [Invoice Payment Header]) - (Select row from [Invoice Payment Header]) - (Click on [Detail Disposition] button) - (Select row from [Invoice Detail]) - (Click on [NDC Comment] button)

6.23.2 Invoice Detail NDC Comment Panel Layout



6.23.3 Invoice Detail NDC Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add invoice detail NDC comment information.	Button	N/A	0
Clerk ID	Identification number of the user that added the comment.	Field	Character	8
Comment	Allows the user to enter comments about the invoice, payment or dispute.	Field	Character	250
Date	Displays the date on which a particular comment was added.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove invoice detail NDC comment information.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Sequence Number	Displays the sequence of comments created.	Field	Number (Integer)	4
Time	Displays the time the comment was added.	Field	Number (Decimal)	8

6.23.4 Invoice Detail NDC Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter a comment.

6.23.5 Invoice Detail NDC Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 Invoice Detail NDC Comment Panel Accessibility

6.23.6.1 To Access the Invoice Detail NDC Comments Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by labeler or NDC search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Invoice by Labeler Search results display.
5	Click on a record from search results.	Invoice Information and Maintenance panels display.
6	Click on **Detail** from the Invoice Maintenance panel.	List of invoice areas to view or modify are displayed.
7	Click on Invoice Detail.	Invoice Detail panel displays.
8	Click on a record from search results.	Invoice Detail Maintenance panel displays.
9	Click on NDC Comment.	NDC Comment panel displays.

6.24 Payment CCN Panel Overview

6.24.1 Payment CCN Panel Narrative

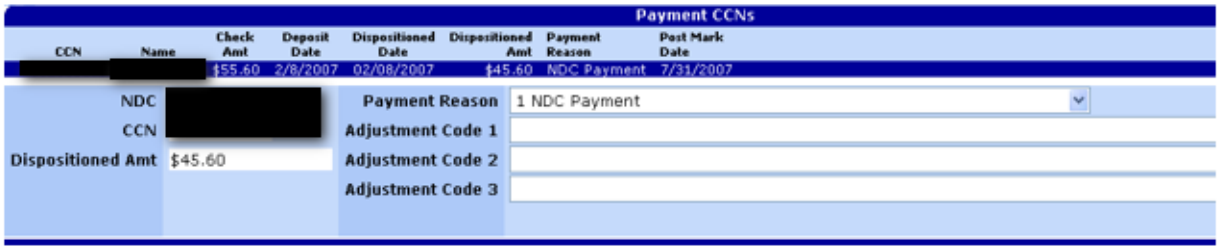
The Payment CCN panel allows the user to disposition payments to an invoice detail. Multiple checks can be applied to an invoice. The panel displays the CCN, check amount, postmark date of the check, amount dispositioned and the payment reason code.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path via Invoice function: [Drug] - [Invoice Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Invoice] - [Detail] - [Invoice Detail] - (Select one detail records) - (Select [Payment CCN] in [Invoice Maintenance])

Navigation Path via Payment function: [Drug] – [Payment] - [CCN mini search - enter CCN and click on search] - [Invoice Payment Header - select row from list - click on Detail Disposition button] - [Invoice Detail - select row from list] - [click on Payment CCNs button]

6.24.2 Payment CCN Panel Layout



6.24.3 Payment CCN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Code 1	Type of adjustment made to an invoice detail such as rate change, utilization change and dispute resolution.	Combo Box	Drop Down List Box	0
Adjustment Code 2	Type of adjustment made to an invoice detail such as rate change, utilization change and dispute resolution.	Combo Box	Drop Down List Box	0
Adjustment Code 3	Type of adjustment made to an invoice detail such as rate change, utilization change and dispute resolution.	Combo Box	Drop Down List Box	0
CCN	Cash control number (CCN) associated with the cash receipt received for this accounts receivable disposition.	Field	Number (Integer)	11
Check Amt	Dollar amount of the check for an invoice sent by a drug labeler.	Field	Number (Decimal)	11
Deposit Date	Date the payment was posted to a drug rebate invoice.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
Dispositioned Amt	Amount of money that has been dispositioned to the National Drug Code (NDC) detail for this invoice from this cash control number.	Field	Number (Decimal)	11
Dispositioned Date	Date the check was dispositioned in production.	Field	Date (MM/DD/CCYY)	8
Name	Name of the labeler for whom money from the check was allocated.	Field	Character	39
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
Payment Reason	Description of the payment dispositioned to the invoice detail.	Combo Box	Drop Down List Box	0
Post Mark Date	Evidence, indicated by the postmark of the United States Postal Service or other common mail carrier, on the envelope (not the postage meter stamp) of the date the check mailed.	Field	Date (MM/DD/CCYY)	8

6.24.4 Payment CCN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.24.5 Payment CCN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Payment CCN Panel Accessibility

6.24.6.1 To Access the Payment CCN Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment Search panel displays.
3	Enter **CCN**.	
4	Click **Search**.	Payment CCN panel displays.

6.25 Payment Prior Period Adjustment (PPA) Panel Overview

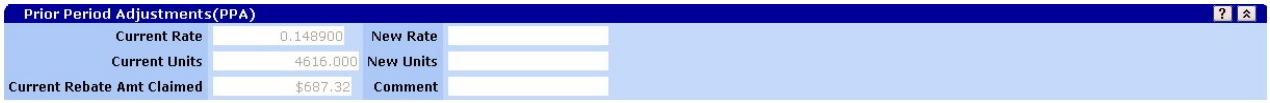
6.25.1 Payment Prior Period Adjustment (PPA) Panel Narrative

The Payment Prior Period Adjustment (PPA) panel allows the user to retrieve or modify a rate or a utilization amount to an invoice detail/NDC. The panel is used when a labeler identifies a rebate amount per unit change or a utilization change for a specific NDC in an invoice quarter. It retrieves the most current rebate amount per unit and utilization amount for the invoice detail. The user has the ability to change the current rebate amount per unit and/or the utilization amount and/or add a comment.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [Invoice Payment Header] - (Select row from list) - (Click on [Detail Disposition] button on [Invoice Payment Header] panel) - (Select a row from [Invoice Detail]) - (Click on [Prior Period Adj] button)

6.25.2 Payment Prior Period Adjustment (PPA) Panel Layout



6.25.3 Payment Prior Period Adjustment (PPA) Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Comment	Comments on adjustments.	Field	Character	20
Current Rate	Current dollar amount per unit.	Field	Number (Decimal)	11
Current Rebate Amt Claimed	Current dollar amount invoiced for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Current Units	Current number of units invoiced.	Field	Number (Decimal)	13
New Rate	New dollar amount per unit.	Field	Number (Decimal)	11
New Units	New number of units invoiced.	Field	Number (Decimal	13

6.25.4 Payment Prior Period Adjustment (PPA) Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
New Rate	Field	91029	Enter a valid value.	Enter a numeric value.
	Field	91077	Rebate Unit Amount must be less than or equal to 99999.999999.	Re-enter a rate less than 100,000.00.
	Field	91115	Rebate Unit Amount must be greater than or equal to 0.000000.	Re-enter a rate greater than or equal to zero.
New Units	Field	91029	Enter a valid value.	Enter a numeric value.

Field	Field Type	Error Code	Error Message	To Correct
	Field	91077	Total Units Reimbursement Quantity must be less than or equal to 9999999999.999.	Re-enter a total less than 10,000,000,000.000.
	Field	91115	Total Unit Reimbursement Quantity must be greater than or equal to 0.000.	Re-enter a total greater than or equal to zero.

6.25.5 Payment Prior Period Adjustment (PPA) Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Payment Prior Period Adjustment (PPA) Panel Accessibility

6.25.6.1 To Access the Payment Prior Period Adjustment (PPA) Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search**.	Invoice by labeler or NDC search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Results of search displays.
4	Click on an Invoice Detail Record.	
5	Click on Invoice Maintenance.	Invoice Maintenance panel displays.
6	Select a row from **Invoice Detail**.	Detail record list displays.
7	Select Prior Period Adjustment (PPA).	Payment Prior Period Adjustment (PPA) panel displays.

6.26 Invoice Detail Related Claim Panel Overview

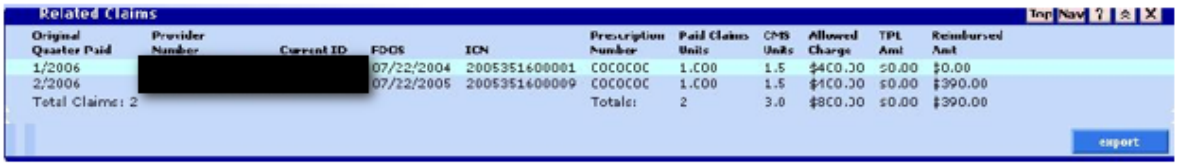
6.26.1 Invoice Detail Related Claim Panel Narrative

The Invoice Detail Related Claim panel shows the Related Claims History for the selected invoice detail. Once a valid invoice is displayed, the user has the option to view all invoice details from the invoice detail panel. After selecting an invoice detail and clicking the Related Claims link from the navigation page, this panel is displayed.

This panel is for inquiry only.

Navigation Path: [Drug] - [Invoice Search] - (Enter 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Invoice Maintenance] - [Detail] - [Invoice Detail] - (Select one detail record) - (Select [Related Claims] in [Invoice Maintenance])

6.26.2 Invoice Detail Related Claim Panel Layout



6.26.3 Invoice Detail Related Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allowed Charge	Displays the maximum amount allowed for reimbursement to the pharmacy.	Field	Number (Decimal)	11
CMS Units	Displays the Centers for Medicare and Medicaid Services (CMS) calculated field.	Field	Number (Integer)	10
Current ID	Displays the unique identifier for the recipient.	Field	Character	12
Export	Allows the user to export all related claims information to an external file.	Button	N/A	0
FDOS	Displays the date on which the drug was dispensed.	Field	Date (MM/DD/CCYY)	8
ICN	Displays the transaction control number for the claim.	Field	Number (Integer)	13
Original Quarter Paid	Displays the date in QCCYY format where Q indicates the quarter when the claims billed on the invoice were paid.	Field	Number (Q/CCYY)	5

Field	Description	Field Type	Data Type	Length
Paid Claims Units	Displays the total units dispensed for a National Drug Code (NDC) for a given quarter.	Field	Number (Integer)	13
Prescription Number	Displays the prescription number for the drug dispensed.	Field	Number (Integer)	7
Provider Number	Displays the unique identifier for the provider.	Field	Number (Integer)	15
Reimbursed Amt	Displays the total dollar reimbursed to providers for a specific claim.	Field	Number (Decimal)	11
TPL Amt	Displays the amount of Third Party Liability (TPL) received.	Field	Number (Decimal)	11
Total	Includes Totals for the following columns: Paid Claims Units, CMS Units, Allowed Charge, TPL Amt and Reimbursed Amt.	Field	Number (Decimal)	13

6.26.4 Invoice Detail Related Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.26.5 Invoice Detail Related Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Invoice Detail Related Claim Panel Accessibility

6.26.6.1 To Access the Invoice Detail Related Claim Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Invoice Search.**	Invoice by Labeler Search panel displays.
3	Enter a Labeler Code; Click Search.	Results of search displays.
4	Click on a record from the Search Results.	Invoice Information, Invoice Maintenance, and Invoice Detail panels display
5	Click on **Invoice Detail** panel.	Invoice Detail Related Claim panel displays.

6.26.6.2 To Navigate the Invoice Detail Related Claim Panel

Step	Action	Response
1	Select the row to be viewed	The Invoice Detail information is displayed.
2	Select the type of Invoice Detail to be viewed (All, Outstanding, Written Off or In Dispute); Click **Search**.	The specified Invoice Detail information is displayed.

6.27 Drug Rebate Labeler Search Panel Overview

6.27.1 Drug Rebate Labeler Search Panel Narrative

The Drug Rebate Labeler Search panel is used to search for a list of drug labelers that meet the entered search criteria. The user can search by labeler code or by labeler name. One or more characters can be entered to search for name.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Labeler Search]

6.27.2 Drug Rebate Labeler Search Panel Layout

6.27.3 Drug Rebate Labeler Search Field Panel Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add drug rebate labeler information.	Button	N/A	0
Clear	Allows the user to clear any changes on the Drug Rebate Labeler Search panel.	Button	N/A	0
Labeler Code	Five-digit code used to identify a labeler.	Field	Number (Integer)	5
Labeler Name	Name of the labeler(s).	Field	Character	39
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Labeler Code and/or Labeler Name.	Button	N/A	0

6.27.4 Drug Rebate Labeler Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.27.5 Drug Rebate Labeler Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Drug Rebate Labeler Search Panel Accessibility

6.27.6.1 To Access the Drug Rebate Labeler Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Labeler Search**.	Drug Rebate Labeler Search panel displays.

6.28 Drug Rebate Labeler Search Results Panel Overview

6.28.1 Drug Rebate Labeler Search Results Panel

The Drug Rebate Labeler Search Results panel is used to view a list of drug labelers that meet the entered search criteria from Drug Labeler Search panel.

This panel is display only.

Navigation Path: [Drug] - [Labeler Search] - (Click on [Search])

6.28.2 Drug Rebate Labeler Search Results Panel Layout

6.28.3 Drug Rebate Labeler Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Labeler Code	Five-digit code used to identify a labeler(s) that matched the search criteria.	Field	Number (Integer)	5
Labeler Name	Name of the labeler(s) that matched the search criteria.	Field	Character	39

6.28.4 Drug Rebate Labeler Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.28.5 Drug Rebate Labeler Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Drug Rebate Labeler Search Results Panel Accessibility

6.28.6.1 To Access the Drug Rebate Labeler Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Labeler Search**.	Labeler Search panel displays.
3	Enter Labeler Code and/or Labeler Name.	Drug Rebate Labeler Search Results panel displays.

6.29 Labeler Mini Search Panel Overview

6.29.1 Labeler Mini Search Panel Narrative

The Labeler Mini Search panel is used to search for a list of drug labelers that meet the entered search criteria. The user can search by labeler code.

This panel is for inquiry only.

Navigation Path: [Drug] - [Labeler Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results)

6.29.2 Labeler Mini Search Panel Layout

6.29.3 Labeler Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Allows the user to perform a detailed search.	Button	N/A	0
Clear	Allows the user to clear any changes on the Labeler Mini Search panel.	Button	N/A	0
Labeler Code	Five-digit code used to identify a labeler.	Field	Number (Integer)	5
Search	Initiates the Search by Labeler Code.	Button	N/A	0

6.29.4 Labeler Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.29.5 Labeler Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Labeler Mini Search Panel Accessibility

6.29.6.1 To Access the Labeler Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Labeler Search**.	Labeler search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Search results display.
5	Click on a record from search results.	Labeler Mini Search information displays.

6.30 Labeler Information Panel Overview

6.30.1 Labeler Information Panel Narrative

This panel displays labeler information for a particular labeler.

This panel is display only.

Navigation Path: [Drug] - [Labeler Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results

6.30.2 Labeler Information Panel Layout

6.30.3 Labeler Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Labeler Code	Five-digit code used to identify a labeler.	Field	Number (Integer)	5
Name	Name of the drug labeler.	Field	Character	39
Invoice Media	Media used to send Drug Labeler Invoice Information. Valid values are blank for paper and 'D' for 3 1/4 inch diskettes. Note: All invoices are always produced on paper as well as the alternate format if requested.	Field	Character	15
Collection Media	Media used to send Drug Labeler Invoice Information.	Field	Character	25
Parent Labeler	Labeler code of the parent manufacturer.	Field	Number (Integer)	5

6.30.4 Labeler Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 Labeler Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.30.6 Labeler Information Panel Accessibility

6.30.6.1 To Access the Labeler Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Labeler Search**.	Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Results of search displays.
5	Click on a record from search results.	Labeler Information panel displays.

6.31 Labeler Maintenance Panel Overview

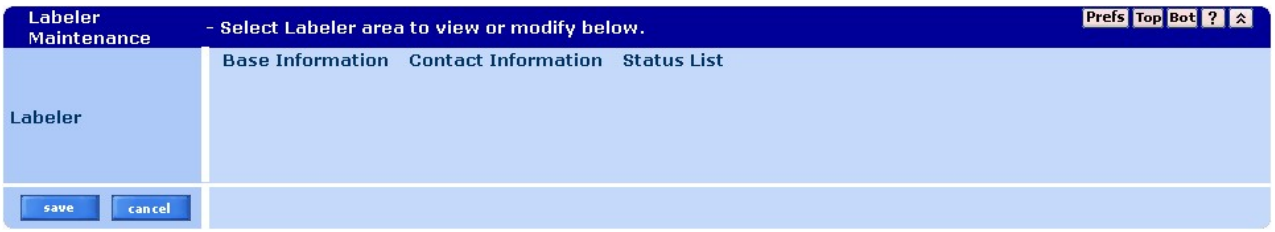
6.31.1 Labeler Maintenance Panel Narrative

The Labeler Maintenance panel is used to view and maintain labeler information.

This panel is for inquiry only.

Navigation path: [Drug] - [Labeler Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Labeler Maintenance]

6.31.2 Labeler Maintenance Panel Layout



6.31.3 Labeler Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Labeler Maintenance panel.	Button	N/A	0
Contact Information	Link to the Contact Information panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Labeler Maintenance panel.	Button	N/A	0
Status List	Link to the Status List panel.	Hyperlink	N/A	0

6.31.4 Labeler Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.31.5 Labeler Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 Labeler Maintenance Panel Accessibility

6.31.6.1 To Access the Labeler Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.

Step	Action	Response
2	Point to **Drug**; Click **Labeler Search**.	Labeler Search panel displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Results of search displays.
5	Click on a record from search results.	Labeler Maintenance panel displays.

6.32 Labeler Base Information Panel Overview

6.32.1 Labeler Base Information Panel Narrative

The Labeler Base Information panel displays basic information about the labeler that would not be found in the Contact Information panel or the Status List panel.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Labeler Search] - (Enter in 5 digit [Labeler Code] and click on [Search] - (Click on a record from search results) - [Labeler Maintenance] - [Labeler] - [Base Information]

6.32.2 Labeler Base Information Panel Layout

6.32.3 Labeler Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Collection Media	Media used to collect rebate payments.	Combo Box	Drop Down List Box	0
Invoicing Media	Media used to send Drug Labeler Invoice Information. Valid values are blank for paper and 'D' for 3 1/4 inch diskettes. Note: All invoices are always produced on paper as well as the alternate format if requested.	Combo Box	Drop Down List Box	0
Mailing Address	Indicates which address should be used for correspondence. Valid values are 'L' (legal), 'T' (technical), and 'I' (invoice). The technical address ('T') is the default mailing address.	Combo Box	Drop Down List Box	0
Labeler Code	Used to uniquely identify the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first 5 characters of the labeler's National Drug Code (NDC).	Field	Number (Integer)	5
Name	Name of the drug labeler.	Field	Character	39
Parent Labeler	Labeler code of the parent manufacturer.	Field	Number (Integer)	5

6.32.4 Labeler Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Name	Field	91080	Name is required.	Enter Name.
Parent Labeler	Field	1	Parent Labeler must be 5 character(s) in length.	Parent Labeler must be 5 character(s) in length.

6.32.5 Labeler Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 Labeler Base Information Panel Accessibility

6.32.6.1 To Access the Labeler Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Labeler Search**.	Labeler search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Search results display.
5	Click on a record from search results.	Labeler Information and Maintenance panels display.
6	Click on **Labeler**.	
7	Click on Base Information.	Labeler Base Information panel displays.

6.33 Labeler Contact Information Panel Overview

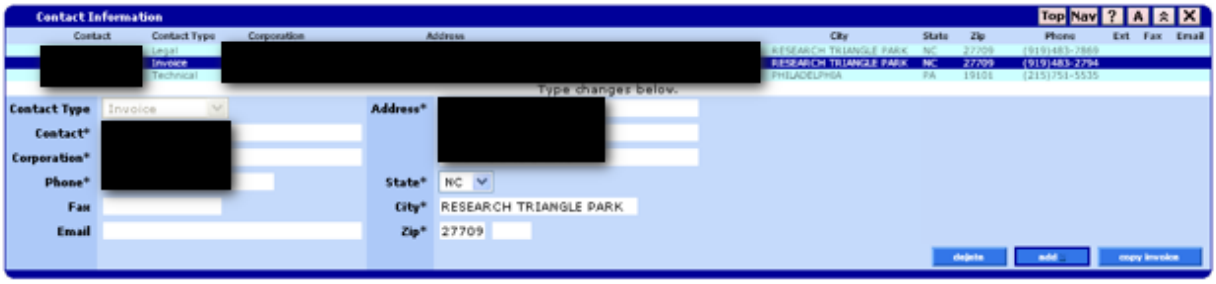
6.33.1 Labeler Contact Information Panel Narrative

The Labeler Contact Information panel is used to view contact address information by contact type. The user can create a new contact and copy the information from the invoice contact type by clicking the add button followed by the copy invoice button.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Labeler Search] - (click on [Search]) - (Click on record in Search Results) - [Labeler Maintenance] - [Contact Information]

6.33.2 Labeler Contact Information Panel Layout



6.33.3 Labeler Contact Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add labeler contact information.	Button	N/A	0
Address	Displays the address of the drug labeler contact.	Field	Character	39
City	Displays the city of the drug labeler contact.	Field	Character	27
Contact	Displays the name of the contact.	Field	Character	39
Contact Type	Displays the type of contact for the labeler. Valid values include: Legal, Invoice, Technical or Supplemental.	Combo Box	Drop Down List Box	0
Copy Invoice	Allows the user to copy invoice information.	Button	N/A	0
Corporation	Displays the corporation name of the drug labeler contact.	Field	Character	39
Delete	Allows the user to remove labeler contact information.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Email	Displays the email address of the drug labeler contact.	Field	Character	40
Fax	Displays the fax number of the drug labeler contact.	Field	Number (Integer)	10
Phone	Displays the telephone number of the drug labeler contact.	Field	Number (Integer)	10
Phone Ext	Displays the telephone extension of the drug labeler contact.	Field	Number (Integer)	5
State	Displays the state of the drug labeler contact.	Combo Box	Drop Down List Box	0
Zip	Displays the zip code of the drug labeler contact.	Field	Number (Integer)	5
Zip4	Displays the zip code plus 4 of the drug labeler contact address.	Field	Number (Integer)	4

6.33.4 Labeler Contact Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Contact Type	Combo Box	1	At least one Contact Information must be of Contact Type - Invoice.	Must have one contact information be of Contact Type – Invoice.
	Combo Box	91019	A duplicate record cannot be saved.	Select a new Contact Type.
State	Combo Box	91080	A valid State is required.	Must select a State to save contact information.
Address	Field	91080	Street1 is required.	Must enter an address to save contact information.
City	Field	91080	City is required.	Must enter a City to save contact information.
Contact	Field	91080	Contact Name is required.	Must enter a Contact name to save contact information.
Corporation	Field	91080	Corporation is required.	Must enter a Corporation to save contact information.
Fax	Field	5049	Fax must be 10 digits numeric number only.	Re-enter a 10-digit fax number.
Phone	Field	91029	Phone Number must be 10 digits numeric number only.	Re-enter a 10-digit numeric phone number.

Field	Field Type	Error Code	Error Message	To Correct
	Field	91080	Phone Number is required.	Must enter a Phone Number to save contact information.
Zip	Field	91029	Zip must be 5 character(s) in length.	Re-enter a five-digit numeric zip code.
	Field	91080	Zip is required.	Must enter a Zip Code to save contact information.

6.33.5 Labeler Contact Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 Labeler Contact Information Panel Accessibility

6.33.6.1 To Access the Labeler Contact Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Labeler Search**.	Labeler Search panel displays.
3	Enter Labeler Code; Click Search.	Labeler Maintenance panel displays.
4	Click Contact Information.	Contact Information panel displays.

6.33.6.2 To Navigate the Labeler Contact Information Panel

Step	Action	Response
1	Click to highlight the row to be viewed.	Contact information displays.

6.33.6.3 To Add on the Labeler Contact Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Contact Type.	
3	Enter Contact Name.	
4	Enter Corporation Name.	
5	Enter Contact Phone Number.	
6	Enter Fax Number.	
7	Enter Email Address.	
8	Enter Mailing Address.	
9	Select **State** from drop down list.	

Step	Action	Response
10	Enter **City**.	
11	Enter **Zip**.	
12	Click **Save**.	Contact Information is saved.

6.33.6.4 To Update the Labeler Contact Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Contact Information is updated.

6.33.6.5 To Delete on the Labeler Contact Information Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.34 Labeler Status List Panel Overview

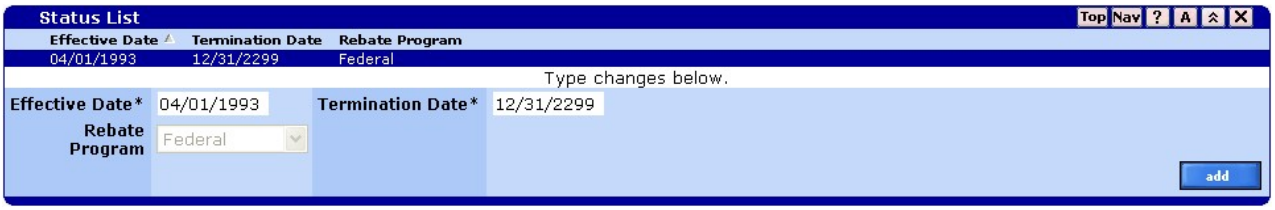
6.34.1 Labeler Status List Panel Narrative

The Labeler Status List panel is used to view and maintain the effective and end dates for a drug labeler's participation in the Drug Rebate program. The information in this panel comes from the CMS tape, and users also are able to manually enter data.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path: [Drug] - [Labeler Search] - (Click on [Search]) - (Click on a record in [Search Results]) - [Labeler Maintenance] - [Labeler] - [Status List]

6.34.2 Labeler Status List Panel Layout



6.34.3 Labeler Status List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add labeler status list information.	Button	N/A	0
Effective Date	Date participation in drug rebate program began.	Field	Date (MM/DD/CCYY)	8
Rebate Program	Type of Rebate Program. Valid values include: Federal or Supplemental.	Combo Box	Drop Down List Box	0
Termination Date	Date participation in drug rebate program ended. Defaults to 12/31/2299.	Field	Date (MM/DD/CCYY)	8

6.34.4 Labeler Status List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Rebate Program	Combo Box	1	A valid Rebate Program is required.	Choose a Rebate Program from the list.
Effective Date	Field	8033	Effective Date is required.	Must enter correct Effective Date.
	Field	8035	Date range overlaps existing segment.	Verify date and re-enter, Effective Date cannot overlap an existing date span.

Field	Field Type	Error Code	Error Message	To Correct
Termination Date	Field	2	Termination Date is required.	Must enter a date before saving.
	Field	91020	Effective Date must be less than or equal to Termination Date.	Verify date. The End Date needs to be greater than or equal to the Effective Date.

6.34.5 Labeler Status List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Labeler Status List Panel Accessibility

6.34.6.1 To Access the Labeler Status List Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Labeler Search**.	Labeler search displays.
3	Enter 5-digit labeler code.	
4	Click **Search**.	Results of search displays.
5	Click on a record from search results.	Record information displays.
6	Click on Labeler Status List.	Labeler Status List panel displays.

6.34.6.2 To Add on the Labeler Status List Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists. Termination Date defaults to 12/31/2299.
2	Enter Effective Date.	
3	Select **Rebate Program** from drop down list.	
4	Click **Save**.	Labeler Status information is saved.

6.35 Payment Mini Search Panel Overview

6.35.1 Payment Mini Search Panel Narrative

The Payment Mini Search panel is used as a Drug Rebate search functionality to view invoice information for a specific CCN. Upon searching a CCN, the Payment Information panel is displayed.

This panel is for inquiry only.

Navigation Path: [Drug] – [Payment]

6.35.2 Payment Mini Search Panel Layout

6.35.3 Payment Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	This number is entered into the system for matching the internal record with its paper copy.	Field	Number (Integer)	11
Clear	Allows the user to clear any changes on the Payment Mini Search panel.	Button	N/A	0
Search	Initiates the Search by CCN.	Button	N/A	0

6.35.4 Payment Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CCN	Field	1	CCN is required.	Enter a CCN.
	Field	91007	CCN must be numeric.	Re-enter numeric characters.
	Field	91161	This is not a valid Drug Rebate cash receipt.	Verify CCN and re-enter.
	Field	91192	This is not a Drug Rebate cash receipt.	Enter a Drug Rebate cash receipt.

6.35.5 Payment Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 Payment Mini Search Panel Accessibility

6.35.6.1 To Access the Payment Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment Mini Search panel displays.

6.36 Payment Information Panel Overview

6.36.1 Payment Information Panel Narrative

The Payment Information panel displays the check amount, postmark date, check date and the amount dispositioned to an invoice.

This panel is for inquiry only.

Navigation Path: [Drug] - [Payment] - [Enter a [CCN] and click [Search]) - [Payment Information]

6.36.2 Payment Information Panel Layout

6.36.3 Payment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Dispositioned	Field populates as the amounts are dispositioned to the line items in the Invoice Detail Disposition panel.	Field	Number (Decimal)	11
Amount Paid	Total dollar amount of the check from the labeler.	Field	Number (Decimal)	11
CCN	Indicates the control number associated with the cash receipt received for this invoice.	Field	Number (Integer)	11
Check Date	Date the check was received at the state.	Field	Date (MM/DD/CCYY)	8
Name	Name of the labeler on the check.	Field	Character	50
Postmark Date	Evidence, as indicated by the postmark of the United States Postal Service or other common mail carrier, on the envelope (not the postage meter stamp) of the date the check mailed.	Field	Date (MM/DD/CCYY)	8
Total Amount Applied	Represents the total amount applied to the labeler invoice(s).	Field	Number (Decimal)	11

6.36.4 Payment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.36.5 Payment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 Payment Information Panel Accessibility

6.36.6.1 To Access the Payment Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
4	Click on a record from search results.	Invoice Maintenance panel appears.
5	Click Payment Information.	Payment Information panel displays.

6.37 Payment Maintenance Panel Overview

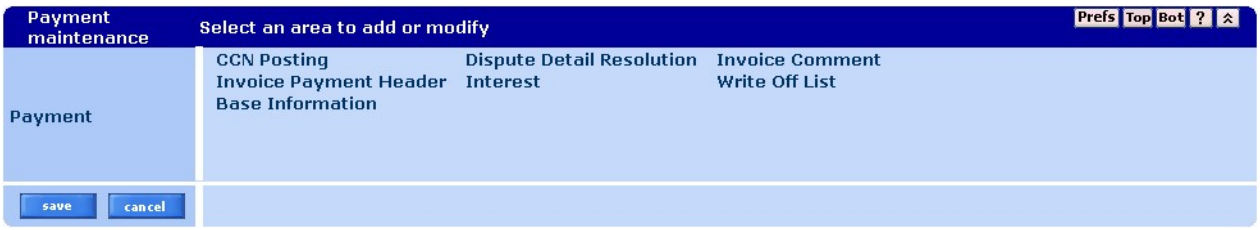
6.37.1 Payment Maintenance Panel Narrative

The Payment Maintenance panel is used to view and maintain payment information.

This panel is for inquiry only.

Navigation path: [Drug] - [Payment] - [Enter a [CCN] and click [Search]) - [Payment Maintenance]

6.37.2 Payment Maintenance Panel Layout



6.37.3 Payment Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Payment Maintenance panel.	Button	N/A	0
CCN Posting	Link to the CCN Posting panel.	Hyperlink	N/A	0
Dispute Detail Resolution	Link to the Dispute Detail Resolution panel.	Hyperlink	N/A	0
Interest	Link to the Interest panel.	Hyperlink	N/A	0
Invoice Comment	Link to the Invoice Comment panel.	Hyperlink	N/A	0
Invoice Payment Header	Link to the Invoice Payment Header panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Payment Maintenance panel.	Button	N/A	0
Write Off List	Link to the Write Off List panel.	Hyperlink	N/A	0

6.37.4 Payment Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Save	Button	1	CCN Fully Dispositioned - Changes Not Allowed.	Cannot make changes once the CCN has been posted to the Cash System - the changes made to the panels are lost.

6.37.5 Payment Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Payment Maintenance Panel Accessibility

6.37.6.1 To Access the Payment Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**.	
4	Click **Search**.	Payment Maintenance panel displays.

6.38 CCN Posting Panel Overview

6.38.1 CCN Posting Panel Narrative

The CCN Posting panel is used to track information that has been keyed in for Drug Rebate Invoice Payment.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [Enter a [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [CCN Posting]

6.38.2 CCN Posting Panel Layout

6.38.3 CCN Posting Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash control number that uniquely identifies the check.	Field	Number (Integer)	11
Check Amount	Amount of the check.	Field	Number (Decimal)	11
Date Posted to Drug Rebate	Date that the cash control number (CCN) was posted in Financial.	Field	Date (MM/DD/CCYY)	8
Dispositioned Amount	Rebate amount dispositioned to the National Drug Code (NDC) level and the interest amount dispositioned to the invoice level from this cash control number (CCN).	Field	Number (Decimal)	11
Post	Allows the user to post a cash control number (CCN).	Button	N/A	0
Remitter Name	Name of entity that submitted the payment.	Field	Character	50

6.38.4 CCN Posting Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Dispositioned Amount	Field	1	Dispositioned amount does not equal check amount for CCN.	Enter valid Dispositioned amount.
	Field	2	Negative amounts cannot be posted to Financial.	Enter valid dispositioned amount.

6.38.5 CCN Posting Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.38.6 CCN Posting Panel Accessibility

6.38.6.1 To Access the CCN Posting Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
4	Click on a record from search results.	Payment Maintenance panel appears.
5	Click CCN Posting.	CCN Posting panel displays.

6.39 Payment Dispute Detail Resolution Panel Overview

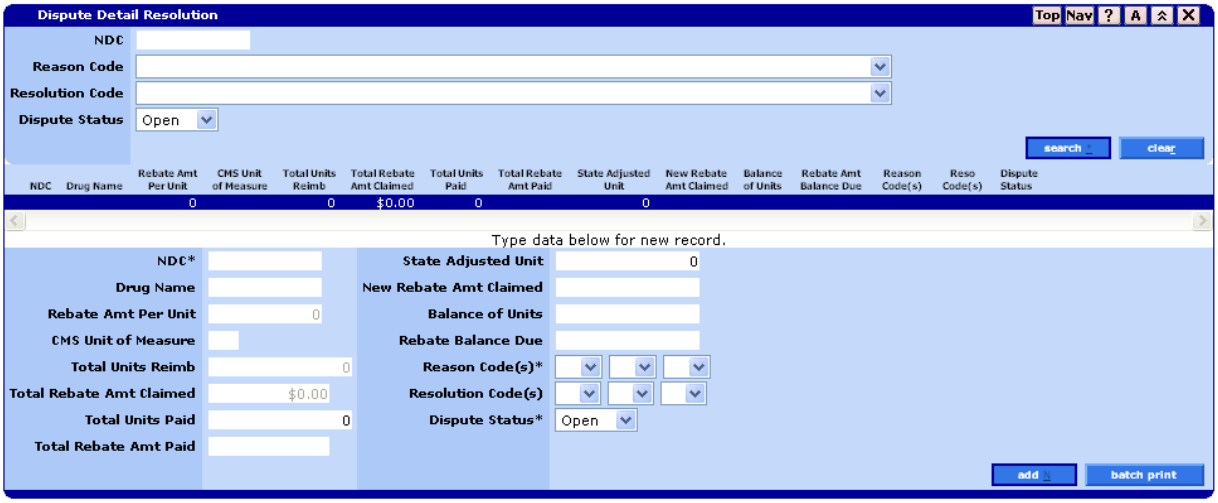
6.39.1 Payment Dispute Detail Resolution Panel Narrative

The Payment Dispute Detail Resolution panel allows users to enter or inquire on Dispute Detail information. The user may enter dispute information when a payment is received. If the labeler identifies disputes through written correspondence or pays $0 on all or a portion of details, the user keys the dispute information into this panel. This panel searches on disputed line item/NDC disputes based upon the search criteria.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path from Payment Maintenance: [Drug] - [Payment] - [Enter CCN and click on Search] - [Payment Maintenance] - [Invoice Payment Header] - [select row from Invoice Payment Header] - [Payment Maintenance] - [Payment] - [Dispute Detail Resolution]

6.39.2 Payment Dispute Detail Resolution Panel Layout



6.39.3 Payment Dispute Detail Resolution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add dispute detail resolution information.	Button	N/A	0
Balance of Units	Displays the number of units due from a labeler for a specific National Drug Code (NDC) drug rebate claim.	Field	Number (Decimal)	14
Batch Print	Allows the user to send disputes to the printer.	Button	N/A	0
Clear	Allows the user to clear any changes on the Dispute Detail Resolution panel.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
CMS Unit of Measure	Basic measurement that represents the smallest unit by which the drug is measured. The rebate amount is calculated per unit.	Field	Character	3
Dispute Status	Identifies the status of the dispute. Valid values include: Open or Closed.	Combo Box	Drop Down List Box	0
Drug Name	Displays the drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Medicaid programs.	Field	Character	10
NDC	Represents the National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
New Rebate Amt Claimed	Displays the new calculated rebate amount due from the manufacturer.	Field	Number (Decimal)	14
Reason Code + Reason Code Description	Represents the labeler explanation of the disputes for a specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Reason Code 1	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 2	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Reason Code 3	Indicates a reason code for the dispute.	Combo Box	Drop Down List Box	0
Rebate Amt Balance Due	Totals re-calculated amount due after subtracting any previous payment. Balance due = balance of units due multiplied by the current rebate amount per unit.	Field	Number (Decimal)	14

Field	Description	Field Type	Data Type	Length
Rebate Amt Per Unit	Indicates the rebate amount per unit supplied by Centers for Medicare and Medicaid Services (CMS) on a quarterly basis for the calculation of the drug rebate amount for each National Drug Code (NDC) in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.	Field	Number (Decimal)	11
Resolution Code + Description	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 1	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 2	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Resolution Code 3	Provides the labeler with an explanation of the resolution code for the specific National Drug Code (NDC).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by NDC, Reason Code, Resolution Code or Dispute Status.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
State Adjusted Unit	Represents the new total number of units after the state has resolved the dispute for a specific National Drug Code (NDC). This would not be an adjusted difference but the total adjusted amount. i.e., if current total units are 300, total paid are 250, and the adjusted decision is 275. 275 would be entered into this field.	Field	Number (Decimal)	14
Total Rebate Amt Claimed	Result of multiplying the "rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Paid	Result of multiplying the rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Units Paid	Indicates the number of units paid.	Field	Number (Decimal)	13
Total Units Reimb	Indicates the total units dispensed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	13

6.39.4 Payment Dispute Detail Resolution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
NDC	Field	91029	Enter a value.	Enter a valid 11 numeric character NDC.
	Field	91080	A valid NDC is required.	Enter a valid 11 numeric character NDC.
NDC [Search]	Field	91029	Enter a valid value.	Enter a valid 11 numeric character NDC.
Reason Code 1	Combo Box	1	A valid Reason Code (1) is required.	Enter a dispute reason.

Field	Field Type	Error Code	Error Message	To Correct
	Combo Box	2	Reason Code is used more than once.	Enter each code only once.
Resolution Code	Combo Box	1	Resolution Code cannot be used on open dispute.	Enter a Resolution Code only when the dispute status is closed.
	Combo Box	2	A valid Resolution Code (1) is required.	Enter a Resolution Code.
	Combo Box	3	Resolution Code is used more than once.	Enter each code only once.
State Adjusted Unit	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	State Adjusted Unit must be less than or equal to 999999999.999.	Enter an adjusted unit's amount than is less than 10,000,000,000.00.
	Field	91115	State Adjusted Unit must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.
Total Units Paid	Field	91029	Enter a valid value.	Enter a numeric amount.
	Field	91076	Total Units Paid must be less than or equal to 9999999999.999.	Enter a Total Units Paid amount that is less than 10,000,000,000.00.
	Field	91115	Total Units Paid must be greater than or equal to 0.	Re-enter amount greater than or equal to zero.

6.39.5 Payment Dispute Detail Resolution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 Payment Dispute Detail Resolution Panel Accessibility

6.39.6.1 To Access the Payment Dispute Detail Resolution Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
4	Click to select a row to be viewed.	Payment Maintenance panel displays.
5	Click Dispute Detail Resolution.	Payment Dispute Detail Resolution panel displays.

6.39.6.2 To Navigate the Payment Dispute Detail Resolution Panel

Step	Action	Response
1	Enter **NDC**.	
2	Select **Reason Code** from drop down list box.	
3	Select **Resolution** from drop down list box.	
4	Select **Dispute Status** from the drop down list box.	
5	Click **Search**.	Payment Dispute Detail Resolution Search results display.

6.39.6.3 To Add on the Payment Dispute Detail Resolution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **NDC**.	
3	Enter Drug Name.	
4	Enter Rebate Amount Per Unit.	
5	Enter CMS Unit of Measure.	
6	Enter Total Units Reimbursed.	
7	Enter Total Rebate Amount Claimed.	
8	Enter Total Units Paid.	
9	Enter Total Rebate Amount Paid.	
10	Enter State Adjusted Unit.	
11	Enter New Rebate Amount Claimed.	
12	Enter Balance of Units.	
13	Enter Rebate Balance Due.	
14	Select **Reason Code** from drop down list box.	
15	Select **Resolution** from drop down list box.	
16	Select **Dispute Status** from the drop down list box.	
17	Click **Save**.	Payment Dispute Detail Resolution information is saved.

6.39.6.4 To Update the Payment Dispute Detail Resolution Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Payment Dispute Detail Resolution information is updated.

6.40 Payment Invoice Comment Panel Overview

6.40.1 Payment Invoice Comment Panel Narrative

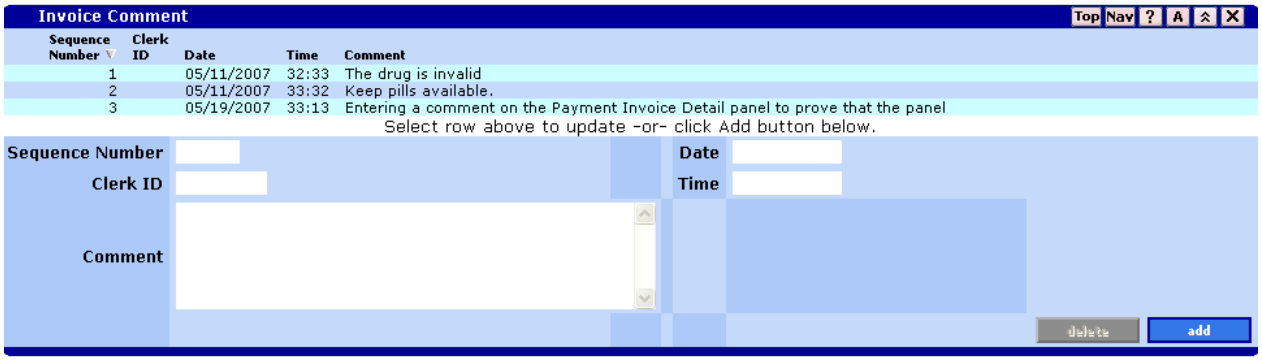
The Payment Invoice Comments panel is used to enter comments relating to a specific invoice. All notes pertaining to verbal or written correspondence for a specific labeler and invoice period are entered in this panel.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path from Payment function: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - (Click on a row from [Search Results]) - [Payment Maintenance] - [Payment] - (Click on [Invoice Payment Header]) - (Click on [Invoice Comment])

Navigation Path from Invoice function: [Drug] - [Invoice Search] - (Enter [Labeler Code] and click [Search]) - (Click on a row from [Search Results] - [Invoice Maintenance] - [Invoice Comment]

6.40.2 Payment Invoice Comment Panel Layout



6.40.3 Payment Invoice Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add payment invoice comment information.	Button	N/A	0
Clerk ID	Identification number of the user that added the comment.	Field	Character	8
Comment	Allows the user to enter comments about the invoice, payment or dispute.	Field	Character	250
Date	Date on which a particular comment was added.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove payment invoice comment information.	Button	N/A	0
Sequence Number	Sequence of comments created.	Field	Number (Integer)	4
Time	Time the comment was added.	Field	Number (Integer)	8

6.40.4 Payment Invoice Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	91080	Comment is required after clicking add.	Enter text before saving.

6.40.5 Payment Invoice Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 Payment Invoice Comment Panel Accessibility

6.40.6.1 To Access the Payment Invoice Comment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
4	Click on a record from search results.	Invoice Maintenance field appears.
5	Click Invoice Comment.	The Invoice Comment Panel displays.
6	Click on Invoice Payment Header.	Payment Invoice Comment panel displays.

6.40.6.2 Add on the Payment Invoice Comment Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Invoice Comment.	
3	Click **Save**.	Payment Invoice Comment is saved.

6.41 Invoice Payment Header Panel Overview

6.41.1 Invoice Payment Header Panel Narrative

The Invoice Payment Header panel allows the user to associate specific payment amounts on a check to the appropriate Drug Rebate invoice. A check may be associated to multiple invoices. The panel displays the check amount, check date and the amount dispositioned to the check. If the user enters labeler code or invoice period incorrectly, the information can be deleted (if the payment application has no dollars dispositioned to the invoice application). When the first payment is applied, the system requires the postmark date to be entered. The postmark date is a required field on the Base Information panel and would need to be entered prior to saving the payment.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [(Enter a CCN) - [(Click on [Search])] - [Invoice Payment Header]

6.41.2 Invoice Payment Header Panel Layout

6.41.3 Invoice Payment Header Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add invoice payment header information.	Button	N/A	0
Applied Amount Remaining	Applied Amount Remaining.	Field	Number (Decimal)	11
Applied Amt	Indicates the dollar amount (negative or positive) that has been applied to each labeler invoice(s). This amount represents all or a portion of the check amount applied to the labeler invoice(s). Dollar amount may be applied to invoice without dispositioning any or all of the cash to an invoice detail.	Field	Number (Decimal)	11
Delete	Allows the user to delete invoice payment header information.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Detail Disposition	Allows the user to create an invoice detail disposition.	Button	N/A	0
Interest Amount Dispositioned	Total amount of interest dispositioned from the applied amount for specified Labeler and invoice quarter. Note: The Interest Amount and Rebate Amount should equal the total applied amount.	Field	Number (Decimal)	11
Invoice Quarter	Identifies the invoice quarter.	Field	Date (Q/CCYY)	5
Invoice Type	Represents the description of the type of the invoice. Valid values include Federal or Supplemental.	Combo Box	Drop Down List Box	0
Labeler Code	Code used to identify the labeler invoiced.	Field	Number (Integer)	5
Labeler Name	Name of the drug labeler (manufacturer).	Field	Character	50
Rebate Amt Dispositioned	The total rebate amount dispositioned from the applied amount. Note: The Rebate Amount and Interest Amount should equal the total applied amount.	Field	Number (Decimal)	11
Status	Status of the Payment Header. Valid values include Open and Closed.	Field	Character	50

6.41.4 Invoice Payment Header Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Labeler Code	Field	1	A valid Invoice is required.	A valid invoice must exist in the database.

6.41.5 Invoice Payment Header Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 Invoice Payment Header Panel Accessibility

6.41.6.1 To Access the Invoice Payment Header Panel

Step	Action	Response
1	Enter User Name and Password;	Main Menu page displays.

Step	Action	Response
	Click Login.	
2	Point to **Drug**; Click **Payment**.	Payment panel appears.
3	Enter a **CCN**.	
4	Click **Search**.	Payment Information and Maintenance panels display.
5	Click on Invoice Payment Header.	Invoice Payment Header panel displays.

6.42 Payment Invoice Detail Panel Overview

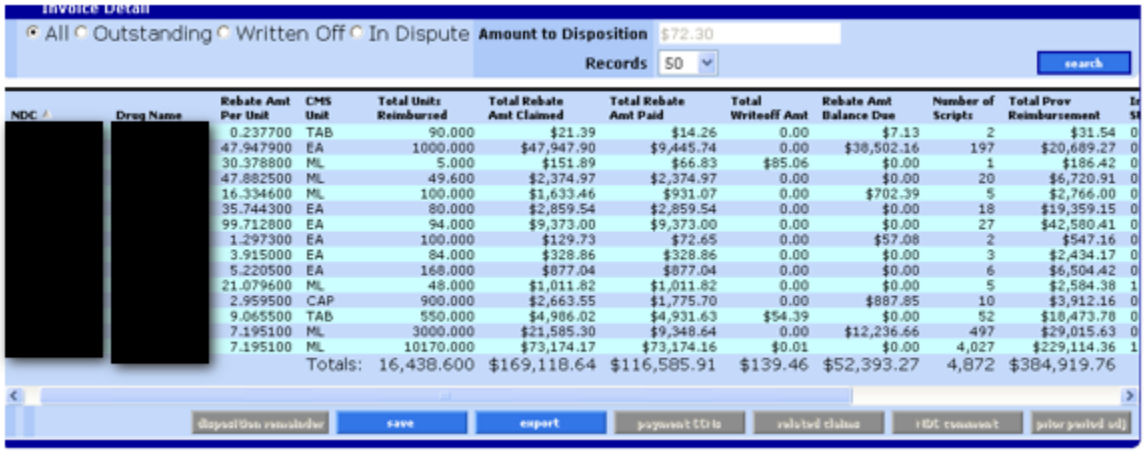
6.42.1 Payment Invoice Detail Panel Narrative

The Payment Invoice Detail panel allows the user to view the most current invoice detail information at a NDC level for a specific invoice period. This panel allows user to perform functions such as NDC comments, payment CCN, Prior Period Adjustment, Related Claims review or move money from one line item to another line item. The disposition remainder function applies the check amount to all of the details after the user makes any changes. This panel is located in the Payment group on the Payment Maintenance Page.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [Invoice Payment Header] - (Click on [Detail Disposition] on [Invoice Payment Header] panel)

6.42.2 Payment Invoice Detail Panel Layout



NDC	Drug Name	Rebate Amt Per Unit	CMS Unit	Total Units Reimbursed	Total Rebate Amt Claimed	Total Rebate Amt Paid	Total Writeoff Amt	Rebate Amt Balance Due	Number of Scripts	Total Prov Reimbursement	In St
[redacted]	[redacted]	0.237700	TAB	90.000	$21.39	$14.26	0.00	$7.13	2	$31.54	0
		47.947900	EA	1000.000	$47,947.90	$9,445.74	0.00	$38,502.16	197	$20,689.27	0
		30.378800	ML	5.000	$151.89	$66.83	$85.06	$0.00	1	$186.42	0
		47.882500	ML	49.600	$2,374.97	$2,374.97	0.00	$0.00	20	$6,720.91	0
		16.334600	ML	100.000	$1,633.46	$931.07	0.00	$702.39	5	$2,766.00	0
		35.744300	EA	80.000	$2,859.54	$2,859.54	0.00	$0.00	18	$19,359.15	0
		99.712800	EA	94.000	$9,373.00	$9,373.00	0.00	$0.00	27	$42,580.41	0
		1.297300	EA	100.000	$129.73	$72.65	0.00	$57.08	2	$547.16	0
		3.915000	EA	84.000	$328.86	$328.86	0.00	$0.00	3	$2,434.17	0
		5.220500	EA	168.000	$877.04	$877.04	0.00	$0.00	6	$6,504.42	0
		21.079600	ML	48.000	$1,011.82	$1,011.82	0.00	$0.00	5	$2,584.38	1
		2.959500	CAP	900.000	$2,663.55	$1,775.70	0.00	$887.85	10	$3,912.16	0
		9.065500	TAB	550.000	$4,986.02	$4,931.63	$54.39	$0.00	52	$18,473.78	0
		7.195100	ML	3000.000	$21,585.30	$9,348.64	0.00	$12,236.66	497	$29,015.63	0
		7.195100	ML	10170.000	$73,174.17	$73,174.16	$0.01	$0.00	4,027	$229,114.36	1
			Totals:	16,438.600	$169,118.64	$116,585.91	$139.46	$52,393.27	4,872	$384,919.76	

6.42.3 Payment Invoice Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All	Radio button used to select invoice detail information on National Drug Codes (NDC) that are outstanding, written off or in dispute.	Combo Box	Radio Button	0
Amount to Disposition	The remaining dollar amount left to disposition.	Field	Number (Decimal)	11
CMS Unit	Basic measurement that represents the smallest unit by which the drug is measured. The rebate amount is calculated per unit.	Field	Character	3
Disposition Remainder	Allows the user to apply the check amount to the details.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Drug Name	Drug description found on the Centers for Medicare and Medicaid (CMS) database provided to all state Medicaid programs.	Field	Character	20
Export	Allows the user to export all the invoice details into an external file.	Button	N/A	0
In Dispute	Radio button used to select invoice detail information on National Drug Codes (NDC) that are in dispute.	Combo Box	Radio Button	N/A
Invoice Dtl Information	Identifies if a correction has been made to the National Drug Code's (NDC) rebate information for a given quarter. Values are "0" (Original Invoice), "1" (In Dispute), and "2" (Written Off).	Field	Character	1
Invoice Status	Used to identify the status of an invoice detail. Values are "0" (Original Invoice), and "1" (Adjusted).	Field	Character	1
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and the two-digit package size code.	Field	Number (Integer)	11
NDC Comment	Opens the NDC Comment panel.	Button	N/A	0
Number of Scripts	Total number of prescriptions for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	6
Outstanding	Radio button used to select invoice detail information on an National Drug Code (NDC) that is outstanding for a period of time.	Combo Box	Radio Button	0
Payment CCNs	Opens the Payment CCNs panel.	Button	N/A	0
Prior Period Adj	Opens the Prior Period Adjustment panel.	Button	N/A	0
Rebate Amt Balance Due	The balance due on a rebate amount.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Rebate Amt Per Unit	Current rebate amount per unit billed to the labeler for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Related Claims	Opens the Related Claims panel.	Button	N/A	0
Save	Allows the user to save a record on the Payment Invoice Detail panel.	Button	N/A	0
Search	Initiates the search by All, Written Off or In Dispute.	Button	N/A	0
Total Prov Reimbursement	Total dollars reimbursed to providers for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Amt Claimed	Current dollar amount invoiced for a specific National Drug Code (NDC).	Field	Number (Decimal)	11
Total Rebate Amt Paid	Total dollars paid by a labeler for a given National Drug Code (NDC).	Field	Number (Decimal)	11
Total Units Reimbursed	The number of units invoiced for a specific invoice period to a labeler for a National Drug Code (NDC).	Field	Number (Decimal)	13
Total Write-Off Amt	Total Write Off dollars by a labeler for a given National Drug Code (NDC).	Field	Number (Decimal)	11
Write-Off Date	Date the invoice detail was written off.	Field	Date (CCYYMMDD)	8
Write-Off Reason	Description why a drug rebate detail was written off.	Field	Character	50
Written Off	Radio button used to select invoice detail information on National Drug Codes (NDC) that are written off.	Combo Box	Radio Button	0
Footer Total of Total Rebate Amt Paid	This is the total of all the values that appear under the column Total Rebate Amt paid. This final total will appear on the footer	Field	Number (Decimal)	15

Field	Description	Field Type	Data Type	Length
Footer Total of Total Units Reimbursed	This is the total of all the values that appear under the column Total Units Reimbursed. This final total will appear on the footer	Field	Number (Decimal)	15
Footer total of Number of scripts	This is the total of all the values that appear under the column number of scripts.	Field	Number (Integer)	15
Footer total of Rebate Amt Balance Due	This is the total of all the values that appear under the column Rebate Amt Balance Due.	Field	Number (Decimal)	15
Footer total of Total Prov Reimbursement	This is the total of all the values that appear under the column Total Prov Reimbursement. This final total will appear on the footer	Field	Number (Decimal)	15
Footer total of Total Rebate Amt Claimed	This is the total of all the values that appear under the column Total Rebate Amt Claimed. This final total will appear on the footer	Field	Number (Decimal)	15
Footer total of Total Writeoff Amt	This is the total of all the values that appear under the column Total Writeoff Amt. This final total will appear on the footer	Field	Number (Decimal)	15

6.42.4 Payment Invoice Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.42.5 Payment Invoice Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 Payment Invoice Detail Panel Accessibility

6.42.6.1 To Access the Payment Invoice Detail Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.

Step	Action	Response
4	Click Invoice Payment Header.	The Invoice Payment Panel displays.
5	Click on Detail Disposition.	Payment Invoice Detail panel displays.

6.43 Payment Related Claims Panel Overview

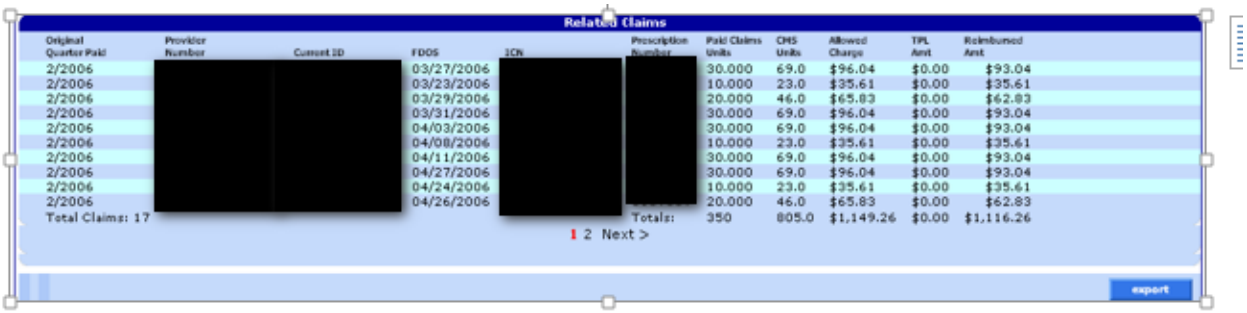
6.43.1 Payment Related Claims Panel Narrative

The Payment Related Data Claims panel is used to view all claims related to an NDC for a specific invoice cycle or that were paid in a specified quarter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [Invoice Payment Header] - (Select row from list) - (Click on [Detail Disposition] button on [Invoice Payment Header] panel) - (Select a row from [Invoice Detail]) - (Click on [Related Claims] button)

6.43.2 Payment Related Claims Panel Layout



6.43.3 Payment Related Claims Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allowed Charge	Maximum amount allowed for reimbursement for the pharmacy.	Field	Number (Decimal)	11
Allowed Charge (Total line)	Total of the Allowed Charge column.	Field	Number (Decimal)	11
CMS Units	Number of units stated in the unit of measure (UOM) provided by Centers for Medicare and Medicaid Services (CMS) to be used in the calculation of the rebate amount due. If the CMS UOM and paid claims UOM are different, the CMS units will be the number of converted units.	Field	Number (Decimal)	11
CMS Units (Total line)	Total of the Centers for Medicare and Medicaid Services (CMS) Units column.	Field	Number (Decimal)	11
Current ID	Identification number of the beneficiary for whom the claim was filed.	Field	Character	12
Export	Exports all the related claim details	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	into an external file.			
FDOS	From Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8
ICN	Internal control number for the claim.	Field	Number (Integer)	13
Original Quarter Paid	Original year and quarter in which the claim was paid.	Field	Date (Q/CCYY)	5
Paid Claims Units	Number of units for which the pharmacy was reimbursed.	Field	Number (Integer)	11
Paid Claims Units (Total line)	Total number of units for which the pharmacy was reimbursed.	Field	Number (Integer)	11
Prescription Number	Prescription number assigned to the treatment.	Field	Number (Integer)	7
Provider ID Type	Provider's identification type.	Field	Character	3
Provider Number	Displays the unique identifier for the provider.	Field	Number (Integer)	10
Reimbursed Amt	Amount reimbursed to the pharmacy for the claim.	Field	Number (Decimal)	11
Reimbursed Amt (Total line)	Total of the Reimbursed Amt column.	Field	Number (Decimal)	11
TPL Amt	Amount reimbursed to the Third Party Liability (TPL) for the claim.	Field	Number (Decimal)	11
TPL Amt (Total line)	Total of the Third Party Liability (TPL) Amount column.	Field	Number (Decimal)	11

6.43.4 Payment Related Claims Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.43.5 Payment Related Claims Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Payment Related Claims Panel Accessibility

6.43.6.1 To Access the Payment Related Claims Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
4	Click Invoice Payment Header.	The Invoice Payment Panel displays.
5	Select row from list.	Detailed information displays.
6	Click on Detail Disposition.	Invoice Detail panel displays.
7	Select a row from **Invoice Detail**.	
8	Click **Related Claims** button.	Payment Related Claims panel displays.

6.44 Payment Invoice Detail Comment Panel Overview

6.44.1 Payment Invoice Detail Comments Panel Narrative

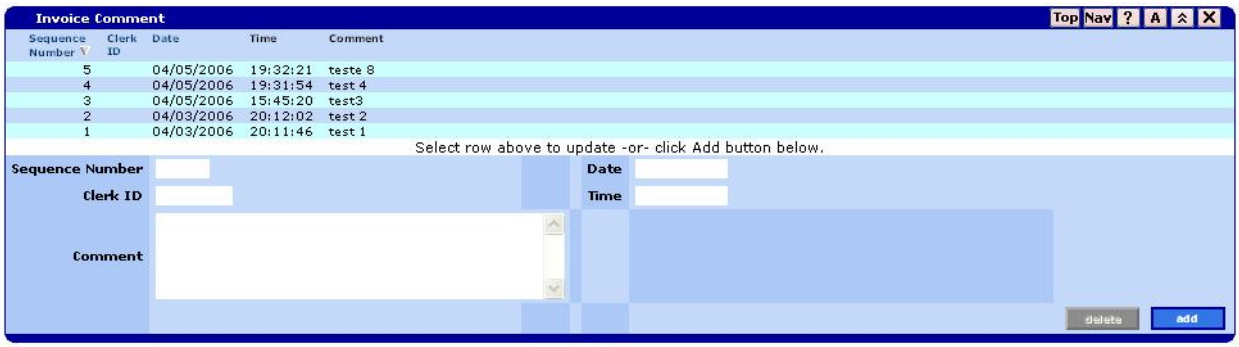
The Payment Invoice Detail Comment panel is used by the analyst to enter comments relating to a specific invoice detail. All notes pertaining to verbal or written correspondence for a specific invoice detail are entered in this panel.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path from Payment function: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - (Click on a row from [Search Results]) - [Payment Maintenance] - [Payment] - (Click on [Invoice Payment Header]) - (Click on [Invoice Comment])

Navigation Path from Invoice function: [Drug] - [Invoice Search] - (Enter [Labeler Code] and click [Search]) - (Click on a row from [Search Results] - [Invoice Maintenance] - [Invoice Comment].

6.44.2 Payment Invoice Detail Comment Panel Layout



6.44.3 Payment Invoice Detail Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clerk ID	Identification number of the user that added the comment.	Field	Character	8
Comment	Allows the user to enter comments about the invoice, payment or dispute.	Field	Character	250
Date	Date on which a particular comment was added.	Field	Date (MM/DD/CCYY)	8
Sequence Number	Sequence of comments created.	Field	Number (Integer)	4
Time	Time that the comment was added.	Field	Number (Integer)	8
Add	Allows the user to add payment invoice detail comment information.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Delete	Allows the user to remove payment invoice detail comment information.	Button	N/A	0

6.44.4 Payment Invoice Detail Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter comment text.

6.44.5 Payment Invoice Detail Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.44.6 Payment Invoice Detail Comment Panel Accessibility

6.44.6.1 To Access the Payment Invoice Detail Comment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information and Payment Maintenance panels display.
4	Click Invoice Payment Header.	Invoice Payment Header panel displays.
5	Click Detail Disposition.	Invoice Detail panel displays.
6	Click Invoice Comment.	Payment Invoice Detail Comment panel displays.

6.44.6.2 Add on the Payment Invoice Detail Comment Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	Invoice Comment is saved.

6.45 Payment Interest Panel Overview

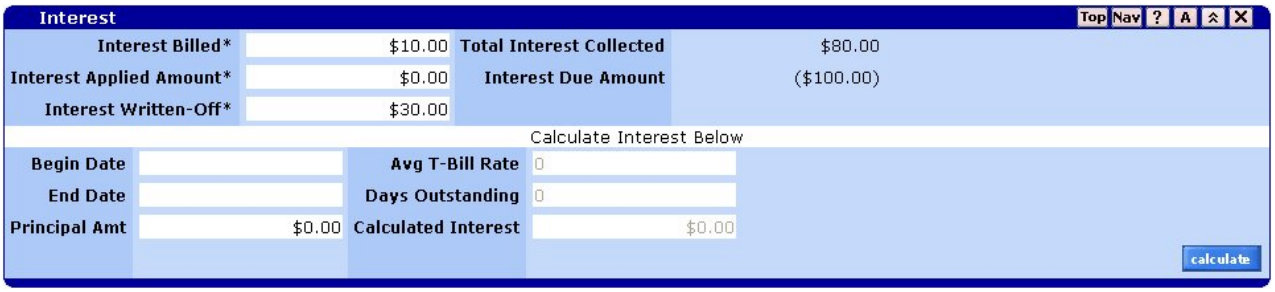
6.45.1 Payment Interest Panel Narrative

The Payment Interest panel displays interest information found on a selected invoice associated with a specific CCN. It allows updates to Interest Billed and Interest Written Off fields on the invoice record; and creates a new record on the interest table when the Interest Applied Amount field is updated.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - (Click on [Invoice Payment Header]) - (Click on [Interest])

6.45.2 Payment Interest Panel Layout



6.45.3 Payment Interest Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Avg T-Bill Rate	Displays average t-bill rate used to determine the calculated interest amount.	Field	Number (Integer)	6
Begin Date	Keyed date used as beginning of date span for interest calculation.	Field	Date (MM/DD/CCYY)	8
Calculate	Calculate interest based on user input.	Button	N/A	0
Calculated Interest	Displays the calculated interest amount.	Field	Number (Decimal)	11
Days Outstanding	Number of days used in interest calculation.	Field	Number (Integer)	5
End Date	Keyed date used as end of date span for interest calculation.	Field	Date (MM/DD/CCYY)	8
Interest Applied Amount	Creates a new Payment Interest record for each selected invoice record for a given cash control number (CCN) when a value greater than zero is entered.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Interest Billed	Displays and updates interest billed amount on selected Invoice record as currency.	Field	Number (Decimal)	11
Interest Due Amt	Displays a value calculated by taking the interest billed amount on the invoice record, and subtracting the Interest withheld amount and the sum of all applied amounts from each Interest record for the invoice associated with a given cash control number.	Field	Number (Decimal)	11
Interest Written-Off	Displays and updates the Interest Written Off amount for a selected invoice associated with a given cash control number.	Field	Number (Decimal)	11
Principal Amt	Keyed principal amount used to calculate interest.	Field	Number (Decimal)	11
Total Interest Collected	Displays sum of all interest applied amounts for each record on the Payment Interest table for each invoice record associated with the cash control number (CCN).	Field	Number (Decimal)	11

6.45.4 Payment Interest Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Date	Field	1	Begin Date is required.	Enter a value for Begin Date.
	Field	4	There is no record of t-bill rates before MM/DD/CCYY.	Verify date and re-enter.
End Date	Field	3	End Date is required.	Enter a value for End Date.
	Field	5	End Date must be greater than Begin Date.	Enter a value > Begin Date.
	Field	6	There is no record of t-bill rates after MM/DD/CCYY Therefore, the average t-bill rate displayed is based on the range MM/DD/CCYY to MM/DD/CCYY.	Warning message. Verify End Date and re-enter.

Field	Field Type	Error Code	Error Message	To Correct
Interest Applied Amount	Field	0	Disbursed Applied Amount must be less than or equal to 999999999.99.	Enter an amount <= 999999999.99.
	Field	13	Enter a valid value.	Verify input data.
Interest Billed Amount	Field	10	Interest Billed Amount must be less than or equal to 999999999.99.	Enter an amount <= 999999999.99.
	Field	11	Enter a valid value.	Verify input data.
	Field	14	Interest Billed must be greater than or equal to 0.00.	Enter an amount >= 0.00.
	Field	16	Incremental Interest Billed must be less than or equal to 999999999.99.	Enter an amount <= 999999999.99 for Interest Billed.
Interest Written-Off	Field	8	Interest Written off Amount must be less than or equal to 999999999.99.	Enter an amount <= 999999999.99.
	Field	12	Enter a valid value.	Verify input data.
	Field	15	Interest Written Off must be greater than or equal to 0.00.	Enter an amount >= 0.00.
	Field	17	Incremental Interest Written-Off must be less than or equal to 999999999.99.	Enter an amount <= 999999999.99 for Interest Written-Off field.
Principal Amt	Field	2	Principal is required.	Enter a value for Principal Amt.

6.45.5 Payment Interest Panel Extra Features

Selecting Payment Interest also brings up a Calculate Interest panel which allows the user to specify start and end dates and a principal amount to calculate an interest amount based on average Treasury bill rate.

6.45.6 Payment Interest Panel Accessibility

6.45.6.1 To Access the Payment Interest Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment search displays.
3	Enter a **CCN**; Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.

Step	Action	Response
4	Click Interest.	Payment Interest panel displays.

6.46 Payment Write Off List Panel Overview

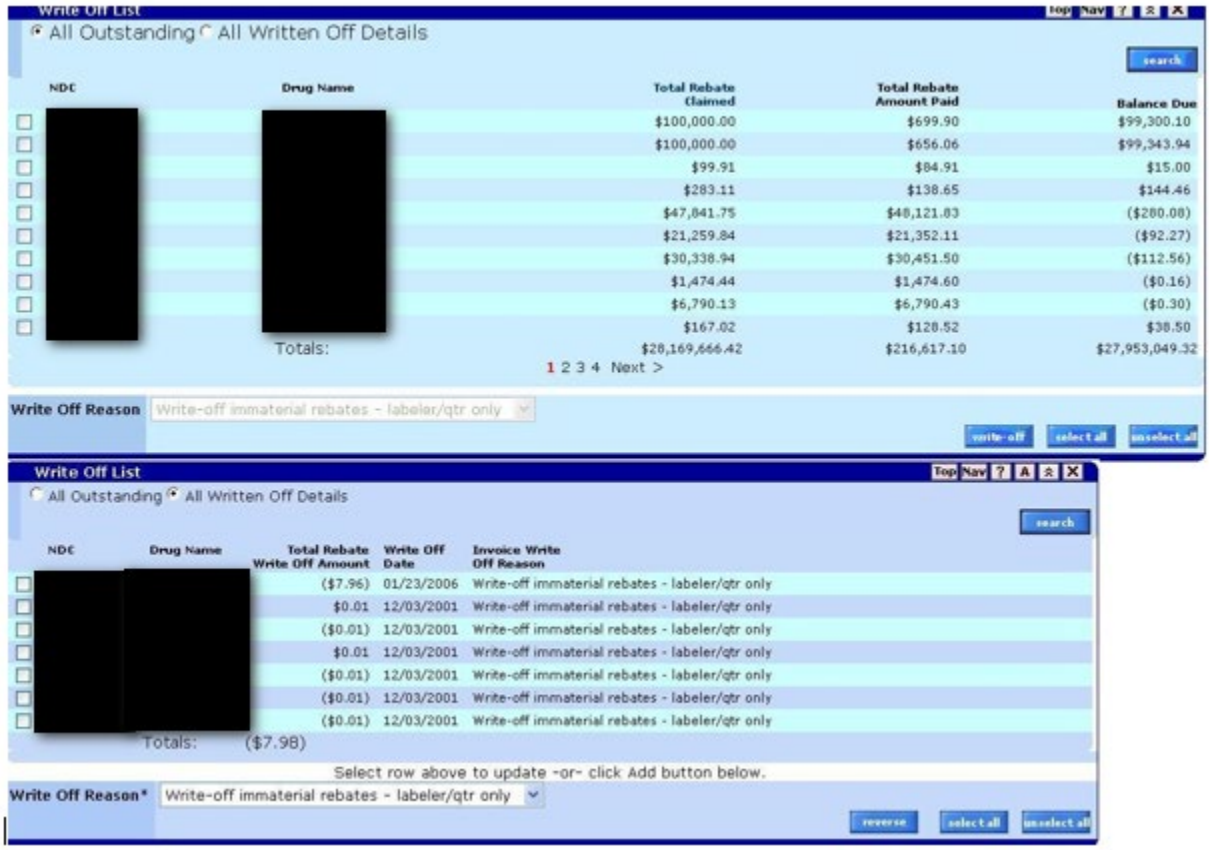
6.46.1 Payment Write Off List Panel Narrative

The Payment Write Off List panel displays quarterly drug utilization data and estimated rebate amounts owed by the manufacturer of a drug that is in the drug rebate program. The panel allows selection of specific invoice details to be written off and reversal of written off details. .

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [Invoice Payment Header] - (Select row from list) - (Click on [Detail Disposition] button on [Invoice Payment Header] panel) - (Select a row from [Invoice Detail]) - (Click on [Write off List] in [Payment Maintenance]).

6.46.2 Payment Write Off List Panel Layout



6.46.3 Payment Write Off List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All Outstanding	Radio button choice for results filter.	Combo Box	Radio Button	0

Field	Description	Field Type	Data Type	Length
All Written Off Details	Radio button choice for results filter.	Combo Box	Radio Button	0
Balance Due	Total Rebate Claim Amount – Total Rebate Paid Amount.	Field	Number (Decimal)	11
Drug Name	Name of the drug as assigned by the Food and Drug Administration (FDA) as reported to Office of Health Care Access (OHCA) by the Centers for Medicare and Medicaid Services (CMS) as part of the quarterly drug rebate information. This name is printed on the drug invoices.	Field	Character	10
Invoice Write Off Reason	A description of the cde_reason_four field.	Field	Character	50
NDC	National Drug Code is comprised of a 5-byte numeric labeler code, 4-byte numeric product code and a 2-byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and prior authorization.	Field	Number (Integer)	11
Reverse	Allows the user to reverse write off details.	Button	N/A	0
Search	Initiates the Search by Current identification number.	Button	N/A	0
Select All	Allows the user to select all records to be written off.	Button	N/A	0
Total Rebate Amount Paid	Total rebate amount paid by the drug labeler for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Claimed	Result of multiplying the rebate amount per unit by the total units reimbursed for a National Drug Code (NDC) for a given quarter/year.	Field	Number (Decimal)	11
Total Rebate Write Off Amount	The dollar amount that was written off for a specific invoice detail.	Field	Number (Decimal)	11

Field	Description	Field Type	Data Type	Length
Unselect All	Allows the user to unselect records to be written off.	Button	N/A	0
Write-Off	Allows the user to write off a selected detail.	Button	N/A	0
Write Off Date	Date the invoice detail was written off.	Field	Date (MM/DD/CCYY)	8
Write Off Reason	Reason the invoice detail was written off.	Combo Box	Drop Down List Box	0

6.46.4 Payment Write Off List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.46.5 Payment Write Off List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 Payment Write Off List Panel Accessibility

6.46.6.1 To Access the Payment Write Off List Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment Mini Search panel displays.
3	Enter **CCN**.	
4	Click **Search**.	Payment Information and Maintenance panels display.
5	Click Invoice Payment Header hyperlink.	Invoice Payment Header panel displays.
6	Select row from list.	Selected row displays detailed information.
6	Click Detail Disposition button.	Invoice Detail panel displays.
7	Click **Write Off List** hyperlink.	Write Off List panel displays.

6.46.6.2 To Navigate the Payment Write Off List Panel

Step	Action	Response
1	Select the record by clicking the checkbox.	

2	Click on **Write Off**.	Write Off List panel displays.

6.47 Payment Base Information Panel Overview

6.47.1 Payment Base Information Panel Narrative

The Payment Base Information panel contains the following fields: CCN, Check Date, Name, Postmark Date, Amount Paid, Amount Dispositioned and Total Amount Applied just as in the Payment Information panel.

Only the Postmark Date can be updated and all other fields are read only.

Navigation Path: [Drug] - [Payment] - [Enter in [CCN] and click [Search]) - [Payment Maintenance] - [Payment] - [Base Information]

6.47.2 Payment Base Information Panel Layout

6.47.3 Payment Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Dispositioned	Total amount applied plus the interest applied to the cash control number (CCN).	Field	Number (Decimal)	11
Amount Paid	Amount of the check received.	Field	Number (Decimal)	9
CCN	This number is entered into the system for matching the internal record with its paper copy.	Field	Number (Integer)	11
Check Date	Date a returned check was issued. This is date actually printed on the check.	Field	Date (MM/DD/CCYY)	8
Name	Name of the source that has submitted a check (system issued or personal) to the account.	Field	Character	50
Postmark Date	Date the payment was posted to a drug rebate invoice.	Field	Date (MM/DD/CCYY)	8
Total Amount Applied	Total up the dollar amount applied from a given cash control number applied to a drug rebate invoice for all of the Payment Headers.	Field	Number (Decimal)	11

6.47.4 Payment Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Postmark Date	Field	91080	Postmark date is required.	Enter a valid date.
	Field	91081	Invalid date.	Enter the date as MM/DD/CCYY.
	Field	91082	Save was not successful. All panels were not saved.	Enter required data in a valid format. Retry Save.

6.47.5 Payment Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.47.6 Payment Base Information Panel Accessibility

6.47.6.1 To Access the Payment Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Payment**.	Payment Mini Search page displays.
3	Enter **CCN**.	
4	Click **Search**.	Payment Information, Payment Maintenance, and Invoice Payment Header panels display.
5	Click on Base Maintenance link.	Payment Base Information panel displays.

6.48 Related Claims Search Panel Overview

6.48.1 Related Claims Search Panel Narrative

This panel is used to search all claims related to a NDC for a specific invoice cycle or that were paid in a specified quarter.

This panel is for inquiry only.

Navigation path: [Drug] - [Related Claims] - [Click on Search] - [Related Claims]

6.48.2 Related Claims Search Panel Layout

6.48.3 Related Claims Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Related Claims Search panel.	Button	N/A	0
Invoice Cycle	Year and quarter of the invoice cycle in which the claim was filed or adjusted.	Field	Number (Q/CCYY)	5
NDC	National Drug Code is comprised of a 5-byte numeric labeler code, 4-byte numeric product code and a 2-byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and prior authorization.	Field	Number (Integer)	11
Original Quarter Paid	Original year and quarter in which the claim was paid.	Field	Date (Q/CCYY)	5
Rebate Program	Rebate program on which to search.	Combo Box	Drop Down List Box	0
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by NDC, Invoice Cycle, Original Quarter Paid or Rebate Program.	Button	N/A	0

6.48.4 Related Claims Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Rebate Program	Combo Box	91080	A Rebate Program is required.	Select a rebate program.
Invoice Cycle	Field	1	Invoice Cycle must be 5 digits if entered.	Enter an Invoice Cycle with 5 characters (Q/CCYY).
	Field	2	Quarter must be 1, 2, 3, or 4.	Check the Quarter and change to be either 1, 2, 3 or 4.
	Field	3	Invoice Cycle must be numeric.	Enter a numeric value.
	Field	91029	Enter a valid value.	Enter a valid Invoice Cycle. (Q/CCYY).
	Field	91159	The Original Quarter Paid or Invoice Cycle is required.	Enter a valid Invoice Cycle. (Q/CCYY).
NDC	Field	91080	An 11 digit NDC Code is required.	Enter an 11-digit code.
Original Quarter Paid	Field	1	Original Quarter Paid must be 5 digits if entered.	Enter an Original Quarter Paid with 5 characters (Q/CCYY).
	Field	2	Quarter must be 1, 2, 3, or 4.	Check the Quarter and change to be either 1, 2, 3 or 4.
	Field	3	Original Quarter Paid must be numeric.	Enter a numeric value.
	Field	91029	Enter a valid value.	Enter a valid Qtr Paid Date. (Q/CCYY).
	Field	91159	The Original Quarter Paid or Invoice Cycle is required.	Enter a valid Qtr Paid Date. (Q/CCYY).

6.48.5 Related Claims Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Related Claims Search Panel Accessibility

6.48.6.1 To Access the Related Claims Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related**	Related Claims panel displays.

Step	Action	Response
	Claims.	

6.49 Related Claims Search Results Panel Overview

6.49.1 Related Claims Search Results Panel Narrative

The Related Claims Search Results panel is used to view all claims related to an NDC for a specific invoice cycle or that were paid in a specified quarter.

This panel is for inquiry only.

Navigation path: [Drug] - [Related Claims] - [Click on Search] - [Related Claims (Search Results)]

6.49.2 Related Claims Search Results Panel Layout

Related Claims

Original Qtr Paid	Invoice Cycle	Provider Number	Current ID	FDOS	ICN	Prescription Number	Paid Claims Units	CMS Units	Rebate Units	Allowed Charge	TPL Amt	Reimbursed Amt	Rebate Eligible
1/2004	1/2004	[redacted]	[redacted]	06/02/2001	[redacted]	[redacted]	30	30	28	$15.33	$0.00	$90.00	N
1/2004	1/2004	[redacted]	[redacted]	06/02/2001	[redacted]	[redacted]	30	30	22	$15.33	$0.00	$90.00	N
Total Claims:2					Total:		60	60	50	$30.66	$0.00	$180.00	

6.49.3 Related Claims Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allowed Charge	Maximum amount allowed for reimbursement for the pharmacy.	Field	Number (Decimal)	11
CMS Units	Number of units stated in the unit of measure (UOM) provided by Centers for Medicare and Medicaid Services (CMS) to be used in the calculation of the rebate amount due. If the CMS UOM and paid claims UOM are different, the CMS units will be the number of converted units.	Field	Number (Integer)	5
Current ID	Identification number of the beneficiary for whom the claim was filed.	Field	Number (Integer)	12
FDOS	From Date of Service for the claim.	Field	Date (MM/DD/CCYY)	8
ICN	Internal control number for the claim.	Field	Number (Integer)	13
Invoice Cycle	This value is the year and quarter of the invoice cycle in which the claim was filed or adjusted.	Field	Date (Q/CCYY)	5
Original Qtr Paid	Original year and quarter in which the claim was paid.	Field	Date (Q/CCYY)	5
Paid Claims Units	Number of units for which the pharmacy was reimbursed.	Field	Number (Integer)	5

Field	Description	Field Type	Data Type	Length
Prescription Number	Prescription number assigned to the treatment.	Field	Number (Integer)	7
Provider ID Type	Provider's identification type.	Field	Character	3
Provider Number	Displays the unique identifier for the provider.	Field	Number (Integer)	10
Rebate Eligible	Indicates whether the claim is used in drug rebate invoicing. Values are 'Y' and 'N'. When a claim is originally invoiced, it is added with a value of 'Y'. The user may change this value to 'N' during dispute processing.	Field	Character	1
Rebate Unit	The number of units rebated against. This can be different than billed units if the units have been converted.	Field	Number (Integer)	5
Reimbursed Amt	Amount reimbursed to the pharmacy for the claim.	Field	Number (Decimal)	11
Total	Total for the Paid Claims Units, CMS Units, Allowed Charge, TPL Amt and Reimbursed Amt columns.	Field	Number (Decimal)	11
Total Claims	Total number of claims for National Drug Code (NDC).	Field	Number (Decimal)	6
TPL Amt	Amount reimbursed to the Third Party Liability (TPL) for the claim.	Field	Number (Decimal)	11

6.49.4 Related Claims Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.49.5 Related Claims Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Related Claims Search Results Panel Accessibility

6.49.6.1 To Access the Related Claims Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.

Step	Action	Response
2	Point to **Drug** and click **Related Claims**.	Related Claims Search panel displays.
3	Enter and NDC and Original Quarter Paid.	
4	Click **Search**.	Results of search displays.
5	Click Related Claims Information.	Related Claims Search Results panel displays.
6	Click on a **Related Claims** record.	Record displays.

6.50 Related Data – Codes Page Overview

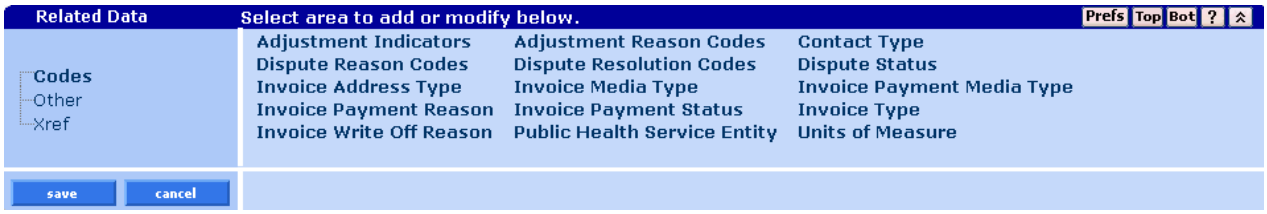
6.50.1 Related Data – Codes Page Narrative

The Related Data for Codes page displays all codes users can maintain for the Drug Rebate system.

This page is for inquiry only.

Navigation path: [Drug] - [Related Data] - [Codes]

6.50.2 Related Data – Codes Page Layout



6.50.3 Related Data – Codes Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Indicators	Link to the Adjustment Indicators panel.	Hyperlink	N/A	0
Adjustment Reason Codes	Link to the Adjustment Reason Codes panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Related Data-Codes page.	Button	N/A	0
Contact Type	Link to Contact Type panel.	Hyperlink	N/A	0
Dispute Reason Codes	Link to Dispute Reason Codes panel.	Hyperlink	N/A	0
Dispute Resolution Codes	Link to the Dispute Resolution Codes panel.	Hyperlink	N/A	0
Dispute Status	Link to the Dispute Status panel.	Hyperlink	N/A	0
Invoice Address Type	Link to the Invoice Address Type panel.	Hyperlink	N/A	0
Invoice Media Type	Link to the Invoice Media Type panel.	Hyperlink	N/A	0
Invoice Payment Media Type	Link to the Invoice Payment Media Type panel.	Hyperlink	N/A	0
Invoice Payment Reason	Link to the Invoice Payment Reason panel.	Hyperlink	N/A	0

Field	Description	Field Type	Data Type	Length
Invoice Payment Status	Link to the Invoice Payment Status panel.	Hyperlink	N/A	0
Invoice Type	Link to the Invoice Type panel.	Hyperlink	N/A	0
Invoice Write Off Reason	Link to the Invoice Write Off Reason panel.	Hyperlink	N/A	0
Public Health Service Entity	Link to the Public Health Service Entity panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data-Codes page.	Button	N/A	0
Units of Measure	Link to the Units of Measure panel.	Hyperlink	N/A	0

6.50.4 Related Data – Codes Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.50.5 Related Data – Codes Page Extra Features

Field	Field Type
No extra features found for this page.	

6.50.6 Related Data – Codes Page Accessibility

6.50.6.1 To Access the Related Data – Codes Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Claims**.	Related Claims panel displays.
3	Click **Codes**.	Related Data – Codes page displays.

6.51 Codes-Adjustment Indicators Panel Overview

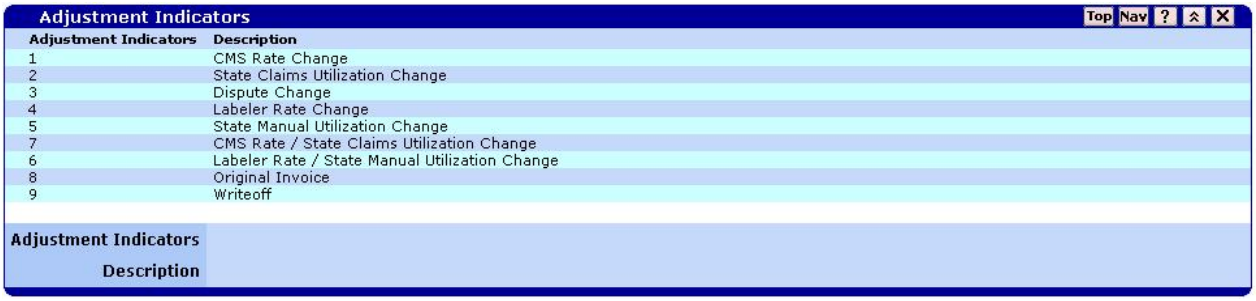
6.51.1 Codes-Adjustment Indicators Panel Narrative

The Codes-Adjustment Indicators panel maintains the adjustment indicator codes and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Adjustment Indicators]

6.51.2 Codes-Adjustment Indicators Panel Layout



6.51.3 Codes-Adjustment Indicators Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Indicators	Code associated with the Adjustment Indicators.	Field	Character	1
Description	Description associated with the Adjustment Indicators.	Field	Character	50

6.51.4 Codes-Adjustment Indicators Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.51.5 Codes-Adjustment Indicators Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 Codes-Adjustment Indicators Panel Accessibility

6.51.6.1 To Access the Codes-Adjustment Indicators Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.

Step	Action	Response
4	Click Adjustment Indicators.	Adjustment Indicators panel displays.

6.52 Codes-Adjustment Reason Codes Panel Overview

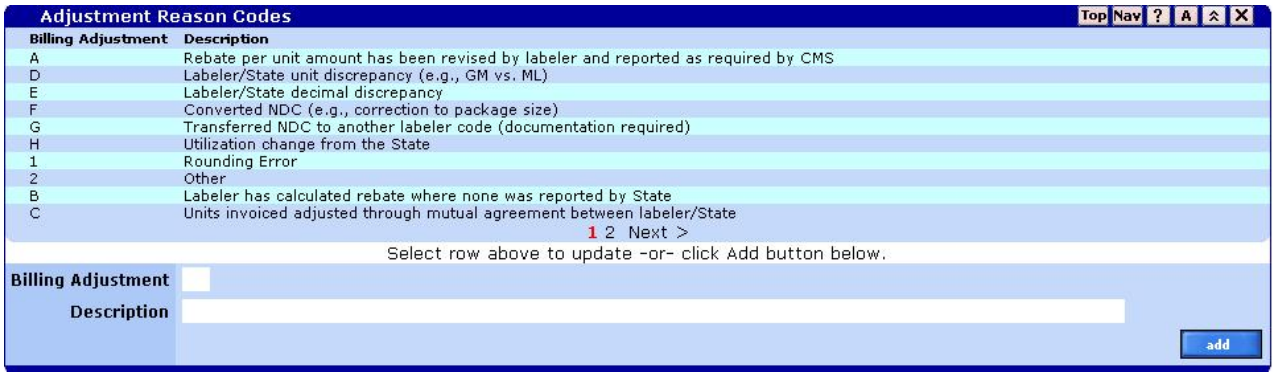
6.52.1 Codes-Adjustment Reason Codes Panel Narrative

The Codes-Adjustment Reason Codes panel provides users with a listing of billing adjustment code values and their descriptions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Adjustment Reason Codes]

6.52.2 Codes-Adjustment Reason Codes Panel Layout



6.52.3 Codes-Adjustment Reason Codes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Adjustment Reason Codes information.	Button	N/A	0
Billing Adjustment	Reason code for the billing adjustment.	Field	Character	1
Description	Description associated with the Billing Adjustment Code.	Field	Character	100

6.52.4 Codes-Adjustment Reason Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billing Adjustment Code	Field	70001	A duplicate record cannot be saved.	Verify keying. Cannot enter duplicate value in Billing Adjustment.
	Field	91080	Billing Adjustment is required.	Verify keying. Enter a Billing Adjustment.
Description	Field	91080	Description is required.	Verify keying. Enter a Description.

6.52.5 Codes-Adjustment Reason Codes Panel Extra Features

Field	Field Type
No extra features found for this page.	

6.52.6 Codes-Adjustment Reason Codes Panel Accessibility

6.52.6.1 To Access the Codes-Adjustment Reason Codes Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Adjustment Reason Codes.	Adjustment Reason Codes panel displays.

6.52.6.2 To Add on the Codes-Adjustment Reason Codes Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Billing Adjustment.	
3	Enter **Description** of the code.	
4	Click **Save**.	Adjustment Reason Codes information is saved.

6.52.6.3 To Update the Codes-Adjustment Reason Codes Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Adjustment Reason Codes information is updated.

6.53 Codes-Contact Type Panel Overview

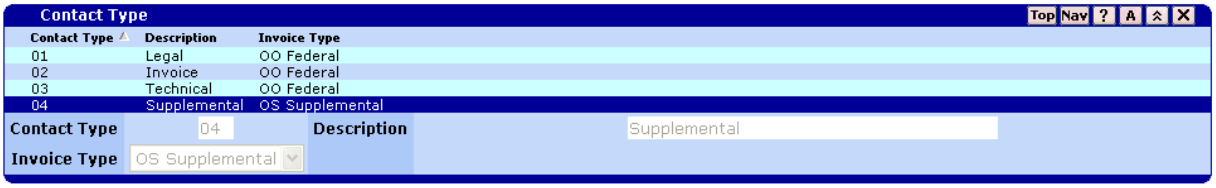
6.53.1 Codes-Contact Type Panel Narrative

The Codes-Contact Type panel shows various contact types and their descriptions. It can be accessed by selecting Related Data from the main menu and clicking Contact Type navigation item under the Codes.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Contact Type]

6.53.2 Codes-Contact Type Panel Layout



6.53.3 Codes-Contact Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Contact Type	Code associated with the Contact Type.	Field	Number (Integer)	2
Description	Description associated with the Contact Type.	Field	Character	40
Invoice Type	Represents the type of the invoice.	Field	Drop Down List Box	0

6.53.4 Codes-Contact Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.53.5 Codes-Contact Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Codes-Contact Type Panel Accessibility

6.53.6.1 To Access the Codes-Contact Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.

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Step	Action	Response
4	Click Contact Type.	Contact Type panel displays.

6.54 Codes-Dispute Reason Codes Panel Overview

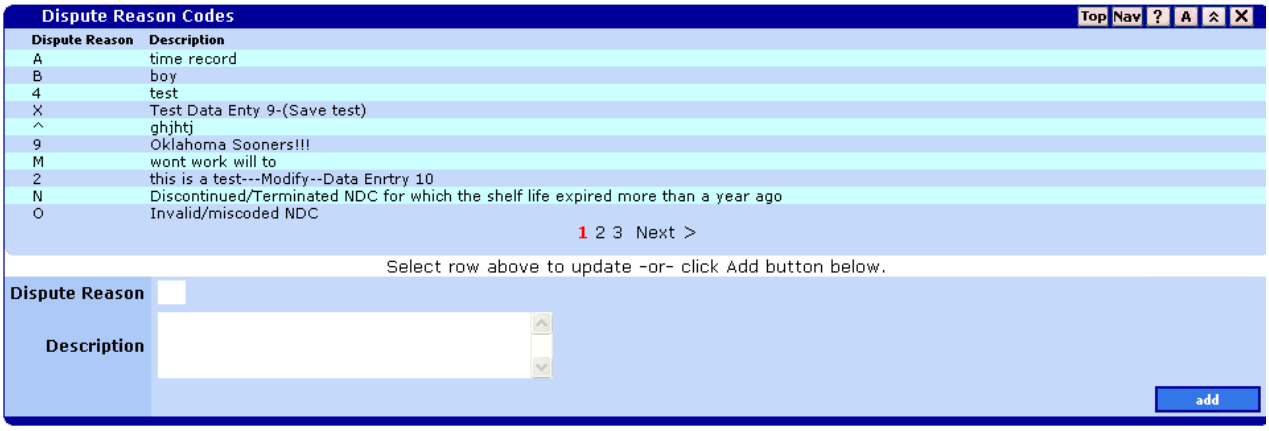
6.54.1 Codes-Dispute Reason Codes Panel Narrative

The Codes-Dispute Reason Codes panel allows users to maintain the Dispute Reason Type code and description.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Dispute Reason Codes]

6.54.2 Codes-Dispute Reason Codes Panel Layout



6.54.3 Codes-Dispute Reason Codes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Dispute Reason Code information.	Button	N/A	0
Description	Description associated with the Dispute Reason Code.	Field	Character	100
Dispute Reason	Code associated with the dispute reason.	Field	Character	1

6.54.4 Codes-Dispute Reason Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91080	Description is required.	Verify keying. Enter a Dispute Reason Description.
Dispute Reason Code	Field	70001	A duplicate record cannot be saved.	Verify keying. Enter a Dispute Reason Code.
	Field	91080	Dispute Reason is required.	Verify keying. Enter a Dispute Reason Code.

6.54.5 Codes-Dispute Reason Codes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 Codes-Dispute Reason Codes Panel Accessibility

6.54.6.1 To Access the Codes-Dispute Reason Codes Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Dispute Reason Codes.	Dispute Reason Codes panel displays

6.54.6.2 To Add on the Codes-Dispute Reason Codes Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Dispute Reason.	
3	Enter **Description** of the code.	
4	Click **Save**.	Dispute Reason Codes information is saved.

6.54.6.3 To Update the Codes-Dispute Reason Codes Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Dispute Reason Codes information is updated.

6.55 Codes-Dispute Resolution Codes Panel Overview

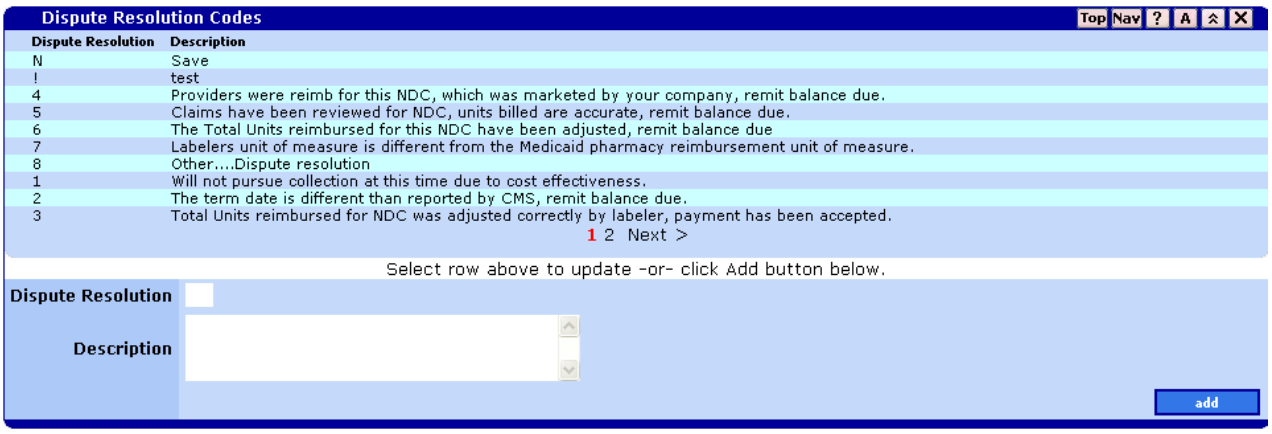
6.55.1 Codes-Dispute Resolution Codes Panel Narrative

The Codes-Dispute Resolution Codes panel allows users to maintain the Dispute Resolution Codes and description for the Drug Rebate application.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Dispute Status]

6.55.2 Codes-Dispute Resolution Codes Panel Layout



6.55.3 Codes-Dispute Resolution Codes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Dispute Resolution Code information.	Button	N/A	0
Description	Description associated with the Dispute Resolution Code.	Field	Character	100
Dispute Resolution	Code associated with the dispute resolution.	Field	Character	1

6.55.4 Codes-Dispute Resolution Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	98001	Description is required.	Verify Keying. Enter a Description.
Dispute Resolution	Field	78001	A duplicate record cannot be saved.	Verify Keying. Enter a Dispute Resolution Code.
	Field	98001	Dispute Resolution is required.	Verify Keying. Enter a Dispute Resolution Code.

6.55.5 Codes-Dispute Resolution Codes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.55.6 Codes-Dispute Resolution Codes Panel Accessibility

6.55.6.1 To Access the Codes-Dispute Resolution Codes Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes panel display.
4	Click Dispute Resolution.	Dispute Resolution Codes panel displays

6.55.6.2 Add on the Codes-Dispute Resolution Codes Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Dispute Resolution.	
3	Enter **Description** of the code.	
4	Click **Save**.	Dispute Resolution Codes information is saved.

6.55.6.3 To Update the Codes-Dispute Resolution Codes Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Dispute Resolution Codes information is saved.

6.56 Codes-Dispute Status Panel Overview

6.56.1 Codes-Dispute Status Panel Narrative

The Codes-Dispute Status panel allows users to maintain the Dispute Status code and description.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Dispute Status]

6.56.2 Codes-Dispute Status Panel Layout

6.56.3 Codes-Dispute Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Dispute Status Code.	Field	Character	100
Dispute Status	Code associated with the dispute status.	Field	Character	1

6.56.4 Codes-Dispute Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.56.5 Codes-Dispute Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 Codes-Dispute Status Panel Accessibility

6.56.6.1 To Access the Codes-Dispute Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Dispute Status.	Dispute Status panel displays.

6.57 Codes-Invoice Address Type Panel Overview

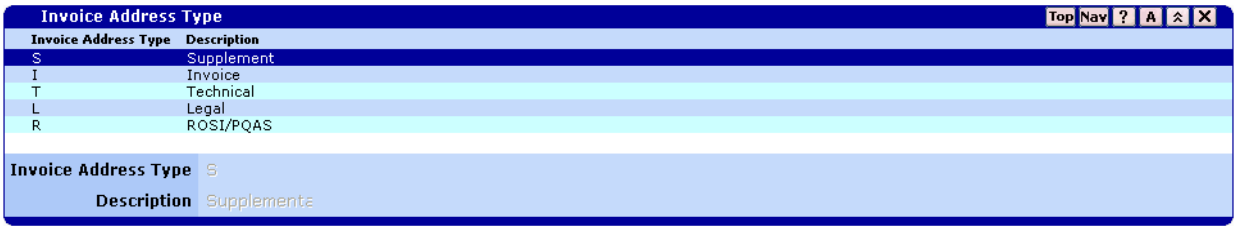
6.57.1 Codes-Invoice Address Type Panel Narrative

The Codes-Invoice Address Type panel allows users to maintain the Invoice Address Type code and description.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Address Type]

6.57.2 Codes-Invoice Address Type Panel Layout



6.57.3 Codes-Invoice Address Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Invoice Address Type Code.	Field	Character	100
Invoice Address Type	Code associated with the Invoice Address Type.	Field	Character	1

6.57.4 Codes-Invoice Address Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.57.5 Codes-Invoice Address Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.57.6 Codes-Invoice Address Type Panel Accessibility

6.57.6.1 To Access the Codes-Invoice Address Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Invoice Address Type.	Invoice Address Type panel displays.

6.58 Codes-Invoice Media Type Panel Overview

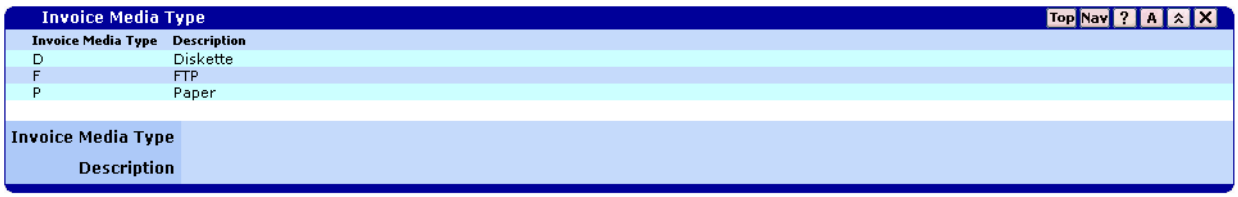
6.58.1 Codes-Invoice Media Type Panel Narrative

The Codes-Invoice Media Type panel enables users to maintain the Invoice Media Type codes and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Media Type]

6.58.2 Codes-Invoice Media Type Panel Layout



6.58.3 Codes-Invoice Media Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with Invoice Media Type Code.	Field	Character	15
Invoice Media Type	Code associated with the Invoice Media Type.	Field	Character	1

6.58.4 Codes-Invoice Media Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.58.5 Codes-Invoice Media Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.58.6 Codes-Invoice Media Type Panel Accessibility

6.58.6.1 To Access the Codes-Invoice Media Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Invoice Media Type.	Invoice Media Type panel displays.

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6.59 Codes-Invoice Payment Media Type Panel Overview

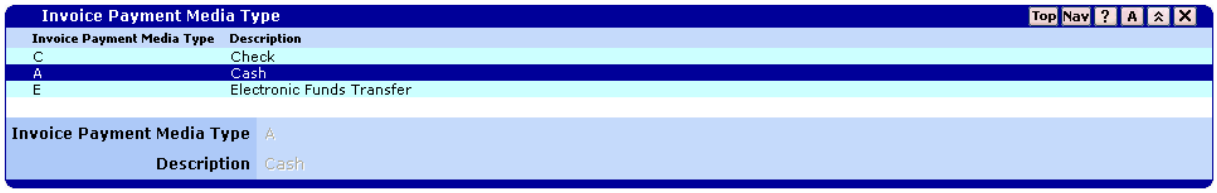
6.59.1 Codes-Invoice Payment Media Type Panel Narrative

The Invoice Payment Media Type panel enables users to view, add, or update the Invoice Payment Media Type codes and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Payment Media Type]

6.59.2 Codes-Invoice Payment Media Type Panel Layout



6.59.3 Codes-Invoice Payment Media Type Panel Field Descriptions\

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Invoice Payment Media Type Code.	Field	Character	25
Invoice Payment Media Type	Code associated with the Invoice Payment Media Type.	Field	Character	1

6.59.4 Codes-Invoice Payment Media Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.59.5 Codes-Invoice Payment Media Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.6 Codes-Invoice Payment Media Type Panel Accessibility

6.59.6.1 To Access the Codes-Invoice Payment Media Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data page displays.
3	Click **Codes**.	Related Data-Codes panel displays.
4	Click Invoice Payment Media Type.	Invoice Payment Media Type panel displays.

6.60 Codes-Invoice Payment Reason Panel Overview

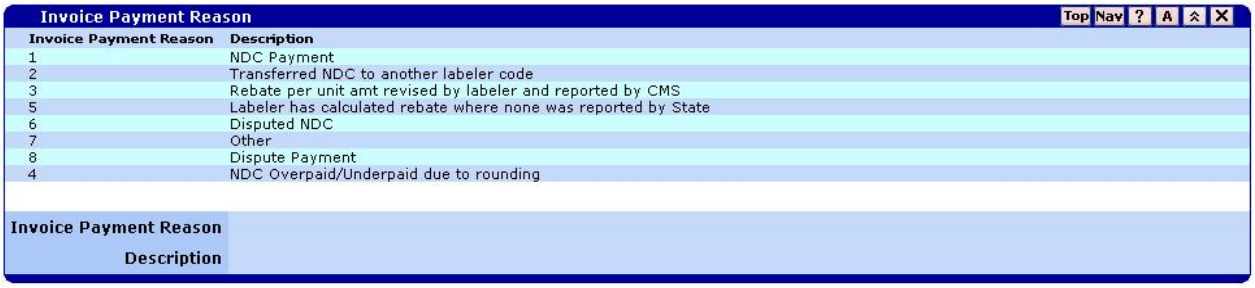
6.60.1 Codes-Invoice Payment Reason Panel Narrative

The Codes-Invoice Payment Reason panel enables users to view, add, or modify the Invoice Payment Reason codes and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Payment Reason]

6.60.2 Codes-Invoice Payment Reason Panel Layout



6.60.3 Codes-Invoice Payment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Invoice Payment Reason Code.	Field	Character	100
Invoice Payment Reason	Code associated with the Invoice Payment Reason.	Field	Character	2

6.60.4 Codes-Invoice Payment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.60.5 Codes-Invoice Payment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.60.6 Codes-Invoice Payment Reason Panel Accessibility

6.60.6.1 To Access the Codes-Invoice Payment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.

Step	Action	Response
4	Click Invoice Payment Reason.	Invoice Payment Reason panel displays.

6.61 Codes-Invoice Payment Status Panel Overview

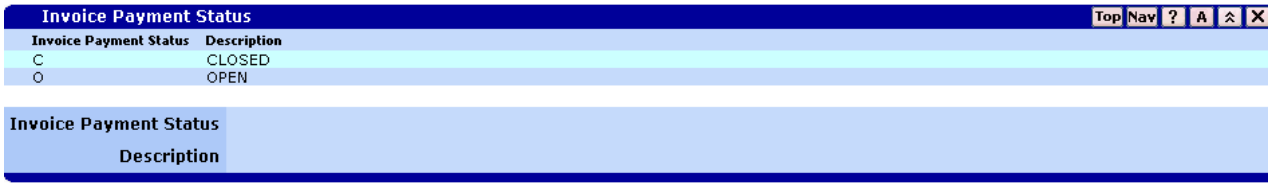
6.61.1 Codes-Invoice Payment Status Panel Narrative

The Codes-Invoice Payment Status panel maintains all Drug Rebate Invoice Payment Status Codes and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Payment Status]

6.61.2 Codes-Invoice Payment Status Panel Layout



6.61.3 Codes-Invoice Payment Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Invoice Payment Status Code.	Field	N/A	50
Invoice Payment Status	Code that indicates the status of the drug rebate invoice payments.	Field	N/A	2

6.61.4 Codes-Invoice Payment Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.61.5 Codes-Invoice Payment Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.61.6 Codes-Invoice Payment Status Panel Accessibility

6.61.6.1 To Access the Codes-Invoice Payment Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Invoice Payment Status.	Invoice Payment Status panel displays.

6.62 Codes-Invoice Type Panel Overview

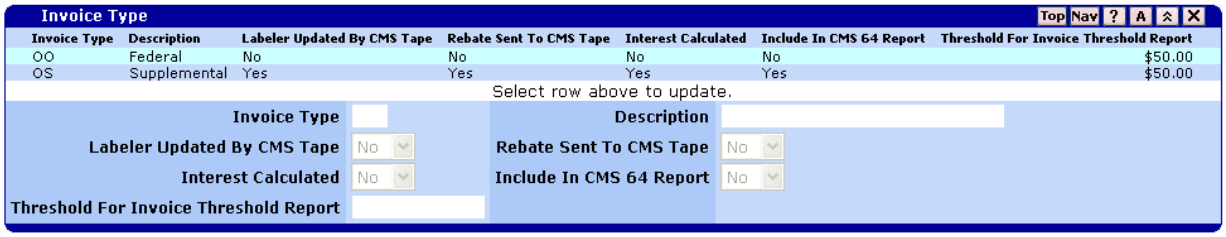
6.62.1 Codes-Invoice Type Panel Narrative

The Codes-Invoice Type panel maintains the valid list of all invoice type codes and descriptions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Type]

6.62.2 Codes-Invoice Type Panel Layout



6.62.3 Codes-Invoice Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The description of the Invoice Type code.	Field	Character	30
Include in CMS 64 Report	Indicates whether data for the invoice type should be included on the CMS 64 report.	Combo Box	Drop Down List Box	0
Interest Calculated	Indicates whether interest should be calculated for this invoice type.	Combo Box	Drop Down List Box	0
Invoice Type	The Invoice Type code which pertains to the Drug Rebate programs, such as Federal or Supplemental.	Field	Character	2
Labeler Updated by CMS Tape	Indicates whether labeler data for this invoice type should be updated by the Quarterly CMS tape.	Combo Box	Drop Down List Box	0
Rebate Sent to CMS Tape	Indicates whether rebate data for this invoice type is sent to CMS.	Combo Box	Drop Down List Box	0
Threshold for Invoice Threshold Report	The dollar threshold used for reporting on the Invoice Threshold Report - RBT-2006-Q.	Field	Number (Decimal)	8

6.62.4 Codes-Invoice Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.

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Field	Field Type	Error Code	Error Message	To Correct
Threshold For Invoice Threshold Report	Field	1	Threshold For Invoice Threshold Report is required.	Enter a valid Threshold For Invoice Threshold Report.
	Field	2	Enter a valid value.	Enter a dollar amount.

6.62.5 Codes-Invoice Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.62.6 Codes-Invoice Type Panel Accessibility

6.62.6.1 To Access the Codes-Invoice Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Invoice Type.	Invoice Type panel displays.

6.62.6.2 To Update the Codes-Invoice Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Invoice Type information is updated.

6.63 Codes-Invoice Write Off Reason Panel Overview

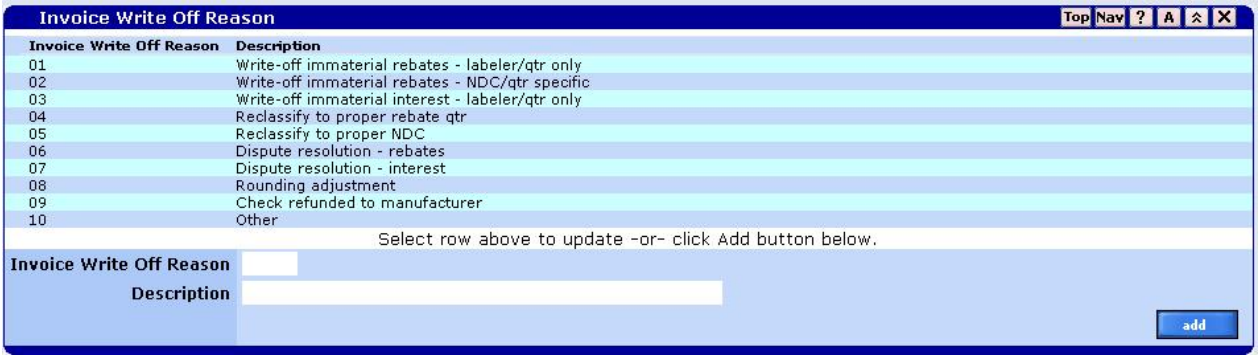
6.63.1 Codes-Invoice Write Off Reason Panel Narrative

The Codes-Invoice Write Off Reason panel maintains the Invoice Write Off Reason codes and Descriptions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Invoice Write Off Reason]

6.63.2 Codes-Invoice Write Off Reason Panel Layout



6.63.3 Codes-Invoice Write Off Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add invoice write off reason information.	Button	N/A	0
Description	Description associated with the Invoice Write Off Reason Code.	Field	Character	50
Invoice Write Off Reason Code	Code associated with the Invoice Write Off Reason Code.	Field	Character	4

6.63.4 Codes-Invoice Write Off Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91080	Description is required.	Verify keying. Enter an Invoice Write Off Reason Description.
Invoice Write Off Reason Code	Field	70001	A duplicate record cannot be saved.	Verify keying. Enter an Invoice Write Off Reason.
	Field	91080	Invoice Write Off Reason Code is required.	Verify keying. Enter an Invoice Write Off Reason.

6.63.5 Codes-Invoice Write Off Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.63.6 Codes-Invoice Write Off Reason Panel Accessibility

6.63.6.1 To Access the Codes- Invoice Write Off Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Invoice Write Off Reason.	Invoice Write Off Reason panel displays.

6.63.6.2 To Add on the Codes-Invoice Write Off Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Invoice Write Off Reason.	
3	Enter **Description** of the code.	
4	Click **Save**.	Invoice Write Off Reason information is saved.

6.63.6.3 To Update the Codes-Invoice Write Off Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Invoice Write Off Reason information is updated.

6.64 Codes-Public Health Service Entity Panel Overview

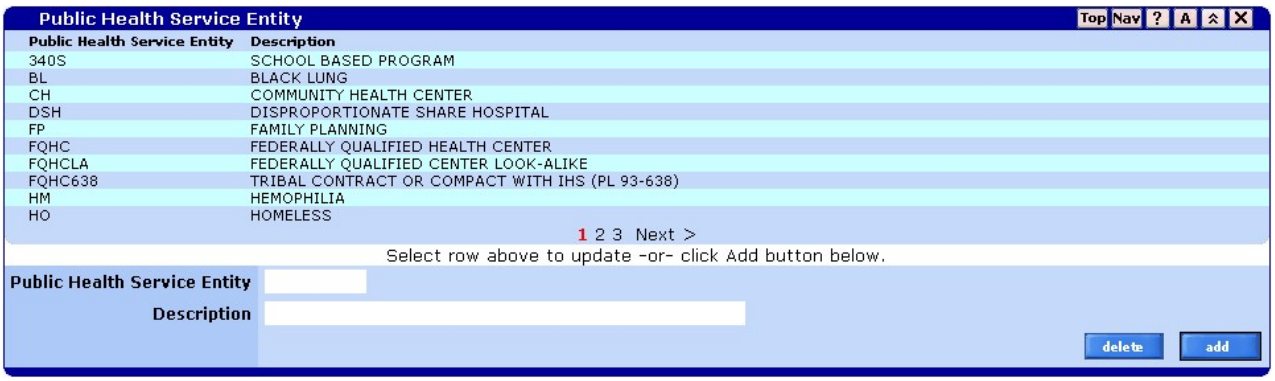
6.64.1 Codes-Public Health Service Entity Panel Narrative

The Codes-Public Health Service Entity panel maintains all Public Health Service Entity Codes and Descriptions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Public Health Service Entity]

6.64.2 Codes-Public Health Service Entity Panel Layout\



6.64.3 Codes-Public Health Service Entity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Public Health Service Entity information.	Button	N/A	0
Delete	Allows the user to remove Public Health Service Entity information.	Button	N/A	0
Description	Description associated with the Public Health Service Entity Code.	Field	Character	50
Public Health Service Entity	Code associated with the Public Health Service Entity.	Field	Character	9

6.64.4 Codes-Public Health Service Entity Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91080	Public Health Service Entity is required.	Verify keying. Enter a Public Health Service Entity Code description.
Public Health Service Entity	Field	70001	A duplicate record cannot be saved.	Verify keying. Enter a Public Health Service Entity Code.

Field	Field Type	Error Code	Error Message	To Correct
	Field	91080	Description is required.	Verify keying. Enter a Public Health Service Entity Code.

6.64.5 Codes-Public Health Service Entity Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.64.6 Codes-Public Health Service Entity Panel Accessibility

6.64.6.1 To Access the Codes-Public Health Service Entity Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Code page display.
4	Click Public Health Service Entity.	Public Health Service Entity panel displays.

6.64.6.2 To Add on the Codes-Public Health Service Entity Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Public Health Service Entity.	
3	Enter **Description** of the code.	
4	Click **Save**.	Public Health Service Entity information is saved.

6.64.6.3 To Update the Codes-Public Health Service Entity Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Public Health Service Entity information is updated.

6.64.6.4 To Delete on the Codes- Public Health Service Entity Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

Step	Action	Response
2	Click **Delete**.	Line item is deleted.

6.65 Codes-Units of Measure Panel Overview

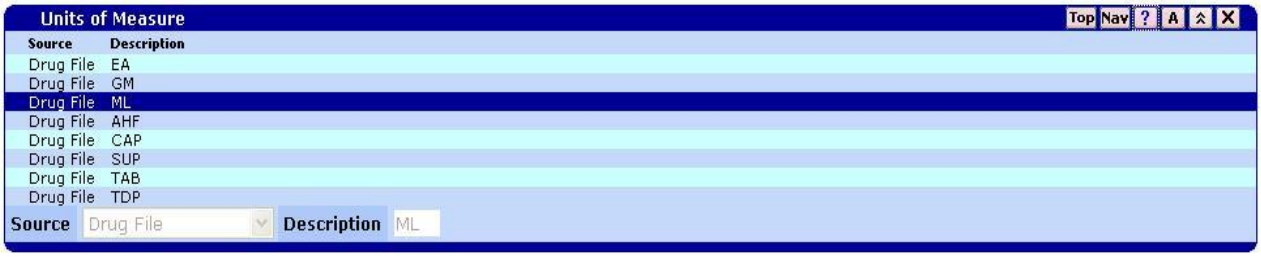
6.65.1 Codes-Units of Measure Panel Narrative

The Codes-Units of Measure panel maintains the unit code, conversion values and descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Codes] - [Units of Measure]

6.65.2 Codes- Units of Measure Panel Layout



6.65.3 Codes- Units of Measure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description associated with the Unit Code field.	Field	Character	3
Source	This field provides the source of the units.	Combo Box	Drop Down list Box	0

6.65.4 Codes -Units of Measure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.65.5 Codes- Units of Measure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.65.6 Codes- Units of Measure Panel Accessibility

6.65.6.1 To Access the Codes-Units of Measure Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes page displays.
4	Click Unit Conversion.	Units of Measure panel displays.

6.66 Related Data – Other Page Overview

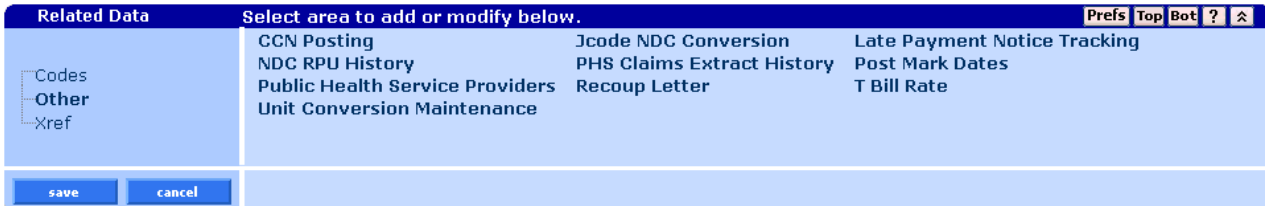
6.66.1 Related Data – Other Page Narrative

The Related Data- Other page allows users to view, add or modify other related data relevant to the Drug Rebate application.

This page is for inquiry only.

Navigation: [Drug] – [Related Data] – [Other]

6.66.2 Related Data – Other Page Layout



6.66.3 Related Data – Other Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Related Data – Other page.	Button	N/A	0
CCN Posting	Link to the CCN Posting panel.	Hyperlink	N/A	0
Jcode NDC Conversion	Link to the Jcode NDC Conversion panel.	Hyperlink	N/A	0
Late Payment Notice Tracking	Link to the Late Payment Notice Tracking.	Hyperlink	N/A	0
NDC RPU History	Link to the NDC RPU History panel.	Hyperlink	N/A	0
PHS Claims Extract History	Link to the PHS Claims Extract History panel.	Hyperlink	N/A	0
Post Mark Dates	Link to the Post Mark Dates panel.	Hyperlink	N/A	0
Public Health Service Providers	Link to the Public Health Service Providers panel.	Hyperlink	N/A	0
Recoup Letter	Link to the Recoup Letter panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data – Other page.	Button	N/A	0
T Bill Rate	Link to the T Bill Rate panel.	Hyperlink	N/A	0

Field	Description	Field Type	Data Type	Length
Unit Conversion Maintenance	Link to the Unit Conversion Maintenance panel.	Hyperlink	N/A	0

6.66.4 Related Data – Other Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.66.5 Related Data – Other Page Extra Features

Field	Field Type
No extra features found for this page.	

6.66.6 Related Data – Other Page Accessibility

6.66.6.1 To Access the Related Data – Other Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Related Data – Other page displays.

6.67 Other-CCN Posting Panel Overview

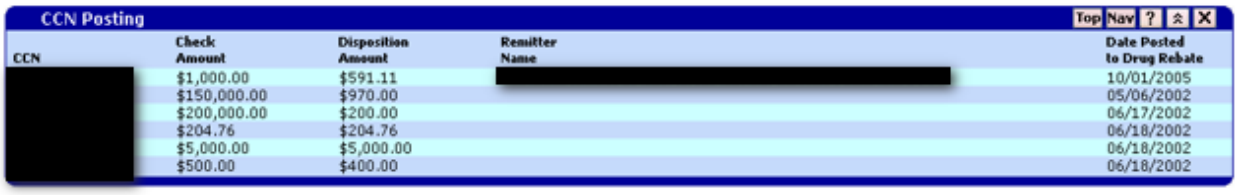
6.67.1 Other-CCN Posting Panel Narrative

The Other-CCN Posting panel is used to track information that has been keyed in for Drug Rebate Invoice Payment.

This panel is for inquiry only.

Navigation path: [Drug] - [Related Data] - [Other] - [CCN Posting]

6.67.2 Other-CCN Posting Panel Layout



CCN Posting

CCN	Check Amount	Disposition Amount	Remitter Name	Date Posted to Drug Rebate
[redacted]	$1,000.00	$591.11	[redacted]	10/01/2005
	$150,000.00	$970.00		05/06/2002
	$200,000.00	$200.00		06/17/2002
	$204.76	$204.76		06/18/2002
	$5,000.00	$5,000.00		06/18/2002
	$500.00	$400.00		06/18/2002

6.67.3 Other-CCN Posting Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash control number (CCN) that uniquely identifies the check.	Field	Number (Integer)	11
Check Amount	Amount of the check.	Field	Number (Decimal)	5
Date Posted to Drug Rebate	Date that the cash control number (CCN) was posted in Financial.	Field	Date (MM/DD/CCYY)	8
Disposition Amount	Rebate amount dispositioned to the National Drug Code (NDC) level and the interest amount dispositioned to the invoice level from this cash control number.	Field	Number (Decimal)	5
Remitter Name	Name of entity that submitted the payment.	Field	Character	50

6.67.4 Other-CCN Posting Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.67.5 Other-CCN Posting Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.67.6 Other-CCN Posting Panel Accessibility

6.67.6.1 To Access the Other - CCN Posting Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other- Related Data page displays.
4	Click CCN Posting.	Other-CCN Posting Panel displays.

6.68 Other Jcode NDC Conversion Panel Overview

6.68.1 Other-Jcode NDC Conversion Panel Narrative

The Other-Jcode NDC Conversion panel contains the cross reference between J-codes and NDCs.

Only users with update authority are allowed to perform maintenance tasks.

Navigation path: [Drug] - [Related Data] - [Other] - [Jcode NDC Conversion]

6.68.2 Other-Jcode NDC Conversion Panel Layout

6.68.3 Other-Jcode NDC Conversion Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add JCode NDC Conversion information.	Button	N/A	0
Clear	Allows the user to clear any changes on the Other -Code NDC Conversion panel.	Button	N/A	0
Conversion Factor	Conversion factor for the difference in dosage units between JCode and NDC.	Field	Number (Integer)	11
Effective Date	Effective date of the JCode and National Drug Code (NDC).	Field	Date (MM/DD/CCYY)	8
End Date	End date of the JCode and National Drug Code (NDC).	Field	Date (MM/DD/CCYY)	8
JCode	JCode procedure code of the National Drug Code (NDC).	Field	Character	5

Field	Description	Field Type	Data Type	Length
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
Search	Initiates the Search by JCode or NDC.	Button	N/A	0

6.68.4 Other-Jcode NDC Conversion Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Conversion Factor	Field	91067	Conversion Factor must be greater than or equal to 0.0001.	Verify keying. Enter a valid Conversion Factor.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify the date and re-enter the input.
Jcode (Detail)	Field	91080	A valid JCode is required.	Verify keying. Enter a valid JCode.
	Field	91088	A valid JCode is required.	A valid JCode must exist in the database.
Jcode (Search)	Field	91067	The JCode must have a minimum of 5 characters.	Verify keying. Enter a Jcode with a minimum of 5 characters.
NDC (Detail)	Field	91080	A valid JCode is required.	Verify keying. Enter a valid Jcode.
	Field	91088	A valid NDC is required.	Verify keying. Enter a valid NDC Code.
NDC(Search)	Field	91073	Enter a valid value.	Verify keying. Enter a valid NDC Code.

6.68.5 Other-Jcode NDC Conversion Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.68.6 Other-Jcode NDC Conversion Panel Accessibility

6.68.6.1 To Access the Other - Jcode NDC Conversion Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related**	Related Data panel displays.

Step	Action	Response
	Data.	
3	Click **Other**.	Other –Related Data page displays.
4	Click Jcode NDC Conversion.	Other-Jcode NDC Conversion panel displays.

6.68.6.2 To Navigate on the Other- Jcode NDC Conversion Panel

Step	Action	Response
1	Enter **JCode** or **NDC**.	
2	Click **Search**. Note: User can click on Search button if Jcode or NDC value is not known. This displays all records available.	Results of search are displayed.

6.68.6.3 To Add on the Other - Jcode NDC Conversion Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Jcode**.	
3	Enter **NDC**.	
4	Enter Conversion Factor.	
5	Enter **Effective Date** if different than date displayed.	
6	Enter **End Date** if different than date displayed.	
7	Click **Save**.	Other-Jcode NDC information is saved.

6.68.6.4 To Update the Other – Jcode NDC Conversion Panel

Step	Action	Response
1	Click to highlight the row to be updated	Data is populated in fields
2	Click in field to perform update.	
3	Click **Save**.	Other- Jcode NDC Conversion information is updated.

6.69 Other-Late Payment Notice Tracking Panel Overview

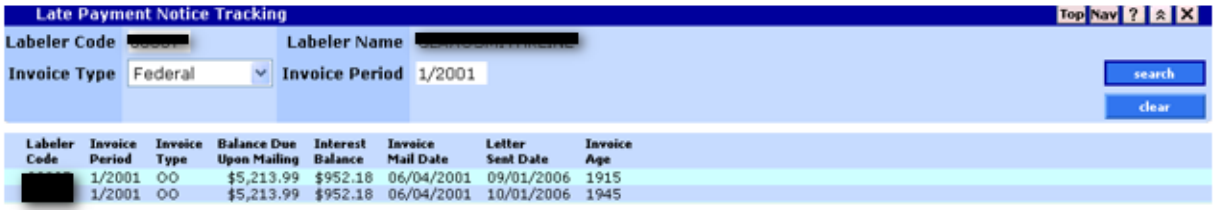
6.69.1 Other-Late Payment Notice Tracking Panel Narrative

The Other-Late Payment Notice Tracking panel is used to inquire on late payment letters that have been sent to labelers for past due payments. A letter is sent to labelers to remind them that a Drug Rebate payment for a quarterly Drug Rebate invoice has not been received. This panel identifies the date a late payment letter was sent to the labeler, the invoice age, and the balance due.

This panel is inquiry only.

Navigation Path: [Drug] - [Related Data] - [Other] - [Late Payment Notice Tracking]

6.69.2 Other-Late Payment Notice Tracking Panel Layout



6.69.3 Other-Late Payment Notice Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Balance Due Upon Mailing	Balance due when the late payment notification is mailed.	Field	Number (Decimal)	11
Clear	Allows the user to clear any changes on the Other-Late Payment Notice Tracking panel.	Button	N/A	0
Interest Balance	Contains the amount of interest due.	Field	Number (Decimal)	11
Invoice Age	Indicates the number of days the invoice from the postmark date of the original invoice.	Field	Number (Integer)	5
Invoice Mail Date	Contains the mail date of the original invoice.	Field	Date (MM/DD/CCYY)	8
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Represents the type of the invoice.	Field	Character	2
Labeler Code	Code used to identify the labeler invoiced.	Field	Number (Integer)	5
Labeler Name	Name of the labeler.	Field	Character	39
Letter Sent Date	Date the late payment notice letter was sent to the labeler.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
Search	Initiates the Search by Labeler Code, Invoice Type or Invoice Period.	Button	N/A	0

6.69.4 Other-Late Payment Notice Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	90782	At least a one-search criterion is required.	Enter valid search criteria.
Invoice Period	Field	8188	Enter a valid value.	Re-enter a valid year and quarter in Q/CCYY format.
Labeler Code	Field	91106	Labeler Code not found.	Verify Labeler Code and re-enter.
	Field	91107	Labeler Code must be 5 characters long.	Verify Labeler Code and re-enter.

6.69.5 Other-Late Payment Notice Tracking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.69.6 Other-Late Payment Notice Tracking Panel Accessibility

6.69.6.1 To Access the Other - Late Payment Notice Tracking Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other – Related Data page displays.
4	Click Late Payment Notice Tracking.	Other-Late Payment Notice Tracking panel is displayed.

6.69.6.2 To Navigate the Other –Late Payment Notice Tracking Panel

Step	Action	Response
1	Enter Labeler Code.	
2	Click **Search**.	List of Late Payment Notices are displayed for associated labeler code.

6.70 Other-NDC RPU History Panel Overview

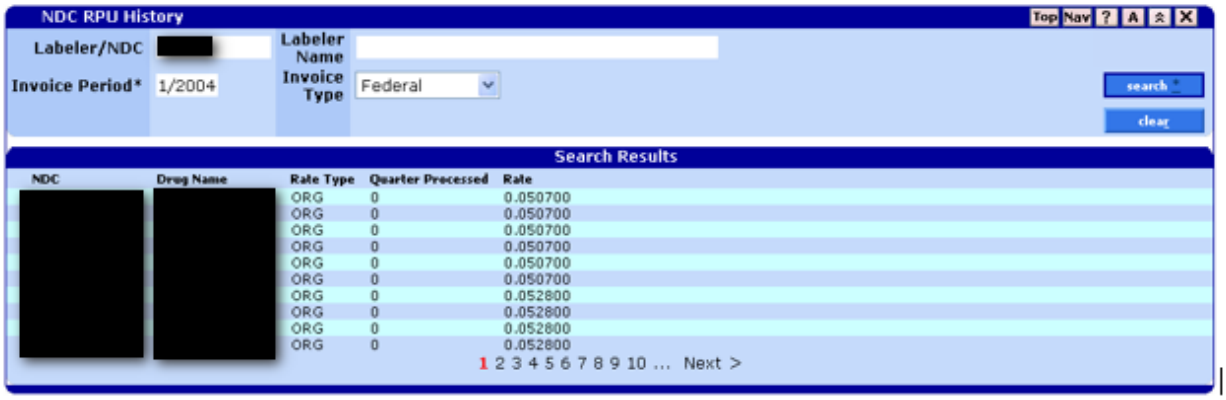
6.70.1 Other-NDC RPU History Panel Narrative

The Other-NDC RPU History panel is used to find a specific NDC by labeler or NDC number.

This panel is inquiry only.

Navigation Path: [Drug] - [Related Data] - [Other] - [NDC RPU History]

6.70.2 Other-NDC RPU History Panel Layout



6.70.3 Other-NDC RPU History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clear user input.	Button	N/A	0
CMS Type	The Centers for Medicare and Medicaid Services (CMS) type for this National Drug Code (NDC) rate.	Field	Character	3
Drug Name	The drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all State Medicaid programs. It is the product name as it appears on the FDA registration form.	Field	Character	30
Invoice Period	This value is the year and quarter (Q/CCYY) of the invoice period. Enter this field so that when the National Drug Code (NDC) is 'Selected' it can bring up the quarter needed for this NDC.	Field	Date (Q/CCYY)	5
Invoice Type	This value is to select the invoice type.	Combo Box	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Labeler Name	This field identifies the name of the drug labeler.	Field	Character	39
Labeler/NDC	This is an input field for either the five-digit labeler code or 11-digit National Drug Code (NDC). The labeler code is used to uniquely identify the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first five characters of the labeler's NDC.	Field	Number (Integer)	1
NDC	The National Drug Code of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and two-digit package size code.	Field	Number (Integer)	11
Quarter Processed	The invoice cycle in which the rate was processed.	Field	Date Quarter (Q/CCYY)	6
Rate	The rebate amount per unit supplied by Centers for Medicare and Medicaid Services (CMS) on a quarterly basis for the calculation of the drug rebate amount for each National Drug Code (NDC) in the program.	Field	Number (Decimal)	12
Search	This button is used to populate the window with the National Drug Code (NDC) Rate information.	Button	N/A	0

6.70.4 Other-NDC RPU History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Period (Search)	Field	2	Enter a valid value.	Verify keying. The invoice period must be in the format Q/CCYY.
	Field	8188	You must enter an invoice period.	Verify keying. The invoice period must be in the format Q/CCYY.
Labeler Name (Search)	Field	91080	You must enter either a Labeler/NDC or a Labeler Name.	Verify keying. Enter a valid labeler name, a valid 5 digit Labeler Code, or an 11 digit

Field	Field Type	Error Code	Error Message	To Correct
				NDC for search criteria.
	Field	91081	You must enter a 5 character Labeler Code or an 11-character NDC code for search criteria.	Verify keying. Enter a valid 5-digit labeler code or an 11 digit NDC for search criteria.
Labeler/NDC (Search)	Field	91088	The NDC Code is not on file.	Verify keying. Enter a valid 11 digit NDC.

6.70.5 Other-NDC RPU History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.70.6 Other-NDC RPU History Panel Accessibility

6.70.6.1 To Access the Other - NDC RPU History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other – Related Data page displays.
4	Click NDC RPU History.	Other- NDC RPU History panel is displayed.

6.71 Other-PHS Claims Extract History Panel Overview

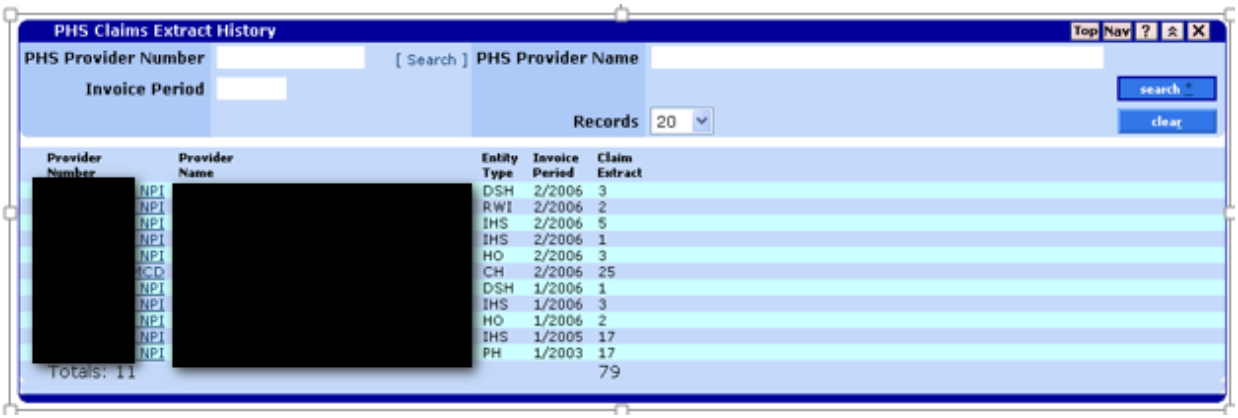
6.71.1 Other-PHS Claims Extract History Panel Narrative

The Other-PHS Claims Extract History panel is used to view the Public Health Service (PHS) and Indian Health Service (IHS) entities which are excluded from the Drug Rebate invoice process. The panel displays the Medicaid provider number, provider name, entity type, invoice period and number of claims extracted. Upon entering the panel, a list of PHS providers that have claim information display without performing a search. The search function only refines the list. A quarterly batch process populates the table that contains the pharmacy claim information.

This panel is inquiry only.

Navigation Path: [Drug] - [Related Data] - [Other] - [PHS Claims Extract History]

6.71.2 Other-PHS Claims Extract History Panel Layout



6.71.3 Other-PHS Claims Extract History Panel Field Description

Field	Description	Field Type	Data Type	Length
Claim Extract	Accumulated total number of claims extracted out of the quarterly invoice for the Public Health Service (PHS) and Indian Health Service (IHS) provider entity or number.	Field	Number (Integer)	9
Claim Extract Total	The total claims extracted for all Public Health Service (PHS) and Indian Health Service (IHS) providers to-date	Field	Number (Integer)	7
Clear	Allows the user to clear input from the search fields.	Button	N/A	0
Entity Type	Identifies the classification of the Public Health Service (PHS) and Indian Health Service (IHS) Entity.	Field	Character	9

Field	Description	Field Type	Data Type	Length
Invoice Period	Calendar quarter and year of the invoice period.	Field	Date (Q/CCYY)	5
PHS Provider Name	Search field used to refine the list of providers based on their name.	Field	Character	50
PHS Provider Number	Search field used to find a particular provider by their provider number and service location code.	Field	Character	15
Provider ID Type	This is the provider's identification type.	Field	Character	3
Provider Name	Contains the name of the Medicaid provider or entity name as identified on the Public Health Service (PHS) and Indian Health Service (IHS) data set files.	Field	Character	50
Provider Number	Uniquely identify a provider.	Field	Character	15
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Allows the user to search by PHS Provider Number, PHS Provider Name or Invoice Period.	Button	N/A	0

6.71.4 Other-PHS Claims Extract History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Invoice Period	Field	1	Enter valid value.	Invoice Period must be format Q\CCYY, where Q is 1 thru 4 and CCYY is a valid year.
	Field	2	Quarter must be 1, 2, 3, or 4.	Re-enter a valid quarter and year.

6.71.5 Other-PHS Claims Extract History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.71.6 Other-PHS Claims Extract History Panel Accessibility

6.71.6.1 To Access the Other - PHS Claims Extract History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other – Related Data page displays.
4	Click PHS Claims Extract History.	Other- PHS Claims Extract History panel is displayed.

6.72 Other-Post Mark Dates Panel Overview

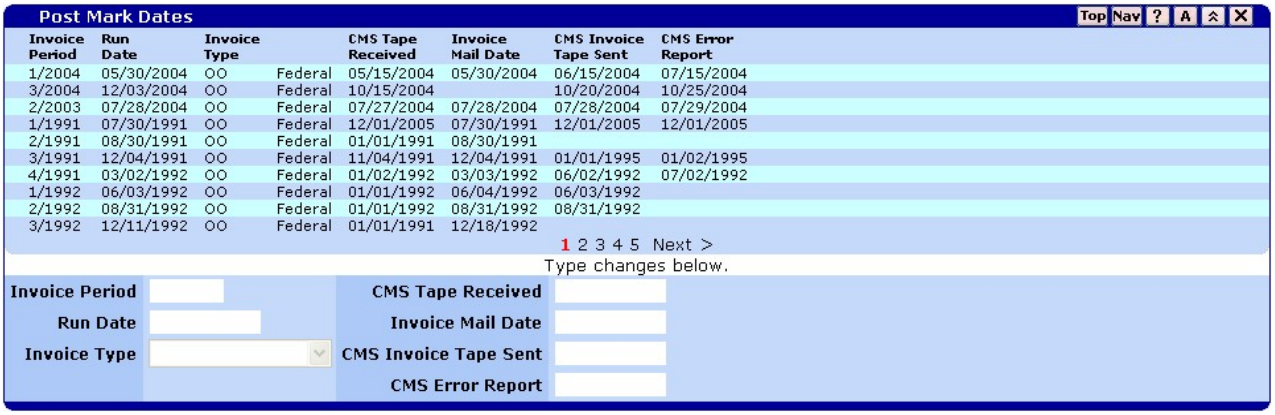
6.72.1 Other-Post Mark Dates Panel Narrative

The Other-Post Mark Dates panel is used to enter the invoice postmarks to keep track of the invoice period, postmark date, and run date.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Other] - [Post Mark Dates]

6.72.2 Other-Post Mark Dates Panel Layout



6.72.3 Other-Post Mark Dates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CMS Error Report	Centers for Medicare and Medicaid Services (CMS) Error Report.	Field	Date (MM/DD/CCYY)	8
CMS Invoice Tape Sent	Centers for Medicare and Medicaid Services (CMS) Invoice Tape Sent.	Field	Date (MM/DD/CCYY)	8
CMS Tape Received	Centers for Medicare and Medicaid Services (CMS) Tape Received.	Field	Date (MM/DD/CCYY)	8
Invoice Mail Date	Evidence, as indicated by the postmark of the United States Postal Service or other common mail carrier, on the envelope (not the postage meter stamp) of the date invoice was mailed.	Field	Date (MM/DD/CCYY)	8
Invoice Period	Quarter and year of the invoice.	Field	Date (Q/CCYY)	5
Invoice Type	Represents the invoice type.	Combo Box	Drop Down List Box	0
Run Date	Date the invoice process was run and entered in AMMIS.	Field	Date (MM/DD/CCYY)	8

6.72.4 Other-Post Mark Dates Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CMS Error Report	Field	1	CMS Error Report must be greater than CMS Invoice Tape Sent.	Enter a date > CMS Invoice Tape Sent.
	Field	98001	Invalid date.	Verify date and re-enter.
CMS Invoice Tape Sent	Field	1	CMS Invoice Tape Sent must be greater than or equal to Run Date.	Enter a date >= Run Date.
	Field	98001	Invalid date.	Verify date and re-enter.
CMS Tape Received	Field	1	CMS Tape Received must be less than Run Date.	Enter a date < Run Date.
	Field	98001	Invalid date. Format is MM/DD/CCYY.	Verify date and re-enter.
Invoice Mail Date	Field	1	Invoice Mail Date must be greater than or equal to Run Date.	Enter a date >= Run Date.
	Field	98001	Invalid date.	Verify date and re-enter.

6.72.5 Other-Post Mark Dates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.72.6 Other-Post Mark Dates Panel Accessibility

6.72.6.1 To Access the Other - Post Mark Dates Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug**; Click **Related Data**.	Related Data Panel displays.
3	Click **Other**.	Other-Related Data page displays.
4	Click Post Mark Dates.	Other-Post Mark Dates panel displays.

6.72.6.2 To Update the Other - Post Mark Dates Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Other-Post Mark Dates panel information is

Step	Action	Response
		updated.

6.73 Other-Public Health Service Providers Panel Overview

6.73.1 Other-Public Health Service Providers Panel Narrative

The Other-Public Health Service Providers panel is used to view the PHS and HIS entities which are excluded from the Drug Rebate invoice process. The panel displays the Medicaid provider number, provider name, and entity type. Upon entering the panel, a list of PHS providers display without performing a search. The search function only refines the list.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Other] - [Public Health Service]

6.73.2 Other-Public Health Service Providers Panel Layout

6.73.3 Other-Public Health Service Providers Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Public Health Service Provider information.	Button	N/A	0
Clear	Allows the user to clear any changes on the Other-Public Health Service Providers panel.	Button	N/A	0
Entity Type	Identifies the classification of the Public Health Service (PHS) and Indian Health Service (IHS) Entity.	Combo Box	Drop Down List Box	0
PHS Provider Name	Search field used to refine the list of Public Health Service (PHS) providers based on their name.	Field	Character	50

Field	Description	Field Type	Data Type	Length
PHS Provider Number	Search field used to find a particular Public Health Service (PHS) provider by their provider number and service location code.	Field	Character	15
Provider ID Type	Provider's identification type.	Field	Character	3
Provider Name	Contains the name of the Medicaid provider or entity name as identified on the Public Health Service (PHS) and Indian Health Service (IHS) Service data set files.	Field	Character	50
Provider Number	Displays the unique identifier for the provider and a Public Health Service (PHS) and Indian Health Service (IHS) as indicated on the PHS and IHS data set files.	Field	Character	15
Search	Initiates the Search by PHS Provider Number or PHS Provider Name.	Button	N/A	0
Segment Effective Date	Date that the Public Health Service (PHS) and Indian Health Service (IHS) provider became eligible to participate in the Medicaid program.	Field	Date (MM/DD/CCYY)	8
Segment End Date	Date the Public Health Service (PHS) and Indian Health Service (IHS) provider is no longer enrolled in the Medicaid program.	Field	Date (MM/DD/CCYY)	8

6.73.4 Other-Public Health Service Providers Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	1	At least on Provider Dates item is required.	Click the Add button on the Provider Dates Panel and enter the Segment Dates; required when creating a PHS Provider.
Entity Type	Field	91080	A valid PHS Entity Type is required.	Select Entity Type from the dropdown list.

Field	Field Type	Error Code	Error Message	To Correct
Provider Name	Field	91080	Provider Name is required.	Enter a valid provider number and service location code in Provider Number field to get the provider name.
Provider Number	Field	91080	A valid PHS Provider Service Location is required.	Enter a valid provider number and service location code in Provider Number field.
Segment Effective Date	Field	8034	Segment Effective Date must be less than or equal to Segment End Date.	Segment Effective Date must be less than or equal to Segment End Date.
	Field	91070	Invalid date.	Enter a valid date in MMDDCCYY or MM/DD/CCYY format.
Segment End Date	Field	8034	Segment Effective Date must be less than or equal to Segment End Date.	Segment Effective Date must be less than or equal to Segment End Date.
	Field	91070	Invalid date.	Enter a valid date in MMDDCCYY or MM/DD/CCYY format.

6.73.5 Other-Public Health Service Providers Extra Features

Field	Field Type
No extra features found for this panel.	

6.73.6 Other-Public Health Service Providers Panel Accessibility

6.73.6.1 To Access the Other - Public Health Service Providers Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other – Related Data page displays.
4	Click Public Health Service Providers.	Other-Public Health Service Providers panel displays.

6.73.6.2 To Add on the Other - Public Health Service Providers Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Provider Number.	
3	Select **Entity Type** from drop down list.	
4	Enter **Segment Effective Date** in MM/DD/CCYY format	
5	Enter **Segment End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Other-Public Health Service Providers Information is saved.

6.73.6.3 To Update on the Other - Public Health Service Providers Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Other –Public Health Service Providers information is updated.

6.74 Other-Recoup Letter Panel Overview

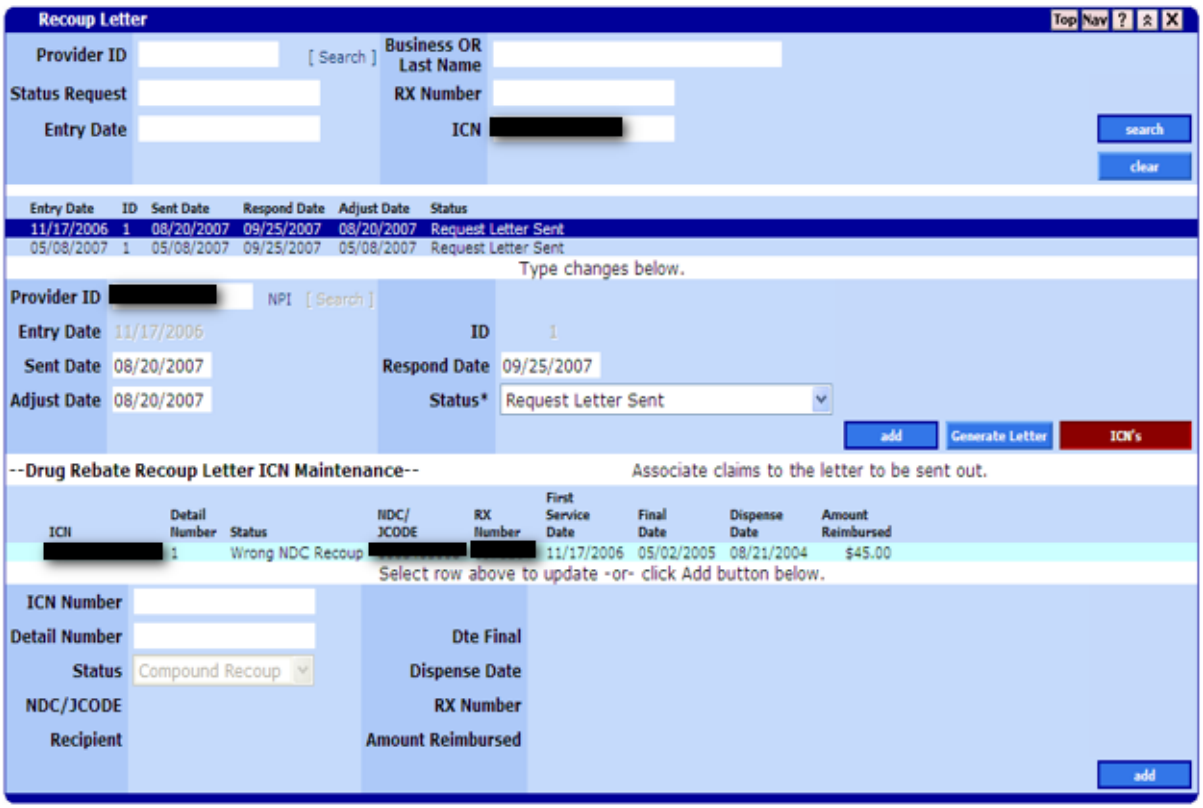
6.74.1 Other-Recoup Letter Panel Narrative

The Other – Recoup Letter panel is the driving panel for the recoupment letter process.

This panel is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Other] - [Recoup Letter]

6.74.2 Other-Recoup Letter Panel Layout



6.74.3 Other-Recoup Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recoup Letter information.	Button	N/A	0
Add	Add a ICN attached to this recoup letter. This is for Recoup Letter ICN Maintenance	Button	N/A	0
Adjust Date	Date the system initiated adjustment transactions against the internal control numbers associated with the request letter.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
Amount Reimbursed	Total amount reimbursed for the claim. This is the amount from the claim header. This is for Recoup Letter internal control number Maintenance.	Field	Number (Decimal)	12
Business Or Last Name	Name of the provider (business or last name).	Field	Character	50
Clear	Allows the user to clear any changes on the Other-Recoup Letter panel.	Button	N/A	0
Detail Number	Detail number of the claim. This is for Recoup Letter internal control number Maintenance.	Field	Number (Integer)	4
Dispense Date	Dispense date on the claim. This is for Recoup Letter internal control number Maintenance.	Field	Date (MM/DD/CCYY)	8
Dte Final	Intended to store the assigned Financial date. This is for Recoup Letter internal control number Maintenance.	Field	Date (MM/DD/CCYY)	8
Entry Date	Date the late request letter was entered in the system.	Field	Date (MM/DD/CCYY)	8
Final Date	Intended to store the assigned Financial date. This is for Recoup Letter internal control number Maintenance.	Field	Date (MM/DD/CCYY)	8
First Service Date	Date the late request letter was entered in the system. This is for Recoup Letter internal control number Maintenance.	Field	Date (MM/DD/CCYY)	8
Generate Letter	Generate a Recoupment Letter. This button is enabled when there is a Recoup Letter AND an ICN Selected (in each Data List) AND when the Recoup Letter Status is either "Request Letter Sent," "Notification Letter Sent" or "Ready To Process/Initiate Adjustments".	Button	N/A	0

Field	Description	Field Type	Data Type	Length
ICN (Number)	Internal Control Number. This is for Recoup Letter internal control number Maintenance.	Field	Number (Integer)	13
ICN's	Displays the Drug Rebate Recoup ICN Maintenance panel.	Button	N/A	0
ID	Unique identification number for the recoupment letter.	Field	Number (Integer)	4
NDC/JCODE	Contains either the JCode or the National Drug Code (NDC) for the internal control number detail, depending on its claim type. This is for Recoup Letter internal control number Maintenance.	Field	Number (Integer)	11
Provider ID	Provider identification value.	Field	Number (Integer)	15
Recipient	Recipient is a person that receives Medicaid coverage or coverage under a special state funded program. This is for Recoup Letter internal control number Maintenance.	Field	Character	35
Respond Date	The postmark date of the response from the provider to the request letter.	Field	Date (MM/DD/CCYY)	8
RX Number	Number assigned by a pharmacy to identify the drug dispensed to a beneficiary. This is for Recoup Letter internal control number Maintenance.	Field	Number (Integer)	12
Search	Initiates the Search by Provider ID, Status Request, Entry Date, Business OR Last Name, RX Date or ICN.	Button	N/A	0
Sent Date	Date on which the recoupment letter was sent.	Field	Date (MM/DD/CCYY)	8
Status	Code indicating the status of the internal control number. This is for Recoup Letter internal control number Maintenance.	Combo Box	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Status Request	Code indicating the status of the letter request.	Combo Box	Drop Down List Box	0

6.74.4 Other-Recoup Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Status	Combo Box	8	Status is required.	Verify keying. Enter a value for Status.
Adjust Date	Field	7	Invalid date.	Verify keying. Use correct date format.
Detail Number	Field	1	Detail Number is required.	Verify keying. Enter a value for Detail Number.
Dispense Date	Field	1	Dispense Date is required.	Enter a valid Dispense Date.
Dte Final	Field	1	Dte Final is required.	Enter a valid Dte Final.
First Service Date	Field	1	First Service Date is required.	Enter a valid First Service Date.
ICN Number	Field	1	ICN is required.	Verify keying. Enter a value for ICN.
ICN	Field	91072	ICN must be numeric.	Verify keying. Enter a valid ICN.
Provider ID	Field	17	A valid Provider Service Loc is required.	Enter a value.
RX Number	Field	1	RX Number is required.	Provide RX Number.
Recipient	Field	29	A valid Recipient is required.	Choose a valid Recipient.
Respond Date	Field	5	Invalid date.	Verify keying. Use correct date format.
	Field	6	Invalid date.	Verify keying. Use correct date format.
	Field	16	Sent Date must be less than or equal to Respond Date.	Type a date that is less or equal to respond date.

6.74.5 Other-Recoup Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.74.6 Other-Recoup Letter Panel Accessibility

6.74.6.1 To Access the Other - Recoup Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data Panel displays.
3	Click **Other**.	Other – Related Data page displays.
4	Click Recoup Letter.	Other-Recoup Letter panel displays.

6.74.6.2 To Add on the Other - Recoup Letter Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Provider ID.	
3	Enter Sent Date.	
4	Enter Adjust Date.	
5	Enter Respond Date.	
6	Enter RX Number.	
7	Enter **ICN**.	
8	Select **Status** from drop down list.	
9	Click **Save**.	Other-Recoup Letter panel is saved.

6.74.6.3 To Update on the Other - Recoup Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Enter updated information in designated fields.	
3	Click **Save**.	Other-Recoup Letter information is updated.

6.75 Other-T Bill Rate Panel Overview

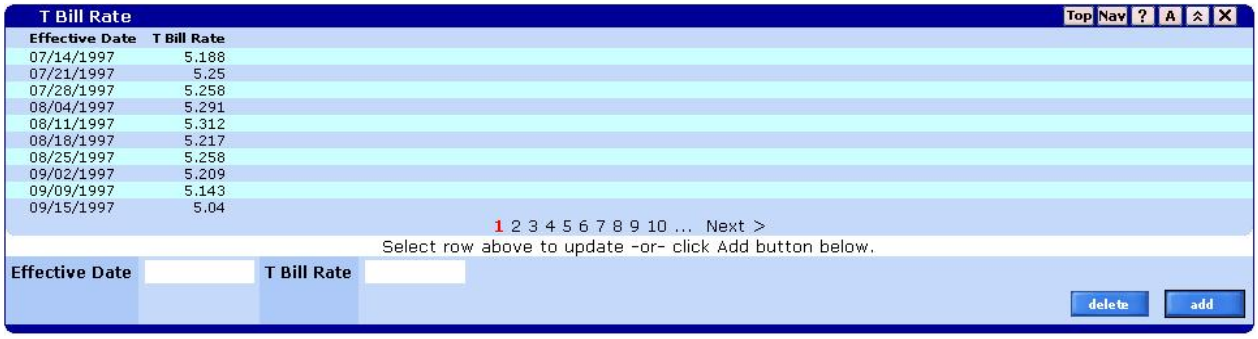
6.75.1 Other-T Bill Rate Panel Narrative

The T-Bill Rate panel is used to inquire, update, or add the 90-day Treasury bill auction rates on a weekly basis. These rates are identified through CMS releases. The T-bill rates are used by the Drug Rebate unit to assess interest.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug - Related Data] - [Other] - [T Bill Rate]

6.75.2 Other-T Bill Rate Panel Layout



6.75.3 Other-T Bill Rate Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add T Bill Rate information.	Button	N/A	0
Delete	Allows the user to remove T Bill Rate information.	Button	N/A	0
Effective Date	Effective date of associated T-bill rate.	Field	Date (MM/DD/CCYY)	8
T Bill Rate	Current T-bill percentage rate for the effective date entered.	Field	Number (Decimal)	9

6.75.4 Other-T Bill Rate Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	8016	A duplicate record cannot be saved.	Cannot use same date previously entered, and must re-enter different date.
	Field	8033	Effective date is required.	Must enter Effective Date.
	Field	8034	Invalid date.	Must enter date with correct format.
T Bill Rate	Field	8185	T Bill Rate must be less than or equal to 99.9999.	Verify rate and re-enter.

Field	Field Type	Error Code	Error Message	To Correct
	Field	8186	Enter a valid value.	Verify rate and re-enter.
	Field	91008	T Bill Rate must be greater than or equal to 0.0001.	Verify rate and re-enter.
	Field	91009	T Bill Rate is required.	Verify rate and re-enter.

6.75.5 Other-T Bill Rate Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.75.6 Other-T Bill Rate Panel Accessibility

6.75.6.1 To Access the Other - T Bill Rate Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data Panel displays.
3	Click **Other**.	Other-Related Data page displays.
4	Click T Bill Rate.	T Bill Rate panel displays.

6.75.6.2 To Add on the Other - T Bill Rate Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Effective Date.	
3	Enter T Bill Rate.	
4	Click **Save**.	T Bill Rate information is saved.

6.75.6.3 To Update on the Other – T Bill Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Other – T Bill Rate information is updated.

6.75.6.4 To Delete on the Other – T Bill Rate Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	User is prompted to answer if the row selected is the row they want marked for deletion.
3	Click **OK**.	Line item is deleted.

6.76 Other-Unit Conversion Maintenance Panel Overview

6.76.1 Other-Unit Conversion Maintenance Panel Narrative

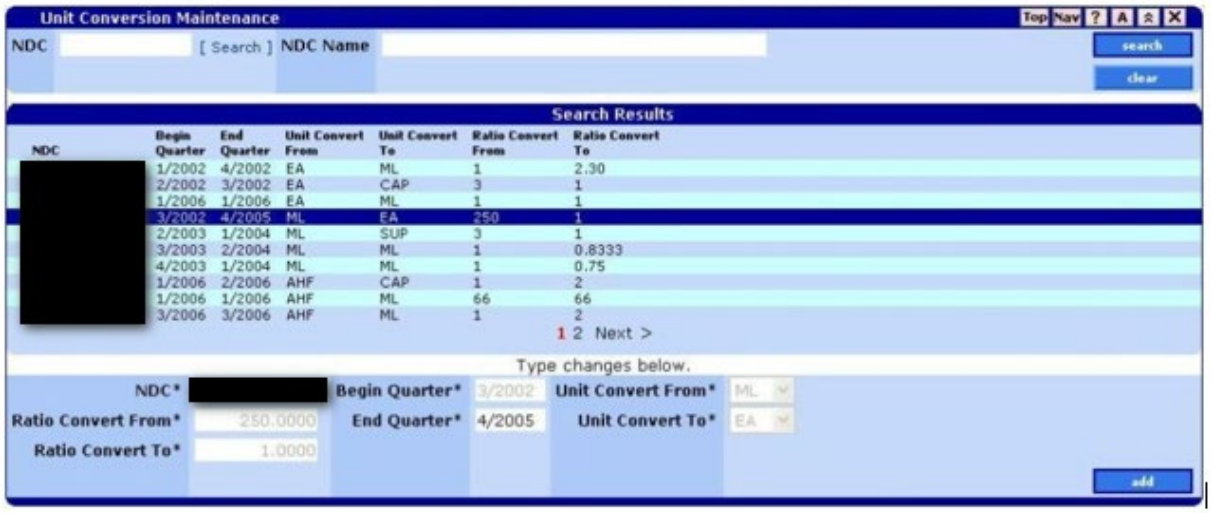
The Other-Unit Conversion Maintenance panel is used to view and maintain conversion information to be used in the invoicing process. This conversion information is used proactively to avoid disputed NDCs.

Sometimes there is a discrepancy between the CMS unit of measure and the First DataBank (FDB) unit of measure. CMS establishes the Rate per Unit (RPU) based on their unit of measure, yet the claims have processed under the FDB unit of measure. This panel allows the drug rebate unit to establish conversion ratios to be used in invoicing to properly convert the units.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [Related Data] - [Other] - [Unit Conversion Maintenance]

6.76.2 Other-Unit Conversion Maintenance Panel Layout



6.76.3 Other-Unit Conversion Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add conversion information.	Button	N/A	0
Begin Quarter	The first quarter in which the conversion should take place.	Field	Date (Q/CCYY)	5
Clear	Allows the user to clear any changes on the Other-Unit Conversation Maintenance panel.	Button	N/A	0
End Quarter	The last quarter in which the conversion should take place.	Field	Date (Q/CCYY)	5

Field	Description	Field Type	Data Type	Length
NDC	National Drug Code of the drug invoiced. This field comprises the five-digit labeler code, four-digit product code, and the two-digit package size code.	Field	Number (Integer)	11
Ratio Convert From	The ratio being converted from.	Field	Number (Decimal)	8
Ratio Convert To	The ratio being converted to	Field	Number (Decimal)	8
Search	Initiates the Search by NDC or NDC Name.	Button	N/A	0
Unit Convert From	The units from which the claim are converted. Valid values are: EA, GM, and ML.	Combo Box	Drop Down List Box	0
Unit Convert To	The units to which the claim are converted. Valid values are: AHF, CAP, EA, GM, ML, SUP, TAB and TDP.	Combo Box	Drop Down List Box	0

6.76.4 Other-Unit Conversion Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Quarter	Field	8188	Enter a valid value.	Re-enter a valid quarter and year.
	Field	91029	Begin Quarter must be less than or equal to End Quarter.	Verify Begin and End Quarters and re-enter.
	Field	91115	Beginning Quarter must be greater than last invoice quarter!	Verify Begin and End Quarters and re-enter.
End Quarter	Field	8188	Enter a valid value.	Re-enter valid quarter and year.
	Field	91029	Begin Quarter must be less than or equal to End Quarter.	Verify Begin and End Quarters and re-enter.
	Field	91081	Ending Quarter must be greater than last invoice quarter.	Verify End Quarter and re-enter.
NDC	Field	1	Enter a valid value.	Verify and re-enter valid

Field	Field Type	Error Code	Error Message	To Correct
				NDC.
Ratio Convert From	Field	91077	Ratio Convert From must be less than or equal to 9999.9999.	Re-enter a ratio less than 10,000.00.
	Field	91136	Ratio Convert From must be greater than or equal to 0.0001.	Re-enter a ratio greater than zero.
Ratio Convert To	Field	91077	Ratio Convert To must be less than or equal to 9999.9999.	Re-enter a ratio less than 10,000.00.
	Field	91136	Ratio Convert To must be greater than or equal to 0.0001.	Re-enter a ratio greater than zero.
Unit Convert To	Combo Box	91152	A valid Unit Convert To is required.	Select a unit to convert to.
Unit Convert From	Combo Box	91152	A valid Unit Convert From is required.	Select a unit to convert from.

6.76.5 Other-Unit Conversion Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.76.6 Other-Unit Conversion Maintenance Panel Accessibility

6.76.6.1 To Access the Other - Unit Conversion Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Other**.	Other-Related Data page displays.
4	Click Unit Conversion Maintenance.	Other-Unit Conversion Maintenance panel displays.

6.76.6.2 To Add on the Other – Unit Conversion Maintenance Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **NDC**.	
3	Enter Ratio Convert From.	
4	Enter Ratio Convert To.	

Step	Action	Response
5	Enter Begin Quarter.	
6	Enter End Quarter.	
7	Enter **Unit Convert From** the drop down list.	
8	Enter **Unit Convert To** from the drop down list.	
9	Click **Save**.	Unit Conversion Maintenance information is saved.

6.76.6.3 To Update on the Other – Unit Conversion Maintenance Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Unit Conversion Maintenance information is updated.

6.77 Xref-Related Data Page Overview

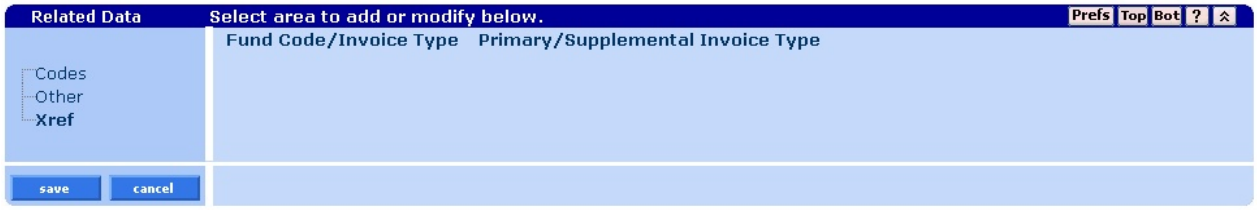
6.77.1 Xref-Related Data Page Narrative

The Xref Related Data page is used to view and maintain Drug Rebate related cross reference code tables.

This page is for inquiry only.

Navigation Path: [Drug] - [Related Data] - [Xref]

6.77.2 Xref-Related Data Page Layout



6.77.3 Xref-Related Data Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Xref Related Data page.	Button	N/A	0
Fund Code/Invoice Type	Link to the Fund Code/Invoice Type.	Hyperlink	N/A	0
Primary/Supplemental Invoice Type	Link to the Primary/Supplemental Invoice Type panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Xref Related Data page.	Button	N/A	0

6.77.4 Xref-Related Data Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.77.5 Xref-Related Data Pa ge Extra Features

Field	Field Type
No extra features found for this page.	

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6.77.6 Xref-Related Data Page Accessibility

6.77.6.1 To Access the Xref – Related Data Page

Step	Action	Response
1	Enter **User Name** and **Passwor**d; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data page displays.

6.78 Xref-Fund Code/Invoice Type Panel Overview

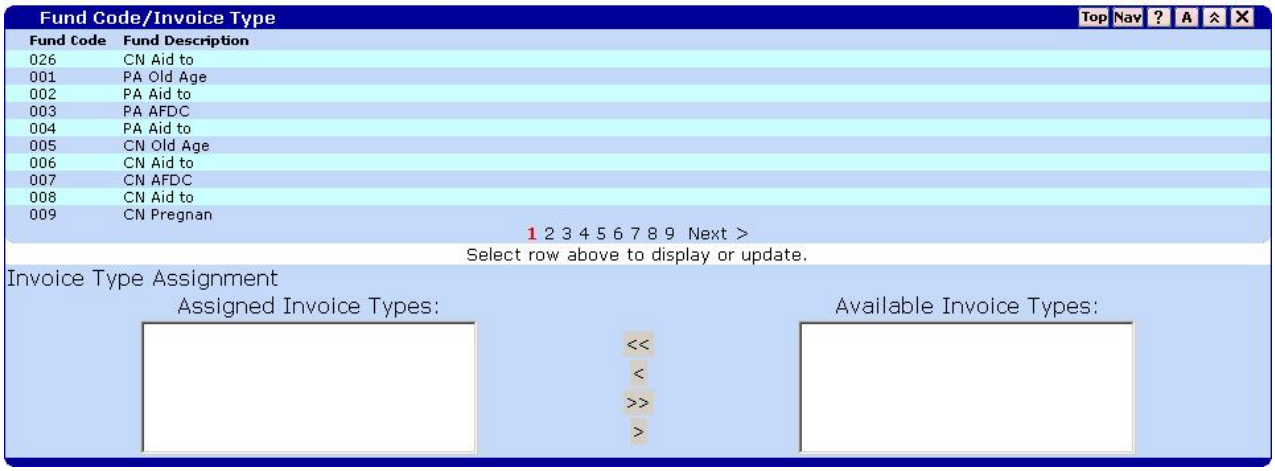
6.78.1 Xref-Fund Code/I nvoice Type Panel Narrative

The Drug Rebate system uses funding codes to determine which rebate program(s) or invoice type(s) a claim is included. The Xref-Fund Code/Invoice Type panel is used for establishing and maintaining which funding codes cross walk to which rebate programs. The claims system assigns the funding code during claims processing and Drug Rebate quarterly processing uses this cross walk to assign the claim to the proper rebate program.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug Rebate] - [Related Data] - [Xref] - [Fund Code/Invoice Type]

6.78.2 Xref-Fund Code/Invoice Type Panel Layout



6.78.3 Xref-Fund Code/Invoice Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
<	Assign the selected available invoice type.	Button	N/A	0
<<	Move all available invoice types to assigned invoice types.	Button	N/A	0
>	Remove one assigned invoice type.	Button	N/A	0
>>	Move all assigned invoice types.	Button	N/A	0
Assigned Invoice Types	Assigned Invoice Type.	Field	Character	33
Available Invoice Types	Available Invoice Type.	Field	Character	33
Fund Code	Fund code that is used in financial reporting to correctly categorize funds (money).	Field	Number (Integer)	3

Field	Description	Field Type	Data Type	Length
Fund Description	Description of the financial fund code that is used for reporting.	Field	Character	50

6.78.4 Xref-Fund Code/Invoice Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.78.5 Xref-Fund Code/Invoice Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.78.6 Xref-Fund Code/Invoice Type Panel Accessibility

6.78.6.1 To Access the Xref - Fund Code/Invoice Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data page displays.
4	Click Fund Code/Invoice Type.	Fund Code/Invoice Type panel displays.

6.78.6.2 To Update the Xref – Fund Code/Invoice Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Fund Code/Invoice Type information is updated.

6.79 Primary/Supplemental Invoice Type Panel Overview

6.79.1 Primary/Supplemental Invoice Type Panel Narrative

The Primary/Supplemental Invoice Type panel is used to view the relationship between Invoice Types (that is, identifying which supplemental invoice type corresponds to which primary invoice type).

This panel is display only.

Navigation Path: [Drug Rebate] - [Related Data] - [Xref] - [Primary/Supplemental Invoice Type]

6.79.2 Primary/Supplemental Invoice Type Panel Layout

6.79.3 Primary/Supplemental Invoice Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	The date the supplemental invoice type became effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date the supplemental invoice type ended.	Field	Date (MM/DD/CCYY)	8
Primary Invoice Type	Primary Invoice Type.	Field	Character	2
Supplemental Invoice Type	Supplemental Invoice Type.	Field	Character	2

6.79.4 Primary/Supplemental Invoice Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.79.5 Primary/Supplemental Invoice Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.79.6 Primary/Supplemental Invoice Type Panel Accessibility

6.79.6.1 To Access the Xref – Primary/Supplemental Invoice Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data page displays.

Step	Action	Response
4	Click Primary/Supplemental Invoice Type.	Primary/Supplemental Invoice Type panel displays.

6.80 Reports and Letters Panel Overview

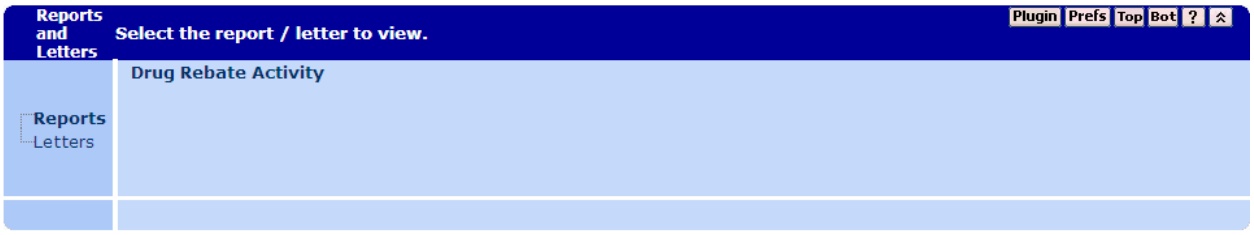
6.80.1 Reports and Letters Panel Narrative

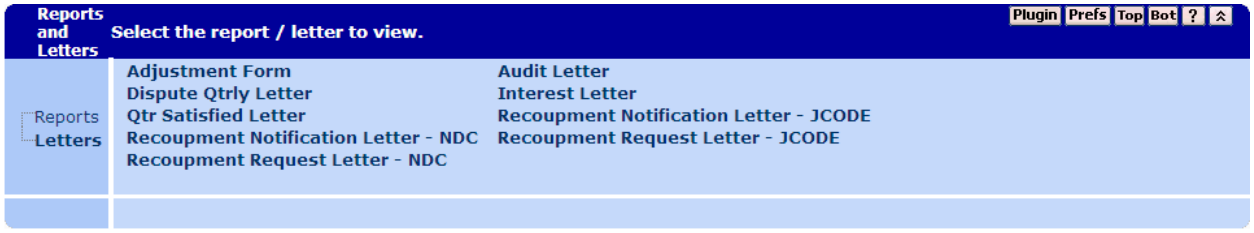
The Reports and Letters panel allows users to select from a list of letters to view.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters]

6.80.2 Reports and Letters Panel Layout





6.80.3 Reports and Letters Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Form	Link to the Adjustment Form panel.	Hyperlink	N/A	0
Audit Letter	Link to the Audit Letter panel.	Hyperlink	N/A	0
Dispute Qtrly Letter	Link to the Dispute Quarterly Letter panel.	Hyperlink	N/A	0
Drug Rebate Activity	Link to the Drug Rebate Activity panel.	Hyperlink	N/A	0
Interest Letter	Link to the Interest Letter panel.	Hyperlink	N/A	0
Letters	Link to all the letter panels.	Hyperlink	N/A	0
Qtr Satisfied Letter	Link to the Qtr Satisfied Letter panel.	Hyperlink	N/A	0

Field	Description	Field Type	Data Type	Length
Recoupment Notification Letter-JCODE	Link to the Recoupment Notification Letter- JCODE panel.	Hyperlink	N/A	0
Recoupment Notification Letter-NDC	Link to the Recoupment Notification Letter- NDC panel.	Hyperlink	N/A	0
Recoupment Request Letter-JCODE	Link to the Recoupment Request Letter- JCODE panel.	Hyperlink	N/A	0
Recoupment Request Letter-NDC	Link to the Recoupment Request Letter- NDC panel.	Hyperlink	N/A	0
Report	Link to the Report panels.	Hyperlink	N/A	0

6.80.4 Reports and Letters Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.80.5 Reports and Letters Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.80.6 Reports and Letters Panel Accessibility

6.80.6.1 To Access the Reports and Letters Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts & Letters**.	Reports and Letters panel displays.

6.81 Adjustment Form Panel Overview

6.81.1 Adjustment Form Panel Narrative

The Adjustment Form panel is used to view claims adjustments by internal control number.

This panel is inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Adjustment Form]

6.81.2 Adjustment Form Panel Layout

6.81.3 Adjustment Form Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Adjustment Form panel.	Button	N/A	0
ICN	Indicates the internal control number for which the Drug Rebate Unit is requesting information.	Field	Number (Integer)	13
Search	Initiates the Search by ICN.	Button	N/A	0

6.81.4 Adjustment Form Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ICN	Field	1	Enter the Internal Control Number.	ICN is required for search.
	Field	2	Internal Control Number must be numeric.	Enter a numeric value.
	Field	3	Internal Control Number length must be at least 13 digits.	ICN length must be at least 13 digits.

6.81.5 Adjustment Form Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 Adjustment Form Panel Accessibility

6.81.6.1 To Access the Adjustment Form Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Drug and click Reports and Letters.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click **Adjustment Form** hyperlink.	Adjustment Form panel displays.

6.81.6.2 To Navigate the Adjustment Form Panel

Step	Action	Response
1	Enter an **ICN** (Internal Control Number).	
2	Click **Search**.	ICN information displays.

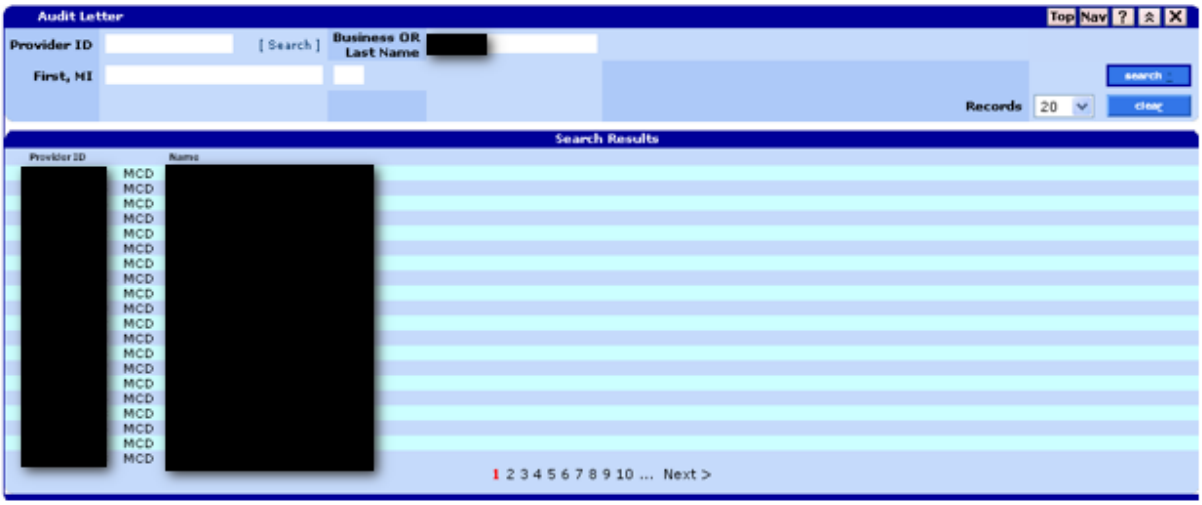
6.82 Audit Letter Panel Overview

6.82.1 Audit Letter Panel Narrative

The Audit Letter panel is used to view Audit letters associated with a specific provider. This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Audit Letter]

6.82.2 Audit Letter Panel Layout



6.82.3 Audit Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Displays the organization name or last name of provider to search on.	Field	Character	25
Clear	Allows the user to clear any changes on the Audit Letter panel.	Button	N/A	0
First	Displays the first name of provider to search on.	Field	Character	13
MI	Displays the middle initial of provider to search on.	Field	Character	11
Name	Displays the organization name or last name, first name, and middle initial of provider.	Field	Character	50
Provider ID	Provider identification number used by the provider.	Field	Number (Integer)	15
Provider ID Type	This is the provider's identification type.	Field	Character	3

Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name.	Button	N/A	0
[Search]	Allows the user to search for a Provider ID.	Hyperlin k	N/A	0

6.82.4 Audit Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
First	Field	1	Business OR Last Name is required when searching on First and/or MI.	Business OR Last Name is required when searching on First and/or MI.
	Field	1	Business OR Last Name is required when searching on First and/or MI.	Business OR Last Name is required when searching on First and/or MI.

6.82.5 Audit Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.82.6 Audit Letter Panel Accessibility

6.82.6.1 To Access the Audit Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Drug and click Reports and Letters.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click Audit Letter.	Audit Letter panel displays.

6.82.6.2 To Navigate the Audit Letter Panel

Step	Action	Response
1	Enter a Provider ID and/or Business/Last Name.	
2	Click **Search**.	List of Labeler Information displays.

Step	Action	Response
3	Click on a record from search results.	Audit Letter Information displays.

6.83 Dispute Qtrly Letter Panel Overview

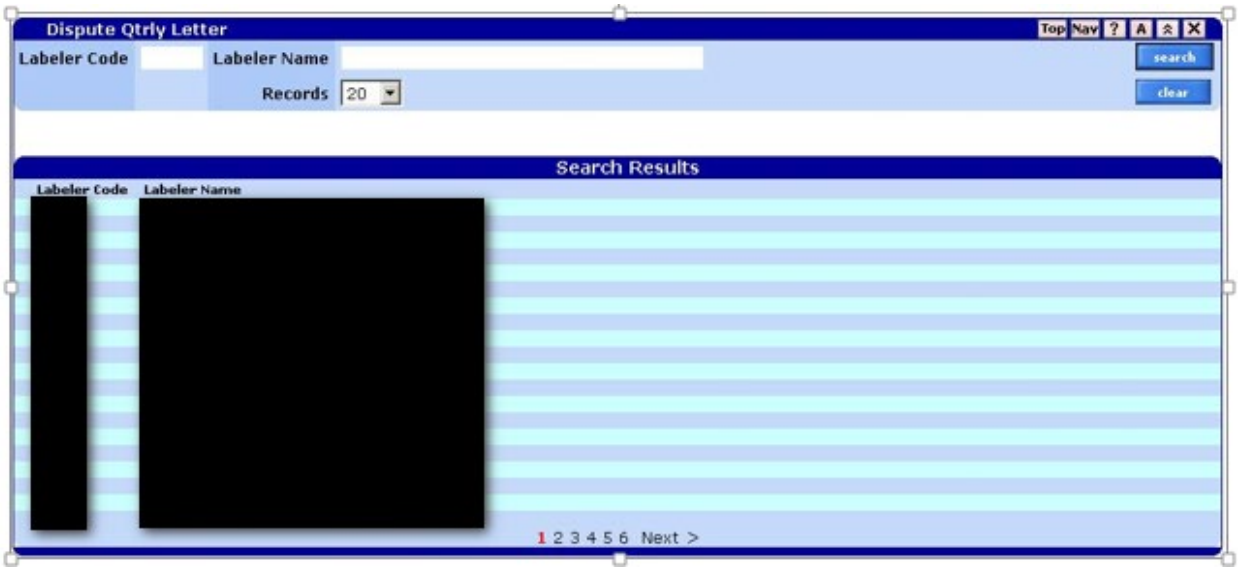
6.83.1 Dispute Qtrly Letter Panel Narrative

This panel is used to view the Dispute Qtrly Criteria Letter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Dispute Qtrly Letter]

6.83.2 Dispute Qtrly Letter Panel Layout



6.83.3 Dispute Qtrly Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Dispute Qtryl Letter panel.	Button	N/A	0
Labeler Code	Code used to uniquely identify the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first 5 characters of the labeler's National Drug Code (NDC).	Field	Number (Integer)	5
Labeler Name	Displays the name of the drug labeler.	Field	Character	39
Records	Allows the user to select the number of records to display per page.	Comb o Box	Drop Down List Box	0
Search	Initiates the Search by Labeler Code and/or Labeler Name.	Button	N/A	0

6.83.4 Dispute Qtrly Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.83.5 Dispute Qtrly Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.6 Dispute Qtrly Letter Panel Accessibility

6.83.6.1 To Access the Dispute Qtrly Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click Letters.	Listing of links for letters displays.
4	Click Dispute Qtrly Letter.	Dispute Qtrly Letter panel displays.

6.83.6.2 To Navigate the Dispute Qtrly Letter Panel

Step	Action	Response
1	Enter a Labeler Code and/or Labeler Name and Click Search.	Dispute Qtrly Letter displays.

Drug Rebate Activity Panel Overview

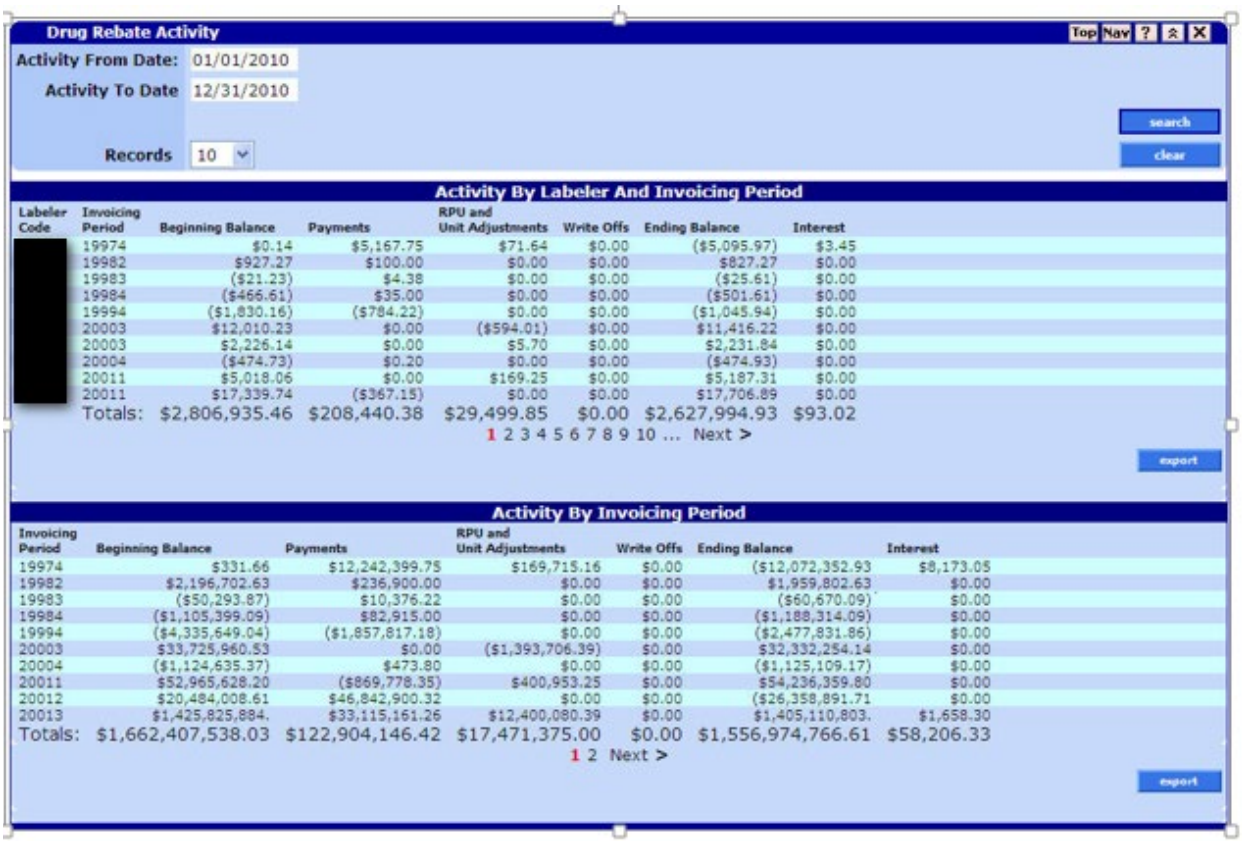
6.83.7 Drug Rebate Activity Panel Overview

The Reports-Drug Rebate Activity panel allows a user to create an on-demand report specifying the Activity From Date and the Activity To Date.

This panel is for inquiry only, and it displays the records initially sorted by labeler and invoicing period.

Navigation Path: [Drug] – [Rpts & Letters] – [Reports] – [Drug Rebate Activity]

6.83.8 Drug Rebate Activity Panel Layout



Drug Rebate Activity

Activity From Date: 01/01/2010
Activity To Date 12/31/2010
Records 10

search
clear

Activity By Labeler And Invoicing Period

Labeler Code	Invoicing Period	Beginning Balance	Payments	RPU and Unit Adjustments	Write Offs	Ending Balance	Interest
[redacted]	19974	$0.14	$5,167.75	$71.64	$0.00	($5,095.97)	$3.45
	19982	$927.27	$100.00	$0.00	$0.00	$827.27	$0.00
	19983	($21.23)	$4.38	$0.00	$0.00	($25.61)	$0.00
	19984	($466.61)	$35.00	$0.00	$0.00	($501.61)	$0.00
	19994	($1,830.16)	($784.22)	$0.00	$0.00	($1,045.94)	$0.00
	20003	$12,010.23	$0.00	($594.01)	$0.00	$11,416.22	$0.00
	20003	$2,226.14	$0.00	$5.70	$0.00	$2,231.84	$0.00
	20004	($474.73)	$0.20	$0.00	$0.00	($474.93)	$0.00
	20011	$5,018.06	$0.00	$169.25	$0.00	$5,187.31	$0.00
	20011	$17,339.74	($367.15)	$0.00	$0.00	$17,706.89	$0.00
	Totals:	$2,806,935.46	$208,440.38	$29,499.85	$0.00	$2,627,994.93	$93.02

1 2 3 4 5 6 7 8 9 10 ... Next >

export

Activity By Invoicing Period

Invoicing Period	Beginning Balance	Payments	RPU and Unit Adjustments	Write Offs	Ending Balance	Interest
19974	$331.66	$12,242,399.75	$169,715.16	$0.00	($12,072,352.93	$8,173.05
19982	$2,196,702.63	$236,900.00	$0.00	$0.00	$1,959,802.63	$0.00
19983	($50,293.87)	$10,376.22	$0.00	$0.00	($60,670.09)	$0.00
19984	($1,105,399.09)	$82,915.00	$0.00	$0.00	($1,188,314.09)	$0.00
19994	($4,335,649.04)	($1,857,817.18)	$0.00	$0.00	($2,477,831.86)	$0.00
20003	$33,725,960.53	$0.00	($1,393,706.39)	$0.00	$32,332,254.14	$0.00
20004	($1,124,635.37)	$473.80	$0.00	$0.00	($1,125,109.17)	$0.00
20011	$52,965,628.20	($869,778.35)	$400,953.25	$0.00	$54,236,359.80	$0.00
20012	$20,484,008.61	$46,842,900.32	$0.00	$0.00	($26,358,891.71	$0.00
20013	$1,425,825,884.	$33,115,161.26	$12,400,080.39	$0.00	$1,405,110,803.	$1,658.30
Totals:	$1,662,407,538.03	$122,904,146.42	$17,471,375.00	$0.00	$1,556,974,766.61	$58,206.33

1 2 Next >

export

6.83.9 Drug Rebate Activity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Activity From Date	The beginning date for the report of invoice activity	Field	Date (MM/DD/CCYY)	10
Activity To Date	The balance of the line item as of the Activity From Date.	Field	Date (MM/DD/CCYY)	10
Beginning Balance	The balance of the line item as of the Activity From Date.	Field	Number (Decimal)	15

Field	Description	Field Type	Data Type	Length
clear	Clear dates entered for a search	Button	N/A	0
Ending Balance	The balance of the line item as of the Activity To Date.	Field	Number (Decimal)	15
export	Export data into Excel spreadsheet	Button	N/A	0
Interest	Sum of all interest applied to the line item between the Activity From and Activity To Dates.	Field	Number (Decimal)	15
Invoicing Period	Displays quarter date for which the Posting Activity information is displayed.	Field	Character	5
Labeler Code	This code is used to uniquely identify the labeler of a drug. This code is assigned by CMS and is used as the first five characters of the labeler's NDCs.	Field	Character	5
Payments	Sum of all payments applied to the line item between the Activity From and Activity To Dates.	Field	Number (Decimal)	15
RPU and Unit Adjustments	Sum of all adjustments made to the line item between the Activity From and Activity To Dates.	Field	Number (Decimal)	15
Records	Select 5, 10, 20, 50, or 100 records to be displayed on the Activity By Labeler And Invoicing Period panel	Combo Box	Drop Down List Box	0
search	Search for activity using the specified dates	Button	N/A	0
Write Offs	Sum of all write-offs performed for the line item	Field	Number (Decimal)	15

Field	Description	Field Type	Data Type	Length
	between the Activity From and Activity To Dates.			

6.83.10 Drug Rebate Activity Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No Edit Error Codes – Panel is for inquiry only				

6.83.11 Drug Rebate Activity Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.12 RDrug Rebate Activity Panel Accessibility

6.83.12.1 To Access the Reports-Drug Rebate Activity Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts and Letters**.	Reports and Letters panel displays; with Reports link highlighted.
3	Click on Drug Rebate Activity	Drug Rebate Activity Search panel will be displayed
4	Enter dates for the search criteria, select the number of records to display and click the **search** button	Activity By Labeler and Invoicing Period and Activity By Invoicing Period panels will display.
5	To export data to Excel spreadsheet for either the Activity By Labeler and Invoicing Period panel or the Activity By Invoicing Period panel, click the **export** button on the corresponding panel	Dialog to view or save the data will be displayed

6.84 Interest Letter Panel Overview

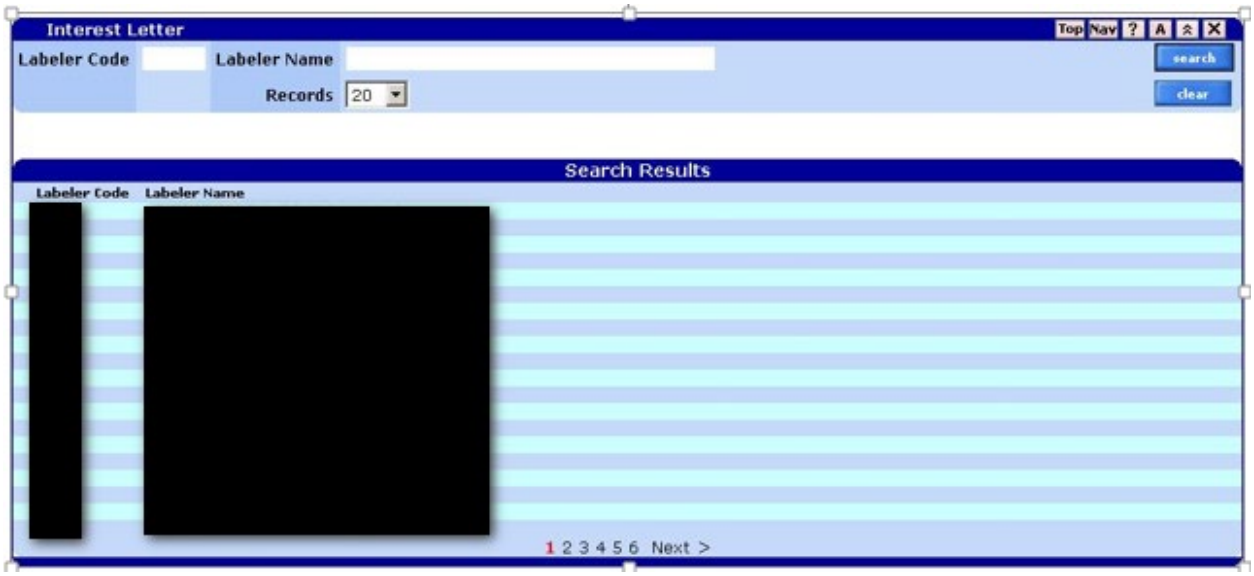
6.84.1 Interest Letter Panel Narrative

The Interest Letter panel is used to view the Interest Letter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Interest Letter]

6.84.2 Interest Letter Panel Layout



6.84.3 Interest Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Interest Letter panel.	Button	N/A	0
Labeler Code	Code used to uniquely identify the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid (CMS) and is used as the first 5 characters of the labeler's National Drug Codes (NDC).	Field	Number (Integer)	5
Labeler Name	Displays the name of the drug labeler.	Field	Character	39
Records	Allows the user to select the number of records to display per page.	Comb o Box	Drop Down List Box	0
Search	Initiates the Search by Labeler Code and/or Labeler Name.	Button	N/A	0

6.84.4 Interest Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.84.5 Interest Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.84.6 Interest Letter Panel Accessibility

6.84.6.1 To Access the Interest Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click Letters.	Listing of links for letters displays.
4	Click Interest Letter.	Interest Letter panel displays.

6.84.6.2 To Navigate the Interest Letter Panel

Step	Action	Response
1	Enter a Labeler Code and/or Labeler Name and click Search.	List of Labeler Information displays.
2	Click on a record from search results.	Interest Letter displays.

6.85 Qtr Satisfied Letter Panel Overview

6.85.1 Qtr Satisfied Letter Panel Narrative

This panel is used to view the Qtr Satisfied Letter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Qtr Satisfied Letter]

6.85.2 Qtr Satisfied Letter Panel Layout

6.85.3 Qtr Satisfied Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Qtr Satisfied Letter Criteria panel.	Button	N/A	0
Labeler Code	Code used to uniquely identify the label of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first 5 characters of the labeler's National Drug Code (CMS).	Field	Number (Integer)	5
Labeler Name	Displays the name of the drug labeler.	Field	Character	39
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Labeler Code and/or Labeler Name.	Button	N/A	0

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6.85.4 Qtr Satisfied Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.85.5 Qtr Satisfied Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.85.6 Qtr Satisfied Letter Panel Accessibility

6.85.6.1 To Access the Qtr Satisfied Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click QTR Satisfied Letter.	QTR Satisfied Letter panel displays.

6.85.6.2 To Navigate the Qtr Satisfied Letter Panel

Step	Action	Response
1	Enter a Labeler Code and/or Labeler Name and click Search.	List of Labeler Information displays.
2	Click on a record from search results.	Qtr Satisfied Letter displays.

6.86 Recoupment Notification Letter-NDC Panel Overview

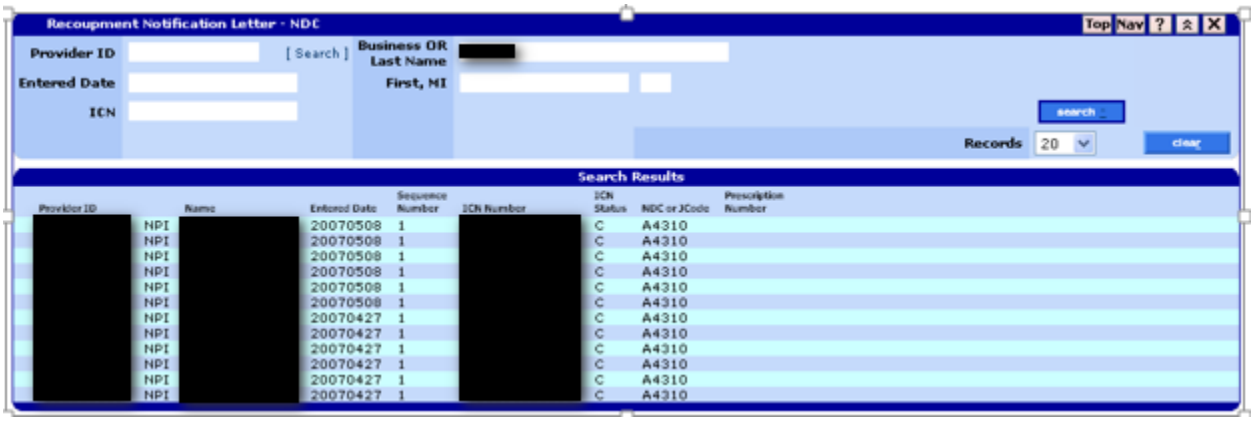
6.86.1 Recoupment Notification Letter-NDC Panel Narrative

This panel is used to view the Recoupment Notification Letter - NDC Letter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Recoupment Notification Letter - NDC]

6.86.2 Recoupment Notification Letter-NDC Panel Layout



6.86.3 Recoupment Notification Letter-NDC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Organization name or last name of provider to search on.	Field	Character	25
Clear	Allows the user to clear any changes on the Recoupment Notification Letter-NDC panel.	Button	N/A	0
Entered Date	Date the late request letter was entered in the system.	Field	Date (CCYYMMDD)	8
First, MI	First name and middle initial of provider.	Field	Character	14
ICN (Number)	Internal control number for which the Drug Rebate Unit is requesting information.	Field	Number (Integer)	13

Field	Description	Field Type	Data Type	Length
ICN Status	Code indicating the status of the internal control number. Valid Values include: C = Compound Recoup T = TPL Recoup U = Units Recoup W = Wrong NDC Recoup N = No Action	Field	Character	1
Name	Organization name or last name, first name, and middle initial of provider.	Field	Character	50
NDC or JCode	Contains either the JCode or the National Drug Code (NDC) for the internal control number detail, depending on its claim type.	Field	Character	11
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Number (Integer)	7
Provider ID	Provider identification number used by the provider.	Field	Number (Integer)	15
Provider ID Type	Provider's identification type.	Field	Character	3
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name, Entered Date or ICN.	Button	N/A	0
[Search]	Allows the user to search for a Provider ID.	Hyperlin k	N/A	0
Sequence Number	Identification number to make the key unique since more than one letter can be entered on the same day.	Field	Number (Integer)	4

6.86.4 Recoupment Notification Letter-NDC Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct

Field	Field Type	Error Code	Error Message	To Correct
First, MI	Field	1	Business OR Last Name is required when searching on First and/or MI.	Enter a value for "Business OR Last Name."

6.86.5 Recoupment Notification Letter-NDC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.86.6 Recoupment Notification Letter-NDC Panel Accessibility

6.86.6.1 To Access the Recoupment Notification Letter-NDC Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click Recoupment Notification Letter-NDC.	Recoupment Notification Letter- NDC panel displays.

6.86.6.2 To Navigate the Recoupment Notification Letter-NDC Panel

Step	Action	Response
1	Enter a Provider ID or Business Name Or Last Name and click Search.	List of Labeler Information displays.
2	Click on a record from search results.	Recoupment Notification Letter –NDC Letter displays.

6.87 Recoupment Notification Letter-JCode Panel Overview

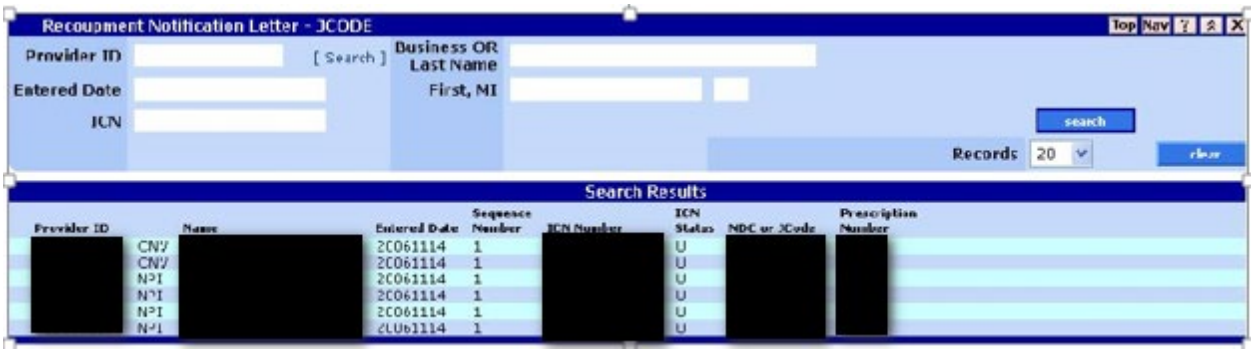
6.87.1 Recoupment Notification Letter-NDC Panel Narrative

This panel is used to view the Recoupment Notification Letter - JCode Letter.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Recoupment Notification Letter - JCode]

6.87.2 Recoupment Notification Letter-JCode Panel Layout



6.87.3 Recoupment Notification Letter- JCode Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Organization name or last name of provider to search on.	Field	Character	25
Clear	Allows the user to clear any changes on the Recoupment Notification Letter-JCode panel.	Button	N/A	0
Entered Date	Date the late request letter was entered in the system.	Field	Date (CCYYMMDD)	8
First, MI	First name and middle initial of provider.	Field	Character	13
ICN (Number)	Internal control number for which the Drug Rebate Unit is requesting information.	Field	Number (Integer)	13
ICN Status	Code indicating the status of the internal control number. Valid Values include: C = Compound Recoup T = TPL Recoup U = Units Recoup W = Wrong NDC Recoup N = No Action	Field	Character	1

Field	Description	Field Type	Data Type	Length
Name	Organization name or last name, first name, and middle initial of provider.	Field	Character	50
NDC or JCode	Contains either the JCode or the National Drug Code (NDC) for the internal control number detail, depending on its claim type.	Field	Character	11
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Number (Integer)	7
Provider ID	Provider identification number used by the provider.	Field	Number (Integer)	15
Provider ID Type	Provider's identification type.	Field	Character	3
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name, Entered Date or ICN.	Button	N/A	0
[Search]	Allows the user to search for a Provider ID.	Hyperlin k	N/A	0
Sequence Number	Identification number to make the key unique since more than one letter can be entered on the same day.	Field	Number (Integer)	4

6.87.4 Recoupment Notification Letter- JCode Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
First, MI	Field	1	Business OR Last Name is required when searching on First and/or MI.	Enter a value for "Business OR Last Name."

6.87.5 Recoupment Notification Letter- JCode Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.87.6 Recoupment Notification Letter- JCode Panel Accessibility

6.87.6.1 To Access the Recoupment Notification Letter- JCode Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click Recoupment Notification Letter- JCode.	Recoupment Notification Letter- JCode panel displays.

6.87.6.2 To Navigate the Recoupment Notification Letter- JCode Panel

Step	Action	Response
1	Enter a **Provider ID** or **Business Name** Or **Last Name** and click Search.	List of Labeler Information displays.
2	Click on a record from search results.	Recoupment Notification Letter – JCode Letter displays.

6.88 Recoupment Request Letter-NDC Panel Overview

6.88.1 Recoupment Request Letter-NDC Panel Narrative

This panel is used to view the Recoupment Request Letter - NDC.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Recoupment Request Letter - NDC]

6.88.2 Recoupment Request Letter-NDC Panel Layout

6.88.3 Recoupment Request Letter-NDC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Organization name or last name of provider.	Field	Character	25
Clear	Allows the user to clear any changes on the Recoupment Notification Letter-NDC panel.	Button	N/A	0
Entered Date	Date the late request letter was entered in the system.	Field	Date (CCYYMMDD)	8
First, MI	Indicates the first name and middle initial of provider.	Field	Character	13
ICN (Number)	Internal control number for which the Drug Rebate Unit is requesting information.	Field	Number (Integer)	13

Field	Description	Field Type	Data Type	Length
ICN Status	Code indicating the status of the internal control number. Valid values include: C = Compound Recoup T = TPL Recoup U = Units Recoup W = Wrong NDC Recoup N = No Action	Field	Character	1
Name	Organization name or last name, first name, and middle initial of provider.	Field	Character	50
NDC or JCode	This field contains either the JCode or the National Drug Code (NDC) for the internal control number detail, depending on its claim type.	Field	Character	11
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Number (Integer)	7
Provider ID	Provider identification number used by the provider.	Field	Number (Integer)	15
Provider ID Type	Provider's identification type.	Field	Character	3
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name, Entered Date or ICN.	Button	N/A	0
[Search]	Allows the user to search for a Provider ID.	Hyperlin k	N/A	0
Sequence Number	Identification number to make the key unique since more than one letter can be entered on the same day.	Field	Number (Integer)	4

6.88.4 Recoupment Request Letter-NDC Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct

Field	Field Type	Error Code	Error Message	To Correct
First, MI	Field	1	Business OR Last Name is required when searching on First and/or MI.	Enter a value for "Business OR Last Name."

6.88.5 Recoupment Request Letter-NDC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.88.6 Recoupment Request Letter-NDC Panel Accessibility

6.88.6.1 To Access the Recoupment Request Letter-NDC Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click Recoupment Request Letter-NDC.	Recoupment Request Letter- NDC panel displays.

6.88.6.2 To Navigate the Recoupment Request Letter-NDC Panel

Step	Action	Response
1	Enter a Provider ID or Business Name or Last Name; Click Search.	List of records displays.
2	Click on a record from search results.	Recoupment Request Letter –NDC displays.

6.89 Recoupment Request Letter-JCode Panel Overview

6.89.1 Recoupment Request Letter-NDC Panel Narrative

This panel is used to view the Recoupment Request Letter - JCode.

This panel is for inquiry only.

Navigation Path: [Drug] - [Rpts & Letters] – [Letters] - [Recoupment Request Letter - JCode]

6.89.2 Recoupment Request Letter- JCode Panel Layout

6.89.3 Recoupment Request Letter- JCode Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Organization name or last name of provider.	Field	Character	25
Clear	Allows the user to clear any changes on the Recoupment Notification Letter-JCode panel.	Button	N/A	0
Entered Date	Date the late request letter was entered in the system.	Field	Date (CCYYMMDD)	8
First, MI	Indicates the first name and middle initial of provider.	Field	Character	14
ICN Number (ICN)	Internal control number for which the Drug Rebate Unit is requesting information.	Field	Number (Integer)	13
ICN Status	Code indicating the status of the internal control number. Valid values include: C = Compound Recoup T = TPL Recoup U = Units Recoup W = Wrong NDC Recoup N = No Action	Field	Character	1

Field	Description	Field Type	Data Type	Length
Name	Organization name or last name, first name, and middle initial of provider.	Field	Character	50
NDC or JCode	This field contains either the JCode or the National Drug Code (NDC) for the internal control number detail, depending on its claim type.	Field	Character	11
Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a recipient.	Field	Number (Integer)	7
Provider ID	Provider identification number used by the provider.	Field	Number (Integer)	15
Provider ID Type	Provider's identification type.	Field	Character	3
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name, Entered Date or ICN.	Button	N/A	0
[Search]	Allows the user to search for a Provider ID.	Hyperlin k	N/A	0
Sequence Number	Identification number to make the key unique since more than one letter can be entered on the same day.	Field	Number (Integer)	4

6.89.4 Recoupment Request Letter JCode Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
First, MI	Field	1	Business OR Last Name is required when searching on First and/or MI.	Enter a value for "Business OR Last Name."

6.89.5 Recoupment Request Letter- JCode Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.89.6 Recoupment Request Letter- JCode Panel Accessibility

6.89.6.1 To Access the Recoupment Request Letter- JCode Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Drug** and Click **Rpts and Letters**.	Reports and Letters panel displays.
3	Click **Letters**.	Listing of links for letters displays.
4	Click Recoupment Request Letter- JCode.	Recoupment Request Letter- JCode panel displays.

6.89.6.2 To Navigate the Recoupment Request Letter- JCode Panel

Step	Action	Response
1	Enter a Provider ID or Business Name or Last Name; Click Search.	List of records displays.
2	Click on a record from search results.	Recoupment Request Letter – JCode displays.

Hewlett Packard Enterprise

AMMIS Drug Rebate User Manual- Part II

Date Modified: 05/11/2016

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6. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

6.1 Document Information Page

Required Information	Definition
Document Title	AMMIS Drug Rebate User Manual – Part II
Version:	4.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/UserManuals/DrugRebate_UM
Owner:	HPE/Agency
Author:	
Approved by:	
Approval Date:	12/12/2011 (HIPAA 5010 #4)

6.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
11/08/2011	1.1		Application of EIP 5010 changes.	CO 8868 RBT-3500-M -- Drug Rebate Payments Received Report – update layout and field descriptions (7.25.2, 7.25.3)
12/12/2011	2.0		Agency approved	
09/24/2012	3.0		Application of change orders moved to Production	CO 9689: Update 7.2 – RBT-2000-Q Drug Rebate Original Invoices Report (7.2.2, 7.2.3) Update 7.3 – RBT-2000-Q Drug Rebate Adjustment Invoice Report (7.3.2, 7.3.3)
05/11/2016	4.0		Application of CO 12703	Add report 6.18 RBT-2012-Q Drug Rebate CMSFDB File Update Pharmacy report.

6.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acrony

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Document	Description	url
	acronyms related to the Title XIX program for Alabama.	ms.htm

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7. Reports

The Drug Rebate User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage.

Layout: Provides a representation of the report and details the exact placement and format of the field names, frequency, values and heading information.

Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 RBT-1001-Q -- Drug Rebate Excluded Provider Listing Report

7.1.1 RBT-1001-Q -- Drug Rebate Excluded Provider Listing Report Narrative

The Drug Rebate Excluded Provider Listing report identifies Public Health Service (PHS) /Indian Health Service (IHS) providers that need to be excluded from the invoicing process as a result of the Veterans Act of 1992. This report is produced quarterly and can be emailed, printed or routed to FEITH.

7.1.2 RBT-1001-Q -- Drug Rebate Excluded Provider Listing Report Layout

```
Report  : RBT-1001-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJR310                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: DRBT0310                           DRUG REBATE EXCLUDED PROVIDER LISTING                           Page:    999,999
                                                 INVOICE QUARTER:  9/9999



                            PHS ENTITY                  PHS ENTITY                                PROVIDER
                               TYPE                        NAME                                     NUMBER


                            XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXX XXXXXXXXXXXXXXX
                            XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXX XXXXXXXXXXXXXXX
                            XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXX XXXXXXXXXXXXXXX


                                        TOTAL NUMBER OF PHS PROVIDERS:99,999

* END OF REPORT **
```

7.1.3 RBT-1001-Q -- Drug Rebate Excluded Provider Listing Report Field Descriptions

Field	Description	Length	Data Type
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	6	Date (Q/CCYY)
PHS Entity Name	Name of the Public Health Service and Indian Health Service (IHS) providers.	41	Character
PHS Entity Type	Entity type of the Public Health Service and Indian Health Service (IHS) providers.	9	Character
Provider Number	Unique number that has been assigned to each Public Health Service and Indian Health Service (IHS) providers.	19	Character

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Field	Description	Length	Data Type
Total Number of PHS Providers	Total number of Public Health Service and Indian Health Service (IHS) providers to be excluded from this invoicing process this quarter.	6	Number (Decimal)

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7.2 RBT-2000-Q -- Drug Rebate Original Invoices Report

7.2.1 RBT-2000-Q -- Drug Rebate Original Invoices Report Narrative

The Drug Rebate Original Invoices report provides the manufacturer with a quarterly bill of rebate amounts calculated for each labeler and for the quantity of drugs reimbursed for a specific quarter. A banner page with the contact name and address accompanies each invoice. All invoices are mailed by the 60th day following the end of the calendar quarter. Separate invoices are produced for each rebate program (e.g. Federal, State Supplemental). This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.2.2 RBT-2000-Q -- Drug Rebate Original Invoices Report Layout

```
Report  : RBT-2000-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJQ246                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: DREX0246                           DRUG REBATE INVOICE - FEDERAL                                   Page:       9999
                                                   ORIGINAL INVOICE
                                             INVOICE QUARTER:  9/9999

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX LABELER CODE: 99999 STATE CODE: XX INVOICE NUMBER: 9999999999 RECORD ID: XXXX

     NDC           DRUG       REBATE AMOUNT     CMS       TOTAL UNITS         TOTAL REBATE       NUMBER OF          TOTAL PROVIDER
    NUMBER         NAME          PER UNIT       UNIT      REIMBURSED         AMOUNT CLAIMED       SCRIPTS            REIMBURSEMENT

99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99
99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99
99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99
99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99
99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99
99999-9999-99   XXXXXXXXXX   $99,999.999999     XXX     9999,999,999.999     $999,999,999.99     99,999,999         $999,999,999.99

GRAND TOTALS:                                           9999,999,999.999     $999,999,999.99     99,999,999        $999,999,999.99


                                 REBATE DUE FROM LABELER:$9,999,999,999.99

                                 TOTAL NUMBER OF NDCs INVOICED:   99,999,999
```

7.2.3 RBT-2000-Q -- Drug Rebate Original Invoices Field Descriptions

Field	Description	Length	Data Type
CMS Unit	Represents the smallest unit of measure for each drug. The rebate amount reflects the type of unit of measurement. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'XXX' in this field.	3	Character

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Field	Description	Length	Data Type
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
Grand Totals	Displays the totals for the following columns: 'Total Units Reimbursed', Total Rebate Amount Claimed', 'Number of Scripts' and 'Total Prov Reimbursement' for the specified quarter	13	Number (Decimal)
Invoice Number	Displays the first five digits of the invoice number which represents the labeler code, and the last 5 digits that represent the year and quarter.	10	Number (Integer)
Invoice Quarter	Displays the quarter and the year reported.	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Number (Integer)
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
NDC Number	Unique National Drug Code (NDC) that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code and the 2-digit package size code.	11	Number (Integer)
Number of Scripts	Displays the total number of prescriptions filled for a National Drug Code (NDC) for the specified quarter. This field is informational only and is not used in calculating the rebate amount.	8	Number (Decimal)
Rebate Amount Per Unit	The rebate amount per unit reported to Centers for Medicare and Medicaid Services (CMS) by the labeler and provided to each state. This amount will appear as zero when the National Drug Code (NDC) amount is reported on the CMS quarterly rate tape. If there is not a record on the quarterly rate tape for an NDC that has had utilization, it will report as a zero in this field as well.	11	Number (Decimal)
Rebate Due From Labeler	Sum of the 'Total Rebate Amount Claimed' field due from the labeler for the specified quarter	12	Number (Decimal)

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Field	Description	Length	Data Type
Record ID	This field displays the Record ID of the invoice. Currently, the only value allowed in this field is FFSU.	4	Character
State Code	State abbreviation to indicate which state Health Coverage Program is billing the labeler.	2	Character
Total Number of NDCs Invoiced	Displays the total of all National Drug Codes (NDC) for the specified quarter.	8	Number (Decimal)
Total Provider Reimbursement	Total state Health Coverage Programs dollars paid for a National Drug Code (NDC), including dispensing fees, but excluding co-payment amounts and Third Party Liability (TPL) by the state for the specified quarter.	11	Number (Decimal)
Total Rebate Amount Claimed	Product of the 'Rebate Amount Per Unit' field times the 'Total Units Reimbursed' field. This figure represents the total rebate amount claimed for a National Drug Code (NDC) by the state for the specified quarter. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as a zero in this field.	11	Number (Decimal)
Total Units Reimbursed	Displays the total number of converted units reimbursed to providers by the state for a National Drug Code (NDC) for the specified quarter. If there is a discrepancy between Centers for Medicare and Medicaid Services (CMS) unit of measure and the state paid claims unit of measure, the units are replaced by the units from the conversion table.	13	Number (Decimal)

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7.3 RBT-2000-Q -- Drug Rebate Adjustment Invoice Report

7.3.1 RBT-2000-Q -- Drug Rebate Adjustment Invoice Report Narrative

The Drug Rebate Adjustment Invoice report provides the manufacturer a quarterly list by invoice period of each National Drug Code (NDC) with utilization changes. The utilization changes are a result of provider-initiated adjusted drug claims or manual unit adjustments made by the state agency. The information is a total replacement record for the line item of the original invoice detail, and may contain rate changes as well. Separate utilization invoices are produced for each rebate program (e.g. Federal, State Supplemental). It can be emailed, printed, or routed to FEITH.

7.3.2 RBT-2000-Q -- Drug Rebate Adjustment Invoice Layout

```
Report  : RBT-2000-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: 03/14/2002
Process : RBTJQ246                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:      07:53
Location: DREX0246                          DRUG REBATE INVOICE - FEDERAL                                    Page:          1
                                       ADJUSTMENT INVOICE - REPLACEMENT RECORDS
                                                INVOICE QUARTER:  3/2001

LABELER NAME: XXX XXXXX XXX XXXXXX                   LABELER CODE: 99999 STATE CODE: XX                         RECORD ID: XXXX

PERIOD        NDC          DRUG      REBATE AMOUNT    CMS      NEW TOTAL UNITS     TOTAL REBATE     NUMBER OF    TOTAL PROVIDER
COVERED      NUMBER        NAME         PER UNIT      UNIT       REIMBURSED       AMOUNT CLAIMED     SCRIPTS     REIMBURSEMENT

1/2000   99999-9999-99  XXXXXXX       $20.000000    TAB      11,111,111.111    $222,222,222.22     123,456    $333,333,333.33
1/2000   99999-9999-99  XXXXXXX-X     $20.000000    TAB      11,111,111.115    $222,222,222.30     123,457    $333,333,333.34

PERIOD TOTALS:                                               22,222,222.226    $444,444,444.52     246,913    $666,666,666.67


                                  TOTAL UTILIZATION CHANGES:       2
```

7.3.3 RBT-2000-Q -- Drug Rebate Adjustment Invoice Field Descriptions

Field	Description	Length	Data Type
CMS Unit	Represents the smallest unit of measure for each drug. The rebate amount reflects the type of unit of measurement. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'XXX' in this field as well.	3	Character
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
Invoice Quarter	Uniquely identifies a specific labeler and quarter.	5	Date (Q/CCYY)

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Field	Description	Length	Data Type
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Number (Integer)
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
NDC Number	Unique National Drug Code that identifies each drug This field is comprised of the 5-digit labeler code, the 4-digit product code and the 2-digit package size code.	11	Number (Integer)
New Total Units Reimbursed	New total number of units reimbursed by the Agency.	11	Number (Decimal)
Number of Scripts	New total number of prescriptions that were filled for a National Drug Code (NDC). This field is informational only and is not used in calculating the rebate amount.	6	Number (Decimal)
Period Covered	Period that is covered in this report (i.e. the original invoice quarter whose records were replaced during this invoice cycle).	5	Date (Q/CCYY)
Period Totals	Period totals for the units reimbursed, rebate claimed, scripts and provider reimbursement.	14	Number (Decimal)
Rebate Amount Per Unit	Rebate amount per unit reported to Centers for Medicare and Medicaid Services (CMS) by the manufacturer.	8	Number (Decimal)
Record ID	This field displays the Record ID of the invoice. Currently, the only value allowed in this field is FFSU.	4	Character
State Code	State abbreviation to indicate which state Health Coverage Program is billing the labeler.	2	Character
Total Provider Reimbursement	New total state Health Coverage Programs dollars paid, including dispensing fees, for a National Drug Code (NDC).	11	Number (Decimal)
Total Rebate Amount Claimed	Product of the 'Rebate Amount Per Unit' field times the 'Total Units Reimbursed' field. This figure represents the total rebate amount claimed for a National Drug Code (NDC) by the state for the specified quarter. If there is not a record on the quarterly rate tape for a NDC that has had utilization, it will report as a zero in this field.	11	Number (Decimal)
Total Utilization Changes	Number of utilization changes for all invoice periods.	11	Number (Integer)

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7.4 RBT-2002-Q -- Drug Rebate Invoice Summary Report

7.4.1 RBT-2002-Q -- Drug Rebate Invoice Summary Report Narrative

The Drug Rebate Invoice Summary report provides an overview of invoice information for all manufacturers invoiced by Medicaid for a specific quarter. All invoice activity is reported to include new invoices and invoices for prior quarters. Invoices for prior periods may have positive or negative activity (plus/minus) based on rate or utilization changes. This report breaks on rebate program (e.g. Federal, State Supplemental) and is produced quarterly. It can be emailed, printed, or routed to FEITH.

7.4.2 RBT-2002-Q -- Drug Rebate Invoice Summary Layout

```
Report  : RBT-2002-Q                                    ALABAMA MEDICAID AGENCY                                          Run Date:
MM/DD/CCYY
Process : RBTJQ250                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:
HH:MM:SS
Location: DRIN2002                    DRUG REBATE INVOICE SUMMARY REPORT - FEDERAL/SUPPLEMENTAL                          Page:
9999
                                                         PLUS/MINUS RECORDS


LABELER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX INVOICE CYCLE QUARTER: Q/CCYY

INVOICE    LABELER SUMMARY                            TOTAL UNITS          TOTAL REBATE     TOTAL INTEREST     TOTAL       TOTAL
NUMBER     CODE    BY QUARTER                         BILLED               AMOUNT CLAIMED   AMOUNT CLAIMED    SCRIPTS
REIMBURSEMENT

XXXXXXXXXX  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Z,ZZZ,ZZZ,ZZ9.999   $ZZZ,ZZZ,ZZ9.99  $ZZZ,ZZZ,ZZ9.99  ZZZ,ZZZ,ZZ9
$Z,ZZZ,ZZZ,ZZ9.99
XXXXXXXXXX  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Z,ZZZ,ZZZ,ZZ9.999   $ZZZ,ZZZ,ZZ9.99  $ZZZ,ZZZ,ZZ9.99  ZZZ,ZZZ,ZZ9
$Z,ZZZ,ZZZ,ZZ9.99
XXXXXXXXXX  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Z,ZZZ,ZZZ,ZZ9.999   $ZZZ,ZZZ,ZZ9.99  $ZZZ,ZZZ,ZZ9.99  ZZZ,ZZZ,ZZ9
$Z,ZZZ,ZZZ,ZZ9.99
XXXXXXXXXX  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX Z,ZZZ,ZZZ,ZZ9.999   $ZZZ,ZZZ,ZZ9.99  $ZZZ,ZZZ,ZZ9.99  ZZZ,ZZZ,ZZ9
$Z,ZZZ,ZZZ,ZZ9.99

            XXXXX  Net Manufacturer Totals:          Z,ZZZ,ZZZ,ZZ9.999   $ZZZ,ZZZ,ZZ9.99   $ZZZ,ZZZ,ZZ9.99  ZZZ,ZZZ,ZZ9
$Z,ZZZ,ZZZ,ZZ9.99




                                     TOTAL NUMBER OF LABELERS INVOICED FOR Q/CCYY:      9999

                                                        ** END OF REPORT**                                                *
```


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7.4.3 RBT-2002-Q -- Drug Rebate Invoice Summary Field Descriptions

Field	Description	Length	Data Type
Invoice Cycle Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Invoice Number	Uniquely identifies a specific labeler and quarter	10	Character
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
Net Manufacturer Totals	Provides the invoice cycle totals (by labeler) for the following fields: Total Units Billed, Total Rebate Amount Claimed, Total Interest Amount Claimed, Total Scripts, and Total Reimbursement.	13	Number (Decimal)
Summary By Quarter	Displays the type of adjustment and the quarter to which it was made. There are four adjustment types: Utilization Rate Interest Original Invoice	34	Character
Total Interest Amount Claimed	Total interest amount claimed for that quarter.	11	Number (Decimal)
Total Number of Labelers Invoiced for Q/CCYY	Total number of labelers invoiced for that quarter.	4	Number (Integer)
Total Rebate Amount Claimed	Total rebate amount claimed for this National Drug Code (NDC).	11	Number (Decimal)
Total Reimbursement	Total reimbursement amount for that quarter.	12	Number (Decimal)
Total Scripts	Total number of scripts for that quarter.	9	Number (Decimal)
Total Units Billed	Total units billed for that quarter.	13	Number (Decimal)

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7.5 RBT-2002-S -- Drug Rebate Invoice Summary Report

7.5.1 RBT-2002-S -- Drug Rebate Invoice Summary Report Narrative

The Drug Rebate Invoice Summary report is the summary and totals information for the RBT-2002-Q report. Please refer to the RBT-2002-Q report for detail information and report layout. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced quarterly and can be emailed, printed, or routed to FEITH.

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7.5.2 RBT-2002-S -- Drug Rebate Invoice Summary Report Layout

```
Report  : RBT-2002S                                ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : RBTJQ250                            MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: DRIN2002                          DRUG REBATE INVOICE SUMMARY REPORT - FEDERAL                Page:          1
                                                 INVOICE CYCLE QUARTER: Q/CCYY

                                            TOTALS FOR ALL QUARTERS AND ALL MANUFACTURERS

 QUARTER   YEAR                    TOTAL UNITS        TOTAL REBATE       TOTAL INTEREST        TOTAL              TOTAL
                                     BILLED          AMOUNT CLAIMED      AMOUNT CLAIMED       SCRIPTS          REIMBURSEMENT

    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
    Q      CCYY                 9,999,999,999.999  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99


        UNIT ADJ        :          999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
        PPA             :          999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99


        DISKETTE        :          999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
        FTP             :          999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99
        PAPER           :          999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99

 TOTALS   :                        999,999,999.99  $  999,999,999.99   $  999,999,999.99       999,999,999      $  999,999,999.99


                                                   ** End of Report **
```


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7.5.3 RBT-2002-S -- Drug Rebate Invoice Summary Report Field Descriptions

Field	Description	Length	Data Type
Diskette	Total number of invoices sent by diskette.	11	Number (Decimal)
FTP	Total number of invoices sent by File Transfer Protocol (FTP).	11	Number (Decimal)
Invoice Cycle Quarter	Quarter/year of the invoice cycle in question.	5	Date (Q/CCYY)
Quarter	Quarter of the invoice cycle in question.	1	Number (Integer)
Paper	Total number of invoices sent by paper.	11	Number (Decimal)
PPA	Prior Period Adjustment.	11	Number (Decimal)
Total Interest Amount Claimed	Total interest amount claimed for that quarter	11	Number (Decimal)
Total Rebate Amount Claimed	Total rebate amount claimed for this National Drug Code (NDC).	11	Number (Decimal)
Total Reimbursement	Total reimbursement amount for that quarter.	11	Number (Decimal)
Total Scripts	Total number of scripts for that quarter.	9	Number (Integer)
Total Units Billed	Total units billed for that quarter.	13	Number (Decimal)
Totals	Provides the invoice cycle totals (for all quarters and manufacturers) for the following fields: Total Units Billed, Total Rebate Amount Claimed, Total Interest Amount Claimed, Total Scripts and Total Reimbursement.	11	Number (Decimal)
Unit ADJ	Total amount of units adjusted.	11	Number (Decimal)
Year	Year of the invoice cycle in question.	4	Date (CCYY)

7.6 RBT-2003-Q -- Drug Rebate Manufacturer Remittance Summary Report

7.6.1 RBT-2003-Q -- Drug Rebate Manufacturer Remittance Summary Report Narrative

The Drug Rebate Manufacturer Remittance Summary report allows labelers to specify how their invoice payments should be applied. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced quarterly and can be emailed, printed, or routed to FEITH. This report is not currently used by Alabama.

7.6.2 RBT-2003-Q -- Drug Rebate Manufacturer Remittance Summary Report Layout

```
Report  : RBT-2003-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : RBTJQ250                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: DRIN2002                         MEDICAID REBATE PROGRAM - FEDERAL                            Page:          9999
                                            MANUFACTURER REMITTANCE SUMMARY


INVOICE QUARTER:        XXXXXX
   LABELER CODE:        XXXXX
MANUFACTURER NAME:      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

       _____________________________________________________________________________________________
       |                |                          |                          |                          |
       |    QUARTER     |      REBATE AMOUNT       |     INTEREST AMOUNT      |     TOTAL AMOUNT         |
       |                |          PAID            |          PAID            |         PAID             |
       |________________|__________________________|__________________________|__________________________|
       |                |                          |                          |                          |
       |    9/9999      |                          |                          |                          |
       |________________|__________________________|__________________________|__________________________|
       |                |                          |                          |                          |
       |                |                          |                          |                          |
       |________________|__________________________|__________________________|__________________________|
       |                |                          |                          |                          |
       |                |                          |                          |                          |
       |________________|__________________________|__________________________|__________________________|
       |                |                          |                          |                          |
       |                |                          |                          |                          |
       |________________|__________________________|__________________________|__________________________|
                   ** PLEASE REMIT THIS AMOUNT TO:   ALABAMA MEDICAID AGENCY
                                                     ATTN: DRUG REBATE
                                                     501 DEXTER AVENUE
                                                     PO BOX 5624
                                                     MONTGOMERY, AL 36103-5624

                    *** RETURN THIS SUMMARY WITH PAYMENT TO ENSURE PROPER CREDIT ***
```

```
Report  : RBT-2003-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : RBTJQ250                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: DRIN2002                      MEDICAID REBATE PROGRAM - SUPPLEMENTAL                           Page:          9999
                                           MANUFACTURER REMITTANCE SUMMARY

INVOICE QUARTER:        XXXXXX
   LABELER CODE:        XXXXX
MANUFACTURER NAME:      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

QUARTER	REBATE AMOUNT PAID	INTEREST AMOUNT PAID	TOTAL AMOUNT PAID
9/9999			
Total			

```
                ** PLEASE REMIT THIS AMOUNT TO:   ALABAMA MEDICAID AGENCY
                                                  ATTN: DRUG REBATE
                                                  501 Dexter Avenue
                                                       PO BOX 5624
                                                  Montgomery, AL  36103-5624

*** RETURN THIS SUMMARY WITH PAYMENT TO INSURE PROPER CREDIT ***
```

7.6.3 RBT-2003-Q -- Drug Rebate Manufacturer Remittance Summary Report Field Descriptions

Field	Description	Length	Data Type
Interest Amount Paid	Total amount that the labeler will apply toward interest for the quarter. This field is left blank for the labeler to fill in.	0	Number (Decimal)
Invoice Quarter	Uniquely identifies a specific labeler and quarter	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Manufacturer Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
Quarter	Every quarter in which an adjustment was made, since the last cycle.	6	Number (Integer)
Rebate Amount Paid	Total amount that the labeler will apply toward rebates for the quarter. This field is left blank for the labeler to fill in.	0	Number (Decimal)
Total	Sum of the following fields: Rebate Amount Paid Interest Amount Paid Total Amount Paid This field is left blank for the labeler to fill in.	0	Number (Decimal)
Total Amount Paid	Total amount that the labeler will apply toward the quarter. This field is left blank for the labeler to fill in.	0	Number (Decimal)

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7.7 RBT-2004-Q -- Drug Rebate CMS Unit Discrepancy Report

7.7.1 RBT-2004-Q -- Drug Rebate CMS Unit Discrepancy Report Narrative

The Drug Rebate CMS Unit Discrepancy report identifies NDCs on the quarterly rate tape with a unit of measure that does not correspond to the unit of measure on the drug database, First Data Bank (FDB). This report is produced quarterly and is used to reconcile the discrepancies by updating the unit conversion tables as necessary. It can be emailed, printed, or routed to FEITH.

7.7.2 RBT-2004-Q -- Drug Rebate CMS Unit Discrepancy Report Layout

```
Report: RBT-2004-Q                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process: RBTJQ250                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                   Run Time:   HH:MM:SS
Location: RBT2004Q                   DRUG REBATE CMS UNIT DISCREPANCY REPORT                                     Page:       9999
                                             INVOICE QUARTER: Q/CCYY


            NDC             CMS DRUG       REBATE AMOUNT      FDB DRUG                        FDB UNIT        CMS
           NUMBER             NAME            PER UNIT        DESCRIPTION                    DRUG FORM CODE   UNIT

         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999
         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999
         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999
         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999
         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999
         99999-9999-99      XXXXXXXXXX     999999.999999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XX          999


                                   NUMBER OF NDC UNIT DISCREPANCIES:   99999


                                            ** End of Report **
```


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7.7.3 RBT-2004-Q -- Drug Rebate CMS Unit Discrepancy Report Field Descriptions

Field	Description	Length	Data Type
CMS Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
CMS Unit	Represents the smallest unit of measure for each drug. The rebate amount reflects the type of unit of measurement. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'XXX' in this field as well.	3	Character
FDB Drug Description	Description of the drug provided by First Data Bank (FDB).	30	Character
FDB Unit Drug Form Code	Drug form code that indicates the basic unit of measure for performing price calculations	2	Character
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
NDC Number	Unique National Drug Code that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code, and the 2-digit package size code.	11	Number (Integer)
Number of NDC Unit Discrepancies	Total number of National Drug Code (NDC) unit discrepancies.	5	Number (Integer)
Rebate Amount Per Unit	Rebate amount per unit reported to Centers for Medicare and Medicaid (CMS) by the labeler and provided to each state.	12	Number (Decimal)

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7.8 RBT-2005-Q -- Drug Rebate Amount > Reimbursement Amount Report

7.8.1 RBT-2005-Q -- Drug Rebate Amount > Reimbursement Amount Report Narrative

The Drug Rebate Amount > Reimbursement Amount report identifies NDCs with a manufacturer rebate amount claimed that is greater than the total amount reimbursed to the provider. This report enables interChange AMMIS clients to produce pharmacy-billing guidelines for provider educational purposes to be administered with both provider bulletins and/or workshops. This report creates a supplement to a bulletin that outlines the most common erroneously billed products by NDC, with a method of correction. This report breaks on rebate program (e.g. Federal, State Supplemental) and is produced quarterly. It can be emailed, printed, or routed to FEITH.

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7.8.2 RBT-2005-Q -- Drug Rebate Amount > Reimbursement Amount Layout

```
REPORT: RBT-2005-Q                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS: RBTJQ250                          MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME:   HH:MM:SS
LOCATION: RBT2005Q                   DRUG REBATE AMOUNT > REIMBURSEMENT AMOUNT - FEDERAL                     PAGE:          1
                                                   INVOICE QUARTER: Q/CCYY
```

NDC NUMBER	DRUG NAME	REBATE AMOUNT PER UNIT	CMS UNIT	TOTAL UNITS REIMBURSED	TOTAL REBATE AMOUNT CLAIMED	TPL AMOUNT	NUMBER OF SCRIPTS	TOTAL PROV REIMBURSEMENT
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99
99999-9999-99	XXXXXXXX-X	$0.99999999999	XXX	9,999,999.99	$9,999,999.99	$9,999,999.99	9999999	$9,999,999.99

```
                    TOTAL NUMBER OF NDCs W/ INVOICE AMOUNT > REIMBURSEMENT AMOUNT:  99999

                                                   ** END OF REPORT **
```


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7.8.3 RBT-2005-Q -- Drug Rebate Amount > Reimbursement Amount Report Field Descriptions

Field	Description	Length	Data Type
CMS Unit	Represents the smallest unit of measure for each drug. The rebate amount reflects the type of unit of measurement. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'XXX' in this field as well.	3	Character
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
Invoice Quarter	Quarter and year being reported.	5	Date (Q/CCYY)
NDC Number	Unique National Drug Code that identifies each drug. This field will comprise the 5-digit labeler code, the 4-digit product code, and the 2-digit package size code.	11	Number (Integer)
Number of Scripts	Total number of prescriptions that were filled for a National Drug Code. This field is informational only and is not used in calculating the rebate amount.	7	Number (Integer)
Rebate Amount Per Unit	Rebate amount per unit calculated and provided to CMS.	12	Number (Decimal)
TPL Amount	Third party liability amount.	9	Number (Decimal)
Total Number of NDCs w/ Invoice Amount > Reimbursement Amount	Total number of National Drug Codes with an invoice amount greater than the reimbursement amount.	5	Number (Integer)
Total Prov Reimbursement	Total State Health Coverage Programs dollars paid, including dispensing fees, for a National Drug Code by interChange client for the specified quarter.	9	Number (Decimal)
Total Rebate Amount Claimed	Product of the Rebate Amount Per Unit times the Total Units Reimbursed. This figure represents the total rebate amount claimed for this National Drug Code by interChange client.	9	Number (Decimal)
Total Units Reimbursed	Total number of units reimbursed by interChange client for a National Drug Code for a specified quarter.	9	Number (Decimal)

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7.9 RBT-2006-Q -- Drug Rebate Invoice $50 or Less Report

7.9.1 RBT-2006-Q -- Drug Rebate Invoice $50 or Less Report Narrative

The Drug Rebate Invoice $50 or Less report identifies all manufacturers with invoice amounts of less than the $50 threshold amount. The invoices identified on this report are mailed to the manufacturer for information purposes and as a good faith effort to collect the rebate dollars. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.9.2 RBT-2006-Q -- Drug Rebate Invoice $50 or Less Report Layout

```
Report  : RBT-2006-Q                          ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : RBTJQ250                   MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:       HH:MM:SS
Location: RBT2006Q                      DRUG REBATE INVOICE $50 OR LESS                                    Page:           9999
                                              INVOICE QUARTER: Q/CCYY

                  LABELER                       LABELER                                    REBATE
                   CODE                          NAME                                   AMOUNT CLAIMED

                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99
                   XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $Z,ZZZ,ZZZ,ZZ9.99

                                              TOTAL REBATE AMOUNT CLAIMED      $ZZ,ZZZ,ZZZ,ZZ9.99


                        NUMBER OF LABELERS INVOICED FOR $50.00 or LESS:                    9999

                                   NUMBER OF LABELERS INVOICED FOR $ 0:                    9999


                                            *** END OF REPORT ***
```

7.9.3 RBT-2006-Q -- Drug Rebate Invoice $50 or Less Field Descriptions

Field	Description	Length	Data Type
Invoice Quarter	Indicates the quarter and year being reported. Valid format is Q/CCYY.	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character

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Field	Description	Length	Data Type
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
Number of Labelers Invoiced for $0	Total number of labelers invoiced for $0.	4	Number (Integer)
Number of Labelers Invoiced for $50 or Less	Total number of labelers invoiced for $50 or less, but not for $0.	4	Number (Integer)
Rebate Amount Claimed	Product of the Rebate Amount Per Unit times the Total Units Reimbursed. This figure represents the total rebate amount claimed for this National Drug Code (NDC) by interChange client.	12	Number (Decimal)
Total Rebate Amount Claimed	Sum of the Rebate Amount Claimed field.	13	Number (Decimal)

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7.10 RBT-2007-Q -- Drug Rebate CMS Rate Per Unit Discrepancy Report

7.10.1 RBT-2007-Q -- Drug Rebate CMS Rate Per Unit Discrepancy Report Narrative

The Drug Rebate CMS Rate Per Unit Discrepancy report identifies Rebate Per Unit (RPU) discrepancies. The report is used to research and resolve RPU discrepancies with CMS and manufacturers. It identifies NDCs where the RPU from the quarterly CMS tape differs from the RPU on the invoice for that specific NDC and quarter. The discrepancy would be the result of a manual change to the RPU from the Prior Period Adjustment panel. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.10.2 RBT-2007-Q -- Drug Rebate CMS Rate Per Unit Discrepancy Report Layout

```
Report  : RBT-2007-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : RBTJQ400                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: DRBT0400                         DRUG REBATE CMS RATE PER UNIT DISCREPANCY                       Page:       9999
                                                INVOICE QUARTER: Q/CCYY


            QUARTER      NDC                 DRUG              CMS REBATE          STATE REBATE          REBATE AMOUNT
                                             NAME            AMOUNT PER UNIT       AMOUNT PER UNIT         DIFFERENCE

            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99
            Q/CCYY       99999-9999-99       XXXXXXXXXX       9.999999999999        9.999999999999        $ZZ,ZZZ,ZZ9.99


TOTAL REBATE AMOUNT CLAIMED DIFFERENCE:   $ZZ,ZZZ,ZZ9.99

NUMBER OF DISCREPANCIES:       99,999,999


*** END OF REPORT ***
```

7.10.3 RBT-2007-Q -- Drug Rebate CMS Rate Per Unit Discrepancy Report Field Descriptions

Field	Description	Length	Data Type
CMS Rebate Amount Per Unit	Most current rebate amount per unit calculated by Centers for Medicare and Medicaid Services (CMS) and provided to interChange client.	13	Number (Decimal)

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Field	Description	Length	Data Type
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
NDC	Unique National Drug Code that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code, and the 2-digit package size code.	11	Number (Integer)
Number of Discrepancies	Total number of Prior Period Adjustment discrepancies on this report.	8	Number (Decimal)
Quarter	Invoiced quarter and year of the prior period adjustment.	5	Date (Q/CCYY)
Rebate Amount Difference	Difference between the rebate amount as originally calculated and the calculation after the adjustment.	10	Number (Decimal)
State Rebate Amount Per Unit	Rebate amount per unit calculated by the manufacturer and provided to the interchange client.	13	Number (Decimal)
Total Rebate Amount Claimed Difference	Sum of all of the Rebate Amount Claimed Difference fields for each invoice.	10	Number (Decimal)

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7.11 RBT-2008-Q -- Drug Rebate NDCS W/2 QTRS URA=0 Report

7.11.1 RBT-2008-Q -- Drug Rebate NDCS W/2 QTRS URA=0 Report Narrative

The Drug Rebate NDCS W/2 QTRS URA=0 report lists all NDCs on the CMS tape where the Unit Rebate Amount has been zero for two consecutive quarters. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.11.2 RBT-2008-Q -- Drug Rebate NDCS W/2 QTRS URA=0 Report Layout

```
Report: RBT-2008-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process: RBTJQ405                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: RBT2008Q                       DRUG REBATE NDCS W/2 QTRS URA = 0                               Page:       9999
                                             INVOICE QUARTER: Q/CCYY

                    NDC                 DRUG                FDB DRUG
                                        NAME                DESCRIPTION

                    99999-9999-99       XXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    99999-9999-99       XXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    99999-9999-99       XXXXXXXXXX          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                              NUMBER OF NDCS:            9999
** END OF REPORT **
```

7.11.3 RBT-2008-Q -- Drug Rebate NDCS W/2 QTRS URA=0 Report Field Descriptions

Field	Description	Length	Data Type
Drug Name	Drug description as found on the Centers for Medicare and Medicaid (CMS) quarterly tape.	10	Character
FDB Drug Description	Description of the drug, as supplied by First Data Bank (FDB), which is carried on the Drug Master file.	30	Character
Invoice Quarter	Quarter and year of the invoice period for which the report is produced.	5	Date (Q/CCYY)
NDC	Unique National Drug Code (NDC) that identifies each drug.	11	Number (Integer)
Number of NDCs	Number of National Drug Codes (NDC) included on the report.	4	Number (Integer)

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7.12 RBT-2010-Q -- Drug Rebate NDCs Not on CMS Report

7.12.1 RBT-2010-Q -- Drug Rebate NDCs Not on CMS Report Narrative

The Drug Rebate NDCs Not on CMS report lists all NDCs that had utilization in the current quarter, but were not on the CMS tape. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.12.2 RBT-2010-Q -- Drug Rebate NDCs Not on CMS Report Layout

```
Report: RBT-2010-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process: RBTJQ41(                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: RBT201(Q                          DRUG REBATE NDCS NOT ON CMS                                   Page:       9999
                                              INVOICE QUARTER: Q/CCYY


              NI C              LABELER NAME                                DRUG NAME

             99999-9999-99     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXX
             99999-9999-99     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXX
             99999-9999-99     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXX


                                          NUMBER OF NDCS:        9999


                                                   ** END OF REPORT **
```

7.12.3 RBT-2010-Q -- Drug Rebate NDCs Not on CMS Report Field Descriptions

Field	Description	Length	Data Type
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) rate tape.	10	Character
Invoice Quarter	Quarter and year of the Centers for Medicare and Medicaid Services (CMS) tape being compared to the National Drug Code (NDC) master file.	5	Date (Q/CCYY)
Labeler Name	Name of labeler of this specific National Drug Code (NDC).	39	Character
NDC	Displays the unique National Drug Code that identifies each drug. The National Drug Code includes the five-digit labeler code, the four-digit product code, and the two-digit package size code.	11	Number (Integer)
Number of NDCs	Total number of National Drug Codes (NDC) reported.	4	Number (Integer)

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7.13 RBT-2011-Q -- Drug Rebate Invoice Summary Activity Report

7.13.1 RBT-2011-Q -- Drug Rebate Invoice Summary Activity Report Narrative

The Drug Rebate Invoice Summary report provides summary-level invoice data. This report is essential for performing quality control measures to justify that the invoice data is accurate and consistent with previous quarterly invoice data. This report breaks on rebate program (e.g. Federal, State Supplemental) and is produced quarterly. It can be emailed, printed, or routed to FEITH.

7.13.2 RBT-2011-Q -- Drug Rebate Invoice Summary Activity Layout

```
Report  : RBT-2011-Q                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : RBTJQ255                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: DRIN2011                         DRUG REBATE INVOICE - FEDERAL                       Page:           9999
                                                INVOICE QTR: Q/CCYY


                                   QUARTER/YEAR                                        9/9999
                                   NUMBER OF LABELERS INVOICED                    ZZZ,ZZZ,ZZ9
                                   NUMBER OF LABELERS WITH INVOICE = $0           ZZZ,ZZZ,ZZ9
                                   NUMBER OF LABELERS WITH INVOICE $50 or LESS    ZZZ,ZZZ,ZZ9
                                   NUMBER OF SCRIPTS INVOICED                     ZZZ,ZZZ,ZZ9
                                   NUMBER OF NDCs INVOICED                        ZZZ,ZZZ,ZZ9
                                   TOTAL REBATE AMOUNT CLAIMED              $Z,ZZZ,ZZZ,ZZ9.99
                                   NUMBER OF LABELERS INVOICED WITH ELECTRONIC DATA    ZZZ,ZZZ,ZZ9
                                   NUMBER OF PHS PROVIDERS                        ZZZ,ZZZ,ZZ9
                                   NUMBER OF PHS CLAIMS                           ZZZ,ZZZ,ZZ9


                                                 ** END OF REPORT **
```

7.13.3 RBT-2011-Q -- Drug Rebate Invoice Summary Activity Field Descriptions

Field	Description	Length	Data Type
Invoice Quarter	Quarter and year of the Centers for Medicare and Medicaid Services (CMS) tape being compared to the National Drug Code (NDC) master file.	5	Date (Q/CCYY)
Number of Labelers Invoiced	Number of labelers invoiced for the quarter.	9	Number (Decimal)
Number of Labelers Invoiced with Electronic Data	Number of labelers invoiced with electronic data in the quarter.	9	Number (Decimal)
Number of Labelers with Invoice $50 or Less	Number of labelers invoiced with amounts less than $zz (zz is the amt_threshold).	9	Number (Decimal)

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Field	Description	Length	Data Type
Number of Labelers with Invoice = $0	Number of labelers invoiced with $0.00 amounts.	9	Number (Decimal)
Number of NDCs Invoiced	Number of National Drug Codes invoiced for the quarter.	9	Number (Decimal)
Number of PHS Claims	Number of Public Health Service (PHS) claims and Indian Health Service (IHS) paid in the quarter.	11	Number (Decimal)
Number of Scripts Invoiced	Number of scripts invoiced for the quarter.	9	Number (Decimal)
Number of PHS Providers	Total number of Public Health Service (PHS) and Indian Health Service (IHS) providers who had claims extracted from cycle processing for the quarter.	9	Number (Decimal)
Quarter/Year	Year and quarter of the current invoicing cycle.	5	Date (Q/CCYY)
Total Rebate Amount Claimed	Represents the total rebate amount claimed for this quarter by the Agency.	12	Number (Decimal)

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7.14 RBT-2012-Q -- Drug Rebate CMS Quarterly Updates Report

7.14.1 RBT-2012-Q -- Drug Rebate CMS Quarterly Updates Report Narrative

The Drug Rebate CMS Quarterly Updates report is used to compile information for the quarterly bulletin used to notify providers of non-covered drug-effectiveness source identifier (DESI) items. The report is also used to update the drug reference file of non-covered DESI services. DESI drugs are identified on the report with a classification of 5 and 6. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.14.2 RBT-2012-Q -- Drug Rebate CMS Quarterly Updates Report Layout

```
Report  : RBT-2012-Q                                ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY

Process : RBTJQ215                             MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: RBT2012Q                                      CMS QUARTERLY UPDATES                                      Page:       9999
                                                       INVOICE QUARTER: Q/CCYY



NDC         Drug Description                   FDA FDA   Market    CMS        Generic            CMS   --- DESI ---   CMS      CDE
                                               Appr Dte  Ent Dte   Term Dte   Ind     CMS UPPS   Unit  Ind Eff Dte    DrugType SRC

99999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD    X      999999999  XXX    X   CCYYMMDD   X        XX
99999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD    X      999999999  XXX    X   CCYYMMDD   X        XX
99999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD    X      999999999  XXX    X   CCYYMMDD   X        XX
99999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  CCYYMMDD  CCYYMMDD  CCYYMMDD    X      999999999  XXX    X   CCYYMMDD   X        XX


TOTAL NUMBER OF NDC:  99,999,999

                                                   ** END OF REPORT **
```

7.14.3 RBT-2012-Q -- Drug Rebate CMS Quarterly Updates Report Field Descriptions

Field	Description	Length	Data Type
CDE SRC	Indicates source of update information. Valid values include: CQ = CMS, FW = FDB.	2	Character
CMS Drug Type	Drug Type Indicator represents the Rx or Over the Counter (OTC) status of the drug product.	1	Character

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Field	Description	Length	Data Type
CMS Term Dte	Date actually supplied to Centers for Medicare and Medicaid Services (CMS) from the drug manufacturer/distributor. The date represents the shelf life expiration date of the last batch produced.	8	Date (CCYYMMDD)
CMS UPPS	Units Per Package Size indicates the number of units per package as supplied on the CMS quarterly tape.	11	Number (Integer)
CMS Unit	Unit Type Indicator indicates the unit of measure as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly tape.	3	Character
DESI - Eff Dte	Date the Centers for Centers for Medicare and Medicaid Services (CMS) drug-effectiveness source identifier status took effect.	8	Date (CCYYMMDD)
DESI - Ind	Drug-effectiveness source identifier indicator from Centers for Medicare and Medicaid Services (CMS). Valid values are: 0 = NDC not on CMS tape (no information submitted by manufacturer) 2 = Safe and Effective or non-DESI 3 = DESI/IRS Drugs Under Review (no Notice of Opportunity for a Hearing [NOOH] issued) 4 = Less than effective DESI/IRS Drugs for Some Indications 5 = Less than effective DESI/IRS Drugs for All Indications 6 = Less than effective DESI/IRS Drugs Removed from the Market.	1	Character
Drug Description	Drug description found on the state database provided by First DataBank (FDB). If there is not a record, the state tables reports as 'Not Found'.	30	Character
FDA	Therapeutic class code of the drug.	2	Character
FDA Appr Dte	Date the Federal Drug Agency (FDA) approved the drug.	8	Date (CCYYMMDD)
Generic Ind	Centers for Medicare and Medicaid Services (CMS) drug category identifies single source, multi-source, or innovator status.	1	Character
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)

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Field	Description	Length	Data Type
Market Ent Dte	Market Entry Date represents the date a manufacturer releases the drug product to the marketplace, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly tape.	8	Date (CCYYMMDD)
NDC	Unique National Drug Code that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code, and the 2-digit package size code.	11	Number (Integer)
Total Number of NDC	Total number of National Drug Codes (NDC) reported.	8	Number (Integer)

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7.15 RBT-2013-Q -- Drug Rebate NDCs URA= 0 W/ Paid Claims Report

7.15.1 RBT-2013-Q -- Drug Rebate NDCs URA = 0 W/ Paid Claims Report Narrative

The Drug Rebate Utilization Exception report is used to identify discrepancies between the FDB drug master file and the CMS tape. This report lists NDCs that have a claim utilization with no corresponding record on the quarterly rate tape or that have a unit rebate amount equal to zero. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.15.2 RBT-2013-Q -- Drug Rebate NDCs URA = 0 W/ Paid Claims Layout

```
REPORT: RBT-2013-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
PROCESS: RBTJQ250                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
LOCATION: RBT2013Q                     DRUG REBATE NDCS URA = 0 W/PAID CLAIMS                            Page:       9999
                                               INVOICE QUARTER: Q/CCYY


     NDC                DRUG NAME       --- CURRENT QUARTER  ---          TOTAL PROV       URA           URA           URA
                                         CLM COUNT     ORIG UNITS        REIMBURSEMENT    Q/CCYY        Q/CCYY        Q/CCYY


     99999-9999-99      XXXXXXXXXX       99999999999  99999999999        999,999,999     0.000000      0.000000      0.000000
     99999-9999-99      XXXXXXXXXX       99999999999  99999999999        999,999,999     0.000000      0.000000      0.000000
     99999-9999-99      XXXXXXXXXX       99999999999  99999999999        999,999,999     0.000000      0.000000      0.000000
     99999-9999-99      XXXXXXXXXX       99999999999  99999999999        999,999,999     0.000000      0.000000      0.000000
     99999-9999-99      XXXXXXXXXX       99999999999  99999999999        999,999,999     0.000000      0.000000      0.000000


                                                NUMBER OF NDCS:    9999

                                               ** END OF REPORT **
```

7.15.3 RBT-2013-Q -- Drug Rebate NDCs URA = 0 W/ Paid Claims Field Descriptions

Field	Description	Length	Data Type
Current Quarter CLM Count	Indicates the current quarter claim count. This is the number of claims that have no corresponding record on the rate Centers for Medicare and Medicaid Service (CMS) tape or that have a unit rebate amount equal to zero.	11	Number (Integer)
Current Quarter ORIG Units	Indicates the current quarter original units. This is the number of units associated with the current quarter claim count.	11	Number (Integer)

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Field	Description	Length	Data Type
Drug Name	Drug description found on the Centers for Medicare and Medicaid Services (CMS) database provided to all state Health Coverage Programs. If there is not a record on the quarterly rate tape for a National Drug Code (NDC) that has had utilization, it will report as 'Not Found'.	10	Character
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
NDC	Displays the unique National Drug Code that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code and the 2-digit package size code. Items that are classified as a vaccine, nutritional or supply are not included on this report.	11	Number (Integer)
Number of NDCs	Displays the total number National Drug Codes (NDC) on the Utilization report with 'Not Found' as the description for the report.	4	Number (Integer)
Total Prov Reimbursement	Total state Health Coverage Programs dollars paid for a National Drug Code (NDC), including dispensing fees, but excluding co-payment amounts and Third Party Liability (TPL) by interChange client for the specified quarter.	9	Number (Decimal)
URA QCCYY (1)	Unit rebate amount for the current quarter.	7	Number (Decimal)
URA QCCYY (2)	Unit rebate amount for the previous quarter.	7	Number (Decimal)
URA QCCYY (3)	Unit rebate amount for the quarter prior to the previous quarter.	7	Number (Decimal)

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7.16 RBT-2014-Q -- Drug Rebate Address Update Report

7.16.1 RBT-2014-Q -- Drug Rebate Address Update Report Narrative

The Drug Rebate Address Update report identifies discrepancies to the address update process that need to be resolved with CMS, or the manufacturer. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.16.2 RBT-2014-Q -- Drug Rebate Address Update Report Layout

```
Report  :  RBT-2014-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process :  RBTJQ320                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location:  DRBT0014                      DRUG REBATE ADDRESS UPDATE REPORT                                Page:       9999
                                               INVOICE QUARTER: Q/CCYY


  LABELER  LABELER NAME                            EFFECTIVE   TERMINATION            MESSAGE
    CODE                                              DATE        DATE
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


            TOTAL NUMBER OF LABELERS WITH ADDRESS INFORMATION UPDATED:                          99,999
            TOTAL LABELERS WITH NEW EFFECTIVE DATE (VERIFY EFFECTIVE DATE):                     99,999
            TOTAL NUMBER OF LABELERS WITH TERMINATION DATE UPDATED (VERIFY TERMINATION DATE):   99,999
            TOTAL NUMBER OF NEW LABELERS ADDED:                                                 99,999
            TOTAL NUMBER OF LABELERS WITH NAME UPDATED:                                         99,999

                                                          END OF REPORT
```

7.16.3 RBT-2014-Q -- Drug Rebate Address Update Report Field Descriptions

Field	Description	Length	Data Type
Effective Date	Date a labeler begins participation in the Drug Rebate Program.	8	Date (MM/DD/CCYY)
Invoice Quarter	Displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character

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Field	Description	Length	Data Type
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
Message	Updates or changes made to the Drug Rebate Address Maintenance window from the Centers for Medicare and Medicaid Services (CMS) Address tape.	50	Character
Termination Date	Date a labeler terminates participation in the Drug Rebate Program.	8	Date (MM/DD/CCYY)
Total Labelers with New Effective Date (Verify Effective Date)	Total number of labelers with effective date changes.	5	Number (Decimal)
Total Number of Labelers with Name Updated	Total number of labeler name changes.	5	Number (Decimal)
Total Number of Labelers with Address Information Updated	Total number of addresses updated.	5	Number (Decimal)
Total Number of Labelers with Termination Date Updated (Verify Termination Date)	Total number of labelers with termination date changes.	5	Number (Decimal)
Total Number of New Labelers Added	Total number of new labelers added.	6	Number (Decimal)

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7.17 RBT-2015-R -- Drug Rebate Participation by Labeler Code Report

7.17.1 RBT-2015-R -- Drug Rebate Participation by Labeler Code Report Narrative

The Drug Rebate Participation by Labeler Code report is used as an attachment to pharmacy provider bulletins. The report provides the labeler code, the labeler name, and the participation effective and end dates in the drug rebate program. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced upon request and can be emailed, printed, or routed to FEITH.

7.17.2 RBT-2015-R -- Drug Rebate Participation by Labeler Code Report Layout

```
Report  : RBT-2015-R                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : RBTJR330                           MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: RBT2015R                                 DRUG REBATE PARTICIPATION                                 Page    : 99999
                                                        BY LABELER CODE



          LABELER                                          REBATE            REBATE
          CODE           LABELER NAME                      EFFECTIVE DATE    TERMINATION DATE

          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY
          99999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY         MM/DD/CCYY



                  TOTAL ELIGIBLE LABELERS:            999
                  TOTAL TERMINATED LABELERS:          999


                                                   ** END OF REPORT **
```


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7.17.3 RBT-2015-R -- Drug Rebate Participation by Labeler Code Report Field Descriptions

Field	Description	Length	Data Type
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the NDC.	5	Number (Integer)
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
Rebate Effective Date	Date a labeler begins participation in the Drug Rebate Program.	8	Date (MM/DD/CCYY)
Rebate Termination Date	Date a labeler terminates participation in the Drug Rebate Program.	8	Date (MM/DD/CCYY)
Total Eligible Labelers	Total number of eligible labelers participating in the Drug Rebate Program.	3	Number (Integer)
Total Terminated Labelers	Total number of terminated labelers that no longer participate in the Drug Rebate program.	3	Number (Integer)

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7.18 RBT-2016-Q -- Drug Rebate CMSFDB File Update-Pharmacy Report

7.18.1 RBT-2016-Q -- Drug Rebate CMSFDB File Update-Pharmacy Report Narrative

This report displays updates made to the Drug Master Table (t_drug) termination date, updates made to the CMSFDB Info Table (t_drug_cmsfdb_info) reactivation date, and all updates made to the DESI Table (t_desi).

7.18.2 RBT-2016-Q -- Drug Rebate CMSFDB File Update-Pharmacy Report Layout

```
Report  : RBT-2016-Q                              ALABAMA MEDICAID AGENCY                                    Run Date:
11/12/2015
Process : RBTJQ215                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
14:48:30
Location: RBT2016Q                          CMSFDB FILE UPDATE REPORT-PHARMACY                                 Page:
1

CHANGE TO DRUG FILE              NDC: 00005250002   FIBERCON 625 MG CAPLET
     CMS TERMINATION DATE     OLD:        0          NEW: 20141231

CHANGE TO CMSFDB INFO FILE       NDC: 50419010510   BETAPACE 80 MG TABLET
     CMS REACTIVATION DATE    OLD:        0          NEW: 20160601

DESI UPDATE                      NDC: 62856000110   HEXALEN 50 MG CAPSULE                      OLD: 6      NEW: 5

DESI ADDED                       NDC: 63653117101   PLAVIX 75 MG TABLET                        DESI: 5

DESI ADDED                       NDC: 63717089516   ZAMICET SOLUTION                           DESI: 6

DESI UPDATE                      NDC: 63739000410   ACETAMINOPHEN-COD #3 TABLET                OLD: 5      NEW: 6


                                                      ***   END OF REPORT   ***
```

7.18.3 RBT-2012-Q -- Drug Rebate CMSFDB File Update-Pharmacy Report Field Descriptions

Field	Description	Length	Data Type
MESSAGE	The action-taken message displayed by the program.	131	Character

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7.19 RBT-3000-M -- Accounts Receivable - By Labeler Report

7.19.1 RBT-3000-M -- Accounts Receivable - By Labeler Report Narrative

The Accounts Receivable by Labeler report monitors the age of the invoice, the associated collection activities, and outstanding balances. It is used to control and ensure that all efforts are being made to collect outstanding funds for the drug rebate program. The report details collection activity by labeler code and period for each invoice for the reporting period. It reports collection activities, adjustments such as rate changes, dispute resolution, and utilization, write-offs, interest amounts and outstanding balances. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced monthly and can be emailed, printed, or routed to FEITH.

7.19.2 RBT-3000-M -- Accounts Receivable - By Labeler Report Layout

Drug Rebate Accounts Receivable - By Labeler Report Layout

```
Report: RBT-3000-M                                   ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process: RBTJM300                                MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: DRBT0300                           ACCOUNTS RECEIVABLE - BY LABELER - FEDERAL                          Page:     999,999
                                                   REPORT AS OF MM/DD/CCYY

                                                     FOR LABELER:  XXXXX

                  ORIGINAL
INVOICE           AMOUNT          REBATES        REBATE        REBATES     CURRENT REBATE      INTEREST     INTEREST     INTEREST        INTEREST          ENDING
PERIOD            INVOICED        COLLECTED     ADJUSTMENTS   WRITTEN-OFF    AMOUNT DUE         BILLED      COLLECTED   WRITTEN-OFF        DUE             BALANCE

Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99
Q/YYYY    $999,999,999.99   $999,999,999.99   $99,999,999.99   $999,999.99   $999,999,999.99   $999,999.99   $999,999.99   $999,999.99    $999,999.99    $999,999,999.99

SUB-
 TOTALS $9,999,999,999.99 $9,999,999,999.99  $999,999,999.99 $9,999,999.99 $9,999,999,999.99 $9,999,999.99 $9,999,999.99 $9,999,999.99  $9,999,999.99  $9,999,999,999.99

GRAND  $99,999,999,999.99                $9,999,999,999.99              $99,999,999,999.99              $99,999,999.99              $99,999,999.99
TOTALS                   $99,999,999,999.99                $99,999,999.99                  $9,999,999.99               $9,999,999.99                $99,999,999,999.99

                                                          ** END OF REPORT **
```


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7.19.3 RBT-3000-M -- Drug Rebate Accounts Receivable - By Labeler Report Field Descriptions

Field	Description	Length	Data Type
Current Rebate Amount Due	Rebate amount that is still outstanding for the invoice period. It is the sum of Original Amount Invoiced - Rebates Collected + Rebate Adjustments - Rebates Written Off.	11	Number (Decimal)
Ending Balance	Sum of Current Rebate Amount Due + Interest Due.	11	Number (Decimal)
Grand Totals	Summarizes all the subtotals for collection activity for each labeler.	12	Number (Decimal)
Interest Billed	Net interest amount billed to-date for each invoice period.	8	Number (Decimal)
Interest Collected	Total dollars of interest collected to-date, through the end of the reporting period, applied to respective invoice periods.	8	Number (Decimal)
Interest Due	Interest amount that is still outstanding for the invoice.	8	Number (Decimal)
Interest Written-Off	Interest amount that has been written-off.	8	Number (Decimal)
Invoice Period	Year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1- 4.	65	Date (Q/CCYY)
For Labeler	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Original Amount Invoiced	Represents the original invoice billed amount.	11	Number (Decimal)
Rebate Adjustments	This amount represents the rebate adjustments to-date, to be added to or subtracted from the original invoice amount as a result of a rebate amount per unit change, resolved dispute or utilization adjustment that increases or decrease an outstanding or credit balance for the specified quarter.	10	Number (Decimal)

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Field	Description	Length	Data Type
Rebates Collected	This amount represents the total dollar amount applied to the drug rebate quarterly invoice during the reporting period. This amount contains interest payments and credit amounts resulting from an overpayment that has been re-applied to another invoice.	11	Number (Decimal)
Rebates Written-Off	Total dollar amount of rebates that will not be collected that has been written off.	8	Number (Decimal)
Report As Of	Date the report was created.	8	Date (MM/DD/CCYY)
Sub-totals	Summarizes the collection activity totals for each labeler.	12	Number (Decimal)

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7.20 RBT-3001-M -- Accounts Receivable - By Invoice Period Report

7.20.1 RBT-3001-M -- Accounts Receivable – By Invoice Period Report Narrative

The Accounts Receivable by Invoice Period report monitors the age of the invoice, the associated collection activities, and outstanding balances. It is used to control and ensure that all efforts are being made to collect outstanding funds for the drug rebate program. The report details collection activity by period / labeler code for each invoice for the reporting period. It reports collection activities, adjustments such as rate changes, dispute resolution, and utilization, write-offs, interest amounts, and outstanding balances. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced monthly and can be emailed, printed, or routed to FEITH.

7.20.2 RBT-3001-M -- Accounts Receivable - By Invoice Period Report Layout

Drug Rebate Accounts Receivable - By Period Report Layout

```
Report  : RBT-3001-M                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : RBTJM300                             MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: DRBT0300                        ACCOUNTS RECEIVABLE - BY INVOICE PERIOD - FEDERAL                            Page:    999,999
                                                     REPORT AS OF MM/DD/CCYY

                                                   INVOICE PERIOD :  1/1991

                 ORIGINAL
LABELER           AMOUNT        REBATES       REBATE        REBATES     CURRENT REBATE   INTEREST     INTEREST    INTEREST      INTEREST       ENDING
 CODE            INVOICED      COLLECTED    ADJUSTMENTS    WRITTEN-OFF   AMOUNT DUE      BILLED      COLLECTED   WRITTEN-OFF      DUE          BALANCE

XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99
XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99
XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99
XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99
XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99
XXXXXXX $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99


SUB-
TOTALS  $9999,999,999.99 $9999,999,999.99 $999,999,999.99 $9999,999.99 $9999,999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999.99 $9999,999,999.99

GRAND   $9999,999,999.99                  $999,999,999.99              $9999,999,999.99              $9999,999.99              $9999,999.99
TOTALS                   $9999,999,999.99                 $9999,999.99                  $9999,999.99              $9999,999.99              $9999,999,999.99


                                                          ** END OF REPORT **
```


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7.20.3 RBT-3001-M -- Drug Rebate Accounts Receivable - By Period Report Field Descriptions

Field	Description	Length	Data Type
Current Rebate Amount Due	Rebate amount that is still outstanding for the labeler. It is the sum of Original Amount Invoiced - Rebates Collected + Rebate Adjustments - Rebates Written Off.	12	Number (Decimal)
Ending Balance	Sum of Current Rebate Amount Due + Interest Due.	12	Number (Decimal)
Grand Totals	Summarizes all the subtotals for collection activity for each invoice period.	12	Number (Decimal)
Interest Billed	Interest amount billed for the invoice.	9	Number (Decimal)
Interest Collected	Total dollar amount of interest applied to the drug rebate quarterly invoice during the reporting period.	9	Number (Decimal)
Interest Due	Interest amount that is still outstanding for the invoice.	9	Number (Decimal)
Interest Written-Off	Interest amount that has been written-off.	12	Number (Decimal)
Invoice Period	The year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Original Amount Invoiced	Represents the original invoice billed amount.	1612	Number (Decimal)
Rebate Adjustments	This amount represents the rebate adjustments to-date, to be added to or subtracted from the original invoice amount as a result of a rebate amount per unit change, resolved dispute or utilization adjustment that increases or decrease an outstanding or credit balance for the specified quarter.	12	Number (Decimal)
Rebates Collected	This amount represents the total dollar amount applied to the drug rebate quarterly invoice during the reporting period. This amount contains interest payments and credit amounts resulting from an overpayment that has been re-applied to another invoice.	12	Number (Decimal)

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Field	Description	Length	Data Type
Rebates Written-Off	Total dollar amount of rebates that will not be collected that has been written off.	9	Number (Decimal)
Report As Of	Date report was created.	8	Date (MM/DD/CCYY)
Sub-totals	Summarizes the collection activity totals for each invoice period.	12	Number (Decimal)

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7.21 RBT-3002-D -- Drug Rebate Cash Exception Report

7.21.1 RBT-3002-D -- Drug Rebate Cash Exception Report Narrative

The Drug Rebate Cash Exception report measures compliance of applying drug rebate payments to an invoice within 24 hours of receipt. Therefore, the report helps prioritize workload. The report itemizes drug rebate CCNs that have not been fully applied to an invoice by the age of the CCN. This report is produced daily and can be emailed, printed, or routed to FEITH.

7.21.2 RBT-3002-D -- Drug Rebate Cash Exception Report Layout

```
Report  : RBT-3002-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJD100                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: RBT3002D                            DRUG REBATE CASH EXCEPTION                                      Page:    999,999
                                               REPORTING DATE: MM/DD/CCYY


            CCN                  CHECK AMOUNT              AMOUNT APPLIED            BALANCE TO APPLY        AGE

        99999999999             $99,999,999.99            $99,999,999.99             $99,999,999.99        99,999
        99999999999             $99,999,999.99            $99,999,999.99             $99,999,999.99        99,999
        99999999999             $99,999,999.99            $99,999,999.99             $99,999,999.99        99,999
        99999999999             $99,999,999.99            $99,999,999.99             $99,999,999.99        99,999
        99999999999             $99,999,999.99            $99,999,999.99             $99,999,999.99        99,999

          GRAND TOTALS         $9,999,999,999.99         $9,999,999,999.99          $9,999,999,999.99


                                                   *** END OF REPORT ***
```

7.21.3 RBT-3002-D -- Drug Rebate Cash Exception Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the cash control number. It indicates the number of days that have elapsed since the deposit date of the check and the time the report is generated.	5	Number (Integer)
Amount Applied	Dollar amount that has been applied to the labeler invoice(s). This amount represents all or a portion of the check amount applied to the labeler invoice(s).	10	Number (Decimal)
Balance to Apply	Accumulated amount from the check and/or cash control number that needs to be applied, to the labeler invoice (Balance to Apply = Check amount - Amount Applied).	10	Number (Decimal)

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Field	Description	Length	Data Type
CCN	Unique number (cash control number) assigned to track cash receipts in the system.	11	Number (Integer)
Check Amount	Amount of the check that is being processed as a cash receipt.	10	Number (Decimal)
Grand Totals	Total dollar amount of the Check Amount, Amount Applied, and the Balance To Apply.	12	Number (Decimal)
Reporting Date	Date Report was created.	8	Date (MM/DD/CCYY)

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7.22 RBT-3003-M -- Drug Rebate Credit Due – Federal Report

7.22.1 RBT-3003-M -- Drug Rebate Credit Due – Federal Report Narrative

The Drug Rebate Credit Due – Federal report monitors drug rebate credits. The report displays NDC details and CCNs in which the payment is greater than the current invoice amount.
This report breaks on rebate program (e.g. Federal, State Supplemental) and is produced monthly. It can be emailed, printed, or routed to FEITH.

7.22.2 RBT-3003-M -- Drug Rebate Credit Due – Federal Report Layout

```
Report  : RBT-3003-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJM400                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: RBT3003M                         DRUG REBATE CREDIT DUE - Federal                                  Page:    999,999
                                            REPORTING DATE: MM/DD/CCYY

         LABELER NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         LABELER CODE     XXXXX

                      INVOICE NUMBER              NDC                   CREDIT DUE

                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99
                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99
                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99
                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99
                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99
                       XXXXXXXXXXX               XXXXXXXXXXX           $999,999,999.99


     SUBTOTAL                                                         $9,999,999,999.99


  GRAND TOTALS                                                        $9,999,999,999.99


                                       *** END OF REPORT ***
```

7.22.3 RBT-3003-M -- Drug Rebate Labeler Credit Due – Federal Report Field Descriptions

Field	Description	Length	Data Type
Credit Due	Credit balance due for each specific National Drug Code (NDC) and invoice period. The amount represents the difference between the current total rebate amount claimed and rebate amount paid for each N. (Credit Due = Current Rebate Amount Claimed - Rebate Amount Paid).	11	Number (Decimal)

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Field	Description	Length	Data Type
Grand Totals	Outstanding amount of credit due per all labeler codes listed on the report. The accumulated total of the Credit Due field for all labelers.	12	Number (Decimal)
Invoice Number	First five digits of the invoice number that represents the labeler code, and the last 5 digits that represent the year and quarter.	11	Character
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
NDC	Unique National Drug Code that identifies each drug. This field is comprised of the 5-digit labeler code, the 4-digit product code, and the 2-digit package size code. If a NDC has multiple overpayments, it will display each NDC associated with the cash control number.	11	Character
Reporting Date	Date Report was created.	108	Date (MM/DD/CCYY)
Subtotal	Outstanding amount of credit due per labeler code. The accumulated subtotal of the Credit Due field for each labeler.	12	Number (Decimal)

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7.23 RBT-3004-D – Drug Rebate Invoice Disposition Exception – Federal Report

7.23.1 RBT-3004-D -- Drug Rebate Invoice Disposition Exception – Federal Report Narrative

The Invoice Disposition Exception – Federal report measures compliance in posting drug rebate dollars to the invoice detail within three days. The report helps prioritize workloads. The report itemizes drug rebate cash control numbers that have been applied to an invoice but are not fully dispositioned to the NDC detail by the age of the CCN. This report breaks on rebate program (e.g. Federal, State Supplemental) and is produced daily. It can be emailed, printed, or routed to FEITH.

7.23.2 RBT-3004-D -- Drug Rebate Invoice Disposition Exception – Federal Report Layout

```
Report  : RBT-3004-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJD200                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: RBT3004D                DRUG REBATE INVOICE DISPOSITION EXCEPTION - FEDERAL                      Page:    999,999
                                            REPORTING DATE: MM/DD/CCYY


      CCN            INVOICE #          AMOUNT APPLIED         AMOUNT DISPOSITIONED     BALANCE TO DISPOSITION     AGE
                                                                      TO DATE


   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999
   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999
   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999
   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999
   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999
   99999999999       9999999999        $99,999,999.99            $99,999,999.99            $99,999,999.99         99,999


 GRAND TOTALS                       $9,999,999,999.99         $9,999,999,999.99         $9,999,999,999.99


                                              *** END OF REPORT ***
```

7.23.3 RBT-3004-D -- Invoice Disposition Exception Report – Federal Field Descriptions

Field	Description	Length	Data Type
Age	Age of the cash control number. It indicates the number of days that have elapsed since the deposit date of the check and the time the report is generated.	5	Number (Integer)
Amount Applied	Dollar amount that has been applied to the labeler invoice(s). This amount represents all or a portion of the check amount applied to the labeler invoice(s).	10	Number (Decimal)

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Field	Description	Length	Data Type
Amount Dispositioned to Date	Amount that has been dispositioned to the invoice detail to date.	10	Number (Decimal)
Balance to Disposition	Accumulated amount that has been applied from the checks/cash control number but needs to be dispositioned to the invoice detail. (Balance to Disposition = Amount Applied - Amount Disposition to Date).	10	Number (Decimal)
CCN	Unique number assigned to track cash receipts in the system.	11	Number (Integer)
Grand Totals	Total dollar amount of the Amount Applied, Amount Disposition to Date, and the Balance to Disposition fields. The average of the AGE field is the total number of days divided by the number of outstanding cash control numbers.	12	Number (Decimal)
Invoice #	First five digits of the invoice number that represents the labeler code, and the last five digits that represent the year and quarter.	10	Number (Integer)
Reporting Date	Date Report was created.	8	Date (MM/DD/CCYY)

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7.24 RBT-3005-Q -- Labelers W/ Highest Dispute Amounts – Federal Report

7.24.1 RBT-3005-Q -- Labelers W/ Highest Dispute Amounts - Federal Report Narrative

The Labelers with Highest Dispute Amounts report lists the labelers with the largest dispute amounts. This report is produced quarterly and breaks on rebate program (e.g. Federal, State Supplemental). It can be emailed, printed or routed to FEITH.

7.24.2 RBT-3005-Q -- Labelers with W/ Dispute Amounts - Federal Report Layout

```
Report  : RBT-3005-Q                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : RBTJQ305                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: DRBT3005Q                  LABELERS W/ HIGHEST DISPUTE AMOUNTS - FEDERAL                                 Page:       9999
                                                INVOICE QTR: Q/CCYY

                            LABELER                 LABELER                          TOTAL
                             CODE                    NAME                         DISPUTE AMT

       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99
       99999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.      $999,999.99


                         TOTALS:                                                  $9,999,999.99


                                          ** END OF REPORT **
```

7.24.3 RBT-3005-Q -- Drug Rebate Labelers W/ Highest Dispute Amounts - Federal Report Field Descriptions

Field	Description	Length	Data Type
Invoice Quarter	The year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Labeler Code	Identifies the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first five characters of the labeler's National Drug Code (NDC).	5	Number (Integer)
Labeler Name	Name of the drug rebate labeler.	39	Character
Total Dispute Amount	Total disputed amount.	8	Number (Decimal)

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Field	Description	Length	Data Type
Totals	Total of all the disputed amounts for the 100 labelers with the highest dispute amounts.	9	Number (Decimal)

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7.25 RBT-3007-M -- Drug Rebate Delinquent Payments Report

7.25.1 RBT-3007-M -- Drug Rebate Delinquent Payments Report Narrative

The Drug Rebate Delinquent Payments report lists, by period, the labelers with delinquent rebate amounts due. This report is produced monthly and breaks on rebate program (e.g. Federal, State Supplemental). The report can be emailed, printed, or routed to FEITH.
Labelers are listed for the following two reasons:

1. No payments have been received after the 38th day of the invoice being sent (interest may start to accrue at this point).

2. No activity has been noted for a labeler/quarter for a period of six months (no payments, adjustments, write-offs).

7.25.2 RBT-3007-M -- Drug Rebate Delinquent Payments Report Layout

```
Report  : RBT-3007-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJM280                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:  HH:MM:SS
Location: RBT3007Q                     DRUG REBATE DELINQUENT PAYMENTS - FEDERAL                           Page:    999,999
                                               REPORT AS OF MM/DD/CCYY

   LABELER ID     LABELER NAME
   99999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  INVOICE                                          ORIGINAL         PAST DUE                DAYS PAST     TOTAL PAST DUE
  QUARTER       NDC       NDC DESCRIPTION      INVOICE AMOUNT   REBATE AMOUNT    DISPUTE      DUE         REBATE AMOUNT

  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99
  Q/CCYY    XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX  $9,999,999.99    $9,999,999.99      X        9,999       $999,999,999.99

                                                                        GRAND TOTAL                       $999,999,999.99


**END OF REPORT**
```


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7.25.3 RBT-3007-M -- Drug Rebate Delinquent Payments Report Field Descriptions

Field	Description	Length	Data Type
Days Past Due	Total number of days that the invoice and amount are past due.	4	Number (Integer)
Dispute	Indicates whether the National Drug Code (NDC) is in dispute. A 'Y' indicates a dispute, otherwise the fields will be blank.	1	Character
Grand Total	Grand total of all past due rebate amounts for the reporting period.	11	Number (Decimal)
Invoice Quarter	Invoice quarter.	5	Date (Q/CCYY)
Labeler ID	Uniquely identifies the labeler of a drug. This code is assigned by Centers for Medicare and Medicaid Services (CMS) and is used as the first five characters of the labeler's National Drug Codes.	5	Number (Integer)
Labeler Name	Name of the drug labeler.	39	Character
NDC	National Drug Code assigned to a drug.	11	Number (Integer)
NDC Description	Description of the National Drug Code (NDC).	20	Character
Original Invoice Amount	The amount invoiced for the National Drug Code (NDC) on the original invoice.	9	Number (Decimal)
Past Due Rebate Amount	Rebate amount that is past due.	9	Number (Decimal)
Total Past Due Rebate Amount	Subtotal of the past due rebate amounts for each labeler.	11	Number (Decimal)

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7.26 RBT-3500-M -- Drug Rebate Payments Received Report

7.26.1 RBT-3500-M -- Drug Rebate Payments Received Report Narrative

The Drug Rebate Payments Received report lists the drug rebate payments received within the specified time period. This report is produced monthly and can be emailed, printed, or routed to FEITH.

7.26.2 RBT-3500-M -- Drug Rebate Payments Received Report Layout

```
Report  : RBT-3500-M                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : RBTJM350                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: DRBT0350                           DRUG REBATE PAYMENTS RECEIVED                                         Page:    999,999
                                       REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY



REMITTER                                 RECEIPT  CASH CONTROL           CHECK                CHECK    POSTMARK    TOTAL CCN         APPLIED
                                          DATE       NUMBER               NUMBER               DATE       DATE       AMOUNT           AMOUNT

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY XXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY $999,999,999.99 $999,999,999.99


                                                                 TOTAL CCN AMOUNT FOR THIS PERIOD: $999,999,999.99

                                                              TOTAL APPLIED AMOUNT FOR THIS PERIOD: $999,999,999.99


                                                        ** END OF REPORT **
```


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7.26.3 RBT-3500-M -- Drug Rebate Payments Received Report Field Descriptions

Field	Description	Length	Data Type
Applied Amount	Amount applied for the invoice.	11	Number (Decimal)
Cash Control Number	Cash control number for the receipt.	11	Character
Check Date	Date on the check.	8	Date (MM/DD/CCYY)
Check Number	Check number.	30	Character
Deposit Date	Date the check was deposited.	8	Date (MM/DD/CCYY)
Postmark Date	Postmark date on the envelope in which the check came.	8	Date (MM/DD/CCYY)
Receipt Date	Date the check was received.	8	Date (MM/DD/CCYY)
Remitter	Name of the remitter of the payment.	40	Character
Reporting Period	From and through dates for this report.	16	Date (MM/DD/CCYY)
Total Applied Amount For This Period	Total Amount of the CCNs listed on the report that have been applied to invoices.	11	Number (Decimal)
Total CCN Amount	Total Amount of the CCN.	11	Number (Decimal)
Total CCN Amount For This Period	Total Amount of the CCNs listed on the report.	11	Number (Decimal)

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7.27 RBT-3600-W -- Drug Rebate Weekly Receipts By Quarter - Federal Report

7.27.1 RBT-3600-W -- Drug Rebate Weekly Receipts By Quarter - Federal Report Narrative

The Drug Rebate Receipts Weekly by Quarter - Federal report lists all cash receipts received within the specified period and to what quarter(s) they apply. This report is produced weekly and breaks on rebate program (e.g. Federal, State Supplemental). The report can be emailed, printed, or routed to FEITH.

7.27.2 RBT-3600-W -- Drug Rebate Weekly Receipts By Quarter - Federal Report Layout

```
Report  : RBT-3600-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : RBTJW360                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: DRBT0360                  DRUG REBATE WEEKLY RECEIPTS BY QUARTER - FEDERAL                        Page:       9999


                                     REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY


                              QUARTER          REBATE RECEIPTS    INTEREST          TOTAL RECEIPTS

                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99
                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99
                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99
                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99
                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99
                               Q/CCYY           $99,999,999.99    $99,999,999.99    $99,999,999.99


                       TOTAL FOR THIS PERIOD:  $99,999,999.99    $99,999,999.99    $99,999,999.99




                                                ** END OF REPORT **
```

7.27.3 RBT-3600-W -- Drug Rebate Weekly Receipts By Quarter - Federal Report Field Descriptions

Field	Description	Length	Data Type
Interest	Total interest receipts posted for the week.	10	Number (Decimal)
Quarter	Quarter for which receipts were received.	5	Date (Q/CCYY)
Rebate Receipts	Total rebate receipts for the week.	10	Number (Decimal)

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Field	Description	Length	Data Type
Reporting Period	Beginning and ending dates of the reporting period.	16	Date (MM/DD/CCYY)
Total Receipts	Total cash receipts posted for the week.	10	Number (Decimal)
Total for this Period	Total of the following columns: rebate receipts, interest, total receipts.	1210	Number (Decimal)

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7.28 RBT-4000-M -- Drug Rebate Dispute Summary - Federal Report

7.28.1 RBT-4000-M -- Drug Rebate Dispute Summary Report - Federal Narrative

The Drug Rebate Dispute Summary - Federal report provides a comprehensive summary of dispute information for each invoice period. If an invoiced period has no activity it is not listed on the report. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced monthly and can be emailed, printed, or routed to FEITH.

7.28.2 RBT-4000-M -- Drug Rebate Dispute Summary Report - Federal Layout

```
Report  : RBT-4000-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : RBTJM103                       MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: DRBT4000                     DRUG REBATE DISPUTE SUMMARY REPORT - FEDERAL                       Page:    999,999
                                         REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY


INVOICE       ------------------   ACTIVE DISPUTES -------------------          ---------------- CLOSED DISPUTES  ------------------
 PERIOD             LABELERS              COUNT             DOLLARS                 LABELERS              COUNT             DOLLARS


 9/9999              999,999            999,999      $999,999,999.99                 999,999            999,999      $999,999,999.99
 9/9999              999,999            999,999      $999,999,999.99                 999,999            999,999      $999,999,999.99
 9/9999              999,999            999,999      $999,999,999.99                 999,999            999,999      $999,999,999.99
 9/9999              999,999            999,999      $999,999,999.99                 999,999            999,999      $999,999,999.99
 9/9999              999,999            999,999      $999,999,999.99                 999,999            999,999      $999,999,999.99


 TOTALS:          99,999.999         99,999,999    $9,999,999,999.99              99,999,999         99,999,999    $9,999,999,999.99


                                                   ** End of Report **
```

7.28.3 RBT-4000-M -- Drug Rebate Dispute Summary by Invoice Period Report - Federal Field Descriptions

Field	Description	Length	Data Type
Active Disputes Count	The total number of National Drug Codes (NDC) with open dispute details (CDE_STATUS = 0) for the specified invoice period.	6	Number (Decimal)
Active Disputes Dollars	The sum of the amount for all open dispute details (CDE_STATUS = 0) for the specified invoice period. This field can be positive or negative.	11	Number (Decimal)
Active Disputes Labelers	The total number of labelers with at least one open dispute detail (CDE_STATUS = 0) for the specific invoice period.	6	Number (Decimal)

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Field	Description	Length	Data Type
Closed Disputes Count	The total number of National Drug Codes (NDC) with closed dispute details (CDE_STATUS = 1) for the specified invoice period.	6	Number (Decimal)
Closed Disputes Dollars	The total dollar amount of closed dispute details (CDE_STATUS = 1) for the specific invoice period. This field can be positive or negative. (Balance = New Rebate Claimed - Paid - Write-off).	11	Number (Decimal)
Closed Disputes Labelers	The total number of labelers with a closed status for all dispute details (CDE_STATUS = 1) for the specified invoice period.	6	Number (Decimal)
Invoice Period	The year and quarter of the invoice. The date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Reporting Period	From and To dates for this report.	16	Date (MM/DD/CCYY)
Totals	Sum of each field on the report.	12	Number (Decimal)

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7.29 RBT-4001-M -- Drug Rebate Amounts - Federal (Billed, Adjusted and Collected) Report

7.29.1 RBT-4001-M -- Drug Rebate Amounts - Federal (Billed, Adjusted and Collected) Report Narrative

The Drug Rebate Amounts Billed, Adjusted and Collected report monitors drug rebate invoice amounts, adjustments, write-offs and collection activities by invoice period. The report is used to compile data for the CMS-64 report. This report breaks on rebate program (e.g. Federal, State Supplemental). This report is produced monthly and can be emailed, printed, or routed to FEITH.

7.29.2 RBT-4001-M -- Drug Rebate Amounts - Federal (Billed, Adjusted and Collected) Report Layout

```
Report  : RBT-4001-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : RBTJM401                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: DRBT0401                           DRUG REBATE AMOUNTS - FEDERAL                                 Page:    999,999
                                            BILLED, ADJUSTED, AND COLLECTED

                                              REPORT AS OF MM/DD/CCYY


INVOICE PERIOD      ORIGINAL AMOUNT         WRITE-OFF            ADJUSTMENT AMOUNT       COLLECTED           REBATES RECEIVABLE
                         BILLED

XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99
XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99
XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99
XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99
XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99
XXXXXXXXXXXXX       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99


 YEAR TO DATE       $999,999,999.99      $999,999,999.99          $999,999,999.99     $999,999,999.99          $999,999,999.99


    TOTAL           $999,999,999.99      $999,999,999.99         $999,999,999.99     $999,999,999.99          $999,999,999.99


                                              ** END OF REPORT **
```


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7.29.3 RBT-4001-M -- Drug Rebate Amounts - Federal (Billed and Adjusted and Collected) Report Field Descriptions

Field	Description	Length	Data Type
Adjustment Amount	Amount represents a change in the dollar amount from the original invoice amount as a result of a rebate amount per unit change, resolved dispute and utilization adjustment that increases or decreases an outstanding or credit balance for the specified invoice period. (Adjusted Amount = Original Rebate Amount Claimed - Current Rebate Amount Claimed.)	11	Number (Decimal)
Collected	Amount represents the total dollar amount disposition to the specified invoice period.	11	Number (Decimal)
Invoice Period	Year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1- 4.	13	Character
Original Amount Billed	Represents the Rebate Amount Claimed of the original invoice for the specified invoice period	11	Number (Decimal)
Rebates Receivable	Uncollected = Original Invoice - Write-offs + or - Adjustments - Collected. This amount includes open disputes (CDE_STATUS = 0).	11	Number (Decimal)
Report As Of	Date the report was created.	8	Date (MM/DD/CCYY)
Total	Summarizes the subtotals for all activity totals for all invoice periods.	11	Number (Decimal)
Write-Off	Total dollar amount that will not be collected that has been written off.	11	Number (Decimal)
Year To Date	Summarizes the activity totals for each invoice period within a year.	11	Number (Decimal)

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7.30 RBT-4002-Q -- Drug Rebate Aging Report

7.30.1 RBT-4002-Q -- Drug Rebate Aging Report Narrative

The Drug Rebate Aging report provides the information to prepare the CMS 64.9R report. It reports the beginning balances for invoices, newly invoiced amounts, adjustments, payments and the resulting balances (by quarter).

The CMS 64.9R report is a section (schedule) of the CMS 64 Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. Medicaid State agencies use the CMS 64 to report their actual program benefit costs and administrative expenses to the CMS. CMS then uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.30.2 RBT-4002-Q -- Drug Rebate Aging Report Layout

```
Report: RBT-4002-Q                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process: RBTJQ402                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: RBT4002Q                          DRUG REBATE AGING REPORT                                      PAGE:          1
                                          QUARTER ENDING: MM/DD/CCYY


                        QTR ENDING        QTR ENDING        QTR ENDING        QTR ENDING        QTRS PRIOR          TOTAL
                        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY        MM/DD/CCYY

  Balance Beg          $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
  Adjustments          $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
  Rebates Inv          $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
  Subtotal             $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99

  Receipts             $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99

  Balance End          $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99




  Interest             $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99


                                                   ** END OF REPORT **
```


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7.30.3 RBT-4002-Q -- Drug Rebate Aging Report Field Descriptions

Field	Description	Length	Data Type
Adjustments	Adjustment amounts applied during the reporting quarter, which are applicable to a particular invoice 'produced' quarter.	11	Number (Decimal)
Balance Beg	Amounts invoiced less all payments and adjustments for prior quarters.	11	Number (Decimal)
Balance End	Subtotal less Receipts for each applicable quarter.	11	Number (Decimal)
Interest	Interest paid during the reporting quarter, which is applicable to a particular invoice 'produced' quarter.	11	Number (Decimal)
Rebates Inv	Amounts invoiced during the reporting quarter. Only the first column will display an amount and only for invoices 'produced' during the reporting quarter.	11	Number (Decimal)
Receipts	Receipts applied during the reporting quarter, which are applicable to a particular invoice 'produced' quarter.	11	Number (Decimal)
Subtotal	Balance Beginning less Adjustments plus Rebates Inventory.	11	Number (Decimal)

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7.31 RBT-5000-R -- Drug Rebate Resolution Statement Report

7.31.1 RBT-5000-R -- Drug Rebate Resolution Statement Report Narrative

The Drug Rebate Resolution Statement report is used to notify the manufacturer that the dispute for an invoice period has been closed. The report provides the manufacturer with NDC detail data of the research and the dispute determination for the specific invoice period. This report breaks on rebate program (e.g. Federal, State Supplemental) This report is produced weekly and can be emailed, printed or routed to FEITH.

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7.31.2 RBT-5000-R -- Drug Rebate Resolution Statement Report Layout

```
Report  : RBT-5000-R                                    ALABAMA MEDICAID AGENCY                      Run Date:   MM/DD/CCYY
Process : RBTJW300                                MEDICAID MANAGEMENT INFORMATION SYSTEM              Run Time:   HH:MM:SS
Location: RBT5000R                               DRUG REBATE RESOLUTION STATEMENT - FEDERAL                Page:    999,999
                                                              INVOICE PERIOD: Q/CCYY


LABELER CODE  XXXXX        LABELER NAME  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   INVOICE PERIOD  XXXXXX       STATE CODE  XX

NDC     CURRENT        TOTAL UNITS     CURRENT REBATE        UNITS PAID     REBATE AMOUNT        STATE           BALANCE OF      BALANCE     RSN    RESO
        REBATE AMT     REIMBURSED      AMOUNT CLAIMED        BY LABELER       PAID BY         NEW ADJUSTED       UNITS DUE      DUE FROM    CDE    CODE
        PER UNIT       TO PROVIDER                                            LABELER            UNITS                           LABELER

XXXXXX XXXXXXXXXXXX 9,999,999,999.999  $999,999,999.99  99,999,999,999.999  $999,999,999.99  9,999,999,999.999  9,999,999.999  $9,999,999.99  XXXXX XXXXX
XXXXXX XXXXXXXXXXXX 9,999,999,999.999  $999,999,999.99  99,999,999,999.999  $999,999,999.99  9,999,999,999.999  9,999,999.999  $9,999,999.99  XXXXX XXXXX
XXXXXX XXXXXXXXXXXX 9,999,999,999.999  $999,999,999.99  99,999,999,999.999  $999,999,999.99  9,999,999,999.999  9,999,999.999  $9,999,999.99  XXXXX XXXXX
XXXXXX XXXXXXXXXXXX 9,999,999,999.999  $999,999,999.99  99,999,999,999.999  $999,999,999.99  9,999,999,999.999  9,999,999.999  $9,999,999.99  XXXXX XXXXX
XXXXXX XXXXXXXXXXXX 9,999,999,999.999  $999,999,999.99  99,999,999,999.999  $999,999,999.99  9,999,999,999.999  9,999,999.999  $9,999,999.99  XXXXX XXXXX


  SUB TOTALS       99,999,999,999.999            999,999,999,999.999                  99,999,999,999.999            $9,999,999,999.99
                            $9,999,999,999.99                    $9,999,999,999.99               999,999,999,999.999


                                                 NUMBER OF NDCS RESOLVED:            9,999
                                                 BALANCE DUE:              $999,999,999.99
                                                 CREDIT DUE LABELER:       $999,999,999.99

                    PLEASE REMIT TO THE FOLLOWING ADDRESS:

                                  Alabama Medicaid Agency
                                 Attn: Drug Rebate/Accounts Receivable
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL  36103-5624


   REASON      DESCRIPTION
    CODE
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 RESOLUTION    DESCRIPTION
    CODE
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     XX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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7.31.3 RBT-5000-R -- Drug Rebate Resolution Statement Report Field Descriptions

Field	Description	Length	Data Type
Balance Due	Total amount of money owed by the labeler for the invoice period in question.	11	Number (Decimal)
Balance Due From Labeler	Represents the total re-calculated amount due from the labeler after subtracting any previous payment (Balance Due from Labeler = Balance of Units Due * Current Rebate Amount Claimed). This field can be either positive or negative.	9	Number (Decimal)
Balance of Units Due	Represents the number of units due from the labeler for a specific National Drug Code. (Balance of Units Due = State New Adjusted Units - Units Paid by Labeler). This field can be either positive or negative.	10	Number (Decimal)
Credit Due Labeler	Total amount of money owed to the labeler for the invoice period in question.	11	Number (Decimal)
Current Rebate Amount Claimed	Current rebate amount due from the manufacturer for the specified invoiced period. (Current Rebate Amount Claimed = Current Rebate Amount Per Unit * Total Units Reimbursed to Provider).	15	Number (Decimal)
Current Rebate Amount Per Unit	Current rebate amount per unit reported to Centers for Medicare and Medicaid Services (CMS) by the labeler and provided to each state.	12	Character
Description	Provides the labeler with an explanation of the reason or resolution code for the closed National Drug Codes (NDC) for the specified invoice period	100	Character
Invoice Period	Year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Labeler Code	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Labeler Name	Manufacturer labeler name as reported on the Drug Rebate address file provided by Centers for Medicare and Medicaid Services (CMS).	39	Character
NDC	The unique National Drug Code that identifies each drug. This field is comprised of the 4-digit product code, and the 2-digit package size code.	6	Character
Number of NDCs Resolved	Number of National Drug Codes (NDC) closed for the specified invoice period.	4	Number (Decimal)

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Field	Description	Length	Data Type
Please Remit to the Following Address	Literal field used only if the balance due is a positive amount owed by the labeler.	37	Character
Reason Code	Displays all of the reason codes referenced in the report	2	Character
Rebate Amount Paid by Labeler	Total dollar amount paid by the labeler and dispositioned to the invoice detail, for the disputed National Drug Code (NDC) for the specified invoice period.	11	Number (Decimal)
Reso Code	Displays the resolution code(s) for the specified closed dispute.	5	Character
Resolution Code	Displays all of the resolution codes referenced in the report.	2	Character
Rsn Cde	Displays the dispute reason code(s) for the specified closed dispute.	5	Character
State Code	State abbreviation to indicate which state Health Coverage Program is billing the labeler.	2	Character
State New Adjusted Units	State New Adjusted Units are the new total number of units after the state has resolved (closed) the disputed National Drug Code (NDC) for a specified invoice period.	13	Number (Decimal)
Subtotals	Represents the total amount due for the following fields: Total Units Reimbursed to Provider, Current Rebate Amount Claimed, Units Paid by Labeler, Rebate Amount Paid by Labeler, State New Adjusted Units, Balance of Units Due and Balance Due from Labeler.	15	Number (Decimal)
Total Units Reimbursed to Provider	Displays the total number of units reimbursed to Providers for a National Drug Code (NDC) for the specified quarter. This field is populated with the number of units on the invoice detail when the dispute is opened each time.	13	Number (Decimal)
Units Paid by Labeler	Total number of units for which payment has been made by the labeler.	14	Number (Decimal)

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7.32 RBT-5003-W -- Drug Rebate Recoupment Detail Report

7.32.1 RBT-5003-W -- Drug Rebate Recoupment Detail Report Narrative

The Drug Rebate Recoupment Detail report lists internal control numbers which have been recouped in the prior week, as a result of claim corrections. This report is sorted by Provider Number and Recipient Identification number. This report is produced weekly and can be emailed, printed or routed to FEITH.

7.32.2 RBT-5003-W -- Drug Rebate Recoupment Detail Report Layout

```
REPORT: RBT-5003-W                                    ALABAMA MEDICAID AGENCY                                    RUN DATE:
MM/DD/CCYY
PROCESS: RBTJM503                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:
HH:MM:SS
LOCATION: RBT5003W                                DRUG REBATE RECOUPMENT DETAIL REPORT                              PAGE:
1
                                                   REPORT DATE: MM/DD/CCYY


   PROVIDER     RECIPIENT     ORIGINAL       ADJUSTED      NDC          DATE        RX    ORIG ICN  ADJ ICN   LETTER      RECOUP
FINAL
   NUMBER          ID           ICN            ICN                   DISPENSED   NUMBER    UNITS    UNITS     DATE        AMT
DATE

NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY
NPI XXXXXXXXXX  000000000000 9999999999999  9999999999999 99999999999  MM/DD/CCYY  9999999  999.99  999.99   MM/DD/CCYY  $9,999.99
MM/DD/CCYY


                                                                                                  SUB TOTAL:    $9,999,999.99


                                                                                                   GRAND TOTAL:  $9,999,999.99

                                                                  ** END OF REPORT **
```


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7.32.3 RBT-5003-W -- Drug Rebate Recoupment Detail Report Field Descriptions

Field	Description	Length	Data Type
Adj ICN Units	Adjusted internal control number units.	5	Number (Decimal)
Adjusted ICN	Adjusted internal control number; this is the unique identifier of the replacement claim.	13	Number (Integer)
Date Dispensed	Date drug dispensed.	8	Date (MM/DD/CCYY)
Final Date	Date the claim processed.	8	Date (MM/DD/CCYY)
Grand Total	Grand total of all recoupment amount.	8	Number (Decimal)
Letter Date	Date that the letter was sent.	8	Date (MM/DD/CCYY)
NDC	Unique National Drug Code that identifies each drug. This field is comprised of the five-digit labeler code, the four-digit product code, and the two-digit package size code.	11	Number (Integer)
Orig ICN Units	Original internal control number units.	5	Number (Decimal)
Original ICN	Original internal control number; this is the unique identifier of the claim.	13	Character
Provider Number	State Health Coverage Programs Provider Identification number.	15	Character
Provider ID Type	Provider's identification type.	3	Character
Recipient ID	Recipient identification number.	12	Character
Recoup Amt	Recoupment amount.	6	Number (Decimal)
RX Number	Pharmacy number.	7	Number (Integer)
Sub Total	Sub total by provider of amount.	9	Number (Decimal)

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7.33 RBT-5004-Q -- Drug Rebate Recoupment Summary Report

7.33.1 RBT-5004-Q -- Drug Rebate Recoupment Summary Report Narrative

The Drug Rebate Recoupment Summary report provides a summary of internal control numbers (ICN) recouped and listed on the RBT-5003-W report. This report is produced quarterly and can be emailed, printed, or routed to FEITH.

7.33.2 RBT-5004-Q -- Drug Rebate Recoupment Summary Report Layout

```
REPORT: RBT-5004-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
PROCESS: RBTJW504                     MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
LOCATION: RBT5004Q                     DRUG REBATE RECOUPMENT SUMMARY REPORT                             Page:     1
                                               REPORT QUARTER: Q/CCYY

                        PROVIDER          ORIG ICN         ADJ ICN          RECOUP
                         NUMBER            UNITS            UNITS            AMT


                   NPI 99999999999999X     999.999          999.999         $999,999
   **** JCODE ****  NPI 99999999999999X     999.999          999.999         $999,999


                                     PHARMACY PROVIDER SUB TOTAL:      $9,999,999.99
                                        JCODE PROVIDER SUB TOTAL:      $9,999,999.99
                                                      GRAND TOTAL:      $9,999,999.99

                                              ** END OF REPORT **
```

7.33.3 RBT-5004-Q -- Drug Rebate Recoupment Summary Report Field Descriptions

Field	Description	Length	Data Type
Adj ICN Units	Adjusted internal control number units.	6	Number (Decimal)
Grand Total	Grand total amount of recoupment for report summary.	9	Number (Decimal)
JCode Provider Sub Total	Total amount recouped from JCode provider.	9	Number (Decimal)
Orig ICN Units	Original internal control number units.	6	Number (Decimal)
Pharmacy Provider Sub Total	Total amount recouped from Pharmacy provider.	9	Number (Decimal)
Provider ID Type	This is the provider's identification type.	3	Character

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Field	Description	Length	Data Type
Provider Number	State Health Coverage Programs provider identification number.	15	Character
Recoup Amt	Total amount of recoupment.	6	Number (Decimal)

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7.34 RBT-5006-W -- Drug Rebate Recoup Letters > Than 30 Days Old & No Response Report

7.34.1 RBT-5006-W -- Drug Rebate Recoup Letters > Than 30 Days Old & No Response Narrative

The Drug Rebate Recoup Letters > Than 30 Days Old & No Response report lists providers that have not responded to letters within 30 days of the sent date. The letters requested additional documentation from the provider regarding specific ICNs. This report is produced weekly and can be emailed, printed, or routed to FEITH.

After viewing this report, the user may then update the letter status to 'No Response'. When this status or 'Ready for process/adjust' is entered, the user should adjust/void the associated ICNs using the Claims panels. After entry of these two statuses, the status is automatically updated to 'Adjusted', and letters are built notifying the providers that their claims have been adjusted.

7.34.2 RBT-5006-W -- Drug Rebate Recoup Letters > Than 30 Days Old & No Response Report Layout

```
REPORT: RBT-5006-W                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS: RBTJM506                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME:   HH:MM:SS
LOCATION: RBTJW506                 DRUG REBATE RECOUP LETTERS > 30 DAYS OLD & NO RESPONSE                       PAGE:        9999

    PROVIDER NUMBER     LETTER ID        PROVIDER NAME                                              LETTER DATE

NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY
NPI 999999999            9999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/CCYY

                                                   TOTAL PROVIDERS        999

                                                 ** END OF REPORT **
```


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7.34.3 RBT-5006-W -- Drug Rebate Recoup Letters Greater Than 30 Days Old Report Field Descriptions

Field	Description	Length	Data Type
Letter Date	Date on which the letter was sent.	8	Date (MM/DD/CCYY)
Letter ID	Unique identification number assigned to a letter for a provider/same day scenario.	4	Number (Integer)
Provider ID Type	This is the provider's identification type.	3	Character
Provider Number	Provider number and service location code of the pharmacy or provider receiving the letter.	15	Character
Provider Name	Name of the provider.	50	Character
Total Providers	Total number of providers that have an outstanding notice.	3	Number (Integer)

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7.35 RBT-9001-M -- Drug Rebate Outstanding Balance Summary - Federal Report

7.35.1 RBT-9001-M -- Drug Rebate Outstanding Balance Summary- Federal Report Narrative

The Drug Rebate Outstanding Balance Summary - Federal report provides a summary of outstanding balances per manufacturer per invoice period, as well as an accumulated total for all invoice periods. The cover letter and summary report are sent to labelers in an effort to collect outstanding balances that are over 68 days old. A copy of the cover letter and summary report will be sent as notification to CMS in the event of repeated delinquency. This report breaks on rebate program (e.g. Federal, State Supplemental). It can be emailed, printed, or routed to FEITH.

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7.35.2 RBT-9001-M -- Drug Rebate Outstanding Balance Summary - Federal Report Layout

Drug Rebate Outstanding Balance Letter and Summary Rpt Report Layout

Report : RBT-9001-M
Process : RBTJM105
Location: RBT9001M

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
DRUG REBATE OUTSTANDING BALANCE SUMMARY - FEDERAL
REPORT AS OF MM/DD/CCYY

Run Date: MM/DD/CCYY
Run Time: HH:MM:SS
Page: 9999

FOR LABELER: 99999

INVOICE PERIOD	ORIGINAL AMOUNT INVOICED	REBATES COLLECTED	REBATE ADJUSTMENTS	REBATES WRITTEN-OFF	CURRENT REBATE AMOUNT DUE	INTEREST BILLED	INTEREST COLLECTED	INTEREST WRITTEN-OFF	INTEREST DUE	ENDING BALANCE
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
Q/CCYY	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99
TOTALS	$999,999,999.99	$999,999,999.99	$99,999,999.99	$999,999.99	$999,999,99.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999,999.99

** END OF REPORT **

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7.35.3 RBT-9001-M -- Drug Rebate Outstanding Balance Letter and Summary - Federal Report Field Descriptions

Field	Description	Length	Data Type
Current Rebate Amount Due	Rebate amount that is still outstanding for the invoice.	10	Number (Decimal)
Ending Balance	Sum of Current Rebate Amount Due + Interest Due.	11	Number (Decimal)
For Labeler	Unique five-digit code that identifies each drug manufacturer's labeler number. This number represents the first five digits of the National Drug Code (NDC).	5	Character
Interest Billed	Interest amount billed for the invoice.	8	Number (Decimal)
Interest Collected	Total dollar amount of interest applied to the drug rebate quarterly invoice during the reporting period.	8	Number (Decimal)
Interest Due	Interest amount that is still outstanding for the invoice.	8	Number (Decimal)
Interest Written-Off	Interest amount that has been written-off.	8	Number (Decimal)
Invoice Period	Year and quarter of the invoice. This field displays the date in Q/CCYY format where Q indicates the quarter. Valid values for the quarter are 1-4.	5	Date (Q/CCYY)
Original Amount Invoiced	Represents the original invoice billed amount.	11	Number (Decimal)
Rebate Adjustments	Represents the adjusted dollar amount from the original invoice amount as a result of a rebate amount per unit change, resolved dispute or utilization adjustment that increases or decrease an outstanding or credit balance for the specified quarter.	10	Number (Decimal)
Rebates Collected	Represents the total dollar amount applied to the drug rebate quarterly invoice during the reporting period. This amount contains interest payments and credit amounts resulting from an overpayment that has been re-applied to another invoice.	11	Number (Decimal)
Rebates Written Off	Total dollar amount that will not be collected that has been written off.	8	Number (Decimal)
Report As Of	Date the report was created.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Totals	Summarizes the collection activity totals for each labeler.	11	Number (Decimal)

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AMMIS DUR User Manual

Date Modified: 05/01/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS DUR User Manual
Version:	4.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/UserManuals/DUR_UM
Owner:	DXC Technology/Agency
Author:	DUR Team
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
10/3/2013	1.0		Application of ICD-10 implementation change order	CO 10131: - Update Section 7.10: DUR-0010-M -- Diagnosis to FDBDX Disease Cross Reference Updates Report Layout and Field Descriptions. CO 10214: Update section 6.16 Reported Disease Panel Layout and Field Descriptions CO 10132: Update section 6.3 Allergy Diagnosis Panel Layout and Field Descriptions
11/12/2013	2.0		Application of CO 8361	Added the following reports to the DUR Manual: Addictive Toxicity Panel, Addictive Toxicity Factor Panel, Geriatric Precaution Panel, Pregnancy Alert Panel, Ingredient Duplication Panel, Low Dose Precaution Panel, Pediatric Precaution Panel, Pregnancy Diagnosis Panel, Maximum Duration Therapy Panel, Minimum Duration Therapy Panel, Underuse Precaution Panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
05/11/2016	3.0		Application of CO 12819	CO 12819: Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS
05/01/2018	4.0		Application of CO 14834	CO 14834: Redact all PHI/PII as well as non-public test data. Update screen layouts for: 5.2.1 Pop-Up Search 6.25.2 Recipient Profile Panel Layout 6.27.2 Suspended Claim Alert Panel

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 DUR INTRODUCTION

2.1 DUR USER MANUAL OVERVIEW

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the DUR functional area.

This manual covers the following:

- DUR Overview
- DUR Getting Started
- System Wide Common Terminology and Layouts
- DUR Panels
- DUR Reports

2.2 DUR USER MANUAL OBJECTIVE

The objective of the AMMIS DUR User Manual is to provide system users with detailed descriptions of the online system, including panel and report field descriptions, panel functionality descriptions and graphical representations of panels and report layouts.

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3 OVERVIEW

3.1 INTRODUCTION TO DUR

The AMMIS performs Prospective Drug Utilization Review (ProDUR) against drug claims, alerting the pharmacist of potentially inappropriate prescriptions. Criteria, supplied by both First DataBank (FDB) and the Alabama Medicaid Agency (Agency), are used in the real-time editing of the Point of Sale (POS) drug claims. The following alerts are supported by the AMMIS:

- Drug High/Low Dose
- Drug/Disease
- Drug/Pregnancy
- Drug/Age-Pediatric & Geriatric
- Drug/Drug
- Drug/Allergy
- Therapeutic Duplication
- Ingredient Duplication
- Duration of Therapy
- Underutilization (late refill)
- Overutilization (early refill)
- Allergy

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4 DUR GETTING STARTED

4.1 OVERVIEW

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 SYSTEM SECURITY

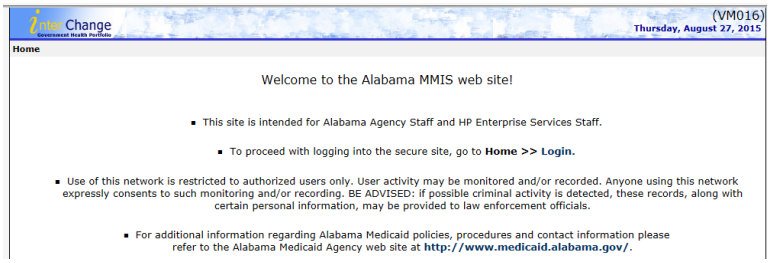
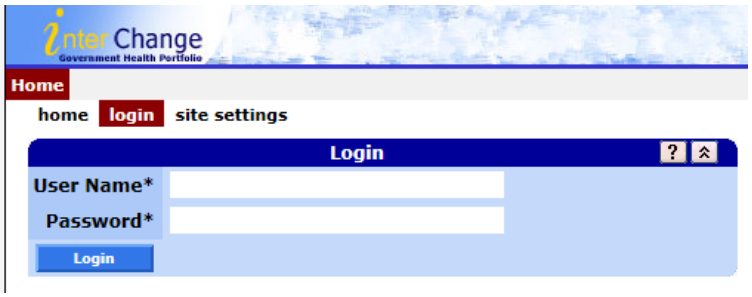
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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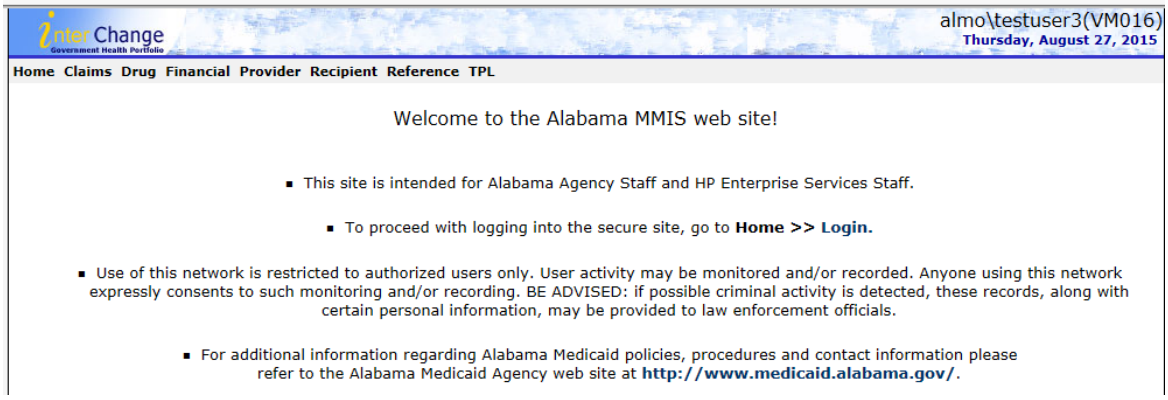
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 SCREEN DISPLAY FEATURES

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.4.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team recipients, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt +shortcut key)
- Main Menu bar
- Panel
- Mini Search panel
- Hot Link
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the Electronic Data System (EDS) copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

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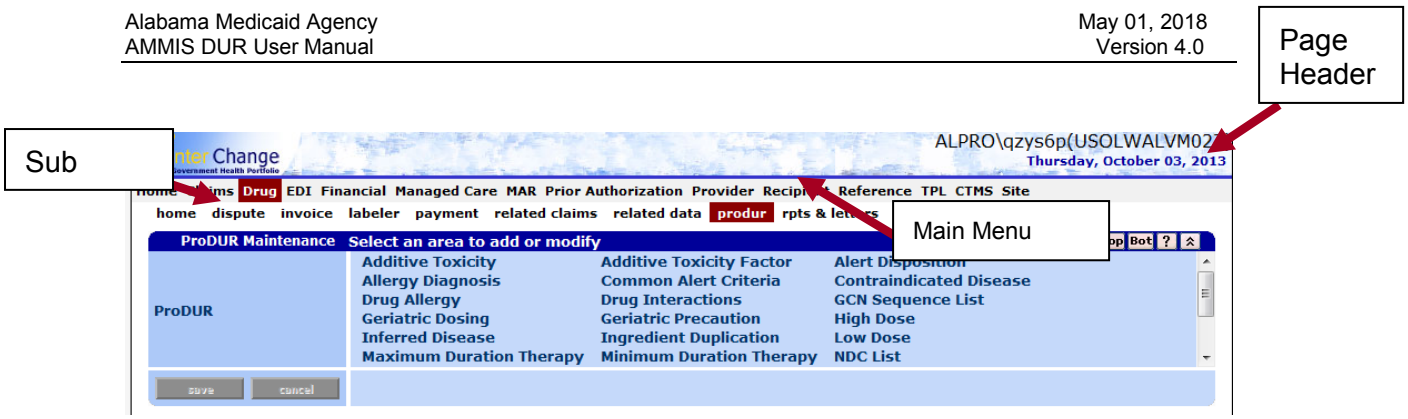
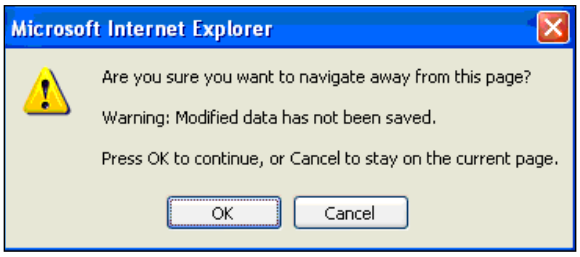


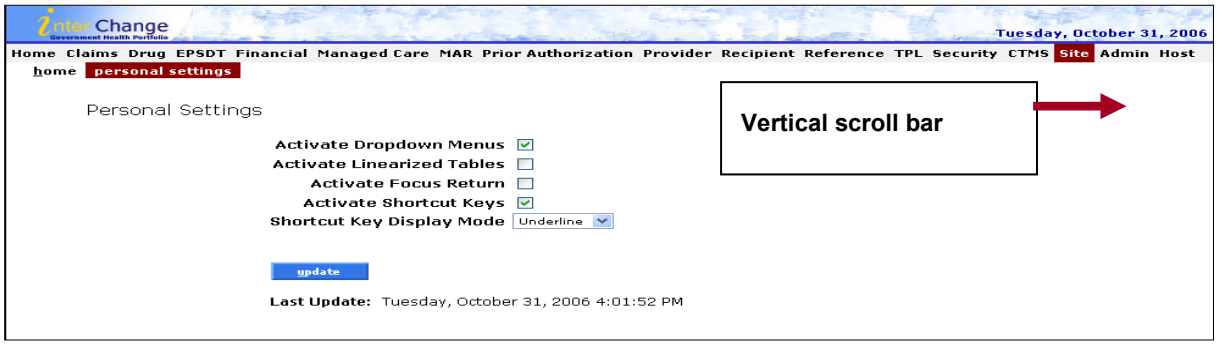
If a user attempts to add, update or delete information within a page the system prompts the user to “Save” or “Cancel” their changes via a pop-up window message prior to navigating away from the page. When the system generates the message, the detail panel is locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 SHORTCUT KEYS

If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated panel.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

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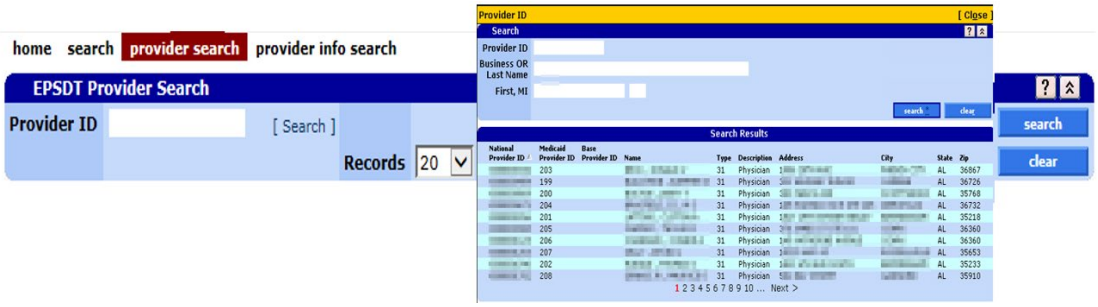
5.2.1 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the [Search] link, the user accesses the search panel that is associated with that particular field.



5.3 PANEL LAYOUT

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.3.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on panels within the EPSDT system:

Name	Icon	Description
Clear Button	clear	Clears all actions to all panels on the page. Can be found on the navigation panel.
Close Button	✕	Closes a panel.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
[Search]	[Search]	Opens a search panel associated to a particular field. Allows the user to search for unknown information, such as a Provider ID, using other information, such as the Provider Name.
Search	search	Searches for information based on criteria entered into field(s) on panel.

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5.3.2 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.3.3 Question Mark Icon

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.3.4 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

Reports - Drug Rebate Activity

The Report-Drug Rebate Activity panel allows a user to create an on-demand report specifying the Activity From Date and the Activity To Date.

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field Descriptions:

Field	Description	Field Type	Data Type	Length
clear	Clear dates entered for a search	Button	N/A	0
export	Export data into Excel spreadsheet	Button	N/A	0
search	Search for activity using the specified dates	Button	N/A	0
Invoice Type	The Invoice Type code which pertains to the Drug Rebate programs, such as Federal or Supplemental.	Combo Box	Drop Down List Box	0
Records	Select 5, 10, 20, 50 or 100 records to be displayed on the Activity By Labeler And Invoicing Period panel	Combo Box	Drop Down List Box	0
Activity From Date	The beginning date for the report of invoice activity.	Field	Date (MM/DD/CCYY)	10
Activity To Date	The ending date for the report of invoice activity	Field	Date (MM/DD/CCYY)	10
Beginning Balance	The balance of the line item as of the Activity From Date.	Field	Number	15
Brand Drug Payments	The sum of payments received for drugs considered to be Brand drugs	Field	Number	15
Ending Balance	The balance of the line item as of the Activity To Date.	Field	Number	15
Generic Drug Payments	The sum of payments received for drugs considered to be Generic drugs	Field	Number	15
Interest	Sum of all interest applied to the line item between the Activity From and Activity To Dates.	Field	Number	15
Invoicing Period	Displays quarter date for which the Posting Activity information is displayed.	Field	Character	5
Labeler Code	This code is used to uniquely identify the labeler of a drug. This code is assigned by CMS and is used as the first five characters of the labeler's NDCs.	Field	Character	5
Payments	Sum of all payments applied to the line item between the Activity From and Activity To Dates.	Field	Number	15
RPU and Unit Adjustments	Sum of all adjustments made to the line item between the Activity From and Activity To Dates.	Field	Number	15
Write Offs	Sum of all write-offs performed for the line item between the Activity From and Activity To Dates.	Field	Number	15

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field Edits:

Field	Field Type	Error Code	Error Message	To Correct
Activity From Date	Field	1	Activity From Date is needed for a search	Enter a valid Activity From Date
	Field	2	Activity From Date is Invalid.	Enter a valid Activity From Date
Activity To Date	Field	1	Activity To Date is needed for a search	Enter a valide Activity To Date
	Field	2	Activity To Date is Invalid.	Enter a valid Activity To Date

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The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as; Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

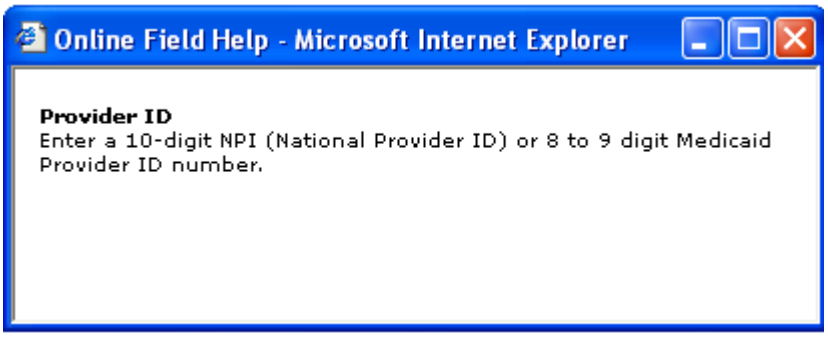
5.3.5 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.3.5.1 Field Level Help Description

When hovering the cursor over a field name, such as **Provider ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 DUR PANELS

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each panel covers the following:

- Panel Narrative
- Panel Layout
- Panel Field Descriptions
- Panel Field Edit Error Code Tables
- Panel Extra Features
- Panel Accessibility

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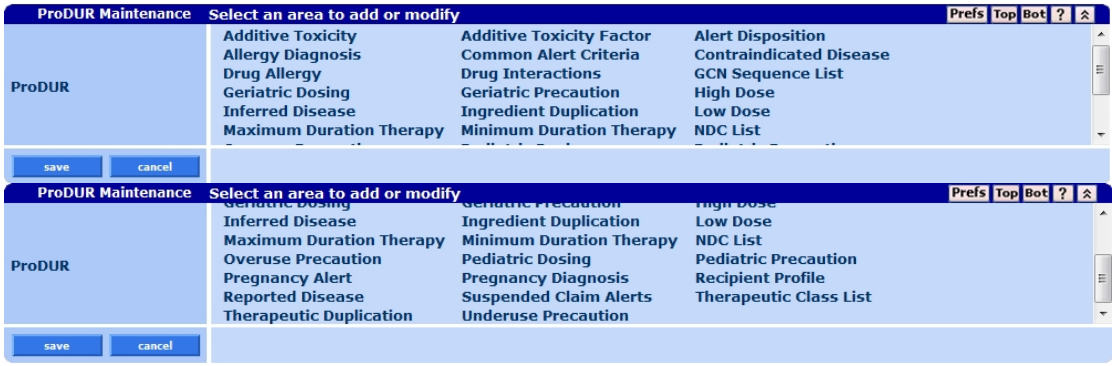
6.1 DRUG UTILIZATION PRODUR PAGE OVERVIEW

6.1.1 Drug ProDUR Page Narrative

The ProDUR Maintenance page displays all the panels used to support the Drug Utilization Review (DUR) subsystem.

Navigation Path: [Drug] – [ProDUR]

6.1.2 Drug ProDUR Page Layout



6.1.3 Drug ProDUR Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Additive Toxicity	Link to the Additive Toxicity panel.	Hyperlink	N/A	0
Additive Toxicity Factor	Link to the Additive Toxicity Factor panel.	Hyperlink	N/A	0
Alert Disposition	Link to the Alert Disposition panel.	Hyperlink	N/A	0
Allergy Diagnosis	Link to the Allergy Diagnosis panel.	Hyperlink	N/A	0
Cancel	This allows the user to cancel any changes on the ProDUR panel.	Button	N/A	0
Common Alert Criteria	Link to the Common Alert Criteria panel.	Hyperlink	N/A	0
Contraindicated Disease	Link to the Contraindicated Disease panel.	Hyperlink	N/A	0
Drug Allergy	Link to the Drug Allergy panel.	Hyperlink	N/A	0
Drug Interactions	Link to the Drug Interactions panel.	Hyperlink	N/A	0
GCN Sequence List	Link to the GCN Sequence List panel.	Hyperlink	N/A	0
Geriatric Dosing	Link to the Geriatric Dosing panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Geriatric Precaution	Link to the Geriatric Precaution panel.	Hyperlink	N/A	0
High Dose	Link to the High Dose panel.	Hyperlink	N/A	0
Inferred Disease	Link to the Inferred Disease panel.	Hyperlink	N/A	0
Ingredient Duplication	Link to the Ingredient Duplication panel.	Hyperlink	N/A	0
Low Dose	Link to the Low Dose panel.	Hyperlink	N/A	0
Maximum Duration Therapy	Link to the Maximum Duration Therapy panel.	Hyperlink	N/A	0
Minimum Duration Therapy	Link to the Minimum Duration Therapy panel.	Hyperlink	N/A	0
NDC List	Link to the NDC List panel.	Hyperlink	N/A	0
Overuse Precaution	Link to the Overuse Precaution panel.	Hyperlink	N/A	0
Pediatric Dosing	Link to the Pediatric Dosing panel.	Hyperlink	N/A	0
Pediatric Precaution	Link to the Pediatric Precaution panel.	Hyperlink	N/A	0
Pregnancy Alert	Link to the Pregnancy Alert panel.	Hyperlink	N/A	0
Pregnancy Diagnosis	Link to the Pregnancy Diagnosis panel.	Hyperlink	N/A	0
Recipient Profile	Link to the Recipient Profile panel.	Hyperlink	N/A	0
Reported Disease	Link to the Reported Disease panel.	Hyperlink	N/A	0
Save	This allows the user to save a record for ProDUR.	Button	N/A	0
Suspended Claims Alert	Link to the Suspended Claims Alert panel.	Hyperlink	N/A	0
Therapeutic Class List	Link to the Therapeutic Class List panel.	Hyperlink	N/A	0
Therapeutic Duplication	Link to the Therapeutic Duplication panel.	Hyperlink	N/A	0
Underuse Precaution	Link to the Underuse Precaution panel.	Hyperlink	N/A	0

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6.1.4 Drug ProDUR Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.1.5 Drug ProDUR Page Extra Features

Field	Field Type
No extra features found for this page.	

6.1.6 Drug ProDUR Page Accessibility

6.1.6.1 To Access the Drug ProDUR Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	Drug ProDUR Maintenance page displays.

6.1.6.2 To Navigate from the Drug ProDUR Maintenance Page

Step	Action	Response
1	Click selected hyperlink from the ProDUR Maintenance panel. Active panels are indicated by bold print, inactive panels are grayed out.	Selected panel displays.

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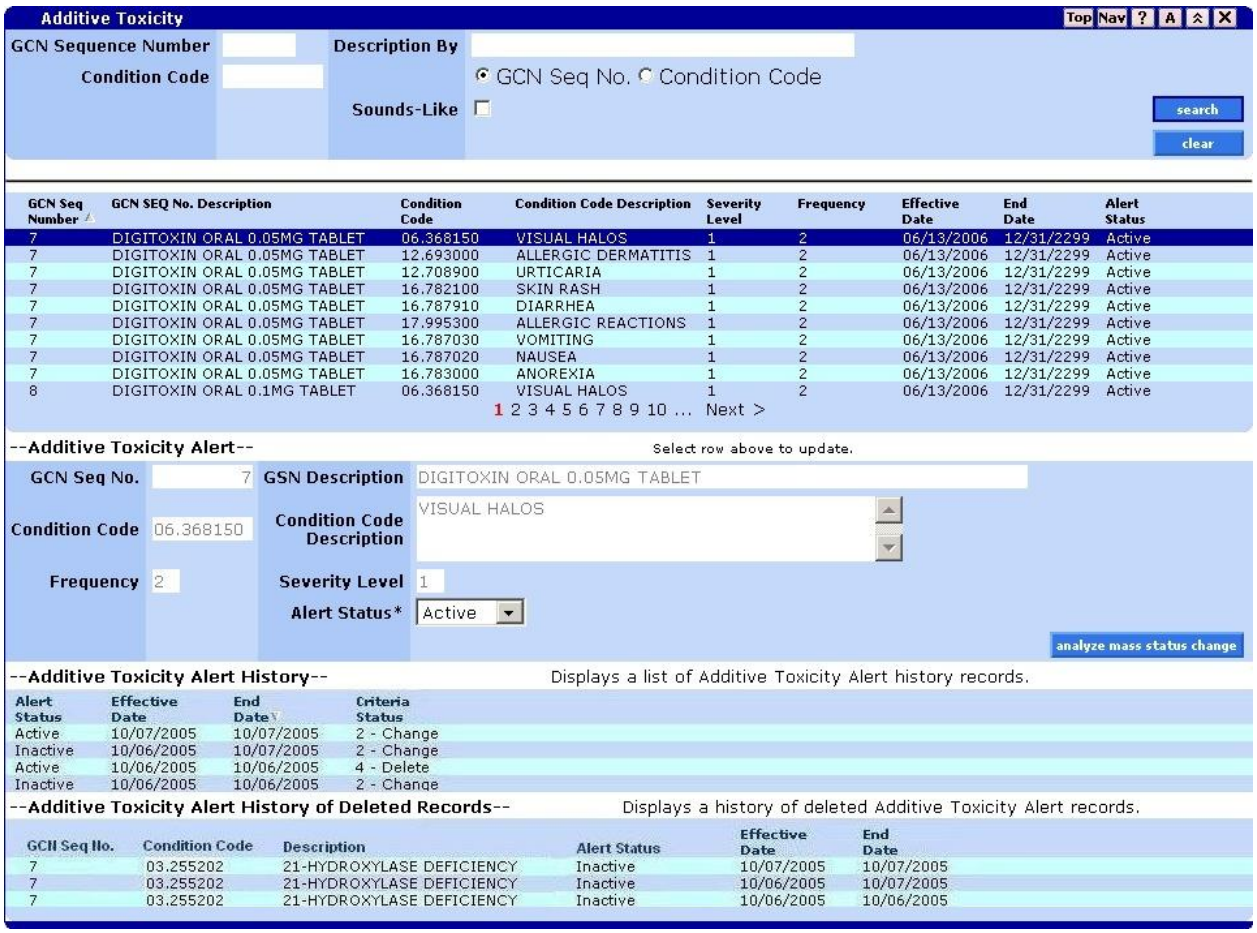
6.2 ADDITIVE TOXICITY PANEL OVERVIEW

6.2.1 Additive Toxicity Panel Narrative

This panel is used to maintain the drug criteria for the Additive Toxicity Alert.

Navigation Path: [Drug - ProDUR] - [Additive Toxicity]

6.2.2 Additive Toxicity Panel Layout



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6.2.3 Additive Toxicity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Analyze Mass Status Change	This button will update the status for all Condition Codes associated with the Additive Toxicity Side Effect. This will update independent of the GCN Sequence Number. The user will still have to save the changes, after this button is pushed.	Button	N/A	0
Alert Status	This field tells whether the Side Effect is active or inactive to set the AT Alert.	Field	Character	10
Clear	Allows the user to clear any changes on the Additive Toxicity panel.	Button	N/A	0
Search	Initiates search by GCN Sequence, Description by, or Condition Code.	Button	N/A	0
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description by field.	Field	Check Box	0

6.2.4 Additive Toxicity Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
GCN Seq No.	Field	9999	GCN Seq. No., Description By, or Condition Code is required to perform search	Return to field and enter data in at least one of these Search fields.
Description By	Field	9999	GCN Seq. No, Description By, or Condition Code is required to perform search	Return to field and enter data in at least one of these Search fields.
Condition Code	Field	9999	GCN Seq. No., Description By, or Condition Code is required to perform search.	Return to field and enter data in at least one of these Search fields.

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6.2.5 Additive Toxicity Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.2.6 Additive Toxicity Panel Accessibility

6.2.6.1 To Access the Additive Toxicity Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Additive Toxicity**.	Additive Toxicity panel displays.

6.2.6.2 To Update the Additive Toxicity Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description by**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Additive Toxicity search results are displayed.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status**.	
5	Click **Save**.	Additive Toxicity information is saved.

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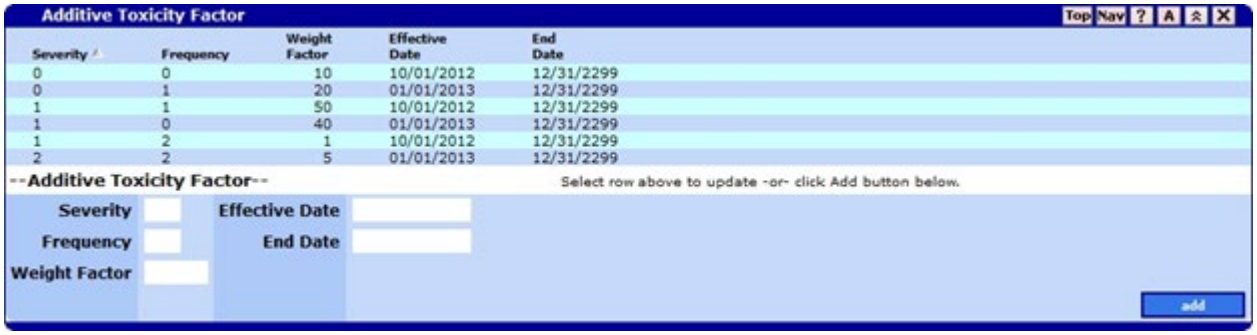
6.3 ADDITIVE TOXICITY FACTOR PANEL OVERVIEW

6.3.1 Additive Toxicity Factor Panel Narrative

This panel will maintain the T_Additive_Toxicity_Factor table. This table maintains all of the data to set the weighting factors for the additive toxicity alert.

Navigation Path: [Drug - ProDUR] - [Additive Toxicity Factor]

6.3.2 Additive Toxicity Factor Panel Layout



6.3.3 Additive Toxicity Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a new Additive Toxicity Factor record.	Button	N/A	0
Effective Date	The effective date that this factor is to be used.	Field	Date (MM/DD/CCYY)	8
End Date	The last date that this factor is valid.	Field	Date (MM/DD/CCYY)	8
Frequency	The frequency of the side effect.	Field	Character	1
Severity	This is the severity of the side effect.	Field	Character	1
Weight Factor	The weight factor applied for each Side effect.	Field	Number (Integer)	3

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6.3.4 Additive Toxicity Factor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective date must be less than or equal to End Date.	Enter an effective date that is less than or equal to the end date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date in mm/dd/yyyy format.
	Field	3	Effective Date is required.	Enter an Effective Date.
	Field	4	Effective date must be greater than or equal to 1/1/1900.	Enter an Effective Date that is greater than or equal to 1/1/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date in mm/dd/yyyy format.
	Field	3	End Date must be greater than or equal to 1/1/1900.	Enter an End date that is greater than or equal to 1/1/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Frequency	Field	1	Frequency Code is required.	Enter a valid Frequency Code.
Severity	Field		Severity Level Code is required.	Enter a valid Severity Level Code.
Weight Factor	Field	1	Enter a valid value.	Enter a numeric Weight Factor.
	Field	2	Weight Factor must be greater than or equal to 1.	Enter a value greater than zero.
	Field	3	Weight Factor must be less than or equal to 100.	Enter a value less than or equal to 100.

6.3.5 Additive Toxicity Factor Panel Extra Features

Field	Field Type
No extra features on this panel.	

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6.3.6 Additive Toxicity Factor Panel Accessibility

6.3.6.1 To Access the Additive Toxicity Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Additive Toxicity Factor**.	Additive Toxicity Factor panel displays.

6.3.6.2 To Add record to the Additive Toxicity Factor Panel

Step	Action	Response
1	Click the **Add** button.	A new record is displayed.
2	Enter the sufficient data in each of the required/desired fields.	
5	Click **Save**.	Additive Toxicity Factor information is saved.

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6.4 ALERT DISPOSITION PANEL OVERVIEW

6.4.1 Alert Disposition Panel Narrative

The Alert Disposition panel is used to view and update alert priority and disposition. The priority shows the order of how alerts are sent to the pharmacist.

In addition to being used to view alert information, this panel is also used to add (activate) DUR alerts, and set the order in which they are returned to the provider. This panel is also used to set the disposition of an alert (what you want it to do). The values are:

O – Provider override

I – Informational (not currently used by Alabama)

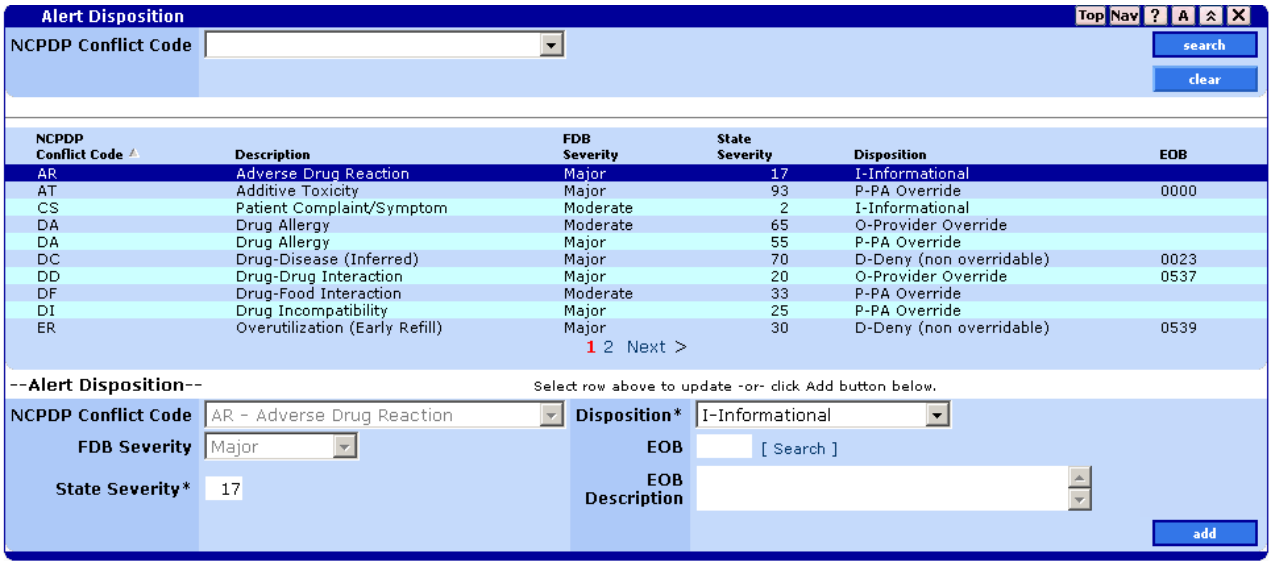
P – PA Override

D – Deny

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR] - [Alert Disposition]

6.4.2 Alert Disposition Panel Layout



6.4.3 Alert Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Alert Disposition.	Button	N/A	0
Clear	Clears user input from search fields.	Button	N/A	0
Disposition	Indicates if a claim that sets the referenced alert is to pay, deny or can be overridden. Valid values are: I – Informational, D – Deny, O – Provider Override, and P - PA Override.	Field	Drop Down List Box	1
EOB	Explanation of Benefit Code.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
EOB Description	Explanation of Benefits description.	Field	Character	80
FDB Severity	Severity level assigned by First DataBank.	Field	Drop Down List Box	1
NCPDP Conflict Code	NCPDP Conflict Code that is sent to providers indicating the alert that was set.	Field	Drop Down List Box	1
Search	Activates the search feature.	Button	N/A	0
State Severity	Severity of the alert level assigned by the State.	Field	Number (Integer)	2

6.4.4 Alert Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Disposition	Field	4	Disposition is required.	Select a disposition.
EOB	Field	1	EOB is required if Disposition = D.	Enter a valid EOB if Disposition Code = D (deny).
NCPDP Conflict Code	Field	9	A duplicate record cannot be saved.	Enter a unique record.
	Field	91006	Field required.	A valid NCPDP Conflict Code is required.
State Severity	Field	7	State Severity must be greater than or equal to 1.	Enter a unique value from 1 - 99.

6.4.5 Alert Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Alert Disposition Panel Accessibility

6.4.6.1.1 To Access the Alert Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Alert Disposition**.	Alert Disposition panel displays.

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6.4.6.1.2 To Add to the Alert Disposition Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Select **NCPDP Conflict Code** from drop down list box.	
3	Select **FDB Severity** from drop down list box.	
4	Enter **State Severity**.	
5	Select **Disposition** from drop down list box.	
6	If applicable, Enter the **EOB** code, or use the [Search] feature, and select from the list.	
7	Enter **EOB description**, if applicable.	
8	Click **Save**.	Alert Disposition information is saved.

6.4.6.1.3 To Update the Alert Disposition Panel

Step	Action	Response
1	Select row to be updated.	
2	Make the desired update.	
3	Click **Save**.	Alert Disposition information is saved.

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6.5 ALLERGY DIAGNOSIS PANEL OVERVIEW

6.5.1 Allergy Diagnosis Panel Narrative

The Allergy Diagnosis panel is used to maintain the Cross Reference Relationship between Allergy and Diagnosis Code. The user is able to search and select current Allergy-to-Diagnosis data.

The Allergy Diagnosis panel has an extra panel associated with it, which include:

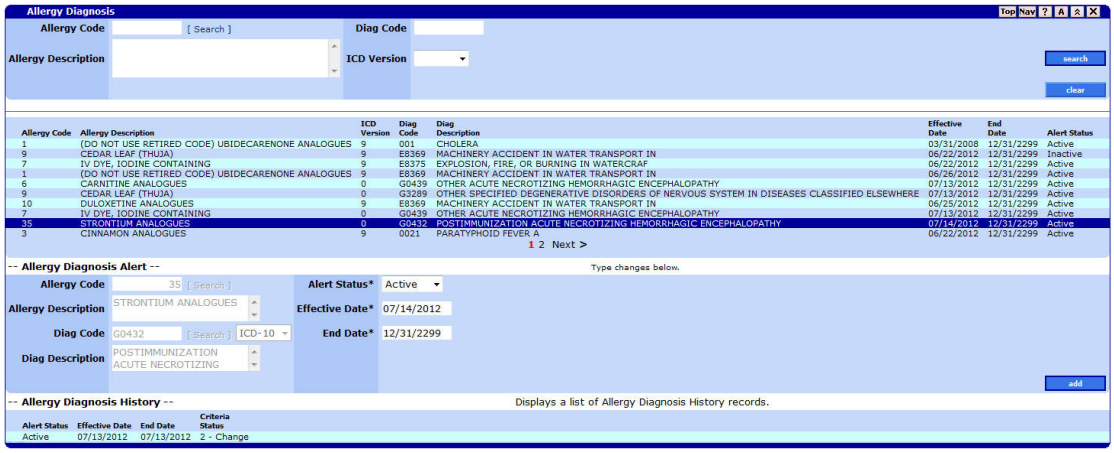
- Allergy Diagnosis History Panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected Alert Status.

The layout below indicates a person with diagnosis code 00320 (Local Salmonella Inf) could be allergic to Gymnema (Allergy code 111).

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR] - [Allergy Diagnosis]

6.5.2 Allergy Diagnosis Panel Layout



6.5.3 Allergy Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Allergy Diagnosis Alert.	Button	N/A	0
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Allergy Code	Allergy code supplied by First DataBank (FDB).	Field	Character	6
Allergy Description	Description of the allergy code supplied by FDB.	Field	Character	50
Clear	Clears user input from search fields.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Criteria Status	This field shows the action that was taken on this Drug Allergy to generate the record on the history panel.	Listview	Character	1
Diag Code	Diagnosis Code supplied by FDB that is being Cross Referenced to an Allergy Code.	Field	Character	10
Diag Description	The first 50 characters of the Long description of the Diagnosis Code.	Field	Character	50
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	Date the criteria are no longer in effect.	Field	Date (MM/DD/CCYY)	8
ICD Version	ICD Version of the Diagnosis code. Valid Values are Blank, ICD-9 & ICD-10.	Field	Drop Down List Box	0
Search	Activates the search feature.	Button	N/A	0

6.5.4 Allergy Diagnosis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Alert Status	Field	1000	Alert Status is Required.	Select Alert Status.
Allergy Code	Field	91204	A valid Specific Allergy Group Code (AGCSP) is required.	Enter a valid Allergy Code.
	Field	91204	No Match Found.	Try different search criteria.
Allergy Description	Field	91204	No Match Found.	Allergy Description could not be found. Try different search criteria.
Diag Code	Field	91204	A valid Diagnosis is required.	Enter a valid Diagnosis Code.
	Field	91204	No Match Found.	Diagnosis Code could not be found. Try different search criteria.
Effective Date	Field	1000	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	91204	Effective Date is required.	Enter a valid Effective Date.
End Date	Field	91204	End Date is required.	Enter a Valid End Date.

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6.5.5 Allergy Diagnosis Panel Extra Features

The Allergy Diagnosis panel is used to maintain the relationship between drug Hierarchical Ingredient Codes (HICs), Allergy (Specific Allergen Group Code – AGCSP) and Cross-Sensitive Allergen Group Code - AGCCS. The user can view and update all cross references between drug and allergy, as well as update the data using this panel. A history and a deleted history panel are also associated with this.

6.5.6 Allergy Diagnosis Panel Accessibility

1.1.1.1 To Access the Allergy Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Allergy Diagnosis**.	Allergy Disposition panel displays.

1.1.1.2 To Add to the Allergy Diagnosis Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter the **Allergy Code** and **Diag code** or use the [Search] feature and select from the available lists. Select **Alert Status** from the Drop Down List Box and enter valid values in the **Effective Date** and **End Date** fields.	
3	Click **Save**.	Allergy Diagnosis information is saved.

1.1.1.3 To Update the Allergy Diagnosis Panel

Step	Action	Response
1	Enter valid values in the **Allergy Code**, **Diag Code** or **Allergy Description** field, if using the Allergy code, enter the code or use the [search] feature, and select from the list.	
2	Enter search criteria and click **Search**, or click **Search**.	The Allergy Diagnosis search results panel displays. If no Search criteria are entered, all information for Allergy Diagnosis codes currently on file display in numerical order.
3	Select the row to be updated.	
4	Make the desired update.	
5	Click **Save**.	Allergy Disposition information is saved.

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6.6 COMMON ALERT CRITERIA PANEL OVERVIEW

6.6.1 Common Alert Criteria Panel Narrative

The ProDUR Common Alert Criteria panel is used to maintain alert criteria, such as comparison days and day's supply, for recipient prescriptions used by the Prospective Drug Utilization Review (ProDUR) System. This panel serves many functions, such as how many days back into history the system searches for claims to set ProDUR alerts and the percentage of time allowed before certain alerts set.

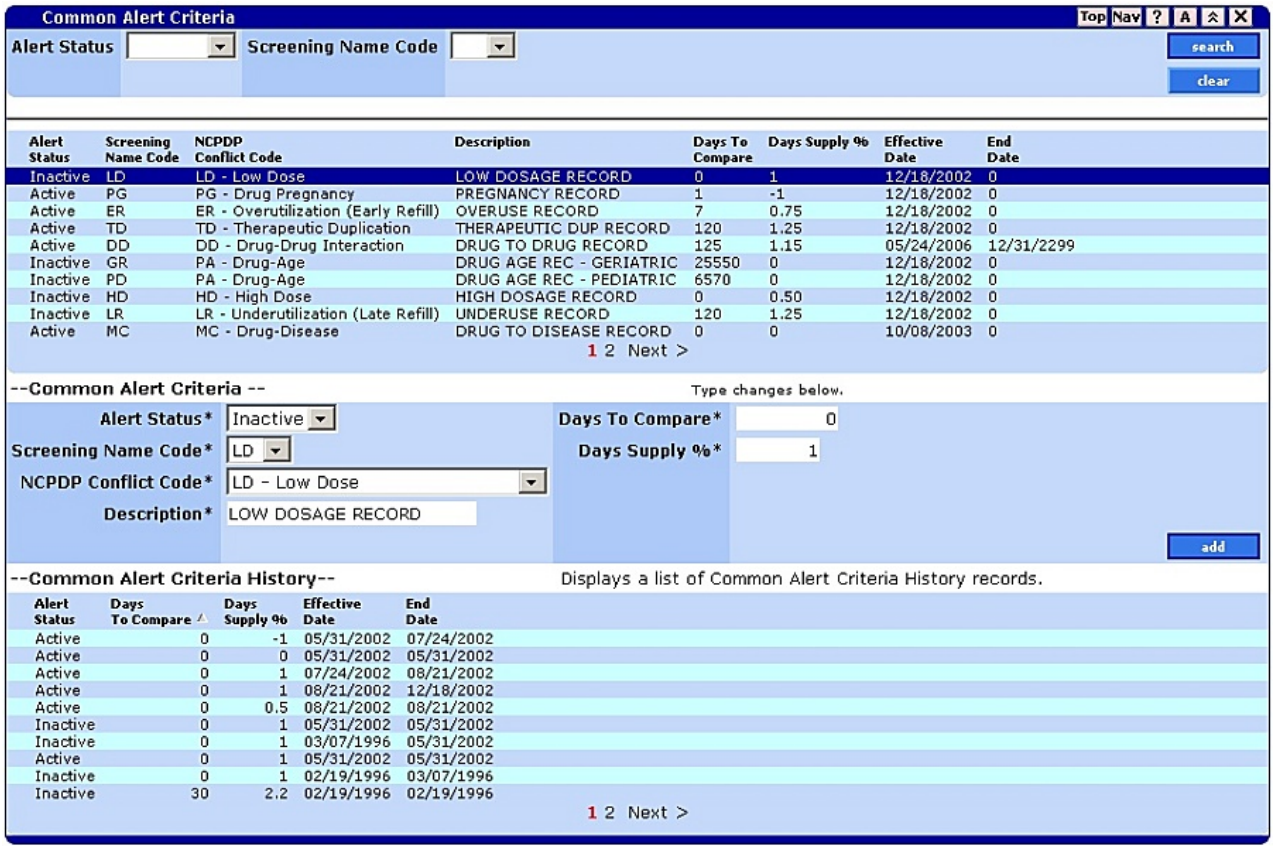
The Common Alert Criteria panel has an extra panel associated with it as noted below:

- Common Alert Criteria History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected Alert Status.

Only users with update capabilities have the authority to perform maintenance tasks.

Navigation Path: [Drug] - [ProDUR] - [Common Alert Criteria]

6.6.2 Common Alert Criteria Panel Layout



6.6.3 Common Alert Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Common Alert Criteria.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Butto n	N/A	0
Days Supply %	Percentage to be applied to the day's supply on history claims to determine if the screen should set.	Field	Number (Decimal)	4
Days to Compare	Number of days in history to search for claims to perform the screen against.	Field	Number (Integer)	9
Description	Description of NCPDP Conflict code that is sent to providers indicating the alert that was set.	Field	Character	25
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
NCPDP Conflict Code	This field contains the NCPDP Conflict Code that is sent to providers indicating the alert that was set.	Field	Drop Down List Box	1
Screening Name Code	The screening name code is the internal code for the ProDUR screening.	Field	Drop Down List Box	1
Search	Activates the search feature.	Butto n	N/A	0

6.6.3.1 Common Alert Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Alert Status	Field	91037	Field is required.	Enter a type.
Days Supply %	Field	1	Days Supply % must be zero for NCPDP Conflict Code of PG.	Set days supply % to zero.
	Field	2	Days Supply % must be zero for NCPDP Conflict Code of PA.	Set days supply % to zero.
	Field	91007	Data must be numeric.	Re-enter a numeric percentage.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	91076	Days Supply % must be less than or equal to 9.999.	Re-enter a decimal numeric entry.
	Field	91128	Must be zero.	Percentage must be zero for this particular NCPDP code.
	Field	91136	Days To Supply % must be greater than or equal to zero.	Re-enter a percentage greater than zero.
Days to Compare	Field	91007	Data must be numeric.	Re-enter a numeric entry.
	Field	91136	Days To Compare must be greater than or equal to zero.	Re-enter an amount greater than zero.
Description	Field	91037	Field is required.	Enter a description.
NCPDP Conflict Code	Field	91037	Field is required.	Enter a code.
Screening Name Code	Field	8227	Duplicate Screening Name found. Not Allowed.	Verify active type and screening name code before re-entering.
	Field	91037	Field is required.	Enter a code.

6.6.3.2 Common Alert Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.3.2.1 Common Alert Criteria Panel Accessibility

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Common Alert Criteria**.	Common Alert Criteria panel displays.

6.6.3.2.2 To Navigate the Common Alert Criteria Panel

Step	Action	Response
1	Select **Alert Status** and/or **Screening Name Code** from the Drop Down List boxes.	

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Step	Action	Response
2	Enter search criteria and click **Search**, or Click **Search.**	The search results panel for the selected Alert Status and Screening Code name and status displays. If no alert status or screening code name is entered, all screening codes currently on file display.

6.6.3.2.3 To Add on the Common Alert Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Alert Status** from drop down list box.	
3	Select **Screening Name Code** from drop down list box.	
4	Select **NCPDP Conflict Code** from drop down list box.	
5	Enter **Description**.	
6	Enter **Days to Compare**, if applicable.	
7	Enter **Days Supply**, if applicable.	
8	Click **Save**.	Common Alert Criteria information is saved.

6.6.3.3 To Update the Common Alert Criteria Panel

Step	Action	Response
1	Choose the code to be updated using the **Screening Code Name** drop-down box. To display only active alerts, select Active from the Alert Status drop-down list box, leave the Screening Code Name field blank. To display only inactive alerts, select Inactive from the Alert Status drop-down box, leave the Screening Code Name field blank.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for the selected Screening Code name and status displays. If no alert status or screening code name is entered, all screening codes currently on file display.
3	Select the row to be updated.	
4	Make the desired update.	
5	Click **Save**.	Common Alert Criteria information is saved.

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6.7 CONTRAINDICATED DISEASE PANEL OVERVIEW

6.7.1 Contraindicated Disease Panel Narrative

The Contraindicated Disease panel allows searches and updates of GCN Sequence Number/Contraindicated Disease Code cross-references. Also, it shows the Contraindication of a Drug to a Disease – the panel shows a list of drugs a person should not take if his/her profile indicates a condition for a disease associated with the drug.

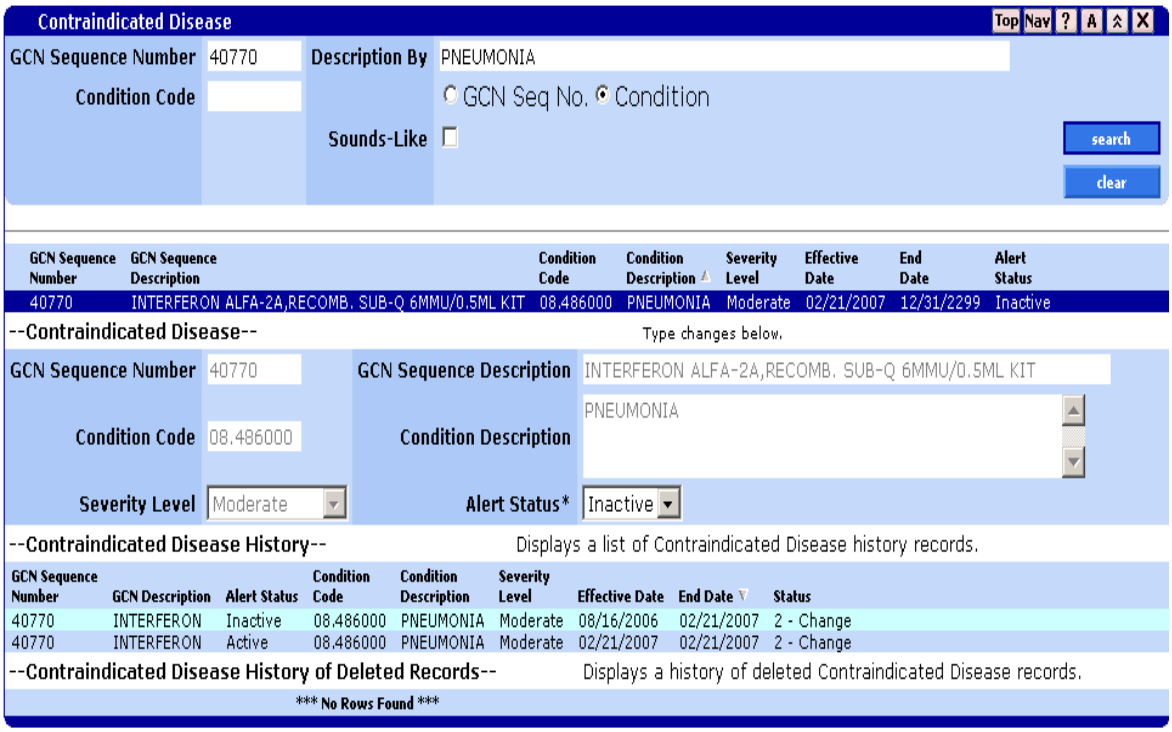
This panel has two extra panels associated with it, which include:

- Contraindicated Disease History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- Contraindicated Disease History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table. The records are generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [ProDUR] - [Contraindicated Disease]

6.7.2 Contraindicated Disease Panel Layout



Note: Contraindicated Disease History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.7.3 Contraindicated Disease Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Condition Code	The First DataBank disease code (FDBDX in FDB manual) that identifies specific diseases.	Field	Number (Integer)	9
Condition Description	The text description of the condition code.	Field	Character	56
Description By	This field allows the user to search by Generic Code Number sequence number description or by Condition code description.	Field	Character	63
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (M M/DD/CCYY)	8
GCN Sequence Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	56
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Search	Activates the search feature.	Button	N/A	0
Severity Level	The severity of the alert. Valid values include: Major, Minor and Moderate.	Field	Drop Down List Box	1
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Field	Check Box	0

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Field	Description	Field Type	Data Type	Length
Status	Shows the action taken on the referenced GCN Sequence Number/Condition Code combination that generated the record on the history panel. Valid Values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.7.4 Contraindicated Disease Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window				

6.7.5 Contraindicated Disease Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Contraindicated Disease Panel Accessibility

6.7.6.1.1 To Access the Contraindicated Disease Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Contraindicated Disease**.	Contraindicated Disease panel displays.

6.7.6.1.2 To Update the Contraindicated Disease Panel

Step	Action	Response
1	Enter valid values in the **GCN Sequence Number**, **Condition Code** or **Description By** field. If searching by Description, select the appropriate radio button and select **Sounds Like** to further expand the search condition	
2	Enter search criteria and click **Search**.	The Contraindicated Disease search results panel displays.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status**.	
5	Click **Save**.	Contraindicated Disease information is saved.

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6.8 DRUG ALLERGY PANEL OVERVIEW

6.8.1 Drug Allergy Panel Narrative

The Drug Allergy panel is used to maintain the relationship between drug (HICs) and Allergy (AGCSP – Specific Allergy Group Code and AGCCS – Cross Sensitivity Allergy Group Code). The user can view and update all cross references between drug and allergy and can update this data through this panel.

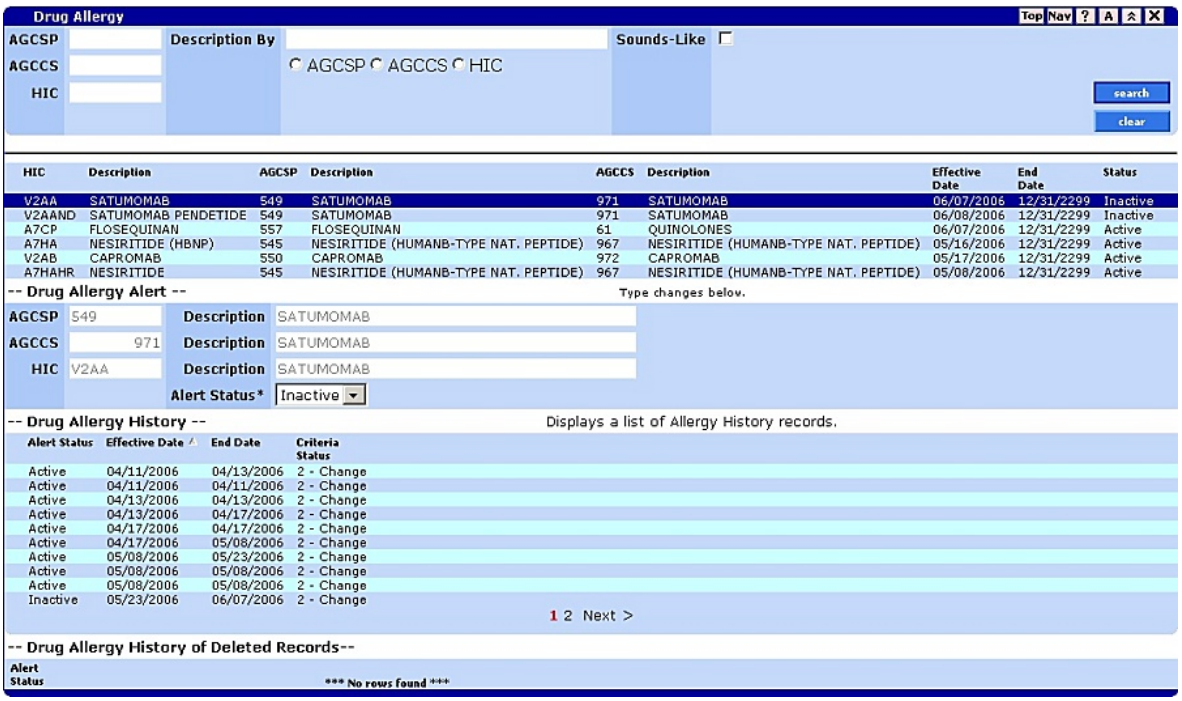
This panel has two extra panels associated with it, which include:

- Drug Allergy History panel -This panel shows the history of all changes to records on the Drug Allergy table. The user sees changes to only the selected drug and allergy cross reference.
- Drug Allergy History of Deleted Records panel - This panel shows the history of the selected drug and allergy cross references deleted from the Drug Allergy table. The records are generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR] - [Drug Allergy]

6.8.2 Drug Allergy Panel Layout



Note: Drug Allergy History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

6.8.3 Drug Allergy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AGCCS	First DataBank assigned code for Cross Sensitive Allergy.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
(AGCCS) Description	This description of the AGCCS Code.	Field	Character	50
AGCSP	First DataBank assigned code for Specific Allergy.	Field	Character	6
(AGCSP) Description	The description of the AGCSP Code.	Field	Character	50
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Criteria Status	This field shows the action that was taken on the Drug Allergy to generate the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Listview	Character	1
Description By	Used in conjunction with the corresponding radio button to allow the user to search using either the AGCCS Description, the AGCSP Description or the HIC description.	Field	Character	50
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
HIC	A number used to identify a drug or a drug class.	Field	Character	6
HIC Description	The description of the HIC Code.	Field	Character	50
Radio Button (AGCSP, AGCCS, HIC)	Three options to allow the user the flexibility to search on different descriptions. (AGCSP, AGCCS, HIC).	Button	Radio Button	0
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user	Check Box	Check Box	0

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Field	Description	Field Type	Data Type	Length
	selects this check box, the query searches for partial matches of data entered into the Description Field.			
Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Character	1

6.8.4 Drug Allergy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.8.5 Drug Allergy Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Drug Allergy Panel Accessibility

6.8.6.1 To Access the Drug Allergy Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Drug Allergy**.	Drug Allergy panel displays.

6.8.6.2 To Update the Drug Allergy Panel

Step	Action	Response
1	Enter valid data in the **AGCSP**, **AGCCS**, **HIC** or **Description** field. If searching with Description, select the appropriate radio button and select **Sounds Like** to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for Drug Allergy information entered displays. If no Search criteria are entered, information for all Drug Allergy codes currently on file display in numerical order.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status** field.	
5	Click **Save**.	Drug Allergy information is saved.

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6.9 DRUG INTERACTIONS PANEL OVERVIEW

6.9.1 Drug Interactions Panel Narrative

The Drug Interactions panel is used to view and maintain Drug - Drug interaction screening criteria. Each combination of drugs known to negatively interact with each other is assigned an Adverse Drug Interaction (ADI) code from First DataBank. Information displayed is the ADI code, ADI code description, severity level, and the ADI code status.

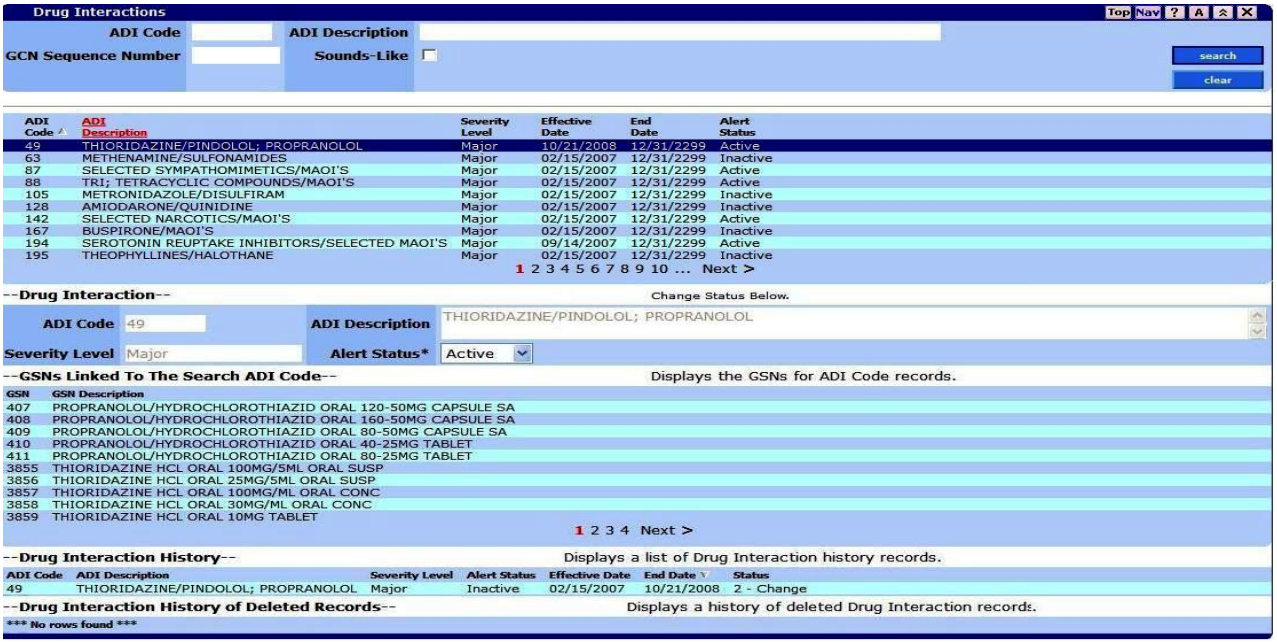
This panel has two extra panels associated with it, which include:

- Drug Interaction History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected ADI Code.
- Drug Interaction History of Deleted Records panel - This panel shows the history of all ADI codes from this table. The records are generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]-[Drug Interactions]

6.9.2 Drug Interactions Panel Layout



Note: Drug Interaction History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.9.3 Drug Interactions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ADI Code	Adverse Drug Interaction used to represent a combination of drugs which negatively interact with each other.	Field	Character	5
ADI Description	Name of the generic descriptions which together make up the interaction.	Field	Character	200
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Search	Activates the search feature.	Button	N/A	0
Severity Level	Severity level assigned to a specific interaction. The severity assigned by First DataBank is major, minor, or moderate.	Field	Drop Down List Box	1
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Check Box	Check Box	0
Status	Shows the action taken on the referenced ADI Code that generated the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.9.4 Drug Interactions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ADI Number	Field	91024	No Match Found.	Return to field and enter correct data.
	Field	91056	Please enter at least one search field.	Return to field and enter correct data.

6.9.5 Drug Interactions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.9.6 Drug Interactions Panel Accessibility

6.9.6.1.1 To Access the Drug Interactions Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Drug Interactions**.	Drug Interactions panel displays.

6.9.6.1.2 To Navigate the Drug Interactions Panel

Step	Action	Response
1	Enter the **ADI** code or **ADI Description**.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for Drug Interactions displays. If no search criterion is entered, all ADI codes currently on file display in numerical order.

6.9.6.1.3 To Update the Drug Interactions Panel

Step	Action	Response
1	Enter the code to be updated in the **ADI Code** field, or, enter valid values in either the **ADI Code** or **ADI Description field**. If searching with ADI Description, select **Sounds Like** to further expand the search condition.	
2	Click **Search**.	The Drug Interactions search results panel displays.
3	Select the row to be updated.	

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6.10 GCN SEQUENCE LIST PANEL OVERVIEW

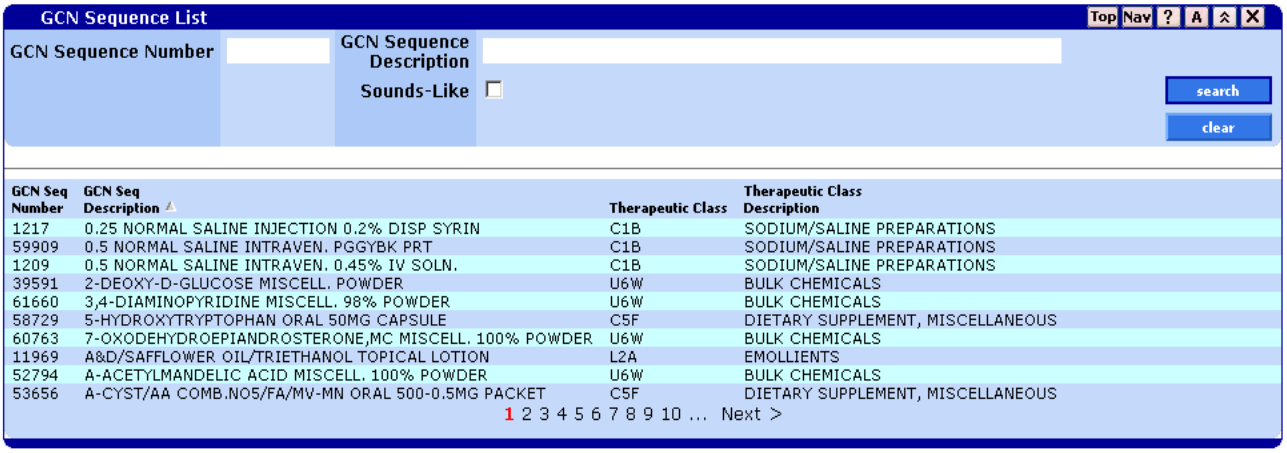
6.10.1 GCN Sequence List Panel Narrative

The GCN Sequence Number List panel displays all Generic Code Number Sequence Numbers and the Therapeutic Class Code, Specific (TC) to which they belong. The descriptions of both the GCN Sequence Numbers and TC are also provided.

This panel is inquiry only.

Navigation Path: [Drug] – [ProDUR] - [GCN Sequence List]

6.10.2 GCN Sequence List Panel Layout



6.10.3 GCN Sequence List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears user input from search fields.	Button	N/A	0
GCN Sequence Description	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	63
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Search	Activates the search feature.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Check Box	Check Box	0
Therapeutic Class	Therapeutic Class Code, Specific (GC3, Alias HIC3). The most specific therapeutic class code offered by First DataBank.	Field	Character	3
Therapeutic Class Description	Therapeutic Class Code, Specific description.	Field	Character	50

6.10.4 GCN Sequence List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
GCN Sequence Description	Field	1	Please enter at least one search field.	Enter at least 1 search criteria.
GCN Sequence Number	Field	1	Please enter at least one search field.	Enter at least 1 search criteria.

6.10.5 GCN Sequence List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 GCN Sequence List Panel Accessibility

6.10.6.1.1 To Access the GCN Sequence List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **GCN Sequence List**.	GCN Sequence List panel displays.

6.10.6.1.2 To Navigate the GCN Sequence List Panel

Step	Action	Response
1	Enter valid values in either the **GCN Sequence Number** or Description field. If searching with Description, select Sounds Like to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for the GCN Sequence number displays. If no search criterion is entered, all GCN Sequence codes currently on file display in numerical order.

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6.11 GERIATRIC DOSING PANEL OVERVIEW

6.11.1 Geriatric Dosing Panel Narrative

The Geriatric Dosing Panel is used to view and maintain dosing criteria for recipients in the Geriatric age range.

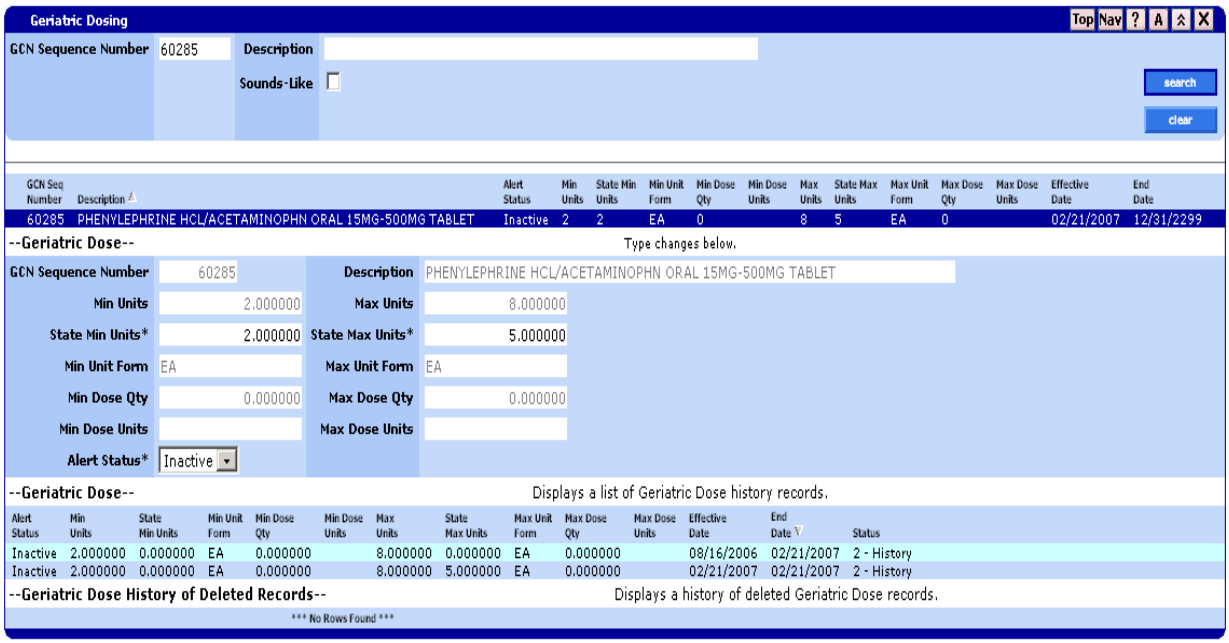
This panel has two additional panels associated with it, which include:

- Geriatric Dose History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- Geriatric Dose History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table by the User Interface. Information on this panel is generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR] - [Geriatric Dosing]

6.11.2 Geriatric Dosing Panel Layout



Note: Geriatric Dose History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.11.3 Geriatric Dosing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Description	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	50
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Max Dose Qty	The maximum geriatric daily dose. Format = 999999.999999.	Field	Number (Decimal)	12
Max Dose Units	This field represents the unit of measure of the maximum daily dose.	Field	Character	3
Max Unit Form	The form of the maximum unit quantity which should be taken each day.	Field	Character	2
Max Units	This field provides the quantitative value for the maximum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).	Field	Number (Decimal)	12
Min Dose Qty	This field provides the quantitative value for the minimum adult daily dosage	Field	Number (Decimal)	12

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Field	Description	Field Type	Data Type	Length
	usually expressed in metric strength units (i.e., mg, mcg, gm). Format = 999999.999999			
Min Dose Units	This field represents the unit of measure of the minimum daily dose.	Field	Character	3
Min Unit Form	The form of the minimum unit quantity which should be taken each day.	Field	Character	2
Min Units	This field provides the quantitative value for the minimum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.). Format = 999999.999999	Field	Number (Decimal)	12
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Check Box	N/A	0
State Max Units	The state defined field that represents the unit of measure of the maximum daily dose. Format = 999999.999999	Field	Number (Decimal)	12
State Min Units	The state defined field that represents the unit of measure of the minimum daily dose. Format = 999999.999999	Field	Number (Decimal)	12
Status	Shows the action taken on the referenced GCN Sequence Number that generated the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.11.4 Geriatric Dosing Panel Field Edit Error Codes

Field	Field Type	Error Message	To Correct
State Max Units	Field	State Max Unit must be greater than or equal to zero.	Re-enter an amount greater than or equal to zero.
	Field	State Max Unit must be less than or equal to 999999.999999.	Re-enter an amount smaller than or equal to 999999.999999.

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Field	Field Type	Error Message	To Correct
	Field	State Max Unit is required.	Enter a value.
	Field	Enter a valid value.	Re-enter a numeric value.
State Min Units	Field	State Min Unit quantity must be less than the state maximum unit quantity.	Re-enter an amount smaller than State Max Unit Quantity.
	Field	State Min Unit must be greater than or equal to zero.	Re-enter an amount greater than or equal to zero.
	Field	State Min Unit must be less than or equal to 999999.999999.	Re-enter an amount smaller than or equal to 999999.999999.
	Field	State Min Unit is required.	Enter a value.
	Field	Enter a valid value.	Re-enter a numeric value.

6.11.5 Geriatric Dosing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Geriatric Dosing Panel Accessibility

6.11.7 To Access the Geriatric Dosing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Geriatric Dosing**.	Geriatric Dosing panel displays.

6.11.8 To Update the Geriatric Dosing Panel

Step	Action	Response
1	Enter a valid value in the **GCN Sequence Number** or Description field. If searching with Description, select **Sounds Like** to further expand the search condition.	
2	Click **Search**.	The Geriatric Dosing search results panel displays. If no search criterion is entered, information for all GSNs currently on file with Geriatric Dosing information is displayed in numerical order.
3	Select the row to be updated.	

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Step	Action	Response
4	Make the desired update to the **Alert Status**, **State Maximum Units** and/or **State Minimum Units** fields.	
5	Click **Save**.	Geriatric Dosing information is saved.

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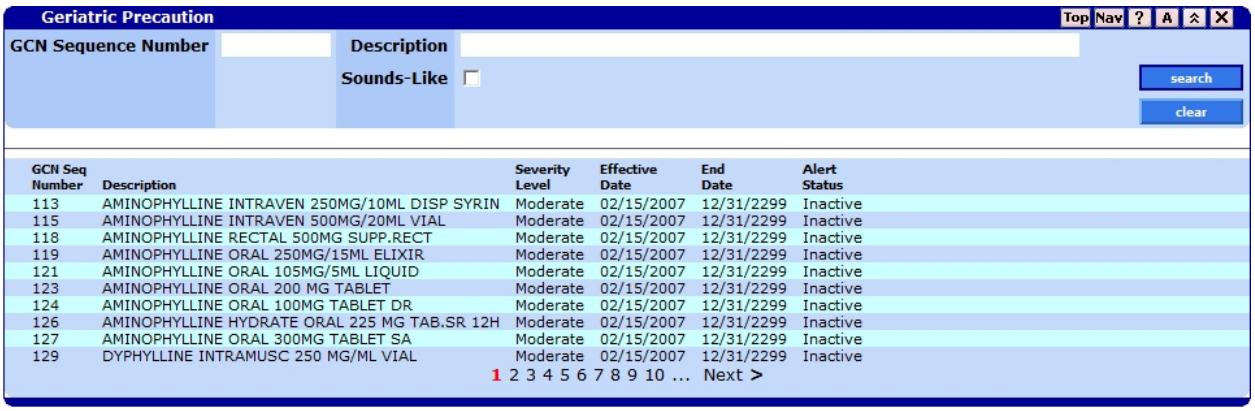
6.12 GERIATRIC PRECAUTION PANEL OVERVIEW

6.12.1 Geriatric Precaution Panel Narrative

The ProDUR Drug Age - Geriatric Precaution window is used to view and maintain geriatric age precaution criteria for each generic code. Information included is the generic code, severity level, and the generic status.

Navigation Path: [Drug - ProDUR] - [Geriatric Precaution]

6.12.2 Geriatric Precaution Panel Layout



6.12.3 Geriatric Precaution Panel Field Descriptions Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Character	8
Clear	Allows the user to clear any changes on the Geriatric Precaution panel.	Button	N/A	0
Description	Generic Code Number Sequence description search field.	Field	Character	60
Description(List)	Generic Code Number Sequence description.	Field	Character	35
Effective Date	The date the criteria became active.	Field	Date (MM/DD/CCYY)	8
End Date	The date the criteria became active.	Field	Date (MM/DD/CCYY)	8
GCN Seq. Number	GCN Sequence Number.	Field	Character	9
GCN Sequence Number	The GCN Sequence Number search field.	Field	Character	9
Severity Level	The severity level of the GCN Sequence Number within the alert. The severity assigned by First DataBank is major, moderate, or minor.	Field	Character	8

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Field	Description	Field Type	Data Type	Length
Search	Initiates search by GCN Sequence Number or Description.	Button	N/A	0
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.12.4 Geriatric Precaution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No Error codes.				

6.12.5 Geriatric Precaution Panel Extra Features

Field	Field Type
No field edits found for this window.	

6.12.6 Geriatric Precaution Panel Accessibility

6.12.6.1 To Access the Geriatric Precaution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Geriatric Precaution**.	Geriatric Precaution panel displays.

6.12.6.2 To Search the Geriatric Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Geriatric Precaution search results are displayed.

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6.13 HIGH DOSE PANEL OVERVIEW

6.13.1 High Dose Panel Narrative

The High Dose panel is used to view and maintain high dose precaution information. Displayed on the panel are the drug generic code and description, generic code alert status, max unit quantity, max unit form code, max dose quantity, and max dose units code established by the Agency. If the Agency's maximum unit quantity (MUQ) differs from FDB's, the Agency's MUQ is used.

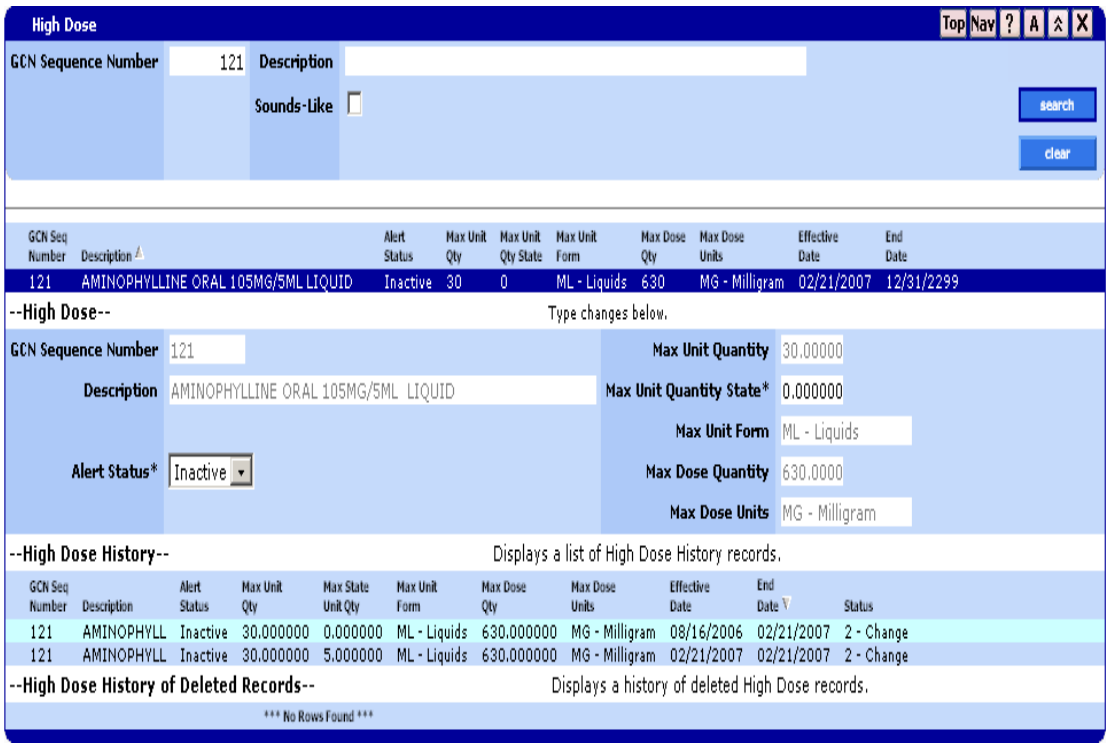
The High Dose panel has two additional panels associated with it, which include:

- High Dose History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- High Dose History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table by the User Interface. Information on this panel is generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]- [High Dose]

6.13.2 High Dose Panel Layout



Note: High Dose History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.13.3 High Dose Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Description	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	63
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Max Dose Quantity	Maximum adult daily dose. Format = 999999.999999	Field	Number (Decimal)	12
Max Dose Units	Unit of measure of the maximum daily dose. This value is for History Records.	Field	Character	3
Max Unit Quantity State	Provides the state defined quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.). This value is for History of Records. Format = 999999.999999.	Field	Number (Decimal)	12
Max Unit Form	Form of the max unit quantity which should be taken each day.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Max Unit Quantity	Maximum units that should be consumed each day. User may enter a decimal for partial units. Format = 999999.999999	Field	Number (Decimal)	12
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Check Box	Check Box	0
Status	Shows the action taken on the referenced GCN Sequence Number that generated the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.13.4 High Dose Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
GCN Sequence Number	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
Max Dose QTY	Field	91007	Data must be numeric.	Return to area and enter new quantity.
Max Unit QTY	Field	91007	Data must be numeric.	Return to area and enter new quantity.

6.13.5 High Dose Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.13.6 High Dose Panel Accessibility

6.13.6.1 To Access the High Dose Panel

Step	Action	Response
1	Enter **User Name** and **Password**; click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **High Dose**.	High Dose panel displays.

6.13.6.2 To Update the High Dose Panel

Step	Action	Response
1	Enter valid values in either the **GCN Sequence Number** or **Description** field. If searching with Description, select **Sounds Like** to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for the GCN Sequence number entered displays. If no search criterion is entered, all GCN Sequence numbers on file display in numerical order.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status** and/or **Max Quantity** fields.	
5	Click **Save**.	High Dose Precaution information is saved.

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6.14 INFERRED DISEASE PANEL OVERVIEW

6.14.1 Inferred Disease Panel Narrative

The Inferred Disease panel is used to view and maintain inferred disease alert criteria

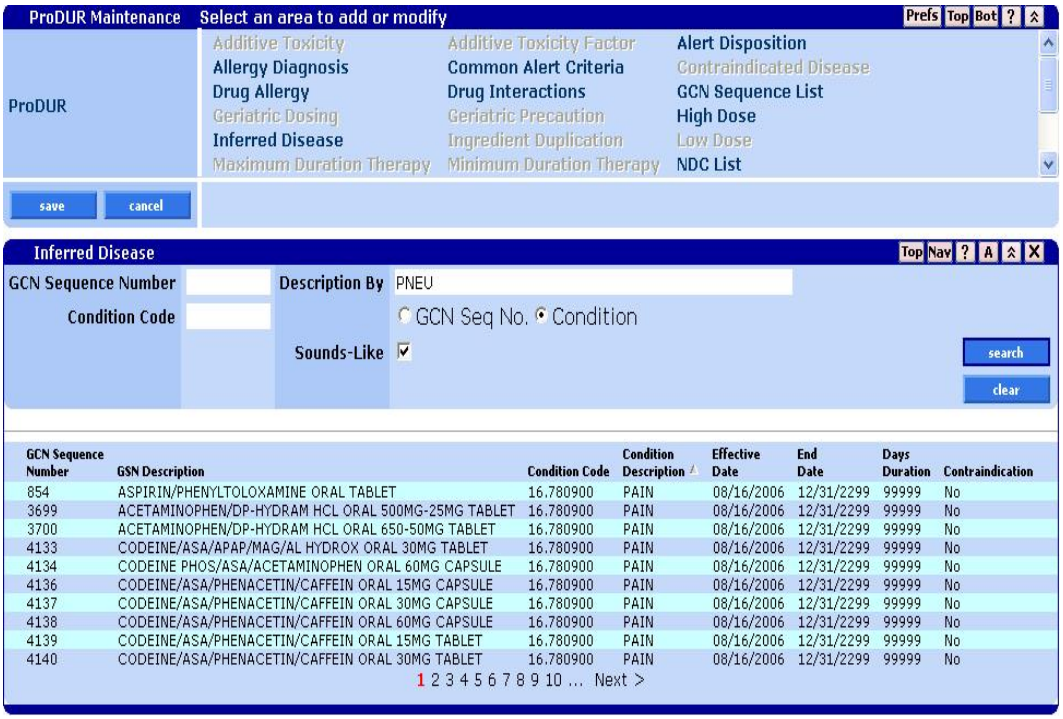
This panel has two additional panels associated with it, which include:

- Inferred Disease History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- Inferred Disease History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table by the User Interface. Information on this panel is generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]- [Inferred Disease]

6.14.2 Inferred Disease Panel Layout



Note: Inferred Disease History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.14.3 Inferred Disease Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Condition Code	First DataBank Disease Code (FDBDX in FDB manual) identifies specific disease states and side effects.	Field	Number (Decimal)	9
Condition Description	Text description of the FDB Disease Code (FDBDX in FDB manual).	Field	Character	56
Contraindicatio n	Indicates if the GCN Sequence Number has a contraindicated disease at the time this row was added or last updated via the monthly load job.	Field	Drop Down List Box	1
Days Duration	Number of days duration for a disease.	Field	Number (Integer)	9
Description By	Allows the user to perform a search using either the GCN Sequence Number Description or Condition Description.	Field	Character	56
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
GCN Sequence Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	63
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Check Box	Check Box	0
Status	Shows the action taken on the referenced GCN Sequence Number/Condition Code that generated the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.14.4 Inferred Disease Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be < to End Date.
	Field	91001	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	Date must be numeric.	Verify keying. Date must be numeric characters only (0-9).
GCN Description	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
GCN Sequence Number	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

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6.14.5 Inferred Disease Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Inferred Disease Panel Accessibility

6.14.6.1 To Access the Inferred Disease Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Inferred Disease**.	Inferred Disease panel displays.

6.14.6.2 To Update the Inferred Disease Panel

Step	Action	Response
1	Enter valid values in the **GCN Sequence Number**, **Condition Code** or **Description** field. If searching by Description, select the appropriate **radio button**. Select **Sounds Like** to further expand the search condition.	
2	Click **Search**. Users must enter a valid search criterion or an error message displays.	The search results panel for the Inferred Disease information entered displays.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status** and/or **Days Duration** field(s).	
5	Click **Save**.	Inferred Disease information is saved.

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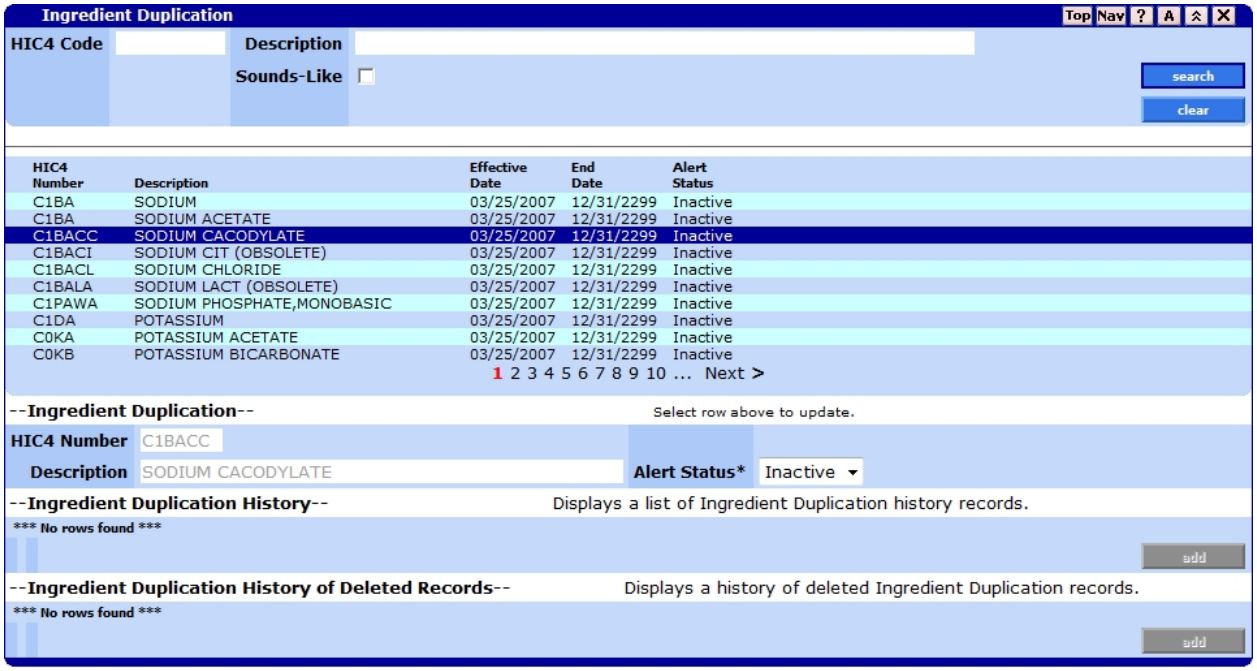
6.15 INGREDIENT DUPLICATION PANEL OVERVIEW

6.15.1 Ingredient Duplication Panel Narrative

The ProDUR Ingredient Duplication window is used to view and maintain the ingredient duplication criteria. Displayed on the window are the ingredient HIC4 code and description, severity level, and alert status. Drug ingredients on the current claim will be checked against the ingredients of any active prescriptions for the recipient to determine if ingredient duplication has occurred.

Navigation Path: [Drug - ProDUR] - [Ingredient Duplication]

6.15.2 Ingredient Duplication Panel Layout



6.15.3 Ingredient Duplication Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. Status can be either active or inactive	Field	Character	8
Clear	Allows the user to clear any changes on the Ingredient Duplication panel.	Button	N/A	0
Description	HIC4 Description.	Field	Character	60
Effective Date	The date the criteria took effect.	Field	Date (MM/DD/CCYY)	8
End Date	The last date this criteria was active.	Field	Date (MM/DD/CCYY)	8
HIC4 Code	HIC4 Code.	Field	Number (Integer)	9
HIC4 Number	HIC4 Code.	Field	Number (Integer)	9
Search	Initiates the Search by HIC4 or Description.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.15.4 Ingredient Duplication Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.15.5 Ingredient Duplication Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.15.6 Ingredient Duplication Panel Accessibility

6.15.6.1 To Access the Ingredient Duplication Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Ingredient Duplication**.	Ingredient Duplication panel displays.

6.15.6.2 To Search the Ingredient Duplication Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Ingredient Duplication search results are displayed.

6.15.6.3 To Modify the Ingredient Duplication Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Ingredient Duplication search results are displayed.

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Step	Action	Response
3	Click the desired row to edit.	Ingredient Duplication data panel, Ingredient Duplication History and Ingredient Duplication History of Deleted Records appear.
4	Select the desired Alert Status.	
5	Click **Save**.	The Ingredient Duplication information is saved.

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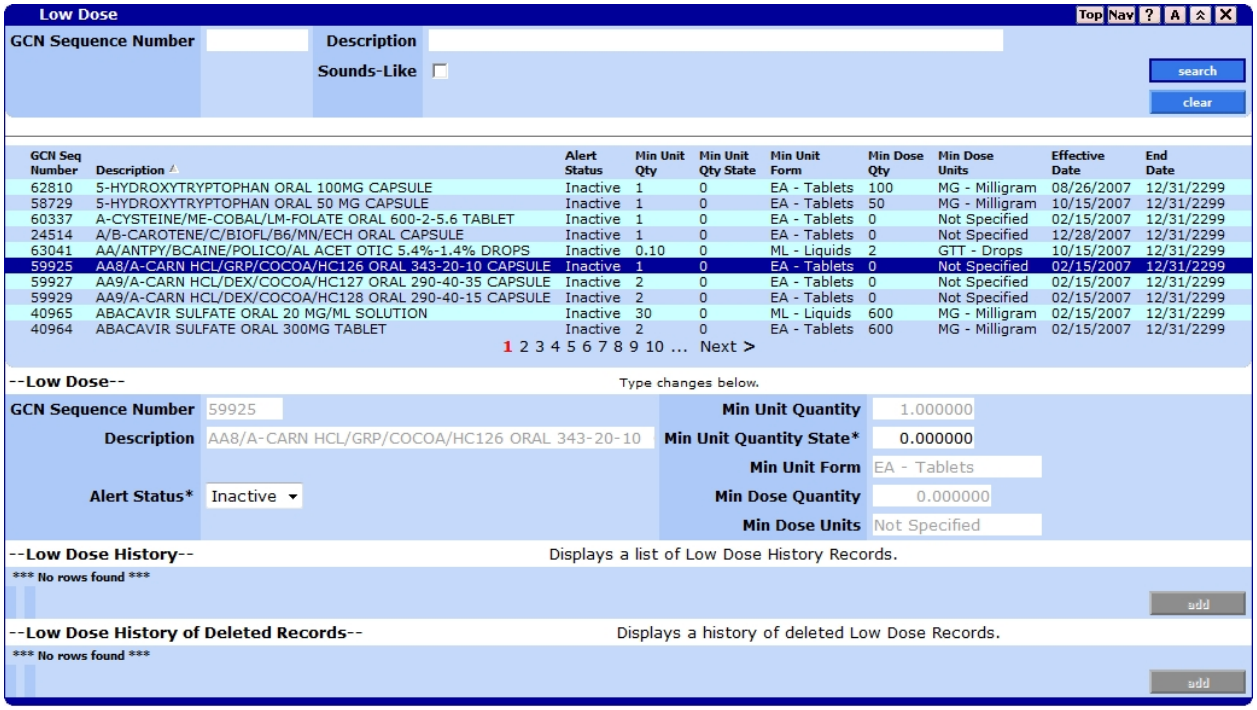
6.16 LOW DOSE PRECAUTION PANEL OVERVIEW

6.16.1 Low Dose Precaution Panel Narrative

The ProDUR Low Dose Precaution is used to view and maintain low dose precaution information. Displayed on the window are the Drug Generic Code and Description, Severity Level, Generic Code Alert Status, Min Unit Qty, Unit Form Code, Min Dose Qty, and Min Dose Units Code.

Navigation Path: [Drug - ProDUR] - [Low Dose Precaution]

6.16.2 Low Dose Precaution Panel Layout



6.16.3 Low Dose Precaution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. It can be either active or inactive	Field	Character	1
Alert Status [Panel]	The status of the GCN Sequence Number within the alert. It can be either active or inactive	Field	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Low Does Precaution panel.	Button	N/A	0
Description	Generic Code Number Sequence description.	Field	Character	60
Effective Date	The date the criteria took effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the criteria no longer applies.	Field	Date (MM/DD/CCYY)	8
GCN Seq. Number	GCN Sequence Number.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
GCN Sequence Number	The Generic Code Number Sequence Number is a unique number representing a generic formulation.	Field	Number (Integer)	9
Min Dose Qty	The minimum adult daily dose.	Field	Number (Decimal)	12
Min Dose Units	This field represents the unit of measure of the minimum daily dose.	Field	Character	3
Min Unit Form	The form of the minimum unit quantity which should be taken each day. The valid values are GM (gram), EA (each), and ML (milliliter).	Field	Character	2
Min Unit Qty	This field represents the minimum units that should be consumed each day. User may enter a decimal for partial units.	Field	Number (Decimal)	12
Min Unit Quantity State	This field provides the State-defined quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).	Field	Number (Decimal)	12
Search	Initiates the search by GCN Sequence Number of Description.	Button	N/A	0
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.16.4 Low Dose Precaution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Min Unit Quantity State	Field	1	Enter a valid value.	Enter a numeric value.
	Field	2	State Min Unit Quantity is required.	Enter a State Minimum Unit Quantity.
	Field	3	State Min Unit Quantity must be greater than or equal to 0.000000.	Enter a value greater than or equal to zero.

6.16.5 Low Dose Precaution Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.16.6 Low Dose Precaution Panel Accessibility

6.16.6.1 To Access the Low Dose Precaution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Low Dose**.	Low Dose Precaution panel displays.

6.16.6.2 To Search the Low Dose Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Low Dose Precaution search results are displayed.

6.16.6.3 To Modify the Low Dose Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Low Dose Precaution search results are displayed.
3	Click the desired row to edit.	Low Dose Precaution data panel, Low Dose Precaution History and Low Dose Precaution History of Deleted Records appear.
4	Select the desired Alert Status and Min Unit Quantity State values.	
5	Click **Save.**	The Low Dose Precaution information is saved.

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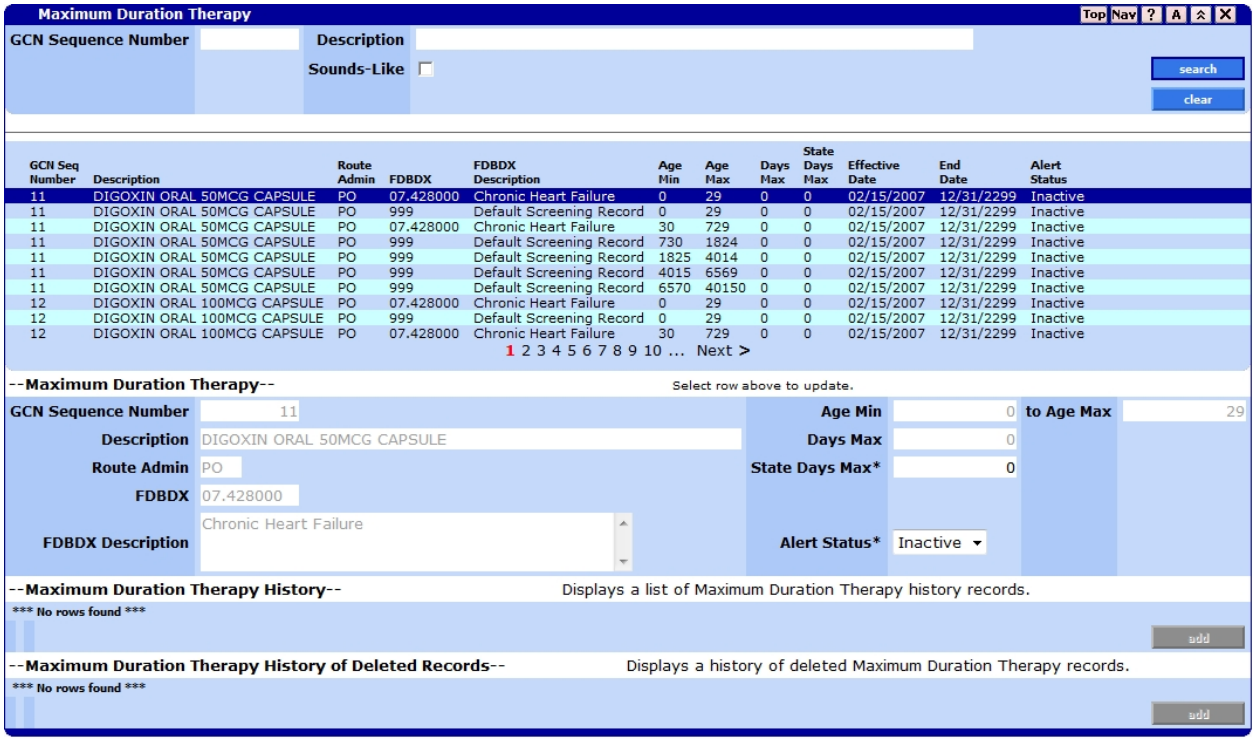
6.17 MAXIMUM DURATION THERAPY PANEL OVERVIEW

6.17.1 Maximum Duration Therapy Panel Narrative

The ProDUR Maximum Duration of Therapy window is used to view and maintain maximum duration of therapy criteria. Displayed on the window are the drug GCN Seq No. and description, age category, age category range in days, max days supply, max state days supply, severity level and alert status. There are three records - pediatric, adult and geriatric - associated with and displayed for each GCN Seq No. The three recipient age categories are initialized with the default age ranges in days defined by First Data Bank (FDB) as follows: pediatric is 1 to 4,340 days, adult is 4,381 to 21,900 days, and geriatric is 21,901 to 99999 days. These values may be adjusted as desired for each GCN Seq No, though the values may not overlap between age categories for a GCN Seq No. and the age ranges for a GCN Seq No. are also shared by the Minimum Duration of Therapy alert. The FDB supplied maximum days supply will be stored in the max days field. If a value is placed in the max state days field, it will be used to override the default value from FDB. Duration values of 0 or 999 signify undetermined or unlimited duration (respectively) and will cause the alert to be bypassed. Each age category criteria record for a GCN Seq No. may be made active or inactive individually.

Navigation Path: [Drug - ProDUR] - [Maximum Duration Therapy]

6.17.2 Maximum Duration Therapy Panel Layout



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6.17.3 Maximum Duration Therapy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Max	Maximum age accepted.	Field	Number (Integer)	9
Age Min	Minimum age accepted.	Field	Number (Integer)	9
Alert Status	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Character	8
Alert Status [Panel]	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Drop Down List Box	0
Days Max	State-defined maximum number of days of therapy. 0=not applicable.	Field	Character	9
Description	Generic Code Number Sequence description.	Field	Character	60
FDBDX	The First DataBank disease code (FDBDX in FDB manual) identifies specific disease states and side effects.	Field	Number (Decimal)	9
FDBDX Description	The First DataBank disease code (FDBDX in FDB manual) Description.	Field	Character	100
Effective Date	The date the criterion becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the criteria no longer applies.	Field	Date (MM/DD/CCYY)	8
GCN Seq Number	The Generic Code Number Sequence.	Field	Number (Integer)	9
GCN Sequence Number	The Generic Code Number Sequence is a unique number representing a generic formulation.	Field	Number (Integer)	9
Route Admin	This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.	Field	Character	2
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0
State Days Max	State-specified maximum number of days of therapy in days for the precaution.	Field	Number (Integer)	9

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6.17.4 Maximum Duration Therapy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
State Days Max	Field	1	Max State Days is required.	Enter a value for the State Days Max.
	Field	2	Max State Days must be greater than or equal to 0.	Enter a State Days Max greater or equal to Zero.
	Field	3	Enter a valid value.	Enter a valid value for State Days Max.

6.17.5 Maximum Duration Therapy Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.17.6 Maximum Duration Therapy Panel Accessibility

6.17.6.1 To Access the Maximum Duration Therapy Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Maximum Duration Therapy**.	Maximum Duration Therapy panel displays.

6.17.6.2 To Search the Maximum Duration Therapy Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Maximum Duration Therapy search results are displayed.

6.17.6.3 To Modify the Maximum Duration Therapy Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Maximum Duration Therapy search results are displayed.
3	Click the desired row to edit.	Maximum Duration Therapy data panel, Maximum Duration Therapy History and Maximum Duration Therapy History of Deleted Records appear.

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Step	Action	Response
4	Modify the values accordingly.	
5	Click **Save.**	The Maximum Duration Therapy information is saved.

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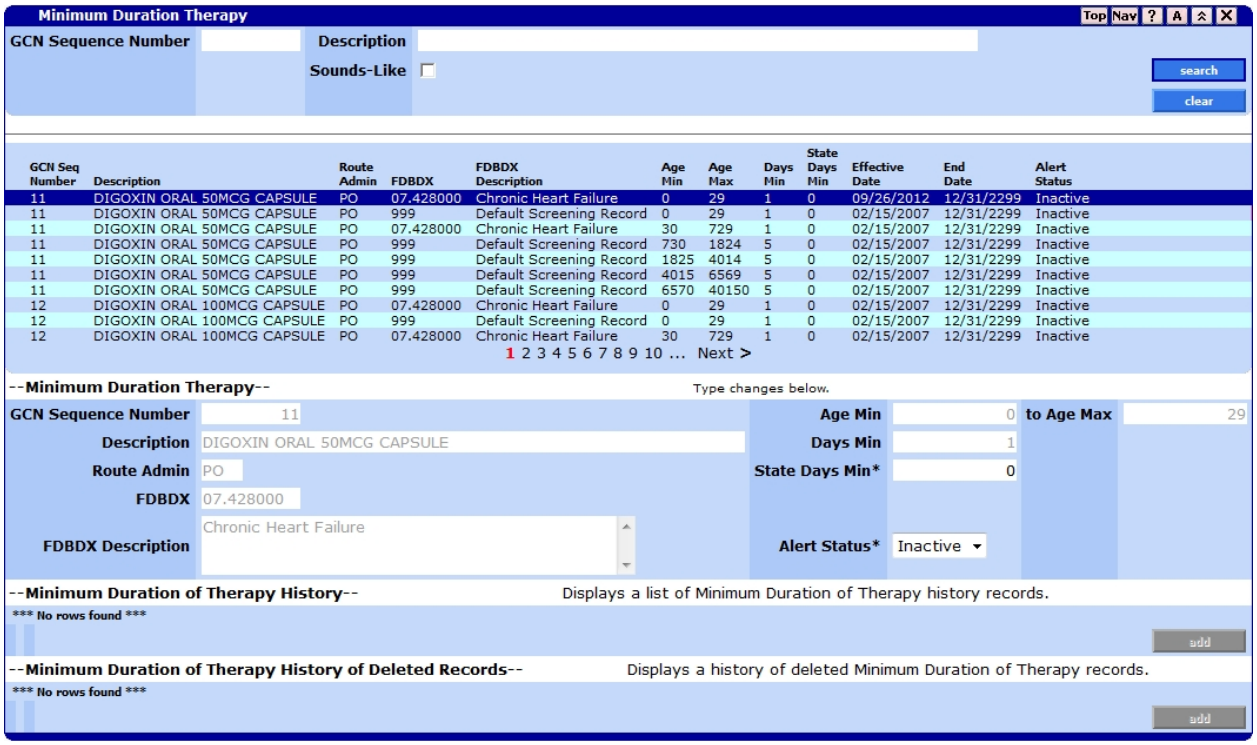
6.18 MINIMUM DURATION THERAPY PANEL OVERVIEW

6.18.1 Minimum Duration Therapy Panel Narrative

The ProDUR Minimum Duration of Therapy window is used to view and maintain minimum duration of therapy criteria. Displayed on the window are the drug GCN Seq No. and description, age category, age category range in days, min days supply, min state days supply, severity level and alert status. There are three records - pediatric, adult and geriatric - associated with and displayed for each GCN Seq No. The three recipient age categories are initialized with the default age ranges in days defined by First Data Bank (FDB) as follows: pediatric is 1 to 4,340 days, adult is 4,381 to 21,900 days, and geriatric is 21,901 to 99999 days. These values may be adjusted as desired for each GCN Seq No., though the values may not overlap between age categories for a GCN Seq No. and the age ranges for a GCN Seq No. are also shared by the Maximum Duration of Therapy alert. FDB does not supply minimum duration data at this time, so the min days field will be initialized to zero. To establish minimum days supply criteria, a value may be entered in the min state days field and will override the default from FDB. Duration values of 0 or 999 signify undetermined or unlimited duration (respectively) and will cause the alert to be bypassed. Each age category criteria record for a GCN Seq No. may be made active or inactive individually.

Navigation Path: [Drug - ProDUR] - [Minimum Duration Therapy]

6.18.2 Minimum Duration Therapy Panel Layout



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6.18.3 Minimum Duration Therapy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Max	Maximum age accepted.	Field	Number (Integer)	9
Age Min	Minimum age accepted.	Field	Number (Integer)	9
Alert Status	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Character	8
Alert Status [Panel]	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Drop Down List Box	0
Days Min	State-defined maximum number of days of therapy. 0=not applicable.	Field	Character	9
Description	Generic Code Number Sequence description.	Field	Character	60
Effective Date	The date the criterion becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the criteria no longer applies.	Field	Date (MM/DD/CCYY)	8
FDBDX	The First DataBank disease code (FDBDX in FDB manual) identifies specific disease states and side effects.	Field	Number (Decimal)	9
FDBDX Description	The First DataBank disease code (FDBDX in FDB manual) Description.	Field	Character	100
GCN Seq Number	The Generic Code Number Sequence.	Field	Number (Integer)	9
GCN Sequence Number	The Generic Code Number Sequence is a unique number representing a generic formulation.	Field	Number (Integer)	9
Route Admin	This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.	Field	Character	2
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0
State Days Max	State-specified maximum number of days of therapy in days for the precaution.	Field	Number (Integer)	9

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1.1.1 Minimum Duration Therapy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
State Days Max	Field	1	Max State Days is required.	Enter a value for the State Days Max.
	Field	2	Max State Days must be greater than or equal to 0.	Enter a State Days Max greater or equal to Zero.
	Field	3	Enter a valid value.	Enter a valid value for State Days Max.

6.18.4 Minimum Duration Therapy Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.18.5 Minimum Duration Therapy Panel Accessibility

6.18.5.1 To Access the Minimum Duration Therapy Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Minimum Duration Therapy**.	Minimum Duration Therapy panel displays.

6.18.5.2 To Search the Minimum Duration Therapy Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Minimum Duration Therapy search results are displayed.

6.18.5.3 To Modify the Minimum Duration Therapy Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Minimum Duration Therapy search results are displayed.
3	Click the desired row to edit.	Minimum Duration Therapy data panel, Minimum Duration Therapy History and Minimum Duration Therapy History of Deleted Records appear.

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Step	Action	Response
4	Modify the values accordingly.	
5	Click **Save.**	The Minimum Duration Therapy information is saved.

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6.19 NDC LIST PANEL OVERVIEW

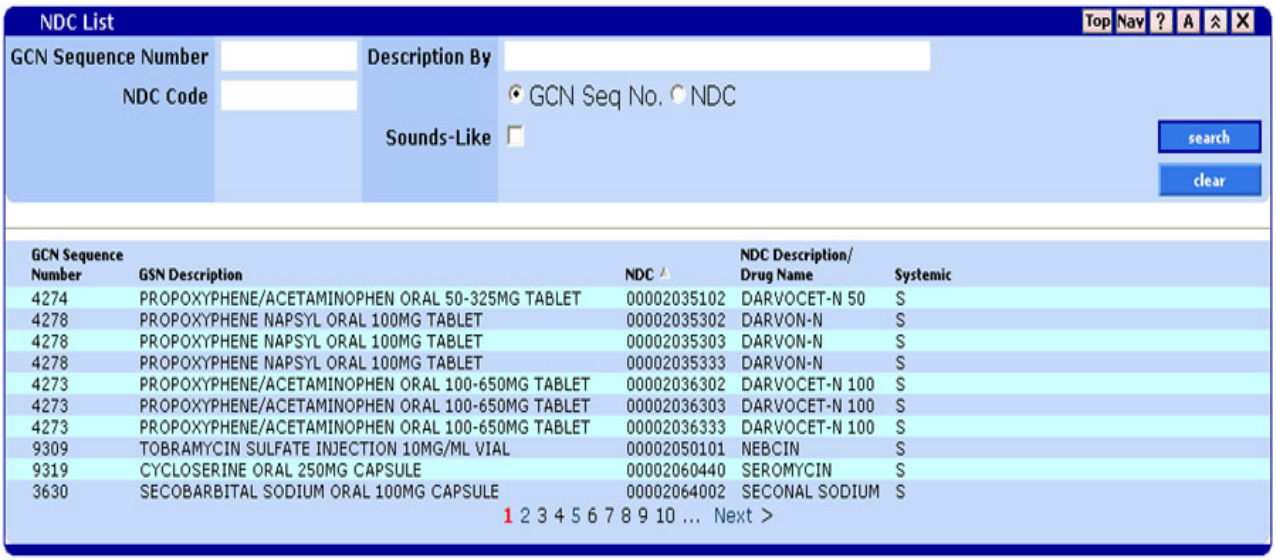
6.19.1 NDC List Panel Narrative

The NDC List panel is used to view all National Drug Codes (NDC) for a particular GCN Sequence Number. This panel is used to research provider inquiries regarding ProDUR alerts.

This panel is for inquiry only.

Navigation Path: [Drug] – [ProDUR]- [NDC List]

6.19.2 NDC List Panel Layout



6.19.3 NDC List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears user input from search fields.	Button	N/A	0
Description By	Allows the user to perform a search using a Generic Code Number Sequence Number description or NDC description.	Field	Character	63
GSN Description	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	63
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
NDC Code	Allows user to perform a search using a specific NDC Code.	Field	Number (Integer)	11
NDC Description/Drug Name	Description of the NDC that pertains to a certain GCN Sequence Number.	Field	Character	30
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Check Box	Check Box	0
Systemic	Indicates if a drug is systemic (enters the blood stream) non-systemic (does not enter the blood stream). Valid Values are: S - Systemic, N - Non-Systemic.	Field	Character	1

6.19.4 NDC List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
GCN Sequence Number	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
NDC Code	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

6.19.5 NDC List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 NDC List Panel Accessibility

6.19.6.1.1 To Access the NDC List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **NDC List**.	NDC List panel displays.

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6.19.6.2 To Navigate from the NDC List Panel

Step	Action	Response
1	Enter valid values in the **GCN Sequence Number**, **Condition Code** or **Description** field. If searching by Description, select the appropriate **radio button.** Select **Sounds Like** to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The NDC List search results panel displays. If no Search criteria are entered, information for all NDCs on file display in GCN Sequence number order.
3	Click one of the **NDCs** in the detail list.	System navigates the user to the Reference>> Drug Information panel, and displays drug information for the selected NDC.

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6.20 OVERUSE PRECAUTION PANEL OVERVIEW

6.20.1 Overuse Precaution Panel Narrative

The Overuse Precaution panel is used to view and maintain overuse precaution alert criteria. Information displayed includes the drug generic code description, the severity level, and drug generic code status.

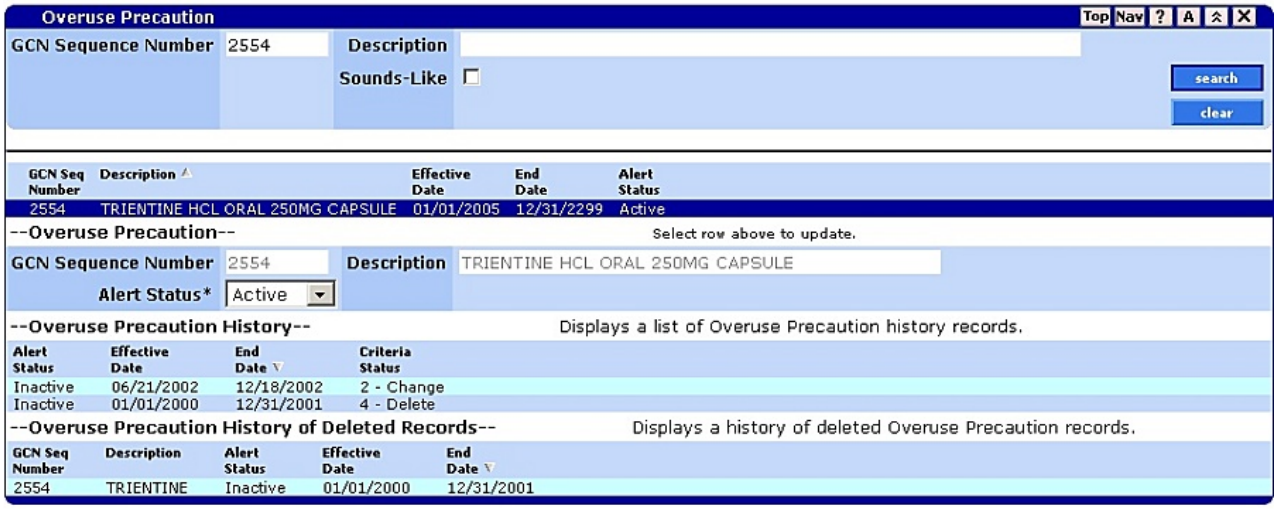
This panel has two additional panels associated with it, which includes:

- Overuse Precaution History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- Overuse Precaution History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table by the User Interface. Information on this panel is generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]- [Overuse Precaution]

6.20.2 Overuse Precaution Panel Layout



Note: Overuse Precaution History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

6.20.3 Overuse Precaution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Criteria Status	Shows the action that was taken on the Overuse Precaution record to generate the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1
Description	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	63
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Check Box	Check Box	0

6.20.4 Overuse Precaution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
GCN Sequence Number	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

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6.20.5 Overuse Precaution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Overuse Precaution Panel Accessibility

6.20.6.1.1 To Access the Overuse Precaution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Overuse Precaution**.	Overuse Precaution panel displays.

6.20.6.2 To Update the Overuse Precaution Panel

Step	Action	Response
1	Enter valid values in the **GCN Sequence Number** or **Description** field. If searching with **Description**, select **Sounds Like** to expand the search condition further.	
2	Enter search criteria and click **Search**, or click **Search**.	The search results panel for the GCN Sequence number information entered displays. If no Search criteria are entered, all information for all GCN Sequence codes on file display in numerical order.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status** field.	
5	Click **Save**.	Overuse Precaution information is saved.

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6.21 PEDIATRIC DOSING PANEL OVERVIEW

6.21.1 Pediatric Dosing Panel Narrative

The Pediatric Dosing Panel is used to view and maintain dosing criteria for recipients in the Pediatric age range.

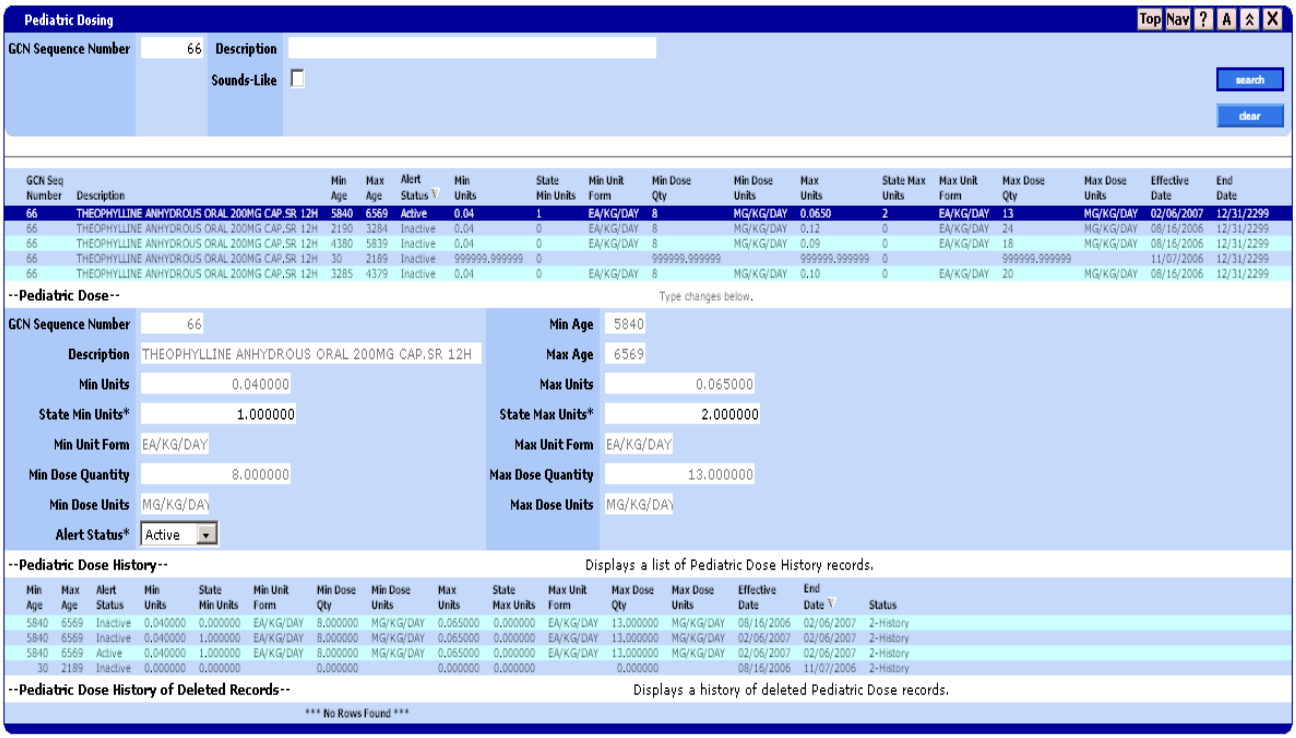
There are two panels associated with the Pediatric Dosing panel, which includes:

- Pediatric Dose History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected GCN Sequence Number.
- Pediatric Dose History of Deleted Records panel - This panel shows the history of all GCN Sequence Numbers deleted from this table. Records are generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]- [Pediatric Dosing]

6.21.2 Pediatric Dosing Panel Layout



Note: Pediatric Dose History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.21.3 Pediatric Dosing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Butto n	N/A	0
Description (Detail)	Describes the corresponding GSN. The first field is the generic drug name, the second is the route description, third is the drug strength description and the fourth is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	Field	Character	65
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
GCN Sequence Number	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	Field	Number (Integer)	9
Max Age	Maximum age in days for the precaution.	Field	Number (Integer)	4
Max Dose Quantity	This field provides the quantitative value for the maximum pediatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.	Field	Number (Decimal)	12
Max Dose Units	This field represents the unit of measure of the maximum daily dose.	Field	Number (Decimal)	2
Max Unit Form	The form of the maximum unit quantity which should be taken each day.	Field	Character	2
Max Units	This field provides the quantitative value for the maximum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for	Field	Number (Decimal)	12

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Field	Description	Field Type	Data Type	Length
	liquids, etc.). This field must be used in conjunction with the Maximum Unit Form field.			
Min Age	Minimum age in days for the precaution.	Field	Number (Integer)	4
Min Dose Quantity	This field provides the quantitative value for the minimum pediatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.	Field	Number (Decimal)	12
Min Dose Units	This field represents the unit of measure of the minimum daily dose.	Field	Number (Decimal)	2
Min Unit Form	The form of the minimum unit quantity which should be taken each day.	Field	Character	30
Min Units	This field provides the quantitative value for the minimum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.). This field must be used in conjunction with the Minimum Unit Form field.	Field	Number (Decimal)	12
Search	Activates the search feature.	Butto n	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Field	Check Box	0
State Max Units	This field provides the state defined quantitative value for the maximum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).	Field	Number (Decimal)	12
State Min Units	This field provides the state defined quantitative value for the minimum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).	Field	Number (Decimal)	12

6.21.4 Pediatric Dosing Panel Field Edit Error Codes

Field	Field Type	Error Message	To Correct
State Max Units	Field	State Max Unit must be greater than or equal to 0.	Re-enter an amount greater than or equal to zero.

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Field	Field Type	Error Message	To Correct
	Field	State Max Unit must be less than or equal to 999999.999999.	Re-enter an amount smaller than or equal to 999999.999999.
	Field	State Max Unit is required.	Enter a value.
	Field	Enter a valid value.	Re-enter a numeric value.
State Min Units	Field	State Min Unit Quantity must be less than the State Maximum Unit Quantity.	Re-enter an amount smaller than State Max Unit Quantity.
	Field	State Min Unit must be greater than or equal to 0.	Re-enter an amount greater than or equal to zero.
	Field	State Min Unit must be less than or equal to 999999.999999.	Re-enter an amount smaller than or equal to 999999.999999.
	Field	State Max Unit is required.	Enter a value.
	Field	Enter a valid value.	Re-enter a numeric value.

6.21.5 Pediatric Dosing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Pediatric Dosing Panel Accessibility

6.21.6.1 To Access the Pediatric Dosing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Pediatric Dosing**.	Pediatric Dosing panel displays.

6.21.6.2 To Update the Pediatric Dosing Panel

Step	Action	Response
1	Enter a valid value in the **GCN Sequence Number** or **Description** field. If searching with Description, select **Sounds Like** to further expand the search condition.	
2	Click **Search**.	The Pediatric Dosing search results panel displays. If no search criterion is entered, information for all GSNs currently on file with pediatric dosing information displays in numerical order.
3	Select the row to be updated.	

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Step	Action	Response
4	Make the desired update to the **Alert Status, State Maximum Units and/or State Minimum Units fields.**	
5	Click **Save**.	Pediatric Dosing information is saved.

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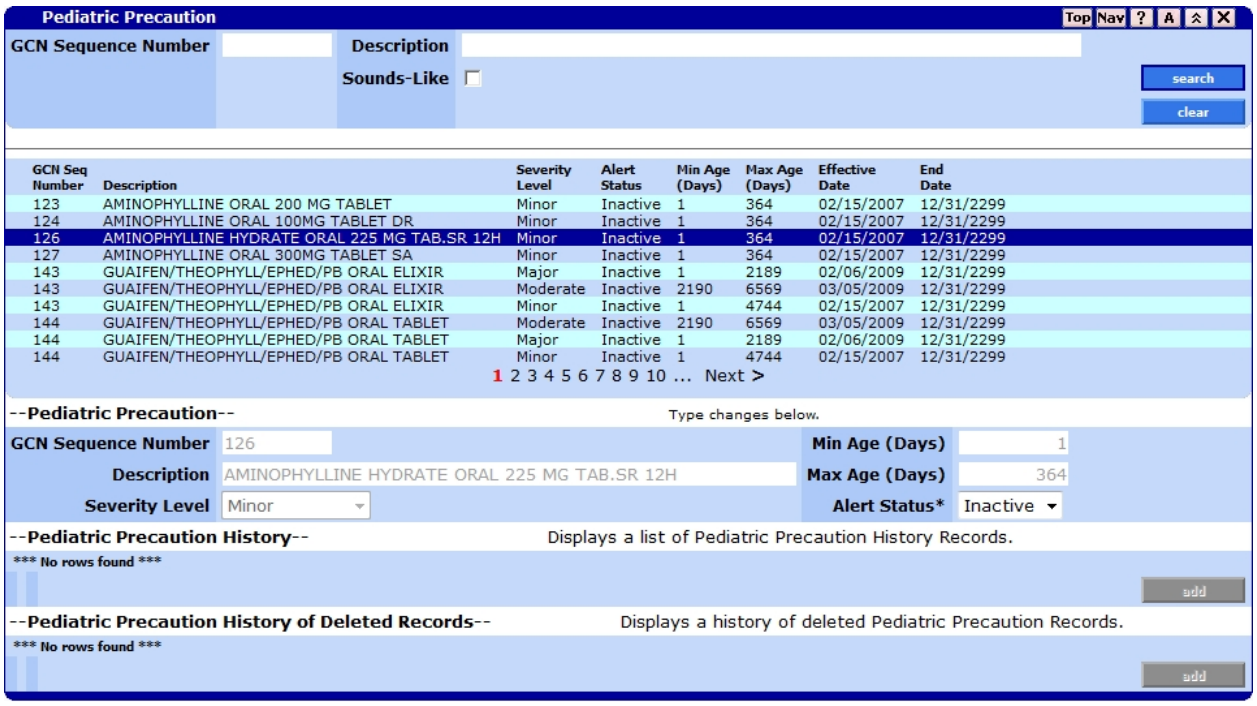
6.22 PEDIATRIC PRECAUTION PANEL OVERVIEW

6.22.1 Pediatric Precaution Panel Narrative

The ProDUR Drug Age - Pediatric Precaution window is used to view and maintain pediatric age precaution criteria for each generic code. Information included is the generic code, severity level, generic code status, and the min and max age days.

Navigation Path: [Drug - ProDUR] - [Pediatric Precaution]

6.22.2 Pediatric Precaution Panel Layout



6.22.3 Pediatric Precaution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. It can be either active or inactive	Field	Character	1
Alert Status [Panel]	The status of the GCN Sequence Number within the alert. It can be either active or inactive	Field	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Pediatric Precaution panel.	Button	N/A	0
Description	Generic Code Number Sequence description.	Field	Character	60
Effective Date	The date the criteria took effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the criteria expires.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
GCN Seq Number	GCN Sequence Number.	Field	Number (Integer)	9
GCN Sequence Number	The Generic Code Number Sequence Number is a unique number representing a generic formulation.	Field	Number (Integer)	9
Max Age (Days)	The maximum age for a Drug Pediatric precaution.	Field	Number (Integer)	9
Min Age (Days)	The minimum age for a Drug Pediatric precaution.	Field	Number (Integer)	9
Severity Level	The severity level of the GCN Sequence Number within the alert. The severity assigned by First DataBank is major, moderate or minor.	Field	Character	1
Search	Initiates the search by GCN Sequence Number or Description.	Button	N/A	0
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.22.4 Pediatric Precaution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.22.5 Pediatric Precaution Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.22.6 Pediatric Precaution Panel Accessibility

6.22.6.1 To Access the Pediatric Precaution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Pediatric Precaution**.	Pediatric Precaution panel displays.

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6.22.6.2 To Search the Pediatric Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Pediatric Precaution search results are displayed.

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6.22.6.3 To Modify the Pediatric Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Pediatric Precaution search results are displayed.
3	Click the desired row to edit.	Pediatric Precaution data panel, Pediatric Precaution History and Pediatric Precaution History of Deleted Records appear.
4	Select the desired Alert Status value.	
5	Click **Save.**	The Pediatric Precaution information is saved.

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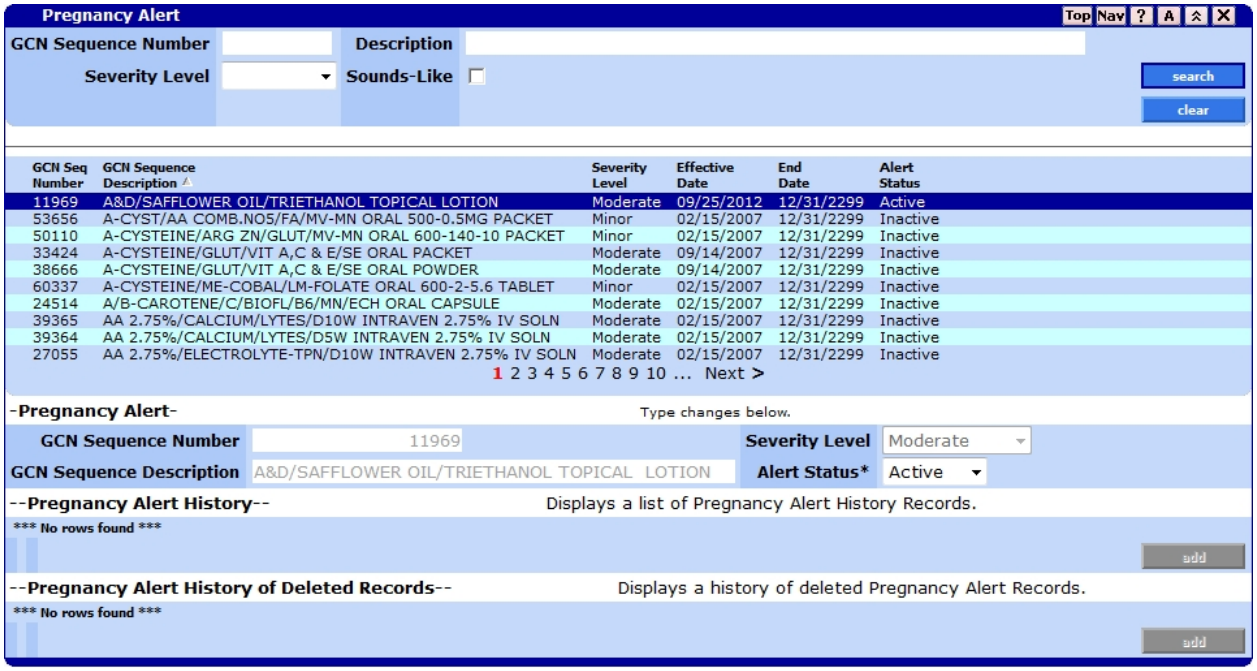
6.23 PREGNANCY ALERT PANEL OVERVIEW

6.23.1 Pregnancy Alert Panel Narrative

The ProDUR Pregnancy Alert window is used to view and maintain pregnancy alert criteria information. Information displayed includes the drug generic code and description, severity level, and generic code alert status.

Navigation Path: [Drug - ProDUR] - [Pregnancy Alert]

6.23.2 Pregnancy Alert Panel Layout



6.23.3 Pregnancy Alert Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. Status can be either active or inactive.	Field	Character	8
Clear	Allows the user to clear any changes on the Pregnancy Alert panel.	Button	N/A	0
(GCN Sequence) Description	Generic Code Number Sequence description search field.	Field	Character	60
Effective Date	The date the criteria became active.	Field	Date (MM/DD/CCYY)	8
End Date	The date the criteria became active.	Field	Date (MM/DD/CCYY)	8
GCN Seq. Number	The Generic Code Number Sequence Number is a unique number representing a generic formulation.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
GCN Sequence Number	The Generic Code Number Sequence Number is a unique number representing a generic formulation.	Field	Character	9
Severity Level	The severity level of the GCN Sequence Number within the alert. The severity assigned by First DataBank is major, moderate, or minor.	Field	Character	8
Search	Initiates search by GCN Sequence Number, Description or Severity Level.	Button	N/A	0
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.23.4 Pregnancy Alert Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
GCN Sequence Number	Field	1	Enter a valid value.	Enter a Numeric GCN Sequence Number.

6.23.5 Pregnancy Alert Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.23.6 Pregnancy Alert Panel Accessibility

6.23.6.1 To Access the Pregnancy Alert Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Pregnancy Alert**.	Pregnancy Alert panel displays.

6.23.6.2 To Search the Pregnancy Alert Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Pregnancy Alert search results are displayed.

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6.23.6.3 To Modify the Pregnancy Alert Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Pregnancy Alert search results are displayed.
3	Click the desired row to edit.	Pregnancy Alert data panel, Pregnancy Alert History and Pregnancy Alert History of Deleted Records appear.
4	Select the desired Alert Status.	
5	Click **Save**.	The Pregnancy Alert information is saved.

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6.24 PREGNANCY DIAGNOSIS PANEL OVERVIEW

6.24.1 Pregnancy Diagnosis Panel Narrative

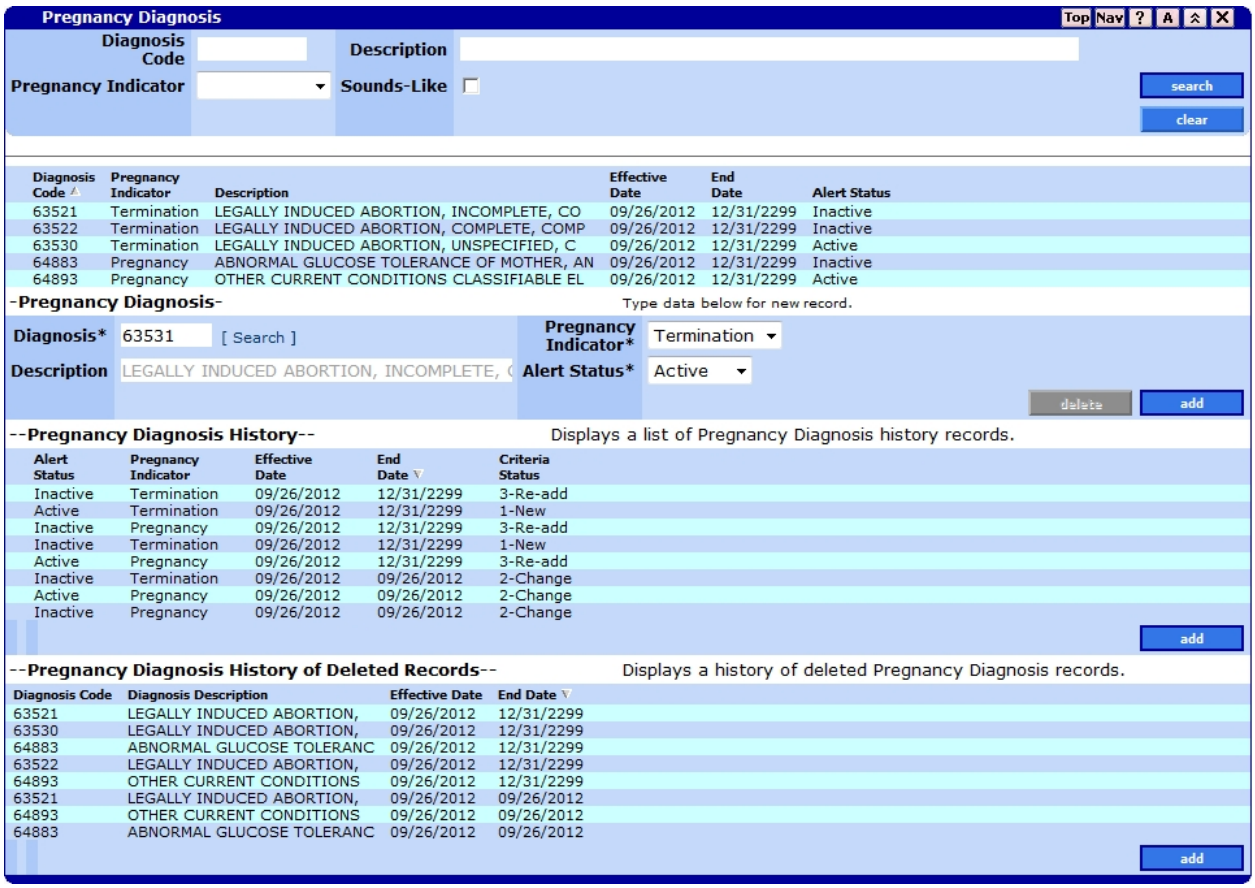
This Panel will maintain the Pregnancy Diagnosis Table. The user will be able to update, add, or delete diagnoses from the table. This panel has two extra panels associated, which include:

History Panel - This panel shows the history of all changes to records on this table. The user will see changes to only the selected Diagnosis Code.

History of Deleted Records Panel - This panel shows the history of all Diagnosis Codes deleted from this table by the User Interface.

Navigation Path: [Drug - ProDUR] - [Pregnancy Diagnosis]

6.24.2 Pregnancy Diagnosis Panel Layout



6.24.3 Pregnancy Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	This field tells whether the Diagnosis Code is active or inactive to set the alert.	Field	Drop Down List Box	0
Criteria Status	This field shows the action that was taken on the severity level, to generate the record on the history panel.	Field	Character	12
Description	This is the ICD-CM Description of the Pregnancy Diagnosis.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Diagnosis Code	The ICD-CM Diagnosis code that indicates pregnancy or termination of pregnancy.	Field	Character	7
Effective Date	The date the criterion becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date when the criteria no longer applies.	Field	Date (MM/DD/CCYY)	8
Pregnancy Indicator	This shows whether the diagnosis code is Pregnancy or Pregnancy Termination.	Field	Character	1
Pregnancy Indicator [Search]	Allows the user to search records based on Pregnancy Indicator.	Field	Drop Down List Box	0
Sounds-Like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the check box is unchecked a literal search is performed.	Field	Check Box	0

6.24.4 Pregnancy Diagnosis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.24.5 Pregnancy Diagnosis Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.24.6 Pregnancy Diagnosis Panel Accessibility

6.24.6.1 To Access the Pregnancy Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Pregnancy Diagnosis**.	Pregnancy Diagnosis panel displays.

6.24.6.2 To Search the Pregnancy Diagnosis Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	

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Step	Action	Response
2	Click the **Search** button.	The Pregnancy Diagnosis search results are displayed.

6.24.6.3 To Add a record to the Pregnancy Diagnosis Panel

Step	Action	Response
1	Click the **Add** button.	A new record is displayed.
2	Enter the sufficient data in each of the required/desired fields.	
3	Click **Save**.	The Pregnancy Diagnosis information is saved.

6.24.6.4 To Modify the Pregnancy Diagnosis Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Pregnancy Diagnosis search results are displayed.
3	Click the desired row to edit.	Pregnancy Diagnosis data panel, Pregnancy Diagnosis History and Pregnancy Diagnosis History of Deleted Records appear.
4	Modify the values accordingly.	
5	Click **Save.**	The Pregnancy Diagnosis information is saved.

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6.25 RECIPIENT PROFILE PANEL OVERVIEW

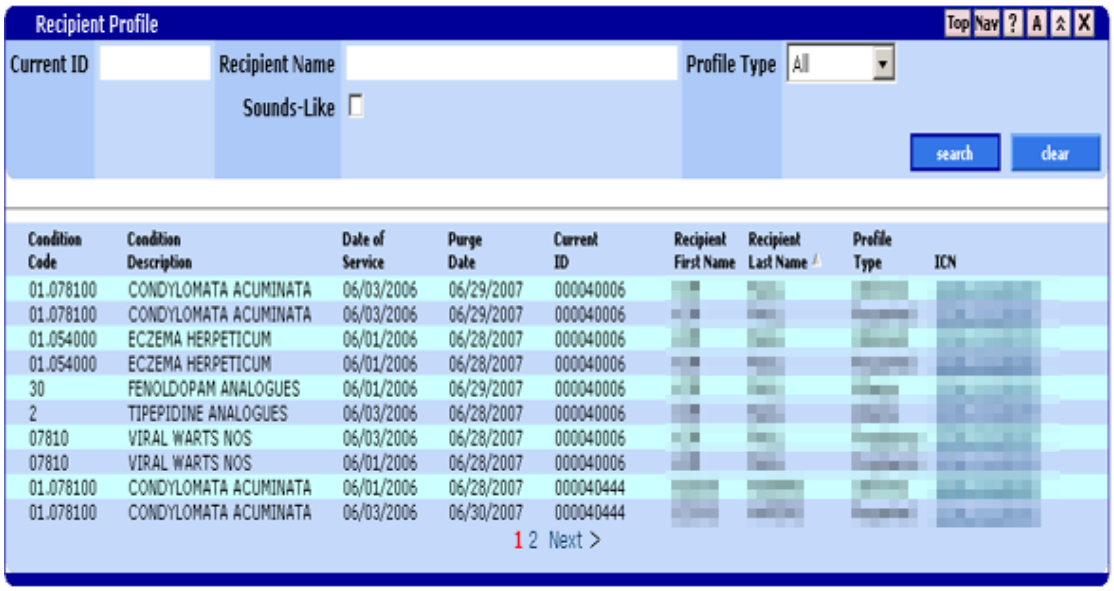
6.25.1 Recipient Profile Panel Narrative

The Recipient Disease Profile is used to view the Inferred Disease Code and start and stop dates for the disease, for a patient (recipient). This panel is used in conjunction with the Reported Disease, Inferred Disease and paid claims panels. All paid Medical and Pharmacy claims are used in building the Recipient Disease profile.

This panel is inquiry only.

Navigation Path: [Drug] - [ProDUR] - [Recipient Profile]

6.25.2 Recipient Profile Panel Layout



6.25.3 Recipient Profile Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears user input from search fields.	Button	N/A	0
Condition Code	Disease code or the Pregnancy Diagnosis code for the Profile.	Field	Number (Decimal)	10
Condition Description	Description of the corresponding Condition Code.	Field	Character	50
Current ID	The Recipient's Medicaid identification number.	Field	Number (Integer)	12
Date of Service	Date of service from the claim that created the profile.	Field	Date (MM/DD/CCYY)	8
ICN	Internal Control Number (ICN) of the claim that created or last updated the Profile. The ICN is hyperlinked so the user can be taken to the claims panel to view data about the claim.	Field	Number (Integer)	13

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Field	Description	Field Type	Data Type	Length
Profile Type	Type of condition or disease.	Field	Drop Down List Box	1
Purge Date	Termination date of the profile. If the disease is a life time disease, the termination date is set to 12/31/2199; otherwise, the date is calculated based off of the criteria for acute diseases.	Field	Date (MM/DD/CCYY)	8
Recipient Name [Detail]	Displays the recipient's last name followed by the first name.	Field	Charter	50
Recipient Name [Search]	Allows the user to perform a search using the Recipient's last name, first name or last name followed by the first name.	Field	Character	50
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Check Box	Check Box	0

6.25.4 Recipient Profile Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data

6.25.5 Recipient Profile Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Recipient Profile Panel Accessibility

1.1.1.1 To Access the Recipient Profile Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance page displays.
3	Click **Recipient Profile**.	Recipient Profile panel displays.

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6.25.6.1 Navigate from the Recipient Profile Panel

Step	Action	Response
1	Enter valid data in either the **Current ID** or **Recipient Name** field. If searching with Recipient Name, select **Sounds Like** to further expand the search condition. Select the appropriate profile type from the **Profile Type** drop-down box.	
2	Enter search criteria and click **Search**, or click **Search**.	Recipient Profile search results panel displays. If no search criteria are entered, all recipient profiles on file display.
3	Click an **ICN** in the detail list.	System opens a new browser and navigates the user to the Claims>>Claim Information panel, for the selected ICN.

6.25.6.2 To Update the Recipient Profile Panel

Step	Action	Response
1	Enter valid values in the **Current ID** field or the **Recipient Name** field. If searching with **Recipient Name**, select **Sounds Like** to further expand the search condition.	
2	Select a **Profile Type** from the drop-down box.	
3	Click **Search**.	Recipient Profile search results panel displays.
4	Select the row to be updated.	
5	Make the desired update to the **Condition Code** field.	
6	Click **Save**.	Recipient Profile information is saved.

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6.26 REPORTED DISEASE PANEL OVERVIEW

6.26.1 Reported Disease Panel Narrative

The Reported Disease panel is used to maintain the diagnosis codes to condition codes for the reported disease alert.

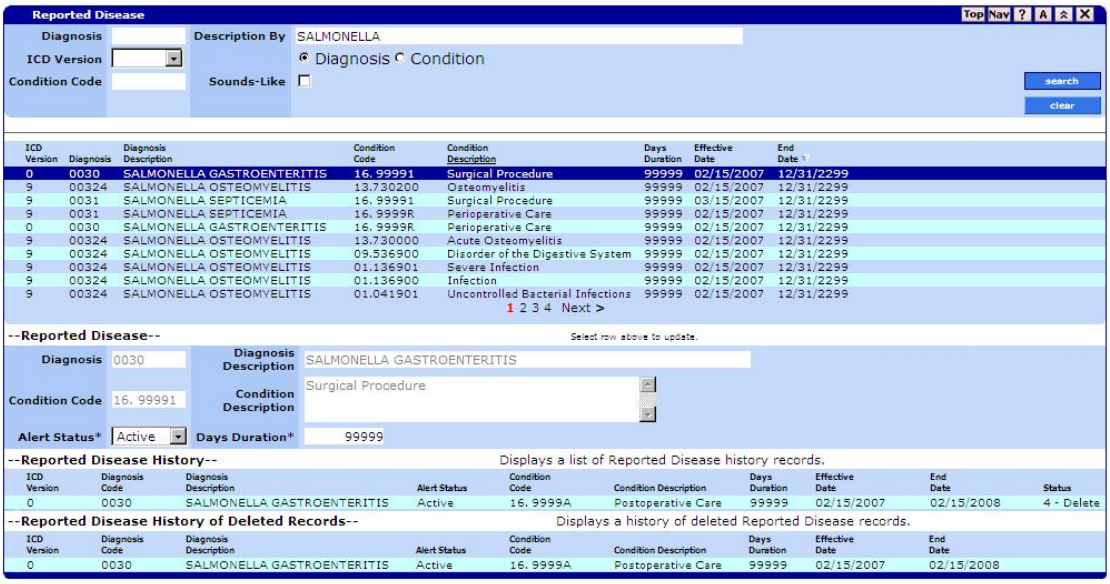
This panel has two extra panels associated with it, which includes:

- Reported Disease History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected Diagnosis Code.
- Reported Disease History of Deleted Records panel - This panel shows the history of all Diagnosis Code to Disease Code relationship deleted from this table. These deletions are generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] - [ProDUR] - [Reported Disease]

6.26.2 Reported Disease Panel Layout



Note: Reported Disease History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.26.3 Reported Disease Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Condition Code	A code assigned by First DataBank that identifies specific disease states and side effects. The Condition Code incorporates the ICD code and is further delineated by FDB for more specificity.	Field	Character	9
Condition Description	Describes the corresponding Condition Code.	Field	Character	56
Days Duration	Number of days duration for a specific acute or chronic disease.	Field	Number (Integer)	9
Diagnosis Code	FDB Diagnosis Code that indicates a particular illness or medical condition.	Field	Character	6
Description By (Search)	Allows the user to perform a search using either a Condition Code Description or Diagnosis Code Description.	Field	Character	56
Diagnosis Description	Describes the corresponding FDB Diagnosis Code.	Field	Character	56
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9, '0' for ICD-10 or blank if corresponding code is not present.	Field	Character	1
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Field	Check Box	0

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Field	Description	Field Type	Data Type	Length
Status	Shows the action taken on the referenced reported disease that generated the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	1

6.26.4 Reported Disease Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis	Field	91024	No match found.	Return to field and enter correct data.

6.26.5 Reported Disease Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Reported Disease Panel Accessibility

6.26.6.1 To Access the Reported Disease Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Reported Disease**.	Reported Disease panel displays.

6.26.6.2 To Update the Reported Disease Panel

Step	Action	Response
1	Enter valid values in the **Diagnosis** field or the **Condition code** field. If searching with Description (diagnosis or condition), select **Sounds Like** to further expand the search condition.	
2	Click **Search**.	The Reported Disease search results panel displays.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status** and/or **Days Duration** field.	
5	Click **Save**.	Reported Disease information is saved.

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6.27 SUSPENDED CLAIMS ALERT PANEL OVERVIEW

6.27.1 Suspended Claims Alert Panel Narrative

The Suspended Claim Alert panel is used to view all of the alerts which set on a specific claim. Important data which pertains to the specific alert set is also displayed. This panel is used to research providers regarding ProDUR Alerts. Alerted claims information, for any one claim, remains available for display 72 hours (3 days) after the alert is initially set.

This panel is for inquiry only.

Navigation Path: [Drug] – [ProDUR] - [Suspended Claims Alerts]

6.27.2 Suspended Claims Alert Panel Layout

6.27.3 Suspended Claims Alert Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Name	Indicates which ProDUR alert that the claim set. Click the alert name to view ICN and NDC information associated with the Alert.	Field	Character	3
Clear	Clears user input from search fields.	Button	N/A	0
Current Claim ICN	A link to the Internal Control Number of the claim setting the ProDUR Alert. When clicked, this link takes the user to the Pharmacy Claim information panel to view the alerted claim.	Hyperlink	N/A	
Dispensed Date	Dispense date of the claim in suspense. This field is automatically populated when the Provider ID and RX# fields are entered and unique. If the Provider number and Rx # find more than one match, the system prompts the user to enter the dispensed date before displaying information on the panel.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
History Dispense Date	If the alert which set is an alert that set against a claim in history, the dispense date on the claim in history is displayed. If the alert set only on the basis of the current claim, the history dispense date is 00/00/0000.	Field	Date (MM/DD/CCYY)	8
History Claim ICN	A link to the Internal Control Number of the claim causing the ProDUR Alert. When clicked, this link takes the user to the Pharmacy Claim Information panel to view the history claim.	Hyperlink	N/A	
ICN	The Internal Control Number which uniquely identifies a claim. This field is one of four possible search criteria to bring up a claim in suspense. Users will enter the ICN of the Current or History claim in this field to determine the DUR Alert information related to the suspended claim.	Field	Number	13
NDC	National Drug Code that uniquely identifies a drug. It is comprised of a 5 byte numeric labeler code, a 4 byte numeric product code, and a 2 byte numeric package code.	Field	Number	11
NDC Available	Indicates if another NDC is available. If the alert which set is an alert that set against a drug claim in history, the NDC Available field shows Yes. By double clicking on Yes the NDC in history shows, otherwise a No is displayed.	Field	Character	3
NDC Description	The brand name of the drug associated with the corresponding NDC.	Field	Number	11
Other Pharmacy	Indicates whether the ProDUR warning is against a drug dispensed by the same or a different pharmacy as the current claim.	Field	Character	16
Other Prescriber	Indicates whether the ProDUR warning is against a drug prescribed by the same or a different physician as the current claim.	Field	Character	1
Provider ID	The identification number of the provider of service. This field is one of four possible search criteria to bring up a claim in suspense.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
RX Number	Prescription number of the claim in suspense. This field is one of four possible search criteria to bring up the claim.	Field	Number (Integer)	7
Search	Activates the search feature.	Button	N/A	0
Severity	This is the severity level of the alert which was set. If the alert is one which no severity level is supplied by First DataBank, the field is blank. 1 = Major, 2 = Moderate, 3 = Minor.	Field	Character	8

6.27.4 Suspended Claims Alert Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ICN	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
Dispensed Date	Field	91001	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	Date must be numeric.	Verify keying. Date must be numeric characters only (0-9).
Provider ID	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
Rx Number	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

6.27.5 Suspended Claims Alert Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Suspended Claims Alert Panel Accessibility

6.27.6.1 To Access the Suspended Claims Alert Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.

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Step	Action	Response
3	Click **Suspended Claims**.	Suspended Claims panel displays.

6.27.6.2 To Navigate on the Suspended Claims Alert Panel

Step	Action	Response
1	Enter valid data in the **ICN** field or the **Provider ID** AND **RX Number** fields (**Dispensed Date** field is optional). Enter a valid **Provider ID** or click [Search] and select from the Provider ID list.	
2	Click **Search**.	Suspended Claims that match the search criteria displays.
3	For further details, click 'YES' in the **NDC Available** field.	If the alert which set is an alert that set against a drug claim in history, the NDC Available field shows "Yes." Double click on "Yes' the NDC in history shows, otherwise a "No" is displayed.
4	Click **Current Claim ICN** or **History Claim ICN.**	When Current Claim ICN is clicked, the user will be taken to the Pharmacy Claim Information panel to view the claim that set the ProDUR Alert When History Claim ICN is clicked, the user will be taken to the Pharmacy Claim Information panel to view the claim that caused the ProDUR Alert..

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6.28 THERAPEUTIC CLASS LIST PANEL OVERVIEW

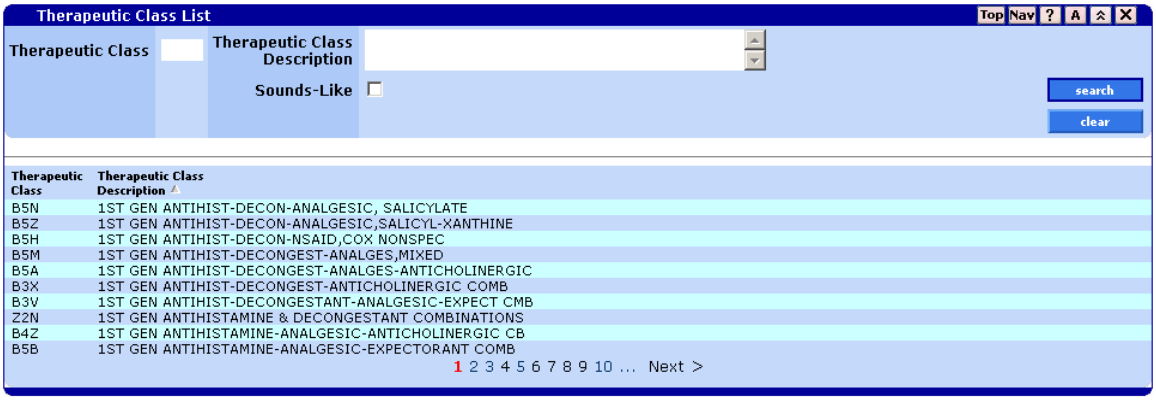
6.28.1 Therapeutic Class List Panel Narrative

The Therapeutic Class List panel displays all Therapeutic Class Code, specific codes and their descriptions. This panel is used to obtain therapeutic class codes and their descriptions.

This panel is for inquiry only.

Navigation Path: [Drug] – [ProDUR] - [Therapeutic Class List]

6.28.2 Therapeutic Class List Panel Layout



6.28.3 Therapeutic Class List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears user input from search fields.	Button	N/A	0
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description Field.	Field	Check Box	0
Therapeutic Class	Therapeutic Class Code, Specific (GC3, Alias HIC3). The most specific therapeutic class code offered by First DataBank.	Field	Character	3
Therapeutic Class Description	Description of the corresponding Therapeutic Class Code, Specific Code.	Field	Character	50

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6.28.4 Therapeutic Class List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Therapeutic Class	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.
Therapeutic Class Description	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

6.28.5 Therapeutic Class List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Therapeutic Class List Panel Accessibility

6.28.6.1 To Access the Therapeutic Class List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Therapeutic Class List**.	Therapeutic Class List panel displays.

6.28.6.2 To Navigate the Therapeutic Class List Panel

Step	Action	Response
1	Enter valid values in the **Therapeutic Class** or the **Therapeutic Class Description** field. If searching with Therapeutic Class Description, select the select **Sounds Like** to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The Therapeutic Class Code(s) and Description(s) for the search criteria entered display. If no search criteria is entered, all Therapeutic class codes currently on file display in numerical order.

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6.29 THERAPEUTIC DUPLICATION PANEL OVERVIEW

6.29.1 Therapeutic Duplication Panel Narrative

The Therapeutic Duplication panel is used to view and maintain Therapeutic Duplication alert criteria. Displayed on the panel are the Therapeutic Class Code and description, severity level and Therapeutic Class status.

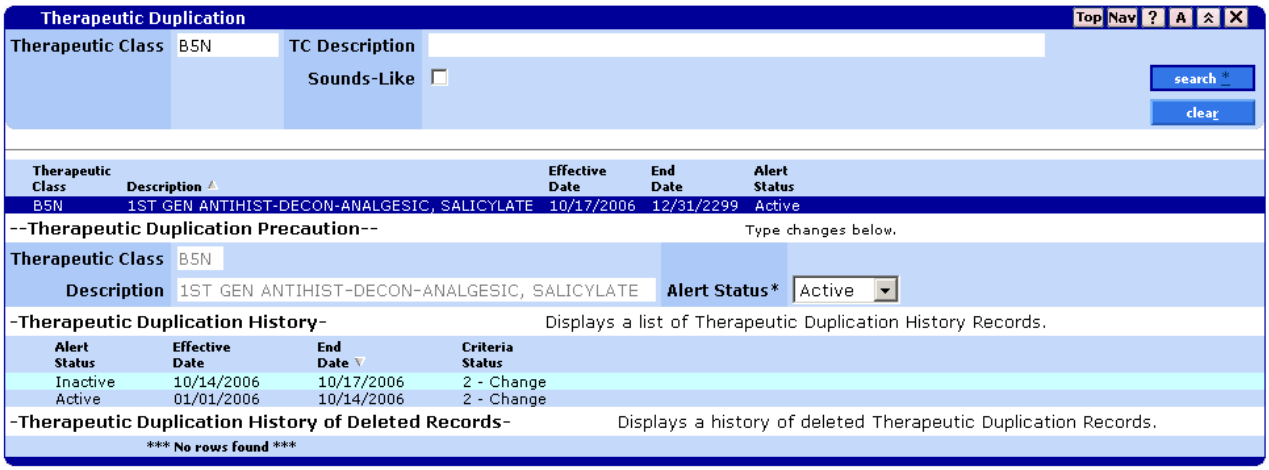
The Therapeutic Duplication panel has two additional panels associated with it, which include:

- Therapeutic Duplication History panel - This panel shows the history of all changes to records on this table. The user sees changes to only the selected Therapeutic Class.
- Therapeutic Duplication History of Deleted Records panel - This panel shows the history of all Therapeutic Classes deleted from this table by the User Interface. Information on this panel is generated by First DataBank deletions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Drug] – [ProDUR]- [Therapeutic Duplication]

6.29.2 Therapeutic Duplication Panel Layout



Note: Therapeutic Duplication History of Deleted Records are generated by First DataBank deletions. An image containing this information is unavailable.

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6.29.3 Therapeutic Duplication Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	Indicates the status of the criteria record within the alert - Active or Inactive indicating whether or not to use the corresponding criteria for editing claims.	Field	Drop Down List Box	1
Clear	Clears user input from search fields.	Button	N/A	0
Criteria Status Code + Description	Shows the action that was taken on the Therapeutic Duplication record to generate the record on the history panel. Valid values are: 1 = New 2 = Change 3 = Current 4 = Deleted	Field	Character	20
Effective Date	The start date of the status or criteria.	Field	Date (MM/DD/CCYY)	8
End Date	The date the status or criteria is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Search	Activates the search feature.	Button	N/A	0
Sounds-Like	Used with the 'search' feature. When the user selects this check box, the query searches for partial matches of data entered into the Description field.	Field	Check Box	0
Therapeutic Class	Therapeutic Class Code (GC3, Alias HIC3); The most specific therapeutic class code offered by First DataBank.	Field	Character	3
(TC) Description	Therapeutic Class Code description.	Field	Character	50

6.29.4 Therapeutic Duplication Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Therapeutic Class Description	Field	91024	No Match Found.	Return to field and enter correct data.
	Field	91087	Must be at least 3 characters.	Return to field and enter correct data.
Therapeutic Class	Field	91024	No Match Found.	Return to field and enter data.
	Field	91056	Please enter at least one search field.	Return to field and enter data.

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6.29.5 Therapeutic Duplication Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Therapeutic Duplication Panel Accessibility

6.29.6.1 To Access the Therapeutic Duplication Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Therapeutic Duplication**.	Therapeutic Duplication panel displays.

6.29.6.2 To Update the Therapeutic Duplication Panel

Step	Action	Response
1	Enter valid values in the **Therapeutic Class** or **TC Description** fields. If searching with **Description**, select **Sounds Like** to further expand the search condition.	
2	Enter search criteria and click **Search**, or click **Search**.	The Therapeutic Duplication search results panel displays. If no search criterion is entered, all Therapeutic Class codes, currently on file, display in numerical order.
3	Select the row to be updated.	
4	Make the desired update to the **Alert Status**.	
5	Click **Save**.	Therapeutic Duplication information is saved.

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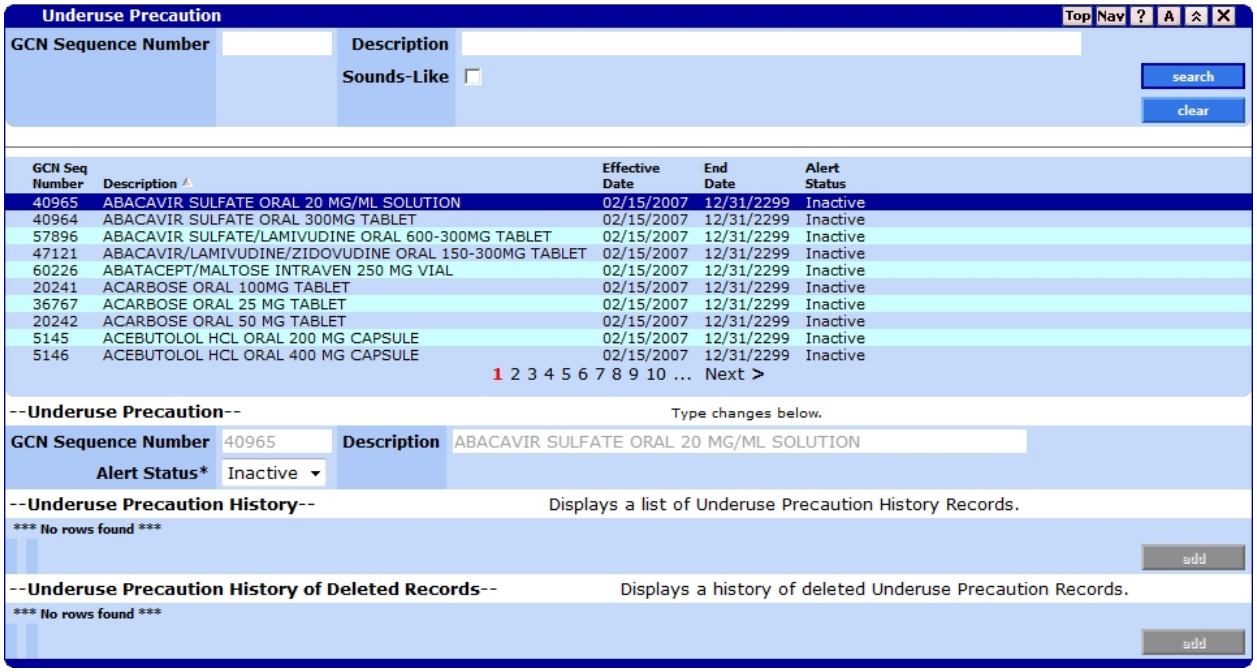
6.30 UNDERUSE PRECAUTION PANEL OVERVIEW

6.30.1 Underuse Precaution Panel Narrative

The ProDUR Underuse Precaution window is used to view and maintain Underuse precaution alert criteria. Information displayed includes the drug generic code and description, the severity level, and the drug generic code status.

Navigation Path: [Drug - ProDUR] - [Underuse Precaution]

6.30.2 Underuse Precaution Panel Layout



6.30.3 Underuse Precaution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Status	The status of the GCN Sequence Number within the alert. Valid values include: active or inactive.	Field	Character	8
Alert Status [Panel]	The status of the GCN Sequence Number within the alert. It can be either active or inactive.	Field	Drop Down List Box	0
Description	Generic Code Number Sequence description.	Field	Character	60
Effective Date	The date the criterion becomes effective.	Field	Date (MM/DD /CCYY)	8
End Date	The date when the criteria no longer applies.	Field	Date (MM/DD /CCYY)	8
GCN Seq Number	The Generic Code Number Sequence.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
GCN Sequence Number	The Generic Code Number Sequence is a unique number representing a generic formulation.	Field	Number (Integer)	9
Sounds-Like	When the user selects this check box, the query will search for partial matches of data entered into the Description field.	Field	Check Box	0

6.30.4 Underuse Precaution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.30.5 Underuse Precaution Panel Extra Features

Field	Field Type
No extra features on this panel.	

6.30.6 Underuse Precaution Panel Accessibility

6.30.6.1 To Access the Underuse Precaution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Drug** and click **ProDUR**.	ProDUR Maintenance panel displays.
3	Click **Underuse Precaution**.	Underuse Precaution panel displays.

6.30.6.2 To Search the Underuse Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Underuse Precaution search results are displayed.

6.30.6.3 To Modify the Underuse Precaution Panel

Step	Action	Response
1	Enter valid values in the **Search criteria** fields. If searching with **Description**, select **Sounds-Like** to further expand the search condition.	
2	Click the **Search** button.	The Underuse Precaution search results are displayed.

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Step	Action	Response
3	Click the desired row to edit.	Underuse Precaution data panel, Underuse Precaution History and Underuse Precaution History of Deleted Records appear.
4	Modify the values accordingly.	
5	Click **Save.**	The Underuse Precaution information is saved.

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7 DUR REPORTS

The DUR User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 DUR-0001-M -- HIGH DOSE UPDATE REPORT

7.1.1 DUR-0001-M -- High Dose Update Report Narrative

The High Dose Update report lists the updates to the ProDUR High Dose Criteria table from the National ProDUR Criteria Update File. This report is produced monthly.

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7.1.2 DUR-0001-M -- High Dose Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0001-M                                    ALABAMA MEDICAID AGENCY                        Run Date: MM/DD/CCYY

Process : DURJM180                                MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS

Location: DURP180M                                      HIGH DOSING UPDATE REPORT                          Page:       9999

                                                  REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY

TRANSACTION  GCN      DESCRIPTION                                     DOSE QTY   &    UNIT    UNIT QTY         UNIT QTY  &    FORM  A
             SEQNO                                                                           (STATE)         (FDB)

    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X

                                                        * * END OF REPORT * *
                                                     * * NO DATA THIS REPORT * *
```


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7.1.3 DUR-0001-M -- High Dose Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
Dose QTY	Maximum adult daily dose for the Generic Code Number Sequence Number. The maximum daily dose units are usually expressed as metric strength units. These units may be gm. (gram), mg. (milligram), mcg. (microgram), meq. (milliequivalent), etc.	12	Number (Decimal)
Dose Unit	Dose unit defines the unit of use which must be used in conjunction with the Dose Quantity.	3	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character
Unit Form	Unit form defines the unit of use form which must be used in conjunction with the maximum daily units quantity.	2	Character
Unit QTY (State)	Minimum daily units established by the State. The minimum daily units value provides the quantitative amount for the minimum adult daily dose, expressed in units of use.	12	Number (Decimal)
Unit QTY (FDB)	This is the minimum daily units established by First DataBank. The minimum daily units value provides the quantitative amount for the minimum adult daily dose, expressed in units of use.	12	Number (Decimal)

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7.2 DUR-0002-M -- LOW DOSE UPDATE REPORT

7.2.1 DUR-0002-M -- Low Dose Update Report Narrative

The Low Dose Update report lists the updates to the ProDUR Low Dose Criteria table from the National ProDUR Criteria Update File. This report is produced monthly.

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7.2.2 DUR-0002-M -- Low Dose Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0002-M                                ALABAMA MEDICAID AGENCY                        Run Date: MM/DD/CCYY

Process : DURJM170                            MEDICAID MANAGEMENT INFORMATION SYSTEM              Run Time:   HH:MM:SS

Location: DURP170M                                   LOW DOSING UPDATE REPORT                         Page:       9999

                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


 TRANSACTION GCN      DESCRIPTION                                        DOSE QTY   &   UNIT    UNIT QTY         UNIT QTY  &    FORM  A
             SEQNO                                                                             (STATE)          (FDB)


    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X
    XXXXXX  999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999.999999    XXX   999999.999999    999999.999999     XX   X

                                                          * END OF REPORT * *
                                                        * * NO DATA THIS RUN * *
```


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7.2.3 DUR-0002-M -- Low Dose Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
Dose QTY	Minimum daily dose for the Generic Code Number Sequence Number. The minimum daily dose units are usually expressed as metric strength units. These units can be gm. (gram), mg. (milligram), mcg. (microgram), meq. (milliequivalent), etc.	12	Number (Decimal)
Dose Unit	Dose form defines the unit of use form which must be used in conjunction with the minimum daily dose quantity.	3	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character
Unit Form	Unit form defines the unit of use form which must be used in conjunction with the minimum daily units quantity.	2	Character
Unit QTY (State)	Minimum daily units established by the State. The minimum daily units value provides the quantitative amount for the minimum adult daily dose, expressed in units of use.	12	Number (Decimal)
Unit QTY (FDB)	This is the minimum daily units established by First DataBank. The minimum daily units value provides the quantitative amount for the minimum adult daily dose, expressed in units of use.	12	Character

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7.3 DUR-0003-M -- DRUG PREGNANCY UPDATE REPORT

7.3.1 DUR-0003-M -- Drug Pregnancy Update Report Narrative

The Drug Pregnancy Update report lists Drug Generic Code Number Sequence Numbers and their descriptions updated, added or deleted from the ProDUR Drug Pregnancy Alert criteria. These updates are received from the National ProDUR Criteria Update File. This report is produced monthly.

7.3.2 DUR-0003-M -- Drug Pregnancy Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0003-M                                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : DURJM160                               MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: DURP160M                                    DRUG PREGNANCY UPDATE REPORT                           Page:       9999
                                                       REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY

      TRANSACTION        GCN          DESCRIPTION                                                   S              A
                                     SEQNO
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X
           XXXXXX        999999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X              X


* * END OF REPORT * *

* * NO DATA THIS REPORT * *
```


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7.3.3 DUR-0003-M -- Drug Pregnancy Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
S	Severity level of 1 (major), 2 (moderate) or 3 (minor). These severity levels are assigned as follows from the supplied FDB pregnancy category/severity level field: 1 = FDB severity level of 1 or Federal Drug Agency (FDA) pregnancy category of X or D 2 = FDB severity level of 2 or FDA pregnancy category of C 3 = FDA pregnancy category of A or B.	1	Character
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.4 DUR-0004-M -- ADVERSE DRUG INTERACTION CODE UPDATE REPORT

7.4.1 DUR-0004-M -- Adverse Drug Interaction Code Update Report Narrative

The Adverse Drug Interaction Code Update report lists the updates to the ProDUR ADI (Adverse Drug Interaction) Drug to Drug Interactions Criteria table from the National ProDUR Criteria Update File. This report is produced monthly.

7.4.2 DUR-0004-M -- Adverse Drug Interaction Code Update Report Layout

This section presents the detail of the report.

```
Report : DUR-0004-M                          ALABAMA MEDICAID AGENCY                        Run Date:  MM/DD/CCYY
 Process : DURJM120                     MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:    HH:MM:SS
 Location: DURP120M                   ADVERSE DRUG INTERACTION CODE UPDATE REPORT          Page:        9999
                                     REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY


TRANSACTION         ADI CODE         DESCRIPTION                                                S     A

     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X
     XXXXXX          99999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X


                                                  * * END OF REPORT * *
                                               * * NO DATA THIS REPORT * *
```


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7.4.3 DUR-0004-M -- Adverse Drug Interaction Code Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
ADI Code	The Adverse Drug Interaction Code represents any combination of drugs which negatively interact with each other.	5	Number (Integer)
Description	Describes the corresponding Adverse Drug Interaction Code.	55	Character
S	Severity level of (1) major, (2) moderate or (3) minor is supplied by First DataBank. All severity levels may appear on the report.	1	Character
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.5 DUR-0005-M -- DRUG AGE UPDATE REPORT

7.5.1 DUR-0005-M -- Drug Age Update Report Narrative

The Drug Age Update report lists updates to the ProDUR Drug Geriatric and Pediatric criteria tables. These updates are received from the National ProDUR Criteria Update File. This report is produced monthly.

7.5.2 DUR-0005-M -- Drug Age Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0005-M                                interChange MMIS                                          Run Date: MM/DD/CCYY
Process : DURJM140                        MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: DURP140M                                 DRUG AGE UPDATE REPORT                                   Page:     9999
                                             PERIOD: MM/DD/CCYY - MM/DD/CCYY

TRANSACTION      GCN        DESCRIPTION                                                    -- AGE IN DAYS --          S   A
                 SEQNO                                                                     MINIMUM    MAXIMUM

     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X
     XXXXXX      999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999       9999            X   X

                                                   ** END OF REPORT **

                                                 ** NO DATA THIS REPort **
```


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7.5.3 DUR-0005-M -- Drug Age Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
Maximum (Age in Days)	Maximum age that a recipient may be to receive a prescription for a particular drug. This age is expressed in days so that elderly recipients may be effectively protected from an inappropriate prescription.	4	Number (Integer)
Minimum (Age in Days)	Minimum age a recipient must be to receive a prescription for a particular drug. This age is expressed in days so that very young recipients, such as babies, may be effectively protected from an inappropriate prescription.	4	Number (Integer)
S	Severity level of (1) major, (2) moderate, or (3) minor is supplied by First DataBank. All severity codes may appear on the report.	1	Number (Integer)
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.6 DUR-0006-M -- UNDER UTILIZATION UPDATE REPORT

7.6.1 DUR-0006-M -- Under Utilization Update Report Narrative

The Under Utilization Update report lists the updates to the ProDUR Drug Underuse Criteria table from the National ProDUR Criteria Update file. This report is produced monthly.

7.6.2 DUR-0006-M -- Under Utilization Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0006-M                                ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : DURJM190                        MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: DURP190M                            UNDER UTILIZATION UPDATE REPORT                          Page:       9999
                                                   PERIOD: MM/DD/CCYY - MM/DD/CCYY


                   TRANSACTION        GCN                              DESCRIPTION                                    A
                                     SEQNO

         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
         XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  X
```

```
                                                   * * END OF REPORT * *

                                                 * * NO DATA THIS REPORT * *
```


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7.6.3 DUR-0006-M -- Under Utilization Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.7 DUR-0007-M -- OVER UTILIZATION UPDATE REPORT

7.7.1 DUR-0007-M -- Over Utilization Update Report Narrative

The Over Utilization Update report lists updates to the ProDUR Drug Overuse Criteria table from the National ProDUR Criteria Update file. This report is produced monthly.

7.7.2 DUR-0007-M -- Over Utilization Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0007-M                                    ALABAMA MEDICAID AGENCY                        Run Date: MM/DD/CCYY
Process : DURJM111                                MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS
Location: DURP111M                                     OVER UTILIZATION UPDATE REPORT                      Page:       9999
                                                            PERIOD: MM/DD/CCYY - MM/DD/CCYY


                  TRANSACTION          GCN                              DESCRIPTION                                          A
                                      SEQNO

          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X
          XXXXXX          999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                      X


* * END OF REPORT * *

* * NO DATA THIS REPORT * *
```


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7.7.3 DUR-0007-M -- Over Utilization Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	55	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.8 DUR-0008-M -- THERAPEUTIC DUPLICATION UPDATE REPORT

7.8.1 DUR-0008-M -- Therapeutic Duplication Update Report Narrative

The Therapeutic Duplication Update Report lists additions, updates and deletions to the Therapeutic Duplication criteria table from the National ProDUR Criteria Update file. This report is produced monthly.

7.8.2 DUR-0008-M -- Therapeutic Duplication Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0008-M                                ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : DURJM100                            MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: DURP100M                             THERAPEUTIC DUPLICATION UPDATE REPORT                     Page:       9999
                                                     REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


                  TRANSACTION     THERAPEUTIC CLASS                     DESCRIPTION                                    A

          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X
          XXXXXX           XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     X



* * END OF REPORT * *

* * NO DATA THIS REPORT * *
```


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7.8.3 DUR-0008-M -- Therapeutic Duplication Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Description	Describes the corresponding Therapeutic Class Code.	55	Character
Therapeutic Class	Therapeutic Class Code, Specific (GC3, Alias HIC3). The most specific therapeutic class code offered by First DataBank.	3	Character
Transaction	Shows whether the data was added, updated or deleted from the files.	6	Character

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7.9 DUR-0009-M -- CONTRAINDICATED DISEASE UPDATE REPORT

7.9.1 DUR-0009-M -- Contraindicated Disease Update Report Narrative

The Contraindicated Disease Update report displays the updates to the Drug/Disease alert criteria. The updates include additions, updates and deletions to the current criteria. The updates are received through the National ProDUR Criteria Update file from First DataBank. This report is produced monthly.

7.9.2 DUR-0009-M -- Contraindicated Disease Update Report Layout

This section presents the detail of the report.

```
Report  : DUR-0009-M                                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : DURJM060                                MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: DRDXUPDT                                CONTRAINDICATED DISEASE UPDATE REPORT                      Page:       9999
                                                     REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY


        TRANSACTION    GCN     DESCRIPTION                                  -----------------CONTRAINDICATED -----------------------  S A
                      SEQNO                                              DISEASE CD      DISEASE DESCRIPTION

     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X
     XXXXXX    999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  X X



* * END OF REPORT * *

* * NO DATA THIS REPORT * *
```


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7.9.3 DUR-0009-M -- Contraindicated Disease Update Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
A	Status of the criteria update. Valid values are: Y for active or N for inactive.	1	Character
Contraindicated Disease CD	A 9-digit First DataBank Disease Code (FDBDX).	9	Character
Contraindicated Disease Description	Describes the corresponding First DataBank Disease Code (FDBDX).	44	Character
Description	Describes the corresponding GSN. The first field is the generic drug name, the next is the route description, next is the drug strength description and last is the dosage form. These fields are each separated by a space, for a total of 3 spaces.	43	Character
GCN SEQNO	The Generic Code Sequence Number (GSN) is a unique number representing the generic formulation of a drug. The GSN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GSN is the same across manufacturers.	6	Number (Integer)
S	Severity level of (1) major, (2) moderate, or (3) minor is supplied by First DataBank. All severity codes may appear on the report.	1	Character
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.10 DUR-0010-M -- DIAGNOSIS TO FDBDX DISEASE CROSS REFERENCE UPDATES REPORT

7.10.1 DUR-0010-M -- Diagnosis to FDBDX Disease Cross Reference Updates Report Narrative

The Diagnosis to FDBDX Disease Cross Reference Update report displays all of the updates to the ICD Diagnosis to FDBDX (FDB Disease Code) cross-reference table received from the monthly National ProDUR Update file from First DataBank. The report lists all additions, deletions and changes to the cross-reference table. This report is produced monthly.

7.10.2 DUR-0010-M -- Diagnosis to FDBDX Disease Cross Reference Updates Report Layout

This section presents the detail of the report.

```
Report  : DUR-0010-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : DURJM070                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: DURP070M              DIAGNOSIS TO FDBDX DISEASE CROSS REFERENCE UPDATE REPORT                   Page:       9999
                                         REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY

TRANSACTION    ------------------- ICD DIAGNOSIS ----------------------    ---------------------- FDBDX DISEASE ----------------------
               ICD  CODE       DESCRIPTION                                CODE         DESCRIPTION

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

     XXXXXX     X   XXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  ** END OF REPORT **


                                             ** NO DATA THIS REPORT **
```


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7.10.3 DUR-0010-M -- Diagnosis to FDBDX Disease Cross Reference Updates Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
FDBDX Disease Code	First DataBank Disease Code being associated with the International Classification of Diseases (ICD) diagnosis.	9	Character
FDBDX Disease Description	Describes the corresponding First DataBank Disease Code.	45	Character
ICD Diagnosis Code	International Classification of Diseases (ICD) diagnosis code that was added, updated, or deleted from the cross-reference table.	7	Character
ICD Diagnosis Description	Describes the corresponding International Classification of Diseases (ICD) diagnosis code.	39	Character
ICD Diagnosis Version	Code to identify the Diagnosis Code as ICD-9 or ICD-10. Values are ‘9’ (ICD-9) and ‘0’ (ICD-10).	1	Character
Transaction	Shows whether the data was added, updated, or deleted from the files.	6	Character

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7.11 DUR-0011-A -- HIGH LEVEL SUMMARY BY DUR ALERT ANNUAL REPORT

7.11.1 DUR-0011-A -- High Level Summary by DUR Alert Annual Report Narrative

The High Level Summary by DUR Alert report lists the number of alerts, overrides, non-responses and cancellations for each DUR screen. It also reports the percentage of all alerts each screen generates. This report is produced annually.

7.11.2 DUR-0011-A -- High Level Summary by DUR Alert Annual Report Layout

This section presents the detail of the report.

```
Report  : DUR-0011-A                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : DURJA205                        MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS Location:
DUR0011A                                HIGH LEVEL SUMMARY BY DUR ALERT                          Page:       9999
                                                  Period: MM/DD/CCYY  - MM/DD/CCYY


     DUR Alert        #Alerts            #Overrides          #Cancellations        #Non-Responses       %of All DUR Alerts

         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999              999.9

* * END OF REPORT * *


* * NO DATA THIS REPORT * *
```


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7.11.3 DUR-0011-A -- High Level Summary by DUR Alert Annual Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
# Alerts	Number of claims that created alerts for each DUR screen during the year.	12	Number (Integer)
# Cancellations	Number of claims canceled based on outcome codes submitted with the response claim.	12	Number (Integer)
# Non-Responses	Number of claims not responded to and auto-denied after three days.	12	Number (Integer)
# Overrides	Number of claims overridden based on outcome codes submitted with the response claim.	12	Number (Integer)
% of All DUR Alerts	Percentage of all alerts generated by type. This calculation is done by adding all DUR alerts together and dividing it by the number of alerts.	4	Number (Decimal)
DUR Alert	Two-byte National Council for Prescription Drug Plan (NCPDP) Conflict Code associated with each alert. This field is used for sorting this report.	2	Character

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7.12 DUR-0011-M -- HIGH LEVEL SUMMARY BY DUR ALERT REPORT

7.12.1 DUR-0011-M -- High Level Summary by DUR Alert Report Narrative

The High Level Summary by DUR Alert report lists the number of alerts, overrides, non-responses and cancellations for each DUR screen. It also reports the percentage of all alerts each screen generates.

This report is produced on the 3rd of each Month.

7.12.2 DUR-0011-M -- High Level Summary by DUR Alert Report Layout

This section presents the detail of the report.

```
Report  : DUR-0011-M                                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : DURJA215                              MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: DUR0011M                                  HIGH LEVEL SUMMARY BY DUR ALERT                          Page:       9999
           Period: MM/DD/CCYY  - MM/DD/CCYY




        DUR Alert        #Alerts           #Overrides          #Cancellations        #Non-Responses       %of All DUR Alerts

         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9
         XX          999,999,999,999    999,999,999,999       999,999,999,999       999,999,999,999             999.9





* * END OF REPORT * *

* * NO DATA THIS REPORT * *
```


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7.12.3 DUR-0011-M -- High Level Summary by DUR Alert Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
# Alerts	Number of claims that created alerts for each DUR screen during the month.	12	Number (Integer)
# Cancellations	Number of claims cancelled based on outcome codes submitted with the response claim.	12	Number (Integer)
# Non-Responses	Number of claims not responded to and auto-denied after three days.	12	Number (Integer)
# Overrides	Number of claims overridden based on outcome codes submitted with the response claim.	12	Number (Integer)
% of All DUR Alerts	Percentage of all alerts generated by type. This calculation is done by adding all DUR alerts together and dividing it by the number of alerts.	4	Number (Decimal)
DUR Alert	Two-byte National Council for Prescription Drug Programs (NCPDP) Conflict Code associated with each alert. This field is used for sorting this report.	2	Character

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7.13 DUR-0012-A -- SUMMARY BY DRUG INVOLVED IN DUR ALERTS ANNUAL REPORT

7.13.1 DUR-0012-A -- Summary by Drug Involved in DUR Alerts Annual Report Narrative

The Summary by Drug Involved in DUR Alerts report displays the most frequently involved Therapeutic Category and Hierarchical Ingredient in each DUR screen. This report is produced annually.

7.13.2 DUR-0012-A -- Summary by Drug Involved in DUR Alerts Annual Report Layout

This section presents the detail of the report.

```
Report  : DUR-0012-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : DURJA235                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            Time:   HH:MM:SS
Location: DUR0012A                    Summary Data by Drug Involved in DUR Alerts                       Page:       999.9
                                           PERIOD: MM/DD/CCYY  -  MM/DD/CCYY
DUR    Therapeutic Category/                                        # Cancellations   # Claims    % Alerts    % Cancels

Alert  Drug(s) (Hierarchical Ingredient)          # Alerts    # Overrides   & Non-Responses    Screened    /Total Rx   /Total Rx

 XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999   999,999,999     999,999,999     999,999,999    999.9      999.9

                                                                  * * END OF REPORT * *

                                                                 * * NO DATA THIS RUN * *
```


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7.13.3 DUR-0012-A -- Summary by Drug Involved in DUR Alerts Annual Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
# Alerts	Number of alerts generated for the therapeutic category, with a breakdown of the number of alerts generated for each individual drug in the therapeutic category.	9	Number (Integer)
# Cancellations & Non-Responses	Number of claims canceled or not responded to because of the alert for the therapeutic category, with a breakdown of the number of claims canceled or not responded to for each individual drug in the therapeutic category.	9	Number (Integer)
# Claims Screened	Number of POS claims processed that contained drugs in the therapeutic category, with a breakdown of the number of claims processed for each individual drug in the therapeutic category.	9	Number (Integer)
# Overrides	Number of alerts overridden for the therapeutic category, with a breakdown of the number of alerts overridden for each individual drug in the therapeutic category.	9	Number (Integer)
% Alerts/Total RX	Percentage of claims that set alerts for the therapeutic category and individual drugs in the therapeutic category.	5	Number (Decimal)
% Cancels/Total RX	Percentage of claims canceled because of the therapeutic category and individual drugs in the therapeutic category.	5	Number (Decimal)
DUR Alert	Two-byte NCPDP conflict code associated with each alert. This field is used for sorting this report.	2	Character
Therapeutic Category/Drug(s) (Hierarchical Ingredient)	Therapeutic category of drugs, such as Penicillin, and the individual drugs within the category, such as Ampicillin. Totals are provided for the Therapeutic Category as a whole, with a breakdown of the totals for each individual drug in the Therapeutic Category.	42	Character

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1.2 DUR-0012-M -- SUMMARY BY DRUG INVOLVED IN DUR ALERTS MONTHLY REPORT

7.14 DUR-0012-M -- SUMMARY BY DRUG INVOLVED IN DUR ALERTS MONTHLY REPORT NARRATIVE

The Summary by Drug Involved in DUR Alerts report displays the most frequently involved Therapeutic Category and Hierarchical Ingredient in each DUR screen.

This report is produced on the 3rd of each Month.

7.14.1 DUR-0012-M -- Summary by Drug Involved in DUR Alerts Monthly Report Layout

This section presents the detail of the report.

```
Report  : DUR-0012-M                                ALABAMA MEDICAID AGENCY                          Run Date:   MM/DD/CCYY
Process : DURJA235                             MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:     HH:MM:SS
       Location: DUR0012M                        SUMMARY DATA BY DRUG INVOLVED IN DUR ALERTS                    Page:         9999
             Period: MM/DD/CCYY  - MM/DD/CCYY


     DUR    Therapeutic Category/                                                # Cancellations     #Claims       % Alerts     % Cancels
    Alert   Drug(s) (Hierarchical Ingredient)           # Alerts     # Overrides    & Non-Responses     Screened      /Total Rx    /Total Rx

XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9


XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999    999,999,999      999,999,999     999,999,999       999.9        999.9



* * END OF REPORT * *
* * NO DATA THIS REPORT * *
```


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7.14.2 DUR-0012-M -- Summary by Drug Involved in DUR Alerts Monthly Report Field Descriptions

This section describes, in detail, the characteristics and fields of the report.

Field	Description	Length	Data Type
# Alerts	Number of alerts generated for the therapeutic category, with a breakdown of the number of alerts generated for each individual drug in the therapeutic category.	9	Number (Integer)
# Cancellations & Non-Responses	Number of claims canceled or not responded to because of the alert for the therapeutic category, with a breakdown of the number of claims canceled or not responded to for each individual drug in the therapeutic category.	9	Number (Integer)
# Claims Screened	Number of POS claims processed that contained drugs in the therapeutic category, with a breakdown of the number of claims processed for each individual drug in the therapeutic category.	9	Number (Integer)
% Alerts/Total RX	Percentage of claims that set alerts for the therapeutic category and individual drugs in the therapeutic category.	5	Number (Decimal)
% Cancels/Total RX	Percentage of claims canceled because of the therapeutic category and individual drugs in the therapeutic category.	5	Number (Decimal)
# Overrides	Number of claims overridden based on outcome codes submitted with the response claim.	9	Number (Integer)
DUR Alert	Two-byte National Council for Prescription Drug Plan (NCPDP) Conflict Code associated with each alert. This field is used for sorting this report.	2	Character
Therapeutic Category/Drug(s) (Hierarchical Ingredient)	Therapeutic Category of drugs, such as Penicillin, and the individual drugs within the category, such as Ampicillin. Totals are provided for the Therapeutic Category as a whole, with a breakdown of the totals for each individual drug in the Therapeutic Category.	43	Character

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AMMIS EPSDT User Manual

Date Modified: 04/15/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
				Update 4.3.2 Logging off the AMMIS
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04/15/2018	6.0		General Updates	Produced new screen shots for sections 5.3.2, 5.3.4, 6.2.2, 6.4.2, and 6.6.2 to redact PHI.

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 EPSDT INTRODUCTION

2.1 EPSDT USER MANUAL OVERVIEW

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) functional area.

This manual covers the following:

- EPSDT Overview
- EPSDT Getting Started
- System Wide Common Terminology and Layouts
- EPSDT Panels
- EPSDT Reports

2.2 EPSDT USER MANUAL OBJECTIVE

The objective of the AMMIS EPSDT User Manual is to provide system users with detailed descriptions of the online system, including panel and report field descriptions, panel functionality descriptions and graphical representations of panels and report layouts.

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3 EPSDT OVERVIEW

3.1 INTRODUCTION TO EPSDT

The EPSDT processing function serves as the state's mechanism to enroll, adjudicate, identify, and track EPSDT services, referrals and costs to eligible recipients. Medicaid-eligible children under the age of 21 are eligible for EPSDT services. The state does not require Medicaid-eligible children to be formally enrolled in the EPSDT program. The EPSDT processing function supports the state's goals of:

- Providing medical assistance to recipients under the age of 21 with a continuing system of health screenings and treatment services to permit early detection of potentially chronic or disabling health conditions and referrals as medically necessary
- Encouraging regular health care for recipients under the age of 21 to reduce the occurrence of more serious and costly health problems
- Maximizing federal funds for the provision of healthcare to eligible recipients under the age of 21
- EPSDT-eligible children are allowed to receive services not always available to the general medical assistance population. EPSDT screening and treatment services are submitted on the Centers for Medicare and Medicaid Services (CMS)-1500, the Universal Billing (UB)-04, dental claim form, and managed care plan encounters using special state assigned procedure codes, revenue codes, or Current Dental Terminology (CDT) codes. The primary objectives of the automated EPSDT function of the AMMIS are to:
    - Maintain identification of all individuals eligible for EPSDT services
    - Provide paid claim records data to the state for EPSDT paid services
    - Provide reports for tracking and monitoring purposes
    - Meet federal and state reporting requirements (CMS-416).

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4 EPSDT GETTING STARTED

4.1 OVERVIEW

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 SYSTEM SECURITY

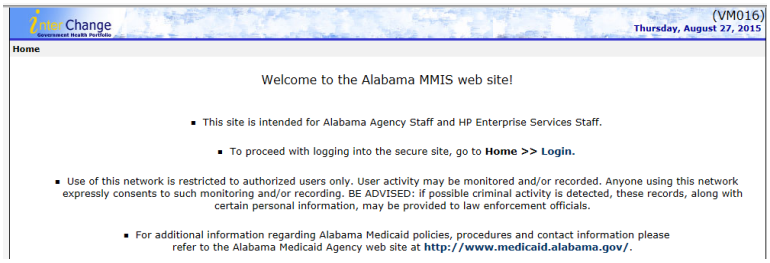
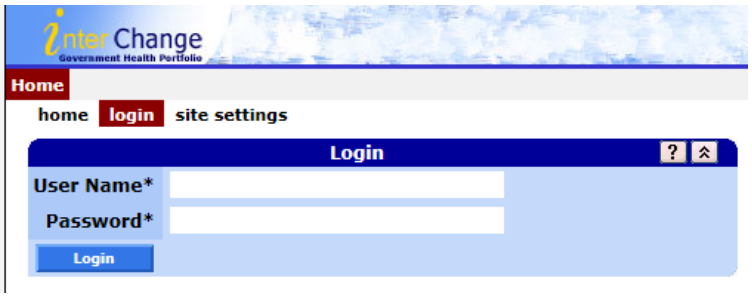
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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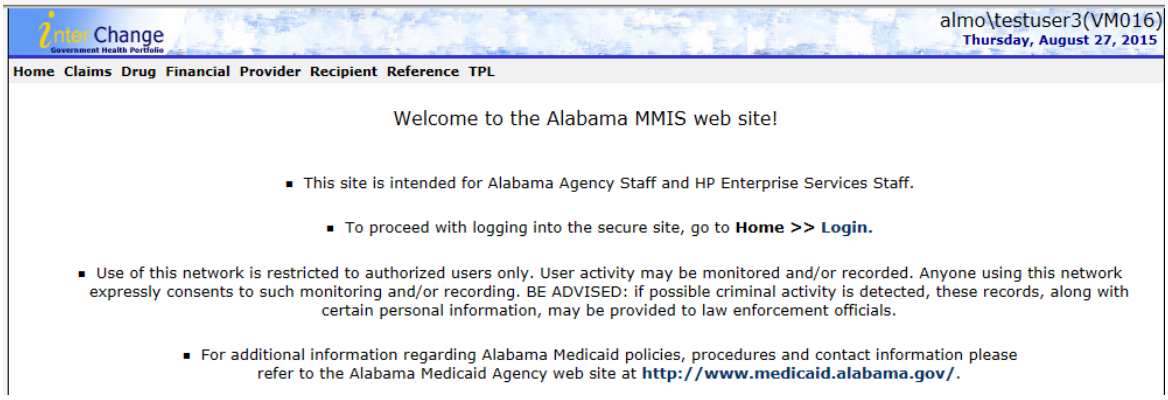
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.1 SCREEN DISPLAY FEATURES

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.1.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

4.2 CHANGING PASSWORDS

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

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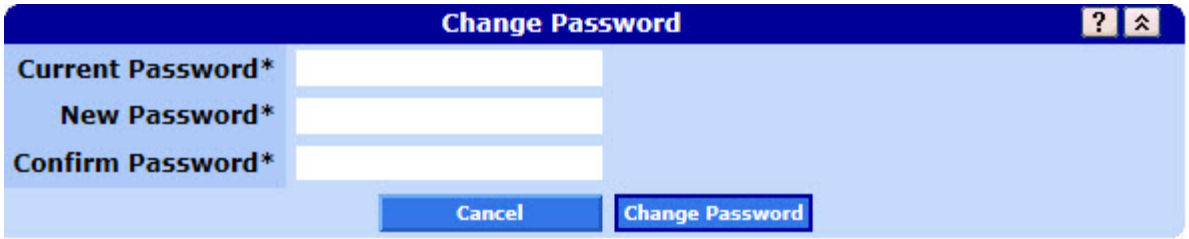

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact the Assistant MMIS Coordinator.

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team recipients, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

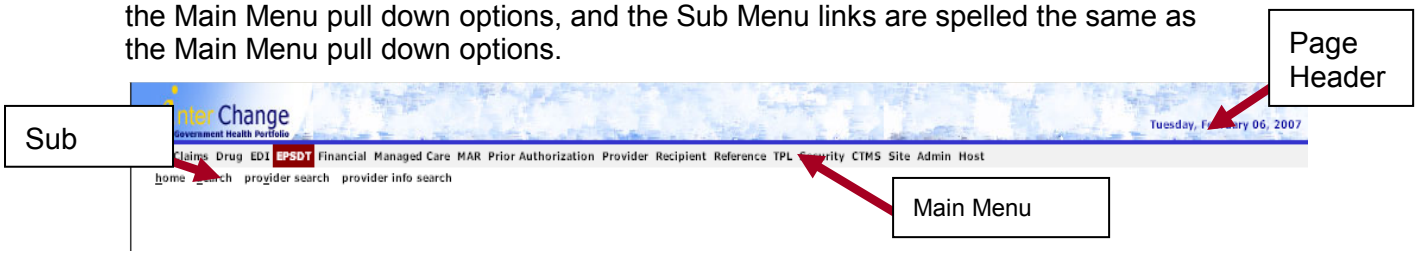
- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt +shortcut key)
- Main Menu bar
- Panel
- Mini Search panel
- Hot Link
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the Electronic Data System (EDS) copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



If a user attempts to add, update or delete information within a page the system prompts the user to “Save” or “Cancel” their changes via a pop-up window message prior to navigating away from the page. When the system generates the message, the detail panel is locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.

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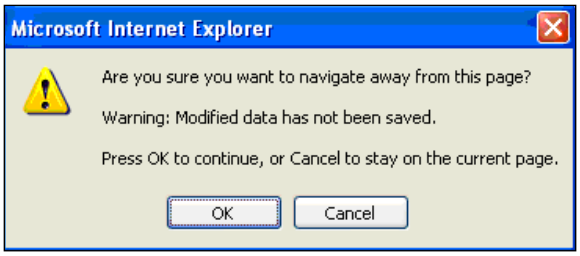
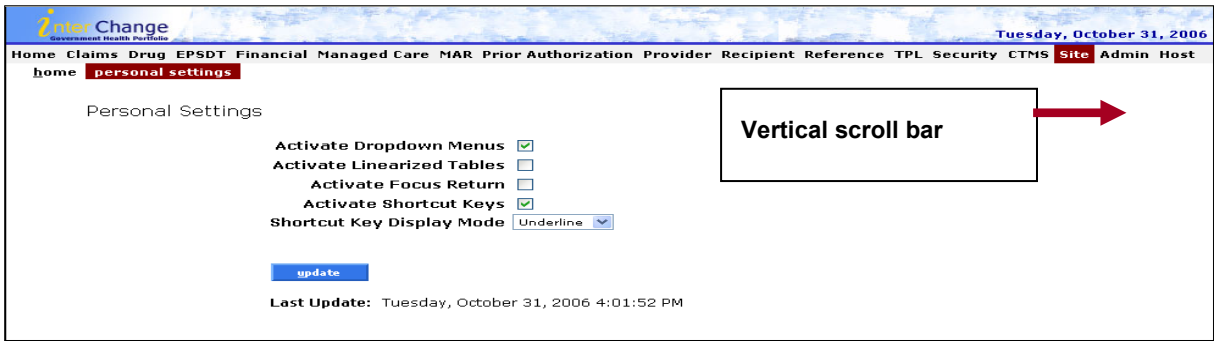


5.2 SHORTCUT KEYS

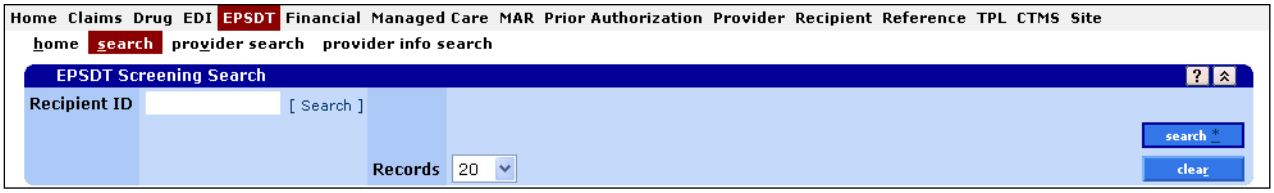
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated panel.

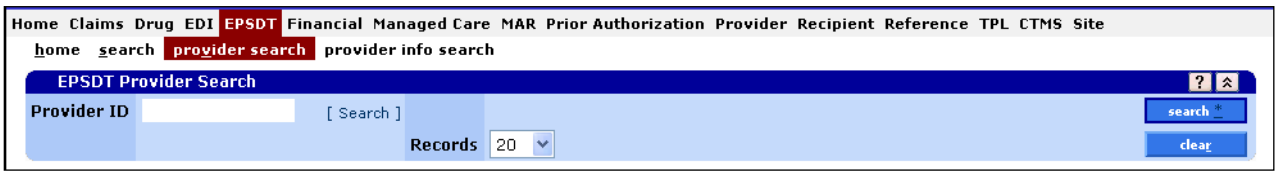
To activate the shortcut key, click on the Site link, select Personal Settings, check "Activate Shortcut Keys" and click the blue "Update" button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the EPSDT Sub Menu, the user can use the shortcut keys to quickly navigate from the EPSDT Search panel to the EPSDT Provider Search panel by using the following shortcut key combination: (Ctrl + Alt + V) since the letter "V" is found within the horizontal bars on the Sub Menu provider search link.





5.3 SEARCH OPTIONS

There are several search options available within interChange.

5.3.1 Search Panels

The AMMIS contains two types of search panels: Search and Advanced Search. An example of the EPSDT Screening Search panel with the Search button displaying is shown below:

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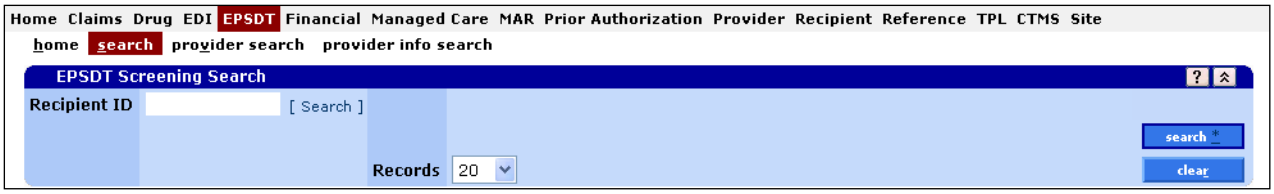
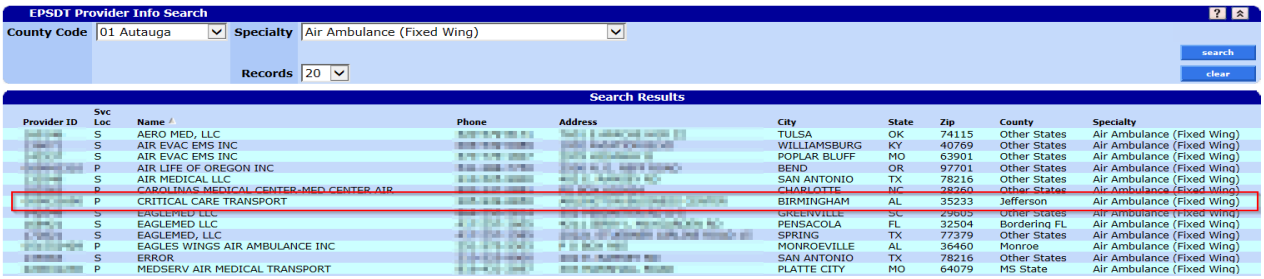


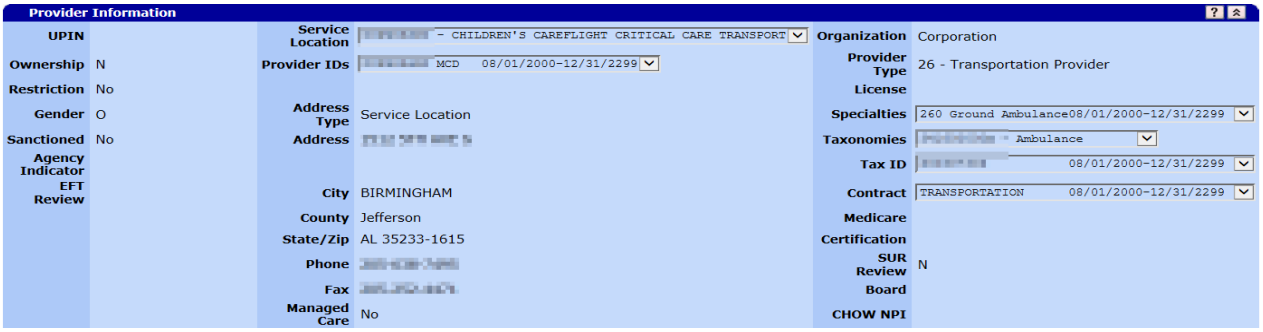
Note: The Advanced Search button functionality does not exist in the EPSDT subsystem.

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.

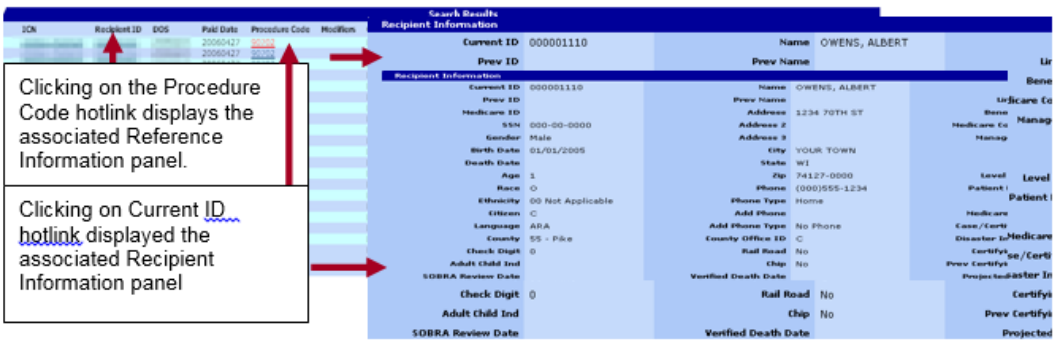


If the user clicks once on a search result row, the associated information panel opens. For example, the user clicked the 3rd row of the EPSDT Provider Info Search Results panel (as shown above) and the associated Provider Information panel displayed.



5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available. Users are provided with additional information related to a field by clicking the hotlink, as shown below.



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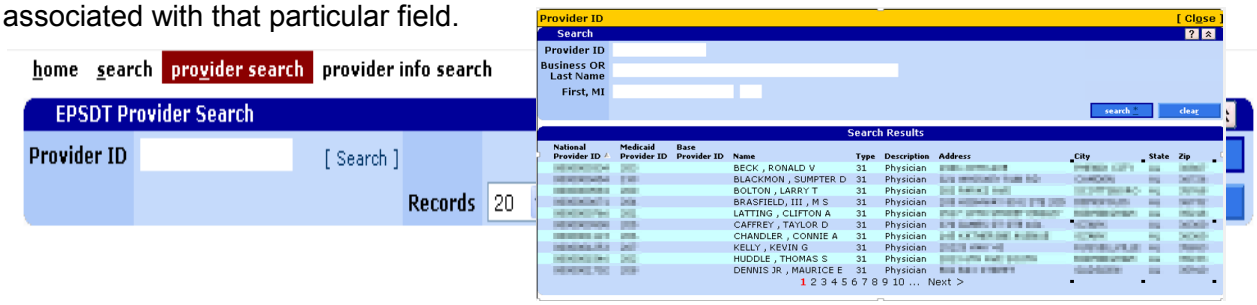
5.3.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the [Search] link, the user accesses the search panel that is associated with that particular field.



5.4 PANEL LAYOUT

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on panels within the EPSDT system:

Name	Icon	Description
Clear Button	clear	Clears all actions to all panels on the page. Can be found on the navigation panel.
Close Button	✕	Closes a panel.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
[Search]	[Search]	Opens a search panel associated to a particular field. Allows the user to search for unknown information, such as a Provider ID, using other information, such as the Provider Name.
Search	search	Searches for information based on criteria entered into field(s) on panel.

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5.4.2 Help Functionality

The interChange system contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.3 Question Mark Icon

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.4.3.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Clear	Clears previous searches	Button	N/A	0
Search	Searches through Recipient records	Button	N/A	0
Recipient ID	Recipient identification number of the Recipient. Must be 12 characters in length.	Field	Number	12
Records	Number of records to display per page.	Field	Drop Down List Box	0
[Search]	Hyperlink to a list of Recipients	Hyperlink	N/A	0

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	0	Validate	Recipient ID must be numeric.
	Field	1	Validate	Recipient ID must be entered for search criteria.

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The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as; Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

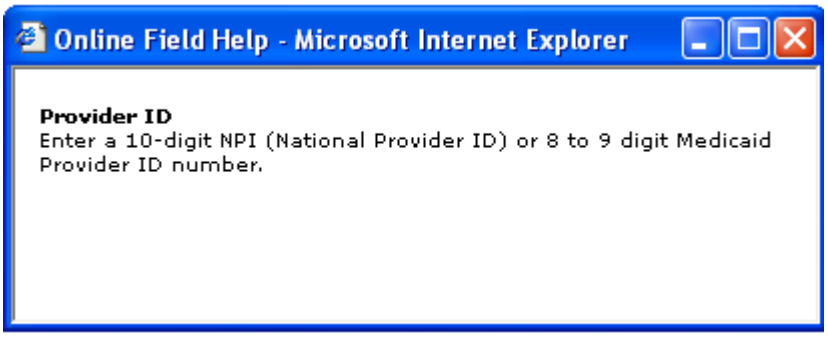
5.4.4 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.4.4.1 Field Level Help Description

When hovering the cursor over a field name, such as **Provider ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 EPSDT PANELS

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each panel covers the following:

- Panel Narrative
- Panel Layout
- Panel Field Descriptions
- Panel Field Edit Error Code Tables
- Panel Extra Features
- Panel Accessibility

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6.1 EPSDT SCREENING SEARCH PANEL OVERVIEW

6.1.1 EPSDT Screening Search Panel Narrative

The EPSDT Screening Search panel is used to view screening claims history and immunization claim history performed for EPSDT-eligible recipients.

This panel is for inquiry only.

Navigation Path: [EPSDT] – [Search]

6.1.2 EPSDT Screening Search Panel Layout

6.1.3 EPSDT Screening Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear information entered into the Recipient ID search field.	Button	N/A	0
Recipient ID	Current Medicaid identification number of recipient.	Field	Number (Integer)	12
Records	Allows the user to select the number of records to display per page. Valid values include: 5, 10, 20, 50 and 100.	Combo Box	Drop Down List Box	0
Search	Searches for recipient identification number entered.	Button	N/A	0
[Search]	Hyperlink to a list of recipients.	Hyperlink	N/A	0

6.1.4 EPSDT Screening Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	0	Validate.	Recipient ID must be numeric.
	Field	1	Validate.	Recipient ID must be entered for search criteria.

6.1.5 EPSDT Screening Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 EPSDT Screening Search Panel Accessibility

6.1.6.1 To Access the EPSDT Screening Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **EPSDT** and click **Search**.	EPSDT Screening Search panel displays.

6.1.6.2To Navigate on the EPSDT Screening Search Panel

Step	Action	Response
1	Enter **Recipient ID**. If Recipient ID is unknown, use the [Search] button to locate recipient by SSN, Last Name and First Name.	
2	Click **Search**.	EPSDT Screening Search Results panel displays.

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6.2 EPSDT SCREENING SEARCH RESULTS PANEL OVERVIEW

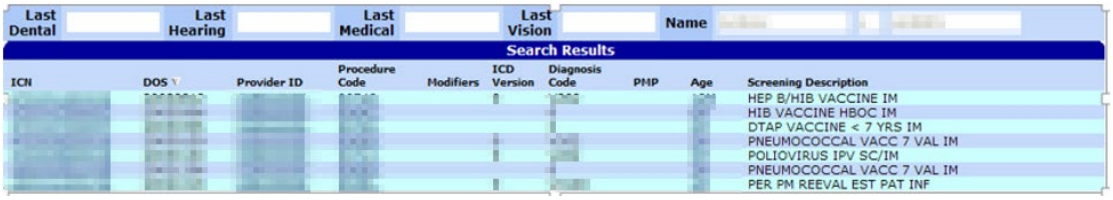
6.2.1 EPSDT Screening Search Results Panel Narrative

The EPSDT Screening Search Results panel displays all the applicable claims for the Recipient ID based on the user input on the EPSDT Screening Search Panel.

This panel is for inquiry only.

Navigation Path: [EPSDT] – [Search] - [Enter the Recipient ID] - [Click Search]

6.2.2 EPSDT Screening Search Results Panel Layout



6.2.3 EPSDT Screening Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age	Lists records by age of recipient on the date of service.	Field	Alphanumeric	3
Diagnosis Code	Lists records by primary diagnosis code from the claim.	Field	Alphanumeric	7
DOS	Lists records by date of service.	Field	Date (CCYYMMDD)	8
ICD Version	Code to denote which version of the ICD diagnosis or surgical procedure code set is being referenced. The valid values will be '9' for ICD-9, '0' for ICD-10 or blank if corresponding code is not present.	Field	Character	1
ICN	Lists records by claim internal control number.	Field	Number (Integer)	13
Last Dental	Date of last dental exam.	Field	Date (MM/DD/CCYY)	8
Last Hearing	Date of last hearing exam.	Field	Date (MM/DD/CCYY)	8
Last Medical	Date of last medical exam.	Field	Date (MM/DD/CCYY)	8
Last Vision	Date of last vision exam.	Field	Date (MM/DD/CCYY)	8
Modifiers	Lists records by primary procedure code modifier. Displays up to 3 modifiers per record.	Field	Characters	6
Name	Read only display of the recipient first name, middle initial and last name.	Field	Character	50
PMP	Lists records by primary medical provider on the recipient's file when claim is processed.	Field	Number (Integer)	10

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Field	Description	Field Type	Data Type	Length
Procedure Code	Lists records by primary procedure code.	Field	Character	6
Provider ID	Lists records by performing provider identification number.	Field	Number (Integer)	10
Screening Description	Lists records by primary screening procedure code description.	Field	Character	50

6.2.4 EPSDT Screening Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 EPSDT Screening Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 EPSDT Screening Search Results Panel Accessibility

6.2.6.1 To Access the EPSDT Screening Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **EPSDT** and click **Search**.	EPSDT Screening Search panel displays.
3	Enter **Recipient ID**. If Recipient ID is unknown, use the [Search] button to locate recipient by SSN, Last Name and First Name.	
4	Click **Search**.	EPSDT Screening Search Results panel displays.

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6.3 EPSDT PROVIDER INFO SEARCH PANEL OVERVIEW

6.3.1 EPSDT Provider Info Search Panel Narrative

The EPSDT Provider Info Search panel is used to search for existing provider records. Any combination of search criteria may be entered to narrow or expand the search. Upon clicking the search button, the system displays up to the number of records selected in the records field. This panel is for inquiry only.

Navigation Path: [EPSDT] – [Provider Info Search]

6.3.2 EPSDT Provider Info Search Panel Layout

6.3.3 EPSDT Provider Info Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear information entered into the County Code or Specialty search fields.	Button	N/A	0
County Code	County code of the provider.	Combo Box	Drop Down List Box	0
Records	Allows the user to select the number of records to display per page. Valid values include: 5, 10, 20, 50 and 100.	Combo Box	Drop Down List Box	0
Search	Initiates the search by County Code or Specialty.	Button	N/A	0
Specialty	Primary specialty of the provider.	Combo Box	Drop Down List Box	0

6.3.4 EPSDT Provider Info Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 EPSDT Provider Info Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 EPSDT Provider Info Search Panel Accessibility

6.3.6.1 To Access the EPSDT Provider Info Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **EPSDT** and click **Provider Info Search**.	EPSDT Provider Info Search panel displays.

6.3.6.2 To Navigate the EPSDT Provider Info Search Panel

Step	Action	Response
1	Select **County Code** and/or **Specialty** from the drop down list box.	
3	Click the **Search** button. (Once County Code and/or Specialty field(s) is populated).	Search Results panel displays all ICNs with EPSDT screenings.

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6.4 EPSDT PROVIDER INFO SEARCH RESULTS PANEL OVERVIEW

6.4.1 EPSDT Provider Info Search Results Panel Narrative

The EPSDT Provider Info Search Results panel displays provider records based on search criteria. This panel is for inquiry only.

Navigation Path: [EPSDT] – [Provider Info Search] - [Select Criteria] - [Click Search]

6.4.2 EPSDT Provider Info Search Results Panel Layout

6.4.3 EPSDT Provider Info Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Address 1 and Address 2 of provider.	Field	Character	40
City	City where provider is located.	Field	Character	15
County	County description where provider is located.	Field	Character	14
Name	Last name, first name and middle initial of provider.	Field	Character	40
Phone	Phone number corresponding to provider's address listed.	Field	Number (Integer)	12
Provider ID	Identification number of the provider.	Field	Character	10
Specialty	Specialty description of provider.	Field	Character	24
State	State where provider is located.	Field	Character	2
Svc Loc	Service location of the provider. Valid values include: M – Mail P – Pay To H – Home Office S – Service Location	Field	Character	1
Zip	Zip code of provider.	Field	Number (Integer)	5

6.4.4 EPSDT Provider Info Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.4.5 EPSDT Provider Info Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 EPSDT Provider Info Search Results Panel Accessibility

6.4.6.1 To Access the EPSDT Provider Info Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **EPSDT** and click **Provider Info Search**.	EPSDT Provider Info Search panel displays.
3	Select **County Cod**e and/or **Specialty** from the drop down list box.	
4	Click **Search**. Note: Users can omit entering information into the search fields. Clicking on the Search button with no criteria entered yields a listing of all records on file.	EPSDT Provider Info Search Results panel displays.

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6.5 EPSDT PROVIDER SEARCH PANEL OVERVIEW

6.5.1 EPSDT Provider Search Panel Narrative

The EPSDT Provider Search panel allows users to enter a provider ID to locate all EPSDT screening claims performed by this provider. This panel is for inquiry only.

Navigation Path: [EPSDT] – [Provider Search]

6.5.2 EPSDT Provider Search Panel Layout

6.5.3 EPSDT Provider Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear information entered into the Provider ID search field.	Button	N/A	0
ID Type	This is a 3-character code that identifies the provider ID type in the Provider ID field to the left. When the user clicks on the code, the Provider ID/Number pop-up window opens displaying all the Provider IDs and types for this Provider. The user can select any of these values to populate that ID in the Provider ID field. Until the provider number is entered and searched, the panel will not display the type of provider ID: NPI (National Provider ID), CNV (Converted) and MCD (Medicaid).	Hyperlink	N/A	0
Provider ID	Identification number of the provider.	Field	Number (Integer)	15
Records	Allows the user to select the number of records to display per page. Valid values include: 5, 10, 20, 50 and 100.	Combo Box	Drop Down List Box	0
Search	Initiates the search by provider identification number.	Button	N/A	0
[Search]	Hyperlink to a list of providers.	Hyperlink	N/A	0

6.5.4 EPSDT Provider Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.5.5 EPSDT Provider Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 EPSDT Provider Search Panel Accessibility

6.5.6.1 To Access the EPSDT Provider Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **EPSDT** and click **Provider Search**.	EPSDT Provider Search panel displays.

6.5.6.2 To Navigate the EPSDT Provider Search Panel

Step	Action	Response
1	Enter **Provider ID**. If Provider ID is unknown, use the [Search] button to locate a Provider ID.	
2	Click the **Search** button.	Search Results panel displays all ICNs with EPSDT screenings.
3	Click the desired ICN.	Claims Information panel appears displaying selected claim's data.

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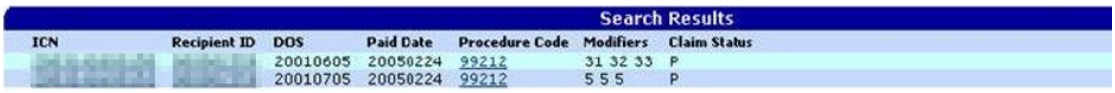
6.6 EPSDT PROVIDER SEARCH RESULTS PANEL OVERVIEW

6.6.1 EPSDT Provider Search Results Panel Narrative

The EPSDT Provider Search Results panel displays the EPSDT claim history and immunization claim history performed for EPSDT eligible recipients by Provider ID. This panel is for inquiry only.

Navigation Path: [EPSDT] – [Provider Search] - [Select Criteria] - [Click Search Button]

6.6.2 EPSDT Provider Search Results Panel Layout



Search Results

ICN	Recipient ID	DOS	Paid Date	Procedure Code	Modifiers	Claim Status
[illegible]	[illegible]	20010605	20050224	99212	31 32 33	P
[illegible]	[illegible]	20010705	20050224	99212	5 5 5	P

6.6.3 EPSDT Provider Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Status	Indicates the status of a claim in the system.	Field	Character	1
Recipient ID	Current recipient identification number of recipient.	Field	Number (Integer)	12
DOS	Date on which service was first provided.	Field	Date (CCYYMMDD)	8
ICN	Internal control number associated with the recipient.	Field	Number (Integer)	13
Modifiers	Lists records by primary procedure code modifier. Displays up to 3 modifiers per record.	Field	Character	6
Paid Date	This date represents Check Issue date that corresponds with the first financial cycle run for payers that finalize the claim on that cycle.	Field	Date (CCYYMMDD)	8
Procedure Code	Code used to identify a medical, dental, or durable medical equipment (DME) procedure.	Field	Alphanumeric	5

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6.6.4 EPSDT Provider Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.5 EPSDT Provider Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 EPSDT Provider Search Results Panel Accessibility

6.6.6.1 To Access the EPSDT Provider Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **EPSDT** and click **Provider Search**.	EPSDT Provider Search panel displays.
3	Enter **Provider ID**. If Provider ID is unknown, use the [Search] button to locate provider by Business OR Last Name.	
4	Click **Search**.	EPSDT Provider Search Results panel displays.

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7 EPSDT REPORTS

The EPSDT User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 EPS-0011-A – CMS-416 ANNUAL EPSDT PARTICIPATION REPORT

7.1.1 EPS-0011-A – CMS-416 Annual EPSDT Participation Report Narrative

The CMS-416 Annual EPSDT Participation Report provides basic information on participation in the child health programs by Medicaid recipients within the State's jurisdiction. This information is used to assess the effectiveness of the State's EPSDT program in terms of the number of children, by age group and basis of Medicaid eligibility, who are: 1) provided child health screening services, 2) referred for corrective treatment, and 3) receive dental, hearing, and vision assessments. There are fourteen lines on the report that provide data such as; recipient counts of eligibles, eligibles that received screenings, participation ratios, and eligibles referred for corrective treatment. The data includes fee-for-service and managed care totals. The recipient's age is reported as of September 30th during each report period. If a child is born after September 30th, the child is listed in the "Under One Year" age group. The report period follows the Federal Fiscal year. This report is produced annually. The CMS-416 may also be ran quarterly. (EPS-0011-Q).

The CMS-416 Report contains all Alabama specific calculations and any modifications based on the most recent federally mandated changes currently being put in place in the Legacy system (See Defect 1202). Since the FY 2006 report is created from the legacy system, the report from iTrace is updated with all necessary changes prior to the first quarterly run after implementation as was previously agreed to during GAP analysis meeting.

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7.1.2 EPS-0011-A -- CMS-416 Annual EPSDT Participation Report Layout

```
Report: EPS-0011-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process: EPSJA416                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: EPA41603                    CMS-416 ANNUAL EPSDT PARTICIPATION REPORT                           Page:      9,999
                                       REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

STATE:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CAT                                    AGE GROUPS
FY CCYY

                                             TOTAL        < 1      1   2      3   5      6   9     10   14    15   18    19   20

 1  NUMBER OF INDIVIDUALS              CN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
     ELIGIBLE FOR MEDICAID             MN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                     TOTAL 999,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

 2A STATE PERIODICITY SCHEDULE                                  5          4          3          4          5          4          2
 2B NUMBER OF YEARS IN AGE GROUP                                1          2          3          4          5          4          2
 2C ANNUALIZED PERIODICITY SCHEDULE                          5.00       2.00       1.00       1.00       1.00       1.00       1.00

 3A TOTAL MONTHS OF ELIGIBILITY     CN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                    MN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                 TOTAL 999,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

 3B AVERAGE PERIOD OF ELIGIBILITY   CN        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99
                                    MN        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99
                                 TOTAL        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99

 4  EXPECTED NUMBER OF SCREENINGS   CN        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99
     PER ELIGIBLE                   MN        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99
                                 TOTAL        9.99       9.99       9.99       9.99       9.99       9.99       9.99       9.99

 5  EXPECTED NUMBER OF SCREENINGS   CN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                    MN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                 TOTAL 999,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999


 6  TOTAL SCREENS RECEIVED          CN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                    MN  99,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999  9,999,999
                                 TOTAL 999,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999 99,999,999


 7  SCREENING RATIO                 CN      999.99%     99.99%    999.99%     99.99%    999.99%     99.99%    999.99%    999.99%
                                    MN      999.99%     99.99%    999.99%     99.99%    999.99%     99.99%    999.99%    999.99%
                                 TOTAL      999.99%     99.99%    999.99%     99.99%    999.99%     99.99%    999.99%    999.99%
```


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Report: EPS-0011-A
Process: EPSJA416
Location: EPA41603

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
CMS-416 ANNUAL EPSDT PARTICIPATION REPORT
REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

Run Date: MM/DD/CCYY
Run Time: HH:MM:SS
Page: 9,999

STATE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
FY CCYY

	CAT	TOTAL	< 1	1 2	3 5	6 9	10 14	15 18	19 20
			AGE GROUPS						
8 TOTAL ELIGIBLES WHO SHOULD RECEIVE AT LEAST ONE INITIAL OR PERIODIC SCREEN	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
9 TOTAL ELIGIBLES RECEIVING AT LEAST ONE INITIAL OR PERIODIC SCREEN	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
10 PARTICIPANT RATIO	CN	999.99%	99.99%	999.99%	99.99%	999.99%	99.99%	999.99%	999.99%
	MN	999.99%	99.99%	999.99%	99.99%	999.99%	99.99%	999.99%	999.99%
	TOTAL	999.99%	99.99%	999.99%	99.99%	999.99%	99.99%	999.99%	999.99%
11 NUMBER OF ELIGIBLES REFERRED FOR CORRECTIVE TREATMENT	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
12A NUMBER OF ELIGIBLES RECEIVING ANY DENTAL SERVICES	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
12B NUMBER OF ELIGIBLES RECEIVING PREVENTIVE DENTAL SERVICES	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
12C NUMBER OF ELIGIBLES RECEIVING DENTAL TREATMENT SERVICES	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
13 TOTAL NUMBER OF ELIGIBLES ENROLLED IN MANAGED CARE	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
14 TOTAL NUMBER OF SCREENING BLOOD LEAD TESTS	CN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	MN	99,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
	TOTAL	999,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

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```
Report: EPS-0011-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process: EPSJA416                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: EPA41603                    CMS-416 ANNUAL EPSDT PARTICIPATION REPORT                           Page:      9,999
                                       REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

STATE:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CAT                                      AGE GROUPS
FY CCYY

                                            TOTAL        < 1      1   2      3   5      6   9     10   14    15   18    19   20

THE FOLLOWING BENEFICIARIES COULD NOT BE ASSIGNED EITHER CATEGORICALLY OR MEDICALLY NEEDY
  99999999999 MONEY CD: 9 PGM CD: MP CMS ELIG: 9
  99999999999 MONEY CD: 9 PGM CD: MP CMS ELIG: 9
```

Attachment A
Attachment: Report Notes
(not a part of the report)

The data in Attachment A includes the procedure codes and criteria used in the CMS-416 report as well as the new screening procedure codes and criteria for EPSDT in the interChange AMMIS system.

Classification of Totals by Categorically Needy (CN) / Medically Needy (MN):

1) Categorically and Medically Needy are determined from the recipient eligibility record. The recipient eligibility record identifies a unique medical assistance program or benefit plan under which the recipient participates.
2) Participation in any plan that is not specifically categorized as medically needy is reported as categorically needy.
3) Recipient program information is found on the t_re_elig table.
4) The recipient may be a participant in multiple medical assistance programs during the reporting period. In this event, the recipient will be reported once, as CMS directs that the totals are to be "unduplicated". "Unduplicated" means an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. If a recipient participates in both a categorically needy program and a medically needy program he/she will be reported as categorically needy (CN).
5) MN is given a key value of 2 (Core Value). This key value of three that identifies the MN programs is the sak_pub_hlth on the t_pub_hlth_pgm table.

Recipient Age Group Assignment

The recipient's age will report as their age as of September 30 during each report period. If a child is born after September 30, the recipient would report in the "Under One Year" age group.

Each Line item calculation is truncated, not rounded.

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Line 1 Number of Individuals Eligible for EPSDT

1) The numbers are read from the t_re_base and the t_re_elig. The t_re_elig identifies the program of coverage for each recipient which tells us whether he/she is MN or CN.
2) CN TOTAL = addition of all CN age groups.
3) MN TOTAL = addition of all MN age groups.
4) TOTAL = addition of all TOTAL age groups, or the addition of CN + MN = TOTAL.

Line 2A State Periodicity Schedule

The number of screens per age group according to the periodicity schedule. For example: age group <1 includes birth, 1, 2, 4, 6, and 9 month old screens = 5.

Line 2B Number of Years in Age Group

The number of years per age group according to the periodicity schedule. For example: age group <1 = 1 year; group 1-2 = 2 years (1 & 2).

Line 2C Annulaised Periodicity Schedule

Line 2A divided by Line 2B

Line 3A: Total Months Of Eligibility:

The total months of eligibility is the total of the number of the months during the fiscal year in which the beneficiaries were eligible. This count includes any eligibility within a given month regardless of the actual number of days of eligibility within that month. This is an unduplicated count.

Line 3B: Average Period of Eligibility

The "Totals" line age group values are calculated by dividing the applicable Line 3A age group
Total by the applicable Line1 age group. Total and dividing that quotient by 12. In other words: Line 3B = (Line 3A / Line 1) / 12.

Line 4: Expected Number of Screenings per Eligible

Line 2C multiplied by Line 3B.
a) CN equals the addition of all CN age groups.
b) MN equals the addition of all MN age groups.
c) The TOTAL equals the addition of all TOTAL age groups.

Line 5: Expected Number of Screenings

Line 4 multiplied by Line 1.
a) CN equals the addition of all CN age groups.
b) MN equals the addition of all MN age groups.
c) TOTAL line equals the sum of CN and MN totals.

Line 6: Total Screens Received

These include the paid procedures billed that reside within the following procedure code groupings regardless of diagnosis code on the claim:

- 44 - the preventive procedures codes
- 45 - the Local procedure codes (until 10/15/2003) are non-covered as of DOS = 10/16/2003)
- 2120 - the Dental Screening codes
- 2121 - the Hearing Screening codes

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- 2122 - the Vision Screening codes
- 2147 – Selected office or other outpatient visits

Procedure group 44 includes:
99201-99205 (with a well child diagnosis) – AL: These should not pay – L0013
99211-99215 (with a well child diagnosis) – AL: These should not pay – L0013
99381-99385 – AL: include EP Modifier
99391-99395 – AL: include EP Modifier
99431 – AL: Omit 99431, it is not used for EPSDT

Procedure group 45 includes:
Define local codes – AL: N/A

Procedure group 2120 includes:

D0120 D0140 D0150
D0170 D9420
D0145 – AL: added

Procedure group 2121 includes:

92551-92553 92555-92557 92582
92567 92551EP

Procedure group 2122 includes:

92002 92004 92012
92014 99173EP

Line 7: Screening Ratio

Line 6 divided by Line 5 equals the percent (decimal multiplied by 100).
Calculations greater than 100%, default to 100%.

Line 8: Total Eligibles Who Should Receive At Least One Initial or Periodic Screen

a) Line 4 number. If that number is greater than 1, use 1.
If the number in Line 4 is less than or equal to 1, use that number.
b) Multiply that number by the number in Line 1. Line 8 equals that product.

1) CN equals the addition of all CN age groups.
2) MN equals the addition of all MN age groups.
3) The TOTAL equals the addition of all TOTAL age groups or, the CN total plus the MN total = TOTAL

Line 9: Total Eligibles Receiving At Least One Initial Or Periodic screening:

An unduplicated count of beneficiaries who have received a screening during the fiscal year. See the applicable screenings codes in Line 6.

Line 10: Participation Ratio

Line 9 divided by Line 8 equals the ratio

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Line 11: Total Eligibles Referred for Corrective Treatment

An unduplicated count of beneficiaries who had received treatment during the fiscal and were referred for corrective treatment. These referrals are identified by entries in the t_clm_crc table for EPSDT services that have a condition code of either "S2" or "ST".

AL: Alabama does not have the capability to collect the referred indicators from screening claims. Also include vision and hearing screenings

Lines 12a, b and c: Dental Assessment Procedures

Individuals receiving: ADA CDT Code

any dental service
procedure group 2126 (ADA)
D0100-D9999
preventative dental service
procedure group 2123 (ADAP)
D1000-D1999
treatment dental services
procedure group 2124 (ADAT)
D2000-D9999

Line 13: Total Eligibles Enrolled in Managed Care

- The PMP table tells us which enrollees are with an MCO.
  AL: Patient 1st is not an MCO
  Alabama counts Patient 1st as Managed Care although not an MCO.

Line 14: Total number of Screening Blood Lead Tests

- CPT 83655 except with ICD9 of 984.0-.9, E861.5 or E866.0.
- The procedure grouping for BLTE is 2125 which contains the procedure code of 83655.
- The diagnosis grouping for BLTE exclusions is 2030 which contains ICD9 codes of 984.0-.9, E861.5, and E866.0.

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7.1.3 EPS-0011-A -- CMS-416 Annual EPSDT Participation Report Field Descriptions

Field	Description	Data Type	Length
Age Groups (Columns 4, through 10)	These columns display recipient data by categorically needy, medically needy, and a total of both groups for each line of data appearing on the report, based on the seven age groups of under 1, 1-2 years, 3-5 years, 6-9 years, 10-14 years, 15-18 years and 19-20 years.	Number (Decimal)	6
CN	These lines report the data for recipients in the Categorically Needy basis of the eligibility grouping. All eligible recipients age 0 through 20 are included as EPSDT eligible in the Categorically Needy grouping. Length for Age Grouping: 9 except for averages and ratios Length for CN Totals: 10 except for averages and ratios	Number (Decimal)	10
Line 1: Number of Individuals Eligible For EPSDT	These fields display the total number of recipients, from birth to age 20, determined to be eligible for Medicaid. This number includes only the Categorically Needy, because Medicaid does not distinguish the Medically Needy. An eligible person is reported only once, although he or she may have had more than one period of eligibility during the reporting period.	Number (Decimal)	9
Line 2A: State Periodicity Schedule	This field displays the state-specific values reflecting the average number of annual initial or periodic screening services for individuals in each age group.	Number (Decimal)	4
Line 2B: Number of Years in Age Group	This is a fixed number reflecting the number of years included in each age group.	Number (Decimal)	4
Line 2C: Annualized Periodicity Schedule	Divide State Periodicity Schedule (2a) by Number Of Years In Age Group (2b). This is the number of screenings expected to be received by an individual in each age group in one year.	Number (Decimal)	4
Line 3A: Total Months of Eligibility	The total months of eligibility for the individuals in Total Individuals Eligible For EPSDT (1).	Number (Decimal)	9

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Field	Description	Data Type	Length
Line 3B: Average Period of Eligibility	Divide Total Months of Eligibility (3a) by Total Individuals Eligible For EPSDT (1). Divide that number by 12. This is the portion of the year individuals remain eligible for Medicaid during the reported year. The formula for calculation is: (Line 3A / Line 1) / 12.	Number (Decimal)	4
Line 4: Expected Number of Screenings per Eligible	This line reflects the expected number of screenings per child per year. The field calculation is Annualized State Periodicity Schedule (2c) times Average Period of Eligibility (3b), for each age group and eligibility category.	Number (Decimal)	4
Line 5: Expected Number of Screenings	This is the total screenings expected to be provided. Multiply Expected Number of Screenings per Eligible (4) times Total Individuals Eligible For EPSDT (1).	Number (Decimal)	9
Line 6: Total Screens Received	This field displays the combined number of initial and periodic EPSDT screening examinations with dates of service within the fiscal year. The sources of data include reports from continuing care providers and claims paid for such screening services. See Attachment A for the CPT-4 codes included.	Number (Decimal)	9
Line 7: Screening Ratio	This ratio represents the extent to which EPSDT eligibles receive the number of screening services required by the periodicity schedule. This ratio should not be over 100%. Calculate as Total Screens Received (6) divided by Expected Number of Screenings (5).	Number (Decimal)	7
Line 8: Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	This is the number of persons who should receive at least one initial or periodic screening. Use the following calculation: Use the lesser of 1.0 or Expected Number of Screenings per Eligible (4). Multiply this by Total Individuals Eligible For EPSDT (1).	Number (Decimal)	9
Line 9: Total Eligibles Receiving at Least One Initial or Periodic Screening	This is the unduplicated count of individuals, including those enrolled in managed care arrangements, who received at least one initial or periodic screening during the year. See attachment A for codes.	Number (Decimal)	9

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Field	Description	Data Type	Length
Line 10: Participant Ratio	This ratio indicates the extent to which eligibles are receiving screening services during the year. Calculate as Total Eligibles Receiving At Least One Initial Or Periodic Screening (9) divided by Total Eligibles Who Should Receive At Least One Initial Or Periodic Screening (8).	Number (Decimal)	7
Line 11: Number of Eligibles Referred for Corrective Treatment	This is the unduplicated count of individuals, including those enrolled in managed care arrangements, who as a result of at least one health problem identified during a screening including vision and hearing screenings, were scheduled for further services.	Number (Decimal)	9
Line 12A: Number of Eligibles Receiving Any Dental Services	This is the unduplicated count of individuals receiving any dental service (HCPC) codes D0100-D9999).	Number (Decimal)	9
Line 12B: Number of Eligibles Receiving Preventative Dental Services	This is the unduplicated count of individuals receiving preventative dental service (HCPC) codes DD1000-D1999.	Number (Decimal)	9
Line 12C: Number of Eligibles Receiving Dental Treatment Services	This is the unduplicated count of individuals receiving dental services (HCPC) codes D2000-D9999. Note that 12b + 12c does not equal 12a. Also, "unduplicated" applies to each line, so a child could be counted once for 12a and again for 12b.	Number (Decimal)	9
Line 13: Total Eligibles Enrolled in Managed Care	For informational purposes only. This is the number enrolled in some form of managed care as of September 30. These people and their services should be included in Lines 1, 6, 8, 11 and 12.	Number (Decimal)	9
Line 14: Total Number of Screening Blood Lead Tests	The number of blood lead tests, not including those for people diagnosed or under treatment for lead poisoning. All Age Groups are counted. Attachment A lists the procedure codes that should be included for calculation on this line.	Number (Decimal)	9

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Field	Description	Data Type	Length
MN	These lines report the data for recipients in the medically needy basis of the eligibility grouping. Length for Age Grouping: 9 except for averages and ratios Length for MN Totals: 10 except for averages and ratios	Number (Decimal)	10
Total	These lines display totals for both Categorically Needy and Medically Needy eligibility groupings, for each of the age groups and lines of data appearing on the report. Length for Age Grouping: 10 except for averages and ratios Length for CN Totals: 11 except for averages and ratios	Number (Decimal)	11
Total (Column 3)	This column displays count totals for the seven recipient age groupings, for each line of data appearing on the report. Length of 10 except for averages and ratios	Number (Decimal)	10

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7.2 EPS-0500-M -- EPSDT PERIODIC RESCREEN LIST REPORT

7.2.1 EPS-0500-M -- EPSDT Periodic Rescreen List Report Narrative

Users access the EPSDT Periodic Rescreen List report to acquire information by provider concerning Recipient rescreening dates. This report lists those recipients who have met their date due for rescreening in a given month. The Periodic Rescreen List Report includes the Recipient ID, name, address, date due, date of birth and last screening date. The report is sorted by provider and then by the Recipient ID and is created for the primary care provider. If there is no primary care provider, then the report is created for the last screening provider. A page is created in front of each provider's report and is used as a mailing label for the provider. This report is produced monthly.

The report is generated based on the recipient's birth date. If the screening has not been performed / billed, the name appears on the report as needing a screening.

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7.2.2 EPS-0500-M -- EPSDT Periodic Rescreen List Report Layout

```
Labeler Layout

PROVIDER ADDR MAILING LABELER FORMAT
9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  XXXXX-XXXX




NEW PAGE


Report  : EPS-0500-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : EPSJMA50                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: EPSPA510                            PERIODIC RESCREEN LIST                                         Page:      9,999
                                               REPORT PERIOD: MM/CCYY


                    PROVIDER: XXXXXXXXXXXXXXXXXXXXXX - 9999999999
RECIPIENT NO  *** NAME OF RECIPIENT *** *************** ADDRESS OF RECIPIENT ************** *ZIP*  DATE DUE  BIRTHDAY  LAST SCREEN
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX XX   XXXXX  MM/DD/YY  MM/DD/YY   MM/DD/YY

SUBTOTAL ____________ 999999
 COUNTY   XX



                                                   ***   END OF REPORT   ***

                                                  ***   NO DATA THIS RUN   ***
```


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7.2.3 EPS-0500-M -- EPSDT Periodic Rescreen List Report Field Descriptions

Field	Description	Data Type	Length
Address of Recipient	Recipient's physical address. Address: length 25 Space: Length 1 City: Length 20 Space: Length 1 State: Length 2	Character	49
Birthday	Recipient's date of birth.	Date (MM/DD/YY)	8
County	Number representing provider's county code.	Number (Integer)	2
Date Due	The date on which the recipient is due for a rescreening examination. This is the recipient's birthday for the current year.	Date (MM/DD/YY)	8
Label Line 1	Provider Number.	Number (Integer)	10
Label Line 2	Provider Name. May either be a person or a business.	Character	50
Label Line 3	Provider Address Line 1.	Character	30
Label Line 4	Provider Address 2.	Character	30
Label Line 5 - City	Provider City.	Character	30
Label Line 5 - State	Provider State.	Character	2
Label Line 5 - ZIP	Provider Zip Code plus four.	Character	10
Last Screen	Date of recipient's last screening.	Date (MM/DD/YY)	8
Medicaid Number	Recipient's Medicaid Identification Number.	Number (Integer)	12
Name of Recipient	Recipient's first and last name.	Character	25

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Field	Description	Data Type	Length
Provider Name	The provider name associated with the provider who rendered the screening services.	Character	22
Provider Number	The provider number associated with the provider who rendered the screening services.	Number (Integer)	10
Subtotal	Total number of recipients due for screening for the provider.	Number (Integer)	6
ZIP	Recipient's Zip Code.	Number (Integer)	5

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7.3 EPS-0550-M – PERIODIC SCREENING LIST

7.3.1 EPS-0550-M – Periodic Screening List Report Narrative

Report will list all the recipients who are part of a PMP who have upcoming or past due screening(s). The report will be grouped based on Group Provider.

One section of the report shows “UPCOMING” screening(s) for recipients in that month (based on birthday). The other section of the report shows “PAST DUE” screening(s) for recipients ages 3-20 who have not received the proper screening(s) (based on birthday). These recipients will stay on the report until the screening is reported or for one year (based on birthday).

7.3.2 EPS-0550-M -- Periodic Screening List Report Layout

```
Report  : EPS-0550-M                                        ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : EPSJM550                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: EPSPM550                                          PERIODIC SCREENING LIST                                     Page:     999999
                                                          REPORT PERIOD: MM/DD/CCYY
         GROUP PROVIDER (NPI:MCD:NAME): 9999999999 : 9999999999 : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PMP PROVIDER NPI: 9999999999
RECIPIENT NO  NAME OF RECIPIENT              ADDRESS OF RECIPIENT                          ZIP    DATE DUE   BIRTHDAY   LAST SCREEN
-------------------------------------------------------------------------------------------------------------------------------------
                                                              UPCOMING
-------------------------------------------------------------------------------------------------------------------------------------
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231

-------------------------------------------------------------------------------------------------------------------------------------
                                                              PAST DUE
-------------------------------------------------------------------------------------------------------------------------------------
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999  22991231   22991231   22991231
                                             ** End of Report **
```


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7.3.3 EPS-0550-M – Periodic Screening List Report Field Descriptions

Field	Description	Length	Data Type
ADDRESS OF RECIPIENT	This is the address associated with Recipient.	44	Character
BIRTHDAY	This is the birthday associated to Recipient.	8	Number (Integer)
DATE DUE	This is the date that the screening is due for Recipient.	8	Number (Integer)
GROUP PROVIDER (NPI: MCD:NAME)	Group Provider's NPI, MCD and Name.	76	Character
LAST SCREEN	This is the date that the Recipient underwent last screening.	8	Number (Integer)
NAME OF RECIPIENT	This is the name associated Recipient.	30	Character
PAST DUE	This section will list all the Recipient assigned to the PMP who has screening due during that particular month.	8	Character
PMP PROVIDER NPI	NPI ID of the PMP Provider under the Group Provider.	10	Character
RECIPIENT NO	Medicaid ID of the Recipient.	12	Character
UPCOMING	This section will list all the Recipient assigned to the PMP who has screening coming up that particular month.	8	Character
ZIP	Zip Code associated with Recipient address.	5	Number (Integer)

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7.4 EPS-3002-M -- IMMUNIZATION REGISTRY REPORT

7.4.1 EPS-3002-M -- Immunization Registry Report Narrative

The Immunization Registry report provides Medicaid immunization information to the Alabama Department of Public Health. The report sorts by Recipient ID and is scheduled to run monthly on the last day of the month.

This report is set to run automatically on the Decision Support System (DSS) Broadcast Agent Server once a month. The results are automatically sent to the Department of Public Health (DPH) personnel's DSS user ID. The public health personnel logs into DSS through the web to retrieve the report.

7.4.2 EPS-3002-M -- Immunization Registry Report Layout

Image not available to display as this report is never printed. This report is only written to a file.

7.4.1 EPS-3002-M -- Immunization Registry Report Field Descriptions

Field	Description	Length	Data Type
Billing Prov License Number	The number assigned to a provider which indicates whether or not the provider is certified.	9	Number (Integer)
Billing Provider NPI	The billing provider's National Provider Identifier.	10	Alphanumeric
Date of Birth	The date the recipient was born.	10	Date (MM/DD/CCYY)
Detail Status Code	An alpha code indicating the current status of the claim. If you do not want adjustments, use "Claim Region" (in Claim Categories folder) not in list 50, 51 in your conditions.	1	Character
First Date of Service	The date the first service was rendered on a claim.	10	Date (MM/DD/CCYY)
Payee Name	The name of the adult who made the application in the SOBRA household.	29	Character
Payee Number	The recipient's payee identification number. This is also used to identify the head of household.	12	Alphanumeric

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Field	Description	Length	Data Type
Perf/Surg Prov Address	The performing provider's address in mailing label format.	30	Character
Perf/Surg Prov Type	A 2-digit code indicating the classification of the provider rendering health and medical services as approved under the state Medicaid plan.	2	Character
Perf/Surg Provider Last Name	The last name of the provider of Medicaid services as used on official state records.	16	Character
Performing/Surgical Provider ID	This field is the surgical provider identification number for hospital claims and the performing provider identification number for dental and medical claims.	10	Number (Integer)
Procedure Code	This field indicates the 5 character (alpha and/or numeric) Current Procedural Terminology (CPT) code of the procedure performed by the provider.	5	Character
Provider City	The city where the Perf/Surg provider's office resides.	20	Character
Provider State	The state where the billing provider's office resides.	2	Character
Provider ZIP Code	The zip code of the Perf/Surg provider's office.	5	Number (Integer)
Recipient Base ID	A number that uniquely identifies an individual eligible for Medicaid benefits. This is the original recipient number.	13	Number (Integer)
Recipient City	The recipient’s city of residence.	20	Character
Recipient ID	A number that uniquely identifies an individual eligible for Medicaid benefits. The individual's currently active Medicaid number.	13	Number (Integer)
Recipient First Name	The recipient’s first name.	10	Character
Recipient Last Name	The recipient’s last name.	16	Character
Recipient Middle Initial	The recipient’s middle initial.	1	Character

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Field	Description	Length	Data Type
Recipient State	The state in which the Recipient resides.	2	Character
Recipient Street 1	The recipient's address - 1st line.	22	Character
Recipient Street 2	The recipient's address - 2nd line.	22	Character
Recipient Zip Code	The zip code of the recipient's residence.	5	Number (Integer)
Sex Code	The recipient's sex code on the claim.	1	Character
Social Security Number	The recipient's social security number.	9	Number (Integer)
State Race Code	The state defined code for the recipient's race.	1	Character

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7.5 EPS-4161-R -- SUMMARY OF PREVENTATIVE SERVICES FOR RECIPIENTS UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.5.1 EPS-4161-R -- Summary of Preventative Services for Recipients under 21 for FDOS Fiscal Year Report Narrative

The Summary of Preventative Services for Recipients under 21 for From Date of Service (FDOS) Fiscal Year report is a DSS report of all dental preventative services for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.5.2 EPS-4161-R -- Summary of Preventative Services for Recipients under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Summary of Preventive Dental Services for Recipients under 21 for FDOS Fiscal Year: 200

Report: EPS-4161-R

Run Date: 8/30/2007

Run Time: 5:36:54 PM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
1	1	Under Age 1
822	2	Ages 1-2
6,149	3	Ages 3-5
9,466	4	Ages 6-9
8,238	5	Ages 10-14
4,305	6	Ages 15-18
540	7	Ages 19-20
61	8	Age falls outside of HCFA 416 type
Sum: 29,582		

End of Report

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7.5.3 EPS-4161-R -- Summary of Preventative Services for Recipients under 21 for FDOS Fiscal Year Report Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories.	1	Number (Integer)
CMS-416 Age Type Desc	Description of the specific age categories the report is sorted into. Note: No information is reflected on the report if the age range = 0.	20	Character
Sum	Summary of amounts for Undup Recipient Count.	9	Number (Integer)
Undup Recipient Count	Recipient count listed on report that is unduplicated.	9	Number (Integer)

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7.6 EPS-4162-R -- SUMMARY OF RESTORATIVE SERVICES FOR RECIPIENTS UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.6.1 EPS-4162-R -- Summary of Restorative Services for Recipients under 21 for FDOS FY Report Narrative

The Summary of Restorative Services for Recipients under 21 for FDOS Fiscal Year report is a DSS report of all dental restoration services for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.6.2 EPS-4162-R -- Summary of Restorative Services for Recipients under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Summary of Restorative Dental Services for Recipients under 21 for FDOS Fiscal Year: 2006

Report: EPS-4162-R
Run Date: 8/30/2007
Run Time: 5:37:11 PM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
1	1	Under Age 1
220	2	Ages 1-2
3,141	3	Ages 3-5
4,942	4	Ages 6-9
4,018	5	Ages 10-14
3,395	6	Ages 15-18
462	7	Ages 19-20
81	8	Age falls outside of HCFA 416 type
Sum: 16,260		

End of Report

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7.6.3 EPS-4162-R -- Summary of Restorative Services for Recipients under 21 FDOS for Fiscal Year Report Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories.	1	Number (Integer)
CMS-416 Age Type Desc	Description of the specific age categories the report is sorted into. Note: No information is reflected on the report if the age range = 0.	20	Character
Sum	Summary of amounts for Undup Recipient Count.	9	Number (Integer)
Undup Recipient Count	Number of distinct recipients that are not duplicated on the report.	9	Number (Integer)

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7.7 EPS-4163-R -- FY LEAD TESTS CMS VALIDATION REPORT

7.7.1 EPS-4163-R -- FY Lead Tests CMS Validation Report Narrative

The Fiscal Year (FY) Lead Tests CMS Validation Report is a DSS report of all lead screening blood tests for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.7.2 EPS-4163-R -- FY Lead Tests CMS Validation Report Layout

Alabama Medicaid Agency

FY Lead Tests CMS Validation

Report: EPS-4163-R
Run Date: 7/31/2006
Run Time: 11:46:02 AM

Undup ICN Count	Undup Recipient Count	Recipient Age	Procedure Code	Quantity Service Units Billed
4	4	0	83655	4
129	129	1	83655	129
10	10	2	83655	10
7	7	3	83655	7
10	10	4	83655	10
2	2	5	83655	2
1	1	15	83655	1
163				

End of Report

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7.7.3 EPS-4163-R – FY Lead Tests CMS Validation Report Field Descriptions

Field	Description	Length	Data Type
Procedure Code	Procedure code for lead testing.	5	Character
Quantity Service Units Billed	Quantity of units of service billed.	9	Number (Integer)
Recipient Age	Age of recipient.	4	Number (Integer)
Sum	Summary of amounts for Undup Recipient Count.	9	Number (Integer)
Undup ICN Count	Sum of the distinct internal control numbers.	13	Character
Undup Recipient Count	Sum of distinct recipients.	9	Number (Integer)

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7.8 EPS-4164-R -- EPSDT PERIODIC SCREENS BY FY PAID DATE REPORT

7.8.1 EPS-4164-R -- EPSDT Periodic Screens By FY Paid Date Report Narrative

The EPSDT Periodic Screens By FY Paid Date report is a DSS report of all periodic screens by age group for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.8.2 EPS-4164-R -- EPSDT Periodic Screens By FY Paid Date Report Layout

Alabama Medicaid Agency

EPSDT Periodic Screens By FY Paid Date

Report: EPS-4164-R
Run Date: 8/2/2007
Run Time: 1:56:42 PM

Paid Date Fiscal Year	CMS 416 Age Type	CMS 416 Age Type Description	Undup Recipient Count	Quantity Billed Count	Dtl Undup ICN Count	Dtl Allowed Amount	ICN Per Recip	Allow Per Unit
2005	1	Under Age 1	22	22	22	$1,507.74	1.00	$68.53
	2	Ages 1-2	25	25	25	$1,779.89	1.00	$71.20
	3	Ages 3-5	28	28	28	$2,097.66	1.00	$74.92
	4	Ages 6-9	37	37	37	$2,558.45	1.00	$69.15
	5	Ages 10-14	50	50	50	$3,774.00	1.00	$75.48
	6	Ages 15-18	33	33	33	$2,244.19	1.00	$68.01
	7	Ages 19-20	1	1	1	$70.00	1.00	$70.00
2005		**Sum:**	**196**	**196**	**196**			
2006	1	Under Age 1	20,479	20,856	20,852	$1,505,258.89	1.02	$72.17
	2	Ages 1-2	11,129	11,193	11,193	$807,497.71	1.01	$72.14
	3	Ages 3-5	5,882	5,883	5,883	$423,840.33	1.00	$72.04
	4	Ages 6-9	4,012	4,013	4,013	$286,785.06	1.00	$71.46
	5	Ages 10-14	4,206	4,206	4,206	$299,539.45	1.00	$71.22
	6	Ages 15-18	2,089	2,089	2,089	$152,260.96	1.00	$72.89
	7	Ages 19-20	71	71	71	$5,165.08	1.00	$72.75
	8	Age falls outsic	1	1	1	$70.00	1.00	$70.00
2006		**Sum:**	**47,869**	**48,308**	**48,308**			

End Of Report

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7.8.3 EPS-4164-R -- EPSDT Periodic Screens By FY Paid Date Report Field Descriptions

Field	Description	Length	Data Type
Allow Per Unit	(Detail Allowed Amount)/(Quantity Billed Count) rounded to the nearest hundredth.	9	Number (Decimal)
CMS-416 Age Type	Sort order of specific age categories.	1	Number (Integer)
CMS-416 Age Type Description	Age grouping of recipient.	20	Character
Dtl Allowed Amount	Summary of the allowed amount.	9	Number (Decimal)
Dtl Undup ICN Count	Distinct Detail internal control number (ICN).	4	Number (Integer)
ICN Per Recip	(Detail Undup ICN Count)/(Undup Recipient Count) rounded to the nearest hundredth.	9	Number (Decimal)
Paid Date Fiscal Year	Fiscal Year of the internal control number paid date.	8	Date (CCYY)
Sum	Summary of amounts for Undup Recipient Count, Quantity Billed Count and Detail Undup internal control number Count.	9	Number (Decimal)
Quantity Billed Count	Quantity of units of service billed.	9	Number (Integer)
Undup Recipient Count	Number of recipients on report that are not duplicates.	9	Number (Integer)

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7.9 EPS-4165-R -- SUMMARY OF RECIPIENTS WHO RECEIVED DENTAL SERVICES UNDER AGE 21 FOR FDOS FISCAL YEAR REPORT

7.9.1 EPS-4165-R -- Summary of Recipients who Received Dental Services under age 21 for FDOS Fiscal Year Report Narrative

The Summary of Recipients who Received Dental Services under age 21 for FDOS Fiscal Year is a DSS report that shows the number of recipients under 21 who received dental services for a fiscal year. This report is produced upon request.

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7.9.2 EPS-4165-R -- Summary of Recipients who Received Dental Services under age 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Summary of Recipients who Received Dental Services under age 21 for FDOS Fiscal Year: 2005

Report: EPS-4165-R
Run Date: 7/31/2006
Run Time: 12:45:54 PM

Undup Recipient Count	CMS 416 Age Type Desc
12	Ages 1-2
29	Ages 6-9
29	Ages 15-18
Sum: 70	

End of Report

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7.9.3 EPS-4165-R -- Summary of Recipients who Received Dental Services under age 21 for FDOS Fiscal Year Report Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type Desc	Age grouping of recipient.	20	Character
Sum	Summary of amounts for Undup Recipient Count.	9	Number (Integer)
Undup Recipient Count	Number of recipients on report that are not duplicated.	9	Number (Integer)

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7.10 EPS-4166-R -- SUMMARY OF RECIPIENTS WHO RECEIVED DENTAL SEALANT SERVICES UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.10.1 EPS-4166-R -- Summary of Recipients who Received Dental Sealant Services Under 21 for FDOS Fiscal Year Report Narrative

The Summary of Preventative Services for Recipients under 21 for From Date of Service (FDOS) Fiscal Year report is a DSS report of the number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non-dentist for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.10.2 EPS-4166-R -- Summary of Recipients who Received Dental Sealant Services Under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Summary of Recipients who Received Dental Sealant Services Under 21 for FDOS Fiscal Year

10/01/2009 To 09/30/2010

Report: EPS-4166-R
Run Date: 3/30/2011
Run Time: 4:24:04 PM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
410	3	Ages 3-5
14,938	4	Ages 6-9
7,991	5	Ages 10-14
3	6	Ages 15-18
Sum: 23,342		

End of Report

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7.10.3 EPS-4166-R -- Summary of Recipients who Received Dental Sealant Services Under 21 for FDOS Fiscal Year Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories	1	Number (Integer)
CMS 416 Age Type Desc	Age grouping of recipient	20	Character
Undup Recipient Count	Distinct # of Recipients	9	Number (Integer)

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7.11 EPS-4167-R --SUMMARY OF RECIPIENTS WHO RECEIVED DENTAL DIAGNOSTIC SERVICES UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.11.1 EPS-4167-R --Summary of Recipients who Received Dental Diagnostic Services Under 21 for FDOS Fiscal Year Report Narrative

The Summary of Preventative Services for Recipients under 21 for From Date of Service (FDOS) Fiscal Year report is a DSS report of the number of children receiving at least one diagnostic dental service by or under the supervision of a dentist for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.11.2 EPS-4167-R --Summary of Recipients who Received Dental Diagnostic Services Under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Summary of Recipients who Received Dental Diagnostic Services Under 21 for FDOS Fiscal Year

10/01/2009 To 09/30/2010

Report: EPS-4167-R
Run Date: 3/30/2011
Run Time: 4:24:05 PM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
90	1	Under Age 1
16,814	2	Ages 1-2
57,208	3	Ages 3-5
67,750	4	Ages 6-9
65,992	5	Ages 10-14
37,982	6	Ages 15-18
5,913	7	Ages 19-20
18	8	Age falls outside of HCFA 416 type
Sum: 251,767		

End of Report

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7.11.3 EPS-4167-R -- Summary of Recipients who Received Dental Diagnostic Services Under 21 for FDOS Fiscal Year Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories	1	Number (Integer)
CMS 416 Age Type Desc	Age grouping of recipient	20	Character
Undup Recipient Count	Distinct # of Recipients	9	Number (Integer)

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7.12 EPS-4168-R -- SUMMARY OF RECIPIENTS WHO RECEIVED NON-DENTAL ORAL HEALTH SERVICES UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.12.1 EPS-4168-R -- Summary of Recipients who Received Non-Dental Oral Health Services Under 21 for FDOS Fiscal Year Report Narrative

The Summary of Preventative Services for Recipients under 21 for From Date of Service (FDOS) Fiscal Year report is a DSS report of the number of children receiving at least one oral health service as defined a HCPCS or CDT code furnished by a licensed practitioner that is not a dentist for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.12.2 EPS-4168-R -- Summary of Recipients who Received Non-Dental Oral Health Services Under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Total Eligibles Receiving Any Oral Health Service By a Non-Dentist for FDOS (12F)

10/01/2009 To 09/30/2010

Report: EPS-4168-R
Run Date: 3/30/2011
Run Time: 4:24:06 PM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
19	1	Under Age 1
4,455	2	Ages 1-2
1,608	3	Ages 3-5
14,938	4	Ages 6-9
7,991	5	Ages 10-14
3	6	Ages 15-18
Sum: 29,014		

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7.12.3 EPS-4168-R -- Total Summary of Recipients who Received Non-Dental Oral Health Services Under 21 for FDOS Fiscal Year Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories	1	Number (Integer)
CMS 416 Age Type Desc	Age grouping of recipient	20	Character
Undup Recipient Count	Distinct # of Recipients	9	Number (Integer)

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7.13 EPS-4169-R -- SUMMARY OF RECIPIENTS WHO RECEIVED DENTAL OR ORAL HEALTH SERVICES UNDER 21 FOR FDOS FISCAL YEAR REPORT

7.13.1 EPS-4169-R -- Summary of Recipients who Received Dental or Oral Health Services Under 21 for FDOS Fiscal Year Report Narrative

The Summary of Preventative Services for Recipients under 21 for From Date of Service (FDOS) Fiscal Year report is a DSS report of the number of children who received a dental service by or under the supervision of a dentist or an oral health service by a non-dentist for a certain fiscal year to verify the CMS-416 report. This report is produced upon request.

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7.13.2 EPS-4169-R -- Summary of Recipients who Received Dental or Oral Health Services Under 21 for FDOS Fiscal Year Report Layout

Alabama Medicaid Agency

Total Eligibles Receiving Any Dental or Oral Health Services for FDOS (12G)

10/01/2009 To 09/30/2010

Report: EPS-4169-R
Run Date: 3/26/2009
Run Time: 9:35:18 AM

Undup Recipient Count	CMS 416 Age Type	CMS 416 Age Type Description
94	1	Under Age 1
10,272	2	Ages 1-2
45,257	3	Ages 3-5
57,676	4	Ages 6-9
52,518	5	Ages 10-14
32,827	6	Ages 15-18
4,814	7	Ages 19-20
541	8	Age falls outside of HCFA 416 type
Sum: 203,999		

End of Report

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7.13.3 EPS-4169-R -- Summary of Recipients who Received Dental or Oral Health Services Under 21 for FDOS Fiscal Year Field Descriptions

Field	Description	Length	Data Type
CMS 416 Age Type	Sort order of specific age categories	1	Number (Integer)
CMS 416 Age Type Desc	Age grouping of recipient	20	Character
Undup Recipient Count	Distinct # of Recipients	9	Number (Integer)

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7.14 EPS-5002-Q VFC IMMUNIZATION PROGRAM PAYMENTS REPORT

7.14.1 EPS-5002-Q VFC Immunization Program Payments Report Narrative

The VFC Immunization Program Payments report is a DSS report that allows users to view a list of providers by provider name, provider number, number of claims paid and total amount paid for Vaccinations for Children (VFC). This report is divided into the following sections:

1. County Health Departments Excluding Jefferson and Mobile Counties
2. Jefferson County Health Departments
3. Mobile County Health Departments

Each section has the same report layout other than the title.

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7.14.2 EPS-5002-Q VFC Immunization Program Payments Report Layout

Alabama Medicaid Agency

VFC Immunization Program Payments
Department of Public Health County Health Departments
Excluding Jefferson and Mobile Counties
For Quarter:12/01/2006 - 12/31/2006

Report: EPS-5002-Q
Run Date: 8/3/2007
Run Time: 3:03:39 PM

Billing Provider Name & NPI	Number of Claims Paid	Dtl Paid Amount
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999

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Alabama Medicaid Agency

VFC Immunization Program Payments
Department of Public Health County Health Departments
Jefferson County Only
For Quarter:12/01/2006 - 12/31/2006

Report: EPS-5002-Q
Run Date: 8/3/2007
Run Time: 3:03:39 PM

Billing Provider Name & NPI	Number of Claims Paid	Dtl Paid Amount
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999

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Alabama Medicaid Agency

VFC Immunization Program Payments
Department of Public Health County Health Departments
Mobile County Only
For Quarter:12/01/2006 - 12/31/2006

Report: EPS-5002-Q
Run Date: 8/3/2007
Run Time: 3:03:39 PM

Billing Provider Name & NPI	Number of Claims Paid	Dtl Paid Amount
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999
XXXXXXXXXXXXXXXXXXXXXXXXXX	99999	$9,999.99
9999999999	999999999999	$999,999.999

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7.14.1 EPS-5002-Q VFC Immunization Program Payments Report Field Descriptions

Field	Description	Data Type	Length
Billing Provider Name & NPI	The billing provider's full name and National Provider Identifier.	Character	37
DTL Paid Amount	Amount paid to individual Vaccinations for Children (VFC) provider.	Number (Decimal)	9
Grand Total	Grand total for the 'Number of Claims Paid' column and grand total for the 'Detail Paid Amount' column for each section of the report.	Number (Decimal)	12
Number of Claims Paid	Lists number of claims paid by provider.	Number (Integer)	5

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7.15 EPS-5003-R – EPSDT REFERRED SERVICES REPORT

7.15.1 EPS-5003-R – EPSDT Referred Services Report Narrative

The EPSDT Referred Services report is a DSS report that is used to view information on paid EPSDT referred services based on the referring physician. This report is ranked in order of the provider with the highest number of referral services. This report is produced upon request.

7.15.2 EPS-5003-R – EPSDT Referred Services Report Layout

Alabama Medicaid Agency

EPSDT Referred Services
Summary of Referred Physicians - By Rank
For Adjudicated Claims:200605 - 200605

Report: EPS-5003-R
Run Date: 7/25/2006
Run Time: 10:11:22 AM

Rank	Referring Provider NPI	Referring Provider Name	Number of Referrals	Total Submit	Total Amount Paid
1	[illegible]	NAME529302690	5	$590.00	$282.00
2	[illegible]	NAME891002920	1	$275.00	$207.00

End of Report

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7.15.3 EPS-5003-R –EPSDT Referred Services Report Field Descriptions

Field	Description	Length	Data Type
For Adjudicated Claims	The beginning and ending months to be reported for referred claims. This information is located in the heading of the report.	6	Date (CCYYMM)
Number of Referrals	The total number of paid claims with provider as referring provider.	6	Number (Integer)
Rank	Ranking of provider based on number of referral services.	6	Number (Integer)
Referring Provider NPI	Medicaid referring provider National Provider Identifier.	10	Number (Integer)
Referring Provider Name	Provider name of referring physician.	28	Character
Total Amount Paid	The total amount paid on paid claims with provider as referring provider.	9	Number (Decimal)
Total Submit	The total amount submitted on paid claims with provider as referring provider.	9	Number (Decimal)

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AMMIS Financial Services Operations Manual

11/06/2014

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

HP Enterprise Services
301 Technacenter Drive
Montgomery, Alabama 36117

Version 4.0

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Financial Services Operations Manual
Version:	4.0
Location:	https://pwb.alxix.slg.eds.com/alxix/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/Financial
Owner:	HPES/Alabama Medicaid
Author:	
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for Change	Changes (Section, Page(s) and Text Revised)
03/08/2008	1.0		Final Version Approval	
08/12/2009	2.0		CO 6970	Update to Section 5, pages 18 and 19.
03/09/2010	3.0		CO 7451	Update Section 9, page 29, to reflect the following: Cease printing/mailing of RAs
11/06/2014	4.0		Updates to reflect current processing	

1.3 RELATED DOCUMENTATION

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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2 INTRODUCTION

The information contained within this manual will assist staff members with the administration of the Alabama Medicaid Management Information System (AMMIS) and account support.

2.1 FINANCIAL SERVICES UNIT FUNCTIONS

The Financial Services unit consists of the following:

- Banking Services
- Provider Adjustments
- Provider Cash Receipts

2.2 FINANCIAL SERVICES FORMS

All forms referenced in this document can be found in iTRACE under the functional area.

2.2.1 Financial Services Tasks

The following list identifies the tasks most frequently performed by the Financial Services unit:

- Enter provider payout (expenditure) and recoupment (account receivable) transactions and track to completion.
- Produce annual 1099 documents that are sent to providers and 1099 tapes that are sent to the Internal Revenue Service (IRS) and State Department of Revenue.
- Issue corrected 1099 documents as requested and notify the Agency, the State Department of Revenue, and IRS of the corrections.
- Open and maintain separate bank accounts for Medicaid fund disbursements and money returned to the Medicaid program.
- Process mass adjustments to claims.
- Produce warrants (checks).
- Receive and deposit refund checks daily for providers.
- Reconcile bank accounts.
- Research and enter individual claim adjustments.
- Research money returned and enter cash transactions to post the returned funds to the correct claims in history or open accounts receivable.

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2.3 INPUT, PROCESSES, AND OUTPUT

2.3.1 Input

The table below documents the inputs to the Financial Services area:

Common Financial Services Input

Input	Source	Purpose
Claim Adjustment request	Agency Contractor staff	To make a change to a paid claim. This can result in: • An Additional Payment • A claim specific account receivable • A data change that creates neither an additional payment nor an AR.
Bank statements and transaction files	Agency Bank	Used in conjunction with AMMIS financial reports and manual process logs to reconcile all deposits and disbursements from the Medicaid bank accounts.
Check payment database	AMMIS financial processing cycle	To produce checks and Electronic Funds Transfer (EFT) transactions to pay providers for services rendered.
Mass adjustment request	Agency Contractor	Identifies a large volume of claims that require the same adjustment correction: *Examples:* Retroactive provider rate change. Retroactive procedure price change. Retroactive patient liability change for a recipient.
Money	Agency	Deposits made to the Medicaid disbursement account used to pay Medicaid checks and EFTs issued to providers.
Payout transaction (expenditure)	Agency Contractor	To pay a provider an additional lump sum of money that is non-claim specific: *Example:* The State owes the provider additional money at the conclusion of an annual hospital cost settlement audit.
Provider earnings database	AMMIS	Used to produce annual 1099 documents that are sent to providers and 1099 tape files that are sent to the IRS.

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Input	Source	Purpose
Recoupment transaction (account receivable)	State Contractor	To recover a lump sum of money from a provider that is non-claim specific: ***Examples***: A Surveillance Utilization Review (SUR) review identifies the provider over-billed and must repay money. The provider owes the State money at the conclusion of an annual hospital cost settlement audit.
Refund check	Provider	To refund money to the Medicaid program due to an overpayment on an account by sending in a check to Financial Services.
Returned Medicaid warrant (check)	Post Office Provider	An original Medicaid issued check that the provider does not accept or is returned from the post office marked as undeliverable.

2.3.2 Processes

Processes accomplished in the Financial Services unit include the following:

- 1099 reporting
- Bank reconciliation
- Financial balancing
- Payment Release
- Individual claim and mass adjustments
- Non-Claim Expenditures and Accounts Receivables
  - Non-Claim Expenditures
  - Non-Claim Account Receivables
- Provider Cash Receipts
  - Refunds
  - Voids and stale dates
- Provider Payments
  - Each of these items are described in the individual sections in the manual.

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2.3.3 Output

The table below documents the outputs from the Financial Services unit:

Common Financial Services Output

Output	Source	Purpose
1099 documents and tape files	AMMIS	To notify providers, the IRS, and the State Department of Revenue of the total amount of Medicaid dollars paid to each provider.
Reports, including Remittance Advices (RAs)	AMMIS	To provide summaries, statistics, and comprehensive audit trails for all Medicaid dollars paid and received.
Warrants (checks) and EFTs	AMMIS	Instruments of payment to providers for services rendered.

2.4 FINANCIAL AREA RESPONSIBILITIES

The following responsibilities for the Financial Services unit were extracted from section 3.07 of the Invitation To Bid (ITB):

General

1. Operate the Claims Reporting and Financial component of the Alabama MMIS, including improvements as they are implemented.
2. Support all claims reporting functions, files, and data elements necessary to meet the requirements of this ITB.
3. Support all financial application functions, files, and data elements to meet all requirements in the ITB.
4. Transmit payment invoices to the State by paper and electronically.
5. Complete the payment cycles within established time frames so that provider payments can be electronically transmitted or mailed in a timely manner.
6. Process and generate capitation payments for HMO and managed care providers.
7. Process and generate case management fees for the PCCM Program and the Recipient Lock-In Program.
8. Process and generate capitation payments for Prepaid Inpatient Health Plan (PIHP). *(NOTE: This requirement was excluded in the GAP session. To further clarify, the financial team manually keys from a list provided by State. An expenditure transaction for each of the PHP districts and the amount is keyed. That is how these capitation payments are made.)*
9. Update the claims history file/database with the check number, financial cycle date, and amount paid information by the first business day following each financial cycle.
10. Prevent processing of checks and EFTs for those test transactions processed through the Integrated Test Facility (Model Office and UAT).
11. Perform all internal balancing activities to ensure accurate disbursement of payments.

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12. Provide on-line access to claims and financial information.
13. Provide training and instructions in an on-line user manual to State staff on accessing claims and financial information, initially and on an ongoing basis, as requested by the State.
14. Provide payment data from the provider claims, adjustment, accounts receivable, and transaction processing activities to Medicaid.
15. Process and generate provider and recipient claims history requests.
16. Provide systematic update capabilities to claims and financial history.
17. Provide a contingency plan for processing payments in the event that there is an interruption of the payment cycles.
18. Maintain a claim control and inventory system approved by the State.
19. Provide the State with imaged and/or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and facsimile copies of all electronic transactions processed.
20. Produce and transmit a monthly paid claims extract file to the State's peer review organization to support retrospective hospital utilization reviews. (Note: This is a function of the Claims Subsystem.)
21. Utilize EFT to deposit payments to provider accounts.
22. Apply check number file to claims history.
23. Identify all checks to be pulled for stop payment.
24. Receive and deposit all returned provider checks.
25. Review provider 1099 earnings reports and resolve any discrepancies.
26. Establish capability to split-release provider payments as directed by the State.
27. Make written recommendations on any area in which the Contractor thinks improvements can be made.
28. Provide to Medicaid, two (2) months prior to Operations, a detailed allocation by cost centers for Contractor activities on which percentages of the administrative fees are allocable at ninety percent (90%), at seventy-five percent (75%), and at fifty percent (50%) federal financial participation. Such allocation shall be in accordance with the requirements of federal regulations for Alabama MMIS, Section 11276 in Part 11 of the State Medicaid Manual and in a manner prescribed by the State.

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Reports

1. Produce internal control reports documenting workload by location, providers, recipients, or claim types on a weekly, monthly, and annual basis, and make available to Medicaid on request.
2. Produce all required claims operations reports, and make available on-line or deliver to the State within established timeframes and State-specific distribution procedures.
3. Produce all required financial/fiscal management operations reports, and make available on-line or deliver to Medicaid within established time frames.
4. Produce and make available on-line or deliver to Medicaid all required Federal and State financial reports within established time frames.
5. Produce reports necessary for the State to monitor accounts receivable, recoupments, and other financial transactions.
6. Produce reports necessary to meet the requirements of the Federal Cash Management Improvement Act of 1990.
7. Submit to designated State staff a monthly report listing separately all Contractor or State identified inappropriate and/or incorrect provider payments. *(NOTE: This requirement was excluded in the GAP session.)*

Recipient Explanation of Medical Benefits (REOMBs) (Note: This is a function of the Claims subsystem.)

1. Generate and distribute REOMBS (based on 42 CFR 433.116 and Claims Processing Policy PA-029 requirements) to a selected sample of recipients monthly according to a sampling plan approved by Medicaid. Confidential services shall be excluded from the REOMBs. REOMBs shall be mailed promptly, but in no case shall the delay exceed forty-five (45) calendar days from the date of claims payment and/or ten (10) days from the REOMBs requested date. REOMBs shall be sent to each recipient, in a specified sample, who received services during a specified time period, except for those services specifically excluded by Medicaid. REOMBs shall contain a stamped return envelope or business reply envelope. These requested REOMBS will be ordered in different samplings on a yearly basis. REOMBS are to be returned to the requesting individual, including a copy of the REOMBS mailing list. The sample size shall be up to one thousand three hundred (1,300) per month. The cover letters for the REOMBs will change specific to the information given by the requestor.
2. Generate special targeted REOMBs to be sent to recipients who have received services from a specific provider for a specified time period. Targeted REOMBs are to be mailed promptly, but in no case shall the delay exceed ten (10) days from the REOMBs requested date. Targeted REOMBs shall contain a stamped return envelope or business reply envelope. Targeted REOMBs are to be returned to the requesting individual, including a copy of the REOMBs mailing list. A cover letter will be prepared for each requested targeted REOMB specific to information given by the requestor. A maximum of four (4) targeted providers per month is anticipated.

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3. Receive returned REOMBs at a separate post office box used specifically for the receipt of such REOMBs. Review and sort returned REOMB responses into the following three categories: (1) services were received, (2) services were not received or amount paid by the recipient did not match co-payment, or (3) recipient has questions or is not sure about the Medicaid payment or services. Attempt to clarify suspicious or questionable responses through the use of a follow-up letter and/or a call to the recipient. All responses that remain suspicious or unusual after follow-up shall be referred to the Associate Director, Investigations. REOMBs which do not require follow-up correspondence shall be microfilmed/imaged and forwarded to the state for record keeping purposes.

Explanation of Payments (EOPs)

1. Produce and distribute provider RAs in an electronic format approved by the State, within State-established timeframes.
2. Support multiple formats for the EOPs, including the ASC X12N 835 format, by provider type and claim type, electronically, and on-line access by State staff.
3. Provide the capability for the provider or vendors to download 835 EOPs through the web.
4. Produce the remittance advice statements/EOPs in a format approved by the State. The remittance advice shall be clear and in a readable format, such that the information is easily located and interpreted by the user.
5. Produce all claims text and data information on the RA in a format which is understandable to providers. Medicaid's Interactive Web portal allows providers to view RAs on-line. RAs are stored for six months on the interactive database. RAs can also be printed, saved to a personal computer, or viewed from the web portal.
6. Print or display third party resource data on provider EOPs for claims denied for potential TPL insurance.
7. Provide additional copies of RAs to providers for a State approved charge.
8. Make RAs available via internet in a readable format.

Provider Earning Statements (1099s)

1. Generate and distribute a consolidated 1099 earnings report to providers.
2. Create 1099 file.
3. Generate and submit a 1099 tape to the IRS and the State Department of Revenue.
4. Capture and store 1099 data.
5. Respond to provider inquiries regarding 1099 discrepancies.
6. Research, revise and reissue any 1099s which are in error.

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Banking

1. Establish and maintain a separate depository account for the receipt of funds from Medicaid for provider payments. As warrants are presented for payment or electronic fund transfers are made, the contractor shall ensure that funds are transferred from the Depository Account to the Disbursement Account. Remaining funds shall be invested in standard overnight repurchase agreements. Furnish the necessary bank information to accommodate Federal requirements for sharing interest on undistributed funds. All bank charges on this account shall be the responsibility of the contractor.
2. Establish and maintain a separate disbursement account for the purpose of paying Medicaid providers. All bank charges to this account shall be the responsibility of the contractor.
3. Establish and maintain a separate interest bearing account for deposit of income earned on repurchase agreements. All deposits to and interest earned on this shall accrue to and be paid to Medicaid at least monthly. All bank charges on this account shall be the responsibility of the contractor.
4. Establish and maintain a separate interest bearing account for deposit of refunds from Medicaid providers. All deposits to and interest earned on this account shall accrue to and be paid to Alabama Medicaid at least monthly. All bank charges on this account shall be the responsibility of the contractor.
5. Prepare a solicitation for bids for banking services to be approved by Alabama Medicaid. Solicit bids from Alabama banks with net assets over one billion dollars ($1,000,000,000) to determine the best possible interest arrangement for Medicaid funds. Select the bank which offers the highest overall return on all accounts and finalize banking arrangements following written approval of said arrangements by Alabama Medicaid.
6. Pay providers by Electronic Funds Transfer (EFT). Deliver to its bank the necessary EFT file to cover all or any portion of the provider payroll, as directed by Alabama Medicaid, for the timely release of funds. Release all EFT provider payments the day the funds are received from Alabama Medicaid and all paper checks within twenty-four (24) hours of receipt of funds from Medicaid unless otherwise directed.
7. For each financial cycle performed, provide electronically to the State automated itemized invoices detailing, in a manner and timeframe prescribed by Medicaid and consistent with federal reporting requirements, benefits paid (including interim payments), adjustments made, and the administrative fees charged. If the Contractor, for any reason, makes payment to a provider for an amount different from that shown on the register, the State shall be notified immediately of the change and the reason thereof.
8. Submit on a monthly basis one (1) hard copy and one (1) electronic copy of the check/EFT register of all manual payments issued from the disbursement account for the current month.

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9. Submit on a monthly basis two (2) hard copy listings and one (1) on-line copy of all void transactions for the current month. Funds from these voids that are not reissued shall be returned to the State by the tenth calendar day of the following month. Sixty (60) calendar days after the date of check/EFT transaction, void all transactions that have not been paid.
10. Submit on a monthly basis a full reconciliation of the depository account, the benefit disbursement account and investments in repurchase agreements. The purpose of such reconciliation is to fully account for all monies outstanding for provider payrolls. The reconciliation shall include an analysis of the account, listing in numerical sequence all checks/EFT transactions issued. This listing shall indicate whether the checks/EFT have been paid, voided, canceled or are still outstanding. Provide a daily account analysis indicating the ledger and collected cash balances in the account on each day during the month.

Accounts Receivable

1. Provide the capability to link Accounts Receivable transactions (e.g. Medicaid providers and recipients, TPL, and for Drug Rebate manufacturers, liens, etc.) to the corresponding claims in the MMIS and process adjustment transactions, where appropriate. For each MMIS functional area that generates Accounts Receivable transactions, provide the following capabilities:
   - Case tracking functions to maintain claims that are in the process of review and evaluation to determine if a payment is due from a third party (Note: This is a function of the TPL subsystem.)
   - Identification and tracking of contingent receivables when the State believes that an amount is owed but the specific amount or the collect ability of the amount has not yet been determined
   - An Accounts Receivable file for providers to maintain amounts that have been determined to be owed to the Agency and are also likely to be collected.
2. Monitor the status of each provider accounts receivable, and report after every provider payroll to the State in aggregate or individual accounts as specified by the State, both on paper and on-line.
3. Monitor outstanding provider accounts receivable, issue collection notifications, apply recoveries or write-off transactions where appropriate, and report the outstanding accounts receivable to the State after every provider payroll.
4. Monitor the status of each recipient accounts receivable and report monthly to the State in aggregate or individual accounts as specified by the State, both on paper and on-line. (Note: This is part of the Recipient AR Subsystem.)
5. Monitor recipient accounts receivables, issue collection notifications, and report the outstanding accounts receivables to the State monthly. (Note: This is part of the RECIPIENT AR Subsystem.)
6. Accept, store, and report information on those individuals or entities subjected to Tax Intercept. (Note: This is part of the Recipient AR Subsystem.)
7. Generate letters to those subject to Tax Intercept. (Note: This is part of the Recipient AR Subsystem.)

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8. Generate Tax Intercept tape for the State Department of Revenue which contains name, social security number, reason for debt, and amount of debt. (Note: This is part of the Recipient AR Subsystem.)
9. Monitor compliance with written procedures to meet state and federal guidelines for collecting accounts receivables.
10. Create an aging statement after every provider payroll for outstanding accounts receivables.
11. Receive requests to process cost settlements and recoveries from the State.
12. Enter accounts receivable transactions into the MMIS Claims History, as directed by Medicaid.
13. Verify input and monitor status of outstanding accounts receivables.
14. Provide access for the State to post payments to accounts receivable subsystem.
15. Provide an interface with the Drug Rebate system as described in Section 3.10.
16. Update provider accounts receivable balances after every provider payroll.
17. Generate accounts receivable balance reports.
18. Receive, track, process, and report provider recoupments.

Adjustments

29. Enter all Medicaid requested adjustment transactions into the MMIS.
30. Process audit payments/credits as directed by Medicaid.
31. Process Medicaid-established individual (a single claim for a single individual) and gross adjustments (entire caseload) to managed care providers on the provider payroll following receipt of the request from Medicaid.
32. Perform mass (adjustments which correct many claims due to a change in the system) and gross lump sum adjustments (provider adjustments), when directed by Medicaid.
33. Identify and correct any erroneous payments resulting from changes in patient liabilities, individual nursing facility rates, or Long Term Care (LTC) File.
34. Process credit adjustments and recoupments and apply to claims history.
35. Identify and process adjustments resulting from system-caused errors or contractor negligence. Notify Medicaid and providers of such adjustments within Medicaid agreed-upon time frame.
36. Process adjustments to original and adjusted claims and maintain records of all previous processing.
37. Adjust provider 1099 and claims history based on returned checks, HPES issued manual checks, audit adjustments and provider personal checks.
38. Deliver to the State a report listing lump-sum adjustments after every provider payroll.
39. Create facsimiles of electronic adjustments and image paper adjustment requests and make available on-line via provider ID, RID or transaction number.

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2.5 PEFORMANCE EXPECTATIONS

The following performance expectations for the Financial Services unit were extracted from section 3.07 of the Invitation To Bid (ITB):

1. Produce to the State all required financial reports no later than noon on the first business day following the adjudication cycle.
2. The percentage of EFT payments to total payments per payment cycle must remain above the Alabama Cash Management Improvement Act standard, currently ninety-five percent (95%) of total dollars.
3. Produce to the State the electronic transmittal of invoices, in a format established by Medicaid, no later than 10:00 a.m. local time on the first business day following the adjudication cycle.
4. Process monies received from providers for services paid for recipients retroactively determined to be ineligible, SUR recoupments, returned checks, provider checks and any other checks received. Checks from third party payers will be forwarded to the State for processing.
5. Perform two (2) payment cycles per month, on demand cycle, or on a schedule established by Medicaid.
6. Process State-established individual and gross adjustments for Managed Care capitation payments prior to monthly capitation processing.
7. Provide Medicaid with imaged or hard-copy original claims, adjustments, attachments, non-claim transaction documents, and all facsimile copies of electronic transactions processed within ten (10) business days, upon request.
8. Generate, image, make available on-line, RAs by the first business day following each payment cycle.
9. Generate recipient and provider history printouts within one (1) business day of receipt of requests.
10. Produce to the State and/or make available online claims inventory, operations, and other reports after each claims processing payment cycle.
11. RAs shall be imaged and available on-line the first business day following each payment cycle.
12. Enter provider refunds within fifteen (15) business days of receipt.
13. Produce and transmit a monthly paid claims extract file to the State's peer review organization to support retrospective hospital utilization reviews within ten (10) business days of the last payment processing cycle of the month.
14. Produce and mail (or transmit electronically) provider 1099 earnings reports to providers no later than January 31, each year.
15. Produce and mail federal and state 1099 tapes in accordance with federal and state regulations no later than January 31, each year. Reissue any 1099's which are found to be in error.
16. Produce and submit to the State and make available online after each provider payroll reports on accounts receivable collections and outstanding balances in aggregate and/or individual accounts, as approved by the State.

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17. Produce and submit to the State and make available online monthly reports on recipient accounts receivable collections and outstanding balances in aggregate and/or individual accounts as approved by the State. (Note: This is a function of the Recipient AR Subsystem.)
18. Generate and send Tax Intercept tape to the State Department of Revenue no later than last business day of the year. (Note: This is a function of the Recipient AR Subsystem.)
19. Generate and mail Tax Intercept notification letters to recipients by October 15 of each year. Approximately two thousand five hundred (2,500) letters are mailed to recipients annually. (Note: This is a function of the Recipient AR Subsystem.)
20. Process adjustments entered on-line in the next adjudication cycle.
21. Process all State-approved mass adjustments in the next adjudication payment cycle.
22. Provide copies of bank statements and reconciliations of the depository account and disbursement account no later than twenty-five (25) calendar days following the end of each month.
23. Provide reconciliations of the provider refund account and the income earned account no later than ten (10) calendar days following the end of the month.
24. Create accounts receivable records and produce and mail (or submit electronically) third party invoices on a schedule approved by Medicaid. Create pre-production reports for review by State staff prior to creation of accounts receivable records and claims. Reports shall be available on COLD for State review and approval. Within two (2) business days of State approval of reports, Contractor shall create accounts receivable records for State approval. Within two (2) business days of receipt of approval of accounts receivable records, Contractor shall produce paper and electronic billings for State approval prior to mailing Contractor shall mail/transmit post-payment billings within four (4) business days of State approval of the billings. Invoices shall not be added to accounts receivable or distributed prior to State approval. Approximately seven thousand (7,000) invoices are mailed or submitted electronically per month. Pre-production reports, accounts receivable entries, and claims facsimiles (or hard copy claim facsimiles) shall be available for on-line viewing. (Note: This is a function of the TPL Subsystem.)

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3 1099 REPORTING

All dollars paid to Medicaid providers must be reported to State and Federal taxing authorities according to Medicaid regulations. At enrollment, every provider must report his Federal Employer Identification Number (FEIN) or Social Security Number (SSN) for correct income reporting to tax authorities. AMMIS maintains the provider information on the Provider Master File and accumulates all dollars paid and recovered from providers on the Provider Earnings file.

After the last payment cycle for a calendar year, the 1099 process creates individual 1099 forms. The 1099 forms are mailed to providers no later than January 31st of each calendar year for the previous years' earnings. During this process, a magnetic tape with identical information is created and sent to the IRS and the State Department of Revenue. These tapes are delivered no later than January 31st of each calendar year for the previous years' earnings.

NOTE:

During the third quarter of each calendar year, it is important to review the 1099 process. This will ensure that any changes that are required by the IRS in the 1099 form, magnetic tape specifications, or record layouts are identified and sufficient time is allocated to make the modifications in AMMIS.

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4 BANK RECONCILIATION

Each month, the bank produces bank account statements and sends them to Financial Services. The Cash Financial Clerk (s) reviews the statements and compares them to information produced in AMMIS financial reports. A monthly report of bank account status and the results of bank statement account reconciliation for each open bank account is prepared. Account reconciliation is typically completed within 15 days of receipt of account statements and no discrepancies are left unresolved. Completed monthly reports are delivered to the Agency.

4.1 DEPOSITORY AND DISBURSEMENT ACTIVITY

Financial Services completes the bank reconciliation procedures each month for the Master Funding and Disbursement accounts.

Financial Services receives the reconciliation from Regions Bank by the 15th day of each month. Regions Bank sends a Depository and Disbursement statement along with a CD-ROM of cleared checks to verify transactions. The Cash Financial Clerk then performs the following tasks:

1. Obtain the following items to use each month to prepare the Depository and Disbursement account reconciliation:
   - Current month's bank statements.
   - Listing of manual checks.
   - Listing of voided checks.

     If an original check was not voided, and a replacement check was issued, make sure the check number was keyed correctly. If the check number was keyed incorrectly, add the check to the next month's void sheet that is sent to the bank. This check is also considered a reconciling item.
   - Returned EFT payments.
   - The following bank reports:
     - Bank Reconciliation Report from Regions Bank.
     - Diagnostic Summaries Report.
2. Send a listing of new issues and a listing of voided checks to Regions Bank.
3. Verify the deposits and the EFT totals on the statements.
4. Obtain the deposit amount.
5. Obtain the new issue amount.
6. Obtain the void amount from the Bank Reconciliation Report.
7. Prepare the reconciliation and deliver it to the Agency, along with a copy of the Bank Reconciliation Report in Paid Date order, and another copy of the Bank Reconciliation Report in Check Number order.

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4.2 REFUND ACCOUNT

Financial Services completes the following bank reconciliation procedures each month for the Refund account:

1. Obtain the reconciliation statement that Regions Bank sends to HPES and a complete reconciliation statement by the 15th day of each month.
2. Compare the daily refund deposits using the actual deposit slips against the Regions Bank statement to ensure that all deposits were posted accurately. The total daily refund deposits should match the total deposit balance on the Regions bank statement, excluding the total interest paid.

NOTE:

If the amounts do not match, the bank is immediately notified. This process will not continue until the discrepancies are corrected.

3. Post the weekly processed refund amounts, taken from the report for the reconciliation month, on the Daily Cash Receipt Log.
4. Obtain a total processed refund amount, using the weekly amounts posted, on the Daily Cash Receipt Log.
5. Obtain totals for any refund transactions not posted to the AMMIS within three months of deposit.

NOTE:

Refund transactions may age to three months or more if HPES has requested the provider submit additional documentation for the refund request and the provider has not yet responded.

6. Obtain the weekly excess refund amounts from the Financial Exception report for the reconciliation month on the Daily Cash Receipt Log.
7. Obtain totals for any refund transactions that are over three months old which have been processed by the AMMIS.
8. Obtain the total interest paid amount from the bank statement for the reconciliation month.
9. Obtain the processed refund amount, by invoice category, from the Approved to Pay reports produced from the financial cycles for the reconciliation month.
10. After all of the totals in items 3 through 9 are obtained, the monthly refund letter is generated by performing the following steps:
    - List the daily refund deposits and the total refund amount.
    - Add the monthly interest earned to the total refund amount which determines the total amount.
    - Add to the amount derived from adding the daily refunds and the interest earned (in the previous bullet item) the Total (Month) Balance from the previous months' Refund Letter to determine the current (Month) Balance.

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- Using the current (Month) Balance, determine the Total Check amount by adding or deducting the following items:

NOTE:

The Total Check amount is turned over to the Agency each month with the completed Refund Letter by obtaining a cashier's check from Regions Bank, drawn on the Refund Account.

  - Deduct the total processed refund amount (refer to item 4).
  - Deduct the refunds over three months old total amount (refer to item 5).
  - Deduct the total excess refund amount (refer to item 6).
  - Add the refunds over three months that processed total amount (refer to item 7).
  - Deduct the total interest paid amount (refer to item 8).

11. Document the Uncashed Checks total amount for stale dated checks, if applicable, on the Refund Letter.
12. Document the total amount for HPES computer generated checks that were returned to HPES by providers and not reissued.

NOTE:

These checks in items 11 and 12 were originally issued through the Disbursement Account, therefore the refund checks for these funds are drawn on this account.

13. Document the Interest Earned from the Depository Bank statement.

NOTE:

The total Interest Earned amount is turned over to the Agency each month with the completed Refund Letter by obtaining a cashier's check from Regions Bank, drawn on the Depository Account.

14. Deliver the Refund Letter, AMMIS report documenting voided checks and uncashed checks, and the applicable cashier's or manual checks to the Agency by the 10th of each month following the reconciliation month.

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5 FINANCIAL BALANCING

The AMMIS balances when the Financial Cycle is complete. Financial compares the amount of money actually paid on the checks/EFT's to the records that are brought into the cycle (claims, adjustments, cap, payouts, etc...) minus recoupments made (AR's, Liens). If the two amounts do not balance, then the cycle abends. The cycle is stopped and the problem is identified and resolved before proceeding.

Reports are generated based on the balancing of financial and claims information. The number of claims and total dollars recorded as paid, denied, recouped, or paid out in transactions (from the claims and financial cycles) are compared to the categories for the output.

The Cash Financial Clerks then compares the Alabama Invoice to the Approved to Pay and the Payment Register totals to further confirm that the financial cycle is balanced.

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6 PAYMENT RELEASE

After the financial checkwrite cycle, money must be deposited into the Medicaid depository bank account on which provider checks are drawn. The Agency will determine the fund groups to be held and released. Once this determination is made, the Agency will contact Financial Services at HPES and the process will begin to release and hold fund groups. Provider checks can be released and mailed to the provider when the fund transfer is complete. .

NOTE:

The customer can view electronic invoices on FEITH the first morning following a financial cycle. (This only applies to business days.)

The State divides the payments into fourteen fund groups and each fund group is reviewed to determine which payments will be held in the event of a fiscal pend. The fund groups are as follows:

- Alabama Department of Senior Services (ADSS)
- Department of Public Health (DPH)
- Department of Human Resources (DHR)
- Drugs
- Hospitals
- Mental Health
- Non-Institutional
- Nursing Homes
- Other State Agencies
- Disproportionate Share Hospital Enhanced(DSH)
- Pregnancy Related
- Targeted Case Management (TCM)
- Medicaid Emergency Psychiatric Demonstration (MEPD)
- Electronic Health Record Meaningful Use (EHRMU)t

The State notifies HPES which fund groups to release when they have made their decision. As funding becomes available for held fund groups, the same release pattern is followed to control release of the fund groups for that financial cycle.

A separate financial cycle for On Demand payments will run on a requested day of the week determined by the State. A separate invoice is produced for this cycle. The release process is exactly the same as the Main Financial cycle payments.

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HPES Financial Services will complete the following steps in order to process a Funds Request:

1. Locate the financial cycle jobs and reports.

   Obtain the Approved to Pay Report, the invoices, and the Payment Register to determine the checkwrite totals for the cycle. These cycle reports provide category total amounts.

2. Ensure the invoices match the total Payment Register amount. Produce invoices, Payment Register, and AMMIS financial reports on the first workday following the adjudication cycle.

3. The Cash Financial Clerk enters the Agency fund group release decisions for the financial cycle on the EFT Release panel. The EFT release program will run automatically. The Financial SE provides the file to the Cash Financial Clerk. The Cash Financial Clerk FTP's the file to the bank.

NOTE:

The customer can view electronic invoices on FEITH the first morning following a financial cycle. (This only applies to business days.)

6.1 MANUAL PAYMENTS

A manual payment is usually requested if a provider was underpaid or the provider submitted claims and received no payment. The provider contacts the Agency and the Agency informs Financial Services. The Agency provides the provider number, provider name, and the amount to be paid. The Cash Financial Clerk submits an invoice to the Agency with the preceding information and the fund code. The Agency will contact the Cash Financial Clerk when the funds are available to pay the provider.

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7 INDIVIDUAL CLAIM AND MASS ADJUSTMENTS

Through review of their RA, providers may find a payment error caused by a billing error in their office or an error made during claims processing. Should this occur, the provider may perform an adjustment through the Medicaid's Interactive Web Portal. This allows the adjustment to be submitted in an on line in a real time environment. The Provider Electronic Solutions (PES) software allows providers to submit adjustments on-line in batch mode.

For a single claim adjustment request by the Agency or Contractor staff, the adjustment specialist enters the adjustment into the Claim Adjustment Entry Panel by entering the Internal Claim Number (ICN) number or selecting a valid number from the search panel. The adjustment specialist modifies the data to correct the billing error. Every claim adjustment request form is scanned on the day of receipt. It receives an adjustment ICN and is also filed for historical audit trail purposes.

The Mass Adjustment transaction process is used when the same change or correction can be applied to an entire set of claims. Examples of mass adjustments include situations when retroactive rate changes occur to a provider's set reimbursement rate or procedure or drug code payment amounts, or when a recipient's nursing home patient liability amount changes retroactively.

All previous claims for the specified occurrence and time period may be adjusted by submitting a single mass adjustment transaction. The system uses the transaction criteria to search claims history to identify all claims that meet the specified selection criteria and automatically create individual claim adjustments with the corrected data for processing in the claims processing cycle. The adjustments are processed to determine the net underpayment or overpayment that will then appear in the weekly provider check amount and on the affected provider RA.

The following steps indicate the process the adjustment specialist must follow to complete a claim adjustment:

1. Receive all Adjustment Request forms and related mail from the mailroom.
2. Sort all adjustment requests into appropriate adjustment region codes and bundle the adjustments into batches.
3. Review each incoming adjustment to determine if it is a claim that can be adjusted. Claims that can be adjusted are as follows:
   - Claim is in a paid status.
   - Claim is on the history file.
   - Claim has a valid reason for the adjustment.
4. Prepare a return letter and return adjustment requests to the provider (or other initiator) if the request is not valid.
5. Complete an Adjustment Batch Cover Sheet and attach it to the batch of adjustment requests.
6. Log the batches of adjustments into the Adjustment Batch Log Book to record daily counts of receipts and to track special priority batches.
7. Deliver all batched adjustment request forms to the mailroom for scanning and Internal Control Number (ICN) assignment.

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8. The mailroom scans the batches and assigns ICN numbers to the batches then returns them to the Adjustment Specialist. Once the document is returned, sign on to AMMIS and enter the adjustment transaction via the adjustment panel.
9. Enter all adjustment requests using the adjustment panel, making appropriate changes to the original paid claim information and resolving online edits that appear on the panel during data entry.
10. Obtain adjustment worksheets via the data corrections panel and perform resolutions to edits or audits that suspended during the claims processing cycle.
11. Enter data corrections into the Claims system.
12. Once each month, compile the Adjustment Statistics, using the Adjustment Batch Log Book and last month's ending adjustments inventory count, and submit them to the Financial Services manager.

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8 NON-CLAIM EXPENDITURES AND ACCOUNT RECEIVABLES

In addition to claims payments and claims adjustments, AMMIS processes two other primary financial transactions. They are as follows:

- Non-Claim Expenditures
- Non-Claim Account Receivables

8.1 NON-CLAIM EXPENDITURES

The Agency determines when a non-claim expenditure (audit adjustment payment) should be requested and only those persons who are authorized at the Agency may submit them. After the requests are received from the Agency, the Cash Financial Clerk prepares and submits the expenditure transaction to AMMIS. An expenditure amount (lump sum payment amount) is added to the provider's check amount to satisfy this audit request. In-house expenditures (audit payment adjustments) are done to correct a refund error.

To ensure separation of duties, a different Cash Financial Clerk reviews expenditure (audit adjustment) reports to confirm that the amount paid matches the original authorized request. Every audit adjustment transaction is assigned a transaction tracking number and filed for historical audit trail purposes.

8.2 NON-CLAIM ACCOUNT RECEIVABLES

The Agency determines when a non-claim accounts receivable (audit adjustment recoupment) should be requested and only those persons who are authorized at the Agency may submit them. After the requests are received from the Agency, the Cash Financial Clerk prepares and submits the account receivable transaction to AMMIS. An account receivable amount (audit adjustment recoupment amount) is subtracted from the provider's check amount to satisfy this account receivable request. Any positive payment money for the provider in the current or subsequent financial payment cycles is applied to the open account receivable until all of the money has been recovered.

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9 PROVIDER CASH RECEIPTS

Providers who owe money to the Medicaid program may pay by writing a personal check. The check is attached to a Check Refund Request form and may be accompanied by a letter that identifies the reason for the refund and the claims that are being refunded.

A separate, interest-bearing account is maintained by HPES for handling provider refunds. To ensure separation of duties and provide adequate financial controls, multiple individuals play a part in processing refunds. Monthly, the funds deposited into this account, along with the interest earned, are turned over to the Agency.

There are two other primary cash receipt transactions. They are as follows:

- Refunds
- Voids and stale dates

The Cash Financial Clerk performs appropriate research on the money refunded and prepares financial transactions to correctly post the money to individual claims or open accounts receivable as directed by the provider.

The responsibilities of opening the mail and depositing the checks into the refund account are assigned to the staff in Financial Services. Refunds that are not accompanied by the Check Refund Request form are deposited into the Refund account. The check copy and associated documentation are returned to the provider for additional information so that accurate posting can occur.

Cash Financial Clerk 1

1. Receive mail from the mailroom that is directed to Financial Services.
2. Open the mail and sort the mail into the categories described in the table below:

Cash Unit Categories

Category	Description	Disposition
Adjustments	Checks received by Financial Services for a recoupment that was established as the result of an adjustment. The provider can send a copy of the RA Financial Item page that shows the recoupment and the Check Refund form with the check to help identify the A/R.	Checks are given to the person responsible for applying money to the open A/R during the current week.
Cashed HPES checks	The provider requests a copy of a check with a letter asking that a copy of a cashed Medicaid check be pulled and sent back to them.	A copy of the check is printed from Regions iTreasury listing all cashed checks. This copy is sent to the provider as proof of payment.

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Category	Description	Disposition
Checks received in another unit	Checks received in any unit within HPES.	When a check is received in another unit, a person from that unit brings the check and other information to the person responsible for that day's mail and the check is logged along with all other refund checks.
RA copies	Checks received with a letter requesting a copy of a RA.	Checks are forwarded to Financial Services. The Cash Financial Clerk lists these checks on the check log for RA copies. The current date is stamped on the check and the check is forwarded to the Administrative Secretary.
Return mail	Mail not delivered by the post office. The yellow sticker placed on HPES envelopes by the post office identifies these checks. The sticker indicates that either the check could not be delivered or that there is a forwarding address on file at the post office.	The copy of the check is forwarded to Provider Enrollment so that the address for the provider can be verified. The original check is forwarded to Financial Services. After the provider address has been verified and corrected on file, the Cash Financial Clerk mails the original check to the correct address.
Stop payment request	A form filled out by the PAC team member to have a payment stopped on the original check and a new check reissued.	This form goes to Financial Services for the stop payment.
Warrants (checks)	Returned HPES checks that the provider refused. These checks can be identified by a note written on the HPES envelope or on the HPES check issued to the provider stating why the check was refused.	All HPES checks that are returned because the provider refused the check are given to a Cash Financial Clerk.

3. Determine the check is for a refund. Make a copy of all checks and attach to associated documentation. The check information is then entered into the AMMIS under financial panel/cash receipt.

Refund Check Types

Refund Type	Refund Type Description
Letter	Checks that require a letter to the sender because information is needed to determine where to apply the refunded money. All checks deposited into the refund account must have an amount of refund to apply to each individual claim ICN when a provider is sending one refund check for numerous claims.
Medicare	Claims that are refunded because Medicare made payment for a service that was also paid by Medicaid.
Personal	Claims that are refunded due to duplicate claims, billing errors, payments to the wrong provider, etc.
TPL	Claims that are refunded because a third-party payer made payment for the service which was also paid by Medicaid.

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4. Enter the following information on the financial cash receipt panel:

Field	Entry Description
Payment Type	Select from drop down box, choose cash, check, EFT or money Order
Paid Amount	Enter the amount of the check.
Payment Number	Enter the check number.
Payment Date	Enter the date of the check.
Payee Type	Select Provider from drop down box.
Payee ID	Click Search and enter provider ID.
Reason/Unit	Enter 100-Medical.

6. Print a Daily Cash Receipt by Unit Log and passes the checks and associated document to Cash Financial Clerk 2.

Cash Financial Clerk 2

1. Compares the checks to the Daily Cash Receipt Log.

2. Review all checks to be deposited into the refund account for the following information:

- Reason for the refund.
- Amount applied to each ICN.
- Patient's name.
- Patient's Medicaid number.
- Dates of service so that the ICN can be identified.

> Make sure the check is made payable to HPES or Alabama Medicaid. Checks not made payable to HPES or Alabama Medicaid are returned to the check owner.

3. Stamp the back of each check that will be scanned and deposited through Regions Quick Deposit Service into the refund account with the stamp that has the following information:

**PAY TO THE ORDER
OF REGIONS
BANKFOR DEPOSIT
ONLY**

**ELECTRONIC DATA SYS
CORP/ALA TITLE XIX
AGENT FOR ALABAMA**

4. Make a copy of each check and staple with the associated documents.

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NOTE:

If a check requires additional information, make a copy of the check and send the check copy and the associated documents back to the provider with a cover letter that requests additional information. The original check is deposited with all other checks.

5. Scan the original checks through Regions Quick Deposit Service to be deposited into the refund account. Print out the deposit slip and attach to the Daily Cash Receipt Log.

6. For returned HPES checks, sort the checks by those returned for address change from those returned by the provider.

7. When a computer generated check is returned by the provider, stamp the check with the date of receipt, make a copy of the check, and deliver the original checks to Financial Services.

8. For a computer generated check returned for an address change, stamp the check with the date of receipt, make a copy of the check, and deliver the original check to Financial Services.

9. The check copies and the associated documents are delivered to Provider Enrollment for address verification. Once the provider address information has been updated on the Provider Master file, Provider Enrollment notifies Financial Services that the original check may be mailed back to the provider. Checks not mailed back within 60 days of the issue date are processed according to the Stale Date guidelines.

Cash Financial Clerk

1. Batch the check copies and associated documents.
2. Complete a batch cover sheet for each batch.

General Duties

Refund transactions are entered into the AMMIS after the checks are properly logged, deposited, and returned to the Financial Services. The Cash Financial Clerk code and enter each refund transaction in the AMMIS system.

9.1 VOIDS AND STALE DATES

A provider may return checks issued by the Medicaid program if the provider does not accept payment made for claims included in the check amount. This occurs when the claims were paid incorrectly. Checks may also be returned when they could not be delivered because the provider had an address change.

If a provider fails to cash a Medicaid HPES check within 60 days, the check becomes stale dated. Stale dated checks are turned over to the Agency once a month in a refund letter. A check from the Disbursement account is given to the Agency and identified with a description of voided and uncashed checks. The checks are not voided in the system and the claims are not affected.

Checks that are returned due to a wrong provider being paid or billed in error are voided in the system along with the associated claims with the checks. A check from the Disbursement account is given to the Agency and identified with a description of voided and uncashed checks.

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10 PROVIDER PAYMENTS

Each completed financial processing cycle establishes the total amount of money to be paid to each provider. Additionally, the AMMIS produces the following documents:

- RAs that are available for providers to download from the web portal
- Provider checks

The Agency reviews the completed reports, approves the financial amounts, and requests a draw down from the Federal government for the Federal share of benefit dollars. The Agency deposits the funds into the Depository account. These funds are then transferred to the Disbursement account as checks are presented for payment.

Blank check stock is stored in a locked safe in the Operations facility, along with printed checks that are ready to be mailed. Checks are prepared for mailing to providers and are mailed when the State has released the funds.

> Signature stamps, and access to programs with digitized signatures, are strictly controlled to ensure that the check stock and printed checks are secured.

In certain situations, checks may be set aside and withheld from distribution. Financial Services maintains a Special Pull List. The Special Pull List identifies the following types of checks that require special handling:

- Checks requested by the State.
- Checks pulled as a result of an early emergency payment.
- Checks requiring special delivery—these checks require prior approval from the Agency.
- Checks to be picked up by providers.
- Checks paid to sanctioned providers or providers who are under an IRS imposed tax levy.

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GLOSSARY

The table below defines the terms used in the Financial Services functional area:

Financial Services Functional Area Terms

Term	Definition
1099	An annual report form sent to a provider that informs the provider of the total annual amount received from the Medicaid program. An electronic reporting process to the Internal Revenue Service (IRS) and the State Department of Revenue that tells the Federal and State government agencies the amount of money paid to a Medicaid provider.
Accounts receivable (A/R)	A financial transaction that creates a record of a specified amount of money to be recovered from a provider.
Adjustment	An action to correct a claim paid in error. An adjustment transaction typically is a two-part procedure performed at one time. The two-part procedure voids the original claim and establishes an accounts receivable to recover the original claim paid amount and processes the new adjusted claim. If the adjusted claim payment is more than the original claim payment, the provider receives the net increase. If the adjusted claim payment is less than the original claim payment, the account receivable established recovers the difference from the provider's total claim payment amount.
Audit Adjustment	A transaction to provide a lump sum payment to or recoupment of provider monies. In the AMMIS, these are referred to as expenditure transactions and account receivable transactions.
Backup withholding	A process that must be in place to withhold Federal income taxes if a provider fails to submit signed *W-9* forms to declare tax reporting status.
Check	A paper instrument of payment to providers for services rendered to Medicaid recipients.
Clear	A transaction that occurs when a provider presents a check to the bank or when an EFT transaction is received at the provider's bank. When a transaction has cleared, the money is claimed and paid from the Medicaid/HPES bank account.

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Term	Definition
Cost settlement	An audit process that is part of certain provider reimbursement methods. This process allows the State to set a fixed payment amount for claim services and then performs an accounting of a provider's actual cost for rendering services compared to amounts Medicaid has paid. If the State has paid less than the provider's documented cost to perform the service, then the State "cost settles" and issues a payout transaction for the difference. If the State has paid more than the providers' documented costs to perform the service, then the provider "cost settles" and the State issues a recoupment transaction to recover the difference.
Disbursement	The act of paying money to providers.
Draw down	The act of the State claiming the Federal share of Medicaid benefit dollars from Federal bank accounts.
Electronic Funds Transfer (EFT)	The paying of providers for approved claims using electronic transfer of funds from the Medicaid/HPES disbursement account directly to the provider's bank account.
Federal Employer Identification Number (FEIN)	A number assigned by the IRS to track and report earnings.
Fiscal pend	A process to suspend and hold payment to specified providers, provider types, or all providers for all or a specified set of service dates if a State budget is under-funded and the State cannot meet its' payment obligations. This process most commonly occurs at the end of the State fiscal year. (Note: Although fiscal pend is not done in Alabama, fund groups can be held from release within each financial cycle until a specified time.)
Interest-bearing	A bank account that earns money from the bank which is paid to the State for allowing the bank to use the State's Medicaid money while it is in the bank.
Lien	A transaction to establish an amount of money to be withheld from a provider's payment to satisfy a debt owed by the provider to another entity. ***Example***: IRS tax liens for failure of a provider to pay appropriate income taxes.
Manual check	A process to obtain a blank check from available check stock and issue it to a provider (usually as an advance payment for claims that will be paid) for a State-approved amount. This process is performed outside the system's financial cycles and requires subsequent manual entry and tracking into AMMIS.
Provider Earnings File	The file that accumulates provider payment amounts and is used to produce annual 1099 reports and documents.
Receipts	The daily accumulation of checks received from providers which are deposited in the bank.

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Term	Definition
Recoupment	A transaction to establish an account receivable in AMMIS. This occurs when a provider owes the Medicaid program money. Payment is withheld from the provider by AMMIS until all money is recovered from the provider.
Refund	A check from a provider to return money that has been overpaid by the Medicaid program as a result of a claims processing error or a check for repayment on an open account receivable.
Separation of duties	A process or series of processes which ensure one person does not handle a cash or financial transaction from receipt through disposition; follows standard cash procedures to prevent fraud or financial abuse.
Stale date	A process to cancel a check still available to be claimed for payment because it has remained uncashed for a specified period of time.
Stop Pay and Reissue	A transaction to notify the bank to stop payment of a Medicaid check which was issued (usually reported as lost or never received by a provider) and then subsequently reissue a replacement check to satisfy payment.
Void	A transaction to cancel a prior transaction. Typically used in the context of voiding a claim which in turn causes a financial transaction to be established to collect the money originally paid on the claim.
W-9	A form that must be completed by a provider to declare an official name and address to an entity reporting to the IRS. The names and numbers that appear on the W-9 must match IRS records or the IRS may assess substantial penalties against the reporting entity.
Warrant (check)	Another name for a check drawn on a State Medicaid Program's bank account that is paid to the provider.

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AMMIS Financial User Manual (Part I)

Date Modified: April 4, 2018

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1. Document Control

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1.1 Document Information Page

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Approved by:	
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1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

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11/09/2011	1.1		Application of EIP 5010 changes.	CO 8426 835 Contacts Panel (6.78.2, 6.78.3, 6.78.4, 6.78.3.2) CO 8871 FCRI Financial Cash Receipt Base Information Panel (6.21.3, 6.21.4) FCRI Financial Cash Receipt Information Panel (6.20.3) FCRI Financial Cash Receipt Search Panel (6.18.2, 6.18.3)
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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
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04/27/2016	6.0		Application of CO 12819, 13151 and 12893	**CO 12819:** Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS CO 13151 Modify 6.26 FES Financial Expenditure Search Panel layout and field descriptions Modify 6.27 FES Financial Expenditure Search Results Panel layout and field descriptions Modify 6.33 FEI Financial Expenditure Mini Search Panel layout and field descriptions CO 12893 Modify 6.5 Financial AR Base Information panel layout and field descriptons Modify 6.7 Financial AR Dispositions Panel layout and field descriptions
10/27/2026	7.0		Application of CO 13778	CO 13778 – Section 4.5- Added Changing Passwords
4/04/2018	8.0		Application of CO 14836	CO 14836- Remove PHI Sections 6.28.2, 6.31.2, 6.32.2, 6.35.2, 6.36.2, 6.38.2, 6.39.2, 6.40.2. 6.43.2, 6.44.2, 6.46.2, 6.51.2, 6.52.2, 6.63.2, 6.64.2, 6.78.2, 6.82.2, 6.85.2

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1.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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2. Financial Introduction

2.1 Financial User Manual Overview

The Alabama Medicaid Management Information System (AMMIS System) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Financial functional area.

This manual covers the following:

- Financial Overview
- Financial Getting Started
- System Wide Common Terminology and Layouts
- Financial Pages/Panels
- Financial Reports

2.2 Financial User Manual Objective

The objective of the AMMIS Financial User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

This manual contains references to current Medicaid Management Information System (MMIS) screens, when applicable. This information will be deleted after implementation training, and is identified in the narrative text in italics.

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3. Financial Overview

3.1 Introduction to Financial

The Financial Processing function encompasses claim payment processing, Accounts Receivable (AR) and payable processing and all associated financial transaction processing. It ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are accounted for and applied accurately. Among the processes that the Financial Processing function includes is generation of payments to providers and the production of a remittance advice for each provider who has had claims adjudicated and/or financial transactions processed. The payments can take the form of checks or Electronic Funds Transfers (EFTs).

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4. Financial Getting Started

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 System Security

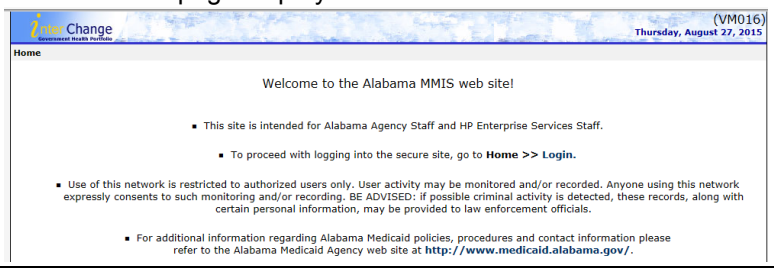
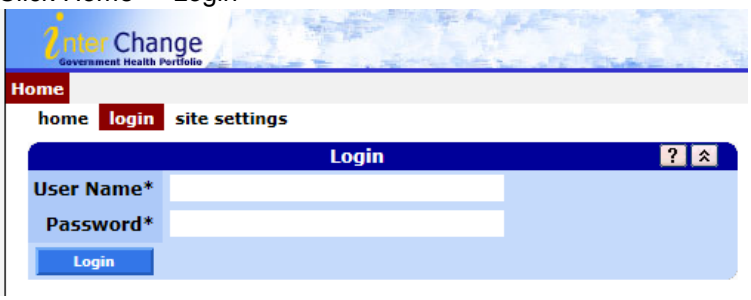
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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Step	Action	Response

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.3.3 Changing Passwords

Users are prompted to change their password every thirty (30) days. The password must be seven characters in length and contain alpha/numeric values. The Password Manager panel displays when it is time to enter a new password.

Note: The Account ID is automatically populated when the panel displays.

Follow the steps below to change your password:

Step	Action	Response
1	Enter **Old password**.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter **New password**.	
4	Press **Tab**.	User is taken to the Confirm new password field.
5	Confirm new password by entering it again.	

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Step	Action	Response
6	Click **OK**.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message.

The following message displays upon successful password change:

4.4 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.4.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select View.	View menu displays.
3	Point to Text Size and click Smaller.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

4.5 Changing passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

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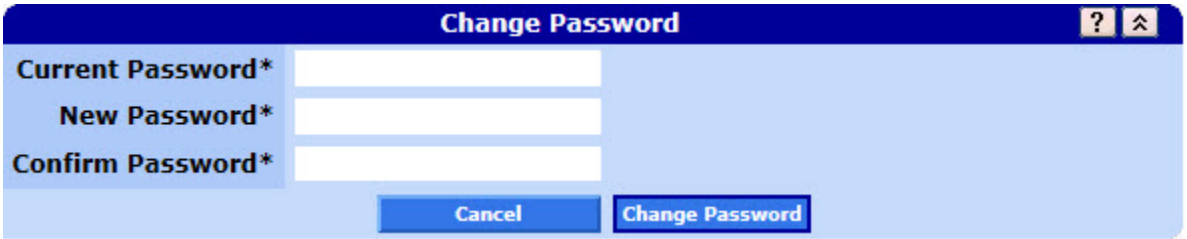

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact the Assistant MMIS Coordinator.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, users click the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

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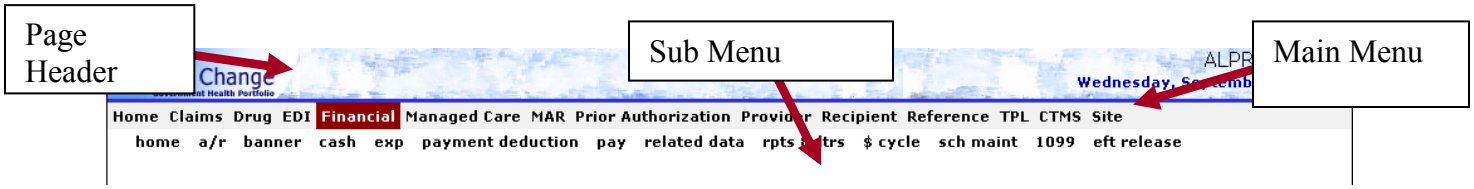
5.1 Page Layout

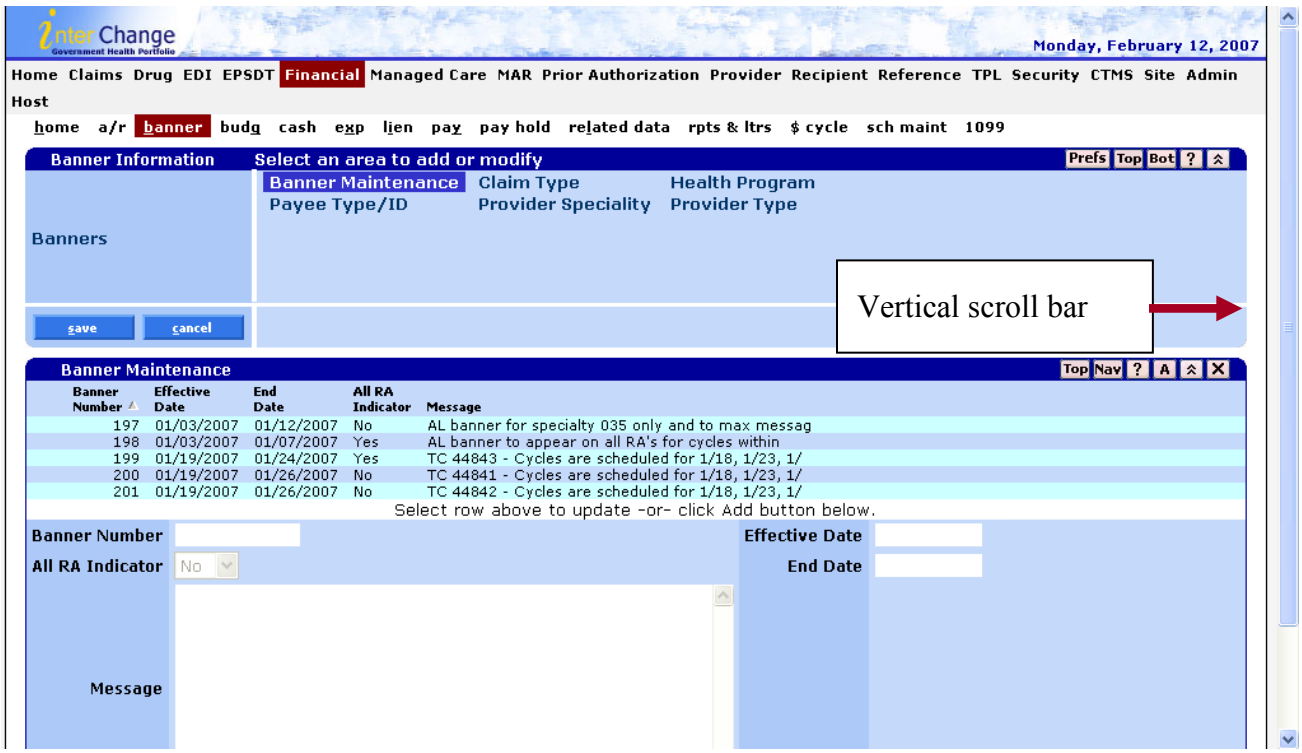
A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the HPES Enterprise Services copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu will open an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



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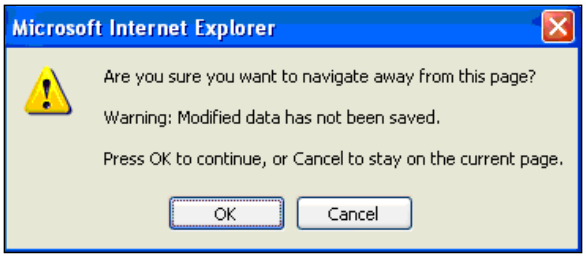
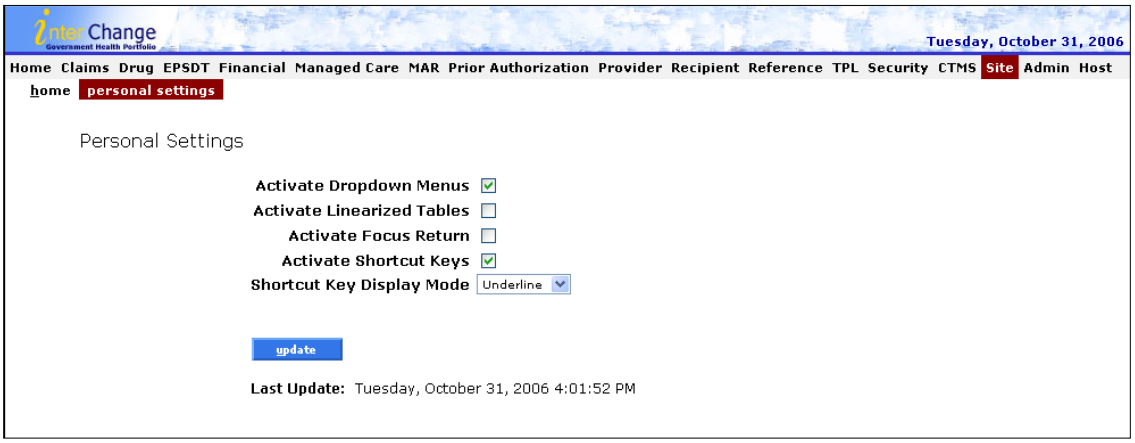
If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 Shortcut Keys

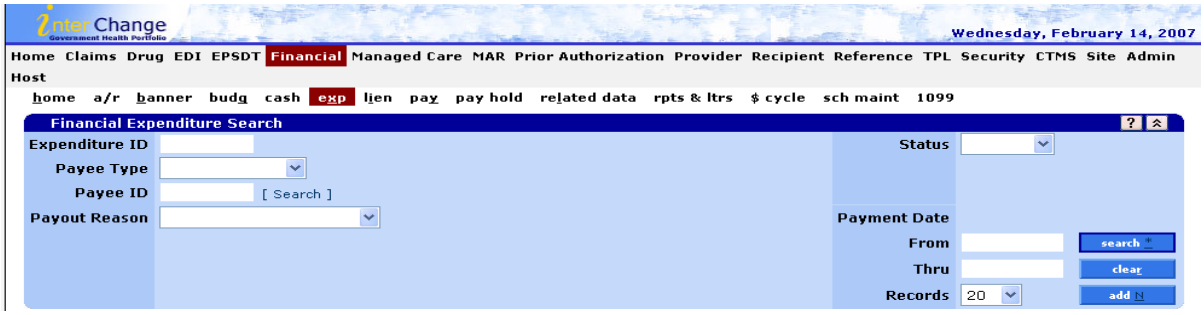
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated page.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the Financial Sub Menu, the user can use the shortcut keys to quickly navigate from the Financial Expenditure Search panel to the Financial Payment panel by using the following shortcut key combination: (Ctrl + Alt + Y) since the letter “Y” is found within the horizontal bars on the Sub Menu payment link.



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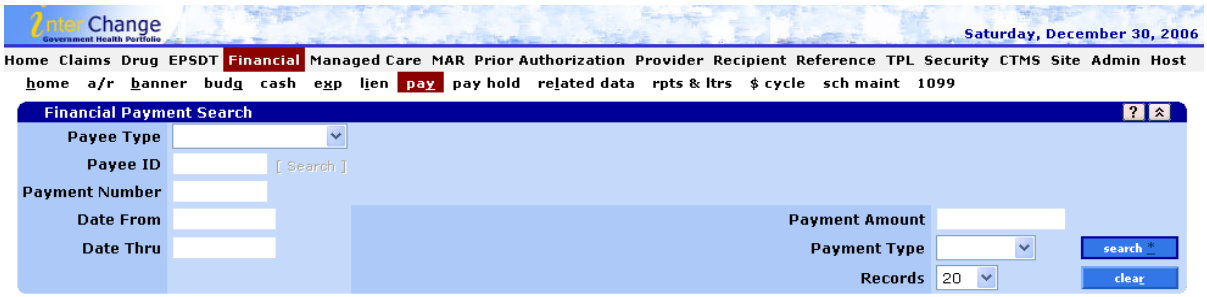
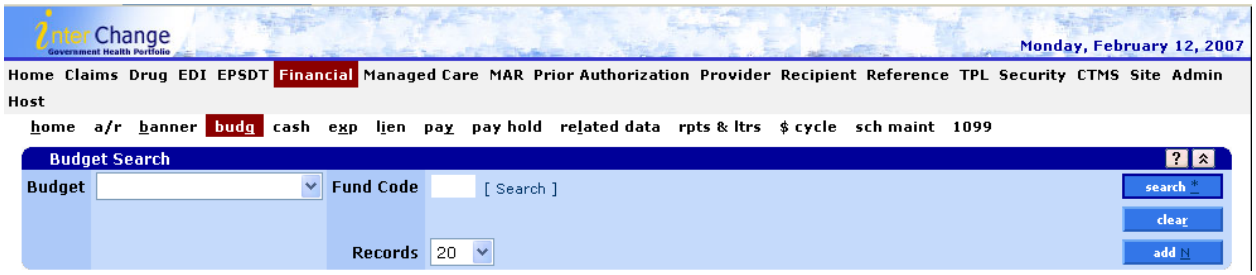


5.3 Search Options

There are several search options available within the AMMIS.

5.3.1 Search Panels

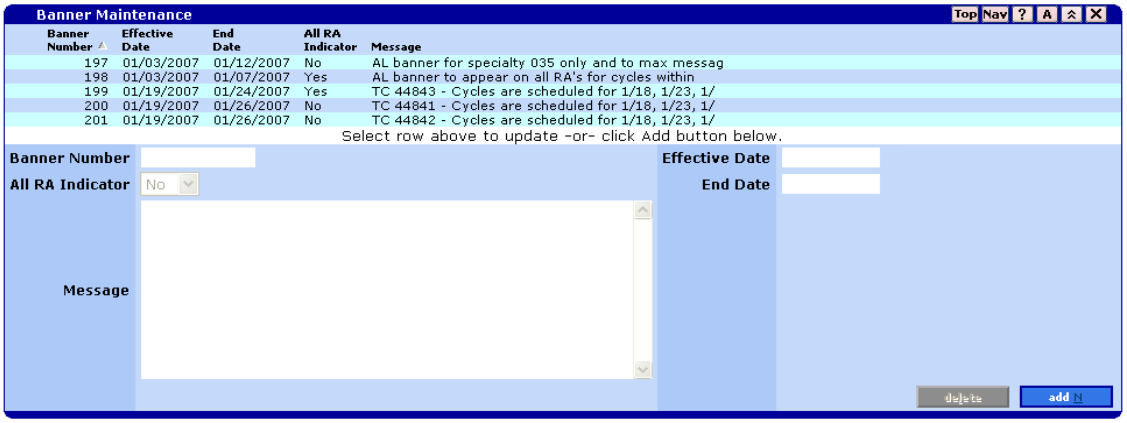
The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Financial subsystem contain a search panel without an advanced search button included on the panel, such as the image below.



The following is an example of the Financial Cash Receipt Mini-Search panel with an advanced search button included on the panel:

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results will be resorted, not just the search results displayed on the current search result panel.



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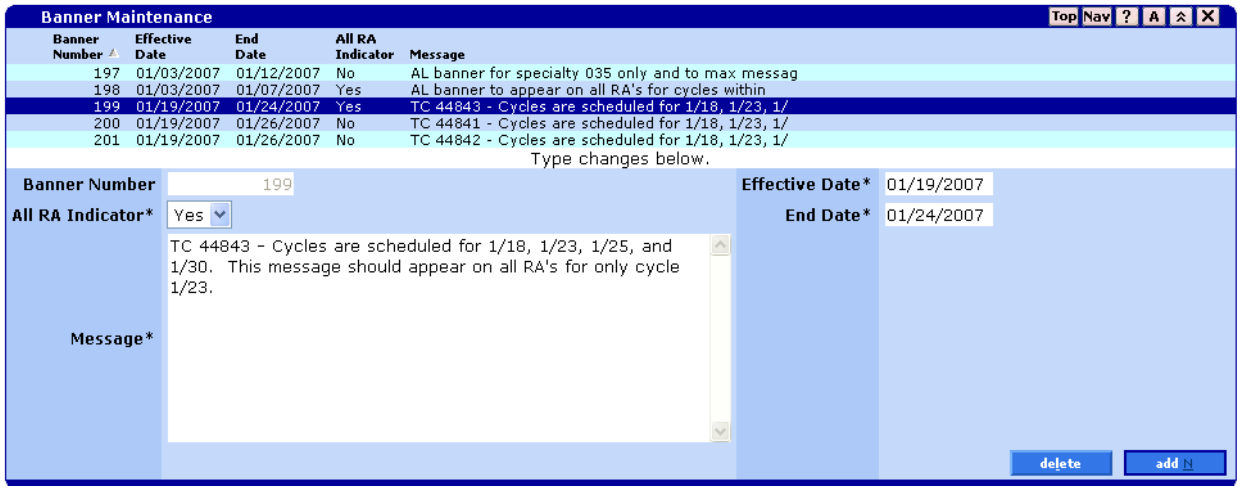
If the user clicks once on a search result row, the associated information panel will open. In the following figure, the user clicked the third row of the Banner Maintenance panel and detailed information displayed at the bottom of the panel.



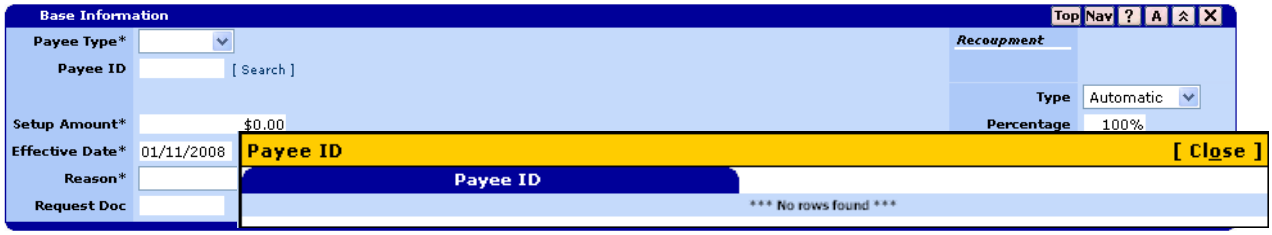
5.3.3 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain up to two primary search fields related to the business process. The following example provides a mini-search panel with one primary search field.

5.3.4 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel associated with that particular field.



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5.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message will display in the Task List panel. Can be found on the navigation panel.
Maintain Button	maintain	Maintains a selected data record.
Preferences Button	Prefs	Displays a checkmark box next to each Navigator Item link. By checking the box, the link will automatically open whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
Navigation Button	Nav	Allows a user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.

Among the panel types are the following:

- Maintenance panel
- Task List panel
- Maintenance Item Panel
- Audit panel

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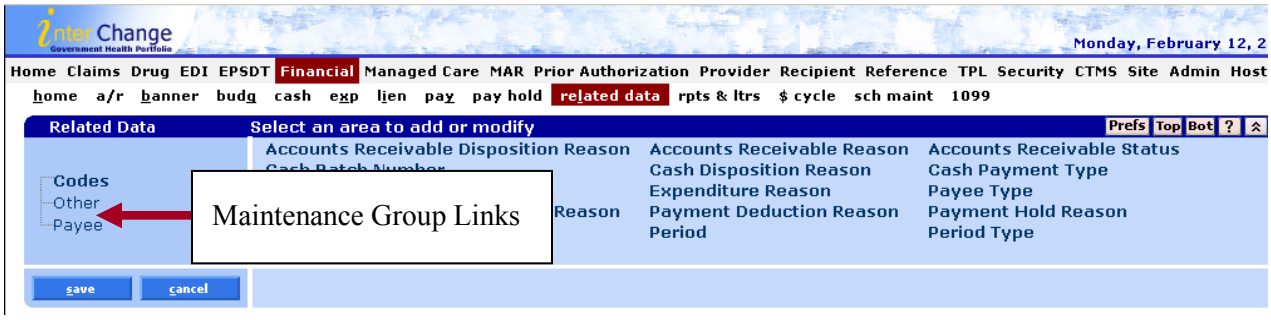
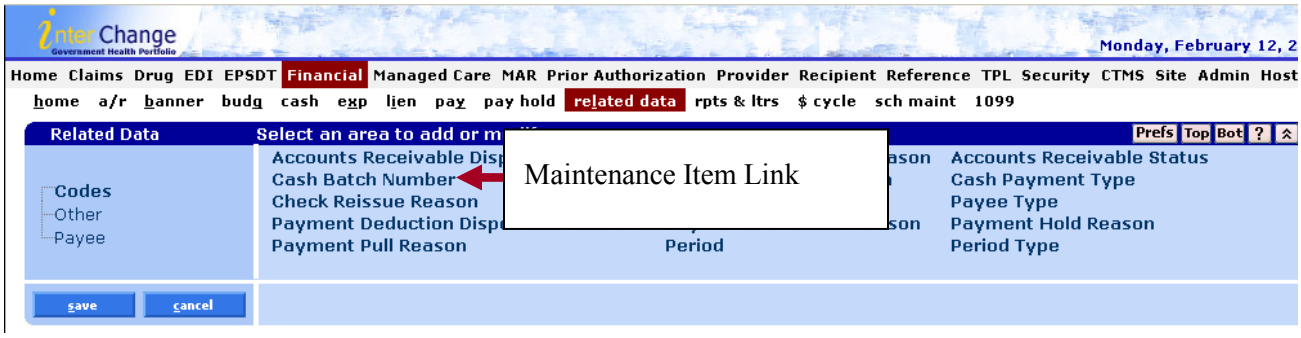
5.4.2 Maintenance Panel

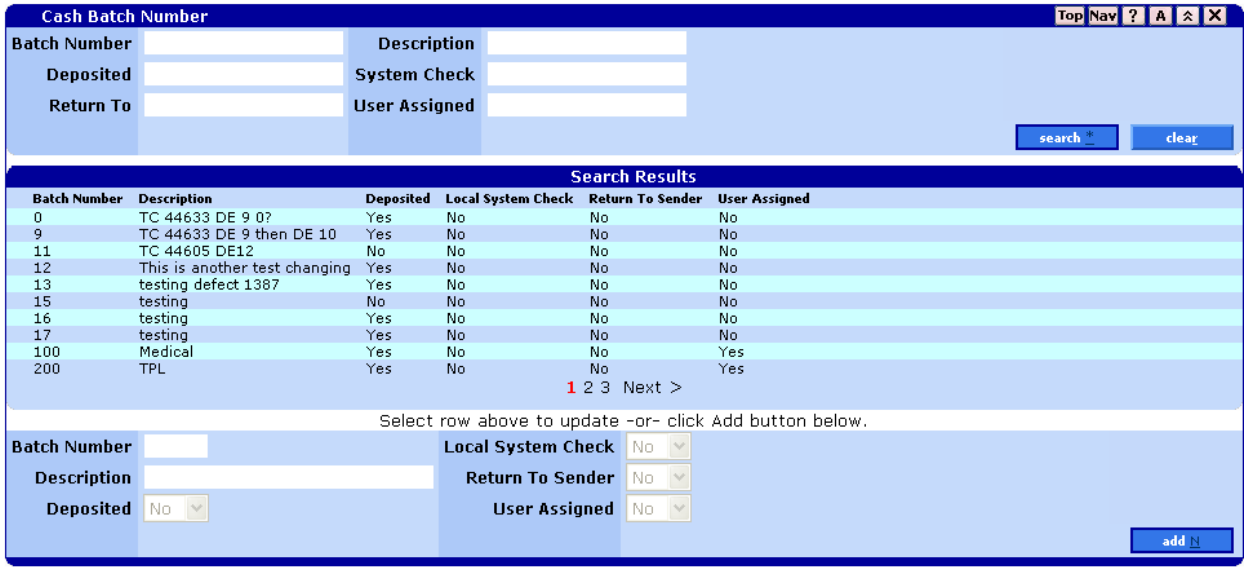
A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page. The following image demonstrates Maintenance Group Links (Codes, Other, and Payee) and the associated Maintenance Item links.





By clicking on a Maintenance Item Link (such as Cash Batch Number), the associated panel opens.



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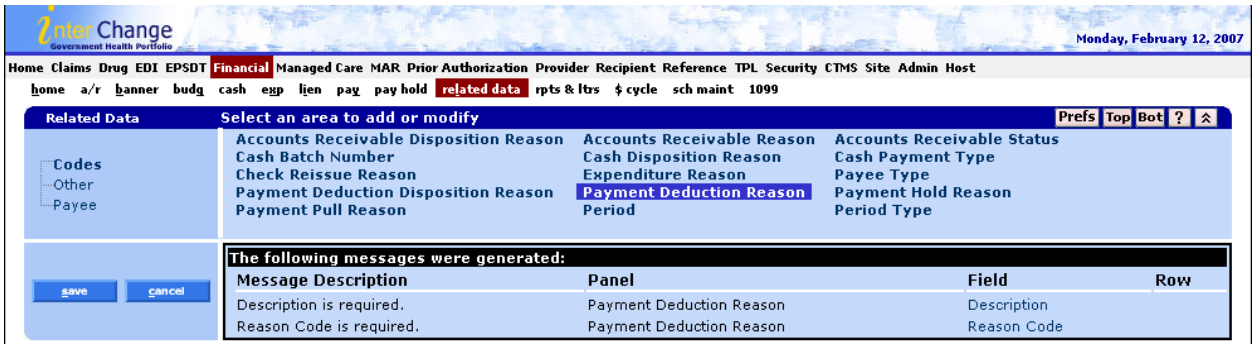
5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.



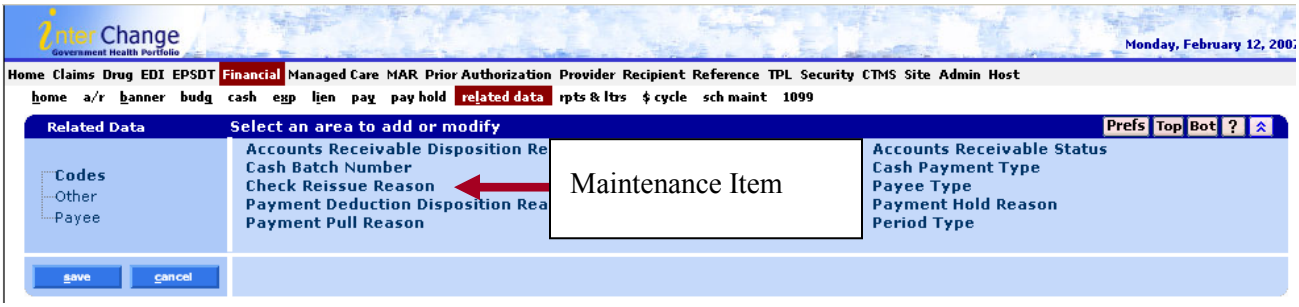
The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

5.4.4 Maintenance Item Panel

A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



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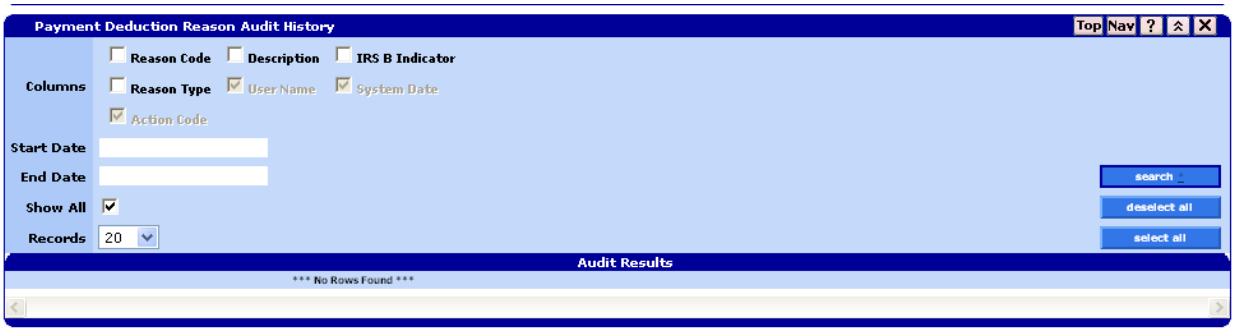
5.4.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



5.5 Help Functionality

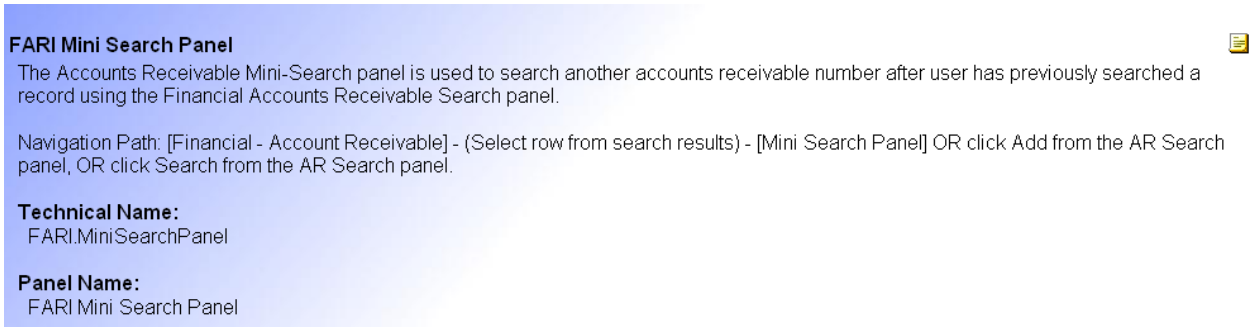
The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.5.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



The second item displayed is the **Panel Layout**:

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The third item displayed is the **Field Description** information related to the panel:

Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows user to clear AR Number search field.	Button	N/A	0
Search	Allows user to search for a record.	Button	N/A	0
Next Search By: AR Number	Unique number assigned to track accounts receivable.	Field	Alphanumeric	13

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window				

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any Associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

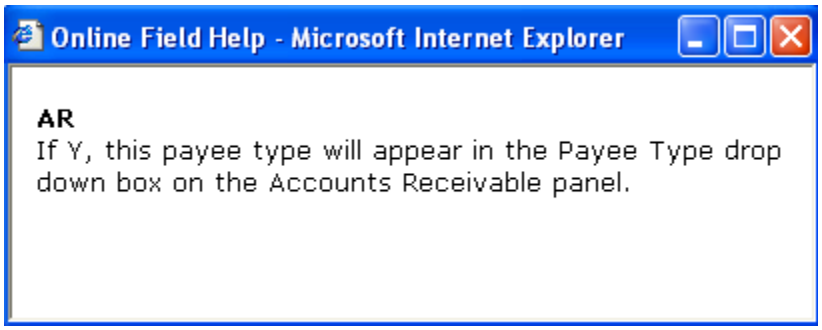
5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.5.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **AR**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6. Financial Pages/Panels

This section gives a brief description of each window, shows a sample, and describes all associated window fields and field edits.

Note: Any names, addresses, or other personal information displayed in window images are fictitious and are not representative of an actual person.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each window covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 Financial AR Search Panel Overview

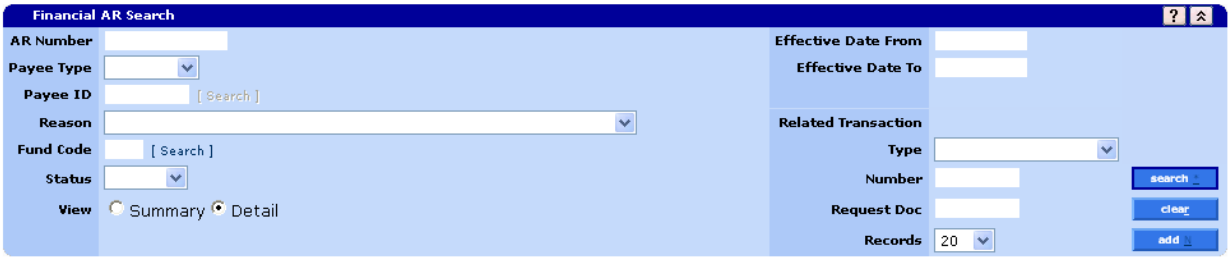
6.1.1 Financial AR Search Panel Narrative

The Financial AR Search Panel is used to enter search criteria when searching AR records. At least one of AR Number, Payee ID, Request Doc, or Effective Date From and Effective Date To is required.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [a/r] – [Search]

6.1.2 Financial AR Search Panel Layout



6.1.3 Financial AR Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to bring up a new AR Base Information panel to enter a new AR transaction.	Button	N/A	0
AR Number	Unique number used to track provider AR activity.	Field	Number (Integer)	13
Clear	Allows user to clear the Financial AR Search panel.	Button	N/A	0
Effective Date From	Indicates a beginning date range to be used as a search parameter. All ARs within the Effective From and To Date range are displayed.	Field	Date (MM/DD/CCYY)	8
Effective Date To	Indicates an ending to the date range to be used as a search parameter.	Field	Date (MM/DD/CCYY)	8
Fund Code	Description of the fund code assigned to the AR.	Field	Alphanumeric	20
Payee ID	Unique number which identifies the payee to whom the AR is being applied.	Field	Number (Integer)	15
Payee Type	Type of Payee identification number displayed. In Alabama Financial AR, this will always be Provider.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Reason	Indicates the specific reason that an AR was setup (e.g. check advance, non-claim offset, adjustment).	Combo Box	Drop Down List Box	0
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Related Transaction Number	Transaction number related to the AR.	Field	Character	13
Related Transaction Type	Type of Transaction the AR is related to (Adjustment, Expenditure, etc.).	Combo Box	Drop Down List Box	0
Request Doc	Number used to reference a correspondence document to the AR.	Field	Character	9
Search	Allows user to search using entered criteria.	Button	N/A	0
Status	Indicates the status of the AR. Active or Closed.	Combo Box	Drop Down List Box	0
View Detail	Displays the search results in the Detail (default) view, which is the AR record as they are saved on the database.	Combo Box	Radio Button	0
View Summary	Displays the Search results in the Summary view, which displays the ARs the same way the payee sees them on the RA, summarized by control number.	Combo Box	Radio Button	0

6.1.4 Financial AR Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AR Number	Field	1	Enter a valid value.	Enter a number.
Effective Date From	Field	2	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct date in MM/DD/CCYY format.
Effective Date To	Field	2	Invalid date. Format is MM/DD/CCYY.	Verify entry and re-enter a correct date in MM/DD/CCYY format.
Payee ID	Field	1	At least one of AR Number, Payee ID, Request Doc or effective Date From and Effective Date To is required.	Verify entry and re-enter valid provider number.

6.1.5 Financial AR Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.6 Financial AR Search Panel Accessibility

6.1.6.1 To Access the Financial AR Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r.**	Financial AR Search panel displays.

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6.2 Financial AR Search Results Panel Overview

6.2.1 Financial AR Search Results Panel Narrative

The Financial AR Search Results panel allows the user to review results of AR Search. Users can choose a Summary View or a Detail View. The Summary View is useful when viewing ARs that are set up as a result of a claim adjustment. ARs can only be assigned one fund code. If a claim with multiple fund codes is adjusted, then a separate AR is created for each fund code. All of these ARs have the same control number as the AR control number. If a claim with three fund codes is adjusted to zero, three separate ARs are created for each fund code. That is what the user will see on the Detail View. If the user clicks on the Summary View, those three ARs are summarized into one row with a fund count of 3.

This panel is display only.

Navigation: [Financial]- [a/r] – [Search]

6.2.2 Financial AR Search Results Panel Layout

(Detail View)

Search Results (Detail View)

AR Number	Payee ID	Payee Type	Fund Code	Reason Code	Effective Date	Setup Amount	Disposition Amount	Outstanding Balance	Related Txn Type	Related Txn Number
[redacted]	[redacted]	Provider	070	8402	01/01/2001	$0.00	$0.00	$0.00		
		Provider	102	8401	04/23/2002	$0.00	$0.00	$0.00		4652
		Provider	001	8412	05/01/2002	$0.00	$0.00	$0.00		4647
		Provider	001	8412	05/01/2002	$0.00	$0.00	$0.00	EXPENDITURES	12
		Provider	067	8402	05/07/2002	$0.00	$0.00	$0.00		
		Provider	067	8402	05/09/2002	$0.00	$0.00	$0.00		
		Provider	067	8406	05/09/2002	$0.00	$0.00	$0.00		
		Provider	067	8406	05/09/2002	$0.00	$0.00	$0.00		
		Provider	067	8409	05/09/2002	$0.00	$0.00	$0.00		
		Provider	067	8412	05/09/2002	$0.00	$0.00	$0.00	EXPENDITURES	42
		Provider	067	8412	05/09/2002	$200,000.00	$0.00	$200,000.00	EXPENDITURES	520
		Provider	004	8401	05/09/2002	$300,000.00	$0.00	$300,000.00	EXPENDITURES	521
		Provider	005	8402	05/09/2002	$0.00	$0.00	$0.00		
		Provider	112	8409	05/09/2002	$0.00	$0.00	$0.00		
		Provider	012	8401	05/09/2002	$0.00	$0.00	$0.00		
		Provider	067	8419	05/24/2002	$0.00	$0.00	$0.00		
		Provider	011	8412	05/01/2002	$210,000.00	$0.00	$210,000.00		4671
		Provider	011	8412	05/01/2002	$210,000.00	$0.00	$210,000.00	EXPENDITURES	522
		Provider	005	8401	05/09/2002	$0.00	$0.00	$0.00		
		Provider	102	8412	05/15/2002	$0.00	$0.00	$0.00	EXPENDITURES	54

Total Number of A/Rs: 159 Totals: $940,000.00 $0.00 $940,000.00

1 2 3 4 5 6 7 8 Next >

(Summary View)

Search Results (Summary View)

AR Number	Payee ID	Payee Type	Effective Date	Setup Amount	Disposition Amount	Outstanding Balance	Related Txn Type	Related Txn Number	Fund Count
[redacted]	[redacted]	Provider	01/03/2007	$25.00	$25.00	$0.00			1
		Provider	01/03/2007	$35.00	$35.00	$0.00			1
		Provider	01/04/2007	$23.00	$23.00	$0.00			1
		Provider	01/11/2007	$150.00	$0.00	$150.00			1
		Provider	01/17/2007	$234.00	$0.00	$234.00			1
		Provider	01/17/2007	$9.99	$9.99	$0.00			1
		Provider	01/17/2007	$467.25	$0.00	$467.25			1
		Provider	01/18/2007	$999.00	$0.00	$999.00			1
		Provider	01/18/2007	$1,015.22	$0.00	$1,015.22			1
		Provider	01/23/2007	$25,477.22	$0.00	$25,477.22			1
		Provider	01/25/2007	$97.89	$0.00	$97.89			1
		Provider	01/25/2007	$1,000,000.00	$1,000,000.00	$0.00			1
		Provider	01/26/2007	$25.00	$25.00	$0.00			1
		Provider	01/28/2007	$3,000.00	$3,000.00	$0.00			1
		Provider	01/29/2007	$55.00	$0.00	$55.00			1
		Provider	01/29/2007	$1,125.00	$0.00	$1,125.00			1
		Provider	01/29/2007	$65.57	$0.00	$65.57			1
		Provider	01/30/2007	$54,545.00	$0.00	$54,545.00			1
		Provider	01/30/2007	$11.00	$0.00	$11.00			1
		Provider	01/30/2007	$1.00	$0.00	$1.00			1

Total Number of A/Rs: 37 Totals:$2,564,160.93$1,660,117.99$904,042.94

1 2 Next >

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6.2.3 Financial AR Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Number	Unique number used to track provider AR activity.	Field	Number (Integer)	13
Disposition Amount	Indicates the dollar amount (negative/positive) which has been applied to the AR to-date.	Field	Number (Decimal)	10
Effective Date	Indicates the effective date of the A/R.	Field	Date (MM/DD/CCYY)	8
Fund Code	This is the fund code assigned to the A/R.	Field	Number (Integer)	3
Fund Count	If a claim with multiple fund codes is adjusted, then a separate AR is created for each fund code. All of these ARs will have the same control number as the AR control number. If a claim with three fund codes is adjusted to zero, a separate AR is created for each fund code. This is what the user will see on the Detail View. If the user clicks on the Summary View, the three ARs are summarized into one row with a fund count of 3.	Field	Number (Integer)	1
Outstanding Balance	Indicates the dollar amount which is outstanding on the AR.	Field	Number (Decimal)	10
Payee ID	Unique number which identifies the provider to whom the AR is being applied. Alabama Medicaid Identification numbers or National Provider Identification numbers will only use part of the 15 byte field length.	Field	Alphanumeric	15
Payee Type	Type of payee. In Alabama, this will always be Provider.	Field	Character	8
Reason Code	This indicates the specific reason that an accounts receivable was setup (e.g. check advance, non-claim offset, adjustment).	Field	Character	6
Related TXN Number	Transaction number related to the Accounts Receivable.	Field	Number (Integer)	13
Related Txn Type	Type of Transaction the Accounts Receivable is related to (Adjustment, Expenditure, etc.).	Field	Character	16
Setup Amount	Indicates the original setup dollar amount of the AR.	Field	Number (Decimal)	10
Total Number of A/Rs	Total number of AR's on the list.	Field	Number (Interger)	10
Totals	Totals for the Set Up Amount, Disposition Amount, and Outstanding Balance columns.	Field	Number (Decimal)	10

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6.2.4 Financial AR Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Financial AR Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Financial AR Search Results Panel Accessibility

6.2.6.1 To Access the Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r**.	Financial AR Search panel displays.
3	Enter AR data and click **Search**.	Financial AR Search Results panel displays.

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6.3 Financial AR Information Panel Overview

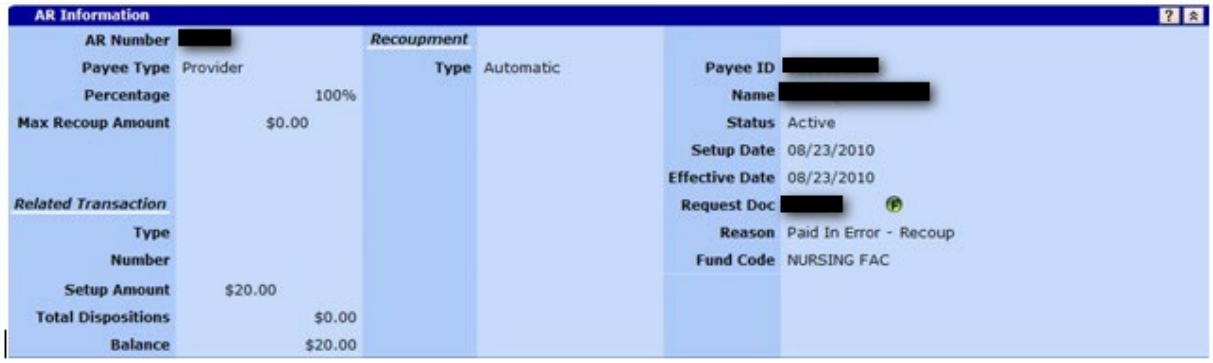
6.3.1 Financial AR Information Panel Narrative

The Financial AR Information panel displays the information related to the current Accounts Receivable.

This panel is display only.

Navigation: [Financial] – [a/r] + an Accounts Receivable number, or a payee type + a payee ID and then [Search].

6.3.2 Financial AR Information Panel Layout



6.3.3 Financial AR Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Number	Unique number which is assigned to each provider AR to track AR activity.	Field	Number (Integer)	13
Effective Date	Date the Accounts Receivable begins recouping dollars in the cycle.	Field	Date (MM/DD/CCYY)	8
Fund Code	Description of the financial fund code tied to the AR.	Field	Character	20
Max Recoup Amount	Indicates the maximum dollar amount to be offset from the provider's claims processed each cycle until the AR is satisfied.	Field	Number (Decimal)	10
Name	Name of the Payee to which the AR belongs.	Field	Character	15
Payee ID	Payee Number to which the AR belongs. Alabama Medicaid ID's or NPI's will only use part of the 15 byte field length.	Field	Number (Integer)	15
Payee Type	Type of Payee. In Alabama, this will always be Provider.	Field	Character	10
Percentage	Indicates the percentage to be offset from the provider's claims processed each cycle until the AR is satisfied.	Field	Number (Decimal)	5

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Field	Description	Field Type	Data Type	Length
Reason	Indicates the specific reason that the AR is being setup (e.g. check advance, non-claim offset, etc.).	Field	Number (Integer)	20
Recoupment Type	Type of recoupment for the AR. "Automatic" will recover money in the cycle. Manual" ARs will not recover money in the cycle.	Field	Alphanumeric	9
Related Transaction Balance	Setup amount less any dispositions applied to date.	Field	Number (Decimal)	10
Related Transaction Number	Number of the transaction related to the AR.	Field	Number (Decimal)	13
Related Transaction Setup Amount	Indicates the original setup dollar amount of the AR.	Field	Number (Decimal)	10
Related Transaction Total Dispositions	Displays the total dispositioned dollar amount (increased/decreased) which has been applied to the AR to date.	Field	Number (Decimal)	10
Related Transaction Type	Identifies the type of transaction related to the AR (Adjustment, Expenditure, etc.).	Field	Character	20
Request Doc	Displays the request doc correspondence number associated with an AR.	Field	Character	9
Setup Date	Date the AR was manually or systematically created.	Field	Date (MM/DD/CCYY)	8
Status	Indicates the status of the AR. Active or Closed.	Field	Character	10

6.3.4 Financial AR Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 Financial AR Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.3.6 Financial AR Information Panel Accessibility

6.3.6.1 To Access the Financial AR Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Financial** and click **a/r**.	Financial AR Search page displays.
3	Enter AR data and click **Search**.	Financial AR Search Results panel displays.
4	Select row from list of search results.	Financial AR Information panel displays.

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6.4 Financial AR Maintenance Panel Overview

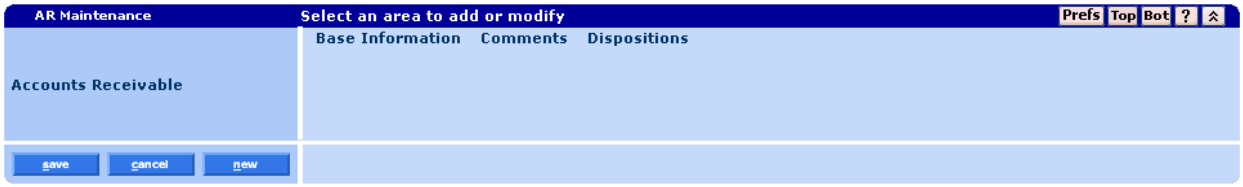
6.4.1 Financial AR Maintenance Panel Narrative

The Financial AR Maintenance panel allows the user to select from a list of areas to add or modify as they related to Accounts Receivable functions

This panel is inquiry only.

Navigation: [Financial] – [a/r] - [select row from search results]

6.4.2 Financial AR Maintenance Panel Layout



6.4.3 Financial AR Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows user to delete any unsaved data entered on any of the AR panels.	Button	N/A	0
Comments	Link to the Comments panel.	Hyperlink	N/A	0
Dispositions	Link to the Dispositions panel.	Hyperlink	N/A	0
New	When a Base Information panel has been completed and saved, clicking the new button will display a blank Base Information panel.	Button	N/A	0
Save	When any of the Maintenance Item panels has been completed, clicking the Save button will save the AR data.	Button	N/A	0

6.4.4 Financial AR Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.4.5 Financial AR Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.4.6 Financial AR Maintenance Panel Accessibility

6.4.6.1 To Access the Financial AR Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r**.	Financial AR Search panel displays.
3	Enter search criteria and click **Search**.	Financial AR Maintenance panel displays.

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6.5 Financial AR Base Information Panel Overview

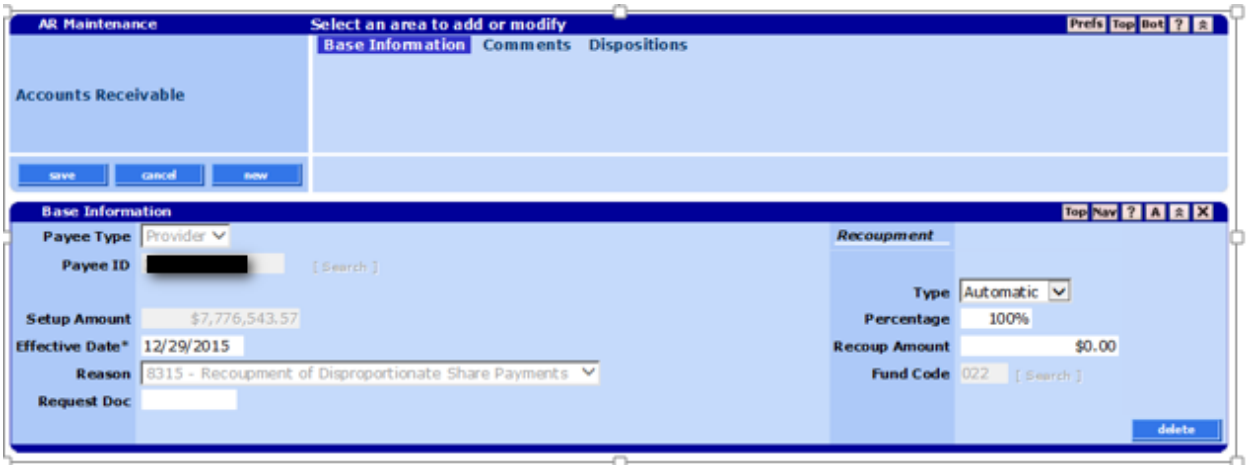
6.5.1 Financial AR Base Information Panel Narrative

The Financial AR Base Information panel is used to add and maintain Accounts Receivable records.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [a/r] - (Fill in at least one of the first three Financial AR Search criteria) - (Click Search button to the extreme right) - (Click on one record) - [Base Information]

6.5.2 Financial AR Base Information Panel Layout



6.5.3 Financial AR Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Clicking the cancel button on the AR Maintenance panel allows the user to cancel data entered on the AR Base Information panel before it is saved	Button	N/A	0
Delete	The delete button is only displayed when AR deletion is allowed. Clicking the delete button removes the AR.	Button	N/A	0
Effective Date	Field is autopopulated with system date. It can be changed to a future date if the AR is to begin in the future.	Field	Date (MM/DD/CCYY)	8
Fund Code	This is the financial fund code tied to the AR.	Field	Alphanumeric	4
New	When an AR Base Information panel has been completed and saved, clicking the New button on the AR Maintenance panel will display a new blank Base Information panel.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Payee ID	Payee Number to which the AR belongs.	Field	Character	15
Payee Type	This is the Type of Payee. In Alabama, this is always Provider.	Combo Box	Drop Down List Box	0
Reason	This indicates the specific reason code and description for the AR being set up. Example: 8404 - Manual setup - State directed.	Combo Box	Drop Down List Box	0
Recoupment Amount	If the AR is to be reduced by a specific dollar amount each financial cycle instead of a percentage, this indicates the maximum dollar amount to be offset from the provider's claims processed each cycle until the AR is satisfied.	Field	Number (Decimal)	10
Recoupment Percentage	This indicates the percentage to be offset from the payee's payments processed each cycle until the AR is satisfied. (Default is 100%).	Field	Number (Decimal)	5
Recoupment Type	This identifies what type of recoupment. Automatic will recoup in the cycle. Manual will have to be recouped manually. (Default is Automatic).	Combo Box	Drop Down List Box	0
Request Doc	This is a number used to reference a correspondence document to the AR transaction.	Field	Character	9
Save	Clicking the Save button on the AR Maintenance panel will save the data entered in the AR. Base Information panel.	Button	N/A	0
Setup Amount	This indicates the original setup dollar amount of the AR.	Field	Number (Decimal)	10

6.5.4 Financial AR Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective date must be equal or greater than today.	Verify entry and re-enter a correct Date.
	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter valid date.
Fund Code	Field	6	A valid Fund Code is required.	Enter a valid Fund Code.
Payee ID	Field	1	Payee ID is required.	Enter a valid Payee ID.
Payee Type	Field	1	A valid Payee Type is required.	Choose a valid Payee Type.
Percentage	Field	3	Recoupment Percentage and Recoupment Amount cannot	Enter either a percentage or a recoupment amount.

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Field	Field Type	Error Code	Error Message	To Correct
			both be greater than 0.	
	Field	9058	Recoup Percentage must be less than or equal to 100%.	Verify entry and re-enter a valid Recoup Percentage.
Reason	Field	7	A valid reason is required.	Enter a valid AR Reason.
Recoupment Amount	Field	4	Recoup Amount must be Numeric.	Verify entry and re-enter a valid Recoup Amount.
	Field	8	Recoup Amount must be less than or equal to the Setup Amount.	Make Recoup Amount greater than or equal to Setup Amount.
Setup Amount	Field	5	Setup Amount must be greater than or equal to 0.01.	Verify the amount is greater than or equal to 0.01.

6.5.5 Financial AR Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Financial AR Base Information Panel Accessibility

6.5.6.1 To Access the Financial AR Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r**.	Financial AR Search panel displays.
3	Click **Add**.	Financial AR Information and AR Maintenance panels display.
4	Click **Base Information** hyperlink.	Financial AR Base Information panel displays.

6.5.6.2 To Add Financial AR Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Payee Type**.	
3	Enter a **Provider ID** also referred to as the Requesting or Prescribing provider; Or click [search] to select a Provider ID from the list.	
4	Enter a **Set Up Amount**.	
5	Enter an **Effective Date**.	
6	Select **Reason** from drop down list.	
7	Enter a **Fund Code**; Or click [search] to select a Fund Code from the list.	

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Step	Action	Response
9	Select **Recoupment Type** from Drop Down List.	
10	Enter **Recoupment %**.	
11	Enter **Recoupment Amount**.	
12	Enter **Request Doc**.	
13	Click **Save**.	Financial AR Base Information is saved.

6.5.6.3 To Update Financial AR Base Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click Save.	Financial AR Base information is saved.

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6.6 Financial AR Comments Panel Overview

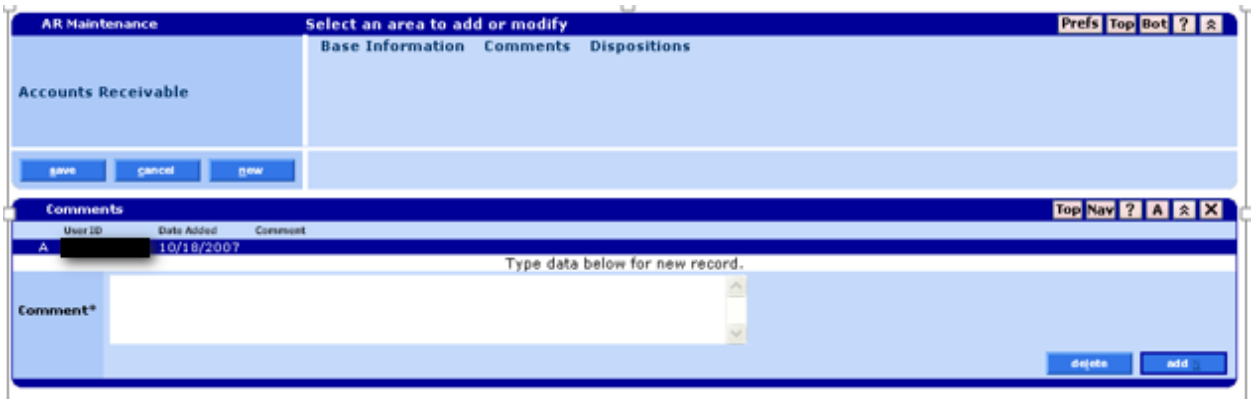
6.6.1 Financial AR Comments Panel Narrative

The Financial AR Comments panel allows the user to add narrative comments on an Accounts Receivable.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [a/r] - [select row from search results] - [Comments]

6.6.2 Financial AR Comments Panel Layout



6.6.3 Financial AR Comments Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add comment information.	Button	N/A	0
Cancel	Clicking the cancel button on the AR Maintenance panel allows the user to cancel data entered on the Comments panel before it is saved	Button	N/A	0
Comment	Allows the user to enter comments regarding the AR. If viewing the list of comments, the list displays the first 90 bytes of the comment. Clicking on that comment line will populate the comment box so the user can view the entire comment.	Field	Character	250
Date Added	When the comment was added to the system.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove comment information.	Button	N/A	0
New	When an AR Base Information panel has been completed and saved, clicking the New button on the AR Maintenance panel will display a blank Comments panel.	Button	N/A	0
Save	Clicking the Save button allows the user to save the comment.	Button	N/A	0
User ID	Identification of the user entering the comment.	Field	Character	6

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6.6.4 Financial AR Comments Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is Required.	Enter a Comment up to 250 characters.
	Field	2	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 250 characters.	Either save truncated message or shorten message to maximum of 250 characters.

6.6.5 Financial AR Comments Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 Financial AR Comments Panel Accessibility

6.6.6.1 To Access the Financial AR Comments Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r**.	Financial AR Search panel displays.
3	Click **Add**.	Financial AR Information panel displays.
4	Click **Comments** hyperlink.	Financial AR Comments panel displays.

6.6.6.2 To Add Financial AR Comments Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	Financial AR Comment is saved.

6.6.6.3 To Update Financial AR Comments Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Financial AR Comment is saved.

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6.6.6.4 To Delete Financial AR Comments Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.7 Financial AR Dispositions Panel Overview

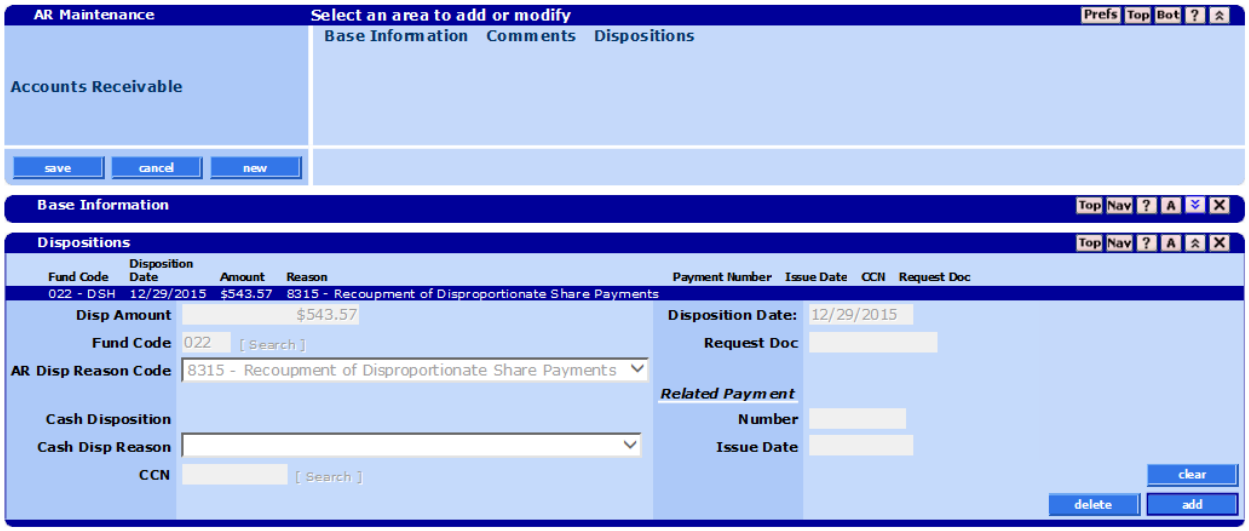
6.7.1 Financial AR Dispositions Panel Narrative

The Financial AR Dispositions panel allows the user to enter or review AR dispositions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [a/r] - [(Add button) OR (select row from search results)] - [Dispositions]

6.7.2 Financial AR Dispositions Panel Layout



6.7.3 Financial AR Dispositions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add another disposition.	Button	N/A	0
Amount [List]	This indicates the disposition amount.	Field	Number (Decimal)	10
AR Disp Reason Code	This indicates why the AR is being dispositioned. Choosing a cash receipt related reason will activate the Cash Disp Reason and CCN field to allow the user to relate the cash receipt to the AR disposition.	Combo Box	Drop Down List Box	0
Cancel	Clicking the cancel button on the AR Maintenance panel allows the user to cancel data entered on the Dispositions panel before it is saved	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Cash Disp Reason	This indicates why the cash is being dispositioned. This field is activated for data entry when a cash receipt related AR Disposition Reason is entered in the AR Disposition Reason Code field.	Combo Box	Drop Down List Box	0
CCN	Cash Control Number associated with the cash receipt received for this AR disposition. This field is activated for data entry when a cash receipt related AR Disposition Reason is entered in the AR Disposition Reason Code field.	Field	Number (Integer)	11
Clear	Allows user to clear entered disposition data before it is saved.	Button	N/A	0
Delete	The delete button only displays when deleting the selected disposition is allowed. Clicking the delete button marks the selected disposition for deletion. Once a disposition is marked for deletion the save button must be clicked.	Button	N/A	0
Disp Amount	This indicates the disposition amount.	Field	Number (Decimal)	10
Disposition Date	Date the AR is dispositioned.	Field	Date (MM/DD/CCYY)	8
Fund Code	Fund code and fund code description entered for the AR. Note the fund code is auto plugged from the Base Accounts Receivable.	Combo Box	Drop Down List Box	0
Issue Date [List]	If this is a batch/system disposition, this is the issue date of the related payment. If this is an online disposition, this is the transaction date.	Field	Date (MM/DD/CCYY)	8
New	When an AR Base Information panel has been completed and saved, clicking the New button on the AR Maintenance panel will display a blank Dispositions panel.	Button	N/A	0
Payment Number [List]	This is the EFT/check number from which the money is recouped.	Field	Number (Integer)	10
Reason [List]	This indicates why the AR is being dispositioned.	Field	Character	20
Related Payment Issue Date	If this is a batch/system disposition, this is the issue date of the related payment. If this is an online disposition, this is the transaction date.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Related Payment Number	Electronic Funds Transfer/check number from which the money is recouped.	Field	Number (Integer)	10
Request Doc	This was designed for Alabama HWT Document Numbers; however anything entered can be used as a document number for reference.	Field	Alphanumeric	13
Save	Allows user to save disposition data.	Button	N/A	0

6.7.4 Financial AR Dispositions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AR Disp Reason Code	Field	4	A valid reason code is required.	Enter a valid reason code.
Disp Amount	Field	5	Amount must be greater than or equal to 0.01.	Enter an amount greater or equal to 0.01.
	Field	17	Amount is required.	Enter a valid disposition dollar amount.
	Field	71	AR Disp Amount must be greater than 0.	Enter a valid dollar amount.
Disposition Date	Field	6	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in MM/DD/CCYY format.
Fund Code	Field	2	A valid Fund Code is required.	Enter a valid Fund Code.
Cash Disp Reason	Field	3	A valid Reason Code is required.	Enter a valid reason code.
AR Reason	Field	3	A valid Reason Code is required.	Enter a valid reason code.
CCN	Field	3	Cash Control Number (CCN) required for selected AR Disposition Reason Code!	Enter a valid CCN.

6.7.5 Financial AR Dispositions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Financial AR Dispositions Panel Accessibility

6.7.6.1 To Access the Financial AR Dispositions Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r.**	Financial AR Search panel displays.
3	Enter **AR Number** and click **Search**.	Financial AR Maintenance panel displays.

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Step	Action	Response
4	Click **Dispositions** hyperlink.	Financial AR Dispositions panel displays.

6.7.6.2 To Add Financial AR Dispositions Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Disp Amount**.	
3	Enter **Fund Code**.	
4	Select **AR Reason Code** from drop down list box.	
5	Enter **Disposition Date** in MM/DD/CCYY format.	
6	Click **Save**.	Financial AR Disposition is saved.

6.7.6.3 To Update Financial AR Dispositions Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Financial AR Disposition information is saved.

6.7.6.4 To Clear Financial AR Dispositions Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Clear**.	Financial AR Dispositions is cleared.

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6.8 Financial AR Mini-Search Panel Overview

6.8.1 Financial AR Mini-Search Panel Narrative

The Financial AR Information (FARI) Mini-Search panel appears at the top when an Accounts Receivable Search is entered. This panel allows the user to enter another Accounts Receivable number to search. This panel is inquiry only.

Navigation: [Financial] - [a/r] - [(select from search results)] - [(mini search is on top of page)]

6.8.2 Financial AR Mini-Search Panel Layout

6.8.3 Financial AR Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Number	This is the Accounts Receivable Number assigned by the system.	Field	Number (Integer)	11
Clear	This allows the user to clear any changes on the Mini-Search panel.	Button	N/A	0
Search	Initiates the Search by AR Number.	Button	N/A	0

6.8.4 Financial AR Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.8.5 Financial AR Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Financial AR Mini-Search Panel Accessibility

6.8.6.1 To Access the Financial AR Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **a/r**.	Financial AR Search panel displays.
3	Enter an **Account Receivable Numbe**r and click **Search**.	Financial AR Mini-Search appears.

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6.9 Financial Check Banner Search Panel Overview

The Financial Check Banner Search panel allows the user to Search for a specific banner information by banner number or effective date and end date.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Financial] - [Banner]

6.9.1 Financial Check Banner Search Panel Layout

6.9.2 Financial Check Banner Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to bring up a new banner base information panel to enter a new banner message.	Button	N/A	0
Banner Number	This is the unique number to identify banner.	Field	Number (Integer)	9
Clear	Allows the user to clear any changes on the Financial Check Banner Search panel.	Button	N/A	0
Effective Date	This is the beginning date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8
End Date	This is the ending date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8
Records	Allows user to select number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Banner Number, Effective Date or End Date.	Button	N/A	0

6.9.3 Financial Check Banner Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
End Date	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.

6.9.4 Financial Check Banner Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.9.5 Financial Check Banner Search Panel Accessibility

6.9.5.1 To Access Financial Check Banner Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Financial Check Banner Search panel displays.

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6.10 Financial Check Banner Search Results Panel Overview

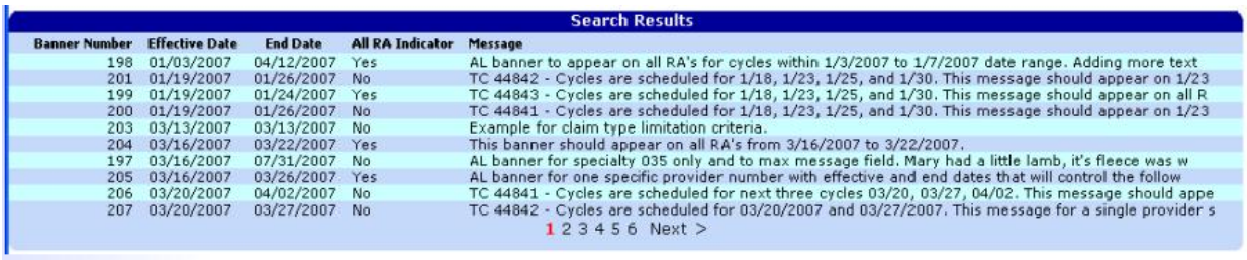
6.10.1 Financial Check Banner Search Results Panel Narrative

This Financial Check Banner Search Results panel displays all of the Check Banner records that relate to the search criteria keyed in the Check Banner Search panel.

This panel is display only.

Navigation Path: [Financial] – [Banner] - (Fill in Search criteria for other than a single banner number) - (Click Search button to the extreme right). Simply clicking the Search Button without entering any criteria will return Search Results containing all the banner messages

6.10.2 Financial Check Banner Search Results Panel Layout



Search Results

Banner Number	Effective Date	End Date	All RA Indicator	Message
198	01/03/2007	04/12/2007	Yes	AL banner to appear on all RA's for cycles within 1/3/2007 to 1/7/2007 date range. Adding more text
201	01/19/2007	01/26/2007	No	TC 44842 - Cycles are scheduled for 1/18, 1/23, 1/25, and 1/30. This message should appear on 1/23
199	01/19/2007	01/24/2007	Yes	TC 44843 - Cycles are scheduled for 1/18, 1/23, 1/25, and 1/30. This message should appear on all R
200	01/19/2007	01/26/2007	No	TC 44841 - Cycles are scheduled for 1/18, 1/23, 1/25, and 1/30. This message should appear on 1/23
203	03/13/2007	03/13/2007	No	Example for claim type limitation criteria.
204	03/16/2007	03/22/2007	Yes	This banner should appear on all RA's from 3/16/2007 to 3/22/2007.
197	03/16/2007	07/31/2007	No	AL banner for specialty 035 only and to max message field. Mary had a little lamb, it's fleece was w
205	03/16/2007	03/26/2007	Yes	AL banner for one specific provider number with effective and end dates that will controll the follow
206	03/20/2007	04/02/2007	No	TC 44841 - Cycles are scheduled for next three cycles 03/20, 03/27, 04/02. This message should appe
207	03/20/2007	03/27/2007	No	TC 44842 - Cycles are scheduled for 03/20/2007 and 03/27/2007. This message for a single provider s

1 2 3 4 5 6 Next >

6.10.3 Financial Check Banner Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All RA Indicator	Yes indicates that the banner message will appear on all Remittance Advice for the selected time span.	Listview	Character	3
Banner Number	Systematically assigned number to identify the banner message.	Listview	Number (Integer)	3
Effective Date	Effective date for banner message to begin to appear on the Remittance Advice.	Listview	Date (MM/DD/CCYY)	8
End Date	Last date for banner message to appear on the Remittance Advice.	Listview	Date (MM/DD/CCYY)	8
Message	Display of the first 100 characters of the banner message.	Listview	Alphanumeric	100

6.10.4 Financial Check Banner Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.10.5 Financial Check Banner Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Financial Check Banner Search Results Panel Accessibility

6.10.6.1 To Access the Financial Check Banner Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Financial Check Banner Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Financial Check Banner Search Results panel displays.

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6.11 Financial Banner Information Panel Overview

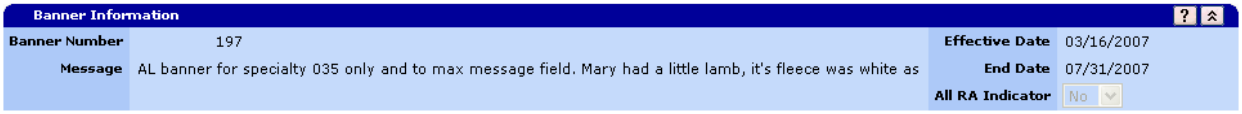
6.11.1 Financial Banner Information Panel Narrative

The Financial Banner Information panel display the information related to the current banner number.

This panel is display only.

Navigation Path: [Financial] – [Banner] -(Click Search button to the extreme right) - (Click on one record) - [Banner Information.] or Enter a banner number and click search

6.11.2 Financial Banner Information Panel Layout



6.11.3 Financial Banner Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
All RA Indicator	This is the indicator that will determine if the banner message is to be sent to all providers or just select providers based on the entered conditions. If YES, the banner was sent to all providers. If NO, then the banner was sent to providers based on selected criteria.	Field	Character	1
Banner Number	This is the unique number which identifies each banner.	Field	Number (Integer)	9
Effective Date	This is the beginning date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8
End Date	This is the ending date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8
Message	This displays the first 100 characters of the banner message.	Field	Character	100

6.11.4 Financial Banner Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.11.5 Financial Banner Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Financial Banner Information Panel Accessibility

6.11.6.1 To Access the Financial Banner Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Check Banner Search panel displays.
3	Enter **Banner Number**, **Effective Date** or **End Date**.	Use may also click the Search button without entering search criteria. All results are displayed.
4	Click **Search**.	**Financial Banner Information** and Maintenance panels display.

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6.12 Financial Banner Maintenance - Banners Panel

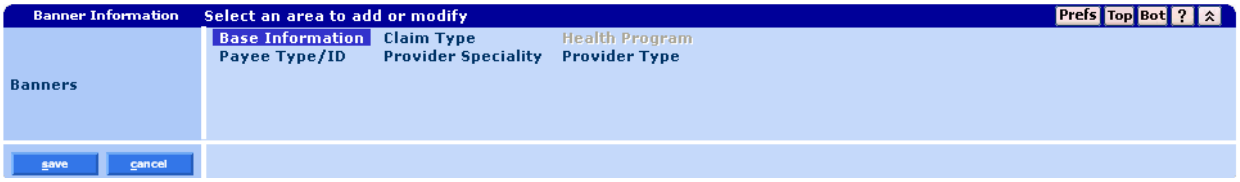
6.12.1 Financial Banner Maintenance - Banners Panel Narrative

When the Add Button on the Financial Banner Search Panel is clicked, the Banner Information - Banners panel displays. The panel will display with only the Base Information link bolded with the remaining links grayed out. Clicking the Banners link will bold the banner criteria links. In addition, the Base Information panel is also displayed and is ready for data entry. The remaining Maintenance Item Links allows the user to select specific criteria.

This panel is inquiry only.

Navigation: [Financial] – [Banner] - [(select from search results)

6.12.2 Financial Banner Maintenance - Banners Panel



6.12.3 Financial Banner Maintenance - Banners Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Banner Maintenance panel.	Button	N/A	0
Claim Type	Link to the Claim Type panel.	Hyperlink	N/A	0
Health Program	Link to the Health Program panel. Not utilized in Alabama.	Hyperlink	N/A	0
Save	When any of the banner maintenance panels has been completed, clicking the Save button will save the banner data.	Button	N/A	0
Payee Type/ID	Link to the Payee Type/ID panel.	Hyperlink	N/A	0
Provider Specialty	Link to the Provider Specialty panel.	Hyperlink	N/A	0
Provider Type	Link to the Provider Type panel.	Hyperlink	N/A	0

6.12.4 Financial Banner Maintenance - Banners Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.12.5 Financial Banner Maintenance - Banners Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 Financial Banner Maintenance - Banners Panel Accessibility

6.12.6.1 To Access the Financial Banner Maintenance - Banners Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Check Banner Search panel displays.
3	Enter **Banner Number**, **Effective Date** or **End Date**.	Use may also click the Search button without entering search criteria. All results are displayed.
4	Click **Search**.	Financial Banner Information and **Maintenance** panels display.

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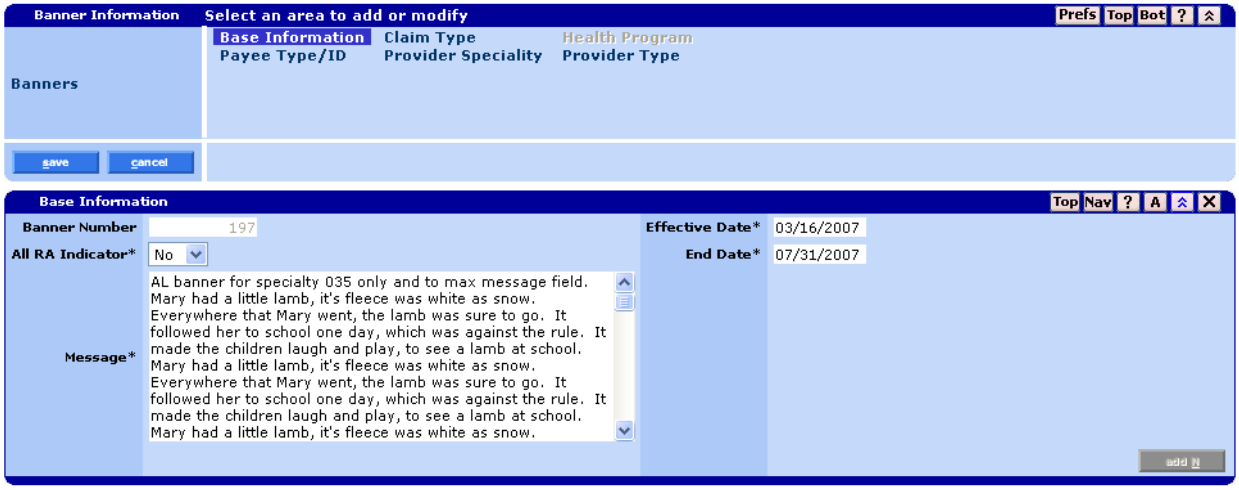
6.13 Financial Banner Base Information Panel Overview

The Financial Banner Base Information panel is used to add and maintain Banner Information records.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Financial] – [Banner] - (Fill in at least one of the Search criteria) - (Click Search button to the extreme right) - (Click on one record) - [Base Information]

6.13.1 Financial Banner Base Information Panel Layout



6.13.2 Financial Banner Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This button is grayed out because clicking the add button from the Banner Search panel has already activated the Base Information panel to add status.	Button	N/A	0
All RA Indicator	This is the indicator that will determine if the banner message is to be sent to all providers or just select providers based on the entered conditions. If the user selects YES then the conditional buttons will not be available. If the user selects NO, then the user will have to enter at least one condition for the banner.	Combo Box	Drop Down List Box	0
Banner Number	This is the unique number which identifies each banner.	Field	Number (Integer)	9
Cancel	Allows the user to cancel any changes on the Banner Base Information panel.	Button	N/A	0
Effective Date	This is the beginning date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8
End Date	This is the ending date that the banner will be sent to providers.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Message	This is the text box of the banner message.	Field	Character	4000
Save	Allows the user to save Base information.	Button	N/A	0

6.13.3 Financial Banner Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
All RA Indicator	Field	9104	At least one banner condition required.	If All RA indicator is set to NO then the user must enter a condition on the banner.
Message	Field	1	Message is required!	Enter message text.
Effective Date	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.
	Field	91006	Field is required.	Enter a valid date.
End Date	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.
	Field	91020	End Date must be >= Effective Date.	Enter a valid thru date.

6.13.4 Financial Banner Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.5 Financial Banner Base Information Panel Accessibility

6.13.5.1 To Access Financial Banner Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Check Banner Search panel displays.
3	Enter **Banner Number**, **Effective Date** or **End Date**.	Use may also click the Search button without entering search criteria. All results are displayed.
4	Click **Search**.	Financial Banner Information and Maintenance panels display.
5	Click **Base Information**.	Financial Base Information panel displays.

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6.14 Financial Banner Claim Type Panel Overview

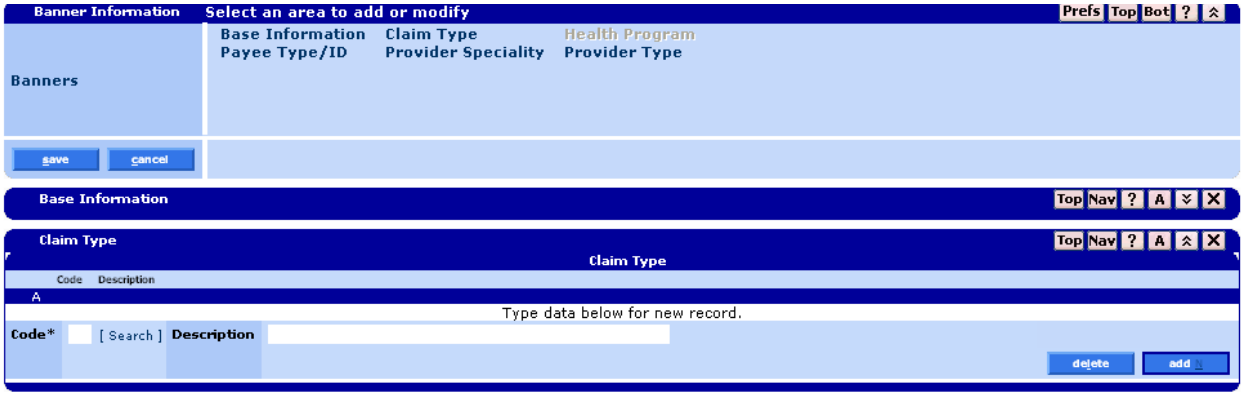
6.14.1 Financial Banner Claim Type Panel Narrative

The Financial Banner Claim Type panel allows the user to choose claim types as condition criteria for banner message receivers.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Banner] – [Banner Maintenance] - [Claim Type]

6.14.2 Financial Banner Claim Type Panel Layout



6.14.3 Financial Banner Claim Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Claim Type information.	Button	N/A	0
Cancel	Allows the user to cancel any changes on the Banner Claim Type panel.	Button	N/A	0
Code	Code used to identify a claim type. A claim type is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc.	Field	Character	1
Delete	Allows the user to remove Claim Type information.	Button	N/A	0
Description	The description for the Claim Type code.	Field	Character	50
Save	Allows the user to save Claim Type information on the Banner Claim Type panel.	Button	N/A	0
[Search]	Allows user to search for code by Claim Type, Description or Audit Claim Form.	Hyperlink	N/A	0

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6.14.4 Financial Banner Claim Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	A valid claim type is required.	Choose a valid claim type after clicking [search] to display the list of valid choices.

6.14.5 Financial Banner Claim Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Financial Banner Claim Type Panel Accessibility

6.14.6.1 To Access the Financial Banner Claim Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Banner Information panel displays.
3	Click **Base Information**.	Financial Banner Base Information panel displays.
4	Select **Claim Type** hyperlink.	Financial Banner Claim Type panel displays. Note that this will not activate the panel. Banner message must be saved first.

6.14.6.2 To Add Financial Banner Claim Type Panel

Step	Action	Response
1	Banner message must be saved with All RA Indicator marked No before this panel is activated. Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click on **[Search]** hyperlink and choose a claim type from list. User may add as many claim types as needed.	
3	Click **Save**.	Financial Banner Claim Type is saved.

6.14.6.3 To Delete Financial Banner Claim Type Panel

Step	Action	Response
1	Click on **Claim Type** to be deleted.	Banner Claim Type displays.
2	Click **Delete**.	Financial Banner Claim Type is deleted.

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6.15 Financial Banner Payee Type/ID Panel Overview

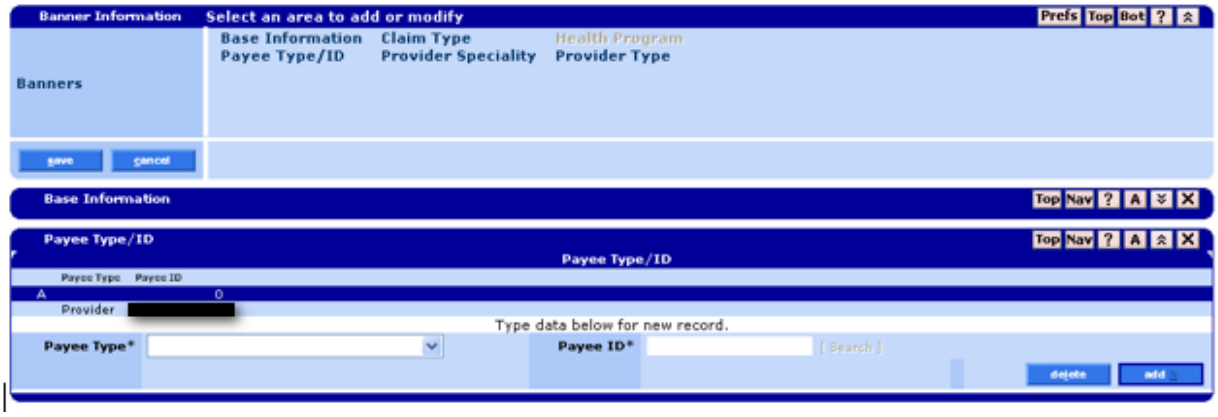
6.15.1 Financial Banner Payee Type/ID Panel Narrative

The Financial Banner Payee Type/ID panel allows user to choose a specific Payee ID's as condition criteria to receive a banner message.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Banner] – [Banner Maintenance] - [Payee Type/ID]

6.15.2 Financial Banner Payee Type/ID Panel Layout



6.15.3 Financial Banner Payee Type/ID Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Payee Type/ID information.	Button	N/A	0
Cancel	Allows the user to cancel Payee Type/ID information.	Button	N/A	0
Payee ID	This list displays the payee ID chosen to receive this banner message.	Field	Alphanumeric	35
Payee Type	Allows user to select a payee type to receive the banner message. In Alabama, the choices are Provider and Lien Holder. The only Lien Holders in Alabama are the IRS and the Alabama Department of Revenue.	Combo Box	Drop Down List Box	0
Save	Allows the user to save a record for Payee Type/ID information.	Button	N/A	0
[Search]	Allows user to search for Payee ID using advanced search criteria.	Hyperlink	N/A	0

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6.15.4 Financial Banner Payee Type/ID Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Payee ID	Field	3	Payee Type and Payee ID are required.	Add a valid Payee Type and Payee ID.
Payee Type	Field	1	A valid Payee Type is required.	Enter a valid Payee Type.

6.15.5 Financial Banner Payee Type/ID Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Financial Banner Payee Type/ID Panel Accessibility

6.15.6.1 To Access the Financial Banner Payee Type/ID Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Banner Information panel displays.
3	Select **Base Information**.	Financial Banner Base Information panel displays.
4	Select **Payee Type/ID** hyperlink.	Financial Banner Payee Type/ID panel displays. Note that this will not activate the panel. Banner message must be saved first.

6.15.6.2 To Add Financial Banner Payee Type/ID Panel

Step	Action	Response
1	Banner message must be saved with All RA Indicator marked No before this panel is activated. Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click on **[Search]** and choose a Payee Type/ID from list. User may add as many Payee Type/ID's as needed. Note that this is the Payee Type/ID of the billing provider for the RA, not the performing providers.	
3	Click **Save**.	Financial Banner Payee Type/ID is saved.

6.15.6.3 To Delete Banner Payee Type/ID Panel

Step	Action	Response
1	Click **Delete**.	Financial Banner Payee Type/ID specialty is deleted.

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6.16 Financial Banner Provider Specialty Panel Overview

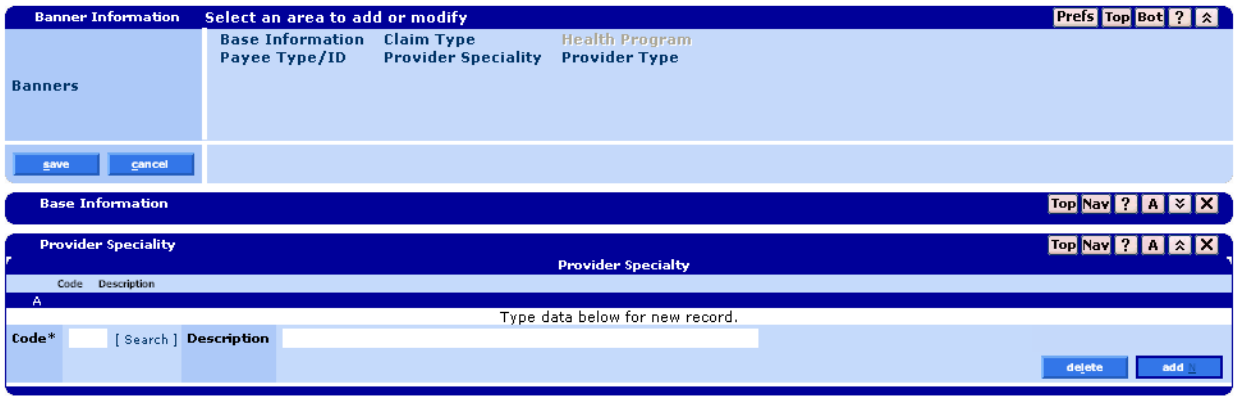
6.16.1 Financial Banner Provider Specialty Panel Narrative

The Financial Banner Provider Specialty panel allows the user to choose provider specialties as conditions for RA receivers.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Banner] – [Provider Specialty]

6.16.2 Financial Banner Provider Specialty Panel Layout



6.16.3 Financial Banner Provider Specialty Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider Specialty information.	Button	N/A	0
Cancel	Allows the user to cancel any changes on the Banner Provider Specialty panel.	Button	N/A	0
Code	Code used to identify the Provider Specialty.	Field	Alphanumeric	2
Delete	Allows the user to remove Provider Specialty information.	Button	N/A	0
Description	Description for the Provider Specialty code.	Field	Character	50
Save	Allows the user to save a record for Provider Specialty information.	Button	N/A	0
[Search]	Allows the user to search for a Provider Specialty code by specialty.	Hyperlink	N/A	0

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6.16.4 Financial Banner Provider Specialty Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	A valid provider specialty is required.	Choose a valid provider specialty from the [search] list.

6.16.5 Financial Banner Provider Specialty Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Financial Banner Provider Specialty Panel Accessibility

6.16.6.1 To Access the Financial Banner Provider Specialty Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Financial Banner Information panel displays.
3	Click **Base Information**.	Financial Banner Base Information panel displays.
4	Select **Provider Specialty** hyperlink.	Financial Provider Specialty panel displays. Note that this will not activate the panel. Banner message must be saved first.

6.16.6.2 To Add Financial Banner Provider Specialty Panel

Step	Action	Response
1	Banner message must be saved with All RA Indicator marked No before this panel is activated. Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click on **[Search]** and choose a provider specialty from list. User may add as many specialties as needed. Note that this is the specialty of the billing provider for the RA, not the performing providers.	
3	Click **Save**.	Financial Banner Provider Specialty is saved.

6.16.6.3 To Delete Banner Provider Specialty Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Financial Banner Provider specialty is deleted.

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6.17 Financial Banner Provider Type Panel Overview

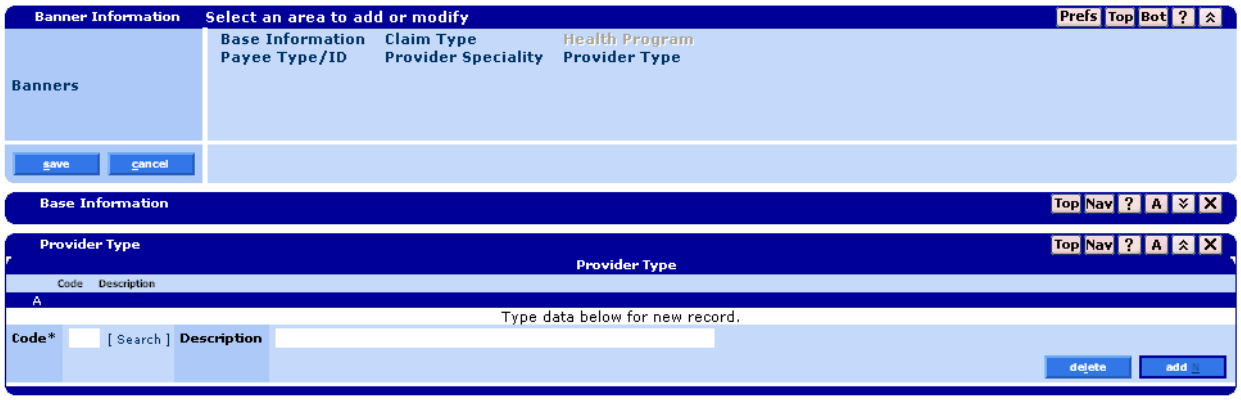
6.17.1 Financial Banner Provider Type Panel Narrative

The Financial Banner Provider Type panel allows the user to choose provider types as condition criteria for RA receivers.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Banner] – [Provider Type]

6.17.2 Financial Banner Provider Type Panel Layout



6.17.3 Financial Banner Provider Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider Type information.	Button	N/A	0
Cancel	Allows the user to cancel any changes on the Banner Provider Type panel.	Button	N/A	0
Code	Code used to identify the Provider Type.	Field	Alphanumeric	3
Delete	Allows the user to remove Provider Type information.	Button	N/A	0
Description	Description for the Provider Type code.	Field	Character	50
Save	Allows the user to save a record for Provider Type information.	Button	N/A	0
[Search]	Allows the user to search for a Provider Type by Type.	Hyperlink	N/A	0

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6.17.4 Financial Banner Provider Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	A valid Provider Type Code is required.	Choose a valid provider type from the [search] list.

6.17.5 Financial Banner Provider Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 Financial Banner Provider Type Panel Accessibility

6.17.6.1 To Access the Financial Banner Provider Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Banner**.	Financial Banner Information panel displays.
3	Click **Base Information**.	Financial Banner Base Information panel displays.
4	Select **Provider Type** hyperlink.	Financial Banner Provider Type panel displays. Note that this will not activate the panel. Banner message must be saved first.

6.17.6.2 To Add Financial Banner Provider Type Panel

Step	Action	Response
1	Banner message must be saved with All RA Indicator marked No before this panel is activated. Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click on **[Search]** hyperlink and choose a provider type from list. User may add as many types as needed. Note that this is the type of the billing provider for the RA, not the performing providers.	
3	Click **Save**.	Financial Banner Provider Type is saved.

6.17.6.3 To Delete Financial Banner Provider Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Financial Banner Provider type is deleted.

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6.18 FCRS Financial Cash Receipt Search Panel Overview

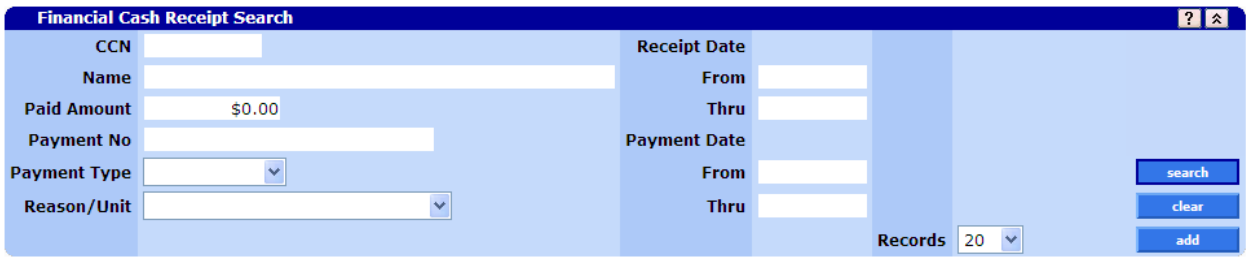
6.18.1 FCRS Financial Cash Receipt Search Panel Narrative

The FCRS Financial Cash Receipt Search panel displays Cash Receipt information. The panel allows Cash Receipts to be searched and reviewed. You must enter either a CCN, Payment No., Name, Receipt Date Range, or Payment Date Range.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Cash] –

6.18.2 FCRS Financial Cash Receipt Search Panel Layout



6.18.3 FCRS Financial Cash Receipt Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user bring up a new Cash Receipt Base Information panel to enter a new cash receipt.	Button	N/A	0
CCN	Allows the user to search by the Cash Control Number assigned by the system for the cash receipt or other criteria entered.	Field	Number (Integer)	11
Clear	Allows the user to clear any changes on the Cash Receipt Search panel.	Button	N/A	0
Name	Allows the user to search by the name on the check.	Field	Character	50
Paid Amount	Allows user to limit search by amount of the check received.	Field	Number (Decimal)	11
Payment Date (From)	When performing a search for cash receipts by payment date (date on the check), this is the beginning date.	Field	Date (MM/DD/CCYY)	8
Payment Date (Thru)	When performing a search for cash receipts payment date (date on the check), this is the ending date.	Field	Date (MM/DD/CCYY)	8
Payment No	Allows user to limit search by bank sequence number printed on the check.	Field	Number (Integer)	30
Payment Type	Allows user to limit search by indicating the type of payment,	Combo Box	Drop Down List Box	0
Reason/Unit	Allows the user to limit search by indicating	Combo	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
	the department the check is returned to and the type of check that was received.	Box		
Receipt Date (From)	When performing a search for cash receipts by payment date (date on the check), this is the beginning date.	Field	Date (MM/DD/CCYY)	8
Receipt Date (Thru)	When performing a search for cash receipts by payment date (date on the check), this is the ending date.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by the criteria entered on the panel.	Button	N/A	0

6.18.4 FCRS Financial Cash Receipt Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CCN	Field	1	You must enter a CCN, Name, Payment Date Range or Receipt Date Range.	Enter valid data.
	Field	2	You must enter either a CCN, Name, Receipt Date Range or Payment Date Range.	Enter CCN or date range.
From	Field	3	Invalid date.	Enter a valid date in MM/DD/CCYY format.
Payment Date	Field	1	Payment Date From cannot be greater than Payment Date Thru.	Verify and enter correct dates.
	Label	2	Invalid Date.	Enter a valid date.
	Label	3	Payment Date Thru is Required.	Enter a valid Payment Date Thru.
	Label	4	Payment Date From is Required.	Enter a valid Payment Date From.
Payment No	Field	1	Enter a valid value.	Enter a numeric value.
Receipt Date	Field	1	Receipt Date From cannot be greater than Payment Date Thru.	Verify and enter correct dates.
	Label	2	Invalid Date.	Enter a valid date.
	Label	3	Receipt Date Thru is Required.	Enter a valid Receipt Date Thru.
	Label	4	Receipt Date From is required.	Enter a valid Receipt Date From.
Thru	Field	1	Invalid date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Payment Date Thru is required.	Enter a valid date.

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6.18.5 FCRS Financial Cash Receipt Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 FCRS Financial Cash Receipt Search Panel Accessibility

6.18.6.1 To Access the FCRS Financial Cash Receipt Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipts.**	FCRS Financial Cash Receipts Search panel displays.

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6.19 FCRS Financial Cash Receipt Search Results Panel Overview

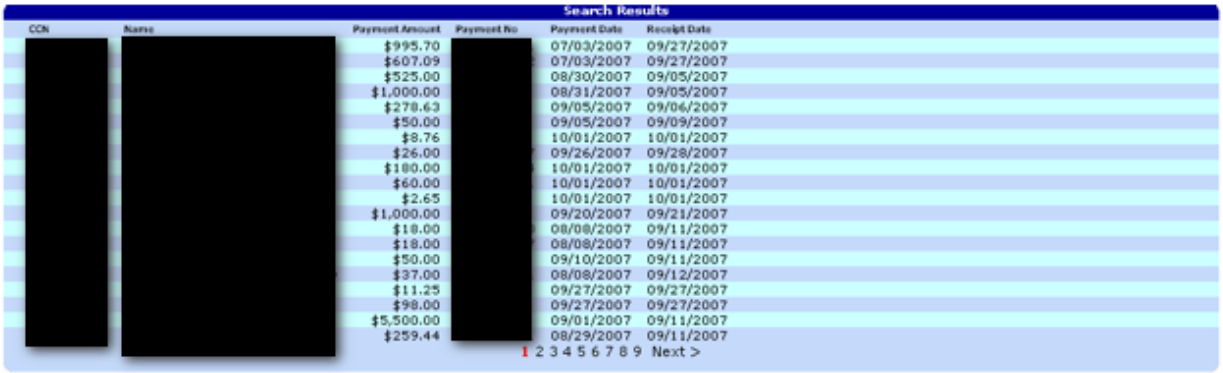
6.19.1 FCRS Financial Cash Receipt Search Results Panel Narrative

The Financial Cash Receipts Search (FCRS) Search Results panel displays Cash Receipts information.

This panel is display only.

Navigation: [Financial] - [Cash] - [(search button to get search results)]

6.19.2 FCRS Financial Cash Receipt Search Results Panel Layout



6.19.3 FCRS Financial Cash Receipt Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash Control Number assigned by the system for the cash receipt.	Label	Number (Integer)	11
Name	This is the name on the check.	Label	Character	50
Payment Amount	Amount of the check or cash received.	Label	Number (Decimal)	11
Payment Date	This is the date on the check.	Label	Date (MM/DD/CCYY)	8
Payment No	Bank sequence number printed on the check. The word CASH can be entered if cash is received.	Label	Number (Integer)	13
Receipt Date	Date the check or cash is received.	Label	Date (MM/DD/CCYY)	8

6.19.4 FCRS Financial Cash Receipt Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.19.5 FCRS Financial Cash Receipt Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 FCRS Financial Cash Receipt Search Results Panel Accessibility

6.19.6.1 To Access the FCRS Financial Cash Receipt Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipts.**	FCRS Financial Cash Receipts Search panel displays.
3	Enter a **Payment Date Range**, **Receipt Date Range**, or **Name**, and click **Search**.	FCRS Financial Cash Receipt Search Results displays.

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6.20 FCRI Financial Cash Receipt Information Panel Overview

6.20.1 FCRI Financial Cash Receipt Information Panel Narrative

The FCRI Financial Cash Receipt Information panel is a read only panel that displays cash receipt information. This panel is display only.

Navigation: [Financial] – [Cash] - [Cash Receipt Search] - [(Add button) OR (select row from search results)]

6.20.2 FCRI Financial Cash Receipt Information Panel Layout

6.20.3 FCRI Financial Cash Receipt Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash Control Number assigned by the system for the cash receipt.	Field	Number (Integer)	9
Name	Indicates the payer name that is on the check.	Field	Character	50
Paid Amount	This is the amount of the check received.	Field	Number (Decimal)	11
Payment Date	Date printed on the check.	Field	Date (MM/DD/CCYY)	8
Payment No	Bank sequence number printed on the check.	Field	Alphanumeric	30
Payment Type	Indicates the type of payment. Choices are: EFT, Business Check, Personal Check, Cashiers Check, Money Order or Cash.	Field	Alphanumeric	15
Reason/Unit	Unit/reason entered for the cash receipt.	Field	Character	15
Receipt Date	Date that the cash was received.	Field	Date (MM/DD/CCYY)	8
Second Name	Second name on the cash receipt. It is also known as the remitter's name.	Field	Alphanumeric	50
Status	This indicates the status of the cash receipt.	Field	Character	15

6.20.4 FCRI Financial Cash Receipt Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.20.5 FCRI Financial Cash Receipt Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 FCRI Financial Cash Receipt Information Panel Accessibility

6.20.6.1 To Access the FCRI Financial Cash Receipt Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipts**.	FCRI Financial Cash Receipt Search panel displays.
3	Enter **CCN** and click **Search**.	FCRI Financial Cash Receipt Information panel displays.
4	Click **Add**.	FCRI Financial Cash Receipt Information panel displays.

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6.21 FCRI Financial Cash Receipt Base Information Panel Overview

6.21.1 FCRI Cash Receipt Base Information Panel Narrative

The FCRI Financial Cash Receipts Base Information panel allows data entry of cash receipt information.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Cash] - [(select from search results)] – [Base Information]

6.21.2 FCRI Financial Cash Receipt Base Information Panel Layout

6.21.3 FCRI Financial Cash Receipt Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel changes on Cash Receipts panels.	Button	N/A	0
CCN	Cash Control Number assigned by the system for the cash receipt.	Field	Number (Integer)	9
Name	Indicates the payer name that is on the check.	Field	Character	50
New	Opens a new Cash Receipts Base Information panel.	Button	N/A	0
Paid Amount	Amount of the check received.	Field	Number (Decimal)	11
Payee ID	Indicates the payee identification. This field will accommodate the different length ID's for Labelers, Carriers, HIPP Resources and Providers. Note that if a valid payee ID is entered using the [search] hyperlink, the payee name will be autopopulated in the Name field.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Payee Type	Indicates the payee type. Choices are Labeler for Drug Rebate, Carrier for TPL, HIPP Resource for HIPP Resources and Provider.	Combo Box	Drop Down List Box	0
Payment Date	Date printed on the check.	Field	Date (MM/DD/CCYY)	8
Payment No.	Bank sequence number printed on the check. The word CASH can be entered if cash is received.	Field	Number (Integer)	30
Payment Type	Indicates the type of payment. Choices are: EFT, Business Check, Personal Check, Cashiers Check, Money Order or Cash.	Combo Box	Drop Down List Box	0
Reason/Unit	Unit/reason entered for the cash receipt. Note when TPL 200 is chosen, and the Payment No. is entered correctly, the cash receipt is directed to the TPL subsystem for disposition. When Drug Rebate 400 is chosen, the cash receipt is directed to the Drug Rebate subsystem for disposition. Otherwise, cash receipts remain within the Financial subsystem for disposition.	Combo Box	Drop Down List Box	0
Receipt Date	Date that the cash was received.	Field	Date (MM/DD/CCYY)	8
Save	Allows the user to save a cash receipt or changes made to the Cash Receipt panels	Button	N/A	0
Second Name	Second name on the cash receipt. It is also known as the remitter's name.	Field	Character	50
Status	Indicates the status of the cash receipt. Default status is ACTIVE. When a check is returned by the bank, this field can be updated to Insufficient Funds. Any dispositioned amount is returned to zero and the check cannot be dispositioned when so marked.	Combo Box	Drop Down List Box	0

6.21.4 FCRI Financial Cash Receipt Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CCN	Field	13	Enter a valid value.	Select a valid CCN.
Name	Field	9019	Name is required.	Enter a name.
Paid Amount	Field	1	Paid amount must be greater than or equal to 0.01.	Verify entry and re-enter a valid amount.
	Field	2	Paid Amount is required.	Enter a valid Paid Amount.
	Field	3	Payment Amount must be less than or equal to 99999999.99.	Enter a valid Paid Amount.
Payee Type	Field	6	Payee Type is required if Payee ID is present.	Enter a valid Payee Type for the Payee ID that is present.

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Field	Field Type	Error Code	Error Message	To Correct
Payment Date	Field	2	Payment Date is required.	Verify entry and re-enter a correct date.
	Field	3	Invalid date.	Verify entry and re-enter a correct date.
	Field	1022	Payment Date cannot be greater than Today.	Verify entry and re-enter a correct date.
Payment No	Field	1	Payment Number is required.	Enter a payment number.
Payment Type	Field	3	A valid Payment Type is required.	Enter a valid Payment Type.
Reason/Unit	Field	1	A valid Reason/Unit is required.	Enter a valid Reason/Unit.
Receipt Date	Field	1	Receipt Date is required.	Verify entry and re-enter a correct date.
	Field	122	Receipt Date cannot be greater than Today.	Verify entry and re-enter a correct date.
	Field	1	Receipt Date is required.	Verify entry and re-enter a correct date.

6.21.5 FCRI Financial Cash Receipt Base Information Panel Extra Features

Field	Field Type
There are no extra features on this panel.	

6.21.6 FCRI Financial Cash Receipt Base Information Panel Accessibility

6.21.6.1 To Access the FCRI Financial Cash Receipt Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash**.	FCRS Financial Cash Receipt Search panel displays.
3	Click **Add** hyperlink.	FCRS Financial Cash Receipt Base Information panel displays.
4	Enter a **CCN** and click **Search**.	FCRI Financial Cash Receipt Navigation panel displays.
5	Click **Base Information**.	FCRI Financial Cash Receipt Base Information panel displays.

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6.21.6.2 To Add FCRI Financial Cash Receipt Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Payment Type**.	
3	Enter **Paid Amount**.	
4	Enter **Payment Number**.	
5	Enter **Payment Date** in MM/DD/CCYY format.	
6	Enter **Payee Type**.	
7	Enter **Payee ID**.	
8	Enter **Receipt Date** in MM/DD/CCYY format.	
9	Enter **Reason/Unit**.	
10	Enter **Name** from check.	
11	Enter **Second Name** from check, if applicable.	
12	Click **Save**.	FCRI Financial Cash Receipt Base Information is saved.

6.21.6.3 To Update FCRI Financial Cash Receipt Base Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click Save.	FCRI Financial Cash Receipt Base information is saved.

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6.22 FCRI Financial Cash Receipt Comment Panel Overview

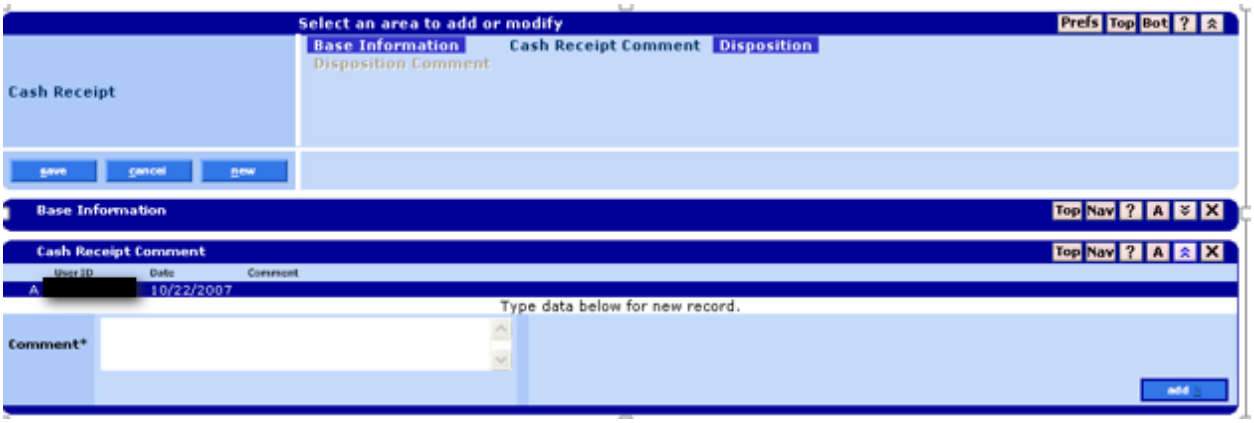
6.22.1 FCRI Financial Cash Receipt Comment Panel Narrative

The FCRI Financial Cash Receipt Comment panel allows the user to add narrative comments on a Cash Receipt.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Financial] – [Cash] - [(Add button) OR (select row from search results)] - [Cash Receipt Comment]

6.22.2 FCRI Financial Cash Receipt Comment Panel Layout



6.22.3 FCRI Financial Cash Receipt Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a cash receipt comment.	Button	N/A	0
Cancel	Allows the user to cancel changes on the Cash Receipt panels.	Button	N/A	0
Comment	Text containing comment added to disposition.	Field	Character	150
Date	Date the comment was entered.	Field	Date (MM/DD/CCYY)	8
New	Opens a new Cash Receipts Base Information panel.	Button	N/A	0
Save	Allows the user to save a cash receipt or changes on the Cash Receipt panels.	Button	N/A	0
User ID	Identification of the user entering the comment.	Field	Character	6

6.22.4 FCRI Financial Cash Receipt Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is Required.	Enter a comment.

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6.22.5 FCRI Financial Cash Receipt Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 FCRI Financial Cash Receipt Comment Panel Accessibility

6.22.6.1 To Access the FCRI Financial Cash Receipt Comment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash**.	FCRS Financial Cash Receipt Search panel displays.
3	Enter a **CCN** and click **Search**.	FCRS Financial Cash Receipt Navigation panel displays.
4	Click on the **Cash Receipt Comment** hyperlink.	FCRI Financial Cash Receipt Comment panel displays.

6.22.6.2 To Add FCRI Financial Cash Receipt Comment Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment text**.	
3	Click **Save**.	FCRI Financial Cash Receipt Comment is saved.

6.22.6.3 To Update FCRI Financial Cash Receipt Comment Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FCRI Financial Cash Receipt Comment information is saved.

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6.23 FCRI Financial Cash Receipt Disposition Panel Overview

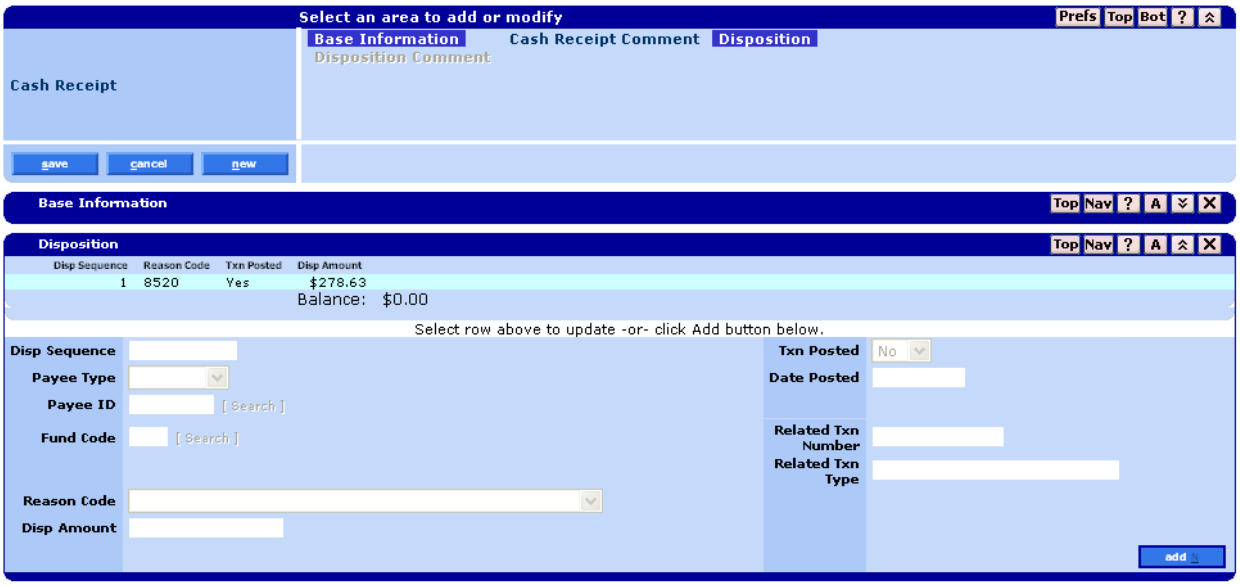
6.23.1 FCRI Financial Cash Receipt Disposition Panel Narrative

The FCRI Financial Cash Receipt Disposition panel allows the user to enter dispositions for Cash Receipts. Cash is rarely dispositioned from this panel. It is primarily used as an informational panel to review cash that is dispositioned through the claims adjustment panels or the accounts receivable panels.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Cash] - [(Add button) OR (select row from search results)] - [Disposition]

6.23.2 FCRI Financial Cash Receipt Disposition Panel Layout



6.23.3 FCRI Financial Cash Receipt Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to enter dispositions for Cash Receipts.	Button	N/A	0
Cancel	Allows the user to cancel changes on the Disposition panel.	Button	N/A	0
Date Posted	Date the cash disposition was posted.	Field	Date (MM/DD/CCYY)	8
Disp Amount	Identifies the amount being dispositioned from the check received.	Field	Number (Decimal)	11

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Field	Description	Field Type	Data Type	Length
Disp Sequence	This number uniquely identifies each individual disposition associated with a check; it will increase by one for each new disposition associated with the check.	Field	Number (Integer)	5
Fund Code	Fund Code to which this cash was posted/applied.	Field	Number (Integer)	4
New	Opens a new Cash Receipts Base Information panel.	Button	N/A	0
Payee ID	Indicates the payee identification number. This field accommodates the different length ID's for Labelers, Carriers, HIPP Resources and Providers.	Field	Number (Integer)	10
Payee Type	Indicates the payee type. Valid values include: Labeler for Drug Rebate, Carrier for TPL, HIPP Resource for HIPP Resources and Provider.	Combo Box	Drop Down List Box	0
Reason Code	Indicates the specific reason code and description for the cash receipt disposition.	Combo Box	Drop Down List Box	0
Related Txn Number	This is the Related Transaction number	Field	Number (Integer)	13
Related Txn Type	This is the Related Transaction Type.	Field	Character	15
Save	Allows the user to save a cash receipt or changes on the Disposition panel.	Button	N/A	0
Txn Posted	Indicates if transaction has been posted. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0

6.23.4 FCRI Financial Cash Receipt Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Disp Amount	Field	1	Disposition Amount is Required.	Enter a Disposition Amount.
	Field	4	Total Disposition Amount is greater than the paid amount by.	Adjust the disposition amount. The overage amount is calculated and populated by the system at the end of the text message.
	Field	32	Enter a valid value.	Enter a valid Disp Amount.

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Field	Field Type	Error Code	Error Message	To Correct
Fund Code	Field	1	A Fund Code is required.	Please enter the Fund Code.
Payee ID	Field	29	Payee ID is not valid.	Enter a valid Payee ID.
	Field	30	Payee Type and Payee ID are required.	Enter valid Payee Type and Payee ID.
	Field	31	Payee ID is required if Reason/Unit is a System Originated Payment.	Enter a valid Payee ID.
Payee Type	Field	30	Payee Type and Payee ID are required.	Enter a valid Payee Type and Payee ID.
	Field	34	Payee Type is required if Reason/Unit is a System Originated Payment.	Enter a valid Payee Type.
Reason Code	Field	90	A valid Reason Code is required.	Enter a valid Reason Code.

6.23.5 FCRI Financial Cash Receipt Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 FCRI Financial Cash Receipt Disposition Panel Accessibility

6.23.6.1 To Access the FCRI Financial Cash Receipt Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipts**.	FCRS Financial Cash Receipt Search panel displays.
3	Enter **CCN** and click **Search**.	FCRI Financial Cash Receipt Information panel displays.
4	Click **Disposition** hyperlink.	FCRI Financial Cash Receipt Disposition panel displays.

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6.23.6.2 To Add FCRI Financial Cash Receipt Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Payee Type**.	
3	Enter a **Payee**; or click [Search] to select a Payee ID from the list.	
4	Enter a **Fund Code**; or click [Search] to select a Fund Code from the list.	
5	Select **Reason** from drop down list box.	
6	Enter a **Disposition Amount**.	
7	Enter a **Disposition Date**.	
8	Click **Save**.	FCRI Financial Cash Receipt Disposition is saved.

6.23.6.3 To Update FCRI Financial Cash Receipt Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FCRI Financial Cash Receipt Disposition information is saved.

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6.24 FCRI Financial Cash Receipt Disposition Comment Panel Overview

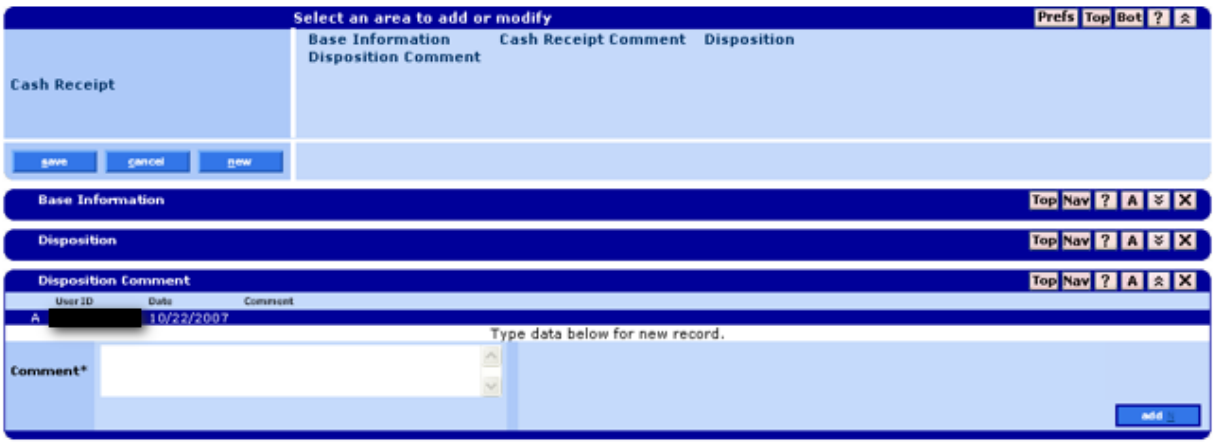
6.24.1 FCRI Financial Cash Receipt Disposition Comment Panel Narrative

The FCRI Financial Cash Receipt Disposition Comments panel allows the user to add narrative comments on a Cash Receipt Disposition.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Cash] - [select row from search results] - [Disposition Comment]

6.24.2 FCRI Financial Cash Receipt Disposition Comment Panel Layout



6.24.3 FCRI Financial Cash Receipt Disposition Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Disposition Comment.	Button	N/A	0
Cancel	Allows the user to cancel changes on the Disposition Comment panel.	Button	N/A	0
Comment	The comment for the disposition.	Field	Character	150
Date	Date the comment was entered.	Field	Date (MM/DD/CCYY)	8
New	Opens a new Cash Receipts Base Information panel.	Button	N/A	0
Save	Allows the user to save a cash receipt or changes on the Cash Receipts panels.	Button	N/A	0
User ID	Identification of the user entering the comment.	Field	Alphanumeric	6

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6.24.4 FCRI Financial Cash Receipt Disposition Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is Required.	Enter a comment.
	Field	2	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 150 characters.	Revise text to be within the maximum 150 characters allowed.

6.24.5 FCRI Financial Cash Receipt Disposition Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 FCRI Financial Cash Receipt Disposition Comment Panel Accessibility

6.24.6.1 To Access the FCRI Financial Cash Receipt Disposition Comment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipt**.	FCRS Financial Cash Receipts Search panel displays.
3	Enter a **CCN** and click **Search**.	FCRI Financial Cash Receipts Information and NAV panels display.
4	Click **Disposition** hyperlink.	FCRI Financial Cash Receipt Disposition panel displays.
5	Select a row or click the **Add** button.	Activates hyperlink to FCRI Financial Cash Receipt Disposition Comments panel.
6	Click **Disposition Comments** hyperlink.	FCRI Financial Disposition Comments panel displays.

6.24.6.2 To Add FCRI Financial Cash Receipt Disposition Comments Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	FCRI Financial Cash Receipt Disposition Comment is saved.

6.24.6.3 To Update FCRI Financial Cash Receipt Dispositions Comments Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FCRI Financial Cash Receipt Disposition Comment information is saved.

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6.25 FCRI Financial Cash Receipt Mini-Search Panel Overview

6.25.1 FCRI Financial Cash Receipt Mini-Search Panel Narrative

The FCRI Financial Cash Receipt Mini-Search panel appears at the top of the panel when a Cash Control Number (CCN) Search is entered. This panel allows the user to enter another CCN to search for that cash receipt. The Advanced Search button brings up a cleared FCRI Search panel.

This panel is inquiry only.

Navigation: [Financial] - [Cash] - [(select from search results)] - [(mini search is on top of page)]

6.25.2 FCRI Financial Cash Receipt Mini-Search Panel Layout

6.25.3 FCRI Financial Cash Receipt Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CCN	Cash Control Number assigned by the system for the cash receipt	Field	Number (Integer)	11
Adv Search	Allows the user to further define the search by entering specific criteria.	Button	N/A	0
Clear	Allows the user to clear any changes on the Mini Search panel.	Button	N/A	0
Search	Initiates the Search by Cash Control Number.	Button	N/A	0

6.25.4 FCRI Financial Cash Receipt Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	Field
No field edits found for this panel.				

6.25.5 FCRI Financial Cash Receipt Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 FCRI Financial Cash Receipt Mini-Search Panel Accessibility

6.25.6.1 To Access the FCRI Financial Cash Receipt Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Cash Receipts**.	FCRS Financial Cash Receipts Search panel displays.

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Step	Action	Response
3	Enter a **CCN** and click **Search**.	FCRI Financial Cash Receipts Mini-Search appears.

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6.26 FES Financial Expenditure Search Panel Overview

6.26.1 FES Financial Expenditure Search Panel Narrative

The Financial Expenditure Search (FES) panel is used to access expenditure information using various criteria.

This panel is inquiry only.

Navigation: [Financial] - [Exp] - (Search)

6.26.2 FES Financial Expenditure Search Panel Layout

6.26.3 FES Financial Expenditure Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Clicking Add will open an Expenditure Base Information panel to allow user to enter an expenditure transaction.	Button	N/A	0
Clear	Clicking Clear will clear data previously entered on the Financial Expenditure Search panel.	Button	N/A	0
Expenditure ID	Number of the expenditure that uniquely identifies the expenditure.	Field	Number (Integer)	9
Fund Code	This is the financial fund code tied to the Expenditure.	Combo Box	Drop Down List Box	5
Payee ID	Unique number identifying the Payee of the Expenditure.	Field	Number (Integer)	15
Payee Type	Indicates the payee type. Carrier for systematic TPL expenditures, HIPP Resource for systematic HIPP Resource expenditures, Lien Holder for systematic payments to the Internal Revenue Service (IRS) when the Lien process is used, and Provider.	Combo Box	Drop Down List Box	0
Payment Date From	Beginning date for payment search.	Field	Date (MM/DD/CCYY)	8
Payment Date Thru	Ending date for payment search.	Field	Date (MM/DD/CCYY)	8
Payout Reason	Specific reason for the expenditure.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Clicking Search will trigger search function using search criteria entered.	Button	N/A	0
Status	Status of expenditure: Pending, Active or Paid.	Combo Box	Drop Down List Box	0

6.26.4 FES Financial Expenditure Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Expenditure ID	Field	1	Enter an Expenditure ID or Payee Type and Payee ID.	Enter valid information for search
From	Field	1	Invalid Date.	Enter valid date in MM/DD/CCYY format.
Thru	Field	1	Invalid Date.	Enter valid date in MM/DD/CCYY.

6.26.5 FES Financial Expenditure Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 FES Financial Expenditure Search Panel Accessibility

6.26.6.1 To Access the FES Financial Expenditure Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Expenditure**.	FES Financial Expenditure Search panel displays.

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6.27 FES Financial Expenditure Search Results Panel Overview

6.27.1 FES Financial Expenditure Search Results Panel Narrative

The FES Financial Expenditure Search Results panel allows the user to review expenditures requested from Financial Expenditure Search panel. This panel is display only.

Navigation: [Financial] - [Exp] - (Click on Search)

6.27.2 FES Financial Expenditure Search Results Panel Layout

Search Results

Expenditure ID	Payee ID	Payee Type	Fund Code	Payout Reason	Expenditure Amount	Payment Date	Activation Date
[redacted]	[redacted]	Carrier	998	8340 - TPL Hlth Refund	$31.55	0	0
		Carrier	998	8340 - TPL Hlth Refund	$31.55	0	0
		Carrier	998	8340 - TPL Hlth Refund	$31.55	0	0
		Carrier	998	8310 - Over Refund	$31.55	0	0
		Carrier	998	8340 - TPL Hlth Refund	$33.25	0	03/05/2014
		Carrier	998	8310 - Over Refund	$31.55	0	0
		Carrier	998	8310 - Over Refund	$10.00	0	0
Total Number of Expenditures: 7				Total:	$201.00		

6.27.3 FES Financial Expenditure Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Activation Date	Date that the expenditure was activated for payment.	Field	Date (MM/DD/CCYY)	8
Expenditure Amount	Amount of the expenditure.	Field	Number (Decimal)	9
Expenditure ID	Number of the expenditure that uniquely identifies the expenditure.	Field	Number (Integer)	9
Fund Code	This is the fund code assigned to the Expenditure.	Field	Number (Integer)	3
Payee ID	Unique identification number of the Payee.	Field	Alphanumeric	10
Payment Date	Date the expenditure actually paid.	Field	Date (MM/DD/CCYY)	8
Payout Reason	This is the reason for the expenditure.	Field	Character	20
Payee Type	This indicates the payee type. Carrier for systematic TPL expenditures, HIPP Resource for systematic HIPP Resource expenditures, Lien Holder for systematic payments to IRS when the Lien process is used, and Provider.	Field	Character	15
Total Number of Expenditures	Total number of Expenditures on the list.	Field	Number (Integer)	10
Totals	Totals for the Set Up Amount, Disposition Amount, and Outstanding Balance columns.	Field	Number (Decimal)	10

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6.27.4 FES Financial Expenditure Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.27.5 FES Financial Expenditure Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 FES Financial Expenditure Search Results Panel Accessibility

6.27.6.1 To Access the FES Financial Expenditure Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Expenditure**.	FES Financial Expenditure Search panel displays.
3	Enter search criteria and click **Search**.	FES Financial Expenditure Search Results displays.

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6.28 FEI Financial Expenditure Information Panel Overview

6.28.1 FEI Financial Expenditure Information Panel Narrative

The FEI Financial Expenditure Information panel displays information on expenditures. This panel is display only.

Navigation Path: [Financial] - [Exp] - [(select from search results)]

6.28.2 FEI Financial Expenditure Information Panel Layout

6.28.3 FEI Financial Expenditure Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Activated	Date the expenditure was activated to release for payment.	Field	Date (MM/DD/CCYY)	8
Add Date	Date the expenditure request was initiated.	Field	Date (MM/DD/CCYY)	8
Address line 1	Stores the first part of the payee address.	Field	Alphanumeric	30
Address line 2	Stores the second part of the payee address.	Field	Alphanumeric	30
Approval User ID	Identification of the person approving the expenditure transaction.	Field	Character	6
CCN	This is the Cash Control Number associated with the cash receipt received for this expenditure.	Field	Number (Integer)	11
City	The city of the payee address.	Field	Character	15
Expenditure ID	Number used to identify payout.	Field	Number (Integer)	9
Fund Code	This is the Fund Code of the expenditure.	Field	Character	3
Fund Payer	Fund that provides the payment to the payee.	Field	Character	30
Issue Date	Issue date of the check paid the expenditure.	Field	Date (MM/DD/CCYY)	8
Name	Name that the payee uses for payments.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Payee ID	Unique number identifying the Payee of the Expenditure.	Field	Number (Integer)	15
Payee Type	This indicates the payee type. Valid values include: Carrier for systematic TPL expenditures, HIPP Resource for systematic HIPP Resource expenditures, Lien Holder for systematic payments to IRS when the Lien process is used, and Provider.	Field	Character	10
Payment #	Payment number for the expenditure. This is populated after the Expenditure pays in the cycle.	Field	Number (Integer)	9
Payout Amt	This is the amount the Expenditure will pay.	Field	Number (Decimal)	13
Payout Reason	This is the specific reason for the expenditure.	Field	Character	50
Phone	The telephone number of payee.	Field	Number (Integer)	10
Process Type	Indicates what cycle the Expenditure will pay in. Regular means payment will be made in the financial cycle and the payee will receive payment in, EFT or paper check according to how that payee is to be paid. Manual means the payment is a manual check.	Field	Character	50
Related Transaction Number	Number of the transaction related to the expenditure. For example, if the expenditure is an advance payment or a refund, the number is an AR or Cash Receipt number.	Field	Number (Integer)	13
Related Transaction Type	This is the description of the Type of control number in Related Transaction Number field. For example 'Accounts Receivable' or 'Cash Receipt'.	Field	Character	20
Request Doc	Number used to reference a correspondence document to the expenditure transaction.	Field	Alphanumeric	6
Setup User ID	Identification of the person that established the expenditure.	Field	Character	8
State	The state code of payee address.	Field	Character	2
Status	This is the status of the Expenditure transaction. The possible values are Pending, Active, Paid, and Voided.	Field	Character	10
Time Active	Time that the expenditure was activated for release to payment.	Field	Number (Decimal)	6

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Field	Description	Field Type	Data Type	Length
Zip	Zip code of payee address. This may or may not contain the zip plus four.	Field	Number (Integer)	10

6.28.4 FEI Financial Expenditure Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.28.5 FEI Financial Expenditure Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 FEI Financial Expenditure Information Panel Accessibility

6.28.6.1 To Access the FEI Financial Expenditure Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Enter an **Expenditure Number** and click **Search**.	FEI Financial Expenditure Information panel displays.

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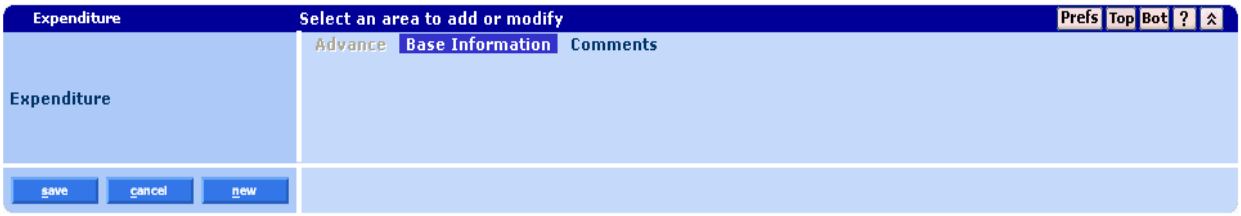
6.29 FEI Financial Expenditure Maintenance Panel Overview

6.29.1 FEI Financial Expenditure Maintenance Panel Narrative

The FEI Financial Expenditure Maintenance panel contains links to the Advance, Base Information and Advance panels. This panel is inquiry only.

Navigation: [Financial] – [Exp] - [(enter search criteria and select row)] or click Add.

6.29.2 FEI Financial Expenditure Maintenance Panel Layout



6.29.3 FEI Financial Expenditure Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Advance	Link to the Advance panel.	Hyperlink	N/A	0
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows a user to cancel a request related to expenditures.	Button	N/A	0
Comments	Link to the Comments panel.	Hyperlink	N/A	0
New	Allows a user to add new information related to expenditures.	Button	N/A	0
Save	Allows a user to save information related to expenditures.	Button	N/A	0

6.29.4 FEI Financial Expenditure Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.29.5 FEI Financial Expenditure Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.29.6 FEI Financial Expenditure Maintenance Panel Accessibility

6.29.6.1 To Access the FEI Financial Expenditure Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Enter an **Expenditure Number** and click **Search**.	The Expenditure panel displays.
3	Point to **Financial** and click **Expenditure**.	FES Financial Expenditure Search panel displays.
4	Click **Add**.	FEI Financial Expenditure Base panel and Expenditure Maintenance panel displays.

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6.30 FEI Financial Expenditure Advance Panel Overview

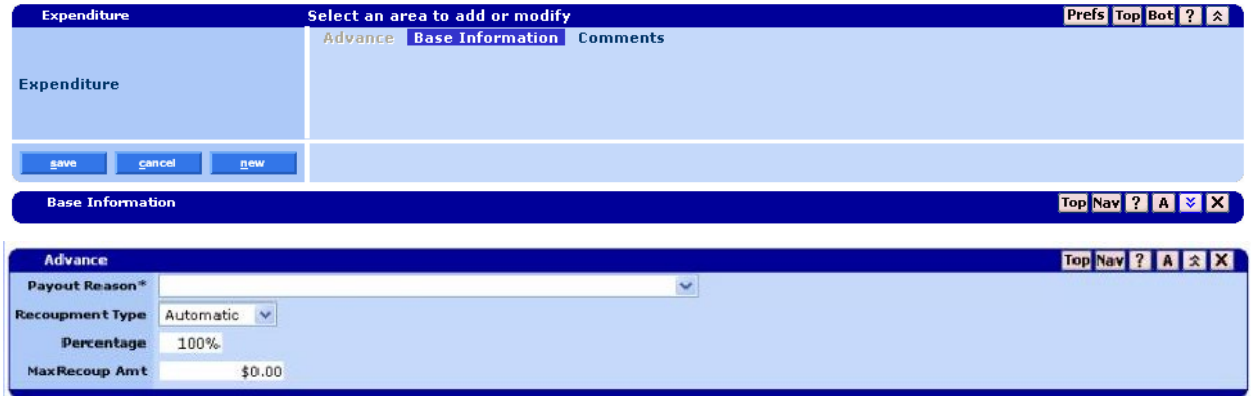
6.30.1 FEI Financial Expenditure Advance Panel Narrative

The FEI Financial Expenditure Advance panel allows the user to set up the AR criteria for the Advance if expenditure is entered as an Advance. When an expenditure reason code for an Advance is entered on the Expenditure Base Information panel, the grayed out Advance Maintenance link is bolded for use. The link is clicked to display the Advance panel so that the AR conditions can be set up to recoup the advance payout. The entire transaction, expenditure and advance AR is saved, and then activated at the same time.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Exp] - [Add or Search] – [Advance]

6.30.2 FEI Financial Expenditure Advance Panel Layout



6.30.3 FEI Financial Expenditure Advance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows a user to cancel a request related to Advance Expenditure and Advance AR information.	Button	N/A	0
MaxRecoup Amt	This the dollar amount of payment to recoup against the advance per financial cycle.	Field	Number (Decimal)	9
New	Allows a user to open a new Expenditure panel to enter another expenditure.	Button	N/A	0
Payout Reason	This is the payout reason.	Combo Box	Drop Down List Box	0
Percentage	This is the percentage of payment to recoup against the advance per financial cycle.	Field	Number (Decimal)	5
Recoupment Type	This is the recoupment type. Automatic means the recoupment will happen automatically with the next financial cycle.	Combo Box	Drop Down List Box	0
Save	Allows the user to save the Advance Expenditure and Advance AR information.	Button	N/A	0

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6.30.4 FEI Financial Expenditure Advance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
MaxRecoup Amt	Field	1	Either Percentage or MaxRecoup Amt is required.	Enter a Maximum Recoupment Amount.
	Field	2	Enter either a Max Recoupment Amount or Percentage.	Either a Max Recoupment Amount or Percentage
Payout Reason	Field	3	Payout Reason is required.	Enter a valid payout reason.
Percentage	Field	1	Either Percentage or MaxRecoup Amt is required.	Enter a percentage.

6.30.5 FEI Financial Expenditure Advance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 FEI Financial Expenditure Advance Panel Accessibility

6.30.6.1 To Access the FEI Financial Expenditure Advance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Expenditure**.	Expenditure Search panel displays.
3	Click **Add**.	FEI Financial Expenditure Information panel displays.
4	Click **Advance** hyperlink.	FEI Financial Expenditure Advance panel displays.

6.30.6.2 To Add FEI Financial Expenditure Advance Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Payout Reason** from drop down list box.	
3	Select **Recoupment Type** from drop down list box.	
4	Enter a **Percentage**.	
5	Enter **a MaxRecoup Amt.**	
6	Select **Recoupment Frequency** from drop down list box.	
7	Click **Save**.	Advance is saved in pending status.
8	Click **Activate**.	Expenditure and Advance is saved in activate status.
9	Click **Save**.	FEI Financial Expenditure Advance is saved.

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6.30.6.3 To Update FEI Financial Expenditure Advance Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	FEI Financial Expenditure Advance is saved.

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6.31 FEI Financial Expenditure Base Information Panel Overview

6.31.1 FEI Financial Expenditure Base Information Panel Narrative

The FEI Financial Expenditure Base Information panel displays after searching the Financial Expenditure Search and then selecting one of the search results records.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Financial] - [Exp] - [(select from search results)] - [Base Information] or select Add from the Expenditure Search Panel.

6.31.2 FEI Financial Expenditure Base Information Panel Layout

6.31.3 FEI Financial Expenditure Base Information Panel Field Descriptions

Field	Description	pe	Data Type	h
Activate	Allows the user to activate the expenditure. (An expenditure must be saved first and will be 'pending' until activated.)	Button	N/A	0
Activated	Date that the expenditure was activated for release to payment.	Field	Date (MM/DD/CCYY)	8
Add Date	Date on which the expenditure request was initiated.	Field	Date (MM/DD/CCYY)	8

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Field	Description	pe	Data Type	th
Address1	Displays the first part of the address of the Payee.	Field	Alphanumeric	30
Address2	Displays the second part of the address of the Payee.	Field	Alphanumeric	30
Approval User ID	User identification of the person approving the expenditure.	Field	Character	6
Cancel	Allows the user to cancel changes on the FEI Expenditure Base Information panel.	Button	N/A	0
Cash Disposition - CCN	The Cash Control Number associated with expenditure payout.	Field	Number (Integer)	11
Cash Disposition - Disp Reason	Reason for this cash control number (CCN) associated with expenditure payout.	Combo Box	Drop Down List Box	0
City	This is the city of the payee.	Field	Character	15
Expenditure ID	This is the system assigned number used to identify the payout.	Field	Number (Integer)	9
Fund Code	This is the Fund Code to which the expenditure is posted.	Field	Character	0
Issue Date	Financial payment issue date. This is the date the actual check was issued to pay the expenditure.	Field	Date (MM/DD/CCYY)	8
Name	Name that the payee uses for payments.	Field	Character	50
New	When a Base Information panel has been completed and saved, clicking the New button will display a blank base information panel.	Button	N/A	0
Payee ID	This is the payee's unique identification number.	Field	Character	15
Payee Type	This indicates the payee type. Valid values include: Carrier for systematic TPL expenditures, HIPP Resource for HIPP Resources, Provider and Lien Holder, which is used specifically for IRS in Alabama.	Combo Box	Drop Down List Box	0
Payment #	Payment number for the expenditure. (It is the EFT or check number.)	Field	Number (Integer)	9
Payout Amt	Amount the Expenditure will pay.	Field	Number (Decimal)	13
Payout Reason	Specific reason for the expenditure.	Combo Box	Drop Down List Box	0
Phone	This is the telephone number of the payee.	Field	Number (Integer)	10

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Field	Description	pe	Data Type	h
Process Type	Indicates what cycle the Expenditure will pay in. Regular means 'the next financial cycle'.	Combo Box	Drop Down List Box	0
Request Doc	This was designed for Alabama HWT Document Numbers, however anything entered can be used as a document number.	Field	Alphanumeric	6
Save	Allows the user to save changes on the FEI Expenditure Base Information panel.	Button	N/A	0
Setup User ID	Identification number of the clerk that established the expenditure.	Field	Character	6
State	This is the state of the Payee address.	Field	Character	2
Status	Status of the Expenditure transaction. The possible values are Pending, Activated, Paid and Voided.	Field	Character	10
Time Active	Time that the expenditure was activated for release to payment.	Field	Number (Decimal)	8
Zip	Zip code of the payee address.	Field	Number (Integer)	10

6.31.4 FEI Financial Expenditure Base Information Panel Field Edit Error Codes

Field	ype	Code	ror Message	To Correct
CCN	Field	5	Enter a valid value.	Enter a valid CCN.
Disp Reason	Field	2	Disposition Reason must be entered first before selecting CCN.	CCN must be entered so that Cash Disposition Reason Code can be verified for the Payout Reason entered.
	Field	2	Invalid Cash Disposition for the selected Payout Reason.	A Cash Disposition reason code is required when saving a refund type expenditure.
Fund Code	Field	91006	A valid Fund Code is required.	Please enter a valid Fund Code.
Payee ID	Field	12	Payee ID is required.	Enter a valid Payee ID.
Payee Type	Field	1	Payee type is required.	Enter a valid Payee Type.
Payout Amount	Field	1	Payout Amount is required.	Enter a valid Payout Amount.
	Field	2	Payout amount must be equal to or greater than 0.01.	Enter a Payout Amount.
	Field	5	Enter a valid value	Enter a valid dollar payout amount.
Payout Reason	Field	91006	Payout Reason is required.	Enter a valid payout reason.

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Field	ype	Code	ror Message	To Correct
Process Type	Field	1	Process Type is required	Choose a valid Process Type.
	Field	2	Cde Txn is required. This message only appears if Save is clicked on a blank panel.	Enter expenditure data.

6.31.5 FEI Financial Expenditure Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 FEI Financial Expenditure Base Information Panel Accessibility

6.31.6.1 To Access the FEI Financial Expenditure Base Information Panel

	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Enter an **Expenditure Number** and click **Search**.	The Expenditure panel displays.
3	Point to **Financial** and click **Expenditure**	FES Financial Expenditure Search panel displays.
4	Click **Add**.	FEI Financial Expenditure Base panel and Expenditure panel displays.

6.31.6.2 To Add FEI Financial Expenditure Base Information Panel

	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Provider** from the **Payee Type** drop down list.	
3	Enter a **Provider ID**; Or click [search] to select a Provider ID from the list.	
4	Enter **Payout Amount**.	
5	Select **Regular** from the **Process Type** drop down list.	
6	Select a **Payout Reason** from the drop down list.	
7	Enter a valid **Fund Code**, or choose a Fund Code from the drop down list.	
8	If Expenditure is HWT related, enter the document number in the **Request Doc** field.	

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	Action	Response
9	If the expenditure is related to a Cash Control Number (and the Expenditure Reason is for a Refund) enter the CCN in the **CCN** field.	
10	If a CCN has been entered, enter the Cash Disposition Reason in the **Disp Reason** field.	
11	Click **Save**.	Base Information is saved in pending status. This allows for quality control review prior to activating the expenditure. User ID and add date will populate the Expenditure Information panel.
12	Click **Activate**.	Expenditure is saved in activation status.
13	Click **Save**.	Activated Expenditure is saved. User ID and activation date will populate the Expenditure Information panel. Expenditure will post in the next financial cycle.

6.31.6.3 To Update FEI Financial Base Information Panel

	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FEI Expenditure Base information is saved.

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6.32 FEI Financial Expenditure Comments Panel Overview

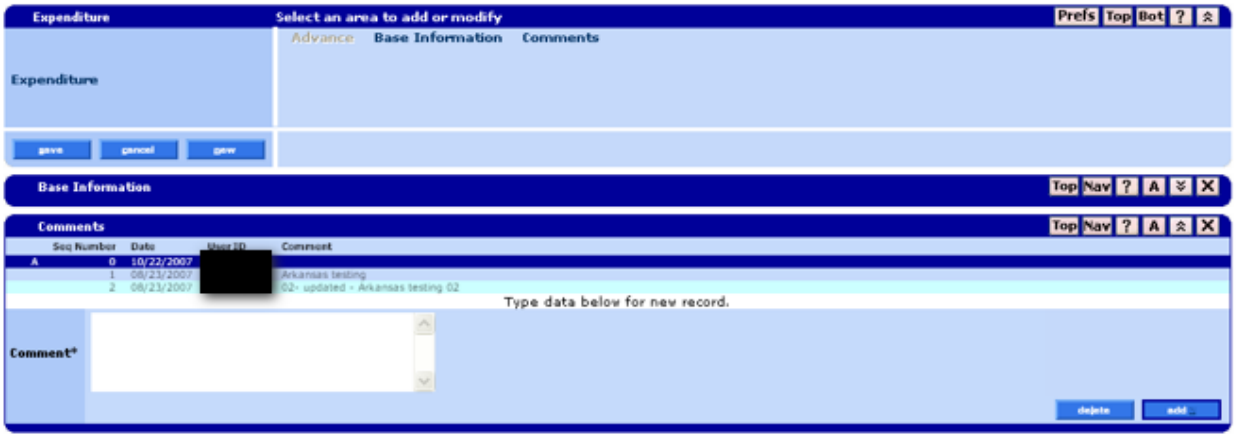
6.32.1 FEI Financial Expenditure Comments Panel Narrative

The FEI Financial Expenditure Comments panel is found after searching for a record and then clicking on its details. It is used to make comments on expenditure.

Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Financial] - [Exp] - [(select from search results)] – [Comments]

6.32.2 FEI Financial Expenditure Comments Panel Layout



6.32.3 FEI Financial Expenditure Comments Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a comment on an expenditure.	Button	N/A	0
Cancel	Allows the user to cancel any changes on the FEI Comments panel.	Button	N/A	0
Comment	Comment entered for the expenditure.	Field	Character	250
Date	System applied date when the comment was added.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete a comment on an expenditure.	Button	N/A	0
New	Allows a user to open a new expenditure panel.	Button	N/A	0
Save	Allows the user to save a comment on an expenditure.	Button	N/A	0
Seq Number	Sequence number assigned to the comment. It becomes useful when several comments are added on the same date.	Field	Number (Integer)	2
User ID	The User identification of the user entering the comment.	Field	Alphanumeric	6

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6.32.4 FEI Financial Expenditure Comments Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter a comment.
	Field	2	You have exceeded the maximum number of characters allowed for the field. Your text has been truncated to the maximum 250 characters.	Abbreviate your message to 250 characters.

6.32.5 FEI Financial Expenditure Comments Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 FEI Financial Expenditure Comments Panel Accessibility

6.32.6.1 To Access the FEI Financial Expenditure Comments Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Enter an **Expenditure Number** and click **Search**.	The Expenditure panel displays.
3	Click on the **Comments** hyperlink.	The Expenditure Comment panel displays.
4	Point to **Financial** and click **Expenditure**.	FES Financial Expenditure Search panel displays.
5	Click **Add**.	FEI Financial Expenditure Base panel and Expenditure panel displays.
6	Click on the **Comments** hyperlink.	FEI Financial Expenditure Comment panel displays.

6.32.6.2 To Add FEI Financial Expenditure Comments Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	FEI Financial Expenditure Comment is saved.

6.32.6.3 To Update FEI Financial Comments Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FEI Financial Comment information is saved.

6.32.6.4 To Delete FEI Financial Comments Panel

Step	Action	Response

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Step	Action	Response
1	Click **Delete**.	Comment is marked deleted.
2	Click **Save**.	FEI Financial Comment is deleted.

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6.33 FEI Financial Expenditure Mini-Search Panel Overview

6.33.1 FEI Financial Expenditure Mini-Search Panel Narrative

The FEI Financial Expenditure Mini-Search panel allows user to enter an Expenditure ID to search.

This panel is inquiry only.

Navigation: [Financial] - [Exp] - [(select from search results)] – Mini-Search appears at the top of the page. Clicking advanced search will bring up a cleared Expenditure Search panel.

6.33.2 FEI Financial Expenditure Mini-Search Panel Layout

6.33.3 FEI Financial Expenditure Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Allows the user to further define the search by entering more detailed search criteria.	Button	N/A	0
Back	Allows the user to return to Expenditures Search Results.	Button	N/A	0
Clear	Allows the user to clear any changes on the Mini-Search panel.	Button	N/A	0
Expenditure	Number of the expenditure that uniquely identifies the expenditure.	Field	Number (Integer)	9
Search	Initiates the Search by Expenditure number.	Button	N/A	0

6.33.4 FEI Financial Expenditure Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 FEI Financial Expenditure Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 FEI Financial Expenditure Mini-Search Panel Accessibility

6.33.6.1 To Access the FEI Financial Expenditure Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Enter an **Expenditure Number** and click **Search**.	FEI Financial Expenditure Information panel displays with the Mini-Search panel at the top.

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6.34 FLS Financial Payment Deduction Search Panel Overview

6.34.1 FLS Financial Payment Deduction Search Panel Narrative

The FLS Financial Payment Deduction Search panel allows the user to review information on a Payment Deduction.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Payment Deduction] – [Search]

6.34.2 FLS Financial Payment Deduction Search Panel Layout

6.34.3 FLS Financial Payment Deduction Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Payment Deduction information by opening and activating the payment deduction base information panel.	Button	N/A	0
Clear	This allows the user to clear any changes on the Payment Deduction Search panel.	Button	N/A	0
Deduction Number	Unique number for the payment deduction.	Field	Number (Integer)	18
Payee ID	Provider identification number.	Field	Alphanumeric	15
Payee Type	Identifies the type of payee. In Alabama, this is always provider.	Combo Box	Drop Down List Box	0
Reason	This is the payment deduction reason.	Combo Box	Drop Down List Box	0
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by criteria entered on the panel.	Button	N/A	0
Status	Status of the payment deduction. Valid values are Open or Closed.	Combo Box	Drop Down List Box	0

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6.34.4 FLS Financial Payment Deduction Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Deduction Number	Field	1	At least one of Deduction Number or Payee Type and Payee ID is required.	Enter either a Deduction Number or Payee Type and Payee ID.
	Field	2	Enter a valid value.	Field is numeric. Enter a number.

6.34.5 FLS Financial Payment Deduction Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 FLS Financial Payment Deduction Search Panel Accessibility

6.34.6.1 To Access the FLS Financial Payment Deduction Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.

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6.35 FLS Financial Payment Deduction Search Results Panel Overview

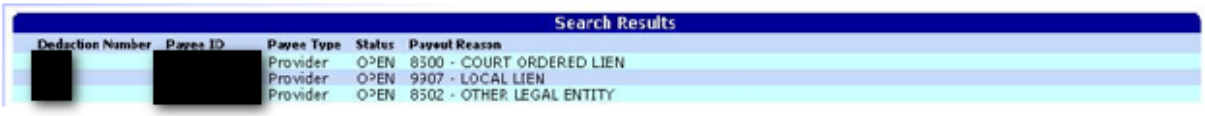
6.35.1 FLS Financial Payment Deduction Search Results Panel Narrative

The FLS Financial Payment Deduction Search Results panel allows the user to review Payment Deduction information.

This panel is display only.

Navigation: [Financial] – [Payment Deduction] – [Search]

6.35.2 FLS Financial Payment Deduction Search Results Panel Layout



6.35.3 FLS Financial Payment Deduction Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Deduction Number	Unique number for the payment deduction.	Listview	Number (Integer)	18
Payee ID	Provider identification number.	Listview	Number (Integer)	15
Payee Type	Identifies the type of payee. In Alabama, this is always provider.	Listview	Character	15
Payout Reason	This is the payment deduction reason.	Listview	Character	30
Status	Status of the payment deduction. Valid values are Open or Closed.	Listview	Character	15

6.35.4 FLS Financial Payment Deduction Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.35.5 FLS Financial Payment Deduction Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.35.6 FLS Financial Payment Deduction Search Results Panel Accessibility

6.35.6.1 To Access the FLS Financial Payment Deduction Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Enter **Payee Type** and **Payee ID** and click **Search**.	FLS Financial Payment Deduction Search Results displays.

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6.36 FLI Financial Payment Deduction Information Panel Overview

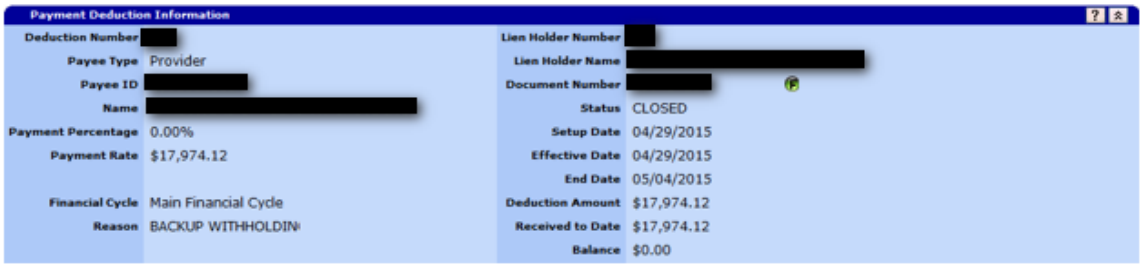
6.36.1 FLI Financial Payment Deduction Information Panel Narrative

The FLI Financial Payment Deduction Information panel displays Payment Deduction information set up on a provider to send payments to the IRS. The words Payment Deduction and Lien are interchangeable.

This panel is display only.

Navigation: [Financial] – [Payment Deduction] - [(select row from search results)] - [Base Information]

6.36.2 FLI Financial Payment Deduction Information Panel Layout



6.36.3 FLI Financial Payment Deduction Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Balance	Amount remaining on the lien.	Field	Number (Decimal)	9
Deduction Amount	Total deduction amount set up for this provider.	Field	Number (Decimal)	9
Deduction Number	System assigned number for the payment deduction.	Field	Number (Integer)	9
Document Number	Document number for lien holder that identifies the original lien.	Field	Alphanumeric	20
Effective Date	Date the lien transactions start. Claims received and processed during the effective date range are subject to the lien.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	Date the lien transactions end.	Field	Date (MM/DD/CCYY)	8
Financial Cycle	Financial cycle in which the payment deduction will be applied. This will always be Main Financial Cycle.	Field	Character	20
Lien Holder Name	Name of the entity that has a legal right to the monies from the provider.	Field	Character	30
Lien Holder Number	Number used to identify the lien holder	Field	Number (Integer)	9
Payee ID	Number that indicates which provider the lien is assessed.	Field	Number (Integer)	9
Payee Type	Indicates the type of payee. In Alabama, it is always Provider.	Field	Character	10
Payment Percentage	Percentage of the provider payment deducted each financial cycle to satisfy the lien. Default to 100% if no payment percentage or lien rate amount is typed.	Field	Number (Decimal)	6
Payment Rate	Maximum dollar amount deducted from the provider's payments each cycle to satisfy the lien.	Field	Number (Decimal	10
Name	Provider name to which the lien belongs.	Field	Character	50
Reason	Indicates why a lien is established.	Field	Character	25
Received to Date	Amount received from the provider to date.	Field	Number (Decimal)	9
Setup Date	Indicates the date the lien was set up.	Field	Date (MM/DD/CCYY)	8
Status	This is the status of the lien. If Open, the deductions will continue to be deducted until the deduction amount is satisfied. If the Status is changed to Closed, the deductions will stop, even if the amount is not satisfied.	Field	Character	10

6.36.4 FLI Financial Payment Deduction Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.36.5 FLI Financial Payment Deduction Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.36.6 FLI Financial Payment Deduction Information Panel Accessibility

6.36.6.1 To Access the FLI Financial Payment Deduction Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Enter search criteria and click **Search**.	FLI Financial Payment Deduction Information displays.

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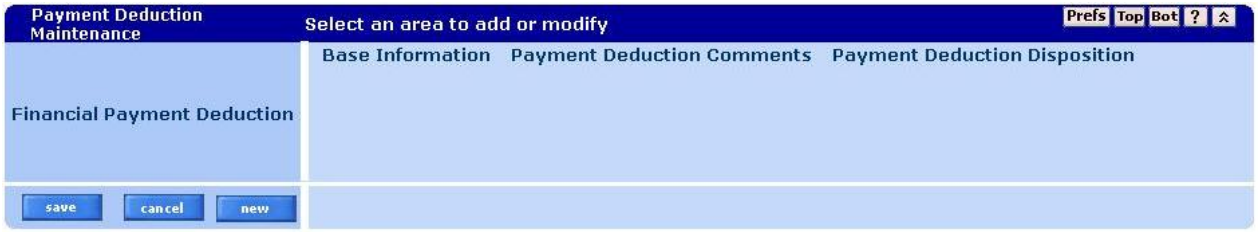
6.37 FLI Financial Payment Deduction Maintenance Panel Overview

6.37.1 FLI Financial Payment Deduction Maintenance Panel Narrative

The FLI Financial Payment Deduction Maintenance panel provides access to the Base Information, Payment Deduction Comments, and Payment Deduction Disposition panels. This panel is inquiry only.

Navigation: [Financial] – [Payment Deduction] - [Add or Search]

6.37.2 FLI Financial Payment Deduction Maintenance Panel Layout



6.37.3 FLI Financial Payment Deduction Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on any of the Payment Deduction panels.	Button	N/A	0
New	Allows the user to create a new Payment Deduction.	Button	N/A	0
Payment Deduction Comments	Link to the Payment Deduction Comments panel.	Hyperlink	N/A	0
Payment Deduction Disposition	Link to the Payment Deduction Disposition panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for a Payment Deduction.	Button	N/A	0

6.37.4 FLI Financial Payment Deduction Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.37.5 FLI Financial Payment Deduction Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.37.6 FLI Financial Payment Deduction Maintenance Panel Accessibility

6.37.6.1 To Access the FLI Financial Payment Deduction Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Enter a valid Payment Deduction number and click **Search**.	FLI Financial Payment Deduction Maintenance panel displays.

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6.38 FLI Financial Payment Deduction Base Information Panel Overview

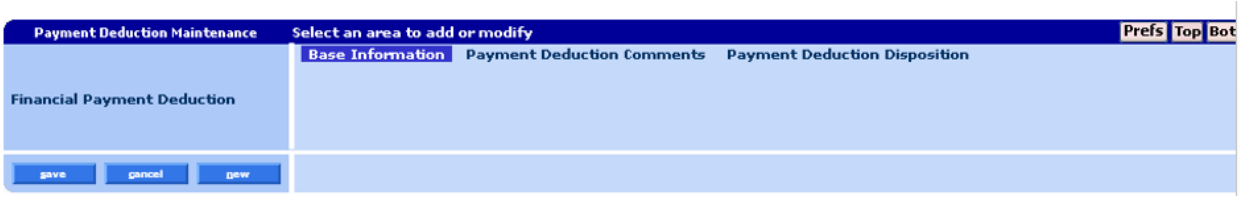
6.38.1 FLI Financial Payment Deduction Base Information Panel Narrative

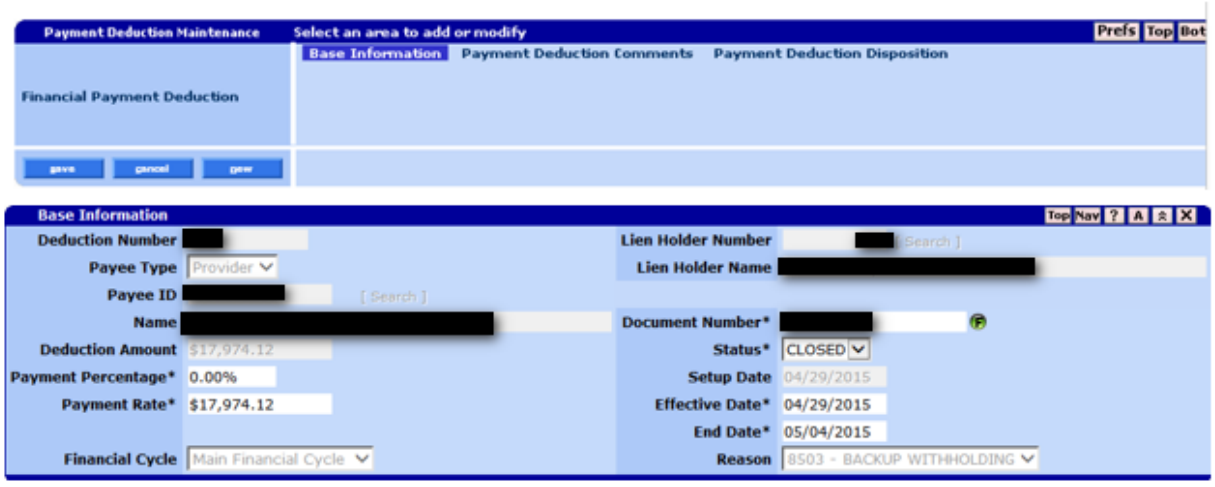
The Financial Payment Deduction Base Information allows the user to set up a Payment Deduction. In Alabama, this panel is used to set up IRS tax levies and backup withholding.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Payment Deduction] - [(select row from search results)] or click Add on the Payment Deduction Search panel- [Base Information]

6.38.2 FLI Financial Payment Deduction Base Information Panel Layout





6.38.3 FLI Financial Payment Deduction Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Payment Deduction Base Information panel.	Button	N/A	0
Deduction Amount	Dollar amount of the original lien.	Field	Number (Decimal)	10
Deduction Number	System assigned number to track the lien.	Field	Alphanumeric	9

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Field	Description	Field Type	Data Type	Length
Document Number	A unique number assigned by the State recorded on the original documentation received that initiates a lien.	Field	Number (Integer)	20
Effective Date	Date the lien transactions start. Claims received and processed during the effective date range are subject to the lien.	Field	Date (MM/DD/CCYY)	8
End Date	This indicates the lien stop date.	Field	Date (MM/DD/CCYY)	8
Financial Cycle	Financial cycle for the payment hold. This will always be Main Financial cycle.	Combo Box	Drop Down List Box	0
Lien Holder Name	Name of the entity that has a legal right to the monies from the provider.	Field	Character	50
Lien Holder Number	Number used to identify the lien holder.	Field	Number (Integer)	9
Name	Provider name to which the lien belongs.	Field	Character	50
New	Allows the user to create a new Payment Deduction.	Button	N/A	0
Payee ID	Number that indicates which provider the lien is assessed.	Field	Number (Integer)	9
Payee Type	Indicates the type of payee. In Alabama, it is always Provider.	Combo Box	Drop Down List Box	0
Payment Percentage	Percentage of the provider payment deducted each financial cycle to satisfy the lien. Default to 100% if no payment percentage or lien rate amount is typed.	Field	Number (Decimal)	6
Payment Rate	Maximum dollar amount deducted from the provider's payments each financial cycle to satisfy the lien.	Field	Number (Decimal)	10
Reason	This indicates why a lien is established.	Combo Box	Drop Down List Box	0
Save	Allows the user to save the payment deduction.	Button	N/A	0
Setup Date	Date of the original lien setup.	Field	Date (MM/DD/CCYY)	8
Status	Status of the lien.	Combo Box	Drop Down List Box	0

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6.38.4 FLI Financial Payment Deduction Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Deduction Amount	Field	9130	Lien Amount is required.	Enter a Lien Amount.
	Field	9131	Enter a valid value.	Deduction Amount must be numeric.
Document Number	Field	3	Document number is required.	Enter a document number.
Effective Date	Field	4	Effective date is required.	Enter a valid date.
	Field	12	Effective date must be less than or equal to the End Date.	Correct dates entered.
	Field	9135	Effective Date is less than the current date.	Check and correct Effective Date entered.
	Field	91001	Invalid Date.	Type a valid date in MM/DD/CCYY format.
End Date	Field	1	End date is required.	Enter a valid date.
	Field	91001	Invalid Date.	Type a valid date in MM/DD/CCYY format.
Financial Cycle	Field	1	A valid Financial Cycle is required.	Enter a valid Financial Cycle.
Lien Amount	Field	9130	Lien Amount and Effective Date are both infinite.	Verify Lien Amount.
Payee ID	Field	1	Payee ID is required.	Enter a valid Payee ID.
	Field	19	Payee Type and Payee ID are required.	Enter a valid Payee Type and Payee ID.
Payee Type	Field	19	Payee Type and Payee ID are required.	Enter a valid Payee Type and Payee ID.
Payment Percentage	Field	9035	Enter Payment Percentage or Payment Rate.	Type a Payment Percentage or Payment Rate.
	Field	9036	Payment Percentage is required.	Enter a Payment Percentage.
	Field	9058	Percent cannot exceed 100%.	Lien Payment Percentage cannot be greater than 100.
	Field	9133	Remove Payment Percentage or payment rate.	Remove Payment Percentage or Payment Rate.
	Field	91029	Enter a valid value.	Payment percentage must be numeric.
Payment Rate	Field	8132	May not be negative.	Type a positive number.
	Field	9035	Enter Payment Percentage or Payment Rate.	Type a Payment Rate or Payment Percentage.
	Field	9036	Payment Rate cannot be greater than Lien Amount.	Enter a valid Payment Rate.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	9133	Remove Payment Percentage or Payment Rate.	Remove Payment Percentage or Payment Rate.
Reason	Field	5	A valid Reason is required.	Enter a valid Reason code.
	Field	55	Lien Holder number is required for the selected Lien Reason Code.	Select a Lien Holder number from the drop down box.
Setup Date	Field	11	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
	Field	111	Lien Date is required.	Enter a valid date.
Status	Field	7	A valid Status is required.	Enter a valid Status code.

6.38.5 FLI Financial Payment Deduction Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.38.6 FLI Financial Payment Deduction Base Information Panel Accessibility

6.38.6.1 To Access the FLI Financial Payment Deduction Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Click **Add**.	FLI Financial Payment Deduction Base panel displays.

6.38.6.2 To Add FLI Financial Payment Deduction Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Payee Type** from drop down list box.	
3	Enter a **Payee ID**.	
4	Enter a **Document Number**.	
5	Enter a **Deduction Amount**.	
6	Enter a **Payment Percentage** or **Payment Amount**.	
7	Enter a **Frequency**.	
8	Enter a **Financial Cycle**.	
9	Enter a **Lien Holder Number**.	
10	Enter a **Status.**	

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Step	Action	Response
11	Enter an **Effective Date** in MM/DD/CCYY format.	
12	Enter an **End Date** in MM/DD/CCYY format.	
13	Enter a **Payment Deduction Reason**.	
14	Click **Save**.	FLI Financial Payment Deduction Base Information is saved.

6.38.6.3 To Update FLI Financial Payment Deduction Base Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FLI Financial Payment Deduction Base Information is saved.

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6.39 FLI Financial Payment Deduction Comments Panel Overview

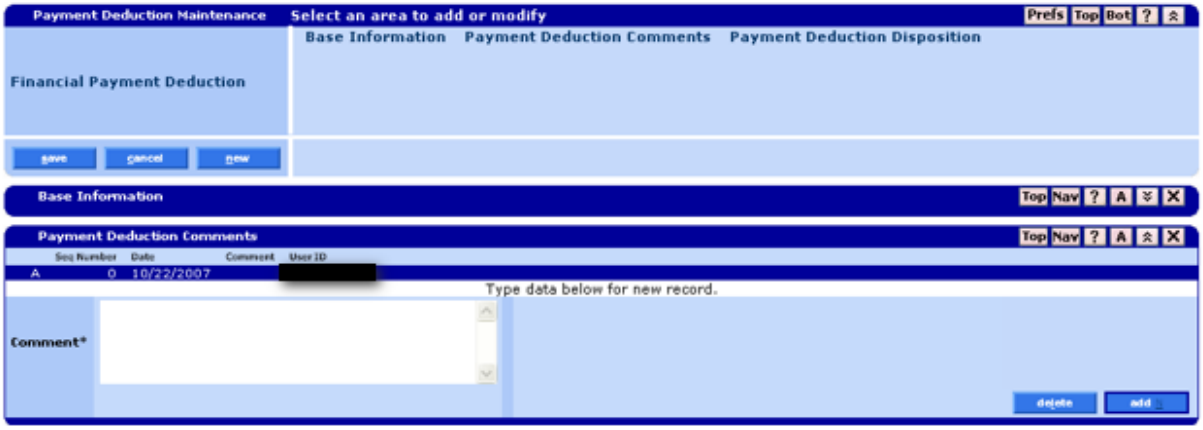
6.39.1 FLI Financial Payment Deduction Comments Panel Narrative

The FLI Financial Payment Deduction Disposition panel allows the user to disposition cash received against the lien and to review cash dispositions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Payment Deduction] - [(select row from search results)] - [Payment Deduction Comments]

6.39.2 FLI Financial Payment Deduction Comments Panel Layout



6.39.3 FLI Financial Payment Deduction Comments Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a comment.	Button	N/A	0
Cancel	Allows the user to cancel any changes on the Payment Deduction panel.	Button	N/A	0
Comment	Allows the user to enter comments regarding the payment deduction.	Field	Character	250
Date	When the payment deduction comment was added to the system.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to the comment.	Button	N/A	0
New	Allows the user to open and enter a new Payment Deduction.	Button	N/A	0
Save	Allows the user to save Payment Deduction information.	Button	N/A	0
Seq Number	A unique number that identifies the sequence of the comment.	Field	Number (Integer)	2
User ID	The unique identifier of the user.	Field	Character	6

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6.39.4 FLI Financial Payment Deduction Comments Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter a comment of up to 250 characters.

6.39.5 FLI Financial Payment Deduction Comments Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 FLI Financial Payment Deduction Comments Panel Accessibility

6.39.6.1 To Access the FLI Financial Payment Deduction Comments Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Enter a valid Payment Deduction number and click **Search**.	FLI Financial Payment Deduction Maintenance panel displays.
4	Click **Payment Deduction Comments** hyperlink.	FLI Financial Payment Deduction Comments panel displays.

6.39.6.2 To Add FLI Financial Payment Deduction Comments Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Comment**.	
3	Click **Save**.	FLI Financial Payment Deduction Comments information is saved.

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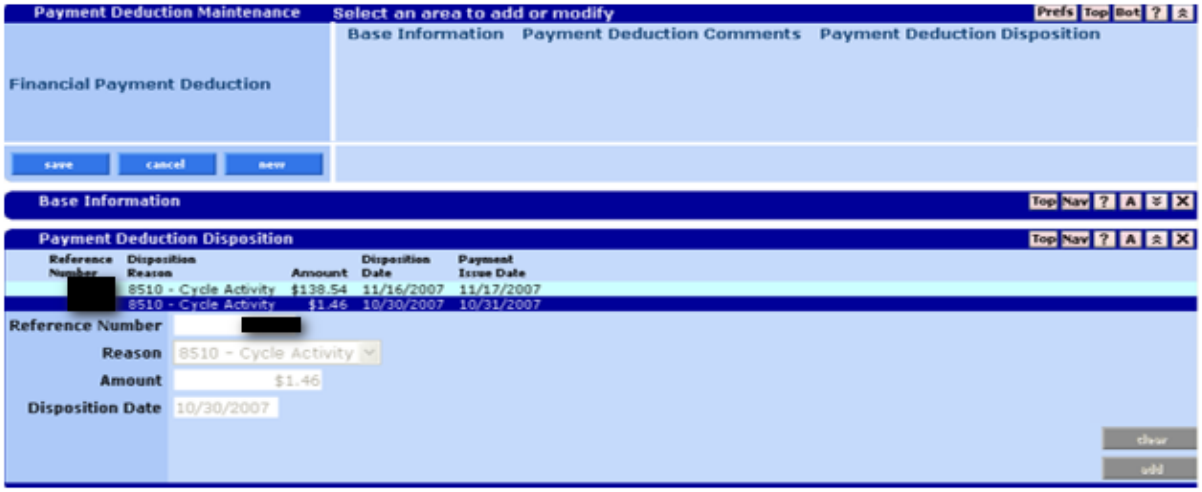
6.40 FLI Financial Payment Deduction Disposition Panel Overview

6.40.1 FLI Financial Payment Deduction Disposition Panel Narrative

The FLI Financial Payment Deduction Disposition panel allows the user to review payment dispositions for the payment deduction. This is a view only panel

Navigation: [Financial] – [Payment Deduction] - [(select row from search results)] - [Payment Deduction Disposition]

6.40.2 FLI Financial Payment Deduction Disposition Panel Layout



6.40.3 FLI Financial Payment Deduction Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a payment deduction disposition.	Button	N/A	0
Amount	Amount that has been dispositioned towards the lien.	Field	Number (Decimal	10
Clear	Allows user to clear the Payment Deduction Disposition panel.	Button	N/A	0
Disposition Date	This is the date of the disposition.	Field	Date (MM/DD/CCYY)	8
Payment Issue Date	This is the date the payment was issued.	Field	Date (MM/DD/CCYY)	8
Reason	This is the reason for the disposition.	Combo Box	Drop Down Box	0
Reference Number	Internal system assigned number used to track individual disposition.	Field	Character	18

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6.40.4 FLI Financial Payment Deduction Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.40.5 FLI Financial Payment Deduction Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 FLI Financial Payment Deduction Disposition Panel Accessibility

6.40.6.1 To Access the FLI Financial Payment Deduction Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.
3	Enter a valid Payment Deduction number and click **Search**.	FLI Financial Payment Deduction Maintenance panel displays.
4	Click **Payment Deduction Disposition** hyperlink.	Financial Payment Deduction Disposition panel displays.

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6.41 FLI Financial Payment Deduction Mini-Search Panel Overview

6.41.1 FLI Mini-Search Panel Narrative

The FLI Mini-Search panel allows the user to enter a Payment Deduction Number to search.

This panel is inquiry only.

Navigation: [Financial] – [Payment Deduction] - [Search] - [Select from Search Result] - [Next Search By Payment Deduction Number]

6.41.2 FLI Mini-Search Panel Layout

6.41.3 FLI Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Mini-Search panel.	Button	N/A	0
Deduction Number	Field to enter system assigned number to access next payment deduction record	Field	Number (Decimal)	9
Search	Initiates the Search by Deduction Number.	Button	N/A	0

6.41.4 FLI Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Next Search by: Deduction Number	Field	1	Deduction Number is required.	Enter a valid value.

6.41.5 FLI Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 FLI Mini-Search Panel Accessibility

6.41.6.1 To Access the FLI Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment Deduction**.	FLS Financial Payment Deduction Search panel displays.

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Step	Action	Response
3	Enter a valid Payment Deduction number and click **Search**.	FLI Payment Deduction Information panel displays with FLI Payment Deduction Mini-Search panel at the top.

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6.42 FPS Financial Payment Search Panel Overview

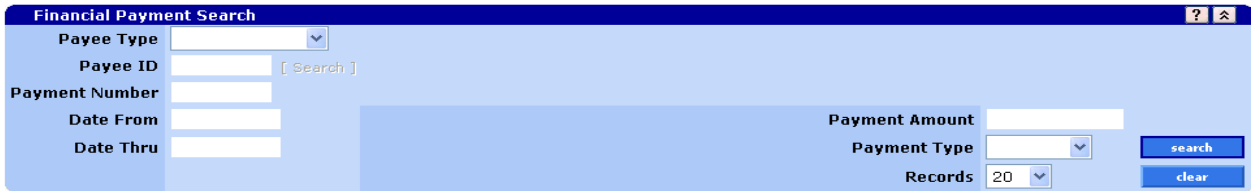
6.42.1 FPS Financial Payment Search Panel Narrative

The Financial Payment Search (FPS) panel allows the user to search for payment information.

This panel is inquiry only.

Navigation: [Financial] – [Payment]

6.42.2 FPS Financial Payment Search Panel Layout



6.42.3 FPS Financial Payment Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows user to clear all fields.	Button	N/A	0
Date From	From Date used to search for a specific date range of payments.	Field	Date (MM/DD/CCYY)	8
Date Thru	Thru Date used to search for a specific date range of payments.	Field	Date (MM/DD/CCYY)	8
Payee ID	Contains the number of the payee tied to the check.	Field	Character	15
Payee Type	Identifies the type of payee receiving payment (provider)	Combo Box	Drop Down List Box	0
Payment Amount	Amount of the payment issued.	Field	Number (Decimal)	11
Payment Number	Number that is assigned and printed on the system payment.	Field	Number (Integer)	9
Payment Type	This is the payment type. Valid values include: EFT, Check or Transfer.	Combo Box	Drop Down List Box	0
Records	Number of records to display per page when doing a search.	Combo Box	Drop Down List Box	0
Search	Allows user to search based on criteria entered.	Button	N/A	0

6.42.4 FPS Financial Payment Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date From	Field	1	Issue Date From must be less than or equal to Issue Date To.	Verify date. Enter correct date.
	Field	91001	Invalid Date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
Date Thru	Field	10	Issue Date From must be less than or equal to Issue Date To.	Please correct the date search criteria.
	Field	91001	Invalid Date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
Payee Type	Field	10	Payee Type and Payee ID OR Payment Number OR Date Range is required.	Enter criteria for search.
Payment Amount	Field	1	Enter a valid value.	Verify keying. Format must be numeric.
	Field	10	Payment Amount cannot be negative.	Please enter an amount greater than or equal to zero.

6.42.5 FPS Financial Payment Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 FPS Financial Payment Search Panel Accessibility

6.42.6.1 To Access the FPS Financial Payment Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.

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6.43 FPS Financial Payment Search Results Panel Overview

6.43.1 FPS Financial Payment Search Results Panel Narrative

The FPS Financial Payment Search Results are displayed when either (Payee Type and Payee ID) or a date range is entered in the Payment Search panel.

This panel is display only.

Navigation: [Financial] – [Payment] - [Search]

6.43.2 FPS Financial Payment Search Results Panel Layout

6.43.3 FPS Financial Payment Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Issued	Date that the payment was issued.	Field	Date (MM/DD/CCYY)	8
Payee ID	Unique system identification for the payee the payment belongs to.	Field	Character	15
Payee Type	Represents the type of payee who is receiving the check. Unique character value for payees. Valid values include: (Provider, HIPP Resource)	Field	Character	20
Payment Amount	This is the amount of the payment issued.	Field	Number (Decimal)	11
Payment Number	Number that is assigned and printed on the system payment.	Field	Number (Integer)	9
Payment Status	Current status of the payment. (Issued, cleared, stopped or voided)	Field	Character	25
Payment Type	Media type that the payment was made on. (EFT, Check or Transfer)	Field	Character	15

6.43.4 FPS Financial Payment Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.43.5 FPS Financial Payment Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 FPS Financial Payment Search Results Panel Accessibility

6.43.6.1 To Access the FPS Financial Payment Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter a date range or Payee Type and Payee ID and click **Search**.	FPS Financial Payment Search Results panel displays.
4	Select a row from the list of results.	FPS Financial Payment Information page displays.

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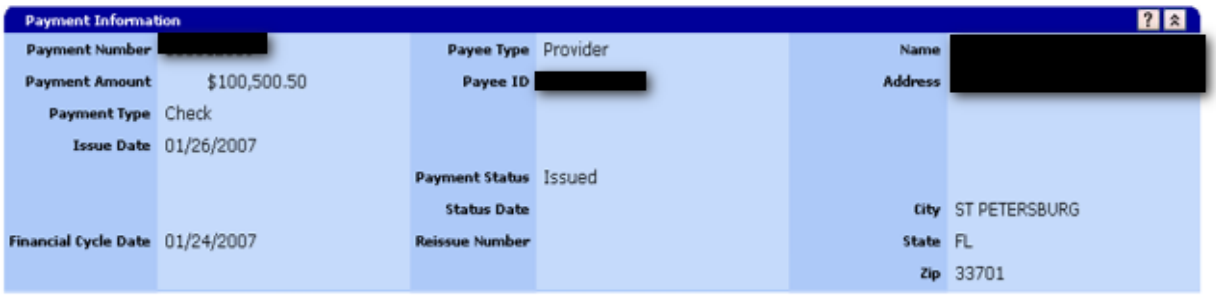
6.44 FPI Financial Payment Information Panel Overview

6.44.1 FPI Financial Payment Information Panel Narrative

The FPI Financial Payment Information panel displays payment information for a single payment. This panel is display only.

Navigation: [Financial] – [Payment] - [(select row from search results)] – Or enter specific search criteria on the Payment Search panel.]

6.44.2 FPI Financial Payment Information Panel Layout



6.44.3 FPI Financial Payment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Address of the payee.	Field	Character	30
City	City of the payee address.	Field	Character	20
Financial Cycle Date	Date of the financial cycle.	Field	Date (MM/DD/CCYY)	8
Issue Date	Date displayed on the check or electronic funds transfer record.	Field	Date (MM/DD/CCYY)	8
Name	This field contains the name of the payee tied to the payment.	Field	Character	30
Payee ID	Identification Number of the payee tied to the payment .	Field	Alphanumeric	15
Payee Type	Type of payee receiving payment.	Field	Character	20
Payment Amount	This is the amount of the payment issued.	Field	Number (Decimal)	11
Payment Number	Number that is assigned and printed on the system payment.	Field	Number (Integer)	9
Payment Status	Current status of the payment.	Field	Character	25
Payment Type	This is the type of payment. Valid values include: EFT or Check.	Field	Character	15
Reissue Number	Number that is assigned and printed on the reissued payment.	Field	Number (Integer)	9
State	State of the payee address.	Field	Character	2
Status Date	Date of the most recent status of the payment.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Zip	Zip code of the payee address.	Field	Number (Integer)	10

6.44.4 FPI Financial Payment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.44.5 FPI Financial Payment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.44.6 FPI Financial Payment Information Panel Accessibility

6.44.6.1 To Access the FPI Financial Payment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter search criteria and click **Search**.	FPI Financial Payment Information panel displays.

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6.45 FPI Financial Payment Maintenance Panel Overview

6.45.1 FPI Financial Payment Maintenance Panel Narrative

The FPI Financial Payment panel allows the user to access links to Related Transactions, Stop/Reissue/Void Request and Status History.

This panel is inquiry only.

Navigation: [Financial] – [Payment] – [Add] or perform a [Search]

6.45.2 FPI Financial Payment Maintenance Panel Layout

6.45.3 FPI Financial Payment Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel changes on the Payment Maintenance panels.	Button	N/A	0
Related Transactions	Link to the Related Transactions panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Payment Maintenance panels.	Button	N/A	0
Status History	Link to the Status History panel.	Hyperlink	N/A	0
Stop/Void/Reissue	Link to the Stop/Void/Reissue panel.	Hyperlink	N/A	0

6.45.4 FPI Financial Payment Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.45.5 FPI Financial Payment Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.45.6 FPI Financial Payment Maintenance Panel Accessibility

6.45.6.1 To Access the FPI Financial Payment Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter search criteria and click **Search**.	FPI Financial Payment Maintenance panel displays.

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6.46 FPI Financial Payment Related Transactions Panel Overview

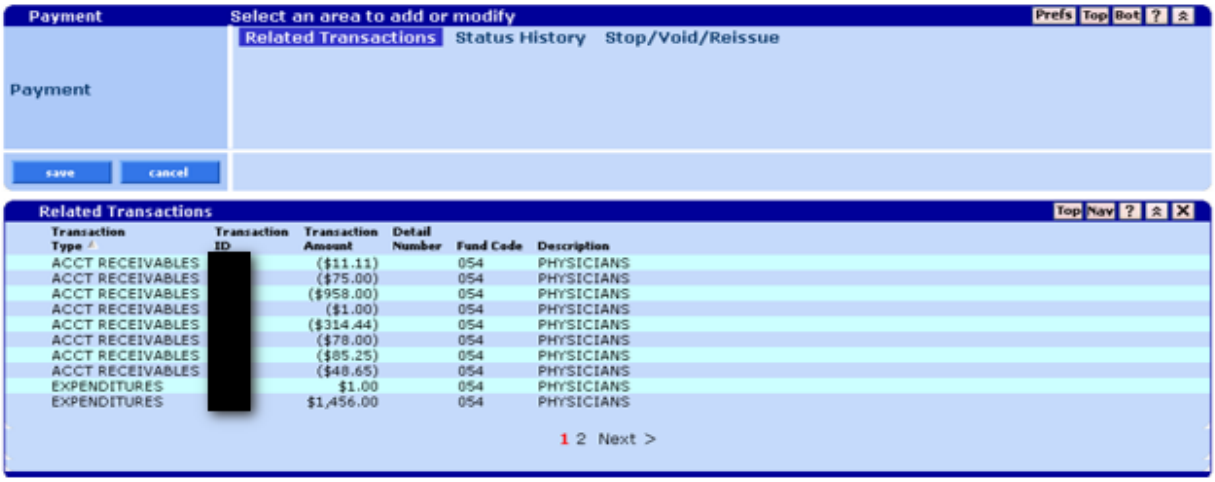
6.46.1 FPI Financial Payment Related Transactions Panel Narrative

The FPI Financial Payment Related Transactions panel displays transactions related to a payment. This includes claim internal control numbers, expenditure transaction numbers and AR numbers. Each item displays the type of transaction, the amount of the transaction and the Fund Code applied to each transaction.

This is a read only panel.

Navigation: [Financial] – [Payment] - [Search] - [Select on search result] - [Related Transactions]

6.46.2 FPI Financial Payment Related Transactions Panel Layout



6.46.3 FPI Financial Payment Related Transactions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the Fund Code, related to the transaction that is being summarized on the line.	Field	Character	30
Detail Number	Detail number of the claim if the transaction is a claim. For a claim, 0 would indicate that the claim was paid at the header and not the detail level.	Field	Number (Integer)	4
Fund Code	Fund Code related to the detail that is being summarized on the line.	Field	Number (Integer)	3
Transaction Amount	Amount specified on the transaction.	Field	Number (Decimal)	9
Transaction ID	Claims ICN, expenditure number, AR number, lien number, or managed care payment number related to the payment.	Field	Number (Integer)	13

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Field	Description	Field Type	Data Type	Length
Transaction Type	Describes the type of transaction.	Field	Alphanumeric	15

6.46.4 FPI Financial Payment Related Transactions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.46.5 FPI Financial Payment Related Transactions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 FPI Financial Payment Related Transactions Panel Accessibility

6.46.6.1 To Access the FPI Financial Payment Related Transactions Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter search criteria and click **Search**.	Payment (Navigation) panel displays.
4	Click **Related Transactions** hyperlink.	FPI Financial Payment Related Transactions panel displays.

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6.47 FPI Financial Payment Status History Panel Overview

6.47.1 FPI Financial Payment Status History Panel Narrative

The FPI Financial Payment Status History panel allows the user to view the status of individual payment information.

This panel is display only.

Navigation: [Financial] - [Payment] - [(enter Payment Number or Provider ID/LOC) (select row from search results)] - [Status History]

6.47.2 FPI Financial Payment Status History Panel Layout

6.47.3 FPI Financial Payment Status History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Check Status	Identifies the status of the check related to the payment. Issued, Cleared, Stopped, Voided or Reissued.	Field	Character)	15
Released/Cleared Date	The actual date the status was changed externally.	Listview	Date (MM/DD/CCYY)	8
Status Date	Indicates the date of the status of the check.	Field	Date (MM/DD/CCYY)	8

6.47.4 FPI Financial Payment Status History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.47.5 FPI Financial Payment Status History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.47.6 FPI Financial Payment Status History Panel Accessibility

6.47.6.1 To Access the FPI Financial Payment Status History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter search criteria and click **Search**.	Payment (Navigation) panel displays.
4	Click **Status History** hyperlink.	FPI Financial Payment Status History panel displays.

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6.48 FPI Financial Payment Stop/Void/Reissue Request Panel Overview

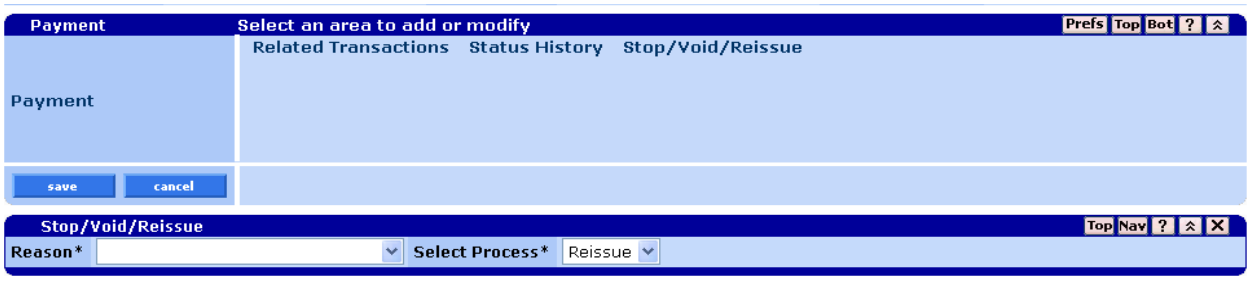
6.48.1 FPI Financial Payment Stop/Void/Reissue Request Panel Narrative

The FPI Financial Payment Stop/Void/Reissue Request panel allows the user to enter a Stop, Void, or Reissue request. The request stops payment on the original check and reissues it again with the next available check number. If void or stop is chosen without reissue, a check is not reissued. Note that the transaction must also be keyed into the bank software for the check to actually be stopped. Choosing Void will also void all the claim payments and financial transactions for the payment. As in the legacy system, any zero paid claims must be manually recouped.

This panel is inquiry only.

Navigation: [Financial] - [Pay] - [(enter Payment Number or Provider ID/LOC) (select row from search results)] - [Stop/Void/Reissue Request]

6.48.2 FPI Financial Payment Stop/Void/Reissue Request Panel Layout



6.48.3 FPI Financial Payment Stop/Void/Reissue Request Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel the transaction before it is saved.	Button	N/A	0
Reason	Reason for either stop pay or void (e.g. check outstanding, check voided, mutilated check, void/wrong provider, etc).	Combo Box	Drop Down List Box	0
Save	Allows the user to save the Stop/Void/Reissue transaction.	Button	N/A	0
Select Process	This is where the user selects the process of stop pay or void check. Valid values include: Stop, Void and Reissue	Combo Box	Drop Down List Box	0

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6.48.4 FPI Financial Payment Stop/Void/Reissue Request Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Reason	Field	10002	A valid Reason is required.	Verify and select valid Reason.

6.48.5 FPI Financial Payment Stop/Void/Reissue Request Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 FPI Financial Payment Stop/Void/Reissue Request Panel Accessibility

6.48.6.1 To Access the FPI Financial Payment Stop/Void/Reissue Request Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter search criteria and click **Search**.	Payment (Navigation) panel displays.
4	Click **Stop/Void/Reissue** hyperlink.	FPI Financial Payment Stop/Void/Reissue panel displays.

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6.49 FPI Financial Payment Mini-Search Panel Overview

5.49.1 FPI Financial Payment Mini-Search Panel Narrative

The FPI Financial Payment Mini-Search panel allows the user to enter a payment number to search for that payment. .

This panel is inquiry only.

Navigation: [Financial] – [Payment] – [Search] When the Payment Information panel appears, the Mini-Search panel is displayed at the top of the page.

5.49.2 FPI Financial Payment Mini-Search Panel Layout

5.49.3 FPI Financial Payment Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Payment Number	Number assigned to either the check or EFT.	Field	Number (Integer)	9
Clear	Allows the user to clear any changes on the Mini-Search panel.	Button	N/A	0
Search	Initiates the Search by Payment Number	Button	N/A	0
Back	Allows the user to return to Payment Search Results.	Button	N/A	0

5.49.4 FPI Financial Payment Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

5.49.5 FPI Financial Payment Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

5.49.6 FPI Financial Payment Mini-Search Panel Accessibility

5.49.6.1 To Access the FPI Financial Payment Mini-Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Payment**.	FPS Financial Payment Search panel displays.
3	Enter **Search** criteria and click search button.	FPI Financial Payment Mini-Search displays.

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6.50 FRDC Financial Related Data Code Page Overview

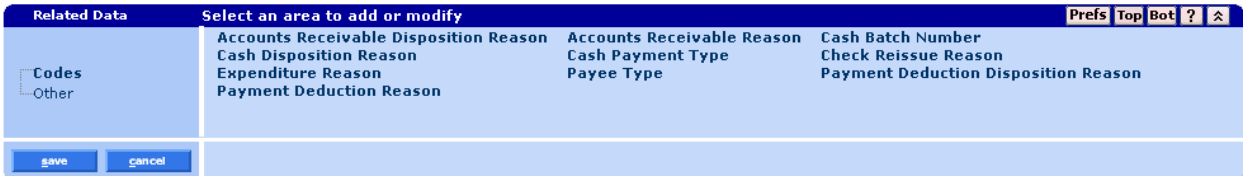
6.50.1 FRDC Financial Related Data Code Page Narrative

FRDC Financial Related Data - Codes panels contain tables related to Financial that can be added to and updated to support other financial panels.

This panel is inquiry only.

Navigation: [Financial] – [Related Data] – [Codes]

6.50.2 FRDC Financial Related Data Code Page Layout



6.50.3 FRDC Financial Related Data Code Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Accounts Receivable Disposition Reason	Link to the Accounts Receivable Disposition Reason panel.	Hyperlink	N/A	0
Accounts Receivable Reason	Link to the Accounts Receivable Reason panel.	Hyperlink	N/A	0
Cancel	This allows the user to cancel any changes on the Codes panel.	Button	N/A	0
Cash Batch Number	Link to the Cash Batch Number panel.	Hyperlink	N/A	0
Cash Disposition Reason	Link to the Cash Disposition Reason panel.	Hyperlink	N/A	0
Cash Payment Type	Link to the Cash Payment Type panel.	Hyperlink	N/A	0
Check Reissue Reason	Link to the Check Reissue Reason panel.	Hyperlink	N/A	0
Expenditure Reason	Link to the Expenditure Reason panel.	Hyperlink	N/A	0
Payee Type	Link to the Payee Type panel.	Hyperlink	N/A	0
Payment Deduction Disposition Reason	Link to the Payment Deduction Disposition Reason panel.	Hyperlink	N/A	0
Payment Deduction Reason	Link to the Payment Deduction Reason panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Codes panel.	Button	N/A	0

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6.50.4 FRDC Financial Related Data Code Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.50.5 FRDC Financial Related Data Code Page Extra Features

Field	Field Type
No extra features found for this page.	

6.50.6 FRDC Financial Related Data Code Page Accessibility

6.50.6.1 To Access the FRDC Financial Related Data Code Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data panel displays.
3	Select the **Codes** hyperlink.	FRDC Financial Related Data-Codes panel displays.

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6.51 FRDC Accounts Receivable Disposition Reason Panel Overview

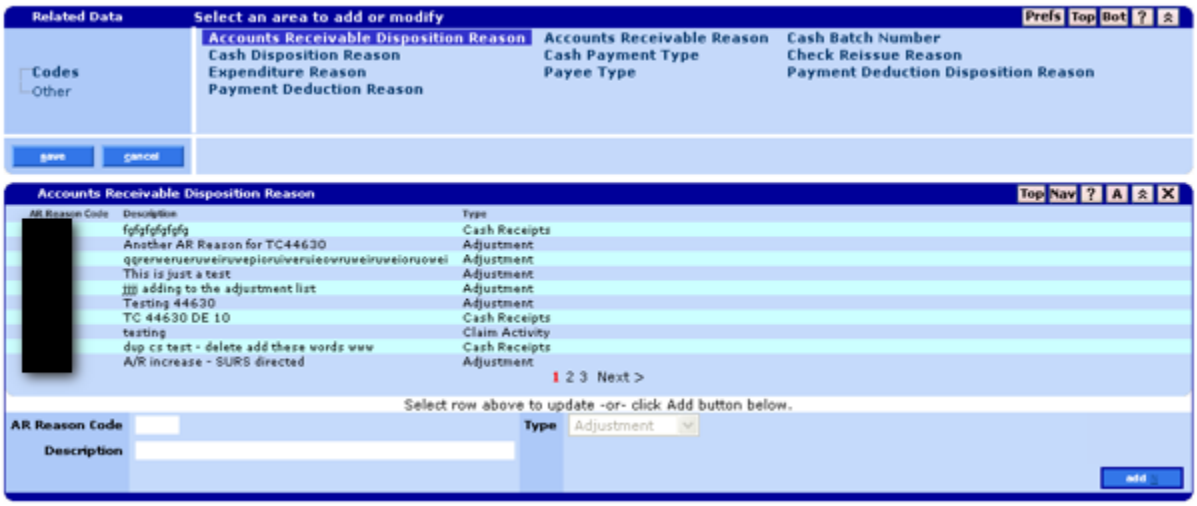
6.51.1 FRDC Accounts Receivable Disposition Reason Panel Narrative

The FRDC Accounts Receivable Disposition Reason panel allows the user to add or update Accounts Receivable Disposition Reason Codes.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Related Data] - [Codes] - [Accounts Receivable Disposition Reason]

6.51.2 FRDC Accounts Receivable Disposition Reason Panel Layout



6.51.3 FRDC Accounts Receivable Disposition Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Accounts Receivable Disposition Reason.	Button	N/A	0
AR Reason Code	This is a four digit code number that is used to tell why a specific AR is being dispositioned.	Field	Number (Integer)	4
Cancel	Allows user to cancel Accounts Receivable Disposition Reason add or change before it is saved.	Button	N/A	0
Description	This field is used to describe the AR Reason Code field.	Field	Character	50
Save	Allows user to save an Accounts Receivable Disposition Code Reason change or add.	Button	N/A	0
Type	This field describes the type of reason associated with the specific description. Valid values include; Adjustment, Cash Receipts and Claim Activity.	Combo Box	Drop Down List Box	0

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6.51.4 FRDC Accounts Receivable Disposition Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AR Reason	Field	2	AR Reason code is a required field.	Enter a number for the AR Reason Code.
Description	Field	1001	Description is required.	Enter a Description.

6.51.5 FRDC Accounts Receivable Disposition Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 FRDC Accounts Receivable Disposition Reason Panel Accessibility

6.51.6.1 To Access the FRDC Accounts Receivable Disposition Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Accounts Receivable Disposition Reason** hyperlink.	FRDC Accounts Receivable Disposition Reason panel displays.

6.51.6.2 To Add FRDC Accounts Receivable Disposition Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **AR Reason Code**.	
3	Enter **Description**.	
4	Select **Type** from the drop down list box.	
5	Click **Save**.	FRDC Accounts Receivable Disposition Reason is saved.

6.51.6.3 To Update FRDC Accounts Receivable Disposition Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Accounts Receivable Disposition Reason is saved.

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6.52 FRDC Accounts Receivable Reason Panel Overview

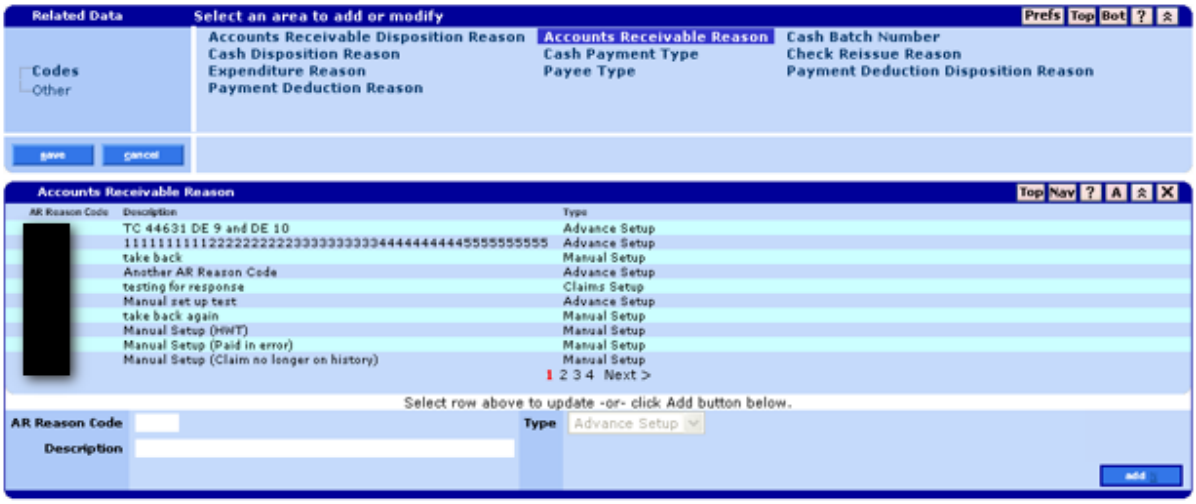
6.52.1 FRDC Accounts Receivable Reason Panel Narrative

The FRDC Accounts Receivable Reason panel allows the user to add or update Accounts Receivable Reason Codes.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes] – [Accounts Receivable Reason]

6.52.2 FRDC Accounts Receivable Reason Panel Layout



6.52.3 FRDC Accounts Receivable Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Accounts Receivable Reason.	Button	N/A	0
AR Reason Code	Four-digit code number that is used to tell why a specific AR was setup. This code also drives the system to print a corresponding explanation of benefits (EOB) message on the provider's remittance advice.	Field	Character	4
Cancel	Allows user to cancel AR Reason code add or change before it is saved.	Button	N/A	0
Description	This field is used to describe the AR Reason Code field.	Field	Character	50
Save	Allows user to save AR Reason code add or change.	Button	N/A	0
Type	This field describes the type of reason associated with the description. Valid values include: Manual Setup, Claims Setup and Advance Setup.	Combo Box	Drop Down List Box	0

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6.52.4 FRDC Accounts Receivable Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Accounts Receivable Reason	Field	1	AR Reason Code is required.	Enter a number for the reason.
	Field	2	Cannot save record. Duplicate exists.	Enter a unique number for the reason.
Description	Field	1	Description is required.	Enter a Description.
Type	Field	1	Type is required.	Choose a Type from the drop down list.

6.52.5 FRDC Accounts Receivable Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.6 FRDC Accounts Receivable Reason Panel Accessibility

6.52.6.1 To Access the FRDC Accounts Receivable Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Accounts Receivable Reason** hyperlink.	FRDC Accounts Receivable Reason panel displays.

6.52.6.2 To Add FRDC Accounts Receivable Disposition Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **AR Reason Code**.	
3	Enter **Description**.	
4	Select a **Type** from the drop down list box.	
5	Click **Save**.	FRDC Accounts Receivable Reason is saved.

6.52.6.3 To Update FRDC Accounts Receivable Disposition Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Accounts Receivable Reason is saved.

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6.53 FRDC Cash Batch Number Panel Overview

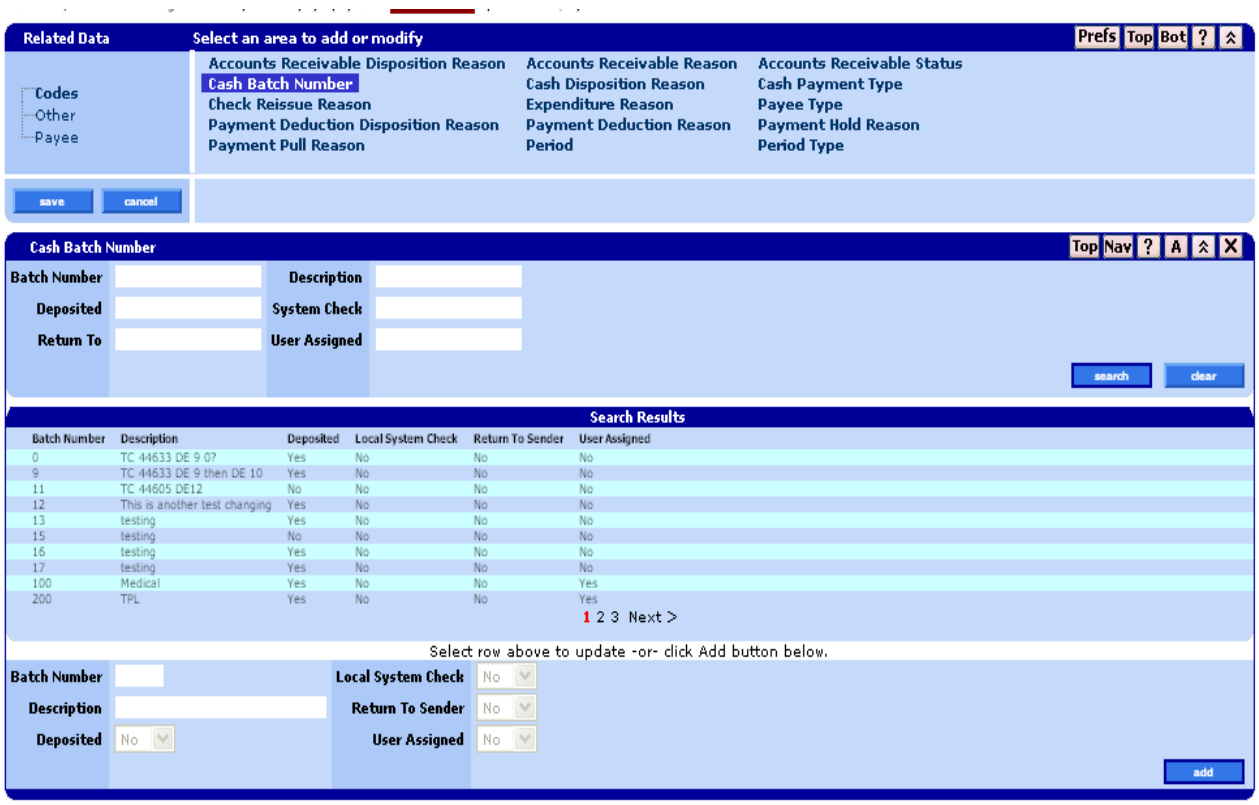
6.53.1 FRDC Cash Batch Number Panel Narrative

When a cash receipt is entered in the Cash Receipt panel, the Reason/Unit code entered is called the Cash Batch Number. When the online cash receipt reports are created in Reports and Letters, the cash batch numbers allow the cash receipts to group under Reason/Unit code.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes]- [Cash Batch Number]

6.53.2 FRDC Cash Batch Number Panel Layout



6.53.3 FRDC Cash Batch Number Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Cash Batch Number information.	Button	N/A	0
Batch Number	This is a unique number that is used to identify the type of check received. Most are informational only. In Alabama, 300 TPL and 200 Drug Rebate have hard coding to link them to those subsystems.	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Cancel	Allows user to cancel Cash Batch Number information before it is saved.	Button	N/A	0
Clear	Allows the user to clear any information on the Cash Batch Number search panel.	Button	N/A	0
Deposited	This indicates whether the check is deposited.	Combo Box	Drop Down List Box	0
Description	Description entered for the cash batch number.	Field	Alphanumeric	30
Local System Check	"Yes" indicates that the check is a local system check.	Combo Box	Drop Down List Box	0
Return to Sender	Indicates whether or not the batch contains checks which must be returned to the sender.	Combo Box	Drop Down List Box	0
Save	Allows user to save Cash Batch Number information.	Button	N/A	0
Search	Initiates the search by Batch Number.	Button	N/A	0
User Assigned	Yes indicates that the user can assign the cash batch number and that it will appear in the Reason/Unit drop down box on the Cash Receipt Base Information panel. No indicates that the cash batch number is assigned by the system.	Combo Box	Drop Down List Box	0

6.53.4 FRDC Cash Batch Number Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Number	Field	1	Default is zero.	Ensure that a number is entered.
Description	Field	1	Description is required.	Description is required when adding or modifying.

6.53.5 FRDC Cash Batch Number Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 FRDC Cash Batch Number Panel Accessibility

6.53.6.1 To Access the FRDC Cash Batch Number Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Cash Batch Number** hyperlink.	FRDC Cash Batch Number panel displays.

6.53.6.2 To Add FRDC Cash Batch Number Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Batch Number**.	
3	Enter **Description**.	
4	Select **Deposited** from drop down list box.	
5	Select **Local System Check** from drop down list box.	
6	Select **Return to Sender** from drop down list box.	
7	Select **User Assigned** from drop down list box.	
8	Click **Save**.	FRDC Cash Batch Number is saved.

6.53.6.3 To Update FRDC Cash Batch Number Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Cash Batch Number information is saved.

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6.54 FRDC Cash Disposition Reason Panel Overview

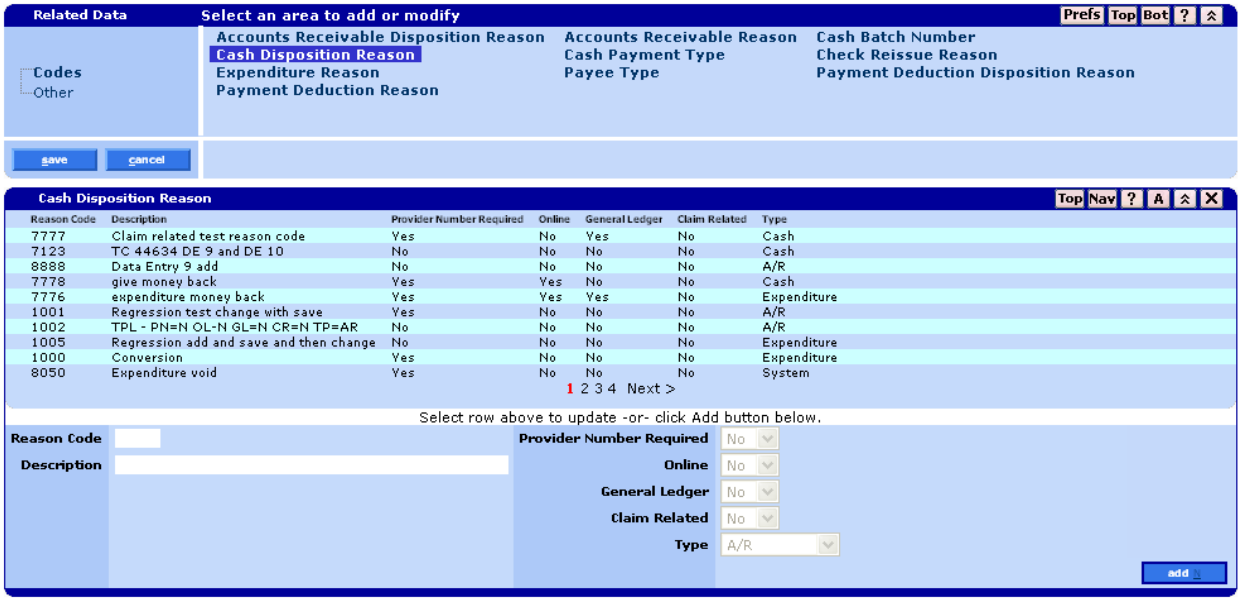
6.54.1 FRDC Cash Disposition Reason Panel Narrative

When a cash receipt is dispositioned in the Cash Receipt panel, the Reason/Unit code that is chosen is the Cash Disposition Reason Code.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes] - [Cash Disposition Reason]

6.54.2 FRDC Cash Disposition Reason Panel Layout



6.54.3 FRDC Cash Disposition Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Cash Disposition Reason information.	Button	N/A	0
Cancel	Allows user to cancel Cash Disposition Reason information before it is saved.	Button	N/A	0
Claim Related	This field if set to 'Y' means that the reason code is associated with a disposition that is claim related.	Combo Box	Drop Down List Box	0
Description	Description entered for the cash disposition reason code.	Field	Character	50
General Ledger	This field if set to 'Y' means that the reason code is associated with a disposition that will be reported on the general ledger (provider earnings).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Online	This field if set to 'Y' means that the reason code is associated with a disposition that will be posted online (in a UI panel). A 'N' value will indicate posting in Batch.	Combo Box	Drop Down List Box	0
Provider Number Required	Indicates with Y or N whether or not a provider number is required when applying the disposition.	Combo Box	Drop Down List Box	0
Reason Code	This number entered for the disposition reason.	Field	Number (Integer	4
Save	Allows user to save the Cash Disposition Reason information.	Button	N/A	0
Type	Type of cash disposition. Valid values include: Accounts Receivable, Cash, Expenditure, and System.	Combo Box	Drop Down List Box	0

6.54.4 FRDC Cash Disposition Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Related	Field	2	Claim Related is required.	Enter Y or N.
Description	Field	1	Description is required.	Description is required when adding or modifying.
General Ledger	Field	5	General Ledger is required.	Enter Y or N.
Online	Field	2	Online is required.	Enter Y or N.
Reason Code	Field	1	Reason code is required.	Ensure that a number is entered.
	Field	10	Reason Code must be Alphanumeric.	Enter a valid reason code.
	Field	20	Duplicate Record cannot be saved.	Enter a unique value.
Type	Field	3	Type is required.	Choose a type.

6.54.5 FRDC Cash Disposition Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 FRDC Cash Disposition Reason Panel Accessibility

6.54.6.1 To Access the FRDC Cash Disposition Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Cash Disposition Reason** hyperlink.	FRDC Cash Disposition Reason panel displays.

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6.54.6.2 To Add FRDC Cash Disposition Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Reason Code**.	
3	Enter **Description**.	
4	Select **Provider Number Required** from drop down list box.	
5	Select **Online** from drop down list box.	
6	Select **General Ledger** from drop down list box.	
7	Select **Claim Related** from drop down list box.	
8	Select **Type** from drop down list box.	
9	Click **Save**.	FRDC Cash Disposition Reason is saved.

6.54.6.3 To Update FRDC Cash Disposition Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Cash Disposition Reason information is saved.

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6.55 FRDC Cash Payment Type Panel Overview

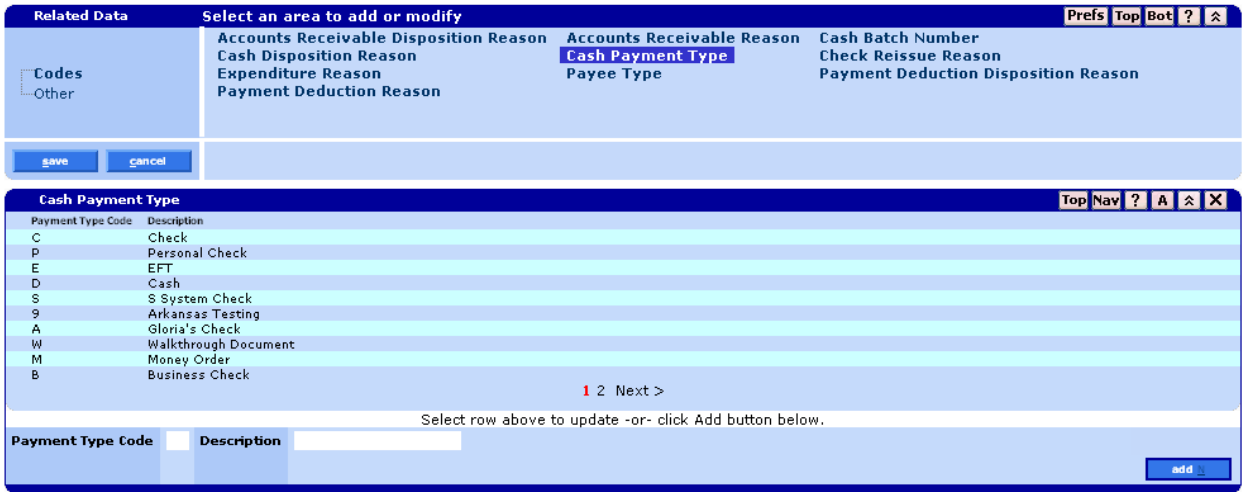
6.55.1 FRDC Cash Payment Type Panel Narrative

The FRDC Cash Payment Type panel allows the user to add or update cash payment types

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Related Data] – [Codes] – [Cash Payment Type]

6.55.2 FRDC Cash Payment Type Layout



6.55.3 FRDC Cash Payment Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Cash Payment Type code information.	Button	N/A	0
Cancel	Allows user to cancel Cash Payment Type information before it is saved.	Button	N/A	0
Description	Description of the Cash Payment Type Code.	Field	Character	30
Payment Type Code	Code for Payment Type.	Field	Character	1
Save	Allows user to save Cash Payment Type information.	Button	N/A	0

6.55.4 FRDC Cash Payment Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	0	Description is required.	Enter a Description..
Payment Type Code	Field	0	Payment type code is required.	Enter a Payment Type Code.

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6.55.5 FRDC Cash Payment Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.55.6 FRDC Cash Payment Type Panel Accessibility

6.55.6.1 To Access the FRDC Cash Payment Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Cash Payment Type** hyperlink.	FRDC Cash Payment Type panel displays.

6.55.6.2 To Add FRDC Cash Payment Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Payment Type Code**.	
3	Enter **Description**.	
4	Click **Save**.	FRDC Cash Payment Type is saved.

6.55.6.3 To Update FRDC Cash Payment Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Cash Payment Type information is saved.

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6.56 FRDC Check Reissue Reason Panel Overview

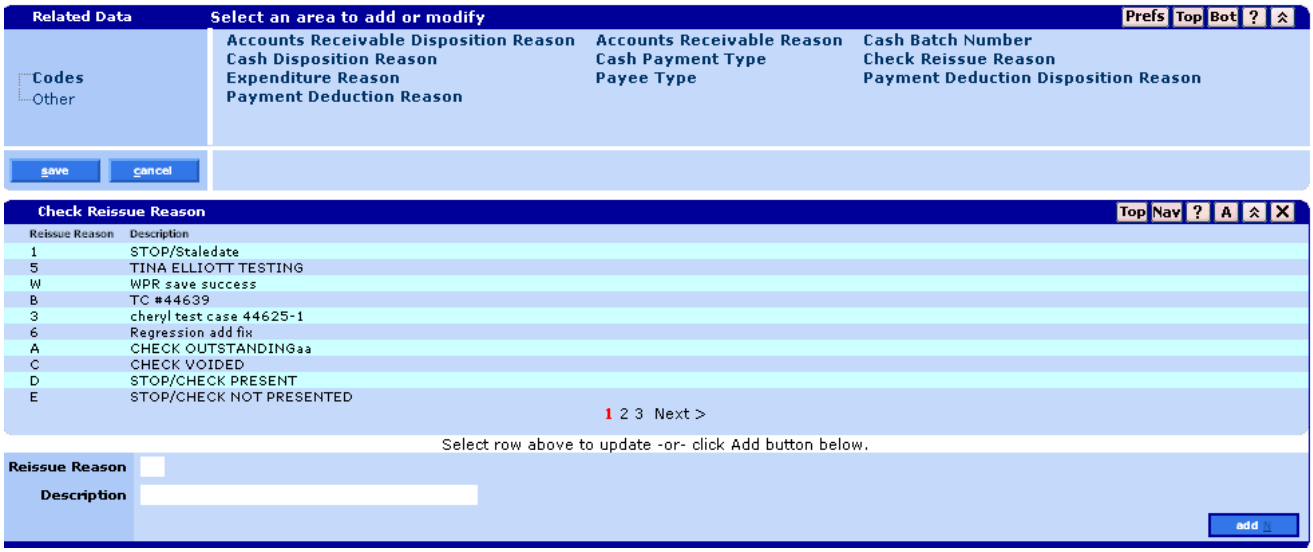
6.56.1 FRDC Check Reissue Reason Panel Narrative

The FRDC Check Reissue Reason panel allows the user to add or update Check Reissue Reason codes and descriptions.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes]- [Check Reissue Reason]

6.56.2 FRDC Check Reissue Reason Panel Layout



6.56.3 FRDC Check Reissue Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Reissue Reason information.	Button	N/A	0
Cancel	Allows user to cancel Reissue Reason information before it is saved.	Button	N/A	0
Description	Description associated with the reason code for the check reissues.	Field	Character	25
Reissue Reason	Letter code associated with the Check Reissue Reason.	Field	Character	1
Save	Allows user to save Reissue Reason information.	Button	N/A	0

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6.56.4 FRDC Check Reissue Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description is required when adding or modifying the record.
Reissue Reason	Field	1	Reissue Reason is required.	Reissue Reason is required when adding or modifying the record.
	Field	2	A duplicate record cannot be saved.	Choose an unduplicated reason code.

6.56.5 FRDC Check Reissue Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 FRDC Check Reissue Reason Panel Accessibility

6.56.6.1 To Access the FRDC Check Reissue Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Check Reissue Reason** hyperlink.	FRDC Check Reissue Reason panel displays.

6.56.6.2 To Add FRDC Check Reissue Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Reason Code** (letter).	
3	Enter **Description**.	
4	Click **Save**.	FRDC Check Reissue Reason is saved.

6.56.6.3 To Update FRDC Check Reissue Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Check Reissue Reason information is saved.

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6.57 FRDC Expenditure Reason Panel Overview

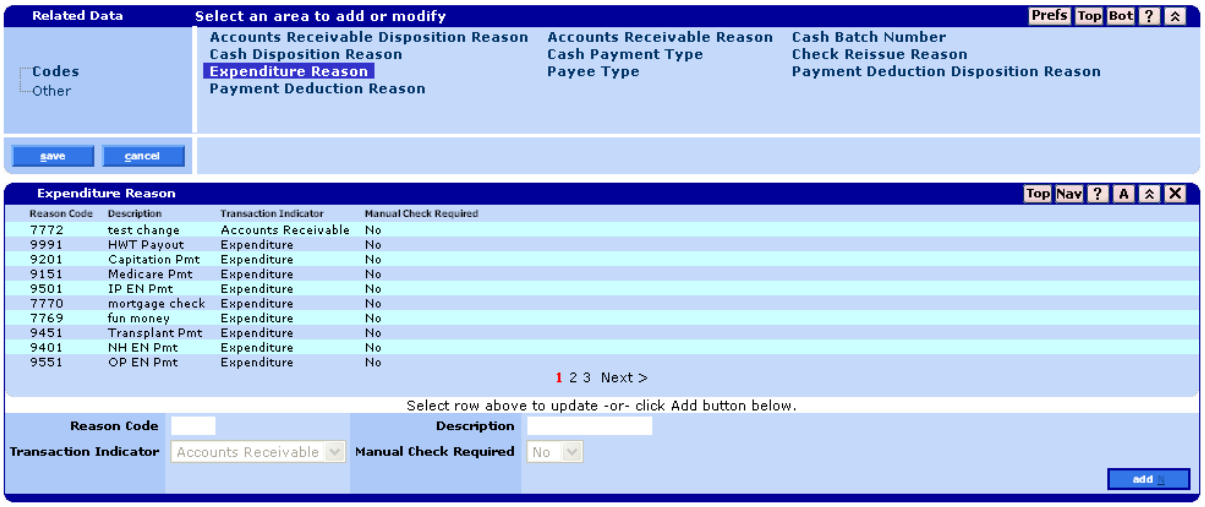
6.57.1 FRDC Expenditure Reason Panel Narrative

The FRDC Expenditure Reason panel allows the user to review, enter and update Expenditure Reason Codes.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes]- [Expenditure Reason]

6.57.2 FRDC Expenditure Reason Panel Layout



6.57.3 FRDC Expenditure Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Expenditure Reason information.	Button	N/A	0
Cancel	Allows the user to cancel Expenditure Reason information before it is saved.	Button	N/A	0
Description	Used to describe the specific Reason Code being added or updated.	Field	Character	15
Manual Check Required	Indicates whether the expenditure requires a manual check.	Combo Box	Drop Down List Box	0
Reason Code	Indicates the reason for which an expenditure is added to the system.	Field	Character	4
Save	Allows user to save Expenditure Reason information.	Button	N/A	0
Transaction Indicator	Transaction associated with Expenditure Reason Code.	Combo Box	Drop Down List Box	0

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6.57.4 FRDC Expenditure Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	91006	Field is required.	Type a Description.
Reason Code	Field	91029	Must be numeric.	Type valid code.
	Field	91029	Reason code must be numeric.	Enter a valid number.

6.57.5 FRDC Expenditure Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.57.6 FRDC Expenditure Reason Panel Accessibility

6.57.6.1 To Access the FRDC Expenditure Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Expenditure Reason** hyperlink.	FRDC Expenditure Reason panel displays.

6.57.6.2 To Add FRDC Expenditure Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Reason Code**.	
3	Select **Transaction Indicator** from drop down list box.	
4	Enter a **Description**.	
5	Select **Manual Check Required** from the drop down list box.	
6	Click **Save**.	FRDC Expenditure Reason is saved.

6.57.6.3 To Update FRDC Expenditure Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Expenditure Reason information is saved.

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6.58 FRDC Payee Type Panel Overview

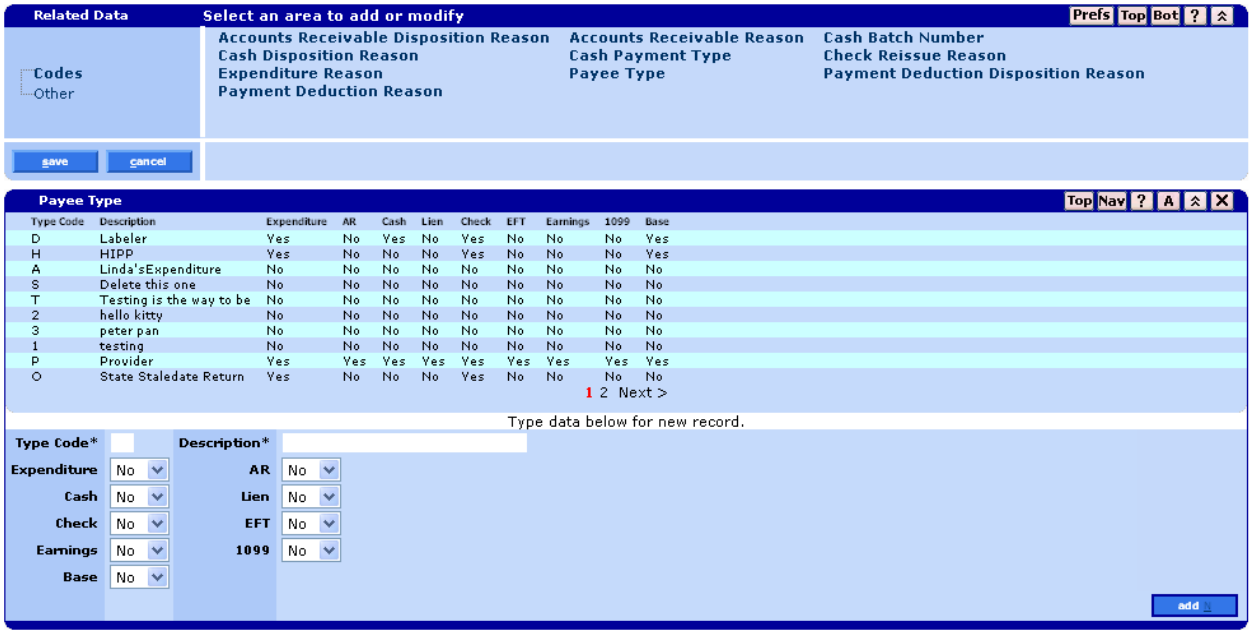
6.58.1 FRDC Payee Type Panel Narrative

The FRDC Payee Type panel allows the user to review, add and update Payee Types.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Related Data] – [Codes] – [Payee Type]

6.58.2 FRDC Payee Type Panel Layout



6.58.3 FRDC Payee Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
1099	Indicates if this Payee Type will receive a 1099.	Combo Box	Drop Down List Box	0
Add	Allows user to activate panel to add Payee Type information.	Button	N/A	0
AR	Indicates if this Payee Type can have an AR created.	Combo Box	Drop Down List Box	0
Base	This indicates if this Payee Type is listed on a base table file.	Combo Box	Drop Down List Box	0
Cancel	Allows user to cancel Payee Type information before it is saved.	Button	N/A	0
Cash	Indicates if this Payee Type can have cash receipts entered.	Combo Box	Drop Down List Box	0
Check	Indicates if this Payee Type can receive payment by check.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Description	Description of the Payee Type.	Field	Character	20
Earnings	Indicates if this Payee Type will have earnings reported.	Combo Box	Drop Down List Box	0
EFT	Indicates if this Payee Type can receive payment by EFT.	Combo Box	Drop Down List Box	0
Expenditure	Indicates if this Payee Type can receive expenditures.	Combo Box	Drop Down List Box	0
Lien	Indicates if this Payee Type can have a payment deduction created.	Combo Box	Drop Down List Box	0
Save	Allows user to save Payee Type information.	Button	N/A	0
Type Code	This is the Payee Type code.	Field	Character	1

6.58.4 FRDC Payee Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	4	Description is required.	Enter a Description.
Type Code	Field	9000	Type code is required.	Enter a Type Code.

6.58.5 FRDC Payee Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.58.6 FRDC Payee Type Panel Accessibility

6.58.6.1 To Access the FRDC Payee Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDO Financial Related Data – Codes page displays.
3	Click **Payee Type** hyperlink.	FRDC Payee Type panel displays.

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6.58.6.2 To Add FRDC Payee Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Type** code.	
3	Enter **Description.**	
4	Select **Expenditure** from drop down list box.	
5	Select **AR** from drop down list box.	
6	Select **Cash** from drop down list box.	
7	Select **Check** from drop down list box.	
8	Select **Earnings** from drop down list box.	
9	Select **Lien** from drop down list box.	
10	Select **EFT** from drop down list box.	
11	Select **Base** from drop down list box.	
12	Select **1099** from drop down list box.	
13	Click **Save**.	FRDC Payee Type is saved.

6.58.6.3 To Update FRDC Payee Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Payee Type information is saved.

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6.59 FRDC Payment Deduction Disposition Reason Panel Overview

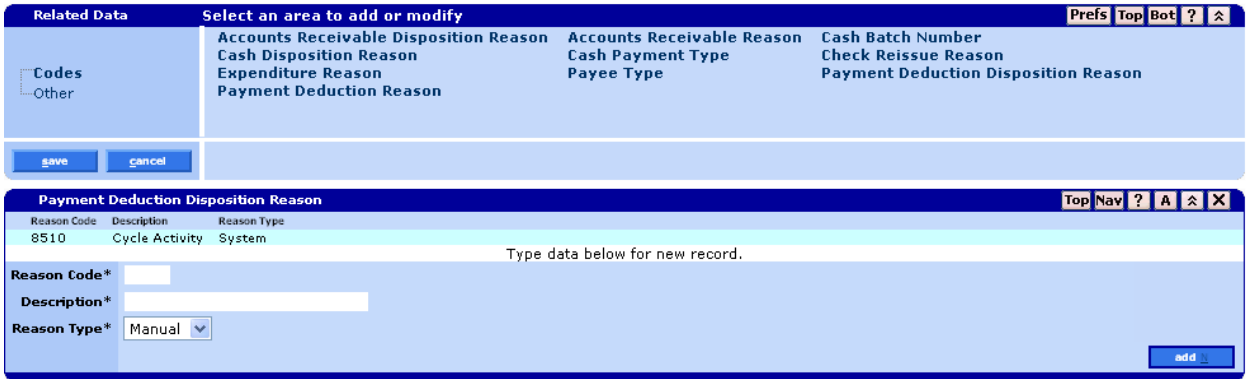
6.59.1 FRDC Payment Deduction Disposition Reason Panel Narrative

The FRDC Payment Deduction Disposition Reason panel allows the user to review, enter and update Payment Deduction Reason code information.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes]- [Payment Deduction Disposition Reason]

6.59.2 FRDC Payment Deduction Disposition Reason Panel Layout



6.59.3 FRDC Payment Deduction Disposition Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Payment Deduction Disposition Reason information.	Button	N/A	0
Cancel	Allows the user to cancel Payment Deduction Disposition Reason information before it is saved.	Button	N/a	0
Description	Specific Reason Code being added or updated.	Field	Character	20
Reason Code	This is the numeric portion of the Reason Code table.	Field	Character	4
Reason Type	This indicates the type of disposition.	Combo Box	Drop Down List Box	0
Save	Allows the user to save Payment Deduction Disposition Reason information.	Button	N/A	0

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6.59.4 FRDC Payment Deduction Disposition Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description is required when adding or modifying the record.
Reason Code	Field	1	Reason Code is required.	Reason Code is required when adding or modifying the record.
Type	Field	1	Type is required.	Type is required when adding or modifying the record.

6.59.5 FRDC Payment Deduction Disposition Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.6 FRDC Payment Deduction Disposition Reason Panel Accessibility

6.59.6.1 To Access the FRDC Payment Deduction Disposition Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Payment Deduction Disposition Reason** hyperlink.	FRDC Payment Deduction Disposition Reason panel displays.

6.59.6.2 To Add FRDC Payment Deduction Disposition Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Reason Code**.	
3	Enter **Description**.	
4	Select **Type** from drop down list box.	
5	Click **Save**.	FRDC Payment Deduction Disposition Reason is saved.

6.59.6.3 To Update FRDC Payment Deduction Disposition Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Payment Deduction Disposition Reason information is saved.

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6.60 FRDC Payment Deduction Reason Panel Overview

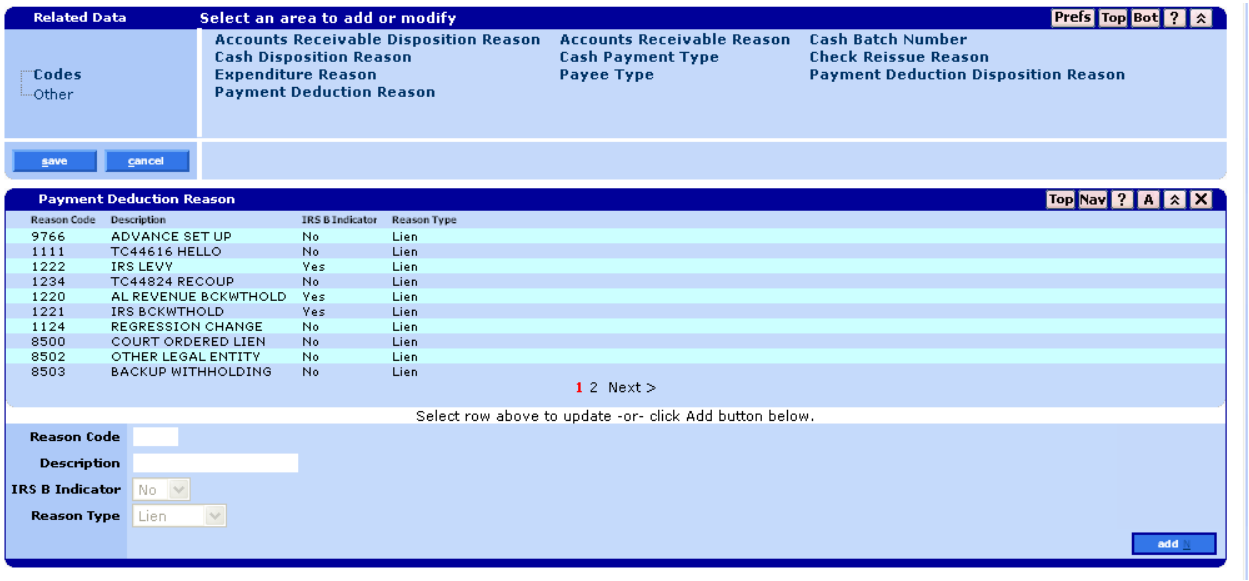
6.60.1 FRDC Payment Deduction Reason Panel Narrative

The FRDC Payment Deduction Reason panel allows the user to review, add, or update Payment Deduction Reason Codes.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Codes] - [Payment Deduction Reason]

6.60.2 FRDC Payment Deduction Reason Panel Layout



6.60.3 FRDC Payment Deduction Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Payment Deduction Reason information.	Button	N/A	0
Cancel	Allows the user to cancel Payment Deduction Reason information before it is saved.	Button	N/A	0
Description	Specific Reason Code being added or updated.	Field	Character	39
IRS B Indicator	Indicates if the Reason Code is used for IRS Backup Withholding.	Combo Box	Drop Down List Box	0
Reason Code	Code used to uniquely identify the reason for the original lien against a provider on the AMMIS.	Field	Number (Integer)	4
Reason Type	Indicates the type of reason. Valid values include: Lien, Withhold or Sanction.	Combo Box	Drop Down List Box	0
Save	Allows user to save Payment Deduction Reason information.	Button	N/A	0

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6.60.4 FRDC Payment Deduction Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description is required when adding or modifying the record.
Reason Code	Field	1	Reason Code is required.	Reason Code is required when adding or modifying the record.
	Field	2	Reason code must be numeric.	Enter a number.

6.60.5 FRDC Payment Deduction Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.60.6 FRDC Payment Deduction Reason Panel Accessibility

6.60.6.1 To Access the FRDC Payment Deduction Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	FRDC Financial Related Data – Codes page displays.
3	Click **Payment Deduction Reason** hyperlink.	FRDC Payment Deduction Reason panel displays.

6.60.6.2 To Add FRDC Payment Deduction Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Reason Code**.	
3	Enter **Description**.	
4	Select **IRS B Indicator** from drop down list box.	
5	Select **Type** from drop down list box.	
6	Click **Save**.	FRDC Payment Deduction Reason is saved.

6.60.6.3 To Update FRDC Payment Deduction Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDC Payment Deduction information is saved.

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6.61 FRDO Financial Related Data Other Page Overview

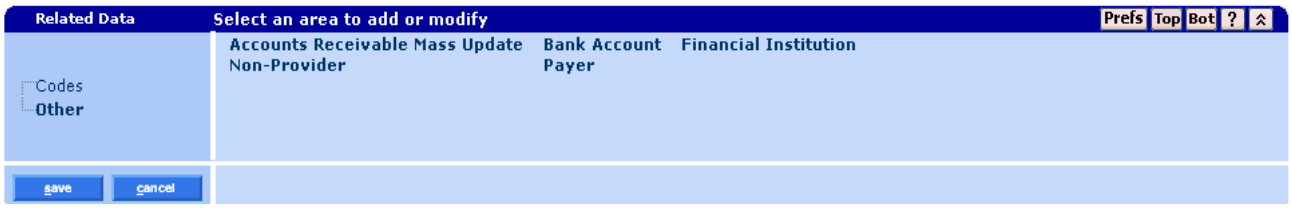
6.61.1 FRDO Financial Related Data Other Page Narrative

FRDO Financial Related Data - Other panels contain tables related to Financial that can be added to and updated to support other financial panels.

This panel is inquiry only.

Navigation: [Financial] - [Related Data] - [Other]

6.61.2 FRDO Financial Related Data Other Page Layout



6.61.3 FRDO Financial Related Data Other Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Accounts Receivable Mass Update	Link to the Accounts Receivable Mass Update panel.	Hyperlink	N/A	0
Bank Account	Link to the Bank Account panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel changes on the Related Data Code panel.	Button	N/A	0
Financial Institution	Link to the Financial Institution panel.	Hyperlink	N/A	0
Non-Provider	Link to the Non-Provider panel.	Hyperlink	N/A	0
Payer	Link to the Payer panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data Code panel.	Button	N/A	0

6.61.4 FRDO Financial Related Data Other Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.61.5 FRDO Financial Related Data Other Page Extra Features

Field	Field Type
No extra features found for this panel.	

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6.61.6 FRDO Financial Related Data Other Page Accessibility

6.61.6.1 To Access the FRDO Financial Related Data Other Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Financial** and click **Related Data.**	FRDO Financial Related Data panel displays.
3	Click the **Other** hyperlink.	FRDO Financial Related Data-Other panel displays.

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6.62 FRDO Accounts Receivable Mass Update Panel Overview

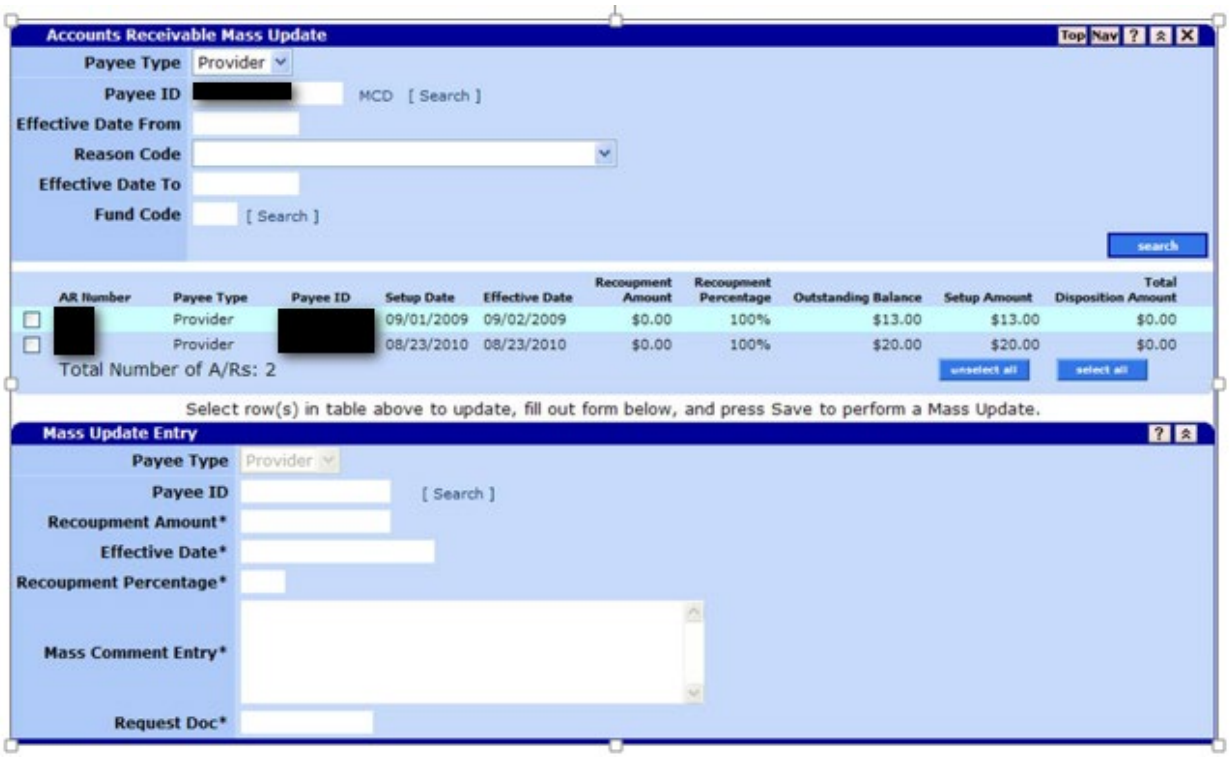
6.62.1 FRDO Accounts Receivable Mass Update Panel Narrative

The FRDO Accounts Receivable Mass Update allows the user to set up an Accounts Receivable Mass Update. The panel is used to transfer an account receivable from one provider to another. The panel is generally used to transfer all the outstanding ARs. However, it can be used to selectively transfer specific ARs. The Account Receivable Mass Update panel at the top is used to search for the provider with the outstanding ARs to be transferred. The resulting search information appears with check boxes preceding each outstanding AR, and a Select All, and Unselect All Button. The user can choose to check specific boxes, or Select All. Then the Mass Update Entry panel at the bottom is completed to identify the receiver of the ARs. This panel also contains a Comment box to record notes concerning the transfer.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Other] - [Accounts Receivables Mass Update]

6.62.2 FRDO Accounts Receivable Mass Update Panel Layout



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6.62.3 FRDO Accounts Receivable Mass Update Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Number	Unique number used to track provider AR activity.	Field	Character	13
Cancel	Allows the user to cancel the Accounts Receivable Mass Update before it is saved.	Button	N/A	0
Effective Date	This indicates the beginning Date for the AR.	Field	Date (MM/DD/CCYY)	8
Effective Date From	Indicates a beginning date range to be used as a search parameter. All ARs within the effective from and thru date range will be displayed.	Field	Date (MM/DD/CCYY)	8
Effective Date To	Indicates an ending to the date range to be used as a search parameter.	Field	Date (MM/DD/CCYY)	8
Fund Code	This is the financial fund code tied to the AR	Combo Box	Drop Down List Box	
Mass Comment Entry	Allows user to enter text for the Accounts Receivable Mass Update.	Field	Character	250
Outstanding Balance	Setup amount less any dispositions applied to date.	Field	Number (Decimal)	9
Payee ID	Unique number which identifies the provider to whom the AR is being applied.	Field	Number (Integer)	10
Payee Type	This is the type of payee. (Always provider in Alabama).	Combo Box	Drop Down List Box	0
Reason Code	Indicates the specific reason that the AR was setup (e.g. check advance, non-claim offset, etc.).	Combo Box	Drop Down List Box	0
Recoupment Amount	Indicates the maximum dollar amount to be offset from the provider's claims processed each cycle until the AR is satisfied.	Field	Number (Decimal)	10
Recoupment Percentage	Indicates the percentage to be offset from the provider's claims processed each cycle until the AR is satisfied.	Field	Number (Decimal)	5
Request Doc	This was designed for Alabama HWT Document Numbers; however anything entered can be used as a document number for reference.	Field	Alphanumeric	13
Search	Allows user to search for the provider that has the outstanding AR.	Button	N/A	0
Save	Allows user to save the Accounts Receivable Mass Update.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Select All	Allows the user to select all of the ARs to be transferred.	Button	N/A	0
Setup Amount	Indicates the original setup dollar amount of the AR to be established.	Field	Number (Decimal)	9
Setup Date	Indicates the date the AR was set up.	Field	Date (MM/DD/CCYY)	8
Total Dispositions Amount	Displays the total dispositioned dollar amount (increased/decreased) which has been applied to the AR to date.	Field	Number (Decimal)	9
Unselect All	Allows the user to unselect all of the ARs to be transferred.	Button	N/A	0

6.62.4 FRDO Accounts Receivable Mass Update Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date From	Field	9057	Effective date must be equal or greater than today.	Verify entry and re-enter a correct Date.
Effective Date To	Field	6	Invalid date.	Enter a valid date in the MM/DD/CCYY format.
Effective Date	Field	6	Invalid date.	Enter a valid date in the MM/DD/CCYY format.
Fund Code	Field	18	Invalid Fund Code.	Select a valid Fund Code.
Payee ID	Field	15	Invalid Payee ID.	Select a valid Payee ID.
Recoupment Amount	Field	14	Enter either Recoupment amount or percentage, not both.	Enter either a Recoupment Amount or Percentage; Both are not allowed.
	Field	17	Enter a valid value.	Enter a valid dollar amount.
Recoupment Percentage	Field	14	Enter either Recoupment amount or percentage, not both.	Enter either a Recoupment Amount or Percentage; Both are not allowed.

6.62.5 FRDO Accounts Receivable Mass Update Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.62.6 FRDO Accounts Receivable Mass Update Panel Accessibility

6.62.6.1 To Access the FRDO Accounts Receivable Mass Update Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	Related Data page displays.
3	Click **Other**.	FRDO Financial Related Data – Other page displays.
4	Click **Accounts Receivable Mass Update** hyperlink.	FRDO Accounts Receivable Mass Update panel displays.

6.62.6.2 To Add FRDO Accounts Receivable Mass Update Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Payee Type**.	
3	Enter **Payee ID**.	
4	Enter **Effective Date From**.	
5	Enter **Effective Date To**	
6	Enter **Reason Code**.	
7	Enter **Fund Code**.	
8	Enter **Payee Type**.	
9	Enter **Payee ID**.	
10	Enter **Recoupment Amount**.	
11	Enter **Recoupment Percentage**.	
12	Enter **Effective Date** in MM/DD/CCYY format.	
13	Enter **Mass Comment**.	
14	Click **Save**.	FRDO Accounts Receivable Mass Update is saved.

6.62.6.3 To Update FRDO Accounts Receivable Mass Update Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDO Accounts Receivable Mass Update is saved.

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6.63 FRDO Bank Account Panel Overview

6.63.1 FRDO Bank Account Panel Narrative

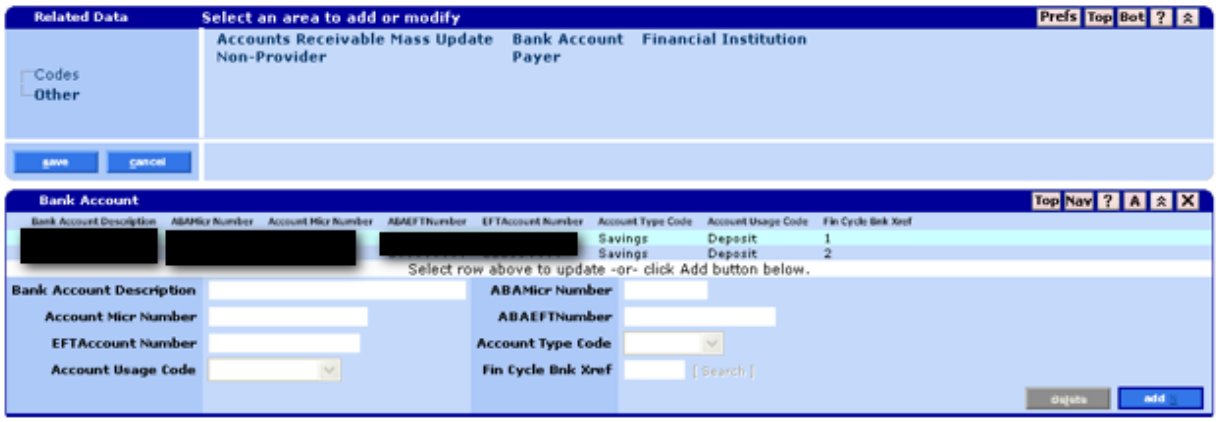
The FRDO Bank Account panel allows the user to review, add or update Bank Account information. This panel is for information specific to the Medicaid provider and Medicaid HIPP accounts. It is not for the provider's accounts.

This panel will be accessed by SE staff only.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Related Data] – [Other] – [Bank Account]

6.63.2 FRDO Bank Account Panel Layout



6.63.3 FRDO Bank Account Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a Bank Account.	Button	N/A	0
Bank Account Description	Bank Account Description.	Field	Character	18
Account Micr Number	Account Micr Number.	Field	Number (Integer)	9
Cancel	Allows user to cancel a Bank Account add before it is saved.	Button	N/A	0
Delete	Allows user to delete a Bank Account.	Button	N/A	0
EFTAccount Number	EFT Account Number.	Field	Number (Integer)	15
Account Usage Code	Account Usage Code.	Combo Box	Drop Down List Box	0
ABAMicr Number	ABA Micr Number.	Field	Number (Integer)	15

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Field	Description	Field Type	Data Type	Length
ABAEFNumber	ABAEFNumber.	Field	Number (Integer)	15
Account Type Code	Account Type Code.	Combo Box	Drop Down List Box	0
Fin Cycle Bnk xref	Financial Cycle Bank cross reference.	Combo Box	Drop Down List Box	0
Save	Allows the user to save a Bank Account add.	Button	N/A	0

6.63.4 FRDO Bank Account Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.63.5 FRDO Bank Account Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.63.6 FRDO Bank Account Panel Accessibility

6.63.6.1 To Access the FRDO Bank Account Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	Related Data – Codes page displays.
3	Click **Other**.	FRDO Financial Related Data – Other page displays.
3	Click **Bank Account** hyperlink.	FRDO Bank Account panel displays.

6.63.6.2 To Add FRDO Bank Account Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Bank Account Description**.	
3	Enter **Account Micr Number**.	
4	Enter **EFTAccount Number**.	
5	Select **Account Usage Code** from drop down list box.	
6	Enter **ABAMicr Number**.	
7	Enter **ABAEFNumber**.	
8	Select **Account Type Code** from drop down list box.	

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Step	Action	Response
9	Select **Fin Cycle Bnk xref** from drop down list box.	
10	Click **Save**.	FRDO Bank Account is saved.

6.63.6.3 To Update FRDO Bank Account Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	FRDO Bank Account information is saved.

6.63.6.4 To Delete FRDO Bank Account Panel

Step	Action	Response
1	Click line to be deleted.	
2	Click **Delete.**	The following system message displays: 'Are you sure this is the row you want marked for deletion?'
3	Click **OK** if this is the correct row to deleted or click **Cancel** if this is not the desired row to be deleted.	FRDO Bank Account is deleted or request is cancelled.

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6.64 FRDO Financial Institution Panel Overview

6.64.1 FRDO Financial Institution Panel Narrative

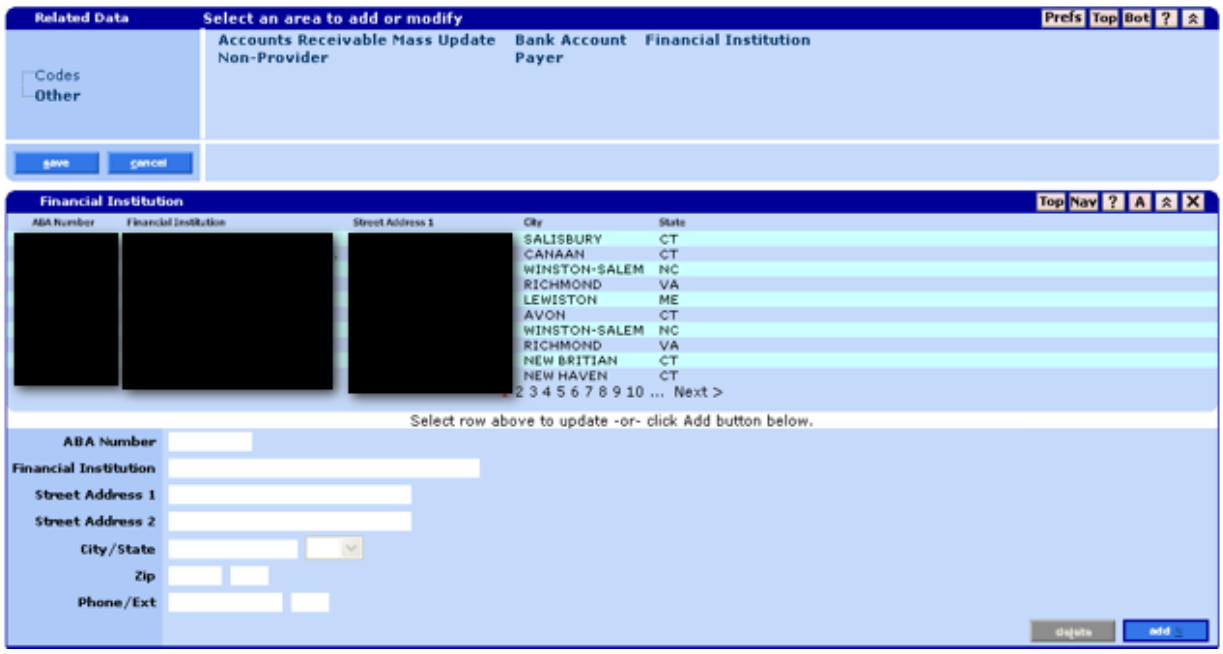
FRDO Financial Institution allows the user to review, add or update Financial Institution information. It is used by the Provider Enrollment EFT process.

The original loading of the table supporting this panel was acquired from the ABA data from the https://www.fededirectory.frb.org/ web site. This is the list of all routing numbers registered with the Federal Reserve. Any table changes or new ABA numbers will be manually added through the UI after implementation. The table can also be updated annually by downloading data from the Financial Institution website.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Other] - (Financial Institution)

6.64.2 FRDO Financial Institution Panel Layout



6.64.3 FRDO Financial Institution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ABA Number	American Banking Association bank routing number.	Field	Character	9
Add	Allows the user to add a Financial Institution.	Button	N/A	0
Cancel	Allows the user to cancel a Financial Institution information before it is saved.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
City/State	City and state location of the bank.	Field	Character	15
Delete	Allows user to delete a Financial Institution.	Button	N/A	0
Financial Institution	This is the name of the bank.	Field	Character	39
Phone/Ext	Phone number and extension of the bank.	Field	Number (Integer)	10
Save	Allows the user to save a Financial Institution information.	Button	N/A	0
Street Address 1	First street line in an address.	Field	Character	30
Street Address 2	Second street line in an address.	Field	Character	30
Zip	This is the zip code of the bank.	Field	Number (Integer)	5

6.64.4 FRDO Financial Institution Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ABA Number	Field	1	It must not be empty.	Type a valid ABA number.
	Field	91032	May not be zero.	Type a valid ABA number.
	Field	91038	Must be 9 characters.	Type a valid ABA number.
City	Field	4	A city name is required.	Type in city name.
Financial Institution	Field	91037	Field is required.	Type an institution.
Phone/Ext.	Field	7	At least one phone number is required.	Type in a phone number.
State	Field	5	A state is required.	Choose a state.
Street Address 1	Field	3	At least one address is required.	Type in an address.
Zip	Field	6	A valid zip code is required.	Type in a valid zip code.
	Field	8	Enter a valid value.	Enter a valid zip + 4 code.

6.64.5 FRDO Financial Institution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.64.6 FRDO Financial Institution Panel Accessibility

6.64.6.1 To Access the FRDO Financial Institution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Financial** and click **Related Data**.	Related Data page displays.
3	Click **Other**.	FRDO Financial Related Data – Other page displays.
4	Click **Financial Institution** hyperlink.	FRDO Financial Institution panel displays.

6.64.6.2 To Add FRDO Financial Institution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ABA Number**.	
3	Enter **Financial Institution**.	
4	Enter **Street Address 1**.	
5	Enter **Street Address 2**.	
6	Enter **City and State**.	
7	Enter **Zip code**.	
8	Enter **Phone number**.	
9	Click **Save**.	FRDO Financial Institution is saved.

6.64.6.3 To Update Financial Institution Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	Financial Institution is saved.

6.64.6.4 To Delete Financial Institution Panel

Step	Action	Response
1	Click line to be deleted.	
2	Click **Delete.**	The following system message displays: 'Are you sure this is the row you want marked for deletion?'
3	Click **OK** if this is the correct row. Click **Cancel** if this is not the desired row.	FRDO Financial Institution information is deleted or request is cancelled.

6.65 FRDO Non-Provider Panel Overview

6.65.1 FRDO Non-Provider Panel Narrative

The FRDO Non-Provider panel allows the user to enter non-provider ID and address information. This is where the addresses for IRS and Alabama Department of Revenue reside for system checks generated through the Lien (Payment Deduction) panels.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [Related Data] – [Other] – [Non-provider]

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6.65.2 FRDO Non-Provider Address Type Panel Layout

6.65.3 FRDO Non-Provider Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Non-Provider Address Type information.	Button	N/A	0
Address 1	First line of the Non-Provider Address.	Field	Character	30
Address 2	Second line of the Non-Provider Address.	Field	Character	30
Cancel	Allows the user to cancel Non-Provider information before it is saved.	Button	N/A	0
City	City of the Non-Provider Address.	Field	Character	20
Name	This is the name of the Non-Provider. This is the payee name for expenditure checks.	Field	Character	50
Non-Provider ID	System assigned number for the non-provider.	Field	Number (Integer)	3
Non-Provider Type	This is the type of non-provider. The only choice in Alabama is lien holder. This is for IRS and Alabama Revenue.	Combo Box	Drop Down List Box	0
Phone Number	Phone number of the non-provider.	Field	Number (Integer)	14

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Field	Description	Field Type	Data Type	Length
Save	Allows the user to save Non-Provider information.	Button	N/A	0
State	State of the non-provider address.	Combo Box	Drop Down List Box	0
Zip	Zip code of the non-provider address.	Field	Number (Integer)	9

6.65.4 FRDO Non-Provider Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address1	Field	1	Address 1 is required.	Ensure that an Address is entered.
City	Field	3	City is required.	Ensure that a City is entered.
Name	Field	2	Name is required.	Ensure that a Name is entered.
Phone Number	Field	1	Phone Number is required.	Ensure that a Phone Number is entered.
State	Combo Box	1	State is required.	Ensure that a State is entered.
Zip	Field	4	Zip Code is required.	Ensure that a Zip Code is entered.
	Field	17	Enter a valid value.	Enter a valid 5 digit zip code and the 4 digit extension.

6.65.5 FRDO Non-Provider Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.65.6 FRDO Non-Provider Panel Accessibility

6.65.6.1 To Access the FRDO Non-Provider Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	Related Data page displays.
3	Click **Other**.	FRDO Financial Related Data – Other displays.
4	Click **Non-Provider** hyperlink.	FRDO Non-Provider panel displays.

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6.65.6.2 To Add FRDO Non-Provider Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Non-Provider Type** from drop down list box.	
3	Enter **Name**.	
4	Enter **Address 1**.	
5	Enter **Address 2** if applicable.	
6	Enter **City**.	
7	Select **State** from drop down list box.	
8	Enter **Zip Code**.	
9	Enter **Phone Number**.	
10	Click **Save**.	FRDO Non-Provider is saved.

6.65.6.3 To Update FRDO Non-Provider Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FRDO Non-Provider information is saved.

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6.66 FRDO Payer Panel Overview

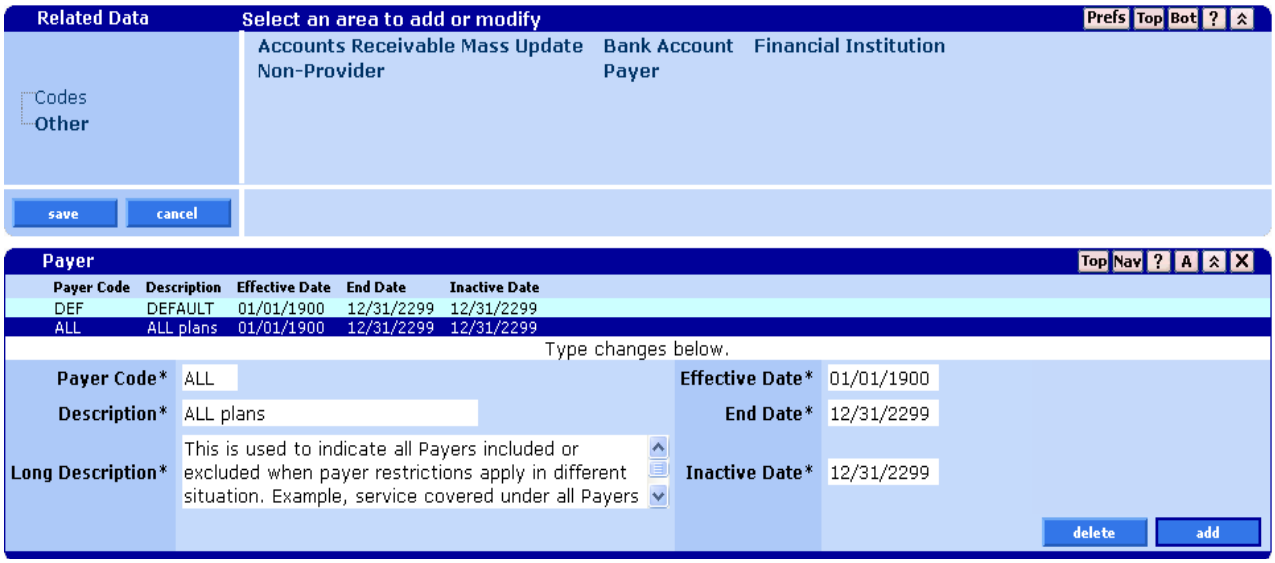
6.66.1 FRDO Payer Panel Narrative

The FRDO Payer panel allows the user to review, add and update Payer information. In Alabama, there is only one payer.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Related Data] - [Other] - [Payer]

6.66.2 FRDO Payer Panel Layout



6.66.3 FRDO Payer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Payer information.	Button	N/A	0
Cancel	Allows the user to cancel an add for Payer information before it is saved.	Button	N/A	0
Delete	Allows the user to remove Payer information.	Button	N/A	0
Description	This is the description of the Payer.	Field	Character	30
Effective Date	This is the effective date of the Payer.	Field	Date (MM/DD/CCYY)	8
End Date	This is the end date of the Payer.	Field	Date (MM/DD/CCYY)	8
Long Description	This is the long description of the Payer.	Field	Character	1000
Payer Code	This is the code for the Payer.	Field	Character	4
Inactive Date	This is the inactive date for the Payer.	Field	Date (MM/DD/CCYY)	8
Save	Allows the user to save Payer information.	Button	N/A	0

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6.66.4 FRDO Payer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	3	Financial Payer Short Description is required.	Enter a short description of the payer that will be used for reporting and panel display.
Description [list]	Field	2	Enter description of the payer.	Payer description is required for this field.
Effective Date	Field	1	Effective Date is required.	Enter a valid date.
	Field	18	Invalid Date.	Enter a valid date in the correct format.
End Date	Field	18	Invalid date.	Enter a valid date in the correct format.
Long Description	Field	1	Fin Payer Description is required.	Enter a long description of the cash receipt.
Payer Code	Field	1	Fin Payer Code is required.	Choose a valid Payer Code.
	Field	13	Required input must be 4 characters in length.	Enter a 4 digit payer code.

6.66.5 FRDO Payer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.66.6 FRDO Payer Panel Accessibility

6.66.6.1 To Access the FRDO Payer Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Related Data**.	Related Data page displays.
3	Click **Other**.	FRDO Financial Related Data – Other page displays.
4	Click **Payer** hyperlink.	FRDO Payer panel displays.

6.66.6.2 To Add FRDO Payer Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Payer Code**.	
3	Enter **Description**.	
4	Enter **Effective Date**.	
5	Enter **End Date**.	
6	Enter **Inactive Date**.	
7	Enter **Long Description**.	

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Step	Action	Response
8	Click **Save**.	FRDO Payer is saved.

6.66.6.3 To Update FRDO Payer Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	FRDO Payer information is saved.

6.66.6.4 To Delete FRDO Payer Panel

Step	Action	Response
1	Click line to be deleted.	
2	Click **Delete**.	Line is identified for deletion.
3	Click **Save**.	FRDO Payer is deleted.

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6.67 FRLP Financial Reports and Letters Page Overview

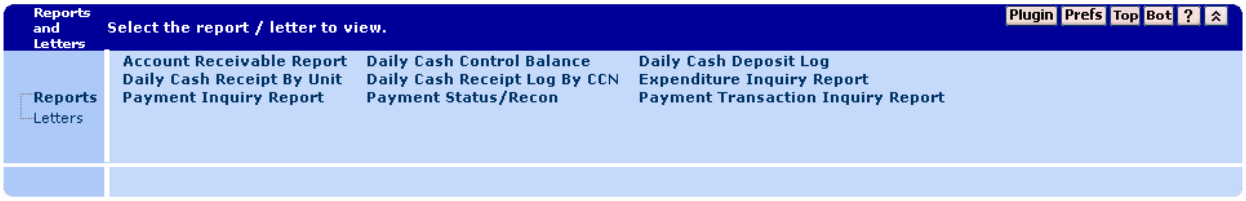
6.67.1 FRLP Financial Reports and Letters Page Narrative

The FRLP Financial Reports and Letters page allows the user to request the financial reports and letters that are available online.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs]

6.67.2 FRLP Financial Reports and Letters Page Layout



6.67.3 FRLP Financial Reports and Letters Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Account Receivable Report	Link to the Account Receivable Report panel.	Hyperlink	N/A	0
Daily Cash Control Balance	Link to the Daily Cash Control Balance panel.	Hyperlink	N/A	0
Daily Cash Deposit Log	Link to the Daily Cash Deposit Log panel.	Hyperlink	N/A	0
Daily Cash Receipt by Unit	Link to the Daily Cash Receipt by Unit panel.	Hyperlink	N/A	0
Daily Cash Receipt Log by CCN	Link to the Daily Cash Receipt Log by CCN panel.	Hyperlink	N/A	0
Expenditure Inquiry Report	Link to the Expenditure Inquiry Report panel.	Hyperlink	N/A	0
Payment Inquiry Report	Link to the Payment Inquiry Report panel.	Hyperlink	N/A	0
Payment Status/Recon	Link to the Payment Status/Recon panel.	Hyperlink	N/A	0
Payment Transaction Inquiry Report	Link to the Payment Transaction Inquiry Report panel.	Hyperlink	N/A	0

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6.67.4 FRLP Financial Reports and Letters Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.67.5 FRLP Financial Reports and Letters Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.67.6 FRLP Financial Reports and Letters Page Accessibility

6.67.6.1 To Access the FRLP Financial Reports and Letters Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters panel displays.

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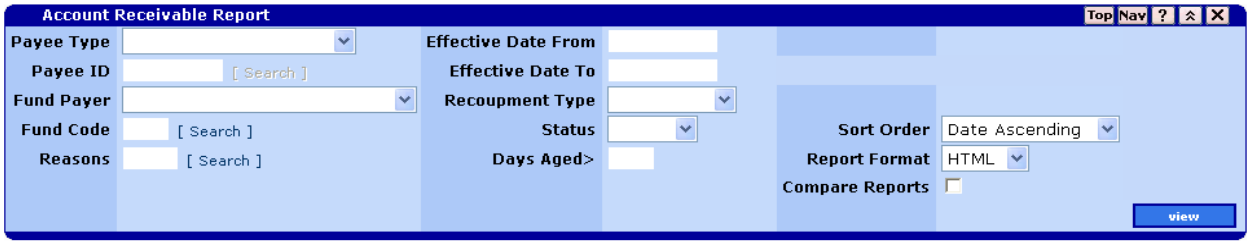
6.68 FRLP Account Receivable Report Panel Overview

6.68.1 FRLP Account Receivable Report Panel Narrative

The FRLP Account Receivable is the panel for generating the online report: FIN-AL04-O. This panel is inquiry only. This panel is inquiry only

Navigation: [Financial] – [Rpts & Ltrs] - [Reports] - [Account Receivable Report]

6.68.2 FRLP Account Receivable Report Panel Layout



6.68.3 FRLP Account Receivable Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Days Aged >	Allows the user to access the report by the days aged. This will return the report for ARs days greater than the number of days entered from the AR Date Liability Established Date.	Field	Number (Integer)	4
Effective Date From	Allows user to choose the Effective Date From of the AR.	Field	Date (MM/DD/CCYY)	8
Effective Date To	Allows user to choose the Effective Date To of the AR.	Field	Date (MM/DD/CCYY)	8
Fund Code	Allows the user to access the report by the fund code. This is the fund code that is used in financial reporting to correctly categorize funds (money).	Field	Number (Integer)	3
Fund Payer	Allows the user to access the report by the Fund Payer. This is always Alabama Medicaid.	Combo Box	Drop Down List Box	0
Payee ID	Allows the user to access reports by a specific Payee identification number.	Field	Number (Integer)	15
Payee Type	Allows the user to choose the Payee Type. Choices are: Provider, Lien Holder, Carrier and HIPP Resource. In Alabama, only Providers will have ARs.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Reasons	Allows the user to access the report by reason. A four digit code assigned to describe the reason for setting up the AR.	Field	Number (Integer)	4
Status	Allows the user to access the report by AR Status. Choices are Open or Closed.	Combo Box	Drop Down List Box	0
Recoupment Type	Allows the user to access the report by Recoupment Type. Valid values include: Automatic, Manual or Repayment.	Combo Box	Drop Down List Box	0
Report Format	Output options to view report. Current options are: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Sort Order	Field sort options to display report data. Valid values include: Date Ascending and Date Descending.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.68.4 FRLP Account Receivable Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.68.5 FRLP Account Receivable Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.68.6 FRLP Account Receivable Report Panel Accessibility

6.68.6.1 To Access the FRLP Account Receivable Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Accounts Receivable Report** hyperlink.	FRLP Accounts Receivable Report panel displays.

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6.69 FRLP Daily Cash Control Balance Panel Overview

6.69.1 FRLP Daily Cash Control Balance Panel Narrative

The FRLP Daily Cash Control Balance is the panel for generating the online report: FIN-CR18-O.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] - [Reports] - [Daily Cash Control Balance]

6.69.2 FRLP Daily Cash Control Balance Panel Layout

6.69.3 FRLP Daily Cash Control Balance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Receipt Date	This field is preset to today's date. The field allows user to enter another date.	Field	Date (MM/DD/CCYY)	8
Report Format	Allows user to choose format of report: Valid values include: PDF, Excel or RTF.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.69.4 FRLP Daily Cash Control Balance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Receipt date	Field	1	Receipt Date is required.	Enter Receipt Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.

6.69.5 FRLP Daily Cash Control Balance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.69.6 FRLP Daily Cash Control Balance Panel Accessibility

6.69.6.1 To Access the FRLP Daily Cash Control Balance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Daily Cash Control Balance** hyperlink.	FRLP Daily Cash Control Balance panel displays.

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6.70 FRLP Daily Cash Deposit Log Panel Overview

6.70.1 FRLP Daily Cash Deposit Log Panel Narrative

The FRLP Daily Cash Deposit Log is the panel for generating the online report: FIN-CR19-O.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] - [Reports] - [Daily Cash Deposit Log]

6.70.2 FRLP Daily Cash Deposit Log Panel Layout

6.70.3 FRLP Daily Cash Deposit Log Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Receipt Date	This field is preset to today's date. The field allows user to enter another date.	Field	Date (MM/DD/CCYY)	8
Report Format	Allows user to choose format of report: Valid values include: PDF, Excel or RTF.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.70.4 FRLP Daily Cash Deposit Log Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Receipt date	Field	1	Receipt Date is required.	Enter Receipt Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.

6.70.5 FRLP Daily Cash Deposit Log Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.70.6 FRLP Daily Cash Deposit Log Panel Accessibility

6.70.6.1 To Access the FRLP Daily Cash Deposit Panel

Step	Action	Response

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Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Daily Cash Deposit Log** hyperlink.	FRLP Daily Cash Deposit Log panel displays.

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6.71 FRLP Daily Cash Receipt by Unit Panel Overview

6.71.1 FRLP Daily Cash Receipt by Unit Panel Narrative

The FRLP Daily Cash Receipt by Unit is the panel for generating the online report: FIN-CR17-O, which breaks out Cash Receipts by the Reason Code/Unit entered on the Cash Receipts Base Information panel.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] - [Reports] - [Daily Cash Receipt by Unit]

6.71.2 FRLP Daily Cash Receipts by Unit Panel Layout

6.71.3 FRLP Daily Cash Receipt by Unit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Receipt Date	This field is preset to today's date. The field allows user to enter another date.	Field	Date (MM/DD/CCYY)	8
Report Format	Allows user to choose format of report: Valid values include: PDF, Excel or RTF.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.71.4 FRLP Daily Cash Receipt by Unit Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Receipt date	Field	1	Receipt Date is required.	Enter Receipt Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.

6.71.5 FRLP Daily Cash Receipt by Unit Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.71.6 FRLP Daily Cash Receipt by Unit Panel Accessibility

6.71.6.1 To Access the FRLP Daily Cash Receipt by Unit Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Daily Cash Receipt by Unit** hyperlink.	FRLP Daily Cash Receipt by Unit panel displays.

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6.72 FRLP Daily Cash Receipt Log by CCN Panel Overview

6.72.1 FRLP Daily Cash Receipt Log by CCN Panel Narrative

The FRLP Daily Cash Receipt Log by CCN is the panel for generating the online report: FIN-CR16-O, which displays CCN's in numeric order.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] - [Reports] - [Daily Cash Receipt Log by CCN]

6.72.2 FRLP Daily Cash Receipt Log by CCN Panel Layout

6.72.3 FRLP Daily Cash Receipt Log by CCN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Receipt Date	This field is preset to today's date. The field allows user to enter another date.	Field	Date (MM/DD/CCYY)	8
Report Format	Allows user to choose format of report. Valid values include: PDF, Excel or RTF.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.72.4 FRLP Daily Cash Receipt Log by CCN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Receipt date	Field	1	Receipt Date is required.	Enter Receipt Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.

6.72.5 FRLP Daily Cash Receipt Log by CCN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.72.6 FRLP Daily Cash Receipt Log by CCN Panel Accessibility

6.72.6.1 To Access the FRLP Daily Cash Receipt Log by CCN Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays
3	Click **Daily Cash Receipt Log by CCN** hyperlink.	FRLP Daily Cash Receipt Log by CCN panel displays.

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6.73 FRLP Expenditure Inquiry Report Panel Overview

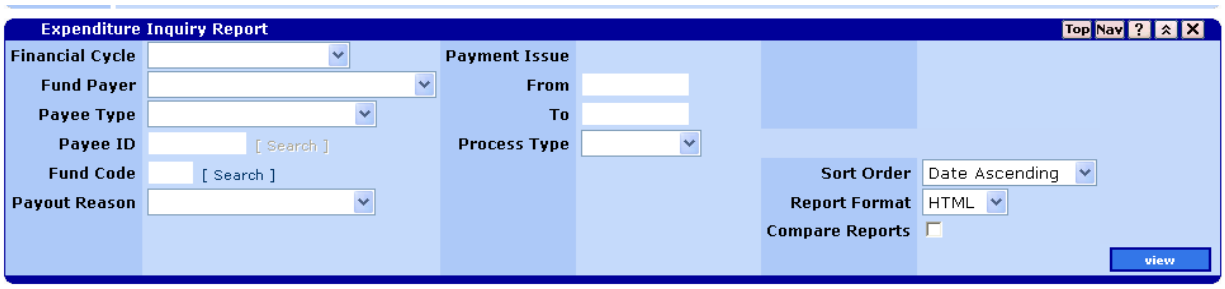
6.73.1 FRLP Expenditure Inquiry Report Panel Narrative

The FRLP Expenditure Inquiry Report panel is used for generating the online report: FIN-EX10-O.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] – [Reports] - [Payment Transaction Inquiry Report]

6.73.2 FRLP Expenditure Inquiry Report Panel Layout



6.73.3 FRLP Expenditure Inquiry Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Financial Cycle	Allows the user to access the report by financial cycle. This is a value used to identify the financial cycle. In Alabama, there are only three financial cycles: Main Financial Cycle, HIPP Financial Cycle and On Demand Financial Cycle.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to access the report by the fund code. This is the fund code that is used in financial reporting to correctly categorize funds (money).	Field	Character	3
Fund Payer	Allows the user to access the report by the Fund Payer. This is always Alabama Medicaid.	Combo Box	Drop Down List Box	0
Payee ID	Allows the user to access reports by a specific Payee identification number.	Field	Number (Integer)	15
Payee Type	Allows the user to access reports by payee type. Valid values include: Provider, Lien Holder, HIPP Resource and Carrier.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Payment Issue From	Allows the user to access the report by the date the payment was issued. The Date From is the start of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payment Issue To	Allows the user to access the report by the date the payment was issued. The Date to is the end of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payout Reason	Allows the user to choose a payout reason as part of the report criteria.	Combo Box	Drop Down List Box	0
Process Type	Allows the user to choose a process type. Valid values include: Regular and Manual.	Combo Box	Drop Down List Box	0
Report Format	Output options to view report. Valid values include: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Sort Order	Field sort options to display report data.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.73.4 FRLP Expenditure Inquiry Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.73.5 FRLP Expenditure Inquiry Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.73.6 FRLP Expenditure Inquiry Report Panel Accessibility

6.73.6.1 To Access the FRLP Expenditure Inquiry Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Expenditure Inquiry Report** hyperlink.	FRLP Expenditure Inquiry Report panel displays.

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6.74 FRLP Payment Inquiry Report Panel Overview

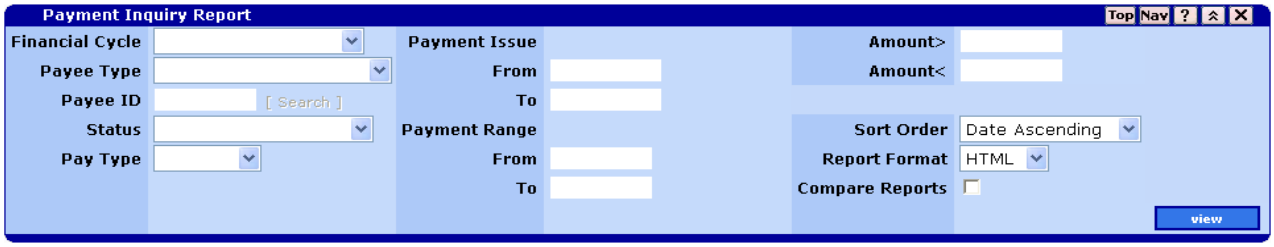
6.74.1 FRLP Payment Inquiry Report Panel Narrative

The FRLP Payment Inquiry Report panel is used for generating the online report: FIN-PY50-O.

This panel is inquiry only.

Navigation Path: [Financial] – [Rpts & Ltrs] - [Reports] - [Payment Inquiry Report]

6.74.2 FRLP Payment Inquiry Report Panel Layout



6.74.3 FRLP Payment Inquiry Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount <	Allows the user to set the dollar range for the report results.	Field	Number (Decimal)	9
Amount >	Allows the user to set the dollar range for the report results.	Field	Number (Decimal)	9
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Financial Cycle	Allows the user to access the report by financial cycle. This is a value used to identify the financial cycle. In Alabama, there are only three financial cycles: Main Financial Cycle, HIPP Financial Cycle and On Demand Financial Cycle	Combo Box	Drop Down List Box	0
Pay Type	Allows the user to choose the Pay Type. Valid values include: Check or EFT.	Combo Box	Drop Down List Box	0
Payee ID	Allows the user to enter the Payee identification number for the search.	Field	Number (Integer)	30
Payee Type	Allows the user to select the Payee Type. (Provider, Carrier, HIPP Resource)	Combo Box	Drop Down List Box	0
Payment Issue Date From	Allows the user to access the report by the payment issue date. The Date From is the start of the date range to search.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Payment Issue Date To	Allows the user to access the report by the payment issue date. The Date To is the end of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payment Range Date From	Allows the user to access the report by the payment Range date. The Date From is the start of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payment Range Date To	Allows the user to access the report by the payment range date. The Date To is the end of the date range to search.	Field	Date (MM/DD/CCYY)	8
Report Format	Output options to view report. Valid values include: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Sort Order	Field sort options to display report data.	Combo Box	Drop Down List Box	0
Status	Allows the user to access the report by Status. Valid values include: Issued, Cleared, Reissued, Stopped and Voided.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.74.4 FRLP Payment Inquiry Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
From	Field	0	Invalid date.	Enter a valid date in MM/DD/CCYY format.
To	Field	0	Invalid date.	Enter a valid date in MM/DD/CCYY format.

6.74.5 FRLP Payment Inquiry Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.74.6 FRLP Payment Inquiry Report Panel Accessibility

6.74.6.1 To Access the FRLP Payment Inquiry Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Rpts & Ltrs**.	FRLP Financial Reports and Letters page displays.
3	Click **Payment Inquiry Report** hyperlink.	FRLP Payment Inquiry Report panel displays.

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6.75 FRLP Payment Status/Recon Report Panel Overview

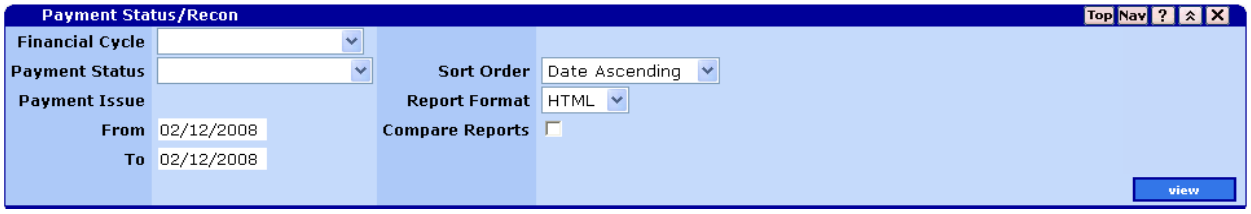
6.75.1 FRLP Payment Status/Recon Report Panel Narrative

The FRLP Payment Status/Recon Report panel allows the selection of financial cycle and a date range to display all checkwrite dates/totals contained within the check range. The report displays detailed dollar distribution between various payment categories, such as EFT, Checks, Void, Check Cleared, Staledate, etc. FIN-PY60-O.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] – [Reports] - [Payment Status/Recon Report]

6.75.2 FRLP Payment Status/Recon Report Panel Layout



6.75.3 FRLP Payment Status/Recon Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Financial Cycle	Allows the user to access the report by financial cycle. This is a value used to identify the financial cycle. In Alabama, there are only three financial cycles: Main Financial Cycle, HIPP Financial Cycle and On Demand Financial Cycle	Combo Box	Drop Down List Box	0
Payment Issue From	Beginning date of the checkwrite date range being queried.	Field	Date (MM/DD/CCYY)	8
Payment Issue To	End date of the checkwrite date range being queried.	Field	Date (MM/DD/CCYY)	8
Payment Status	The list of payment status for which to show on the report.	Combo Box	Drop Down List Box	0
Report Format	Output options to view report. Valid values include: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Sort Order	Field sort options to display report data.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

6.75.4 FRLP Payment Status/Recon Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Payment Issue From	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a From date in the valid format.
Payment Issue To	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a To date in the valid format.

6.75.5 FRLP Payment Status/Recon Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.75.6 FRLP Payment Status/Recon Report Panel Accessibility

6.75.6.1 To Access the FRLP Payment Status/Recon Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Reports and Letters**.	FRLP Financial Reports and Letters page displays.
3	Click **Payment Status/Recon Report** hyperlink.	FRLP Payment Status/Recon Report panel displays.

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6.76 FRLP Payment Transaction Inquiry Report Panel Overview

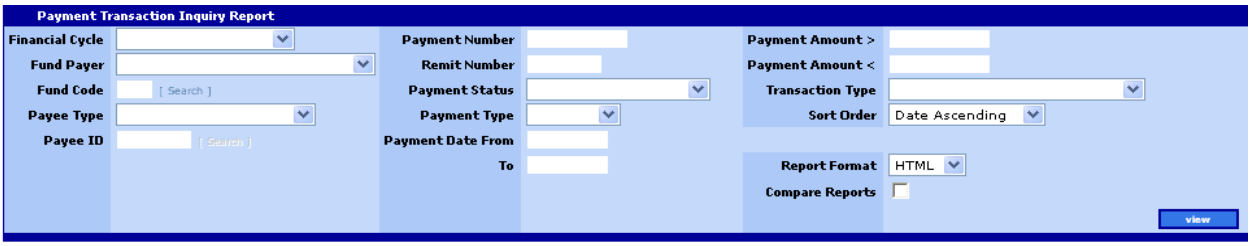
6.76.1 FRLP Payment Transaction Inquiry Report Panel Narrative

The FRLP Payment Transaction Inquiry Report panel is used for generating the online report: FIN-PY51-O.

This panel is inquiry only.

Navigation: [Financial] – [Rpts & Ltrs] – [Reports] - [Payment Transaction Inquiry Report]

6.76.2 FRLP Payment Transaction Inquiry Report Panel Layout



6.76.3 FRLP Payment Transaction Inquiry Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Compare Reports	This is a universal field for Reports & Letters that is used in MAR to display comparative reports. It is a non-functional field in Financial.	Check box	N/A	0
Financial Cycle	Allows the user to access the report by financial cycle. This is a value used to identify the financial cycle. In Alabama, there are only three financial cycles: Main Financial Cycle, HIPP Financial Cycle and On Demand Financial Cycle.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to access the report by the fund code. This is the Fund Code used in financial reporting to correctly categorize funds (money).	Field	Number (Integer)	3
Fund Payer	Allows the user to access the report by the Fund Payer. This is always Alabama Medicaid.	Combo Box	Drop Down List Box	0
Payee ID	Allows the user to access reports by a specific Payee identification number.	Field	Number (Integer)	15
Payee Type	Allows the user to access reports by payee type. Valid values include: Provider, Lien Holder, HIPP Resource and Carrier.	Combo Box	Drop Down List Box	0
Payment Amount <	Allows the user to access the report by searching for a payment amount less than a certain value.	Field	Number (Decimal)	13

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Field	Description	Field Type	Data Type	Length
Payment Amount >	Allows the user to access the report by searching for a payment amount greater than a certain value.	Field	Number (Decimal)	13
Payment Date From	Allows the user to access the report by the date the payment was issued. The Date From is the start of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payment Date To	Allows the user to access the report by the date the payment was issued. The Date to is the end of the date range to search.	Field	Date (MM/DD/CCYY)	8
Payment Number	Allows the user to access the report by the Payment identification number. This is the unique Identifier of the payment. Examples include check number or EFT transmission number.	Field	Number (Integer)	9
Payment Status	Allows the user to access the report by the status of the payment. Examples include issued, voided, stopped or cleared.	Combo Box	Drop Down List Box	0
Payment Type	Allows the user to access the report by payment type. Valid values include: Check and EFT.	Combo Box	Drop Down List Box	0
Remit Number	Allows the user to access the report by Remit Number. This is the Remittance Advice number, a unique identifier to access payment information.	Field	Number (Integer)	9
Report Format	Output options to view report. Valid values include: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Sort Order	Field sort options to display report data.	Combo Box	Drop Down List Box	0
Transaction Type	Allows the user to access the report by the type of payment transaction. This is the description of the financial transaction. Examples include claim, AR, expenditure and capitation.	Combo Box	Drop Down List Box	0
View	Allows the user to view the report based on the criteria entered on the panel.	Button	N/A	0

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6.76.4 FRLP Payment Transaction Inquiry Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Payee ID	Field	2	At least one of Payee ID, or Payment Date From and Payment Date To is required.	Enter either/or a Payee ID, Payment Date From and Payment Date To.
Payment Date From	Field	1	Invalid date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	At least one of Payee ID, or Payment Date From and Payment Date To is required.	Enter either/or a Payee ID, Payment Date From and Payment Date To.
Payment Date To	Field	1	Invalid date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	At least one of Payee ID, or Payment Date From and Payment Date To is required.	Enter either/or a Payee ID, Payment Date From and Payment Date To.

6.76.5 FRLP Payment Transaction Inquiry Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.76.6 FRLP Payment Transaction Inquiry Report Panel Accessibility

6.76.6.1 To Access the FRLP Payment Transaction Inquiry Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Reports and Letters**.	FRLP Financial Reports and Letters page displays.
3	Click **Payment Transaction Inquiry Report** hyperlink.	FRLP Payment Transaction Inquiry Report panel displays.

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6.77 Financial Cycle Base Information Panel Overview

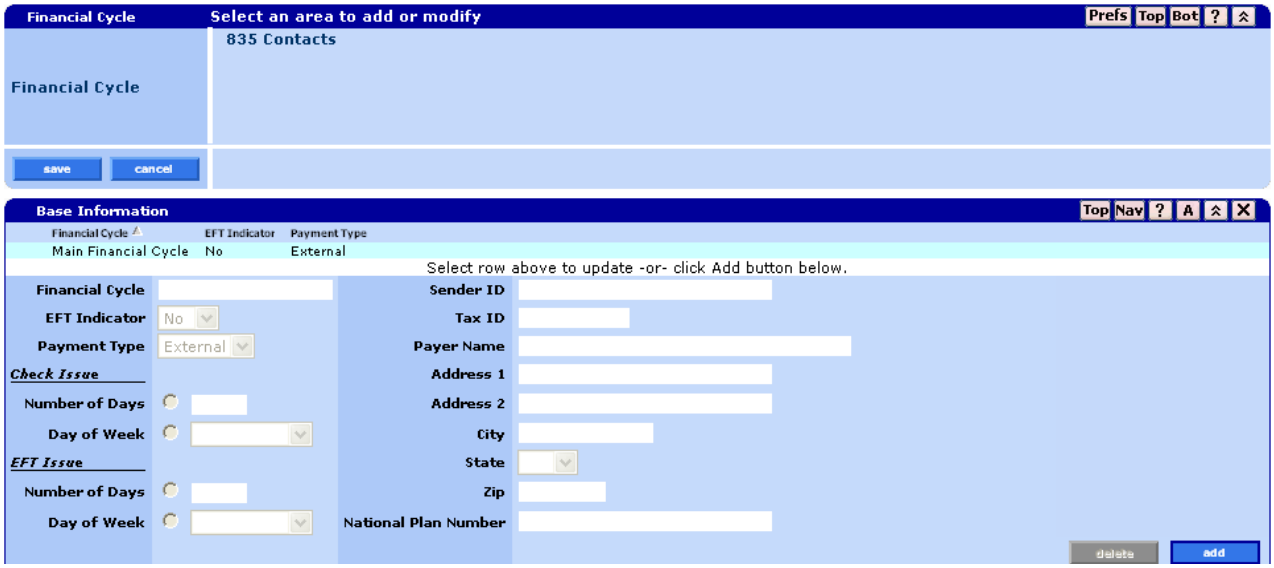
6.77.1 Financial Cycle Base Information Panel Narrative

The Financial Cycle Base Information panel allows the systems team to set up and maintain financial cycles.

Use of this panel is limited to the Systems Team.

Navigation: [Financial] – [$ Cycle] – [Base Information]

6.77.2 Financial Cycle Base Information Panel Layout



6.77.3 Financial Cycle Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Financial Cycle Base information.	Button	N/A	0
Address 1	First address line of the State's return address that will be displayed on the 835.	Field	Character	30
Address 2	Second address line of the State's return address that will be displayed on the 835.	Field	Character	30
Cancel	Allows the user to cancel any changes on the Financial Cycle Base Information panel.	Button	N/A	0
Check Issue Day of the Week	Allows user to pick the day of the week for the Check Issue cycle. To not specify a date parameter, the default issue date will be the date of cycle.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Check Issue Number of Days	Number of days a Check can be issued from the process date or financial run date. (optional). To not specify a Check date parameter results in the default issue date, which is the date of cycle.	Field	Number (Integer)	3
City	City of the State's return address that will be displayed on the 835.	Field	Character	1
Delete	Allows the user to remove Financial Cycle Base information.	Button	N/A	0
EFT Indicator	An indicator to drive EFT processing. If the indicator is set to 'N', system will not check the provider to see if they are setup for EFT payments. If the indicator is set on 'Y', system checks the provider to see if they are setup for EFT payments.	Combo Box	Drop Down List Box	0
EFT Issue Day of the Week	Allows user to enter the Day of the Week for the EFT Issue. To not specify a date parameter the default issue date is the date of cycle.	Combo Box	Drop Down List Box	0
EFT Issue Number of Days	Number of days an EFT can be issued from the process date or financial run date. (optional). To not specify an EFT date parameter results in the default issue date which is the date of cycle.	Field	Number (Integer)	3
Financial Cycle	An optional business code value used to identify the financial cycle. This code may be used for reporting or identifying the financial cycle on feeds to external systems.	Field	Character	30
National Plan Number	National plan number of the State that will be displayed on the 835.	Field	Character	50
Payer Name	Name by which the State is identified on the 835.	Field	Character	50
Payment Type	This code is used to determine if the payment is to be made by AMMIS or by an external system to AMMIS. (I = Internal, E = External)	Combo Box	Drop Down List Box	0
Save	Allows the user to save Financial Cycle Base information.	Button	N/A	0
Sender ID	Sender identification that identifies the State program on the 835.	Field	Character	30
Stat	State code of the State's return address that will be displayed on 835.	Combo Box	Drop Down List Box	0
Tax ID	Tax identification (for Electronic Data Systems).	Field	Character	12
Zip Code	Zip code of the bank.	Field	Number (Integer)	9

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6.77.4 Financial Cycle Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required	Enter Address 1.
Address 2	Field	1	Address 2 is required.	Enter Address 2.
City	Field	1	City is required.	Enter City.
EFT Indicator	Field	1	EFT Indicator is required.	Enter EFT Indicator.
Financial Cycle	Field	1	Financial cycle is required.	Enter Financial cycle.
National Plan Number	Field	1	National Plan Number is required.	Enter National Plan Number.
Payer Name	Field	1	Payer Name is required.	Enter Payer Name.
Payment Type	Field	1	Payment Type is required.	Enter Payment Type.
Sender ID	Field	1	Sender ID is required.	Enter Sender ID.
State	Field	1	State is required.	Enter State.
Tax ID	Field	1	Tax ID is required.	Enter Tax ID.
Zip	Field	1	Zip is required.	Enter zip code.

6.77.5 Financial Cycle Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.77.6 Financial Cycle Base Information Panel Accessibility

6.77.6.1 To Access the Financial Cycle Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Financial Cycle**.	Financial Cycle Base Information panel displays.

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6.77.6.2 To Add Financial Cycle Base Information Panel

Step	Action	Response
1	Enter a **Financial Cycle**.	
2	Select **EFT Indicator** from drop down list box.	
3	Select **Payment Type** from drop down list box.	
4	If required, Select **Check Issue Number of Days**, or **Day of week** from drop down list box.	
5	If required, Select **EFT Issue Number of Days** or **Day of week** from drop down list box.	
6	Enter **Sender ID**.	
7	Enter **Tax ID**.	
8	Enter **Payer Name**.	
9	Enter **Address 1**.	
10	Enter **Address 2**.	
11	Enter **City**.	
12	Enter **State**.	
13	Enter **Zip**.	
14	Enter **National Plan Number**.	
15	Click **Save**.	Financial Cycle Base Information is saved.

6.77.6.3 To Update Financial Cycle Base Information Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	Financial Cycle Base Information is saved.

6.77.6.4 To Delete Financial Cycle Base Information Panel

Step	Action	Response
1	Click line to be deleted.	
2	Click **Delete.**	The following system message displays: ‘Are you sure this is the row you want marked for deletion?’
3	Click **OK** if this is the correct row to delete or click **Cancel** if this is not the desired row to be deleted.	Financial Cycle Base information is deleted or request is cancelled.

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6.78 835 Contacts Panel Overview

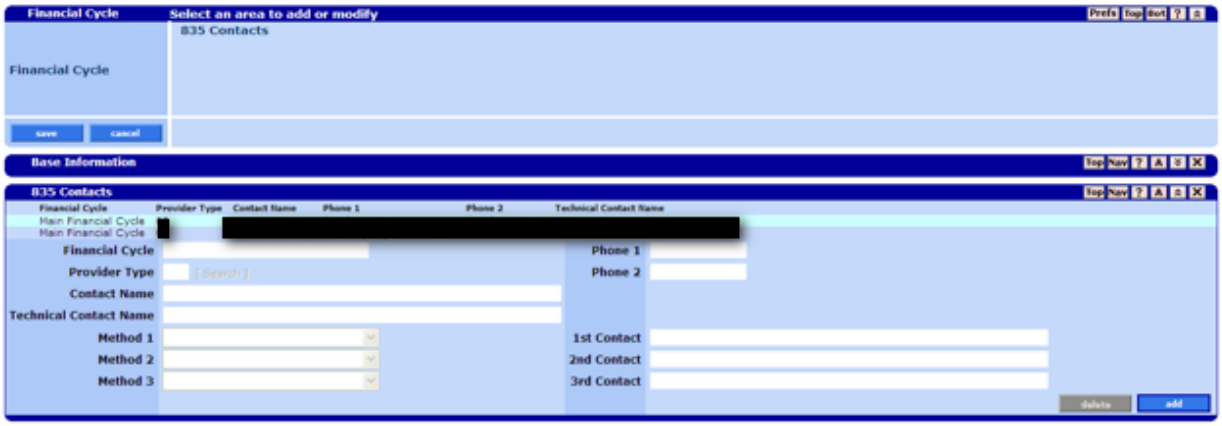
6.78.1 835 Contacts Panel Narrative

835 Contacts panel displays the contact information for 835 inquiries by provider type.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [$ Cycle] – [835 Contacts]

6.78.2 835 Contacts Panel Layout



6.78.3 835 Contacts Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
1st Contact	First form of contact information.	Field	Character	256
2nd Contact	Second form of contact information.	Field	Character	256
3rd Contact	Third form of contact information.	Field	Character	256
Add	Allows the user to add 835 Contact information.	Button	N/A	0
Contact Name	Name of the contact that is reported on the 835.	Field	Character	60
Delete	Allows the user to remove 835 Contact information.	Button	N/A	0
Financial Cycle	Description that identifies a unique financial cycle within the AMMIS.	Field	Character	30
Method 1	First form of contact. Valid values are: EM = Email TE = Telephone UR =URL	Combo Box	Character	2
Method 2	Second form of contact. Valid values are: EM = Email EX = Extension FX = Facsimile TE = Telephone UR =URL	Combo Box	Character	2
Method 3	Third form of contact. Valid values	Combo Box	Character	2

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Field	Description	Field Type	Data Type	Length
	are: EM = Email EX = Extension FX = Facsimile UR =URL			
Phone 1	Phone number one on the AMMIS contact.	Field	Number (Integer)	10
Phone 2	Phone number two on the AMMIS contact.	Field	Number (Integer)	10
Provider Type	Displays the Provider Type (Alabama is set to 00 All Provider Types).	Combo Box	Drop Down List Box	0
Technical Contact Name	Contact name for 835 technical questions.	Field	Character	60

6.78.4 835 Contacts Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
1st Contact	Field	1	1st Contact is required.	1st Contact is required.
2nd Contact	Field	1	Secondary contact is required when Method 2 is selected.	Secondary contact is required when Method 2 is selected.
3rd Contact	Field	1	Third contact is required when Method 3 is selected.	Third contact is required when Method 3 is selected.
Contact Name	Field	2	A contact name is required.	Contact Name is required field.
Method 1	Field	1	Method 1 is required.	Method 1 is required field.
Method 2	Field	1	Method 2 is required when entering a second contact value.	Method 2 is required when entering a second contact value.
Method 3	Field	1	Method 3 is required when entering a third contact value.	Method 3 is required when entering a third contact value.
Phone 1	Field	3	Phone number 1 is required.	Phone 1 is required field.
Phone 2	Field	4	Phone number 2 is required.	Phone 2 is required field.
Provider Type	Field	1	A valid provider type is required.	Provider Type is required field.
Technical Contact Name	Field	1	Technical Contact Name is required.	Technical Contact Name is required field.

6.78.5 835 Contacts Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.78.6 835 Contacts Panel Accessibility

6.78.6.1 To Access the 835 Contacts Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Financial Cycle**.	Financial Cycle Base Information panel displays.
3	Click **835 Contacts** hyperlink.	835 Contacts panel displays.

6.78.6.2 To Add 835 Contacts Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter a **Financial Cycle**.	
3	Enter **Contact Name**.	
4	Enter **Phone 1**.	
5	Enter **Phone 2**.	
6	Enter **Technical contact name**.	
7	Enter **First Contact**.	
8	Enter **Method 1**	
9	Click **Save**.	835 Contacts Information is saved.

6.78.6.3 To Update 835 Contacts Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	835 Contacts Information is saved.

6.78.6.4 To Delete 835 Contacts Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Delete**.	835 Contacts Information is identified for deletion.
3	Click **Save**.	835 Contacts Information is deleted.

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6.79 FSM Financial Schedule Maintenance Page Overview

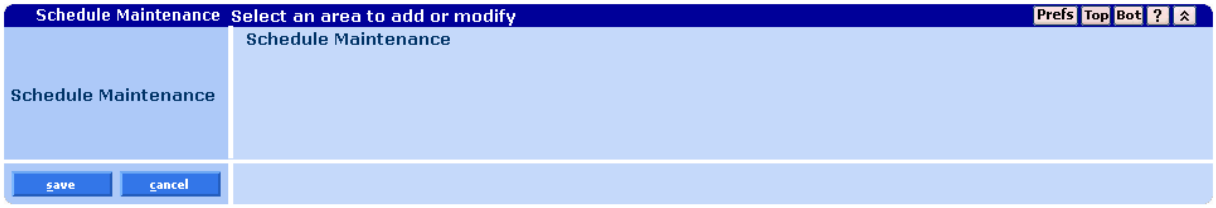
6.79.1 FSM Financial Schedule Maintenance Page Narrative

The FSM Financial Schedule Maintenance panel allows the user to set up maintenance for, review, update and delete financial schedules. The Navigation panel contains the hyperlink to the panel that allows the user to set up and maintain the financial schedules. These panels are controlled by the Systems Team.

This panel is inquiry only.

Navigation: [Financial] – [Sch Maint] – [Schedule Maintenance]

6.79.2 FSM Financial Schedule Maintenance Page Layout



6.79.3 FSM Financial Schedule Maintenance Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Schedule Maintenance panel.	Button	N/A	0
Save	Allows the user to save a record for the Schedule Maintenance.	Button	N/A	0
Schedule Maintenance	Link to the Schedule Maintenance panel.	Hyperlink	N/A	0

6.79.4 FSM Financial Schedule Maintenance Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.79.5 FSM Financial Schedule Maintenance Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.79.6 FSM Financial Schedule Maintenance Page Accessibility

6.79.6.1 To Access the FSM Financial Schedule Maintenance Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Financial** and click **Sch Maint**.	FSM Financial Schedule Maintenance Navigation panel displays.
3	Click **Schedule Maintenance** hyperlink.	FSM Financial Schedule Maintenance panel displays.

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6.80 FSM Financial Schedule Maintenance Panel Overview

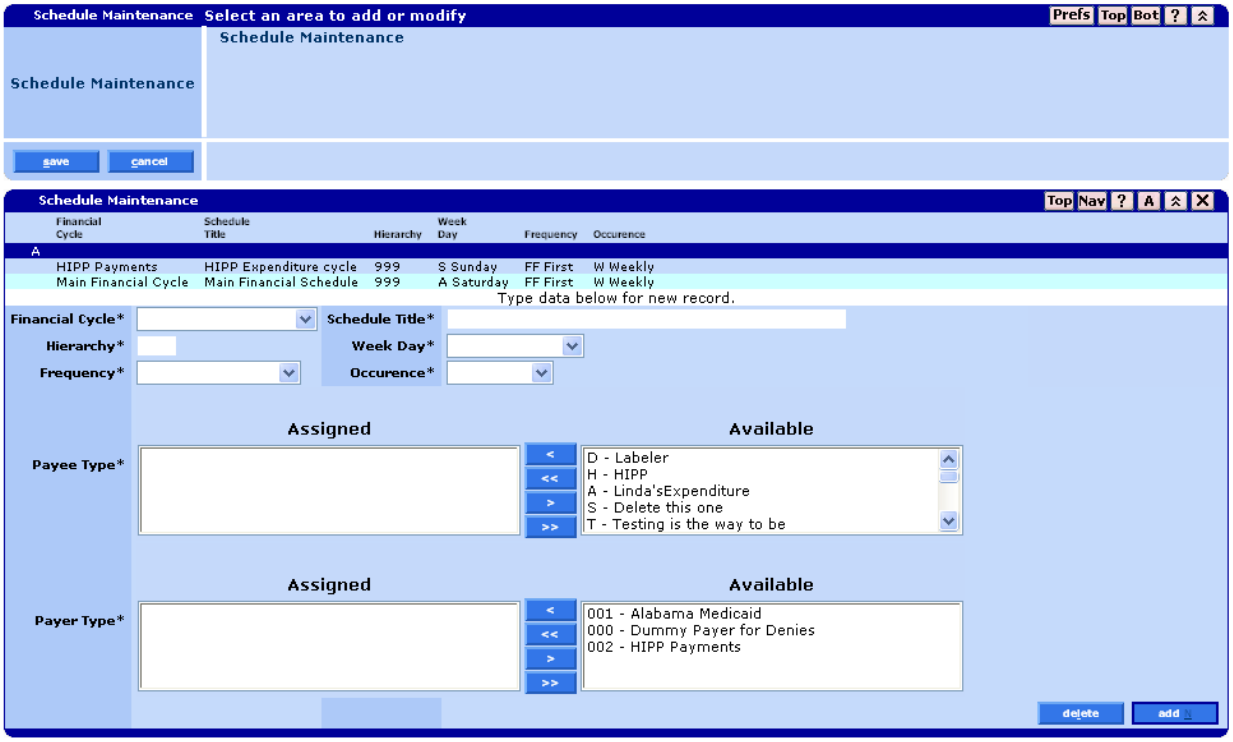
6.80.1 FSM Financial Schedule Maintenance Panel Narrative

The FSM Financial Schedule Maintenance panel allows the user to add, update and delete a financial schedule. This panel is controlled by the systems team.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [Sch Maint] - [Schedule Maintenance]

6.80.2 FSM Financial Schedule Maintenance Panel Layout



6.80.3 FSM Financial Schedule Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add financial Schedule information.	Button	N/A	0
Available	Payee types that can be selected to be paid in a financial cycle.	Combo Box	List	1
<	Allows user to move a highlighted available payee type (or payer type) to the assigned box.	Button	N/A	0
<<	Allows user to move ALL available payee types (or payer types) to the assigned box.	Button	N/A	0
Assigned	Payee types that have been selected to be paid in a financial cycle.	Combo Box	List	0

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Field	Description	Field Type	Data Type	Length
>	Allows user to move a highlighted assigned payee type (or payer type) to the available box.	Button	N/A	0
>>	Allows user to move ALL available payee types (or payer types) to the available box.	Button	N/A	0
Save	Allows the user to save a Financial Schedule.	Button	N/A	0
Delete	Allows the user to remove Financial Schedule information.	Button	N/A	0
Financial Cycle	A business description of the financial cycle that will be used for reporting and panels.	Combo Box	Drop Down List Box	0
Frequency	FF=First, SS=Second, TT=Third, LL=Last, SL=Second to Last. A value of 'D' or 'W' in cde_occur would result in any value in this field being ignored.	Combo Box	Drop Down List Box	0
Hierarchy	A numeric value assigned to indicate the order the system will check a transaction for scheduling. Once a transaction meets all criteria on a single financial schedule, it will use that assigned scheduled period. Therefore, the order in which we check the different schedules for the same transaction type is important.	Field	Number (Integer)	4
Occurrence	Time frame associate with Financial Schedule Maintenance. Valid values include: D = Daily W = Weekly M = Monthly	Combo Box	Drop Down List Box	0
Payee Type	Unique character value for payees. Valid values include: P = Provider R = Recipient O = Other C = Carrier	Field	Multi-List Selection	1
Payer Type	Type of payer. In Alabama, there are two payers: One for the Main Financial Cycle, and one for the HIPP Financial Cycle.	Field	Multi-List Selection	1
Schedule Title	Text description of scheduled maintenance plan.	Field	Character	30
Week Day	Indicates the day of the week for the Financial Schedule. Valid values include: M = Monday T = Tuesday W = Wednesday TH = Thursday F = Friday A value of 'D' in cde_occur would result in any value in this field being ignored.	Combo Box	Drop Down List Box	0

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6.80.4 FSM Financial Schedule Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Financial Cycle	Field	91006	Field required.	Verify input. Select a valid Financial Cycle from the Financial Cycle Drop Down List.
Frequency	Field	91006	Field required.	Verify input. Select a valid Frequency from the Frequency Drop Down List.
Hierarchy	Field	91006	Field required.	Verify input. Select a valid Hierarchy from the Hierarchy Drop Down List.
Occurrence	Field	91006	Field required.	Verify input. Select a valid Occurrence from the Occurrence Drop Down List.
Schedule Title	Field	91006	Field required.	Verify input. Enter a valid schedule title.
Week Day	Field	91006	Field required.	Verify input. Select a valid Day of the Week from the Day of the Week Drop Down List.

6.80.5 FSM Financial Schedule Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.80.6 FSM Financial Schedule Maintenance Panel Accessibility

6.80.6.1 To Access the FSM Financial Schedule Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **Schedule Maint**.	Financial Schedule Maintenance page displays.
3	Click **Schedule Maintenance** hyperlink.	Schedule Maintenance panel displays and criteria Panels are bolded.

6.80.6.2 To Add FSM Financial Schedule Maintenance Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Financial Cycle** from drop down list box.	
3	Enter a **Schedule Title**.	
4	Select **Frequency** from drop down list box.	
5	Enter **Hierarchy**.	
6	Select **Occurrence** from drop down list box.	
7	Select **Payer Type** from drop down list box.	
8	Select **Payee Type** from drop down list box.	
9	Click **Save**.	FSM Financial Schedule Maintenance is saved.

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6.80.6.3 To Update FSM Financial Schedule Maintenance Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FSM Financial Schedule Maintenance information is saved.

6.80.6.4 To Delete FSM Financial Schedule Maintenance Panel

Step	Action	Response
1	Click on row to be deleted.	
2	Click **Save**.	FSM Financial Schedule Maintenance is deleted.

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6.81 F1099 Financial 1099 Maintenance Panel Overview

6.81.1 F1099 Financial 1099 Maintenance Panel Narrative

The Financial 1099 Maintenance panel is used to access 1099 Detail information. This panel is inquiry only.

Navigation: [Financial] – [1099]

6.81.2 F1099 Financial 1099 Maintenance Panel Layout

6.81.3 F1099 Financial 1099 Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
1099	Link to the 1099 panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the F1099 Financial 1099 Maintenance panel.	Button	N/A	0
Save	Allows the user to save a record for the F1099 Financial 1099 Maintenance panel.	Button	N/A	0

6.81.4 F1099 Financial 1099 Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.81.5 F1099 Financial 1099 Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 F1099 Financial 1099 Maintenance Panel Accessibility

6.81.6.1 To Access F1099 Financial 1099 Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **1099**.	Financial 1099 page displays.

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6.82 F1099 1099 Detail Panel Overview

6.82.1 F1099 1099 Detail Panel Narrative

The F1099 1099 Detail panel displays the year-to-date 1099 information by provider for a specific calendar year. The total line displays year-to-date totals for refunds, voids, manual payouts and net year-to-date totals. The information on this panel cannot be updated.

This panel is display only.

Navigation: [Financial] - [1099] - [1099]

6.82.2 F1099 1099 Detail Panel Layout

6.82.3 F1099 1099 Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Backup Withholding Amount	Amount of backup withholding on this record. This is not coded for Alabama.	Field	Number (Decimal)	12
Claim Refunds	Amount returned from an individual provider for claims that had previously been overpaid.	Field	Number (Decimal)	12
Clear	Allows the user to clear any changes on the F1099 1099 Detail panel.	Button	N/A	0
FICA Amount	Amount of Federal Insurance Contributions Act paid for this detail payment record. This is not coded for Alabama.	Field	Number (Decimal)	12
Issue Date	Date the payment was issued to the provider.	Field	Date (MM/DD/CCYY)	8
Manual Earnings	Dollar amount of earnings produced by manually issuing payments to the provider.	Field	Number (Decimal)	12
Non-Claim Refunds	Amount returned from an individual provider for a reason other than overpayment of claims.	Field	Number (Decimal)	12
Payee ID	Unique number which identifies	Field	Number (Integer)	10

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Field	Description	Field Type	Data Type	Length
	the provider to whom the 1099 is being applied. The provider number will also show by location code all the locations associated with a specific FEIN/SSN. Location Code is not coded for Alabama.			
Payee Type	Indicates the Payee Type. Valid values include: Provider.	Field	Character	15
Search	Initiates the Search by Year or Tax ID.	Button	N/A	0
System Earnings	Dollar amount of earnings produced by the system for regular claim payments.	Field	Number (Decimal)	12
Tax ID	Identifies the provider's tax identification or Social Security Number.	Field	Number (Integer)	9
Totals Earnings	Indicates the provider's year-to-date Total Earnings.	Field	Number (Decimal)	12
Void Amount	Amount an individual provider's 1099 is credited for due to a check that has never been cashed.	Field	Number (Decimal)	12
Year	Indicates the year of the 1099 payment detail information being viewed.	Field	Number (Integer)	4

6.82.4 F1099 1099 Detail Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Tax ID	Field	1	Tax ID is required.	The user must enter Tax ID.
	Field	2	Tax ID must be 9 digits.	Enter a 9 digit Tax ID.
Year	Field	1	Year must be 4 digits long and cannot be greater than current year.	Year must be 4 digits long and cannot be greater than current year.
	Field	4	Year is required.	Enter year in CCYY format.

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6.82.5 F1099 1099 Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.82.6 F1099 1099 Detail Panel Accessibility

6.82.6.1 To Access the F1099 1099 Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **1099**.	Financial 1099 Panel displays.
3	Click **1099**.	1099 Detail Panel displays.

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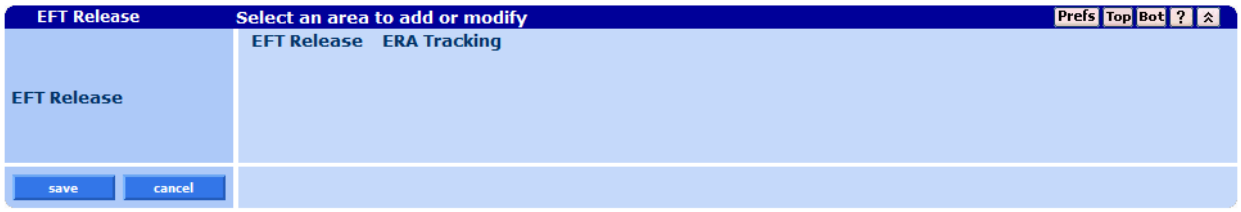
6.83 Financial EFT Release Maintenance Panel Overview

6.83.1 Financial EFT Release Maintenance Panel Narrative

The Financial EFT Release Maintenance panel allows the user to select from a list of areas to add or modify as they related to EFT functions.

Navigation: [Financial] – [eft release]

6.83.2 Financial EFT Release Maintenance Panel Layout



6.83.3 Financial EFT Release Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
EFT Release	Link to the EFT Release panel.	Hyperlink	N/A	0
ERA Tracking	Link to the ERA Tracking panel.	Hyperlink	N/A	0
Cancel	Allows user to delete any unsaved data entered on any of the EFT Release panels.	Button	N/A	0
Save	When any of the Maintenance Item panels has been completed, clicking the Save button will save the EFT Release data.	Button	N/A	0

6.83.4 Financial EFT Release Maintenance Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.83.5 Financial EFT Release Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.6 Financial EFT Release Maintenance Panel Accessibility

6.83.6.1 To Access the Financial EFT Release Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Financial** and click **eft release**.	Financial EFT Release Maintenance panel displays.

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6.84 Financial EFT Release Panel Overview

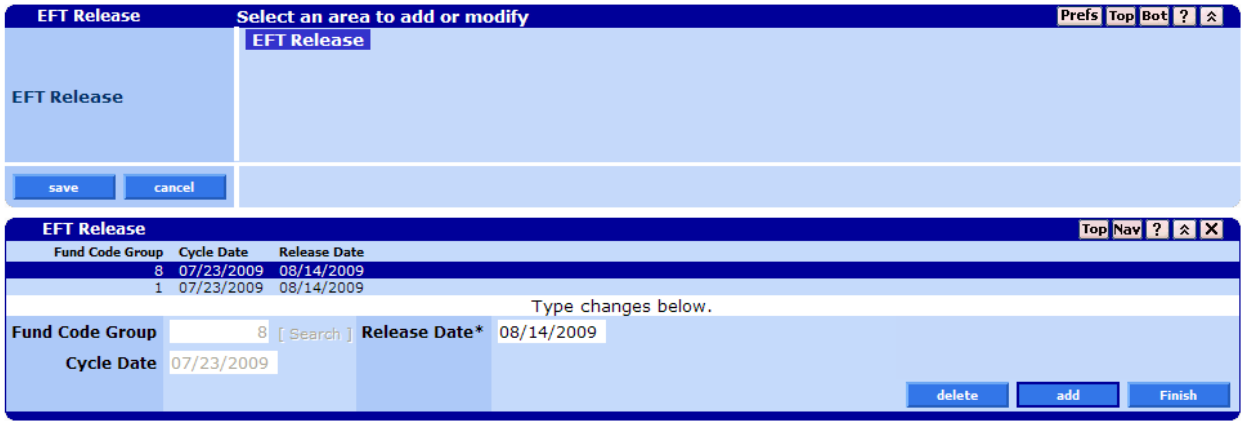
6.84.1 Financial EFT Release Panel Narrative

The Financial EFT Release panel allows the user to enter or review EFT release information.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] – [eft release] – [EFT Release] - [(Delete/Add/Finish button)]

6.84.2 Financial EFT Release Panel Layout



6.84.3 Financial EFT Release Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a row to the EFT Release panel.	Button	N/A	0
Cancel	Clicking the cancel button on the EFT Release Maintenance panel allows the user to cancel data entered on the EFT Release panel before it is saved.	Button	N/A	0
Cycle Date	The cycle date for which funds are to be released.	Field	Date (MM/DD/CCYY)	8
Delete	Allows user to delete a row from the EFT Release panel.	Button	N/A	0
Finish	Allows user to insert the EFT Release data in table T_SYSTEM_PARMS for program name = 'FINPEFTR' with indicator 'Y'.	Button	N/A	0
Fund Code Group	Fund Code Group for which funds are to be released.	Field	Number (Integer)	9
Release Date	The date funds are to be released.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Save	Allows user to save EFT Release data.	Button	N/A	0

6.84.4 Financial EFT Release Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Cycle Date	Field	1	Cycle Date is required.	The user must enter a cycle date.
Fund Code Group	Field	0	A duplicate record cannot be saved.	Verify and re-type. Fund Code Group already exists.
	Field	3	A valid Fund Code Group is required.	The user must enter a valid Fund Code Group.
Release Date	Field	2	Release Date is required	The user must enter a Release Date.

6.84.5 Financial EFT Release Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.84.6 Financial EFT Release Panel Panel Accessibility

6.84.6.1 To Access the Financial EFT Release Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **eft release.**	Financial EFT Release Maintenance panel displays.
3	Click **EFT Release**	Financial EFT Release panel displays.

6.84.6.2 To Add EFT Release Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data.
2	Enter **Fund Code Group**.	
3	Enter **Cycle Date** in MM/DD/CCYY format.	
5	Enter **Release Date** in MM/DD/CCYY format.	
6	Click **Save**.	Financial EFT Release is saved.

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6.84.6.3 To Update Financial EFT Release Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Financial EFT Release information is saved.

6.84.6.4 To Delete Financial EFT Release Panel

Step	Action	Response
1	Click to highlight the row to be deleted.	Data is populated in fields.
2	Click **Delete**.	Financial EFT Release data is marked for deletion.
3	Click **Save**.	Row is deleted.

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6.85 Financial ERA Tracking Panel Overview

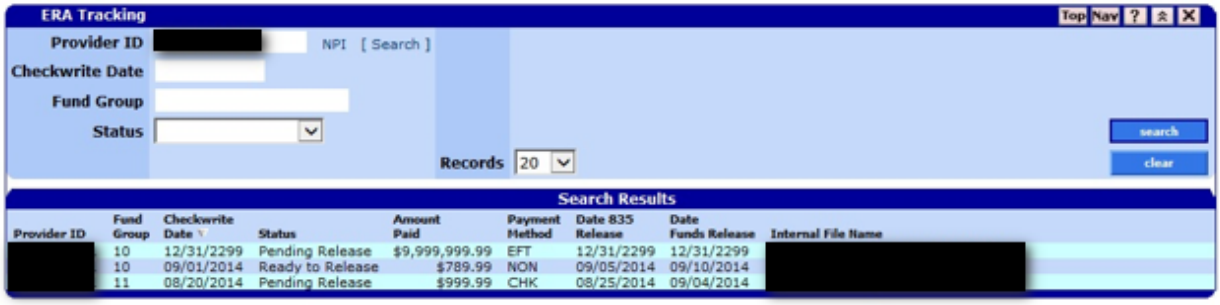
6.85.1 Financial ERA Tracking Panel Narrative

The Financial ERA Tracking Panel is used to enter search criteria when searching for Electronic Remittance Advice (ERA) records. Provider ID is a required field.

Only users with update authority are allowed to perform maintenance tasks.

Navigation: [Financial] - [eft release] – [ERA Tracking]

6.85.2 Financial ERA Tracking Panel Layout



6.85.3 Financial ERA Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Paid	Amount paid to the provider on the 835.	Field	Number (Decimal)	12
Checkwrite Date	This is the date of the check write cycle when the 835 was created.	Field	Date (MM/DD/CCYY)	8
Clear	Allows user to clear the Financial ERA Tracking Panel.	Button	N/A	0
Date 835 Release	Indicates the date 835 released to the provider.	Field	Date (MM/DD/CCYY)	8
Date Funds Release	Indicates the date when EFT funds are released.	Field	Date (MM/DD/CCYY)	8
Fund Group	This is the fund group assigned to the ERA.	Field	Number (Integer)	2
Internal File Name	Filename of the proprietary 835 file to be summarized and sent to EDI.	Field	Character	50
Payment Method	The method of payment code. Valid values include: • **NON** (nonpayment) • **CHK** (Check) • **EFT** (Electronic Funds).	Field	Character	3
Provider ID	Unique number used to track provider ERA activity.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Search	Allows user to search using entered criteria.	Button	N/A	0
Status	Indicates the current status of the 835. Valid values include: • Pending Release • Ready to Release • Released	Combo Box	Drop Down List Box	0

6.85.4 Financial ERA Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Checkwrite Date	Field	2	Invalid date. The format is MM/DD/CCYY.	Verify entry and re-enter a correct date in MM/DD/CCYY format.
Provider ID	Field	1	Provider ID is required.	Enter a number.

6.85.5 Financial ERA Tracking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.85.6 Financial ERA Tracking Panel Accessibility

6.85.6.1 To Access the Financial ERA Tracking Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Financial** and click **eft release.**	Financial EFT Release Maintenance panel displays.
3	Point to **EFT Release Maintenance panel** and click **ERA Tracking**.	ERA Tracking Search panel displays.

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6. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

6.1 Document Information Page

Required Information	Definition
Document Title	AMMIS Financial User Manual – Part II
Version:	6.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/UserManuals/Financial_UM
Owner:	HPE/Agency
Author:	Financial Team
Approved by:	
Approval Date:	

6.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
11/09/2011	1.1		Application of EIP 5010 changes.	CO 8423 – Updated Layout and field descriptions to expand on MRN field from 15 to 50 digits. 7.20 - CRA-IPAD-R - Remittance Advice - Inpatient Claim Adjustments 7.21 - CRA-IPDN-R - -- Remittance Advice - Inpatient Claims Denied 7.22 - CRA-IPPD-R -- Remittance Advice - Inpatient Claims Paid 7.23 - CRA-IPSU-R -– Remittance Advice – Inpatient Claims In Process 7.24 - CRA-LTAD-R -– Remittance Advice – Long Term Care Claim Adjustments

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				7.25 - CRA-LTDN-R - Remittance Advice - Long Term Care Claims Denied 7.26 - CRA-LTPD-R - Remittance Advice - Long Term Care Claims Paid 7.27 - CRA-LTSU-R-- Remittance Advice - Long Term Care Claims In Process 7.28 - CRA-OPAD-R-- Remittance Advice - Outpatient Claim Adjustments 7.29 - CRA-OPDN-R-- Remittance Advice - Outpatient Claims Denied 7.30 - CRA-OPPD-R-- Remittance Advice - Outpatient Claims Paid 7.31 - CRA-OPSU-R-- Remittance Advice - Outpatient Claims In Process 7.32 - CRA-PRAD-R– Remittance Advice – CMS 1500 Claim Adjustments 7.33 - CRA-PRDN-R-- Remittance Advice - CMS 1500 Claims Denied 7.34 - CRA-PRPD-R– Remittance Advice – CMS 1500 Claims Paid 7.35 - CRA-PRSU-R CRA-PRSU-R -- Remittance Advice - CMS 1500 Claims In Process 7.39 - CRA-XAAD-R-- Remittance Advice - Medicare Crossover Part A Claim Adjustments 7.40 - CRA-XADN-R-- Remittance Advice - Medicare Crossover Part A Claims Denied 7.41 - CRA-XAPD-R-- Remittance Advice - Medicare Crossover Part A Claims Paid 7.42 - CRA-XASU-R-- Remittance Advice - Medicare Crossover Part A Claims in Process 7.43 - CRA-XBAD-R-- Remittance Advice - Medicare Crossover Part B Claim Adjustments 7.44 - CRA-XBDN-R - Remittance Advice - Medicare Crossover Part B Claims Denied

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				7.45 - CRA-XBPD-R-- Remittance Advice - Medicare Crossover Part B Claims Paid 7.46 - CRA-XBSU-R-- Remittance Advice - Medicare Crossover Part B Claims in Process 7.47 - CRA-XCAD-R-- Remittance Advice - Medicare Crossover Part C Claim Adjustments 7.48 - CRA-XCDN-R-- Remittance Advice - Medicare Crossover Part C Claims Denied 7.49 - CRA-XCPD-R-- Remittance Advice - Medicare Crossover Part C Claims Paid 7.50 - CRA-XCSU-R-- Remittance Advice - Medicare Crossover Part C Claims In Process CO 8563 Updated layout and field descriptions to expand on the RX # from 7 to 12 digits. 7.14 - CRA-DRSU-R -- Remittance Advice - Drug Claims In Process - 7.13 - CRA-DRPD-R -- Remittance Advice - Drug Claims Paid 7.12 - CRA-DRDN-R -- Remittance Advice - Drug Claims Denied 7.11- CRA-DRAD-R -- Remittance Advice - Drug Claim Adjustments 7.6 - CRA-CDSU-R -- Remittance Advice - Compound Drug Claims In Process 7.5 - CRA-CDPD-R -- Remittance Advice - Compound Drug Claims Paid 7.4- CRA-CDDN-R -- Remittance Advice - Compound Drug Claims Denied 7.3 - CRA-CDAD-R -- Remittance Advice - Compound Drug Claim Adjustments
10/16/2013	2.0		Application of CO 11024	Update section 7.52 FIN-AL02-R Alabama Invoice Layout Report.

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Updatesection 7.53 FIN-AL03-R Electronic Invoices Transmitted report.
07/15/2015	3.0		Application of ACA III production change orders.	CO 12145/DF 12477 Added 7.62 FIN-AU01-M 835/EFT 3 Day Compliance Audit Report Narrative
10/26/2015	4.0		Application of CO 12748	Add 7.63 FIN-AU02-R EOB CARC/RARC Cross Walking Audit Report
/2016	5.0		Application of RCO COs.	CO 12984 – Added DRG Ind to RA and DRG to 835. • 7.20 CRA-IPAD-R - Remittance Advice Inpatient Adjusted Claims • 7.21 CRA-IPDN-R - Remittance Advice Inpatient Denied Claims • 7.22 CRA-IPPD-R - Remittance Advice Inpatient Paid Claims • 7.23 CRA-IPSU-R - Remittance Advice Inpatient Claims in Process CO 12763 Modify reports to include RCO capitations with RCO identifier. • 7.50 FIN-AL02-R Alabama Invoice • 7.51 FIN-AL03-R Electronic Invoices Transmitted CO 12762

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Include narrative change reflecting the Fund Code group increase from 13 to 16 on the following existing reports in the Financial User Manual: • 7.50 Alabama Invoice (FIN-AL02-R) • 7.89 Approved to Pay (FIN-PR30-R) 7.90 Approved to Pay by Line (FIN-PR31-R) • 7.91 FIN-PR32-R – Approved to Pay Encounter Line Count Report Narrative
02/07/2017	6.0		Application of CO 7883 amd 13838	Revise reports to expand PAN field to 38 characters. • CRA-ENAD-R_20161019 • CRA-ENDN-R_20161019 • CRA-ENPD-R_20161019 • CRA-ENSU-R_20161019 • CRA-IPAD-R_20161019 • CRA-IPDN-R_20161019 • CRA-IPPD-R_20161019 • CRA-IPSU-R_20161019 • CRA-LTDN-R_20161019 • CRA-LTPD-R_20161019 • CRA-LTSU-R_20161019 • CRA-OPAD-R_20161019 • CRA-OPDN-R_20161019 • CRA-OPPD-R_20161019 • CRA-OPSU-R_20161019 • CRA-PRAD-R_20161019 • CRA-PRDN-R_20161019 • CRA-PRPD-R_20161019 • CRA-PRSU-R_20161019 • CRA-XAAD-R_20161019 • CRA-XADN-R_20161019 • CRA-XAPD-R_20161019 • CRA-XASU-R_20161019 • CRA-XBAD-R_20161019 • CRA-XBDN-R_20161019 • CRA-XBPD-R_20161019 • CRA-XBSU-R_20161019 • CRA-XCAD-R_20161019

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				• CRA-XCDN-R_20161019 • CRA-XCPD-R_20161019 • CRA-XCSU-R_20161019 7.89 FIN-PR30-R Approved to Pay Report – add AR amount per fund code to report.
4/4/2018	7.0		Remove PHI	Removed PHI on print screens 7.52.2 7.55.2 7.58.2 7.73.2 7.74.2 7.80.2 7.81.2 7.99.2

6.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

7. Financial Reports

The Financial User Manual-Part II provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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7.1 CRA-AL01-R -- Credit Balance Due – Withhold Payments – No Activity

7.1.1 CRA-AL01-R -- Credit Balance Due Narrative

The Credit Balance Due report appears as the last page of the provider's Remittance Advice. It is generated anytime the Provider has an outstanding balance on the Accounts Receivable file.

Remittance Advices are generated any time a financial cycle is run and are both printed for distribution to providers and also sent to COLD. A Remittance Advice is one document that contains separate sections for paid claims, denied claims, adjusted claims and suspended claims.

7.1.2 CRA-AL01-R -- Credit Balance Due Layout

```
REPORT:   CRA-AL01-R                                    ALABAMA MEDICAID AGENCY                          RUN DATE:  MM/DD/CCYY
PROCESS:  FINJR_RA                                MEDICAID MANAGEMENT INFORMATION SYSTEM
LOCATION: FINP_RA                                       PROVIDER REMITTANCE ADVICE                        PAGE:     999,999
                                                BALANCE DUE - WITHHOLD PAYMENTS - NO ACTIVITY

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                PAYEE           999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                       ISSUE DATE           MM/DD/CCYY


SUBJECT:        CREDIT BALANCE DUE
THE ATTACHED REMITTANCE ADVICE REFLECTS A CREDIT BALANCE OF 484.00 DUE THE ALABAMA MEDICAID AGENCY.  THE CREDIT BALANCE WAS CREATED DUE TO
INSUFFICIENT PAID CLAIMS TO COVER THE CREDIT ACTIVITY PROCESSED DURING THIS CHECKWRITE OR A PREVIOUS CHECKWRITE.  IF YOU HAVE ANY QUESTIONS
CONCERNING YOUR CREDIT ACTIVITY, PLEASE CONTACT THE PROVIDER ASSISTANCE CENTER AT 1-800-688-7989 OR 334-215-0111

PAYMENT FOR THE CREDIT BALANCE SHOULD BE SENT TO:
ALABAMA MEDICAID AGENCY
ATTENTION: PROVIDER ACCOUNTS RECEIVABLE
P.O. BOX 5624
MONTGOMERY, AL 36103-5624

YOU SHOULD RETAIN THE ATTACHED REMITTANCE ADVICE TO POST TO YOUR PATIENT ACCOUNTS.
```


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7.1.3 CRA-AL01-R -- Credit Balance Due – Withhold Payments – No Activity Field Descriptions

Field	Description	Length	Data Type
Credit Balance Due	Amount of the balance due from the payee receiving the credit balance PAGE. This is located in the first line of the text.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Issue Date	Date the remittance advice is generated.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	15	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	ZIP code of the payee address. It may or may not contain the zip + four.	10	Character

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7.2 CRA-BANN-R -- Remittance Advice - Banner Messages

7.2.1 CRA-BANN-R -- Remittance Advice - Banner Messages Narrative

The Remittance Advice -Banner Messages PAGE provides text messages and a place to print the address for the window envelope. This report is produced during the financial cycle.

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7.2.2 CRA-BANN-R -- Remittance Advice - Banner Messages Layout

```
REPORT:   CRA-BANN-R                                  ALABAMA MEDICAID AGENCY                                  DATE:  MM/DD/CCYY
RA#:      999999999                             MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:  9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                           BANNER MESSAGES


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                     ISSUE DATE           MM/DD/CCYY


 SUBJECT: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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7.2.3 CRA-BANN-R -- Remittance Advice - Banner Messages Field Descriptions

Field	Description	Length	Data Type
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Issue Date	Date the remittance advice is generated.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	15	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	ZIP code of the payee address. It may or may not contain the zip + four.	10	Character
RA #	The system assigned number for the Remittance Advice.	10	Number (Integer)
Subject	Text field for messages.	4000	Character

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7.3 CRA-CDAD-R -- Remittance Advice - Compound Drug Claim Adjustments

7.3.1 CRA-CDAD-R -- Remittance Advice - Compound Drug Claim Adjustments Narrative

The Remittance Advice – Compound Drug Claim Adjustments report lists compound drug claims that were adjusted. The report is separated by individual claims. It displays the header data for the claim being adjusted and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all compound drug claims that were adjusted along with explanations on why the claims were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.3.2 CRA-CDAD-R -- Remittance Advice - Compound Drug Claim Adjustments Layout

```
REPORT:   CRA-CDAD-R                                    ALABAMA MEDICAID AGENCY                                  DATE:  MM/DD/CCYY
RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                           PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                    COMPOUND DRUG CLAIMS ADJUSTMENTS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                 CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                 ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                            DISPENSE                      BILLED             DISPENSING          TPL              CO-PAY
PAID
    --ICN--     RX NO.         DATE                       AMOUNT                FEE             AMOUNT           AMOUNT
AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXX
 RRYYJJJBBBSSS XXXXXXXXXXXX   MMDDYY                   (9,999,999.99)         (999.99)      (9,999,999.99)   (999,999.99)
(9,999,999.99)
 RRYYJJJBBBSSS XXXXXXXXXXXX   MMDDYY                    9,999,999.99           999.99        9,999,999.99     999,999.99
9,999,999.99

HEADER EOBS    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

   NDC       DESC  UNITS               EOB  CODES
99999999999 XXXXXX 999999              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 999999              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 999999              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 999999              9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999

                                                                                   ADDITIONAL PAYMENT:      9,999,999.99
                                                                                   NET OVERPAYMENT(AR):     9,999,999.99
                                                                                   REFUND AMOUNT APPLIED:   9,999,999.99

   TOTAL COMPOUND DRUG ADJUSTMENT CLAIMS:              99,999,999.99       999,999.99       99,999,999.99  99,999,999.99
99,999,999.99
```


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7.3.3 CRA-CDAD-R -- Remittance Advice - Compound Drug Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if the daughter pays more that the mother.	9	Number (Decimal)
Allowed [detail]	Computed detail level dollar amount allowable for the dispensed drug being billed.	9	Number (Decimal)
Allowed Amount [header]	Computed dollar amount allowable for the dispensed drugs being billed. This amount is arrived at by pricing each of the individual ingredients used to formulate the compound and adding up the individual prices.	9	Number (Decimal)
Billed Amount [header]	Dollar amount requested by the provider for the drugs that were dispensed.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount that is deducted depends on the type of drug that was dispensed.	8	Number (Decimal)
Desc [detail]	First six characters of the National Drug Code description.	6	Number (Integer)
Dispense Date [header]	Date the drug was actually dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOB Codes [detail]	Explanation of Benefits (EOB) codes that apply to the detail on the compound drug claim form. There could be a maximum of twenty EOB codes per claim detail.	4	Number (Integer)
Header EOBS [header]	Explanation of Benefits (EOB) codes that apply to the header on the compound drug claim form. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)

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Field	Description	Length	Data Type
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NDC [detail]	National Drug Code that pertains to the ingredients used in the compound. There is a maximum number of 15 ingredients that can be entered on one claim.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient	30	Character
Net Overpayment (AR)	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Paid Amount [header]	Dollar amount paid for the drug. This is arrived at by computing the allowable amount for the drug and deducting the Third Party Payment (TPL) amount, and co-pay amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	15	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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Field	Description	Length	Data Type
Rx No. [header]	Prescription number for the dispensed drug.	12	Character
Recipient ID [header]	Medicaid identification number of the recipient.	13	Character
Refund Amount Applied	Calculated amount if daughter pays less than the mother on a Cash related adjustment.	9	Number (Decimal)
TPL Amount [header]	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Compound Drug Adjustment Claims Paid – Allowed Amount	Total amount allowed for claims for the payee. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total Compound Drug Adjustment Claims Paid - Co-Pay Amount	Total amount of co-pay for the payee's claims. Subtract the total daughter copay amounts from the total mother copay amounts.	9	Number (Decimal)
Total Compound Drug Adjustment Claims Paid – Billed Amount	Total amount billed for the payee. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Compound Drug Adjustment Claims Paid – Paid Amount	Total amount paid for the payee's claims. Subtract the total daughter paid amounts from the total mother billed amounts.	10	Number (Decimal)
Total Compound Drug Adjustment Claims Paid – TPL Amount	Total dollar amount paid for the drugs by any source outside of the Alabama Medicaid program that is being billed. Subtract the total daughter TPL amounts from the total mother TPL amounts.	10	Number (Decimal)
Units [detail]	Quantity of the ingredient(s) used.	6	Number (Integer)

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7.4 CRA-CDDN-R -- Remittance Advice - Compound Drug Claims Denied

7.4.1 CRA-CDDN-R -- Remittance Advice - Compound Drug Claims Denied Narrative

This report lists compound drug claims that were denied. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all compound drug claims that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

7.4.2 CRA-CDDN-R -- Remittance Advice - Compound Drug Claims Denied Layout

```
REPORT:   CRA-CDDN-R                                    ALABAMA MEDICAID AGENCY                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                     PAGE:  9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                       COMPOUND DRUG CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                       NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                        CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                              DISPENSE                              BILLED            TPL
    --ICN--      RX NO.        DATE                                AMOUNT           AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX RECIPIENT ID.: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  RRYYJJJBBBSSS XXXXXXXXXXXX  MMDDYY                          9,999,999.99     9,999,999.99

EOBS  00  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

   NDC        DESC   UNITS  EOB CODES
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

     TOTAL COMPOUND DRUG CLAIMS DENIED:                     99,999,999.99    99,999,999.99
```


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7.4.3 CRA-CDDN-R -- Remittance Advice - Compound Drug Claims Denied Field Descriptions

Field	Description	Length	Data Type
Billed Amount [header]	Dollar amount requested by the provider for the drug that was dispensed.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Desc [detail]	First six characters of the National Drug Code description.	6	Number (Integer)
Dispense Date [header]	Date the drug was actually dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOB Codes [detail]	Explanation of Benefits (EOB) codes that apply to the detail on the compound drug claim form. There can be a maximum of twenty EOB codes per detail.	4	Number (Integer)
EOBS 00 [header]	Explanation of Benefits (EOB) codes that apply to the header on the compound drug claim form. There can be a maximum of twenty EOB codes per claim.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the payment was issued.	10	Date (MM/DD/CCYY)
NDC [detail]	National Drug Code that pertains to the ingredients used in the compound. There is a maximum number of 15 ingredients that can be entered on one claim.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	15	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of payee address.	2	Character
Payee Zip Code	Zip code of the payee. It may or may not contain the zip plus four.	10	Number (Integer)
Rx No.	Prescription number for the dispensed drug.	12	Character
Recipient ID	Medicaid Identification Number of the recipient.	13	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
TPL Amount [header]	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Compound Drug Claims Denied – Billed Amount	Total dollar amount billed by the payee.	10	Number (Decimal)
Total Compound Drug Claims Denied – TPL Amount	Total dollar amount paid for the drugs by any source outside of the Alabama Medicaid program that is being billed.	10	Number (Decimal)
Units [detail]	Quantity of the ingredient(s) used.	6	Number (Integer)

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7.5 CRA-CDPD-R -- Remittance Advice - Compound Drug Claims Paid

7.5.1 CRA-CDPD-R -- Remittance Advice - Compound Drug Claims Paid Narrative

The Remittance Advice- Compound Drug Claims Paid Narrative report lists compound drug claims that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all compound drug claims that were paid along with explanations of any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

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7.5.2 CRA-CDPD-R -- Remittance Advice - Compound Drug Claims Paid Layout

```
REPORT:   CRA-CDPD-R                                    ALABAMA MEDICAID AGENCY                        DATE:  MM/DD/CCYY
RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                    PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                       COMPOUND DRUG CLAIMS PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                           NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                            DISPENSE                      BILLED             DISPENSING            TPL            CO-PAY
PAID
    --ICN--     RX NO.         DATE                       AMOUNT                FEE                AMOUNT         AMOUNT
AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID.: XXXXXXXXXXXXX  MRN:
 RRYYJJJBBBSSS XXXXXXXXXXXX   MMDDYY                    9,999,999.99           999.99         9,999,999.99     999,999.99
9,999,999.99

HEADER EOBS    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

   NDC       DESC   UNITS              EOB CODES
99999999999 XXXXXX 9999.99             9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 9999.99             9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 9999.99             9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
99999999999 XXXXXX 9999.99             9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999

         TOTAL COMPOUND DRUG CLAIMS PAID:              99,999,999.99       999,999.99        99,999,999.99   9,999,999.99
99,999,999.99
```


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7.5.3 CRA-CDPD-R -- Remittance Advice - Compound Drug Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed [detail]	Computed detail level dollar amount allowable for the dispensed drug being billed.	9	Number (Decimal)
Allowed Amount [header]	Computed dollar amount for the dispensed drug under the Alabama Medicaid program being billed. This amount is arrived at by pricing each of the individual ingredients used to formulate the compound and adding up the individual prices.	9	Number (Decimal)
Billed Amount [header]	Dollar amount requested by the provider for the sum of the drugs that make up the compound drugs.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount. Amount is based on the allowed amount of the drugs dispensed, unless there is an exemption from co-pay because of age, pregnancy or nursing home status.	8	Number (Decimal)
Dispense Date [header]	Date the drug was dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
Desc	First six characters of the National Drug Code description.	6	Number (Integer)
EOB Codes [detail]	Explanation of Benefits (EOB) codes that apply to the detail on the compound drug claim form. There can be a maximum of twenty EOB codes per detail.	4	Number (Integer)
EOBS 00 [header]	Explanation of Benefits (EOB) codes that apply to the header on the compound drug claim form. There can be a maximum of twenty EOB codes per claim.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the payment was issued.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
NDC [detail]	National Drug Code that corresponds to the ingredients used. There is a maximum of 15 ingredients that can be entered on one claim.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Paid Amount [header]	Dollar amount paid for the drug. This is arrived at by computing the allowable amount for the drug and deducting the Third Party payment (TPL) amount, and co-pay amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice	10	Number (Integer)
Rx No.	Prescription number for the dispensed drug.	12	Character
Recipient ID [header]	Medicaid Identification Number of the recipient.	13	Number (Integer)
TPL Amount [header]	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total Compound Drug Claims Paid – Allowed Amount	Total amount allowed for claims for the payee.	10	Number (Decimal)
Total Compound Drug Claims Paid – Billed Amount	Total amount billed for the payee.	10	Number (Decimal)
Total Compound Drug Claims Paid - Co-Pay Amount	Total amount of co-pay for the payee's claims.	9	Number (Decimal)
Total Compound Drug Claims Paid – Paid Amount	Total amount paid for the payee's claims.	10	Number (Decimal)
Total Compound Drug Claims Paid – TPL Amount	Total amount of Third Party (TPL) payment for the payee's claims.	10	Number (Decimal)
Units [detail]	Quantity of the ingredient(s) used.	6	Number (Integer)

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7.6 CRA-CDSU-R -- Remittance Advice - Compound Drug Claims In Process

7.6.1 CRA-CDSU-R -- Remittance Advice - Compound Drug Claims In Process Narrative

The Remittance Advice – Compound Drug Claims in Process Narrative report lists compound drug claims that are in suspense. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefits (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all compound drug claims that are still in process (suspended) along with explanations on why they are in suspense.

This report is produced during the financial cycle.

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7.6.2 CRA-CDSU-R -- Remittance Advice - Compound Drug Claims In Process Layout

REPORT: CRA-CDSU-R ALABAMA MEDICAID AGENCY DATE: MM/DD/CCYY

RA#: 999999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 9,999

PROVIDER REMITTANCE ADVICE

COMPOUND DRUG CLAIMS IN PROCESS

XXXX

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXX

RRYYJJJBBBSSS XXXXXXXXXXXX MMDDYY 9,999,999.99 9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

NDC DESC UNITS EOB CODES

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

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99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

99999999999 XXXXXX 999999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL COMPOUND DRUG CLAIMS IN PROCESS: 99,999,999.99 99,999,999.99

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7.6.3 CRA-CDSU-R -- Remittance Advice - Compound Drug Claims In Process Field Descriptions

Field	Description	Length	Data Type
Billed Amount [header]	Dollar amount requested by the provider for the drug that was dispensed.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Desc	First six characters of the National Drug Code description.	6	Number (Integer)
Dispense Date [header]	Date the drug was actually dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOB Codes [detail]	Explanation of Benefits (EOB) codes that apply to the detail on the compound drug claim form. There can be a maximum of twenty EOB codes per detail.	4	Number (Integer)
EOBS 00 [header]	Explanation of Benefits (EOB) codes that apply to the header on the compound drug claim form. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NDC [detail]	National Drug Code that pertains to the ingredients used in the compound. There is a maximum number of 15 ingredients that can be entered on one claim.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	The name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
Rx No. [detail]	Indicates the prescription number on the prescription that was used to dispense the drug.	12	Character
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
TPL Amount [header]	This is the dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Compound Drug Claims In Process – Billed Amount	This is the total amount billed for the payee.	10	Number (Decimal)
Total Compound Drug Claims In Process – TPL Amount	This is the total amount of Third Party Liability for the payee's claims.	10	Number (Decimal)
Units [detail]	This is the quantity of the ingredient(s) used.	6	Number (Integer)

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7.7 CRA-DNAD-R -- Remittance Advice - Dental Claim Adjustments

7.7.1 CRA-DNAD-R -- Remittance Advice - Dental Claim Adjustments Narrative

The Remittance Advice-Dental Claim Adjustments Narrative report lists dental claims that were adjusted. The report is separated by individual claims and displays the header data for the claim that is being adjusted (original claim) and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the dental provider a list of all dental claims that were adjusted along with explanations on why the claims were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.7.2 CRA-DNAD-R -- Remittance Advice - Dental Claim Adjustments Layout

```
RE REPORT:   CRA-DNAD-R                                ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
      RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                           PROVIDER REMITTANCE ADVICE
                                                            DENTAL CLAIM ADJUSTMENTS


XXXX
```

7.7.3 CRA-DNAD-R -- Remittance Advice - Dental Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated dollar amount if daughter pays more that the mother.	9	Number (Decimal)
Allowed Amount [header]	Computed dollar amount allowable for the services rendered on the claim.	9	Number (Decimal)
Allowed Amount [detail]	Computed dollar amount allowable for the services rendered on each detail line under the Alabama Medicaid program being billed.	9	Number (Decimal)
Billed Amount [header]	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amount [detail]	Dollar amount requested by the provider for the service billed on each detail line.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Date Svc Perf [detail]	Date the service was performed.	8	Date (MM/DD/CCYY)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the dental claim form. There could be a maximum of twenty EOB codes per claim detail.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header on the dental claim form. These codes are used to explain why the claim was adjusted. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Number (Integer)

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Field	Description	Length	Data Type
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed [detail]	The computed non-allowed amount for this detail. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Non-Allowed [header]	The computed non-allowed amount for the claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
MRN	Medical Record Number submitted for the claim	15	Character
OCD [detail]	Oral Cavity code identifying oral cavity location where service was rendered.	2	Number (Integer)
Paid Amount [header]	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the Third Party (TPL) payment amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character

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Field	Description	Length	Data Type
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Number (Integer)
POS [detail]	Place of service code indicating where the services were actually rendered.	2	Character
Proc Cd [detail]	American Dental Association (ADA) code used to indicate what services were actually rendered to the recipient by the provider.	5	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Refund Amount Applied	Calculated amount if daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Rendering Provider [header]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Decimal)
Service Dates –From [header]	The earliest dates of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates –Thru [header]	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
Surf [detail]	Surface code identifying location on tooth where service was rendered.	5	Character
TN [detail]	Tooth number identifying tooth or the tooth quadrant where service was rendered.	2	Character
TPL Amount [header]	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total Dental Adjustments Claims – Allowed Amount	Total allowed amount for the payee's claims. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total Dental Adjustments Claims – Billed Amount	Total billed amount for the payee's claims. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Dental Adjustments Claims - Non-Allowed	Total of non-allowed amount for the adjusted dental claims.	10	Number (Decimal)
Total Dental Adjustments Claims – Paid Amount	Total amount paid for the payee's claims. Subtract the total daughter paid amounts from the total mother paid amounts.	10	Number (Decimal)
Total Dental Adjustments Claims – TPL Amount	Total amount of Third Party (TPL) payment for the payee's claims. Subtract the total daughter TPL amounts from the total mother TPL amounts.	10	Number (Decimal)

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7.8 CRA-DNDN-R -- Remittance Advice - Dental Claims Denied

7.8.1 CRA-DNDN-R -- Remittance Advice - Dental Claims Denied Narrative

The Remittance Advice- Dental Claims Denied Narrative report lists dental claims that were denied. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the dental provider a list of all dental claims that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

7.8.2 CRA-DNDN-R -- Remittance Advice - Dental Claims Denied Layout

```
REPORT:   CRA-DNDN-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                          DENTAL CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                    ISSUE DATE           MM/DD/CCYY

                     RENDERING              SERVICE DATES            BILLED           TPL
          --ICN--    PROVIDER                FROM    THRU            AMOUNT          AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXX
       RRYYJJJBBBSSS  XXXXXXXXXXXXXXX        999999 999999      9,999,999.99    9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

  POS     PROC CD  TN  SURF   OCD    DATE SVC   RENDERING   BILLED
                                     PERF       PROVIDER    AMOUNT                    DETAIL EOBS
   XX     XXXXXX   XX  XXXXX  XX    999999      XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    999999      XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    999999      XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    999999      XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                          TOTAL DENTAL CLAIMS DENIED:            99,999,999.99   99,999,999.99
```


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7.8.3 CRA-DNDN-R -- Remittance Advice - Dental Claims Denied Field Descriptions

Field	Description	Length	Data Type
Billed Amount (Detail)	Dollar amount requested by the provider for the service billed on each detail line.	9	Number (Decimal)
Billed Amount (Header)	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Date Svc Perf (Detail)	The date the service was performed.	6	Date (MM/DD/YY)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the dental claim form. There could be a maximum of twenty EOB codes per claim detail.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header on the dental claim form. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)
ICN (Header)	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	15	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
OCD (Detail)	Oral Cavity code identifying oral cavity location where service was rendered.	2	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Number (Integer)
POS (Detail)	Place of service code indicating where the service was rendered.	2	Character
Proc Cd (Detail)	American Dental Association (ADA) code used to indicate what services were actually rendered to the recipient by the provider.	5	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID (Header)	Medicaid identification number of the recipient.	13	Number (Integer)
Rendering Provider (Detail)	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Character
Rendering Provider [header]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Decimal)
Service Dates –From [header]	The earliest dates of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates –Thru [header]	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
Surf (Detail)	Surface code identifying location on tooth where service was rendered.	5	Character

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Field	Description	Length	Data Type
TN (Detail)	Tooth number of the tooth or the tooth quadrant where surface was rendered.	2	Character
TPL Amount (Header)	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Dental Claims Denied – Billed Amount	Total billed amount for the payee's claims.	10	Number (Decimal)
Total Dental Claims Denied – TPL Amount	Total amount of Third Party (TPL) payment for the payee's claims.	10	Number (Decimal)

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7.9 CRA-DNPD-R -- Remittance Advice - Dental Claims Paid

7.9.1 CRA-DNPD-R -- Remittance Advice - Dental Claims Paid Narrative

The Remittance Advice- Dental Claims Paid Narrative report lists dental claims that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the dental provider a list of all dental claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

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7.9.2 CRA-DNPD-R -- Remittance Advice - Dental Claims Paid Layout

```
REPORT:   CRA-DNPD-R                                    ALABAMA MEDICAID                                                  DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                  PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                          DENTAL CLAIMS PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

                RENDERING            SERVICE DATES                    BILLED           ALLOWED        NON            TPL                  PAID
     --ICN--    PROVIDER             FROM    THRU                     AMOUNT           AMOUNT       ALLOWED         AMOUNT
AMOUNT


NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID:   XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXX
RRYYJJJBBBMOM  XXXXXXXXXXXXXXX      999999  999999                  (9,999,999.99)   (9,999,999.99)  9,999,999.99  (9,999,999.99)
(9,999,999.99)

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

POS  PROC CD  TN  SURF   OCD  DATE SVC     BILLED          ALLOWED        NON         TPL
                                            AMOUNT           AMOUNT       ALLOWED     AMOUNT       DETAIL EOBS
XX     XXXXXX   XX  XXXXX  XX    MMDDYY  ,9,999,999.99   9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
XX     XXXXXX   XX  XXXXX  XX    MMDDYY  ,9,999,999.99   9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
XX     XXXXXX   XX  XXXXX  XX    MMDDYY  ,9,999,999.99   9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
XX     XXXXXX   XX  XXXXX  XX    MMDDYY  ,9,999,999.99   9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
9999 9999


                  TOTAL DENTAL CLAIMS PAID    :                  99,999,999.99     99,999,999.99   99,999,999.99    99,999,999.99.
99,999,999.99
```


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7.9.3 CRA-DNPD-R -- Remittance Advice - Dental Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amount (Detail)	Computed dollar amount allowable for the services rendered on each detail line under the Alabama Medicaid program being billed.	9	Number (Decimal)
Allowed Amount (Header)	Computed dollar amount allowable for the services rendered on the claim.	9	Number (Decimal)
Billed Amount (Detail)	Dollar amount requested by the provider for the service billed on each detail line.	9	Number (Decimal)
Billed Amount (Header)	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Transfer Funds payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Date Svc Perf (Detail)	Date the service was performed.	6	Date (MM/DD/YY)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the dental claim form. There could be a maximum of twenty EOB codes per claim detail.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header on the dental claim form. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)
ICN (Header)	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer (EFT) was issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	15	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character

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Field	Description	Length	Data Type
Non-Allowed (Header)	Total computed non-allowed amount for the claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Non-Allowed (Detail)	Total computed non-allowed amount for this detail. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
OCD (Detail)	Oral Cavity code identifying oral cavity location where service was rendered.	2	Number (Integer)
Paid Amount (detail)	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the Third Party (TPL) amount.	9	Number (Decimal)
Paid Amount (Header)	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the Third Party (TPL) amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Number (Integer)
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Number (Integer)
POS (Detail)	Place of service code(s) indicating where the services were actually rendered.	2	Character
Proc Cd (Detail)	American Dental Association (ADA) code used to indicate what services were rendered to the recipient by the provider.	5	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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Field	Description	Length	Data Type
Recipient ID (Header)	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider [header]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Decimal)
Surf (Detail)	Surface code identifying location on tooth where service was rendered.	5	Character
Service Dates From (Header)	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates Thru (Header)	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
TN (Detail)	Tooth number identifying tooth or the tooth quadrant where service was rendered.	2	Character
TPL Amount (detail)	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
TPL Amount (Header)	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Dental Claims Paid – Allowed Amount	Total allowed amount for the payee's claims.	10	Number (Decimal)
Total Dental Claims Paid – Billed Amount	Total billed amount for the payee's claims.	10	Number (Decimal)
Total Dental Claims Paid - Non-Allowed	Total of non-allowed amount for the dental claims paid.	10	Number (Decimal)
Total Dental Claims Paid – Paid Amount	Total amount paid for the payee's claims.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Dental Claims Paid – TPL Amount	Total amount of Third Party (TPL) payment for the payee's claims.	10	Number (Decimal)

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7.10 CRA-DNSU-R -- Remittance Advice - Dental Claims In Process

7.10.1 CRA-DNSU-R -- Remittance Advice - Dental Claims In Process Narrative

The Remittance Advice-Dental Claims in Process Narrative report lists dental claims that are in suspense. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the dental provider a list of all dental claims that are in suspense along with explanations on what caused the claims to be suspended.

This report is produced during the financial cycle.

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7.10.2 CRA-DNSU-R -- Remittance Advice - Dental Claims In Process Layout

```
REPORT:   CRA-DNSU-R                                  ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                       DENTAL CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

                     RENDERING               SERVICE DATES               BILLED           TPL
          --ICN--    PROVIDER                FROM    THRU                AMOUNT          AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXX  MRN: XXXXXXXXXXXXXXX
       RRYYJJJBBBSSS      XXXXXXXXXXXXXXX    MMDDYY  MMDDYY           9,999,999.99    9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

   POS    PROC CD  TN  SURF   OCD  DATE SVC   RENDERING                  BILLED
                                    PERF     PROVIDER                   AMOUNT   DETAIL EOBS
   XX     XXXXXX   XX  XXXXX  XX    MMDDYY    XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    MMDDYY    XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    MMDDYY    XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
   XX     XXXXXX   XX  XXXXX  XX    MMDDYY    XXXXXXXXXXXXXXX       9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                 TOTAL DENTAL CLAIMS IN PROCESS:    99,999,999.99   99,999,999.99
```


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7.10.3 CRA-DNSU-R -- Remittance Advice - Dental Claims In Process Field Descriptions

Field	Description	Length	Data Type
Billed Amount (Header)	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amount (Detail)	Dollar amount requested by the provider for the service billed on each detail line.	9	Number (Decimal)
Check/EFT Number	Check number of Electronic Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Date Svc Perf (Detail)	Date the service was performed.	6	Date (MM/DD/YY)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the dental claim form. There could be a maximum of twenty EOB codes per claim detail.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header on the dental claim form. There could be a maximum of twenty EOB codes per claim header.	4	Number (Integer)
ICN (Header)	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	15	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name (Header)	Name of the recipient.	29	Character
OCD (Detail)	Oral Cavity code identifying oral cavity location where service was rendered.	2	Character
POS (Detail)	Place of service code(s) indicating where the services were rendered.	2	Character
Proc Cd (Detail)	American Dental Association (ADA) code used to indicate what services were rendered to the recipient by the provider.	5	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Number (Integer)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Number (Integer)
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID (Header)	Medicaid Identification number of the recipient.	13	Number (Integer)
Provider (Detail)	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Integer)
Rendering Provider [header]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Decimal)
Surf (Detail)	Surface code identifying location on tooth were service was performed.	5	Character
Service Dates –From (Header)	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru (Header)	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
TN (Detail)	Tooth number identifying tooth or the tooth quadrant where service was rendered.	2	Character

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Field	Description	Length	Data Type
TPL Amount (Header)	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Dental Claims In Process – Billed Amount	Total billed amount for the payee's claims.	10	Number (Decimal)
Total Dental Claims In Process – TPL Amount	Total amount of Third Party (TPL) payment for the payee's claims.	10	Number (Decimal)

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7.11 CRA-DRAD-R -- Remittance Advice - Drug Claim Adjustments

7.11.1 CRA-DRAD-R -- Remittance Advice - Drug Claim Adjustments Narrative

The Remittance Advice-Drug Claim Adjustments Narrative report lists drug claims (except compound drugs) that were adjusted. The report is separated by individual claims. It displays the header data for the claim being adjusted (Original) and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded monies. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all drug claims (except compound drugs) that were adjusted along with explanations on why the claims were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.11.2 CRA-DRAD-R -- Remittance Advice - Drug Claim Adjustments Layout

REPORT: CRA-DRAD-R ALABAMA MEDICAID AGENCY DATE: MM/DD/CCYY

RA#: 999999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 9,999

PROVIDER REMITTANCE ADVICE

DRUG CLAIMS ADJUSTMENTS

XXXX

(9,999,999.99)

RRYYJJJBBBSSS XXXXXXXXXXXX 99999999999 XXXXXX 9,999,999.999 MMDDYY (9,999,999.99) (9,999,999.99) (999.99) (9,999,999.99) (9,999,999.99)

(9,999,999.99)

(9,999,999.99)

ADDITIONAL PAYMENT: 9,999,999.99

NET OVERPAYMENT (AR): 9,999,999.99

REFUND AMOUNT APPLIED: 9,999,999.99

EOBS: 01 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

02 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL DRUG ADJUSTMENT CLAIMS: 99,999,999.99 99,999,999.99 9,999.99 99,999,999.99 99,999,999.99

99,999,999.99

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7.11.3 CRA-DRAD-R -- Remittance Advice - Drug Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Allowed Amount [detail]	Computed dollar amount allowable for the services rendered on each detail line under the Alabama Medicaid program being billed.	9	Number (Decimal)
Allowed Amount [header]	Computed dollar amount allowable for the dispensed drug under the Alabama Medicaid program being billed. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Billed Amount [header]	Dollar amount requested by the provider for the drug that was dispensed. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Co-Pay Amount (header)	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount that is deducted depends on the type of drug that was dispensed.	8	Number (Decimal)
Desc [detail]	First six characters of the National Drug Code description.	6	Character
Dispense Date [header]	Date the drug was dispensed to the recipient. For drug claims, this serves as the service date. This is the same for both the original and the adjusted claim.	6	Date (MM/DD/YY)
EOB Codes [detail]	Explanation of Benefits (EOB) that apply to the detail on the drug claim form. There could be a maximum of twenty EOP codes per claim detail.	4	Number (Integer)

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Field	Description	Length	Data Type
EOBS 00 [header]	Explanation of Benefits (EOB) codes that apply to the header on the drug claim form. These codes are used to explain how the claim was processed. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer (EFT) was issued.	10	Date (MM/DD/CCYY)
NDC [detail]	National Drug Code for the drug.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if the daughter pays less than the mother without Cash.	9	Number (Decimal)
Paid Amount [header]	Dollar amount paid for the drug. This is arrived at by computing the allowable amount for the drug and deducting the Third Party (TPL) amount, and co-pay amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	This is the state in which the payee resides.	2	Character
Payee Zip Code	Zip code of the payee. It may or may not contain the zip plus four.	10	Character

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Field	Description	Length	Data Type
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rx No. [header]	Prescription number on the prescription that was used to dispense the drug. This is the same for both the original and the adjusted claim.	12	Character
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Refund Amount Applied	Calculated amount if daughter pays less than the mother on a Cash related adjustment.	9	Number (Decimal)
TPL Amount [header]	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Total Drug Claims Adj Paid - Allowed Amount	Allowed amount total of all the Drug Claims Adjustments Paid. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total Drug Claims Adj Paid - Billed Amount	Total billed amount of all the Drug Claims Adjustments Paid. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Drug Claims Adj Paid - Co-Pay Amount	Total of co-pay amounts for all the Drug Claims Adjustments Paid. Subtract the total daughter copay amounts from the total mother copay amounts.	9	Number (Decimal)
Total Drug Claims Adj Paid - Paid Amount	Total of all the Drug Claims Adjustments Paid. Subtract the total daughter paid amounts from the total mother paid amounts.	10	Number (Decimal)
Total Drug Claims Adj Paid - TPL Amount	Total of all Third Party Liability amounts for the Drug Claims Adjustments Paid. Subtract the total daughter TPL amounts from the total mother TPL amounts	10	Number (Decimal)
Units [detail]	Quantity of the drug that was dispensed.	5	Number (Integer)

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7.12 CRA-DRDN-R -- Remittance Advice - Drug Claims Denied

7.12.1 CRA-DRDN-R -- Remittance Advice - Drug Claims Denied Narrative

The Remittance Advice-Drug Claims Denied Narrative report lists drug claims (except compound drugs) that were denied. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all drug claims (except compound drugs) that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

7.12.2 CRA-DRDN-R -- Remittance Advice - Drug Claims Denied Layout

```
RA#:  999999999          MEDICAID MANAGEMENT INFORMATION SYSTEM          PAGE:     9,999

                       PROVIDER REMITTANCE ADVICE

                         DRUG CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                PAYEE ID
XXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                NPI ID
9999999999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        CHECK/EFT NUMBER     999999999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        ISSUE DATE       MM/DD/CCYY

XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX


                    DISPENSE     BILLED          TPL
```


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--ICN-- RX NO. NDC DESC QTY DATE AMOUNT AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXX RECIPIENT ID.: XXXXXXXXXXXX MRN: XXXXXXXXXXXX

RRYYJJJBBBSSS XXXXXXXXXXXX 99999999999 XXXXXX 9,999,999.999 MMDDYY 9,999,999.99
9,999,999.99

EOBS 01 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

02 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL DRUG CLAIMS DENIED 99,999,999.99 99,999,999.99

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7.12.3 CRA-DRDN-R -- Remittance Advice - Drug Claims Denied Field Descriptions

Field	Description	Length	Data Type
Billed Amount	Dollar amount requested by the provider for the drug that was dispensed.	9	Number (Decimal)
Check/EFT Number	Check number of Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Desc	First six characters of the National Drug Code description.	6	Character
Dispense Date	Date the drug was actually dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOBS	Sequential line number of the EOB code corresponding to the claim detail lines. Number 00 corresponds to the header EOB codes. Followed by the Explanation of Benefits (EOB) codes that apply to the drug claim form. These codes are used to explain how the claim was processed. There could be a maximum of twenty EOB codes per claim.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NDC	National Drug Code for the drug.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character

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Field	Description	Length	Data Type
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee. It may or may not contain the zip plus four.	10	Character
Qty	Quantity of the drug that was dispensed.	5	Number (Integer)
RA #	The system assigned number for the remittance advice	10	Number (Integer)
Rx No.	Prescription number for the dispensed drug.	12	Character
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
TPL Amount	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Drug Claims Denied - Billed Amount	Total billed amount of all the drug claims.	10	Number (Decimal)
Total Drug Claims Denied - TPL Amount	Total of all Third Party (TPL) payment amounts for the drug claims denied.	10	Number (Decimal)

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7.13 CRA-DRPD-R -- Remittance Advice - Drug Claims Paid

7.13.1 CRA-DRPD-R -- Remittance Advice - Drug Claims Paid Narrative

The Remittance Advice-Drug Claims Paid Narrative report lists drug claims (except compound drugs) that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes s are also displayed on this report. The purpose of this report is to give the drug provider a list of all drug claims (except compound drugs) that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

7.13.2 CRA-DRPD-R -- Remittance Advice - Drug Claims Paid Layout

```
REPORT:  CRA-DRPD-R                    ALABAMA MEDICAID AGENCY                    DATE:  MM/DD/CCYY

  RA#:   999999999                MEDICAID MANAGEMENT INFORMATION SYSTEM              PAGE:      9,999

                                 PROVIDER REMITTANCE ADVICE

                                    DRUG CLAIMS PAID


XXXX
```

--ICN--	RX NO.	NDC	DESC	DISPENSE QTY	BILLED DATE	ALLOWED AMOUNT	DISPENSING AMOUNT	CO-PAY FEE	TPL	PAID AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX RECIPIENT ID.: XXXXXXXXXXXXX MRN:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

RRYYJJJBBBSSS XXXXXXXXXXXX 99999999999 XXXXXX 9,999,999.999 MMDDYY 9,999,999.99 9,999,999.99 999.99
9,999,999.99 9,999,999.99 9,999,999.99

EOBS 01 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

02 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL DRUG CLAIMS PAID: 99,999,999.99 99,999,999.99 9,999.99 99,999,999.99 99,999,999.99

99,999,999.99

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7.13.3 CRA-DRPD-R -- Remittance Advice - Drug Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amount	Computed dollar amount allowable for the dispensed drug under the Alabama Medicaid program being billed.	9	Number (Decimal)
Billed Amount	Dollar amount requested by the provider for the drug that was dispensed.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Co-Pay Amount	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The co-pay amount is based on the allowed charge for the drug dispensed.	8	Number (Decimal)
DESC	First six characters of the National Drug Code description.	6	Character
Dispense Date	Date the drug was dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOBS	Sequential line number of the EOB code corresponding to the claim detail lines. Number 00 corresponds to the header EOB codes. Followed by the Explanation of Benefits (EOB) codes that apply to the drug claim form. These codes are used to explain how the claim was processed. There could be a maximum of twenty EOB codes per claim.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NDC	National Drug Code for the drug .	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Paid Amount	Dollar amount paid for the drug. This is arrived at by computing the allowable amount for the drug and deducting the TPL amount, and co-pay amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character

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Field	Description	Length	Data Type
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee. It may or may not contain the zip plus four.	10	Character
Qty	Quantity of the drug that was dispensed.	5	Number (Decimal)
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rx No.	Prescription number for the dispensed drug.	12	Character
Recipient ID	Medicaid Identification number of the recipient.	13	Character
TPL Amount	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Drug Claims Paid - Allowed Amount	Allowed amount total of all the drug claims paid.	10	Number (Decimal)
Total Drug Claims Paid - Billed Amount	Total billed amount of all the drug claims.	10	Number (Decimal)
Total Drug Claims Paid - Co-Pay Amount	Total of co-pay amounts for all the drug claims paid.	10	Number (Decimal)
Total Drug Claims Paid - Paid Amount	Total of all the drug claims paid.	10	Number (Decimal)
Total Drug Claims Paid - TPL Amount	Total of all Third Party (TPL) payment amounts for the drug claims paid.	10	Number (Decimal)

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7.14 CRA-DRSU-R -- Remittance Advice - Drug Claims In Process

7.14.1 CRA-DRSU-R -- Remittance Advice - Drug Claims In Process Narrative

The Remittance Advice - Drug Claims In Process Narrative report lists drug claims (except compound drugs) that are in suspense. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the drug provider a list of all drug claims (except compound drugs) that are in suspense along with explanations on why they are in suspense.

This report is produced during the financial cycle.

7.14.2 CRA-DRSU-R -- Remittance Advice - Drug Claims In Process Layout

```
REPORT:   CRA-DRSU-R                    ALABAMA MEDICAID AGENCY                    DATE:  MM/DD/CCYY

  RA#:   999999999                MEDICAID MANAGEMENT INFORMATION SYSTEM                PAGE:      9,999

                              PROVIDER REMITTANCE ADVICE

                               DRUG CLAIMS IN PROCESS


XXXX
```

--ICN--	RX NO.	NDC	DESC	DISPENSE QTY	BILLED DATE	AMOUNT	TPL AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX RECIPIENT ID.: XXXXXXXXXXXXX MRN: XXXXXXXXXXXXXXX

RRYYJJJBBBSSS XXXXXXXXXXXX 99999999999 XXXXXX 9,999,999.99 MMDDYY 99,999.99 99,999.99

EOBS 00 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

01 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

02 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

03 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL DRUG CLAIMS IN PROCESS: 999,999.99 999,999.99

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7.14.3 CRA-DRSU-R -- Remittance Advice - Drug Claims In Process Field Descriptions

Field	Description	Length	Data Type
Billed Amount	Dollar amount requested by the provider for the drug that was dispensed.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Desc	First six characters of the National Drug Code description.	6	Character
Dispense Date	Date the drug was dispensed to the recipient. For drug claims, this serves as the service date.	6	Date (MM/DD/YY)
EOBS	Sequential line number of the EOB code corresponding to the claim detail lines. Number 00 corresponds to the header EOB codes. Followed by the Explanation of Benefits (EOB) codes that apply to the drug claim form. These codes are used to explain how the claim was processed. There could be a maximum of twenty EOB codes per claim.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NDC	National Drug Code for the drug.	11	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee. It may or may not contain the zip plus four.	10	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	The name of the payee provider.	50	Character
Qty	Quantity of the drug that was dispensed.	5	Number (Decimal)
RA #	The system assigned number for the remittance advice	10	Number (Integer)
Rx No.	Prescription number on the prescription that was used to dispense the drug.	12	Character
Recipient ID	Medicaid Identification number of the recipient.	13	Character
TPL Amount	Dollar amount paid for the drug by any source outside of the Alabama Medicaid program that is being billed.	9	Number (Decimal)
Total Drug Claims In Process - Billed Amount	Total billed amount of all the drug claims.	10	Number (Decimal)
Total Drug Claims In Process - TPL Amount	Total of all Third Party Liability (TPL) payment amounts for the drug claims in process.	10	Number (Decimal)

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7.15 CRA-ENAD-R -- Remittance Advice - Encounter Claim Adjustments

7.15.1 CRA-ENAD-R -- Remittance Advice - Encounter Claim Adjustments Narrative

The Remittance Advice - Encounter Claim Adjustments Narrative report lists adjusted inpatient encounter claims. No money is received for these claims. Those with District H01 through H08 are Partnership Hospital Program encounter claims. Those with District Codes P01 through P12 are Maternity Care encounter claims. They are listed here so the hospital can correctly invoice the specific District provider. This report is produced during the financial cycle.

The only manual adjustments done to Encounter claims is to have them recouped. Since the claims are zero paid, the recoupment will not produce an AR. Therefore, none of the statements, NET OVERPAYMENT (AR), REFUND AMOUNT APPLIED, or ADDITIONAL PAYMENT will appear below the mother and daughter ICNs.

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7.15.2 CRA-ENAD-R -- Remittance Advice - Encounter Claim Adjustments Layout

```
REPORT:   CRA-ENAD-R                                   ALABAMA MEDCAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                 PAGE:     9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                      ENCOUNTER CLAIM ADJUSTMENTS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

                                                                                            SERVICE DATES
AMOUNT               DIST
NAME                        RECIPIENT ID. PAT ACCT NO.                            ICN         FROM    THRU     REV   DAYS
BILLED               CODE
XXXXXXXXXXXXXXXXXXXXXXXXXX   999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJBBBSSS MMDDYY  MMDDYY    999    999
(9,999,999.99)           X99
XXXXXXXXXXXXXXXXXXXXXXXXXX   999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJBBBSSS MMDDYY  MMDDYY    999    999
9,999,999.99            X99


     TOTAL ENCOUNTER ZERO CLAIMS ADJUSTED:                                                                   99,999,999,99
```

7.15.3 CRA-ENAD-R -- Remittance Advice - Encounter Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Billed Amount [header]	Dollar amount billed by the provider for the hospitalization stay. The first amount displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These amounts may vary.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer (EFT) payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the hospital.	3	Number (Integer)
Dist Code [header]	District Code that identifies the type of encounter. Codes H01 through H08 identify the claim as a Partnership Hospital Program encounter claim. Codes P01 through P12 identify the claim as a Maternity Care encounter claim. These codes assist the provider in correct invoicing of the specific District.	3	Character

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Field	Description	Length	Data Type
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Name	Name of the Recipient.	29	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Pat Acct No. [header]	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes. It is the same on the original and adjusted claim.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Character
REV	Revenue Code from the last detail on the claim.	3	Number (Interger)
Service Dates – From [header]	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates –Thru [header]	The latest date of service on the detail lines.	6	Date (MM/DD/YY)

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Field	Description	Length	Data Type
Total Inpatient Encounter Adjustment Claims Paid - Billed Amount	Total billed amount of all the inpatient encounter claims adjusted. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)

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7.16 CRA-ENDN-R -- Remittance Advice - Encounter Claims Denied

7.16.1 CRA-ENDN-R -- Remittance Advice - Encounter Claims Denied Narrative

The Remittance Advice - Encounter Claims Denied Narrative section lists denied inpatient encounter claims. No money is received for these claims through claims processing. Encounter claims only report header information. The type of encounter is noted by the District Code on each claim. Those with District Codes H01 though H08 are Partnership Hospital Program encounters. Those with District Codes P01 through P12 are Maternity Care Encounters. These codes allow the provider to review the system assigned encounter codes. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

7.16.2 CRA-ENDN-R -- Remittance Advice - Encounter Claims Denied Layout

```
REPORT:   CRA-ENDN-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                           PAGE:      9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                         ENCOUNTER CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

                                                                                          SERVICE DATES
AMOUNT            DIST
NAME                    RECIPIENT ID.   PAT ACCT NO.                              ICN            FROM    THRU     REV      DAYS
BILLED            CODE

XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX
9,999,999.99          P01
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX
9,999,999.99          H12
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX
9,999,999.99          H03
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
TOTAL ENCOUNTER ZERO CLAIMS DENIED
99,999,999.99
```


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7.16.3 CRA-ENDN-R -- Remittance Advice - Encounter Claims Denied Field Descriptions

Field	Description	Length	Data Type
Amount Billed	Amount billed for the claim.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number that corresponds to the check or EFT that is generated.	9	Number (Integer)
Days	Number of days billed for the claim.	3	Number (Integer)
Dist Code	District Code that identifies the type of encounter. Codes H01 through H08 identify the claim as a Partnership Hospital Program claim. Codes P01 through P12 identify the claim as a Maternity Care claim. These codes allow the provider to review the system assigned district codes for correctness.	3	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header.	4	Number (Integer)
ICN	Internal Control Number used to identify and track the claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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Field	Description	Length	Data Type
Rev	The revenue code from the first detail line.	3	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Service Dates - From	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
Total Encounter Zero Claims Denied	Total of the billed amount for the denied encounter claims	11	Number (Decimal)

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7.17 CRA-ENPD-R -- Remittance Advice - Encounter Claims Paid

7.17.1 CRA-ENPD-R -- Remittance Advice - Encounter Claims Paid Narrative

The Remittance Advice - Encounter Claims Paid Narrative section lists paid inpatient encounter claims. No money is received for these claims. Encounter claims only report header information. The type of encounter is noted by the District Code on each claim. Those with District Codes H01 through H08 are Partnership Hospital Program encounters. They are listed here so the hospital can correctly invoice the Partnership Hospital Program, which is administered by the Alabama Hospital Association. Those with District Codes P01 through P12 are Maternity Care Encounters. They are listed here so the hospital can correctly invoice the specific Maternity Care District provider.

This report is produced during the financial cycle.

7.17.2 CRA-ENPD-R -- Remittance Advice - Encounter Claims Paid Layout

```
REPORT:   CRA-ENPD-R                          ALABAMA MEDICAID AGENCY                                  DATE:  MM/DD/CCYY
   RA#:    999999999                   MEDICAID MANAGEMENT INFORMATION SYSTEM                         PAGE:       9,999
                                            PROVIDER REMITTANCE ADVICE
                                              ENCOUNTER CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                       ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                                                                                 SERVICE DATES                                AMOUNT            DIST
NAME                    RECIPIENT ID.   PAT ACCT NO.                   ICN       FROM    THRU     REV      DAYS              BILLED            CODE
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          P01
HEADER EOBS: 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          H12
HEADER EOBS: 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          H03
HEADER EOBS: 9999 9999 9999 9999 9999

TOTAL ENCOUNTER ZERO PAID CLAIMS:                                                                    999,999,999.99
```


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7.17.3 CRA-ENPD-R -- Remittance Advice - Encounter Claims Paid Field Descriptions

Field	Description	Length	Data Type
Amount Billed	Amount billed for the claim.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days	The number of days billed for the claim.	3	Number (Integer)
Dist Code	District Code that identifies the type of encounter. Codes H01 through H08 identify the claim as a Partnership Hospital Program claim. Codes P01 though P12 identify the claim as a Maternity Care claim. These codes assist the provider in correct invoicing of these programs.	3	Character
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. It is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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Field	Description	Length	Data Type
Rev	The revenue code from the last detail line.	3	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Service Dates - From	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
Total Encounter Zero Claims Paid	Total of the allowed amounts for the paid encounter claims	11	Number (Decimal)

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7.18 CRA-ENSU-R -- Remittance Advice - Encounter Claims In Process

7.18.1 CRA-ENSU-R -- Remittance Advice - Encounter Claims In Process Narrative

The Remittance Advice - Encounter Claims In Process Narrative report lists inpatient encounter claims in process. No money is received for these claims. Encounter claims only report header information. The type of encounter is noted by the District Code on each claim. Those with District Codes P01 through P12 are Maternity Care encounters. Those with District codes H01 through H08 are Partnership Hospital Program encounters. Display of these codes allows the provider to review the system assigned codes for correctness.

This report is produced during the financial cycle.

7.18.2 CRA-ENSU-R -- Remittance Advice - Encounter Claims In Process Layout

```
REPORT:   CRA-ENSU-R                                  ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:    999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                        PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                       ENCOUNTER CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX

                                                                                   SERVICE DATES                                AMOUNT            DIST
NAME                    RECIPIENT ID.   PAT ACCT NO.  I                   ICN     FROM    THRU     REV      DAYS              BILLED            CODE

XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          P01
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          H12
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999
XXXXXXXXXX XXXXXXXXXX   XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSS  MMDDYY MMDDYY    XXX      XXX           9,999,999.99          H03
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999

TOTAL ENCOUNTER ZERO CLAIMS IN PROCESS:                                                                   999,999,999.99
```


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7.18.3 CRA-ENSU-R -- Remittance Advice - Encounter Claims In Process Field Descriptions

Field	Description	Length	Data Type
Amount Billed	Amount billed for the claim.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days	Number of days billed for the claim.	3	Number (Integer)
Dist Code	District Code that identifies the type of encounter. Codes H01 through H08 identify the claim as a Partnership Hospital Program claim. Codes P01 through P12 identify the claim as a Maternity Care claim. Display of these codes allows the provider review of these system assigned codes for correctness.	3	Character
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
Rev	The revenue code from the last detail.	3	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)

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Field	Description	Length	Data Type
Service Dates - From	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service from the detail lines.	6	Date (MM/DD/YY)

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7.19 CRA-EOBM-R -- Remittance Advice - EOB Code Descriptions

7.19.1 CRA-EOBM-R -- Remittance Advice - EOB Code Descriptions Narrative

The Remittance Advice - EOB Code Descriptions Narrative report lists all the Explanation of Benefit (EOB) codes used in the preceding Remittance Advice (R/A) PAGEs and displays their corresponding descriptions. The purpose of this report is to give the provider a better explanation of the reasons why claims were either suspended or denied. The EOB codes and descriptions are also used to explain any discrepancies between amounts billed and amounts paid on paid claims.

This report is produced during the financial cycle.

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7.19.2 CRA-EOBM-R -- Remittance Advice - EOB Code Descriptions Layout

```
REPORT:   CRA-EOBM-R                                ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                            MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:      9,999
                                                     PROVIDER REMITTANCE ADVICE
                                                       EOB CODE DESCRIPTIONS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

EOB CODE     DESCRIPTION

9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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7.19.3 CRA-EOBM-R -- Remittance Advice - EOB Code Descriptions Field Descriptions

Field	Description	Length	Data Type
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Description	Descriptions corresponding to the EOB codes that were used. These descriptions give the provider the reasons why submitted claims were suspended, denied or not paid in full.	100	Character
EOB Code	Explanation of Benefits (EOB) codes that were applied to the submitted claims - either on the header or detail lines.	4	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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7.20 CRA-IPAD-R -- Remittance Advice - Inpatient Claim Adjustments

7.20.1 CRA-IPAD-R -- Remittance Advice - Inpatient Claim Adjustments Narrative

The Remittance Advice - Inpatient Claim Adjustments Narrative report lists Inpatient claims that were adjusted. The report is separated by individual claims. It displays header data for the both the claim being adjusted (Original) and the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were adjusted along with explanations on why the claims were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.20.2 CRA-IPAD-R -- Remittance Advice - Inpatient Claim Adjustments Layout

```
REPORT:   CRA-IPAD-R                                    ALABAMA MEDCAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:    999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                             PAGE:       9,999
                                                          PROVIDER REMITTANCE ADVICE
                                                          INPATIENT CLAIM ADJUSTMENTS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                        ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.                        SERVICE  DATES  DAYS   ADMIT     BILLED AMT    ALLOWED AMT       PAT LIAB      TPL AMT
PAID AMT
    ICN         ATTENDING ID  FROM                   THRU  DRG     DATE   DRG SUPPMNTL    NON ALLOWED        COPAY
NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY  MMDDYY  999   MMDDYY  (9,999,999.99)  (9,999,999.99)   (999,999.99)
(9,999,999.99)    9,999,999.99)
                XXXXXXXXXXXXXXXX                                        XXXX        (999,999,999.99)  (9,999,999.99)   (999,999.99)
 RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY  MMDDYY  999   MMDDYY   9,999,999.99    9,999,999.99     999,999.99
9,999,999.99      9,999,999.99
                XXXXXXXXXXXXXXXX                                        XXXX         999,999,999.99    9,999,999.99     999,999.99
                                                                                                   ADDITIONAL PAYMENT           9,999,999.99
                                                                                                   NET OVERPAYMENT (AR)         9,999,999.99
                                                                                                   REFUND AMOUNT APPLIED        9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD  SRV DATE                                                                   UNITS    BILLED AMT              DETAIL EOBS
 999     MMDDYY                                                                  9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999     MMDDYY                                                                  9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999     MMDDYY                                                                  9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999     MMDDYY                                                                  9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999     MMDDYY                                                                  9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999

        TOTAL INPATIENT ADJUSTMENT CLAIMS:                                          99,999.999,99  99,999,999.99     9,999,999.99
99,999,999.99    99,999,999,99
                                                                                                   99,999,999.99     9,999,999.99
```

7.20.3 CRA-IPAD-R -- Remittance Advice - Inpatient Claim Adjustments Field Descriptions

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Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Admit Date [header]	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Allowed Amt [header]	Computed allowable dollar amount for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Attending ID [header]	License number of the attending provider.	10	Character
Billed Amt [header]	Dollar amount billed by the provider for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for the hospitalization stay on this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	8	Number (Decimal)
Days [header]	Number of days the recipient was in the hospital.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the claim.	4	Number (Integer)
DRG	Diagnosis Related Group.	4	Character
DRG SUPPLMNTL	DRG Supplemental Amount.	9	Number (Decimal)
Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the header of the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)

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Field	Description	Length	Data Type
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN [header]	Medical Record Number submitted by provider.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
MRN [header]	Medical Record Number submitted by provider.	15	Number (Integer)
Paid Amt [header]	Dollar amount that is payable for the hospitalization stay. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	38	Character
Pat Liab	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character

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Field	Description	Length	Data Type
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Character
Refund Amount Applied	Calculated amount if the daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Srv Date [detail]	The detail service date.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
TPL Amt [header]	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Total Inpatient Claims Adjustments - Allowed Amt	Allowed amount total of all the Inpatient Claims. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Inpatient Claims Adjustments - Billed Amt	Total billed amount of all the Inpatient Claims. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Inpatient Claims Adjustments - Co-Pay	Total of all co-pay amounts for the Inpatient Claims. Subtract the total daughter copay amounts from the total mother copay amounts.	9	Number (Decimal)
Total Inpatient Claims Adjustments – Non-Allowed	Total of non-allowed amount for the inpatient claim adjustments. Subtract the total daughter non-allowed amounts from the total mother non-allowed amounts.	10	Number (Decimal)
Total Inpatient Claims Adjustments - Paid Amt	Total of all the Inpatient Claims Adjustments. Subtract the total daughter paid amounts from the total mother paid amounts.	10	Number (Decimal)
Total Inpatient Claims Adjustments – Pat Liab	Total amount of Patient Liability amounts for the inpatient claims. Subtract the total daughter Patient Liability amounts from the total mother Patient Liability amounts.	10	Number (Decimal)
Total Inpatient Claims Adjustments - TPL Amt	Total of all TPL amounts for the Inpatient Claims Adjustments. Subtract the total daughter TPL amounts from the total mother TPL amounts.	10	Number (Decimal)
Units [detail]	Units of service rendered on each detail.	8	Number (Integer)

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7.21 CRA-IPDN-R -- Remittance Advice - Inpatient Claims Denied

7.21.1 CRA-IPDN-R -- Remittance Advice - Inpatient Claims Denied Narrative

The Remittance Advice - Inpatient Claims Denied Narrative report lists Inpatient claims that were denied. The report is separated by individual claims and displays header data only. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were denied along with an explanation as to why they were denied.

This report is produced during the financial cycle.

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7.21.2 CRA-IPDN-R -- Remittance Advice - Inpatient Claims Denied Layout

```
REPORT:   CRA-IPDN-R                                  ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   9999999999                             MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:      9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                        INPATIENT CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.                          SERVICE DATES   DAYS   ADMIT        BILLED                     TPL
     ICN        ATTENDING ID.                         FROM    THRU           DATE         AMOUNT                   AMOUNT         DRG
DRG SUPPLMNTL

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXXX      MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY  MMDDYY   999  MMDDYY  9,999,999.99                 9,999,999.99     XXXX
999,999,999.99
                XXXXXXXXXXXXXXXX
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


REV CD            SRV DATE                                                          UNITS   BILLED AMT  DETAIL EOBS
 999               MMDDYY                                                          9999999 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                       9999 9999 9999 9999 9999 9999 9999 9999
9999 9999

 999               MMDDYY                                                          9999999 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                       9999 9999 9999 9999 9999 9999 9999 9999
9999 9999

 999               MMDDYY                                                          9999999 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                       9999 9999 9999 9999 9999 9999 9999 9999
9999 9999

 999               MMDDYY                                                          9999999 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                       9999 9999 9999 9999 9999 9999 9999 9999
9999 9999

                          TOTAL INPATIENT CLAIMS DENIED:                                 99,999,999.99                 99,999,999.99
```


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7.21.3 CRA-IPDN-R – Remittance Advice – Inpatient Claims Denied Field Descriptions

Field	Description	Length	Data Type
Admit Date [header]	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the hospital.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail on the claim.	4	Number (Integer)
DRG	Diagnosis Related Group.	4	Character
DRG SUPPLMNTL	DRG Supplemental Amount.	9	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header of claim. These codes are used to explain how the claim was processed or priced.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN [header]	Medical Record Number assigned by the provider. Usually used for tracking purposes.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of recipient.	13	Character
Srv Date [detail]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Inpatient Claims Denied - Billed Amount	Total billed amount of all the Inpatient Claims.	10	Number (Decimal)
Total Inpatient Claims Denied - TPL Amount	Total of all TPL amounts for the Inpatient Claims Denied.	10	Number (Decimal)
Units [detail]	Units of service rendered on each detail.	8	Number (Integer)

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7.22 CRA-IPPD-R -- Remittance Advice - Inpatient Claims Paid

7.22.1 CRA-IPPD-R -- Remittance Advice - Inpatient Claims Paid Narrative

The Remittance Advice - Inpatient Claims Paid Narrative report lists Inpatient claims that were paid. The report is separated by individual claims and displays header data only. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the acute inpatient provider a list of all inpatient claims that were paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

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7.22.2 CRA-IPPD-R -- Remittance Advice - Inpatient Claims Paid Layout

```
REPORT:   CRA-IPPD-R                                   ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   9999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                          INPATIENT CLAIMS PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.                          SERVICE  DATES  DAYS   ADMIT     BILLED AMT    ALLOWED AMT       PAT LIAB      TPL AMT
PAID AMT
    ICN         ATTENDING ID                           FROM     THRU  DRG     DATE  DRG SUPPLMNTL    NON ALLOWED        COPAY

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY  MMDDYY   999   MMDDYY   9,999,999.99    9,999,999.99     999,999.99
9,999,999.99      9,999,999.99
                XXXXXXXXXXXXXXX              XXXX                                  999,999,999.99    9,999,999.99     999,999.99

REV CD            SRV DATE                                                          UNITS    BILLED AMT              DETAIL EOBS
 999               MMDDYY                                                          9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999               MMDDYY                                                          9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999               MMDDYY                                                          9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999               MMDDYY                                                          9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
 999               MMDDYY                                                          9999999 9,999,999.99              9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999


                  TOTAL INPATIENT CLAIMS PAID:                                        99,999.999,99  99,999,999.99     9,999,999.99
99,999,999.99    99,999,999,99
                                                                                                   99,999,999.99     9,999,999.99
```


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7.22.3 CRA-IPPD-R -- Remittance Advice - Inpatient Claims Paid Field Descriptions

Field	Description	Length	Data Type
Admit Date [header]	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Allowed Amt [header]	Computed allowable dollar amount for claim.	9	Number (Decimal)
Attending ID[header]	National Provider Identification number of the attending physician.	10	Character
Billed Amt [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Days [header]	Number of days the recipient was in the hospital.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply the details of the claim.	4	Number (Integer)
DRG	Diagnosis Related Group.	4	Character
DRG SUPPLMNTL	DRG Supplemental Amount.	9	Number (Decimal)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
MRN [header]	.Medical Record Number submitted on the claim.	50	Character
Paid Amt [header]	Dollar amount that is payable for the claim.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character

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Field	Description	Length	Data Type
Patient Liability [header]	Patient Liability amount the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [header]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amt [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Inpatient Claims Paid – Allowed Amt	Allowed amount total of all the Inpatient Claims.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Inpatient Claims Paid – Billed Amt	Total billed amount of all the Inpatient Claims.	10	Number (Decimal)
Total Inpatient Claims Paid – Co-Pay Amt	Total of all co-pay amounts for the Inpatient Claims paid.	9	Number (Decimal)
Total Inpatient Claims Paid – Liability Amt	Total of patient liability amounts for all the Inpatient Claims paid.	9	Number (Decimal)
Total Inpatient Claims Paid – Non-Allowed	Total of non-allowed amounts for the inpatient claims paid.	10	Number (Decimal)
Total Inpatient Claims Paid – Paid Amt	Total of all the Inpatient Claims paid.	10	Number (Decimal)
Total Inpatient Claims Paid – TPL Amt	Total of all TPL amounts for the Inpatient Claims paid.	10	Number (Decimal)
Units [detail]	Units of service rendered.	8	Number (Integer)

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7.23 CRA-IPSU-R – Remittance Advice – Inpatient Claims In Process

7.23.1 CRA-IPSU-R – Remittance Advice – Inpatient Claims In Process Narrative

The Remittance Advice – Inpatient Claims In Process Narrative report lists Inpatient claims that are in suspense. The report is separated by individual claims and displays header data only. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

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7.23.2 CRA-IPSU-R – Remittance Advice – Inpatient Claims In Process Layout

```
REPORT:   CRA-IPSU-R                                  ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE:      9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                      INPATIENT CLAIMS IN PROCESS


XXXX
```

7.23.3 CRA-IPSU-R – Remittance Advice – Inpatient Claims In Process Field Descriptions

Field	Description	Length	Data Type
Admit Date [header]	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [detail]	Number of days the recipient was in the hospital.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the detail.	4	Number (Integer)
DRG	Diagnosis Related Group.	4	Character
DRG SUPPLMNTL	DRG Supplemental Amount.	9	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header of the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [detail]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Inpatient Claims In Process – Billed Amount	Total billed amount of all the Inpatient Claims.	10	Number (Decimal)
Total Inpatient Claims In Process – TPL Amount	Total of all TPL amounts for the Inpatient Claims.	10	Number (Decimal)
Units [detail]	Units of service rendered on each detail.	8	Number (Integer)

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7.22 CRA-LTAD-R – Remittance Advice – Long Term Care Claim Adjustments

7.22.1 CRA-LTAD-R – Remittance Advice – Long Term Care Claim Adjustments Narrative

The Remittance Advice – Long Term Care Claim Adjustments Narrative report lists Long Term Care claims that were adjusted. The report is separated by individual claims. It displays the header data for the claim being adjusted (Original) and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded monies. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all long term care claims that were adjusted along with explanations on why the claims were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.22.2 CRA-LTAD-R – Remittance Advice – Long Term Care Claim Adjustments Layout

```
REPORT:   CRA-LTAD-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:      9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                     LONG TERM CARE CLAIMS ADJUSTMENTS


XXXX
```

7.22.3 CRA-LTAD-R – Remittance Advice – Long Term Care Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Allowed Amount [header]	Computed allowable amount for the services billed. The data displayed pertains to the adjusted claim.	9	Number (Decimal)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount requested by the provider for the service billed on this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the nursing home.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. These codes are used to explain why the claim was adjusted. There could be a maximum of twenty EOB codes per detail line.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)

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Field	Description	Length	Data Type
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amount [header]	Dollar amount that is payable for the recipient's stay.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	30	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd	Revenue code pertaining to the service billed on the detail line.	3	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Character
Refund Amount Applied	Calculated amount if the daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Srv Date	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The data displayed pertains to the adjusted claim.	6	Date (MM/DD/YY)

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Field	Description	Length	Data Type
Service Dates - From	The earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
TPL Amount	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Total Long Term Care Claims ADJ - Allowed Amount	Allowed amount total of all the Long Term Care Claims Adjustments. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total Long Term Care Claims ADJ - Billed Amount	Total billed amount of all the Medicare Crossover Part A Claims. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Long Term Care Claims ADJ - Non-Allowed	Total of non-allowed amounts for the long term care adjusted claims. Subtract the total daughter non-allowed amounts from the total mother non-allowed amounts.	10	Number (Decimal)
Total Long Term Care Claims ADJ - Paid Amount	Total of all the Long Term Care Claims Adjustments. Subtract the total daughter paid amounts from the total mother paid amounts	10	Number (Decimal)
Total Long Term Care Claims ADJ - Patient Liability	Total of Patient Liability amounts for all the Long Term Care Claims Adjustments. Subtract the total daughter Patient Liability amounts from the total mother Patient Liability amounts.	9	Number (Decimal)
Total Long Term Care Claims ADJ - TPL Amount	Total of all TPL amounts for the Long Term Care Claims Adjustments. Subtract the total daughter TPL amounts from the total mother TPL amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Units [detail]	Number of units of service.	8	Number (Integer)

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7.23 CRA-LTDN-R -- Remittance Advice - Long Term Care Claims Denied

7.23.1 CRA-LTDN-R -- Remittance Advice - Long Term Care Claims Denied Narrative

The Remittance Advice – Long Term Care Claims Denied report lists Long Term Care claims that were denied. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all long term care claims that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

7.23.2 CRA-LTDN-R – Remittance Advice – Long Term Care Claims Denied Layout

```
REPORT:   CRA-LTDN-R                                    ALBAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
REPORT:   CRA-LTDN-R                                    ALBAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                 PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                     LONG TERM CARE CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

               PAT ACCT NO.                          SERVICE DATES  DAYS              BILLED                TPL              PATIENT
     --ICN--   ATTENDING ID                          FROM   THRU                     AMOUNT              AMOUNT            LIABILITY

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY MMDDYY  999           9,999,999.99         9,999,999.99         999,999.99
                XXXXXXXXXXXXXXXX
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


REV CD             SRV DATE                        UNITS    BILLED AMT   DETAIL EOBS
999               MMDDYY                                                 9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
999               MMDDYY                                                 9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
999               MMDDYY                                                 9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                 9999 9999 9999 9999 9999 9999 9999 9999 9999
9999

                  TOTAL LONG TERM CARE CLAIMS DENIED:                             99,999,999.99        99,999,999.99       9,999,999.99
```


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7.23.3 CRA-LTDN-R – Remittance Advice – Long Term Care Claims Denied Field Descriptions

Field	Description	Length	Data Type
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	This is the dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amt [detail]	This is the dollar amount requested by the provider for the service billed on the detail line.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the nursing home.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
MRN	Medical Record Number submitted on the claim.	50	Character
Name [header]	Name of the recipient.	29	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character

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Field	Description	Length	Data Type
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
Rev Cd [detail]	This shows the revenue code pertaining to the service billed on the detail line.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Srv Date [detail]	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Long Term Care Claims Denied - Billed Amount	Total billed amount of all the Long Term Care Claims.	10	Number (Decimal)
Total Long Term Care Claims Denied - Patient Liability	Total of Patient Liability amounts for all the Long Term Care Claims Denied.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total Long Term Care Claims Denied – TPL Amount	Total of all TPL amounts for the Long Term Care Claims Denied.	10	Number (Decimal)
Units [detail]	Number of units of service.	8	Number (Integer)

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7.24 CRA-LTPD-R -- Remittance Advice - Long Term Care Claims Paid

7.24.1 CRA-LTPD-R -- Remittance Advice - Long Term Care Claims Paid Narrative

The Remittance Advice - Long Term Care Claims Paid report lists Long Term Care claims that were paid. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all long term care claims that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

7.24.2 CRA-LTPD-R – Remittance Advice – Long Term Care Claims Paid Layout

```
REPORT:   CRA-LTPD-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:      9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                        LONG TERM CARE CLAIMS PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.                          SERVICE DATES DAYS         BILLED        ALLOWED AMT            TPL            PATIENT
PAID
     --ICN--    ATTENDING ID                           FROM   THRU  UNITS        AMOUNT        NON ALLOWED          AMOUNT          LIABILITY
AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY MMDDYY  999     9,999,999.99      9,999,999.99      9,999,999.99
9,999,999.99      9,999,999.99
               XXXXXXXXXXXXXXX                                                                      9,999,999.99

 HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


REV CD            SRV DATE                          UNITS                                            BILLED AMT      DETAIL EOBS
 999               MMDDYY                         9999999                                           9,999,999.99     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999
                                                                                                                     9999 9999 9999 9999 9999 9999
9999 9999 9999 9999

          TOTAL LONG TERM CARE CLAIMS PAID:                                     99,999,999.99     99,999,999.99     99,999,999.99
99,999,999.99     99,999,999.99
                                                                                                  99,999,999.99
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7.24.3 CRA-LTPD-R – Remittance Advice – Long Term Care Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amt [header]	Computed allowable amount for the services billed.	9	Number (Decimal)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	This is the dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amt [detail]	This is the dollar amount requested by the provider for the service billed on the detail line.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the nursing home.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amount [header]	Dollar amount that is payable for the recipient's stay.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character

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Field	Description	Length	Data Type
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue code pertaining to the service billed on the detail line.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [detail]	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Long Term Care Claims Paid - Allowed Amt	Allowed amount total of all the Long Term Care Claims Paid.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Long Term Care Claims Paid - Billed Amount	Total billed amount of the Long Term Care Claims.	10	Number (Decimal)
Total Long Term Care Claims Paid - Non-Allowed	Total of non-allowed amounts for the long term care paid claims.	10	Number (Decimal)
Total Long Term Care Claims Paid - Paid Amount	Total of all the Long Term Care Claims Paid.	10	Number (Decimal)
Total Long Term Care Claims Paid - Patient Liability	Total of Patient Liability amounts for all the Long Term Care Claims Paid.	9	Number (Decimal)
Total Long Term Care Claims Paid - TPL Amount	Total of all TPL amounts for the Long Term Care Claims Paid.	10	Number (Decimal)
Units [detail]	Number of units of service.	8	Number (Integer)

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7.25 CRA-LTSU-R -- Remittance Advice - Long Term Care Claims In Process

7.25.1 CRA-LTSU-R -- Remittance Advice - Long Term Care Claims In Process Narrative

The Remittance Advice - Long Term Care Claims In Process report lists Long Term Care claims that are in suspense. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all long term care claims that are in suspense along with explanations as to why they were suspended.

This report is produced during the financial cycle.

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7.25.2 CRA-LTSU-R – Remittance Advice – Long Term Care Claims In Process Layout

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REPORT:   CRA-LTSU-R                                  ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                  LONG TERM CARE CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY

               PAT ACCT NO.                          SERVICE DATES  DAYS            BILLED                  TPL                PATIENT
     --ICN--   ATTENDING ID                            FROM   THRU                  AMOUNT                 AMOUNT             LIABILITY

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MMDDYY MMDDYY  999           9,999,999.99           9,999,999.99          9,999,999.99
                XXXXXXXXXXXXXXXX
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


REV CD            SRV DATE                                                   UNITS     BILLED AMT  DETAIL EOBS
 999               MMDDYY                                                  9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
 999               MMDDYY                                                  9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
 999               MMDDYY                                                  9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
 999               MMDDYY                                                  9999999  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999

              TOTAL LONG TERM CARE CLAIMS IN PROCESS:                                 99,999,999.99          99,999,999.99          9,999,999.99
```


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7.25.3 CRA-LTSU-R – Remittance Advice – Long Term Care Claims In Process Field Descriptions

Field	Description	Length	Data Type
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount requested by the provider for the service billed on the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount requested by the provider for the service billed on the detail line.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Days [header]	Number of days the recipient was in the nursing home.	3	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of twenty EOB codes per detail line.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character

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Field	Description	Length	Data Type
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue code pertaining to the service billed on the detail line.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	12	Number (Integer)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
Srv Date [detail]	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Medical Assistance Program being billed for the recipient's stay. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Long Term Care Claims In Process - Billed Amount	Total billed amount of the Long Term Care Claims.	10	Number (Decimal)
Total Long Term Care Claims In Process - Patient Liability	Total of Patient Liability amounts for all the Long Term Care Claims In Process.	9	Number (Decimal)
Total Long Term Care Claims In Process - TPL Amount	Total of all TPL amounts for the Long Term Care Claims In Process.	10	Number (Decimal)

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Field	Description	Length	Data Type
Units [detail]	Number of units of service.	8	Number (Integer)

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7.26 CRA-OPAD-R -- Remittance Advice - Outpatient Claim Adjustments

7.26.1 CRA-OPAD-R -- Remittance Advice - Outpatient Claim Adjustments Narrative

The Remittance Advice -Outpatient Claim Adjustments report lists Outpatient claims that were adjusted. The report is separated by individual claims. It displays the header data for the claim being adjusted (Original) and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the outpatient provider a list of all outpatient claims that were adjusted along with explanations on why they were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.26.2 CRA-OPAD-R -- Remittance Advice - Outpatient Claim Adjustments Layout

```
REPORT:   CRA-OPAD-R                                    ALABAMA MEDICAID                                                  DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                  PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                     OUTPATIENT CLAIM ADJUSTMENTS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                       ISSUE DATE           MM/DD/CCYY

      ICN        PAT ACCT NO.                          SERVICE DATES        BILLED      ALLOWED AMT          TPL         CO-PAY
PATIENT          PAID
                 ATTENDING ID                          FROM     THRU        AMOUNT      NON ALLOWED         AMOUNT       AMOUNT
LIABILITY        AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYY MMDDYY (9,999,999.99)   (9,999,999.99)   (9,999,999.99)   (999,999.99)
(999,999.99)   (9,999,999.99)
                 XXXXXXXXXXXXXXXX                                                          9,999,999.99
  RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYY MMDDYY  9,999,999.99     9,999,999.99     9,999,999.99     999,999.99
999,999.99     9,999,999.99
                 XXXXXXXXXXXXXXXX                                                          9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD PROC CODE                      SRV DATE  MODIFIERS      UNITS     BILLED AMT       ALLOWED AMT   NON ALLOWED   DETAIL EOBS
 999    XXXXXX                        MMDDYY  XX XX XX XX  999999.99   9,999,999.99      9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999
9999 9999 9999 9999 9999
                                                                                                                      9999 9999 9999 9999 9999
9999 9999 9999 9999 9999
 999    XXXXXX                        MMDDYY  XX XX XX XX  999999.99   9,999,999.99      9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999
9999 9999 9999 9999 9999
                                                                                                                      9999 9999 9999 9999 9999
9999 9999 9999 9999 9999
 999    XXXXXX                        MMDDYY  XX XX XX XX  999999.99   9,999,999.99      9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999
9999 9999 9999 9999 9999
                                                                                                                      9999 9999 9999 9999 9999
9999 9999 9999 9999 9999

                                                                                          ADDITIONAL PAYMENT                 9,999,999.99
                                                                                          NET OVER PAYMENT                   9,999,999.99
                                                                                          REFUND AMOUNT APPLIED              9,999,999.99

     TOTAL OUTPATIENT ADJUSTMENT CLAIMS:                                 99,999,999.99    99,999,999.99 99,999,999.99       9,999,999
9,999,999.99   99,999,999.99
                                                                                         99,999,999.99
```


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7.26.3 CRA-OPAD-R -- Remittance Advice - Outpatient Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Allowed Amt [header]	Computed allowable dollar amount for claim.	9	Number (Decimal)
Allowed Amt [detail]	Computed allowable dollar amount for this detail.	9	Number (Decimal)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the details.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number on the submitted claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Net Over Payment	Calculated amount if the daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed [detail]	The computed non-allowed amount for this detail. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)

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Field	Description	Length	Data Type
Non-Allowed [header]	The computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Proc Cd [detail]	Procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered.	6	Character
Paid Amount [header]	Dollar amount that is payable for the claim.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	38	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Refund Amount Applied	Calculated amount if the daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)

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Field	Description	Length	Data Type
Srv Date [detail]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
TPL Amount [header]	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Total Outpatient Adjustment Claims - Allowed Amount	Total of allowed amounts of all the Adjustment Claims. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total Outpatient Adjustment Claims - Billed Amount	Total billed amount of all the Adjustment Claims. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total Outpatient Adjustment Claims - Co-Pay Amount	Total of all co-pay amounts for the Adjustment Claims paid. Subtract the total daughter copay amounts from the total mother copay amounts.	9	Number (Decimal)
Total Outpatient Adjustment Claims – Non-Allowed	Total of non-allowed amount for the outpatient claim adjustments. Subtract the total daughter non-allowed amounts from the total mother non-allowed amounts	10	Number (Decimal)
Total Outpatient Adjustment Claims - Paid Amount	Total of all the Adjustment Claims paid. Subtract the total daughter paid amounts from the total mother paid amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Outpatient Adjustment Claims - Patient Liability	Total of all patient liability amounts for the Outpatient Claims. Subtract the total daughter patient liability amounts from the total mother patient liability amounts.	10	Number (Decimal)
Total Outpatient Adjustment Claims - TPL Amount	Total of all TPL amounts for the Adjustment Claims paid. Subtract the total daughter TPL amounts from the total mother TPL amounts	10	Number (Decimal)
Units [detail]	Units of service rendered.	6	Number (Decimal)

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7.27 CRA-OPDN-R -- Remittance Advice - Outpatient Claims Denied

7.27.1 CRA-OPDN-R -- Remittance Advice - Outpatient Claims Denied Narrative

The Remittance Advice - Outpatient Claims Denied report lists Outpatient claims that were denied. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the outpatient provider a list of all outpatient claims that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

7.27.2 CRA-OPDN-R -- Remittance Advice - Outpatient Claims Denied Layout

```
REPORT:   CRA-OPDN-R                                  ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                       OUTPATIENT CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.  SERVICE DATES                                BILLED          TPL                    PATIENT
    ICN         ATTENDING ID   FROM   THRU                                 AMOUNT         AMOUNT                 LIABILITY

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXXX     MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYY MMDDYY   9,999,999.99     9,999,999.99            999,999.99
                XXXXXXXXXXXXXXXX
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD PROC CODE   MODIFIERS                        SRV DATE UNITS     BILLED AMT    DETAIL EOBS
 999    XXXXXX    XX XX XX XX                       MMDDYY  9999999    9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                       MMDDYY  9999999    9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                       MMDDYY  9999999    9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                       MMDDYY  9999999    9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                       MMDDYY  9999999    9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

            TOTAL OUTPATIENT CLAIMS DENIED:                           99,999,999.99     99,999,999.99           9,999,999.99
```


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7.27.3 CRA-OPDN-R -- Remittance Advice - Outpatient Claims Denied Field Descriptions

Field	Description	Length	Data Type
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Detail EOBS	Explanation of Benefit (EOB) codes that apply to the detail of the claim.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number assigned by the provider. Usually used for tracking purposes.	50	Number (Integer)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Proc Code [detail;]	Procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered.	6	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability [header]	Dollar amount the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character

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Field	Description	Length	Data Type
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [detail]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Outpatient Claims Denied - Billed Amount	Total of all the Outpatient Claims billed for the provider.	10	Number (Decimal)
Total Outpatient Claims Denied - Patient Liability	Total of patient liability amounts for all the Outpatient Claims Denied.	9	Number (Decimal)
Total Outpatient Claims Denied - TPL Amount	Total of all TPL amounts for the Outpatient Claims Denied, for the provider.	10	Number (Decimal)
Units [detail]	Units of service rendered.	8	Number (Integer)

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7.28 CRA-OPPD-R -- Remittance Advice - Outpatient Claims Paid

7.28.1 CRA-OPPD-R -- Remittance Advice - Outpatient Claims Paid Narrative

The Remittance Advice - Outpatient Claims Paid report lists Outpatient claims that were paid. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the outpatient provider a list of all outpatient claims that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

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7.28.2 CRA-OPPD-R -- Remittance Advice - Outpatient Claims Paid Layout

```
REPORT:   CRA-OPPD-R                                  ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:  9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                        OUTPATIENT CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      ISSUE DATE           MM/DD/CCYY
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX

      ICN        PAT ACCT NO.                          SERVICE DATES        BILLED      ALLOWED AMT         TPL           CO-PAY          PATIENT           PAID
                 ATTENDING ID                          FROM     THRU        AMOUNT      NON ALLOWED        AMOUNT         AMOUNT         LIABILITY         AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MMDDYY MMDDYY    (9,999,999.99) (9,999,999.99)   (9,999,999.99)   (999,999.99)   (999,999.99)   (9,999,999.99)
                 XXXXXXXXXXXXXXXX                                                9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD PROC CODE   MODIFIERS                          SRV DATE  UNITS    BILLED AMT     ALWD AMT     DETAIL EOBS
 999    XXXXXX    XX XX XX XX                        MMDDYY  9999999   9,999,999.99   9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                        MMDDYY  9999999   9,999,999.99   9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                        MMDDYY  9999999   9,999,999.99   9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 999    XXXXXX    XX XX XX XX                        MMDDYY  9999999   9,999,999.99   9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

      TOTAL OUTPATIENT CLAIMS PAID:                                   99,999,999.99  99,999,999.99    99,999,999.99    9,999,999.99    99,999,999.    99,999,999.99
                                                                                     99,999,999.99
```


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7.28.3 CRA-OPPD-R -- Remittance Advice - Outpatient Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amount [header]	Computed allowable dollar amount for the claim.	9	Number (Decimal)
Alwd Amt [detail]	Computed allowable dollar amount for this detail.	9	Number (Decimal)
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to the details.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header of the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number on the submitted claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)

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Field	Description	Length	Data Type
Proc Code [detail]	Procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered.	6	Character
Paid Amount [header]	Dollar amount that is payable for the claim.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA Number	The system assigned number for the remittance advice. There is only one number for each checkwrite. All RAs for that checkwrite will have the same RA number.	15	Number (Integer)
Rev Cd [detail]	Revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [detail]	Dates the services were rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)

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Field	Description	Length	Data Type
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Outpatient Claims Paid - Allowed Amount	Total of the allowed amounts of the Outpatient Claims.	10	Number (Decimal)
Total Outpatient Claims Paid - Billed Amount	Total billed amount of all the Outpatient Claims.	10	Number (Decimal)
Total Outpatient Claims Paid - Co-Pay Amount	Total of all co-pay amounts for the Outpatient Claims.	9	Number (Decimal)
Total Outpatient Claims Paid - Non-Allowed	Total of non-allowed amounts for the outpatient claims paid.	10	Number (Decimal)
Total Outpatient Claims Paid - Paid Amount	Total of all the Outpatient Claims paid.	10	Number (Decimal)
Total Outpatient Claims Paid - Patient Liability	Total of all patient liability amounts for the Outpatient Claims.	10	Number (Decimal)
Total Outpatient Claims Paid - TPL Amount	Total of all TPL amounts for the Outpatient Claims paid.	10	Number (Decimal)
Units [detail]	Units of service rendered.	8	Number (Integer)

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7.29 CRA-OPSU-R -- Remittance Advice - Outpatient Claims In Process

7.29.1 CRA-OPSU-R -- Remittance Advice - Outpatient Claims In Process Narrative

The Remittance Advice - Outpatient Claims In Process report lists Outpatient claims that are in suspense. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the outpatient provider a list of all outpatient claims that are in suspense along with explanations on why they were suspended.

This report is produced during the financial cycle.

7.29.2 CRA-OPSU-R -- Remittance Advice - Outpatient Claims In Process Layout

```
REPORT:   CRA-OPSU-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                       OUTPATIENT CLAIMS IN PROCESS

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                      ISSUE DATE           MM/DD/CCYY

                PAT ACCT NO.                            SERVICE DATES                       BILLED             TPL             PATIENT
    ICN         ATTENDING ID                             FROM   THRU                        AMOUNT           AMOUNT           LIABILITY

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 RRYYJJJBBBSSS  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYY MMDDYY                    9,999,999.99        9,999,999.99       999,999.99
                XXXXXXXXXXXXXXXX
HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

REV CD PROC CODE   MODIFIERS                            SRV DATE  UNITS                  BILLED AMT    DETAIL EOBS
 999    XXXXXX    XX XX XX XX                          MMDDYY  9999999                  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
 999    XXXXXX    XX XX XX XX                          MMDDYY  9999999                  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
 999    XXXXXX    XX XX XX XX                          MMDDYY  9999999                  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
 999    XXXXXX    XX XX XX XX                          MMDDYY  9999999                  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
 999    XXXXXX    XX XX XX XX                          MMDDYY  9999999                  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
                                                                                                      9999 9999 9999 9999 9999 9999 9999 9999
9999 9999
```


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```
TOTAL OUTPATIENT CLAIMS IN PROCESS:                                    99,999,999.99      99,999,999.99     9,999,999.99
```

7.29.3 CRA-OPSU-R -- Remittance Advice - Outpatient Claims In Process Field Descriptions

Field	Description	Length	Data Type
Attending ID [header]	National Provider Identification number of the attending provider.	10	Character
Billed Amount [header]	Dollar amount billed by the provider for the claim.	9	Number (Decimal)
Billed Amt [detail]	Dollar amount billed by the provider for this detail.	9	Number (Decimal0
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Detail EOBS	Explanation of Benefits (EOB) for the details.	4	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) for the header.	4	Number (Integer)
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number on the submitted claim.	50	Character
Name [header]	Name of the recipient.	29	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Proc Code [detail]	These are the procedure codes that correspond to the revenue codes on each of the detail lines being billed.	6	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability [header]	Patient liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Rev Cd [detail]	These are the revenue codes that pertain to the services being billed on the detail lines.	3	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Number (Integer)
Srv Date [detail]	Dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the recipient.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid by sources other than the Alabama Medicaid program being billed for the recipient's services. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Outpatient Claims In Process - Billed Amount	Total of all the Outpatient Claims billed for the provider.	10	Number (Decimal)
Total Outpatient Claims In Process - Patient Liability	Total of all patient liability amounts for the Outpatient Claims.	10	Number (Decimal)
Total Outpatient Claims In Process - TPL Amount	Total of all TPL amounts for the Outpatient Claims In Process.	10	Number (Decimal)

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Field	Description	Length	Data Type
Units [detail]	This shows the units of service rendered. May occur twenty-three times depending on the number of detail lines billed.	8	Number (Integer)

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7.30 CRA-PRAD-R – Remittance Advice – CMS 1500 Claim Adjustments

7.30.1 CRA-PRAD-R – Remittance Advice – CMS 1500 Claim Adjustments Narrative

The Remittance Advice - CMS 1500 Claim Adjustments report lists CMS 1500 claims that were adjusted. The report is separated by individual claims. It displays the header data for the claim being adjusted (Original) and both header and detail data for the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the medical professional provider a list of all CMS 1500 claims that were adjusted along with explanations on why they were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

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7.30.2 CRA-PRAD-R – Remittance Advice – CMS 1500 Claim Adjustments Layout

```
REPORT:   CRA-PHAD-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                        CMS 1500 CLAIM ADJUSTMENTS
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                       NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                       CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                        ISSUE DATE           MM/DD/CCYY


 --ICN--     PAT ACCT NO.                          SERVICE DATES          BILLED       ALLOWED          NON            COPAY
TPL          PAID
                                                    FROM   THRU           AMOUNT        AMOUNT         ALLOWED        AMOUNT
AMOUNT       AMOUNT
NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXXX       MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MMDDYY MMDDYY      (9,999,999.99)   (9,999,999.99) (9,999,999.99)  (9,999,999.99)
(999,999.99)  (9,999,999.99)
RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MMDDYY MMDDYY       9,999,999.99     9,999,999.99   9,999,999.99    9,999,999.99
999,999.99    9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                                    SERVICE DATES  RENDERING          BILLED         ALLOWED      COPAY
POS PROC CD  MODIFIERS   UNITS                       FROM   THRU    PROVIDER          AMOUNT        NON-ALLOWED      TPL          PAID
DETAIL EOBS
XX    XXXXX  XX XX XX XX 9999                      MMDDYY MMDDYY  XXXXXXXXXX      9,999,999.99  9,999,999.99  9,999,999.99 9,999,999.99  9999
9999 9999 9999 9999 9999 9999 9999
                                                                                                  9,999,999.99  9,999,999.99               9999
9999 9999 9999 9999 9999 9999 9999
XX    XXXXX  XX XX XX XX 9999                      MMDDYY MMDDYY  XXXXXXXXXX      9,999,999.99  9,999,999.99  9,999,999.99 9,999,999.99  9999
9999 9999 9999 9999 9999 9999 9999
                                                                                                  9,999,999.99  9,999,999.99               9999
9999 9999 9999 9999 9999 9999 9999
XX    XXXXX  XX XX XX XX 9999                      MMDDYY MMDDYY  XXXXXXXXXX      9,999,999.99  9,999,999.99  9,999,999.99 9,999,999.99  9999
9999 9999 9999 9999 9999 9999 9999
                                                                                                  9,999,999.99  9,999,999.99               9999
9999 9999 9999 9999 9999 9999 9999

                                                                                                  ADDITIONAL PAYMENT           9,999,999.99
                                                                                                  NET OVERPAYMENT (AR)         9,999,999.99
                                                                                                  REFUND AMOUNT APPLIED        9,999,999.99

   TOTAL CMS 1500 ADJUSTMENT CLAIMS:         (99,999,999.99)  (99,999,999.99)  (99,999,999.99) (99,999,999.99) (9,999,999.99)  (99,999,999.99)
                                              99,999,999.99    99,999,999.99    99,999,999.99   99,999,999.99   9,999,999.99    99,999,999.99
```


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7.30.3 CRA-PRAD-R – Remittance Advice – CMS1500 Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Allowed Amount [header]	Computed dollar amount allowable for the services rendered under the Alabama Medicaid program being billed. This amount is arrived at by adding all the allowable amounts for all the services described on the detail lines. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Allowed Amount [detail]	Computed dollar amount allowable for the services rendered under the Alabama Medicaid program for this detail.	9	Number (Decimal)
Billed Amount [detail]	Total dollar amount requested by the provider for the services billed on all the detail lines. This is arrived at by adding all the billed amounts on all the detail lines. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Billed Amount [header]	Total dollar amount requested by the provider for the services billed on this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that was generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	8	Number (Decimal)
Co-Pay [detail]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount on this detail.	8	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to each detail line on the claim form.	4	Character

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Field	Description	Length	Data Type
Header EOBS	Explanation of Benefits (EOB) codes that apply to the header of the claim. These codes are used to explain why the claim was adjusted. There could be a maximum of twenty EOB codes.	4	Character
ICN [header]	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number submitted on the claim. Usually used for tracking purposes.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed [detail]	The computed non-allowed amount for this detail. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
POS [detail]	Place of Service code indicating where the service was rendered. The data displayed pertains to the adjusted claim.	2	Character
Proc Cd [detail]	HCPCS or CPT code used to indicate what services were rendered to the recipient by the provider. The data displayed pertains to the adjusted claim.	5	Character

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Field	Description	Length	Data Type
Paid Amount [header]	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the Third Party Liability (TPL) amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Pat Acct No. [header]	Patient account number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Character
Refund Amount Applied	Calculated amount if daughter pays less tan the mother on Cash related adjustment.	9	Number (Decimal)
Rendering Provider [detail]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Character
Service Dates – From [header]	The earliest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)

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Field	Description	Length	Data Type
Service Dates – Thru [header]	The latest date of service on all the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	6	Date (MM/DD/YY)
Service Dates – From [detail]	The earliest date of service on the detail line of the adjusted claim.	6	Date (MM/DD/YY)
Service Dates – Thru [detail]	The latest date of service on the detail line of the adjusted claim.	6	Date (MM/DD/YY)
TPL Amount [header]	Dollar amount paid for the services by any source outside of the Alabama Medicaid program that is being billed. If present, this amount is subtracted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Total CMS 1500 Claims Adj Paid - Allowed Amount	Allowed amount total of all the CMS 1500 Claims Adjustments Paid. Subtract the total daughter allowed amounts from the total mother allowed amounts.	10	Number (Decimal)
Total CMS 1500 Claims Adj Paid - Billed Amount	Total billed amount of all the CMS 1500 Claims. Subtract the total daughter billed amounts from the total mother billed amounts.	10	Number (Decimal)
Total CMS 1500 Claims Adj Paid - Co-Pay Amount	Total of Co-pay amounts for all the CMS 1500 Claims Adjustments Paid. Subtract the total daughter copay amounts from the total mother copay amounts.	9	Number (Decimal)
Total CMS 1500 Claims Adj Paid - Non-Allowed	Total of non-allowed amounts for the CMS 1500 adjusted claims. Subtract the total daughter non-allowed amounts from the total mother non-allowed amounts.	10	Number (Decimal)
Total CMS 1500 Claims Adj Paid - Paid Amount	Total of all the CMS Claims Adjustments Paid. Subtract the total daughter paid amounts from the total mother paid amounts.	10	Number (Decimal)
Total CMS 1500 Claims Adj Paid - TPL Amount	Total of all Third Party (TPL) payment amounts for the CMS 1500 Claims Adjustments Paid. Subtract the total daughter TPL amounts from the total mother TPL amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Units [detail]	Units of service being billed on each detail line. The data displayed pertains to the adjusted claim.	6	Number (Integer)

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7.31 CRA-PRDN-R -- Remittance Advice - CMS 1500 Claims Denied

7.31.1 CRA-PRDN-R -- Remittance Advice - CMS 1500 Claims Denied Narrative

The Remittance Advice - CMS 1500 Claims Denied report lists CMS 1500 claims that were denied. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the medical professional provider a list of all CMS 1500 claims that were denied along with explanations on why they were denied.

This report is produced during the financial cycle.

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7.31.2 CRA-PRDN-R -- Remittance Advice - CMS 1500 Claims Denied Layout

```
REPORT:   CRA-PHDN-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                          CMS 1500 CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY


         --ICN--         PAT ACCT NO.                           SERVICE DATES                                BILLED
TPL
                                                                FROM   THRU                                  AMOUNT          COPAY
AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: XXXXXXXXXXXXXX       MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
          RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999 999999                                 9,999,999.99    9,999,999.99
9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                  SERVICE DATES  RENDERING             BILLED
 POS  PROC CD  MODIFIERS   UNITS    FROM   THRU   PROVIDER             AMOUNT       COPAY        DETAIL EOBS
  XX   XXXXXX  XX XX XX XX 9999   999999 999999    XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
  XX   XXXXXX  XX XX XX XX 9999   999999 999999    XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
  XX   XXXXXX  XX XX XX XX 9999   999999 999999    XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
  XX   XXXXXX  XX XX XX XX 9999   999999 999999    XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999 9999
9999
```

TOTAL CMS 1500 CLAIMS DENIED: 99,999,999.99 99,999,999.99 99,999,999.99

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7.31.3 CRA-PRDN-R -- Remittance Advice - CMS 1500 Claims Denied Field Descriptions

Field	Description	Length	Data Type
Billed Amount [header]	Total dollar amount requested by the provider for the services billed on all the detail lines. This is arrived at by adding all the billed amounts on all the detail lines.	9	Number (Decimal)
Billed Amount [detail]	Total dollar amount requested by the provider for the services billed on this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT generated.	9	Number (Integer)
Copay [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount for the claim.	9	Number (Decimal)
Copay [detail]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount for this detail.	9	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to each detail line on the claim form.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Character
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
Medical Record Number [header]	Medical Record Number assigned by the provider for tracking purposes.	15	Number (Integer)
Modifiers[detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
MRN	Medical Record Number Submitted on the claim, used for tracking purpose.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
POS [detail]	Place of Service code indicating where the services were rendered.	2	Character

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Field	Description	Length	Data Type
Proc Cd [detail]	HCPCS or CPT used to indicate what services were rendered to the recipient by the provider.	5	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Character
Rendering Provider [detail]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Character
Service Dates – From [detail]	The earliest date of service on the detail line.	6	Date (MM/DD/YY)
Service Dates – Thru [detail]	The latest date of service on the detail line.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount [header]	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total CMS 1500 Claims Denied – Billed Amount	Total billed amount of all the CMS 1500 Claims.	10	Number (Decimal)
Total CMS 1500 Claims Denied – Copay	Total amount of co-pay for all the CMS 1500 claims.	10	Number (Decimal)
Total CMS 1500 Claims Denied – TPL Amount	Total of all Third Party (TPL) payment amounts for the CMS 1500 Claims Denied.	10	Number (Decimal)
Units [detail]	Units of service being billed on each detail line.	4	Number (Integer)

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7.32 CRA-PRPD-R – Remittance Advice – CMS 1500 Claims Paid

7.32.1 CRA-PRPD-R – Remittance Advice – CMS 1500 Claims Paid Narrative

The Remittance Advice - CMS 1500 Claims Paid report lists CMS 1500 claims that were paid. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the medical professional provider a list of all CMS 1500 claims that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

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7.32.2 CRA-PRPD-R – Remittance Advice – CMS 1500 Claims Paid Layout

```
REPORT:   CRA-PRPD-R                                  ALABAMA MEDICAID AGENCY                                    DATE:   MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                         PAGE:        9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                         CMS 1500 CLAIMS PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                   ISSUE DATE           MM/DD/CCYY


     --ICN--  PAT ACCT NO. SERVICE DATES           BILLED       ALLOWED           NON           COPAY              TPL            PAID
                           FROM    THRU            AMOUNT        AMOUNT          ALLOWED        AMOUNT            AMOUNT         AMOUNT
NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXXX    MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXRRYYJJJBBBSSS
XXXXXXXXXXXX MMDDYY MMDDYY       9,999,999.99     9,999,999.99   9,999,999.99    9,999,999.99     999,999.99     9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                   SERVICE DATES  RENDERING       BILLED     ALLOWED     COPAY
 POS   PROC CD  MODIFIERS   UNITS   FROM     THRU  PROVIDER        AMOUNT    NON-ALLOWED   TPL        PAID          DETAIL EOBS
XX   XXXXX  XX XX XX XX  9999    MMDDYY  MMDDYY XXXXXXXXXX  9,999,999.99 9,999,999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99  9,999,999.99
XX   XXXXX  XX XX XX XX  9999    MMDDYY  MMDDYY XXXXXXXXXX  9,999,999.99 9,999,999.99  9,999,999.99 9,999,999.99  9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99  9,999,999.99

    TOTAL CMS 1500 CLAIMS PAID               99,999,999.99    99,999,999.99  99,999,999.99   99,999,999.99   9,999,999.99    99,999,999.99
```

7.32.3 CRA-PRPD-R – Remittance Advice – CMS 1500 Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amount [header]	Computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. This amount is arrived at by adding all the allowable amounts for all the services described on the detail lines.	9	Number (Decimal)
Allowed Amount [detail]	Computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed for this detail.	9	Number (Decimal)
Billed Amount [header]	Total dollar amount requested by the provider for the services billed on all the detail lines. This is arrived at by adding all the billed amounts on all the detail lines.	9	Number (Decimal)
Billed Amount [detail]	Total dollar amount requested by the provider for the services billed on this detail line.	9	Number (Decimal)

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Field	Description	Length	Data Type
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amount [header]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Copay [detail]	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount for this detail.	4	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to each detail line on the claim form.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Character
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number assigned by the provider for tracking purposes.	50	Character
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
Non-Allowed [detail]	The computed non-allowed amount for this detail. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Non-Allowed [header]	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
POS [detail]	Place of Service code indicating where the service was rendered.	2	Character
Proc Cd [detail]	HCPCS or CPT code used to indicate what services were rendered to the recipient by the provider.	5	Character

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Field	Description	Length	Data Type
Paid Amount [header]	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the Third Party (TPL) amount.	9	Number (Decimal)
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID [header]	Medicaid Identification number of the recipient.	13	Character
Rendering Provider [detail]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Character
Service Dates – From [detail]	The earliest date of service on the detail line.	6	Date (MM/DD/YY)
Service Dates – Thru [detail]	The latest date of service on the detail line.	6	Date (MM/DD/YY)
Service Dates – From [header]	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates – Thru [header]	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)

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Field	Description	Length	Data Type
TPL Amount [header]	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
TPL: Amount [detail]	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total CMS 1500 Claims Paid - Allowed Amount	Total allowed amount of all the CMS 1500 Claims Paid.	10	Number (Decimal)
Total CMS 1500 Claims Paid - Billed Amount	Total billed amount of all the CMS 1500 Claims.	10	Number (Decimal)
Total CMS 1500 Claims Paid - Co-Pay Amount	Total of Co-pay amounts for all the CMS 1500 Claims Paid.	9	Number (Decimal)
Total CMS 1500 Claims Paid - Non-Allowed	Total of non-allowed amount for the CMS 1500 Claims paid.	10	Number (Decimal)
Total CMS 1500 Claims Paid - Paid Amount	Total of all the CMS 1500 Claims Paid.	10	Number (Decimal)
Total CMS 1500 Claims Paid - TPL Amount	Total of all TPL amounts for the CMS 1500 Claims Paid.	10	Number (Decimal)
Units [detail]	Units of service being billed on each detail line.	6	Number (Integer)

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7.33 CRA-PRSU-R -- Remittance Advice - CMS 1500 Claims In Process

7.33.1 CRA-PRSU-R -- Remittance Advice - CMS 1500 Claims In Process Narrative

The Remittance Advice - CMS 1500 Claims In Process report lists CMS 1500 claims that are in suspense. The report is separated by individual claims and displays both header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the medical professional provider a list of all CMS 1500 claims that are in suspense along with explanations on why they were suspended.

This report is produced during the financial cycle.

7.33.2 CRA-PRSU-R -- Remittance Advice - CMS 1500 Claims In Process Layout

```
REPORT:   CRA-PHSU-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                        CMS 1500 CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

              --ICN--     PAT ACCT NO.                          SERVICE DATES                        BILLED                                TPL
                                                                 FROM   THRU                         AMOUNT       COPAY
AMOUNT

NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RECIPIENT ID: 999999999999   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            RRYYJJJBBBSSS XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MMDDYY MMDDYY                    9,999,999.99     9,999,999.99
9,999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                                  SERVICE DATES RENDERING            BILLED
 POS    PROC CD  MODIFIERS   UNITS  FROM   THRU   PROVIDER             AMOUNT        COPAY       DETAIL EOBS
  XX     XXXXXX  XX XX XX XX 9999   MMDDYY MMDDYY  XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999   MMDDYY MMDDYY  XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999   MMDDYY MMDDYY  XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
  XX     XXXXXX  XX XX XX XX 9999   MMDDYY MMDDYY  XXXXXXXXXX        9,999,999.99  9,999,999.99   9999 9999 9999 9999 9999 9999 9999 9999
                                                                                                   9999 9999 9999 9999 9999 9999 9999 9999
                           TOTAL  CMS 1500 CLAIMS IN PROCESS:         99,999,999.99    99,999,999.99          99,999,999.99
```


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7.33.3 CRA-PRSU-R -- Remittance Advice - CMS 1500 Claims In Process Field Descriptions

Field	Description	Length	Data Type
Billed Amount [header]	Total dollar amount requested by the provider for the services billed on all the detail lines. This is arrived at by adding all the billed amounts on all the detail lines.	9	Number (Decimal)
Billed Amount [detail]	Total dollar amount requested by the provider for the services billed on this detail.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Copay [header]	Total dollar amount of copay for claim.	9	Number (Decimal)
Copay [detail]	Total dollar amount of copay for detail.	9	Number (Decimal)
Detail EOBS	Explanation of Benefits (EOB) codes that apply to each detail line on the claim form.	4	Character
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim. These codes are used to explain how the claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Character
ICN [header]	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim used for tracking purpose.	50	Character
Modifiers [detail]	Modifiers used to further describe the service rendered. Up to four modifiers may be displayed on each detail line.	2	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name [header]	Name of the recipient.	29	Character
POS [detail]	Place of service code indicating where the service was rendered.	2	Character

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Field	Description	Length	Data Type
Proc Cd [detail]	HCPCS or CPT code used to indicate what services were rendered to the recipient by the provider.	5	Character
Pat Acct No. [header]	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	12	Character
Rendering Provider [detail]	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Character
Service Dates - From	The earliest date of service on all the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service on all the detail lines.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total CMS 1500 Claims In Process - Billed Amount	Total billed amount of all the CMS 1500 Claims In Process.	10	Number (Decimal)
Total CMS 1500 Claims In Process – Copay	Total copay of all the CMS 1500 Claims In Process	10	Number (Decimal)

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Field	Description	Length	Data Type
Total CMS 1500 Claims In Process - TPL Amount	Total of all Third Party (TPL) payment amounts for the CMS 1500 Claims In Process.	10	Number (Decimal)
Units	Units of service being billed on each detail line.	6	Number (Integer)

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7.34 CRA-SUMM-R -- Remittance Advice Summary

7.34.1 CRA-SUMM-R -- Remittance Advice Summary Narrative

The Remittance Advice Summary is generated each claims payment cycle. Its purpose is to summarize all claim and financial activity for a each financial cycle and to report year-to-date totals of all claim and financial activity.

This report is produced during the financial cycle.

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7.34.2 CRA-SUMM-R -- Remittance Advice Summary Layout

```
REPORT:   CRA-SUMM-R                                  ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE:  9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                       REMITTANCE ADVICE SUMMARY

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

                                                 -------------------------CLAIMS DATA--------------------------

                                                 CURRENT             CURRENT      YEAR-TO-DATE      YEAR-TO-DATE
                                                  NUMBER              AMOUNT          NUMBER           AMOUNT
          CLAIMS PAID                            999,999       99,999,999.99        9,999,999     999,999,999.99
          CLAIM ADJUSTMENTS                      999,999       99,999,999.99        9,999,999     999,999,999.99
             TOTAL CLAIMS PAYMENTS               999,999       99,999,999.99        9,999,999     999,999,999.99
          CLAIMS DENIED                          999,999                            9,999,999
          CLAIMS IN PROCESS                      999,999                            9,999,999

                                                      -----------------------EARNINGS DATA-----------------------
          PAYMENTS:
             CLAIMS PAYMENTS                                 99,999,999.99                      999,999,999.99

             CAPITATION PAYMENT†                             99,999,999.99                      999,999,999.99
             PAYOUTS                                         99,999,999.99                      999,999,999.99
             ACCOUNTS RECEIVABLE:
                CLAIM SPECIFIC:
                   CURRENT CYCLE                           (99,999,999.99)                    (999,999,999.99)
                   OUTSTANDING FROM PREVIOUS CYCLES        (99,999,999.99)                    (999,999,999.99)
                NON-CLAIM SPECIFIC                         (99,999,999.99)                    (999,999,999.99)

      NET PAYMENT**                                        99,999,999.99                      999,999,999.99

        REFUNDS:
          CLAIM SPECIFIC ADJUSTMENTS REFUNDS              (99,999,999,99)                    (999,999,999,99)
          NON-CLAIM SPECIFIC REFUNDS                      (99,999,999,99)                    (999,999,999,99)

       OTHER FINANCIAL:
           OTHER PAYOUTS                                   99,999,999.99                      999,999,999.99
           VOIDS                                          (99,999,999.99)                    (999,999,999.99)
           DEDUCTIONS THIS CYCLE                           99,999,999.99

       NET EARNINGS                                        99,999,999.99                      999,999,999.99
                                      -----CURRENT DEDUCTIONS------
                                LIEN HOLDER NAME/TYPE                                 DEDUCTION AMOUNT
                                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       99,999,999.99
** NET PAYMENT AMOUNT HAS BEEN REDUCED DUE TO DEDUCTIONS.  PLEASE SEE 'CURRENT DEDUCTIONS' FOR DETAILS.

† THIS AMOUNT MAY INCLUDE CAPITATION, CASE MANAGEMENT PAYMENTS.  PLEASE REFER TO YOUR ROSTER.
  PLEASE REFER TO YOUR ROSTER FOR ADDITIONAL DETAIL.
```

7.34.3 CRA-SUMM-R -- Remittance Advice Summary Field Descriptions

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Field	Description	Length	Data Type
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Claims Data - Current Amount - Claim Adjustments	The total net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments which result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the Remittance Advice.	10	Number (Decimal)
Claims Data - Current Amount - Claims Paid	The total dollar amount of the claims paid during the current financial cycle.	10	Number (Decimal)
Claims Data - Current Amount - Total Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized during the current financial cycle.	10	Number (Decimal)
Claims Data - Current Number - Claim Adjustments	The total net dollar amount of all positive adjustments finalized during the current financial cycle. Negative adjustments which result in an A/R are reported below in the offsets section. Refund adjustments are reported in the Refunds section of the Remittance Advice.	6	Number (Decimal)
Claims Data - Current Number - Claims Denied	The total number of claims denied during the current financial cycle.	6	Number (Integer)
Claims Data - Current Number - Claims Paid	The total number of claims paid during the current financial cycle.	6	Number (Integer)
Claims Data - Current Number - Claims in Process	The total number of claims in process during the current financial cycle.	6	Number (Integer)
Claims Data - Current Number - Total Claims Payments	The total number of claims paid and adjustments finalized during the current financial cycle.	6	Number (Integer)
Claims Data - Y-T-D Amount - Claims Adjustments	The total net dollar amount of all positive adjustments finalized year to date Negative adjustments and Refund adjustments are reported elsewhere on the Remittance Advice.	10	Number (Decimal)

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Field	Description	Length	Data Type
Claims Data - Y-T-D Amount - Claims Paid	The total dollar amount of claims paid year to date.	10	Number (Decimal)
Claims Data - Y-T-D Amount - Total Claims Payments	The total dollar amount of all claims paid and the net dollar amount of all positive adjustments finalized year to date.	10	Number (Decimal)
Claims Data - Y-T-D Number - Claims Adjustments	The total number of adjustments finalized year to date.	7	Number (Integer)
Claims Data - Y-T-D Number - Claims Denied	The total number of claims denied year to date.	7	Number (Integer)
Claims Data - Y-T-D Number - Claims In Process	The total number of claims in process year to date.	7	Number (Integer)
Claims Data - Y-T-D Number - Claims Paid	The total number of claims paid year to date.	7	Number (Integer)
Claims Data - Y-T-D Number - Total Claims Payments	The total number of claims paid and adjustments finalized year to date.	7	Number (Integer)
Earnings Data - Current Amount Accounts Receivable Claim Specific Current Cycle	The total dollar amount of all Claim Specific Accounts Receivables established during the current financial cycle.	10	Number (Decimal)
Earnings Data - Current Amount Capitation Payment+	The total dollar amount of the Capitation Payment for the current month. This dollar amount will only be reported on the first financial cycle of every month. In addition, this number will be reported on the Remittance Advice only for those provider's who have received Capitation Payments during the financial cycle.	10	Number (Decimal)
Earnings Data - Current Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claim specific refunds received and applied during the current financial cycle.	10	Number (Decimal)
Earnings Data - Current Amount Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized from the current financial cycle. This number is propagated from the Total Claims Payments field of the Claims Data section.	10	Number (Decimal)

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Field	Description	Length	Data Type
Earnings Data – Current Amount Deductions This Cycle	The total dollar amount of deductions this cycle. Details appear at the bottom of the Summary page.	10	Number (Decimal)
Earnings Data - Current Amount Net Earnings	Calculates the net earnings for the current financial cycle. Calculation is as follows: Payments and manual payouts less offsets, refunds and voids.	9	Number (Decimal)
Earnings Data - Current Amount Net Payment	The sum of all claims payments less any offsets for the current financial cycle. If there is a double asterisk (**) after NET PAYMENT, a message will appear at the bottom of the Summary page detailing items that affected the net payment. **This amount will equal the provider's financial cycle payment and the provider's check write.**	9	Number (Decimal)
Earnings Data - Current Amount Non Claim Specific	The total dollar amount of all non-claim specific accounts receivables established during the current financial cycle.	9	Number (Decimal)
Earnings Data - Current Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied during the current weekly financial cycle.	9	Number (Decimal)
Earnings Data - Current Amount Other Payouts	Other payouts entered into the system during the current financial cycle. This only includes those checks which were issued outside the system through a manual checkwrite versus a system payout which is issued through the system.	10	Number (Decimal)
Earnings Data - Current Amount Outstanding A/R from Prev Cycles	The total dollar amount of all claim specific Accounts Receivables established in previous cycles which have not been satisfied.	9	Number (Decimal)
Earnings Data - Current Amount System Payouts (Non Claim Specific)	The total dollar amount of all non-claim specific payouts made to the provider for the current financial cycle.	9	Number (Decimal)
Earnings Data - Current Amount Voids	The total dollar amount of all EDS issued checks which were voided during the current financial cycle.	9	Number (Decimal)

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Field	Description	Length	Data Type
Earnings Data - Y-T-D Amount Accounts Receivable Claim Specific	The total dollar amount of all current cycle claim specific Accounts Receivables established year to date. This will be equal to the current cycle amount. Accumulated year to date totals for claims specific offsets will be reported in the previous cycle A/R year to date field.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Capitation Payment	The total dollar amount of the Capitation Payment year to date. This number will be reported on the Remittance Advice only for those providers who have received admin payments during the current year.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Claim Specific Adjustment Refunds	The sum dollar amount of all claims specific refunds received and applied year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Claims Payments	The total dollar amount of all claims paid and positive adjustments finalized year to date. This number is propagated from the Total Claims Payment field of the Claims Data section.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Net Earnings	Calculates the net earnings year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Net Payment	The sum of all claims payments less any offsets year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Non Claim Specific Refunds	The sum dollar amount of all non-claim specific refunds received and applied year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Non-Claim Specific	The total dollar amount of all non-claim specific Accounts Receivables established year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Other Payouts (Non Claim Specific)	Other payouts issued year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Outstanding A/R from Prev Cycles	The total dollar amount of all claim specific Accounts Receivables established year to date.	10	Number (Decimal)

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Field	Description	Length	Data Type
Earnings Data - Y-T-D Amount System Payouts	The total dollar amount of all non-claim specific payouts made to the provider year to date.	10	Number (Decimal)
Earnings Data - Y-T-D Amount Voids	The total dollar amount of all voids for year.	10	Number (Decimal)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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7.35 CRA-TPLM-R -- Remittance Advice - TPL Information

7.35.1 CRA-TPLM-R -- Remittance Advice - TPL Information Narrative

The Remittance Advice - TPL Information report lists Third Party Liability (TPL) information pertinent to claims processed during the current financial cycle. The purpose of this report is to give the provider a listing of all TPL carriers pertinent to the recipients to whom services were rendered. This report provides information necessary for billing a third party carrier on claims denied for failing TPL edits.

This report is produced during the financial cycle.

7.35.2 CRA-TPLP-R -- Remittance Advice - TPL Information Layout

```
REPORT:   CRA-TPLM-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                             TPL INFORMATION


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                      CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

NAME                              RECIPIENT ID      --ICN--            CARRIER/EMP ID      CARRIER/EMPLOYER NAME
POLICY HOLDER NAME                POLICY NUMBER  /  GROUP NUMBER       BILLING ADDRESS

XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXX   RRYYJJJBBBSSS        XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX/XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXX   RRYYJJJBBBSSS        XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX/XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXX   RRYYJJJBBBSSS        XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX/XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXX   RRYYJJJBBBSSS        XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX/XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX, XX  XXXXX-XXXX

XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXX   RRYYJJJBBBSSS        XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX X XXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX/XXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX, XX  XXXXX-XXXX
```


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7.35.3 CRA-TPLM-R -- Remittance Advice - TPL Information Field Descriptions

Field	Description	Length	Data Type
Billing Address	The address where insurance claims are to be sent to bill the other insurance carrier. This includes the street address, city, state and nine-digit zip code.	80	Character
Carrier/Emp Id	Number assigned to the recipient's insurance carrier or employer, if the employer is self insured.	7	Character
Carrier/Employer Name	The name of the insurance carrier, or the name of the recipient's employer if the employer is self-insured.	45	Character
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Group Number	This is the number assigned to the employer group insured under the other insurance carrier. The group number does not apply to non-employer based policies.	16	Character
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient: First, Middle Initial, and Last.	29	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Policy Holder Name	The name of the owner of the insurance policy under which the recipient could be covered. This may or may not be the recipient.	29	Character
Policy Number	The individual identification number assigned to the policyholder by the private insurance carrier.	16	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character

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Field	Description	Length	Data Type
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)

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7.36 CRA-TRAN-R -- Remittance Advice - Financial Transactions

7.36.1 CRA-TRAN-R -- Remittance Advice - Financial Transactions Narrative

The Remittance Advice – Financial Transactions report details the provider's financial activity for both payouts and non-claim specific refunds received and applied during the current financial cycle. In addition, it lists all outstanding Accounts Receivables (A/R) in A/R number order. The purpose is to give the providers a full accounting of their financial activity. In addition, it informs the providers of all their outstanding accounts receivables.

This report is produced during the financial cycle.

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7.36.2 CRA-TRAN-R -- Remittance Advice - Financial Transactions Layout

```
REPORT:   CRA-TRAN-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:      9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                          FINANCIAL TRANSACTIONS
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                    ISSUE DATE           MM/DD/CCYY

                            ---------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS---------------
   TRANSACTION                 PAYOUT    REASON     REASON CODE
     NUMBER       --CCN--       AMOUNT     CODE      DESCRIPTION

   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   99999999999  99999999999   9,999,999.99  9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

                            ---------------REFUNDS FROM PROVIDERS-----------------------
                     REFUND     REASON     REASON CODE
      --CCN--        AMOUNT      CODE      DESCRIPTION

    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    99999999999   9,999,999.99   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           NO REFUNDS FROM PROVIDERS

                        ----------------------------ACCOUNTS RECEIVABLE-----------------
      A/R          SETUP    RECOUPED      ORIGINAL        TOTAL                   REASON     REASON CODE
   NUMBER/ICN      DATE    THIS CYCLE      AMOUNT      -RECOUPED-    --BALANCE--    CODE      DESCRIPTION

   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
   XXXXXXXXXXXXX  MMDDYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99   9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            NO OUTSTANDING ACCOUNTS RECEIVABLE
```

7.36.3 CRA-TRAN-R -- Remittance Advice - Financial Transactions Field Descriptions

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Field	Description	Length	Data Type
A/R Number / ICN	The unique identifying Accounts Receivable number assigned during processing.	13	Character
Balance	Account Receivable balance remaining after the current financial cycle processes.	9	Number (Decimal)
CCN	Cash Control Number assigned to the cash receipt. This is used when a provider has refunded the Alabama Medicaid Agency in error or has over refunded the Alabama Medicaid Agency. For expenditures, if an expenditure is tied to a cash receipt then this field contains the corresponding CCN for the cash receipt otherwise it remains blank.	11	Number (Integer)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT generated.	9	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer was issued.	10	Date (MM/DD/CCYY)
NPI ID	National Provider Identification number of payee.	10	Number (Integer)
Original Amount	Amount of the original Accounts Receivable (A/R) setup.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
Payout Amount	Amount of the payout transaction.	9	Number (Decimal)
RA #	The system assigned number for the remittance advice. .	10	Number (Integer)
Reason Code (A/R)	Reason code which identifies the type and reason the Accounts Receivable (A/R) is established. This also generates an Explanation of Benefits (EOB) code which gives a brief explanation of the A/R transaction.	4	Character

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Field	Description	Length	Data Type
Reason Code (Payout)	Reason code assigned to indicate why the payout/refund action is taken. This also generates an associated Explanation of Benefits (EOB) code which gives a brief explanation of why the payout is issued.	4	Character
Reason Code (Refund)	Reason the non-claim specific refund transaction was performed. This also generates an associated Explanation of Benefits (EOB) code which gives a brief description of the action taken.	4	Character
Reason Code Description (A/R)	Gives a brief explanation of the A/R transaction.	50	Character
Reason Code Description (Payout)	Gives a brief explanation of why the Payout is issued.	50	Character
Reason Code Description (Refund)	Gives a brief explanation of the Refund.	50	Character
Recouped this Cycle	Dollar amount recouped this financial cycle.	9	Number (Decimal)
Refund Amount	The non-claim specific refund amount.	9	Number (Decimal)
Setup Date	Date of the original Accounts Receivable (A/R) setup.	6	Date (MM/DD/YY)
Total Recouped	Total dollar amount recouped this cycle for the AR.	9	Number (Decimal)
Transaction Number	The number assigned by the system to uniquely identify the payout transaction.	11	Number (Integer)

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7.37 CRA-XAAD-R -- Remittance Advice - Medicare Crossover Part A Claim Adjustments

7.37.1 CRA-XAAD-R -- Remittance Advice - Medicare Crossover Part A Claim Adjustments Narrative

The Remittance Advice - Medicare Crossover Part A Claim Adjustments report lists Medicare Crossover Part A claims that were adjusted. The report is separated by individual claims. It displays the header data for both the claims being adjusted (Original) and the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part A claims that were adjusted along with explanations on why they were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

This report is produced during the financial cycle.

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7.37.2 CRA-XAAD-R -- Remittance Advice - Medicare Crossover Part A Claim Adjustments Layout

```
REPORT:   CRA-XAAD-R                                ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                            MEDICAID MANAGEMENT INFORMATION SYSTEM                         PAGE:       9,999
                                                     PROVIDER REMITTANCE ADVICE
                                             MEDICARE CROSSOVER PART A CLAIM ADJUSTMENTS


XXXX
```

Field	Description	Length	Data Type
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim used for tracking purpose.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Net Overpayment (AR)	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amount	Dollar amount that is payable for the hospitalization stay.	9	Number (Decimal)
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Pat Liability	Patient Liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character

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Field	Description	Length	Data Type
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Refund Amount Applied	Calculated amount if the daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Service Dates - From	The earliest date of service or the admit date.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service or discharge date.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part A Claim Adjustments - Allowed Amt	Total of allowed amounts for the Medicare Crossover Part A Claim Adjustments. Subtract total daughter allowed amounts from total mother allowed amounts.	9	Number (Decimal)
Total Medicare Crossover Part A Claim Adjustments - Billed Amt	Total billed amount of the Medicare Crossover Part A Claims. Subtract total daughter billed amounts from total mother billed amounts.	10	Number (Decimal)
Total Medicare Crossover Part A Claim Adjustments - Co-Pay	Total of all co-pay amounts for the Medicare Crossover Part A Claim Adjustments. Subtract total daughter copay amounts from total mother copay amounts.	9	Number (Decimal)
Total Medicare Crossover Part A Claim Adjustments - Paid Amt	Total of all the Medicare Crossover Part A Claim Adjustments. Subtract total daughter paid amounts from total mother paid amounts.	10	Number (Decimal)
Total Medicare Crossover Part A Claim Adjustments - TPL Amt	Total of all TPL amounts for the Medicare Crossover Part A Claim Adjustments. Subtract total daughter TPL amounts from total mother TPL amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicare Crossover Part A Claim Adjustments - Non-Allowed	Total of non-allowed amount for the Part A adjusted claims. Subtract total daughter non-allowed amounts from total mother non-allowed amounts.	10	Number (Decimal)

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7.38 CRA-XADN-R -- Remittance Advice - Medicare Crossover Part A Claims Denied

7.38.1 CRA-XADN-R -- Remittance Advice - Medicare Crossover Part A Claims Denied Narrative

The Remittance Advice - Medicare Crossover Part A Claims Denied report lists Medicare Crossover Part A claims that were denied. Part A crossover claims consist of inpatient, home health, and extended care claims. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part A claims that denied along with the explanations of benefits explaining the reason for denial.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.38.2 CRA-XADN-R – Remittance Advice – Medicare Crossover Part A Claims Denied Layout

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REPORT:   CRA-XADN-R                                    ALABAMA MEDICAID AGENCY                                        DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                            PAGE:       9,999
                                                         PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART A CLAIMS DENIED


XXXX
```

7.38.3 CRA-XADN-R – Remittance Advice – Medicare Crossover Part A Claims Denied Field Descriptions

Field	Description	Length	Data Type
Admit Date	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Allowed Amount	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amount	Dollar amount billed by the provider for the hospitalization stay.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer Payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amount	Dollar amount that the recipient should pay on the claim.	9	Number (Decimal)
Days	Number of days the recipient was in the hospital.	3	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability	The amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character

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Field	Description	Length	Data Type
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Service Dates - From	The earliest date of service or the admit date.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service or discharge date.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part A Claims Denied – Allowed Amount	Total of all allowed amounts for the Medicare Crossover Part A Claims Denied.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Denied - Billed Amount	Total billed amount of all the Medicare Crossover Part A Claims.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Denied – Co-Pay Amount	Total of all co-ins amounts for the Medicare Crossover Part A Claims Denied.	9	Number (Decimal)
Total Medicare Crossover Part A Claims Denied - TPL Amount	Total of all TPL amounts for the Medicare Crossover Part A Claims Denied.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Denied - Patient Liability	Total of all Patient Liability amounts for the Medicare Crossover Part A Claims Denied.	9	Number (Decimal)

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7.39 CRA-XAPD-R -- Remittance Advice - Medicare Crossover Part A Claims Paid

7.39.1 CRA-XAPD-R -- Remittance Advice - Medicare Crossover Part A Claims Paid Narrative

The Remittance Advice - Medicare Crossover Part A Claims Paid report lists Medicare Crossover Part A claims that were paid. Part A Crossover claims consist of inpatient, home health, and extended care claims. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part A claims that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.39.2 CRA-XAPD-R -- Remittance Advice - Medicare Crossover Part A Claims Paid Layout

```
REPORT:   CRA-XAPD-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                         PROVIDER REMITTANCE ADVICE
                                                    MEDICARE CROSSOVER PART A CLAIMS PAID
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                       NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                       CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                      ISSUE DATE           MM/DD/CCYY

          --ICN--    SERVICE DATES      ADMIT          PATIENT       CO-PAY      ALLOWED AMT      BILLED          TPL           PAID
         PAT ACCT NO. FROM   THRU  DAYS DATE          LIABILITY      AMOUNT      NON ALLOWED      AMOUNT         AMOUNT        AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
       RRYYJJJBBBSSS MMDDYY MMDDYY 999 MMDDYY         999,999.99    999,999.99    9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX
       RRYYJJJBBBSSS MMDDYY MMDDYY 999 MMDDYY         999,999.99    999,999.99    9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                    9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

     TOTAL MEDICARE CROSSOVER PART A CLAIMS PAID:   9,999,999.99  9,999,999.99   99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99
                                                                                  99,999,999.99
```


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7.39.3 CRA-XAPD-R -- Remittance Advice - Medicare Crossover Part A Claims Paid Field Descriptions

Field	Description	Length	Data Type
Admit Date	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Allowed Amt	Computed dollar amount allowable for the services rendered.	8	Number (Decimal)
Billed Amount	Dollar amount billed by the provider for the hospitalization stay.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amount	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Days	Number of days the recipient was in the hospital.	3	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amount	Dollar amount that is payable for the hospitalization stay.	9	Number (Decimal)

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Field	Description	Length	Data Type
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability	Patient Liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Character
Service Dates - From	The earliest date of service or the admit date.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service or discharge date.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - Allowed Amt	Total of all allowed amounts for the Medicare Crossover Part A Claims paid.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - Billed Amount	Total billed amount of the Medicare Crossover Part A Claims.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - Co-Pay Amount	Total of all Co-Pay amounts for the Medicare Crossover Part A Claims paid, for the provider.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicare Crossover Part A Claims Paid - Paid Amount	Total of all the Medicare Crossover Part A Claims paid.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - TPL Amount	Total of all TPL amounts for the Medicare Crossover Part A Claims paid.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - Non-Allowed	Total of non-allowed amounts for the Part A claims paid.	10	Number (Decimal)
Total Medicare Crossover Part A Claims Paid - Patient Liability	Total amount of patient liability amounts for the Inpatient Crossover Part A claims.	10	Number (Decimal)

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7.40 CRA-XASU-R -- Remittance Advice - Medicare Crossover Part A Claims in Process

7.40.1 CRA-XASU-R -- Remittance Advice - Medicare Crossover Part A Claims in Process Narrative

The Remittance Advice - Medicare Crossover Part A Claims in Process report lists Medicare Crossover Part A claims that are in process. Part A crossover claims consist of inpatient, home health, and extended care claims. The report is separated by individual claims and displays header and detail data. The purpose of this report is to give the provider a list of all Medicare Crossover Part A claims that are in process. The "in process" claims are also included on the remittance advice to help decrease the amount of duplicate claims submitted by the provider.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.40.2 CRA-XASU-R -- Remittance Advice - Medicare Crossover Part A Claims in Process Layout

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REPORT:   CRA-XASU-R                                    ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                         PAGE:       9,999
                                                         PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART A CLAIMS IN PROCESS


XXXX
```

7.40.3 CRA-XASU-R -- Remittance Advice - Medicare Crossover Part A Claims in Process Field Descriptions

Field	Description	Length	Data Type
Admit Date	Date the recipient was admitted into the hospital.	6	Date (MM/DD/YY)
Billed Amount	Dollar amount billed by the provider for the hospitalization stay.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-pay Amount	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Days	Number of days the recipient was in the hospital.	3	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Patient Liability	Patient Liability amount that the recipient is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	9	Number (Decimal
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Service Dates - From	The earliest date of service or the admit date.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service or discharge date.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part A Claims in Process - Billed Amount	Total billed amount of all the Medicare Crossover Part A Claims.	10	Number (Decimal)
Total Medicare Crossover Part A Claims in Process – Patient Liability	Total of all Patient Liability amounts for the Medicare Crossover Part A Claims in Process.	10	Number (Decimal)
Total Medicare Crossover Part A Claims in Process - Copay Amount	Total copay amount of all the Medicare Crossover Part A Claims.	10	Number (Decimal)
Total Medicare Crossover Part A Claims in Process - TPL Amount	Total of all TPL amounts for the Medicare Crossover Part A Claims in Process.	10	Number (Decimal)

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7.41 CRA-XBAD-R -- Remittance Advice - Medicare Crossover Part B Claim Adjustments

7.41.1 CRA-XBAD-R -- Remittance Advice - Medicare Crossover Part B Claim Adjustments Narrative

The Remittance Advice - Medicare Crossover Part B Claim Adjustments report lists Medicare Crossover Part B claims that were adjusted. The report is separated by individual claims. It displays the header data for both the claims being adjusted (Original) and the adjustment claim. The net result of the adjustment is also displayed along with the application of any refunded money. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part B claims that were adjusted along with explanations on why they were adjusted.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

This report is produced during the financial cycle.

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7.41.2 CRA-XBAD-R -- Remittance Advice - Medicare Crossover Part B Claim Adjustments Layout

```
REPORT:   CRA-XBAD-R                                    ALABAMA MEDICAID                                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                             MEDICARE CROSSOVER PART B CLAIM ADJUSTMENTS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

                ICN       SERVICE DATES RENDERING                            ALLOWED AMT
             PAT ACCT NO. FROM   THRU  PROVIDER              COPAY AMT      NON ALLOWED       BILLED AMT        TPL AMT          PAID AMT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX   MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
           RRYYJJJBBBSSS  MMDDYY MMDDYY XXXXXXXXXXXXXXX      (999,999.99)   (9,999,999.99)   (9,999,999.99)   (9,999,999.99)   (9,999,999.99)
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  (9,999,999.99)
           RRYYJJJBBBSSS  MMDDYY MMDDYY XXXXXXXXXXXXXXX       999,999.99     9,999,999.99     9,999,999.99     9,999,999.99     9,999,999,99
            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   9,999,999.99
                                                                                            ADDITIONAL PAYMENT              9,999,999.99
                                                                                            NET OVERPAYMENT (AR)            9,999,999.99
                                                                                            REFUND AMOUNT APPLIED           9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

  TOTAL MEDICARE CROSSOVER PART B ADJ CLAIMS:              9,999,999.99    99,999,999.99    99,999,999.99    99,999,999.99    99,999,999,99
                                                                           99,999,999.99
```

7.41.3 CRA-XBAD-R -- Remittance Advice - Medicare Crossover Part B Claim Adjustments Field Descriptions

Field	Description	Length	Data Type
Additional Payment	Calculated amount if daughter pays more than the mother.	9	Number (Decimal)
Allowed Amt	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amt	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amt	The dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)

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Field	Description	Length	Data Type
ICN	Internal Control Number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	13	Character
Issue Date	Date check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amt	Dollar amount that is payable.	9	Number (Decimal)
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)

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Field	Description	Length	Data Type
Refund Amount Applied	Calculated amount if the daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Rendering Provider	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Integer)
Service Dates - From	The earliest date of service.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service.	6	Date (MM/DD/YY)
TPL Amt	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - Allowed Amt	Total of all allowed amounts for the Medicare Crossover Part B claims. Subtract total daughter allowed amounts from total mother allowed amounts.	9	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - Billed Amt	Total billed amount of all the Medicare Crossover Part B claims. Subtract total daughter billed amounts from total mother billed amounts.	10	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - Co-Pay Amt	Total of all co-pay amounts for the Medicare Crossover Part B claims Adjustments. Subtract total daughter copay amounts from total mother copay amounts.	9	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - Non-Allowed	Total of non-allowed amount for the Part B adjusted claims. Subtract total daughter non-allowed amounts from total mother non-allowed amounts.	10	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - Paid Amt	Total of all the paid Medicare Crossover Part B claims Adjustments. Subtract total daughter paid amounts from total mother paid amounts	10	Number (Decimal)
Total Medicare Crossover Part B Adj Claims - TPL Amt	Total of all TPL amounts for the Medicare Crossover Part B claims Adjustments. Subtract total daughter TPL amounts from total mother TPL amounts	10	Number (Decimal)

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7.42 CRA-XBDN-R -- Remittance Advice - Medicare Crossover Part B Claims Denied

7.42.1 CRA-XBDN-R -- Remittance Advice - Medicare Crossover Part B Claims Denied Narrative

The Remittance Advice - Medicare Crossover Part B Claims Denied report lists Medicare Crossover Part B claims that were denied. Part B crossover claims consist of CMS 1500 medical claims, and outpatient claims. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part B claims that denied along with the explanations of benefits explaining the reason for denial.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.42.2 CRA-XBDN-R -- Remittance Advice - Medicare Crossover Part B Claims Denied Layout

```
REPORT:   CRA-XBDN-R                                    ALABAMA MEDICAID                                                DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART B CLAIMS DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

         --ICN--      SERVICE DATES     RENDERING
         PAT ACCT NO.  FROM    THRU     PROVIDER                          COPAY         ALLOWED          BILLED         TPL AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX         MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
     RRYYJJJBBBSSS MMDDYY  MMDDYY  XXXXXXXXXXXXXXX                      999,999.99    9,999,999.99      9,999,999.99    9,999,999.99
     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL MEDICARE CROSSOVER PART B CLAIMS DENIED:                          9,999,999.99   99,999,999.99     99,999,999.99   99,999,999.99
```


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7.42.3 CRA-XBDN-R -- Remittance Advice - Medicare Crossover Part B Claims Denied Field Descriptions

Field	Description	Length	Data Type
Allowed Amt	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amt	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Copay Amt	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
HEADER EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number assigned by the provider. Usually used for tracking purposes.	50	Number (Integer)
Name	Name of the recipient.	29	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character

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Field	Description	Length	Data Type
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Integer)
Service Dates - From	The earliest date of service.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service.	6	Date (MM/DD/YY)
TPL Amount	Indicates the payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part B Claims Denied - Allowed	Total of all allowed amounts for the denied Medicare Crossover Part B claims.	9	Number (Decimal)
Total Medicare Crossover Part B Claims Denied - Billed	Total billed amount for the denied Medicare Part B Crossover claims.	10	Number (Decimal)
Total Medicare Crossover Part B Claims Denied - Copay	Total amount of all Co-pay amounts for the denied Medicare Crossover Part B claims.	9	Number (Decimal)
Total Medicare Crossover Part B Claims Denied - TPL Amount	Total of all TPL amounts for the denied Medicare Crossover Part B claims.	10	Number (Decimal)

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7.43 CRA-XBPD-R -- Remittance Advice - Medicare Crossover Part B Claims Paid

7.43.1 CRA-XBPD-R -- Remittance Advice - Medicare Crossover Part B Claims Paid Narrative

The Remittance Advice - Medicare Crossover Part B Claims Paid report lists Medicare Crossover Part B claims that were paid. Part B crossover claims consist of CMS 1500 medical claims, and outpatient claims. The report is separated by individual claims and displays header and detail data. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report. The purpose of this report is to give the provider a list of all Medicare Crossover Part B claims that are being paid along with explanations on any discrepancies between the billed and the paid amount.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.43.2 CRA-XBPD-R -- Remittance Advice - Medicare Crossover Part B Claims Paid Layout

```
REPORT:   CRA-XBPD-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                               PAGE:       9,999
                                                         PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART B CLAIMS PAID


XXXX
```

7.43.3 CRA-XBPD-R -- Remittance Advice - Medicare Crossover Part B Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amt	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amt	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-Pay Amt	The dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	8	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Character
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amt	Dollar amount that is payable for the Part B claim.	9	Number (Decimal)
Pat Acct No.	Patient Account Number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character

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Field	Description	Length	Data Type
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Integer)
Service Dates - From	The earliest date of service or the admit date.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service or discharge date.	6	Date (MM/DD/YY)
TPL Amt	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part B Claims Paid – Allowed Amt	Total of all the allowed amounts for Medicare Part B Claims.	10	Number (Decimal)
Total Medicare Crossover Part B Claims Paid - Billed Amt	Total of all billed amounts for the Medicare Part B Crossover claims.	10	Number (Decimal)
Total Medicare Crossover Part B Claims Paid - Co-Pay Amt	Total of all co-pay amounts for the Medicare Crossover Part B claims.	9	Number (Decimal)
Total Medicare Crossover Part B Claims Paid - Non-Allowed	Total of non-allowed amount for the Part B paid claims.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicare Crossover Part B Claims Paid - Paid Amt	Total of all the paid amounts for Medicare Crossover Part B claims.	10	Number (Decimal)
Total Medicare Crossover Part B Claims Paid - TPL Amt	Total of all TPL amounts for the Medicare Crossover Part B claims.	10	Number (Decimal)

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7.44 CRA-XBSU-R -- Remittance Advice - Medicare Crossover Part B Claims in Process

7.44.1 CRA-XBSU-R -- Remittance Advice - Medicare Crossover Part B Claims in Process Narrative

The Remittance Advice - Medicare Crossover Part B Claims in Process report lists Medicare Crossover Part B claims that are in process. Part B crossover claims consist of CMS 1500 medical claims, and outpatient claims. The report is separated by individual claims and displays header and detail data. The purpose of this report is to give the provider a list of all Medicare Crossover Part B claims that are in process. The "in process" claims are also included on the remittance advice to help decrease the amount of duplicate claims submitted by the provider. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

Presently, no details appear for Medicare crossover claims. A Post Implementation Defect has been written to display details on Medicare crossovers.

7.44.2 CRA-XBSU-R -- Remittance Advice - Medicare Crossover Part B Claims in Process Layout

```
REPORT:   CRA-XBSU-R                                    ALABAMA MEDICAID                                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                    PAGE:       9,999
                                                       PROVIDER REMITTANCE ADVICE
                                                MEDICARE CROSSOVER PART B CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                   PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                   NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                    CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

      --ICN--        SERVICE DATES  RENDERING
    PAT ACCT. NO.    FROM   THRU    PROVIDER                                COPAY           ALLOWED             BILLED           TPL AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  RRYYJJJBBBSSS MMDDYY  MMDDYY  XXX XXXXXXXXXXXXXXX                      999,999.99      9,999,999.99        9,999,999.99       9,999,999.99
  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL MEDICARE CROSSOVER PART B CLAIMS IN PROCESS:                     9,999,999.99     99,999,999.99       99,999,999.99      99,999,999.99
```


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7.44.3 CRA-XBSU-R -- Remittance Advice - Medicare Crossover Part B Claims in Process Field Descriptions

Field	Description	Length	Data Type
Allowed	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-pay	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Header EOB Codes	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
Name	Name of the recipient.	29	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Pat Acct. No.	Unique number assigned by the provider. This is usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character

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Field	Description	Length	Data Type
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	12	Number (Integer)
Rendering Provider	The National Provider Identification number of the provider that performed the services. If the provider does not have an NPI, their Medicaid provider number will be displayed.	15	Number (Integer)
Service Dates - From	This is the earliest date of service.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part B Claims in Process - Allowed	The total of all allowed amounts for the Medicare Crossover Part B claims.	9	Number (Decimal)
Total Medicare Crossover Part B Claims in Process - Billed	The total billed amount of all the Medicare Crossover Part B claims.	10	Number (Decimal)
Total Medicare Crossover Part B Claims in Process - Co - Pay	The total of all copay amounts for the Medicare Crossover Part B claims.	9	Number (Decimal)
Total Medicare Crossover Part B Claims in Process - TPL Amount	The total of all TPL amounts for the Medicare Crossover Part B claims.	10	Number (Decimal)

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7.45 CRA-XCAD-R -- Remittance Advice - Medicare Crossover Part C Claim Adjustments

7.45.1 CRA-XCAD-R -- Remittance Advice - Medicare Crossover Part C Claim Adjustments Narrative

The Remittance Advice - Medicare Crossover Part C Claim Adjustments report lists Medicare Crossover Part C adjustment claims. Part C Crossovers consist of either the outpatient services billed through Part A Intermediaries or the outpatient services billed by Part B Intermediaries. These services are billed on the UB04 claim. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

If the adjustment produces an Accounts Receivable, only the statement NET OVERPAYMENT (AR) will appear below the mother and daughter ICNs. If the adjustment produces and additional payment, only the statement ADDITIONAL PAYMENT will appear below the mother an daughter ICNs. If the adjustment is the result of a refund being posted, only the statement REFUND AMOUNT APPLIED will appear below the mother and daughter ICNs. If the adjustment produces none of the above, no statement will appear.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare Crossovers.

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7.45.2 CRA-XCAD-R -- Remittance Advice - Medicare Crossover Part C Claim Adjustments Layout

```
REPORT:   CRA-XCAD-R                                ALABAMA MEDICAID AGENCY                                    DATE:  MM/DD/CCYY
   RA#:   999999999                              MEDICAID MANAGEMENT INFORMATION SYSTEM                        PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                MEDICARE CROSSOVER PART C CLAIM ADJUSTMENTS


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Field	Description	Length	Data Type
Co-pay AMT	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount. The first amount displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	The date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Net Overpayment	Calculated amount if the daughter pays less than the mother without Cash.	9	Number (Decimal)
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amt	Dollar amount paid for the services rendered. The first amount displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	9	Number (Decimal)
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Refund Amount Applied	Calculated amount if daughter pays less than the mother on Cash related adjustment.	9	Number (Decimal)
Rendering Provider	The National Provider Identification number of the attending physician.	15	Number (Integer)
Service Dates - From	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest dates of service from the detail lines.	6	Date (MM/DD/YY)
TPL Amt	Indicates the payment made by sources outside the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part C Claim Adjustments - Allowed Amt	Total of all allowed amounts for the adjusted Medicare Crossover Part C claims. Subtract total daughter allowed amounts from total mother allowed amounts.	10	Number (Decimal)
Total Medicare Crossover Part C Claim Adjustments - Billed Amt	Total amount billed for the Medicare Part C Crossover adjustment claims. Subtract total daughter billed amounts from total mother billed amounts.	10	Number (Decimal)
Total Medicare Crossover Part C Claim Adjustments – Co-pay	Total amount of all copay amounts for the Medicare Crossover Part C adjustment claims. Subtract total daughter copay amounts from total mother copay amounts	10	Number (Decimal)
Total Medicare Crossover Part C Claim Adjustments – Non-Allowed	Total of non-allowed amount for the Part C adjusted claims. Subtract total daughter non-allowed amounts from total mother non-allowed amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicare Crossover Part C Claim Adjustments – Paid Amt	Total of all paid Medicare Part C claim adjustments. Subtract total daughter paid amounts from total mother paid amounts.	10	Number (Decimal)
Total Medicare Crossover Part C Claim Adjustments - TPL Amt	Total of all TPL amounts for the Medicare Crossover Part C Claim Adjustments. Subtract total daughter TPL amounts from total mother TPL amounts.	10	Number (Decimal)

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7.46 CRA-XCDN-R -- Remittance Advice - Medicare Crossover Part C Claims Denied

7.46.1 CRA-XCDN-R -- Remittance Advice - Medicare Crossover Part C Claims Denied Narrative

The Remittance Advice - Medicare Crossover Part C Claims Denied report lists Medicare Crossover Part C claims that are denied. Part C crossovers consist of either the outpatient services billed through Part A Intermediaries or the outpatient services billed by Part B Intermediaries. These services are billed on the UB04 claim. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

Presently, no details appear for Medicare crossover claims. A Post Implementation Defect has been written to display details on Medicare Crossovers.

7.46.2 CRA-XCDN-R -- Remittance Advice - Medicare Crossover Part C Claims Denied Layout

```
REPORT:   CRA-XCDN-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                   MEDICARE CROSSOVER PART C CLAIMS DENIED


XXXX
```

7.46.3 CRA-XCDN-R -- Remittance Advice - Medicare Crossover Part C Claims Denied Field Descriptions

Field	Description	Length	Data Type
Allowed Amount	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amount	Dollar amount billed by the provider for the services rendered.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Co-pay Amount	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character

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Field	Description	Length	Data Type
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider	The National Provider Identification number of the attending physician.	15	Number (Interger)
Service Dates - From	The earliest date of service from the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service from the detail lines.	6	Date (MM/DD/YY)
TPL Amount	Indicates the payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part C Claims Denied - Allowed Amount	Total of all allowed amounts for the denied Medicare Crossover Part C claims.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Denied - Billed Amount	Total billed amount for the denied Medicare Part C Crossover claims.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Denied – Co-pay Amount	Total amount of all copay amounts for the denied Medicare Crossover Part C claims.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Denied - TPL Amount	Total of all TPL amounts for the denied Medicare Crossover Part C clams.	10	Number (Decimal)

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7.47 CRA-XCPD-R -- Remittance Advice - Medicare Crossover Part C Claims Paid

7.47.1 CRA-XCPD-R -- Remittance Advice - Medicare Crossover Part C Claims Paid Narrative

The Remittance Advice - Medicare Crossover Part C Claims Paid report lists Medicare Crossover Part C claims that are paid. Part C crossover claims consist of either the outpatient services billed through Part A Intermediaries or the outpatient services billed by Part B Intermediaries. These services are billed on the UB04 claim. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare Crossovers.

7.47.2 CRA-XCPD-R -- Remittance Advice - Medicare Crossover Part C Claims Paid Layout

```
REPORT:   CRA-XCPD-R                                    ALABAMA MEDICAID AGENCY                                                    DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                         PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                  MEDICARE CROSSOVER PART C CLAIMS PAID


XXXX
```

7.47.3 CRA-XCPD-R -- Remittance Advice - Medicare Crossover Part C Claims Paid Field Descriptions

Field	Description	Length	Data Type
Allowed Amt	Computed dollar amount allowable for the services rendered.	9	Number (Decimal)
Billed Amount	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number or Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Copay Amount	Dollar amount that the recipient should pay and is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track the claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Name	Name of the recipient.	29	Character
Non-Allowed	Total computed non-allowed amount for this claim. The allowed amount is subtracted from the billed amount to arrive at the non-allowed amount.	9	Number (Decimal)
Paid Amount	Dollar amount that is payable for the services rendered.	9	Number (Decimal)
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character

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Field	Description	Length	Data Type
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider	The National Provider Identification number of the attending physician.	15	Number (Integer)
Service Dates - From	The earliest date of service on the detail lines.	6	Date (MM/DD/YY)
Service Dates - Thru	The latest date of service on the detail lines.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicaid Crossover Part C Claims Paid - Allowed Amt	Total of all allowed amounts for the Medicaid Crossover Part C claims.	10	Number (Decimal)
Total Medicaid Crossover Part C Claims Paid - Non-Allowed	Total on non-allowed amount for the dental claims paid.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Paid - Billed Amount	Total billed amount of the Medicare Crossover Part C Claims Paid.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Paid – Co-pay Amount	Total of all the Medicare Crossover Part C Claims Paid Copay amounts.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicare Crossover Part C Claims Paid - Paid Amount	Total of all the Medicare Crossover Part C Claims Paid Amounts.	10	Number (Decimal)
Total Medicare Crossover Part C Claims Paid - TPL Amount	Total of all TPL amount for the Medicare Crossover Part C Claims Paid.	10	Number (Decimal)

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7.48 CRA-XCSU-R -- Remittance Advice - Medicare Crossover Part C Claims In Process

7.48.1 CRA-XCSU-R -- Remittance Advice - Medicare Crossover Part C Claims In Process Narrative

The Remittance Advice - Medicare Crossover Part C Claims In Process report lists Medicare Crossover Part C claims that are in process. Part C crossovers consist of either the outpatient services billed through Part A Intermediaries or the outpatient services billed through Part B Intermediaries. These services are billed on the UB04 claim. Pertinent Explanation of Benefit (EOB) codes are also displayed on this report.

This report is produced during the financial cycle.

Presently, no details appear for Medicare Crossover claims. A Post Implementation Defect has been written to display details on Medicare Crossovers.

7.48.2 CRA-XCSU-R -- Remittance Advice - Medicare Crossover Part C Claims In Process Layout

```
REPORT:   CRA-XCSU-R                                    ALABAMA MEDICAID AGENCY                                          DATE:  MM/DD/CCYY
   RA#:   999999999                                MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE:       9,999
                                                        PROVIDER REMITTANCE ADVICE
                                                 MEDICARE CROSSOVER PART C CLAIMS IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  PAYEE ID              XXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     NPI ID               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                     CHECK/EFT NUMBER      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                     ISSUE DATE           MM/DD/CCYY

            --ICN--    SERVICE DATES  RENDERING
          PAT ACCT NO. FROM   THRU    PROVIDER                      COPAY       ALLOWED        BILLED        TPL AMOUNT

NAME: XXXXXXXXXXXX XXXXXXXXXXXXXXXX    RECIPIENT ID: XXXXXXXXXXXXX MRN: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
          RRYYJJJBBBSSS MMDDYY MMDDYY 9999999999                    999,999.99   9,999,999.99   9,999,999.99    9,999,999.99
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER EOBS:9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

     TOTAL MEDICARE CROSSOVER PART C CLAIMS IN PROCESS:           9,999,999.99 99,999,999.99  99,999,999.99    99,999,999.99
```


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7.48.3 CRA-XCSU-R -- Remittance Advice - Medicare Crossover Part C Claims In Process Field Descriptions

Field	Description	Length	Data Type
Billed Amount	Dollar amount billed by the provider.	9	Number (Decimal)
Check/EFT Number	Check number of Electronic Funds Transfer payment number corresponding to the check or EFT that is generated.	9	Number (Integer)
Header EOBS	Explanation of Benefits (EOB) codes that apply to the claim header. These codes are used to explain how the adjustment claim was processed or priced. There could be a maximum of twenty EOB codes.	4	Number (Integer)
ICN	Internal Control Number used to identify and track a claim processed through the system.	13	Number (Integer)
Issue Date	Date the check or Electronic Funds Transfer is issued.	10	Date (MM/DD/CCYY)
MRN	Medical Record Number submitted on the claim.	50	Character
Name	Name of the recipient.	29	Character
NPI ID	National Provider Identification number of the payee.	10	Number (Integer)
Pat Acct No.	Patient Account Number assigned by the provider. Usually used for filing or tracking purposes.	38	Character
Payee Address 1	Line one of the payee address.	30	Character
Payee Address 2	Line two of the payee address.	30	Character
Payee City	City of the payee address.	20	Character
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID.	15	Character
Payee Name	Name of the payee provider.	50	Character
Payee State	State code of the payee address.	2	Character
Payee Zip Code	Zip code of the payee address. It may or may not contain the zip plus four.	10	Character
RA #	The system assigned number for the remittance advice.	10	Number (Integer)

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Field	Description	Length	Data Type
Recipient ID	Medicaid Identification number of the recipient.	13	Number (Integer)
Rendering Provider	The National Provider Identification number of the attending physician.	15	Number (Integer)
Service Dates - From	This is the earliest date of service.	6	Date (MM/DD/YY)
Service Dates - Thru	This is the latest date of service.	6	Date (MM/DD/YY)
TPL Amount	Payments made by sources outside of the Alabama Medicaid program. This amount is deducted from the allowed amount to arrive at the paid amount.	9	Number (Decimal)
Total Medicare Crossover Part C Claims in Process - Billed Amount	The total billed amount of all the Medicare Crossover Part C claims.	10	Number (Decimal)
Total Medicare Crossover Part C Claims in Process - TPL Amount	The total of all TPL amounts for the Medicare Crossover Part C claims.	10	Number (Decimal)

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7.49 FIN-AL01-R -- Credit Balance Aging

7.49.1 FIN-AL01-R -- Credit Balance Aging Narrative

The Credit Balance Aging Report is based on Alabama Credit Balance Aging Report HMDR897B. This report allows the Agency to report Financial data for the CMS-64 report.

This report is produced during the financial cycle.

7.49.2 FIN-AL01-R -- Credit Balance Aging Layout

```
REPORT:   FIN-AL01-R                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
PROCESS:  FINJRAL01                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
LOCATION: FINPAL01R                                 CREDIT BALANCE AGING REPORT                                      Page:          9,999
                                                        PERIOD: MM/DD/CCYY


                                                     UNDER 60        OVER 60      TOT ALREADY      AMOUNT TO         AMOUNT TO
    F/C   FUND CODE DESCRIPTION       AMOUNT DUE        DAYS           DAYS         REPORTED         REPORT            RECLAIM
    ---   -------------------------   -------------- -------------- -------------- -------------- -------------- --------------
    999   XXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999.99  999,999,999.99  999,999,999.99  999,999,999. 99 999,999,999.99  999,999,999.99
    999   XXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999.99  999,999,999.99  999,999,999.99  999,999,999. 99 999,999,999.99  999,999,999.99
    999   XXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999.99  999,999,999.99  999,999,999.99  999,999,999. 99 999,999,999.99  999,999,999.99
    999   XXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999.99  999,999,999.99  999,999,999.99  999,999,999. 99 999,999,999.99  999,999,999.99
    999   XXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999.99  999,999,999.99  999,999,999.99  999,999,999. 99 999,999,999.99  999,999,999.99

          *** GRAND TOTALS            999,999,999.99  999,999,999.99  999,999,999.99  999,999,999 .99 999,999,999.99  999,999,999.99

                                                          ** END OF REPORT **
```


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7.49.3 FIN-AL01-R -- Credit Balance Aging Field Descriptions

Field	Description	Length	Data Type
Amount Due	Account Receivable (Credit Balance) amount due for the fund code.	10	Number (Decimal)
Amount to Reclaim	Account Receivable (Credit Balance) amount previously reported that needs to be reclaimed because it has been collected for the fund code..	10	Number (Decimal)
Amount to Report	Account Receivable (Credit balance) amount that has not been reported for the fund code..	10	Number (Decimal)
F/C	Fund Code.	3	Number (Integer)
Fund Code Description	Description of the Fund Code.	15	Character
Over 60 Days	Account Receivable (Credit Balance) amount due over 60 days for the fund code..	10	Number (Decimal)
Tot Already Reported	Account Receivable (Credit Balance) amount due reported for previous quarter as over 60 days due for the fund code..	10	Number (Decimal)
Under 60 Days	Account Receivable (Credit Balance) amount due less than 60 days for the fund code..	10	Number (Decimal)

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7.50 FIN-AL02-R – Alabama Invoice

7.50.1 FIN-AL02-R -- Alabama Invoice Narrative

HPE produces and delivers paper invoices to the State after each financial cycle. These reports detail the number of line items, dollars paid, and credit changes for each fund code within each of the sixteen fund groups. Medicaid providers report within twelve of these fund groups. When the invoice is delivered after the Main Financial Cycle, the twelve provider fund groups will report activity and the thirteenth will show no activity. When the invoice is delivered after the monthly Tuesday evening HIPP Financial Cycle, the twelve provider fund groups will report no activity, and the thirteenth will show the HIPP Resource activity. These reports are used by the State to draw State and Federal funds to be deposited in the appropriate payout accounts for provider resources. These reports are produced for every financial cycle.

The report has two sections: The first ‘half’ details the credit activity. The second ‘half’ details the amounts paid.

The cycle produces invoices for each State/Hurricane Evacuee combination in addition to the Alabama Invoice. The following list details the report numbers and title of the invoice reports:

FIN-AL02-R	Alabama Invoice
FIN-AL02-RRT	Alabama Invoice -Rita –Texas
FIN-AL02-RRL	Alabama Invoice – Rita - Louisiana
FIN-AL02-RYA	Alabama Invoice - Katrina – Alabama
FIN-AL02-RYL	Alabama Invoice - Katrina – Louisiana
FIN-AL02-RRM	Alabama Invoice - Katrina - Mississippi

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7.50.2 FIN-AL02-R -- Alabama Invoice Layout

```
REPORT:   FIN-AL02-R                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS:  FINJRAL02                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME:   HH:MM:SS
LOCATION: FINPAL02R                              ALABAMA INVOICE                                                   PAGE:      9,999
                                               PERIOD: MM/DD/CCYY
HP Enterprise Services, LLC
301 TECHNACENTER DRIVE
MONTGOMERY, ALABAMA  36117 (334) 215-0111
ALABAMA MEDICAID AGENCY
ATTN: ASSOCIATE DIRECTOR ACCOUNTS PAYABLE
FISCAL OPERATIONS

                                                                    MM/DD/CCYY

             FUND GROUP: XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         CREDIT ACTIVITY

             FUND CODE/ DESC      RCO  COUNTY CODE   PUB/PRIV IND   CLAIM TYPE    NBR LINE ITEMS       TOTAL AMT PAID     CREDIT CHANGES

             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X           9,999,999            99,999,999.99       99,999,999.99
             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X           9,999,999            99,999,999.99       99,999,999.99
             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X           9,999,999            99,999,999.99       99,999,999.99

                    TOTAL                                                        999,999,999          999,999,999.99      999,999,999.99

                GRAND TOTAL                                                      999,999,999          999,999,999.99      999,999,999.99
```

```
REPORT:   FIN-AL02-R                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS:  FINJRAL02                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME:   HH:MM:SS
LOCATION: FINPAL02R                              ALABAMA INVOICE                                                   PAGE:      9,999
                                               PERIOD: MM/DD/CCYY
 HP Enterprise Services, LLC
  301 TECHNACENTER DRIVE (334) 215-0111
                                                ALABAMA MEDICAID AGENCY
                                         ATTN: ASSOCIATE DIRECTOR ACCOUNTS PAYABLE
                                                      FISCAL OPERATIONS

                                                                    XX/XX/CCXX

             FUND GROUP: XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       PAID UNDER STATE MEDICAID PROGRAM

             FUND CODE/ DESC      RCO  COUNTY CODE   PUB/PRIV IND   CLAIM TYPE   NBR LINE ITEMS     TOTAL AMT PAID      CREDIT CHANGES

             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X            9,999,999        99,999,999.99        99,999,999.99
             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X            9,999,999        99,999,999.99        99,999,999.99
             XXX XXXXXXXXXXXXXXX  XXXXX   XXXX          X              X            9,999,999        99,999,999.99        99,999,999.99

                     TOTAL                                                      999,999,999          999,999,999.99      999,999,999.99

                 GRAND TOTAL                                                    999,999,999          999,999,999.99      999,999,999.99
```


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7.50.3 FIN-AL02-R -- Alabama Invoice Field Descriptions

Field	Description	Length	Data Type
Claim Type	Shows specific indicator for claim type	1	Character
County Code	Shows the County Code for a specific claim	4	Character
Credit Changes	Credit change amount for the Fund Code.	10	Number (Decimal)
Fund Code	Fund Code number along with the Fund Code description.	15	Character
Fund Code Desc	Short description of fund code.	15	Character
Fund Group	Fund Group to which the listed Fund Codes report.	50	Character
NBR Line Items	Number of Line Items for the paid claims or credit activity.	9	Number (Integer)
Grand Total Credit Changes	Total sum of the Credit Changes for all Fund Groups	10	Number (Decimal)
Grand Total NBR Line Items	The grand total sum of NBR Line Items for all Fund Groups.	9	Number (Integer)
Grand Total Total Amt Paid	The grand total sum of the Total Amt Paid for all Fund Groups.	10	Number (Decimal)
Total NBR Line Items	Total sum of the NBR Line Items per Fund Group.	9	Number (Integer)
Pub/Priv Ind	Determines if a claim is Public – B or Private – V	1	Character
RCO	Regional Care Organization designation.	5	Character
Total Credit Changes	Total sum of the Total Credit Changes per Fund Group.	10	Number (Decimal)
Total Amt Paid	Total amount paid for the Fund Code.	10	Number (Decimal)
Total Total Amt Paid	Total sum of the Total Amount Paid per Fund Group	10	Number (Decimal)

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7.51 FIN-AL03-R -- Electronic Invoices Transmitted

7.51.1 FIN-AL03-R -- Electronic Invoices Transmitted Narrative

Electronic Invoices Transmitted is the paper report displaying the data that is transmitted electronically to the State after each Main Financial Cycle.

This report is produced during the financial cycle.

7.51.2 FIN-AL03-R -- Electronic Invoices Transmitted Layout

```
REPORT:   FIN-AL03-R                          ALABAMA MEDICAID AGENCY                        Run Date: MM/DD/CCYY
PROCESS:  FINJRAL03                   MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS
LOCATION: FINPAL03R                      ELECTRONIC INVOICES TRANSMITTED                       Page:       9,999
                                              PERIOD: MM/DD/CCYY


                                                        PUB/PRIV    Claim                                   PYMT
 FUND GROUP      Fund Code/DESC        RCO     County Code   IND       Type        # LINES     PYMT DATE     AMOUNT
 XXX             XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                        TOTAL                                                       999,999                 999,999,999.99

 XXX             XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                        TOTAL                                                       999,999                 999,999,999.99

 XXX             XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                 XXX XXXXXXXXXXXXXXX   XXXXX     XXXX          X         X          999,999     YY/MM/DD    999,999,999.99
                        TOTAL                                                       999,999                 999,999,999.99

                     GRAND TOTAL                                                 999,999,999                 999,999,999.99
```

7.51.3 FIN-AL03-R -- Electronic Invoices Transmitted Field Descriptions

Field	Description	Length	Data Type
# Lines	Number of line items paid.	5	Number (Integer)
Claim Type	Shows specific indicator for claim type.	1	Character
County Code	Shows the County Code for a specific claim	4	Character
Fund Code	Shows Fund Code	3	Character

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Field	Description	Length	Data Type
Fund Code Desc	Short Description of Fund Code	15	Character
Fund Group	The Fund Group (current system known as Bene Type).	3	Number (Integer)
Pymt Amount	The payment amount for the Fund Group.	11	Number (Decimal)
Pymt Date	Payment Date.	8	Date (YY/MM/DD)
RCO	Regional Care Organization designation.	5	Character
Total # Lines	Total number of line items paid for the Fund Group	5	Number (Integer)
Total Pymt Amount	Total payment amount for the Fund Group.	11	Number (Decimal)
Grand Total # Lines	Grand total number of line items paid.	5	Number (Integer)
Grand Total Pymt Amount	Grand total payment amount.	11	Number (Decimal)
Pub/Priv Ind	Determines if a claim is Public – B or Private – V	1	Character

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7.52 FIN-AL04-O --REQ Account Receivable Report

7.52.1 FIN-AL04-O --REQ Account Receivable Report Narrative

The REQ Account Receivable Report is an online report generated from the Financial Reports and Letters panel. This is an online report that can be run at any time for any date. Please refer to the Financial User Manual-Part I for criteria input to generate this report.

7.52.2 FIN-AL04-O – REQ Account Receivable Report Layout

Report: FIN AL04-O | STATE MMIS | Date: 2009/10/01

From Date: 2008/01/01 | REQ ACCOUNT RECEIVABLE REPORT | Time: 10:38 AM

To Date: 2009/01/01 | Page # 1 of 1

REQ DOC	AR No	RECOUP TYPE	PAYEE ID	PAYEE TYPE	NAME	FUND CODE	AR STATUS	DATE ADDED	DATE EFFECTIVE	AMOUNT	BALANCE
	[redacted]	Automatic	[redacted]	Provider	[redacted]	001	A	11/25/2008	11/25/2008	$11.00	$11.00
	[redacted]	Automatic	[redacted]	Provider	[redacted]	012	A	06/18/2008	06/18/2008	$110.00	$109.00

7.52.3 FIN-AL04-O -- Account Receivable Report Field Descriptions

Field	Description	Length	Data Type
AR No	This is a unique number which is assigned to each provider accounts receivable to track accounts receivable activity	13	Number (Integer)
AR Status	This is the status assigned to the AR (A = Active, C = Closed).	1	Character
Date Added	The date the Accounts Receivable was added.	10	Date (MM/DD/CCYY)
Fund Code	This is the fund code assigned to the A/R.	3	Number (Integer)
Payee ID	This is the provider number (nine characters) or NPI (ten digits).	15	Character
Payee Type	This is the type of payee (always PROVIDER in Alabama).	2	Character
Recoup Type	The type of recoupment (manual, automatic.).	15	Character

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Field	Description	Length	Data Type
Req Doc	Request Document – (designed specifically for HWT numbers).	9	Character

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7.53 FIN-AR01-W -- Weekly Accounts Receivable Summary

7.53.1 FIN-AR01-W -- Weekly Accounts Receivable Summary Narrative

The Weekly Accounts Receivable report lists summary information for accounts receivables setups, recoupments, and counts for the previous Financial cycle. Although this report is titled “Weekly”, it is produced for each financial cycle.

This report is produced during the financial cycle.

7.53.2 FIN-AR01-W -- Weekly Accounts Receivable Summary Layout

```
Report  : FIN-AR01-W                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/YYYY
Process : FINJWAR01                           MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: FINPAR01W                             WEEKLY ACCOUNTS RECEIVABLE SUMMARY                            Page:      9,999
                                                 PERIOD: MM/DD/YYYY - MM/DD/YYYY


  Accounts Receivable Set Up (System) ............    9,999,999,999.99
  Accounts Receivable Set Up (Manual) ............    9,999,999,999.99
                                                    ==================
     Total AR Set Up ............................   99,999,999,999.99


`
  Accounts Receivable Recoupments (System) .......    9,999,999,999.99
  Accounts Receivable Recoupments (Manual) .......    9,999,999,999.99
                                                    ==================
     Total AR Recoupment ........................   99,999,999,999.99



  Number of Open Accounts Receivables ............          99,999,999



  Original Setup Amount of Open ARs ..............    9,999,999,999.99
  Recouped Amount of Open ARs ....................    9,999,999,999.99
                                                    ==================
    Outstanding Balance of Open ARs ..............    9,999,999,999.99


                                              * * * * END OF REPORT * * * *
```

7.53.3 FIN-AR01-W -- Weekly Accounts Receivable Summary Field Descriptions

Field	Description	Length	Data Type
Accounts Receivable Recoupments (Manual)	This is the amount of ARs manually recouped for the date parameters of the Financial cycle.	10	Number (Decimal)

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Field	Description	Length	Data Type
Accounts Receivable Recoupments (System)	This is the amount of ARs recouped by the system for the date parameters of the Financial cycle.	10	Number (Decimal)
Accounts Receivable Set Up (Manual)	This is the amount of ARs manually setup for the date parameters of the Financial cycle.	10	Number (Decimal)
Accounts Receivable Set Up (System)	This is the amount of ARs setup by the system for the date parameters of the Financial cycle.	10	Number (Decimal)
Number of Open Accounts Receivables	This is the number of Open Accounts Receivables at the end of the Financial cycle.	8	Number (Decimal)
Original Setup Amount of Open ARs	This is the original setup amount of all ARs still in the Open status.	10	Number (Decimal)
Outstanding Balance of Open ARs	This is the difference between the Original Setup Amount and the Amount Recouped for all open ARs.	10	Number (Decimal)
Recouped Amount of Open ARs	This is the recouped amount of all ARs still in the Open status.	10	Number (Decimal)
Total AR Recoupment	This is the sum of the AR recoupments manually and systematically recouped for the date parameters of the Financial cycle.	10	Number (Decimal)
Total AR Set Up	This is the sum of the ARs setup systematically and manually during the dates of the Financial cycle.	10	Number (Decimal)

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7.54 FIN-AR04-W -- Provider Manually Recovered Accounts Receivable

7.54.1 FIN-AR04-W -- Provider Manually Recovered Accounts Receivable Narrative

The Provider Manually Recovered Accounts Receivable report is a list of all ARs that will not be systematically recouped. These A/Rs have been set up for providers and will be processed and recouped by means of the provider sending in payments.

This report is produced weekly.

7.54.2 FIN-AR04-W -- Provider Manually Recovered Accounts Receivable Layout

```
Report  : FIN-AR04-W                          ALABAMA MEDICAID AGNECY                                    RUN DATE: MM/DD/CCYY
Process : FINJWAR04                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:   HH:MM:SS
Location: FINPAR04W                PROVIDER MANUALLY RECOVERED ACCOUNTS RECEIVABLE                       PAGE    :          1
                                                   AS OF: MM/DD/CCYY

                                                        SET-UP      LAST-ACT          ORIGINAL          APPLIED          BALANCE
 PAYOR    ID   PAYOR    NAME                    ACCTNUM    DATE        DATE               AMOUNT           AMOUNT           AMOUNT
 ------------  ------------------------------ ---------- ---------- ----------  --------------   --------------   --------------
 XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999999   MM/DD/CCYY MM/DD/CCYY   $9,999,999.99    $9,999,999.99   $9,999,999.99
 XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999999   MM/DD/CCYY MM/DD/CCYY   $9,999,999.99    $9,999,999.99   $9,999,999.99
 XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999999   MM/DD/CCYY MM/DD/CCYY   $9,999,999.99    $9,999,999.99   $9,999,999.99
 XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999999   MM/DD/CCYY MM/DD/CCYY   $9,999,999.99    $9,999,999.99   $9,999,999.99
 XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  99999999   MM/DD/CCYY MM/DD/CCYY   $9,999,999.99    $9,999,999.99   $9,999,999.99
                                                                                 ---------------- ---------------- ----------------
                                                                     TOTALS:     $99,999,999.99   $99,999,999.99   $99,999,999.99
                                                                                                                    ================


                                                   ** END OF REPORT **
```


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7.54.3 FIN-AR04-W -- Provider Manually Recovered Accounts Receivable Field Descriptions

Field	Description	Length	Data Type
Acctnum	This is the Account Receivable number.	8	Number (Decimal)
Applied Amount	This is the amount that has been recouped to date.	11	Number (Decimal)
Balance Amount	This is the outstanding balance of the A/R at the time of the report.	11	Number (Decimal)
Last-Act Date	This is the date that the A/R received it's last recoupment.	10	Date (MM/DD/CCYY)
Original Amount	This is the original set up amount of the A/R.	11	Number (Decimal)
Payor ID	This is the provider number (nine characters) or NPI (ten digits).	10	Number (Integer)
Payor Name	This is the provider name.	30	Character
Set-Up Date	This is the date that the A/R was set up.	10	Date (MM/DD/CCYY)
Totals	Displays the totals for Original Amount, Applied Amount and Balance Amount.	12	Number (Decimal)

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7.55 FIN-AR10-W -- Accounts Receivable - Aging by Provider

7.55.1 FIN-AR10-W -- Accounts Receivable - Aging by Provider Narrative

The Accounts Receivable - Aging by Provider report lists all accounts receivables for each provider. The beginning of each provider's information includes: provider number, tax ID, address and phone number. This is followed by the ARs that are outstanding. ARs can be either adjustment ICNs that created the AR, or AR numbers for ARs that are entered on the Financial Accounts Receivable panel.

This report is produced during the financial cycle.

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7.55.2 FIN-AR10-W -- Accounts Receivable - Aging by Provider Layout

```
$Report  : FIN-AR10-W                                   ALABAMA MEDICAID AGENCY                                   Run Date: 03/13/2007
Process : FINJWAR10                              MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   15:31:25
Location: FINPAR10W                                       ACCOUNTS RECEIVABLE                                        Page:         18
                                                        AGING BY PROVIDER ID
                                                 PERIOD: 03/08/2007 - 03/13/2007

AR NUM        CLAIM          RECIPIENT          RECIPIENT        DOS        AR EFF  LAST ACT.  DAYS    ORIGINAL   AMT APPLIED   BALANCE
              TYPE             NAME              NUMBER       FROM - TO     DATE     DATE    OUTST.     AMT       TO DATE

P O BOX 36549
BIRMINGHAM, AL 35236-6549
(205) 939-9874
405                                                                        20070202 20070207    39     350,000.00                218,000.00
                                                                                                                132,000.00

Total for [redacted]    : $    218,000.00

PSY9002E
636-00-0619
BRYCE HOSPITAL ADOLESCENT UNIT
200 UNIVERSITY BOULEVARD
TUSCALOOSA, AL 35401-1294
(205) 759-0734
407                                                                        20070202        0    39     280,000.00                280,000.00
                                                                                                                      0.00

Total for [redacted]    : $    280,000.00

SPR0018H
301-79-437
SPRINGFIELD HOSPITAL
31 GRANITE STREET STE 3
MILFORD, MA 01757
(508) 482-9600
424                                                                        20070214        0    27       1,000.00                  1,000.00
                                                                                                                      0.00

Total for [redacted]    : $      1,000.00


Beginning AR Balance : $  1,214,822.87
Recouped this week   : $     12,200.23
Ending AR Balance    : $  1,202,622.64

                                          * * * END OF REPORT * * *
```


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7.55.3 FIN-AR10-W -- Accounts Receivable - Aging by Provider Field Descriptions

Field	Description	Length	Data Type
Amt Applied to Date	This is the amount applied to date for this AR.	11	Number (Decimal)
AR Num	This is the unique number assigned to track accounts receivables. The format of the number is RRYYJJJBBBSSS if it is an claim adjustment AR. It is the AR number if it is an AR entered on the Financial Accounts Receivable panel.`.	13	Number (Integer)
AR Eff Date	This is the Accounts Receivable Effective Date.	10	Date (MM/DD/CCYY)
Beginning AR Balance	The beginning account balance for the total Account Receivables.	11	Number (Decimal)
Claim Type	If this is a claim based Account Receivable, the claim type will display (A – Part A crossover, B – Part B crossover, C – Outpatient crossover, D – Dental, I – Inpatient, L – Nursing Home, M – CMS-1500, O – Outpatient, P – Drug, Q – Compound Drug..	2	Character
DOS From –To	From and To Date of Service on claim.	16	Date (MM/DD/CCYY
Days Outst.	This is the number of Days the Account Receivable is Outstanding.	8	Number (Integer)
Ending AR Balance	This is the total ending balance on the Account Receivables.	11	Number (Decimal)
Last Act. Date	This is the last date of activity on the Account Receivable	10	Number (MM/DD/CCYY)
Original Amt	This is the original Amount of the Account Receivable.	11	Number (Decimal)
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID or the 10 digit NPI.	15	Character
Payee Name	This is the name of the payee.	50	Character
Payee Address1	This is line one of the payee address.	30	Character
Payee Address2	This is line two of the payee address.	30	Character
Payee City	This is the city of the payee address.	15	Character
Recipient Name	If this is a claim based Account Receivable, this is the Recipient's name.	30	Character

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Field	Description	Length	Data Type
State	This is the two character abbreviation for the payee state.	2	Character
Recipient Number	If this is a claim based Account Receivable, this is the Recipient's Medicaid ID number.	12	Number (Integer)
Recouped this Week	This is the total amount recouped this financial cycle.	11	Number (Decimal)
Total For + provider number	Total Account Receivable amount for the Provider Number.	13	Number (Decimal)
Zip	This is the zip code for the payee. It may or may not display the +4 code.	9	Number

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7.56 FIN-AR20-M -- Accounts Receivable Recoupment Summary by Reason Code

7.56.1 FIN-AR20-M -- Accounts Receivable Recoupment Summary by Reason Code Narrative

The Accounts Receivable Recoupment Summary by Reason Code report summarizes the recoupments towards accounts receivable record by the accounts receivable setup reason code. The report provides counts and totals for the current month and counts and totals for year to date. On the bottom of the report are the grand totals for each column.

This report is produced monthly.

7.56.2 FIN-AR20-M -- Accounts Receivable Recoupment Summary by Reason Code Layout

```
Report  : FIN-AR20-M                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
Process : FINJMAR20                        MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:      16:30
Location: FINPAR20M                   ACCOUNTS RECEIVABLE RECOUPMENT SUMMARY BY REASON CODE               PAGE    :          1
                                                     PERIOD: Month   CCYY

                                              MTD RECOUP                          YTD RECOUP
     ACCOUNTS RECEIVABLE SETUP REASON           COUNT        MTD RECOUP AMT          COUNT           YTD RECOUP AMT
   ----------------------------------------   ---------    -----------------      -----------     ------------------
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999       $999,999,999.99      999,999,999      $9,999,999,999.99
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999       $999,999,999.99      999,999,999      $9,999,999,999.99
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999       $999,999,999.99      999,999,999      $9,999,999,999.99
   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999       $999,999,999.99      999,999,999      $9,999,999,999.99

                                              ---------    -----------------    -------------     ------------------
          GRAND TOTALS:                       9,999,999    $9,999,999,999.99    9,999,999,999     $99,999,999,999.99


       ** END OF REPORT **
```


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7.56.3 FIN-AR20-M -- Accounts Receivable Recoupment Summary by Reason Code Field Descriptions

Field	Description	Length	Data Type
Accounts Receivable Setup Reason	This is the reason an accounts receivable was setup.	40	Character
Grand Total - MTD Recoup Amt	Grand total amount of money dispositioned for the month for this reason code.	12	Number (Decimal)
Grand Total - MTD Recoup Count	Grand total number of disposition records for the month for this reason code.	7	Number (Decimal)
Grand Total - YTD Recoup Amount	Grand total amount of money dispositioned for the year for this reason code.	13	Number (Decimal)
Grand Total - YTD Recoup Count	Grand total number of disposition records for the year for this reason code.	10	Number (Decimal)
MTD Recoup Amt	Total amount of money dispositioned for the month for this reason code.	11	Number (Decimal)
MTD Recoup Count	Number of disposition records for the month for this reason code.	6	Number (Decimal)
YTD Recoup Amt	Total amount of money dispositioned for the year for this reason code.	12	Number (Decimal)
YTD Recoup Count	Number of disposition records for the year for this reason code.	9	Number (Integer)

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7.57 FIN-AR41-W -- Accounts Receivable - Weekly Activity

7.57.1 FIN-AR41-W -- Accounts Receivable - Weekly Activity Narrative

The Accounts Receivable-Weekly Activity report summarizes activity associated with outstanding provider account receivables (A/R) for each financial cycle. This report is utilized to aid in the tracking and control of account receivables, and to report to the Agency all activity associated with an outstanding A/R.

This report is generated during the financial cycle.

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7.57.2 FIN-AR41-W -- Accounts Receivable - Weekly Activity Layout

```
REPORT  : FIN-AR41-W                                ALABAMA MEDICAID AGENCY                                  DATE: MM/DD/CCYY
PROCESS : FINJWAR41                            MEDICAID MANAGEMENT INFORMATION SYSTEM                        TIME:   HH:MM:SS
LOCATION: FINPAR41W                             ACCOUNTS RECEIVABLE WEEKLY ACTIVITY                          PAGE:     99,999
                                                 PERIOD: MM/DD/CCYY - MM/DD/CCYY

PAYOR TYPE:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                    LAST
PAYOR             ACTIVITY        A/R     RSN   ----RECOUPMENT----      BEGINNING      CASH AMOUNT    OFFSET AMOUNT      ADJUSTMENT
ENDING
ID                  DATE         NUMBER   CODE  PERCENT      AMOUNT      BALANCE       THIS CYCLE      THIS CYCLE
BALANCE
999999999999999   MMDDCCYY  9999999999999 9999  999.99 999,999,999.99 999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99
999999999999999   MMDDCCYY  9999999999999 9999  999.99 999,999,999.99 999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99
999999999999999   MMDDCCYY  9999999999999 9999  999.99 999,999,999.99 999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99
999999999999999   MMDDCCYY  9999999999999 9999  999.99 999,999,999.99 999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99


                                                          T0TALS    9,999,999,999.99                 9,999,999,999.99
9,999,999,999.99
                                                                                     9,999,999,999.99                 9,999,999,999.99


                                                         * * END OF REPORT * *
```


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7.57.3 FIN-AR41-W -- Accounts Receivable - Weekly Activity Field Descriptions

Field	Description	Length	Data Type
A/R Number	This is the number used to track ARs throughout the system. It will be an adjustment claim ICN if the AR is a claim AR, or an AR number assigned by the system if the AR is created manually from the Financial Accounts Receivable panel.	13	Number (Integer)
Adjustment	This is the change made to the A/R balance other than cash or offsets, such as state directed write-offs or increases.	11	Number (Decimal)
Beginning Balance	This is the last account receivable balance for this A/R number and provider prior to the start of the current financial cycle. This should equal the ending balance of the previous financial cycle report.	11	Number (Decimal)
Cash Amount this Cycle	This indicates cash payments made in this processing cycle to decrease an account receivable.	11	Number (Decimal)
Ending Balance	This is the current account receivable balance after this cycle date. Calculated by taking the A/R Balance, less the cash amount this cycle, less the offset amount this cycle, and plus or minus the adjustments.	11	Number (Decimal)
Last Activity Date	This is the date the last activity was posted to the claims system.	10	Date (MM/DD/CCYY)
Offset Amount this Cycle	This is the amount satisfied in this cycle due to offsetting amounts otherwise due to the provider.	11	Number (Decimal)
Payor ID	Medicaid Identication Number of the payor. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID or the 10 digit NPI.	15	Character
Payor Type	This is the payor type. (Provider).	30	Character
Rsn Code	This is the reason code assigned at the establishment of this A/R.	4	Number (Integer)
Recoupment Amount	This is the dollar amount determined by the Alabama Medicaid Agency that is to be recouped from claims activity for each payment cycle until the A/R balance has been recovered.	20	Number (Decimal)

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Field	Description	Length	Data Type
Recoupment Percent	This is the percent amount determined by the Alabama Medicaid Agnecy that is to be recouped from claims activity for each payment cycle until the A/R balance has been recovered.	20	Number (Decimal)
Totals	These are the totals calculated for the appropriate columns.	80	Number (Decimal)

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7.58 FIN-AR42-W – Accounts Receivable – Aging by Fund Code

7.58.1 FIN-AR42-W – Accounts Receivable – Aging by Fund Code Narrative

The Accounts Receivable-Aging by Fund Code report lists all accounts receivable in aged category order. An ‘X’ in the ‘Activity Flag’ field indicates that the accounts receivable has aged 30 days with no activity within the last 30 day period. This report is utilized to aid in the control of all aged account receivables and to report all accounts which are outstanding at the end of each financial cycle. In addition, it is used to research and validate those accounts receivables which have aged greater than 15 days prior to collection action being initiated.

This report is produced weekly.

7.58.2 FIN-AR42-W – Accounts Receivable – Aging by Fund Code Layout

```
Report  : FIN-AR42-W                          ALABAMA MEDICAID AGENCY                          Run Date: 01/11/2007
Process : FINJWAR42                   MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   19:12:12
Location: FINPAR420                             ACCOUNTS RECEIVABLE                                Page:        24
                                              AGING BY FUND CODE
                                        PERIOD: 12/29/2006 - 01/11/2007

FUND CODE: PHYSICIANS
------PAYEE-------  DAYS    LAST     EFF    ACT      A/R          ICN        RSN     ORIGINAL     CASH       OFFSET    ADJUSTMENT    BALANCE
ID            TYPE  OUTST   DATE     DATE   FLG     NUMBER                  CODE    AMOUNT     RECEIPTS     AMOUNT      AMOUNT

[redacted]     P    10 20061011 20060627    X [redacted]                    9000        15.79                  0.00                      5.79
                                                                                                   0.00                    10.00
SUBTOTALS     00-15                                                              15.79                  0.00                      5.79
                                                                                                   0.00                    10.00

[redacted]     P   427 20060928 20050426    X [redacted]                    8404       797.99                342.86                    455.13
                                                                                                   0.00                     0.00
SUBTOTALS     121+                                                               797.99                342.86                    455.13
                                                                                                   0.00                     0.00

FUND TOTALS                                                                      813.78                342.86                    460.92
                                                                                                   0.00                    10.00

GRAND TOTALS                                                                 164,633.01              4,098.23               160,439.78
                                                                                                  50.00                    45.00

                                        * * * END OF REPORT * * *
```


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7.58.3 FIN-AR42-W – Accounts Receivable – Aging by Fund Code Field Descriptions

Field	Description	Length	Data Type
A/R Number	This is the number used to track account receivables throughout the system.	13	Number (Integer)
Act Flg	Activity Flag, this indicates if no activity has occurred within the last 30 days.	1	Character
Adjustment Amount	This indicates the changes made to the A/R balance other than cash or offsets, such as state directed write-offs or increases.	10	Number (Decimal)
Balance	This is the original amount less any recovered amounts.	10	Number (Decimal)
Cash Receipts	This indicates a manual payment made to the fund to decrease an account receivable file.	10	Number (Decimal)
Days Outst	This field indicates the number of days from the “effective date” to the current cycle date for this A/R number. The field will report in the following groupings: 121+ days, 91-120 days, 61-90 days, 31-60 days, 16-30 days and 00-15 days.	4	Number (Integer)
Eff Date	This is the date on which the accounts receivable became active.	8	Date (CCYYMMDD)
Fund	This is the fund description of which the A/R is associated.	50	Character
Fund Totals	This is the subtotal amounts for each fund.	11	Number (Decimal)
Grand Totals	This is the grand total for each column.	12	Character
ICN	This is the claim number related to the account receivable.	13	Number (Integer)
Last Date	This is the last activity date on which the provider last had debit activity.	8	Date (CCYYMMDD)
Offset Amount	This indicates the amount which has been offset from the weekly claim cycle to satisfy the accounts receivable to date. In addition, other state directed offsets will also be reflected in this field.	10	Number (Decimal)
Original Amount	This is the original amount indicates the setup amount of the receivable.	10	Number (Decimal)
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID or 10 digit NPI.	15	Character
Payee Type	This is the unique code which identifies the Payee Type. (In Alabama, this will always be Provider.)	1	Character
Rsn Code	This reason code indicates how and why the A/R was established.	4	Character
Subtotals	This is the subtotal amounts for each aging period.	11	Number (Decimal)

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7.59 FIN-AR43-W – Accounts Receivable – Weekly Activity – by RSN Code

7.59.1 FIN-AR43-W – Accounts Receivable – Weekly Activity – by RSN Code Narrative

The Accounts Receivable-Weekly Activity-by RSN Code report summarizes weekly activity associated with outstanding provider account receivables (A/R) for each financial cycle. This report is utilized to aid in the tracking and control of account receivables, and to track all weekly activity associated with an outstanding A/R. This report is grouped by reason code, including subtotals at reason code breaks.

This report is produced weekly.

7.59.2 FIN-AR43-W – Accounts Receivable – Weekly Activity – by RSN Code Layout

```
REPORT  : FIN-AR43-W                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
PROCESS : FINJWAR41                           MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
LOCATION: FINPAR41W                                   ACCOUNTS RECEIVABLE                                     Page:     99,999
                                                 WEEKLY ACTIVITY - BY RSN CODE
                                                 PERIOD: MM/DD/CCYY - MM/DD/CCYY

                          LAST
  -------PAYEE------    ACTIVITY        A/R        ----RECOUPMENT----        BEGINNING     CASH AMOUNT  OFFSET AMOUNT    ADJUSTMENT       ENDING
  ID             TYPE     DATE         NUMBER      PERCENT      AMOUNT        BALANCE      THIS CYCLE      THIS CYCLE                     BALANCE
RSN CODE: 9999
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
                                          SUBTOTAL FOR REASON CODE:     99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99

RSN CODE: 9999
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
  XXXXXXXXXXXXXXX  X  MM/DD/CCYY  XXXXXXXXXXXX    999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99   9,999,999.99
                                          SUBTOTAL FOR REASON CODE:     99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99

                                                     TOTALS:            99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99
```


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7.59.3 FIN-AR43-W – Accounts Receivable – Weekly Activity – by RSN Code Field Descriptions

Field	Description	Length	Data Type
A/R Number	This is the number used to track account receivables throughout the system.	13	Number (Integer)
Adjustment	These are the changes made to the A/R balance other than cash or offsets, such as state directed write-offs or increases.	11	Number (Decimal)
Beginning Balance	This is the last receivable balance for this A/R number and provider prior to the start of the current financial cycle. This should equal the ending balance of the previous weeks report.	11	Number (Decimal)
Cash Amount This Cycle	This indicates the cash payments made in this processing cycle to decrease an account receivable.	11	Number (Decimal)
Ending Balance	This is the current Account Receivable balance after this cycle date. Calculated by taking the A/R Balance At the Beginning of the Cycle, less the Cash Receipts This Cycle, less the Offset Amount This Cycle, and plus or minus the Adjustments.	11	Number (Decimal)
Last Activity Date	This is the date the last activity was posted to the claims system.	10	Date (MM/DD/CCYY)
Offset Amount This Cycle	This is the Amount satisfied in this cycle due to offsetting amounts otherwise due to the provider.	11	Number (Decimal)
Payee ID	Medicaid Identification Number of the payee. The field allows for 15 bytes. It displays the 8 or 9 byte Medicaid provider ID or the 10 byte NPI.	15	Character
Payee Type	This is the unique code which identifies the Payee Type. (In Alabama, this will always be Provider.)	1	Character
RSN Code	This is the reason code assigned at the establishment of this A/R.	4	Character
Recoupment Amount	This is the dollar amount determined by the Agency to be recouped from claims activity for each payment cycle until the A/R balance has been recovered.	11	Number (Decimal)
Recoupment Percent	This is the percent amount determined by the State to be recouped from claims activity for each payment cycle until the A/R balance has been recovered.	5	Number (Decimal)

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Field	Description	Length	Data Type
Subtotal for Reason Code	This is the subtotal for each column per reason code.	11	Number (Decimal)
Totals	This is the total for each column.	12	Number (Decimal)

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7.60 FIN-AU01-M 835/EFT 3 Day Compliance Audit Report

7.60.1 FIN-AU01-M 835/EFT 3 Day Compliance Audit Report Narrative

The 835/EFT 3 Day Compliance Audit Report shows that Alabama is within the 90% compliance for ACA III Rule 370 that states that all 835's must be returned within 3 days of the providers EFT being sent.

The report details the number of 835's released to providers that also receive an EFT payment between the first and last day of the month previous to today. Within that, it also shows the number of those 835's that were in compliance and those that were out of compliance, along with percentages for each. For those that were out of compliance, details of Medicaid ID, provider name, check write date, 835 release date, EFT release date, funding group and number of days(days out of compliance) between 835 release date and EFT release date are shown.

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7.60.2 FIN-AU01-M 835/EFT 3 Day Compliance Audit Report Layout

```
Report  : FIN-AU01-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : FINAU01                        MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: FINAU01M                        835/EFT 3 DAY COMPLIANCE AUDIT REPORT                             Page:      9,999
                                     AUDIT REPORT PERIOD:  MM/DD/YY THROUGH MM/DD/YY
-------------------------------------------------------------------------------------------------------------------------------

 TOTAL 835/TRANSMITTED:       999,999

 TOTAL 835/EFT <= 3 DAYS:     999,999     999.99% (IN COMPLIANCE)
 TOTAL 835/EFT > 3 DAYS:      999,999     999.99% (OUT OF COMPLIANCE)

                                                  --- 835/EFT OUT OF COMPLIANCE ---

 PROVIDER ID       PROVIDER NAME                                        CHECK WRITE   835 RELEASE    EFT RELEASE   FUNDING   NUMBER
                                                                            DATE          DATE           DATE       GROUP     DAYS
 XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY     XXX      9999


    ********************************************** NO PROVIDERS OUT OF COMPLIANCE **********************************************

    ************************************************** END OF REPORT ***************************************************************
```

7.60.3 FIN-AU01-R 835/EFT 3 Day Compliance Audit Report Descriptions

Field	Description	Length	Data Type
835 Release Date	The 835 release date	10	Date (MM/DD/CCYY)
Audit Report Period--begin	The beginning date for the period of this run	10	Date (MM/DD/CCYY)
Audit Report Period--end	The ending date for the period of this run	10	Date (MM/DD/CCYY)
Check Write Date	The check write date	10	Date (MM/DD/CCYY)
EFT Release Date	The EFT Release Date	10	Date (MM/DD/CCYY)
Funding Group	The funding group code	2	Character
Number Days	The number of days out of compliance	4	Number (Integer)

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Field	Description	Length	Data Type
Provider ID	The pay-to provider's Medicaid ID	15	Character
Provider Name	The provider's pay-to name	50	Character
Total 835/EFT <= 3 Days	The 835/EFT transactions that are less that or equal to 3 days (in compliance)	7	Number (Integer)
Total 835/EFT <= 3 Days Percent	The percent in compliance	7	Number (Decimal)
Total 835/EFT > 3 Days	The 835/EFT transactions that are that 3 days (out of compliance)	7	Number (Integer)
Total 835/EFT > 3 Days Percent	The percent out of compliance	7	Number (Decimal)
Total 835/Transmitted	The total 835 Transmitted in this period	7	Number (Integer)

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7.61 FIN-AU02-R EOB CARC/RARC Cross Walking Audit Report

7.61.1 FIN-AU02-R EOB CARC/RARC Cross Walking Audit Report Narrative

The EOB CARC/RARC Cross Walking Audit Report reports any EOB that did not cross walk in the check write cycle. The result of not cross walking will cause a CO/193 to be sent to the provider.

A cross walk takes place for each EOB to a Claim Adjustment Reason Code (CARC) and Remarks Reason Code (RARC). This cross walk is maintained for the 835 processing of a claim. For each EOB that is set, a valid cross walk combination is established that is sent to a provider, that gives an explanation about their claims (such as to why something did not pay as they submitted). Alabama specific EOB's cannot be sent, but they must be cross walked to a valid HIPAA CARC/RARC combination. EOB's are cross walked by a combination of the date of service on a claim and the date that the claim is processed on an 835. If any EOB is processed that does not have a valid combination on the date of the check write cycle, a default CARC of 193 (which was determined by the Agency as a general generic response) is sent (no RARC). This is then detailed on this report so that a cross walk combination can be established before the next check write cycle.

The report details each EOB and each claim and detail that did not cross walk. This lists each error, sorted by error type (Either by paid date, run date, or using a previous cross walk), EOB, financial run date, claim to date of service, ICN, and detail number.

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7.61.2 FIN-AU02-R EOB CARC/RARC Cross Walking Audit Report Layout

```
Report  : FIN-AU02-R                          ALABAMA MEDICAID AGENCY                                    Run Date: xx/xx/xxxx
Process : FINJRA02                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   xx:xx:xx
Location: FINPAU02                        EOB CARC/RARC CROSS WALKING REPORT                                 Page:      xxxxx
                                          CHECK WRITE CYCLE DATE: XX/XX/XXXX

                                          - CARC/RARC CROSS WALKING ISSUES -

                             DETAIL   CLAIM   CLAIM     TO DATE OF    PAID
 EOB      ICN                NUMBER    TYPE   STATUS     SERVICE      DATE      CROSS WALK ISSUE
-------------------------------------------------------------------------------------------------------------------------------

 XXXX     XXXXXXXXXXXXX        999       X       X       XX/XX/XXXX  XX/XX/XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXX     XXXXXXXXXXXXX        999       X       X       XX/XX/XXXX  XX/XX/XXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 TOTAL EOBS WITH CROSS WALKING ISSUES:               999,999
 TOTAL CLAIMS WITH CROSS WALKING ISSUES:             999,999
 TOTAL CLAIM DETAILS WITH CROSS WALKING ISSUES:      999,999
    ********************************************** NO CROSS WALK ISSUES ***********************************************

    ************************************************* END OF REPORT ***************************************************
```

7.61.3 FIN-AU02-R EOB CARC/RARC Cross Walking Audit Report Descriptions

Field	Description	Length	Data Type
Claim Status	Claim status, Paid (P), Denied (D), Suspended (S).	1	Character
Claim Type	Type of Claim.	1	Character

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Field	Description	Length	Data Type
Cross Walk Issue	Type of cross walk issue that failed. • NO CROSS WALK FOUND USING RUN DATE AND TDOS -> No cross walk was found using current check write run date and claim TDOS • NO CROSS WALK FOUND USING PAID DATE AND TDOS -> No cross walk was found using original paid date and claim TDOS (adjusted claim) – This would occur in the original claim never had a cross walked value • NO CROSS WALK FOUND USING ORIGINAL CROSS WALK DATA -> No cross walk was found using the original cross walked values that were returned on the original 835 (adjusted claim)	50	Character
Cycle Date	Date of the financial cycle.	10	Date (MM/DD/CCYY)
Detail Number	Claim detail number.	3	Number (integer)
EOB	Explanation of Benefits Code.	4	Character
ICN	ICN Number.	15	Character
Paid Date	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	10	Date (MM/DD/CCYY)
To Date of Service	To date of service for the claim detail	10	DATE(MM/DD/CCYY)
Total EOBS With Cross Walking Issues	Total number of unique EOBs that failed the cross walk in the financial cycle.	6	Number (Integer)
Total Claims With Cross Walking Issues	Total number of unique ICN's that failed the cross walk in the financial cycle	6	Number (Decimal)

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Field	Description	Length	Data Type
Total Claim Details With Cross Walking Issues	Total number of claim details that failed the cross walk in the financial cycle	6	Number (Integer)

7.62 FIN-BAAR-R – Provider YTD Offset Balancing

7.62.1 FIN-BAAR-R – Provider YTD Offset Balancing Narrative

The Provider YTD Offset Balancing report is an internal EDS Financial report used to verify that the provider earnings files are in balance with the payment transactions. This report contains some System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This report reports any differences between the sum of AR offsets and the YTD offsets for claims and non-claims transactions.

This report is produced during the financial cycle.

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7.62.2 FIN-BAAR-R – Provider YTD Offset Balancing Layout

```
REPORT:   FIN-BAAR-R                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS:  FINJRBAL-AR                   MEDICAID MANANGMENT INFORMATION SYSTEM                   RUN TIME: HH:MM:SS
LOCATION: FINP_BAL_AR                      PROVIDER YTD OFFSET BALANCING                            PAGE: 9,999
                                         PERIOD: MM/DD/CCYY - MM/DD/CCYY


PROVIDER SAK      YTD NON-CLAIM OFFSET   YTD ADVANCED OFFSET       YTD CAIM OFFSET      AR TABLE OFFSET


                                                 * * REPORT BALANCED * * *
```

```
REPORT:   FIN-BAAR-R                          ALANAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS:  FINJRBAL-AR                   MEDICAID MANAGEMENT INFORMATION SYSTEMS                  RUN TIME: HH:MM:SS
LOCATION: FINP_BAL_AR                      PROVIDER YTD OFFSET BALANCING                            PAGE: 9,999
                                         PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                         FINANCIAL CYCLE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


 PROVIDER SAK      YTD NON-CLAIM OFFSET   YTD ADVANCED OFFSET       YTD CAIM OFFSET      AR TABLE OFFSET

 999999999           99,999,999.99          99,999,999.99          99,999,999.99         99,999,999.99
 999999999           99,999,999.99          99,999,999.99          99,999,999.99         99,999,999.99
 999999999           99,999,999.99          99,999,999.99          99,999,999.99         99,999,999.99
 999999999           99,999,999.99          99,999,999.99          99,999,999.99         99,999,999.99


                                             * * * REPORT NOT BALANCED * * *
```


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7.62.3 FIN-BAAR-R -- Provider YTD Offset Balancing Field Descriptions

Field	Description	Length	Data Type
AR Table Offset	This is the account receivable Offset amount.	10	Number (Decimal)
Financial Cycle	This is the name of the financial cycle that is being balanced. For Provider, this will be Main Financial Cycle.	30	Character
Provider SAK	This is the provider's system assigned key for the out of balance record.	8	Number (Integer)
YTD Advanced Offset	This is the year to date advanced offset amount.	10	Number (Decimal)
YTD Claim Offset	This is the year to date offset amount for claims type transactions.	10	Number (Decimal)
YTD Non-Claim Offset	This is the year to date offset amount for non-claims transactions.	10	Number (Decimal)

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7.63 FIN-BACH-R -- Provider YTD Check Balancing

7.63.1 FIN-BACH-R -- Provider YTD Check Balancing Narrative

The Provider YTD Check Balancing report is an internal EDS Financial report used to verify that provider earnings files are in balance with the payment transactions. This report contains some System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This reports any differences between the total sum of checks for the provider and the YTD check amount.

This report is produced during the financial cycle.

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7.63.2 FIN-BACH-R -- Provider YTD Check Balancing Layout

```
REPORT : FIN-BACH-R                                    ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS: FINJRBAL_CHK                             MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME: HH:MM:SS
LOCATION:FINP_BAL_CHK                                PROVIDER YTD CHECK BALANCING                                   PAGE:     9,999
                                                   PERIOD: MM/DD/CCYY - MM/DD/CCYY


PROVIDER
TOTAL AMT PAID +PAID TOT ADJ  +PAID ADMIN  + PAID CAP + EXPENSE TOT + CLAIM INTEREST -CLAIM OFFSET - NONCLM OFFSET - ADVANCE OFFSET = CHECK TOT

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99

999999999999999
999,999,999.99  9,999,999.99 9,999,999.99 9,999,999.99  9,999,999.99  9,999.999.99  99,999,999.99  99,999,999.99  99,999,999.99  999,999,999.99


  TOTAL CHECK/EFT BY PROVIDER:         ####
  TOTAL CHECK/EFT BY DATE ISSUED:      ####

                                                   * * * END OF REPORT * * *

                                              * * * REPORT DOES NOT BALANCE!!! * * *
```


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7.63.3 FIN-BACH-R -- Provider YTD Check Balancing Field Descriptions

Field	Description	Length	Data Type
Advance Offset	This is the amount deducted for advance offsets.	10	Number (Decimal)
Check Tot	This is the total amount of the check.	11	Number (Decimal)
Claim Interest	This is the amount paid for claim interest.	9	Number (Decimal)
Claim Offset	This is the amount deducted for claim offsets.	10	Number (Decimal)
Expense Tot	This is the amount paid for expenses.	9	Number (Decimal)
NonClm Offset	This is the amount deducted for non-claim offsets.	10	Number (Decimal)
Paid Admin	This is the amount paid for admin fee.	9	Number (Decimal)
Paid Cap	This is the amount paid for capitation fee.	9	Number (Decimal)
Paid Tot Adj	This is the total amount paid for adjustments.	9	Number (Decimal)
Provider	This is the provider system assigned key code.	9	Character
Total Amt Paid	This is the total amount paid for original claims.	9	Number (Decimal)
Total Check/EFT by Date Issued	This is the number of checks or electronic fund transfers issued for the payment date.	4	Number (Integer)
Total Check/EFT by Provider	This is the number of checks or electronic fund transfers issued to providers.	4	Number (Integer)

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7.64 FIN-BACY-R -- Financial Balancing

7.64.1 FIN-BACY-R -- Financial Balancing Narrative

The Financial Balancing Report contains system-generated financial counts and dollar totals on claim and non-claim transactions processed in the financial cycle. The Financial Balancing Report is a system-generated tool created for the purpose of allowing the cycle monitor to ensure the financial cycle is balanced and no errors have occurred. Please note: The form counts for paid claims represent the paid claims that were selected for payment. Please note that there are entries on this CORE report that do not apply to Alabama, and there fore will always be zero. Alabama does not do fiscal pends, payment holds, or FICA. Since this is a standard CORE balancing report, these items will remain and will simply report zeros.

This report is produced during the financial cycle.

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7.64.2 FIN-BACY-R -- Financial Balancing Layout

```
REPORT:   FIN-BACY-R                          ALABAMA MEDICAID AGENCY                                                    RUN DATE: MM/DD/CCYY
PROCESS:  FINJRBAL_CYC                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                        RUN TIME:   HH:MM:SS
LOCATION: FINP_BAL_CYCLE                       FINANCIAL BALANCING REPORT                                                PAGE:          9,999
                                             PERIOD: MM/DD/CCYY - MM/DD/CCYY
       Claims Extracted By Form:


                PHARMACY:
                         Original Claims      +       999,999,999.99                Number of Paid Claims           999,999,999
                         Paid Adjustments     +       999,999,999.99                Number of Denied Claims         999,999,999
                         A/R Adjustments      -       999,999,999.99                Number of Suspended Claims      999,999,999
                         C/R Adjustments      -       999,999,999.99                Number of Adjusted Claims       999,999,999
                         Payment Holds        -       999,999,999.99                Number of Holds                 999,999,999
                         Fiscal Pend          -       999,999,999.99                Number of Pends                 999,999,999
                                                                                    Number of Encounters            999,999,999

                CMS 1500:
                         Original Claims      +       999,999,999.99                Number of Paid Claims           999,999,999
                         Paid Adjustments     +       999,999,999.99                Number of Denied Claims         999,999,999
                         A/R Adjustments      -       999,999,999.99                Number of Suspended Claims      999,999,999
                         C/R Adjustments      -       999,999,999.99                Number of Adjusted Claims       999,999,999
                         Payment Holds        -       999,999,999.99                Number of Holds                 999,999,999
                         Fiscal Pend          -       999,999,999.99                Number of Pends                 999,999,999
                                                                                    Number of Encounters            999,999,999

                DENTAL:
                         Original Claims      +       999,999,999.99                Number of Paid Claims           999,999,999
                         Paid Adjustments     +       999,999,999.99                Number of Denied Claims         999,999,999
                         A/R Adjustments      -       999,999,999.99                Number of Suspended Claims      999,999,999
                         C/R Adjustments      -       999,999,999.99                Number of Adjusted Claims       999,999,999
                         Payment Holds        -       999,999,999.99                Number of Holds                 999,999,999
                         Fiscal Pend          -       999,999,999.99                Number of Pends                 999,999,999
                                                                                    Number of Encounters            999,999,999

                UB04:
                         Original Claims      +       999,999,999.99                Number of Paid Claims           999,999,999
                         Paid Adjustments     +       999,999,999.99                Number of Denied Claims         999,999,999
                         A/R Adjustments      -       999,999,999.99                Number of Suspended Claims      999,999,999
                         C/R Adjustments      -       999,999,999.99                Number of Adjusted Claims       999,999,999
                         Payment Holds        -       999,999,999.99                Number of Holds                 999,999,999
                         Fiscal Pend          -       999,999,999.99                Number of Pends                 999,999,999
                                                                                    Number of Encounters            999,999,999
                                            -----------------------
                TOTAL CLAIMS EXTRACTED       =       999,999,999.99

       Regular Expenditures Extracted        +       999,999,999.99
       Immediate Expenditures Extracted      +       999,999,999.99
       Manual Expenditures Extracted         +       999,999,999.99
          Expenditure Holds                  -       999,999,999.99
          Expenditure Fiscal Pends           -       999,999,999.99
       Capitation Payment                    +       999,999,999.99
          Capitation Holds                   -       999,999,999.99
```


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```
          Capitation Fiscal Pends              -       999,999,999.99

                                             -----------------------
       TOTAL  EXPENSES                        =       999,999,999.99
       ------------------------------------------------------------
       Offsets Applied In Current Cycle       -       999,999,999.99
       Total FICA Deducted In Current Cycle   -       999,999,999.99
                                             -----------------------
          Total Payments Due Before Credits   =       999,999,999.99

       History Credits:
          System A/R's Created                +       999,999,999.99
          System Cash Receipt Dispositions    +       999,999,999.99
          Cash Receipt Disposition Reissue    +       999,999,999.99
                                             -----------------------
       TOTAL PAYMENTS DUE                             999,999,999.99
       ============================================================

REPORT:   FIN-BACY-R                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS:  FINJRBAL_CYC                      MEDICAID MANAGEMENT INFORMATION SYSTEM                             RUN TIME:   HH:MM:SS
LOCATION: FINP_BAL_CYCLE                      FINANCIAL BALANCING REPORT                                       PAGE:          9,999
                                            PERIOD: MM/DD/CCYY - MM/DD/CCYY

       Payments:
          System Checks Issued                           999,999,999.99
          Manual Checks Issued/Reissued                  999,999,999.99
          EFT's Transmitted                              999,999,999.99
                                             -----------------------
       TOTAL PAYMENTS ISSUED                             999,999,999.99
       ============================================================
       Difference (Payments Due - Payments Issued)       999,999,999.99


                ADJUSTMENT CLAIM SUMMARY INFORMATION:

                                                 GROSS PAID AMOUNT                                   COUNTS

                    PHARMACY ADJUSTMENTS     -      999,999,999.99           ADJUSTMENT COUNT          99,999
                    CMS 1500 ADJUSTMENTS     -      999,999,999.99           ADJUSTMENT COUNT          99,999
                    DENTAL ADJUSTMENTS       -      999,999,999.99           ADJUSTMENT COUNT          99,999
                    UB04 ADJUSTMENTS         -      999,999,999.99           ADJUSTMENT COUNT          99,999

                                                         END OF REPORT
```


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7.64.3 FIN-BACY-R -- Financial Balancing Field Descriptions

Field	Description	Length	Data Type
Capitation Fiscal Pend	Dollar totals of all capitations that were held due to fiscal pends	11	Number (Decimal)
Capitation Holds	Dollar totals of all capitations that were held due to Payment holds	11	Number (Decimal)
Capitation Payment	The dollar amount of capitation payments processed from the Managed Care program. To be accumulated the following must be true: the Date effective must equal the maximum date effective for the MCO and code region, the system assigned key MCO must be valid and the Code region must be valid. The dollar amounts will only be brought in to the financial cycle once every month since Managed Care jobs run monthly to produce the current month payments.	11	Number (Decimal)
Cash Receipt Disposition Reissue	The amount of the cash receipt disposition reissue.	11	Number (Decimal)
Dental Adjustments – Gross Paid Amount	This is gross paid amount for Dental Adjustments.	11	Number (Decimal)
Dental Adjustments – Adjustment Count	The Dental Adjustments Adjustment Count.	5	Number (Integer)
Dental - A/R Adjustments	Total dollar amount of negative payment result adjustments for claim type D. To be accumulated the following must be true: Adjustment claim may be paid or denied, amount paid of adjustment claim will be less than amount paid of original claim. ICN will have region 45, 46, or 49 – 60. If the region is 51 or 54 then the following equation applies - (adjustment claim amount paid minus original claim amount paid) plus cash receipt disposition amount will be less than zero. For all other regions 45, 46, 49-50, 52-53, 55-60, the adjustment claim amount paid minus the original claim amount paid less than zero.	11	Number (Decimal)
Dental - C/R Adjustments	Total dollar amount of negative payment result adjustments for claim type D. To be accumulated the following must be true: Adjustment claim may be paid or denied, amount paid of adjustment claim equal to or less than amount paid of original claim. ICN will have region 51 or 54 and (adjustment claim amount paid minus original claim amount paid) plus cash receipt disposition amount is zero.	11	Number (Decimal)

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Field	Description	Length	Data Type
Dental - Number of Adjusted Claims	Total count of all finalized adjustment dental claims processed during the financial cycle. Claim type D are paid or denied with an ICN region of 45, 46, or 49-60.	9	Number (Integer)
Dental - Number of Denied Claims	Total count of all denied status dental claims processed in the financial cycle. Claim type D with claim status D.	9	Number (Integer)
Dental - Number of Paid Claims	Total count of all paid status dental claims processed in the financial cycle. Claim type D with claim status P.	9	Number (Integer)
Dental - Number of Suspended Claims	Total count of all suspended status dental claims at the time of the financial cycle. Claim type D with claim status S.	9	Number (Integer)
Dental - Original Claims	Dollar totals of all claim net payments on paid original claims processed during the cycle for claim type D.	11	Number (Decimal)
Dental - Paid Adjustments	Dollar totals of claim net payments for paid positive result adjustments for claim type D. To be accumulated the following must be true: The region of the ICN 45, 46, or 49-60. The adjustment claim amount is greater or equal to the original claim payment.	11	Number (Decimal)
Dental Fiscal Pend	This is the total dollar amount of fiscal pends for claim type D.	11	Number (Decimal)
Dental Number of Encounters	Total count of all encounters for claim type D.	9	Number (Integer)
Dental Number of Holds	Total count of all payment holds for claim type D.	9	Number (Integer)
Dental Number of Pends	Total count of all fiscal pends for claim type D.	9	Number (Integer)
Dental Payment Holds	This is the total dollar amount of payment holds for claim type D.	11	Number (Decimal)
Difference (Payments Due -- Payments Issued)	This is the difference between (Total Payments Due - Total Payments Issued). If the difference is zero, then the cycle has balanced. Anything other than a zero will be researched by the cycle monitor for the cause of the out of balance situation and corrected where possible.	11	Number (Decimal)
Expenditure Fiscal Pend	Dollar totals of all expenditures that were held due to fiscal pend.	11	Number (Decimal)

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Field	Description	Length	Data Type
Expenditure Holds	Dollar totals of all expenditures that were held due to payment holds.	11	Number (Decimal)
CMS1500 Adjustments – Gross Paid Amount	The adjustment gross amount for CMS 1500.	5	Number (Decimal)
CMS1500 Adjustments – Adjustment Count	The CMS 1500 Adjustments Adjustment Count.	5	Number (Integer)
CMS1500 - A/R Adjustments	Total dollar amount of negative payment result adjustments for claim types M and B. To be accumulated the following must be true: Adjustment claim may be paid or denied. Amount paid of the adjustment will be less than amount paid of original claim. ICN has region 45, 46, or 49-60.If the region is 51 or 54 then the following equation applies: adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount less than zero. For all other regions 45, 46, 49-50, 52- 3, 55-60, adjustment amount paid minus original claim amount paid less than zero.	11	Number (Decimal)
CMS1500 - C/R Adjustments	Total dollar amount of negative payment result adjustments for claim types M and B. To be accumulated the following must be true: Adjustment claim may be paid or denied. Amount paid of the adjustment will be equal to or less than amount paid of original claim. ICN has region 51 or 54 and (adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount is zero.	11	Number (Decimal)
CMS1500 - Number of Adjusted Claims	Total count of all finalized adjustment CMS 1500 claims processed during the financial cycle. Claim types M and B that are paid or denied with an ICN region of 45, 46, or 49-60.	9	Number (Integer)
CMS1500 - Number of Denied Claims	Total count of all denied status CMS 1500 claims processed in the financial cycle. Claim types M and B with claim status D.	9	Number (Integer)
CMS1500 - Number of Paid Claims	Total count of all paid status CMS 1500 claims processed in the financial cycle. Claim types M and B with claim status P.	9	Number (Integer)
CMS1500 - Number of Suspended Claims	Total count of all suspended status CMS 1500 claims at the time of the financial cycle. Claim types M and B with claim status S.	9	Number (Integer)

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Field	Description	Length	Data Type
CMS1500 - Original Claims	Dollar totals of all claim net payments for paid original claims processed during the cycle for claim types M and B.	11	Number (Decimal)
CMS1500 - Paid Adjustments	Dollar totals of claim net payments for paid positive result adjustments for claim types M and B. To be accumulated the following must be true: The region of the ICN must 45, 46, or 49-60 The adjustment amount is more than or equal to the original claim payment.	11	Number (Decimal)
CMS1500 Fiscal Pend	This is the total dollar amount of fiscal pends for claim types M and B.	11	Number (Decimal)
CMS1500 Number of Encounters	Total count of all encounters for claim types M and B.	9	Number (Integer)
CMS1500 Number of Holds	Total count of all payment holds for claim types M and B.	9	Number (Integer)
CMS1500 Number of Pends	Total count of all fiscal pends for claim types M and B.	9	Number (Integer)
CMS1500 Payment Holds	This is the total dollar amount of payment holds for claim types M and B.	11	Number (Decimal)
History Credits: System A/R's Created	This field contains the Accounts Receivable which were system generated. The amounts are taken from the Accounts Receivable table where the Date added is within the financial cycle dates and the Code Reason Four is '8400' or '8420'. NOTE: For the report to balance, system A/R's created must equal the sum of all A/R adjustments from the claim extracted by form section of the report.	11	Number (Decimal)
History Credits: System Cash Receipt Dispositions	This field contains the cash receipt dispositions that were system generated. The amounts are taken from the Cash Receipt Dispositions table where the Date posted is within the financial cycle dates and the Code Reason Four is between '8000' and '8219' or the Code Reason Four is '8230'. NOTE: For the report to balance, system cash receipt dispositions must equal the sum of all C/R adjustments from the claim extracted by form section of the report.	11	Number (Decimal)
History Credits: Total Payments Due	This is the sum of (Total Payments Due Before Credits + System A/Rs Created + System Cash Receipt Dispositions).	11	Number (Decimal)

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Field	Description	Length	Data Type
Immediate Expenditures Extracted	The amount of Immediate Expenditures Extracted	11	Number (Decimal)
Manual Expenditures Extracted	The amount of Manual Expenditures Extracted	11	Number (Decimal)
Offsets Applied in Current Cycle	The amount of offsets applied in the current cycle	11	Number (Decimal)
Payments: EFT's Transmitted	This is the total accumulated amount of electronic fund transfers generated for the current financial cycle.	11	Number (Decimal)
Payments: Manual Checks Issues/Reissued	This field contains the checks that were manually generated by clerks. The amount is derived from the Expenditures table where the Date issued is within the financial cycle dates and the Code Payment Type = 'M'(manual).	11	Number (Decimal)
Payments: System Checks Issued	This amount is the total accumulated amount of paper checks written in the financial cycle.	11	Number (Decimal)
Payments: Total Payments Issued	This is the sum of all payments.	11	Number (Decimal)
Pharmacy Adjustments – Gross Paid Amount	The gross paid amount for Pharmacy Adjustments	5	Number (Decimal)
Pharmacy Adjustments – Adjustment Count	The Pharmacy Adjustments Adjustment Count	5	Number (Integer)
Pharmacy - A/R Adjustments	Total dollar amount of negative payment result adjustments for claim type P and Q. To be accumulated the following must be true: The adjustment may be paid or denied - amount paid of the adjustment less than amount paid of original claim - ICN region 45, 46, or 49 – 60. If the region is 51 or 54 then the following equation will apply - (adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount will be less than zero. For all other regions 45, 46, 49 - 50, 52 - 53, 55 - 60, adjustment amount paid minus original claim amount paid will be less than zero.	11	Number (Decimal)

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Field	Description	Length	Data Type
Pharmacy - C/R Adjustments	Total dollar amount of negative payment result adjustments for claim types P and Q. To be accumulated the following must be true: The adjustment claim can be paid or denied - Amount paid of the adjustment will be equal to or less than amount paid of original claim. ICN will have region 51 or 54 - (adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount will be zero.	11	Number (Decimal)
Pharmacy - Number of Adjusted Claims	Total count of all finalized adjustment pharmacy claims processed during the financial cycle. Claim types P and Q that are paid or denied with an ICN region of 45, 46, or 49-60.	9	Number (Integer)
Pharmacy - Number of Denied Claims	Total count of all denied status pharmacy claims processed in the financial cycle. Claim types P and Q with claim status D.	9	Number (Integer)
Pharmacy - Number of Paid Claims	Total count of all paid status pharmacy claims processed in the financial cycle. Claim types P and Q with claim status P.	9	Number (Integer)
Pharmacy - Number of Suspended Claims	Total count of all suspended status pharmacy claims at the time of the financial cycle. Claim types P and Q with claim status S.	9	Number (Integer)
Pharmacy - Original Claims	Dollar totals of all claim net payments for paid original claims processed during the cycle for claim types P and Q.	11	Number (Decimal)
Pharmacy - Paid Adjustments	Dollar totals of claim net payments on paid positive result adjustments for claim types P and Q. To be accumulated the following must be true: The region of the ICN must 45, 46, or 49 - 60- The adjustment amount is more than or equal to the original claim payment.	11	Number (Decimal)
Pharmacy Fiscal Pend	This is the total dollar amount of fiscal pends for claim types P and Q.	11	Number (Decimal)
Pharmacy Number of Encounters	Total count of all encounters for claim types P and Q.	9	Number (Integer)
Pharmacy Number of Holds	Total count of all payment holds for claim types P and Q.	9	Number (Integer)
Pharmacy Number of Pends	Total count of all fiscal pends for claim types P and Q.	9	Number (Integer)
Pharmacy Payment Holds	This is the total dollar amount of payment holds for claim types P and Q.	11	Number (Decimal)

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Field	Description	Length	Data Type
Regular Expenditures Extracted	The amount of Regular Expenditures Extracted.	11	Number (Decimal)
Total Claims Extracted	This is the sum of (Original Claims + Paid Claims - A/R Adjustments - C\R Adjustments) for all claims processed in the financial cycle.	11	Number (Decimal)
Total Expenses	This is the sum of (Total Claims Extracted + System Expenditures Extracted + Manual Expenditures Extracted + Capitation Payment).	11	Number (Decimal)
Total FICA Deducted in Current Cycle	This is the total dollar amount of FICA withheld in the current cycle.	11	Number (Decimal)
UB04 Adjustments – Gross Adjustment Amount	This is gross paid amount for UB04 Adjustments.	5	Number (Decimal)
UB04 Adjustments – Adjustment Count	The UB04 Adjustments Adjustment Count.	5	Number (Integer)
UB04 - A/R Adjustments	Total dollar amount of negative payment result adjustments for claim type A, C, I, L, and O. To be accumulated the following must be true: Adjustment claim may be paid or denied- Amount paid of adjustment less than amount paid of original claim- ICN will have region 45, 46, or 49-60. If the region is 51 or 54 the following equation applies: adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount less than zero. For all other regions 45, 46, 49-50, 52 - 53, 55-60, adjustment amount paid minus original claim amount paid less than zero.	11	Number (Decimal)
UB04 - C/R Adjustments	Total dollar amount of negative payment result adjustments for claim types A, C, I, L, and O. To be accumulated the following must be true: Adjustment claim may be paid or denied- Amount paid of Adjustment equal to or less than amount paid of original claim. ICN region 51 or 54 and (Adjustment amount paid minus original claim amount paid) plus cash receipt disposition amount is zero.	11	Number (Decimal)
UB04 - Number of Adjusted Claims	Total count of all finalized adjustment UB04 claims processed during the financial cycle. Claim types A, C, I, L, and O that are paid or denied with an ICN region of 45, 46, or 49 - 60.	9	Number (Decimal)

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Field	Description	Length	Data Type
UB04 - Number of Denied Claims	Total count of all denied status UB04 claims processed in the financial cycle. Claim types A, C, I, L, and O with claim status D.	9	Number (Integer)
UB04 - Number of Paid Claims	Total count of all paid status UB04 claims processed in the financial cycle. Claim types A, C, I, L, and O with claim status P.	9	Number (Integer)
UB04 - Number of Suspended Claims	Total count of all suspended status UB04 claims at the time of the financial cycle. Claim types A, C, I, L, and O with claim status S.	9	Number (Integer)
UB04 - Original Claims	Dollar totals of all claim net payments for paid original claims processed during the cycle for claim types A, C, I, L, and O.	11	Number (Decimal)
UB04 - Paid Adjustments	Dollar totals of claim net payments for paid positive result adjustments for claim types A, C, I, L, and O. To be accumulated the following must be true: The region of the ICN 45, 46, or 49-60. The adjustment is greater or equal to the original claim payment.	11	Number (Decimal)
UB04 Fiscal Pend	This is the total dollar amount of fiscal pends for claim types A, C, I, L, and O.	11	Number (Decimal)
UB04 Number of Encounters	Total count of all encounters for claim types A, C, I, L, and O.	9	Number (Integer)
UB04 Number of Holds	Total count of all payment holds for claim types A, C, I, L, and O.	9	Number (Integer)
UB04 Number of Pends	Total count of all fiscal pends for claim types A, C, I, L, and O.	9	Number (Integer)
UB04 Payment Holds	This is the total dollar amount of payment holds for claim types A, C, I, L, and O.	11	Number (Decimal)

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7.65 FIN-BAEX-R -- Provider YTD Expenditure Balancing

7.65.1 FIN-BAEX-R -- Provider YTD Expenditure Balancing Narrative

The Provider YTD Expenditure Balancing report is an internal EDS Financial report to verify that the provider earnings files are in balance with the payment transactions. This report contains some System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This report reports any differences between the provider YTD expenditure amount and the sum of expenditures.

This report is produced during the financial cycle.

7.65.2 FIN-BAEX-R -- Provider YTD Expenditure Balancing Layout

```
REPORT:   FIN-BAEX-R                          ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
Process:  FINJRBAL_EXP                   MEDICAID MANAGEMENT INFORMATION SYSTEM                       RUN TIME: HH:MM:SS
Location: FINP_BAL_EXP                     PROVIDER YTD EXPENDITURE BALANCING                           PAGE:     99,999
                                            PERIOD: MM/DD/CCYY - MM/DD/CCYY

 PROVIDER SAK           AMOUNT EXPENSE            MANUAL CHECK AMOUNT        AMOUNT EXPENSE TOTAL

  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99
  999999999             999,999,999.99               999,999,999.99             999,999,999.99

                                     * * * REPORT OUT OF BALANCE * * *
```


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7.65.3 FIN-BAEX-R -- Provider YTD Expenditure Balancing Field Descriptions

Field	Description	Length	Data Type
Amount Expense	This is the expense amount.	11	Number (Decimal)
Amount Expense Total	This is the total amount of the expenses.	11	Number (Decimal)
Manual Check Amount	This is the amount of the manual payment.	11	Number (Decimal)
Provider SAK	This is the provider system assigned key and location.	9	Number (Integer)

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7.66 FIN-BAMC-R -- Financial Managed Care Balancing

7.66.1 FIN-BAMC-R -- Financial Managed Care Balancing Narrative

The Financial Managed Care Balancing report is an internal EDS Financial report used to verify the provider earnings files are in balance with the payment transactions. This report shows the Capitation amounts for Providers. It also shows the year to date (YTD) amounts as well.

This report is produced during the financial cycle.

7.66.2 FIN-BAMC-R -- Financial Managed Care Balancing Layout

```
REPORT:   FIN-BAMC-R                        ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS:  FINJRBAL_CAP                 MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME:      HH:MM
LOCATION: FINP_BAL_CAP                  FINANCIAL MANAGED CARE BALANCING                         PAGE:      9,999
                                         PERIOD: MM/DD/CCYY - MM/DD/CCYY

 PROVIDER ID          AMT CAPITATION YTD    AMT CAPITATION

 999999999999999      $999,999,999.99       $999,999,999.99
 999999999999999      $999,999,999.99       $999,999,999.99
 999999999999999      $999,999,999.99       $999,999,999.99
 999999999999999      $999,999,999.99       $999,999,999.99
 999999999999999      $999,999,999.99       $999,999,999.99
 999999999999999      $999,999,999.99       $999,999,999.99


                                                 ***REPORT BALANCED***
```


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7.66.3 FIN-BAMC-R -- Financial Managed Care Balancing Field Descriptions

Field	Description	Length	Data Type
Amt Capitation	The dollar amount of the capitation payments for the provider for the week.	11	Number (Decimal)
Amt Capitation YTD	The dollar amount of the capitation payments accumulated Year To Date.	11	Number (Decimal)
Provider ID	This is the provider number (nine characters) or NPI (ten digits).	15	Number (Integer)

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7.67 FIN-BARE-R -- Provider YTD Refund Balancing

7.67.1 FIN-BARE-R -- Provider YTD Refund Balancing Narrative

The Provider YTD Refund Balancing report is an internal EDS Financial report used to verify the provider earnings files are in balance with the payment transactions. This report contains System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This report reports any differences between the provider year to date (YTD) refunds and the provider refunds.

This report is produced during the financial cycle.

7.67.2 FIN-BARE-R -- Provider YTD Refund Balancing Layout

```
 REPORT : FIN-BARE-R                                ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
 PROCESS: FINJRBAL_REF                            MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME: HH:MM:SS
 LOCATION:FINP_BAL_REF                              PROVIDER YTD REFUND BALANCING                             PAGE: 9,999
                                                   PERIOD: MM/DD/CCYY - MM/DD/CCYY


PROVIDER SAK          AMT CLAIM REFUND    AMT CLAIM REFUND YTD  AMT NON-CLAIM REFUND     AMT NON-CLAIM REFUND YTD


                                                 * * * REPORT BALANCED * * *




REPORT : FIN-BARE-R                                 ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS: FINJRBAL_REF                            MEDICAID MANANGMENT INFORMATION SYSTEM              RUN TIME: HH:MM:SS
LOCATION:FINP_BAL_REF                              PROVIDER YTD REFUND BALANCING                             PAGE: 9,999
                                                  PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                  FINANCIAL CYCLE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER SAK          AMT CLAIM REFUND    AMT CLAIM REFUND YTD  AMT NON-CLAIM REFUND     AMT NON-CLAIM REFUND YTD
999999999               99,999,999.99       99,999,999.99         99,999,999.99                 99,999,999.99
999999999               99,999,999.99       99,999,999.99         99,999,999.99                 99,999,999.99
999999999               99,999,999.99       99,999,999.99         99,999,999.99                 99,999,999.99
999999999               99,999,999.99       99,999,999.99         99,999,999.99                 99,999,999.99
999999999               99,999,999.99       99,999,999.99         99,999,999.99                 99,999,999.99


                                                 * * * REPORT NOT BALANCED * * *
```

7.67.3 FIN-BARE-R -- Provider YTD Refund Balancing Field Descriptions

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Field	Description	Length	Data Type
Amt Claim Refund	This is the amount of claim refund for this period.	11	Number (Decimal)
Amt Claim Refund YTD	This is the amount of claim refund for the year.	11	Number (Decimal)
Amt Non-Claim Refund	This is the amount of non-claim refund for this period.	11	Number (Decimal)
Amt Non-Claim Refund YTD	This is the amount of non-claim refund for the year.	11	Number (Decimal)
Provider SAK	This is the provider system assigned key and location.	9	Number (Integer)

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7.68 FIN-BAVO-R -- Provider YTD Void Balancing

7.68.1 FIN-BAVO-R -- Provider YTD Void Balancing Narrative

The Provider YTD Void Balancing report is an internal EDS Financial report used to verify the provider earnings files are in balance with the payment transactions. This report contains System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This report reports any differences between the provider YTD check voids and the provider voids on the t_check table and t_check_void table.

This report is produced during the financial cycle.

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7.68.2 FIN-BAVO-R -- Provider YTD Void Balancing Layout

```
REPORT : FIN-BAVO-R                                ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS: FINJRBAL_VOD                           MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME: HH:MM:SS
LOCATION:FINP_BAL_VOI                               PROVIDER YTD VOID BALANCING                              PAGE: 9,999
                                                  PERIOD: MM/DD/CCYY - MM/DD/CCYY

PROVIDER SAK       YTD VOID AMT   CASH RCPT NUM     CASH RCPT AMT   NUM CHECK     VOID      CHECK AMT

 NUMBER OF VOID CASH RECEIPTS PROCESSED:      0
 NUMBER OF VOID CASH RECEIPTS ON FILE:        0


* * REPORT BALANCED * *  *




REPORT : FIN-BAVO-R                                ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS: FINJRBAL_VOD                           MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME: HH:MM:SS
  LOCATION:FINP_BAL_VOI                             PROVIDER YTD VOID BALANCING                              PAGE: 9,999
                                                  PERIOD: MM/DD/CCYY - MM/DD/CCYY


 PROVIDER SAK       YTD VOID AMT   CASH RCPT NUM     CASH RCPT AMT    NUM CHECK     VOID      CHECK AMT
 999999999          99,999,999.99   XXXXXXXXX         99,999,999.99   XXXXXXXXX      X        99,999,999.99
 999999999          99,999,999.99   XXXXXXXXX         99,999,999.99   XXXXXXXXX      X        99,999,999.99
 999999999          99,999,999.99   XXXXXXXXX         99,999,999.99   XXXXXXXXX      X        99,999,999.99
 999999999          99,999,999.99   XXXXXXXXX         99,999,999.99   XXXXXXXXX      X        99,999,999.99

 NUMBER OF VOID CASH RECEIPTS PROCESSED:      0
 NUMBER OF VOID CASH RECEIPTS ON FILE:        0


                                                  * * * REPORT NOT BALANCED * *  *
```


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7.68.3 FIN-BAVO-R -- Provider YTD Void Balancing Field Descriptions

Field	Description	Length	Data Type
Cash Rcpt Amt	This is the cash receipt amount.	10	Character
Cash Rcpt Num	This is the unique identifier for the cash receipt.	11	Character
Check Amt	This is the check amount.	10	Number (Decimal)
Num Check	This is the check number identifier.	9	Character
Number of Void Cash Receipts Processed	This is the number of void cash receipt transactions that were processed.	6	Number (Decimal)
Number of Void Cash Receipts on File	This is the number of void cash receipt transactions that are on file.	6	Number (Decimal)
Provider SAK	This is the provider system assigned key and location.	9	Character
Void	This is the code status of the check.	1	Character
YTD Void Amt	This is the amount of voided checks for the provider.	10	Number (Decimal)

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7.69 FIN-BAXR-R -- Financial Payment Xref Balancing

7.69.1 FIN-BAXR-R -- Financial Payment Xref Balancing Narrative

The Financial Payment Xref Balancing report is an internal EDS Financial report used to verify that the provider earnings files are in balance with the payment transactions. This report contains System Assigned Keys (SAK) to assist the EDS staff to locate and address balancing issues quickly. This report is typically used by EDS's internal staff.

This report shows checks that are out of balance with the chk_clm_xref file. This report will show any differences between the check amount to the sum of all the amounts associated by the check xref table.

This report is produced during the financial cycle.

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7.69.2 FIN-BAXR-R -- Financial Payment Xref Balancing Layout

```
REPORT:   FIN-BAXR-R                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS:  FINJRBAL_XREF                  MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN TIME: HH:MM:SS
LOCATION: FINP_BAL_XREF                     FINANCIAL CHECK XREF BALANCING                          PAGE: 9,999
                                              CHECK DATE:  MM/DD/CCYY
                                                EFT DATE:  MM/DD/CCYY


                          CHECK NUMBER          CHECK AMOUNT              CHECK XREF AMOUNT
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99
                          999999999            999,999,999.99               999,999,999.99

                                              * * * REPORT NOT BALANCED * * *



REPORT:   FIN-BAXR-R                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/YYYY
PROCESS:  FINJRBAL_XREF                  MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN TIME: HH:MM:SS
LOCATION: FINP_BAL_XREF                     FINANCIAL CHECK XREF BALANCING                          PAGE: 9,999
                                              CHECK DATE:  MM/DD/CCYY
                                                EFT DATE:  MM/DD/CCYY


                          CHECK NUMBER         CHECK AMOUNT              CHECK XREF AMOUNT


                                                 * * * REPORT BALANCED * * *
```


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7.69.3 FIN-BAXR-R -- Financial Payment Xref Balancing Field Descriptions

Field	Description	Length	Data Type
Check Amount	This field shows the amount of the check issued.	11	Number (Decimal)
Check Date	Date the check was issued.	10	Date (MM/DD/CCYY)
Check Number	This field shows the number of the check in question.	9	Number (Decimal)
Check Xref Amount	This field shows the sum of the records from the check claims cross reference table.	11	Number (Decimal)
EFT Date	Date the electronic funds transfer was created.	10	Date (MM/DD/CCYY)

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7.70 FIN-CR05-W -- Cash Dispositioned Not Posted

7.70.1 FIN-CR05-W -- Cash Dispositioned Not Posted Narrative

The Cash Dispositioned Not Posted report itemizes all provider refund cash receipts which have been fully dispositioned but not fully posted. It lists the original cash receipt amount, disposition amounts posted to date and not posted to date for each receipt. It is broken down by Unit and for each Unit it is segregated into age categories of 00 - 20, 21 - 45, 46 - 60, 61 - 90, 91 - 120, 121 - 365 and 365 +days. It is used to identify cash control numbers with dispositions that still need to be posted. Appropriate staff will review this report on a weekly basis and those cash receipts will be prioritized for resolution.

The sequence is by Unit (MED, SURS,), then by age in days, then by Cash Control Number (CCN). Note that Drug Rebate and TPL are not represented on this report because their cash receipts are dispositioned within their own subsystems.

This report is produced during the financial cycle.

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7.70.2 FIN-CR05-W -- Cash Dispositioned Not Posted Layout

```
Report  : FIN-CR05-W                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : FINJWCR05                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:      HH:MM
Location: FINPCR05W                               CASH DISPOSITIONED                                       PAGE:      9,999
                                           UNIT: Medical

                     CCN                ORIGINAL AMOUNT          DISPOSITIONS                 DISPOSITIONS
                                                                 POSTED TO DATE               NONPOSTED TO DATE

                                            NO CASH RECEIPTS FOUND THAT ARE +365 DAYS OLD
121 - 364 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 91 - 120 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 61 - 90 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 46 - 60 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 21 - 45 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 0 - 20 DAYS
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
                     XXXXXXXXXXX            $9,999,999.99              $9,999,999.99              $9,999,999.99
     SUBTOTALS                            $999,999,999.99            $999,999,999.99            $999,999,999.99

 Medical                   TOTALS         $999,999,999.99            $999,999,999.99            $999,999,999.99
```


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```
Report  : FIN-CR05-W                          ALABAMA MEDICAID                                                    RUN DATE: MM/DD/CCYY
Process : FINJWCR05                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                    RUN TIME:   HH:MM:SS
Location: FINPCR05W                       CASH DISPOSITION NOT POSTED                                                 PAGE:      9,999
                                                   UNIT: All Units

 Medical                    TOTALS        $999,999,999.99             $999,999,999.99             $999,999,999.99
 TPL                        TOTALS        $999,999,999.99             $999,999,999.99             $999,999,999.99
 SURS                       TOTALS        $999,999,999.99             $999,999,999.99             $999,999,999.99
 Drug Rebate                TOTALS        $999,999,999.99             $999,999,999.99             $999,999,999.99
                                     ________________________    ________________________    ________________________
 = GRAND TOTALS FOR ALL UNITS            $999,999,999.99             $999,999,999.99             $999,999,999.99
                                     ========================    ========================    ========================
                                                   ** END OF REPORT **
```

7.70.3 FIN-CR05-W -- Cash Dispositioned Not Posted Field Descriptions

Field	Description	Length	Data Type
CCN	A unique number used for tracking cash receipts in the system.	11	Number (Integer)
Dispositions Nonposted to Date	This indicates the amount from the original check amount that can be directly associated with a specific adjustment or financial transaction grouping and has not been posted yet.	9	Number (Decimal)
Dispositions Posted to Date	This indicates the amount from the original check amount that can be directly associated with a specific adjustment or financial transaction grouping and has been posted.	9	Number (Decimal)
Grand Totals for All Units	The sum of all units.	12	Number (Decimal)
Original Amount	A check amount received by cash control clerk.	9	Number (Decimal)
Subtotals	Subtotals are calculated for each aging category.	9	Number (Decimal)
Totals	Totals are calculated for each Unit.	11	Number (Decimal)

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7.71 FIN-CR10-W -- Cash Disposition Adjustment Postings Report

7.71.1 FIN-CR10-W -- Cash Disposition Adjustment Postings Report Narrative

The Cash Disposition Adjustment Postings report details each of the Cash Control Numbers (CCN) that had a disposition during this Financial Cycle. The sort order of the report is by CCN. The last line of the report is the sum of the Total Cash Posted in Cycle. This number corresponds with the sum of each of the C/R Adjustments for each claim type from the FIN-BACY-R and also the System Cash Receipt Dispositions line near the bottom of the FIN-BACY-R report.

This report is produced weekly.

7.71.2 FIN-CR10-W -- Cash Disposition Adjustment Postings Report Layout

```
Report  : FIN-CR10-W                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : FINJRUCSH                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: FIN_UPDT_CASH                   CASH DISPOSITION ADJUSTMENT POSTINGS REPORT                       Page:      9,999
                                          PERIOD:   MM/DD/CCYY - MM/DD/CCYY
                                               POSTING DATE: MM/DD/CCYY

 CASH CNTL NUMBER   SEQ BATCH         AMOUNT DISPOSITION        AMOUNT CASH DISPOSITION
   999999999          999               999,999,999.99                 999,999,999.99


                                                                 ==================
       Total Cash Posted in Cycle (C/R Adjustments on FIN-BACY-R)      999,999,999.99


                                               ** NO DATA THIS REPORT **
```


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7.71.3 FIN-CR10-W -- Cash Disposition Adjustment Postings Report Field Descriptions

Field	Description	Length	Data Type
Amount Cash Disposition	This is the cash dollar amount dispositioned.	12	Number (Decimal)
Amount Disposition	This is the dollar amount dispositioned.	12	Number (Decimal)
Cash Cntl Number	This is the unique number assigned to the cash receipt.	9	Number (Integer)
Posting Date	This is the date the cash disposition was posted.	10	Date (MM/DD/CCYY)
Seq Batch	This is the sequence number assigned to the cash control number when the cash is dispositioned	3	Number (Integer)
Total Cash Posted in Cycle	This is the total dollar amount posted during this reported cycle.	13	Number (Decimal)

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7.72 FIN-CR11-M -- Cash Receipts Posted By Fund Code

7.72.1 FIN-CR11-M -- Cash Receipts Posted By Fund Code Narrative

The Cash Receipts Posted by Fund Code report lists all posted cash transactions by fund code. The report does NOT show cash refunds or Drug Rebate cash postings.

This report is produced monthly.

7.72.2 FIN-CR11-M -- Cash Receipts Posted By Fund Code Layout

```
Report  : FIN-CR11-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : FINJMCR11                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: FINPCR11M                        CASH RECEIPTS POSTED BY FUND CODE                               Page:      9,999
                                                     FOR: Month

FUND CODE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

               NUM SEQ                                   REASON                 DATE               AMOUNT
  CCN          BATCH    UNIT DESCRIPTION                 CODE   ADJUSTED ICN    POSTED             POSTED
99999999999    9999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX  9999999999999   MM/DD/CCYY        9,999,999.99


                                                                            SUBTOTAL:            9,999,999.99

                                                                               TOTAL:            9,999,999.99

                                                        **  END OF REPORT  **
```


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7.72.3 FIN-CR11-M – Cash Receipts Posted By Fund Code Field Descriptions

Field	Description	Length	Data Type
Adjusted ICN	This is the number of the adjusted claim.	13	Number (Integer)
Amount Posted	This is the amount of cash posted.	11	Number (Decimal)
CCN	This is the cash control number.	11	Number (Integer)
Date Posted	This is the date the cash receipt was posted.	10	Date (MM/DD/CCYY)
Fund Code	This is the recipient fund code category.	10	Character
Num Seq Batch	This field reports sequential batch number that uniquely identifies each individual disposition which was applied to a cash receipt.	4	Number (Integer)
Reason Code	This is the code for the transaction reason.	4	Character
Subtotal	This is the subtotal of cash posted by fund code.	11	Number (Decimal)
Total	This is the total of all amounts posted for all fund codes.	11	Number (Decimal)
Unit Description	This is a description of the unit handling the cash receipt posting: Drug Rebate, Medical, or TPL.	3	Character

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7.73 FIN-CR16-O -- Daily Cash Receipts Log by CCN

7.73.1 FIN-CR16-O -- Daily Cash Receipts Log by CCN Narrative

The Daily Cash Receipts Log by CCN is a report that displays the sequence of cash receipts by CCN, then by Unit. Daily, this reports all deposit transactions by CCN Number. This is an online report that can be run at any time for any deposit date.

This report shows the complete total at the bottom of the report for all CCN's.

7.73.2 FIN-CR16-O -- Daily Cash Receipts Log by CCN Layout

Report: FIN-1907-D	STATE MMIS	Date: 2007/03/20
Receipt Date: 2007/03/20	Daily Cash Receipt Log	Time: 2:32 PM
	by CCN	Page # 1 of 1

CCN	Unit / Reason	Check Number	Remitter Name	Check Amount
[redacted]	Drug Rebate	[redacted]	[redacted]	$5.00
[redacted]	Drug Rebate			$5.00
[redacted]	Drug Rebate			$50.00
			Total:	$60.00

7.73.3 FIN-CR16-O -- Daily Cash Receipts Log by CCN Field Descriptions

Field	Description	Length	Data Type
CCN	This is the cash control number.	11	Character
Check Amount	This is the amount of deposit.	11	Number (Decimal)
Check Number	This is the check number of the check that was sent in as a cash receipt.	9	Character
Remitter Name	This is the name of the remitter.	39	Character
Total (Check Amount)	This is the total amount of deposits.	11	Number (Decimal)
Unit/Reason	This is the unit/reason that applies to MED, TPL, Drug Rebate.	15	Character

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7.74 FIN-CR17-O -- Daily Cash Receipts Log by Unit

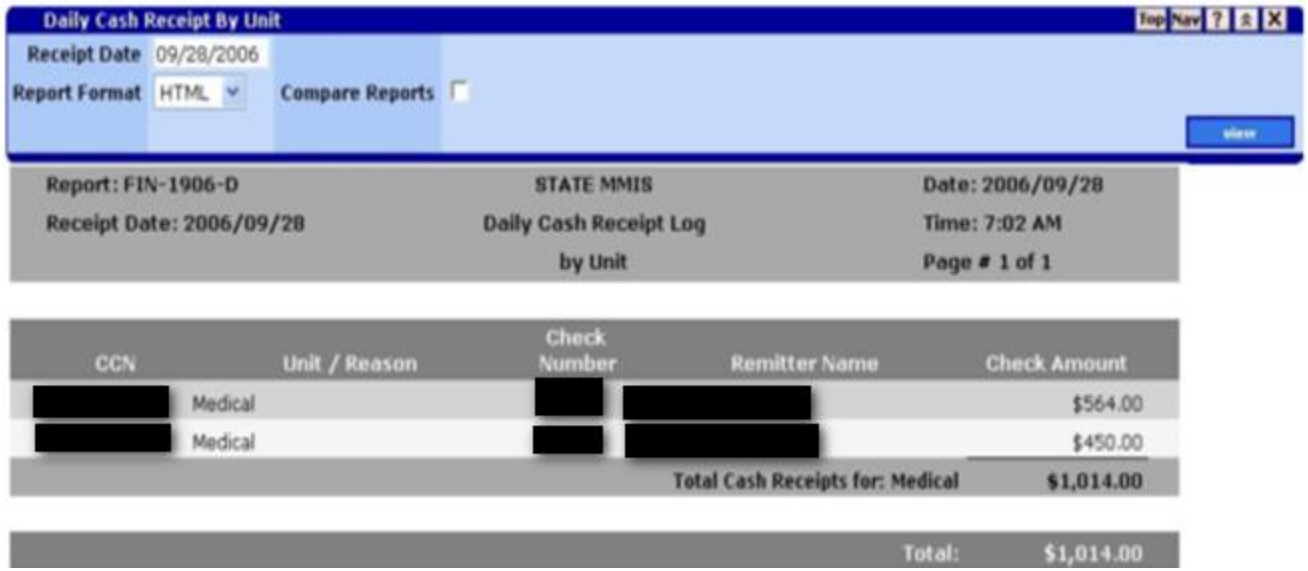
7.74.1 FIN-CR17-O -- Daily Cash Receipts Log by Unit Narrative

The sequence is by Unit (Drug Rebate, MED, SUR, TPL), then Cash Control Number (CCN). Daily, this reports all deposit transactions by each unit. This is an online report that can be run at any time for any deposit date.

This report will sub-total by unit and report the complete total at the bottom of the report for all of the units.

This report is available online.

7.74.2 FIN-CR17-O -- Daily Cash Receipts Log by Unit Layout



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7.74.3 FIN-CR17-O -- Daily Cash Receipts Log by Unit Field Descriptions

Field	Description	Length	Data Type
CCN	This is the cash control number.	11	Character
Check Amount	This is the amount of deposit.	11	Number (Integer)
Check Number	This is the check number of the check that was sent in as a cash receipt.	9	Character
Remitter Name	This is the name of the remitter.	39	Character
Total (Check Amount)	This is the total check amount.	11	Number (Decimal)
Total	This is the total number of deposits.	6	Number (Integer)
Unit/Reason	This is the unit/reason that applies to MED, TPL, SUR.	15	Character

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7.75 FIN-CR18-O -- Cash Control Balance Report

7.75.1 FIN-CR18-O -- Cash Control Balance Report Narrative

The Cash Control Balance report is used to balance the daily cash receipts. It reports the total count of CCN's for the day and the number of CCN's that will be deposited. This is an online report that can be run at any time for any deposit date.

This report is available online.

7.75.2 FIN-CR18-O -- Cash Control Balance Report Layout

```
Report: FIN-1908-D                STATE MMIS                Date: 2007/02/15
Receipt Date: 2007/02/15          Cash Control Balance Report  Time: 8:15 PM
                                                            Page # 1 of 1

Check Receipts:      3
      Deposits:      3
      Variance:      0

                CCN                 Explanation
```

7.75.3 FIN-CR18-O -- Cash Control Balance Report Field Descriptions

Field	Description	Length	Data Type
CCN	This is the cash control number that is part of the variance.	11	Number (Integer)
Check Receipts	This is the total number of cash receipts for the day.	6	Number (Decimal)
Deposits	This is the total number of cash receipts that will be deposited.	6	Number (Decimal)
Explanation	This is the reason the cash control number reported as a variance.	35	Character
Variance	This is the number of difference between the total receipt count and the deposit count.	6	Number (Decimal)

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7.76 FIN-CR19-O -- Daily Cash Deposit Log

7.76.1 FIN-CR19-O -- Daily Cash Deposit Log Narrative

The Daily Cash Deposit Log report is the daily deposit log that is used to balance deposits. It is summarized by unit/reason and provides the total of the deposit on the bottom of the page.

This is an online report that can be run at any time for any deposit date.

7.76.2 FIN-CR19-O -- Daily Cash Deposit Log Layout

Report: FIN-1909-D	STATE MMIS	Date: 2007/02/15
Receipt Date: 2007/02/15	Daily Cash Deposit Log	Time: 8:24 PM
		Page # 1 of 1

Unit / Reason	Number Of Checks	Amount Deposited
Medical	3	$102.25
Total:	3	$102.25

7.76.3 FIN-CR19-O -- Daily Cash Deposit Log Field Descriptions

Field	Description	Length	Data Type
Amount Deposited	This is the total deposit amount for each unit/reason.	11	Number (Decimal)
Number of Checks	This is the total count of checks for each unit/reason.	6	Number (Decimal)
Total (Amount Deposited)	This is the total amount deposited.	11	Number (Decimal)
Total (Number of Checks)	This is the total number of all checks.	6	Number (Decimal)
Unit/Reason	This is the unit/reason for the cash receipt.	15	Character

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7.77 FIN-CR21-M -- Cash Receipts Posted by Unit

7.77.1 FIN-CR21-M -- Cash Receipts Posted by Unit Narrative

The Cash Receipts Posted by Unit report is a detail listing of all posted cash transactions by business unit except for Drug Rebate. The report does not show cash refunds or Drug Rebate cash postings.

This report is produced monthly.

7.77.2 FIN-CR21-M -- Cash Receipts Posted by Unit Layout

```
Report  : FIN-CR21-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : FINJMCR11                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:      HH:MM
Location: FINPCR21M                          CASH RECEIPTS POSTED BY UNIT                                    Page:      9,999
                                                 PERIOD: XXXXXXXX     CCYY

       UNIT:  XXX  XXXXXXXXXXXXXXXXXXXX
                                                                                                  DATE
CCN         FUND CODE  DESCRIPTION                                          ADJUSTED ICN       POSTED              AMOUNT

XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99
XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99
XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99

                                                                                                SUBTOTAL:         $999,999,999.99

       UNIT:  XXX  XXXXXXXXXXXXXXXXXXXX
                                                                                                  DATE
CCN         FUND CODE  DESCRIPTION                                          ADJUSTED ICN       POSTED              AMOUNT

XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99
XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99
XXXXXXXXXXX XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999999999999    MM/DD/CCYY          $9,999,999.99

                                                                                                SUBTOTAL:         $999,999,999.99

                                                                                                   TOTAL:         $999,999,999.99

                                                   ** END OF REPORT **
```


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7.77.3 FIN-CR21-M -- Cash Receipts Posted by Unit Field Descriptions

Field	Description	Length	Data Type
Adjusted ICN	This is the number of the adjusted claim.	13	Number (Integer)
Amount	This is the amount of cash posted.	9	Number (Decimal)
CCN	This is the cash control number.	11	Number (Integer)
Date Posted	This is the date the cash receipt was posted.	10	Date (MM/DD/CCYY)
Description	This is a description of the Fund Code.	40	Character
Fund Code	This is the Fund Code to which the Cash Receipt is posted. The field is 10 bytes. Alabama's Fund Codes will report as 3 digits.	10	Number (Integer)
Subtotal	This is the subtotal of cash posted by the unit.	11	Number (Decimal)
Total	This is the total of cash posted for all units.	11	Number (Decimal)
Unit	This is the unit/reason entered on the cash receipt. The field also displays a 20 byte description of the unit.	3 + 20	Character

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7.78 FIN-CR22-M -- Cash Summary - by Reason

7.78.1 FIN-CR22-M -- Cash Summary - by Reason Narrative

The Cash Summary-by Reason report summarizes the number and amount of cash receipts posted during the month. It is grouped by reason code.

This report is produced monthly.

7.78.2 FIN-CR22-M -- Cash Summary - by Reason Layout

```
Report  : FIN-CR22-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : FINJMCR11                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: FINPCR22M                           CASH SUMMARY BY REASON                                       Page:          1
                                                  PERIOD: NOVEMBER      CCYY

  REASON     REASON                                                NUMBER                     AMOUNT
  CODE       DESCRIPTION                                           POSTED                     POSTED

  XXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        99                   $999,999,999.99
  XXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        99                   $999,999,999.99
  XXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        99                   $999,999,999.99
  XXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        99                   $999,999,999.99

                                                   TOTAL                    TOTAL
                                                   NUMBER:     9,999        AMOUNT:   $9,999,999,999.99

                                                    ** END OF REPORT **
```


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7.78.3 FIN-CR22-M -- Cash Summary - by Reason Field Descriptions

Field	Description	Length	Data Type
Amount Posted	This is the amount of cash posting for the related reason code, grouped by month-to-date and by year-to-date.	11	Number (Decimal)
Number posted	This is the number of cash postings for the related reason code, grouped by month-to-date and by year-to-date.	5	Number
Reason Code	This is the reason code for cash disposition.	4	Character
Reason Description	This is the reason for the transaction.	50	Character
Total Amount	This is the total amount of cash postings for all reason codes.	11	Number (Decimal)
Total Number	This is the total number of cash postings for all reason codes.	6	Number (Decimal)

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7.79 FIN-ERR-W -- Financial Extractor Error Report

7.79.1 FIN-ERR-W -- Financial Extractor Error Report Narrative

The Financial Extractor Error report contains all claims that have failed edits in the financial batch cycle. The claims listed on the report were not able to be processed due to critical data problems that would make it impossible to process within financial. The reason the claim was identified is also posted. This report is reviewed by the Claims subsystem SEs after each financial so that errors can be researched and solved. The claims will continue to report until the error is resolved. Once resolved, the claims will process in the next financial cycle.

This report is produced during the financial cycle.

Note that the ICNs on this report do appear on the claims UI panels. However, they will not appear on the Remittance Advice until the error is resolved.

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7.79.2 FIN-ERR-W -- Financial Extractor Error Report Layout

```
Report  : FIN-ERR-W                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : FINP_FLUSH_RPT                  MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: FINJWERR                           FINANCIAL EXTRACTOR ERROR REPORT                                Page:      99999
                                                   RUN DATE: MM/DD/CCYY

                                                    ENVIRONMENT: XXXX
                                                    DATABASE:    XXXXXX

CLAIM      SAK      CLAIM        ICN         ERROR TYPE  ERROR   ERROR DESRIPTION
TYPE                STATUS      NUMBER                   NUMBER


XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXX    999999999     X      XXXXXXXXXXXXX   XXXXXXXXX   9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


Report  : FIN-ERR-W                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : FINP_FLUSH_RPT                  MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: FINJWERR                           FINANCIAL EXTRACTOR ERROR REPORT                                Page:      99999
                                                    RUN DATE: MM/DD/CCYY

                                                   ENVIRONMENT: XXXX
                                                   DATABASE:    XXXXXX

                                             * * *  S U M M A R Y  R E P O R T  * * *

ERROR NUMBER   OCCURRENCE    DESCRIPTION
=====================================================================
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999           99999       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


NUMBER OF PAID      UB04 CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF DENIED    UB04 CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF SUSPENDED UB04 CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF REJECTED  UB04 CLAIMS IN ERROR THIS RUN:       99999
-----------
TOTAL NUMBER OF UB04 CLAIMS IN ERROR THIS RUN:           99999
```


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```
NUMBER OF PAID      DNTL CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF DENIED    DNTL CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF SUSPENDED DNTL CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF REJECTED  DNTL CLAIMS IN ERROR THIS RUN:       99999
-----------
TOTAL NUMBER OF DNTL CLAIMS IN ERROR THIS RUN:           99999
_____________________________________________________________________________________________________________________

NUMBER OF PAID      PHRM CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF DENIED    PHRM CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF SUSPENDED PHRM CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF REJECTED  PHRM CLAIMS IN ERROR THIS RUN:       99999
-----------
TOTAL NUMBER OF PHRM CLAIMS IN ERROR THIS RUN:           99999
_____________________________________________________________________________________________________________________

NUMBER OF PAID      PHYS CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF DENIED    PHYS CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF SUSPENDED PHYS CLAIMS IN ERROR THIS RUN:       99999
NUMBER OF REJECTED  PHYS CLAIMS IN ERROR THIS RUN:       99999
-----------
TOTAL NUMBER OF PHYS CLAIMS IN ERROR THIS RUN:           99999
_____________________________________________________________________________________________________________________

GRAND TOTAL OF CLAIMS IN ERROR THIS RUN:                 99999

=====================================================================================================================

Report  : FIN-ERR-W                            ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : FIN_FLUSH_RPT                  MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: FINJWERR                          FINANCIAL EXTRACTOR ERROR REPORT                             Page:      99999
                                                   RUN DATE:  MM/DD/CCYY

                                                ENVIRONMENT: XXXX
                                                DATABASE:    XXXXXX

                                            * * *  S U M M A R Y   R E P O R T   * * *

TOTAL AMOUNT OF PAID UB04 CLAIMS IN ERROR THIS RUN:     999,999,999.99
TOTAL AMOUNT OF PAID PHYS CLAIMS IN ERROR THIS RUN:     999,999,999.99
TOTAL AMOUNT OF PAID PHRM CLAIMS IN ERROR THIS RUN:     999,999,999.99
TOTAL AMOUNT OF PAID DNTL CLAIMS IN ERROR THIS RUN:     999,999,999.99
_____________________________________________________________________________________________________________________

                                                      ** END OF REPORT **
```


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7.79.3 FIN-ERR-W -- Financial Extractor Error Report Field Descriptions

Field	Description	Length	Data Type
Claim Status	The status of the claim (Paid, Denied, Adjusted, Suspended).	1	Character
Claim Type	This is the type claim (PHYS, PHRM, DNTL and UB04).	4	Character
Database	The related database the report was run against. (Example: almism)	6	Character
Environment	The environment region that the report is generated for (Acceptance, Model Office, Production, Test)	4	Character
Error Description	This is the description of the error.	100	Character
Error Number	This is the number assigned to the error which corresponds to the fin_error_code table.	4	Number (Integer)
Error Type	This is the type of edit which error occurred in. (Provider, Claim, Fund Code, Recipient.)	10	Character
Grand Total of Claims in Error this Run	This is the grand total of claims that occur on the report.	9	Number (Integer)
ICN Number	This is the internal claim number of the claim as specified on the claim header.	13	Number (Integer)
Number of Denied	This is the number of denied claims that occur on the report for each claim type, UB04, Physician, Dental and Pharmacy.	9	Number (Integer)
Number of Paid	This is the number of paid claims that occur on the report for each claim type, UB04, Physician, Dental and Pharmacy.	9	Number (Integer)
Number of Rejected	This is the number of rejected claims that occur on the report for each claim type, UB04, Physician, Dental and Pharmacy.	9	Number (Integer)
Number of Suspended	This is the number of suspended claims that occur on the report for each claim type, UB04, Physician, Dental and Pharmacy.	9	Number (Integer)

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Field	Description	Length	Data Type
Occurrence	This is the frequency of which a given error occurs on the report.	9	Number (Integer)
SAK	This is the system assigned key of the claim in error. Since this is an internal report to target problems to be fixed, the claim sak is correctly displayed.	9	Number (Integer)
Total Number of Dental Claims in Error this Run	This is the total number claims in error for dental.	9	Number (Integer)
Total Number of Physician Claims in Error this Run	This is the total number claims in error for physician.	9	Number (Integer)
Total Number of UB04 Claims in Error this Run	This is the total number claims in error for UB04.	9	Number (Integer)
Total Number of Pharmacy Claims in Error this Run	This is the total number claims in error for pharmacy.	9	Number (Integer)
Total Amount of Paid UB04 Claims In Error This Run	This is the total amount of paid UB04 claims in error this run.	12	Number (Decimal)
Total Amount of Paid PHYS Claims in Error this Run	This is the total amount of paid Physician claims in error this run.	12	Number (Decimal)
Total Amount of Paid PHRM Claims in Error this Run	This is the total amount of paid Pharmacy claims in error this run.	12	Number (Decimal)
Total Amount of Paid DNTL Claims in Error this Run	This is the total amount of paid Dental claims in error this run.	12	Number (Decimal)

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7.80 FIN-EX10-O -- Expenditure Report-Online

7.80.1 FIN-EX10-O -- Expenditure Report-Online Narrative

The Expenditure report is an online report that lists all expenditures that meet the report criteria selected. The report displays the Expenditure ID and type, Reason Codes, Payee information, fund and category of service codes, issue date and dollar amount. This report can be run at any time from the Financial Reports and Letters – Expenditure Report panel.

7.80.2 FIN-EX10-O -- Expenditure Report-Online Layout

Report: Fin EX10-O
From Date: 2002/01/01
To Date: 2006/11/11

STATE MMIS
Expenditure Inquiry REPORT

Date: 2006/12/01
Time: 1:03 PM
Page # 1 of 1

EXPEND ID	PROCES TYPE	EXPEND REASON	PAYEE ID	PAYEE TYPE	PAYEE NAME	FUND CODE	PAYMENT DATE	EXPEND AMOUNT
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	678.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	906.00
[redacted]	Regular	8300	[redacted]	Provider	[redacted]	007	05/08/2005	915.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	679.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	890.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	890.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	889.00
[redacted]	Regular	8330	[redacted]	Provider	[redacted]	007	05/08/2005	456.00
[redacted]	Regular	8400	[redacted]	Provider	[redacted]	007	05/08/2005	4434.00

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7.80.3 FIN-EX10-O -- Expenditure Report-Online Field Descriptions

Field	Description	Length	Data Type
Expend Amount	This field reports the amount of the expenditure.	11	Number (Decimal)
Expend ID	This is the unique system-generated number that identifies an expenditure transaction.	11	Number (Integer)
Expend Reason	This is the reason for the transaction.	10	Character
Fund Code	This field reports the fund code that is used in financial reporting to correctly categorize funds (money).	4	Character
Payee ID	A unique number that identifies a payee in the system. This number is dependent on the Payee Type selected. If Provider, it will display the Medicaid ID or Provider NPI. If HIPP Resource, it will display the HIPP Resource Payee ID.	15	Number (Integer)
Payee Name	This is the name of the payee (organization or person) associated with the payment.	30	Character
Payee Type	The type of the Payee. (Provider, Carrier, HIPP Resource)	20	Character
Payment Date	This is the date the payment was issued.	8	Date (MM/DD/CCYY)
Process Type	This field reports the type of expenditure	15	Character

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7.81 FIN-LN01-R -- Provider Lien Activity

7.81.1 FIN-LN01-R -- Provider Lien Activity Narrative

The Provider Lien Activity report details provider lien activity for the current and previous payment cycles. The provider lien activity report is used to show the current status of a provider lien. In Alabama, the lien panels and subsequent reports are used only for IRS tax levies.

This report is produced during the financial cycle.

7.81.2 FIN-LN01-R -- Provider Lien Activity Layout

```
$Report  : FIN-LN01-R                    ALABAMA MEDICAID AGENCY                                  Run Date: 03/06/2007
Process : FINJRLN01                  MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   12:35:21
Location: FINPLN01R                              LIEN ACTIVITY                                        Page:          2
                                       PERIOD: 02/27/2007-03/05/2007
                                       FINANCIAL CYCLE: Main Financial Cycle

PAYEE TYPE: Provider

PAYEE          STATUS  LIEN        LIEN    RSN     ORIG LIEN        LIEN PAYMENTS          APPLIED AMOUNT          INCREASE     BALANCE
ID                     DATE        NUMBER  CODE      AMOUNT      %              $     THIS WEEK      TO DATE       /DECREASE

[redacted]       0     20020507    [redacted]  8500      30,333.00   0.00         300.00        0.00          0.00          0.00     30,333.00
                 0     20020509        8500   5,000,000.00   0.00   1,000,000.00        0.00          0.00          0.00  5,000,000.00
                 0     20020509        8500      50,000.00  30.00         0.00        0.00          0.00          0.00     50,000.00
                 0     20020423        8502         100.00   0.00        25.00        0.00          0.00          0.00        100.00
                 0     20020423        8503           0.00  31.00         0.00        0.00          0.00          0.00          0.00
                 0     20060517        9907      10,000.00   0.00        10.00        0.00          0.00          0.00     10,000.00
                 0     20060517        9907      10,000.00   0.00        10.00        0.00          0.00          0.00     10,000.00

                                GRAND TOTALS    8,318,467.00           1,001,220.00        0.00      2,232.80          0.00  8,316,234.20

                                                        ** End of Report **
```


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7.81.3 FIN-LN01-R -- Provider Lien Activity Field Descriptions

Field	Description	Length	Data Type
Applied Amount This Week	This indicates the dollar amount from claims processing that was applied to the lien this financial cycle.	11	Number (Decimal)
Applied Amount To Date	This indicates the dollar amount from claims processing that was applied to the lien to date.	11	Number (Decimal)
Balance	This indicates the difference between the original amount, less any payments made to date or any increases/decreases made.	11	Number (Decimal)
Grand Totals	This is the Grand Total for each amount column.	11	Number (Decimal)
Increase/Decrease	This indicates the dollar amount that the lien amount increased or decreased by a manual adjustment during the current weekly cycle.	11	Number (Decimal)
Lien Date	This is the setup date of the original lien transaction.	8	Date (MM/DD/CCYY)
Lien Number	This is the number used to track the lien through the system.	9	Number (Integer)
Lien Payments $	This indicates the dollar amount of the provider's total claims payment to be deducted each cycle.	11	Number (Decimal)
Lien Payments %	This indicates the percentage of the provider's total claims payment to be deducted each cycle.	5	Number (Decimal)
Original Lien Amount	This indicates the initial setup amount associated with this lien.	11	Number (Decimal)
Payee ID	This is the provider number from which lien payments are being deducted. The field is 15 bytes to accommodate either Medicaid 8 or 9 character ID or 10 digit NPI.	15	Number (Integer)
Payee Type	This is the type of payee. In Alabama, it will always be Provider.	10	Character
Rsn Code	This indicates the reason why a lien is issued and the source of the lien document.	4	Character
Status	This indicates the current status of the lien (O = open or C = closed).	1	Character

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7.82 FIN-PR01-R -- Payment Register by Benefit Plan

7.82.1 FIN-PR01-R -- Payment Register by Benefit Plan Narrative

The Payment Register by Benefit Plan is a cycle report that generates the Pre-Payment Register by Benefit Plan in benefit plan order. For each benefit plan, the report provides the claim count and payment amounts for the category, current fiscal year, and previous fiscal years. It also provides summarized Account Receivables, Liens, and FICA information. Note that in Alabama, payments are not broken out by specific Benefit Plan. However, since TXIX and XIXQ are identified as paying Benefit Plans, payments made for claims for recipients that are covered by these major plans will report dollars paid.

This report is produced during the financial cycle.

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7.82.2 FIN-PR01-R -- Payment Register by Benefit Plan Layout

```
REPORT:   FIN-PR01-R                          ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY
PROCESS:  FINJRPR01                   MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:   HH:MM:SS
LOCATION: FINPPR01R                      PAYMENT REGISTER BY BENEFIT PLAN                    Page:      9,999
                                               PERIOD: MM/DD/CCYY

                                  ------------------PAYMENT TOTALS-------------------
BENEFIT PLAN                 CLAIM        CATEGORY        CURRENT          PREVIOUS
                             COUNT         TOTAL          FISCAL YR.       FISCAL YR.

ALIEN                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
CCP                         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
CUST                        999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
LOCMR                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
MN                          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
MNCAT                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
NET                         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
NFMED                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
PE                          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
PKU                         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
Q1                          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
Q2                          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
QMB                         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
S-CHC                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
S-IHS                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
S-PLS                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
SLA                         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
SLMB                        999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
TB                          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
TXIX                        999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
W-ADP                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
W-ADV                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
W-IHA                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
W-IHC                       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
W-MR                        999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            -------   ---------------   ---------------   ---------------
      CLAIMS TOTALS         999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            -------   ---------------   ---------------   ---------------
                 ARs        999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99

                 LIENS      999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99

                 FICA       999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99

                            -------   ---------------   ---------------   ---------------
      OTHER TOTALS          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            -------   ---------------   ---------------   ---------------
                            -------   ---------------   ---------------   ---------------
      GRAND TOTALS          999,999   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            =======   ===============   ===============   ===============

                                              ** END OF REPORT **
```


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7.82.3 FIN-PR01-R -- Payment Register by Benefit Plan Field Descriptions

Field	Description	Length	Data Type
ARs (Amounts)	This is the amount of account receivables in the prepayment cycle. Category Total, Current Fiscal Yr., Previous Fiscal Yr.	11	Number (Decimal)
ARs (Claim Count)	This is the number of account receivables in the prepayment cycle	6	Number (Integer)
Benefit Plan	This is the benefit plan.	15	Character
Category Total	This column contains category total for the corresponding Benefit Plan.	11	Number (Decimal)
Claim Count	This column contains the claim count total for the corresponding Benefit Plan.	6	Number
Claims Totals (Category Total)	This is the total sum of the Category Total for Benefit Plan.	11	Number (Decimal)
Claims Totals (Claim Count)	This is the total of the Claim Count for Benefit Plan.	6	Number (Integer)
Claims Totals (Current Fiscal Yr.)	This is the total sum of the Current Fiscal Yr. for Benefit Plan.	11	Number (Decimal)
Claims Totals (Previous Fiscal Yr.)	This is the total sum of the Previous Fiscal Yr. for Benefit Plan.	11	Number (Decimal)
Current Fiscal YR	This column contains current fiscal year total for the corresponding benefit plan.	11	Number (Decimal)
FICA (Amounts)	This is the amount of Federal Insurance Contribution Act transactions in the prepayment cycle. Category Total, Current Fiscal Yr., Previous Fiscal Yr. This amount will be zero for Alabama reporting.	11	Number (Decimal)
FICA (Claim Count)	This is the number of Federal Insurance Contribution Act transactions in the prepayment cycle.	6	Number (Integer)
Grand Totals (Category Total)	This is the grand total sum of the Category Total.	11	Number (Decimal)
Grand Totals (Claim Count)	This is the grand total of the Claim Count.	6	Number (Integer)
Grand Totals (Current Fiscal Yr.)	This is the grand total sum of the Current Fiscal Yr.	11	Number (Decimal)

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Field	Description	Length	Data Type
Grand Totals (Previous Fiscal Yr.)	This is the grand total sum of the Previous Fiscal Yr.	11	Number (Decimal)
Liens (Amounts)	This is the amount of liens in the prepayment cycle. Category Total, Current Fiscal Yr., Previous Fiscal Yr.	11	Number (Decimal)
Liens (Claim Count)	This is the number of liens in the prepayment cycle	6	Number (Integer)
Other Totals (Category Total)	This is the total sum of the Category Total for ARs, Liens and FICA.	11	Number (Decimal)
Other Totals (Claim Count)	This is the total of the Claim Count for ARs, Liens and FICA.	6	Number (Integer)
Other Totals (Current Fiscal Yr.)	This is the total sum of the Current Fiscal Yr. for ARs, Liens and FICA.	11	Number (Decimal)
Other Totals (Previous Fiscal Yr.)	This is the total sum of the Previous Fiscal Yr. for ARs, Liens and FICA.	11	Number (Decimal)
Previous Fiscal YR	This column contains the previous fiscal year total for the corresponding benefit plan.		

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7.83 FIN-PR03-R -- Payment Register by Fund Code

7.83.1 FIN-PR03-R -- Payment Register by Fund Code Narrative

The Payment Register by Fund Code is a weekly report that generates the Pre-Payment Register by Fund Code in fund code order. For each fund code, the report provides the claim count and payment amounts for the category, current fiscal year, and previous fiscal years.

This report is produced during the financial cycle.

7.83.2 FIN-PR03-R -- Payment Register by Fund Code Layout

```
REPORT:   FIN-PR03-R                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
PROCESS:  FINJRPR03                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
LOCATION: FINPPR03R                                PAYMENT REGISTER BY FUND CODE                                   Page:      9,999
                                                   PERIOD: MM/DD/CCYY

                         ---------------- PAYMENT AMOUNT -------------------   -----------------RECOUPMENT TOTALS-----------------
FUND CODE                    CATEGORY        CURRENT          PREVIOUS            CATEGORY           CURRENT          PREVIOUS
                              TOTAL          FISCAL YR.       FISCAL YR.           TOTAL            FISCAL YR.        FISCAL YR.

XXX XXXXXXXXXXXXXXXXX   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
XXX XXXXXXXXXXXXXXXXX   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
XXX XXXXXXXXXXXXXXXXX   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
XXX XXXXXXXXXXXXXXXXX   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
                        ---------------   ---------------   ---------------   ---------------   ---------------   ---------------
GRAND TOTALS            $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
                        ===============   ===============   ===============   ===============   ===============   ===============
```


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7.83.3 FIN-PR03-R -- Payment Register by Fund Code Field Descriptions

Field	Description	Length	Data Type
Fund Code	This is the fund code and fund code description.	12	Character
Grand Totals	These are the grand totals for each of the amount fields.	11	Number (Decimal)
Recoupment Totals (Category Total)	This is the Category Total amount for each fund code.	11	Number (Decimal)
Recoupment Totals (Current Fiscal Yr.)	This is the Current Fiscal Yr. amount for each fund code.	11	Number (Decimal)
Recoupment Totals (Previous Fiscal Yr.)	This is the Previous Fiscal Yr. amount for each fund code.	11	Number (Decimal)
Payment Amount (Category Total)	This is the Category Total amount for each fund code.	11	Number (Decimal)
Payment Amount (Current Fiscal Yr.)	This is the Current Fiscal Yr. amount for each fund code.	11	Number (Decimal)
Payment Amount (Previous Fiscal Yr.)	This is the Previous Fiscal Yr. amount for each fund code.	11	Number (Decimal)

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7.84 FIN-PR04-R -- Payment Register by Provider Type

7.84.1 FIN-PR04-R -- Payment Register by Provider Type Narrative

The Payment Register by Provider Type report generates the Pre-Payment Register by Provider Type (M2750R10) in provider type order. For each provider type, the report provides both the payment and recoupment amounts for the category, current fiscal year, and previous fiscal years. It also summarizes the Non-Provider payment information.

This report is produced during the financial cycle.

7.84.2 FIN-PR04-R -- Payment Register by Provider Type Layout

```
REPORT  : FIN-PR04-R                                ALABAMA MEDICAID AGENCY                        Run Date: MM/DD/CCYY
PROCESS : FINJRPR04                            MEDICAID MANAGEMENT INFORMATION SYSTEM              Run Time:   HH:MM:SS
LOCATION: FINPPR04R                           PAYMENT REGISTER BY PROVIDER TYPE                        Page:      9,999
                                                     PERIOD: MM/DD/CCYY - MM/DD/CCYY

                            -------------------PAYMENT AMOUNT------------------   -----------------RECOUPMENT TOTALS-----------------
  PROVIDER                     CATEGORY          CURRENT          PREVIOUS          CATEGORY          CURRENT          PREVIOUS
   TYPE                         TOTAL           FISCAL YR.       FISCAL YR.         TOTAL           FISCAL YR.       FISCAL YR.

99 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
99 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            ---------------   ---------------   ---------------   ---------------   ---------------   ---------------
         TOTALS             $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            ---------------   ---------------   ---------------   ---------------   ---------------   ---------------

  NONPROVIDER                  CATEGORY          CURRENT          PREVIOUS
   TYPE                         TOTAL           FISCAL YR.       FISCAL YR.

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            $999,999,999.99   $999,999,999.99   $999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                            $999,999,999.99   $999,999,999.99   $999,999,999.99
                            ---------------   ---------------   ---------------
 NONPROV TOTALS             $999,999,999.99   $999,999,999.99   $999,999,999.99
                            ---------------   ---------------   ---------------

                            ---------------   ---------------   ---------------   ---------------   ---------------   ---------------
   GRAND TOTALS             $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99   $999,999,999.99
                            ===============   ===============   ===============   ===============   ===============   ===============
```


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7.84.3 FIN-PR04-R -- Payment Register by Provider Type Field Descriptions

Field	Description	Length	Data Type
Grand Totals	These are the grand totals for each of the amount columns.	11	Number (Decimal)
Non Provider Type	Non Provider does not have a numeric code for type. Non Providers are listed on the Financial – Related Data – Other - Non-Provider panel. In Alabama, these will be the IRS Tax levy entities. Note there is no data for 'recoupment' because payouts to these entities are never recouped.	50	Character
Recoupment Totals (Category Total)	This is the Category Total amount for each provider type.	11	Number (Decimal)
Recoupment Totals (Current Fiscal Yr.)	This is the Current Fiscal Yr. amount for each provider type.	11	Number (Decimal)
Recoupment Totals (Previous Fiscal Yr.)	This is the Previous Fiscal Yr. amount for each provider type.	11	Number (Decimal)
Payment Amount (Category Total)	This is the Category Total amount for each provider type.	11	Number (Decimal)
Payment Amount (Current Fiscal Yr.)	This is the Current Fiscal Yr. amount for each provider type.	11	Number (Decimal)
Payment Amount (Previous Fiscal Yr.)	This is the Previous Fiscal Yr. amount for each provider type.	11	Number (Decimal)
Provider Type	The type of Provider for each category (Provider Type). Displays the 2 digit provider type and the description of the provider type.	50	Character
Totals	Totals for the provider type and non-provider type groupings.	11	Number (Decimal)

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7.85 FIN-PR05-R -- Payment Register by Provider Type to be Paid

7.85.1 FIN-PR05-R -- Payment Register by Provider Type to be Paid Narrative

The Payment Register by Provider Type to be Paid report generates the Pre-Payment Register by Provider Type (M2750R02) in provider type order. For each provider type, the report provides the number of providers and the paid amount. It also summarizes Non-Provider payments.

This report is produced during the financial cycle.

7.85.2 FIN-PR05-R -- Payment Register by Provider Type to be Paid Layout

```
Report  : FIN-PR05-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : FINJRPR05                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: FINPPR05R                           PAYMENT REGISTER BY PROVIDER TYPE                          Page:              1
                                                     TO BE PAID
                                                PERIOD: MM/DD/CCYY - MM/DD/CCYY

       PROVIDER   PROVIDER                                        TOTAL PROVIDERS          TOTAL
       TYPES      DESC                                            SELECTED                 AMOUNT PAID
       --------   --------                                        ---------------          -----------
       99         Extended Care Facility                           999999                         $10.00
       31         Physician                                        999999                    $233,983.40
       40         Specialized Foster Care/MR                       999999                         $10.00
                                                                   _______________      ____________________
                                                       TOTALS      999999                    $234,003.40

                                                        NON-PROVIDER PAYOUTS                      $21,977.76
                                                                ==========           =======================
                                                                GRAND TOTAL                   $255,981.17

                                                     ** END OF REPORT **
                                                  ** NO DATA THIS REPORT **
```


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7.85.3 FIN-PR05-R -- Payment Register by Provider Type to be Paid Field Descriptions

Field	Description	Length	Data Type
Grand Totals (Total Amount Paid)	This is the grand total of the Total Amount Paid field.	12	Number (Decimal)
Non-Provider Payouts	This is the non-provider payout amount. Non Providers are listed on the Financial – Related Data – Other – Non Provider panel. In Alabama, these will always be Tax Levy entities.	11	Number (Decimal)
Provider Desc	This is the description of the provider type.	30	Character
Provider Types	This is the provider type code.	2	Number (Integer)
Total Amount Paid	This is the total amount paid.	11	Number (Decimal)
Total Providers Selected	This is the total providers selected in the provider type.	5	Number (Decimal)
Totals (Total Providers Selected)	This is the grand total of the Total Providers Selected field.	6	Number (Decimal)

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7.86 FIN-PR06-R -- Payment Register by Claim Type

7.86.1 FIN-PR06-R -- Payment Register by Claim Type Narrative

The Payment Register by Claim Type report generates the Pre-Payment Register by Claim Type in claim type order. For each claim and financial transaction type, the report provides the claim count and payment amounts for the category, current fiscal year, and previous fiscal years.

This report is produced during the financial cycle.

7.86.2 FIN-PR06-R -- Payment Register by Claim Type Layout

```
REPORT:   FIN-PR06-R                          ALABAMA MEDICAID AGENCY                      Run Date: MM/DD/CCYY
PROCESS:  FINJRPR06                   MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS
LOCATION: FINPPR06R                           PAYMENT REGISTER BY CLAIM TYPE                    Page:     9,999
                                                  PERIOD: MM/DD/CCYY


                                                                        ------------------PAYMENT TOTALS------------------
TXN TYPE                                   TXN                              CATEGORY         CURRENT          PREVIOUS
                                          COUNT                               TOTAL          FISCAL YR.       FISCAL YR.

CLAIM TYPE A  INPATIENT XOVER CLAIMS     999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
CLAIM TYPE D  DENTAL                     999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
CLAIM TYPE I  INPATIENT                  999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
CLAIM TYPE O  OUTPATIENT                 999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99

FIN TXN    F  FICA                       999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
FIN TXN    R  AR                         999,999                          $-999,999,999.99  $-999,999,999.99  $-999,999,999.99
FIN TXN    S  EXPENDITURE                999,999                           $999,999,999.99   $999,999,999.99   $999.999,999.99
FIN TXN    V  CAPITATION                 999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
FIN TXN    X  LIEN                       999,999                           $999,999,999.99   $999,999,999.99   $999,999,999.99
                                 -------                                   ---------------   ---------------   ---------------
GRAND TOTALS                     999,999                                   $999,999,999.99   $999,999,999.99   $999,999,999.99
                                 =======                                   ===============   ===============   ===============

                                                   ** END OF REPORT **
```


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7.86.3 FIN-PR06-R -- Payment Register by Claim Type Field Descriptions

Field	Description	Length	Data Type
TXN Count	The count for each transaction type.	6	Number (Integer)
TXN Type	This is the name and code of the type of claim or transaction. The claim type section lists only the claim types that were paid for the financial cycle. The financial transaction type lists all the financial transaction types whether there is activity or not. Note that for Alabama, FICA will always be zeros.	13	Character
Grand Totals (Claim Count)	This is the grand total for Transaction Count.	6	Number (Integer)
Grand Totals (Amounts)	This is the grand total sum of each amount. Category Total, Current Fiscal Yr., Previous Fiscal Yr.	11	Number (Decimal)
Payment Totals (Category Total)	This is the total sum of Category Total per Transaction Type.	11	Number (Decimal)
Payment Totals (Current Fiscal Yr.)	This is the total sum of Current Fiscal Yr. per Transaction Type.	11	Number (Decimal)
Payment Totals (Previous Fiscal Yr.)	This is the total sum of Previous Fiscal Yr. per Transaction Type.	11	Number (Decimal)

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7.87 FIN-PR08-R -- Payment Register

7.87.1 FIN-PR08-R -- Payment Register

The Payment Register report is ordered by Payment Number. This report lists the name of the payee, their mailing address, their street address with the city, state, and zip. Payment number, the type of media that was used (Electronic Funds Transfer or Paper), and the Payment amount are displayed for each payee.

On the bottom part of the report the payment types are broken down by Title XIX and non Title XIX. The first column is the count and the final column is the payment amount.

This report is produced during the financial cycle.

7.87.2 FIN-PR08-R -- Payment Register Layout

Report : FIN-PR08-R ALABAMA MEDICAID AGENCY Run Date: MM/DD/CCYY

Process : FINJRPR08 MEDICAID MANAGEMENT INFORMATION SYSTEM Run Time: HH:MM:SS

Location: FINPPR08R PAYMENT REGISTER Page: 9999

PAYMENT DATE: MM/DD/CCYY

PAYEE TYPE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

NAME OF PAYEE	PAYEE ID	MAILING ADDRESS CITY AND STATE	PAYMENT NUM	ISSUE DATE	MEDIA TYPE	PAYMENT AMOUNT
---	---	---	---	---	---	---
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999999999	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	CCYYMMDD	XXXXX	999,999,999,999.99

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XXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXX, XX 99999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999
CCYYMMDD XXXXX 999,999,999,999.99

XXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXX, XX 99999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999
CCYYMMDD XXXXX 999,999,999,999.99

XXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXX, XX 99999

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Report : FIN-PR08-R ALAMBAMA MEDICAID AGENCY RUN DATE: MM/DD/CCYY

Process : FINJRPR08 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN TIME: HH:MM:SS

Location: FINPPR08R PAYMENT REGISTER PAGE: 9999

PAYMENT DATE: MM/DD/CCYY

	COUNT TOTALS:	PAYMENT AMOUNT
EFT-PAYMENTS	999,999,999	99,999,999,999.99
T19: 999,999,999.99		
NON-T19: 999,999,999.99		
PAPER-PAYMENTS	999,999,999	99,999,999,999.99
T19: 999,999,999.99		
NON-T19: 999,999,999.99		
STATE TRANSFER	999,999,999	99,999,999,999.99
T19: 999,999,999.99		
NON-T19: 999,999,999.99		

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REGISTER-TOTALS	9,999,999,999	999,999,999,999.99

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7.87.3 FIN-PR08-R -- Payment Register Field Descriptions

Field	Description	Length	Data Type
EFT-Payments Count	This field is the number of electronic fund transfer payments.	9	Number (Decimal)
EFT-Payments Non-T19 Amount	This field is the total reimbursement amount of the non-T19 electronic fund transfer payments. In Alabama, this will always be zero.	11	Number (Decimal)
EFT-Payments Payment Amount Total	This field is the total payment amount of warrants on all EFT payments.	13	Number (Decimal)
EFT-Payments T19 Amount	This field is the total reimbursement amount of T19 electronic fund transfer payments.	11	Number (Decimal)
Issue Date	Issue date of payment (Checkwrite date).	8	CCYYMMDD
Mailing Address City and State	The payee's mailing address.	26	Character
Media Type	This field is the media indicator. The two possible values are: electronic fund transfer, or check.	5	Character
Name of Payee	This field is the payee name.	31	Character
Paper-Payments Count	This field is the number of paper payments paid.	9	Number (Decimal)
Paper-Payments Non-T19 Amount	This field is the total reimbursement amount of non-T19 paper payments. In Alabama, this will always be zero.	11	Number (Decimal)
Paper-Payments Payment Amount	This field is the total payment amount of payments (checks) on all paper payments.	13	Number (Decimal)
Paper-Payments T19 Amount	This field is the total reimbursement amount of T19 paper payments.	11	Number (Decimal)
Payee ID	This is the identification number of the payee.	15	Number (Integer)
Payee Type	This is the number for the payee type.	30	Character
Payment Amount	This field is the payment amount.	14	Number (Decimal)
Payment Date	This is the period for which the report was run.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Payment Num	This field is the payment number.	9	Number (Integer)
Register-Totals Count	This field is the total number of payments made for electronic funds transfer, paper, and state transfers.	10	Number (Decimal)
Register-Totals Payment Amount	This field is the total payment amount of payments made, both electronic funds transfer, paper and state transfers.	14	Number (Decimal)
State transfer - Reimbursement Amount	This field is the total reimbursement amount reimbursed on the state transfer payments. This field is N/A for Alabama Medicaid.	13	Number (Decimal)
State transfer - Payment Amount	This field is the total payment amount of payments (checks) on all state transfer payments. This field is N/A for Alabama Medicaid.	13	Number (Decimal)
State transfer - Count	This field is the number of state transfer payments. This field is N/A for Alabama Medicaid.	9	Number (Decimal)
State transfer - Non-T19 Amount	This field is the total reimbursement amount of non-T19 state transfer payments. This field is N/A for Alabama Medicaid.	11	Number (Decimal)
State transfer - T19 Amount	This field is the total reimbursement amount of T19 state transfer payments. This field is N/A for Alabama Medicaid.	11	Number (Decimal)

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7.88 FIN-PR10-R -- Payment Register - Summary of Counts

7.88.1 FIN-PR10-R -- Payment Register - Summary of Counts Narrative

The Payment Register-Summary of Counts report provides summary information for the Payment Register. This report gives the paper payment amount, Electronic Funds Transfer (EFT) amount, and the ON-US transfer amount. Finally the report gives a count of paper payments, EFT's, and ON-US transfers.

This report is produced in the financial cycle.

7.88.2 FIN-PR10-R -- Payment Register - Summary of Counts Layout

```
Report  : FIN-PR10-R          ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

Process : FINJRPR08           MEDICAID MANAGEMENT INFORMATION SYSTEM     Run Time:  HH:MM:SS

Location: FINPPR08R           PAYMENT REGISTER SUMMARY OF COUNTS         Page:      9999

                              PERIOD: MM/DD/CCYY
```

```
TOTAL PAYMENT AMOUNT          999,999,999,999.99
```


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PAPER CHECK AMOUNT	999,999,999,999.99
EFT AMOUNT	999,999,999,999.99
ON-US TRANSFER AMOUNT	999,999,999,999.99

PAPER CHECK COUNT	999,999,999
EFT COUNT	999,999,999
ON-US TRANSFER COUNT	999,999,999

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7.88.3 FIN-PR10-R -- Payment Register - Summary of Counts Field Descriptions

Field	Description	Length	Data Type
EFT Amount	This is the electronic fund transfer amount.	14	Number (Decimal)
EFT Count	This is the electronic fund transfer count.	9	Number (Decimal)
ON-US Transfer Amount	This is the state transfer amount. This field is N/A for Alabama Medicaid.	14	Number (Decimal)
ON-US Transfer Count	This is the state transfer count. This field is N/A for Alabama Medicaid.	9	Number (Decimal)
Paper Check Amount	This is the paper payment amount.	14	Number (Decimal)
Paper Payment Count	This is the paper payment count.	9	Number (Decimal)
Total Payment Amount	This is the total payment amount.	14	Number (Decimal)

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7.89 FIN-PR30-R -- Approved To Pay Reports

7.89.1 FIN-PR30-R -- Approved To Pay Narrative

The Approved to Pay reports list financial totals by Fund Group/Fund Code. These reports are produced for every financial cycle. These reports detail the paid amounts, denied amounts, credited, paid adjustments, AR [er fimd cpde created per checkwrite, payouts, refunds and total paid amounts for each fund code within each of the sixteen fund groups. Fund Group 13 is designated for HIPP payments and is no longer used.

The cycle produces Approved to Pay Reports for each State/Hurricane Evacuee combination in addition to the 'standard' Approved to Pay. The following list details the report numbers and total of the reports.

FIN-PR30-R	Approved To Pay
FIN-PR30-RRT	Approved To Pay - Rita – Texas
FIN-PR30-RRL	Approved To Pay - Rita – Louisiana
FIN-PR30-RYA	Approved To Pay - Katrina – Alabama
FIN-PR30-RYL	Approved To Pay - Katrina – Louisiana
FIN-PR30-RYM	Approved To Pay - Katrina – Mississippi

Approved to Pay reports may be regenerated at the Agency's request. Regenerated reports are created with the same report name and number as the original. Regenerated reports are identified by (Rerun) appearing in the report title. Example: Approved to Pay (Rerun)

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7.89.2 FIN-PR30-R -- Approved To Pay Layout

```
REPORT:   FIN-PR30-R                    ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

PROCESS:  FINJRPR30                MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS

LOCATION: FINPPR30R                      Approved To Pay                      Page:     9,999

                                 PERIOD: MM/DD/CCYY



FUND GROUP:  999 - XXXXXXXXXXXXXXXXXXXXXX



FUND CODE              PAID        DENIED       CREDITS      PAID ADJ     ACCT REC      PAYOUTS       REFUNDS
TOTAL PAID
```

```
 999 XXXXXXXX      999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99  999,999,999.99

 999 XXXXXXXX      999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99  999,999,999.99

 999 XXXXXXXX      999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99  999,999,999.99

 999 XXXXXXXX      999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
999,999,999.99  999,999,999.99
```


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999 XXXXXXXX 999,999,999.99 999,999,999.99 999,999,999.99 999,999,999.99 999,999,999.99 999,999,999.99
999,999,999.99 999,999,999.99

SUBTOTALS 999,999,999.99 999,999,999.99 999,999,999.99 999,999,999.99 $999,999,999.99 999,999,999.99
999,999,999.99 999,999,999.99

GRANDTOTALS 999,999,999.99 999,999,999.99 999,999,999.99 999,999,999.99 $999,999,999.99 999,999,999.99
999,999,999.99 999,999,999.99

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7.89.3 FIN-PR30-R -- Approved To Pay Field Descriptions

Field	Description	Length	Data Type
Credits	Dollar amount of claims credited.	16	Number (Decimal)
Denied	Dollar amount of claims denied.	16	Number (Decimal)
Acct Rec	Dollar amount of AR per fund code created per checkwrite.	16	Number (Decimal)
Fund Code	Identifies the Fund Code (invoice category) by fund code number.	3	Character
Fund Code Description	Description of the fund code.	8	Character
Fund Group	Identifies the Fund Group (benefit category) by fund group number and description..	3	Number (Decimal)
Fund Group Description	Description of the fund group.	15	Character
Grandtotals	Grand total sums of the amounts for each column.	16	Number (Decimal)
Paid	Dollar amount paid for the fund code.	7	Number (Decimal)
Paid Adj	Dollar amount of adjusted claims paid.	16	Number (Decimal)
Payouts	Dollar amount of claims adjustments due to expenditures (lump sum audit payments)..	16	Number (Decimal)
Refunds	Dollar amount refunded on paid claims.	16	Number (Decimal)
Subtotals	Total sum of the amounts for each column within a Fund Group..	16	Number (Decimal)
Total Paid	Total dollar amount paid for the fund code.	16	Number (Decimal)

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7.90 FIN-PR31R – Approved to Pay by Line Count Reports

7.90.1 FIN-PR31-R – Approved to Pay by Line Count Narrative

The Approved to Pay by Line Count reports list financial line item count by Fund Group/Fund Code. These reports are produced for every financial cycle. These reports detail the number of paid claims, denied amounts, credited, paid adjustments, denied adjustments, payouts, refunds and total paid amounts for each fund code within each of the sixteen fund groups. Fund Group 13 is designated for HIPP payments and is no longer used.

The cycle produces Approved to Pay Reports for each State/Hurricane Evacuee combination in addition to the Approved to Pay. The following list details the report numbers and total of the reports.

FIN-PR31-R	Approved To Pay by Line Count
FIN-PR31-RRT	Approved To Pay by Line Count - Rita – Texas
FIN-PR31-RRL	Approved To Pay by Line Count - Rita – Louisiana
FIN-PR31-RYA	Approved To Pay by Line Count - Katrina – Alabama
FIN-PR31-RYL	Approved To Pay by Line Count - Katrina – Louisiana
FIN-PR31-RYM	Approved To Pay by Line Count - Katrina – Mississippi

Approved to Pay reports may be regenerated at the Agency's request. Regenerated reports are created with the same report name and number as the original. Regenerated reports are identified by (Rerun) appearing in the report title. Example: Approved to Pay by Line Count (Rerun)

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7.90.2 FIN-PR31-R – Approved to Pay by Line Layout

REPORT: FIN-PR31-R ALABAMA MEDICAID AGENCY Run Date: MM/DD/CCYY

PROCESS: FINJRPR31 MEDICAID MANAGEMENT INFORMATION SYSTEM Run Time: HH:MM:SS

LOCATION: FINPPR31R Approved To Pay by Line Count Page: 9,999

PERIOD: MM/DD/CCYY

Fund Group: 999 XXXXXXXXXXXXXXXXXXXXXXX

FUND CODE	PAID	DENIED	PROCESSED	CREDITS	PAID ADJ	DENY ADJ	PAYOUTS	REFUNDS	TOTAL PAID
999 XXXXXXXXXXXXXX	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999
999 XXXXXXXXXXXXXX	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999
999 XXXXXXXXXXXXXX	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999
999 XXXXXXXXXXXXXX	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999
SUBTOTALS	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999	99,999

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```
GRANDTOTALS      99,999  99,999    99,999    99,999      99,999      99,999      99,999      99,999      99,999
 ------------------------------------------------------------------------------------------------------------------------------------------------------------
 ------------------------------------------------------------------------------------------------------------------------------------------------------------
```


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7.90.3 FIN-PR31-R – Approved to Pay by Line Field Descriptions

Field	Description	Length	Data Type
Credits	Number of claims credited.	5	Number (Decimal)
Denied	Number of denied claims.	5	Number (Decimal)
Deny Adj	Number of claims with denied adjustments.	5	Number (Decimal)
Fund Code	Identifies the Fund Code (invoice category) by fund code number.	3	Character
Fund Code Description	Description of the fund code	15	Character
Fund Group	Identifies the Fund Group (benefit category) by fund group number and description..	3	Number (Decimal)
Fund Group Description	Decription of the fund group.	15	Character
Grandtotals	Grand totals for each column.	5	Number (Decimal)
Paid	Number of paid claims.	5	Number (Decimal)
Paid Adj	Number of claims with paid adjustments.	5	Number (Decimal)
Payouts	Number of claims with lump sum audits.	5	Number (Decimal)
Processed	Number of claims processed.	5	Number (Decimal)
Refunds	Number of claims with refunds.	5	Number (Decimal)
Subtotals	Total sum of each column.	5	Number (Decimal)
Total Paid	Total sum paid of all the columns in a row.	5	Number (Decimal)

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7.91 FIN-PR32R – Approved to Pay Encounter Line Count Report

7.91.1 FIN-PR32-R – Approved to Pay Encounter Line Count Report Narrative

The Approved to Pay Encounter Line Count report lists financial Encounter line item count by Fund Group/Fund Code. These reports are produced for every financial cycle. These reports detail the number of paid claims, denied amounts, credited, paid adjustments, denied adjustments, payouts, refunds and total paid amounts for each fund code within each of the sixteen fund groups. Fund Group 13 is designated for HIPP payments and is longer used.

7.91.2 FIN-PR32-R – Approved to Pay Encounter Line Count Report Layout

```
REPORT:   FIN-PR32-R                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS:  FINJRPR32                   MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:   HH:MM:SS
LOCATION: FINPPR32R                        Approved To Pay Encounter Line Count                        PAGE:          9,999
                                                PERIOD: MM/DD/CCYY
FUND GROUP: 001 - Nursing Home

FUND CODE                      PAID     DENIED  PROCESSED      CREDITS    PAID ADJ       DENY ADJ      PAYOUTS      REFUNDS      TOTAL PAID
001 NURSING FAC             999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
999 XXXXXXXXXXXXXXX         999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
999 XXXXXXXXXXXXXXX         999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
999 XXXXXXXXXXXXXXX         999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
999 XXXXXXXXXXXXXXX         999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
-----------------------------------------------------------------------------------------------------------------------------------------------
SUBTOTALS                   999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999

GRANDTOTALS                 999,999    999,999     999,999      999,999     999,999        999,999      999,999      999,999         999,999
===============================================================================================================================================

                                                        **** END OF REPORT ****
```

7.91.3 FIN-PR32-R – Approved to Pay Encounter Line Count Report Field Descriptions

Field	Description	Data Type	Length
Credits	Number of claims credited.	Number	9
Denied	Number of denied claims.	Number	9

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Field	Description	Data Type	Length
Deny Adj	Number of claims with denied adjustments.	Number	9
Fund Code	Invoice category.	Character	3
Fund Code Description	Description of the Fund Code (Invoice Category)	Character	15
Fund Group	Invoice Group	Number	3
Fund Group Description	Description of the fund group (benefit category).	Character	15
Grandtotals	All Lines find County by groups.	Number	9
Paid	Number of paid claims	Number	9
Paid Adj	Number of claims with paid adjustments.	Number	9
Payouts	Number of claims with lump sum audits.	Number	9
Processed	Number of claims processed.	Number	9
Refunds	Number of claims with refunds.	Number	9
Subtotals	Total Lines find County by groups.	Number	9
Total Paid	Total number of claims paid.	Number	9

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7.91 FIN-PY05-W -- Voided Payments by External Number

7.91.1 FIN-PY05-W -- Voided Payments by External Number Narrative

The Voided Payments by External Number report identifies system payments voided during the current cycle. It is used to validate that all void transactions have processed appropriately through the system. The purpose of this report is to identify any external payment numbers which were voided during the current cycle.

This report is produced during the financial cycle.

7.91.2 FIN-PY05-W -- Voided Payments by External Number Layout

```
Report  : FIN-PY05-W          ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

Process : FINJWPY05     MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   HH:MM:SS

Location: FINPPY05W           VOIDED PAYMENTS BY EXTERNAL NUMBER         Page:     9,999

                        Period: MM/DD/YYYY - MM/DD/CCYY
```

```
     -----PAYEE . ------    EXTERNAL PYMNT NUMBER    PAYMENT DATE     CCN     PYMNT AMOUNT        REASON

ID              TYPE    PAYMENT NUMBER

XXXXXXXXXXXXXXX         X      999999999          MM/DD/CCYY     99999999999   999,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXX



TOTAL # OF VOIDS:                 99,999
```


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TOTAL VOIDED DOLLARS 999,999,999.99

** END OF REPORT **

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7.91.3 FIN-PY05-W -- Voided Payments by External Number Field Descriptions

Field	Description	Length	Data Type
CCN	Cash Control Number: This is a unique number assigned by the system to track payments received.	11	Number (Integer)
External Payment Number	The number assigned to the check during the payment printing process.	9	Number (Integer)
Payee ID	The unique number which identifies the payee for which the payment is being voided. This will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	15	Character
Payment Amount	This indicates the amount of the system payment being voided.	11	Number (Decimal)
Payment Date	This indicates the issue date for the payment to be voided.	10	Date (MM/DD/CCYY)
Reason	This indicates the reason the payment was voided.	25	Character
Total # of Voids	This indicates the total number of payments that have been voided.	3	Number (Decimal)
Total Voided Dollars	This indicates the total dollar amount for the total number of payments that have been voided.	11	Number (Decimal)
Payee Type	This code indicates the type of payee: P=- provider.	4	Character

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7.92 FIN-PY10-M -- Stop Payment

7.92.1 FIN-PY10-M -- Stop Payment Narrative

The Stop Payment report is a monthly report of all 'stop payments' that the state requested. It details the date the payment was issued, date the payment was stopped, the payment number, the payment amount, and the payee name.

This report is produced monthly.

7.92.2 FIN-PY10-M -- Stop Payment Layout

```
REPORT:   FIN-PY10-M                    ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

PROCESS:  FINJMPY10                MEDICAID MANAGEMENT INFORMATION SYSTEM              Run Time:   HH:MM:SS

LOCATION: FINPPY10M                     STOP PAYMENT REPORT                      Page:     9,999

                              PERIOD:  OCTOBER CCYY



  DATE          DATE OF        PAYMENT      PAYMENT

  ISSUED        STOP PAY       NUMBER       AMOUNT              PAYEE NAME


  MM/DD/CCYY    MM/DD/CCYY     999999999    999,999,999.99      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  MM/DD/CCYY    MM/DD/CCYY     999999999    999,999,999.99      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  MM/DD/CCYY    MM/DD/CCYY     999999999    999,999,999.99      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  MM/DD/CCYY    MM/DD/CCYY     999999999    999,999,999.99      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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MM/DD/CCYY	MM/DD/CCYY	999999999	999,999,999.99	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	999999999	999,999,999.99	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	999999999	999,999,999.99	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	999999999	999,999,999.99	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

TOTALS	99,999	999,999,999.99

** END OF REPORT **

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7.92.3 FIN-PY10-M -- Stop Payment Field Descriptions

Field	Description	Length	Data Type
Date Issued	This is the date the stop payment was issued.	10	Date (MM/DD/CCYY)
Date of Stop Pay	This is the date the stop payment was effective.	10	Date (MM/DD/CCYY)
Payee Name	This is the name of the payee.	30	Character
Payment Amount	This is the amount of the payment.	11	Number (Decimal)
Payment Number	This is the payment number.	9	Number (Integer)
Total Issued (Count)	This is the total issued count.	5	Number (Decimal)
Total Issued (Amount)	This is the total sum of the payment amount.	11	Number (Decimal)

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7.93 FIN-PY11-M -- Cleared Payments

7.93.1 FIN-PY11-M -- Cleared Payments Narrative

The Cleared Payments report shows all cleared payments summarized by the paid date, number of payments, and payment amount. This report is produced monthly.

7.93.2 FIN-PY11-M -- Cleared Payments Layout

```
Report  : FIN-PY11-M                ALABAMA MEDICAID AGENCY                    RUN DATE: MM/DD/CCYY
Process : FINJMPY11            MEDICAID MANAGEMENT INFORMATION SYSTEM                RUN TIME:   HH:MM:SS
  Location: FINPPY11M                 CLEARED PAYMENTS REPORT                     PAGE:        9
                             PERIOD: AUGUST     CCYY

    DATE                        PAYMENT              PAYMENT
   CLEARED                        NUMBER               AMOUNT
  ----------                   ----------           ---------------
   MM/DD/CCYY                    999999999            999,999,999.99
   MM/DD/CCYY                    999999999            999,999,999.99
   MM/DD/CCYY                    999999999            999,999,999.99
   MM/DD/CCYY                    999999999            999,999,999.99
```


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GRAND TOTAL 999,999,999.99

** END OF REPORT **

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7.93.3 FIN-PY11-M -- Cleared Payments Field Descriptions

Field	Description	Length	Data Type
Date Cleared	This is the date the payment was cleared..	10	Date (MM/DD/CCYY)
Grand Total	The total payment amounts for all payments cleared in the month.	11	Number (Decimal)
Payment Amount	This is the amount of the payment.	11	Number (Decimal)
Payment Number	This is the number that identifies the payment.	9	Number (Integer)

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7.94 FIN-PY12-M -- Payments Staledated

7.94.1 FIN-PY12-M -- Payments Staledated Narrative

The Payments Staledated report provides Alabama Medicaid Agency (Agency) with a monthly report of all payments staledated. The sequence is by payment number, date issued, date the payment was staledated, the payment amount, and the payee name.

This report is produced monthly.

7.94.2 FIN-PY12-M -- Payments Staledated Layout

```
REPORT  : FIN-PY12-M                    ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

PROCESS : FINJMPY12                MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS

LOCATION: FINPPY12M                     PAYMENTS STALEDATED REPORT                     Page:     9,999

                              PERIOD: OCTOBER  CCYY



    DATE        DATE        FUND  PAYMENT       PAYMENT       PAYEE

    ISSUED      STALEDATED  CODE  NUMBER        AMOUNT        ID            PAYEE NAME


    MM/DD/CCYY  MM/DD/CCYY  XXX   XXXXXXXXX     999,999,999.99  XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    MM/DD/CCYY  MM/DD/CCYY  XXX   XXXXXXXXX     999,999,999.99  XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    MM/DD/CCYY  MM/DD/CCYY  XXX   XXXXXXXXX     999,999,999.99  XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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MM/DD/CCYY MM/DD/CCYY XXX XXXXXXXXX 999,999,999.99 XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MM/DD/CCYY MM/DD/CCYY XXX XXXXXXXXX 999,999,999.99 XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MM/DD/CCYY MM/DD/CCYY XXX XXXXXXXXX 999,999,999.99 XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MM/DD/CCYY MM/DD/CCYY XXX XXXXXXXXX 999,999,999.99 XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

GRAND

TOTALS 99,999 999,999,999.99

** END OF REPORTS **

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7.94.3 FIN-PY12-M -- Payments Staledated Field Descriptions

Field	Description	Length	Data Type
Date Issued	This is the date issued.	10	Date (MM/DD/CCYY)
Date Staledated	This is the staledated date.	10	Date (MM/DD/CCYY)
Fund Code	This is the fund code.	3	Character
Payee ID	This is the payee identification number. This will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	15	Character
Payee Name	This is the payee name.	30	Character
Payment Amount	This is the amount on the payment.	11	Number (Decimal)
Payment Number	This is the payment number of check or electronic funds transfer.	9	Character
Total Staledate Amount	This is the total amount of payments.	11	Number (Decimal)
Total Staledate Count	This is the total number of payments.	5	Number (Decimal)

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7.95 FIN-PY13-M -- Payments Staledated FY YTD

7.95.1 FIN-PY13-M -- Payments Staledated FY YTD Narrative

The Payments Staledated FY YTD report provides the Agency with a monthly report of all payments staledated from FY YTD. The sequence is by payment number, date issued, fund code, date the payment was staledated, the payment amount, and the payee name.

This report is produced monthly.

7.95.2 FIN-PY13-M -- Payments Staledated FY YTD Layout

```
REPORT  : FIN-PY13-M                ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

PROCESS : FINJMPY13            MEDICAID MANAGEMENT INFORMATION SYSTEM              Run Time:   HH:MM:SS

LOCATION: FINPPY13M                 PAYMENTS STALEDATED FY YTD REPORT                Page:     9,999

                              PERIOD: MM/DD/CCYY
```

DATE ISSUED	DATE STALEDATED	FUND CODE	PAYMENT NUMBER	PAYMENT AMOUNT	PAYEE ID	PAYEE NAME
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY	MM/DD/CCYY	XXX	999999999	999,999,999.99	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

GRAND TOTALS	99,999	999,999,999.99

** EMD OF REPORT **

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7.95.3 FIN-PY13-M -- Payments Staledated FY YTD Field Descriptions

Field	Description	Length	Data Type
Date Issued	This is the date issued.	10	Date (MM/DD/CCYY)
Date Staledated	This is the staledated date.	10	Date (MM/DD/CCYY)
Fund Code	This is the fund code.	3	Character
Payee ID	This is the payee identification number. This will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	15	Character
Payee Name	This is the payee name.	30	Character
Payment Amount	This is the amount on the payment.	11	Number (Decimal)
Payment Number	This is the payment number of check or electronic funds transfer.	9	Number (Integer)
Total Staledate Amount	This is the total amount of payments from the fiscal year beginning Oct.1.	11	Number (Decimal)
Total Staledate Count	This is the total staledate count from the fiscal year beginning Oct. 1.	5	Number (Decimal)

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7.96 FIN-PY16-R -- EFT Activity

7.96.1 FIN-PY16-R -- EFT Activity Narrative

The EFT Activity report summarizes electronic funds transfer (EFT) activity for the current Release Date. It lists each individual transaction for the providers participating in EFT for the Release Date and the total dollar amount transferred. This report is used to identify EFT activity for each Release Date. It will also allow tracking of EFT participation trends and the associated dollars.

This report is produced during the EFT Release process which is triggered by the user clicking 'Finished' in the EFT Release Panel.

7.96.2 FIN-PY16-R -- EFT Activity Layout

REPORT : FIN-PY16-R ALABAMA MEDICAID AGENCY Run Date: MM/DD/CCYY

PROCESS : FINJRPY17 ELECTRONIC FUNDS TRANSFER ACTIVITY REPORT Run Time: HH:MM:SS

LOCATION: FINPPY17 RELEASE DATE: MM/DD/CCYY Page: 99,999

PAYEE TYPE: Provider

PAYEE ID	ACCOUNT NAME	BANK ROUTING	ACCT NUMBER	EFT NUMBER	EFT AMOUNT
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	99999999999999999999	999999999	$999,999,999.99

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999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	999999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	999999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	999999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	999999999999999999999	999999999	$999,999,999.99
999999999 .	XXXXXXXXXXXXXXXXXXXXXXXX	999999999	999999999999999999999	999999999	$999,999,999.99

SUBTOTAL: $999,999,999.99

TOTAL: $999,999,999.99

* * END OF REPORT * *

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7.96.3 FIN-PY16-R -- EFT Activity Field Descriptions

Field	Description	Length	Data Type
Account Name	This is the name of the provider on the electronic funds transfer.	22	Character
Acct Number	This is the bank account number to which the electronic funds transfer is transmitted.	21	Character
Payee ID	This is the identification provider number and service location number to which the electronic funds transfer was issued.	10	Character
Bank Routing	This indicates the bank routing number to which the electronic funds transfer is transmitted.	9	Number (Integer)
EFT Amount	This is the amount of the electronic funds transfer.	11	Number (Decimal)
EFT Number	This indicates the unique number assigned for electronic funds transfer tracking purposes.	9	Number (Integer)
Subtotal	This is the subtotal of the Payee Type group. Note that in Alabama, only Provider has EFT, so there will only be one group.	11	Number (Decimal)
Total	This is the total dollar amount of all Electronic Funds Transfers for the current financial cycle.	11	Number (Decimal)

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7.97 FIN-PY17-W -- Stoppay - Reissue Detail Weekly Activity

7.97.1 FIN-PY17-W -- Stoppay - Reissue Detail Weekly Activity Narrative

The Stoppay-Reissue Detail Weekly Activity report lists all stopped check numbers that have been reissued, dates and amounts, the reissued check number, the provider number and name, the reason code, the stoppay and reissue dates. This report is run on a weekly basis, showing the activity for the week. This report is used to follow-up with providers as necessary, and provides detail backup for bank reconciliations.

This report is produced weekly.

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7.97.2 FIN-PY17-W -- Stoppay - Reissue Detail Weekly Activity Layout

```
REPORT  : FIN-PY17-W                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
PROCESS : FINJWPY17                           MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
LOCATION: FINPPY17W                                 STOPPAY/VOID REISSUE DETAIL                                        Page:      9,999
                                                      PERIOD: MM/DD/CCYY - MM/DD/CCYY

ORIGINAL     ORIGINAL    REISSUE     REISSUE      PAYEE           PAYEE    PAYEE
PAYMENT
PYMT NUM     PYMT DATE   PYMT NUM    PYMT DTE     ID              TYPE     NAME
AMOUNT

REASON    F MUTILATED CHECK

999999999    MM/DD/CCYY  999999999   MM/DD/CCYY   999999999999999   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999,999,999.99
999999999    MM/DD/CCYY  999999999   MM/DD/CCYY   999999999999999   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999,999,999.99


REASON:   0 FAILED EFT


999999999    MM/DD/CCYY  999999999   MM/DD/CCYY   999999999999999   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999,999,999.99
999999999    MM/DD/CCYY  999999999   MM/DD/CCYY   999999999999999   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999,999,999.99

                                                          * * END OF REPORT * *
```

Reissue Reason Codes

```
REISSUE REASON  DESCRIPTION
A               CHECK OUTSTANDING
C               CHECK VOIDED
D               STOP/CHECK PRESENT
E               STOP/CHECK NOT PRESENTED
F               MUTILATED CHECK
G               VOID/INCORRECT PAYMENT
H               VOID/WRONG PROVIDER
I               VOID/DUPLICATE PAYMENT
J               VOID/WRONG LOCATION
K               VOID/WRONG PROVIDER ID
L               VOID/CHECK STALE-DATED
M               VOID/NEW TAX ID NUMBER
N               VOID/WRONG PROCEDURE CODE
O               VOID/FAILED EFT
```


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7.97.3 FIN-PY17-W -- Stoppay - Reissue Detail Weekly Activity Field Descriptions

Field	Description	Length	Data Type
Payment Amount	This is the dollar amount of the original payment.	11	Number (Decimal)
Original Payment Date	This is the date of the original payment.	8	Date (MM/DD/CCYY)
Original Payment Number	This is the payment number of the original payment.	9	Number (Integer)
Payee ID	This is the ID of the payee for whom the stoppay and reissue has been requested. This will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	9	Number (Integer)
Payee Name	This is the name of the payee for whom the stoppay and reissue has been requested.	23	Character
Payee Type	The type of the Payee. (Provider)	1	Character
Reason	The code and description of the reason the stoppay request was issued.	40	Character
Reissue Payment Date	This is the date of the reissue (replacement) payment.	8	Date (MM/DD/CCYY)
Reissue Payment Number	This is the check number of the reissued (replacement) payment.	9	Number (Integer)

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7.98 FIN-PY50-O -- Payment Inquiry Online Report

7.98.1 FIN-PY50-O -- Payment Inquiry Online Report Narrative

Payment Inquiry Online Report is generated from the Financial – Reports and Letters - Payment Inquiry Panel. It can be generated at any time.

7.98.2 FIN-PY50-O -- Payment Inquiry Online Report Layout

Report: FIN-PY50-O
From Date: 2002/07/26
To Date: 2005/07/26

STATE MMIS
Payment Inquiry Report

Date: 2005/07/26
Time: 11:49 AM
Page # 1 of 1

PAYMENT NUMBER	PAYMENT TYPE	RA NUMBER	PAYMENT STATUS	PAYMENT DATE	AMOUNT
11111111111	CHECK	11111111111	VOIDED	07/27/2005	$99,999.99
11111111111	CHECK	999999999	CLEARED	02/23/2005	$9,999.99
	TOTAL				**$110,999.97**
999999999	EFT	11111111111	VOIDED	07/27/2005	$99,999.99
999999999	EFT	999999999	CLEARED	02/23/2005	$9,999.99
	TOTAL				**$110,999.97**

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7.98.3 FIN-PY50-O -- Payment Inquiry Online Report Field Descriptions

Field	Description	Length	Data Type
Amount	This field reports the amount of the payment.	11	Number (Decimal)
Payment Date	This is the date the payment was issued.	8	Date (MM/DD/CCYY)
Payment Number	This is the unique system-generated identifier of the payment transaction. Examples include check number or electronic funds transfer transmission number.	9	Number (Integer)
Payment Status	This field reports the status of the payment. Examples include issued, voided, stopped or cleared.	10	Character
Payment Type	This field shows the payment type. Examples include check, electronic funds transfer and money order.	15	Character
RA Number	This field reports the Remittance Advice Number.	11	Number (Integer)
Total	This field reports the total payment amount for the payment identification number.	11	Number (Decimal)

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7.99 FIN-PY51-O -- Payment Transaction Inquiry Report

7.99.1 FIN-PY51-O -- Payment Transaction Inquiry Report Narrative

The Payment Transaction Inquiry report lists all transactions associated with a payment or a Remittance Advice. This report can be generated at any time from the Financial – Reports and Letters – Payment Transaction Inquiry Panel..

7.99.2 FIN-PY51-O -- Payment Transaction Inquiry Report Layout

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Report: Fin-PY51-O
From Date: 01/01/2002
To Date: 11/11/2006

STATE MMIS
Payment Transaction Inquiry Report

Date: 2006/12/01
Time: 1:12 PM
Page # 1 of 15

FINANCIAL CYCLE	RA NUMBER	PAYMENT ID	PAYMENT TYPE	PAYMENT STATUS	ISSUE DATE	TXN TYPE	FUND CODE	FUND PAYER
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	LIEN RECOVERY	065	Test Fund Payer [redacted]
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	LIEN RECOVERY	065	Test Fund Payer [redacted]
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	LIEN RECOVERY	065	Test Fund Payer [redacted]
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	LIEN RECOVERY	065	Test Fund Payer [redacted]
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	LIEN RECOVERY	065	Test Fund Payer [redacted]
desc fin cycle	[redacted]	[redacted]	EFT	Issued	02/26/2005	ALL CLAIM TYPES	001	Test Fund Payer [redacted]

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7.99.3 FIN- PY51-O -- Payment Transaction Inquiry Report Field Descriptions

Field	Description	Length	Data Type
Financial Cycle	This is the financial cycle the payment occurred in.	15	Character
Fund Code	This field reports the fund code that is used in financial reporting to correctly categorize funds (money).	3	Character
Fund Payer	This field reports the fund payer associated with the transaction.	15	Character
Issue Date	This is the date the payment was issued.	8	Date (MM/DD/CCYY)
Payment ID	This is the unique system-generated identifier of the payment transaction. Examples include check number or electronic funds transfer transmission number.	9	Character
Payment Status	This field reports the status of the payment. Examples include issued, voided, stopped or cleared.	10	Character
Payment Type	This field shows the payment type. Examples include check, electronic funds transfer and money order.	15	Character
RA Number	This field reports the Remittance Advice Number.	9	Character
Txn Type	This is the type of transaction. Transactions can be a specific claim transaction, such as, Dental or Centers for Medicare and Medicaid Services (CMS) 1500; or a financial transaction, such as, Accounts Receivable, Expenditures or Cash Receipts.	15	Character

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7.100 FIN-PY60-O -- Payment Status Recon Report

7.100.1 FIN-PY60-O -- Payment Status Recon Report Narrative

The Payment Status Recon report lists checkwrite total information for the range and financial cycle selected. This report can be generated at any time from the Financial – Reports and Letters – Payment Status Recon Panel.

7.100.2 FIN-PY60-O -- Payment Status Recon Report Layout

Report: FIN-PY60-O
From Date: 2005/08/01
To Date: 2005/08/15

STATE MMIS
Payment Status/Recon Report

Date: 2005/08/26
Time: 11:49 AM
Page # 1 of 1

	Checkwrite Total	Category Total
08/07/2005 Checkwrite	$254,070,093.31	
EFT Amount		$96,568,721.25
Check Amount		$157,501,372.06
Check Cleared Amount		$0.00
Void Amount		$3,162,824.81
Reissue Amount		$9,194.81
Staledate Amount		$882,456.03
Stop Pay Amount		$1,713,302.70
Staledate Cleared Amount		$0.00
08/14/2005 Checkwrite	$43,257,710.65	
EFT Amount		$13,284,263.89
Check Amount		$29,973,446.76
Check Cleared Amount		$153,539,933.56
Void Amount		$7,591,112.50
Reissue Amount		$4,700.81
Staledate Amount		$1,282,488.38
Stop Pay Amount		$7,627,355.44
Staledate Cleared Amount		$2,882,456.03

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7.100.3 FIN-PY60-O -- Payment Status Recon Report Field Descriptions

Field	Description	Length	Data Type
Category Total	The subtotal amounts of the various checkwrite categories associated with the payment cycle.	11	Number (Decimal)
Check Amount	Total amount of paper checks that were issued during the financial cycle.	11	Number (Decimal)
Check Cleared Amount	Total amount of the paper checks that were cleared during the payment cycle.	11	Number (Decimal)
Checkwrite Date	Date of the checkwrite.	8	Date (MM/DD/CCYY)
Checkwrite Total	Total amount paid for the issue date (checkwrite date) listed.	11	Number (Decimal)
EFT Amount	Total amount included that was included in the Electronic Funds Transfer during the payment cycle.	11	Number (Decimal)
Reissue Amount	Total amount that was reissued during the payment cycle.	11	Number (Decimal)
Staledate Amount	Total amount that was staledated during the payment cycle.	11	Number (Decimal)
Statedate Cleared Amount	Total amount of staledated checks that were cleared during the financial cycle.	11	Number (Decimal)
Stop Pay Amount	Total amount of payments that were stopped during the financial cycle.	11	Number (Decimal)
Void Amount	Total amount that was voided during the financial cycle.	11	Number (Decimal)

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7.101 FIN-TI01-R -- Financial Transactions Input - Payouts

7.101.1 FIN-TI01-R -- Financial Transactions Input - Payouts Narrative

The Financial Transaction Input - Payouts report lists all system generated and manual payout transactions entered into the system for the current processing financial cycle. It lists each transaction by payee number with summary totals for the number of transactions input and their associated dollar amount.

This report is used as a monitoring and control report for all financial payout transactions entered into the system during the current processing cycle. It is one of a series of reports utilized to ensure that all financial transactions received are input into the system on a weekly basis. This report will be sorted by reason code and is produced with every financial cycle.

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7.101.2 FIN-TI01-R -- Financial Transactions Input - Payouts Layout

```
Report  : FIN-TI01-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : FINJRTI01                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:      HH:MM
Location: FINPTI01                           FINANCIAL TRANSACTIONS INPUT                                 Page:     99,999
                                                       PAYOUTS
                                            PERIOD: MM/DD/YYYY - MM/DD/YYYY

   TRANSACTION      ---PAYEE---                                                    RECIPIENT       PAYOUT      REASON FUND   USER
     NUMBER        NUMBER    TYPE        ---------PAYEE NAME---------             NUMBER         AMOUNT       CODE  CODE    ID

 9999999999999  999999999999  BE  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX
 9999999999999  999999999999  OT  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX
 9999999999999  999999999999  CY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX
 9999999999999  999999999999  BE  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX
 9999999999999  999999999999  CR  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX
 9999999999999  999999999999  PR  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX  99,999,999.99  XXXX  XXXXX  XXXXXXXX

                   TOTAL PAYOUT TRANSACTIONS INPUT:                                                   999,999,999.99


                                                  * * * END OF REPORT * * *
                                                * * * NO DATA THIS REPORT * * *
```


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7.101.3 FIN-TI01-R -- Financial Transactions Input - Payouts Field Descriptions

Field	Description	Length	Data Type
Fund Code	This is the recipient fund code category code.	3	Character
Payee Name	This is the name of the payee. The payee name is extracted from the following sources: Provider - provider database; Carrier - TPL database; and Recipient - recipient database. All other payee names are manually entered into the expenditure payout file.	50	Character
Payee Number	This is the account identification number of the payee. This number is extracted from the following sources: Provider-provider number from the provider file; and Carrier-carrier ID from the TPL carrier file. All other payee types are assigned an account identification number by the system which is carried on a payee table. This is used to maintain an audit trail of all payees which are not carried on file in the system for other purposes such as a third party carrier, etc. For providers, this will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	12	Character
Payee Type	This is the code describing the type of payee; valid values are: H = TPL Carrier P = Provider	2	Character
Payout Amount	This is the payout amount for the specific transaction.	10	Number (Decimal)
Reason Code	This is the 4 byte reason code assigned to the transaction which identifies the type and purpose of the action taken.	4	Character
Recipient Number	This is the recipient's Program identification number. This field is N/A for Alabama.	12	Number
Total Payout Transactions Input (Count)	This is the total number of payout transactions input this week.	5	Number (Integer)
Total Payout Transactions Input (Amount)	This is the total amount payout transactions input this week.	11	Number (Decimal)
Transaction Number	This is the transaction number assigned at entry to the payout transaction.	13	Number (Integer)
User ID	This is the user identification number.	8	Character

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7.102 FIN-TI02-R -- Financial Transactions Input - Provider Accounts Receivable

7.102.1 FIN-TI02-R -- Financial Transactions Input - Provider Accounts Receivable Narrative

The Financial Transaction Input - Provider Accounts Receivables report lists all manual accounts receivable setups and dispositions entered into the system for the current financial cycle. It lists each transaction in provider number order with summary totals for the number of transactions input and their associated dollar amount. This report is used as a monitoring and control report for all financial manual accounts receivable setups and dispositions transactions entered into the system during the current processing cycle. It is one of a series of reports utilized to ensure that all financial transactions received are input into the system on a cycle basis.

This report is produced upon during the financial cycle.

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7.102.2 FIN-TI02-R -- Financial Transactions Input - Provider Accounts Receivable Layout

```
Report  : FIN-TI02-R                          ALABAMA MEDICAID AGENCY                                  Run Date:  MMDDCCYY
Process : FINJRTI02                         FINANCIAL TRANSACTIONS INPUT                               Run Time:  HH:MM:SS
Location: FINPTI02                               ACCOUNTS RECEIVABLES                                      Page:     9,999
                                             Period: MM/DD/CCYY-MM/DD/CCYY

                 PAYEE                                  A/R                                 REASON            USER
          ID              TYPE        RID NO.            NUMBER              AMOUNT          CODE              ID

     SETUPS

            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX
            9999999999     P        999999999999        9999999999999        999,999,999.99     XXXX            XXXXXXXX

    TOTAL A/R SETUPS INPUT:                     99,999                       999,999,999.99


                                                 * * * END OF REPORT * * *

                                                * * * NO DATA THIS RUN * * *
```


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7.102.3 FIN-TI02-R -- Financial Transactions Input - Provider Accounts Receivable Field Descriptions

Field	Description	Length	Data Type
A/R Number	This is the unique control number assigned to each manual accounts receivable transaction.	13	Character
Amount	This is the amount of the accounts receivable transaction. For the section on setups, this field will contain the original setup amount of the provider accounts receivable. For the section titled manual dispositions, this field will contain the manual disposition amount (increase or decrease) entered for an existing accounts receivable.	11	Number (Decimal)
Payee Type	This is a one-byte alphabetic code used to indicate the payee type (P = Provider).	1	Character
Payee ID	For providers, this will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	10	Number (Integer)
RID No.	This is the recipient's identification number.	12	Character
Reason code	This is the 4 byte reason code assigned to the transaction which identifies the type and purpose of the action taken.	4	Character
Setups	This section lists all manual accounts receivable setup during the current processing cycle.	0	Character
Total A/R Setups Input (Count)	This is the total number of manual accounts receivable setups for the current week.	5	Number (Integer)
Total A/R Setups Input (Amount)	This is the total amount of manual accounts receivable setups for the current week.	11	Number (Decimal)
User ID	This is the identification number of the clerk who initiated the transaction.	8	Character

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7.103 FIN-TI04-R -- Financial Transactions Input - Payouts by Reason Code

7.103.1 FIN-TI04-R -- Financial Transactions Input - Payouts by Reason Code Narrative

The Financial Transaction Input - Payouts by reason code report lists all system generated and manual payout transactions entered into the system for the current processing cycle in Reason Code order. At each reason code break there is a subtotal line with a count of inputs for that reason code and the total amount of the inputs for that reason code.

This report is produced during the financial cycle.

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7.103.2 FIN-TI04-R -- Financial Transactions Input - Payouts by Reason Code Layout

```
Report  : FIN-TI04-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : FINJRTI04                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: FINPTI04                           FINANCIAL TRANSACTIONS INPUT                                    Page:     99,999
                                               PAYOUTS - BY REASON CODE
                                            PERIOD: MM/DD/CCYY - MM/DD/CCYY

REASON   TRANSACTION      ---PAYEE---                                                    RECIPIENT      PAYOUT         FUND    USER
 CODE      NUMBER     ID           TYPE         ---------PAYEE NAME---------            NUMBER         AMOUNT         CODE    ID

 XXXX  9999999999999  999999999999  RE  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999999  99,999,999.99   XXX  XXXXXXXX
 XXXX  9999999999999  999999999999  OT  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999999  99,999,999.99   XXX  XXXXXXXX
 XXXX  9999999999999  999999999999  CY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999999  99,999,999.99   XXX  XXXXXXXX
 XXXX  9999999999999  999999999999  CR  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999999  99,999,999.99   XXX  XXXXXXXX
 XXXX  9999999999999  999999999999  PR  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999999  99,999,999.99   XXX  XXXXXXXX
                            REASON CODE TOTAL FOR PAYOUTS:       99,999                                 999,999,999.99

                            TOTAL PAYOUT TRANSACTIONS INPUT:     99,999                                 999,999,999.99


* * * END OF REPORT * * *
* * * NO DATA THIS REPORT * * *
```


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7.103.3 FIN-TI04-R -- Financial Transactions Input - Payouts by Reason Code Field Descriptions

Field	Description	Length	Data Type
Fund Code	This is the recipient fund code category code.	3	Character
Payee Name	This is the name of the payee. The payee name is extracted from the following sources: Provider - provider database; Carrier - TPL database; and Recipient - recipient database. All other payee names are manually entered into the expenditure payout file.	50	Character
Payee ID	This is the payee identification number of the payee. This number is extracted from the following sources: Provider - provider number from the provider file Carrier - carrier ID from the TPL carrier file Recipient - recipient ID from the recipient file. All other payee types are assigned an account ID number by the system which is carried on a payee table. This is used to maintain an audit trail of all payees which are not carried on file in the system for other purposes such as a third party carrier, etc.	12	Character
Payee Type	This is the code describing the type of payee; valid values are: R = Recipient O = Other H =TPL Carrier P = Provider	2	Character
Payout Amount	This is the payout amount for the specific transaction.	10	Number (Decimal)
Recipient Number	This is the recipient's identification number. This field is N/A in Alabama.	12	Number (Integer)
Reason Code	This is the 4 byte reason code assigned to the transaction which identifies the type and purpose of the action taken.	4	Character
Reason Code Total for Payouts (Amount)	This is the total amount of payouts by reason code.	11	Number (Decimal)
Reason Code Total for Payouts (Count)	This is the total count of payouts by reason code.	11	Number (Decimal)
Total Payout Transactions Input (Amount)	This is the total amount of both system and manual payout transactions input this cycle.	11	Number (Decimal)

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Field	Description	Length	Data Type
Total Payout Transactions Input (Count)	This is the total count of all payout transactions input for the cycle.	11	Number (Decimal)
Transaction Number	This is the transaction number assigned at entry to the payout transaction.	13	Number (Integer)
User ID	This is the identification number of the clerk who initiated the transaction.	8	Character

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7.104 FIN-TX05-Q -- 1099 Payment Summary

7.104.1 FIN-TX05-Q -- 1099 Payment Summary Narrative

The 1099 Payment Summary is used to view all entities that have received payment during the year. The sequence is by Tax ID and then Provider ID. This report lists all entities that received money during the year.

The report displays the tax ID, the Provider ID, location code (LOC), the check amount, the manual check amount, the claim refunds, the non-claim refunds, the voids, and the net 1099.

At the end of the report is the 1099 totals. This gives totals for all of the Tax ID's. It displays totals for check amount, manual check amount, claim refunds, non-claim refunds, voids, and the net 1099 amount.

This report is produced quarterly.

7.104.2 FIN-TX05-Q -- 1099 Payment Summary Layout

```
Report:    FIN-TX05-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process:   FINJ1099_40                   MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:  HH:MM:SS
Location:  Finptx05q                           1099 PAYMENT SUMMARY                                         Page:     9,999
                                                     TAX YEAR: CCYY

                                          MANUAL PAYMENT                    NON-CLAIM                   BACKUP WITHHOLD
TAX ID        PROVIDER ID    PAYMENT AMOUNT     AMOUNT       CLAIM REFUNDS     REFUNDS         VOIDS            AMOUNT     NET 1099 AMOUNT

XXX-XX-XXXX XXXXXXXXXXXXXXX  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
XXX-XX-XXXX XXXXXXXXXXXXXXX  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
XXX-XX-XXXX XXXXXXXXXXXXXXX  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
XXX-XX-XXXX XXXXXXXXXXXXXXX  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
XXX-XX-XXXX XXXXXXXXXXXXXXX  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99

             1099 TOTALS     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
     NUMBER OF RECORDS:            999,999

                                                  ***END OF REPORT***
```


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7.104.3 FIN-TX05-Q -- 1099 Payment Summary Field Descriptions

Field	Description	Length	Data Type
1099 Totals	This is the totals for each of the columns.	12	Number (Decimal)
Backup Withhold Amount	This is the total amount of backup withholding for the year for the provider number.	10	Number (Decimal)
Payment Amount	This is the total dollar amount of all system-generated payments received by the provider during the year.	10	Number (Decimal)
Claim Refunds	This is the total dollar amount of all claim specific refunds received and processed during the year for the provider number.	10	Number (Decimal)
Manual Payment Amount	This is the total dollar amount of all manual payments received by the provider during the year.	10	Number (Decimal)
Net 1099 Amount	This is the sum of Check Amount + Manual Check Amount - Claim Refunds - Non Claim Refunds - Voids.	10	Number (Decimal)
Non-Claim Refunds	This is the total dollar amount of all non-claim specific refunds received and processed during the year for the provider number.	10	Number (Decimal)
Number of Records	Total number of payment records.	9	Number (Integer)
Provider ID	This is the Provider identification of the provider who received monies during the year. For providers, this will be the provider's Medicaid 8 or 9 character provider number or 10 digit NPI.	10	Character
Tax ID	This is the tax identification of the provider who received monies during the year.	11	Character
Voids	This is the total dollar amount of all voids processed during the year for the provider number.	10	Number (Decimal)

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7.105 FIN-TX06-Q -- 1099 Exception

7.105.1 FIN-TX06-Q -- 1099 Exception Narrative

The 1099 Exception report, sorted by Tax ID and provider number, lists all errors encountered during the 1099 process. The errors reported are: Total Amount Paid is Less than $600.00, Provider Number is Not On File, Provider Pay to Name Missing, Provider Pay to Address Missing, and Provider EIN/SSN is Missing or Invalid.

The report displays the Tax ID, the Provider ID, the location code (LOC), the amount, and the error message that corresponds to the Tax ID. This report is produced quarterly.

7.105.2 FIN-TX06-Q -- 1099 Exception Layout

```
Report:    FIN-TX06-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process:   FIN1099_40                          1099 EXCEPTION REPORT                                    Run Time:   HH:MM:SS
Location:  finptx05q                           FOR CALENDAR YEAR: CCYY                                      Page:      9,999


                TAX ID         PROVIDER ID              AMOUNT                        ERROR MESSAGE
              -----------     ---------------        ---------------                -------------------------------
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              XXX-XX-XXXX     XXXXXXXXXXXXXXX          99,999,999.99                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
NUMBER OF RECORDS: 9,999,999     TOTAL AMOUNT:     $9,999,999,999.99


                                                     *** END OF REPORT ***
```


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7.105.3 FIN-TX06-Q -- 1099 Exception Field Descriptions

Field	Description	Length	Data Type
Amount	This is the net dollar amount of the entity for which a 1099 is being processed.	10	Number (Decimal)
Error Message	This is the description of the error encountered during the 1099 process.	30	Character
Number of Records	The total number of error records.	7	Number (Integer)
Provider ID	This is the Provider identification or payee identification of the entity for which a 1099 is being processed.	9	Character
Tax ID	This is the tax identification of the entity for which a 1099 is being processed.	11	Character
Total Amount	This is the total dollar amount.	10	Number (Decimal)

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7.106 FIN-TX10-Q -- Missing Provider Information

7.106.1 FIN-TX10-Q -- Missing Provider Information Narrative

The Missing Provider Information report shows which providers are missing tax related information. The information they are missing is shown and the totals of the different pieces of information that is missing is shown. This report is produced quarterly.

7.106.2 FIN-TX10-Q -- Missing Provider Information Layout

```
Report : FIN-TX10-Q                                  ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process: FINJ1099_00                            MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location:FINP1566                                MISSING PROVIDER INFORMATION REPORT                      Page:      9,999
TAX YEAR:  CCYY

PROVIDER ID         PROVIDER NAME                         ISSUE DATE    TAX ID                  ERROR MSG

XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


NUMBER OF MISSING TAX IDs            :       9999
NUMBER OF MISSING IRS TAX INFORMATION:         9999

                                                                    *** END OF REPORT ***
```


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7.106.3 FIN-TX10-Q -- Missing Provider Information Field Descriptions

Field	Description	Length	Data Type
Issue Date	This is the date of the cycle.	10	Date (MM/DD/CCYY)
Number of Missing Tax IDs	This is the number of providers that are missing the tax identification number.	6	Number (Integer)
Number of Missing IRS Tax Information	This is the total number of records that are missing IRS Tax Information.	6	Number (Integer)
Provider Address	This is the provider’s address.	49	Character
Error Message	This is the error message reporting either Missing Tax IDs or Missing IRS Tax Information.	27	Character
Provider Name	This is the provider's name.	39	Character
Tax ID	This is the tax identification number assigned to a provider by the Internal Revenue Service.	11	Character

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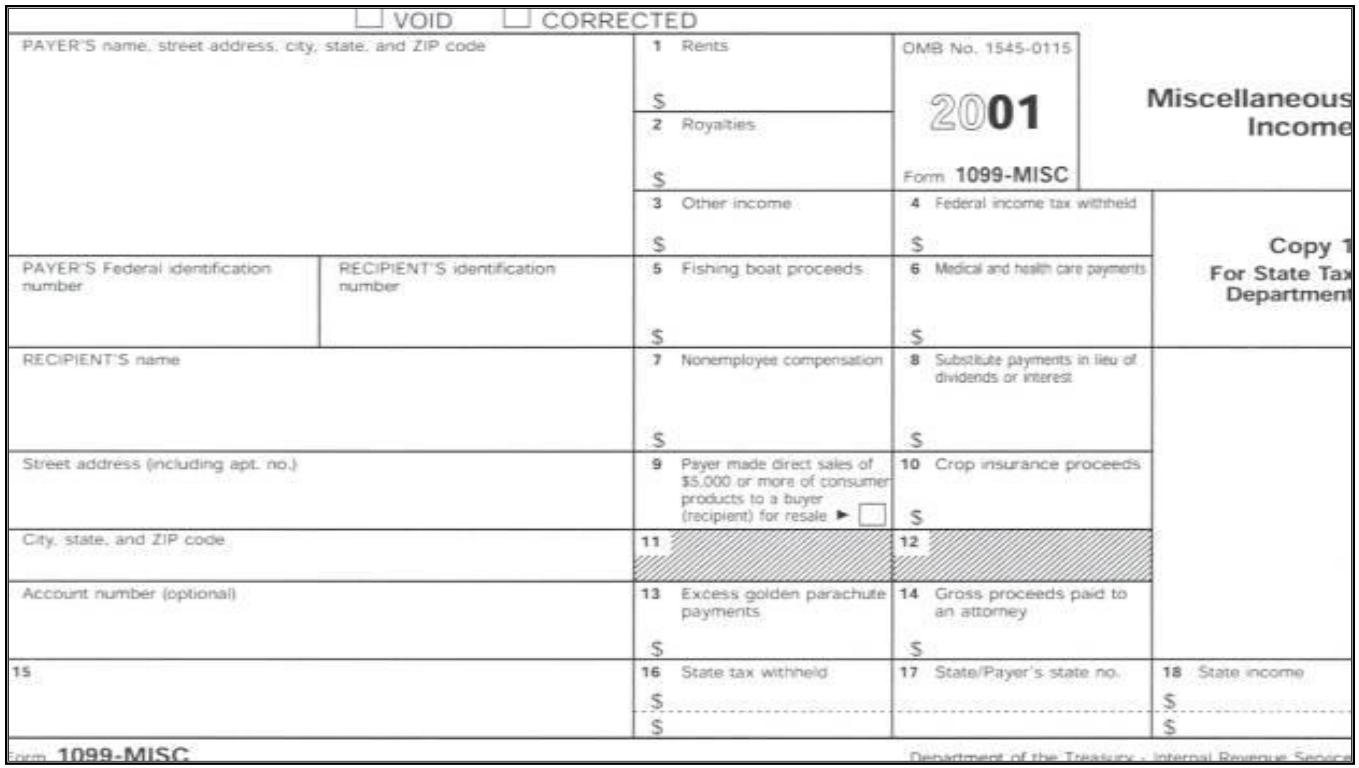
7.107 PAPR1099 -- Paper 1099

7.107.1 PAPR1099 -- Paper 1099 Narrative

The paper 1099 report is printed on preprinted 1099 forms. The form is systematically generated and printed as defined by federal guidelines.

7.107.2 PAPR1099 -- Paper 1099 Layout



☐ VOID ☐ CORRECTED			
PAYER'S name, street address, city, state, and ZIP code	1 Rents $	OMB No. 1545-0115 2001 Form 1099-MISC	Miscellaneous Income
	2 Royalties $		
	3 Other income $	4 Federal income tax withheld $	Copy 1 For State Tax Department
PAYER'S Federal identification number / RECIPIENT'S identification number	5 Fishing boat proceeds $	6 Medical and health care payments $	
RECIPIENT'S name	7 Nonemployee compensation $	8 Substitute payments in lieu of dividends or interest $	
Street address (including apt. no.)	9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ► ☐	10 Crop insurance proceeds $	
City, state, and ZIP code	11	12	
Account number (optional)	13 Excess golden parachute payments $	14 Gross proceeds paid to an attorney $	
15	16 State tax withheld $ $	17 State/Payer's state no.	18 State income $ $
Form 1099-MISC		Department of the Treasury - Internal Revenue Service	

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7.107.3 PAPR1099 -- Paper 1099 Field Descriptions

Field	Description	Length	Data Type
Payee Address 1	This is the mailing address street 1. This is the street address for a carrier.	30	Character
Payee Address 2	This is the mailing address street 2. This is the street address for a carrier.	30	Character
Payee City	This is the mailing address city. This is the city where a carrier would deliver business mail.	15	Character
Payee Name	This is the name associated with an organization or person.	39	Character
Payee Payment Amount	This is the totals accumulated for one 1099 record.	11	Number (Decimal)
Payee State	This is the mailing address state. The carrier entity uses this to designate what state to direct business mail.	2	Character
Payee Tax ID	This is the tax identification number assigned to a provider by the Internal Revenue Service.	9	Character
Payee Zip Code	This is the mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.	5	Character
Payee Zip Code 4	This is the mailing address zip code + 4. This is the last 4 digits of a zip code.	4	Character
Payer Address	This is the Payer's address.	30	Character
Payer City, State, and Zip	This is the Payer's city, state, and zip code.	30	Character
Payer EIN	This is the Payer's employee identification number.	10	Character
Payer Name	This is the Payer's name.	30	Character

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7.108 FIN-PR12-R – Medicaid Check/EFT Register Summary

7.108.1 FIN-PR12-R – Medicaid Check/EFT Register Summary Narrative

The Medicaid Check/EFT Register Summary is used to view Fund Group Total Check/EFT amounts for the financial cycle. The report displays the Fund Group, the total EFT and total Non-EFT for the Fund Group and the grand totals.

This report is produced with each financial cycle.

7.108.2 FIN-PR12-R – Medicaid Check/EFT Register Summary Layout

```
Report : FIN-PR12-R                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process: FINJRPR12                  MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location:FINPR12R                     MEDICAID CHECK/EFT REGISTER SUMMARY                        Page:      9,999
                                      REPORT PERIOD: MM/DD/CCYY TO MM/DD/CCYY
                                      CHECK NUMBERS: 9999999999 TO 9999999999

_____________________________________________________________________________________________________________________
                    FUND GROUP                                   TYPE          COUNT           AMOUNT
_____________________________________________________________________________________________________________________

     XXX  Hospitals                                                EFT:        999,999      999,999,999.99
                                                               NON-EFT:        999,999      999,999,999.99
                                                                 TOTAL:        999,999      999,999,999.99
     XXX  Non-Institutional                                       EFT :        999,999      999,999,999.99
                                                               NON-EFT :        999,999      999,999,999.99
                                                                 TOTAL :        999,999      999,999,999.99

    **  GRAND TOTALS  **                                          EFT :        999,999      999,999,999.99
                                                               NON-EFT :        999,999      999,999,999.99
                                                                 TOTAL :        999,999      999,999,999.99

                                                            *** END OF REPORT ***
```


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7.108.3 FIN-PR12-R – Medicaid Check/EFT Register Summary Descriptions

Field	Description	Length	Data Type
Fund Group	Number and Description of the Fund Group.	30	Character
Type	Payment Type: EFT or Check, and Total for Group.	8	Character
Count	Count for EFT, Check, and Total for Group.	6	Number
Amount	Amount for EFT, Check, and Total for Group.	11	Number (Decimal)
Grand Totals	Grand Totals for EFT, Check, and Count for all Fund Groups	11	Number (Decimal)

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7.109 FIN-PR13-R – Medicaid Check/EFT Register Detail

7.109.1 FIN-PR13-R – Medicaid Check/EFT Register Detail Narrative

The Medicaid Check/EFT Register Detail is used to view Fund Group Total Check/EFT amounts for the financial cycle. This report is used by the EDS Financial Team to identify paper checks within a Fund Group that are to be held until the Agency makes funds available.

The report page breaks by Fund Group. It displays the check number, payee number, payee name, Remittance Advice number, payment amount, issue date, fund code, and payment type for each payment within the fund group.

This report is produced with each financial cycle.

7.109.2 FIN-PR13-R – Medicaid Check/EFT Register Detail Layout

```
Report : FIN-PR13-R                                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process: FINJRPR13                               MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location:FINPR13R                                  MEDICAID CHECK/EFT REGISTER DETAIL                       Page:      9,999
                                                   REPORT PERIOD: MM/DD/CCYY TO MM/DD/CCYY
                                                   CHECK NUMBERS: 9999999999 TO 9999999999
                                                     FUND GROUP: 999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

_____________________________________________________________________________________________________________________________
   CHECK NUM      PAYEE NUM                    PAYEE NAME           RA NUM        AMOUNT       TYPE    ISSUE DATE    FUND CODE
_____________________________________________________________________________________________________________________________

   999999999  999999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999  99999999999.99   XXXXX   MM/DD/CCYY       999
   999999999  999999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999  99999999999.99   XXXXX   MM/DD/CCYY       999

       TOTALS                                                   EFT :         999,999,999.99
                                                            NON-EFT :         999,999,999.99
                                                              TOTAL :         999,999,999.99

    **  GRAND TOTALS  **                                        EFT :         999,999,999.99
                                                            NON-EFT :         999,999,999.99
                                                              TOTAL :         999,999,999.99


                                                                      *** END OF REPORT ***
```


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7.109.3 FIN-PR13-R – Medicaid Check/EFT Register Detail Descriptions

Field	Description	Length	Data Type
Check Num	EFT or Check Number of the payment.	9	Character
Payee Num	This is the payee identification number of the payee. This number is extracted from the following sources: Provider - provider number from the provider file Carrier - carrier ID from the TPL carrier file Recipient - recipient ID from the recipient file. All other payee types are assigned an account ID number by the system which is carried on a payee table. This is used to maintain an audit trail of all payees which are not carried on file in the system for other purposes such as a third party carrier, etc.	15	Character
Payee Name	Name of the Payee.	50	Character
Amount	Amount of the payment.	11	Number (Decimal)
Grand Totals	Grand Totals for EFT, Check, and Count for all Fund Groups.	11	Number (Decimal)
Totals	Totals for EFT, Check, and Count for the Fund Group.	11	Number (Decimal)
RA Num	Number of the Remittance Advice.	9	Number
Issue Date	Issue date of the EFT/Check.	10	Date (MM/DD/CCYY)
Type	Payment type: Paper or EFT	5	Character
Fund Code	Fund Code to which the payment reported.	3	Number

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7.110 FIN-PHPV-R – Encounter Voids Report

7.110.1 FIN-PHPV-R – Encounter Voids Report Narrative

Reports PHP voids between September 12, 2009 and February 28, 2010 and the A/R transactions that were created to recoup claims at PHP per diem rates for the reporting period. This report is produced with the regular Financial cylce.

7.110.2 FIN-PHPV-R – Encounter Voids Report Layout

```
Report  : FIN-PHPV-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : FINJRPHPR                   MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: FINPPHPVR                         Encounter Adjustments/Voids                                  Page:      9,999
                                              PERIOD: MM/DD/CCYY


PROVIDER          SAK CLAIM     AR NUM / ICN     SAK AR        SAK PAYEE  ENCOUNTER AMT       A/R AMT         ERROR
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX   999999999     XXXXXXXXXXXXX    XXXXXX        XXXXX      999,999,999.99    999,999,999.99  XXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------------
GRANDTOTALS                                                                 999,999,999.99    999,999,999.99

                                                  **** END OF REPORT ****
```


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7.110.3 FIN-PHPV-R – Encounter Voids Report Field Descriptions

Field	Description	Length	Data Type
A/R AMT	This is the A/R amount of the voided claim.	11	Number (Decimal)
A/R Number	This is the number used to track account receiveables throughout the system.	6	Number
Enounter Amt	This is the Encounter amout of the voided claim.	12	Number (Decimal)
Error	This is the description of the error.	22	Character
Grandtotal – A/R AMT	This is the grand total of the AR's.	11	Number (Decimal)
Grandtotal – Encounter AMT	This is the grand total of the voided Encounters.	11	Number (Decimal)
ICN	This is the ICN of the voided claim.	13	Number
Payee	This is the SAK payee number.	5	Number
Provider	This is the provider number	15	Character
SAK Claim	This is the SAK of the voided claim.	9	Number

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AMMIS Interactive Services Website User Manual

Date Modified: 05/15/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technologies
301 Technacenter Drive
Montgomery, Alabama 36117

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1. Introduction

1.1 Interactive Services Website User Manual Overview

The AMMIS has several functional areas that perform specific operations for the Alabama Medicaid users. This user manual is designed to cover the information necessary to perform the tasks associated with the Interactive Services website.

This manual covers the following:

- Interactive Services Website Overview
- Interactive Services Website System Navigation
- System Wide Common Terminology and Layouts
- Interactive Services Website Pages/Panels
- Help

1.2 Interactive Services Website User Manual Objective

The purpose of the AMMIS Interactive Services Website User Manual is to provide Alabama Medicaid users with detailed descriptions of the online system, including pages/panels field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels.

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2. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

2.1 Document Information Page

Required Information	Definition
Document Title	AMMIS Interactive Services Website User Manual
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Location:	https://pwb.alxix.slg.eds.com/alxix/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/UserManuals/EVCM_UM/WebUser
Owner:	DXC/Agency
Author:	Web Portal Team
Approved by:	
Approval Date:	12/14/2012

2.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
10/11/2011	0.1		Added EIP Change Orders	8594 – Dental Claim panel (12.4) 9265 – Pharmacy Claim panel (12.10) 8330 – Elig Verification (12.1) 8557 – Prior Authorization (15.1, 15.2, 15.3) 8791 - Pharmacy Claim panel (12.10) 9162- Information (9.1, 9,2)
10/14/2011	0.2		Agency request Added additional Defect	Added PA Assignment Code table to section 15.1.1. DF 9391 – Pharmacy Claim panel (12.10)
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12/14/2012	1.0		Agency approved	
03/02/2012	1.1		Application of EIP Provider Web Enhancement change orders.	CO 8307 – Added 16.1 Provider Maintenance Panel Added 16.2 Provider Location Contact Information panel. Added 16.2 Added Provider Payer Information panel.
03/02/2012	2.0		Agency approved on 03/01/2012.	
03/16/2012	2.1		Agency approved	User will able to see the PES software instructions and downloadable PES 3.0 software
07/09/2012	3.0		Application of Production change orders	CO 9563: 14.1.2 –File Download Search Layout, 17.18 Group Member Provider ID Search CO 8891 – 7.1.2 Home Panel Layout 15.1.2 – Prior Authorization Search Panel Layout
12/21/2012	3.1		Application of Production Change order for PES	CO 10831: PES Relese 3.02-Section 9.1 AL Links panel Layout
04/04/2013	4.0		Application of Production change orders	CO 7169 - Dental Claim Panel (12.4)-update Carrier Code field length.

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Professional Claim Panel – 12.11- update Carrier Code field length. Institutional Claim Panel – 12.5- update Carrier Code field length. CO 7756: Updates made to Eligibility Verification Panel, Recipient Information, Coverage Type, TPL Panel, Managed Care Panel, Lockin/Lockout Panel, Benefit Limits Panel, Dental Benefits Panel, EPSDT Screening Dates Panel CO 7930 – Occurrence Panel-updated field edit error messages CO 8098 – Update Eligilibity Verification Panel. Add Recpient Application Status panel
05/29/2013	5.0		Application of Production Change Orders	CO 8814 – Update 12.11.3 Professional Claim Panel Field Descriptions CO 9325 – Update 11.1.4 - Account Setup Panel Field Edit Error Codes and 11.8.4 – Update Reset Password Panel Field Edit Error Codes CO 9966 – Update 9.1.2 AL Links Panel Layout CO 8490 – Update layout and extra features in Section 7 Home panel
10/03/2013	6.0		Application of ICD-10 change orders	CO 10185: Update 15.1.1 Prior Authorization Searc h Panel layout and field descriptions. Update 15.1.2 Prior Authorization Search Results panel layout and field descriptions Update 15.2 Prior Authorization Search Results panel layout and field descriptions CO 10106: Update Section 12.10 Pharmacy Claim panel layout and field descriptions and field edit error messages. Update 17.4 Diagnosis Search panel layout and field descriptions

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				CO 10107: Update section 12.11 Professional Claim Panel layout, field descriptons and field edit error messages Update section 12.5 Instituional Claim Panel layout, field descriptions and field edit error messages. Update section 12.8 ICD-9 Procedures Panel (known now as ICD Procedure Panel) layout, field descriptions and fied edit error messages. Update section 18.13 Procedure ICD-9 Search panel (known now as Procedure ICD Search) panel layout and field descriptions Update section 18.4 Diagnosis Search panel layout and field descriptions CO 10186: Update section 15.3 Prior Authorization Submit panel. Update panel layout, field descriptions and field edit error messages. Update Section 15.4 Base Information panel. Update panel layout and field descriptions. Update section 15.5 Line Item Panel. Add new field edit error message.
10/9/2013	7.0		Application of change order 7939	Add Consent Form Search panel. (new section 17.1)
10/25/2013	8.0		Application of ACA Change orders	CO 10121 Update section 13.1 Eligibiity Verification panel – add new layout and field descriptions Add new section 13.13 Service Type/Co-Pay Search Results panel
11/25/2013	9.0		Application of CO 9822	12.4 Dental Claim Panel – Layout and field descriptions updated. 12.5 Institutional Claim Panel – Layout and field descriptions updated.

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01/02/214	10.0		Application of CO 8194	Add new section: 17: PMP Assignment Panel
02/26/2014	11.0		Application of CO 11480	12.11 Professional Claim panel – narrative, panel layout, field descriptions, field edit error messages updated.
07/23/2014	12.0		Application of CO 10338	Add section 14.5.Claim Level Detail panel
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10/28/2014	15.0		Application of CO 12074	Update Dental Claim and Institutional Claim Panel layouts
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01/22/2015	16.0		Application of CO 12402	Update Institutional Claim Panel and Professional Claim Panel field edit error messages.
07/15/2015	17.0		Application of ACA III production change orders	CO 12130 12.4 Dental Claim panel 12.5 Institutional Claim panel 12.10 Pharmacy Claim panel 12.11 Profressional Claim panel All 4 Claim Status Information panel replaced with new layouts to reflect hte additon of the 'Checkwrite Date' field. CO 12163 – Home page – update layout
07/21/2015	18.0		Application of CO 12475	Additon of the 13.6 PRCO Information panel.
01/14/2016	19.0		Application of CO 12410	Additon of section 19 PMP Dismiss

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
04/01/2016	20.0		Application of Cos 12902, 12579, 12314, 11399, 12588, 13290, 13378, 13414	**CO 12902** Section 13 - Eligibility Verification Request Panel Field Descriptions- Add Recipient Application Status Section 13.6.2 Household Inquiry Search Results panel layout replaced Section 13.3.2 – Recipient Application Satus Panel layout replaced **CO 12579** **Section 15.5.4 –** Prior Authorization Submit – Line Item Panel Field Edit Error Codes – Add Line Item **CO 12314** Section 15.5 Prior Authorization Submit – Line Item Panel – replaced layout, added Reason field description, and extra feature. Section 15.3.Prior Authorizatin Submit Panel- updated layout, field descriptions Section 15.6 – added new section: Prior Authorization Submit New – Analyst Remarks Panel **CO 12588** Section 18.1.3 PMP Assignment Panel – update field edit error codes **CO 13290** Section 20 PMP Dismiss Panel – Update panel layout and field descriptions **CO 13378** 12.10 Pharmacy Claim panel – update data type for Prescription Number field.
07/19/2016	21.0		Application of CO 13031	Section 4.3.1 User Roles Section 14.6 Forms Panel Narrative, Field Descriptions, and step action table.

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09/16/2016	22.0		Application of COs 13438 and 12056	13438 – 12.5 Institutional Claim panel – update layout and field descriptions 12056 – 12.4 Dental Claim panel - Update field edit error messages 12.5 Institutional Claim panel - Update field edit error messages 12.11 Professional Claim panel - Update field edit error messages
09/26/2016	23.0		Application of RCO Production COs	CO 13030 13.18 PRCO Information Panel – change to MCO Panel CO 13033 12.2 Claim Search Panel – modify panel layout and field description table CO 13032 15.1 Prior Authorization Search Panel – replace panel layout 15.3 Prior Authjorization Submit Panel - modifyField Edit Error Messages 15.5 Prior Authjorization Submit – Line ItemPanel - modifyField Edit Error Messages
09/27/2016	24.0		Application of Base COs	CO 13679 12.10 Pharmacy Claim Panel – update panel layout, field desccriptons and step acton table – Add CO 13831 13414 Service Type/Co-Pay Search Results – update panel layout CO 12834 12.5 Institutional Claim Panel – update panel layout, field descriptions, and step action table – add
10/26/2016	25.0		Application of CO 13509 and 13806	CO 13509 18.1 Consent Form Search Panel – updated layout,

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				field descriptions and field edit error message
12/06/2016	26.0		Application of CO 13311 and 13806	CO 13311 Section 4.3.1 User Roles – add OPR Providers CI 13806
03/24/2017	27.0		Addition of field edit for Consent Form ID	Section 14.6.4 Field Edit Error Message
04/17/2017	28.0		Application of CO 14038 13914 Update cover page and footers with DXC Logo and copyright informaton.	CO 14038 12.5 Instituional Claim Panel – updated layout, field descriptions, and field edit error messages CO 13914 12.5 Instituional Claim Panel – updated layout, field descriptions, and field edit error messages CO 14212 Add Hospice Election panel
10/13/2017	29.0		Application of CO 14272, 14407, 14409	CO 14272 14 Trade Files – update layout, field descriptions, field edit descriptions CO 14407 – Forms Panel- Update narrative, field descriptions
11/17/2017	30.0		Application of CO 14440, CO 14180, and DF 14409	CO 14440 12.2 Claim Search Panel 13.1 Eligibility Verification Request Panel 15.1 Prior Authhorization Search Panel15.1 15.1 Update panel layouts (From RCO to MCO) CO 14180 14.6 Forms Panel- add PA3 - Rehabilitative Services PA Supporting Documentation CO 14409 14.6 Forms Panel- remove OPR Application Supporting Documentation
12/20/2017	31.0		Application of CO 14391	13.3 Recipient Information panel
01/12/2018	32.0		MCO Changes	13.17 MCO Information

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03/03/2018	33.0		PHI Removal	5.2.1 Search Panels 6.1 Info Panel Layout 10.2.2 Patient 1st Provider Location Results Panel Layout 11.7.2 Switch Provider Panel Layout 11.9.2 Reset Password Panel Layout 11.2.2 Claim Search Panel Layout 12.4.2 Dental Claim Panel Layout 12.5.2 Institutional Claim Panel 12.10.2 Pharmacy Claim Panel Layout 12.11.2 Professional Claim Panel Layout 13.3.2 Recipient Information Panel Layout 13.5.2 TPL Panel Layout 13.9.2 Dental Benefit Limits Panel Layout 13.12.2 Maternity Waiver Panel Layout 13.15.2 HouseHold Inquiry Panel Layout 13.16.1 HouseHold Inquiry Search Results Panel Layout 14.1.2 File Download Search and Results Layout 14.2.2 Current Files Available for Download Panel Layout 14.5.2 Claim Level Detail Panel Layout 15.3.2 Prior Authorization Submit Panel Layout 16.2.2 Provider Location Contact Information Panel Layout 16.3.2 Provider Payer Information Panel Layout

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				18.1.2 Consent Form Search Panel Layout 20.11.2 Prescriber License Search Panel Layout 20.14.2 Provider ID Search Panel Layout 20.19.2 Group Member Provider ID Search Panel Layout
05/15/2018	34.0	M. Spear	Application of Production CO	CO 14763- Update Field Edit Error Codes on the following panels Professional Claim panel Dental Claim Panel Institutinal Claim Panel Pharmacy Claim Panel CO 14514 Prior Authorization Search Panel- update layout and field descriptions

2.3 Related documentation

Document	Description	url

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3. Introduction to the Interactive Services Website

The Interactive Services website allows providers to verify Alabama Medicaid recipient eligibility, claim status, and to upload and download claim files.

The website has been developed by DXC Technology and is offered at no cost to Alabama Medicaid providers. This site is available 24-hours a day, seven days a week, excluding time for scheduled maintenance. Through the use of online user friendly forms, a provider is able to inquire on recipient eligibility, claim status, prior authorization requests and household inquiries. A provider is also able to enter and submit claims, including online voids and adjustments and prior authorization requests.

3.1 Audience

The information described in this document is designed for use by recipients, providers, clerks, and billing agents participating in the Alabama Medicaid program.

3.2 Purpose

This document provides the user with the necessary steps to log on to the website, navigate the website, verify eligibility and claims status, upload and download files, seek assistance for technical issues, and logoff the website.

3.3 Applications

The Interactive Services website provides the user with a choice of applications. The primary application is the Eligibility Verification application where Alabama Medicaid recipient eligibility can be verified. A second application is the Claim Status Inquiry. Using this application allows providers to check on the status of adjudicated claims. The third application available is the uploading and downloading of batch files.

3.4 Supporting Documentation

Readers of this document may find it useful to consult the *Alabama Medicaid Provider Manual* to completely understand the policy behind the billing procedures of the Alabama Medicaid program. To receive a CD-ROM containing the *Alabama Medicaid Provider Manual,* contact DXC Provider Assistance Center at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid homepage at http://www.medicaid.alabama.gov/ .

3.5 Content Changes

Readers of this document should note that this is a living document and is subject to change at any time based on functionality changes within the website.

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4. Interactive Services Website Navigation

4.1 Web Browser Setup

Workstations must be minimally equipped with Internet Explorer (IE) version 6.0, and is also compatible with IE7, and IE8.

Please refer to the websites for Internet Explorer (www.microsoft.com) for additional information on downloading the versions available.

NOTE:

Please refer to the browser installation information to find out the appropriate personal computer recommendations and configurations. The AOL browser does not work well with this Web application.

4.1.1 Navigation Buttons

Do not select the previous/back or following/forward website navigation buttons in the toolbar if the website navigation button offers a selection for “next” or “previous” screen. If you use the navigation or windows buttons instead of those provided by the application, you may risk losing work in progress.

4.1.2 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a minimum screen resolution of 1024 x 768 pixels and preferred screen resolution of 1400 X 1050 pixels. However, in order to fit large system objects such as panels and pages into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.1.3 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the Interactive Service website.	Home page displays.
2	Select **View** from browser toolbar.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

4.2 Web Address

The address to access the Interactive Services website is:

https://www.medicaid.alabamaservices.org/ALPortal

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4.3 Users

4.3.1 User Roles

Interactive Services website users fall into one of four distinct and secure user roles:

- Guests
- Providers
- Clerks
- Trading Partners

The following table describes what features each user can access in the Interactive Services website based on user role:

Feature	Guests	Providers	Clerks*	Trading Partners	OPR Providers
Home	✓	✓	✓	✓	✓
Site Settings	✓	✓	✓	✓	✓
Information	✓	✓	✓	✓	✓
AL Links	✓	✓	✓	✓	✓
Contact Us	✓	✓	✓	✓	✓
Account	✓	✓	✓	✓	✓
Account Setup	✓				✓
Account Maintenance		✓	✓	✓	✓
Clerk Maintenance		✓			✓
Change Password		✓	✓	✓	✓
Messages		✓	✓	✓	✓
Switch Provider			✓		✓
Logoff		✓	✓	✓	✓
Reset Password	✓				
Secure Site	✓	✓	✓	✓	✓
Claims		✓	✓		
Search		✓	✓		
Dental		✓	✓		
Institutional		✓	✓		
Pharmacy		✓	✓		

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Feature	Guests	Providers	Clerks*	Trading Partners	OPR Providers
Professional		✓	✓		
Eligibility		✓	✓		
Eligibility Verification		✓	✓		
HouseHold Inquiry		✓	✓		
Trade Files		✓	✓	✓	✓
Download		✓	✓	✓	
Upload				✓	
Forms			✓	✓	✓
Prior Authorization		✓	✓		
Search		✓	✓		
New		✓	✓		
Providers		✓			

* Access privileges determined by permissions granted by Provider.

4.3.2 User IDs and Passwords

Providers who use the Interactive Services website must have a valid user ID and password to access the system. Billing provider IDs, with an active contract, will be issued a Personal Identification Number (PIN) in the form of a letter. Refer to section *9.1 Account Setup* for instructions related to setting up a provider account based on the information received in the Provider PIN letter. An active provider account will be able to access the interactive features noted in the above section, *3.4.1 User Roles*.

Along with the Provider Electronic Solutions software, providers should receive a letter from DXC issuing a web Personal Identification Number (PIN) which permits a user to create a Trading Partner user ID and password on the Interactive Services website. A Trading Partner web user ID will be restricted to the upload and download features as noted in the above section, *3.4.1 User Roles*. If a Trading Partner PIN letter has not been received, contact the Electronic Media Claims (EMC) Helpdesk at 1 (800) 456-1242, to request a copy. This form is also readily available on the Interactive Services web site mentioned in section 3.3, by navigating to Information then AL Links.

- Providers that use the Provider Electronic Solutions Software or vendor-based software to submit claims to Alabama Medicaid will be required to request a new Trading Partner ID. Once the ID has been issued, refer to section *9.1 Account Setup* for instructions related to setting up a Trading Partner account based on the information received in the Trading Partner PIN letter. To request a new Trading Partner ID, navigate to the Information then AL Links page on the new Interactive Services web site, mentioned in section 3.3, where

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this form resides. Otherwise contact the Electronic Media Claims (EMC) Helpdesk at 1 (800) 456-1242, to request a copy.

NOTE:

To update the Provider Electronic Solutions software with the new user ID and password, click on Tools > Options within the Provider Electronic Solutions software. Select the Batch Tab. Enter the Login ID, from the letter, into the Trading Partner ID field, then enter the new Trading Partner web user ID and password in the corresponding fields displayed based on the User Name and Password created on the Account Setup page.

4.3.2.1 Resetting Passwords

When users initially log in to the website, an option displays allowing a user to set up two security questions and answers that can be used to create a new password in the event the password is forgotten.

4.4 Application Lists

The following features are available through the website:

This option…	Does this…
Home	Displays the Home page and allows users to access the Site Settings panel.
Information	Displays the Information page and allows users to access the Software and Documentation via Hyperlinks as well as Contact information.
Account	Displays the Account page and allows users to set up or maintain account information, such as passwords and messages. Users can access the secure site from this location, as well as logoff the Interactive Services website.
Claims	Displays the Claims page and allows users to search for or submit dental, institutional, professional, crossover, pharmacy or compound drug claims.
Eligibility	Displays the Eligibility page and allows users to verify eligibility or conduct a HouseHold inquiry.
Trade Files	Displays the Trade Files page and allows users to download or upload Health Insurance Portability and Accountability Act (HIPAA) compliant files.
Prior Authorization	Displays the Prior Authorization page and allows users to search for or submit prior authorization requests.
Providers	Displays the Providers page.

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4.5 Login Page Rules

The rules for the Login page are listed below:

- After six invalid password attempts in succession the user's status is changed to a "locked" status. After 10 minutes, the user's account is automatically unlocked, after which the user may again attempt six invalid password attempts in succession before the account is once again "locked". If the user is unable to recall their web password and security answers, they must call the EMC Helpdesk at 1(800) 456-1242 and identify themselves through a security process. The EMC Helpdesk associate resets the user's account by issuing a new PIN, which is sent to the caller's address by mail. Once the new PIN is received, the caller is required to once again setup their account.
- All users will be required to change their password every 30 days. The system prompts the user to change their password.
- After a user changes the password, there is no restriction to the number of times the password can be changed during the 30-day forced change.
- When the web session becomes inactive for an amount of time, the web session "times out" and all unsaved information is destroyed. A message appears requiring the user to "log on" again, creating a new session.

4.6 Connecting Through an Internet Service Provider (ISP)

Users must successfully log in to the Interactive Services website in order to utilize the services available within the secure portal.

Follow the steps below to log in to the website using an Internet Service Provider:

Step	Action	Response
1	Click Internet Explorer located on your workstation.	Internet Explorer launches.
2	Enter https://www.medicaid.alabamaservices.org/ALPortal; press **Enter** key on your keyboard.	Home page of the Interactive Services website displays.

Connecting through Remote Access Server (RAS) is an option created by the Provider Electronic Solutions Software. Remote access is the ability to obtain access to a computer or a network from a remote distance. This section provides steps to log in to the Web Server through RAS when an Internet Service Provider (ISP) is not available.

This method requires users to be minimally equipped with Internet Explorer version 6.0 and a dial-up modem. If your system does not currently support these options please contact your computer administrator to have it set up on your computer.

NOTE:

Before beginning this process, you should have followed the instructions outlined in section 2.5.2 Web Tab of the *Provider Electronic Solutions Manual*. If you have not, please refer to the instructions to setup your connection method through a modem. Follow the instructions described in the "Install RAS" and the "Dialup Network" fields.

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Follow the steps below to log in to the website using a RAS:

Step	Action	Response
1	Select the <Start> menu option located at the bottom left corner of your computer screen.	The Start Menu displays.
2	Windows 2000 Users: Select Settings > Control Panel > Network and Dial-Up Connections. Open the "AL RAS" option. Windows XP Users: Select Control Panel > Network Connections. Open the "AL RAS" option.	Connect AL RAS screen displays. Note: Do not modify the User name or Password. The default information must be present. If information has been changed or deleted, contact the EMC Helpdesk to obtain the User name or Password.
3	Click **Properties**, and then select the **Networking** tab.	
4	Highlight **Internet Protocol (TCP/IP)** and click **Properties**.	
5	Click **Obtain DNS server address automatically**.	
6	Click **OK** to save your changes, and then click **OK** to exit the Networking tab.	
7	Click **Dial** to continue to connect through RAS.	A connection is established with Alabama Medicaid.
8	Click Internet Explorer located on your workstation.	Internet Explorer launches. Note: If you have a default home page within your browser a message may appear that it was unable to connect. Ignore this message.
9	In the browser address bar, enter https://www.medicaid.alabamaservices.org/ALPortal; and then press **Enter** key on your keyboard.	The Home page of the Interactive Services website displays.

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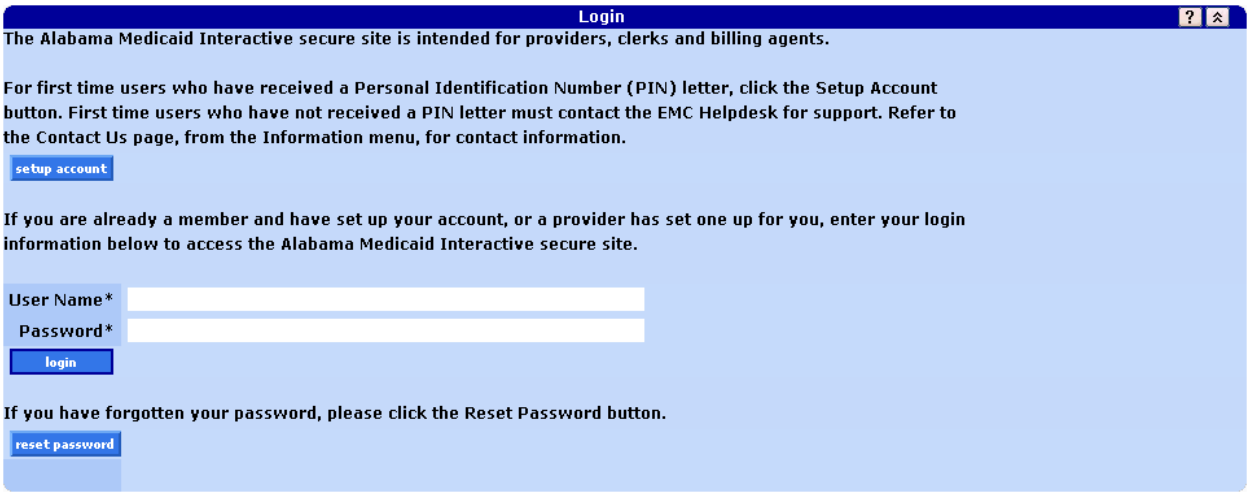
4.7 Login

4.7.1 Login Panel Narrative

The Login panel, accessible via the Secure Site link, allows users to login to the secure Interactive Services website.

Navigation Path: [Account] – [Secure Site]

4.7.2 Login Panel Layout



4.7.3 Login Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
login	This button logs the user into the secure site.	Button	N/A	0
reset password	This button redirects the user to the Reset Password page.	Button	N/A	0
setup account	This button redirects the user to the Account Setup page.	Button	N/A	0
Password	Displays the password of the account user in the form of dots for security purposes.	Field	Character	30
User Name	Displays the Login ID of the user.	Field	Alphanumeric	20

NOTE:

A new PIN letter issuing a new password was mailed to all providers. Users must have a new password to use this application.

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4.7.4 Login Panel Field Edit Error Codes

Field	Error Message	To Correct
Password	Invalid User Name and/or Password.	Enter a valid User Name and/or Password.
	We are sorry but your password has expired. Please change your password.	Enter a new password.
	We are sorry but the user name or password is incorrect. Please try again.	Enter a password that is between 6 to 30 characters in length.
User Name	We are sorry but you are not authorized to access this web site. If you believe this is incorrect please contact the help desk.	The account has been reset. Setup the account once the new Personal Identification Number (PIN) has been received or contact the EMC Helpdesk at 1 (800) 456-1242 for additional assistance.
	Invalid User Name and/or Password.	Enter a valid User Name and/or Password.
	We are sorry but your account has been locked out due to invalid password attempts. Please contact the system administrator to have it unlocked.	Account Locked. Wait 10 minutes and the account will be automatically unlocked or contact the EMC Helpdesk at 1 (800) 456-1242 for additional assistance.

4.7.5 Login Panel Extra Features

Field	Field Type
No extra features found for this panel.	

4.7.6 Login Panel Accessibility

4.7.6.1 To Access the Login Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Secure Site**.	Login panel opens.

4.7.6.2 To Add on the Login Panel

Step	Action	Response
1	Enter **User Name**.	
2	Enter **Password**.	
3	Click **login**.	Providers page displays for Provider users. Messages page displays for Clerks and Billing Agents.

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4.7.6.3 To Update on the Login Panel

Step	Action	Response
1	Click **setup account**.	Account Setup panel displays.
2	Click **reset password**.	Reset Password panel displays.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and an associated screen capture or design layout where applicable. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the novice user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or, more importantly, documenting aspects of the system.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Main Menu
- Sub Menu
- Search Panel
- Data List Panel
- Mini Search Panel
- Pop Up Search Panel
- Panel

5.1 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed a Main Menu bar, a Sub Menu bar, and any associated panels.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

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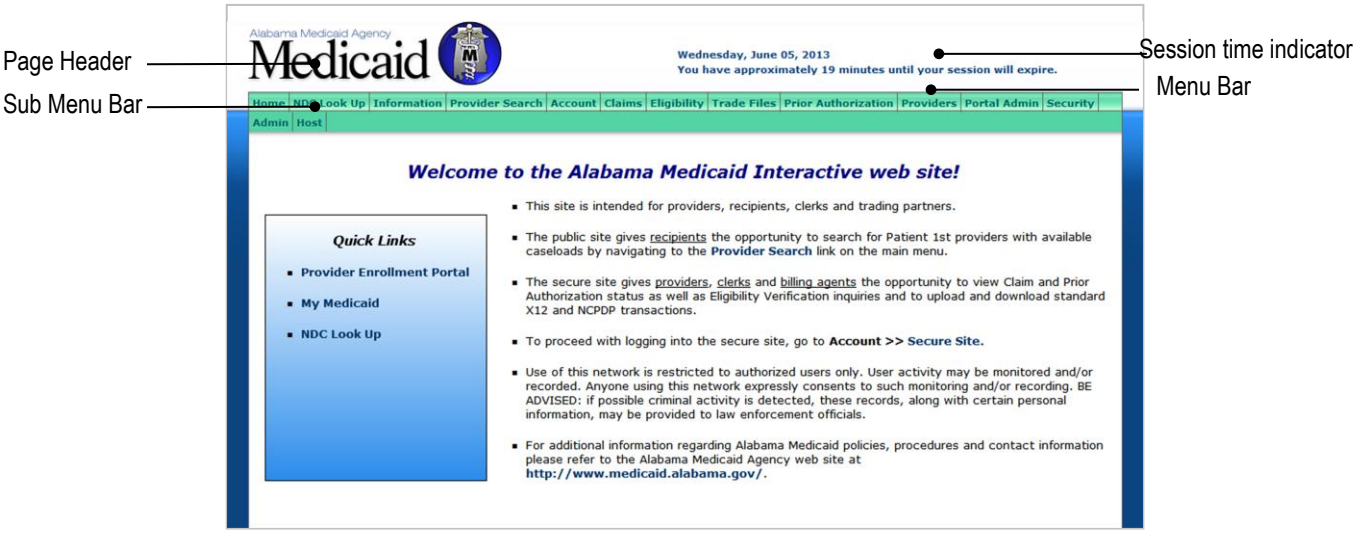
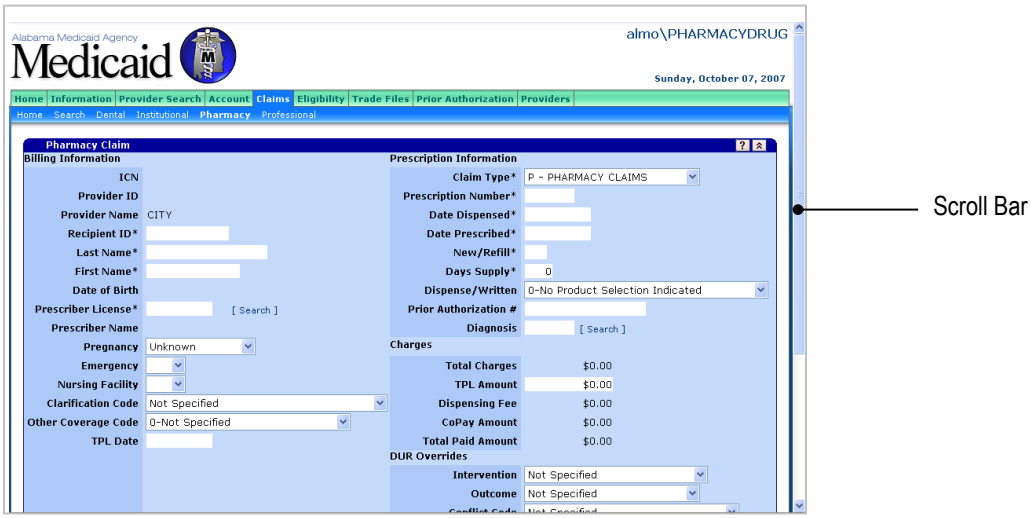
Beneath the Main Menu bar is the Sub Menu bar of horizontal links that open an associated page within the system. The Sub Menu bar appears in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical scroll bar is the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or cancelling the changes, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open and navigation away from the page is not permitted until changes are either correctly saved or cancelled.

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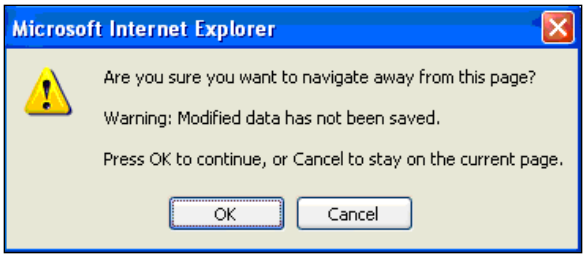
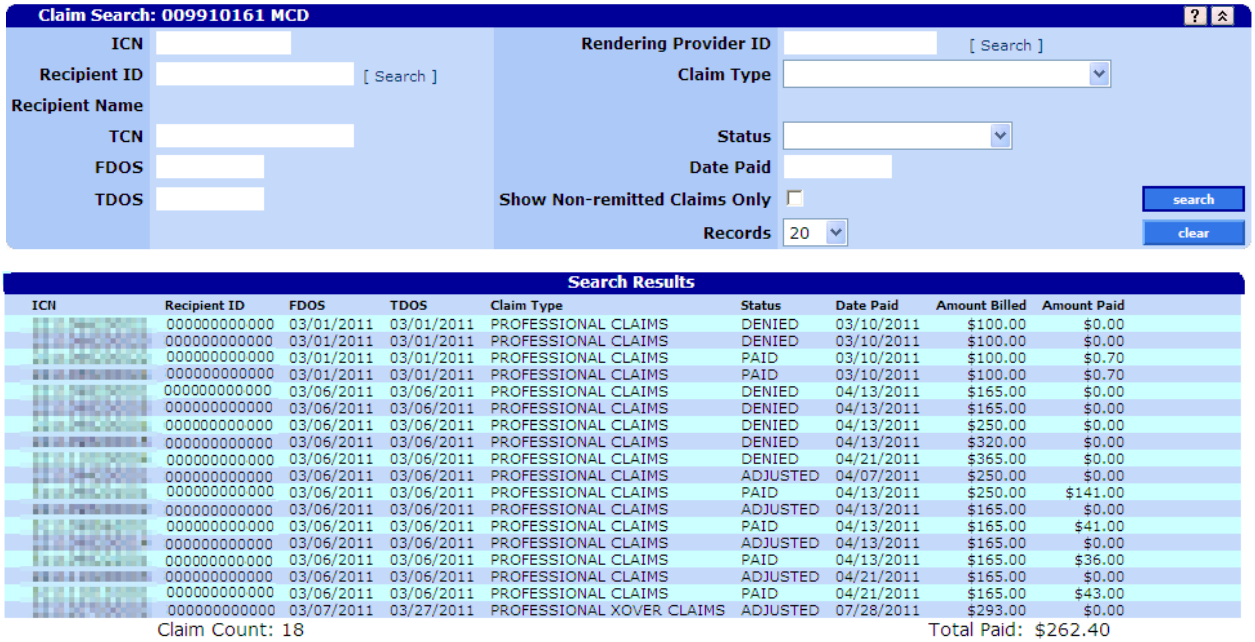


5.2 Search Options

There are several search options available within the AMMIS Interactive Services website, including search panels, data list panels, mini search panels and pop up search panels.

5.2.1 Search Panels

Search panels let users enter any combination of search criteria. Clicking **search** displays subsequent search results (if any) in the corresponding search results panel.



2.2 Data List Panels

Data List can be sorted in ascending or descending order by clicking the column name in the panel which contains multiple rows. All rows are resorted, not just the rows displayed on the current page.

In some cases, if the user clicks once on a row, the associated information displays in the corresponding panel on the same page. In other cases for search related panels, the associated information displays in a corresponding panel on another page. In the following figure, the user clicks the first row of the Detail panel and detailed information displays at the bottom of the panel.

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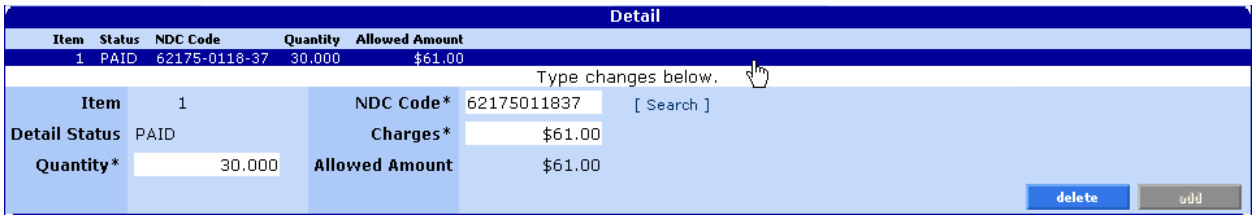


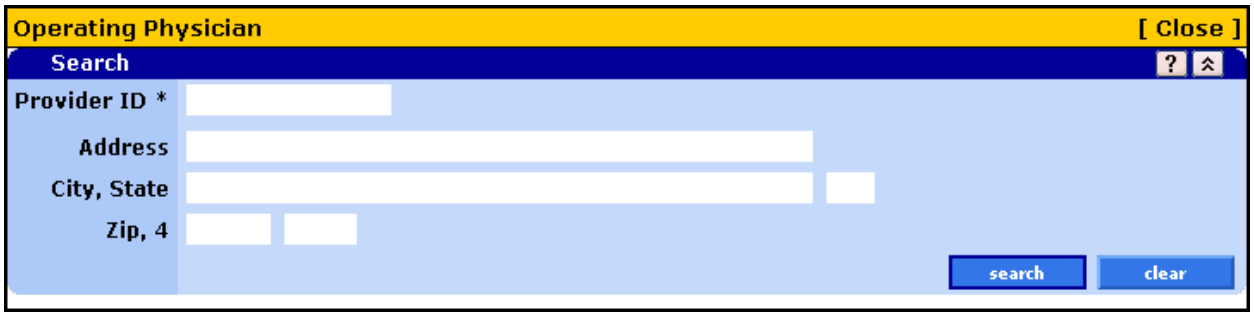
2.3 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search results.

Mini Search panels contain one or two primary search fields related to the business process.

2.4 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the [Search] link, the user accesses the search panel that is associated with that particular field.



After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

All of the Pop Up Search panels are described in detail in Chapter 14.

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5.3 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.3.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page.
Clear Button	clear	Clears all data applied to a panel.
Close	[Close]	Closes a pop up search panel.
Delete Button	delete	Deletes a selected data record.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Next Button	Next	Progresses from one panel to the next.
Previous Button	Previous	Progresses from one panel to the previous.
Save Button	save	Saves all changes to all panels on the page.
Search	[Search]	Performs search based on criteria entered and displays search results within the pop up search panel. Selecting the desired result returned populates the main panel with the corresponding data.
Search Button	search	Performs search based on criteria entered and displays subsequent search results (if any) in the corresponding search results panel.
Submit	submit	Submits a new or updated data record.

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6. Providers

The Providers page is the first to display after a provider logs into the secure site.

The Providers page permits users to view provider-related information.

Info Panel Narrative

This is the main page for all secure site users. It shows some user specific information for the current user logged in.

Navigation Path: [Providers]

6.1 Info Panel Layout

```
Provider ID:[redacted] WEB
Taxonomy:200000000X
Zip Code: 36111 - 2711

Your 835 transactions and/or Paper Remittance Advice is being sent to:
835 Receiver(s) : N/A
Paper RA : PAY TO NAME
           PAY TO ADDRESS 1, PAY TO ADDRESS 2
           PAY TO CITY, ST ZIP
```

6.1.1 Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
835 Receiver(s)	Displays the Trading Partner ID and contact name to which the provider's 835 files are being sent.	Label	N/A	0
Paper RA	Displays the Payee provider address.	Label	N/A	0
Provider ID	Displays the Web number, used to activate the account, of the user currently logged in the application.	Label	N/A	0
Taxonomy	Displays the taxonomy number for the provider currently logged in the application.	Label	N/A	0
Zip Code	Displays the zip code for the provider currently logged in the application.	Label	N/A	0

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6.1.2 Info Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

6.1.3 Info Panel Extra Features

A dynamic feature will display a Trading Partner that has accepted to receive 835 transactions on the part of the Provider. If no action has been taken regarding the provider 835 transaction files, the message is marked as N/A.

6.1.4 Info Panel Accessibility

6.1.4.1 To Access the Info Panel

Step	Action	Response
1	Click **Providers**.	Providers page and Info panel display.

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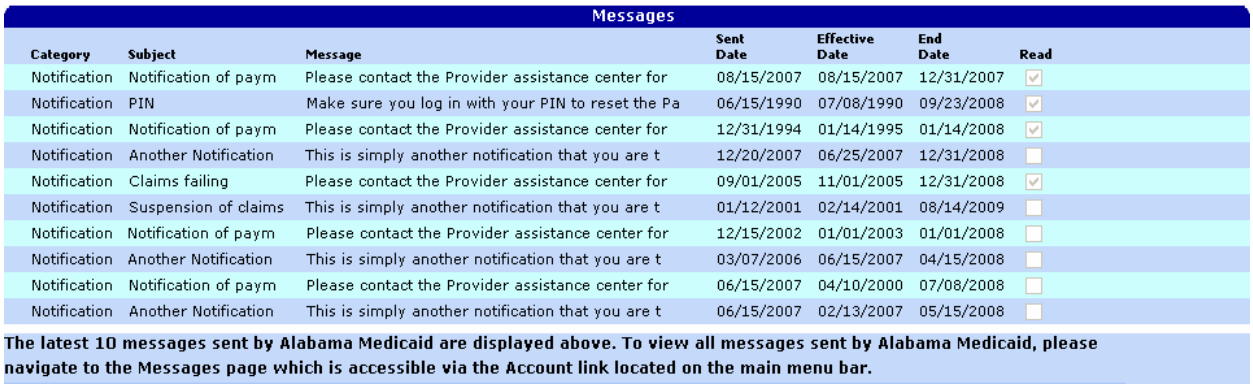
6.2 Messages

6.2.1 Messages Panel Narrative

The Messages panel displays the latest ten messages from the user's secure mailbox.

Navigation Path: [Providers]

6.2.2 Messages Panel Layout



Messages

Category	Subject	Message	Sent Date	Effective Date	End Date	Read
Notification	Notification of paym	Please contact the Provider assistance center for	08/15/2007	08/15/2007	12/31/2007	☑
Notification	PIN	Make sure you log in with your PIN to reset the Pa	06/15/1990	07/08/1990	09/23/2008	☑
Notification	Notification of paym	Please contact the Provider assistance center for	12/31/1994	01/14/1995	01/14/2008	☑
Notification	Another Notification	This is simply another notification that you are t	12/20/2007	06/25/2007	12/31/2008	☐
Notification	Claims failing	Please contact the Provider assistance center for	09/01/2005	11/01/2005	12/31/2008	☑
Notification	Suspension of claims	This is simply another notification that you are t	01/12/2001	02/14/2001	08/14/2009	☐
Notification	Notification of paym	Please contact the Provider assistance center for	12/15/2002	01/01/2003	01/01/2008	☐
Notification	Another Notification	This is simply another notification that you are t	03/07/2006	06/15/2007	04/15/2008	☐
Notification	Notification of paym	Please contact the Provider assistance center for	06/15/2007	04/10/2000	07/08/2008	☐
Notification	Another Notification	This is simply another notification that you are t	06/15/2007	02/13/2007	05/15/2008	☐

The latest 10 messages sent by Alabama Medicaid are displayed above. To view all messages sent by Alabama Medicaid, please navigate to the Messages page which is accessible via the Account link located on the main menu bar.

6.2.3 Messages Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Category	Displays the category of the message.	Field	Alphanumeric	30
Effective Date	Displays the effective date of the message.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of the message.	Field	Date (MM/DD/CCYY)	10
Message	Displays the messages.	Field	Alphanumeric	30
Read	Indicates if the message has been read. (Read-Only)	Combo Box	Check Box	0
Sent Date	Displays the sent date of the message.	Field	Date (MM/DD/CCYY)	10
Subject	Displays the subject line of the message.	Field	Alphanumeric	100

6.2.4 Messages Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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6.2.5 Messages Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Messages Panel Accessibility

6.2.6.1 To Access the Messages Panel

Step	Action	Response
1	Click **Providers**.	Providers page and Messages panel display.

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7. Home

The Home page opens when you access the AMMIS Interactive Services website and click on Home.

From the Home link in the Main Menu toolbar, users can access the following Sub Menu options:

- Site Settings

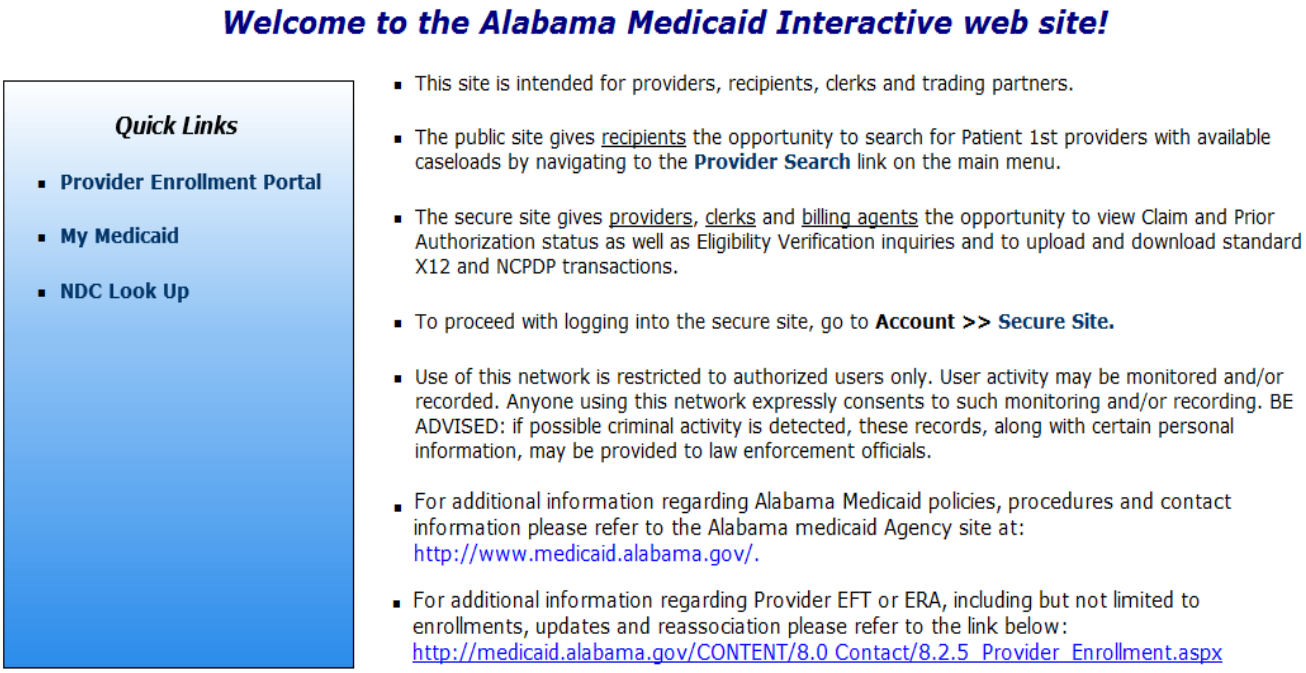
7.1 Home

7.1.1 Home Panel Narrative

The Home panel is the welcome page for the Interactive Services website. The user has the capability to access any Interactive Services website features from here.

Navigation Path: [Home]

7.1.2 Home Panel Layout



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7.1.3 Home Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
No field documentation found for this panel.				

7.1.4 Home Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

7.1.5 Home Panel Extra Features

Field	Field Type
A Quick Links section on the left side contains hyperlinks to navigate users quickly to the Provider Enrollment Portal, the Member Portal, and the NDC Lookup screen. Additional hyperlinks are provided on the right side to navigate users to the Provider Search screen, the Login screen, and the Alabama Medicaid Agency web site.	

7.1.6 Home Panel Accessibility

7.1.6.1 To Access the Home Panel

Step	Action	Response
1	Click **Home**.	Home page displays.

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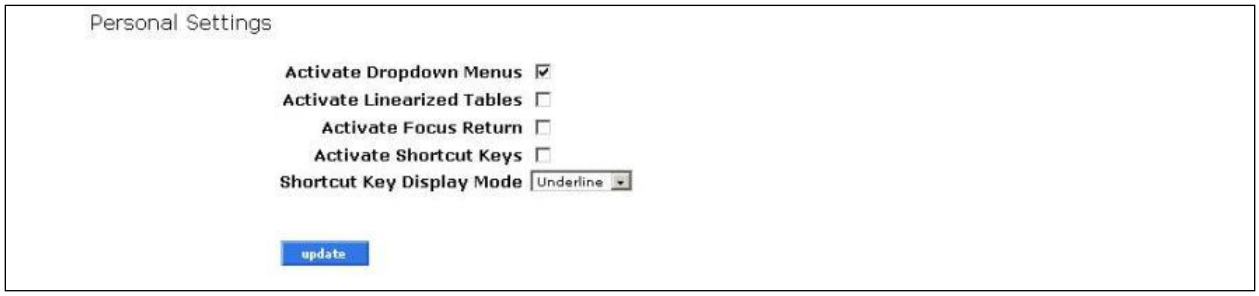
7.2 Site Settings

7.2.1 Site Settings Panel Narrative

The Site Settings panel allows the user to customize the website according to need. The user has the capability to activate dropdown menus, shortcut keys and focus return.

Navigation Path: [Home] – [Site Settings]

7.2.2 Site Settings Panel Layout



7.2.3 Site Settings Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
update	This button saves the settings.	Button	N/A	0
Activate Dropdown Menus	This checkbox activates drop down menus in the Interactive Services website.	Combo Box	Checkbox	0
Activate Focus Return	This checkbox activates focus return on the Interactive Services website.	Combo Box	Checkbox	0
Activate Linearized Tables	This checkbox activates linearized tables in the Interactive Services website.	Combo Box	Checkbox	0
Activate Shortcut Keys	This checkbox activates shortcut keys on buttons in the Interactive Services website.	Combo Box	Checkbox	0
Shortcut Key Display Mode	This drop down list box determines how buttons are displayed in the Interactive Services website. Valid values: None, Underline, ADA Mode.	Combo Box	Drop Down List Box	0

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7.2.4 Site Settings Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

7.2.5 Site Settings Panel Extra Features

Field	Field Type
No extra features found for this panel.	

7.2.6 Site Settings Panel Accessibility

7.2.6.1 To Access the Site Settings Panel

Step	Action	Response
1	Click **Home**.	Home page displays.
2	Click **Site Settings**.	Site Settings panel displays.

7.2.6.2 To Update on the Site Settings Panel

Step	Action	Response
1	Click **Activate Dropdown Menus** checkbox.	Activates drop down menus in the Interactive Services website.
2	Click **Activate Focus Return** checkbox.	Activates focus return on the Interactive Services website.
3	Click **Activate Linearized Tables** checkbox.	Activates linearized tables in the Interactive Services website.
4	Click **Activate Shortcut Keys** checkbox.	Activates shortcut keys on buttons in the Interactive Services website.
5	Select option from **Shortcut Key Display Mode** dropdown menu.	Displays buttons in the Interactive Services website according to valid values: None, Underline, ADA Mode.
6	Click **update**.	Site settings save.

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8. NDC Look Up Search

8.1 NDC Look Up Search Panel Narrative

The NDC Look Up Search panel allows users to search for Medicaid covered drugs using NDC, NDC and Date, Drug Name, or Drug Name and Date. Since both covered and non-covered drugs will be included in the search results, repack and obsolete drugs will be omitted to help reduce the number of rows returned.

Navigation Path: [NDC LookUp]

8.1.1 NDC Look Up Panel Layout

8.1.2 NDC Look Up Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears all the search criteria fields.	Button	N/A	0
Dispense As Written	If DAW is selected, the AAC/brand rate will be displayed. If no AAC/brand rate is on file, the WAC rate will be displayed.	Field	Check Box	0
Drug Information Status Date	Allows the user to select search results that will display drugs currently covered (Today), or drugs covered on a previous date (Other Date).	Field	Radio Button	0
Drug Information Status Date Entry (field)	If “Other Date” is selected, a valid, previous date must be entered in the date field.	Field	Date (MM/DD/CCYY)	10
Drug Name	Enter a partial or complete label name of a drug used to perform a search.	Field	Alphanumeric	40
Drug Name [search]	Allows the user to search for corresponding field data without leaving the page.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
NDC	Enter National Drug Code number to perform a search.	Field	Character	11

8.1.3 NDC Look Up Search Panel Field Edit Error Codes

Field	Error Message	To Correct
SEARCH	Please enter NDC or drug name and date to perform a search.	Enter a valid NDC or drug name in search criteria fields.
NDC	Numeric field only, user will not be able to enter alpha or special characters.	Enter a numeric NDC.
NDC	No drug information found that matches the search criteria.	Enter a valid, 11-digit NDC.
NDC and Drug Name	Return drug information on the NDC that was entered, ignoring the data entered in the “Drug Name” field. No drug information found that matches the search criteria.	Perform the drug search using either the NDC or the drug name.
Drug Name	No drug information found that matches the search criteria	Enter a valid NDC or drug name.
Drug Information Status Date	Date entered cannot be a future date.	Perform the drug search using either the current date or a valid previous date.
Drug Information Status Date	Date format should be mmddccyy or mm/dd/ccyy.	The user selects OTHER DATE and enters the date in MMDDCCYY format.

8.1.4 NDC Look Up Search Panel Extra Features

Field	Field Type
Drug Name	Search Hyperlink appears after the Drug Name.
Search	Main Search Button of the Panel.
A ‘pop-up’ search panel allows the user to search for field data without leaving the page. By clicking the [Search] hyperlink, the user accesses the search panel that is associated with that particular field.	

8.1.5 NDC Look Up Search Panel Accessibility

8.1.5.1 To Access the NDC Look Up Panel

Step	Action	Response
1	Click the **NDC Look Up** tab.	NDC Look Up Panel will display.

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8.1.5.2 To Search on the NDC Look Up Search Panel

Step	Action	Response
1	Enter one or a combination of the following fields: **NDC**, **Drug Name And Drug Status Information Date**.	
2	Click **search**.	Drug Information Status Date panel will display.

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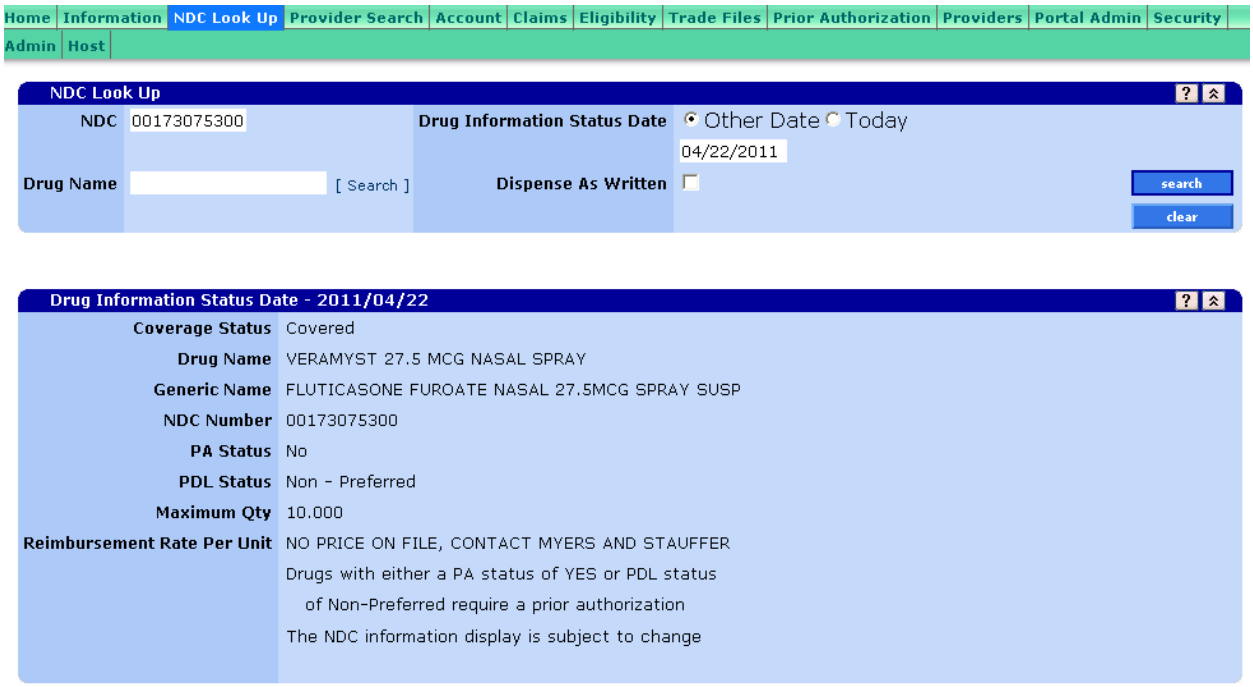
8.2 Drug Information Status Date Panel

8.2.1 Drug Information Status Date Panel Narrative

The Drug Information Status Date panel displays NDC information matching the search criteria from the NDC Look Up Search panel. The date entered by the user is shown in the title of the panel. If the user does not enter a Drug Information Status Date, the current date is used as the default date in the search criteria.

Navigation Path: [NDC Lookup] – [Search]

8.2.2 Drug Information Status Date Search Results Panel Layout



8.2.3 Drug Information Status Date Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coverage Status	Indicates whether or not the drug is covered on the date selected.	Field	Character	11
Drug Information Status Date	Displays the date used in the search criteria entered on the NDC Look Up panel. If no date is entered, the current date displays.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Drug Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	10
Generic Name	Combination of active ingredient names, route of administration, dosage form and strength.	Field	Alphanumeric	100
Maximum Quantity	The maximum units of the drug which can be dispensed within a 30-day period without an override.	Field	Number (Integer)	14
NDC Number	Displays the NDC number that was entered at the search. The National Drug Code used to uniquely identify a drug to be searched.	Field	Character	11
PA Status	Displays if a Prior Authorization is required. Valid values are 'Yes' and 'No.'	Field	Character	1
PDL Status	Indicates whether the drug or drug product is preferred or non-preferred	Field	Character	1
Reimbursement Rate per Unit	Displays the lowest reimbursement rate unless the user selects DAW. If DAW is selected, the AAC/brand rate will be displayed. If no AAC/brand rate is on file, the WAC rate will be displayed. Lower of methodology should follow Rule No. 560-X-16-.06. Reimbursement for Covered Drugs and Services of the administrative code.	Field	Number (Integer)	14

8.2.4 Drug Information Status Date Panel Field Edit Error Codes

Field	Error Message	To Correct
Reimbursement rate per unit	No price on file, contact myers and stauffer.	No price on file. Contact Myers and Stauffer at 800-591-1183.
Reimbursement rate per unit	Drug price not available for search date.	Re-enter a search date that is not greater than 12 months prior to the current date.

8.2.5 Drug Information Status Date Panel Extra Features

Field	Field Type
Max Qty	Number(Integer)

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Field	Field Type
Reimbursement rate per unit	Number(Integer)
If Max Qty is 9999999.999, N/A will be displayed, otherwise the quantity will display in numeric format 9999999.999. For Reimbursement rate per unit: the lowest reimbursement rate will be displayed unless the user selects DAW. If DAW is selected, the AAC/brand rate will be displayed. If no AAC/brand rate is on file, the WAC rate will be displayed. Lower of methodology should follow Rule No. 560-X-16-.06. Reimbursement for Covered Drugs and Services of the administrative code.	

8.2.6 Drug Information Status Date Panel Accessibility

8.2.6.1 To Access the Drug Information Status Date Results Panel

Step	Action	Response
1	Enter search criteria and click **search**.	Detail Information of NDC is displayed in the summary panel or Drug Search Window pop-up is displayed based on search criteria.

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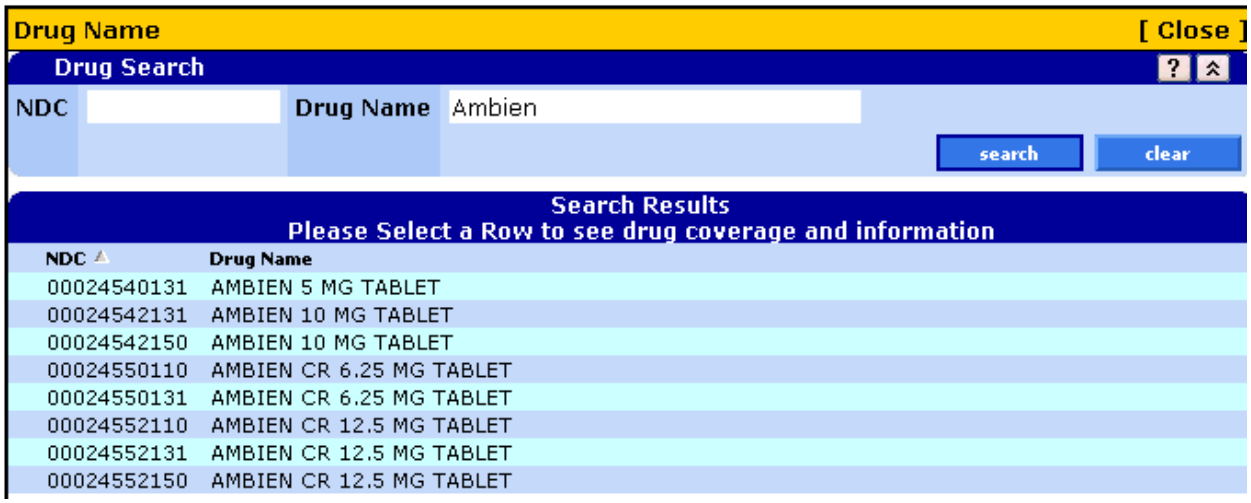
8.3 Drug Name Search Panel Layout

8.3.1 Drug Name Search Panel Narrative

The Drug Name Search panel will display to allow users to search by a different NDC or Drug Name. After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [NDC Lookup] – [Search]

8.3.2 Drug Name Search Panel Layout



8.3.3 Drug Name Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the drug look up search.	Button	N/A	0
Drug Name	Enter partial or complete label name of a drug to perform a search.	Field	Alphanumeric	40
NDC	Enter National Drug Code number to perform a search.	Field	Character	11

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8.3.4 Drug Name Search Panel Field Edit Error Codes

Field	Error Message	To Correct
NDC and Drug Name	Please enter at least one search criteria.	Enter valid search criteria.
NDC	NDC not found.	Enter a valid NDC.

8.3.5 Drug Name Search Panel Extra Features

Field	Field Type
Up to 50 rows per page will be returned on searches using the Drug Name Search panel. When the user selects an NDC from the search results pop-up window, drug information for the selected NDC will display in the main Drug Information Status Date Panel.	

8.3.6 Drug Name Search Panel Accessibility

8.3.6.1 To Access the Drug Name Search Panel

Step	Action	Response
1	Enter search criteria and click **search.**	If searching with a NDC, the Drug Information Status Date panel will display. If searching with a drug name with more than one (1) NDC, a drug search panel will pop-up displaying the drug name and corresponding NDCs to select from.

8.3.6.2 To Search on the Drug Search Panel

Step	Action	Response
1	Enter one or a combination of the following fields **NDC, Drug Name**.	
2	Click **search.**	Displays up to 50 rows per page if available.

If data is more than one (1) row, then Drug Search Panel is displayed.

When searching with the drug name and more than one (1) row of data is found, the pop-up drug search panel displays.

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9. Information

From the Information link in the Main Menu toolbar, users can access the following Sub Menu options:

- AL Links
- Contact Us

9.1 AL Links

9.1.1 AL Links Panel Narrative

The AL Links panel provides users the ability to view available documentation or download the Provider Electronic Solutions or Long Term Care (LTC) Admission Notification software full installations or upgrades.

Click a hyperlink to navigate to the selected section of the Interactive Services website.

Navigation Path: [Information] – [AL Links]

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9.1.2 AL Links Panel Layout

Business Actions

- **Explanation of Benefit (EOB) Crosswalk**
- **Carrier Code Information**

Software Download

Provider Electronic Solution

PLEASE REVIEW PRIOR TO SELECTING AN OPTION FOR SOFTWARE DOWNLOAD

PES version 3.0 must be in place before March 31st to submit 5010 and NCPDP 1.2 transactions.

Users have two options: **1)** An upgrade from PES version 2.16 to PES version 3.0 (desired), or **2)** A full install of PES version 3.0.

1) Upgrade information:

Prior to upgrading to PES version 3.0:

- Users must be using PES version 2.16
  - If not, you must upgrade to PES version 2.16 or do a full install

- Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

Once PES version 3.0 upgrade has completed list information will remain unchanged, but users will not be able to change, copy, resubmit, or restore archived transactions that were entered in PES version 2.16 of the Provider Electronic Solutions Software.

All transactions converted from PES version 2.16 to version 3.0 will be flagged with a new status based on the status the transaction was in at the time of the upgrade. No further action can be taken on X12 4010 or NCPDP 1.1 transactions.

The following new status codes will be used:

U – All transactions previously in an 'I' status at the time the upgrade is performed will have the status changed to 'U'. U = 4010 Unfinished/Incomplete
B – All transactions previously in an 'A' status at the time the upgrade is performed will have the status changed to 'B'. B = 4010 Backup record/Archive
C – All transactions previously in an 'R' status at the time the upgrade is performed will have the status changed to 'C'. C = 4010 Completed not yet Submitted/Ready
S – All transactions previously in an 'F' status at the time the upgrade is performed will have the status changed to 'S'. S = 4010 Successfully Submitted/Finalized

2) Full Install information:

Prior to full installation to PES version 3.0:

- Users may be new to PES or using any previous version of PES

- Current PES users:
  - Lists will not be retained. It is recommended that users print their lists prior to installation so that their lists can be manually created in PES version 3.0.

- Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

- **PES Software Full Install**
- **PES Software Upgrades**
- **Microsoft Internet Explorer**

LTC Admission Notification

- **LTC Admission Notification Full Install**
- **LTC Admission Notification Upgrades**

Documentation

- **Vendor Interface Specifications**
- **Interactive Service - Web User Guide**
- **PES Software User Guide**
- **LTC Software User Guide**
- **HIPAA Companion Guides**
- **Trading Partner ID Request Form - This form is to be completed for each unique submitter interested in submitting electronic batch files.**

9.1.3 AL Links Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Code Information	Hyperlink to allow user to access the Carrier Code values and definitions.	Hyperlink	N/A	0
Explanation of Benefit (EOB) Crosswalk	Hyperlink to allow user to access the Explanation of Benefit (EOB) Crosswalk.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
HIPAA Companion Guides	Hyperlink to allow user to access the HIPAA Companion Guides.	Hyperlink	N/A	0
Interactive Service - Web User Guide	Hyperlink to allow user to access the Interactive Services Website User Manual.	Hyperlink	N/A	0
LTC Admission Notification Full Install	Hyperlink to allow user to access the Long Term Care (LTC) Admission Notification Full Installs. (Only for LTC Providers.)	Hyperlink	N/A	0
LTC Admission Notification Upgrades	Hyperlink to allow user to access the Long Term Care (LTC) Admission Notification Upgrades. (Only for LTC Providers.)	Hyperlink	N/A	0
LTC Software User Guide	Hyperlink to allow user to access the Long Term Care (LTC) Admission Notification user guide. (Only for LTC Providers.)	Hyperlink	N/A	0
Microsoft Internet Explorer	Hyperlink to allow user to access the Microsoft Internet Explorer browser download.	Hyperlink	N/A	0
PES Software Full Install	Hyperlink to allow user to access the Provider Electronic Solutions Full Installs.	Hyperlink	N/A	0
PES Software Upgrades	Hyperlink to allow user to access the Provider Electronic Solutions Upgrades.	Hyperlink	N/A	0
PES Software User Guide	Hyperlink to allow user to access the Provider Electronic Solutions user guide.	Hyperlink	N/A	0
interChange Trading Partner ID Request Form	Hyperlink to allow user to access the Trading Partner ID Request form.	Hyperlink	N/A	0
Vendor Interface Specifications	Hyperlink to allow user to access the Vendor Specifications on Alabama Medicaid's Vendor page.	Hyperlink	N/A	0

9.1.4 AL Links Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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9.1.5 AL Links Panel Extra Features

Field	Field Type
No extra features found for this panel.	

9.1.6 AL Links Panel Accessibility

9.1.6.1 To Access the AL Links Panel

Step	Action	Response
1	Click **Information**.	Information panel displays.
2	Click **AL Links**.	AL Links page displays.

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9.2 Contact Us

9.2.1 Contact Us Panel Narrative

The Contact Us panel provides contact information for the Customer Service Help Desk.

Navigation Path: [Information] – [Contact Us]

9.2.2 Contact Us Panel Layout

The Alabama Medicaid Interactive web site is intended for providers, clerks, and billing agents. This is meant to supplement the Customer Service Help Desk by handling claims status inquiry, eligibility inquiry, and other common requests.

The Customer Service Help Desk is available to handle your general billing, claim, or policy questions.

The Help Desk hours are Monday through Friday, 7:00 AM to 8:00 PM. Saturday (including holidays) 9:00 AM to 5:00 PM.

The local and long distance number is 1-334-215-0111

The toll free number when calling within Alabama and border communities is 1-800-456-1242

The email address is AlabamaSystemsEMC@hp.com

The mailing address:
Hewlett-Packard Enterprise Services (HPES)
Attn: EMC Helpdesk
301 Technacenter Drive
Montgomery, AL 36117

Use of the Alabama secure web pages is restriced to authorized users. You must obtain a username and password to be used to access the secure web pages. Access to individual web pages may further be restricted by the profile assigned to your username. Access to the remainder of the help pages requires a valid login.

9.2.3 Contact Us Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
No field documentation found for this panel.				

9.2.4 Contact Us Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

9.2.5 Contact Us Panel Extra Features

Field	Field Type
No extra features found for this panel.	

9.2.6 Contact Us Panel Accessibility

9.2.6.1 To Access the Contact Us Panel

Step	Action	Response
1	Click **Information**.	Information page displays.

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Step	Action	Response
2	Click **Contact Us**.	Contact Us page displays.

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10. Provider Search

From the Provider Search link in the Main Menu toolbar, recipients can access the following Sub Menu option:

- Patient 1st

10.1 Patient 1st

10.1.1 Patient 1st Provider Location – Search Panel Narrative

The Patient 1st panel allows recipients to perform searches for Patient 1st providers that are close to their residence who may be currently accepting new patients.

Navigation Path: [Provider Search] – [Patient 1st]

10.1.2 Patient 1st Provider Location – Search Panel Layout

NOTE:

Recipients should call the provider prior to calling the Recipient Call Center to ensure the provider is accepting new Alabama Medicaid recipients.

10.1.3 Patient 1st Provider Location – Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
search	This button initiates the search.	Button	N/A	0
Recipient ID	Displays the Recipient's first 12-digits of their Medicaid identification number.	Field	Character	12

10.1.4 Patient 1st Provider Location – Search Panel Field Edit Error Codes

Field	Error Message	To Correct
Recipient ID	A Medicaid Recipient ID is required.	Enter a 12 digit Medicaid Recipient ID.

10.1.5 Patient 1st Provider Location – Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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10.1.6 Patient 1st Provider Location – Search Panel Accessibility

10.1.6.1 To Access the Patient 1st Provider Location – Search Panel

Step	Action	Response
1	Click **Provider Search**.	Provider Search page opens.
2	Click **Patient 1st**.	Patient 1st Provider Location – Search panel opens.

10.1.6.2 To Search on the Patient 1st Provider Location – Search Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Click **search**.	Search results panel displays.

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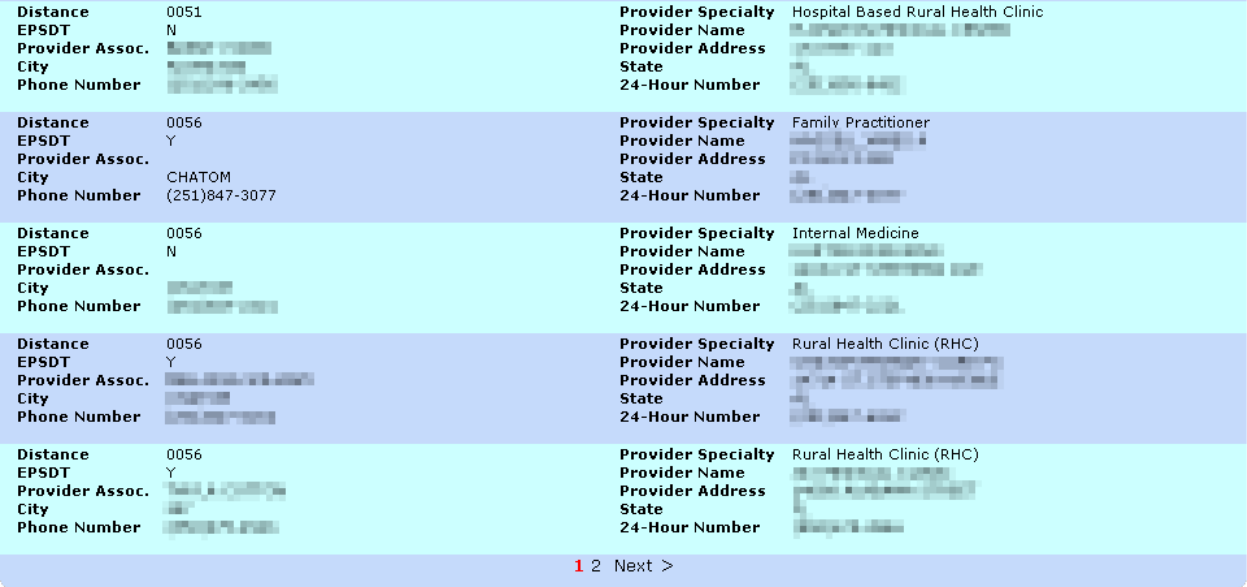
10.2 Patient 1st Provider Location Results

10.2.1 Patient 1st Provider Location Results Panel Narrative

The Patient 1st Search Results panel displays Patient 1st provider information matching search criteria entered in the Patient 1st Provider Location - Search panel.

Navigation Path: [Provider Search] – [Patient 1st] – [search]

10.2.2 Patient 1st Provider Location Results Panel Layout



10.2.3 Patient 1st Provider Location Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
24-Hour Number	Displays the provider's 24-hour phone number.	Field	Number (Integer)	12
City	Displays the provider's city.	Field	Character	20
Distance	Displays the distance, in miles, between the provider and recipient.	Field	Number (Integer)	4
EPSDT	Displays if the provider is an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screener.	Field	Character	1
Phone Number	Displays the provider's phone number.	Field	Number (Integer)	12
Provider Address	Displays the provider's address.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Provider Assoc.	Displays the Mid Level associate to the provider.	Field	Character	20
Provider Name	Displays the Provider's name.	Field	Character	20
Provider Specialty	Displays the provider's specialty description.	Field	Character	15
State	Indicates the provider's state.	Field	Character	2

10.2.4 Patient 1st Provider Location Results Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

10.2.5 Patient 1st Provider Location Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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11. Account

Account features allows users to setup or maintain personal account information or, as a provider, to setup or maintain the account information for a designated clerk. Users can access the secure site from this location, as well as logoff the Interactive Services website.

From the Account link in the Main Menu toolbar, users can access the following Sub Menu options prior to login:

- Account Setup
- Reset Password
- Secure Site

From the Account link in the Main Menu toolbar, users can access the following Sub Menu options after login:

- Account Maintenance
- Clerk Maintenance
- Change Password
- Messages
- Switch Provider
- Logoff

11.1 Patient 1st Provider Location Results Panel Accessibility

11.1.1 To Access the Patient 1st Provider Location Results Panel

Step	Action	Response
1	Click **Provider Search**.	Provider Search page opens.
2	Click **Patient 1st**.	Patient 1st Provider Location – Search panel opens.
3	Enter search criteria and click **search**.	Search results panel displays.

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11.2 Account Setup

11.2.1 Account Setup Panel Narrative

The Account Setup panel allows users to setup their account and profile after receiving their PIN Letter. The user has the capability to update personal information, set security questions, create and/or change a password.

Navigation Path: [Account] – [Account Setup]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

11.2.2 Account Setup Panel Layout

NOTE:

Section 9.1.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the Account Setup panel. Please refer to section 9.1.6.2 for step by step instructions on how to complete the Account Setup panel.

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11.2.3 Account Setup Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
cancel	This button discards any changes made to the page and stays on the same page.	Button	N/A	0
setup account	This button displays the user profile panel.	Button	N/A	0
submit	This button submits the user profile and navigates to the Home page.	Button	N/A	0
1st Answer	Enter the 1st secret question Answer.	Field	Alphanumeric	20
1st Secret Question	Enter 1st secret security question for the account user.	Field	Character	50
2nd Answer	Enter Answer to 2nd Secret Question.	Field	Alphanumeric	20
2nd Secret Question	Enter 2nd secret security question for the account user.	Field	Character	50
Confirm Email	Enter the email address again to confirm.	Field	Character	50
Confirm Password	Enter the password again to confirm.	Field	Alphanumeric	30
Contact First Name	Enter the first name of the account user.	Field	Character	50
Contact Last Name	Enter the last name of the account user.	Field	Character	50
Email	Enter the email address of the account user.	Field	Character	50
Login ID	Enter the login identification.	Field	Alphanumeric	10
Password	Enter the password for User account. A Web Password must, at a minimum, include the following format: ▪ 1 Lower and 1 Upper Case value; ▪ 1 numeric value; and ▪ be at least 8 bytes in length.	Field	Alphanumeric	30
Personal Identification Number	Enter the personal identification number (PIN).	Field	Alphanumeric	10
Phone Number	Enter the Phone Number of the account user.	Field	Number (Integer)	10
Phone Number Ext	Enter the extension for the phone number of the account user. This field is optional.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
User Name	Enter the login identification for the user account.	Field	Alphanumeric	20

11.2.4 Account Setup Panel Field Edit Error Codes

Field	Error Message	To Correct
setup account	Sorry, we could not find that Login ID/Personal Identification Number. Please try again.	Enter correct Login ID/Personal Identification Number.
	This Login ID/Personal Identification Number has already been used to register a user.	Enter Unregistered Login ID/Personal Identification Number.
	Unable to setup account at this time, please contact the EMC Help Desk for further assistance. (800) 456-1242 – AL, FL, GA, MS and TN (334) 215-0111 – All other locations	Contact the EMC Help Desk for further assistance.
1st Answer	1st Answer cannot contain other than [A-Z/a-z/0-9] and blank spaces.	Ensure that the field contains only alphanumeric A-Z and 0-9 and blank spaces.
	1st Answer is required.	Enter an answer that corresponds with the 1st Secret Question entered.
1st Secret Question	1st Secret Question is required.	Enter the 1st Secret Question.
2nd Answer	2nd Answer cannot contain other than [A-Z/a-z/0-9] and blank spaces.	Ensure that the field contains only alphanumeric A-Z and 0-9 and blank spaces.
	2nd Answer is required when Secret question2 is entered.	Please check whether the Secret Answer 2 is filled.
2nd Secret Question	2nd Secret Question is required when Secret answer2 is entered.	Please check whether the 2nd secret Question is filled.
Confirm Email	Confirm Email contains an invalid value.	Re-enter a valid email address.
	Confirm Email is required.	Re-enter a valid email address.
	Email must be same as Confirm Email.	Check whether the Email and Confirm Email values are typed the same.
	Confirm Email is invalid for a Email type value.	Re-enter a valid email address.
Confirm Password	Password must be same as Confirm Password.	Check whether the Password and Confirm Password values are typed the same.
	Confirm Password is required.	Re-enter the password.

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Field	Error Message	To Correct
Contact First Name	First Name is required.	Enter the contact's first name.
Contact Last Name	Last Name is required.	Enter the contact's last name.
Email	Email is invalid for a Email type value.	Enter a valid email address.
	Email contains an invalid value.	Enter a valid email address.
	Email is required.	Enter the contact's email address.
Password	Password is required.	Enter a password.
	The new password does not meet the security requirements of the domain. Please refer to the field help on the New Password field for requirements and try again.	Ensure the format of the password is correct. Format requirements are noted within the help text for the Password field.
Phone Number	Phone Number contains an invalid value.	Enter the contact's phone number.
User Name	User Name cannot contain values other than [A-Z/a-z/0-9].	Ensure the field contains only A - Z and 0 - 9.
	User Name must be at least 6 characters in length.	Enter a user name that is at least 6 bytes in length.
	User Name is required.	Enter a user name that is at least 6 bytes in length.
	The User Name entered is already registered to another user. Please try again.	Enter a different user name that is not already registered to another user.
	User Name must be less than or equal to 20 characters in length.	Enter a user name that is less than or equal to 20 characters in length.

11.2.5 Account Setup Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.2.6 Account Setup Panel Accessibility

11.2.6.1 To Access the Account Setup Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Account Setup**.	Account Setup panel opens.

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11.2.6.2 To Add on the Account Setup Panel

Step	Action	Response
1	Enter **Login ID**.	
2	Enter **Personal Identification Number**.	
3	Click **setup account**.	Web User Profile panel displays.
4	Enter **User Name**.	
5	Enter **Contact Last Name**.	
6	Enter **Contact First Name**.	
7	Enter **Phone Number** and (optional) extension.	
8	Enter **1st Secret Question**.	
9	Enter **1st Answer** that corresponds with the 1st Secret Question entered.	
10	Enter **2nd Secret Question**.	
11	Enter **2nd Answer** that corresponds with the 2nd Secret Question entered.	
12	Enter **Password**.	
13	Re-enter password in **Confirm Password** field.	
14	Enter **Email** address.	
15	Re-enter email address in **Confirm Email** field.	
16	Click **submit**.	Account Setup information saves.

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11.3 Account Maintenance

11.3.1 Account Maintenance Panel Narrative

The Account Maintenance panel allows users to manage profile information. The user has the capability to update personal information and security questions, as well as the option to go to the Change Password panel.

Navigation Path: [Account] – [Account Maintenance]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

11.3.2 Account Maintenance Panel Layout

NOTE:

Section 9.2.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the Account Maintenance panel. Please refer to section 9.2.6.2 for step by step instructions on how to complete the Account Maintenance panel.

11.3.3 Account Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
cancel	This button discards any changes made to the page.	Button	N/A	0
change password	This button redirects the user to the change password page so the user can change their password.	Button	N/A	0
save	This button saves the changes made to the page.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
1st Answer	Enter the answer to 1st Secret Question.	Field	Alphanumeric	20
1st Secret Question	Enter the 1st secret security question for the account user.	Field	Character	50
2nd Answer	Enter the answer to 2nd Secret Question.	Field	Alphanumeric	20
2nd Secret Question	Enter the 2nd secret security question for the account user.	Field	Character	50
Confirm Email	Enter the email identification again to confirm.	Field	Character	50
Contact First Name	Enter the first name of the account user.	Field	Character	50
Contact Last Name	Enter the last name of the account user.	Field	Character	50
Email	Enter the email address of the account user.	Field	Character	50
Phone Number	Enter the phone number of the account user.	Field	Number (Integer)	10
Phone Number Ext	Enter the extension for the phone number of the account user. This field is optional.	Field	Number (Integer)	4
User Name	This field is auto populated after user logs into secure site.	Field	Alphanumeric	20

11.3.4 Account Maintenance Panel Field Edit Error Codes

Field	Error Message	To Correct
save	Save was Successful.	Message is displayed when successfully updated.
1st Answer	1st Answer is Required.	Enter an answer that corresponds with the 1st Secret Question entered.
	1st Answer cannot contain other than [A-Z/a-z/0-9] and blank spaces.	Field should be alpha numeric including spaces.
1st Secret Question	1st Secret Question is required.	Enter the 1st Secret Question.
2nd Answer	2nd Answer cannot contain other than [A-Z/a-z/0-9] and blank spaces.	Field should be alpha numeric including spaces.
	2nd Answer is Required when Secret question 2 is entered.	This field must be completed when 2nd secret question is entered.

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Field	Error Message	To Correct
2nd Secret Question	2nd Secret Question is Required.	This field must be completed when 2nd Answer is entered.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
Confirm Email	Confirm Email contains an invalid value.	Re-enter a valid email address.
	Email must be same as Confirm Email.	Email and Confirm Email should match this case valid only when the modified Email and the previously entered are different.
	Confirm Email is required.	Re-enter a valid email address.
Contact First Name	First Name is required.	Enter the contact's first name.
Contact Last Name	Last Name is required.	Enter the contact's last name.
Email	Email is invalid for a Email type value.	Enter a valid email address.
	Email contains an invalid value.	Enter a valid email address.
	Email is required.	Enter the contact's email address.
Phone Number	Phone Number is required.	Enter the contact's phone number.

11.3.5 Account Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.3.6 Account Maintenance Panel Accessibility

11.3.6.1 To Access the Account Maintenance Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Account Maintenance**.	Account Maintenance panel opens.

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11.3.6.2 To Add on the Account Maintenance Panel

Step	Action	Response
1	Enter **Contact First Name**.	
2	Enter **Contact Last Name**.	
3	Enter **Phone Number** and (optional) extension.	
4	Enter **Email** address.	
5	Re-enter email address in **Confirm Email** field.	
6	Enter **1st Secret Question**.	
7	Enter **1st Answer** that corresponds with the 1st Secret Question entered.	
8	Enter **2nd Secret Question**.	
9	Enter **2nd Answer** that corresponds with the 2nd Secret Question entered.	
10	Click **save**.	Account Maintenance information saves.

11.3.6.3 To Update on the Account Maintenance Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **save**.	Account Maintenance information saves.

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11.4 Clerk Maintenance

11.4.1 Clerk Maintenance Panel Narrative

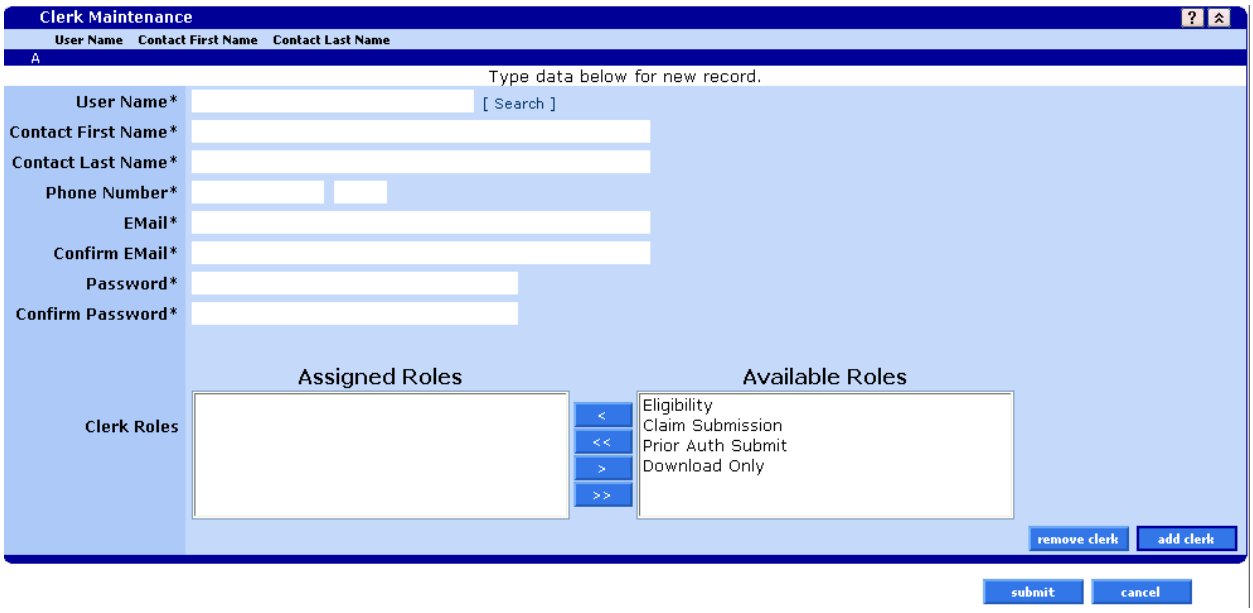
This panel allows providers to create/add, manage or remove clerks. The user has the capability to grant roles to clerks. The role configuration set applies only when the clerk is representing a particular provider.

Navigation Path: [Account] – [Clerk Maintenance] - [add clerk]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

11.4.2 Clerk Maintenance Panel Layout



11.4.3 Clerk Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add clerk	This button allows user to create and add a new clerk.	Button	N/A	0
cancel	This button cancels any changes made to the page.	Button	N/A	0
remove clerk	This button removes a selected clerk from the clerk data list.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
submit	This button initiates the save process.	Button	N/A	0
Assigned Roles	Allows the user to select roles from the Available Roles List Box and move them to the Assigned Roles Box.	Field	N/A	0
Available Roles	Displays the list of available roles.	Field	N/A	0
Clerk Roles	Displays the list of assigned and available roles.	Combo Box	Drop Down List Box	0
Confirm Email	Displays the confirmation of the Email address of the account user.	Field	Character	50
Confirm Password	Displays the retyping of the password to confirm.	Field	Alphanumeric	30
Contact First Name	Displays the contact's last name for the account user.	Field	Character	50
Contact Last Name	Displays the contact's last name for the account user.	Field	Character	50
Email	Displays the email address of the account user.	Field	Character	50
Password	Displays the initial password for the clerk. Will be set as expired requiring the user to change the password when logging in. A Web Password must, at a minimum, include the following format: ▪ 1 Lower and 1 Upper Case value; ▪ 1 numeric value; and ▪ be at least 8 bytes in length.	Field	Alphanumeric	30
Phone Number	Displays the phone number of the account user.	Field	Number (Integer)	10
Phone Number Ext	Displays the phone number extension of the clerk.	Field	Number (Integer)	4
User Name	Displays the login identification of the user.	Field	Alphanumeric	20

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11.4.4 Clerk Maintenance Panel Field Edit Error Codes

Field	Error Message	To Correct
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
Confirm Email	Email must be same as Confirm Email.	Check whether the Email and Confirm Email values are typed the same.
	Confirm Email is required.	Re-enter the Email address.
Confirm Password	Password must be same as Confirm Password.	Check whether the Password and Confirm Password values are typed the same.
	Confirm Password is required.	Re-enter the password.
Contact First Name	Contact First Name is required.	Enter the contact's first name.
Contact Last Name	Contact Last Name is required.	Enter the contact's last name.
Email	Email is required.	Enter the contact's email address.
	Email is invalid for a Email type value.	Enter a valid email address.
Password	The new password does not meet the security requirements of the domain. Please refer to the field help on the New Password field for requirements and try again.	Ensure the format of the password is correct. Format requirements are noted within the help text for the Password field.
	Password is required.	Enter a password.
Phone Number	Phone Number is required.	Enter the contact's phone number.
User Name	User Name must be at least 6 characters in length.	Enter a user name that is at least 6 bytes in length.
	The User Name already exists.	Enter a unique user ID.
	User Name cannot contain values other than [A-Z/a-z/0-9].	Ensure the field contains only A - Z and 0 - 9.
	User Name cannot contain Numeric in the beginning.	Enter a User Name that begins with an alpha character.
	User Name is required.	Enter a User Name that is between 6 to 20 bytes in length.

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11.4.5 Clerk Maintenance Panel Extra Features

The Clerk Maintenance panel is visible and the Contact Name, Phone and E-mail are read-only for an existing clerk (a clerk was selected in the clerks list).

When the "add clerk" button is clicked, the Contact Name, Phone and E-mail, password is editable.

When Add New Clerk is clicked, if an existing clerk, search for current clerk by username, select current clerk, and add the necessary roles and click submit. If not an existing clerk, enter the new clerk's contact name, phone, e-mail and roles and click the submit button.

Roles may be edited on existing clerks by selecting the clerk in the Clerk data list and modifying the roles for the clerk.

The provider verbally communicates or emails password to distribute to clerk (password is set as expired so when clerk logs in they are required to change their password).

When a clerk is selected in the list, the corresponding information of that selected clerk is displayed in the clerk panel as read-only and the fields Confirm Email, Password and Confirm Password are not visible.

The users are allowed to assign/revoke roles.

11.4.6 Clerk Maintenance Panel Accessibility

11.4.6.1 To Access the Clerk Maintenance Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Clerk Maintenance**.	Clerk Maintenance panel opens.

11.4.6.2 To Add on the Clerk Maintenance Panel

Step	Action	Response
1	Click **add clerk**.	Activates fields for entry of data or selection from lists.
2	Enter **User Name** or click [Search] to select from list.	Clicking [Search] activates the User Name Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
3	Enter **Contact First Name**.	
4	Enter **Contact Last Name**.	
5	Enter **Phone Number** and (optional) extension.	
6	Enter **Email**.	
7	Re-enter email address in **Confirm Email** field.	
8	Enter **Password**.	

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Step	Action	Response
9	Re-enter password in **Confirm Password** field.	
10	Select option(s) from **Available Roles**, and then click [<] or [<<] to add to **Assigned Roles**.	
11	Click **submit**.	Clerk Maintenance information saves.

11.4.6.3 To Update on the Clerk Maintenance Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Select option(s) from **Assigned Roles**, and then click [>] or [>>] to return to **Available Roles** or click [<] or [<<] to add to **Assigned Roles**.	
3	Click **save**.	Clerk Maintenance information saves.

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11.5 Change Password

11.5.1 Change Password Panel Narrative

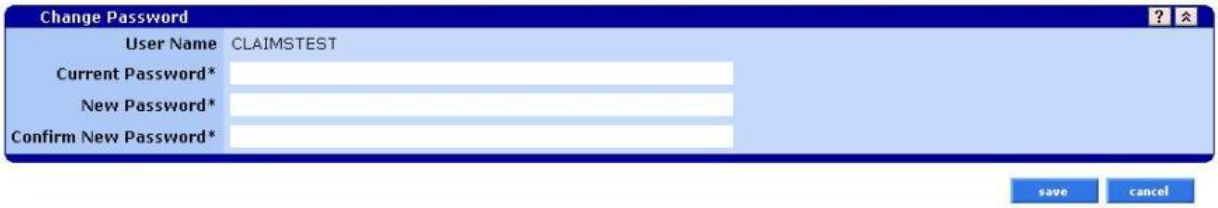
The Change Password panel allows users to change their account password.

Navigation Path: [Account] – [Change Password] OR [Account] – [Account Maintenance] – [click on change password button]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

11.5.2 Change Password Panel Layout



11.5.3 Change Password Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
cancel	This button discards any changes made and return you to the home page.	Button	N/A	0
save	This button confirms and saves the new password.	Button	N/A	0
Confirm New Password	Enter your new password again to ensure it matches the password entered above.	Field	Alphanumeric	30
Current Password	Enter your current password.	Field	Alphanumeric	30
New Password	Enter the password for User account. A Web Password must, at a minimum, include the following format: ▪ 1 Lower and 1 Upper Case value; ▪ 1 numeric value; and ▪ be at least 8 bytes in length.	Field	Alphanumeric	30
User Name	This is your user name.	Label	Alphanumeric	20

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11.5.4 Change Password Panel Field Edit Error Codes

Field	Error Message	To Correct
Confirm New Password	Confirm New Password is required.	Re-enter to confirm the new password.
Current Password	Password must be same as Confirm Password.	Ensure New Password matches Confirm New Password.
	Current Password is required.	Enter the current password.
New Password	New Password field is required.	Enter the new password.
	We were unable to update the password for this account. The account has been created but not activated. Please contact your system administrator.	Ensure the format of the password is correct. Format requirements are noted within the help text for the New Password field.

11.5.5 Change Password Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.5.6 Change Password Panel Accessibility

11.5.6.1 To Access the Change Password Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Change Password**.	Change Password panel opens.

11.5.6.2 To Update on the Change Password Panel

Step	Action	Response
1	Enter **Current Password**.	
2	Enter **New Password**.	
3	Re-enter new password in **Confirm New Password** field.	
4	Click **save**.	Change Password information saves.

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11.6 Messages

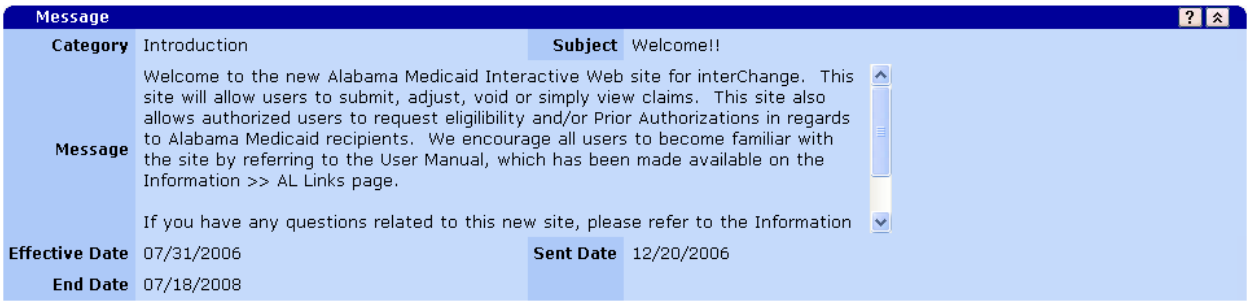
11.6.1 Messages Panel Narrative

The Messages panel displays all the messages for a user. The user has the capability to view the details for any message selected.

Select a message from the Messages list to display the full text and details of the message.

Navigation Path: [Account] – [Messages]

11.6.2 Messages Panel Layout



11.6.3 Messages Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
deselect All	Unchecks all of the Read check boxes.	Button	N/A	0
save	Updates the Read field on the database.	Button	N/A	0
select All	Checks all of the Read check boxes.	Button	N/A	0
Category	Displays the category of the message. (Read-Only).	Field	Alphanumeric	30
Effective Date	Displays the effective date of the message. (Read-Only).	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of the message. (Read-Only).	Field	Date (MM/DD/CCYY)	10
Message	Displays the body of the message. (Read-Only).	Field	Alphanumeric	4000

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Field	Description	Field Type	Data Type	Length
Read	Displays whether the user has read the message.	Combo Box	Check Box	0
Sent Date	Displays the date the message was sent. (Read-Only).	Field	Date (MM/DD/CCYY)	10
Subject	Displays the short description of the message.	Field	Alphanumeric	100

11.6.4 Messages Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

11.6.5 Messages Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.6.6 Messages Panel Accessibility

11.6.6.1 To Access the Messages Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Messages**.	Messages panel opens.

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11.7 Switch Provider

11.7.1 Switch Provider Panel Narrative

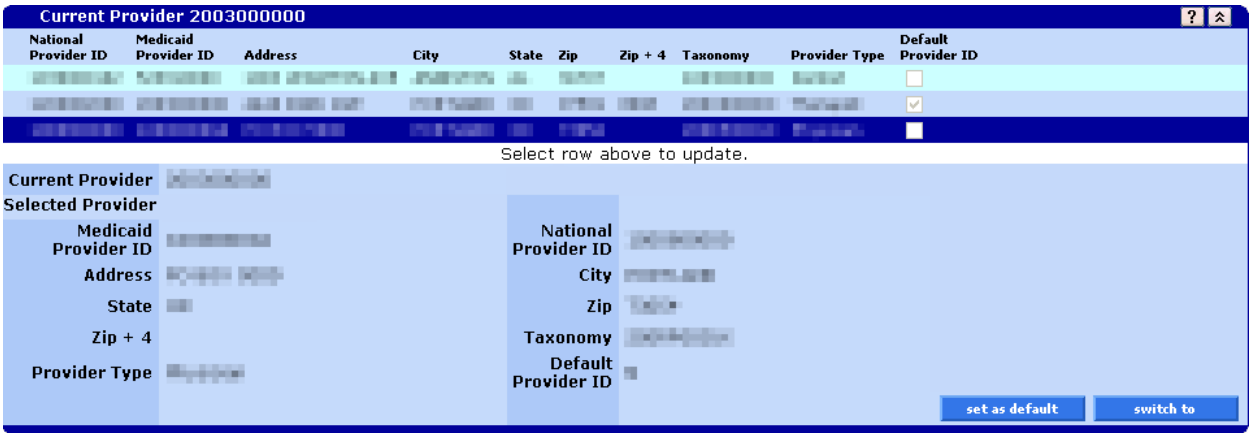
The Switch Provider panel allows clerks to switch to different authorized provider account profiles and locations. The user has the capability to select from a list of authorized providers. A default user indicator can be set so the provider account is set automatically when the user logs on.

After logging in the clerk can switch providers by selecting which provider to represent. Clerks will switch providers by selecting a row in a list of available providers and clicking 'switch to'. Confirmation of the current National Provider Identifier (NPI) number will appear as a page title. After selection, the clerk will be redirected to the Account Home page.

To associate a clerk to a billing NPI number, please refer to Section *9.3 Clerk Maintenance*.

Navigation Path: [Account] – [Switch Provider]

11.7.2 Switch Provider Panel Layout



11.7.3 Switch Provider Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
set as default	This button sets the selected provider as the default provider for when the clerk logs into the secured site.	Button	N/A	0
switch to	This button switches to the selected provider.	Button	N/A	0
Address	Displays address line 1 of the provider's physical address. (Read-Only)	Field	Alphanumeric	30

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Field	Description	Field Type	Data Type	Length
City	Displays the city of the provider's physical address. (Read-Only)	Field	Alphanumeric	30
Current Provider	Displays the current provider number who the clerk is logged in to represent. (Read-Only)	Field	Alphanumeric	10
Default Provider ID	This checkbox indicates that this provider should be used as the default when the user is logging into the web portal. (Read-Only)	Combo Box	Check Box	0
Medicaid Provider ID	Displays the Medicaid Provider Identification of the provider. (Read-Only)	Field	Alphanumeric	10
National Provider ID	Displays the National Provider Identifier (NPI) of the provider. (Read-Only)	Field	Alphanumeric	10
Provider Type	Displays the provider type description. (Read-Only)	Field	Alphanumeric	30
State	Displays the state of the provider's physical address. (Read-Only)	Field	Alphanumeric	2
Taxonomy	Displays the taxonomy code of the provider. (Read-Only)	Field	Alphanumeric	10
Zip	Displays the zip code of the provider's physical address. (Read-Only)	Field	Number (Integer)	5
Zip 4	Displays the zip code extension of the provider's physical address. (Read-Only)	Field	Number (Integer)	4

11.7.4 Switch Provider Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

11.7.5 Switch Provider Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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11.7.6 Switch Provider Panel Accessibility

11.7.6.1 To Access the Switch Provider Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Switch Provider**.	Switch Provider panel opens.

11.7.6.2 To Update on the Switch Provider Panel

Step	Action	Response
1	Select a provider from the provider data list.	
2	Click **set as default**.	Default provider information saves.

Step	Action	Response
By following these steps, a user may also switch to another NPI number, so they may masquerade as that provider when submitting and/or inquiring on claims and prior authorization requests.		
1	Select a provider from the provider data list.	
2	Click **switch to**.	
3	Click **OK**.	User will act as the provider selected.

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11.8 Logoff

11.8.1 Logoff Panel Narrative

The Logoff panel displays when a user's session has expired. The only functionality of this window is a button that allows the user to return to the Login panel.

A session expires after 20 minutes since the last request was sent to the web server. A request is sent to the web server when the user causes the screen to refresh, such as by clicking a button or navigating between menu items. Simply entering data into a field does not send a request to the web server and thereby does not cause the 20 minute setting to reset.

Navigation Path: N/A – session expired

11.8.2 Logoff Panel Layout

11.8.3 Logoff Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Login	This button takes the user to the log on screen.	Button	N/A	0
Session Expired	Informs the user of a session expiration.	Label	N/A	0

11.8.4 Logoff Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

11.8.5 Logoff Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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11.8.6 Logoff Panel Accessibility

11.8.6.1 To Access the Logoff Panel

Step	Action	Response
1	Allow session to expire.	Logoff panel displays.

11.8.6.2 To Update on the Logoff Panel

Step	Action	Response
1	Click **Login**.	Login panel displays.

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11.9 Reset Password

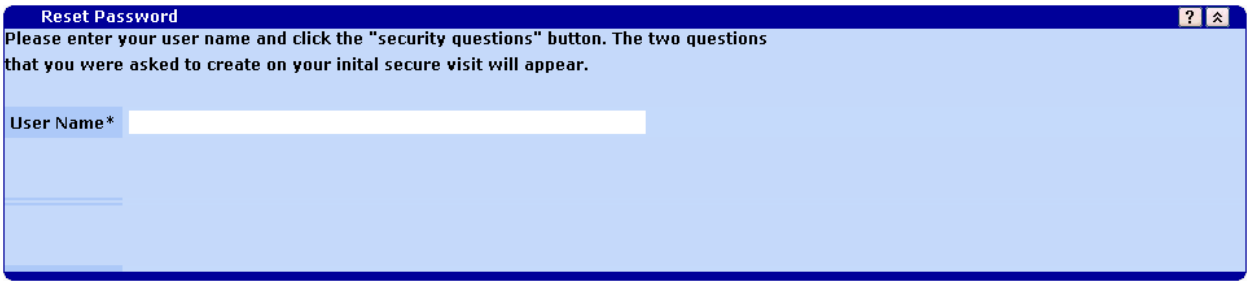
11.9.1 Reset Password Panel Narrative

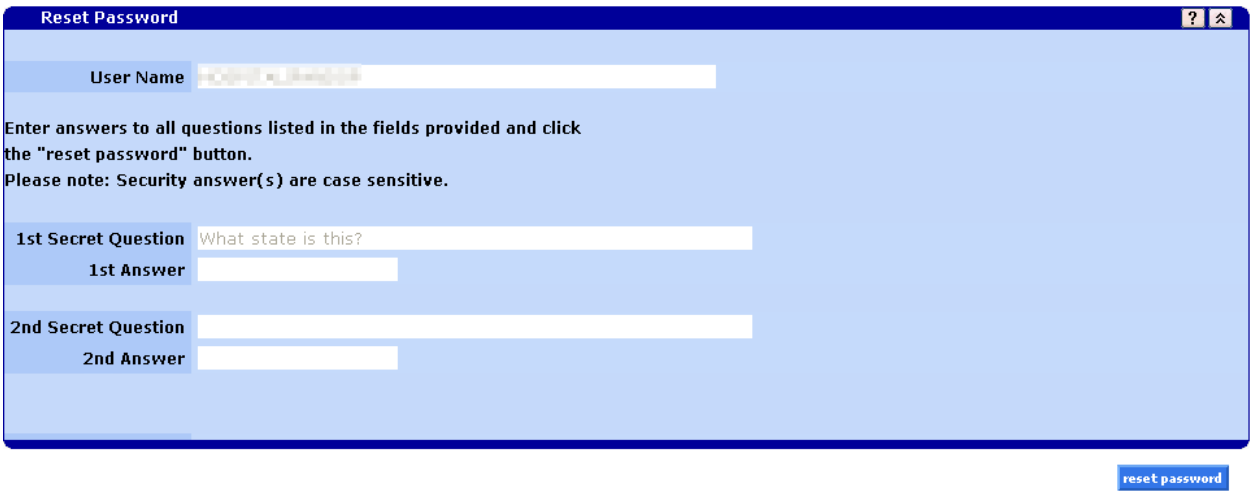
The Reset Password panel allows users to reset their Interactive Services website password. The user needs to provide self authentication before he or she is allowed to change his or her password.

The Reset Password panel also allows users to reset the password for a clerk selected from the Clerk Maintenance panel.

Navigation Path: [Account] – [Reset password]

11.9.2 Reset Password Panel Layout





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11.9.3 Reset Password Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
reset password	This button validates security answers and displays the password fields.	Button	N/A	0
security questions	This button validates the user name and displays the secret questions.	Button	N/A	0
submit	This button initiates the reset password changes to the active directory.	Button	N/A	0
1st Answer	Displays the answer for the 1st secret question.	Field	Alphanumeric	20
1st Secret Question	Displays the 1st secret question to prompt user to remember password.	Field	Character	50
2nd Answer	Displays the answer for the 2nd secret question.	Field	Alphanumeric	20
2nd Secret Question	Displays the 2nd secret question to prompt user to remember password.	Field	Character	50
Confirm Password	Displays the re-typed password of the user in the form of dots for security purposes.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
New Password	Enter your new password. The new Web Password must differ from past passwords and must also, at a minimum, include the following format: ▪ 1 Lower and 1 Upper Case value; ▪ 1 numeric value; and ▪ be at least 8 bytes in length.	Field	Character	30
User Name	Displays the user name of the user.	Field	Alphanumeric	20

11.9.4 Reset Password Panel Field Edit Error Codes

Field	Error Message	To Correct
1st Answer	Invalid Secret Answer(s).	Enter a valid secret Answer.
	1st Answer cannot contain values other than [A-Z/a-z/0-9] and blank spaces.	Ensure that the field matches the datatype as documented in the field descriptions above. character fields must only contain A-Z; alphanumeric fields must only contain A-Z and 0-9.
	1st Answer is required	Enter an answer that corresponds with the 1st Secret Question entered.
2nd Answer	Invalid Secret Answer(s)	Enter a valid secret Answer.
	2nd Answer cannot contain values other than [A-Z/a-z/0-9] and blank spaces.	Ensure that the field matches the datatype as documented in the field descriptions above. Character fields must only contain A-Z; alphanumeric fields must only contain A-Z and 0-9.
	2nd Answer is required.	Enter an answer that corresponds with the 2nd Secret Question entered.
Confirm Password	Confirm Password is required.	Re-enter the new password.
	New Password must be same as Confirm New Password.	Confirm Password should be the same as New Password.
New Password	Password is required.	Enter the new password.
	The new password does not meet the security requirements of the domain. Please refer to the field help on the New Password field for requirements and try again.	Ensure the format of the password is correct. Format requirements are noted within the help text for the Password field.

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Field	Error Message	To Correct
security questions	You are not authorized to access this account, please contact the EMC Help Desk for further assistance. (800) 456-1242 – AL, FL, GA, MS and TN (334) 215-0111 – All other locations	Contact the EMC Help Desk for further assistance.
User Name	Invalid User entered.	Enter a valid user name.
	User Name cannot contain other than [A-Z/a-z/0-9].	Ensure that the field matches the data type as documented in the field descriptions above. Character fields must only contain A-Z; alphanumeric fields must only contain A-Z and 0-9.

11.9.5 Reset Password Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.9.6 Reset Password Panel Accessibility

11.9.6.1 To Access the Reset Password Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Reset Password**.	Reset Password panel opens.

11.9.6.2 To Update on the Reset Password Panel

Step	Action	Response
1	Enter **User Name**.	
2	Click **security questions**.	Security questions display.
3	Enter **1st Answer** and **2nd Answer,** if **2nd Secret Question** is not blank.	
4	Click **reset password**.	New password fields display.
5	Enter **New Password**.	
6	Re-enter new password in **Confirm Password** field.	
7	Click **submit**.	Reset Password information saves.

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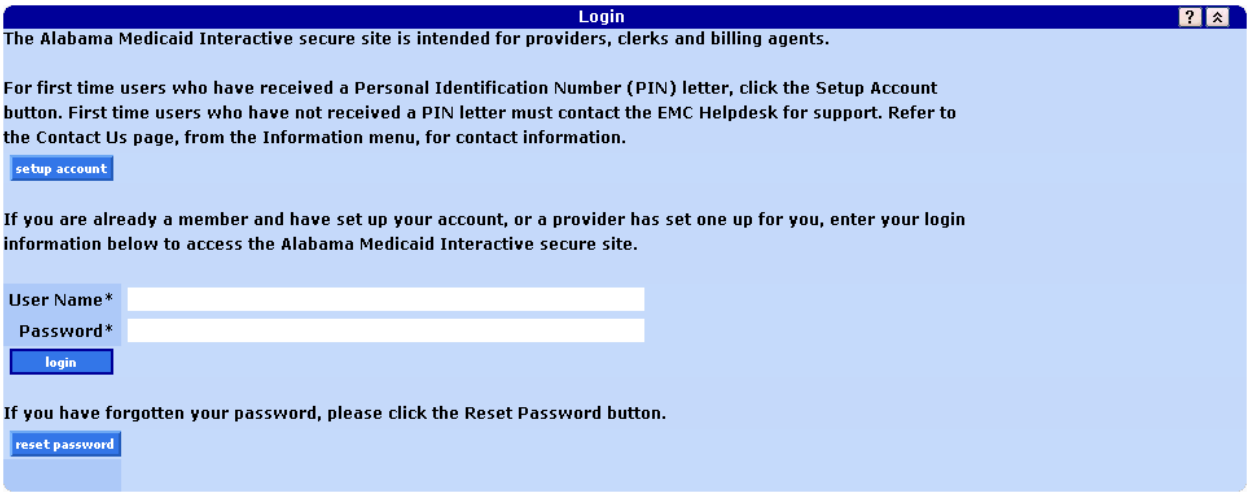
11.10 Secure Site

11.10.1 Login Panel Narrative

The Login panel, accessible via the Secure Site link, allows users to login to the secure Interactive Services website.

Navigation Path: [Account] – [Secure Site]

11.10.2 Login Panel Layout



11.10.3 Login Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
login	This button logs the user into the secure site.	Button	N/A	0
reset password	This button redirects the user to the Reset Password page.	Button	N/A	0
setup account	This button redirects the user to the Account Setup page.	Button	N/A	0
Password	Displays the password of the account user in the form of dots for security purposes.	Field	Character	30
User Name	Displays the Login ID of the user.	Field	Alphanumeric	20

NOTE:

A new PIN letter issuing a new password was mailed to all providers. Users must have a new password to use this application.

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11.10.4 Login Panel Field Edit Error Codes

Field	Error Message	To Correct
Password	Invalid User Name and/or Password.	Enter a valid User Name and/or Password.
	We are sorry but your password has expired. Please change your password.	Enter a new password.
	We are sorry but the user name or password is incorrect. Please try again.	Enter a password that is between 6 to 30 characters in length.
User Name	We are sorry but you are not authorized to access this web site. If you believe this is incorrect please contact the help desk.	The account has been reset. Setup the account once the new Personal Identification Number (PIN) has been received or contact the EMC Helpdesk at 1 (800) 456-1242 for additional assistance.
	Invalid User Name and/or Password.	Enter a valid User Name and/or Password.
	We are sorry but your account has been locked out due to invalid password attempts. Please contact the system administrator to have it unlocked.	Account Locked. Wait 10 minutes and the account will be automatically unlocked or contact the EMC Helpdesk at 1 (800) 456-1242 for additional assistance.

11.10.5 Login Panel Extra Features

Field	Field Type
No extra features found for this panel.	

11.10.6 Login Panel Accessibility

11.10.6.1 To Access the Login Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Secure Site**.	Login panel opens.

11.10.6.2 To Add on the Login Panel

Step	Action	Response
1	Enter **User Name**.	
2	Enter **Password**.	
3	Click **login**.	Providers page displays for Provider users. Messages page displays for Clerks and Billing agents.

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11.10.6.3 To Update on the Login Panel

Step	Action	Response
1	Click **setup account**.	Account Setup panel displays.
2	Click **reset password**.	Reset Password panel displays.

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12. Claims

Claims features allow users to search for or submit dental, institutional, professional, crossover, pharmacy or compound drug claims via the Interactive Services website.

From the Claims link in the Main Menu toolbar, users can access the following Sub Menu options:

- Search
- Dental
- Institutional
- Pharmacy
- Professional

NOTE:

Medicare/Medicaid (crossover) claims will be entered within the respective claims types of Institutional and/or Professional.

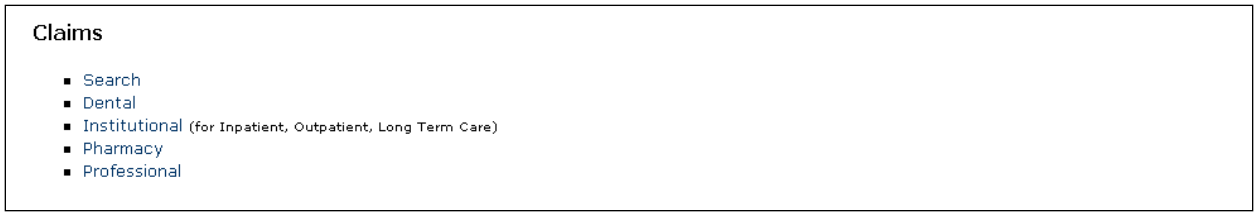
12.1 Claims

12.1.1 Claims Panel Narrative

The Claim Submission Links panel allows users to launch a claim search and entry panel for any of the four types of claims: dental, institutional, pharmacy or professional.

Navigation Path: [Claims]

12.1.2 Claims Panel Layout



12.1.3 Claims Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Dental	Hyperlink to allow user to enter Dental claims.	Hyperlink	N/A	0
Institutional	Hyperlink to allow user to enter Institutional claims.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Pharmacy	Hyperlink to allow user to enter Pharmacy claims.	Hyperlink	N/A	0
Professional	Hyperlink to allow user to enter Professional claims.	Hyperlink	N/A	0
Search	Hyperlink to allow user to search for a claim.	Hyperlink	N/A	0

12.1.4 Claims Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

12.1.5 Claims Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.1.6 Claims Panel Accessibility

12.1.6.1 To Access the Claims Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.

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12.2 Claim Search

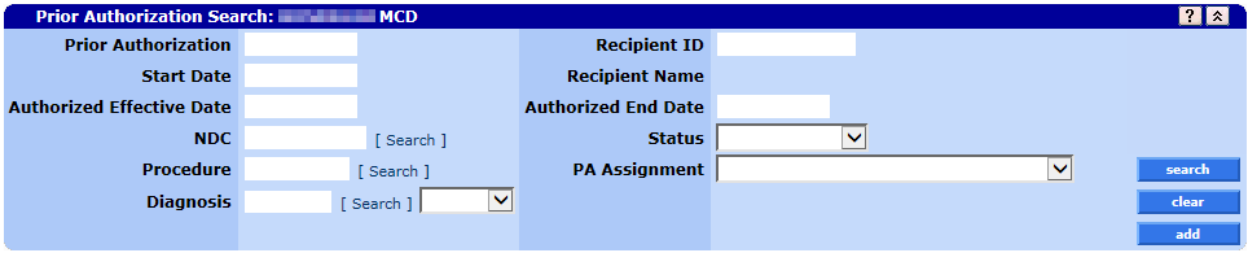
12.2.1 Claim Search Panel Narrative

The Claim Search panel allows users to search for all of the claims associated with their corresponding billing NPI number. The user also has the capability to narrow the search results by entering specific search criteria.

Navigation Path: [Claims] – [Search]

12.2.2 Claim Search Panel Layout

Prior Authorization returned is related to Fee for Service claims only. Encounter related inquiries should be directed to the MCO.



12.2.3 Claim Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears all the search criteria fields.	Button	N/A	0
search	This button allows user to search on a specific claim.	Button	N/A	0
Claim Type	Displays the type of claim.	Combo Box	Drop Down List Box	0
Date Paid	Displays the date of the check write.	Field	Date (MM/DD/CCYY)	10
FDOS	Displays the from date of service.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
ICN	Displays the Internal Control Number (ICN) which uniquely identifies the claim. To identify a range of claims, enter the first 7 digits of the ICN which identifies the ICN region, year and Julian date. Regions are: ▪ 40 - Converted Electronic Claim ▪ 47 - Converted Paper Claim ▪ 41 - Converted Medicare Claim ▪ 20 - Electronic Claim ▪ 22 - Web Claim ▪ 10 - Paper Example ICN fuzzy search: 2007011 (Electronic (20) Year 2007 (07) Date January 11th (011).	Field	Number (Integer)	13
Recipient ID	Displays the recipient's first 12-digits of their Medicaid identification number.	Field	Character	12
Recipient Name	Displays the Recipient's name including Last Name, First Name and Middle Initial.	Field	Character	50
Records	Allows the user to select the number of search results to display per page.	Combo Box	Drop Down List Box	0
Rendering Provider ID	Displays the provider who performed the service on 1st detail on the claim.	Field	Alphanumeric	10
Show Non-remitted Claims Only	Displays claims that are still in process. Claims are still in process when they have not yet been written to a remittance advice as being either paid or denied.	Check Box	Check Box	0
Status	Displays the status of the claim in the system.	Combo Box	Drop Down List Box	0
TCN	Displays a cross reference between claims from the old system (identified by a TCN) and their converted counterpart claims (identified by a claim System Assigned Key) on the current MMIS.	Field	Character	17
TDOS	Displays the to date of service.	Field	Date (MM/DD/CCYY)	10

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12.2.4 Claim Search Panel Field Edit Error Codes

Field	Error Message	To Correct
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
	The total number of claims that would be returned exceeds # which is the maximum number allowed. Please add additional search criteria that would limit the number of claims found. The total number of claims that would be returned is: # with a total billed amount of: $#.## and a total paid amount of: $#.##.	Add more items to the search criteria to try to narrow the results to a lower number of claims found.
ICN	ICN must be Numeric.	Enter a numeric ICN.
TDOS	FDOS must be less than or equal to TDOS.	Ensure that the date is on or after FDOS.

12.2.5 Claim Search Panel Extra Features

Field	Field Type
NPI or MCD	Hyperlink appears after the Rendering Provider ID field is populated with a valid provider ID. The NPI or MCD link indicates the provider number type displayed in the main panel: National Provider Identification (NPI) or Medicaid (MCD) number. Clicking NPI or MCD displays the Provider ID / Number panel, from which users can switch the provider number displayed from NPI to MCD.
Based on the User ID to NPI number association, the billing NPI number is automatically inserted as part of the search criteria. To search using a different billing NPI number, clerks may access the Switch Provider panel.	

12.2.6 Claim Search Panel Accessibility

12.2.6.1 To Access the Claim Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Search**.	Claim Search panel displays.

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12.2.6.2 To Search on the Claim Search Panel

Step	Action	Response
1	Enter one or a combination of the following fields: **ICN**, **Recipient ID**, **TCN**, **FDOS**, **TDOS**, **Rendering Provider ID**, **Claim Type**, **Status** and/or **Date Paid**.	
2	Click **search**.	Claim Search Results panel displays.

NOTE:

"No rows found" indicates a match was not identified based on the search criteria. A user can refine his or her search or contact the DXC Provider Assistance Center at 1 (800) 688-7989 for additional assistance during normal business hours; Monday – Friday from 8:00am – 5:00pm CST.

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12.3 Claim Search Results

12.3.1 Claim Search Results Panel Narrative

The Claim Search Results panel displays claim information matching the search criteria from the Claim Search panel. The billing NPI number is automatically used as part of the search criteria based on the provider account selected for the corresponding user identification number. To view claims for a different billing NPI number, the clerk must switch to that provider account by means of the Switch Provider panel. Only clerks with direct permission from the billing provider may access their account to view or submit claims.

Navigation Path: [Claims] – [Search] – [search]

12.3.2 Claim Search Results Panel Layout

Search Results

ICN	Recipient ID	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
[illegible]	000000000000	03/01/2011	03/01/2011	PROFESSIONAL CLAIMS	DENIED	03/10/2011	$100.00	$0.00
[illegible]	000000000000	03/01/2011	03/01/2011	PROFESSIONAL CLAIMS	DENIED	03/10/2011	$100.00	$0.00
[illegible]	000000000000	03/01/2011	03/01/2011	PROFESSIONAL CLAIMS	PAID	03/10/2011	$100.00	$0.70
[illegible]	000000000000	03/01/2011	03/01/2011	PROFESSIONAL CLAIMS	PAID	03/10/2011	$100.00	$0.70
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	DENIED	04/13/2011	$165.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	DENIED	04/13/2011	$165.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	DENIED	04/13/2011	$250.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	DENIED	04/13/2011	$320.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	DENIED	04/21/2011	$365.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	ADJUSTED	04/07/2011	$250.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	PAID	04/13/2011	$250.00	$141.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	ADJUSTED	04/13/2011	$165.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	PAID	04/13/2011	$165.00	$41.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	ADJUSTED	04/13/2011	$165.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	PAID	04/13/2011	$165.00	$36.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	ADJUSTED	04/21/2011	$165.00	$0.00
[illegible]	000000000000	03/06/2011	03/06/2011	PROFESSIONAL CLAIMS	PAID	04/21/2011	$165.00	$43.00
[illegible]	000000000000	03/07/2011	03/27/2011	PROFESSIONAL XOVER CLAIMS	ADJUSTED	07/28/2011	$293.00	$0.00

Claim Count: 18 Total Paid: $262.40

12.3.3 Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Billed	Displays the amount billed for the claim.	Field	Number (Decimal)	9
Amount Paid	Amount sent to a provider for payment of services rendered to a recipient.	Field	Number (Decimal)	9
Claim Type	Displays the type of claim.	Field	Alphanumeric	50
Date Paid	Displays the date on which the claim was paid.	Field	Date (MM/DD/CCYY)	10
FDOS	Displays the from date of service for the claim.	Field	Date (MM/DD/CCYY)	10
ICN	Displays the internal control number for the claim issued by Medicaid.	Field	Alphanumeric	13
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Alphanumeric	12
Status	Displays the status of the claim.	Field	Alphanumeric	10

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Field	Description	Field Type	Data Type	Length
TDOS	Displays the end date of service for the claim.	Field	Date (MM/DD/CCYY)	10
Next	Displays the link to the next page of search results.	Hyperlink	N/A	0
Previous	Displays the link to the previous page of search results.	Hyperlink	N/A	0

12.3.4 Claim Search Results Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

12.3.5 Claim Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.3.6 Claim Search Results Panel Accessibility

12.3.6.1 To Access the Claim Search Results Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Search**.	Claim Search panel displays.
3	Enter search criteria and click **search**.	Claim Search Results panel displays.

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12.4 Dental

12.4.1 Dental Claim Panel Narrative

The Dental panel allows a dental provider to submit a claim and/or adjust or void a paid claim. The user has the capability to enter all of the required information to submit a dental claim, including multiple detail lines. For a paid claim, the user has the option of updating select fields and re-submitting the claim as an adjustment or to void the claim.

The Dental Claim panel includes the following sections:

- Dental Claim
- Third Party Liability (TPL)
- Detail
- Surfaces
- Claim Status Information
- Adjustment Information
- Explanation of Benefit (EOB) Information

NOTE:

The Adjustment Information and EOB Information panels appear after a claim has been submitted.

Navigation Path: [Claim] - [Dental] OR [Claim]-[click on Dental link] OR [Claim] - [Search] - [search for dental claims]-[select dental claim from search results]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data.

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12.4.2 Dental Claim Panel Layout

Dental Claim

Billing Information

ICN
Provider ID
Provider Name
Recipient ID*
Last Name*
First Name*
Date of Birth
Patient Account #

Service Information

Emergency: No
POS* [Search]

Related Causes

Cause 1
Cause 2

Total Charges

Total Charges	$0.00
TPL Amount	$0.00
Total Paid Amount	$0.00

TPL

*** No rows found ***

Select row above to update -or- click Add button below.

Policy Number
Plan Name
Relationship to Insured
Carrier Code [Search]
Carrier Name
Payer Respons. Code: Primary
Paid Date
Paid Amt
Deductible Amt
CoInsurance Amt
CoPay Amt

Policy Holder

Last Name
First Name, MI
Date of Birth

delete add

Third Party Payments (Detail Item 1)

Carrier Code	Paid Date	Paid Amt	Deductible Amt	CoInsurance Amt	CoPay Amt
A		$0.00			

Type data below for new record.

Carrier Code*
Paid Date*
Paid Amt*: $0.00
Deductible Amt
CoInsurance Amt
CoPay Amt

delete add

Claim Status Information

Claim Status: PAID
Claim ICN
Checkwrite Date
Allowed Amount: $10.45

EOB Information

Detail Number	Code	Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED

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NOTE:

Section 10.4.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the dental claim form. Please refer to section 10.4.6.2 for step by step instructions on how to complete the dental claim form.

12.4.3 Dental Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Detail, Surfaces, TPL).	Button	N/A	0
adjust	This button submits adjustments for a paid claim.	Button	N/A	0
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
copy claim	This button creates a new claim from the current claim.	Button	N/A	0
delete	This button is used to delete data from a panel (Detail, Surfaces, TPL).	Button	N/A	0
re-submit	This button submits modifications made to a denied claim for adjudication.	Button	N/A	0
submit	This button submits a claim for adjudication.	Button	N/A	0
void	This button submits a void request for a paid claim.	Button	N/A	0
Adjustment Analyst ID	Displays the identification number of the analyst that adjusted the claim. (Read-Only)	Field	Alphanumeric	10
Adjustment Reason	Displays the adjustment reason code. (Read-Only)	Field	Number (Integer)	4
Allowed Amount	Displays the amount approved to pay for services provided to a recipient. (Read-Only)	Field	Number (Decimal)	9
Carrier Code	Displays the 5-digit carrier code that identifies the recipient's TPL insurance plan.	Field	Number (Integer)	10
Carrier Name	Displays the carrier name based on the carrier code entered. (Read-Only)	Field	Character	45

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Field	Description	Field Type	Data Type	Length
Cause 1	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.	Combo Box	Drop Down List Box	0
Cause 2	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.	Combo Box	Drop Down List Box	0
Charges	Displays the usual and customary charge for the service provided.	Field	Number (Decimal)	13
Checkwrite Date	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	10
Claim ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Claim Status	Indicates the status after adjudication. Possible values are PAID, DENIED, SUSPENDED or ADJUSTED. The status of "Adjusted" reflects this claim is no longer paid. Refer to the Adjustment Information panel for claims which have reprocessed per the Adjustment process.	Field	N/A	0
Claim Status History Date	Displays the original claim date before the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Code	Displays the explanation of benefits code. (Read-Only)	Field	Number (Integer)	4
CoInsurance Amt	Medicare Information: the coinsurance amount Medicare applied to this claim.	Field	Number (Decimal)	8
CoPay Amt	Copay amount the third party payer applied to this claim (TPL) or to the detail (Third Party Payer).	Field	Number (Decimal)	10
DOS	Displays the date of service on the claim.	Field	Date (MM/DD/CCYY)	10
Date Adjusted	Displays the date the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Date of Birth	Header: Displays the recipient's date of birth. (Read-Only and defaulted.) TPL: Displays the date of birth of the third party policy holder.	Field	Date (MM/DD/CCYY)	10
Deductible Amt	Displays the amount the recipient must pay before Medicare.	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
Denied Date	Displays the date the claim was denied. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Description	Displays the explanation of benefits description. (Read-Only)	Field	Alphanumeric	79
Detail Number	Displays the line item detail number of the claim. (Read-Only)	Field	Number (Integer)	2
Detail Status	Displays the status of the detail line. (Read-Only).	Field	Alphanumeric	10
Emergency	Displays if the service was provided as the result of an emergency situation.	Combo Box	Drop Down List Box	0
First Name	Displays the first name of the recipient on the header.	Field	Character	35
First Name, M	Displays the first name and middle initial of third party policy holder.	Field	Alphanumeric	25
ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Item	Displays the detail line number. (Read-Only)	Field	Number (Integer)	3
Last Name	Displays the last name of the recipient. TPL: Displays the last name of third party policy holder.	Field	Character	60
Location	Displays the location code of the claim.	Field	Number (Integer)	2
POS	Displays the place of service (POS) where the service was rendered.	Field	Number (Integer)	2
Paid Amt	Medicare Information: Displays the dollar amount paid by Medicare for the services (may be a negative or positive amount).	Field	Character	10
Paid Date	Displays the date the claim was billed and paid. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Patient Account	Displays the identification for a recipient assigned by a provider and used in their system.	Field	Character	38
Payer Responsibility Code	Value identifying the third payer’s level of responsibility on this claim.	Combo Box	Drop Down List Box	0
Plan Name	Displays the TPL plan name.	Field	Alphanumeric	60

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Field	Description	Field Type	Data Type	Length
Policy Number	Displays the TPL policy number.	Field	Alphanumeric	30
Procedure	Displays the code used to identify a dental procedure.	Field	Alphanumeric	6
Provider ID	Displays the National Provider Identification number of the billing provider. (Read-Only and Defaulted.)	Field	Alphanumeric	10
Provider Name	Displays the name of the billing provider. (Read Only and defaulted on header panel.)	Field	Alphanumeric	15
Quadrant	Displays the quadrant of the mouth where services were performed.	Combo Box	Drop Down List Box	0
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	13
Relationship to Insured	Displays the third party liability's insured relationship.	Combo Box	Drop Down List Box	0
Rendering Provider	Displays the identification number of the rendering physician.	Field	Alphanumeric	10
Surface	Displays the code which identifies the tooth surface on which a service was performed. This surface displayed is associated to a specific detail as noted in the title bar as (Detail Item).	Combo Box	Drop Down List Box	0
TPL Amount	Displays the amount paid by a third party liability insurance.	Field	Number (Decimal)	14
Tooth Number	Displays the tooth number that identifies the tooth on which the provider rendered services. A letter indicates temporary teeth and a number indicates permanent teeth.	Field	Alphanumeric	2
Total Charges	Displays the total amount charged for the claim. (Read-Only and calculated from Detail Charges.)	Field	Number (Decimal)	13
Total Paid Amount	Displays the total amount paid. (Read-Only)	Field	Number (Decimal)	13
Units	Displays the units of service on this detail. (Dental services will always be billed one unit per line item.)	Field	Number (Decimal)	6

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12.4.4 Dental Claim Panel Field Edit Error Codes

Field	Error Message	To Correct
adjust	Adjust was successful. See Claim Status Information for details.	Ensures that the claim adjustment request was sent successfully and status details can be viewed on the Claim Status Information panel.
copy claim	Copy was successful.	Ensures that the copy was successful and modifications can be made prior to submission.
submit	Submit was successful. See Claim Status Information for details.	Ensures that the claim was sent successfully and status details can be viewed on the Claim Status Information panel.
void	Void was successful. See Claim Status Information for details.	Ensures that the claim void request was sent successfully and status details can be viewed on the Claim Status Information panel.
All fields	Invalid number / Invalid date / Invalid character data/Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 - 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
	Exceeded maximum number of details.	Exceeded maximum number of details - 50 detail lines.
Carrier Code	Carrier Code is required.	Enter a Carrier Code when TPL is being entered.
Charges	Charges must be less than or equal to 9999999.99.	Ensure the amount is not greater than $9,999,999.99.
	Charges must be greater than or equal to 0.01.	Ensure that the amount is greater than or equal to 0.01.
	Charges are required.	Enter the detail charges.
DOS	DOS is required.	Enter the date of service.
	DOS must be less than or equal to Today.	Enter a date of service that is less than or equal to today's date.
	DOS must be greater than or equal to 01/01/1990.	Enter a date of service that is greater than or equal to 01/01/1990.
	DOS must be less than or equal to 12/31/2299.	Enter a date of service that is less than or equal to 12/31/2299.

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Field	Error Message	To Correct
Date of Birth	Date of Birth is required.	Ensure that the Date of Birth, on the TPL panel, is on or before today's date.
	Date of Birth must be greater than or equal to 01/01/1900.	Enter a Date of Birth greater than or equal to 01/01/1900.
	Date of Birth must be less than or equal to 12/31/2299.	Enter a Date of Birth less than or equal to 12/31/2299.
	Date of Birth must be less than or equal to Today.	Ensure that the Date of Birth, on the TPL panel, is on or before today's date.
First Name	First Name is required.	Enter the recipient's first name.
First Name, MI	First Name is required.	Enter a first name when TPL is applicable.
Last Name	Last Name is required.	Header: Enter the recipient's last name. TPL: Enter a last name when TPL is applicable.
POS	A valid POS is required.	Enter a valid Place of Service (POS).
	POS contains an invalid value.	Enter a valid Place of Service (POS).
Paid Date	Paid Date is required.	Enter a Paid Date when TPL is being entered.
	Paid Date must be greater than or equal to 01/01/1900.	Enter a Paid Date greater than or equal to 01/01/1900 when TPL is being entered.
	Paid Date must be less than or equal to 12/31/2299.	Enter a Paid Date less than or equal to 12/31/2299 when TPL is being entered.
	Paid Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Plan Name	Plan Name is required.	Enter a Plan Name when TPL is being entered.
Policy Number	Policy Number is required.	Enter a Policy Number when TPL is being entered.
Procedure	A valid Procedure is required.	Enter a valid ICD-9 procedure.
Recipient ID	A valid Recipient ID is required and must be 13 digits.	Enter a valid 13 digit Recipient ID.
	Recipient ID must be numeric.	Enter a valid Recipient ID.
Relationship to Insured	Relationship to Insured is required.	Select a Relationship to Insured when TPL is applicable.
re-submit	Cannot resubmit failed adjusted claim. Please adjust and resubmit original claim.	Correct the claim and resubmit.
Surface	A valid Surface is required.	Enter a valid tooth surface code.
TPL Amount	TPL Amount is required when TPL records are present.	Enter a TPL Amount in the Dental Claim panel when data is entered into the TPL panel.

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Field	Error Message	To Correct
	TPL Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	TPL Amount must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Tooth Number	Tooth Number is not valid.	Ensure that the tooth value is a valid value. Value = 00-33, A-T.
Total Charges	Total Charges must be less than or equal to 9999999.99.	Ensure the amount is not greater than $9,999,999.99.
Units	Units must be less than or equal to 999999999999.999.	Ensure the units billed are not greater than 999,999,999,999.999.
	Units must be greater than or equal to 0.01.	Ensure that the amount is greater than or equal to 0.01.
	Units are required.	Enter the detail units.

12.4.5 Dental Claim Panel Extra Features

Field	Field Type
Date of Birth	Read-only field displays after Recipient ID field populated.
First Name, MI	Read-only field displays after Recipient ID field populated.
Last Name	Read-only field displays after Recipient ID field populated.
NPI or MCD	Hyperlink appears after the Rendering Physician ID field is populated with a valid NPI number. The NPI or MCD link indicates the provider number type displayed in the main panel: National Provider Identification (NPI) or Medicaid (MCD) number. Clicking NPI or MCD displays the Provider ID / Number panel, from which users can switch the provider number displayed from NPI to MCD.
Provider ID	Read-only field displays the billing NPI number associated with the user's ID.
Provider Name	Read-only field associated with the Provider ID field.
Surface	There is a limit of five surfaces.

12.4.6 Dental Claim Panel Accessibility

12.4.6.1 To Access the Dental Claim Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Dental**.	Dental Claim panel displays.

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12.4.6.2 To Add on the Dental Claim Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Enter the recipient's **Last Name**.	
3	Enter the recipient's **First Name**.	
4	Enter **Patient Account #.**	
5	Select **Emergency** indicator from drop down list.	
6	Enter **POS** or click [Search] to select from list.	Clicking [Search] activates the POS Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
7	Select a related cause from the **Cause 1** drop down list.	
8	Select a related cause from the **Cause 2** drop down list.	
9	Enter **TPL Amount**.	
10	Click **add** in TPL section.	Activates fields for entry of data or selection from lists.
11	Enter **Policy Number**.	
12	Enter **Plan Name**.	
13	Select **Relationship to Insured** from drop down list.	
14	Enter **Carrier Code** or click [Search] to select from list.	Clicking [Search] activates the Carrier Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
15	Enter **Paid Date**.	
16	Enter policy holder **Last Name**.	
17	Enter policy holder **First Name, MI**.	
18	Enter policy holder **Date of Birth**.	
19	Click **add** in Detail section.	Activates fields for entry of data or selection from lists.
20	Enter **Procedure** code or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
21	Enter **Tooth Number**.	
22	Select **Quadrant** from drop down list.	
23	Enter **Rendering Provider** number or click [Search] to select from list.	Clicking [Search] activates the Rendering Provider ID Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
24	Enter **DOS**.	
25	Enter **Units**.	
26	Enter **Charges**.	
27	Enter **POS** or click [Search] to select from list.	Clicking [Search] activates the POS Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
28	Click **add** in Surfaces section.	Activates fields for entry of data or selection from lists.
29	Select **Surface** from drop down list.	
30	Click **add** in Detail section to add another service line and repeat steps 21 thru 30.	Activates fields for entry of data or selection from lists.
31	Click **submit**.	Submits dental claim.

12.4.6.3 To Update on the Dental Claim Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **adjust, void** or **re-submit**.	Submits an adjustment, void or re-submits a denied dental claim.

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12.5 Institutional

12.5.1 Institutional Claim Panel Narrative

The Institutional panel allows an institutional provider to submit an inpatient, outpatient, long term care (LTC), or crossover claim, and/or adjust or void a paid claim. The user has the capability to enter all of the required information to submit an institutional claim, including multiple detail lines. For a paid claim, the user has the option of updating select fields and re-submitting the claim as an adjustment or to void the claim.

The Institutional Claim panel includes the following sections:

- Institutional Claim
- Diagnosis
- TPL
- Medicare Information
- Detail
- Claim Status Information
- Adjustment Information
- EOB Information

NOTE:

The Adjustment Information and EOB Information panels appear after a claim has been submitted.

Click the link to activate and display the following panels. Only one panel can be displayed at a time.

- Condition
- Payer
- Procedure
- Occurrence

Navigation Path: [Claim] – [Institutional] OR [Claim]-[click on Institutional link] OR [Claim] – [Search] - [search for institutional claims]-[select institutional claim from search results]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data.

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12.5.2 Institutional Claim Panel Layout

Institutional Claim

Billing Information

ICN
Provider ID
Provider Name
Recipient ID*
Last Name*
First Name*
Date of Birth
Patient Account #
Medical Record #
Attending Phys* [Search]
Referring Phys [Search]
Operating Physician [Search]
Service Location [Search]

Diagnosis

Admitting Diagnosis [Search]
Primary E-Code [Search]
Primary Diagnosis [Search]
Patient Rsn Visit1 [Search]
Patient Rsn Visit2 [Search]
Patient Rsn Visit3 [Search]

Service Information

Claim Type*
Service Authorization
Delay Reason
Type Of Bill*
From Date*
To Date*
Patient Status [Search]
Admit Source
Admission Type [Search]
Admission Date
Admission Hour
Discharge Time
Covered Days 0
Non Covered Days 0

	Baby 1	Baby 2	Baby 3
Birth Weight(gm)	0	0	0

District Plan

Charges

TPL Amount $0.00
Total Charges $0.00
Total Copay $0.00
Total Paid Amount $0.00

Click the link below to activate the corresponding panel:
Condition Procedure Occurrence

Diagnosis

	Sequence	ICD Version	Diagnosis	Description
A	1			

Type data below for new record.

Sequence 1
Diagnosis* [Search]

delete add Add E-Code

TPL

*** No rows found ***

Select row above to update -or- click Add button below.

Policy Number
Plan Name
Relationship to Insured
Carrier Code [Search]
Carrier Name
Payer Respons. Code Primary
Paid Date
Paid Amt
Deductible Amt
CoInsurance Amt
CoPay Amt

Policy Holder

Last Name
First Name, MI
Date of Birth

delete add

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Medicare Information

Medicare Paid Date		Deductible Amount	$0.00
Medicare Allowed Amount	$0.00	Coinsurance Amount	$0.00
Original Medicare Paid Amount	$0.00	Coinsurance Days	
2% Sequestration Amount	$0.00	Lifetime Reserve Days	
Final Medicare Paid Amount	$0.00	Medicare CoPay Amount	$0.00

Detail

	Item	Status	Revenue Code	HCPCS	Units	Charges	Non Covered Charges	Allowed Amount
A	1				0	$0.00	$0.00	$0.00

Type data below for new record.

Item	1	Revenue Code*	[Search]
Detail Status		HCPCS	[Search]
From DOS		Modifier 1	[Search]
To DOS		Modifier 2	[Search]
Units*	0	Modifier 3	[Search]
Charges*	$0.00	Modifier 4	[Search]
Non Covered Charges	$0.00	Units of Measurement	Unit
		Allowed Amount	$0.00
		CoPay Amount	$0.00

delete add

Third Party Payments (Detail Item 1)

*** No rows found ***

Select row above to update -or- click Add button below.

Carrier Code	
Paid Date	
Paid Amt	
Deductible Amt	
CoInsurance Amt	
CoPay Amt	

delete add

Claim Status Information

Claim Status	Not Submitted

submit cancel

Claim Status Information

Claim Status	PAID
Claim ICN	[redacted]
Checkwrite Date	[redacted]
Allowed Amount	$4,712.00

EOB Information

Detail Number	Code	Description
0	9505	PRICING ADJUSTMENT - MEDICARE LONG TERM CARE PRICING APPLIED
0	9907	TPL AMOUNT APPLIED

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Adjustment Information

ICN	Date Adjusted	Claim Status History Date	Claim Status	Location	Adjustment Reason	Adjustment Analyst ID
[illegible]	09/10/2002	09/13/2002	DENIED	99	X989	

Claim Status Information

Claim Status	PAID
Claim ICN	[illegible]
Paid Date	[illegible]
Allowed Amount	[illegible]

EOB Information

Detail Number	Code	Description
1	X357	PAYMENT AMOUNT, IF ANY, REPRESENTS THE MAXIMUM PAYMENT ALLOWED BY MEDICAID.
2	X357	PAYMENT AMOUNT, IF ANY, REPRESENTS THE MAXIMUM PAYMENT ALLOWED BY MEDICAID.
3	X357	PAYMENT AMOUNT, IF ANY, REPRESENTS THE MAXIMUM PAYMENT ALLOWED BY MEDICAID.

NOTE:

Section 12.5.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the institutional claim form. Please refer to section 12.5.6.2 for step by step instructions on how to complete the institutional claim form.

12.5.3 Institutional Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
Add E-Code	This button is used to add additional External Cause of Injury Diagnosis Code. (max of 12 total allowed).	Button	N/A	0
adjust	This button submits adjustments for a paid claim.	Button	N/A	0
Birth Weight(gm)	Birth weight in grams for a new born baby 28 days or younger of age. The amount must be entered as a positive whole number.	Field	Number (Decimal)	7
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
copy claim	This button creates a new claim from the current claim.	Button	N/A	0
delete	This button is used to delete data from a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
re-submit	This button submits modifications made to a denied claim for adjudication.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
submit	This button submits a claim for adjudication.	Button	N/A	0
void	This button submits a void request for a paid claim.	Button	N/A	0
2% Sequestration Amount	The dollar amount of the 2% sequestration as required by the ACA.	Field	Number (Decimal)	8
Adjustment Analyst ID	Displays the identification number of the analyst that adjusted the claim. (Read-Only)	Field	Alphanumeric	10
Adjustment Reason	Displays the adjustment reason code. (Read-Only)	Field	Number (Integer)	4
Admission Date	Displays the date that the recipient was admitted by the provider for inpatient care, outpatient care or start of care.	Field	Date (MM/DD/CCYY)	10
Admission Hour	Displays the hour during which the patient was admitted for inpatient or outpatient care, in military time.	Field	Number (Integer)	4
Admission Type	Displays the code which indicates the priority of the admission for inpatient or outpatient care.	Field	Character	2
Admitting Diagnosis	This field is used for the Admitting Diagnosis Code for Inpatient claims and for the Patient Reason For Visit Diagnosis Code for certain outpatient claims.	Field	Character	7
Allowed Amount	Displays the amount approved to pay for services provided to a recipient. (Read-Only)	Field	Number (Decimal)	9
Attending Phys#	Displays the identification number of the physician who would be expected to certify and recertify the medical necessity of the services rendered and /or who has primary responsibility for the patient's medical care and treatment.	Field	Alphanumeric	10
Birth Weight(gm)	Birth weight for a new born baby 1, baby 2 and baby 3 who is 28 days or younger of age. The amount must be entered as a positive whole number.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Carrier Code	Displays the 5-digit carrier code that identifies the recipient's third party liability's insurance plan.	Field	Number (Integer)	5
Carrier Name	Displays the carrier name based on the carrier code entered. (Read-Only)	Field	Character	45
Charges	Displays the usual and customary charge for the service provided.	Field	Number (Decimal)	13
Checkwrite Date	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	10
Claim ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Claim Status	Indicates the status after adjudication. Possible values are PAID, DENIED, SUSPENDED or ADJUSTED. The status of "Adjusted" reflects this claim is no longer paid. Refer to the Adjustment Information panel for claims which have reprocessed per the Adjustment process.	Field	N/A	0
Claim Status History Date	Displays the original claim date before the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Claim Type	Displays the code and description that specifies the type of claim. Note: Long Term Care Crossover claims are listed as claim type A – UB04 Inst Xover Claims.	Combo Box	Drop Down List Box	0
CoPay Amount	Displays the amount recipient is to pay for service rendered. (Read-Only)	Field	Number (Decimal)	9
Code	Displays the explanation of benefits code. (Read-Only)	Field	Number (Integer)	4
Coinsurance Amount	Displays the amount which represents the recipients' coinsurance payment.	Field	Number (Decimal)	8
Coinsurance Days	Displays the amount of coinsurance days used during the inpatient stay on this claim.	Field	Number (Integer)	5
Condition	Displays the code used to identify conditions relating to a UB04 claim that may affect payer processing.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
CoPay Amt	Copay amount the third party payer applied to this claim.	Field	Number(Decimal)	10
Covered Days	Displays the number of days covered for the statement period of the claim.	Field	Number (Integer)	5
Date Adjusted	Displays the date the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Date of Birth	Header: Displays the recipient's date of birth. (Read-Only and defaulted.) TPL: Displays the date of birth of the third party policy holder.	Field	Date (MM/DD/CCYY)	10
Deductible Amount	Displays the amount the recipient must pay before Medicare.	Field	Number (Decimal)	8
Delay Reason	Displays the delay reason codes that are used by specific Medicaid providers. These do not affect hospitals, State Mental Health or Nursing Home providers. These delay reasons cannot override claims over the year past filing limit.	Combo Box	Drop Down List Box	0
Denied Date	Displays the date the claim was denied. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Description	Displays the explanation of benefits description. (Read-Only)	Field	Alphanumeric	79
Detail	Displays the line item detail number of the claim. (Read-Only)	Field	Number (Integer)	2
Detail Number	Displays the line item detail number of the claim. (Read-Only)	Field	Number (Integer)	2
Detail Status	Displays the status of the detail line. (Read-Only).	Field	Alphanumeric	10
Diagnosis	Displays the diagnosis code.	Field	Character	7
Discharge Time	Displays the discharge time.	Field	Number (Integer)	4
District Plan	Displays the district code that identifies the type of encounter. H01 – H08 identifies a Partnership Hospital Program claim. P01 – P14 identifies a Maternity Care claim. (Read-Only)	Field	Alphanumeric	5
Drug Unit Price	Price per unit of product.	Field	Number(Integer)	19
E-code	Displays the E-code.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
Final Medicare Paid Amount	The dollar amount paid by Medicare for the services provided.The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.	Field	Number (Decimal)	10
First Name	Displays the first name of the recipient.	Field	Character	35
First Name, MI	Displays the first name and middle initial of third party policy holder.	Field	Character	35
From DOS	Displays the beginning date on which service was provided.	Field	Date (MM/DD/CCYY)	10
From Date	Displays the date on which the statement period on the claim began. Occurrence: The date when the occurrence code began.	Field	Date (MM/DD/CCYY)	10
HCPCS	Displays the code that identifies the service that was provided.	Field	Alphanumeric	6
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Item	Displays the line item number. (Read-Only)	Field	Number (Integer)	3
Last Name	Displays the last name of the recipient. TPL: Displays the last name of third party policy holder.	Field	Character	60
Lifetime Reserve Days	Displays the amount of lifetime reserve days used during the inpatient stay on this claim. Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	Field	Number (Integer)	5
Location	Displays the place of service (POS) where the service was rendered.	Field	Number (Integer)	2
Medical Record#	Displays the medical record number assigned to the recipient by the provider for the service that was performed.	Field	Alphanumeric	50

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Field	Description	Field Type	Data Type	Length
Medicare Allowed Amount	Displays the amount allowed by Medicare.	Field	Number (Decimal)	10
Medicare CoPay Amount	Medicare advanced copay amount.	Field	Number (Decimal)	8
Medicare Paid Amount	Displays the amount paid by Medicare.	Field	Number (Decimal)	10
Medicare Paid Date	Displays the date Medicare paid for the services rendered.	Field	Date (MM/DD/CCYY)	10
Modifier 1	Displays the first modifier when applicable.	Field	Number (Integer)	2
Modifier 2	Displays the second modifier when applicable.	Field	Number (Integer)	2
Modifier 3	Displays the third modifier when applicable.	Field	Number (Integer)	2
Modifier 4	Displays the fourth modifier when applicable.	Field	Number (Integer)	2
NDC	This is the National Drug Code.	Field	Character	16
NDC Sequence Number	The number of the detail on a claim record. (Read Only)	Field	Number(Integer)	4
Non Covered Charges	Displays the amount not covered by insurance.	Field	Number (Decimal)	8
Non Covered Days	Displays the number of days not covered for the statement period of the claim.	Field	Number (Integer)	5
Occurrence	Displays the code identifying a significant event relating to this bill that may affect payer processing.	Field	Character	2
Operating Physician	Displays the identification number of other physician who performed services.	Field	Alphanumeric	10
Original Medicare Paid Amount	Displays the amount paid by Medicare (may be a negative or positive amount).	Field	Number (Decimal)	10
Paid Amt	The total paid amount for this claim by the Third Party Payer.	Field	Number (Decimal)	10
Paid Date	Displays the date the claim was billed and paid. (Read-Only) Medicare: Displays the date Medicare paid for the services. TPL: Displays the date third party policy paid for the services.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Patient Account#	Displays the identification for a recipient assigned by a provider and used in their system.	Field	Alphanumeric	38
Patient Rsn Visit1	This field is used for the Patient Reason Visit1 Code for outpatient claims.	Field	Character	7
Patient Rsn Visit2	This field is used for the Patient Reason Visit2 Code for outpatient claims.	Field	Character	7
Patient Rsn Visit3	This field is used for the Patient Reason Visit3 Code for outpatient claims.	Field	Character	7
Patient Status	Displays the code which indicates the status of the recipient as of the ending service date of the period covered on a UB04 claim.	Field	Alphanumeric	2
Payer	Displays if the payer is Medicaid, Medicare, or other third party.	Combo Box	Drop Down List Box	0
Payer Respons. Code	Value identifying the third payer's level of responsibility on this claim.	Combo Box	Drop Down List Box	0
Plan Name	Displays the third party liability's plan name.	Field	Alphanumeric	60
Policy Number	Displays the third party liability's policy number.	Field	Alphanumeric	30
PoA Indicator	Displays the PoA indicator associated to diagnosis code for UB92 claims	Combo Box	Alphanumeric	1
Prescription Number	The prescription number.	Field	Character	50
Prescription Qualifier	The Prescription Qualifier.	Combo Box	Character	3
Primary Diagnosis	Displays the Primary Diagnosis code.	Field	Character	7
Primary E-code	Displays the Primary E-code.	Field	Character	7
Primary NDC	Indicates the selected NDC, is the primary NDC.	Check Box	N/A	0
Prior Payment	Displays the amount that has been received prior to this billing from this payer.	Field	Number (Decimal)	9
Procedure	Displays the surgical code which identifies the service provided.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
Procedure Date	Displays the date on which the surgical procedure code was performed.	Field	Date (MM/DD/CCYY)	10
Provider ID	Displays the National Provider Identification number of the billing provider. (Read-Only and Defaulted.)	Field	Alphanumeric	10
Provider Name	Displays the name of the billing provider. (Read Only and defaulted on header panel.)	Field	Alphanumeric	15
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	13
Referring Phys	Displays the identification number of the referring physician.	Field	Alphanumeric	10
Relationship to Insured	Displays the third party liability's insured relationship.	Combo Box	Drop Down List Box	0
Revenue Code	Displays the code which identifies a specific accommodation, ancillary service or billing calculation.	Field	Character	4
Sequence	Displays the sequence number which indicates the position in which the information occurs on the claim.	Label	Alphanumeric	2
Service Authorization	Displays the type of maternity override or if the service was due to an emergency.	Combo Box	Drop Down List Box	0
Service Location	Displays the identification number of the servicing facility.	Field	Alphanumeric	10
TPL Amount	Displays the dollar amount paid by a third party liability insurance. (Read-Only)	Field	Number (Decimal)	15
To DOS	Displays the ending date on which service was provided.	Field	Date (MM/DD/CCYY)	10
To Date	Displays the date on which the statement period on the claim ended.	Field	Date (MM/DD/CCYY)	10
Total Charges	Displays the total amount charged for the claim. (Read-Only and calculated from Detail Charges.)	Field	Number (Decimal)	13
Total Copay	Displays the total amount recipient is to pay for services rendered. (Read-Only)	Field	Number (Decimal)	9
Total Paid Amount	Displays the total amount paid. (Read-Only).	Field	Number (Decimal)	13

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Field	Description	Field Type	Data Type	Length
Type Of Bill	Displays bill type on a UB04 claim form.	Field	Alphanumeric	3
Units of Measurement	Displays the measurement of units. (Read-Only)	Combo Box	Drop Down List Box	0
Units	Displays the units of service on this detail.	Field	Number (Integer)	6
UOM	Code specifying the units in which a value is being expressed.	Combo Box	Character	0
Unit Quantity Calculated	This is the unit quantity calculated.	Field	Number (Integer)	18
Unit Quantity Submitted	This is the unit count that the provider submitted. The Drug – not HCPCS – units.	Field	Number (Integer)	18

12.5.4 Institutional Panel Field Edit Error Codes

Field	Error Message	To Correct
adjust	Adjust was successful. See Claim Status Information for details.	Ensures that the claim adjustment request was sent successfully and status details can be viewed on the Claim Status Information panel.
copy claim	Copy was successful.	Ensures that the copy was successful and modifications can be made prior to submission.
submit	Submit was successful. See Claim Status Information for details.	Ensures that the claim was sent successfully and status details can be viewed on the Claim Status Information panel.
void	Void was successful. See Claim Status Information for details.	Ensures that the claim was sent successfully and status details can be viewed on the Claim Status Information panel.
Admission Date	Admission Date is required for the selected Claim Type.	Enter the Admission Date when the claim type is Inpatient, Long Term Care or Inpatient Crossover.
	Admission Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Admission Hour	Admission Hour must be Numeric.	Enter a 4 digit numeric value represent time.
	Admission Hour must be 4 character(s) in length.	Ensure the Admission Hour is valid and in HHMM format.
	Admission Hour is required for the selected Claim Type and Type of Bill.	Enter the Admission Hour when the claim type is Inpatient Crossover and the Type of Bill begins with '1'.
Admission Type	Admission Type is required for the selected Claim Type and Type of Bill.	Enter the Admission Type when the claim type is Inpatient Crossover and the Type of Bill begins with '1'.

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Field	Error Message	To Correct
	Admission Type contains an invalid value.	Enter a valid Admission Type.
Admission Type	Admission Type is required for the selected Claim Type and Type of Bill.	Enter the Admission Type when the claim type is Inpatient Crossover and the Type of Bill begins with '1'.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 - 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
	Exceeded maximum number of details.	Enter a claim with 999 detail lines or less.
Attending Phys	Attending Phys is required.	Enter a valid Attending Physician.
	A valid Attending Physician is required.	Enter a valid Attending Physician.
Birth Weight (gm)	Birth weight must be entered in sequence and no blank birth weights are allowed between values.	Enter Baby weight 1 then enter baby weight 2 and then baby 3 weight.
Carrier Code	Carrier Code is required.	Enter a valid Carrier Code.
Charges	Charges must be less than or equal to 99999999.99.	Ensure the amount is not greater than $9,999,999.99.
	Charges must be greater than or equal to 0.01.	Ensure that the amount is greater than or equal to 0.01.
	Charges are required.	Enter the detail charges.
Claim Type	A valid Claim Type is required.	Enter a valid Claim Type.
Coinsurance Amount	Coinsurance Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	Coinsurance Amount must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Coinsurance Days	Coinsurance Days must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
	Coinsurance Days must be less than or equal to 9999.99.	Ensure that the number of days is not greater than 9999.
Condition	A valid Condition is required.	Enter a valid condition if adding Conditions.
Covered Days	Covered Days must be less than or equal to 9999.	Ensure that the number of days is not greater than 9999.

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Field	Error Message	To Correct
	Covered Days is required for the selected Claim Type.	Enter the Covered Days when the claim type is Inpatient, Long Term Care or Inpatient Crossover.
Date of Birth	Date of Birth is required.	Enter a date of birth in the TPL panel.
	Date of Birth must be less than or equal to Today.	Ensure that the Date of Birth, on the TPL panel, is on or before today's date.
	Date of Birth must be greater than or equal to 01/01/1900.	Enter a Date of Birth greater than or equal to 01/01/1900.
	Date of Birth must be less than or equal to 12/31/2299.	Enter a Date of Birth less than or equal to 12/31/2299.
Deductible Amount	Deductible Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	Deductible Amount must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Diagnosis	A valid Diagnosis is required.	Enter a valid diagnosis code.
Discharge Time	Discharge Time is not valid.	Ensure the Discharge Time is valid and in HHMM format.
First Name	First Name is required.	Enter the recipient's first name.
First Name, MI	First Name is required.	Enter a first name when TPL is applicable.
From DOS	From DOS must be less than or equal to To DOS.	Ensure From DOS is less than or equal to the To DOS.
	From DOS must be less than or equal to Today.	Ensure that the date is on or before today's date.
	From DOS must be greater than or equal to 1/1/1990.	Enter a From date of service that is greater than or equal to 1/1/1990.
	From DOS must be less than or equal to 12/31/2299.	Enter a From date of service that is less than or equal to 12/31/2299.
From Date	From Date is required.	Enter a from date.
	From Date must be less than or equal to To Date.	Ensure From Date is less than or equal to the To Date.
	From Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
	From Date must be greater than or equal to 01/01/1990.	Ensure From Date is greater than or equal to 01/01/1990.
	From Date must be less than or equal to 12/31/2299.	Ensure From Date is less than or equal to 12/31/2299.
HCPCS	HCPCS contains an invalid value.	Enter a valid HCPCS code.

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Field	Error Message	To Correct
ICD Version	ICD Version for Diagnosis and Procedure codes should be the same type.	Ensure version type of all diagnosis codes and Procedure codes are same.
Last Name	Last Name is required.	Header: Enter the recipient's last name. TPL: Enter a last name when TPL is applicable.
Lifetime Reserve Days	Lifetime Reserve Days must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
	Lifetime Reserve Days must be less than or equal to 9999.99.	Ensure that the number of days is not greater than 9999.
Medicare Allowed Amount	Medicare Allowed Amount must be less than or equal to 99999999.99.	Ensure that the amount is not greater than $99,999,999.99.
	Medicare Allowed Amount must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Medicare Paid Amount	Medicare Paid Amount must be less than or equal to 99999999.99.	Ensure that the amount is not greater than $99,999,999.99.
	Medicare Paid Amount must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Medicare CoPay Amount	Copayment Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
Medicare Paid Date	Medicare Paid Date is required.	Enter a Medicare Paid Date when crossover information is entered.
	Medicare Paid Date must be greater than or equal to 01/01/1900.	Enter a Medicare Paid Date greater than or equal to 01/01/1900.
	Medicare Paid Date must be less than or equal to 12/31/2299.	Enter a Medicare Paid Date less than or equal to 12/31/2299.
	Medicare Paid Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Modifier 1	Modifier 1 contains an invalid value.	Enter a valid Modifier Code.
Modifier 2	Modifier 2 contains an invalid value.	Enter a valid Modifier Code.
	Modifiers must be entered in sequence and no blank Modifiers are allowed between values.	Enter modifiers in sequence and do not skip modifier fields.
Modifier 3	Modifier 3 contains an invalid value.	Enter a valid Modifier Code.
	Modifiers must be entered in sequence and no blank Modifiers are allowed between values.	Enter modifiers in sequence and do not skip modifier fields.

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Field	Error Message	To Correct
Modifier 4	Modifier 4 contains an invalid value.	Enter a valid Modifier Code.
	Modifiers must be entered in sequence and no blank Modifiers are allowed between values.	Enter modifiers in sequence and do not skip modifier fields.
NDC	NDC contains invalid characters. Please enter only Numeric characters in this field.	Enter a NDC number that does not contain special characters.
	NDC is required. Please type or select a valid NDC.	Enter a valid National Drug Code, or select one from the Search panel.
Non Covered Charges	Non Covered Charges must be less than or equal to 999999.99.	Ensure the amount is not greater than $999,999.99.
	Non Covered Charges must be greater than or equal to 0.	Ensure that the amount is greater than or equal to 0.
Non Covered Days	Non Covered Days must be less than or equal to 9999.	Ensure that the number of days is not greater than 9999.
Occurrence Code	A valid Occurrence Code is required.	Enter a valid Occurrence Code if Occurrence is being added.
Operating Physician	A valid Operating Physician is required.	Enter a valid Operating Physician.
Paid Date	Paid Date is required.	Enter a Paid Date when TPL is being entered.
	Paid Date must be greater than or equal to 01/01/1900.	Enter a Paid Date greater than or equal to 01/01/1900.
	Paid Date must be less than or equal to 12/31/2299.	Enter a Paid Date less than or equal to 12/31/2299.
	Paid Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Recipient ID	Recipient ID is required and must be 13 digits.	Enter a valid 13 digit Recipient ID.
	Recipient ID must be numeric.	Enter a valid Recipient ID.
re-submit	Cannot resubmit failed adjusted claim. Please adjust and resubmit original claim.	Correct the claim and resubmit.
Service Location	A valid Service Location is required.	Enter a valid service location.

12.5.5 Institutional Claim Panel Extra Features

Field	Field Type
Carrier Name	Read-only field displays after Carrier Code field populated.

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Date of Birth	Read-only field displays after Recipient ID field populated.
NPI or MCD	Hyperlink appears after the Attending Phys, Referring Phys or Operating Physician field(s) is populated with a valid NPI number. The NPI or MCD link indicates the provider number type displayed in the main panel: National Provider Identification (NPI) or Medicaid (MCD) number. Clicking NPI or MCD displays the Provider ID / Number panel, from which users can switch the provider number displayed from NPI to MCD.
Provider ID	Read-only field displays the billing NPI number associated with the user's ID.
Provider Name	Read-only field associated with the Provider ID field.

12.5.6 Institutional Claim Panel Accessibility

12.5.6.1 To Access the Institutional Claim Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.

12.5.6.2 To Add on the Institutional Claim Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Enter the recipient's **Last Name**.	
3	Enter the recipient's **First Name**.	
4	Enter **Patient Account #**.	
5	Enter **Medical Record #**.	
6	Enter **Attending Phys** or click [Search] to select from list.	Clicking [Search] activates the Attending Phys Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
7	Enter **Referring Phys** or click [Search] to select from list.	Clicking [Search] activates the Referring Phys Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
8	Enter **Operating Physician** or click [Search] to select from list.	Clicking [Search] activates the Operating Physician Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
9	Enter **Service Location** or click [Search] to select from list.	Clicking [Search] activates the Service Location Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
10	Enter **Admitting Diagnosis** or Patient Reason for Visit and click [Search] to select from list.	Clicking [Search] activates the Admitting Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
11	Select **Claim Type** from drop down list.	
12	Select **Service Authorization** from drop down list.	
13	Select **Delay Reason** from drop down list.	
14	Enter **Type Of Bill**.	
15	Enter **From Date**.	
16	Enter **To Date**.	
17	Enter **Patient Status** or click [Search] to select from list.	Clicking [Search] activates the Patient Status Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
18	Enter **Admission Type** or click [Search] to select from list.	Clicking [Search] activates the Admission Type Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
19	Enter **Admission Date**.	
20	Enter **Admission Hour**.	
21	Enter **Discharge Time**.	
22	Enter **Covered Days**.	
23	Enter **Non Covered Days**.	
24	Enter **Birth Weight** of Baby 1.	
25	Enter **Birth Weight** of Baby 2.	
26	Enter **Birth Weight** of Baby 3.	
27	Click **Condition**.	Condition panel displays. Please refer to section 10.6.6.2 for step by step instructions on how to complete the Condition panel.
28	Click **Payer**.	Payer panel displays. Please refer to section 10.7.6.2 for step by step instructions on how to complete the Condition panel.
29	Click **Procedure**.	Procedure panel displays. Please refer to section 10.8.6.2 for step by step instructions on how to complete the Condition panel.
30	Click **Occurrence.**	Occurrence panel displays. Please refer to section 10.9.6.2 for step by step instructions on how to complete the Condition panel.

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Step	Action	Response
31	Enter **Sequence**.	
32	Enter **Diagnosis** or click [Search] to select from list.	Clicking [Search] activates the Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
33	Click **add** in Diagnosis section to add another diagnosis and repeat steps 28 thru 29.	Activates fields for entry of data or selection from lists.
34	Enter Primary E-code or click [Search] to select.	Clicking [Search] activates the Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
35	Click add E-Code in Diagnosis section to add another diagnosis and repeat steps 28 thru 29.	Activates fields for entry of data or selection from lists.
36	Click **add** in TPL section.	Activates fields for entry of data or selection from lists.
37	Enter **Policy Number**.	
38	Enter **Plan Name**.	
39	Select **Relationship to Insured** from drop down list.	
40	Enter **Carrier Code** or click [Search] to select from list.	Clicking [Search] activates the Carrier Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
41	Select **Payer Respons. Code** from drop down list.	
42	Enter TPL **Paid Date**.	
43	Enter policy holder **Last Name**.	
44	Enter policy holder **First Name, MI**.	
45	Enter policy holder **Date of Birth**.	
46	Click **add** in TPL section to add another TPL carrier and repeat steps 32 thru 39.	Activates fields for entry of data or selection from lists.
47	Enter **Medicare Paid Date**.	
48	Enter **Medicare Allowed Amount**.	
49	Enter **Medicare Paid Amount**.	
50	Enter **Lifetime Reserve Days**.	
51	Enter **Deductible Amount**.	
52	Enter **Coinsurance Amount**.	

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Step	Action	Response
53	Enter **Coinsurance Days**.	
54	Enter **From DOS**.	
55	Enter **To DOS**.	
56	Enter **Units**.	
57	Enter **Charges**.	
58	Enter **Non Covered Charges**.	
59	Enter **Revenue Code** or click [Search] to select from list.	Clicking [Search] activates the Revenue Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
60	Enter **HCPCS** or click [Search] to select from list.	Clicking [Search] activates the HCPCS Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
61	Enter **Unit Rates**.	
62	Enter **Modifiers** or click [Search] to select from list.	Clicking [Search] activates the Modifiers Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
63	Click **add** in Detail section to add another service line and repeat steps 48 thru 56.	Activates fields for entry of data or selection from lists.
64	Click **submit**.	Submits institutional claim.

64.5.1.1 To Update on the Institutional Claim Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **adjust, void** or **re-submit**.	Submits an adjustment, void or re-submits a denied institutional claim.

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12.6 Condition Panel

12.6.1 Condition Panel Narrative

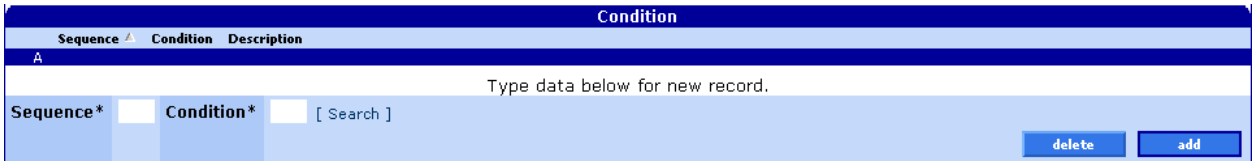
The Condition panel allows users to add condition information to an institutional claim.

Navigation Path: [Claims] – [Institutional] – [Condition]

NOTE:

Each field which contains an asterisk represents a required field after a user has clicked on 'add'. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data. If you do not wish to complete these fields, click 'delete'.

12.6.2 Condition Panel Layout



12.6.3 Condition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
delete	This button is used to delete data from a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
Condition	Displays the code used to identify conditions relating to a UB04 claim that may affect payer processing.	Field	Character	2
Sequence	Displays the sequence number which indicates the position in which the information occurs on the claim.	Field	Number (Integer)	2

12.6.4 Condition Panel Field Edit Error Codes

Field	Error Message	To Correct
Condition	A valid Condition is required.	Enter a valid condition if adding Conditions.
Sequence	Sequence is required.	Enter a valid Sequence number.

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Field	Error Message	To Correct
	Sequence must be greater than or equal to 1.	Ensure that the Sequence is greater than or equal to 1.
	Sequence must be Numeric.	Ensure the Sequence is numeric.
	Sequence contains duplicates.	Enter a unique Sequence.

12.6.5 Condition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.6.6 Condition Panel Accessibility

12.6.6.1 To Access the Condition Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Condition**.	Condition panel displays.

12.6.6.2 To Add on the Condition Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence**.	
3	Enter **Condition** or click [Search] to select from list.	Clicking [Search] activates the Condition Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	Click **submit**.	Submits institutional claim.

12.6.6.3 To Update on the Condition Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **submit**.	Submits institutional claim.

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12.7 Payer

12.7.1 Payer Panel Narrative

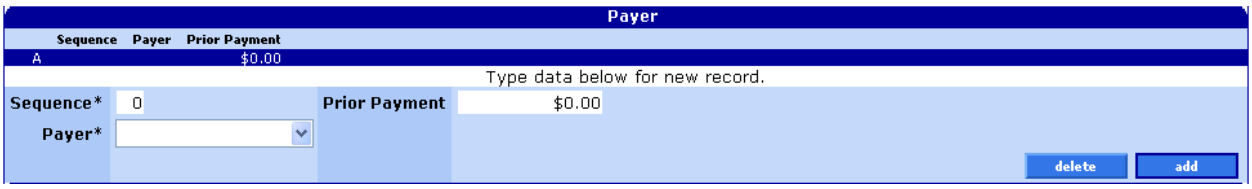
The Payer panel allows users to add payer information to an institutional claim.

Navigation Path: [Claims] – [Institutional] – [Payer]

NOTE:

Each field which contains an asterisk represents a required field after a user has clicked on 'add'. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data. If you do not wish to complete these fields, click 'delete'.

12.7.2 Payer Panel Layout



12.7.3 Payer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
delete	This button is used to delete data from a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
Payer	Displays if the payer is Medicaid, Medicare, or other third party.	Combo Box	Drop Down List Box	0
Prior Payment	Displays the amount that has been received prior to this billing from this payer.	Field	Number (Decimal)	9
Sequence	Displays the sequence number which indicates the position in which the information occurs on the claim.	Field	Number (Integer)	2

12.7.4 Payer Panel Field Edit Error Codes

Field	Error Message	To Correct
Payer	Payer is required.	Enter a valid payer if adding Payers.

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Field	Error Message	To Correct
Prior Payment	Prior Payment must be greater than $0.00.	Ensure that the amount is greater than 0.
	Prior Payment must be greater than or equal to $0.00	Ensure that the amount is greater than or equal to 0.
	Prior Payment must be less than or equal to 9999999.99.	Ensure that the amount is not greater than $9,999,999.99.
Sequence	Sequence is required.	Enter a valid sequence number.
	Sequence must be greater than or equal to 1.	Ensure that the sequence is greater than or equal to 1.
	Sequence must be less than or equal to 3.	Ensure that the sequence is greater than or equal to 3 on the Payer panel.
	Sequence must be Numeric.	Ensure the sequence is numeric.
	Sequence contains duplicates.	Enter a unique sequence.

12.7.5 Payer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.7.6 Payer Panel Accessibility

12.7.6.1 To Access the Payer Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Payer**.	Payer panel displays.

12.7.6.2 To Add on the Payer Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence**.	
3	Select **Payer** from drop down list.	
4	Enter **Prior Payment**.	
5	Enter **Estimated Amount Due**.	
6	Click **submit**.	Submits institutional claim.

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64.5.1.2 To Update on the Payer Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **submit**.	Submits institutional claim.

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12.8 ICD Procedures

12.8.1 ICD Procedures Panel Narrative

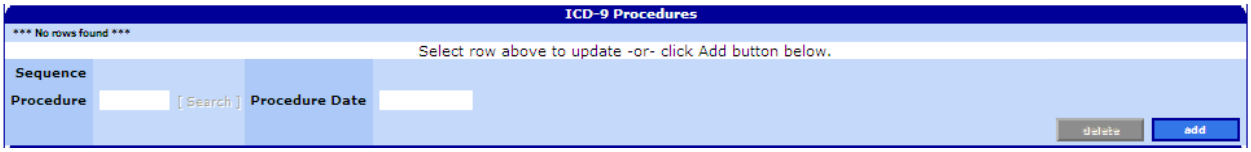
The ICD Procedures panel allows users to add surgical procedure information to an institutional claim.

Navigation Path: [Claims] – [Institutional] – [Procedure]

NOTE:

Each field which contains an asterisk represents a required field after a user has clicked on 'add'. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data. If you do not wish to complete these fields, click 'delete'.

12.8.2 ICD Procedures Panel Layout



12.8.3 ICD Procedures Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
delete	This button is used to delete data from a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
Description	Displays the Medical Description of surgical or diagnostic procedure.	Field	Alphanumeric	60
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Procedure	Displays the surgical code which identifies the service provided.	Field	Character	7
Procedure Date	Displays the date on which the surgical procedure code was performed.	Field	Date (MM/DD/CCYY)	10
Sequence	Displays the sequence number which indicates the position in which the information occurs on the claim.	Field	Number (Integer)	2

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12.8.4 ICD Procedures Panel Field Edit Error Codes

Field	Error Message	To Correct
Procedure	A valid Procedure is required.	Enter a valid ICD procedure.
Procedure Date	Procedure Date must be greater than or equal to 01/01/1990.	Enter a Procedure Date that is greater than or equal to 01/01/1990.
	Procedure Date must be less than or equal to 12/31/2299.	Enter a Procedure Date that is less than or equal to 12/31/2299.

12.8.5 ICD Procedures Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.8.6 ICD Procedures Panel Accessibility

12.8.6.1 To Access the ICD Procedures Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Procedure**.	ICD Procedures panel displays.

12.8.6.2 To Add on the ICD Procedures Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence**.	
3	Enter **Procedure** or click [Search] to select from list.	Clicking [Search] activates the Procedure ICD Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	Enter **Procedure Date**.	
5	Click **submit**.	Submits institutional claim.

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12.8.6.3 To Update on the ICD Procedures Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **submit**.	Submits institutional claim.

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12.9 Occurrence

12.9.1 Occurrence Panel Narrative

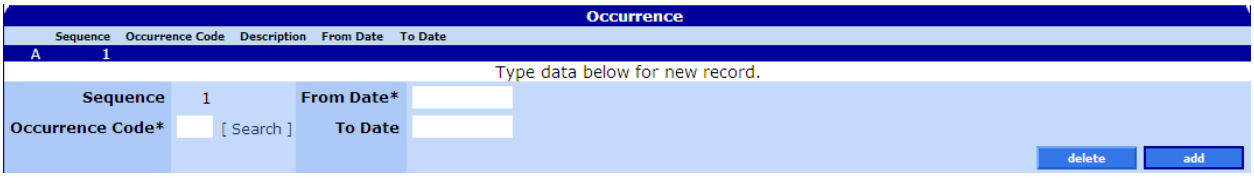
The Occurrence panel allows users to add occurrence and duration information to an institutional claim.

Navigation Path: [Claims] – [Institutional] – [Occurrence]

NOTE:

Each field which contains an asterisk represents a required field after a user has clicked on 'add'. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data. If you do not wish to complete these fields, click 'cancel'.

12.9.2 Occurrence Panel Layout



12.9.3 Occurrence Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
delete	This button is used to delete data from a panel (Diagnosis, Condition, Payer, Procedure, Occurrence, TPL and Detail).	Button	N/A	0
From Date	Displays the date on which the statement period on the claim began. Occurrence: The date when the occurrence code began.	Field	Date (MM/DD/CCYY)	10
Occurrence Code	Displays the code identifying a significant event relating to this bill that may affect payer processing.	Field	Character	2
Sequence	Displays the sequence number which indicates the position in which the information occurs on the claim.	Field	Number (Integer)	1

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Field	Description	Field Type	Data Type	Length
To Date	Displays the date on which the statement period on the claim ended. Occurrence: The date when the occurrence code ended.	Field	Date (MM/DD/CCYY)	10

12.9.4 Occurrence Panel Field Edit Error Codes

Field	Error Message	To Correct
From Date	From Date is required.	Enter a from date.
	From Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
	From Date must be greater than or equal to 01/01/1990.	Ensure From Date is greater than or equal to 01/01/1990.
	From Date must be less than or equal to 12/31/2299.	Ensure From Date is less than or equal to 12/31/2299.
Occurrence Code	A valid Occurrence Code is required.	Enter a valid Occurrence Code if Occurrence is being added.
Sequence	Sequence is required.	Enter a valid sequence number.
	Sequence must be greater than or equal to 1.	Ensure that the sequence is greater than or equal to 1.
	Sequence must be Numeric.	Ensure the sequence is numeric.
	Sequence contains duplicates.	Enter a unique sequence.
TO Date	From Date must be less than or equal to To Date.	From Date must be less than or equal to To Date.
	From Date must be greater than or equal to 01/01/1990.	Ensure From Date is greater than or equal to 01/01/1990.

12.9.5 Occurrence Panel Extra Features

Field	Field Type
No extra features found for this panel.	

12.9.6 Occurrence Panel Accessibility

12.9.6.1 To Access the Occurrence Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.

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Step	Action	Response
3	Click **Occurrence**.	Occurrence panel displays.

12.9.6.2 To Add on the Occurrence Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence**.	
3	Enter **Occurrence Code** or click [Search] to select from list.	Clicking [Search] activates the Occurrence Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	Enter **From Date**.	
5	Click **submit**.	Submits institutional claim.

12.9.6.3 To Update on the Occurrence Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **submit**.	Submits institutional claim.

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12.10 Pharmacy

12.10.1 Pharmacy Claim Panel Narrative

The Pharmacy panel allows a pharmacy provider to submit a claim and/or adjust or void a paid claim. The user has the capability to enter all of the required information to submit a pharmacy claim, including multiple detail lines for a compounded drug claim. For a paid claim, the user has the option of updating selected fields and re-submitting the claim as an adjustment or to void an entire claim.

The Pharmacy Claim panel includes the following sections:

- Pharmacy Claim
- Detail
- Claim Status Information
- Adjustment Information
- EOB Information

NOTE:

The Adjustment Information and EOB Information panels appear after a claim has been submitted.

Navigation Path: [Claim] – [Pharmacy] OR [Claim]-[click on Pharmacy link] OR [Claim] – [Search] - [search for pharmacy claims]-[select pharmacy claim from search results].

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data.

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12.10.2 Pharmacy Claim Panel Layout

Pharmacy Claim

Billing Information

ICN	
Provider ID	[illegible]
Provider Name	[illegible]
Recipient ID*	
Last Name*	
First Name*	
Date of Birth	
Prescriber License*	[Search]
Prescriber Name	
Pregnancy	Unknown
Nursing Facility	
Clarification Code 1	Not Specified
Clarification Code 2	Not Specified
Clarification Code 3	Not Specified
Other Coverage Code	Not Specified
TPL Date	
Compound Dispensing Unit	
Compound Dosage Code	

Prescription Information

Claim Type*	P - PHARMACY CLAIMS
Prescription Number*	
Date Dispensed*	
Date Prescribed*	
New/Refill*	
Days Supply*	0
Prescription Origin*	
Dispense/Written*	0-No Product Selection Indicated
Copay Exemption	
Prior Authorization #	
Diagnosis	[Search]

Charges

Gross Due Amt*	$0.00
Usual/Cust Amt	$0.00
TPL Amount	$0.00
Dispensing Fee	$0.00
Copay	$0.00
Total Paid Amount	$0.00
Patient Responsibility Amt	$0.00

DUR Overrides

Intervention	Not Specified
Outcome	Not Specified
Conflict Code	Not Specified

Compound Drug Claim Detail

Detail

Item	Status	NDC Code	Quantity
A 1			0

Type data below for new record.

Item	1	NDC Code*	[Search]
Detail Status		Ingred Cost*	$0.00
Quantity*	0		

delete add

Claim Status Information

Claim Status: Not Submitted

submit cancel

Claim Status Information

Claim Status	PAID
Claim ICN	[illegible]
Checkwrite Date	[illegible]
Allowed Amount	$94.07

EOB Information

Detail Number	Code	Description
0	9910	PHARMACY DISPENSING FEE APPLIED
1	9908	PRICING ADJUSTMENT - PHARMACY PRICING APPLIED

cancel void copy claim

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NOTE:

Section 12.10.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the pharmacy claim form. Please refer to section 12.10.6.2 for step by step instructions on how to complete the pharmacy claim form.

12.10.3 Pharmacy Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to the detail panel. Only 25 detail lines are allowed for compound claim types.	Button	N/A	0
adjust	This button submits adjustments for a paid claim.	Button	N/A	0
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
copy claim	This button creates a new claim from the current claim.	Button	N/A	0
delete	This button is used to delete data from the detail panel.	Button	N/A	0
re-submit	This button submits modifications made to a denied claim for adjudication.	Button	N/A	0
submit	This button submits a claim for adjudication.	Button	N/A	0
void	This button submits a void request for a paid claim.	Button	N/A	0
Adjustment Analyst ID	Displays the identification number of the analyst that adjusted the claim. (Read-Only)	Field	Alphanumeric	10
Adjustment Reason	Displays the adjustment reason code. (Read-Only)	Field	Number (Integer)	4
Allowed Amount	Amount approved to pay for services provided to a recipient on claim type 'P' Pharmacy Claims. (Read-Only)	Field	Number (Decimal)	9
Checkwrite Date	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	10
Claim ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13

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Field	Description	Field Type	Data Type	Length
Claim Status	Indicates the status after adjudication. Possible values are PAID, DENIED, SUSPENDED or ADJUSTED. The status of "Adjusted" reflects this claim is no longer paid. Refer to the Adjustment Information panel for claims which have reprocessed per the Adjustment process.	Field	N/A	0
Claim Status History Date	Displays the original claim date before the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Claim Type	Displays the code that specifies the type of claim.	Combo Box	Drop Down List Box	0
Clarification Code	Displays the code indicating that the pharmacist is clarifying the submission. Alabama recognizes a value of 8 for compound drugs.	Combo Box	Drop Down List Box	0
CoPay Amount	Displays the amount the recipient is to pay for services rendered. (Read-Only)	Field	Number (Decimal)	9
Copay Exemption	Select ‘Y’ (Yes) if the Medicaid recipient is a Native American Indian with an active user letter from the Indian Health Services. Otherwise this field is left “blank”.	Combo Box	Drop Down List Box	0
Code	Displays the explanation of benefits code. (Read-Only)	Field	Number (Integer)	4
Conflict Code	Displays the code for the drug utilization review conflict.	Combo Box	Drop Down List Box	0
Date Adjusted	Displays the date the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Date Dispensed	Displays the date on which a pharmacy filled a prescription for a recipient.	Field	Date (MM/DD/CCYY)	10
Date Prescribed	Displays the date on which physician prescribed a drug for a recipient.	Field	Date (MM/DD/CCYY)	10
Date of Birth	Displays the recipient's date of birth. (Read-Only and defaulted.)	Field	Date (MM/DD/CCYY)	10
Days Supply	Displays the number of days a prescribed drug should last a recipient.	Field	Number (Integer)	3
Denied Date	Displays the date the claim was denied. (Read-Only)	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Description	Displays the explanation of benefits description. (Read-Only)	Field	Character	79
Detail Number	Displays the line item detail number of the claim. (Read-Only)	Field	Number (Integer)	2
Detail Status	Displays the status of the detail line. (Read-Only)	Field	Alphanumeric	10
Diagnosis	Displays the diagnosis code.	Field	Alphanumeric	7
Dispense/Written	Displays the dispense as written indicator.	Combo Box	Drop Down List Box	0
Dispensing Fee	Displays the amount of the dispensing fee, if paid. Format 99999.99. (Read-Only)	Field	Number (Decimal)	7
First Name	Displays the first name of the recipient.	Field	Character	35
Gross Due Amt	Total Amount Billed or Sum of Ingredient Cost.	Field	Number (Decimal)	13
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced.The valid values are '9' for ICD-9, '0' for ICD-10 or blank if corresponding code is not present.	Combo Box	Drop Down List Box	1
ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Ingred Cost	Cost of an ingredient on a Compound drug claim detail.	Field	Number (Decimal)	13
Intervention	Displays the pharmacist's interaction when a conflict code has been established.	Combo Box	Drop Down List Box	0
Item	Displays the detail line number. (Read-Only)	Field	Number (Integer)	3
Last Name	Displays the last name of the recipient.	Field	Character	60
Location	Displays the place of service (POS) where the service was rendered.	Field	Number (Integer)	2
NDC Code	Displays the National Drug Code used to identify a specific drug.	Field	Alphanumeric	11
New/Refill	Displays if the prescription is new or a refill. '00' represents a "new" prescription.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Nursing Facility	Displays if the drug was prescribed in a nursing home facility.	Combo Box	Drop Down List Box	0
Other Coverage Code	Displays the code that indicates the recipient's primary insurance coverage status on the particular prescription being filled.	Combo Box	Drop Down List Box	0
Outcome	Indicates the action taken by the pharmacist after a drug utilization review warning is returned.	Combo Box	Drop Down List Box	0
Paid Date	Displays the date the claim was billed and paid. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Patient Responsibility Amt	The patient's cost share from a previous payer.	Field	Number(Decimal)	10
Pregnancy	Displays the code indicating the patient as pregnant or not pregnant.	Combo Box	Drop Down List Box	0
Prescriber License	Displays the license number of the provider who prescribed the drugs being administered to the recipient.	Field	Alphanumeric	10
Prescriber Name	Displays the name of the prescriber. (Read-Only and defaulted on header panel.)	Field	Alphanumeric	2
Prescription Number	Displays the number which uniquely identifies a drug dispensed to a recipient.	Field	Number (Integer)	7
Prior Authorization	Displays the Prior Authorization number.	Field	Alphanumeric	10
Provider ID	Displays the National Provider Identification number of the billing provider. (Read-Only and Defaulted.)	Field	Alphanumeric	10
Provider Name	Displays the name of the billing provider. (Read-Only and defaulted on header panel.)	Field	Alphanumeric	15
Quantity	Displays the number of units of a drug dispensed to a recipient.	Field	Number (Integer)	14
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	13
TPL Amount	Displays the dollar amount paid by a third party liability insurance.	Field	Number (Decimal)	14

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Field	Description	Field Type	Data Type	Length
TPL Date	Displays the date the third party paid towards the drug.	Field	Date (MM/DD/CCYY)	10
Total Paid Amount	Displays the total amount paid. (Read-Only)	Field	Number (Decimal)	13
Usual/Cust Amt	Amount charged to the Recipient.	Field	Number (Decimal)	13

12.10.4 Pharmacy Claim Panel Field Edit Error Codes

Field	Error Message	To Correct
add	Only 25 details are allowed for Compound claim types.	Add button will be disabled after 25 detail lines for Compound claim types.
adjust	Adjust was successful. See Claim Status Information for details.	Ensures that the claim adjustment request was sent successfully and status details can be viewed on the Claim Status Information panel.
copy claim	Copy was successful.	Ensures that the copy was successful and modifications can be made prior to submission.
submit	Submit was successful. See Claim Status Information for details.	Ensures that the claim was sent successfully and status details can be viewed on the Claim Status Information panel.
void	Void was successful. See Claim Status Information for details.	Ensures that the claim void request was sent successfully and status details can be viewed on the Claim Status Information panel.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 - 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
Date Dispensed	Date Dispensed is required.	Enter the dispensed date.
	Date Dispensed must be less than or equal to Today.	Enter a dispensed date that is less than or equal to today's date.
	Date Dispensed must be greater than or equal to 01/01/1990.	Enter a dispensed date that is greater than or equal to 01/01/1990.
	Date Dispensed must be less than or equal to 12/31/2299.	Enter a dispensed date that is less than or equal to 12/31/2299.

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Field	Error Message	To Correct
Date Prescribed	Date Prescribed is required.	Enter the prescribed date.
	Date Prescribed must be less than or equal to Today.	Enter a prescribed date that is less than or equal to today's date.
	Date Prescribed must be greater than or equal to 1/1/1990.	Enter a prescribed date that is greater than or equal to 1/1/1990.
	Date Prescribed must be less than or equal to 12/31/2299.	Enter a prescribed date that is less than or equal to 12/31/2299.
Days Supply	Days Supply is required.	Enter a Days Supply.
	Days Supply must be greater than 0.	Ensure that the days supply is greater than 0.
Diagnosis	Diagnosis contains an invalid value.	Enter a valid Diagnosis code, or use the search panel to search a valid code.
First Name	First Name is required.	Enter the recipient's first name.
Gross Due Amt	Gross Due Amt must be greater than or equal to .01.	Enter a dollar amount equal to or greater than $.01.
	Gross Due Amt must be equal to or greater than the Usual/Cust Amt	Verify the amount entered in the Gross Due Amt field is equal to or greater than the Usual/Cust Amt field.
	Gross Due Amt is Required	Enter the Gross Amount Due on the claim.
Ingred Cost	Ingred Cost must be less than or equal to 999999.99.	Enter a dollar amount equal to or less than 999999.99.
	Ingred Cost must be greater than or equal to 0.01.	Enter a dollar amount equal to or greater than $.01.
	Ingred Cost is required.	Ingredient Cost is required on each compound drug claim detail.
Last Name	Last Name is required.	Enter the recipient's last name.
NDC Code	A valid NDC Code is required.	Enter a valid NDC code.
New/Refill	New/Refill is required.	Enter a New/Refill.
	New/Refill must be Numeric.	Enter a valid numeric value.
Prescriber License	A valid Prescriber License is required.	Enter a valid prescriber license.
Prescription Number	Prescription Number is required.	Enter a prescription number.
	Prescription Number must be AlphaNumeric.	Enter a prescription number that contains alpha [A-Z] or numeric [0-9] values.

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Field	Error Message	To Correct
Quantity	Quantity must be less than or equal to 9999999.999.	Ensure the quantity billed is not greater than 9,999,999.999.
	Quantity must be greater than or equal to 0.001.	Ensure that the quantity is greater than or equal to 0.001.
	Quantity is required.	Enter the detail quantity.
Recipient ID	Recipient ID is required and must be 13 digits.	Enter a valid 13 digit Recipient ID.
	Recipient ID must be numeric.	Enter a valid Recipient ID.
TPL Amount	TPL Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	TPL Amount must be greater than or equal to 0.	Enter a TPL amount greater than or equal to 0.
TPL Date	TPL Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
	TPL Date must be greater than or equal to 1/1/1990.	Enter a TPL Date greater than or equal to 01/01/1900.
	TPL Date must be less than or equal to 12/31/2299.	Enter a TPL Date less than or equal to 12/31/2299.

12.10.5 Pharmacy Claim Panel Extra Features

Field	Field Type
Date of Birth	Read-only field displays after Recipient ID field populated.
Prescriber ID	Entering and tabbing through the Prescriber ID field displays the Prescriber Name field.
Provider ID	Read-only field displays the billing NPI number associated with the user's ID.
Provider Name	Read-only field associated with the Provider ID field.

12.10.6 Pharmacy Claim Panel Accessibility

12.10.6.1 To Access the Pharmacy Claim Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Pharmacy**.	Pharmacy Claim panel displays.

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12.10.6.2 To Add on the Pharmacy Claim Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Enter the recipient's **Last Name**.	
3	Enter the recipient's **First Name**.	
4	Enter **Prescriber License** or click [Search] to select from list.	Clicking [Search] activates the Prescriber License Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
5	Select **Pregnancy** indicator from drop down list.	
6	Select **Nursing Facility** indicator from drop down list.	
7	Select **Clarification Code** from drop down list.	
8	Select **Other Coverage Code** from drop down list.	
9	Enter **TPL Date**.	
10	Select **Claim Type** from drop down list.	
11	Enter **Prescription Number**.	
12	Enter **Date Dispensed**.	
13	Enter **Date Prescribed**.	
14	Enter **New/Refill**.	
15	Enter **Days Supply**.	
16	Select **Dispense / Written** from drop down list.	
17	Enter **Prior Authorization #**.	
18	Enter **Diagnosis** or click [Search] to select from list.	Clicking [Search] activates the Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
19	Enter **TPL Amount**.	
20	Select **Intervention** from drop down list.	
21	Select **Outcome** from drop down list.	
22	Select **Conflict Code** from drop down list.	
23	Enter **Quantity**.	
24	Enter **NDC Code** (without dashes) or click [Search] to select from list.	Clicking [Search] activates the NDC Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
25	Click **add** in Detail section to add another service line and repeat steps 24 thru 26.	Activates fields for entry of data or selection from lists.
26	Click **submit**.	Submits pharmacy claim.

12.10.6.3 To Update on the Pharmacy Claim Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **adjust, void** or **re-submit**.	Submits an adjustment, void or re-submits a denied pharmacy claim.

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12.11 Professional

12.11.1 Professional Claim Panel Narrative

The Professional panel allows a medical provider to submit a professional or crossover claim and/or adjust or void a paid claim. The user has the capability to enter all of the required information to submit a professional claim, to include multiple detail lines. For a paid claim, the user has the option of updating select fields and re-submitting the claim as an adjustment or to void the claim.

The Professional Claim panel includes the following sections:

- Professional Claim
- Diagnosis
- TPL
- Detail
- Claim Status Information
- Adjustment Information
- EOB Information

NOTE:

The Adjustment Information and EOB Information panels appear after a claim has been submitted.

Navigation Path: [Claim] - [Professional] OR [Claim] - [Click on Professional link] OR [Claim] – [Search] - [search for professional claims]-[select professional claim from search results]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the claim is not considered complete until those fields have been completed with the appropriate data.

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12.11.2 Professional Claim Panel Layout

Professional Claim

Billing Information

ICN
Provider ID
Provider Name
Recipient ID*
Last Name*
First Name*
Date of Birth
Medical Record #
Patient Account #
Referring Physician [Search]

Service Information

Claim Type* M - PROFESSIONAL CLAIMS
Service Authorization
Delay Reason
First Prenatal Visit
Last Menstrual Period

Related Causes

Cause 1
Cause 2

Charges

TPL Amount $0.00
Total Charges $0.00
Total Copay $0.00
Total Paid Amount $0.00

Diagnosis

	Sequence	ICD Version	Diagnosis	Description
A	1			

Type data below for new record.

Sequence 1
Diagnosis* [Search]

delete add

TPL

*** No rows found ***

Select row above to update -or- click Add button below.

Policy Number
Plan Name
Relationship to Insured
Carrier Code [Search]
Carrier Name
Payer Respons. Code Primary
Paid Date
Paid Amt
Deductible Amt
CoInsurance Amt
CoPay Amt

Policy Holder

Last Name
First Name, MI
Date of Birth

delete add

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Detail

	Item	Status	From DOS	To DOS	Procedure	Units	Charges	Paid Amount
A	1					0	$0.00	$0.00

Type data below for new record.

Item	1	POS*	[Search]
Detail Status		Procedure*	[Search]
From DOS*		Emergency	
To DOS*		EPSDT Ref	
Units*	0	Family Planning	
		Copay Exemption	
Charges*	$0.00	Allowed Amount	$0.00
Rendering Physician*	[Search]	CoPay Amount	$0.00
Diagnosis Code Pointer*		Paid Amount	$0.00
Modifier 1	[Search]		
Modifier 2	[Search]		
Modifier 3	[Search]		
Modifier 4	[Search]		
Referring Physician	[Search]	Ordering Physician	[Search]

Medicare Information

Medicare Paid Date		Coinsurance Amount	$0.00
Allowed Amount	$0.00	Deductible Amount	$0.00
Original Medicare Paid Amount	$0.00		
2% Sequestration Amount	$0.00	eRX Reduction Amount	$0.00
Final Medicare Paid Amount	$0.00	Medicare CoPay Amount	$0.00

delete add

NDC (Detail Item 1)

*** No rows found ***

Select row above to update -or- click Add button below.

NDC Sequence Number		Drug Unit Price	
NDC	[Search]	Unit Quantity Submitted	
UOM		Unit Quantity Calculated	
Prescription Number		Primary NDC	☐
Prescription Qualifier			

delete add

Third Party Payments (Detail Item 1)

*** No rows found ***

Select row above to update -or- click Add button below.

Carrier Code	
Paid Date	
Paid Amt	
Deductible Amt	
CoInsurance Amt	
CoPay Amt	

delete add

Claim Status Information

Claim Status Not Submitted

submit cancel

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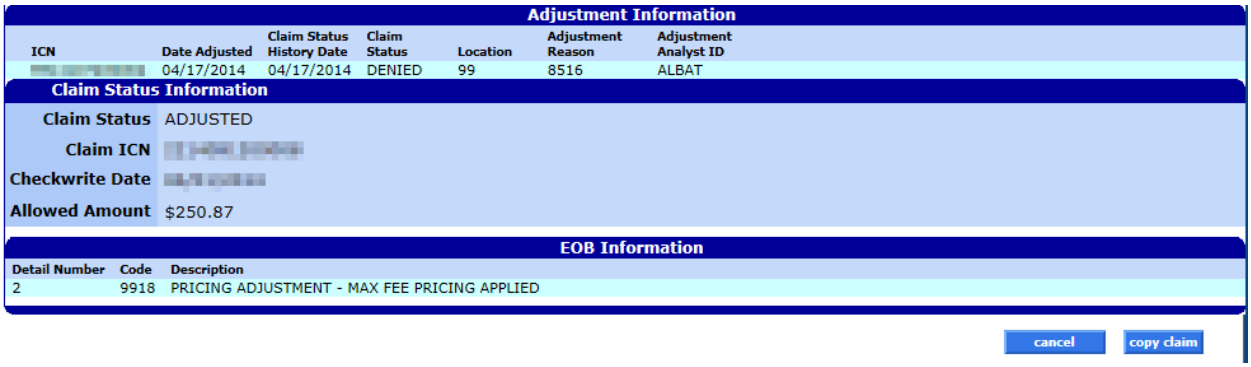

NOTE:

This Section 12.11.3 acts as a reference guide to further define each field, listed in alphabetical order, and the buttons available on the professional claim form. Please refer to section 12.11.6.2 for step by step instructions on how to complete the professional claim form.

12.11.3 Professional Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
2% Sequestration Amount	The dollar amount of the 2% sequestration as required by the Affordable Care Act (ACA)	Field	Number (Decimal)	8
add	This button is used to add data to a panel (Diagnosis, TPL and Detail). This button becomes disabled in the Diagnosis panel after eight diagnoses have been added, and in the Detail panel after 50 details have been added.	Button	N/A	0
adjust	This button submits adjustments for a paid claim.	Button	N/A	0
Adjustment Analyst ID	Displays the identification number of the analyst that adjusted the claim. (Read-Only)	Field	Alphanumeric	10

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Field	Description	Field Type	Data Type	Length
Adjustment Reason	Displays the adjustment reason code. (Read-Only)	Field	Number (Integer)	4
Allowed Amount	Displays the amount approved to pay for services provided to a recipient. (Read-Only) Medicare: Displays the amount allowed by Medicare.	Field	Number (Decimal)	10
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
Carrier Code	Displays the 5-digit carrier code that identifies the recipient's TPL insurance plan.	Field	Number (Integer)	10
Carrier Name	Displays the carrier name based on the carrier code entered. (Read-Only)	Field	Character	45
Cause 1	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.	Combo Box	Drop Down List Box	0
Cause 2	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.	Combo Box	Drop Down List Box	0
Charges	Displays the usual and customary charge for the service provided.	Field	Number (Decimal)	13
Checkwrite Date	This is the date the claim is finalized through adjudication. This is not the date the funds are released.	Field	Date (MM/DD/CCYY)	10
Claim ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Claim Status	Indicates the status after adjudication. Possible values are PAID, DENIED, SUSPENDED or ADJUSTED. The status of "Adjusted" reflects this claim is no longer paid. Refer to the Adjustment Information panel for claims which have reprocessed per the Adjustment process.	Field	N/A	0
Claim Status History Date	Displays the original claim date before the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Claim Type	Displays the code and description that specifies the type of claim.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Code	Displays the explanation of benefits code. (Read-Only)	Field	Number (Integer)	4
Coinsurance Amount	Displays the amount which represents the recipients' coinsurance payment.	Field	Number (Decimal)	1
CoPay Amount	Displays the amount the recipient is to pay for services rendered. (Read-Only)	Field	Number (Decimal)	9
Copay Exemption	Enter 'Y' (Yes) if the Medicaid recipient is a Native American Indian with an active user letter from the Indian Health Services. Otherwise this field is left "blank".	Combo Box	Drop Down List	0
copy claim	This button creates a new claim from the current claim.	Button	N/A	0
Date Adjusted	Displays the date the claim was adjusted. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Date of Birth	Header: Displays the recipient's date of birth. (Read-Only and defaulted.) TPL: Displays the date of birth of the third party policy holder	Field	Date (MM/DD/CCYY)	10
Deductible Amount	Displays the amount the recipient must pay before Medicare.	Field	Number (Decimal)	10
Delay Reason	Displays the delay reason codes that are used by specific Medicaid providers. These do not affect hospitals, State Mental Health or Nursing Home providers. These delay reasons cannot override claims over the year past filing limit.	Combo Box	Drop Down List Box	0
delete	This button is used to delete data from a panel (Diagnosis, TPL and Detail).	Button	N/A	0
Denied Date	Displays the date the claim was denied. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Description	Displays the explanation of benefits description. (Read-Only)	Field	Alphanumeric	79
Detail Number	Displays the line item detail number of the claim. (Read-Only)	Field	Number (Integer)	2
Detail Status	Displays the status of the detail line. (Read-Only).	Field	Alphanumeric	10
Diagnosis	Displays the diagnosis code.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
Diagnosis Code Pointer	Indicates which diagnosis (or diagnoses) for which services were provided. If a diagnosis code was entered, enter the matching sequence number as seen on the 'Diagnosis' panel to indicate which diagnosis the procedure is a result of.	Field	Alphanumeric	2
Diagnosis Code Pointer 2	Indicates which diagnosis (or diagnoses) for which services were provided. If a diagnosis code was entered, enter the matching sequence number as seen on the 'Diagnosis' panel to indicate which diagnosis the procedure is a result of.	Field	Alphanumeric	2
Diagnosis Code Pointer 3	Indicates which diagnosis (or diagnoses) for which services were provided. If a diagnosis code was entered, enter the matching sequence number as seen on the 'Diagnosis' panel to indicate which diagnosis the procedure is a result of.	Field	Alphanumeric	2
Diagnosis Code Pointer 4	Indicates which diagnosis (or diagnoses) for which services were provided. If a diagnosis code was entered, enter the matching sequence number as seen on the 'Diagnosis' panel to indicate which diagnosis the procedure is a result of.	Field	Alphanumeric	2
Drug Unit Price	Price per unit of product.	Field	Number (Decimal)	19
Emergency	Displays if the service was provided as the result of an emergency situation.	Combo Box	Drop Down List Box	0
EPSDT Ref	Displays if the service being billed is due to an EPSDT referral.	Combo Box	Drop Down List Box	0
eRX Reduction Amount	The dollar amount of the eRX reduction.	Field	Number (Decimal)	9
Family Planning	Displays if the service is family planning related.	Combo Box	Drop Down List Box	0
Final Medicare Paid Amount.	The dollar amount paid by Medicare for the services provided. The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.	Field	Number (Decimal)	10
First Name	Displays the first name of the recipient on the header.	Field	Character	35

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Field	Description	Field Type	Data Type	Length
First Name, MI	Displays the first name and middle initial of third party policy holder.	Field	Character	35
From DOS	Displays the beginning date on which service was provided.	Field	Date (MM/DD/CCYY)	10
ICD	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
ICN	Displays the claim's internal control number (ICN) issued by Medicaid. (Read-Only)	Field	Number (Integer)	13
Item	Displays the line item number. (Read-Only)	Field	Number (Integer)	3
Last Name	Displays the last name of the recipient. TPL: Displays the last name of third party policy holder	Field	Character	60
Medical Record#	Displays the medical record number assigned to the recipient by the provider for the service that was performed.	Field	Alphanumeric	50
Medicare CoPay Amount	Medicare advanced copay amount.	Field	Number (Decimal)	8
Medicare Paid Date	Displays the date Medicare paid for the services rendered.	Field	Date (MM/DD/CCYY)	10
Modifier 1	Displays the first modifier when applicable.	Field	Alphanumeric	2
Modifier 2	Displays the second modifier when applicable.	Field	Alphanumeric	2
Modifier 3	Displays the third modifier when applicable.	Field	Alphanumeric	2
Modifier 4	Displays the fourth modifier when applicable.	Field	Alphanumeric	2
NDC	National Drug Code.	Field	Number (Integer)	16
NDC Sequence Number	Number of the detail on the claim record. Display Only.	Field	Number (Integer)	4
Original Medicare Paid Amount	The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
Paid Amount	Detail: Displays the dollar amount paid by Medicaid for the services. (Read-Only) Medicare: Displays the amount paid by Medicare	Field	Character	1
Paid Date	Displays the date the claim was billed and paid. (Read-Only) TPL: Displays the date the third party paid for the services rendered.	Field	Date (MM/DD/CCYY)	10
Patient Account#	Displays the identification for a recipient assigned by a provider and used in their system.	Field	Alphanumeric	38
Payer Respons. Code	Value identifying the third payer's level of responsibility on this claim.	Combo Box	Drop Down List Box	0
Plan Name	Displays the TPL plan name.	Field	Alphanumeric	60
Policy Number	Displays the TPL policy number.	Field	Alphanumeric	30
POS	Displays the place of service (POS) where the service was rendered.	Field	Number (Integer)	2
Prescription Number	The prescription number.	Field	Character	50
Prescription Qualifier	The prescription qualifier.	Field	Character	3
Primary NDC	Indicates the selected NDC is the primary NDC.	Check Box	N/A	0
Procedure	Displays the code which identifies the service provided.	Field	Alphanumeric	6
Provider ID	Displays the National Provider Identification number of the billing provider. (Read-Only and Defaulted.)	Field	Alphanumeric	10
Provider Name	Displays the name of the billing provider. (Read Only and defaulted on header panel.)	Field	Alphanumeric	15
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	13
Referring Physician	Displays the identification number of the referring physician.	Field	Alphanumeric	10
Relationship to Insured	Displays the third party liabilities insured relationship.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Rendering Physician	Displays the rendering (performing) provider's NPI number.	Field	Alphanumeric	10
re-submit	This button submits modifications made to a denied claim for adjudication.	Button	N/A	0
Sequence	Displays the sequence number which indicates the position in which the diagnosis information occurs on the claim.	Field	Alphanumeric	2
Service Authorization	Displays the type of maternity override or if the service was due to an emergency.	Combo Box	Drop Down List Box	0
submit	This button submits a claim for adjudication.	Button	N/A	0
To DOS	Displays the ending date on which service was provided.	Field	Date (MM/DD/CCYY)	10
Total Charges	Displays the total amount charged for the claim. (Read-Only and calculated from Detail Charges.)	Field	Number (Decimal)	13
Total Copay	Displays the total amount the recipient is to pay for services rendered. (Read-Only)	Field	Number (Decimal)	9
Total Paid Amount	Displays the total amount paid. (Read-Only).	Field	Number (Decimal)	13
TPL Amount	Displays the dollar amount paid by third party liability.	Field	Number (Decimal)	14
Unit Quantity Calculated	The unit quantity calculated.	Field	Number (Decimal)	18
Unit Quantity Submitted	The unit count that the provider submitted. The Drug units.	Field	Number (Decimal)	18
Units	Displays the units of service on this detail.	Field	Number (Integer)	12
UOM	Unit of Measure. Code specifying the units in which a value is being expressed.	Combo Box	Character	0
void	This button submits a void request for a paid claim.	Button	N/A	0

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12.11.4 Professional Claim Panel Field Edit Error Codes

Field	Error Message	To Correct
2% Sequestration Amount	2% Sequestration Amount must be less than or equal to $ 99999.99	Ensure that the amount is less than or equal to $99999.99.
	2% Sequestration Amount must be greater than or equal to $-99999.99.	Ensure that the amount is greater than or equal to $-99999.99.
adjust	Adjust was successful. See Claim Status Information for details.	Ensures that the claim adjustment request was sent successfully and status details can be viewed on the Claim Status Information panel.
Copy claim	Copy was successful.	Ensures that the copy was successful and modifications can be made prior to submission.
Submit	Submit was successful. See Claim Status Information for details.	Ensures that the claim was sent successfully and status details can be viewed on the Claim Status Information panel.
Void	Void was successful. See Claim Status Information for details.	Ensures that the claim void request was sent successfully and status details can be viewed on the Claim Status Information panel.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 – 9; date fields must only contain valid dates; character fields must only contain A – Z; alphanumeric fields must only contain A – Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
	Exceed maximum number of details.	Ensure that the maximum number of details are not exceeded – 50 detail lines.
	Exceed maximum number of diagnoses.	Ensure that the maximum number of diagnoses are not exceeded – 8 diagnosis lines.
Allowed Amount	Allowed Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	Allowed Amount must be greater than or equal to 0.01.	Ensure that the amount is greater than or equal to 0.01.
Carrier Code	Carrier Code is required.	Enter a valid Carrier Code.
Charges	Charges must be less than or equal to 9999999.99.	Ensure the amount is not greater than $9,999,999.99.
	Charges must be greater than or equal to 0.01.	Ensure that the amount is greater than or equal to 0.01.
	Charges is required.	Enter the detail charges.

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Field	Error Message	To Correct
Coinsurance Amount	Coinsurance Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
Date of Birth	Date of Birth is required.	Enter a date of birth in the TPL panel.
	Date Of Birth must be less than or equal to Today.	Ensure that the Date of Birth, on the TPL panel, is on or before today's date.
	Date of Birth must be greater than or equal to 01/01/1900.	Enter a Date of Birth greater than or equal to 01/01/1900.
	Date of Birth must be less than or equal to 12/31/2299.	Enter a Date of Birth less than or equal to 12/31/2299.
Deductible Amount	Deductible Amount must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
	Either Coinsurance Amount or Deductible Amount must be greater than $0.00.	Ensure either the Coinsurance or Deductible Amount is greater than $0.00.
Diagnosis	A valid Diagnosis is required.	Enter a diagnosis code.
Diagnosis Code Pointer	Diagnosis indicator must be less than or equal to number of diagnosis on the claim.	Ensure all of the numbers in any of the Diagnosis Code Pointer fields are less than or equal to the total number of diagnoses on the claim.
	Diagnosis Code Pointer cannot contain duplicate values.	Ensure the Diagnosis Code Pointer fields do not contain the same number for the same claim detail.
	Diagnosis Code Pointer is required.	Enter a diagnosis code pointer.
	Boxes must be completed left to right and cannot be skipped. At least one diagnosis indicator is required on each detail.	Verify the value and make sure all left side diagnosis indicator box is filled with value.
eRX Reduction Amount	eRX Reduction Amount must be less than or equal to 99999999.99.	Ensure that the amount is less than or equal to 9999999.99.
	eRX Reduction Amount must be greater than or equal to 9999999.99.	Ensure that the amount is greater than or equal to -9999999.99.
First Name	First Name is required.	Enter the recipient's first name.
First Name, MI	First Name is required.	Enter a First Name when TPL is applicable.
Final Medicare Paid Amount	Final Medicare Paid Amount must be less than or equal to 99999999.99.	Ensure that the amount is not greater than $99,999,999.99.

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Field	Error Message	To Correct
	Final Medicare Paid Amount must be greater than or equal to 9999999.99.	Ensure that the amount is greater than or equal to -9999999.99.
From DOS	From DOS is required.	Enter a from date of service.
	From DOS must be less than or equal to To DOS.	Ensure From DOS is less than or equal to the To DOS.
	From DOS must be less than or equal to Today.	Ensure that the date is on or before today's date.
	From DOS must be greater than or equal to 01/01/1990.	Enter a From date of service that is greater than or equal to 01/01/1990.
	From DOS must be less than or equal to 12/31/2299.	Enter a From date of service that is less than or equal to 12/31/2299.
ICD Version	ICD Version for Diagnosis codes should be the same type.	Ensure version type of all diagnosis codes are same.
Last Name	Last Name is required.	Header: Enter the recipient's last name. TPL: Enter a last name when TPL is applicable.
Medicare Copay Amount	Copay must be less than or equal to 999999.99.	Ensure that the amount is not greater than $999,999.99.
Medicare Paid Date	Medicare Paid Date is required.	Enter a Medicare Paid Date when crossover information is entered.
	Medicare Paid Date must be greater than or equal to 01/01/1990.	Enter a Medicare Paid Date greater than or equal to 01/01/1990.
	Medicare Paid Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Modifier 1	Modifier1 contains an invalid value.	Enter a valid Modifier Code.
Recipient ID	Recipient ID is required and must be 13 digits.	Enter a valid 13 digit Recipient ID.
	Recipient ID must be numeric.	Enter a valid Recipient ID.
re-submit	Cannot resubmit failed adjusted claim. Please adjust and resubmit original claim.	Correct the claim and resubmit.

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12.11.5 Professional Claim Panel Extra Features

Field	Field Type
Carrier Name	Read-only field displays after Carrier Code field populated.
Date of Birth	Read-only field displays after Recipient ID field populated.
NPI or MCD	Hyperlink appears after the Referring Physician or Rendering Physician field(s) is populated with a valid NPI number. The NPI or MCD link indicates the provider number type displayed in the main panel: National Provider Identification (NPI) or Medicaid (MCD) number. Clicking NPI or MCD displays the Provider ID / Number panel, from which users can switch the provider number displayed from NPI to MCD.
Provider ID	Read-only field displays the billing NPI number associated with the user's ID.
Provider Name	Read-only field associated with the Provider ID field.

12.11.5 Professional Claim Panel Accessibility

12.11.6.1 To Access the Professional Claim Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Professional**.	Professional Claim panel displays.

12.11.6.2 To Add on the Professional Claim Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Enter the recipient's **Last Name**.	
3	Enter the recipient's **First Name**.	
4	Enter **Medical Record #**.	
5	Enter **Patient Account #**.	
6	Enter **Referring Physician** or click [Search] to select from list.	Clicking [Search] activates the Referring Physician Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
7	Select **Claim Type** from drop down list.	
8	Select **Service Authorization** from drop down list.	
9	Select **Delay Reason** from drop down list.	
10	Select **Cause 1** accident related cause indicator from drop down list.	
11	Select **Cause 2** accident related cause indicator from drop down list.	

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Step	Action	Response
12	Enter **TPL Amount**.	
13	Enter **Sequence**.	
14	Enter **Diagnosis** or click [Search] to select from list.	Clicking [Search] activates the Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
15	Click **add** in TPL section.	Activates fields for entry of data or selection from lists.
16	Enter **Policy Number**.	
17	Enter **Plan Name**.	
18	Select **Relationship to Insured** from drop down list.	
19	Enter **Carrier Code** or click [Search] to select from list.	Clicking [Search] activates the Carrier Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
20	Select **Payer Respons. Code** from drop down list.	
21	Enter TPL **Paid Date**.	
22	Enter policy holder **Last Name**.	
23	Enter policy holder **First Name, MI**.	
24	Enter policy holder **Date of Birth**.	
25	Enter **From DOS**.	
26	Enter **To DOS**.	
27	Enter **Units**.	
28	Enter **Charges**.	
29	Enter **Rendering Physician** or click [Search] to select from list.	Clicking [Search] activates the Rendering Physician Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
30	Enter **Diagnosis Code Pointer**(s).	
31	Enter **Modifier**(s) or click [Search] to select from list. (Maximum of 4 can be added)	Clicking [Search] activates the Modifiers Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
32	Enter **Referring Physician** or click [Search] to select from list.	Clicking [Search] activates the Referring Physician Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
33	Enter **POS** or click [Search] to select from list.	Clicking [Search] activates the POS Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
34	Enter **Procedure** or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
35	Select **Emergency** indicator from drop down list.	
36	Select **EPSDT Ref** indicator from drop down list.	
37	Select **Family Planning** indicator from drop down list.	
38	Select **Copay Exemption** indicator from drop down list.	
39	Enter **Medicare Paid Date**.	
40	Enter Medicare **Allowed Amount**.	
41	Enter **Original Medicare Paid Amount**.	
42	Enter Medicare **2% Sequestration Amount**.	
43	Enter Medicare **eRX Reduction Amount**.	
44	Enter Medicare **Coinsurance Amount**.	
45	Enter Medicare **Deductible Amount**.	
46	Enter Medicare **Final Medicare Paid Amount**.	
47	Click **add** in Detail section to add another service line and repeat steps 25 thru 42.	Activates fields for entry of data or selection from lists.
48	Click **submit**.	Submits professional claim.

12.11.6.3 To Update on the Professional Claim Panel

Step	Action	Response
1	Click row to update.	
2	Click in field(s) to update and perform update.	
3	Click **adjust, void** or **re-submit**.	Submits an adjustment, void or re-submits a denied professional claim.

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13. Eligibility

The Eligibility and Verification Request (270 transaction) and Response (271 transaction) web pages are used by the provider to request and receive eligibility verification information for a recipient.

The HouseHold Inquiry request and response web pages are used by the provider to obtain a household member's recipient identification number using the parent/guardian's identification number and the household member's date of birth.

From the Eligibility link in the Main Menu toolbar, users can access the following Sub Menu options:

- Eligibility Verification
- HouseHold Inquiry

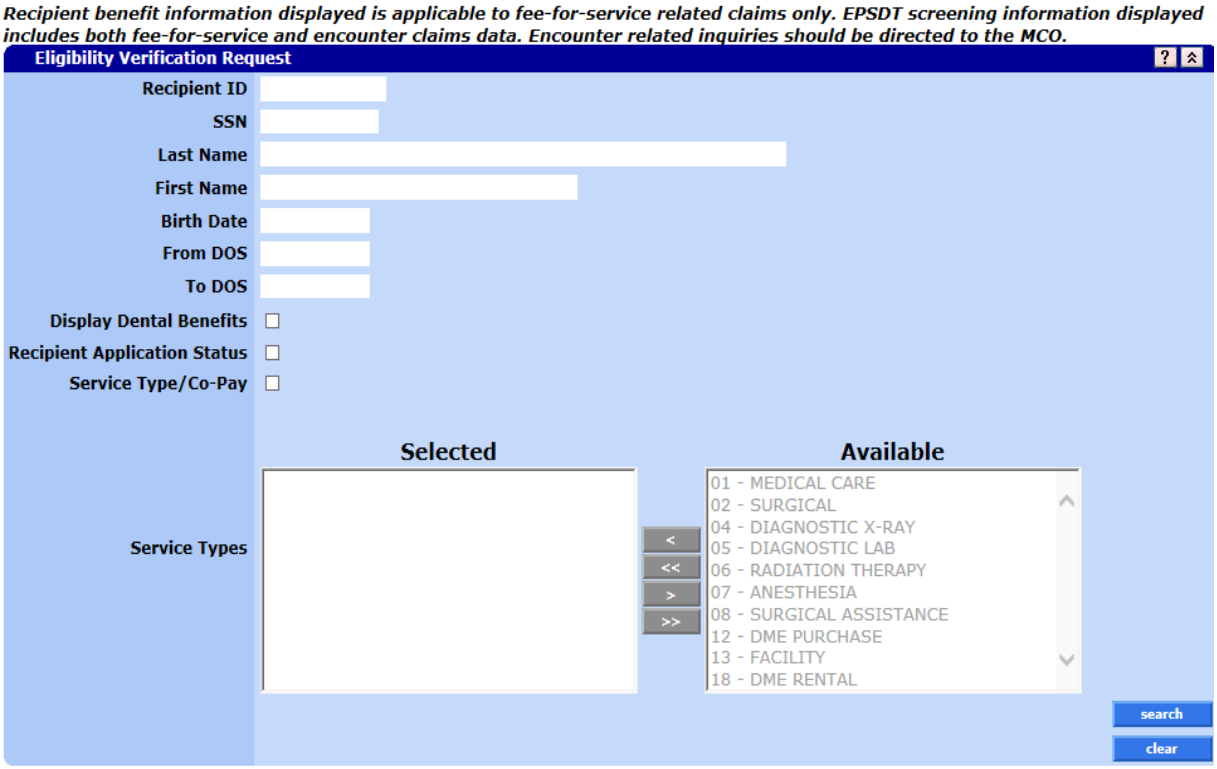
13.1 Eligibility Verification

13.1.1 Eligibility Verification Request Panel Narrative

The Eligibility panel allows users to verify eligibility of recipients for Alabama Medicaid.

Navigation Path: [Eligibility] – [Eligibility Verification]

13.1.2 Eligibility Verification Request Panel Layout



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13.1.3 Eligibility Verification Request Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears all search criteria fields.	Button	N/A	0
search	This button initiates the search process.	Button	N/A	0
Birth Date	Displays the date of birth of the recipient.	Field	Date (MM/DD/CCYY)	10
Display Dental Benefits	If the check box is selected, the user will see all non-dental and dental benefits. If the check box is not selected, then the user will only see non-dental benefits	Check box	N/A	N/A
First Name	Displays the first name of the recipient.	Field	Character	35
From DOS	Displays the from date of service.	Field	Date (MM/DD/CCYY)	10
Last Name	Displays the last name of the recipient.	Field	Character	60
Recipient Application Status	If the check box is selected, the user will see Recipient Application Status Information. If the check box is not selected, then the panel will be hidden.	Check box	N/A	N/A
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	12
Service Type/Co-Pay	Determines if the Service Type/Co-Pay panel will be included in the search results	Check box	N/A	N/A
Service Types	The service types to include in the eligibility search	Available /Select	N/A	N/A
SSN	Displays the social security number of the recipient. Ex. 000-12-1234.	Field	Number (Integer)	11
To DOS	Displays the thru date of service.	Field	Date (MM/DD/CCYY)	10
Recipient Application Status	If the Check Box is selected, the user will see Recipient Application Status Information. If the check box is not selected, then the panel will be hidden	Check box	N/A	N/A

13.1.4 Eligibility Verification Request Panel Field Edit Error Codes

Field	Error Message	To Correct
search	At least one search field should be entered for search criteria.	Enter at least one search field to complete the search request.

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Field	Error Message	To Correct
Birth Date	Recipient last name, first name, and date of birth are required if there is no SSN or Recipient ID.	Enter the recipient's Last Name, First Name and DOB.
	No Recipient match using search criteria Last Name: [], First Name: [], and DOB: [].	Ensure search criteria are correct or attempt the search with the Recipient ID.
	No Recipient match using search criteria SSN: [] and DOB: [].	Ensure search criteria are correct or attempt the search with the Recipient ID.
First Name	Recipient last name, first name, and date of birth are required if there is no SSN or Recipient ID.	Recipient last name, first name, and date of birth are required if there is no SSN or Recipient ID.
	No Recipient match using search criteria Last Name: [], First Name: [], and DOB: [].	Ensure search criteria are correct or attempt the search with the Recipient ID.
From DOS	The from and to dates of service must be in a 13 month window.	Date must not be greater than 13 months in the past.
	The to date of service must be on or after the from date of service.	Ensure From DOS is less than or equal to the To DOS.
	Future eligibility cannot be requested.	Enter a date of service that is equal to or less than the current date.
	Service Dates not within Provider Plan Enrollment.	Enter a From Date of Service that is within the provider's active enrollment period.
Last Name	Recipient last name, first name, and date of birth are required if there is no SSN or Recipient ID.	Recipient last name, first name, and date of birth are required if there is no SSN or Recipient ID.
	No Recipient match using search criteria Last Name: [], First Name: [], and DOB: [].	Ensure search criteria are correct or attempt the search with the Recipient ID.
Recipient ID	Recipient ID is Invalid or not Active.	Ensure the Recipient ID is correct and try again. If correct, contact the Provider Assistance Center for further information. (800-688-7989)
SSN	No Recipient match using search criteria SSN: [] and DOB: [].	Ensure search criteria are correct or attempt the search with the Recipient ID.
To DOS	The from and to dates of service must be in a 13 month window.	Date must not be greater than 13 months in the past.
	The to date of service must be on or after the from date of service.	Ensure From DOS is less than or equal to the To DOS.
	Future eligibility cannot be requested.	Enter a date of service that is equal to or less than the current date.
	Service Dates not within provider plan enrollment.	Enter a To Date of Service that is within the provider's active enrollment period.

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13.1.5 Eligibility Verification Request Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.1.6 Eligibility Verification Request Panel Accessibility

13.1.6.1 To Access the Eligibility Verification Request Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.

13.1.6.2 To Search on the Eligibility Verification Request Panel

Step	Action	Response
1	Enter one or a combination of the following fields: **Recipient ID**, **SSN**, **Last Name**, **First Name**, **Birth Date**, **From DOS** and/or **To DOS**.	
2	Click **search**.	Displays Recipient Eligibility Information for the requested timeframe.

NOTE:

"No rows found" indicates a match was not identified based on the search criteria. A user can refine his or her search or contact the DXC Provider Assistance Center at 1 (800) 688-7989 for additional assistance during normal business hours; Monday – Friday from 8:00am – 5:00pm CST.

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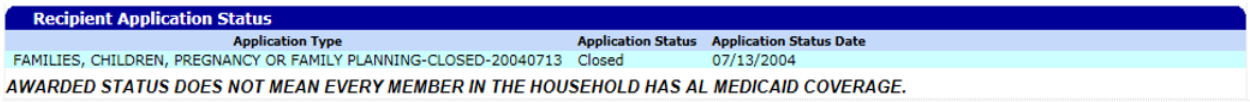
13.2 Recipient Application Status

13.2.1 Recipient Application Status Panel Narrative

Provides the latest status on a Recipient's application to the Medicaid program.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.2.2 Recipient Application Status Panel Layout



Recipient Application Status

Application Type	Application Status	Application Status Date
FAMILIES, CHILDREN, PREGNANCY OR FAMILY PLANNING-CLOSED-20040713	Closed	07/13/2004

AWARDED STATUS DOES NOT MEAN EVERY MEMBER IN THE HOUSEHOLD HAS AL MEDICAID COVERAGE.

13.2.3 Recipient Application Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Application Status	Displays the most current status of a specific Medicaid application.	Field	Character	1
Application Status Date	Displays the last or most recent date an application status was updated.	Field	Date (MM/DD/CCYY)	10
Application Type	Displays the type of Medicaid application a recipient has applied for.	Field	Character	50

13.2.4 Recipient Application Status Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.2.5 Recipient Application Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.2.6 Recipient Application Status Panel Accessibility

13.2.6.1 To Access the Recipient Application Status Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Recipient Application Status panel displays.

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13.3 Recipient Information

13.3.1 Recipient Information Panel Narrative

The Recipient Information panel displays basic information about the recipient.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.3.2 Recipient Information Panel Layout

13.3.3 Recipient Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Authorization Code	Displays the authorization number for the eligibility transaction. Also called a Verification Number.	Field	Alphanumeric	10
Birth Date	Displays the date of birth of the recipient.	Field	Date (MM/DD/CCYY)	10
Eligibility Indicator	Displays the HIPAA eligibility indicators if the recipient is ‘Active’ or ‘Inactive’.	Field	Alphanumeric	10
First Name	Displays the first name of the recipient.	Field	Character	20
Gender	Displays the recipient’s gender.	Field	Alphanumeric	1
Medicare ID	Displays the recipient’s Medicare IDnumber.	Field	Alphanumeric	15
Last Name	Displays the last name of the recipient.	Field	Character	30
Medicare A	Displays the dates the recipient is eligible for Medicare Part A.	Field	Date (MM/DD/CCYY)	10
Medicare B	Displays the dates the recipient is eligible for Medicare Part B.	Field	Date (MM/DD/CCYY)	10
Recipient ID	Displays the recipient’s Medicaid identification number.	Field	Number (Integer)	13
SSN	Displays the social security number (SSN) of the recipient.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Transaction Date	Displays the date the eligibility transaction was performed.	Field	Date (MM/DD/CCYY)	10
Transaction Time	Displays the time that the eligibility transaction was performed.	Field	Alphanumeric	8

13.3.4 Recipient Information Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.3.5 Recipient Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.3.6 Recipient Information Panel Accessibility

13.3.6.1 To Access the Recipient Information Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Recipient Information panel displays.

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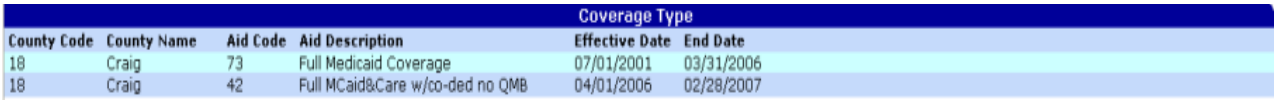
13.4 Coverage Type

13.4.1 Coverage Type Panel Narrative

The Coverage Type panel displays specific information about the recipient's coverage type.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.4.2 Coverage Type Panel Layout



Coverage Type

County Code	County Name	Aid Code	Aid Description	Effective Date	End Date
18	Craig	73	Full Medicaid Coverage	07/01/2001	03/31/2006
18	Craig	42	Full MCaid&Care w/co-ded no QMB	04/01/2006	02/28/2007

13.4.3 Coverage Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Code	Displays the recipient's eligibility aid category code.	Field	Alphanumeric	2
Aid Description	Displays the recipient's eligibility aid category code description.	Field	Character	50
County Code	Displays the recipient's eligibility aid county code.	Field	Alphanumeric	2
County Name	Displays the recipient's eligibility aid county code description.	Field	Character	20
Effective Date	Displays the recipients eligibility begin/effective date.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the recipient's eligibility end/stop date.	Field	Date (MM/DD/CCYY)	10

13.4.4 Coverage Type Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.4.5 Coverage Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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13.4.6 Coverage Type Panel Accessibility

13.4.6.1 To Access the Coverage Type Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Coverage Type panel displays.

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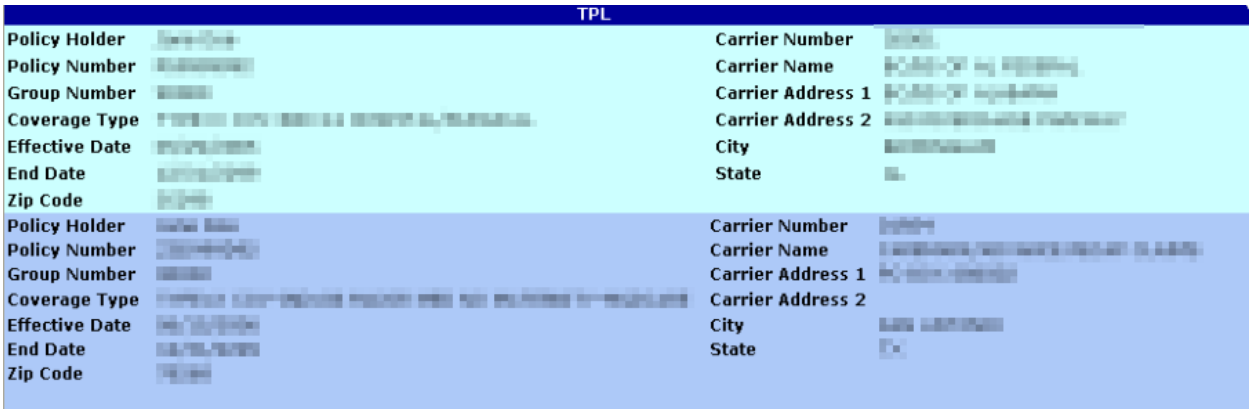
13.5 TPL

13.5.1 TPL Panel Narrative

The TPL panel displays specific information about the recipient's third party liability (TPL) coverage.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.5.2 TPL Panel Layout



13.5.3 TPL Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Address 1	Displays the primary address of each third party liability carrier.	Field	Character	55
Carrier Address 2	Displays the secondary address of each third party liability carrier.	Field	Character	55
Carrier Name	Displays the name of each third party liability carrier.	Field	Alphanumeric	30
Carrier Number	Displays the number of each third party liability carrier.	Field	Alphanumeric	10
City	Displays the city of each third party liability carrier.	Field	Character	30
Coverage Type	Displays the coverage type of the third party liability insurance.	Field	Alphanumeric	120
Effective Date	Displays the effective date of each third party liability insurance.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of each third party liability insurance.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Group Number	Displays the group number of the policy.	Field	Alphanumeric	30
Policy Holder	Displays the policy holder of the third party liability insurance.	Field	Alphanumeric	30
Policy Number	Displays the policy number of the third party liability insurance.	Field	Alphanumeric	16
State	Displays the state of each third party liability carrier.	Field	Alphanumeric	2
Zip Code	Displays the zip code of each third party liability carrier.	Field	Number (Integer)	15

13.5.4 TPL Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.5.5 TPL Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.5.6 TPL Panel Accessibility

13.5.6.1 To Access the TPL Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	TPL panel displays.

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13.6 Managed Care

13.6.1 Managed Care Panel Narrative

The Managed Care panel displays specific information about the recipient's managed care coverage.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.6.2 Managed Care Panel Layout

Managed Care

Plan Code	Provider Name	Provider Phone	24 Hour Phone	Effective Date	End Date
PT1ST			( ) -	01/01/2007	02/28/2007

13.6.3 Managed Care Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
24 Hour Phone	Displays the 24 hour phone number of the primary care physician.	Field	Character	13
Effective Date	Displays the effective date of the Managed Care coverage.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of the Managed Care coverage.	Field	Date (MM/DD/CCYY)	10
Plan Code	Displays the recipient's Managed Care Plan Code. MDADV denotes Medicare Advantage and PT1ST denotes Patient 1st .	Field	Alphanumeric	5
Provider Name	Displays the name of the primary care physician for the managed care program or the name of the Medicare Advantage Plan.	Field	Alphanumeric	20
Provider Phone	Displays the phone number of the primary care physician.	Field	Character	13

13.6.4 Managed Care Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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13.6.5 Managed Care Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.6.6 Managed Care Panel Accessibility

13.6.6.1 To Access the Managed Care Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Managed Care panel displays.

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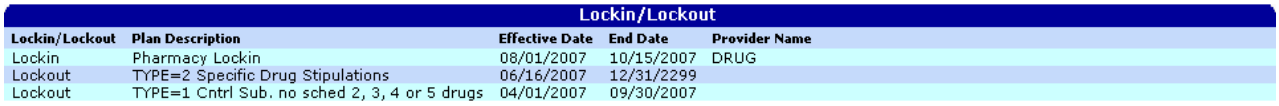
13.7 Lockin/Lockout

13.7.1 Lockin/Lockout Panel Narrative

The Lockin/Lockout panel displays specific information about the recipient's lockin and lockout coverage.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.7.2 Lockin/Lockout Panel Layout



Lockin/Lockout

Lockin/Lockout	Plan Description	Effective Date	End Date	Provider Name
Lockin	Pharmacy Lockin	08/01/2007	10/15/2007	DRUG
Lockout	TYPE=2 Specific Drug Stipulations	06/16/2007	12/31/2299	
Lockout	TYPE=1 Cntrl Sub. no sched 2, 3, 4 or 5 drugs	04/01/2007	09/30/2007	

13.7.3 Lockin/Lockout Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	Displays the effective date of each lockin period.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of each lockin period.	Field	Date (MM/DD/CCYY)	10
Lockin/Lockout	Displays if the recipient is locked in or locked out of the plan.	Field	Alphanumeric	10
Plan Description	Displays the lockin plan for the recipient.	Field	Character	50
Provider Name	Displays the name of the lockin provider.	Field	Alphanumeric	30

13.7.4 Lockin/Lockout Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.7.5 Lockin/Lockout Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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13.7.6 Lockin/Lockout Panel Accessibility

13.7.6.1 To Access the Lockin/Lockout Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Lockin/Lockout panel displays.

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13.8 Benefit Limits

13.8.1 Benefit Limits Panel Narrative

The Benefit Limits panel displays information about the recipient's services suspended and services paid for the requested year.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.8.2 Benefit Limits Panel Layout

Benefit Limits

Service Description	Paid	Suspended
INPT Days	0	0
Outpat Days	0	0
Physician Office Visits	0	0
Home Health Visits	0	0
Ambulatory Surgery	0	0
Dialysis Services	0	0
Eye Frames	0	0
Eye Lens	0	0
Eye Fitting	0	0
Eye Exam	0	0

13.8.3 Benefit Limits Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Paid	Displays the amount of services paid for the calendar year, to date.	Field	Number (Integer)	3
Service Description	Displays the types of service offered.	Field	Character	20
Suspended	Displays the amount of services suspended for the calendar year, to date.	Field	Number (Integer)	3

13.8.4 Benefit Limits Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.8.5 Benefit Limits Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.8.6 Benefit Limits Panel Accessibility

13.8.6.1 To Access the Benefit Limits Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.

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Step	Action	Response
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Benefit Limits panel displays.

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13.9 Dental Benefit Limits

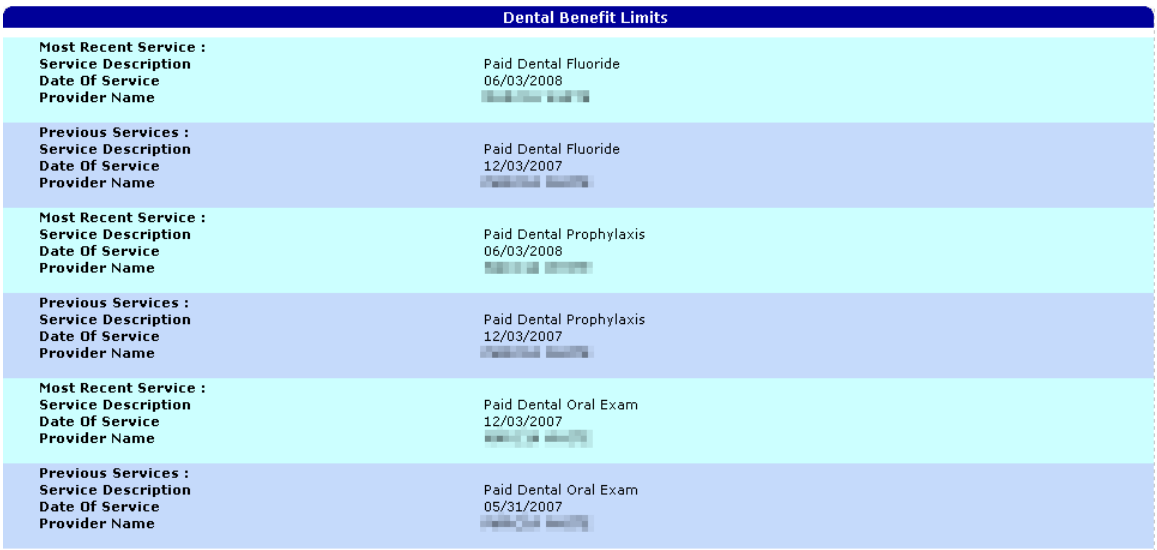
13.9.1 Dental Benefit Limits Panel Narrative

The Dental Benefit Limits panel displays information about the recipient's paid dental services. This includes the two most recent dates those services occurred as well as the provider whom performed those services.

The category "Paid Dental Xray" reflects full and/or panoramic xrays.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.9.2 Dental Benefit Limits Panel Layout



13.9.3 Dental Benefit Limits Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date of Service	The date for when the dental service was paid.	Field	Date (MM/DD/CCYY)	10
Provider Name	The name of the Provider who performed the service on the Date of Service listed.	Field	Character	20
Service Description	Displays the types of service paid.	Field	Character	25

13.9.4 Dental Benefit Limits Panel Field Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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13.9.5 Dental Benefit Limits Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.9.6 Dental Benefit Limits Panel Accessibility

13.9.6.1 To Access the Dental Benefit Limits Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Dental Benefit Limits panel displays.

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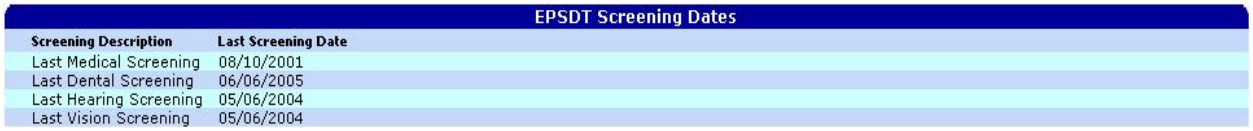
13.10 EPSDT Screening Dates

13.10.1 EPSDT Screening Dates Panel Narrative

The EPSDT Screening Dates panel displays information about the recipient's last EPSDT screening date(s).

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.10.2 EPSDT Screening Dates Panel Layout



EPSDT Screening Dates

Screening Description	Last Screening Date
Last Medical Screening	08/10/2001
Last Dental Screening	06/06/2005
Last Hearing Screening	05/06/2004
Last Vision Screening	05/06/2004

13.10.3 EPSDT Screening Dates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Last Screening Date	Displays the date of the last Medical, Dental, Hearing and Vision EPSDT screening.	Field	Date (MM/DD/CCYY)	10
Screening Description	Displays the description for the type of EPSDT screening.	Field	Alphanumeric	30

13.10.4 EPSDT Screening Dates Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.10.5 EPSDT Screening Dates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.10.6 EPSDT Screening Dates Panel Accessibility

13.10.6.1 To Access the EPSDT Screening Dates Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	EPSDT Screening Dates panel displays.

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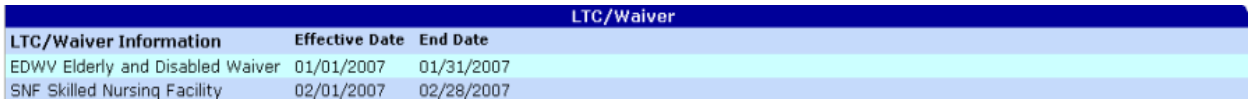
13.11 LTC/Waiver

13.11.1 LTC/Waiver Panel Narrative

The LTC/Waiver Information panel displays information about the recipient's waiver type, description and date information. This panel also returns Long Term Care (LTC) admission information based on the dates requested.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.11.2 LTC/Waiver Panel Layout



LTC/Waiver

LTC/Waiver Information	Effective Date	End Date
EDWV Elderly and Disabled Waiver	01/01/2007	01/31/2007
SNF Skilled Nursing Facility	02/01/2007	02/28/2007

13.11.3 LTC/Waiver Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	Displays the effective date of the LTC or waiver admission period.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of the LTC or waiver admission period.	Field	Date (MM/DD/CCYY)	10
LTC/Waiver Information	Displays the code and description of the LTC or waiver enrollment type.	Field	Character	50

13.11.4 LTC/Waiver Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.11.5 LTC/Waiver Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.11.6 LTC/Waiver Panel Accessibility

13.11.6.1 To Access the LTC/Waiver Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	LTC/Waiver panel displays.

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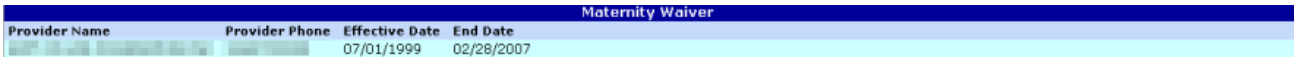
13.12 Maternity Waiver

13.12.1 Maternity Waiver Panel Narrative

The Maternity Waiver Information panel displays information about the recipient's maternity waiver provider and effective/end dates.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.12.2 Maternity Waiver Panel Layout



13.12.3 Maternity Waiver Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	Displays the effective date of the waiver.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date of the waiver.	Field	Date (MM/DD/CCYY)	10
Provider Name	Displays the provider's name.	Field	Character	20
Provider Phone	Displays the provider's phone number.	Field	Character	10

13.12.4 Maternity Waiver Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.12.5 Maternity Waiver Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.12.6 Maternity Waiver Panel Accessibility

13.12.6.1 To Access the Maternity Waiver Information Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Maternity Waiver panel displays.

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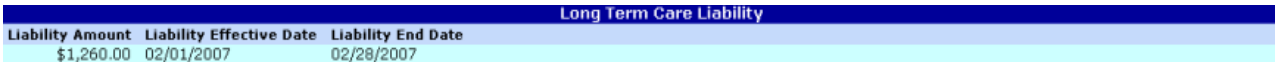
13.13 Long Term Care Liability

13.13.1 Long Term Care Liability Panel Narrative

The Long Term Care Liability panel displays information about the recipient's long term care liability dates and amounts.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.13.2 Long Term Care Liability Panel Layout



Long Term Care Liability

Liability Amount	Liability Effective Date	Liability End Date
$1,260.00	02/01/2007	02/28/2007

13.13.3 Long Term Care Liability Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Liability Amount	Displays the long term care liability amount.	Field	Character	9
Liability Effective Date	Displays the long term care liability effective date.	Field	Date (MM/DD/CCYY)	10
Liability End Date	Displays the long term care liability end date.	Field	Date (MM/DD/CCYY)	10

13.13.4 Long Term Care Liability Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.13.5 Long Term Care Liability Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.13.6 Long Term Care Liability Panel Accessibility

13.13.6.1 To Access the Long Term Care Liability Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Long Term Care Liability panel displays.

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13.14 Service Type/Co-Pay Search Results

13.14.1 Service Type/Co-Pay Search Results Panel Narrative

The Service Type/Co-Pay Search Results panel displays qualifying service type information matching the search criteria from the Eligibility Verification Search panel.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.14.2 Service Type/Co-Pay Search Results Panel Layout

Service Type Codes/Co-Pay

Benefit Plan	Service Type	Co-Pay Min	Co-Pay Max	Co-Insurance	Deductible	Status	Message
TXIX	01 - MEDICAL CARE	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	30 - HEALTH BENEFIT PLAN	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	47 - HOSPTIAL	$0.00	$50.00	$0.00	$0.00	Covered	
TXIX	48 - HOSPITAL-INPATIENT	$0.00	$50.00	$0.00	$0.00	Covered	
TXIX	50 - HOSPITAL-OUTPATIENT	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	86 - EMERGENCY SERVICES	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	88 - PHARMACY	$0.00	$3.90	$0.00	$0.00	Covered	Lockin data may be returned, if applicable, for service type(s):88
TXIX	98 - PROFESSIONAL VISIT-OFFICE	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	AL - VISION(OPTOMETRY)	$0.00	$3.90	$0.00	$0.00	Covered	Vision Screening data may be returned, if applicable, for service type(s):AL
TXIX	MH - MENTAL HEALTH	$0.00	$3.90	$0.00	$0.00	Covered	
TXIX	UC - URGENT CARE	$0.00	$3.90	$0.00	$0.00	Covered	

VARIABLE COPAY IS DISPLAYED. PLEASE REFER TO THE PROVIDER MANUAL FOR COPAY INFORMATION.
SBRW RECIPIENTS COVERED FOR PREGNANCY/FAMILY PLANNING SERVICES ONLY PRIOR TO 11/01/2015.
ESDLV RECIPIENTS COVERED FOR DELIVERY ONLY PRIOR TO 11/01/2015.
NO COPAY ALLOWED FOR PREGNANCY RELATED SERVICES.

13.14.3 Service Type/Co-Pay Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Displays the benefit plan code.	Field	Character	4
Co-Insurance	Displays the Co-Insurance amount for the service type.	Field	Number (Decimal)	6
Co-Pay Max	Displays the Maximum Co-Pay amount for the service type.	Field	Number (Decimal)	6
Co-Pay Min	Displays the Minimum Co-Pay amount for the service type.	Field	Number (Decimal)	6
Deductible	Displays the Deductible amount for the service type	Field	Number (Decimal)	6
Message	Displays the coverage message	Field	Character	50
Service Type	Displays the code and description of the service type.	Field	Character	50
Status	Displays the coverage status of the service type.	Field	Character	11

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13.14.4 Service Type/Co-Pay Search Results Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.14.5 Service Type/Co-Pay Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.14.6 Service Type/Co-Pay Search Results Panel Accessibility

13.14.6.1 To Access the Service Type/Co-Pay Search Results Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Eligibility Verification Search Results panels display.

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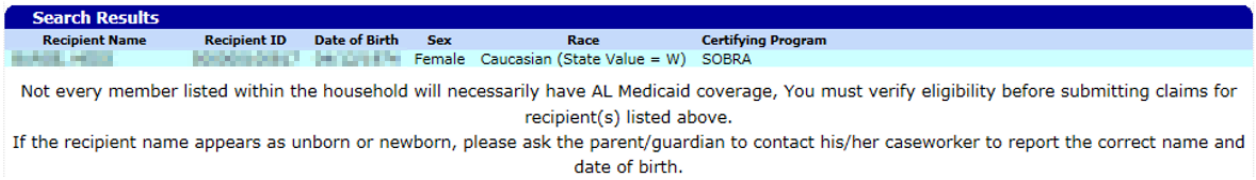
13.15 HouseHold Inquiry

13.15.1 HouseHold Inquiry Panel Narrative

The HouseHold Inquiry panel allows users to inquire on recipient records based on the payee's Medicaid number.

Navigation Path: [Eligibility] – [HouseHold Inquiry]

13.15.2 HouseHold Inquiry Panel Layout



13.15.3 HouseHold Inquiry Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears all the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Records	Displays the number of records to display per page in the Search Results list.	Combo Box	Drop Down List Box	0
Parent ID Number	Displays the parent's first 12-digits of their Medicaid identification number.	Field	Number (Integer)	12
Recipient Date of Birth	Displays the child's date of birth.	Field	Date (MM/DD/CCYY)	10

13.15.4 HouseHold Inquiry Panel Field Edit Error Codes

Field	Error Message	To Correct
Parent ID Number	Parent ID Number and Recipient Date of Birth is required for search criteria.	Enter the Parent ID Number and Recipient Date of Birth.
	Parent ID Number must be numeric.	Enter a valid parent ID.
Recipient Date of Birth	Parent ID Number and Recipient Date of Birth is required for search criteria.	Enter the Parent ID Number and Recipient Date of Birth.
	Invalid date. Format is MM/DD/YYYY.	Enter a valid date in MM/DD/CCYY format.

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13.15.5 HouseHold Inquiry Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.15.6 HouseHold Inquiry Panel Accessibility

13.15.6.1 To Access the HouseHold Inquiry Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **HouseHold Inquiry**.	HouseHold Inquiry panel displays.

13.15.6.2 To Add on the HouseHold Inquiry Panel

Step	Action	Response
1	Enter **Parent ID Number**.	
2	Enter **Recipient Date of Birth.**	
3	Select **Records** from drop down list.	Determines the number of records to display in the search results panel.
4	Click **search**.	HouseHold Inquiry Search Results panel displays.

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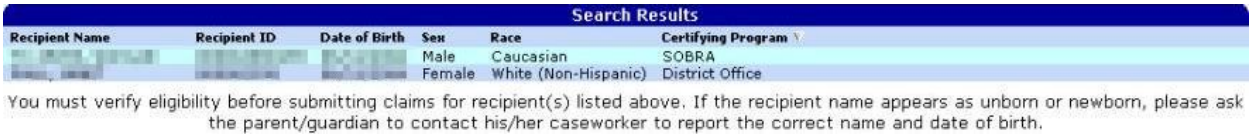
13.16 HouseHold Inquiry Search Results

13.16.1 Search Results Panel Narrative

The HouseHold Inquiry Search Results panel displays household inquiry information matching the search criteria from the HouseHold Inquiry Search panel.

Navigation Path: [Eligibility] – [HouseHold Inquiry] – [search]

13.16.1 Search Results Panel Layout



13.16.2 Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Certifying Program	Displays the child's eligibility category.	Field	Character	20
Date of Birth	Displays the child's date of birth.	Field	Date (MM/DD/CCYY)	10
Race	Displays the child's race.	Field	Character	15
Recipient ID	Displays the child's first 12 digits of their Medicaid identification number.	Field	Number (Integer)	12
Recipient Name	Displays the child's name in Last Name, First Name format.	Field	Character	50
Sex	Displays the child's sex.	Field	Character	7

13.16.3 Search Results Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.16.4 Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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13.16.5 Search Results Panel Accessibility

13.16.5.1 To Access the Search Results Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **HouseHold Inquiry**.	HouseHold Inquiry panel displays.
3	Enter search criteria and click **search**.	HouseHold Inquiry Search Results panel displays.

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13.17 MCO Information

13.17.6 MCO Information Panel Narrative

The Managed Care Orgnaization Information Panel displays Probationary Health Home region the recipient is assigned.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.17.7 MCO Information Panel Layout

Managed Care Organization Information

MCO	Primary Phone	Secondary Phone	From Elig Date	To Elig Date
HD1 - Care Network of Alabama			05/01/2015	12/31/2299

13.17.8 MCO Information Panel Descriptions

Field	Description	Field Type	Data Type	Length
From Elig Date	Displays the effective date of the Managed Care Organization.	Field	Date (MM/DD/CCYY)	10
MCO	Managed Care Organization for which a Recipient is enrolled.	Field	Character	50
Primary Phone	Displays the primary phone number for the managed care organization.	Field	Character	13
Secondary Phone	Displays the secondary phone number for the managed care organization.	Field	Character	13
To Elig Date	Displays the end date of the Managed Care Organization.	Field	Date (MM/DD/CCYY)	10

13.17.9 MCO Information Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.17.10 MCO Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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13.17.11 MCO Information Panel Accessibility

13.17.11.1 To Access the MCO Information Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	MCO Information panel displays.

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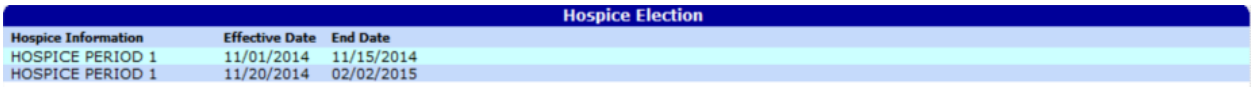
13.18 Hospice Election

13.18.1 Hospice Election Panel Narrative

Then panel displays Hospice Election information for the recipient.

Navigation Path: [Eligibility] – [Eligibility Verification] – [search]

13.18.2 Hospice Election Panel Layout



Hospice Election

Hospice Information	Effective Date	End Date
HOSPICE PERIOD 1	11/01/2014	11/15/2014
HOSPICE PERIOD 1	11/20/2014	02/02/2015

13.18.3 Hospice Election Panel Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	Displays the effective date for the election period.	Field	Date (MM/DD/CCYY)	10
End Date	Displays the end date for the election period.	Field	Date (MM/DD/CCYY)	10
Hospice Information	Displays the Hospice Election Periods.	Field	Alphanumeric	18

13.18.4 Hospice Election Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

13.18.5 Hospice Election Panel Extra Features

Field	Field Type
No extra features found for this panel.	

13.18.6 Hospice Election Panel Accessibility

13.18.6.1 To Access the Hospice Election Panel

Step	Action	Response
1	Click **Eligibility**.	Eligibility page opens.
2	Click **Eligibility Verification**.	Eligibility Verification panel displays.
3	Enter search criteria and click **search**.	Hospice Election panel displays.

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14. Trade Files

Trading Partners can upload batch files from directories within their personal computer (PC) or Local Area Network (LAN) to Alabama Medicaid's web server for processing. Authorized users can access the Interactive Services website to perform this function or use a software program that runs on a user's PC or server that connects to the secure website.

Another function within the Interactive Services website allows users to download batch files from Alabama Medicaid's web server to directories within their PC or LAN. Authorized users can access the Interactive Services website to perform this function or use a software program that runs on a user's PC or server that connects to the secure website. The user's site sends a request using the HTTPS protocol containing parameters that include the User ID, the associated password, and the requested transaction type.

From the Trade Files link in the Main Menu toolbar, users can access the following Sub Menu options:

- Download
- Upload
- Forms

14.1 Download

14.1.1 File Download Search Narrative

This window allows the user to download specific files from the state's secure website. The files are ordered by the date they become available, beginning with the most recent. A hyperlink is provided to allow users to download and install Adobe Acrobat Reader which is required to view an electronic Explanation of Payment (EOP).

The File Download panel allows users to download specific files from the Alabama Medicaid secure website. The user has the capability to search for files based on transaction type, and then download selected files from the available files.

Providers or clerks may use this feature to download an electronic Remittance Advice (RA) or their Managed Care Enrollment Roster in the PDF format, which requires Adobe Acrobat Reader.

Navigation Path: [Trade Files] – [Download]

14.1.2 File Download Search and Results Layout

Drug Manufacturer

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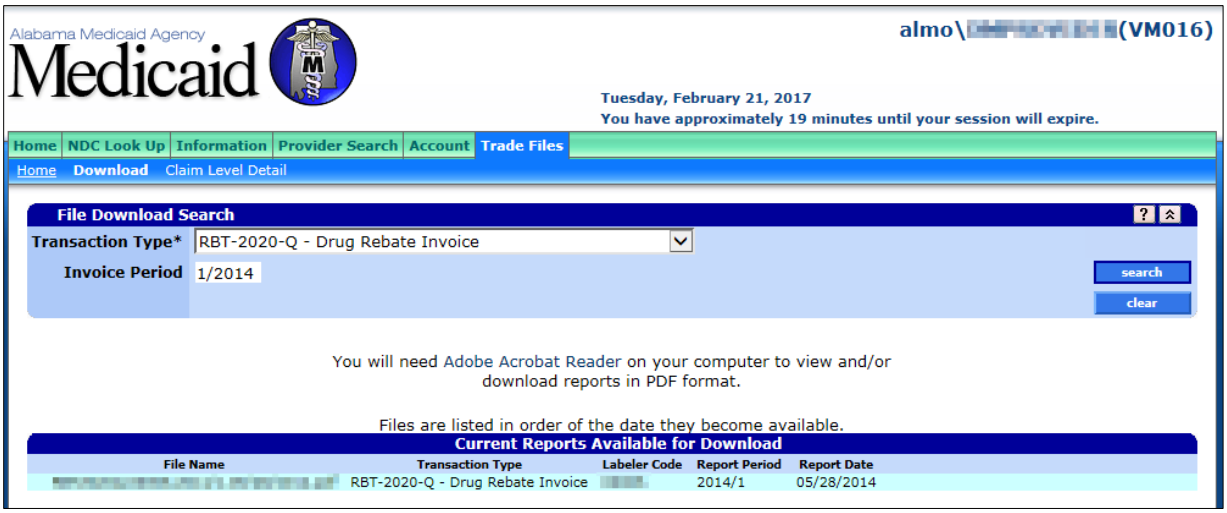
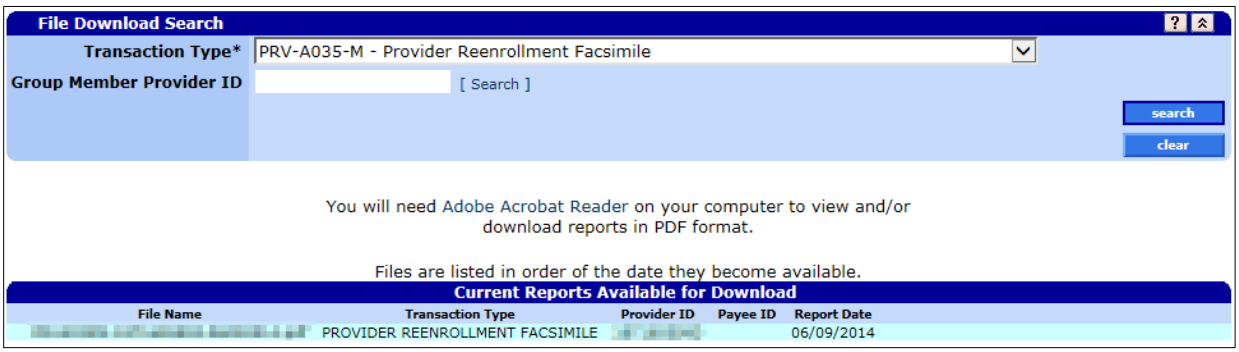
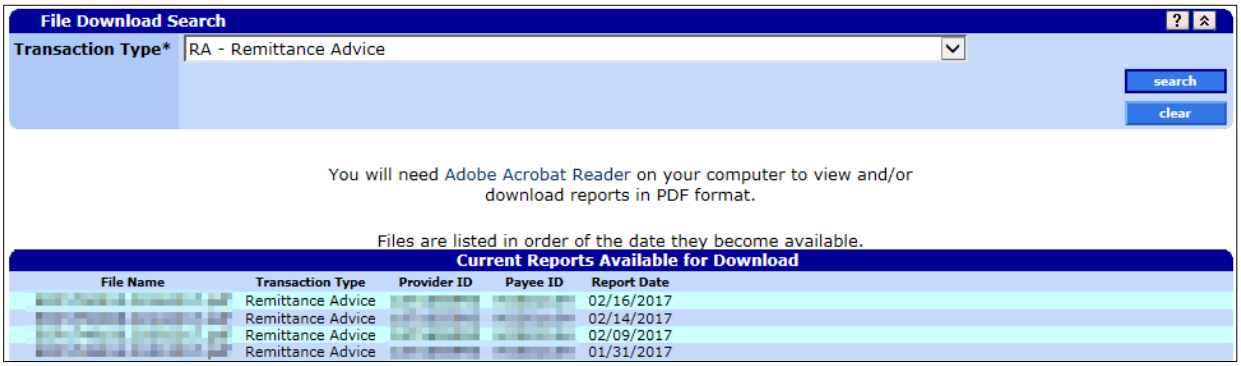


Provider Reenrollment Facsimile



Provider Remittance Advance



Provider Trading Partner

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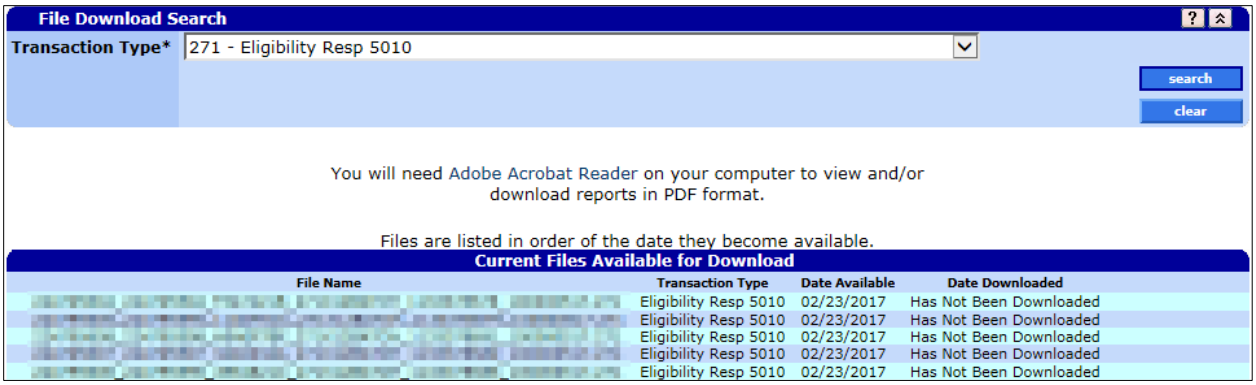

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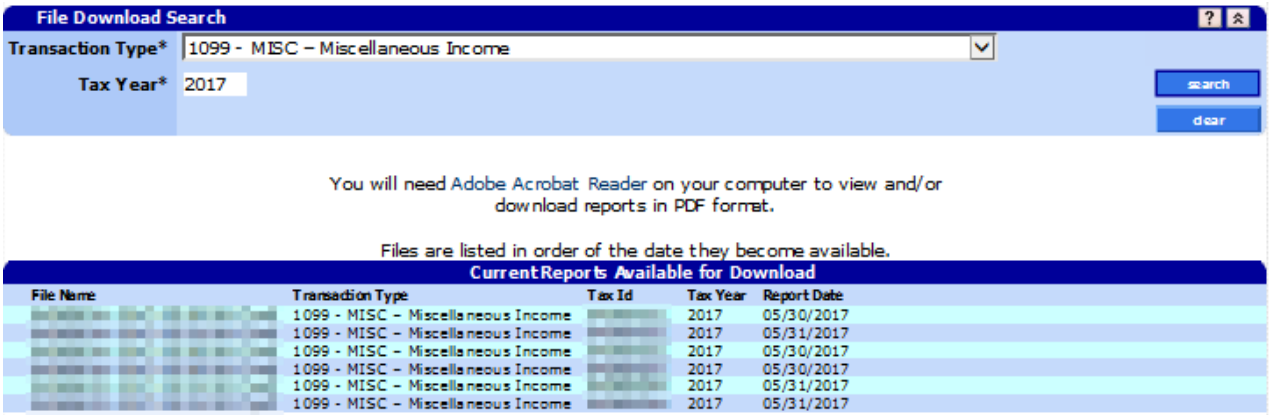
Provider Financial Report



14.1.3 File Download Search Field Descriptions

Field	Description	Field Type	Data Type	Length
search	The button that initiates the search.	Button	N/A	0
Clear	Clears the search criteria fields.	Button	N/A	0
Transaction Type	The transaction type of the file to search on.	Combo Box	Drop Down List Box	0
Group Member Provider ID	Group Member Provider ID Search.	Field	Alphanumeric	15
Invoice Period	Displays the invoice period of the report to be searched.	Field	Character	5
Date Available	Displays the date the file became available for download.	Field	Date (MM/DD/CCYY)	10
Date Downloaded	Displays the date the file was downloaded.	Field	Date (MM/DD/CCYY)	10
File Name	Name of the file available for download.	Field	Alphanumeric	50
Payee ID	Displays the Payee ID for the Remittance Advice.	Field	Character	15
Provider ID	Displays the individual Provider ID for the Remittance Advice.	Field	Character	10
Labeler Code	Displays the Drug Manufacturer or DM Clerk labeler code.	Field	Character	6
Report Period	Displays the invoice period.	Field	Character	5
Report Date	The date the Report became available for download.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Tax ID	Tax Id of the provider.	Field	Character	9
Tax Year	Displays the Tax Year of the report to be searched.	Field	Numeric	4

14.1.4 File Download Search Field Edit Error Codes

Field	Error Message	To Correct
Transaction Type	A Transaction Type is required. Please select a Transaction Type and try your search again.	Select a Transaction Type and try your search again.
Invoice Period	The Invoice Period is required (in Q/CCYY).	Select an Invoice Period.
	Invoice Period must be in Q/CCYY format.	Enter in Q/CCYY format.
	Format: Q/CCYY; Quarter (Q) must be 1, 2, 3, or 4.	Enter Invoice Period in specified format.
Tax Year	Tax Year is required (in YYYY) format.	Enter tax year in YYYY format.
	Tax year must be between 1900 and 2299.	Enter tax year between 1900 and 2299.

14.1.5 File Download Search Extra Features

Field	Field Type
Adobe Acrobat Reader	Hyperlink to http://www.adobe.com/products/acrobat/readstep2.html.

14.1.6 File Download Search Accessibility

14.1.6.1 To Access the File Download Search Panel

Step	Action	Response
1	Click **Trade Files**.	Trade Files page opens.
2	Click **Download**.	File Download Search panel opens.
3	Select **Transaction Type** and click **search.**	Current Files Available for Download panel displays

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14.1.6.2 To Add on the File Download Search Panel

Step	Action	Response
1	Select **Transaction Type** from drop down list.	
2	Click **search**.	Current Files Available for Download panel displays.

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14.2 Current Files Available for Download

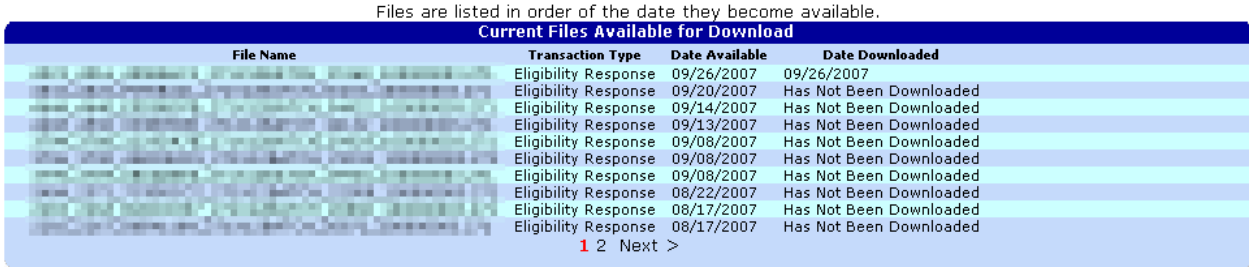
14.2.1 Current Files Available for Download Panel Narrative

The Current Files Available for Download panel displays the files available for download that match the search criteria from the Download panel.

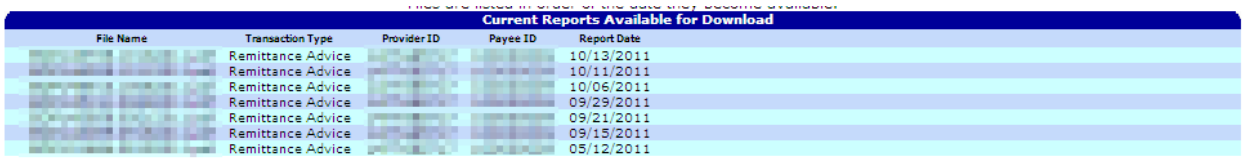
Navigation Path: [Trade Files] – [Download] – [search]

14.2.2 Current Files Available for Download Panel Layout

Trading Partner Download Panel Layout



Provider Download Panel Layout



14.2.3 Current Files Available for Download Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Available	Displays the date the file became available for download.	Field	Date (MM/DD/CCYY)	10
Date Downloaded	Displays the date the file was downloaded.	Field	Date (MM/DD/CCYY)	10
File Name	Displays the name of the file available for download.	Field	Alphanumeric	50
Payee ID	Displays the Payee ID for the Remittance Advice.	Field	Character	10
Provider ID	Displays the individual Provider ID for the Remittance Advice.	Field	Character	10
Report Date	Date the Remittance Advice is generated.	Field	Date (MM/DD/CCYY)	10
Transaction Type	Displays the file type.	Field	Alphanumeric	20

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14.2.4 Current Files Available for Download Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

14.2.5 Current Files Available for Download Panel Extra Features

Field	Field Type
No extra features found for this panel.	

14.2.6 Current Files Available for Download Panel Accessibility

14.2.6.1 To Access the Current Files Available for Download Panel

Step	Action	Response
1	Click **Trade Files**.	Trade Files page opens.
2	Click **Download**.	File Download Search panel opens.
3	Select a transaction type and click **search**.	Current Files Available for Download panel displays.

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14.3 Upload

14.3.1 File Upload Panel Narrative

The Upload panel allows the user to upload HIPAA compliant files to the Alabama Medicaid secure web server. A Trading Partner has the capability to view all the files uploaded to the Alabama Medicaid secure web server. This option is not available under a Provider logon.

Navigation Path: [Trade Files] – [Upload]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

14.3.2 File Upload Panel Layout

14.3.3 File Upload Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Browse	This button allows the user to navigate their hard drive to select a local file they wish to upload.	Button	N/A	0
upload	This button initiates the upload process.	Button	N/A	0
Transaction Type	Displays a type of transaction that is being transmitted.	Combo Box	Drop Down List Box	0
Save As Filename	Displays the name the user wishes to name the uploaded file. This overrides the selected file name.	Field	Alphanumeric	50
Upload File	Allows the user to select the file they wish to upload.	Field	Character	50

14.3.4 File Upload Panel Field Edit Error Codes

Field	Error Message	To Correct
Upload	Please select a file to upload.	Click on <browse> button to select a file to upload onto the server.

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Field	Error Message	To Correct
	File is either invalid or has 0 bytes size. Please validate file and upload again.	File selected for upload is empty. Select a non-empty or correct file name.
Transaction Type	Transaction Type is required.	Select a Transaction Type.

14.3.5 File Upload Panel Extra Features

Field	Field Type
No extra features found for this panel.	

14.3.6 File Upload Panel Accessibility

14.3.6.1 To Access the File Upload Panel

Step	Action	Response
1	Click **Trade Files**.	Trade Files page opens.
2	Click **Upload**.	File Upload panel opens.

14.3.6.2 To Add on the File Upload Panel

Step	Action	Response
1	Click **Browse**.	Allows the user to navigate their hard drive to select a local file to upload.
2	Select **Transaction Type** from drop down list.	Identifies the type of file being uploaded.
3	Enter **Save as filename**.	Overrides the selected file name.
4	Click **upload**.	Uploads file and Uploaded Files panel displays.

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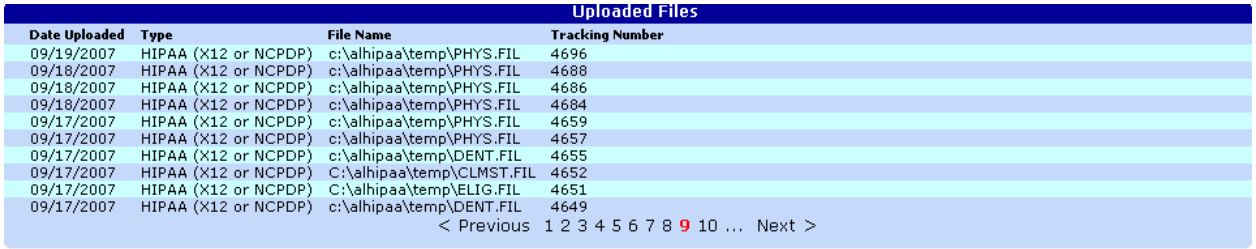
14.4 Uploaded Files

14.4.1 Uploaded Files Panel Narrative

The Uploaded Files panel allows users to view files that have been uploaded to the Alabama Medicaid secure website using the File Upload panel.

Navigation Path: [Trade Files] – [Upload – [click on upload]

14.4.2 Uploaded Files Panel Layout



Uploaded Files

Date Uploaded	Type	File Name	Tracking Number
09/19/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4696
09/18/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4688
09/18/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4686
09/18/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4684
09/17/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4659
09/17/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\PHYS.FIL	4657
09/17/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\DENT.FIL	4655
09/17/2007	HIPAA (X12 or NCPDP)	C:\alhipaa\temp\CLMST.FIL	4652
09/17/2007	HIPAA (X12 or NCPDP)	C:\alhipaa\temp\ELIG.FIL	4651
09/17/2007	HIPAA (X12 or NCPDP)	c:\alhipaa\temp\DENT.FIL	4649

< Previous 1 2 3 4 5 6 7 8 9 10 ... Next >

14.4.3 Uploaded Files Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Uploaded	Displays the date the file was uploaded.	Field	Date (MM/DD/CCYY)	10
File Name	Displays the name of the file that was uploaded.	Field	Alphanumeric	30
Tracking Number	Displays the tracking number used to identify and track the uploaded file.	Field	Number (Integer)	15
Type	Displays the type of file that was uploaded.	Field	Alphanumeric	25

14.4.4 Uploaded Files Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

14.4.5 Uploaded Files Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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14.4.6 Uploaded Files Panel Accessibility

14.4.6.1 To Access the Uploaded Files Panel

Step	Action	Response
1	Click **Trade Files**.	Trade Files page opens.
2	Click **Upload**.	File Upload panel opens.
3	Click **Browse**.	Allows the user to navigate their hard drive to select a local file to upload.
4	Select **Transaction Type** from drop down list.	Identifies the type of file being uploaded.
5	Enter **Save as filename**.	Overrides the selected file name.
6	Click **upload**.	Uploads file and Uploaded Files panel displays.

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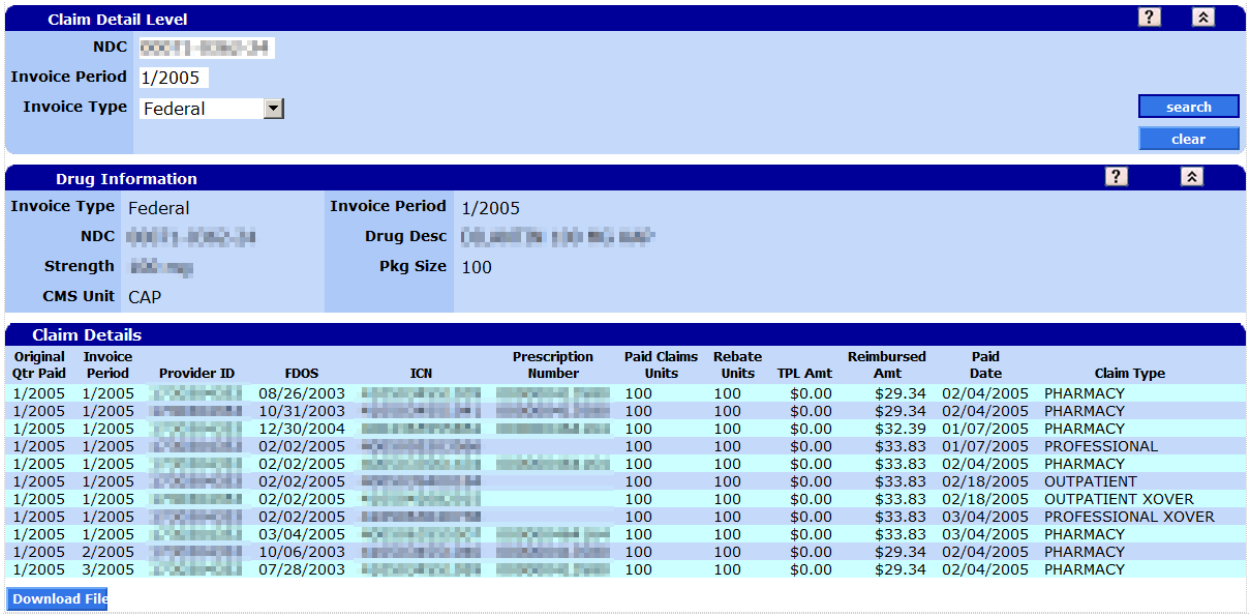
14.5 Claim Level Detail

14.5.1 Claim Level Detail Panel Narrative

This panel is to provide Drug Rebate Information on a Web Portal. The information will be accessed by Drug Manufacturers. The information to be provided will include Drug Rebate Invoices and Drug Rebate Related Claims data.

Navigation Path: [Trade Files] – [Claim Level Detail]

14.5.2 Claim Level Detail Panel Layout



Original Qtr Paid	Invoice Period	Provider ID	FDOS	ICN	Prescription Number	Paid Claims Units	Rebate Units	TPL Amt	Reimbursed Amt	Paid Date	Claim Type
1/2005	1/2005		08/26/2003			100	100	$0.00	$29.34	02/04/2005	PHARMACY
1/2005	1/2005		10/31/2003			100	100	$0.00	$29.34	02/04/2005	PHARMACY
1/2005	1/2005		12/30/2004			100	100	$0.00	$32.39	01/07/2005	PHARMACY
1/2005	1/2005		02/02/2005			100	100	$0.00	$33.83	01/07/2005	PROFESSIONAL
1/2005	1/2005		02/02/2005			100	100	$0.00	$33.83	02/04/2005	PHARMACY
1/2005	1/2005		02/02/2005			100	100	$0.00	$33.83	02/18/2005	OUTPATIENT
1/2005	1/2005		02/02/2005			100	100	$0.00	$33.83	02/18/2005	OUTPATIENT XOVER
1/2005	1/2005		02/02/2005			100	100	$0.00	$33.83	03/04/2005	PROFESSIONAL XOVER
1/2005	1/2005		03/04/2005			100	100	$0.00	$33.83	03/04/2005	PHARMACY
1/2005	2/2005		10/06/2003			100	100	$0.00	$29.34	02/04/2005	PHARMACY
1/2005	3/2005		07/28/2003			100	100	$0.00	$29.34	02/04/2005	PHARMACY

14.5.3 Claim Level Detail Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	This button clears all the search criteria fields.	Button	N/A	0
Download File	This button allows end users to download an excel spreadsheet file of the Claim Level Detail search results.	Button	N/A	0
Search	Search for NDC in a user given Invoice Period and Invoice Type by the user.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Invoice Type	The Invoice Type code which pertains to the Drug Rebate programs, such as Federal, Supplemental, MCO Federal, or MCO Supplemental..	Combo Box	Drop Down List Box	0
CMS Unit	Indicates a product's unit of measure, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. These units represent the standard measurements used by CMS for determining rebate quantities.	Field	Character	3
Claim Type	The type of claim that was submitted for this NDC.	Field	Character	50
Drug Desc	Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.	Field	Character	35
FDOS	The date on which the drug was dispensed.	Field	Date (MM/DD/CCYY)	8
ICN	The transaction control number for the claim.	Field	Number	13
Invoice Period	Invoice Period - It is in Q/CCYY format. Q indicates the quarter when the claims billed on the invoice were paid, and CCYY is a four digit year for the invoice period.	Field	Number	5
NDC	National Drug Code (NDC) of the drug invoiced. This field comprises the five digit labeler code, four digit product code, and the two digit package size code	Field	Number	11
Original Qtr Paid	Original Qtr Paid is the Original Quarter Paid. It is	Field	Number	5

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Field	Description	Field Type	Data Type	Length
	in a format of Q/CCYY, which quarter (Q) is the quarter of the invoice period and CCYY is a four digit year for the invoice period.			
Paid Claim Units	Total units dispensed for an NDC for a given quarter.	Field	Number	13
Paid Date	The date that was paid for this NDC.	Field	Date (MM/DD/CCYY)	8
Pkg Size	This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc.	Field	Number	11
Prescription Number	The prescription number for the drug dispensed.	Field	Character	7
Provider ID	Uniquely identify a provider.	Field	Number	9
Rebate Unit	Total units rebate given for an NDC for a given quarter.	Field	Number	13
Reimbursed Amt	Total dollar reimbursed to providers for a specific claim.	Field	Number	11
Strength	The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.	Field	Character	60
TPL Amt	Third Party Liability Amount	Field	Number	11

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14.5.4 Claim Detail Level Panel Field Edit Error Codes

Field	Error Message	To Correct
Download File	Unable to find information on this NDC.	Enter a valid NDC.
	You are not allowed to search by this NDC.	Enter a NDC under this user account.
Invoice Period	The Invoice Period is required (in Q/CCYY).	Enter Invoice Period in the format of Q/CCYY. (e.g. - The third quarter of 2010 needs to be entered in as 3/2010)
	Invoice Period must be 5 digits if entered (in Q/CCYY).	Enter Invoice Period in the format of Q/CCYY. (e.g. - The third quarter of 2010 needs to be entered in as 3/2010)
	Invoice Period must be numeric (in Q/CCYY).	Enter Invoice Period in the format of Q/CCYY. (e.g. - The third quarter of 2010 needs to be entered in as 3/2010)
	Format: Q/CCYY; Quarter (Q) must be 1, 2, 3, or 4.	Enter Invoice Period in the format of Q/CCYY. (e.g. - The third quarter of 2010 needs to be entered in as 3/2010)
NDC	You are not allowed to search by this NDC.	Enter a NDC code that is under this user account.
	An 11 digit NDC Code is required.	Enter an 11 digit (numeric) NDC code.
	NDC must be numeric, please enter a valid NDC.	Enter an 11 digit (numeric) NDC code.

14.5.5 Claim Level Detail Panel Extra Features

Field	Field Type
No extra features found for this panel.	

14.5.6 Claim Level Detail Panel Accessibility

14.5.6.1 To Access the Claim Level Detail Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Trade Files** and click **Claim Level Detail**.	Claim Level Detail panel displays.

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14.6 Forms Panel Overview

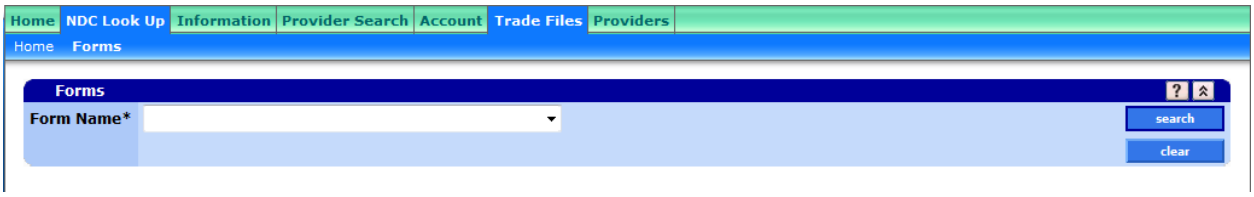
14.6.1 Forms Panel Narrative

The Forms panel is available through the secure Provider web portal and allows end users to perform a search for and complete the following forms: Consent Form and Supporting Documentation, Enrollment Updates, Hospice, LTC, PEC Bed and Swing Bed, Psychiatric and Retrospective Review, Dental PA Supporting Documentation, and Medical PA Supporting Documentation for review.

Upon completion of the forms, supporting documentation articles will be uploaded or faxed directly into Feith utilizing the barcode coversheet.

Navigation Path: [Trade Files] – [Forms]

14.6.2 Forms Panel Layout



14.6.3 Forms Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears all the search criteria fields.	Button	N/A	0
Form Name	Displays the names of the Form to be searched. Valid options include: • CS1 – Consent Form • ERU – Enrollment Updates • LTC - Hospice Records • LTC - LTC Records • LTC - PEC/Swing Bed Records • LTC - Psychiatric/Retrospective Review Records • PA1 – Dental PA Supporting Documentation • PA2 – Medical PA Supporting Documentation • PA3 - Rehab PA Supporting Documentation • REA – Re-Enrollment Application Supporting Documentation	Combo Box	Character	0

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Field	Description	Field Type	Data Type	Length
search	This button initiates the search.	Button	N/A	0

14.6.4 Forms Panel Field Edit Error Codes

The form functionality itself is that of Feith. It resides within the Web Portal in this panel. The error messages below are those of the Feith form functionality and not that of the Web Portal.

Form	Field	Error Message	Corrective Action
All	Consent Form ID	ICN is not unique. To complete submission, please refresh browser, ensuring ICN and Record ID are different. Complete form. Submit	Refresh Browser, complete form, and submit.
	Medicaid ID	"Medicaid ID" is a required field	Enter Medicaid ID.
	Recipient First Name	"Recipient First Name" is a required field	Enter Recipient First Name.
	Recipient Last Name	"Recipient Last Name" is a required field	Enter Recipient Last Name.
	Provider ID	"Provider ID" is a required field	Enter Provider ID.
	Provider First Name	"Provider First Name" is a required field	Enter Provider First Name.
	Provider Last Name	"Provider Last Name" is a required field	Enter Provider Last Name.
	Provider Mailing Address Line 1	"Mailing Address" is a required field	Enter Provider Mailing Address.
	Provider City	"City" is a required field	Enter Provider City.
	Provider Zip Code	"Zip" is a required field	Enter Provider Zip Code.
	Provider Contact Telephone Number	"Phone" is a required field	Enter Provider Telephone number.
	Provider Email Address	"Email" is a required field	Enter Provider Email address.
	Medicaid ID	Please enter a valid Medicaid ID.	Enter a valid Medicaid ID. A valid Medicaid ID is 13 digits and numeric in value.
	Provider ID	Please enter a valid Provider ID.	Enter a valid Provider ID. A valid Provider Id is 6-13 digits and can

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Form	Field	Error Message	Corrective Action
			be alphanumeric in value.
	Zip Code	Please enter a valid zip code.	Enter a valid zip code. A valid zip code includes 5 digit zip or zip plus four.
	To upload a document in PDF format:	File "XXXX.xlsx" has an invalid extension.	Upload a PDF document for submission
PEC / Swing Bed Records and Psychiatric Retrospective Records	Type of Record Submitting	“Type of Record Submitting” is a required field	Select a Type of Record from the drop down listing.
Psychiatric Retrospective Records	Source of Admission	“Source of Admission” is a required field	Select a Source of Admission from the drop down listing.

14.6.5 Forms Panel Extra Features

Field	Feature
To upload documentation in PDF format	The name of the document being uploaded is displayed on the screen for the user.
All Fields	Field validations are in place to alert the user of miskeyed information. See Error Codes listing above.
Barcode	Beneath the barcode on the generated coversheet, the unique Record ID is present for the user.
Print Friendly View	The Print Friendly View button removes the confirmation message for a clean print view of the fax coversheet.
Confirmation Message	The “Your form was submitted successfully.” Message is displayed following successful creation of fax coversheet and upload of documentation.

14.6.6 Forms Panel Accessibility

14.6.6.1 To Access the Forms Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Trade Files** and click **Forms.**	Forms panel displays.

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14.6.6.2 To Submit a Form or Geneate Barcode Fax Coversheet

Step	Action	Response
1	Select **Form Name** from drop down list.	
2	Click **search**.	Selected form displays.
3	Complete all fields. **Please Note:** Record ID and Consent Form ID are auto generated and require no action by the user.	Failure to complete required fields will result in error. Please refer to Error Codes listing above for corrective action.
4	To upload documentation, press the **Browse** button and select required documentation in PDF format.	Document will be uploaded upon form submission.
5	Press the **Submit** button.	Form will be successfully saved along with any supporting documentation uploaded. User is automatically taken to Fax Coversheet page for printing and retention.
6	Select the **Print Friendly View button**.	Print the barcode coversheet or save as a PDF and retain for records in the event additional documentation is required.
7	Fax required supporting documentation with barcode coversheet on top to (334) 215-7416. • Do not fax double sided pages. • Do not fax multiple sets of records at the same time. Each fax should be sent separately. • The bar code cover sheet is required for each fax submission. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the barcode on the cover sheet or alter it in any manner. • The barcode cover sheet is unique to this transaction. To submit documentation for another recipient, please complete the process for that unique recipient transaction.	Successful transmission of medical records.

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15. Prior Authorization

The Prior Authorization features allow users to search for or submit prior authorizations via the Interactive Services website.

From the Prior Authorization link in the Main Menu toolbar, users can access the following Sub Menu options:

- Search
- Submit
- Submit New

15.1 Prior Authorization Search

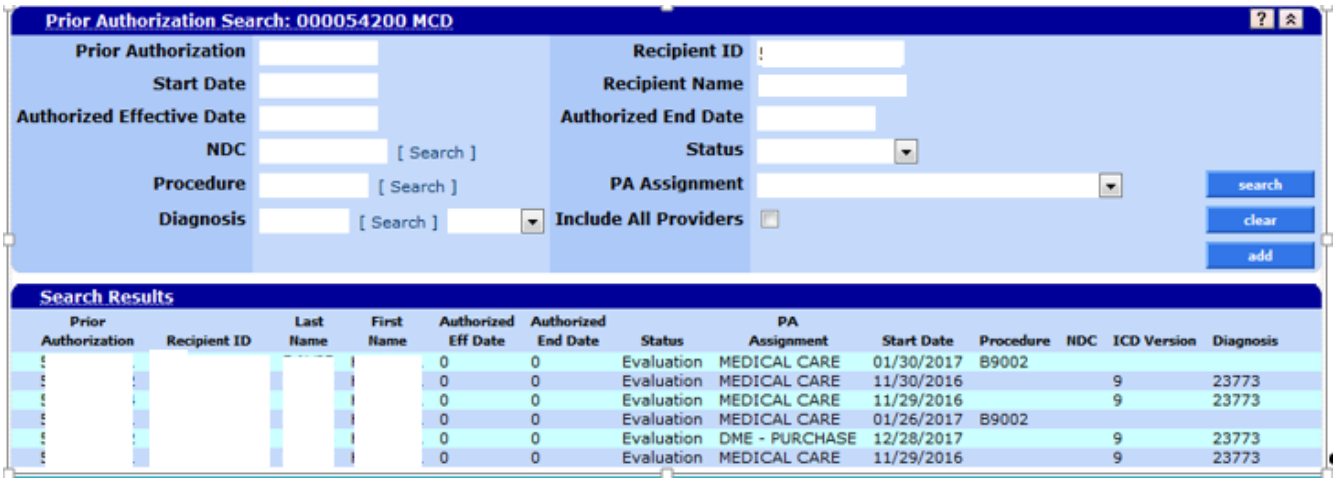
15.1.1 Prior Authorization Search Panel Narrative

The Prior Authorization panel allows users to search for prior authorizations and determine their status. The user has the capability to view the details and status of each prior authorization submitted or start a new prior authorization.

The corresponding prior authorization search results appear on the Prior Authorization panel in a list of ten prior authorizations per page. This list contains summary information about the prior authorization. The prior authorization number is hyperlinked to the prior authorization Submit panel for review. The prior authorization wizard process, used to submit a new prior authorization request, can be initiated by clicking the add button.

Navigation Path: [Prior Authorization] – [Search]

15.1.2 Prior Authorization Search Panel Layout



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15.1.3 Prior Authorization Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button initiates adding a new prior authorization.	Button	N/A	0
clear	This button clears all the search criteria fields.	Button	N/A	0
search	This button initiates the query.	Button	N/A	0
Authorized Effective Date	The date the PA becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
Authorized End Date	The date the PA is no longer active for claims processing.	Field	Date (MM/DD/CCYY)	8
Diagnosis	Displays the diagnosis code.	Field	Alphanumeric	7
First Name	Displays the first name of the recipient.	Field	Alphanumeric	13
ICD Version	This field has no label. It is used to identify which ICD Version of the Diagnosis code needs to be used in the search criteria. Valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	0
Include All Providers	Allow DME providers an option to search all DME PAs.	Combo Box	Checkbox	0
NDC	Displays the National Drug Code used to identify a specific drug.	Field	Alphanumeric	11
Last Name	Displays the last name of the recipient.	Field	Alphanumeric	15
PA Assignment	Displays the type of the prior authorization request. Refer to section 15.1.1 for details on PA Assignment Codes.	Combo Box	Drop Down List Box	0
Prior Authorization	Displays the number assigned to identify a specific Prior Authorization request.	Field	Alphanumeric	10
Procedure	Displays the code to uniquely identify a procedure.	Field	Alphanumeric	9
Recipient ID	Displays the recipient who received the service.	Field	Alphanumeric	13
Recipient Name	Displays the recipient name. (Read-Only)	Field	Alphanumeric	40
Start Date	Displays the date the prior authorization was added.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Status	Displays the status of the prior authorization.	Combo Box	Drop Down List Box	0

15.1.4 Prior Authorization Search Panel Field Edit Error Codes

Field	Error Message	To Correct
ICD Version	Diagnosis code required if ICD Version is not blank.	Enter a diagnosis code or select “BLANK” for the ICD Version.
Prior Authorization	Prior Authorization is not valid.	Enter a valid Prior Authorization number.
Recipient ID	Recipient ID is not valid.	Enter a valid Recipient ID.
	Recipient ID or Prior Authorization is required.	Enter either a Recipient ID or a Prior Authorization number.

15.1.5 Prior Authorization Search Panel Extra Features

Field	Field Type
Recipient Name	Read-only field displays after Recipient ID field populated.

15.1.6 Prior Authorization Search Panel Accessibility

15.1.6.1 To Access the Prior Authorization Search Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **Search**.	Prior Authorization Search panel displays.

15.1.6.2 To Search on the Prior Authorization Search Panel

Step	Action	Response
1	Enter one or a combination of the following fields: **Prior Authorization** number, **Start Date**, **Authorized Effective Date**, **NDC** or click [Search] to select from list, **Procedure** or click [Search] to select from list, **Diagnosis** or click [Search] to select from list, **Recipient ID**, **Authorized End Date**, **Status** and/or **PA Assignment**.	Clicking [Search] activates the NDC, Procedure, and/or Diagnosis Search panel(s). Refer to Chapter 14 for additional information regarding these pop-up panels.
2	Click **search**.	Clicking search displays the Prior Authorization Search panel.

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NOTE:

"No rows found" indicates a match was not identified based on the search criteria. A user can refine his or her search or contact the DXC Provider Assistance Center at 1 (800) 688-7989 for additional assistance during normal business hours; Monday – Friday from 8:00am – 5:00pm CST.

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15.2 Prior Authorization Search Results

15.2.1 Search Results Panel Narrative

The Prior Authorization Search Results panel displays records that match the search criteria from the Prior Authorization Search panel.

This panel displays the prior authorization information that matched the search criteria.

Navigation Path: [Prior Authorization] – [Search] – [search]

15.2.2 Search Results Panel Layout

Search Results

Prior Authorization	Recipient ID	Last Name	First Name	Authorized Eff Date	Authorized End Date	Status	PA Assignment	Start Date	Procedure	NDC	ICD Version	Diagnosis
50091	5000	SH	JO	0	0	Evaluation	SURGICAL	04/17/2009				
50101	5000	SH	JO	0	0	Evaluation	SURGICAL	05/25/2010	D2951			
50102	5000	SH	JO	0	0	Evaluation	SURGICAL	09/08/2010	0002F			
50101	5000	SH	JO	0	0	Evaluation	SURGICAL	05/25/2010	D2951			
50101	5000	SH	JO	0	0	Evaluation	MEDICAL CARE	05/25/2010	D2951			
50111	5000	SH	JO	0	0	Evaluation	DME - PURCHASE	04/28/2011	0006F		9	V874678
50121	5000	SH	JO	0	0	Evaluation	MEDICAL CARE	04/12/2012	0001F			
50096	5000	SH	JO	0	0	Evaluation	DENTAL CARE	03/19/2009			9	0020
50096	5000	SH	JO	0	0	Evaluation	DENTAL CARE	03/18/2009	D2951		9	0011
50091	5000	SH	JO	0	0	Evaluation	DENTAL CARE	04/15/2009				

1 2 Next >

15.2.3 Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Authorized Eff Date	The date the PA becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
Authorized End Date	The date the PA is no longer active for claims processing.	Field	Date (MM/DD/CCYY	8
Diagnosis	Displays the diagnosis code.	Field	Alphanumeric	7
First Name	Displays the first name of the recipient.	Field	Character	13
ICD Version	Indicates ICD Version of the Diagnosis code.	Field	Character	1
Last Name	Displays the last name of the recipient.	Field	Character	15
NDC	Displays the National Drug Code used to uniquely identify a drug.	Field	Alphanumeric	11
PA Assignment	Displays the type of prior authorization request.	Field	Alphanumeric	20
Prior Authorization	Displays the prior authorization number. Clicking the link will direct user to the Prior Authorization Detailed Info Display panel.	Field	Alphanumeric	10

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Field	Description	Field Type	Data Type	Length
Procedure	Displays the code to uniquely identify a procedure.	Field	Alphanumeric	5
Recipient ID	Displays the Recipient's first 12-digits of their Medicaid identification number, for who received the service.	Field	Alphanumeric	12
Start Date	Displays the date the prior authorization was added.	Field	Date (MM/DD/CCYY)	10
Status	Displays the Prior Authorization current status.	Field	Alphanumeric	11
Next	Displays the link to the next page of search results.	Hyperlink	N/A	0
Previous	Displays the link to the previous page of search results.	Hyperlink	N/A	0

15.2.4 Search Results Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

15.2.5 Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

15.2.6 Search Results Panel Accessibility

15.2.6.1 To Access the Search Results Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **Search**.	Prior Authorization Search panel displays.
3	Enter search criteria and click **search**.	Prior Authorization Search Results panel displays.

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15.3 Prior Authorization Submit

15.3.1 Prior Authorization Submit Panel Narrative

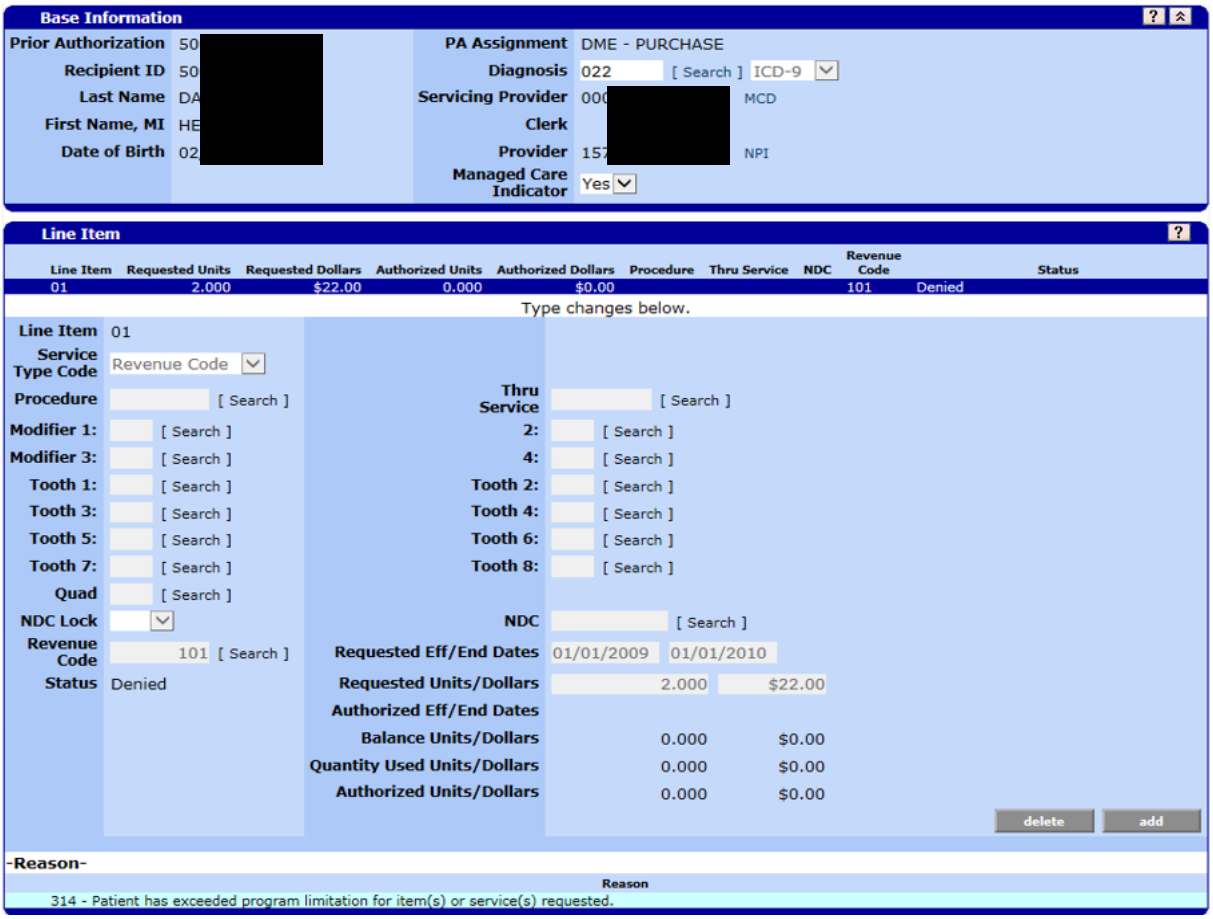
The Prior Authorization Submit panel allows users to update a prior authorization (PA) using the web application. The user has the capability to review/update existing PAs. Users can also view/update the notes provided for the PA. However, only the requesting provider is permitted to view/update a prior authorization request.

Navigation Path: [Prior Authorization] – [Search] - [search] - [select row in search results]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the prior authorization is not considered complete until those fields have been completed with the appropriate data.

15.3.2 Prior Authorization Submit Panel Layout



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15.3.3 Prior Authorization Submit Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button is used to add data to a panel.	Button	N/A	0
Analyst Remarks Description	Displays the remarks text entered by the analyst. This information is printed on the PA Notice.	Field	Character	500
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
delete	This button removes the record.	Button	N/A	0
save	This button saves current operation and re-submits the request to Medicaid.	Button	N/A	0
Authorized Eff/End Dates	Displays the requested prior authorization start and stop date for the line item. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Authorized Units/Dollars	Displays the units and/or dollar amount authorized for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14

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Field	Description	Field Type	Data Type	Length
Balance Units/Dollars	Displays the units and/or dollar amount balance for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14
Clerk	Displays the clerk that entered the prior authorization. Defaulted to clerk that is logged in. Consist of User Name and First and Last Name. (Read-Only)	Field	Alphanumeric	130
Control Number	Displays the attachment/paperwork identifier (E.G. Document Control Number).	Field	Character	80
Date Entered [Notes List]	Displays the date that the PA note was entered. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Date of Birth	Displays the date of birth of the recipient. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Description	Displays the free form text for the internal text (clinical note).	Field	Character	900
Description [Attachment Panel]	Displays the free form text for the attachment/paperwork.	Field	Character	80
Diagnosis	Displays the diagnosis code.	Field	Alphanumeric	7
First Name, MI	Displays the first name and middle initial of the recipient on the header. (Read-Only and defaulted on header panel.)	Field	Character	15
ICD Version	This field has no label and is read only. It is used to identify which ICD Version of Diagnosis code will be saved. Value of ICD Version will not be saved in the table.	Combo Box	Drop Down List Box	0
Last Name	Displays the last name of the recipient. (Read-Only and defaulted on header panel.)	Field	Character	15
Line Item	Displays the line items (or details) of a prior authorization record. (Read-Only)	Field	N/A	2
Line Item [Attachment Panel]	Displays the line number of the Prior Authorization attachment form text entered. It is used to uniquely identify rows of attachment form text that may have been entered for the same prior authorization.	Field	N/A	2

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Field	Description	Field Type	Data Type	Length
Managed Care Indicator	Displays whether a recipient participates in Managed care.	Combo Box	Drop Down List Box	0
Modifier 1	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 2	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 3	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 4	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
NDC	Displays the NDC. Dynamic field that appears when 'NDC' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	11
NDC Lock	Displays the drop down list to indicate National Drug Code Lock. Valid values: P - GCN, T - GC3, N – NDC.	Combo Box	Drop Down List Box	0
PA Assignment	Displays the type of prior authorization request. (Read-Only)	Combo Box	Drop Down List Box	0
Prior Authorization	Displays the number assigned to identify a specific Prior Authorization request. (Read-Only)	Field	Number (Integer)	10
Procedure	Displays the procedure code. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	6
Provider	Displays the requesting/prescribing provider for the prior authorization. (Read-Only. Defaulted from login provider.)	Field	Alphanumeric	10
Quad	Displays the tooth quadrant. Dynamic field that appears when Procedure is selected from the Service Type Code drop down list.	Field	Alphanumeric	3

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Field	Description	Field Type	Data Type	Length
Quantity Used Units/Dollars	Displays the units and/or dollar amount used for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14
Reason	Displays the denial reasons. Read only field that appears when a 'Line Item' is selected from the 'Line Item' list.	Field	Alphanumeric	500
Recipient ID	Displays the recipient's Medicaid identification number. (Read-Only)	Field	Number (Integer)	13
Report Type	Displays the code describing the type of attachment/paperwork.	Combo Box	Drop Down List Box	0
Requested Eff/End Dates	Displays the requested Prior Authorization start and stop date for the line item.	Field	Date (MM/DD/CCYY)	10
Requested Units/Dollars	Displays the number of units and/or the dollar amount requested for the Prior Authorization line item service.	Field	Number (Decimal)	14
Revenue Code	Displays the revenue code. Dynamic field that appears when 'Revenue Code' is selected from the 'Service Type Code' drop down list.	Field	Number (Integer)	4
Service Type Code	Displays the drop down list to indicate the service type code.	Combo Box	Drop Down List Box	0
Servicing Provider	Displays the servicing provider. Servicing Provider is also referred to as the Performing, Rendering or Billing provider. (Read-Only)	Field	Alphanumeric	10
Status	Displays the status of the prior authorization line item. (Read-Only). Default to Evaluation.	Combo Box	Drop Down List Box	0
Thru Service	Displays the thru procedure code, used to represent a range of procedure codes. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	6
Tooth 1	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2

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Field	Description	Field Type	Data Type	Length
Tooth 2	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 3	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 4	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 5	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 6	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 7	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 8	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Transmission	Displays the code defining timing, transmission method or format of attachment/paperwork.	Combo Box	Drop Down List Box	0

15.3.4 Prior Authorization Submit Panel Field Edit Error Codes

Field	Error Message	To Correct
add	Exceeded maximum number of Line Items.	Enter a prior authorization with 26 detail lines or less.
save	Cannot save any changes when a line item has a status outside of Evaluation!	PA record cannot be updated if any of the line items are no longer in an Evaluation status.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the datatype as documented in the field descriptions above. Number fields must only contain digits 0 - 9;

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Field	Error Message	To Correct
		date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
Description	Description is required.	Enter data in the Description box.
Diagnosis	Diagnosis contains an invalid value.	Enter a valid Diagnosis Code.
Modifier 1	Modifier 1 is not valid.	Enter a valid Modifier Code
Modifier 2	Modifier 2 is not valid.	Enter a valid Modifier code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Modifier 3	Modifier 3 is not valid.	Enter a valid Modifier Code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Modifier 4	Modifier 4 is not valid.	Enter a valid Modifier Code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Procedure	Procedure Code is required.	Enter a valid procedure code.
	Procedure Code is not valid.	Enter a valid procedure code.
Quad	Quad is not valid.	Enter a valid Quadrant Code.
Report Type	A valid Type is required.	Select a valid Report Type.
Requested Eff/End Dates	Requested Eff Date is required.	Enter a valid Requested Effective Date.
	Requested Eff Date must be less than or equal to Requested End Date.	Ensure Requested Effective Date is less than or equal to the Requested End Date .
	Requested Eff Date must be greater than or equal to 01/01/1900.	Enter a Requested Effective Date that is greater than or equal to 01/01/1900.
	Requested Eff Date must be less than or equal to 12/31/2299.	Enter a Requested Effective Date that is less than or equal to 12/31/2299.
	Requested End Date is required.	Enter a valid Requested End Date.
	Requested End Date must be greater than or equal to 01/01/1900.	Enter a Requested End Date that is greater than or equal to 01/01/1900.
	Requested End Date must be less than or equal to 12/31/2299.	Enter a Requested End Date that is less than or equal to 12/31/2299.

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Field	Error Message	To Correct
	Requested Effective Dates invalid for Diagnosis ICD version selected, please correct.	If Diagnosis code has a version as ICD-9 the Required Effective date should be Less than or Equal to the ICD-9 Diagnosis End Date. If Diagnosis code has a version as ICD-10 the Required Effective date should be Greater than or Equal to the ICD-10 Diagnosis Implementation Date. The ICD-9 Diagnosis End Date and ICD-10 Diagnosis Implementation Date are published on the CMS Web site.
	Assignment Type invalid for Recipient with RCO coverage for PA effective date of service.	If the PA requested effective date falls within the recipient's active assignment to an RCO, verify PA requested date. If entered incorrectly, re-enter the date. If entered correctly, the PA request should be submitted with the RCO on file.
Requested Units/Dollars	Requested Dollars must be greater than or equal to 0.00.	Ensure that this field is greater than or equal to zero.
	Requested Dollars must be less than or equal to 9999999.99.	Ensure the requested amount is not greater than $9,999,999.99.
	Requested Units must be greater than or equal to 0.000.	Ensure that this field is greater than or equal to zero.
	Requested Units must be less than or equal to 9999999.999.	Ensure the units requested are not greater than 9,999,999.999.
	Either Requested Units or Requested Dollars is required.	Enter a value in either the Requested Dollars or Requested Units fields.
Revenue Code	Revenue Code is not valid.	Enter a valid Revenue Code.
	Revenue Code is required.	Enter a valid Revenue Code.
Service Type Code	Service Type Code is required.	Select a valid Service Type Code.
	Service Type Code must be one of the following values: Empty, 1 = Revenue Code, 2 = Procedure Code.	A PA with the 'Service Type Code' of 'NDC Code' cannot be updated. Only an authorized clerk at DXC or HID may update a PA with an NDC service type.
Thru Service	Thru Service is not valid.	Enter a valid procedure code for the Thru Service.
Tooth 1	Tooth is not valid.	Enter a valid Tooth number.
Tooth 2	Tooth 2 is not valid.	Enter a valid Tooth number.
Tooth 3	Tooth 3 is not valid.	Enter a valid Tooth number.
Tooth 4	Tooth 4 is not valid.	Enter a valid Tooth number.

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Field	Error Message	To Correct
Tooth 5	Tooth 5 is not valid.	Enter a valid Tooth number.
Tooth 6	Tooth 6 is not valid.	Enter a valid Tooth number.
Tooth 7	Tooth 7 is not valid.	Enter a valid Tooth number.
Tooth 8	Tooth 8 is not valid.	Enter a valid Tooth number.
Transmission	A valid Transmission Code is required.	Select a valid Transmission Code.

15.3.5 Prior Authorization Submit Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

15.3.6 Prior Authorization Submit Panel Accessibility

15.3.6.1 To Access the Prior Authorization Submit Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **Search**.	Prior Authorization Search panel displays.
3	Enter search criteria and click **search**.	Prior Authorization Search Results panel displays.
4	Click line item from search results panel.	Prior Authorization Submit panel displays.

15.3.6.2 To Add on the Prior Authorization Submit Panel

Step	Action	Response
1	Click **add** in Line Item section.	Activates fields for entry of data or selection from lists.
2	Select a **Service Type Code** from the drop down list.	
3	If applicable, enter a **Procedure** or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	If applicable, enter a **Modifier 1**, **Modifier 2**, **Modifier 3** or **Modifier 4** code, or click [Search] to select from list.	Clicking [Search] activates the Modifiers Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
5	If applicable, enter a **Tooth 1**, **Tooth 2**, **Tooth 3**, **Tooth 4**, **Tooth 5**, **Tooth 6**, **Tooth 7** or **Tooth 8** code, or click [Search] to select from list.	Clicking [Search] activates the Tooth Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
6	If applicable, enter a **Quad** or click [Search] to select from list.	Clicking [Search] activates the Quadrant Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
7	If applicable, enter **Revenue Code** or click [Search] to select from list.	Clicking [Search] activates the Revenue Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
8	If applicable, enter a **Thru Service** procedure or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
9	Enter **Requested Eff Dates** date.	
10	Enter **Requested End Dates** date.	
11	Enter **Requested Units** number.	
13	Enter **Requested Dollars** amount.	
14	Click **add** in Notes section.	Activates fields for entry of data or selection from lists.
15	Enter **Description**.	
16	Click **add** in Attachments section.	Activates fields for entry of data or selection from lists.
17	Enter **Control Number**.	
18	Select **Transmission** from drop down list.	
19	Select **Report Type** from drop down list.	
20	Enter **Description**.	
21	Click **save**.	Prior Authorization information saved and re-sent to Medicaid for further review.

15.3.6.3 To Update on the Prior Authorization Submit Panel

Step	Action	Response
1	Select item from list.	
2	Click in field(s) to update and perform update.	
3	Click **save**.	Prior Authorization information saved and re-sent to Medicaid for further review.

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15.4 Prior Authorization Submit - Base Information Panel

15.4.1 Prior Authorization Submit - Base Information Panel Narrative

The Prior Authorization Submit - Base Information panel allows users to enter base information for a new prior authorization.

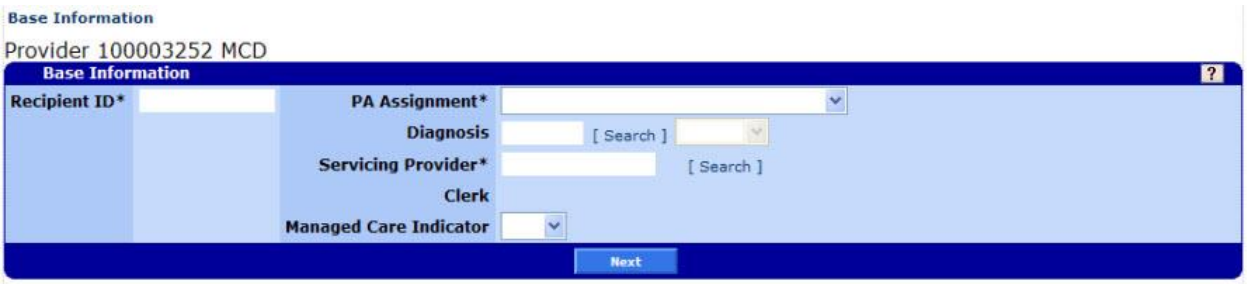
The Base Information panel is the first of four steps in the prior authorization wizard process, used to submit a new prior authorization.

Navigation Path: [Prior Authorization] – [New] OR [Prior Authorization - Search] – [add]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the prior authorization is not considered complete until those fields have been completed with the appropriate data.

15.4.2 Prior Authorization Submit - Base Information Panel Layout



15.4.3 Prior Authorization Submit - Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
New	This button is used to add a new PA request.	Button	N/A	0
Next	This button redirects the user to the next panel for the prior authorization new submit process.	Button	N/A	0
Clerk	Displays the clerk that entered the prior authorization. (Read-Only)	Field	Alphanumeric	8
Diagnosis	Displays the diagnosis code.	Field	Alphanumeric	7
ICD Version	This field has no label and is read only. It is used to identify which ICD Version of Diagnosis code will be saved. Value of ICD Version will not be saved in the table.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Managed Care Indicator	Displays whether a recipient participates in the Managed Care program.	Combo Box	Drop Down List Box	0
PA Assignment	Displays the type of prior authorization request.	Combo Box	Drop Down List Box	0
Recipient ID	Displays the recipient's Medicaid identification number.	Field	Number (Integer)	13
Servicing Provider	Displays the servicing provider. Servicing Provider is also referred to as the Performing, Rendering or Billing provider.	Field	Alphanumeric	10

15.4.4 Prior Authorization Submit - Base Information Panel Field Edit Error Codes

Field	Error Message	To Correct
PA Assignment	PA Assignment is required.	Select a PA Assignment.
Recipient ID	Recipient ID is required.	Enter a valid recipient ID.
	Recipient ID contains an Invalid number.	Enter a valid 13 digit Recipient ID.
	The Check Digit Number is not Valid for this recipient.	Enter the correct check digit for the recipient.
	Recipient ID must be 13 Digits with a valid Check Digit Number.	Enter a valid 13 digit Recipient ID.
	Recipient ID is not current, resubmit with their current Medicaid ID.	Enter the recipient's current ID that usually begins with 500.
Servicing Provider	Servicing Provider is Required.	Enter a valid servicing provider ID.

15.4.5 Prior Authorization Submit - Base Information Panel Extra Features

Field	Field Type
NPI or MCD	Hyperlink appears after the Servicing Provider field is populated with a valid NPI number. The NPI or MCD link indicates the provider number type displayed in the main panel: National Provider Identification (NPI) or Medicaid (MCD) number. Clicking NPI or MCD displays the Provider ID / Number panel, from which users can switch the provider number displayed from NPI to MCD.
Based on the User ID to NPI number association, the requesting/prescribing NPI number is automatically inserted as part of the prior authorization request. To submit a prior authorization request using a different NPI number, access the Switch Provider panel.	

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15.4.6 Prior Authorization Submit - Base Information Panel Accessibility

15.4.6.1 To Access the Prior Authorization Submit - Base Information Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **New**, or click **Search** and then **add**.	Base Information panel displays.

15.4.6.2 To Add on the Prior Authorization Submit - Base Information Panel

Step	Action	Response
1	Enter **Recipient ID**.	
2	Select **PA Assignment** from drop down list.	
3	Enter **Diagnosis** or click [Search] to select from list.	Clicking [Search] activates the Diagnosis Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	Enter **Servicing Provider**.	
5	Select **Managed Care Indicator** from drop down list.	
6	Click **Next**.	Line Item panel displays.

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15.5 Prior Authorization Submit - Line Item Panel

15.5.1 Prior Authorization Submit - Line Item Panel Narrative

The Line Item panel allows users to enter multiple line items for a new prior authorization.

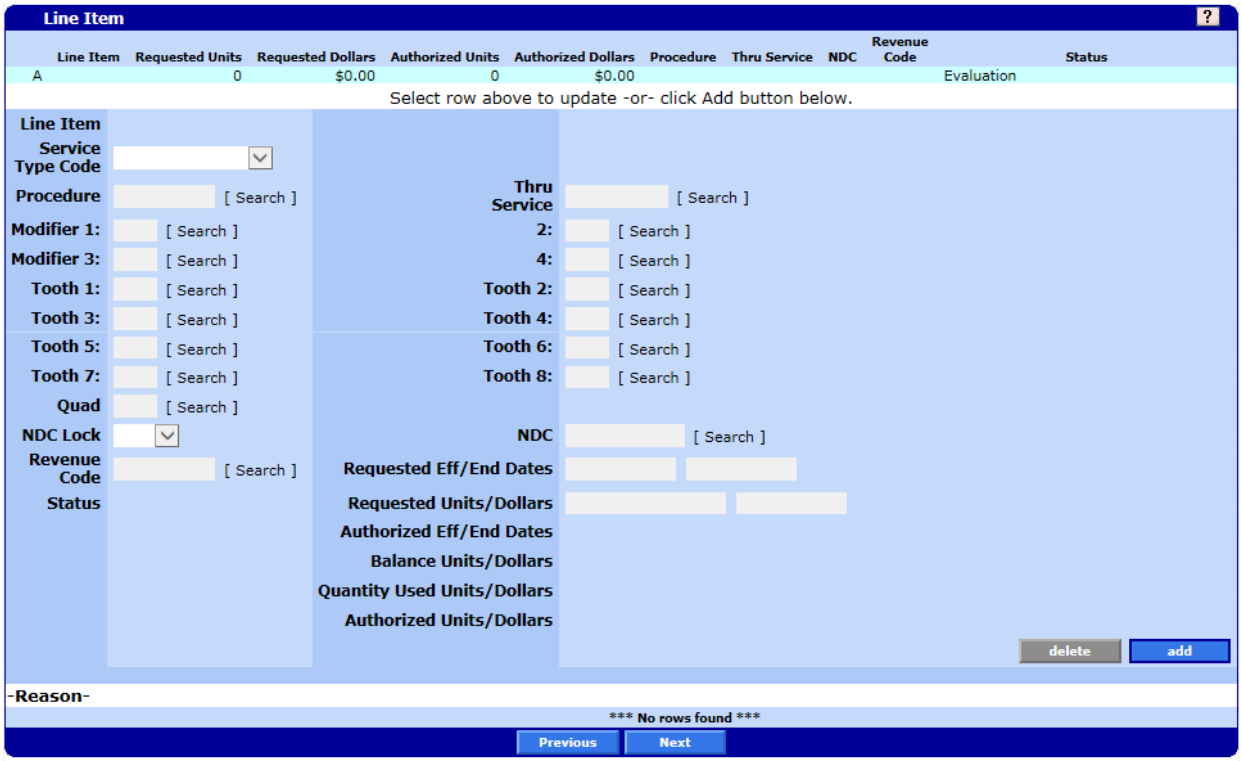
The Line Item panel is the second of four steps in the prior authorization wizard process, used to submit a new prior authorization.

Navigation Path: [Prior Authorization] – [New] – [click on Next from the Base Information panel]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the prior authorization is not considered complete until those fields have been completed with the appropriate data.

15.5.2 Prior Authorization Submit - Line Item Panel Layout



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15.5.3 Prior Authorization Submit - Line Item Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button adds detail lines.	Button	N/A	0
Authorized Eff/End Dates	Displays the requested prior authorization start and stop date for the line item. (Read-Only)	Field	Date (MM/DD/CCYY)	10
Authorized Units/Dollars	Displays the units and/or dollar amount authorized for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14
Balance Units/Dollars	Displays the units and/or dollar amount balance for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14
delete	This button is used to remove detail lines.	Button	N/A	0
Line Item	Displays the line items (or details) of a prior authorization record. (Read-Only)	Field	Number (Integer)	2
Modifier 1	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 2	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 3	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Modifier 4	Displays a procedure code modifier. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
NDC	Displays the NDC. Dynamic field that appears when 'NDC' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	11
NDC Lock	Displays the drop down list to indicate National Drug Code Lock. Valid values: P - GCN, T - GC3, N – NDC.	Combo Box	Drop Down List Box	0
New	This button is used to add a new PA request.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Next	This button redirects the user to the next panel for the prior authorization new submit process.	Button	N/A	0
Previous	This button redirects the user to the previous panel in prior authorization new submit process.	Button	N/A	0
Procedure	Displays the procedure code. Dynamic field that appears when ‘Procedure’ is selected from the ‘Service Type Code’ drop down list.	Field	Alphanumeric	6
Quad	Displays the tooth quadrant. Dynamic field that appears when ‘Procedure’ is selected from the ‘Service Type Code’ drop down list.	Field	Alphanumeric	3
Quantity Used Units/Dollars	Displays the units and/or dollar amount used for the prior authorization line item service. (Read-Only)	Field	Number (Decimal)	14
Reason	Displays the denial reasons. Dynamic field that appears when a ‘Line Item’ is selected from the ‘Line Item’ list.	Field	Alphanumeric	500
Requested Eff/End Dates	Displays the requested Prior Authorization start and stop date for the line item.	Field	Date (MM/DD/CCYY)	10
Requested Units/Dollars	Displays the number of units and/or the dollar amount requested for the Prior Authorization line item service.	Field	Number (Decimal)	14
Revenue Code	Displays the revenue code. Dynamic field that appears when ‘Revenue Code' is selected from the ‘Service Type Code’ drop down list.	Field	Number (Integer)	4
Service Type Code	Displays the drop down list to select the service type code.	Combo Box	Drop Down List Box	0
Status	Displays the status of the prior authorization line item. (Read-Only). Default to Evaluation.	Combo Box	Drop Down List Box	0
Thru Service	Displays the thru procedure code, used to represent a range of procedure codes. Dynamic field that appears when ‘Procedure’ is selected from the ‘Service Type Code’ drop down list.	Field	Alphanumeric	6

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Field	Description	Field Type	Data Type	Length
Tooth 1	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 2	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 3	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 4	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 5	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 6	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 7	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2
Tooth 8	Displays the tooth number. Dynamic field that appears when 'Procedure' is selected from the 'Service Type Code' drop down list.	Field	Alphanumeric	2

15.5.4 Prior Authorization Submit - Line Item Panel Field Edit Error Codes

Field	Error Message	To Correct
add	Exceeded maximum number of Line Items.	Enter a prior authorization with 26 detail lines or less.
All fields	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the datatype as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character

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Field	Error Message	To Correct
		fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9.
	Field exceeds max length.	Ensure that the field matches the field lengths as documented in the field descriptions above.
Modifier 1	Modifier 1 is not valid.	Enter a valid Modifier code.
Modifier 2	Modifier 2 is not valid.	Enter a valid Modifier code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Modifier 3	Modifier 3 is not valid.	Enter a valid Modifier Code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Modifier 4	Modifier 4 is not valid.	Enter a valid Modifier Code.
	Duplicate Modifier on same Line Item.	Ensure a duplicate modifier is not on the same PA line item.
Procedure	Procedure Code is required.	Enter a valid procedure code.
	Procedure Code is not valid.	Enter a valid procedure code.
Quad	Quad is not valid.	Enter a valid Quadrant Code.
Requested Eff /End Dates	Requested Eff Date is required.	Enter a valid Requested Effective Date.
	Requested Eff Date must be less than or equal to Requested End Date.	Ensure Requested Effective Date is less than or equal to the Requested End Date
	Requested Eff Date must be greater than or equal to 01/01/1900.	Enter a Requested Effective Date that is greater than or equal to 01/01/1900.
	Requested Eff Date must be less than or equal to 12/31/2299.	Enter a Requested Effective Date that is less than or equal to 12/31/2299.
	Requested End Date is required.	Enter a valid Requested End Date.
	Requested End Date must be greater than or equal to 01/01/1900.	Enter a Requested End Date that is greater than or equal to 01/01/1900.
	Requested End Date must be less than or equal to 12/31/2299.	Enter a Requested End Date that is less than or equal to 12/31/2299.
	Requested Effective Dates invalid for Diagnosis ICD version selected, please correct.	If Diagnosis code has a version as ICD-9 the Required Effective date should be Less than or Equal to the ICD-9 Diagnosis End Date. If Diagnosis code has a version as ICD-10 the Required Effective date should be Greater than or Equal to the ICD-10 Diagnosis Implementation Date. The ICD-9 Diagnosis End Date and ICD-10

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Field	Error Message	To Correct
		Diagnosis Implementation Date are published on the CMS Web site.
	Assignment Type invalid for Recipient with RCO coverage for PA effective date of service.	If the PA requested effective date falls within the recipient's active assignment to an RCO, verify PA requested date. If entered incorrectly, re-enter the date. If entered correctly, the PA request should be submitted with the RCO on file.
Requested Units/Dollars	Requested Dollars must be greater than or equal to 0.00.	Ensure that this field is greater than or equal to zero.
	Requested Dollars must be less than or equal to 9999999.99.	Ensure the requested amount is not greater than $9,999,999.99.
	Requested Units must be greater than or equal to 0.000.	Ensure that this field is greater than or equal to zero.
	Requested Units must be less than or equal to 9999999.999.	Ensure the units requested are not greater than 9,999,999.999.
	Either Requested Units or Requested Dollars is required.	Enter a value in either the Requested Dollars or Requested Units fields.
Revenue Code	Revenue Code is not valid.	Enter a valid Revenue Code.
	Revenue Code is required.	Enter a valid Revenue Code.
Service Type Code	Service Type Code is required.	Select a valid Service Type Code.
Thru Service	Thru Service is not valid.	Enter a valid procedure code for the Thru Service.
Tooth 1	Tooth is not valid.	Enter a valid Tooth number.
Tooth 2	Tooth 2 is not valid.	Enter a valid Tooth number.
Tooth 3	Tooth 3 is not valid.	Enter a valid Tooth number.
Tooth 4	Tooth 4 is not valid.	Enter a valid Tooth number.
Tooth 5	Tooth 5 is not valid.	Enter a valid Tooth number.
Tooth 6	Tooth 6 is not valid.	Enter a valid Tooth number.
Tooth 7	Tooth 7 is not valid.	Enter a valid Tooth number.
Tooth 8	Tooth 8 is not valid.	Enter a valid Tooth number.

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15.5.5 Prior Authorization Submit - Line Item Panel Extra Features

Field	Field Type
Reason	Selecting a 'Line Item' from the 'Line Item' list activates the read only Reason Panel.
Service Type Code	Selecting "Procedure Code" from the Service Type Code drop down list option activates the Procedure Code fields.
	Selecting "Revenue Code" from the Service Type Code drop down list option activates the Revenue Code fields.

15.5.6 Prior Authorization Submit - Line Item Panel Accessibility

15.5.6.1 To Access the Prior Authorization Submit - Line Item Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **New**.	Base Information panel displays.
3	Click **Next**.	Line Item panel displays.

15.5.6.2 To Add on the Prior Authorization Submit - Line Item Panel

Step	Action	Response
1	Select a **Service Type Code** from the drop down list.	
2	Enter a **Procedure** or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
3	Enter a **Modifier 1**, **Modifier 2**, **Modifier 3** or **Modifier 4** code, or click [Search] to select from list.	Clicking [Search] activates the Modifiers Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
4	Enter a **Tooth 1**, **Tooth 2**, **Tooth 3**, **Tooth 4**, **Tooth 5**, **Tooth 6**, **Tooth 7** or **Tooth 8** code, or click [Search] to select from list.	Clicking [Search] activates the Tooth Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
5	Enter a **Quad** or click [Search] to select from list.	Clicking [Search] activates the Quadrant Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
6	Enter **Revenue Code** or click [Search] to select from list.	Clicking [Search] activates the Revenue Code Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.
7	Enter a **Thru Service** procedure or click [Search] to select from list.	Clicking [Search] activates the Procedure Search panel. Refer to Chapter 14 for additional information regarding this pop-up panel.

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Step	Action	Response
8	Enter **Requested Eff Dates** date.	
9	Enter **Requested End Dates** date.	
10	Enter **Requested Units** number.	
11	Enter **Requested Units** dollar amount.	
12	Click **add** in Line Item section to add another service line and repeat steps 1 thru 11.	Activates fields for entry of data or selection from lists.
13	Click **Next**.	Notes panel displays.

15.5.6.3 To Update on the Prior Authorization Submit - Line Item Panel

Step	Action	Response
1	Select item from list.	
2	Click in field(s) to update and perform update.	
3	Click **Next**.	Notes panel displays.

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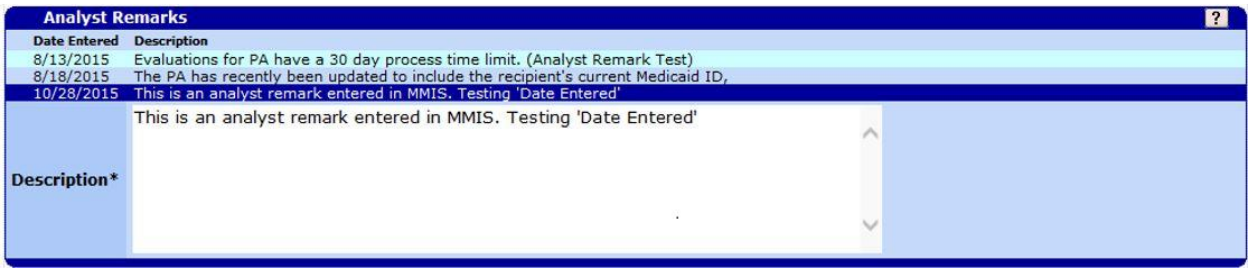
15.6 Prior Authorization Submit New – Analyst Remarks Panel

15.6.1 Prior Authorization Submit New – Analyst Remarks Panel Narrative

The Prior Authorization Submit New – Analyst Remarks panel allows users to review analyst remarks entered for a prior authorization.

15.6.2 Prior Authorization Submit New – Analyst Remarks Panel Layout



15.6.3 Prior Authorization Submit New – Analyst Remarks Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The remarks text entered by the analyst. This information is printed on the PA Notice.	Field	Character	500

15.6.4 Prior Authorization Submit New – Analyst Remarks Panel Field Edit Error Codes

Field	Error Message	To Correct
No Field Edit Error Codes found for this panel.		

15.6.5 Prior Authorization Submit New – Analyst Remarks Panel Extra Features

Field	Field Type
No extra features found for this panel.	

15.6.6 Prior Authorization Submit – Analyst Remarks Panel Accessibility

15.6.6.1 To Access the Prior Authorization Submit – Analyst Remarks Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **Search**.	Prior Authorization Search panel displays.

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Step	Action	Response
3	Enter search criteria and click **search**.	Prior Authorization Search Results panel displays.
4	Click line item from search results panel.	Prior Authorization Analyst Remarks panel displays.

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15.7 Prior Authorization Submit New – Notes Panel

15.7.1 Prior Authorization Submit New – Notes Panel Narrative

The Prior Authorization Submit New – Notes panel allows users to enter multiple clinical notes for a new prior authorization.

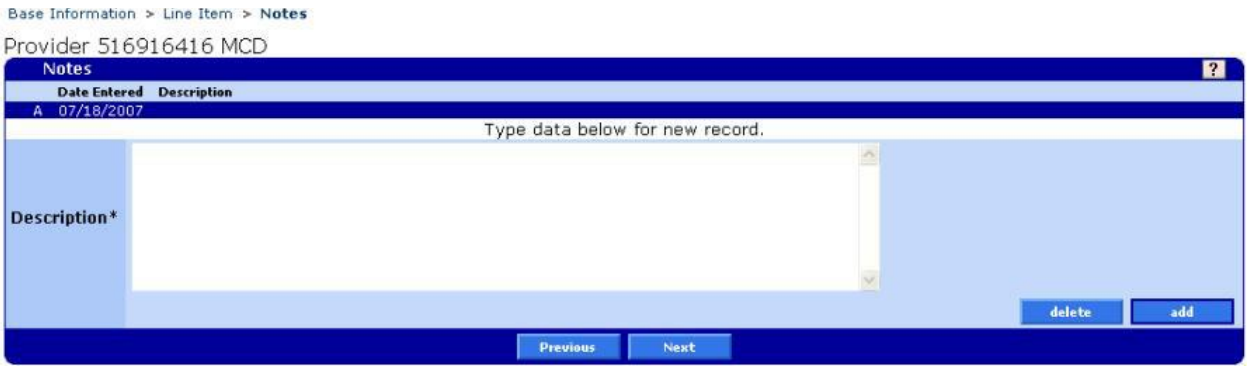
The Prior Authorization Submit New – Notes panel is the third of four steps in the prior authorization wizard process, used to submit a new prior authorization.

Navigation Path: [Prior Authorization] - New – [click on Next from the Line Item panel]

NOTE:

This panel is for informational purposes only. It does not permit a user to attach an electronic file for submission to Alabama Medicaid. If attachment information is included, please print and attach the PA response to the required attachments. Mail these attachments to DXC, Attention to: PA Unit. Address: PO Box 244032, Montgomery, AL 36124.

15.7.2 Prior Authorization Submit New – Notes Panel Layout



15.7.3 Prior Authorization Submit New – Notes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button adds a new note record.	Button	N/A	0
delete	This button deletes a note record.	Button	N/A	0
New	This button is used to add a new PA request.	Button	N/A	0
Next	This button redirects the user to the next panel for the prior authorization new submit process.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Previous	This button redirects the user to the previous panel in prior authorization new submit process.	Button	N/A	0
Date Entered [List]	Displays the date that the prior authorization note was entered.	Field	Date (MM/DD/CCYY)	10
Description	Displays the free form text for the internal text (clinical note).	Field	Character	540
Line Item [List]	Displays the line item of the prior authorization.	Field	Number (Integer)	2

15.7.4 Prior Authorization Submit New – Notes Panel Field Edit Error Codes

Field	Error Message	To Correct
Description	Description is required.	Enter data in the notes Description box.

15.7.5 Prior Authorization Submit New – Notes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

15.7.6 Prior Authorization Submit New – Notes Panel Accessibility

15.7.6.1 To Access the Prior Authorization Submit New – Notes Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **New**.	Base Information panel displays.
3	Click **Next**.	Line Item panel displays.
4	Click **Next**.	Notes panel displays.

15.7.6.2 To Add on the Prior Authorization Submit New – Notes Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Click **save** or **Next**.	Notes information saves and/or Attachments panel displays.

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15.7.6.3 To Update on the Prior Authorization Submit New – Notes Panel

Step	Action	Response
1	Select item from list.	
2	Click in field(s) to update and perform update.	
3	Click **save** or **Next**.	Notes information saves and/or Attachments panel displays.

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15.8 Prior Authorization Submit - Attachments

15.8.1 Prior Authorization Submit - Attachments Panel Narrative

The Prior Authorization Submit - Attachments panel allows users to enter multiple, internal attachments for a new prior authorization.

The Prior Authorization Submit - Attachments panel is the last of four steps in the prior authorization wizard process, used to submit a new prior authorization.

Navigation Path: [Prior Authorization] - New – [click on Next from the Notes panel]

15.8.2 Prior Authorization Submit - Attachments Panel Layout

15.8.3 Prior Authorization Submit - Attachments Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button adds a new note record.	Button	N/A	0
cancel	This button cancels the current operation and discards any changes.	Button	N/A	0
delete	This button deletes a note record.	Button	N/A	0
new	This button is used to add a new PA request.	Button	N/A	0
save	This button saves current operation and submits the request to Medicaid.	Button	N/A	0
Control Number	Displays the attachment/paperwork identifier (e.g. Document Control Number).	Field	Character	80
Description	Displays the free form text for the attachment/paperwork.	Field	Character	80

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Field	Description	Field Type	Data Type	Length
Line Item	Displays the line number of the prior authorization attachment form text entered. It is used to uniquely identify rows of attachment form text that may have been entered for the same prior authorization.	Field	Number (Integer)	3
Report Type	Displays the code describing the type of attachment/paperwork.	Combo Box	Drop Down List Box	0
Transmission Code	Displays the code defining timing, transmission method or format of attachment/paperwork.	Combo Box	Drop Down List Box	0

15.8.4 Prior Authorization Submit - Attachments Panel Field Edit Error Codes

Field	Error Message	To Correct
Report Type	A valid Type is required.	Select a valid Report Type.
Transmission Code	A valid Transmission Code is required.	Select a valid Transmission Code.

15.8.5 Prior Authorization Submit - Attachments Panel Extra Features

Field	Field Type
No extra features found for this panel.	

15.8.6 Prior Authorization Submit - Attachments Panel Accessibility

15.8.6.1 To Access the Prior Authorization Submit - Attachments Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **New**.	Base Information panel displays.
3	Click **Next**.	Line Item panel displays.
4	Click **Next**.	Notes panel displays.
5	Click **Next**.	Attachments panel displays.

15.8.6.2 To Add on the Prior Authorization Submit - Attachments Panel

Step	Action	Response
1	Click **add**.	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Enter **Control Number**.	
3	Select **Transmission** from drop down list.	
4	Select **Report Type** from drop down list.	
5	Enter **Description**.	
6	Click **save**.	Attachments information saves.

15.8.6.3 To Update on the Prior Authorization Submit - Attachments Panel

Step	Action	Response
1	Select item from list.	
2	Click in field(s) to update and perform update.	
3	Click **save**.	Attachments information saved.

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16. Provider Maintenance

16.1 Provider Maintenance Panel Overview

16.1.1 Provider Maintenance Panel Narrative

The Provider Maintenance panel contains links to information at the provider level. This panel is utilized as a navigation tool to access provider related panels such as the Provider Payer Information panel and Provider Location Contact Information panel. This panel is inquiry only.

Navigation Path: [Provider] – [ProviderMaintenance]

16.1.2 Provider Maintenance Panel Layout

16.1.3 Provider Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Provider Maintenance panels.	Button	N/A	0
Provider Location Contract Information	Link to Provider Location Information Panel.	Hyperlink	N/A	0
Provider Payer Information	Link to Provider Payer Information Panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Provider Maintenance panels.	Button	N/A	0

16.1.4 Provider Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

16.1.5 Provider Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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16.1.6 Provider Maintenance Panel Accessibility

16.1.6.1 To Access the Provider Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **ProviderMaintenance**.	Provider Maintenance panel displays.

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16.2 Provider Location Contact Information Panel Overview

16.2.1 Provider Location Contact Information Panel Narrative

Provider Location Contact Information panel allows providers to submit updates to specific information such as contact information.

Navigation Path: [Provider] – [Provider Maintenance] – [Click on Hyperlink Provider Location Contact Information]

16.2.2 Provider Location Contact Information Panel Layout

16.2.3 Provider Location Contact Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	First line of the provider's address.	Field	Character	30
Address 2	Second line of the provider's address.	Field	Character	30
City	City related to the provider's address.	Field	Character	15
Clear	Clears all data applied to a panel.	Button	N/A	0
Contact E-mail	Contact person's e-mail address attached with provider address.	Field	Character	50
Contact Fax	Contact person's fax number attached with provider address.	Field	Numeric (Integer)	10
Contact Name	Name of the Primary Contact attached with provider address	Field	Character	50
Contact Phone Number	Contact person's phone number attached with provider address.	Field	Numeric (Integer)	10
Provider ID	Provider ID of the Provider.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Search	Performs search based on criteria entered and displays search results within the pop up search panel. Selecting the desired result returned populates the main panel with the corresponding data.	Button	N/A	0
Service Location Email	Email address for the provider's service location.	Field	Character	50
Service Location Phone Number	Phone number for the provider's service location.	Field	Numeric (Integer)	10
Service Location Fax Number	Fax number for the provider's service location.	Field	Numeric (Integer)	10
State	State of the provider's address.	Field	Character	2
Toll Free Phone	Toll free phone+4 numbers associated to the provider's address.	Field	Character	10
Zip	Zip +4 of the provider's address.	Field	Numeric (Integer)	9

16.2.4 Provider Location Contact Information Panel Field Edit Error Codes

Field	Error Message	To Correct
All Fields	Enter a valid value.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9. Email addresses must be in the format XXXXX@xxx.xxx Fields must be completely filled in.
Contact Name	Contact Name is Required	Enter the Contact Name.
Service Location Phone	Service Location Phone is required.	Enter the phone number for the Service Location.

16.2.5 Provider Location Contact Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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16.2.6 Provider Location Contact Information Panel Accessibility

16.2.6.1 To Access the Provider Location Contact Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **ProviderMaintenance**.	Provider Maintenance panel displays.
3	Click on **Provider Location Contact Information** Hyperlink.	Provider Location Contact Information panel displays.

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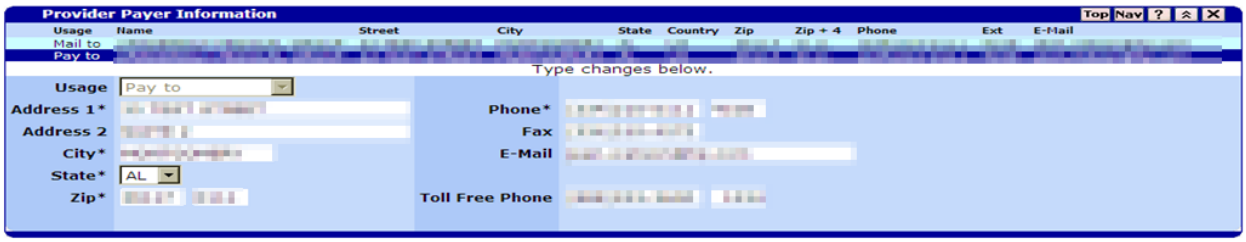
16.3 Provider Payer Information Panel Overview

16.3.1 Provider Payer Information Panel Narrative

Provider Payer Information Panel allows providers to submit updates to specific information such as address and phone number.

Navigation Path: [Provider] – [Provider Maintenance] – [Click on Hyperlink Provider Payer Information Panel]

16.3.2 Provider Payer Information Panel Layout



16.3.3 Provider Payer Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	The first line of the provider address.	Field	Character	30
Address 2	The Second line of the provider address.	Field	Character	30
City	The city associated with the provider address	Field	Character	30
E-mail	The email address of the provider.	Field	Character	50
Fax	The fax number for the provider	Field	Numeric (Integer)	10
Phone	Phone+4 phone number for the provider.	Field	Numeric (Integer)	14
State	The two character state code for the provider address.	Combo Box	Drop Down List Box	2
Toll Free Phone	Toll Free Phone+4 phone number for the provider.	Field	Numeric (Integer)	14
Usage	The type of provider address.	Combo Box	Drop Down List Box	1
Zip	Zip +4 of the provider's address	Field	Character	9

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16.3.4 Provider Payer Information Panel Field Edit Error Codes

Field	Error Message	To Correct
All Fields	Enter a valid value.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z; alphanumeric fields must only contain A - Z and 0 – 9. Email addresses must be in the format XXXXXX@xxx.xxx Fields such as phone number must be completely filled in when present.
Address 1	Address 1 is required.	Enter Address 1 information.
City	City is required.	Enter City.
State	State is required.	Enter State.
Zip	Zip is required.	Enter Zip Code.
Phone	Phone is required.	Enter Phone Number.

16.3.5 Provider Payer Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

16.3.6 Provider Payer Information Panel Accessibility

16.3.6.1 To Access the Provider Payer Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **ProviderMaintenance**.	Provider Maintenance panel displays.
3	Click on **Provider Payer Information** Hyperlink.	Provider Payer Information panel displays.

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17. PMP Assignment

17.1 PMP Assignment Panel Narrative

This panel allows providers the capability to make Patient 1st assignments.

Navigation Path: [Provider] – [PMP Assignment]

17.1.1 PMP Assignment Panel Layout

17.1.2 PMP Assignment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Assign	Initiates the assignment of new recipient to the PMP.	Button	N/A	0
Cancel	Cancels the transaction and clears the fields of PMP Assignment panel.	Button	N/A	0
Recipient ID	Recipient identification number.	Field	Number (Integer)	12
Recipient Name	Recipient name is displayed based on the Medicaid ID.	Field	Alphanumeric	40
[search]	Opens a new window for search based on Medicaid ID, Last Name, First Name or SSN.	Hyperlink	N/A	0
Validate	Initiates the validation for the recipient for his eligibility of Patient 1st.	Button	N/A	0

17.1.3 PMP Assignment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Validate				
	Button	3	Unable to make PMP assignment as the requesting provider is not a Patient 1st participating provider.	The requesting provider is not a Patient 1st participating provider.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	4	<Recipient Name>(RID <Medicaid ID>) already assigned to PMP, no update/changes allowed.	The requesting recipient has already been assigned to the requesting PMP provider.
	Button	5	PMP panel at contractual maximum limit, unable to assign recipient.	No more assignments can be made for the requesting provider as PMP contractual max has been reached.
	Button	6	Unable to assign recipient due to PMP Provider panel restriction placed by the Medicaid Agency, please contact the Provider Assistance Center for further assistance (800-688-7989).	Panel hold has been placed for the requesting provider by Agency or DXC, please contact the Provider Assistance Center for further assistance.
	Button	7	<Recipient Name>(RID <Medicaid ID>) does not meet Distance restriction set by PMP. Do you want to ignore restriction and assign the Recipient? If yes, select Assign otherwise select Cancel.	The requested recipient does not meet the Distance restriction criteria placed by requesting provider. The provider can ignore this message and assign the recipient, but after assignment he needs to contact the Provider Assistance Center to update his Distance restriction.
	Button	8	<Recipient Name>(RID <Medicaid ID>) does not meet Age restriction set by PMP. Do you want to ignore restriction and assign the Recipient? If yes, select Assign otherwise select Cancel.	The requested recipient does not meet the Age restriction criteria placed by requesting provider. The provider can ignore this message and assign the recipient, but after assignment he needs to contact the Provider Assistance Center to update his Age restriction.
	Button	9	<Recipient Name>(RID <Medicaid ID>) does not meet Gender restriction set by PMP. Do you want to ignore restriction and assign the Recipient? If yes, select Assign otherwise select Cancel.	The requested recipient does not meet the Gender restriction criteria placed by requesting provider. The provider can ignore this message and assign the recipient, but after assignment he needs to contact the Provider Assistance Center to update his Gender restriction.
	Button	10	Unable to assign Recipient due to panel hold placed by PMP. Do you want to ignore restriction and assign the Recipient? If yes, select Assign otherwise select Cancel.	The requesting provider has placed Panel hold. The provider can ignore this message and assign the recipient, but after assignment he needs to contact the Provider Assistance Center to update his Panel hold restriction.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	11	<Recipient Name>(RID <Medicaid ID>) has been previously dismissed from PMP, no update/changes allowed.	The requested recipient has been dismissed from being assigned to PMP by the requesting provider.
	Button	12	<Recipient Name>(RID <Medicaid ID>) is deceased, no update/changes allowed .	The requested recipient is dead. So no updates can be made for him.
	Button	13	<Recipient Name>(RID <Medicaid ID>) not currently eligible for PMP assignment since First Name is Unborn.	The requested recipient cannot be assigned as the first name is UNBORN.
	Button	14	Unable to make PMP assignment, please contact the Provider Assistance Center for further assistance (800-688-7989).	Due to some reason the PMP assignment cannot be done, please contact the Provider Assistance Center for further assistance.
	Button	15	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient has an invalid Aid Category for Patient 1st.	The requested recipient is not eligible for Patient 1st assignment.
	Button	16	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient has a Patient 1st exemption.	The requested recipient is not eligible for Patient 1st assignment.
	Button	17	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient residential county invalid for Patient 1st.	The requested recipient is not eligible for Patient 1st assignment.
	Button	18	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient has an invalid Patient 1st aid category.	The requested recipient is not eligible for Patient 1st assignment.
	Button	19	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient is not currently eligible for Patient 1st due to benefit plan assignment.	The requested recipient is not eligible for Patient 1st assignment.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	20	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient enrolled in Medicare.	The requested recipient is not eligible for Patient 1st assignment.
	Button	21	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient has an active HMO policy on file.	The requested recipient is not eligible for Patient 1st assignment.
	Button	22	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient is not currently eligible for Patient 1st due to special condition assignment.	The requested recipient is not eligible for Patient 1st assignment.
	Button	23	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient considered adult, Aid Category assigned not valid for Patient 1st.	The requested recipient is not eligible for Patient 1st assignment.
	Button	24	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient has an active long term care segment on file.	The requested recipient is not eligible for Patient 1st assignment.
	Button	25	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient is currently Inactive.	The requested recipient is not eligible for Patient 1st assignment.
	Button	26	<Recipient Name>(RID <Medicaid ID>) is not currently eligible for the Patient 1st program and cannot be assigned to the PMP - Recipient does not currently reside in Alabama.	The requested recipient is not eligible for Patient 1st assignment.
	Button	27	Unable to make PMP assignment as the requesting provider does not have a valid NPI on file. Please contact the Provider Assistance Center for further assistance (800-688-7989).	The requesting provider does not have a vaid NPI.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	28	<Recipient Name> (RID <Medicaid ID>) does not meet Distance restriction max set by Alabama Medicaid and assignment to PMP is not allowed.	The requested recipient is not eligible for Patient 1st assignment.
	Button	29	Recipient is enrolled in a mutually-exclusive program.	Verify the MC Program.
	Button	30	Recipient does not live in an active Probationary RCO county.	Verify the recipient county.

17.1.4 PMP Assignment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

17.1.5 PMP Assignment Panel Accessibility

17.1.5.1 To Access the PMP Assignment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click PMP Assignment.	PMP Assignment panel displays.
3	Enter Recipient Medicaid ID and move the control away from the text box.	Validate button will be enabled.
4	Click on the Validate button to validate the recipient.	Respective message will be displayed and the Assign button will be enabled.
5	Click the Assign button to assign the requested recipient to the requesting provider.	Saved successfully message will be displayed.

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18. Consent Form Search

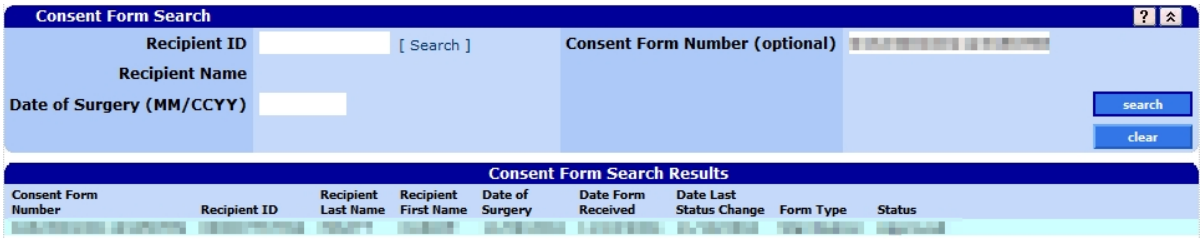
18.1 Consent Form Search Panel Overview

18.1.1 Consent Form Search Panel Narrative

This panel is available through the secure Provider web portal and allows end users to do a search for Recipient Consent Forms.

Navigation Path: [Providers] – [ConsentFormSearch]

18.1.2 Consent Form Search Panel Layout



18.1.3 Consent Form Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	This button clears all the search criteria fields.	Button	N/A	0
Consent Form Number (optional)	This is an 11 to 20 digit Consent Form Number.	Field	Character	20
Date of Surgery (MM/CCYY)	The date Surgery was performed.	Field	Date (MM/CCYY)	7
Recipient ID	This is 12 digit Recipient Identification Number.	Field	Character	12
Recipient Name	Recipient Last Name First Name, Middle Name.	Field	Character	39
Search	This button initiates the search.	Button	N/A	0

18.1.4 Consent Form Search Panel Field Edit Error Codes

Field	Error Message	To Correct
Consent Form Number (optional)	Required search criteria is Consent Form Number OR Recipient ID and Surgery Date.ddi	Enter a valid Consent Form Number.

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Field	Error Message	To Correct
	Consent Form Number must be between 11 and 20 digits.	Enter a Consent Form Number Between 11 and 20 digits.
Date of Surgery (MM/CCYY)	Required search criteria is Consent Form Number OR Recipient ID and Surgery Date.	Enter a valid Date of Surgery.
	Date of Surgery is not valid, should be equal to or less than current month & year.	Enter a valid Date of Surgery in the (MM/CCYY) format.
	Date of Surgery is required to search with Recipient ID.	Enter a valid Date of Surgery.
Recipient ID	Required search criteria is Consent Form Number OR Recipient ID and Surgery Date	Enter a valid Recipient ID.
	Recipient ID is required to search with Date of Surgery.	Enter a valid Recipient ID.
	Recipient ID must be 12 digits.	Enter a valid 12 digit Recipient ID.

18.1.5 Consent Form Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

18.1.6 Consent Form Search Panel Accessibility

18.1.6.1 To Access the Consent Form Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Providers** and click **ConsentFormSearch**.	Consent Form Search panel displays.

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19. PMP Dismiss

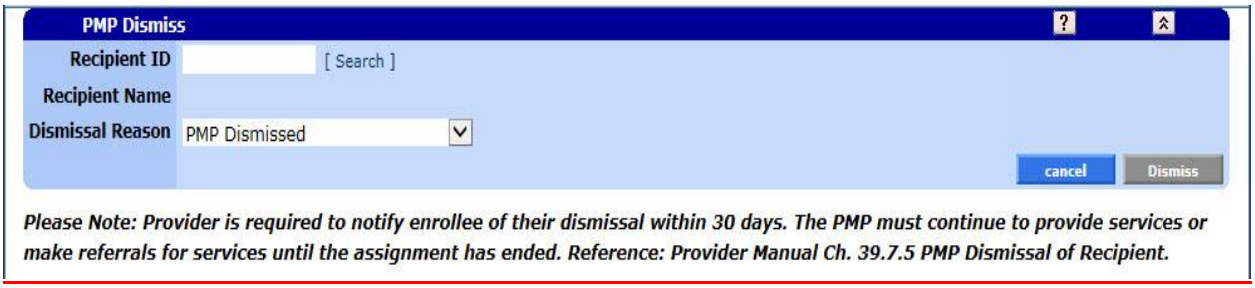
19.1 PMP Dismiss Panel Overview

19.1.1 PMP Dismiss Panel Narrative

This panel allows providers the capability to make Patient 1st assignments.

Navigation Path: [Provider] – [PMP Dismiss]

19.1.2 PMP Dismiss Panel Layout



19.1.3 PMP Dismiss Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancels the transaction and clears the fields of PMP Assignment panel.	Button	N/A	0
Dismiss	End the recipient assignment with the PMP provider.	Button	N/A	0
Dismissal Reason	This indicates the reason a recipient was dismissed by a specific PMP. Valid values are PMP Dismissal, Recipient Never Seen, Recipient Behavior, Non Compliance with Treatment and Other.	Field	Character	2
Recipient ID	Recipient identification number.	Field	Number (Integer)	12
Recipient Name	Recipient name is displayed based on the Medicaid ID.	Field	Alphanumeric	40
[search]	Opens a new window for search based on Medicaid ID, Last Name, First Name or SSN.	Hyperlink	N/A	0

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19.1.4 PMP Dismiss Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Dismiss	Button	1	Recipient ID <Medicaid ID> is not currently assigned to PMP. Unable to dismiss.	Recipient must be assigned to the provider to get dismissed.
	Button	2	Recipient ID <Medicaid ID> has been successfully dismissed, effective date <MM/dd/yyyy>.	Recipient was dismissed successfully.
	Button	3	<Recipient Name>(RID <Medicaid ID>) already dismissed, no update/changes required.	Recipient has been dismissed previously.
	Button	4	By selecting Ok the Recipient shall be locked out and re-assignment through the provider web portal will be unavailable. Please select Ok to continue with dismissal or Cancel.	This is a confirmation message for the provider.

19.1.5 PMP Dismiss Panel Extra Features

Field	Field Type
No extra features found for this panel.	

19.1.6 PMP Dismiss Panel Accessibility

19.1.6.1 To Access the PMP Dismiss Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click PMP Dismiss.	PMP Dismiss panel displays.
3	Enter Recipient Medicaid ID and move the control away from the text box.	Name of the recipient is displayed.
5	Click the Dismiss button to dismiss the recipient.	“By selecting Ok the Recipient shall be locked out and re-assignment through the provider web portal will be unavailable. Please select Ok to continue with dismissal or Cancel.”
6	If the provider selected OK from the popup confirmation window the recipient will be dismissed.	“Recipient ID XXXXXXXXXXXX has been successfully dismissed, effective date XX/XX/XXXX” message will be displayed.

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20. Search Pop-Up Panels

Search pop-up panels are accessed by means of a [search] hyperlink which is displayed alongside the related field. Each search window is related to a specific field and will permit a user to enter search criteria when the particular value or number is not known.

NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to check eligibility, billing restrictions and/or requirements as noted within the Alabama Medicaid Provider Manual.

The Search Pop-Up panels include the following sections:

- Search – Admission Type
- Search – Carrier Code
- Search – Condition
- Search – Diagnosis
- Search – Modifiers
- Search – NDC
- Search – Occurrence Code
- Search – Patient Status
- Search – POS
- Search – Prescriber License
- Search – Procedure
- Search – Procedure ICD-9
- Search – Provider ID
- Search – Quadrant
- Search – Revenue Code
- Search – Tooth
- Search – User Name

Navigation Path: [search] hyperlink.

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20.1 Admission Type Search

20.1.1 Admission Type Search Panel Narrative

The Admission Type Search pop-up panel allows for the search of an admission type.

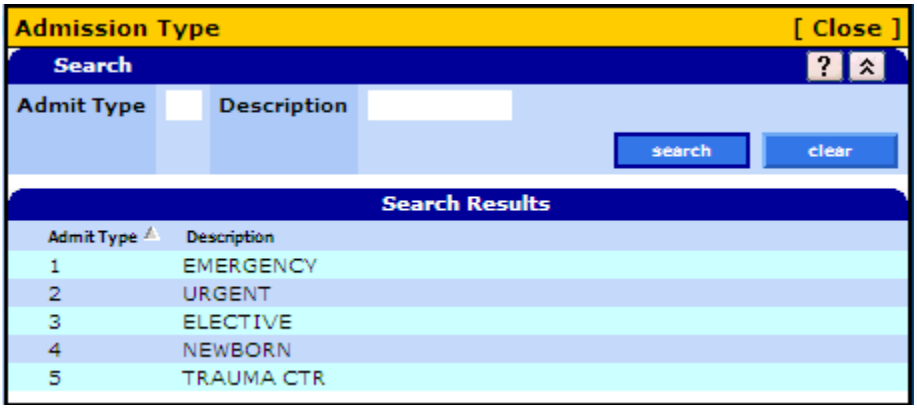
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Search]

20.1.2 Admission Type Search Panel Layout



20.1.3 Admission Type Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Admit Type	Displays the code which indicates the priority of the admission of a recipient for inpatient services.	Field	Character	1
Description	Displays the description for the priority of the admission of a recipient for inpatient services.	Field	Alphanumeric	10

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20.1.4 Admission Type Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.1.5 Admission Type Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.1.6 Admission Type Search Panel Accessibility

20.1.6.1 To Access the Admission Type Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **[Search]**.	Admission Type Search panel displays.

20.1.6.2 To Search on the Admission Type Search Panel

Step	Action	Response
1	Enter **Admit Type** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.2 Carrier Code Search

20.2.1 Carrier Code Search Panel Narrative

The Carrier Code Search pop-up panel allows for the search of a carrier.

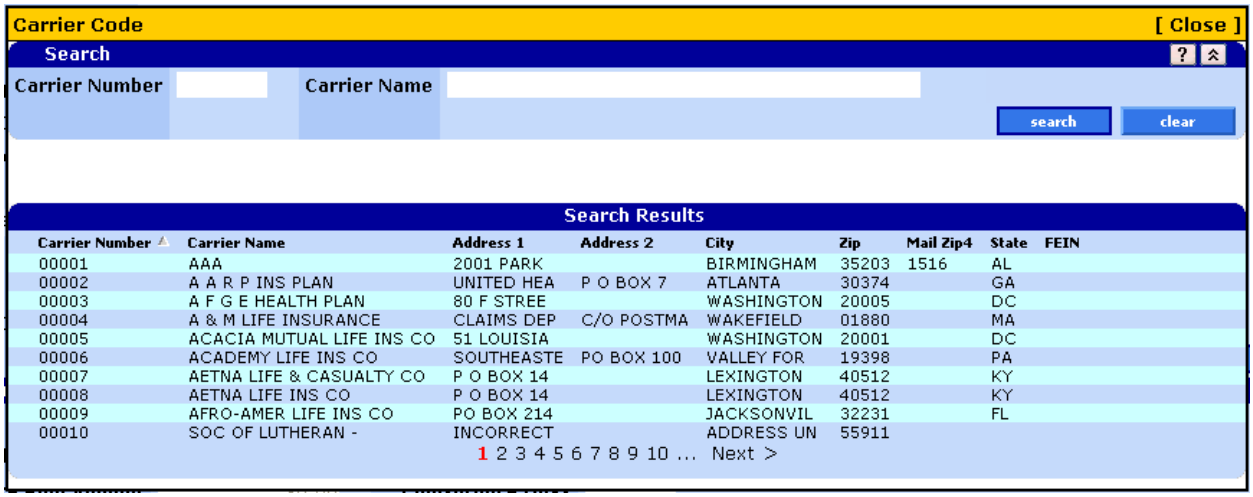
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [(Select a Dental, Institutional or Professional claim form)] – [TPL Panel] – [Search]

20.2.2 Carrier Code Search Panel Layout



20.2.3 Carrier Code Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Address 1	Displays the street address for the carrier.	Field	Character	30
Address 2	Displays the second street address for the carrier.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Carrier Name	Displays the description of the carrier code.	Field	Character	45
Carrier Number	Displays the carrier code.	Field	Number (Integer)	10
City	Displays the city for the carrier.	Field	Character	15
FEIN	Displays the Federal Employer Identification Number (FEIN) for the carrier.	Field	Number (Integer)	9
Mail Zip4	Displays the zip code + 4 for the carrier.	Field	Number (Integer)	4
State	Displays the state for the carrier.	Field	Alphanumeric	2
Zip	Displays the first 5 digits of the zip code for the carrier.	Field	Number (Integer)	5

20.2.4 Carrier Code Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.2.5 Carrier Code Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.2.6 Carrier Code Search Panel Accessibility

20.2.6.1 To Access the Carrier Code Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Select a **Dental**, **Institutional** or **Professional** claim form.	Claim panel displays.
3	Select a row or click add on the TPL panel.	TPL panel is activated, displaying the Carrier Code field.
4	Click **[Search]**.	Carrier Code Search panel displays.

20.2.6.2 To Search on the Carrier Code Search Panel

Step	Action	Response
1	Enter **Carrier Number** or **Carrier Name**.	
2	Click **search**.	

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Step	Action	Response
3	Select row from search results.	Adds search result selected to the main panel.

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20.3 Condition Search

20.3.1 Condition Search Panel Narrative

The Condition Search pop-up panel allows for the search of a condition.

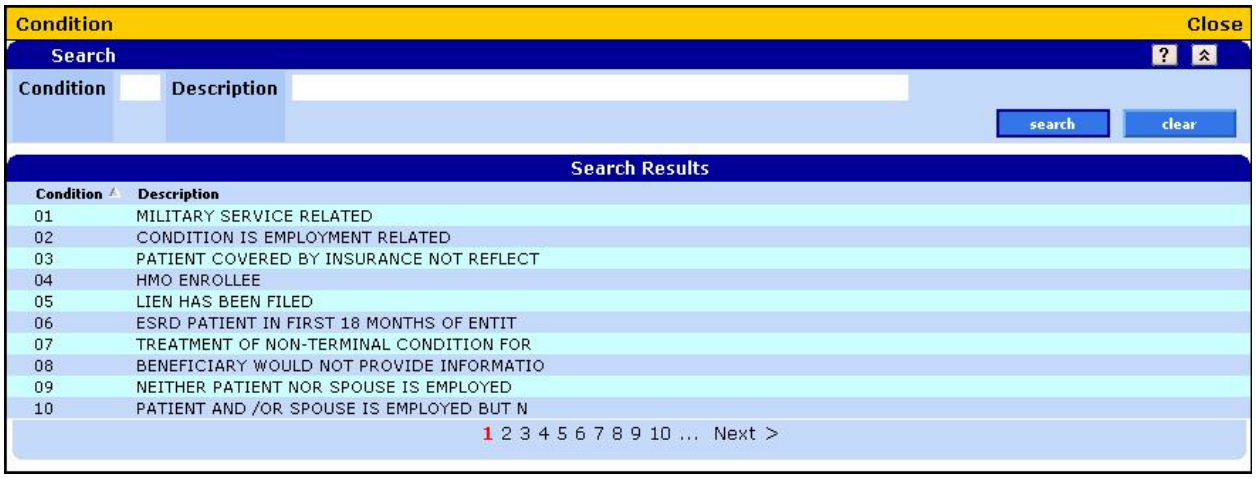
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Condition] – [Search]

20.3.2 Condition Search Panel Layout



20.3.3 Condition Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Condition	Displays the code used to identify conditions relating to a UB04 claim that may affect payer processing.	Field	Character	2
Description	Displays the description of conditions relating to a UB04 claim that may affect payer processing.	Field	Alphanumeric	40

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20.3.4 Condition Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.3.5 Condition Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.3.6 Condition Search Panel Accessibility

20.3.6.1 To Access the Condition Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Condition**.	Condition panel displays.
4	Select a row or click add on the Condition panel.	Condition panel is activated, displaying the Condition field.
5	Click **[Search]**.	Condition Search panel displays.

20.3.6.2 To Add on the Condition Search Panel

Step	Action	Response
1	Enter **Condition** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.4 Diagnosis Search

20.4.1 Diagnosis Search Panel Narrative

The Diagnosis Search pop-up panel allows for the search of a diagnosis code.

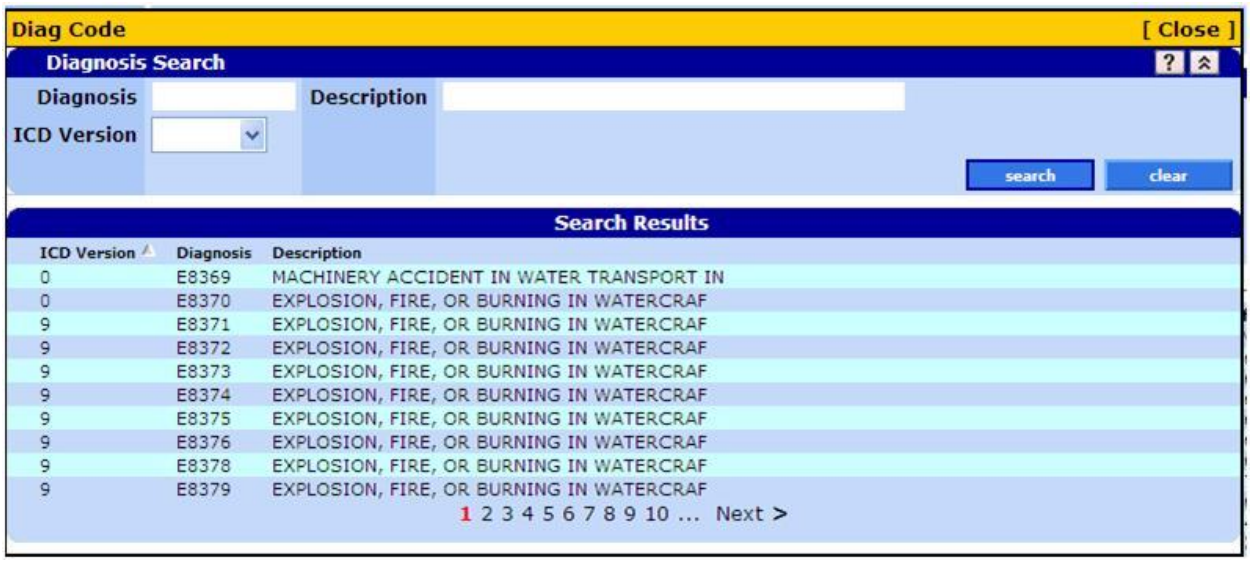
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – (Select a claim form)] – [Diagnosis Panel] – [Search] OR [Prior Authorization] – [(Select Search or New)] – [Search]

20.4.2 Diagnosis Search Panel Layout



20.4.3 Diagnosis Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Description	Displays the explanation of the medical condition.	Field	Alphanumeric	40

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Field	Description	Field Type	Data Type	Length
Diagnosis	Code that identifies the Diagnosis (condition requiring medical attention). Represents a medical classification of a disease or condition according to ICD-9 /ICD-10.	Field	Alphanumeric	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Combo Box	Drop Down List Box	1

20.4.4 Diagnosis Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.4.5 Diagnosis Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.4.6 Diagnosis Search Panel Accessibility

20.4.6.1 To Access the Diagnosis Search Panel

Step	Action	Response
1	Click **Claims** or **Prior Authorization**.	Claims or Prior Authorization page displays.
2	Click on form from the Claims or Prior Authorization page that you wish to complete.	Claim or Prior Authorization panel displays.
3	If viewing a claim form, click **Diagnosis**. If viewing a prior authorization form, proceed to step 4.	If viewing a claim form, Diagnosis panel displays.
4	Click **[Search]**.	Diagnosis Search panel displays.

20.4.6.2 To Search on the Diagnosis Search Panel

Step	Action	Response
1	Enter **Diagnosis** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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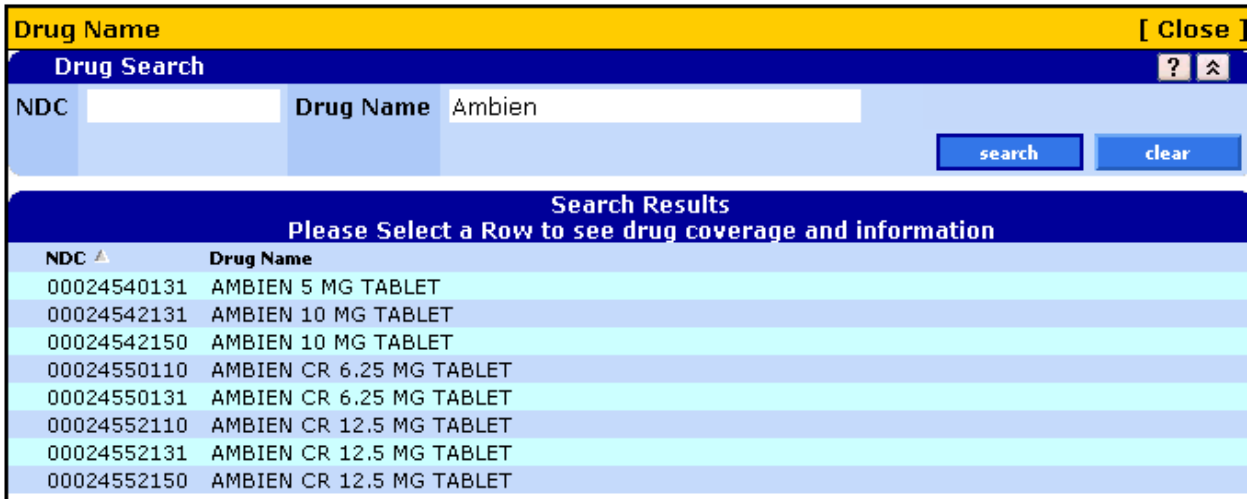
20.5 Drug Search Panel Narrative

The Drug Search panel will be displayed to allow users to search by a different NDC or Drug Name. After entering search criteria in the pop-up panel, simply select the desired result returned in the list and the Drug Information panel is populated with the related drug information.

Navigation Path: [NDC Look Up] – [Drug Name - Search]

20.5.1 Drug Search Panel Layout



20.5.2 Drug Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Drug Name	Partial or complete label name of a drug to perform a search.	Field	Alphanumeric	40
NDC	National Drug Code number to perform a search.	Field	Number (Integer)	11

20.5.3 Drug Search Panel Field Edit Error Codes

Field	Error Message	To Correct
NDC and Drug Name	Please Enter At Least One Search Criteria.	No value entered in either field.
NDC	NDC Not Found.	Invalid NDC entered.

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20.5.4 Drug Search Panel Extra Features

Field	Field Type
Pagination is provider up to 50 rows per page. A user may select any NDC record and the related drug information is displayed in the main Drug Coverage Information panel and the Drug Search Popup Panel remains open so that a user can search on another record.	

20.5.5 Drug Search Panel Accessibility

20.5.5.1 To Access the Drug Search Panel

Step	Action	Response
1	Enter search criteria and click **search**	If data returns more than 1 row then Drug Search Panel is dispalyed
2	Click on HyperLink beside Drug Name Search Button	Drug Search Panel is displayed without data for fresh search.

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20.6 Modifiers Search

20.6.1 Modifiers Search Panel Narrative

The Modifiers Search pop-up panel allows for the search of a modifier.

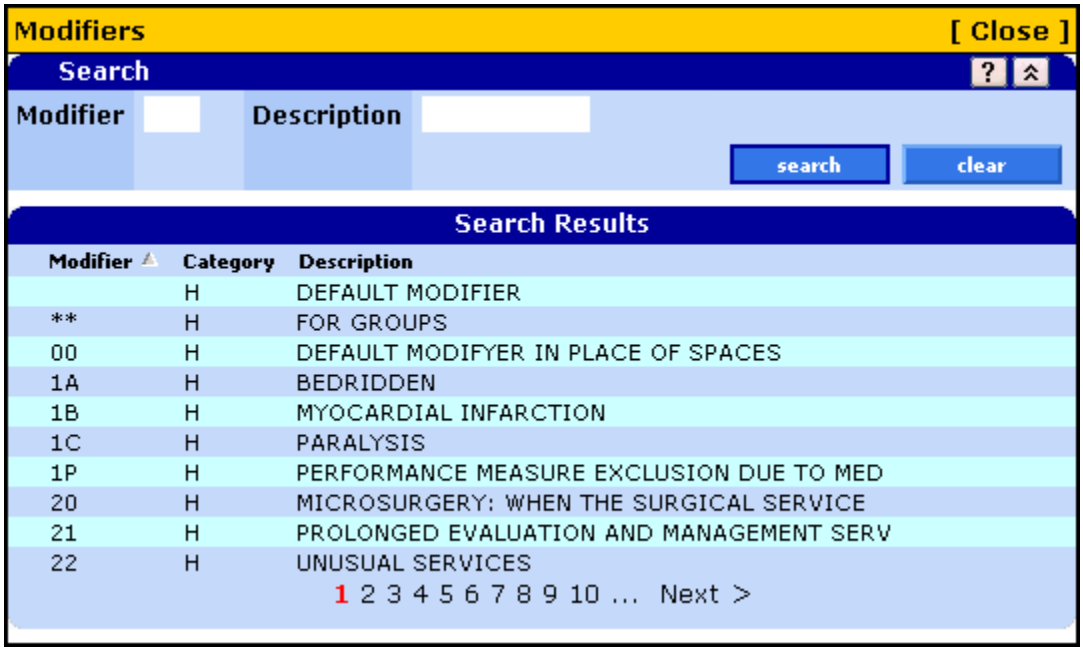
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – (Select a claim form)] – [Detail Panel] – [Search] OR [Prior Authorization] – [(Select the Search or New form)] – [Search]

20.6.2 Modifiers Search Panel Layout



20.6.3 Modifiers Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Category	Displays whether the modifier is a HCPCS modifier or an Ambulance modifier.		Alphanumeric	1
Description	Displays the short description of the modifier.	Field	Alphanumeric	40
Modifier	Displays the modifier.	Field	Character	2

20.6.4 Modifiers Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.6.5 Modifiers Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.6.6 Modifiers Search Panel Accessibility

20.6.6.1 To Access the Modifiers Search Panel

Step	Action	Response
1	Click **Claims** or **Prior Authorization**.	Claims or Prior Authorization page displays.
2	Click on form from the Claims or Prior Authorization page that you wish to complete.	Claim or Prior Authorization panel displays.
3	Click **[Search]**.	Modifiers Search panel displays.

20.6.6.2 To Search on the Modifiers Search Panel

Step	Action	Response
1	Enter **Modifier** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.7 NDC Search

20.7.1 NDC Search Panel Narrative

The NDC Search pop-up panel allows for the search of a National Drug Code (NDC).

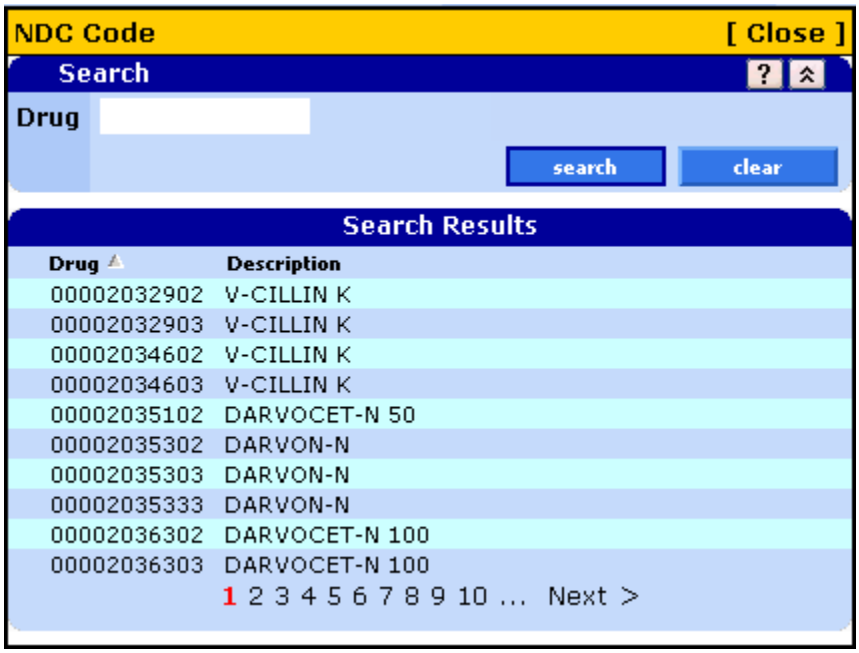
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements. For example, prior authorization, max unit, non-preferred, recipient aid category and age limitations.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Pharmacy] – [Search]

20.7.2 NDC Search Panel Layout



20.7.3 NDC Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Description	Displays the brand name of the drug. The brand name is usually the drug name appearing on the package label and frequently is a trademark. If necessary, it is edited to fit space requirements. For non-branded generic products, the description is usually the generic name.	Field	Alphanumeric	35
Drug	Displays the National Drug Code (NDC).	Field	Alphanumeric	11

20.7.4 NDC Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.7.5 NDC Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.7.6 NDC Search Panel Accessibility

20.7.6.1 To Access the NDC Search Panel

Step	Action	Response
1	Click Claims.	Claims page displays.
2	Click Pharmacy.	Pharmacy Claim panel displays.
3	Select a row or click add on the Detail panel.	Detail panel is activated, displaying the NDC Code field.
4	Click [Search].	NDC Code Search panel displays.

20.7.6.2 To Search on the NDC Search Panel

Step	Action	Response
1	Enter **Drug** code.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.8 Occurrence Code Search

20.8.1 Occurrence Code Search Panel Narrative

The Occurrence Code Search pop-up panel allows for the search of an occurrence code.

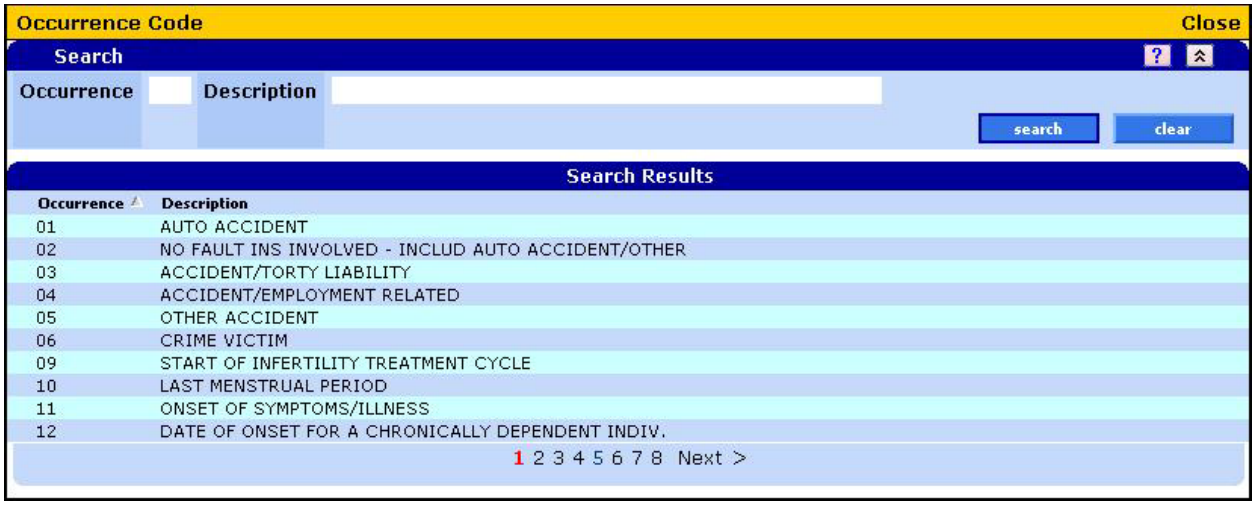
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Occurrence] – [Search]

20.8.2 Occurrence Search Panel Layout



20.8.3 Occurrence Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Description	Displays the description of a significant event relating to a particular UB04 claim that may affect payer processing occurred.	Field	Alphanumeric	50

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Field	Description	Field Type	Data Type	Length
Occurrence	Displays the code which defines a significant event relating to a particular UB04 claim that may affect payer processing.	Field	Character	2

20.8.4 Occurrence Code Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.8.5 Occurrence Code Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.8.6 Occurrence Code Search Panel Accessibility

20.8.6.1 To Access the Occurrence Code Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Occurrence**.	Occurrence panel displays.
4	Select a row or click add on the Occurrence panel.	Occurrence panel is activated, displaying the Occurrence Code field.
5	Click **[Search]**.	Procedure Search panel displays.

20.8.6.2 To Search on the Occurrence Code Search Panel

Step	Action	Response
1	Enter **Occurrence** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.9 Patient Status Search

20.9.1 Patient Status Search Panel Narrative

The Patient Status Search pop-up panel allows for the search of a patient status code.

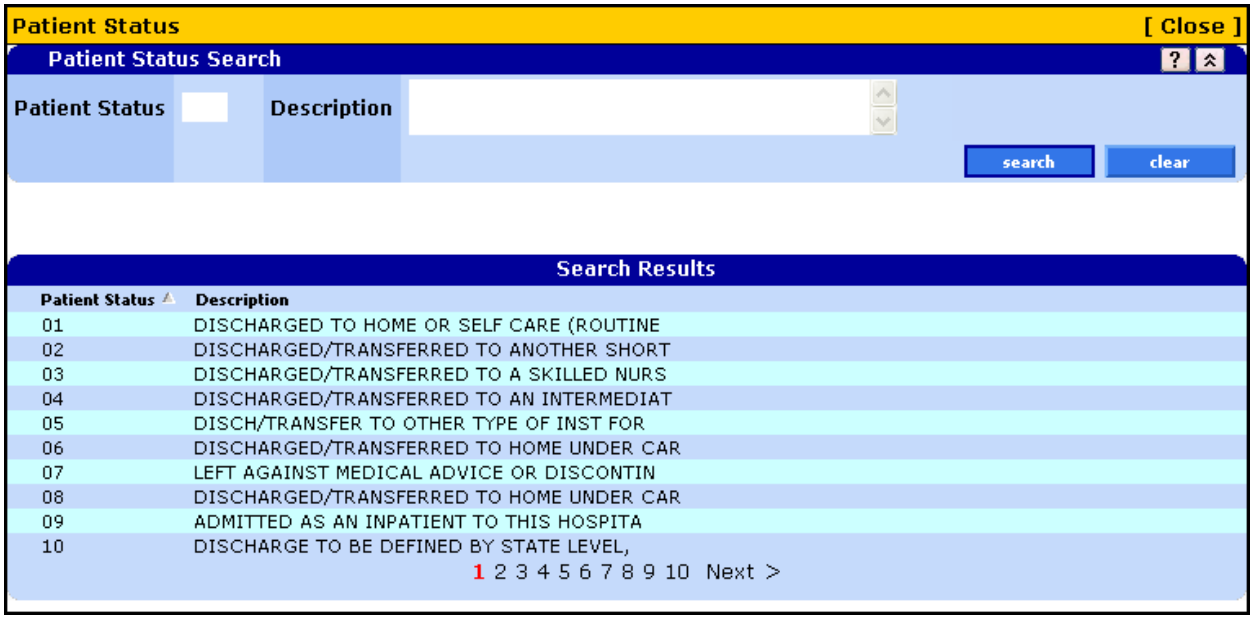
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Search]

20.9.2 Patient Status Search Panel Layout



20.9.3 Patient Status Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Description	Displays the description of the status of the recipient as of the ending service date of the period covered on a UB04 claim.	Field	Alphanumeric	80
Patient Status	Displays the status of the recipient as of the ending service date of the period covered on a UB04 claim.	Field	Character	2

20.9.4 Patient Status Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.9.5 Patient Status Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.9.6 Patient Status Search Panel Accessibility

20.9.6.1 To Access the Patient Status Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **[Search]**.	Patient Status Search panel displays.

20.9.6.2 To Search on the Patient Status Search Panel

Step	Action	Response
1	Enter **Patient Status** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.10 POS Search

20.10.1 POS Search Panel Narrative

The POS Search pop-up panel allows for the search of a Place of Service (POS).

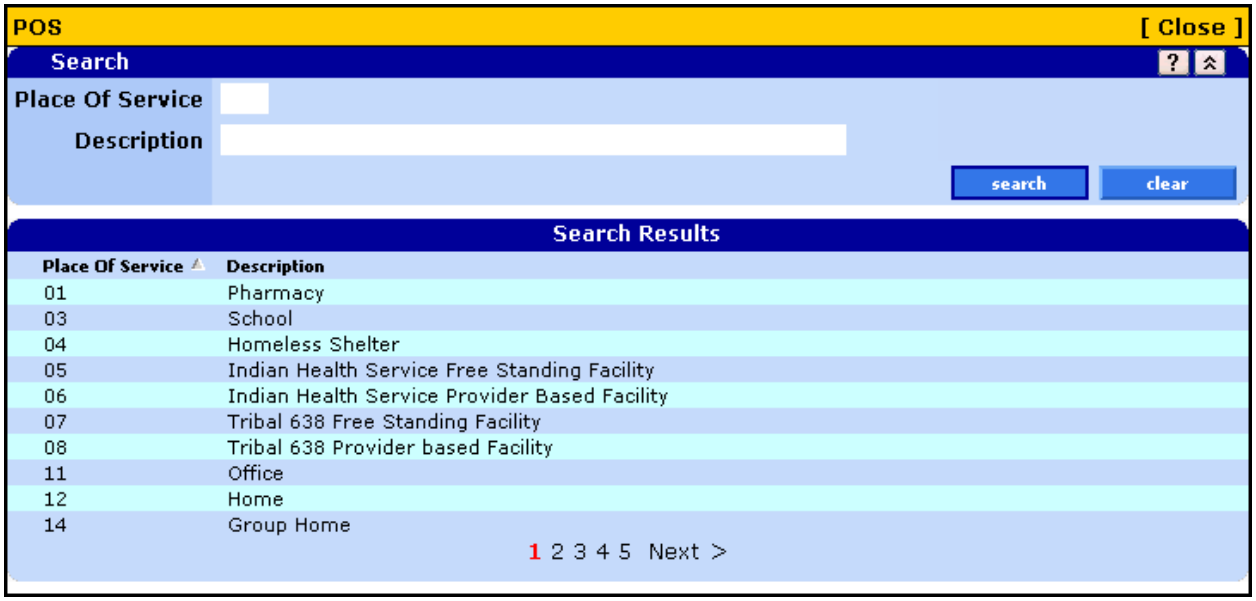
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [(Dental or Professional)] – [Search] OR [Prior Authorization – (Select the Search or New form)] – [Search]

20.10.2 POS Search Panel Layout



20.10.3 POS Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Description	Displays the description of the location where the medical assistance service was performed.	Field	Alphanumeric	50
Place Of Service	Displays the location code where the medical assistance service was provided.	Field	Character	2

20.10.4 POS Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.10.5 POS Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.10.6 POS Search Panel Accessibility

20.10.6.1 To Access the POS Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Dental** or **Professional**.	Dental or Professional Claim panel displays.
3	Click **[Search]**.	POS Search panel displays.

20.10.6.2 To Search on the POS Search Panel

Step	Action	Response
1	Enter **Place Of Service** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.11 Prescriber License Search

20.11.1 Prescriber License Search Panel Narrative

The Prescriber License Search pop-up panel allows for the search of a prescriber license number.

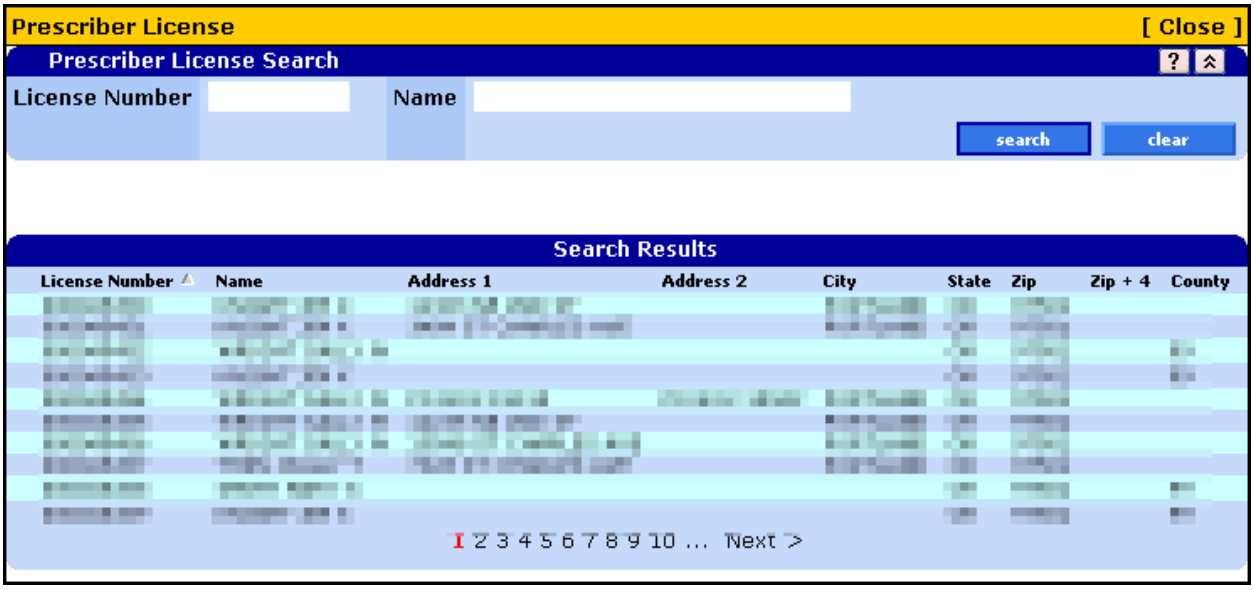
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Pharmacy] – [Search]

20.11.2 Prescriber License Search Panel Layout



20.11.3 Prescriber License Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Address 1	Displays the provider's primary address.	Field	Alphanumeric	40

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Field	Description	Field Type	Data Type	Length
Address 2	Displays the provider's secondary address.	Field	Alphanumeric	20
City	Displays the provider's city.	Field	Alphanumeric	20
County	Displays the provider's county code.	Field	Alphanumeric	2
License Number	Displays the provider's state license number.	Field	Character	10
Name	Displays the name of the provider who is issued the license number.	Field	Alphanumeric	50
State	Displays the provider's state.	Field	Alphanumeric	2
Zip	Displays the provider's zip code.	Field	Number (Integer)	5
Zip + 4	Displays the provider's zip + 4.	Field	Number (Integer)	4

20.11.4 Prescriber License Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.11.5 Prescriber License Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.11.6 Prescriber License Search Panel Accessibility

20.11.6.1 To Access the Prescriber License Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Pharmacy**.	Pharmacy Claim panel displays.
3	Click **[Search]**.	Prescriber License Search panel displays.

20.11.6.2 To Search on the Prescriber License Search Panel

Step	Action	Response
1	Enter **License Number** or **Name**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.12 Procedure Search

20.12.1 Procedure Search Panel Narrative

The Procedure Search pop-up panel allows for the search of a procedure code.

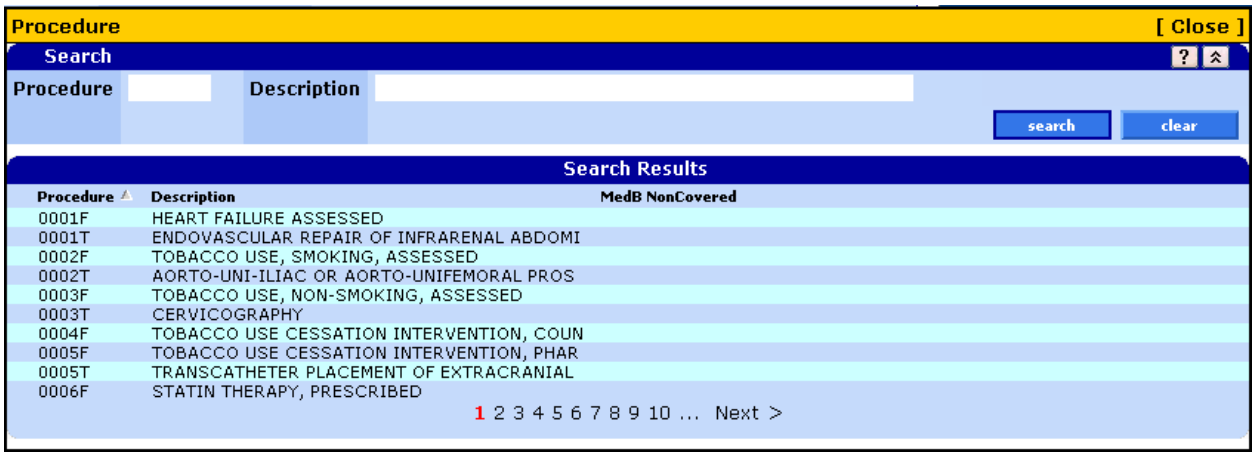
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements. For example, this includes prior authorization, max unit, recipient aid category and age limitations.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [(Dental or Professional)] – [Search] OR [Prior Authorization – (Select Search or New)] – [Search]

20.12.2 Procedure Search Panel Layout



20.12.3 Procedure Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Description	Displays the description of the procedure.	Field	Alphanumeric	40
Procedure	Displays the code for the procedure.	Field	Alphanumeric	6

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20.12.4 Procedure Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.12.5 Procedure Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.12.6 Procedure Search Panel Accessibility

20.12.6.1 To Access the Procedure Search Panel

Step	Action	Response
1	Click **Claims** or **Prior Authorization**.	Claims or Prior Authorization page displays.
2	Click on form from the Claims or Prior Authorization page that you wish to complete.	Claim or Prior Authorization panel displays.
3	Click **[Search]**.	Procedure Search panel displays.

20.12.6.2 To Search on the Procedure Search Panel

Step	Action	Response
1	Enter **Procedure** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.13 Procedure ICDSearch

20.13.1 Procedure ICD Search Panel Narrative

The Procedure ICD Search pop-up panel allows for the search of an ICD surgical procedure code.

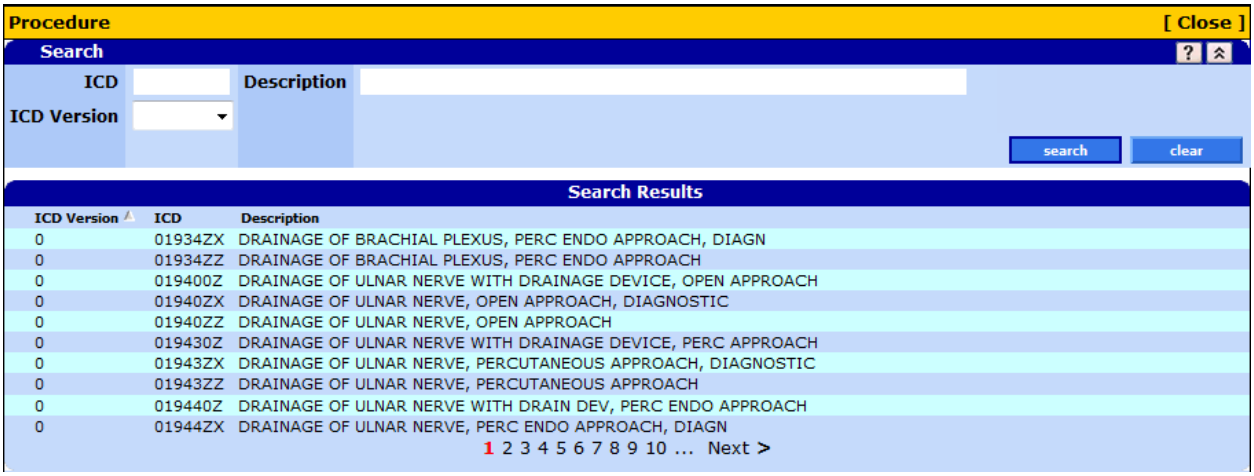
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Procedure] – [Search]

20.13.2 Procedure ICD Search Panel Layout



20.13.3 Procedure ICD Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Description	Displays the Medical Description of surgical or diagnostic procedure.	Field	Alphanumeric	60
ICD	Displays the code which indicates a specific, surgical or diagnostic procedure.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
ICD Version	Code to denote which version of the ICD procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Field	Character	1

20.13.4 Procedure ICD Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.13.5 Procedure ICD Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.13.6 Procedure ICD Search Panel Accessibility

20.13.6.1 To Access the Procedure ICD Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Click **Institutional**.	Institutional Claim panel displays.
3	Click **Procedure**.	Procedures panel displays.
4	Select a row or click add on the Procedure panel.	Procedure panel is activated, displaying the Procedure field.
5	Click **[Search]**.	Procedure ICD Search panel displays.

20.13.6.2 To Search on the Procedure ICD Search Panel

Step	Action	Response
1	Enter **ICD** code or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.14 Provider ID Search

20.14.1 Provider ID Search Panel Narrative

The Provider ID Search pop-up panel allows for the search of a specific service location for a provider. This search applies to Rendering, Referring, Operating, Attending and Servicing Provider ID fields.

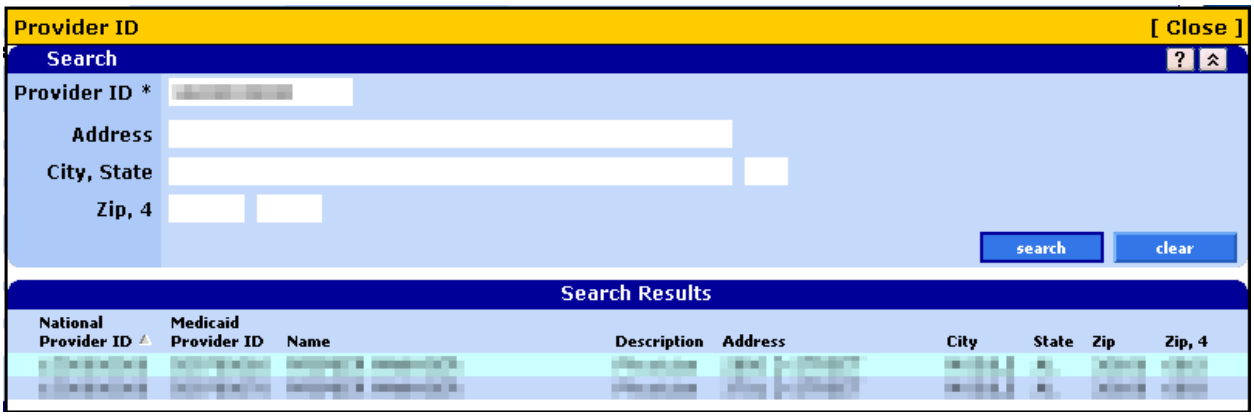
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] - (Select a Dental, Institutional or Professional claim form)] – [Search] OR [Prior Authorization] – [New]

20.14.2 Provider ID Search Panel Layout



20.14.3 Provider ID Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Address	Displays the provider's primary address.	Field	Alphanumeric	40
City	Displays the provider's city.	Field	Alphanumeric	20
Description	Displays the provider's type description.	Field	Alphanumeric	20
Name	Displays the provider's name.	Field	Alphanumeric	40

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Field	Description	Field Type	Data Type	Length
Medicaid Provider ID	Displays the Medicaid number of the provider.	Field	Alphanumeric	9
National Provider ID	Displays the national identification number of the provider.	Field	Alphanumeric	10
Provider ID *	Displays the identification number of the provider.	Field	Alphanumeric	10
State	Displays the provider's state.	Field	Alphanumeric	2
Zip, 4	Displays the provider's zip code plus 4.	Field	Number (Integer)	5

20.14.4 Provider ID Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.14.5 Provider ID Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.14.6 Provider ID Search Panel Accessibility

20.14.6.1 To Access the Provider ID Search Panel

Step	Action	Response
1	Click **Claims**.	Claims page displays.
2	Select a **Dental**, **Institutional,** Professional claim form or **Prior Authorization** and then **New**.	Claim panel displays or Prior Authorization New panel displays.
3	Click **[Search]**.	Provider ID Search panel displays.

20.14.6.2 To Search on the Provider ID Search Panel

Step	Action	Response
1	Enter **Provider ID, Address, City, State** or **Zip + 4**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.15 Quadrant Search

20.15.1 Quadrant Search Panel Narrative

The Quadrant Search pop-up panel allows for the search of a tooth quadrant which is used for prior authorizations to identify the area of the mouth where services will be performed.

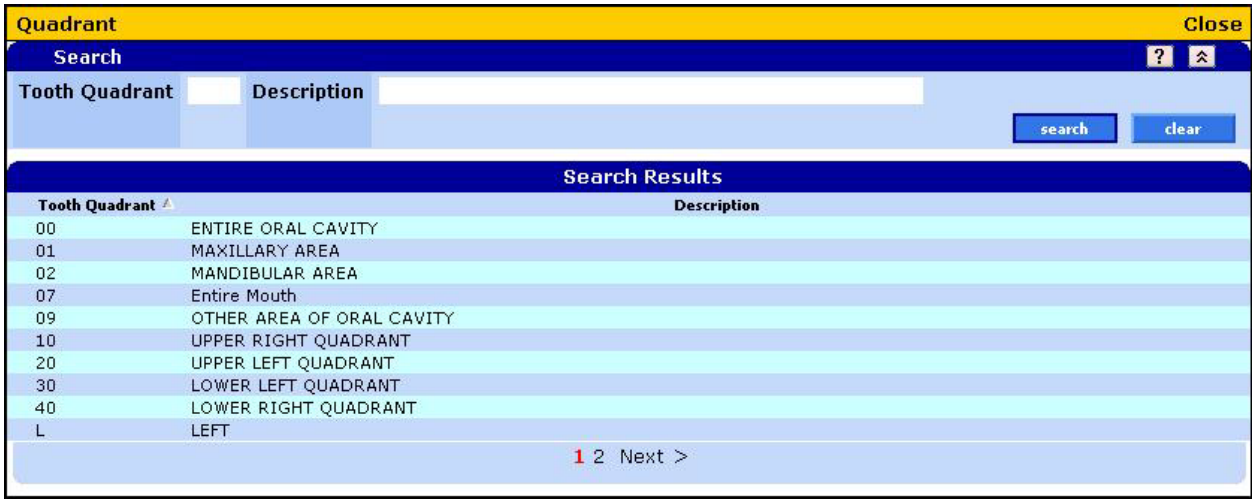
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Prior Authorization] – [New] – [click on Next from the Base Information panel] – [Search]

20.15.2 Quadrant Search Panel Layout



20.15.3 Quadrant Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	Clears the search criteria fields.	Button	N/A	0
search	Search button initiates the search results.	Button	N/A	0
Description	Displays the tooth quadrant code description.	Field	Alphanumeric	50
Tooth Quadrant	Displays the corresponding tooth quadrant code.	Field	Alphanumeric	3

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20.15.4 Quadrant Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.15.5 Quadrant Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.15.6 Quadrant Search Panel Accessibility

20.15.6.1 To Access the Quadrant Search Panel

Step	Action	Response
1	Click **Claims** or **Prior Authorization**.	Claims or Prior Authorization page displays.
2	Click **Prior Authorization** and then **New**. If viewing the Prior Authorization New panel, click **Next**.	Prior Authorization New panel displays. If viewing the Prior Authorization New panel, the Line Item panel displays.
3	Click **[Search]**.	Quadrant Search panel displays.

20.15.6.2 To Search on the Quadrant Search Panel

Step	Action	Response
1	Enter **Tooth Quadrant** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.16 Revenue Code Search

20.16.1 Revenue Code Search Panel Narrative

The Revenue Code Search pop-up panel allows for the search of a revenue code.

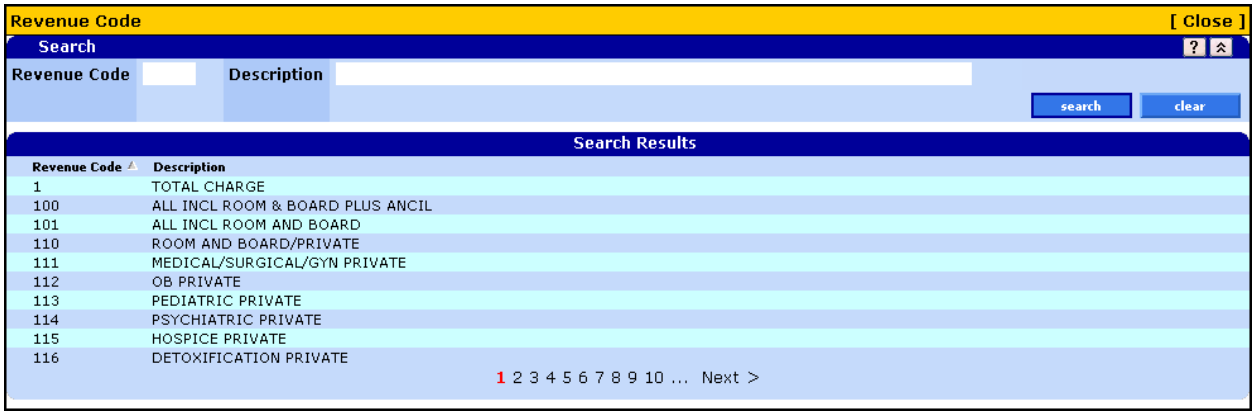
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel is populated with the corresponding data.

Navigation Path: [Claims] – [Institutional] – [Search] OR [Prior Authorization – New] – [click on Next from the Base Information panel] – [Search]

20.16.2 Revenue Code Search Panel Layout



20.16.3 Revenue Code Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search results.	Button	N/A	0
Description	Displays the specific accommodation or ancillary service.	Field	Alphanumeric	70
Revenue Code	Displays the revenue codes of specific accommodation or ancillary service.	Field	Number	4

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20.16.4 Revenue Code Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.16.5 Revenue Code Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.16.6 Revenue Code Search Panel Accessibility

20.16.6.1 To Access the Revenue Code Search Panel

Step	Action	Response
1	Click **Claims** or **Prior Authorization**.	Claims or Prior Authorization page displays.
2	Click **Institutional**, or **Prior Authorization** and then **New**. If viewing the Prior Authorization New panel, click **Next**.	Institutional Claim or Prior Authorization New panel displays. If viewing the Prior Authorization New panel, the Line Item panel displays.
3	Click **[Search]**.	Revenue Code Search panel displays.

20.16.6.2 To Search on the Revenue Code Search Panel

Step	Action	Response
1	Enter **Revenue Code** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.17 Tooth Search

20.17.1 Tooth Search Panel Narrative

The Tooth Search pop-up panel allows for a search of a valid tooth number.

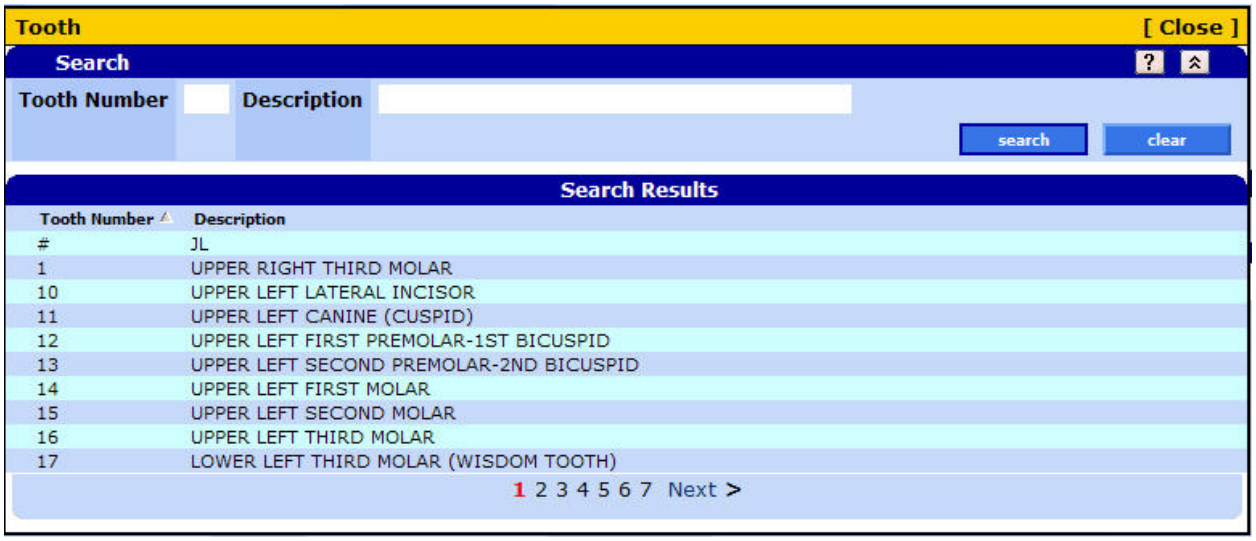
NOTE:

This information is pulled from the DXC claims processing system. However, a match based on search criteria does not guarantee payment. Therefore, providers must continue to consult the Alabama Medicaid Provider Manual for billing restrictions and/or requirements.

After entering search criteria in the pop-up panel, simply select the desired result returned and the main panel will be populated with the corresponding data.

Navigation Path: [Prior Authorization] – [New] – [click on Next from the Base Information panel] – [Search]

20.17.2 Tooth Search Panel Layout



20.17.3 Tooth Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search.	Button	N/A	0
Description	Displays the description of the tooth number.	Field	Alphanumeric	40
Tooth Number	Displays the correspondent tooth number.	Field	Character	2

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20.17.4 Tooth Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

20.17.5 Tooth Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.17.6 Tooth Search Panel Accessibility

20.17.6.1 To Access the Tooth Search Panel

Step	Action	Response
1	Click **Prior Authorization**.	Prior Authorization page displays.
2	Click **New**.	Base Information panel displays.
3	Click **Next**.	Line Item panel displays.
4	Click **[Search]**.	Tooth Search panel displays.

20.17.6.2 To Search on the Tooth Search Panel

Step	Action	Response
1	Enter **Tooth Number** or **Description**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.18 User Name Search

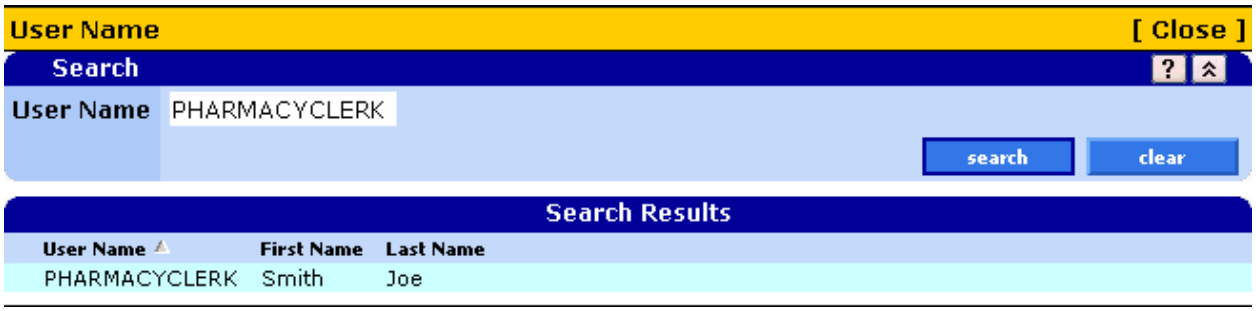
20.18.1 User Name Search Panel Narrative

The User Name Search panel allows users to search for another user or clerk. The user can then select the desired user or clerk from the corresponding search results.

The User Name Search panel allows a provider or billing agent to identify an existing user so they may associate that ID to their billing NPI number, granting the clerk permission to act as their NPI number when submitting claims, prior authorization requests, etc.

Navigation Path: [Account] – [Clerk Maintenance] - [Search]

20.18.2 User Name Search Panel Layout



20.18.3 User Name Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
clear	This button clears the search criteria fields.	Button	N/A	0
search	This button initiates the search results.	Button	N/A	0
First Name	Displays the first name of the user.	Field	Character	50
Last Name	Displays the last name of the user.	Field	Character	50
User Name	Displays the login identification of the user.	Field	Alphanumeric	20

20.18.4 User Name Search Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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20.18.5 User Name Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.18.6 User Name Search Panel Accessibility

20.18.6.1 To Access the User Name Search Panel

Step	Action	Response
1	Click **Account**.	Account page opens.
2	Click **Clerk Maintenance**.	Clerk Maintenance panel opens.
3	Click **add clerk**.	Activates the Clerk Maintenance panel.
4	Click **[Search]**.	Activates the User Name Search panel.

20.18.6.2 To Search on the User Name Search Panel

Step	Action	Response
1	Enter **User Name**.	
2	Click **search**.	
3	Select row from search results.	Adds search result selected to the main panel.

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20.19 Group Member Provider ID Search

20.19.1 Group Member Provider ID Search Panel Narrative

The Group Member Provider ID Search panel allows users to search for group members enrolled under the Group Provider. The user can then select the desired Group Member from the corresponding search results.

20.19.2 Group Member Provider ID Search Panel Layout

20.19.3 Group Member Provider ID Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Display the primary address of Group Member Provider.	Field	Alphanumeric	30
Business or Last Name	Displays the Group Member Provider's Business or last name.	Field	Character	50
City	Displays city of Group Member Provider.	Field	Character	30
clear	This button clears the search criteria fields.	Button	N/A	0
First ,MI	Displays the Group Member Provider's first name, Middle Initial.	Field	Character	50
Group Member Base Provider ID	Displays Group Member Provider's Base Provider Identification Number.	Field	Alphanuemric	15
Group Member Name	Last Name, First Name and Middle Initial of Group Member Provider	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Group Member National Provider ID	Displays the Group Member Provider's National Provider Identification Number.	Field	Alphanuemric	15
Group Member Medicaid Provider ID	Displays the Group Member Provider's Medicaid Provider Identification Number.	Field	Alphanuemric	15
Provider ID	Displays the Group Member Provider's Provider ID.	Field	Alphanumeric	15
search	This button initiates the search results.	Button	N/A	0
State	Displays the Group Member Provider's state.	Field	Character	2
Zip	Displays the Group Member Provider's zip.	Field	Numeric	5

20.19.4 Group Member Provider ID Search Panel Field Edit Error Codes

Field	Error Message	To Correct
First ,MI	Business OR Last Name is required when searching on First and/or MI.	Please Enter Business OR Last Name.

20.19.5 Group Member Provider ID Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

20.19.6 Group Member Provider ID Search Panel Accessibility

20.19.6.1 To Access the Group Member Search Panel

Step	Action	Response
1	Click **Trade Files - Download**	File Download Search Panel opens.
2	Select "**PRV-A035 - M-Provider Reenrollment Facsimile** from dropdown	"Group Member Provider ID" Field is displayed.
3	Click **[Search]**.	Opens "Group Member Provider ID Search" pop-up search.

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20.19.6.2 To Search on the Group Member Search Panel

Step	Action	Response
1	Click **search**.	
2	Select row from search results.	Adds search result selected to the main panel.

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21. Help

The EMC Helpdesk is available to providers and vendors to answer questions, or to address any problems which may occur while using the Interactive Services website. Providers may contact the EMC Helpdesk for help with the following issues:

- Initial User ID and Password
- Password Resets
- Connectivity Problems

The EMC Helpdesk can be contacted through one of the following sources:

Phone	Mail	Email
1(800) 456-1242 1(334) 215-4272 (fax)	DXC Technology Attn: EMC Helpdesk 301 Technacenter Drive Montgomery, AL 36117	AlabamaSystemsEMC@hpe.com

NOTE:

The EMC Helpdesk can be reached Monday through Friday, 7:00 a.m. to 8:00 p.m. (CST); 9:00 a.m. to 5:00 p.m. on Saturdays; and 9:00 a.m. to 5:00 p.m. on all holidays.

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AMMIS Long Term Care Admission Notification User Manual

08/26/2013

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

HP Enterprise Services
301 Technacenter Drive
Montgomery, Alabama 36117

Version 9.0

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1. Document Control

The latest version of this document is stored **electronically**. Any printed copy has to be considered an uncontrolled copy.

1.1 Document Information Page

Required Information	Definition
Document Title	AMMIS LTC Admission Notification User Manual
Version:	9.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/UserManuals/LTC_UM
Owner:	HPES/Agency
Author:	
Approved by:	
Approval Date:	08/26/2013

1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
	7.0		CO 7962	Change the LTC Admissions software to accept 6, 7, 8, 9 or 10 alpha numeric characters in the Provider ID field and the Performing Provider ID field.
	7.0		CO 7966	Change every occurrence of 'EDS' in the LTC Admissions Notifications software, to 'HP.' Also; update every occurrence of the logo.
	7.0		CO 8167	When submission reason is "7" (death/discharge/termination/revoke), it will require a selection from the drop down box of the following options: H - Recipient discharged home D - Recipient died T - Recipient was terminated from the program Do not allow the option to be blank when reason

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				code "7" is selected. Provider may select only one option.
	7.0		CO 8222	Add a 'self edit' to the Client ID field in the LTC software to display the following error message if a Client ID that begins with '000' is entered: ENTER THE CLIENT'S CURRENT MEDICAID ID NUMBER.
03/15/2012	8.0		CO 9222	Add in information regarding the Program of All-inclusive Care for the Elderly (PACE). Also including updated program information from the Agency to reflect current policy.
08/26/2013	9.0		CO 5981	Update rejection messages in section 14.2.

1.3 Related documentation

Document	Description	url

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2. Introducing Alabama Long Term Care (LTC) Admission Notification

Thank you for using HP Enterprise Services (HP) Alabama Long Term Care (LTC) Admission Notification. This software enables you to submit electronic LTC Admission Notifications on behalf of Alabama Medicaid recipients. Providers who submit admission notifications to Medicaid electronically receive the following benefits:

- Quicker admission notification turnaround
- Quicker admission notification corrections for notifications with errors

Alabama LTC Admission Notification is available at no charge to Alabama Medicaid providers. It provides installation procedures and a contact number for the HP Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility, claims, and medical eligibility application submission.

Chapter 1, Introducing Alabama LTC Admission Notification, is comprised of three sections:

- What You Need to Know to Use Alabama LTC Admission Notification, which provides definitions for important electronic admission notification submission concepts.
- How to Use this Manual, which describes the contents of the user manual.
- Where to Get Help, which provides a contact list for the EMC Help Desk and other HP personnel who can assist you with Alabama LTC Admission Notification related questions.

2.1 What You Need to Know to Use Alabama LTC Admission Notification

Below are some terms and concepts that will enhance your ability to use Alabama LTC Admission Notification:

Batch

The most important concept to understand about Alabama LTC Admission Notification is that it enables users to submit admission notifications in groups or batches.

Batch submission refers to sending groups of admission notifications to HP. A batch may contain one record or many records. These transactions are not sent directly to the HP system, but to an intermediary referred to as the Web Server. The HP system accesses the Web Server each evening Monday through Friday and downloads any batches providers have placed there. The next morning after the batches have been received and processed by HP, providers can inquire for a response using the software.

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Using a Personal Computer

Alabama LTC Admission Notification operates in a Microsoft® Windows™ environment. The software is very user-friendly and features point-and-click functionality similar to Windows applications.

To use Alabama LTC Admission Notification, you should have basic knowledge about personal computers and be able to navigate in Microsoft Windows. Specifically, you should know how to:

- Use a mouse, drop down menus, and navigation buttons.
- Toggle between open windows on your desktop.
- Determine some information about your personal computer's (PC) hard drive and be able to distinguish between a hard drive and a disk (or CD) drive. For instance, you should know how much Random Access Memory (RAM) you have, and how much disk space (space available on your hard drive) you have. Chapter 2, Installing Alabama LTC Admission Notification, describes archiving, file retention, and other subjects that have an impact on your PC's available space.
- Access the Windows Control Panel. Section 2.4, Setting up Personal Options, provides a brief description of how to use the Control Panel to research information about your modem.
- Determine a file and path name as necessary. The path name refers to a specific drive (for instance, your hard drive) and folders within those drives, if applicable.

Your Microsoft Windows user guide should give you information about these topics if you aren't already familiar with them.

Using a Modem

Providers must have a modem. Your modem may be part of your PC, or attached to your PC, and it must also be attached to a working phone line. If you plan to submit batch transactions and you live outside the Montgomery calling area, you must be able to place a long distance call over the phone line. Section 2.4, Setting Up Personal Options, describes how to set up Alabama LTC Admission Notification with your modem information.

Alabama LTC Admission Notification User Manual versus the Alabama Medicaid Provider Manual

The Alabama LTC Admission Notification User Manual describes how to complete the electronic admission notification form correctly to enable you to submit notifications that process correctly. It does not provide program-specific information. This user manual explains how to:

- install and set up Alabama LTC Admission Notification
- navigate in Alabama LTC Admission Notification
- complete the required and optional fields on the electronic forms
- submit transactions

If you did not receive a copy of the Alabama Medicaid Provider Manual, contact HP Provider Relations at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid Home Page at http://www.medicaid.alabama.gov.

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2.2 How to Use This Manual

This manual is comprised of the following chapters:

	Chapter Title	Contents
1	Document Control	Provides information regarding amendment history and related documentation.
2	Introducing Alabama Long Term Care (LTC) Admission Notification	Describes what you need to know to use Alabama LTC Admission Notification, how to use the user manual, and who to contact if you have questions.
3	Installing Alabama LTC Admission Notification	Covers equipment requirements, getting a copy of Alabama LTC Admission Notification, installation procedures, setting up personal options, and other maintenance options such as database recovery.
4	Getting Around Alabama LTC Admission Notification	Describes general navigation concepts of Alabama LTC Admission Notification.
5	Customizing Alabama LTC Admission Notification	Describes how to build lists for values you use over and over, such as recipient or provider numbers. This increases your ability to submit correct Notifications quickly and efficiently.
6	LTC Admission Notification Form	Describes the LTC Admission Notification form fields
7	Retrospective Review	Describes the Medicaid Agency process of retrospective review of documentation. Although this is not specifically related to the software, it is necessary to understand the importance of adhering to policy rules regarding documentation required prior to submitting admission notifications and the consequences of not adhering to policy.
8	Nursing Home	Describes how nursing home providers complete the form.
9	Hospice	Describes how hospice providers complete the form.
10	Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Describes how ICFMR providers complete the form.
11	JCBS – Intellectual Disabilities (ID) and Living at Home	Describes how ID and LAHW providers complete the form.
12	Elderly and Disabled, HIV/AIDS, SAIL, and ACT	Describes how Elderly and Disabled, HIV/AIDS, SAIL, and ACT providers complete the form.

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	Chapter Title	Contents
13	Program of All-inclusive Care for the Elderly (PACE)	Describes how PACE providers complete the form.
14	Receiving a Response	Describes how to resubmit a batch and understand the corresponding submission reports. It also discusses diskette submission and response.
15	The Web Server	Describes what steps to take when connecting to the web server to update your Web password.
16	AL LTC Admission Notification Software File Specifications	Describes the file specification for creating a transmit file for admission notification.

Many of the manual chapters feature step-by-step instructions with illustrations. Throughout the manual, note boxes draw the reader's attention to important concepts.

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2.3 Where to Get Help

As you become more familiar with Alabama LTC Admission Notification, you will probably refer to this manual less often. HP provides this paper user manual to ensure you access to as much information as possible about Alabama LTC Admission Notification.

If you still have questions, or if you should encounter difficulty using Alabama LTC Admission Notification or dialing into the HP system, contact the EMC Help Desk at 1 (800) 456-1242.

The Help Desk staff is available from 7:00 a.m. to 9:00 p.m., Central Standard Time (CST), Monday through Friday.

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3. Installing Alabama LTC Admission Notification

This chapter covers equipment requirements, instructions on obtaining a copy of Alabama LTC Admission Notification, installation procedures, setting up personal options, installing software upgrades, and other maintenance options such as archiving and database recovery.

3.1 Equipment Requirements

Before installing Alabama LTC Admission Notification, you must ensure you have the proper equipment. Alabama LTC Admission Notification is designed to operate on a personal computer with the following equipment requirements:

Minimum	Recommended
Pentium II	Pentium III
Windows 2000	Windows XP
64 Megabytes RAM	128 Megabytes RAM
800 x 600 Resolution or higher	1024 x 786 Resolution or higher
28.8 Baud Rate modem (required only for dial-up transmission)	56K Baud Rate modem (only for dial-up transmission)
CD/ROM drive	
100 Megabytes free Hard Drive space	

A printer is optional, but recommended.

To check or change the Windows resolution, click the Start button and select Settings, then Control Panel. In the Control Panel screen, click the Display icon and once it opens select the Settings Tab. Be sure the Screen Area field shows a resolution of 800 x 600 or higher.

Note: Providers who wish to install Alabama LTC Admission Notification on a Local Area Network (LAN) or configuration other than a standalone personal computer should contact the EMC Help Desk at 1(800) 456-1242 for instructions.

3.2 Getting a Copy of Alabama LTC Admission Notification

You can receive a copy of the software CD/ROM by contacting your HP Representative or calling the EMC Help Desk at 1(800) 456-1242. HP will send you one CD/ROM with accompanying documentation. Please allow three to five business days to receive the package.

Alabama LTC Admission Notification is available for PCs running Windows 2000/XP. After installing the program, store the CD/ROM in a safe place. In the event the program and files are damaged or deleted while on your PC, you must re-install Alabama LTC Admission Notification from the CD/ROM.

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3.3 Installation Procedures

You should install your Alabama LTC Admission Notification software only once, unless the software is damaged while on your PC. This section describes installation procedures from the CD/ROM.

Installing from the CD-ROM

Providers are strongly encouraged to exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications.

This section provides step-by-step instructions for installing Alabama LTC Admission Notification on a PC running Windows 2000/XP.

Windows NT has some special installation instructions. HP can fax or email a copy of the instructions upon request. Contact your Provider Relations Representative or the Provider Assistance Center at 1 (800) 688-7989 for Windows NT installation instructions.

Installing from CD

To install the software from a CD, begin the process by inserting the CD in your CD drive (The installation should begin automatically). The Welcome screen should appear next, Click NEXT. Be sure to follow and read all installation prompts before proceeding to the next step.

NOTE

When installing to computer running Windows 7, you will be prompted to confirm that you want this program to make changes to your computer. Please confirm that you do want to allow changes.

When the installation is complete, a window will appear that asks for the user ID and password to logon to the software. This is because the LTC software is compliant with the new HIPAA security regulations. The first user ID is for the designated system administrator (pes-admin) and will require the input of an initial password. This password is on the coversheet you receive in the packet containing your CD. This should be changed to a password known only to the person responsible for maintaining the security for the LTC software.

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The ‘pes-admin’ is responsible for assigning a user ID and initial password for each person accessing the software. Each user will then be prompted to change that initial password to a personally recognized password.

3.4 Setting Up Personal Options

The Alabama LTC Admission Notification packet you received contains a cover sheet with data specific to your provider number. You will need this data to set up your personal options. If you do not receive a copy of this cover sheet with your packet, contact the EMC Help Desk at 1 (800) 456-1242. You will not be able to use Alabama LTC Admission Notification to submit batch without this information.

To use Alabama LTC Admission Notification, you must set up your personal options, including the following:

- Logon IDs and passwords, as provided to you by the EMC Help Desk.

When you access Alabama LTC Admission Notification for the first time, the following message displays:

Click OK to access the Options window.

You can also access this window by selecting Tools>>Options from the menu bar.

The Options window contains three tabs and three main buttons, described below:

Tabs

Tab	Usage
Web	Use this tab to set up method of connection.
Batch	Use this tab to set up Trading Partner ID, Web logon ID, and password to log into the Web Server.
Retention	Use this tab to establish retention settings for archive days, batch information, verification information, and logs.

Buttons

Button	Usage
Print	Use this button to print options selected for all of the tabs.
OK	Use this button to save the information added or modified.
Close	Use this button to close the Options window.

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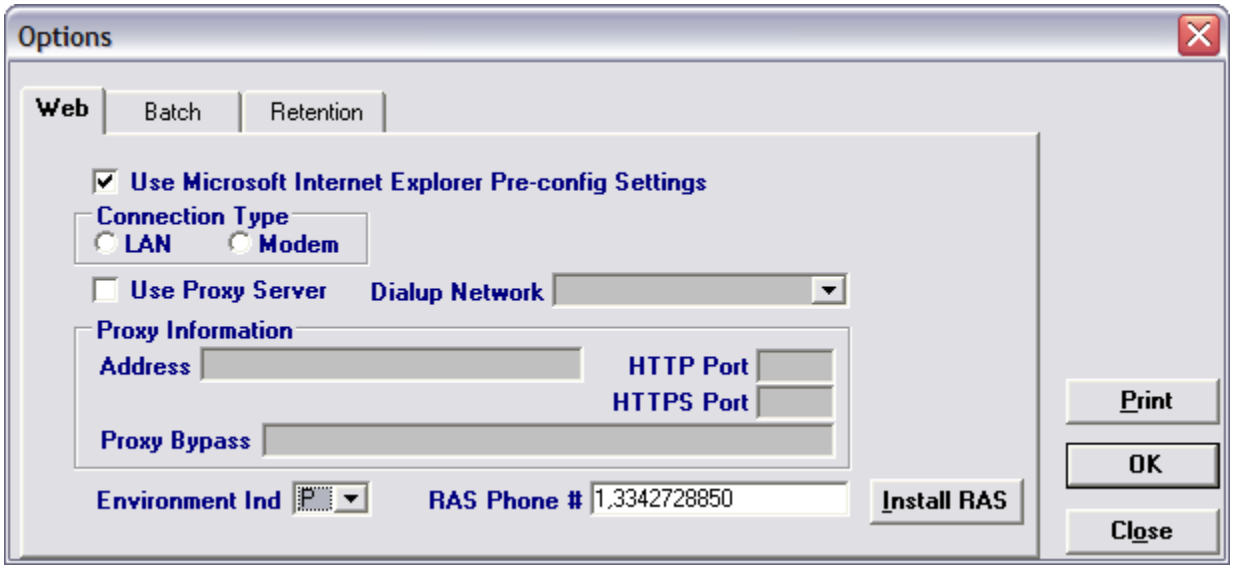
3.4.1 Web Tab

Users access the Web tab to modify their method of connection to the Medicaid Submission site. A sample Options window displaying the Web tab is pictured below:



Field	Guidelines
Use Microsoft IE Pre-config Settings	If checked, the pre-config settings within your Internet Explorer will be accessed to connect to the batch submission website.
Connection Type	If the Internet Explorer Pre-config Settings option is not checked, you must choose either LAN or Modem to identify how the PC connects to the Internet.
Use Proxy Server	If the Internet Explorer Pre-config Settings option is not checked and your Internet access is filtered through a Proxy Server check this setting.
Dialup Network	If you choose the Modem Connection Type, you must select one of the Dialup Networks from the drop-down box. If you do not have an option listed, follow the instructions for the Install (Remote Access Server) RAS button.
Proxy Information – Address	To obtain the address of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings to obtain the proxy address.
HTTP Port	To obtain the HTTP Port of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings. Click on Advanced and review the Port information for HTTP:
HTTPS Port	To obtain the HTTPS Port, follow the instructions above under HTTP Port and enter the Secure port number in this field.

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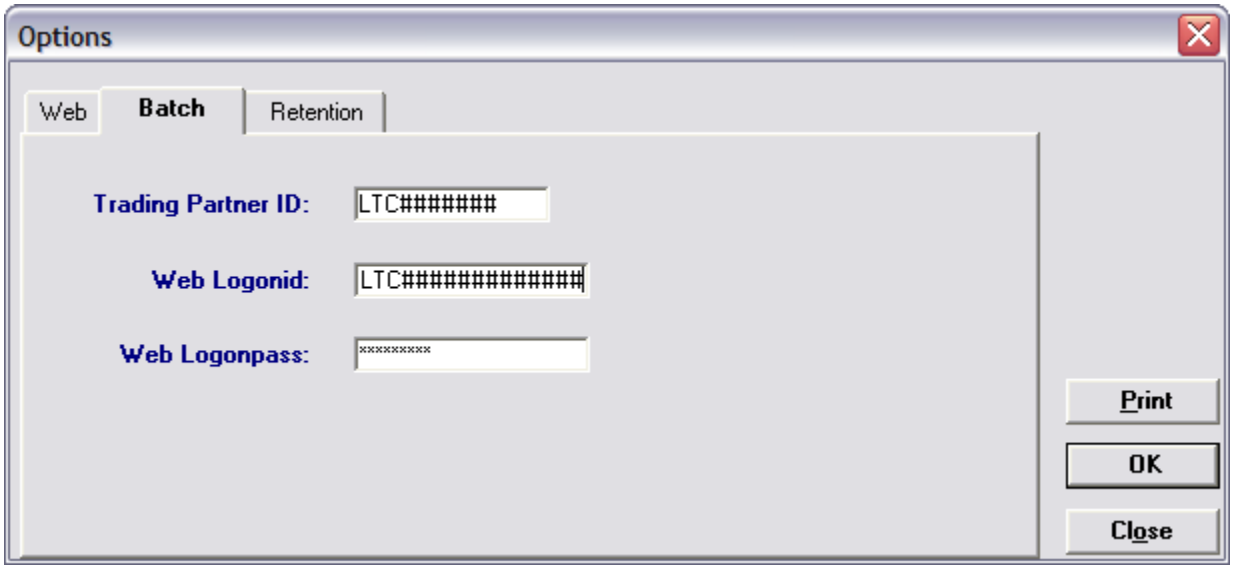
Field	Guidelines
Proxy Bypass	The Proxy Bypass information is found on the same window as the HTTP and HTTPS ports in the Exceptions text area.
Environment Ind	Choose the best value to indicate if the submission is Production or Test. Remember, if you have your indicator as Test your claims will not be paid.
RAS Phone #	If you use a dialup modem, enter (if long distance to Montgomery) 1,3342728850; if not long distance to Montgomery's calling area you do not have to enter 1,334. If your phone service requires additional dialing features you may adjust this number to add those features. For example, dialing a '9' to get an outside line would be entered as: 9,13342728850.
Install RAS	If you choose to use a dial-up modem to connect to Medicaid, you must choose a Dialup Network option provided. If you have no option provided, press the Install RAS button and the option AL RAS will be available to you. NOTE: Due to a delay in installing RAS, the user may have to click on the 'LAN' option and then back to the 'Modem' option for the RAS Dial-up Network to display.

3.4.2 Batch Tab

Users access the Batch tab to enter a trading partner ID, web logon ID, password and the requesters contact information. A sample Options window displaying the Batch tab is pictured below:



Field	Guidelines
Trading Partner ID	If you have used the software previously, continue using the same Trading Partner ID. If you need a new Trading Partner ID contact the EMC Help Desk at 1 (800) 456-1242. Download the Trading Partner Request Form from the Alabama Medicaid

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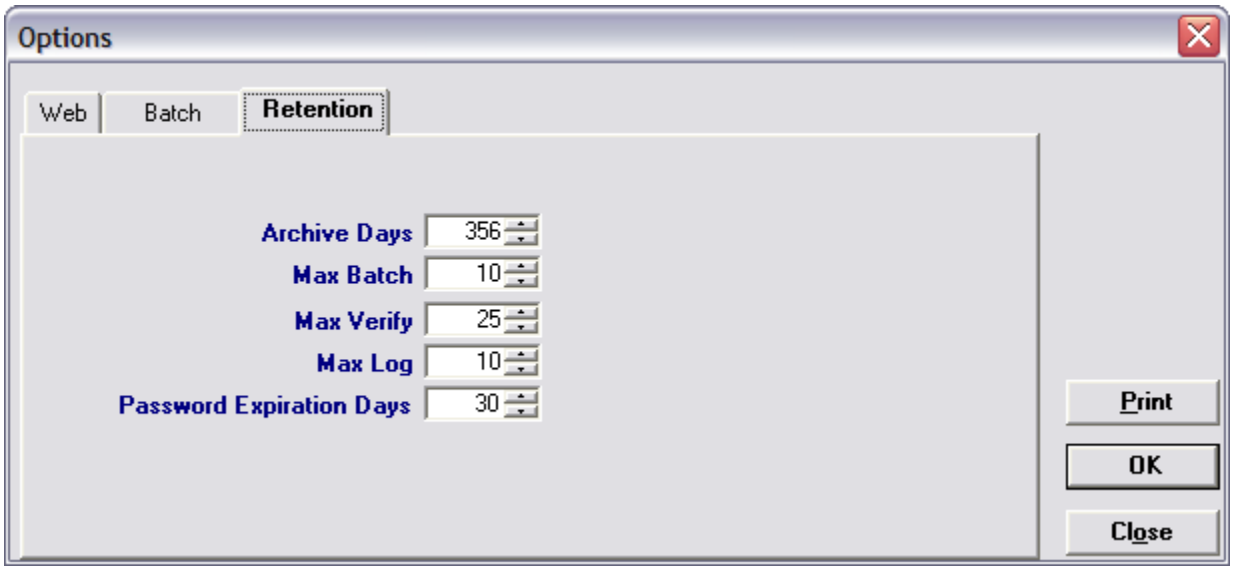
Field	Guidelines
	Interactive web site (web portal). Click on Information, AL Links and scroll to the bottom of the page under Documentation.
Web Logon ID	If you have used the software previously, continue using the same user ID. You will use the User Name created when setting up your Trading Partner ID on the web portal. If you need assistance contact the EMC Help Desk at 1 (800) 456-1242.
Web Password	The password will be the same as the one created when setting up your Trading Partner ID on the web portal. Please refer to chapter 13 on updating your password. You must complete that process before continuing.

3.4.3 Retention Tab

Users access the Retention tab to establish retention settings for archive days, batch information, verification information, and logs. A sample Options window displaying the Retention tab is pictured below:



Retention settings indicate the number of day's worth of data the software should save. Users may set retention settings as required, or may retain the default settings. Click OK to save the information.

Increasing the retention settings, results in more data being saved to your hard drive. Alabama LTC Admission Notification enables you to archive most of types of data generated by the system. There may be a better alternative to increasing your retention settings. For more information, refer to Section 3.6, Other Maintenance Options.

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3.5 Installing Software Updates

Occasionally, HP will release updates to Alabama LTC Admission Notification. You will be notified how to receive the upgrade.

Receiving Notification of Upgrades

HP notifies providers of software updates in two ways:

- Update notices in the Provider Insider, the Alabama Medicaid bulletin
- Mail out to all providers that use admission notification software

3.6 Other Maintenance Options

The Tools menu options enable users to archive data, recover the database, and set up options. Setting up options is covered in Section 3.4, Setting up Personal Options.

3.6.1 Archiving

Archiving data is the process used to keep the size of your data small enough for it to be useful, while maintaining historical records of the forms you have entered.

Archiving is designed to make management of forms easier and to keep the space on your hard drive used by the Alabama LTC Admission Notification application to a minimum.

One of the options available under Tools>>Archive>>Create is the setting that controls how many days of forms you wish to keep online on your PC. The standard setting is 30 days; however, you may select whatever setting best suits your needs. This means that when you select Tools>>Archive>>Create Archive from the menu bar, you will keep a copy of any form which was submitted more than 30 days ago. The form is copied to a compressed file and then deleted from your database. Forms submitted in the past 30 days are still accessible through the Alabama LTC Admission Notification database.

You can store the compressed file on a diskette or leave it on your hard drive. Forms that are ready to be submitted (that have a status of 'R') are not archived, but remain on your online database until you have submitted or deleted them. Forms that are incomplete, (that have a status of 'I'), and are older than the archive data are deleted during the archive process and are not saved on the archived files.

This section describes how to create an archive and how to restore archived files.

Create Archive

If running Alabama LTC Admission Notification on a network, other users must exit the application (must not be viewing, adding, or modifying any forms or lists) before you create an archive. The user creating the archive should have the only open copy of the software while the process runs.

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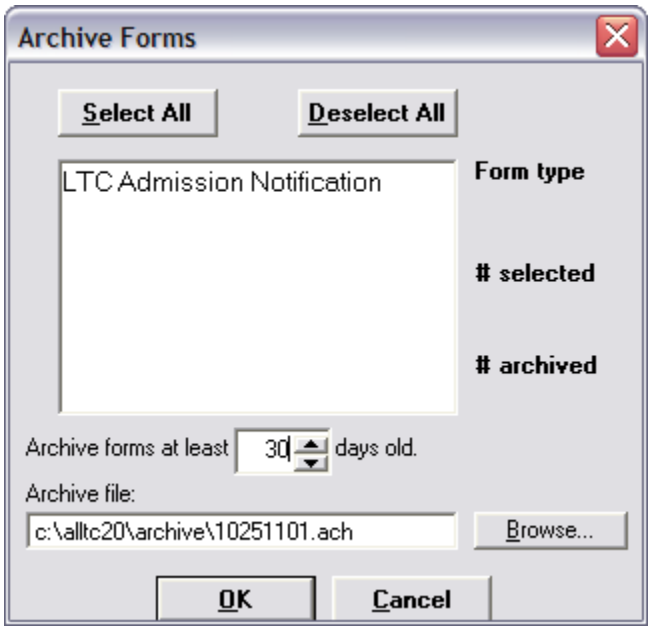
Archive occurs automatically when selected.



To create an archive, select Tools>>Archive>>Create from the menu bar.

After verifying that all forms and lists are closed, click OK to open the Archive Forms window:

Using the Archive Forms window, you can:

- Select all the form types to archive by clicking the Select All button (click on Deselect All to deselect). You may also select the specific form type to archive by clicking on the form type.
- Change the default directory and the name of the file to archive by typing the path name in the Archive file field, or by clicking on the Browse button.
- Change the number of days used to archive the forms (This change applies to the current session only. Select Tools>>Options>>Retention Tab to change the number of retention days for all future sessions.

Select OK to archive the selected forms. Select Cancel to exit the archive function.

You can use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Restore Archive

The Restore Archive process enables users to recall forms from an archive file and put them back into the online database.

3.6.2 Database Recovery

There may be times when there is a problem with your database. The Database Recovery option is designed to help you work with the EMC Help Desk personnel to fix problems with your database.

3.6.2.1 Compact Database

Compact is used to make the database files smaller and better organized. When you use this option, an empty space is created in the database where that form used to be. Compact will release all the empty space so that it is available for you to use again.

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3.6.2.2 Repair Database

Repair will attempt to validate all system tables and all indexes. Generally, this feature is helpful when you are having trouble accessing your data. The EMC Help Desk staff will let you know when this is necessary. You may use this feature any time you feel that it would be helpful. Compact is recommended after the Repair.

3.6.2.3 Unlock Database

Sometimes errors will cause database locks. The database may lock when you are submitting forms, archiving forms, restoring forms, and sometimes when you are adding or editing forms. Use the Unlock feature to unlock the database tables.

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4. Getting Around Alabama LTC Admission Notification

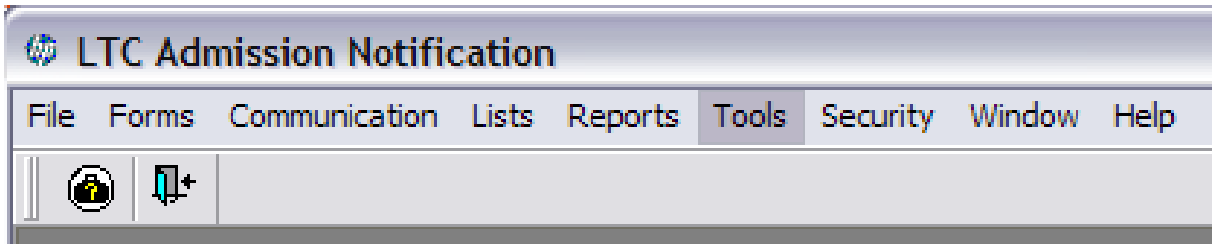
This chapter describes general navigation concepts of Alabama LTC Admission Notification.

4.1 Navigating in Alabama LTC Admission Notification

Before you begin using Alabama LTC Admission Notification, review the following section and learn how to navigate through the admission notification with your keyboard and mouse.

Navigating through Alabama LTC Admission Notification is similar to other Windows-compatible applications. The navigation options available are menus, toolbars, and command buttons. Your mouse and keyboard enable you to access these navigation options. Use your mouse to point-and-click as a method for navigating through Alabama LTC Admission Notification.

Below are samples of the menu and icon toolbars that display on the Alabama LTC Admission Notification main window:



This section describes the menu and icon options available with Alabama LTC Admission Notification.

4.1.1 Menus

Alabama LTC Admission Notification uses menus to navigate throughout the admission notification. The menu options change depending on what window you access. When you first open the Alabama LTC Admission Notification software, the main menu will display. You can access items on a menu using the mouse. You can also access these items by clicking on their icon.

The list below provides two methods for accessing the LTC Admission Notification form from the Forms menu option:

Position your cursor over the Forms menu option and click the left mouse button to display the drop down menu.

Position your cursor over the LTC Admission Notification and click once with your left mouse button to display the LTC Admission Notification form.

Click on the LTC Admission Notification icon

Refer to Section 4.1.2, Icons for a listing of main menu icons.

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The following options are accessible from the main menu.

This menu option…	Allows you to …
File	Exit from the application
Form	Select the LTC Admission Notification form
Communication	Submit batches of LTC Admission Notification forms and process batch responses. Resubmit batches of forms. View Verification. View Communication Log files. View responses.
Lists	Add and edit reference lists, which allow you to collect information to be auto plugged in the LTC Admission Notification form
Reports	Print summary or detail reports with information from forms or reference lists.
Tools	Create and work with archives, perform database maintenance, retrieve upgrades, and change your options. The Options selection allows you to set up communications options and determine retention settings.
Security	Add, delete and restrict users other than the administrator.
Window	Standard options available for most Windows compatible applications
Help	Displays the version and copyright for Alabama LTC Admission Notification

4.1.2 Icons

The Icons toolbar displays below the menu bar on the main menu. The two icons displayed are:

- Exit
- LTC Admission Notification

Users can position the cursor over an icon to display a brief description.

4.1.3 Command Keys

Like most Windows applications, Alabama LTC Admission Notification, provides the user with command keys. This enables the user to perform actions using either the mouse (point and click) or the keyboard. This section describes them.

Command keys

The table below describes some standard navigation keys available with Alabama LTC Admission Notification.

To do this…	Press this key…
Go to the next field	<Tab> or <Enter>
Go to the previous field	<Shift>+<Tab>
Move backward within a field	Left Arrow
Move forward within a field	Right Arrow
Scroll up through a list	Up Arrow

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To do this…	Press this key…
Scroll down through a list	Down Arrow

Note that the list includes function keys (usually located at the top of the keyboard and numbered ‘F1’ thorough ‘F12’), command keys (such as <Alt>, <Shift>, <Tab>, >Ctrl>, and <Enter>, and arrow keys.

Depending on your keyboard, the arrow keys may be located on the numeric keyboard, or in a keypad section separate from the numeric keyboard.

To use arrow keys on the numeric keypad, you will probably press the ‘Num Loc’ key. Press the ‘Num Lock’ key again to disable the arrow keys on the numeric keypad, making them display numbers instead.

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5. Customizing Alabama LTC Admission Notification

Alabama LTC Admission Notification enables you to build lists for values you use over and over, specifically provider and recipient information. This increases your ability to submit correct admission notifications quickly and efficiently.

This chapter describes three ways to build lists with Alabama LTC Admission Notification and how to use lists when completing admission notifications.

5.1 Building Lists

There are three ways to build lists with Alabama LTC Admission Notification.

- Accessing list windows through the List menu.
- Accessing list windows using short cut keys described in Chapter 3, Getting Around
- Double clicking on certain fields while you are completing an admission notification form. Double clicking on these fields accesses the corresponding list window.

With Alabama LTC Admission Notification, you have the option of building lists as a separate task or building (adding) to them as you submit admission notifications.

To access a list window from an Admission Notification form, double click in the field that corresponds to the list window. For example, while submitting the admission notification form, enter a provider number in the Provider ID field. Double click the Provider ID field to access the list window for providers. The provider number entered in the field displays in the list window. Click the Add button to add it to the list.

You can build the following lists using Alabama LTC Admission Notification:

- Client (Recipient)
- Provider

Each list type corresponds to a list window. Users may add, modify, or delete list records using list windows.

The following table describes the buttons that display on each list window:

Button	Usage
Add	Pressing this button enables you to refresh the Admission Notification screen so you may add a new record. Please note that if you key over data that already displays on the list window and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.

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Button	Usage
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved record.
Print	Pressing this button enables you to print the record.
Select	Pressing this button enables you to select the current list record to add to the current transaction.
Close	Pressing this button enables you to close the window.

To Add a New Record to a List

Step	Action
1	Click on the List menu from the toolbar, and select the list to add a record to by clicking on it.
2	Key information into all required fields. You can enter information in any order, or may enter it in the order presented on the record. Click the Tab key to move to the next field.
3	Click the Save button to save the record. The system returns error messages if the record contains errors. Scroll through the error messages and double click on each error to access the field on the record that contains the error.
4	Correct the mistake(s) and then click Save.
5	Click the Add button to add another record.

To Modify a Record from a List

Step	Action
1	Click on the List menu from the toolbar. Select the list to modify by clicking on it.
2	Scroll through the list of records that display at the bottom of the list window. Highlight the record you wish to modify, and perform one of the following: ▪ Key over incorrect data on the record. Press Undo All if you inadvertently overwrite a record. ▪ Press Delete to delete an unwanted record.

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To Find a Record in a List

Step	Action
1	Press the Find button to display the Find pop-up window. Options are: ▪ Find Where ○ Last Name ○ First Name ○ Middle Initial ○ SSN ○ Client ID ▪ Find What (Users must select an option from “Find Where” to utilize this feature). “Find What” allows a user to filter the search, for example: A user selects “Last Name” from the “Find Where” drop down list. He/she can then enter a specific last name to search by in the “Find What” field. ▪ Search (select up or down from the drop down list)
2	Once you have entered the search criteria, click the Find Next button with your mouse to search for the next record that matches the search criteria. Continue clicking Find Next until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.
3	Press Cancel when you have finished searching.

5.2 Using Lists

The lists you maintain can speed up your Admission Notification filing process.

When you are submitting an Admission Notification form and you access a field that corresponds to a list (for example, the Client ID field), the system displays an arrow. When you click on the arrow, the system displays a drop down list that contains all records you added to the list.

Scroll through the records and select one. Tab through the field and the system populates the field (and any corresponding fields, such as Client Name and Social Security number) with the information from the list record.

Alternatively, you can double click in any field that corresponds to a list to access the list window. From the list window, you may search for a record, modify an existing record, or add a new record.

Note: The system does not verify the accuracy of the data you maintain on lists, other than requiring data to be the correct length, if applicable.

If you key errors in your list file, (for example, if you transpose digits for a Client (recipient) ID, you may not know you have made an error until you submit the Admission Notification to the Web Server and the Admission Notification is rejected.

If you use lists, please print and review the lists occasionally to ensure their accuracy.

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6. LTC Admission Notification Form

This chapter provides general instructions for completing the electronic LTC Admission Notification form.

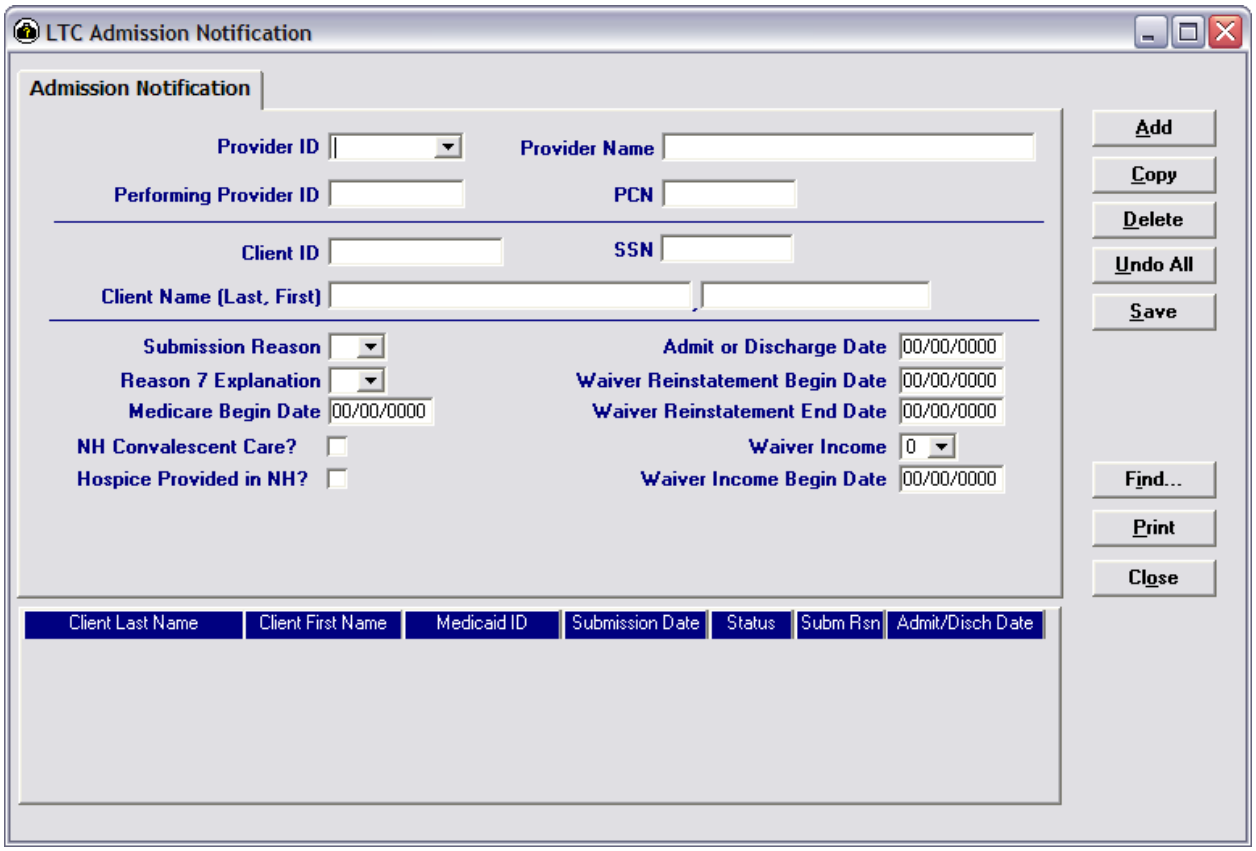
Users access the LTC Admission Notification from using one of the following methods:

- Selecting the LTC Admission Notification icon from the toolbar
- Selecting Forms>>LTC Admission Notification

The electronic form displays with a single tab: Notification Form.

6.1 Entering Admission Notifications on the Electronic LTC Admission Notification Form

The following is a sample electronic LTC Admission Notification form.



The screen contains three main parts:

- Updateable fields used to enter admission notification data
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form that enables users to view basic information about several admission notifications. Users may highlight a row to delete, copy, print, or modify an admission notification.

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6.1.1 Screen Buttons

Basic button functionality is described in the following table.

Button	Usage
Add	Pressing this button enables you to refresh the Admission Notification screen so you may add a new record. Please note that if you key over data that already displays on the list window and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new Admission Notification form from an existing Admission Notification.
Delete	Pressing this button enables you to delete the Admission Notification currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the Admission Notification currently being displayed
Save	Pressing this button enables you to save the Admission Notification you just added or modified. The saved Admission Notification displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved Admission Notification.
Print	Pressing this button enables you to print the Admission Notification.
Close	Pressing this button enables you to close the window.

6.1.2 List Fields

The list fields at the bottom of the screen display basic information about several admission notifications. This list may be scrolled to view all the admission notifications that are not immediately visible. The list may be sorted by any of the columns to assist the user in locating a desired admission notification. Below is a description of the data that displays in the list fields.

Column	Information
Client Last Name	Displays recipient's last name as entered on the Admission Notification.
Client First Name	Displays recipient's first name as entered on the Admission Notification.
Medicaid ID	Displays recipient's Medicaid number as entered on the Admission Notification.
Submission Date	Displays date Admission Notification was transmitted to HP.

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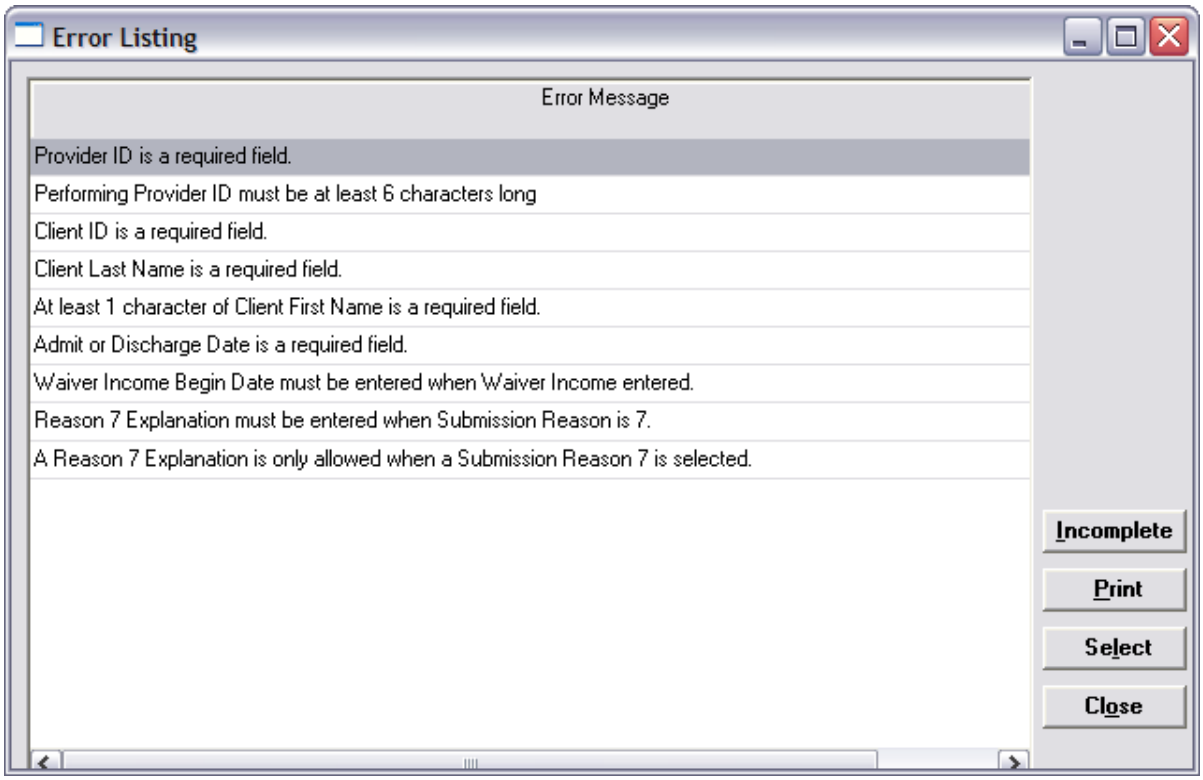
Column	Information
Status	F = Transmitted R = Ready to transmit A = Brought back from archives
Submission Reason	Displays the submission reason as entered on the Admission Notification.
Admit/Discharge Date	Displays the New admission/Initial assessment/Election date as entered on the Admission Notification.

6.1.3 Error Messaging and Saving

When the user saves an LTC Admission Notification, the system performs edits on the data entered. If the system finds errors, it displays a list of error messages. For example, if all the required fields are not entered, a box like this may appear:



These error messages define the specific location and nature of the error.

To correct an error:

Step	Action
1	Double click on the specific error message in the list to display the LTC Admission Notification. The cursor displays in the field containing the error.
2	Perform updates on the incorrect data.

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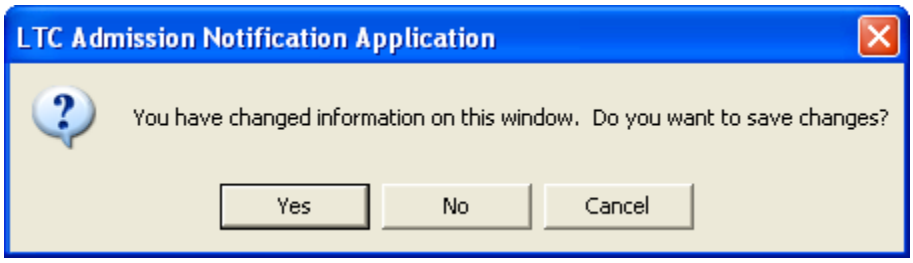
Step	Action
3	If there are still errors on the LTC Admission Notification, the Error Listing will display again. Continue correcting errors until all data on the screens is entered correctly. The LTC system will not allow you to save an Admission Notification with errors in it.
4	Click Save. If there are no more errors, the error messages list does not display and the LTC Admission Notification is completed and saved. Note: An admission notification can be unlimitedly corrected or saved prior to transmission to the Web Server.

Additional Error Messages

The LTC Admission Notification also displays error message boxes alerting the user to problems.

For example, if you click on the Add button before saving the admission notification, a message box like the one that appears below (It states, " You have changed information on this window. Do you want to save changes?"). Click 'Yes' to acknowledge the error message box and correct the error.



6.1.4 Look-Up Functionality

A look-up field provides the user with the only valid values available for the field. Users may enter the value, or choose it from a drop-down list.

To view the list, click on the arrow to the right of the field. Highlight the desired value by clicking it once with the mouse. The value displays in the field.

There are three look up fields on the LTC Admission Notification form.

- Submission Reason
- Reason 7 Explanation
- Waiver Income

All providers using the LTC Admission Notification form must choose one value from the Submission Reason drop down list. Specific instructions for each provider type are reviewed in appropriate sections following this one.

Submission Reason

The following is an illustration of the Submission Reason drop down list.

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New Admission/Initial Assessment/Election	1
Readmission	2
WAIVER Redetermination/PEC Continuation	3
WAIVER Early Redetermination	4
WAIVER Reinstatement	5
Transfer In	6
Death/Discharge/Termination/Revoke	7

Refer to one of the following chapters to review choices specific to your program.

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Reason 7 Explanation

The following is an illustration of the Reason 7 Explanation drop down list.

Recipient discharged home	H
Recipient died	D
Recipient was terminated from the program	T

Providers will need to select one of the explanations from the list for clarification when the Submission Reason is 7.

Waiver Income

The following is an illustration of the Waiver Income drop down window.

	0
300% slot	1
Institutionally deeming	2
Deinstitutionalized	3

Waiver providers may choose one of the values displayed in the Waiver Income drop down box.

Specific instructions for Waiver providers are reviewed in following chapters.

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7. Retrospective Review

Policy

Although the Alabama Medicaid Agency (Agency) has delegated authority of initial level of care determinations to long term care providers, the Agency still maintains ultimate authority and oversight of this process. The Agency, or its designee, will develop and modify level of care criteria, determine provider standards, and develop and implement new policies as deemed appropriate. To ensure that state and federal rules and guidelines are adhered to by long term care providers, the Agency will retrospectively review monthly a 10% sample of admissions, readmissions, and redeterminations of Medicaid recipients served by long term care providers.

Procedures

The Agency professional nursing and medical staff will conduct retrospective reviews of long term care providers on a monthly basis.

Each provider will be notified of records to mail to HP Enterprises. (The Agency will not be responsible for any cost associated with the copying or mailing of requested documents.)

The Agency professional staff, or its designee, will review requested documents to ensure compliance with state and federal guidelines governing the specific program and to ensure the medical necessity of the services rendered.

The review must be completed by Agency, or its designee, within 30 days from receipt of the requested information from the long term care provider.

The provider must make every effort to send all requested information upon the first request. A checklist will be provided to you to ensure that all documents are included before mailing.

Payment for services will be recommended for recoupment if client records are determined to be deficient or the medical need for the services cannot be determined.

The Agency, or its designee, may initiate a second request to providers for the requested information or additional information. If this information is not received, recoupment proceedings will be initiated.

Upon review of the requested documents, the provider will be notified in writing within 30 days if further action will be taken or if additional information is needed (Providers will only be notified if further action is necessary.)

Providers will be notified of their appeal rights including the informal reconsideration as well as the fair hearing process.

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8. Nursing Home

Authorized users access the LTC Admission Notification Form screen to view or add the LTC Admission Notification. This screen is used to enter a new admission, readmission, transfer in, or discharge or death of, a recipient to the Medicaid nursing home program.

The following fields are required to add information on the Admission Notification screen.

- Provider Number
- Provider Name
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Client (recipient) Medicaid Number
- Submission Reason
- Date of new admission, readmission, transfer in, discharge or death

8.1 Submission Reason Instructions

Policy

Applicants to Medicaid certified nursing facilities must meet the Medicaid approved criteria. Each nursing home must have a designated Registered Nurse who is responsible for determining if a potential resident meets the Medicaid approved criteria for nursing facility care.

Procedure

1. The Agency provides each nursing facility (NF) with all policies and procedures and state and federal guidelines governing admissions and readmissions to the facility and discharges from the facility.

2. The NF designates a Registered Nurse to assess the potential resident and determine the need for nursing facility level of care.

3. Each NF is provided with the Medicaid approved criteria to be used to determine the medical necessity of the admission to the NF.

4. The NF is required to complete all state and federal documents within the timeframes mandated by state and federal rules. If documents are not fully completed in a timely manner, the NF may be penalized and funds may be recouped. These documents include the Admission and Evaluation Data (Form 161), Minimum Data Set (MDS), Level I Screening and determination, and the Level II determination, when applicable.

5. Once the medical determination has been made, the NF should hold the medical ‘approval’ in a pending file until the financial award letter has been received. Do not submit admission notifications to HP until financial eligibility has been established.

6. For applicants that have not been determined to be financially eligible for nursing facility care, the NF should, whenever possible assist with the application process. The applicant and/or sponsor should be referred to the appropriate Medicaid District Office (DO). The DO will notify the NF in writing of the approval or denial of financial eligibility.

7. Once the financial award approval is received, the NF may complete the LTC Admission Notification, using the beginning date of approval on the DO award notice and transmit to HP.

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The HP system accepts or rejects the admission notification and notifies the provider on the next business day when the provider submits for a response.

8. When admission notifications are accepted, the information is automatically written to the Level of Care Assignment Plan table. The NF may at that point begin billing for services rendered.

9. When transmitted admission notifications are rejected, the NF is notified on the next business day when the provider submits for a response. The NF should make the necessary changes and resubmit the admission notification to HP.

10. Neither the Agency nor HP will send out Notification letters. The response record titled "NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE" containing the resident's Level of Care Assignment table date segments is your record of 'approval' to begin rendering service.

11. For applications where the level of care (LOC) is questionable, you may submit the Applications to the Medical and Quality Review Unit or designee for review by a nurse and or a physician.

12. Once a segment is written to the LOC Assignment Plan table, the Agency, or its designee, is the only entity that may make changes. A Request for Action form is completed and faxed with supporting documentation to the Agency's designee. The requestor is notified by fax when the change is made.

New Admission

Required documents to be maintained:

- Form 161
- Minimum Data Set (MDS)
- Preadmission screening and Annual resident review (PASARR) Information
- Level I request, Determination letter, and Level II determination, if indicated

Readmissions

Required documents to be maintained:

- Form 161
- PASARR Information, if indicated

Transfer In Admissions

If you are the facility sending the resident to another nursing facility or hospice provider, the process should be the same as a discharge.

If you are the facility receiving a resident from another nursing facility or hospice provider, the process required is the same as a new admission (see new admission for requirements). However, instead of checking New Admission from the Submission Reason drop down box on the LTC Admission Notification screen, check Transfer In.

Discharges

Residents discharged from the nursing facility should have discharge information submitted using LTC Admission Notification software within 48 hours.

If the resident is transferring from your nursing facility to another nursing home facility, this is a discharge for the "from or sending facility" and processed as a discharge.

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NOTE

When the discharge is submitted an additional clarification for the discharge is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field.

Break In Financial

If a resident is already on the LOC Assignment Plan table as medically eligible, and they lose financial eligibility and regain it again but there is NO BREAK IN STAY, the Level of Care Assignment Plan table requires no update.

If a resident is already on the LOC Assignment Plan table file as medically eligible, and they lose financial eligibility, and regain it again but there is a BREAK IN STAY, then follow the discharge and readmission process. The new admission date would be the date the financial eligibility is reestablished.

Convalescent Care or Short-Term Stay

Policy:

Residents who are admitted to nursing facilities for 120 days (formerly known as Convalescent Care) or other short-term stays will be required to apply through the Medicaid DO and will be treated as a nursing home case.

Procedure:

Residents admitted to nursing facilities for short-term stays must apply through the Medicaid DO for financial approval the same as other residents seeking Medicaid reimbursement of nursing facility stays.

Once financial eligibility has been awarded by the Medicaid DO, the LTC Admission Notification Form can be submitted to HP electronically.

The admission date requested will be the approval date of the medical care level on the Level of Care Assignment Plan table. The end date will be open ended until the resident is discharged.

8.1.1 LTC Admission Notification Form Field Descriptions

Field names are followed by a one-character abbreviation indicating field type.

- R indicates a required field
- O indicates an optional field.

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Field	Description
Provider ID (R)	Requires the user to enter the Nursing Home's Medicaid provider number. The field length for provider number is ten bytes. Please note: It is not necessary to key a space in front of your eight byte alpha numeric provider number. If the Nursing Home has received their ten digit National Provider Identifier (NPI) number, enter that in this field. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the facility. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider ID, provider name and performing provider ID.
Provider Name (R)	Requires the user to enter the provider name.
PCN (O)	Not required for nursing home program.
Performing Provider ID (O)	Not required for nursing home program.
Client ID (R)	Requires the user to enter the recipient's Medicaid number. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
SSN (R)	Requires the user to enter the recipient's Social Security Number.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's last name.
Submission Reason (R)	Requires the user to choose a submission reason. Valid reasons for nursing homes are: 1. New admission 2. Readmission 6. Transfer In 7. Death/Discharge
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.

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Field	Description
Admit or Discharge Date (R)	Requires the user to enter the date of the new admission, readmission, transfer in, discharge or death.
Medicare Begin Date (O)	Allows user to enter Medicare begin date. Complete the Medicare Begin Date information only if the resident has had Medicare coverage just preceding this Medicaid admission.
NH Convalescent Care? (O)	Allows user to enter a ‘check’ if care provided by the Nursing Home is Convalescent Care.
Hospice provided in NH? (O)	Not required for nursing home program.
Waiver Reinstatement Begin Date (O)	Not required for nursing home program.
Waiver Reinstatement End Date (O)	Not required for nursing home program.
WAIVER Income (O)	Not required for nursing home program.
Waiver Income Begin Date (O)	Not required for nursing home program.

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9. Hospice

Authorized users access the Long Term Care Admission Notification Form screen to add and view data for recipients who are electing the Medicaid Hospice Option. This screen is used to enter an election, transfer in, readmission, discharge, revocation, or death of a recipient to the Hospice program.

Presently, all hospice applications require a medical review by the Agency's designee . For policies and procedures related to hospice admissions, please refer to the Medicaid web site hospice care chapter of the Alabama Medicaid Provider Manual at www.medicaid.alabama.gov.

The Medical and Quality Review Unit in the Agency and the Agency's designee (contractor) are presently the only authorized users that access and update Long Term Care Admission Notifications for the Medicaid Hospice Option.

The following fields are required to add information on the LTC Admission Notification Form screen for Hospice providers.

- Provider Number
- Provider Name
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Client (recipient) Medicaid Number
- Submission Reason
- Date of election, transfer in, readmission, discharge, revocation or death
- If applicable, check box if Hospice is provided in the Nursing Home

9.1 Submission Reason Instructions

Policy:

Applicants applying for Medicaid approved hospice services must be certified by the attending physician or hospice medical director as having a terminal illness.

Procedure

1. The Agency provides each hospice provider with all policies and procedures and state and federal guidelines governing election of the hospice benefit.
2. The hospice provider is required to complete all state and federal documents within the timeframes mandated by state and federal rules. The document required is the Medicaid Hospice Election and Physician's Form (165). If the hospice benefit is being provided in a nursing facility, the hospice provider is responsible for ensuring that the MDS is completed per federal guidelines.

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3. Once these forms are complete, the hospice provider ensures that financial eligibility has been established. If there is no financial award, the hospice provider will hold the election form in a pending status until financial eligibility is established4. Once financial eligibility is established either through Social Security Administration (SSA) or the appropriate Medicaid DO, the provider may submit the record to HP Enterprise for electronic review by the Agency's designee for a medical approval for Medicaid-only recipients, or recipients with other than Medicare for hospice in the nursing home. The HP system accepts or rejects the form and notifies the Agency or designee the next business day when a response is submitted. For dually eligible recipients in the nursing home, for room and board payment, the provider should submit the Hospice Recipient Status Change Form (Form 165B) to the Agency's designee, so the dates can be entered to the LOC Assignment Plan table.

4. When the applications are accepted, the information automatically writes to the LOC Assignment Plan table. The hospice provider may then begin billing for services rendered.

5. When transmitted applications are rejected, the Agency or designee has the opportunity make necessary changes and resubmit the LTC Admission Notification.

6. Neither the Agency nor HP will send out notification letters. The Agency's designee will send out the approval letters for Medicaid-only or recipients with other than Medicare. The Agency's designee will fax back the Form 165B when the dates have been processed to the LOC Assignment Plan table for room and board payment.

7. Once the resident's information has been added to the LOC Assignment Plan table, only authorized Medicaid staff or its designee can make changes. To request a change, the hospice provider completes the Hospice Recipient Status Change form (Form 165B) and sends it to the Agency's designee. The Agency's designee will notify the requestor when the change is made.

Election

The following is required information that must be included on all Hospice new elections:

Hospice Election and Physician's Certification Form 165 must be completed. This information must be obtained on the paper format of the form. Original signatures and dates are required. This form is to be maintained in the provider files.

Readmissions

Examples of Hospice Readmissions:

1) If a patient revokes care then elects to return to the same hospice for care during the same hospice period.
2) If a dually eligible recipient discharges from the NF and then returns to the NF.

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Transfer In Admissions

If the facility is sending the resident to another hospice or to a nursing facility, the process should be the same as a discharge.

If the facility is receiving a resident from a nursing facility or another hospice provider, the process required is the same as a new admission (see new admission for requirements). However, instead of checking New Admission from the Submission Reason drop down box on the LTC Admission Notification screen, check Transfer In.

Discharge, Death or Revocation of Hospice Benefits

Residents discharged from the hospice should have discharge information submitted using the Form 165B to the Agency's designee within 48 hours.

NOTE

When the discharge is submitted an additional clarification for the discharge is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field.

9.1.1 LTC Admission Notification Form Field Descriptions for Hospice

Field names are followed by a one-character abbreviation indicating field type. R indicates a required field, and O indicates an optional field.

Field	Description
Provider ID (R)	Requires the user to enter the hospice Medicaid provider number. The field length for provider number is ten bytes. Please note: It is not necessary to key a space in front of your eight byte alpha numeric provider number. If the hospice has received your NPI number, enter that number in this field. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the Hospice location. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider ID, provider name and performing provider ID.
Provider Name (R)	Requires the user to enter the provider name.
PCN (O)	Not required for Hospice.
Performing Number (O)	Not required for Hospice.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's first name.

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Field	Description
SSN (R)	Requires the user to enter the recipient's Social Security Number.
Client ID (R)	Requires the user to enter the recipient's Medicaid number.
Submission Reason (R)	Requires the user to choose Submission Reason type. Valid reasons for hospice are: 1. Election 2. Readmission 6. Transfer In 7. Discharge/Death/Revoke
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.
Admit or Discharge Date (R)	Requires the user to enter the date of the election, transfer in, readmission, revocation, discharge, or death.
Medicare Begin Date (O)	Not required for Hospice
NH Convalescent Care? (O)	Not required for Hospice.
Hospice provided in NH? (O)	Allows user to enter a 'check' if Hospice care is provided in a Nursing Home.
Waiver Reinstatement Begin Date (O)	Not required for Hospice.
Waiver Reinstatement End Date (O)	Not required for Hospice.
WAIVER Income (O)	Not required for Hospice.
Waiver Income Begin Date (O)	Not required for Hospice.

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10. Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Authorized users access the LTC Admission Notification Form screen, to add and view the LTC Admission Notification information. This screen is used to enter a new admission, readmission, discharge, or death of a recipient to the Intermediate Care Facility for the Mentally Retarded (ICF/MR) program.

The following fields are required to add information on the LTC Admission Notification Form screen for ICF/MR providers.

- Provider Number
- Provider Name
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Client (recipient) Medicaid Number
- Submission Reason
- Date of new admission, readmission, discharge, or death

10.1 Submission Reason Instructions

Policy

Applicants to Medicaid certified ICF/MR facilities must meet the Medicaid ICF/MR level of care criteria. Each facility will have a designated QMRP to be responsible for determining if a resident meets the Medicaid approved criteria for ICF/MR care.

Procedures

1. The Agency provides each ICF/MR facility with all policies and procedures and state and federal guidelines governing admissions and readmissions to the facility and discharges from the facility.

2. The facility designates a QMRP to assess the potential resident and determine the need for ICF/MR level of care.

3. Each facility is provided with the Medicaid approved criteria to determine the necessity of the admission for ICF/MR level of care.

4. The facility is required to complete all state and federal documents within the timeframes mandated by state and federal laws. If documents are not fully completed in a timely manner the facility may be penalized and funds may be recouped. These forms include the Form199 and ICF/MR Level of Care Evaluation for Institutional Care (Form 361), physician evaluation, social evaluation, psychological evaluation, and interim rehabilitation plan.

5. Once the level of care determination is made, the ICF/MR will hold the application in a pending file until the financial award letter is received. Do not submit LTC Admission Notification until the financial award letter is received from the Medicaid DO.

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6. For applicants that have not been determined to be financially eligible for institutional care, the ICF/MR facility personnel will assist with the application process whenever possible. The applicant and/or sponsor will be referred to the appropriate Medicaid DO. The DO notifies the facility in writing of the approval or denial of financial eligibility.

7. Once the financial award approval is received, the ICF/MR facility personnel will complete the LTC Admission Notification Form using the beginning date of the approval on the DO award notice and electronically submit to HP. The HP system accepts or rejects the admission notification and notifies the provider on the next business day when the provider submits a response.

8. When applications are accepted, the information is automatically written to the LOC Assignment Plan table. The ICF/MR facility may begin billing for services rendered.

9. When transmitted applications are rejected, the ICF/MR provider has the opportunity make necessary changes and resubmit the LTC Admission Notification.

10. Once a segment is written to the LOC Assignment Plan table, the Agency or its designee are the only entities that may make changes. A Request for Action form is completed and faxed with supporting documentation to the Agency's designee. The requestor is notified by fax when the change is made.

New Admission

The Medicaid Patient Status Notification (Form 199) should be completed.

ICF/MR Level of Care Evaluation for Institutional Care Form (Form 361), which requires physician original signature, must be maintained in the facility record.

The facility is to complete and have on file a current physical assessment, social evaluation, psychological examination, and individual rehabilitation plan.

Readmissions

Readmissions are processed the same as a new admission. ICF/MR residents cannot be receiving skilled care.

Discharges

If a resident is moving from ICF-MR into the care of the ID program, submit this discharge timely so the ID program can submit their "deinstitutionalized" admission notification.

Residents discharged from the facility should have discharge information submitted using LTC Admission Notification software within 48 hours.

NOTE
When the discharge is submitted an additional clarification for the discharge is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field.

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10.1.1 LTC Admission Notification Form Field Descriptions for ICF/MR

Field names are followed by a one-character abbreviation indicating field type.

- R indicates a required field
- O indicates an optional field

Field	Description
Provider ID (R)	Requires the user to enter the ICF/MR Medicaid provider number. The field length for provider number is nine bytes. Please note: It is not necessary to key a space in front of your eight byte alpha numeric provider number. If the ICF/MR has received their ten digit NPI number, enter that here. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the facility. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider ID, provider name and performing provider ID.
Provider Name (R)	Requires the user to enter the provider name.
PCN (O)	Not required for ICF/MR.
Performing Provider ID (O)	Not required for ICF/MR.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's first name.
SSN (R)	Requires the user to enter the recipient's Social Security Number.
Client ID (R)	Requires the user to enter the recipient's Medicaid number.
Submission Reason (R)	Requires the user to 'check' the type of Medical Admission Notification. Valid reasons for ICF/MR are: 1. Election 2. Readmission 6. Transfer In 7. Discharge/Death/Revoke
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.

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Field	Description
Admit or Discharge Date (R)	Requires the user to enter the date of the New Admission, Readmission, Transfer In, Death or Discharge.
Medicare Begin Date (O)	Not required for ICF-MR.
NH Convalescent Care? (O)	Not required for ICF-MR.
Hospice provided in NH? (O)	Not required for ICF-MR.
Waiver Reinstatement Begin Date (O)	Not required for ICF-MR.
Waiver Reinstatement End Date (O)	Not required for ICF-MR.
Waiver Income (O)	Not required for ICF-MR.
Waiver Income Begin Date (O)	Not required for ICF-MR.

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11. HCBS - Intellectual Disabilities (ID)/Living at Home

Authorized users access the Long Term Care Admission Notification Form screen to add and view the LTC Admission Notification form. The screen is used to enter an Initial Assessment, Redetermination, Early Redetermination, Reinstatement, Transfer In, or Discharge of a recipient to the HCBS - Intellectual Disabilities (ID) or Living At Home Waiver program.

The following fields are required to add information on the LTC Admission Notification Form screen.

- Provider Number
- Provider Name
- Performing Provider ID
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Client (recipient) Medicaid Number
- Submission Reason
- Date of Initial Assessment, Redetermination, Early Redetermination, Reinstatement, Transfer In, or Discharge
- If applicable, Waiver Income type
- If applicable, Waiver Income begin date

11.1 Submission Reason Instructions

Policy:

The requests for ID or Living At Home Waiver are submitted to the OA for data entry. The regional QMRP will determine if the individual meets the Agency's level of care criteria and review the plan of care.

Procedure:

1. The Agency provides the OA with the approved level of care criteria along with any additional policies that govern the level of care determination process.

2. Determination of Medicaid financial eligibility is made by the case manager. They ensure that the appropriate documents are completed and routed to the Medicaid DO. The Application/Redetermination for Elderly and Disabled Programs (Form 204/205) is submitted if financial eligibility is to be established.

3. Individuals seeking approval under the 300% financial eligibility and institutional deeming category who have not had a disability determination must be determined disabled by the Agency Office of the Associate Medical Director.

4. If a disability determination has been made, the OA should complete the Waiver Slot Confirmation (Form 376).

5. A copy of the ID medical application should be forwarded to the appropriate DO with the original Form 376 and Form 204/205.

6. The QMRP completes the level of care determination and reviews the Plan of Care

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development.

7. The OA is required to adhere to all federal and state guidelines in the determination of the level of care approval.

8. The applicant's physician certifies that without waiver services, the client is at risk of institutionalization.

9. The OA or its designee (case manager) ensures that the applicant has been screened and assessed to determine if the services provided through the ID or Living At Home Wavier will meet the applicant's needs in the community.

10. The OA or its designee develops a Plan of Care that includes waiver as well as non-waiver services.

11. Once financial eligibility is established, the OA transmits the LTC Admission Notification to HP. The HP system accepts or rejects the admission notification and notifies the provider on the next business day. The provider must submit for the accepted/rejected response using the LTC Admission Notification software.

12. When admission notifications are accepted, the information is automatically written to the Level of Care Assignment Plan table. The OA or its designee may at that point begin billing for services rendered.

13. When transmitted admission notifications are rejected, the OA or its designee is notified on the next business day. The OA or its designee should make the necessary changes and resubmit the admission notification to HP.

14. The response record titled "NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE" containing the resident's LOC Assignment Plan table date segments is your record of 'approval' to begin rendering service.

15. For applications where the LOC is questionable, you may submit the Applications to the Long Term Care Admissions/Records Unit for review by a nurse and or a Medicaid Physician.

16. Once the resident's information has been added to the LOC Assignment Plan table, only authorized Medicaid staff can make changes. To request a change, the OA or its designee completes the LTC Request for Action form and faxes it to the Long Term Care Admissions/Records Unit at (334) 353-5901. The requestor is notified when the change is made.

New Admission (Initial Assessment)

The ICF/MR Waiver Application forms must be completed and maintained in the files. The signatures and dates as applicable on this form must be original.

Applications for recipients age 65 and under who have not had a disability determination that have financial forms (204/ 205) attached to them will need to continue to be mailed to the Alabama Medicaid Office, LTC Admissions/Records Unit at 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103.

Re-determinations

Re-determinations must be received in the office no greater than 45 days prior to the re-determination end date or no less than the fifteenth (15) day of the month the re-determination is due. Please see the second bullet under Transfers In if you are the receiving center for a client transferring from one center to another within the same Waiver program.

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Original signatures and dates are required on the ICF/MR Level of Care Evaluations and the plan of care. The paper original forms are to be retained at the Center as listed in the first three digits of your nine-digit prior approval number.

Transfers In

There are two different types of transfers. A transfer may occur within an administering agency, simply transferring the recipient from one center to another. Or, the recipient may transfer out of one agency, like Public Health to another agency, like ID.

When a client transfers from one center to another within the same administering agency, no information should be submitted until the re-determination. At the time of re-determination, the center code should be changed to reflect the center providing services at that time.

When a client transfers from one administering agency to another, the original provider who will no longer be providing services must submit a termination.

The new administering agency should submit a new admission (initial assessment).

Termination

Residents discharged from the center should have discharge information submitted using LTC Admission Notification software within 48 hours.

NOTE

When the discharge is submitted an additional clarification for the discharge is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field.

11.1.1 LTC Admission Notification Form Field Descriptions for ID

Field names are followed by a one-character abbreviation indicating field type.

- R indicates a required field
- O indicates an optional field

Field	Description
Provider ID (R)	Requires the user to enter the provider number. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider ID, provider name, and performing provider ID. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the facility.
Provider Name (R)	Requires the user to enter the provider name
PCN (O)	Not required for ID.

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Field	Description
Performing Provider ID (R)	Although this is an optional field as defined by the screen entry rules, it is REQUIRED for ID. Allows the user to enter the ID or LAHW performing number. This number is critical for ID or LAHW. It is used in the response process to accurately notify the specific center that Medical Approval information is on file at Medicaid.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's first name.
SSN (R)	Requires the user to enter the recipient's Social Security Number.
Client ID (R)	Requires the user to enter the recipient's Medicaid number.
Submission Reason (R)	Requires the user to 'check' the type of Medical Admission Notification.
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.
Admit or Discharge Date (R)	Requires the user to enter the date of the new admission, re-determination, transfer in or discharge
NH Convalescent Care? (O)	Not required for ID.
Hospice provided in NH? (O)	Not required for ID.
Waiver Reinstatement Begin Date (O)	Allows the user to enter Reinstatement Begin Date.
Waiver Reinstatement End Date (O)	Allows the user to enter the original Waiver End Date. This allows the system to correctly 'replace' the original end date.
Waive Income (O)	Allows the user to enter the type of Waiver Income if applicable. Valid values are: 1. 300% slot 2. Institutionally Deeming 3. Deinstitutionalized
Waiver Income Begin Date (O)	Allows the user to enter the begin date for the Waiver Income.

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12. Elderly and Disabled, HIV/AIDS, SAIL, and ACT

Authorized users access the Long Term Care Admission Notification form screen to view or add the LTC Admission Notification. This screen is used to enter an initial assessment, re-determination, reinstatement, transfer in, readmission or termination of a recipient to the Home and Community Based Service (HCBS) program.

The following fields are required to add information on the LTC Admission Notification form screen.

- Provider Number
- Provider Name
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Client (recipient) Medicaid Number
- Submission Reason
- Date of initial assessment, re-determination, early redetermination, reinstatement, transfer in or termination
- If applicable, Waiver Income type
- If applicable, Waiver Income begin date

12.1 Policy Rules

Policy

Requests for HCBS Waivers are submitted to the OA for approval. The OA will determine if the individual meets the Agency level of care criteria and financial requirements.

Procedure

1. The Agency provides the OA with the approved level of care criteria along with any additional policies that govern the level of care determination process.

2. The OA determines if the applicant is financially eligible for Medicaid and ensures that the appropriate documents are completed and routed to the appropriate Medicaid DO. Form 204/205 is submitted if eligibility is to be established.

3. Individuals age 65 and under seeking approval under the 300% financial eligibility or institutional deeming category must be determined disabled by the Agency Office of the Associate Medical Director. These applications should be submitted to Agency LTC Admissions Records Unit.

4. If a disability determination has been made, the OA Nurse Reviewer should complete Form 376.

5. A copy of the HCBS medical application should be forwarded to the appropriate DO with the original Form 376 and Form 204/205.

6. The OA Nurse Reviewer completes the level of care determination and reviews the Plan of Care development.

7. The OA is required to adhere to all federal and state guidelines in the determination of the

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level of care approval.

8. The applicant's physician certifies that without waiver services, the client is at risk of institutionalization.

9. The OA or its designee (case manager) ensures that the applicant has been screened and assessed to determine if the services provided through the EDW will meet the applicant's needs in the community.

10. The OA or its designee develops a Plan of Care that includes waiver as well as non-waiver services.

11. Upon receipt of the financial award letter from Agency, the LTC Admission Notification is completed and transmitted to HP. The HP system accepts or rejects the admission notification and notifies the provider on the next business day when the provider submits for a response.

12. When admission notifications are accepted, the information is automatically written to the Level of Care Assignment Plan table. The OA or its designee may at that point begin billing for services rendered.

13. When transmitted admission notifications are rejected, the OA or its designee is notified on the next business day when they submit for a response. The OA or its designee should make the necessary changes and resubmit the admission notification to HP.

14. The response record titled "NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE" containing the resident's LOC Assignment Plan table date segments is your record of 'approval' to begin rendering service.

15. For applications where the LOC is questionable, you may submit the Applications to the Long Term Care Admissions/Records Unit for review by a nurse and or a Medicaid Physician.

16. Once a segment is written to the LOC Assignment Plan table, the Agency is the only entity that may make changes. A Request for Action form is completed and faxed with supporting documentation to the Long Term Care Admissions/Records Unit at (334) 353-5901. The requestor is notified by fax when the change is made.

Initial Assessment

The original application with patient and physician signatures and dates must be on file in your office.

Those applications that have financial forms (204/205) attached to them and have NOT had a disability determination made for individual 65 and under will need to continue to be mailed to the Alabama Medicaid Office, LTC Admissions/Records Unit at 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103. Those applications that have financial forms (204/205) attached to them and HAVE had a disability determination made for individual 65 and under should have Form 376 completed and attached by the OA nurse reviewer and mailed to the appropriate DO. The DO will return the financial award notice and at that point, the OA may transmit the LTC Admission Notification.

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Re-determinations

Re-determinations should be sent in no more than 45 days prior to the re-determination date and no later than the last day of the month for the system.

The original patient and physician signature dates must be on file based upon the current waiver document. This form must be retained in the case manager's records.

Early Re-determinations

Re-determinations sent in more than 45 days prior to the re-determination date and no later than the fifteenth (15) day of the month in which the re-determination expires.

The original patient and physician signature dates must be on file. Original HCBS form pages 1-4 must be retained in the case manager records.

Reinstatements

A reinstatement from short stay nursing home care brings a client back into Waiver care within the same span of care for which they were originally approved. As a simple example, a client has a date segment span on the Level of Care Panel of 06/12/2011 through 06/30/2012. They leave the program altogether on 08/19/2011. (An appropriate termination notification is received and applied to the file) They are to come back to the program on 10/24/2011. To bring the client back into the same span of care requires that HP be supplied the original end date of 06/30/2012. To accomplish this, chose submission reason Waiver Reinstatement, enter a Reinstatement Begin Date of 10/24/2011 and a Reinstatement End Date of 6/30/2012.

Termination

Clients terminated from the HCBS Waiver should have termination information submitted using LTC Admission Notification software within 48 hours.

NOTE
When the discharge is submitted an additional clarification for the discharge is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field.

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Transfers In

Transfers occur between different providers (example: Alabama Department of Public Health and Commission on Aging) or between counties or centers within an agency (example: patient moves from Montgomery County to Shelby County).

When a client transfers from one center to another within the same administering agency, no information should be submitted until the re-determination is due. At the time of re-determination, the county code should be changed to reflect the center providing services at that time.

When a client transfers from one agency to another, the original provider who will no longer be providing services must submit a termination. The new provider should complete a readmission. The new provider will be picking up the time left on the current waiver to their agency provider number. You should receive notification of the termination from the provider and keep this copy in your files. The patient would require a reassessment prior to submitting the readmission on the LTC Admission Notification form of the LTC Admission Notification software.

12.1.1 LTC Admission Notification Form Field Descriptions for Elderly and Disabled, HIV/AIDS, SAIL, and ACT

Field names are followed by a one-character abbreviation indicating field type.

R indicates a required field, and O indicates an optional field.

Field	Description
Provider ID (R)	Requires the user to enter the provider number. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider number, provider name, and performing provider ID. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the facility.
Provider Name (R)	Requires the user to enter the provider name.
PCN (O)	Not Required by HCBS.
Performing Provider ID (R)	Not required by HCBS.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's first name.
SSN (R)	Requires the user to enter the recipient's Social Security Number.
Client ID (R)	Requires the user to enter the recipient's Medicaid number.
Submission Reason (R)	Requires the user to 'check' the type of Medical Admission Notification.

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Field	Description
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.
Admit or Discharge Date (R)	Requires the user to enter the beginning date of the Initial Assessment, Re-determination, Early Re-determination, Reinstatement, or the date of Termination from the HCBS program.
Medicare Begin Date (O)	Not required for HCBS.
NH Convalescent Care? (O)	Not required for HCBS.
Hospice provided in NH? (O)	Not required for HCBS.
Waiver Reinstatement Begin Date (O)	Allows the user to enter the beginning date of Waiver Reinstatement.
Waiver Reinstatement End Date (O)	Allows the user to enter the original end date of the previous Waiver segment to correctly ‘replace’ the original end date.
Waiver Income (O)	Allows the user to ‘check’ the type of WAIVER eligibility if it applies to this recipient.
Waiver Income Begin Date (O)	Allows the user to enter the start date of WAIVER eligibility. This field becomes a required field if the type of WAIVER eligibility field is completed.

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13. Program of All-inclusive Care for the Elderly (PACE)

Authorized users access the Long Term Care Admission Notification Form screen to add and view the LTC Admission Notification form. The screen is used to enter an enrollment or disenrollment of a participant to the Program of All-inclusive Care for the Elderly (PACE).

The following fields are required to add information on the LTC Admission Notification Form screen.

- Provider Number
- Provider Name
- Client (recipient) Last Name
- Client (recipient) First Name
- Client (recipient) SSN
- Submission Reason
- Client (recipient) Medicaid Number
- Date of Initial Assessment or Discharge

13.1 Submission Reason Instructions

Policy:

Applicants to the PACE Program must meet Medicaid approved criteria. PACE Organizations (PO) must submit appropriate documents to the appropriate Medicaid District Office or Customer Service Center (DO/CSC) for determination that the potential participant meets the financial eligibility requirements. The PACE Organizations will determine that the potential participant meets the requirements for the Level of Care Determination.

Monthly reviews for all enrollments will be conducted by the Agency PACE Unit nursing staff according to established Agency policy and procedures. The PO must submit the required documents to the PACE Unit nursing staff by the established timeframe. The nursing staff will request additional information if it is determined to be necessary during their review of the documents. If the PO fails to provide the requested information, recoupment proceedings will be initiated following Agency policy and procedures. If it is determined during the review that a participant has not met the requirements for participation in the PACE Program, the PO will be notified in writing and recoupment proceedings will be initiated.

Procedure:

1. The Agency provides the PO with the approved level of care criteria along with any additional policies that govern the level of care determination process.

2. If applicable, the PO will assist the potential participant in completing and routing the appropriate documents to the appropriate DO/CSC for determination that financial eligibility requirements are met.

3. The PO will have the appropriate staff determine that the potential participant meets the requirements for the Level of Care Determination. Questions pertaining to the Level of Care should be directed to the Managed Care/PACE Unit nursing staff.

4. The PO is required to adhere to all federal and state guidelines when assessing the potential participant for the Level of Care Determination.

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5. The PO's designated staff will ensure that the potential participant has been appropriately assessed and that PACE services will meet the participant's needs to live safely in the community.

6. The PO's physician will certify that the potential participant meets the Level of Care requirements and that without PACE services, is at risk of admission to a nursing facility.

7. The PO will develop an individualized Plan of Care in accordance to state and federal requirements for the PACE Program when all enrollment processes have been completed for the potential participant.

8. If financial eligibility does not have to be established, the PO will transmit the LTC Admission Notification to HP following the below procedures.

9. Once financial eligibility is established, the PO will transmit the LTC Admission Notification to HP. The HP system will accept or reject the admission notification and notify the PO provider on the next business day. The PO provider must submit for the accepted/rejected response using the LTC Admission Notification software.

10. When admission notifications are accepted, the information is automatically written to the Level of Care Assignment Plan table. The PO may then begin billing the Agency for the capitated payment for the enrolled participant.

11. When transmitted admission notifications are rejected, the PO will be notified on the next business day. The PO must make the necessary changes and resubmit the admission notification to HP.

12. The response record titled "NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE" containing the participant's Level of Care Assignment Plan table date segments is the record of "approval" for the PO to begin rendering PACE services.

13. Individuals seeking approval under the 300% financial eligibility and institutional deeming category who have not had a disability determination must be determined disabled by the Agency Office of the Associate Medical Director.

14. If a disability determination has been made, the PO should complete the Form 376.

15. A copy of the ~~ID~~ medical application should be forwarded to the appropriate DO with the original Form 376 and Form 204/205.

16. Once the participant's information has been added to the LOC Assignment Plan table, only authorized Medicaid staff can make changes. To request a change, the PO must complete the LTC Request for Action form and faxes it to Managed Care/PACE Program Unit at (334) 353-9356. The PO will be notified when the change is made.

New Admission (Initial Assessment)

The Program of All-inclusive Care for the Elderly (PACE) Application forms and supporting documentation must be completed and maintained in the files. The signatures and dates as applicable on forms and supporting documentation must be original.

Applications for recipients age 55 and above who have not had a disability determination that have financial forms (204/ 205) attached to them will need to continue to be mailed to the Medical and Quality Review Unit at 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103.

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Termination

Participants disenrolled from the PACE Program should have disenrollment information submitted using LTC Admission Notification software within 48 hours.

NOTE

Involuntary dis-enrollments must be reviewed and approved by the Agency according to established procedures.

NOTE

When the disenrollment is submitted an additional clarification for the disenrollment is needed. A selection of Recipient discharged home (H), Recipient died (D) or Recipient was Terminated from the program (T) will need to be made in the Reason 7 Explanation field. For the Purpose of this program H will be used for a voluntary disenrollment and T will be used to signify an involuntary disenrollment.

13.1.1 LTC Admission Notification Form Field Descriptions for PACE

Field names are followed by a one-character abbreviation indicating field type.

- R indicates a required field
- O indicates an optional field

Field	Description
Provider ID (R)	Requires the user to enter the provider number. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific number will automatically fill in the provider ID, provider name, and performing provider ID. If your NPI is associated with more than one Alabama Medicaid provider number, then use your unique Medicaid provider for the facility.
Provider Name (R)	Requires the user to enter the provider name
PCN (O)	Not required for PACE program.
Performing Provider ID (O)	Not required for PACE program.
Client Name (Last) (R)	Requires the user to enter the recipient's last name. This field links to a list file. If the field is clicked, a list appears. Clicking on a specific name will automatically fill in the recipient's last name, first name, SSN and Medicaid number.
Client Name (First) (R)	Requires the user to enter the recipient's first name.
SSN (R)	Requires the user to enter the recipient's Social Security Number.

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Field	Description
Client ID (R)	Requires the user to enter the recipient's Medicaid number.
Submission Reason (R)	Requires the user to 'check' the type of Medical Admission Notification.
Reason 7 Explanation (O)	Requires the user to select an Explanation ONLY when a 7 is selected as the Submission Reason.
Admit or Discharge Date (R)	Requires the user to enter the date of the new Assessment or discharge
NH Convalescent Care? (O)	Not required for PACE program.
Hospice provided in NH? (O)	Not required for PACE program.
Waiver Reinstatement Begin Date (O)	Not required for PACE program.
Waiver Reinstatement End Date (O)	Not required for PACE program.
Waive Income (O)	Not required for PACE program.
Waiver Income Begin Date (O)	Not required for PACE program.

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14. Receiving a Response

This chapter describes how to resubmit a batch and understand the corresponding submission reports. It also discusses diskette submission and response.

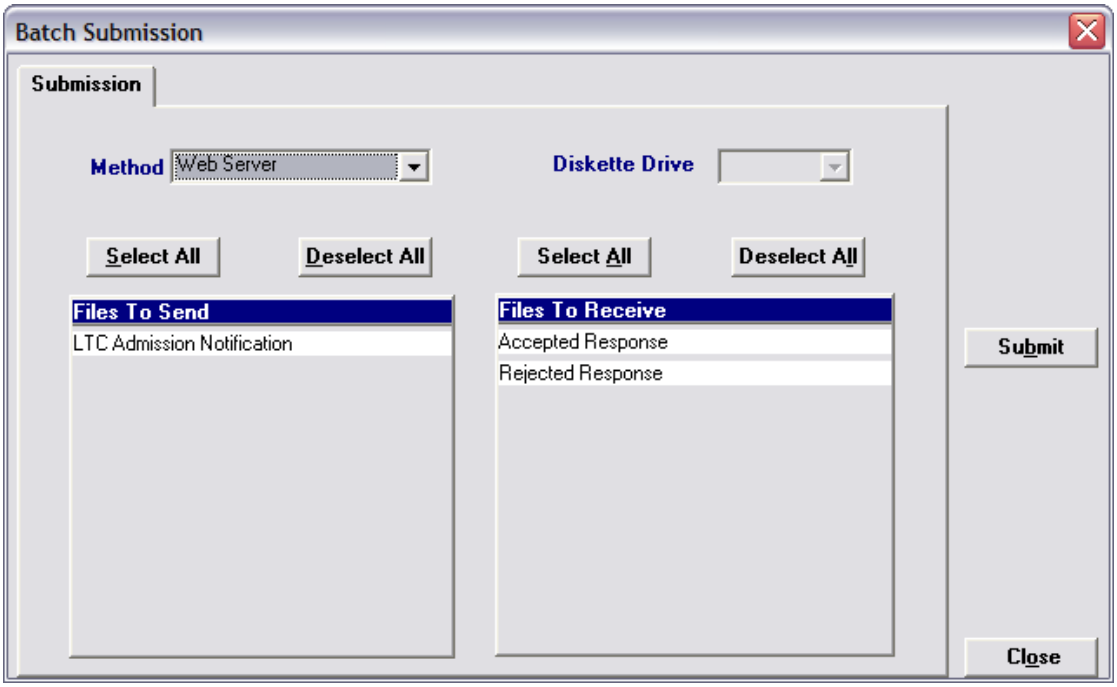
Chapter 14, Receiving a Response, contains the following sections:

- Sending batch transactions to the Web Server
- Viewing responses
- Resubmitting batches
- Submitting batches by diskette

14.1 Sending Batch Transactions to the Web Server

Alabama LTC Admission Notification enables you to submit batch (groups of one or more records) transactions to the HP Web Server for all Admission Notification types. You can send batch transmissions for any combination of record types – for example, you can enter all your daily Admission Notifications for Elderly and Disabled, HIV/AIDS, SAIL, ACT, Hospice, ICF/MR, Form199, and ID, and then submit them all in one batch transmission.

Once you have added and saved all the records you want to include in your batch, perform the following steps to submit a batch transmission:

Step	Action
1	Select Communication>>Submission to display the Batch Submission window, pictured below:
2	
3	Determine whether you want to submit by batch or diskette by selecting the correct submission method from the Method drop down list. See Section 14.4, Submitting Batches by Diskette, for instructions on submitting diskettes to HP.
4	Determine which files you want to send from the Files to Send list.
5	Choose Select All to select all files to send, Deselect All to undo any selections you have

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Step	Action
	made, or use the mouse (click once with the left mouse button) to select one form at a time.

Alabama LTC Medical Admission accesses the Web Server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

When you submit a batch, Alabama LTC Admission Notification accesses the web server and submits the batch. The system displays a 'Submission Successful' message when it successfully completes connection with the host. This does not always mean that a batch was uploaded. Alabama LTC Admission Notification's communication log will indicate the number of files transmitted during the transmission process.

14.2 Viewing Responses

This section describes viewing the communication log and response files.

View Communication Log

This option enables the user to view a log of each transaction that occurs between Alabama LTC Admission Notification and the Web Server. Each occurrence is assigned a file name. Users scroll down the list of file names located at the top of the Communication Log window and click on a row to access the log associated with the file name. The Communication Log displays only the number of bytes to be transferred when uploading the LTC Notification file and whether the submission was successful or unsuccessful. For downloads, it displays the number of files to be downloaded if any, and whether the download was successful or unsuccessful.

View Response

This option enables the user to view a log of each Admission Notification received and accepted by the Web Server.

To receive this information the following steps must be taken:

Step	Action
1	Admission Notifications that are transmitted during the day are taken into the system that evening.
2	The following day, you must select submission, highlight response, and submit to the Web Server for your response files.
3	You will immediately be able to view the response file by selecting View Response.

Response Reports

The information returned to you contains two sections:

- Admission Notifications Accepted and Written to File
- Admission Notifications Not Accepted and Reason Not Accepted

The information displayed tells you what dates were added to Medicaid's file so you can begin submitting claims, or tells you why dates were not added to Medicaid's file.

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Admission Notifications Accepted and Written to File.

The information returned contains the recipient's SSN, Medicaid number and name, the provider number (and either performing number or Patient Control Number (PCN) for appropriate Waiver providers), the Submission Reason and admit/discharge date requested, and the dates that are posted to the Medicaid LTC file. The following example illustrates 'accepted' Admission Notifications.

```
Report  : LTC-0006-M                                ALABAMA MEDICAID AGENCY                                Run Date: 07/28/2006
Process : LTCJM006                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   10:25:13
Location: LTCPM006                          NOTIFICATIONS ACCEPTED AND WRITTEN TO FILE                       Page:          2
                                                         DATE: 07/28/06


   SSN/                    PROVIDER/                                RECIPIENT NAME/                    DATES ON FILE
MEDICAID #                 CNTRL/PERF #                          APPROVAL SUBMITTED FOR              DATE ON NOTIFICATION
=================================================================================================================================
=================================================================================================================================


123456789/                 000000000                     DOE                      , MARY             01/09/06-05/19/06
111111111111                                                        REDETERMINATION                        05/19/06
```

Admission Notifications Not Accepted and Reason Not Accepted.

The information returned contains the recipient's SSN, Medicaid number and name, the provider's number (and either performing number or PCN for appropriate Waiver providers), the Submission Reason, the admit/discharge date requested, and the reason the Admission Notification was rejected. The following example illustrates 'rejected' Admission Notifications.

```
<-> TC34798
Report  : LTC-0005-M                                ALABAMA MEDICAID AGENCY                                Run Date: 07/28/2006
Process : LTCJM005                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   13:56:03
Location: LTCPM005                      NOTIFICATIONS NOT ACCEPTED AND REASON NOT ACCEPTED                   Page:          1
                                                         DATE: 07/28/07


   SSN/                    PROVIDER/                                RECIPIENT NAME/
MEDICAID #                 CNTRL/PERF #                          APPROVAL SUBMITTED FOR            DATE ON NOTIFICATION
=================================================================================================================================
=================================================================================================================================


112233445/                 00000000                      SMITH                    , JOHN
222222222222                                                        REDETERMINATION                     01/01/2007
              REDETERMINATION REQUEST AFTER SERVICES ON OUR FILE HAVE ENDED
```


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Rejection Messages

The follow table details rejection messages and the reason for rejection.

Message	Why?
EARLY REDETERMINATION IS REQUESTED AFTER 15TH OF THE MONTH IN WHICH REDETERMINATION EXPIRES'.	Early Redetermination was sent after the 15th of the month in which the Redetermination expires.
'EARLY REDETERMINATION REQUESTED MORE THAN 45 DAYS BEFORE CURRENT SERVICES END'.	If an Early Redetermination is received more than 45 days before the current services end.
ENTER THE CLIENT'S CURRENT MEDICAID ID NUMBER.	The old “000” Recipient ID was used on the application. Use the current Medicaid ID Number beginning with “500”.
THIS PROVIDER NUMBER IS NOT ON OUR FILES AS A VALID ALABAMA MEDICAID NUMBER.	An invalid provider number was submitted.
RECIPIENT DOES NOT HAVE FINANCIAL ELIGIBILITY FOR THESE SERVICES.	▪ An invalid recipient Medicaid number was submitted. ▪ The number is valid, but the recipient is no longer eligible for Medicaid. ▪ The number is valid, but the recipient is not in an Aid Category that covers services under the provider that you are submitting.
SOCIAL SECURITY NUMBER AND MEDICAID NUMBER ARE MISMATCHED.	The Social Security and Medicaid number you submitted do not match on our eligibility file.
THIS IS A DUPLICATE OF A PREVIOUSLY SUBMITTED APPLICATION.	If an exact duplicate is received.
RECIPIENT HAS CURRENT PROVIDER ON FILE WITH OPEN ENDED DATE.	Date span submitted overlaps an existing open ended segment on file. Admission record and discharge record submitted in same cycle shows the admission record is over 1 year old from the current date.
DATES ARE OVERLAPPING A PREVIOUS PROVIDER.	Date span submitted overlaps an existing segment on file. Admission record and discharge record submitted in same cycle shows the admission record is over 1 year old from the current date.

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Message	Why?
THIS DATE IS PRIOR TO THE CURRENT SERVICES ON FILE. CONTACT MEDICAID.	Start date submitted is before the start date of the existing record on file.
REQUEST MADE FOR A PROVIDER WITH NO PREVIOUS SERVICES ON FILE.	▪ If a readmission is received and there are no previous services on file. ▪ If a redetermination is received and there are no previous services on file.
YOU ARE NOT THE CURRENT PROVIDER ON FILE. DISCHARGE CANNOT BE APPLIED.	▪ If submitted discharge provider does not match the provider on file. ▪ If discharge is submitted and there is NO provider on file.
OUR FILES SHOW CURRENT SEGMENT IS AFTER THIS DISCHARGE DATE.	If the submitted discharge date is BEFORE the current segment on file. Admission record and discharge record submitted in same cycle shows the admission record is over 1 year old from the current date.
ENDING DATE ON FILE IS LESS THAN OR EQUAL TO DATE SUBMITTED.	If the submitted discharge dates is AFTER, or the same as, the end date on file for the same provider.
TRANSFER REQUESTED WITH NO SERVICES ON FILE FOR TRANSFER.	If transfer is submitted and there is NO provider on file.
INVALID SUBMISSION REASON.	If the submission reason submitted is not valid for the provider type.
RECIPIENT HAS MEDICARE PART A FOR AT-HOME HOSPICE. BILL MEDICARE.	If a hospice at-home admission notification is received and the recipient has Part A Medicare.
REDETERMINATION REQUESTED MORE THAN 45 DAYS BEFORE CURRENT SERVICES END.	If a redetermination is received more than 45 days before the current services end.
REDETERMINATION REQUEST AFTER SERVICES ON OUR FILE HAVE ENDED.	If a redetermination is submitted after the current services on file have ended.
REINSTATEMENT END DATE IS LESS THAN BEGIN DATE.	If reinstatement end date is prior to reinstatement begin date.
RECIPIENT IS STILL ON FILE AS BEING INSTITUTIONALIZED.	If submitted ID admission notification is received indicating deinstitutionalized and the recipient has an open ended ICF-MR segment on file.
TRANSFER DATE DOES NOT MATCH PREVIOUS END DATE.	If a transfer is submitted and the transfer date does not match the end date of the previous provider.

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Message	Why?
PROVIDER NUMBER IS NOT ELIGIBLE FOR THESE BENEFITS.	If the provider submitted is not a waiver or long term care provider.
RECOUPMENT ISSUES. CONTACT MEDICAID.	If the provider has been notified by the Agency that there are outstanding issues with these services.
REINSTATEMENT REQUESTED WITHOUT QUALIFYING NURSING HOME STAY.	Not enough time has passed between date of termination and the reinstatement date to allow for a qualifying Nursing Home stay. Please verify your reinstatement date.
CHANGE NPI TO VALID MEDICAID PROVIDER ID AND RESUBMIT.	Provider's NPI is associated with more than one service location with an active enrollment. Please resubmit application using the appropriate Provider Medicaid Number associated with the service location.

14.3 Resubmitting Batches

Selecting Communication>>Resubmission enables users to resubmit entire batches, resubmit records within batches, or to copy batches or records within batches for modification and resubmission.

The Batch Resubmission window displays, enabling users to select from a list of previously submitted batches. The user highlights a particular batch to display all records stored within the batch. The user may perform any of the following:

- Click Select All to select all records within a batch for resubmission, then press the Resubmit button to resubmit the batch
- Click on one or more records for the batch displayed and press Resubmit
- Select the Copy button to copy the entire batch
- Click on one or more records for the batch displayed and press Copy

To modify copied records, access the corresponding Admission Notification form and select the copied record from the list that displays at the bottom of the form. Modify and save the record, then submit according to the instructions provided in Section 14.1, Sending Batch Transactions to the Web Server.

14.4 Resubmitting Batches by Diskette

To submit batches by diskette, select Diskette from the Method drop down list on the Batch Submission window. Insert a diskette in your PC's diskette drive. Click on the record type(s) you want to submit. Press the Submit button and follow the directions issued from the system.

Mail the disk to the following address:

HP Electronic Media Claims (EMC) Help Desk

301 Technacenter Drive

Montgomery, AL 36117

HP receives the diskette and submits the data using a locally installed copy of Alabama LTC Admission Notification. Communication Logs are sent to the provider.

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15. The Web Server

This chapter provides instructions on what steps to take when connecting to the web Server to update your passwords according to the logon ID's provided to you by the EMC Helpdesk.

Users access the Web Server by the following methods:

- Connecting through an ISP (Internet Service Provider)
- Connecting through the RAS (an option provided by the LTC Admission Notification software)

15.1 Updating and Maintaining your Web Server Password

Now that you have your LTC Admission Notification software, a representative needs to contact one of the following telephone numbers to request a logon ID and password to connect to the Web Server:

- Providers located in Alabama: Contact the EMC Helpdesk at 1-800-456-1242.
- Providers located outside the state of Alabama: Dial (334) 215-0111 and ask for the EMC Helpdesk.

You may connect to the Web Server either through an ISP (Internet Service Provider) or through Remote Access Server (RAS).

15.1.1 Connecting through an ISP (Internet Service Provider)

This section will inform you how to logon to the Web Server through an ISP (Internet Service Provider), such as AOL, NetZero, etc.

Step 1 Open your ISP application and connect to the Internet accordingly

Step 2 Once properly logged onto the World Wide Web, type in the following URL:

Step 3 https://www.medicaid.alabamaservices.org/ALPortalContinue to **Step 3** in section 15.1.3 Updating your Password for further instructions.

15.1.2 Connecting through RAS

Connecting through RAS (Remote Access Server) is an option created by the LTC Admission Notification software. This section will inform you how to logon to the Web Server through RAS if you do not have an ISP.

This method requires you to have Internet Explorer version 5.5 and a dial-up modem. If you do not have one or the other, you will need to contact your computer administrator to have it set up for you.

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NOTE

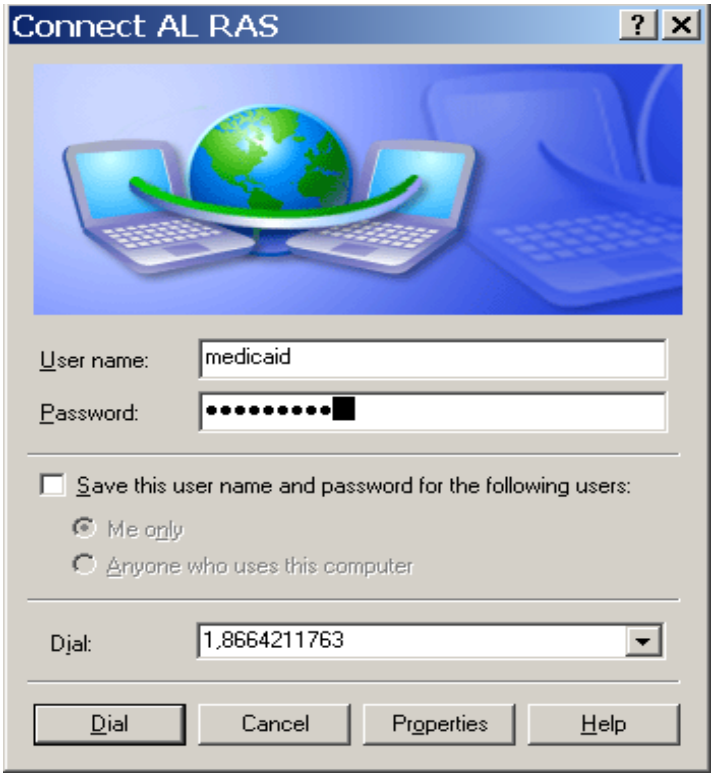
Before beginning this process, you should have followed the instructions outlined in section 3.4.1 Web Tab. If you have not, please refer to the instructions to set up your connection method through 'modem'. You will need to follow the instructions described in the 'Install RAS' and the 'Dialup Network' fields.

Step 1 Open your AL RAS connection. To do so, click on Start >> Settings >> Control Panel >> 'Network and Dial-Up Connections' and open the 'AL RAS' option.

Step 2 Once opened, a screen should appear as shown below: (If you have completed these steps you may continue to **Step 3** in section 15.1.3 Updating your Password for further instructions.)

NOTE

Enter your Trading Partner ID in the User Name and password fields. Contact the EMC Helpdesk at 800-456-1242 to give them your Trading partner ID so that dial-up permissions can be granted to you.



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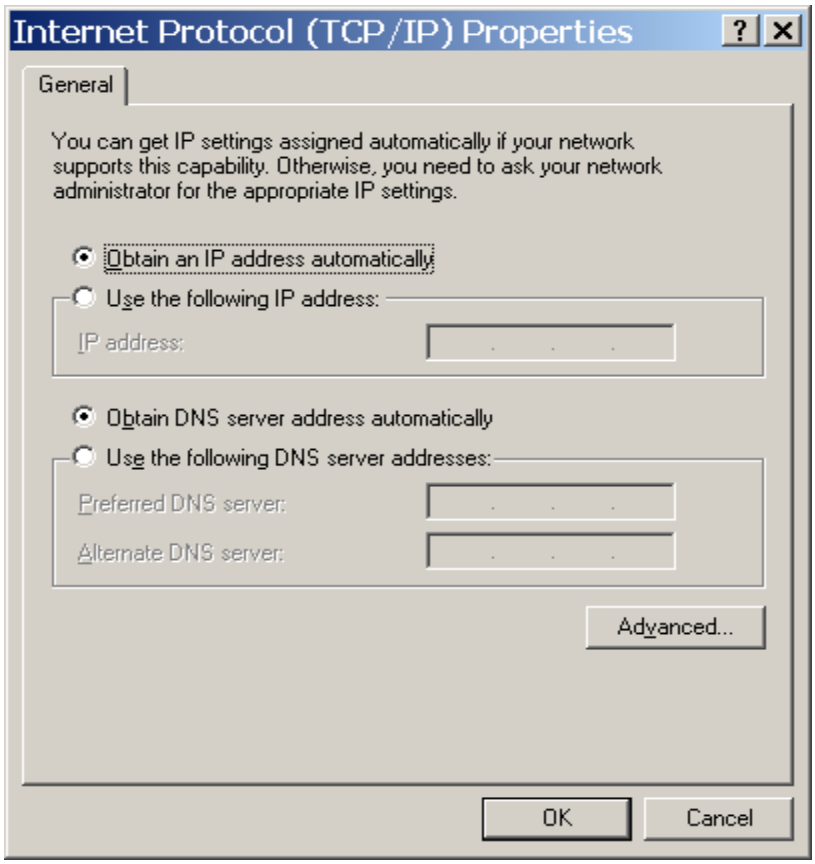
Step 3 Click on 'Properties' and click on the 'Networking' tab. A sample screen is pictured below:



Step 4 Make sure the Internet Protocol (TCP/IP) option is highlighted and click on 'Properties'.

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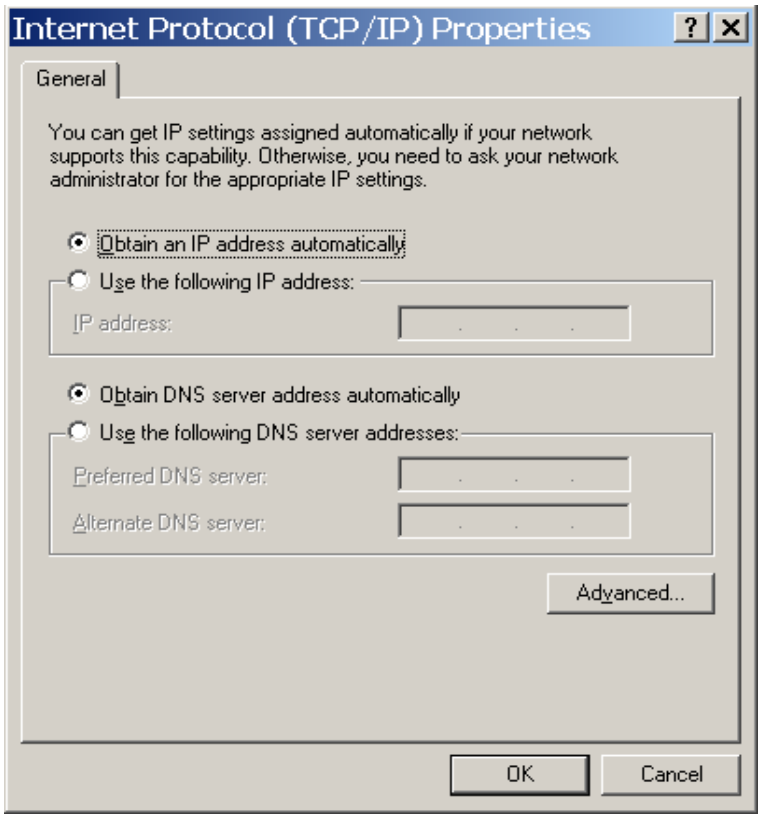
Step 5 Make sure the option for '**Obtain DNS server address automatically**' has been chosen.



Step 6 Click 'OK' to save your changes. Click on 'OK' to exit the Networking tab.

Step 7 Click 'DIAL' to continue to connect through RAS. This will begin the dial-up process according to the number you entered in the web tab. Refer to section 3.4.1 Web Tab.

Step 8 Once connected you may open your Internet Explorer browser.

Step 9 The options for accessing your Internet Explorer browser are described below:

- Go to your Internet Explorer icon located on your desktop.

Click on Start >> Programs >>Internet Explorer. In the browser address bar, enter https://www.medicaid.alabamaservices.org/ALPortal; and then press the **Enter** key on your keyboard."

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NOTE

If you have a default home page within your IE browser, a message may appear that it was unable to connect. Ignore this message and in the browser address https://www.medicaid.alabamaservices.org/ALPortal

Step 10 Continue to **Step 3** in section 15.1.3 Updating your Password for further instructions.

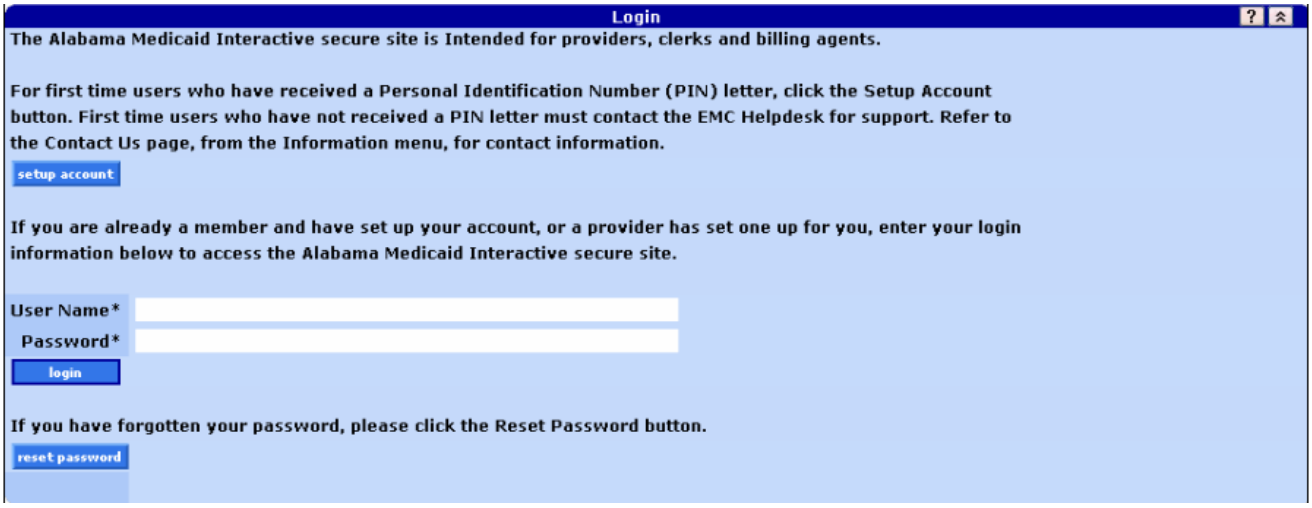
15.1.3 Updating your Password

Your password will need to be updated before a transmission can be attempted through the software. As a security measure, this password will need to be updated every 60 days. Follow the steps below to complete this process according to the method you use to connect to the Internet.

Step 1 Connect to the Web Server using either method as outlined above. Click 'Account' then 'Secure Site' to reach the Logon page.

Step 2 To change your password, follow steps 3 through 9.

Step 3 The main logon screen will look as follows:



Step 4 Type in the Web Logon ID and Web password you have keyed within your Tools >> Options screen. (Refer to section *3.4.2 Batch Tab)*

Step 5 Press the 'Login' button to continue.

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Step 6 A screen should appear as follows:

Step 7 Enter your current and new password in the designated fields. Press the 'change password' button to continue.

Step 8 You will be notified if you have completed this update successfully.

Step 9 Go to Account>>Logoff and proceed to your Tools >> Options screen to enter your updated password. (Refer to section 3.4.2 Batch Tab)

Providers that use the LTC Admission Notification software to submit claims to Alabama Medicaid are required to use their new web user ID and password after creating one on the new Interactive Services website. In addition, LTC Admission Notification software users are required to request a new Trading Partner ID.

NOTE

To update the LTC Admission Notification software with the new user ID and password, click on Tools >> Options within the Provider Electronic Software. Select the Batch Tab. Enter the new web user ID and password in the corresponding fields displayed.

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16. AL LTC Admission Notification Software File Specifications

16.1 Form

Please note the following specifications were implemented on interChange 2008 and 2012.

16.1.1 Form Transaction Format

Field	Name	Req/Opt	Format	Length	Position
LTC0001	SUBMITTER ID	R	A/N	9	001-009
LTC0002	PROVIDER ID	R	A/N	10	0010-019
LTC0003	PROVIDER NAME	R	A/N	50	020-069
LTC0004	PCN	O	A/N	10	070-079
LTC0005	PERFORMING PROVIDER ID	O	A/N	10	080-089
LTC0006	CLIENT FIRST NAME	R	A/N	20	090-109
LTC0007	CLIENT LAST NAME	R	A/N	30	110-139
LTC0008	CLIENT SSN	R	N	9	140-148
LTC0009	CLIENT MEDICAID ID	R	N	12	149-160
LTC0010	SUBMISSION REASON:	R	N	1	161-161
LTC0011	REASON 7 EXPLANATION	O	A	1	162-162
LTC0012	ADMIT OR DISCHARGE DATE	R	N	8	163-170
LTC0013	WAIVER INCOME	R	N	1	171-171
LTC0014	WAIVER INCOME DATE	R	N	8	172-179
LTC0015	MEDICARE START DATE	O	N	8	180-187
LTC0016	NH CONVALESCENT CARE?	O	N	1	188-188
LTC0017	HOSPICE PROVIDED IN NH?	O	N	1	189-189
LCT0018	WAIVER REINSTATMENT BEGIN DATE	O	N	8	190-197
LTC0019	WAIVER REINSTATEMENT END DATE	O	N	8	198-205
LTC0020	SUBMISSION DATE	R	N	8	206-213
	EOLN				214

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16.1.2 Form Comments and Values

Field #	Name	Comments/Values
LTC0001	SUBMITTER ID	Eight byte submitter ID.
LTC0002	PROVIDER NUMBER	Enter the provider number. This is a ten byte field. Provider number examples: 1234567890 or _ABC1234D _ = blank
LTC0003	PROVIDER NAME	Enter the provider name. This is not edited; it is for visual recognition only.
LTC0004	WAIVER PRIOR CONTROL NUMBER	This field is required IF first character of provider number is NOT blank. Specifically, only the WAIVER programs use this number. This is not edited. However, it is used to sort the response to allow different district offices (HCBS, E&D, and Homebound) to retrieve their own information regardless of whether the main office or the individual district office submitted the application.
LTC0005	PERFORMING PROVIDER NUMBER	Enter the provider number. This is a ten byte field. Provider number examples: 1234567890 _ = blank This field is used to sort IDDD WAIVER and Living At Home WAIVER responses for individual retrieval.
LTC0006	CLIENT FIRST NAME	Enter the recipient's first name.
LTC0007	CLIENT LAST NAME	Enter the recipient's last name.
LTC0008	CLIENT SSN	Enter the recipient's 9 digit social security number.
LTC0009	CLIENT MEDICAID NUMBER	Enter the recipient's 12 digit Medicaid number.
LTC0010	SUBMISSION REASON:	Enter one digit value code as follows: 1 = New Admission/Initial Assessment/Election 2 = Readmission 3 = WAIVER Redetermination 4 = WAIVER Early Redetermination 5 = WAIVER Reinstatement 6 = Transfer In 7 = Death/Discharge/Termination

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Field #	Name	Comments/Values
LTC0011	REASON 7 EXPLANATION	When the Submission Reason is "7" (Death/Discharge/Termination), select one of the prompts from the Reason 7 Explanation drop down box: H - Recipient discharged home D - Recipient died T - Recipient was terminated from the program
LTC0012	ADMIT OR DISCHARGE DATE	Enter date of admission or discharge. Date format = CCYYMMDD
LTC0013	WAIVER INCOME	Enter one digit value code as follows: Blank = 0 1 = 300% slot 2 = Institutionally deeming 3 = Deinstitutionalized
LTC0014	WAIVER INCOME DATE	Enter begin date of WAIVER INCOME. Date format = CCYYMMDD This field is required if WAIVER INCOME is 1, 2, or 3
LTC0015	MEDICARE DAYS START DATE	Enter start date of Medicare days. Date format = CCYYMMDD
LTC0016	NH CONVALESCENT CARE?	Not required. Valid values: Blank = N Not blank = Y
LTC0017	HOSPICE PROVIDED IN NURSING HOME?	Not required. Valid values: Blank = N Not blank = Y
LTC0018	WAIVER REINSTATMENT BEGIN DATE	Enter begin date of WAIVER reinstatement. Date format = CCYYMMDD
LTC0019	WAIVER REINSTATEMENT END DATE	Enter end date of WAIVER reinstatement. Date format = CCYYMMDD
LTC0020	SUBMISSION DATE	Date format = MMDDCCYY

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AMMIS Managed Care User Manual

Date Modified: 12/20/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technologies
301 Technacenter Drive
Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

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1.1 DOCUMENT INFORMATION PAGE

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07/15/2018	22.0		Application of CO 14843	Remove PHI/PHII from MC manual
11/15/2018	23.0		Application of CO 15150	Mass Capitation Adjustment Request panel- removed from manual. Capitation Information panel – remove Mass Capitation Adjustment History panel from list.

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
			Application of CO 15000	Capitation Adjustment Approval panel – update layout and field descriptions
			Application of CO 14399	MC Assignment Reason panel – update layout and field descriptions MCP PMP Focus – update panell layout MC Special Condition – update panel layout Xref MC Region/Program Xref Panel – updated layout Xref-MC Special Conditioins/Class Xref Panel– updated layout Xref-MC Special Conditions/MC Program/Xref panel– updated layout Xref MC Special Conditions/Type Xref Panel– updated layout
12/20/2018	24.0		Application of Production COs	CO 15104 Added MGD-A821 – M ICN Overlaping Special Conditions Reprot Added MGD-A820-M—Monthly ICN Enrollment and Errors Report CO 15096 Added ICN Assignment History panel CO 15097 Revise Field Edit Error Messages for Recipient MC Special Conditions panel CO 15113 Added Mgm71822.dat – ICN Capitation Reconciliation Report CO 15146 MGD-A131-M—Capitation Payment Summary by PLAN report CO 15159 Modified narrative, layout and field descriptions on

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				MGD – 0004-M Capitation Payment Listing Report CO 15328 Modified MGD-0080-M—Capitation Errors Report narrative, layout, and field descriptions Added MGD-0081-M Capitation Errors Report

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 MANAGED CARE INTRODUCTION

2.1 MANAGED CARE USER MANUAL OVERVIEW

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Managed Care functional area.

This manual covers the following:

- Managed Care Overview
- Managed Care Getting Started
- System Wide Common Terminology and Layouts
- Managed Care Panels
- Managed Care Reports

2.2 MANAGED CARE USER MANUAL OBJECTIVE

The objective of the AMMIS Managed Care User Manual is to provide system users with detailed descriptions of the online system, including panel and report field descriptions, panel functionality descriptions and graphical representations of panels and report layouts.

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3 MANAGED CARE OVERVIEW

3.1 INTRODUCTION TO MANAGED CARE

The Managed Care function is designed to allow the state the ability to develop and implement various managed care systems to ensure recipient access to necessary medical care, while at the same time controlling medical assistance program costs. Currently the State uses a combination of Primary Care Case Management (PCCM) programs and Medicare Advantage Plans. Through each of these programs recipients are assigned a primary medical provider (PMP) or Medicare contract vendor, who is responsible for managing the recipient's healthcare needs. Though designed to be comprehensive in meeting patient needs, payment does not include all services that may be provided. As a result, the managed care system must support both capitation, global, and fee for service payment options. The objectives of each managed care program are:

- increased recipient access to healthcare,
- increased use of case management and preventive services, and
- optimal patient outcomes.

The Managed Care has the following main areas:

- Recipient enrollment and eligibility in the various plans.
- Provider enrollment for both Patient 1st PMPs and Medicare Advantage Vendors.
- Auto assignment of eligible recipients into the plans.
- Capitation Payment information.
- Enrollment Roster information.
- Mass Disenrollment and Panel Transfer information

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4 MANAGED CARE GETTING STARTED

4.1 OVERVIEW

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 SYSTEM SECURITY

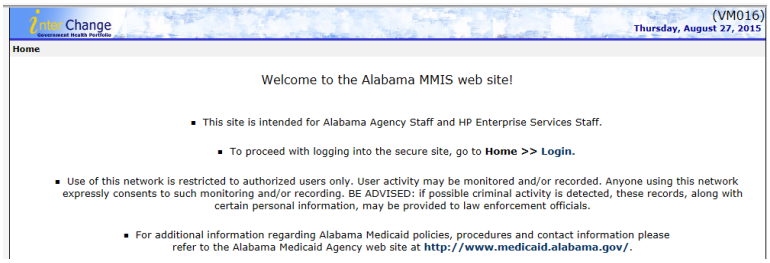
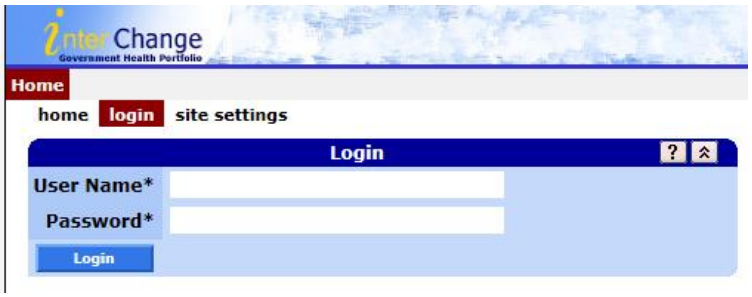
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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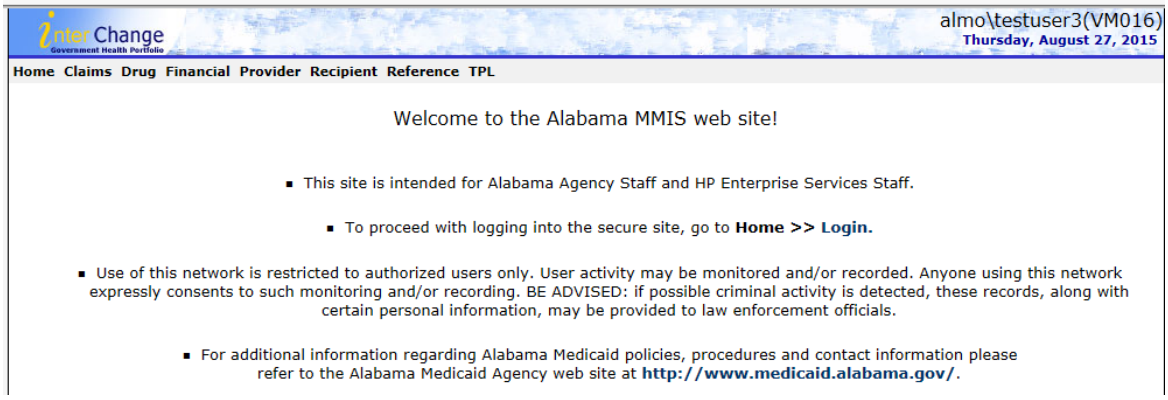
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 SCREEN DISPLAY FEATURES

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.4.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

4.5 CHANGING PASSWORDS

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

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Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team recipients, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt +shortcut key)
- Main Menu bar
- Panel
- Mini Search panel
- Hot Link
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the Hewlett Packard copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

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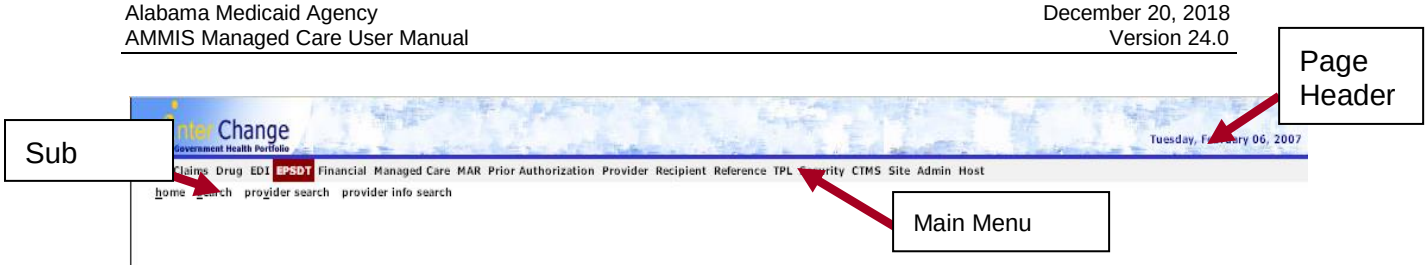
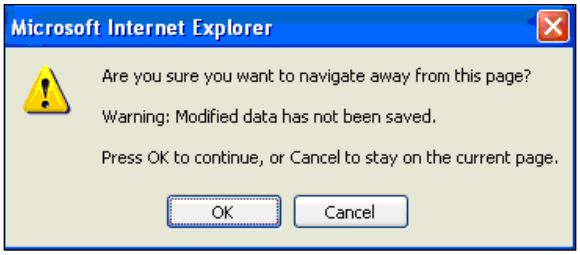


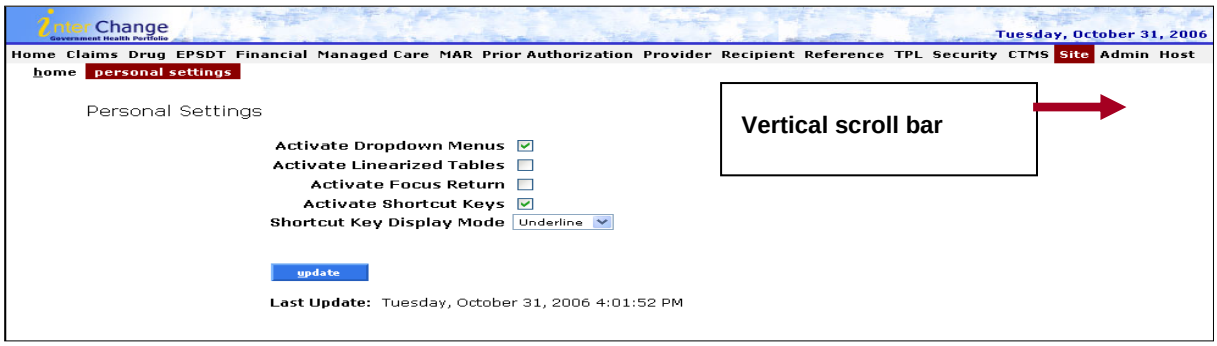
If a user attempts to add, update or delete information within a page the system prompts the user to "Save" or "Cancel" their changes via a pop-up window message prior to navigating away from the page. When the system generates the message, the detail panel is locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 SHORTCUT KEYS

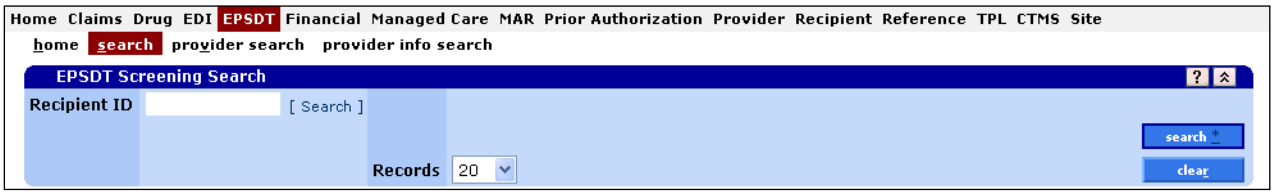
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated panel.

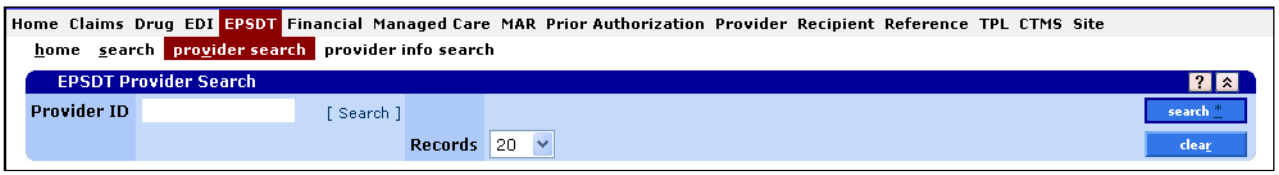
To activate the shortcut key, click on the Site link, select Personal Settings, check "Activate Shortcut Keys" and click the blue "Update" button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the EPSDT Sub Menu, the user can use the shortcut keys to quickly navigate from the EPSDT Search panel to the EPSDT Provider Search panel by using the following shortcut key combination: (Ctrl + Alt + V) since the letter "V" is found within the horizontal bars on the Sub Menu provider search link.





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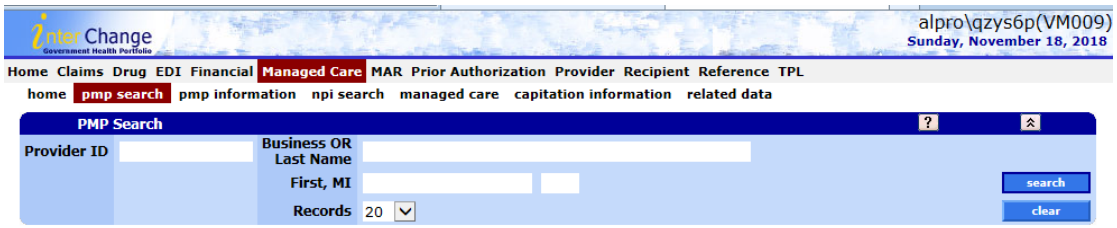
5.3 SEARCH OPTIONS

There are several search options available within interChange.

5.3.1 Search Panels

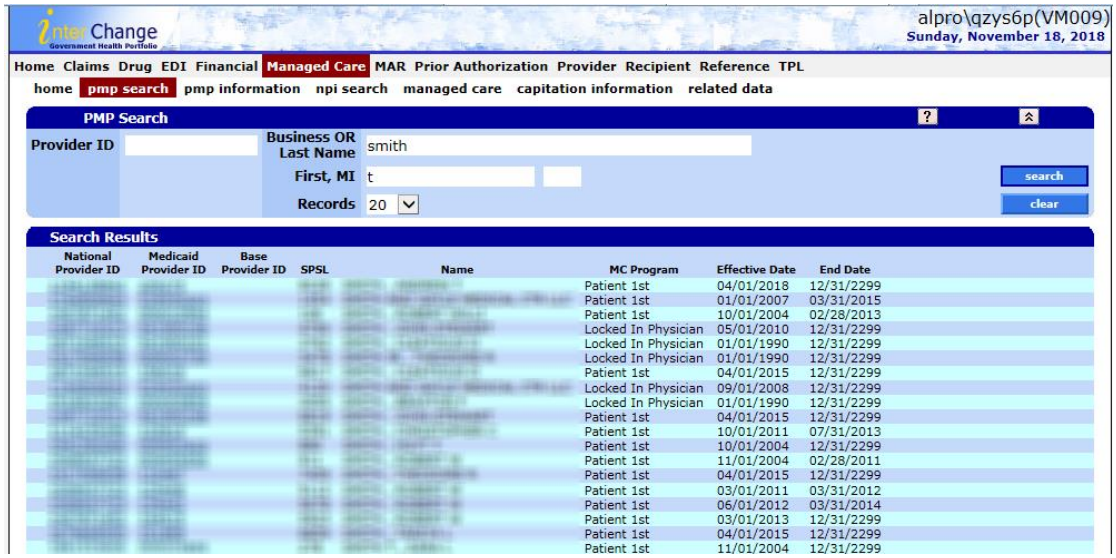
The AMMIS contains two types of search panels: Search and Advanced Search. An example of the EPSDT Screening Search panel with the Search button displaying is shown below:



Note: The Advanced Search button functionality does not exist in the EPSDT subsystem.

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. For example, the user clicked the 3rd row of the EPSDT Provider Info Search Results panel (as shown above) and the associated Provider Information panel displayed.

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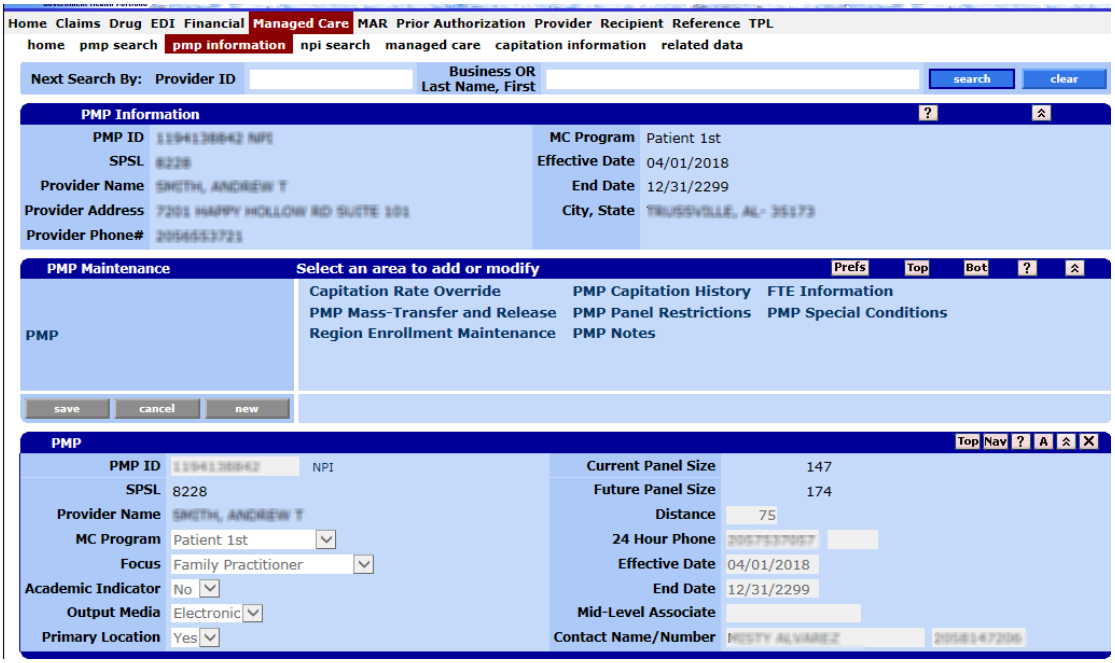

5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available. Users are provided with additional information related to a field by clicking the hotlink, as shown below.

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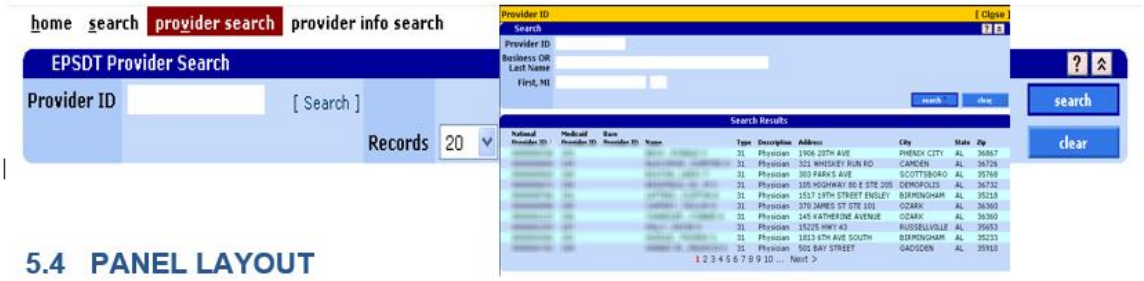
5.3.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the [Search] link, the user accesses the search panel that is associated with that particular field.



5.4 PANEL LAYOUT

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on panels within the EPSDT system:

Name	Icon	Description
Clear Button	clear	Clears all actions to all panels on the page. Can be found on the navigation panel.
Close Button	✕	Closes a panel.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
[Search]	[Search]	Opens a search panel associated to a particular field. Allows the user to search for unknown information, such as a Provider ID, using other information, such as the Provider Name.
Search	search	Searches for information based on criteria entered into field(s) on panel.

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5.4.2 Help Functionality

The interChange system contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.3 Question Mark Icon ?

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.4.3.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Clear	Clears previous searches	Button	N/A	0
Search	Searches through Recipient records	Button	N/A	0
Recipient ID	Recipient identification number of the Recipient. Must be 12 characters in length.	Field	Number	12
Records	Number of records to display per page.	Field	Drop Down List Box	0
[Search]	Hyperlink to a list of Recipients	Hyperlink	N/A	0

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	0	Validate	Recipient ID must be numeric.
	Field	1	Validate	Recipient ID must be entered for search criteria.

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The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as; Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

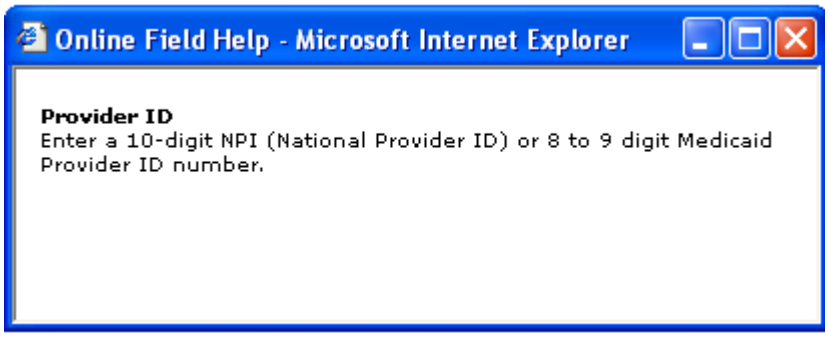
5.4.4 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.4.4.1 Field Level Help Description

When hovering the cursor over a field name, such as **Provider ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 MANAGED CARE PANELS

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each panel covers the following:

- Panel Narrative
- Panel Layout
- Panel Field Descriptions
- Panel Field Edit Error Code Tables
- Panel Extra Features
- Panel Accessibility

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6.1 PMP SEARCH PANEL OVERVIEW

6.1.1 PMP Search Panel Narrative

The PMP Search panel allows the user to enter criteria for searching through the Managed Care providers (PMPs).

This panel is inquiry only.

Navigation Path: [Managed Care] – [PMP Search]

6.1.2 PMP Search Panel Layout

6.1.3 PMP Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the PMP Search panel.	Button	N/A	0
Business OR Last Name	Provider individual Last Name or the business name.	Field	Character	50
First, MI	First Name and Middle Initial of the Provider.	Field	Character	50
Provider ID	Provider identification number used for the search.	Field	Character	15
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID.	Button	N/A	0

6.1.4 PMP Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.5 PMP Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.6 PMP Search Panel Accessibility

6.1.6.1 To Access the PMP Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.

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6.2 PMP SEARCH RESULTS PANEL OVERVIEW

6.2.1 PMP Search Results Narrative

The PMP Search Results panel displays the results of the user's search for Managed Care providers (PMPs) based on the entered criteria.

This panel is inquiry only.

Navigation Path: [Managed Care] – [PMP Search] - [(click the search button)]

6.2.2 PMP Search Results Layout

Search Results

National Provider ID	Medicaid Provider ID	Base Provider ID	SPSL	Name	MC Program	Effective Date	End Date
[illegible]		[illegible]	[illegible]	[illegible]	Locked In Physician	07/01/2007	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Locked In Physician	01/01/2008	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	07/31/2006
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	11/01/2004	12/31/2299
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	08/01/2004	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	08/31/2007
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	08/01/2004	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	11/01/2004	08/31/2005
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	11/01/2004	12/31/2299
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Locked In Physician	07/01/2007	12/31/2299
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	11/01/2004	12/31/2299
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Locked In Physician	07/01/2007	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	09/01/2004	08/31/2006
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	03/01/2005	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	03/31/2006
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	01/01/2005	12/31/2299
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	10/01/2004	12/31/2299
	[illegible]	[illegible]	[illegible]	[illegible]	Patient 1st	02/01/2005	12/31/2299

1 2 3 4 5 6 7 8 9 10 ... Next >

6.2.3 PMP Search Results Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Provider ID	Provider's base identification number.	Hyperlink	N/A	0
Effective Date	Effective date Managed Care program is active.	Field	Date (MM/DD/CCYY)	8
End Date	Date the PMP's Managed Care program ends.	Field	Date (MM/DD/CCYY)	8
MC Program	Identification of the Managed Care program.	Field	Character	50
Medicaid Provider ID	Provider's Medicaid Provider identification number.	Hyperlink	N/A	0
Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
National Provider ID	Provider's National Provider identification number.	Hyperlink	N/A	0
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9

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6.2.4 PMP Search Results Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 PMP Search Results Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 PMP Search Results Accessibility

6.2.6.1 To Access the Region Enrollment Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	PMP Search results display.

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6.3 PMP MINI SEARCH PANEL OVERVIEW

6.3.1 PMP Mini Search Panel Narrative

The PMP Mini Search panel allows the user to search for Managed Care providers (PMPs) and Business or Last Name, First using limited criteria.

This panel is inquiry only.

Navigation Path: [Managed Care] – [PMP Information] - [(select row from search results)]

6.3.2 PMP Mini Search Panel Layout

6.3.3 PMP Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business or Last Name, First	Business or Provider Last Name, First used for the search.	Field	Character	50
Clear	Allows the user to clear any changes on the Codes panel.	Button	N/A	0
Provider ID	Provider identification used for the search.	Field	Character	15
Search	Initiates the Search by Current Provider identification number, Business or Last Name, First.	Button	N/A	0
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0

6.3.4 PMP Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 PMP Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.3.6 PMP Mini Search Panel Accessibility

6.3.6.1 To Access the PMP Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.

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Step	Action	Response
3	Enter the **Provider ID** and click **Search**; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Mini Search panel displays.

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6.4 PMP INFORMATION PANEL OVERVIEW

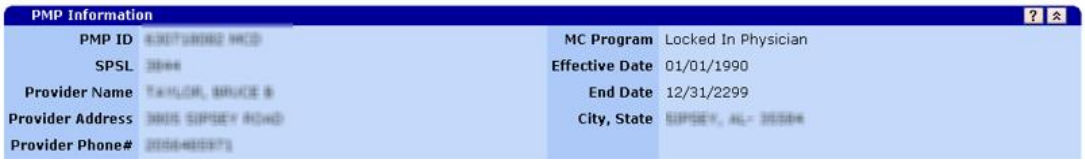
6.4.1 PMP Information Panel Narrative

The PMP Information panel displays information about the selected Managed Care provider (PMP).

This panel is inquiry only.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)]

6.4.2 PMP Information Panel Layout



6.4.3 PMP Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
City, State	Provider's Service Location City, State and Zip code.	Field	Character	32
Effective Date	Effective date for PMP for this managed care program. Used to signify the start of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8
End Date	End date for PMP for this managed care program. Used to signify the end of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8
MC Program	Identification of the Managed Care program.	Field	Character	50
PMP ID	Unique provider identification number.	Field	Character	15
PMP ID Type (no label)	The PMP identification type.	Field	Character	3
Provider Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
Provider Phone#	Provider's phone number.	Field	Character	10
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9

6.4.4 PMP Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.4.5 PMP Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 PMP Information Panel Accessibility

6.4.6.1 To Access the PMP Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.

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6.5 NPI SEARCH PANEL OVERVIEW

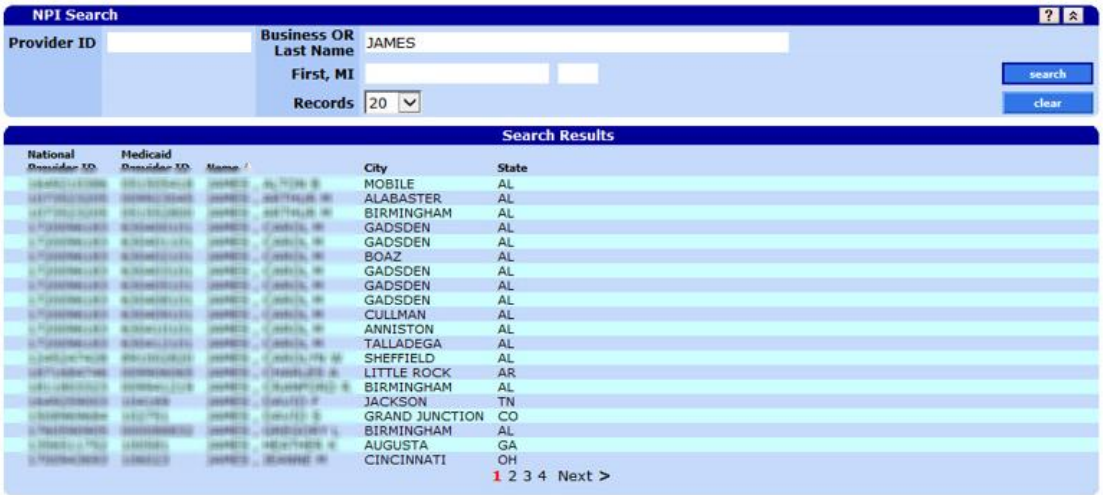
6.5.1 NPI Search Panel Narrative

The NPI Search panel allows the user to enter criteria for searching through the Managed Care providers.

This panel is inquiry only.

Navigation Path: [Managed Care] – [NPI Search]

6.5.2 NPI Search Panel Layout



6.5.3 NPI Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	The Clear button will clear the search fields.	Button	N/A	0
Search	Search for a NPI.	Button	N/A	0
Records	Number of records to display in the search results.	Combo Box	Drop Down List Box	0
Business OR Last Name	Provider individual Last Name or the business name.	Field	Character	50
City	Mailing address city. This is the city where a provider would receive business mail.	Field	Character	30
First, MI	First Name and Middle Initial of the Provider.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Medicaid Provider ID	The provider's Medicaid Provider identification number.	Field	Character	15
Name	Provider's individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
National Provider ID	The provider's National Provider identification number.	Field	Character	15
Provider ID	Provider identification number to search for.	Field	Character	15
State	Mailing address state. This is the state where a provider would receive business mail.	Field	Character	2

6.5.4 NPI Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.5.5 NPI Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 NPI Search Results Accessibility

6.5.6.1 To Access the NPI Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **NPI Search**.	NPI Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	NPI Search results display.

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6.6 NPI MAINTENANCE PANEL OVERVIEW

6.6.1 NPI Maintenance Panel Narrative

The NPI Maintenance panel allows inquiries or updates to a provider's NPI Note and Eligibility information.

This panel is inquiry only.

Navigation Path: [Managed Care] - [NPI Search] - [(select row from search results)]

6.6.2 NPI Maintenance Panel Layout

6.6.3 NPI Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Cancel Changes.	Button	N/A	0
Save	Save Changes.	Button	N/A	0
NPI Eligibility	Link to the NPI Eligibility panel.	Hyperlink	N/A	0
NPI Notes	Link to the NPI Notes panel.	Hyperlink	N/A	0

6.6.4 NPI Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.5 NPI Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 NPI Maintenance Results Accessibility

6.6.6.1 To Access the NPI Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **NPI Search**.	NPI Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	NPI Search results display.
4	If the above search results in only one row then **NPI Maintenance** panel is displayed directly or if the	NPI Maintenance panel displays.

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Step	Action	Response
	search results in multipay rows then select a row from the data list.	

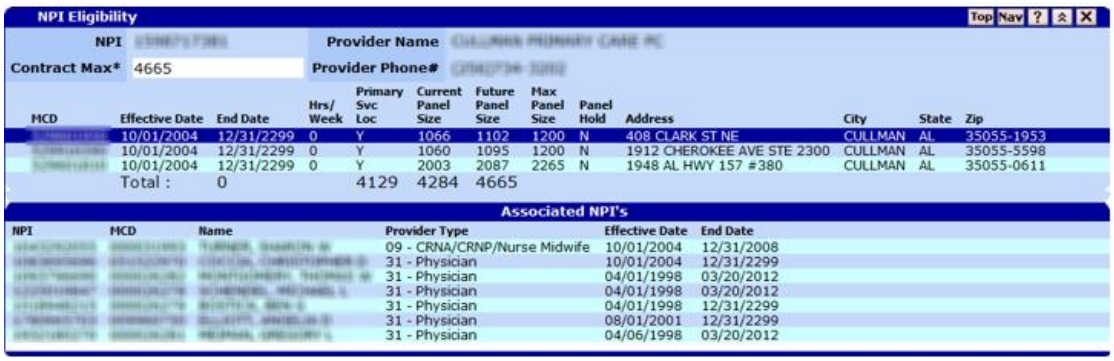
6.7 PI ELIGIBILITY PANEL OVERVIEW

6.7.1 NPI Eligibility Panel Narrative

This panel displays the list of all the service locations that are associated with an NPI and also provides the capability to update Contract Max for an NPI.

Navigation Path: [Managed Care] - [NPI Search] - [(select row from search results)] - [NPI Eligibility]

6.7.2 NPI Eligibility Panel Layout



6.7.3 NPI Eligibility Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Service Location address street 1 + 2. This is the street address for a provider.	Field	Character	60
City	Service Location address city. This is the city where a provider would receive business mail.	Field	Character	30
Contract Max	The maximum number of recipients an NPI is allowed to service. This field can be updated with the revised Contract Max value.	Field	Number (Integer)	9
Current Panel Size	This is the number of recipients that are assigned to the PMP as of the current date. This applies only to the Inclusion Restriction.	Field	Number (Integer)	9
Effective Date	This is the effective date for PMP for this managed care program and service location. Used to signify the start of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	This is the end date for PMP for this managed care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8
Future Panel Size	This is the number of recipients that are assigned to the PMP as of the next enrollment date for the program. This applies only to the Inclusion Restriction.	Field	Number (Integer)	9
Hrs/Week	Number of hours the provider works at the service location per week.	Field	Number (Integer)	9
MCD	Provider ID value of type MCD.	Field	Character	15
Max Panel Size	This is the maximum number of recipients that the PMP is willing to see in the restricted demographics. No max panel is set for a Restriction Type of 'Exclusion'.	Field	Number (Integer)	9
Name	Last Name, First Name and Middle Initial of Provider.	Field	Character	50
NPI	NPI Provider identification number to search for.	Field	Character	15
Panel Hold	This column allows the user to halt new assignments for the Inclusion restriction.	Field	Character	1
Primary Svc Loc	Indicates if this service location is the PMP's primary location.	Field	Character	1
Provider Name	This is the name associated with an organization or person.	Field	Character	50
Provider Phone	This is the 24 hour availability phone number for the provider in the format area code + prefix + suffix.	Field	Character	10
Provider Type	Provider Type for that particular service location.	Field	Character	20
State	Service Location address state. This is the state where a provider would receive business mail.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Zip	Service Location address zip code. This is the first 5 digits of the zip code for a business mailing zip code. Mailing address zip code + 4. This is the last 4 digits of a zip code.	Field	Character	9

6.7.4 NPI Eligibility Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.7.5 NPI Eligibility Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 NPI Eligibility Results Accessibility

6.7.6.1 To Access the NPI Eligibility Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Car**e and click **NPI Search**.	NPI Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	NPI Search results display.
4	If the above search results in only one row then **NPI Maintenance** panel is displayed directly or if the search results in multipay rows then select a row from the data list.	NPI Maintenance panel displays.
5	Click on **NPI Eligibility** panel link.	NPI Eligibility panel is displayed.
6	Select a record from **NPI Eligibility** panel	**Associated NPI** panel is displayed.

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6.8 NPI NOTES PANEL OVERVIEW

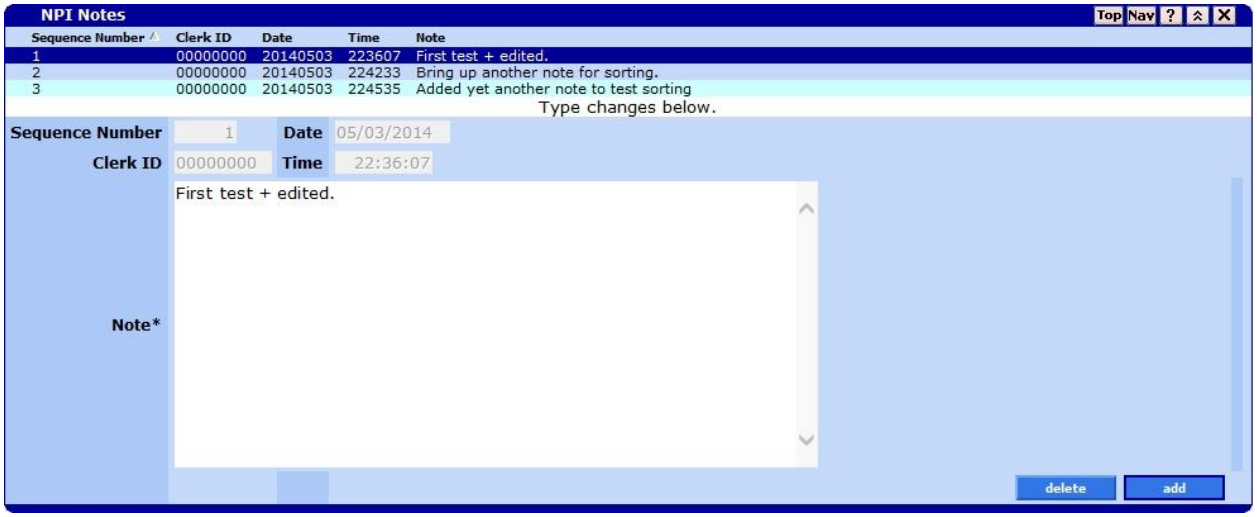
6.8.1 NPI Notes Panel Narrative

Use the Note panel to enter notes. Includes fields for date, time, clerk number and note sequence number.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] - [NPI Search] - [(select row from search results)] - [NPI Notes]

6.8.2 NPI Notes Panel Layout



6.8.3 NPI Notes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a note.	Button	N/A	0
Clerk ID	ID of the user who enters the note. This value will be set from the user's security profile.	Field	Character	8
Date	Date that the note was added. Updates do not change this.	Field	Date (MM/DD/CCYY)	8
Date (Label)	Date that the note was added. Updates do not change this.	Field	Date (CCYYMMDD)	8
Delete	Delete a note.	Button	N/A	0
Note	Actual text of the note.	Field	Character	1000

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Field	Description	Field Type	Data Type	Length
Sequence Number	Sequence number than uniquely identifies a note.	Field	Number (Integer)	9
Time	Actual Time that the note was added. Updates do not change this.	Field	Number (Integer)	6

6.8.4 NPI Notes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.8.5 NPI Notes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 NPI Notes Results Accessibility

6.8.6.1 To Access the NPI Notes Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **NPI Searc**h.	NPI Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	NPI Search results display.
4	If the above search results in only one row then NPI Maintenance panel is displayed directly or if the search results in multipay rows then select a row from the data list.	NPI Maintenance panel displays.
5	Click on **NPI Notes** panel link	NPI Notes panel is displayed.

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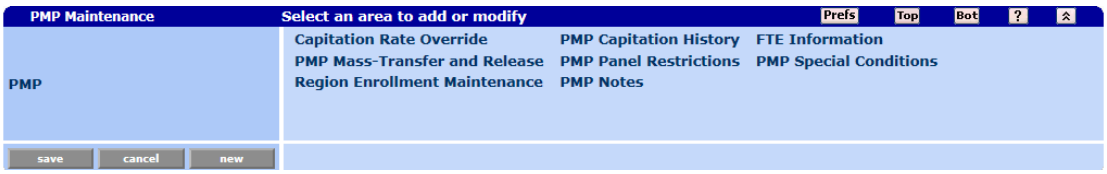
6.9 PMP MAINTENANCE PANEL OVERVIEW

6.9.1 PMP Maintenance Panel Narrative

The PMP Maintenance panel allows inquiries or updates to a provider's PMP (Managed Care Provider) information. This panel is inquiry only.

Navigation Path: [Managed Care] - [PMP Search] - [(select row from search results)]

6.9.2 PMP Maintenance Panel Layout



6.9.3 PMP Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the PMP Maintenance panel.	Button	N/A	0
Capitation Rate Override	Hyperlink to PMP Capitation Rate Override panel.	Hyperlink	N/A	0
FTE Information	Hyperlink to FTE Information panel.	Hyperlink	N/A	0
New	Allows the user to create a new record for PMP.	Button	N/A	0
PMP Capitation History	Hyperlink to PMP History Capitation panel.	Hyperlink	N/A	0
PMP CMF Search	Hyperlink to PMP CMF Search panel.	Hyperlink	N/A	0
PMP Mass-Transfer and Release	Hyperlink to PMP Mass-Transfer & Release panel.	Hyperlink	N/A	0
PMP Notes	Hyperlink to the PMP Notes panel.	Hyperlink	N/A	0
PMP Panel Restrictions	Hyperlink to PMP Panel Restrictions panel.	Hyperlink	N/A	0
PMP Special Conditions	Hyperlink to PMP Special Condition panel.	Hyperlink	N/A	0
Region Enrollment Maintenance	Hyperlink to Region Enrollment Maintenance panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the PMP Maintenance panel.	Button	N/A	0

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6.9.4 PMP Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.9.5 PMP Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 PMP Maintenance Panel Accessibility

6.9.6.1 To Access the PMP Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.

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6.10 PMP PANEL OVERVIEW

6.10.1 PMP Panel Narrative

The PMP panel displays information about the selected Managed Care provider (PMP).

Only users with update authority are allowed to add or change information on this panel.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - PMP

6.10.2 PMP Panel Layout

6.10.3 PMP Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
24 Hour Phone	The 24 hour availability phone number for the provider in the format area code + prefix + suffix. This field is divided into 2 fields, which are 24 Hour Phone (length 10) and Extension (length 4).	Field	Character	14
Academic Indicator	Indicates whether the provider is associated with a teaching facility.	Comb o Box	Drop Down List Box	0
Contact Name/Number	Identifies the name of a contact person and contact phone number, which can be used to contact the contact person.	Field	Character	36
Current Panel Size	Number of recipients currently assigned to the PMP service location.	Field	Number (Integer)	9
Distance	Indicates how many miles in all directions that the provider is willing to provide coverage.	Field	Number (Integer)	4
Effective Date	Effective date the PMP's managed care program and service location began. Used to signify the start of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	End date for PMP's Managed Care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.	Field	Date (MM/DD/CCYY)	8
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: General Practitioner, Internist, and Pediatrition.	Combo Box	Drop Down List Box	0
Future Panel Size	Number of recipients assigned to the PMP service location that are effective AFTER this month.	Field	Number (Integer)	9
MC Program	Identification of the Managed Care program.	Combo Box	Drop Down List Box	0
Mid-Level Associate	Identifies the name of 'mid-level' medical personnel contact (e.g., nurse practitioner).	Field	Character	16
Output Media	Type of media used for output. Valid values are "Electronic", "Paper" and "Both".	Combo Box	Drop Down List Box	0
PMP ID	Primary Medical Provider (PMP) Identification number.	Field	Character	15
PMP ID Type (no label)	Primary Medical Provider (PMP) Identification number type.	Field	Character	3
Provider Name	Provider's individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9

6.10.4 PMP Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
24 Hour Phone	Field	1	24 Hour Phone is required.	Enter a valid 24 Hour Phone.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Required input must be 10 characters in length.	Enter a valid 24 Hour Phone Number.
Distance	Field	8	Distance is required.	Distance is Required if MC Program is Patient 1st.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	4122	Effective Date must be the first day of the month.	The valid Effective Date is the first day of the month.
	Field	10063	Date range is not within the Provider's Medicaid Eligibility.	Verify keying. Effective Date must be within the provider's eligibility.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
End Date	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
Focus	Combo Box	1	A valid Focus is required.	Select a Focus from the Drop Down list.
MC Program	Combo Box	1	A valid MC Program is required.	Select a valid MC Program from the Drop Down list.

6.10.5 PMP Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 PMP Panel Accessibility

6.10.6.1 To Access the PMP Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.

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Step	Action	Response
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.

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6.11 CAPITATION RATE OVERRIDE PANEL OVERVIEW

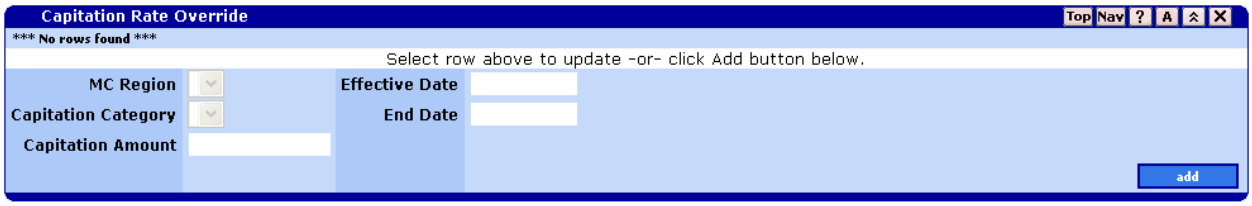
6.11.1 Capitation Rate Override Panel Narrative

The Capitation Rate Override panel allows the user to override the standard capitation rates for a specific PMP. Unless an override rate is entered, the rate specified in the Standard Capitation Rates panel will be utilized for the given capitation category.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [Capitation Rate Override]

6.11.2 Capitation Rate Override Panel Layout



6.11.3 Capitation Rate Override Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Capitation Rate Override information.	Button	N/A	0
Capitation Amount	Amount of the capitation payment. Format 9999999.99.	Field	Number (Decimal)	9
Capitation Category	Category of the capitation. Format Code - Description.	Combo Box	Drop Down List Box	0
Effective Date	Effective date of the payment record.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the payment record.	Field	Date (MM/DD/CCYY)	8
MC Region	Identification of the Managed Care region.	Combo Box	Drop Down List Box	0

6.11.4 Capitation Rate Override Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Capitation Amount	Field	3	Capitation Amount must be greater than zero.	Verify Input. Capitation Amount must be greater than 0.
	Field	4	Enter a valid value.	Enter a valid numeric value.
Capitation Category	Combo Box	91006	A valid Capitation Category is required.	Select valid option from Capitation Category list.

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Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be equal to first day of the month.	Effective Date must be in the form MM/DD/CCYY where DD = 01.
	Field	2	Effective Date is required.	Enter a valid Effective Date. Format is MM/DD/CCYY.
	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be <= to End Date
	Field	91001	Invalid date. Format is mm/dd/ccyy.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91030	Date segments can not overlap.	Verify dates against list. Date segments cannot overlap for the same MC Region and Capitation Category.
End Date	Field	2	End Date must be equal to last day of the month.	End Date must be in the form MM/DD/CCYY where DD is the last day of the month, ex: Jan has 31 days, 01/31/2099.
	Field	91001	Invalid date. Format is mm/dd/ccyy.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	End Date is required.	Enter a valid End Date. Format is MM/DD/CCYY.
	Field	91030	Date segments can not overlap.	Verify Effective Date, End Date, MC Region, and Capitation Category against the list. Date segments cannot overlap for the same MC Region and Capitation Category.
MC Region	Combo Box	91006	A valid MC Region is required.	Select valid option from MC Region List.

6.11.5 Capitation Rate Override Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.11.6 Capitation Rate Override Panel Accessibility

6.11.6.1 To Access the Capitation Rate Override Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select Capitation Rate Override.	Capitation Rate Override panel displays.

6.11.6.2 To Add on the Capitation Rate Override Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **MC Region** from drop down list box.	
3	Select **Capitation Category** from drop down list box.	
4	Enter Capitation Amount.	
5	Enter Effective Date.	
6	Enter End Date.	
7	Click **Save**.	Capitation Rate Override information is saved.

6.11.6.3 To Update on the Capitation Rate Override Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Capitation Rate Override information is saved.

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6.12 PMP CAPITATION HISTORY PANEL OVERVIEW

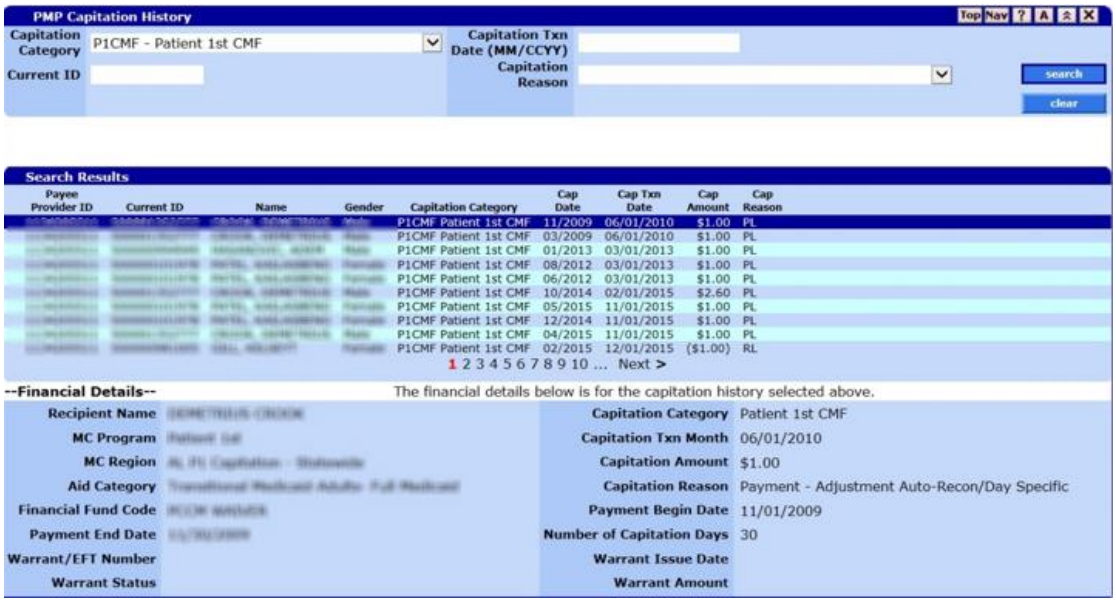
6.12.1 PMP Capitation History Panel Narrative

The PMP Capitation History panel is used to display all capitation transactions made to a specific Managed Care provider and to show financial details for each of those transactions. It can be used to verify that all payments have been made to a provider during a given capitation month and to verify that the amounts for those payments are correct.

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [PMP Capitation History]

6.12.2 PMP Capitation History Panel Layout



6.12.3 PMP Capitation History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Identifies the type of aid for which a recipient is eligible. In the datalist the Aid Category is the code (length 2) and in the data panel the Aid Category is the code (length 1) " - " and description (length 36).	Field	Character	40
Cap Amount	Amount of money (check or EFT) we will pay to an external entity for capitation. Format 9999999.99.	Field	Number (Decimal)	9
Cap Date	Month that the capitation payment covers.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Cap Reason	Code of the reason the capitation is being done.	Field	Character	2
Cap Txn Date	Date that the capitation payment was made.	Field	Date (MM/DD/CCYY)	8
Cap Txn Date [Search]	Allows the user to search by the date the capitation payment was made.	Field	Date (MM/DD/CCYY)	8
Capitation Amount	Amount of money (check or EFT) we will pay to an external entity for capitation. Format 9999999.99.	Field	Number (Decimal)	10
Capitation Category	Describes the managed care CapitationCategory.	Field	Character	35
Capitation Category [Search]	Allows the user to search by the category of the capitation.	Combo Box	Drop Down List Box	0
Capitation Reason	Reason the capitation is being done. In the datalist, the code is displayed and in the data panel, the description is displayed.	Field	Character	50
Capitation Reason [Search]	Allows the user to search by Capitation Reason. The drop down list consists of the code and description. The data list field contains only the code.	Combo Box	Drop Down List Box	0
Capitation TXN Date	Date that the capitation payment was made.	Field	Date (MM/DD/CCYY)	8
Capitation Txn Month	Date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, i.e., payment in April of February admin fee, this date would have the April payment date.	Field	Date (MM/DD/CCYY)	8
Clear	The Clear button will clear the search fields.	Button	N/A	0
Current ID	Recipient’s identification number.	Field	Character	12

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Field	Description	Field Type	Data Type	Length
Current ID [Search]	Allows the user to search by the Recipient's identification number.	Combo Box	Drop Down List Box	0
Financial Fund Code	Description of the Financial Fund Code.	Field	Character	50
Gender	Gender of recipient.	Field	Character	12
MC Region	Identification of the Managed Care region.	Field	Character	40
MC Program	Describes the medical assistance program.	Field	Character	50
Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
Number of Capitation Days	Number of days out of the month that the capitation payment covers.	Field	Number (Integer)	2
Payee Provider ID	Number of the provider that received the capitation payment.	Field	Character	15
Payment Begin Date	Date that capitation payment coverage began.	Field	Date (MM/DD/CCYY)	8
Payment End Date	Date that the capitation payment coverage ended.	Field	Date (CCYYMMDD)	8
Recipient Name	Name of the Recipient.	Field	Character	50
Search	The Search button will return the search results.	Button	N/A	0
Warrant /EFT Number	This is the payment/check number for the payment.	Field	Character	9
Warrant Amount	Amount for which the check was written.	Field	Number (Decimal)	11
Warrant Issue Date	Date that the payment was issued.	Field	Date (CCYYMMDD)	8
Warrant Status	Description of the check statuses that is used for display and reporting purposes.	Field	Character	30

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6.12.4 PMP Capitation History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Capitation Txn Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
Capitation Category [Search]	Combo Box	1	Sorting requries at least one search criteria. If searching for either Capiation Category or Capiation Reason then a second criteria is required.	Please select appropriate search criteria.

6.12.5 PMP Capitation History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 PMP Capitation History Panel Accessibility

6.12.6.1 To Access the PMP Capitation History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP Capitation History.	PMP Capitation History panel displays.
6	Enter search criteria or leave capitation category blank and click search; or select a detail line from the results displayed.	PMP Capitation History information displays.

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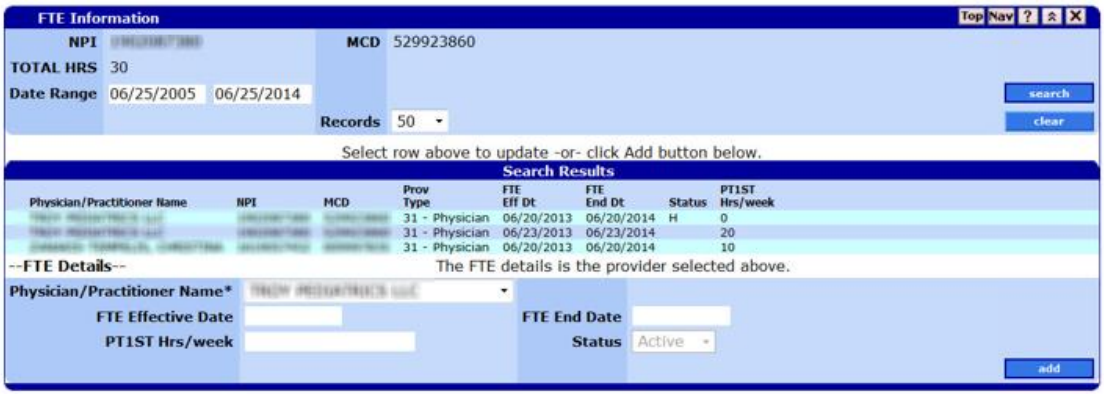
6.13 FTE INFORMATION PANEL OVERVIEW

6.13.1 FTE Information Panel Narrative

This panel contains Patient 1st full time employment (FTE) application information.

Navigation Path: [Managed Care] - [PMP Search] - [(select row from search results)] - [FTE Information]

6.13.2 FTE Information Panel Layout



6.13.3 FTE Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add FTE Information.	Button	N/A	0
Clear	Allows a user to clear search criteria entered on the panel.	Button	N/A	0
Date Range	Date Range to be displayed in Search Results panel	Field Type	Data Type	8
FTE Effective Date	Effective Date of the FTE.	Field	Date (MM/DD/CCYY)	8
FTE End Date	End Date of the FTE.	Field	Date (MM/DD/CCYy)	8
MCD	Medicaid assigned provider ID for group/group member	Label	Character	15
NPI	National Provider Identification number of the provider at the service location. Only healthcare providers are assigned NPI IDs.	Label	Character	15
Physician/Practitioner Name	Name of the provider. This can be a personal or business name. The contents of this attribute (business or personal) can be determined by checking the provider name type.	Combo Box	Character	50

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PT1ST Hrs/week	Number of hours the provider works at the service location per week.	Field	Number (Integer)	9
Records	Allows the user to select the number of records to display.	Combo Box	Drop Down List Box	0
Search	Search for records matching NPI and MCD criteria.	Button	N/A	0
Status	Specifies if the assignment is valid (space) or if the assignment has been historied ('H').	Field	Character	1
TOTAL HRS	TOTAL HRS assign to providers.	Label	N/A	0

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6.13.4 FTE Information Panel Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
FTE Effective Date	Field	1	Invalid date. Format is mm/dd/ccyy	Enter a valid End Date. Format is MM/DD/CCYY.
		2	Effective Date must be greater than or equal to 1/1/1900.	Please enter the valid date.
		3	Effective Date must be less than or equal to 12/31/2299.	Please enter the valid date.
FTE End Date	Field	1	Invalid date. Format is mm/dd/ccyy	Enter a valid End Date. Format is MM/DD/CCYY.
		2	End Date must be greater than or equal to 1/1/1900.	Please enter the valid date.
		3	End Date must be less than or equal to 12/31/2299.	Please enter the valid date.
PT1ST Hrs/ Week	Field	1	PT1ST Hrs/ Week must be greater than or equal to 0.	Please enter greater than or equal to 0.
Physician/Practitioner Name	Field	1	Date segments cannot overlap.	Physician/Practitioner Name can not have overlapping dates. Please modify dates to correct edit.

6.13.5 FTE Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 FTE Information Panel Accessibility

6.13.6.1 To Access the FTE Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click Login.	Main Menu page displays.
2	Point to **Managed Care** and click PMP Search.	PMP Search panel displays.

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Step	Action	Response
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select **FTE Information** panel.	FTE Information panel displays.

6.13.6.2 To Add on the FTE Information Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter comments in the **Note** field.	
3	Click **Save**.	FTE information is saved.

6.13.6.3 To Update on the FTE Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	FTE Information panel information is saved.

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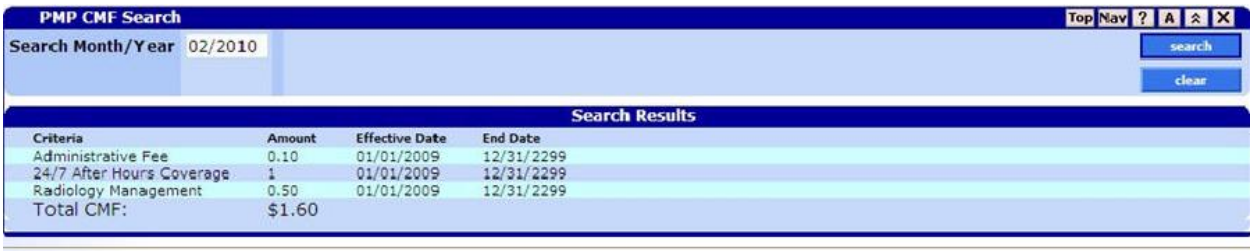
6.14 PMP CMF SEARCH PANEL OVERVIEW

6.14.1 PMP CMF Search Panel Narrative

The PMP CMF (Case Management Fee) Search panel allows the user to see what was paid to a given provider for a given month and year. This panel is inquiry only.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [PMP CMF Search]

6.14.2 PMP CMF Search Panel Layout



6.14.3 PMP CMF Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount	Amount that was paid for that component on the requested date is displayed.	Field	Number (Decimal)	5
Clear	Allows the user to clear any changes on the PMP CMF Search panel.	Button	N/A	0
Criteria	Name of the case management fee component.	Field	Character	25
Effective Date	Date the case management fee criteria's component became effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date the case management fee criteria's coverage ends.	Field	Date (MM/DD/CCYY)	8
Search	Initiates the Search by Month/Year.	Button	N/A	0
Search Month/Year [Search]	Allows the user to search by the month and year of the case management fee.	Field	Date (MM/CCYY)	7

6.14.4 PMP CMF Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search Month/Year	Field	1	Search Month/Year is required.	The Search Month/Year is required.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Invalid Format. Format is MM/CCYY format.	The date must be in MM/CCYY format.

6.14.5 PMP CMF Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 PMP CMF Search Panel Accessibility

6.14.6.1 To Access the PMP CMF Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Managed Care** and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP CMF Search.	PMP CMF Search panel displays.
6	Enter the **search month/year** and click search.	PMP CMF information displays.

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6.15 PMP MASS-TRANSFER & RELEASE PANEL OVERVIEW

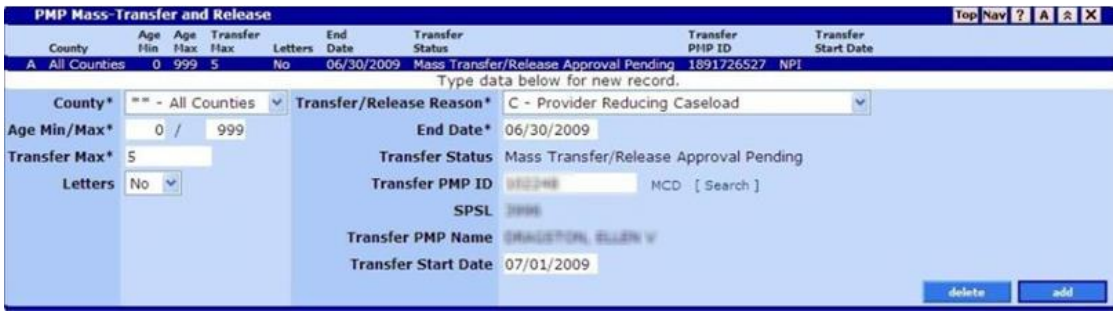
6.15.1 PMP Mass-Transfer & Release Panel Narrative

The PMP Mass-Transfer & Release panel allows the user to transfer or release selected parts of a provider's caseload of recipients.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [PMP Mass-Transfer & Release]

6.15.2 PMP Mass-Transfer & Release Panel Layout



6.15.3 PMP Mass-Transfer & Release Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Mass-Transfer & Release information.	Button	N/A	0
Age Max	Maximum age of the recipients the PMP wishes to transfer/release. Default value is 999.	Field	Number (Integer)	3
Age Min	Minimum age of the recipients the PMP wishes to transfer/release. Default value is 000.	Field	Number (Integer)	3
Age Min/Max	Minimum age of the recipients the PMP wishes to transfer/release. Default value is 000. / Maximum age of the recipients the PMP wishes to transfer/release. Default value is 999.	Field	Number (Integer)	6
County	Name of the county that the PMP wishes to transfer/release recipients. Default is All Counties.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove PMP Mass-Transfer & Release information.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
End Date	Assignment end date for the recipient's being transferred/released from their current PMP.	Field	Date (MM/DD/CCYY)	8
Letters	Indicates if letters should be produced as a result of this transfer/release. Default value is No.	Combo Box	Drop Down List Box	0
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Transfer Max	Maximum number of recipients the PMP wishes to transfer/release.	Field	Number (Integer)	6
Transfer PMP ID	Identifies the transfer provider enrollment tracking ID. This field is the Transfer PMP ID.	Field	Character	15
Transfer PMP Name	Transfer PMP provider individual name (format Last Name, First Name, Middle Initial) or the business name.	Field	Character	50
Transfer Start Date	Displays the date the system has been requested to use as the new assignment date for the recipients.	Field	Date (MM/DD/CCYY)	8
Transfer Status	Contains the transfer/release status description.	Combo Box	Drop Down List Box	0
Transfer/Release Reason	Contains the PMP transfer/release reason description. Format is code (length 2) " - ", and description (length 50).	Combo Box	Drop Down List Box	0

6.15.4 PMP Mass-Transfer & Release Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Age Max	Field	11	Max age must be larger than min age.	Enter a value larger than in the min age field.
	Field	12	Age Max is required.	Enter a valid numeric Age Max.
Age Min	Field	1	Min Age must be numeric.	Enter a valid minimum age.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Age Min is required.	Enter a valid numeric minimum age.
	Field	3	Minimun Age must be less than Maximum Age.	Modify Age Min/Max so that minumum age is less than maximum age.
End Date	Field	1	End Date must be the last day of the month.	Enter the last day of the month in the DD portion of the end date.
	Field	2	End Date is required.	Enter a valid End Date. Format is MM/DD/CCYY.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter a valid End Date.
Transfer PMP ID	Field	1	Selected Transfer PMP ID/SPSL is no longer enrolled.	Please select a PMP that is enrolled as of the current date.
	Field	2	Transfer PMP ID not active for Transfer Start Date.	Selected a Transfer Start Date that is within the PMP's active period.
	Field	3	Selected Transfer PMP does not have the same plan as the current PMP within the same region. Please select a valid Transfer PMP ID.	Select a PMP that is enrolled in the same Health Care Program and region as the current PMP.
	Field	4	Transfer PMP ID cannot be the same as the disenrolling PMP.	Select a different PMP or SPSL than the one currently working on.
Transfer Start Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid Transfer Start Date. Format is MM/DD/CCYY.
	Field	2	Transfer PMP ID not active for Transfer Start Date	Verify Input.Transfer Start Date must be between Effective Date and End Date of the PMP ID
	Field	3	Selected Transfer PMP ID/SPSL is no longer enrolled.	Verify Input. Transfer PMP ID is no longer enrolled.
	Field	4	Transfer PMP ID is required, because Transfer Start Date was entered.	Enter a valid PMP ID or remove the value in the Transfer Start Date.

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Field	Field Type	Error Code	Error Message	To Correct
Transfer/Release Reason	Field	1	A valid Transfer Reason is required.	Select a valid value from the Transfer/Release dropdown list.

6.15.5 PMP Mass-Transfer & Release Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 PMP Mass-Transfer & Release Panel Accessibility

6.15.6.1 To Access the PMP Mass-Transfer & Release Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP Mass-Transfer & Release.	PMP Mass-Transfer & Release panel displays.

6.15.6.2 To Add on the PMP Mass-Transfer & Release Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **County** from drop down list box.	
3	Enter Age Min/Max.	
4	Enter Transfer Max.	
5	Select **Letters** from drop down list box.	
6	Select **Transfer/Release Reason** from drop down list box.	
7	Enter End Date.	
8	Enter Transfer PMP ID.	
9	Enter Transfer Start Date.	
10	Click **Save**.	PMP Mass-Transfer & Release information is saved.

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6.15.6.3 To Update on the PMP Mass-Transfer & Release Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Mass-Transfer & Release information is saved.

6.15.6.4 To Delete from the PMP Mass-Transfer & Release Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.16 PMP PANEL RESTRICTIONS PANEL OVERVIEW

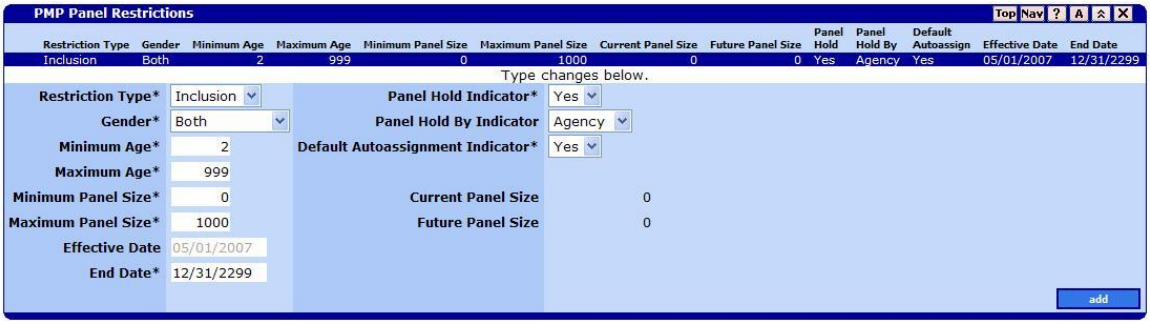
6.16.1 PMP Panel Restrictions Panel Narrative

The PMP Panel Restrictions panel allows the user to specify restrictions, such as age, gender, and maximum number of recipients that PMPs are allowed to place on their panel of recipients. This information is retained at a PMP level.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [PMP Panel Restrictions]

6.16.2 PMP Panel Restrictions Panel Layout



6.16.3 PMP Panel Restrictions Panel Field Description

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Panel Restriction information.	Button	N/A	0
Current Panel Size	Specifies the current number of recipients who meet the specified restrictions that the PMP will allow.	Field	Number (Integer)	9
Default Autoassignment Indicator	Indicates if default auto assignment processing is allowed on this PMP.	Combo Box	Drop Down List Box	0
Default Autoassign	Indicates if default auto assignment processing is allowed on this PMP.	Field	Character	0
Effective Date	Date that the restrictions become effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the restrictions are no longer effective.	Field	Date (MM/DD/CCYY)	8
Future Panel Size	Specifies the future number of recipients who meet the specified restrictions that the PMP will allow.	Field	Number (Integer)	9
Gender	Specifies the gender of the recipients who are either included or excluded from the PMP's panel.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Maximum Age	Specifies the maximum age of the recipients who are either included or excluded from the PMP's panel.	Field	Number (Integer)	3
Maximum Panel Size	Specifies the maximum number of recipients who meet the specified restrictions that the PMP will allow.	Field	Number (Integer)	9
Minimum Age	Specifies the minimum age of the recipients who are either included or excluded from the PMP's panel.	Field	Number (Integer)	3
Minimum Panel Size	Specifies the minimum number of recipients who meet the specified restrictions that the PMP will allow. This is an informational field.	Field	Number (Integer)	9
Panel Hold Indicator	Indicates if panel hold has been placed on the panel restriction.	Combo Box	Drop Down List Box	0
Panel Hold	Indicates if panel hold has been placed on the panel restriction.	Field	Character	0
Panel Hold By Indicator	Indicates by whom the panel hold has been placed, if panel hold has been placed on the panel restriction. The four valid values for this Combo Box are A – Agency, P – Provider, H – HP and N – No hold. If the value of Panel Hold Indicator is Yes then the valid values are A, P and H. If the value of Panel Hold Indicator is No then the valid value is only N.	Combo Box	Drop Down List Box	0
Panel Hold By	Indicates by whom the panel hold has been placed, if panel hold has been placed on the panel restriction. If the value of Panel Hold Indicator is Yes then the valid values are A=Agency, P=Provider, and H=HP. If the value of Panel Hold Indicator is No then the valid value is only N=No Hold.	Field	Character	1
Restriction Type	Specifies the type of restriction: Inclusion or Exclusion.	Combo Box	Drop Down List Box	0

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6.16.4 PMP Panel Restrictions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	70	Invalid date. Format is MM/DD/CCYY.	Enter a valid End Date in MM/DD/CCYY format. 12/31/2299 indicates open ended end date.
Gender	Combo Box	10	Gender is required.	Select a valid value from the Gender dropdown list.
Maximum Panel Size	Field	50	Max Panel Size is required.	Enter a valid Maximum Panel Size for PMP.
	Field	51	Maximum Panel Size must be greater than or equal to Minimum Panel Size.	Enter a Maximum Panel Size that is greater than or equal to the Minimum Panel Size.
Maximum Age	Field	30	Max Age is required.	Enter a valid maximum age limit for the PMP. 999 is a valid maximum age.
Minimum Panel Size	Field	40	Min Panel Size is required.	Enter a valid Minimum Panel Size for PMP. Zero is a valid value. If field spaced out, may need to enter 000000 to get past edit.
Minimum Age	Field	20	Min Age is required.	Enter a valid minimum age limit for this PMP. Zero is a valid value.
	Field	21	Minimum Age must be Less than or Equal to Maximum Age.	Modify Minimum or Maximum age so that age limits are correct. Minimum must be less than or equal to Maximum Age.
Restriction Type	Combo Box	1	Panel Restriction: At least ONE Inclusion should have an end date that matches the PMP Panel's end date.	Choose a valid value from the Restriction Type dropdown list if blank and other value present.
Panel Hold By Indicator	Combo Box		Panel Hold By Indicator required when Panel Hold Indicator = Yes	If value for Panel Hold Indicator is Yes then value for this Combo Box should be either Agency, Provider or DXC.

6.16.5 PMP Panel Restrictions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.16.6 PMP Panel Restrictions Panel Accessibility

6.16.6.1 To Access the PMP Panel Restrictions Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP Panel Restrictions.	PMP Panel Restrictions panel displays.

6.16.6.2 To Add on the PMP Panel Restrictions Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **Restriction Type** from drop down list box.	
3	Select **Gender** from drop down list box.	
4	Enter Minimum Age.	
5	Enter Maximum Age.	
6	Enter Minimum Panel Size.	
7	Enter Maximum Panel Size.	
8	Enter Effective Date.	
9	Enter End Date.	
10	Select **Panel Hold Indicator** from drop down list box.	
11	Select **Panel Hold By Indicator** from drop down list box.	
12	Select **Default Autoassignment Indicator** from drop down list box.	
13	Click **Save**.	PMP Panel Restriction information is saved.

6.16.6.3 To Update on the PMP Panel Restrictions Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Panel Restriction information is saved.

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6.17 PMP SPECIAL CONDITIONS PANEL OVERVIEW

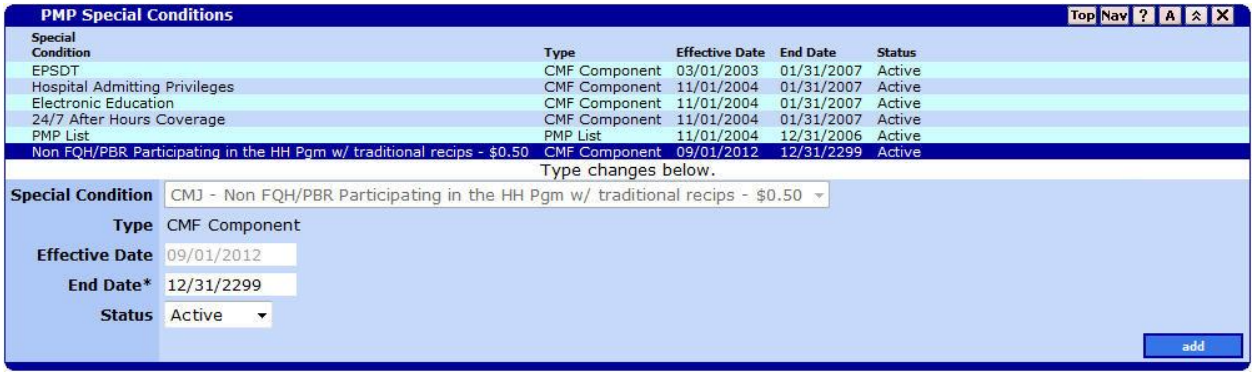
6.17.1 PMP Special Conditions Panel Narrative

This PMP Special Conditions panel allows the user to specify state-specific, special conditions that apply to the selected PMP service location.

Only users with update authority are allowed to change information on this panel.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [PMP Special Conditions]

6.17.2 PMP Special Conditions Panel Layout



6.17.3 PMP Special Conditions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Special Conditions information.	Button	N/A	0
Effective Date	Date that the Special Condition became effective for the PMP.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the Special Condition no longer applied to the PMP.	Field	Date (MM/DD/CCYY)	8
Special Condition	Describes the Special Condition that applies to the PMP.	Combo Box	Drop Down List Box	0
Status	Status of the Special Condition. The Status may either be Active or History.	Combo Box	Drop Down List Box	0
Type	Describes the Type of the Special Condition.	Field	Character	0

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6.17.4 PMP Special Conditions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Effective Date is required. Format is MM/DD/CCYY.
	Field	2	Effective Date must be less than end date.	Effective Date must be less than end date. Modify one of the dates to correct this edit.
	Field	3	Overlapping date segments	Special Conditions of the same type can not have overlapping dates. Please modify dates to correct edit.
End Date	Field	10	End Date is required.	Enter a valid End Date. Format is MM/DD/CCYY.
	Field	11	End Date must be the last day of the month.	Enter a valid end of month date. Example: 01/31/2008.
	Field	12	Invalid date. Format is MM/DD/CCYY.	Enter a valid End Date. Format is MM/DD/CCYY

6.17.5 PMP Special Conditions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 PMP Special Conditions Panel Accessibility

6.17.6.1 To Access the PMP Special Conditions Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click **Search**; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP Special Conditions.	PMP Special Conditions panel displays.

6.17.6.2 To Add on the PMP Special Conditions Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **Special Conditions** from drop down list box.	
3	Enter Effective Date.	

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Step	Action	Response
4	Enter End Date.	
5	Select **Status** from drop down list box.	
6	Click **Save**.	PMP Special Conditions information is saved.

6.17.6.3 To Update on the PMP Special Conditions Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Special Conditions information is saved.

6.17.6.4 To Delete from the PMP Special Conditions Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.18 REGION ENROLLMENT MAINTENANCE PANEL OVERVIEW

6.18.1 Region Enrollment Maintenance Panel Narrative

The Region Enrollment Maintenance panel allows the user to enroll the selected Managed Care provider (PMP) into one or more geographical regions of the state.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [PMP Search] - [(select row from search results)] - [Region Enrollment Maintenance]

6.18.2 Region Enrollment Maintenance Panel Layout

6.18.3 Region Enrollment Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Region Enrollment Maintenance information.	Button	N/A	0
Disenroll Date	Date that the PMP has elected to disenroll from the specified region.	Field	Date (MM/DD/CCYY)	8
Disenrollment Information	This label defines the "Disenrollment Information" section on the panel.	Field	N/A	0
Disenroll Reason	Contains the PMP enrollment reason description. Format is code (length 2), " - ", and description (length 50).	Combo Box	Drop Down List Box	0
Effective Date	Effective date of the Managed Care region assignment.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the Managed Care region.	Field	Date (MM/DD/CCYY)	8
Enrollment Status	Contains the enrollment status description.	Combo Box	Drop Down List Box	0
Letters	Indicates whether letters should be produced as a result of the disenrollment. Default value is 'No'.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
MC Region	Identification of the Managed Care region.	Combo Box	Drop Down List Box	0
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Transfer PMP ID	Primary Medical Provider (PMP) Identification number of the provider who is receiving the transferred recipients.	Field	Character	15
Transfer PMP Name	Transfer PMP provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
Transfer Start Date	Start date of the transfer.	Field	Date (MM/DD/CCYY)	8

6.18.4 Region Enrollment Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Disenroll Date	Field	10232	End/Disenrollment Dates not within the Provider's Managed Care contract dates	Verify input. Disenrollment and Assign date must be >= Effective Date and <= End Date.
	Field	10233	Disenroll Date must Match the End Date.	Enter the same value in Disenroll Date tha is currently entered in End Date.
	Field	10234	Invalid date. Format is MM/DD/CCYY.	Enter a valid Disenroll Date in MM/DD/CCYY format.
Disenroll Reason	Field	10002	Disenroll Reason is required.	Select a valid Disenroll Reason from the Disenroll Reason drop down menu.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date in MM/DD/CCYY format.
	Field	4122	Effective Date must be the first day of the month.	Effective Date must be in the form MM/DD/CCYY where DD must be 01.
	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be < to End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
End Date	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91030	Date segments can not overlap.	Verify Effective Date, End Date, and MC Region against the list. Date segments cannot overlap for the same MC Region.
	Field	91135	End Date must be the last day of the month.	End Date must be in the format MM/DD/CCYY where DD must be the last day of the month. Example: Jan 2099 has 31 days; therefore the end date would be 01/31/2099.
Enrollment Status	Combo Box	1	Valid Enrollment Status is required.	Select an Enrollment Status from the drop down list.
	Combo Box	10070	Enrollment Status may only change to Enrolled.	Verify input. Initial Status must be 'Enrolled'
	Combo Box	10071	Enrollment Status may only change to Mass Disenrollment Approval Pending.	Verify input. Status change from 'enrolled' can only change to Mass Disenrollment Approval Pending.
	Combo Box	10072	Enrollment Status may only change to Enrolled or Mass Disenrollment Approved.	Verify input. Status change from 'Mass Disenrollment Approval Pending' may only change to 'Enrolled' or 'Mass Disenrollment Approved'.
	Combo Box	10073	Enrollment Status may only change to Enrolled or Mass Disenrollment Approval Pending.	Verify input. Status change from 'Mass Disenrollment Approved' may only change to 'Enrolled' or 'Mass Disenrollment Approval Pending'.
	Combo Box	10079	Enrollment Status may not change.	Verify input. Enrollment status may not change when currently 'Disenrolled'.
MC Region	Combo Box	1	Valid MC Region is required.	Select an MC Region from the drop down list.

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Field	Field Type	Error Code	Error Message	To Correct
Transfer PMP ID	Field	10075	Transfer PMP ID is required, because Transfer Start Date was entered.	Verify input. Enter a valid PMP ID or remove the Transfer Start Date.
	Field	10076	Transfer PMP ID cannot be the same as the disenrolling PMP.	Verify input. Enter a valid Transfer PMP ID that is different from the original PMP ID.
	Field	10080	Transfer PMP ID must be enrolled in a MC Region on the Transfer Start Date.	Verify input. Validate the Transferring PMP ID has a MC Region for the Transfer Date.
	Field	1	Selected Transfer PMP ID/SPSL is no longer enrolled.	Please select a PMP that is enrolled as of the current date.
	Field	2	Transfer PMP ID not active for Transfer Start Date.	Selected a Transfer Start Date that is within the PMP's active period.
	Field	3	Selected Transfer PMP does not have the same plan as the current PMP. Please select a valid Transfer PMP ID.	Select a PMP that is enrolled in the same Health Care Program as the current PMP.
Transfer Start Date	Field	10074	Transfer Start Date is required, because Transfer PMP ID was entered.	Verify Input. Either remove the PMP ID or enter a valid transfer start date.
	Field	10077	Transfer Start Date must fall between enrolled dates.	Verify Input. Transfer Start Date must be >= Effective Date and <= End Date.
	Field	10078	Transfer Start Date must be after the Disenrollment and Assign End Date.	Verify Input. Transfer Date must be > Disenrollment & Assign End Date.
	Field	10079	Transfer PMP ID not active for Transfer Start Date	Verify Input.Transfer Start Date must be between Effective Date and End Date of the PMP ID.
	Field	10080	Selected Transfer PMP ID/SPSL is no longer enrolled.	Verify Input.Transfer PMP ID is no longer enrolled.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.

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6.18.5 Region Enrollment Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 Region Enrollment Maintenance Panel Accessibility

6.18.6.1 To Access the Region Enrollment Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select Region Enrollment Maintenance.	Region Enrollment Maintenance panel displays.

6.18.6.2 To Add on the Region Enrollment Maintenance Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **MC Region** from drop down list box.	
3	Enter Effective Date.	
4	Enter End Date.	
5	Enter Default Autoassign.	
6	Enter Panel Hold.	
7	Select **Enrollment Status** from drop down list box.	
8	Select **Disenroll Reason** from drop down list box.	
9	Enter Disenroll Date.	
10	Enter Transfer PMP ID.	
11	Enter Transfer Start Date.	
12	Select **Letters** from drop down list box.	
13	Click **Save**.	Region Enrollment information is saved.

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6.18.6.3 To Update on the Region Enrollment Maintenance Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Region Enrollment information is saved.

6.18.6.4 To Delete from the Region Enrollment Maintenance Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.19 PMP NOTES PANEL OVERVIEW

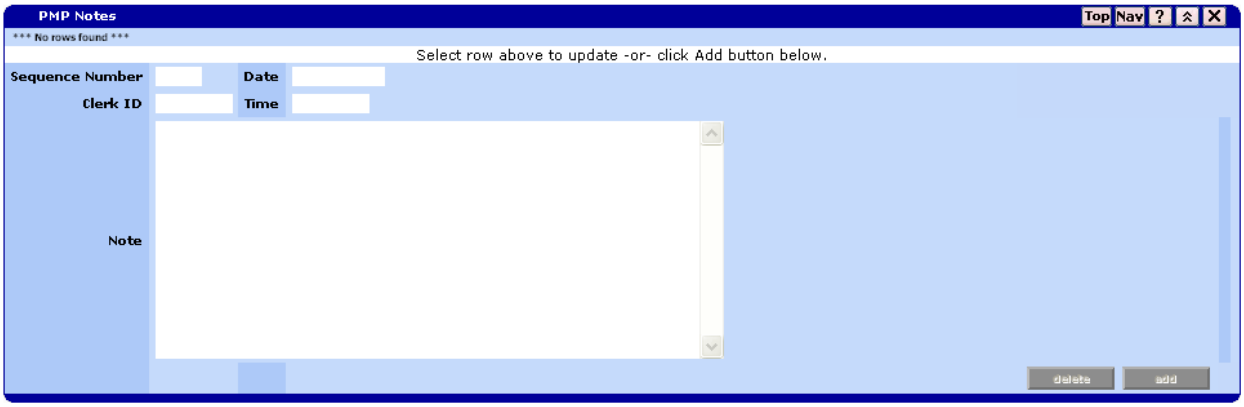
6.19.1 PMP Notes Panel Narrative

Use the Note panel to enter notes regarding the specific Managed Care recipient. Includes fields for date, time, clerk number, and note sequence number.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] - [PMP Search] - [(select row from search results)] - [PMP Notes]

6.19.2 PMP Notes Panel Layout



6.19.3 PMP Notes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a note.	Button	N/A	0
Delete	Delete a note.	Button	N/A	0
Clerk ID	ID of the user who enters the note. This value will be set from the user's security profile.	Field	Character	8
Date	Date that the note was added. Updates do not change this.	Field	Date (MM/DD/CC	8
Note	Actual text of the note.	Field	Character	1000
Sequence Number	Sequence number than can uniquely identify a note.	Field	Number (Integer)	9
Time	Actual Time that the note was added. Updates do not change this.	Field	Number (Integer)	6

6.19.4 PMP Notes Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add PMP Note text.

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6.19.5 PMP Notes Panel Extra Features

PMP Notes Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for pmp + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.19.6 PNP Notes Panel Accessibility

6.19.7 To Access PMP Notes Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click Login.	Main Menu page displays.
2	Point to **Managed Care** and click PMP Search.	PMP Search panel displays.
3	Enter the **Provider ID** and click search; Or click search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the Provider ID entered; Clicking search allows a list of PMP Providers to display.
4	Select a detail line from the results displayed.	PMP Information, PMP Maintenance, and PMP panels display.
5	Select PMP Notes.	PMP Notes panel displays.

6.19.7.1 To Add on the PMP Notes Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter comments in the Note field.	
3	Click **Save**.	Region Enrollment information is saved.

6.19.7.2 To Update on the PMP Note Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Note information is saved.

6.19.7.3 To Delete on the PMP Note Panel

Step	Action	Response
1	Click to highlight the row to be deleted.	Data is populated in fields.
2	Click Delete button.	
3	Click OK to confirm deletion.	PMP Note information is deleted.

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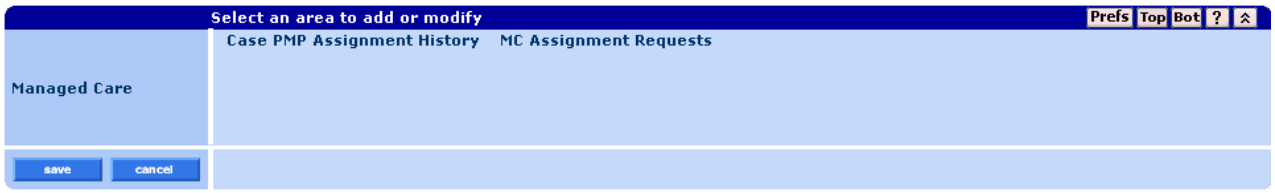
6.20 MANAGED CARE MAINTENANCE PANEL OVERVIEW

6.20.1 Managed Care Maintenance Panel Narrative

This panel displays the Managed Care Maintenance data panels. This panel is inquiry only.

Navigation Path: [Managed Care] – [Managed Care]

6.20.2 Managed Care Maintenance Panel Layout



6.20.3 Managed Care Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Managed Care panel.	Button	N/A	0
Case PMP Assignment History	Hyperlink to Case PMP Assignment History panel.	Hyperlink	N/A	0
MC Assignment Requests	Hyperlink to MC Assignment Request's panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for Managed Care.	Button	N/A	0

6.20.4 Managed Care Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.20.5 Managed Care Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Managed Care Maintenance Panel Accessibility

6.20.6.1 To Access the Managed Care Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Managed Care.	Managed Care panel displays.

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6.21 CASE PMP ASSIGNMENT HISTORY PANEL OVERVIEW

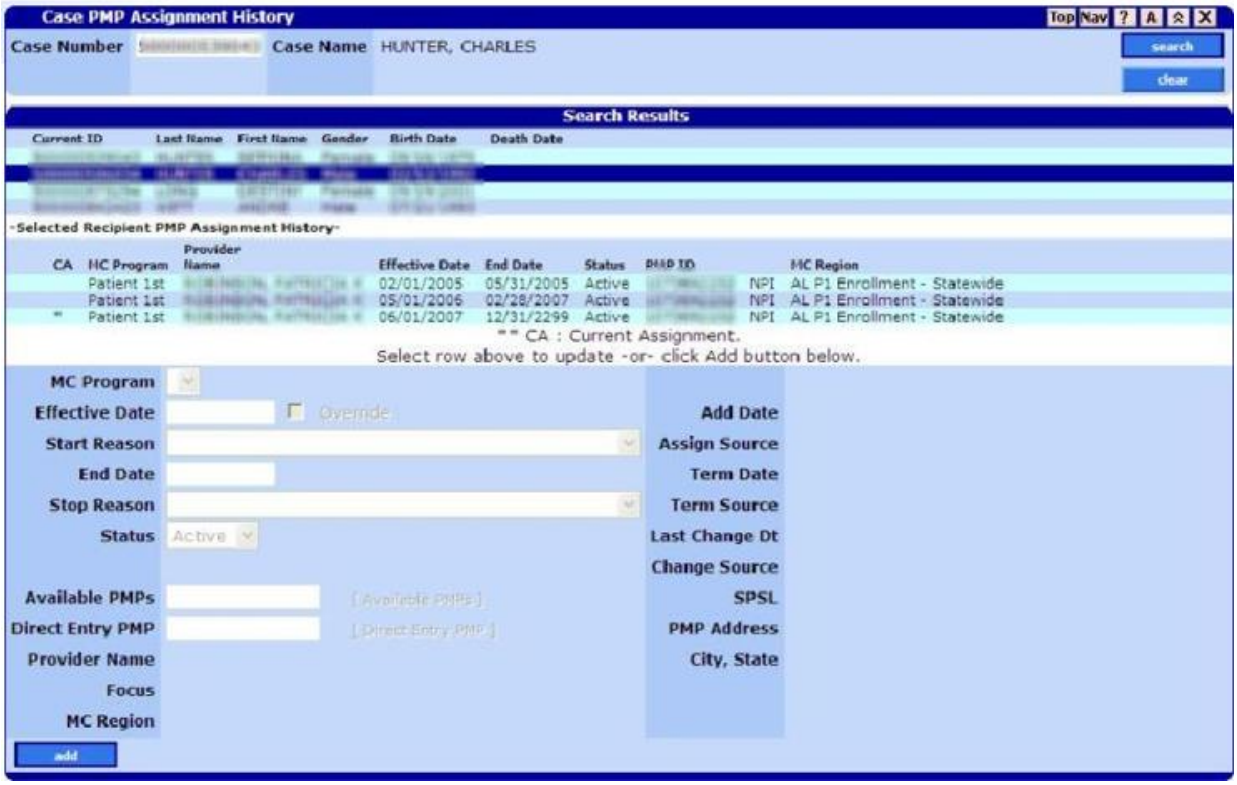
6.21.1 Case PMP Assignment History Panel Narrative

The Case PMP Assignment History panel displays the PMP assignment history for all members of the specified case and allows the user to create new assignments and end date previously existing ones.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Managed Care] - [Case PMP Assignment History]

6.21.2 Case PMP Assignment History Panel Layout



6.21.3 Case PMP Assignment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Case PMP Assignment History information.	Button	N/A	0
Add Date	Indicates the actual date the assignment was made.	Field	Date (MM/DD/CCYY)	8
Assign Source	Identifies how the PMP Assignment record was assigned to this recipient.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Available PMPs	Search for available PMP's. Once one is selected from the search list, it will be returned in the Available PMP ID field as well as populates the provider name.	Field	Character	15
Birth Date	Case member's date of birth.	Field	Date (MM/DD/CCYY)	8
CA	Current Assignment. Displays an asterisk on the assignment which includes the current date.	Field	Character	1
Case Name [Search]	Identifies the name of the recipient that is the case head.	Field	Character	35
Case Number [Search]	Uniquely identifies a Medicaid case - grouping of recipients.	Field	Number (Integer)	10
Change Source	Identifies what last changed PMP Assignment record.	Field	Character	40
City, State	Provider's Service Location City, State.	Field	Character	33
Clear	Allows the user to clear any changes on the Case PMP Assignment History panel.	Button	N/A	0
Current ID	Recipient's identification number.	Field	Character	12
Death Date	Case member's date of death.	Field	Date (MM/DD/CCYY)	8
Direct Entry PMP	If you know the provider id, use Direct Entry PMP. If there is multiple service locations associated with the NPI, you will need to search for the correct PMP location. Once one is selected from the search list, it will be returned in the Available PMP ID field as well as populates the provider name.	Field	Character	15
Effective Date	Date that the PMP assignment became effective.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	Date that the PMP assignment is no longer effective.	Field	Date (MM/DD/CCYY)	8
First Name	The case member's first name.	Field	Character	13
Focus	PMP focus: A focus is similar to a provider specialty, but is NOT related in our system. Examples include: General Practitioner, Internist, and Pediatrician.	Field	Character	30
Gender	Case member’s gender.	Field	Character	18
Last Change Dt	Date the assignment information was last changed.	Field	Date (MM/DD/CCYY)	8
Last Name	The case member's last name.	Field	Character	15
MC Program	Identification of the Managed Care program.	Combo Box	Drop Down List Box	0
MC Region	Description or name of the Managed Care region.	Field	Character	40
Override Effective Dt	Enter check in box if Effective Date needs to be changed from the defaulted value.	Check Box	Check Box	0
PMP Address	Provider's Service Location street address line 1.	Field	Character	30
PMP ID	Primary Medical Provider (PMP) Identification number and Type.	Field	Character	15
Provider ID Type (no label)	The provider identification type.	Field	Character	3
Provider Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
Search	Initiates the Search for a record by Case number.	Button	N/A	0
SPSL	Sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Start Reason	Describes why the recipient was assigned to this provider.	Combo Box	Drop Down List Box	0
Status	Indicates the status of the aid category eligibility (Active or History).	Combo Box	Drop Down List Box	0
Stop Reason	Describes why the recipient was no longer assigned to this provider.	Combo Box	Drop Down List Box	0
Term Date	Date the assignment was terminated.	Field	Date (MM/DD/CCYY)	8
Term Source	Identifies how the PMP Assignment was stopped.	Field	Character	40

6.21.4 Case PMP Assignment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	4156	Recipient is deceased as of Effective Date.	Verify keying. The recipient cannot be deceased on the Effective Date.
	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be < to End Date.
	Field	10058	Effective Date not within PMP Start and End Date.	Verify input. Enter an Effective Date before the PMP start date.
	Field	10144	Warning: Effective date is prior to today.	Verify keying. This is a warning and can be ignored.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	1024	Must NOT have an active segment on the LTC file.	There cannot be a PMP assignment done when there is an active LTC segment on file that covers the PMP effective date.
End Date	Field	4159	Stop Reason requires End Date.	Select a valid stop reason or remove the End Date.
	Field	10052	The End Date may not be increased.	Verify keying. The End Date cannot be increased.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	91030	Date segment cannot overlap.	Verify Effective Date, End Date, and MC Program against the list. Date segments cannot overlap for the same MC Program.
MC Program	Combo Box	1	A valid MC Program is required.	Select a MC Program from the Drop Down list.
	Combo Box	10146	Recipient has an invalid living arrangement for the MC Program.	Verify keying. The living arrangement for the MC Program must be valid.
	Combo Box	10162	Recipient has no pre-requisite program eligibility that spans assignment.	Verify keying. The Recipient has no MC Program eligibility for the Effective Date.
	Combo Box	10163	Recipient is enrolled in a mutually-exclusive program.	Verify keying. The Recipient is excluded from this MC Program and Effective Date.
	Combo Box	10164	Recipient has invalid aid category eligibility.	Verify keying. The recipient has invalid aid category eligibility for this MC Program and Effective Date.
MC Region	Field	4163	Recipient not in Provider Region.	Verify the data entered. If the recipient and PMP aren't in the same region, then the recipient shouldn't be assigned to the PMP. The only option is to select a PMP that is enrolled in the same region as the recipient.
PMP I	Field	1	There is no Provider in the system with that ID & Location Code.	Verify keying. PMP ID and Svc Loc must be a valid provider and service location in the application.
	Field	2	PMP Provider ID/Service Location not found.	Verify keying. The PMP ID/Svc Loc must be a valid PMP Provider.
	Field	3	MC Program is needed to validate the PMP ID / Svc Loc.	Enter a MC Program, so that the PMP ID can be verified.
	Field	4	No PMP ID / Svc Loc found given Effective Date.	Verify keying. There was a PMP ID found, but not for the Effective Date.
	Field	5	A valid PMP ID/Svc Loc is required.	Enter a valid PMP ID/Svc Loc or click [search] to select one.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	10073	PMP ID is not in this MC Program.	The PMP ID/Svc Loc is not valid for this MC Program.
	Field	10172	Recipient locked out from Provider Svc Location.	Verify keying. The Recipient is locked out of the PMP ID/Svc Location.
Save	Button	1	CAUTION: MC Assignment Request was Ended.	Informational message. Recipient has been removed from MC Assignment Request panel.
	Button	2	CAUTION: MC Enrollments were Ended.	Informational message. MC Enrollments were Ended.
Start Reason	Combo Box	1	A valid Start Reason is required.	Select a Start Reason from the Drop Down list.
Stop Reason	Combo Box	4023	End Date requires Stop Reason.	Select appropriate Stop Reason from Stop Reason drop down list box.

6.21.5 Case PMP Assignment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Case PMP Assignment History Panel Accessibility

6.21.6.1 To Access the Case PMP Assignment History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Select Case PMP Assignment History.	Case PMP Assignment History panel displays.
4	Enter a case number and click **Search**.	Entering a case number and clicking search allows results to display that are based on the criteria entered.
5	Select a detail line from the results displayed.	Case PMP History information displays.

6.21.6.2 To Add on the Case PMP Assignment History Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **MC Program** from drop down list box.	

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Step	Action	Response
3	Enter Effective Date.	
4	Enter End Date.	
5	Select **Status** from drop down list box.	
6	Enter Group Member ID.	
7	Select **Start Reason** from drop down list box.	
8	Select **Stop Reason** from drop down list box.	
9	Click **Save**.	Case PMP Assignment information is saved.

6.21.6.3 To Update on the Case PMP Assignment History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Case PMP Assignment information is saved.

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6.22 MC ASSIGNMENT REQUESTS PANEL OVERVIEW

6.22.1 MC Assignment Requests Panel Narrative

The MC Assignment Requests panel allows the user to request an assignment for a specific PMP for the newborn children or unborn children of Recipients that are under the Managed Care system. For either situation, the first 6 positions of the recipient's first name must equal UNBORN, at the time this request is made. This information is then utilized by the Auto assignment batch process when creating an assignment for the recipient once eligibility is received in the MMIS. The actual assignment will not be made as long as the first 6 positions of the first name is equal to "UNBORN". An assignment request can stay on the T_MC_RE_PMP_SEL for up to four months. If not assigned to the requested PMP by then, the entry in this table is removed and the recipient will fall into the non-newborn assignment logic in the next run of the assignment process.

Navigation Path: [Managed Care] - [Managed Care] - [MC Assignment Requests]

6.22.2 MC Assignment Requests Panel Layout

6.22.3 MC Assignment Requests Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Assignment Request information.	Button	N/A	0
Added With	Description of the Managed Care entity.	Field	Character	60
Clear	Allows the user to clear any changes on the MC Assignment Requests panel.	Button	N/A	0
Current ID [Search]	Allows the user to search by the recipient's identification number.	Hyperlink	N/A	0
Date Added	Date that the selection was added.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove MC Assignment Request information.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Override Panel Hold	Indicates if the panel hold should be overridden for newborn assignment. Valid values include: No, Yes. Field defaults to “No”. User must have security level 2 or 3 to change.	Combo Box	Character	1
PMP ID	The unique provider identification number.	Hyperlink	N/A	0
Provider ID	Unique provider identification number and identification Type.	Hyperlink	N/A	0
Provider ID Type (no label)	The provider identification type.	Field	Character	3
Provider Name	Provider individual name or the Business name.	Field	Character	50
Provider Panel Hold	Indicates if panel hold has been placed on the provider's panel restrictions. Valid values are Yes, No.	Field	Character	1
Search	Initiates the Search by Current ID.	Button	N/A	0

6.22.4 MC Assignment Requests Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	1	Current ID is required.	Enter a valid current ID; this ID edited for a valid Recipient.
Provider ID	Hyperlink	1	A valid Provider ID is required.	Enter a Provider ID and ID Type or click [search] to select one.
	Hyperlink	3	There is no Provider in the system with that ID & Type Code.	The Provider ID and ID type entered is not a valid Provider in the application.
	Hyperlink	4	Provider ID entered is not a PMP Provider.	The Provider ID entered is not a PMP Provider.
	Hyperlink	5	Provider ID entered is a PMP Provider, but not active for the enrollment date.	The Provider ID/ID Type is a valid PMP, but not for the System Enrollment Date.

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6.22.5 MC Assignment Requests Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 MC Assignment Requests Panel Accessibility

6.22.6.1 To Access the MC Assignment Requests Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click PMP Search.	PMP Search panel displays.
3	Select MC Assignment Request.	Case PMP Assignment History panel displays.
4	Enter a **Current ID** and click **Search**.	Entering a Recipient current ID and clicking search allows results to display that are based on the criteria entered.
5	Select a detail line from the results displayed.	MC Assignment Requests information displays.

6.22.6.2 To Add on the MC Assignment Requests Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Current ID.	
3	Enter Provider ID.	
4	Enter Group Member ID.	
5	Select Override Panel Hold value (Yes/No)	
6	Click **Save**.	MC Assignment Requests information is saved.

6.22.6.3 To Update on the MC Assignment Requests Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	MC Assignment Requests information is saved.

6.22.6.4 To Delete from the MC Assignment Requests Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.23 RECIPIENT CAPITATED LOCK-IN ASSIGNMENT HISTORY PANEL OVERVIEW

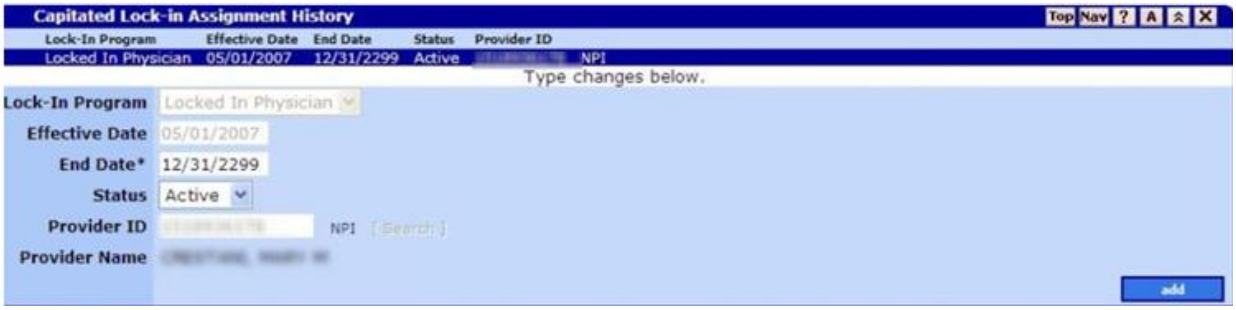
6.23.1 Recipient Capitated Lock-In Assignment History Panel Narrative

The Recipient Capitated Lock-In Assignment History panel is a listing of all providers that a recipient has ever been assigned to for the Lock-In program. It also allows the user to create new assignments and end date previously created assignments.

Only users with update authority are allowed to change information on this panel..

Navigation Path: [Recipient] – [Information] - Enter Current ID and click 'search'- [Managed Care] - [Capitated Lock-In Assignment History]

6.23.2 Recipient Capitated Lock-In Assignment History Panel Layout



6.23.3 Recipient Capitated Lock-In Assignment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Capitated Lock-In Assignment History information.	Button	N/A	0
Effective Date	Date that the Lock-In assignment became effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the Lock-In assignment ends.	Field	Date (MM/DD/CCYY)	8
Lock-In Program	Lock-In assignment plan/program that the recipient is tied in to.	Combo Box	Drop Down List Box	0
Provider ID	Provider that the recipient is locked in to.	Field	Character	15
Provider ID Type (No label)	The Provider Id Type.	Field	Character	3
Provider Name	Name of the provider that the recipient is locked in to.	Field	Character	50
Status	Indicates the status of the assignment (Active or History).	Combo Box	Drop Down List Box	0

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6.23.4 Recipient Capitated Lock-In Assignment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edit found for this panel.				

6.23.5 Recipient Capitated Lock-In Assignment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 Recipient Capitated Lock-In Assignment History Panel Accessibility

6.23.6.1 To Access the Recipient Capitated Lock-In Assignment History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click **Search**.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select Managed Care.	A list of hyperlinks to panel(s) displays.
6	Select Capitated Lock-In Assignment History.	Capitated Lock-In Assignment History panel displays.

6.23.6.2 To Add on the Recipient Capitated Lock-In Assignment History Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Lock-In Program.	
3	Enter Effective Date.	
4	Enter End Date.	
5	Enter **Status**.	
6	Enter Provider ID.	
7	Click **Save**.	Capitated Lock-In Assignment information is saved.

6.23.6.3 To Update on the Recipient Capitated Lock-In Assignment History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Capitated Lock-In Assignment information is saved.

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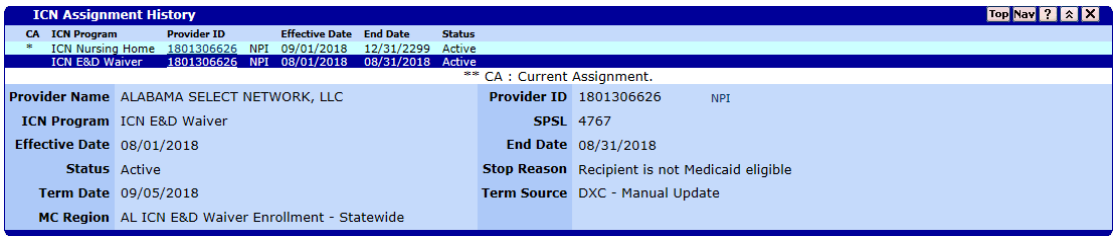
6.24 RECIPIENT ICN ASSIGNMENT HISTORY PANEL

6.24.1 Recipient ICN Assignment History Panel Narrative

The Recipient ICN Assignment History panel is a listing of all Managed Care Providers (ICNs) that a recipient has ever been assigned to.

Navigation Path: [Recipient] - [Information] – enter Current ID [search] – [Managed Care] - [ICN Assignment History]

6.24.2 Recipient ICN Assignment History Panel Layout



6.24.3 Recipient ICN Assignment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CA	Displays an asterisk on the assignment which includes the current date.	Field	Character	1
Effective Date	Indicates the effective date of the ICN Assignment.	Field	Date (MM/DD/CCYY)	8
End Date	Indicates the end date of the ICN Assignment.	Field	Date (MM/DD/CCYY)	8
ICN Program	Identification of the Managed Care program.	Field	Character	50
MC Region	Identification of the Managed Care region.	Field	Character	50
Provider ID	Indicates provider identifier information.	Field	Character	15
Provider Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
SPSL	Helps to uniquely define the provider's different service locations.	Field	Number	9
Status	Indicates the status of the aid category eligibility (Active or History).	Field	Character	7
Stop Reason	Describes why the recipient was no longer assigned to this provider.	Field	Character	100
Term Date	Date the assignment was terminated.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Term Source	Identifies how the ICN Assignment was stopped.	Field	Character	50

6.24.4 Recipient ICN Assignment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.24.5 Recipient ICN Assignment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Recipient ICN Assignment History Panel Accessibility

6.24.6.1 To Access the Recipient ICN Assignment History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click **Search**.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select **Managed Care**.	A list of hyperlinks to panel(s) displays.
6	Select **ICN Assignment History**.	ICN Assignment History panel displays.

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6.25 RECIPIENT MC SPECIAL CONDITIONS PANEL OVERVIEW

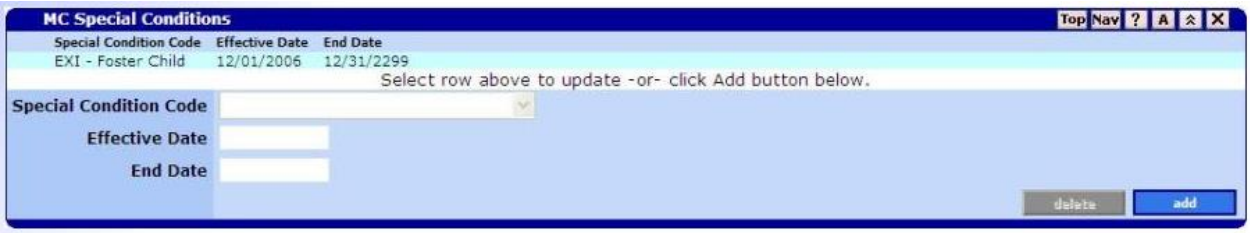
6.25.1 Recipient MC Special Conditions Panel Narrative

The Recipient MC Special Conditions panel allows the user to add new special conditions for a recipient.

Only users with update authority are allowed to change information on this panel..

Navigation Path: [Recipient] – [Information] - Enter Current ID and click 'search'- [Managed Care] - [MC Special Conditions]

6.25.2 Recipient MC Special Conditions Panel Layout



6.25.3 Recipient MC Special Conditions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a MC Special Conditions.	Button	N/A	0
Delete	Delete a MC Special Conditions.	Button	N/A	0
Effective Date	The initial date that the special condition takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	The ending date for the special condition.	Field	Date (MM/DD/CCYY)	8
Special Condition Code	Description of the special condition.	Field	Drop Down List Box	0

6.25.4 Recipient MC Special Conditions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to the End Date.	Enter a valid Effective and End Date.
	Field	1001	Effective Date must be first day of the month.	Effective Date must be the first day of the month.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
	Field	91003	Effective Date is required.	Enter a valid Effective Date in MM/DD/CCYY.
End Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	1002	End Date must be last day of the month.	End Date must be the last day of the month.
	Field	91003	End Date is required.	Enter a valid End Date in MM/DD/CCYY format.
Special Condition Code	Field	1003	Recip has same Spec Cond or Spec Cond with same Type with overlapping dates.	Verify keying. Date segments can not overlap for the same Special Condition Code.
	Field	1005	ICN Special Condition Codes can only be added thru batch process.	ICN Special Condition Codes can not be added thru UI.
	Field	10137	A valid Special Condition Code is required.	Select a Special Condition from the Drop Down list.
	Field	10138	Only users with LVL3 security can add a special condition with spec cond type = HHV.	Only users with LVL3 security can add a special condition with spec cond type = HHV.
	Field	10139	Only users with special MC/LTC security can add GCL special conditions.	Only users with special MC/LTC security can add GCL special conditions.
	Field	10140	Only users with special MC/LTC security can delete GCL special conditions.	Only users with special MC/LTC security can delete GCL special conditions.
	Field	10142	Only users with LVL2 or LVL3 security can add/update special condition NAO.	Only users with LVL2 or LVL3 security can add/update special condition NAO.
	Field	10143	Only users with LVL2 or LVL3 security can add/update a special condition of type EXR.	Only users with LVL2 or LVL3 security can add/update a special condition of type EXR.
	Field	10144	Only users with LVL2 or LVL3 security can delete special condition NAO.	Only users with LVL2 or LVL3 security can delete special condition NAO.
	Field	10145	Only users with LVL2 or LVL3 security can delete a special condition of type EXR.	Only users with LVL2 or LVL3 security can delete a special condition of type EXR.

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6.25.5 Recipient MC Special Conditions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Recipient MC Special Conditions Panel Accessibility

6.25.6.1 To Access the Recipient MC Special Conditions Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click **Search**.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select Managed Care.	A list of hyperlinks to panel(s) displays.
6	Select MC Special Conditions.	Recipient MC Special Conditions panel displays.

6.25.7 To Add on the Recipient MC Special Conditions Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Select **Special Condition Code** from the drop down list box.	
3	Enter Effective Date.	
4	Enter End Date.	
5	Click **Save**.	Recipient MC Special Conditions information is saved.

6.25.8 To Update on the Recipient MC Special Conditions Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Recipient MC Special Conditions information is saved.

6.25.8.1 To Delete from the Recipient MC Special Conditions Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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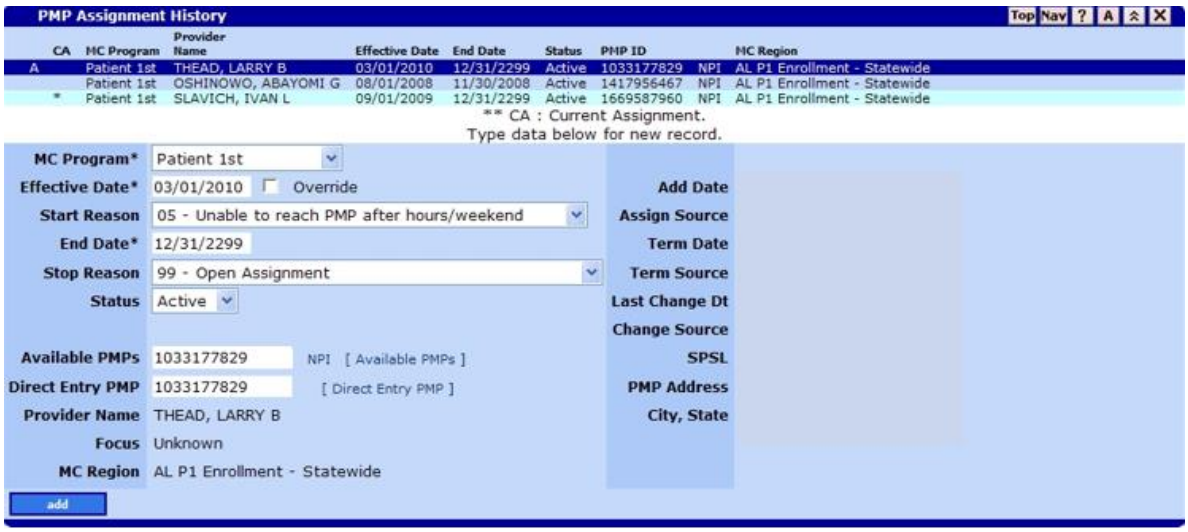
6.26 RECIPIENT PMP ASSIGNMENT HISTORY PANEL

6.26.1 Recipient PMP Assignment History Panel Narrative

The Recipient PMP Assignment History panel is a listing of all Managed Care Providers (PMPs) that a recipient has ever been assigned to. It also allows the user to create new assignments and end date previously created assignments. Only users with update authority are allowed to perform such tasks.

Navigation Path: [Recipient] – [Information] - Enter Current ID and click 'search'- [Managed Care] - [PMP Assignment History]

6.26.2 Recipient PMP Assignment History Panel Layout



6.26.3 Recipient PMP Assignment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Assignment History information.	Button	N/A	0
Add Date	Indicates the actual date the assignment was made.	Field	Date (MM/DD/CCYY)	8
Assign Source	Identifies how the PMP Assignment record was assigned to this recipient.	Field	Character	40
Available PMP's	Search for available PMP's. Once one is selected from the search list, it will be returned in this field.	Field	Character	15
CA	Displays an asterisk on the assignment which includes the current date.	Field	Alphanumeric	1
Change Source	Identifies what last changed PMP Assignment record.	Field	Character	40
City, State.	Provider's Service Location City, State.	Field	Character	33

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Field	Description	Field Type	Data Type	Length
Direct Entry PMP	If you know the provider id, use Direct Entry PMP. If there are multiple service locations associated with the NPI, you will need to search for the correct PMP location. Once one is selected from the search list, it will be returned in the Available PMP ID field as well as populate the provider name.	Field	Character	15
Effective Date	Indicates the effective date of the PMP Assignment.	Field	Date (MM/DD/CCYY)	8
End Date	Indicates the end date of the PMP Assignment.	Field	Date (MM/DD/CCYY)	8
Focus	PMP focus. A “focus” is similar to a provider specialty, but is NOT related in our system. Examples include: General Practitioner, Internist, and Pediatrician.	Field	Character	30
Last Change Dt	Date the assignment information was last changed.	Field	Date (MM/DD/CCYY)	8
MC Program	Identification of the Managed Care program.	Combo Box	Drop Down List Box	0
MC Region	Identification of the Managed Care region.	Field	Character	50
Override Effective Dt	Enter check in box if Effective Date needs to be changed from the defaulted value.	Check Box	Check Box	0
PMP Address	Provider's Service Location street address line 1.	Field	Character	30
PMP ID	Primary Medical Provider (PMP) Identification.	Field	Character	15
PMP ID Type (no label)	The Primary Medical Provider (PMP) identification type.	Field	Character	3
Provider Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number	9
Start Reason	Describes why the recipient was assigned to this provider.	Combo Box	Drop Down List Box	0
Status	Indicates the status of the aid category eligibility (Active or History).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Stop Reason	Describes why the recipient was no longer assigned to this provider.	Combo Box	Drop Down List Box	0
Term Date	Date the assignment was terminated.	Field	Date (MM/DD/CCYY)	8
Term Source	Identifies how the PMP Assignment was stopped.	Field	Character	40

6.26.4 Recipient PMP Assignment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
MC Program	Field	1	A valid MC Program is required.	Select a MC Program from the Drop Down list.
	Field	2	Locked-in-Physician should be maintained in Capitated Lock-in Assignment History panel	Verify the MC Program
	Field	10146	Recipient has an invalid living arrangement for the MC Program.	Verify the MC Program.
	Field	10162	Recipient has no pre-requisite program eligibility that spans assignment.	Verify the MC Program.
	Field	10163	Recipient is enrolled in a mutually-exclusive program.	Verify the MC Program.
	Field	10164	Recipient has invalid aid category eligibility.	Verify the MC Program.
Start Reason	Field	1	A valid Start Reason is required.	Select a valid Start Reason from the Drop Down list.
Stop Reason	Field	4023	End Date requires Stop Reason.	Enter a valid End Date or remove the Stop Reason.
Effective Date	Field	1024	Must NOT have an active segment on the LTC file.	There cannot be a PMP assignment done when there is an active LTC segment on file that covers the PMP effective date.
	Field	4156	Recipient is deceased as of Effective Date.	Verify keying. The recipient cannot be deceased on the Effective Date.
	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be < to End Date.
	Field	10058	Effective Date not within PMP Start and End Date.	Verify the Effective Date and PMP ID.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	10144	Effective Date must be the 1st day of the month.	Date Effective Date must be in the format MM/DD/CCYY where DD must be 01.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
End Date	Field	0	End Date must be the last day of the month.	The date must be in MM/DD/CCYY format.
	Field	4159	Stop Reason requires End Date.	Select a valid stop reason or remove the End Date.
	Field	10052	The End Date may not be increased.	The End Date can be changed but not increased.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91030	Date segments cannot overlap.	Verify Effective Date, End Date, and MC Program against the list. Date segments cannot overlap for the same MC Program.
MC Region	Field	4163	Recipient not in Provider Region.	Verify the data entered. If the recipient and PMP aren't in the same region, then the recipient shouldn't be assigned to the PMP. The only option is to select a PMP that is enrolled in the same region as the recipient.
PMP ID	Field	1	There is no Provider in the system with that ID.	Verify keying. PMP ID must be a valid provider in the application.
	Field	2	PMP Provider ID not found.	Verify keying. The PMP ID must be a valid PMP Provider.
	Field	3	MC Program is needed to validate the PMP ID.	Enter a MC Program, so that the PMP ID can be verified.
	Field	4	No PMP ID found given Effective Date.	Verify keying. There was a PMP ID found, but not for the Effective Date.
	Field	5	A valid PMP ID is required.	Enter a valid PMP ID or click [search] to select one.
	Field	6	Provider Service Location ID Effective period does not cover this PMP Assignment. Please verify Provider ID dates.	Check Provider Effective Period and make sure it covers at least the PMP assignment start date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	7	Unable to assign, recipient either does not meet PMP restrictions or has failed other Provider validations. Contact Managed Care TFAL if unable to determine reason.	Provider Information is not meeting one or more restrictions. Contact Managed Care TFAL for more information.
	Field	10073	PMP ID is not in this MC Program.	Verify the PMP ID and MC Program.
	Field	10172	Recipient locked out from Provider ID.	Verify the PMP ID.
Save	Button	1	CAUTION: MC Assignment Request was Ended.	Informational message. Recipient has been removed from MC Assignment Request panel.
	Button	2	CAUTION: MC Enrollments were Ended.	Informational message. MC Enrollments were Ended.

6.26.5 Recipient PMP Assignment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Recipient PMP Assignment History Panel Accessibility

6.26.6.1 To Access the Recipient PMP Assignment History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click **Search**.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select **Managed Care**.	A list of hyperlinks to panel(s) displays.
6	Select **PMP Assignment History**.	PMP Assignment History panel displays.

6.26.6.2 To Add on the Recipient PMP Assignment History Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **MC Program**.	
3	Enter **Start Reason**.	

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Step	Action	Response
4	Enter **Effective Date**.	
5	Enter **Stop Reason**.	
6	Enter **End Date**.	
7	Enter **Status**.	
8	Enter **Group Member ID**.	
9	Enter **PMP ID**.	
10	Click **Save**.	PMP Assignment information is saved.

6.26.6.3 To Update on the Recipient PMP Assignment History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Assignment information is saved.

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6.27 RECIPIENT PMP DISTANCE PANEL OVERVIEW

6.27.1 Recipient PMP Distance Panel Narrative

The Recipient PMP Distance panel shows a listing of all PMPs that are within a specified distance to the recipient. This panel is inquiry only.

Search Criteria: Distance to PMP is required, Focus is optional, and Name is optional

Navigation Path: [Recipient] – [Information] - Enter Current ID and click 'search'- [Managed Care] - [PMP Assignment History] - [Available PMPs]

6.27.2 Recipient PMP Distance Panel Layout

6.27.3 Recipient PMP Distance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
24 Hour Phone	PMP's 24 hour phone number.	Field	Character	12
Address	The PMP's street address, city, state, zip.	Field	Alphanumeric	66
Clear	Allows the user to clear any changes on the Recipient PMP Distance panel.	Button	N/A	0
Dist	Indicates actual distance from recipient to selected PMP in partial mileage.	Field	Character	6
Distance to PMP [Search]	User indicates the maximum distance from recipient's location to PMP's location.	Combo Box	Drop Down List Box	0
Focus	PMP Focus for PMP's returned in the search.	Field	Character	30
Focus (Search)	User indicates the PMP Focus for PMP's returned in the search.	Combo Box	Drop Down List Box	0
MC Program	Identifies the provider's program.	Field	Character	40
Name [Search]	Provider Name user wishes to search for.	Combo Box	Drop Down List Box	0
Phone	PMP's office phone number.	Field	Character	12
Provider ID [Search]	User identifies a PMP within the proximity range.	Hyperlink	N/A	0
Provider ID	The provider identification Number.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Provider ID Type (no label)	The provider identification type.	Field	Character	3
Provider Name	PMP's full name.	Field	Character	40
Search	Initiates the Search by Distance to PMP, Focus or Name.	Button	N/A	0
Type	PMP Provider Type.	Field	Character	3
Zip	PMP's zip code.	Field	Character	5

6.27.4 Recipient PMP Distance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.27.5 Recipient PMP Distance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Recipient PMP Distance Panel Accessibility

6.27.6.1 To Access the Recipient PMP Distance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click search.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select Managed Care.	A list of hyperlinks to panel(s) displays.
6	Select PMP Assignment History.	PMP Assignment History panel displays.
7	Click **Available PMPs** [Search].	PMP Distance panel displays.

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6.28 RECIPIENT PMP LOCKOUT PANEL OVERVIEW

6.28.1 Recipient PMP Lockout Panel Narrative

The Recipient PMP Lockout panel serves as a cross-reference between a recipient and any Managed Care providers that the recipient should not be assigned to. It allows the user to maintain existing lockouts and to create new ones. Only users with update authority are allowed to perform such tasks.

Navigation Path: [Recipient] – [Information] Enter Current ID and click 'search'- [Managed Care] - [PMP Lockout]

6.28.2 Recipient PMP Lockout Panel Layout

6.28.3 Recipient PMP Lockout Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Lockout information.	Button	N/A	0
Effective Date	Initial date that the recipient can no longer be assigned to the provider.	Field	Date (MM/DD/CCYY)	8
End Date	End date for the recipient/provider lockout.	Field	Date (MM/DD/CCYY)	8
Lock Source	Indicates who requested the lockout, the Provider/PMP or the Recipient.	Combo Box	Drop Down List Box	0
Provider ID	Provider identification number used by the provider.	Field	Character	15
Provider ID Type (no label)	The provider identification type.	Field	Character	3
Provider Name	Provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50

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6.28.4 Recipient PMP Lockout Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1001	Effective Date must be first day of the month.	Effective date must be in the format MM/DD/CCYY where DD = 01.
	Field	1002	Effective Date is required.	Enter a valid effective date. Format is MM/DD/CCYY.
	Field	8012	Effective date must be less than or equal to End Date.	Verify keying. Effective Date must be < to End Date.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
End Date	Field	1002	End Date must be last day of the month.	Format must be in MM/DD/CCYY where DD is the last day of month MM.
	Field	1003	End Date is required.	Enter a valid End Date. Format is MM/DD/CCYY.
	Field	91001	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91030	Date segments cannot overlap.	Verify Effective Date, End Date, and Provider ID against the list. Date segments cannot overlap for the same Provider ID.
Lock Source	Field	1	Lock Source is required.	Select a Lock Source from the Drop Down list.
Provider ID	Field	1	A valid Provider ID is required.	Enter a Provider ID or click [search] to select one from the list.
	Field	2	Both a Provider ID & Location Code are needed.	Enter Provider ID with proper Location Code.
	Field	4	Provider ID entered is not a PMP Provider.	Provider ID is not a PMP Provider.
	Field	5	Provider ID entered is a PMP Provider, but not active for the enrollment date.	Provider is a valid PMP Provider, but no MC Program for the Effective Date entered.

6.28.5 Recipient PMP Lockout Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.28.6 Recipient PMP Lockout Panel Accessibility

6.28.6.1 To Access the Recipient PMP Lockout Panel

Step	Action	Response
1	Enter **User Name** and Password; Click Login.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Information panel displays.
3	Enter the **Recipient ID** and click **Search**.	Entering search criteria and clicking search allows results to display that are based on the Recipient ID entered.
4	Select a detail line from the results displayed.	Recipient Information panel displays.
5	Select **Managed Care**.	A list of hyperlinks to panel(s) displays.
6	Select **Recipient PMP Lockout**.	PMP Lockout panel displays.

6.28.6.2 To Add on the Recipient PMP Lockout Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **Provider ID**.	
3	Enter **Effective Date**.	
4	Enter **End Date**.	
5	Enter **Lock Source**.	
6	Click **Save**.	PMP Lockout information is saved.

6.28.6.3 To Update on the Recipient PMP Lockout Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Lockout information is saved.

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6.29 CAPITATION INFORMATION PANEL OVERVIEW

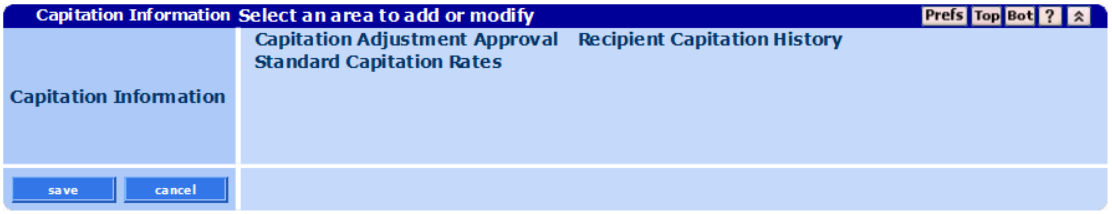
6.29.1 Capitation Information Panel Narrative

The Managed Care Capitation Information panel is the access point for the Managed Care Capitation panels.

This panel is inquiry only.

Navigation Path: [Managed Care] – [Capitation Information]

6.29.2 Capitation Information Panel Layout



6.29.3 Capitation Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Capitation Information panel.	Button	N/A	0
Recipient Capitation History	Link for Recipient Capitation History panel.	Hyperlink	N/A	0
Capitation Adjustment Approval	Link for Capitation Adjustment Approval panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Capitation Information panel.	Button	N/A	0
Standard Capitation Rates	Link for Standard Capitation Rates panel.	Hyperlink	N/A	0

6.29.4 Capitation Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.29.5 Capitation Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.29.6 Capitation Information Panel Accessibility

6.29.6.1 To Access the Capitation Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Capitation Information.	Capitation Information panel displays.

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6.30 CAPITATION ADJUSTMENT APPROVAL PANEL OVERVIEW

6.30.1 Capitation Adjustment Approval Panel Narrative

The Capitation Adjustment Approval panel is used to update the status (Active, Denied, Delete,Hold and 'In Suspension'.) of adjustments that have already been created, but not yet processed through the monthly capitation cycle (and Financial). Adjustments that are in an Active status at the time the monthly capitation cycle is run will be processed and passed to Financial for payment or recoupment. Adjustments in a Hold or Denied status are not. In this panel, the adjustments are not updated individually, but in mass, based on criteria specified by the user, such as the PMP ID, the Capitation Month, the Managed Care Program (Patient 1st, Medicare Advantage), etc. The Adjustment Status field allows the user to specify which status the adjustments that meet the criteria should be changed to. Once the criteria have been entered, and the Status set, the user clicks the ‘update’ button and the panel updates the status for each adjustment meeting the criteria to the Status that the user specified. Once the "update" is performed the changes are permanent, the user does NOT need to click ‘save’ when all changes have been made.

Users that create manual adjustments via the Recipient Capitation Adjustments panel have an option to set the Status for a specific adjustment to Active, Denied, Delete,Hold and 'In Suspension'.. Adjustments created via the Automated Capitation Adjustment batch process may either be automatically set in a Hold status or an Active status, depending on how the Managed Care TFAL has configured the system. This panel may be used to change the status of adjustments created by either of those processes. Alabama has chosen to generate the transactions in an Active status at this time.

Panel Functions:

Search records based on the search criteria.

Records dropdown in the search criteria sets the numbers of rows to be displayed and max rows that can be updated by the user (Maximum of 500).

Once the Search Results are displayed, either click "Select All" button or Check the checkbox on the rows that needs to be updated.

Select "Adjustment Status" dropdown to the user desired status then click the "Update" button to update the rows.

"Select All" Works on the Current page ONLY.

"Update" will ONLY update the rows that has the checkbox checked. This is a permanent update, save button is not needed.

User can update Maximum of 500 rows on a single page at any given time.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] - [Capitation Information] - [Capitation Adjustment Approval]

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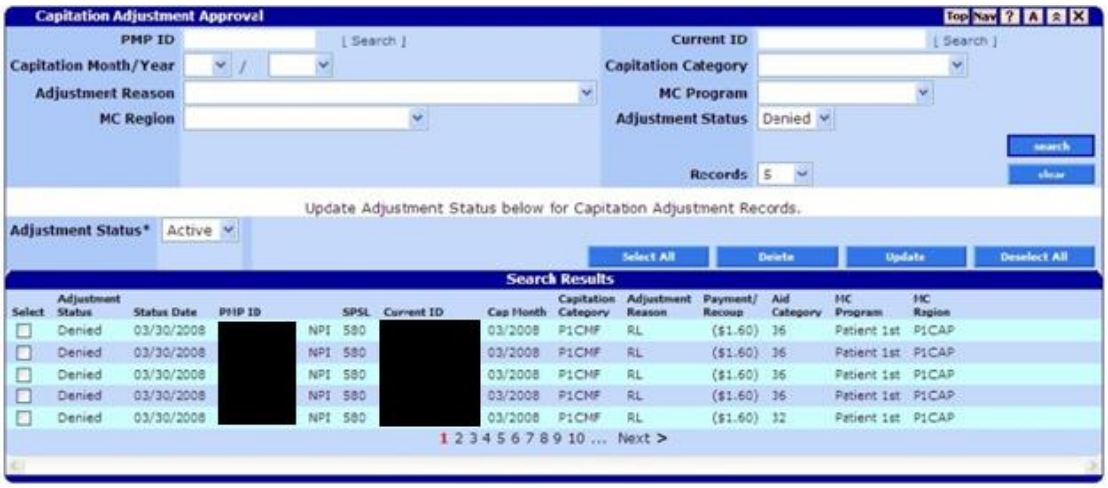
6.30.2 Capitation Adjustment Approval Panel Layout



6.30.3 Capitation Adjustment Approval Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Reason	Code of the reason the capitation is being done.	Combo Box	Drop Down List Box	0
Adjustment Status	Status of the Adjustment. Valid options are: Active, Denied, Delete,Hold and 'In Suspension'.	Combo Box	Drop Down List Box	0
Aid Category	Identifies the type of aid for which a recipient is eligible.	Field	Character	2
Capitation Category	Category of the capitation.	Combo Box	Drop Down List Box	0
Capitation Month	Month that the capitation adjustment is being made for in format MM/CCYY.	Field	Date (MM/CCYY)	7
Capitation Month/Year	The Capitation Month/Year field is actually two fields used in conjustion to determine the correct capitation month and year to search for. Month is 2 positions and Year is 4 in CCYY format.	Field	Drop Down List Box	6
Clear	Allows the user to clear any changes on the Capitation Adjustment Approval panel.	Button	N/A	0
Current ID	Recipient's identification number.	Field	Character	12
Delete	Allows the user to delete the records marked for deletion.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Deselect All	The Deselect All button is used to change the Select box from checked to unchecked, for all rows in the search results, on the current page.	Button	N/A	0
MC Program	Identification of the Managed Care program.	Combo Box	Drop Down List Box	0
MC Region	Identification of the Managed Care region.	Combo Box	Drop Down List Box	0
PMP ID	Primary Medical Provider (PMP) ID.	Field	Character	15
Payment/Recoupment	Amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment. Format 99999999.99.	Field	Number (Decimal)	11
Provider ID Type (no label)	The provider identification type.	Field	Character	3
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Search	Search for rows on the search criteria entered.	Button	N/A	0
Select	When checked, the Select box is used to indicate which rows in the search results should be changed when the Update button is selected.	Check Box	Check Box	0
Select All	The Select All button is used to change the Select box from unchecked to checked, for all 85 rows in the search results, on the current page and any rows that are not shown.	Button	N/A	0
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Status Date	Date the adjustment was added to this entity as pending (hold) or the date the status was changed to processed (active).	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Update	Allows the user to update the status for the records that match the data entered in the "Change Adjustment Status Criteria" fields.	Button	N/A	0

6.30.4 Capitation Adjustment Approval Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Row selected is not marked for deletion, row num.	Select an appropriate row to delete.
Capitation Month/Year	Field	1	Capitation Month/Year is Invalid (Future Date).	Verify Selection; select a date that is not a future date.
	Field	2	Capitation Month/Year is Invalid.	Need to select both Month and Year.

6.30.5 Capitation Adjustment Approval Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 Capitation Adjustment Approval Panel Accessibility

6.30.6.1 To Access the Capitation Adjustment Approval Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Capitation Information.	Capitation Information panel displays.
3	Select Capitation Adjustment Approval.	Capitation Adjustment Approval panel displays.

6.30.6.2 To Update the Capitation Adjustment Approval Panel

Step	Action	Response
1	Enter search criteria.	
2	Select an **Adjustment Status** from the drop down list box.	
3	Click **Update**.	Capitation Adjustment status is updated.
4	Click **Save**.	Capitation Adjustment status information is saved.

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6.31 MASS CAPITATION ADJUSTMENT REQUESTS PANEL OVERVIEW

6.31.1 Mass Capitation Adjustment Requests Panel Narrative

NOTE: Panel valid for Patient 1st and Medicare Advantage only.

The Mass Capitation Adjustment Requests panel allows the user to create a request for a mass capitation adjustment. Mass capitation adjustments are generally used to correct previous payments for a specific provider when the provider's rate was incorrect at the time of the original capitation payment cycle. The request specifies the amount that any processed capitation payments for the given provider; capitation month, etc. should be increased or decreased by. Once placed in an Adjustment Status of Active, and saved, the request will be processed during the nightly cycle by a separate batch process. That batch process will identify all Capitation History payments that meet the criteria specified in the request and create an adjustment for each one for the amount specified on the request. It will then update the request to a "Processed" status along with providing the total number of adjustments created and the total dollar amount of those adjustments. Once processed, an adjustment request can no longer be modified.

Cap Rate Override for provider must be adjusted to reflect what was done through Mass Cap Adjustment panel. Example: Cap Rate Override 2.50, PI of .10 for 200805, then Cap Rate Override for 200805 needs to be changed to 2.60 prior to the next run of the Cap Adjustment process. **Suggest doing the cap rate override change the next day.**

Cross Edits

Capitation Date month must be between 01 and 12.
Recoupment for Death is not valid for Rate Adjustment.
Adjustment Amount can not equal zero.
Recoupment Amount must be less than zero.
Adjustment Amount must be greater than zero.
Capitation Category inactive on capitation month.
Adjustment Status can not be set to Processed.
Duplicate Record can not be saved.
Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Capitation Information] - [Mass Capitation Adjustment Requests]

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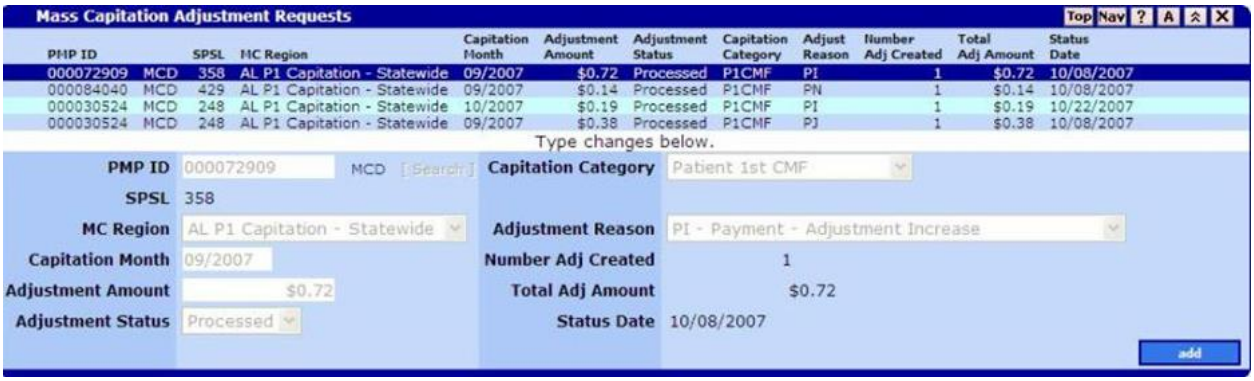
6.31.2 Mass Capitation Adjustment Requests Panel Layout



6.31.3 Mass Capitation Adjustment Requests Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Mass Capitation Adjustment Request information.	Button	N/A	0
Adjustment Amount	Amount to increase or decrease the payment. Format 99999999.99.	Field	Number (Decimal)	11
Adjustment Reason	Code of the reason the capitation is being done. Format is code - description.	Combo Box	Drop Down List Box	0
Adjustment Status	Indicates the status of the request. Valid options include: (A) Active, (D) Denied, (H) Hold or (P) Processed.	Combo Box	Drop Down List Box	0
Capitation Category	Category of the capitation.	Combo Box	Drop Down List Box	0
Capitation Month	Month of the capitation.	Field	Date (MM/CCYY)	7
Delete	Delete a Mass Capitation Adjustment Requests.	Button	N/A	0
MC Region	Identification of the Managed Care region (or coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, districts, or the entire state.	Combo Box	Drop Down List Box	0
Number Adj Created	Number of transactions created when the rate increase was processed.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
PMP ID	Primary Medical Provider (PMP) ID and ID Type. In the data list this field is divided into 2 fields, which are PMP ID (length 10) and ID Type (length 3).	Field	Character	15
PMP ID Type (no label)	The provider identification type.	Field	Character	3
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Status Date	Date that the current status was done.	Field	Date (MM/DD/CCYY)	8
Total Adj Amount	Total amount paid or recouped on a rate change or correction adjustment once it has been processed. Format 999999999.99.	Field	Number (Decimal)	12

6.31.4 Mass Capitation Adjustment Requests Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Adjustment Amount	Field	3	Adjustment Amount can not equal zero.	Insert a non zero value in this field under one exception: If the adjustment reason is full recoupment, you can not insert a zero.
	Field	4	Recoupment Amount must be zero on a Full Recoup. The System will compute the Full Recoupment.	Insert zero value when the adjustment reason is full recoupment..
	Field	5	Recoupment Amount must be less than zero.	Insert a value less than zero when the reason is for recoupments.
	Field	6	Adjustment Amount must be greater than zero.	Insert a value greater than zero when the reason is not for recoupments.
Adjustment Reason	Field	1	A valid Adjustment Reason is required	Select an Adjustment Reason form the Drop Down list.
	Field	2	Recoupment for Death is not valid for Rate Adjustment.	Do not insert Death Recoupment in this field.

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Field	Field Type	Error Code	Error Message	To Correct
Adjustment Status	Field	1	Adjustment Status is required.	Select a valid Adjustment Status from the Drop Down list.
Capitation Category	Field	1	A valid Capitation Category is required.	Select a valid Capitation Category form the Drop Down list.
	Combo Box	9	Capitation Category invalid for PMP's MC region	Select valid option from Capitation Category list.
MC Region	Field	1	A valid MC Region is required.	Select a MC Region for the Drop Down list.
PMP ID (Search)	Field	1	A valid PMP ID/Svc Loc is required.	Enter a valid PMP ID/Svc Loc or click [Search] to select a value.

6.31.5 Mass Capitation Adjustment Requests Panel Extra Feature

Field	Field Type
No extra features found for this panel.	

6.31.6 Mass Capitation Adjustment Requests Panel Accessibility

6.31.6.1 To Access the Mass Capitation Adjustment Requests Panel

Step	Action	Response
1	Enter **User Name** and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Capitation Information.	Capitation Information panel displays.
3	Select Mass Capitation Adjustment Requests.	Mass Capitation Adjustment Requests panel displays.

6.31.7 To Add on the Mass Capitation Adjustment Requests Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **PMP ID**.	
3	Enter Capitation Category.	
4	Enter MC Region.	
5	Enter Adjustment Reason.	
6	Enter Capitation Month.	
7	Enter Adjustment Amount.	
8	Enter Adjustment Status.	

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Step	Action	Response
9	Click **Save**.	Mass Capitation Adjustment Requests information is saved.

6.31.8 To Update on the Mass Capitation Adjustment Requests Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Mass Capitation Adjustment Requests information is saved.

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6.32 STANDARD CAPITATION RATES PANEL OVERVIEW

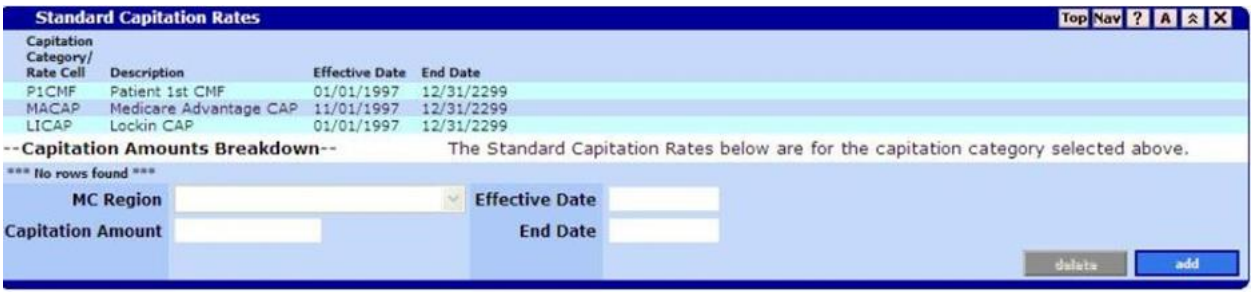
6.32.1 Standard Capitation Rates Panel Narrative

The Standard Capitation Rates panel allows the user to maintain the default capitation rates. These rates are utilized for the specified capitation category when a PMP does not have their own (override) rate defined in the Capitation Rate Override panel. No gaps in dates should ever be left betweens rates for a given Managed Care plan.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Capitation Information] - [Standard Capitation Rates]

6.32.2 Standard Capitation Rates Panel Layout



6.32.3 Standard Capitation Rates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Standard Capitation Rates information.	Button	N/A	0
Capitation Amount	Amount of the capitation payment. Format is 9999999.99.	Field	Number (Decimal)	9
Capitation Category/Rate Cell	Capitation category code represents the various groups of demographics for Managed Care recipients.	Field	Character	5
Delete	Allows the user to remove Standard Capitation Rates information.	Button	N/A	0
Description	Describes the managed care rate cell.	Field	Character	35
Effective Date	Effective date for the payment record.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the payment record.	Field	Date (MM/DD/CCYY)	8
MC Region	Region that the capitation rate is effective in.	Field	Drop Down Box	50

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6.32.4 Standard Capitation Rates Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Capitation Amount	Field	91067	Capitation Amount must be greater than zero.	Enter a Capitation Amount.
Effective Date	Field	1	Effective Date is required.	Insert the Effective Date where the Effective Date is less than the End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	Effective Date must be less than or equal to End Date.	Reenter the Effective Date or End Date.
	Field	4	Effective Date must be equal to first day of the month.	Reenter the Effective Date.
	Field	5	Capitation Category is not effective for the dates entered.	Check the Effective Date and reenter.
End Date	Field	1	End Date is required.	Insert the End Date where the End Date is greater than the Effective Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	Date segments can not overlap.	Verify Effective Date, End Date, and MC Region against the list. Date segments cannot overlap for the same MC Region.
	Field	4	End Date must be equal to last day of the month.	Reenter the End Date.

6.32.5 Standard Capitation Rates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 Standard Capitation Rates Panel Accessibility

6.32.6.1 To Access the Standard Capitation Rates Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Capitation Information.	Capitation Information panel displays.

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3	Select Standard Capitation Rates.	Standard Capitation Rates panel displays.

6.32.6.2 To Add on the Standard Capitation Rates Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **MC Region**.	
3	Enter **Effective Date**.	
4	Enter **Capitation Amount**.	
5	Enter **End Date**.	
6	Click **Save**.	Standard Capitation Rate information is saved.

6.32.6.3 To Update on the Standard Capitation Rates Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Standard Capitation Rate information is saved.

6.32.6.4 To Delete from the Standard Capitation Rates Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.33 RELATED DATA – CODES PAGE OVERVIEW

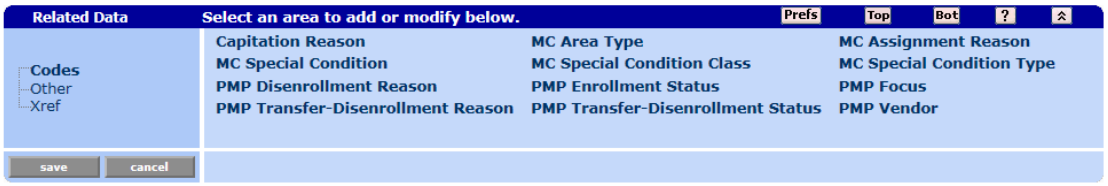
6.33.1 Related Data - Codes Page Narrative

The Related Data for Codes page displays all codes users can maintain for the Managed Care system.

This panel is inquiry only.

Navigation Path: [Managed Care] – [Related Data] [Codes]

6.33.2 Related Data – Codes Page Layout



6.33.3 Related Data – Codes Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Related Data-Codes panel.	Button	N/A	0
Capitations Reason	Link for Capitation Reason panel.	Hyperlink	N/A	0
MC Area Type	Link for MC Area Type panel.	Hyperlink	N/A	0
MC Assignment Reason	Link for MC Assignment Reason panel.	Hyperlink	N/A	0
MC Special Condition	Link for MC Special Condition panel.	Hyperlink	N/A	0
MC Special Condition Class	Link for MC Special Condition Class panel.	Hyperlink	N/A	0
MC Special Condition Type	Link for MC Special Condition Type panel.	Hyperlink	N/A	0
PMP Disenrollment Reason	Link for PMP Disenrollment Reason panel.	Hyperlink	N/A	0
PMP Enrollment Status	Link for PMP Enrollment Status panel.	Hyperlink	N/A	0
PMP Focus	Link for PMP Focus panel.	Hyperlink	N/A	0
PMP Transfer-Disenrollment Reason	Link for PMP Transfer-Disenrollment Reason panel.	Hyperlink	N/A	0
PMP Transfer-Disenrollment Status	Link for PMP Transfer-Disenrollment Status panel.	Hyperlink	N/A	0
PMP Vendor	Link for PMP Vendor panel	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data-Codes panel..	Button	N/A	0

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6.33.4 Related Data – Codes Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 Related Data – Codes Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 Related Data – Codes Page Accessibility

6.33.6.1 To Access the Related Data – Codes Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data – Codes page displays.

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6.34 CODES-CAPITATION REASON PANEL OVERVIEW

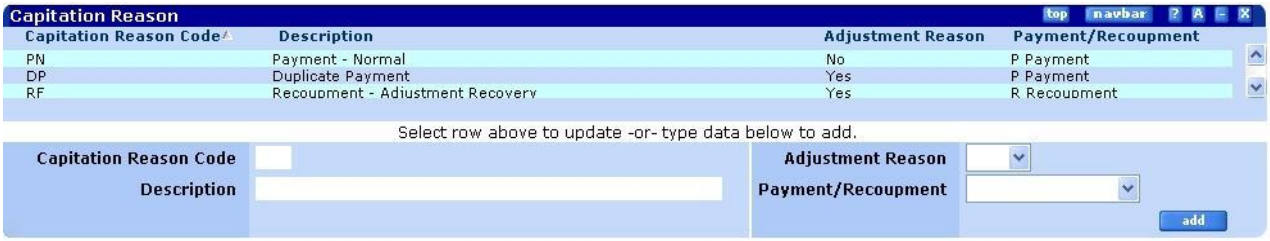
6.34.1 Codes-Capitation Reason Panel Narrative

The Capitation Reason panel allows the user to maintain the reason codes/descriptions that capitation payments and adjustments were created.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [Capitation Reason]

6.34.2 Codes-Capitation Reason Panel Layout



6.34.3 Codes-Capitation Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Capitation Reason information.	Button	N/A	0
Adjustment Reason	Indicates whether this reason code can be used for an adjustment or not. Valid values are Yes and No.	Combo Box	Drop Down List Box	0
Capitation Reason Code	This is the reason code for why the capitation is being done. DP - Duplicate Payment ,PA - Payment - Adjustment Payment ,PB - Payment - Credit Balance ,PC - Payment - Demographic Change ,PI - Payment - Adjustment Increase ,PJ - Payment - Recip Elig Adj ,PL - Payment - Adjustment Auto-Recon/Day Specific ,PN - Payment - Normal ,PO - Payment - Adjustment Auto-Recon Birth Month ,PR - Payment - Retro ,RA - Recoupment - Demographic Change ,RB - Recoupment - Clear Credit Balance ,RC - Recoupment - Delivery ,RD - Recoupment - Death ,RE - Recoupment - Recip Elig Adj ,RF - Recoupment - Adjustment Recovery ,RI - Recoupment - Recipient Incarcerated ,RK - Recoupment - EPSDT Claim ,RL - Recoupment - Adjustment Auto-Recon ,RO - Recoupment - Other ,RP - Recoupment - Family Planning.	Field	Character	2
Description	Description on the Adjustment Reason code.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Payment/Recoupment	Specifies if the reason is for payments or recoupments. Valid values are Payment and Recoupment.	Combo Box	Drop Down List Box	0

6.34.4 Codes-Capitation Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Capitation Reason Code	Field	1	Capitation Reason Code is required.	Enter a valid Reason Code.
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Capitation Reason Code. A duplicate Capitation Reason Code cannot be entered.
Description	Field	1	Description is required.	Enter a Description.
Payment/Recoupment	Field	1	Payment/Recoupment is required.	Select a Payment/Recoupment from the Drop Down list.

6.34.5 Codes-Capitation Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Codes-Capitation Reason Panel Accessibility

6.34.6.1 To Access the Capitation Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Capitation Reason.	Capitation Reason panel displays.

6.34.6.2 To Add on the Capitation Reason Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **Capitation Reason Code.**	
3	Enter **Adjustment Reason**.	
4	Enter **Description**.	

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Step	Action	Response
5	Enter **Payment/Recoupment**.	
6	Click **Save**.	Capitation Reason information is saved.

6.34.6.3 To Update on the Capitation Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Capitation Reason information is saved.

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6.35 CODES-MC AREA TYPE PANEL OVERVIEW

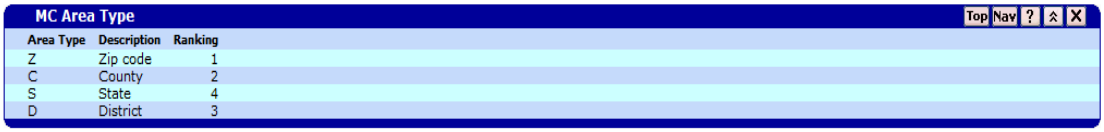
6.35.1 Codes-MC Area Type Panel Narrative

The MC Area Type panel allows the user to view the Managed Care area type definitions which regions are comprised of. Examples of area types include zip, county and state.

This panel is inquiry only.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [MC Area Type]

6.35.2 Codes-MC Area Type Panel Layout



6.35.3 Codes-MC Area Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Area Type	Represents the type of geographical area. Examples include Zip Code (Z), County (C) and State (S).	Field	Character	1
Description	Describes the type of geographical area. Examples include Zip Code, County and State.	Field	Character	15
Ranking	Defines the rank that the area has when determining what region a particular area is in. For example, 'zip code' receives a higher rank than 'county', which has a higher rank that 'state-wide'. Format is 9999.	Field	Number (Integer)	4

6.35.4 Codes-MC Area Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.35.5 Codes-MC Area Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 Codes-MC Area Type Panel Accessibility

6.35.6.1 To Access the MC Area Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select MC Area Type.	MC Area Type panel displays.

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6.36 CODES-MC ASSIGNMENT REASON PANEL OVERVIEW

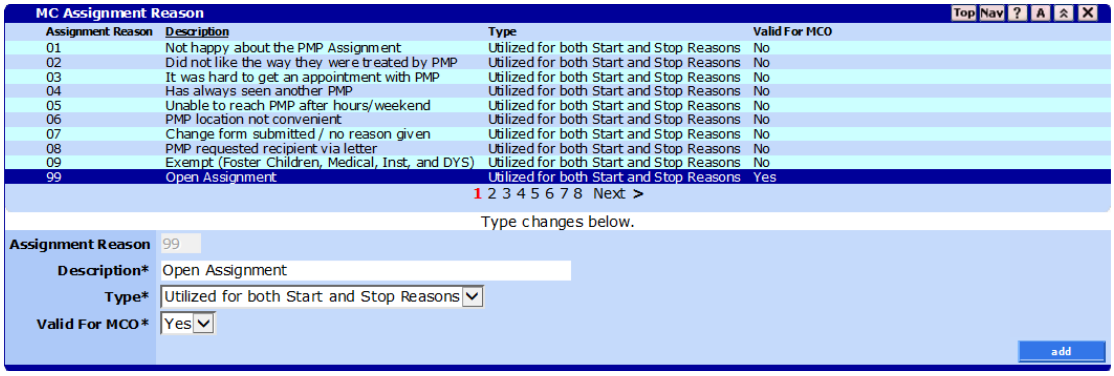
6.36.1 Codes-MC Assignment Reason Panel Narrative

The MC Assignment Reason panel allows the user to maintain the start and stop reason codes/descriptions for Managed Care assignments. Do **NOT** use special characters in description as it may cause it not to appear in the Start/Stop dropdowns on the PMP Assignment History panel.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [MC Assignment Reason]

6.36.2 Codes-MC Assignment Reason Panel Layout



6.36.3 Codes-MC Assignment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Assignment Reason information.	Button	N/A	0
Assignment Reason	Indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change. MDP stands for Mass Disenrollment Process, MTRP stands for Mass Transfer & Release Process.	Field	Character	2
Description	Description of the reason a recipient was assigned to a PMP, or the recipient's reason for disenrollment from a PMP.	Field	Character	50
Type	Indicates if a reason code may be used as only a start reason, as only a stop reason, or both a start and stop reason.	Combo Box	Drop Down List Box	0
Valid For MCO	Identify whether the assignment reason is valid for MCO.	Combo Box	Drop Down List Box	1

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6.36.4 Codes-MC Assignment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Assignment Reason	Field	1	Assignment Reason is required.	Enter an Assignment Reason.
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Assignment Reason. A duplicate Assignment Reason cannot be entered.
Description	Field	1	Description is required.	Enter a Description.
Type	Field	1	Type is required.	Select a Type from the Drop Down list.

6.36.5 Codes-MC Assignment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 Codes-MC Assignment Reason Panel Accessibility

6.36.6.1 To Access the MC Assignment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select MC Assignment Reason.	MC Assignment Reason panel displays.

6.36.6.2 To Add on the Capitation Reason Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Assignment Reason.	
3	Enter Description.	
4	Enter **Type**.	
5	Click **Save**.	MC Assignment Reason information is saved.

6.36.6.3 To Update on the Capitation Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	

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Step	Action	Response
3	Click **Save**.	MC Assignment Reason information is saved.

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6.37 CODES-MC SPECIAL CONDITION PANEL OVERVIEW

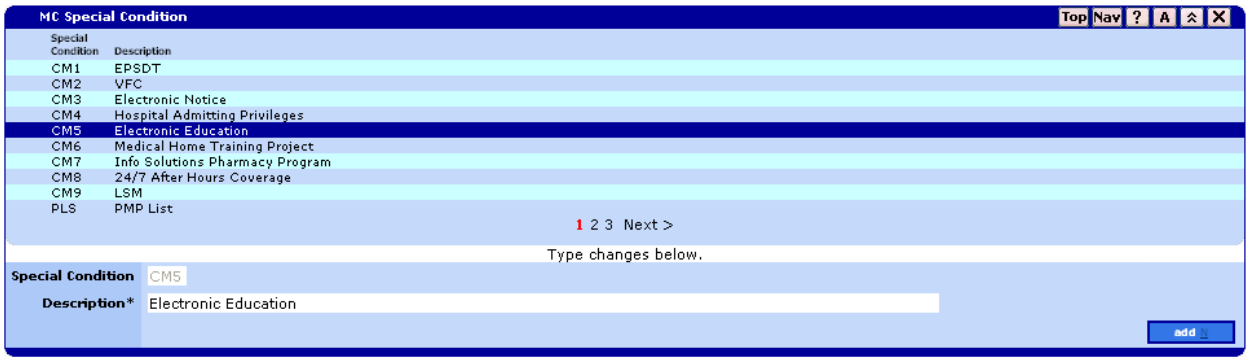
6.37.1 Codes MC Special Condition Panel Narrative

The MC Special Condition panel allows the user to maintain the Managed Care special condition codes and descriptions. Special Conditions are implementation-specific, but examples may include Disaster Survivors, Case Management Fee components, etc.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [MC Special Condition]

6.37.2 Codes-MC Special Condition Panel Layout



6.37.3 Codes-MC Special Condition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition information.	Button	N/A	0
Description	Description of the Special Condition.	Field	Character	100
Special Condition	Code representing the Special Condition.	Field	Character	3

6.37.4 Codes-MC Special Condition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Special Condition	Field	1	Special Condition is required.	Enter a Special Condition.
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Special Condition. A duplicate Special Condition cannot be entered.

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6.37.5 Codes-MC Special Condition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Codes-MC Special Condition Panel Accessibility

6.37.6.1 To Access the MC Special Condition Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select MC Special Condition.	MC Special Condition panel displays.

6.37.6.2 To Add on the MC Special Condition Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Special Condition.	
3	Enter Description.	
4	Click **Save**.	MC Special Condition information is saved.

6.37.7 To Update on the MC Special Condition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	MC Special Condition information is saved.

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6.38 CODES-MC SPECIAL CONDITION CLASS PANEL OVERVIEW

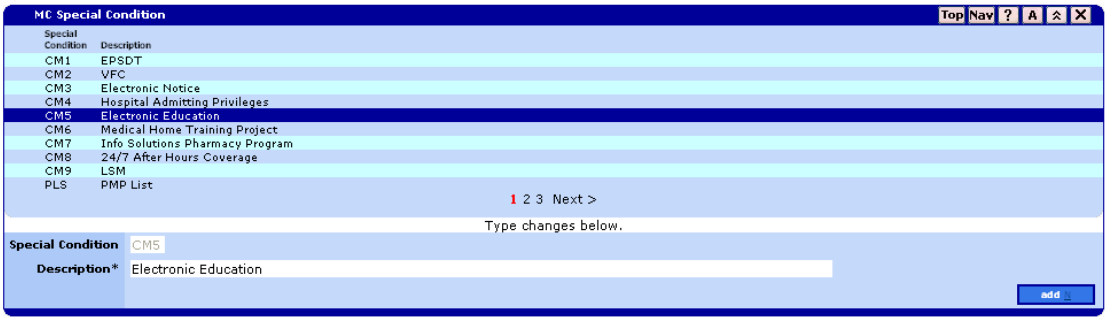
6.38.1 Codes-MC Special Condition Class Panel Narrative

The MC Special Condition Class panel associates Managed Care Special Conditions with a Managed Care entity such as a Recipient or Managed Care Provider. Additional classes may be defined as needed in each implementation.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [MC Special Condition Class]

6.38.2 Codes-MC Special Condition Class Panel Layout



6.38.3 Codes-MC Special Condition Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition information.	Button	N/A	0
Description	Description of the s Special Condition Class.	Field	Character	50
Special Condition Class	Code representing the class of the special condtion, such as PMP or RCP.	Field	Character	3

6.38.4 Codes-MC Special Condition Class Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter a Description.
Special Condition Class	Field	1	A Special Condition Class is required.	Enter a Special Condition Class.
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Special Condition Class. A duplicate Special Condition Class cannot be entered.

6.38.5 Codes-MC Special Condition Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.38.6 Codes-MC Special Condition Class Panel Accessibility

6.38.6.1 To Access the MC Special Condition Class Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select MC Special Condition Class.	MC Special Condition Class panel displays.

6.38.6.2 To Add on the MC Special Condition Class Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Special Condition Class.	
3	Enter Description.	
4	Click **Save**.	MC Special Condition Class information is saved.

6.38.6.3 To Update on the MC Special Condition Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	MC Special Condition Class information is saved.

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6.39 CODES-MC SPECIAL CONDITION TYPE PANEL OVERVIEW

6.39.1 Codes-MC Special Condition Type Panel Narrative

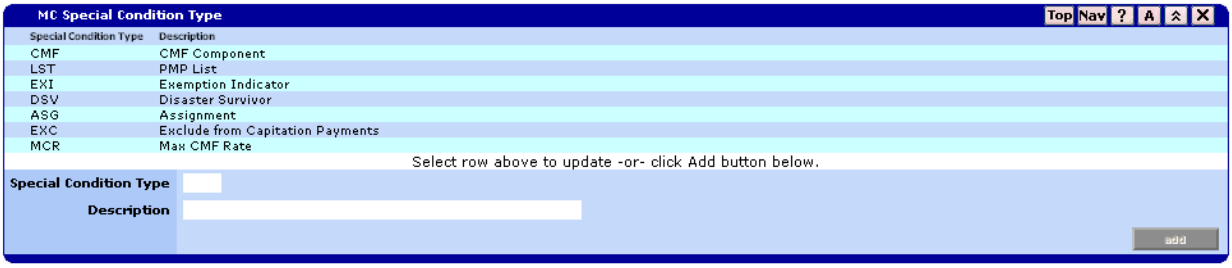
The MC Special Condition Type panel allows the user to maintain the Managed Care special condition type/descriptions. A Special Condition Type allows a class of special conditions to be used for multiple purposes. For example, a recipient special condition may be used for capitation override purposes as well as other reporting purposes.

The Recipient Special Condition Class has a special condition type of 'CAP' that will over-ride aid-category grouping used in the rate cell determination. The Special Condition Type of 'EXM' will exempt a recipient from Managed Care assignment. Each implementation can add additional special condition types as needed.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [MC Special Condition Type]

6.39.2 Codes-MC Special Condition Type Panel Layout



6.39.3 Codes-MC Special Condition Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition information.	Button	N/A	0
Description	Description of the Special Condition Type.	Field	Character	50
Special Condition Type	Code representing the type of the special condition, such as CMF, EXI, and DSV.	Field	Character	3

6.39.4 Codes-MC Special Condition Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	A description is required.	Enter a Description.
Special Condition Type	Field	1	Special condition type is required.	Enter a Special Condition Type.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Special Condition Type. A duplicate Special Condition Type cannot be entered.

6.39.5 Codes-MC Special Condition Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 Codes-MC Special Condition Type Panel Accessibility

6.39.6.1 To Access the MC Special Condition Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select MC Special Condition Type.	MC Special Condition Type panel displays.

6.39.6.2 To Add on the MC Special Condition Type Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Special Condition Type.	
3	Enter Description.	
4	Click **Save**.	MC Special Condition Type information is saved.

6.39.6.3 To Update on the MC Special Condition Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	MC Special Condition Type information is saved.

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6.40 CODES-PMP DISENROLLMENT REASON PANEL OVERVIEW

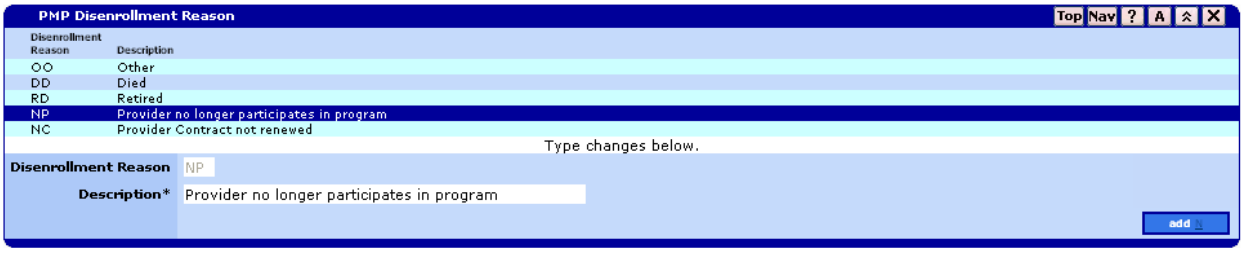
6.40.1 Codes-PMP Disenrollment Reason Panel Narrative

The PMP Disenrollment Reason panel allows the user to maintain the various reason codes/descriptions that a Managed Care provider may select when disenrolling from a program.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [PMP Disenrollment Reason]

6.40.2 Codes-PMP Disenrollment Reason Panel Layout



6.40.3 Codes-PMP Disenrollment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition information.	Button	N/A	0
Description	Description of the Disenrollment Reason code.	Field	Character	50
Disenrollment Reason	Identifies the Disenrollment Reason.	Field	Character	2

6.40.4 Codes-PMP Disenrollment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Disenrollment Reason	Field	1	Disenrollment Reason is required.	Enter a Disenrollment Reason.
	Field	2	A duplicate record cannot be saved.	Verify the data entered and enter a valid Disenrollment Reason. A duplicate Disenrollment Reason cannot be entered.

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6.40.5 Codes-PMP Disenrollment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 Codes-PMP Disenrollment Reason Panel Accessibility

6.40.6.1 To Access the PMP Disenrollment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Disenrollment Reason.	PMP Disenrollment Reason panel displays.

6.40.6.2 To Add on the PMP Disenrollment Reason Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Disenrollment Reason.	
3	Enter Description.	
4	Click **Save**.	PMP Disenrollment Reason information is saved.

6.40.6.3 To Update on the PMP Disenrollment Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Disenrollment Reason information is saved.

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6.41 CODES-PMP ENROLLMENT STATUS PANEL OVERVIEW

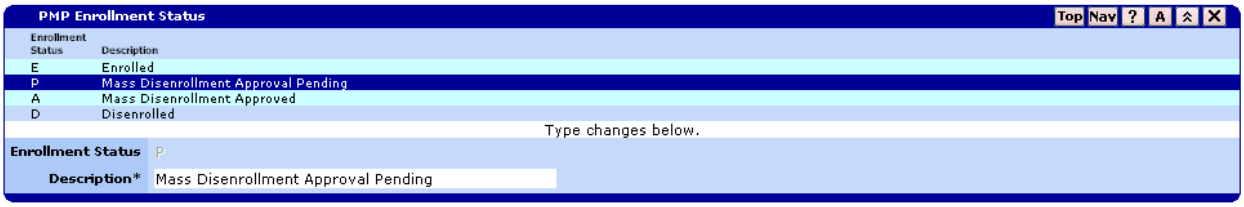
6.41.1 Codes-PMP Enrollment Status Panel Narrative

The PMP Enrollment Status panel allows the user to maintain the statuses that a Managed Care provider may have during the course of their enrollment. The Description can be changed, but no new Ernollment Statuses added.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [PMP Enrollment Status]

6.41.2 Codes-PMP Enrollment Status Panel Layout



6.41.3 Codes-PMP Enrollment Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the Enrollment Status Code.	Field	Character	50
Enrollment Status	Identifies the Enrollment status code, it is read only.	Field	Character	1

6.41.4 Codes-PMP Enrollment Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.

6.41.5 Codes-PMP Enrollment Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 Codes-PMP Enrollment Status Panel Accessibility

6.41.6.1 To Access the PMP Enrollment Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Enrollment Status.	PMP Enrollment Status panel displays.

6.41.6.2 To Update on the PMP Enrollment Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Enrollment Status information is saved.

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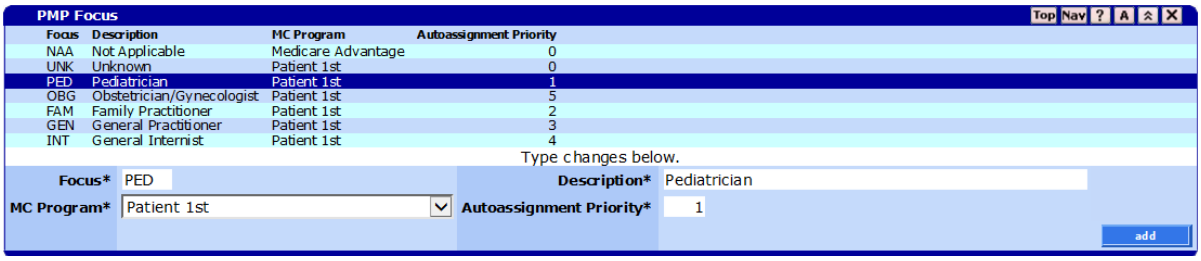
6.42 CODES-PMP FOCUS PANEL OVERVIEW

6.42.1 Codes-PMP Focus Panel Narrative

The PMP Focus panel allows the user to maintain the different focus codes and descriptions that a Managed Care provider can select. Focuses are implementation-specific, but examples include: General Practitioner, Pediatrician, OB/GYN and HMO/MCO. For Alabama, Focus is currently information only, no processing is based on the values within this table. Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [PMP Focus]

6.42.2 Codes-PMP Focus Panel Layout



6.42.3 Codes-PMP Focus Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Focus information.	Button	N/A	0
Autoassignment Priority	Specific priority order for the focuses to receive and the order that they should be processed (1 = highest priority, 2 = next, etc.). Format is 99.	Field	Number (Integer)	2
Description	Description of the focus.	Field	Character	100
Focus	Unique code that identifies the focus.	Field	Character	3
MC Program	Managed Care program for this PMP Focus.	Combo Box	Drop Down List Box	0

6.42.4 Codes-PMP Focus Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a description.
Focus	Field	1	Focus is required.	Enter a code for the focus.
	Field	2	A duplicate record cannot be saved.	Verify the Focus and MC Program selected. A duplicate Focus/MC Program combination can not be entered.
MC Program	Field	1	A valid MC Program is required.	Select a MC Program from the Drop Down list.

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6.42.5 Codes-PMP Focus Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 Codes-PMP Focus Panel Accessibility

6.42.6.1 To Access the PMP Focus Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Focus.	PMP Focus panel displays.

6.42.6.2 To Add on the PMP Focus Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **Focus**.	
3	Enter Description.	
4	Enter MC Program.	
5	Enter Autoassignment Priority.	
6	Click **Save**.	PMP Focus information is saved.

6.42.6.3 To Update on the PMP Focus Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Focus information is saved.

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6.43 CODES-PMP TRANSFER-DISENROLLMENT REASON PANEL OVERVIEW

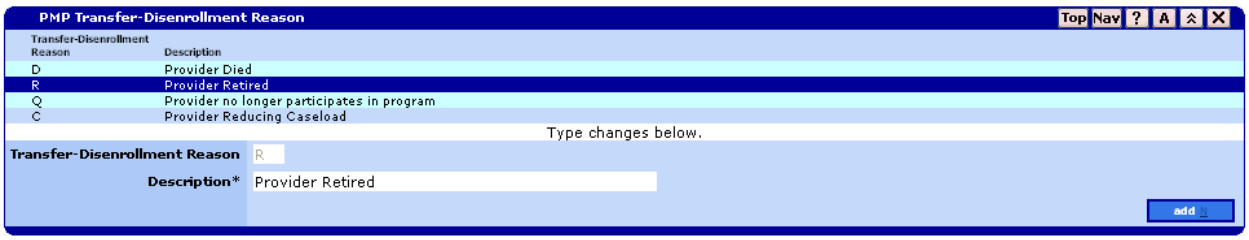
6.43.1 Codes-PMP Transfer-Disenrollment Reason Panel Narrative

The PMP Transfer-Disenrollment Reason panel allows the user to maintain the various reason codes/descriptions that a Managed Care provider may select when transferring or disenrolling selected recipients from their panel.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Codes] - [PMP Transfer-Disenrollment Reason]

6.43.2 Codes-PMP Transfer-Disenrollment Reason Panel Layout



6.43.3 Codes-PMP Transfer-Disenrollment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Transfer-Disenrollment Reason information.	Button	N/A	0
Description	Description of the Transfer-Disenrollment Reason code.	Field	Character	50
Transfer-Disenrollment Reason	Identifies the Transfer-Disenrollment Reason.	Field	Character	2

6.43.4 Codes-PMP Transfer-Disenrollment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Transfer-Disenrollment Reason	Field	10	Transfer-Disenrollment Reason is required.	Enter a Transfer-Disenrollment Reason.

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6.43.5 Codes-PMP Transfer-Disenrollment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Codes-PMP Transfer-Disenrollment Reason Panel Accessibility

6.43.6.1 To Access the PMP Transfer-Disenrollment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Transfer-Disenrollment Reason.	PMP Transfer-Disenrollment Reason panel displays.

6.43.6.2 To Add on the PMP Transfer-Disenrollment Reason Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Transfer-Disenrollment Reason.	
3	Enter Description.	
4	Click **Save**.	PMP Transfer-Disenrollment Reason information is saved.

6.43.6.3 To Update on the PMP Transfer-Disenrollment Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Transfer-Disenrollment Reason information is saved.

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6.44 CODES-PMP TRANSFER-DISENROLLMENT STATUS PANEL OVERVIEW

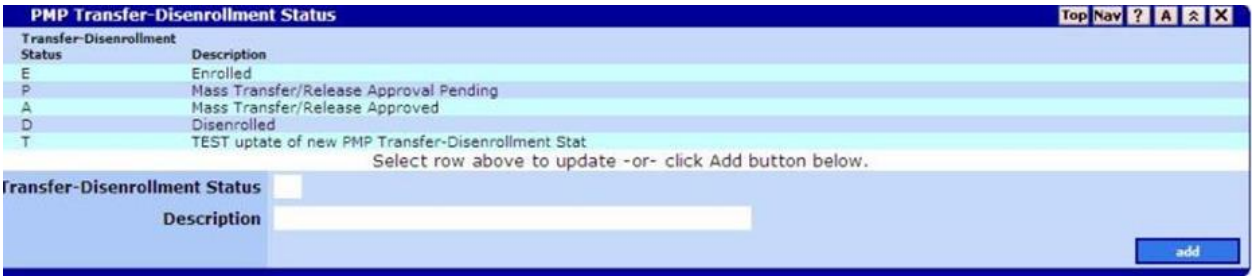
6.44.1 Codes-PMP Transfer-Disenrollment Status Panel Narrative

The PMP Transfer-Disenrollment Status panel allows the user to maintain the statuses that a Managed Care provider may have during the course of their selective Transfer-Disenrollment of recipients.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] - [Related Data] - [Codes] - [Potential MC Recipient Reason]

6.44.2 Codes-PMP Transfer-Disenrollment Status Panel Layout



6.44.3 Codes-PMP Transfer-Disenrollment Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP Transfer-Disenrollment Reason information.	Button	N/A	0
Description	Description of the Transfer-Disenrollment Status code.	Field	Character	50
Transfer-Disenrollment Status	Identifies the Transfer-Disenrollment Status.	Field	Character	1

6.44.4 Codes-PMP Transfer-Disenrollment Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Transfer-Disenrollment Status	Field	10	Transfer-Disenrollment Status is required.	Enter a Transfer-Disenrollment Status.

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6.44.5 Codes-PMP Transfer-Disenrollment Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.44.6 Codes-PMP Transfer-Disenrollment Status Panel Accessibility

6.44.6.1 To Access the PMP Transfer-Disenrollment Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Transfer-Disenrollment Status.	PMP Transfer-Disenrollment Status panel displays.

6.44.6.2 To Add on the PMP Transfer-Disenrollment Status Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter Transfer-Disenrollment Status.	
3	Enter Description.	
4	Click **Save**.	PMP Transfer-Disenrollment Status information is saved.

6.44.6.3 To Update on the PMP Transfer-Disenrollment Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Transfer-Disenrollment Status information is saved.

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6.45 CODES-PMP VENDOR PANEL OVERVIEW

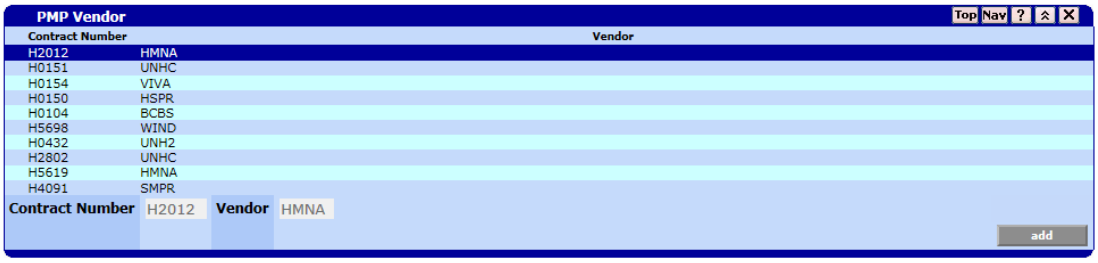
6.45.1 Codes-PMP Vendor Panel Narrative

The PMP Vendor panel allows the user to maintain the list of valid Medicare Advantage vendors by Contract Number and 4 character Vendor name.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] - [Related Data] - [Codes] - [PMP Vendor]

6.45.2 Codes-PMP Vendior Panel Layout



6.45.3 Codes-PMP VendorPanel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP vendor.	Button	N/A	0
Contract Number	EDB Contract Number.	Field	Character	5
Vendor	Vendor acronym - BCBS, HSPR, VIVA, UNHC or WIND.	Field	Character	4

6.45.4 Codes-PMP Vendor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Contract Number	Field	20	Contract Number is required.	Enter a valid Vendor Contract Number. It should exist on the EDB GHO table.
Vendor	Field	10	Vendor is required.	Add a valid Vendor acronym.

6.45.5 Codes-PMP Vendor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Codes-PMP Vendor Panel Accessibility

6.45.6.1 To Access the PMP Vendor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select **PMP Vendor**.	PMP Vendor panel displays.

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6.45.6.2 To Add on the PMP Vendor Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **Contract Description**.	
3	Enter **Vendor**.	
4	Click **Save**.	PMP Vendor information is saved.

6.45.6.3 To Update on the PMP Transfer-Disenrollment Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Transfer-Disenrollment Status information is saved.

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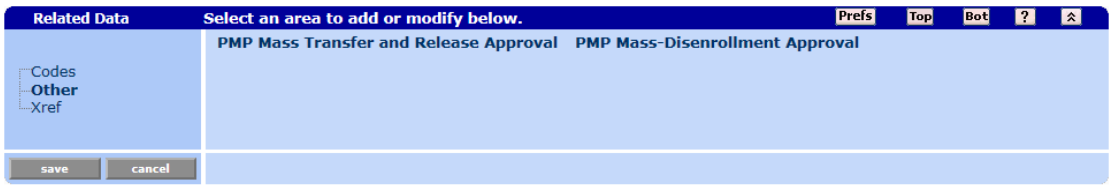
6.46 RELATED DATA – OTHER PAGE OVERVIEW

6.46.1 Related Data - Other Page Narrative

This page displays the related data for Managed Care containing Other. This panel is inquiry only.

Navigation Path: [Managed Care] – [Related Data] [Other]

6.46.2 Related Data – Other Page Layout



6.46.3 Related Data – Other Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Related Data-Other page.	Button	N/A	0
PMP Mass Transfer & Release Approval	Link for PMP Mass Transfer and Release Approval panel.	Hyperlink	N/A	0
PMP Mass-Disenrollment Approval	Link for PMP Mass-Disenrollment Approval panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data-Other page.	Button	N/A	0

6.46.4 Related Data – Other Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.46.5 Related Data – Other Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 Related Data – Other Page Accessibility

6.46.6.1 To Access the Related Data – Other Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Click **Other**.	Related Data – Other page displays.

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6.48 OTHER-PMP MASS-TRANSFER & RELEASE APPROVAL PANEL OVERVIEW

6.48.1 Other PMP Mass-Transfer & Release Approval Panel Narrative

The Other PMP Mass-Transfer & Release Approval panel allows the user to approve mass-transfer/releases so that they can be processed through the batch cycle, where assignments get end-dated, new assignments created, etc.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Other] - [PMP Mass-Transfer & Release Approval]

6.48.2 Other-PMP Mass-Transfer & Release Approval Panel Layout

6.48.3 Other-PMP Mass-Transfer & Release Approval Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Min	Minimum age of the recipients the PMP wishes to transfer/release.	Field	Number (Integer)	3
Age Max	Maximum age of the recipients the PMP wishes to transfer/release.	Field	Number (Integer)	3
Age Min/Max	Minimum age of the recipients the PMP wishes to transfer/release. / Maximum age of the recipients the PMP wishes to transfer/release.	Field	Number (Integer)	6
County	Name of the county from which the provider is transferring/releasing recipients.	Field	Character	2
Delete	Allows the user to remove PMP Mass Transfer & Release Approval information.	Button	N/A	0
End Date	Date the system has been requested to use to end date any recipient's current assignment that is included in the Mass Transfer or Release request.	Field	Date (MM/DD/CCYY)	8
Letters	Indicates what letters are to be produced as a result of this transfer/release.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
PMP ID	Displays the Provider identification of the transferring/releasing provider.	Field	Character	15
PMP ID Type (no label)	The Primary Medical Provider (PMP) identification type.	Field	Character	3
PMP Name	Provider's individual name (format Last Name, First Name, Middle Initial) or the business name.	Field	Character	50
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Transfer Max	Maximum number of recipients the PMP wishes to transfer/release.	Field	Number (Integer)	6
Transfer PMP ID	Provider identification of the receiving provider.	Field	Character	15
Transfer PMP Name	Transfer PMP provider individual name (format Last Name, First Name, Middle Initial) or the business name.	Field	Character	50
Transfer Start Date	Date the system has been requested to use as the new assignment date for the recipients.	Field	Date (MM/DD/CCYY)	8
Transfer Status	Transfer/release status description.	Combo Box	Drop Down List Box	0
Transfer/Release Reason	PMP transfer/release reason description.	Combo Box	Drop Down List Box	0

6.48.4 Other-PMP Mass-Transfer & Release Approval Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.48.5 Other-PMP Mass-Transfer & Release Approval Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.48.6 Other-PMP Mass-Transfer & Release Approval Panel Accessibility

6.48.6.1 To Access the PMP Mass-Transfer & Release Approval Other Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Mass-Transfer & Release Approval.	PMP Mass-Transfer & Release Approval panel displays.

6.48.6.2 To Update on the PMP Mass-Transfer & Release Approval Other Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Mass-Transfer & Release Approval information is saved.

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6.49 OTHER PMP MASS-DISENROLLMENT APPROVAL PANEL OVERVIEW

6.49.1 Other PMP Mass-Disenrollment Approval Panel Narrative

The PMP Mass-Disenrollment Approval panel allows the user to approve mass-disenrollments so that they can be processed through the batch cycle, where assignments get end-dated, new assignments created, etc.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Other] - [PMP Mass-Disenrollment Approval]

6.49.2 Other PMP Mass-Disenrollment Approval Panel Layout

6.49.3 Other PMP Mass-Disenrollment Approval Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Disenroll Code	Contains the code and description for the PMP disenrollment.	Combo Box	Drop Down List Box	0
Disenroll Date	Date that the PMP has elected to disenroll from the specified region.	Field	Date (MM/DD/CCYY)	8
Disenroll Status	Contains the disenrollment status description.	Combo Box	Drop Down List Box	0
Letters	Indicates where to produce letters for the mass disenrollment.	Field	Character	3
MC Program	Identification of the Managed Care program.	Field	Character	30
MC Region	Identification of the Managed Care region.	Field	Character	30
PMP ID	Primary Medical Provider (PMP) ID and ID Type.	Field	Character	15
SPSL	The sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Transfer PMP ID	Primary Medical Provider (PMP) Identification number of the provider who is receiving the transferred recipients.	Field	Character	18

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Field	Description	Field Type	Data Type	Length
Transfer PMP Name	Transfer PMP provider individual name (format Last Name, First Name Middle initial) or the business name.	Field	Character	50
Transfer SPSL	Sak_pmp_ser_loc for the Transfer PMP ID. Helps to uniquely define the provider's different service locations.	Field	Number (Integer)	9
Transfer Start Date	The date that the PMP assignments will start with the transfer PMP.	Field	Date (MM/DD/CCYY)	8

6.49.4 Other PMP Mass-Disenrollment Approval Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Disenroll Status	Field	10070	Disenrollment Status may only change to Enrolled.	Verify that correct Disenrollment Status has been picked.
	Field	10071	Disenrollment Status may only change to Mass Disenrollment Approval Pending.	Verify that correct Disenrollment Status has been picked.
	Field	10072	Disenrollment Status may only change to Enrolled or Mass Disenrollment Approved.	Verify that correct Disenrollment Status has been picked.
	Field	10073	Disenrollment Status may only change to Enrolled or Mass Disenrollment Approval Pending.	Verify that correct Disenrollment Status has been picked.
	Field	10079	Disenrollment Status may not change.	Verify that Disenrollment Status was not changed.
	Field	10083	Disenroll Date must be less than 12/31/2299.	Update the Disenroll date to < 12/31/2299.
	Field	10084	Disenroll Date must be same as End Date.	Set Disenroll date to same as end date.

6.49.5 PMP Mass-Disenrollment Approval Other Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.49.6 Other PMP Mass-Disenrollment Approval Panel Accessibility

6.49.6.1 To Access the PMP Mass-Disenrollment Approval Other Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select PMP Mass-Disenrollment Approval.	PMP Mass-Disenrollment Approval panel displays.

6.49.6.2 To Update on the PMP Mass-Disenrollment Approval Other Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP Mass-Disenrollment Approval information is saved.

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6.50 RELATED DATA – XREF PAGE OVERVIEW

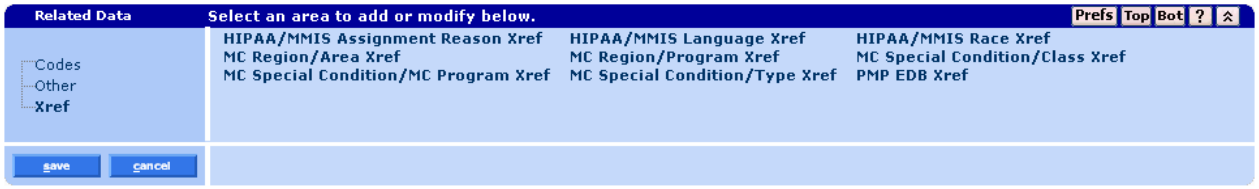
6.50.1 Related Data - Other Page Narrative

The Xref Related Data page is used to view and maintain Drug Rebate related cross reference code tables.

This panel is inquiry only.

Navigation Path: [Managed Care] – [Related Data] [Xref]

6.50.2 Related Data – Xref Page Layout



6.50.3 Related Data – Xref Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Related Data-Xref page.	Button	N/A	0
HIPAA/MMIS Assignment Reason Xref	Link for HIPAA/MMIS Assignment Reason Xref panel.	Hyperlink	N/A	0
HIPAA/MMIS Language Xref	Link for HIPAA/MMIS Language Xref panel.	Hyperlink	N/A	0
HIPAA/MMIS Race Xref	Link for HIPAA/MMIS Race Xref panel.	Hyperlink	N/A	0
MC Region/Area Xref	Link for MC Region/Area Xref panel.	Hyperlink	N/A	0
MC Region/Program Xref	Link for MC Region/Program Xref panel.	Hyperlink	N/A	0
MC Special Condition/Class Xref	Link for MC Special Condition/Class Xref panel.	Hyperlink	N/A	0
MC Special Condition/MC Program Xref	Link for MC Special Condition/MC Program Xref panel.	Hyperlink	N/A	0
MC Special Condition/Type Xref	Link for MC Special Condition/Type Xref panel.	Hyperlink	N/A	0
PMP EDB Xref	Link for PMP EDB Xref panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Related Data-Xref page.	Button	N/A	0

6.50.4 Related Data – Xref Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

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6.50.5 Related Data – Xref Page Extra Features

Field	Field Type
No extra features found for this page.	

6.50.6 Related Data – Xref Page Accessibility

6.50.6.1 To Access the Related Data – Xref Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.

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6.51 XREF HIPAA MMIS ASSIGNMENT REASON XREF PANEL OVERVIEW

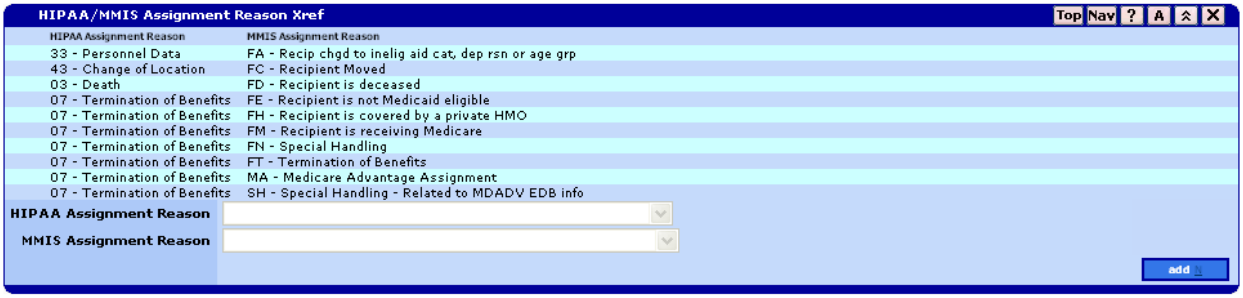
6.51.1 Xref HIPAA MMIS Assignment Reason Xref Panel Narrative

The Xref HIPAA MMIS Assignment Reason Xref panel serves as a cross-reference of the AMMIS assignment start/stop reason codes/descriptions and the corresponding HIPAA codes/descriptions.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [HIPAA/MMIS Assignment Reason Xref]

6.51.2 Xref HIPAA MMIS Assignment Reason Xref Panel Layout



6.51.3 Xref HIPAA MMIS Assignment Reason Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add HIPAA MMIS Assignment Reason Xref information.	Button	N/A	0
HIPAA Assignment Reason	Managed care eligibility reason codes for HIPAA. Format is code (length 2), “ - “, and description (length 50).	Combo Box	Drop Down List Box	0
MMIS Assignment Reason	PMP assignment reason codes and descriptions used to begin and end a recipient’s assignment to a PMP. Format is code (length 2), “ - “, and description (length 100).	Combo Box	Drop Down List Box	0

6.51.4 Xref HIPAA MMIS Assignment Reason Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
HIPAA Assignment Reason	Field	1	A valid HIPAA Assignment Reason is required.	Select a HIPAA Assignment Reason from the Drop Down list.
MMIS Assignment Reason	Field	1	A valid MMIS Assignment Reason is required.	Select a MMIS Assignment Reason from the Drop Down list.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Verify the MMIS Assignment Reason and HIPAA Assignment Reason selected. A duplicate MMIS Assignment Reason/HIPAA Assignment Reason combination can not be entered.

6.51.5 Xref HIPAA MMIS Assignment Reason Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 Xref HIPAA MMIS Assignment Reason Xref Panel Accessibility

6.51.6.1 To Access the HIPAA MMIS Assignment Reason Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select HIPAA/MMIS Assignment Reason Xref.	HIPAA/MMIS Assignment Reason Xref panel displays.

6.51.6.2 To Add on the HIPAA MMIS Assignment Reason Xref Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter MMIS Assignment Reason.	
3	Enter HIPAA Assignment Reason.	
4	Click **Save**.	HIPAA/MMIS Assignment Reason Xref information is saved.

6.51.6.3 To Update on the HIPAA MMIS Assignment Reason Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	HIPAA/MMIS Assignment Reason Xref information is saved.

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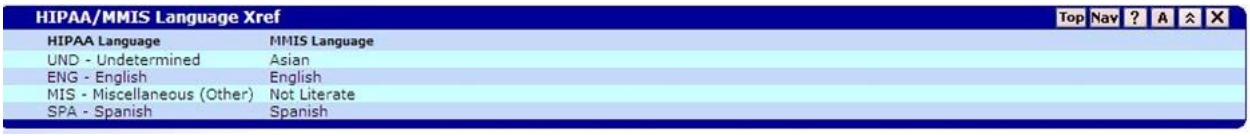
6.52 XREF-HIPAA MMIS LANGUAGE XREF PANEL OVERVIEW

6.52.1 Xref-HIPAA MMIS Language Xref Panel Narrative

The Xref HIPAA MMIS Language Xref panel serves as a cross-reference of the MMIS race codes/descriptions and the corresponding HIPAA codes/descriptions.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [HIPAA/MMIS Language Xref]

6.52.2 Xref-HIPAA MMIS Language Xref Panel Layout



6.52.3 Xref-HIPAA MMIS Language Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
HIPAA Language Code	This is the language codes for HIPAA (3 character), " - ", and the HIPAA description for a specific language (50 characters).	Field	Character	55
MMIS Language Code	This is MMIS description for a specific language.	Field	Character	12

6.52.4 Xref-HIPAA MMIS Language Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.52.5 Xref-HIPAA MMIS Language Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.6 Xref-HIPAA MMIS Language Xref Panel Accessibility

6.52.6.1 To Access the HIPAA MMIS Language Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select HIPAA/MMIS Language Xref.	HIPAA/MMIS Language Xref panel displays.

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6.53 XREF-HIPAA MMIS RACE XREF PANEL OVERVIEW

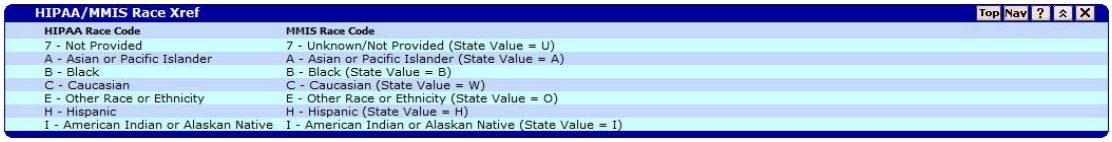
6.53.1 Xref-HIPAA MMIS Race Xref Panel Narrative

The Xref HIPAA MMIS Race Xref panel serves as a cross-reference of the AMMIS race codes/descriptions and the corresponding HIPAA codes/descriptions.

This panel is an inquiry only panel.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [HIPAA/MMIS Race Xref]

6.53.2 Xref-HIPAA MMIS Race Xref Panel Layout



HIPAA/MMIS Race Xref

HIPAA Race Code	MMIS Race Code
7 - Not Provided	7 - Unknown/Not Provided (State Value = U)
A - Asian or Pacific Islander	A - Asian or Pacific Islander (State Value = A)
B - Black	B - Black (State Value = B)
C - Caucasian	C - Caucasian (State Value = W)
E - Other Race or Ethnicity	E - Other Race or Ethnicity (State Value = O)
H - Hispanic	H - Hispanic (State Value = H)
I - American Indian or Alaskan Native	I - American Indian or Alaskan Native (State Value = I)

6.53.3 Xref-HIPAA MMIS Race Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
HIPAA Race Code	HIPAA-specific race code (3 characters)" - ", and the HIPAA-specific race code description (50 characters).	Field	Character	56
MMIS Race Code	MMIS-specific race code (2 characters), " - ", and the MMIS-specific race code description (100 characters).	Field	Character	104

6.53.4 Xref-HIPAA MMIS Race Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.53.5 Xref-HIPAA MMIS Race Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Xref-HIPAA MMIS Race Xref Panel Accessibility

6.53.6.1 To Access the HIPAA MMIS Race Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select HIPAA/MMIS Race Xref.	HIPAA/MMIS Race Xref panel displays.

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6.54 XREF-MC REGION/AREA XREF PANEL OVERVIEW

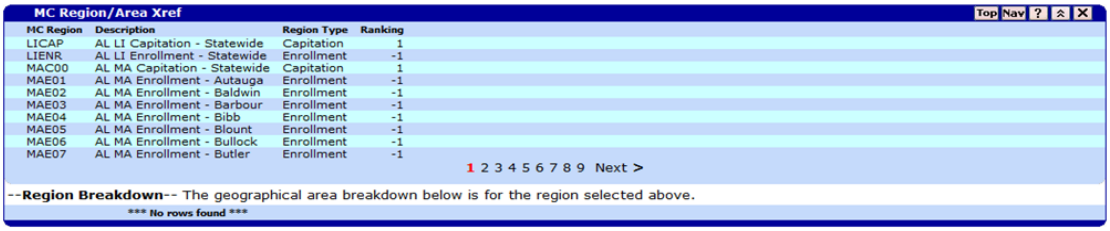
6.54.1 Xref-MC Region/Area Xref Panel Narrative

The Xref MC Region Area Xref panel serves as a cross-reference between the Managed Care regions and the areas (specific counties, zip codes, etc) that they are comprised of.

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [MC Region/Area Xref]

6.54.2 Xref-MC Region/Area Xref Panel Layout



MC Region/Area Xref

MC Region	Description	Region Type	Ranking
LICAP	AL LI Capitation - Statewide	Capitation	1
LIENR	AL LI Enrollment - Statewide	Enrollment	-1
MAC00	AL MA Capitation - Statewide	Capitation	1
MAE01	AL MA Enrollment - Autauga	Enrollment	-1
MAE02	AL MA Enrollment - Baldwin	Enrollment	-1
MAE03	AL MA Enrollment - Barbour	Enrollment	-1
MAE04	AL MA Enrollment - Bibb	Enrollment	-1
MAE05	AL MA Enrollment - Blount	Enrollment	-1
MAE06	AL MA Enrollment - Bullock	Enrollment	-1
MAE07	AL MA Enrollment - Butler	Enrollment	-1

1 2 3 4 5 6 7 8 9 Next >

--Region Breakdown-- The geographical area breakdown below is for the region selected above.

*** No rows found ***

6.54.3 Xref-MC Region/Area Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Area Code (Region)	Area Code for the region.	Field	Character	5
Area Type (Region)	Area Type for the region.	Field	Character	15
Description	Description or name of the Managed Care region.	Field	Character	50
Effective Date (Region)	Effective date for the region.	Field	Date (MM/DD/CCYY)	8
End Date (Region)	End date for the region.	Field	Date (MM/DD/CCYY)	8
MC Region	Code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.	Field	Character	5
Ranking	Field specifies how regions rank when they overlap. This is primarily for regions created for capitation rate overrides.	Field	Number [Integer}	4
Region Type	Field defines the type of the region. Values are C=Capitation, E=Enrollment.	Field	Character	10

6.54.4 Xref-MC Region/Area Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.54.5 Xref-MC Region/Area Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 Xref-MC Region/Area Xref Panel Accessibility

6.54.6.1 To Access the MC Region/Area Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select MC Region/Area Xref.	MC Region/Area Xref panel displays.

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6.55 XREF MC REGION/PROGRAM XREF PANEL OVERVIEW

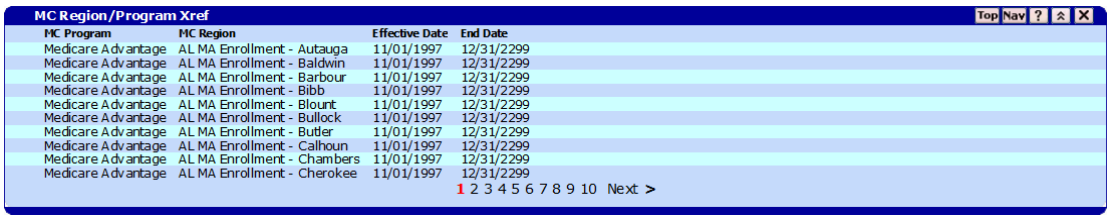
6.55.1 Xref MC Region/Program Xref Panel Narrative

The Xref MC Region/Program Xref panel serves as a cross-reference between the Managed Care regions and the programs/benefit plans that are valid for them.

This panel is an inquiry panel, but the audit button exists because this table is updated in a batch process.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [MC Region/Program Xref]

6.55.2 Xref MC Region/Program Xref Panel Layout



MC Region/Program Xref

MC Program	MC Region	Effective Date	End Date
Medicare Advantage	AL MA Enrollment - Autauga	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Baldwin	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Barbour	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Bibb	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Blount	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Bullock	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Butler	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Calhoun	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Chambers	11/01/1997	12/31/2299
Medicare Advantage	AL MA Enrollment - Cherokee	11/01/1997	12/31/2299

1 2 3 4 5 6 7 8 9 10 Next >

6.55.3 Xref MC Region/Program Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	Date that the program/region combination became valid.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the program/region combination is no longer valid.	Field	Date (MM/DD/CCYY)	8
MC Program	Valid Managed Care program/benefit plan.	Field	Character	5
MC Region	Regions within the state. Different regions can be created for different Managed Care programs.	Field	Character	50

6.55.4 Xref MC Region/Program Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.55.5 Xref MC Region/Program Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.55.6 Xref MC Region/Program Xref Panel Accessibility

6.55.6.1 To Access the MC Region/Area Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Managed Care and click Related Data.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select MC Region/Program Xref.	MC Region/Program Xref panel displays.

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6.56 XREF-MC SPECIAL CONDITION/CLASS XREF PANEL OVERVIEW

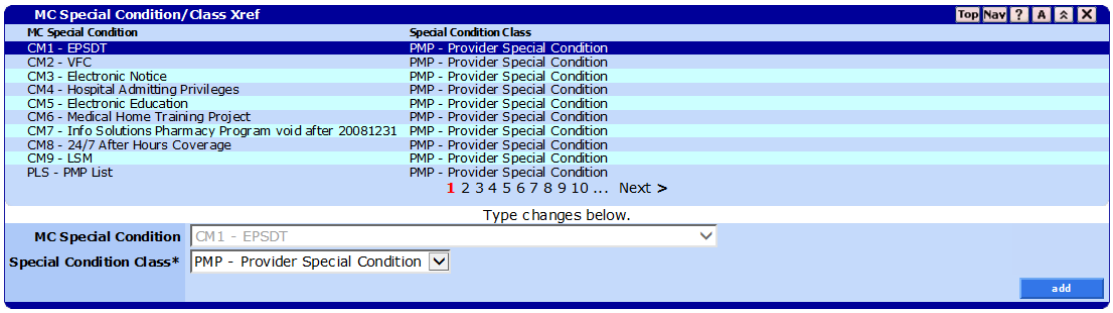
6.56.1 Xref-MC Special Condition/Class Xref Panel Narrative

The Xref MC Special Condition/Special Condition Class Xref panel identifies the special condition class of the special condition. A special condition class defines the entity that the special condition can impact, such as recipient or MC provider.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [MC Special Condition/Special Condition Class Xref]

6.56.2 Xref-MC Special Condition/Class Xref Panel Layout



6.56.3 Xref-MC Special Condition/Class Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Conditions/Class Xref information.	Button	N/A	0
MC Special Condition	List of available MC Special Conditions.	Combo Box	Drop Down List Box	0
Special Condition Class	List of available MC Special Condition classes.	Combo Box	Drop Down List Box	0

6.56.4 Xref-MC Special Condition/Class Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
MC Special Condition	Combo Box	1	MC Special Condition is required.	Select a MC Special Condition from the list.
Special Condition Class	Combo Box	2	A special condition class is required.	Select a special condition class from the list.

6.56.5 Xref-MC Special Condition/Class Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.56.6 Xref-MC Special Condition/Class Xref Panel Accessibility

6.56.6.1 To Access the MC Special Condition/Class Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data.**	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select **MC Special Condition/Class Xref**.	MC Special Condition/Class Xref panel displays.

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6.57 XREF-MC SPECIAL CONDITION/MC PROGRAM XREF PANEL OVERVIEW

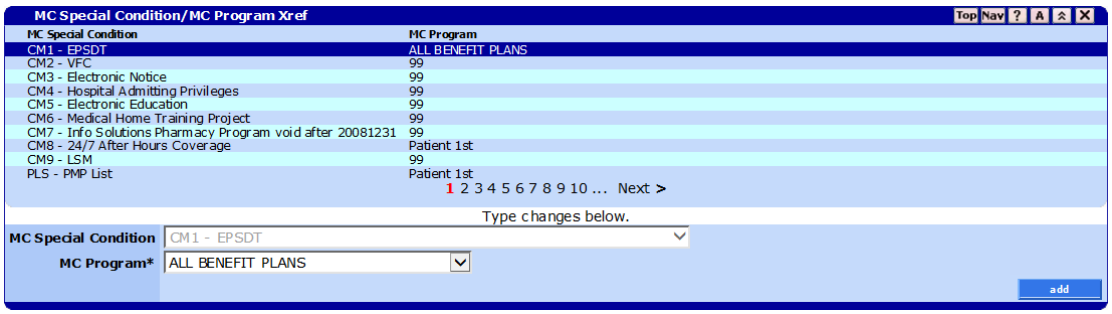
6.57.1 Xref-MC Special Condition/MC Program Xref Panel Narrative

The Xref MC Special Condition/MC Program Xref panel serves as a cross-reference between the Managed Care Special Conditions and the programs/benefit plans that are valid for them.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [MC Special Condition/MC Program Xref]

6.57.2 Xref-MC Special Condition/MC Program Xref Panel Layout



6.57.3 Xref-MC Special Condition/MC Program Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition/MC Program Xref information.	Button	N/A	0
MC Program	List of available MC Programs.	Combo Box	Drop Down List Box	0
MC Special Condition	List of available MC Special Conditions.	Combo Box	Drop Down List Box	0

6.57.4 Xref-MC Special Condition/MC Program Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
MC Program	Combo Box	2	MC Program is required.	Select an available MC Program from the list.
MC Special Condition	Combo Box	1	MC Special Condition is required.	Select a MC Special Condition from the list.

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6.57.5 Xref-MC Special Condition/MC Program Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.57.6 Xref-MC Special Condition/MC Program Xref Panel Accessibility

6.57.6.1 To Access the MC Special Condition/MC Program Xref Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data**.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select **MC Special Condition/MC Program Xref**.	MC Special Condition/MC Program Xref panel displays.

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6.58 XREF MC SPECIAL CONDITION/TYPE XREF PANEL OVERVIEW

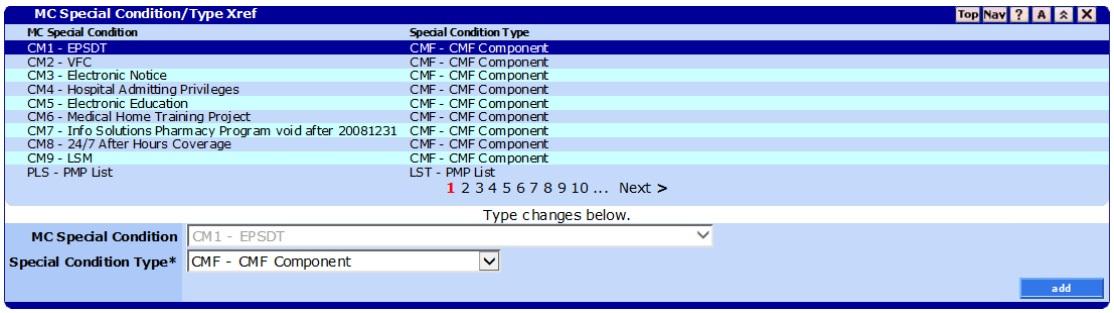
6.58.1 Xref MC Special Condition/Type Xref Panel Narrative

The Xref MC Special Condition/Special Condition Type Xref panel serves as a cross-reference between the Managed Care Special Conditions and the Special Condition Types that are valid for them.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [MC Special Condition/Special Condition Type Xref]

6.58.2 Xref MC Special Condition/Type Xref Panel Layout



6.58.3 Xref MC Special Condition/Type Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add MC Special Condition/Type Xref information.	Button	N/A	0
MC Special Condition	List of available MC Special Conditions.	Combo Box	Drop Down List Box	0
Special Condition Type	List of available MC Special Condition Types.	Combo Box	Drop Down List Box	0

6.58.4 Xref MC Special Condition/Type Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
MC Special Condition	Combo Box	2	A MC Special Condition is required.	Select a MC Special Condition from the list.
Special Condition Type	Combo Box	2	A Special Condition Type is required.	Select a Special Condition Type from the list.
	Combo Box	3	A special condition may not be both exemption 'EXM' and capitation 'CAP' types.	Select a different special condition type from the list.

6.58.5 Xref MC Special Condition/Type Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.58.6 Xref MC Special Condition/Type Xref Panel Accessibility

6.58.6.1 To Access the MC Special Condition/Type Xref Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data**.	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select **MC Special Condition/Type Xref**.	MC Special Condition/Type Xref panel displays.

6.58.6.2 To Add on the MC Special Condition/Type Xref Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **MC Special Condition**.	
3	Enter **Special Condition Type**.	
4	Click **Save**.	MC Special Condition/Type Xref information is saved.

6.58.6.3 To Update on the MC Special Condition/Type Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	MC Special Condition/Type Xref information is saved.

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6.59 XREF-PMP EDB XREF PANEL OVERVIEW

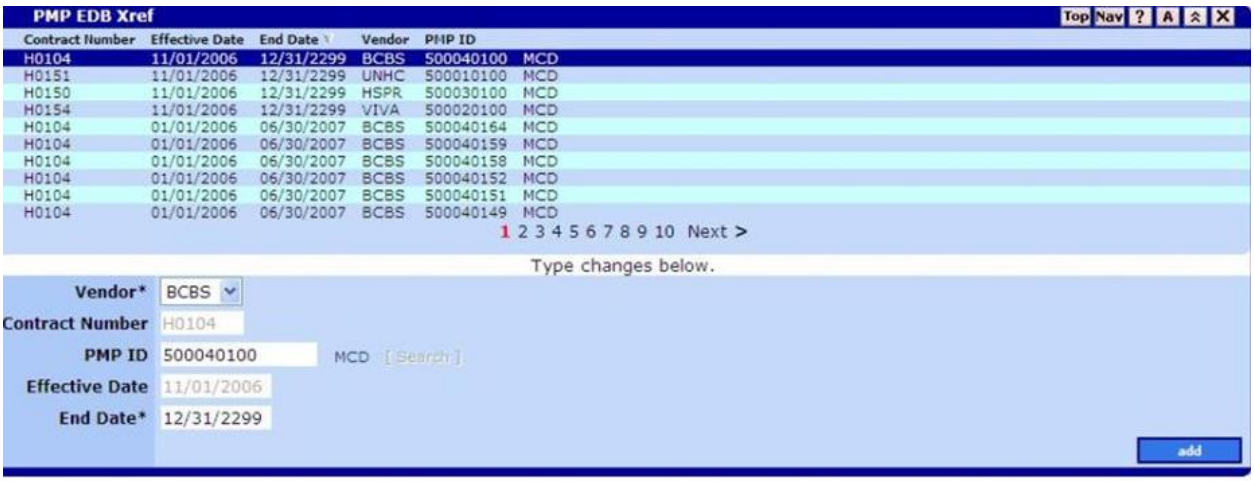
6.59.1 Xref-PMP EDB Xref Panel Narrative

The Xref-PMP EDB Xref panel contains Medicare Advantage PMP EDB information.

Only users with update authority are allowed to perform such tasks.

Navigation Path: [Managed Care] – [Related Data] - [Xref] - [PMP EDB Xref]

6.59.2 Xref-PMP EDB Xref Panel Layout



6.59.3 Xref-PMP EDB Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add PMP EDB Xref information.	Button	N/A	0
Contract Number	EDB Contract Number.	Field	Character	5
Effective Date	Effective date of the EDB contract.	Field	Date (MM/DD/CCYY)	8
End Date	End Date of the EDB Contract.	Field	Date (MM/DD/CCYY)	8
PMP ID	Provider Identification.	Field	Character	15
PMP ID Type (no label)	The PMP identification type.	Field	Character	3
Vendor	Vendor Name - BCBS, HSPR, VIVA, or UNHC.	Combo Box	Drop Down List Box	0

6.59.4 Xref-PMP EDB Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Contract Number	Field	1	Contract Number is required.	Enter a valid Contract Number.
Effective Date	Field	10	Effective Date is required.	Enter a valid Effective Date.
	Field	11	Date must be in MM/DD/CCYY Format.	Enter Effective Date in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	20	End Date must be in MM/DD/CCYY Format.	Enter End Date in MM/DD/CCYY format.
Vendor	Field	30	Vendor is required.	Enter a valid Vendor acronym.

6.59.5 Xref-PMP EDB Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.6 Xref-PMP EDB Xref Panel Accessibility

6.59.6.1 To Access the PMP EDB Xref Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Managed Care** and click **Related Data.**	Related Data panel displays.
3	Select **Xref**.	A list of hyperlinks to panel(s) displays.
4	Select PMP EDB Xref.	PMP EDB Xref panel displays.

6.59.6.2 To Add on the PMP EDB Xref Panel

Step	Action	Response
1	Click **Add**.	Activates selection list(s) and/or field(s) for entry of data.
2	Enter **Vendor**.	
3	Enter **Contract Number**.	
4	Enter **Effective Date**.	
5	Enter **End Date**.	
6	Enter **PMP ID**.	
7	Click **Save**.	PMP EDB Xref information is saved.

6.59.6.3 To Update on the PMP EDB Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	PMP EDB Xref information is saved.

6.59.6.4 To Delete from the PMP EDB Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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7 MANGED CARE REPORTS

The Managed Care User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 HMNMC046—EMERGENCY ROOM MANAGEMENT REPORT

7.1.1 HMNMC046—Emergency Room Management Report Narrative

The Emergency Room Management report is a mail out to the provider to report information about their patients using emergency services. It is produced quarterly by Maggie Kilgore.

1st qtr (Jan - Mar) run after last checkwrite in March
2nd qtr (Apr - Jun) run after last checkwrite in June
3rd qtr (Jul - Sep) run after last checkwrite in September
4th qtr (Oct - Dec) run after last checkwrite in December

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7.1.2 HMNMC046—Emergency Room Management Report Layout

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A

ALABAMA MEDICAID AGENCY
501 DEXTER AVE.
P.O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

Emergency Room Management Report
Claims with Services Between: 4/1/2013 - 4/18/2013

Dear Provider:

This information is being provided as a resource to you regarding patients on your panel utilizing ER services. Medicaid only pays for three non-emergency ER visits each calendar year. Certified ER visits are not limited. To provide a more accurate picture of patient utilization, both paid and denied claims are reflected. If the claim is denied, then zero will be reflected in the paid amount column. The emergency indicator explains whether the visit was a certified or non-certified emergency. Please note that the attending physician at the ER, makes the emergency determination.

The paid amount field is the total amount paid for all services provided on the claim. This includes the facility fee as well as any ancillary charges that may be billed. The physician charges are not included. If you have any questions regarding this information, please contact Latonda Cunningham at 334-353-4122.

HARRY L RICHARDSON JR
PO BOX 670
REFORM,AL 35481-0670

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ALABAMA MEDICAID AGENCY
501 DEXTER AVE.
P.O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

Emergency Room Management Report
Claims with Services Between: 4/1/2013 - 4/18/2013

PCP: HARRY L RICHARDSON JR **PCP ID: 1780627356**

Enrollee Name	Medicaid Number	ICD	Primary Diag	Description	Billing Provider	DOS	Paid Amt.	Emergency Ind
G	I8	0	K088	OTHER SPECIFIED DISORDERS OF	MOBILE INFIRMARY	04/05/2013	$45.95	N

PHI has been covered

B

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C

Alabama Medicaid Agency

Emergency Room Management Report
Claims with Services Between: 4/1/2013 - 4/18/2013

Report: HMNMC046

Run Date: 4/19/2013

Run Time: 7:54:09 AM

Recipient ID	Full Recipient Name	PCP Provider ID	Emergency Indicator	Billing Provider Number	Billing Provider Full Name	Dtl Paid Amount	Procedure Code	ICD	First Hdr Diag Code	First Hdr Diag Description
5	C D	NPI ID: 1558364802 Medicaid ID: HOS0113H Base ID: 6754	N	6754	MOBILE INFIRMARY	$40.66	99282	0	K088	SPECIFIED DISORDERS OF TEETH AND SUPPORTING
	C D	NPI ID: 1558364802 Medicaid ID: HOS0113H Base ID: 6754	N	6754	MOBILE INFIRMARY	$3.39	J2270	0	K088	SPECIFIED DISORDERS OF TEETH AND SUPPORTING
	C D	NPI ID: 1558364802 Medicaid ID: HOS0113H Base ID: 6754	N	6754	MOBILE INFIRMARY	$1.90	J2550	0	K088	SPECIFIED DISORDERS OF TEETH AND SUPPORTING
5	Count:		1							

		1								

PHI has been covered

End of Report

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7.1.3 HMNMC046—Emergency Room Management Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Emergency Room Management report

Field	Description	Data Type	Length
Billing Provider / Billing Provider Full Name	The name of the billing Provider participating in the Medicaid program.	Character	50
DOS	The date the first service was rendered on a claim.	Date (MM/DD/CCYY)	10
Description / First Hdr Diag Description	The description of the primary diagnosis code.	Character	40
Dtl Paid Amount	Amount paid on a detail line of the claim.	Number (Decimal)	22
Emergency Ind / Emergency Indicator	Indicates whether this was an emergency claim.	Character	1
Enrollee Name	Recipient's Full Name in Last, First MI format.	Character	38
Full Recipient Name	Recipient's Full Name in Last, First MI format.	Character	38
Medicaid Number	A number that uniquely identifies an individual eligible for Medicaid benefits under Managed Care. This is the original recipient number.	Character	12
PCP	The name of the provider participating in the Managed Care program.	Character	50
PCP ID / PCP Provider ID	A unique number assigned by the State to each provider of services participating in the Managed Care program.	Character	15
Paid Amt	The computed amount of payment due a provider for a claim or an adjustment transaction.	Number (Decimal)	22
Primary Diag / First Hdr Diag Code	The primary condition established after study to be mainly responsible for the patient's need for health care services from a provider.	Character	7
Procedure Code	The procedure code on a detail line of the claim.	Character	6

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Field	Description	Data Type	Length
Recipient Base ID	Unique identifier for the recipient.	Character	12

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7.2 HMNMC047—MEDICARE ELIGIBLES REPORT

7.2.1 HMNMC047—Medicare Eligibles Report Narrative

This report lists the Medicare Eligibles that are eligible for Medicare Advantage. The first table lists the SLIMB recipients; the 2nd tab lists the True Duals and the 3rd Tab list All Medicare Eligibles.

Report is created by Lisa Kurtti, exported, and sent to the Mailing Service by secure e-mail.

7.2.2 HMNMC047—Medicare Eligibles Report Layout

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A

Alabama Medicaid Agency

Medicare Eligibles Report
Medicare Eligibles as of 06/01/2010
With No Medicaid Eligibility as of 12/01/2009

Report: HMNMC047

Run Date: 11/3/2010

Run Time: 11:49:01 AM

Recipient Base ID	First Name	Middle Initial	Last Name	Full Street Address	City	State	Zip Code	Zip Code + 4	County Code Description
					DALEVILLE	AL	36322	0000	23 - Dale
					DADEVILLE	AL	36853	0509	62 - Tallapoosa
					ALBERTVILLE	AL	35950	0000	48 - Marshall
					WEBB	AL	36376	3506	35 - Houston
					PRICHARD	AL	36610	0000	49 - Mobile
					BESSEMER	AL	35020	0000	37 - Jefferson
					SYLACAUGA	AL	35150	0000	61 - Talladega
					BROOKWOOD	AL	35444	0000	63 - Tuscaloosa
8									

PHI has been covered

End of Report

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B

Alabama Medicaid Agency

Medicare Eligibles Report
Medicare Eligibles as of 06/01/2010
With No Medicaid Eligibility as of 12/01/2009

Report: HMNMC047

Run Date: 11/3/2010

Run Time: 11:49:01 AM

Recipient Base ID	First Name	Middle Initial	Last Name	Full Street Address	City	State	Zip Code	Zip Code + 4	County Code Description
					ALBERTVILLE	AL	35950	0000	48 - Marshall
					WEBB	AL	36376	3506	35 - Houston
					PRICHARD	AL	36610	0000	49 - Mobile
					BESSEMER	AL	35020	0000	37 - Jefferson
4									

PHI has been covered

End of Report

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C

Alabama Medicaid Agency

Medicare Eligibles Report
Medicare Eligibles as of 06/01/2010
With No Medicaid Eligibility as of 12/01/2009

Report: HMNMC047

Run Date: 11/3/2010

Run Time: 11:49:01 AM

Recipient Base ID	First Name	Middle Initial	Last Name	Full Street Address	City	State	Zip Code	Zip Code + 4	County Code Description
					DALEVILLE	AL	36322	0000	23 - Dale
					DADEVILLE	AL	36853	0509	62 - Tallapoosa
2									

PHI has been covered

End of Report

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7.2.3 HMNMC047—Medicare Eligibles Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Medicare Eligibles report.

Field	Description	Data Type	Length
City	The city where the recipient resides.	Character	18
County Code/Description	Code and name of the county in which the recipient's resides.	Character	15
First Name	The first name of a recipient.	Character	15
Full Street Address	The first line of the recipient's street address.	Character	30
Last Name	The last name of a recipient.	Character	20
Middle Initial	The middle initial of the recipient.	Character	1
Recipient Base ID	Unique identifier for the recipient.	Character	12
State	The state where the recipient resides.	Character	2
Zip Code	The five character zip code for the recipient.	Character	9
Zip Code + 4	The zip code plus four of the recipient.	Character	4

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7.3 MGD-0002-M—CAPITATION PAYMENT LISTING FOR PATIENT 1ST REPORT

7.3.1 MGD-0002-M—Capitation Payment Listing for Patient 1st Report Narrative

This report, which is produced monthly, provides a detailed listing of all recipients for whom the Patient 1st PMP is receiving a capitation payment.

This report is also available to providers from the Alabama Medicaid Interactive Services Web site.

7.3.2 MGD-0002-M—Capitation Payment Listing for Patient 1st Report Layout

```
Report  : MGD-0002-M                                ALABAMA MEDICAID AGENCY
Run Date: MM/DD/CCYY
Process : MGDJM410                            MEDICAID MANAGEMENT INFORMATION SYSTEM
Run Time:   99:99:99
Location: MGD0002M                                  CAPITATION PAYMENT LISTING
Page:        999
                                            REPORT PERIOD:  MM/DD/CCYY  -  MM/DD/CCYY

PMP Identification Number: XXX  XXXXXXXXXX                                                                    Payment Issue
Date: MM/DD/CCYY
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Payment No: XXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          Total
Amount: 9999999.99
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Payee PMP Identification Number:  XXX  XXXXXXXXXX
Payee PMP Name:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RECIPIENT ID         RECIP NAME                          EFF DATE      END DATE      AMOUNT         ADJUSTMENT
                                                                                     PAID           AMOUNT
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99
                                                       *** END OF REPORT ***
```


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7.3.3 MGD-0002-M—Capitation Payment Listing for Patient 1st Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Payment Listing for Patient 1st report.

Field	Description	Data Type	Length
Adjustment Amount	Adjustment amount for this recipient.	Number (Decimal)	14
Amount Paid	Capitation payment made to the PMP for the recipient.	Number (Decimal)	9
Eff Date	Recipient assignment date.	Date (MM/DD/CCYY)	10
End Date	Rate recipient assignment will end.	Date (MM/DD/CCYY)	10
Payee PMP Identification Number	Identification number of the PMP who is receiving a cap payment.	Character	15
Payee PMP Name	Name of the PMP who receives cap payments.	Character	20
Payment Issue Date	Payment issue date.	Date (MM/DD/CCYY)	10
Payment No	Payment number.	Number (Integer)	9
PMP Address1	PMP street address 1.	Character	30
PMP Address2	PMP street address 2.	Character	30
PMP City, State, Zip	PMP city, state, and zip code address.	Character	30
PMP Identification Number	Identification number of the PMP who performed the service. They may or may not actually be receiving the capitation payment.	Character	15
PMP Name	Name of the PMP who performed the service. They may or may not receive the actual cap payments.	Character	20
Recip Name	Recipient last name, first name, middle name initial.	Character	31
Recipient ID	Recipient identification number.	Character	12

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Field	Description	Data Type	Length
Report Period	The reporting time period range in MM/DD/CCYY – MM/DD/CCYY format.	Date (MM/DD/CCYY)	23
Total Amount	Total amount paid to the PMP. This amount will be total of both Patient 1st and Lockin cap payments, if provider participates in both MC programs.	Number (Decimal)	14

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7.4 MGD-0004-M—CAPITATION PAYMENT LISTING FOR MEDICARE ADVANTAGE REPORT

7.4.1 MGD-0004-M—Capitation Payment Listing for Medicare Advantage Report Narrative

This report, which is produced monthly, provides a detailed listing of all recipients for whom the Medicare Advantage or ICN PMP is receiving a capitation payment.

This report is available to providers from the Alabama Medicaid Interactive Services Web Site in pdf and csv formats.

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7.4.2 MGD-0004-M—Capitation Payment Listing for Medicare Advantage Report Layout

```
Report  : MGD-0004-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM004                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   99:99:99
Location: MGD0002M                           CAPITATION PAYMENT LISTING                            Page:        999
PLAN    : XXXXX                        REPORT PERIOD:  MM/DD/CCYY  -  MM/DD/CCYY

PMP Identification Number: XXX  XXXXXXXXXX                                          Payment Issue Date:
MM/DD/CCYY
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  Payment No:
XXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                       Total Amount:
9999999.99
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Payee PMP Identification Number:  XXX  XXXXXXXXXX
Payee PMP Name:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


RECIPIENT ID         RECIP NAME                          EFF DATE      END DATE      AMOUNT         ADJUSTMENT     ADJ
                                                                                     PAID           AMOUNT         RC
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX
XXXXXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY    99999999.99    99999999.99    XX

Code Legend:
```


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```
Adjustment Reason Codes:

XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                   ***END OF REPORT***
```

7.4.3 MGD-0004-M—Capitation Payment Listing for Medicare Advantage Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Payment Listing for Medicare Advantage report.

Field	Description	Data Type	Length
Adj RC	The reason code for adjustment	Character	2
Adjustment Amount	Adjustment amount for this recipient.	Number (Decimal)	14
Amount Paid	Capitation payment made to the PMP for the recipient.	Number (Decimal)	9
Code Legend Adjustment Reason Codes	Legend contains the code and description of all adjustment reason code(s) displayed under ADJ RC column.	Character	57
Eff Date	Recipient assignment date.	Date (MM/DD/CCYY)	10
End Date	Date recipient assignment will end.	Date (MM/DD/CCYY)	10
PLAN	The cde_pgm_health of the PMP. The folowing are the valid values: • *ICNNH =ICN Nursing Home* • *ICNWA = ICN ACT Waiver* • *ICNWE = ICN E&D Waiver* • *MDADV = Medicare Advantage.*	Character	5
PMP Address1	First part of PMP street address.	Character	30

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Field	Description	Data Type	Length
PMP Address2	Second part of PMP street address.	Character	30
PMP City, State, Zip	PMP city state and zip code address.	Character	30
PMP Identification Number	Identification number of the PMP who performed the service. They may or may not actually be receiving the capitation payment.	Character	15
PMP Name	Name of the PMP who performed the service. They may or may not receive the actual capitation payments.	Character	20
Payee PMP Identification Number	Identification number of the PMP who is receiving a capitation payment.	Character	15
Payee PMP Name	Name of the PMP who receives capitation payments.	Character	20
Payment Issue Date	Check issue date.	Date (MM/DD/CCYY)	10
Payment No	Check number.	Number (Integer)	9
Recip Name	Recipient last name, first name, middle name initial.	Character	31
Recipient ID	Recipient identification number.	Character	12
Report Period	The reporting time period range in MM/DD/CCYY – MM/DD/CCYY format.	Date (MM/DD/CCYY)	23
Total Amount	Total amount paid to the PMP.	Number (Decimal)	14

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7.5 MGD-0055-M—MONTHLY PMP ENROLLMENT ROSTER FOR PATIENT 1ST REPORT

7.5.1 MGD-0055-M—Monthly PMP Enrollment Roster for Patient 1st Report Narrative

The Monthly PMP Enrollment Roster for Patient 1st report, which is produced monthly, lists PMP enrollment information by recipient. The report is broken out by Pending, New, Continuing, and Terminated recipients. A legend is provided at the end of the report listing aid category and start/stop reason.

This report is available to providers from the Alabama Medicaid Interactive Services Web Site.

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7.5.2 MGD-0055-M—Monthly PMP Enrollment Roster for Patient 1st Report Layout

```
Report  : MGD-0055-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM055                   MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: MGD0055M                        MONTHLY PMP ENROLLMENT ROSTER                           Page:        999
                                             REPORT PERIOD:  MM/CCYY


PMP Identification Number:  XXXXXXXXXX              Case Mgmt Fee:     $999.99                    Payee PMP ID: 123456789012345
PMP Name:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        SPSL:       123456789
Address 1:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address 2:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State  ZIP:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



                                                                                   CURRENT      FUTURE
REGION                                   FOCUS                                     PANEL SIZE   PANEL SIZE   DISTANCE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999      999,999     XXXX


RESTRICTION TYPE                MIN AGE       MAX AGE     GENDER     MAX PANEL SIZE     EFFECTIVE DATE     END DATE
XXXXXXXXXXXXXXXXXXXX            999           999         X              999,999        MM/DD/CCYY         MM/DD/CCYY
XXXXXXXXXXXXXXXXXXXX            999           999         X              999,999        MM/DD/CCYY         MM/DD/CCYY
XXXXXXXXXXXXXXXXXXXX            999           999         X              999,999        MM/DD/CCYY         MM/DD/CCYY

SPECIAL CONDITIONS:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                    THIS IS FOR INFORMATION ONLY

This information reflects your Patient 1st enrollment data. Indicated above is the distance in which you have agreed to
see Patient 1st eligibles, the maximum caseload requested, the current caseload, any age criteria specified and whether you
appear on the PMP List.  The current caseload will not, reflect the numbers on the enrollment reports due to patients
continuously being enrolled and disenrolled.  A special condition of 'Patient 1st Max Caseload Override Hold' indicates that you
have requested that no new patients be assigned without express permission.  If you wish to make changes to your enrollment
data,please contact the EDS Provider Enrollment Unit.
<PAGE BREAK>
```


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```
Process : MGDJM055                          MEDICAID MANAGEMENT INFORMATION SYSTEM                                    Run Time:   HH:MM:SS
Location: MGD0055M                               MONTHLY PMP ENROLLMENT ROSTER                                           Page:        999
                                                    REPORT PERIOD:  MM/CCYY

PMP Identification Number:  XXXXXXXXXX              Case Mgmt Fee:     $999.99                     Payee PMP ID: 123456789012345
PMP Name:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                            SPSL:       123456789
Address 1:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address 2:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State  ZIP:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                        NEW ENROLLEES

RECIP ID /SSN              STREET ADDRESS 1               SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                   BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                  DEATH      ENDDATE           IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                     CONTINUING ENROLLEES
RECIP ID /SSN              STREET ADDRESS 1               SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                   BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                  DEATH      ENDDATE           IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
TERMINATED ENROLLEES
RECIP ID /SSN              STREET ADDRESS 1                SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                     BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                    DEATH      ENDDATE          IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

<PAGE BREAK>

Report  : MGD-0055-M                                ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MGDJM055                            MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MGD0055M                                 MONTHLY PMP ENROLLMENT ROSTER                                 Page:        999
                                                     REPORT PERIOD:  MM/CCYY

PMP Identification Number:  XXXXXXXXXX                                                     Payee PMP ID: 123456789012345

TOTAL PENDING ENROLLEES    :  999,999,999
TOTAL NEW ENROLLEES        :  999,999,999
TOTAL CONTINUING ENROLLEES :  999,999,999
TOTAL TERMINATED ENROLLEES :  999,999,999


Code Legend:
       Aid Category

          32   MLIF-Child with No Money-full Medicaid coverage
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
       Start/Stop Reason
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   *** END OF REPORT ***
```


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7.5.3 MGD-0055-M—Monthly PMP Enrollment Roster for Patient 1st Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly PMP Enrollment Roster for Patient 1st report.

Field	Description	Data Type	Length
Aid Cat	Recipient's state aid category at time of enrollment.	Character	2
Assignmnt EffDate	Effective date of recipient's assignment with the PMP.	Date (MM/DD/CCYY)	10
Assignmnt Enddate	End Date of assignment with the PMP.	Date (MM/DD/CCYY)	10
Code Legend: Aid Category	Aid Category Code (length 2) and Description (50).	Character	52
Code Legend: Start/Stop Reason	Recipient eligibility start or stop reasons (length 2) and description (length 50).	Character	52
County	Recipient's county of residence.	Character	10
Current Panel Size	Number of th recipients currently assigned to the PMP service location.	Number (Integer)	7
Distance	Indicates how many miles in all directions that the provider is will to provide coverage.	Number (Integer)	4
Focus	Contains list of valid focuses that a PMP can have. A "focus" is similar to a provider specialty, but is NOT related in our system. Examples include: General Practitioner, Internist, and Pediatrician.	Character	3
Future Panel Size	This is the number of recipients assigned to the PMP service location that are effective AFTER the current date.	Number (Integer)	7
Gender	Specifies the gender of the recipients who are either included or excluded from the PMP's panel.	Character	1

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Field	Description	Data Type	Length
Max Age	Specifies the maximum age of the recipients who are either included or excluded from the PMP's panel.	Number (Integer)	3
Max Panel Size	Specifes the maximum number of recipients that the PMP will allow.	Number (Integer)	7
Min Age	Specifies the minimum age of the recipients who are either included or excluded from the PMP's panel.	Number (Integer)	
Office Ind	The county DHS office that the recipient lives near.	Character	1
PMP Address 1	First part of PMP Street Address.	Character	30
PMP Address 2	Second part of PMP Street Address.	Character	30
PMP City, State, Zip	PMP city, state and zip plus 4.	Character	30
PMP Identification Number	PMP identification number.	Character	15
PMP Name	PMP's Name.	Character	30
Payee PMP ID	This field displays the provider's id number if an individual provider or the group provider number if part of a group.	Character	15
Recipient - City, State, Zip	Recipient city, state and zip plus 4.	Character	30
Recipient - Date Of Birth	Recipient's date of birth.	Date (MM/DD/CCYY)	10
Recipient - Date Of Death	Recipient's date of death.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Recipient - Last Name, First Name MI	Recipient Name (Last, First, MI).	Character	31
Recipient's Sex	Sex of recipient.	Character	1
Recipient SSN	Social Security Number.	Number (Integer)	9
Recipient Street Address 1	Recipient street address.	Character	30
Recipient Street Address 2	Recipient street address 2.	Character	30
Recipient ID	Recipient identification number.	Character	12
Region	This is the identification of the Managed Care region.	Character	30
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
Restriction Type	Specifies the type of restriction: Inclusion or Exclusion.	Character	20
Review Date	Date of recipient's last eligibility review.	Date (MM/CCYY)	7
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Number (Integer)	9
Special Condition	Describes the Special Condition(s) that applies to the PMP.	Character	50
Start / Stop Rsn	Recipient eligibility start or stop reason.	Character	2
Total Continuing Enrollees	Total number of continuing enrollees assigned to the PMP.	Number (Decimal)	11

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Field	Description	Data Type	Length
Total New Enrollees	Total number of new enrollees assigned to the PMP.	Number (Decimal)	11
Total Pending Enrollees	Total number of pending enrollees assigned to the PMP.	Number (Decimal)	11
Total Terminated Enrollees	Total number of terminated enrollees.	Number (Decimal)	11

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7.6 MGD-0056-M—MONTHLY PMP ENROLLMENT ROSTER FOR MEDICARE ADVANTAGE REPORT

7.6.1 MGD-0056-M—Monthly PMP Enrollment Roster for Medicare Advantage Narrative Report

The Monthly PMP Enrollment Roster for Medicare Advantage report, which is produced monthly, lists PMP enrollment information by recipient. The report is broken out by New, Continuing, and Terminated recipients. A legend is provided at the end of the report listing aid category and start/stop reason.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

7.6.2 MGD-0056-M—Monthly PMP Enrollment Roster for Medicare Advantage Report Layout

```
Report  : MGD-0056-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM500                   MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: MGD0055M                       MONTHLY PMP ENROLLMENT ROSTER                            Page:        999
                                             REPORT PERIOD:  MM/CCYY


PMP Identification Number:  XXXXXXXXXX                                          Payee PMP ID: 123456789012345
PMP Name:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          SPSL:       123456789
Address 1:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address 2:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State  ZIP:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                 NEW ENROLLEES

RECIP ID /SSN              STREET ADDRESS 1              SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                   BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                  DEATH      ENDDATE           IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X  MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
                                                    CONTINUING ENROLLEES
RECIP ID /SSN              STREET ADDRESS 1               SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                    BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                    DEATH      ENDDATE          IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                    TERMINATED ENROLLEES

RECIP ID /SSN              STREET ADDRESS 1               SEX  DATE OF    ASSIGNMNT    AID  COUNTY/         START/   REVIEW
LAST NAME, FIRST NAME MI   STREET ADDRESS 2                    BIRTH /    EFFDATE/     CAT  OFFICE          STOP     DATE
                           CITY, STATE  ZIP                    DEATH      ENDDATE          IND             RSN

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXX/XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX   X   MM/DD/CCYY MM/DD/CCYY   XX   XX              XX       MM/CCYY
XXXXXXXX, XXXXXXX, X       XXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY MM/DD/CCYY        X
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           XXXXXXXXXXXXXXXXXXXXXXXXXXXX

<PAGE BREAK>
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```
Report  : MGD-0056-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM500                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: MGD0055M                         MONTHLY PMP ENROLLMENT ROSTER                           Page:        999
                                               REPORT PERIOD:  MM/CCYY


PMP Identification Number:  XXXXXXXXXX                                          Payee PMP ID: 123456789012345



TOTAL NEW ENROLLEES        :  999,999,999
TOTAL CONTINUING ENROLLEES :  999,999,999
TOTAL TERMINATED ENROLLEES :  999,999,999


Code Legend:

       Aid Category

         32   MLIF-Child with No Money-full Medicaid coverage
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

       Start/Stop Reason

         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                 *** END OF REPORT ***
```


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7.6.3 MGD-0056-M—Monthly PMP Enrollment Roster for Medicare Advantage Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly PMP Enrollment Roster for Medicare Advantage report.

Field	Description	Data Type	Length
Aid Cat	Recipients State aid category at time of enrollment.	Character	2
Assignmnt Effdate	Effective Date of recipient's assignment with the PMP.	Date (MM/DD/CCYY)	10
Assignmnt Enddate	End Date of assignment with the PMP.	Date (MM/DD/CCYY)	10
Code Legend: Aid Category	Aid Category Code (length 2) and Description (50).	Character	52
Code Legion: Start/Stop Reason	Recipient eligibility start or stop reasons (length 2) and description (length 50).	Character	52
County	The Recipient county of residence.	Character	10
Office Ind	The county DHS office that the recipient lives near.	Character	1
PMP - Address 1	PMP Street Address 1.	Character	30
PMP - Address 2	PMP Street Address 2.	Character	30
PMP - City, State, Zip	PMP City, State and Zip Plus 4.	Character	30
PMP Identification Number	PMP Identification Number.	Character	15
PMP Name	PMP's Service location Name is printed on the report header. The PMP's Mailing location Name is printed on the mailing address page.	Character	30

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Field	Description	Data Type	Length
Payee PMP ID	This field displays the provider's id number if an individual provider or the group provider number if part of a group.	Character	15
Recipient - City, State, Zip	Recipient city, state and zip plus 4.	Character	30
Recipient - Date Of Birth	Recipient's date of birth.	Date (MM/DD/CCYY)	10
Recipient - Date Of Death	Recipient's date of death.	Date (MM/DD/CCYY)	10
Recipient - Last Name, First Name MI	Recipient Name (Last, First, MI).	Character	31
Recipient - SSN	Social Security Number.	Number (Integer)	9
Recipient - Sex	Sex of Recipient.	Character	1
Recipient - Street Address 1	Recipient Street Address 1.	Character	30
Recipient - Street Address 2	Recipient Street Address 2.	Character	30
Recipient ID	Recipient identification number.	Character	12
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
Review Date	Date of recipient's last eligibility review.	Date (MM/CCYY)	7
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Number (Integer)	9

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Field	Description	Data Type	Length
Start / Stop Rsn	Recipient eligibility start or stop reasons.	Character	2
Total Continuing Enrollees	Total number of continuing enrollees assigned to the PMP.	Number (Decimal)	11
Total New Enrollees	Total number of new enrollees assigned to the PMP.	Number (Decimal)	11
Total Terminated Enrollees	Total number of terminated enrollees.	Number (Decimal)	11

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7.7 MGD-0070-M—MONTHLY MANAGED CARE ENROLLED BUT NOT ELIGIBLE REPORT

7.7.1 MGD-0070-M—Monthly Managed Care Enrolled but Not Eligible Report Narrative

This report lists recipients who are enrolled in Patient 1st, but are no longer eligible. The report is sorted by provider ID and Recipient ID. It also prints a total disenrolled summary for provider and another one for the whole State. This report is produced monthly.

7.7.2 MGD-0070-M—Monthly Managed Care Enrolled but Not Eligible Report Layout

```
Report  : MGD-0070-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : MGDJM070                             MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   99:99:99
Location: MGD0070M                        MONTHLY MANAGED CARE ENROLLED BUT NOT ELIGIBLE                     Page:        999
                                                     REPORT PERIOD: MM/CCYY
                                                       LISTING BY PROVIDER


PMP Identification Number: XXXXXXXXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


RECIP ID            RECIP NAME                                PROGRAM    EFF DATE        PREV            END DATE       REASON
                                                              CODE                       END DATE                       CODE

999999999999        XXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X        XXXXX      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      XXX
999999999999        XXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X        XXXXX      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      XXX
999999999999        XXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X        XXXXX      MM/DD/CCYY      MM/DD/CCYY      MM/DD/CCYY      XXX



<PAGE BREAK>
```


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```
Report  : MGD-0070-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : MGDJM070                             MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   99:99:99
Location: MGD0070M                         MONTHLY MANAGED CARE ENROLLED BUT NOT ELIGIBLE                     Page:        999
                                                   REPORT PERIOD: MM/CCYY
                                                       PROVIDER SUMMARY
PMP Identification Number: XXXXXXXXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

REASON CODE       REASON DESCRIPTION                              TOTAL

    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999
    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999
    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999

TOTAL DISENROLLED  9999999999

<PAGE BREAK>
Report  : MGD-0070-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : MGDJM070                             MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   99:99:99
Location: MGD0070M                         MONTHLY MANAGED CARE ENROLLED BUT NOT ELIGIBLE                     Page:        999
                                                   REPORT PERIOD: MM/CCYY
                                                      STATEWIDE SUMMARY

REASON CODE       REASON DESCRIPTION                              TOTAL

    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999
    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999
    999           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999


TOTAL DISENROLLED FOR STATE: 9999999999


                                                  *** END OF REPORT ***
```


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7.7.3 MGD-0070-M—Monthly Managed Care Enrolled But Not Eligible Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly Managed Care Enrolled But Not Eligible report.

Field	Description	Data Type	Length
Eff Date	Recipient assignment effective date.	Character	31
New End Date	The date recipient is disenrolled from Managed Care.	Character	31
PMP - Address 1	Provider street address 1.	Character	30
PMP - Address 2	Provider street address 2.	Date (MM/DD/CCYY)	10
PMP - City, State, Zip	Provider city, state, and zip.	Date (MM/DD/CCYY)	10
PMP Identification Number	PMP identification number.	Character	15
PMP Name	Name of Primary Medical Provider.	Character	50
Prev End Date	Recipient assignment end date prior to being disenrolled.	Date (MM/DD/CCYY)	10
Program Code	The health program recipient is assigned to.	Character	5
Reason Code	The reason code for recipient disenrollment: 101-Recipient deceased on specified date 102-Recipient has invalid aid category 103-Recipient has invalid demographics 104-Recip has invalid aid cat elig (not found) 105-No valid Mgd Care living arrangement 106-Adult/child ind invalid for aid cat	Number (Integer)	4

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Field	Description	Data Type	Length
	108-TPL invalid for Mgd Care 110-Age exceeds program limitations 111-Invalid Medicare coverage for pgm 112-Out-of-state county 113-Recp has invalid aid category group 114-Enrolled in mutually−exclusive program 115-Not enrolled in prerequisite program 116-Program is not valid for recp region 117-Excluded from Managed Care 118-has no valid LOC for PACE program 119-Invalid PACE capitation demographics 120-Vol Recp has opted-out of Mgd Care 121-Enrolled in mutually-excl mgd care pgm 122-Invalid HW21M capitation 125-does not meet PACE age requirements 126-Recip region invalid − check county code 127-Recip state invalid 128-Recip has Medicare A(Invalid for pgm) 129-Recip has Medicare B(Invalid for pgm) 130-Recipient ID is classified as Inactive		

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Field	Description	Data Type	Length
	150-Voluntary Recipient - CSHCN 151-Voluntary Recipient - Race 152-Voluntary Recp - SSI < 21 160-Recp has both QMB and TXIX elig 161-Recp has no QMB eligibility 170-Recp has no pre-requisite program elig 601-PMP does not service specified program 602-PMP svc loc is not active 603-PMP panel (region enrollment) is on hold 604-Assign dates outside of PMP date range 605-PMP not in recp's county 606-Recp is locked out of PMP or Group Mbr 611-Recp doesn’t meet PMP age/gender 612-PMP has reached maximum panel size 613-Recp age/gender is excluded from PMP 614-PMP has NO region enrollments 615-PMP panel (restrictions) is on hold 800-Invalid MCO ID 805-Invalid MCO Service Location 810-Invalid Group		

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Field	Description	Data Type	Length
	815-Invalid Group Service Location 820-Invalid Member ID 825-Invalid Member Service Location 830-Invalid Effective Date 835-Invalid End Date 840-Invalid PMP Focus 845-Invalid 24 Hour Phone 850-Invalid Phone Extension 855-Invalid Special Conditions Indicator 875-Invalid PCP Indicator 885-Missing Record 900-Invalid Medicaid ID 905-Invalid Provider ID 910-Invalid Service Location Code 915-Recp Not Assigned to MCO 920-Provider Not With MCO Note: Some of the reason codes may not be valid for Alabama		
Reason Description	The actual reason why the recipient is disenrolled.	Character	40
Recip ID	Recipient Identification number.	Character	12
Recip Name	Recipient last name, first name, and middle initial.	Character	31

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Field	Description	Data Type	Length
Report Period	The reporting time period in MM/CCYY format.	Number (Integer)	10
Total	Total number of recipient disenrolled, for the reason code, for this provider.	Number (Integer)	10
Total Disenrolled	Total number of recipients disenrolled, for all the reason codes, for this provider.	Number (Integer)	10

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7.8 MGD-0080-M—CAPITATION ERRORS REPORT

7.8.1 MGD-0080-M—Capitation Errors Report Narrative

This report lists all recipient-related errors encountered during the capitation cycles for all plans. The report is sorted by program, provider id and recipient id.

7.8.2 MGD-0080-M—Capitation Errors Report Layout

```
Report  : MGD-0080-M                          ALABAMA MEDICAID AGENCY                                Run Date: MM/YY/CCYY
Process : MGDJM106                      MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   99:99:99
Location: MGD0080M                             CAPITATION ERRORS REPORT                                Page:        999
                                              REPORT PERIOD:  MM/CCYY

PMP ID          RECIPIENT ID  RECIPIENT NAME                    HLTH   ASSIGNMENT  CAP    CAP         ERROR REASON
                                                                PGM    DATE        PGM    MONTH

XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  *** END OF REPORT ***
```


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7.8.3 MGD-0080-M—Capitation Errors Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Errors Field report.

Field	Description	Data Type	Length
Assignment Date	Recipient assignment effective date.	Date (MM/DD/CCYY)	10
Cap Month	Capitation month.	Date (MM/DD/CCYY)	10
Cap Pgm	Recipient capitation program. Valid options include: • A-Adj -- Created out of mgd_capadjauto processes. • Main -- Created out of mgd_capmain processes.	Character	5

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Field	Description	Data Type	Length
Error Reason	Capitation error reasons: • Unable to retrieve hlth pgm/aid cat Check to see if recipient had a valid Benefit Plan for date listed. Adjust assignment as needed. • Recip region invalid; check county code This could be an invalid county code or an invalid State code. Assignment needs to be backed back to EOM prior to attempted cap payment. If this would cause the end date to be before the effective date, change the status to History. • Parent eligibility not found Change End Date back to a covered month or history entire assignment if coverage was never there. • Cap Adj Pmt bypassed, cap amt is zero <BRFor Patient 1st, go to the Capitation Rate Override panel and verify if a rate existed for the Cap Month indicated. If PMP has a FQH, PBR or CM0 Special Condition then rate should exist with rate of zero. If rate or Special condition does not exist, then research how PMP should be paid. • Recipient deceased on specified date Check to see if recipient has died. If so, change end date to be the EOM of date of death. If this would cause the end date to be before the effective date, change the status to History. • Invalid aid category on CCYYMMDD. Check to see if recipient had a valid aid cat for the date listed. Recipient Information - Benefit Plan - select row which covers date listed. • Recipient's aid category elig NOT FOUND Assignment should be end dated with End of Month that eligibility was lost. • Cannnot determine if PMP participating PMP may have cap rate override rows for 4, 5, and 6. Can have either 4 & 5, or 6.	Character	38

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Field	Description	Data Type	Length
Hlth Pgm	Recipient health program. Valid options include: • *PT1ST - Patient 1st.* • *MDADV - Medicare Advantage.* • *ICNNH =ICN Nursing Home* • *ICNWA = ICN ACT Waiver* • *ICNWE = ICN E&D Waiver*	Character	5
PMP ID	Unique number identifying a provider.	Character	15
Recipient ID	Recipient identification number.	Character	12
Recipient Name	Recipient Name (Last, First, MI).	Character	32
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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7.9 MGD-0081-M – CAPITATION ERRORS REPORT

This report lists all recipient-related errors encountered during the ICN capitation cycles.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site in pdf format.

It is sorted by program, provider id and recipient id.

7.9.1 MGD-0081-M – Capitation Errors Layout Report

```
Report  : MGD-0081-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/YY/CCYY
Process : MGDJM081                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGD0080M                             CAPITATION ERRORS REPORT                                    Page:        999
                                              REPORT PERIOD:  MM/CCYY

PMP ID          RECIPIENT ID  RECIPIENT NAME                    HLTH   ASSIGNMENT  CAP    CAP         ERROR REASON
                                                                PGM    DATE        PGM    MONTH

XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX 999999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXX  MM/DD/CCYY  XXXXX  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 *** END OF REPORT ***
```


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7.9.2 MGD-0081-M – Capitation Errors Report Field Descriptions

Field	Description	Data Type	Length
Assignment Date	Recipient assignment effective date.	Date (MM/DD/CCYY)	10
Cap Month	Capitation Month.	Date (MM/DD/CCYY)	10
Cap Pgm	Recipient capitation program. • A-Adj -- Created out of mgd_capadjauto_icn process. • Main -- Created out of mgd_capmain_icn process.	Character	5
Error Reason	Capitation Error Reason • Unable to retrieve hlth pgm/aid cat *Check to see if recipient had a valid Benefit Plan for date listed. Adjust assignment as needed.* • Recip region invalid - check county code *This could be an invalid county code or an invalid State code. Assignment needs to be backed back to EOM prior to attempted cap payment. If this would cause the end date to be before the effective date, change the status to History.* • Parent eligibility not found *Change End Date back to a covered month or history entire assignment if coverage was never there.* • Cap Adj Pmt bypassed, cap amt is zero. *If PCP has a CM0 Special Condition then rate should exist with rate of zero. If rate or Special condition does not exist, then research how PCP should be paid.* • Recipient deceased on specified date *Check to see if recipient has died. If so, change end date to be the EOM of date of death. If this would cause the end date to be before the effective date, change the status to History.* • Invalid aid category on CCYYMMDD. *Check to see if recipient had a valid aid cat for the date listed. Recipient Information - Benefit Plan - select row which covers date listed.*	Character	38

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Field	Description	Data Type	Length
	• Recipient's aid category elig NOT FOUND *Assignment should be end dated with End of Month that eligibility was lost.*		
Hlth Pgm	Recipient Health Program. • ICNNH =ICN Nursing Home • ICNWA = ICN ACT Waiver • ICNWE = ICN E&D Waiver	Character	5
PMP ID	Provider identification number.	Character	15
Recipient ID	Recipient identification number.	Character	12
Recipient Name	Recipient Name (Last, First, MI).	Character	32
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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7.10 MGD-0100-M—CAPITATION PAYMENT SUMMARY BY PROVIDER REPORT

7.10.1 MGD-0100-M—Capitation Payment Summary by Provider Report Narrative

The Capitation Payment Summary by Provider report, which is produced monthly, summarizes all capitation transactions by provider, and is year-to-date.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

7.10.2 MGD-0100-M—Capitation Payment Summary by Provider Report Layout

```
Report  : MGD-0100-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : MGDJM790                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   99:99:99
Location: MGD0140M                            CAPITATION PAYMENT SUMMARY BY PROVIDER                         Page:        999
                                             REPORT PERIOD:  MM/DD/YYYY - MM/DD/YYYY
PMP Identification Number: XXX  XXXXXXXXXX
PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State  Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                     CAPITATION WORKSHEET

CAPITATION CATEGORY                          CONT       ADJUST      TOTAL         GROSS         TOTAL        TOTAL          TOTAL
                                             ENROLL     ENROLL      ENROLL        AMOUNT        ADJUST      RECOUPED        AMT
                                             MONTHS     MONTHS      MONTHS        PAID          AMOUNT        AMT           PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   99,999     99,999      99,999       999999.99    99,9999.99    99,9999.99    99,9999.99

TOTALS                                    999,999    999,999     999,999   9999999999.99 9999999999.99 9999999999.99 9999999999.99

                                                     *** END OF REPORT ***
```

7.10.3 MGD-0100-M—Capitation Payment Summary by Provider Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Payment Summary by Provider report.

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Field	Description	Data Type	Length
Adjust Enroll Months	Recipient adjusted enrollee months.	Number (Decimal)	6
Capitation Category	Recipient capitation category description.	Character	35
Cont Enroll Months	Recipient continuing enrollee months.	Number (Decimal)	6
Gross Amount Paid	Gross Amount Paid.	Number (Decimal)	10
PMP - Address 1	Provider street address 1.	Character	30
PMP - Address 2	Provider street address 2.	Character	30
PMP - City, State, Zip	Provider's city, state, and zip code.	Character	30
PMP Identification Number	Provider identification number.	Character	15
PMP Name	Name of Primary Medical Provider.	Character	50
Report Period	The reporting time period in MM/DD/CCYY - MM/DD/CCYY format.	Date (MM/DD/CCYY)	23
Total Adjust Amount	Total Adjusted Amount.	Number (Decimal)	10
Total Amt Paid	Total amt paid - sum of gross amt and adjusted amt.	Number (Decimal)	10
Total Enroll Months	Recipient total enrollee months.	Number (Decimal)	6
Total Recouped Amt	Total Recouped Amount.	Number (Decimal)	10
Totals - Adjust Enroll Months	Total of adjusted enrollee months column.	Number (Decimal)	6
Totals - Cont Enroll Months	Total of continuing enrollee months column.	Number (Decimal)	6

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Field	Description	Data Type	Length
Totals - Gross Amount Paid	Total of gross amount paid column.	Number (Decimal)	12
Totals - Total Adjust Amount	Total of total adjust amount column.	Number (Decimal)	12
Totals - Total Amt Paid	Total of total amount paid column.	Number (Decimal)	12
Totals - Total Enroll Months	Total of total enrollee months column.	Number (Decimal)	6
Totals - Total Recouped Amt	Total of total recouped amount column.	Number (Decimal)	12

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7.11 MGD-0302-M—CAPITATION SUMMARY BY PROGRAM REPORT

7.11.1 MGD-0302-M—Capitation Summary by Program Report Narrative

The Capitation Summary by Program report, which is produced monthly, provides a summary of capitation details by program and Managed Care MCO breakout.

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7.11.2 MGD-0302-M—Capitation Summary by Program Report Layout

```
Report  : MGD-0302-M                          ALABAMA MEDICAID AGENCY                                  Run Date:  MM/DD/CCYY
Process : MGDJM302                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:    99:99:99
Location: MGD0302M                         CAPITATION SUMMARY BY PROGRAM                                  Page:         999
                                               REPORT PERIOD:  MM/CCYY
                                                                          PROGRAM            PROGRAM
PROGRAM CODE     PROGRAM DESCRIPTION                                       COUNT              AMOUNT
------------     ---------------------------------------------------   ------------      ---------------
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    999,999,999       999,999,999.99

                                                                      ============      ===============
           GRAND TOTAL FOR ALL PROGRAMS                                999,999,999       999,999,999.99
                                          MEDICARE ADVANTAGE PMP SUMMARY

PMP ID                PMP NAME                                            COUNT              AMOUNT
---------------       ---------------------------------------------   ------------      ---------------
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
XXX  XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   999,999,999       999,999,999.99
                                                                      ============      ===============
           GRAND TOTAL FOR MEDICARE ADVANTAGE                          999,999,999       999,999,999.99
                                                   *** END OF REPORT ***
```

7.11.3 MGD-0302-M—Capitation Summary by Program Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the report Capitation Summary by Program.

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Field	Description	Data Type	Length
Grand Total For All Programs - Program Amount	Grand Total Amount for all capitation payments.	Number (Decimal)	14
Grand Total For All Programs - Program Count	Grand Total Program Count for all capitation programs.	Number (Decimal)	11
Grand Total For Medicare Advantage - Program Amount	Grand Total Amount of Medicare Advantage capitation payments.	Number (Decimal)	14
Grand Total For Medicare Advantage - Program Count	Grand Total Count of PMP capitation payments.	Number (Decimal)	11
PMP Amount	Amount of capitation for the PMP.	Number (Decimal)	14
PMP Count	Count of PMP capitation transactions.	Number (Decimal)	11
PMP ID	Provider identification number.	Character	15
PMP Name	Medicare Advantage vendor name.	Character	50
Program Amount	Amount of capitation for the program.	Number (Decimal)	14
Program Code	Program code for the capitation transactions.	Character	5
Program Count	Count of capitation for the program.	Number (Decimal)	11
Program Description	Program description.	Character	50
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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7.12 MGD-A037-W- PATIENT 1ST PROVIDERS NOT YET REENROLLED REPORT

7.12.1 MGD-A037-W- Patient 1st Providers Not Yet Reenrolled Report Narrative

Report list Patient 1st providers who have not re-enrolled and are in danger of losing the privilege to be Medicaid Providers. It should report all Patient First providers who have not responded 15 days after notification. The report should run weekly and be sorted by Ltr Date (ascending), Future Caseload (descending), Group NPI (ascending) and NPI (ascending).

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7.12.2 MGD-A037-W- Patient 1st Providers Not Yet Reenrolled Report Layout

```
Report  : MGD-A037-W                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJWA37                   MEDICAID MANAGEMENT INFORMATION SYSTEM                    Run Time:   HH:MM:SS
Location: MGDA037W                  PATIENT 1ST PROVIDERS NOT YET REENROLLED                       Page:        999
                                           REPORT PERIOD: MM/DD/CCYY

LTR DATE/    PROVIDER NAME/                                    PROVIDER NPI/     GROUP NPI         SVC LOC PHONE/  CNTY
CURR/FUTR
ENROLL FREQ  PROVIDER EMAIL                                    PROVIDER MCD                        EXTENSION
CASELOAD

MM/DD/CCYY   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX    (XXX)XXX-XXXX   XX
999999999
X            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX                            XXXX
999999999

MM/DD/CCYY   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX    (XXX)XXX-XXXX   XX
999999999
X            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX                            XXXX
999999999

MM/DD/CCYY   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX    (XXX)XXX-XXXX   XX
999999999
X            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX                            XXXX
999999999

MM/DD/CCYY   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX    (XXX)XXX-XXXX   XX
999999999
X            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX                            XXXX
999999999

TOTAL PROVIDERS LISTED                                        999,999,999

                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.12.3 MGD-A037-W- Patient 1st Providers Not Yet Reenrolled Report Field Descriptions

Field	Description	Data Type	Length
Cnty	Provider's service location county.	Character	2
Curr Caseload	Provider's current caseload.	Number	9
Enroll Freq	Type of enrollment frequency provider has. Values are 1=Every year, 5=Every five years, S=State Agency, V=Visit required every year.	Character	1
Extension	Provider's service location phone number extension.	Character	4
Futr Caseload	Provider's future caseload.	Number	9
Group NPI	Group provider's National Provider ID.	Character	15
Ltr Date	Date initial reenrollment letter sent to provider.	Character	10
Provider Email	Provider email address.	Character	50
Provider MCD	Provider's Medicaid ID.	Character	15
Provider NPI	Provider's National Provider ID.	Character	15
Provider Name	Provider's service location name.	Character	50
Svc Loc Phone	Provider's service location phone number.	Character	13

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7.13 MGD-A059-M—MEDICARE ADVANTAGE ENROLLMENT SUMMARY REPORT

7.13.1 MGD-A059-M—Medicare Advantage Enrollment Summary Report Narrative

The Medicare Advantage Enrollment Summary is produced monthly and displays all Medicare Advantage vendors, what counties they support, and number of new, deleted, or continuing recipients per county for the reporting period month.

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7.13.2 MGD-A059-M— Medicare Advantage Enrollment Summary Report Layout

```
Report  : MGD-A059-M                          ALABAMA MEDICAID AGENCY                          Run Date:
MM/DD/CCYY
Process : MGDJM590                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:
HH:MM:SS
Location: MGDA059M                     MEDICARE ADVANTAGE ENROLLMENT SUMMARY                       Page:
999
     REPORT PERIOD:  MM/CCYY

MEDICARE ADVANTAGE PLAN                PLAN ID       COUNTY                    NEW            DELETED        CONTINUING

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999999999     XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                             TOTAL    XXXXXXXXXXXX        9,999             9,999             9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999999999     XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                             TOTAL    XXXXXXXXXXXX        9,999             9,999             9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999999999     XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                             TOTAL    XXXXXXXXXXXX        9,999             9,999             9,999

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          999999999     XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                                      XXXXXXXXXXXX        9,999             9,999             9,999
                                             TOTAL    XXXXXXXXXXXX        9,999             9,999             9,999

GRAND TOTAL FOR ALL VENDORS                                            999,999           999,999           999,999


                                                      *** END OF REPORT ***
```


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7.13.3 MGD-A059-M— Medicare Advantage Enrollment Summary Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Medicare Advantage Enrollment Summary report.

Field	Description	Data Type	Length
Continuing	Total number of continuing enrollees assigned to the Medicare Advantage PMP for the specified county.	Number (Decimal)	5
County	County name.	Character	12
Deleted	Total number of deleted enrollees per Medicare Advantage PMP for a specified county.	Number (Decimal)	5
Grand total for all vendors	Grand total number of new, deleted, or continuing enrollees for all Medicare Advantage PMPs.	Number (Decimal)	7
Medicare Advantage Plan	Medicare Advantage Plan Name.	Character	30
New	Total number of new enrollees assigned to the Medicare Advantage PMP for the specified county.	Number (Decimal)	5
Plan ID	The plan identification number.	Number (Decimal)	10
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
Total	Total number of new, deleted, or continuing enrollees per Medicare Advantage PMP.	Number (Decimal)	6

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7.14 MGD-A115-M—PATIENT 1ST ASSIGNMENT ERRORS REPORT

7.14.1 MGD-A115-M—Patient 1st Assignment Errors Report Narrative

The Patient 1st Assignment Errors report (MGD-A115-M) will report any recipient that was unable to be assigned because of either a bad address or there were no available providers within the default max assignment distance, currently set at 75 miles. This report is produced monthly.

7.14.2 MGD-A115-M—Patient 1st Assignment Errors Report Layout

```
Report  : MGD-A115-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM115                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: MGDA115M                         PATIENT 1ST ASSIGNMENT ERRORS                           Page:        999
                                              REPORT PERIOD:  MM/CCYY



RECIPIENT ID       RECIPIENT NAME                CERT AGENCY   ERROR REASON

XXXXXXXXXXXX        XXXXXXXX, XXXXXXX, X              X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX        XXXXXXXX, XXXXXXX, X              X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX        XXXXXXXX, XXXXXXX, X              X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   *** END OF REPORT ***
```

7.14.3 MGD-A115-M—Patient 1st Assignment Errors Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Patient 1st Assignment Errors.

Field	Description	Data Type	Length
Cert Agency	Indicates the certified agency. H = All human resource recipients, D = D.O., M = Medicaid SOBRA, S = SSI, Y = Foster Care-ADC	Character	1
Error Reason	Reason for the assignment was unable to be made. Valid options include: No available pmp w/in max auto−assignment distance	Character	50

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Field	Description	Data Type	Length
	Recipient could not be assigned due to bad address		
Recipient ID	Recipient identification number.	Character	12
Recipient Name	Recipient name (Last, First, MI).	Character	31
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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7.15 MGD-A120-M -- CAPITATION PAYMENT SUMMARY BY PAYEE PROVIDER REPORT

7.15.1 MGD-A120-M – Capitation Payment Summary by Payee Providers Report Narrative

The Capitation Payment Summary by Payee Providers report displays who was paid by Capitation by Payee Number so Providers can be paid correctly.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

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7.15.2 MGD-A120-M – Capitation Payment Summary by Payee Providers Report Layout

```
Report  : MGD-A120-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM120                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   99:99:99
Location: MGDA120M                     CAPITATION PAYMENT SUMMARY BY PAYEE PROVIDER               Page:        999
                                                REPORT PERIOD:  MM/CCYY

PAYEE PMP Identification Number: XXX  XXXXXXXXXX                                   Payment Issue Date:
MM/DD/CCYY
PAYEE PMP Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  Payment No:
XXXXXXXXX
Address1: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                            Total Amount:
9999999.99
Address2: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
City, State, Zip: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PMP ID                  SPSL              PMP NAME                                AMOUNT              PLAN
                                                                                  PAID
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        Patient 1st
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        Medicare Advantage
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX XXX        XXXXXXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         99999999.99-        XXXXXXXXXXXXXXXXXXX

                                                  *** END OF REPORT ***
```


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7.15.3 MGD-A120-M – Capitation Payment Summary by Payee Providers Report Field Descriptions

Field	Description	Data Type	Length
Address 1	Payee Provider's street address 1.	Character	30
Address 2	Payee Provider's street address 2.	Character	30
Amount Paid	Total amount paid to the PMP within a specific plan.	Decimal	14
City, State, Zip	The city, state, and zip of the Payee Provider's address.	Character	30
PMP ID	The ID number of the PMP who performed the service. They may or may not actually be receiving the cap payment. The code that indicates the type of provider number is also displayed, ie. NPI, MCD, etc.	Character	19
PMP Name	The name of the PMP who performed the service. They may or may not receive the actual cap payments.	Character	20
Payee PMP Identification Number	The ID number of the PMP who is receiving a cap payment.	Character	15
Payee PMP Name	The name of the PMP who receives cap payments.	Character	20
Payment Issue Date	Date the payment was made to the Payee provider.	Date (MM/DD/CCYY)	10
Payment No	Payment number.	Number (Integer)	9
Plan	The Managed Care Plan that the capitation payment is for.	Character	19
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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Field	Description	Data Type	Length
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Number (Integer)	9
Total Amount	Total amount paid to the Payee Provider for all Managed Care plans.	Decimal	14

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7.16 MGD-A130-M—CAPITATION PAYMENT SUMMARY

7.16.1 MGD-A130-M—Capitation Payment Summary

This report, which is produced monthly, summarizes all capitation transactions by provider.

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7.16.2 MGD-A130-M—Capitation Payment Summary

```
Report  : MGD-A130-M                          ALABAMA MEDICAID AGENCY                          Run Date:
MM/DD/CCYY
Process : MGDJM130                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:
99:99:99
Location: MGDA130M                            CAPITATION PAYMENT SUMMARY                           Page:
999
                                        REPORT PERIOD: MM/DD/YYYY - MM/DD/YYYY
                                                                   NORMAL      POSITIVE     NEGATIVE      TOTAL
                                                         CAP      CAP ADJ      CAP ADJ      CAP ADJ     CAP ADJ
PMP NAME                        PMP ID          SPSL     FEE      CNT/AMT      CNT/AMT      CNT/AMT    CNT/AMT
PD


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX    XXXXXXXXX  99.99      99,999       99,999       99,999
99,999
                                                                 999,999.99   999,999.99   999,999.99
999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX    XXXXXXXXX  99.99      99,999       99,999       99,999
99,999
                                                                 999,999.99   999,999.99   999,999.99
999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX    XXXXXXXXX  99.99      99,999       99,999       99,999
99,999
                                                                 999,999.99   999,999.99   999,999.99
999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX    XXXXXXXXX  99.99      99,999       99,999       99,999
99,999
                                                                 999,999.99   999,999.99   999,999.99
999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX    XXXXXXXXX  99.99      99,999       99,999       99,999
99,999
                                                                 999,999.99   999,999.99   999,999.99
999,999.99
<PAGE BREAK>
```


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```
Report  : MGD-A130-M                                ALABAMA MEDICAID AGENCY                                Run Date:
MM/DD/CCYY
Process : MGDJM130                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:
99:99:99
Location: MGDA130M                                  CAPITATION PAYMENT SUMMARY                               Page:
999
                                              REPORT PERIOD: MM/DD/YYYY - MM/DD/YYYY
                                       ****** PATIENT 1ST *******        *** MEDICARE ADVANTAGE ***
TOTALS - NORMAL CAP ADJ CNT/AMT        9999,999    999,999,999.99        9999,999    999,999,999.99

TOTALS - POSITIVE CAP ADJ CNT/AMT      9999,999    999,999,999.99        9999,999    999,999,999.99

TOTALS - NEGATIVE CAP ADJ CNT/AMT      9999,999    999,999,999.99        9999,999    999,999,999.99

TOTALS - TOTAL CAP ADJ CNT/AMT PD      9999,999    999,999,999.99        9999,999    999,999,999.99

                                                  *** END OF REPORT ***
```

7.16.3 MGD-A130-M—Capitation Payment Summary Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Payment Summary report.

Field	Description	Data Type	Length
Cap Fee	Case Management Fee (Patient 1st) or Capitation Fee (Medicare Advantage) paid for each recipient assigned to the provider.	Number (Decimal)	5
Negative Cap Adj Amt	Amount of Payment Adjustment capitations to be recouped from the provider. Negative Cap Adj Cnt X Cap Fee for month of adjustment = Negative Cap Adj Amt	Number (Decimal)	10
Negative Cap Adj Cnt	Number of Recoupment Adjustments (Reason Code = R*) created for any recipient who's capitation payment needs to be recouped due to death, lost eligibility, etc.	Number (Decimal)	6

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Field	Description	Data Type	Length
Normal Cap Adj Amt	Amount of Normal (future) Capitations paid to the provider in the same month. Cap Fee X Normal Cap Adj Cnt = Normal Cap Adj Amt	Number (Decimal)	10
Normal Cap Adj Cnt	Number of Payment Normal (PN) Adjustments created for each recipient assigned to provider in reporting month.	Number (Decimal)	6
PMP ID	Provider identification number.	Character	12
PMP Name	Name of Primary Medical Provider.	Character	30
Positive Cap Adj Amt	Amount of Payment Adjustment capitations paid to the provider. Positive Cap Adj Cnt X Cap Fee for month of adjustment = Positive Cap Adj Amt	Number (Decimal)	10
Positive Cap Adj Cnt	Number of Payment Adjustments (Reason Code = P*, but not PN) created for any recipient who's capitation payment for a previous month had not been paid.	Number (Decimal)	6
Report Period	The reporting time period in MM/DD/CCYY - MM/DD/CCYY format.	Date (MM/DD/CCYY)	23
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Number (Decimal)	9
Total Cap Adj Amt Pd	The total amount of capitations for the reporting period. Normal Cap Adj Amt + Positive Cap Adj Amt - Negative Cap Adj Amt = Total Cap Adj Amt Pd	Number (Decimal)	10
Total Cap Adj Cnt	The total number of capitation adjustments created for the reporting period. Normal Cap Adj Cnt + Positive Cap Adj Cnt + Negative Cap Adj Cnt = Total Cap Adj Cnt	Number (Decimal)	6
Totals - Negative Cap Adj Amt	Total of the Negative Cap Adj Amt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	14

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Field	Description	Data Type	Length
Totals - Negative Cap Adj Cnt	Total of the Negative Cap Adj Cnt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	8
Totals - Normal Cap Adj Amt	Total of the Normal Cap Adj Amt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	14
Totals - Normal Cap Adj Cnt	Total of the Normal Cap Adj Cnt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	8
Totals - Positive Cap Adj Amt	Total of the Positive Cap Adj Amt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	14
Totals - Positive Cap Adj Cnt	Total of the Positive Cap Adj Cnt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	8
Totals - Total Cap Adj Amt Pd	Total of the Total Cap Adj Amt Pd column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	14
Totals - Total Cap Adj Cnt	Total of the Total Cap Adj Cnt column. Totals are accumulated into Patient 1st and Medicare Advantage totals. If Cap Fee is >= 15.00, then it is a Medicare Advantage provider and will add to the Medicare Advantage totals, otherwise, it adds to the Patient 1st totals.	Number (Decimal)	8

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7.17 MGD-A131-M—CAPITATION PAYMENT SUMMARY BY PLAN

7.17.1 MGD-A131-M—Capitation Payment Summary by PLAN

This report, which is produced monthly, summarizes all capitation transactions by PLAN.

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7.17.2 MGD-A131-M—Capitation Payment Summary by PLAN

```
Report  : MGD-A131-M                                ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MGDJM131                            MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGDA131M                              CAPITATION PAYMENT SUMMARY BY PLAN                               Page:        999
PLAN    : XXXXX                               REPORT PERIOD: MM/DD/YYYY - MM/DD/YYYY

PLAN ID:  XXXXXXXXXXXX

                                                                          NORMAL        POSITIVE       NEGATIVE        TOTAL
                                                     CAP        CAP     CAP ADJ         CAP ADJ        CAP ADJ       CAP ADJ
PLAN NAME                                       SPSL CATG       FEE     CNT/AMT         CNT/AMT        CNT/AMT      CNT/AMT PD

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX  XXXXX  9,999.99    999,999         999,999         999,999         999,999
                                                                     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
                                                     XXXXX  9,999.99    999,999         999,999         999,999         999.999
                                                                     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
                                                     XXXXX  9,999.99    999,999         999,999         999,999         999.999
                                                                     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
                                                     XXXXX  9,999.99    999,999         999,999         999,999         999.999
                                                                     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99
                                                     XXXXX  9,999.99    999,999         999,999         999,999         999.999
                                                                     999,999,999.99  999,999,999.99  999,999,999.99  999,999,999.99

<PAGE BREAK>


Report  : MGD-A131-M                                ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MGDJM131                            MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   99:99:99
Location: MGDA131M                              CAPITATION PAYMENT SUMMARY BY PLAN                               Page:        999
PLAN    : XXXXX                               REPORT PERIOD: MM/DD/YYYY - MM/DD/YYYY

PLAN ID:  XXXXXXXXXXXX

TOTALS - NORMAL CAP ADJ CNT/AMT        9999,999    999,999,999.99
```


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```
TOTALS - POSITIVE CAP ADJ CNT/AMT      9999,999    999,999,999.99

TOTALS - NEGATIVE CAP ADJ CNT/AMT      9999,999    999,999,999.99

TOTALS - TOTAL CAP ADJ CNT/AMT PD      9999,999    999,999,999.99

                                                  *** END OF REPORT ***
```

7.17.3 MGD-A131-M—Capitation Payment Summary Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Payment Summary by Plan report.

Field	Description	Data Type	Length
Cap Catg	Capitation category: • INHCP = ICN Nursing Home Cap • IWACP =ICN ACT Waiver Cap • IWECP = ICN E&D Waiver Cap	Character	5
Cap Fee	Capitation Fee paid for each recipient assigned to the Plan.	Number (Decimal)	5
Negative Cap Adj Amt	Amount of Payment Adjustment capitations to be recouped from the provider. Negative Cap Adj Cnt X Cap Fee for month of adjustment = Negative Cap Adj Amt.	Number (Decimal)	10
Negative Cap Adj Cnt	Number of Recoupment Adjustments (Reason Code = R*) created for any recipient who's capitation payment needs to be recouped due to death, lost eligibility, etc.	Number (Integer)	6
Normal Cap Adj Amt	Amount of Normal (future) Capitations paid to the provider in the same month. Cap Fee X Normal Cap Adj Cnt = Normal Cap Adj Amt	Number (Decimal)	10
Normal Cap Adj Cnt	Number of Payment Normal (PN) Adjustments created for each recipient assigned to provider in reporting month.	Number (Integer)	6
Positive Cap Adj Amt	Amount of Payment Adjustment capitations paid to the provider. Positive Cap Adj Cnt X Cap Fee for month of adjustment = Positive Cap Adj Amt.	Number (Decimal)	10

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Field	Description	Data Type	Length
Positive Cap Adj Cnt	Number of Payment Adjustments (Reason Code = P*, but not PN) created for any recipient who's capitation payment for a previous month had not been paid.	Number (Integer)	6
Plan ID	PLAN identification number.	Character	12
Plan Name	PLAN Organization Name.	Character	44
Report Period	The reporting time period in MM/DD/CCYY - MM/DD/CCYY format.	Date (MM/DD/CCYY)	23
SPSL	This is the sak_pmp_ser_loc for the PMP. Helps to uniquely define the provider's different service locations.	Number (Decimal)	9
Total Cap Adj Amt Pd	The total amount of capitations for the reporting period. Normal Cap Adj Amt + Positive Cap Adj Amt - Negative Cap Adj Amt = Total Cap Adj Amt Pd.	Number (Decimal)	10
Total Cap Adj Cnt	The total number of capitation adjustments created for the reporting period. Normal Cap Adj Cnt + Positive Cap Adj Cnt + Negative Cap Adj Cnt = Total Cap Adj Cnt.	Number (Decimal)	6
Totals - Negative Cap Adj Amt	Total of the Negative Cap Adj Amt column. Totals are accumulated into each plan.	Number (Decimal)	14
Totals - Negative Cap Adj Cnt	Total of the Negative Cap Adj Cnt column.	Number (Integer)	8
Totals - Normal Cap Adj Amt	Total of the Normal Cap Adj Amt column.	Number (Decimal)	14
Totals - Normal Cap Adj Cnt	Total of the Normal Cap Adj Cnt column.	Number (Integer)	8
Totals - Positive Cap Adj Amt	Total of the Positive Cap Adj Amt column.	Number (Decimal)	14
Totals - Positive Cap Adj Cnt	Total of the Positive Cap Adj Cnt column.	Number (Integer)	8

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Field	Description	Data Type	Length
Totals - Total Cap Adj Amt Pd	Total of the Total Cap Adj Amt Pd column.	Number (Decimal)	14
Totals - Total Cap Adj Cnt	Total of the Total Cap Adj Cnt column.	Number (Integer)	8

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7.18 MGD-A500-Q—PATIENT 1ST REFERRAL REPORT

7.18.1 MGD-A500-Q—Patient 1st Referral Report Narrative

Users access the Patient 1st Provider Referral report to see a list of recipients by name that have claims paid for the month that were adjudicated as referred services under the provider's ID number. This report, which is produced on the first of each quarter, for the previous quarter, is sent to providers in hard copy format and also stored in COLD. A legend is created at the end of the report displaying the descriptions related to the procedure and diagnosis codes.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

The Claims subsystem handles these claims as follows:

Physician and Outpatient claims that require a referral will pay, as long as the PMP, PMP's Group, or a member of the PMP's group is the referral, or the PMP and the referral are members of the same group.

The mgd_ref_ind is only set if the actual PMP is in one of the referral fields, and report is only created when this indicator is set.

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7.18.2 MGD-A500-Q—Patient 1st Referral Report Layout

```
Report  : MGD-A500-Q                    ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY

                                                                    Mailing Label
XXXXXXXXXX                                                          <-Provider Number
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   <-Provider Name
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                               <-Provider Street Address 1
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                               <-Provider City, St Zip+4


<Page Break>
```


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```
Report  : MGD-A500-Q                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJQ500                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: MGDA500M                           PATIENT 1ST REFERRAL REPORT                          Page:        999
                                         REPORT PERIOD:  MM/DD/CCYY - MM/DD/CCYY

PROVIDER NUMBER: XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    Payee PMP ID:
XXXXXXXXXXXXXXX            The following services have been paid for by the Agency as a result of your name and Medicaid provider
number being used as authorization.  Please carefully review this list and determine if any of these services were not referred.
If any discrepancies are found, please indicate this and return to the attention of Barbara J. Luther at the Alabama Medicaid
Agency, 501 Dexter Avenue, Montgomery, AL. 36103-5624.  Phone (334) 242-5196 Fax (334) 353-4642.  Remember, the dates-of-service
contained in the report may be in the past; therefore; the recipient may no longer be on your panel or the PMP associated with
the group.

LAST                    FIRST              MEDICAID         FIRST           PRCD         DGCD      CONSULTING
NAME                    NAME               NUMBER           DOS             CODE     ICD CODE      PROVIDER

XXXXXXXXXXXXXXXX        XXXXXXXX           999999999999     MM/DD/CCYY      XXXXXX    X  XXXXXXX   XXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXX    X  XXXXXXX
XXXXXXXXXXXXXXXX        XXXXXXXX           999999999999     MM/DD/CCYY      XXXXXX    X  XXXXXXX   XXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXX    X  XXXXXXX
XXXXXXXXXXXXXXXX        XXXXXXXX           999999999999     MM/DD/CCYY      XXXXXX    X  XXXXXXX   XXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXX    X  XXXXXXX
CODE LEGEND:

    PROCEDURE CODE

    XXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    XXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ICD DIAGNOSIS CODE

 X  XXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                   *** END OF REPORT ***
```


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7.18.3 MGD-A500-Q—Patient 1st Referral Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Patient 1st Referral report.

Field	Description	Data Type	Length
Code Legend: Diagnosis Code	ICD Version Code (length 1), spaces (2), Diagnosis Code (length 7), space, and Description (length 60).	Character	71
Code Legend: Procedure Code	Procedure Code (length 6), spaces(2), and Description (length 47).	Character	55
Consulting Provider	Name of the consulting provider.	Character	21
DGCD Code	Diagnosis code from the claim.	Character	7
ICD	DGCD ICD Version code to identify the Diagnosis Code as ICD-9 or ICD-10. Values are ‘9’ (ICD-9) and ‘0’ (ICD-10).	Character	1
First DOS	First date of service on the claim.	Date (MM/DD/CCYY)	10
First Name	Recipient’s first name.	Character	8
Last Name	Recipient’s last name.	Character	16
Mailing Label: Provider City, St Zip+4	PMP City, State and Zip Plus 4.	Character	30
Mailing Label: Provider Name	Provider's name.	Character	30
Mailing Label: Provider Number	PMP identification number.	Character	10
Mailing Label: Provider Street Address1	PMP Street Address 1.	Character	30
Medicaid Number	Recipient's Medicaid Number.	Character	12

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Field	Description	Data Type	Length
Payee PMP ID	This field displays the provider's id number if an individual provider or the group provider number if part of a group.	Character	15
PRCD Code	The procedure code from the claim.	Character	6
Provider Number	The Provider's ID (length 10) and Name (length 50).	Number (Integer)	60
Report Period	The quarterly reporting time period in MM/DD/CCYY - MM/DD/CCYY format.	Date (MM/CCYY)	23

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7.19 MGD-A810-M—MONTHLY MEDICARE ADVANTAGE ENROLLMENT AND ERRORS REPORT

7.19.1 MGD-A810-M—Monthly Medicare Advantage Enrollment and Errors Report Narrative

This report, which is produced monthly, list HMO enrollment information by recipient within each Medicare Advantage Plan. The report is broken out by New/Continuing, Terminated, and Rejected enrollees.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

7.19.2 MGD-A810-M—Monthly Medicare Advantage Enrollment and Errors Report Layout

```
Report  : MGD-A810-M                                ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGDJM810                       MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: MGDA810M                     MONTHLY MEDICARE ADVANTAGE ENROLLMENT AND ERRORS                  Page:        999
                                                     REPORT PERIOD: MM/CCYY


MEDICARE ADVANTAGE PLAN:  JOHNSON LAKE REHABILITATION

                                                NEW/CONTINUING ENROLLEES

RECIPIENT ID   SSN         LAST NAME, FIRST NAME, MI    MESSAGE                                      EFFDATE   ENDDATE   QMB

XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD
XXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD
XXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD
XXXXXXXXXX


                                                TERMINATED ENROLLEES

RECIPIENT ID   SSN         LAST NAME, FIRST NAME, MI    MESSAGE                                      EFFDATE   ENDDATE

XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD  CCYYMMDD


                                                REJECTED ENROLLEES
```


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```
RECIPIENT ID   SSN         LAST NAME, FIRST NAME, MI    MESSAGE                                        PROCESS DT

XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CCYYMMDD
<PAGE BREAK>



Report  : MGD-A810-M                                ALABAMA MEDICAID AGENCY                                  Run Date:
MM/DD/CCYY
Process : MGDJM810                            MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:
HH:MM:SS
Location: MGDA810M                       MONTHLY MEDICARE ADVANTAGE ENROLLMENT AND ERRORS                       Page:
999
                                                    REPORT PERIOD: MM/CCYY


TOTAL NEW / CONTINUING ENROLLESS:           999,999,999
TOTAL TERMINATED ENROLLEES:                 999,999,999
TOTAL REJECTED ENROLLEES:                   999,999,999
                                                     *** END OF REPORT ***
```

7.19.3 MGD-A810-M—Monthly Medicare Advantage Enrollment and Errors Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly Medicare Advantage Enrollment and Errors report.

Field	Description	Data Type	Length
Eff Date	Recipient assignment effective date.	Date (MM/DD/CCYY)	10
End Date	Recipient assignment end date.	Date (MM/DD/CCYY)	10
Medicare Advantage Plan	Name of the Medicare Advantage Plan.	Character	30

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Field	Description	Data Type	Length
Message	Message which describes what, if anything happened with the Medicare Advantage recipient's transaction. New/Continuing Messages: Existing Recipient EDB assignment created. Terminated or Rejected Messages: Recipient aid category/county not found. EDB GHO was end dated. Recp is locked out of PMP or Group Mbr Recip state invalid PMP has NO region enrollments Init dte [CCYYMMDD] out of CCYYMMDD/CCYYMMDD Can’t extend MMIS assignment end date. MMIS end can’t be prior to effective date. Enrolled in mutually−exclusive program Invalid Medicare coverage for pgm	Character	50
QMB	Description of the type of aid category (QMB) that the recipient has.	Character	10
Recipient ID	Recipient identification number.	Character	12
Recipient - Last Name, First Name, MI	Recipient Name (Last, First, MI).	Character	3

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Field	Description	Data Type	Length
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
SSN	Recipient's Social Security Number.	Character	9
Total New/Continuing Enrollees	Total number of new and continuing enrollees assigned to the HMO.	Number (Decimal)	11
Total Rejected Enrollees	Total recipients we were unable to enroll.	Number (Decimal)	11
Total Terminated Enrollees	Total number of continuing enrollees disenrolled from the HMO.	Number (Decimal)	11

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7.20 MGD-A815-M—MANUAL OVERRIDE OF EDB INFORMATION REPORT

7.20.1 MGD-A815-M—Manual Override of EDB Information Report Narrative

The Medicaid Agency uses the this report, which is produced monthly, to identify all Medicare Advantage recipients whose enrollment information has been changed from what is currently on the EDB tables.

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7.20.2 MGD-A815-M—Manual Override of EDB Information Report Layout

```
Report  : MGD-A815-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : MGDJM815                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: MGDA815M                              MANUAL OVERRIDE OF EDB INFORMATION                            Page:        999
                                                      REPORT PERIOD:  MM/CCYY
               -------------------EDB INFORMATION---------------------     ---------------------MMIS INFORMATION----------------
---

RECIP ID        VENDOR  EDB ID   PMP ID        EFFDATE       ENDDATE         VENDOR EDB ID  PMP ID       EFFDATE      ENDDATE
ST

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X

XXXXXXXXXXXX    XXXX    XXXXX    XXXXXXXXXX    MM/DD/CCYY    MM/DD/CCYY      XXXX   XXXXX   XXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY
X
                                                      *** END OF REPORT ***
```


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7.20.3 MGD-A815-M—Manual Override of EDB Information Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Manual Override of EDB Information report.

Field	Description	Data Type	Length
EDB ID	Medicare Advantage EDB Identification Number / Contract Number.	Date (MM/DD/CCYY	5
EffDate	Effective date with Medicare Advantage Vendor.	Date (MM/DD/CCYY	10
EndDate	End date with Medicare Advantage Vendor.	Character	10
PMP ID	PMP identification number.	Character	15
Recip ID	Recipient identification number.	Character	12
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
ST	Recipient's assignment status.	Character	1
Vendor	Vendor acronym - BCBS, HSPR, UNHC, or VIVA.	Character	4

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7.21 MGD-A820-M—MONTHLY ICN ENROLLMENT AND ERRORS REPORT

7.21.1 MGD-A820-M—Monthly ICN Enrollment and Errors Report Narrative

This report list ICN enrollment information by recipient within each ICN Plan. The report is broken out by New/Continuing, Terminated, and Rejected enrollees.

This report is also available to providers from the Alabama Medicaid Interactive Services Web Site.

7.21.2 MGD-A820-M— Monthly ICN Enrollment and Errors Report Layout

```
Report  : MGD-A820-M                                ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY
Process : MGD_UPD_ICN_ASGN                    MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: MGDA820M                              MONTHLY ICN ENROLLMENT AND ERRORS                                Page:
999
PLAN    : XXXXX                                     REPORT PERIOD: MM/CCYY

ICN ID:  XXXXXXXXXXXXXXX
                                                 NEW/CONTINUING ENROLLEES

RECIPIENT ID   RECIPIENT NAME               EFF DATE     END DATE     ADD DATE

XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     CCYYMMDD
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     CCYYMMDD


                                                 TERMINATED ENROLLEES

RECIPIENT ID   RECIPIENT NAME               EFF DATE     END DATE     ST    RSN

XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     X     XX
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     X     XX
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     CCYYMMDD     CCYYMMDD     X     XX


                                                 REJECTED ENROLLEES

RECIPIENT ID   RECIPIENT NAME               SC      RSN

XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXX     XX
```


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```
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXX     XX
XXXXXXXXXXXX   XXXXXXXXXX, XXXXXXXXX, X     XXX     XX



<PAGE BREAK>

Report  : MGD-A820-M                                ALABAMA MEDICAID AGENCY                    Run Date: MM/DD/CCYY
Process : MGD_UPD_ICN_ASGN                   MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: MGDA820M                             MONTHLY ICN ENROLLMENT AND ERRORS                                Page:
999
PLAN    : XXXXX                                     REPORT PERIOD: MM/CCYY

ICN ID:  XXXXXXXXXXXXXXX

TOTAL NEW / CONTINUING ENROLLESS:                      999,999,999

TOTAL TERMINATED ENROLLEES DUE TO RSN FA:              999,999,999
TOTAL TERMINATED ENROLLEES DUE TO RSN FE:              999,999,999
TOTAL TERMINATED ENROLLEES DUE TO RSN FS:              999,999,999

TOTAL REJECTED ENROLLEES DUE TO RSN FA:                999,999,999
TOTAL REJECTED ENROLLEES DUE TO RSN FE:                999,999,999
TOTAL REJECTED ENROLLEES DUE TO RSN FS:                999,999,999


RSN FA - Recip chgd to inelig aid cat, dep rsn or age grp
RSN FE - Recipient is not Medicaid eligible
RSN FS - Recipient ICN Special Condition ended or removed


                                                       *** END OF REPORT ***
```


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7.21.3 MGD-A820-M—Monthly ICN Enrollment and Errors Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly ICN Enrollment and Errors Report.

Field	Description	Data Type	Length
Add Date	The date the ICN assignment was added. The date is in CCYYMMDD format.	Character	8
Eff Date	Recipient assignment effective date in CCYYMMDD format.	Character	8
End Date	Recipient assignment end date in CCYYMMDD format.	Character	8
ICN ID	The Integrated Care Network's NPI.	Character	15
PLAN	The Integrated Care Network Assignment Plan: ICNNH -Assignment plan for ICN Nursing Home Services. ICNWA -Assignment plan for ICN Alabama Community Transition (ACT) Waiver Services. ICNWE -Assignment plan for ICN Elderly and Disabled (E&D) Waiver Services.	Character	5
RECIPIENT NAME	Recipient Name (Last, First, MI).	Character	31
Recipient ID	Recipient identification number.	Character	12
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7
RSN	The reason code of the termination or rejection.	Character	2
SC	The recipients special condition code that was rejected.	Character	3

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Field	Description	Data Type	Length
ST	The Status of the Assignment: blank = Active H = Historied	Character	1
Total Rejected Enrollees due to RSN FA	Total number of continuing enrollees disenrolled from the Integrated Care Network due to invalid aid category.	Number (Integer)	11
Total Rejected Enrollees due to RSN FE	Total number of continuing enrollees disenrolled from the Integrated Care Network due to lost eligibility.	Number (Integer)	11
Total Rejected Enrollees due to RSN FS	Total number of continuing enrollees disenrolled from the Integrated Care Network due to special condition being ended.	Number (Integer)	11
Total Terminated Enrollees due to RSN FA	Total number of continuing enrollees disenrolled from the Integrated Care Network due to invalid aid category.	Number (Integer)	11
Total Terminated Enrollees due to RSN FE	Total number of continuing enrollees disenrolled from the Integrated Care Network due to lost eligibility.	Number (Integer)	11
Total Terminated Enrollees due to RSN FS	Total number of continuing enrollees disenrolled from the Integrated Care Network due to special condition being ended.	Number (Integer)	11
Total New/Continuing Enrollees	Total number of new and continuing enrollees assigned to the Integrated Care Network.	Number (Integer)	11

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7.22 MGD-A821-M—ICN OVERLAPPING SPECIAL CONDITIONS

7.22.1 MGD-A821-M—ICN Overlapping Special Conditions Report Narrative

This report will list all the records of any recipient who had a single/multiple overlapping segments across the same or different plans.

7.22.2 MGD-A821-M— ICN Overlapping Special Conditions Report Layout

```
Report  : MGD-A821-M                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MGD_UPD_ICN_ASGN                MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:   HH:MM:SS
Location: MGDA820M                          ICN OVERLAPPING SPECIAL CONDITIONS                     Page:        999
                                                REPORT PERIOD: MM/CCYY

RECIPIENT ID     RECIPIENT NAME                        EFF DATE     END DATE     SC

XXXXXXXXXXXX     XXXXXXXXXX, XXXXXXXXX, X              CCYYMMDD     CCYYMMDD     XXX
XXXXXXXXXXXX     XXXXXXXXXX, XXXXXXXXX, X              CCYYMMDD     CCYYMMDD     XXX
XXXXXXXXXXXX     XXXXXXXXXX, XXXXXXXXX, X              CCYYMMDD     CCYYMMDD     XXX

                                                ** No Data This Report **
                                                  ** End of Report **
```

7.22.3 MGD-A821-M— ICN Overlapping Special Conditions Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Monthly ICN Enrollment and Errors Report.

Field	Description	Data Type	Length
EFF DATE	Recipient special condition effective date in CCYYMMDD format.	Character	8
END DATE	Recipient assignment end date in CCYYMMDD format.	Character	8
RECIPIENT ID	Recipient identification number.	Character	12
RECIPIENT NAME	Recipient Name (Last, First, MI).	Character	31
Report Period	The reporting time period in MM/CCYY format.	Date (MM/CCYY)	7

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Field	Description	Data Type	Length
SC	The recipients special condition code.	Character	3

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7.23 MGM71802DAT – CAPITATION RECONCILIATION REPORT

7.23.1 Mgm71802.dat – Capitation Reconciliation Report Narrative

This data file contains the monthly report for the capitation reconciliation process, in tab-delimited format so that the data can be easily imported into Excel, Access, etc.

7.23.2 Mgm71802.dat – Capitation Reconciliation Report Layout

```
Adj      PMP            Last     FI  MI      RID              Age      Sex      Eff              End          St       Stop     DOB
DOD      Cap              Cap      Rsn     Prv     Amt          Prv
Type     ID             Name                                              Date             Date                  Rsn Cd
Date             Catg     Cd       Rsn Cd  Paid        Amt Paid
X      9999999999     XXXXXXXX  X   X      99999999999      99      X      CCYY/MM/DD      CCYY/MM/DD    X        XX     CCYY/MM/DD
CCYY/MM/DD CCYY/MM/DD      XXXXX   XX      XX      -99999.99  -99999.99
```

7.23.3 Mgm71802.dat – Capitation Reconciliation Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Reconciliation report.

Field	Description	Data Type	Length
Adj Type	Adjustment Type. Valid options include: D - Death recoupment E - Excluded recoupment F - Future payment H - Historied recoupment M - Missed Payment R - Recalculated payment	Character	1
Age	Recipient's age.	Number (Integer)	3
Amt Paid	Amount of adjustment paid.	Number (Decimal)	12

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Field	Description	Data Type	Length
Cap Catg	New capitation category. Valid options include: MACAP - Medicare Advantage Capitation P1CMF - Patient 1st CMF Capitation	Character	5
Cap Date	Capitation date.	Date (CCYY/MM/DD)	10
DOB	Recipient's date of birth.	Date (CCYY/MM/DD)	10
DOD	Recipient's date of death.	Date (CCYY/MM/DD)	10
Efft Date	Effective date of PMP assignment.	Date (CCYY/MM/DD)	10
End Date	End date of PMP assignment.	Date (CCYY/MM/DD)	10
FI	Recipient's first name initial.	Character	1
Last Name	Recipient's last name.	Character	15
MI	Recipient's middle name initial.	Character	1
PMP ID	Provider identification number.	Character	15
Prv Amt Paid	Original amount paid to the PMP.	Number (Decimal)	12

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Prv Rsn Cd	Reason for previous capitation payment. Valid options include: DP - Duplicate Payment PA - Payment - Adjustment Payment PB - Payment - Credit Balance PC - Payment - Demographic Change PI - Payment - Adjustment Increase PJ - Payment - Recip Elig Adj PL - Payment - Adjustment Auto-Recon/Day Specific PN - Payment - Normal PO - Payment - Adjustment Auto-Recon Birth Month PR - Payment - Retro RA - Recoupment - Demographic Change RB - Recoupment - Clear Credit Balance RC - Recoupment - Delivery RD - Recoupment - Death RE - Recoupment - Recip Elig Adj RF - Recoupment - Adjustment Recovery RI - Recoupment - Recipient Incarcerated RK - Recoupment - EPSDT Claim RL - Recoupment - Adjustment Auto-Recon RO - Recoupment - Other RP - Recoupment - Family Planning	Character	2

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Field	Description	Data Type	Length
RID	Recipient's identification number.	Character	12

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Rsn Cd	Reason for capitation adjustment. Valid options include: DP - Duplicate Payment PA - Payment - Adjustment Payment PB - Payment - Credit Balance PC - Payment - Demographic Change PI - Payment - Adjustment Increase PJ - Payment - Recip Elig Adj PL - Payment - Adjustment Auto-Recon/Day Specific PN - Payment - Normal PO - Payment - Adjustment Auto-Recon Birth Month PR - Payment - Retro RA - Recoupment - Demographic Change RB - Recoupment - Clear Credit Balance RC - Recoupment - Delivery RD - Recoupment - Death RE - Recoupment - Recip Elig Adj RF - Recoupment - Adjustment Recovery RI - Recoupment - Recipient Incarcerated RK - Recoupment - EPSDT Claim RL - Recoupment - Adjustment Auto-Recon RO - Recoupment - Other RP - Recoupment - Family Planning	Character	2

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Field	Description	Data Type	Length
Sex	Recipient's sex. Valid options include: F - Female M – Male U - Unknown	Character	1
ST	Assignment status code.	Character	1
Stop Rsn Cd	Assignment stop reason code.	Character	2

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7.24 MGM71822DAT – ICN CAPITATION RECONCILIATION REPORT

7.24.1 Mgm71822.dat – ICN Capitation Reconciliation Report Narrative

This data file contains the monthly report for the capitation reconciliation process, in tab-delimited format so that the data can be easily imported into Excel, Access, etc.

7.24.2 Mgm71822.dat – ICN Capitation Reconciliation Report Layout

```
Adj     PMP           Last    FI  MI      RID             Age     Sex     Eff             End         St      Stop    DOB
DOD     Cap             Cap     Rsn     Prv     Amt         Prv
Type    ID            Name                                            Date            Date                Rsn Cd
Date            Catg    Cd      Rsn Cd  Paid        Amt Paid
X     9999999999     XXXXXXXX  X   X      99999999999      99     X      CCYY/MM/DD      CCYY/MM/DD    X        XX    CCYY/MM/DD
CCYY/MM/DD CCYY/MM/DD      XXXXX   XX      XX      -99999.99  -99999.99
```

7.24.3 Mgm71822.dat – ICN Capitation Reconciliation Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the Capitation Reconciliation report.

Field	Description	Data Type	Length
Adj Type	Adjustment Type. Valid options include: D - Death recoupment E - Excluded recoupment F - Future payment H - Historied recoupment M - Missed Payment R - Recalculated payment	Character	1
Age	Recipient's age.	Number (Integer)	3
Amt Paid	Amount of adjustment paid.	Number (Decimal)	12
Cap Catg	Capitation category. Valid options include: • *ICNNH =ICN Nursing Home* • *ICNWA = ICN ACT Waiver* • *ICNWE = ICN E&D Waiver*	Character	5

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Field	Description	Data Type	Length
Cap Date	Capitation date.	Date (CCYY/MM/DD)	10
DOB	Recipient’s date of birth.	Date (CCYY/MM/DD)	10
DOD	Recipient’s date of death.	Date (CCYY/MM/DD)	10
Efft Date	Effective date of PMP assignment.	Date (CCYY/MM/DD)	10
End Date	End date of PMP assignment.	Date (CCYY/MM/DD)	10
FI	Recipient’s first name initial.	Character	1
Last Name	Recipient’s last name.	Character	15
MI	Recipient’s middle name initial.	Character	1
PMP ID	Provider identification number.	Character	15
Prv Amt Paid	Original amount paid to the PMP.	Number (Decimal)	12

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Field	Description	Data Type	Length
Prv Rsn Cd	Reason for previous capitation payment. Valid options include: DP - Duplicate Payment PA - Payment - Adjustment Payment PB - Payment - Credit Balance PC - Payment - Demographic Change PI - Payment - Adjustment Increase PJ - Payment - Recip Elig Adj PL - Payment - Adjustment Auto-Recon/Day Specific PN - Payment - Normal PO - Payment - Adjustment Auto-Recon Birth Month PR - Payment - Retro RA - Recoupment - Demographic Change RB - Recoupment - Clear Credit Balance RC - Recoupment - Delivery RD - Recoupment - Death RE - Recoupment - Recip Elig Adj RF - Recoupment - Adjustment Recovery RI - Recoupment - Recipient Incarcerated RK - Recoupment - EPSDT Claim RL - Recoupment - Adjustment Auto-Recon RO - Recoupment - Other RP - Recoupment - Family Planning	Character	2
RID	Recipient's identification number.	Character	12

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Field	Description	Data Type	Length
Rsn Cd	Reason for capitation adjustment. Valid options include: DP - Duplicate Payment PA - Payment - Adjustment Payment PB - Payment - Credit Balance PC - Payment - Demographic Change PI - Payment - Adjustment Increase PJ - Payment - Recip Elig Adj PL - Payment - Adjustment Auto-Recon/Day Specific PN - Payment - Normal PO - Payment - Adjustment Auto-Recon Birth Month PR - Payment - Retro RA - Recoupment - Demographic Change RB - Recoupment - Clear Credit Balance RC - Recoupment - Delivery RD - Recoupment - Death RE - Recoupment - Recip Elig Adj RF - Recoupment - Adjustment Recovery RI - Recoupment - Recipient Incarcerated RK - Recoupment - EPSDT Claim RL - Recoupment - Adjustment Auto-Recon RO - Recoupment - Other RP - Recoupment - Family Planning	Character	2

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Field	Description	Data Type	Length
Sex	Recipient's sex. Valid options include: F - Female M – Male U - Unknown	Character	1
ST	Assignment status code.	Character	1
Stop Rsn Cd	Assignment stop reason code.	Character	2

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AMMIS MAR User Manual

Date Modified: 03/27/2018

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501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS MAR User Manual
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Owner:	DXC/Agency
Author:	MAR Team
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
09/19/2013	1.0		Application of CO 8367	6.19 – MAR Reports – Provider Page - update layout
10/03/2013	2.0		Application of ICD-10 production change orders	CO 10259 – MAR-2100-M -- Monthly Abortion Detail Report – Add ICD Version code MAR-2110-M -- Monthly Sterilization Detail Report – Add ICD Version code MAR-2100-A -- Annual Abortion Detail Report – Add ICD Version Codes MAR-2110-A -- Annual Sterilization Detail Report – add ICD Version Codes
05/11/2016	3.0		Application of CO 12819:	Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS
03/28/2018	4.0		Application of CO 14858	Removal of PHI/PII

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1.3 RELATED DOCUMENTATION

Document	Description	url

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2 MAR INTRODUCTION

2.1 MAR USER MANUAL OVERVIEW

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Management and Administrative Reporting (MAR) functional area.

This manual covers the following:

- MAR Overview
- MAR Getting Started
- System Wide Common Terminology and Layouts
- MAR Panels
- MAR Reports

2.2 MAR USER MANUAL OBJECTIVE

The objective of the AMMIS MAR User Manual is to provide system users with detailed descriptions of the online system, including panel and report field descriptions, panel functionality descriptions and graphical representations of panels and report layouts.

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3 MAR OVERVIEW

3.1 INTRODUCTION TO MAR

The purpose of the Management and Administrative Reporting (MAR) function is to provide programmatic, financial, and statistical reports to assist the state and federal government with fiscal planning, control, monitoring, program and policy development, and evaluation of the State Medical Assistance Programs.

The MAR function is a comprehensive management tool which provides information on program status and trends, has the ability to analyze historical trends, and predicts the impact of policy changes on programs. This function uses key information from other Alabama Medicaid Management Information System (AMMIS) functions to generate standard reports.

The major inputs to MAR are data from all the claims processing functions as well as the financial, recipient, reference and provider areas. The major process is the generation of reports and program data, and the major outputs are the financial, statistical, and summary reports and data required by federal regulations, and other reports and data that assist the state in the management and administration of State Medical Assistance Programs.

This function is flexible enough to meet both existing and proposed changes in format and data requirements of federal and state management statistical reporting without major reprogramming or expense, and provide maximum flexibility to accommodate future changes.

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4 MAR GETTING STARTED

4.1 OVERVIEW

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 SYSTEM SECURITY

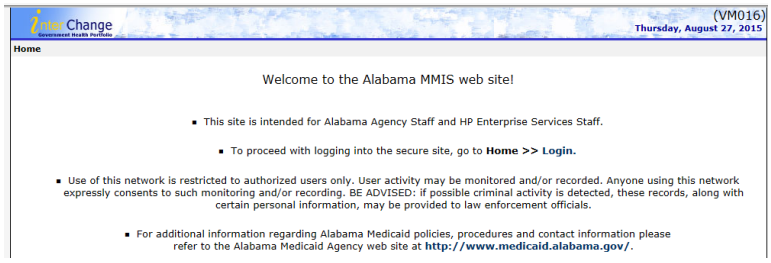
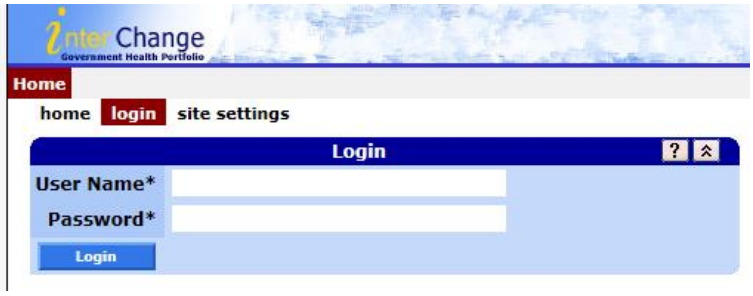
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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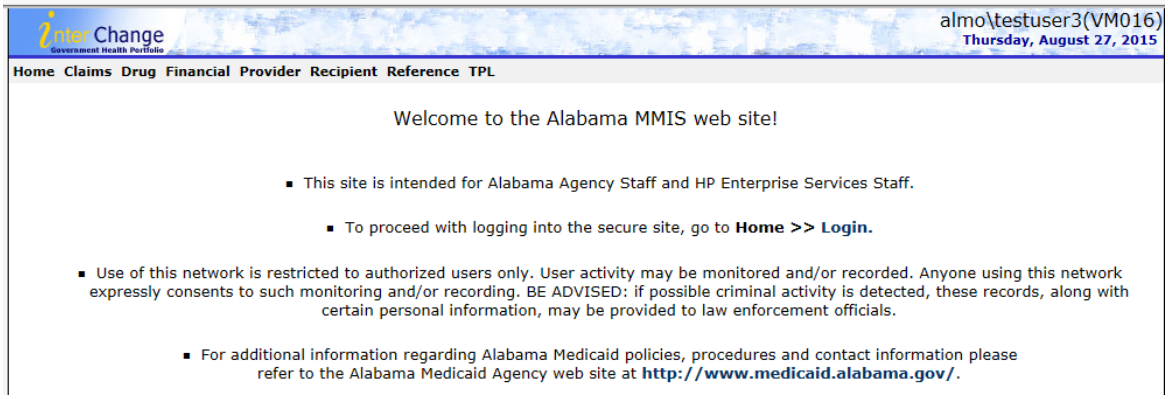
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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4.1 SCREEN DISPLAY FEATURES

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.1.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team recipients, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt +shortcut key)
- Main Menu bar
- Panel
- Mini Search panel
- Hot Link
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a Page Header with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the DXC.technology copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

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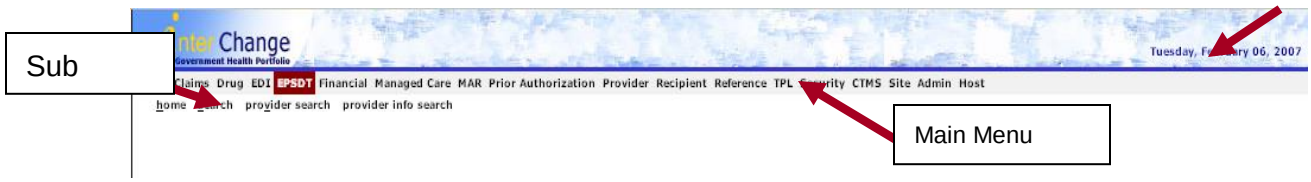
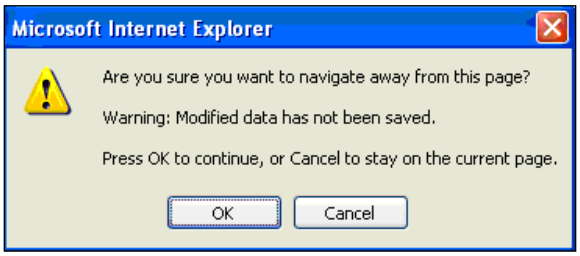


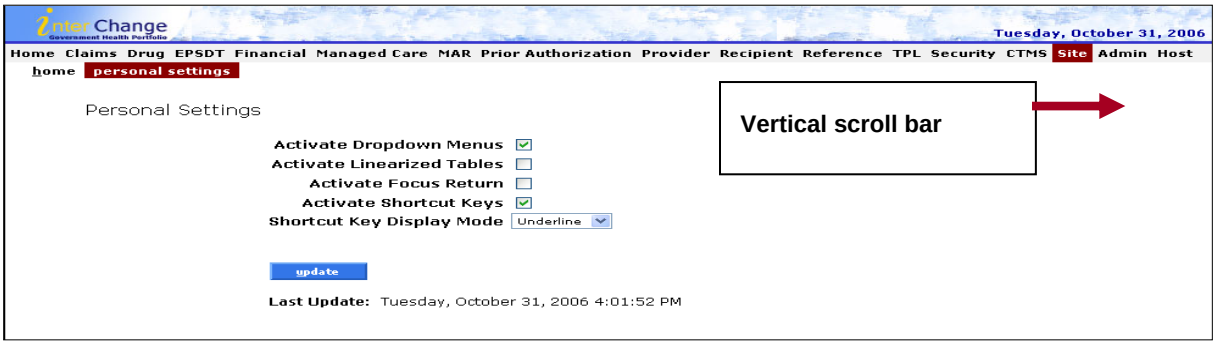
If a user attempts to add, update or delete information within a page the system prompts the user to “Save” or “Cancel” their changes via a pop-up window message prior to navigating away from the page. When the system generates the message, the detail panel is locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 SHORTCUT KEYS

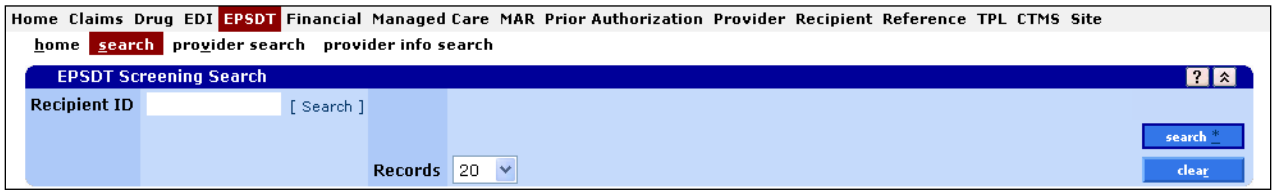
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated panel.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the EPSDT Sub Menu, the user can use the shortcut keys to quickly navigate from the EPSDT Search panel to the EPSDT Provider Search panel by using the following shortcut key combination: (Ctrl + Alt + V) since the letter “V” is found within the horizontal bars on the Sub Menu provider search link.



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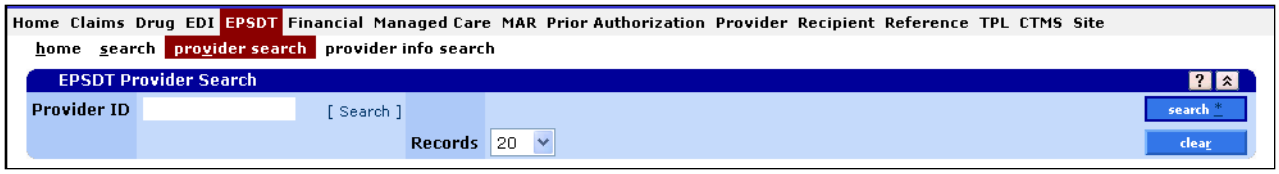
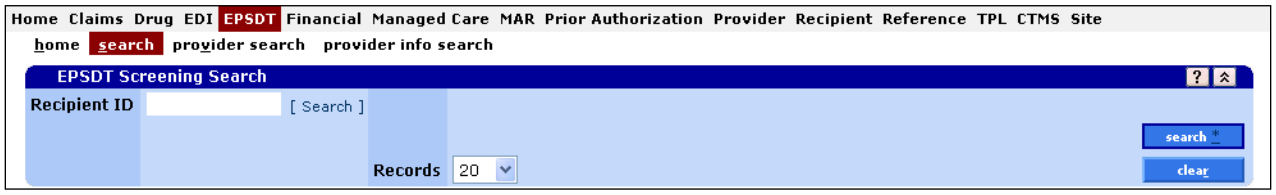


5.3 SEARCH OPTIONS

There are several search options available within interChange.

5.3.1 Search Panels

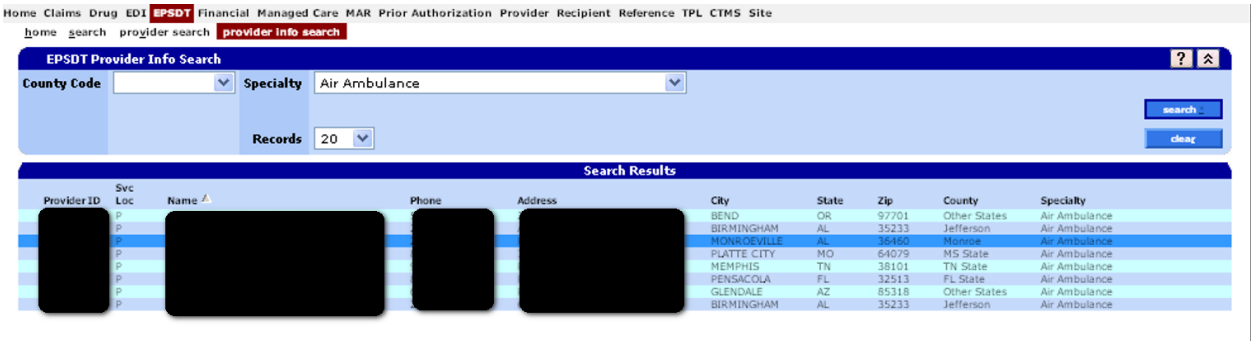
The AMMIS contains two types of search panels: Search and Advanced Search. An example of the EPSDT Screening Search panel with the Search button displaying is shown below:



Note: The Advanced Search button functionality does not exist in the EPSDT subsystem.

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. For example, the user clicked the 3rd row of the EPSDT Provider Info Search Results panel (as shown above) and the associated Provider Information panel displayed.

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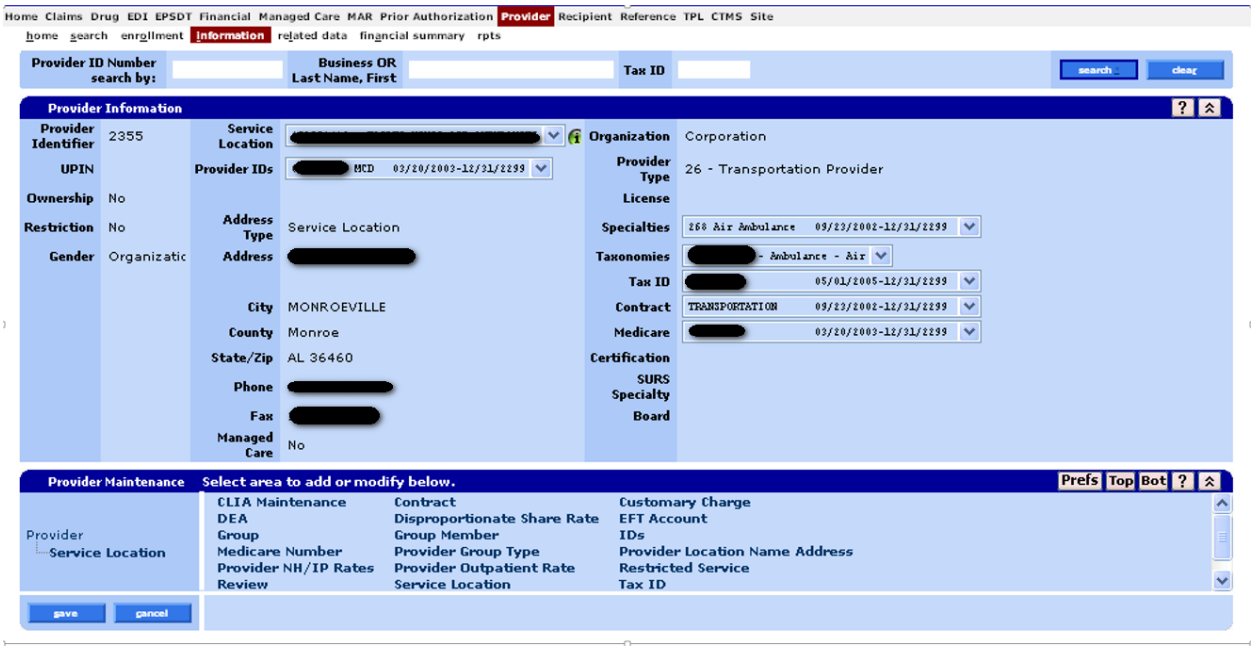
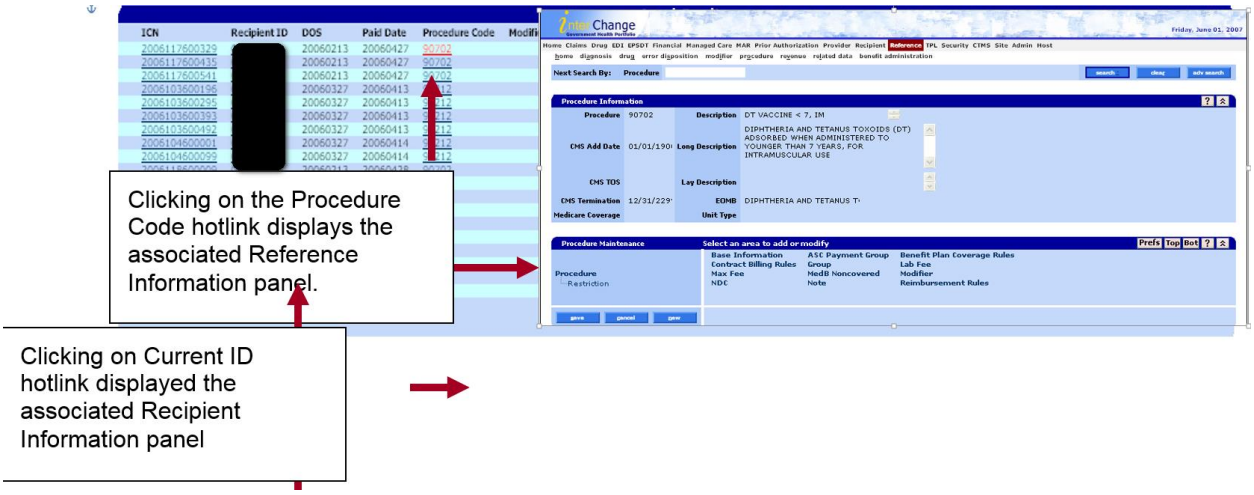


5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available. Users are provided with additional information related to a field by clicking the hotlink, as shown below.



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5.3.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the [Search] link, the user accesses the search panel that is associated with that particular field.

5.4 PANEL LAYOUT

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on panels within the EPSDT system:

Name	Icon	Description
Clear Button	clear	Clears all actions to all panels on the page. Can be found on the navigation panel.
Close Button	✕	Closes a panel.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button	⌄	Expands a panel to display all of its content.
Minimize Button	⌃	Collapses a panel.
[Search]	[Search]	Opens a search panel associated to a particular field. Allows the user to search for unknown information, such as a Provider ID, using other information, such as the Provider Name.
Search	search	Searches for information based on criteria entered into field(s) on panel.

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5.4.2 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.3 Question Mark Icon ?

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.4.3.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Clear	Clears previous searches	Button	N/A	0
Search	Searches through Recipient records	Button	N/A	0
Recipient ID	Recipient identification number of the Recipient. Must be 12 characters in length.	Field	Number	12
Records	Number of records to display per page.	Field	Drop Down List Box	0
[Search]	Hyperlink to a list of Recipients	Hyperlink	N/A	0

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	0	Validate	Recipient ID must be numeric.
	Field	1	Validate	Recipient ID must be entered for search criteria.

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The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as; Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

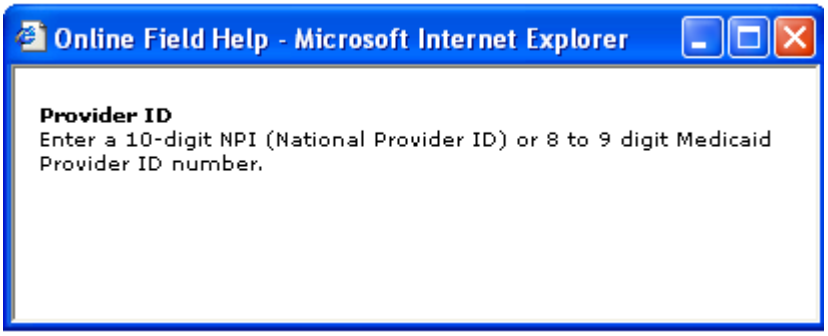
5.4.4 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.4.4.1 Field Level Help Description

When hovering the cursor over a field name, such as **Provider ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 MAR PANELS

This section gives a brief description of each panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each panel covers the following:

- Panel Narrative
- Panel Layout
- Panel Field Descriptions
- Panel Field Edit Error Code Tables
- Panel Extra Features
- Panel Accessibility

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6.1 MAR REPORTS - EXPENDITURES PAGE OVERVIEW

6.1.1 MAR Reports - Expenditures Page Narrative

The MAR Reports – Expenditures page is the access point within the MAR system that allows users to view reports that fall under the category of expenditures.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures]

6.1.2 MAR Reports - Expenditures Page Layout

6.1.3 MAR Reports - Expenditures Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Expenditures By COS	Link to Expenditures By COS panel.	Hyperlink	N/A	0
Participation By Aid Category	Link to Participation By Aid Category panel.	Hyperlink	N/A	0
Participation By COS	Link to Participation By COS panel.	Hyperlink	N/A	0
Payment By COS	Link to Payment By COS panel.	Hyperlink	N/A	0
Payment By Provider Type	Link to Payment By Provider Type panel.	Hyperlink	N/A	0
Place of Service Analysis	Link to Place of Service Analysis panel.	Hyperlink	N/A	0

6.1.4 MAR Reports - Expenditures Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.1.5 MAR Reports - Expenditures Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.1.6 MAR Reports - Expenditures Page Accessibility

6.1.6.1 To Access Expenditures Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.

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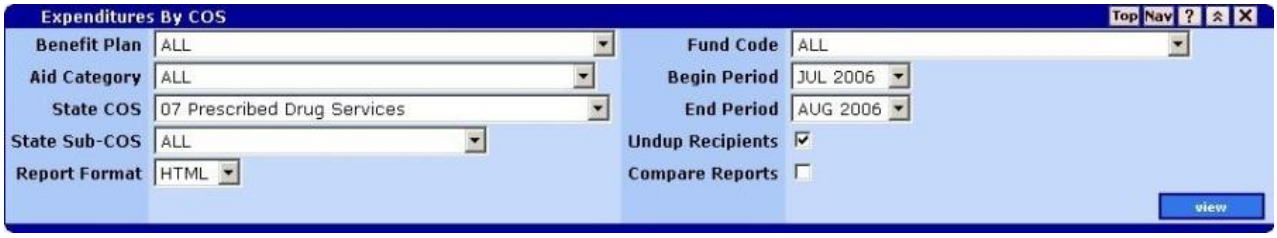
6.2 EXPENDITURES BY COS - SEARCH PANEL OVERVIEW

6.2.1 Expenditures By COS - Search Panel Narrative

The Expenditures by COS panel allows users to generate a report that displays paid claim data grouped by State Category of Service (COS) and aid category. It includes recipient, units and paid dollars as applicable for paid claims. When the user selects the Undup Recipients check box, the number of unduplicated recipients is displayed for the listed COS, aid category combination.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Expenditures By COS]

6.2.2 Expenditures By COS - Search Panel Layout



6.2.3 Expenditures By COS - Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Combo Box	Check Box	0
View	Allows the user to view the Expenditures By COS report.	Button	N/A	0

6.2.4 Expenditures By COS - Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than Six months after the Begin Period.	Change Begin Period to be within 6 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than Six months after the Begin Period.	Change End Period to be within 6 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.2.5 Expenditures By COS - Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.2.6 Expenditures By COS - Search Panel Accessibility

6.2.6.1 To Access and View Expenditure Analysis by COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Expenditures by COS** hyperlink on the Expenditures page.	Expenditures by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate panel opens and the Expenditure Analysis by Category of Service report displays.

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6.2.7 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Narrative

The Expenditure Analysis By Category of Service report displays paid claim data grouped by State category of service and aid category. It includes recipient, units and paid dollars as applicable for paid claims.

This report is designed to consistently display fee-for-service or encounter information.

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6.2.8 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Layout

9/8/2006 9:14

State of Alabama

Expenditure Analysis By Category of Service

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
State COS	07 Prescribed Drug Services	**Aid Category**	ALL
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

State Category of Service	Aid Category	*Undup Recip	Units of Service	Paid Amount	*Avg Paid per Recip
0710 Prescribed Drugs - Legend	A Public Assistance, Aged	3	3	$164	$55
0710 Prescribed Drugs - Legend	E Public Assistance, Blind	3	3	$240	$80
0710 Prescribed Drugs - Legend	I Public Assistance, Disabled	6	8	$848	$141
0710 Prescribed Drugs - Legend	I1 Institutionalized with income less than 300%, Aged	1	1	$3	$3
0710 Prescribed Drugs - Legend	I3 Institutionalized with income < 300%, Disabled	1	2	$281	$281
0710 Prescribed Drugs - Legend	M Public Assistance, TANF	16	17	$619	$39
0710 Prescribed Drugs - Legend	N Medical Assistance, Categorically Needy, TANF	10	8	$731	$73
0720 Prescribed Drugs - Non-Legend	E Public Assistance, Blind	3	3	$50	$17
0720 Prescribed Drugs - Non-Legend	G Medical Assistance, Categorically Needy, Blind	1	1	$32	$32
0720 Prescribed Drugs - Non-Legend	M Public Assistance, TANF	3	3	$31	$10
0720 Prescribed Drugs - Non-Legend	N Medical Assistance, Categorically Needy, TANF	3	3	$38	$13
Totals:		**51**	**52**	**$3,037**	**$60**

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6.2.9 Expenditure Analysis By Category of Service (MAR.ExpendituresByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Aid Category	Eligibility category for which a recipient is assigned.	30	Character
Paid Amount	Amount reimbursed for all paid claims for each State Category of Service, Aid Category combination. This total reflects the criteria selected by the user.	15	Number (Decimal)
State Category of Service	Displays the combined high-level State Category of Service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	30	Character
Totals	Totals for corresponding columns.	15	Number (Integer)
Units of Service	Total units of service for paid claims for each State Category of Service, Aid Category combination. This total reflects the criteria selected by the user.	10	Number (Integer)

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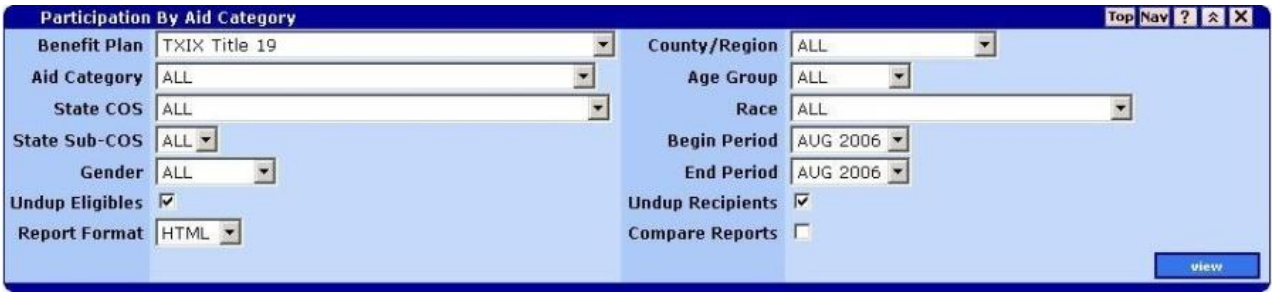
6.3 PARTICIPATION BY AID CATEGORY PANEL OVERVIEW

6.3.1 Participation By Aid Category Panel Narrative

The Participation by Aid Category panel allows users to generate a report that displays number of eligible recipients, recipients receiving a service and paid claims along with the billed, allowed and paid amounts for paid claims. The panel results are grouped by aid category.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Participation By Aid Category]

6.3.2 Participation By Aid Category Panel Layout



6.3.3 Participation By Aid Category Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Participation By Aid Category report.	Button	N/A	0

6.3.4 Participation By Aid Category Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.3.5 Participation By Aid Category Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Participation By Aid Category Panel Accessibility

6.3.6.1 To Access and View Participation by Aid Category Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Participation by Aid Category** hyperlink on the Expenditures page.	Participation by Aid Category panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Locality Participation Analysis by Aid Category report displays.

6.3.7 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Narrative

The Locality Participation Analysis by Aid Category report displays number of eligible recipients, recipients receiving a service, and paid claims along with the billed, allowed and paid amounts for paid claims. When the user selects the Undup Recipient checkbox, the number of participating recipients and average payment per recipient is displayed. When the user selects the Undup Eligibles checkbox, the number of eligibles and the average payment per eligible recipient is displayed. When both checkboxes are selected, the eligibles and participating counts are displayed. The window results are grouped by aid category. Selection criteria for this window is: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.3.8 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Layout

9/8/2006 9:39

State of Alabama

Locality Participation Analysis By Aid Category

Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Age Group**	ALL
County/Region	ALL	**Race**	ALL
Aid Category	ALL	**Gender**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Aid Category	*Eligibles	*Undup Recip	*Pct Elig Prtcp	Claims Paid	Billed Amount	Allowed Amount	Paid Amount	*Avg Paid per Elig	*Avg Paid per Recip
A Public Assistance, Aged	529	2	0.4%	2	$129	$104	$102	$0	$51
I Public Assistance, Disabl	79	6	7.6%	16	$2,328	$1,969	$1,949	$25	$325
I1 Institutionalized with in	15	1	6.7%	1	$25	$0	$3	$0	$3
K Medical Assistance, Categ	60	2	3.3%	5	$1,164	$1,039	$560	$9	$280
M Public Assistance, TANF	271	7	2.6%	9	$805	$173	$162	$1	$23
N Medical Assistance, Categ	182	7	3.8%	11	$1,100	$596	$543	$3	$78
T1 TEFRA Nursing Facility	2	1	50.0%	7	$2,475	$789	$728	$364	$728
Totals:	**1,320**	**26**	**2.0%**	**51**	**$8,026**	**$4,670**	**$4,047**	**$3**	**$156**

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6.3.9 Locality Participation Analysis by Aid Category (MAR.PrtcpByAidCategory.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Elig	Average of dollars paid per eligible for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Eligibles	Count of recipients eligible for service during the reporting period.	8	Number (Integer)
*Pct Elig Prtcp	When both checkboxes are selected, the percentage of all eligible recipients who participate in the program.	6	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Claims Paid	Displays the number of claims in the selected criteria finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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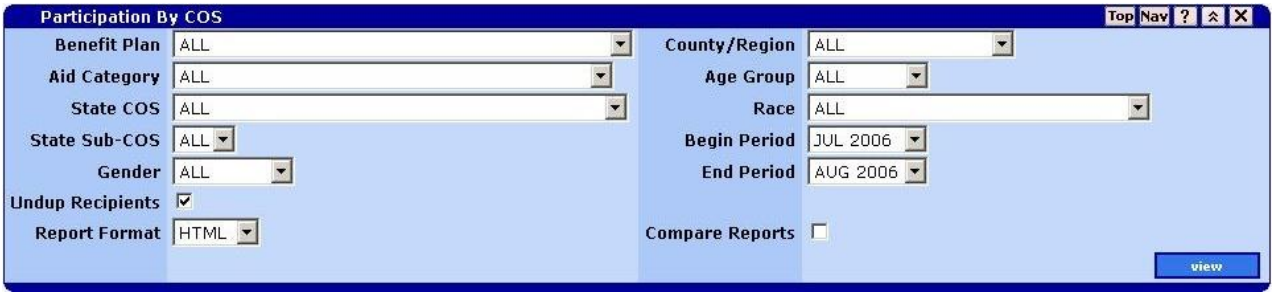
6.4 PARTICIPATION BY COS PANEL OVERVIEW

6.4.1 Participation By COS Panel Narrative

The Participation by COS panel allows users to generate a report that displays recipient and claim counts and dollars for paid claims. When the user selects the Undup Recipients checkbox, the number of recipients participating recipient information and average paid per recipient are displayed. The report is grouped by state category of service. Selection criteria for this panel includes: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender, and reporting period date range.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Participation By COS]

6.4.2 Participation By COS Panel Layout



6.4.3 Participation By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. When a State COS is selected, the report displays the State sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Combo Box	Check Box	0
View	View the Participation By COS report.	Button	N/A	0

6.4.4 Participation By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than Six Months after the Begin Period.	Change Begin Period to be within 6 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than Six Months after the Begin Period.	Change End Period to be within 6 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.4.5 Participation By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.4.6 Participation By COS Panel Accessibility

6.4.6.1 To Access and View Participation By COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Participation by COS** hyperlink on the Expenditures page.	Participation by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Locality Participation Analysis by State COS report displays.

6.4.7 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Narrative

The Locality Participation Analysis by State COS report displays recipient and claim counts and dollars for paid claims. When the user selects the Undup Recipients checkbox, the number of recipients participating recipient information and average paid per recipient are displayed. The report is grouped by state category of service. Selection criteria for this window includes: benefit plan, region/county, state category of service, state sub-category of service, aid category, age group, race, gender, and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.4.8 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Layout

9/8/2006 9:27

State of Alabama

Locality Participation Analysis By State COS

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Age Group**	ALL
County/Region	ALL	**Race**	ALL
State COS	ALL	**Gender**	ALL
State Sub-COS	ALL		
Aid Category	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

State Category of Service	*Undup Recip	*Pct Elig Prtcp	Claims Paid	Billed Amount	Allowed Amount	Paid Amount	*Avg Paid per Recip
03 Outpatient Services	7	0.5%	9	$9,191	$1,354	-$7	-$1
06 Physician Services	29	1.9%	65	$9,228	$4,626	$4,350	$150
07 Prescribed Drug Services	51	3.3%	58	$7,274	$3,086	$3,037	$60
08 MSDG Services	8	0.5%	15	$1,651	$1,597	$1,535	$192
10 Clinic Services	1	0.1%	1	$100	$57	$47	$47
15 ICF-MR Services	2	0.1%	2	$5,891	$2,986	$0	$0
29 Eyewear Services	2	0.1%	4	$1,264	$1,159	$745	$373
30 Dental Services	11	0.7%	24	$8,060	$3,385	$2,452	$223
42 Advanced Practice Nurse (APN) Services	27	1.8%	37	$3,960	$2,008	$2,008	$74
99 Unknown Services by Record Type	1	0.1%	-1	-$200	-$17	-$17	-$17
Totals:	**184**	**12.0%**	**214**	**$46,419**	**$20,241**	**$14,150**	**$77**

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6.4.9 Locality Participation Analysis by State COS (MAR.PrtcpByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Average of dollars paid per recipient for claims adjudicated for payments during the reporting period.	10	Number (Decimal)
*Pct Elig Prtcp	When both checkboxes are selected, the percentage of all eligible recipients who participate in the program.	6	Number (Decimal)
*Undup Recip	Count of unique recipients served in the selection criteria for claims finalized during the reporting period.	8	Number (Integer)
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Claims Paid	Displays the number of claims in the selected criteria finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
State Category of Service	Displays the combined high-level State category of service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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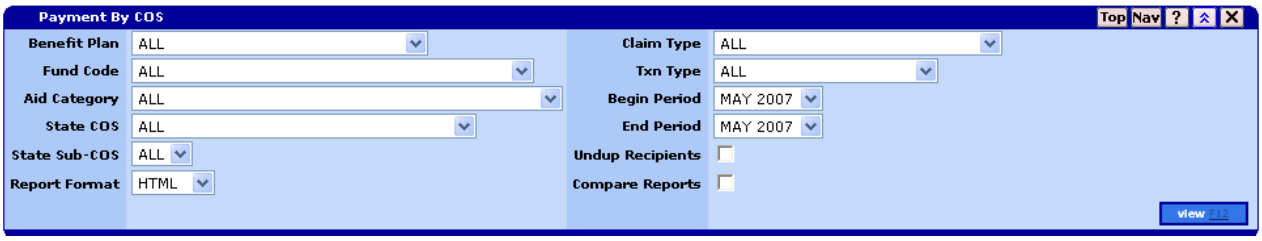
6.5 PAYMENT BY COS PANEL OVERVIEW

6.5.1 Payment By COS Panel Narrative

The Payment By COS panel allows the user to generate a report that displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year, and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Payment By COS]

6.5.2 Payment By COS Panel Layout



6.5.3 Payment By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	This field allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	This field allows the user to select the beginning report month that represents the first paid month for which data will be displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	This field allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	This field allows the user to select the ending report month that represents the last paid month for which data will be displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Txn Type	This field allows the user to select a specific transaction type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each category of service.	Check Box	Check Box	0
View	Allows the user to view the Payment By COS report.	Button	N/A	0

6.5.4 Payment By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.5.5 Payment By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Payment By COS Panel Accessibility

6.5.6.1 To Access and View Payment By COS Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditure page displays.
4	Click **Payment By COS** hyperlink on the Provider page.	Payment By COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Category of Service report displays.

6.5.7 Payment Comparison by Category of Service Report (MAR.ComparisonByCOS.rdl) Narrative

The Payment Comparison by Category of Service report displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year, and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, state category of service, state sub-category of service and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.5.8 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Layout

9/21/2006 9:35

State of Alabama

Payment Comparison By Category of Service

Fee For Service

Report Criteria			
Benefit Plan	ALL	County/Region	ALL
State COS	07 Prescribed Drug Services	Fund Code	ALL
State Sub-COS	ALL	Reporting Period	MAY 2006

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
State Category of Service	Paid Claims	Paid Amount	Paid Claims	Paid Amount	Paid Claims	Paid Amount	Paid Claims	Paid Amount
0710 Prescribed Drugs - Legend	38	$765	2	$1,425	45	$748	143	$19,180
0720 Prescribed Drugs - Non-Legend	3	$124	0	$0	5	$124	2	$36
0730 Prescribed Drugs - Compounds	9	$728	-4	-$482	10	$728	57	$1,958
Totals:	**50**	**$1,617**	**-2**	**$943**	**60**	**$1,600**	**202**	**$21,174**

6.5.9 Payment Comparison by Category of Service (MAR.ComparisonByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)

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Field	Description	Length	Data Type
State Category of Service	Displays the combined high-level State category of service (COS) and detail-level State Sub-COS value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.6 PAYMENT BY PROVIDER TYPE PANEL OVERVIEW

6.6.1 Payment By Provider Type Panel Narrative

The Payment By Provider Type panel allows the user to generate a report that displays paid and denied claim statistics grouped by provider type and specialty. It includes claim counts, billed and paid dollars as applicable for paid and denied claims. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Payment By Provider Type]

6.6.2 Payment By Provider Type Panel Layout

6.6.3 Payment By Provider Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Transaction Type	Allows the user to select a specific transaction type to limit data returned on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Payment By Provider Type report.	Button	N/A	0

6.6.4 Payment By Provider Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.6.5 Payment By Provider Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.6.6 Payment By Provider Type Panel Accessibility

6.6.6.1 To Access and View Payment by Provider Type Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Payment by Provider Type** hyperlink on the Expenditures page.	Payment Comparison by Provider Type panel displays.

6.6.7 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Narrative

The Payment Statistics by Provider Type report displays paid and denied claim statistics grouped by provider type and specialty. It includes claim counts, billed and paid dollars as applicable for paid and denied claims. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, provider type, provider specialty, claim type, transaction type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.6.8 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Layout

8/15/2006 11:09

State of Alabama

Payment Statistics By Provider Type

Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Claim Type**	ALL
Fund Code	ALL	**Transaction Type**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

	Paid			Denied	
Provider Type / Provider Specialty	**Claims**	**Units of Service**	**Paid Amount**	**Claims**	**Billed Amount**
01 Hospital	0	0	$0	7	$73,050
02 Ambulatory Surgical Center (ASC)	6	0	$130	0	$0
08 Clinic	0	0	$0	5	$1,065
09 Advance Practice Nurse	30	0	$6,068	0	$0
19 Optician	9	0	$1,688	18	$7,500
24 Pharmacy	89	89	$20,740	74	$13,588
25 DME/Medical Supply Dealer	12	2	$156	0	$0
27 Dentist	21	21	$7,614	31	$3,717
31 Physician	94	0	$12,227	81	$10,136
Totals:	**261**	**112**	**$48,623**	**216**	**$109,056**

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6.6.9 Payment Statistics by Provider Type (MAR.PaymentByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Denied - Billed Amount	Amount billed for all denied claims for each provider type and specialty. This total reflects the criteria selected by the user.	15	Number (Decimal)
Denied - Claims	Number of claims that have been denied for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Claims	Number of claims that have been paid for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Paid Amount	Amount reimbursed for all paid claims for each provider type and specialty. This total reflects the criteria selected by the user.	15	Number (Decimal)
Paid - Units of Service	Total units of service for paid claims for each provider type and specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for corresponding columns.	15	Number (Integer & Decimal)

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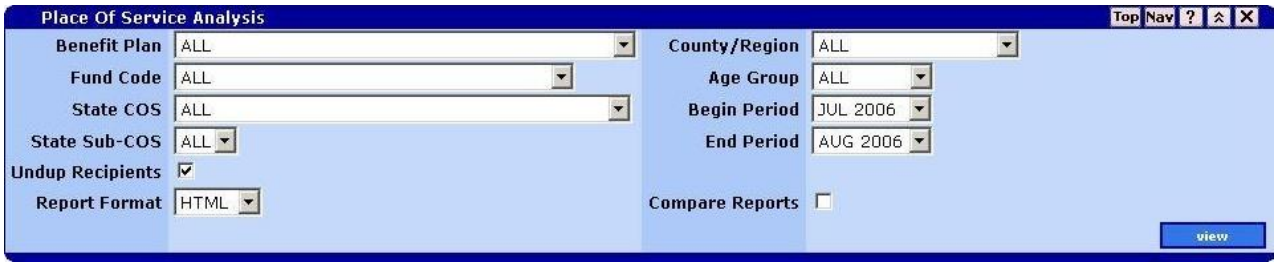
6.7 PLACE OF SERVICE ANALYSIS PANEL OVERVIEW

6.7.1 Place Of Service Analysis Panel Narrative

The Place of Service Analysis panel allows the user to generate a report that provides analysis of recipients and dollars paid for each state category of service by region/county and location (place) of service. It includes the number of unduplicated recipients, claims and dollars paid and average paid per claim and recipient.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Expenditures] - [Place Of Service Analysis]

6.7.2 Place Of Service Analysis Panel Layout



6.7.3 Place Of Service Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows user to view the Place of Service Analysis report.	Button	N/A	0

6.7.4 Place Of Service Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.7.5 Place Of Service Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Place Of Service Analysis Panel Accessibility

6.7.6.1 To Access and View Place Of Service Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Expenditures** hyperlink.	Expenditures page displays.
4	Click **Place of Service Analysis** hyperlink on the Expenditures page.	Place of Service Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Place of Service Analysis report displays.

6.7.7 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Narrative

The Place of Service Analysis report provides analysis of recipients and dollars paid for each state category of service by region/county and location (place) of service. It includes the number of unduplicated recipients, claims and dollars paid and average paid per claim and recipient. When the user selects the Undup Recipients checkbox, the number of recipients and average expenditures per recipient are displayed. Selection criteria for this report are: benefit plan, region/county, state category of service, state sub-category of service, age group and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.7.8 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Layout

9/8/2006 9:43

State of Alabama

Place Of Service Analysis

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Age Group**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

Place Of Service	*Undup Recip	Claims Paid	Paid Amount	Avg Paid per Claim	*Avg Paid per Recip
## Unknown	1	2	$4	$2	$4
00 Pharmacy	80	98	$20,858	$213	$261
11 Office	63	132	$14,034	$106	$223
12 Home	4	5	$52	$10	$13
21 Inpatient Hospital	5	16	$1,542	$96	$308
22 Outpatient Hospital	55	115	$17,810	$155	$324
23 Emergency Room - Hospital	1	1	$33	$33	$33
31 Skilled Nursing Facility	2	4	$0	$0	$0
42 Ambulance - Air or Water	2	7	$1,172	$167	$586
Totals:	**182**	**380**	**$55,505**	**146**	**$305**

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6.7.9 Place Of Service Analysis (MAR.PlaceOfService.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Displays an average of the dollars reimbursed per recipient for the count of unduplicated recipients for claims finalized for payment during the reporting period.	10	Number (Decimal)
*Undup Recip	Displays a count of the unique recipients served at the location for claims finalized during the reporting period. This count only includes recipients from paid claims.	8	Number (Integer)
Avg Paid per Claim	Displays an average of the dollars paid per claim for claims finalized for payment during the reporting period.	10	Number (Decimal)
Claims Paid	Displays the number of paid claims for the listed location for the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollars paid for services rendered at the location for claims finalized during the reporting period.	15	Number (Decimal)
Place Of Service	Displays the location (place) of service where claims paid with criteria selected.	50	Character
Totals	Totals for the corresponding columns. Unduplicated recipients is the unduplicated total across all the places of service displayed.	15	Number (Integer & Decimal)

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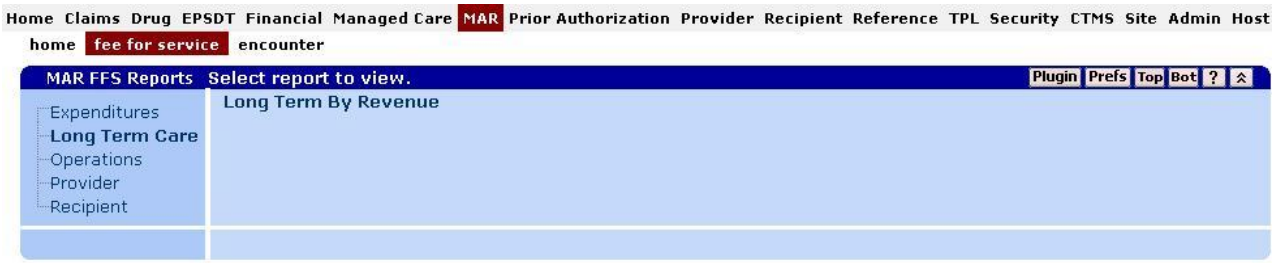
6.8 MAR REPORTS - LONG TERM CARE PAGE OVERVIEW

6.8.1 MAR Reports - Long Term Care Page Narrative

The MAR Reports – Long Term Care page is the access point within the MAR system that allows users to view reports that fall under the category of Long Term Care.

[MAR] – [Fee for Service or Encounter] – [Long Term Care]

6.8.2 MAR Reports - Long Term Care Page Layout



6.8.3 MAR Reports - Long Term Care Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Long Term By Revenue	Link to Long Term By Revenue panel.	Hyperlink	N/A	0

6.8.4 MAR Reports - Long Term Care Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.8.5 MAR Reports - Long Term Care Page Extra Features

Field	Field Type
No extra features found for this page.	

6.8.6 MAR Reports - Long Term Care Page Accessibility

6.8.7 To Access Long Term Care Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Long Term Care** hyperlink.	Long Term Care page displays.

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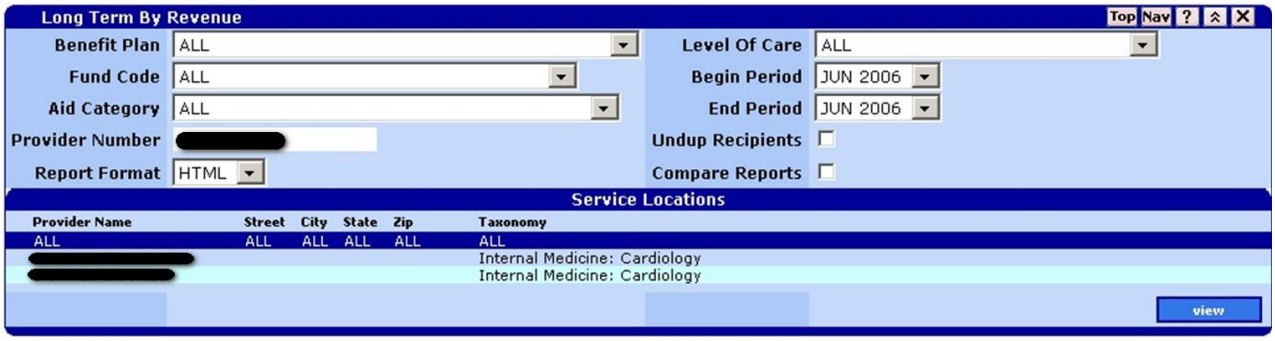
6.9 LONG TERM BY REVENUE PANEL OVERVIEW

6.9.1 Long Term By Revenue Panel Narrative

The Long Term by Revenue panel allows the user to generate a report that displays paid long term care claim information. The top section of the data results includes averages and amounts based on the criteria selected by the user. The bottom section of the data results displays the unduplicated recipient count, days of care and billed amount by revenue code for the user selected criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Long Term Care] - [Long Term By Revenue]

6.9.2 Long Term By Revenue Panel Layout



6.9.3 Long Term By Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Level Of Care	Allows the user to select the recipient's level of care to limit data results on this report.	Combo Box	Drop Down List Box	0
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Long Term By Revenue report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

6.9.4 Long Term By Revenue Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	2	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.9.5 Long Term By Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Long Term By Revenue Panel Accessibility

6.9.6.1 To Access and View Long Term Care by Revenue Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Long Term Care** hyperlink.	Long Term Care page displays.
4	Click **Long Term by Revenue** hyperlink on the Long Term Care page.	Long Term by Revenue panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Long Term Care Payments by Revenue Code report displays.

6.9.7 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Narrative

The Long Term Care Payments by Revenue Code report displays paid long term care claim information. The top section of the data results includes averages and amounts based on the criteria selected by the user. The bottom section of the data results displays the unduplicated recipient count, days of care and billed amount by revenue code for the user selected criteria. When the user selects the Undup Recipients box, the number of recipients and average paid per recipient are displayed. Selection criteria for this window includes: benefit plan, aid category, level of care, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.9.8 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Layout

9/8/2006 8:59

State of Alabama

Long Term Care Payments By Revenue Code

Fee For Service

Report Criteria			
Benefit Plan	ALL	Fund Code	ALL
Aid Category	ALL	Provider Number	
Level Of Care	ALL	Begin/End Period	FEB 2005 / OCT 2005

Avg Paid per Patient Day	$88	Allowed Amount	$54,191
Avg Paid per Provider	$9,623	Other Insurance Amount	$0
Avg Applied Income per Patient Day	$10	Patient Liability Amount	$5,185
*Avg Paid per Recip	$5,346	Paid Amount	$48,117
Total Number Providers	5		

Revenue Code	*Undup Recip	Days Of Care	Billed Amount
120 SEMI-PRIVATE ROOM	9	469	$45,815
130 ROOM-BOARD/3&4 BED	5	76	$6,743
Totals:	**9**	**545**	**$52,558**

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6.9.9 Long Term Care Payments by Revenue Code (MAR.LongTermByRev.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	Displays the average of the dollars reimbursed per the count of unique recipients served for claims paid during the reporting period.	10	Number (Decimal)
*Undup Recip	Displays a count of the unique recipients for who services paid during the reporting period.	8	Number (Integer)
Allowed Amount	Total dollars allowed for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Avg Applied Income per Patient Day	Displays the average of the dollar amount of applied income per recipient days of care for claims paid during the reporting period.	10	Number (Decimal)
Avg Paid per Patient Day	This field displays the average of dollars reimbursed per recipient days of care for claims paid during the reporting period.	10	Number (Decimal)
Avg Paid per Provider	Displays the average of dollars reimbursed per the unique number of providers for claims paid during the reporting period.	10	Number (Decimal)
Billed Amount	Displays the total dollars billed for services rendered in the selection criteria during the reporting period.	15	Number (Decimal)
Days Of Care	Displays the total number of the days of care rendered for claims paid during the reporting period.	10	Number (Integer)
Other Insurance Amount	Displays the amount of any third party payments for long term care claims finalized for payment during the reporting period.	15	Number (Decimal)
Paid Amount	Displays the total dollars paid for services rendered in the selection criteria for claims paid during the reporting period.	15	Number (Decimal)
Patient Liability Amount	Displays the payment liability for the recipients.	15	Number (Decimal)
Revenue Code	Displays the code and description representing the services allowed for claims finalized during the reporting period.	50	Character
Total Number Providers	Displays the total number of providers paid for services rendered during the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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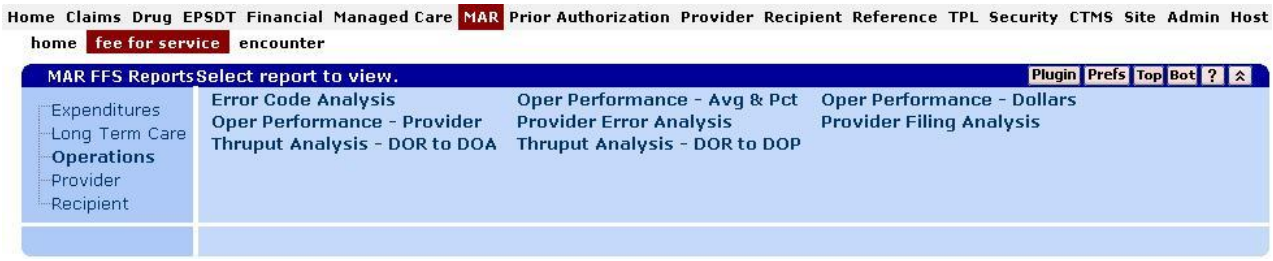
6.10 MAR REPORTS - OPERATIONS PAGE OVERVIEW

6.10.1 MAR Reports - Operations Page Narrative

The MAR Reports – Operations page is the access point within the MAR system that allows users to view reports that fall under the category of Operations.

Navigation Path: [MAR] – [Fee for Service or Encounter] – [Operations]

6.10.2 MAR Reports - Operations Page Layout



6.10.3 MAR Reports - Operations Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Error Code Analysis	Link to Error Code Analysis panel.	Hyperlink	N/A	0
Oper Performance – Avg & Pct	Link to Oper Performance – Avg & Pct panel.	Hyperlink	N/A	0
Oper Performance – Dollars	Link to Oper Performance – Dollars panel.	Hyperlink	N/A	0
Oper Performance – Provider	Link to Oper Performance – Provider panel.	Hyperlink	N/A	0
Provider Error Analysis	Link to Provider Error Analysis panel.	Hyperlink	N/A	0
Provider Filing Analysis	Link to Provider Filing Analysis panel.	Hyperlink	N/A	0
Thruput Analysis – DOR to DOA	Link to Thruput Analysis – DOR to DOA panel.	Hyperlink	N/A	0
Thruput Analysis – DOR to DOP	Link to Thruput Analysis – DOR to DOP panel.	Hyperlink	N/A	0

6.10.4 MAR Reports - Operations Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

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6.10.5 MAR Reports - Operations Page Extra Features

Field	Field Type
No extra features found for this page.	

6.10.6 MAR Reports - Operations Page Accessibility

6.10.6.1 To Access MAR Reports – Operations Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.

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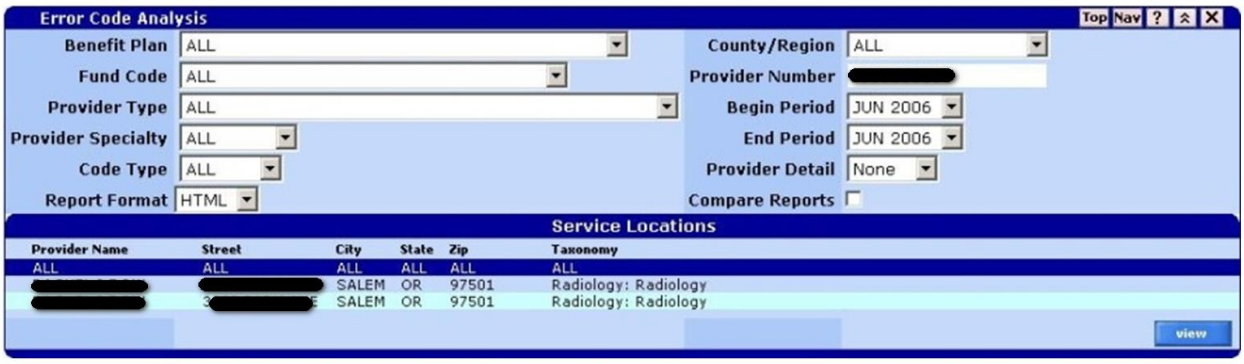
6.11 ERROR CODE ANALYSIS PANEL OVERVIEW

6.11.1 Error Code Analysis Panel Narrative

The Error Code Analysis panel allows the user to generate a report that displays the most common provider billing errors in a selected time period and includes the number of error claims and the percent of total errors. This highlights the overall provider understanding of billing procedures and program policies. The type of detail lines (all, override, or denial) reported in the data window is controlled by the code types selection criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Error Code Analysis]

6.11.2 Error Code Analysis Panel Layout



6.11.3 Error Code Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Code Type	Allows the user to select a specific error code type.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	This field allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Detail	Allows the user to request and display provider detail statistics for each error code. The choices are Top 10 or Top 20 providers.	Combo Box	Drop Down List Box	0
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Error Code Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

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6.11.4 Error Code Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	Change Begin Period to be within 12 months of End Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	Change End Period to be within 12 months of Begin Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	0	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

6.11.5 Error Code Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Error Code Analysis Panel Accessibility

6.11.6.1 To Access and View Error Code Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Error Code Analysis** hyperlink on the Operations page.	Error Code Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Error Code Analysis report displays.

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6.11.7 Error Code Analysis (MAR.ErrorCode.rdl) Report Narrative

The Error Code Analysis report displays the most common provider billing errors in a selected time period and includes the number of error claims and the percent of total errors. This highlights the overall provider understanding of billing procedures and program policies. The type of detail lines (all, override, or denial) reported in the data window is controlled by the code types selection criteria. For example if the user selects the Code Types - All radio button, the data window displays denial and override error code detail lines. When the user selects the Provider Detail check box, the provider detail is displayed. Selection criteria for report are benefit plan, region/county, provider type, provider specialty, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.11.8 Error Code Analysis (MAR.ErrorCode.rdl) Report Layout

9/26/2006 12:53

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
5001 EXACT DUPLICATE	39			30.7%
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	28			22.0%
6162 EMERGENCY ROOM CONFLICT	25			19.7%
5007 EXACT DUPLICATE - HEADER	21			16.5%
3007 NO PRIOR AUTHORIZATION FOR LEVEL OF CARE	7			5.5%
4133 NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS	7			5.5%
Totals:	**127**			

9/26/2006 12:54

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
5001 EXACT DUPLICATE	39			30.7%
		[redacted]	18	46.2%
			7	17.9%
			7	17.9%
			6	15.4%
			1	2.6%
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	28			22.0%
		[redacted]	21	75.0%
			7	25.0%
6162 EMERGENCY ROOM CONFLICT	25			19.7%
		[redacted]	9	36.0%
			7	28.0%
			7	28.0%
			1	4.0%
			1	4.0%
5007 EXACT DUPLICATE - HEADER	21			16.5%
		[redacted]	21	100.0%
3007 NO PRIOR AUTHORIZATION FOR LEVEL OF CARE	7			5.5%
		[redacted]	7	100.0%
4133 NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS	7			5.5%
		[redacted]	7	100.0%
Totals:	**127**			

9/26/2006 12:58

State of Alabama
Error Code Analysis
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Provider Number**	1000000971
Provider Type	01 Hospital	**Code Type**	DENIAL
Provider Specialty	ALL	**Begin/End Period**	AUG 2006 / AUG 2006

Error Code	Error Claims	*Provider Number	*Provider Claims	*Percent of Total
1030 ANCIL NOT COVERED IN BIRTH CNTR GRP	21			48.8%
5007 EXACT DUPLICATE - HEADER	21			48.8%
6162 EMERGENCY ROOM CONFLICT	1			2.3%

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6.11.9 Error Code Analysis (MAR.ErrorCode.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Provider Claims	Displays the total number of provider claims receiving this error code for the top providers if the Provider Detail option is selected.	10	Number (Integer)
*Provider Number	Displays the top provider numbers receiving the error code if the Provider Detail option is selected. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Error Claims	Displays the total number of claims receiving the error code.	10	Number (Integer)
Error Code	Displays the edit or audit code and description for paid and denied claims.	50	Character
Percent of Total	Displays the total number of claims with this code as a percent of the total number of claims with all codes. On a provider detail line, this field displays the total code claims for this provider as a percent of the total code claims.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	10	Number (Integer & Decimal)

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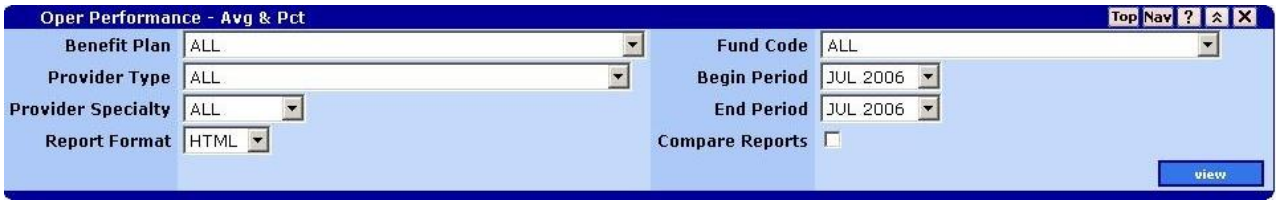
6.12 OPER PERFORMANCE - AVG & PCT PANEL OVERVIEW

6.12.1 Oper Performance – Avg & Pct Panel Narrative

The Oper Performance – Avg & Pct panel allows the user to generate a report that displays percents and averages of original paid claims, denied claims, corrected claims, adjudicated without correction, average number of days from service to receipt, service to payment and service to adjudication. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Avg & Pct]

6.12.2 Oper Performance – Avg & Pct Panel Layout



6.12.3 Oper Performance – Avg & Pct Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Oper Performance - Avg & Pct report.	Button	N/A	0

6.12.4 Oper Performance – Avg & Pct Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.12.5 Oper Performance - Avg & Pct Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.12.6 Oper Performance - Avg & Pct Panel Accessibility

6.12.6.1 To Access and View Operational Performance –Averages & Percents Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance – Avg & Pct** hyperlink on the Operations page.	Oper Performance – Avg & Pct panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary – Averages and Percents report displays.

6.12.7 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Narrative

The Operational Performance Summary – Averages & Percents report displays percents and averages of original paid claims, denied claims, corrected claims, adjudicated without correction, average number of days from service to receipt, service to payment and service to adjudication. The data results are grouped by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.12.8 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Layout

8/15/2006 11:36

State of Alabama

Operational Performance Summary - Averages & Percents

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Pct Paid	Pct Adjud w/o Corr	Pct Denied	Pct Corrected	Avg DOS to DOR	Avg DOS to DOA	Avg DOS to DOP
01 Hospital	17.1%	0.0%	82.9%	100.0%	225.5	225.7	230.2
02 Ambulatory Surgical Center (ASC)	100.0%	0.0%	0.0%	100.0%	41.3	41.3	41.9
03 Extended Care Facility	25.0%	0.0%	75.0%	100.0%	1179.6	1179.6	1180.6
05 Home Health Agency	14.3%	0.0%	85.7%	100.0%	64.8	64.8	153.8
08 Clinic	12.5%	0.0%	87.5%	100.0%	233.6	233.6	234.6
09 Advance Practice Nurse	91.1%	0.0%	8.9%	100.0%	58.8	58.8	59.1
19 Optician	33.3%	0.0%	66.7%	100.0%	92.1	92.1	93.3
24 Pharmacy	50.3%	0.0%	49.7%	100.0%	53.7	60.2	68.6
25 DME/Medical Supply Dealer	85.7%	0.0%	14.3%	100.0%	122.0	122.0	122.5
27 Dentist	35.4%	0.0%	64.6%	100.0%	111.5	111.5	111.5
31 Physician	46.7%	0.0%	53.3%	100.0%	88.2	88.2	89.4
Totals:	**43.7%**	**0.0%**	**56.3%**	**100.0%**	**118.4**	**120.2**	**124.5**

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6.12.9 Operational Performance Summary - Averages & Percents (MAR.PerformanceAvgPct.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg DOS to DOA	Average number of days from date of service to date of adjudication. Note: Date of adjudication is the date the claim was either paid or denied.	6	Number (Decimal)
Avg DOS to DOP	Average number of days from date of service to date of payment.	6	Number (Decimal)
Avg DOS to DOR	Average number of days from date of service to date of receipt. Note: Date of receipt is the date the claim was received into interChange.	6	Number (Decimal)
Pct Adjud w/o Corr	Displays the percent of the paid and denied claims that were adjudicated without being corrected.	6	Number (Decimal)
Pct Corrected	Displays the percent of the paid and denied claims that were corrected, (corrected paid + corrected denied) / (total paid + total denied).	6	Number (Decimal)
Pct Denied	Displays the percent of the paid and denied claims that were denied.	6	Number (Decimal)
Pct Paid	Displays the percent of the paid and denied claims that were paid.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for the corresponding columns.	6	Number (Decimal)

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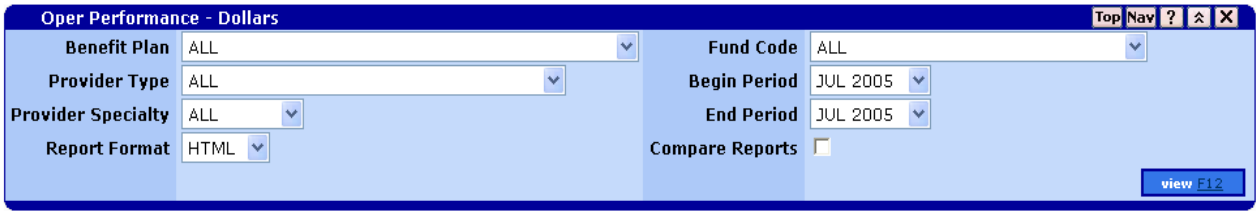
6.13 OPER PERFORMANCE - DOLLARS PANEL OVERVIEW

6.13.1 Oper Performance - Dollars Panel Narrative

The Oper Performance - Dollars panel allows the user to generate a report that displays for original claims and financial transactions the billed amount for paid, denied and pending claims, total charges submitted (the sum of the paid, denied and pending billed amounts) and the difference between the paid claims billed amount and the reimbursement amount. Results are listed by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Dollars]

6.13.2 Oper Performance - Dollars Panel Layout



6.13.3 Oper Performance - Dollars Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Oper Performance - Dollars report.	Button	N/A	0

6.13.4 Oper Performance - Dollars Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.13.5 Oper Performance - Dollars Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.13.6 Oper Performance - Dollars Panel Accessibility

6.13.6.1 To Access and View Operational Performance -Dollars Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance - Dollars** hyperlink on the Operations page.	Oper Performance - Dollars panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary - Dollars report displays.

6.13.7 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Narrative

The Operational Performance Summary - Dollars report displays for original claims and financial transactions the billed amount for paid, denied and pending claims, total charges submitted (the sum of the paid, denied and pending billed amounts), and the difference between the paid claims billed amount and the reimbursement amount. Results are listed by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

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6.13.8 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Layout

8/15/2006 12:36

State of Alabama

Operational Performance Summary - Dollars

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

	Billed Amount				
Provider Type / Provider Specialty	**Paid Claims**	**Denied Claims**	**Pending Claims**	**Total Charges Submitted**	**Paid Billed - Paid Amt**
## Unknown	$1,516	$7,652	$134,407	$143,575	$0
01 Hospital	$27,533	$316,693	$3,064,486	$3,408,712	$17,740
02 Ambulatory Surgical Center (ASC)	$1,130	$0	$945	$2,075	$1,000
03 Extended Care Facility	$5,891	$17,674	$230,353	$253,918	$5,891
05 Home Health Agency	$2,000	$8,450	$161,408	$171,858	$2,000
08 Clinic	$3,331	$8,265	$52,235	$63,831	$2,500
09 Advance Practice Nurse	$12,078	$345	$2,945	$15,368	$5,442
19 Optician	$2,070	$7,500	$5,292	$14,862	$382
24 Pharmacy	$32,880	$14,468	$14,675	$62,023	$12,130
25 DME/Medical Supply Dealer	$480	$60	$180	$720	$324
27 Dentist	$13,867	$4,393	$57,230	$75,490	$5,480
31 Physician	$35,818	$16,679	$549,335	$601,832	$18,267
Totals:	**$138,594**	**$402,179**	**$4,273,491**	**$4,814,264**	**$71,156**

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6.13.9 Operational Performance Summary - Dollars (MAR.PerformanceDollars.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Billed Amount - Denied Claims	Billed amount for denied claims.	15	Number (Decimal)
Billed Amount - Paid Claims	Billed amount for paid claims.	15	Number (Decimal)
Billed Amount - Pending Claims	Billed amount for pending claims.	15	Number (Decimal)
Paid Billed - Paid Amount	Displays the difference between the billed amount for paid claim and the reimbursement amount for paid claims.	15	Number (Decimal)
Provider Type/ Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Charges Submitted	Total billed amount for paid, denied and suspended claims.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Decimal)

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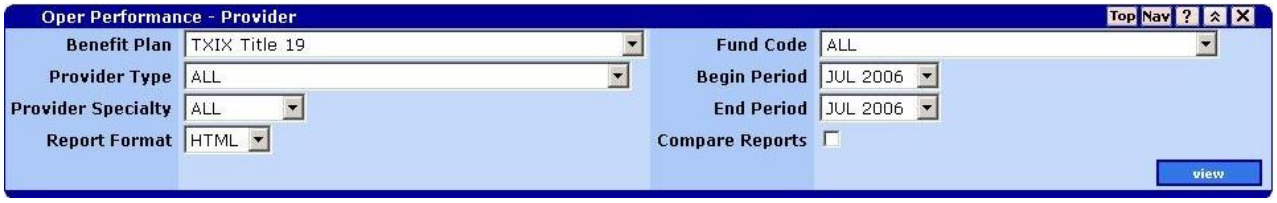
6.14 OPER PERFORMANCE - PROVIDER PANEL OVERVIEW

6.14.1 Oper Performance - Provider Panel Narrative

The Oper Performance – Provider panel allows the user to generate a report that displays the counts of claims processed, original claims paid, original claims denied, claims pending, adjustment claims paid, adjustment claims denied and billed amount for pending claims. Results are listed by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Oper Performance - Provider]

6.14.2 Oper Performance - Provider Panel Layout



6.14.3 Oper Performance - Provider Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Oper Performance - Provider report.	Button	N/A	0

6.14.4 Oper Performance - Provider Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.14.5 Oper Performance - Provider Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.14.6 Oper Performance - Provider Panel Accessibility

6.14.6.1 To Access and View Oper Performance - Provider Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Oper Performance - Provider** hyperlink on the Operations page.	Oper Performance - Provider panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Operational Performance Summary - Provider report displays.

6.14.7 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Narrative

The Operation Performance Summary - Provider report displays the counts of claims processed, original claims paid, original claims denied, claims pending, adjustment claims paid, adjustment claims denied and billed amount for pending claims. Results are listed by provider type and specialty. Selection criteria for this report are: benefit plan, fund code, provider type, provider specialty and reporting period date range.

Pending claims do not have a Fund Code Assignment, therefore, each Fund Code category reports all claims pending billed amount.

This report is designed to consistently display fee-for-service or encounter information.

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6.14.8 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Layout

8/15/2006 11:22

State of Alabama
Operational Performance Summary - Provider
Fee For Service

Report Criteria			
Benefit Plan	TXIX Title 19	**Fund Code**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

					|------- Adjustments -----|		
Provider Type / Provider Specialty	**Claims Processed**	**Claims Paid**	**Claims Denied**	**Claims Pending**	**Claims Paid**	**Claims Denied**	**Pending Billed Amt**
01 Hospital	600	0	7	592	1	0	$1,992,399
02 Ambulatory Surgical Center (ASC)	16	6	0	10	0	0	$945
08 Clinic	46	0	5	40	1	0	$3,349
09 Advance Practice Nurse	63	30	0	33	0	0	$1,250
19 Optician	45	9	18	18	0	0	$5,292
24 Pharmacy	317	89	74	149	5	0	$13,078
25 DME/Medical Supply Dealer	18	12	0	6	0	0	$180
27 Dentist	229	21	31	177	0	0	$10,060
31 Physician	1,525	94	81	1,350	0	0	$504,773
Totals:	**2,859**	**261**	**216**	**2,375**	**7**	**0**	**$2,531,326**

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6.14.9 Operational Performance Summary - Provider (MAR.PerformanceProvider.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Adjustments - Claims Denied	Count of denied adjustment claims.	8	Number (Integer)
Adjustments - Claims Paid	Count of paid adjustment claims.	8	Number (Integer)
Claims Denied	Count of denied claims.	8	Number (Integer)
Claims Paid	Count of paid claims.	8	Number (Integer)
Claims Pending	Count of pending claims.	8	Number (Integer)
Claims Processed	Count of claims processed - paid and denied original and adjustment claims, and pending claims. Non-claim financial transactions are not included.	8	Number (Integer)
Pending Billed Amount	Billed amount for pending claims.	15	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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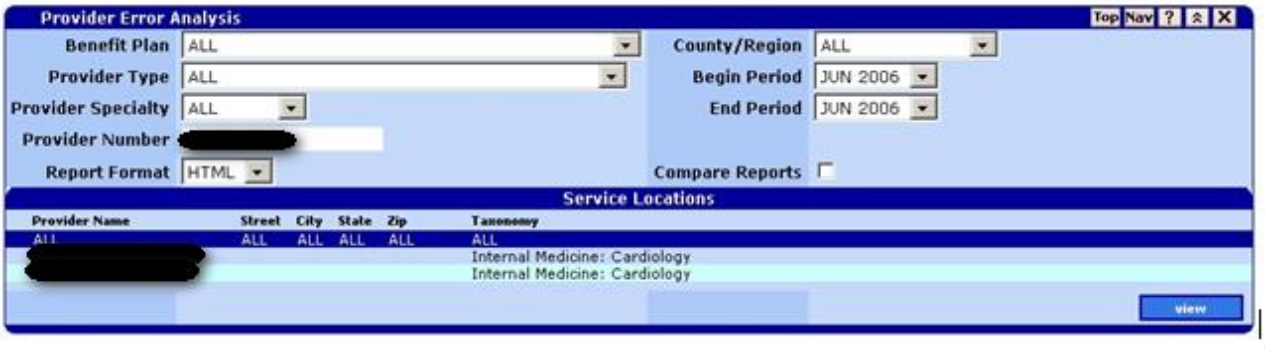
6.15 PROVIDER ERROR ANALYSIS PANEL OVERVIEW

6.15.1 Provider Error Analysis Panel Narrative

The Provider Error Analysis panel allows the user to generate a report that displays statistical data about errors and claims payment percentages in order to highlight the overall provider understanding of billing procedures and program policies. Results are given by individual provider and provider peer group total.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Provider Error Analysis]

6.15.2 Provider Error Analysis Panel Layout



6.15.3 Provider Error Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	This field allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	This field allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	This field allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Provider Error Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Character	5

6.15.4 Provider Error Analysis Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	Change Begin Period to be within 12 months of End Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	Change End Period to be within 12 months of Begin Period.	End Period must be no longer than 1 year after the Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	2	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.15.5 Provider Error Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Provider Error Analysis Panel Accessibility

6.15.6.1 To Access and View Provider Error Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Provider Error Analysis** hyperlink on the Operations page.	Provider Error Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Error Analysis report displays.

6.15.7 Provider Error Analysis Report (MAR.ProviderError.rdl) Narrative

The Provider Error Analysis report displays statistical data about errors and claims payment percentages in order to highlight the overall provider understanding of billing procedures and program policies. Results are given by individual provider and provider peer group total. Selection criteria for this window are: benefit plan, region/county, provider type, provider specialty, provider number and report period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.15.8 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Layout

9/26/2006 13:43

State of Alabama

Provider Error Analysis

Fee For Service

Report Criteria

Benefit Plan	ALL	County/Region	ALL
Provider Type	ALL	Provider Number	[redacted]
Provider Specialty	ALL	Begin/End Period	OCT 2005 / AUG 2006

	Individual Provider	Provider Peer Group
Total Claims	465	10,505
Claims Paid	425	1,278
Claims Denied	40	9,227
Total Claims Corrected	465	10,527
Paid After Corrected	425	1,302
Pct Paid After Corrected	91.4%	12.4%
Pct Paid w/ No Error	0.0%	82.8%
Pct w/Error Override	0.0%	0.1%
Pct Denied	8.6%	87.8%
Avg Error per Adjud Claim	0.1	0.9

6.15.9 Provider Error Analysis Report (MAR.ProviderError.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Error per Adjud Claim	Average number of errors per adjudicated claim for the selected provider group.	5	Number (Integer)
Claims Denied	Displays the number of claims for the selected provider/group finalized during the reporting period denied for payment.	10	Number (Integer)
Claims Paid	Displays the number of claims for the selected provider/group finalized during the reporting period that processed for payment.	10	Number (Integer)
Individual Provider	When a provider number is entered in the selection criteria, this column displays the data for that provider.	0	Character
Paid After Corrected	Displays the number of claims for the selected provider/group that required error correction to finalize for payment during the reporting period.	10	Number (Integer)
Pct Denied	Displays the number of paid claims for the selected provider/group that were denied as a percent of the total number of paid and denied claims finalized during the reporting period for the same provider/group.	6	Number (Decimal)
Pct Paid After Corrected	Displays the number of corrected claims as a percentage of the total paid claims finalized during the reporting period for the selected provider/group.	6	Number (Decimal)

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Field	Description	Length	Data Type
Pct Paid w/No Error	Displays the number of paid claims that did not require correction as a percentage of the total paid claims finalized during the reporting period for the selected provider/group.	6	Number (Decimal)
Pct w/Error Override	Displays the number of claims for the selected provider/group that were overridden as a percent of the total number of paid and denied claims finalized during the reporting period for the same provider/group.	6	Number (Decimal)
Provider Peer Group	Displays the data for all providers with claim data that matches the selection criteria. When a provider number is entered in the selection criteria, the data for that provider is included in this column as well as in the Individual Provider column.	0	Character
Total Claims	Displays the number of claims submitted by the selected provider/group finalized during the reporting period.	10	Number (Integer)
Total Claims Corrected	Displays a count of error corrections or adjudications to claims submitted by the provider/group and finalized during the reporting period.	10	Number (Integer)

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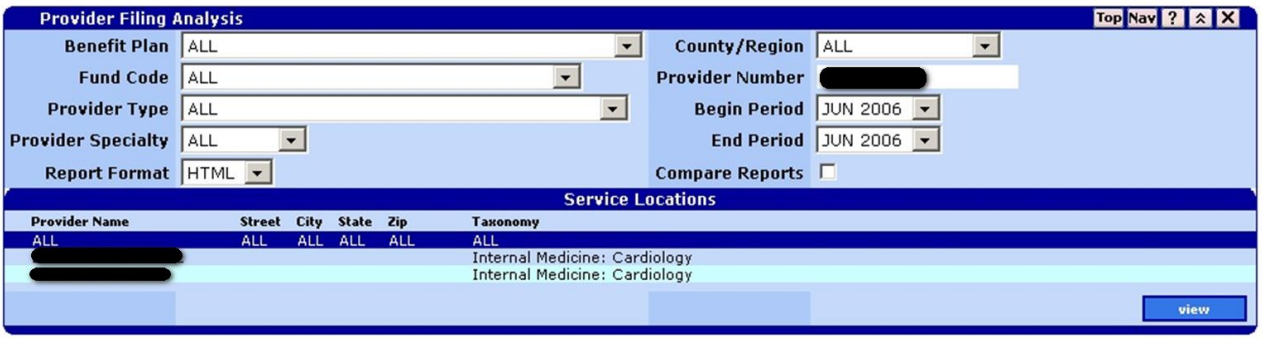
6.16 PROVIDER FILING ANALYSIS PANEL OVERVIEW

6.16.1 Provider Filing Analysis Panel Narrative

The Provider Filing Analysis panel allows the user to generate a report that provides statistical data about provider filing trends. Results are given by individual provider and provider peer group total.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Provider Filing Analysis]

6.16.2 Provider Filing Analysis Panel Layout



6.16.3 Provider Filing Analysis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the provider on this service location.	Field	Character	30
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Name	Name of the provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
View	Allows the user to view the Provider Filing Analysis report.	Button	N/A	0
Zip	Zip Code for the provider on this service location.	Field	Number (Integer)	5

6.16.4 Provider Filing Analysis Panel Field Edit Error Codes

Field Type	Field	Error Code	Error Message	To Correct
Combo Box	Begin Period	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
Combo Box		1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Combo Box	End Period	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
Combo Box		1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Field	Provider Number	2	The provider Number entered is invalid or not on file.	Enter a valid provider ID.

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6.16.5 Provider Filing Analysis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Provider Filing Analysis Panel Accessibility

6.16.6.1 To Access and View Provider Filing Analysis Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Provider Filing Analysis** hyperlink on the Operations page.	Provider Filing Analysis panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Filing Analysis report displays.

6.16.7 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Narrative

The Provider Filing Analysis report provides statistical data about provider filing trends. Results are given by individual provider and provider peer group total. Selection criteria for this report are: benefit plan, region/county, provider type, provider specialty, provider number and reporting period date range.

Extra Feature: If a provider number is entered in the provider number field, the individual provider column displays for that provider the search results that meet the user's selections.

This report is designed to consistently display fee-for-service or encounter information.

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6.16.8 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Layout

10/11/2006 14:11

State of Alabama
Provider Filing Analysis
Fee For Service

Report Criteria			
Benefit Plan	ALL	County/Region	ALL
Fund Code	ALL	Provider Number	[redacted]
Provider Type	ALL		
Provider Specialty	ALL	Begin/End Period	AUG 2006 / AUG 2006

	Individual Provider	Provider Peer Group
Avg DOS to DOR	57	150
Avg DOR to DOP	2	2
Avg DOS to DOP	59	152

DOS to DOR	Number of Claims	Percent of Total	Number of Claims	Percent of Total
1 - 7 Days	0	0.0%	13	2.2%
8 - 14 Days	3	13.0%	25	4.2%
15 - 30 Days	0	0.0%	76	12.7%
31 - 60 Days	13	56.5%	111	18.5%
61 - 90 Days	0	0.0%	85	14.2%
> 90 Days	7	30.4%	290	48.3%
Total Claims	**23**	**100.0%**	**600**	**100.0%**

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6.16.9 Provider Filing Analysis (MAR.ProviderFiling.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg DOR to DOP	Average number of days from date of receipt to date of payment for the provider/group.	6	Number (Integer)
Avg DOS to DOP	Average number of days from date of service to date of payment for the provider/group.	6	Number (Integer)
Avg DOS to DOR	Average number of days from date of service to date of receipt for the provider/group.	6	Number (Integer)
Individual Provider	When a provider number is entered in the selection criteria, this column displays the data for that provider.	0	Character
Number of Claims - 1-7 Days	Displays the number of claims received from the provider/group within seven days from the date of service.	10	Number (Integer)
Number of Claims - 8-14 Days	Displays the number of claims received from the provider/group between eight and 14 days from the date of service.	10	Number (Integer)
Number of Claims - 15-30 Days	Displays the number of claims received from the provider/group between 15 and 30 days from the date of service.	10	Number (Integer)
Number of Claims - 31-60 Days	Displays the number of claims received from the provider/group between 31 and 60 days from the date of service.	10	Number (Integer)
Number of Claims - 61-90 Days	Displays the number of claims received from the provider/group between 61 and 90 days from the date of service.	10	Number (Integer)
Number of Claims - >90 Days	Displays the number of claims received from the provider/group more than 90 days from the date of service.	10	Number (Integer)
Number of Claims - Total Claims	Displays the total number of claims received from the provider/group in the reporting period.	10	Number (Integer)
Percent of Total - 1-7 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received within seven days from the date of service.	6	Number (Decimal)
Percent of Total - 8-14 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 8 and 14 days from the date of service.	6	Number (Decimal)
Percent of Total - 15-30 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 15 and 30 days from the date of service.	6	Number (Decimal)
Percent of Total - 31-60 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 31 and 60 days from the date of service.	6	Number (Decimal)

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Field	Description	Length	Data Type
Percent of Total - 61-90 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received between 61 and 90 days from the date of service.	6	Number (Decimal)
Percent of Total - >90 Days	Displays the number of claims as a percent of the total number of received claims from the provider/group received more than 90 days from the date of service.	6	Number (Decimal)
Percent of Total - Total Claims	Displays the total number of claims as a percent of the total number of received claims from the provider/group during the reporting period.	6	Number (Decimal)
Provider Peer Group	Displays the data for all providers with claim data that matches the selection criteria. When a provider number is entered in the selection criteria, the data for that provider is included in this column as well as in the Individual Provider column.	0	Character

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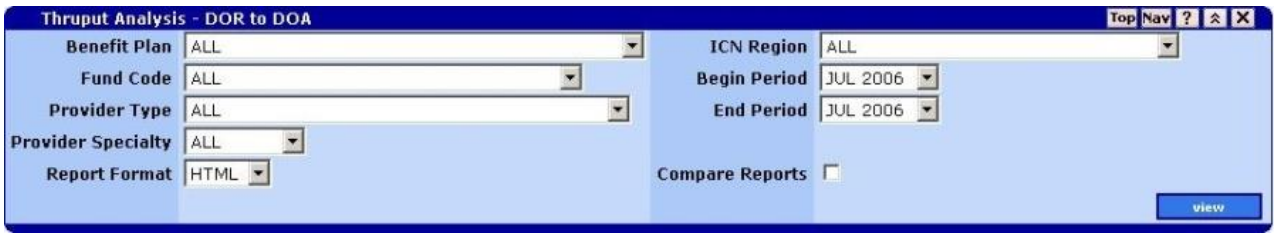
6.17 THRUPUT ANALYSIS - DOR TO DOA PANEL OVERVIEW

6.17.1 Thruput Analysis - DOR to DOA Panel Narrative

The Thruput Analysis – DOR (Date of Receipt) to DOA (Date of Adjudication) Search panel allows the user to generate a report that displays the percentage of claims paid based on the length of time between receipt of a claim to adjudication. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims adjudication. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Thruput Analysis - DOR to DOA]

6.17.2 Thruput Analysis - DOR to DOA Panel Layout



6.17.3 Thruput Analysis - DOR to DOA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
ICN Region	Allows the user to select a specific claim Internal Control Number (ICN) region code to limit data returned on this report. The ICN region code is the first two characters of the claim ICN.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Thruput Analysis - DOR to DOA report.	Button	N/A	0

6.17.4 Thruput Analysis - DOR to DOA Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.17.5 Thruput Analysis - DOR to DOA Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.17.6 Thruput Analysis - DOR to DOA Page Accessibility

6.17.6.1 To Access and View Thruput Analysis DOR to DOA Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Thruput Analysis DOR to DOA** hyperlink on the Operations page.	Thruput Analysis DOR to DOA panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Thruput Analysis DOR to DOA report displays.

6.17.7 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Narrative

The Claims Processing Throughput Analysis report displays the percentage of claims paid based on the length of time between receipt of a claim to adjudication. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims adjudication. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, claim type, provider type, provider specialty, ICN region code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.17.8 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Layout

8/15/2006 11:31

State of Alabama

Claims Processing Throughput Analysis - DOR to DOA

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	ALL	**ICN Region Code**	ALL
Provider Specialty	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Total Claims	2 Days	4 Days	7 Days	14 Days	21 Days	30 Days	60 Days	Over 60 Days	Avg Days to Adjud
## Unknown	83	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
01 Hospital	123	99.2%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	1.2
02 Ambulatory Surgical Center (ASC)	7	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
03 Extended Care Facility	8	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
05 Home Health Agency	7	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
08 Clinic	16	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
09 Advance Practice Nurse	45	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
19 Optician	27	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
24 Pharmacy	177	99.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	7.4
25 DME/Medical Supply Dealer	14	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
27 Dentist	2	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
31 Physician	229	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
Totals:	**738**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.1%**	**0.0%**	**0.0%**	**0.1%**	**2.6**

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6.17.9 Claims Processing Throughput Analysis - DOR to DOA (MAR.ThruputDORDOA.rdl) Report Field Descriptions

Field	Description	Length	Data Type
2 Days	Percent of total claims for the provider type and provider specialty that were adjudicated within two days of being received.	6	Number (Decimal)
4 Days	Percent of total claims for the provider type and provider specialty that were adjudicated within four days of being received.	6	Number (Decimal)
7 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in five to seven days of being received.	6	Number (Decimal)
14 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in eight to 14 days of being received.	6	Number (Decimal)
21 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 15 to 21 days of being received.	6	Number (Decimal)
30 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 22 to 30 days of being received.	6	Number (Decimal)
60 Days	Percent of total claims for the provider type and provider specialty that were adjudicated in 31 to 60 days of being received.	6	Number (Decimal)
Avg Days to Adjud	Average number of days from being received to adjudication for the provider type and provider specialty. This average reflects the criteria selected by the user.	6	Number (Decimal)
Over 60 Days	Percent of total claims for the provider type and provider specialty that were adjudicated over 60 days of being received.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Claims	Total number of claims that have been adjudicated for the provider type and provider specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Totals	Totals for the corresponding columns. For the percentage columns, the values are calculated for the total claims displayed.	10	Number (Integer & Decimal)

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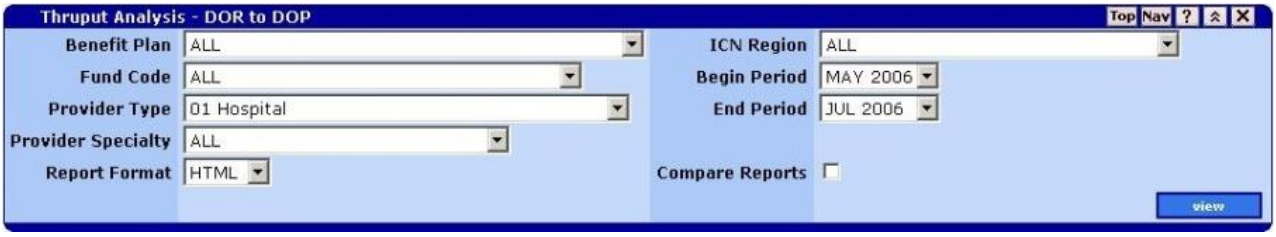
6.18 THRUPUT ANALYSIS - DOR TO DOP PANEL OVERVIEW

6.18.1 Thruput Analysis - DOR to DOP Panel Narrative

The Thruput Analysis – DOR (Date of Receipt) to DOP (Date of Payment) Search panel allows the user to generate a report that displays the percentage of claims paid based on the length of time between claim receipt date to claim payment date. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims payment. The data results are grouped by provider type and specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Operations] - [Thruput Analysis - DOR to DOP]

6.18.2 Thruput Analysis - DOR to DOP Panel Layout



6.18.3 Thruput Analysis - DOR to DOP Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
ICN Region	Allows the user to select a specific claim Internal Control Number (ICN) region code to limit data returned on this report. The ICN region code is the first two characters of the claim ICN.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Thruput Analysis - DOR to DOP report.	Button	N/A	0

6.18.4 Thruput Analysis - DOR to DOP Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.18.5 Thruput Analysis - DOR to DOP Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.18.6 Thruput Analysis - DOR to DOP Panel Accessibility

6.18.6.1 To Access and View Thruput Analysis DOR to DOP Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Operations** hyperlink.	Operations page displays.
4	Click **Thruput Analysis DOR to DOP** hyperlink on the Operations age.	Thruput Analysis DOR to DOP panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Thruput Analysis DOR to DOP report displays.

6.18.7 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Narrative

The Claims Processing Throughput Analysis – DOR to DOP report displays the percentage of claims paid based on the length of time between claim receipt date to claim payment date. The percentages are reported in seven categories to provide the user with a summary of timeliness on claims payment. The data results are grouped by provider type and specialty. Selection criteria for this report includes: benefit plan, fund code, claim type, provider type, provider specialty, ICN region code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.18.8 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Layout

8/15/2006 12:33

State of Alabama

Claims Processing Throughput Analysis - DOR to DOP

Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Provider Type	01 Hospital	**ICN Region Code**	ALL
Provider Specialty	ALL	**Begin/End Period**	MAY 2006 / JUL 2006

Provider Type / Provider Specialty	Total Claims	7 Days	14 Days	21 Days	30 Days	60 Days	90 Days	Over 90 Days	Avg Days to Paid
01 Hospital 010 Acute Care	595	35.6%	8.7%	2.2%	3.9%	37.8%	7.4%	4.4%	33.0
01 Hospital 011 Psychiatric	17	47.1%	0.0%	5.9%	5.9%	0.0%	0.0%	41.2%	96.1
01 Hospital 012 Rehabilitation	7	57.1%	14.3%	14.3%	0.0%	0.0%	0.0%	14.3%	53.0
01 Hospital 015 Childrens Specialty	1	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0
01 Hospital 016 Emergency	386	39.9%	10.4%	4.4%	6.0%	33.4%	6.0%	0.0%	24.9
Totals:	**1,006**	**37.7%**	**9.2%**	**3.2%**	**4.7%**	**35.2%**	**6.7%**	**3.4%**	**31.1**

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6.18.9 Claims Processing Throughput Analysis - DOR to DOP (MAR.ThruputDORDOP.rdl) Report Field Descriptions

Field	Description	Length	Data Type
7 Days	This is the percent of total claims for the provider type and provider specialty that were paid within seven days of being received.	6	Number (Decimal)
14 Days	This is the percent of total claims for the provider type and provider specialty that were paid in eight to 14 days of being received.	6	Number (Decimal)
21 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 15 to 21 days of being received.	6	Number (Decimal)
30 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 22 to 30 days of being received.	6	Number (Decimal)
60 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 31 to 60 days of being received.	6	Number (Decimal)
90 Days	This is the percent of total claims for the provider type and provider specialty that were paid in 61 to 90 days of being received.	6	Number (Decimal)
Avg Days to Paid	This is the average number of days from being received to paid for the provider type and provider specialty. This average reflects the criteria selected by the user.	6	Number (Decimal)
Over 90 Days	This is the percent of total claims for the provider type and provider specialty that were paid over 90 days after being received.	6	Number (Decimal)
Provider Type / Provider Specialty	This field displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Total Claims	This is the total number of claims that have been paid for the provider type and provider specialty. This total reflects the criteria selected by the user.	10	Number (Integer)
Totals	These are the totals for the corresponding columns. For the percentage columns, the values are calculated for the total claims displayed.	10	Number (Integer & Decimal)

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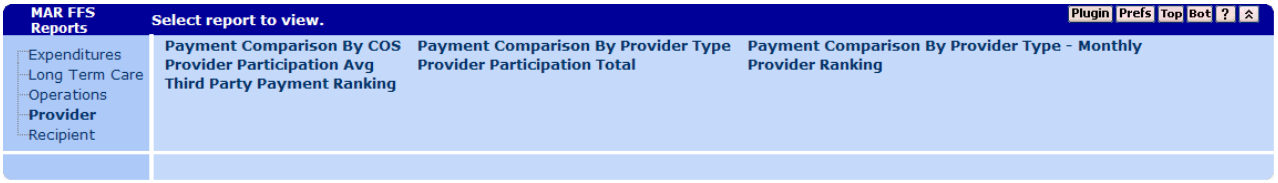
6.19 MAR REPORTS - PROVIDER PAGE OVERVIEW

6.19.1 MAR Reports - Provider Page Narrative

The MAR Reports – Provider page is the access point within the MAR system that allows users to view reports that fall under the category of Provider.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider]

6.19.2 MAR Reports - Provider Page Layout



6.19.3 MAR Reports - Provider Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Payment Comparison By COS	Link to Payment Comparison By COS panel.	Hyperlink	N/A	0
Payment Comparison By Provider Type	Link to Payment Comparison By Provider Type panel.	Hyperlink	N/A	0
Payment Comparison By Provider Type - Monthly	Link to Payment Comparison By Provider Type panel - Monthly.	Hyperlink	N/A	0
Provider Participation Avg	Link to Provider Participation Avg panel.	Hyperlink	N/A	0
Provider Participation Total	Link to Provider Participation Total panel.	Hyperlink	N/A	0
Provider Ranking	Link to Provider Ranking panel.	Hyperlink	N/A	0
Third Party Payment Ranking	Link to Third Party Payment Ranking panel.	Hyperlink	N/A	0

6.19.4 MAR Reports - Provider Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.19.5 MAR Reports - Provider Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.19.6 MAR Reports - Provider Page Accessibility

6.19.6.1 To Access MAR Reports – Provider Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.

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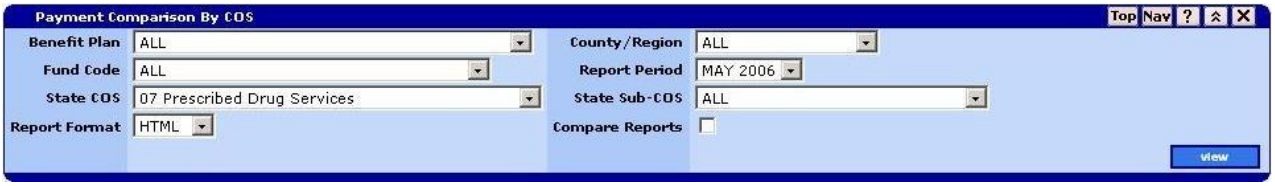
6.20 PAYMENT COMPARISON BY COS PANEL OVERVIEW

6.20.1 Payment Comparison By COS Panel Narrative

The Payment Comparison by COS panel allows the user to generate a report that displays a comparison of payments listed by State Category of Service (COS) and State-Sub COS. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By COS]

6.20.2 Payment Comparison By COS Panel Layout



6.20.3 Payment Comparison By COS Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report displays in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By COS will include.	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Payment By Provider Type report.	Button	N/A	0

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6.20.4 Payment Comparison By COS Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.20.5 Payment Comparison By COS Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Payment Comparison By COS Panel Accessibility

6.20.6.1 To Access and View Payment Comparison by Category of Service Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by COS** hyperlink on the Provider page.	Payment Comparison by COS panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Category of Service report displays.

6.20.7 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Narrative

The Payment Statistics by COS report displays paid and denied claim statistics grouped by State category of service. It includes recipient, claim, billed and paid dollars as applicable for paid and denied claims. When the user selects the Unduplicated Recipients box, the number of unduplicated recipients is displayed for the listed category of service. The data results are grouped by the four character State COS. Selection criteria for this window includes: benefit plan, fund code, state category of service, state sub-category of service, aid category, claim type, transaction type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.20.8 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Layout

9/8/2006 9:23

State of Alabama

Payment Statistics By State COS

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Aid Category**	ALL
Fund Code	ALL	**Claim Type**	ALL
State COS	ALL	**Transaction Type**	ALL
State Sub-COS	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

		Paid			Denied	
State Category of Service	***Undup Recip**	**Claims**	**Units of Service**	**Paid Amount**	**Claims**	**Billed Amount**
01 Inpatient Services	0	0	0	$0	52	$493,000
02 Psychiatric Services	0	0	0	$0	20	$13,700
03 Outpatient Services	7	9	9	-$7	50	$40,251
06 Physician Services	29	65	0	$4,350	287	$39,677
07 Prescribed Drug Services	51	58	58	$3,037	176	$20,888
08 MSDG Services	8	15	7	$1,535	22	$829
10 Clinic Services	1	1	0	$47	11	$7,065
15 ICF-MR Services	2	2	33	$0	14	$40,794
29 Eyewear Services	2	4	0	$745	25	$9,250
30 Dental Services	11	24	22	$2,452	138	$19,669
42 Advanced Practice Nurse (APN) Services	27	37	0	$2,008	11	$870
99 Unknown Services by Record Type	1	-1	-1	-$17	2	$130
Totals:	**184**	**214**	**128**	**$14,150**	**808**	**$686,123**

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6.20.9 Payment Statistics by State COS (MAR.PaymentByCOS.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Undup Recip	Count of unduplicated recipients for all finalized claims that meet the selected criteria.	8	Number (Integer)
Denied - Billed Amount	Amount billed for all denied claims for each State Category of Service. This total reflects the criteria selected by the user.	15	Number (Decimal)
Denied - Claims	Number of claims that have been denied for each State Category of Service. This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Claims	Number of claims that have been paid for each State Category of Service This total reflects the criteria selected by the user.	10	Number (Integer)
Paid - Paid Amount	Amount reimbursed for all paid claims for each State Category of Service. This total reflects the criteria selected by the user.	15	Number (Decimal)
Paid - Units of Service	Total units of service for paid claims for each State Category of Service. This total reflects the criteria selected by the user.	10	Number (Integer)
State Category of Service	Displays the combined high-level State category of service and detail-level State Sub-Category of Service value. The State category of service is a derived value assigned to each record reported in MAR.	50	Character
Totals	Totals for corresponding columns.	15	Number (Integer & Decimal)

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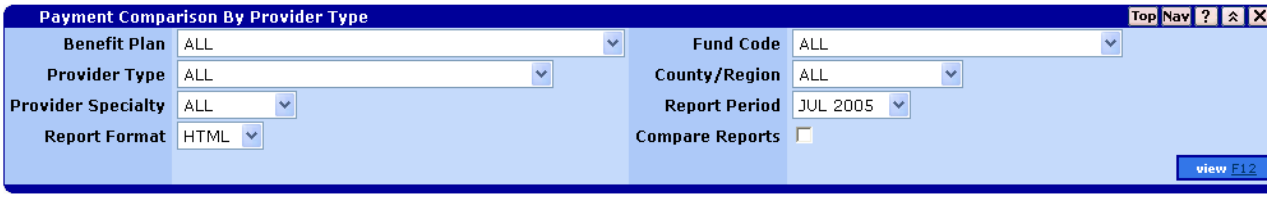
6.21 PAYMENT COMPARISON BY PROVIDER TYPE PANEL OVERVIEW

6.21.1 Payment Comparison By Provider Type Panel Narrative

The Payment Comparison By Provider Type panel allows the user to generate a report that displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By Provider Type]

6.21.2 Payment Comparison By Provider Type Panel Layout



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6.21.3 Payment Comparison By Provider Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By Provider Type will include.	Combo Box	Drop Down List Box	0
View	View the Payment Comparison By Provider Type report.	Button	N/A	0

6.21.4 Payment Comparison By Provider Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.21.5 Payment Comparison By Provider Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Payment Comparison By Provider Type Panel Accessibility

6.21.6.1 To Access and View Payment Comparison by Provider Type Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by Provider Type** hyperlink on the Provider page.	Payment Comparison by Provider Type panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Provider Type report displays.

6.21.7 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Narrative

The Payment Comparison by Provider Type report displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.21.8 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Layout

8/15/2006 16:18

State of Alabama

Payment Comparison By Provider Type

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**Fund Code**	ALL
Provider Specialty	ALL	**Reporting Period**	JUN 2006

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
Provider Type / Specialty	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**
## Unknown	-4	$725	2	$9,076	-4	$725	4,623	$385,031
01 Hospital	8	$2	3	$3	130	$537	218	$526,622
02 Ambulatory Surgical Center (ASC)	0	$0	0	$0	0	$0	13	$858
03 Extended Care Facility	2	$0	0	$0	14	$0	28	$51,139
05 Home Health Agency	1	$18	0	$0	13	$172	28	$4,731
07 Capitation Provider	0	$0	2	$33	5	$20	71	$6,961
08 Clinic	2	$70	0	$0	28	$3,280	21	$698
09 Advance Practice Nurse	5	$232	0	$0	5	$232	2	$243
11 Mental Health Provider	0	$0	0	$0	0	$0	45	$7,604
15 Chiropractor	0	$0	0	$0	1	$20	17	$623
17 Therapist	0	$0	0	$0	0	$0	9	$255
18 Optometrist	0	$0	0	$0	1	$27	41	$3,616
19 Optician	1	$250	0	$0	1	$250	1	$31
21 Case Manager (Targeted)	-1	$398	0	$0	-1	$398	23	$822
24 Pharmacy	14	$234	0	$0	65	$3,359	204	$31,686
25 DME/Medical Supply Dealer	6	$610	0	$0	12	$1,015	30	$5,466
26 Transportation Provider	1	$2,953	0	$0	2	$3,343	36	$3,124
27 Dentist	1	$1,197	0	$0	485	$46,780	138	$15,351
28 Laboratory	0	$0	0	$0	2	$0	6	$190
30 End-Stage Renal Disease (RSD) Clinic	0	$0	0	$0	0	$0	0	$0
31 Physician	4	$6,569	0	$9,897	132	$12,885	658	$519,041
36 Personal Care Services	0	$0	0	$0	2	$679	27	$441
Totals:	**40**	**$13,258**	**7**	**$19,009**	**893**	**$73,722**	**6,239**	**$1,564,533**

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6.21.9 Payment Comparison by Provider Type (MAR.ComparisonByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Provider Type / Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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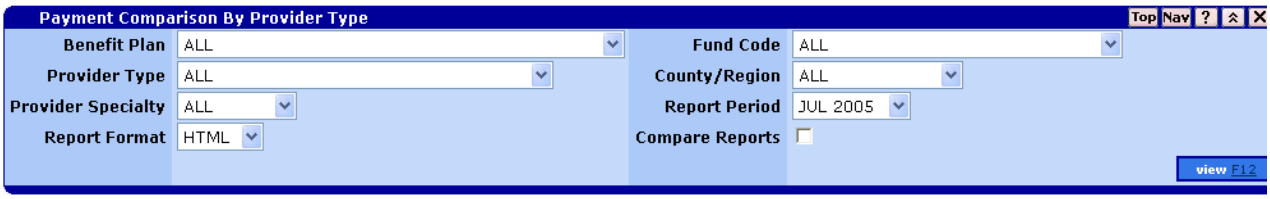
6.22 PAYMENT COMPARISON BY PROVIDER TYPE – MONTHLY PANEL OVERVIEW

6.22.1 Payment Comparison By Provider Type - Monthly Panel Narrative

The Payment Comparison By Provider Type - Monthly panel allows the user to generate a report that displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Payment Comparison By Provider Type- Monthly]

6.22.2 Payment Comparison By Provider Type - Monthly Panel Layout



6.22.3 Payment Comparison By Provider Type - Monthly Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Report Period	Period requested that the report Payment Comparison By Provider Type - Monthly will include.	Combo Box	Drop Down List Box	0
View	View the Payment Comparison By Provider Type - Monthly report.	Button	N/A	0

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6.22.4 Payment Comparison By Provider Type - Monthly Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.22.5 Payment Comparison By Provider Type - Monthly Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 Payment Comparison By Provider Type - Monthly Panel Accessibility

6.22.6.1 To Access and View Payment Comparison by Provider Type - Monthly Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Payment Comparison by Provider Type - Monthly** hyperlink on the Provider page.	Payment Comparison by Provider Type - Monthly panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Payment Comparison by Provider Type - Monthly report displays.

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6.22.7 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Narrative

The Payment Comparison by Provider Type - Monthly report displays a comparison of provider payments listed by provider type and specialty. It includes the number of claims paid and paid amounts for this month, same month last year, SFYTD this year and SFYTD last year. Selection criteria for this window are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period.

This report is designed to consistently display fee-for-service or encounter information.

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6.22.8 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Layout

8/8/2013 10:23

State of Alabama

Payment Comparison By Provider Type - Monthly

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**Fund Code**	ALL
Provider Specialty	ALL	**Reporting Period**	MAR 2005

	|------- This Month ------|		|- Same Month Last Year -|		|---- SFYTD This Year ----|		|---- SFYTD Last Year ---|	
Provider Type / Specialty	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**	**Paid Claims**	**Paid Amount**
	483	$239,805	0	$0	4,868	$681,206	0	$0
01 Hospital	0	$0	0	$0	0	$0	0	$0
03 Nursing Home/Hospital Swing Bed	28	$737	0	$0	30	$787	0	$0
05 Home Health Agency	6	$190	0	$0	6	$190	0	$0
Totals:	**517**	**$240,732**	**0**	**$0**	**4,904**	**$682,183**	**0**	**$0**

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6.22.9 Payment Comparison by Provider Type - Monthly (MAR.ComparisonByProvType.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Provider Type / Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
SFYTD Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the prior state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, through the prior state fiscal year reporting period for the month indicated.	15	Number (Decimal)
SFYTD This Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	10	Number (Integer)
SFYTD This Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty through the current state fiscal year reporting period for the selected reporting period.	15	Number (Decimal)
Same Month Last Year - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	10	Number (Integer)
Same Month Last Year - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty for the same month last year based on the selected reporting period.	15	Number (Decimal)
This Month - Paid Claims	Displays the number of paid claims by provider type and provider specialty for the selected reporting period.	10	Number (Integer)
This Month - Paid Amount	Displays the paid amount for paid claims by provider type and provider specialty, claims during the month indicated.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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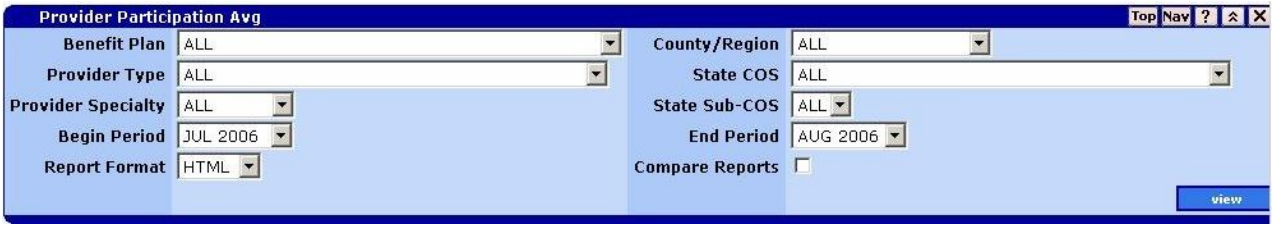
6.23 PROVIDER PARTICIPATION AVG PANEL OVERVIEW

6.23.1 Provider Participation Avg Panel Narrative

The Provider Participation Avg panel allows the user to generate a report that displays provider participation by averages of provider activity, including recipients, paid claims, denied claims, reimbursement, and billed amounts per participating provider. Participation is defined as claim or non-claim activity within the selection criteria. Detail lines are grouped by provider type and provider specialty.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Participation Avg]

6.23.2 Provider Participation Avg Panel Layout



6.23.3 Provider Participation Avg Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Provider Participation Avg report.	Button	N/A	0

6.23.4 Provider Participation Avg Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.23.5 Provider Participation Avg Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 Provider Participation Avg Panel Accessibility

6.23.6.1 To Access and View Provider Participation Average Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Participation Avg** hyperlink on the Provider page.	Provider Participation Avg panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Participation Average report displays.

6.23.7 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Narrative

The Provider Participation Average report provides analysis of provider participation by averages of provider activity, including recipients, paid claims, denied claims, reimbursement and billed amounts per participating provider. Participation is defined as claim or non-claim activity within the selection criteria. Detail lines are grouped by provider type and provider specialty. Selection criteria for this report are: benefit plan, fund code, region/county, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.23.8 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Layout

8/15/2006 16:27

State of Alabama
Provider Participation Average
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**State COS**	ALL
Provider Specialty	ALL	**State Sub-COS**	ALL
		Begin/End Period	JUL 2006 / AUG 2006

Provider Type / Provider Specialty	Recips per Provider	Paid Claims per Prov	Denied Claims per Prov	Paid per Provider	Paid per Recip	Billed per Paid Claim	Billed per Denied Claim
## Unknown	1	5	20	$3,893	$3,893	$779	$383
01 Hospital	1	1	8	$553	$684	$1,032	$3,615
02 Ambulatory Surgical Center (ASC)	3	4	0	$65	$26	$161	$0
03 Extended Care Facility	2	4	15	$0	$0	$2,946	$2,916
05 Home Health Agency	0	0	2	$0	$0	$2,000	$1,408
08 Clinic	1	1	2	$165	$331	$775	$590
09 Advance Practice Nurse	39	61	11	$9,929	$255	$263	$79
19 Optician	3	12	25	$2,183	$728	$257	$370
24 Pharmacy	6	7	17	$2,376	$381	$449	$131
25 DME/Medical Supply Dealer	7	19	2	$2,520	$360	$153	$30
27 Dentist	1	3	15	$847	$605	$527	$137
31 Physician	1	3	8	$611	$441	$352	$145
Totals:	**2**	**4**	**9**	**$939**	**$515**	**$447**	**$853**

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6.23.9 Provider Participation Average (MAR.ProviderPrtcpAvg.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Billed per Denied Claim	Displays an average of the dollars billed for denied claims per the quantity of the denied claims.	10	Number (Decimal)
Billed per Paid Claim	Displays an average of the dollars billed for paid claims per the quantity of the paid claims.	10	Number (Decimal)
Denied Claims per Prov	Displays an average of the number of denied claims per the number of participating providers.	8	Number (Integer)
Paid Claims per Prov	Displays an average of the number of paid claims per the number of participating providers.	8	Number (Integer)
Paid per Provider	Displays an average of the total reimbursement per participating provider.	10	Number (Decimal)
Paid per Recip	Displays an average of the total reimbursement per participating eligible.	10	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Recips per Provider	Displays an average of the number of participating eligibles per the number of participating providers for claims finalized for payment within the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	10	Number (Integer & Decimal)

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6.24 PROVIDER PARTICIPATION TOTAL PANEL OVERVIEW

6.24.1 Provider Participation Total Panel Narrative

The Provider Participating Total panel allows the user to generate a report that displays totals of provider participation including number of providers enrolled, number of providers participating, percent participating, number unduplicated recipients, claims paid and denied and reimbursement amount. Participation is defined as claim or non-claim activity within the selection criteria.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Participation Total]

6.24.2 Provider Participation Total Panel Layout

6.24.3 Provider Participation Total Panel Field Descriptions

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Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report. When a provider type is selected, the report displays the provider specialty statistics for that provider type.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report. Also when a State COS is selected, the report displays the State Sub-COS statistics for that State COS.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Recipients	This check box is used to request and display unduplicated recipient statistics for each aid category.	Combo Box	Check Box	0
View	View the Provider Participation Total report.	Button	N/A	0

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6.24.4 Provider Participation Total Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

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6.24.5 Provider Participation Total Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Provider Participation Total Panel Accessibility

6.24.6.1 To Access and View Provider Participation Total Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Participation Total** hyperlink on the Provider page.	Provider Participation Total panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Participation Total report displays.

6.24.7 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Narrative

The Provider Participation Total report provides analysis of totals of provider participation including number of providers enrolled, number of providers participating, percent participating, number unduplicated recipients, claims paid and denied and reimbursement amount. Participation is defined as claim or non-claim activity within the selection criteria. When the user selects the Undup Recipients box, the average payment per participating recipient is displayed. Results are grouped by provider type and provider specialty. Selection criteria for this report are: benefit plan, fund code, county/region, provider type, provider specialty and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.24.8 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Layout

9/21/2006 9:21

State of Alabama
Provider Participation Total
Fee For Service

Report Criteria

Benefit Plan	ALL	**County/Region**	ALL
Provider Type	ALL	**State COS**	ALL
Provider Specialty	ALL	**State Sub-COS**	ALL
		Begin/End Period	JUL 2006 / JUL 2006

Provider Type / Provider Specialty	Providers Enrolled	Providers Prtcp	Pct Prov Prtcp	*Undup Recip	Claims Paid	Claims Denied	Paid Amount
## Unknown	0	1	0.0%	1	4	20	$2,004
01 Hospital	63	21	33.3%	17	26	103	$9,853
02 Ambulatory Surgical Center (ASC)	9	2	22.2%	5	7	0	$130
03 Extended Care Facility	36	1	2.8%	2	2	6	$0
05 Home Health Agency	36	3	8.3%	1	1	6	$0
08 Clinic	75	7	9.3%	3	3	14	$856
09 Advance Practice Nurse	11	1	9.1%	21	41	4	$6,636
19 Optician	3	1	33.3%	2	9	18	$1,688
24 Pharmacy	26	12	46.2%	72	89	88	$20,776
25 DME/Medical Supply Dealer	30	1	3.3%	6	12	2	$156
27 Dentist	34	9	26.5%	11	23	42	$8,387
31 Physician	443	37	8.4%	51	106	122	$19,597
Totals:	**787**	**96**	**12.2%**	**157**	**323**	**425**	**$70,083**

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6.24.9 Provider Participation Total (MAR.ProviderPrtcpTotals.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Undup Recip	Displays an unduplicated count of the number of participating eligibles that meet the criteria selected. This count only includes recipients from paid claims that finalized during the reporting period.	8	Number (Integer)
Claims Denied	Displays the number of submitted claims that meet the criteria selected that denied.	10	Number (Integer)
Claims Paid	Displays the number of submitted claims that meet the criteria selected that processed for payment.	10	Number (Integer)
Paid Amount	Displays the dollar amount paid for finalized claims.	15	Number (Decimal)
Pct Prov Prtcp	Displays the number of participating providers as a percentage of the total enrolled providers.	6	Number (Decimal)
Provider Type / Provider Specialty	Displays the provider type and description or the provider specialty codes and descriptions for the providers who had data for the chosen selection criteria on this report.	50	Character
Providers Enrolled	Displays the total number of providers enrolled that meet the criteria selected.	8	Number (Integer)
Providers Prtcp	Displays the number of enrolled providers with claims that processed to pay during the reporting period.	8	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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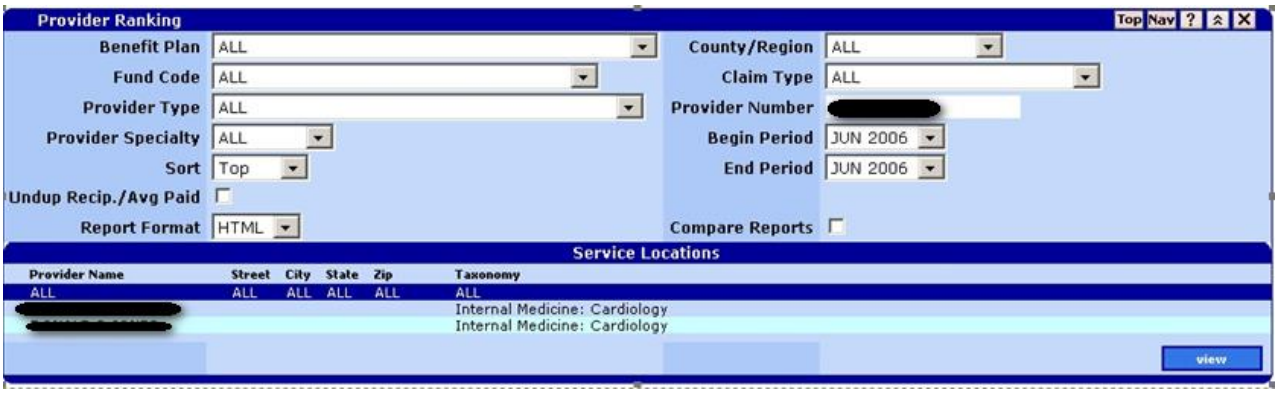
6.25 PROVIDER RANKING PANEL OVERVIEW

6.25.1 Provider Ranking Panel Narrative

The Provider Ranking panel allows the user to generate a report that displays provider performance ranking among selected groups of like providers. Results can be displayed as either the top 100 ranked providers or the bottom 100 ranked providers, via the Sort option. The providers are ranked by paid amount, paid claims and denied claims.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Provider Ranking]

6.25.2 Provider Ranking Panel Layout



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6.25.3 Provider Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
City	City name for the Provider on this service location.	Field	Character	30
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Provider Name	Name of the Provider for one of the service locations.	Field	Character	50
Provider Number	Allows the user to enter a specific provider number to limit data results on this report. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	Field	Alphanumeric	15
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Sort	Allows the user to select either to view the top 100 ranking list or bottom 100 ranking list.	Combo Box	Drop Down List Box	0
State	State for the provider on this service location.	Field	Character	2
Street	Street for the Provider on this service location.	Field	Character	30
Taxonomy	Used to identify taxonomies for use in certain processing methodologies.	Field	Character	100
Undup Recip./Avg Paid	This check box is used to request and display the average payment per recipient.	Combo Box	Check Box	0
View	Allows the user to view the Provider Ranking report.	Button	N/A	0
Zip	Zip Code for the Provider on this service location.	Field	Number (Integer)	5

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6.25.4 Provider Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
Provider Number	Field	0	The Provider Number entered is invalid or not on file.	Enter a valid provider ID.

6.25.5 Provider Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Provider Ranking Panel Accessibility

6.25.6.1 To Access and View Provider Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Provider Ranking** hyperlink on the Provider page.	Provider Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Provider Ranking report displays.

6.25.7 Provider Ranking (MAR.ProviderRanking.rdl) Report Narrative

The Provider Ranking report displays provider performance ranking among selected groups of like providers. Results can be displayed as either the top 100 ranked providers or the bottom 100 ranked providers, via the Sort option. The providers are ranked by paid amount, paid claims and denied claims. When the user selects the Undup Recip/Avg Paid checkbox, the average payment per unique recipient is displayed. Selection criteria for this report are: benefit plan, fund code, claim type, region/county, provider type, provider specialty, provider number and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.25.8 Provider Ranking (MAR.ProviderRanking.rdl) Report Layout

9/26/2006 13:17

State of Alabama
Provider Ranking
Fee For Service

Report Criteria

Benefit Plan	ALL	**Provider Type**	24 Pharmacy
Fund Code	ALL	**Provider Specialty**	ALL
Claim Type	P PHARMACY CLAIMS	**Provider Number**	
County/Region	ALL	**Begin/End Period**	JUL 2006 / AUG 2006

Provider Number	Provider Name	Claims Paid	Claims Denied	Paid Amount	Billed Amt Paid Claims	Billed Amt Denied Claims	Avg Paid	Pct Paid	Pct Billed	*Avg Paid per Recip	Rank
[redacted]	[redacted]	26	68	$16,929	$21,876	$6,939	$651	81.2%	68.6%		1
[redacted]	[redacted]	21	51	$1,773	$2,514	$9,284	$84	8.5%	7.9%		2
[redacted]	[redacted]	11	20	$668	$690	$1,270	$61	3.2%	2.2%		3
[redacted]	[redacted]	13	22	$649	$723	$829	$50	3.1%	2.3%		4
[redacted]	[redacted]	3	4	$294	$300	$400	$98	1.4%	0.9%		5
[redacted]	[redacted]	1	3	$249	$2,000	$5,500	$249	1.2%	6.3%		6
[redacted]	[redacted]	13	14	$157	$3,100	$1,650	$12	0.8%	9.7%		7
[redacted]	[redacted]	6	15	$135	$550	$1,450	$23	0.6%	1.7%		8
[redacted]	[redacted]	1	7	$4	$25	$175	$4	0.0%	0.1%		9
[redacted]	[redacted]	1	2	$2	$100	$200	$2	0.0%	0.3%		10
[redacted]	[redacted]	1	3	$0	$0	$21	$0	0.0%	0.0%		11
[redacted]	[redacted]	0	7	$0	$0	$350	$0	0.0%	0.0%		12
Totals:		**97**	**216**	**$20,860**	**$31,878**	**$28,068**	**$215**	**100.0%**	**100.0%**		

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6.25.9 Provider Ranking (MAR.ProviderRanking.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Avg Paid per Recip	When undup recip/avg paid checkbox is selected, this field displays an average dollar amount of the total payments made to the provider per the participating eligibles of that provider for claims finalized for payment during the reporting period.	10	Number (Decimal)
Avg Paid	Displays the average dollar amount reimbursed to the individual provider per total number of claims paid to the provider type and specialty.	10	Number (Decimal)
Billed Amt Denied Claims	Displays the total dollars billed for all denied claims during the reporting period.	15	Number (Decimal)
Billed Amt Paid Claims	Displays the total dollars billed for all claims finalized for payment to the provider during the reporting period.	15	Number (Decimal)
Claims Denied	Displays the number of claims submitted by the provider denied during the reporting period.	10	Number (Integer)
Claims Paid	Displays the number of claims submitted by the provider finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollar amount reimbursed on claims finalized for the provider during the reporting period.	15	Number (Decimal)
Pct Billed	Displays this provider's billed amount for paid claims as a percentage of the total billed amount for paid claims for all providers meeting the selection criteria.	6	Number (Decimal)
Pct Paid	This field displays this provider's paid amount as a percentage of the total reimbursed amount for all providers meeting the selection criteria.	6	Number (Decimal)
Provider Name	This field displays the name of the provider.	40	Character
Provider Number	This field displays the numeric value assigned to identify each provider. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Rank	Displays the numeric ranking of total payments for a provider with the same type and specialty during the reporting period.	3	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.26 THIRD PARTY PAYMENT RANKING PANEL OVERVIEW

6.26.1 Third Party Payment Ranking Panel Narrative

The Third Party Payment Ranking panel allows the user to generate a report that displays third party payment trends by provider. It displays claim counts, dollar amounts, related percentages, and rankings of the information in a selected provider grouping for paid claims with third party payment considerations. The top 100 providers, ranked by Third Party Liability (TPL) dollars, that fit the selection criteria, are displayed.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Provider] - [Third Party Payment Ranking]

6.26.2 Third Party Payment Ranking Panel Layout

6.26.3 Third Party Payment Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty	Allows the user to select a specific provider specialty code when returning data on this report.	Combo Box	Drop Down List Box	0
Provider Type	Allows the user to select a specific provider type when returning data on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Third Party Payment Ranking report.	Button	N/A	0

6.26.4 Third Party Payment Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.26.5 Third Party Payment Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.26.6 Third Party Payment Ranking Panel Accessibility

6.26.6.1 To Access and View Third Party Payment Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Provider** hyperlink.	Provider page displays.
4	Click **Third Party Payment Ranking** hyperlink on the Provider page.	Third Party Payment Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Third Party Payment Ranking report displays.

6.26.7 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Narrative

This report analyzes third party payment trends by provider. It displays claim counts, dollar amounts, related percentages, and rankings of the information in a selected provider grouping for paid claims with third party payment considerations. The top 100 providers, ranked by TPL dollars, that fit the selection criteria, are displayed. Selection criteria for this report are: benefit plan, fund code, claim type, provider type, provider specialty and reporting period date range.

The Third Party Payment Report is designed to consistently display fee-for-service or encounter information.

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6.26.8 Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Layout

9/21/2006 9:29

State of Alabama

Third Party Payment Ranking

Fee For Service

Report Criteria

Benefit Plan	ALL	**Claim Type**	ALL
Fund Code	ALL	**County/Region**	ALL
Provider Type	ALL		
Provider Specialty	ALL	**Begin/End Period**	OCT 2005 / AUG 2006

Provider Number	Provider Name	Claims Paid	TPL Claims	TPL / Claim Pct	Total Billed	TPL Dollars	TPL Dollars / Billed Pct	Rank TPL / Paid
[redacted]	[redacted]	18	1	5.6%	$3,518	$90	2.6%	1
[redacted]	[redacted]	16	1	6.3%	$3,340	$70	2.1%	2
[redacted]	[redacted]	24	1	4.2%	$35,038	$22	0.1%	3
[redacted]	[redacted]	21	1	4.8%	$2,514	$15	0.6%	4
[redacted]	[redacted]	24	1	4.2%	$3,138	$10	0.3%	5
[redacted]	[redacted]	34	1	2.9%	$26,622	$1	0.0%	6
Totals:		**137**	**6**	**4.4%**	**$74,170**	**$208**	**0.3%**	

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Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Field DescriptionsField	Description	Length	Data Type
Claims Paid	Displays the number of claims submitted by the provider finalized for payment during the reporting period.	10	Number (Integer)
TPL Claims	Displays the number of paid claims with payment from a third party not including Medicare.	10	Number (Integer)
Provider Name	Displays the name of the provider matching the number listed in the Provider Number column of the data report.	40	Character
Provider Number	Displays the numeric value assigned to identify each provider. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Rank TPL/Paid	Displays the numeric ranking of the provider according to the amount of third party dollars per dollars billed for paid claims for the reporting period. Only the top 100 providers that fit the selection criteria are displayed.	3	Number (Integer)
TPL Dollars	Displays the dollar amount paid by a third party for claims paid to the provider during the reporting period.	15	Number (Decimal)
TPL Dollars/Billed Pct	Displays the dollar amount paid by a third party as a percentage of the total dollars billed for claims paid during the reporting period.	6	Number (Decimal)

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Third Party Payment Ranking (MAR.ThirdPartyPayment.rdl) Report Field DescriptionsField	Description	Length	Data Type
TPL/Claim Pct	Displays the number of paid claims with third party dollars, as a percentage of the total number of claims paid to the provider during the reporting period.	6	Number (Integer)
Total Billed	Displays the total dollars billed by the provider for claims paid during the reporting period.	15	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.27 MAR REPORTS - RECIPIENT PAGE OVERVIEW

6.27.1 MAR Reports - Recipient Page Narrative

The MAR Reports – Recipient page is the access point within the MAR system that allows users to view reports that fall under the category of Recipient.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient]

6.27.2 MAR Reports - Recipient Page Layout

6.27.3 MAR Reports - Recipient Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Medicare Participation Part A	Link to Medicare Participation Part A panel.	Hyperlink	N/A	0
Medicare Participation Part A B	Link to Medicare Participation Part A B.	Hyperlink	N/A	0
Medicare Participation Part B	Link to Medicare Participation Part B panel.	Hyperlink	N/A	0
Recipient Copay	Link to Recipient Copay panel.	Hyperlink	N/A	0
Recipient Participation By County	Link to Recipient Participation By County panel.	Hyperlink	N/A	0
Recipient Ranking	Link to Recipient Ranking panel.	Hyperlink	N/A	0

6.27.4 MAR Reports - Recipient Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.27.5 MAR Reports - Recipient Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.27.6 MAR Reports - Recipient Page Accessibility

6.27.6.1 To Access MAR Reports - Recipient Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.

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6.28 MEDICARE PARTICIPATION PART A PANEL OVERVIEW

6.28.1 Medicare Participation Part A Panel Narrative

The Medicare Participation Part A panel allows the user to generate a report that displays number of Part A claims paid, Medicaid paid amount for Part A claims, Medicaid allowed for Part A claims, Medicare paid amount for Part A claims and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part A eligible, buy in premium, and the percent of buy in as compared to Medicare paid.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part A]

6.28.2 Medicare Participation Part A Panel Layout

6.28.3 Medicare Participation Part A Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Medicare Participation Part A report.	Button	N/A	0

6.28.4 Medicare Participation Part A Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.28.5 Medicare Participation Part A Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.28.6 Medicare Participation Part A Panel Accessibility

6.28.6.1 To Access and View Medicare Participation Part A Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part A** hyperlink on the Recipient page.	Medicare Participation Part A panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part A report displays.

6.28.7 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Narrative

The Medicare Participation Part A report displays number of Part A claims paid, Medicaid paid amount for Part A claims, Medicaid allowed for Part A claims, Medicare paid amount for Part A claims and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part A eligibles, buyin premium, and the percent of buyin as compared to Medicare paid. When the user selects the Eligibles box, the eligibles with Part A coverage, Part A buy-in premium amount, and Part A buy-in premium as a percent of the Medicare paid amount are displayed. Selection criteria for this window are: benefit plan, state category of service, state sub-category of service, aid category and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.28.8 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Layout

8/15/2006 16:45

State of Alabama
Medicare Participation Part A
Fee For Service

Report Criteria			
Benefit Plan	ALL	State COS	ALL
Fund Code	ALL	State Sub-COS	ALL
Aid Category	ALL	Begin/End Period	SEP 2005 / AUG 2006

Aid Category	*Eligibles	Claims Paid	Medicaid Allowed Amount	Medicaid Paid Amount	Medicare Paid Amount	Pct Paid of Total Paid	*Buyin Premium	*Pct Buyin of Medicare Paid
A Public Assistance, Aged	21	2	$32	$22	$0	100.0%	$1	0.0%
E Public Assistance, Blind	0	7	$90	$40	$0	100.0%	$0	0.0%
M Public Assistance, TANF	7	8	$102	$92	$0	100.0%	$0	0.0%
Totals:	**109**	**17**	**$225**	**$155**	**$0**	**100.0%**	**$9**	**0.0%**

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6.28.9 Medicare Participation Part A (MAR.MedicarePartA.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Buyin Premium	Displays the paid amount by Medicaid toward Medicare Part A buy-in premiums during the reporting period.	15	Number (Decimal)
*Eligibles	Displays the current unduplicated number of eligibles who also qualify for Medicare Part A benefits.	8	Number (Integer)
*Pct Buyin of Medicare Paid	Displays the paid amount by Medicaid toward Medicare Part A buy-in premiums as a percentage of the Part A paid amount by Medicare during the reporting period. Formula = Medicare Buyin / Amount Paid by Medicare.	6	Number (Decimal)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Claims Paid	Displays the number of claims with some portion of the total bill paid by Medicare Part A paid during the reporting period.	10	Number (Integer)
Medicaid Allowed Amount	Displays the allowed amount by Medicaid for Part A claims during the reporting period.	15	Number (Decimal)
Medicaid Paid Amount	Displays the paid amount by Medicaid for Part A claims during the reporting period.	15	Number (Decimal)
Medicare Paid Amount	Displays the paid amount by Medicare for Part A claims during the reporting period.	15	Number (Decimal)
Pct Paid of Total Paid	Displays the percent paid by Medicaid on Part A crossover claims as a percentage of the total Part A paid amount by both Medicaid and Medicare paid during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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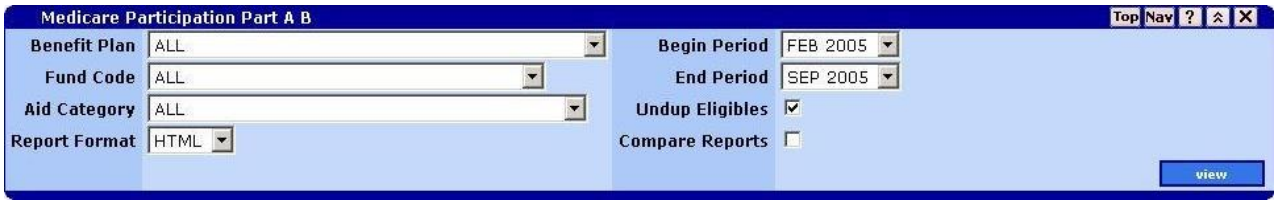
6.29 MEDICARE PARTICIPATION PART A B PANEL OVERVIEW

6.29.1 Medicare Participation Part A B Panel Narrative

The Medicare Participating Part A & B panel allows the user to generate a report that displays total Medicaid payment for Medicaid/Medicare eligible, total Medicaid/Medicare payment for Medicaid/Medicare eligible, total Medicaid payments as a percent of total Medicare and Medicaid payments as well as the total eligible with Part A and Part B.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part A B]

6.29.2 Medicare Participation Part A B Panel Layout



6.29.3 Medicare Participation Part A B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Medicare Participation Part A B report.	Button	N/A	0

6.29.4 Medicare Participation Part A B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.29.5 Medicare Participation Part A B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Medicare Participation Part A B Panel Accessibility

6.29.6.1 To Access and View Medicare Participation Part A and B Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part A B** hyperlink on the Recipient page.	Medicare Participation Part A B panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part A and B report displays.

6.29.7

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6.29.8 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Narrative

The Medicare Participation Part A and B report displays total Medicaid payment for Medicaid/Medicare eligibles, total Medicaid/Medicare payment for Medicaid/Medicare eligibles, total Medicaid payments as a percent of total Medicare and Medicaid payments as well as the total eligibles with Part A and Part B. When the user selects the Options - Eligibles box, the total eligibles with Part A and B coverage is displayed. Selection criteria for this window are: benefit plan, aid category fund code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.29.9 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Layout

8/15/2006 17:03

State of Alabama

Medicare Participation Part A and B

Fee For Service

Report Criteria			
Benefit Plan	ALL	Aid Category	ALL
Fund Code	ALL	Begin/End Period	FEB 2005 / SEP 2005

Total Eligibles with Part A and B	79
Total for Medicaid / Medicare Eligibles:	
Total Medicaid Paid	$9,794
Total Medicare Paid	$1,594
Total Medicare and Medicaid Paid	$11,389
Percent of Medicaid Payment	86.0%

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6.29.10 Medicare Participation Part A and B (MAR.MedicarePartAB.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Percent of Medicaid Payment	Displays the dollars paid by Medicaid on all crossover claims as a percentage of the total dollars reimbursed by both Medicaid and Medicare for claims paid during the reporting period.	6	Number (Decimal)
Total Eligibles with Part A and B	Displays the current number of eligibles who also qualify for Medicare Part A or B benefits.	8	Number (Integer)
Total Medicaid Paid	Displays the dollars paid by Medicaid for the claims with Medicare Part A or B payments.	15	Number (Decimal)
Total Medicare and Medicaid Paid	This field displays the sum of the Total Medicare Paid and Total Medicaid Paid fields. It represents the dollars paid by both Medicaid and Medicare for claims with Medicare Part A or B payments.	15	Number (Decimal)
Total Medicare Paid	Displays the total dollars paid by Medicare for the claims with Medicare Part A or B payments	15	Number (Decimal)

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6.30 MEDICARE PARTICIPATION PART B PANEL OVERVIEW

6.30.1 Medicare Participation Part B Panel Narrative

The Medicare Participation Part B panel allows the user to generate a report that displays number of Part B claims paid, Medicaid paid amount for Part B claims, Medicaid allowed for Part B claims, Medicare paid amount for Part B claims, and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part B eligible, buy in premium, and the percent of buy in as compared to Medicare paid.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Medicare Participation Part B]

6.30.2 Medicare Participation Part B Panel Layout

6.30.3 Medicare Participation Part B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
Undup Eligibles	This check box is used to request and display unduplicated eligible statistics for each aid category.	Combo Box	Check Box	0
View	Allows the user to view the Medicare Participation Part B report.	Button	N/A	0

6.30.4 Medicare Participation Part B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.30.5 Medicare Participation Part B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.30.6 Medicare Participation Part B Panel Accessibility

6.30.6.1 To Access and View Medicare Participation Part B Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Medicare Participation Part B** hyperlink on the Recipient page.	Medicare Participation Part B panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Medicare Participation Part B report displays.

6.30.7 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Narrative

The Medicare Participation Part B report displays number of Part B claims paid, Medicaid paid amount for Part B claims, Medicaid allowed for Part B claims, Medicare paid amount for Part B claims, and the Medicaid paid amount as a percent of total Medicare and Medicaid payments. It also displays the number of Part B eligibles, buyin premium, and the percent of buyin as compared to Medicare paid. When the user selects the Options - Eligibles box, the eligibles with Part B coverage, Part B buy-in premium amount, and Part B buy-in premium as a percent of the Medicare paid amount are displayed. Selection criteria for this window are: benefit plan, state category of service, state sub-category of service, aid category, fund code and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.30.8 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Layout

8/15/2006 17:16

State of Alabama

Medicare Participation Part B

Fee For Service

Report Criteria

Benefit Plan	ALL	**Aid Category**	ALL
State COS	ALL	**State Sub-COS**	ALL
Fund Code	ALL	**Begin/End Period**	FEB 2005 / OCT 2005

Aid Category	*Eligibles	Claims Paid	Medicaid Allowed Amount	Medicaid Paid Amount	Medicare Paid Amount	Pct Paid of Total Paid	*Buyin Premium	*Pct Buyin of Medicare Paid
## Unknown	0	1	$0	$0	$25	0.0%	$0	0.0%
A Public Assistance, Aged	19	8	$0	$40	$679	5.6%	$0	0.0%
C Medical Assistance, Categorica	2	1	$0	$0	$20	0.0%	$0	0.0%
I Public Assistance, Disabled	15	1	$0	$0	$200	0.0%	$0	0.0%
K Medical Assistance, Categorica	31	4	$0	$74	$270	21.5%	$0	0.0%
M Public Assistance, TANF	6	2	$0	$37	$50	42.5%	$0	0.0%
N Medical Assistance, Categorica	4	9	$0	$77	$350	17.9%	$0	0.0%
Totals:	**96**	**26**	**$0**	**$228**	**$1,594**	**12.5%**	**$0**	**0.0%**

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6.30.9 Medicare Participation Part B (MAR.MedicarePartB.rdl) Report Field Descriptions

Field	Description	Length	Data Type
*Buyin Premium	Displays the paid amount by Medicaid toward Medicare Part B buy-in premiums during the reporting period.	15	Number (Decimal)
*Eligibles	Displays the current unduplicated number of eligibles who also qualify for Medicare Part B benefits.	8	Number (Integer)
*Pct Buyin of Medicare Paid	Displays the paid amount by Medicaid toward Medicare Part B buy-in premiums as a percentage of the Part B paid amount by Medicare during the reporting period. Formula = Medicare Buyin / Amount Paid by Medicare.	6	Number (Decimal)
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Claims Paid	Displays the number of claims with some portion of the total bill paid by Medicare Part B paid during the reporting period.	10	Number (Integer)
Medicaid Allowed Amount	Displays the allowed amount by Medicaid for Part B claims during the reporting period.	15	Number (Decimal)
Medicaid Paid Amount	Displays the paid amount by Medicaid for Part B claims during the reporting period.	15	Number (Decimal)
Medicare Paid Amount	Displays the paid amount by Medicare for Part B claims during the reporting period.	15	Number (Decimal)
Pct Paid of Total Paid	Displays the percent paid by Medicaid on Part B crossover claims as a percentage of the total Part B paid amount by both Medicaid and Medicare paid during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.31 RECIPIENT COPAY PANEL OVERVIEW

6.31.1 Recipient Copay Panel Narrative

The Recipient Copay panel allows the user to generate a report that provides a method of tracking claim counts and expenditures saved as a result of copayment policies. It includes claims paid, total claims paid, percentage of claims with copay, copay deducted and claim amounts. Results are listed by aid category depending on user selection of the type of copayment.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Copay]

6.31.2 Recipient Copay Panel Layout

6.31.3 Recipient Copay Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
Co-payment Type	Allows the user to select a specific category of copayment claims to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
View	Allows the user to view the Recipient Copay report.	Button	N/A	0

6.31.4 Recipient Copay Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.31.5 Recipient Copay Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 Recipient Copay Panel Accessibility

6.31.6.1 To Access and View Recipient Copayment by Aid Category Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Copay** hyperlink on the Recipient page.	Recipient Copay panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Copayment by Aid Category report displays.

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6.31.7 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Narrative

The Recipient Copayment by Aid Category report provides a method of tracking claim counts and expenditures saved as a result of copayment policies. It includes claims paid, total claims paid, percentage of claims with copay, copay deducted and claim amounts. Results are listed by aid category depending on user selection of the type of copayment. Selection criteria for this report are: benefit plan, fund code, copayment type and reporting period date range.

This report is designed to consistently display fee-for-service or encounter information.

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6.31.8 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Layout

8/15/2006 16:35

State of Alabama

Recipient Copayment By Aid Category

Fee For Service

Report Criteria			
Benefit Plan	ALL	**Co-payment Type**	400 Prescribed Drug
Aid Category	ALL		
Fund Code	ALL	**Begin/End Period**	SEP 2005 / AUG 2006

Aid Category	Paid Claims with Copay	Total Claims Paid	Pct Claims Copay	Copay Deducted	Billed Amount	Allowed Amount	Paid Amount
A Public Assistance, Aged	12	14	85.7%	$12	$786	$762	$297
B Medical Assistance, Medic	1	1	100.0%	$1	$65	$19	$18
E Public Assistance, Blind	7	7	100.0%	$14	$715	$327	$290
G Medical Assistance, Categ	1	1	100.0%	$2	$100	$34	$32
I Public Assistance, Disabl	18	18	100.0%	$36	$1,104	$4,586	$988
I1 Institutionalized with in	1	1	100.0%	$2	$25	$0	$3
I2 Institutionalized with in	2	2	100.0%	$2	$476	$508	$463
I3 Institutionalized with in	2	2	100.0%	$4	$285	$277	$281
K Medical Assistance, Categ	8	36	22.2%	$8	$200	$30	$22
M Public Assistance, TANF	26	26	100.0%	$44	$3,907	$1,605	$1,098
N Medical Assistance, Categ	20	21	95.2%	$29	$2,975	$1,113	$873
Totals:	**98**	**129**	**76.0%**	**$154**	**$10,638**	**$9,261**	**$4,365**

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6.31.9 Recipient Copayment by Aid Category (MAR.RecipientCopay.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Aid Category	Eligibility category for which a recipient is assigned.	50	Character
Allowed Amount	Allowed amount for the claims that had copayment collected.	15	Number (Decimal)
Billed Amount	Displays the billed amount for the claims that had copayment collected.	15	Number (Decimal)
Copay Deducted	Copayment amount deducted from the total allowed for claims finalized during the reporting period that met the criteria set for co-payment deduction.	15	Number (Decimal)
Paid Amount	Displays the paid amount for the claims that had copayment collected.	15	Number (Decimal)
Paid Claims with Copay	Displays the number of claims finalized during the reporting period with co-pay deducted from the total allowed amount.	10	Number (Integer)
Pct Claims Copay	Displays the percentage of the totals claims paid that had copayment collected.	6	Number (Decimal)
Total Claims Paid	Total number of claims finalized during the reporting period. This total includes claims with co-pay deducted and without co-pay deducted.	10	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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6.32 RECIPIENT PARTICIPATION BY COUNTY PANEL OVERVIEW

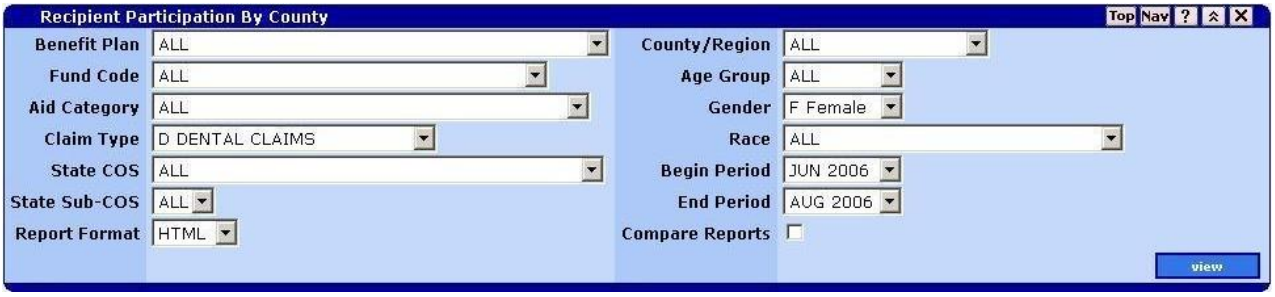
6.32.1 Recipient Participation By County Panel Narrative

The Recipient Participating by County panel allows the user to generate a report that displays recipient utilization grouped by county code and description. Selection criteria for this report includes: benefit plan, fund code, region/county, claim type, state category of service, state sub-category of service, aid category and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Participation By County]

6.32.2 Recipient Participation By County Panel Layout



6.32.3 Recipient Participation By County Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age Group	Allows the user to select a specific recipient age grouping to limit the data returned on this report.	Combo Box	Drop Down List Box	0
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0
Gender	Allows the user to select a specific recipient gender to limit data returned on this report.	Combo Box	Drop Down List Box	0
Race	Allows the user to select a specific recipient race when returning data for this report.	Combo Box	Drop Down List Box	0
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
State COS	Allows the user to select a high-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
State Sub-COS	Allows the user to select a detail-level State category of service to limit data appearing on this report.	Combo Box	Drop Down List Box	0
View	Allows the user to view the Recipient Participation By County report.	Button	N/A	0

6.32.4 Recipient Participation By County Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.32.5 Recipient Participation By County Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.32.6 Recipient Participation By County Panel Accessibility

6.32.6.1 To Access and View Recipient Participation by County Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Participation by County** hyperlink on the Recipient page.	Recipient Participation by County panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Participation by County report displays.

6.32.7 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Narrative

The Recipient Participation Summary by County report displays recipient utilization grouped by county code and description. Selection criteria for this report includes: benefit plan, fund code, region/county, claim type, state category of service, state sub-category of service, aid category and reporting period date range.

The report is designed to consistently display fee-for-service or encounter information.

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6.32.8 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Layout

8/15/2006 16:58

State of Alabama

Recipient Participation Summary By County

Fee For Service

Report Criteria			
Benefit Plan	ALL	**County/Region**	ALL
Fund Code	ALL	**Age Group**	ALL
Aid Category	ALL	**Gender**	F Female
Claim Type	D DENTAL CLAIMS	**Race**	ALL
State COS	ALL		
State Sub-COS	ALL	**Begin/End Period**	JUN 2006 / AUG 2006

County	Eligibles	Undup Recip	Pct of Elig Prtcp	Paid Amount	Avg Paid per Elig	Avg Paid Prtcp Recip
14 Cleveland	11	1	9.1%	$12	$1	$12
23 Ellis	3	1	33.3%	$26	$9	$26
26 Grady	15	1	6.7%	$1,322	$88	$1,322
45 McCurtain	22	1	4.5%	$3,000	$136	$3,000
55 Oklahoma	241	2	0.8%	$3,099	$13	$1,550
Totals:	**934**	**6**	**0.6%**	**$7,459**	**$8**	**$1,243**

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6.32.9 Recipient Participation Summary by County (MAR.RecipPrtcpByCnty.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Paid Per Elig	Average of the dollars paid per eligible for claims adjudicated for payment during the reporting period.	10	Number (Decimal)
Avg Paid Prtcp Recip	Average of the dollars paid per recipient for claims adjudicated for payment during the reporting period.	10	Number (Decimal)
County	Displays the county description associated with the detail line totals. This county description is based on the recipient county code.	50	Character
Eligibles	Displays the total number of persons enrolled in the selected program and eligible to receive services during the reporting period.	8	Number (Integer)
Paid Amount	Displays the total dollar amount paid for claims finalized during the reporting period.	15	Number (Decimal)
Pct of Elig Recip	Displays the unduplicated count of recipients as a percent of the total number of beneficiaries during the reporting period.	6	Number (Decimal)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)
Undup Recip	Displays a unique count of recipients for claims finalized during the reporting period.	8	Number (Integer)

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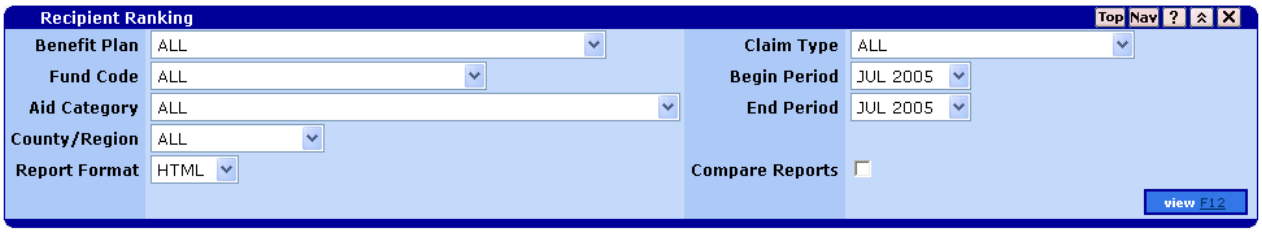
6.33 RECIPIENT RANKING PANEL OVERVIEW

6.33.1 Recipient Ranking Panel Narrative

The Recipient Ranking panel allows the user to generate a report that displays recipient usage ranking among selected groups of like recipients. The top 100 recipients, ranked by paid amount, paid claims and denied claims that fit the selection criteria, are displayed.

Navigation Path: [MAR] – [Fee for Service or Encounter] - [Recipient] - [Recipient Ranking]

6.33.2 Recipient Ranking Panel Layout



6.33.3 Recipient Ranking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category	Allows the user to select a specific aid category to limit data returned on this report.	Combo Box	Drop Down List Box	0
Begin Period	Allows the user to select the beginning report month that represents the first paid month for which data is displayed on this report. This field is used in conjunction with the End Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Benefit Plan	Allows the user to select a specific benefit plan to limit data results returned on this report.	Combo Box	Drop Down List Box	0
Claim Type	Allows the user to select a specific claim type to limit data returned on this report.	Combo Box	Drop Down List Box	0
Compare Reports	A checkbox that when selected displays the reports in a different view or browser so two reports can be displayed side by side.	Combo Box	Check Box	0
County/Region	Allows the user to select a specific county or state-defined geographical area to limit data returned on this report.	Combo Box	Drop Down List Box	0
End Period	Allows the user to select the ending report month that represents the last paid month for which data is displayed on this report. This field is used in conjunction with the Begin Period field to control the range of paid months used to retrieve data.	Combo Box	Drop Down List Box	0
Fund Code	Allows the user to select a specific fund code to limit data returned on this report.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Report Format	The report is displayed in the report format chosen (PDF, HTML, or EXCEL).	Combo Box	Drop Down List Box	0
View	Allows the user to view the Recipient Ranking report.	Button	N/A	0

6.33.4 Recipient Ranking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Begin Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change Begin Period to be within 12 months of End Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.
End Period	Combo Box	0	End Period must be no longer than 1 year after the Begin Period.	Change End Period to be within 12 months of Begin Period.
	Combo Box	1	Begin Period [<Date>] must be less than or equal to End Period [<Date>].	Enter Begin Period that is less than or equal to the End Period.

6.33.5 Recipient Ranking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.33.6 Recipient Ranking Panel Accessibility

6.33.6.1 To Access and View Recipient Ranking Report

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **MAR** and click **Fee For Service** or **Encounter**.	MAR Fee for Service or Encounter page displays.
3	Click **Recipient** hyperlink.	Recipient page displays.
4	Click **Recipient Ranking** hyperlink on the Recipient page.	Recipient Ranking panel displays.
5	Select report parameters from drop down list and click **View**.	A separate browser window opens and the Recipient Ranking report displays.

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6.33.7 Recipient Ranking (MAR.RecipientRanking.rdl) Report Narrative

The Recipient Ranking report displays recipient usage ranking among selected groups of like recipients. The top 100 recipients, ranked by paid amount, paid claims and denied claims that fit the selection criteria, are displayed. Selection criteria includes: benefit plan, region/county, claim type, aid category, fund code and reporting period date range.

Note: This report only displays the most recent rolling 6 months of data.

This report is designed to consistently display fee-for-service or encounter information.

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6.33.8 Recipient Ranking (MAR.RecipientRanking.rdl) Report Layout

8/15/2006 17:09

State of Alabama
Recipient Ranking
Fee For Service

Report Criteria

Benefit Plan	ALL	**Fund Code**	ALL
Claim Type	D DENTAL CLAIMS	**County/Region**	ALL
Aid Category	ALL	**Begin/End Period**	JUL 2006 / JUL 2006

RID	Claims Paid	Claims Denied	Paid Amount	Billed Amt Paid Claims	Billed Amt Denied Claims	Avg Paid	Percent Paid	Percent Billed	Rank
[redacted]	2	0	$3,099	$3,100	$0	$1,550	40.7%	26.1%	1
[redacted]	1	0	$3,000	$3,000	$0	$3,000	39.4%	25.3%	2
[redacted]	10	12	$1,322	$2,065	$683	$132	17.4%	17.4%	3
[redacted]	1	3	$100	$100	$195	$100	1.3%	0.8%	4
[redacted]	2	2	$26	$200	$200	$13	0.3%	1.7%	5
[redacted]	1	0	$26	$100	$0	$26	0.3%	0.8%	6
[redacted]	1	0	$26	$100	$0	$26	0.3%	0.8%	6
[redacted]	1	0	$12	$200	$0	$12	0.2%	1.7%	8
[redacted]	1	0	$2	$2	$0	$2	0.0%	0.0%	9
[redacted]	1	0	$0	$3,000	$0	$0	0.0%	25.3%	10
[redacted]	0	12	$0	$0	$1,200	$0	0.0%	0.0%	11
[redacted]	0	6	$0	$0	$996	$0	0.0%	0.0%	12
[redacted]	0	6	$0	$0	$996	$0	0.0%	0.0%	12
[redacted]	0	4	$0	$0	$260	$0	0.0%	0.0%	14
[redacted]	0	1	$0	$0	$65	$0	0.0%	0.0%	15
[redacted]	0	0	$0	$0	$0	$0	0.0%	0.0%	16
Totals:	**21**	**46**	**$7,613**	**$11,867**	**$4,595**	**$363**	**100.0%**	**100.0%**	

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6.33.9 Recipient Ranking (MAR.RecipientRanking.rdl) Report Field Descriptions

Field	Description	Length	Data Type
Avg Paid	Displays the average dollar amount paid on behalf of the recipient per total number of paid claims.	10	Number (Decimal)
Billed Amt Denied Claims	Displays the total dollars billed for all denied claims during the reporting period.	15	Number (Decimal)
Billed Amt Paid Claims	Displays the total dollars billed for all claims finalized for payment on behalf of the recipient during the reporting period.	15	Number (Decimal)
Claims Denied	Displays the number of claims submitted on behalf of the recipient and denied during the reporting period.	10	Number (Integer)
Claims Paid	Displays the number of claims submitted on behalf of the recipient and finalized for payment during the reporting period.	10	Number (Integer)
Paid Amount	Displays the total dollar amount paid for claims finalized on behalf of the recipient during the reporting period.	15	Number (Decimal)
Percent Billed	Displays this recipient's billed amount for paid claims as a percentage of the total billed amount for paid claims for all recipients meeting the selection criteria.	6	Number (Decimal)
Percent Paid	Displays this recipient's paid amount as a percentage of the total paid amount for all recipients meeting the selection criteria.	6	Number (Decimal)
RID	Displays the recipient identification number (RID).	30	Number (Integer)
Rank	Displays the numeric ranking of total payments for the recipient during the reporting period.	3	Number (Integer)
Totals	Totals for the corresponding columns.	15	Number (Integer & Decimal)

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7 MAR REPORTS

The MAR User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 MAR-0111-M -- MAR MONTHLY RECONCILIATION REPORT

7.1.1 MAR-0111-M -- MAR Monthly Reconciliation Report Narrative

The MAR Monthly Reconciliation report compares input data from the Data Warehouse with numbers from various tables in the MAR summary database, to help verify the results of the MAR monthly summary process.

7.1.2 MAR-0111-M -- MAR Monthly Reconciliation Report Layout

```
Report  : MAR-0111-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : MARJM111                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   99:99:99
Location: MRM0111                              MAR MONTHLY RECONCILIATION                                  Page:        999
                                         DATE RANGE:  MM/DD/CCYY  -  MM/DD/CCYY

                         NUMBER OF     NUMBER OF      ---------------------------- DOLLARS ----------------------------
PAID CLAIMS                 CLAIMS    RECIPIENTS            BILLED           ALLOWED              PAID               TPL
--------------          -----------    ----------      ------------      ------------     ------------     ------------
DATA WAREHOUSE           99,999,999    99,999,999      $999,999,999      $999,999,999     $999,999,999     $999,999,999
MAR
   T_MR_PROV             99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999     $999,999,999
   T_MR_RECIP            99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999              N/A
   T_MR_RE_CNTY          99,999,999           N/A      $999,999,999      $999,999,999     $999,999,999              N/A
   T_MR_RE                      N/A     9,999,999               N/A               N/A              N/A              N/A
   T_MR_POS_RE                  N/A     9,999,999               N/A               N/A              N/A              N/A

DENIED CLAIMS
--------------
DATA WAREHOUSE           99,999,999           N/A      $999,999,999               N/A              N/A              N/A
MAR
   T_MR_PROV             99,999,999           N/A      $999,999,999               N/A              N/A              N/A
   T_MR_RECIP            99,999,999           N/A      $999,999,999               N/A              N/A              N/A

                         NUMBER OF     NUMBER OF        CAPITATION
CAPITATION PMTS           PAYMENTS    RECIPIENTS            AMOUNT
---------------         -----------    ----------      ------------
DATA WAREHOUSE           99,999,999    99,999,999      $999,999,999
MAR                      99,999,999    99,999,999      $999,999,999


                                                  *** END OF REPORT ***
```


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7.1.3 MAR-0111-M -- MAR Monthly Reconciliation Report Field Descriptions

Field	Description	Length	Data Type
Capitation Pmts - Capitation Amount - Data Warehouse	Total amount of capitation payments in the data warehouse.	12	Number (Decimal)
Capitation Pmts - Capitation Amount - Mar	Total amount of capitation payments in the T_MR_PROV table.	12	Number (Decimal)
Capitation Pmts - Number Of Payments - Data Warehouse	Number of capitation payments in the data warehouse.	10	Number (Decimal)
Capitation Pmts - Number Of Payments - Mar	Number of capitation payments in the T_MR_PROV table.	10	Number (Decimal)
Capitation Pmts - Number Of Recipients - Data Warehouse	Number of recipients on capitation payments in the data warehouse.	10	Number (Decimal)
Capitation Pmts - Number Of Recipients - MAR	Number of recipients on capitation payments in the T_MR_PROV_RE table.	10	Number (Decimal)
Denied Claims - Dollars Billed - Data Warehouse	Dollars billed on denied claims in the data warehouse.	12	Number (Decimal)
Denied Claims - Dollars Billed - T_Mr_Prov	Dollars billed on denied claims in the T_MR_PROV table.	12	Number (Decimal)
Denied Claims - Dollars Billed - T_Mr_Recip	Dollars billed on denied claims in the T_MR_PROV table.	12	Number (Decimal)
Denied Claims - Number Of Claims - Data Warehouse	Number of denied claims in the T_MR_PROV table.	10	Number (Decimal)
Denied Claims - Number Of Claims - T_MR_Prov	Number of denied claims in the T_MR_PROV table.	10	Number (Decimal)
Denied Claims - Number Of Claims - T_MR_Recip	Number of denied claims in the T_MR_RECIP table.	10	Number (Decimal)
Paid Claims - Dollars Allowed - Data Warehouse	Dollars allowed on paid claims in the data warehouse.	12	Number (Decimal)

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Field	Description	Length	Data Type
Paid Claims - Dollars Allowed - T_MR_Prov	Dollars allowed on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Allowed - T_MR_Recip	Dollars allowed on paid claims in the T_MR_RECIP table.	12	Number (Decimal)
Paid Claims - Dollars Allowed - T_MR_RE_Cnty	Dollars allowed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Billed - Data Warehouse	Dollars billed on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_Prov	Dollars allowed on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_Recip	Dollars billed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Billed - T_MR_RE_Cnty	Dollars billed on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars Paid - Data Warehouse	Dollars paid on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_Prov	Dollars paid on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_Recip	Dollars paid on paid claims in the T_MR_RECIP table.	12	Number (Decimal)
Paid Claims - Dollars Paid - T_MR_RE_Cnty	Dollars paid on paid claims in the T_MR_RE_CNTY table.	12	Number (Decimal)
Paid Claims - Dollars TPL - Data Warehouse	Dollars paid on paid claims in the data warehouse.	12	Number (Decimal)
Paid Claims - Dollars TPL - T_MR_Prov	Dollars paid on paid claims in the T_MR_PROV table.	12	Number (Decimal)
Paid Claims - Number of Claims - Data Warehouse	Number of paid claims in the data warehouse.	10	Number (Decimal)
Paid Claims - Number of Claims - T_MR_Prov	Number of paid claims in the T_MR_PROV table.	10	Number (Decimal)

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Field	Description	Length	Data Type
Paid Claims - Number of Claims - T_MR_Recip	Number of paid claims in the T_MR_RECIP table.	10	Number (Decimal)
Paid Claims - Number of Claims - T_MR_RE_Cnty	Number of paid claims in the T_MR_RE_CNTY table.	10	Number (Decimal)
Paid Claims - Number of Recipients - Data Warehouse	Number of recipients on paid claims in the data warehouse.	10	Number (Decimal)
Paid Claims - Number of Recipients - T_Mr_POS_REe	Number of recipients on paid claims in the T_MR_POS_RE table.	9	Number (Decimal)
Paid Claims - Number Of Recipients - T_MR_RE	Number of recipients on paid claims in the T_MR_RE table.	9	Number (Decimal)

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7.2 MAR-0310-O – EXPENDITURE BY COS REPORT

7.2.1 MAR-0310-O – Expenditure By COS Report Narrative

This report displays paid claim data grouped by State category of service and aid category. It includes recipient, units and paid dollars as applicable for paid claims. When the reporting period is specified through table t_system_parms, the number of unduplicated recipients is displayed for the listed category of service, aid category combination during that period.

7.2.2 MAR-0310-O – Expenditure By COS Report Layout

```
Report  : MAR-0310-O                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MARJO310                   MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: MAR0310O                              EXPENDITURE BY COS                            Page:        999,999
                                        REPORTING PERIOD  MM/DD/CCYY  -  MM/DD/CCYY

COS     COS DESCRIPTION          AID    AID CAT DESCRIPTION                UNDUP        UNITS OF          PAID        AVG PAID
                                 CAT                                       RECIP         SERVICE        AMOUNT      PER RECIPS
01 UNKNOWN                       R3 Retro-full Medicaid with QMB Plus   99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
01 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
02 UNKNOWN                       A  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
02 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
06 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
21 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
44 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
53 UNKNOWN                       M  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
99 UNKNOWN                       N  UNKNOWN                             99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999
-- Total:                                                              99,999,999  99,999,999,999  $9,999,999,999  $9,999,999,999

                                                   *** END OF REPORT ***
```

7.2.3 MAR-0310-O – Expenditure By COS Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	Code identifying the type of aid for which a recipient is eligible.	2	Character
Aid Cat Description	Describes the type of aid for which a recipient is eligible.	50	Character
Avg Paid Per Recips	(The accumulation of the paid amounts for the paid claims for the reporting period)/ (Unique identification number for the recipient)	13	Number (Integer)
COS	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	2	Character

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Field	Description	Length	Data Type
COS Description	Description for the Category of Service value.	50	Character
Paid Amount	The accumulation of the paid amounts for the paid claims for the reporting period.	13	Number (Integer)
Undup Recip	Count of unduplicated rows of the recipient.	11	Number (Integer)
Units of Service	The accumulation of the units of service for the paid claims for the reporting period.	14	Number (Integer)

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7.3 MAR-0320-O – PARTICIPATION BY COS REPORT

7.3.1 MAR-0320-O – Participation By COS Report Narrative

This report displays recipient and claim counts and dollars for paid claims. When the date range is specified through the table t_system_parms, the number of recipients participating in the COS, total claims paid and average paid per recipient are displayed during that date range.

7.3.2 MAR-0320-O – Participation By COS Report Layout

```
Report  : MAR-0320-O                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : MARJO320                  MEDICAID MANAGEMENT INFORMATION SYSTEM                   Run Time:   HH:MM:SS
Location: MAR0320O                            PARTICIPATION BY COS                             Page:        999,999
                                          REPORTING PERIOD  MM/DD/CCYY - MM/DD/CCYY

COS      COS DESCRIPTION                UNDUP    ELIG       CLAIMS          BILLED         ALLOWED           PAID       AVG PAID
                                        RECIP   PRTCP         PAID          AMOUNT          AMOUNT         AMOUNT     PER RECIPS
01 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
02 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
06 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
14 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
18 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
38 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
42 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
47 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
48 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
52 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
53 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
99 UNKNOWN                          99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999
-- TOTAL:                           99,999,999  999.9%  999,999,999  $99,999,999,999  $9,999,999,999  $9,999,999,999 $9,999,999,999

                                                   *** END OF REPORT ***
```

7.3.3 MAR-0320-O – Participation By COS Report Field Descriptions

Field	Description	Length	Data Type
Allowed Amount	The accumulation of the allowed amounts for the paid claims for the reporting period.	13	Number (Integer)
Avg Paid Per Recip	Round((T_MR_RE_CNTY.AMT_PAID / T_MR_RE.ID_MEDICAID),0)	13	Number (Integer)
Billed Amount	The accumulation of the billed amounts for the paid claims during the reporting period.	14	Number (Integer)

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Field	Description	Length	Data Type
Claims Paid	The total number of claims paid during the reporting period.	11	Number (Integer)
COS	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.	2	Character
COS Description	Description for the Category of Service value.	50	Character
Elig Prtcp	Round(((T_MR_RE.ID_MEDICAID / T_MR_ELIG.ID_MEDICAID)*100),1)	5	Number (Decimal)
Paid Amount	The accumulation of the paid amounts for the paid claims for the reporting period.	13	Number (Integer)
Undup Recip	Count of unduplicated rows of the recipient.	11	Number (Integer)

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7.4 MAR-2100-M -- MONTHLY ABORTION DETAIL REPORT

7.4.1 MAR-2100-M -- Monthly Abortion Detail Report Narrative

The Monthly Abortion Detail report provides a monthly list of abortion services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.4.2 MAR-2100-M -- Monthly Abortion Detail Report Layout

```
Report  : MAR-2100-M                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: MRM2100                                     MONTHLY ABORTION DETAIL REPORT                                  Page:
999,999
                                                              PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER         ICD PROCEDURE  ICD PRIMARY  ICD SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT
AMT BILLED   AMT PAID
                            NUMBER              CODE MOD       DIAG         DIAG   TYPE  CODE              UNT

XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X  XXXXXX XX   X   XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                      *** END OF REPORT ***
```

7.4.3 MAR-2100-M -- Monthly Abortion Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)

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Field	Description	Length	Data Type
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
SVC Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
SVC Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.5 MAR-2110-M -- MONTHLY STERILIZATION DETAIL REPORT

7.5.1 MAR-2110-M -- Monthly Sterilization Detail Report Narrative

The Monthly Sterilization Detail report provides a monthly list of sterilization services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.5.2 MAR-2110-M -- Monthly Sterilization Detail Report Layout

```
Report  : MAR-2110-M                                        ALABAMA MEDICAID AGENCY                                          Run Date:
MM/DD/CCYY
Process : MARJM100                                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:
HH:MM:SS
Location: MRM2100                                        MONTHLY STERILIZATION DETAIL REPORT                                    Page:
999,999
                                                                     PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER       ICD PROCEDURE  ICD PRIMARY ICD  SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT  AMT
BILLED   AMT PAID
                             NUMBER               CODE  MOD      DIAG         DIAG    TYPE  CODE              UNT
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX   X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                          *** END OF REPORT ***
```

7.5.3 MAR-2110-M -- Monthly Sterilization Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category Of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric

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Field	Description	Length	Data Type
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
Svc Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
Svc Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.6 MAR-2100-A -- ANNUAL ABORTION DETAIL REPORT

7.6.1 MAR-2100-A -- Annual Abortion Detail Report Narrative

The Annual Abortion Detail report provides an annual list of abortion services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, ICD version codes, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.MAR-2100-A -- Annual Abortion Detail Report Layout

```
Report  : MAR-2100-A                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                              MEDICAID MANAGEMENT INFORMATION SYSTEM                             Run Time:
HH:MM:SS
Location: MRA2100                                   ANNUAL ABORTION DETAIL REPORT                                    Page:
999,999
                                                            PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER         ICD PROCEDURE  ICD PRIMARY  ICD SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT
AMT BILLED   AMT PAID
                           NUMBER              CODE MOD       DIAG         DIAG   TYPE  CODE              UNT

XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X  XXXXXX XX   X   XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX  X  XXXXXXX  X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                        *** END OF REPORT ***
```


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7.6.2 MAR-2100-A -- Annual Abortion Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category of Service for this claim. **XX**-XX	2	Character
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character

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Field	Description	Length	Data Type
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
SVC Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
SVC Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.7 MAR-2110-A -- ANNUAL STERILIZATION DETAIL REPORT

7.7.1 MAR-2110-A -- Annual Sterilization Detail Report Narrative

The Annual Sterilization Detail report provides an annual list of sterilization services claims. For each claim, details such as recipient number, ICN, provider number, ICD version codes, procedure codes, diagnosis codes, claim type, fund code, date paid, and amount paid are reported. Information from this report supports the appropriate HCFA64.9 and MSIS data.

7.7.2 MAR-2110-A -- Annual Sterilization Detail Report Layout

```
Report  : MAR-2110-A                                    ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : MARJM100                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: MRA2100                                   ANNUAL STERILIZATION DETAIL REPORT                               Page:
999,999
                                                              PERIOD: MM/CCYY

RECIPIENT ID  ICN            PROVIDER       ICD PROCEDURE  ICD PRIMARY ICD  SECOND  CLM   FUND  POS   COS   SVC  AGE  SEX  SVC DT  PMT DT  AMT
BILLED   AMT PAID
                             NUMBER               CODE  MOD      DIAG         DIAG    TYPE  CODE             UNT
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX  X   XXXXXX XX   X  XXXXXXX   X  XXXXXXX  X    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99
XXXXXXXXXXXX  9999999999999  XXXXXXXXXXXXXXX X   XXXXXX XX   X  XXXXXXX   X   XXXXXXXX    XXX   XX   XX-XX  999  999   X   MMDDYY  MMDDYY
$99,999.99 $99,999.99

PROFESSIONAL DOLLARS : $999,999,999.99
OUTPATIENT   DOLLARS : $999,999,999.99
INPATIENT    DOLLARS : $999,999,999.99
TOTAL        DOLLARS : $999,999,999.99

                                                        *** END OF REPORT ***
```

7.7.3 MAR-2110-A -- Annual Sterilization Detail Report Field Descriptions

Field	Description	Length	Data Type
Age	Age of the recipient on the date of service.	3	Number (Integer)
Amt Billed	Amount billed for this claim.	10	Number (Decimal)
Amt Paid	Amount paid for this claim.	10	Number (Decimal)
Clm Type	Claim type for this claim.	1	Character
COS (State)	State Category Of Service for this claim. **XX**-XX	2	Character

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Field	Description	Length	Data Type
COS (Sub)	State Sub-COS for this claim. XX-**XX**	2	Character
Fund Code	Fund code assigned to this claim.	3	Character
ICD	The version code of an ICD procedure or diagnosis code. Valid values are '9' for an ICD 9 procedure or diagnosis code, and '0' for an ICD 10 procedure or diagnosis code. For HCPC procedure codes or claims that do not have secondary diagnosis codes, this field will be blank.	1	Character
ICN	Internal control number assigned to this claim.	13	Number (Integer)
Inpatient Dollars	Sum of amounts paid for inpatient claims (claim types A and I).	14	Number (Decimal)
Outpatient Dollars	Sum of amounts paid for outpatient claims (claim types C and O).	14	Number (Decimal)
Pmt Dt	Date this claim was paid.	6	Date (MM/DD/YY)
POS	Place of service code for this claim.	2	Character
Primary Diag	Primary diagnosis code for this claim.	7	Character
Procedure Code	Procedure code for this claim. In cases where a claim has multiple procedure codes, this is the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_PROC_PRIM. For all UB92 claim types, this data element is either T_CA_ICD9_PROC - CDE_PROC_ICD9 or T_CA_HDR_DTL - CDE_PROC.	6	Character
Procedure Mod	Procedure code modifier for this claim. In cases where a claim has multiple procedure codes, this is the modifier for the primary procedure code. For professional claim types (B and M), this data element is T_CA_ICN - CDE_MODIFIER_1. For all UB92 claim types, this data element is T_CA_HDR_DTL - CDE_MODIFIER_1 if the procedure code is a HCPCS code. If the procedure code is an ICD9 code, the modifier is blank.	2	Character
Professional Dollars	Sum of amounts paid for professional claims (claim types B and M).	14	Number (Decimal)
Provider Number	Provider number for this claim. If the provider has an NPI number, that provider ID (ID_PROVIDER_NPI) is used. Otherwise, the Medicaid provider ID (ID_PROVIDER_MCAID) is used.	15	Alphanumeric

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Field	Description	Length	Data Type
Recipient ID	Recipient identification number for this claim.	12	Character
Second Diag	Secondary diagnosis code for this claim.	7	Character
Sex	Sex (gender) of the recipient.	1	Character
Svc Dt	Date of first service for this claim.	6	Date (MM/DD/YY)
Svc Unt	Number of units of service provided for this claim.	3	Number (Integer)
Total Dollars	Sum of amounts paid for all claims.	14	Number (Decimal)

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7.8 MAR-4812-A -- CMS 372 ANNUAL REPORT ON HCBS ID WAIVER (SHORT) REPORT

7.8.1 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS ID Waiver (Short) report contains information on the participation of recipients in the ID (Intellectual Disability) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.8.2 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Layout

```
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                    ICF-MR
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS
A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    DAY HABILITATION SERVICES - LEVEL 1                                      9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 2                                      9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 3                                      9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 4                                      9,999,999,999
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                              9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                              9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                              9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                              9,999,999,999
A.9    RESIDENTIAL HABILITATION                                                 9,999,999,999
A.10   IN-HOME RESPITE                                                          9,999,999,999
A.11   OUT-OF-HOME RESPITE                                                      9,999,999,999
A.12   INSTITUTIONAL RESPITE                                                    9,999,999,999
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                       9,999,999,999
A.14   SUPPORTED EMPLOYMENT SERVICES                                            9,999,999,999
A.15   PREVOCATIONAL SERVICES                                                   9,999,999,999
A.16   PHYSICAL THERAPY                                                         9,999,999,999
A.17   OCCUPATIONAL THERAPY                                                     9,999,999,999
A.18   SPEECH AND LANGUAGE THERAPY                                              9,999,999,999
A.19   PERSONAL CARE                                                            9,999,999,999
A.20   PERSONAL CARE ON WORKSITE                                                9,999,999,999
A.21   PERSONAL CARE TRANSPORTATION                                             9,999,999,999
A.22   COMPANION SERVICES                                                       9,999,999,999
A.23   BEHAVIOR THERAPY - LEVEL 1                                               9,999,999,999
A.24   BEHAVIOR THERAPY - LEVEL 2                                               9,999,999,999
A.25   BEHAVIOR THERAPY - LEVEL 3                                               9,999,999,999
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                  9,999,999,999
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A.27   ASSISTIVE TECHNOLOGY                                                    9,999,999,999
A.28   SKILLED NURSING-RN                                                      9,999,999,999
A.29   SKILLED NURSING-LPN                                                     9,999,999,999
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                9,999,999,999
A.31   COMMUNITY SPECIALIST                                                    9,999,999,999
A.32   CRISIS INTERVENTION                                                     9,999,999,999
B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                 9,999,999,999
       RECIPIENTS SERVED
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA481                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                       CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                           Page:          2
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                               ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES           $9,999,999,999.99

A.1    DAY HABILITATION SERVICES - LEVEL 1                                     $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 2                                     $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 3                                     $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 4                                     $9,999,999,999.99
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                             $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                             $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                             $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                             $9,999,999,999.99
A.9    RESIDENTIAL HABILITATION                                                $9,999,999,999.99
A.10   IN-HOME RESPITE                                                         $9,999,999,999.99
A.11   OUT-OF-HOME RESPITE                                                     $9,999,999,999.99
A.12   INSTITUTIONAL RESPITE                                                   $9,999,999,999.99
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                      $9,999,999,999.99
A.14   SUPPORTED EMPLOYMENT SERVICES                                           $9,999,999,999.99
A.15   PREVOCATIONAL SERVICES                                                  $9,999,999,999.99
A.16   PHYSICAL THERAPY                                                        $9,999,999,999.99
A.17   OCCUPATIONAL THERAPY                                                    $9,999,999,999.99
A.18   SPEECH AND LANGUAGE THERAPY                                             $9,999,999,999.99
A.19   PERSONAL CARE                                                           $9,999,999,999.99
A.20   PERSONAL CARE ON WORKSITE                                               $9,999,999,999.99
A.21   PERSONAL CARE TRANSPORTATION                                            $9,999,999,999.99
A.22   COMPANION SERVICES                                                      $9,999,999,999.99
A.23   BEHAVIOR THERAPY - LEVEL 1                                              $9,999,999,999.99
A.24   BEHAVIOR THERAPY - LEVEL 2                                              $9,999,999,999.99
A.25   BEHAVIOR THERAPY - LEVEL 3                                              $9,999,999,999.99
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                 $9,999,999,999.99
A.27   ASSISTIVE TECHNOLOGY                                                    $9,999,999,999.99
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A.28   SKILLED NURSING-RN                                                    $9,999,999,999.99
A.29   SKILLED NURSING-LPN                                                   $9,999,999,999.99
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                              $9,999,999,999.99
A.31   COMMUNITY SPECIALIST                                                  $9,999,999,999.99
A.32   CRISIS INTERVENTION                                                   $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                      $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA481                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                       CMS 372 ANNUAL REPORT ON HCBS MR WAIVER                   Page:          3
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : MR WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                             ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                  $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                   9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
```


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```
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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```
Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                             Page:          5
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    DAY HABILITATION SERVICES - LEVEL 1                                          9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 2                                          9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 3                                          9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 4                                          9,999,999,999
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  9,999,999,999
A.9    RESIDENTIAL HABILITATION                                                     9,999,999,999
A.10   IN-HOME RESPITE                                                              9,999,999,999
A.11   OUT-OF-HOME RESPITE                                                          9,999,999,999
A.12   INSTITUTIONAL RESPITE                                                        9,999,999,999
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                           9,999,999,999
A.14   SUPPORTED EMPLOYMENT SERVICES                                                9,999,999,999
A.15   PREVOCATIONAL SERVICES                                                       9,999,999,999
A.16   PHYSICAL THERAPY                                                             9,999,999,999
A.17   OCCUPATIONAL THERAPY                                                         9,999,999,999
A.18   SPEECH AND LANGUAGE THERAPY                                                  9,999,999,999
A.19   PERSONAL CARE                                                               9,999,999,999
A.20   PERSONAL CARE ON WORKSITE                                                    9,999,999,999
A.21   PERSONAL CARE TRANSPORTATION                                                 9,999,999,999
A.22   COMPANION SERVICES                                                           9,999,999,999
A.23   BEHAVIOR THERAPY - LEVEL 1                                                   9,999,999,999
A.24   BEHAVIOR THERAPY - LEVEL 2                                                   9,999,999,999
A.25   BEHAVIOR THERAPY - LEVEL 3                                                   9,999,999,999
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      9,999,999,999
A.27   ASSISTIVE TECHNOLOGY                                                         9,999,999,999
A.28   SKILLED NURSING-RN                                                           9,999,999,999
A.29   SKILLED NURSING-LPN                                                          9,999,999,999
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                     9,999,999,999
A.31   COMMUNITY SPECIALIST                                                         9,999,999,999
A.32   CRISIS INTERVENTION                                                          9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          6
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    DAY HABILITATION SERVICES - LEVEL 1                                          $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 2                                          $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 3                                          $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 4                                          $9,999,999,999.99
A.5    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  $9,999,999,999.99
A.9    RESIDENTIAL HABILITATION                                                     $9,999,999,999.99
A.10   IN-HOME RESPITE                                                              $9,999,999,999.99
A.11   OUT-OF-HOME RESPITE                                                          $9,999,999,999.99
A.12   INSTITUTIONAL RESPITE                                                        $9,999,999,999.99
A.13   RESIDENTIAL HABILITATION-OTHER LIVING ARRANGEMENTS                           $9,999,999,999.99
A.14   SUPPORTED EMPLOYMENT SERVICES                                                $9,999,999,999.99
A.15   PREVOCATIONAL SERVICES                                                       $9,999,999,999.99
A.16   PHYSICAL THERAPY                                                             $9,999,999,999.99
A.17   OCCUPATIONAL THERAPY                                                         $9,999,999,999.99
A.18   SPEECH AND LANGUAGE THERAPY                                                  $9,999,999,999.99
A.19   PERSONAL CARE                                                                $9,999,999,999.99
A.20   PERSONAL CARE ON WORKSITE                                                    $9,999,999,999.99
A.21   PERSONAL CARE TRANSPORTATION                                                 $9,999,999,999.99
A.22   COMPANION SERVICES                                                           $9,999,999,999.99
A.23   BEHAVIOR THERAPY - LEVEL 1                                                   $9,999,999,999.99
A.24   BEHAVIOR THERAPY - LEVEL 2                                                   $9,999,999,999.99
A.25   BEHAVIOR THERAPY - LEVEL 3                                                   $9,999,999,999.99
A.26   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      $9,999,999,999.99
A.27   ASSISTIVE TECHNOLOGY                                                         $9,999,999,999.99
A.28   SKILLED NURSING-RN                                                           $9,999,999,999.99
A.29   SKILLED NURSING-LPN                                                          $9,999,999,999.99
A.30   SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES                                     $9,999,999,999.99
A.31   COMMUNITY SPECIALIST                                                         $9,999,999,999.99
A.32   CRISIS INTERVENTION                                                          $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                             $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                              Page:          7
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.
```


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```
       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4812-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA481                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ID WAIVER                            Page:          8
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0001.90.R2.0
WAIVER TITLE    : ID WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________


                                                   *** END OF REPORT ***
```

7.8.3 MAR-4812-A -- CMS 372 Annual Report On HCBS ID Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Day Habilitation Services -Level 1	Total unduplicated count of waiver recipients receiving day habilitation services - level 1 within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.2 Day Habilitation Services –Level 2	Total unduplicated count of waiver recipients receiving day habilitation services - level 2 services within the waiver year.	11	Number (Decimal)
I. A.3 Day Habilitation Services- Level 3	Total unduplicated count of waiver recipients receiving s day habilitation services - level 3 services within the waiver year.	11	Number (Decimal)
I. A.4 Day Habilitation Services -Level 4	Total unduplicated count of waiver recipients receiving day habilitation services - level 4 services within the waiver year.	11	Number (Decimal)
I. A.5 Day Habilitation – W/Transportation –Level 1	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 1 services within the waiver year.	11	Number (Decimal)
I. A.6 Day Habilitation - W/Transportation –Level 12	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 2 services within the waiver year.	11	Number (Decimal)
I. A.7 Day Habilitation W/Transportation - Level 3	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 3 services within the waiver year.	11	Number (Decimal)
I. A.8 Day Habilitation - W/Transportation - Level 4	Total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 4 services within the waiver year.	11	Number (Decimal)
I. A. 9 Residential Habilitation	Total unduplicated count of waiver recipients receiving residential habilitation services within the waiver year.	11	Number (Decimal)
I. A. 10 In-Home Respite	Total unduplicated count of waiver recipients receiving in-home respite services within the waiver year.	11	Number (Decimal)
I. A. 11 Out-Of-Home Respite	Total unduplicated count of waiver recipients receiving respite out-of-home respite services within the waiver year.	11	Number (Decimal)
I. A. 12 Institutional Respite	Total unduplicated count of waiver recipients receiving institutional respite services within the waiver year.	11	Number (Decimal)
I. A 13 Residential Habilitation-Other Living Arrangements	Total unduplicated count of waiver recipients receiving residential habilitation-other living arrangements services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.14 Supported Employment Services	Total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	11	Number (Decimal)
I. A.15 Prevocational Services	Total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	11	Number (Decimal)
I. A.16 Physical Therapy	Total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	11	Number (Decimal)
I. A.17 Occupational Therapy	Total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	11	Number (Decimal)
I. A.18 Speech/Language Therapy	Total unduplicated count of waiver recipients receiving speech/language therapy services within the waiver year.	11	Number (Decimal)
I. A.19 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.20 Personal Care On Worksite	Total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	11	Number (Decimal)
I. A.21 Personal Care Transportation	Total unduplicated count of waiver recipients receiving personal care transportation services within the waiver year.	11	Number (Decimal)
I. A.22 Companion Services	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
I. A.23 Behavior Therapy - Level 1	Total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	11	Number (Decimal)
I. A.24 Behavior Therapy - Level 2	Total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	11	Number (Decimal)
I. A.25 Behavior Therapy - Level 3	Total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	11	Number (Decimal)
I. A.26 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
I. A.27 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. A.28 Skilled Nursing-RN	Total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	11	Number (Decimal)
I. A.29 Skilled Nursing-LPN	Total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	11	Number (Decimal)
I. A.30 Specialized Medical Equipment & Supplies	Total unduplicated count of waiver recipients receiving specialized medical equipment & supplies services within the waiver year.	11	Number (Decimal)
I. A.31 Community Specialist	Total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	11	Number (Decimal)
I. A.32 Crisis Intervention	Total unduplicated count of waiver recipients receiving crisis intervention services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total CMS Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II A.1 Day Habilitation – Level 1	Total unduplicated count of waiver recipients receiving day habilitation-level 1 services within the waiver year.	11	Number (Decimal)
II A.2 Day Habilitation – Level 2	Total unduplicated count of waiver recipients receiving day habilitation services - level 2 services within the waiver year.	11	Number (Decimal)
II. A.3 Day Habilitation Services – Level 3	Total unduplicated count of waiver recipients receiving day habilitation services - level 3 services within the waiver year.	11	Number (Decimal)
II. A.4 Day Habilitation Services – Level 4	Total unduplicated count of waiver recipients receiving day habiliation-level 4 services within the waiver year.	11	Number (Decimal)
II. A.5 Day Habilitation - W/Transportation-Level 1	Total unduplicated count of waiver recipients receiving day habilitation - w/transportation-level 1 services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.6 Day Habilitation – W/Transportation-Level 2	Total unduplicated count of waiver recipients receiving day habilitation –w/transportation-level 2 services within the waiver year.	11	Number (Decimal)
II A.7 Day Habilitation – W/Transportation-Level 3	Total unduplicated count of waiver recipients receiving day habilitation –w/transportation-level 3 services within the waiver year.	11	Number (Decimal)
II. A.8 Day Habilitation - W/Transportation-Level 4	Total unduplicated count of waiver recipients receiving day habilitation -w/transportation-level 4 services within the waiver year.	11	Number (Decimal)
II. A.9 Residential Habiliation	Total unduplicated count of waiver recipients receiving residential habiliation services within the waiver year.	11	Number (Decimal)
II. A.10 In-Home Respite	Total unduplicated count of waiver recipients receiving in-home respite services within the waiver year.	11	Number (Decimal)
II. A.11 Out-Of-Home Respite	Total unduplicated count of waiver recipients receiving out-of-home respite services within the waiver year.	11	Number (Decimal)
II. A.12 Institutional Respite	Total unduplicated count of waiver recipients receiving institutional respite services within the waiver year.	11	Number (Decimal)
II. A.13 Residential Habilitation-Other Living Arrangements	Total unduplicated count of waiver recipients receiving residential habilitation-other living arrangements services within the waiver year.	11	Number (Decimal)
II. A.14 Supported Employment Services	Total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	11	Number (Decimal)
II. A.15 Prevocational Services	Total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	11	Number (Decimal)
II. A.16 Physical Therapy	Total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	11	Number (Decimal)
II. A.17 Occupational Therapy	Total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.18 Speech/Language Therapy	Total unduplicated count of waiver recipients receiving speech/language therapy services within the waiver year.	11	Number (Decimal)
II. A.19 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
II. A.20 Personal Care on Worksite	Total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	11	Number (Decimal)
II. A.21 Personal Care Transporation	Total unduplicated count of waiver recipients receiving personal care transporation services within the waiver year.	11	Number (Decimal)
II. A.22 Companion Services	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
II. A.23 Behavior Therapy - Level 1	Total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	11	Number (Decimal)
II. A.24 Behavior Therapy - Level 2	Total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	11	Number (Decimal)
II. A.25 Behavior Therapy - Level 3	Total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	11	Number (Decimal)
II. A.26 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)
II. A.27 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
II. A.28 Skilled Nursing-RN	Total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	11	Number (Decimal)
II. A.29 Skilled Nursing-LPN	Total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	11	Number (Decimal)
II. A.30 Specialized Medical Equipment & Supplies	Total unduplicated count of waiver recipients receiving specialized medical equipment & supplies services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A.31 Community Specialist	Total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	11	Number (Decimal)
II. A.32 Crisis Intervention	Total unduplicated count of waiver recipients receiving crisis intervention services within the waiver year.	11	Number (Decimal)
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.9 MAR-4822-A -- CMS 372 ANNUAL REPORT ON HCBS ED WAIVER (SHORT) REPORT

7.9.1 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS Waiver (Short) report contains information on the participation of recipients in the E&D (Elderly & Disabled) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.9.2 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Layout

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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                                     9,999,999,999
A.2    PERSONAL CARE                                                                       9,999,999,999
A.3    ADULT DAY HEALTH                                                                    9,999,999,999
A.4    RESPITE CARE - SKILLED                                                              9,999,999,999
A.5    RESPITE CARE - UNSKILLED                                                            9,999,999,999
A.6    HOMEMAKER                                                                           9,999,999,999
A.7    COMPANION                                                                           9,999,999,999
A.8    WAIVER FROZEN MEALS                                                                 9,999,999,999
A.9    WAIVER SHELF-STABLE MEALS                                                           9,999,999,999
A.10   WAIVER BREAKFAST MEALS                                                              9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                             9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                       $9,999,999,999.99

A.1    CASE MANAGEMENT                                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                       $9,999,999,999.99
A.3    ADULT DAY HEALTH                                                                    $9,999,999,999.99
A.4    RESPITE CARE - SKILLED                                                              $9,999,999,999.99
A.5    RESPITE CARE - UNSKILLED                                                            $9,999,999,999.99
A.6    HOMEMAKER                                                                           $9,999,999,999.99
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A.7    COMPANION                                                          $9,999,999,999.99
A.8    WAIVER FROZEN MEALS                                                $9,999,999,999.99
A.9    WAIVER SHELF-STABLE MEALS                                          $9,999,999,999.99
A.10   WAIVER BREAKFAST MEALS                                             $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                   $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA482                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                       CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                   Page:          2
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                            NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH AND EXPANDED                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                 9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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```
C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
```


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```
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          4
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                              9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    ADULT DAY HEALTH                                                             9,999,999,999
A.4    RESPITE CARE - SKILLED                                                       9,999,999,999
A.5    RESPITE CARE - UNSKILLED                                                     9,999,999,999
A.6    HOMEMAKER                                                                    9,999,999,999
A.7    COMPANION                                                                    9,999,999,999
A.8    WAIVER FROZEN MEALS                                                          9,999,999,999
A.9    WAIVER SHELF-STABLE MEALS                                                    9,999,999,999
A.10   WAIVER BREAKFAST MEALS                                                       9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    CASE MANAGEMENT                                                             $9,999,999,999.99
A.2    PERSONAL CARE                                                               $9,999,999,999.99
A.3    ADULT DAY HEALTH                                                            $9,999,999,999.99
A.4    RESPITE CARE - SKILLED                                                      $9,999,999,999.99
A.5    RESPITE CARE - UNSKILLED                                                    $9,999,999,999.99
A.6    HOMEMAKER                                                                   $9,999,999,999.99
A.7    COMPANION                                                                   $9,999,999,999.99
A.8    WAIVER FROZEN MEALS                                                         $9,999,999,999.99
A.9    WAIVER SHELF-STABLE MEALS                                                   $9,999,999,999.99
A.10   WAIVER BREAKFAST MEALS                                                      $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                              Page:          5
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                  9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
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```
Report  : MAR-4822-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA482                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS ED WAIVER                            Page:          6
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 069.91.R1.04
WAIVER TITLE    : ED WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
```


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7.9.3 MAR-4822-A -- CMS 372 Annual Report On HCBS ED Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Case Management	Total unduplicated count of waiver recipients receiving case management services within the waiver year.	11	Number (Decimal)
I. A.2 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.3 Adult Day Health	Total unduplicated count of waiver recipients receiving adult day health services within the waiver year.	11	Number (Decimal)
I. A.4 Respite Care- Skilled	Total unduplicated count of waiver recipients receiving skilled respite care services within the waiver year.	11	Number (Decimal)
I. A.5 Respite Care- Unskilled	Total unduplicated count of waiver recipients receiving unskilled respite care services within the waiver year.	11	Number (Decimal)
I. A.6 Homemaker	Total unduplicated count of waiver recipients receiving homemaker services within the waiver year.	11	Number (Decimal)
I. A.7 Companion	Total unduplicated count of waiver recipients receiving companion services within the waiver year.	11	Number (Decimal)
I. A.8 Waiver Frozen Meals	Total unduplicated count of waiver recipients receiving waiver frozen meal services within the waiver year.	11	Number (Decimal)
I. A.9 Waiver Shelf Stable Meals	Total unduplicated count of waiver recipients receiving waiver shelf stable meal service within the waiver year.	11	Number (Decimal)
I. A.10 Waiver Breakfast Meals	Total unduplicated count of waiver recipients receiving home delivered breakfast meal services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients Served	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Case Management	Total Medicaid expenditures for case management services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. A.2 Personal Care	Total Medicaid expenditures for personal care services for the waiver year.	17	Number (Decimal)
II. A.3 Adult Day Health	Total Medicaid expenditures for adult day health services for the waiver year.	17	Number (Decimal)
II. A.4 Respite Care -Skilled	Total Medicaid expenditures for skilled respite care services for the waiver year.	17	Number (Decimal)
II. A.5 Respite Care- Unskilled	Total Medicaid expenditures for unskilled respite care services for the waiver year.	17	Number (Decimal)
II. A.6 Homemaker	Total Medicaid expenditures for adult homemaker services for the waiver year.	17	Number (Decimal)
II A.7 Companion	Total Medicaid expenditures for companion services-for the waiver year.	17	Number (Decimal)
II. A.8 Waiver Frozen Meals	Total unduplicated count of waiver recipients receiving waiver frozen meal services within the waiver year.	11	Number (Decimal)
II. A.9 Waiver Shelf Stable Meals	Total unduplicated count of waiver recipients receiving waiver shelf stable meals service within the waiver year.	11	Number (Decimal)
II. A.10 Waiver Breakfast Meals	Total unduplicated count of waiver recipients receiving home delivered meals (breakfast) services within the waiver year.	11	Number (Decimal)
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver members during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of members in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage By Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.10 MAR-4832-A -- CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER (SHORT) REPORT

7.10.1 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Narrative

The CMS 372 Annual Report on HCBS Living at Home Waiver (Short) report contains information on the participation of recipients in the Living At Home waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.10.2 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Layout

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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                       Page:          1
                                                      EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    IN-HOME RESIDENTIAL HABILITATION                                            9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 1                                         9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 2                                         9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 3                                         9,999,999,999
A.5    DAY HABILITATION SERVICES - LEVEL 4                                         9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                 9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                 9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                 9,999,999,999
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                 9,999,999,999
A.10   SUPPORTED EMPLOYMENT                                                        9,999,999,999
A.11   PREVOCATIONAL SERVICES                                                      9,999,999,999
A.12   RESPITE IN-HOME                                                             9,999,999,999
A.13   RESPITE OUT-OF-HOME                                                         9,999,999,999
A.14   PERSONAL CARE                                                              9,999,999,999
A.15   PERSONAL CARE ON WORKSITE                                                  9,999,999,999
A.16   PERSONAL CARE TRANSPORATION                                                9,999,999,999
A.17   PHYSICAL THERAPY                                                            9,999,999,999
A.18   OCCUPATIONAL THERAPY                                                       9,999,999,999
A.19   SPEECH THERAPY                                                             9,999,999,999
A.20   BEHAVIOR THERAPY - LEVEL 1                                                 9,999,999,999
A.21   BEHAVIOR THERAPY - LEVEL 2                                                 9,999,999,999
A.22   BEHAVIOR THERAPY - LEVEL 3                                                 9,999,999,999
A.23   SKILLED NURSING-RN                                                          9,999,999,999
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A.24   SKILLED NURSING-LPN                                                  9,999,999,999
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                              9,999,999,999
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                               9,999,999,999
A.27   COMMUNITY SPECIALIST                                                 9,999,999,999
A.28   CRISIS INTERVENTION                                                  9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                              9,999,999,999
       RECIPIENTS SERVED
Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA483                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                  CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER            Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                            ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES        $9,999,999,999.99

A.1    IN-HOME RESIDENTIAL HABILITATION                                     $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 1                                  $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 2                                  $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 3                                  $9,999,999,999.99
A.5    DAY HABILITATION SERVICES - LEVEL 4                                  $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                          $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                          $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                          $9,999,999,999.99
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                          $9,999,999,999.99
A.10   SUPPORTED EMPLOYMENT                                                 $9,999,999,999.99
A.11   PREVOCATIONAL SERVICES                                               $9,999,999,999.99
A.12   RESPITE IN-HOME                                                      $9,999,999,999.99
A.13   RESPITE OUT-OF-HOME                                                  $9,999,999,999.99
A.14   PERSONAL CARE                                                        $9,999,999,999.99
A.15   PERSONAL CARE ON WORKSITE                                            $9,999,999,999.99
A.16   PERSONAL CARE TRANSPORATION                                          $9,999,999,999.99
A.17   PHYSICAL THERAPY                                                     $9,999,999,999.99
A.18   OCCUPATIONAL THERAPY                                                 $9,999,999,999.99
A.19   SPEECH THERAPY                                                       $9,999,999,999.99
A.20   BEHAVIOR THERAPY - LEVEL 1                                           $9,999,999,999.99
A.21   BEHAVIOR THERAPY - LEVEL 2                                           $9,999,999,999.99
A.22   BEHAVIOR THERAPY - LEVEL 3                                           $9,999,999,999.99
A.23   SKILLED NURSING-RN                                                   $9,999,999,999.99
A.24   SKILLED NURSING-LPN                                                  $9,999,999,999.99
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                              $9,999,999,999.99
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A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                  $9,999,999,999.99
A.27   COMMUNITY SPECIALIST                                                    $9,999,999,999.99
A.28   CRISIS INTERVENTION                                                     $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                        $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)

Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA483                       MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER             Page:          3
                                                     EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                               ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                    $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                 D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                   9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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```
C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          5
                                                       EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    IN-HOME RESIDENTIAL HABILITATION                                              9,999,999,999
A.2    DAY HABILITATION SERVICES - LEVEL 1                                           9,999,999,999
A.3    DAY HABILITATION SERVICES - LEVEL 2                                           9,999,999,999
A.4    DAY HABILITATION SERVICES - LEVEL 3                                           9,999,999,999
A.5    DAY HABILITATION SERVICES - LEVEL 4                                           9,999,999,999
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                   9,999,999,999
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                   9,999,999,999
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                   9,999,999,999
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                   9,999,999,999
A.10   SUPPORTED EMPLOYMENT                                                          9,999,999,999
A.11   PREVOCATIONAL SERVICES                                                        9,999,999,999
A.12   RESPITE IN-HOME                                                               9,999,999,999
A.13   RESPITE OUT-OF-HOME                                                           9,999,999,999
A.14   PERSONAL CARE                                                                 9,999,999,999
A.15   PERSONAL CARE ON WORKSITE                                                     9,999,999,999
A.16   PERSONAL CARE TRANSPORATION                                                   9,999,999,999
A.17   PHYSICAL THERAPY                                                              9,999,999,999
A.18   OCCUPATIONAL THERAPY                                                          9,999,999,999
A.19   SPEECH THERAPY                                                                9,999,999,999
A.20   BEHAVIOR THERAPY - LEVEL 1                                                    9,999,999,999
A.21   BEHAVIOR THERAPY - LEVEL 2                                                    9,999,999,999
A.22   BEHAVIOR THERAPY - LEVEL 3                                                    9,999,999,999
A.23   SKILLED NURSING-RN                                                            9,999,999,999
A.24   SKILLED NURSING-LPN                                                           9,999,999,999
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                       9,999,999,999
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                        9,999,999,999
A.27   COMMUNITY SPECIALIST                                                          9,999,999,999
A.28   CRISIS INTERVENTION                                                           9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                       9,999,999,999
       RECIPIENTS SERVED
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                      ICF-MR

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    IN-HOME RESIDENTIAL HABILITATION                                             $9,999,999,999.99
A.2    DAY HABILITATION SERVICES - LEVEL 1                                          $9,999,999,999.99
A.3    DAY HABILITATION SERVICES - LEVEL 2                                          $9,999,999,999.99
A.4    DAY HABILITATION SERVICES - LEVEL 3                                          $9,999,999,999.99
A.5    DAY HABILITATION SERVICES - LEVEL 4                                          $9,999,999,999.99
A.6    DAY HABILITATION W/TRANSPORTATION - LEVEL 1                                  $9,999,999,999.99
A.7    DAY HABILITATION W/TRANSPORTATION - LEVEL 2                                  $9,999,999,999.99
A.8    DAY HABILITATION W/TRANSPORTATION - LEVEL 3                                  $9,999,999,999.99
A.9    DAY HABILITATION W/TRANSPORTATION - LEVEL 4                                  $9,999,999,999.99
A.10   SUPPORTED EMPLOYMENT                                                         $9,999,999,999.99
A.11   PREVOCATIONAL SERVICES                                                       $9,999,999,999.99
A.12   RESPITE IN-HOME                                                              $9,999,999,999.99
A.13   RESPITE OUT-OF-HOME                                                          $9,999,999,999.99
A.14   PERSONAL CARE                                                               $9,999,999,999.99
A.15   PERSONAL CARE ON WORKSITE                                                   $9,999,999,999.99
A.16   PERSONAL CARE TRANSPORATION                                                 $9,999,999,999.99
A.17   PHYSICAL THERAPY                                                             $9,999,999,999.99
A.18   OCCUPATIONAL THERAPY                                                        $9,999,999,999.99
A.19   SPEECH THERAPY                                                              $9,999,999,999.99
A.20   BEHAVIOR THERAPY - LEVEL 1                                                  $9,999,999,999.99
A.21   BEHAVIOR THERAPY - LEVEL 2                                                  $9,999,999,999.99
A.22   BEHAVIOR THERAPY - LEVEL 3                                                  $9,999,999,999.99
A.23   SKILLED NURSING-RN                                                          $9,999,999,999.99
A.24   SKILLED NURSING-LPN                                                         $9,999,999,999.99
A.25   ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                     $9,999,999,999.99
A.26   SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES                                      $9,999,999,999.99
A.27   COMMUNITY SPECIALIST                                                         $9,999,999,999.99
A.28   CRISIS INTERVENTION                                                          $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                       Page:          7
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          ICF-MR

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
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Report  : MAR-4832-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA483                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                 CMS 372 ANNUAL REPORT ON HCBS LIVING AT HOME WAIVER                     Page:          8
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0391
WAIVER TITLE    : LAH WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                        ICF-MR

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
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7.10.3 MAR-4832-A -- CMS 372 Annual Report On HCBS Living At Home Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 In-Home Residential Habilitation	A total unduplicated count of waiver recipients receiving in-home residential habilitation services within the waiver year.	Number (Decimal)	11
I. A.10 Supported Employment	A total unduplicated count of waiver recipients receiving supported employment services within the waiver year.	Number (Decimal)	11
I. A.11 Prevocational Services	A total unduplicated count of waiver recipients receiving prevocational services within the waiver year.	Number (Decimal)	11
I. A.12 Respite In-Home	A total unduplicated count of waiver recipients receiving respite in-home services within the waiver year.	Number (Decimal)	11
I. A.13 Respite Out-Of-Home	A total unduplicated count of waiver recipients receiving respite out-of-home services within the waiver year.	Number (Decimal)	11
I. A.14 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.15 Personal Care On Worksite	A total unduplicated count of waiver recipients receiving personal care on worksite services within the waiver year.	Number (Decimal)	11
I. A.16 Personal Care Transporation	A total unduplicated count of waiver recipients receiving personal care transporation services within the waiver year.	Number (Decimal)	11
I. A.17 Physical Therapy	A total unduplicated count of waiver recipients receiving physical therapy services within the waiver year.	Number (Decimal)	11
I. A.18 Occupational Therapy	A total unduplicated count of waiver recipients receiving occupational therapy services within the waiver year.	Number (Decimal)	11
I. A.19 Speech Therapy	A total unduplicated count of waiver recipients receiving speech therapy services within the waiver year.	Number (Decimal)	11
I. A.2 Day Habilitation Services - Level 1	A total unduplicated count of waiver recipients receiving day habilitation - level 1 serviceswithin the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.20 Behavior Therapy - Level 1	A total unduplicated count of waiver recipients receiving behavior therapy - level 1 services within the waiver year.	Number (Decimal)	11
I. A.21 Behavior Therapy - Level 2	A total unduplicated count of waiver recipients receiving behavior therapy - level 2 services within the waiver year.	Number (Decimal)	11
I. A.22 Behavior Therapy - Level 3	A total unduplicated count of waiver recipients receiving behavior therapy - level 3 services within the waiver year.	Number (Decimal)	11
I. A.23 Skilled Nursing-RN	A total unduplicated count of waiver recipients receiving skilled nursing-RN services within the waiver year.	Number (Decimal)	11
I. A.24 Skilled Nursing-LPN	A total unduplicated count of waiver recipients receiving skilled nursing-LPN services within the waiver year.	Number (Decimal)	11
I. A.25 Environmental Accessibility Adaptations	A total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	Number (Decimal)	11
I. A.26 Specialized Medical Equipment/Supplies	A total unduplicated count of waiver recipients receiving specialized medical equipment/supplies services within the waiver year.	Number (Decimal)	11
I. A.27 Community Specialist	A total unduplicated count of waiver recipients receiving community specialist services within the waiver year.	Number (Decimal)	11
I. A.28 Crisis Intervention	A total unduplicated count of waiver recipients receiving cisis intervention services within the waiver year.	Number (Decimal)	11
I. A.3 Day Habilitation Services - Level 2	A total unduplicated count of waiver recipients receiving day habilitation - level 2 services within the waiver year.	Number (Decimal)	11
I. A.4 Day Habilitation Services - Level 3	A total unduplicated count of waiver recipients receiving day habilitation level 3 services within the waiver year.	Number (Decimal)	11
I. A.5 Day Habilitation Services - Level 4	A total unduplicated count of waiver recipients receiving day habilitation - level 4 services within the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.6 Day Habilitation W/Transportation - Level 1	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 1 services within the waiver year.	Number (Decimal)	11
I. A.7 Day Habilitation W/Transportation - Level 2	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 2 services within the waiver year.	Number (Decimal)	11
I. A.8 Day Habilitation W/Transportation - Level 3	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 3 services within the waiver year.	Number (Decimal)	11
I. A.9 Day Habilitation W/Transportation - Level 4	A total unduplicated count of waiver recipients receiving day habilitation w/transportation - level 4 services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II. A.1 In-Home Residential Habilitation	The total Medicaid expenditures for in-home residential habilitation services for the waiver year.	Number (Decimal)	17
II. A.10 Supported Employment	The total Medicaid expenditures for supported employment services for the waiver year.	Number (Decimal)	17
II. A.11 Prevocational Services	The total Medicaid expenditures for prevocational services services for the waiver year.	Number (Decimal)	17
II. A.12 Respite In-Home	The total Medicaid expenditures for respite in-home services for the waiver year.	Number (Decimal)	17
II. A.13 Respite Out-Of-Home	The total Medicaid expenditures for respite out-of-home services for the waiver year.	Number (Decimal)	17
II. A.14 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.15 Personal Care On Worksite	The total Medicaid expenditures for personal care on worksite services for the waiver year.	Number (Decimal)	17
II. A.16 Personal Care Transporation	The total Medicaid expenditures for personal care transporation services for the waiver year.	Number (Decimal)	17
II. A.17 Physical Therapy	The total Medicaid expenditures for physical therapy services for the waiver year.	Number (Decimal)	17
II. A.18 Occupational Therapy	The total Medicaid expenditures for occupational therapy services for the waiver year.	Number (Decimal)	17
II. A.19 Speech Therapy	The total Medicaid expenditures for speech therapy services for the waiver year.	Number (Decimal)	17
II. A.2 Day Habilitation Services - Level 1	The total Medicaid expenditures for day habilitation level 1 services for the waiver year.	Number (Decimal)	17
II. A.20 Behavior Therapy - Level 1	The total Medicaid expenditures for behavior therapy - level 1 services for the waiver year.	Number (Decimal)	17
II. A.21 Behavior Therapy - Level 2	The total Medicaid expenditures for behavior therapy - level 2 services for the waiver year.	Number (Decimal)	17
II. A.22 Behavior Therapy - Level 3	The total Medicaid expenditures for behavior therapy - level 3 services for the waiver year.	Number (Decimal)	17
II. A.23 Skilled Nursing-RN	The total Medicaid expenditures for skilled nursing-RN services for the waiver year.	Number (Decimal)	17
II. A.24 Skilled Nursing-LPN	The total Medicaid expenditures for skilled nursing-LPN services for the waiver year.	Number (Decimal)	17
II. A.25 Environmental Accessibility Adaptations	The total Medicaid expenditures for environmental accessibility adaptations services for the waiver year.	Number (Decimal)	17
II. A.26 Specialized Medical Equipment/Supplies	The total Medicaid expenditures for specialized medical equipment/supplies services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.27 Community Specialist	The total Medicaid expenditures for community specialist services for the waiver year.	Number (Decimal)	17
II. A.28 Crisis Intervention	The total Medicaid expenditures for crisis intervention services for the waiver year.	Number (Decimal)	17
II. A.3 Day Habilitation Services - Level 2	The total Medicaid expenditures for day habilitation - level 2 services for the waiver year.	Number (Decimal)	17
II. A.4 Day Habilitation Services - Level 3	The total Medicaid expenditures for day habilitation - level 3 services for the waiver year.	Number (Decimal)	17
II. A.5 Day Habilitation Services - Level 4	The total Medicaid expenditures for day habilitation - Level 4 services for the waiver year.	Number (Decimal)	17
II. A.6 Day Habilitation W/Transportation - Level 1	The total Medicaid expenditures for day habilitation w/transportation - level 1 services for the waiver year.	Number (Decimal)	17
II. A.7 Day Habilitation W/Transportation - Level 2	The total Medicaid expenditures for day habilitation w/transportation - level 2 services for the waiver year.	Number (Decimal)	17
II. A.8 Day Habilitation W/Transportation - Level 3	The total Medicaid expenditures for day habilitation w/transportation - level 3 services for the waiver year.	Number (Decimal)	17
II. A.9 Day Habilitation W/Transportation - Level 4	The total Medicaid expenditures for day habilitation w/transportation - level 4 services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III. Average Per Capita Annual Expenditure for All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915 C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1	Number (Decimal)	17
Levels of Care In Approved Waiver	All institutional care claims within a waiver year are associated with ICF-MR.	Character	20
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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7.11 MAR-4842 – CMS 372 ANNUAL REPORT ON HCBS TA WAIVER (SHORT) REPORT

7.11.1 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS TA Waiver (Short) report contains information on the participation of recipients in the TA (Technology Assisted Waiver For Adults) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.11.2 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Layout

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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    PRIVATE DUTY NURSING-RN                                                     9,999,999,999
A.2    PRIVATE DUTY NURSING-LPN                                                    9,999,999,999
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             9,999,999,999
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             9,999,999,999
A.5    ASSISTIVE TECHNOLOGY                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                     9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    PRIVATE DUTY NURSING-RN                                                     $9,999,999,999.99
A.2    PRIVATE DUTY NURSING-LPN                                                    $9,999,999,999.99
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             $9,999,999,999.99
A.5    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                          9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                  9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                            Page:          4
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    PRIVATE DUTY NURSING-RN                                                     9,999,999,999
A.2    PRIVATE DUTY NURSING-LPN                                                    9,999,999,999
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             9,999,999,999
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             9,999,999,999
A.5    ASSISTIVE TECHNOLOGY                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                     9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    PRIVATE DUTY NURSING-RN                                                     $9,999,999,999.99
A.2    PRIVATE DUTY NURSING-LPN                                                    $9,999,999,999.99
A.3    PERSONAL CARE/ATTENDANT SERVICE                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES AND APPLIANCES                                             $9,999,999,999.99
A.5    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                              Page:          5
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                           $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                  D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4842-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA484                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                      CMS 372 ANNUAL REPORT ON HCBS TA WAIVER                            Page:          6
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0407
WAIVER TITLE    : TA WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                      *** END OF REPORT ***
```


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7.11.3 MAR-4842-A -- CMS 372 Annual Report On HCBS TA Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Private Duty Nursing RN	Total unduplicated count of waiver recipients receiving private duty nursing (RN) services within the waiver year.	11	Number (Decimal)
I. A.2 Private Duty Nursing LPN	Total unduplicated count of waiver recipients receiving private duty nurse (LPN) services within the waiver year.	11	Number (Decimal)
I. A.3 Personal Care/ Attendant Services	Total unduplicated count of waiver recipients receiving personal care attendant services within the waiver year.	11	Number (Decimal)
I. A.4 Medical Supplies and Appliances	Total unduplicated count of waiver recipients receiving medical supplies and appliances services within the waiver year.	11	Number (Decimal)
I. A.5 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)
II. A. Total CMS Approved Section 1915(C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Private Duty Nursing RN	The total Medicaid expenditures for Private Duty Nurse RN services for the waiver year.	17	Number (Decimal)
II. A.2 Private Duty Nursing LPN	The total Medicaid expenditures for Private Duty Nurse LPN services for the waiver year.	17	Number (Decimal)
II. A.3 Personal Care/ Attendant Services	The total Medicaid expenditures for Personal Care Attendant services for the waiver year.	17	Number (Decimal)
II. A.4 Medical Supplies and Appliances	The total Medicaid expenditures for Medical Supplies and Appliances services for the waiver year.	17	Number (Decimal)
II.. A.5 Assistive Technology	The total Medicaid expenditures for Assistive Technology services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	Unduplicated count of waiver recipients receiving physician services while in the waiver within the waiver year.	17	Number (Decimal)
Levels of Care in Approved Waiver	The average acute care service expenditures accumulated by the waiver members during the waiver year.	20	Character
V. A. 1. Total Days of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.12 MAR-4852-A -- CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER (SHORT) REPORT

7.12.1 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS SAIL Waiver (Short) report contains information on the participation of recipients in the SAIL (State of Alabama Independent Living) waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.12.2 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Layout

```
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA485                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                            Page:          1
                                                     EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:
LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                                     9,999,999,999
A.2    PERSONAL CARE                                                                       9,999,999,999
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                             9,999,999,999
A.4    MEDICAL SUPPLIES                                                                    9,999,999,999
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                         9,999,999,999
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                         9,999,999,999
A.7    ASSISTIVE TECHNOLOGY                                                                9,999,999,999
A.8    MINOR ASSISTIVE TECHNOLOGY                                                          9,999,999,999
A.9    PERSONAL ASSISTIVE SERVICES                                                         9,999,999,999
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                                 9,999,999,999
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                        9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                             9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                       $9,999,999,999.99

A.1    CASE MANAGEMENT                                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                       $9,999,999,999.99
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                             $9,999,999,999.99
A.4    MEDICAL SUPPLIES                                                                    $9,999,999,999.99
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                         $9,999,999,999.99
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                         $9,999,999,999.99
A.7    ASSISTIVE TECHNOLOGY                                                                $9,999,999,999.99
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A.8    MINOR ASSISTIVE TECHNOLOGY                                          $9,999,999,999.99
A.9    PERSONAL ASSISTIVE SERVICES                                         $9,999,999,999.99
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                 $9,999,999,999.99
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                        $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                    $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                   Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                             NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                 9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
```


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C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.

ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          3
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          4
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT                                                              9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                      9,999,999,999
A.4    MEDICAL SUPPLIES                                                             9,999,999,999
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                  9,999,999,999
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                  9,999,999,999
A.7    ASSISTIVE TECHNOLOGY                                                         9,999,999,999
A.8    MINOR ASSISTIVE TECHNOLOGY                                                   9,999,999,999
A.9    PERSONAL ASSISTIVE SERVICES                                                  9,999,999,999
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                          9,999,999,999
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                 9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES               $9,999,999,999.99

A.1    CASE MANAGEMENT                                                             $9,999,999,999.99
A.2    PERSONAL CARE                                                               $9,999,999,999.99
A.3    ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS                                     $9,999,999,999.99
A.4    MEDICAL SUPPLIES                                                            $9,999,999,999.99
A.5    PERSONAL EMERGENCY RESPONSE SYSTEMS-INITIAL                                 $9,999,999,999.99
A.6    PERSONAL EMERGENCY RESPONSE SYSTEMS-MONTHLY                                 $9,999,999,999.99
A.7    ASSISTIVE TECHNOLOGY                                                        $9,999,999,999.99
A.8    MINOR ASSISTIVE TECHNOLOGY                                                  $9,999,999,999.99
A.9    PERSONAL ASSISTIVE SERVICES                                                 $9,999,999,999.99
A.10   EVALUATION FOR ASSISTIVE TECHNOLOGY                                         $9,999,999,999.99
A.11   ASSISTIVE TECHNOLOGY REPAIRS                                                $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                            $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
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Process : MARJA485                    MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                            Page:          5
                                                   EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                          $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                   9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                            9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4852-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA485                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: MR372RPT                     CMS 372 ANNUAL REPORT ON HCBS SAIL WAIVER                           Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/YYYY - MM/DD/YYYY
WAIVER NUMBER   : 0241.90.021
WAIVER TITLE    : SAIL WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                        *** END OF REPORT ***
```


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7.12.3 MAR-4852-A -- CMS 372 Annual Report On HCBS SAIL Waiver (Short) Report Field Descriptions

Field	Description	Length	Data Type
I. A.1 Case Management	Total unduplicated count of waiver recipients receiving case management services within the waiver year.	11	Number (Decimal)
I. A.2 Personal Care	Total unduplicated count of waiver recipients receiving personal care services within the waiver year.	11	Number (Decimal)
I. A.3 Environmental Accessibility Adaptations	Total unduplicated count of waiver recipients receiving environmental accessibility adaptations services within the waiver year.	11	Number (Decimal)
I. A.4 Medical Supplies	Total unduplicated count of waiver recipients receiving medical supplies services within the waiver year.	11	Number (Decimal)
I. A.5 Personal Emergency Response System (Initial)	Total unduplicated count of waiver recipients receiving personal emergency response system (initial) services within the waiver year.	11	Number (Decimal)
I. A.6 Personal Emergency Response System (Monthly)	Total unduplicated count of waiver recipients receiving personal emergency response system (monthly) services within the waiver year.	11	Number (Decimal)
I. A.7 Assistive Technology	Total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	11	Number (Decimal)
I. A.8 Minor Assistive Technology	Total unduplicated count of waiver recipients receiving evaluations for minor assistive technology services within the waiver year.	11	Number (Decimal)
I. A.9 Personal Assistive Services	Total unduplicated count of waiver recipients receiving personal assistive service within the waiver year.	11	Number (Decimal)
I. A.10 Evaluation for Assitive Technology	Total unduplicated count of waiver recipients receiving evaluation for assistive technology services within the waiver year.	11	Number (Decimal)
I. A.11 Assistive Technology Repairs	The total Medicaid expenditures for assistive technology repairs services for the waiver year.	17	Number (Decimal)
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients Served	Total unduplicated count of waiver recipients receiving waiver services within the waiver year.	11	Number (Decimal)

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Field	Description	Length	Data Type
II. A. Total CMS Approved Section 1915 (C) Waiver Services Expenditures	Total expenditures on waiver services during the waiver year.	17	Number (Decimal)
II. A.1 Case Management	Total Medicaid expenditures for case management services for the waiver year.	17	Number (Decimal)
II. A.2 Personal Care	Total Medicaid expenditures for personal care services for the waiver year.	17	Number (Decimal)
II. A.3 Environmental Accessibility Adaptations	Total Medicaid expenditures for environmental accessibility adaptation services for the waiver year.	17	Number (Decimal)
II. A.4 Medical Supplies	Total Medicaid expenditures for medical supplies services for the waiver year.	17	Number (Decimal)
II. A.5 Personal Emergency Response System (Initial)	Total Medicaid expenditures for personal emergency response system (initial) services for the waiver year.	17	Number (Decimal)
II. A.6 Personal Emergency Response System (Monthly)	Total Medicaid expenditures for personal emergency response system (monthly) services for the waiver year.	17	Number (Decimal)
II. A.7 Assistive Technology	Total Medicaid expenditures for assistive technology services for the waiver year.	17	Number (Decimal)
II. A.8 Minor Assistive Technology	Total Medicaid expenditures for evaluations for minor assistive technology service for the waiver year.	17	Number (Decimal)
II. A.9 Assistive Technology Repairs	Total Medicaid expenditures for assistive technology repair service for the waiver year.	17	Number (Decimal)
II. A.10 Personal Assistance Services	Total Medicaid expenditures for personal assistance services within the year.	17	Number (Decimal)
II. A.11 Assistive Technology Repairs	The total Medicaid expenditures for assistive technology repairs services for the waiver year.	17	Number (Decimal)

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Field	Description	Length	Data Type
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures (Actual Factor D Values)	Average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	17	Number (Decimal)
III. Average Per Capita Annual Expenditure for all Other Medicaid Services	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver members receiving services while in the waiver within the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver members during the waiver year.	17	Number (Decimal)
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver members during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of members in Section V. B.1.	17	Number (Decimal)
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	11	Number (Decimal)
V. A. 2. Average Length Of Waiver Coverage By Level Of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	17	Number (Decimal)

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7.13 MAR-4862-A -- CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER (SHORT) REPORT

7.13.1 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) report contains information on the participation of recipients in the HIV / AIDS waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

7.13.2 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Layout

```
Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          1
                                                      EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                   9,999,999,999
A.2    PERSONAL CARE                                                              9,999,999,999
A.3    RESPITE CARE-SKILLED                                                       9,999,999,999
A.4    RESPITE CARE-UNSKILLED                                                     9,999,999,999
A.5    HOMEMAKER SERVICES                                                         9,999,999,999
A.6    SKILLED NURSING                                                            9,999,999,999
A.7    COMPANION SERVICE                                                          9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                    9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES              $9,999,999,999.99

A.1    CASE MANAGEMENT SERVICES                                                   $9,999,999,999.99
A.2    PERSONAL CARE                                                              $9,999,999,999.99
A.3    RESPITE CARE-SKILLED                                                       $9,999,999,999.99
A.4    RESPITE CARE-UNSKILLED                                                     $9,999,999,999.99
A.5    HOMEMAKER SERVICES                                                         $9,999,999,999.99
A.6    SKILLED NURSING                                                            $9,999,999,999.99
A.7    COMPANION SERVICE                                                          $9,999,999,999.99
B.1.   AVERAGE PER CAPITA SECTION 1915C                                           $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
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       FACTOR D VALUE/S)


Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                        Page:          2
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                                $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                            9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                     9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          3
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          4
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                     9,999,999,999
A.2    PERSONAL CARE                                                                9,999,999,999
A.3    RESPITE CARE-SKILLED                                                         9,999,999,999
A.4    RESPITE CARE-UNSKILLED                                                       9,999,999,999
A.5    HOMEMAKER SERVICES                                                           9,999,999,999
A.6    SKILLED NURSING                                                              9,999,999,999
A.7    COMPANION SERVICE                                                            9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                                      9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES

A.     TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES                $9,999,999,999.99

A.1    CASE MANAGEMENT SERVICES                                                     $9,999,999,999.99
A.2    PERSONAL CARE                                                                $9,999,999,999.99
A.3    RESPITE CARE-SKILLED                                                         $9,999,999,999.99
A.4    RESPITE CARE-UNSKILLED                                                       $9,999,999,999.99
A.5    HOMEMAKER SERVICES                                                           $9,999,999,999.99
A.6    SKILLED NURSING                                                              $9,999,999,999.99
A.7    COMPANION SERVICE                                                            $9,999,999,999.99

B.1.   AVERAGE PER CAPITA SECTION 1915C                                             $9,999,999,999.99
       WAIVER SERVICES EXPENDITURES (ACTUAL
       FACTOR D VALUE/S)
```


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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                        Page:          5
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                                   NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                              $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + ______________

                                          $9,999,999,999.99 <= ______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                            9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                     9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
```


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```
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
```


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Report  : MAR-4862-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA486                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                    CMS 372 ANNUAL REPORT ON HCBS HIV - AIDS WAIVER                      Page:          6
                                                        EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : 0382
WAIVER TITLE    : HIV/AIDS WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                          NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES
                 WERE DETECTED, (NOTE: INDIVIDUAL REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR
                 PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND

       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED
                 AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY
                 KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________

                                                        *** END OF REPORT ***
```


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7.13.3 MAR-4862-A -- CMS 372 Annual Report On HCBS HIV - AIDS Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 Case Management Services	A total unduplicated count of waiver recipients receiving case management services within the waiver year.	Number (Decimal)	11
I. A.2 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.3 Respite Care-Skilled	A total unduplicated count of waiver recipients receiving respite care-skilled services within the waiver year.	Number (Decimal)	11
I. A.4 Respite Care-Unskilled	A total unduplicated count of waiver recipients receiving respite care-unskilled services within the waiver year.	Number (Decimal)	11
I. A.5 Homemaker Services	A total unduplicated count of waiver recipients receiving homemaker services services within the waiver year.	Number (Decimal)	11
I. A.6 Skilled Nursing	A total unduplicated count of waiver recipients receiving skilled nursing services within the waiver year.	Number (Decimal)	11
I. A.7 Companion Service	A total unduplicated count of waiver recipients receiving companion services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II.A.1 Case Management Services	The total Medicaid expenditures for case management services for the waiver year.	Number (Decimal)	17
II.A.2 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17
II.A.3 Respite Care-Skilled	The total Medicaid expenditures for respite care-skilled services for the waiver year.	Number (Decimal)	17
II. A.4 Respite Care-Unskilled	The total Medicaid expenditures for respite care-unskilled services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.5 Homemaker Services	The total Medicaid expenditures for homemaker services for the waiver year.	Number (Decimal)	17
II. A.6 Skilled Nursing	The total Medicaid expenditures for skilled nursing services for the waiver year.	Number (Decimal)	17
II. A.7 Companion Service	The total Medicaid expenditures for companion services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III.Average Per Capita Annual Expenditure For All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
Levels Of Care In Approved Waiver	All institutional care claims within a waiver year are associated with NF.	Character	20
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11

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Field	Description	Data Type	Length
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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7.14 MAR-4872-A -- CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER (SHORT) REPORT

7.14.1 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Narrative

The CMS 372 Annual Report On HCBS ACT Waiver (Short) report contains information on the participation of recipients in the ACT waiver and compares the participation and expenditures of these recipients to other institutional recipients who are not participating in the waiver program. This is the short form for CMS 372 reporting.

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7.14.2 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Layout

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Report  : MAR-4872-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : MARJA487                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER                          Page:          1
                                                      EXHIBIT B


STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                      NF

I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS

A.1    CASE MANAGEMENT SERVICES                                                  9,999,999,999
A.2    TRANSITIONAL ASSISTANCE                                                   9,999,999,999
A.3    PERSONAL CARE                                                             9,999,999,999
A.4    HOMEMAKER                                                                 9,999,999,999
A.5    ADULT DAY HEALTH                                                          9,999,999,999
A.6    HOME DELIVERED MEAL                                                       9,999,999,999
A.7    WAIVER SHELF STABLE                                                       9,999,999,999
A.8    BREAKFAST MEALS                                                           9,999,999,999
A.9    RESPITE CARE SKILLED                                                      9,999,999,999
A.10   RESPITE CARE UNSKILLED                                                    9,999,999,999
A.11   SKILLED NURSING RN                                                        9,999,999,999
A.12   SKILLED NURSING LPN                                                       9,999,999,999
A.13   ADULT COMPANION                                                           9,999,999,999
A.14   HOME MODIFICATIONS                                                        9,999,999,999
A.15   ASSISTIVE TECHNOLOGY                                                      9,999,999,999
A.16   PERS INSTALLATION                                                         9,999,999,999
A.17   PERS MONTHLY FEE                                                          9,999,999,999
A.18   MEDICAL EQUIPMENT SUPPLIES                                                9,999,999,999
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B.1.	TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED	9,999,999,999
II.	ANNUAL SECTION 1915C WAIVER EXPENDITURES	
A.	TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES	$9,999,999,999.99
A.1	CASE MANAGEMENT SERVICES	$9,999,999,999.99
A.2	TRANSITIONAL ASSISTANCE	$9,999,999,999.99
A.3	PERSONAL CARE	$9,999,999,999.99
A.4	HOMEMAKER SERVICES	$9,999,999,999.99
A.5	ADULT DAY HEALTH	$9,999,999,999.99
A.6	HOME DELIVERED MEAL	$9,999,999,999.99
A.7	WAIVER SHELF STABLE	$9,999,999,999.99
A.8	BREAKFAST MEALS	$9,999,999,999.99
A.9	RESPITE CARE SKILLED	$9,999,999,999.99
A.10	RESPITE CARE UNSKILLED	$9,999,999,999.99
A.11	SKILLED NURSING RN	$9,999,999,999.99
A.12	SKILLED NURSING LPN	$9,999,999,999.99
A.13	ADULT COMPANION	$9,999,999,999.99
A.14	HOME MODIFICATIONS	$9,999,999,999.99
A.15	ASSISTIVE TECHNOLOGY	$9,999,999,999.99
A.16	PERS INSTALLATION	$9,999,999,999.99
A.17	PERS MONTHLY FEE	$9,999,999,999.99
A.18	MEDICAL EQUIPMENT SUPPLIES	$9,999,999,999.99
B.1.	AVERAGE PER CAPITA SECTION 1915C WAIVER SERVICES EXPENDITURES (ACTUAL FACTOR D VALUE/S)	$9,999,999,999.99

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Report  : MAR-4872-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : MARJA487                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: MR372RPT                   CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER                            Page:          2
                                                       EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                                  NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                            $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                                        9,999,999,999

   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                                9,999,999,999.99
```


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       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.

C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE
                 ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR
                 LICENSED, AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)

       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND
                 STANDARDS UNDER THE WAIVER.
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Report  : MAR-4872-A                  ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM           Run Time:   HH:MM:SS
Location: MR372RPT          CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER              Page:          3
                                          EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ?????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : X   LAG REPORT:

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF
FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)
       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR
       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES WERE DETECTED, (NOTE: INDIVIDUAL
REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND
       [  ]  7.  ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED AS WELL AS AN EXPLANATION OF WHAT STEPS
HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.
CERTIFICATION:   I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED: ____________________________________________

TITLE: ____________________________________________

DATE: ____________________________________________

CONTACT PERSON: ____________________________________

TELEPHONE NUMBER: ___________________________________
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Report  : MAR-4872-A                ALABAMA MEDICAID AGENCY                  Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   HH:MM:SS
Location: MR372RPT          CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER         Page:          4
                                         EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  : LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                  NF
I.     ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS
A.     CMS APPROVED SECTION 1915C WAIVER SERVICES RECIPIENTS
A.1    CASE MANAGEMENT SERVICES                                              9,999,999,999
A.2    TRANSITIONAL ASSISTANCE                                               9,999,999,999
A.3    PERSONAL CARE                                                         9,999,999,999
A.4    HOMEMAKER                                                             9,999,999,999
A.5    ADULT DAY HEALTH                                                      9,999,999,999
A.6    HOME DELIVERED MEAL                                                   9,999,999,999
A.7    WAIVER SHELF STABLE                                                   9,999,999,999
A.8    BREAKFAST MEALS                                                       9,999,999,999
A.9    RESPITE CARE SKILLED                                                  9,999,999,999
A.10   RESPITE CARE UNSKILLED                                                9,999,999,999
A.11   SKILLED NURSING RN                                                    9,999,999,999
A.12   SKILLED NURSING LPN                                                   9,999,999,999
A.13   ADULT COMPANION                                                       9,999,999,999
A.14   HOME MODIFICATIONS                                                    9,999,999,999
A.15   ASSISTIVE TECHNOLOGY                                                  9,999,999,999
A.16   PERS INSTALLATION                                                     9,999,999,999
A.17   PERS MONTHLY FEE                                                      9,999,999,999
A.18   MEDICAL EQUIPMENT SUPPLIES                                            9,999,999,999

B.1.   TOTAL UNDUPLICATED SECTION 1915C WAIVER                               9,999,999,999
       RECIPIENTS SERVED

II.    ANNUAL SECTION 1915C WAIVER EXPENDITURES
```


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A.	TOTAL CMS APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES	$9,999,999,999.99
A.1	CASE MANAGEMENT SERVICES	$9,999,999,999.99
A.2	TRANSITIONAL ASSISTANCE	$9,999,999,999.99
A.3	PERSONAL CARE	$9,999,999,999.99
A.4	HOMEMAKER SERVICES	$9,999,999,999.99
A.5	ADULT DAY HEALTH	$9,999,999,999.99
A.6	HOME DELIVERED MEAL	$9,999,999,999.99
A.7	WAIVER SHELF STABLE	$9,999,999,999.99
A.8	BREAKFAST MEALS	$9,999,999,999.99
A.9	RESPITE CARE SKILLED	$9,999,999,999.99
A.10	RESPITE CARE UNSKILLED	$9,999,999,999.99
A.11	SKILLED NURSING RN	$9,999,999,999.99
A.12	SKILLED NURSING LPN	$9,999,999,999.99
A.13	ADULT COMPANION	$9,999,999,999.99
A.14	HOME MODIFICATIONS	$9,999,999,999.99
A.15	ASSISTIVE TECHNOLOGY	$9,999,999,999.99
A.16	PERS INSTALLATION	$9,999,999,999.99
A.17	PERS MONTHLY FEE	$9,999,999,999.99
A.18	MEDICAL EQUIPMENT SUPPLIES	$9,999,999,999.99
B.1.	AVERAGE PER CAPITA SECTION 1915C WAIVER SERVICES EXPENDITURES (ACTUAL FACTOR D VALUE/S)	$9,999,999,999.99

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```
Report  : MAR-4872-A                    ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487              MEDICAID MANAGEMENT INFORMATION SY              Run Time:   HH:MM:SS
Location: MR372RPT            CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER          Page:          5
                                            EXHIBIT B

STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  :     LAG REPORT:  X

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF

III.   AVERAGE PER CAPITA ANNUAL EXPENDITURE FOR ALL OTHER
       MEDICAID SERVICES TO WAIVER RECIPIENTS INCLUDING HOME
       HEALTH, PERSONAL CARE, ADULT DAY HEALTH and EXPANDED                     $9,999,999,999.99
       EPSDT SERVICES EXPENDITURES (ACTUAL FACTOR D' VALUES)

IV.    1915C WAIVER COST-NEUTRALITY FORMULA

                                                   D + D' <= G + G'

                      $9,999,999,999.99 + $9,999,999,999.99 <= _______________ + _______________

                                          $9,999,999,999.99 <= _______________

TO COMPUTE THE COST NEUTRALITY FORMULA, ADD THE ACTUAL D (SECTION II.B.1) PLUS THE ACTUAL D' (SECTION III) ON
THE CMS-372(S).  THE SUM OF D' MUST BE LESS THAN OR EQUAL TO THE SUM OF THE ESTIMATED G PLUS G' IN THE
APPROVED WAIVER REQUEST.

* IF D + D' IS GREATER THAN G + G', ATTACH AN EXPLANATION TO FORM CMS-372(S) WITH DOCUMENTATION TO SUPPORT
  REVISION OF G AND/OR G'.

V.     OTHER REQUIRED DATA

A. 1.  TOTAL DAYS OF WAIVER COVERAGE:                                            9,999,999,999
```


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```
   2.  AVERAGE LENGTH OF WAIVER COVERAGE BY LEVEL OF CARE:                          9,999,999,999.99
       ( TOTAL DAYS OF COVERAGE DIVIDED BY LINE B.1. OF SECTION I )

B.     ATTACH A LAG REPORT FOR THE PREVIOUS YEAR OF THIS WAIVER (INCLUDING RENEWALS AND REPLACEMENTS) OR AN
       EXPLANATION OF WHY THERE IS NO LAG DATA.
C.     IMPACT OF THE WAIVER ON THE HEALTH AND WELFARE OF THE RECIPIENTS.  COMPLETE ITEMS 2 THROUGH 7 ONLY IF YOU
       ARE SUBMITTING AN INITIAL REPORT.
ASSURANCES:  ( PLEASE CHECK )

       [  ]  1.  ASSURANCES WERE SUBMITTED WITH THE INITIAL REPORT.

       [  ]  2.  ALL PROVIDER STANDARDS AND HEALTH AND WELFARE SAFEGUARDS HAVE BEEN MET AND CORRECTIVE ACTIONS HAVE BEEN TAKEN WHERE APPROPRIATE.

       [  ]  3.  ALL PROVIDERS OF WAIVERS SERVICES WERE PROPERLY TRAINED, SUPERVISED, AND CERTIFIED AND/OR LICENSED, AND CORRECTIVE ACTIONS HAVE
BEEN TAKEN WHERE APPROPRIATE.

DOCUMENTATION: (PLEASE CHECK AND ATTACH)
       [  ]  4.  ATTACHED IS A BRIEF DESCRIPTION OF THE PROCESS FOR MONITORING THE SAFEGUARDS AND STANDARDS UNDER THE WAIVER.

Report  : MAR-4872-A                ALABAMA MEDICAID AGENCY                 Run Date: MM/DD/YYYY
Process : MARJA487           MEDICAID MANAGEMENT INFORMATION SYSTEM         Run Time:   HH:MM:SS
Location: MR372RPT           CMS 372 ANNUAL REPORT ON HCBS ACT WAIVER       Page:          6
                                          EXHIBIT B
STATE           : ALABAMA
REPORTING PERIOD: MM/DD/CCYY - MM/DD/CCYY
WAIVER NUMBER   : ?????
WAIVER TITLE    : ACT WAIVER
INITIAL REPORT  :     LAG REPORT: X

LEVEL/S OF CARE IN APPROVED WAIVER                                                    NF

FINDINGS OF MONITORING: (PLEASE CHECK AND ATTACH DOCUMENTATION IF APPROPRIATE)

       [  ]  5.  NO DEFICIENCIES WERE DETECTED DURING THE MONITORING PROCESS; OR

       [  ]  6.  DEFICIENCIES WERE DETECTED.  ATTACHED IS A SUMMARY OF THE SIGNIFICANT AREA WHERE DEFICIENCIES WERE DETECTED, (NOTE: INDIVIDUAL
REPORTS OR ASSESSMENT FORMS FOR WAIVER RECIPIENTS AND/OR PROVIDERS DISCLOSING DEFICIENCIES AND WHICH DOCUMENT THE SUMMARY ARE NOT NECESSARY); AND
```


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[ ] 7. ATTACHED IS AN EXPLANATION OF HOW THESE DEFICIENCIES HAVE BEEN, OR ARE BEING CORRECTED AS WELL AS AN EXPLANATION OF WHAT STEPS HAVE BEEN TAKEN TO ENSURE THAT THE DEFICIENCIES DO NOT OCCUR.

CERTIFICATION: I DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM CMS 372(S) IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED: _____

TITLE: _____

DATE: _____

CONTACT PERSON: _____

TELEPHONE NUMBER: _____

*** END OF REPORT ***

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7.14.3 MAR-4872-A -- CMS 372 Annual Report On HCBS ACT Waiver (Short) Report Field Descriptions

Field	Description	Data Type	Length
I. A.1 Case Management Services	A total unduplicated count of waiver recipients receiving case management services within the waiver year.	Number (Decimal)	11
I. A.2 Transitional Assistance	A total unduplicated count of waiver recipient's transitional assistance services within the waiver year.	Number (Decimal)	11
I. A.3 Personal Care	A total unduplicated count of waiver recipients receiving personal care services within the waiver year.	Number (Decimal)	11
I. A.4 Homemaker Services	A total unduplicated count of waiver recipients receiving homemaker services within the waiver year.	Number (Decimal)	11
I. A.5 Adult Day Health	A total unduplicated count of waiver recipients receiving adult day health services within the waiver year.	Number (Decimal)	11
I. A.6 Home Delivered Meal	A total unduplicated count of waiver recipients receiving home delivered meal services within the waiver year.	Number (Decimal)	11
I. A.7 Waiver Shelf Stable	A total unduplicated count of waiver recipients receiving waiver shelf stable services within the waiver year.	Number (Decimal)	11
I. A.8 Breakfast Meals	A total unduplicated count of waiver recipients receiving breakfast meal services within the waiver year.	Number (Decimal)	11
I. A.9 Respite Care-Skilled	A total unduplicated count of waiver recipients receiving respite care-skilled services within the waiver year.	Number (Decimal)	11
I. A.10 Respite Care-Unskilled	A total unduplicated count of waiver recipients receiving respite care-unskilled services within the waiver year.	Number (Decimal)	11
I. A.11 Skilled Nursing RN	A total unduplicated count of waiver recipients receiving skilled nursing RN services within the waiver year.	Number (Decimal)	11

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Field	Description	Data Type	Length
I. A.12 Skilled Nursing LPN	A total unduplicated count of waiver recipients receiving skilled nursing LPN services within the waiver year.	Number (Decimal)	11
I. A.13 Adult Companion	A total unduplicated count of waiver recipients receiving adult companion services within the waiver year.	Number (Decimal)	11
I. A.14 Home Modifications	A total unduplicated count of waiver recipients receiving home modification services within the waiver year.	Number (Decimal)	11
I. A.15 Assistive Technology	A total unduplicated count of waiver recipients receiving assistive technology services within the waiver year.	Number (Decimal)	11
I. A.16 PERS Installation	A total unduplicated count of waiver recipients receiving PER installation services within the waiver year.	Number (Decimal)	11
I. A.17 PERS Monthly Fee	A total unduplicated count of waiver recipients receiving PER monthly fee services within the waiver year.	Number (Decimal)	11
I. A.18 Medical Equipment Supplies	A total unduplicated count of waiver recipients receiving medical equipment supplies services within the waiver year.	Number (Decimal)	11
I. B.1 Total Unduplicated Section 1915(C) Waiver Recipients	The total unduplicated count of waiver recipients receiving waiver services within the waiver year.	Number (Decimal)	11
II. A. Total Approved Section 1915 (C) Waiver Services Expenditures	The total expenditures on waiver services during the waiver year.	Number (Decimal)	17
II.A.1 Case Management Services	The total Medicaid expenditures for case management services for the waiver year.	Number (Decimal)	17
II. A.2 Transitional Assistance	The total Medicaid expenditures for transitional assistance services for the waiver year.	Number (Decimal)	17
II. A.3 Personal Care	The total Medicaid expenditures for personal care services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.4 Homemaker Services	The total Medicaid expenditures for homemaker services for the waiver year.	Number (Decimal)	17
II. A.5 Adult Day Health	The total Medicaid expenditures for adult day health services for the waiver year.	Number (Decimal)	17
II. A.6 Home Delivered Meal	The total Medicaid expenditures for home delivered meal services for the waiver year.	Number (Decimal)	17
II. A.7 Waiver Shelf Stable	The total Medicaid expenditures for waiver shelf stable services for the waiver year.	Number (Decimal)	17
II. A.8 Breakfast Meals	The total Medicaid expenditures for breakfast meal services for the waiver year.	Number (Decimal)	17
II. A.9 Respite Care-Skilled	The total Medicaid expenditures for respite care-skilled services for the waiver year.	Number (Decimal)	17
II. A.10 Respite Care-Unskilled	The total Medicaid expenditures for respite care-unskilled services for the waiver year.	Number (Decimal)	17
II. A.11 Skilled Nursing RN	The total Medicaid expenditures for skilled nursing RN services for the waiver year.	Number (Decimal)	17
II. A.12 Skilled Nursing LPN	The total Medicaid expenditures for skilled nursing LPN services for the waiver year.	Number (Decimal)	17
II. A.13 Adult Companion	The total Medicaid expenditures for adult companion services for the waiver year.	Number (Decimal)	17
II. A.14 Home Modifications	The total Medicaid expenditures for home modification services for the waiver year.	Number (Decimal)	17
II. A.15 Assistive Technology	The total Medicaid expenditures for assistive technology services for the waiver year.	Number (Decimal)	17

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Field	Description	Data Type	Length
II. A.16 PERS Installation	The total Medicaid expenditures for PER installation services for the waiver year.	Number (Decimal)	17
II. A.17 PERS Monthly Fee	The total Medicaid expenditures for PER monthly fee services for the waiver year.	Number (Decimal)	17
II. A.18 Medical Equipment Supplies	The total Medicaid expenditures for medical equipment supplies services for the waiver year.	Number (Decimal)	17
II. B.1 Average Per Capita Section 1915(C) Waiver Services Expenditures	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
III.Average Per Capita Annual Expenditure For All Other Medicaid Services	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D Plus D')	The total calculated sum of 1915C Waiver cost-neutrality formula for D and D' for the waiver recipients receiving services while in the waiver within the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D')	The average acute care service expenditures accumulated by the waiver recipients during the waiver year.	Number (Decimal)	17
IV. 1915C Waiver Cost-Neutrality Formula (D)	The average waiver service expenditures accumulated by the waiver recipients during the waiver year. Calculated by dividing the TOTAL APPROVED SECTION 1915C WAIVER SERVICES EXPENDITURES in Section VI. A., by the number of recipients in Section V. B.1.	Number (Decimal)	17
Levels Of Care In Approved Waiver	All institutional care claims within a waiver year are associated with NF.	Character	20

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Field	Description	Data Type	Length
V. A. 1. Total Days Of Waiver Coverage	The total number of days that all waiver recipients were covered by the waiver.	Number (Decimal)	11
V. A. 2. Average Length of Waiver Coverage by Level of Care	The average number of days that waiver recipients were covered by the waiver. Calculated by dividing the TOTAL DAYS OF WAIVER COVERAGE in Section V. A. 1. by TOTAL UNDUPLICATED SECTION 1915C WAIVER RECIPIENTS SERVED in section B. 1.	Number (Decimal)	17

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AMMIS Prior Authorization Operations Manual

11/04/2013

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

HP Enterprise Services
301 Technacenter Drive
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Version 3.0

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Prior Authorization Operations Manual
Version:	3.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/PriorAuth
Owner:	HPES/Agency
Author:	Prior Authorization Team
Approved by:	
Approval Date:	

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
07/31/2012	2.0		Updated ITB Requirements	Sections 1.3.2, 1.4. and 1.5
11/04/2013	3.0		Application of CO 10898	Section 1.4 Functional Area Responsibilities, line 17. Remove “Amended”.

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 I INTRODUCTION

Alabama's Medicaid program guidelines designate selected non-emergency medical items and services that must receive prior approval before delivery. The Agency's Prior Authorization (PA) Unit serves as a cost monitoring, utilization review measure, and quality assurance team for the Alabama Medicaid Program. The team ensures that payment from the Alabama Medicaid Management Information System (AMMIS) is only for those treatments and services that are medically necessary, appropriate, and cost-effective. Hewlett Packard Enterprise Services (HPES) PA Unit assists in this process by data entering non-drug and by data entering and approving Targeted Case Management PA requests.

1.1 PRIOR AUTHORIZATION UNIT FUNCTIONS

The Prior Authorization unit consists of the following:

Prior Authorization (Non-Pharmacy)

Targeted Case Management (TCM)

1.2 PRIOR AUTHORIZATION TASKS

The following tasks are performed in the Prior Authorization functional area:

1. Prior Authorization Requests (Non-Pharmacy), which includes Targeted Case Management (TCM) and non-emergency requests
2. Dental Care Prior Authorization

1.3 INPUT, PROCESSES, AND OUTPUT

1.3.1 Input

The table below documents the inputs to the Prior Authorization functional area.

Prior Authorization Inputs

Input	Source	Purpose
Alabama Prior Review and Authorization Dental Request	Provider	To request prior authorization for dental services.
Alabama Prior Review and Authorization Request	Provider	To request prior authorization for non-pharmacy services.

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1.3.2 Processes

Processes accomplished in the Prior Authorization functional unit include the following:

1. Non-Pharmacy and Dental prior authorization requests.
2. TCM prior authorization requests.
3. Pharmacy prior authorization requests (Processed by Pharmacy PA contractor, currently Health Information Designs [HID]).

Non-Pharmacy and Dental Prior Authorization Requests

The PA specialists enter PA requests submitted by providers for all Non-Pharmacy and Dental PA requests. After all Non-Pharmacy and Dental PA requests are entered, American Psychiatric Services Healthcare (APS) reviews the PA requests online—along with any supporting documentation submitted by providers—and makes a decision on the request based on the prior authorization criteria for the request. The Agency's decision generates an approval or denial letter. This letter is then mailed to the provider.

NOTE:

If the Non-Pharmacy PA request has a PA Assignment code of 74—Private Duty Nursing— or a line item has been denied, a letter is also be sent to the recipient.

Targeted Case Management (TCM) Prior Authorization Requests

HPES' Targeted Case Management (TCM) Prior Authorization Coordinator is responsible for issuing prior authorization numbers for Targeted Case Management for Disabled Children. Based on a request from the provider, the coordinator reviews the prior authorization file to determine if the child is already receiving services. If not, the coordinator assigns a prior authorization number and immediately loads it to the file. If the child already has an existing prior authorization number, the coordinator instructs the provider to contact Medicaid's LTC – Program Management Unit.

Pharmacy Prior Authorization Requests

Pharmacy PA requests are approved or denied by the pharmacy PA contractor, currently HID, based on criteria supplied by Alabama Medicaid. The Alabama Medicaid Agency contracts with HID to perform this function. HID processes the requests via a T1 line, which allows them to process National Council for Prescription Drug Programs (NCPDP) P4 transactions interactively with HPES as well as access the online panels.

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1.3.3 Output

The table below documents the outputs from the Prior Authorization functional area:

Prior Authorization Outputs

Input	Source	Purpose
Non-Pharmacy Prior Authorization Letter	AMMIS	Inform the provider of acceptance or denial of prior authorization request for non-pharmacy services.
PA Cover Sheet	Prior Authorization	Inform the Agency of prior authorization requests that require Agency review.

1.4 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Prior Authorization functional unit were extracted from section 3.05 of the Invitation To Bid (ITB):

1. Operate the Prior Approval Subsystem, including improvements, modifications, and/or electronic interfaces as they are implemented.
2. Designate a Targeted Case Management TCM Prior Authorization Coordinator who shall be responsible for issuing prior authorization numbers to providers for Targeted Case Management for Disabled Children. Based on paper or electronic requests from the provider, the coordinator shall review the prior authorization file to determine if the child is already receiving services. If not, the coordinator shall assign a prior authorization number and load it to the file within two (2) business days of the request. Contractor shall produce a follow-up letter and a report the next day following each update. If the child already has a prior authorization number, Contractor shall instruct the provider to contact Medicaid's LTC-Program Management Unit.
3. Receive, review and enter all paper PA forms from providers within two (2) days of receipt. Review all paperforms for completeness prior to entry into the MMIS and return incomplete forms to providers within two (2) days of receipt.
4. Support online submittal and response of the electronic PA (HIPAA ASC X12N 278 5010) transaction. Allow the providers to modify a request prior to its review or approval. Allow the providers access to electronic and paper PA requests (e.g., oxygen, home health, etc).
5. Accept on-line, real-time updates to PA information from the Agency or their contractors. For pharmacy claims, prior authorization updates must be accepted from the Pharmacy AdministrativeServices contactor online real-time for immediate use in Electronic Verification System (EVS) processing.
6. Provide the capability to globally change data, for example, provider ID numbers or procedure codes or modifiers, on active or pending PAs within an Agency approved timeframe.
7. Support automated distribution of PA requests to appropriate Medicaid staff.
8. Accept and process nightly updates to the PA data set from Agency specified contractors.
9. Respond to telephone inquiries, written inquiries and questions from providers and recipients regarding prior-authorized services for those areas that are the Contractor's responsibility within two (2) business days.
10. Auto-assign unique prior authorization control numbers to prior authorization items/services at time of entry into the system.

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11. Create and distribute PA forms, in electronic and paper formats, to providers at no charge.
12. Maintain and update PA files/database tables to support all prior-authorized services.
13. Research PA or certification issues or problems identified by the system and/or operational staff; obtain documentation, determine impact, present findings to system support area; and perform further reviews once the issue/problem is fixed. Provide analysis and estimated date of correction within three (3) days of notification of any issues or defects.
14. Edit prior authorization requests entered into the MMIS, including verification of the eligibility of the recipient and provider for the PA request being made, including Medicare and other Third Party Liability (TPL) coverage and Health Maintenance Organization (HMO) enrollment, as well as all field verifications and inter-field relationships (i.e., approved status but presence of a denial reason code).
15. Automatically generate and mail letters to notify Providers of approvals and durations or denials of the PA request per Agency defined criteria and provide information regarding recipient appeal rights.
16. Automatically generate and mail letters to notify recipients denials of the PA request per Agency defined criteria and provide information regarding recipient appeal rights.
17. Identify and display on-line the status of PAs, including Evaluation, Approved, Denied, Pending, Cancelled, Denied Need Further Doco and Reconsideration.
18. Maintain and update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars (decrement when appropriate); increment units and/or dollars when necessary. Deny claims for any service that has been performed by a provider or group other than the provider or group who authorized the PA for the services.
19. 21. Make available on-line, real-time, the number of authorized services provided and show how many authorized services remain, by individual prior authorization numbers.
20. 22. Produce and make available to the Agency and/or their contractors all PA reports defined in the Alabama MMIS Reports Listing located in the Procurement Library.
21. 23. Identify issues and develop recommendations regarding policy guidelines which are unclear and/or cause problems in adjudicating PA requests. The issues may be identified by the Vendor, the Agency or their PA Contractors. These are to be forwarded to the State in writing (on paper or electronically) for review and approval within two (2) business days of identification and/or notification.

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24. Provide EPSDT screening data for recipients who are eligible for extended benefits through prior authorization on-line, real-time.

1.5 PERFORMANCE EXPECTATIONS

The following performance expectations for the Prior Authorization functional unit were extracted from section 3.05 of the Invitation To Bid (ITB):

1. Process and assign a unique reference number to all Prior Authorizations received from Providers, Agency staff or Agency contractors within two (2) business days of receipt. Pharmacy electronic PA requests must be accepted online, real-time.

NOTE:

HPES does not process Pharmacy PAs. All Pharmacy PA requests are processed by Health Information Designs (HID). If a pharmacy claims is received by HPES it is forwarded directly to HID.

2. After the State determines medical necessity of requests, approving or denying, the Contractor must electronically generate and mail letters and appropriate forms responding to appropriate designees (providers, recipients, etc.) for PA services within two (2) business days.
3. Respond to provider's requests for the status of PA requests within one (1) business day, or within the timeframe specified by the state for pharmacy PAs.

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2. INTRODUCTION

The Prior Authorization Unit reviews requests submitted by providers for designated non-emergency medical items and services that must receive prior approval from the Agency before the service can be delivered to the recipient. Requests are scanned, reviewed, and forwarded to the appropriate unit for disposition of the request, and letters are generated that indicate the acceptance or denial of the request.

2.1 PRIOR AUTHORIZATION REQUESTS

PA requests are processed according to the following procedure:

1. A provider completes the Alabama Prior Review and Authorization Request for Non-Pharmacy services or the Alabama Prior Review and Authorization Dental Request for dental services.
2. The provider mails the completed form to Prior Authorization at P.O. Box 244032, Montgomery, AL, 36124-4032 which has been designated for PA requests.

> A request sent to P.O. Box 244032, Montgomery, AL, 36124-4032 is considered extremely sensitive in nature, due to supporting documentation that may accompany the request. Only authorized personnel in the HPES mailroom are permitted to open a PA request.

3. The courier delivers the PA mail to the mailroom, and places the mail in the PA basket.
4. The mailroom specialist authorized to open PA requests opens the requests.

> Photographs and x-rays may accompany the request but are not scanned. If the photographs or x-rays are not in envelopes within the original request envelope, then the PA specialist puts the photographs or x-rays in a separate envelope, records the recipient's Recipient Identification Number (RID) on the envelope, the requesting provider's name and provider number, and seals the envelope. The mailroom specialist then puts the sealed envelope back in the original envelope. This ensures that the photographs or x-rays are protected and that they will not become misplaced during the scanning process.

5. Prior to scanning, the PA specialist splits the requests into batches of 50, and determines the correct region code to apply to the PA. The table below identifies the region numbers that can be assigned to the PA request during the scanning process.

Prior Authorization Regions for Scanned PA Requests

Region	Region Description
10–49	Non-Pharmacy Non-Electronic
50-69	Non-Pharmacy Electronic
70–89	Pharmacy Non-Electronic
90–99	Emergency

6. The mailroom specialist scans the PA request form and any supporting paper documentation that is attached to the PA.

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7. During scanning, the ICN—indicating the selected region code and the Julian date of receipt—prints on the form to identify the scan as a PA scan. The ICN also becomes the PA number for the PA request.

NOTE:

Refer to Section 3. Scanning Claims and ICN section of the Document Control Manual for further information on the scanning process and ICN values.

8. After scanning, the mailroom specialist records the new ICN number on the envelope that contains x-rays or photographs that accompany the PA request.
9. The mailroom specialist forwards all scanned PA requests, attachments, and supporting documents to the PA specialist.
10. A PA specialist sorts the PA requests by PA type.
11. A PA specialist processes the PA request as follows:
    - If the request is a Non-Pharmacy or Dental PA request, the PA specialist follows the procedures in Non-Pharmacy and Dental Prior Authorization Requests outlined in Section 2.1.1 below.

NOTE:

HPES does not process Pharmacy PAs. All Pharmacy PA requests are processed by Health Information Designs (HID). If a pharmacy claims is received by HPES it is forwarded directly to HID.

- If the PA Request has a PA Assignment Code of AC-Targeted Case Management, the TCM specialist follows the procedures detailed in Targeted Case Management (TCM) Prior Authorization Requests outlined in Section 2.1.2 below.

2.1.1 Non-Pharmacy and Dental Prior Authorization Requests

Non-Pharmacy and Dental Prior Authorization System Entry

The PA specialist performs the following steps to enter the PA information into the system:

1. Double-click the AMMIS icon to open the PA application. Non-Pharmacy, Pharmacy and Dental PA requests are keyed using the following PA panels:
    - Prior Authorization Information page which includes multiple panels for PA entry.
2. Using the Prior Authorization User Manual as a reference, key the required data elements for each PA request form in the batch until all of the forms are entered. Required data elements on the form are as follows:
    - Service and Request/Prescribing Provider Medicaid or National Provider Identification (NPI) Number.
    - Current RID.
    - Requested Procedure Code (if applicable).
    - Requested Effective Date.
    - Requested End Date.
    - Requested Units and/or Requested Dollars.

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NOTE:

As fields are entered on the panel, the system informs the PA specialist if the field is required. If a field is required and left blank, an error message displays and the PA cannot be added to the system until the value for the required field is added.

Non-Pharmacy and Dental Agency Delivery

1. After the PA requests are keyed, the PA specialist completes a PA Cover Sheet for the requests. There is one PA Cover Sheet created for Dental PAs. The cover sheet indicates the Julian date of the scanned PA. The specialist completes the following information:
   a. For each PA service type, the specialist checks the appropriate box and records the number of entries in the "Number in Batch" Column.
   b. The "Number in Batch" is totaled and a count entered in the "Total" Line on the cover sheet.
   c. The PA specialist initials the "HPES PA Specialist Initials" Line.
   d. The PA specialist attaches the PA Cover Sheet to the batches and related attachments, and places the batches with the cover sheets in the outgoing Agency Mail basket.

NOTE:

A separate PA Cover Sheet for each Julian date must be completed if requests for more than one Julian date are forwarded to the Agency at the same time.

2. The courier retrieves the batch(es) and related documents and delivers them to the PA Division at the Agency.

The courier must deliver all documents for the batch to the Agency. The Agency may need the actual paper attachments, photographs or x-rays in order to make a conclusive decision on the PA request.

1. The courier waits while a representative from the Agency signs and dates the PA Cover Sheet on the "Agency PA Representative" Line. The Agency is responsible for making copies of the PA Cover Sheet; the Agency keeps the original and gives the copy to the courier.
4. The courier returns the PA Cover Sheet to the mailroom at HPES.
5. The mailroom forwards the completed PA Cover Sheet to the PA Unit.
6. The Agency reviews each PA request and either approves or denies the PA request.

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2.1.2 Targeted Case Management (TCM) Prior Authorization Requests

The TCM PA Specialist reviews each request to determine if other TCM services are already being rendered for the recipient, and makes a determination based on the Agency's guidelines. The following steps are performed when reviewing a request from a TCM provider:

1. The specialist signs on to the online PA panel and determines if the recipient is already receiving TCM services. Using the RID, the specialist accesses any PA information for the recipient. If no TCM PA is present or active, the specialist proceeds to Step 2. If there is a current TCM PA on file for the recipient, the specialist goes to Step 3.
2. The specialist verifies the service requested is a covered TCM PA service. If covered, the TCM request is approved.
3. If not covered or there is an existing PA, the specialist denies the TCM PA request with a decision code of Denied (D).

2.2 PRIOR AUTHORIZATION LETTERS

During the nightly processing cycle, Alabama Medicaid Prior Review and Authorization Request Decision Letters are generated based on the Agency's and HPES' TCM PA coordinator's PA decision for each PA request. The letters are processed and delivered according to the following daily procedure:

1. HPES Operations prints the PA letters. The provider's and recipient's addresses are printed in the upper left-hand quadrant of the letter to facilitate mailing in a #10 window envelope.

NOTE:

Two letters print if the PA Type on a PA request is 74—Private Duty Nursing. One is mailed to the provider and the other to the recipient.

2. After the letters are printed, Operations delivers the letters to the PA specialist for verification. After verification, the letters are delivered to the mailroom.
3. The mailroom inserts the letters into the window envelopes and meters them with first-class postage.

If the PROCEDURE DESCRIPTION on the letter is PRIVATE DUTY NURSE or a line item has been denied, then two copies of the letter must be mailed. The mailroom specialist inserts one copy of the letter into a window envelope that shows the provider address, and inserts the other copy into a window envelope that shows the recipient address.

PA letters must be printed and mailed within two business days of the Non-Pharmacy PA decision.

2.3 PHARMACY PRIOR AUTHORIZATION REQUESTS

Providers submit a PA request to the PA contractor, currently HID, for prior authorization of specific drugs. The PA contractor accesses the on-line PA application and uses the Prior Authorization panels to enter the applicable information. Once information is entered and a PA number is assigned, the database is updated and the pharmacy provider may submit the pharmacy claim for processing.

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Glossary

The table below defines the terms used in the Prior Authorization functional area.

Prior Authorization Functional Area Terms

Term	Definition
Billing/Rendering/Service provider	The provider who is authorized to perform the requested services.
Diagnosis code	The code describing the diagnosis of the patient, which is used to determine the treatment or admission of the patient. This code is designated on the prior authorization form and the claim form.
Prescribing/Requesting provider	The provider who prescribed or requested the service requiring prior authorization.
Procedure code	The code describing the medical service the provider supplied to the recipient. This code is designated on the prior authorization form and the claim form.
Non-Medicaid/License Provider	The state license number of the provider who prescribed the service requiring prior authorization.
Recipient	An individual who has been certified by the State as eligible for assistance in accordance with the State plans under Title XIV and Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, and Title IV of the Immigration and Naturalization Act.

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AMMIS Prior Authorization User Manual

Date Modified: 4/9/2018

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1 DOCUMENT CONTROL

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1.1 DOCUMENT INFORMATION PAGE

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
				Remove 7.10 PAU-007A-M – Prior Authorization Hearings and Appeals Received Report and 7.11 PAU-007B-M – PA Monthly Hearings and Appeals – Finalized Report 7.3 PAU-0005-M – Prior Authorization Monthly Activity Report – update report layout and field descriptions Remove PAU-0006-M – Prior Authorization Monthly Administrative Review Report 7.5 - PAU-0008-M – Prior Authorization Monthly Utilization Report SVC Provider - update report layout and field descriptions 7.6 PAU-0009-M – Prior Authorization Monthly Utilization Report-REQ Provider – update report layout and field descriptions 7.8 PAU-001A-M -- Prior Authorization Analyst Activity Report – update report layout and field descriptions
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06/12/2014	7.0		Application of CO 11843	7.2 PAU-0003-D – Prior Authorization Quality Review Report – Medicaid 7.3 PAU-003A-D – Prior Authorization Quality Review Report – CHIP

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
				New—7.4 PAU-003B-D – Prior Authorization Quality Review Report – ACA
09/24/2014	8.0		Application of CO 7540	6.13 – Base Information Panel – updated layout, field descriptions.
11/05/2014	9.0		Application of CO 11646	6.13 - Base Information Panel – updated layout and field descriptions
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07/27/2016	11.0		Application of RCO COs	CO 13103 6.15 Modify Assignment Panel to include 'RCO Covered Service' field. CO 13104 6.8.4 Modify Prior Authorization Line Item Panel to include new field edit error message to validate Recipient against Assignment Type and Requested date.
11/17/2017	12.0		Application of CO 14497	6.15 Assignment Panel Overview
04/09/2018	13.0		General Updates	

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 PRIOR AUTHORIZATION INTRODUCTION

2.1 PRIOR AUTHORIZATION USER MANUAL OVERVIEW

The Alabama AMMIS System has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Prior Authorization functional area.

This manual covers the following:

- Prior Authorization Overview
- Prior Authorization System Navigation
- System Wide Common Terminology and Layouts
- Provider Pages/Panels
- Provider Reports

2.2 PRIOR AUTHORIZATION USER MANUAL OBJECTIVE

This section explains the objective of the Alabama AMMIS Prior Authorization User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

This manual contains references to current Alabama Medicaid Management Information System (AMMIS) screens, when applicable. This information will be deleted after implementation training, and is identified in the narrative text in italics.

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3 PRIOR AUTHORIZATION OVERVIEW

3.1 INTRODUCTION TO PRIOR AUTHORIZATION

Prior Authorization (PA) is a mechanism to review, assess, and pre-approve or deny selected non-emergency medical services prior to payment. PA serves as a cost-containment and utilization review mechanism, enabling payment for only those treatments and services that are medically necessary, appropriate, and cost-effective.

The AMMIS PA functional area supports the following functions and processes:

Direct Data Entry (DDE) and Health Insurance Portability and Accountability Act (HIPAA) 278 Electronic Data Interchange (EDI) submissions of requests for medical services.

Direct Data Entry (DDE) requests for pharmacy services.

Generation of PA Notices to communicate decision information to both recipients and providers.

Integration with claims processing to provide online, real time processing and adjudication of claims against PA requests.

Integration with other functional areas to provide online, real-time access to Provider, Recipient and Reference data, including front-end editing and validation of keyed requests into the online application Web-based panels.

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4 PRIOR AUTHORIZATION SYSTEM NAVIGATION

4.1 OVERVIEW

The Alabama AMMIS System is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within AMMIS.

4.2 SYSTEM SECURITY

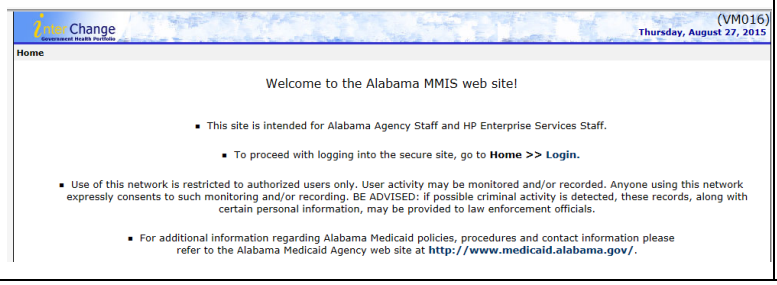
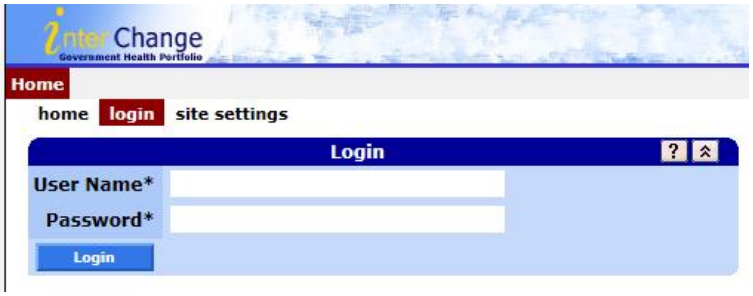
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 LOGGING IN/LOGGING OUT

Users must successfully log in to the Alabama AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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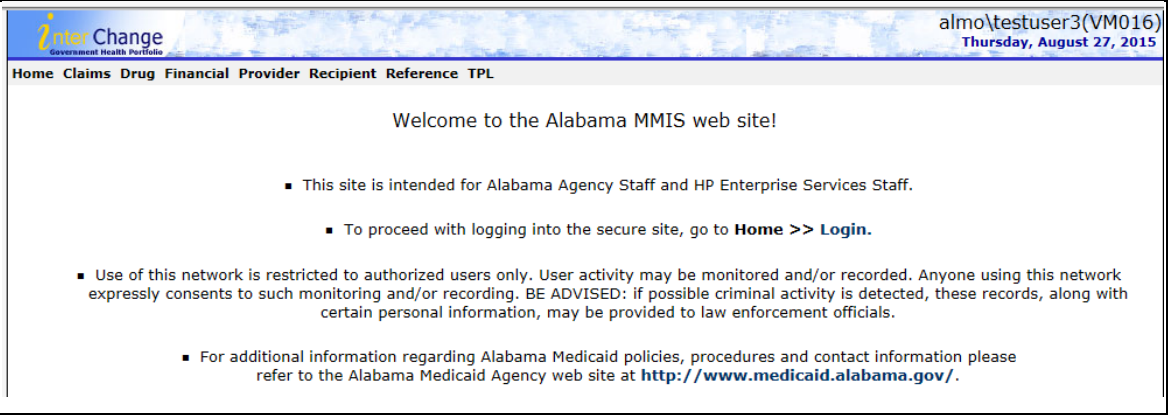
Step	Action	Response
		

4.3.2 Logging off AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 CHANGING PASSWORDS

Users are prompted to change their password every thirty (30) days. The password must be seven characters in length and contain alpha/numeric values. The Password Manager panel displays when it is time to enter a new password.

Note: The Account ID is automatically populated when the panel displays.

Follow the steps below to change your password:

Step	Action	Response
1	Enter **Old password**.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter **New password**.	
4	Press **Tab**.	User is taken to the Confirm new password field.

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Step	Action	Response
5	Confirm new password by entering it again.	
6	Click **OK**.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message.

The following message displays upon successful password change:

4.5 SCREEN DISPLAY FEATURES

The AMMIS system is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into AMMIS.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or more importantly, documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Hot Link
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the DXC Technology copyright text displayed.

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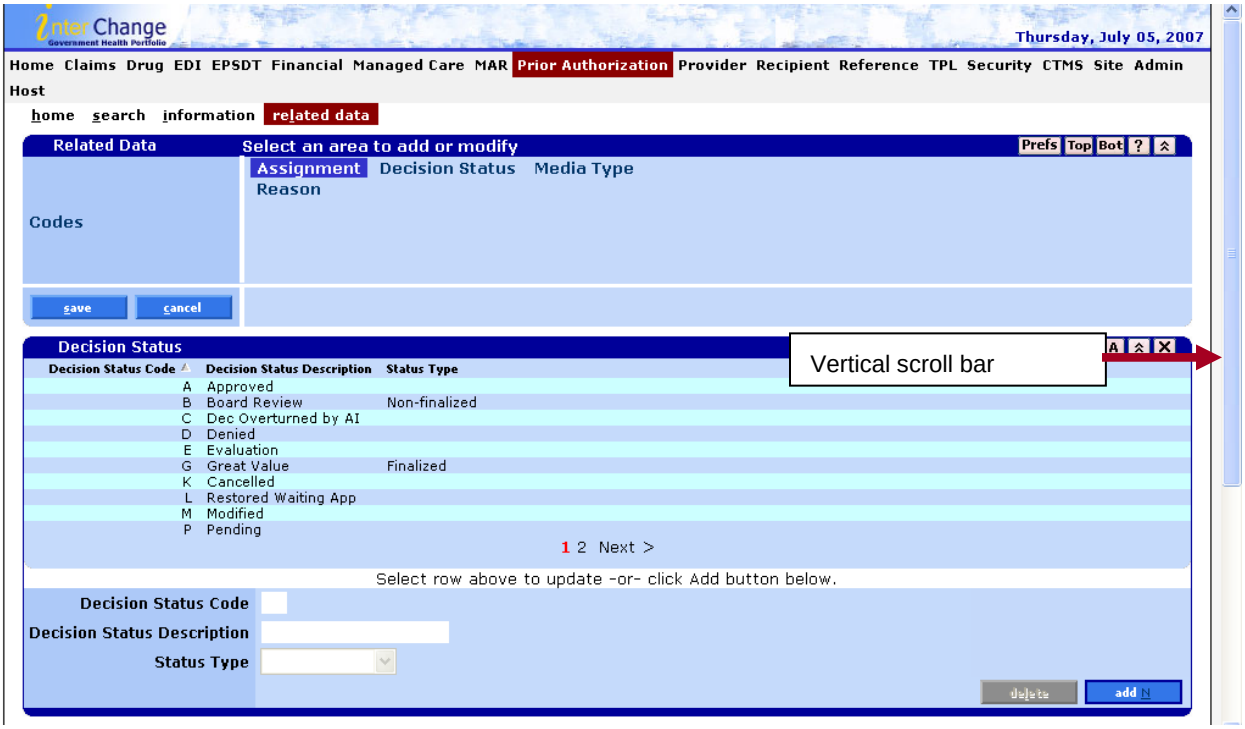
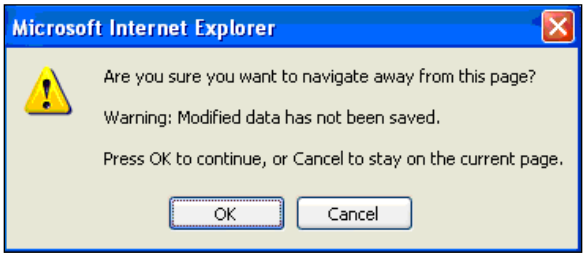
The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

In general, when navigating a page, the vertical scroll bar is the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or canceling the transaction, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



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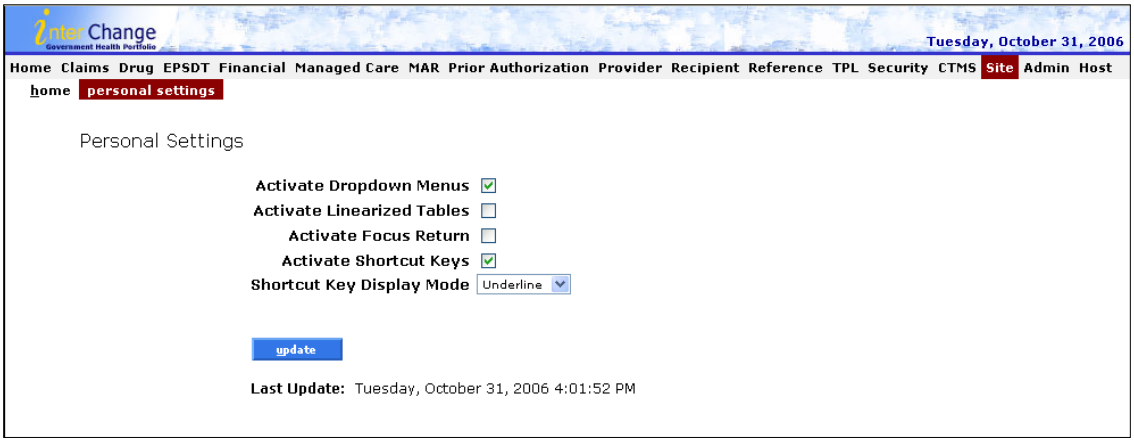
5.2 SHORTCUT KEYS

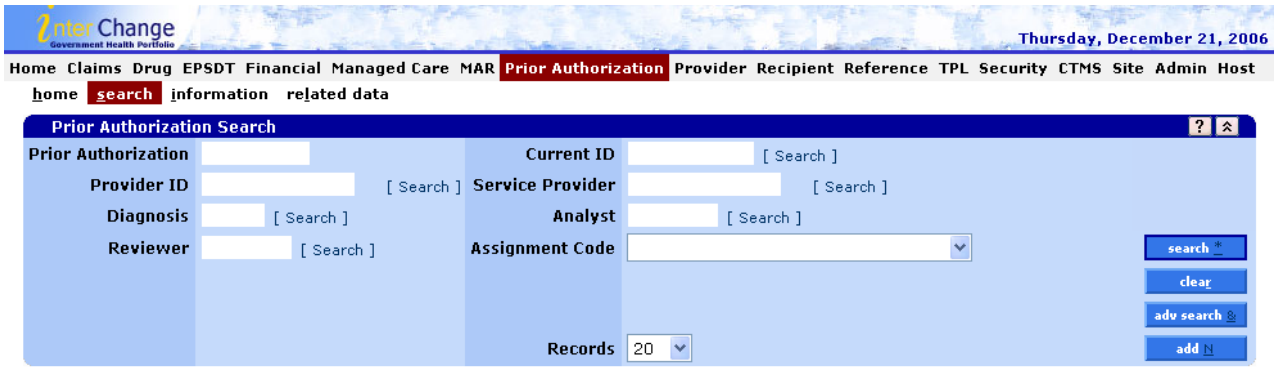
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated page.

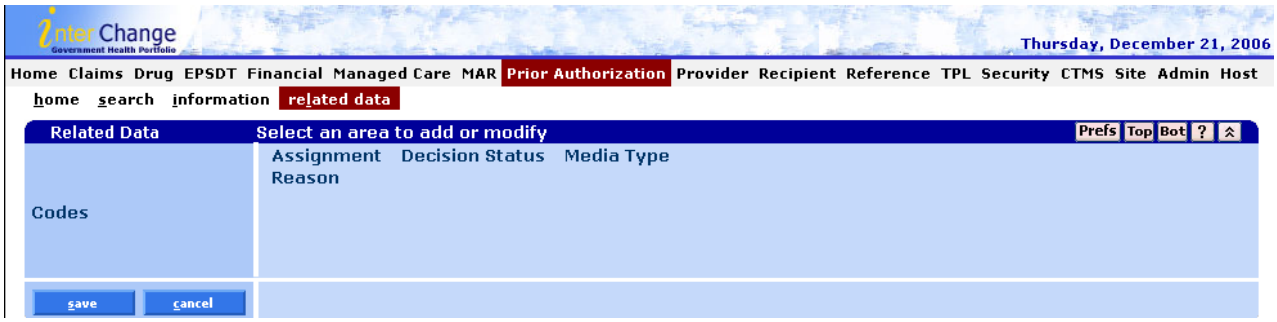
To activate the shortcut key, click on the Site link, Select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the Prior Authorization Sub Menu, the user can use the shortcut keys to quickly navigate from the Prior Authorization Search panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter “L” is found within the horizontal bars on the Sub Menu related data link.





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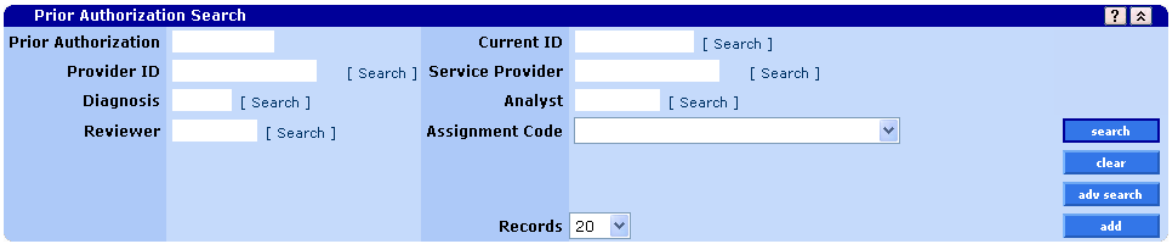
5.3 SEARCH OPTIONS

There are several search options available within AMMIS.

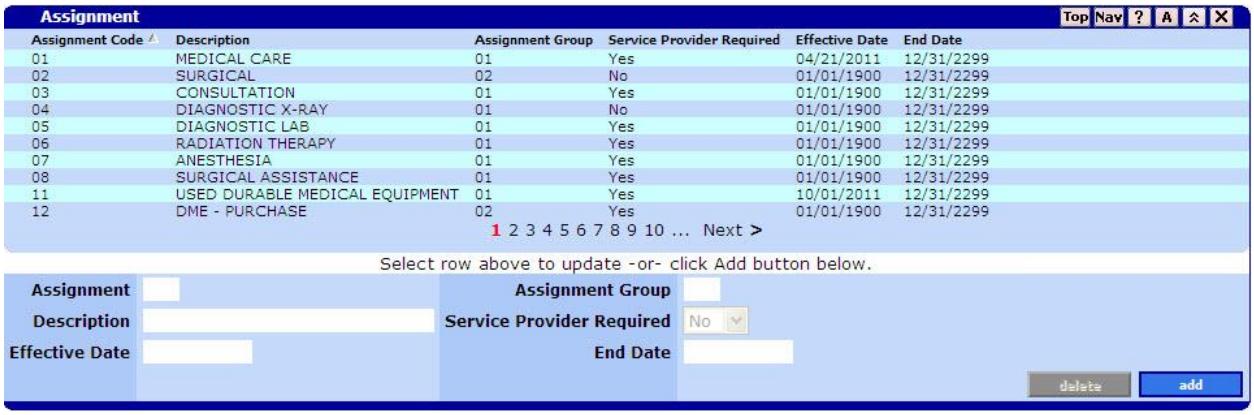
5.3.1 Search Panels

The AMMIS system contains more than one type of search panel: Search and Advanced Search. The Prior Authorization Search panel, as displayed below, contains both a Search button and an Advanced Search button.



5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



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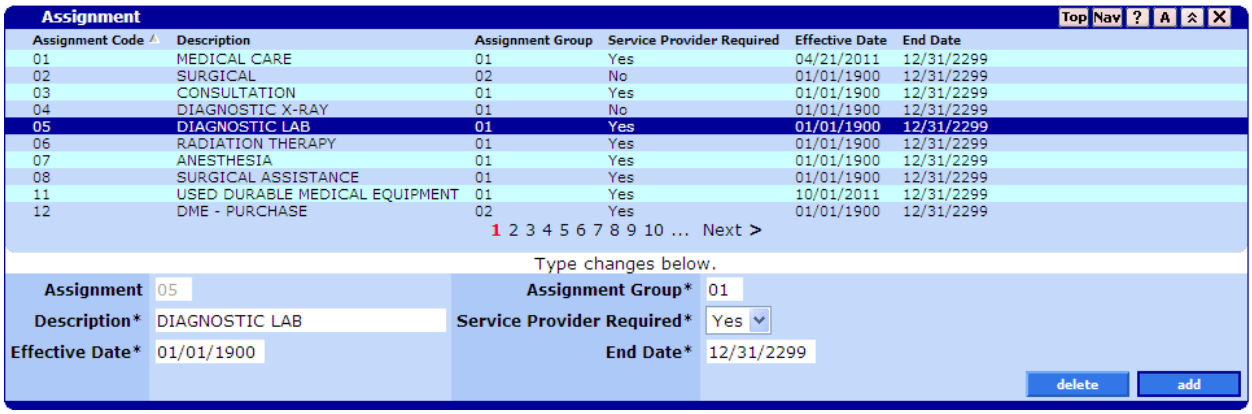
In the following figure, the fifth row of the Assignment panel is selected and detailed information displays at the bottom of the panel.



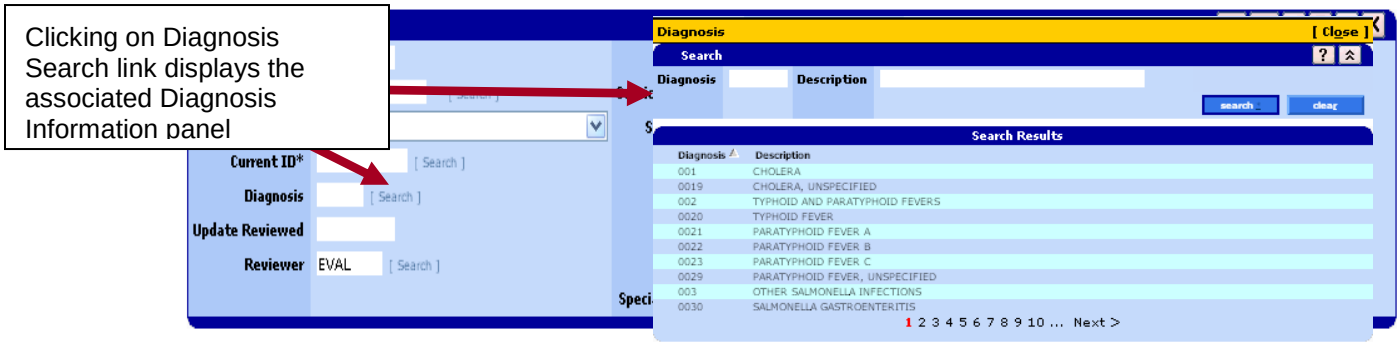
5.3.3 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.

5.3.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.



5.4 PANEL LAYOUT

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

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Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Preferences Button	Prefs	Allows user to place a checkmark next to each navigation panel they would like to see whenever they browse the Prior Authorization subsystem. Click the checkbox a second time to remove the navigation panel as preferred panel to see upon entering the Prior Authorization subsystem. This function can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

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Among the panel types are the following:

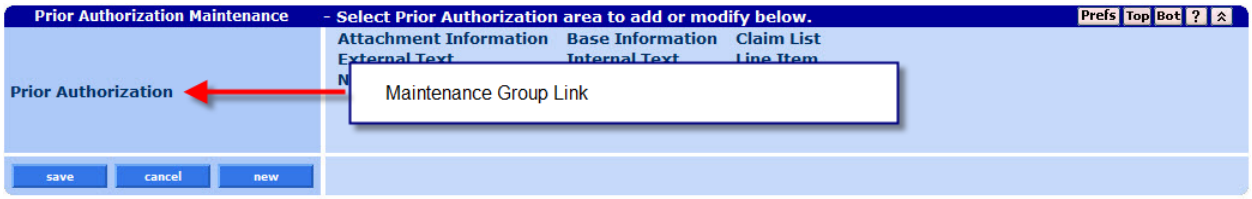
- Maintenance panel
- Task List panel
- Maintenance Item Panel
- Audit panel

5.4.2 Maintenance Panel

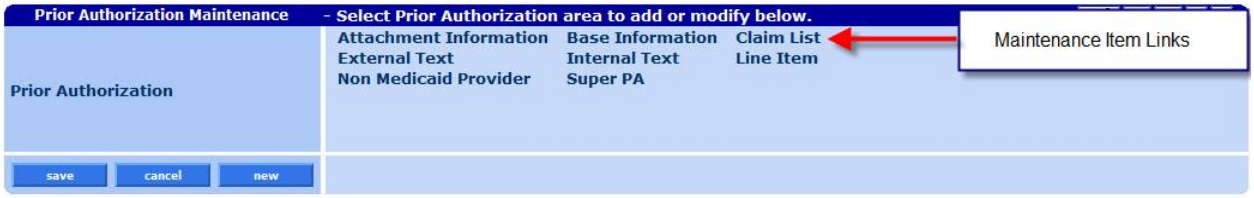
A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page.

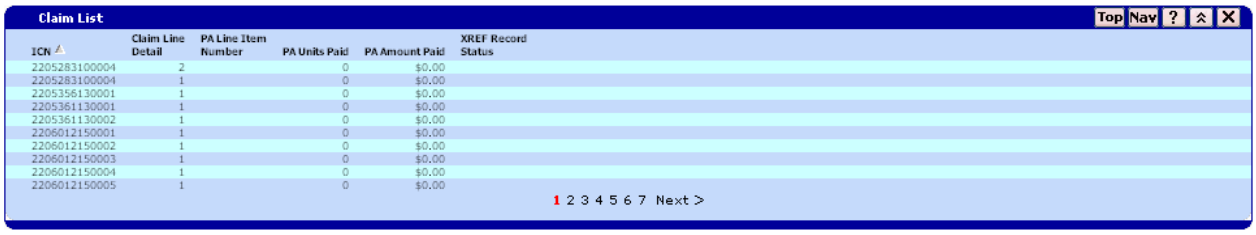
The following image demonstrates Maintenance Group Links (Prior Authorization) and the associated Maintenance Item links.



By clicking on a Maintenance Item Link (such as Claim List), the associated panel opens.



Results: Claim List panel displays



5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

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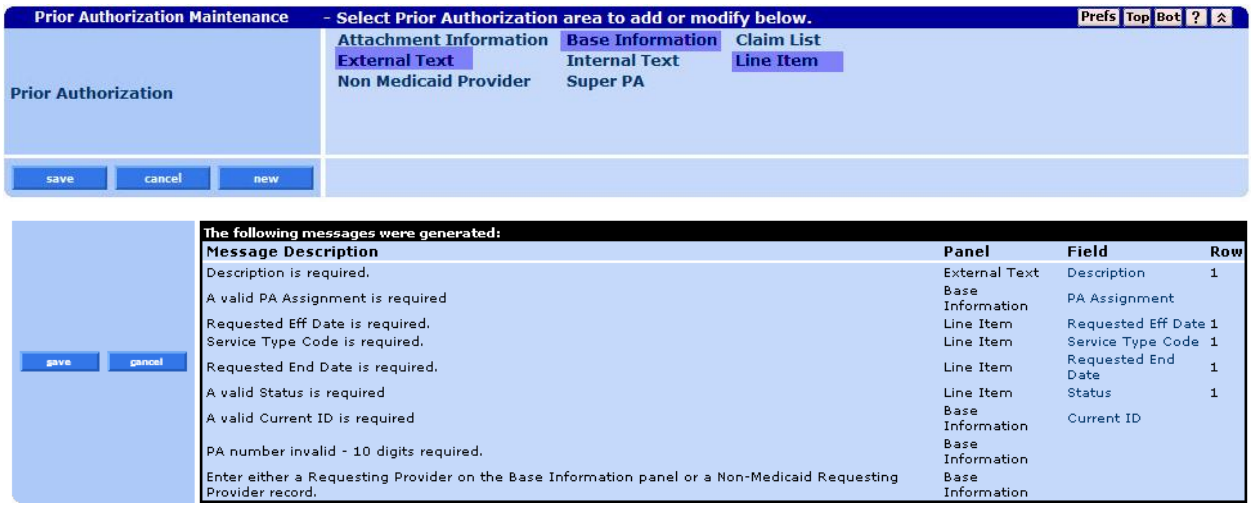


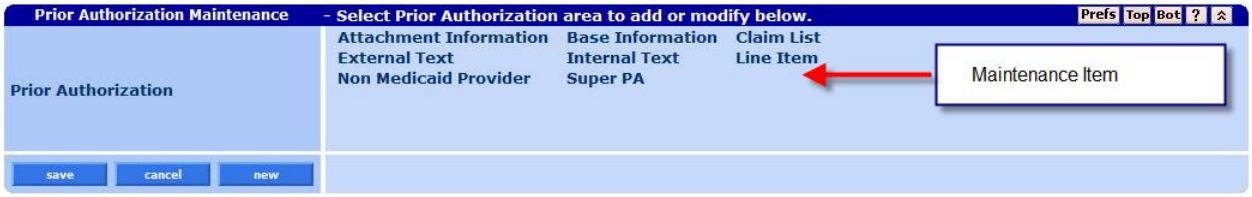
The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

5.4.4 Maintenance Item Panel

A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.4.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.

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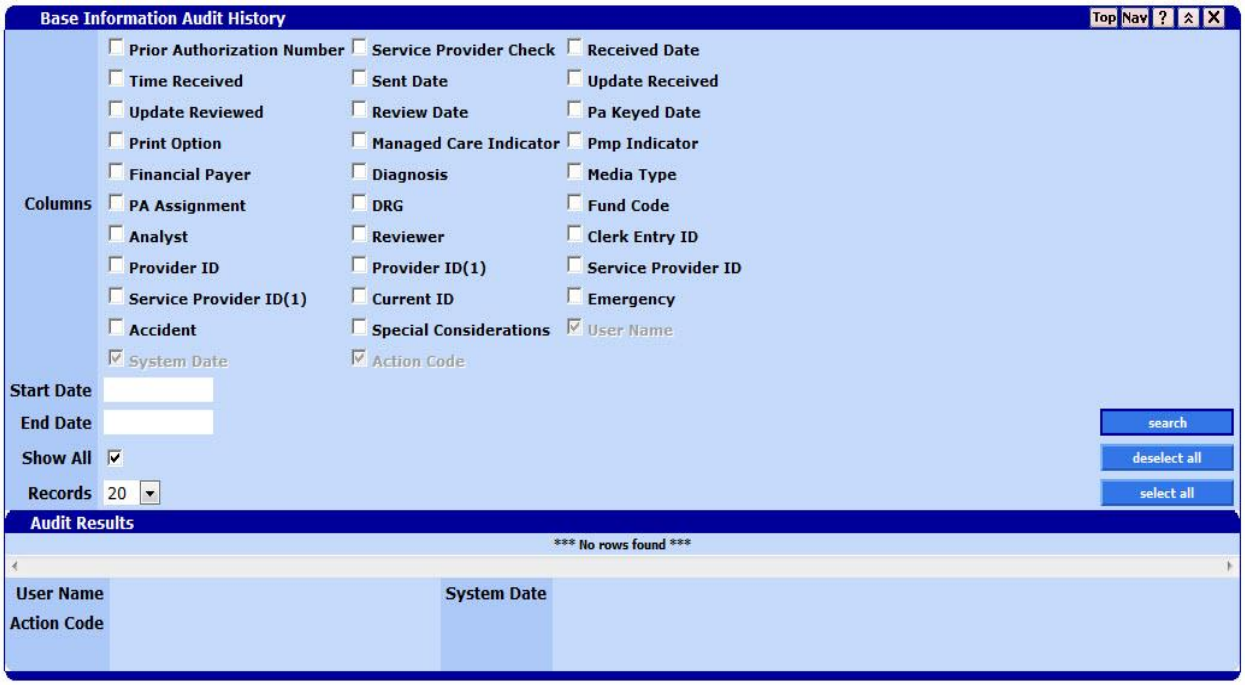


5.5 HELP FUNCTIONALITY

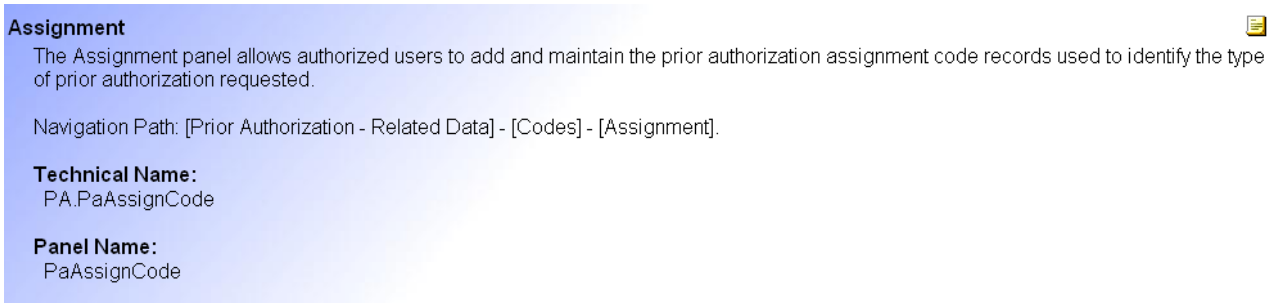
The AMMIS system contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon

The Question Mark icon ? is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



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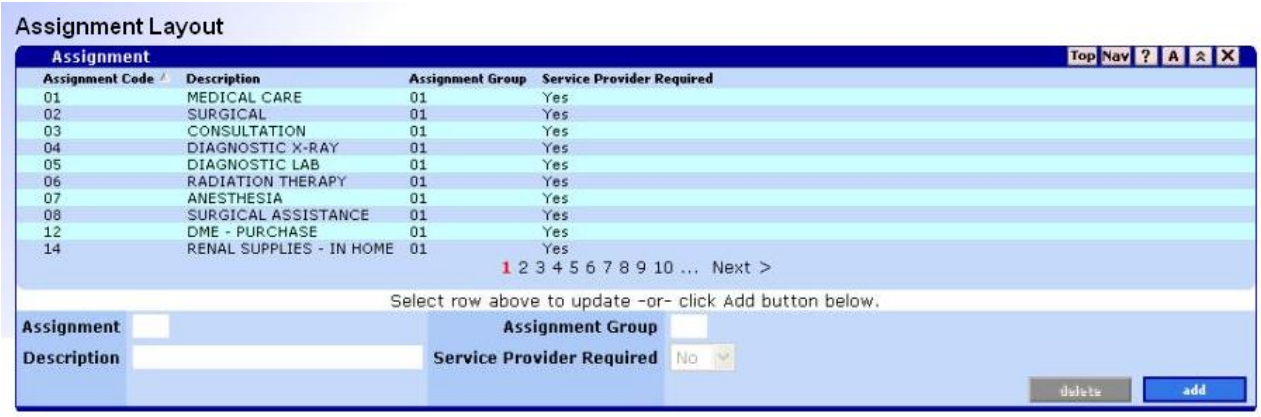
The second item displayed is the **Panel Layout**:



The third item displayed is the **Field Description** information related to the panel:

Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Assignment	The code that identifies the type of PA request. Once the assignment code record has been created, this field becomes disabled and cannot be modified.	Field	Character	2
Assignment Group	The code identifying the higher level grouping of related PA Assignment Codes.	Field	Character	2
Description	The description of the prior authorization assignment code.	Field	Character	30
Service Provider Required	Indicates if a service provider is required on PAs that use this assignment code.	Field	Drop Down List Box	3

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	0	Delete Error: Assignment Code record cannot be deleted - Assignment Code in use.	Record cannot be deleted because the assignment code is currently associated with an existing PA.
Assignment	Field	0	A duplicate record cannot be saved.	Verify and re-type. Assignment code already exists.
	Field	5001	Assignment is required.	Enter a 2-character assignment code.
Assignment Group	Field	5001	Assignment Group is required.	Enter an assignment group code.
	Field	5010	Assignment Group must be Numeric.	Enter a numeric assignment group code.
Description	Field	5001	Description is required.	Enter a text description for the assignment code.

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as,

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Requirements, Test Cases, Change Orders/Defects and any Associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

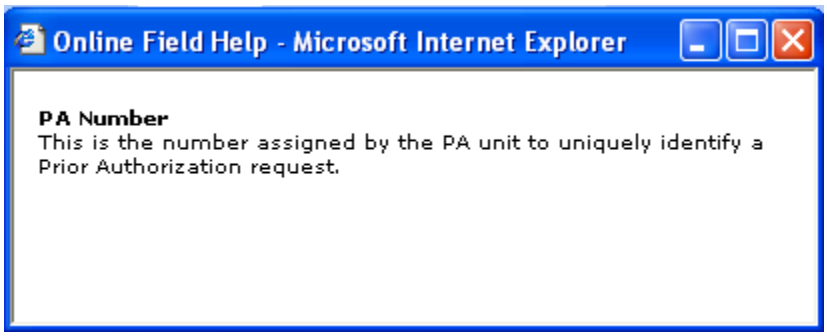
5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

Field Level Help Description

When hovering the cursor over a field name, such as **PA Number**, a question mark appears as part of the cursor.

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6 PRIOR AUTHORIZATION PAGES/PANELS

This section gives a brief description of each page/panel, shows a sample, and describes all associated panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in panel images are fictitious and are not representative of an actual person.

The panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each page or panel covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Codes
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 PRIOR AUTHORIZATION SEARCH PANEL OVERVIEW

6.1.1 Prior Authorization Search Panel Narrative

The Prior Authorization Search panel allows the user to enter search criteria and query for prior authorization requests, which match the search criteria entered.

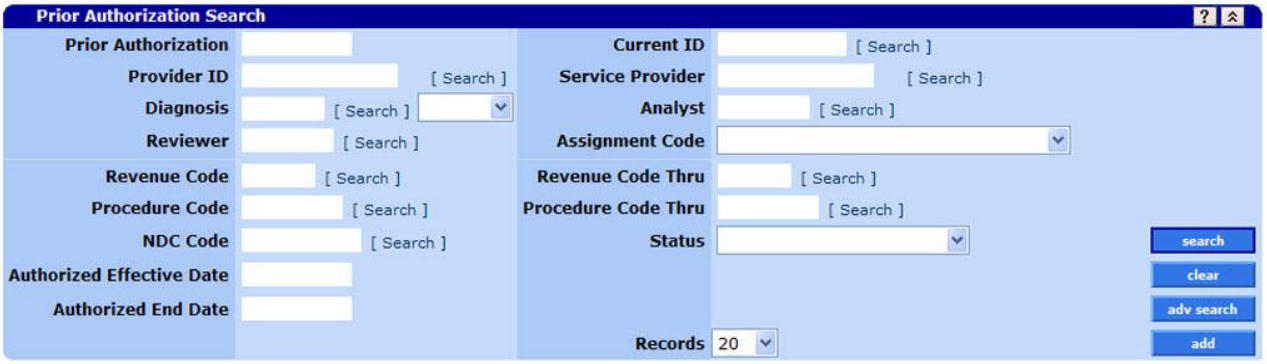
This panel is inquiry only.

Navigation Path: [Prior Authorization] – [Search]

NOTE:

To view the advanced search panel, click the 'Adv Search' button.

6.1.2 Prior Authorization Search Panel Layout



6.1.3 Prior Authorization Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Links the user to the Information page where they are able to enter a new prior authorization.	Button	N/A	0
Adv Search	This button opens an extended search panel that presents additional search options from the standard search panel.	Button	N/A	0
Analyst	The PA analyst that actually entered the PA request.	Field	Character	8
Assignment Code	Code that describes the type of prior authorization. Reference the Assignment panel for valid values.	Combo Box	Drop Down List Box	2
Authorized Effective Date	Prior authorization authorized Effective (start) Date.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Authorized End Date	Prior authorization authorized End Date.	Field	Date (MM/DD/CCYY)	10
Clear	Clears all of the search criteria fields.	Button	N/A	0
Current ID	Recipient Medicaid identification. The system assigned internal key for a unique recipient.	Field	Number (Integer)	12
Diagnosis	A code used to identify the Diagnosis (condition requiring medical attention). Represents a medical classification of a disease or condition according to ICD.	Field	Character	7
ICD Version	This field has no label. It is used to identify which ICD Version of Diagnosis code needs to be used in the search criteria. Valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	0
NDC Code	The National Drug Code used to uniquely identify a drug.	Field	Character	11
Prior Authorization	This is the number assigned by the PA unit to uniquely identify a prior authorization request.	Field	N/A	10
Procedure Code	A code to uniquely identify a procedure.	Field	Character	6
Procedure Code Thru	The procedure code ending the procedure code range.	Field	Character	6
Provider ID	The provider identification number that uniquely identifies the provider. Also referred to as the Requesting or Prescribing provider.	Field	Character	15
Records	Allows the user to select the number of records to display per page.	Combo Box	Drop Down List Box	0
Revenue Code	This identifies a specific accommodation or ancillary service.	Field	Character	4
Revenue Code Thru	The revenue code ending the revenue code range.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
Reviewer	The identification number of the reviewer who reviewed the prior authorization.	Field	Character	8
Search	Initiates the search process.	Button	N/A	0
Service Provider	The provider identification number that uniquely identifies the service provider. Also referred to as the Performing, Rendering or Billing provider.	Field	Character	15
Status	The status of the PA line item.	Combo Box	Drop Down List Box	1

6.1.4 Prior Authorization Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	1	At least one search criterion is required.	Enter at least one search criterion.
ICD Version	Combo Box	2	Diagnosis code required if ICD Version is not blank.	Enter a diagnosis code or select “BLANK” for the ICD Version.

6.1.5 Prior Authorization Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Prior Authorization Search Panel Accessibility

6.1.6.1 To Access the Prior Authorization Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Search**.	Prior Authorization Search panel displays.

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6.2 PRIOR AUTHORIZATION SEARCH RESULTS PANEL OVERVIEW

6.2.1 Prior Authorization Search Results Panel Narrative

This displays the prior authorization Search Results.

This panel is display only.

Navigation Path: [Prior Authorization] – [Search] - [Search]

6.2.2 Prior Authorization Search Results Panel Layout

Search Results

PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Assignment Code	Provider		Service Provider		Service Code	Service Code Thru	Status	Current ID
0102042001	01	05/01/2001	07/31/2001	DME	[redacted]		[redacted]	NPI	E0110		Approved	[redacted]
0102043001	01	01/01/2001	12/31/2001	DME	[redacted]	NPI	[redacted]		E0111		Approved	[redacted]
0102043002	01	07/01/2001	07/31/2001	DME	[redacted]	NPI	[redacted]	NPI	E0110		Approved	[redacted]
0102071010	01	01/01/2001	02/02/2001	DME	[redacted]	NPI	[redacted]	NPI	32851		Approved	[redacted]
0102072008	01	01/17/2001	01/18/2001	DME	[redacted]	NPI	[redacted]	NPI	21260		Approved	[redacted]
0102073019	01	02/02/2001	02/03/2001	DME	[redacted]	NPI	[redacted]	NPI	E1399		Approved	[redacted]
0102073020	01	06/30/2001	06/30/2001	DME	[redacted]	NPI	[redacted]	NPI	21260		Approved	[redacted]
0102086001	01	06/01/2001	06/01/2001	DME	[redacted]	NPI	[redacted]	NPI	E1230		Approved	[redacted]
0102086004	01	01/05/2001	01/05/2001	DME	[redacted]	NPI	[redacted]	NPI	E1230		Approved	[redacted]
0102086004	02	02/05/2001	02/05/2001	DME	[redacted]	NPI	[redacted]	NPI	E1399		Approved	[redacted]
0102087003	06	09/04/2000	09/04/2000	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102087003	08	11/01/2000	11/01/2000	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102087003	04	11/02/2000	11/02/2000	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102087003	07	11/10/2000	11/10/2000	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102087003	01	01/13/2001	01/14/2001	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102087003	05	01/19/2001	01/19/2001	DME	[redacted]	NPI			E1230	W4687	Approved	[redacted]
0102087003	02	02/03/2001	02/03/2001	DME	[redacted]	NPI			E1230		Cancelle	[redacted]
0102087003	03	02/12/2001	02/12/2001	DME	[redacted]	NPI			E1230		Approved	[redacted]
0102098001	01	07/01/2001	07/31/2001	DME	[redacted]	NPI	1000000371	NPI	W0401		Approved	[redacted]
0102099004	01	07/01/2001	07/01/2001	DME	[redacted]	NPI			W0401		Approved	[redacted]

1 2 3 4 5 6 Next >

6.2.3 Prior Authorization Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Assignment Code	The code that describes the type of prior authorization. Reference the Assignment panel for valid values.	Listview	Character	30
Authorized Eff. Date	Prior authorization authorized Effective (start) Date.	Listview	Date (MM/DD/CCYY)	8
Authorized End Date	Prior authorization authorized End Date.	Listview	Date (MM/DD/CCYY)	8
Current ID	The Recipient's Medicaid identification number.	Listview	Number (Integer)	12
Line Item	The sequence number for the services requested. It is used to uniquely identify prior authorization details that have been entered for the same PA.	Listview	Character	1

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Field	Description	Field Type	Data Type	Length
PA Number	This is the number assigned by the PA unit to uniquely identify a prior authorization request.	Listview	Character	10
Provider	The provider identification number that uniquely identifies the provider. Also referred to as the Requesting or Prescribing provider.	Listview	Character	15
Service Code	This represents either the 4-digit Revenue Code, 6-digit Procedure Code or 11-digit NDC associated with the PA line item.	Listview	Character	11
Service Code Thru	The end of the service code range on the line item (if applicable). This includes Healthcare Common procedure Coding System (HCPCS) and Revenue codes.	Listview	Character	6
Service Provider	The provider identification number that uniquely identifies the service provider. Also referred to as the Performing, Rendering or Billing provider.	Listview	Character	15
Status	The status of a PA line item.	Listview	Character	20

6.2.4 Prior Authorization Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Prior Authorization Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.2.6 Prior Authorization Search Results Panel Accessibility

6.2.6.1 To Access the Prior Authorization Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Search**.	Prior Authorization Search panel displays.
3	Enter search criteria and click search on the Prior Authorization Search panel.	Entering search criteria and clicking search allows results to display that are based on the criteria entered.

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6.3 MINI SEARCH PANEL OVERVIEW

6.3.1 Mini Search Panel Narrative

The Mini Search panel provides authorized users with the ability to inquire on a specific existing prior authorization request by entering the Prior Authorization Number. If an exact match is identified and only one line item is associated to the PA, the search returns the user to the PA Information page; otherwise the user is directed to the PA Search page.

This panel is inquiry only.

Navigation Path: [Prior Authorization] – [Information]

6.3.2 Mini Search Panel Layout

6.3.3 Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears all of the search criteria fields.	Button	N/A	0
Prior Authorization	Number assigned by the prior authorization unit to a prior authorization request.	Field	Character	10
Search	Initiates the search process.	Button	N/A	0

6.3.4 Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	0	Prior Authorization not found.	Verify and re-type. There is no PA in history that matches the PA Number entered.

6.3.5 Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Mini Search Panel Accessibility

6.3.6.1 To Access the Mini Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Mini Search panel displays.

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6.4 ATTACHMENT INFORMATION PANEL OVERVIEW

6.4.1 Attachment Information Panel Narrative

The Attachment Information panel provides information from the requester which informs the PA clerk that an attachment is available if requested. This provides the type and description of the attachment, which is indicated by the requester.

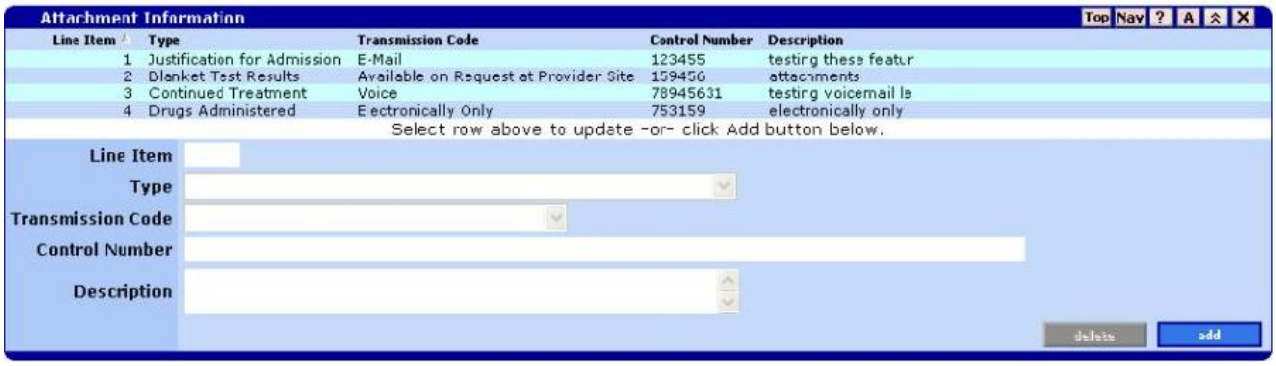
Only users with update authority are allowed to modify this panel.

NOTE:

This panel is for informational purposes only and does not contain actual electronic attachments from the requesting provider.

Navigation Path: [Prior Authorization] – [Information] – [Attachment Information]

6.4.2 Attachment Information Panel Layout



6.4.3 Attachment Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the Add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Control Number	The attachment/paperwork identifier from the requesting provider's internal filing system (e.g. Document Control Number). This allows the requesting provider to more easily locate such documentation based on their internal filing system, if requested by the PA clerk.	Field	Character	80

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Field	Description	Field Type	Data Type	Length
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Description	If needed, additional notes about the attachment/paperwork.	Field	Character	80
Line Item	This is the line number of the PA attachment text entered. It is used to uniquely identify rows of attachment text that may have been entered for the same PA.	Field	Number (Integer)	4
Transmission Code	Code defining timing, transmission method or format of attachment/paperwork.	Combo Box	Drop Down List Box	0
Type	Code describing the type of attachment/paperwork.	Combo Box	Drop Down List Box	0

6.4.4 Attachment Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Transmission Code	Field	2	A valid Transmission Code is required.	Select a valid attachment Transmission Code.
Type	Field	1	A valid Type is required.	Select a valid attachment Type.

6.4.5 Attachment Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Attachment Information Panel Accessibility

6.4.6.1 To Access the Attachment Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Attachment Information** hyperlink on the Prior Authorization Maintenance panel.	Attachment Information panel displays.

6.4.6.2 To Add to the Attachment Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Type** from drop down list box.	
3	Select **Transmission Code** from drop down list box.	
4	Enter **Control Number**.	
5	Enter **Description** of the attachment.	
6	Click **Save**.	Attachment Information is saved.

6.4.6.3 To Update the Attachment Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Attachment Information is saved.

6.4.6.4 To Delete from the Attachment Information Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	‘D’ appears to the left of the line item to be deleted.
3	Click **Save**.	Line item is deleted.

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6.5 CLAIM LIST PANEL OVERVIEW

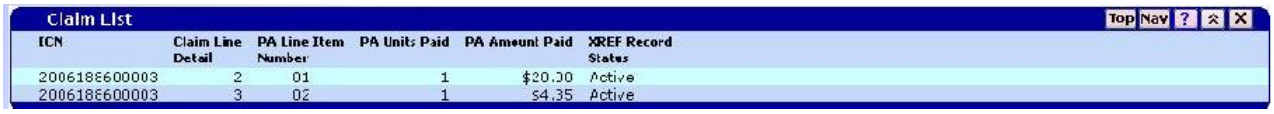
6.5.1 Claim List Panel Narrative

The Claim List panel displays Claim-to-PA cross reference information for claims that used a PA to pay. Clicking on any of the rows displayed within the Claim List panel displays the appropriate claim type.

This panel is display only.

Navigation Path: [Prior Authorization] – [Information] - [Claim List].

6.5.2 Claim List Panel Layout



Claim List

ICN	Claim Line Detail	PA Line Item Number	PA Units Paid	PA Amount Paid	XREF Record Status
2006188600003	2	01	1	$20.30	Active
2006188600003	3	02	1	$4.35	Active

6.5.3 Claim List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Line Detail	The number associated with the selected claim detail.	Field	Number (Integer)	4
ICN	Internal Control Number (ICN) of the claim that is associated with the PA. Hyperlinks back to the claim details for the specified ICN.	Field	Character	13
PA Amount Paid	The up-to-date dollar amount used for a prior authorization line item per the detail line of a claim.	Field	Number (Decimal)	9
PA Line Item Number	Unique identifier for the prior authorization line item on which the claim paid against.	Field	Character	2
PA Units Paid	The up-to-date units used for a prior authorization line item per the detail line of a claim.	Field	Number (Decimal)	15
XREF Record Status	Indicates whether the cross-reference record is active or not. It will become inactive only after an adjustment to the claim is released. Only active rows are used in accumulating prior authorization used amounts and units.	Field	Character	8

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6.5.4 Claim List Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.5.5 Claim List Panel Extra Feature

Field	Field Type
No extra features found for this panel.	

6.5.6 Claim List Panel Accessibility

6.5.6.1 To Access the Claim List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Claim List** hyperlink on the Prior Authorization Maintenance panel.	Claim List panel displays.

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6.6 EXTERNAL TEXT PANEL OVERVIEW

6.6.1 External Text Panel Narrative

The External Text panel provides users with the ability to view, enter and modify external free form notes and comments associated with a prior authorization request. This information is printed on the PA Notice. The PA Unit users are able to enter as many as 540-bytes of text per entry. Multiple external text entries are permitted per PA request.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Prior Authorization] – [Information] - [External Text].

6.6.2 External Text Panel Layout

6.6.3 External Text Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the Add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
External Text Description	The external free form text entered by the user. This information is printed on the PA Notice.	Field	Character	540
External Text Description (row summary)	The first 100 characters of the external free form text comment. This field is display only.	Field	Character	100
External Text Line Number (row summary)	The sequence number of the external free form text record. It is used to uniquely identify external free form text records that may have been entered	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
	for the same PA. The sequence numbering begins at 1. This field is display only, and is populated by the system.			

6.6.4 External Text Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
External Text Description	Field	5001	Description is required.	Enter a free form text comment or click 'Cancel' if external text is not required.

6.6.5 External Text Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 External Text Panel Accessibility

6.6.6.1 To Access the External Text Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **External Text** hyperlink on the Prior Authorization Maintenance panel.	External Text panel displays.

6.6.6.2 To Add to the External Text Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **External Text Description**.	
3	Click **Save**.	External Text information is saved.

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6.6.6.3 To Update the External Text Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in description field.
2	Click in **External Text Description** field to update and perform update.	
3	Click **Save**.	External Text information is saved.

6.6.6.4 To Delete from the External Text Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	'D' appears to the left of the line item to be deleted.
3	Click **Save**.	Line item is deleted.

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6.7 INTERNAL TEXT PANEL OVERVIEW

6.7.1 Internal Text Panel Narrative

The Internal Text panel provides users with the ability to view, enter and modify internal free form notes and comments associated with a prior authorization request. This information is not printed on the PA Notice, or displayed externally. The PA Unit users are able to enter as many as 540-bytes of text per entry. Multiple internal text entries are permitted per PA request.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Prior Authorization] – [Information] - [Internal Text]

6.7.2 Internal Text Panel Layout

6.7.3 Internal Text Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the Add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Date Entered (row summary)	The date the internal text comment was originally added. If the internal text comment is updated at a later date, this date is not updated. This field is display only, and is populated by the system.	Field	Date (MM/DD/CCYY)	8
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Description	The internal free form text entered by the user.	Field	Character	900
Description (row summary)	The first 100 characters of the internal free form text comment. This field is display only.	Field	Character	100
User ID Clerk (row summary)	The identification of the person who entered the internal text comment. This field is display only, and is populated by the system.	Field	Character	8

6.7.4 Internal Text Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	5001	Description is required.	Enter a free form text comment or click 'Cancel' if internal text is not required.

6.7.5 Internal Text Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

6.7.6 Internal Text Panel Accessibility

6.7.6.1 To Access the Internal Text Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Internal Text** hyperlink on the Prior Authorization Maintenance panel.	Internal Text panel displays.

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6.7.6.2 To Add to the Internal Text Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter internal text **Description**.	
3	Click **Save**.	Internal Text information is saved.

6.7.6.3 To Update the Internal Text Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in description field.
2	Click in **Description** field to update and perform update.	
3	Click **Save**.	Internal Text information is saved.

6.7.6.4 To Delete from the Internal Text Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	'D' appears to the left of the line item to be deleted.
3	Click **Save**.	Line item is deleted.

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6.8 LINE ITEM PANEL OVERVIEW

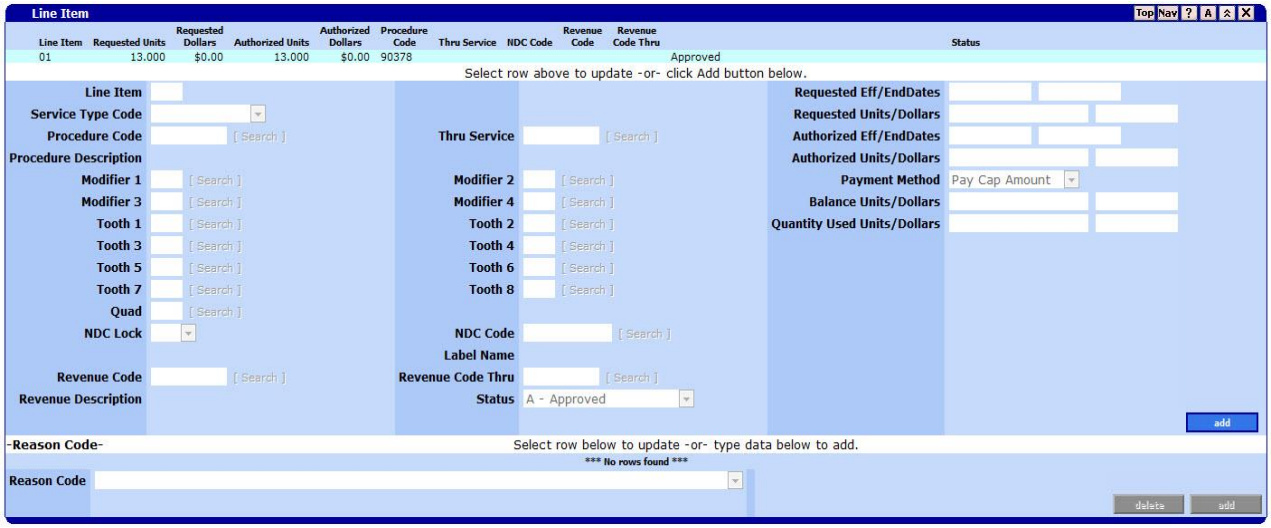
6.8.1 Line Item Panel Narrative

The Line Item panel provides users with the ability to view, enter and modify service detail information on a prior authorization request. Each prior authorization allows up to 99 line items.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Prior Authorization] – [Information] - [Line Item]

6.8.2 Line Item Panel Layout



6.8.3 Line Item Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Authorized Eff/End Dates	Two date fields representing the authorized start and end dates for the PA line item.	Field	Date (MM/DD/CCYY)	8
Authorized Units/Dollars	Two fields representing the authorized units and/or dollars for the PA line item. Units permit a (15,3) data type and dollars permit a (9,2) data type.	Field	Number (Decimal)	15

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Field	Description	Field Type	Data Type	Length
Balance Units/Dollars	Displays the fields representing the amount of units and/or dollars remaining for the PA line item. Units permit a (15,3) data type and dollars permit a (9,2) data type.	Field	Number (Decimal)	15
Delete	Click the Delete button on the panel to delete the selected reason code record. A reason code record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Label Name	A combination of the drug name, the strength description, and the dosage form description.	Field	Character	35
Line Item	The sequence number for the services requested. It is used to uniquely identify prior authorization details that have been entered for the same PA. The sequence numbering begins at 1. This field is display only, and is populated by the system.	Field	Character	2
Modifier 1	A code used in combination with a procedure code to provide additional information regarding the procedure. This field will be disabled if a claim has paid against the line item.	Field	Character	2
Modifier 2	The secondary code used in combination with a procedure code to provide additional information regarding the procedure. This field will be disabled if a claim has paid against the line item.	Field	Character	2
Modifier 3	The tertiary code used in combination with a procedure code to provide additional information regarding the procedure. This field will be	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	disabled if a claim has paid against the line item.			
Modifier 4	The fourth code used in combination with a procedure code to provide additional information regarding the procedure. This field will be disabled if a claim has paid against the line item.	Field	Character	2
NDC Code	The National Drug Code used to uniquely identify a drug.	Field	Character	11
NDC Lock	If a National Drug Code (NDC) is displayed, the prior authorization is locked into the NDC that is listed. If a Generic Code Number (GCN) is displayed, then the authorization is for the GCN sequence number represented by the NDC entered in the service code. If a GC3 is displayed, then the authorization is for the therapeutic class represented by the NDC entered in the service code. This field is hidden unless the service code is an NDC.	Combo Box	Drop Down List Box	0
Payment Method	The method to be used when paying the authorized service. The payment method field is established to set either a system calculated price, a unit fee, or a cap amount. Pay Cap Amount - Allows only Authorized Dollars, no units. Pay Unit Fee - Requires both Authorized Units and Authorized dollars. Pay System Price - Allows only Authorized Units, no dollars.	Combo Box	Drop Down List Box	0
Procedure Code	A code to uniquely identify a procedure.	Field	Character	6
Procedure Description	The description of the Procedure Code for the selected line item	Field	Character	35

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Field	Description	Field Type	Data Type	Length
Quad	A code used to identify the quadrant of the mouth where services are to be performed.	Field	Character	2
Quantity Used Units/Dollars	Displays the fields representing the amount of units and/or dollars used for the PA line item. Units permit a (15,3) data type and dollars permit a (9,2) data type.	Field	Number (Decimal)	15
Reason Code	The code that uniquely identifies a reason code used to document prior authorization decisions.	Combo Box	Drop Down List Box	0
Reason Description	The descriptive text associated with a reason code. This field is display only based on the reason code selected in the Reason Code field. Only a portion of the reason code description is displayed on the Reason Code panel.	Field	Character	500
Requested Eff/End Dates	Two date fields representing the requested start and end dates for the PA line item.	Field	Date (MM/DD/CCYY)	8
Requested Units/Dollars	Two fields representing the requested units and/or dollars for the PA line item. Units permit a (15,3) data type and dollars permit a (9,2) data type.	Field	Number (Decimal)	15
Revenue Code	This identifies a specific accommodation or ancillary service.	Field	Character	3
Revenue Code Thru	The code that identifies a specific accommodation or ancillary service that ends the revenue code range.	Field	Character	3
Revenue Description	The description of the Revenue Code for the selected line item	Field	Character	35
Service Type Code	Identifies if the prior authorization service line is a	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
	procedure, revenue or drug code.			
Status	The status of a PA line item.	Combo Box	Drop Down List Box	0
Thru Service	This is the procedure code ending the procedure code range that is used at the line item level on a PA.	Field	Character	6
Tooth 1	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 2	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 3	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 4	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 5	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 6	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2
Tooth 7	Tooth number used in combination with a procedure code to provide more	Field	Character	2

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Field	Description	Field Type	Data Type	Length
	information concerning the service.			
Tooth 8	Tooth number used in combination with a procedure code to provide more information concerning the service.	Field	Character	2

6.8.4 Line Item Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Authorized Eff/End Dates	Field	0	Authorized dates overlap existing PA for NDC.	Enter valid Authorized Eff/End Dates.
	Field	5015	Authorized Eff Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5115	Authorized End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5501	Invalid date. Format is MM/DD/CCYY.	Verify and re-enter date(s) in valid format.
	Field	5502	Invalid Authorized Effective Date - cannot exclude a paid claim.	Enter valid Authorized Effective Date.
	Field	5503	Invalid Authorized End Date - cannot exclude a paid claim.	Enter valid Authorized End Date.
	Field	1	Assignment Type invalid for Recipient with RCO coverage for PA date of service.	If the PA requested effective date falls within the recipient's active assignment to an RCO, verify PA requested date. If entered incorrectly, re-enter the date. If entered correctly, the PA request should be submitted with the RCO on file.
Authorized Units/Dollars	Field	1	Authorized Dollars must be 0 if 'Pay System Price' is selected as payment method.	Remove Authorized Dollars entry or change payment method selection.
	Field	2	Authorized Units must be present.	Enter value for units. Required if Payment Method is either Pay System Price or Pay Unit

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Field	Field Type	Error Code	Error Message	To Correct
				Fee and Status is Approved.
	Field	3	Authorized Dollars must be present.	Enter dollar amount. Required if Payment Method is either Pay Unit Fee or Pay Cap Amount and Status is Approved.
	Field	4	Authorized Units must be 0 if 'Pay Cap Amount' is selected as payment method.	Enter zero for Authorized Units if Payment Method is Pay Cap Amount.
	Field	5500	Enter a valid value.	Authorized Units and Dollars must be numeric. Verify and re-enter value(s).
Modifier 1	Field	1	Duplicate Modifier on same Line Item.	Remove Duplicate Modifier code on the line item.
	Field	5504	Procedure code and modifier combination invalid, please resubmit with the required modifier for the procedure code.	Enter valid Modifier for this Procedure Code
	Field	1000	Modifier 1 is not found.	Enter a valid Modifier or select one from the search list.
Modifier 2	Field	0	Modifier 2 is not found.	Enter a valid Modifier or select one from the search list.
	Field	2	Duplicate Modifier on same Line Item.	Remove Duplicate Modifier code on the line item.
	Field	5505	Procedure code and modifier combination invalid, please resubmit with the required modifier for the procedure code.	Enter valid Modifier for this Procedure Code
Modifier 3	Field	0	Modifier 3 is not found.	Enter a valid Modifier or select one from the search list.
	Field	2	Duplicate Modifier on same Line Item.	Remove Duplicate Modifier code on the line item.
	Field	5506	Procedure code and modifier combination	Enter valid Modifier for this Procedure Code

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Field	Field Type	Error Code	Error Message	To Correct
			invalid, please resubmit with the required modifier for the procedure code.	
Modifier 4	Field	0	Modifier 4 is not found.	Enter a valid Modifier or select one from the search list.
	Field	2	Duplicate Modifier on same Line Item.	Remove Duplicate Modifier code on the line item.
	Field	5507	Procedure code and modifier combination invalid, please resubmit with the required modifier for the procedure code.	Enter valid Modifier for this Procedure Code
NDC Code	Field	0	NDC Code must be present.	Enter a valid NDC when the Service Type Code selected is NDC Code.
	Field	1	Invalid NDC Code.	Enter a valid NDC or select one from the search list.
NDC Lock	Field	-1	The NDC entered does not have an associated therapeutic class.	Verify the NDC entered or select another value from the drop down list.
	Field	0	The NDC entered does not have an associated generic drug code.	Verify the NDC entered or select another value from the drop down list.
	Field	1	NDC Lock is required when NDC Code is entered.	Select a value from the NDC Lock field.
Procedure Code	Field	0	Procedure Code must be present.	Enter a Procedure Code when the Service Type Code selected is Procedure Code.
	Field	1000	Invalid Procedure Code.	Enter a valid Procedure or select one from the search list.
Quad	Field	1000	Invalid Quadrant Code.	Enter a valid tooth Quadrant or select one from the search list.
Reason Code	Field	1	A reason code must be entered for a status of Denied.	Select a reason code in the range of 300-499 for a status of denied.
	Field	2	Reason Code segments contains duplicates.	Verify keying. The information entered already exists. Cannot

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Field	Field Type	Error Code	Error Message	To Correct
				add a reason code that already exists for the line item.
Requested Eff/End Dates	Field	1	Warning: The Recipient may have TPL coverage for the Authorized Effective Date.	Select Ignore and click continue.
	Field	2	Warning: The Recipient may have Medicare for the Authorized Effective Date.	Select Ignore and click continue.
	Field	3	The Recipient does not have an active eligibility period that covers the Authorized effective date.	Enter the Authorized Effective Date for which the recipient has active eligibility period.
	Field	4	Warning: The Service Provider does not have an active eligibility period that covers the Authorized effective date.	Select ignore and click continue.
	Field	5	Requested Eff Date is required.	Enter a Requested Effective Date.
	Field	6	Requested End Date is required.	Enter a Requested End Date.
	Field	7	Requested Effective Dates invalid for Diagnosis ICD version selected, please correct.	If Diagnosis code has a version as ICD-9 the Required Effective date should be Less than or Equal to the ICD-9 Diagnosis End Date. If Diagnosis code has a version as ICD-10 the Required Effective date should be Greater than or Equal to the ICD-10 Diagnosis Implementation Date.
	Field	5015	Requested End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5115	Requested Eff Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5501	Invalid date. Format is MM/DD/CCYY.	Verify and re-enter date(s) in valid format.
Requested Units/Dollars	Field	1	Either Requested Units or Requested Dollars must be present.	Enter either Requested Units or Requested Dollars.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Requested Units is only allowed to have 3 decimal places.	Enter Requested Units with at least 3 decimal places.
	Field	3	Authorized Units is only allowed to have 3 decimal places.	Enter Authorized Units with at least 3 decimal places.
	Field	4	Requested Units must be less than or equal to 9999999.999.	Enter Requested Units equal to or less than 9,999,999.999.
	Field	5	Authorized Units must be less than or equal to 9999999.999.	Enter Authorized Units equal to or less than 9,999,999.999.
	Field	5500	Enter a valid value.	Requested Units and Dollars must be numeric. Verify and re-enter value(s).
Revenue Code	Field	0	Revenue Code must be present.	Enter a Revenue Code when the Service Type Code selected is Revenue Code.
	Field	1	Invalid Revenue Code.	Enter a valid Revenue code or select one from search list.
Service Type Code	Field	5001	Service Type Code is required.	Select a Service Type Code.
Status	Field	1	Reason Code For Approved Status Must Be Between 100 to 299.	Select a Reason Code between 100 to 299 when the status is approved.
	Field	2	Reason Code For Denied Status Must Be Between 300 to 499.	Select a Reason Code between 300 to 499 when the status is denied.
	Field	5	Reason Code For Pending Status Must Be Between 600 to 699.	Select a Reason Code between 600 to 699 when the status is pending.
	Field	5029	A valid Status is required.	Select a valid Status from the list.
Thru Service	Field	0	Invalid Procedure Code range.	Enter a valid Thru Service or select one from the search list.
Tooth 1	Field	1	Invalid Tooth number.	Enter a valid Tooth or select one from search list.
Tooth 2	Field	1	Invalid Tooth2 number.	Enter a valid Tooth or select one from search list.

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Field	Field Type	Error Code	Error Message	To Correct
Tooth 3	Field	1	Invalid Tooth3 number.	Enter a valid Tooth or select one from search list.
Tooth 4	Field	1	Invalid Tooth4 number.	Enter a valid Tooth or select one from search list.
Tooth 5	Field	1	Invalid Tooth5 number.	Enter a valid Tooth or select one from search list.
Tooth 6	Field	1	Invalid Tooth6 number.	Enter a valid Tooth or select one from search list.
Tooth 7	Field	1	Invalid Tooth7 number.	Enter a valid Tooth or select one from search list.
Tooth 8	Field	1	Invalid Tooth8 number.	Enter a valid Tooth or select one from search list.

6.8.5 Line Item Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Line Item Panel Accessibility

6.8.6.1 To Access the Line Item Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Line Item** hyperlink on the Prior Authorization Maintenance panel.	Line Item panel displays.

6.8.6.2 To Add to the Line Item Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Service Type Code** from drop down list.	Fields not related to the value selected becomes inactive.
3	Enter **Procedure Code**; Or click [search] to select a Procedure Code from the list.	Clicking [search] opens the Procedure Code search panel.

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Step	Action	Response
4	Enter **Modifier 1**; Or click [search] to select a Modifier from the list.	Clicking [search] opens the Modifier 1 search panel.
5	Enter **Modifier 3**; Or click [search] to select a Modifier from the list.	Clicking [search] opens the Modifier 3 search panel.
6	Enter **Tooth 1**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 1 search panel.
7	Enter **Tooth 3**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 3 search panel.
8	Enter **Tooth 5**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 5 search panel.
9	Enter **Tooth 7**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 7 search panel.
10	Enter **Quad**; Or click [search] to select a Tooth Quadrant from the list.	Clicking [search] opens the Quad search panel.
11	Select **NDC Lock** from drop down list.	
12	Enter **Revenue Code**; Or click [search] to select a Revenue Code from the list.	Clicking [search] opens the Revenue Code search panel.
13	Select **Status** from drop down list.	
14	Enter **Thru Service**; Or click [search] to select a Procedure Code from the list.	Clicking [search] opens the Thru Service search panel.
15	Enter **Modifier 2**; Or click [search] to select a Modifier from the list.	Clicking [search] opens the Modifier 2 search panel.
16	Enter **Modifier 4**; Or click [search] to select a Modifier from the list.	Clicking [search] opens the Modifier 4 search panel.
17	Enter **Tooth 2**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 2 search panel.
18	Enter **Tooth 4**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 4 search panel.
19	Enter **Tooth 6**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 6 search panel.
20	Enter **Tooth 8**; Or click [search] to select a Tooth Number from the list.	Clicking [search] opens the Tooth 8 search panel.

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Step	Action	Response
21	Enter **NDC Code**; Or click [search] to select an NDC Code from the list.	Clicking [search] opens the NDC Code search panel.
22	Enter **Revenue Code Thru**; Or click [search] to select a Revenue Code from the list.	Clicking [search] opens the Revenue Code Thru search panel.
23	Enter **Requested Effective Date** in MM/DD/CCYY format.	
24	Enter **Requested End Date** in MM/DD/CCYY format.	
25	Enter **Requested Units**.	
26	Enter **Requested Dollars**.	
27	Enter **Authorized Effective Date** in MM/DD/CCYY format.	
28	Enter **Authorized End Date** in MM/DD/CCYY format.	
29	Enter **Authorized Units**.	
30	Enter **Authorized Dollars**.	
31	Select **Payment Method** from drop down list box.	
32	Click **Add** to add a reason code to the corresponding line item.	Activates fields for entry of data or selection from lists.
33	Select a **Reason Code** from drop down list box.	Reason Code description field is populated.
34	Click **Save**.	Line Item information is saved.

6.8.6.3 To Update the Line Item Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Line Item information is saved.

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6.8.6.4 To Delete from the Line Item Panel

Step	Action	Response
1	Click a reason code line item to be deleted.	Fields are populated with data related to the reason code line selected.
2	Click **Delete**.	'D' appears to the left of the reason code line item to be deleted.
3	Click **Save**.	Reason Code line item is deleted.

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6.9 NON MEDICAID PROVIDER PANEL OVERVIEW

6.9.1 Non Medicaid Provider Panel Narrative

The Non Medicaid Provider panel provides users the ability to view, enter and modify, state license, name and address information for Requesting providers that are not enrolled in the Medicaid program. This allows the PA Unit to contact the requesting provider if there are questions.

Only users with update authority are allowed to modify this panel.

Navigation: [Prior Authorization] – [Information] - [Non Medicaid Provider]

6.9.2 Non Medicaid Provider Panel Layout

6.9.3 Non Medicaid Provider Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Address 1	The primary street address of the Non Medicaid Provider.	Field	Character	30
Address 2	The secondary address of the Non Medicaid Provider.	Field	Character	30
Address Type	This indicates the type of Non Medicaid Provider record. (Read-Only and defaulted to Requesting Provider.)	Combo Box	Drop Down List Box	0
City	Represents the mailing address City for the non-Medicaid provider requesting prior authorization.	Field	Character	15
Delete	Click the Delete button on the panel to delete the selected data record. Prior to saving the delete request, a user must enter a Provider ID on the Base Information panel to track the requesting/prescribing provider. A user	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	must also have the proper permissions to perform a delete.			
License Number	The provider's license number. This field is informational only, and can hold any identifier the PA Unit wishes to capture. The information entered in this field is not validated by the provider system.	Field	Character	10
Phone/Ext	A 10-digit phone number (including area code), and the optional phone extension of the non-Medicaid provider requesting prior authorization.	Field	Character	14
Provider Name	The name of the Non Medicaid provider.	Field	Character	39
State	The State mailing address for the non-Medicaid provider requesting prior authorization.	Combo Box	Drop Down List Box	0
Zip	The Zip Code plus the 4-digit optional Zip Code Extension mailing address for the non-Medicaid provider requesting the prior authorization.	Field	Number (Integer)	9

6.9.4 Non Medicaid Provider Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
License Number	Field	0	License Number is required.	Enter a valid License Number.
Phone/Ext	Field	5018	Enter a valid value.	Enter a 10-digit numeric value.
Provider Name	Field	5001	Provider Name is required.	Enter the provider's name.
Zip	Field	0	Enter a valid value.	Enter a numeric 5-digit zip code.

6.9.5 Non Medicaid Provider Extra Features

Field	Field Type
No extra features found for this panel.	

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6.9.6 Non Medicaid Provider Accessibility

6.9.6.1 To Access the Non Medicaid Provider Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Non Medicaid Provider** hyperlink on the Prior Authorization Maintenance panel.	Non Medicaid Provider panel displays.

6.9.6.2 To Add to the Non Medicaid Provider Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **License Number**.	
3	Enter **Provider Name**.	
4	Enter **Address 1**.	
5	Enter **Address 2**.	
6	Enter **City**.	
7	Select **State** from drop down list box.	
8	Enter **Zip** and Zip+4.	
9	Enter **Phone** number and **Ext**ension.	
10	Click **Save**.	Non Medicaid Provider information is saved.

6.9.6.3 To Update the Non Medicaid Provider Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Non Medicaid Provider information is saved.

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6.9.6.4 To Delete from the Non Medicaid Provider Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	'D' appears to the left of the line item to be deleted.
3	Enter a **Provider ID** also referred to as the Requesting or Prescribing provider; Or click [search] to select a Provider ID from the list on the Base Information panel.	Clicking [search] opens the Provider ID search panel.
4	Click **Save**.	Line item is deleted.

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6.10 SUPER PA PANEL OVERVIEW

6.10.1 Super PA Panel Narrative

The Super PA panel provides authorized users with the ability to view and enter claim error status codes for pharmacy prior authorization requests, allowing pharmacy claims to be overridden during claims processing. This replaces the current usage of the following hard DUR alert codes: Therapeutic Duplicate (TD) and Early Refill (ER).

Only users with update authority are allowed to modify this panel.

In order for an error status code to be overridden during claims processing using Super PA, the following conditions must be true:

- The Super PA must be set up for error code 7003 to override DUR alerts TD or ER.
- Claim type must be Pharmacy.

In addition, the Override Day Supply Edit indicator must be set to "Yes" in Reference for the NDC that is billed on the claim if related to the edit entered on the Super PA panel.

Navigation: [Prior Authorization] – [Information] - [Super PA]

6.10.2 Super PA Panel Layout

6.10.3 Super PA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Date Added [List]	The date the edit was added to the PA.	Field	Date (MM/DD/CCYY)	8
Delete	Click the Delete button on the panel to delete the selected data record. Prior to saving the delete request, a user must enter a Provider ID on the Base Information panel to track the requesting/prescribing provider.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	A user must also have the proper permissions to perform a delete.			
Description [List]	The description of the error status code.	Field	Character	32
Error Code	The error status code that is overridden for this prior authorization.	Field	Number (Integer)	5
Error Code (row summary)	The claims error code that is set up to be overridden by this Super PA. This field is display only.	Field	Number (Integer)	5

6.10.4 Super PA Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Error Code	Field	0	A valid Error Code is required.	Enter a valid claim error code or select one from the search list.
	Field	1	A duplicate record cannot be saved.	Verify and re-type. The error code already exists on the Super PA record.

6.10.5 Super PA Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

6.10.6 Super PA Panel Accessibility

6.10.6.1 To Access the Super PA Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Base Information** hyperlink on the Prior Authorization Maintenance panel.	Base Information panel displays.

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Step	Action	Response
4	Select Pharmacy from the **PA Assignment** field and tab to the next field.	Super PA hyperlink becomes activated.
5	Click **Super PA** hyperlink on the Prior Authorization Maintenance panel.	Super PA panel displays.

6.10.6.2 To Add to the Super PA Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter the **Error Code**; Or click [search] to select an Error Code from the list.	Clicking [search] opens the Error Code search panel.
3	Click **Save**.	Super PA information is saved.

6.10.6.3 To Delete from the Super PA Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	‘D’ appears to the left of the line item to be deleted.
3	Click **Save**.	Line item is deleted.

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6.11 PRIOR AUTHORIZATION INFORMATION PANEL OVERVIEW

6.11.1 Prior Authorization Information Panel Narrative

The Prior Authorization Information panel displays a summary of the prior authorization record.

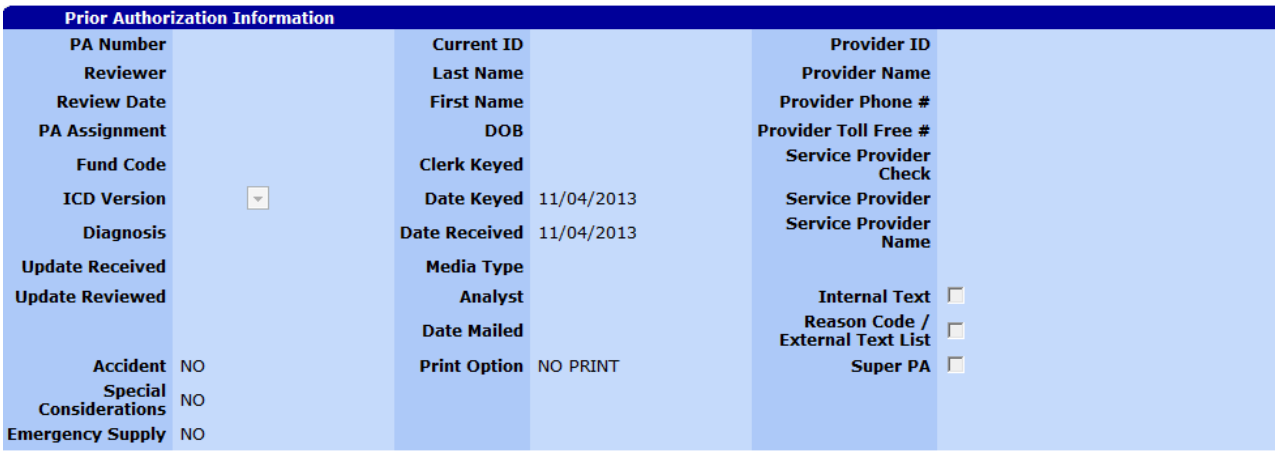
This panel is display only.

Navigation: [Prior Authorization] – [Information]

NOTE:

If navigating directly to the PA Information panel without selecting a PA, the Information Panel defaults to "add" mode.

6.11.2 Prior Authorization Information Panel Layout



6.11.3 Prior Authorization Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident	Indicator signifies if the prior authorization was precipitated by an accident.	Field	Character	1
Analyst	Identification number of the Analyst that entered the prior authorization.	Field	Character	6
Clerk Keyed	Identification number of the clerk who entered the prior authorization.	Field	Character	6
Current ID	The recipient's current Medicaid ID.	Field	Number (Integer)	12

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Field	Description	Field Type	Data Type	Length
Date Keyed	Date the prior authorization was entered.	Field	Date (MM/DD/CCYY)	8
Date Mailed	Date a prior authorization notice was sent to the provider and recipient for either an original PA request or a PA update. Note: A notice is only sent to a recipient if the PA Assignment is Private Duty Nursing or a line item was denied.	Field	Date (MM/DD/CCYY)	8
Date Received	The date the prior authorization was received.	Field	Date (MM/DD/CCYY)	8
Diagnosis	A code used to identify the Diagnosis (condition requiring medical attention). Represents a medical classification of a disease or condition according to ICD.	Field	Character	7
DOB	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	8
Emergency Supply	Indicator used to identify if the authorization is related to an emergency. Valid values include Yes or No.	Field	Character	1
First Name	First name of the recipient.	Field	Character	15
Fund Code	Fund code for the PA.	Field	Number (Integer)	3
ICD Version	This field is read only. It is used to display the ICD Version of Diagnosis code. Valid values are Blank, ICD-9, ICD-10.	Label	N/A	0
Internal Text	Box is checked if there are any internal text items.	Combo Box	Checkbox	0
Last Name	Last name of the recipient.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Media Type	Communication type used to identify how a PA was added to the system.	Field	Character	9
PA Assignment	Code that describes the type of prior authorization. Reference the Assignment panel for valid values.	Field	Character	30
PA Number	Number assigned by the PA unit to uniquely identify a prior authorization request.	Field	Character	10
Print Option	Indicator used to say whether a prior authorization notice is to be mailed to the provider. Saving a PA with the value 'Batch' generates a decision letter printed and mailed by DXC.	Field	Character	1
Provider ID	The provider identification number that uniquely identifies the provider. Also referred to as the Requesting or Prescribing provider.	Field	Character	15
Provider Name	The provider name associated to the Provider ID. Also referred to as the Requesting or Prescribing provider.	Field	Character	35
Provider Phone #	Provider's Phone Number.	Field	Character	10
Provider Toll Free #	Provider's Toll Free Number.	Field	Character	10
Reason Code / External Text List	Box is checked if there are any external text items.	Combo Box	Checkbox	0
Review Date	The date the prior authorization was reviewed.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Reviewer	Identification number of the user who reviewed the prior authorization.	Field	Character	6
Service Provider	The provider identification number that uniquely identifies the service provider. Also referred to as the Performing, Rendering or Billing provider.	Field	Character	15
Service Provider Name	The provider name associated to the Service Provider ID. Also referred to as the Performing, Rendering or Billing provider.	Field	Character	35
Service Provider Check	Indicates the type of provider validation performed on a prior authorization.	Field	Character	30
Special Considerations	Indicator signifies if there are special circumstances surrounding the prior authorization.	Field	Character	1
Super PA	Box is checked if there are any Super prior authorization items.	Combo Box	Checkbox	0
Update Received	Date that the reviewer received a prior authorization update request from the provider.	Field	Date (MM/DD/CCYY)	8
Update Reviewed	Date that the reviewer reviewed a prior authorization system update request sent in by the provider.	Field	Date (MM/DD/CCYY)	8

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6.11.4 Prior Authorization Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.11.5 Prior Authorization Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Prior Authorization Information Panel Accessibility

6.11.6.1 To Access the Prior Authorization Information

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information panel displays.

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6.12 PRIOR AUTHORIZATION MAINTENANCE PANEL OVERVIEW

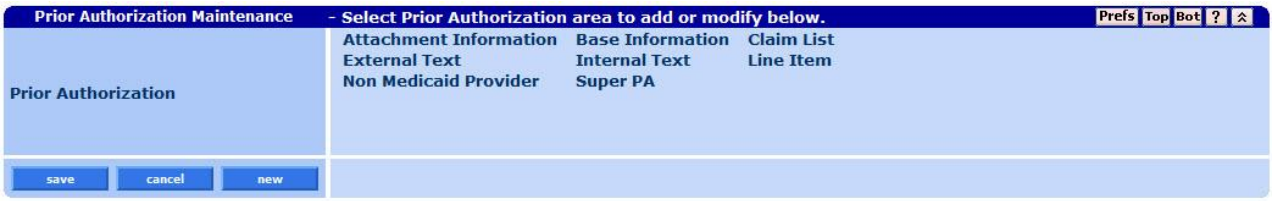
6.12.1 Prior Authorization Maintenance Panel Narrative

The Prior Authorization maintenance panel contains navigation links to information in relation to a prior authorization request.

This panel is inquiry only.

Navigation Path: [Prior Authorization] – [Information]

6.12.2 Prior Authorization Maintenance Panel Layout



6.12.3 Prior Authorization Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Attachment Information	Links to the Attachment Information panel.	Hyperlink	N/A	0
Base Information	Links to the Base Information panel.	Hyperlink	N/A	0
Cancel	Click on the Cancel button to cancel all changes applied to all panels on the page.	Hyperlink	N/A	0
Claim List	Links to the Claim List panel.	Hyperlink	N/A	0
External Text	Links to the External Text panel.	Hyperlink	N/A	0
Internal Text	Links to the Internal text panel.	Hyperlink	N/A	0
Line Item	Links to the Line Item panel.	Hyperlink	N/A	0
New	Links the user to the Information page where they are able to enter a new prior authorization.	Button	N/A	0
Non Medicaid Provider	Links to the Non Medicaid Provider panel.	Hyperlink	N/A	0
Save	Saves the current panel information as it relates to a prior authorization record.	Button	N/A	0
Super PA	Links to the Super PA panel.	Hyperlink	N/A	0

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6.12.4 Prior Authorization Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.12.5 Prior Authorization Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 Prior Authorization Maintenance Panel Accessibility

6.12.6.1 To Access the Prior Authorization Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Maintenance panel displays.

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6.13 BASE INFORMATION PANEL OVERVIEW

6.13.1 Base Information Panel Narrative

The Base Information panel provides users with the ability to view, enter and modify header level information on a prior authorization request.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Prior Authorization] – [Information] - [Base Information]

6.13.2 Base Information Panel Layout

6.13.3 Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident	Indicator specifies if the Prior Authorization request was precipitated by an accident.	Combo Box	Drop Down List Box	0
Attachments	This link opens up PA letters from the FEITH database. Attachments link is enabled only if documents are available.	Hyperlink	N/A	0
Current ID	The Recipient's Medicaid identification number. The Search function is available on this field. This field will be disabled if a claim has paid against this PA.	Field	Character	12
Diagnosis	Code that represents the medical classification of a disease or condition according to ICD-9-CM.	Field	Character	7
Electronic	This link opens up electronic PA information documents from FEITH database. Electronic link is enabled only if documents are available.	Hyperlink	N/A	0
Emergency	This indicator is used to identify the authorization as an emergency 72-hour supply of drugs.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Letter	This link opens up claim related documents from the FEITH database. Letter link is enabled only if documents are available.	Hyperlink	N/A	0
PA Assignment	Code that describes the type of prior authorization. Reference the Assignment panel for valid values.	Combo Box	Drop Down List Box	0
PA Number	This is the number assigned by the PA unit to uniquely identify a Prior Authorization request.	Field	Character	10
Print Option	Indicator used to say whether a prior authorization (PA) notice is to be mailed to the provider. Saving a PA with the value 'Batch' generates a decision letter printed and mailed by DXC.	Combo Box	Drop Down List Box	0
Provider ID	The requesting provider's identification number. The provider ID entered can be either the National Provider Identifier (NPI) or the Medicaid ID (MCD). The Search function is available on this field. When a provider record is selected from the Provider ID search, the providers NPI number is populated back onto the Base Information panel in the Provider ID field. The 3-character provider ID type identifier appears as a hyperlink to the right of the field once a value is entered or selected. Provider ID is also referred to as the Requesting or Prescribing provider.	Field	Character	15
Reviewer	The identification (ID) of the clerk assigned to review the prior authorization.	Field	Character	8
Reconsideration	This link opens up documents from the FEITH database. This link is enabled only if documents are available.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Service Provider Check	The Service Provider Check field is an indicator specifying the type of provider validation required, which is automatically selected based on the following logic. If the PA Assignment equals 02 (Surgical), 'All Service Providers' is selected, which allows claims to adjudicate against the PA regardless if the Billing Provider matches the Service Provider ID. If the PA Assignment does not equal '02', the value is selected based on the type of ID in the Service Provider ID field. NPI = Same NPI Providers, MCD = Specified Service Provider and BSE = Same Base ID Providers.	Combo Box	Drop Down List Box	0
Service Provider ID	The service provider's identification number. The provider ID entered can be either the National Provider Identifier (NPI) or the Medicaid ID (MCD). The Search function is available on this field. When a provider record is selected from the Provider ID search, the providers NPI number is populated back onto the Base Information panel in the Provider ID field. The 3-character provider ID type identifier appears as a hyperlink to the right of the field once a value is entered or selected. If the PA Assignment selected does not require a service provider, this field becomes disabled. This field will be disabled if a claim has paid against the PA. Service Provider is also referred to as the Performing, Rendering or Billing provider.	Field	Character	15
Special Considerations	Indicator specifies if there are any special circumstances surrounding the Prior Authorization.	Combo Box	Drop Down List Box	0
Update Received	Date that the reviewer received a prior authorization update request from the provider.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Update Reviewed	Date that the reviewer reviewed a prior authorization system update request sent in by the provider.	Field	Date (MM/DD/CCYY)	10
(provider ID type identifier)	This is a 3-character code that identifies the provider ID type in the provider ID field to the left. When the user clicks on the code, the Provider ID pop-up panel opens displaying all the provider IDs and types for this provider. The user can select any of these values to populate that ID in the provider ID field.	Hyperlink	N/A	3

6.13.4 Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	5029	A valid Current ID is required.	Enter a valid recipient ID or select one from the search list.
Diagnosis	Field	0	Need valid Diagnosis.	Enter a valid diagnosis code or select one from the search list.
PA Assignment	Field	5	PA Assignment requires a service provider to be entered.	Verify Service Provider ID.
	Field	5029	A valid PA Assignment is required.	Select an assignment from the drop down list.
PA Number	Field	0	PA number region is invalid for assignment code selected.	Enter a valid PA number which is in the range of the Assignment Code selected.
	Field	1	PA Julian Date is invalid.	Enter a PA with valid Julian date in it.
Provider ID	Field	0	Enter either a Requesting Provider on the Base Information panel or a Non-Medicaid Requesting Provider record.	Enter a valid ID for an enrolled provider, or create a Non-Medicaid record.
	Field	1	Need valid Provider ID.	Enter a valid ID for an enrolled provider, or select one from the search list.
Service Provider Check	Field	1	Service Provider ID must be an NPI ID or a MCD ID.	Enter a valid NPI or Medicaid ID and change the Service Provider Check selection accordingly.
	Field	2	At least one Line Item must be added.	Enter at least one Line Item.

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Field	Field Type	Error Code	Error Message	To Correct
Service Provider ID	Field	0	PA Assignment requires a service provider to be entered.	Enter an enrolled provider ID or select one from the search list.
	Field	2	Need valid Service Provider ID.	Enter a valid enrolled provider ID or select one from the search list.
Update Received	Field	1	Update Received Date cannot be greater than today's date.	Enter a date that is less than or equal to Today's date.
	Field	5015	Update Received must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	5501	Invalid Date.	Verify and re-enter date in valid format.
	Field	5502	Update Received [date] must be less than or equal to Update Reviewed [date].	Verify and re-enter Update Received and Update Reviewed dates.
Update Reviewed	Field	1	Update Review Date cannot be less than PA Received Date.	Enter a Review Date that is greater than the PA Received Date.
	Field	2	Update Reviewed Date cannot be greater than today's date.	Enter a Reviewed Date that is less than or equal to the current date.
	Field	5015	Update Reviewed must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	5501	Invalid Date.	Verify and re-enter date in valid format.

6.13.5 Base Information Panel Extra Feature

Field	Field Type
No extra features found for this panel.	

6.13.6 Base Information Panel Accessibility

6.13.6.1 To Access the Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Information**.	Prior Authorization Information page displays.
3	Click **Base Information** hyperlink on the Prior Authorization Maintenance panel.	Base Information panel displays.

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Step	Action	Response
4	Click **Attachments** hyperlink on the Base information panel	Attachment related FEITH document will be displayed.
5	Click **Letter** hyperlink on the Base information panel	Letter related FEITH document will be displayed.
6	Click **Electronic** hyperlink on the Base information panel	Electronic related FEITH document will be displayed.
7	Click **Reconsideration** hyperlink on the Base information panel	FEITH document will be displayed.

6.13.6.2 To Add to the Base Information Panel

Step	Action	Response
1	Enter **PA Number**.	
2	Enter **Provider ID** also referred to as the Requesting or Prescribing provider; Or click [search] to select a Provider ID from the list.	Clicking [search] opens the Provider ID search panel.
3	Select **PA Assignment** from drop down list.	
4	Enter **Current ID**; Or click [search] to select a Current ID from the list.	Clicking [search] opens the Current ID search panel.
5	Enter **Diagnosis**; Or click [search] to select a Diagnosis from the list.	Clicking [search] opens the Diagnosis search panel.
6	Enter **Update Reviewed** in MM/DD/CCYY format.	
7	Enter **Reviewer** ID; Or click [search] to select a Reviewer from the list.	Clicking [search] opens the Reviewer search panel.
8	Select **Service Provider Check** from drop down list.	
9	Enter **Service Provider ID** also referred to as the Performing, Rendering or Billing provider; Or click [search] to select a Service Provider ID from the list.	Clicking [search] opens the Provider ID search panel.
10	Select **Print Option** from drop down list.	
11	Enter **Update Received** in MM/DD/CCYY format.	
12	Select **Emergency** from drop down list.	

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Step	Action	Response
13	Select **Accident** from drop down list.	
14	Select **Special Considerations** from drop down list.	
15	Click **Save**.	Base Information is saved.

6.13.6.3 To Update the Base Information Panel

Step	Action	Response
1	Click in field(s) to update and perform update.	
2	Click **Save**.	Base Information is saved.

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6.14 RELATED DATA PAGE OVERVIEW

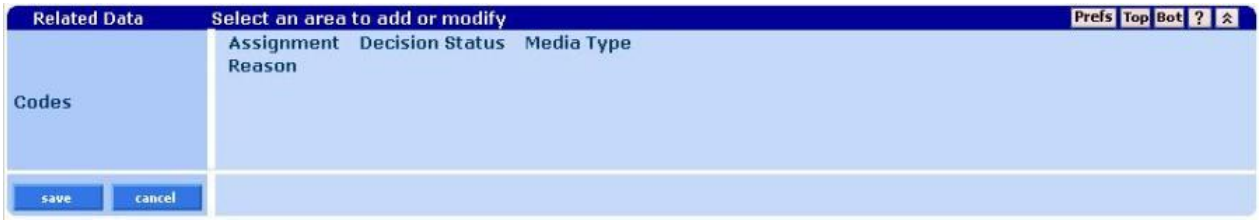
6.14.1 Related Data Page Narrative

The Related Data page contains hyperlinks to the prior authorization code maintenance panels.

This panel is inquiry only.

Navigation: [Prior Authorization] – [Related Data]

6.14.2 Related Data Page Layout



6.14.3 Related Data Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Assignment	Links to the Assignment panel.	Hyperlink	N/A	0
Cancel	Click on the Cancel button to cancel all changes applied to all panels on the page.	Button	N/A	0
Decision Status	Links to the Decision Status panel.	Hyperlink	N/A	0
Media Type	Links to the Media Type panel.	Hyperlink	N/A	0
Reason	Links to the Reason panel.	Hyperlink	N/A	0
Save	Saves the current panel information as it relates to a prior authorization record.	Button	N/A	0

6.14.4 Related Data Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.14.5 Related Data Page Extra Features

Field	Field Type
No extra features found for this page.	

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6.14.6 Related Data Page Accessibility

6.14.6.1 To Access the Related Data Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Related Data**.	Related Data page displays.

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6.15 ASSIGNMENT PANEL OVERVIEW

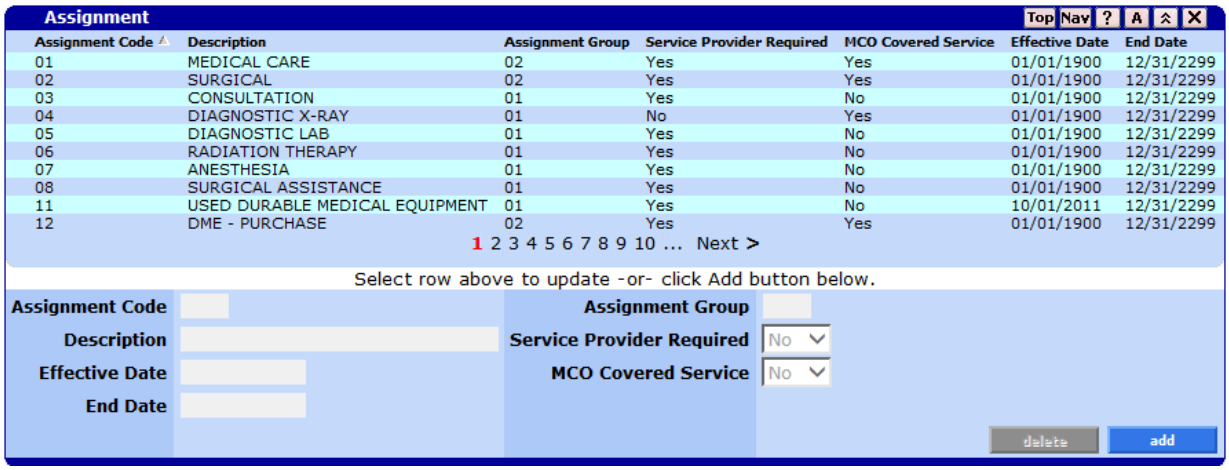
6.15.1 Assignment Panel Narrative

The Assignment panel allows users to add and maintain the prior authorization assignment code records used to identify the type of prior authorization requested.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Prior Authorization] – [Related Data] - [Codes] - [Assignment]

6.15.2 Assignment Panel Layout



6.15.3 Assignment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Assignment Code	The code that identifies the type of PA request. Once the assignment code record has been created, this field becomes disabled and cannot be modified.	Field	Character	2
Assignment Group	The code identifying the higher level grouping of related PA Assignment Codes.	Field	Character	2
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	user must have the proper permissions to perform a delete.			
Description	The description of the prior authorization assignment code.	Field	Character	30
Effective Date	The effective date of the PA assignment code.	Field	Date (MM/DD/CCYY)	8
End Date	The end date of the PA assignment code.	Field	Date (MM/DD/CCYY)	8
MCO Covered Service	Indicates if the PA assignment code is a MCO covered service.	Combo Box	Drop Down List Box	0
Service Provider Required	Indicates if a service provider is required on PAs that use this assignment code.	Combo Box	Drop Down List Box	0

6.15.4 Assignment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Assignment	Field	0	A duplicate record cannot be saved.	Verify and re-type. Assignment code already exists.
	Field	5001	Assignment is required.	Enter a 2-character assignment code.
Assignment Group	Field	5001	Assignment Group is required.	Enter an Assignment Group code.
	Field	5010	Assignment Group must be Numeric.	Enter a numeric Assignment Group code.
Delete	Button	0	Delete Error: Assignment Code record cannot be deleted - Assignment Code in use.	Record cannot be deleted because the assignment code is currently associated with an existing PA.
Description	Field	5001	Description is required.	Enter a text description for the assignment code.
Effective Date	Field	5501	Invalid date. Format is mm/dd/ccyy.	Enter a valid date.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	5501	Invalid date. Format is mm/dd/ccyy.	Enter a valid date.

6.15.5 Assignment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Assignment Panel Accessibility

6.15.6.1 To Access the Assignment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Related Data**.	Related Data panel displays.
3	Click **Assignment** hyperlink on Related Data panel.	Assignment panel displays.

6.15.6.2 To Add to the Assignment Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Assignment** code.	
3	Enter **Description** of the code.	
4	Enter **Assignment Group**.	
5	Select **Service Provider Required** from drop down list.	
6	Select M**CO Covered Service** from drop down list.	
7	Click **Save**.	Assignment information is saved.

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6.15.6.3 To Update the Assignment Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Assignment information is saved.

6.15.6.4 To Delete from the Assignment Code Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.16 DECISION STATUS PANEL OVERVIEW

6.16.1 Decision Status Panel Narrative

The Decision Status panel allows users to add and maintain the prior authorization status code records used to indicate line item status.

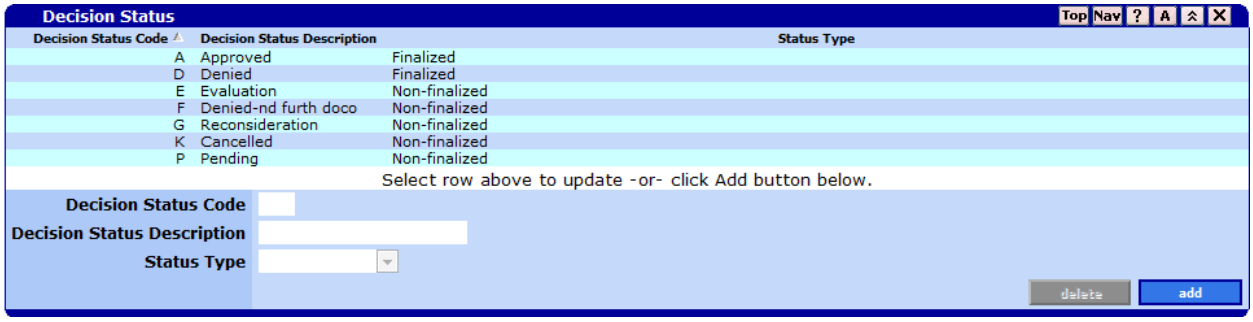
Only users with update authority are allowed to modify this panel.

Decision status codes are hard-coded throughout the prior authorization functional area in order to determine processing logic. Because decision statuses can be added and modified by users, the following is a listing of the PA objects that contain hard-coded status codes:

- Pharmacy Auto PA Module for DUR+ (clmsAutoPa.sc)
- General Claim PA (clmsPaPauth.sc)
- PA Analyst Activity Report (PAU-001A-M)
- PA 30 Days Aging Report (PAU-0002-M)
- PA Monthly Utilization Report (PAU-0008-M)
- PA Monthly Activity Report (PAU-0005-M)
- PA Notices (PAU-0001-D)
- PA Batch editor (paupedit.sc)
- Prior Authorization online application User Interface (panels)

Navigation Path: [Prior Authorization] – [Related Data] - [Codes] - [Decision Status]

6.16.2 Decision Status Panel Layout



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6.16.3 Decision Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Decision Status Code	The code that identifies the line item status.	Field	Character	1
Decision Status Description	The description of the status code.	Field	Character	20
Status Type	Indicates the type of status. Values are Finalized and Non-Finalized.	Combo Box	Drop Down List Box	0

6.16.4 Decision Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	0	Delete Error: Decision Status Code record cannot be deleted - Status Code in use.	Record cannot be deleted because the status code is currently associated with an existing PA line item.
Decision Status Code	Field	5001	Decision Status Code is required.	Enter a status code value.
	Field	5111	Delete Error: Decision Status Code record cannot be deleted - Status Code in use.	Do not try to delete Decision Status codes that are being used by a PA line item.
	Field	5200	A duplicate record cannot be saved.	Verify and re-type. Status code already exists.
Decision Status Description	Field	5001	Decision Status Description is required.	Enter a text description for the status code.

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Field	Field Type	Error Code	Error Message	To Correct
Status Type	Field	0	Status Type is required.	Select a value from the drop down list.

6.16.5 Decision Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Decision Status Panel Accessibility

6.16.6.1 To Access the Decision Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Related Data**.	Related Data panel displays.
3	Click **Decision Status** hyperlink on Related Data panel.	Decision Status panel displays.

6.16.6.2 To Add to the Decision Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Decision Status Code**.	
3	Enter **Decision Status Description**.	
4	Select **Status Type** from drop down list.	
5	Click **Save**.	Decision Status information is saved.

6.16.6.3 To Update the Decision Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Decision Status information is saved.

6.16.6.4 To Delete from the Decision Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.17 MEDIA TYPE PANEL OVERVIEW

6.17.1 Media Type Panel Narrative

The Media Type panel allows users to add and maintain the prior authorization media type records used to indicate how the PA request entered the system, or how the PA request was received by the PA Unit.

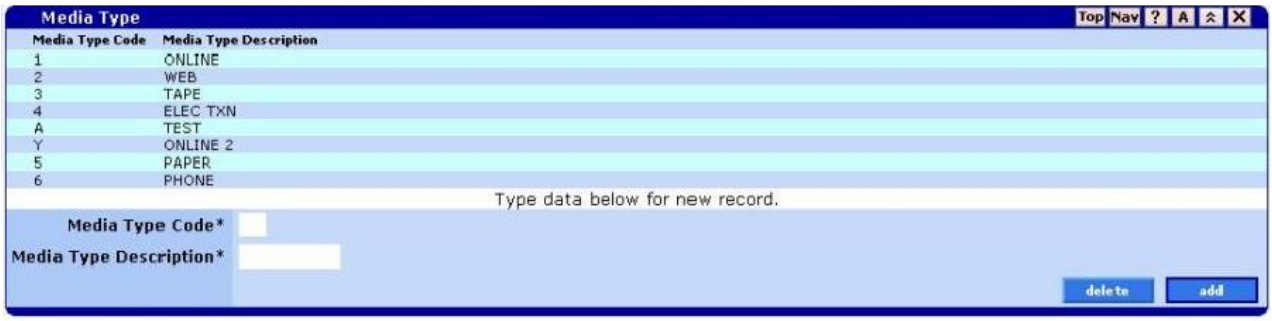
Only users with update authority are allowed to modify this panel.

Because Media Type codes can be added and modified by users, the following is a listing of the PA objects that contain hard-coded media type codes:

- PA Electronic Activity Report (PAU-002A-D)
- Prior Authorization online application User Interface (panels)
- PA Batch editor (paupedit.sc)

Navigation: [Prior Authorization] – [Related Data] - [Codes] - [Media Type]

6.17.2 Media Type Panel Layout



6.17.3 Media Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Media Type Code	The code that identifies the PA submission method.	Field	Character	1
Media Type Description	The description of the media type code.	Field	Character	9

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6.17.4 Media Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	0	Delete Error: Media Type is associated with a PA. Cannot delete.	Record cannot be deleted because the media type code is currently associated with an existing PA.
Media Type Code	Field	5001	Media Type Code is required.	Enter a media type code.
	Field	5200	A duplicate record cannot be saved.	Verify and re-type. Media type code already exists.
Media Type Description	Field	6001	Media Type Description is required.	Enter a text description of the media type code.

6.17.5 Media Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 Media Type Panel Accessibility

6.17.6.1 To Access the Media Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Related Data**.	Related Data panel displays.
3	Click **Media Type** hyperlink on Related Data panel.	Media Type panel displays.

6.17.6.2 To Add to the Media Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Media Type Code**.	
3	Enter **Media Type Description**.	

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Step	Action	Response
4	Click **Save**.	Media Type information is saved.

6.17.6.3 To Update the Media Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Media Type information is saved.

6.17.6.4 To Delete from the Media Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.18 REASON PANEL OVERVIEW

6.18.1 Reason Panel Narrative

The Reason panel allows users to add and maintain the prior authorization reason code records used to document decisions on PA line items.

Only users with update authority are allowed to modify this panel.

Navigation: [Prior Authorization] – [Related Data] - [Codes] – [Reason]

6.18.2 Reason Panel Layout

6.18.3 Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Click on the add button on the panel to insert a new data record. A user must have proper permission to perform an add.	Button	N/A	0
Delete	Click the Delete button on the panel to delete the selected data record. A data record from the list must be selected before a user can perform a delete. A user must have the proper permissions to perform a delete.	Button	N/A	0
Reason Code	The code that uniquely identifies a reason code used to document prior authorization decisions.	Field	Character	25
Reason Code Description	The description of the reason code.	Field	Character	500

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6.18.4 Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Delete Error: Reason Code record cannot be deleted - Reason Code in use.	Record cannot be deleted because the Reason Code is currently associated with an existing PA.
Reason Code	Field	5001	Reason is required.	Reason cannot be empty. Enter a valid Reason code.
	Field	5200	A duplicate record cannot be saved.	Verify and re-type. Reason code already exists.
Reason Code Description	Field	5001	Reason Code Description is required.	Description cannot be empty. Enter a description for this reason code.

6.18.5 Reason Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

6.18.6 Reason Panel Accessibility

6.18.6.1 To Access the Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Prior Authorization** and click **Related Data**.	Related Data panel displays.
3	Click **Reason** hyperlink on Related Data panel.	Reason panel displays.

6.18.6.2 To Add to the Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Enter **Reason Code**.	
3	Enter **Reason Code Description**.	
4	Click **Save**.	Reason information is saved.

6.18.6.3 To Delete from the Reason Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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7 PRIOR AUTHORIZATION REPORTS

The Prior Authorization User Manual provides the following information for each report:

- Narrative: Provides a brief description of the report functionality and usage.
- Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.
- Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 PAU-0002-D – PRIOR AUTHORIZATION 30 DAYS AGING REPORT

7.1.1 PAU-0002-D – Prior Authorization 30 Days Aging Report Narrative

The Prior Authorization 30 Days Aging Report (PAU-0002-D) displays all prior authorizations (PAs) that are older than 30 days and have not been worked. This report is used by the PA Unit in order to determine what PAs must be worked in order to meet timeliness deadlines. This report is sorted by Assignment Code, and within Assignment Code the records are sorted by PA number and grouped by Review Clerk.

This report selects all PA records where the status on any line item is E (evaluation) and where the Date Received is older than 30 days from the current date.

This report is generated daily.

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7.1.2 PAU-0002-D – Prior Authorization 30 Days Aging Layout

```
Report  : PAU-0002-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYCC
Process : PAUJD002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PAUPD002                    PRIOR AUTHORIZATION 30 DAYS AGING REPORT                             Page:       9999

ASSIGNMENT CODE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
REVIEW         PA       SERVICE   LINE RECIPIENT                     RECIPIENT   PROVIDER  PROVIDER                          DAYS
CLERK        NUMBER      CODE     ITEM   NAME                         NUMBER      NUMBER    NAME                              AGED
-------------------------------------------------------------------------------------------------------------------------------

XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999
XXXXXXXX  9999999999 XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX 999999999999 999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX 9999

TOTAL PRIOR AUTHORIZATIONS AGED GREATER THAN 30 DAYS:    999999

                                                        ***END OF REPORT***
                                                         **NO DATA THIS REPORT**
```


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7.1.3 PAU-0002-D -- Prior Authorization 30 Days Aging Field Descriptions

Field	Description	Data Type	Length
Assignment Code	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
Days Aged	Number of days that the prior authorization has aged.	Number (Integer)	4
Line Item	Unique identifier for prior authorization line item.	Character	1
PA Number	Unique ten-digit prior authorization number.	Number (Integer)	10
Provider Name	Full name of the provider.	Character	35
Provider Number	A unique number identifying the requesting provider.	Number (Integer)	10
Recipient Name	Last name and first name of the recipient.	Character	28
Recipient Number	The Recipient's Medicaid identification number.	Number (Integer)	12
Review Clerk	User ID assigned to review the authorization.	Character	8
Service Code	The unique service code across all of the line items for the Assignment Code. This includes HCPCS, NDC and Revenue codes. If the service code is a HCPCS procedure, and modifiers are requested on the line item, the modifiers are linked with the service code on the report.	Character	14
Total Prior Authorizations Aged Greater Than 30 Days	Total number of prior authorizations aged greater than 30 days.	Number (Integer)	6

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7.2 PAU-0003-D – PRIOR AUTHORIZATION QUALITY REVIEW REPORT - MEDICAID

7.2.1 PAU-0003-D – Prior Authorization Quality Review Report - Medicaid Narrative

The Prior Authorization Quality Review Report – Medicaid (PAU-0003-D) displays all new prior authorization (PA) line items received or any PA line items whose status has changed since the last run of the report. It displays only those PA line items with a status of A (approved), D (denied), or E (evaluation), and only those line items with a service type of revenue code or procedure code. This report is used by the PA medical and quality review services contractor. It is sorted by PA number and PA line item.

This report includes or excludes certain ranges of procedure codes and revenue codes. The procedure codes and revenue codes to be included or excluded are contained in database tables that can be updated if the ranges of procedure codes and revenue codes change. The report excludes PAs when the recipient has an identified CHIP Aid Category (5E, 5F, EK and EY) or ACA Aid Category (75, 76, 77, 78, 79, 7Q, 86, 3L, 3M, PC, PW, PP, and PB).

This report is generated daily.

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7.2.2 PAU-0003-D – Prior Authorization Quality Review Report – Medicaid Layout

```
Report  : PAU-0003-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJD003                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: PAUPD003                 PRIOR AUTHORIZATION QUALITY REVIEW REPORT - MEDICAID                Page:           9999

-------------------------------------------------------------------------------------------------------------------------------
PA NUMBER     LINE ITEM      PROC/REV CODE      STATUS      ANALYST      RECIPIENT ID      REQ PROV ID        SVC PROV ID
      REQ/AUTH         REQ/AUTH                       REQ UNITS            REQ AMT            AUTH UNITS            AUTH AMT
      EFF DATE         END DATE
-------------------------------------------------------------------------------------------------------------------------------

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX
      MM/DD/CCYY       MM/DD/CCYY             999999999999.999         9999999.99      999999999999.999          9999999.99

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX
      MM/DD/CCYY       MM/DD/CCYY             999999999999.999         9999999.99      999999999999.999          9999999.99

                                                        ****END OF REPORT
                                                    *** NO DATA THIS RUN***
```

7.2.3 PAU-0003-D -- Prior Authorization Quality Review Report – Medicaid Field Descriptions

Field	Description	Data Type	Length
Analyst	User ID assigned to review the authorization.	Character	8
Auth Units	The number of units authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	16
AuthAmt	The dollar amount authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	10
Line Item	Unique identifier for prior authorization line item.	Character	2
PA Number	Unique ten-digit prior authorization number.	Number (Integer)	10
Proc / Rev Code	Depending on the type of service code for the PA line item, this is either the procedure code used to identify the medical, dental or DME procedure, or the revenue code identifying the specific accommodation or ancillary service.	Character	5

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Field	Description	Data Type	Length
Recipient ID	The recipient's Medicaid identification number.	Number (Integer)	12
Req / Auth Eff Date	For PA line items with a status of A (Approved), this is the authorized start date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested start date for the line item.	Character	10
Req / Auth End Date	For PA line items with a status of A (Approved), this is the authorized end date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested end date for the line item.	Character	10
Req Amt	The dollar amount requested for the line item service.	Number (Decimal)	10
Req Prov ID	A unique number identifying the requesting provider.	Character	15
Req Units	The number of units requested for the line item service.	Number (Decimal)	16
Status	This represents the decision status of the PA line item.	Character	1
Svc Prov ID	A unique number identifying the servicing provider.	Character	15

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7.3 PAU-003A-D – PRIOR AUTHORIZATION QUALITY REVIEW REPORT - CHIP

7.3.1 PAU-003A-D – Prior Authorization Quality Review Report - CHIP Narrative

The Prior Authorization Quality Review Report - CHIP (PAU-003A-D) displays all new prior authorization (PA) line items received or any PA line items whose status has changed since the last run of the report. It displays only those PA line items with a status of A (approved), D (denied), or E (evaluation), and only those line items with a service type of revenue code or procedure code. This report is used by the PA medical and quality review services contractor. It is sorted by PA number and PA line item.

This report includes or excludes certain ranges of procedure codes and revenue codes. The procedure codes and revenue codes to be included or excluded are contained in database tables that can be updated if the ranges of procedure codes and revenue codes change. The report only includes PAs when the recipient has an identified CHIP Aid Category (5E, 5F, EK and EY).

This report is generated daily.

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7.3.2 PAU-003A-D – Prior Authorization Quality Review Report - CHIP Layout

```
Report  : PAU-003A-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PAUJD003                             MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: PAUPD003                        PRIOR AUTHORIZATION QUALITY REVIEW REPORT - CHIP                 Page:          9999

-------------------------------------------------------------------------------------------------------------------------------------
PA NUMBER     LINE ITEM      PROC/REV CODE      STATUS      ANALYST      RECIPIENT ID      REQ PROV ID        SVC PROV ID
       REQ/AUTH         REQ/AUTH                       REQ UNITS           REQ AMT           AUTH UNITS            AUTH AMT
       EFF DATE         END DATE
-------------------------------------------------------------------------------------------------------------------------------------

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX
       MM/DD/CCYY       MM/DD/CCYY              999999999999.999         9999999.99      999999999999.999          9999999.99

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX
       MM/DD/CCYY       MM/DD/CCYY              999999999999.999         9999999.99      999999999999.999          9999999.99

                                                  ***   END OF REPORT   ***
                                                   **  NO DATA THIS RUN **
```


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7.3.3 PAU-0030A-D -- Prior Authorization Quality Review Report – CHIP Field Descriptions

Field	Description	Data Type	Length
Analyst	User ID assigned to review the authorization.	Character	8
Auth Amt	The dollar amount authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	10
Auth Units	The number of units authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	16
Line Item	Unique identifier for prior authorization line item.	Character	2
PA Number	Unique ten-digit prior authorization number.	Number (Integer)	10
Proc / Rev Code	Depending on the type of service code for the PA line item, this is either the procedure code used to identify the medical, dental or DME procedure, or the revenue code identifying the specific accommodation or ancillary service.	Character	5
Recipient ID	The recipient's Medicaid identification number.	Number (Integer)	12
Req / Auth Eff Date	For PA line items with a status of A (Approved), this is the authorized start date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested start date for the line item.	Character	10
Req / Auth End Date	For PA line items with a status of A (Approved), this is the authorized end date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested end date for the line item.	Character	10
Req Amount	The dollar amount requested for the line item service.	Number (Decimal)	10
Req Units	The number of units requested for the line item service.	Number (Decimal)	16
ReqProv ID	A unique number identifying the requesting provider.	Character	15
Status	This represents the decision status of the PA line item.	Character	1

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Field	Description	Data Type	Length
Svc Prov ID	A unique number identifying the servicing provider.	Character	15

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7.4 PAU-003B-D – PRIOR AUTHORIZATION QUALITY REVIEW REPORT - ACA

7.4.1 PAU-003B-D – Prior Authorization Quality Review Report - ACA Narrative

The Prior Authorization Quality Review Report - ACA (PAU-003B-D) displays all new prior authorization (PA) line items received or any PA line items whose status has changed since the last run of the report. It displays only those PA line items with a status of A (approved), D (denied), or E (evaluation), and only those line items with a service type of revenue code or procedure code. This report is used by the PA medical and quality review services contractor. It is sorted by PA number and PA line item.

This report includes or excludes certain ranges of procedure codes and revenue codes. The procedure codes and revenue codes to be included or excluded are contained in database tables that can be updated if the ranges of procedure codes and revenue codes change. The report only includes PAs when the recipient has an identified ACA Aid Category (75, 76, 77, 78, 79, 7Q, 86, 3L, 3M, PC, PW, PP, PB).

This report is generated daily.

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7.4.2 PAU-003B-D – Prior Authorization Quality Review Report - ACA Layout

```
Report  : PAU-003B-D                          ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PAUJD003                       MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: PAUPD003                   PRIOR AUTHORIZATION QUALITY REVIEW REPORT - ACA                 Page:           9999

-------------------------------------------------------------------------------------------------------------------------------
PA NUMBER     LINE ITEM      PROC/REV CODE      STATUS      ANALYST      RECIPIENT ID      REQ PROV ID        SVC PROV ID
       REQ/AUTH         REQ/AUTH                       REQ UNITS           REQ AMT            AUTH UNITS            AUTH AMT
       EFF DATE         END DATE
-------------------------------------------------------------------------------------------------------------------------------

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXX
       MM/DD/CCYY       MM/DD/CCYY              999999999999.999         9999999.99      999999999999.999          9999999.99

9999999999       99            XXXXX             X         XXXXXXXX     999999999999      XXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXX
       MM/DD/CCYY       MM/DD/CCYY              999999999999.999         9999999.99      999999999999.999          9999999.99

                                                  ***   END OF REPORT   ***
                                                   **  NO DATA THIS RUN **
```


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7.4.3 PAU-003B-D -- Prior Authorization Quality Review Report – ACA Field Descriptions

Field	Description	Data Type	Length
Analyst	User ID assigned to review the authorization.	Character	8
Auth Amt	The dollar amount authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	10
Auth Units	The number of units authorized for the line item service. Displayed for line items with a status of A (approved) only.	Number (Decimal)	16
Line Item	Unique identifier for prior authorization line item.	Character	2
PA Number	Unique ten-digit prior authorization number.	Number (Integer)	10
Proc / Rev Code	Depending on the type of service code for the PA line item, this is either the procedure code used to identify the medical, dental or DME procedure, or the revenue code identifying the specific accommodation or ancillary service.	Character	5
Recipient ID	The recipient's Medicaid identification number.	Number (Integer)	12
Req / Auth Eff Date	For PA line items with a status of A (Approved), this is the authorized start date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested start date for the line item.	Character	10
Req / Auth End Date	For PA line items with a status of A (Approved), this is the authorized end date for the line item. For PA line items with a status of D (denied) or E (Evaluation), this is the requested end date for the line item.	Character	10
Req Amount	The dollar amount requested for the line item service.	Number (Decimal)	10
Req Units	The number of units requested for the line item service.	Number (Decimal)	16
ReqProv ID	A unique number identifying the requesting provider.	Character	15
Status	This represents the decision status of the PA line item.	Character	1

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Field	Description	Data Type	Length
Svc Prov ID	A unique number identifying the servicing provider.	Character	15

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7.5 PAU-0005-M – PRIOR AUTHORIZATION MONTHLY ACTIVITY REPORT

7.5.1 PAU-0005-M – Prior Authorization Monthly Activity Report Narrative

The Prior Authorization Monthly Activity Report (PAU-0005-M) displays statistical data for PAs where the PA Date Received falls within the prior authorization monthly reporting date range.

The report is sorted by Assignment Code and Service Code. Report lines are summarized for each unique service code within a particular Assignment Code (in descending order) and Service Code.. For example: on PA 1234567890 Line Item 01 is for procedure D5982, and Line Item 02 is for procedure D7880, and Assignment Code is Clinic. On PA 4455559954 Line Item 01 is for procedure D7880, and Assignment Code is Clinic. Only two lines show on the report in the Clinic assignment code section (one for D5982 and one for D7880).

Totals include current month, last month, current year-to-date and last year-to-date. The totals for ALL assignment codes selected for the report are printed on the last page.

This report is generated monthly.

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7.5.2 PAU-0005-M – Prior Authorization Monthly Activity Layout

```
Report  : PAU-0005-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJM005                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PAUPM005                 PRIOR AUTHORIZATION MONTHLY ACTIVITY REPORT                           Page:      99999
                                              MONTH OF XXXXXXXXX CCYY

 ASSIGNMENT CODE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------
SERVICE         # OF          UNITS REQUESTED       UNITS APPROVED       UNITS DENIED           UNITS PENDING       UNITS CANCELLED
CODE            REQUESTS           UNITS OTHER            DOLLARS APPROVED        UNDUP RECIPIENT
-------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXXX  9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999

XXXXXXXXXXXXXX  9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999

XXXXXXXXXXXXXX  9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999

XXXXXXXXXXXXXX  9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999

TOTALS
 THIS MONTH     9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 LAST MONTH     9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 THIS YTD       9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 LAST YTD       9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
```


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```
Report  : PAU-0005-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJM005                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PAUPM005                 PRIOR AUTHORIZATION MONTHLY ACTIVITY REPORT                           Page:      99999
                                              MONTH OF XXXXXXXXX CCYY

 ASSIGNMENT CODE: ALL

-------------------------------------------------------------------------------------------------------------------------------
SERVICE         # OF          UNITS REQUESTED       UNITS APPROVED       UNITS DENIED           UNITS PENDING       UNITS CANCELLED
CODE            REQUESTS           UNITS OTHER            DOLLARS APPROVED        UNDUP RECIPIENT
-------------------------------------------------------------------------------------------------------------------------------

TOTALS
 THIS MONTH     9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 LAST MONTH     9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 THIS YTD       9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999
 LAST YTD       9999999   999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999  999,999,999,999.999
                             999,999,999,999.999   $9,999,999.99            999,999,999

                                          ***   END OF REPORT   ***
                                            ** NO DATA THIS RUN **
```

7.5.3 PAU-0005-M -- Prior Authorization Monthly Activity Field Descriptions

Field	Description	Data Type	Length
# of Requests	The total requested units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period.	Number (Integer)	7
# of Requests (Last Month)	The total requested units within the Assignment Code for PAs that were received within the previous month reporting period.	Number (Integer)	7
# of Requests (Last YTD)	The total requested units within the Assignment Code for PAs that were received within the previous year-to-date reporting period.	Number (Integer)	7
# of Requests (This Month)	The total requested units within the Assignment Code for PAs that were received within the current month reporting period.	Number (Integer)	7

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Field	Description	Data Type	Length
# of Requests (This YTD)	The total requested units within the Assignment Code for PAs that were received within the current year-to-date reporting period.	Number (Integer)	7
Assignment Code	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
Dollars Approved	The total authorized dollars for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Dollars Approved (Last Month)	The total authorized dollars within the Assignment Code for PAs that were received within the previous month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Dollars Approved (Last YTD)	The total authorized dollars within the Assignment Code for PAs that were received within the previous year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Dollars Approved (This Month)	The total authorized dollars within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Dollars Approved (This YTD)	The total authorized dollars within the Assignment Code for PAs that were received within the current year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Month Of	The calendar month name and year of the current month reporting period.	Date (CCYY)	14
Service Code	The unique service code across all of the line items for the Assignment Code. This includes HCPCS, NDC and Revenue codes. If the service code is a HCPCS procedure, and modifiers are requested on the line item, the modifiers are concatenated with the service code on the report.	Character	14
Undup Recipient	Number of unduplicated recipients requesting the unique service code within the Assignment Code for PAs that were received within the current month reporting period.	Number (Integer)	9
Undup Recipient (Last Month)	Number of unduplicated recipients within the Assignment Code for PAs that were received within the previous month reporting period.	Number (Integer)	9
Undup Recipient (Last YTD)	Number of unduplicated recipients within the Assignment Code for PAs that were received within the previous year-to-date reporting period.	Number (Integer)	9

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Field	Description	Data Type	Length
Undup Recipient (This Month)	Number of unduplicated recipients within the Assignment Code for PAs that were received within the current month reporting period.	Number (Integer)	9
Undup Recipient (This YTD)	Number of unduplicated recipients within the Assignment Code for PAs that were received within the current year-to-date reporting period.	Number (Integer)	9
Units Approved	The total authorized units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Approved (Last Month)	The total authorized units within the Assignment Code for PAs that were received within the previous month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Approved (Last YTD)	The total authorized units within the Assignment Code for PAs that were received within the previous year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Approved (This Month)	The total authorized units within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Approved (This YTD)	The total authorized units within the Assignment Code for PAs that were received within the current year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Cancelled	The total cancelled units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	15
Units Cancelled (Last Month)	The total cancelled units within the Assignment Code for PAs that were received within the previous month reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	15
Units Cancelled (Last YTD)	The total cancelled units within the Assignment Code for PAs that were received within the previous year-to-date reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	15
Units Cancelled (This Month)	The total cancelled units within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	15
Units Cancelled (This YTD)	The total cancelled units within the Assignment Code for PAs that were received within the current year-to-date reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	15

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Field	Description	Data Type	Length
Units Denied	The total denied units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as a "denied" type (D and F).	Number (Decimal)	15
Units Denied (Last Month)	The total denied units within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as a "denied" type (D and F).	Number (Decimal)	15
Units Denied (Last YTD)	The total denied units within the Assignment Code for PAs that were received within the previous year-to-date reporting period, and where line item status is defined as a "denied" type (D and F).	Number (Decimal)	15
Units Denied (This Month)	The total denied units within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is defined as a "denied" type (D and F).	Number (Decimal)	15
Units Denied (This YTD)	The total denied units within the Assignment Code for PAs that were received within the current year-to-date reporting period, and where line item status is defined as a "denied" type (D and F).	Number (Decimal)	15
Units Other	The total requested units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, for line item statuses that were not reported under any of the other columns.	Number (Decimal)	15
Units Other (Last Month)	The total requested units within the Assignment Code for PAs that were received within the previous month reporting period, for line item statuses that were not reported under any of the other columns.	Number (Decimal)	15
Units Other (Last YTD)	The total requested units within the Assignment Code for PAs that were received within the previous year-to-date reporting period, for line item statuses that were not reported under any of the other columns.	Number (Decimal)	15
Units Other (This Month)	The total requested units within the Assignment Code for PAs that were received within the current month reporting period, for line item statuses that were not reported under any of the other columns.	Number (Decimal)	15
Units Other (This YTD)	The total requested units within the Assignment Code for PAs that were received within the current year-to-date reporting period, for line item statuses that were not reported under any of the other columns.	Number (Decimal)	15
Units Pending	The total pending units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is P.	Number (Decimal)	15

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Field	Description	Data Type	Length
Units Pending (Last Month)	The total pending units within the Assignment Code for PAs that were received within the previous month reporting period, and where line item status is P.	Number (Decimal)	15
Units Pending (Last YTD)	The total pending units within the Assignment Code for PAs that were received within the previous year-to-date reporting period, and where line item status is P.	Number (Decimal)	15
Units Pending (This Month)	The total pending units within the Assignment Code for PAs that were received within the current month reporting period, and where line item status is P.	Number (Decimal)	15
Units Pending (This YTD)	The total pending units within the Assignment Code for PAs that were received within the current year-to-date reporting period, and where line item status is P.	Number (Decimal)	15
Units Requested	The total requested units for the unique service code within the Assignment Code for PAs that were received within the current month reporting period.	Number (Decimal)	15
Units Requested (Last Month)	The total requested units within the Assignment Code for PAs that were received within the previous month reporting period.	Number (Decimal)	15
Units Requested (Last YTD)	The total requested units within the Assignment Code for PAs that were received within the previous year-to-date reporting period.	Number (Decimal)	15
Units Requested (This Month)	The total requested units within the Assignment Code for PAs that were received within the current month reporting period.	Number (Decimal)	15
Units Requested (This YTD)	The total requested units within the Assignment Code for PAs that were received within the current year-to-date reporting period.	Number (Decimal)	15

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7.6 PAU-0008-M – PRIOR AUTHORIZATION MONTHLY UTILIZATION REPORT-SVC PROVIDER

7.6.1 PAU-0008-M – Prior Authorization Monthly Utilization Report SVC Provider Narrative

The Prior Authorization Monthly Utilization Report (PAU-0008-M) displays statistical data for approved PAs where the PA Date Received falls within the prior authorization monthly reporting date range. Data displayed includes the units and dollars used by claims processing. The report is sorted by Assignment and Service Provider. Report lines are summarized for each unique service code within a particular Service Provider and Assignment.

This report is generated monthly.

7.6.2 PAU-0008-M – Prior Authorization Monthly Utilization Report SVC Provider Layout

```
Report  : PAU-0008-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PAUJM008                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: PAUPM008                  PRIOR AUTHORIZATION MONTHLY UTILIZATION REPORT - SVC PROVIDER            Page:      99999
                                                 MONTH OF XXXXXXXXX CCYY

 ASSIGNMENT: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------
SERVICE         SERVICE       SERVICE   SERVICE # OF     UNITS      DOLLARS       UNITS         DOLLARS     UNITS      DOLLARS   PYMT
PROVIDER ID     PROVIDER TYPE CODE      THRU   REQUESTS  REQST       REQST        APPRVD        APPRVD       USED        USED    MTHD
-------------------------------------------------------------------------------------------------------------------------------

XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
                              XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
                              XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
                              XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99 XXX

TOTAL XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                            999999 9999999999.999 999999999.99 9999999999.999 99999999.99 999999999.999 9999999.99

                                                     * END OF REPORT *
                                                   * NO DATA THIS RUN *
```


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7.6.3 PAU-0008-M – Prior Authorization Monthly Utilization Report SVC Provider Field Descriptions

Field	Description	Data Type	Length
# of Requests	Total number of PA's a provider requested the particular service code.	Number (Integer)	5
# of Requests (Total)	Total number PA requests for the month by assignment code.	Number (Integer)	6
Assignment	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
Dollars Apprvd	Number of approved dollars for the provider ID and service code.	Number (Decimal)	9
Dollars Apprvd (Total)	Total number of approved dollars for an assignment code.	Number (Decimal)	10
Dollars Reqst	Number of requested dollars for the provider ID and service code.	Number (Decimal)	10
Dollars Reqst (Total)	Total number of requested dollars for an assignment code.	Number (Decimal)	11
Dollars Used	Number of used dollars for the provider ID and service code.	Number (Decimal)	9
Dollars Used (Total)	Total number of used dollars for an assignment code.	Number (Decimal)	9
Month Of	The calendar month name and year of the current month reporting period.	Date (Month CCYY)	14
PYMT MTHD	The Payment Method on the Line Item. PUF - Pay Unit Fee. PCA - Pay Cap Amount. PSP - Pay System Price.	Character	3
Service Code	All service codes listed in the assignment code print. The service code field includes CPT, HCPC, Drug, modifiers, and Revenue codes.	Character	11
Service Provider ID	The provider identification number that uniquely identifies the provider of services.	Character	15
Service Provider Type	Alphabetic decryption of the provider's type. Valid values may be found in the Tables Manual.	Character	13
Service Thru	The end of the service code range on the line item (if applicable). This includes HCPCS and Revenue codes.	Character	6

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Field	Description	Data Type	Length
Total	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
Units Apprvd	Number of approved units for the provider ID and service code.	Number (Decimal)	13
Units Apprvd (Total)	Total number of approved units for an assignment code.	Number (Decimal)	13
Units Reqst	Number of requested units for the provider ID and service code.	Number (Decimal)	13
Units Reqst (Total)	Total number of requested units for an assignment code.	Number (Decimal)	13
Units Used	Number of used units for the provider ID and service code.	Number (Decimal)	11
Units Used (Total)	Total number of used units for an assignment code.	Number (Decimal)	12

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7.7 PAU-0009-M – PRIOR AUTHORIZATION MONTHLY UTILIZATION REPORT-REQ PROVIDER

7.7.1 PAU-0009-M – Prior Authorization Monthly Utilization Report-REQ Provider Narrative

The Prior Authorization Monthly Utilization Report (PAU-0009-M) displays statistical data for approved PAs where the PA Date Received falls within the prior authorization monthly reporting date range. Data displayed includes the units and dollars used by claims processing. The report is sorted by Assignment and Requesting Provider. Report lines are summarized for each unique service code within a particular Requesting Provider and Assignment.

This report is generated monthly.

7.7.2 PAU-0009-M – Prior Authorization Monthly Utilization Report-REQ Provider Layout

```
Report  : PAU-0009-M                                ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : PAUJM009                            MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: PAUPM009                  PRIOR AUTHORIZATION MONTHLY UTILIZATION REPORT - REQ PROVIDER                  Page:
99999
                                                   MONTH OF XXXXXXXXX CCYY

 ASSIGNMENT: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------
--
REQUESTING      REQUESTING    SERVICE   SERVICE # OF     UNITS      DOLLARS       UNITS         DOLLARS     UNITS      DOLLARS
PYMT
PROVIDER ID     PROVIDER TYPE CODE      THRU   REQUESTS  REQST       REQST        APPRVD        APPRVD       USED        USED
MTHD
-------------------------------------------------------------------------------------------------------------------------------
--

XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
                             XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
                             XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
                             XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX
```


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```
XXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXXXXX XXXXX 99999 9999999999.999 99999999.99 9999999999.999 9999999.99 99999999.999 9999999.99
XXX

TOTAL XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                    999999 9999999999.999 999999999.99 9999999999.999 99999999.99 999999999.999
9999999.99

                                                          * END OF REPORT *
                                                        * NO DATA THIS RUN *
```

7.7.3 PAU-0009-M – Prior Authorization Monthly Utilization Report-REQ Provider Field Descriptions

Field	Description	Data Type	Length
Assignment	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
# of Requests	Total number of PA's a provider requested the particular service code.	Number (Integer)	5
# of Requests (Total)	Total number PA requests for the month by provider type.	Number (Integer)	6
Dollars Apprvd	Number of approved dollars for the provider ID and service code.	Number (Decimal)	9
Dollars Apprvd (Total)	Total number of approved dollars for an assignment code.	Number (Decimal)	10
Dollars Reqst	Number of requested dollars for the provider ID and service code.	Number (Decimal)	10
Dollars Reqst(Total)	Total number of requested dollars for an assignment code.	Number (Decimal)	11
Dollars Used	Number of used dollars for the provider ID and service code.	Number (Decimal)	9
Dollars Used (Total)	Total number of used dollars for an assignment code.	Number (Decimal)	9
Month Of	The calendar month name and year of the current month reporting period.	Date (Month CCYY)	14
PYMT MTHD	The Payment Method on the Line Item. PUF - Pay Unit Fee. PCA - Pay Cap Amount. PSP - Pay System Price.	Character	3
Requesting Provider ID	The provider identification number that uniquely identifies the requesting provider.	Character	15
Requesting Provider Type	Alphabetic decryption of the provider’s type. Valid values may be found in the Tables Manual.	Character	13

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Field	Description	Data Type	Length
Service Code	All service codes listed in the assignment code will print. The service code field includes CPT, HCPC, Drug, modifiers, and Revenue codes.	Character	11
Service Thru	The end of the service code range on the line item (if applicable). This includes HCPCS and Revenue codes.	Character	6
Total	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
Units Apprvd	Number of approved units for the provider ID and service code.	Number (Decimal)	13
Units Apprvd (Total)	Total number of approved units for an assignment code.	Number (Decimal)	13
Units Reqst	Number of requested units for the provider ID and service code.	Number (Decimal)	13
Units Reqst (Total)	Total number of requested for an assignment code.	Number (Decimal)	13
Units Used	Number of used units for the provider ID and service code.	Number (Decimal)	11
Units Used (Total)	Total number of used units for an assignment code.	Number (Decimal)	12

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7.8 PAU-0015-M – PRIOR AUTHORIZATION MONTHLY PROGRESS REPORT

7.8.1 PAU-0015-M -- Prior Authorization Monthly Progress Report Narrative

The Prior Authorization Monthly Progress Report (PAU-0015-M) displays statistical PA usage information for PA requests for recipients currently under Case Management. This report shows the units and dollars authorized and used for the PA requests that meet the criteria for this report, and is sorted by Recipient ID.

This report selects all PA records where the recipient on the PA is also on the Recipient Case Manager table (in an open status), where the Authorized End Date on the line item is within the reporting date range for this report, and where the line item status is a finalized type.

The reporting date range for this report uses the PA monthly reporting date range parm (PAUMONTH) and then adds 1 month to the parm begin date, and 2 months to the parm end date. For example, if the current PA monthly reporting date range is 06/01/2006 through 06/30/2006, the reporting date range for this report is 07/01/2006 through 08/31/2006.

This report is generated monthly.

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7.8.2 PAU-0015-M -- Prior Authorization Monthly Progress Report Layout

```
Report  : PAU-0015-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJM015                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PAUPM015                    PRIOR AUTHORIZATION MONTHLY PROGRESS REPORT                          Page:       9999

RECIPIENT: XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X
-------------------------------------------------------------------------------------------------------------------------------
ASSIGNMENT CODE     PA         LN SERVICE        SERVICE EFF      END            UNITS       UNITS        DOLLARS       DOLLARS PYMT
                    NUMBER     IT CODE           THRU    DATE     DATE            AUTH        USED           AUTH          USED MTHD
-------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX
XXXXXXXXXXXXXXXXXXX XXXXXXXXXX XX XXXXXXXXXXXXXX XXXXXX  CCYYMMDD CCYYMMDD 9999999.999 9999999.999  $9,999,999.99 $9,999,999.99  XXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS REPORT **
```

7.8.3 PAU-0015-M – Prior Authorization Monthly Progress Report Field Descriptions

Field	Description	Data Type	Length
Assignment Code	The text description of the PA Assignment Code, used to categorize PA requests by type. Only 19 of 30 possible characters are displayed in order to conserve space on the report.	Character	19

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Field	Description	Data Type	Length
Dollars Auth	The authorized dollar amount on the line item. If present, this can represent either a per unit price, or a cap amount depending on the line item Payment Method.	Number (Decimal)	9
Dollars Used	The total allowed amount (from claims processing) applied towards the line item. More than one claim can pay against a line item.	Number (Decimal)	9
Eff Date	The Authorized Effective Date on the line item. Format is CCYYMMDD.	Date (CCYYMMDD)	8
End Date	The Authorized End Date on the line item. Format is CCYYMMDD.	Date (CCYYMMDD)	8
LN IT	Identifies the PA line item.	Character	2
PA Number	The unique prior authorization number assigned to the PA request.	Character	10
PYMT MTHD	The Payment Method on the Line Item. PUF - Pay Unit Fee. PCA - Pay Cap Amount. PSP - Pay System Price.	Character	3
Recipient	The unique Medicaid identification number for the recipient, followed by the recipient's name in the Last, First MI format.	Character	53
Service Code	The service code on the line item. This includes HCPCS, NDC and Revenue codes. If the service code is a HCPCS procedure, and modifiers are requested on the line item, the modifiers are concatenated with the service code on the report.	Character	14
Service Thru	The end of the service code range on the line item (if applicable). This includes HCPCS and Revenue codes.	Character	6
Units Auth	The authorized number of units on the line item. This may be blank depending on the Payment Method.	Number (Decimal)	10
Units Used	The total paid units (from claims processing) applied towards the line item. More than one claim can pay against a line item.	Number (Decimal)	10

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7.9 PAU-001A-M – PRIOR AUTHORIZATION ANALYST ACTIVITY REPORT

7.9.1 PAU-001A-M -- Prior Authorization Analyst Activity Report Narrative

The Prior Authorization Analyst Activity Report (PAU-001A-M) displays current month and year-to-date summary statistical information for PA requests that have been worked by an Analyst (Reviewer). This report is used by the PA Unit for workload analysis, and is sorted by Reviewer. This report shows number of requests worked, and totals of Units and Dollars (by type of status). The report also shows the average number of days between the date received and the date the PA Notice was created.

This report selects all PA records where the date received is within the current year-to-date reporting period (for example, if the date the report was run is 10/31/2005, the year-to-date period would be 01/01/2005 through 10/31/2005), with any line item status except E (evaluation) or K (cancelled).

For each Reviewer, the first line shows totals for the current month reporting period. The second line shows totals for the current year-to-date reporting period.

This report is generated monthly.

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7.9.2 PAU-001A-M -- Prior Authorization Analyst Activity Report Layout

```
Report  : PAU-001A-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : PAUJM01A                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PAUPM01A                    PRIOR AUTHORIZATION ANALYST ACTIVITY REPORT                           Page:       9999
-------------------------------------------------------------------------------------------------------------------------------
  ANALYST    # OF          UNITS          UNITS           UNITS          UNITS           UNITS          DOLLARS     AVG LAG
  CODE       REQUESTS    REQUESTED      CANCELLED        APPROVED       DENIED          PENDING        APPROVED      DAYS
-------------------------------------------------------------------------------------------------------------------------------

  xxxxxxxx  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999
       YTD  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999

  xxxxxxxx  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999
       YTD  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999

  xxxxxxxx  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999
       YTD  99999999   999999999.999  999999999.999   999999999.999  999999999.999  999999999.999  999999999.999     $9,999,999.99  999

                                                   ***   END OF REPORT   ***
                                                    **  NO DATA THIS RUN **
```

7.9.3 PAU-001A-M – Prior Authorization Analyst Activity Report Field Descriptions

Field	Description	Data Type	Length
# of Requests (YTD)	The number of PA requests the Reviewer has worked during the current year-to-date reporting period.	Number (Integer)	8
# of Requests (current month)	The number of PA requests the Reviewer has worked during the current month reporting period.	Number (Integer)	8
Analyst Code	The user ID of the Analyst (Reviewer) who performed the review.	Character	6
Avg Lag Days (YTD)	Average number of days from the date the PA is received until the date the PA Notice is created. This is for the requests received within the current year-to-date reporting period.	Number (Integer)	3
Avg Lag Days (current month)	Average number of days from the date the PA is received until the date the PA Notice is created. This is for the requests received within the current month reporting period.	Number (Integer)	3
Dollars Approved (YTD)	The total authorized dollars on PA requests that were worked within the current year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	12

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Field	Description	Data Type	Length
Dollars Approved (current month)	The total authorized dollars on PA requests that were worked within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	11
Units Approved (YTD)	The total number of authorized units on PA requests that were worked within the current year-to-date reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	15
Units Approved (current month)	The total number of authorized units on PA requests that were worked within the current month reporting period, and where line item status is defined as an "approval" type (A).	Number (Decimal)	13
Units Cancelled (YTD)	The total number of cancelled units on PA requests that were worked within the current year-to-date reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	14
Units Cancelled (current month)	The total number of cancelled units on PA requests that were worked within the current month reporting period, and where line item status is defined as a "cancelled" type (K).	Number (Decimal)	13
Units Denied (YTD)	The total number of requested units on PA requests that were worked within the current year-to-date reporting period, and where line item status is defined as a "denial" type (D and F).	Number (Decimal)	15
Units Denied (current month)	The total number of requested units on PA requests that were worked within the current month reporting period, and where line item status is defined as a "denial" type (D and F).	Number (Decimal)	13
Units Pending (YTD)	The total number of requested units on PA requests that were worked within the current year-to-date reporting period, and where line item status is P (pending).	Number (Decimal)	15
Units Pending (current month)	The total number of requested units on PA requests that were worked within the current month reporting period, and where line item status is P (pending).	Number (Decimal)	13
Units Requested (YTD)	The total number of requested units on PA requests that were worked within the current year-to-date reporting period, and where line item status is not E (evaluation) or G (reconsideration).	Number (Decimal)	13

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Field	Description	Data Type	Length
Units Requested (current month)	The total number of requested units on PA requests that were worked within the current month reporting period, and where line item status is not E (evaluation) or G (reconsideration).	Number (Decimal)	15

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7.10 PAU-002A-D – PRIOR AUTHORIZATION ELECTRONIC ACTIVITY REPORT

7.10.1 PAU-002A-D -- Prior Authorization Electronic Activity Report Narrative

The Prior Authorization Electronic Activity Report (PAU-002A-D) summarizes the PA requests submitted electronically each day, and is sorted by Assignment Code.

This report selects all PA records where the media type is Web (web portal) or Electronic Transaction (HIPAA 278 or NCPDP), and the date received is within the daily cycle parm date range, and the time received is before 6:00pm Central Time.

This report prints the requesting provider's ID and name. A Non-Medicaid provider would not be able to submit PA requests through the web portal or electronically, this report is designed to only show enrolled provider information.

This report is generated daily.

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7.10.2 PAU-002A-D -- Prior Authorization Electronic Activity Report Layout

```
Report  : PAU-002A-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJD02A                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: PAUPD02A                   PRIOR AUTHORIZATION ELECTRONIC ACTIVITY REPORT                        Page:       9999

ASSIGNMENT CODE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
PA           REVIEW    SERVICE        LN BENEFICIARY                    BENEFICIARY   PROVIDER   PROVIDER
NUMBER       CLERK     CODE           IT NAME                           NUMBER        NUMBER     NAME
-------------------------------------------------------------------------------------------------------------------------------
9999999999   XXXXXXXX  XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999999999  999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


Report  : PAU-002A-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PAUJD02A                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: PAUPD02A                   PRIOR AUTHORIZATION ELECTRONIC ACTIVITY REPORT                        Page:       9999
 ASSIGNMENT CODE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
PA           REVIEW    SERVICE        LN BENEFICIARY                    BENEFICIARY   PROVIDER   PROVIDER
NUMBER       CLERK     CODE           IT NAME                           NUMBER        NUMBER     NAME
-------------------------------------------------------------------------------------------------------------------------------
9999999999   XXXXXXXX  XXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   999999999999  999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             XXXXXXXX  XXXXXXXXXXXXXX
             XXXXXXXX  XXXXXXXXXXXXXX
                                                   ***  END OF REPORT ***
                                                 ***   NO DATA THIS RUN   ***
```


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7.10.3 PAU-002A-D -- Prior Authorization Electronic Activity Report Field Descriptions

Field	Description	Data Type	Length
Assignment	The text description of the PA Assignment Code, used to categorize PA requests by type.	Character	30
LN IT	Identifies the PA request line item.	Character	2
PA Number	The unique prior authorization number assigned to the PA request.	Character	10
Provider Name	The name of the requesting provider. The first 30 characters of 50 possible characters are printed.	Character	30
Provider Number	The identification number of the requesting provider.	Character	10
Beneficiary Name	Last name, first name and middle initial of the recipient.	Character	27
Beneficiary Number	The unique Medicaid identification number for the recipient.	Character	12
Review Clerk	The identification of the reviewer assigned to review the request.	Character	8
Service Code	The service code on the line item. This includes HCPCS, NDC and Revenue codes. If the service code is a HCPCS procedure, and modifiers are requested on the line item, the modifiers are concatenated with the service code on the report.	Character	14
Total Electronic Prior Authorization Requests Received	Total number of prior authorization requests reported.	Number (Integer)	6

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AMMIS Provider Enrollment Web Portal User Manual

Date Modified: 11/28/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
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Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

The latest version of this document is stored **electronically**. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	Alabama Provider Enrollment Web Portal User Manual Document
Version:	11.0
Location:	https://pwb.alxix.slg.eds.com/alxix/Subsystem/utils/FolderList.asp?Folder=../../ProjectPlan2010/Enhancements/Provider%20Web
Owner:	DXC/Agency
Author:	DXC Team
Approved by:	Clay Gaddis
Approval Date:	09/06/2011

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
07/25/2011	0.1		Initial draft of document	
08/17/2011	0.2		Revised document based on walkthrough with Agency held on 07/28/2011.	
09/06/2011	1.0		Agency approved	
05/29/2012	2.0		Implementaiton of Address Standardization for CO 8143.	Update Section 6.7 Provider Enrollment: Addresses Panel
05/08/2013	3.0		Application of CO 10719 Application of CO 10782 Application of CO 10924	Section 6.11.1 Provider Enrollment: Agreement Page Narrative and and 6.11.2 Provider Enrollment: Agreement Page Layout Section 6.5.2 Provider Enrollment: Specialities Page Layout updated. Section 6.9.2 Provider Enrollment: Other Information Panel layout and 6.93 Field descriptions updated.
10/24/2014	4.0		Application of CO 10300	Update Provider Enrollment: Welcome Page, Request Information – Individual Within a Group,

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Provider Identification, Provider Agreement Page, Provider Addresses, Bank Information, Enrollment Credentials, Resume Enrollment, Enrollment Status
07/21/2015	5.0		Application of ACA III production change orders	CO 12211 – Updates to the following Existing Panels. Home Page, Provider Enrollment – Welcome Page, Provider Enrollment – Request Information, Provider Enrollment – Specialities, Provider Enrollment –Provider Identification, Provider Enrollment –Addresses, Provider Enrollment –Other Information, Provider Enrollment –Agreement page, Provider Enrollment – Summary Page. Deleted Provider Enrollmlent – Banking Information page CO 12211 – Addition of New EFT Panels. CO 12211 – Addition of New ERA panels.
04/27/2016	6.0		Application of Production CO 12851	
10/13/2017	7.0		Application of CO 14266	Updated screen layouts for the Provider Enrollment: Welcome, Request Information, Provider Identification, Addresses panels.
12/20/2017	8.0		Application of CO 14192	Modify references to HP/HPE to DXC:
04/01/2018	9.0		Applicaiton of CO 14873	Redact PHI/PII as well as non-public test data. Updated screen layouts for: 6.11.2 - Provider Enrollment: Agreement Page Layout 6.12.2 - Provider Enrollment: Summary Page Layout 6.13.2 - Provider Enrollment: Enrollment Credentials Layout 6.18.2 - Provider EFT Enrollment: Agreement Page Layout

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				6.19.2 - Provider EFT Enrollment: Summary Page Layout 6.21.2 - Provider EFT Enrollment: Cover Page Layout 6.24.2 - Provider ERA Enrollment: Agreement Page Layout 6.25.2 - Provider ERA Enrollment: Summary Page Layout
11/15/2018	10.0		Application of CO 14968	6.17.2 Provider EFT Enrollment Page Layout- update field edit error messages
11/28/2018	11.0		Application of CO 15099	6.5.4 Provider Enrollment Specialties- edit field edit error messages

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 INTRODUCTION

2.1 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL OVERVIEW

The Alabama Medicaid Provider Enrollment Web Portal allows new providers to enroll with Alabama Medicaid and allows existing providers to update address and phone number information. This user manual is designed to cover the information necessary to perform the tasks associated with the Alabama Medicaid Provider Enrollment Web Portal.

This manual covers the following:

- Alabama Medicaid Provider Enrollment Web Portal Overview
- Alabama Medicaid Provider Enrollment Web System Navigation
- System Wide Common Terminology and Layouts
- Alabama Medicaid Provider Enrollment Web Pages
- Help

2.2 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL USER MANUAL OBJECTIVE

The purpose of the Alabama Medicaid Provider Enrollment Web Portal User Manual is to provide Alabama Medicaid providers with detailed descriptions of the online system, including page field descriptions, page functionality descriptions and graphical representations of pages.

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3 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL OVERVIEW

3.1 INTRODUCTION TO THE ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL

The Alabama Medicaid Provider Enrollment Web Portal allows providers to enroll with Medicaid as a new provider, check status of a submitted application, make corrections as determined by Provider Enrollment staff on submitted applications, and change address and phone number information on existing providers.

The Web Portal has been developed by Hewlett-Packard Enterprise Systems (HPES) for Alabama Medicaid and is offered at no cost to their providers. This site is available 24-hours a day, seven days a week, excluding time for scheduled maintenance.

3.2 AUDIENCE

The information described in this document is designed for new providers requesting enrollment in the program and by providers already enrolled with Alabama Medicaid.

3.3 PURPOSE

This document equips the provider with the necessary steps to access the Web Portal, navigate the Web Portal, enroll with Alabama Medicaid, and successfully update information. The provider will be required to send in paper documentation for applicable information.

3.4 SUPPORTING DOCUMENTATION

Provider should refer to Alabama Medicaid Provider Billing Manual, Chapter 2, Becoming a Medicaid provider for information on becoming a provider with Alabama Medicaid.

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4 ALABAMA MEDICAID PROVIDER WEB PORTAL NAVIGATION

4.1 WEB BROWSER SETUP

Workstations must be minimally equipped with Internet Explorer version 7.0.

Please refer to the websites for Internet Explorer (*www.microsoft.com*) for additional information on downloading the versions available.

The AOL browser does not work well with this Web application.

4.2 NAVIGATION BUTTONS

Do not select the previous/back or following/forward website navigation buttons in the toolbar if the website navigation button offers a selection for "next" or "previous" screen. If you use the navigation or windows buttons instead of those provided by the application, you may risk losing work in progress.

4.3 PERSONAL COMPUTER RECOMMENDATIONS

The website is designed to operate on a personal computer with the following configurations:

4.4 SCREEN DISPLAY FEATURES

The Alabama Medicaid Provider Enrollment Web Portal is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels and pages into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

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4.5 WEB ADDRESS

The address to access the Interactive Services website is:

https://www.medicaid.alabamaservices.org/ALPortal

4.6 USER IDS AND PASSWORDS

A user ID or password is not required to access and submit a Provider Enrollment application, however, when selecting the “finish later” function a tracking number, tax ID and password will be required. To check the status of a submitted enrollment application, a tracking number and tax ID will be required. The password must be 8 to 20 characters in length, not the same as the user ID and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter. **Be aware that passwords cannot be reset.**

4.7 RESETTING PASSWORDS

Passwords cannot be reset. When an application is submitted or the “finish later” function is selected, a password is created by the user. If the password is not available when returning to the web portal to complete an application, the password cannot be reset. HP Provider Enrollment does not have access to the password nor can they reset the password.

4.8 CONNECTION TIMEOUT

The Provider should be aware that after twenty (20) minutes without activity, the Provider Enrollment web portal will timeout and data entered may be lost.

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5 SYSTEM WIDE COMMON TERMINOLOGY AND LAYOUTS

The following section identifies common system terminology and features, and associated screens capture or design layout where applicable. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the novice user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or, more importantly, documenting aspects of the system.

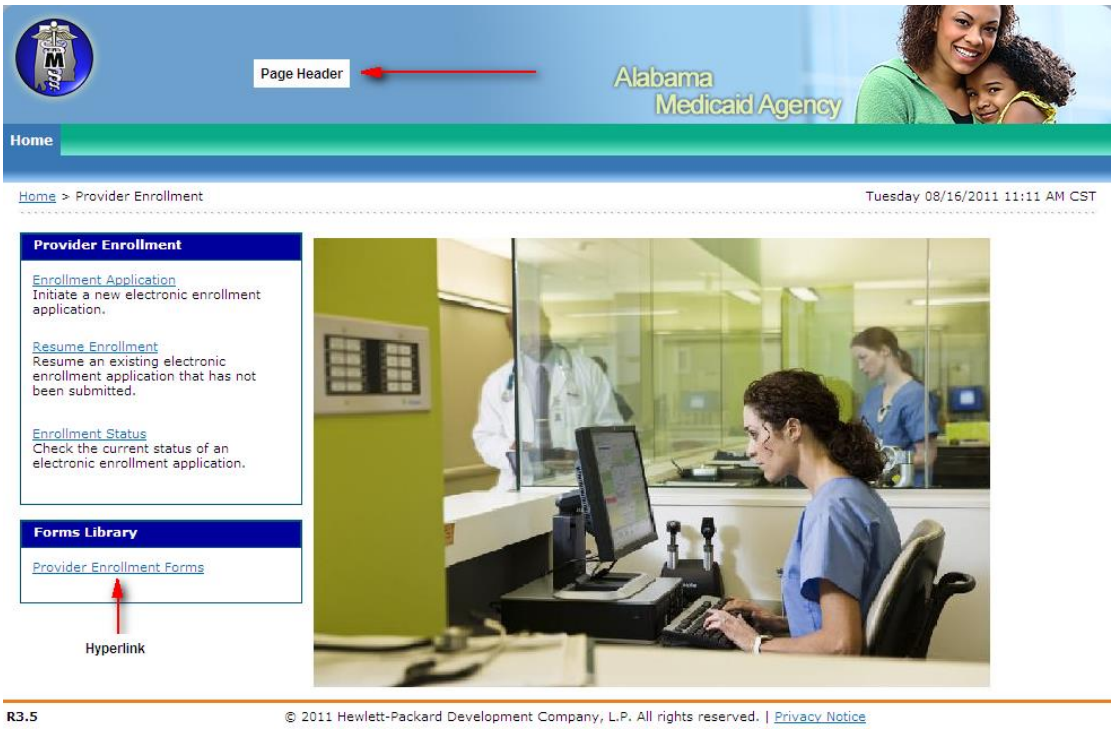
Below is a partial list of common terms described within this document:

- Hyperlink
- Page
- Page Header

5.1 PAGE LAYOUT

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, table of contents, and any associated hyperlinks.

The table of contents contains a vertical list of pages. The pages are accessed after required information is entered on a page and the continue button is selected



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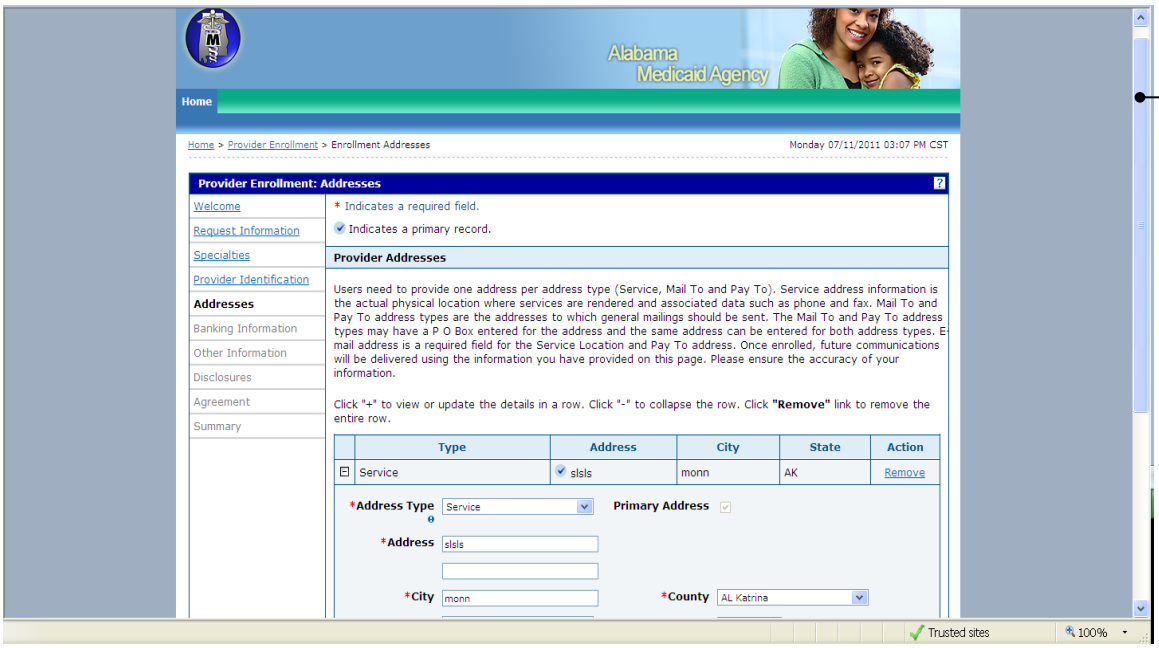
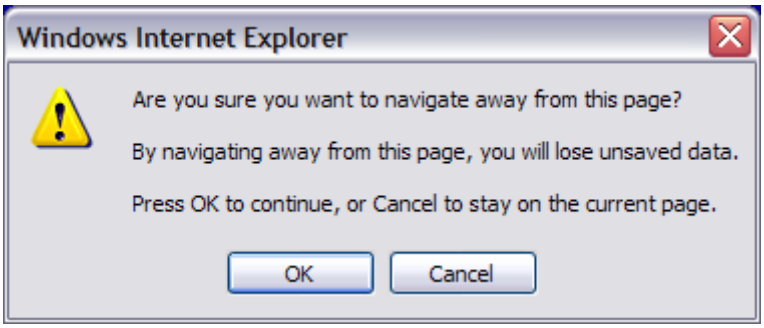
In general, when navigating a page, the vertical scroll bar is the only scroll bar needed to view extended pages.



If a user attempts to add, update, or delete information within the page, then tries to navigate away from the page without saving or cancelling the changes, the system prompts the user with a pop-up window message. When the system generates the message and OK button is selected, any information entered on the page will be lost. If the cancel button is selected the user will be returned to the page to continue processing the application.



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5.2 FUNCTIONS

Listed below are icons that can be found on one or more pages.

Name	Icon	Action
Add Button	Add	Inserts a new data record.
Cancel Button	Cancel	Cancels all changes applied to all panels on the page.
Check Box		Select as applicable.
Continue Button	Continue	Allows user to navigate to the next page.
Print	Print	Prints document.
Radio Button	Yes No	Select appropriate value.
Reset Button	Reset	Resets page to original content.
Save Button	Save	Saves all changes to all panels on the page.
Collapse		Click to collapse a row of data.
View or Update		Click to view or update a row of data.
Help	?	Select to display the help text for the page.

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6 ALABAMA MEDICAID PROVIDER ENROLLMENT WEB PORTAL

6.1 HOME PAGE

6.1.1 Home Page Narrative

The Home page opens when you access the Alabama Medicaid Provider Enrollment Web Portal. From the home page, users can access the following Sub Menu options:

- Enrollment Applications
- EFT Enrollment Application
- ERA Enrollment Application
- Resume Enrollment
- Enrollment Status
- Provider Enrollment Forms

Provider applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Alabama Medicaid Participation Requirements chart. Please review to ensure you meet the minimum enrollment requirements to participate in the Alabama Medicaid program.

To complete an application you will need to know or be able to obtain about the provider applicant all or some of the following information, depending on the type of enrollment you are completing:

- National Provider Identifier (NPI)
- Basic Business Office Data (i.e., address, phone, fax, email address, etc.)
- Specific Office Data (i.e., CLIA Certification, Name and SSN of employees/personnel, etc.)
- Specific Provider Data (i.e., CLIA Certification, SSN, Licensure Information, etc.)
- IRS Tax Identification Data
- Banking Information
- Group Identification Data (i.e., Name, NPI, Medicaid ID, Name and SSN of owners with 5% or more interest, etc.)

As pages of the application are completed, additional information may be required and some documentation may need to be submitted to validate entries. The application can be saved and resumed as needed; however, once a page is accessed, the page must be completed before the application can be saved.

When all steps of the application have been completed, please "submit" and "confirm" the application for further processing by HPES Provider Enrollment Staff.

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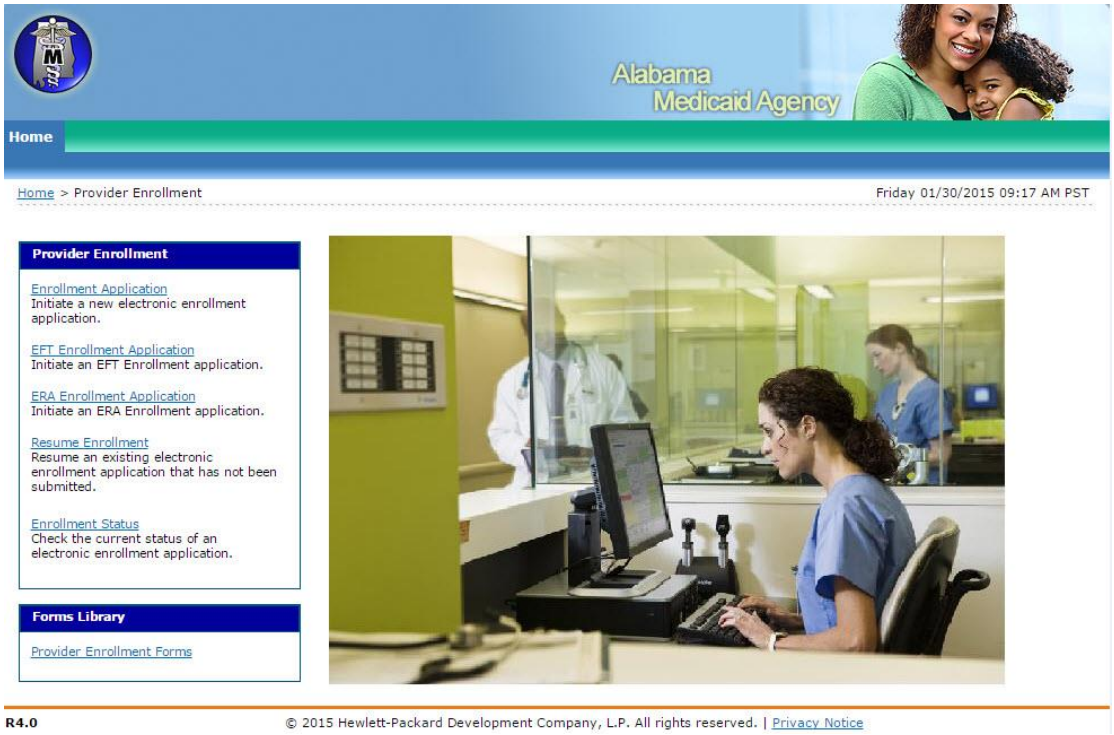
6.1.2 Home Page Panel Layout



6.1.3 Home Page Field Descriptions

Field	Description	Field Type	Data Type	Length
EFT Enrollment Application	Hyperlinks that allows the user to initiate EFT Enrollment Application.	Hyperlink	N/A	0
ERA Enrollment Application	Hyperlinks that allows the user to initiate ERA Enrollment Application.	Hyperlink	N/A	0
Enrollment Application	Hyperlink that allows the user to Initiate a new electronic enrollment application.	Hyperlink	N/A	0
Enrollment Status	Hyperlink that allows the user to Check the current status of an electronic enrollment application.	Hyperlink	N/A	0
Provider Enrollment Forms	Hyperlink that allows the user to access the Alabama Medicaid website's Provider Enrollment Forms page.	Hyperlink	N/A	0
Resume Enrollment	Hyperlink that allows the user to resume processing an existing electronic enrollment application that has not been submitted.	Hyperlink	N/A	0

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6.1.4 My Home Panel Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

6.1.5 My Home Panel Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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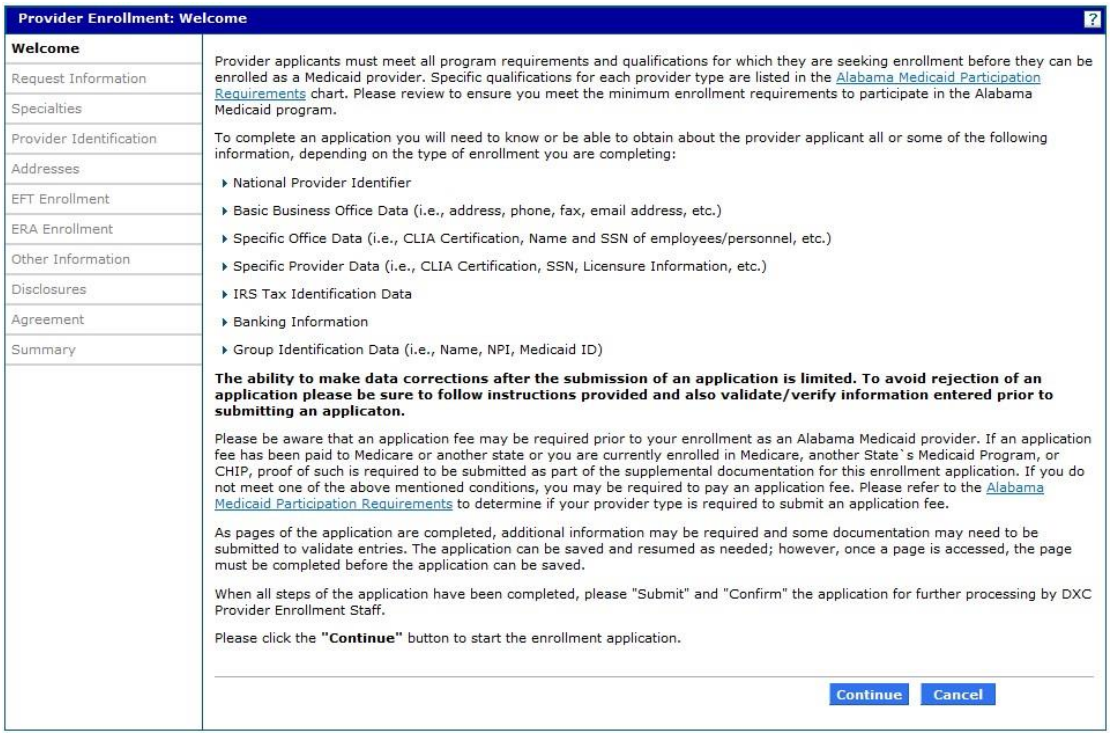
6.2 PROVIDER ENROLLMENT: WELCOME

6.2.1 Provider Enrollment: Welcome Page Narrative

Provider Enrollment allows providers and authorized delegates to enter all pertinent enrollment information via a wizard. The enrollment wizard captures key provider data such as contact information, provider type, specialties, and demographics such as names, identifiers, and locations.

The Provider Enrollment wizard allows the provider to navigate through each page of enrollment, from the contact information in the first page, to the final print and bar coded cover sheet on the last page. The provider can create a print file for future reference and bar coded cover sheet for submissions of supplemental documentation. A tracking number is also provided so that providers can check the status of their enrollment request.

6.2.2 Provider Enrollment: Welcome Page Layout



6.2.3 Provider Enrollment: Welcome Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Alabama Medicaid Participation Requirements	Hyperlink that allows the user to view the specific qualifications for each provider type.	Hyperlink	N/A	0
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Continue	Button that allows the user to begin the enrollment process.	Button	N/A	0

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6.2.4 Provider Enrollment: Welcome Page Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

6.2.5 Provider Enrollment: Welcome Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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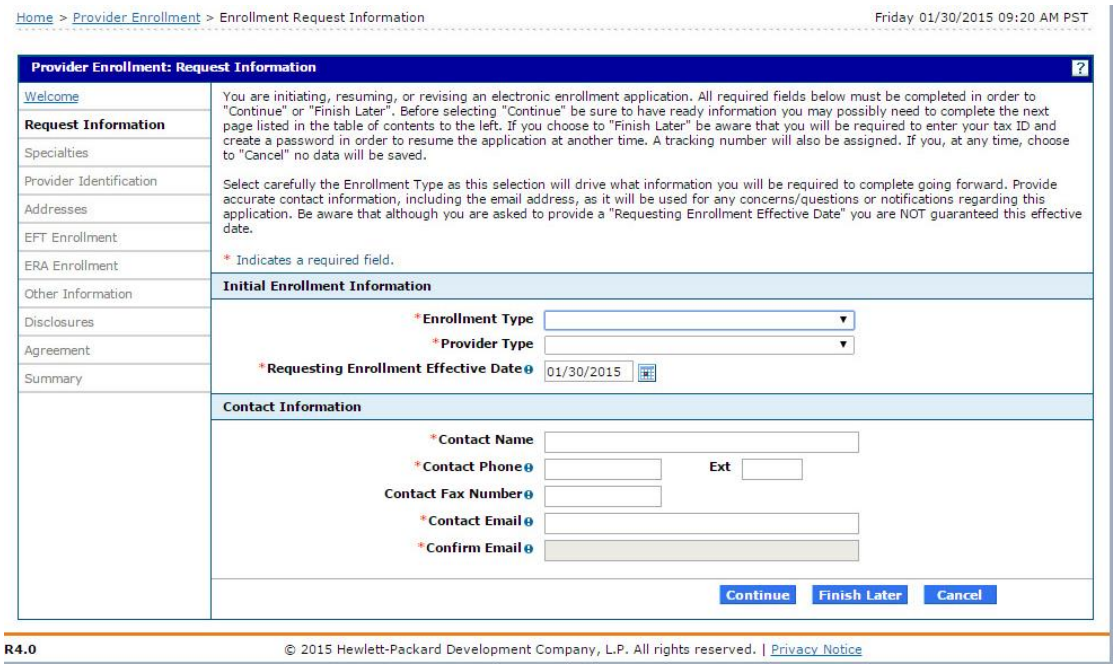
6.3 PROVIDER ENROLLMENT: REQUEST INFORMATION

6.3.1 Provider Enrollment: Request Information Page Narrative

The Provider Enrollment: Request Information page provides the initial enrollment and contact information to begin the provider enrollment process. The provider can initiate, resume, or revise an electronic enrollment application. All required fields below must be completed in order to "continue" or "finish later". Before selecting "continue", the provider should be sure to have ready information needed to complete the next page listed in the table of contents to the left. If the user chooses to "finish later" be aware that he or she will be required to enter a tax ID and create a password in order to resume the application at another time. A tracking number will also be assigned. If the provider, at any time, chooses to "cancel" no data will be saved.

Select carefully the Enrollment Type as this selection will drive what information will be required to complete going forward. Provide accurate contact information, including the email address, as it will be used for any concerns/questions or notifications regarding this application. Be aware that although the provider is asked to provide a "Requesting Enrollment Effective Date" the provider is NOT guaranteed this effective date.

6.3.2 Provider Enrollment: Request Information Page Layout



6.3.3 Provider Enrollment: Request Information Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Confirm Email	Allows the user to confirm that the Email of the contact is correct.	Field	Character	40
Contact Email	Allows the user to enter the Email of the contact.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Contact Fax Number	Allows the user to enter fax number of the contact.	Field	Number (Integer)	10
Contact Name	Allows the user to enter the name of the contact.	Field	Character	40
Contact Phone	Allows the user to enter the telephone number of the contact.	Field	Number (Integer)	10
Contact Phone Ext	Allows the user to enter the telephone number extension of the contact.	Field	Number (Integer)	4
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Enrollment Type	Allows the user to select the type of enrollment (facility, a group, individual or individual within a group).	Combo Box	Drop down List Box	0
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
Provider Type	Allows the user to select a provider type from a drop down list.	Combo Box	Drop down List Box	0
Requesting Enrollment Effective Date	Allows the user to request an effective date of enrollment. Be aware that although the provider is asked to provide a "Requesting Enrollment Effective Date" the provider is NOT guaranteed this effective date.	Field	Date	8

6.3.4 Provider Enrollment: Request Information Field Edit Error Codes

Field	Error Message	To Correct
Confirm Email	Confirm Email is a required field.	Enter a valid confirm email address.
	The email address is invalid. Enter email with 'name@domain' format.	Enter valid email format.
Contact Email	Contact Email is a required field.	Enter a valid email address.
	The email address is invalid. Enter email with 'name@domain' format.	Enter a valid email format.
Contact Email and Confirm Email	Contact Email and Confirm Email fields do not match.	The same email address must be entered in both Contact Email and Confirm Email.
Contact Name	Contact Name is a required field.	Enter a valid contact name.

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Field	Error Message	To Correct
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters in the field.
Contact Phone	Contact Phone is a required field.	Enter a valid contact telephone number.
Enrollment Type	Enrollment Type is a required field.	Enter a valid enrollment type.
Provider Type	Provider Type is a required field.	Enter a valid provider type.
Requesting Enrollment Effective Date	Requesting Enrollment Effective Date is a required field.	Enter a valid date.

6.3.5 Provider Enrollment: Request Information Page Extra Features

Field	Field Type
A selectable calendar function is used in the Requesting Enrollment Effective Date field.	

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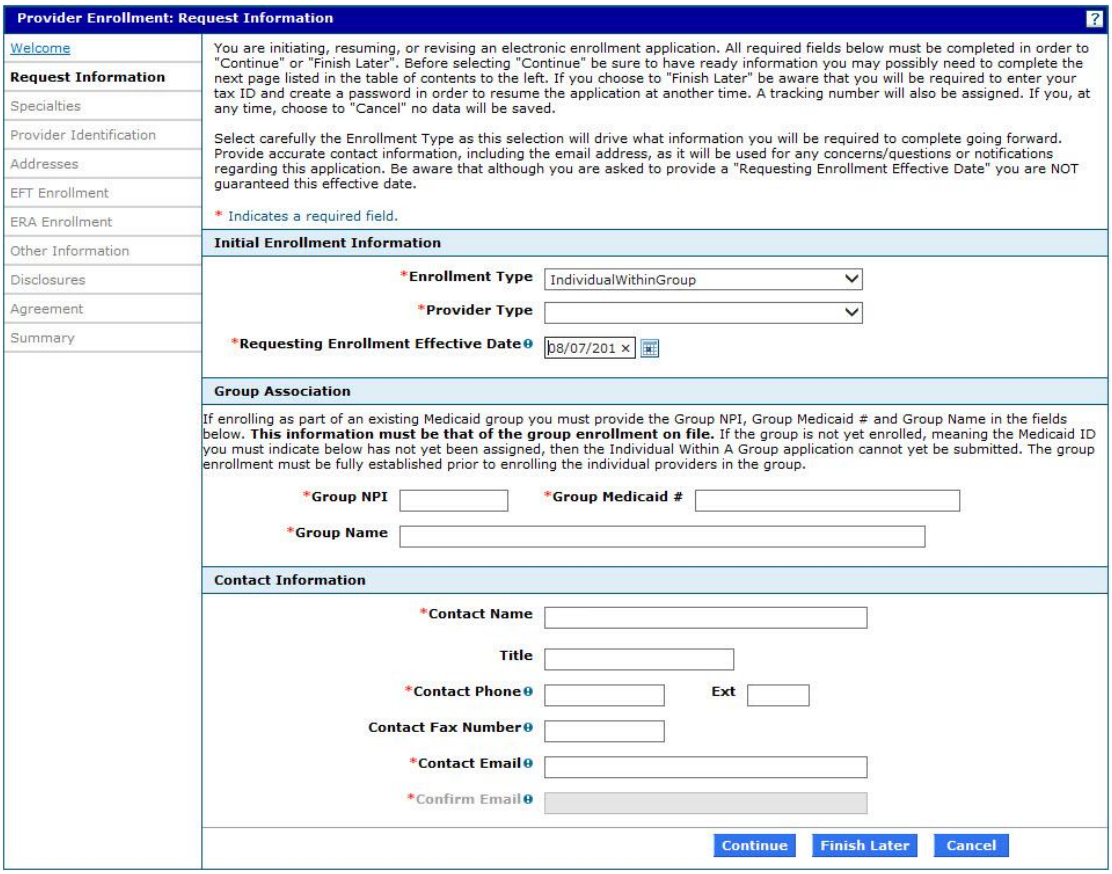
6.4 PROVIDER ENROLLMENT: REQUEST INFORMATION

6.4.1 Provider Enrollment: Request Information – Individual Within Group Selection Page Narrative

The Provider Enrollment: Request Information page allows the provider to enter initial enrollment information, such as the type of enrollment (for a facility, a group, individual, individual within a group or OPR (Ordering, Prescribing or Referring)), the provider type and enrollment date. However, if Individual Within Group is selected, additional information will be needed.

6.4.2 Provider Enrollment: Request Information – Individual Within Group Selection Page Layout



6.4.3 Provider Enrollment: Request Information – Individual Within Group Selection Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Group Medicaid #	Allows the user to enter the group's Medicaid number.	Field	Character	30
Group Name	Allows the user to enter the group's name.	Field	Character	40
Group NPI	Allows the user to enter the group's NPI.	Field	Number (Integer)	10

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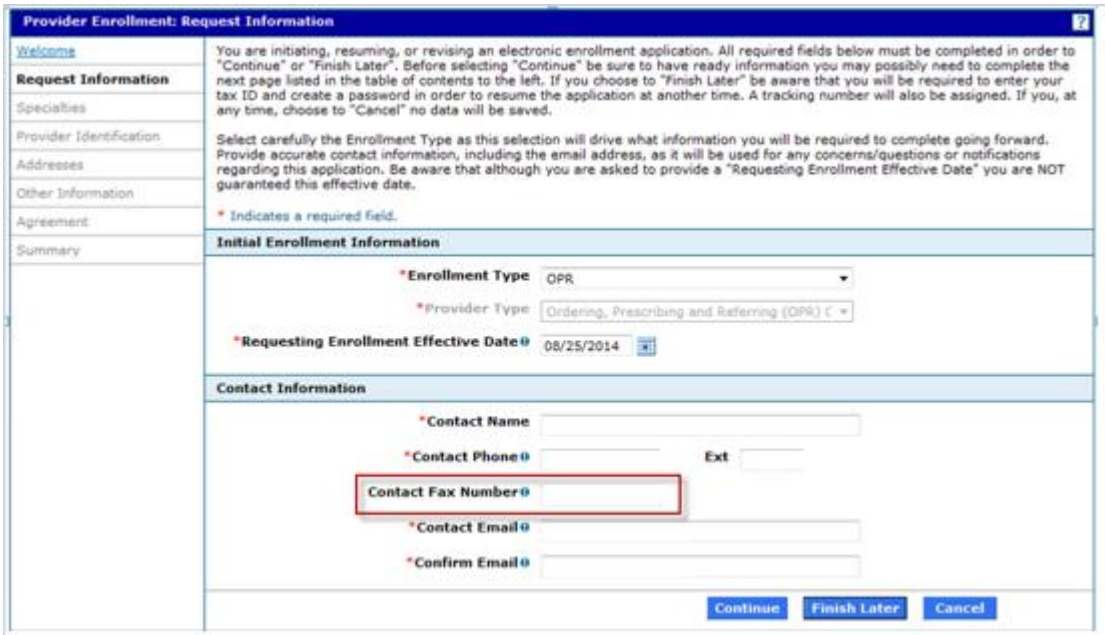
6.4.4 Provider Enrollment: Request Information – Individual Within Group Selection Page Field Edit Error Codes

Field	Error Message	To Correct
Group Medicaid #	Group Medicaid # is a required field.	Enter a valid Group Medicaid #.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Group Name	Group Name is a required field.	Enter a valid group name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Group NPI	Group NPI is a required field.	Enter a valid Group NPI.

6.4.5 Provider Enrollment: Request Information – Individual Within Group Selection Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

6.4.6 Provider Enrollment: Request Information – OPR Selection Page Layout



6.4.7 Provider Enrollment: Request Information – OPR Selection Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Contact Fax	Allows the user to enter the Fax Number.	Field	Character	10

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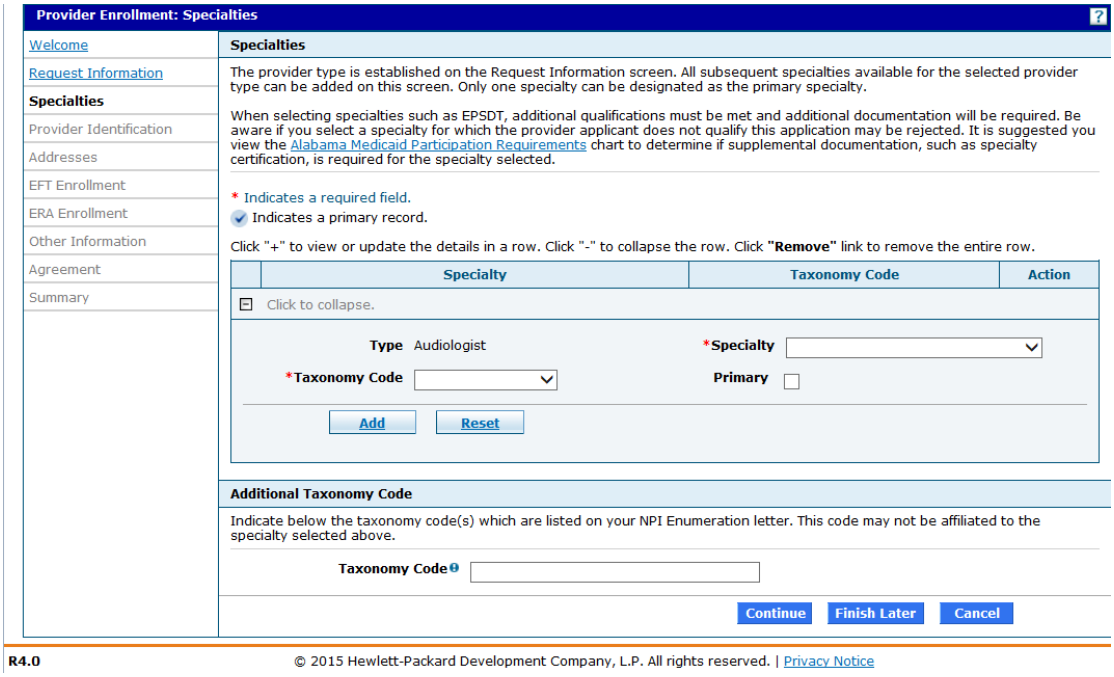
6.5 PROVIDER ENROLLMENT: SPECIALTIES

6.5.1 Provider Enrollment: Specialties Page Narrative

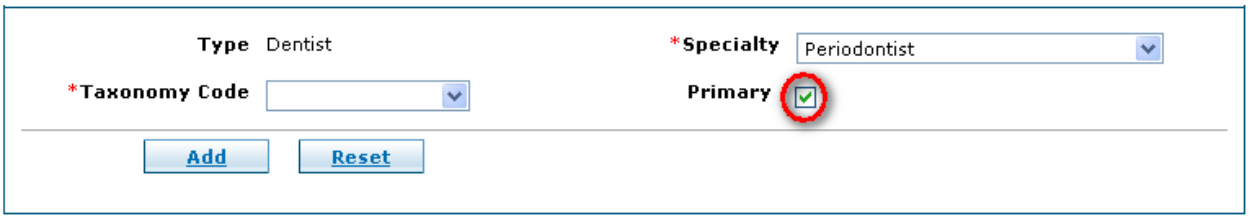
The Provider Enrollment: Specialties page allows the provider to add, view, and maintain specialty information for the provider type established in the initial enrollment.

6.5.2 Provider Enrollment: Specialties Page Layout

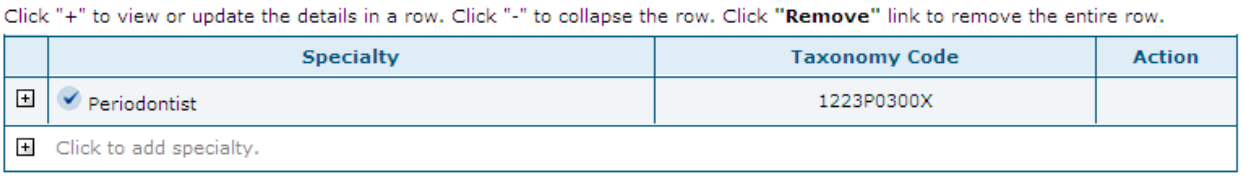
Before Primary Specialty is Selected (Box Unselected)



After Primary Specialty is Selected (Box Selected)



After Primary Specialty is Selected and Added



If a Change Occurs to Specialty

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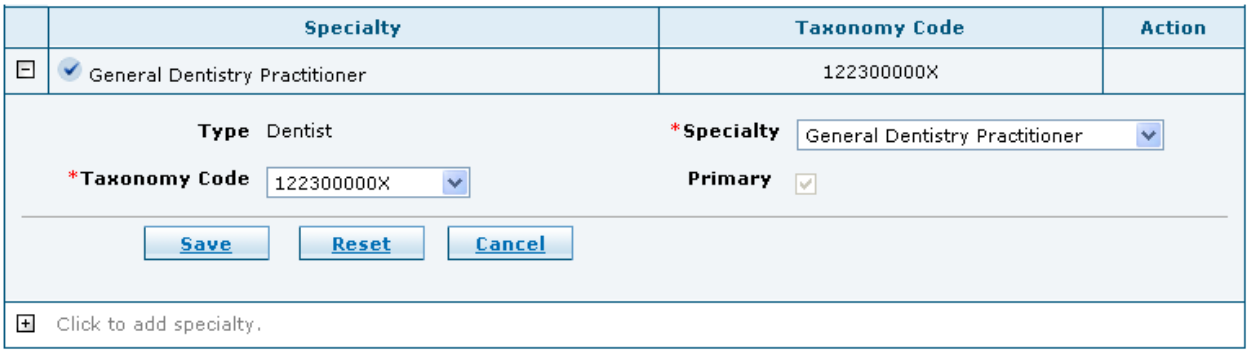

6.5.3 Provider Enrollment: Specialties Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new information segment.	Button	N/A	0
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
Primary	Allows the user to select which specialty is the primary by checking the box. One primary specialty must be selected by clicking the Primary check box. Specialty choices are dependent upon the provider type chosen on the Request Information page.	Check Box	N/A	0
Reset	Allows the user to reset the page to initial appearance.	Button	N/A	0
Save	Allows the user to save any changes to the application.	Button	N/A	0
Specialty	Allows the user to select a specialty. Valid values are subject to the provider type of the provider.	Combo Box	Drop down List Box	0
Taxonomy Code	Allows the user to select their taxonomy code.	Combo Box	Drop down List Box	0
Taxonomy Code (Additional)	Allows the user to enter any additional taxonomy codes.	Field	Character	35
Type	Displays the provider type.	Display	N/A	0

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6.5.4 Provider Enrollment: Specialties Page Field Edit Error Codes

Field	Error Message	To Correct
Primary	One primary specialty is required.	Check box to indicate specialty is primary.
Taxonomy Code	Taxonomy Code is a required field.	Enter a valid taxonomy code.
Specialty	Specialty is a required field.	Enter a valid specialty.
	Specialty Psychiatrist is required if specialty Behavioral Analyst is chosen.	Add Psychiatrist specialty.

6.5.5 Provider Enrollment: Specialties Page Extra Features

Field	Field Type
None	

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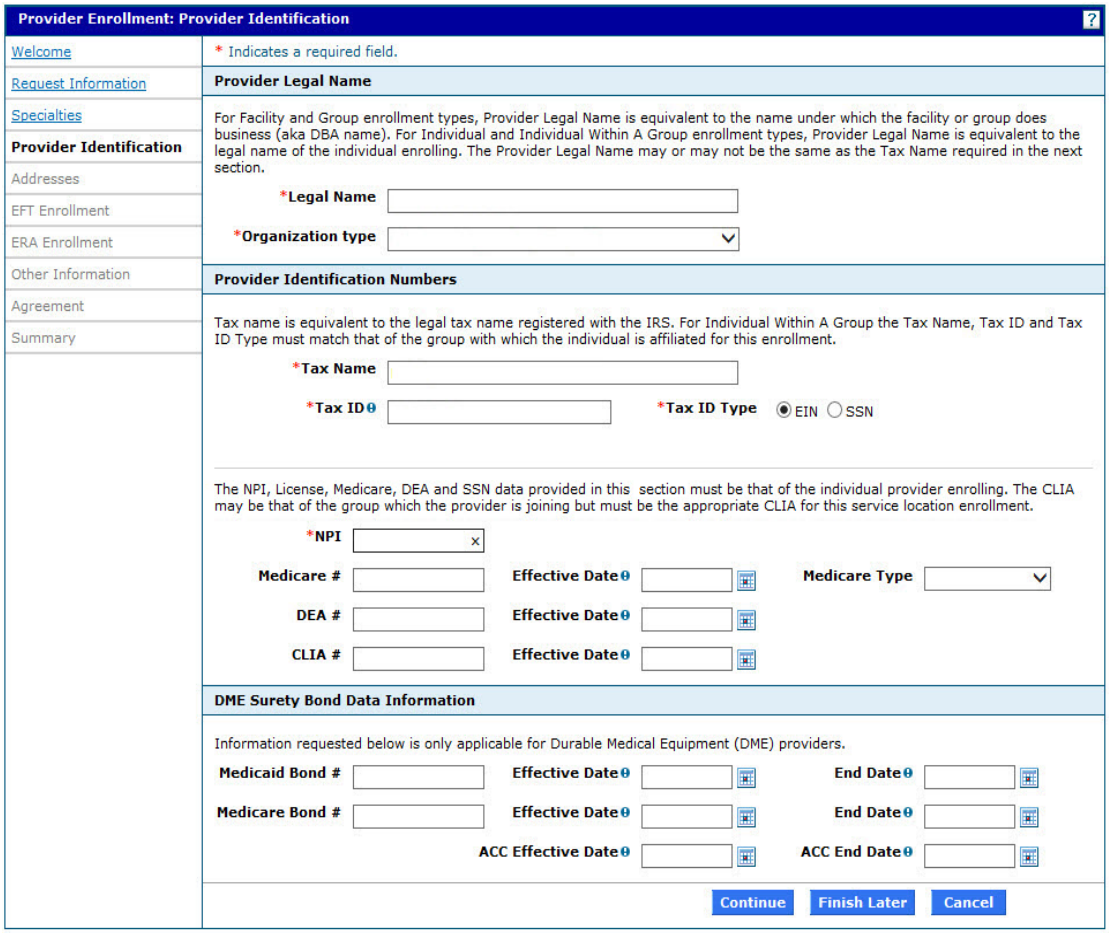
6.6 PROVIDER ENROLLMENT: PROVIDER IDENTIFICATION

6.6.1 Provider Enrollment: Provider Identification Page Narrative

The Provider Enrollment – Provider Identification page allows the provider to enter information, such as your legal name, individual, group practice or facility name and any identification numbers, such as NPI, tax ID, DEA, CLIA, and so on. For Facility and Group enrollment types, Provider Legal Name is equivalent to the name under which the facility or group does business (aka DBA name). Facility enrollment types have an additional section called DME Surety Bond Data Information that needs to be processed. For Individual and Individual Within A Group enrollment types, Provider Legal Name is equivalent to the legal name of the individual enrolling. The Provider Legal Name may or may not be the same as the Tax Name required in the next section.

6.6.2 Provider Enrollment: Provider Identification Page Layout

Provider Enrollment: Provider Identification Page Layout – Facility



Provider Enrollment: Provider Identification Page Layout – Group

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Provider Enrollment: Provider Identification

Welcome
Request Information
Specialties
Provider Identification
Addresses
EFT Enrollment
ERA Enrollment
Other Information
Agreement
Summary

* Indicates a required field.

Provider Legal Name

For Facility and Group enrollment types, Provider Legal Name is equivalent to the name under which the facility or group does business (aka DBA name). For Individual and Individual Within A Group enrollment types, Provider Legal Name is equivalent to the legal name of the individual enrolling. The Provider Legal Name may or may not be the same as the Tax Name required in the next section.

*Legal Name
*Organization type

Provider Identification Numbers

Tax name is equivalent to the legal tax name registered with the IRS. For Individual Within A Group the Tax Name, Tax ID and Tax ID Type must match that of the group with which the individual is affiliated for this enrollment.

*Tax Name
*Tax ID
*Tax ID Type EIN SSN

The NPI, License, Medicare, DEA and SSN data provided in this section must be that of the individual provider enrolling. The CLIA may be that of the group which the provider is joining but must be the appropriate CLIA for this service location enrollment.

*NPI
CLIA #
Effective Date

Continue Finish Later Cancel

Provider Enrollment: Provider Identification Page Layout – Individual And Individual Within A Group

Provider Enrollment: Provider Identification

Welcome
Request Information
Specialties
Provider Identification
Addresses
Other Information
Disclosures
Agreement
Summary

* Indicates a required field.

Provider Legal Name

For Facility and Group enrollment types, Provider Legal Name is equivalent to the name under which the facility or group does business (aka DBA name). For Individual and Individual Within A Group enrollment types, Provider Legal Name is equivalent to the legal name of the individual enrolling. The Provider Legal Name may or may not be the same as the Tax Name required in the next section.

*Last Name
*First Name
Middle
Title
Gender
*Birth Date
*Organization type

Provider Identification Numbers

Tax name is equivalent to the legal tax name registered with the IRS. For Individual Within A Group the Tax Name, Tax ID and Tax ID Type must match that of the group with which the individual is affiliated for this enrollment.

*Tax Name
*Tax ID
*Tax ID Type EIN SSN

The NPI, License, Medicare, DEA and SSN data provided in this section must be that of the individual provider enrolling. The CLIA may be that of the group which the provider is joining but must be the appropriate CLIA for this service location enrollment.

*NPI
*License State
*License #
*Effective Date
*License Expiration Date
Medicare #
Effective Date
Medicare Type
DEA #
Effective Date
CLIA #
Effective Date
*SSN

Continue Finish Later Cancel

Provider Enrollment: Provider Identification Page Layout – OPR

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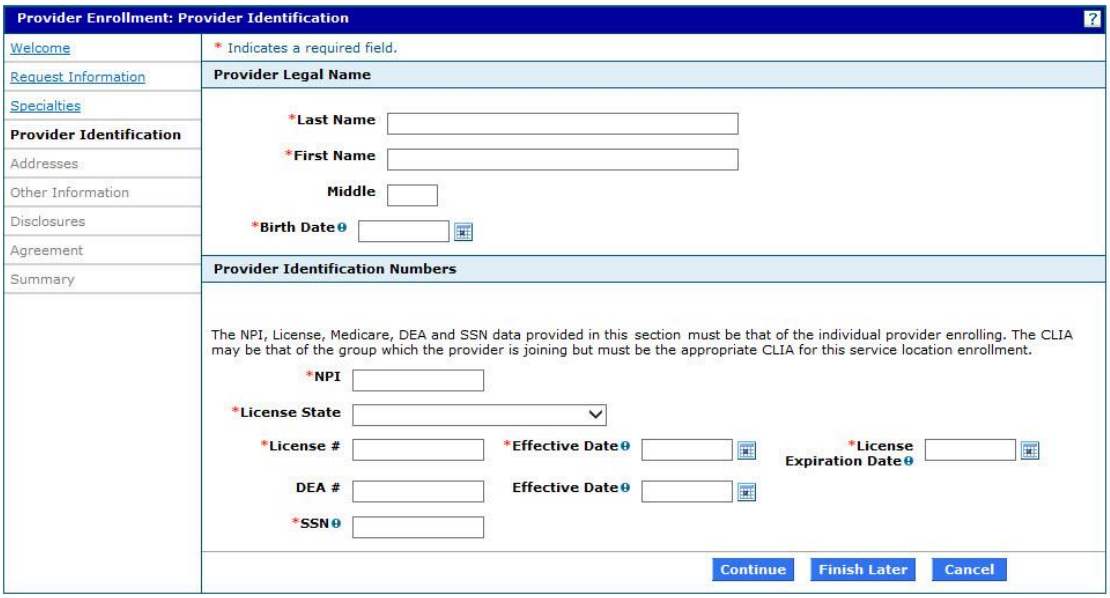

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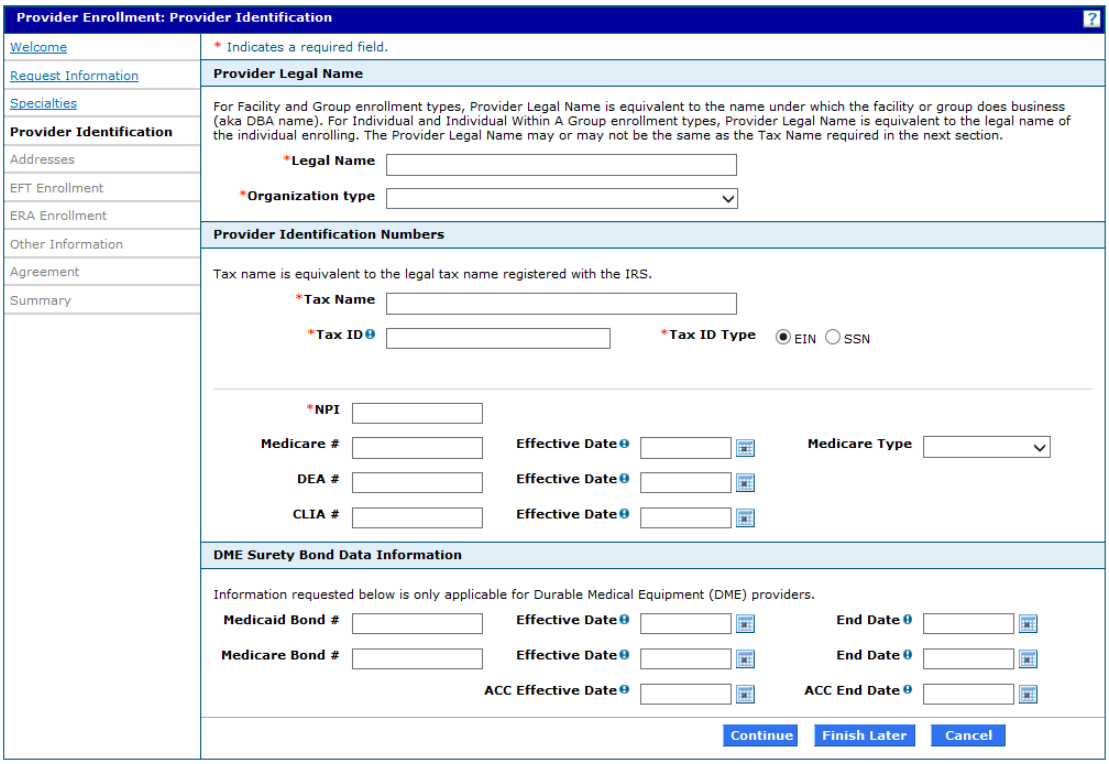
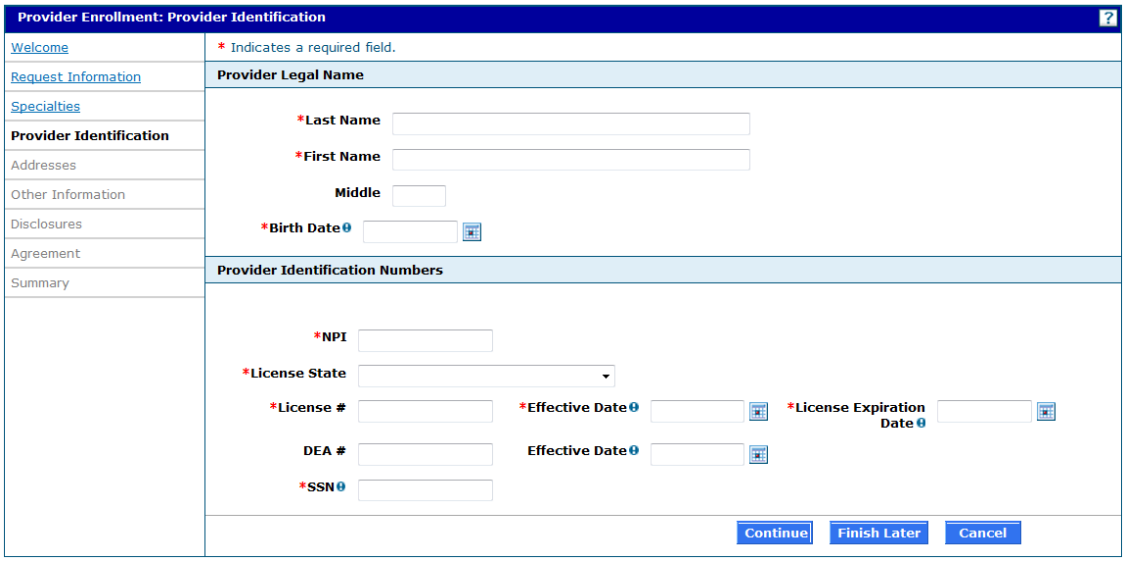
Provider Enrollment: Provider Identification Page Layout – Facility or Group



Provider Enrollment: Provider Identification Page Layout – OPR



6.6.3 Provider Enrollment: Provider Identification Page Field Descriptions

Field	Description	Field Type	Data Type	Length
ACC Effective Date	Allows the user to enter the Medicare accreditation effective date.	Field	Date	8
ACC End Date	Allows the user to enter the Medicare accreditation end date.	Field	Date	8

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Field	Description	Field Type	Data Type	Length
Birth Date	Allows the user to enter the provider's birth date.	Field	Date	8
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
CLIA Effective Date	Allows the user to enter the effective date of the CLIA number.	Field	Date	8
CLIA #	Allows the user to enter the CLIA number.	Field	Character	10
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
DEA Effective Date	Allows the user to enter the effective date of the DEA number.	Field	Date	8
DEA #	Allows the user to enter the DEA number.	Field	Character	9
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
First Name	Allows the user to enter the provider's first name.	Field	Character	15
Gender	Allows the user to select the provider's gender from a drop down list. Valid values are: Male, Female, and Unknown.	Combo Box	Drop down List Box	0
Last Name	Allows the user to enter the provider's last name.	Field	Character	15
Legal Name	Allows the user to enter the provider's legal name.	Field	Character	30
License #	Allows the user to enter the provider's license number.	Field	Character	15
License Effective Date	Allows the user to enter the effective date of the provider's license.	Field	Date	8
License Expiration Date	Allows the user to enter the expiration date of the provider's license.	Field	Date	8
License State	Allows the user to enter the state of origin of the provider's license number.	Combo Box	Drop down List Box	0
Medicaid Bond #	Allows the user to enter the Medicaid Bond number.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Medicaid Bond Effective Date	Allows the user to enter the effective date of the provider's Medicaid Bond.	Field	Date	8
Medicaid Bond End Date	Allows the user to enter the expiration date of the provider's Medicaid Bond.	Field	Date	8
Medicare Bond #	Allows the user to enter the Medicare Bond number.	Field	Character	15
Medicare Bond Effective Date	Allows the user to enter the effective date of the provider's Medicare Bond.	Field	Date	8
Medicare Bond End Date	Allows the user to enter the expiration date of the provider's Medicare Bond.	Field	Date	8
Medicare Effective Date	Allows the user to enter the effective date of the Medicare number.	Field	Date	8
Medicare #	Allows the user to enter the provider's Medicare number.	Field	Character	10
Medicare Type	Allows the user to select the Medicare type that the provider's number associates with from a drop down list. Valid values are: DMERC and Medicare.	Combo Box	Drop down List Box	0
Middle	Allows the user to enter the provider's middle initial.	Field	Character	1
NPI	Allows the user to enter the provider's NPI.	Field	Number (Integer)	10
Organization Type	Allows the user to select the provider's organization type from a drop down list.	Combo Box	Drop down List Box	0
SSN	Allows the user to enter the provider's Social Security Number.	Field	Number (Integer)	9
Tax ID	Allows the user to enter the provider's Tax identification number.	Field	Number (Integer)	9
Tax ID Type	Allows the user to select the provider's Tax identification type. Valid values are: EIN and SSN.	Radio Button	N/A	0
Tax Name	Allows the user to enter the provider's legal tax name.	Field	Character	30
Title	Allows the user to select the provider's title from a drop down list.	Combo Box	Drop down List Box	0

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6.6.4 Provider Enrollment: Provider Identification Page Field Edit Error Codes

Field	Error Message	To Correct
Effective Date	Effective Date is a required field.	Enter a valid effective date
	Effective Date is not in the correct format; enter the value in the format 'MM/DD/YYYY'.	Enter date in correct format.
Expiration Date	Expiration Date is a required field.	Enter a valid expiration date.
	Expiration Date is not in the correct format, enter the value in the format 'MM/DD/YYYY'.	Enter date in correct format.
First Name	First Name is a required field.	Enter a valid first name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Last Name	Last Name is a required field.	Enter a valid last name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
License #	License # is a required field.	Enter a valid license number.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
License State	License State is a required field.	Select a valid state from the drop down list.
Medicaid Bond #	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Medicare #	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Medicare Bond #	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
NPI	NPI is a required field.	Enter a valid NPI number.
	NPI is an invalid numeric value.	Enter a valid numeric value.
SSN	SSN is a required field.	Enter a valid SSN number.
Tax ID	Tax ID is a required field.	Enter a valid tax ID number.
Tax Name	Tax Name is a required field.	Enter a valid tax name.

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Field	Error Message	To Correct
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.6.5 Provider Enrollment: Provider Identification Page Extra Features

Field	Field Type
ACC Effective Date	Selectable calendar function.
ACC End Date	Selectable calendar function.
Effective Date (Medicare, DEA, and CLIA)	Selectable calendar function.
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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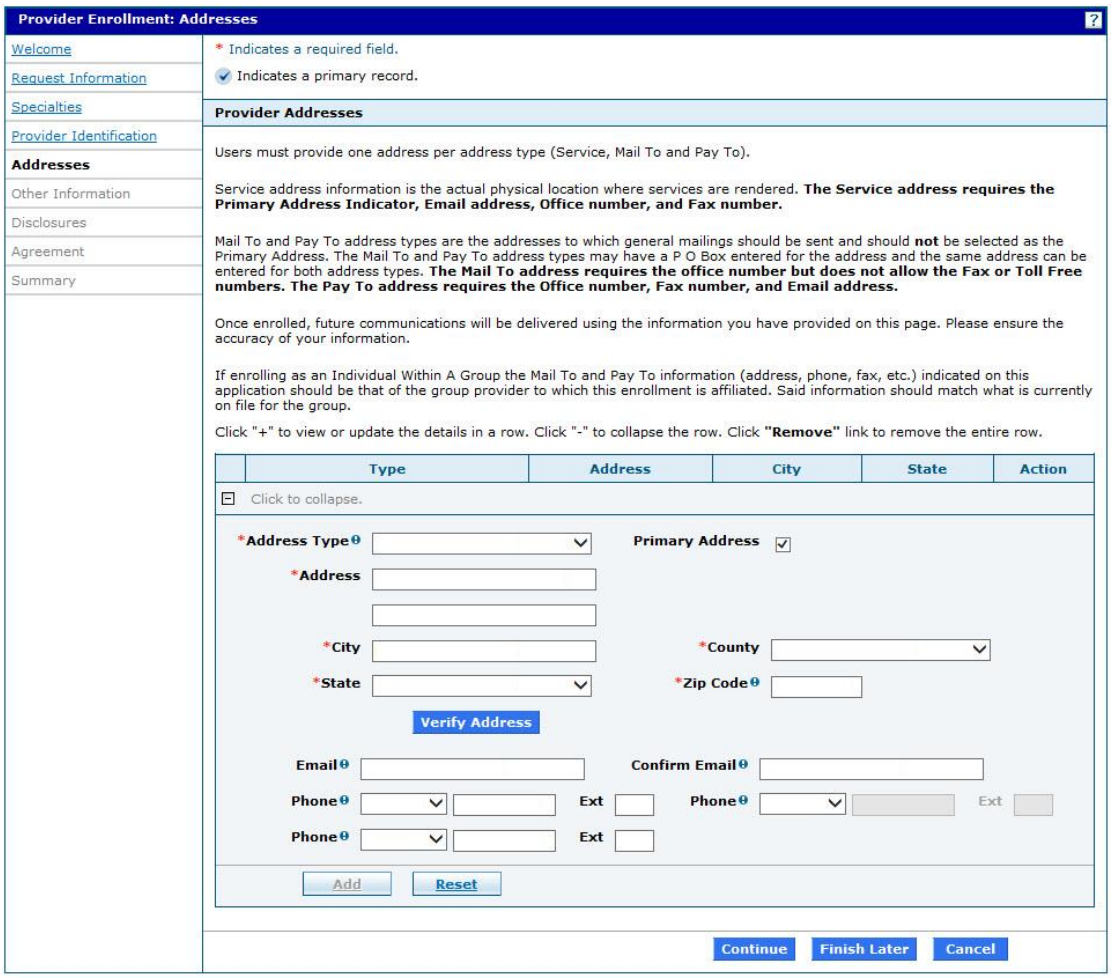
6.7 PROVIDER ENROLLMENT: ADDRESSES

6.7.1 Provider Enrollment: Addresses Page Narrative

The Provider Enrollment – Addresses page allows provider to enter address information. Providers need to provide one address per address type (Service, Mail To and Pay To). Service address information is the actual physical location where services are rendered and associated data such as phone and fax. Mail To and Pay To address types are the addresses to which general mailings should be sent. The Mail To and Pay To address types may have a P O Box entered for the address and the same address can be entered for both address types. E-mail address is a required field for the Service Location and Pay To address. Once enrolled, future communications will be delivered using the information the provider has provided on this page. Please ensure the accuracy of the information.

6.7.2 Provider Enrollment: Addresses Page Layout

Prior to Added Information



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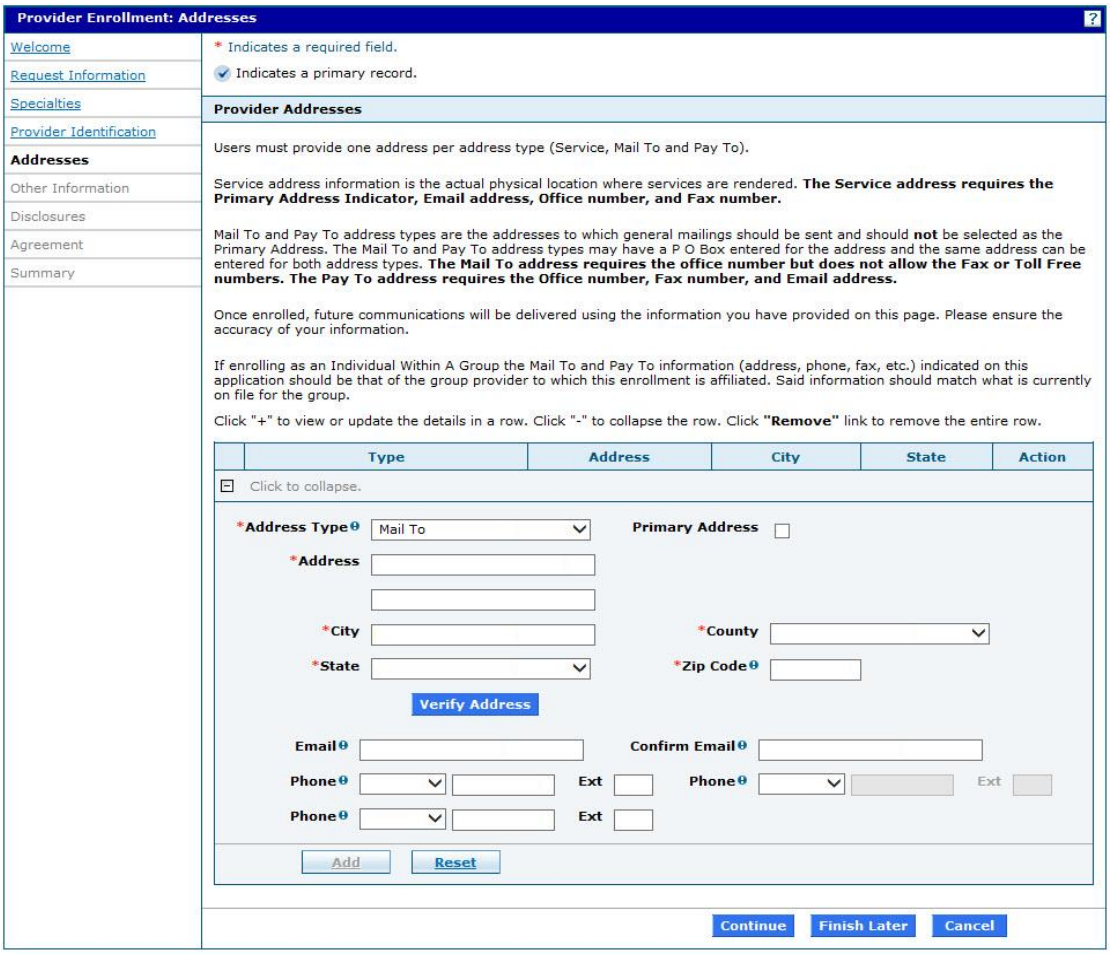
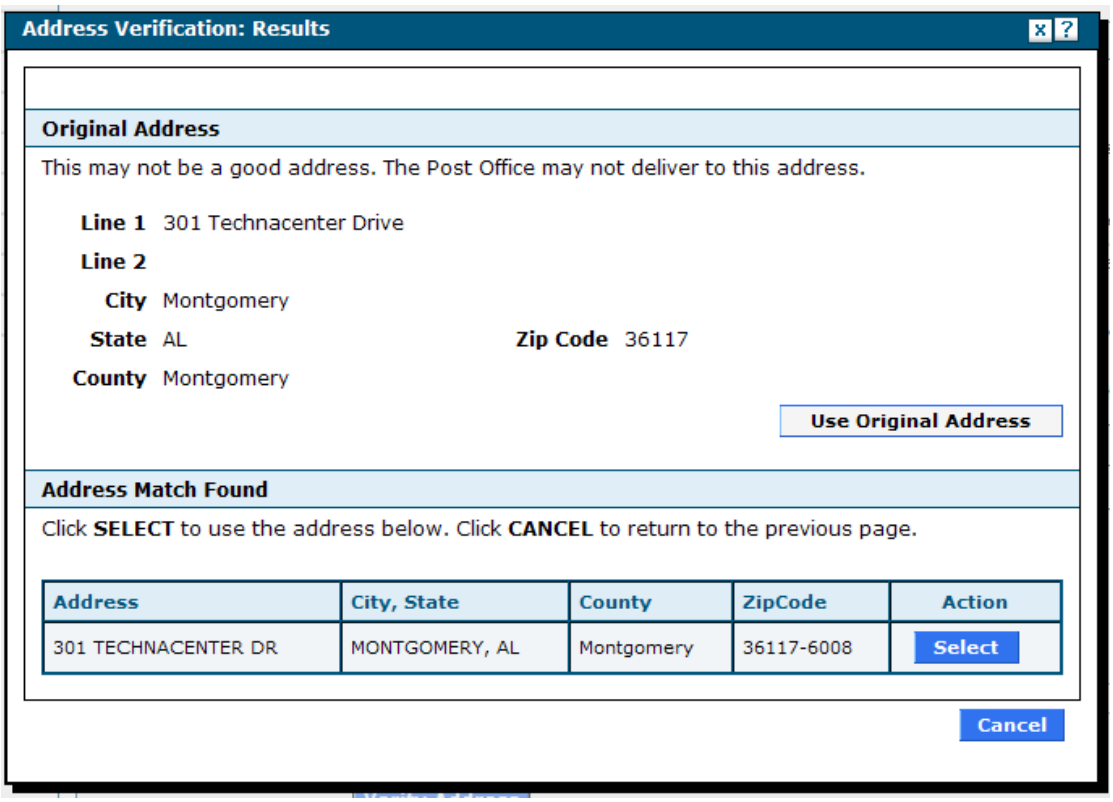
After Address Type has been Selected, Verify Address button is displayed



Enter Address and Click “Verify Address” to validate the address:



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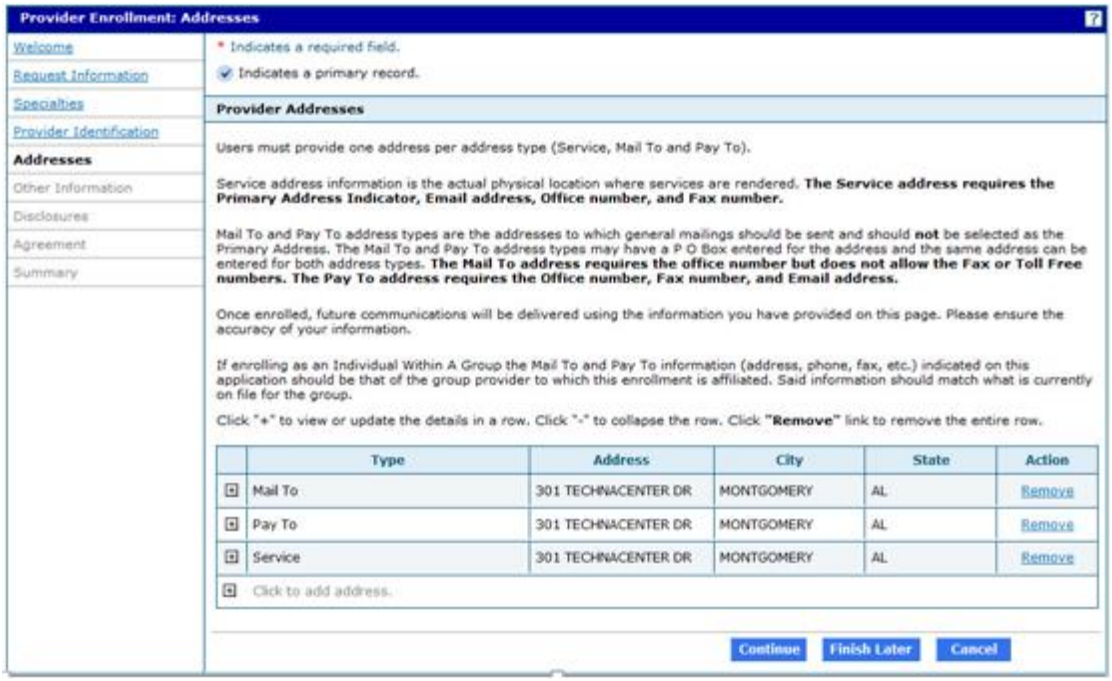
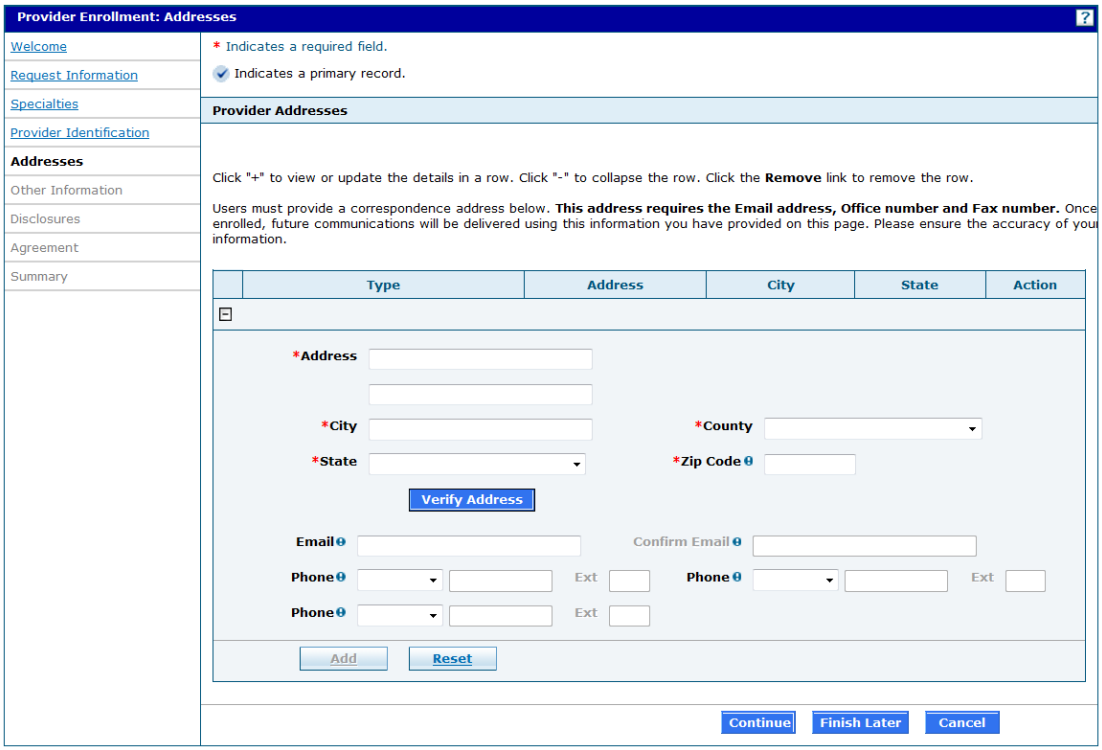
After Information is Added



ADDRESS PAGE for OPR Enrollment



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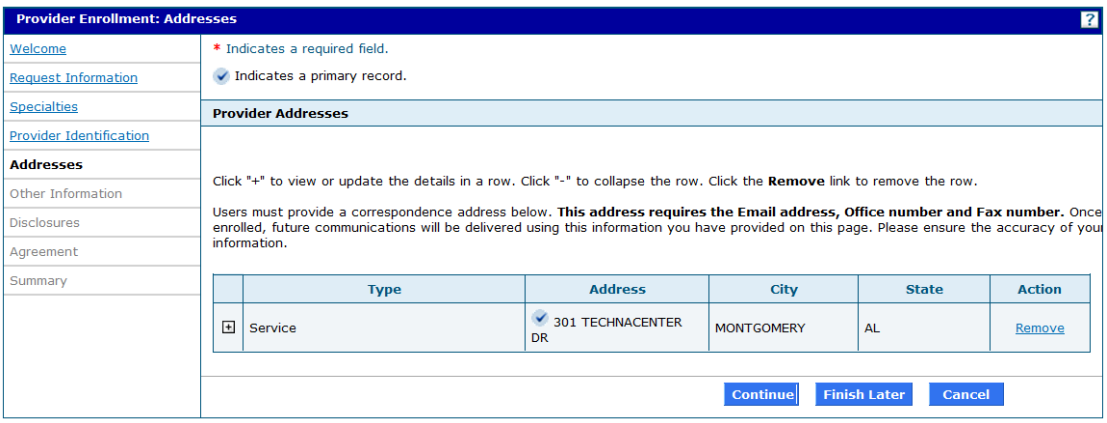
AFTER Address is added:



6.7.3 Provider Enrollment: Addresses Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new information segment. NOTE: Add button is not activated until the address has been verified using the “Verify Address” button.	Button	N/A	0
Address	Allows the user to enter the provider’s address.	Field	Character	55
Address Type	Allows the user to select the provider’s address type from a drop down list. Valid values are: Mail To, Pay To, and Service.	Combo Box	Drop down List Box	0
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
City	Allows the user to enter the provider’s city.	Field	Character	30
Confirm Email	Allows the user to confirm the provider’s email address.	Field	Character	50
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
County	Allows the user to select the provider’s county from a drop down list.	Combo Box	Drop down List Box	0
Email	Allows the user to enter the provider’s email address.	Field	Character	50
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Phone	Allows the user to select the provider's phone type from a drop down list. Valid values are: Cell, Fax, Home, Office, and Toll-Free.	Combo Box	Drop down List Box	0
Phone / Ext	Allows the user to enter the provider's telephone number and extension after the phone type has been selected from drop down list.	Field	Number (Integer)	10 (Phone) 4 (Ext)
Primary Address	Allows the user to indicate which address is the primary address for the provider.	Check Box	N/A	0
Reset	Allows the user to reset the page to initial appearance.	Button	N/A	0
Select	Allows the user to select the standardized address.	Button	N/A	0
State	Allows the user to select the provider's state from a drop down list.	Combo Box	Drop down List Box	0
Use Original Address	Allows the user to select the originally-entered address.	Button	N/A	0
Verify Address	Allows the user to verify and format the address using United States Postal Service standards	Button	N/A	0
Zip Code	Allows the user to enter the provider's zip code.	Field	Number (Integer)	9

6.7.4 Provider Enrollment: Addresses Page Field Edit Error Codes

Field	Error Message	To Correct
Address	Address is a required field.	Enter a valid address.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Address Type	Address Type is a required field.	Enter a valid address type.
	Only the following address types can be primary: Service.	Enter Service as primary type.
	The following address type(s) are required: MailTo, PayTo.	Enter the required address types.
City	City is a required field.	Enter a valid city name.
	The text field contains invalid characters. Acceptable characters	Enter acceptable characters.

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Field	Error Message	To Correct
	include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	
County	County is a required field.	Select a valid county from the drop down list.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Email Address	The email address is invalid. Enter email with 'name@domain' format.	Enter an email address with the proper format.
Email and Confirm Email	Email and Confirm Email fields do not match.	The same email address must be entered in both Email and Confirm Email.
Phone Mail To	The following phone type(s) are required: Office.	Select the required phone types.
Phone Mail To	The following phone type(s) are not allowed for this address type: Fax, Toll-Free.	Only enter required telephone type.
Phone Pay To	The following phone type(s) are required: Office and Fax	Select the required phone types.
Phone Service Location	The following phone type(s) are required: Office and Fax.	Select the required phone types.
Primary Address	At least one primary address must be entered.	Enter a primary address.
Verify Address	An address may result in a warning or suggested standardized address . Screen shot shown below	The user may: • Use the "Select" button to select the standardized address. • Use the "Cancel" button to return to the address panel and re-enter the address. • Select the "Use Original Address" button to use the address as entered, without standardization.
State	State is a required field.	Select a valid state from the drop down list.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Zip Code	Zip Code is a required field.	Enter a valid zip code.

6.7.5 Provider Enrollment: Addresses Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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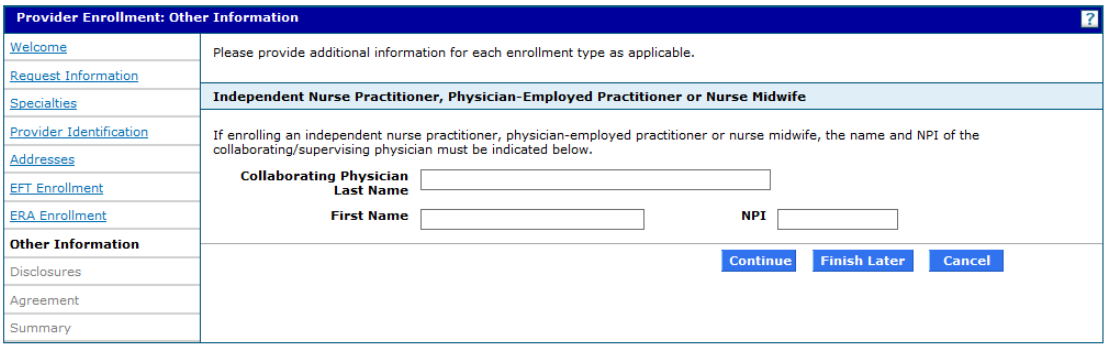
6.9 PROVIDER ENROLLMENT: OTHER INFORMATION

6.9.1 Provider Enrollment: Other Information Page Narrative

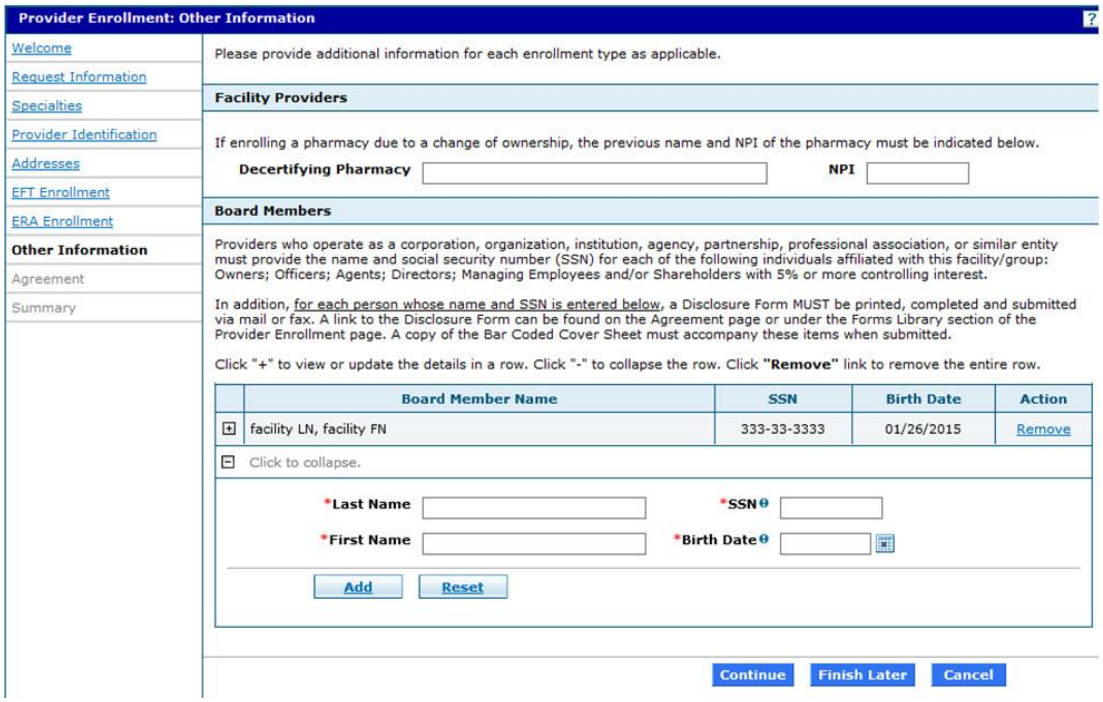
The Provider Enrollment: Other Information page provides any other additional information, such as independent nurse practitioner, physician-employed practitioners or nurse midwife data (if applicable). If the provider is enrolling a pharmacy due to change in ownership, please provide the pharmacy data. Facility or group need to indicate board members.

6.9.2 Provider Enrollment: Other Information Page Layout

Independent Nurse Practitioner, Physician-Employed Practitioners or Nurse Midwife Layout Page



Facility Providers and Board Members Layout Page



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6.9.3 Provider Enrollment: Other Information Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new information segment.	Button	N/A	0
Board Member Birth Date	Allows the user to enter the birth date of the board member.	Field	Date	8
Board Member First Name	Allows the user to enter the first name of the board member.	Field	Character	15
Board Member Last Name	Allows the user to enter the last name of the board member.	Field	Character	20
Board Member SSN	Allows the user to enter the social security number of the board member.	Field	Number (Integer)	9
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Collaborating Physician First Name	Allows the user to enter the Collaborating Physician first name.	Field	Character	25
Collaborating Physician Last Name	Allows the user to enter the Collaborating Physician last name.	Field	Character	50
Collaborating Physician NPI	Allows the user to enter the Collaborating Physician NPI.	Field	Number (Integer)	10
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Decertifying Pharmacy	Allows the user to enter the Decertifying Pharmacy.	Field	Character	50
Decertifying Pharmacy NPI	Allows the user to enter the Decertifying Pharmacy NPI.	Field	Number (Integer)	10
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
Reset	Allows the user to reset the page to initial appearance.	Button	N/A	0

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6.9.4 Provider Enrollment: Other Information Page Field Edit Error Codes

Field	Error Message	To Correct
Board Member Birth Date	Birth Date is a required field.	Enter a valid birth date.
	Birth date must be between 0 and 150 years old.	Enter a valid birth date.
Board Member First Name	First Name is a required field.	Enter a valid first name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Board Member Last Name	Last Name is a required field.	Enter a valid last name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Board Member SSN	SSN is a required field.	Enter a valid SSN number.
Collaborating Physician First Name	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Collaborating Physician Last Name	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.9.5 Provider Enrollment: Other Information Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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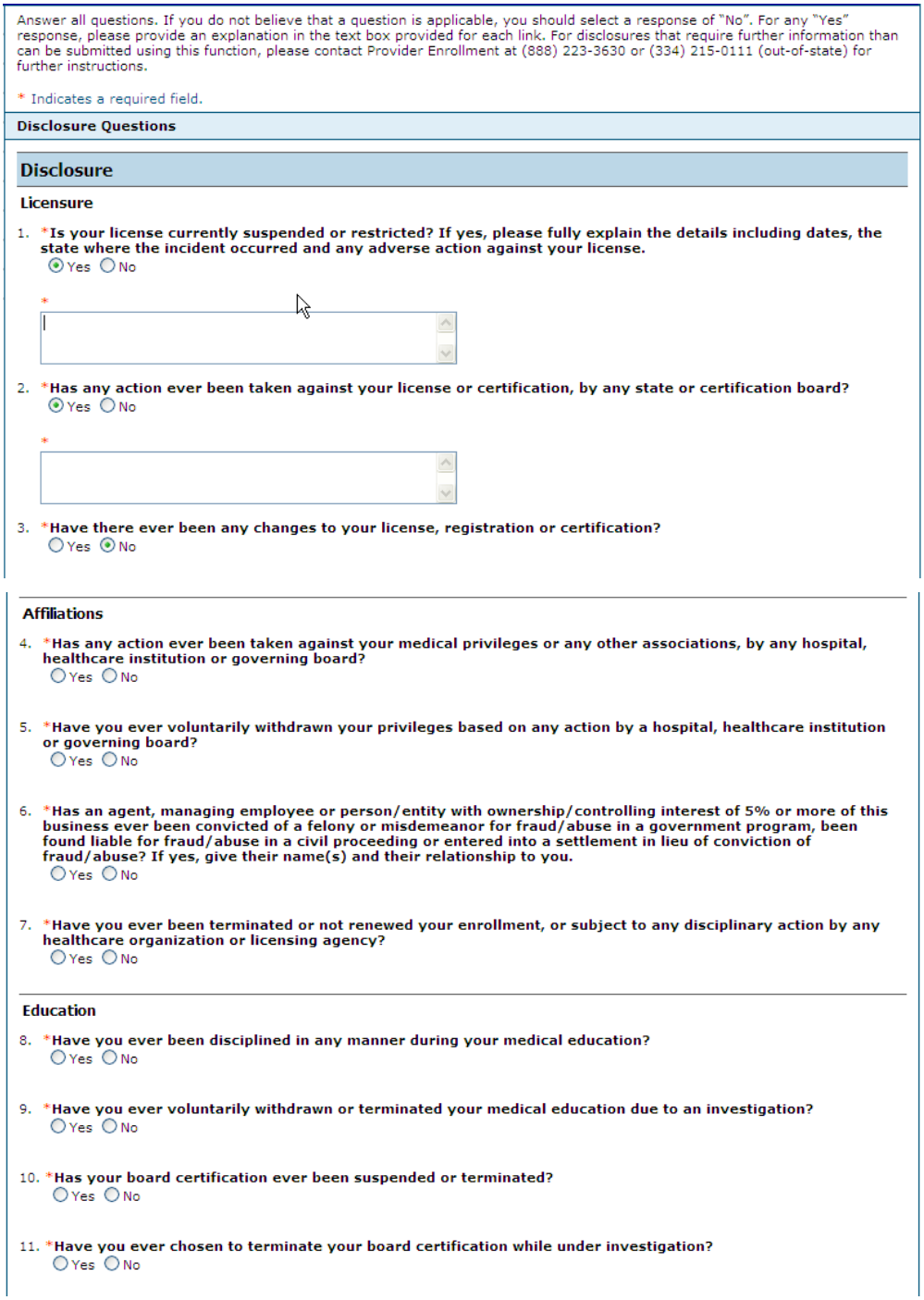
6.10 PROVIDER ENROLLMENT: DISCLOSURES

6.10.1 Provider Enrollment: Disclosures Page Narrative

The Provider Enrollment: Disclosures page allows the provider to answers all disclosure questions. If the question is not applicable to you, answer `No.' For all `Yes' responses, provide an explanation in the text box. **If a disclosure explanation requires more detail than what the text box allows, contact Provider Enrollment.**

6.10.2 Provider Enrollment: Disclosures Page Layout



Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". For any "Yes" response, please provide an explanation in the text box provided for each link. For disclosures that require further information than can be submitted using this function, please contact Provider Enrollment at (888) 223-3630 or (334) 215-0111 (out-of-state) for further instructions.

* Indicates a required field.

Disclosure Questions

Disclosure

Licensure

1. ***Is your license currently suspended or restricted? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license.**
   Yes No
   *

2. ***Has any action ever been taken against your license or certification, by any state or certification board?**
   Yes No
   *

3. ***Have there ever been any changes to your license, registration or certification?**
   Yes No

Affiliations

4. ***Has any action ever been taken against your medical privileges or any other associations, by any hospital, healthcare institution or governing board?**
   Yes No

5. ***Have you ever voluntarily withdrawn your privileges based on any action by a hospital, healthcare institution or governing board?**
   Yes No

6. ***Has an agent, managing employee or person/entity with ownership/controlling interest of 5% or more of this business ever been convicted of a felony or misdemeanor for fraud/abuse in a government program, been found liable for fraud/abuse in a civil proceeding or entered into a settlement in lieu of conviction of fraud/abuse? If yes, give their name(s) and their relationship to you.**
   Yes No

7. ***Have you ever been terminated or not renewed your enrollment, or subject to any disciplinary action by any healthcare organization or licensing agency?**
   Yes No

Education

8. ***Have you ever been disciplined in any manner during your medical education?**
   Yes No

9. ***Have you ever voluntarily withdrawn or terminated your medical education due to an investigation?**
   Yes No

10. ***Has your board certification ever been suspended or terminated?**
    Yes No

11. ***Have you ever chosen to terminate your board certification while under investigation?**
    Yes No

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Substance Registration

12. *Has any action ever been taken against your federal or state controlled substance certifications or authorizations?
Yes No

Governmental Programs

13. *Has any action ever been taken against you during your participation in, or have you ever been excluded, suspended, sanctioned, or debarred from, any federal or state governmental healthcare program? If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license. (Attach additional sheets if necessary)
Yes No

Investigations

14. *Have you ever been the subject of an investigation by any healthcare organization or military agency, related to your performance of medical duties, for any action that qualifies as fraudulent activities?
Yes No

15. *Are you aware of any information being reported regarding your performance as a medical practitioner, to any public medical malpractice reporting agency?
Yes No

16. *Have you ever been under investigation by any state or federal regulatory agencies?
Yes No

17. *Have you ever been convicted, or are you currently under investigation, by any licensing authority, law enforcement agency or any other entity for any legal misconduct?

Convicted Means that:
1) A judgement of conviction has been entered against an individual or entity by a Federal,State or local court, regardless of whether:
a) There is a post trial motion or appeal, or
b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2) A Federal, State or local court has made a finding of guilt against an individual or entity;
3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).
Yes No

Liability

18. *Has any action ever been taken against your professional liability coverage based on your history of medical practice?
Yes No

19. *Have you ever had an adverse professional liability action?
Yes No

Legal History

20. *Have you ever been convicted or plead guilty to a felony or misdemeanor (excluding minor traffic citations)?

Convicted Means that:
1) A judgement of conviction has been entered against an individual or entity by a Federal,State or local court, regardless of whether:
a) There is a post trial motion or appeal, or
b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2) A Federal, State or local court has made a finding of guilt against an individual or entity;
3) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license. (Attach additional sheets if necessary).
Yes No

21. *Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state?
Yes No

Continue | Finish Later | Cancel

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6.10.3 Provider Enrollment: Disclosures Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
Licensure	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Affiliations	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Education	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Substance Registration	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Governmental Programs	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Investigations	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500

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Field	Description	Field Type	Data Type	Length
Liability	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500
Legal History	Allows the user to answer Disclosure questions for this section. Valid answers are 'Yes' or 'No'. If 'Yes' is answered, a text box appears to provide an explanation.	Radio Button / Field	N/A / Character	0 / 500

6.10.4 Provider Enrollment: Disclosures Page Field Edit Error Codes

Field	Error Message	To Correct
Answer	Answer is a required field.	Enter yes or no to the question.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
	Must select yes or no for each question. If you have selected 'Yes', you must provide a text explanation.	

6.10.5 Provider Enrollment: Disclosures Page Extra Features

Field	Field Type
Answer	Text box appears if answered yes.
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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6.11 PROVIDER ENROLLMENT: AGREEMENT

6.11.1 Provider Enrollment: Agreement Page Narrative

The Provider Enrollment Agreement page allows the provider to view the Terms of Enrollment, Provider Agreement and Signature requirements. The provider must accept the terms, agreement and provide an electronic signature in order to submit the enrollment application. Failure to do so means that no enrollment application is retained or submitted. The provider must also access, print, sign, fax and mail with the bar-coded cover sheet, as well as other supplemental documentation. The Signature box must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.

It is strongly advised that the provider access the Summary of Enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again. Once submitted, ability to update data on the application will most likely be limited to specific data and permission to do so is granted only by HPES Provider Enrollment staff and only under specific circumstances.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials (fax and/or paper mailings) to the HPES Provider Enrollment office.

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6.11.2 Provider Enrollment: Agreement Page Layout

Provider Enrollment: Agreement

Welcome
Request Information
Other Information
Agreement
Summary

Instructions

The Terms of Enrollment, the Provider Agreement and Electronic Signature block are provided below. You must accept these terms,

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet must be printed for submission with all hard copy materials (fax and/or paper mailings) to the DXC Provider Enrollment office.

Using the links and fields below, the following actions must be taken to complete the enrollment process. Refer to the Attachments link to determine the supplemental documents you must submit for your application. Read, Print, Complete, Sign, Fax and Mail the Electronic Funds Transfer Form along with a copy of a voided check for verification purposes. If you need to submit supplemental documentation you may do so by fax and/or mail. All items faxed or mailed must be accompanied by the bar coded cover sheet.

Read: Link to page listing required attachments.

Read: Link to CAQH/CORE EFT/ERA Re-association Information.

Print, Complete, Sign & Submit: Link to Disclosure Form.

Print, Complete, Sign & Submit: Link to W-9 Tax Form.

Terms of Agreement

Legal Name
Tax ID Type EIN
Primary Address

Tax ID
NPI
Contact Name
Contact Email

1.2 State and Federal Regulatory Requirements.
1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any progr
Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. section 1320a-
or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal
health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice t
any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could r
in exclusion from the Medicaid program.
1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and
information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on
to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health an
Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or i
agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownersh
or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making
such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to DXC and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/DXC of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/DXC for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

***I accept** ☐ I understand that my electronic signature is equivalent to written signature.

***Authorized Signature/Electronic Signature of Person Submitting Enrollment (Entering your name in the box to the right will constitute your electronic signature.)**
Title

Submission Date 08/30/2017

Submit | Finish Later | Cancel

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6.11.3 Provider Enrollment: Agreement Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Agreement Date	Displays the terms of agreement date of the provider enrollment contract.	Displays	N/A	0
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Contact Name	Displays the contact name of the provider enrollment contract for the provider.	Displays	N/A	0
Contact Email	Displays the contact email of the provider enrollment contract for the provider.	Displays	N/A	0
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
I accept	Allows the user to select the check box next to I accept. This box must have a check indicating the electronic signature is equivalent to the written signature.	Check Box	N/A	0
Legal Name	Displays the provider's legal name.	Displays	N/A	0
NPI	Displays the provider's NPI.	Displays	N/A	0
Primary Address	Displays the provider's primary address.	Displays	N/A	0
Print, Complete, Sign & Submit:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to EFT Form.	Hyperlink	N/A	0
Print, Sign & Submit:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Signature Form.	Hyperlink	N/A	0
Read:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to page listing required attachments.	Hyperlink	N/A	0
Read & Print:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Provider Agreement.	Hyperlink	N/A	0
Submit	Allows the user to submit the application.	Button	N/A	0
Tax ID	Displays the provider's Tax ID,	Displays	N/A	0

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Field	Description	Field Type	Data Type	Length
Tax ID Type	Displays the provider's tax ID type.	Displays	N/A	0
Title	Allows the user to enter the title, if applicable, of the individual signing the agreement.	Field	Character	50
Authorized Signature/Electronic Signature of Person Submitting Enrollment	Allows the user to enter the name of the individual signing the agreement.	Field	Character	50

6.11.4 Provider Enrollment: Agreement Page Field Edit Error Codes

Field	Error Message	To Correct
I Accept	I Accept is a required field.	Click the check box to show a check.
Title	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Authorized Signature/Electronic Signature of Person Submitting Enrollment	Your Signature is a required field.	Enter your name..
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.11.5 Provider Enrollment: Agreement Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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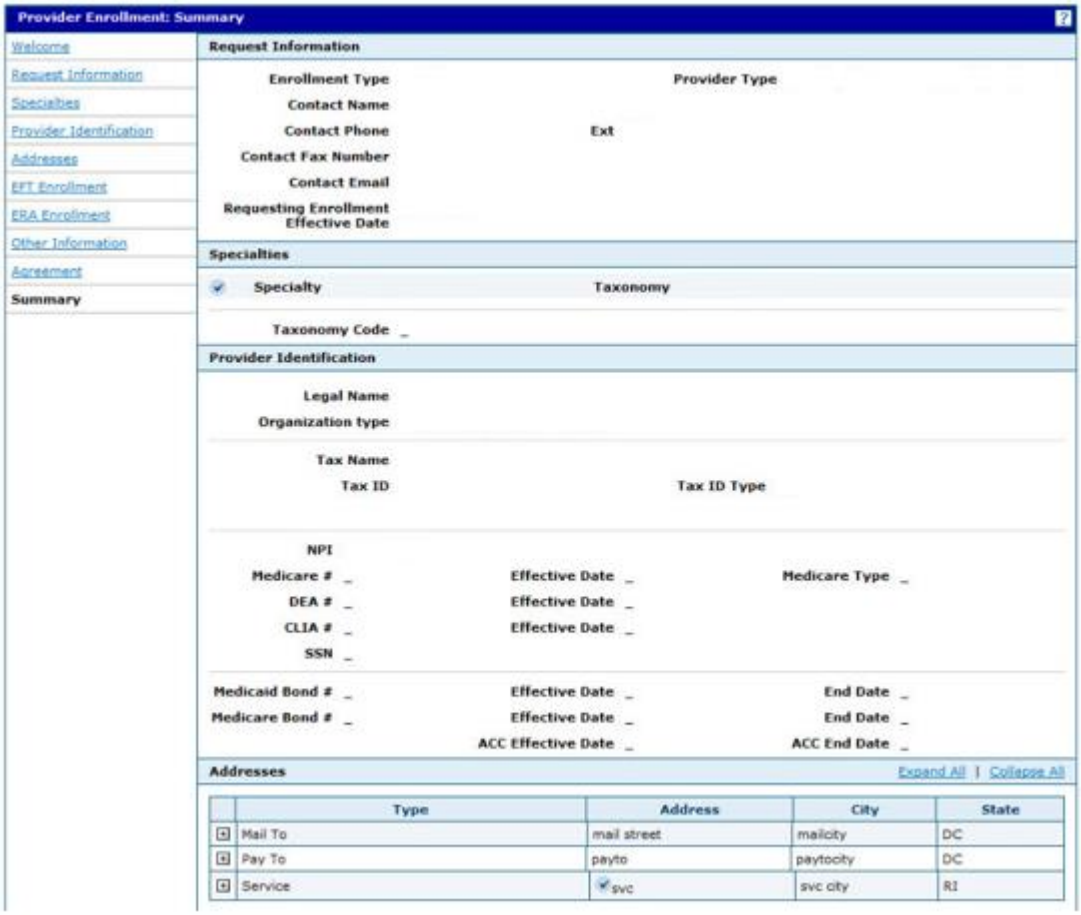
6.12 PROVIDER ENROLLMENT: SUMMARY

6.12.1 Provider Enrollment: Summary Page Narrative

The Provider Enrollment: Summary Page allows the provider to review and make any revisions to previous pages as needed. The provider is **strongly** encouraged to verify if the information on the summary is correct. If the provider needs to make changes it can be done by selecting the appropriate page(s) in the table of contents. If all information is correct the provider is **strongly** encouraged to print a copy of the summary for your records. The provider must click '**Confirm'** for the application to be submitted for review.

6.12.2 Provider Enrollment: Summary Page Layout



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EFT Enrollment

Provider Name
Street
City
State/Province
Zip Code/Postal Code

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
Provider National Provider Identifer (NPI)
Other Identifier
Assigning Authority

Provider Contact Name
Title clerk
Telephone Number
Telephone Number Extension
Email Address
Fax Number

Provider Agent Name
Provider Agent Contact Name
Telephone Number
Email Address

Financial Institution Name
Street
City
State/Province
Zip Code/Postal Code
Financial Institution Telephone Number
Telephone Number Extension
Financial Institution Routing Number
Type of Account at Financial Institution
Provider`s Account Number with Financial Institution
Provider National Provider Identifer (NPI)

ERA Enrollment

Provider Name
Street
City
State/Province
Zip Code/Postal Code

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
Provider National Provider Identifer (NPI)
Other Identifier
Assigning Authority
Trading Partner ID

Provider Contact Name
Title
Telephone Number
Telephone Number Extension
Email Address
Fax Number

Provider Agent Name
Provider Agent Contact Name
Telephone Number
Email Address

Provider National Provider Identifer (NPI)
Method of Retrieval

Clearinghouse Name
Clearinghouse Contact Name
Telephone Number
Email Address

Vendor Name
Vendor Contact Name
Telephone Number
Email Address

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Other Information

Decertifying Pharmacy _ **NPI** _

Board Member Name	SSN	Birth Date

Supporting Documentation

Using the links and fields below, the following actions must be taken to complete the enrollment process. Refer to the Attachments link to determine the supplemental documents you must submit for your application. Read, Print, Complete, Sign, Fax and Mail the Electronic Funds Transfer Form along with a copy of a voided check for verification purposes. If you need to submit supplemental documentation you may do so by fax and/or mail. All items faxed or mailed must be accompanied by the bar coded cover sheet.

Read: Link to page listing required attachments.

Read: Link to CAQH/CORE EFT/ERA Re-association Information.

Print, Complete, Sign & Submit: Link to EFT Form.

Print, Complete, Sign & Submit: Link to W-9 Tax Form.

Terms of Agreement

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to HPES and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/HPES of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/HPES for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

I accept ☑ I understand that my electronic signature is equivalent to written signature.

Authorized Signature/Electronic Signature of Person Submitting Enrollment (Entering your name in the box to the right will constitute your electronic signature.)

Title

Submission Date

Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.
Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing.
Please print a copy of this summary for your records.

Print Preview | Confirm | Finish Later | Cancel

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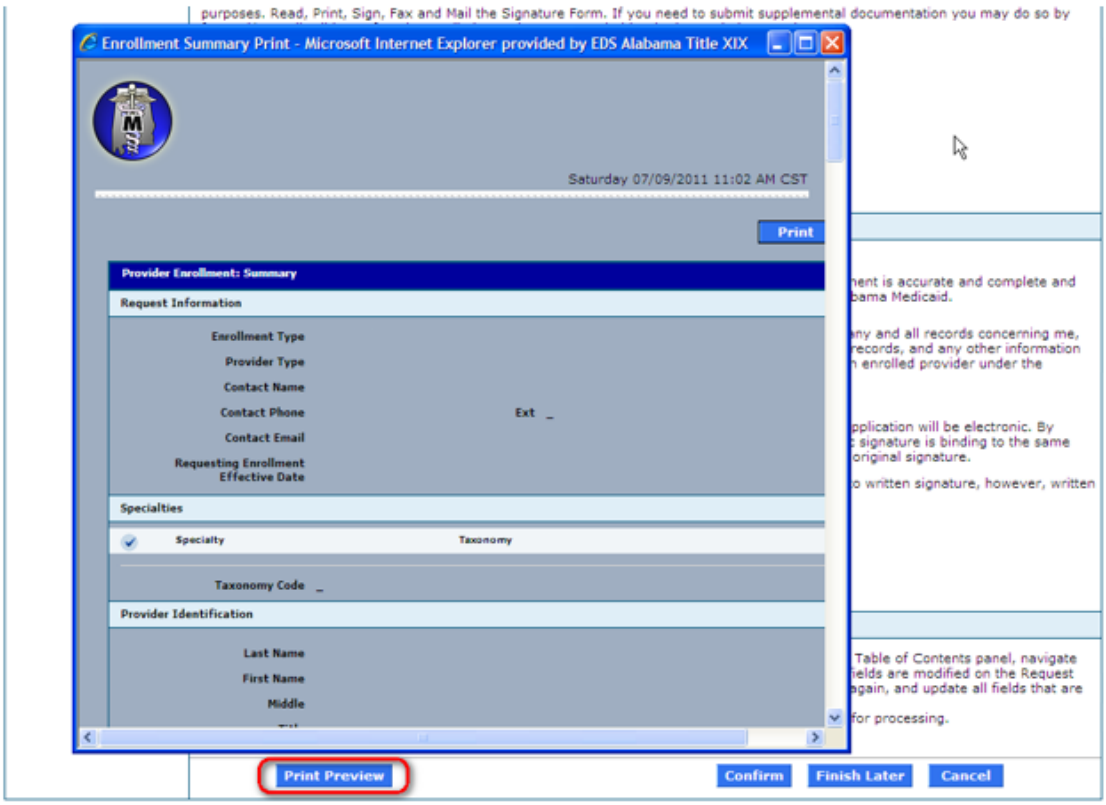
Print Preview Layout



6.12.3 Provider Enrollment: Summary Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Confirm	Allows the user to confirm the Provider Enrollment summary information is correct and submit it.	Button	N/A	0
Finish Later	Allows the user to save the enrollment application and finish it at a later date.	Button	N/A	0
Print	Allows the user to print the Provider Enrollment summary information that is displaying in a pop-up box.	Button	N/A	0
Print, Complete, Sign & Submit:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to EFT Form.	Hyperlink	N/A	0
Print Preview	Allows access to a pop-up box so the user can preview the Provider Enrollment summary information before it is printed.	Pop-up Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Print, Sign & Submit:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Signature Form.	Hyperlink	N/A	0
Read:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to page listing required attachments.	Hyperlink	N/A	0
Read & Print:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to Provider Agreement.	Hyperlink	N/A	0

6.12.4 Provider Enrollment: Summary Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

6.12.5 Provider Enrollment: Summary Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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6.13 PROVIDER ENROLLMENT: ENROLLMENT CREDENTIALS

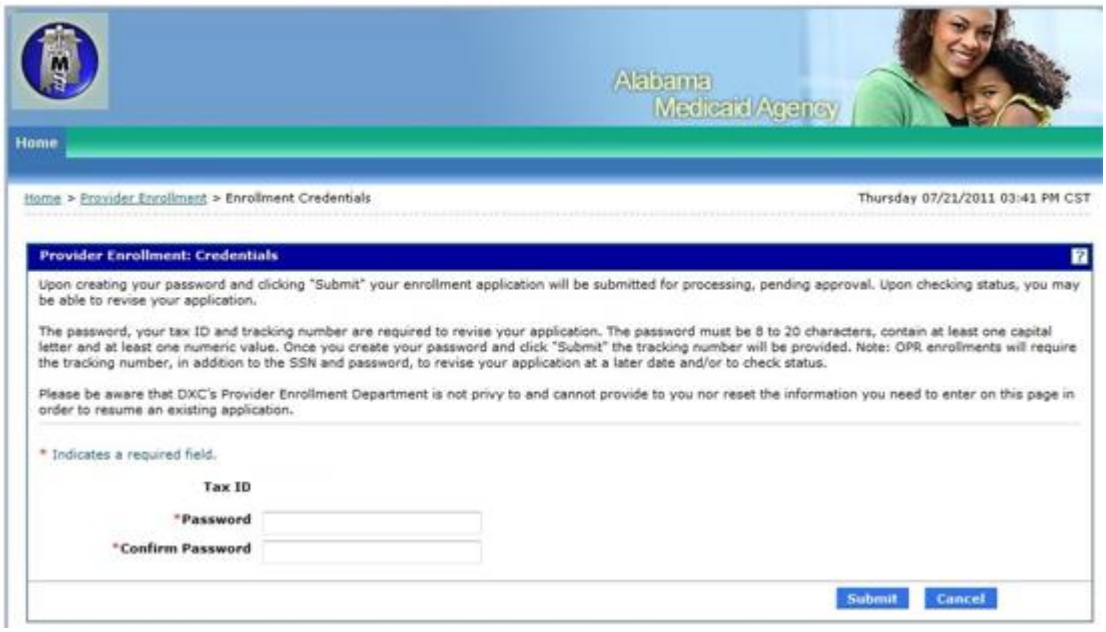
6.13.1 Provider Enrollment: Enrollment Credentials Page Narrative

The Provider Enrollment: Enrollment Credentials Page allows the provider to enter credential information such as tax ID and password. Once the provider enters the credential information and click Submit, a tracking number will be assigned. The tracking number, the provider's tax ID, and password will be used as the credentials to resume the enrollment application or track the status.

If the provider chooses to finish later, the enrollment application will be saved for 60 days. If the provider does not resume completing the enrollment application within the specified number of days, the application will be purged and the provider will need to start a new enrollment application.

6.13.2 Provider Enrollment: Enrollment Credentials Page Layout

Credentials Page for OPR Enrollment:



6.13.3 Provider Enrollment: Enrollment Credentials Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Confirm Password	Allows the user to confirm a password and submit application.	Field	Character	20
Password	Allows the user to enter a password and submit application.	Field	Character	20
Submit	Allows the user to submit the credential information and receive a tracking number.	Button	N/A	0
Tax ID	Displays the provider's Tax ID.	Displays	N/A	0

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6.13.4 Provider Enrollment: Enrollment Credentials Page Field Edit Error Codes

Field	Error Message	To Correct
Confirm Password	Confirm Password is a required field.	Enter a valid password.
	Your password must be 8 to 20 characters in length, not be the same as your user id and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter.	Enter required characters and length.
Password	Password is a required field.	Enter a valid password.
	Your password must be 8 to 20 characters in length, not be the same as your user id and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter.	Enter required characters and length.

6.13.5 Provider Enrollment: Enrollment Credentials Page Extra Features

Field	Field Type
None	

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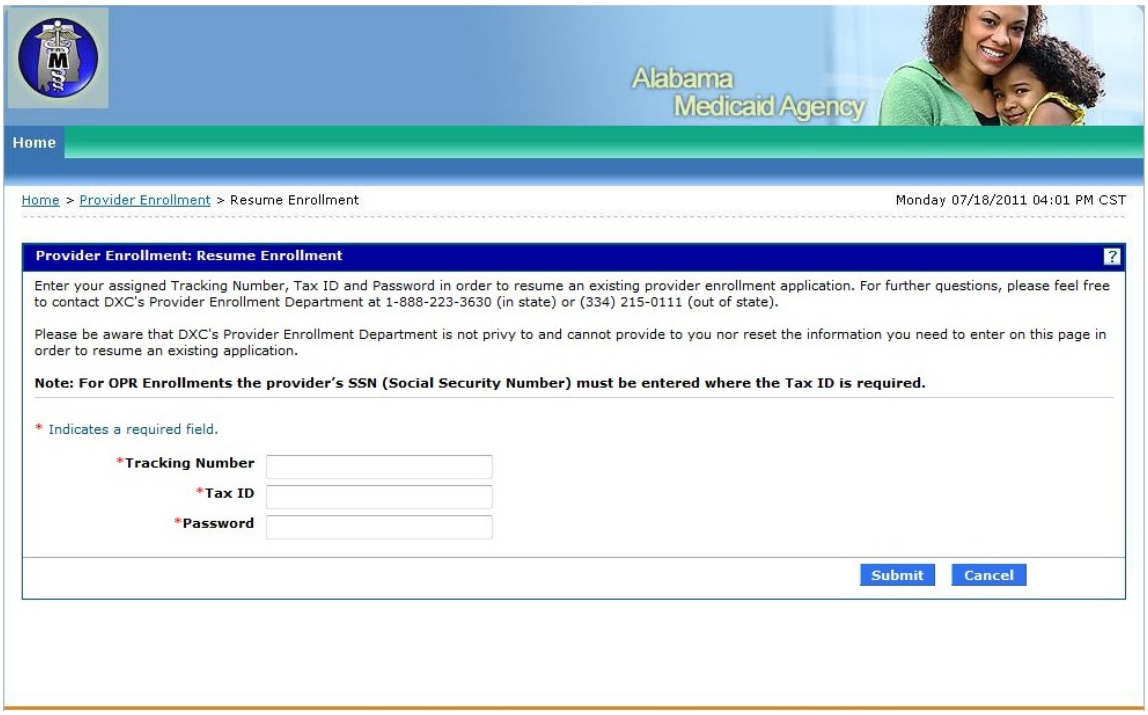
6.14 PROVIDER ENROLLMENT: RESUME ENROLLMENT

6.14.1 Provider Enrollment: Resume Enrollment Page Narrative

The Provider Enrollment: Resume Enrollment Page allows the provider to enter an assigned Tracking Number, Tax ID and Password in order to resume an existing provider enrollment application. For further questions, providers can contact the HPES' Provider Enrollment Department at 1-888-223-3630 (in state) or (334) 215-0111 (out of state). Please be aware that HPES' Provider Enrollment Department is not privy to and cannot provide nor reset the information needed to enter on this page in order to resume an existing application.

6.14.2 Provider Enrollment: Resume Enrollment Page Layout



6.14.3 Provider Enrollment: Resume Enrollment Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Password	Allows the user to enter a password in order to resume an existing application.	Field	Character	20
Submit	Allows the user to submit required information in order to resume an existing application.	Button	N/A	0
Tax ID	Allows the user to enter a tax ID in order to resume an existing application.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Tracking Number	Allows the user to enter a tracking number in order to resume an existing application.	Field	Character	25

6.14.4 Provider Enrollment: Resume Enrollment Page Field Edit Error Codes

Field	Error Message	To Correct
Password	Password is a required field.	Enter a valid password.
	Your password must be 8 to 20 characters in length, not be the same as your user id and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter.	Enter required characters and length.
Tax ID	Tax ID is a required field.	Enter a valid tax ID number.
Tracking Number	Tracking Number is a required field.	Enter a valid tracking number.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.14.5 Provider Enrollment: Resume Enrollment Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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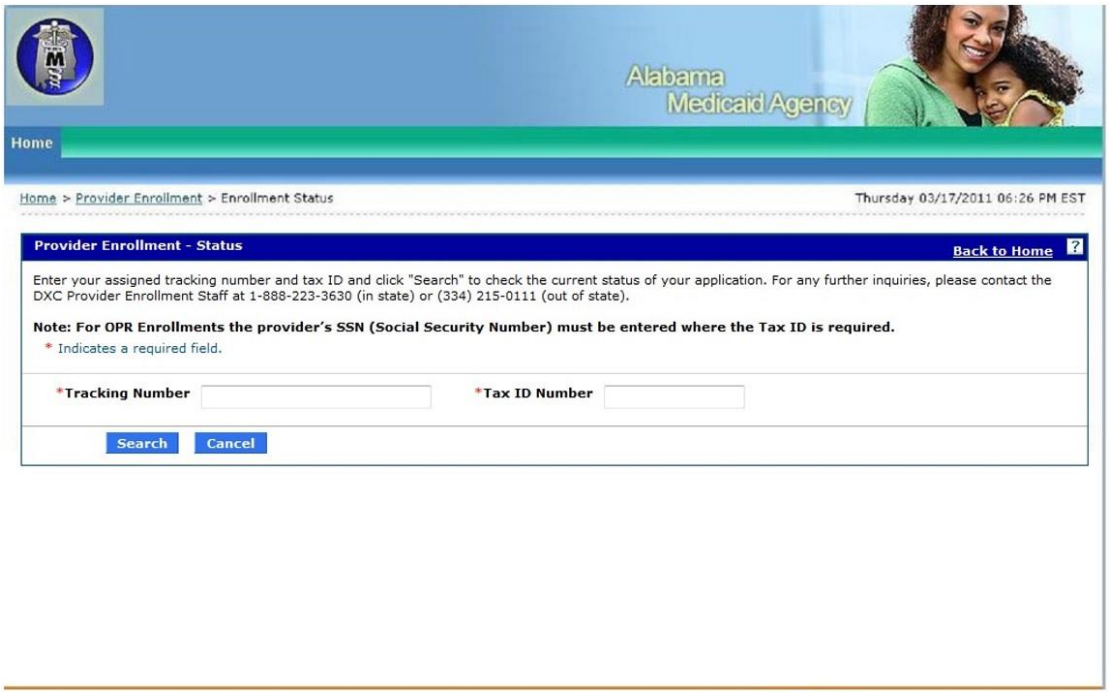
6.15 PROVIDER ENROLLMENT: ENROLLMENT STATUS

6.15.1 Provider Enrollment: Enrollment Status Page Narrative

The Provider Enrollment: Enrollment Status Page allows the provider to enter an assigned tracking number and tax ID and click "Search" to check the current status of an application. For any further inquiries, please contact the HPES Provider Enrollment Staff at 1-888-223-3630 (in state) or (334) 215-0111 (out of state).

6.15.2 Provider Enrollment: Enrollment Status Page Layout



6.15.3 Provider Enrollment: Enrollment Status Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Search	Button that allows the user to view their enrollment status.	Button	N/A	0
Tax ID Number	Allows the user to enter a tax ID in order to check the status of an existing application.	Field	Character	10
Tracking Number	Allows the user to enter a tracking number in order to check the status of an existing application.	Field	Character	25

6.15.4 Provider Enrollment: Enrollment Status Page Field Edit Error Codes

Field	Error Message	To Correct
Tax ID	Tax ID is a required field.	Enter a valid tax ID number.

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Field	Error Message	To Correct
Tracking Number	Tracking Number is a required field.	Enter a valid tracking number.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.15.5 Provider Enrollment: Enrollment Status Page Extra Features

Field	Field Type
A hyperlink is provided to navigate users to the Alabama Medicaid Agency web site.	

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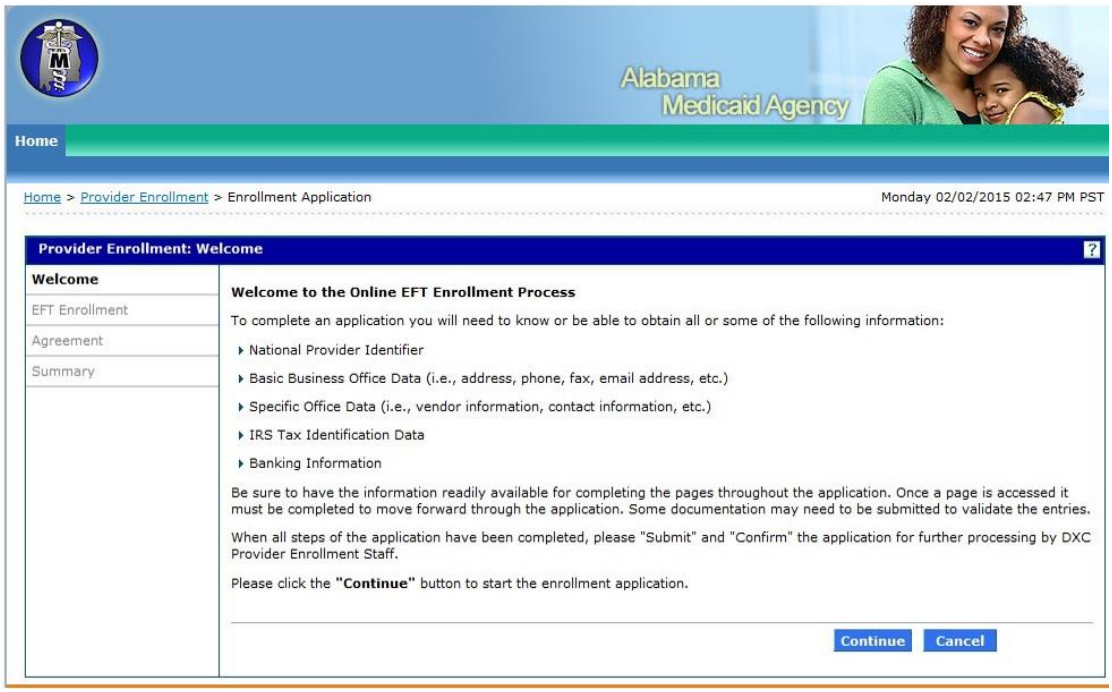
6.16 PROVIDER EFT ENROLLMENT: WELCOME

6.16.1 Provider EFT Enrollment: Welcome Page Narrative

EFT Enrollment allows providers and authorized delegates to enter all pertinent EFT enrollment information via a wizard. The enrollment wizard captures key provider data such as contact information, banking information, and demographics such as names, identifiers, and locations.

The EFT Enrollment wizard allows the provider to navigate through each page of EFT enrollment, from the banking information in the first page, to the final print and bar coded cover sheet on the last page. The provider can create a print file for future reference and bar coded cover sheet for submissions of supplemental documentation. A tracking number is also provided so that providers can check the status of their enrollment request.

6.16.2 Provider EFT Enrollment: Welcome Page Layout



6.16.3 Provider EFT Enrollment: Welcome Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider EFT Enrollment page.	Button	N/A	0
Continue	Button that allows the user to begin the EFT enrollment process.	Button	N/A	0

6.16.4 Provider EFT Enrollment: Welcome Page Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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6.16.5 Provider EFT Enrollment: Welcome Page Extra Features

Field	Field Type
N/A	

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6.17 PROVIDER EFT ENROLLMENT: EFT ENROLLMENT

6.17.1 Provider EFT Enrollment: EFT Enrollment Page Narrative

The EFT Enrollment page allows the provider to enter the contact information, bank name, address, and account information. Electronic Funds Transfer (EFT) is required in order for funds to be deposited to a provider's account. When application is complete be sure to fax OR mail with cover sheet a copy of a voided check for verification purposes.

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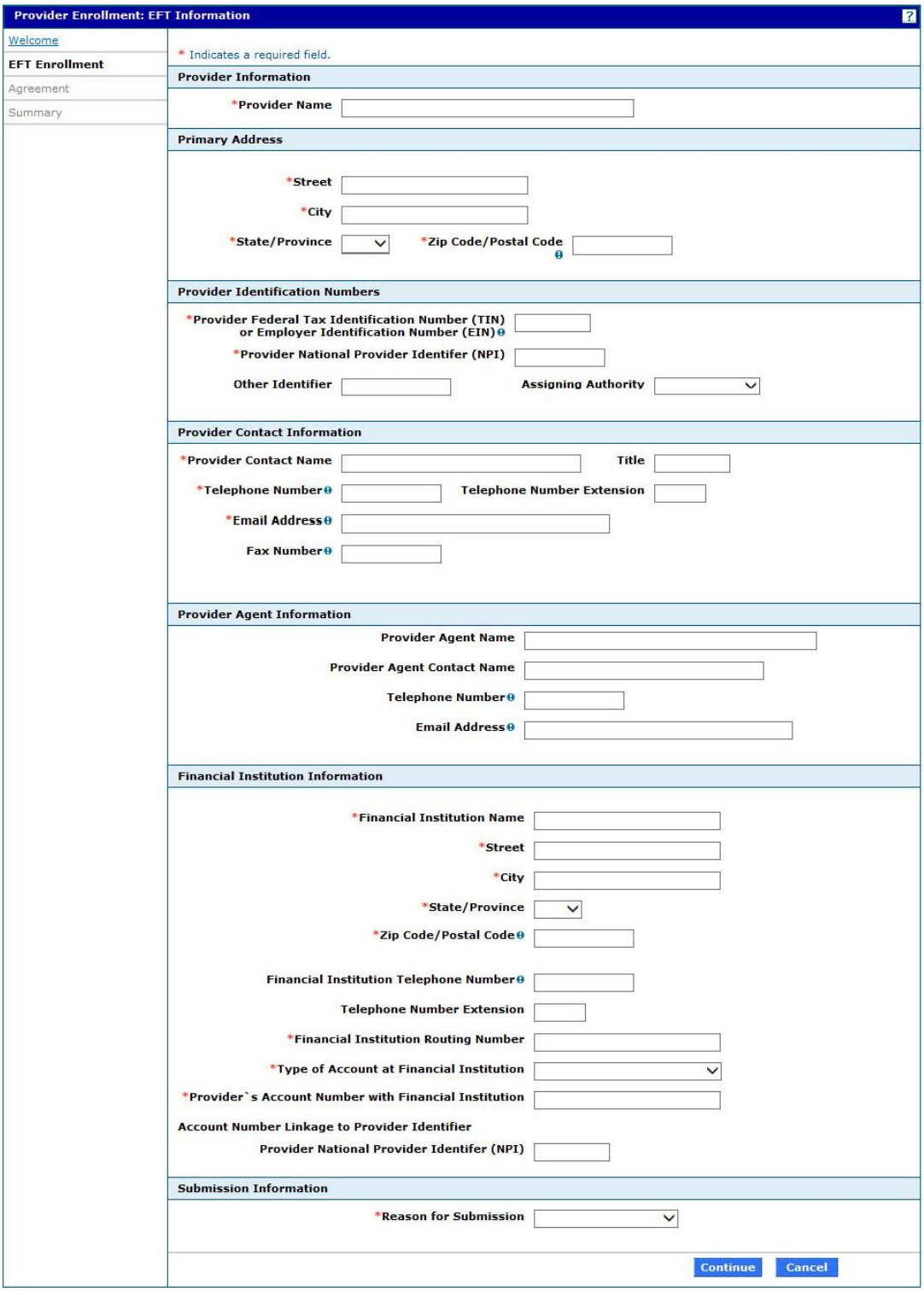
6.17.2 Provider EFT Enrollment: EFT Enrollment Page Layout



6.17.3 Provider EFT Enrollment: EFT Enrollment Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Assigning Authority	Allows the user to select assigning authority.	Combo Box	Drop down List Box	0

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Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
City	Allows the user to enter provider name.	Field	Character	30
Contact Phone Ext	Allows the user to enter the telephone number extension of the contact.	Field	Number (Integer)	4
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Email Address	Allows the user to enter email address.	Field	Character	50
Fax Number	Allows the user to enter fax number.	Field	Number (Integer)	10
Financial Institution Name	Allows the user to enter financial institution name.	Field	Character	39
Financial Institution Routing Number	Allows the user to enter financial institution routing number.	Field	Number (Integer)	9
Financial Institution Telephone Number	Allows the user to enter financial institution telephone number.	Field	Number (Integer)	10
Other Identifier	Allows the user to enter other identifier.	Field	Character	15
Provider Agent Name	Allows the user to enter provider agent name.	Field	Character	50
Provider Agent Contact Name	Allows the user to enter provider agent contact name.	Field	Character	50
Provider Contact Name	Allows the user to enter provider contact name.	Field	Character	50
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Allows the user to enter TIN/EIN.	Field	Number (Integer)	9
Provider Name	Allows the user to enter provider name.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Provider National Provider Identifier (NPI)	Allows the user to enter NPI.	Field	Number (Integer)	10
Provider`s Account Number with Financial Institution	Allows the user to enter provider's account number with financial institution.	Field	Number (Integer)	17
Reason for Submission	Allows the user to select reason for submission.	Combo Box	Drop down List Box	0
State/Province	Allows the user to select state.	Combo Box	Drop down List Box	0
Street	Allows the user to enter street.	Field	Character	30
Telephone Number	Allows the user to enter telephone number.	Field	Number (Integer)	10
Telephone Number Extension	Allows the user to enter telephone number extension.	Field	Number (Integer)	4
Title	Allows the user to enter title.	Field	Character	10
Type of Account at Financial Institution	Allows the user to select type of account at financial institution.	Combo Box	Drop down List Box	0
Zip Code/Postal Code	Allows the user to enter zip code.	Field	Number (Integer)	10

6.17.4 Provider EFT Enrollment: EFT Enrollment Field Edit Error Codes

Field	Error Message	To Correct
City	City is a required field.	Enter a valid city.
Email Address	Email Address is a required field.	Enter a valid email address.
Financial Institution City	Financial Institution City is a required field.	Enter a valid financial institution city.
Financial Institution Name	Financial Institution Name is a required field.	Enter a valid financial institution name.
Financial Institution State	Financial Institution State is a required field.	Enter a valid financial institution state.

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Field	Error Message	To Correct
Financial Institution Zip Code	Financial Institution Zip Code is a required field.	Enter a valid financial institution zip code.
Provider Name	Provider Name is a required field.	Enter a valid provider name.
Provider Contact Name	Provider Contact Name is a required field.	Enter a valid provider contact name.
Provider National Provider Identifier (NPI)	Provider National Provider Identifier (NPI) contains invalid characters.	Enter a valid provider National Provider identifier (NPI)
Provider`s Account Number with Financial Institution	Provider`s Account Number with Financial Institution is a required field.	Enter a valid provider`s account number with financial institution.
	Provider`s Account Number with Financial Institution must be 9 character(s) in length.	Enter a valid provider`s account number with financial institution.
	Provider`s Account Number with Financial Institution is an invalid numeric value.	Enter a valid provider`s account number with financial institution.
	Provider`s Account Number with Financial Institution cannot be all the same digit.	Enter a valid provider`s account number with financial institution.
Reason for Submission	Reason for Submission is a required field.	Enter a valid Reason for Submission.
Street	Street is a required field.	Enter a valid street.
State/Province	State/Province is a required field.	Enter a valid state/province.
Type of Account at Financial Institution	Type of Account at Financial Institution is a required field.	Enter a valid type of account at financial institution.
Zip Code/Postal Code	Zip Code/Postal Code is a required field.	Enter a valid zip code/postal code.

6.17.5 Provider EFT Enrollment: EFT Enrollment Page Extra Features

Field	Field Type
N/A	

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6.18 PROVIDER EFT ENROLLMENT: AGREEMENT

6.18.1 Provider EFT Enrollment: Agreement Page Narrative

The EFT Enrollment Agreement page allows the provider to view the Terms of Enrollment, Provider Agreement and Signature requirements. The provider must accept the terms, agreement and provide an electronic signature in order to submit the enrollment application. Failure to do so means that no enrollment application is retained or submitted. The provider must also access, print, sign, fax and mail with the bar-coded cover sheet, as well as other supplemental documentation. The Signature box must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.

It is strongly advised that the provider access the Summary of Enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials (fax and/or paper mailings) to the HPES Provider Enrollment office.

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6.18.2 Provider EFT Enrollment: Agreement Page Layout

Provider Enrollment: Agreement

Welcome
EFT Enrollment
Agreement
Summary

Instructions

The Terms of Enrollment, the Provider Agreement and Electronic Signature block are provided below. You must accept these terms, the agreement and provide an authorized signature in order to submit the enrollment application. Failure to accept these terms and agreement and/or provide an authorized signature means that no enrollment application is retained or submitted. The signature box must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.

It is strongly advised that you access the Summary of Enrollment link to review all data that has been entered into the enrollment application as well as print a copy of the application for your records. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned and a cover sheet must be printed for submission with all hard copy materials (fax and/or paper mailings) to the DXC Provider Enrollment office.

Terms of Agreement

Provider Name
Address
Tax ID
NPI
Contact Name
Contact Email

such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restrictio suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDIC information related to any such suspension or restriction.
1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health c Medicaid program. As required by 42 C.F.R. section 431.107, Provider agrees to keep any and all records necessa extent of services provided by the Provider to individuals in the Medicaid program and any information relating to p by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records req maintained under 42 C.F.R. section 431.107 and copies of those records free of charge to MEDICAID, its agent, th General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. All suc maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by o behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above ti audit findings, litigation, or other action has not been resolved at the end of the above time period, said records sha retained until resolution and finality thereof.
1.2.4 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to DXC and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/DXC of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/DXC for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

***I accept** ☐ I understand that my electronic signature is equivalent to written signature.

***Authorized Signature/Electronic Signature of Person Submitting Enrollment (Entering your name in the box to the right will constitute your electronic signature.)**

Title

Submission Date 08/31/2017

Submit Cancel

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6.18.3 Provider Enrollment: Agreement Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Authorized Signature/Electronic Signature of Person Submitting Enrollment	Allows the user to enter the name of the individual signing the agreement.	Field	Character	50
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Contact Name	Displays the contact name of the provider enrollment contract for the provider.	Displays	N/A	0
Contact Email	Displays the contact email of the provider enrollment contract for the provider.	Displays	N/A	0
I accept	Allows the user to select the check box next to I accept. This box must have a check indicating the electronic signature is equivalent to the written signature.	Check Box	N/A	0
NPI	Displays the provider's NPI.	Displays	N/A	0
Provider name	Display Provider's name.	Displays	N/A	0
Submission Date	Displays the current date.	Displays	N/A	0
Submit	Allows the user to submit the application.	Button	N/A	0
Tax ID	Displays the provider's Tax ID,	Displays	N/A	0
Title	Allows the user to enter the title, if applicable, of the individual signing the agreement.	Field	Character	50

6.18.4 Provider EFT Enrollment: Agreement Page Field Edit Error Codes

Field	Error Message	To Correct
I Accept	I Accept is a required field.	Click the check box to show a check.
Title	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Your Signature	Authorized Signature/Electronic Signature of Person Submitting Enrollment is a required field.	Enter your name.

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Field	Error Message	To Correct
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.18.5 Provider EFT Enrollment: Agreement Page Extra Features

Field	Field Type
N/A	

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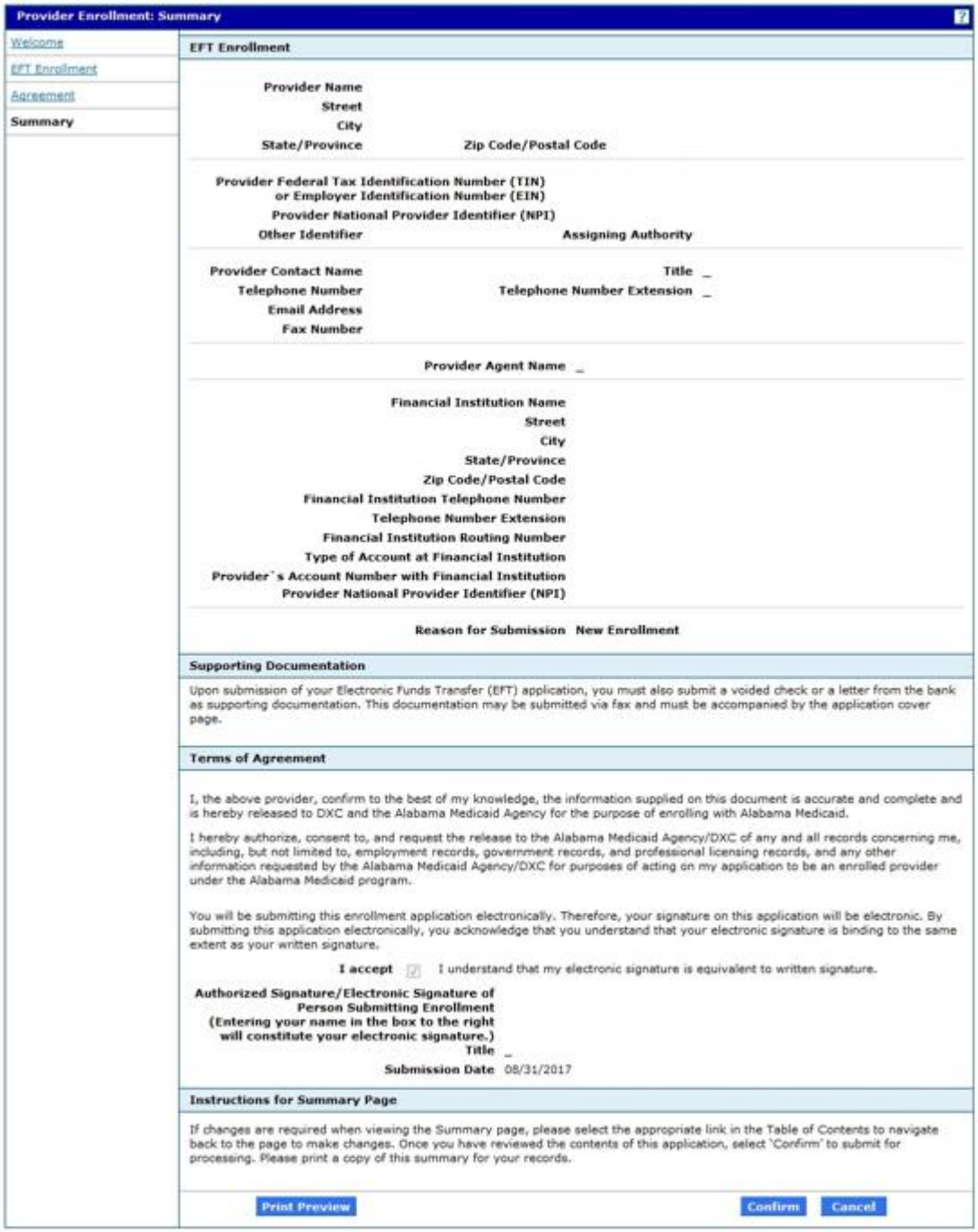
6.19 PROVIDER EFT ENROLLMENT: SUMMARY

6.19.1 Provider EFT Enrollment: Summary Page Narrative

The EFT Enrollment Summary Page allows the provider to review and make any revisions to previous pages, as needed. Providers are **strongly** encouraged to verify the information on the summary is correct. If the provider needs to make changes it can be done by selecting the appropriate page(s) in the table of contents. If all information is correct the provider is **strongly** encouraged to print a copy of the summary for your records. The provider must click '**Confirm'** for the application to be submitted for review.

6.19.2 Provider EFT Enrollment: Summary Page Layout



Provider Enrollment: Summary

Welcome
EFT Enrollment
Agreement
Summary

EFT Enrollment

Provider Name
Street
City
State/Province
Zip Code/Postal Code

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
Provider National Provider Identifier (NPI)
Other Identifier
Assigning Authority

Provider Contact Name
Title
Telephone Number
Telephone Number Extension
Email Address
Fax Number

Provider Agent Name

Financial Institution Name
Street
City
State/Province
Zip Code/Postal Code
Financial Institution Telephone Number
Telephone Number Extension
Financial Institution Routing Number
Type of Account at Financial Institution
Provider`s Account Number with Financial Institution
Provider National Provider Identifier (NPI)

Reason for Submission New Enrollment

Supporting Documentation

Upon submission of your Electronic Funds Transfer (EFT) application, you must also submit a voided check or a letter from the bank as supporting documentation. This documentation may be submitted via fax and must be accompanied by the application cover page.

Terms of Agreement

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to DXC and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/DXC of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/DXC for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

I accept I understand that my electronic signature is equivalent to written signature.

Authorized Signature/Electronic Signature of Person Submitting Enrollment (Entering your name in the box to the right will constitute your electronic signature.)
Title
Submission Date 08/31/2017

Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents to navigate back to the page to make changes. Once you have reviewed the contents of this application, select 'Confirm' to submit for processing. Please print a copy of this summary for your records.

Print Preview Confirm Cancel

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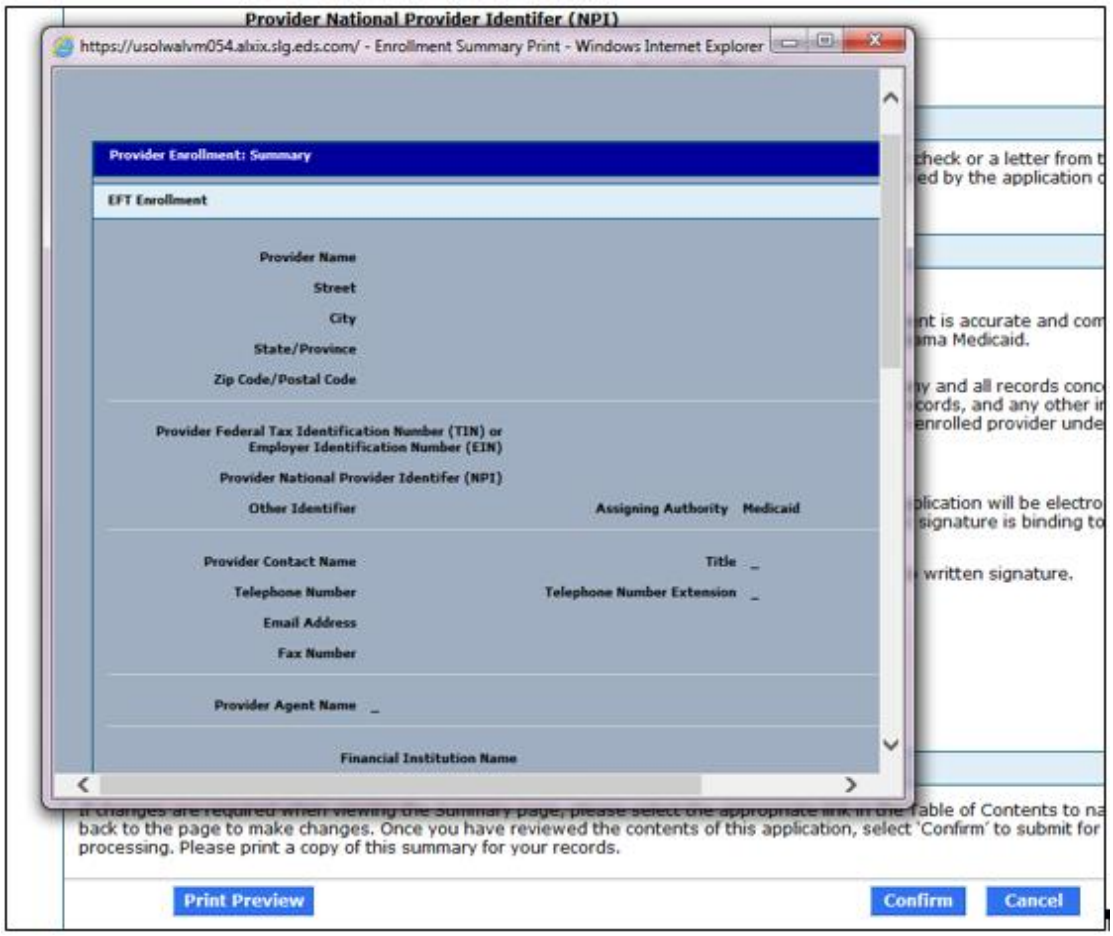
Print Preview Layout



6.19.3 Provider EFT Enrollment: Summary Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Confirm	Allows the user to confirm the Provider Enrollment summary information is correct and submit it.	Button	N/A	0
Print	Allows the user to print the Provider Enrollment summary information that is displaying in a pop-up box.	Button	N/A	0
Print Preview	Allows access to a pop-up box so the user can preview the Provider Enrollment summary information before it is printed.	Pop-up Box	N/A	0
Read:	Hyperlink to the Alabama Medicaid website's Provider Enrollment Forms page to find link to page listing required attachments.	Hyperlink	N/A	0

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6.19.4 Provider EFT Enrollment: Summary Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

6.19.5 Provider EFT Enrollment: Summary Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
N/A	

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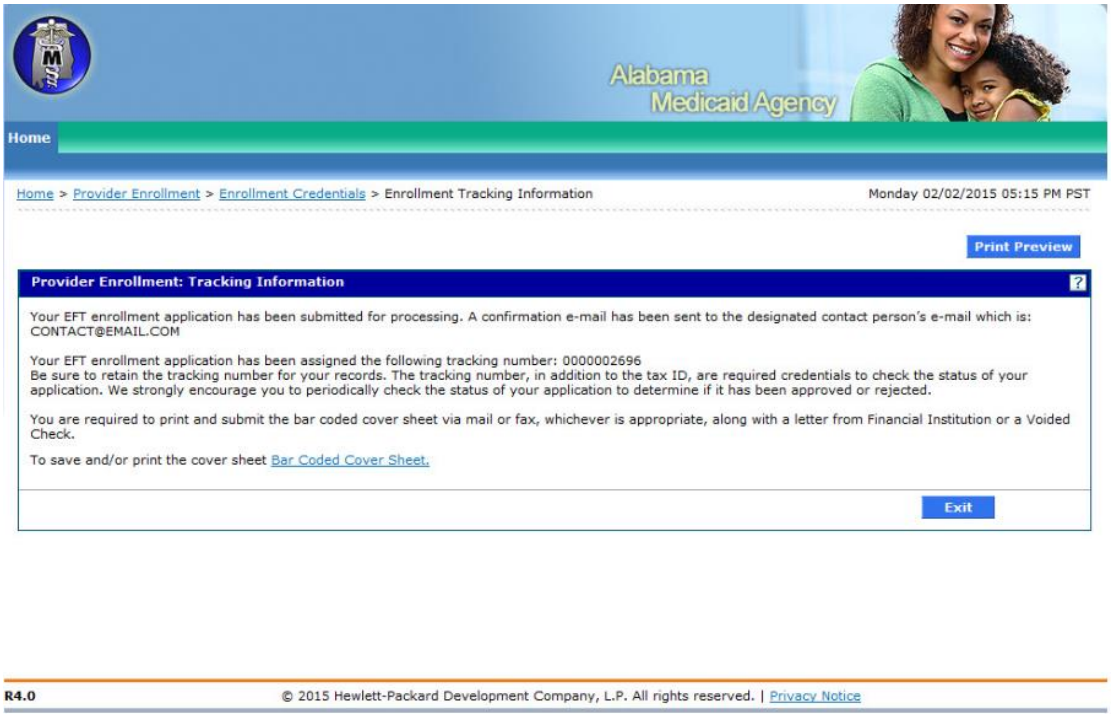
6.20 PROVIDER EFT ENROLLMENT: TRACKING INFORMATION

6.20.1 Provider EFT Enrollment: Tracking Information Page Narrative

Once the provider enters the credential information and clicks Submit, a tracking number will be assigned. This tracking number, as well as a link to the barcoded cover sheet, is provided on the EFT Tracking Information page. This tracking number, along with the tax ID, will be needed to check the status of the application.

6.20.2 Provider EFT Enrollment: Tracking Information Page Layout



6.20.3 Provider EFT Enrollment: Tracking Information Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Exit	Button that allows the user to exit the process and return to the Provider Enrollment page.	Button	N/A	0
Print Preview	Allows access to a pop-up box so the user can preview the Provider Enrollment summary information before it is printed.	Pop-up Box	N/A	0

6.20.4 Provider EFT Enrollment: Tracking Information Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

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6.20.5 Provider EFT Enrollment: Tracking Information Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
N/A	

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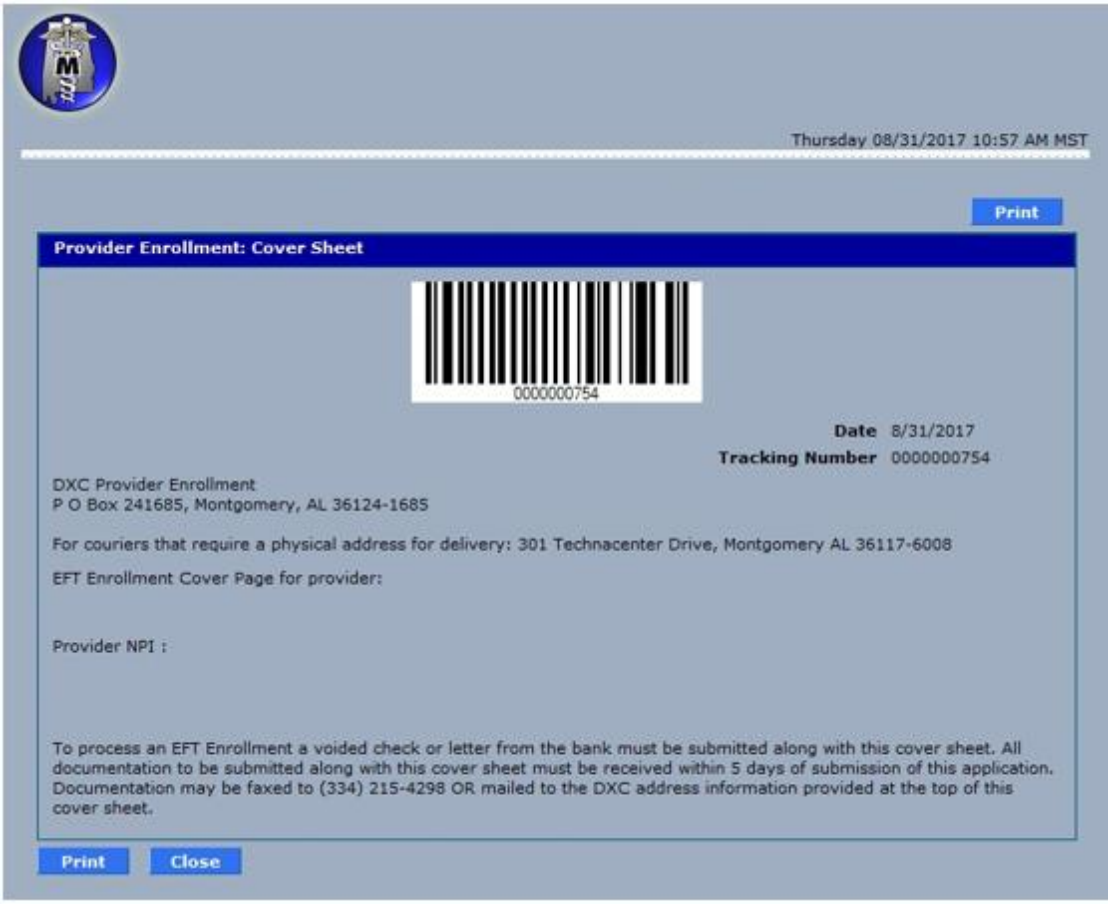
6.21 PROVIDER EFT ENROLLMENT: COVER PAGE

6.21.1 Provider EFT Enrollment: Cover Page Narrative

Provider Enrollment allows providers and authorized delegates to EFT enrollment information via a wizard. The enrollment wizard captures key EFT data such as contact information, banking information such as account number, account type, etc.

The Provider Enrollment wizard allows the provider to navigate through each page of EFT enrollment, from the welcome information in the first page, to the final print and bar coded cover sheet on the last page. The provider can create a print file for future reference and bar coded cover sheet for submissions of supplemental documentation. A tracking number is also provided so that providers can check the status of their enrollment request.

6.21.2 Provider EFT Enrollment: Cover Page Layout



6.21.3 Provider EFT Enrollment: Cover Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Close	Button that allows the user to close the pop-up.	Button	N/A	0
Print	Allows access to a print content of page.	Button	N/A	0

6.21.4 Provider EFT Enrollment: Cover Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

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6.21.5 Provider EFT Enrollment: Cover Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
N/A	

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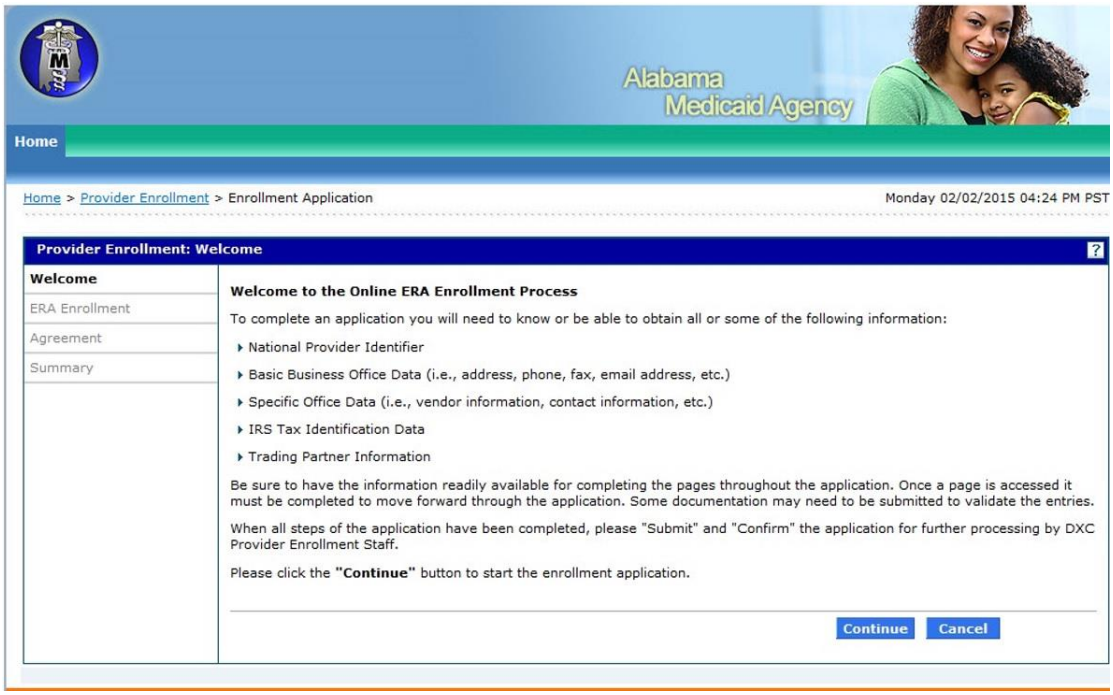
6.22 PROVIDER ERA ENROLLMENT: WELCOME

6.22.1 Provider ERA Enrollment: Welcome Page Narrative

Electronic Remittance Agreement (ERA) Enrollment allows providers and authorized delegates to enter all pertinent ERA enrollment information via a wizard. The enrollment wizard captures key provider data such as contact information, trading partner information, and demographics such as names, identifiers, and locations.

The ERA Enrollment wizard allows the provider to navigate through each page of ERA enrollment, from the trading partner information in the first page, to the final print on the last page. The provider can create a print file for future reference and bar coded cover sheet for submissions of supplemental documentation. A tracking number is also provided so that providers can check the status of their enrollment request.

6.22.2 Provider ERA Enrollment: Welcome Page Layout



6.22.3 Provider ERA Enrollment: Welcome Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider ERA Enrollment page.	Button	N/A	0
Continue	Button that allows the user to begin the ERA enrollment process.	Button	N/A	0

6.22.4 Provider ERA Enrollment: Welcome Page Field Edit Error Codes

Field	Error Message	To Correct
No field edits found for this panel.		

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6.22.5 Provider ERA Enrollment: Welcome Page Extra Features

Field	Field Type
N/A	

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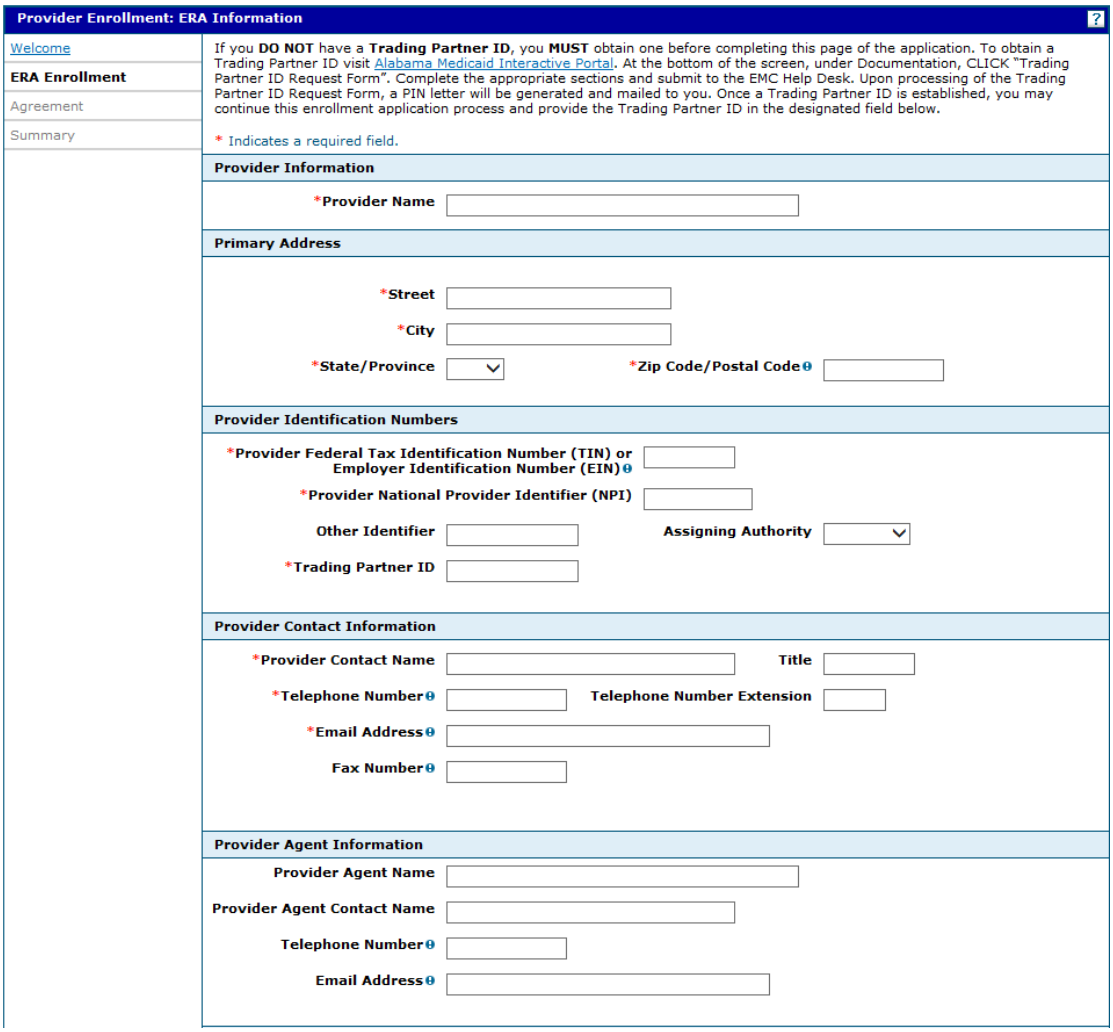
6.23 PROVIDER ERA ENROLLMENT: ERA ENROLLMENT

6.23.1 Provider ERA Enrollment: ERA Enrollment Page Narrative

The ERA Enrollment page allows the provider to enter contact information, trading partner ID, address, and clearinghouse/vendor information. ERA is required in order for providers to access an electronic claims detail file, specifically the 835 transaction.

6.23.2 Provider ERA Enrollment: ERA Enrollment Page Layout



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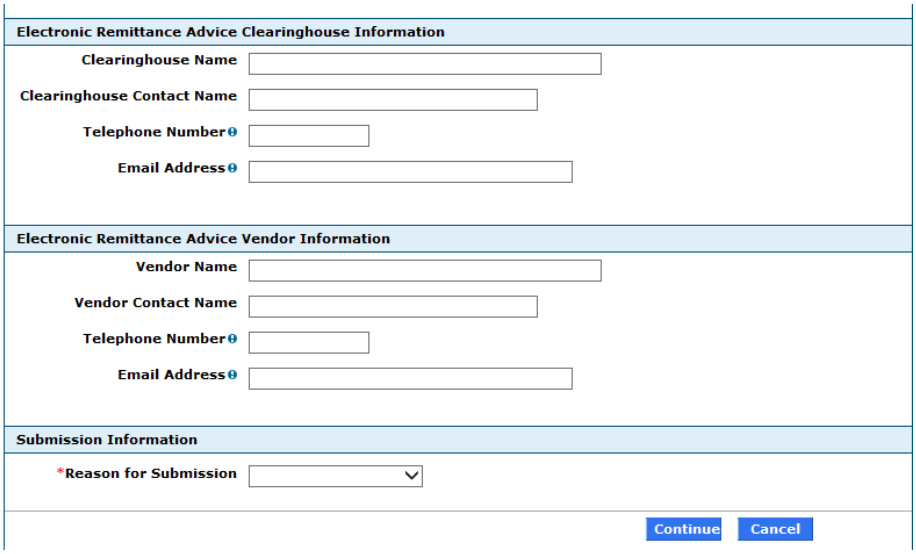

6.23.3 Provider ERA Enrollment: ERA Enrollment Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Assigning Authority	Allows the user to select assigning authority.	Combo Box	Drop down List Box	0
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
City	Allows the user to enter provider name.	Field	Character	30
Clearinghouse Contact Name	Allows the user to enter clearinghouse contact name.	Field	Character	50
Clearinghouse Name	Allows the user to enter clearinghouse name.	Field	Character	50
Continue	Button that allows the user to navigate to the next page of the enrollment process.	Button	N/A	0
Email Address	Allows the user to enter email address.	Field	Character	50
Fax Number	Allows the user to enter fax number.	Field	Number (Integer)	10
Other Identifier	Allows the user to enter other identifier.	Field	Character	15
Provider Agent Name	Allows the user to enter provider agent name.	Field	Character	50
Provider Agent Contact Name	Allows the user to enter provider agent contact name.	Field	Character	50
Provider Contact Name	Allows the user to enter provider contact name.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Allows the user to enter TIN/EIN.	Field	Number (Integer)	9
Provider Name	Allows the user to enter provider name.	Field	Character	50
Provider National Provider Identifier (NPI)	Allows the user to enter NPI.	Field	Number (Integer)	10
Reason for Submission	Allows the user to select reason for submission.	Combo Box	Drop down List Box	0
State/Province	Allows the user to select state.	Combo Box	Drop down List Box	0
Street	Allows the user to enter street.	Field	Character	30
Telephone Number	Allows the user to enter telephone number.	Field	Number (Integer)	10
Telephone Number Extension	Allows the user to enter telephone number extension.	Field	Number (Integer)	4
Title	Allows the user to enter title of the provider contact.	Field	Character	10
Trading Partner ID	Allows the user to enter trading partner id.	Field	Character	35
Vendor Contact Name	Allows the user to enter vendor contact name.	Field	Character	50
Vendor Name	Allows the user to enter vendor name.	Field	Character	50
Zip Code/Postal Code	Allows the user to enter zip code.	Field	Number (Integer)	10

6.23.4 Provider ERA Enrollment: ERA Enrollment Field Edit Error Codes

Field	Error Message	To Correct
City	City is a required field.	Enter a valid city.
Email Address	Email Address is a required field.	Enter a valid email address.

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Field	Error Message	To Correct
Provider Name	Provider Name is a required field.	Enter a valid provider name.
Provider Contact Name	Provider Contact Name is a required field.	Enter a valid provider contact name.
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) is a required field.	Enter a valid Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN).
Provider National Provider Identifier (NPI)	Provider National Provider Identifier (NPI) contains invalid characters.	Enter a valid provider National Provider identifier (NPI).
Reason for Submission	Reason for Submission is a required field.	Enter a valid Reason for Submission.
Street	Street is a required field.	Enter a valid street.
State/Province	State/Province is a required field.	Enter a valid state/province.
Telephone Number	Telephone Number is a required field.	Enter a valid Telephone Number.
Trading Partner ID	Trading Partner ID is a required field.	Enter a valid Trading Partner ID.
Zip Code/Postal Code	Zip Code/Postal Code is a required field.	Enter a valid zip code/postal code.

6.23.5 Provider ERA Enrollment: ERA Enrollment Page Extra Features

Field	Field Type
N/A	

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6.24 PROVIDER ERA ENROLLMENT: AGREEMENT

6.24.1 Provider ERA Enrollment: Agreement Page Narrative

The ERA Enrollment Agreement page allows the provider to view the Terms of Enrollment, Provider Agreement and Signature requirements. The provider must accept the terms, agreement and provide an electronic signature in order to submit the enrollment application. Failure to do so means that no enrollment application is retained or submitted. The provider must also access, print, sign, fax and mail with the bar-coded cover sheet, as well as other supplemental documentation. The Signature box must contain the signature of the individual applicant requesting enrollment OR the signature of an authorized representative of the facility/group requesting enrollment.

It is strongly advised that the provider access the Summary of Enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Upon making changes, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned.

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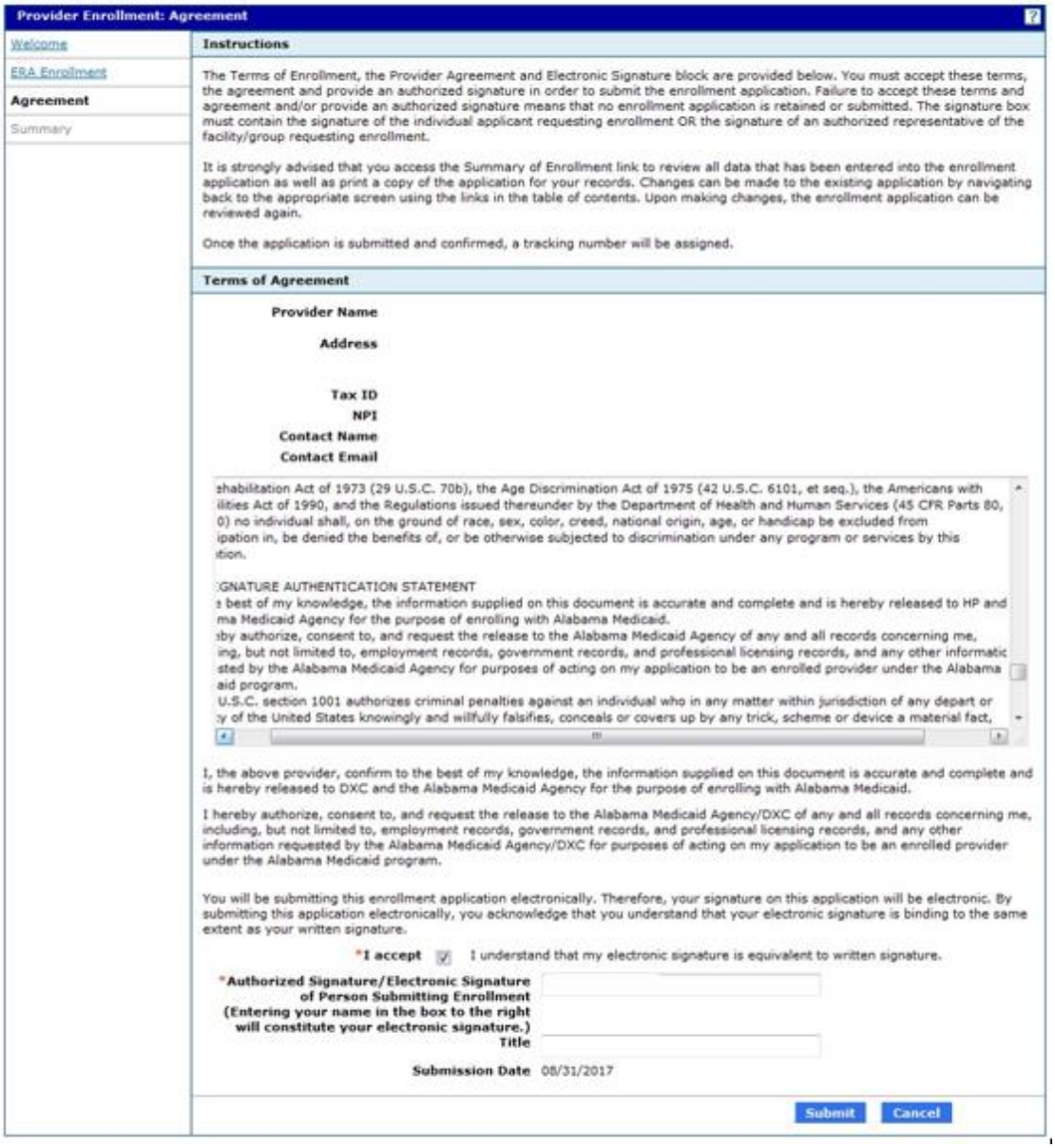
6.24.2 Provider ERA Enrollment: Agreement Page Layout



6.24.3 Provider Enrollment: Agreement Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Authorized Signature/Electronic Signature of Person Submitting Enrollment	Allows the user to enter the name of the individual signing the agreement.	Field	Character	50
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Contact Name	Displays the contact name of the provider enrollment contract for the provider.	Displays	N/A	0

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Field	Description	Field Type	Data Type	Length
Contact Email	Displays the contact email of the provider enrollment contract for the provider.	Displays	N/A	0
I accept	Allows the user to select the check box next to 'I accept'. This box must have a check indicating the electronic signature is equivalent to the written signature.	Check Box	N/A	0
NPI	Displays the provider's National Provider Identifier.	Displays	N/A	0
Provider Name	Display Provider's name.	Displays	N/A	0
Submission Date	Displays the current date.	Displays	N/A	0
Submit	Allows the user to submit the application.	Button	N/A	0
Tax ID	Displays the provider's Tax ID,	Displays	N/A	0
Title	Allows the user to enter the title, if applicable, of the individual signing the agreement.	Field	Character	50

6.24.4 Provider ERA Enrollment: Agreement Page Field Edit Error Codes

Field	Error Message	To Correct
I Accept	I Accept is a required field.	Click the check box to show a check.
Title	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.
Your Signature	Authorized Signature/Electronic Signature of Person Submitting Enrollment is a required field.	Enter your name.
	The text field contains invalid characters. Acceptable characters include [a-z], [A-Z], [0-9], spaces and characters '.?!,()-+:;_.	Enter acceptable characters.

6.24.5 Provider ERA Enrollment: Agreement Page Extra Features

Field	Field Type
N/A	

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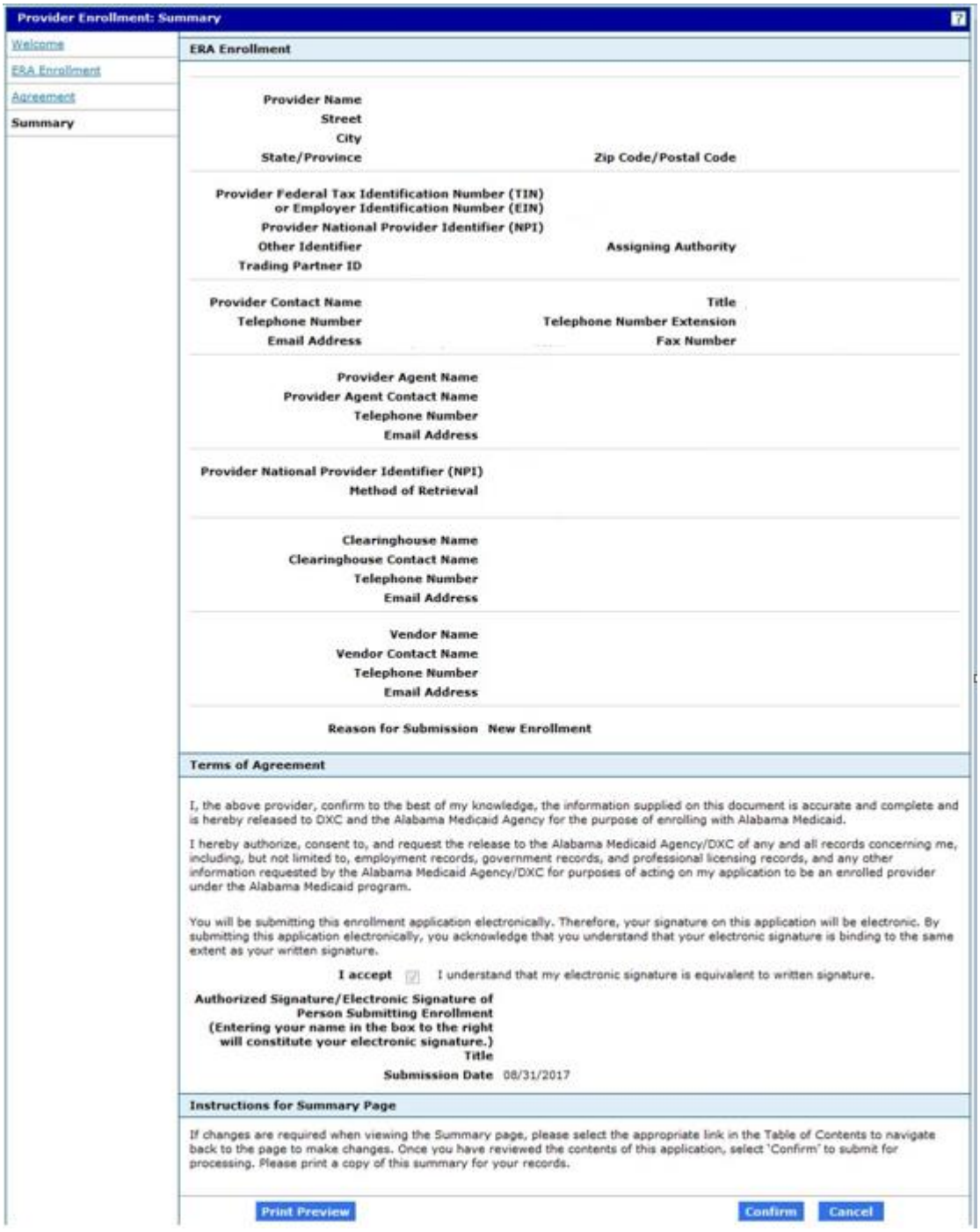
6.25 PROVIDER ERA ENROLLMENT: SUMMARY

6.25.1 Provider ERA Enrollment: Summary Page Narrative

The ERA Enrollment Summary Page allows the provider to review and make any revisions to previous pages as needed. The provider is **strongly** encouraged to verify if the information on the summary is correct. If the provider needs to make changes it can be done by selecting the appropriate page(s) in the table of contents. If all information is correct the provider is **strongly** encouraged to print a copy of the summary for your records. The provider must click '**Confirm'** for the application to be submitted for review.

6.25.2 Provider ERA Enrollment: Summary Page Layout



Provider Enrollment: Summary

Welcome
ERA Enrollment
Agreement
Summary

ERA Enrollment

Provider Name
Street
City
State/Province
Zip Code/Postal Code

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
Provider National Provider Identifier (NPI)
Other Identifier
Assigning Authority
Trading Partner ID

Provider Contact Name
Title
Telephone Number
Telephone Number Extension
Email Address
Fax Number

Provider Agent Name
Provider Agent Contact Name
Telephone Number
Email Address

Provider National Provider Identifier (NPI)
Method of Retrieval

Clearinghouse Name
Clearinghouse Contact Name
Telephone Number
Email Address

Vendor Name
Vendor Contact Name
Telephone Number
Email Address

Reason for Submission New Enrollment

Terms of Agreement

I, the above provider, confirm to the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to DXC and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency/DXC of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency/DXC for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

You will be submitting this enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

I accept I understand that my electronic signature is equivalent to written signature.

Authorized Signature/Electronic Signature of Person Submitting Enrollment (Entering your name in the box to the right will constitute your electronic signature.)
Title
Submission Date 08/31/2017

Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents to navigate back to the page to make changes. Once you have reviewed the contents of this application, select 'Confirm' to submit for processing. Please print a copy of this summary for your records.

Print Preview
Confirm
Cancel

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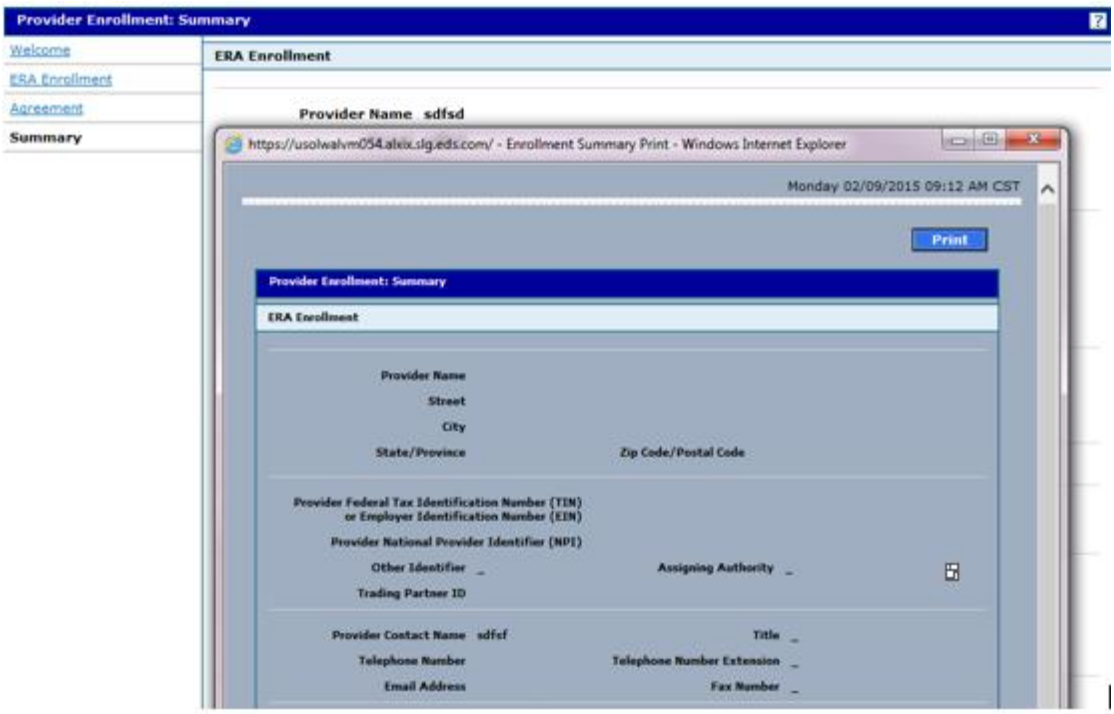
Print Preview Layout



6.25.3 Provider ERA Enrollment: Summary Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Button that allows the user to cancel the process and return to the Provider Enrollment page.	Button	N/A	0
Confirm	Allows the user to confirm the Provider Enrollment summary information is correct and submit it.	Button	N/A	0
Print	Allows the user to print the Provider Enrollment summary information that is displaying in a pop-up box.	Button	N/A	0
Print Preview	Allows access to a pop-up box so the user can preview the Provider Enrollment summary information before it is printed.	Pop-up Box	N/A	0

6.25.4 Provider ERA Enrollment: Summary Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

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6.25.5 Provider ERA Enrollment: Summary Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
N/A	

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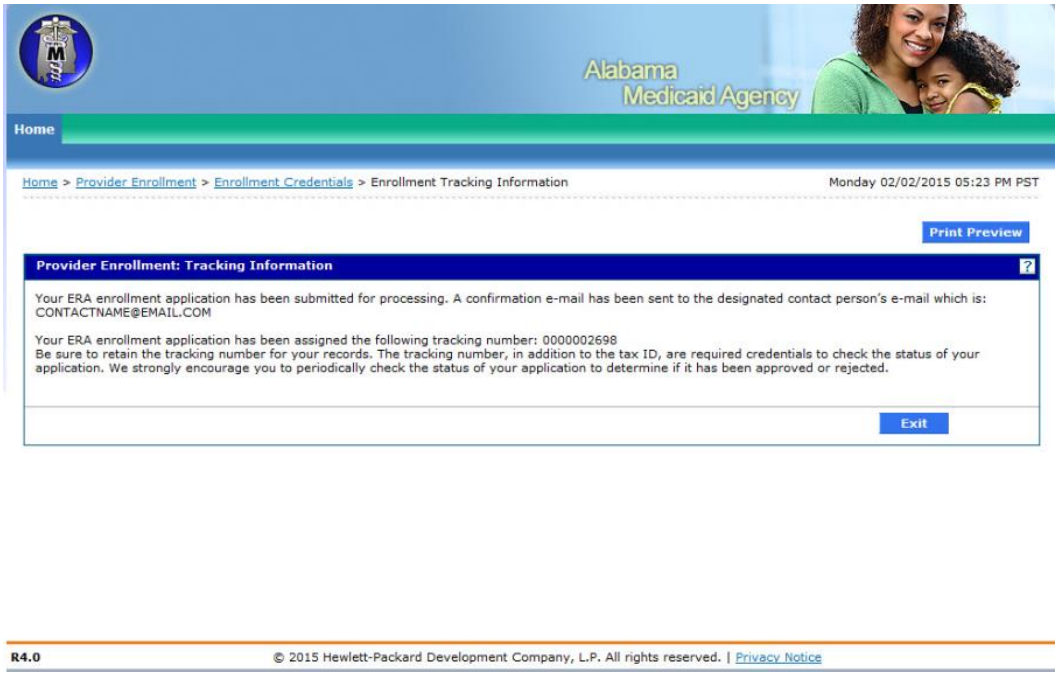
6.26 PROVIDER ERA ENROLLMENT: TRACKING INFORMATION

6.26.1 Provider ERA Enrollment: Tracking Information Page Narrative

Once the provider enters the credential information and clicks Submit, a tracking number will be assigned. This tracking number is provided on the ERA Tracking Information page. This tracking number, along with the tax ID, will be needed to check the status of the application.

6.26.2 Provider ERA Enrollment: Tracking Information Page Layout



6.26.3 Provider ERA Enrollment: Tracking Information Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Exit	Button that allows the user to exit the process and return to the Provider Enrollment page.	Button	N/A	0
Print Preview	Allows access to a pop-up box so the user can preview the Provider Enrollment summary information before it is printed.	Pop-up Box	N/A	0

6.26.4 Provider ERA Enrollment: Tracking Information Page Field Edit Error Codes

Field	Error Message	To Correct
This page contains no error codes.		

6.26.5 Provider ERA Enrollment: Tracking Information Page Extra Features

Field	Field Type
Print Preview	Pop-up Box
N/A	

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7 HELP

Each page of the enrollment application has a help icon located in the upper right hand corner of the page. Help text will display when the user clicks on the icon.

Provider Enrollment is available to answer questions concerning the provider enrollment process and Provider enrollment web portal.

NOTE

Passwords cannot be reset or retrieved by HPES staff.

Phone	Mail
1(334) 215-0111 1(888) 223-3630 Fax - TBD	HPES Provider Enrollment 301 Technacenter Drive Montgomery, Al 36117 or P.O. Box 241685 Montgomery, AL 31624

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AMMIS Provider Services Operations Manual

Date Modified: 10/11/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Provider Services Operations Manual
Version:	18.0
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/Provider
Owner:	DXC/Agency
Author:	
Approved by:	
Approval Date:	09/08/2011

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
08/17/2011	0.1		Updated for EIP #7 Provider Web Portal Enhancement	
08/25/2011	0.2		Responded to Agency comments received 08/24/2011.	
09/06/2011	0.3		Responded to Agency comments received 08/30/2011.	Section 4.1.7 – Corrected typo Section 4.1.14 – responded to comment. Section 4.1.27- responded to comment. Section 4.2 - responded to comment.
09/08/2011	1.0		Agency approved	
05/03/2012	2.0		Agency approved	Updated Sections 4.1.1.14, 4.1.22 and 4.1.37
7/9/2012	3.0		Agency approved	Updated Sections 4.1.14
1/31//2013	4.0		Agency Approved	Updated Sections 4.1.12, 4.1.13, 4.1.22, 4.2.3, 4.2.5, 4.2.6, 4.1.14, 4.1.27, 4.1.3, 4.1.30
5/21/2013	5.0		Agency Approved	4.1.5 and 4.1.43
7/9/2013	6.0		Agency Approved	4.1.37, 4.2.7, 4.4, 4.5

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
5/23/2014	7.0		Agency Directed	Most Provider Enrollment Sections Referencing "PECOS verification"
2/12/2015	8.0		Agency Directed	4.1.14
5/21/2015	9.0		Agency Directed	4.1.9, 4.2.9, 4.1.5
6/25/2015	10.0		Agency Directed	4.2.12, 4.2.13, 4.1.26
8/20/2015	11.0		Agency Directed	4.1.5, 4.1.14
2/25/2016	12.0		Enrollment Procedure Changes	4.1.4 and various sections related to CHOW procedures
06/01/2016	13.0		Enrollment Procedure Changes Fingerprinting Checks CHOW Procedures Change – No Requirement to Keep NPI	4.1.9, 4.1.18, 4.1.38 4.1.5, 4.1.12 3.8, 4.1.14
09/30/2016	14.0		General updates	3.9, 4.1, 4.2.1 to 4.2.2, 4.2.4 to 4.2.6, 4.2.9 to 4.2.11, 4.2.15 to 4.2.16.
2/8/2017	15.0		Update to physician specialties	4.1.28
08/11/2017	16.0		Update to Optometrist section	4.1.25
09/20/2018	17.0		Global updates	
10/11/2018	18.0		Added approved specialty 274 Dental Prevention to provider types 56, 58, 31, 10, 57, 13, and 09 (Physician employed & Independent Nurse Practitioners).	

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 INTRODUCTION

2.1 OVERVIEW

To ensure that the Medicaid recipients have access to quality health care, the Provider Services unit must correctly and promptly enroll providers, respond courteously to provider inquiries, and organize training sessions for the providers. Provider Services has the responsibility to introduce providers to new technology or new guidelines that will change how the providers work with the program. Provider Services also works with providers on a one-on-one basis to resolve issues.

2.2 UNIT FUNCTIONS

Provider Services is comprised of three functional units:

Provider Enrollment

Provider Representatives

Provider Assistance Center

2.3 PROVIDER SERVICES TASK

The following list identifies the tasks that Provider Services units most frequently perform:

Maintain, update, and change the Provider Table with new or modified provider data.

Receive updates from the Agency or providers and apply them to the Provider Table.

Verify required licenses and certifications–including specialty credentials–with the appropriate regulating and accreditation agencies.

Staff and operate a Provider Assistance Center (PAC) from the hours of 8 am to 5 pm local time, Monday through Friday. These time frames exclude DXC-observed holidays.

NOTE:
No DXC holiday can be taken unless also observed by the Alabama Medicaid Agency.

Perform provider enrollment activities.

Advise providers on the process for enrollment into the Automated Eligibility Verification and Claims Management (AEVCS) system.

Perform problem solving with the providers.

Perform system testing.

Provide electronic enrollment application for providers.

Process all applications within Agency-defined standards.

Send notification letters of acceptance or rejection to prospective providers.

Respond to State legislature or State executive inquiries within the State-defined time frame. (In most cases, the response requires approval by the Medicaid Agency before it is sent).

Conduct provider training, and deliver ongoing provider training based on the Agency-approved annual provider training plan.

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Furnish on-site assistance to providers that have billing difficulties when requested by the Agency, the provider, or other departments within DXC (such as the Provider Assistance Center).

Attend provider association meetings and annual conventions.

Develop, print, and distribute provider manuals, updates, and bulletins to the providers.

In Provider Services, a key ingredient to success is follow-up with all customers—providers, provider associations, the Agency, and the State offices. Provider Services must provide prompt, efficient, and reliable service to all of these entities. If an answer to the inquiry is not readily available, Provider Services personnel must research the inquiry and return an answer to the customer as rapidly as possible.

2.4 INPUT, PROCESSES, AND OUTPUT

Input

The table below documents the most common inputs to the Provider Services functional area:

Common Provider Services Input

Input	Source	Purpose
Agency correspondence	Agency	To request information and status on the AMMIS system. To provide requested answers to Provider Services.
Provider correspondence	Provider	To request information about various Medicaid questions. To provide updated information on the Provider, such as name or address change.
Provider requests for enrollment	Potential provider	To request enrollment in the Alabama Medicaid program.

2.4.1 Processes

Provider Enrollment

The Provider Enrollment process enables potential providers to enroll in the Alabama Medicaid system. This process includes the following:

Providing an electronic provider enrollment application on the interactive web site.

Acceptance or denial of the provider application.

Distribution of provider materials—Provider Manual, Provider Billing Manual, provider bulletins, and provider manual updates—to the provider.

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Provider Support

Provider Services supports the providers in several ways. The department staffs 16 toll-free telephone lines that enable the provider to get immediate help for Medicaid related issues. Provider Service Representatives work with the provider to provide education, training, and to resolve issues with the Medicaid process.

Provider Support also supplies updated documents to the providers on a regular basis. These documents include the following:

Provider Manual

Provider Billing Manual

Bi-monthly provider bulletins

Updates to the Provider Manual and the Provider Billing Manual documents

The Technical Writing Department is responsible for ensuring that documents found on the Alabama Medicaid Web site–*http://www.medicaid.alabama.gov* are current and accurate.

2.4.2 Output

The table below lists typical outputs from the Provider Services functional area.

Common Provider Services Output

Output	Source	Purpose
DXC correspondence	Provider Services	To communicate a response to Agency correspondence. To communicate a response to provider correspondence. To provide updated information to the Agency and to providers.
Provider Billing Manual	Provider Services	To provide the latest Alabama Medicaid billing information to providers.
Provider Bulletin	Provider Services	To update the Provider Manual that is supplied to providers with the latest information from the Agency.
Provider Manual	Provider Services	To provide the information necessary for a provider to submit claims and obtain information from Alabama Medicaid.
Provider Table updates	Provider Services	To update the Provider Table with approved provider changes.

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2.5 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Provider Services functional unit were extracted from section 3.02 of the Invitation to Bid (ITB).

Provider Enrollment

1. Perform enrollment activities for all provider types, both contract and non-contract providers. Maintain facility ownership information as a function of provider maintenance. Maintain knowledge of all applicable federal and state provider enrollment and certification regulations, and develop and establish detailed guidelines and procedures for State approval to ensure proper enrollment of all provider types.
2. Receive requests for enrollment and mail all enrollment packets to providers.
3. Accept and process provider enrollment applications in the format specified by the State.
4. Research and compile all information relating to the Provider appeals process for provider enrollment rejections, terminations, and changes to program participation eligibility effective dates in accordance with State guidelines. Submit the material to the State for its use in the provider appeals process.
5. Notify providers by letter of acceptance/rejection as a State provider, and send a start-up packet to approved providers containing all necessary information, forms and/or software needed to bill for Medicaid services for eligible recipients.
6. Contractor will use taxonomy code and location code to match National Provider Identifier (NPI) number to current Medicaid Provider ID.
7. Maintain agreements for billing agencies. This includes:
   Administration access for creating, deleting, setting permissions and resetting passwords for all trading partners. User access for updating their profile to better fit the user's needs.
8. Maintain and update the relationships between group practices and group members.
9. Maintain provider enrollment personnel with a minimum of five (5) full-time equivalents (FTE)-enrollment specialists of which one (1) must be a Managed Care enrollment specialist, one (1) FTE –enrollment quality assurance specialist and one (1) enrollment supervisor.

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2.5.1 Certification/Recertification

1. Process, record, and track, using an automated tracking system, all sanctions and intermediate sanctions against providers, per State specifications, as initiated by CMS (Center for Medicare and Medicaid Services), the federal OIG (Office of Inspector General)or State. The record shall include the provider's full name and address, social security number, license number, date of sanction, and length of sanction from written reports produced by CMS, or any other government agency. Compare the automated file to the master provider file weekly and report matches to Medicaid for further action.
2. Perform certification and recertification activities, as appropriate and directed by the State, to ensure that all Alabama Medicaid providers maintain required certifications for participation in the Medicaid program.
3. Maintain regular communications with the applicable state agencies and licensing organizations to perform certification and licensure verification, including licensure of out-of-state providers; where appropriate, perform electronic data exchanges. Applicable agencies and organizations include the Department of Public Health, the State Board of Medical Examiners, the Joint Commission, and the State Boards (Dental Examiners, Optometry, Nursing, Speech, Occupational and Physical Therapy, Chiropractors and Podiatrists).
4. Upon publication of new licensure information, verify licensure for all instate providers enrolled by Contractor. Update the master provider file with appropriate end dates and deactivate all enrollments for any provider identified as no longer being licensed or certified.
5. Certify electronic media and tape billing services as automated billing service vendors. Run a test submission prior to certification to ensure that the submission format is accepted by the Alabama MMIS.

Provider Communications/Customer Relations/Inquiry

1. Maintain and staff a provider communications/relations inquiry function to include toll-free lines that are staffed from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday (excluding State-observed holidays). A minimum of sixteen (16) (FTE) staff shall be provided to answer sixteen (16) toll-free telephone lines (with the capacity of up to forty (40)). If additional staff is required, reimbursement will be made in accordance with Section 50.141 of this ITB.
2. Provide a call management system or supply phone company reports of all line activities, busy signals, hang-ups, non-connects, and internal reports of number of calls answered, number of calls put on hold, and the length of time each call was held.
3. Train all Contractor provider relations staff in billing procedures, current Alabama Medicaid Program policy, and telephone inquiries.
4. Receive, track and promptly respond to all verbal inquiries on claim status, prior authorization status, billing problems, billing procedures, Medicaid policy and remittance advices immediately, if possible, or in accordance with defined performance expectations.
5. Track and respond in writing to all written correspondence, including inquiries on claim status, billing problems, billing procedures, and remittance advices, in accordance with defined performance expectations.
6. Retain copies of all written correspondence in the appropriate files.
7. Provide the State with monthly and annual reports summarizing all calls answered and timeliness of written correspondence, according to State specifications.

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Provider Training/Representatives

1. Employ sufficient staff to perform quarterly and on-request provider training responsibilities. At a minimum, provide at least thirteen (13) Medicaid-dedicated, full-time provider field representatives, one of which shall be designated as a supervisor, to provide quarterly and on-request training and to assist providers in understanding program policy, the responsibilities of managed care providers, the submission of claims and in the resolution of claims processing problems. A designated number of provider representatives shall be assigned to specific program areas by the State.
2. Employ one (1) full-time EMC coordinator and three (3) EMC full-time staff to provide training, assist providers in the submission of claims and in the resolution of claims processing problems.
3. Ensure that provider field representatives and Inquiry/Customer Relations staff are sensitive to provider training and inquiry needs. Field representatives shall be willing and able to provide on-site support to a provider whenever requested, within a reasonable period of time. Provider representatives should meet individually with designated Medicaid program staff at least monthly.
4. Develop provider training materials and obtain Alabama Medicaid approval of the materials prior to use in the provider training programs.
5. Assume responsibility for all logistical arrangements, training materials, and space costs for provider training.
6. Conduct provider training and training for State-designated organizations at State approved locations.
7. Provide special in-depth training to providers who have been identified (by the Contractor, by Alabama Medicaid, or the provider's association) as having an abnormal number of claims denied or suspended, repeated problems with certification or recertification, an abnormal number of problems using the contractor's systems, underutilization of required immunizations, underutilization of EPSDT screenings and referral requirements and inappropriate patterns as reflected on provider report cards.
8. Develop, distribute, and evaluate provider training questionnaires from all training sessions, and provide the State with a summary of provider responses.
9. Maintain regular contact with all professional associations of health care providers in Alabama Medicaid to promote provider understanding of the Alabama Medicaid program.
10. Develop, and make available, software free of charge, including all future updates, for providers to submit electronic media claims (EMC) data via personal computer, electronic transfer, diskette, or magnetic media. The Contractor shall make available the software updates on the Medicaid WEB Site for downloading by providers.
11. Provide support, including on-site training if required, to instruct providers in using electronic claims submission software or to facilitate the resolution of billing problems.
12. Develop and implement a testing process for providers who wish to begin submitting electronic media claims to ensure provider competency before allowing EMC transmission.
13. Develop a training plan annually at the beginning of the contract year and update the plan as necessary throughout the year.

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2.5.2 Provider Manuals/Bulletins/Notices

1. Write and obtain State approval of, print, and distribute the provider billing manual and provider bulletins. The provider billing manual shall be available on CD-ROM. Copies shall be sent to all providers, all provider associations, the State, and other entities specified by the State, with the number of copies determined by the State.
2. Maintain the provider billing manual in a format that facilitates updates and includes step-by-step billing instructions.
3. Update the provider billing manual on an as-needed or State-requested basis. Updates must be made by full page replacements.
4. Develop, modify, print, and distribute to providers, at no charge, all non-standard claim forms and attachments approved by the Medicaid Program.
5. Work closely with the State to develop provider manual and bulletin formats.
6. Provide the capability to electronically transmit/distribute as specified by the State all provider notices that are prepared by the State.
7. Issue provider bulletins every two (2) months to alert providers of program and/or billing changes.
8. Produce and mail other provider notices, in a format designated by the State, with bulletins, manuals, enrollment packages, or as an individual mailing as directed by the State. These would be notices other than bulletins such as letters, flyers, etc.

2.5.3 Provider Table/Database

1. Maintain a Provider Table/database in which each provider identified by their NPI and includes all data elements currently required by the State, including national provider identifier.
2. Update the Provider Table on a daily basis to reflect changes brought to the attention of the Contractor by the State, providers, or from within DXC.
3. Perform quality assurance of data in the Provider Table and submit results to the State in accordance with Agency instructions. Provider surveys, returned mail, comparison to yellow pages, etc. shall be utilized to verify the accuracy of data such as addresses and phone numbers.
4. Support all provider functions, files, and data elements necessary to meet the requirements of the ITB.
5. Provider Table update access will be limited to designated personnel.
6. Conduct mass updates of the provider file accommodation rates when directed by Medicaid.
7. Establish methods to edit and verify accuracy of provider data as entered on screens.
8. Identify all categories of service and specialties that a provider is allowed to bill, including effective dates.
9. Generate all State-required Provider reports that are currently produced.
10. Establish accounts receivable balances based on claims credits and instructions from the State.
11. Update the accounts receivable balance or percentage withheld for a provider when directed by the State.

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12. Produce data for provider audits and quality assurance.
13. Make recommendations on any area in which the Contractor thinks improvements can be made.
14. Notify the State, in writing, of suspected provider fraud or provider billing errors resulting in overpayment.
15. Submit to the State on a timely basis all provider reports according to the schedule determined by the State.
16. Interface with or utilize the National Provider System being developed by CMS in accordance with directions from Medicaid. CMS has not published final rules on NPS. Medicaid understands that on-line access will be available to the NPESS for verifying NPIs and for the registering of new providers who need an NPI. Federal law requires all providers that provide medical services to be enumerated.
17. Maintain an audit trail of all update transactions applied to the Provider Table.
18. Provide a daily provider file update report to cover update transactions for the previous day.
19. Maintain all demographic and rate information to support claims processing and reporting functions as is currently done and/or needed for NPI.
20. Maintain, and coordinate with Medicaid, updates to the institutional rates on the Provider Table.
21. Maintain and update the provider's Medicare number.
22. Maintain a cross-reference of Medicaid-Medicare provider numbers to support crossover claims processing.
23. Provider on-line inquiry and real-time update access to the Provider Table. Update access will be limited to designated personnel.

2.6 PERFORMANCE EXPECTATIONS

The following performance expectations for the Provider Services functional unit were extracted from section 3.02 of the Invitation to Bid (ITB):

1. Mail all provider enrollment packets within two (2) business days of receipt of the request.
2. Process (approve or deny) provider applications and updates within five (5) business days of receipt. If additional information is required from the provider, an additional five (5) business days is allowed to obtain the information and process the application.
3. Add new providers, according to State guidelines, to the provider table/database within two (2) business days of enrollment approval.
4. Maintain all provider enrollment files on COLD.
5. Update the Provider File/Database on-line within two (2) business days of receipt of change requests from any source. If additional information is required from the provider, an additional three (3) business days is allowed to obtain the information and process the change request.
6. Develop and submit to the State for approval, an annual provider training plan within ten (10) business days of the beginning of each contract year and within three (3) business days of updating the plan as necessary.

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7. Conduct provider training at least quarterly by claim or provider type or as requested by the State.
8. Mail claim forms and other billing documents to providers within five (5) business days of receipt of the request for forms.
9. Mail provider billing manual, (CDs and paper copies) within twenty (20) business days of approval by the State.
10. Mail provider bulletins and billing manual updates (CDs and paper copies) within ten (10) business days of approval by the State.
11. Maintain and update monthly the Patient 1st PMP lists by county on the website for recipient use.
12. Staff provider communications/relations phone lines from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday on all State business days.
13. Respond to all calls and telephone contacts by the end of the next business day.
14. Respond in writing to written correspondence within seven (7) business days of receipt.
15. Update the Provider Master Data Base with renewal information within five (5) business days of verifying licensure or certification.
16. Provide the State with monthly reports on all calls answered, the nature of the inquiries, and the timeliness of responses to correspondence for the prior month's activity.
17. Update Provider Subsystem user manual within the schedule determined by the State.
18. Submit to the State on a timely basis all Provider Subsystem reports according to the schedule determined by the State.
19. Execute provider contract letter and mail any needed materials within two (2) days of enrollment approval.

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3 PROVIDER ENROLLMENT INSTRUCTIONS

Provider Enrollment is the process of determining whether a prospective provider meets the standards for providing services and/or supplies to Medicaid recipients, and then adding the provider to AMMIS. The Alabama Medicaid program provider enrollment procedures are designed to ensure timely, efficient, and accurate processing of Provider Enrollment applications.

Payments are made only to providers who have been enrolled in the Medicaid program and only for necessary and reasonable medical care. A provider must be licensed, registered, or certified by the appropriate professional regulatory agency according to state or Federal law, or must be authorized by the Agency administrating the Medicaid program.

3.1 PROVIDER ENROLLMENT OPERATIONAL PROCEDURES

The process begins when a Provider Enrollment specialist receives a request from a potential provider for enrollment as a Medicaid provider. Requests from providers can be submitted to Providers Services by the following methods:

E-mail submitted through the Alabama Medicaid Web site

Fax

Telephone

Written Request

The following steps determine the enrollment process:

> The Provider Enrollment application must be processed–approved, denied, or returned to provider for corrections–within five business days of the initial receipt of the application.

1. The provider accesses the electronic enrollment application on the interactive web site.
2. The provider completes and submits the electronic application.
3. A facsimile of the application is created and held in the Feith workflow pending receipt of the required agreement and documentation.
4. Provider faxes the completed agreement and the required documentation with the bar-coded fax cover sheet to 334-215-7416
5. The provider sends the completed agreement and the required documentation with the bar-coded fax cover sheet to the Provider Assistance post office box (P. O. Box 241685).
6. The courier retrieves the documentation from the post office and delivers the documentation to the DXC mailroom.
7. The mailroom forwards the documentation to Provider Enrollment.
8. A Provider Enrollment clerk prepares the mail as follows:
    a. Open the mail.
    b. Separate the correspondence from agreements.
    c. Stamp each page of the document with a date stamp.
    d. Scan agreements into COLD.

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e. Place scanned agreements in the appropriate pending tray.

9. Workflow will assign the application to a PE Clerk when the required documentation is received. Assignment will be based on provider type; number of applications received that day and the number of available clerks.

A Provider Enrollment clerk will:

10. Confirm that the agreement and required documentation have a valid signature and matches the submitted electronic application.
11. Request required corrections or follow-up on incomplete documentation.
12. Generate return email with appropriate return reason(s) and updates the electronic application with the appropriate return status.
13. Update workflow with Return to Provider (RTP) status
14. Verify provider credentials.
15. Maintain a mainframe file, which contains all usable Medicare Exclusion Database (MED) information, and specific sanctions/exclusions directed by Medicaid. Maintain an automated system edit, which will deter the enrollment of providers who have an SSN or FEIN that matches the information contained in the mainframe file.
16. Utilize the Provider Information Search Page or Provider Mini-Search Panel to search for possible existing Medicaid enrollments. Use the following search elements to see if the provider is currently enrolled:

License number

SSN

Provider ID

Federal Employer Identification Number

Provider name

Medicare provider number

17. After it is determined that the provider is not currently enrolled in the Alabama Medicaid program at the location on the application, Provider Enrollment will update the application status to approved and a batch process will move all data to AMMIS. Refer to the individual enrollment sections to determine if additional information is required.
18. Provider notification letters are generated each night.
19. Operations personnel deliver the notification letters to the Provider Enrollment unit each morning.
20. Provider Enrollment Specialist, using the enrollment application, verifies the data in the notification letter.
21. Mail the notification letter, provider manual and other required materials to the provider. Send a provider manual only to newly enrolled groups and to new providers that are not members of a group. Do not send a provider manual to providers that have been added to an existing group.

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Notification and materials must be sent to the provider within two business days of the enrollment approval.

The provider must be added to the AMMIS within two business days of the enrollment approval.

3.2 PROVIDER FILE UPDATES

The provider must be updated to the AMMIS within two business days of the receipt of change requests sent to DXC via mail, e-mail or FAX.

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3.3 PROVIDER FILE INFORMATION UPDATES AND COMMUNICATION (I2004 E24S)

DXC provides a method for provider notices/alerts to be sent out electronically via email or facsimiles to providers/vendors who choose to participate in electronic delivery option.

Documentation, such as responses to surveys and submission of the on-line update form, will be used to update provider information and add vendors as non-providers (A non-provider is a vendor that is in the provider file for mailing purposes only). All vendors must be on file as a non-provider to receive distribution of notices or alerts. Non-providers are identified by the number scheme NPxxxxxxP where xxxxxx are the next sequential numbers available. Non-providers submit a written request giving address, fax and telephone information, which is used to add the non-provider number. However, surveys will initially be sent to providers and vendors.

An on-line update form is on the Alabama Medicaid website for detailed informational updates. A simplified version is also available for providers who only want to make the distribution method election. To use these forms the provider/vendor accesses the Alabama Medicaid website, opens and completes one of the forms. The on-line form is printed, signed and submitted to DXC via facsimile or mail. Provider information is received by Provider Enrollment and is used to manually update the Provider Locations Name Address Panel.

DXC will utilize Decision Support System (DSS) to create listings of fax numbers, email addresses and mailing addresses based on the bulletin address preferred by the provider.

3.4 CLIA UPDATES

The Clinical Laboratory Improvement Act (CLIA) sets guidelines for the payment of laboratory services. Beginning June 1, 1998, all claims containing laboratory codes are subject to CLIA editing. To be paid for laboratory CPT codes, providers must have a current CLIA number on file that is in force for the dates of service.

If there is no CLIA number on file for a specific provider location, or if there is a CLIA number on file and the line item date of service is not within the CLIA certification dates, the laboratory line item will deny with Explanation of Payment (EOP) code 4207 (CLIA number not on file/invalid or provider not authorized to bill procedure code) .Also if the laboratory certification is either Waived Test or Physician Performed Microscopy Procedure (PPMP), they are restricted to specific codes. If any other laboratory codes are billed, those line items will deny with EOP code 4207 as well.

The Provider Enrollment specialists add CLIA information to the provider file using the Provider CLIA Maintenance Panel.

1. Providers send in CLIA certification information to Provider Enrollment through one of the following methods:

Sending a letter requesting that the CLIA information is added/changed.

Including the information in the original Provider Enrollment application.

Note: A copy of the CLIA certification must accompany all requests to add or change CLIA information.

2. The Provider Enrollment specialist updates the CLIA information on the AMMIS by accessing the Provider CLIA Maintenance Panel and adding the 10 digit CLIA number to the appropriate NPI.

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3. CLIA information on the AMMIS is systematically verified against the Centers for Medicare and Medicaid Services (CMS) OSCAR file, which contains all valid CLIA certification information. The verification is completed as follows:
   a. Each Thursday night, a job is run that validates the CLIA information on the AMMIS against the CMS OSCAR file.
   b. CLIA information on the AMMIS that is validated against the CMS OSCAR file is automatically added to the Provider CLIA Maintenance Panel. The information contained on the Provider CLIA Maintenance Panel is used in claims processing.

CLIA certification which is added to the provider file will receive the effective date of the enrollment.

3.5 DISCLOSURE INFORMATION

1. Disclosure information on the web portal application must be completed if the applicant is an individual or an individual within a group. If the applicant is enrolling as a group or a facility, disclosure forms for each individual that is an owner, officer, agent, directors, managing employees, or shareholders with 5% or more controlling interest must be completed.
2. Disclosure information on the web portal application or the paper form requires all questions be answered. Each question must contain a ‘yes’ or ‘no’ answer. If the form does contain blanks, return the application to the provider.
3. If any disclosure questions on the web portal application or if the paper form contains any ‘yes’ answers or no answers with qualifying statements, forward the application to the Program Integrity Division of Medicaid.
4. Update the Feith workflow to document the action of forwarding the application to Program Integrity Division at the Medicaid Agency.
5. Send a letter to the provider, stating that the application has been sent to Medicaid for review and is in a pending status.
6. The Provider Enrollment supervisor will monitor all applications forwarded to Program Integrity Division.

3.6 NAME CHANGES

All name changes must be submitted on the Name Change Form or a written, signed request from the provider.

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3.7 LICENSURE VERIFICATION

In-State Providers

It is essential that enrolled providers be licensed to practice medicine in the State of Alabama. To ensure that this is the case, DXC performs, at a minimum, an annual licensure verification process. The following steps are performed to complete the licensure verification process for instate providers:

1. Receive licensure file information from each of the licensure boards, at least annually, via electronic media or hard copy. The table below shows the licensure board and file delivery dates:

Licensure Boards

Licensure Board	Licensure Expiration Date	Data Set Member	Medium
Audiology/Speech Therapy	12/31	SPEECH	Paper
Chiropractor	09/30	CHIRO	Paper
Dental	12/31	DENTISTS	Paper
Medical	12/31	DOCS	Electronic
Nursing	12/31	NURSE	Electronic
Occupational Therapy	04/30	OCTHERPY	Paper
Optometry	12/31	OPTOM	Paper
Physical Therapy	10/01	PHTHERPY	Paper
Podiatry	11/15	PODIATRY	Paper
Psychology	10/15	PSYCHO	Paper
Behavior Analyst	12/31	Behavior Analyst	Paper/Electonic

2. DXC accepts licensure file information in one of two formats: electronic or paper. See the table above for the applicable medium.

Upon receipt, each roster will be saved as a comma delimited file and transmitted to the UNIX server, where an "on request" job will process all rosters. To allow for rosters received (or processed) late, a job parameter will accept a date to be used as the basis for determining expired licenses. If no date is entered, the run date will be assumed.

Roster-specific steps will extract the license number, transfer it into the appropriate database format, and capture or derive the license expiration date. A final step (common to all rosters) will search for each of these license numbers on the “T_PR_HB_LIC” table. If an entry is found with an active status, and an expiration date no older than one year (current for out of state), the expiration date will be updated.

The "T_PR_TYPE" table will then be searched to find all provider locations associated with the license number. Finally, the "T_PR_PHP_ELIG" table is searched for these locations. If an entry is found with an active status, and an expiration date no older than one year (current for out of state), the expiration date will be updated.

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This process will neither add new records to the database, nor modify any data fields other than expiration date.

3.7.1 Out-of-State Bordering Providers

Systematic updates are not applicable. Out of state bordering providers' files are updated as requested by the provider. Provider Enrollment will perform on-line license verification to confirm the provider's license has not expired and that there are no current limitations on the license.

3.7.2 Out-of-State Non-Bordering Providers

Systematic updates are not applicable. Out of state non-bordering providers' files are updated as requested by the provider. Provider Enrollment will perform on-line license verification to confirm the provider's license has not expired and that there are no current limitations on the license.

3.8 CHANGE OF OWNERSHIP

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy.

Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, Civil Rights Compliance Information Request Package, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.
- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement <u>not being retroactive</u> to the date of acquisition

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Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

3.9 PROVIDER FILE CLOSURES

Provider files should be closed accordingly if either of the below situations are encountered or Agency requests are received for file closures. Batch processes have been created to assist in facilitating these changes; however, staff should ensure the closures are completed.

1. When a group provider number and its contracts are closed for any purpose, close all contracts assigned to any individual provider number associated with that group. Close any EFT segments associated with these providers.
2. When all associated individual provider numbers within a group and their assigned contracts are closed for any purpose, close the group number and its contracts. Close any EFT segments associated with these providers.

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4 PROVIDER ENROLLMENT INSTRUCTIONS

4.1 GENERAL INSTRUCTIONS

All potential providers will be required to submit a completed electronic enrollment application. In addition to the completed application, the provider must complete the following items before an application can be considered approved:

Signed Alabama Medicaid Provider Agreement

Disclosure of Ownership and Control Interest Statement

IRS W9 form

Electronic Funds Transfer Authorization Agreement for facility, group enrollments and individual providers who are not associated with a group.

After a completed application is approved, the approval letter will be sent to the provider.

If a provider changes the provider address, a letter must be sent to Provider Services to notify the unit of the new address information.

Provider instructions provided in this section are for the following provider types:

Ambulatory Surgical Center (ASC)

Audiologist

CRNA (Advanced Practice Nurse)

Dentist

Durable Medical Equipment

EPSDT

EPSDT Referrals & QMB/EPSDT

Federally Qualified Health Centers (FQHC)

Hearing Aid Dealer

Home Health

Hospice

Hospital

Independent Laboratory

Independent Nurse Practitioner (Advanced Practice Nurse)

Independent Radiology

Independent Rural Health Clinic

Licensed Social Worker

Lithotripsy (ESWL)

Nursing Home

Nurse Midwife

Off-Site EPSDT

Optician

Optometrist

Patient 1st Enrollment Procedures

Pharmacy

Physician

Physician Employed Nurse Practitioner (Advanced Practice Nurse)

Physician Employed Physician Assistant

Physiological Lab

Plan 1st Enrollment Procedures

Post Extended Care (PEC) Provider

Prenatal Education

Preventive Health Education

Private Duty Nursing

Provider Based Rural Health Clinic

Psych Hospital Over 65

Psych Hospital Under 21

Rehab Hospital

End-Stage Renal Disease (RSD) Clinic

State Agencies

Swing Bed Hospital

Transportation

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4.1.1 Ambulatory Surgical Center (ASC)

Type

02

Specialty

020 ASC

520 Lithotripsy (see Lithotripsy section of this manual for details)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated for all instate and out-of-state bordering ASC facilities:

- Verify Medicare certification in PECOS.
- Copy of the current Hospital Transfer Agreement to a hospital that accepts Alabama Medicaid patients.
- Evidence that all physicians utilizing the Ambulatory Surgical Center (ASC) will accept Alabama Medicaid patients.
- Copy of the current state license.
- A Certification and Transmittal (C&T) has to be received from the Department of Public Health notifying DXC that the facility is certified. (for instate facilities only)
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that ownership has changed. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written request from the provider and attach a W-9 form. A Certification and Transmittal must be received from the Department of Public Health notifying DXC that the name has changed.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

Change of Service Location Address

The Department of Public Health (DPH) will notify DXC that the center has had a change of address. DXC may change the provider's address using the C&T from DPH.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

With the exception of requiring a C&T, out-of-state non-bordering providers are enrolled for the date(s) of service only following the in-state enrollment procedures.

NOTE:

Out-of-state ASC providers may submit the one page Out-of-State ASC/Hospital Update Form in order to extend the enrollment period for either number assigned. This form is only acceptable if the ASC file did not expire more than one year prior to the submission date of the form. If the file has been expired for more than one year, an application must be processed.

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4.1.2 Audiologist

Type

20

Specialty

200 Audiologist

930 School Based Audiologist (See instructions under Local Education Agency)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Provider Enrollment will perform an on-line verification to confirm that the Audiologist's license has not expired.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

<u>OPTION 1</u>

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

<u>OPTION 2</u>

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. This documentation is then used in lieu of contacting

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Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change and Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Out of state non-bordering providers are enrolled for the date of service only.

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4.1.3 CRNA (Advanced Practice Nurse)

Type

09

Specialty

094 CRNA (Certified Registered Nurse Anesthetist)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Copy of current certification with the Alabama Board of Medical Examiners Certification Registration.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Anesthetist license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional Registered Nurse's license. Enrollment stop date will be the expiration date of the professional Registered Nurse's license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

<u>OPTION 1</u>

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

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OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

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4.1.4 Dentist

Type

27

Specialty

271 General Dentistry Practitioner

275 Endodontist

276 Pediatric Dentistry

277 Orthodontist

278 Periodontist

299 Mobile Provider

311 Anesthesiology – (Must submit a copy of their IV Sedation Certification).

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Copy of IV sedation certification, if provider intends to perform IV sedation procedures.
- Copy of DEA Certificate.
- Copy of mobile dental facilities or portable dental operations certificate.
- DXC enrollment staff must perform on-line verification of the dentist license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month, in which request for enrollment was received by DXC. The Medicare enrollment effective date will be utilized if the provider has been approved by Medicare. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, and Provider EFT Account panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

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OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Adding Specialty 299

Providers who are currently enrolled as a Medicaid dental provider must submit a letter requesting that specialty 299 (mobile provider) be added to their file. A copy of the mobile dental facilities or portable dental operations certificate issued by the Board of Dental Examiners must also be submitted. The effective date will be the first of the month in which the request/certification is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

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All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Address Change

Also update the address on Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

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4.1.5 Durable Medical Equipment (DME)

Type

25

Specialty

250 DME/Medical Supply Dealer

251 Prosthetic and Orthotic Provider (Only added if Agency Directs)

254 Mastectomy Fitter

256 Therapeutic Shoe Fitter

NOTE:

Prior to enrollment, DME applications should be forwarded to the DXC Provider Representative for onsite inspections and they will approve the enrollments of DME providers if they meet the requirements. **THE PROVIDER SHOULD NOT BE INFORMED THAT A VISIT WILL BE MADE.**

Program Integrity should only receive applications if there are Disclosure issues or the application is from an out of state provider applicant.

Please forward all governmental agency applications to the Program Integrity Division for approval. If a DME supplier does not have a business license, it may be a governmental agency DO NOT ENROLL.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Provider must be certified to participate as a Medicare provider. A provider's Medicare enrollment must be verified in PECOS. Do not ask for the Medicare certification letter.
- A copy of a valid license from the Alabama Board of Home Medical Equipment Services Providers, when applicable.
- Be certified to participate as a Medicare provider.
- Medicare Accreditation
- Medicare Surety Bond
- Medicaid Surety Bond (See Medicaid surety bond information below)
- A valid business license
- The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

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Specialty Name	Specialty Number	Type of Operations	License/ Certification Required	License/Accreditation Board Website
DME	250	DME only A, B, E, S, T HCPCS codes	HME license	Alabama Board of Home Medical Equipment (HME) Service Providers www.homemed.alabama.gov
Prosthetic, Orthotics & Prosthesis **(POP/YPOP)**	251	Prosthetic, Orthotic & Pedorthic (POP) Services only custom fabricated devices only	O&P facility license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov
Mastectomy Fitter (MSFIT)	254	Mastectomy Fitters "L" HCPCS codes (specified)	**Mastectomy Fitter (MSF) license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov
		HME providers using prefabricated or off-the-shelf orthoses "L" HCPCS codes	MSF **and** HME licenses	
Therapeutic Shoe Fitter (TSFIT)	256	Therapeutic Shoe Fitters "A" HCPCS codes	**Therapeutic Shoe Fitter (TSF) license	Alabama State Board of Prosthetists and Orthotists www.apob.alabama.gov

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Medicaid Surety Bond Requirements

Effective October 1, 2010, all DME providers must have a $50,000.00 Medicaid Surety Bond for each store location. A DME and medical supply business is exempt from the Medicaid Surety Bond requirements if the DME and medical supply business:

- Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or
- Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). DME suppliers who provide Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts are not included in this exemption
- Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or
- Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or
- Are Physical and Occupational Therapists in private practice; or
- Are providers who received $100,000 or less Medicaid payment in the past two calendar years, and have been operating at this same location for at least two consecutive calendar years; or
- Are pharmacy providers; or
- Are phototherapy providers who only provide phototherapy services for infants; or
- Are Federally Qualified Health Centers.

Prosthetic, Orthotic and Pedorthic Providers

The providers of Prosthetic, Orthotic, and Pedorthic devices for adults age 21 – 64 and youth age 0 – 20, must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics. Prosthetic and Orthotic providers should be enrolled with specialty 251.

Applicable to In-State DME providers ONLY. Medicaid does not enroll out of state DME POP providers.

Approval to add specialty 251 is given by the Alabama Medicaid Agency. Applications should be forwarded to the Program Integrity Division, Enrollment and Sanctions Unit via Workflows for review. However, if the application is denied, then it can be forwarded to the DXC Provider Representative for a site visit if they request to be a DME provider.

Providers of Prosthetic, Orthotic, and Pedorthic devices must meet the following requirements which includes the requirements for Durable Medical Equipment providers.

- Licensed by the Alabama Board of Prosthetics, Orthotics, and Pedorthics
- Instate provider ONLY
- Medicare certification must be verified in PECOS.
- Medicare Surety Bond

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- Medicare Accreditation
- Medicaid Surety Bond
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

Alabama Board of Home Medical Equipment Services License Exemption

The following entities or practitioners are exempted from receiving a license from the Alabama Board of Home Medical Equipment Services

- Home Health agencies certified by the State of Alabama to participate in the Medicare and Medicaid programs.
- Hospital based home medical equipment services, whether or not the services are provided through a separate corporation or other business entity.
- Health care practitioners legally eligible to order or prescribe home medical equipment, or who use home medical equipment to treat patients in locations other than the patient's residence.
- Manufacturers and wholesale distributors, when not selling directly to a patient.
- Retail community pharmacies, including providers of home infusion therapy services.
- Hospice programs, except programs which provide home medical equipment services, including delivery to a patient's residence.
- Skilled nursing facilities, except facilities which provide home medical equipment services, including delivery to a patient's residence.
- Governmental agencies, including fire districts which provide emergency medical services and contractors to governmental agencies whose business deals only with the contracted agency.
- Mail order companies, if deliveries are made only via common carriers, including the United States Postal Service.

Medicare Accreditation Exemptions

The following providers are exempted from the Medicare Accreditation:

- Suppliers providing drugs and pharmaceuticals ONLY
- Physicians (including Dentists)
- Audiologists
- Optometrists
- Orthotists
- Prosthetists (including Ocularists)
- Prosthetists are not exempt from Medicare Accreditation if they provide durable medical equipment, breast prosthesis, diabetic shoes and diabetic shoe inserts.
- Opticians

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- Occupational Therapists
- Physical Therapists

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NOTE:

Pharmacy providers are required to be Medicare certified which can be verified in PECOS. Pharmacy providers are not required to submit a Medicare Surety Bond, Medicare Accreditation nor a Medicaid Surety Bond.

DXC will enter the Medicare Surety Bond number, Medicare Surety Bond and Medicare Accreditation dates in interchange. The end date will remain one year from the effective date. If Surety Bond does not show an effective date, the signature date may be used as the effective date for the Bond.

DXC will receive Medicaid Surety Bonds from DME providers. DXC will enter the bond number. The effective date for the Medicaid Surety Bond is the date on the bond. The bond end date is one year from the effective date.

New providers are required to have a Medicare Surety Bond, Medicare Accreditation, and Medicaid Surety Bond. DXC should not accept any bonds that are not complete. All required information should be completed on the bond.

Some bonds are continuous until cancelled by the Surety. The provider will submit the yearly renewal receipt to DXC.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by DXC.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

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NOTE:

Newly enrolling DMEs are always assigned an initial risk screening level of high and must have a fingerprint based criminal background check (FCBC) completed for anyone with 5% or more ownership.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request from the provider and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

NOTE:

If the DME supplier has a new Tax Id number, the DME supplier will be required to complete a new provider enrollment application.

All providers with questions regarding state licensure should be referred to the Alabama Board of Home Medical Equipment Services Providers at (334) 215-3474. DXC should return any application if the license from the board is not enclosed with the application.

The specialty 590 (TA Waiver) can be added to the DME provider file. Medicaid will forward a memo to DXC indicating to add the 590 specialty to the file. The provider does not need to complete the TA Waiver Amendment.

Physicians may enroll with an individual Medicare certification or the group Medicare certification. Medicare certification can be verified in PECOS.

Effective January 1, 2011, Medicaid will accept a copy of the renewal receipt for Medicare and Medicaid Surety Bonds. DME providers must renew their bond each year with the Surety Bond Company. Durable Medical providers have the following language in their Medicare and Medicaid Surety Bonds. "The term of the bond shall be from the ___day of ___,____and shall be continuous until cancelled by the Surety." If the Surety Bonds does not include the language above, the Surety Bond renewal receipt will not be allowed.

Effective June 5, 2015, out-of-state providers of home medical equipment and services provided in accordance with state or federal law or regulation to Alabama Medicaid recipients are exempt from the HME law.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

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All other changes must be submitted in writing and signed.

A W-9 tax form is required if there is a change in the physical address and a site visit must be completed.

All other out-of-state providers are **only** eligible for crossover claims, use current out-of-state enrollment application. Crossover Only providers should be given the “QMB Only” contract only.

If a bordering DME provider is crossover only and would like to change to an “active” provider, a new application must be submitted with all required documentation and follow normal enrollment guidelines to include a site visit.

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4.1.6 Out-of-State Non-Bordering Providers

Type

25

Specialty

250 DME/Medical Supply Dealer

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated for out-of-state non-bordering DME suppliers:

- Copy of current state license, if applicable.
- Medicare Surety Bond
- Copy of DMERC notification from Medicare.
- Medicare Accreditation verified in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

NOTE:

If provider states they are an out-of-state mail order, the provider may enroll as a crossover provider.

To enroll as an out-of-state DME, the provider must have a physical location and a business license. If the provider does not have a business license, due to the state not requiring a business license, the provider must submit written information from the state licensing agency.

All Out-of-State Non-Bordering DME applications should be forwarded to the Agency (Program Integrity Division) for approval before enrolling.

DME Providers of Prosthetic, Orthotic, and Pedorthic devices must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics; be an In-State DME provider ONLY, and meet the same requirements as Durable Medical Equipment (DME) providers.

If a provider has more than one location, each location must be enrolled.

Effective date of enrollment will be the date of service. Enrollment stop date will be open-ended.

Other enrollment guidelines are the same as for in-state providers.

NOTE:

Set provider status to ‘X’-over. Out-of-state non-bordering DME providers should be given the QMB Only contract.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith. If this cannot be verified, the DME

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can be enrolled by verifying the Medicare certification in PECOS to satisfy the site visit requirement.

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4.1.7 End-Stage Renal Disease (ESRD) Clinic

Type

30

Specialty

300 Free-Standing Renal Dialysis Clinic

324 Nephrologist

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated.

- Verify Medicare certification in PECOS.
- Copy of their state license.
- A C&T must be received from the Department of Public Health. When the C&T and current state license is received, the application can be approved for enrollment.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the effective date of the Medicare certification.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Alabama Department of Public Health before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Alabama Department of Public Health. On receiving the C&T, send the provider a name change form, EFT Authorization Agreement form and a W-9 form.

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Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

If a renal dialysis facility has a change of address, DXC will receive a C&T from the Department of Public Health. The provider may notify DXC in writing by fax or e-mail. DXC will make this change due to the risk of returned mail or denied claims, etc. Contact the Deputy Director of the Division of Provider Services at the Department of Public Health at 206-5591 to make sure that the facility has notified him. All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Date of enrollment will be the dates of service.

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4.1.8 EPSDT

Type

31 Physician

58 Rural Health

13 Public Health Agency (Refer to State Agency Instructions)

56 FQHC

09 Independent Nurse Practitioner (Advanced Practice Nurse)

Physician Employed Practitioner (Advanced Practice Nurse)

Specialty

820 Referring Provider Only (Not a screening provider but can refer patients)

560 EPSDT

Additional Approval

Upon initial enrollment the EPSDT Agreement provided on the Medicaid Agency website and current CLIA certificate should be submitted.

If opting to enroll as an EPSDT screener after initial enrollment, the EPSDT Agreement provided on the Medicaid Agency website should be completed.

The effective date of enrollment, for currently enrolled providers, is the first day of the month that the completed EPSDT Agreement is received in the Provider Enrollment department. Effective date of enrollment for new providers is the same date as the Medicaid effective date.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

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NOTE:

When processing an EPSDT Agreement, check the Provider Contract Panel for an active EPSDT specialty code. Check the Provider CLIA Maintenance Panel for an active CLIA number. If specialty code 560 is already present and an active CLIA number is on file, notify the provider of the EPSDT effective date.

If specialty code 820 is on file, which is the Patient 1st non-screening PMP specialty, the 820 should be end dated with a date sequential to the begin date of the 560 specialty. (This end date should be the day before the start date of the 560 specialty).

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4.1.9 EPSDT Referrals & QMB/EPSDT

Type

15 Chiropractor

17 Therapist

14 Podiatrist

54 Psychologist

07 Behavioral Health

Specialty

150 Chiropractic

140 Podiatrist

173 Speech/Hearing Therapist

170 Physical Therapist

171 Occupational Therapist

112 Psychologist

600 QMB/EPSDT

070 Licensed Professional Counselor (LPC)

071 Associate Licensed Counselor (ALC)

072 Licensed Marriage and Family Therapist (LMFT)

073 Licensed Master Social Worker (LMSW)

074 Licensed Independent Clinical Social Worker (LICSW)

175 ABA Therapist

NOTE:

Specialty 600 is required for all of the above listed provider types. Hospital employed therapists are not eligible to enroll in the Alabama Medicaid Program.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

Chiropractor – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Chiropractor license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

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Occupational Therapy – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Occupational Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Physical Therapy – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Physical Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Podiatrists – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Podiatrists license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Psychologists – (QMB/EPSDT)

- Medicare certification verified in PECOS (for QMB).
- DXC enrollment staff must perform on-line verification of the Psychologist license to confirm that the provider's license has not expired and that there are

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no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

- Possess a doctoral degree from an accredited school or department of Psychology.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Speech Therapy – (QMB/EPSDT)

- Certificate of Clinical Competence (CCC).
- DXC enrollment staff must perform on-line verification of the Speech Therapy license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Medicare certification verified in PECOS (for QMB).
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Licensed Professional Counselor (LPC) / Associate Licensed Counselor (ALC) – (EPSDT)

- DXC enrollment staff must perform on-line verification of the LPC or ALC license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- Submit completed Civil Rights Compliance Information Request Package.

Licensed Marriage and Family Therapist (LMFT) – (EPSDT)

- DXC enrollment staff must perform on-line verification of the LMFT license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- Submit completed Civil Rights Compliance Information Request Package.

Licensed Master Social Worker (LMSW) / Licensed Independent Clinical Social Worker (LICSW) – (QMB/EPSDT)

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- Medicare certification verified in PECOS (for QMB)
- DXC enrollment staff must perform on-line verification of the LMSW or LICSW license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Possess a master's degree or above from an accredited school.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Board Certified Behavior Analyst – ABA Therapy – (EPSDT)

- DXC enrollment staff must verify license with the Alabama Behavior Licensing Board to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.
- Submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment is received by DXC or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

<u>OPTION 1</u>

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

<u>OPTION 2</u>

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

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Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Medicare certification is not necessary. Start date will be the date of service.

Site Visits

Licensed Professional Counselor (LPC), Associate Licensed Counselor (ALC), Licensed Marriage and Family Therapist (LMFT), Licensed Master Social Worker (LMSW), Licensed Independent Clinical Social Worker (LICSW), and Physical Therapy - Required to have a site visit completed during initial enrollment and reenrollment.

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4.1.10 Federally Qualified Health Centers (FQHC)

Type

56

Specialty

021	Cardiac Electrophysiology		
023	Sports Medicine		
080	FQHC - Required Specialty	328	Obstetrician/Gynecologist
093	Nurse Practitioner (Other)	329	Oncologist
095	Certified Nurse Midwives	330	Opthamologist
100	Physician's Assistant	331	Orthopedic Surgeon
112	Psychologist		
116	Licensed Social Worker	332	Otologist,Larynologist,Rhinologist
140	*Podiatrist	333	Pathologist
150	*Chiropractor	336	Physical Medicine & Rehab Pract
180	Optometrist	337	Plastic Surgeon
271	General Dentist Practitioner	338	Proctologist
272	Oral Surgeon	339	Psychiatrist
299	Mobile Provider (Cert from Dental Board Required)	340	Pulmonary Disease Specialist
310	Allergist	342	Thoracic Surgeon
311	Anesthesiologist	343	Urologist
312	Cardiologist	345	General Pediatrician
313	Cardiovascular Surgeon	560	EPSDT
314	Dermatologist	600	*QMB/EPSDT – Required for 140/150
315	Emergency Medicine	750	Colon and Rectal Surgery
316	Family Practitioner	770	Endocrinology
317	Gastroenterologist	780	Hematology
318	General Practitioner	790	Infectious Disease
319	General Surgeon	800	Internal Medicine
320	Geriatric Practitioner	810	Orthopedic
321	Hand Surgeon	830	Rheumatology
323	Neonatologist	911	SBIRT – Effective 1/1/2010
324	Nephrologist	931	Telemedicine Services
325	Neurological Surgeon		
274	Dental Prevention		

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Additional Approval

Applicant must provide the following if the FQHC is enrolling for the first time:

- Copy of Grant Award Notice from the Public Health Services that grants permission to operate in Alabama.
- Medicare certification verified in PECOS, if applicable.
- Copy of CLIA certification.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- Budgeted cost report.
- List of all satellite clinics and addresses.
- Enrollment applications for all physicians, nurse midwives, nurse practitioners, physician assistants, dentists, licensed social workers, chiropractors and podiatrists who are employed by the FQHC and the satellite clinics where they are assigned.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- Chiropractors Medicare certification must be verified in PECOS.
- Podiatrists Medicare certification must be verified in PECOS.
- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

Send budgeted cost report to Provider Audit who determines the rate. Enrollment is not complete until this rate has been received and added to the customary charge panel.

NOTE:

Individuals who are being added to an existing FQHC will be assigned the encounter rate, found on the customary charge panel of the existing group.

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Forward notification of any newly established FQHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the FQHC Program.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will be 60 days beyond the end date of the budget period indicated on the Grant Award Notice.

> An updated Grant Award Notice must be sent in annually in order to extend enrollment.

The FQHC must notify DXC in writing when they add a new satellite clinic. The following information must be provided:

- Copy of Health Resources Services Administration (HRSA) Notification showing that the new satellite is approved.
- A completed enrollment application.
- Completed enrollment application for each health care professional at the satellite clinic.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form.

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Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Bordering Providers

Federally Qualified Health Centers that are no more than 30 miles from the Alabama border are eligible to participate in the Alabama Medicaid Program as long as the bordering FQHC meets all the requirements of an in-state FQHC and has permission in the Grant Award Notice to operate in Alabama.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by the Alabama Medicaid for in-state facilities.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type at this time.

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4.1.11 Group/Billing Provider

Type

See enrollment application for type.

Specialty

See enrollment application for specialties.

Additional Approval

- To enroll as a group in the Alabama Medicaid Program, DXC must be supplied with the following:
- A completed enrollment application.
- A completed disclosure form is required for each owner, agent, managing employee, officer, director or shareholder with 5% or more controlling interest that is affiliated with the group. The completed form is to be faxed and mailed to DXC with the bar coded fax cover sheet.
- The Provider Agreement is to be signed and include the authorized person's business title. The signature page is to be faxed and mailed to DXC with the bar coded fax cover sheet.
- The Electronic Funds Transfer Authorization Agreement (EFT) is required.
- Corporations must submit a Certificate of Incorporation for in-state providers. Out-of-State providers must submit a Certificate of Authority to do business in Alabama.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment will be the first day of the month in which, the request for enrollment is received by DXC, if individual providers in the group are not assigned a date prior to the effective date of enrollment. If individual providers associated to the group are assigned an effective date prior to the first of the month the application was received, such as a Medicare certification date, the group/payee provider NPI number should contain the same effective as the earliest date assigned to the individual associated to the group/payee.

Example: Dr. A, who is associated with the group/payee, has a Medicare certification date of January 1, 2003. Dr. B, who is associated with the group/payee, does not have a Medicare certification date, but this provider's application was initially received on February 1, 2003. The group/payee application was initially received on March 1, 2003. Due to the effective date for provider Dr. A being January 1, 2003, which is the earliest date of the provider's enrolling, the group/payee effective should also be January 1, 2003.

The Enrollment stop date will be open ended.

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Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing. The request must be signed and include the business title of the person who signs the request and should contain the group/billing provider NPI number.

Out-of-State Non-Bordering Groups

Start date will be the date of service.

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4.1.12 Hearing Aid Dealer

Type

22

Specialty

220 Hearing Aid Dealer

Additional Approval

- The applicant must supply their State License to dispense hearing aids. An Audiologist's license can be used in lieu of a Hearing Aid Dealer's license because it is a higher rated license.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of the enrollment will be the first day of the month in which the request was received by DXC or issue date of license, whichever is later.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form

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Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.1.13 Home Health

Type

05

Specialty

050 Home Health

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- A certification of meeting the CMS conditions of participation for Home Health Care agencies to participate in the Medicaid program–Certification and Transmittal (C&T)–has to be received from the Department of Public Health before the enrollment process can begin.
- The C&T must be kept in the provider's file folder.
- It is important to check the following information that is listed on the C&T:
    - #2-Provider NPI Number (for changes).
    - #3-Name and address of the facility.
    - #4 Type of action.
    - #5-Date of Change of Ownership (if the C&T is for a change of ownership). Most times the date of the ownership change is found in item #16.
    - #7-Type Code.
    - #16-Remarks.
- Certificate of Need (CON) or a project exemption for the Home Health Agency.
- After the request and the CON from the provider have been received, send the Home Health Agency an enrollment application.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C&T from Public Health unless Medicaid gives DXC another date for enrollment.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment

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- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

NOTE:

Newly enrolling HHAs are always assigned an initial risk screening level of high and must have a fingerprint based criminal background check (FCBC) completed for anyone with 5% or more ownership.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that there has been a change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Department of Public Health notifying DXC of the name change before DXC can make changes to the provider file. Use the Name Change form or a written, signed request and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

NOTE:

Medicaid does not enroll Home Health branch offices and the C & T is filed. Parent offices and sub-units are enrolled.

Address Change

A C&T must be received from the Department of Public Health to change the physical address. DXC will also request a W-9 form and address change update for physical address changes. DXC can change the mailing and payee address without notification from DPH.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

Also, Home Health enrollments with specialty 970 (Disease Management) are exempt from a visit.

Hospice

Type

06

Specialty

060 Hospice

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- A certification of meeting the CMS conditions for participation of Hospice Provider agencies to participate in the Medicaid program – the Certification and Transmittal (C&T)–has to be received from the Department of Public Health before the enrollment process can begin.
- Medicare certification verified in PECOS.
- The C&T must be kept in the provider's file folder.
- It is important to check the following information that is listed on the C&T:
    - #2-Provider NPI number (for changes).
    - #3-Name and address of the facility.
    - #4-Type of Action.
    - #5-Date of Change of Ownership (if the C&T is a change of ownership). Most times the date of the ownership change is found in item # 16.
    - #7-Type Code.
    - #16-Remarks.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C&T from Public Health unless Medicaid gives DXC a different enrollment date.

Rates

LTC Provider/Recipient Services Unit will include the hospice rates with the initial for action memo.

Once the steps above are completed, DXC will send the following information to the provider, with an approval letter.

The Alabama Medicaid Hospice Rates notification letter indicates rates that are based on the geographical location of the hospice.

Hospice rates given to DXC by Medicaid.

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Notify the LTC Provider/Recipient Services Unit at Medicaid of initial enrollments.

CMS notifies Medicaid each year of the rates for Hospice. After CMS sends the rates, the Medicaid Provider Audit Division calculates a formula for the rates and then provides this formula to the LTC Division for the calculation of the rates. The rates are based on the geographical location of the hospice.

The rates are effective October first of each fiscal year and end December thirty-first of the following calendar year.

In order to find the rates for a particular county, find the Metropolitan Statistical Area (MSA) listed next to the county and refer to the rates for that MSA.

NOTE:

All rural rates are MSA 13.

Do not give Hospice providers the rates for hospice nursing home providers. Nursing home hospice rates are also effective from October first of each fiscal year through December thirty-first of the following calendar year. CMS does not send the rates for nursing home hospices; the Medicaid Provider Audit Division calculates them.

Medicaid will enroll all hospice satellite offices. Enrolling each location will enable Medicaid to distinguish the reimbursement rates for the various hospice locations. Item 1 on the C&T reflects information about the satellite offices to be enrolled.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C & T must be received from the Department of Public Health notifying DXC that there has been a change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Address Change

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A C&T must be received from the Department of Public Health to change the physical address. DXC will also request a *W-9* form and address change update for physical address changes. DXC can change the mailing and payee address without notification from DPH.

Name Change

A C&T must be received from the Department of Public Health before name changes can be made to the provider file. Use the Name Change form or a written, signed request.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

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4.1.14 Hospital

Type

01

Specialty

010 Acute Care Hospital

011 Inpatient Psychiatric Hospital over 65

012 Rehabilitation Unit CORE – for crossover claims only

013 Residential Treatment Facility

014 Long Term Care Hospital – for crossover claims only

017 Inpatient Psychiatric Hospital under 21

018 Psych Subpart Enrollment--for crossover claims only

019 Rehab Subpart Enrollment--for crossover claims only

292 Mammography

520 Lithotripsy (see Lithotripsy section of this manual for details)

530 Organ Transplants

540 Post-Extended Care (PEC) Hospital (see Post Extended Care section of this manual for details)

600 QMB/EPSDT

610 QMB only

900 VFC

Additional Approval

NOTE:

New enrollment for new hospital providers has not occurred in the last several years; however, most of the provider file changes are due to a change of ownership or name change.

DXC must receive a request from the provider requesting to participate in the Medicaid Hospital Program.

The effective date of enrollment cannot be earlier than the Medicare certification date.

The hospital must be certified for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital, must be licensed as an Alabama acute care hospital, have a current Certificate of Need, and be accredited by The Joint Commission.

If a hospital is enrolled as a critical access hospital with Medicare, allow providers to enroll in Alabama Medicaid as an acute care hospital. Alabama Medicaid does not recognize the distinction between acute care hospital and critical access hospital. For Alabama Medicaid, they are considered an acute care hospital.

A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed. If we

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receive a new enrollment application from a hospital before we receive the C&T, contact the Agency to determine if the C&T has been received. Do not return an application to the provider because a C&T cannot be found.

The hospital must submit a copy of their current Utilization Review Plan to be maintained with the enrollment record.

The hospital must submit a budget of cost for medical inpatient services (Medicare cost report) for its initial cost reporting period to be maintained with the enrollment record. If the hospital is a CHOW, the inpatient per diem for the old hospital should be loaded as the new hospital inpatient per diem rate and a budgeted cost report is not required.

In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received. The effective date of enrollment will be the Medicare certification date.

Always send a copy of the C&T and all correspondence to Provider Audit.

Add the appropriate HR rates to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panel as well as a 5% outpatient reimbursement rate (DXC). Provider Audit of Medicaid will calculate all rates and notify DXC. Do not add the provider to the AMMIS until rates have been calculated.

If the hospital is government owned, the Public/Private Indicator on the Service Location Panel will need to be updated to “Public” once the hospital has been enrolled.

General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider’s screening categorical risk level is set to HIGH

Provider’s screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider’s risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare’s Change of Ownership (CHOW) policy.

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Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.
- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement <u>not being retroactive</u> to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

When a hospital has had a change of ownership, be sure to check to see if they participate in the PEC or Swing Bed Programs. Any changes to the hospital provider file will also need to be made to these files.

Always send a copy of the C&T and all correspondence to Provider Audit.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. Use the Name Change and attach a copy of the W-9 form. The provider may also notify DXC in writing, e-mail or FAX. Send a copy of the C&T and all correspondence to Provider Audit.

When a hospital has a name change, be sure to check to see if they participate in the PEC or Swing Bed Programs. Any changes to the hospital provider file will also need to be made to these files.

Always send a copy of the C&T and all correspondence to Provider Audit.

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Closure of Hospital

When DXC receives a copy of the Confirmation of Closure letter from the Department of Public Health, close the hospital's Medicaid enrollment using the closure date on the letter. Stamp the letter with the DXC action stamp and put the provider NPI number in the response (for the State copy).

Always send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

A C&T must be received from the Department of Public Health before service location address changes can be made to the provider file.

When a hospital has a change in the number of certified beds for their facility, a C&T will be received from the Department of Public Health. Update the provider file and send a copy of the C&T to Provider Audit.

The Hospital must request in writing to Provider Audit a request to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

All other changes must be submitted in writing and must be signed.

Change of Address

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. The provider may notify DXC in writing by FAX or e-mail. The changes should be made due to the risk of returned mail, denied claims, etc. Contact the Deputy Director of the Division of Provider Services, at the Department of Public Health at (334) 206-5191, to make sure that the hospital has notified the Department of Public Health of the address change. Notify Provider Audit of the address change.

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

Enrollment of Subparts within a Hospital

Type

01

Specialty

010 Acute Care (For hospitals enrolling their Rehab or Psych unit)

018 Psych Subpart Enrollment

019 Rehab Subpart Enrollment

If a currently enrolled hospital has acquired an NPI for their Rehab or Psych unit, enrollment of these units will be for Crossover Only.

The effective date of enrollment will be the first day of the month in which the application is received.

Set provider status to 'X'-over.

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Set the COBA indicator to Yes.

Add the “Inpatient” contract only for subparts.

Add the provider’s data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account, and Provider Medicare Number panels.

Add the appropriate HR rates that have been calculated for the enrolled acute care facility to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panel as well as a 5% outpatient reimbursement rate (DXC) for the subparts.

Any changes to ownership, address, payee or name will be handled through the hospital update process.

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Out-of-State Non-Bordering Providers

Specialty

010 Acute Care

- If a hospital is enrolled as a critical access hospital with Medicare, allow providers to enroll in Alabama Medicaid as an acute care hospital. Alabama Medicaid does not recognize the distinction between acute care hospital and critical access hospital. For Alabama Medicaid, they are considered an acute care hospital.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

292 Mammography

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.

Enrollment period will begin with the date of service and will end 6 months from the first date of service.

NOTE:

Out-of-state Hospitals may submit the one page Out-of-State ASC/Hospital Update Form in order to extend the enrollment period. This form is only acceptable if the OOS Hospital file did not expire more than one year prior to the submission date of the form. If the file has been expired for more than one year, an application must be submitted.

Add the appropriate HR rates to the Provider Outpatient Rate Panel or Provider NH/IP Rates Panels as well as a 5% outpatient reimbursement rate (DXC).

Name Change

Use the Name Change form or a written, signed request and attach a new W-9 form. If the provider has had a tax number change, return the request and inform the provider to complete a new enrollment application.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Can be enrolled as out of state participating with Medicaid's approval.

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4.1.15 Independent Laboratory

Type

28

Specialty

280 Independent Lab

550 Department of Public Health (see instructions for State Agencies)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license or equivalent documentation.
- Copy of the current CLIA certificate
- Continued license will be received from the Department of Public Health. Medicaid enrollment dates should coincide with the licensure dates. Licensure information must be filed in the provider's contract file and the file updated as needed.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment of an independent laboratory will be the date of issuance of license or CLIA certification. Providers who request enrollment more than 120 days after licensure/certification are enrolled on the first day of the month enrollment is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

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Name Change

Use the Name Change form or a written, signed request and attach a W-9 form. Upon receipt of the letter from the Department of Public Health, send the provider a name change form and a W-9.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Follow the same procedures as in-state providers. Provider must attach a state license or equivalent documentation.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith. If this cannot be verified, the lab can be enrolled by verifying the lab is currently enrolled and active with Medicare (verify in PECOS), and is currently Clinical Laboratory Improvement (CLIA) certified or has accreditation through the College of American Pathologists (CAP) to satisfy site visit requirements.

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4.1.16 Independent Nurse Practitioner (Advanced Practice Nurse)

Type

09

Specialty

090 Pediatric Nurse Practitioner

091 Women's Health Care Nurse Practitioner – Effective March 2011

092 Family Nurse Practitioner

093 Nurse Practitioner (Other) – Required Specialty

730 Neonatology (Nurse)

560 EPSDT

911 SBIRT

274 Dental Prevention

NOTE:

Independent Nurse Practitioners (INPs) will have, at a minimum, two specialties, 093, and their actual specialty.

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Must have current certification as a CRNP in the appropriate area of practice from a national certifying agency. Neonatal nurse practitioners must have certification from the Nurses Association of the American College of Obstetricians and Gynecologists. These items must be verified on the Board of Nursing website and a copy attached to application file.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license
- Copy of the certified registered nurse practitioner protocol signed by a collaborating physician.
- Name and provider NPI number of the supervising physician.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the provider license file. CRNPs with prescriptive authority will have RX on the licensure card.
- In order to add the 560 specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the State to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

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- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, and Provider Type and Specialty panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

Nurse practitioner applications submitted for enrollment under the Tax ID of a facility such as a hospital and/or with a letter indicating the nurse practitioner is employed at this facility under special circumstances, MUST be forwarded to the Enrollment & Sanctions Unit of the Program Integrity Division for review.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

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- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

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4.1.17 Independent Radiology (X-Ray Clinic)

Type

29

Specialty

291 Mobile X-Ray Clinic

292 Mammography

327 Nuclear Medicine

290 Radiology

570 Physiological Lab (Independent Diagnosis Testing Facility)

Additional Approval

Provider must furnish the following:

- Medicare certification verified in PECOS (Some radiology providers may be certified by Medicare as an IDTF).
- Copy of Public Health Certificate of X-ray Inspection (Magnetic Resonance [MRI], ultrasound and other non-ionizing radiation will not have a certificate of x-ray inspection from the Alabama Department of Public Health).
- Copy of the mammography certification issued by the Food and Drug Administration (FDA) if the provider will be performing mammograms.
- In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment of an independent radiology facility will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month in which the enrollment was received. DXC will receive a C&T from Public Health on new enrollments, change of ownership, name change and change of address “for certified x-ray facilities only.” (Public Health does not regulate mammography, MRI, ultrasound and other non-ionizing radiation used for medical imagery.)

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider’s screening categorical risk level is set to HIGH

Provider’s screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T must be received from the Department of Public Health notifying DXC that ownership has changed before the provider file can be updated. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

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4.1.18 Independent Rural Health Clinic

Type

58

Specialty

021 Cardiac Electrophysiology

023 Sports Medicine

081 Free Standing Rural Health Clinic

093 Certified Registered Nurse Practitioner – Effective May 11, 2011, this specialty was allowed to enroll because of the meaningful use program. However, the nurse practitioner will continue to bill under the clinic NPI number. Refer to enrollment instructions below.

095 Nurse Midwife

560 EPSDT

911 SBIRT – Effective 1/1/2010

311 Anesthesiology

931 Telemedicine Services

274 Dental Prevention

Additional Approval

To enroll as a Medicaid provider, an Independent Rural Health Clinic (IRHC) must be Medicare certified and must enroll every health care professional working in the clinic. The IRHC must have a Certified Registered Nurse Practitioner (CRNP) or a Physician Assistant (PA) employed before they can enroll the clinic. The only exception is if the facility can obtain a Certificate of Waiver from HHS, which is valid for one year only. The C&T should indicate the provider specialty. The following information is required to enroll clinics:

- C&T from Division of Licensure & Certification (DLC)—address on C&T must match address on the enrollment application. If it does not, return only the application to the provider for correction. Keep the C&T in the DXC file for the provider.
- Medicare certification verified in PECOS.
- Copy of the CLIA certificate or waiver.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. The CRNPs and PAs with prescriptive authority will have an RX on their license. Enrollment staff must print a copy of the license verified on-line and place in the provider's file as well as on COLD.

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- Budgeted Cost Report. Send cost report to Provider Audit who determines the reimbursement rate. Enrollment is not complete until this rate has been received and added to the Customary Charge Panel. Forward notification of any newly established IRHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the IRHC Program.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

The effective date of enrollment of an independent rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

Notify DXC's Adjustment Unit to add the provider to the Customary Charge Panel. Use the forms and follow the rules at the end of the section.

The following information is required to enroll clinic physicians:

Physicians must complete an enrollment application. All signatures must be original signatures.

The address on the application must match the address and phone number on the C&T. If all information is correct, a new enrollment is processed.

Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

Start dates for the Medical Doctors (MDs) can be:

1. The first of the month in which the enrollment application was received.
2. The Medicare start date verified in PECOS.
3. Written, signed notification from the provider that "the provider started with this clinic on XX/XX/XX date."

Using the data entered on the enrollment application, determine the services the provider can bill and notify DXC's Medical Policy Unit to add the provider to the Customary Charge Panel. If the provider should retro their effective date (Medicare start date verified in PECOS), remember to notify DXC's Medical Policy Unit to retro the effective dates on the Customary Charge Panel.

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Effective May 11, 2011, Nurse Practitioners were approved by the state to enroll as a provider in the clinic for enrollment purposes only due to the Meaningful Use Program. However, they will continue to bill using the clinic NPI number.

The following information is required to enroll clinic nurse practitioners:

Nurse Practitioners must complete an enrollment application. All signatures must be original signatures.

The address on the application must match the address and phone number on the C&T. If all information is correct, a new enrollment is processed.

Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD.

Start dates for the Nurse Practitioners (NPs) can be:

4. The first of the month in which the enrollment application was received.
5. The Medicare start date verified in PECOS.
6. Written, signed notification from the provider that "the provider started with this clinic on XX/XX/XX date."

Pricing information should not be placed on the Customary Charge Panel for the nurse practitioner.

NOTE:

Physician Assistants are not enrolled. They bill using the clinic NPI number.

Addition of Services

Written request is received to provide additional services. The codes for new services will be added to the customary charge panel.

The same process applies to deleting a service.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

The IRHC must submit written notification to DLC within 30 days of the date of the ownership change. Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The CHOW cannot be executed until DXC receives the C&T from the Department of Public Health. See detailed CHOW policy under Section 3.8.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Q & A reimbursement program within the 30 day timeframe.

Name Change

IRHC must submit written notification to DLC and Medicaid of the name change within 30 days of the date of the name change. Once notification is received, and the name change amendment form is sent to the provider. The name change form cannot be executed until the C&T is received from DLC.

Address Change

A C&T has to be received from the Department of Public Health to change the physical address. DXC can change a payee address without notification from DPH.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Bordering Providers

Independent Rural Health Centers that are no more than 30 miles from the Alabama border are eligible to participate in the Alabama Medicaid Program as long as the bordering IRHC meets all the requirements of an in-state IRHC. However, the provider may not have a C&T.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Customary Charge Sheets

To determine which codes, prices, and dates to forward to the Adjustment Unit to add to the customary charge panel, use the following guidelines:

Clinic Visits

New clinics and newly added MDs will **always** have clinic visit codes. Use the customary charge sheet titled **Clinic Visit Codes**. Enter the appropriate provider name, NPI number, Payee NPI, rate, and effective and end dates. Circle that this is an ADD (new provider).

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Family Planning

If the enrollee, whether clinic or MD, has checked 'yes' for Family Planning, use the customary charge sheet titled **Family Planning Codes.** Enter the appropriate NPI number, payee NPI number, rate, and effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

Prenatal

If the enrollee, whether clinic or MD, has checked 'yes' for Prenatal, use the customary charge sheet titled **Prenatal Codes.** Enter the appropriate provider name, NPI number, payee NPI number, rate, and the effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

EPSDT

If the enrollee, whether clinic or MD, has completed the EPSDT Agreement use the customary charge sheet titled **EPSDT Codes.** Enter the appropriate provider name, provider NPI number, payee NPI number, rate, and effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes).

NOTE:

The EPSDT Agreement can be found on the Medicaid Agency website. In order for the clinic or MD to enroll in the EPSDT program, the enrollee must meet the EPSDT program guidelines. Refer to the EPSDT section of this manual for details.

Vaccines for Children

IRHC providers can participate in the Vaccines for Children Program. The provider enrolls with the Public Health Department. Public Health sends Enrollment staff a listing of the clinics and physicians enrolled. Staff will update the provider file with specialty code 900 and VFC contract. Staff will forward the customary charge sheet titled **Vaccine Codes** to Medical Policy. Enter the appropriate provider name, provider NPI number, payee NPI number, and the effective and end dates. Circle either ADD (New provider) or UPDATE (existing provider to which we are adding codes.)

If the clinic or MD has been previously enrolled in the VFC program, but is receiving denials on particular codes, a VFC customary charge sheet may need to be forwarded to Medical Policy.

Preventive Health

IHRC providers also provide Preventive Health services. This requires no changes to the provider table. Medicaid sends these customary charge updates directly to Medical Policy.

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4.1.19 Licensed Social Worker – QMB Only

Type

11

Specialty

116 Licensed Social Worker

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Proof of educational degree.
- Perform on-line license verification to confirm the social worker's license has not expired and that there are no current limitations on social worker's license. Print a copy of the license verified on-line and place in the provider's file as well as on COLD
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

NOTE:
Set provider status to 'X'-over.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Effective date will be first day of the month in which the request for enrollment was received by DXC.

NOTE:
Set provider status to 'X'-over.

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4.1.20 Lithotripsy (ESWL)

Type

01 Hospital

02 ASC

Specialty

520 Lithotripsy

Additional Approval

The following documentation is required for enrollment:

- Documentation that the Lithotripsy machine is FDA-approved.
- Copy of the lease agreement if the machine is leased.

NOTE:

If the provider is an existing ASC or hospital and wishes to participate as a lithotripsy provider, an application must be submitted for that purpose. Along with the application the documentation listed above must be submitted.

Effective date of enrollment for existing ASCs or hospitals is the first day of the month that the application is received. If an application for lithotripsy is submitted at the same time as an initial hospital enrollment, effective date of enrollment is the same as the hospital enrollment effective date. If the provider is bordering, the effective date will be the date of service provided by the applicant (cannot retro more than one year from the date of service) or the first of the month that the application is received.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Out-of-State Non-Bordering Providers

Enrollment is not applicable.

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4.1.21 Nurse Midwife (Advanced Practice Nurse)

Type

09

Specialty

095 Nurse Midwife

911 SBIRT – Effective 1/1/2010

Additional Approval

The following information is required for enrollment:

- Perform on-line license verification to confirm the nurse midwife's license has not expired and that there are no current limitations on the nurse midwife's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the American College of Nurse Midwife certificate.
- Copy of the current enrollment in the American College of Nurse Midwife Continuing Competency Assessment Program.
- Copy of the certified nurse midwife protocol signed by a collaborating physician.
- A letter from the hospital granting admitting privileges for deliveries.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights
- letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 911specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.

The effective date is the first date of the month in which the request for enrollment is received by DXC.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.1.22 Nursing Home

Type

03 SNF

03 ICF/MR

Specialty

035 Skilled Nursing Facility

030 Intermediate Care Facility

036 Nursing Home Vent (Only added if Agency Directs)

Additional Approval

The Alabama Department of Public Health (ADPH), Division of Health Care Facilities and the Division of Provider Services perform certifications and transmittals (C&T) on every nursing home and intermediate care facility. These certifications will certify or recertify and will denote any changes in a nursing home name, bed status, address change, complaint, or change in ownership.

It is important to check the following information that is listed on the C&T:

#2- Provider NPI Number.

The provider ID is not always correct on the C&T. Refer to the Nursing Home Directory.

#3-Name and Address of Facility.

This information is not always correct on the C&T. Refer to the Nursing Home Directory.

#4-Type of Action (must be completed).

#5-Date of Change of Ownership.

This date is indicated on a Change of Ownership C&T. Most of the time, the effective date is given in field #16, Remarks.

#6-Date of Survey.

This date is found on Recertification's, On Site Visits, and Complaints.

#7-Type Code.

#12-Total Facility BHP.

#13-Total Certified BHP.

#14-Bed Breakdown.

#16-Remarks.

NOTE:

C&Ts which reflect a Fiscal Year End change should be filed. Enrollment & Sanctions Unit will forward a copy of the C&T to Provider Audit. Provider Audit will take action.

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The ADPH Division of Provider Services will notify DXC with a C&T when a facility is being certified in the Medicaid program. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. A new enrollment application must be completed. Before Provider Enrollment can process the application, the unit must have the following:

A letter from CMS indicating the effective date of certification for the facility. DXC will receive this letter only if the facility is not Medicare certified at the time they enroll with Medicaid, or the facility was a private pay facility prior to Medicaid enrollment.

The effective date of the Medicaid enrollment is the Medicare effective date indicated on the C & T from Public Health unless Medicaid gives DXC another date for enrollment.

- The nursing facility must request in writing their desire to enter into the Medicaid program.
- Must have a Certificate of Need (CON) or Project Exemption. If a facility was enrolled before the CON process began it is not necessary to have a CON. Please contact the State Health Planning & Development Agency (SHPDA) at (334)242-4103 for this information. SHPDA can verify if there is CON for the facility.

General Data section of Civil Rights Compliance Information Request Package, DHHS-Office of Civil Rights letter of compliance, and most recently published newspaper article referencing the provider's nondiscrimination policy.

Send notification of the addition to: (applicable addresses are at the end of this section)

- Director of Long Term Care
- Provider Audit
- Alabama Nursing Home Association
- Fiscal Agent Liaison Division - Fiscal Agent Policy & Systems Management
- Medical & Quality Review Unit
- ADPH, Division of Provider Services / Attention: Deputy Director
- ADPH, Division of Health Care Facilities
- OBRA Screening
- Medicaid Eligibility District Office (applicable location)
- Medicaid Beneficiary Services Director, East and West Region
- Medicaid Beneficiary Services Supervisor, East and West Region
- LTC Provider / Recipient Services Unit

Mail the approval letter to the provider.

Enrollment & Sanctions Unit will notify Provider Audit Division when the C&Ts are received because the facility has to pay taxes once they are licensed.

Increase in Beds

The ADPH Division of Provider Services will notify DXC with a C&T when there has been an increase in beds for a certain facility. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. DXC will complete the following steps:

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1. Update the provider file showing increase in number of beds.
2. After DXC receives the necessary documents (C&T and the CON), a letter is sent to the nursing facility acknowledging the bed increase.
3. Distribute as follows:
   - Original to the nursing facility or intermediate care facility.
   - One copy of the letter to ADPH, Division of Health Care Facilities.
   - One copy of the letter to ADPH, Division of Provider Services / Attention Deputy Director.
   - One copy of the letter to the Medicaid Eligibility District office (applicable location)
   - One copy of the letter to Provider Audit.
   - One copy of the letter to Medicaid Beneficiary Services Director, East and West Region
   - One copy of the letter to Medicaid Beneficiary Services Supervisor, East and West Region
   - LTC Provider / Recipient Services.
4. File the letter and C&T in the contract file. The Enrollment & Sanctions Unit will forward Provider Audit a copy of the increase C&T.

Decrease in Beds

The ADPH Division of Provider Services will notify DXC with a C&T when there has been a decrease in beds for a certain facility. The C&T will be forwarded to DXC by the Enrollment & Sanctions Unit. When DXC receives this notification, complete the following steps:

1. Update the provider file showing decrease in number of beds.
2. Write a letter to the nursing facility acknowledging the bed decrease. Distribute as follows:
   - Original to the nursing facility or intermediate care facility.
   - One copy of the letter to the ADPH Division of Health Care Facilities.
   - One copy of the letter to ADPH, Division of Provider Services / Attention: Director
   - One copy of the letter to the Medicaid Eligibility District office (applicable location)
   - One copy of the letter to Provider Audit Director
   - One copy of letter to Beneficiary Services Director, East and West Region
   - One copy of letter to Beneficiary Services Region Supervisor, East and West Region
   - LTC Provider / Recipient Services Unit
   - Medical & Quality Review Unit
3. File the letter and C&T in the contract file. The Enrollment & Sanctions Unit will forward Provider Audit a copy of the bed decrease C&T.

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Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy as outlined below. A C&T must be received from the ADPH, Division of Provider Services before ownership changes can be made to the provider file. The Enrollment & Sanctions Unit will forward a copy of the CHOW C&T to Provider Audit. The Enrollment & Sanctions Unit will notify the following of the CHOW:

Medical & Quality Review

Fiscal Agent Liaison Division - Fiscal Agent Policy & Systems Management

Provider Audit

LTC Provider / Recipient Services Unit

ADPH, Division of Provider Services / Attention: Deputy Director

ADPH, Division of Health Care Facilities

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Procedures Following a Change in Ownership

Institutions are to notify Medicaid of any CHOW or closure as soon as Medicare has been notified. The new owner has an option to accept assignment of the existing Medicaid Provider agreement or to reject it as outlined below:

Accept previous Owner's Medicaid Agreement results in:

- Uninterrupted participation in Medicaid
- Uninterrupted Medicaid reimbursement for claims by utilizing the previous owner's NPI and Medicaid ID number
- New owner subjected to any liabilities such as overpayments to the previous owner and any adjustment of payment
- The new owner must complete and submit a Change of Ownership form, a new Electronic Funds Transmittal Form (EFT), W-9, and Disclosure Forms. Disclosure Forms must be completed for any new owners, officers, directors,

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agents, managing employees, and shareholders with 5% or more controlling interest. These required forms are located on the Medicaid website.

- New owner completing the CHOW form instead of completing a new enrollment application.

Reject Previous Owner's Medicaid Agreement results in:

- Interrupted participation in Medicaid
- Contract terminated effective the date of acquisition
- The new owner's Medicaid contract will be effective the date of Medicare compliance
- The effective date for claims reimbursement not being retroactive to the date of acquisition

Acquisition followed by combination into one institution:

- If the previous owner's agreement is accepted by the new owner, the acquired institution becomes a remote location or second campus.
- If the previous owner's agreement is rejected by the new owner, the second location must undergo a full Medicare survey.

Name Change

A C&T must be received from the Department of Public Health before name changes can be made to the provider file. Use the Name Change form and attach a current W-9 form. The old file should be closed sequentially with the opening of a new file. Write a letter to the nursing home. Enclose the W-9 form and the name change form. After the W-9 and the name change form are returned, write a memo to Medicaid. Send the one copy of memo to:

- ADPH, Division of Provider Services / Attention: Deputy Director
- ADPH, Division of Health Care Facilities
- Provider Audit
- Medical & Quality Review Unit
- Fiscal Agent Policy & Systems Management
- Beneficiary Services Director, East and West Region
- Beneficiary Services Supervisor, East and West Region
- Medicaid Eligibility District Office (applicable location)
- LTC Provider / Recipient Services Unit

Payee Name Change/Bank Account number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

Address Change

A C&T must be received from the Department of Public Health to change the provider's physical address. DXC can change the payee address without notification from Public Health. DXC will also request a W-9 form and address change update for address changes.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

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All other changes must be submitted in writing and must be signed.

Memo Distribution:

Letters that reflect different actions are copied to certain Medicaid staff and other individuals who work outside the Medicaid Agency. DXC will forward the letters to the Agency and other State Agencies.

DXC forwards the letter to the Medicaid Eligibility District Office that handles the county where the facility is located.
DXC staff was provided a copy of the Medicaid Eligibility District Offices and will receive updates.

Letters that are cc: ADPH, Division of Health Care Facilities are sent to the secretary unless a specific person is listed.

NOTE:

The address for the ADPH, Division of Provider Services is the same as the ADPH, Division of Health Care Facilities. Memos that are forwarded to the Medicaid Beneficiary Services East and West Region will be forwarded to the Director that handles that specific county. The same applies to the Medicaid Beneficiary Services East and West Region Supervisor.

Alabama Nursing Home Association	
ADPH Division of Health Care Facilities	Alabama Department of Public Health
ADPH Division of Provider Services	Alabama Department of Public Health
Beneficiary Services Director East Region	See Medicaid District Office Distribution List
Beneficiary Services Director West Region	See Medicaid District Office Distribution List
Director of Long Term Care	Medicaid
Fiscal Agent Policy & Systems Management	Medicaid
LTC Provider/ Recipient Services Unit	Medicaid
Medicaid District Office	See Medicaid District Office Distribution List
Beneficiary Services Supervisor West Region	See Medicaid District Office Distribution List
Beneficiary Services Supervisor East Region	See Medicaid District Office Distribution List
OBRA Screening	Mental Health
Provider Audit	Medicaid

Q:\BENEFICIARY SERVICES\Beneficiary DO Directory.xls

District Office (West and East Region) Directory

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Mailing Address

Alabama Department of Public Health
Division of Health Care Facilities
RSA Tower, Suite 600
201 Monroe Street
Montgomery, Alabama 36104

Handmail Address

Alabama Department of Public Health
Montgomery, Alabama 36130-3017

Address for OBRA Screening / Mental Health:

Mailing Address

Director
Mental Health / OBRA Screening
PO Box 301410
Montgomery, Alabama 36130-1410

Handmail Address

Director
Mental Health / OBRA Screening
Montgomery, Alabama 36130-1410

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.1.23 Off-Site EPSDT

Type

31 Physician

58 Rural Health Physician

13 Public Health Agency

56 FQHCs

Specialty

560 EPSDT

Additional Approval

Refer all calls and correspondence to the EPSDT Program Manager/Medical Services Division. Medicaid will process and forward update information to DXC. After completed agreement and attachments are received, Medicaid will forward a completed maintenance form with the effective date being the first of the month in which the request was received.

If a provider intends to provide services at different sites, each site must be treated as a distinct and separate enrollment.

The provider must meet the requirements of the Off-Site EPSDT Services protocol.

Forward customary pricing sheet to the Medical Policy Unit. Notification of enrollment should be held until enrollment is complete. Enrollment is not complete until the customary pricing update is completed.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

This action is not applicable to this provider type.

Name Change

Use the name change form.

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Change of Payee

This action is not applicable to this provider type.

All Other Changes

All changes must be submitted in writing and must be signed

Out-of-State Providers

Enrollment is not applicable to this provider type.

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4.1.24 Optician

Type

19

Specialty

190 Optician

Additional Approval

A completed enrollment application must be submitted and approved before the enrollment process can be initiated:

NOTE:

If a provider has more than one location, each location must be enrolled separately.

- Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

<u>OPTION 1</u>

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

<u>OPTION 2</u>

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

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A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

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4.1.25 Optometrist

Type

18

Specialty

180 Optometrist

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the optometrist's license has not expired and that there are no current limitations on the optometrist's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- All optometrists with an Alabama license, (like physicians), enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If the optometrist has a 9-character license number, add the license information to the Provider License Panel.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment

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application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

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Address Change

Also update the address on the Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

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4.1.26 Oral Surgeon

Type

62

Specialty

272 Oral Surgery

311 Anesthesiology (Must submit copy of their IV Sedation Certification).

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- Copy of oral surgery certification.
- Copy of DEA certificate.
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month, in which request for enrollment was received by DXC or the Medicaid Agency's Dental Program or the Medicare effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

<u>OPTION 1</u>

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the

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appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

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OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Address Change

Also update the address on Provider Information Panel.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

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4.1.27 Pharmacy

Type

24

Specialty

240 Retail

241 Governmental

242 Institutional

Additional Approval

After the enrollment application is received, verify the following:

- State Board of Pharmacy Number and Pharmacist's Registered Number (Alabama Pharmacy State Board (205 981-2280, Tennessee (615)-741-2718, Florida (850) 245-4292, Georgia (478) 207-1640, Mississippi (601) 354-6750.
- Verify the Pharmacy Permit number.
- Verify the Pharmacist Register number.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- The effective date is the first day of the month in which the request for enrollment was received by DXC.
- After enrolling a new pharmacy, the NPI should be set as the default in the IDs panel of the provider's enrollment. The "Default NPI Service Location" should be set to "Yes."

NOTE:

All out-of-state non-bordering applications should be sent to the agency for review before enrolling.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

NOTE:

Notify Program Integrity of any decertified pharmacies (closed) and any pharmacy that has been decertified.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Providers located no more than thirty miles from the Alabama state line may be enrolled following the in-state provider process. Others can be enrolled only for the date of service or for specialty drugs not available in Alabama. Forward all requests for enrollment from out of state bordering and non-bordering pharmacies to Provider Enrollment with the Program Integrity Division of Medicaid if the request is for more than the normal one-day enrollment.

Enrollment for Part B Claims

Type

25 DME/Medical Supply Dealer

Specialty

252 DME/Medical Supply Dealer

Additional Approval

After the Pharmacy Medicare Part B/Medicaid Crossover Enrollment Application is received, verify the following:

State Board of Pharmacy Number and Pharmacist's Registered Number (Alabama Pharmacy State Board (205) 981-2280, Tennessee (615) 741-2718, Florida (850) 245-4292, Georgia (478) 207-1640, Mississippi (601) 354-6750.

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- Verify the Pharmacy Permit number
- Verify the Pharmacist Register number
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Assign the following contracts:

- Durable Medical Equipment
- QMB/EPSDT Only

The effective date is the first of the month in which the written request for enrollment was received by DXC. The enrollment end date will be open ended.

Set provider status to ‘X’ –over.

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4.1.28 Physician

Type

31

Specialty

021	Cardiac Electrophysiology		
023	Sports Medicine	272	Oral Surgeon
175	ABA Therapist (Psychiatrist Only – See note below)		
299	Mobile Provider	331	Orthopedic Surgeon
310	Allergist Rhinologist	332	Otologist, Laryngologist,
311	Anesthesiologist	312	Cardiologist
333	Pathologist	313	Cardiovascular Surgeon
336	Physical Medicine and Rehabilitation Practitioner		
314	Dermatologist	315	Emergency Medicine
337	Plastic Surgeon	316	Family Practitioner
338	Proctologist	317	Gastroenterologist
339	Psychiatrist	318	General Practitioner
340	Pulmonary Disease Specialist	341	Radiologist
319	General Surgeon	342	Thoracic Surgeon
320	Geriatric Practitioner	343	Urologist
321	Hand Surgeon	345	General Pediatrician
323	Neonatologist	750	Colon and Rectal Surgery
324	Nephrologist	770	Endocrinology
325	Neurological Surgeon	780	Hematology
328	Obstetrician/Gynecologist	790	Infectious Disease
329	Oncologist	800	Internal Medicine
330	Opthalmologist	830	Rheumatology
810	Orthopedic	911	SBIRT – Effective 1/1/2010
921	Teaching Facility	931	Telemedicine Service
922	Perinatologist		
274	Dental Prevention		

NOTE:

Specialty 175 – ABA Therapist is only allowed for a physician's enrollment if specialty 339 – Psychiatrist is included.

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Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 292 mammography specialty, the provider/facility must submit a copy of the mammography certificate issued by FDA. The effective date of the mammography specialty will be the first of the month in which the certificate was received.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- Approval to add specialty 921 is given by the Alabama Medicaid Agency. Applications from new providers or emails or letters from existing providers requesting to add the 921 specialty should be forwarded to the Program Integrity Division, Enrollment and Sanctions Unit, via Workflows for coordination of approval with the Physician Program. The Enrollment & Sanctions Unit will forward the application to the Physician Program for review and approval. The Physician Program will review and send official approval to add the 921 specialty via memo to DXC through the Enrollment & Sanctions Unit. Once enrollment has been completed, DXC will notify the Physician Program.
- Approval to add specialty 922 is given by the Alabama Medicaid Agency. Providers will submit a written request for approval to the Managed Care Division, Maternity Care Program, to add this specialty. The Managed Care Division will review and send official approval to add the 922 specialty via memo to HPE through the Enrollment & Sanctions Unit. DXC will notify the Maternity Care Program and the Physician Program when the 922 specialty has been added to the provider's file. Once the addition of the specialty has been completed, an official notification with an effective date and guidance will be provided to the provider by the Maternity Care Program in collaboration with the Physician Program.
- In order to add the 820 Referring PMP specialty, the provider must submit a Patient 1st Application, on which the provider indicates that EPSDT screenings for assigned recipients will be performed by a designee.

NOTE:

For additional Patient 1st enrollment instructions, please refer to the Patient 1st section of this manual.

- In order to add the 560 EPSDT specialty, the provider must submit an EPSDT Agreement and also a current CLIA certificate if they have an internal lab at

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which samples are being tested. If the provider is only collecting samples to send to an external lab, a current CLIA certificate is not required.

- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

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If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

To add new groups, reference the group enrollment section of the manual.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing.

Address Changes

Also update the Provider Information Panel.

Out-of-State Providers

Effective date will be the date of service.

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4.1.29 Physician Employed Anesthesiology Assistants

Type

10

Specialty

101 Anesthesiology Assistant

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the anesthesiology assistant's license has not expired and that there are no current limitations on the anesthesiology assistant's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the current certifications with the Alabama Board of Medical Examiners Certificate of Registration and National Commission for Certification of Anesthesiologist Assistants. (AA providers enrolling for a physical location outside of Alabama will not have a certification through the Alabama Board of Medical Examiners. Such providers are required to submit certification from the board of the state in which the provider is practicing and the National Commission for Certification in Anesthesiologist Assistants).
- Medicare certification verified in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- Name and NPI number of the employing physician (found on the additional information page of the electronic application). The NPI number assigned to the physician must be verified as active.

NOTE:

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the Medicare enrollment effective due to the Medicare certification being a requirement. In no event will the Medicaid effective date be prior to the issue date of the professional license. Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

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- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Effective date will be the date of service.

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4.1.30 Physician Employed Nurse Practitioner (Advanced Practice Nurse)

Type

09

Specialty

093 Nurse Practitioner (Other)

560 EPSDT

911 SBIRT - Effective 1/1/2010

274 Dental Prevention

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Copy of the current certification as a CRNP in the appropriate area of practice from a national certifying agency. Neonatal nurse practitioners must submit a copy of the certification from the Nurses Association of the American College of Obstetricians and Gynecologists.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the License Panel.
- CRNPs with prescriptive authority will have RX on the licensure card.
- Name and NPI number of the employing physician (found on the additional information page of the electronic enrollment application). The NPI number assigned to the physician must be verified as active.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 560 (EPSDT) specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

If a provider has more than one location, each location must be enrolled separately.

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The employing physician must be an Alabama Medicaid provider and must be under the same tax number as the Nurse Practitioner.

The effective date of enrollment will be the first day of the month in which the written request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional Registered Nurse's license. Enrollment stop date will be the expiration date of the professional Registered Nurse's license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare verification can be verified in PECOS, We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

NOTE:

Nurse practitioner applications submitted for enrollment under the Tax ID of a facility such as a hospital and/or with a letter indicating the nurse practitioner is employed at this facility under special circumstances, MUST be forwarded to the Enrollment & Sanctions Unit of the Program Integrity Division for review.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

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4.1.31 Physician Employed Physician Assistant (Mid-Level Practitioner)

Type

10

Specialty

100 Physician Assistant

560 EPSDT

911 SBIRT – Effective 1/1/2010

274 Dental Prevention

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD
- Name and NPI number of the employing physician (found on the additional information page of the electronic enrollment application). The NPI number assigned to the physician must be verified as active.
- Copy of the PA's prescriptive authority from the licensure board. If the PA has prescriptive authority, add the information to the License Panel.
- PAs with prescriptive authority will have RX on the licensure card.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- In order to add the 560 (EPSDT) specialty, the provider must submit an EPSDT Agreement and a current CLIA certificate.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

For additional EPSDT enrollment instructions please refer to the EPSDT section of this manual.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment will be the first day of the month in which the request for enrollment was received or the Medicare enrollment effective date. In no event will the Medicaid effective date be prior to the issue date of the professional license.

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Enrollment stop date will be the expiration date of the professional license with a 45-day grace period.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Provider enrollment procedures no longer require that individual providers enroll with Medicare prior to applying to Medicaid. This is due to the often-lengthy enrollment process with Medicare. Providers will be given the option on the enrollment application to enroll with Medicaid prior to being approved to participate with Medicare.

OPTION 1

If the provider chooses to enroll with Medicaid before Medicare, we enroll the provider using the enrollment process currently used for a Pediatrician. This includes ensuring the application is complete and verifying the license information with the appropriate license board. The effective date of enrollment will be the first day of the month in which the application is received.

OPTION 2

If the provider has already been approved to participate in the Medicare program, the effective date of enrollment will be the Medicare effective date. Medicare certification can be verified in PECOS. We can then use this documentation in lieu of contacting Medicare to verify the provider's Medicare information. Obtaining this information will improve enrollment and produce more accurate tax information for 1099 reporting.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request from the provider.

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Change of Payee

If the provider has a new tax number or Medicare number, they must complete a new Medicaid enrollment application and a new number is assigned.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Effective date will be the date of service.

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4.1.32 Physiological Lab (X-Ray Clinic)

Type

29

Specialty

570 Physiological Lab (Independent Diagnostic Testing Facility) IDTF

Additional Approval

The facility must specify the provider's specialty as physiological lab. Physiological lab can only have one specialty.

- Provider must furnish the following:
- Medicare certification verified in PECOS.
- Copy of the current state license.
- Completed Physician's Supervisory Certification.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the first day of the month in which the request for enrollment is received by DXC or issue date of license, whichever is later.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

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All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Same as in-state.

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4.1.33 Plan First Enrollment Procedures

The following outlines the policies and procedures regarding Plan First Enrollment.

Policies

1. Any Medicaid enrolled provider (routinely these are: FP, GP, OB/GYN, Nurse Midwife, Nurse Practitioner) may enroll in the Plan First program.
2. Only enrolled Plan First providers may provide services to a Plan First enrollee.

Procedures

1. Providers wishing to enroll must complete the Plan First Agreement:
   a. The Plan First agreement is located on the required attachment link in the electronic enrollment application for new providers.
   b. For existing providers, the provider should be directed to the Medicaid Agency website to download the agreement.
2. Compare the demographic information included on the enrollment form to the information provided on the agreement. Update fields as necessary following normal DXC operating procedures, contacting the provider as may be required to verify what information is correct.

NOTE:

The contact information is for internal use and should not be indicated on the Provider Information Panel.

3. Place a specialty code of 700 on the provider file with the effective date being the first day of the month in which the agreement was signed. An open-ended stop date should be used.
   a. If the agreement is for a group number, place a 700 code on the group provider file and all providers that may be associated with that group. There is a block on the agreement indicating whether it is a group or individual enrollment. FQHC's and RHC's should be considered group enrollments; however, these providers should send a list of individual practitioners within their clinics to also be considered as Plan First providers.
   b. If the agreement is for an individual, place a 700 code only for the provider file indicated.

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4.1.34 Post Extended Care (PEC) Provider

Type

01

Specialty

540 Post Extended Care (PEC)

Additional Approval

The hospital must be enrolled with Medicaid as an in-state participating acute care facility. The provider must complete an application to provide PEC services. The provider will furnish the effective date for enrollment. The effective date is the date the facility started providing PEC services.

- Add the specialty code to the provider file and update the PEC listing.
- Notify Provider Audit so rates can be established.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

This action is not applicable to this provider type.

Name Change

This action is not applicable to this provider type.

Change of Payee

This action is not applicable to this provider type.

All Other Changes

This action is not applicable to this provider type.

Out-of-State Providers

This action is not applicable to this provider type.

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NOTE:

Any changes to ownership, address, or name will be handled through the hospital update process.

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4.1.35 Prenatal Education

Type

13 Public Health Agency

55 Private Prenatal Education

Specialty

183 Early Intervention Services

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Names and verification of valid licensure for each of the provider's instructors (for unlicensed instructors, providers must supply DXC with the name and resume of the physician supervising the instructor and maintain documentation sufficient to demonstrate their availability to the instructors). A resume of education and experience must be submitted for each instructor.
- A narrative verifying what type of training that will be provided by the facility to a new employee prior to the employee becoming a Prenatal Education instructor.
- A copy of the Prenatal Education curriculum that includes course content and objectives for each class.
- Evaluation process for pre/post instruction.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

After all the information is received, DXC will forward the information to the Maternity Care Program Associate Director for approval. The Maternity Care Program will review the curriculum and credentials to determine the potential provider's qualifications. If approved, the curriculum, credentials and statement describing the training to be provided to new employees will be stamped **'approved'**. The reviewer's initials and the date the information was approved will be placed under the approval stamp. The provider must be sent a copy of the approved curriculum, credentials, and statement describing the training provided to new employees for their file. This information, along with the forms listed below, will be returned to DXC so that the enrollment process can be completed.

- Biographical Data Sheet/Consent Form.
- Class Attendance Record.
- Evaluation Documentation Record.
- Patient Referral Form.

These forms can be duplicated by the provider.

If the submitted information is not approved, the staff person in the Plan Development/Contracts Unit will inform the potential provider of the reason why the

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information is not acceptable and request that the information be corrected and resubmitted. DXC will also be apprised of this action.

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NOTE:

All County Health Departments are currently enrolled as Prenatal Education Providers.

- The effective date of enrollment will be the first day of the month in which the request for enrollment was received by DXC.
- Send pricing information to the Medical Policy Unit of DXC to add the appropriate procedure code to the customary charge panel.

Health Departments are paid $18.20 per class.

Private Prenatal Education providers are paid $10 per class.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Name Change

Use the Name Change or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

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4.1.36 Preventive Health Education (Early Intervention Services)

Type

13 Public Health Agency

55 Private Prenatal Education

Specialty

183 Early Intervention Services

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Verification of a valid license for all staff members who will be teaching or directly supervising instruction of the Adolescent Pregnancy Prevention classes.
- Title and completion date of Medicaid approved training for non-medical professionals.
- Specific written curriculum for the class, including specific course content and objectives that must be prior approved.
- A statement or evidence verifying the type of training that will be provided to a new employee prior to the employee becoming an instructor. The statement or evidence must be submitted for an employee that is not a medical professional, but is a health education instructor.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.
- Evaluation process for pre/post instructions.

Upon receipt of the application, the packet should be forwarded to the Medical Services Division of Medicaid. Medicaid will collect the additional items listed above. Upon approval of the completed agreement and collected attachments, Medicaid will forward a completed maintenance form to DXC. The effective date of enrollment will be the first of the month in which the request was received.

A provider with more than one site must enroll for each separate location where the medical and educational records will be housed.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment

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- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Update Correspondence and Inquiries

Forward all calls and update correspondence to the Medical Services Division. Medicaid will process and forward update information to DXC.

Out-of-State Providers

Enrollment is not permitted for out-of-state providers.

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4.1.37 Private Duty Nursing

Type

52

Specialty

580 Private Duty Nursing

600 QMB/EPSDT

590 T A Waiver

Additional Approval

In addition to the enrollment application the provider must also submit the following:

- Copy of a valid and current year's Alabama business license or State license. The license must include the physical location of the business, and the business cannot be located more than thirty miles from the Alabama state line.
- A copy of the RN license must be provided to enroll.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment is the first day of the month in which the request for enrollment is received by DXC. The enrollment end date will be open ended.

NOTE:

Private Duty Nursing providers can also enroll to provide services under the Technology Assisted Waiver for Adults (TA Waiver) Program. DXC must have approval from the Medicaid Agency to enroll a Private Duty Provider for the TA Waiver. Providers wishing to add the TA Waiver to their enrollment should submit a letter requesting addition of this specialty to DXC. Once received, DXC should send the letter to the Enrollment & Sanctions Unit for coordination and approval from the program manager for the TA Waiver program.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Name Change

Use the Name Change form or a written, signed request and attach a W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment. A visit is not required if Medicare completed a site visit within the last 12 months.

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4.1.38 Provider Based Rural Health Clinic

Type

58

Specialty

021	Cardiac Electrophysiology	112	Psychologist
023	Sports Medicine	140	Podiatrist
185	Provider Based Rural Health Clinic	600	QMB/EPSDT (Required for specialties 112 & 140
560	EPSDT	931	Telemedicine Services

911 SBIRT – Effective 1/1/2010

311 Anesthesiology

093 Certified Registered Nurse Practitioner – Effective May 11, 2011, this specialty was allowed to enroll because of the Meaningful Use Program. However, the nurse practitioner will continue to bill under the clinic NPI number. Refer to enrollment instructions below.

095 Nurse Midwife

274 Dental Prevention

Additional Approval

To enroll as a Medicaid provider, a Provider Based Rural Health Clinic (PBRHC) must be Medicare certified. The PBRHC must have a Certified Registered Nurse Practitioner (CRNP) or a Physician Assistant (PA) employed before they can enroll the clinic. The only exception is if the facility can obtain a Certificate of Waiver from HHS, which is valid for one year only.

The following information is required to enroll a PBRHC:

- A C&T from the Department of Public Health - the address on the C&T must match address on the enrollment application. Also, the C&T should indicate the provider's specialty.
- Medicare participation approval verified in PECOS (hospital based RHCs must have the same fiscal year end (FYE) date as the hospital. The hospital FYE can be verified by using the Provider Information Search Page or Provider Mini-Search Panel by entering the name or tax number of the hospital that owns the clinic.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- Copy of the CLIA certificate or waiver
- Copy of IV Sedation Certification if provider intends to perform IV Sedation procedures.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. The CRNPs and PAs with prescriptive authority will have an RX on their license. Enrollment staff must

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print a copy of the license verified on-line and place in the provider's file as well as on COLD.

- Budgeted Cost Report. Send cost report to Q&A reimbursement, who determines the reimbursement rate. Enrollment is not complete until this rate has been received and added to the customary charge panel. Forward notification of any newly established PBRHC payees to Clinic Services, Medical Services Division, Medicaid, and to the current provider representative for the PBRHC Program.
- Send notification to Q&A Reimbursement for additional information required.

The effective date of enrollment is the date of Medicare certification. If a provider requests enrollment more than 120 days after Medicare certification, the effective date of enrollment is the first day of the month the application is approved.

The physician, nurse practitioner, psychologist and podiatrist must complete an enrollment application. Enrollment staff must perform on-line license verifications to confirm that the provider's license has not expired and that there are no current limitations on the provider's license. Print a copy of the license verified on-line and place in the provider's file on COLD.

The application's address must match the address and phone number on the C&T.

Start dates for the physicians, nurse practitioners, psychologists and podiatrists can be:

1. The first of the month in which the enrollment application was received.
2. The Medicare start date verified in PECOS.
3. Written, signed notification from the provider that "the provider started with this clinic on XXXXX date."

- All physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.
- In order to add the 911 specialty, Provider Enrollment will receive a memo from the state to add this specialty to the provider's file.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

NOTE:

Pricing information should not be placed on the Customary Charge Panel for the nurse practitioner. Physician Assistants are not enrolled. Nurse Practitioners and

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Physician Assistants bill using the clinic NPI number. Appropriate documentation of current licenses and certifications are required.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

The PBRHC must submit written notification to DLC within 30 days of the date-of the ownership change. Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The CHOW cannot be executed until Medicaid receives the C&T from the Department of Public Health. See detailed CHOW policy under Section 3.8.

Medicare will reenroll if the RHC changes provider type—that is, the Provider-Based RHC becomes an independent RHC. If the provider type does not change, Medicare will not reenroll and the Medicaid enrollment will not change.

If Medicare reenrolls due to the provider type changing, terminate Medicaid enrollment. A new enrollment application must be executed (same as IRHC).

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Q&A reimbursement program within the 30 day timeframe.

Name Change

PBRHC must submit written notification to DLC and Medicaid of the name change within 30 days of the date of the name change. Changes cannot be executed until the C&T is received from DLC. Send one executed Signature Page to the provider with a cover letter.

Address Change

A C & T has to be received from the Department of Public Health to change the physical address. DXC can change the payee address without notification from DPH. Requests to change the payee address must be submitted to DXC in writing.

Change of Payee

This action is not applicable to this provider type.

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Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.1.39 Psych Hospital Over 65

Type

01

Specialty

011 Inpatient Psychiatric Hospital over 65

Additional Approval

A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed.

A provider must meet the following requirements:

- Must be licensed as an Alabama free-standing acute geriatric psychiatric hospital.
- Must be accredited by The Joint Commission.
- Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for geriatric patients 65 or older.
- Employ only staff who meets training/certification standards in the area of geriatric psychiatry as defined by the State's mental health authority.
- Recognized as a teaching hospital, and affiliated with at least one four-year institution of higher education with a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illnesses.
- Must provide outpatient and community liaison services throughout the State of Alabama directly or through contract with qualified providers.
- Must be under the jurisdiction of the State's mental health authority.
- Must submit a current utilization review plan.
- The UR Plan is forwarded to the Managed Care Quality Assurance Program for approval. If the plan does not meet Medicaid requirements, the nurse reviewing the Plan will write a letter to the hospital stating the deficiencies. A copy will be forwarded to DXC for the provider file. Once the UR Plan is approved, DXC will receive an approval letter from Quality Assurance.
- Must submit a budget of cost for inpatient services.
- The budget is forwarded to Provider Audit. Provider Audit will notify DXC of approval/rate.
- Verify Medicare certification in PECOS.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment cannot be earlier than the Medicare certification date.

Send a copy of the C&T and all correspondence to Provider Audit.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

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A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T has to be received from the Department of Public Health notifying DXC of a hospital's change of ownership before the changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. The provider may also notify DXC in writing, via fax or e-mail.

Provider is mailed a name change amendment with Supplemental Information Form and an Electronic Funds Transfer Authorization Agreement form. The provider should submit a new W-9 as requested on the Supplemental Info form.

Send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

When a hospital has a change in the number of certified beds, a C&T will be received from the Department of Public Health. DXC updates the provider file and sends a copy of the C&T to Provider Audit.

The hospital must send a written request to Provider Audit to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. DXC will make this change due to the risk of returned mail, denied claims, etc. Contact the Deputy Director of the Division of Provider Services, Department of Public Health, at 334-206-5191 to make sure the hospital has notified him.

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

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All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.1.40 Psych Hospital Under 21

Type

01

Specialty

017 Inpatient Psychiatric Hospital under 21 (Peds Psychiatric)

Additional Approval

A hospital must meet the following requirements in order to acquire approval:

- Must be certified by Medicare. Verify in PECOS.
- Must be licensed as an Alabama psychiatric hospital.
- Must be accredited by The Joint Commission.
- Must have a distinct unit for children and adolescents.
- Must have a separate treatment for children and adolescents.
- A Medicare/Medicaid Certification and Transmittal (C&T) must be received from the Department of Public Health before the enrollment process can be completed.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- The hospital must submit a copy of their current Utilization Review Plan. The UR Plan is forwarded to the Managed Care Quality Assurance Program for approval. If the plan does not meet Medicaid requirements, the nurse reviewing the Plan will write a letter to the hospital stating the deficiencies. A copy will be forwarded to DXC for the provider file. Once the UR Plan is approved, DXC will receive an approval letter from Quality Assurance.
- The hospital must submit a budget of cost for medical inpatient services (Medicare cost report) for its initial cost reporting period. The budget is forwarded to Provider Audit. Provider Audit will notify DXC of approval/rate.

The effective date cannot be earlier than the date of the Medicare certification.

Send a copy of the C&T and all correspondence to Provider Audit.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. A C&T has to be received from the Department of Public Health notifying DXC of a hospital's change of ownership before changes can be made to the provider file. See detailed CHOW policy under Section 3.8.

The hospital must submit a current Utilization Review Plan. The UR Plan is forwarded to the Managed Care Quality Assurance Program. QA will notify DXC in writing of approval. The CHOW cannot be completed without an approved UR Plan.

The hospital must also submit a Medicare Terminating Cost Report to Provider Audit. The provider is instructed to do this in the cover letter.

When DXC receives the C&T, approval from QA on the UR Plan the effective date of the CHOW is the date indicated on the C&T.

Send a copy of the C&T and all correspondence to Provider Audit.

Name Change

A C&T must be received from the Department of Public Health before any changes can be made to the provider file. The provider may also notify DXC in writing, e-mail or fax.

Provider is mailed a name change amendment with Supplemental Information Form and an Electronic Funds Transfer Authorization Agreement form. The provider should submit a new W-9 as requested on the supplemental Information Form.

Send a copy of the C&T and all correspondence to Provider Audit.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed. When a hospital has a change in the number of certified beds, a C&T will be received from the Department of Public Health. Update the provider file and send a copy of the C&T to Provider Audit.

The hospital must request in writing to Provider Audit to change their fiscal year end date. Provider Audit will send DXC a copy of the letter to the provider granting this request.

If a hospital has a change of address, the Department of Public Health will send DXC a C&T. The provider may notify DXC in writing by fax or e-mail before DPH notifies DXC. Contact the Deputy Director of the Division of Provider Services, DPH, at 206-5191 to make sure that the hospital has notified him.

When the C&T is received from DPH, DXC can make the address change due to the risk of returned mail, denied claims, etc.

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Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

Out-of-State Providers

Enrollment is not applicable to this provider type.

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4.1.41 Rehab Hospital (Crossover Only)

Type

01

Specialty

012 Rehabilitation Hospital

600 QMB/EPSDT

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- Copy of the current state license.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If a provider has more than one location, each location must be enrolled separately.

The effective date of enrollment is the first day of the month in which the request for enrollment is received by DXC. The enrollment end date will be open ended.

Set provider status to 'X'-over.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a W-9 form.

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Change of Payee

If the provider has a new tax number, they must complete a new Medicaid enrollment application.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

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4.1.42 Swing Bed Hospital

Type

03

Specialty

035 Swing Bed Hospital (Skilled Nursing BHP)

950 Swing Bed – Effective May 2010

Additional Approval

A hospital must meet the following requirements in order to acquire approval:

- Must be enrolled with Medicaid as an in-state participating acute care facility.
- Must have fewer than 100 beds (rural hospital).
- Must be a Medicare swing bed provider.
- Must have a Certificate of Need (CON) for swing beds.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The provider must complete an enrollment application to provide swing-bed services. If these conditions are met add the specialty code to the provider file and update the Swing Bed Listing. Notify Provider Audit so rates can be established.

(Any changes to ownership, address, payee or name will be handled through the hospital update process.)

The effective date is the date the enrollment application is received by DXC.

Update the swing bed listing.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

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Change of Ownership

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. The swing bed listing will need to be updated. See detailed CHOW policy under Section 3.8.

Name Change

A name change requires file maintenance update. A copy of the hospital contract Amendment should be placed in the provider's Swing bed file.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Providers

Enrollment is not applicable to this provider type.

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4.1.43 Transportation

Type

26

Specialty

260 Ground Ambulance

261 Air Ambulance (Helicopter)

268 Air Ambulance (Fixed Wing)

Additional Approval

In addition to the completed application, the following information must be submitted and approved before the enrollment process can be initiated:

- Medicare certification verified in PECOS.
- If the transportation facility is owned by the hospital, the hospital's Medicare certification is applicable.
- Current state license or permit from the Department of Public Health. Air Ambulance providers will not have a current state license or permit from the Alabama Department of Public Health.
- General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

The effective date of enrollment will be the Medicare enrollment effective date due to the Medicare certification being a requirement. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by DXC.

Add the provider's data to the Provider Service Location, Provider Location Name Address, Provider Contract Eligibility, Provider Tax ID, Provider Type and Specialty, Provider EFT Account and Provider Medicare Number panels.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership/New Tax ID Number

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. See detailed CHOW policy under Section 3.8.

Name Change

Use the Name Change form or a written request from the provider and attach a W-9 form.

Payee Name Change and Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All other Changes

Changes to the Mail to and Pay to addresses, contact names and all telephone numbers should be submitted by the Provider on the Provider Web Portal.

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Out-of-state providers are enrolled for date of service only. The enrollment application must be submitted for each date of service to be billed.

Site Visits

Required to have a site visit completed during initial enrollment and reenrollment.

If the application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the associated state Medicaid Agency should be contacted to determine if a visit was conducted using provided contact information from the Alabama Medicaid Agency. Document the visit by putting the individual contacted and site visit date in the notes in Feith.

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4.2 STATE AGENCIES

The Alabama Medicaid Agency enrolls other State Agencies to provide a variety of nontraditional Medicaid services. Each State Agency must have a contractual agreement with Medicaid which encompasses the service(s) they will provide either directly or indirectly. Prior to entering into a contractual agreement with the State Agency, Medicaid ensures that the provider qualifications of the State Agency are met. A State Agency may also subcontract with other qualified providers who wish to provide the specific service(s) if the provider criteria are met. A state Agency who subcontracts with a provider is responsible for enrolling only those providers who meet Medicaid's enrollment criteria.

State agencies enrolled as a Medicaid provider and the requirements that must be met before the enrollment process is complete are listed in the following sections:

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4.2.1 The Alabama Department of Children's Rehabilitation Services (CRS) / Sparks Clinic

(Enrolled as the administering agency/provider for children's specialty services)

Type

57

Specialty

015 Children's Specialty (Required Specialty for CRS Providers)

021 Cardiac Electrophysiology

023 Sports Medicine

093 Nurse Practitioner

273 Orthodontia (requires Agency approval)

560 EPSDT

850 Sparks Rehab Center

931 Telemedicine

990 Hemophilia

995 Radiology Clinics

274 Dental Prevention

CRS is a specialty clinic that has contractual agreement with the Medicaid Agency. They may contract with any qualified provider who meets Medicaid enrollment criteria (i.e., physicians, and orthodontists). CRS is a payee for children's specialty services.

Physicians

Physicians affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type is:

Type

57

Specialty

015 Children's Specialty (Required Specialty for CRS Physician Providers)

274 Dental Prevention

See Provider Type Specialty Cross Reference Panel for valid Specialty values for CRS Physicians

- Perform on-line license verification to confirm the physician's license has not expired and that there are no current limitations on the physician's license. Print a copy of the license verified on-line and place in the provider's file on COLD.

- All physicians with an Alabama license, including CRS physicians, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to add the 931 Telemedicine Services specialty, the provider must

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submit the Telemedicine Services Agreement/Certification form. As stated on the Agreement/Certification form, Enrollment staff must ensure that a **sample copy** of the Provider's Informed Consent form is attached to this agreement. A sample copy has been provided for Enrollment staff. Enrollment staff must review the submitted Provider's Informed Consent form to ensure that it contains the information that is in the Agency's sample copy.

- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Sparks Clinic

Type

57

Specialty

850 Sparks Rehab Center

274 Dental Prevention

Sparks Clinic is enrolled as a provider of children's specialty services.

Sparks Clinic is a children's specialty clinic that has a contractual agreement with the Medicaid Agency. Sparks Clinic may subcontract with any qualified provider who meets Medicaid enrollment criteria (i.e., physicians). Sparks Clinic is a payee for children's specialty services.

- Sparks Clinic should submit to DXC a memo and pertinent documentation to add providers with which they have subcontracted.
- Forward customary charge sheet to the Medical Policy Unit for group CRS enrollments only. Effective 3/31/2014, individuals within a group will no longer receive rates. Notification of enrollment should be held until enrollment is complete. Enrollment is not complete until the customary charge update is completed (for group enrollments only).
- There is very little activity with Sparks. Sparks will send you a memo letting you know when a doctor has left and when a new staff member is hired.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

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- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Certified Registered Nurse Practitioners (CNRPs)

Certified Registered Nurse Practitioners (CRNPs) affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type is:

Type

57

Specialty

093 Nurse Practitioner

015 Children's Specialty (Required Specialty for CRS Physician Providers)

274 Dental Prevention

See Provider Type Specialty Cross Reference Panel for valid Specialty values for CRS CRNPs

- Copy of the current certification as a CRNP in the appropriate area of practice from a national certifying agency.
- DXC enrollment staff must perform on-line verification of the Certified Registered Nurse Practitioner (CRNP) license to confirm that the provider's license has not expired and that there are no current limitations on the provider's license
- Name and provider NPI number of the supervising physician.
- Proof of the CRNP's prescriptive authority from the licensure board. If the CRNP has prescriptive authority, add the information to the provider license file. CRNPs with prescriptive authority will have RX on the licensure card.
- Perform on-line license verification to confirm the nurse practitioner's license has not expired and that there are no current limitations on the nurse practitioner's license. Print a copy of the license verified on-line and place in the provider's file on COLD.
- In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

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Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.2 The Alabama Department of Children's Rehabilitation Services (CRS)

(Enrolled as the administering agency/provider for Audiology and Therapy services)

Type

17

Specialty

171 Occupational Therapist

170 Physical Therapist

600 QMB / EPSDT

173 Speech/Hearing Therapist

015 Children's Specialty (Required Specialty for CRS Providers)

Type

20

Specialty

200 Audiologist

015 Children's Specialty (Required Specialty for CRS Providers)

The therapist will submit the completed special application with all attachments to: State Supervisor for Professional Services, CRS, P.O. Box 11586, Montgomery, AL 36111-0586. The CRS Supervisor will prepare and forward to DXC a memorandum providing provider's name and effective date for enrollment along with the special application, Statement of Compliance, and all required attachments to DXC for review, approval and addition to Medicaid files. The special application and Statement of Compliance must have original signatures. Add specialty 600 for each therapist enrolled.

The following required attachments must accompany the application. The attachments are as follows:

- Speech Pathologist A copy of their current license from the Alabama Board of Examiners Speech Pathology and Audiology.
- Occupational Therapist A copy of their current license.
- Physical Therapist A copy of their current license.
- Audiologist A copy of their current license.

For all providers listed above:

- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Upon completion, DXC will notify ADRS/CRS at the above address.

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Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.3 Alabama Department of Senior Services (ADSS)

(Enrolled as an administering agency/provider for the Elderly/Disabled waiver.)

Type

53

Specialty

670 ADSS (Elderly and Disabled)

The ADSS has a contractual agreement with the Alabama Medicaid Agency to provide Elderly/Disabled waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria. ADSS is the payee for E/D waiver services.

ADSS is the payee for the Elderly/Disabled Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.4 Alabama Department of Education

(Enrolled as an administering agency/provider for Audiology, Rehabilitation, Therapy and Vision Services.)

Type

12

Specialty

930 School Based Services

NOTE:

Specialty 930 is required for all provider types that are associated with the Department of Education.

The Department of Education has a contractual agreement with the Alabama Medicaid Agency to provide audiology, rehabilitation, therapy (i.e., speech therapy, physical therapy, and occupational therapy) and vision services. The Department of Education may subcontract with any qualified provider who meets Medicaid's enrollment criteria. The State Department of Education is the payee for above referenced therapy services. All NPI numbers should pay to the State Department of Education.

- The Department of Education should submit to DXC an application for the school at which the services will be rendered.
  - If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
  - If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

The effective date of enrollment, for applications initially received on or after March 23, 2004, will be the first day of the month in which the written request for enrollment is received by DXC.

The effective date shall be no earlier than October 1, 2003. Enrollment stop date will be open ended. More than one service may be indicated on the application. Services not indicated on the initial application that are to be added at a later time will require a separate application.

DXC will verify that the physical address and superintendent indicated for the school system is the address and superintendent given in the Alabama Department of Education Directory. Verification of credentials for the providers performing the services is the responsibility of the Department of Education.

DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed

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- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.5 Alabama Department of Mental Health (ADMH/ID)

Type

53

Specialty

680 ADMH/ Intellectual Disabilities Waiver (ID)

Enrolled as the administering agency/provider for the Mentally Retarded.

The ADMH/ID has a contractual agreement with the Alabama Medicaid Agency. The ADMH/ID may subcontract with any qualified provider, who meets Medicaid's enrollment criteria.

- The ADMH/ID is the payee for all ID waiver services and at the approval of ADMHID performing providers are added to the DXC file.
- ADMH/ID will forward a provider file update request to DXC.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

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Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.6 Alabama Department of Mental Health (ADMH)

Type

53

Specialty

690 ADMH Living At Home Waiver (LHW)

Enrolled as the administering agency/provider for the Living at Home Waiver (LHW).

- The ADMH has a contractual agreement with the Alabama Medicaid Agency. The ADMH may subcontract with any qualified provider, who meets Medicaid's enrollment criteria.
- ADMH is the payee for all LHW waiver services and at the approval of ADMH performing providers are added to the DXC file.
- ADMH will forward a provider file update request to DXC.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

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Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.7 Technology Assisted Waiver for Adults (TA Waiver)

Type

53

Specialty

590 TA Waiver

The Technology Assisted (TA) Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning 21, and for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria. The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. Private Duty Nursing providers will service TA recipients. The Alabama Department of Rehabilitation Services will provide Targeted Case Management to TA recipients.

The TA Waiver providers have a provider enrollment contract with the Alabama Medicaid Agency.

The TA Waiver provider is the payee for all TA Waiver services.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or a written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

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Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

NOTE:

Private Duty Nursing providers can also enroll to provide services under the Technology Assisted Waiver for Adults (TA Waiver) Program. DXC must have approval from the Medicaid Agency to enroll a Private Duty Provider for the TA Waiver. Providers wishing to add the TA Waiver to their enrollment should submit a letter to DXC requesting to add this specialty. Once received, DXC should forward those letters to the Enrollment & Sanctions Unit for coordination and approval from the program manager of the TA Waiver program.

The effective date of enrollment is the first day of the month in which the written request for enrollment is received.

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4.2.8 Alabama Department of Senior Services (ADSS)

(Enrolled as an administering agency/provider for the HIV/AIDS Waiver)

Type

53

Specialty

620 HIV/AIDS

- ADSS has a contractual agreement with the Alabama Medicaid Agency to provide HIV/AIDS Waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria. ADSS is the payee for HIV/AIDS Waiver services.
- ADSS is the payee for the ADSS HIV/AIDS Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.9 Alabama Department of Mental Health/Mental Retardation, Department of Public Health, Department of Youth Services, and Department of Human Resources

(Enrolled as providers for Rehab Option Services)

Type

11

Specialty

118 DHR – Submit provider file update to enroll individuals

DPH – Does not enroll individuals

DYS Rehab Services – Submit provider file update to enroll individuals

111 Mental Health Clinic (DMH) Rehab Services (Has their own enrollment application)

339 Psychiatry – Automatically add the 931 specialty to the provider's file.

860 Substance Abuse

931 Telemedicine Services (Applicable for specialty 339 only).

Each agency has a contractual agreement with the Alabama Medicaid Agency to provide Rehab Option services. The State Agency may subcontract with any qualified provider who meets Medicaid's enrollment criteria. The State Agency is a payee for Rehab Option services.

The State Agency should submit to DXC a completed Provider File Update Request for the providers with which they have subcontracted.

For providers enrolling in Substance Abuse (SA) Treatment Services, the Application Update Form will be submitted along with other forms if applicable which may include: Disclosure Forms, Provider Agreement, Corporate Board of Directors Resolution, and an application fee.

For providers enrolling in Mental Illness (MI) Treatment Services, the online Provider Enrollment portal will be used to submit applications.

- The Provider Enrollment Web Portal will be used to enroll the individual providers with the ADMH for MI Treatment Services (Enrollment Type – Individual Within Group).
- Provider type will be "Mental Health Provider" and specialties added will be Psychiatrist and Telemedicine Services.
- The Group Association section of the online application should include the Department of Mental Health name, NPI, and Medicaid ID.
- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Only physicians can enroll with the Department of Mental Health. The Department of Mental Health must provide the physician's Social Security Number and physician's medical license number. A copy of the physician's medical degree should be attached along with a copy of the current license. The SSN can be written on the application or a copy attached.

DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

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Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.10 The Alabama Department of Mental Health(DMH) Mental Illness and Substance Abuse Programs, Alabama Department of Youth Services, Alabama Department of Human Resources, Alabama Department of Public Health, Alabama Institute for Deaf and Blind-Field Services, and the Alabama Department of Rehabilitation Services are enrolled as Targeted Case Management (TCM) providers.

Type

21 (Targeted Case Management)
Note: Targeted Case Management is allowed for provider type 11-Mental Health with a current specialty of 860-Substance Abuse. TCM services for these providers are denoted by adding the specialty 113-Substance Use Disorder Care Coordination.

Specialty

113 Substance Use Disorder Care Coordination (ONLY to be used with Provider Type 11— Mental Health with Specialty--860 Substance Abuse)

209 Mentally Ill Adults

210 Care Coordinator for Pregnant Women

211 AIDS/HIV Positive Individuals

217 Foster Child

229 Intellectually Disabled Adults

590 Technology Assisted (TA) Waiver for Eligible Adults

640 Adult Protective Services

650 Disabled Children

Each Agency/organization has a contractual agreement with the Medicaid Agency to provide targeted case management. The state Agency may subcontract with any qualified provider who meets Medicaid enrollment criteria. The state Agency/organization should submit the request for enrollment for TCM services to Medicaid for the providers with which they have subcontracted. Medicaid will forward a provider file Maintenance Form to DXC.

- If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
- If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

NOTE:

DXC should not process any new TCM providers unless the Maintenance Form is forwarded under OPR.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

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Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

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4.2.11 The Alabama Department of Public Health (DPH)

(Enrolled as an administering agency/provider for county health department services.)

Type

13

Specialty

021	Cardiac Electrophysiology	023	Sports Medicine
274	Dental Prevention		
318	General Practitioner	94	CRNA
319	General Surgeon	770	Endocrinology
310	Allergist	560	EPDST
313	Cardiovascular Surgeon	600	QMB/EPSDT
314	Dermatologist	83	Family Planning
92	Family Nurse Practitioner	700	Plan First
316	Family Practitioner	550	DPH Lab
317	Gastroenterologist	116	Licensed Social Worker
800	Internal Medicine	323	Neonatologist
326	Neurologist	93	Nurse Practitioner (Other)
325	Neurological Surgeon	100	Physician Assistant
328	Obstetrician/Gynecologist	101	Anesthesiology Assistant
330	Opthalmologist	830	Rheumatology
331	Orthopedic Surgeon	312	Cardiologist
321	Hand Surgeon	750	Colon and Rectal Surgery
333	Pathologist	313	Cardiovascular Surgeon
337	Plastic Surgeon	272	Oral Surgeon
339	Psychiatrist	170	Physical Therapist
338	Proctologist	173	Speech/Hearing Therapist
340	Pulmonary Disease Specialist	171	Occupational Therapist
341	Radiologist	271	General Dentistry Practitioner
90	Pediatric Nurse Practitioner	940	Vaccinations
345	General Pediatrician	190	Optician
320	Geriatric Practitioner	180	Optometrist
324	Nephrologist	810	Orthopedic
630	Nephrology	332	Otologist, Laryngologist, Rhinologist
140	Podiatrist	760	EENT
790	Infectious Disease	329	Oncologist
112	Psychologist		

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200 Audiologist

The DPH has a contractual agreement with the Alabama Medicaid Agency to provide county health department services (i.e., EPSDT, family planning, prenatal, preventive health, lead screenings, adult immunizations, home health, hospice, and primary care).

Medicaid will forward copies of the approved contractual agreement to DPH along with instructions for completion of the enrollment process.

The DPH will forward a copy of their contractual agreement with the Medicaid Agency to DXC along with a letter requesting to be enrolled as a Medicaid provider.

DXC will send the Provider Enrollment packet to the DPH for completion of the enrollment process.

The DPH should submit to DXC a completed Provider File Update Request for the providers that they have subcontracted with. DXC will notify Medicaid within 2 days of the enrollment of new Medicaid providers.

In order to add the 274 specialty, the provider should submit a written request along with their certificate of completion. DXC enrollment staff will verify providers completion of the 1st Look training by checking the list provided by ALAAP. Note: This specialty should not be a primary specialty.

If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

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Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

To Add County Health Department Physicians to the Provider Table

Listed below are the procedures to add a County Health Department physician, to the Alabama Medicaid Provider Table.

A claim is submitted for services rendered by a County Health Department physician who is not on the provider file, the claim fails for Error Status 201 (NPI is invalid, not on file or name/number disagree).

Using the provider master list, furnished by the Department of Public Health, verify that the provider is a valid Health Department physician.

If the physician's name is not on the Health Department's master list nor has a new provider transmittal form been received, delete the claim.

If the physician's name is on the master list, add him/her to the Provider Table.

ECS indicator is always 'y.'

Effective date of enrollment is the first day of the "Assigned" month or issue date of license, whichever is later. End date of enrollment is the expiration date of license with a 45-day grace period.

If a provider with a specialty code of 560, 083 or 181 is added to the provider table, give a screen print to Medical Policy department to add the provider to the Customary Charge Panel.

Let the worksheet recycle.

Name Change

Use the Name Change form or written, signed request.

All Other Changes

All other changes must be submitted in writing and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.12 Alabama Department of Rehabilitation Services (ADRS)

Enrolled as the administering agency/provider for the State of Alabama Independent Living (SAIL) Waiver.

Type

53

Specialty

660 SAIL Waiver

- The ADRS has a contractual agreement with the Alabama Medicaid Agency. The ADRS may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

The ADRS is the payee for all SAIL waiver services and no other provider information is added to the file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.13 Alabama Department of Senior Services

Enrolled as an administering agency/provider for the Alabama Community Transition Waiver.

Type

51

Specialty

661 ADSS ACT Waiver – Effective 4/1/2015

The ADSS has a contractual agreement with the Alabama Medicaid Agency to provide Alabama Community Transition waiver services. ADSS may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

- ADSS is the payee for the Alabama Community Transition Waiver Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form or written, signed request and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 and the name change update.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

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Enrollment is not applicable to this provider type.

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4.2.14 Rehab - Early Intervention

Type

63

Specialty

960 Rehab-Early Intervention

The Alabama Department of Rehabilitation Services has a contractual agreement with the Alabama Medicaid Agency to provide Early Intervention Rehab services (i.e., speech, physical, occupational therapy, vision, and audiology).

The Alabama Department of Rehabilitation Services may subcontract with any qualified provider who meets Medicaid's enrollment criteria.

Alabama Department of Rehabilitation Services is the payee for Early Interventions Services and no other provider information is added to the DXC file for subcontracting providers.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Use the Name Change form and attach a current W-9 form.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement Form and attach a new W-9.

All Other Changes

All other changes must be submitted in writing to Medicaid and must be signed.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.2.15 Residential Treatment Facilities

Type

01

Specialty

013 Residential Treatment Facilities

Policy:

Residential psychiatric services for recipients under age 21 are covered services when provided by a psychiatric facility which is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State. All residential treatment facilities (RTFs) requesting enrollment must be under contract with one of the state agencies (DHR, DMH, DYS) who place children in residential settings. The state agency contracting with a certified RTF shall be responsible for collecting all the documentation required for enrollment and forwarding the packet to Medicaid for approval.

Enrollment Procedure:

1. The state agency requesting enrollment for a certified RTF shall forward the enrollment packet to the Associate Director of Institutional Services. This packet shall contain the following documents:

   Evidence of RTF accreditation from The Joint Commission, CARF, COA, or another accrediting organization with comparable standards that is recognized by the State;

   a. Evidence of compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;
   b. A contract or placement agreement between the RTF and the respective state agency to provide RTF services in the State of Alabama;
   c. A provider application from the RTF to participate in the Medicaid program;
   d. A written description of an acceptable Utilization Review plan currently in effect in the RTF;
   e. A written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion in the RTF;
   f. Evidence of compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21;
   g. A budget of costs for the RTF's initial cost reporting period; and
   h. A completed Provider File Maintenance Update Form.

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2. A program file will be established for each RTF enrolled with Medicaid. Copies of all relevant documentation will be maintained in the Institutional Services program area.
3. The Associate Director will review the packet contents to determine if all the required documents have been submitted and meet the requirements as noted in the Conditions of Participation in Chapter 41 of the Administrative Code.
4. The budget of costs will be forwarded to Provider Audit for review in order to establish an interim rate for the RTF. The auditor will return the rate information to the Associate Director so that the rate can be loaded to the Provider NH/IP Rates panel when the enrollment information is sent to DXC.
5. The Associate Director of Institutional Services will forward the Provider File Maintenance Update Form and the established rate to DXC Provider Enrollment through the Agency tracking system.
6. DXC will return the Provider File Maintenance Form to the Associate Director of Institutional Services upon completion of the enrollment process, including loading the established rate to the Provider NH/IP Rates Panel. The Associate Director will forward a copy of the form to the state agency that initiated the enrollment. The enrollment effective date will normally be the date of the contract from the state agency.
7. DXC will direct all inquiries regarding RTF enrollment to the Associate Director of Institutional Services.
8. If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.
9. If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

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The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Name Change

Provider notifies contracting state agency. The contracting state agency will notify DXC. Use the Name Change form or written, signed request and attach a current W-9.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to the contracting state agency.

Out-of-State Non-Bordering Providers

Enrollment is not applicable for this provider type.

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4.2.16 PACE – Program of All-Inclusive Care for the Elderly

Type

64 (PACE Organization)

Specialty

645 (PACE)

Policy:

The Alabama Medicaid Agency is the administering agency for the PACE program.

Enrollment Procedure:

PACE Organizations must be approved by CMS and AMA to participate as a PACE Organization.

The PACE Organization will receive a monthly global fee for each participant enrolled in the PACE program. The PACE Organization will receive the monthly global fee minus the patient liability when a participant enters a nursing home. All claims for any other provider for a PACE participant will be denied.

If Medicare enrolled, submit General Data section of Civil Rights Compliance Information Request Package & DHHS-Office of Civil Rights letter of compliance.

If Medicaid only, submit completed Civil Rights Compliance Information Request Package.

Additional Screening

Fingerprint Based Criminal Background Check (FCBC)

A provider or any person with 5% or more direct or indirect ownership in the provider, must submit to an FCBC if:

Provider's screening categorical risk level is set to HIGH

Provider's screening categorical risk level has been adjusted to HIGH because:

- A payment suspension has been imposed
- Provider has been excluded within the previous 10 years
- Provider has an existing Medicaid overpayment
- Provider was denied enrollment due to a moratorium and is now applying

The Enrollment representative should determine if a provider's risk level is HIGH based on their provider type on their application or has been adjusted to HIGH by checking the Screening Info Panel in interChange. PECOS should be checked first to find fingerprint information on the provider. If no information is found in PECOS, the initial application or reenrollment facsimile should be sent to the Enrollment & Sanctions Unit to request the provider submit for the FCBC.

Change of Ownership

Providers must submit the Change of Ownership (CHOW) form, new provider agreement, new disclosures, new W-9, and new EFT form.

Note: CMS and AMA must be notified within 14 days prior to the effective date of the change of ownership.

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Name Change

Use the Name Change form, or a written, signed request and attach a current W-9 form.

Note: CMS and AMA must be notified within 14 days prior to the effective date of the change of name.

Payee Name Change/Bank Account Number Change

Use the Electronic Funds Transfer Authorization Agreement form and attach a new W-9 form.

All Other Changes

All other changes must be submitted in writing to CMS and AMA. All other requests must be signed by appropriate PACE Organization officials.

Out-of-State Non-Bordering Providers

Enrollment is not applicable to this provider type.

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4.3 PATIENT 1ST ENROLLMENT PROCEDURES FOR PHYSICIANS, GROUPS AND CLINICS

A Medicaid enrolled individual physician or physician group practice may become a Patient 1st Primary Medical Provider (PMP) if the physician or group routinely practices in the field of general practice, family practice, internal medicine, or pediatrics. Federally recognized clinics such as FQHCs or RHCs may also enroll in the program as a PMP. The effective date of enrollment for a PMP (clinic/group/individual) should be the first of the month in which the application is processed for enrollment by DXC staff.

Variations to the above must be coordinated with the Agency.

Enrollment

General Instructions

1. Patient 1st Applications, Agreements and any completed Agreement Attachments must be completed in black ink only and must contain original signatures and original initials where applicable. Patient 1st Applications, Agreements and any completed Agreement Attachments cannot be faxed. In addition, check the Patient 1st enrollment forms to ensure the following information is contained:

2. **SECTION I**

   a. Indication should be made of whether the applicant is enrolling as a (n) Individual, Group, Clinic, FQHC or RHC.

   b. Indication of Yes or No should be made of whether the practice or associated persons participating as a PMP has been sanctioned or terminated by either the Medicaid or Medicaid Program. If “Yes” is indicated, ensure that supporting documentation is supplied with the application. A packet containing such information must be forwarded to Program Integrity for review prior to completing the enrollment process.

   c. Indication of the specialty for the participant should be made by marking a specialty listed. The space marked as “Other:” is to allow the specialty of particular specialists to indicate his/her type and specialty. The enrollment of a provider with a specialty other than those listed requires Agency approval.

   d. Indication of Yes or No should be made of whether the provider is a/is associated with a teaching facility at the site to which this enrollment applies.

   e. Indication of the name of the enrolling provider (individual, group, clinic, etc.) should be made in this section. The name listed should be consistent with the manner in which the provider is enrolling (individual, group, clinic, etc.).

   f. Indication of the provider NPI number assigned to the enrolling provider should be made in this section. The provider NPI number indicated should be applicable to that assigned to the provider name indicated and should be the NPI number applicable to the practice site indicated.

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g. Indication of the group/clinic/FQHC/RHC name should be made in this section. The name listed should be consistent with the manner in which the provider is enrolling (group, clinic, FQHC or RHC name).

h. Indication of the provider NPI number assigned to the enrolling group/clinic/FQHC/RHC should be made in this section. The provider NPI number indicated should be applicable to that assigned to the provider name indicated and should be the NPI number applicable to the practice site indicated.

i. Indication of the person to be contacted regarding Patient 1st should be made in this section.

j. Indication of the phone number where the Patient 1st contact can be reached should be made in this section.

k. Indication of the physical address of the service site should be made in this area.

l. Indication of the mailing address at which the PMP would like to receive Patient 1st mailings should be made here. This address should be provider's mailing address. This address should be applied to the Provider Locations Name Address Panel for the enrolling provider.

NOTE:

If the application is for a clinic or group, the mailing address must be updated on the file of clinic or group as well as the individuals associated to the clinic or group. If the application is for an individual, who is associated to a clinic or group, the mailing address must be updated on the clinic or group file, the individual's file and all other providers associated to the clinic or group.

SECTION II

a. Indication of the county name for which the PMP is enrolling should be indicated in the first column of the table.

b. Indication of the number of patients the PMP would like to have assigned from each county should be indicated in the second column of the table.

NOTE:

Max caseload calculations are based on the PMP serving as a FTE, meaning the PMP practices at the location for a minimum of 32 hours per week.

MAX CASELOAD: The maximum caseload a PMP can serve collectively is 1200 patients unless utilizing physician extenders. PMPs utilizing physician extenders may have an additional 400 patients per physician extender utilized. The overall max caseload for a PMP is 2000. Enrollments of PMPs requesting a caseload of more than the maximum allowed should be coordinated with the Agency.

MINIMUM CASELOAD: The minimum caseload a PMP can serve collectively is 25 patients. Enrollments of PMPs requesting a caseload of less than 25 patients should be coordinated with the Agency.

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c. Indication of the Patient Age Criteria for the patient assigned from each county should be indicated in third column of the table. Assume no specific age. Leave 000-999. If a provider states that they only want newborns, then indicate 000-000. This criterion is determined by "through" logic.

d. Indication of YES or NO regarding the PMP's wish to be published in the Patient 1st List should be indicated in the fourth column of the table for each county in which the PMP is enrolling.

e. If the physician employs a mid-level practitioner(s)/physician extender(s), the name(s) and NPI number(s) for up to two (2) should be listed in this section. The provider NPI number(s) indicated should be associated to the site of practice to which the patients will be assigned.

NOTE:

For each mid-level practitioner (up to two), an additional 400 patients may be added for the specific location. For private providers, a maximum of 2,000 is allowed. (Refer to maximum caseload standards above for additional instructions.)

f. Indication of YES or NO should be made as to whether the enrolling physician/clinic has admitting privileges. If YES is indicated, the name of the hospital at which the PMP has privileges should be given. If NO is indicated Attachment A (Patient 1st Hospital Admitting Agreement) of the contract must be completed.

g. Indication of YES or NO should be made as to whether the PMP will be performing his/her EPSDT screenings. If YES is indicated, verify that the PMP is enrolled in the EPSDT program for the location the patients will be assigned. Also verify that the provider has a CLIA number on file. If NO is indicated, verify that provider is not enrolled in the EPSDT program. If not performing EPSDT screenings Attachment B (EPSDT Agreement) of the contract must be completed. Indicate a specialty type 820 if the PMP is not and does not wish to enroll as an EPSDT screening provider.

h. Indication of 24-Hour Access phone number and the description of the after-hours coverage should be made in this section. The number is not required to be different from office phone. A description of the after-hours coverage is required.

i. Indication of the number of hours per week the PMP practices at the location to which this application applies should be made in this section. The PMP practice must be open a minimum of 32 hours per week and the PMP must practice at the location a minimum of 32 hours per week to be considered a FTE (Full Time Equivalent). If less than a FTE, a percentage of a total patient caseload will be allowed, based on availability.

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SECTION III

a. Indication of all physicians/practitioners and provider NPI numbers associated to this clinic site should be made in this section.

b. Indication of the provider NPI numbers assigned to the individual providers should be made in this section. The numbers indicated should be the number assigned for that provider which is associated to the enrolling clinic/group.

c. Indication of the hours per week which the physician or practitioner will be working at the site should be made in this section. (This information will be used to determine FTE status.)

d. Indication of whether the provider listed is a physician or a practitioner should be made in this section.

For Clinics Only: To determine panel size:

- For every FTE physician minimum (32 hours a week), 1,200 patients will be allowed. If the physician is not a FTE, then a percentage of patients will be allowed based on on-site availability. For example, if the physician is a .5FTE, then a caseload of 600 will be allowed.
- If there is midlevel practitioner participation, then an additional 400 patients per midlevel (up to 800 total) will be allowed. The same FTE criteria will apply to midlevel practitioner participation.
- Physicians and/or midlevel practitioners must be a minimum of .2FTE to carry or extend a caseload.
- If the clinic is an IRHC run by a nurse practitioner, then the clinic can have a maximum caseload of 1,200.
- Only the clinic number is to be enrolled – not the individual providers.
- The Provider Contract Panel should be checked to ensure that the individual doctors are not enrolled as PMPs. If a doctor in the group is enrolled as an active individual PMP, the clinic should be contacted to determine further action.
- The individual specialty of the individual physicians should be checked to correspond to the age requirement specified by the clinic.

For Groups: Group providers can be enrolled with the permission of the Agency. To determine panel size:

- For every FTE physician minimum (32 hours a week), 1,200 patients will be allowed. If the physician is not a FTE, then a percentage of patients will be allowed based on on-site availability. For example, if the physician is a .5 FTE, then a caseload of 600 will be allowed.
- If there is midlevel practitioner participation, then an additional 200 patients per midlevel (up to 400 total) will be allowed. The same FTE criteria will apply to midlevel practitioner participation.
- Physicians and/or midlevel practitioners must be a minimum of .2 FTE to carry or extend a caseload.
- Only the group number is to be enrolled – not the individual providers.
- The Provider Contract Panel should be checked to ensure that the individual doctors are not enrolled as PMPs. If a doctor in the group is as an active individual PMP, the group should be contacted to determine further action.
- The individual specialty of the individual physicians should be checked to correspond to the age requirement specified by the group.

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AGREEMENT INSTRUCTIONS

Page 1

- Indication of the name of clinic/group/individual provider enrolling should be made in this space. (This name should be consistent with that indicated on the Patient 1st application.)
- Indication of the name of the city in which the provider's practice is located should be made in this space. (The name of the city should be consistent with the name of the city indicated as part of the physical location on the Patient 1st application.)
- Indication of the county in which the provider's practice is located should be made in this space.
- Indication of the state in which the provider's practice is located should be made in this space. (The name of the state should be consistent with the name of the state indicated as part of the physical location on the Patient 1st application.)

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- Enrollment staff should indicate the effective date. This date should be consistent. The name of the Enrollment staff member who processed the application/agreement should be indicated. At a minimum, the person's first initial and last name should be indicated.
- The signature of the enrolling PMP should be indicated in this space. This signature must be an original and must be consistent with the signature provided on the Patient 1st application. If enrolling as a clinic or group, the signature must be an original signature of an authorized representative and must be consistent with the signature provided on the Patient 1st application.
- The provider's NPI should be indicated. The number indicated in this space must be consistent with the provider's NPI number indicated on the Patient 1st application.

Patient 1st Hospital Admitting Agreement (Attachment A)

- This form should be completed, only if the clinic/group/individual provider has indicated the absence of hospital admitting privileges. (To determine if there is an absence of hospital admitting privileges refer to the statements regarding hospital admitting privileges in Section II (continued) of the application and the fifth bullet of Attachment C of the Agreement.) If the clinic/group/individual provider does not have admitting privileges this form must be completed in its entirety. The information indicated on this form should pertain to the physician or group agreeing to cover hospital admissions for the enrolling PMP. The provider name and NPI must be verified.

NOTE:

Original signatures required. If an individual is covering hospital admission, the signature must be that of the individual. If a clinic/group is covering hospital admission, the signature must be that of an authorized representative for that clinic/group.

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EPSDT Agreement (Attachment B)

- This form should be completed, only if the clinic/group/individual provider chooses to utilize an EPSDT Screening Designee. (To determine if the PMP is choosing to utilize an EPSDT Screening Designee refer to the statements regarding EPSDT in Section II (continued) of the application and the first bullet of Attachment C of the Agreement.) If the clinic/group/individual provider chooses not to perform EPSDT screenings and intends to utilize an EPSDT Screening Designee, this form must be completed in its entirety. (This form is **not** an EPSDT Agreement to be used to enroll a provider in the EPSDT Program.)

NOTE:

Original signatures required. If the applicant is enrolling as an individual, the PMP signature must be that of the individual. If enrolling as a clinic/group the signature must be that of an authorized representative for that clinic/group. Signatures indicated on Agreement Attachments must be consistent with that indicated on the Application and the Agreement.

If the Screener/Designee is an individual screener the signature must be that of the individual. If the Screener/Designee is a clinic, such as a health department, the signature must be that of an authorized representative for that clinic.

Components of Monthly Fee (Attachment C)

- This form should be completed to show the components in which clinic/group/individual provider intends to participate. Indication of initials shows the component is one in which the clinic/group/individual provider intends to participate. This form will be utilized to determine the Monthly Case Management Fees.

NOTE:

Original initials are required. If enrolling as an individual, the initials must be that of the individual. If enrolling as a clinic/group the initials must be that of an authorized representative for that clinic/group. Initials indicated on this Agreement Attachment must be consistent with the initials for the signatures indicated on the Application and the Agreement.

- EPSDT – If initials are indicated, the enrolling clinic/group/individual provider file must contain an active 560 specialty or must enroll as an EPSDT screener. Otherwise, this component must be corrected.
- VFC – If initials are indicated, the enrolling clinic/group/individual provider file must be a VFC provider or must enroll as a VFC participant. Otherwise, this component must be corrected.
- 24/7 Coverage – If initials are indicated, the enrolling clinic/group/individual provider file must indicate on the Application, a phone number as description of afterhours coverage.

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Medical Home Project – Agency staff will notify EE of the approval of a provider's participation in this component.

- Hospital Admitting Privileges - If initials are indicated, the enrolling clinic/group/individual provider file must indicate on the Application, the hospital privileges information or must submit a completed Attachment A. Otherwise this component must be corrected.
- Electronic Notices - If initials are indicated, the enrolling clinic/group/individual provider file must choose to receive electronic notices. Otherwise, this component must be corrected.
- Electronic Education Materials - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.
- Life State Management - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.
- InfoSolutions - If initials are indicated, the enrolling clinic/group/individual provider's PMP Special Condition Panel should be updated.

Notification

A letter or copy of the PMP's disenrollment request containing the DXC action stamp indicating what action was taken should be returned to the disenrolling PMP.

Changes To The Provider Information Panel For Patient 1st PMPs

Disenrollment of Patient 1st Providers

3. Requests for disenrollment should be sent 30 days prior to the date of disenrollment and must be mailed or faxed correspondence. The request must specify the date in mm/dd/yy format. If the date is not indicated, the PMP should be contacted and written documentation containing the date should be obtained. In addition, specific instructions must be given in the written request in regards to the auto-assignment or reassignment of patients. If specific instructions are not given, the PMP should be contacted and written documentation containing the specific instructions should be obtained.

File Action

- For future disenrollments, the provider file should be end-dated to reflect the last day of the month in which the PMP is requesting disenrollment. If the PMP is requesting a middle of the month date, then the end date should reflect the last day of the preceding month.
- In cases where the PMP has already left, the disenrollment should be reflective of the last day of the month proceeding the month in which the PMP left or quit practicing.
    - If a PMP has indicated that he/she is closing the practice, the appropriate action should be taken to end date the appropriate Provider Panels as well as the Provider Information Panel and Provider Special Condition Panel. If a specific date and auto assignment/reassignment instructions are not given the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.
    - When a PMP leaves a group, the appropriate action should be taken to end date the appropriate Provider Information Panel as well as the PMP

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Special Condition Panel. If a specific date and auto assignment/reassignment instructions are not given or it is uncertain whether the PMP is leaving the group, the group should be contacted and documentation containing the specific date, status of the PMP and auto assignment/ reassignment instructions should be submitted via fax or mail. In the case of a PMP leaving a group, the group may decide to have the patient reassigned to another PMP within the group.

- If a provider has sent notification of disenrolling from the Patient 1st Program the PMP Special Condition Panel should be closed. In addition to updating the PMP Special Condition Panel, the PMP specialty indicator of 820 (if present on file) and should have an end date entered. If a specific date and auto assignment/reassignment instructions are not given the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.
- If a provider has sent notification to disenroll from a specific county or counties for which the provider was participating in for Patient 1st, only those county segments on the PMP Special Condition Panel should have an end date entered. No changes should be made to the provider file. If no date or auto assignment/reassignment instructions were given, the PMP should be contacted and documentation containing the specific date and auto assignment/reassignment instructions should be submitted via fax or mail.

Patient Reassignment

- The termination date applied during the run of the report should be reflective of the end date applied to the PMP's file. (As applied to the PMP Special Condition Panel and the Provider Information Panel, if the date is within the middle of the month, then the date should be reflective of the last day of the month preceding the month in which the PMP left or quit practicing.)
- If the PMP is leaving a group practice, then the patients should be reassigned to a member of the group. If the letter does not specify what group member, the PMP, group or clinic should be contacted to determine to whom the patients should be assigned. Written documentation should be submitted stating the specific action and designee.
- For all reassignments, please verify that the new PMP has an adequate panel size **and** is enrolled for all counties for which the current PMP has patients assigned. If the new PMP does not have an adequate panel size and/or is enrolled for all counties, the new PMP should be contacted to see if he/she would like to increase the panel size and/or enroll for that county. **If the answer is yes, written documentation, containing specific instructions, is required as permission to make needed changes. This documentation may be submitted via fax or mail. If the answer is no, then all patients must be put back through auto assignment, again based on written documentation containing specific instructions is required.** If the reassignment will exceed caseload standards, then the Agency should be contacted for further instructions.

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File Changes

- Provider Service Location Change: If a PMP has requested a new service location, a new Patient 1st application and agreement is required for the provider to participate as a PMP under the location. If the PMP intends to close the old service location, the patients should be transferred from the service location to the new service location. To make such a change, written documentation is required and may be submitted via fax or mail. If a specific date and transfer instructions are not given, the PMP should be contacted to obtain a written request containing the specifics. If the PMP is leaving a group, the group may decide the reassignment of patients.
- Request to decrease/increase caseload of a PMP must be submitted in writing via fax or mail. The request must specify the counties and the specific decrease/increase to occur. If the PMP indicates no new patients should be assigned, the provider's Patient 1st-Region Enrollment Maintenance record is updated to Panel Hold=Yes. If the PMP wants to limit new assignments to "Last PMP", Newborns or Sibling assignments as Max Caseload Cap of 1 should be placed on the segment for the specified county or counties.
- Provider Status 'C" (Provider Cancelled per Request) - Check the screen to see if the provider is an active PMP. If the request does not specify, the DXC Provider Enrollment Unit should contact the PMP to determine what should be done with the patients. (Steps related to file closure that are outlined above should be followed at that point.)
- Provider Status 'P' (Deceased Provider) – Follow processes as outlined for a Provider Cancelled per Request closure
- Provider Status "B' (Bad Address) - Check the Provider Information Panel to determine if the provider is an active PMP. If yes, DXC's Provider Enrollment Unit should contact the PMP to request that the provider submit their change of address information**. The file should be pended for one month**. If after 30 days, the PMP has not complied with the request, patients should be put through the auto assignment process. The PMP should be notified of the action taken.
- Provider Status 'D' (Contract Expired) - Follow processes as outlined for a Provider Cancelled per Request closure.
- Provider Status 'S' (Fraud and Abuse Providers) - Check the Provider Information Panel to determine whether the provider is an active PMP. If yes, patients should be put back through auto assignment. The end date applied to the provider file should reflect the end of the month proceeding the month in which the provider was sanctioned. Case management payments should be recouped from the month in which the PMP's sanction became effective.

If a situation arises that cannot be resolved by the above, instructions should be coordinated with the State. The inherent need in any disenrollment is to ensure that patients are not left assigned to a physician that may no longer be practicing. If it is questionable, contact the State for instructions.

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4.4 PROVIDER REENROLLMENT PROCEDURES

CMS Federal Requirement 455.414 requires that all providers reenroll at least every five years. In order to meet these federal requirements, the following procedures for reenrollment will be accomplished.

Providers who are required to reenroll will be sent a notification letter instructing them to access the secure provider portal and download the Provider Reenrollment Facsimile (PRV-A-035-M). Providers will review the Provider Enrollment Facsimile and make any corrections on the document and sign. Any additional documentation required to include the Provider Agreement and Disclosure forms are mailed with the facsimile to Provider Reenrollment for processing. The following actions will occur by the reenrollment staff to process the reenrollment applications:

The file clerk will:

- Enter the received date in the “Date Response Received” field on the Enrollment Info Panel.
- Log the application on the Reenrollment Log with the NPI and Provider name entered on the application and date received.
- Scan the application into the Feith database. Feith will auto assign the applications to the clerks based on the number of clerks available.
- Forward the original applications to the assigned clerks.

The assigned rep will:

- Run database checks in Accurint (LexisNexis). A PDF copy of the search results should be saved and appended to the scanned copy of the Reenrollment application.
- Verify the provider’s licensure information with the appropriate licensure board if the Accurint database check did not validate the provider’s license. The states’ licensure boards information is located on the provider rep drive in the Reenrollment folder. A PDF copy of the verification should be appended to the scanned provider file.
- Verify the NPI with the NPPES registry if the Accurint database check did not validate the provider’s NPI. A PDF copy of the verification should be appended to the scanned provider file.
- Verify the Medicare number in PECOS and enter on the provider file.
- If CLIA information is added or changed, verify that the CLIA information entered on the application matches the copy of the CLIA certificate submitted by the provider.
- If DEA information is added or changed, verify that the DEA information entered on the application matches the copy of the DEA certificate submitted by the provider.
- Enter any new specialties indicated on the application. If the provider is adding EPSDT or Plan 1st as a specialty the appropriate agreement must be submitted. Provider must have a CLIA on file if adding the EPSDT specialty.
- Verify that all disclosure questions on the applicable disclosure form were answered. If any question was answered “yes” the application should be forwarded to Program Integrity for review. The Feith workflow should be updated to a status of Agency review.

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- Verify that contact information was entered. A contact name and phone number is required. The contact can be the same as the provider.
- Verify that the provider submitted a signed and dated provider agreement. The application must be signed by the provider, not a designee. Contact the provider by telephone if the signature is not the provider's signature or if the agreement was not sent. If unable to contact the provider by telephone send the "Corrections Needed" letter to the provider. Enter a note in Feith with the corrections needed. A copy of the corrections letter should be added to the scanned copy of the application in Feith. Sample letter is on Provider Rep drive in Reenrollment folder.
- Contact the provider if any of the above information (other than signature) is not submitted or submitted incorrectly. Advise the provider to fax any faxable documentation. A note should be entered into Feith indicating the date the provider was notified of needed corrections and the requested corrections. Review the submitted faxes to determine requested corrections were made. The fax should be maintained with the provider file. A copy of the fax should be given to file clerk to scan and add to the scanned application.
- Contact provider if requested corrections are not received within the required time frame. Verify that a site visit has been performed by Medicare within the last 12 months or by the Provider Reps for moderate and high risk provider types. If the site visit was performed by the Provider Representatives a copy of the site visit checklist and photographs should be appended to the scanned reenrollment application. If the site visit was performed by Medicare append a copy of the PECOS screen shot to the scanned reenrollment application. NOTE: if no visit is documented, review the file but do NOT finalize the reenrollment.
- Finalize the reenrollment in interChange when the application has been reviewed and all required documentation or corrections, if any, have been received. Finalize the application by accessing the Enrollment Info panel and changing the "Last Enrollment Date" to the date the application was finalized. Finalize the application in Feith workflow with the date the application was finalized.

<u>Providers Disenrolled due to failure to submit Reenrollment</u>

If a provider has been closed due to failure to submit the reenrollment they will have a 30 day "grace period" to submit the reenrollment.

If the provider calls within 30 days of the disenrollment date, Reenrollment will reopen the provider contracts with an end date that is 30 days from the DISENROLLMENT date (not 30 days from the date they contacted reenrollment). The provider will have to submit the reenrollment documents within the 30 day grace period. If the provider fails to submit the reenrollment the file will be closed due to the end date on the provider contracts.

If the provider file is closed again, there will not be an additional grace period and the provider will have to submit a new enrollment through the Provider Enrollment Web Portal.

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4.5 DATABASE CHECKS

DXC staff will access the LexisNexis web portal to perform the following database checks prior to enrollment and re-enrollment:

- List of Excluded Individuals/Entities (LEIE)
- Excluded Parties List System (EPLS)
- Social Security Administration Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Licensure board databases
- Verification of Social Security Number or Employer Identification Number

These database checks will be performed for providers and any owners, agents, or managing employees that are listed on the enrollment application. Provider enrollment staff will review the LexisNexis results for these database checks. If no negative findings are detected, the enrollment process will proceed. If negative findings are detected, the enrollment/re-enrollment application will be routed via Feith Workflow to the Alabama Medicaid Program Integrity Unit for review. Program Integrity staff will access the report in Feith Workflow, review the materials, and document their decision in the Feith application which will instruct DXC-enrollment staff on how to proceed. DXC enrollment staff will be notified via Feith Workflow that a Program Integrity decision has been reached and will either enroll or deny the application based upon Program Integrity's instructions. A LexisNexis screen-print or report copy will be added to the provider record in the Feith Document Database.

In addition to the above database checks, DXC enrollment staff will also access the Provider Enrollment, Chain and Ownership System (PECOS) for provider types designated as moderate or high risk. This database will indicate whether Medicare has conducted an on-site visit within the past 12 months. If a visit was conducted by Medicare, the enrollment process will continue. If a visit was not conducted by Medicare within the last 12 months, the enrollment application will be staged and a notification will be sent to DXC staff to conduct an unannounced site visit.

The above described database checks are all performed manually. On a monthly basis, all providers, owners, agents, and managing employees will be checked against the EPLS and LEIE databases in an automated process.

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4.6 PROVIDER INFORMATION TO COLD

The Provider Information to COLD Enhancement will allow provider enrollment documents to be available in an electronic format via Feith Document Database (FDD), which is part of the Feith System utilized by the State and DXC. An upgrade to a new version of Feith is in place in order to accommodate the usage of the Workflow software and the more advanced capabilities offered in the new version. Eight DXC jukebox platters are used to store the existing Provider Enrollment documentation within FDD. The transition from paper to electronic storage of files has been completed and now the Agency has access to provider paper files that have been inactive during the past six years.

New Documents to FDD

New provider documents received on an ongoing basis are prepped, scanned, processed and stored in FDD by the staff of the Provider Enrollment unit. A high-speed scanner is in place in the unit's area for this purpose.

When prepping the newly received documents, all binding devices and staples are removed and the files are cleared of any unnecessary documents (See Exhibit 1, Item 1a). Copies of thin and colored paper are made when necessary, to enhance the legibility of the document (Exhibit 1, Item 1b). Documentation is stamped to show the receipt date and logged on the Mail Receipt spreadsheet. Pages within the documents that require an original signature are stamped as "original" so that staff working from an image knows the original signature requirement has been met. If the signatures are not original the page requiring an original signature is not stamped. Separator sheets are then placed between each set of documents within the batch and scanned along with the documents to indicate any break in the document type (Exhibit 1, Item 2). Indicating such breaks in the batch allows the scanner to recognize when a new image file should be created.

At this point, the document images enter a FDD Working bin (Exhibit 1, Item 3a) under the control of a work process control tool from Feith called Workflow iQ (Exhibit 1, Item 3b). Workflow is an application that provides control of the flow of work through the Provider Enrollment unit. It allows the documents to be distributed to enrollment staff at the discretion of the supervisor or an appointed staff member. While the documents are under the control of Workflow, the documents are checked for quality and processed with the appropriate action required such as the assignment of a service location for a new application or updating a physician's license on the AMMIS. Documents failing this inspection are rejected from Workflow and rescanned (Exhibit 1, Item 3c.). Documents, which are incomplete or otherwise not valid, are Returned To the Provider (RTP'ed). Images associated with such paper files are deleted from the Working cabinet. Searchable fields are completed during the Workflow processes such as the provider NPI number, first five characters of the provider's last name, date of processing, and document type. Once the document has completed the appropriate processing, it is released from Workflow and moved from the Working cabinet to the Provider Enrollment document cabinet with the archived files and then is available for retrieval in FDD (Exhibit 1, Item 4).

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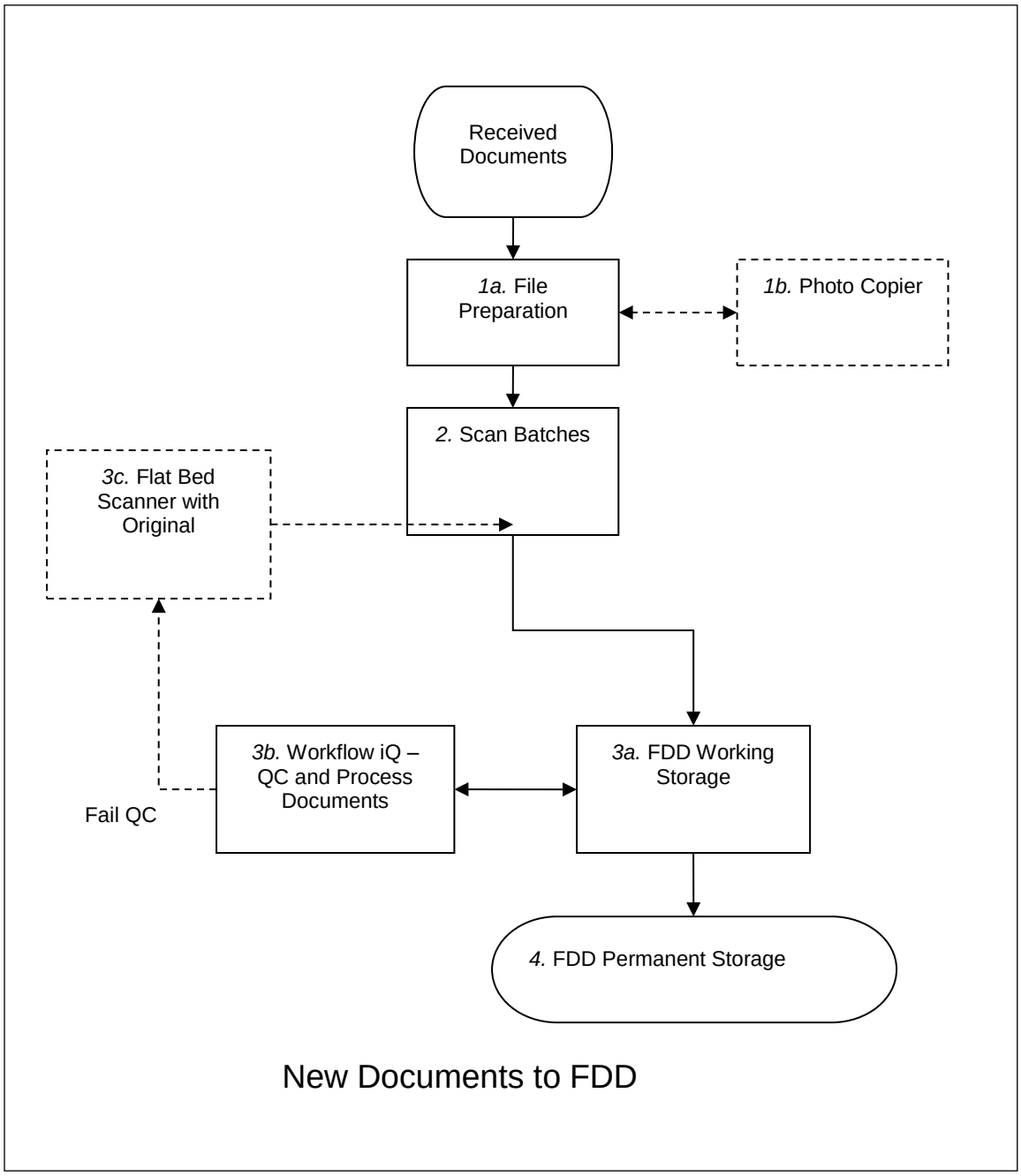

Exhibit 1

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Retrieval of All Documents Within FDD

The searchable fields available to use when retrieving a document in FDD are provider NPI number, first five letters of the organization or individual's last name, date, and document type.

NOTE:

The searchable fields available to use when retrieving documents scanned prior to implementation of NPI are provider number, partial provider last name, date and document type.

The primary field to use when performing a search is the provider NPI number, since this is the most specific data element associated with the images. By using the provider NPI number alone, all images associated with the provider NPI number will be retrieved. Using search criteria that is less specific will allow for a range of documents to be retrieved, whereas search results can be improved by adding more specific criteria in the searchable field areas associated with the Provider Enrollment cabinet. Below are some examples of the search criteria that can be used and the results that will be displayed:

1.) Enter the provider NPI number and the document type of "A". Select the search option. By entering such search criteria, only the applications associated with the indicated provider NPI number will be displayed.
2.) Enter the date and the document type of "U". Select the search option. By entering such search criteria, only the updates associated with the date entered will be displayed.
3.) If the provider NPI number is not known, the first five characters of the provider last name is a searchable field. However, by utilizing only this field, several documents may be returned due to the first five characters being a less specific search criterion.

Back Up of FDD

The FDD database is backed up nightly. A backup of the Sun production box is made every week during cycle. The data is then shipped offsite for Disaster Recovery Assistance (DRA). When the platter used to store the images in FDD becomes full, the platter is then backed up. The backup platter is then sent off site for DRA. It takes approximately 2.5 weeks to fill a backup platter.

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4.7 PROVIDER BULLETIN

The Technical Writers and the State are responsible for writing and producing bi-monthly provider bulletins. The following steps identify the process of producing the bulletin:

1. Prepare an initial copy by soliciting input from the Agency and DXC staff.
2. Submit articles to the Documentation Specialist for draft preparation.
3. After the draft has been prepared, proof the draft. Repeat steps 2 and 3 as necessary.
4. Complete an DXC Correspondence Tracking form. The form can be found in the Share2/Forms - DXC Alabama Title XIX Provider Services directory on the DXC LAN.
5. Submit the form and the draft to the appropriate personnel at the Agency.
6. Receive changes and, if necessary, revise the draft and submit the revised draft to the Agency.
7. Obtain approval from the Agency.
8. Print the Provider Bulletin materials.
9. Distribute the Provider Bulletin to providers, Alabama Medicaid, and others specified by the Agency.

> Distribution must occur within ten business days of the Provider Bulletin approval by the Agency.

10. Notify the Web administrator of the location on the LAN of the Provider Bulletin. The Web administrator posts the Provider Bulletin to the Alabama Medicaid Website— *http://www.medicaid.alabama.gov/*

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5 PROVIDER REPRESENTATIVE

The Provider Relations representatives are a vital part of the Provider Relations team. The representatives work as liaisons between the Alabama Medicaid Agency and the provider community to assist providers with billing, training, and electronic claims submission. Through personal contact with providers during workshops and onsite visits, the representatives give assistance in claims submission, filing of claims, electronic claims submission, and general Medicaid billing information.

5.1 PRIMARY TASKS

The primary tasks for the Provider Representatives are as follows:

- Assist the Agency in accomplishing its goals and objectives.
- Assist the provider in securing prompt and accurate payment for covered Medicaid services provided to eligible Medicaid recipients.
- Secure prompt and accurate answers to provider inquiries.
- Educate providers on Medicaid billing procedures.
- Market ECS to providers.

A provider representative must have a broad knowledge of all areas within DXC and how the various departments operate. A provider representative must have an in-depth knowledge of all their specific programs and how they function. All provider representatives must have a working knowledge of the following:

- Managed Care programs
- ECS options
- Claims Processing procedures
- Claim Completion Instructions
- EPSDT program
- Eligibility verification procedures (Including knowledge of how to use all DXC eligibility verification devices).
- Prior authorization procedures
- Remittance Advices
- Medicaid forms
- HIPAA
- NPI

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5.2 PROVIDER REPRESENTATIVE OPERATIONAL PROCEDURES

A Provider Representative is the liaison between the Alabama Medicaid Agency and DXC. In this role, the Provider representative conducts on-site provider visits, presents workshops and training sessions, markets the PES software, and attends various provider conferences. A provider representative also handles the more complicated provider inquiry issues. The Provider Representative is also responsible for the following:

Marketing Electronic Claims Submission to increase the number of claims received electronically.

Monitoring reports to provide outreach to new providers, evaluate reimbursement amounts, and check to see if an abnormal number of claims deny in a check write.

Contact providers with large numbers of RTPs (Return claims to provider) to see if assistance in claim form completion is required.

Perform in depth research for providers. This research may include a complete review of provider's accounts receivable report, a recap of claim denials over several months for providers, or research on claims processing guidelines.

5.2.1 Annual Provider Training Plan

On an annual basis, the Provider Relations Representative manager and supervisor meet with appropriate Agency staff members to discuss the direction the Provider representatives should take in the upcoming year to effectively train providers and provide outreach.

> The training plan is due to the Agency within ten business days of the first of October. If the training plan is updated, then the updates are due to the Agency within three business days of the update to the plan.

Steps for the training plan are as follows:

1. Determine the type of workshops based on provider issues, program policy changes, and customer requirements. The number of workshops is determined according to provider and claim types.
2. Determine the workshop locations based on provider population and other geographical factors. The range of dates for each workshop is scheduled according to presentation topics and expected provider attendance. Experience has shown that workshops are most widely attended in Birmingham, Huntsville, Mobile, and Montgomery. Other workshop sites can include Dothan and Tuscaloosa.
3. Determine the conventions provider representatives should attend throughout the year.
4. Discuss other meetings that should be conducted between DXC and Medicaid for the upcoming fiscal year.

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5.2.2 On-Site Visits

Provider representatives approach training of providers as pro-active. A Provider representative conducts on-site visits with providers as requested. They try to reach out to all providers enrolled in the Medicaid program to let them know help and training are available whenever needed. When a representative is traveling to a particular area, reports are generated to identify providers within the area to offer a visit. This approach lets providers know representatives are available to assist in resolving any issues the provider may encounter. Provider representative contact information is also regularly published in the Provider Insider.

Provider representatives visit providers one-on-one to assist in recognizing and solving problems, which can be initiated by a request from:

- Medicaid Agency
- Provider Review Unit
- Mailroom/data entry
- PAC/Adjustments/Enrollment/ECS
- The provider
- Provider Representative Supervisor

Visits may also be prompted by ECS calls or a review of:

- The monthly or quarterly reports.
- The DSS reports listing providers in a particular area.

Although the Alabama Medicaid Agency does not contractually require a minimum number of visits, representatives are requested to meet with providers weekly. This ensures the representatives are meeting and training providers; reaching out to the provider community and building strong relationships. If a representative cannot meet with providers in a given week, the representative should notify the supervisor of the reason, giving contact information on providers not wanting a visit.

For quality assurance, each representative must leave a postcard evaluation for the provider to evaluate the quality of the representative's visit. The card should be filled out after the representative leaves, and should be returned to the representative supervisor. The representative supervisor and the representative review the completed evaluation postcards prior to forwarding them to the Alabama Medicaid Agency for review. The representative supervisor follows up on any problem visits or unresolved issues. The supervisor or team leader may also accompany the representative or contact providers after visits have been made to discuss the quality of the visit.

Representatives have lists of general topics and information that should be covered while on provider visits. Representatives also make 'cold call' unscheduled provider visits. While this is not the preferred method of visiting providers, it is acceptable. If the biller has questions, the representative offers assistance as appropriate. If the biller does not have any questions, the representative should thank them for their time and encourage them to contact the account for assistance. When the biller has no questions, the contact is identified as a 'non visit' and the visit does not count toward the representative's weekly total. We document the 'non visits' to show the Agency our outreach efforts to providers which are not experiencing problems.

After each provider visit, representatives document all covered topics during the visits. The contact sheets are reviewed by the representative supervisor for content prior to being delivered to the Agency on a monthly basis.

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In addition to training the provider community, the provider representatives also train other DXC staff members when there is a program change, update, or enhancement to the system. Any instructional material necessary to train DXC staff members is developed by the representatives after the notification of a change. The representatives determine if departments within DXC need training. Training sessions are scheduled with staff members in coordination with the DXC trainer/documentation specialist.

Provider Representatives also train Agency staff members. The training could be on a number of different topics. Some of which include:

- AMMIS Panels
- New Programs
- Refresher training on billing

Training to new Agency programs

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6 PROVIDER ASSISTANCE CENTER

A Provider Assistance Center (PAC) Representative is an individual who has acquired knowledge of the Alabama Medicaid program through extensive training, study of the provider manuals, user documentation, and on-the-job experience. The PAC Representative interacts with the provider community through verbal and written communication regarding the following:

Billing problems

Billing procedures

Claims status

General inquiries

Medical policy

Prior authorization status

Remittance Advices (RAs)

Each PAC Representative has access to a desktop computer. This equipment allows the representative to provide accurate and timely answers during telephone conversations through immediate online research of numerous AMMIS panels.

6.1 PROVIDER SUPPORT

The PAC maintains a minimum of 16 incoming toll-free lines with the capacity of up to 40 for provider support. The Alabama Medicaid provider community uses the toll-free telephone lines to obtain claim status, prior authorization status, billing procedures, medical policy, and Medicaid eligibility and benefits information.

> To meet both the expectations of the provider community and contract obligations, PAC telephone lines are staffed from 8 AM until 5 PM local time on Monday through Friday. The staffing requirement excludes DXC-observed holidays.

All PAC representatives are on an Automated Call Distribution system (ACD), which distributes a call to the next available PAC representative not engaged on another line. If a PAC Representative is completing research, the representative can be excluded from the ACD system by a using a specific touch-tone telephone command.

6.1.1 Call Tracking

The Provider Assistance Center utilizes Helpdesk Expert Automation Tool (HEAT) by FrontRange Solutions. HEAT is used in the Provider Assistance Center to automatically log and track all verbal, written, and walk-in inquiries from the provider community associated with the Provider Assistance Center. HEAT displays the history of the caller once the provider number is entered. The system will record the date of inquiry, the Provider ID, the form of the inquiry, the specific nature of the inquiry, the form of response, the date of response, the respondent, and the relevant comments. This information will be stored in a database that is accessible by provider number and will automatically appear on the staff member's screen after the provider number is entered. If a provider does not enter a number, after answering the call, the associate will enter the information into the call tracking system, and the provider history will appear on the screen.

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6.1.2 Telephone Etiquette

In most cases, the PAC unit is the first contact the provider has with DXC. Because first impressions with the provider community are critical to the success of the Medicaid process, a PAC Representative must follow the telephone etiquette rules outlined in the below table.

Telephone Etiquette

Appropriate	Inappropriate
DXC, Good Morning/Afternoon, this is (your name), How may I help you?	DXC
Let's work together to resolve the issue.	That's the State's fault, not ours.
May I put you on hold, please?	Hold on.
I understand why you are upset.	I am so sorry, I feel so badly.
I'm sorry, I did not understand you.	I can't hear you--huh?
Yes ma'am/sir.	Uh-huh.
Thank you for calling, Good-bye.	Bye.

A PAC Representative must adhere to the following:

Do not leave a caller on hold for more than one minute.

Do not lay the telephone down without first placing the caller on hold or using the mute feature on the telephone, so the caller cannot hear conversation while waiting.

NOTE:

Refer to the INTER-TEL Executone Phone User's Guide for additional information on the basic telephone functions.

Telephone Research

The below table indicates the type of calls that will require immediate attention from the PAC Representative.

A PAC Representative is committed to completing–by the end of the next business day–all telephone inquiries that require follow-up or a return call.

The table provides a list of the types of calls and the necessary research tools used to respond appropriately.

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Telephone Research

Type of Inquiry	Procedure
Claim Status	Access the Claims Search panel. To access the panel, point to Claims and click Search. The representative must enter at least one of the following to perform a search: ICN, Recipient ID, Provider ID, Rendering Provider ID. Determine if the claim has been paid, denied, or is suspended and convey the information to the provider. For paid and denied claims, provide both the payment amount and date of payment or the Explanation of Benefit (EOB) denial code and date of denial. For claims in a suspended status, inform the provider of the reason and that there is no further action required of the provider at this time. If the claims are not found, relay this information to the provider and request that the claims be resubmitted. This is also a good opportunity to inform the provider about the PES software for claims submission and recipient eligibility verification.
Check Amount	Access the FPS Financial Payment Search panel. To access the panel, point to Financial and click Payment. The representative must enter at least one of the following: (Payee Type & Payee ID) OR Payment Number OR Date Range.
Recipient Eligibility/Available Benefits	Access the Recipient Information Page. To access the panel, point to Recipient and click Information, then enter current ID or case ID, and click search. Available eligibility benefits can be obtained via the Recipient Service Usage Panel. To access the panel, point to Recipient and click Service Usage, then enter the RID or SSN, and click search. This panel contains valuable data for determining eligibility for various benefits such as vision checkups, frames, lenses, etc. This type of call is handled only when there is an issue with the AVRS line.
Procedure Code Coverage	Access the Procedure Information panel. To access the panel, point to Reference and click Procedure, enter search criteria, and click search. The representative will answer questions regarding procedure code coverage using the Procedure Information panel and relevant panels that may be accessed through the Procedure Maintenance panel.

NOTE:

Refer to the AEVCS User Manual for additional information.

On occasion, a provider may request information that is restricted. The PAC Representative is not allowed to convey any confidential information and must decline to answer the request due to Medicaid policy provisions.

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Call Log

The Provider Assistance Center has several reports that are generated daily from the telephone system. These reports are utilized to monitor the total number of calls into the center, the number of calls each representative accepted, total hold time, number of abandoned calls, and number of calls transferred into the center. These numbers are captured and are delivered to the state in the form of a monthly status report.

6.1.3 Additional Tasks

When there are no incoming calls, a PAC Representative works on research, and completes the following tasks:

Answer written correspondence

Complete and log Return to Provider (RTP) letters

Research all call backs

Written Correspondence

The mailroom delivers all provider inquiries to Provider Services on a daily basis. A designated analyst separates the mail into batches and files them according to Julian date receipt. The correspondence is generally received in one of the following formats:

Provider Inquiry form.

Provider-generated letter.

An inquiry written on the provider's remittance advice.

The method of processing the inquiry is the same regardless of which type of correspondence is received.

> A PAC Representative or a Provider Representative receives and responds to written correspondence submitted by providers within seven business days of receipt.

Provider Services completes the following steps when replying to the written provider correspondence:

1. The mailroom delivers the mail addressed to Provider Services.
2. After the mail is delivered, each provider inquiry is assigned a Letter Control Number (LCN) and batched in groups of 50 inquiries. The following information is then entered into the Correspondence Tracking System (CTS) using the Provider Correspondence Batch Control window:

LCN information

Provider NPI number

Date received

PAC clerk ID

3. After the written correspondence analyst has sorted, batched, and recorded the inquiries, the inquiry is ready for research. The PAC analyst accesses the CTS and types the batch number in the Provider Correspondence Inquiry Response window. The inquiry is displayed; the PAC analyst reads the inquiry, and types a valid inquiry code and brief description of the inquiry.
4. The PAC analyst completes the necessary research, using the various AMMIS panels and the appropriate reference materials.

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5. The PAC analyst types a response in the free-text area on the Inquiry Response window. When this process is completed, the analyst generates the appropriate inquiry response from a pull-down menu that displays the various provider response letters. The body of each letter is completed from the free-text area that has already been typed by the analyst.
6. If the analyst cannot answer the inquiry immediately, the inquiry is placed in an Open Status Awaiting Additional Research. Once the research is completed, the analyst accesses the system and generates the provider response letter.
7. The letters are printed in Operations, and returned to Provider Services.
8. The PAC analyst verifies the response for accuracy prior to mailing to the provider.
9. The correspondence is sent to the mailroom for scanning.
10. The PAC analyst changes the status to Closed on the CTS for the correspondence.

6.1.4 HIPAA Procedures

1. All Provider Assistance Center representatives have been trained on HIPAA privacy standards. When a provider calls into the center, the provider NPI number is verified against the provider file for validation. If a provider enrollment has expired, associates are not allowed to release information to that provider.

If a suspicious call is received in the area, the information is forwarded to the HIPAA Privacy for investigation.

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7. GLOSSARY

The table below defines the terms used in the Provider Services functional area.

Provider Services Functional Area Terms

Term	Definition
AEVCS	Alabama Automated Eligibility Verification and Claim Submission system.
CHOW	Change of Ownership
NPI	National Provider Identifier
Provider Enrollment	Unit within Provider Services that is responsible for enrolling providers in the Alabama Medicaid program.
Provider Assistance Center	First point of contact with Provider Services when a provider has a billing or Medicaid related question.
Provider Representative	Individual that works with providers participating in Alabama Medicaid. This includes training, education, and support for provider issues.

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AMMIS Provider User Manual

Date Modified: 11/15/2018

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2. Provider Introduction

Provider User Manual Overview

The AMMIS has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Provider functional area.

This manual covers the following:

- Provider Overview
- Provider System Navigation
- System Wide Common Terminology and Layouts
- Provider Pages/Panels
- Provider Reports

Provider User Manual Objective

This section explains the objective of the AMMIS Provider User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

This manual contains references to current Alabama Medicaid Management Information System (AMMIS) screens, when applicable. This information will be deleted after implementation training, and is identified in the narrative text in italics.

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3. Provider Overview

Introduction to Provider

The Provider Data Maintenance function maintains comprehensive current and historical information about providers eligible to participate in the state's medical assistance program. The establishment and maintenance of a single provider data repository with provider demographic, certification, rate, and financial summary information, supports accurate and timely claim records processing, enhanced management reporting and utilization review reporting as well as surveillance activities. The AMMIS must be capable of meeting the requirements of the National Provider Identifier (NPI) standards of the Health Insurance Portability and Accountability Act (HIPAA). This requires identifying providers using the NPI and/or using standards consistent with NPI and HIPAA requirements. This includes identifying all locations, provider types, specialties, authorization, certifications and licensing for services and other required data for that provider as a logical record utilizing only one unique number for a provider. The AMMIS Provider Data Maintenance function objectives are to:

- Encourage the participation of qualified providers by making enrollment and re-enrollment an efficient and accurate process;
- Ensure that providers are qualified to render specific services by screening applicants for state licensure and certification;
- Provide for the processing of provider contracts and changes in a timely and accurate manner;
- Maintain control over all provider data; and
- Maintain all demographic and rate information to support claims processing and reporting functions.

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4. Provider System Navigation

Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

System Security

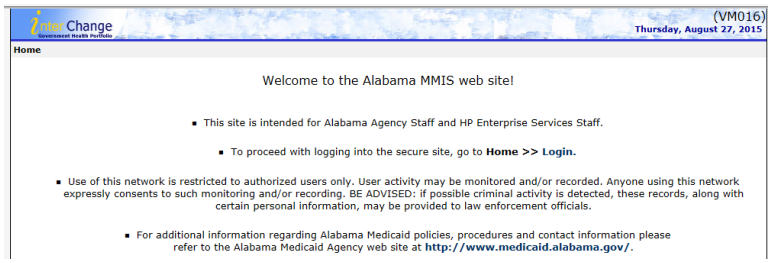
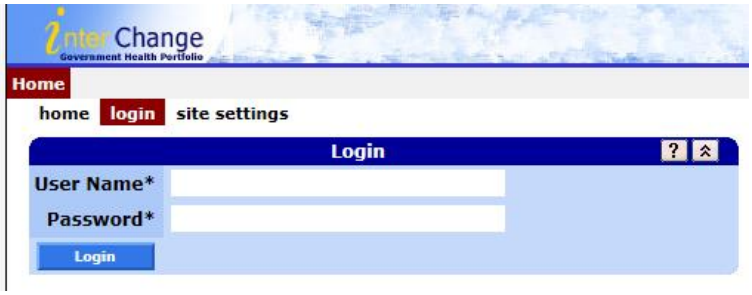
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.1.1 Logging on to the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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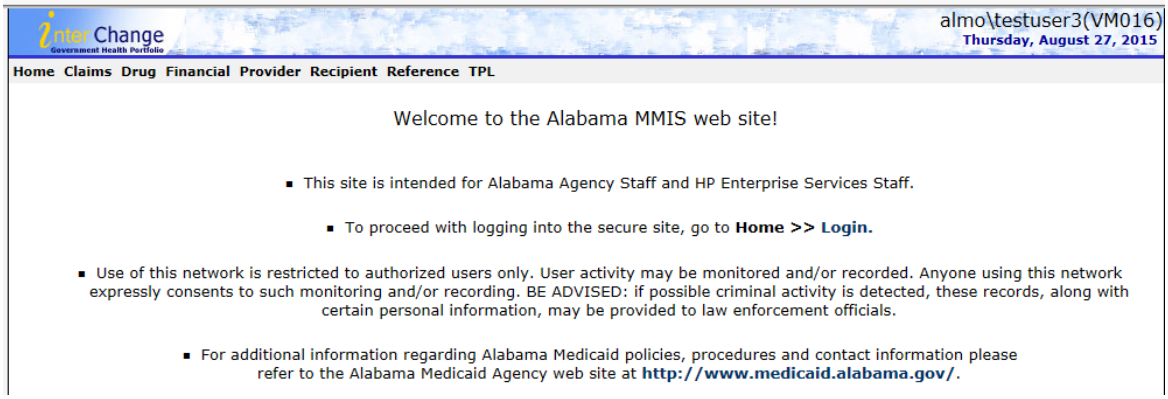
Step	Action	Response
		

4.1.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact theAssistant MMIS Coordinator.

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Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.1.3 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into interChange	Home page displays.
2	Select View.	View menu displays.
3	Point to Text Size and click Smaller.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists and help desk staff when discussing or more importantly documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

Page

Page Header

Page Footer

Sub Menu

Shortcut Keys (ctrl + alt + letter)

Main Menu bar

Panel

Advanced Search

Mini Search panel

Information panel

Navigation panel

Task List panel

Title Bar Icons

Help Functionality

Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels. The bottom of the page contains the Page Footer with the Hewlett Packard Enterprise (HPE) copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.

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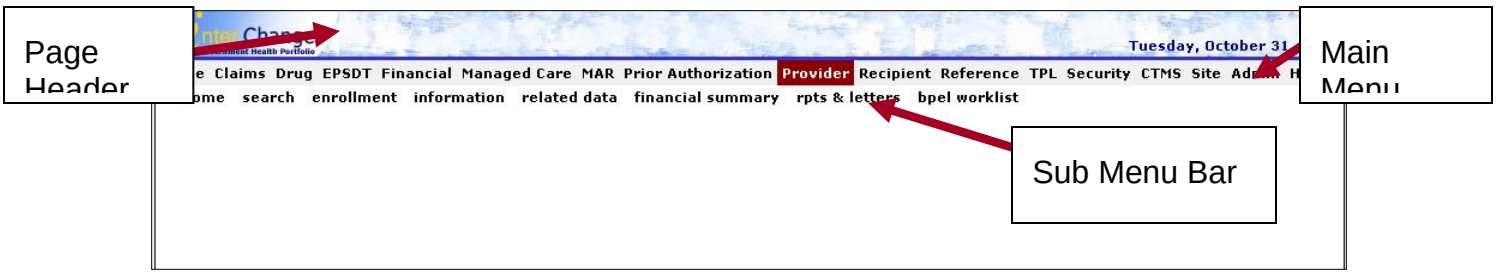
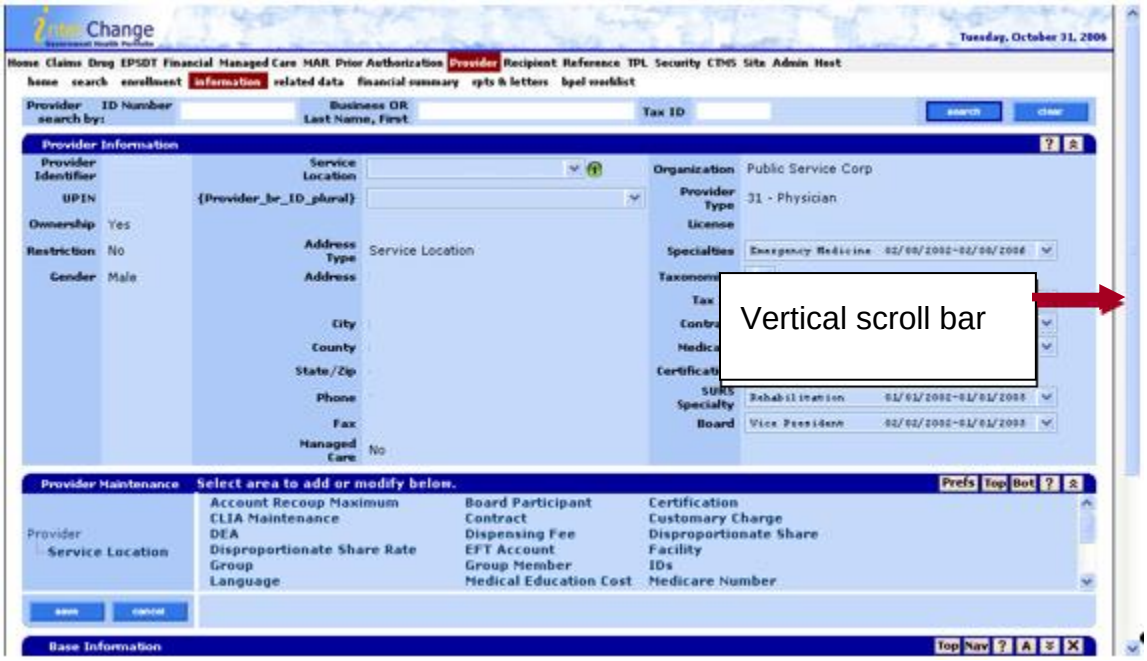
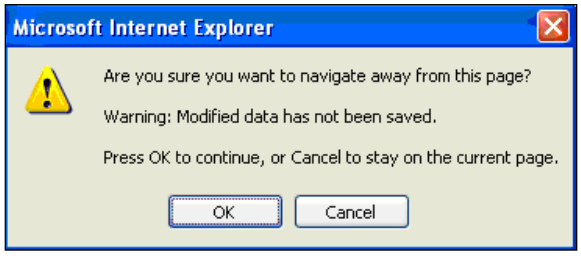


In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



If a user adds, updates or deletes information and then attempts to navigate away from the page without saving or canceling the changes first, the system prompts the user with a pop-up window message. The detail panels on the page are locked open and navigating away from the page is not permitted until changes are either correctly saved or cancelled.



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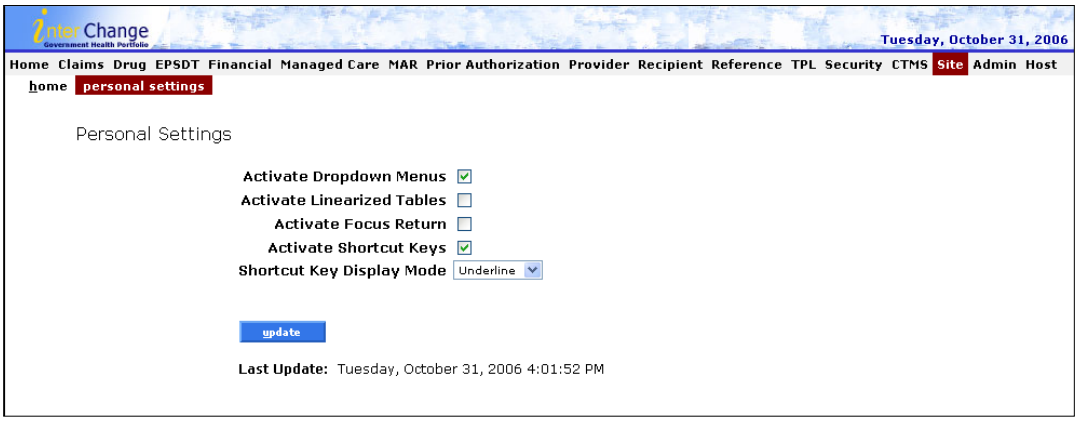
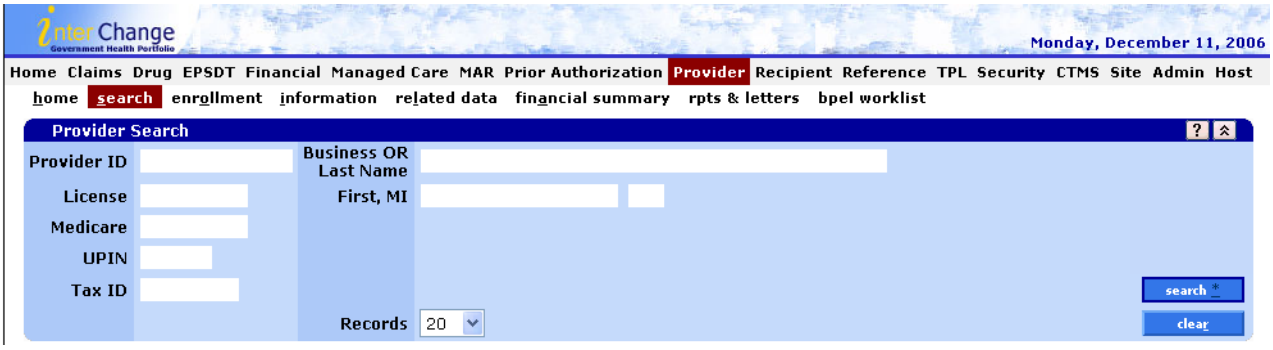
Shortcut Keys

If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated page.

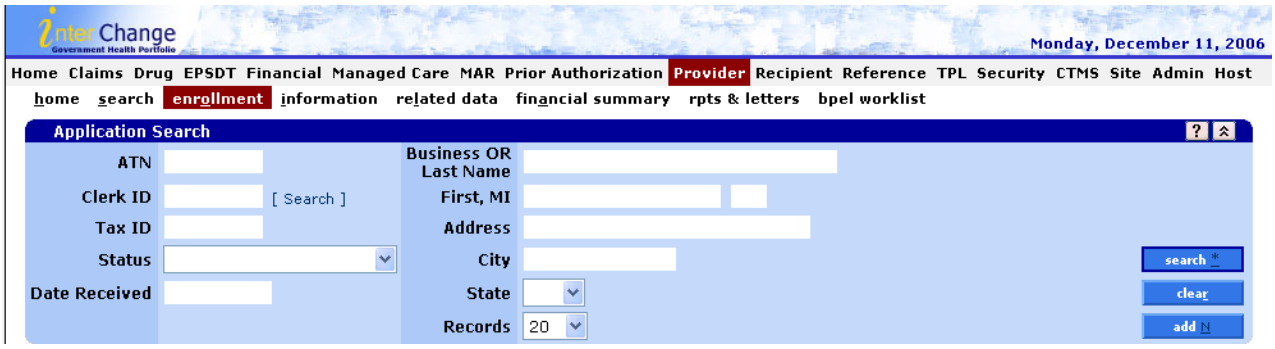
To active the shortcut key, click on the Site link, then click on “Personal Settings”, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.



Within the Provider Sub Menu, the user can use the shortcut keys to quickly navigate from the Provider Search panel to the Application Search panel by using the following shortcut key combination: (Ctrl + Alt + O) since the letter “O” is found within the horizontal bars on the Sub Menu enrollment link.



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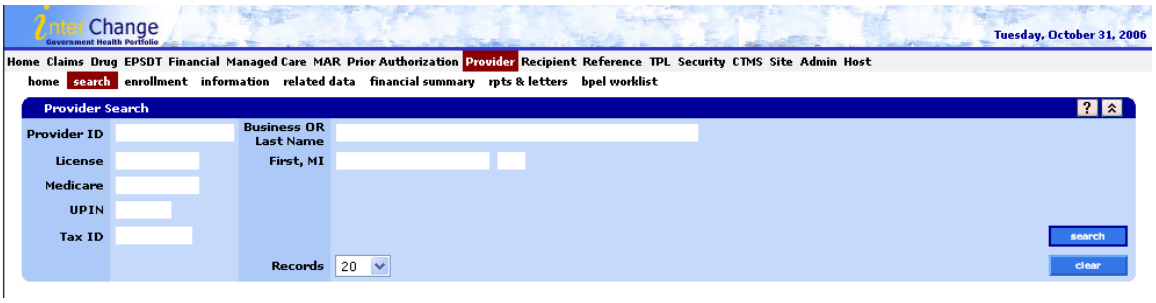
Search Options

There are several search options available within interChange.

5.1.1 Search Panels

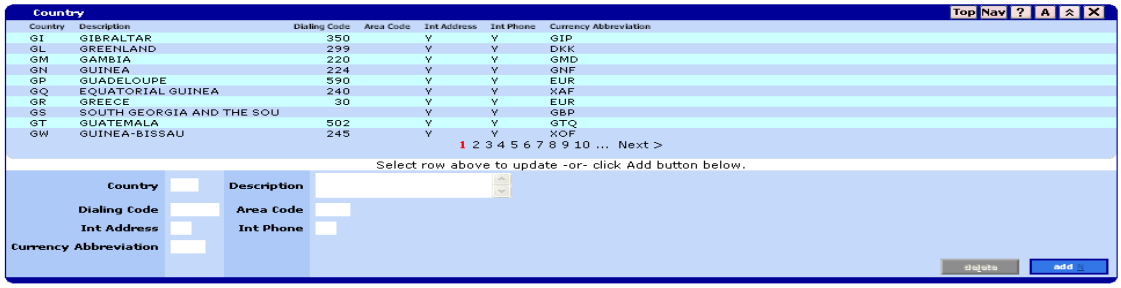
The AMMIS contains two types of search panels: Search and Advanced Search. An example of the Provider Search panel with the Search button displaying is shown below:



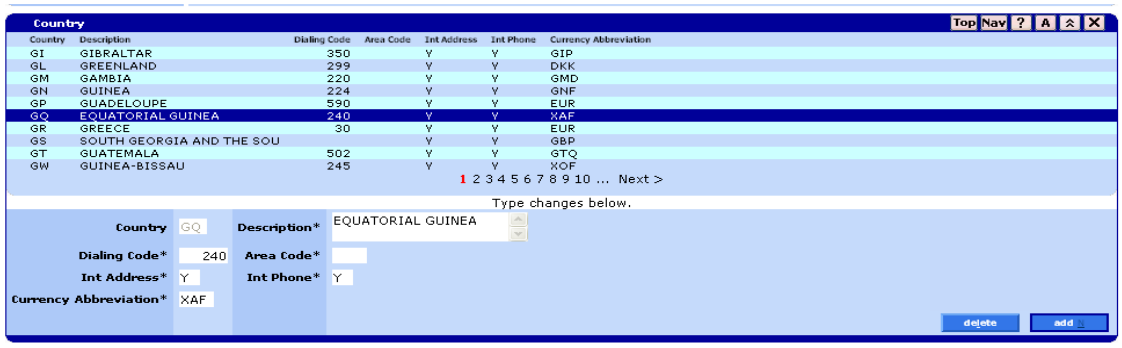
Note: The Advanced Search button functionality does not exist in the Provider subsystem.

5.1.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicks the sixth row of the Country panel and detailed information is displayed at the bottom of the panel.



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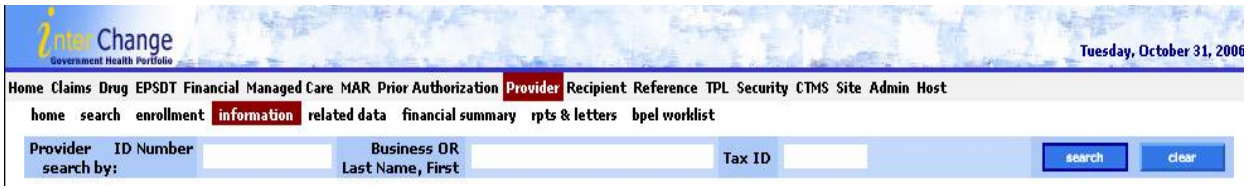
5.1.3 Mini Search

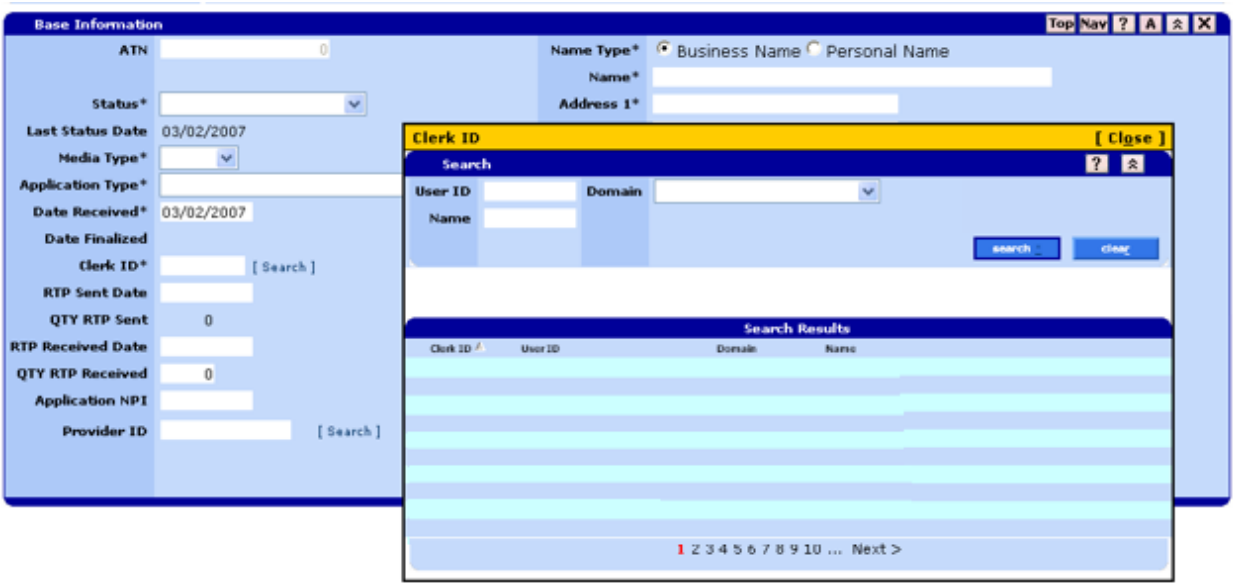
After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process. The Provider Information panel contains three search fields as noted in the following image:



5.1.4 Pop Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accessed the search panel that is associated with that particular field.



Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.1.5 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.

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Name	Icon	Description
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Maintain Button	maintain	Maintains a selected data record.
Preferences Button	Prefs	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

Among the panel types are the following:

Maintenance panel

Task List panel

Maintenance Item Panel

Audit panel

5.1.6 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page.

The following image demonstrates Maintenance Group Links (Provider and Service Location) and the associated Maintenance Item links.

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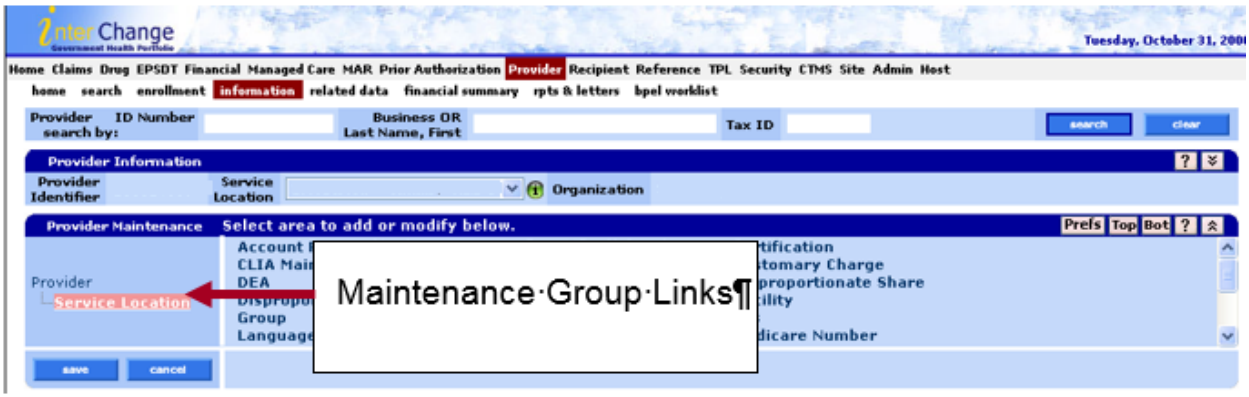
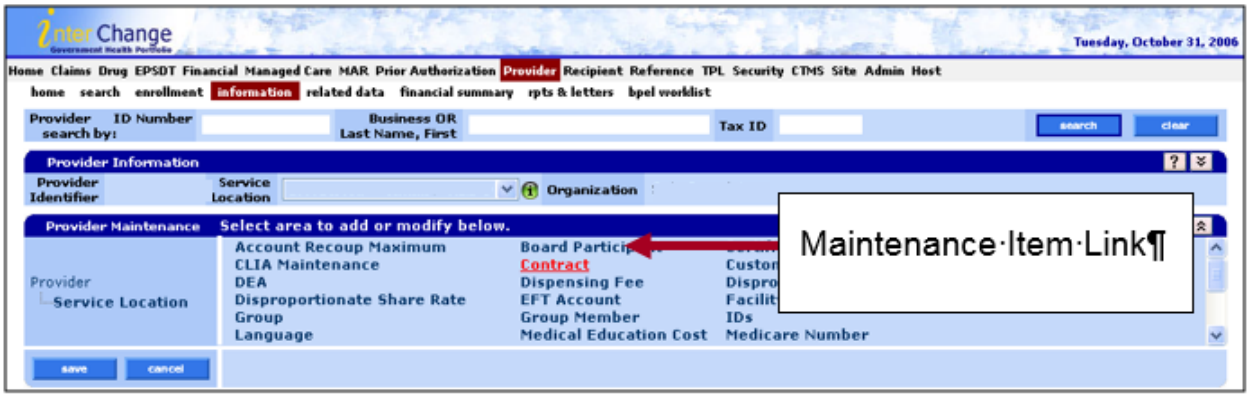
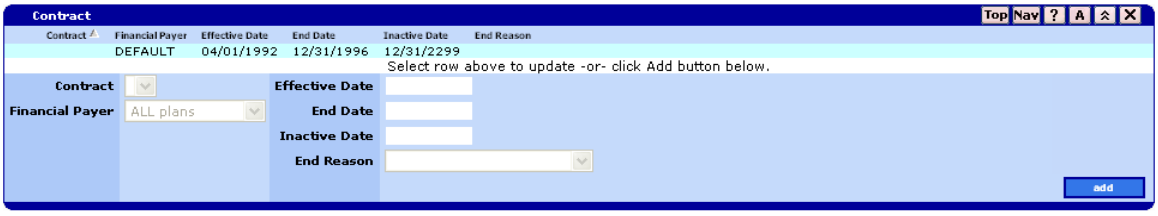


By clicking on a Maintenance Item Link (such as Contract), the associated panel opens.



Results: Contract Panel displays



5.1.7 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.

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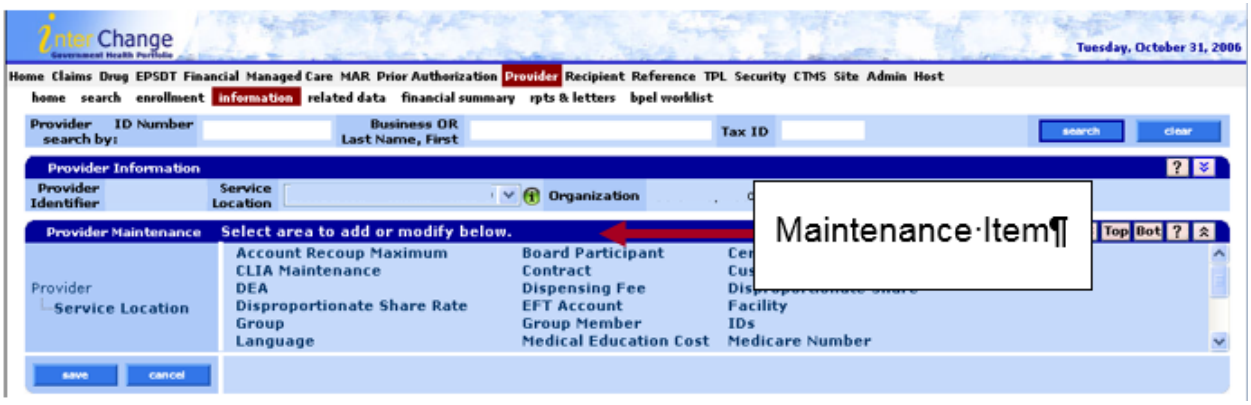
The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add or save. For example, if the user attempts to add duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

5.1.8 Maintenance Item Panel

A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.1.9 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of

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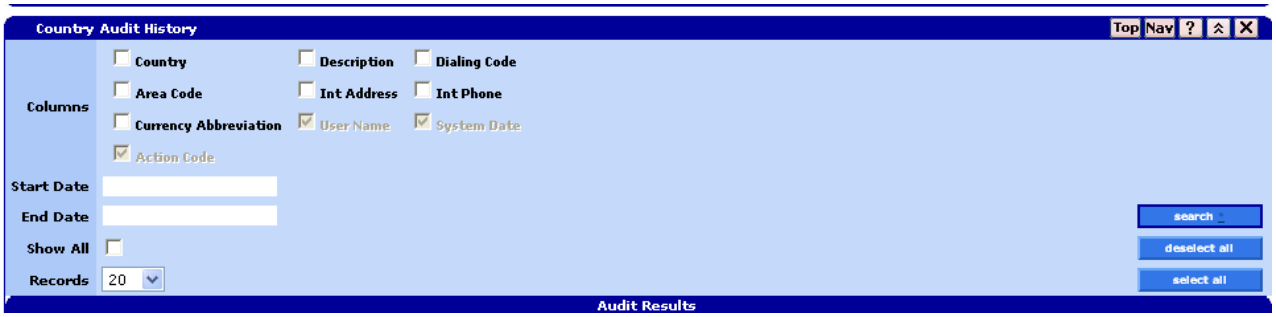
the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



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6. Provider Pages/Panels

This section gives a brief description of each page/panel, shows a sample, and describes all associated page/panel fields and field edits.

Note: Any names, addresses, or other personal information displayed in page/panel images are fictitious and are not representative of an actual person.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each page/panel covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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Provider Search Panel Overview

6.1.1 Provider Search Panel Narrative

The Provider Search panel is used to access provider records using flexible selection criteria. The provider record is selected by keying data in the desired search criteria. This panel allows for the entry of search criteria regarding provider files and is for inquiry only.

Navigation Path: [Provider] – [Search]

6.1.2 Provider Search Panel Layout

6.1.3 Provider Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name	Name of the business of the owner or last name of provider.	Field	Character	50
Clear	Allows the user to clear any changes on the Provider Search panel.	Button	N/A	0
First, MI	First name and middle initial of provider.	Field	Character	50
License	License number assigned to the provider.	Field	Character	10
Medicare	Medicare number.	Field	Character	10
Provider ID	Identification number of the provider.	Field	Character	9
Records	Allows the user to select the number of records to retrieve during a search.	Comb o Box	Drop Down List Box	0
Search	Initiates the Search by Provider ID, Business OR Last Name, License, Medicare, UPIN and Tax ID.	Button	N/A	0
Tax ID	Tax identification number of the provider.	Field	Character	9
UPIN	Provider's Universal Provider Identification Number.	Field	Character	6

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6.1.4 Provider Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.5 Provider Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Provider Search Panel Accessibility

6.1.6.1 To Access the Provider Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.

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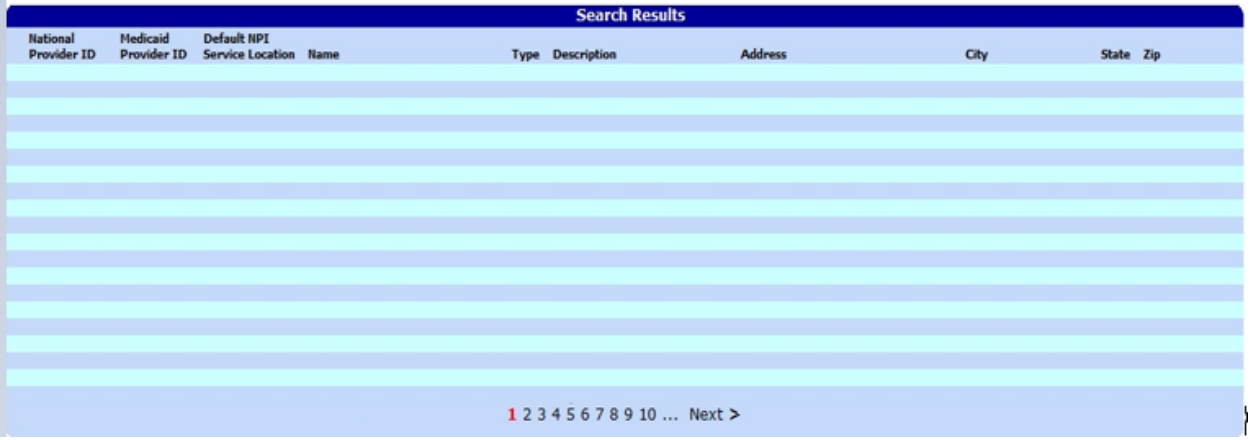
Provider Search Results Panel Overview

6.1.7 Provider Search Results Panel Narrative

The Provider Search Results panel displays provider records based on search criteria. This panel is display only.

Navigation Path: [Provider] – [Search] - [enter search criteria] - [select row from search results]

6.1.8 Provider Search Results Panel Layout



6.1.9 Provider Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Address of the provider.	Field	Character	30
Base Provider ID	Base identification number of the provider.	Field	Character	10
City	The city of the provider.	Field	Character	15
Description	Provider type description for that particular service location.	Field	Character	50
Medicaid Provider ID	The Medicaid provider identification number of the provider.	Field	Character	10
Name	Last name, first name, middle initial or business name of provider.	Field	Character	50
National Provider ID	The National Provider Identifier of the provider.	Field	Character	10
State	The state of the provider.	Field	Character	2
Type	Provider type for that particular service location.	Field	Character	2
Zip	The zip code of the provider.	Field	Number (Integer)	9

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6.1.10 Provider Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.11 Provider Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.12 Provider Search Results Panel Accessibility

6.1.12.1 To Access the Provider Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** on the Provider Search panel.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of provider to display in the search results panel.

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Provider Mini-Search Panel Overview

6.1.13 Provider Mini-Search Panel Narrative

The Provider Mini-Search allows search by Provider ID/name/tax ID from the Provider Information page. This panel allows entry of search criteria regarding provider files and is inquiry only.

Navigation Path: [Provider] – [Information]

6.1.14 Provider Mini-Search Panel Layout

6.1.15 Provider Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business OR Last Name, First	Business or last name, first name of the provider.	Field	Character	50
Clear	Allows the user to clear any changes on the Provider Mini-Search panel.	Button	N/A	0
ID Number	Identification number of the provider.	Field	Character	9
Search	Initiates the Search by ID Number, Business OR Last Name, First, or Tax ID.	Button	N/A	0
Tax ID	Tax identification number of the provider.	Field	Character	9

6.1.16 Provider Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.17 Provider Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.18 Provider Mini-Search Panel Accessibility

6.1.18.1 To Access the Provider Mini-Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Information**.	Provider Information panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.

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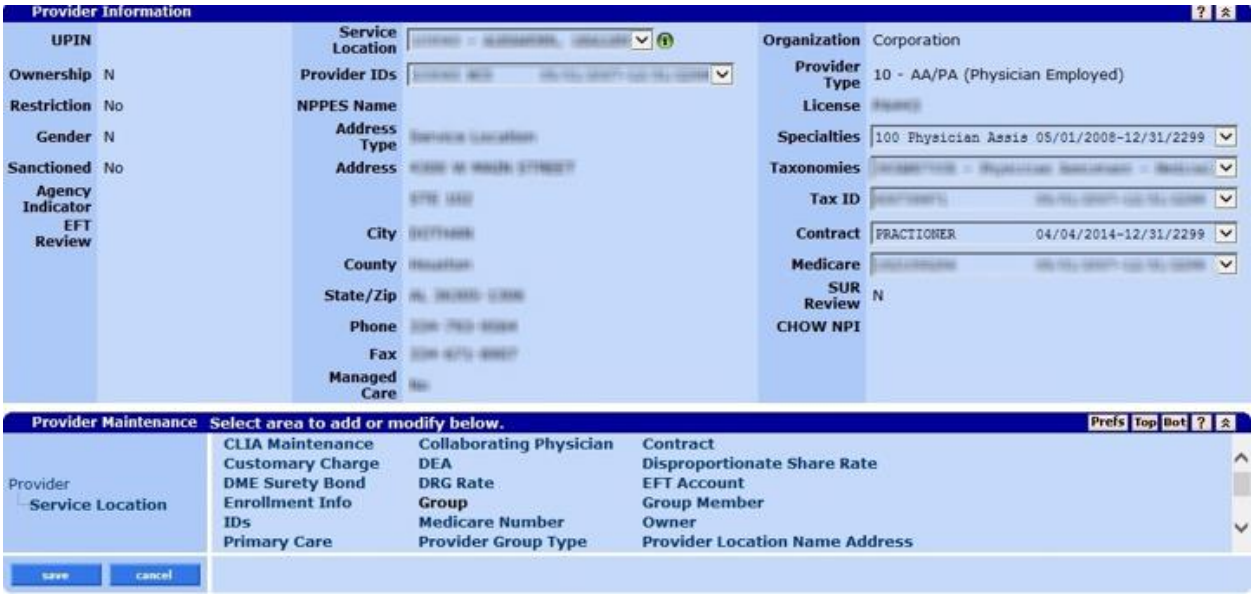
Provider Information Panel Overview

6.1.19 Provider Information Panel Narrative

The Provider Information displays provider related information. This panel is display only.

Navigation Path: [Provider] – [Search] - [select row from search results]

6.1.20 Provider Information Panel Layout



6.1.21 Provider Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	The address of the provider.	Field	Character	15
Address Type	Type of address with valid value to include: Home Office Address, Mail-To Address, Pay-To Address and Service Location Address.	Field	Character	15
Certification	Field which displays the provider's Certification Information, Certification Start Date and Certification End Date.	Combo Box	Drop Down List Box	0
City	The city of the provider.	Field	Character	2
Contract	Field which displays the provider's Contract Eligibility Information, Contract Start Date and Contract End Date.	Combo Box	Drop Down List Box	0
County	The county of the provider.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
EFT Review	The code that indicates if/when the provider's current EFT is suspended for review.	Field	Character	1
Fax	The fax number of the provider.	Field	Character	10
Gender	The gender of the provider.	Field	Character	1
License	Provider's state license number.	Combo Box	Drop Down List Box	0
Managed Care	Indicator for Managed Care.	Combo Box	Drop Down List Box	0
Medicare	Field which displays the provider's Medicare Number, Medicare Start Date and Medicare End Date.	Combo Box	Drop Down List Box	0
Organization	The organization of the provider.	Field	Character	15
Ownership	Field to indicate whether the provider has a controlling ownership interest in any other Health Coverage Programs, provider facility or practice with valid values to include Yes and No.	Combo Box	Drop Down List Box	0
Phone	Provider's phone number.	Field	Character	10
Provider IDs	Field which displays the provider's Provider Numbers, Start Date and End Date.	Combo Box	Drop Down List Box	0
Provider Identifier	The identification number of the provider.	Field	Character	9
Provider Type	Provider type for that particular service location.	Field	Character	20
Restriction	Field to indicate if the provider is currently on prepay review utilization with valid values to include Yes and No.	Field	Character	3
Sanctioned	Field that indicates if a provider is under a State or Federal Sanction which revokes the provider's participation in Medicaid. Valid values are Yes and No	Field	Character	3
Service Location	The service location of the provider.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Specialties	Field which displays the provider's Specialty Code, Specialty Start Date and Specialty End Date.	Combo Box	Drop Down List Box	0
State/Zi0070	Provider's state and zip code.	Field	Character	2
SURS Specialty	Assumes the values 'Y' or 'N' depending on whether a Provider is under review or not	Field	Character	0
Tax ID	Field which displays the provider's Tax ID, Tax ID Start Date and Tax ID End Date	Combo Box	Drop Down List Box	0
Taxonomies	Field which displays the Provider's taxonomy codes (if more than one), Taxonomy Start Date, and Taxonomy End Date.	Combo Box	Drop Down List Box	0
UPIN	Provider's Universal Provider Identification Number.	Field	Character	6

6.1.22 Provider Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.23 Provider Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.24 Provider Information Panel Accessibility

6.1.24.1 To Access the Provider Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information panel displays.

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Provider Maintenance Panel Overview

6.1.25 Provider Maintenance Panel Narrative

The Provider Maintenance panel contains links to information at the provider level. This panel is utilized as a navigation tool to access provider related panels such as the Comment panel. This panel is inquiry only.

Navigation Path: [Provider] – [Search] - [select row from search results]

6.1.26 Provider Maintenance Panel Layout

6.1.27 Provider Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Provider Maintenance panels.	Button	N/A	0
Comment	Link to the Comment panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Provider Maintenance panels.	Button	N/A	0

6.1.28 Provider Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.29 Provider Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.30 Provider Maintenance Panel Accessibility

6.1.30.1 To Access the Provider Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria

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Step	Action	Response
		entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Maintenance panel displays.
5	Select **Provider** hyperlink on the Provider Maintenance panel.	Provider Maintenance panel displays.

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Provider Base Information Panel Overview

6.1.31 Provider Base Information Panel Narrative

The Provider Base Information panel allows the user to update base information carried at the provider level. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Provider] - [Base Information] OR [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Base Information]

6.1.32 Provider Base Information Panel Layout

6.1.33 Provider Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date of Birth	The date of birth of the provider.	Field	Date (MM/DD/CCYY)	8
Gender	The gender of the provider. Valid values include: female, male and organization.	Combo Box	Drop Down List Box	0
Ownership	Field to indicate whether the provider has a controlling ownership interest in any other Health Coverage Contracts provider facility or practice. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
SSN	The Social Security Number of the provider.	Field	Number (Integer)	9
UPIN	Provider's Universal Provider Identification Number.	Field	Character	6

6.1.34 Provider Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
UPIN	Field	10	UPIN must be Alphanumeric.	Verify keying. The UPIN must be 6 alphanumeric characters.
	Field	18	UPIN must be 6 character(s) in length.	Verify keying. The UPIN must be 6 alphanumeric characters.

6.1.35 Provider Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.36 Provider Base Information Panel Accessibility

6.1.36.1 To Access the Provider Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria for an application in Approved status and click **Search**; Or click **Search** and select a line item with a status of Approved.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Enroll Provider link displays at the bottom of the browser page.
5	Click Enroll Provider link.	Provider Base Information panel displays.

6.1.36.2 To Add on Provider Base Information Panel

Step	Action	Response
1	Enter **UPIN**.	
2	Select **Ownership** Indicator.	
3	Enter **SSN**.	
4	Select **Gender**, if applicable.	
5	Enter **Date of Birth** in MM/DD/CCYY format.	
6	Click **Save**.	Provider Base Information is saved.

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Provider ID Search Panel Overview

6.1.37 Provider ID Search Panel Narrative

The Provider ID Search panel is a Pop-up Search panel used to access provider records using flexible selection criteria. The provider record is selected by keying data in the desired search criteria. This panel allows for the entry of search criteria regarding provider files and is for inquiry only.

Navigation Path: [Claims] – [Search] – [Provider ID]

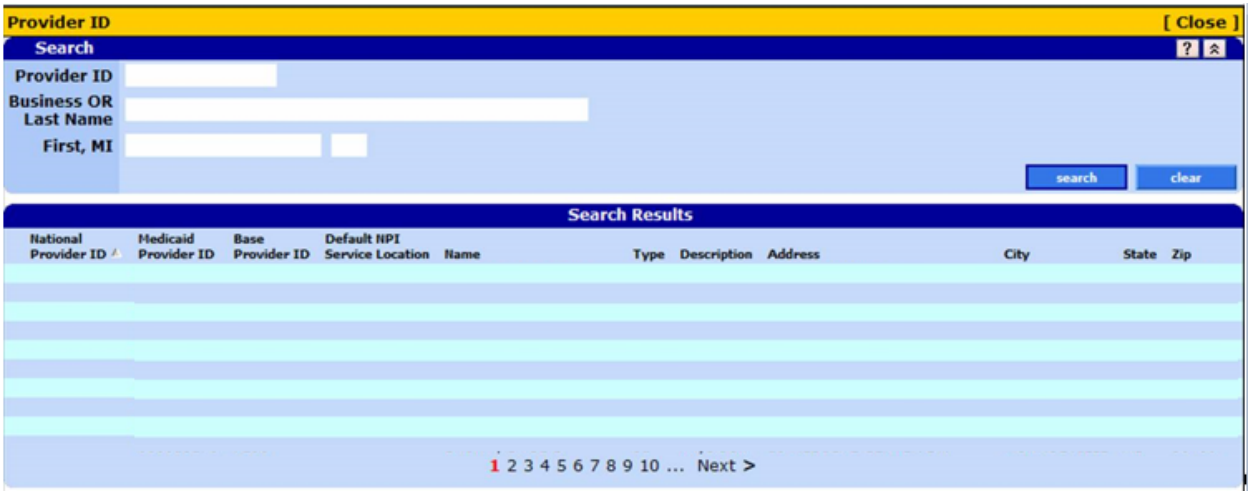
Or

[Prior Authorization] – [Search] – [Provider ID]

Or

[TPL] – [Prebill Claims Search] – [Provider]

6.1.38 Provider ID Search Panel Layout



6.1.39 Provider ID Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	Provider Address.	Field	Character	30
Base Provider ID	Base Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	15
Business OR Last Name	The name of the business of the owner or Last Name of Provider.	Field	Character	50
City	Provider City.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Provider Search panel.	Button	N/A	0
Default NPI Service Location	For NPI entries, indicates that this is the default service location for this NPI.	Field	Character	1
Description	Provider type description for that particular service location.	Field	Character	50
First, MI	The First Name and Middle Initial of the Provider.	Field	Character	50
Medicaid Provider ID	Medicaid Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	15
Name	Last Name, First Name and Middle Initial of Provider.	Field	Character	50
National Provider ID	National Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	15
Provider ID	The ID of the provider.	Field	Alphanumeric	15
Search	Allows user to search for a record.	Button	N/A	0
State	Provider State.	Field	Character	2
Type	Provider Type for that particular service location.	Field	Character	2
Zip	Provider Zip.	Field	Character	5

6.1.40 Provider ID Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.41 Provider ID Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.42 Provider ID Search Panel Accessibility

6.1.42.1 To Access the Provider ID Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Claims** and click **Search**.	Claims Search panel displays.
3	Click on **Provider ID** search link	Provider ID Search panel displays.

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Provider Comment Panel Overview

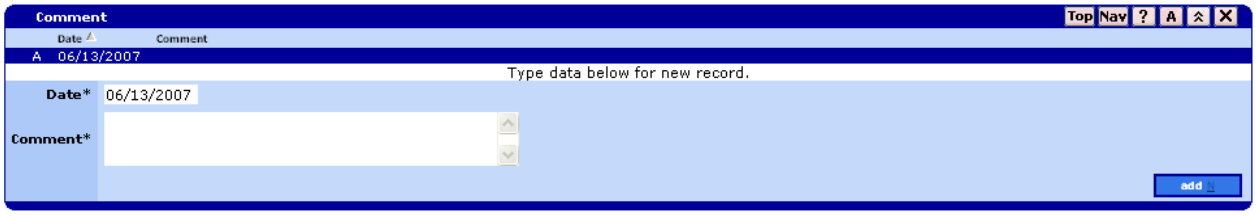
6.1.43 Provider Comment Panel Narrative

The Provider Comment panel is used to hold any comments the user has regarding a provider.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [(Add button) OR (select row from search results)] - [Comment]

6.1.44 Provider Comment Panel Layout



6.1.45 Provider Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a comment.	Button	N/A	0
Comment	Comment field used to notate information regarding a provider's application.	Field	Character	250
Date	Date when comment was entered into system.	Field	Date (MM/DD/CCYY)	8

6.1.46 Provider Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter a Comment.
Date	Field	1	Date is required.	Enter a valid comment Date.

6.1.47 Provider Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.48 Provider Comment Panel Accessibility

6.1.48.1 To Access the Provider Comment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria

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Step	Action	Response
		entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information Maintenance panel displays.
5	Click hyperlink for **Comment** panel.	Provider Comment panel displays.

6.1.48.2 To Add on Provider Comment Panel

Step	Action	Response
1	Click **Add**.	
2	Enter **Date** in MM/DD/CCYY format.	
3	Enter **Comment**.	
4	Click **Save**.	Provider Comment information is saved.

6.1.48.3 To Update the Provider Comment Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Provider Comment information is saved.

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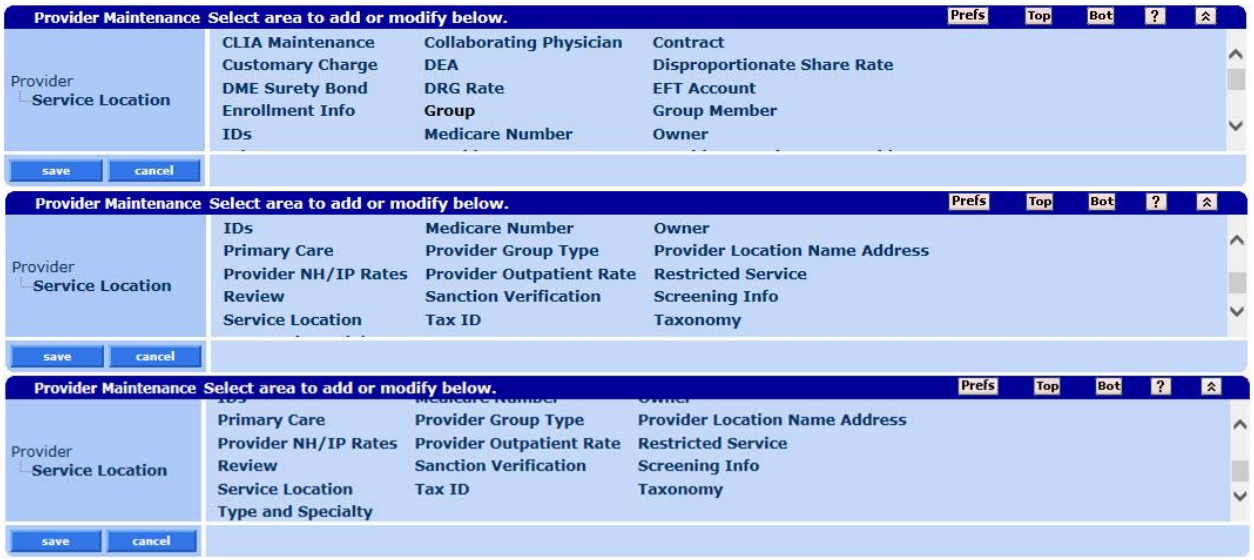
Provider Maintenance Service Location Panel Overview

6.1.49 Provider Maintenance Service Location Panel Narrative

Provider Maintenance Service Location panel contains links to information at the provider service location level. This panel is inquiry only.

Navigation Path: [Provider] – [Search] – [Service Location] - [select row from search results]

6.1.50 Provider Maintenance Service Location Panel Layout



6.1.51 Provider Maintenance Service Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Provider Maintenance Service Location panel.	Button	N/A	0
CLIA Maintenance	Link to the CLIA Maintenance panel.	Hyperlink	N\A	0
Collaborating Physician	Link to Collaborating Physician	Hyperlink	N\A	0
Contract	Link to the Contract panel.	Hyperlink	N\A	0
Customary Charge	Link to the Customary Charge panel.	Hyperlink	N\A	0
DEA	Link to the DEA panel.	Hyperlink	N\A	0
Disproportionate Share Rate	Link to the Disproportionate Share Rate panel.	Hyperlink	N\A	0
DME Surety Bond	Link to the DME Surety Bond panel.	Hyperlink	N/A	0
DRG Rate	Link to the DRG Rate Panel	Hyperlink	N/A	0
EFT Account	Link to the EFT Account panel.	Hyperlink	N\A	0
Enrollment Info	Link to the Enrollment Info panel.	Hyperlink	N\A	0

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Field	Description	Field Type	Data Type	Length
Group	Link to the Group panel.	Hyperlink	N\A	0
Group Member	Link to the Group Member panel.	Hyperlink	N\A	0
IDs	Link to the IDs panel.	Hyperlink	N\A	0
Medicare Number	Link to the Medicare Number panel.	Hyperlink	N\A	0
Owner	Link to the Owner panel.	Hyperlink	N/A	0
Primary Care	Link to the Primary Care panel.	Hyperlink	N/A	0
Provider Group Type	Link to the Provider Group Type panel.	Hyperlink	N/A	0
Provider Location Name Address	Link to the Provider Location Name Address panel.	Hyperlink	N/A	0
Provider NH /IP Rate	Link to the NH/IP Rate panel.	Hyperlink	N/A	0
Provider Outpatient Rates	Link to the Provider Outpatient Rates panel.	Hyperlink	N/A	0
Restricted Service	Link to the Restricted Service panel.	Hyperlink	N/A	0
Review	Link to the Review panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for Service Location.	Button	N/A	0
Screening Info	Link to the Screening Info panel.	Hyperlink	N/A	0
Service Location	Link to the Service Location panel.	Hyperlink	N/A	0
Tax ID	Link to the Tax ID panel.	Hyperlink	N/A	0
Taxonomy	Link to the Taxonomy panel.	Hyperlink	N/A	0
Type and Specialty	Link to the Type and Specialty panel.	Hyperlink	N/A	0

6.1.52 Provider Maintenance Service Location Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.53 Provider Maintenance Service Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.54 Provider Maintenance Service Location Panel Accessibility

6.1.54.1 To Access the Provider Maintenance Service Location Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Maintenance panel displays.
5	Select **Service Location** hyperlink on the Provider Maintenance panel.	Provider Maintenance Service Location panel displays.

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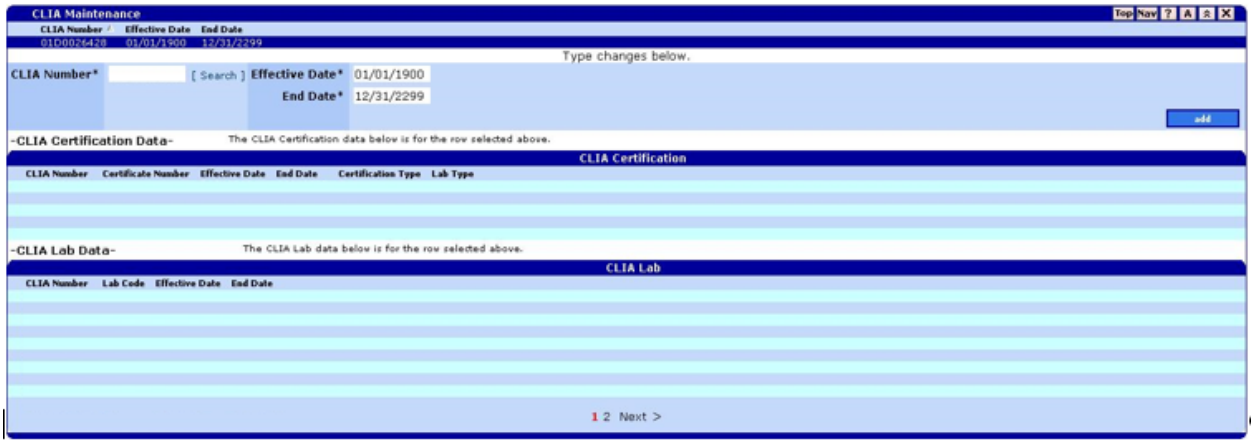
CLIA Maintenance Panel Overview

6.1.55 CLIA Maintenance Panel Narrative

The CLIA Maintenance panel is used to view and update provider Clinical Laboratory Improvement Act (CLIA) numbers and effective dates. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [CLIA Maintenance]

6.1.56 CLIA Maintenance Panel Layout



6.1.57 CLIA Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider Clinical Laboratory Improvement Act (CLIA) information.	Button	N/A	0
CLIA Number –[CLIA Certification Detail]	Provider's Clinical Laboratory Improvement Act (CLIA) identification number.	Field	Character	10
CLIA Number – [CLIA Lab Data]	Provider's Clinical Laboratory Improvement Act (CLIA) identification number.	Field	Character	10
Certificate Number [CLIA Certification Data]	Certificate number of the Clinical Laboratory Improvement Act (CLIA) number, 1 should be the most current.	Field	Number (Integer)	2
Certificate Type [CLIA Certification Data]	Clinical Laboratory Improvement Act (CLIA) certificate type.	Field	Number (Integer)	1
Effective Date (CLIA Certification Data and CLIA Lab Data)	Effective date for certificate and lab codes.	Field	Date (CCYYMMDD)	8

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Field	Description	Field Type	Data Type	Length
Effective Date	Provider's effective date of certification		Date (MM/DD/CCYY)	8
End Date (CLIA Certification Data and CLIA Lab Data)	End date for certificate and lab codes.	Field	Date (CCYYMMDD)	8
End Date	Provider's end date of certification.	Field	Date (MM/DD/CCYY)	8
Lab Code [CLIA Lab Data]	Valid lab codes for this Clinical Laboratory Improvement Act (CLIA) number.	Field	Number (Integer)	3
Lab Type [CLIA Certification Data]	Lab type code.	Field	Character	1

6.1.58 CLIA Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CLIA Number	Field	1	CLIA Number is required.	Verify keying. The CLIA Number field is required.
	Field	10	CLIA Number must be AlphaNumeric.	Verify keying. Entry must be 0-9 or A-Z.
	Field	18	CLIA Number must be 10 character(s) in length.	Verify keying. The CLIA Number must be 10 characters in length.
	Field	5000	Warning: There is no matching CLIA Number from CMS.	Verify keying. The CLIA Number entered is not on the CMS CLIA file. If it is correct select "OK" to save changes, otherwise select "Cancel".
Effective Date	Field	1	Effective Date is required.	Verify keying. Effective Date is required.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Verify keying. The Effective Date must be less than or equal to 12/31/2299.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. The Effective Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Enter Effective Date than is less than or equal to the End Date.
	Field	17	Date segments can not overlap.	Verify keying. The date segments of two rows with the same CLIA number can not overlap.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	End Date is required.	Verify keying. End Date is required.
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Enter End Date greater than or equal to Effective Date.
	Field	17	Date segments can not overlap.	Verify keying. The date segments of two rows with the same CLIA Number cannot overlap.

6.1.59 CLIA Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.60 CLIA Maintenance Panel Accessibility

6.1.60.1 To Access the CLIA Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **CLIA Maintenanc**e hyperlink on the Provider Maintenance panel.	CLIA Maintenance panel displays.

6.1.60.2 To Add on CLIA Maintenance Panel

Step	Action	Response
1	Click **Add**.	
2	Click [**Search**] to select a **CLIA number** from the list.	
3	Enter **Effective Date** in MM/DD/CCYY format.	

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Step	Action	Response
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	
5	Click **Save**.	CLIA Maintenance information is saved.

6.1.60.3 To Update on CLIA Maintenance Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	CLIA Maintenance information is saved.

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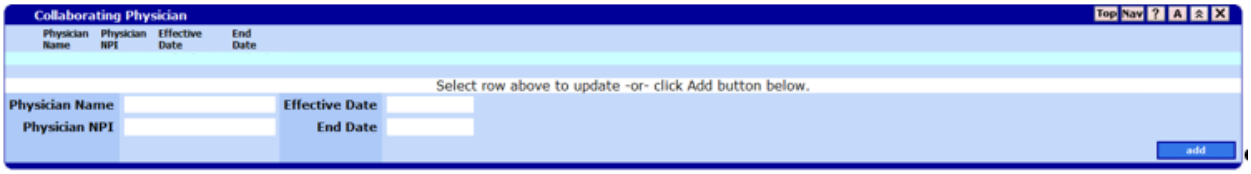
6.11 Collaborating Physician Panel Overview

6.11.1 Collaborating Physician Panel Narrative

This panel holds Supervising/Collaborating physician names and their NPI ID's.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Collaborating Physician]

6.11.2 Collaborating Physician Panel Layout



6.11.3 Collaborating Physician Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider collaborating physician information.	Button	N/A	0
Effective Date	This is the begin date for the supervising physician.	Field	Date (MM/DD/CCYY)	8
End Date	This is the end date for the supervising physician.	Field	Date (MM/DD/CCYY)	8
Physician Name	Person name for the physician that provides oversight for the provider.	Field	Character	50
Physician NPI	National Provider Identification # assigned to the collaborating physician.	Field	Character	15

6.11.4 Collaborating Physician Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Verify keying. Effective Date is required.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Verify keying. The Effective Date must be less than or equal to 12/31/2299.
	Field	3	Effective Date must be less than or equal to End Date.	Verify keying. Enter Effective Date than is less than or equal to the End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Date segments cannot overlap.	Verify keying. The date segments of two rows with the same collaborating Physician number cannot overlap.
End Date	Field	5	End Date is required.	Verify keying. End Date is required.
	Field	6	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	7	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	8	Effective Date must be less than or equal to End Date.	Verify keying. Enter End Date greater than or equal to Effective Date.
	Field	9	Date segments cannot overlap.	Verify keying. The date segments of two rows with the same CLIA Number cannot overlap.
Physician Name	Field	10	Physician Name is required.	Physician Name is required.
Physician NPI	Field	11	Physician NPI is required.	Physician NPI is required.

6.11.5 Collaborating Physician Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Collaborating Physician Panel Accessibility

6.11.6.1 To Access the Collaborating Physician Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Collaborating Physician** hyperlink on the Provider Maintenance panel.	Collaborating Physician panel displays.

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6.11.6.2 To Add on Collaborating Physician Panel

Step	Action	Response
1	Click **Add**.	
2	Enter **Physician Name**.	
3	Enter **Physician NPI**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format, if applicable.	
6	Click **Save**.	CLIA Maintenance information is saved.

6.11.6.3 To Update on Collaborating Physician Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Collaborating Physician information is saved.

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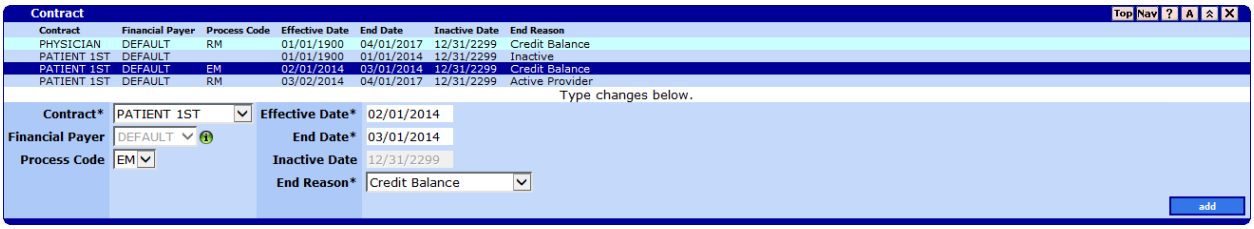
Contract Panel Overview

6.1.61 Contract Panel Narrative

The Contract panel is used to view or update provider contract enrollment information. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Contract] OR [Provider - Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Contract]

6.1.62 Contract Panel Layout



6.1.63 Contract Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider contract information.	Button	N/A	0
Contract	Name of the contract(s) in which the provider is or has been enrolled. Valid values include: Injection, Laboratory, Physician, Radiology and Outside State.	Combo Box	Drop Down List Box	0
Effective Date	Effective date of enrollment for the chosen contract.	Field	Date (MM/DD/CCYY)	8
End Date	Date enrollment was terminated for the chosen contract.	Field	Date (MM/DD/CCYY)	8
End Reason	Status of eligibility.	Combo Box	Drop Down List Box	0
Financial Payer	Financial payer.	Combo Box	Drop Down List Box	0
Inactive Date	Date enrollment of contract chosen is inactive.	Field	Date (MM/DD/CCYY)	8
Process Code	Hold the code, which indicates the reason for provider contract closure/reopen. Valid values for this field are EG, EM, RM and Blank.	Field	Drop Down List Box	2

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6.1.64 Contract Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Contract	Field	1	A valid Contract is required.	Select a Contract.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than or equal to 12/31/2299.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap for the same Contract and same End Reason.	Verify keying. Date segments cannot overlap for the same contract and same End Reason.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	4	End Date may not be greater than deceased date.	Verify that no End Dates are greater than the deceased date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap for the same Contract and same End Reason.	Verify keying. Date segments cannot overlap for the same contract and same End Reason.
End Reason	Field	1	A valid End Reason is required.	Select an End Reason.
	Field	3	End Reason must have 'Active' Status.	Must select an 'Active' status when Process Code is RM.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a contract. The Financial Payer automatically populates depending on the contract value chosen.

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Field	Field Type	Error Code	Error Message	To Correct
Inactive Date	Field	0	Inactive Date is required.	Verify keying. Panel requires entry of an End Date which is populated as the Inactive Date. Enter an End Date if not already entered.

6.1.65 Contract Panel Extra Features

Field	Field Type
A warning message "There are overlapping contract dates. Would you like to ignore overlaps?" will appear if date is overlap between same contract type but End reason is different.	

6.1.66 Contract Panel Accessibility

6.1.66.1 To Access the Contract Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **Contract** on the Provider Maintenance panel.	Contact panel displays.

6.1.66.2 To Add on Contract Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Select **Contract** from drop down list.	
3	Enter **Effective Date** of contract in MM/DD/CCYY format.	
4	Enter **End Date** of contract in MM/DD/CCYY format, if applicable.	
5	Enter **Inactive Date** of contract in MM/DD/CCYY format, if applicable.	
6	Select **End Reason** from drop down list, if applicable.	
7	Click **Save**.	Contract information is saved.

6.1.66.3 To Update the Contract Panel

Step	Action	Response

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1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Contract information is saved.

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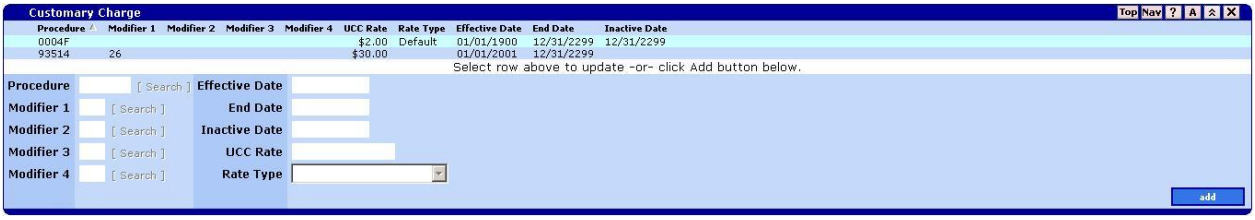
Customary Charge Panel Overview

6.1.67 Customary Charge Panel Narrative

The Customary Charge panel is used to update Usual Customary Charge (UCC) rates. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Customary Charge]

6.1.68 Customary Charge Panel Layout



6.1.69 Customary Charge Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider customary charge information.	Button	N/A	0
Effective Date	Effective date of Usual Customary Charge (UCC) rate.	Field	Date (MM/DD/CCYY)	8
End Date	End date of Usual Customary Charge (UCC) rate.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Inactive date of Usual Customary Charge (UCC) rate.	Field	Date (MM/DD/CCYY)	8
Modifier 1	Modifier code 1.	Field	Character	2
Modifier 2	Modifier code 2.	Field	Character	2
Modifier 3	Modifier code 3.	Field	Character	2
Modifier 4	Modifier code 4.	Field	Character	2
Procedure	Procedure code.	Field	Character	5
Rate Type	Usual and Customary Charge rate. Valid values include: Regular Medicaid, Rural Rate, Teaching Physician, Technical Component and Vaccines for Children.	Combo Box	Drop Down List Box	0
[Search]	Allows the user to search for a procedure code or modifier code.	Hyperlink	N/A	0
UCC Rate	Usual and Customary Charge Rate.	Field	Number (Decimal)	9

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6.1.70 Customary Charge Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same procedure code and modifier (if applicable) where the status code is Active.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same procedure code and modifier (if applicable) where the status code is Active.
Procedure	Field	29	A valid Procedure is required.	Search for or enter a valid Procedure Code.
UCC Rate	Field	15	UCC Rate must be greater than or equal to 0.01.	Verify keying. UCC Rate must be greater than zero.
	Field	16	UCC Rate must be less than or equal to 9999.99.	Verify keying. UCC Rate must be less than or equal to $9,999.99.

6.1.71 Customary Charge Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.72 Customary Charge Accessibility

6.1.72.1 To Access the Customary Charge Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.

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Step	Action	Response
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Customary Charge** hyperlink on the Provider Maintenance panel.	Customary Charge panel displays.

6.1.72.2 To Add on Customary Charge Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter a **Procedure code**; Or click [Search] to select a Procedure from the list.	
3	Enter a **Modifier 1** code; Or click [Search] to select a Modifier from the list.	
4	Enter a **Modifier 2** code; Or click [Search] to select a Modifier from the list.	
5	Enter a **Modifier 3** code; Or click [Search] to select a Modifier from the list.	
6	Enter a **Modifier 4** code; Or click [Search] to select a Modifier from the list.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format, if applicable.	
9	Enter **Inactive Date** in MM/DD/CCYY format, if applicable.	
10	Enter UCC Rate.	
11	Select **Rate Type** from drop down list.	
12	Click **Save**.	Customary Charge information is saved.

6.1.72.3 To Update on Customary Charge Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Customary Charge information is saved.

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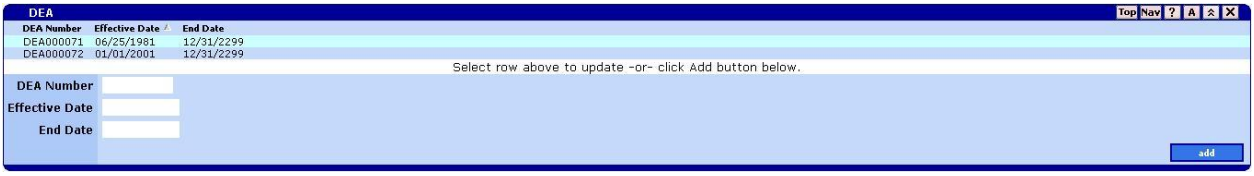
DEA Panel Overview

6.1.73 DEA Panel Narrative

The Drug Enforcement Agency (DEA) panel is used to view and update provider numbers and effective dates. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [DEA]

6.1.74 DEA Panel Layout



6.1.75 DEA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider Drug Enforcement Agency (DEA) information.	Button	N/A	0
DEA Number	Provider's Drug Enforcement Agency (DEA) number.	Field	Character	9
Effective Date	Effective date of Drug Enforcement Agency (DEA) number.	Field	Date (MM/DD/CCYY)	8
End Date	End date of Drug Enforcement Agency (DEA) number.	Field	Date (MM/DD/CCYY)	8

6.1.76 DEA Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
DEA Number	Field	1	DEA Number is required.	Enter a DEA number.
	Field	10	DEA Number must be Alphanumeric.	Verify keying. DEA number must be A-Z and/or 0-9.
	Field	18	DEA Number must be 9 character(s) in length.	Verify keying. The DEA number must be 9 characters in length.
	Field	19	DEA Number contains an invalid value.	Verify keying. DEA number must be greater than zero.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same DEA number.
End Date	Field	1	Effective Date is required.	Enter an End Date.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same DEA number.

6.1.77 DEA Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.78 DEA Panel Accessibility

6.1.78.1 To Access the DEA Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **DEA** hyperlink on the Provider Maintenance panel.	DEA panel displays.

6.1.78.2 To Add on DEA Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter DEA Number.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	

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Step	Action	Response
5	Click **Save**.	DEA information is saved.

6.1.78.3 To Update on DEA Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	DEA information is saved.

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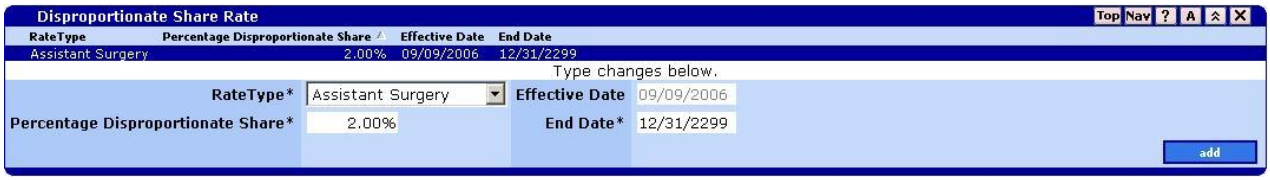
Disproportionate Share Rate Panel Overview

6.1.79 Disproportionate Share Rate Panel Narrative

The Disproportionate Share Rate panel provides information regarding expenditures that were automatically generated by the system to meet this disproportionate share payment. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Disproportionate Share Rate]

6.1.80 Disproportionate Share Rate Panel Layout



6.1.81 Disproportionate Share Rate Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add disproportionate share rate information.	Button	N/A	0
Effective Date	Effective date of the disproportionate share percentage.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the disproportionate share percentage.	Field	Date (MM/DD/CCYY)	8
Percentage Disproportionate Share	Disproportionate share in percentage with four decimals.	Field	Number (Decimal)	4
Rate Type	Rate Type. Valid values include: Regular Medicaid, Rural Rate, Teaching Physician, Technical Component and Vaccines for Children.	Comb o Box	Drop Down List Box	0

6.1.82 Disproportionate Share Rate Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective date must be less than or equal to 12/31/2299.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Enter an Effective Date greater than 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same rate code.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. The End Date must be less than or equal to 12/31/2299.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. Enter an Effective Date greater than 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same rate code.
Percentage Disproportionate Share	Field	15	Percentage Disproportionate Share must be greater than or equal to 00.01.	Verify keying. The percentage must be greater than zero.
	Field	16	Percentage Disproportionate Share must be less than or equal to 999.9900.	Verify keying. The percentage cannot exceed 999.99%.
Rate Type	Field	1	Rate Type is required.	Choose a Rate Type.

6.1.83 Disproportionate Share Rate Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.84 Disproportionate Share Rate Panel Accessibility

6.1.84.1 To Access the Disproportionate Share Rate Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.

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Step	Action	Response
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Disproportionate Share Rate** hyperlink on the Provider Maintenance panel.	Disproportionate Share Rate panel displays.

6.1.84.2 To Add on Disproportionate Share Rate Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Rate Type** from drop down list.	
3	Enter Percentage Disproportionate Share.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format, if applicable.	
6	Click **Save**.	Disproportionate Share Rate information is saved.

6.1.84.3 To Update on Disproportionate Share Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Disproportionate Share Rate information is saved.

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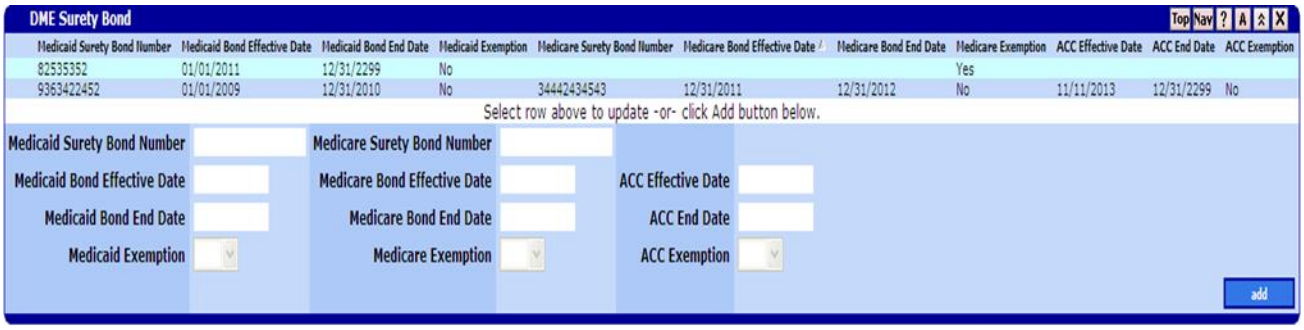
DME Surety Bond Panel Overview

6.1.85 DME Surety Bond Panel Narrative

The Agency and HP Enterprise Services use the DME Surety Bond panel to view and update provider bond numbers and effective/end dates.

Navigation Path: [Provider] – [Search] - [select row from search results] - [DME Surety Bond]

6.1.86 DME Surety Bond Panel Layout



6.1.87 DME Surety Bond Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ACC Effective Date[Detail]	Effective date of accreditation. Used to signify the start of a span or period related to the Accreditation.	Field	Date (MM/DD/CCYY)	8
ACC Effective Date [List]	Effective date of accreditation. Used to signify the start of a span or period related to the Accreditation.	Field	Date (MM/DD/CCYY)	8
ACC End Date [Detail]	End date of accreditation. Used to signify the end of a span or period related to the Accreditation.	Field	Date (MM/DD/CCYY)	8
ACC End Date [List]	End Date of accreditation. Used to signify the end of a span or period related to the Accreditation.	Field	Date (MM/DD/CCYY)	8
ACC Exemption [Detail]	Indicator showing a provider's exemption status for an ACC certificate	Comb o Box	Drop Down List Box	3
ACC Exemption [Detail]	Indicator showing a provider's exemption status for an ACC certificate	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider DME Surety Bond information.	Button	N/A	0
Medicaid Bond Effective Date [Detail]	Effective date of Medicaid Surety Bond. Used to signify the start of a span or period related to the Surety Bond.	Field	Date (MM/DD/CCYY)	8
Medicaid Bond Effective Date [List]	Effective date of Medicaid Surety Bond. Used to signify the start of a span or period related to the Surety Bond.	Field	Date (MM/DD/CCYY)	8
Medicaid Bond End Date [Detail]	End date of Medicaid Surety Bond. Used to signify the end of a span or period related to the Surety Bond.	Field	Date (MM/DD/CCYY)	8
Medicaid Bond End Date [List]	End date of Medicaid Surety Bond. Used to signify the end of a span or period related to the Surety Bond.	Field	Date (MM/DD/CCYY)	8
Medicaid Exemption [Detail]	Indicator showing a provider's exemption status for a Medicaid Surety Bond.	Combo Box	Drop Down List Box	0
Medicaid Exemption [List]	Indicator showing a provider's exemption status for a Medicaid Surety Bond.	Field	Character	3
Medicaid Surety Bond Number [Detail]	Medicaid Bond Number shown on certificate.	Field	Character	15
Medicaid Surety Bond Number [List]	Medicaid Bond Number shown on certificate.	Field	Character	15

6.1.88 DME Surety Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ACC Effective Date [Detail]	Field	1	ACC Effective Date must be greater than or equal to 1/1/1900.	Verify keying. ACC Effective Date must be greater than 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	ACC Effective Date must be less than or equal to ACC End Date.	Verify keying. ACC Effective Date must be less than or equal to the ACC End Date.
	Field	3	ACC Date segments cannot overlap.	Verify keying. ACC Date Segments cannot overlap.
	Field	4	ACC Effective Date must be less than or equal to 12/31/2299.	Verify keying. ACC Effective Date must be less than 12/31/2299.
	Field	5	Medicare Accreditation dates required for a Non-Exempt Provider	Enter ACC Effective Date which must be less than 12/31/2299
	Field	6	Medicare Accreditation dates NOT required for an Exempt Provider	Delete ACC Effective Date
	Field	7	Medicare Accreditation dates NOT required for Non-DME Provider	Delete ACC Effective Date
ACC End Date [Detail]	Field	1	ACC End Date must be greater than or equal to 1/1/1900.	Verify keying. ACC End date must be greater than 1/1/1900.
	Field	2	ACC End Date must be less than or equal to 12/31/2299.	Verify keying. ACC End date must be less than 12/31/2299.
	Field	3	Medicare Accreditation dates required for a Non-Exempt Provider	Enter ACC End Date which must be less than 12/31/2299
	Field	4	Medicare Accreditation dates NOT required for an Exempt Provider	Delete ACC End Date
	Field	5	Medicare Accreditation dates NOT required for Non-DME Provider	Delete ACC End Date
Medicaid Bond Effective Date [Detail]	Field	1	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	3	DME Surety Bond Date segments cannot overlap.	Verify keying. DME Surety Date segments cannot overlap.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than 12/31/2299.
	Field	5	Medicaid Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicaid Bond Effective Date which must be less than 12/31/2299
	Field	6	Medicaid Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicaid Bond Effective Date
	Field	7	Medicaid Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicaid Bond Effective Date
Medicaid Bond End Date [Detail]	Field	1	End Date must be greater than or equal to 1/1/1900.	Verify keying. End Date must be greater than 1/1/1900.
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than 12/31/2299.
	Field	3	Medicaid Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicaid Bond End Date which must be less than 12/31/2299
	Field	4	Medicaid Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicaid Bond End Date
	Field	5	Medicaid Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicaid Bond End Date

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Field	Field Type	Error Code	Error Message	To Correct
Medicaid Surety Bond Number [Detail]	Field	1	Medicaid Bond Number contains an invalid value.	Verify keying. Surety Bond Number must be greater than zero.
	Field	2	Medicaid Bond Number must be Alphanumeric.	Verify keying. Surety Bond Number must be A-Z and/or 0-9.
	Field	3	Required input must be between 3 And 15.	Verify keying. Length of Surety Bond Number must be between 3 and 15.
	Field	4	Medicaid Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicaid Surety Bond Number
	Field	5	Medicaid Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicaid Surety Bond Number
	Field	6	Medicaid Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicaid Surety Bond Number.
Medicare Bond Effective Date [Detail]	Field	1	Medicare Bond Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Medicare Bond Effective Date must be greater than 1/1/1900.
	Field	2	Medicare Bond Effective Date must be less than or equal to Medicare Bond End Date.	Verify keying. Medicare Bond Effective Date must be less than or equal to the Medicare End Date.
	Field	3	Medicare Date segments cannot overlap.	Verify keying. Medicare Bond Date Segments cannot overlap.
	Field	4	Medicare Bond Effective Date must be less than or equal to 12/31/2299.	Verify keying. Medicare Bond Effective Date must be less than 12/31/2299.
	Field	5	Medicare Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicare Bond Effective Date

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6	Medicare Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicare Bond Effective Date
	Field	7	Medicare Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicare Bond Effective Date
Medicare Bond End Date [Detail]	Field	1	Medicare Bond End Date must be greater than or equal to 1/1/1900.	Verify keying. Medicare Bond End Date must be greater than 1/1/1900.
	Field	2	Medicare Bond End Date must be less than or equal to 12/31/2299.	Verify keying. Medicare Bond End Date must be less than 12/31/2299.
	Field	3	Medicare Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicare Bond End Date
	Field	4	Medicare Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicare Bond End Date
	Field	5	Medicare Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicare Bond End Date
Medicare Surety Bond Number [Detail]	Field	1	Medicare Bond Number contains an invalid value.	Verify keying. Medicare Bond Number must be greater than zero.
	Field	2	Medicare Bond Number must be Alphanumeric.	Verify keying. Medicare Bond Number must be A-Z and/or 0-9.
	Field	3	Required input must be between 3 And 15.	Verify keying. Length of Medicare Bond Number must be between 3 and 15.
	Field	4	Medicare Surety Bond Number and dates required for a Non-Exempt Provider	Enter Medicare Surety Bond Number

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Medicare Surety Bond Number and dates NOT required for an Exempt Provider	Delete Medicare Surety Bond Number
	Field	6	Medicare Surety Bond Number and dates NOT required for Non-DME Provider	Delete Medicare Surety Bond Number

6.1.89 DME Surety Bond Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.90 DME Surety Bond Panel Accessibility

6.1.90.1 To Access the DME Surety Bond Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click Search; Or click Search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **DME Surety Bond** hyperlink on the Provider Maintenance panel.	DME Surety Bond panel displays.

6.1.90.2 To Add on DME Surety Bond Panel

To Add on DME Surety Bond Pane

Step	Action	Response
1	Click Add.	Activates fields for entry of data or selection from lists.
To Enter a Non-Exempt Provider (Medicaid Exemption)		
1	Select “No” in Medicaid Exemption Dropdown Box	
2	Enter Surety Bond Number.	Medicaid Bond End Date will be populated with the date 12/31/2299 (This date can be modified)

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Step	Action	Response
3	Enter Effective Date in MM/DD/CCYY format.	
4	Enter/Modify End Date in MM/DD/CCYY format.	
To Enter a Non-Exempt Provider (ACC Exemption)		
1	Select "No" in ACC Exemption Dropdown Box	
2	Enter ACC Effective Date in MM/DD/CCYY format	ACC End Date will be populated with the date 12/31/2299 (/This date can be modified)
3	Enter/Modify ACC End Date in MM/DD/CCYY format.	
To Enter a Non-Exempt Provider (Medicare Exemption)		
1	Select "No" in Medicare Exemption Dropdown Box	
2	Enter Medicare Bond Effective Date in MM/DD/CCYY format	Medicare Bond End Date will be populated with the date 12/31/2299 (This date can be modified)
3	Enter/Modify Medicare Bond End Date in MM/DD/CCYY format.	
To Enter an Exempt Provider (Medicaid, Medicare or ACC Exemption)		
1	Select "Yes" in the Exemption Dropdown Box	
2	Do not enter data in Bond Number or Date Boxes	
To Enter a Non-DME Provider (Medicaid, Medicare or ACC)		
1	Leave/Select the Default selection (blank selection) in the Dropdown Box	
2	Do not enter Data in Bond Number or Date Boxes.	
Click Save after making the required selections as outlined above		DME Surety Bond information is saved

6.1.90.3 To Update on DME Surety Bond Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click Save.	DME Surety Bond information is saved.

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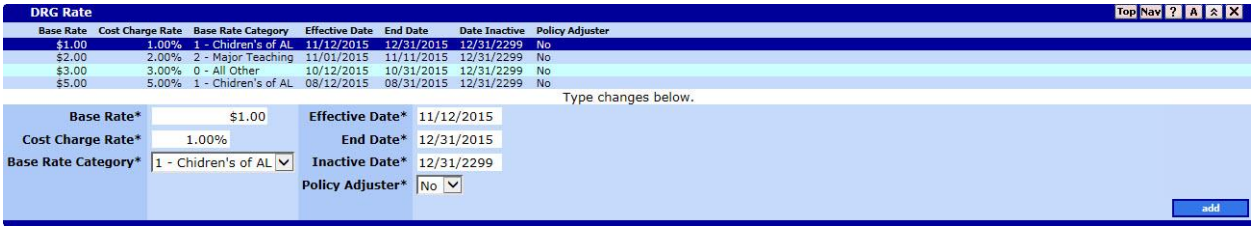
DRG Rate Panel Overview

6.1.91 DRG Rate Panel Narrative

The DRG Rate panel is used to create and update Provider Diagnosis Related Group rates.

Navigation Path: [Provider - Search] - [select row from search results] - [DRG Rate]

6.1.92 DRG Rate Panel Layout



6.1.93 DRG Rate Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a DRG Rate.	Button	N/A	0
Base Rate	Amount for the current Rate. Format 99999999.99.	Field	Number (Decimal)	10
Base Rate Category	Base Rate Category: 0=All Other; 1=Children's of AL; 2=Major Teaching; 3 = USA Women's and Children's.	Field	Drop Down List Box	1
Cost Charge Rate	Percentage to be charged. Format 999.99.	Field	Number (Decimal)	5
Effective Date	The date on which a DRG rate segment becomes applicable.	Field	Date (MM/DD/CCYY)	8
End Date	The date after which the DRG rate segment is no longer applicable.	Field	Date (MM/DD/CCYY)	8
Inactive Date	This is the date the rate can no longer be used for the current Provider ID, regardless of the dates of service on the claim.	Field	Date (MM/DD/CCYY)	0
Policy Adjuster	Policy Adjuster is a Y or N value. Yes means the DRG policy adjustors (multipliers) apply to claims from that provider; No is the Default and means the DRG policy adjustors do not apply to claims from that provider.	Field	Drop Down List Box	1

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6.1.94 DRG Rate Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Base Rate	Field	1	Base Rate is required.	Enter a base rate.
	Field	200	Base Rate must be greater than zero.	Verify the Base Rate it must be greater than zero.
	Field	91001	Enter a valid value.	The value must be in 99999999.99 format
Base Rate Category	Field	1	Base Rate Category is required.	Select a base rate category.
Cost Charge Rate	Field	1	Cost Charge Rate is required.	Enter a cost charge rate.
	Field	100	Cost Charge Rate must be greater than zero.	Verify the Cost Charge Rate it must be greater than zero.
	Field	91001	Enter a valid value.	The value must be in 999.99 format
Effective Date	Field	1	Effective Date is required.	Enter an effective date.
	Field	2	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective date must be greater than 1/1/1900
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective date must be less than 12/31/2299.
	Field	4	Acute Care specialty date range not within DRG Rate date range.	Verify keying. Date range of DRG Rates must cover the date range of Acute Care specialty.
	Field	8012	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be >= to Effective Date.
	Field	91001	Invalid date. Format is mm/dd/yyyy.	The date must be in MM/DD/CCYY format.
	Field	91030	DRG Rate Date segments cannot overlap.	Verify dates against existing segment. DRG code "0" means all DRGs, therefore if there is a segment with DRG code "0", then you cannot enter a DRG code for those date segments.
End Date	Field	1	End Date is required	Enter an end date.
	Field	2	End Date must be greater than or equal to 1/1/1900.	Verify keying. End date must be greater than 1/1/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End date must be less than 12/31/2299.

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6.1.95 DRG Rate Panel Extra Features

Field	Field Type
A warning message “Out of State provider does not require DRG Rate.” will appear if an out-of-state provider has a DRG Rate on record. An error message "DRG Rate required for Acute Care Hospitals." will appear if a hospital-type provider with an Acute Care specialty does not have a DRG Rate on record.	

6.1.96 DRG Rate Panel Accessibility

6.1.96.1 To Access the DRG Rate Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **DRG Rate** hyperlink on the Provider Maintenance panel.	DRG Rate panel displays.

6.1.96.2 To Add on DRG Rate Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update **Base Rate** in 99999999.99 format.	
3	Update **Cost Charge Rate** in 999.99 format	
4	Select **Base Rate Category** from the drop down list	
5	Update **Effective Date** in MM/DD/CCYY format.	
6	Update **End Date** in MM/DD/CCYY format.	
7	Update **Inactive Date** in MM/DD/CCYY format	
8	Select the **Policy Adjuster** from the drop down list.	
9	Enter data in remaining fields as required.	
10	Click **Save**.	Provider DRG Rate information is saved.

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6.1.96.3 To Update on DRG Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click field to update and perform update.	
3	Click **Save**.	Provider DRG Rate is saved.

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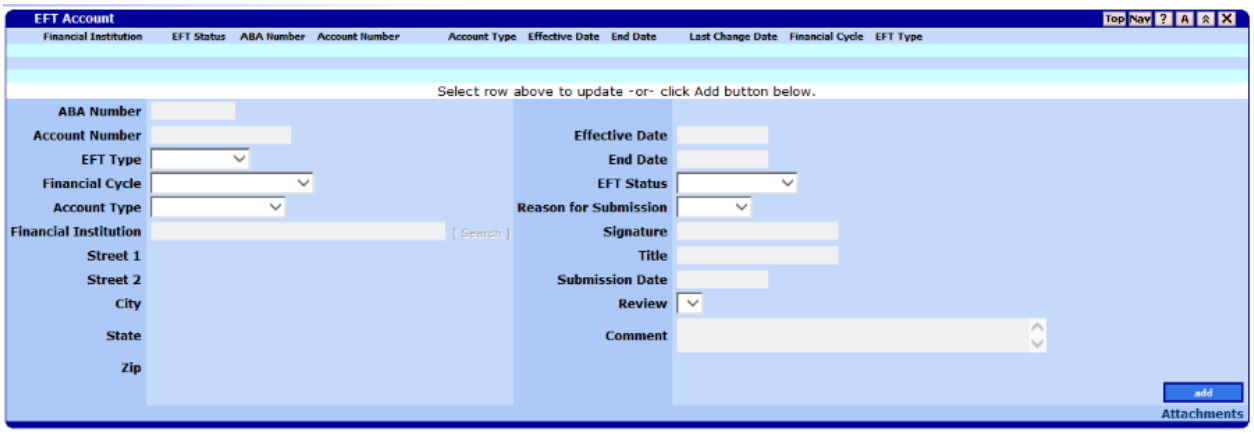
EFT Account Panel Overview

6.1.97 EFT Account Panel Narrative

The EFT Account panel is used to capture Electronic Funds Transfer (EFT) information for providers who wish to receive their payments via EFT. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [EFT Account]

6.1.98 EFT Account Panel Layout



6.1.99 EFT Account Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ABA Number	Indicates the provider's bank routing number to which the Electronic Funds Transfer (EFT) is transferred. The American Bankers Association (ABA) number can be duplicated in a provider's EFT file. Once an ABA number is changed to an active status, the field is protected.	Field	Character	9
Account Number	Indicates the provider's bank account number. When two Electronic Funds Transfer (EFT) entries in a specific provider's file have the same American Bankers Association (ABA) number, the account numbers cannot be the same. Once an account number is changed to an active status, the field is protected.	Field	Character	14
Account Type	Indicates the account type. Valid values include: Checking, Savings and Transfer-State.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider Electronic Funds Transfer (EFT) information.	Button	N/A	0
City	City of the financial institution.	Field	Character	15
Comment	Free form text field where users may provide details about the review reason, associated document number, etc.	Field	Character	50
Effective Date	Indicates the date when the Electronic Funds Transfer (EFT) information becomes active. This date will generate to today's date. If we start during pre-notifications in the future, this date should be no less the 18 days in the future.	Field	Date (MM/DD/CCYY)	8
EFT Status	Indicates the status of the Electronic Funds Transfer (EFT). The EFT status can be changed from any status except canceled.	Combo Box	Drop Down List Box	0
EFT Type	Type of Electronic Funds Transfer (EFT). Valid values include: Deposit.	Combo Box	Drop down List Box	0
End Date	Indicates the date when an Electronic Funds Transfer (EFT) entry will end. Before a new entry can be saved, the End Date associated with any open entries must be updated if the Effective Date of the new entry overlaps with an End Date of any conflicting entries. The End Date can be updated when the entry is in any status except canceled.	Field	Date (MM/DD/CCYY)	8
Financial Cycle	Indicates the financial cycle.	Combo Box	Drop Down List Box	0
Financial Institution	Name of the financial institution.	Field	Character	39
Reason for Submission	Indicates if submission was for the following reasons: N=New C=Change X=Cancel.	Combo Box	Drop Down List Box	1
Review	Indicates if a provider's EFT has ended due to investigation, or if suspension has been lifted.	Combo Box	Drop Down List Box	1
Signature	Electronic Signature of Person Submitting Enrollment.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Submission Date	Submission Date of Application.	Field	Date (MM/DD/CCYY)	8
Title	Printed Title of Person Submitting Enrollment.	Field	Character	40
State	State of the financial institution.	Field	Character	2
Street 1	Street address 1 of the financial institution.	Field	Character	30
Street 2	Street address 2 of the financial institution.	Field	Character	30
Zip	Zip code of the financial institution.	Field	Character	5
Zip + 4	Zip code extension of the financial institution.	Field	Character	4

6.1.100 EFT Account Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ABA Number	Field	1	ABA Number is required.	Validate keying. Enter a valid ABA Number.
	Field	2	Invalid Financial Institution.	Verify keying. ABA Number entered does not relate to Financial Institutions on file.
	Field	3	Account Number is not allowed for State Transfers.	For a State Transfer this field is not allowed. Please remove data.
Account Number	Field	3	For a State Transfer this field is not allowed. Please remove data.	Account Number is not allowed for State Transfers.
Account Type	Combo Box	1	Account Type is required.	Select an account type.
Comment	Field	1	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 50 characters.	Enter not more than 50 characters in comment box.
EFT Status	Combo Box	0	EFT Status can be changed from Active to Cancel only.	Validate keying. If previous status was Active, it can only be changed to Cancel.
	Combo Box	1	EFT Status is required.	Select an EFT status.

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Field	Field Type	Error Code	Error Message	To Correct
	Combo Box	2	Cannot change status to Active.	Validate keying. If previous status was Cancelled or Interrupt, then status cannot be changed to Active.
	Combo Box	3	Pending status allowed only when the present status is Interrupt.	Verify selection. If present status is not Interrupt, status cannot be changed to Pending.
Effective Date	Field	1	Effective Date is required.	Validate keying. Enter the appropriate Effective Date.
	Field	5	Effective Date must be at least Today.	Validate keying. The Effective Date cannot be less than today's date.
	Field	16	Effective Date must be less than or equal to End Date.	Validate keying. Correct the Effective or End Date.
	Field	17	Date segments cannot overlap.	Correct segment. EFT segments have overlapping dates.
	Field	19	Effective date must be less than or equal to 12/31/2299.	Verify keying. Enter a date less than or equal to 12/31/2299.
	Field	20	Invalid date. Format is mm/dd/ccyy.	Enter a valid date of the year using 8 digits or in the stated format.
End Date	Field	1	End Date is required.	Validate keying. Enter the appropriate End Date.
	Field	4	End Date cannot be 12/31/2299 for canceled status.	Please enter the correct End Date for this segment.
	Field	16	Effective Date must be less than or equal to End Date.	Validate keying. Correct the Effective or End Date.
	Field	17	Date segments cannot overlap.	Correct segment. EFT segments have overlapping dates.
	Field	19	End Date must be less than or equal to 12/31/2299.	Verify keying. Enter an End Date that is less than or equal to 12/31/2299.
	Field	20	End Date must be greater than today.	Validate keying. The end date cannot be less than or equal to today's date.
	Field	21	Invalid date. Format is mm/dd/ccyy.	Enter a valid date of the year using 8 digits or in the stated format.

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Field	Field Type	Error Code	Error Message	To Correct
Financial Cycle	Field	1	Financial Cycle is required.	Select a Financial Cycle.
	Combo Box	2	Verify the Financial Cycle selected is appropriate. A user should normally select Main Financial Cycle.	Select the checkbox and click on Continue.
Submission Date	Field	1	Submission Date must be less than or equal to 12/31/2299.	Please enter a valid Submission date that is greater than 12/31/1889 and less than or equal to 12/31/2299.
	Field	2	Submission Date must be greater than or equal to 1/1/1900.	Please enter a valid Submission date that is less than 01/01/2300 and greater than or equal to 12/31/1900.
	Field	3	Invalid date. Format is mm/dd/ccyy.	Please enter a valid date using 8 digits only or in the format mm/dd/ccyy.

6.1.101 EFT Account Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.102 EFT Account Panel Accessibility

6.1.102.1 To Access the EFT Account Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **EFT Account** hyperlink on the Provider Maintenance panel.	EFT Account panel displays.

6.1.102.2 To Add on EFT Account Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Click [**Search**] to select a Financial Institution from the list.	ABA Number, Financial Institution, Street 1, Street 2, City, State and Zip+4 associated to institution selected from list populates.
3	Enter **Account Number**.	
4	Select **EFT Type** from drop down list.	
5	Select **Financial Cycle** from drop down list.	
6	Select **Account Type** from drop down list.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format, if applicable.	
9	Select **Reason for Submission** from drop down list, if available.	
10	Enter **Signature**, if available.	
11	Enter **Title**, if available.	
12	Enter **Submission Date**, if available.	
13	Select **Review** reason from drop down list, if available.	
14	Enter **Comment**, if available.	
15	Click **Save**.	EFT Account information is saved.

6.1.102.3 To Update on EFT Account Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	EFT Account information is saved.

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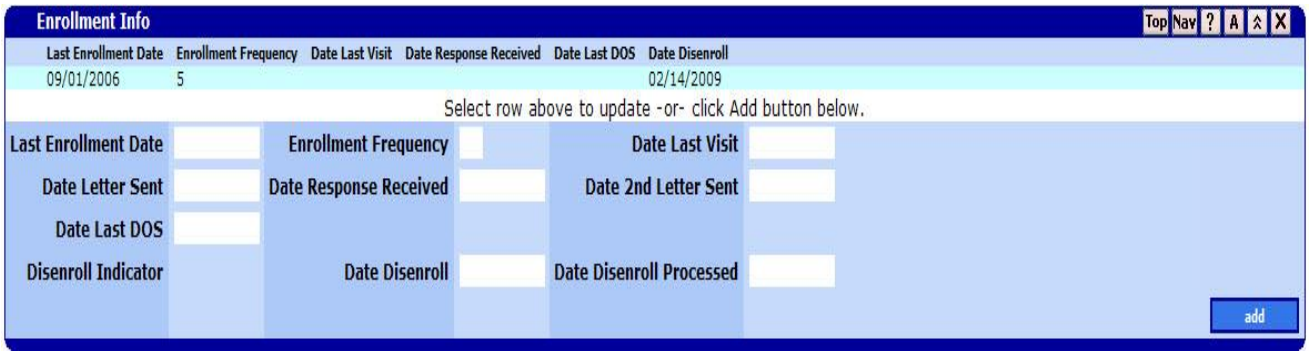
Enrollment Info Panel Overview

6.1.103 Enrollment Info Panel Narrative

The Provider Enrollment Info panel is used to view or maintain provider enrollment information

Navigation Path: [Provider - Search] - [select row from search results] - [Enrollment Info]

6.1.104 Enrollment Info Panel Layout



6.1.105 Enrollment Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider Enrollment information.	Button	N/A	0
Date 2nd Letter Sent	Date second re-enrollment letter sent to Provider.	Field	Date (MM/DD/CCYY)	8
Date Disenroll	Date used to update Provider's contracts end date when End Reason is Prov. Purge/De-activate.	Field	Date (MM/DD/CCYY)	8
Date Disenroll Processed	Date Provider disenrollment/de-activation process ran.	Field	Date (MM/DD/CCYY)	8
Date Last DOS	Most recent DOS from paid claim, in which provider was billing, performing, or rendering Provider.	Field	Date (MM/DD/CCYY)	8
Date Last Visit	Date of last site visit for Providers.	Field	Date (MM/DD/CCYY)	8
Date Letter Sent	Date re-enrollment letter sent to Provider.	Field	Date (MM/DD/CCYY)	8
Date Response Received	Date Provider re-enrollment response received.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Disenroll Indicator	Indicator of whether disenrollment was through: Valid options include: C = Inactive prior to Conversion D = De-activation E = Enrolled F = Failure to re-enroll O = Other P = Pending De-activation X = Exclude from De-activation/Disenrollment.	Field	Character	1
Enrollment Frequency	Frequency that re-enrollment is required.	Field	Character	1
Last Enrollment Date	Date Provider last enrolled.	Field	Date (MM/DD/CCYY)	8

6.1.106 Enrollment Info Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Disenroll	Field	1	Date Disenroll[xx/xx/xxxx 12:00:00 AM] must be greater than Last Enrollment Date[xx/xx/xxxx 12:00:00 AM] and Date Disenroll[xx/xx/xxxx 12:00:00 AM] must be greater than or equal to Date Response Received[xx/xx/xxxx 12:00:00 AM]	Enter a valid date which is greater than Last Enrollment Date and greater than or equal to Date Response Received.
	Field	4	Date Disenroll[xx/xx/xxxx 12:00:00 AM] must be greater than or equal to Date Response Received[xx/xx/xxxx 12:00:00 AM]	Enter a valid date which is greater than or equal to Date Response Received.
	Field	5	Date Disenroll must be less than or equal to 12/31/2299.	Enter a valid date which is less than or equal to 12/31/2299.
	Field	6	Date Disenroll must be greater than or equal to 1/1/1900.	Enter a valide date which is greater than or equal to 1/1/1900.
Date Last Visit	Field	7	Date Last Visit must be less than or equal to 12/31/2299.	Enter a valid date which is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	8	Date Last Visit must be greater than or equal to 1/1/1900.	Enter a valid date which is greater than or equal to 1/1/1900.
	Field	12	Date Last Visit[xx/xx/xxxx 12:00:00 AM must be greater than Date Letter Sent[xx/xx/xxxx 12:00:00 AM]	Enter valid Date Last Visit which is greater than Date Letter Sent.
Date Response Received	Field	3	Date Response Received [xx/xx/xxxx 12:00:00 AM] must be greater than Date Letter Sent [xx/xx/xxxx12:00:00 AM]	Enter valid date for Date Response Received.
	Field	11	Date Response Received must be less than or equal to 12/31/2299.	Enter a valid date which is less than or equal to 12/31/2299.
Last Enrollment Date	Field	2	Last Enrollment Date xx/xx/xxxx cannot be less than Current Date.	Enter a valid date which is greater than current date for Last Enrollment Date.
	Field	9	Last Enrollment Date must be less than or equal to 12/31/2299.	Enter a valid date which is less than or equal to 12/31/2299.
	Field	10	Last Enrollment Date must be greater than or equal to 1/1/1900.	Enter a valid date which is greater than or equal to 1/1/1900.

6.1.107 Enrollment Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.108 Enrollment Info Panel Accessibility

6.1.108.1 To Access the Enrollment Info Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.

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Step	Action	Response
5	Click **Enrollment Info** hyperlink on the Provider Maintenance panel.	Enrollment Info panel displays.

6.1.108.2 To Add on Enrollment Info Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update **Last Enrollment Date** in MM/DD/CCYY format if required.	
3	Click **Save**.	Provider Enrollment information is saved.

6.1.108.3 To Update on Enrollment Info Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click field to update and perform update.	
3	Click **Save**.	Provider Enrollment information is saved.

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Group Panel Overview

6.1.109 Group Panel Narrative

The Group panel is used to view or update a group's members. A group member provider cannot be a group at the same service location. Therefore, if a provider is a group member the Group link is not available. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Group]

6.1.110 Group Panel Layout

6.1.111 Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider group information.	Button	N/A	0
Effective Date	Group membership effective date.	Field	Date (MM/DD/CCYY)	8
End Date	End date of group membership.	Field	Date (MM/DD/CCYY)	8
Member ID	Groups provider identification number.	Field	Character	9
Member ID Type	Member identification type.	Field	Character	3
Member Name	The name of the group.	Field	Character	50
[Search]	Allows the user to perform a search for a Member ID.	Hyperlink	N/A	0

6.1.112 Group Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same member provider number and service location.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same member provider number and service location.
Member Number	Field	5000	Both a Provider ID & Location Code is needed.	Enter a member Provider ID and service location or search and select a member.
	Field	5003	You cannot have a member that's a group.	Verify keying. The member Provider ID and service location entered is a group. A group provider cannot be a member.

6.1.113 Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.114 Group Panel Accessibility

6.1.114.1 To Access the Group Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Group** hyperlink on the Provider Maintenance panel.	Group panel displays.

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6.1.114.2 To Add on Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [**Search**] to select a **Member ID** from the list.	Member Name populates.
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	
5	Click **Save**.	Group information is saved.

6.1.114.3 To Update on Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Group information is saved.

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Group Member Panel Overview

6.1.115 Group Member Panel Narrative

The Group Member panel is used to view or update provider enrollment in a group or in multiple groups if applicable. A group provider cannot be a member at the same service location. Therefore, if a provider is in a group the Group Member link will not be available. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider– [Search] - [select row from search results] - [Group Member]

6.1.116 Group Member Panel Layout

6.1.117 Group Member Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider group member information.	Button	N/A	0
Effective Date	Group membership effective date.	Field	Date (MM/DD/CCYY)	8
End Date	End date of group membership.	Field	Date (MM/DD/CCYY)	8
Group Member ID	Group member's provider identification number.	Field	Character	9
Group Member ID Type	Group member's provider identification type.	Field	Character	3
Group Member Name	The name of the group member.	Field	Character	50
[Search]	Allows a user to perform a detailed search for a Group Member ID using Provider ID, Business OR Last Name, and First, MI.	Hyperlink	N/A	0

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6.1.118 Group Member Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same group Provider ID and service location.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same group Provider ID and service location.
Group Number	Field	5002	There is no Provider in the system with that ID & Location Code.	Verify keying. Group Provider ID and service location does not exist.
	Field	5003	You cannot have a group that's a member.	Verify keying. The Group Provider ID and service location you have entered is a member. Please enter a group Provider ID and service location.

6.1.119 Group Member Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.120 Group Member Panel Accessibility

6.1.120.1 To Access the Group Member Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.

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Step	Action	Response
5	Click **Group Member** hyperlink on the Provider Maintenance panel.	Group Member panel displays.

6.1.120.2 To Add on Group Member Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to select a **Group Member ID** from the list.	Group Member Name populates.
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	
5	Click **Save**.	Group Member information is saved.

6.1.120.3 To Update on Group Member Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Group Member information is saved.

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Provider Group Type Panel Overview

6.1.121 Provider Group Type Panel Narrative

The Provider Group Type panel shows all the respective data of Provider Group Type based on the Provider ID.

This panel is display only.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Provider Group Type]

6.1.122 Provider Group Type Panel Layout

6.1.123 Provider Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the provider type.	Field	Alphanumeric	50
Effective Date	The date of service on which the provider becomes valid for the provider group.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service on which the provider becomes is no longer valid for the provider group.	Field	Date (MM/DD/CCYY)	8
Provider Group Type	System assigned key for a unique provider group that represents a single or collection of provider codes.	Field	Number (Integer)	9
Provider ID	Internal key for a unique program or provider.	Field	Character	15

6.1.124 Provider Group Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.125 Provider Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.126 Provider Group Type Panel Accessibility

6.1.126.1 To Access the Provider Group Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Provider Group Type** hyperlink on the Provider Maintenance panel.	Provider Group Type panel displays.

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IDs Panel Overview

6.1.127 IDs Panel Narrative

The Agency and HPE use the Provider ID panel to view and update provider numbers and effective dates.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [IDs]

6.1.128 IDs Panel Layout

6.1.129 IDs Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider identification information.	Button	N/A	0
Default NPI Service Location	Default NPI Service Location. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove provider identification information.	Button	N/A	0
Effective Date	The effective date of the provider.	Field	Date (MM/DD/CCYY)	8
End Date	The end date of the provider.	Field	Date (MM/DD/CCYY)	8
End Date Reason	The reason for the end date.	Combo Box	Drop Down List Box	0
End Date Reason Code	The reason for the end date.	Field	Character	0
ID Type	Identification type associated with Provider ID. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
NPI Verified	Indicates if NPI was verified. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Provider ID	Medicaid, NPI or other provider number.	Field	Alphanumeric	10

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6.1.130 IDs Panel Field Edit Error

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	12	Effective Date is required.	Enter an Effective Date of the ID.
	Field	55	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Enter a date greater than or equal to 01/01/1900.
	Field	56	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Enter a date less than or equal to 12/31/2299.
	Field	60	EffectiveDate can not be less than today date.	EffectiveDate can not be less than today date.
End Date	Field	13	End Date is required.	Enter an End Date of the ID.
	Field	55	End Date must be greater than or equal to 01/01/1900.	Verify keying. Enter a date greater than or equal to 01/01/1900.
	Field	56	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	57	End Date and End Date Reason Code cannot be applied separately	Force the user to apply both the End Date and End Date Reason Code for an ERX ID (ERX ID only) if the end date applied is less than 12312299
	Field	63	Future end date cannot be greater than 30 days from the current date	Future end date cannot be greater than 30 days from the current date if end date value is not equal to 12/31/2299
	Field	61	End Date must be greater than or equal to the effective Date	End Date must be greater than or equal to the effective Date
End Date Reason Code	Field	58	Apply correct end date reason code	Restrict a user to applying only a N = 'Not ERX Eligible' End Date Reason Code if the ID type is ERX
Provider ID	Field	26	A Provider ID must be enter for that type of Provider Identifier.	Verify selection. Enter Provider ID for selected identifier.
	Field	27	A Provider ID cannot be entered for that type of Provider Identifier. The	Verify selection. If selection is correct,

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Field	Field Type	Error Code	Error Message	To Correct
			Provider ID must be left blank.	remove Provider ID entered.
	Field	28	A duplicate Provider ID has been detected. For this to be allowed, both Provider IDs must belong to the same Provider.	Verify keying. Enter a Provider ID that is unique to this Provider.
	Field	59	This Provider is not valid for ERX ID.	This Provider is not valid for ERX ID.
ID Type	Field	14	A valid ID type is required.	Select an ID type.

6.1.131 IDs Panel Extra Features

Field	Field Type
To prevent replacement of system assigned Medicaid IDs users cannot update Provider ID if ID type is MCD (Medicaid).	

6.1.132 IDs Panel Accessibility

6.1.132.1 To Access the IDs Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **IDs** hyperlink on the Provider Maintenance panel.	IDs panel displays.

6.1.132.2 To Add on IDs Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Provider ID**.	
3	Select **ID Type** from drop down list box.	
4	Select **Default NPI Service Location** from drop down list box.	
5	Select **NPI Verified** from drop down list box.	
6	Enter **Effective Date** in MM/DD/CCYY format.	

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7	Enter **End Date** in MM/DD/CCYY format, if applicable.	
8	Select **End Date Reason** from drop down list box.	
9	Click **Save**.	IDs information is saved.

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6.1.132.3 To Update on IDs Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	IDs information is saved.

6.1.132.4 To Delete from the IDs Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Medicare Number Panel Overview

6.1.133 Medicare Number Panel Narrative

The Medicare Number panel is used to view and update Medicare Billing Provider numbers, Medicare or Durable Medical Equipment Resource Center (DMERC) Contracts, and effective dates. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Medicare Number]

6.1.134 Medicare Number Panel Layout

6.1.135 Medicare Number Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider Medicare number information.	Button	N/A	0
Effective Date	Effective date of Medicare number.	Field	Date (MM/DD/CCYY)	8
End Date	Ending date of Medicare number.	Field	Date (MM/DD/CCYY)	8
Medicare Number	Provider's Medicare number.	Field	Number (Integer)	10
Medicare/DMERC	Indicates if the number is a Medicare or DMERC number.	Combo Box	Drop Down List Box	0

6.1.136 Medicare Number Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same Medicare number and Medicare/DMERC combination.
	Field	18	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	15	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same Medicare number and Medicare/DMERC combination.
	Field	18	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
Medicare Number	Field	1	Medicare Number is required.	Enter a Medicare number.
	Field	10	Medicare Number must be Alphanumeric.	Verify keying. Medicare number must be A-Z and/or 0-9.
Medicare/DMERC	Field	1	Medicare/DMERC is required.	Choose a Medicare/DMERC.

6.1.137 Medicare Number Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.138 Medicare Number Panel Accessibility

6.1.138.1 To Access the Medicare Number Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Medicare Number** hyperlink on the Provider Maintenance panel.	Medicare Number panel displays.

6.1.138.2 To Add on Medicare Number Panel

Step	Action	Response

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1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Medicare Number.	
3	Select **Medicare/DMERC** from drop down list.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format, if applicable.	
6	Click **Save**.	Medicare Number information is saved.

6.1.138.3 To Update on Medicare Number Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Medicare Number information is saved.

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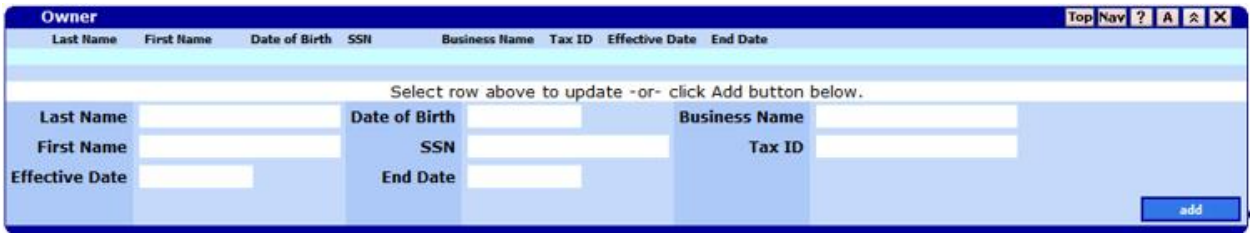
Owner Overview

6.1.139 Owner Panel Narrative

Provider Owner panel is utilized by Provider Enrollment Staff to enter ownership information from provider disclosure pages.

Navigation Path: [Provider - Search] - [select row from search results] - [Owner]

6.1.140 Owner Panel Layout



6.1.141 Owner Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	Allows the user to add a provider owner record.	Button	N/A	0
Business Name [Detail]	The business name of the owner.	Field	Character	50
Business Name [List]	The business name of the owner.	Field	Character	50
Effective Date [Detail]	This is the date the ownership of the provider begins.	Field	Date (MM/DD/CCYY)	8
Effective Date [List]	This is the date the ownership of the provider begins.	Field	Date (MM/DD/CCYY)	8
End Date [Detail]	This is the date the ownership of the provider ends.	Field	Date (MM/DD/CCYY)	8
End Date [List]	This is the date the ownership of the provider ends.	Field	Date (MM/DD/CCYY)	8
First Name [Detail]	This is the first name of the owner.	Field	Character	24
First Name [List]	This is the first name of the owner.	Field	Character	24
Last Name [Detail]	This is the last name of the owner.	Field	Character	24
Last Name [List]	This is the last name of the owner.	Field	Character	24
SSN [Detail]	This is the SSN or FEIN for a provider or owner.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
SSN [List]	This is the SSN or FEIN for a provider or owner.	Field	Number (Integer)	9
Tax ID [Detail]	This is the tax identification number assigned to a provider or owner by the Internal Revenue Service.	Field	Character	9
Tax ID [List]	This is the tax identification number assigned to a provider or owner by the Internal Revenue Service.	Field	Character	9
Date of Birth [Detail]	The date of birth of the owner.	Field	Date (MM/DD/CCYY)	8
Date of Birth [List]	The date of birth of the owner.	Field	Date (MM/DD/CCYY)	8

6.1.142 Owner Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Business Name [Detail]	Field	1	Please enter a business name or a last and first name.	Enter a business name or a last and first name.
	Field	2	Enter either business or personal name.	Delete the business name or the first and last names.
Effective Date [Detail]	Field	3	Effective Date is required.	Enter an effective date.
	Field	4	Effective Date [mm/dd/ccyy hh:mm:ss] must be less than or equal to End Date[mm/dd/ccyy	Verify keying. The effective date must be less than or equal to the end date.
	Field	5	Provider Ownership date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same owner.
	Field	6	Invalid date. Format is mm/dd/ccyy.	Verify keying. Date format must be mm/dd/ccyy.
	Field	14	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than or equal to 1/1/1900.
	Field	15	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
End Date [Detail]	Field	4	Effective Date [mm/dd/ccyy hh:mm:ss] must be less than or equal to End Date[mm/dd/ccyy hh:mm:ss].	Verify keying. The effective date must be less than or equal to the end date.
	Field	5	Provider Ownership date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same owner.
	Field	6	Invalid date. Format is mm/dd/ccyy.	Verify keying. Date format must be mm/dd/ccyy.
	Field	7	End Date is required.	Enter an end date.
	Field	14	End Date must be greater than or equal to 1/1/1900.	Verify keying. End Date must be greater than or equal to 1/1/1900.
	Field	15	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
First Name [Detail]	Field	1	Please enter a business name or a last and first name.	Enter a business name or a last and first name.
	Field	2	Enter either business or personal name.	Delete the business name or the first and last names.
	Field	8	Please enter both last and first names.	Enter both last name and first name.
Last Name [Detail]	Field	1	Please enter a business name or a last and first name.	Enter a business name or a last and first name.
	Field	2	Enter either business or personal name.	Delete the business name or the first and last names.
	Field	8	Please enter both last and first names.	Enter both last name and first name.
SSN [Detail]	Field	9	Please enter a SSN for a personal name. Tax ID should not be entered.	Enter only a 9 digit SSN. Delete the Tax ID if one has been entered.
	Field	10	Please enter a Tax ID for a business name. SSN should not be entered.	Enter only a Tax ID. Delete the SSN if one has been entered.
	Field	13	Please enter a SSN for personal name or Tax ID for business name.	Enter a SSN for a personal name or Tax ID for business name.
Tax ID [Detail]	Field	9	Please enter a SSN for a personal name. Tax ID should not be entered.	Enter only a 9 digit SSN. Delete the Tax ID if one has been entered.
	Field	10	Please enter a Tax ID for a business name. SSN should not be entered.	Enter only a Tax ID. Delete the SSN if one has been entered.
	Field	11	Tax ID must be numeric.	Verify keying. Enter a numeric Tax
	Field	12	Tax ID must be 9 digits in length.	Verify keying. Enter a nine digit Tax ID.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	13	Please enter a SSN for personal name or Tax ID for business name.	Enter a SSN for a personal name or Tax ID for business name.
Date of Birth [Detail]	Field	1	Date of birth is required for individual board member entries containing SSN	Valid Date of Birth required

6.1.143 Owner Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.144 Owner Panel Accessibility

6.1.144.1 To Access the Owner Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click Search; Or click Search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Owner** hyperlink on the Provider Maintenance panel.	Provider Owner panel displays.

6.1.144.2 To Add on Owner Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter data for business owner or personal owner	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	Provider Owner information is saved.

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6.1.144.3 To Update on Owner Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click Save.	Provider Owner information is saved.

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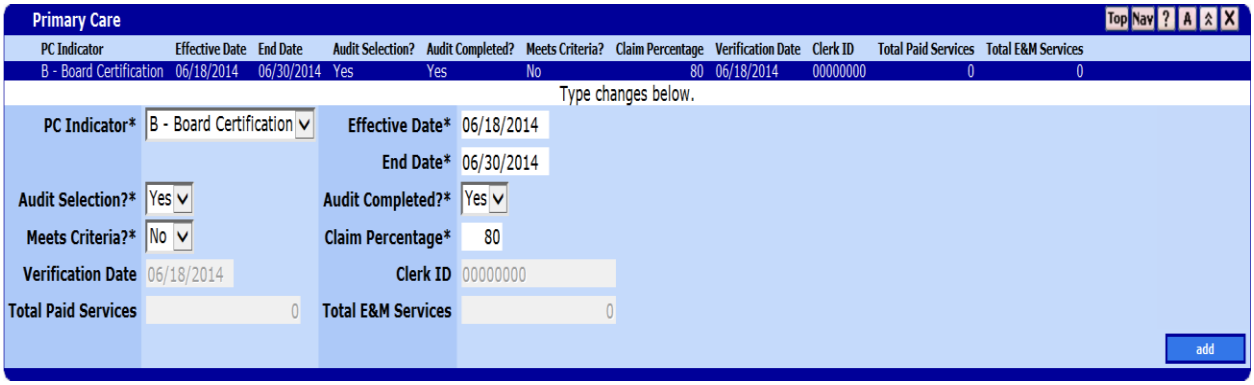
Primary Care Panel

6.1.145 Primary Care Panel Narrative

This is the Provider Enrollment Maintenance panel that contains the ACA Primary Care Physician indicator and associated effective and end dates.

Navigation Path: [Provider - Search] - [select row from search results] - [Primary Care]

6.1.146 Primary Care Panel Layout



6.1.147 Primary Care Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Primary Care indicator record.	Button	N/A	0
Audit Completed?	Indicates if the audit was conducted and completed.	Combo Box	Drop Down List Box	1
Audit Selection?	Indicates if the provider has been selected for auditing purposes.	Combo Box	Drop Down List Box	1
Claim Percentage	The percentage of claims meeting the criteria	Field	Number (Integer)	3
Clerk ID	The logged in user's clerk id.	Field	Alphanumeric	8
Effective Date	This is the date the verification of the provider begins.	Field	Date (MM/DD/CCYY)	8
End Date	This is the date the verification of the provider ends.	Field	Date (MM/DD/CCYY)	8
Meets Criteria?	Indicates if the provider met the audit criteria.	Combo Box	Drop Down List Box	1
PC Indicator	This is an indicator for Provider verification. The valid values are: Claims (C) and Board Certification (B).	Combo Box	Drop Down List Box	1

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Field	Description	Field Type	Data Type	Length
Total E & M Services	Total number of submitted physician details that met PCP evaluation and management criteria for a provider of specific service location	Field	Number (Integer)	9
Total Paid Services	Total number of physician details submitted by a provider of specific service location.	Field	Number (Integer)	9
Verification Date	The date changes were saved.	Field	Date(MM/DD/CCYY)	8

6.1.148 Primary Care Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an ACC Effective Date.
	Field	2	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than 1/1/1900.
	Field	3	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	4	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same Medicare number and Medicare/DMERC combination.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than 12/31/2299.
	Field	6	Invalid date. Format is mm/dd/ccyy.	Enter a date in the mm/dd/ccyy format.
Claim Percentage	Field	1	Enter a valid value.	Enter a value that is not negative.
	Field	2	Claim Percentage must be less than or equal to 100.	Enter a value that is less than or equal to 100.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 1/1/1900.	Verify keying. End date must be greater than 1/1/1900.
	Field	3	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	4	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same Medicare number and Medicare/DMERC combination.
	Field	5	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6	Invalid date. Format is mm/dd/ccyy.	Enter a date in the mm/dd/ccyy format.
PC Indicator	Combo Box	1	PC Indicator is required.	Select a PC Indicator from the Dropdown box.

6.1.149 Primary Care Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.150 Primary Care Panel Accessibility

6.1.150.1 Access the Primary Care Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click Search; Or click Search and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Primary Care** hyperlink on the Provider Maintenance panel.	Primary Care panel displays.

6.1.150.2 To Add on Primary Care Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select PC Indicator	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	Primary Care information is saved.

6.1.150.3 To Update on Primary Care Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in field(s) to update and perform update.	
3	Click Save.	Primary Care information is saved.

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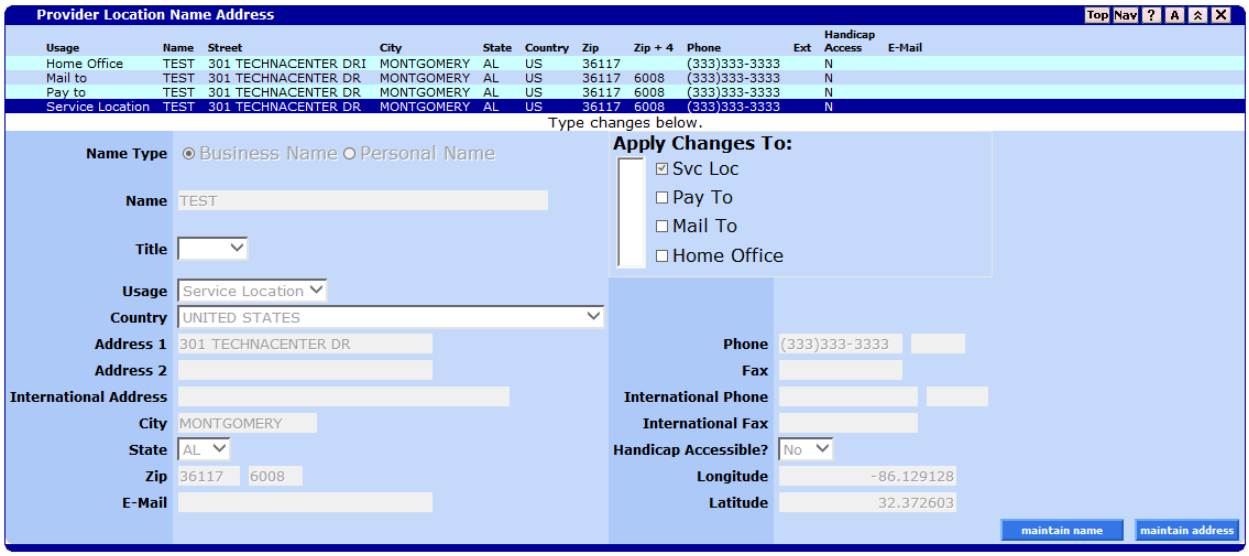
Provider Location Name Address Panel Overview

6.1.151 Provider Location Name Address Panel Narrative

The Provider Location Name Address panel is used to view and update provider names and addresses. The panel displays the list of names and addresses for a specific service location and the user has the capability to change the name and/or address by clicking on the Maintain Name or Maintain Address buttons. At that time, the user can either key in a new name or address or choose Select from List to select a name or address from the list of names and addresses the provider has on file. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Provider Location Name Address] OR [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Location Name Address]

6.1.152 Provider Location Name Address Panel Layout



6.1.153 Provider Location Name Address Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Street address 1 of the financial institution.	Field	Character	30
Address 2	Street address 2 of the financial institution.	Field	Character	30
City	City of the financial institution.	Field	Character	15
Country	The country associated to the address selected.	Combo Box	Drop Down List Box	0
E-Mail	The email address of the provider.	Field	Character	40
Fax	The fax number of the provider.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Handicap Accessible	Provider's handicap access indicator. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Home Office	Mail office type of address.	Combo Box	Check Box	0
International Address	Provider’s international address.	Field	Character	51
International Fax	Provider’s international fax.	Field	Character	15
International Phone + Phone Ext	Provider's international phone number + Provider's international phone extension.	Field	Character	20
Latitude	Provider's calculated latitude.	Field	Number (Integer)	11
Longitude	Provider's calculated longitude.	Field	Number (Integer)	11
Mail To	Mail to type of address.	Combo Box	Check Box	0
Maintain Address	Allows the user to maintain provider address information.	Button	N/A	0
Maintain Name	Allows the user to maintain provider name information.	Button	N/A	0
Name	Provider's name.	Field	Character	50
Name Type	Type of name. Valid values are: Business Name or Personal Name.	Combo Box	Radio Button	0
Pay To	Pay to type of address.	Combo Box	Check Box	0
Phone	Provider's phone number.	Field	Character	10
Phone + Phone Ext	Provider's phone number + Provider's phone extension.	Field	Character	14
Phone Ext	Provider's phone extension.	Field	Character	4
Svc Loc	Provider's service location suffix.	Combo Box	Check Box	0
State	State of the financial institution.	Combo Box	Drop Down List Box	0
Street address 1 + Street address 2	Street address 1 and 2 of the financial institution.	Field	Character	30
Title	Provider's official title with valid values from the title list.	Combo Box	Drop Down List Box	0
Usage	Type of address with valid values to include: Home Office Address, Mail-To Address, Pay-To Address and Service Location Address.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Zip	Zip code of the financial institution.	Field	Character	5
Zip + 4	Zip code extension of the financial institution.	Field	Character	4

6.1.154 Provider Location Name Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address Line 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Latitude	Field	5000	Latitude and Longitude could not be calculated. Please review changes.	This is a warning message. The Latitude and Longitude could not be calculated for the address entered. Please review the changes.
Longitude	Field	5000	Latitude and Longitude could not be calculated. Please review changes.	This is a warning message. The Latitude and Longitude could not be calculated for the address entered. Please review the changes.
Name	Field	1	Name is required.	Enter a name.
	Field	231	Both First Name and Last Name are required.	Enter a first and last name.
Phone	Field	1	Phone is required.	Enter a Phone number.
State	Field	29	A valid State is required.	Choose a State code.
Toll Free Phone	Field	1	Toll Free phone number is required if Ext. is entered.	Enter a Toll Free Phone number.
Zip	Field	1	Zip is required.	Enter a Zip Code.

6.1.155 Provider Location Name Address Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.156 Provider Location Name Address Panel Accessibility

6.1.156.1 To Access the Provider Location Name Address Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.

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Step	Action	Response
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Provider Location Name Address** hyperlink on the Provider Maintenance panel.	Provider Location Name Address panel displays.

6.1.156.2 To Update the Provider Location Name Address Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain Name or Maintain Address button.	Fields are populated with data related to the line selected.
3	Click in field(s) to update and perform update.	
4	Click **Save**.	Provider Location Name Address information is saved.

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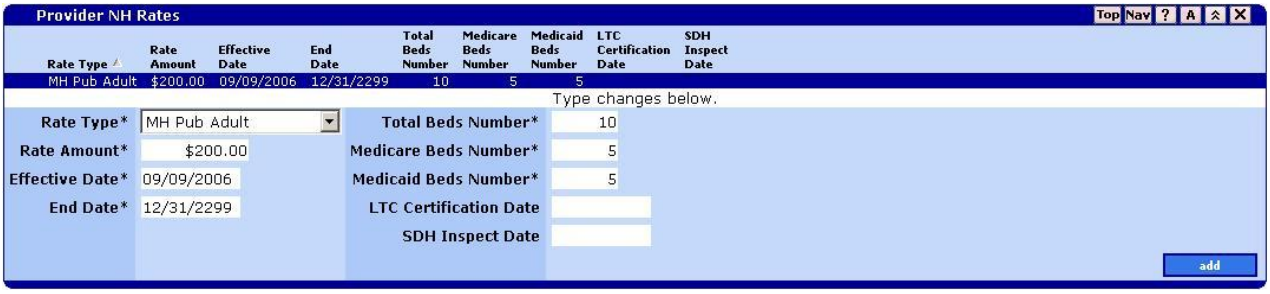
Provider NH/IP Rates Panel Overview

6.1.157 Provider NH/IP Rates Panel Narrative

The Provider NH/IP Rates panel is used to view or update provider specific nursing home and inpatient rate information for providers. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Provider NH/IP Rates]

6.1.158 Provider NH/IP Rates Panel Layout



6.1.159 Provider NH/IP Rates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add rate information.	Button	N/A	0
Effective Date	Effective date of the rate.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the rate.	Field	Date (MM/DD/CCYY)	8
LTC Certification Date	Date that the facility has been certified for long term care by the state.	Field	Date (MM/DD/CCYY)	8
Medicaid Beds Number	Total number of beds in the facility certified for Medicaid patients.	Field	Number (Integer)	5
Medicare Beds Number	Total number of beds in the facility certified for Medicare patients.	Field	Number (Integer)	5
Rate Amount	Provider's rate amount.	Field	Number (Decimal)	8
Rate Type	Provider's approved rate type with valid values. Valid values include: Regular Medicaid, Rural Rate, Teaching Physician, Technical Component and Vaccines for Children.	Comb o Box	Drop Down List Box	0
SDH Inspect Date	Date that the facility was inspected by the state.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Total Beds Number	Total number of beds in the facility.	Field	Number (Integer)	5

6.1.160 Provider NH/IP Rates Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same rate type code.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same rate type code.
Rate Amount	Field	15	Rate Amount must be greater than or equal to 0.01.	Verify amount is not zero or negative.
	Field	16	Rate Amount must be less than or equal to $99999.99.	Verify amount is less than or equal to $99,999.99.
Rate Type	Field	29	A valid Rate Type is required.	Select a Rate Type.

6.1.161 Provider NH/IP Rates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.162 Provider NH/IP Rates Panel Accessibility

6.1.162.1 To Access the Provider NH/IP Rates Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.

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Step	Action	Response
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Provider NH/IP** Rates hyperlink on the Provider Maintenance panel.	Provider NH/IP Rates panel displays.

6.1.162.2 To Add on NH/IP Rates Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Rate Type** from drop down list.	
3	Enter Rate Amount.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format, if applicable.	
6	Enter Total Number of Beds.	
7	Enter Medicare Beds Number.	
8	Enter Medicaid Beds Number.	
9	Enter **LTC Certification Date** in MM/DD/CCYY format, if applicable.	
10	Enter **SDH Inspect Date** in MM/DD/CCYY format, if applicable.	
11	Click **Save**.	Provider NH/IP Rates information is saved.

6.1.162.3 To Update on NH/IP Rates Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Provider NH/IP Rates information is saved.

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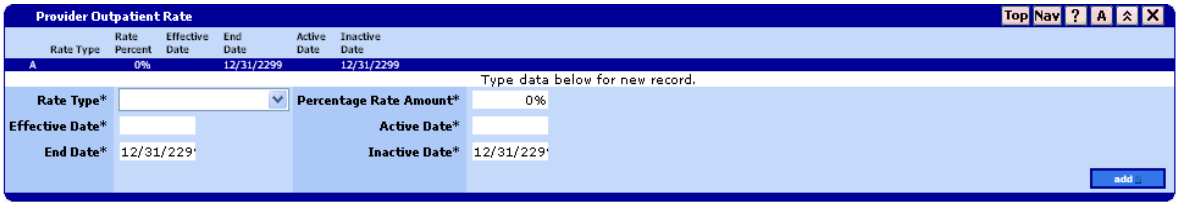
Provider Outpatient Rate Panel Overview

6.1.163 Provider Outpatient Rate Panel Narrative

The Provider Outpatient Rate panel is used to add or update hospital outpatient rates for a specific provider, which is utilized in claims processing. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [Select row from Search Results] - [Provider Maintenance] - [Click Service Location link] - [Click Provider Outpatient Rate link]

6.1.164 Provider Outpatient Rate Panel Layout



6.1.165 Provider Outpatient Rate Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Date	The outpatient rate active date of provider.	Field	Date (MM/DD/CCYY)	8
Add	Allows the user to add provider outpatient rate information.	Button	N/A	0
Effective Date	Provider outpatient rate effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Provider outpatient rate end date.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Provider outpatient rate inactive date.	Field	Date (MM/DD/CCYY)	8
Percentage Rate Amount	Percentage amount for the given rate.	Field	Number (Decimal)	6
Rate Percent	Percentage amount for the given rate.	Field	Number (Decimal)	6
Rate Type	Rate type to determine provider outpatient hospital reimbursement amount. Valid values include: Regular Medicaid, Rural Rate, Teaching Physician, Technical Component and Vaccines for Children.	Comb o Box	Drop Down List Box	0

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6.1.166 Provider Outpatient Rate Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Active Date	Field	2200	Active Date is required.	Enter Active Date (MM/DD/CCYY).
	Field	2300	Active Date must be greater than or equal to today.	Enter Active Date greater than or equal to current date.
	Field	2400	Active Date must be greater then or equal to 01/01/1900.	Enter Active Date greater or equal to 01/01/1900.
	Field	2500	Active Date must be less than or equal to 12/31/2299.	Enter an Active Date equal to current date or future date that is not greater than 12/31/2299.
	Field	2600	Active Date must be less than or equal to Inactive date.	Enter Active Date that is earlier than the inactive date on file.
	Field	2700	Active Date must be less than or equal to End date.	Enter Active Date that is earlier than the End Date on file.
Effective Date	Field	2210	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date equal to current date or future date that is not greater than 12/31/2299.
	Field	2220	Effective Date must be less than or equal to end date.	Enter an Effective Date that is earlier than the End Date on file.
	Field	2260	Date segments cannot overlap.	Date segments cannot overlap for the same rate type.
	Field	2800	Effective Date is required.	Enter Effective Date in MM/DD/CCYY format.
	Field	2900	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date equal to current or future date.
End Date	Field	2230	End Date is required.	Enter End Date in MM/DD/CCYY format.
	Field	2240	End Date must be greater than or equal to 01/01/1900.	Enter an End Date equal to current or future dates.
	Field	2250	End Date must be less than or equal to 12/31/2299.	Enter an End Date equal to current date or future date that is not greater than 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2370	Date segments cannot overlap.	Date segments cannot overlap for the same rate type.
Inactive Date	Field	2310	Inactive Date is required.	Enter Inactive Date in MM/DD/CCYY format.
	Field	2320	Inactive Date must be greater than or equal to today.	Enter Inactive Date equal to current or future date.
	Field	2330	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date equal to current or future date.
	Field	2340	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date equal to current date or future date that is not greater than 12/31/2299.
	Field	2350	Inactive Date must be greater than or equal to Effective Date.	Enter an Inactive Date that is later than the Effective Date on file.
Percentage Rate Amount	Field	5300	Percentage Rate Amount is required.	Enter a Percentage Rate amount.
	Field	5350	Percentage Rate Amount should have a value greater than 0.	Enter a Percentage Rate amount for more than 0.
	Field	5400	Percentage Rate Amount must be less than or equal to 99999.900.	Enter a Percentage Rate amount for max allowed or less.
Rate Type	Field	2510	A valid Rate Type is required.	Select a Rate Type from drop down list.

6.1.167 Provider Outpatient Rate Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.168 Provider Outpatient Rate Panel Accessibility

6.1.168.1 To Access the Provider Outpatient Rate Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria

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Step	Action	Response
		entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Provider Outpatient Rate** hyperlink on the Provider Maintenance panel.	Provider Outpatient Rate panel displays.

6.1.168.2 To Update on Provider Outpatient Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Provider Outpatient Rate information is saved.

6.1.168.3 To Add on Provider Outpatient Rate Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Rate Type** from drop down list.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	
5	Enter Percentage Rate Amount.	
6	Enter **Active Date** in MM/DD/CCYY format.	
7	Enter **Inactive Date** in MM/DD/CCYY format, if applicable.	
8	Click **Save**.	Provider Outpatient Rate information is saved.

6.1.168.4 To Update on Provider Outpatient Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Provider Outpatient Rate information is saved.

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Restricted Service Panel Overview

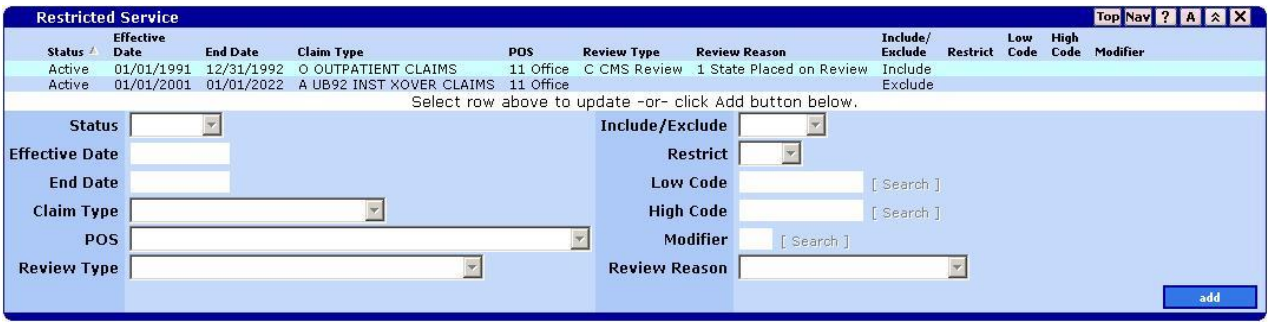
6.1.169 Restricted Service Panel Narrative

The Restricted Service panel allows the user to restrict the types of services a provider is allowed to perform.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Restricted Services]

6.1.170 Restricted Service Panel Layout



6.1.171 Restricted Service Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add restricted service information.	Button	N/A	0
Claim Type	Claim type information.	Combo Box	Drop Down List Box	0
Effective Date	Effective date of the restriction.	Field	Date (MM/DD/CCYY)	8
End Date	End date of restriction.	Field	Date (MM/DD/CCYY)	8
High Code	Highest number in a sequential range of codes.	Field	Character	11
Include/Exclude	Indicates whether the restriction is inclusive to the code displayed, or exclusive of the code displayed with valid values to include inclusive or exclusive.	Combo Box	Drop Down List Box	0
Low Code	Lowest number in a sequential range of restricted codes.	Field	Character	11
Modifier	Procedure code modifiers (if applicable).	Field	Character	2
POS	Provider's place of service.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Restrict	Type of restriction to be viewed. Valid values include: GCN, NDC, Proc and Rev.	Combo Box	Drop Down List Box	0
Review Reason	Reason for review. Valid values include: 0-Federal Investigation 1-State Placed on Review 2-HPES Placed on Review 3-Other 4-OIG Investigation 5-Malpractice	Combo Box	Drop Down List Box	0
Review Type	Type of review. Valid values include: A-OAG Review (Attorney General) C-CMS Review F-Fraud and Abuse I-OIG Review (Inspector General) M-Malpractice Z-Other Law Enforcement Agency Review	Combo Box	Drop Down List Box	0
Status	Status of the restriction. Valid values to include: A - Active, I - Inactive.	Combo Box	Drop Down List Box	0

6.1.172 Restricted Service Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	Claim Type or POS or Low Code and High Code are required.	Enter a restriction. Either a claim type, place of service, or restriction type with Low and High code must be entered.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. The Effective Date must be greater than 01/01/1900.
	Field	16	Effective Date [A] must be less than or equal to End Date [B].	Verify keying. The Effective Date must be less than or equal to the End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same restriction type, high and low codes, modifier, claim type, place of service, and include/exclude indicator where the status is equal to active.
	Field	18	Effective Date less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. The Effective Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date [A] must be less than or equal to End Date [B].	Verify keying. The Effective Date must be greater than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same Restriction Type, High and Low codes, Modifier, Claim Type, Place of Service, and Include/Exclude indicator where the status is equal to active.
	Field	18	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
High Code	Field	1	Claim Type or POS or Low Code and High Code are required.	Enter a restriction. Either a Claim Type, Place of Service, or Restriction Type with Low and High code must be entered.
	Field	5000	The Low Code must be less than or equal to the High Code.	Verify keying. The Low Code must be less than or equal to the High Code.
Include/ Exclude	Field	1	Include/Exclude is required.	Choose Include or Exclude.
Low Code	Field	1	Claim Type or POS or Low Code and High Code are required.	Enter a restriction. Either a Claim Type, Place of Service, or Restriction Type with Low and High Code must be entered.
	Field	5000	The Low Code must be less than or equal to the High Code.	Verify keying. The Low Code must be less than or equal to the High Code.
Modifier	Field	5	Modifier is invalid for this Procedure.	Verify keying. The modifier entered is not valid for the Low Code, High Code, or both.

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Field	Field Type	Error Code	Error Message	To Correct
POS	Field	1	Claim Type or POS or Low Code and High Code are required.	Enter a restriction. Either a Claim Type, Place of Service, or Restriction Type with Low and High Code must be entered.
Review Reason	Field	1	A valid Review Reason is required.	Choose a Review Reason.
Review Type	Field	1	A valid Review Type is required.	Choose a Review Type.
Status	Field	1	Status is required.	Choose a Status.

6.1.173 Restricted Service Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.174 Restricted Service Panel Accessibility

6.1.174.1 To Access the Restricted Service Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Restricted Service** hyperlink on the Provider Maintenance panel.	Restricted Service panel displays.

6.1.174.2 To Add on Restricted Service Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Status** from the drop down list.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable.	
5	Select **Claim Type** from drop down list.	
6	Select **POS (Place of Service)** from drop down list.	

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Step	Action	Response
7	Select **Review Type** from drop down list.	
8	Select **Include/Exclude** from drop down list.	
9	Select **Restrict** indicator from drop down list.	
10	Click [Search] to select **Low Code** from list.	
11	Click [Search] to select **High Code** from list.	
12	Click [Search] to select **Modifier** from list.	
13	Select **Review Reason** from drop down list.	
14	Click **Save**.	Restricted Service information is saved.

6.1.174.3 To Update on Restricted Service Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Restricted Service information is saved.

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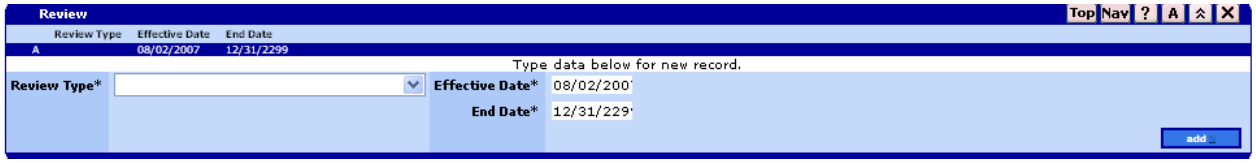
Review Panel Overview

6.1.175 Review Panel Narrative

The Review panel is utilized to show why a provider is on review as well as the date ranges for a given review reason. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Review]

6.1.176 Review Panel Layout



6.1.177 Review Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add review information.	Button	N/A	0
Effective Date	Effective date applicable to review type.	Field	Date (MM/DD/CCYY)	8
End Date	End date applicable to review type.	Field	Date (MM/DD/CCYY)	8
Review Type	Review Type Valid values include: CMS Review, Fraud and Abuse, Malpractice, OAG Review (Attorney General), OIG Review, (Inspector General) and Other Law Enforcement Agency Review.	Combo Box	Drop Down List Box	0

6.1.178 Review Panel Layout Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Verify keying. Enter Effective Date.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. The Effective Date must be greater than or equal to 01/01/1900.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	4	Effective date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to End Date.
End Date	Field	1	End Date is required.	Verify keying. Enter End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be greater than or equal to Effective Date.
Review Type	Field	1	A valid Review Type is required.	Verify keying. Select a valid Review Type.
	Field	2	Review Date segments for [Review Type] cannot overlap.	Verify keying. Select a Review Type not already in use or modify to and from dates to avoid overlapping segments.

6.1.179 Review Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.180 Review Panel Accessibility

6.1.180.1 To Access the Review Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel displays.
5	Click **Review** hyperlink on the Provider Maintenance panel.	Review panel displays.

6.1.180.2 To Add on Review Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Select **Review Type** from the drop down list.	

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Step	Action	Response
3	Enter **Effective Date** in MM/DD/CCYY format. Note: Effective Date defaults to current date.	
4	Enter **End Date** in MM/DD/CCYY format, if applicable. Note: End Date defaults to 12/31/2299.	
5	Select **Claim Type** from drop down list.	
6	Click **Save**.	Review information is saved.

6.1.180.3 To Update on Review Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Review information is saved.

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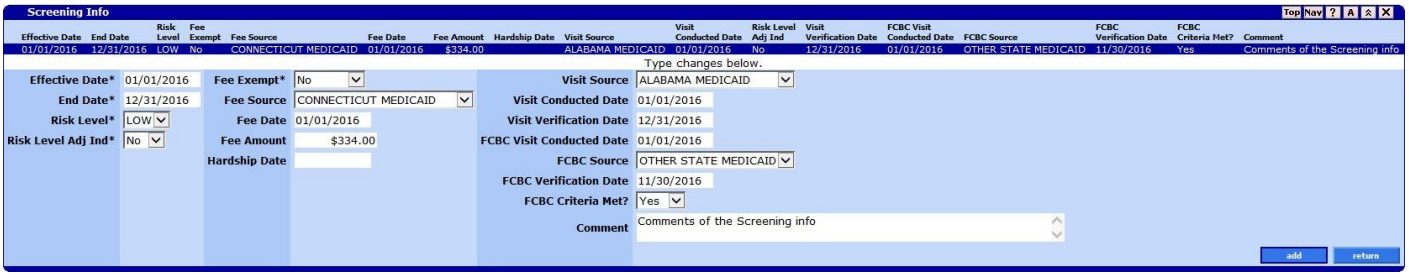
Screening Info Panel Overview

6.1.181 Screening Info Panel Narrative

The Screening Info panel is used to view or maintain provider screening information.

Navigation Path: [Provider - Search] - [select row from search results] - [Screening Info]

6.1.182 Screening Info Panel Layout



6.1.183 Screening Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Provider Screening information.	Button	N/A	0
Comment	Notations significant to the fee collection or return.	Field	Character	250
Effective Date	The date the screening information took effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date the screening data is no longer valid.	Field	Date (MM/DD/CCYY)	8
FCBC Criteria Met?	Indication of whether the provider met the FCBC criteria.	Combo Box	Drop Down List Box	1
FCBC Source	Agency who conducted the visit.	Combo Box	Drop Down List Box	2
FCBC Verification Date	Date in which the clerk verified FCBC was completed.	Field	Date (MM/DD/CCYY)	8
FCBC Visit Conducted Date	Date the visit was conducted by the Agency.	Field	Date (MM/DD/CCYY)	8
Fee Amount	Enrollment Fee paid by provider.	Field	Number	9
Fee Date	Date the fee was paid to the Agency.	Field	Date(MM/DD/CCYY)	8
Fee Exempt	Whether the provider is exempt from paying a fee. Valid values are Yes or No.	Combo Box	Drop Down List Box	1

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Field	Description	Field Type	Data Type	Length
Fee Source	The State/Federal agency to whom the fee was paid. Valid values are: Alabama Medicaid, Chip, Medicare, and Other State Medicaid.	Combo Box	Drop Down List Box	2
Hardship Date	Date Hardship was approved/granted by Medicare.	Field	Date (MM/DD/CCYY)	8
Risk Level	Risk level involved with the provider.	Combo Box	Drop Down List Box	2
Risk Level Adj Ind	Indicator shows the risk level was adjusted manually.	Combo Box	Drop Down List Box	1
Visit Conducted Date	The date the visit was conducted by the State/Federal agency.	Field	Date (MM/DD/CCYY)	8
Visit Source	The State/Federal agency who conducted the visit. Valid values are: Alabama Medicaid, Medicare, and Other State Medicaid.	Combo Box	Drop Down List Box	2
Visit Verification Date	Verification Date.	Field	Date (MM/DD/CCYY)	8

6.1.184 Screening Info Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment must be entered if Fee Exempt is 'Returned'.	Enter comment.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid Effective Date (MM/DD/CCYY).
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Enter a valid Effective Date greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter a valid Effective Date less than or equal to 12/31/2299.
	Field	5	Screening Information date segments cannot overlap.	Enter a valid date range which does not overlap with another segment.
End Date	Field	6	End Date is required.	Enter a valid End Date.
	Field	7	Invalid date. Format is mm/dd/ccyy.	Enter a valid End Date (MM/DD/CCYY).
	Field	8	End Date must be greater than or equal to 01/01/1900.	Enter a valid End Date greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	9	End Date must be less than or equal to 12/31/2299.	Enter a valid End Date less than or equal to 12/31/2299.
	Field	10	Screening Information date segments cannot overlap.	Enter a valid date range which does not overlap with another segment.
	Field	11	End Date must be greater than Effective Date.	Enter a valid End Date after the Effective Date.
FCBC Criteria Met?	Combo Box	118	FCBC Criteria Met? must be 'Yes' or 'No' if FCBC Source, FCBC Visit Conducted Date or FCBC Verification Date is not blank.	Select 'Yes' or 'No' in the field FCBC Criteria Met? when any other FCBC field has data.
FCBC Source	Combo Box	1	Warning: FCBC Source, FCBC Verification Date and FCBC Visit Conducted Date are empty.	Select a valid FCBC Source.
	Combo Box	116	FCBC Source must be entered if FCBC Visit Conducted Date or FCBC Verification Date is not blank and FCBC Criteria Met? is 'Yes' or 'No'.	FCBC Source must not be empty when any other FCBC field has data.
FCBC Verification Date	Field	1	Warning: FCBC Source, FCBC Verification Date and FCBC Visit Conducted Date are empty.	Enter a valid date (MMDDCCYY).
	Field	2	FCBC Verification Date must be greater than or equal to 1/1/1900.	Verify keying. FCBC Verification Date must be greater than 1/1/1900.
	Field	3	FCBC Verification Date must be less than or equal to 12/31/2299.	Verify keying. FCBC Verification Date must be less than 12/31/2299.
	Field	4	Invalid date. Format is mm/dd/ccyy.	Enter a valid Fee Date (MM/DD/CCYY).
	Field	117	FCBC Verification Date must be entered if FCBC Source or FCBC Visit Conducted Date is not blank and FCBC Criteria Met is 'Yes' or 'No'.	Enter a valid FCBC Verification Date when the other FCBC fields has data.
FCBC Visit Conducted Date	Field	1	Warning: FCBC Source, FCBC Verification Date and FCBC Visit Conducted Date are empty.	Enter a valid date (MMDDCCYY).

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	FCBC Visit Conducted Date must be greater than or equal to 1/1/1900.	Verify keying. FCBC Visit Conducted Date must be greater than 1/1/1900.
	Field	3	FCBC Visit Conducted Date must be less than or equal to 12/31/2299.	Verify keying. FCBC Visit Conducted Date must be less than 12/31/2299.
	Field	4	Invalid date. Format is mm/dd/ccyy.	Enter a valid Fee Date (MM/DD/CCYY).
	Field	115	FCBC Visit Conducted Date must be entered if FCBC Source or FCBC Verification Date is not blank and FCBC Criteria Met? is 'Yes' or 'No'.	Enter a valid FCBC Visit Conducted Date when the other FCBC fields has data.
Fee Amount	Field	1	Fee Amount must be entered if Fee Exempt is 'No'.	Enter Fee Amount greater than zero.
	Field	2	Fee Amount must be greater than or equal to 0.00.	Enter Fee Amount greater than or equal to 0.00.
Fee Date	Field	1	Fee Date must be entered if Fee Source is not blank.	Enter a valid date (MMDDCCYY)
	Field	2	Fee Date must be blank if Fee Exempt is ‘Yes’.	Clear the Fee Date field.
	Field	3	Fee Date must be entered if Fee Exempt is ‘No’.	Enter a valid date (MMDDCCYY)
	Field	4	Fee Date must be greater than or equal to 1/1/1900.	Verify keying. Fee date must be greater than 1/1/1900.
	Field	5	Fee Date must be less than or equal to 12/31/2299.	Verify keying. Fee date must be less than 12/31/2299.
	Field	6	Invalid date. Format is MM/DD/CCYY.	Enter a valid Fee Date (MM/DD/CCYY).
Fee Exempt	Field	1	Fee Source, Fee Date and Fee Amount must be blank if Fee Exempt is 'Hardship'.	Remove Fee Source, Fee Date and Fee Amount.
	Field	2	Fee Exempt cannot be ‘Yes’ for this Provider Type.	Change Fee Exempt to a value other than ‘Yes’.
Fee Source	Field	12	Fee Source must be entered if Fee Exempt is ‘No’.	Select a valid Fee Source.
	Field	13	Fee Source must be blank if Fee Exempt is ‘Yes’.	Remove the Fee Source selection.
Hardship Date	Field	1	Hardship Date must be greater than or equal to 1/1/1900.	Verify keying. Hardship date must be greater than 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Hardship Date must be less than or equal to 12/31/2299.	Verify keying. Hardship date must be less than 12/31/2299.
	Field	3	Hardship Date must be entered if Fee Exempt is 'Hardship'.	Enter a valid date (MMDDCCYY)
	Field	4	Invalid date. Format is MM/DD/CCYY.	Enter a valid Hardship Date (MM/DD/CCYY).
	Field	5	Hardship Date must be blank if Fee Exempt is other than 'Hardship'.	Remove Hardship Date if Fee Exempt is other than 'Hardship'.
Risk Level	Combo Box	1	Warning: Risk Level changed. Please update Risk Level Adj Ind as appropriate.	Update 'Risk Level Adj Ind' as appropriate.
Visit Source	Combo Box	18	Visit Source must be entered if Risk Level is ‘High’ or ‘Moderate’.	Select a valid Visit Source.
	Combo Box	19	Visit Source must be entered if Visit Conducted Date is not blank.	Select a valid Visit Source.
Visit Conducted Date	Field	20	Visit Conducted Date must be entered if Visit Source is not blank.	Enter a valid Visit Conducted Date.
	Field	21	Invalid date. Format is mm/dd/ccyy.	Enter a valid Visit Conducted Date (MM/DD/CCYY).
	Field	22	Visit Conducted Date must be greater than or equal to 01/01/1900.	Enter a valid Visit Conducted Date greater than or equal to 01/01/1900.
	Field	23	Visit Conducted Date must be less than or equal to 12/31/2299.	Enter a valid Visit Conducted Date less than or equal to 12/31/2299.
	Field	24	Visit Conducted Date must be entered if Risk Level is 'High' or 'Moderate'.	Enter a valid Visit Conducted Date.
Visit Verification Date	Field	1	Invalid date. Format is mm/dd/ccyy.	Enter a valid Visit Verification Date (MM/DD/CCYY).
	Field	2	Visit Verification Date must be greater than or equal to 1/1/1900.	Enter a valid Visit Verification Date greater than or equal to 01/01/1900.
	Field	3	Visit Verification Date must be less than or equal to 12/31/2299.	Enter a valid Visit Verification Date less than or equal to 12/31/2299.

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6.1.185 Screening Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.186 Screening Info Panel Accessibility

6.1.186.1 To Access the Screening Info Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **Screening Info** hyperlink on the Provider Maintenance panel.	Screening Info panel displays.

6.1.186.2 To Add on Screening Info Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Update **Effective Date** in MM/DD/CCYY format.	
3	Update **End Date** in MM/DD/CCYY format.	
4	Select a **Risk Level** value from the drop down list.	
5	Select a **Fee Exempt** value from the drop down list.	
6	Enter data in remaining fields as required.	
7	Click **Save**.	Provider Screening Information is saved.

6.1.186.3 To Update on Screening Info Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click field to update and perform update.	
3	Click **Save**.	Provider Screening Information is saved.

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Service Location Panel Overview

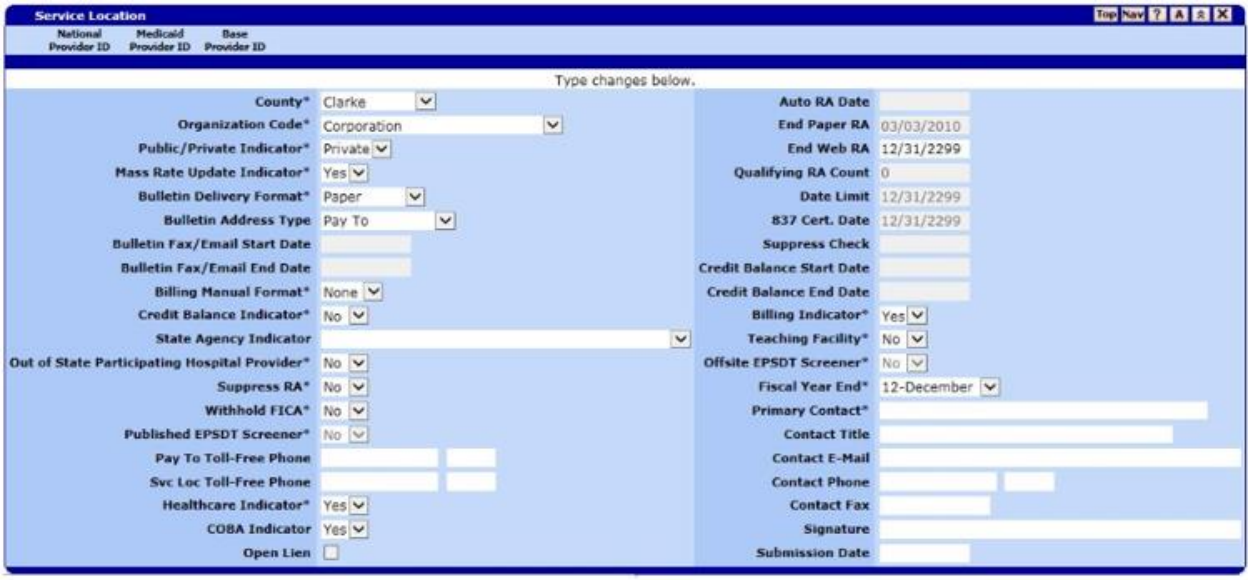
6.1.187 Service Location Panel Narrative

The Service Location panel is used to view or update provider information pertaining to a specific service location.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] - [Search] - [select row from search results] - [Service Location] OR [Provider - Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Service Location]

6.1.188 Service Location Panel Layout



6.1.189 Service Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
837 Cert. Date	The date a provider was certified to submit 837 electronic claims. This is a read only field controlled by the Electronic Data AMMIS (EDI) subsystem.	Field	Date (MM/DD/CCYY)	8
Auto RA Date	Provider's automatic remittance advice (RA) transmittal effective date. This is a read only field controlled by the Electronic Data AMMIS (EDI) subsystem.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Base Provider ID	Base Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	10
Billing Indicator	Indicator to tell the system if this is a billing provider. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Billing Manual Format	Provider's preference for their format of the Billing Manual. Valid values include Paper and CD.	Combo Box	Drop Down List Box	1
Bulletin Address Type	The address type to pull the street address, fax number, or email address from if Bulletin Delivery Format is anything other than 'None'. An address type must be selected when a Bulletin Delivery Format other than 'None' is chosen.	Combo Box	Drop Down List Box	1
Bulletin Delivery Format	Method of delivery for which a service location wishes to receive Provider Bulletins. Valid values include: paper, fax, email and none.	Combo Box	Drop Down List Box	1
Bulletin Fax/Email Start Date	Indicates when a service location would like to begin receiving their Provider Bulletins via the delivery method chosen. This field is required when a Bulletin Delivery Format other than 'None' is chosen.	Field	Date (MM/DD/CCYY)	8
Bulletin Fax/Email End Date	Indicates when a service location would like to stop receiving their Provider Bulletins via the delivery method chosen. This field is required when a Bulletin Delivery Format other than 'None' is chosen.	Field	Date (MM/DD/CCYY)	8
COBA Indicator	Indicates whether a provider's claims cross over. 'Y' if it should or 'N' if it should not.	Combo Box	Drop Down List Box	1
Contact E-Mail	E-mail address of the contact person.	Field	Character	50
Contact Fax	Fax number of the contact person.	Field	Number	10
Contact Phone	Phone number of the contact person.	Field	Number	10

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Field	Description	Field Type	Data Type	Length
Contact Phone Ext	Phone number extension of the contact person.	Field	Number	4
County	The county where the provider is located.	Combo Box	Drop Down List Box	0
Credit Balance Indicator	Indicator to tell if the service location has a credit balance or not. Valid values include Yes and No.	Combo Box	Drop Down List Box	8
Credit Balance Start Date	Effective date of the service locations credit balance.	Field	Date (MM/DD/CCYY)	8
Credit Balance End Date	End date of the service location's credit balance.	Field	Date (MM/DD/CCYY)	8
Date Limit	Maximum date that a provider may extend their PDF version of their paper RA.	Field	Date (MM/DD/CCYY)	8
End Paper RA	The date that the provider's paper RA will be stopped (when provider has requested automatic RA transmittal).	Field	Date (MM/DD/CCYY)	8
End Web RA	The Date when the provider should no longer receive a PDF version of their paper RA. PDF RA's with a date < this date will remain available on the web portal for download.	Field	Date (MM/DD/CCYY)	8
Fiscal Year End	The fiscal year end month of the provider.	Combo Box	Drop Down List Box	2
Healthcare Indicator	Indicates if the provider's type/specialty combination requires a NPI number.	Combo Box	Drop Down List Box	0
Mass Rate Update Indicator	Indicator for eligibility for mass rate update. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Medicaid Provider ID	Medicaid Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	10
National Provider ID	National Provider Identifier. This is a read only field controlled by entries on the Provider IDs panel.	Field	Alphanumeric	10
Offsite EPSDT Screener	Indicates if the provider is an offsite EPSDT screener. Valid values include Yes and No.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Open Lien	Indicates whether a provider has an open lien in the Financial page/panels.	Combo Box	Check Box	0
Organization Code	Provider's organization identification code (type of practice).	Combo Box	Drop Down List Box	0
Out of State Participating Hospital Provider	Out of State Participating Provider Indicator. Valid values include Yes and No.	Combo Box	Drop Down List Box	1
Pay to Toll-Free Phone	The toll-free phone number for the Pay To Address of a service location.	Field	Number (Integer)	10
Pay to Toll-Free Phone Extension	Pay to toll-free phone number extension.	Field	Number (Integer)	4
Primary Contact	The name of the primary contact person for a service location.	Field	Character	50
Public/Private Indicator	Indicator to tell the system that this provider is a private or public provider.	Combo Box	Drop Down List Box	0
Published EPSDT Screener	Indicator of whether provider is a published EPSDT screener. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Qualifying RA Count	The number of occurrences a provider has had a PDF version of their RA created when the provider receives an EFT with total amount paid > 0. Payment type NON and CHK are not considered for this count. This counter is incremented once the associated 835 file has been released.	Field	Number (Integer)	3
State Agency Indicator	The State Agency with which the provider is affiliated. Valid values include: ADPH, ADSS, ADHR, ADMH, ADRS, ADYS, ASDE, AIDB, UCP, and SPARKS.	Combo Box	Drop Down List Box	10
Suppress Check	Effective date of check suppression.	Field	Date (MM/DD/CCYY)	8
Suppress RA	Indicator to suppress the RA for this provider and service location. Valid values include Yes and No.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Svc Loc Toll-Free Phone	The toll-free phone number for the service location address of a service location.	Field	Number (Integer)	10
Svc Loc Toll-Free phone number extension	The service location toll-free phone number extension.	Field	Number (Integer)	4
Teaching Facility	Indicator stating if the service location is a teaching facility. Valid values include Yes and No.	Combo Box	Drop Down List Box	1
Withhold FICA	Indicator to tell financial if this service location should have FICA withheld from its checks. Valid values include Yes and No.	Combo Box	Drop Down List Box	0

6.1.190 Service Location Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
COBA Indicator	Field	1	For types other than 30, 56 and 58 the COBA Indicator must be Yes. Please validate.	Key in value of Y for COBA Indicator for provider types that is not 30, 56 or 58
	Field	2	For types 30, 56 and 58 the COBA Indicator must be NO. Please validate.	Key in value of N for COBA Indicator if provider type is either 30, 56 or 58.
County	Field	1	County is required.	Choose a County.
End Paper RA	Field	2	Trading partner agreement required to end Paper RA.	A provider must receive either an electronic or paper RA. The paper RA cannot end until the provider has a trading partner agreement to receive electronic.
	Field	5	End Paper RA [A] cannot be less than Auto RA Date [B].	A provider must receive either an electronic or paper RA. The paper RA cannot end until the provider has a trading partner agreement to receive electronic.
End Web RA	Field	1	End Web RA date must be greater than or equal to today.	The End Web RA date must be greater than or equal to today.
	Field	2	End Web RA date must be less than the Date Limit.	The End Web RA date must be less than the Date Limit.
	Field	3	End Web RA date is required.	Include a valid date on the End Web RA field.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	End Web RA must be greater than or equal to 1/1/1900.	The End Web RA must be greater than or equal to 1/1/1900.
	Field	5	End Web RA must be less than or equal to 12/31/2299.	The End Web RA must be less than or equal to 12/31/2299.
Fiscal Year End	Field	1	Fiscal Year End is required.	Choose a Fiscal Year End Date.
Organization Code	Field	1	Org Code is required.	Choose an Organization Code.

6.1.191 Service Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.192 Service Location Panel Accessibility

6.1.192.1 To Access the Service Location Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **Service Location** hyperlink on the Provider Maintenance panel.	Service Location panel displays.

6.1.192.2 To Update on Service Location Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Provider Service Location information is saved.

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Tax ID Panel Overview

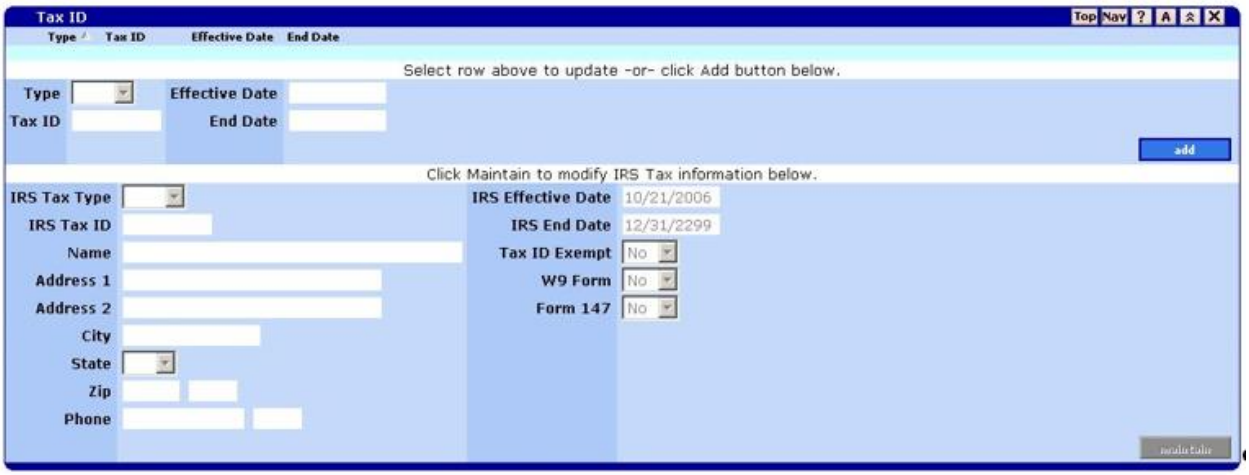
6.1.193 Tax ID Panel Narrative

The Tax ID panel is used to view and update provider Social Security or Tax ID number information.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider - Search] - [select row from search results] - [Tax ID]
OR [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Tax ID]

6.1.194 Tax ID Panel Layout



6.1.195 Tax ID Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add provider tax identification information.	Button	N/A	0
Address 1	Address 1 of the provider.	Field	Character	30
Address 2	Address 2 of the provider.	Field	Character	30
City	City where the provider is located.	Field	Character	15
Effective Date	Effective date of the tax identification number.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the tax identification number.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Form 147	Provider has submitted form 147, stating his name and tax identification number. Valid values are: Yes and No.	Combo Box	Drop Down List Box	0
IRS Effective Date	Effective date of IRS tax identification.	Field	Date (MM/DD/CCYY)	8
IRS End Date	End date of IRS tax identification number.	Field	Date (MM/DD/CCYY)	8
IRS Tax ID	Provider tax identification number.	Field	Character	9
IRS Tax Type	Provider tax identification number type. Valid values are SSN and FEIN.	Combo Box	Drop Down List Box	0
Maintain	Allows the user to modify IRS Tax information.	Button	N/A	0
Name	Provider name.	Field	Character	40
Phone	Provider phone number.	Field	Character	10
Phone Ext	Provider phone number extension.	Field	Character	4
State	State where the provider is located.	Field	Character	2
Tax ID	Provider tax identification number.	Field	Character	9
Tax ID Exempt	Provider is exempt from receiving a 1099. Valid values are: Yes and No.	Combo Box	Drop Down List Box	0
Type	Provider tax identification type Valid values are SSN and FEIN.	Combo Box	Drop Down List Box	0
W9 Form	Provider W9 form. Valid values are: Yes and No.	Combo Box	Drop Down List Box	0
Zip	First five digits of the provider's zip code.	Field	Character	5
Zip+4	Last four digits of the provider's zip code + 4.	Field	Character	4

6.1.196 Tax ID Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter Address 1.
City	Field	1	City is required.	Enter the City.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	105	The fields Effective Date and End Date from row A cannot overlap with row B.	Verify keying. The date segment from row [A] overlaps with the date segment from row [B]. Overlapping date segments are not allowed.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	3	Must have open-ended segment. (End Date = 12/31/2299).	Verify keying. The End Date for one date segment must be 12/31/2299.
	Field	15	End Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	105	The fields Effective Date and End Date from row A cannot overlap with row B.	Verify keying. The date segment from row [A] overlaps with the date segment from row [B]. Overlapping date segments are not allowed.
IRS Effective Date	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap. A provider can only have one Tax ID per date segment.
	Field	5000	New IRS Effective Date must be less than or equal to old IRS Effective Date.	Verify keying. In an update transaction only Effective dates less than or equal to the current Effective Date can be added to prevent gaps in coverage.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter IRS Tax ID.
	Field	10	IRS Tax ID must be Numeric.	Verify keying. IRS Tax ID must be numeric.
	Field	18	IRS Tax ID must be 9 character(s) in length.	Verify keying. IRS Tax ID must be nine numbers.
IRS Tax ID Type	Field	1	IRS Tax Type is required.	Choose the IRS Tax Type.
Name	Field	1	Name is required.	Enter the Name.
State	Field	29	A valid State is required.	Choose a State.

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Field	Field Type	Error Code	Error Message	To Correct
Tax ID	Field	1	Tax ID is required.	Enter a Tax ID.
	Field	2	Warning: Tax ID [A] is assigned to another provider.	Verify keying. The Tax ID [A] is already assigned to one or more providers.
	Field	10	Tax ID must be numeric.	Verify keying. Verify the Tax ID is numeric.
	Field	18	Tax ID must be 9 character(s) in length.	Verify keying. Tax ID must be 9 numeric characters.
	Field	19	Tax ID contains an invalid value.	Verify keying. The Tax ID cannot be nine repeating numbers, for example 111111111 is not a valid Tax ID.
	Field	5000	IRS tax data must be added/updated before saving.	IRS tax information does not exist for some or all of the dates entered. Enter IRS tax ID information.
Tax ID Type	Field	1	Type is required.	Choose a Type.
Zip	Field	1	Zip is required.	Enter the Zip Code.

6.1.197 Tax ID Panel Extra Features

When a new IRS tax segment is created, the end date of the previous IRS date segment (the segment with the 12/31/2299 end date) is automatically set to 1 day before the new IRS effective date.

6.1.198 Tax ID Panel Accessibility

6.1.198.1 To Access the Tax ID Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **Tax ID** hyperlink on the Provider Maintenance panel.	Tax ID panel displays.

6.1.198.2 To Add on Tax ID Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Select **Type** from drop down list.	
3	Enter **Tax ID**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Provider Tax ID information is saved.

6.1.198.3 To Update on Tax ID Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain.	
3	Click field to update and perform update.	
4	Click **Save**.	Provider Tax ID information is saved.

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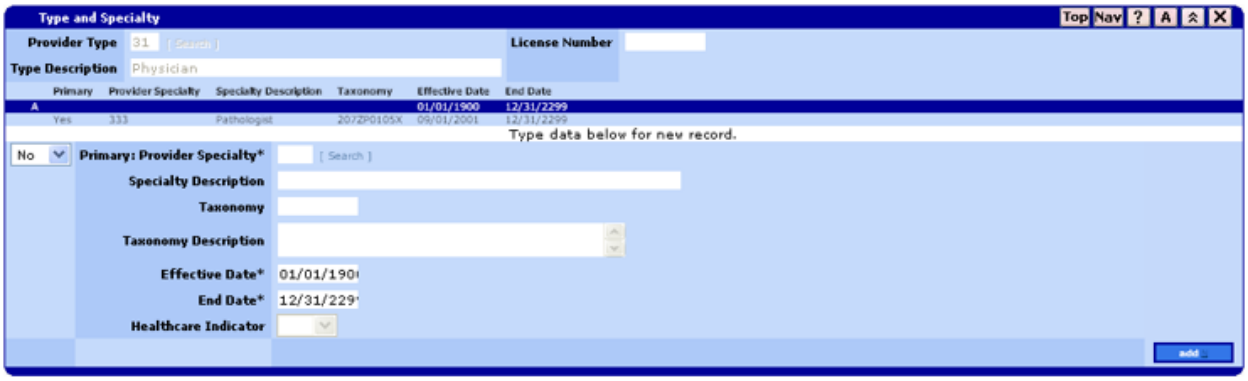
Type and Specialty Panel Overview

6.1.199 Type and Specialty Panel Narrative

The Type and Specialty panel is used to view and update provider type/specialty information by service location. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Type and Specialty]
OR
[Provider - Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Type and Specialty]

6.1.200 Type and Specialty Panel Layout



6.1.201 Type and Specialty Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add reason code information.	Button	N/A	0
Effective Date	Effective date of the provider specialty.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the provider specialty.	Field	Date (MM/DD/CCYY)	8
Healthcare Indicator	Indicates whether a license is required for the given type/specialty. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
License Number	Provider's state license number.	Field	Character	5
Primary	Provider's primary scope of practice (if more than one).	Field	Character	3
Primary: Provider Specialty	Provider's scope of practice.	Combo Box	Drop Down List Box	0
Provider Specialty	Provider's scope of practice.	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Provider Type	Provider's type (license or certification).	Field	Character	2
Specialty Description	Written description of provider's specialty.	Field	N/A	0
Taxonomy	Provider taxonomy code.	Field	Character	10
Taxonomy Description	Description of provider taxonomy code.	Field	Character	50
Type Description	Written description of provider's type.	Field	Character	50

6.1.202 Type and Specialty Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than the 01/01/1900 default date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same specialty code.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than the 01/01/1900 default date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same specialty code.
License Number	Field	10	Provider License Number must be Alphanumeric.	Verify keying. License can only contain A-Z and/or 0-9 characters.
	Field	5000	Warning: Provider License Number is not on file.	This is a warning message. The License Number entered is not on the license file. Choose OK to save, otherwise Cancel.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5001	Warning: Provider License Number is assigned to another provider.	This is a warning message. This License Number is already assigned to another provider in the system. Choose OK to save, otherwise Cancel.
	Field	5002	Warning: Provider License Number is required for this provider type.	This is a warning message. This provider type requires a license. Choose OK to save, otherwise Cancel.
Primary Specialty	Field	100	Select one Provider Specialty as Primary.	Verify keying. Select one Primary Specialty checkbox.
Provider Specialty	Field	100	Provider Type and Provider Specialty combination is invalid.	Verify keying. The chosen specialty is not valid for this Provider Type.
Type	Field	1	A valid Provider Type is required.	Enter or search for a Provider Type.

6.1.203 Type and Specialty Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.204 Type and Specialty Panel Accessibility

6.1.204.1 To Access the Type and Specialty Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Search**.	Provider Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Search results display.
4	Select a detail line from the results displayed.	Provider Information and Provider Maintenance panel display.
5	Click **Type and Specialty** hyperlink on the Provider Maintenance panel.	Type and Specialty panel displays.

6.1.204.2 To Add on Type and Specialty Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click **Primary** checkbox, if applicable.	
3	Click [**Search**] to select a specialty from list.	

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Step	Action	Response
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Select **Healthcare Indicator**, if applicable.	
7	Click **Save**.	Type and Specialty information is saved.

6.1.204.3 To Update on Type and Specialty Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click field to update and perform update.	
3	Click **Save**.	Type and Specialty information is saved.

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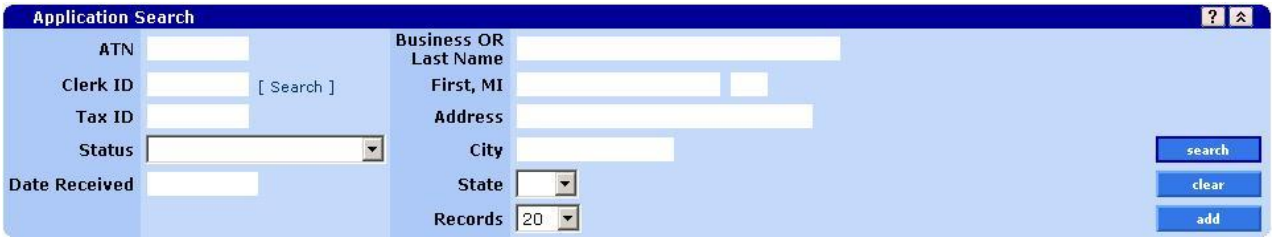
Application Search Panel Overview

6.1.205 Application Search Panel Narrative

The Application Search panel allows the user to enter search criteria and query for providers whose data matches those criteria. This panel allows the entry of search criteria for an application is progress.

Navigation Path: [Provider] – [Enrollment]

6.1.206 Application Search Panel Layout



6.1.207 Application Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add application information.	Button	N/A	0
ATN	System assigned key that uniquely identifies a provider application.	Field	Number (Integer)	9
Address	Provider's street address.	Field	Character	30
Business OR Last Name	Name of the business of provider or provider's last name.	Field	Character	50
City	City where the provider is located.	Field	Character	15
Clear	Allows the user to clear any changes on the Application Search panel.	Button	N/A	0
Clerk ID	The identification of the clerk.	Field	Character	8
Date Received	Date the application was received and put into the system.	Field	Date (MM/DD/CCYY)	8
First	The first name of the provider.	Field	Character	50
MI	The middle initial of the provider.	Field	Character	1
Records	Allows the user to select the number of records to retrieve during a search.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Current identification number.	Button	N/A	0
[Search]	Allows the user to search for a valid Clerk ID.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
State	State where the provider is located.	Combo Box	Drop Down List Box	0
Status	Status of the application in process.	Combo Box	Drop Down List Box	0
Tax ID	Tax identification of the provider.	Field	Character	9

6.1.208 Application Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
ATN	Field	1	Enter a valid value.	ATN value must be numeric.
Date Received	Field	1	Invalid date. Format is MM/DD/CCYY.	Ensure date entered is in a format of MM/DD/CCYY.

6.1.209 Application Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.210 Application Search Panel Accessibility

6.1.210.1 To Access the Application Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.

6.1.210.2 To Add Application Information via the Application Search Page

Step	Action	Response
1	Click **Add**.	Application Information, Application Information Maintenance and Base Information panels display.

6.1.210.3 To Update Application Information via the Application Search Page

Step	Action	Response
1	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.
2	Select a detail line from the results displayed.	Application Search panel displays.

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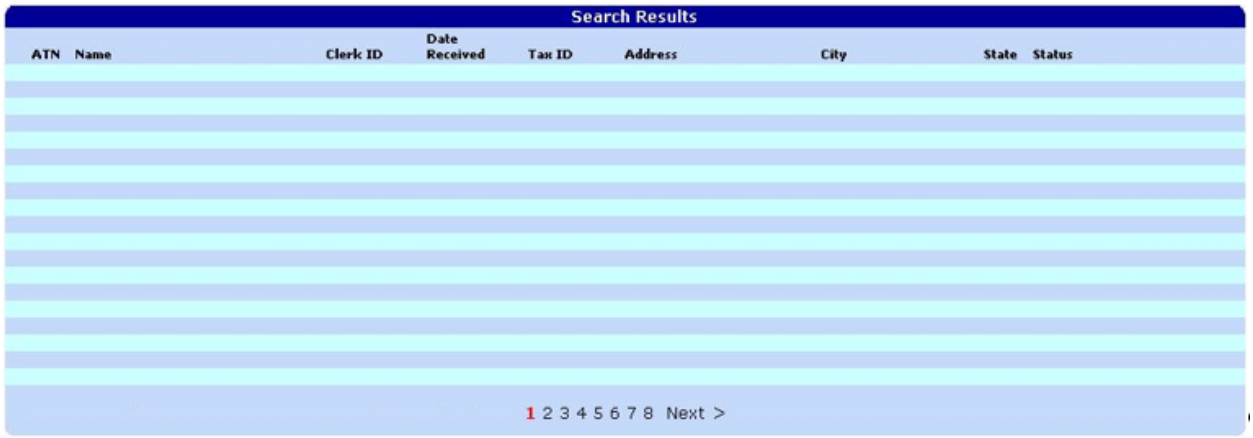
Application Search Results Panel Overview

6.1.211 Application Search Results Panel Narrative

The Application Search Results panel displays provider enrollment records using flexible selection criteria from enrollment search panel. This panel is display only.

Navigation Path: [Provider] – [Enrollment] [select row from search results]

6.1.212 Application Search Results Panel Layout



6.1.213 Application Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ATN	Provider's enrollment tracking number.	Field	Character	9
Address	The street address where the provider is located.	Field	Character	30
City	The city where the provider is located.	Field	Character	15
Clerk ID	Identification number of the clerk.	Field	Character	8
Date Received	Date the application was received and put into the system.	Field	Date (MM/DD/CCYY)	8
Name	The last name and first name of provider.	Field	Character	50
State	The state where the provider is located.	Field	Character	2
Status	Status of the application in process.	Field	Character	25
Tax ID	Tax identification number of the provider.	Field	Character	9

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6.1.214 Application Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.215 Application Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.216 Application Search Results Panel Accessibility

6.1.216.1 To Access Application Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search** and select a line item.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of providers to display.

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Application Mini-Search Panel Overview

6.1.217 Application Mini-Search Panel Narrative

The Application Mini-Search panel provides the user with the ability to search for an application from the Provider Enrollment Application Information page. This panel is inquiry only and allows the entry of search criteria for an application in progress.

Navigation Path: [Provider] – [Application Information]

6.1.218 Application Mini-Search Panel Layout

6.1.219 Application Mini-Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ATN	The provider's enrollment tracking number.	Field	Character	9
Business or Last Name, First	Provider's business, last, or first name.	Field	Character	50
Clear	Allows the user to clear any changes on the Application Mini Search panel.	Button	N/A	0
Search	Initiates the Search by ATN or Business Or Last Name, First.	Button	N/A	0

6.1.220 Application Mini-Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.221 Application Mini-Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.222 Application Mini-Search Panel Accessibility

6.1.222.1 To Access the Application Mini-Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Mini-Search panel displays.

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Application Information Panel Overview

6.1.223 Application Information Panel Narrative

The Application Information panel displays a summary of the provider application information. This panel displays the basic information entered from the enrollment application. This panel is inquiry only.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)]

6.1.224 Application Information Panel Layout

6.1.225 Application Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ATN	The system assigned key that uniquely identifies a provider application.	Field	Number (Integer)	9
Address 1	Street address of the provider.	Field	Character	30
Address 2	Second street address of the provider.	Field	Character	30
Application NPI	National Provider Identification (NPI) for the provider.	Field	Character	10
Application Type	Type of application requested by the provider.	Field	Character	15
City	The city the provider is located.	Field	Character	15
Clerk ID	Clerk identification that entered the application.	Field	Character	8
Contact	Person with which HPE corresponds at the provider applicant's place of business.	Field	Character	15
Date Received	Date the application was received and put into the system.	Field	Date (MM/DD/CCYY)	8
Finalized	Date the application was finalized.	Field	Date (MM/DD/CCYY)	8
Last Status Date	Last date of the current known status of the provider's license.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
License	License number assigned to the provider.	Field	Character	10
License Certification	Effective date of certification.	Field	Date (MM/DD/CCYY)	8
License Certification End	End date of certification.	Field	Date (MM/DD/CCYY)	8
License State	State for which license was granted.	Field	Character	2
License Type	Type of license issued to the provider. Valid values are H for Health Board, P for Prescriber and Other.	Field	Character	15
Media Type	Indicates the method a provider receives media information. Valid values are: fax, mail, phone, email and web.	Field	Character	15
Name	Last Name, First Name and Middle Initial of provider.	Field	Character	50
Phone	Provider's phone number.	Field	Character	10
Provider ID	Provider identification number.	Field	Character	9
RTP Received	Date that the RTP (Return to Provider) object was returned to the account.	Field	Date (MM/DD/CCYY)	8
RTP Sent	Date the RTP (Return to Provider) object was sent.	Field	Date (MM/DD/CCYY)	8
Sanctioned	Indication if the provider is sanctioned. Valid values include Yes and No.	Field	Character	3
State	The state the provider is located.	Field	Character	2
Status	Provider’s enrollment status. Valid values are: Approved, Awaiting Additional Information, Awaiting Initial Info, Denied, Enrolled, In Process and System Converted.	Field	Character	15
Tax ID	Tax identification number of the provider member.	Field	Character	9
Tax ID Type	Provider tax identification type. Valid values are FEIN and SSN.	Field	Character	5
Zip	Provider's zip code.	Field	Character	9

6.1.226 Application Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.1.227 Application Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.228 Application Information Panel Accessibility

6.1.228.1 To Access the Application Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Information panel displays.

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Application Information Maintenance Panel Overview

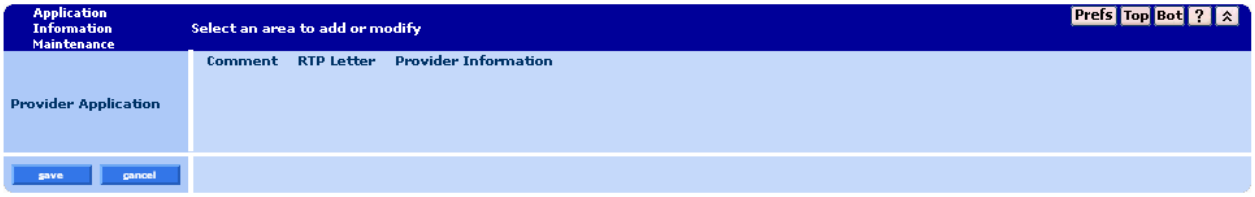
6.1.229 Application Information Maintenance Panel Narrative

The Application Information Maintenance panel provides links to the provider application information maintenance panels. During the enrollment process this panel is utilized as a navigation tool to panels such as the Comment panel.

This panel is inquiry only.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)]

6.1.230 Application Information Maintenance Panel Layout



6.1.231 Application Information Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Provider Application panels.	Button	N/A	0
Comment	Link to the Comment panel.	Hyperlink	N/A	0
Provider Information	Link to the Provider Information page.	Hyperlink	N/A	0
RTP Letter	Link to the RTP (Return to Provider) Letter panel.	Hyperlink	N/A	0
Save	Allows the user to save a record on the Provider Application panels.	Button	N/A	0

6.1.232 Application Information Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.233 Application Information Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.234 Application Information Maintenance Panel Accessibility

6.1.234.1 To Access the Application Information Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Information Maintenance panel displays.

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Application Base Information Panel Overview

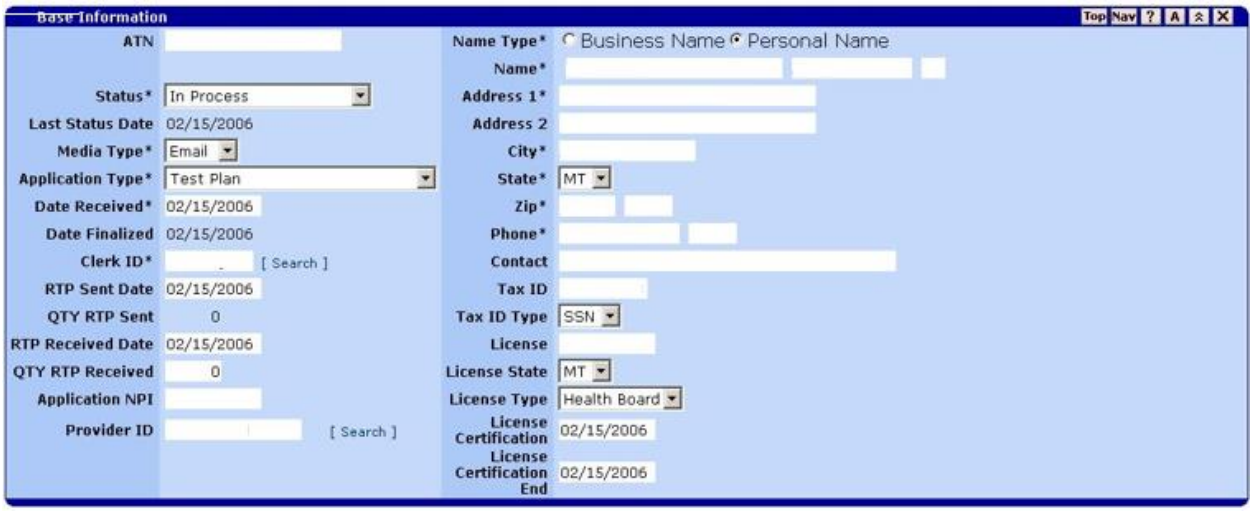
6.1.235 Application Base Information Panel Narrative

The Application Base Information panel allows users to view, update, or add provider application data. This panel is utilized in the application enrollment process to enter basic information regarding the provider enrolling.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Enrollment] [(Add button) OR (select row from search results)] - [Base Information]

6.1.236 Application Base Information Panel Layout



6.1.237 Application Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ATN	Provider's application tracking number.	Field	Character	9
Address 1	Address 1 of provider.	Field	Character	30
Address 2	Address 2 of provider.	Field	Character	30
Application NPI	Providers National Provider Identifier.	Field	Character	15
Application Type	Type of application requested by the provider.	Combo Box	Drop Down List Box	0
City	Provider's city.	Field	Character	15
Clerk ID	Identification of the clerk who entered the application.	Field	Character	8
Contact	Person with which HPE corresponds at the provider applicant's place of business.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Date Finalized	Date the application was finalized.	Field	Date (MM/DD/CCYY)	8
Date Received	Date the application was received and put into the system.	Field	Date (MM/DD/CCYY)	8
Last Status Date	Last date of the current known status of the provider's license.	Field	Date (MM/DD/CCYY)	8
License	License number assigned to the provider.	Field	Character	10
License Certification	Effective date of certification.	Field	Date (MM/DD/CCYY)	8
License Certification End	End date of certification.	Field	Date (MM/DD/CCYY)	8
License State	State for which license was granted.	Combo Box	Drop Down List Box	0
License Type	Type of license issued to the provider. Valid values are H for Health Board, P for Prescriber and Other.	Combo Box	Drop Down List Box	0
Media Type	Indicates the method a provider receives media information. Valid values are: fax, mail, phone, email and web.	Combo Box	Drop Down List Box	0
Name	Name of provider.	Field	Character	50
Name Type	Name type of provider. Must choose between Business and Personal.	Combo Box	Radio Button	0
Phone	Area code and phone number for provider.	Field	Character	10
Provider ID	Identification number of the provider.	Field	Character	9
QTY RTP Received	QTY RTP (Quantity Returned to Provider) Received.	Field	Number (Integer)	1
QTY RTP Sent	QTY RTP (Quantity Returned to Provider) Sent.	Field	Number (Integer)	1
RTP Received Date	Date the RTP (Returned to Provider) object was received.	Field	Date (MM/DD/CCYY)	8
RTP Sent Date	Date the RTP (Returned to Provider) object was sent.	Field	Date (MM/DD/CCYY)	8
State	Provider’s state.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Status	Provider's enrollment status. Valid values are: Approved, Awaiting Additional Information, Awaiting Initial Info, Denied, Enrolled, In Process and System Converted.	Combo Box	Drop Down List Box	0
Tax ID	Tax identification of the provider member.	Field	Character	9
Tax ID Type	Provider tax identification type. Valid values are FEIN and SSN.	Combo Box	Drop Down List Box	0
Zip	Zip code of the provider.	Field	Number (Integer)	5
Zip + 4	Board zip code extension.	Field	Number (Integer)	4

6.1.238 Application Base Information Panel Field Edit Error Code Tables

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter Address 1 field.
Application Type	Field	1	A valid Application Type is required.	Choose an Application Type.
City	Field	1	City is required.	Enter a City.
Clerk ID	Field	5000	Clerk ID is not valid.	Enter a valid Clerk ID.
Date Received	Field	1	Date received is required.	Enter a received date.
	Field	5000	Date Received must be less than or equal to today.	Verify keying. The application received date must be less than or equal to today's date.
License	Field	5000	Warning: License Number already assigned to Provider [A].	This is a warning message. The license entered is assigned to one or more providers in the system. Please ensure this is not a duplicate enrollment.
	Field	5001	License Number must be at least 4 characters in length.	Verify keying. The License Number must be at least four characters.
	Field	5002	License Number must be Alphanumeric.	Verify keying. Entry must be 0-9 or A-Z.
Media Type	Field	1	Media Type is required.	Choose a Media Type.
Name	Field	1	Name is required.	Enter the provider name.
	Field	5000	Both First Name and Last Name are required.	Verify keying. If entering a personal name, the last name and first name fields are required.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5001	Warning: Duplicate Name and Type.	This is a warning message. The name and name type entered is assigned to one or more providers in the system. Please ensure this is not a duplicate enrollment.
Phone	Field	1	Phone is required.	Enter the provider Phone number.
Provider ID	Field	5000	Provider ID must be a valid provider.	Verify keying. The Provider ID entered is not a valid Provider ID. Enter or search for a valid provider.
RTP Received Date	Field	5000	RTP (Returned to Provider) Received Date must be greater than or equal to Date Received.	Verify keying. The RTP received date must be greater than the received date.
RTP Sent Date	Field	5000	RTP (Returned to Provider) Sent Date must be greater than or equal to Date Received.	Verify keying. The RTP sent date must be greater than the received date.
State	Field	1	A valid State is required.	Choose a State.
Status	Field	1	Status is required.	Choose an application status.
	Field	5000	Cannot change Status to Enrolled.	Verify keying. Enrolled is a system assigned status. Please choose another status.
Tax ID	Field	5000	Tax ID must be 9 characters in length.	Verify keying. The Tax ID must be nine characters.
	Field	5001	Tax ID must be Numeric.	Verify keying. Enter a numeric Tax ID.
	Field	5002	Warning: Tax ID [A] is assigned to another provider.	This is a warning message. The Tax ID entered [A] is assigned to one or more providers in the system. Please ensure this is not a duplicate enrollment.
Zip	Field	1	Zip Code is required.	Enter a Zip Code.

6.1.239 Application Base Information Panel Extra Feature

Field	Field Type
No extra features found for this panel.	

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6.1.240 Application Base Information Panel Accessibility

6.1.240.1 Application Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Related Data page displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Base Information panel displays.

6.1.240.2 To Add on Application Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Status** from drop down list.	
3	Select **Media Type** from drop down list.	
4	Select **Application Type** from drop down list.	
5	Enter **Date Received** in MM/DD/CCYY format.	
6	Enter Clerk ID.	
7	Enter **RTP Sent Date** (if applicable).	
8	Enter QTY RTP Sent.	
9	Enter Application NPI.	
10	Enter **Provider ID**; Or click [Search] and select Provider ID.	Clicking [Search] opens Provider ID search panel.
11	Select **Business** or **Personal Name Type** by clicking button.	
12	Enter Address 1.	
13	Enter **Address 2**, if applicable.	
14	Enter **City**.	
15	Select **State** from drop down list.	
16	Enter Zip+4 code.	
17	Enter **Area Code and Phone Number**; enter Extension, if applicable.	
18	Enter Contact Name.	
19	Enter **Tax ID**.	

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Step	Action	Response
20	Select **Tax ID Type** from drop down list.	
21	Enter License Number.	
22	Select **State** from the drop down list.	
23	Select **License Typ**e from the drop down list.	
24	Enter **License Certification Date** in MM/DD/CCYY format.	
25	Enter License Certification End Date in MM/DD/CCYY format.	
26	Click **Save**.	Application Base Information is saved.

6.1.240.3 To Update the Application Base Information Panel

Step	Action	Response
1	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
2	Select a detail line from the results displayed.	Base Information panel displays.
3	Click in field(s) to update and perform update.	
4	Click **Save**.	Application Base Information is saved.

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Application Comment Panel Overview

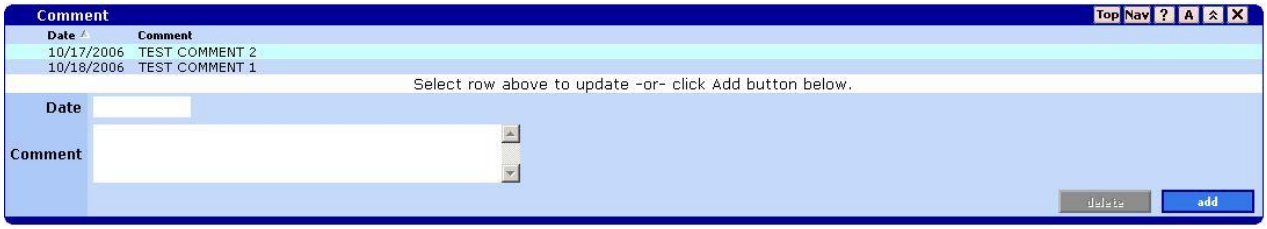
6.1.241 Application Comment Panel Narrative

The Application Comment panel is used to hold any comments the user has regarding the provider's application. The panel is utilized to add comments/notes regarding the application being processed or the provider enrolling.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Comment]

6.1.242 Application Comment Panel Layout



6.1.243 Application Comment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a comment.	Button	N/A	0
Comment	Comment field used to notate information regarding a provider's application.	Field	Character	250
Date	Date when comment was entered into system.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete a record.	Button	N/A	0

6.1.244 Application Comment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comment	Field	1	Comment is required.	Enter a Comment.
Date	Field	1	Date is required.	Enter a valid comment date.
	Field	2	Date must be greater than or equal to 01/01/1900.	Enter a date greater than or equal to 01/01/1990.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter a date with format MM/DD/CCYY.

6.1.245 Application Comment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.246 Application Comment Panel Accessibility

6.1.246.1 To Access the Application Comment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Information Maintenance panel displays.
5	Click hyperlink for **Comment** panel.	Application Comment panel displays.

6.1.246.2 To Add on Application Comment Panel

Step	Action	Response
1	Click **Add**.	
2	Enter **Date** in MM/DD/CCYY format.	
3	Enter **Comment**.	
4	Click **Save**.	Application Comment information is saved.

6.1.246.3 To Update the Application Comment Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Application Comment information is saved.

6.1.246.4 To Delete from the Application Comment Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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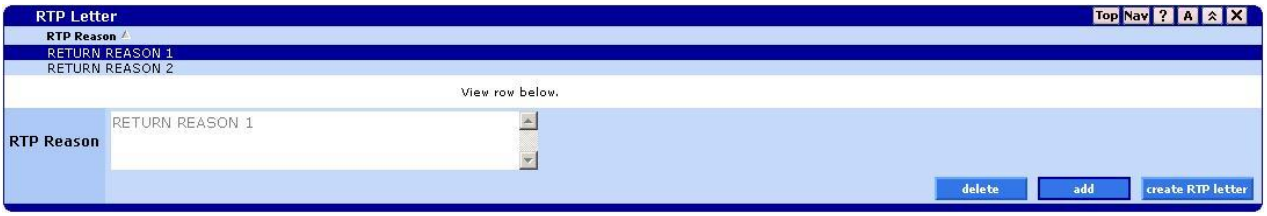
Application RTP Letter Panel Overview

6.1.247 Application RTP Letter Panel Narrative

The Application RTP (Return to Provider) Letter panel is used to save return to provider (RTP) reasons. The reasons then appear on the Provider RTP Letter when the Generate RTP Letter button is selected. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [RTP Letter]

6.1.248 Application RTP Letter Panel Layout



6.1.249 Application RTP Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add return to provider (RTP) information.	Button	N/A	0
Create RTP Letter	Allows the user to create a provider letter.	Button	N/A	0
Delete	Allows the user to delete return to provider (RTP) information.	Button	N/A	0
RTP Reason	The reason that the application has been returned to the provider with valid values.	Field	Character	250

6.1.250 Application RTP Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
RTP Reason	Field	1	RTP (Return to Provider) Reason is required.	Enter an RTP Reason.

6.1.251 Application RTP Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.252 Application RTP Letter Panel Accessibility

6.1.252.1 To Access the Application RTP Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Information Maintenance panel displays.
5	Click hyperlink for **RTP Letter** panel.	Application RTP Letter panel displays.

6.1.252.2 To Add on Application RTP Letter Panel

Step	Action	Response
1	Click **Add**.	
2	Enter RTP Reason.	
3	Click **Save**.	Application RTP Letter information is saved.

6.1.252.3 To Update the Application RTP Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Application RTP Letter information is saved.

6.1.252.4 To Delete from the Application RTP Letter Panel

Step	Action	Response
1	Select line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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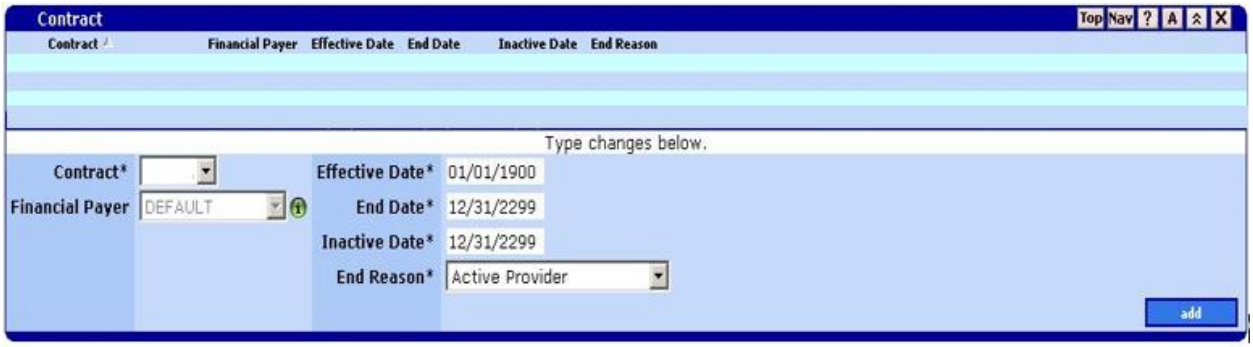
Application Contract Panel Overview

6.1.253 Application Contract Panel Narrative

The Application Contract Maintenance is used during enrollment to add contract eligibility information. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Enroll Provider (only available when application status is Approved and Provider ID field <> blank)]

6.1.254 Application Contract Panel Layout



6.1.255 Application Contract Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add application contract information.	Button	N/A	0
Contract	Name of the contract(s) in which the provider can be enrolled.	Combo Box	Drop Down List Box	0
Effective Date	Effective date of enrollment for the chosen contract.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the enrollment for the chosen contract.	Field	Date (MM/DD/CCYY)	8
End Reason	Status of eligibility.	Combo Box	Drop Down List Box	0
Financial Payer	Financial Payer.	Combo Box	Drop Down List Box	0
Inactive Date	Inactive date of the enrollment for the chosen contract.	Field	Date (MM/DD/CCYY)	8

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6.1.256 Application Contract Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Contract	Field	1	A valid Contract is required.	Select a Contract.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same contract.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same contract.
End Reason	Field	1	A valid End Reason is required.	Select an End Reason.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a contract. The Financial Payer automatically populates depending on the contract value chosen.
Inactive Date	Field	0	Inactive Date is required.	Verify keying. Panel requires entry of a end date which is populated as the inactive date. Enter an End Date if not already entered.

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6.1.257 Application Contract Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.258 Application Contract Panel Accessibility

6.1.258.1 To Access the Application Contract Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria for an application in Approved status and click **Search**; Or click **Search** and select a line item with a status of Approved.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Enroll Provider link displays at the bottom of the browser page.
5	Click Enroll Provider link.	Contract panel displays.

6.1.258.2 To Add on Application Contract Panel

Step	Action	Response
1	Click line item shown for new contract.	
2	Select **Contract** from drop down list.	
3	Enter **Effective Date** of contract in MM/DD/CCYY format.	
4	Enter **End Date** of contract in MM/DD/CCYY format, if applicable.	
5	Enter **Inactive Date** of contract in MM/DD/CCYY format, if applicable.	
6	Select **End Reason** from drop down list, if applicable.	
7	Click **Save**.	Application Contract information is saved.

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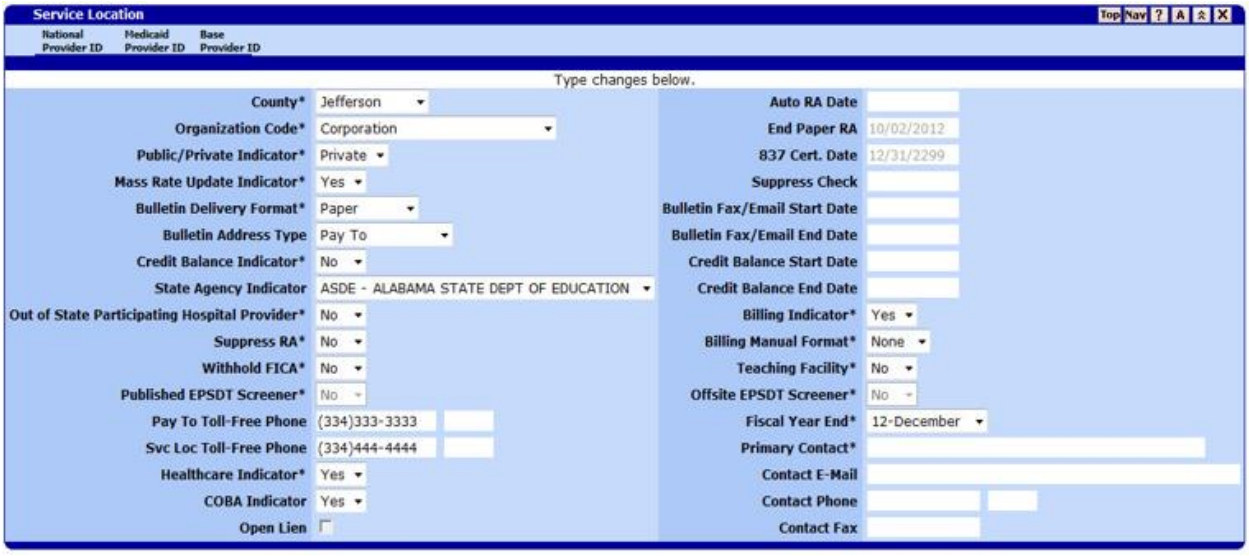
Provider Enrollment Application Information Service Location Panel Overview

6.1.259 Provider Enrollment Application Information Service Location Panel Narrative

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Enrollment] - (select row from search results)] - [Base Information] - [Enroll Provider (only available when application status is Approved and Provider ID field <> blank)]

6.1.260 Provider Enrollment Application Information Service Location Panel Layout



6.1.261 Provider Enrollment Application Information Service Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
No field descriptions found for this panel.				

6.1.262 Provider Enrollment Application Information Service Location Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
County	Field	1	County is required.	Choose a County.
End Paper RA	Field	2	Trading partner agreement required to end Paper RA.	A provider must receive either an electronic or paper RA. The paper RA cannot end until the provider has a trading partner agreement to receive electronic.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	End Paper RA [A] cannot be less than Auto RA Date [B].	A provider must receive either an electronic or paper RA. The paper RA cannot end until the provider has a trading partner agreement to receive electronic.
Fiscal Year End	Field	1	Fiscal Year End is required.	Choose a Fiscal Year End date.
Organization Code	Field	1	Org Code is required.	Choose an Organization Code.

6.1.263 Provider Enrollment Application Information Service Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.264 Provider Enrollment Application Information Service Location Panel Accessibility

6.1.264.1 To Access the Provider Enrollment Application Information Service Location Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria for an application in Approved status and click **Search**; Or click **Search** and select a line item with a status of Approved.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Enroll Provider link displays at the bottom of the browser page.
5	Click Enroll Provider link.	Service Location panel displays.

6.1.264.2 To Add on Application Information Service Location Panel

Step	Action	Response
1	Click Enroll Provider link.	Service Location panel displays.
2	Select **County** from drop down list.	
3	Select **Organization Code** from drop down list.	
4	Select **Public/Private Indicato**r from drop down list.	
5	Select **Mass Rate Update Indicator** from drop down list.	

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Step	Action	Response
6	Select **Bulletin Delivery Format** from drop down list.	
7	Select **Bulletin Address Type** from drop down list, if applicable.	
8	Select **Credit Balance Indicator** from drop down list.	
9	Select Out of State Provider Indicator from drop down list.	
10	Select **Suppress RA Indicator** from drop down list.	
11	Select **Withhold FICA Indicator** from drop down list.	
12	Select Published EPSDT Screener Indicator from drop down list.	
13	Enter **Pay To Toll Free Phone** and extension, if applicable.	
14	Enter **Svc Loc Toll Free Phone** and extension, if applicable.	
15	Select **Healthcare Indicator** from drop down list.	
16	Enter **End Paper RA** date in MM/DD/CCYY format, if applicable.	
17	Enter **Bulletin Fax/Email Start Date** in MM/DD/CCYY format, if applicable.	
18	Enter **Bulletin Fax/Email End Date** in MM/DD/CCYY format, if applicable.	
19	Enter **Credit Balance Start Date** in MM/DD/CCYY format, if applicable.	
20	Enter **Credit Balance End Date** in MM/DD/CCYY format, if applicable.	
21	Select **Billing Indicator** from drop down list.	
22	Select **Teaching Facility** indicator from drop down list.	
23	Select **Offsite EPSDT Screener** indicator, if applicable.	
24	Select **Fiscal Year End** month from drop down list.	
25	Enter **Primary Contact** name, if applicable.	
26	Check **Open Lien** check box, if applicable.	

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Step	Action	Response
27	Click **Save**.	Application Information Service Location is saved.

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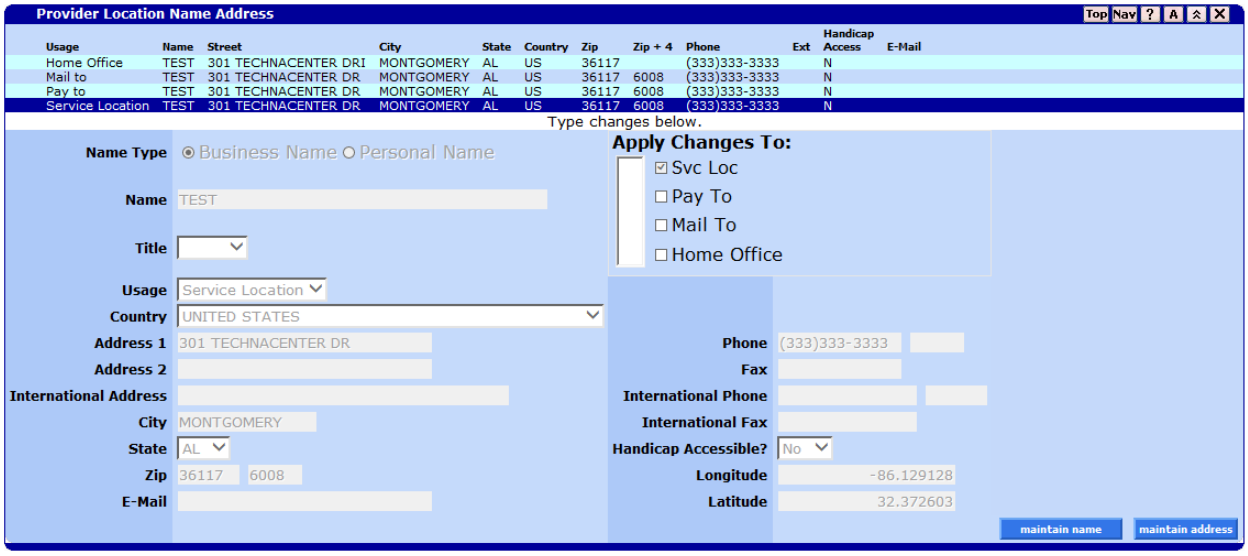
Application Location Name Address Panel Overview

6.1.265 Application Location Name Address Panel Narrative

The Application Location Name Address panel is used to view and update provider names and addresses. The panel displays the list of names and addresses for a specific service location and the user has the capability to change the name and/or address by clicking on the Maintain Name or Maintain Address buttons. At that time, the user can either key in a new name or address or choose Select from List to select a name or address from the list of names and addresses the provider has on file. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Search] - [select row from search results] - [Location Name Address] OR [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Add Service Location (only available when application status is Approved and Provider ID field <> blank) OR Enroll Contract (only available when application status is Approved and Provider ID field = blank)] - [Location Name Address]

6.1.266 Application Location Name Address Panel Layout



6.1.267 Application Location Name Address Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Street address 1 of the financial institution.	Field	Character	30
Address 2	Street address 2 of the financial institution.	Field	Character	30
City	City of the financial institution.	Field	Character	15
Country	The country associated to the address selected.	Combo Box	Drop Down List Box	0
Email	Provider's email address.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Fax	Provider's fax number.	Field	Character	10
Handicap accessible	Provider's handicap access indicator. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Home Office	Mail office type of address.	Combo Box	Check Box	0
International Address	Provider’s international address.	Field	Character	51
International Fax	Provider’s international fax.	Field	Character	15
International Phone	Provider’s international phone.	Field	Character	15
International Phone Extension	Provider’s international phone extension.	Field	Character	5
Latitude	Provider's calculated latitude.	Field	Number (Integer)	11
Longitude	Provider's calculated longitude.	Field	Number (Integer)	11
Mail To	Mail to type of address.	Combo Box	Check Box	0
Name	Provider's name.	Field	Character	50
Name Type	Type of name: Business or Personal.	Combo Box	Radio Button	0
Pay To	Pay to type of address.	Combo Box	Check Box	0
Phone	Provider's phone number.	Field	Character	10
Phone + Phone Ext	Provider's phone number + provider's phone extension.	Field	Character	14
Phone Ext	Provider's phone extension.	Field	Character	4
State	State of the financial institution.	Combo Box	Drop Down List Box	0
Street address 1 + Street address 2	Street address 1 and 2 of the financial institution.	Field	Character	30
Svc Loc	Service location type of address.	Combo Box	Check Box	0
Title	Provider's official title with valid values from the title list.	Combo Box	Drop Down List Box	0
Usage	Type of address with valid value to include: Home Office Address, Mail-To Address, Pay-To Address, and Service Location Address.	Combo Box	Drop Down List Box	0
Zip	Zip code of the financial institution.	Field	Character	5

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Field	Description	Field Type	Data Type	Length
Zip + 4	Zip code extension of the financial institution.	Field	Character	4

6.1.268 Application Location Name Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address Line 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Latitude	Field	5000	Latitude and Longitude could not be calculated. Please review changes.	This is a warning message. The Latitude and Longitude could not be calculated for the address entered. Please review the changes.
Longitude	Field	5000	Latitude and Longitude could not be calculated. Please review changes.	This is a warning message. The Latitude and Longitude could not be calculated for the address entered. Please review the changes.
Name	Field	1	Name is required.	Enter a Name.
	Field	231	Both First Name and Last Name are required.	Enter a first and last name.
Phone	Field	1	Phone is required.	Enter a Phone Number.
State	Field	29	A valid State is required.	Choose a State code.
Toll Free Phone	Field	1	Toll Free phone number is required if Ext. is entered.	Enter a Toll Free phone number.
Zip	Field	1	Zip is required.	Enter a Zip Code.

6.1.269 Application Location Name Address Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.270 Application Location Name Address Panel Accessibility

6.1.270.1 To Access the Application Location Name Address Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria for an application in Approved status and click **Search**; Or click **Search** and select a line item with a status of Approved.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.

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Step	Action	Response
4	Select a detail line from the results displayed.	Enroll Provider link displays at the bottom of the browser page.
5	Click Enroll Provider link.	Application Location Name Address panel displays.

6.1.270.2 To Update the Application Location Name Address Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain Name or Maintain Address button.	Fields are populated with data related to the line selected.
3	Click in field(s) to update and perform update.	
4	Click **Save**.	Application Location Name information is saved.

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Provider Enrollment Application Information Enroll Provider Page Overview

6.1.271 Provider Enrollment Application Information Enroll Provider Page Narrative

The Provider Enrollment Application Information Enroll Provider page displays the Application Information, Application Information Maintenance, Application Mini-Search and Base Information panels.

This page is display only.

Navigation Path: [Provider] – [Enrollment] - [(Add button) OR (select row from search results)] - [Base Information] - [Enroll Provider (only available when application status is Approved and Provider ID field <> blank)]

6.1.272 Provider Enrollment Application Information Enroll Provider Page Layout

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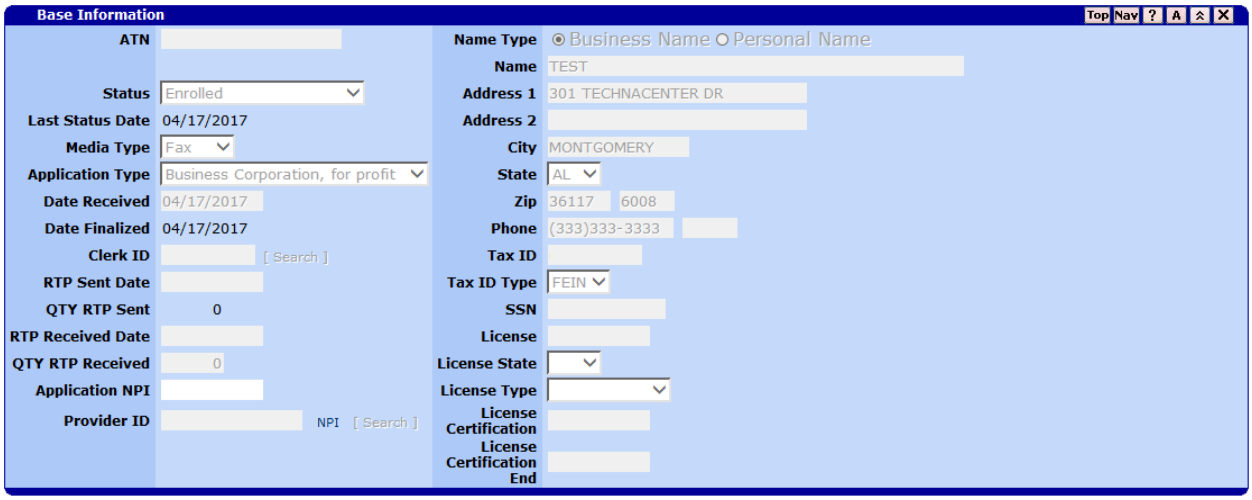

6.1.273 Provider Enrollment Application Information Enroll Provider Page Field Descriptions

Field	Description	Field Type	Data Type	Length
No field descriptions found for this page.				

6.1.274 Provider Enrollment Application Information Enroll Provider Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

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6.1.275 Provider Enrollment Application Information Enroll Provider Page Extra Features

Field	Field Type
No extra features found for this page.	

6.1.276 Provider Enrollment Application Information Enroll Provider Page Accessibility

6.1.276.1 To Access the Provider Enrollment Application Information Enroll Provider Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Enrollment**.	Application Search panel displays.
3	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of applications to display.
4	Select a detail line from the results displayed.	Application Information panel displays.

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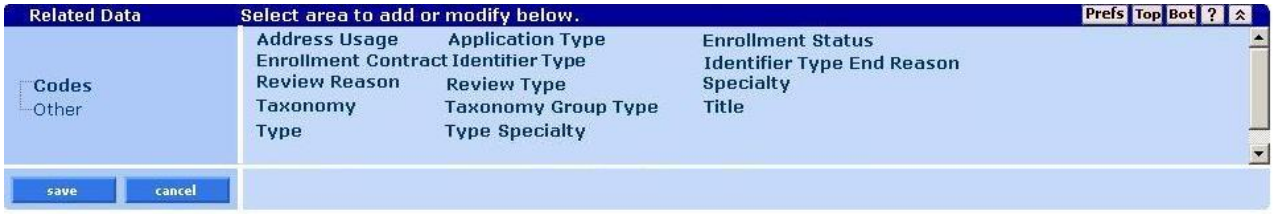
Provider Related Data Codes Page Overview

6.1.277 Provider Related Data Codes Page Narrative

The Provider Related Data Codes page displays the Address Usage, Application Type, Enrollment Contract, Enrollment Status, Identifier Type, Identifier Type End Reason, Review Reason, Review Type, Specialty, Taxonomy, Taxonomy Group Type, Title, Type and Type Specialty panels. This panel is utilized as a navigation tool to access related data panels.

Navigation Path: [Provider] – [Related Data] - [Codes]

6.1.278 Provider Related Data Codes Page Layout



6.1.279 Provider Related Data Codes Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Address Usage	Link to the Address Usage panel.	Hyperlink	N/A	0
Application Type	Link to the Application Type panel.	Hyperlink	N/A	0
Cancel	This allows the user to cancel any changes on the Related Data-Codes panel.	Button	N/A	0
Enrollment Contract	Link to the Enrollment Contract panel.	Hyperlink	N/A	0
Enrollment Status	Link to the Enrollment Status panel.	Hyperlink	N/A	0
Identifier Type	Link to the Identifier Type panel.	Hyperlink	N/A	0
Identifier Type End Reason	Link to the Identifier Type End Reason panel.	Hyperlink	N/A	0
Review Reason	Link to the Review Reason panel.	Hyperlink	N/A	0
Review Type	Link to the Review Type panel.	Hyperlink	N/A	0
Save	This allows the user to save a record for Related Data.	Button	N/A	0
Specialty	Link to the Specialty panel.	Hyperlink	N/A	0
Taxonomy	Link to the Taxonomy panel.	Hyperlink	N/A	0
Taxonomy Group Type	Link to the Taxonomy Group Type panel.	Hyperlink	N/A	0
Title	Link to the Title panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Type	Link to the Type panel.	Hyperlink	N/A	0
Type Specialty	Link to the Type Specialty panel.	Hyperlink	N/A	0

6.1.280 Provider Related Data Codes Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.1.281 Provider Related Data Codes Page Extra Features

Field	Field Type
No extra features found for this page.	

6.1.282 Provider Related Data Codes Page Accessibility

6.1.282.1 To Access the Provider Related Data Codes Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Click **Codes**.	Related Data-Codes panel displays.

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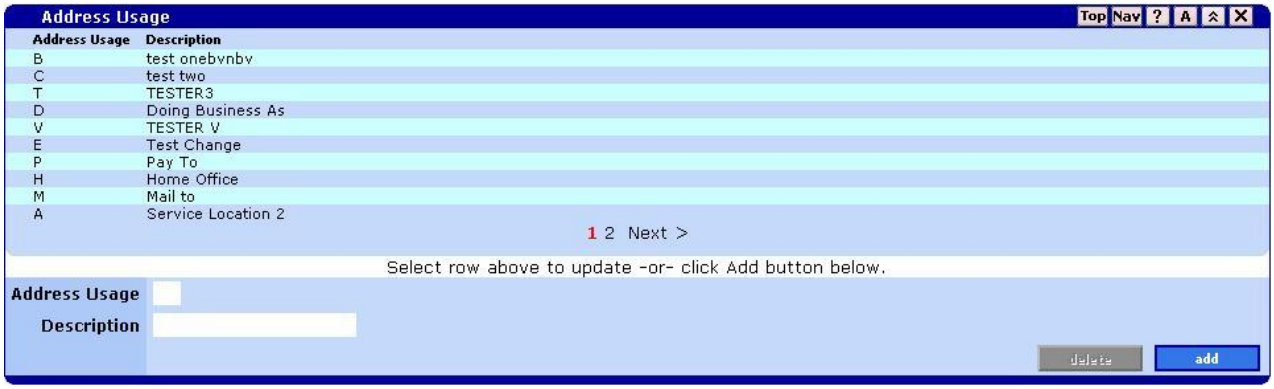
Address Usage Panel Overview

6.1.283 Address Usage Code Panel Narrative

The Address Usage panel is used to maintain address usage codes which feed into the selections available in the Usage drop-down list on the Provider Location Name Address panel. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Address Usage]

6.1.284 Address Usage Panel Layout



6.1.285 Address Usage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add address usage code information.	Button	N/A	0
Address Usage	Code associated with the address usage description.	Field	Character	1
Delete	Allows the user to remove address usage code information.	Button	N/A	0
Description	Type of address with valid value to include: Home Office Address, Mail-To Address, Pay-To Address and Service Location Address.	Field	Character	20

6.1.286 Address Usage Code Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address Usage	Field	1	Address Usage is required.	Enter an Address Usage.
	Field	10	Address Usage must be Alphanumeric.	Verify keying. Address Usage must be 0-9 or A-Z.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The address code entered already exists.
Description	Field	1	Description is required.	Enter a Description.

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6.1.287 Address Usage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.288 Address Usage Panel Accessibility

6.1.288.1 To Access the Address Usage Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Click **Address Usage** hyperlink on Related Data panel.	Address Usage panel displays.

6.1.288.2 To Add on Address Usage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Address Usage Code.	
3	Enter **Description** of the code.	
4	Click **Save**.	Address Usage information is saved.

6.1.288.3 To Update the Address Usage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Address Usage information is saved.

6.1.288.4 To Delete from the Address Usage Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Application Type Panel Overview

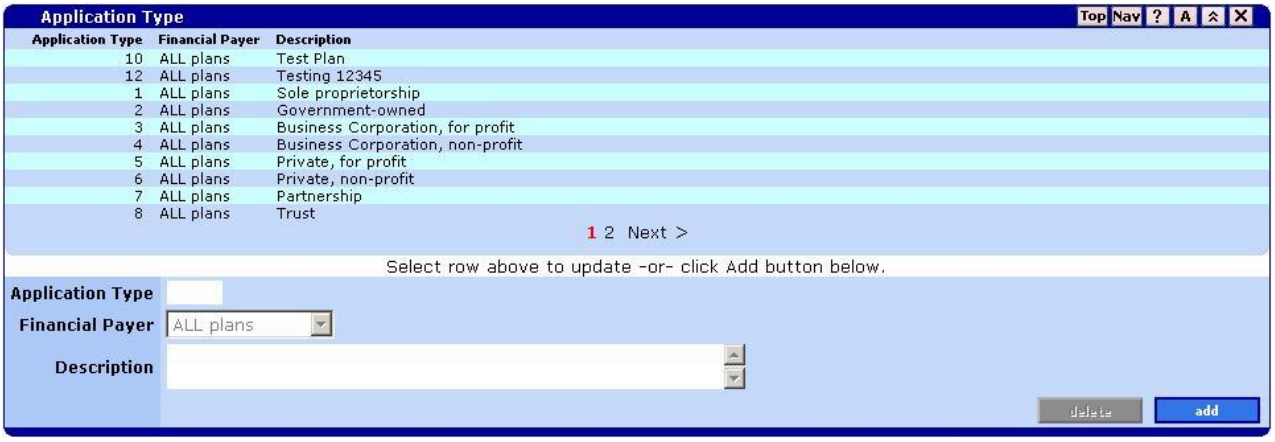
6.1.289 Application Type Panel Narrative

The Application Type panel is used to maintain application type codes which feed into the selections available in the Application Type drop-down list on the Provider Application Base Information panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] - [Related Data] - [Codes] - [Application Type]

6.1.290 Application Type Panel Layout



6.1.291 Application Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add application type code information.	Button	N/A	0
Application Type	Application type code.	Field	Number (Integer)	3
Delete	Allows the user to remove application type code information.	Button	N/A	0
Description	The description of the application type.	Field	Character	100
Financial Payer	Financial payer.	Combo Box	Drop Down List Box	0

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6.1.292 Application Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Application Type	Field	1	Enter a valid value.	Verify value enter is numeric.
	Field	15	Application Type must be greater than or equal to 1.	Verify keying. The Application Type must be greater than or equal to zero.
	Field	16	Application Type must be less than or equal to 999.	Verify keying. The Application Type must be less than or equal to 999.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Application Type entered already exists.
Description	Field	1	Description is required.	Description is required.
Financial Payer	Field	1	A valid Financial Payer is required.	Choose a Financial Payer.

6.1.293 Application Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.294 Application Type Panel Accessibility

6.1.294.1 To Access the Application Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Application Type.	Application Type panel displays.

6.1.294.2 To Add on Application Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Application Type.	
3	Select **Financial Payer** from drop down list.	
4	Enter **Description** of the code.	
5	Click **Save**.	Application Type information is saved.

6.1.294.3 To Update the Application Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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2	Click in field(s) to update and perform update.	
3	Click **Save**.	Application Type information is saved.

6.1.294.4 To Delete from the Application Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Enrollment Contract Panel Overview

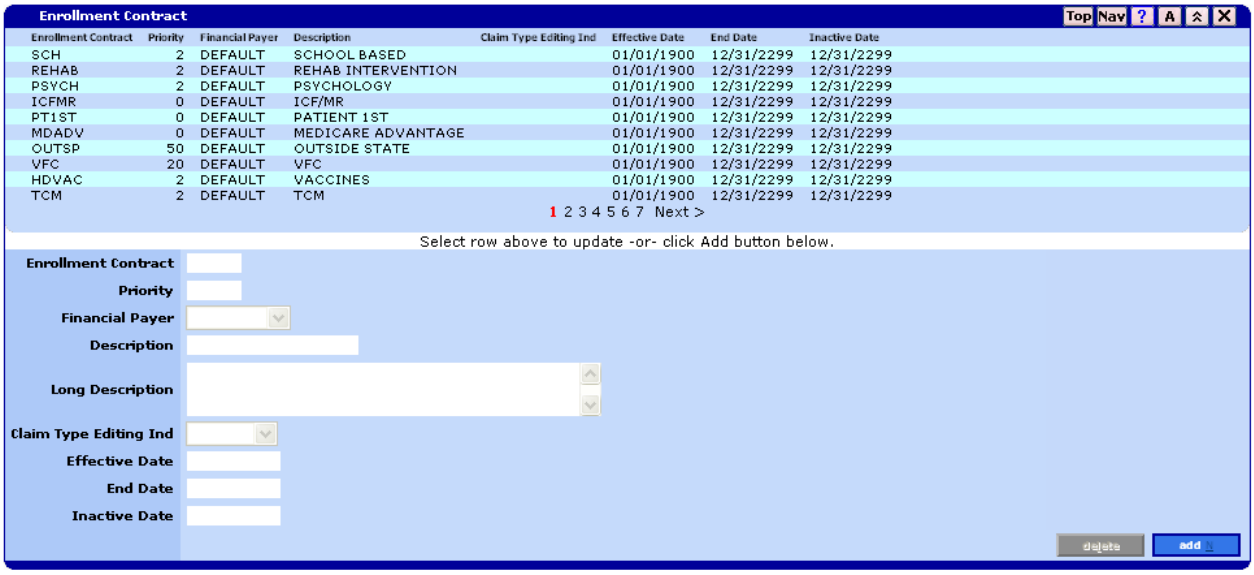
6.1.295 Enrollment Contract Panel Narrative

The Enrollment Contract panel is used to maintain enrollment contract codes which feed into the selections available in the Contract drop-down list on the Provider Contract panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Enrollment Contract]

6.1.296 Enrollment Contract Panel Layout



6.1.297 Enrollment Contract Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add enrollment contract code information.	Button	N/A	0
Claim Type Editing Ind	Indicator for claim type editing.	Comb o Box	Drop Down List Box	0
Delete	Allows the user to remove enrollment contract code information.	Button	N/A	0
Description	Short description of the provider enrollment contract.	Field	Character	20
Effective Date	The effective date of the provider enrollment contract.	Field	Date (MM/DD/CCYY)	8
End Date	The end date of the provider enrollment contract.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Enrollment Contract	Code that represents a provider enrollment contract.	Field	Character	5
Financial Payer	Financial payer for the provider enrollment contract.	Comb o Box	Drop Down List Box	0
Inactive Date	The date the provider enrollment contract became inactive.	Field	Date (MM/DD/CCYY)	8
Long Description	Long description of the provider enrollment contract.	Field	Character	4000
Priority	Priority of the enrollment contract.	Field	Character	5

6.1.298 Enrollment Contract Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Effective Date	Field	1	Effective Date is required.	Enter a valid date [MM/DD/CCYY].
End Date	Field	1	End Date is required.	Enter a valid date [MM/DD/CCYY].
Enrollment Contract	Field	1	Enrollment Contract is required.	Enter an Enrollment Contract.
	Field	2	Enrollment Contract must be at least 3 characters in length.	Enter an Enrollment Contract with 3 characters or more.
	Field	10	Enrollment Contract must be Alphanumeric.	Verify keying. Entry must be 0-9 or A-Z.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Enrollment Contract entered already exists.
Financial Payer	Field	29	A valid Financial Payer is required.	Choose a Financial Payer.
Inactive Date	Field	1	Inactive Date is required.	Inactive Date must be a valid date [MM/DD/CCYY].
	Field	1	Inactive date is required.	Enter a valid date [MM/DD/CCYY]].
Long Description	Field	1	Long Description is required.	Enter a Long Description.

6.1.299 Enrollment Contract Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.300 Enrollment Contract Panel Accessibility

6.1.300.1 To Access the Enrollment Contract Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	A list of hyperlinks to panel(s) displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Enrollment Contract.	Enrollment Contract Code panel displays.

6.1.300.2 To Add on Enrollment Contract Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Enrollment Contract Code.	
3	Enter Priority.	
4	Select Financial Payer.	
5	Enter **Description** of the code.	
6	Enter Long Description.	
7	Select Claim Type Editing Indicator.	
8	Enter Effective Date.	
9	Enter End Date.	
10	Enter Inactive Date.	
11	Click **Save**.	Enrollment Contract information is saved.

6.1.300.3 To Update the Enrollment Contract Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Enrollment Contract information is saved.

6.1.300.4 To Delete from the Enrollment Contract Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Enrollment Status Panel Overview

6.1.301 Enrollment Status Panel Narrative

The Enrollment Status panel is used to maintain enrollment status codes which feed into the selections available in the End Reason drop-down list on the Provider Contract panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Enrollment Status]

6.1.302 Enrollment Status Panel Layout

6.1.303 Enrollment Status Panel Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add enrollment status code information.	Button	N/A	0
Delete	Allows the user to remove enrollment status code information.	Button	N/A	0
Description	Description of the enrollment status code.	Field	Character	21
Enrollment Status	Enrollment status code.	Field	Character	1

6.1.304 Enrollment Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Enrollment Status	Field	1	Enrollment Status is required.	Enter an Enrollment Status.
	Field	10	Enrollment Status must be Alphanumeric.	Verify keying. Enrollment status must be 0-9 or A-Z.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Enrollment Status entered already exists.

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6.1.305 Enrollment Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.306 Enrollment Status Panel Accessibility

6.1.306.1 To Access the Enrollment Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Enrollment Status.	Enrollment Status panel displays.

6.1.306.2 To Add on Enrollment Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Enrollment Status.	
3	Enter **Description** of the code.	
4	Click **Save**.	Enrollment Status information is saved.

6.1.306.3 To Update the Enrollment Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Enrollment Status information is saved.

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6.1.306.4 To Delete from the Enrollment Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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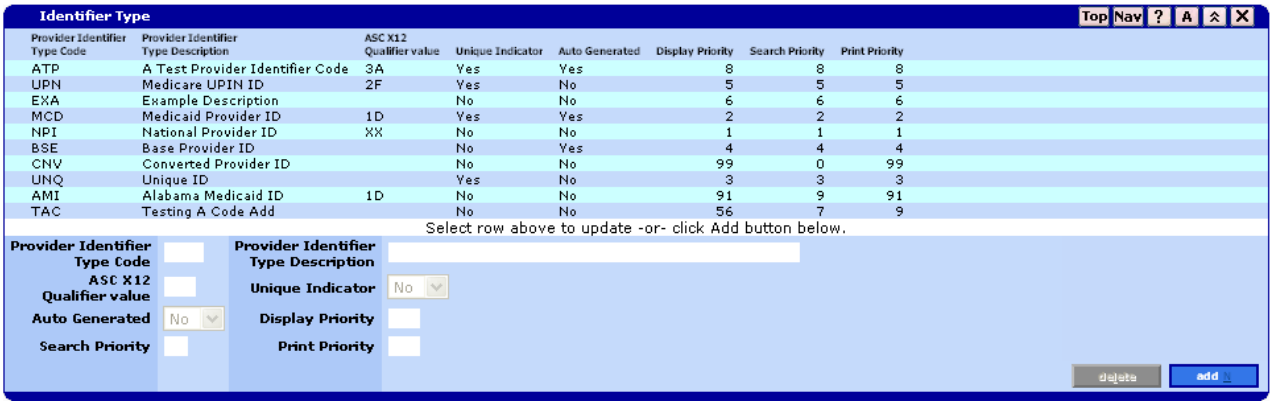
Identifier Type Panel Overview

6.1.307 Identifier Type Panel Narrative

The Identifier Type Code panel contains the values that are applicable to the Identifier Type drop down field on the IDs panel. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Identifier Type]

6.1.308 Identifier Type Panel Layout



6.1.309 Identifier Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Identifier type information.	Button	N/A	0
ASC X12 Qualifier value	ASC X12 qualifier value.	Field	Character	2
Auto Generated	Auto generated indicator. Valid values include Yes and No.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove identifier type information.	Button	N/A	0
Display Priority	Display priority.	Field	Number (Integer)	2
Print Priority	Print priority.	Field	Character	2
Provider Identifier Type Code	Provider identifier type code.	Field	Character	3
Provider Identifier Type Description	Description of the identifier type.	Field	Character	50
Search Priority	Allows the user to set the search priority.	Field	Number (Integer)	1

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Field	Description	Field Type	Data Type	Length
Unique Indicator	Unique Indicator. Valid values are Yes and No.	Combo Box	Drop Down List Box	0

6.1.310 Identifier Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Display Indicator	Field	1	Display indicator must be greater than or equal to 1.	Verify keying. Enter Display Indicator value (1-9).
	Field	2	Display Priority is already in use. The Display Priority must be unique.	Verify keying. Select a Display Priority not already in use.
Provider Identifier Type Code	Field	1	Provider Identifier Type Code is required.	Verify keying. Enter a Provider Identifier Type Code.
Provider Identifier Type Description	Field	1	Provider Identifier Type Description is required.	Verify keying. Enter a Provider Identifier Type Description.
Search Priority	Field	1	Search Priority is already in use. The Search Priority must be unique.	Verify keying. Select a Search Priority not already in use.
Auto Generated	Combo Box	1	Auto Generated is required.	Verify keying. Select Yes or No from Auto Generated drop down list.
Print Priority	Field	1	Print Priority must be greater than or equal to 1.	Verify keying. Enter Print Priority value (1-9).
	Field	2	Print Priority is already in use. The Print Priority must be unique.	Verify keying. Select a Print Priority not already in use.
Unique Indicator	Combo Box	1	Unique indicator is required.	Verify keying. Select Yes or No from Unique Indicator drop down list.

6.1.311 Identifier Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.312 Identifier Type Panel Accessibility

6.1.312.1 To Access the Identifier Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Identifier Type.	Identifier Type panel displays.

6.1.312.2 To Add on Identifier Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Provider Identifier Type Code.	
3	Enter ASC X12 Qualifier Value.	
4	Select **Auto Generated** from the drop down list box.	
5	Enter Search Priority.	
6	Enter Provider Identifier Type Description.	
7	Select **Unique Identifier** from the drop down list box.	
8	Enter Display Priority.	
9	Enter Print Priority.	
10	Click **Save**.	Identifier Type information is saved.

6.1.312.3 To Update the Identifier Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Identifier Type information is saved.

6.1.312.4 To Delete from the Identifier Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Identifier Type End Reason Panel Overview

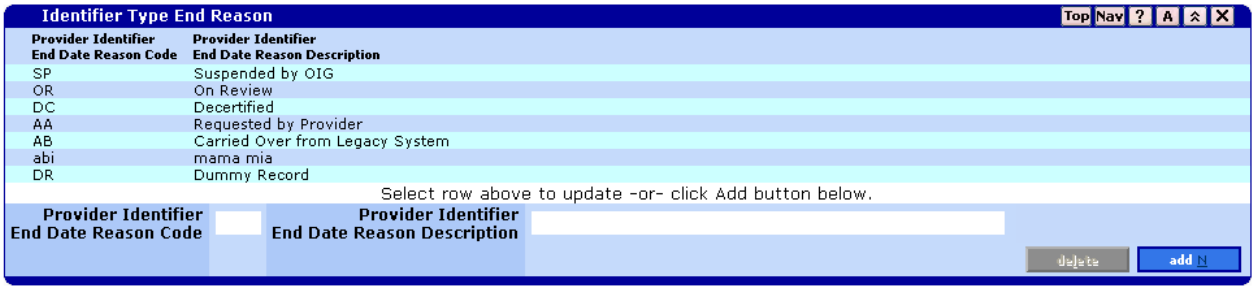
6.1.313 Identifier Type End Reason Panel Narrative

The Identifier Type End Reason Code panel contains the reasons for which an ID can be terminated.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Identifier Type End Reason]

6.1.314 Identifier Type End Reason Panel Layout



6.1.315 Identifier Type End Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add identifier type end reason information.	Button	N/A	0
Delete	Allows the user to remove identifier type end reason information.	Button	N/A	0
Provider Identifier End Date Reason Code	Provider Identifier End Date Reason Code.	Field	Character	3
Provider Identifier End Date Reason Description	Provider Identifier End Date Reason Description.	Field	Character	50

6.1.316 Identifier Type End Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Provider Identifier End Date Reason Code	Field	1	Provider Identifier End Date Reason Code is required.	Verify keying. Enter a Provider Identifier End Date Reason Code.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.
Provider Identifier End Date Reason Description	Field	1	Provider Identifier End Date Reason Description is required.	Verify keying. Enter a Provider Identifier End Date Reason Description.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.

6.1.317 Identifier Type End Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.318 Identifier Type End Reason Panel Accessibility

6.1.318.1 To Access the Identifier Type End Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Identifier Type End Reason.	Identifier Type End Reason panel displays.

6.1.318.2 To Add on Identifier Type End Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Provider Identifier End Date Reason Code.	
3	Enter Provider Identifier End Date Reason Description.	
4	Click **Save**.	Identifier Type End Reason information is saved.

6.1.318.3 To Update the Identifier Type End Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Identifier Type End Reason information is saved.

6.1.318.4 To Delete from the Identifier Type End Reason Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Review Reason Panel Overview

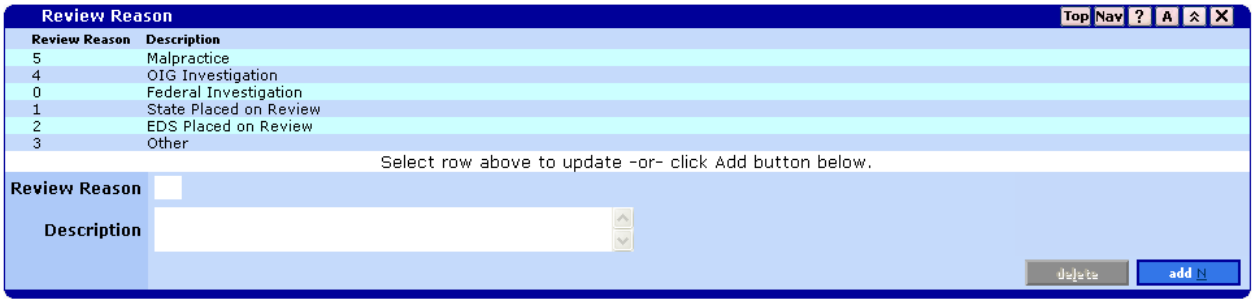
6.1.319 Review Reason Panel Narrative

The Review Reason panel contains the reason codes and associated descriptions which populate the Review Reason drop down on the Restricted Service panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Review Reason]

6.1.320 Review Reason Panel Layout



6.1.321 Review Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add review reason information.	Button	N/A	0
Delete	Allows the user to remove review reason information.	Button	N/A	0
Description	Description of the Review Reason.	Field	Character	50
Review Reason	Code associated with the Review Reason.	Field	Alphanumeric	1

6.1.322 Review Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Verify keying. Enter Description.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.
Review Reason	Field	1	Review Reason is required.	Verify keying. Enter Review Reason.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.

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6.1.323 Review Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.324 Review Reason Panel Accessibility

6.1.324.1 To Access the Review Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Review Reason.	Review Reason panel displays.

6.1.324.2 To Add on Review Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Review Reason.	
3	Enter Description.	
4	Click **Save**.	Review Reason information is saved.

6.1.324.3 To Update the Review Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Review Reason information is saved.

6.1.324.4 To Delete from the Review Reason Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Review Type Panel Overview

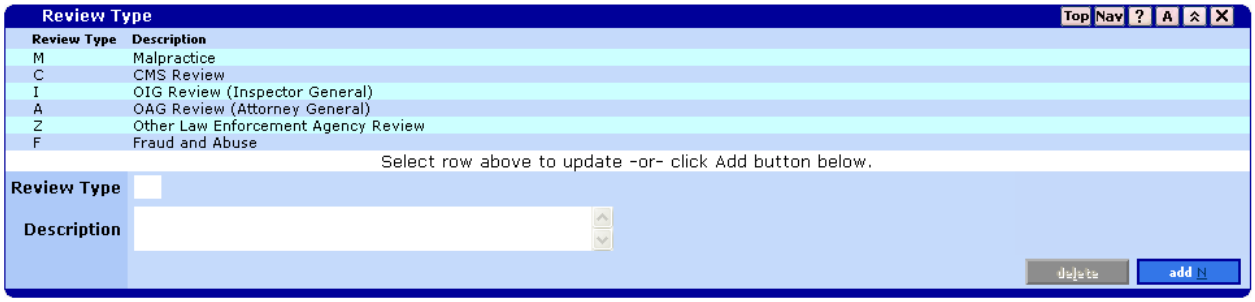
6.1.325 Review Type Panel Narrative

The Review Type panel contains the codes and descriptions which populate the Review Type drop down list of the Restricted Service and Review panels.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Review Type]

6.1.326 Review Type Panel Layout



6.1.327 Review Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add review type information.	Button	N/A	0
Delete	Allows the user to remove review type information.	Button	N/A	0
Description	Review Type Code Description.	Field	Character	50
Review Type	Review Type Code.	Field	Character	1

6.1.328 Review Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Verify keying. Enter Description.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.
Review Type	Field	1	Review Type is required.	Verify keying. Enter Review Type.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.

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6.1.329 Review Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.330 Review Type Panel Accessibility

6.1.330.1 To Access the Review Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Review Type.	Review Type panel displays.

6.1.330.2 To Add on Review Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Review Type.	
3	Enter Description.	
4	Click **Save**.	Review Type information is saved.

6.1.330.3 To Update the Review Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Review Type information is saved.

6.1.330.4 To Delete from the Review Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Specialty Panel Overview

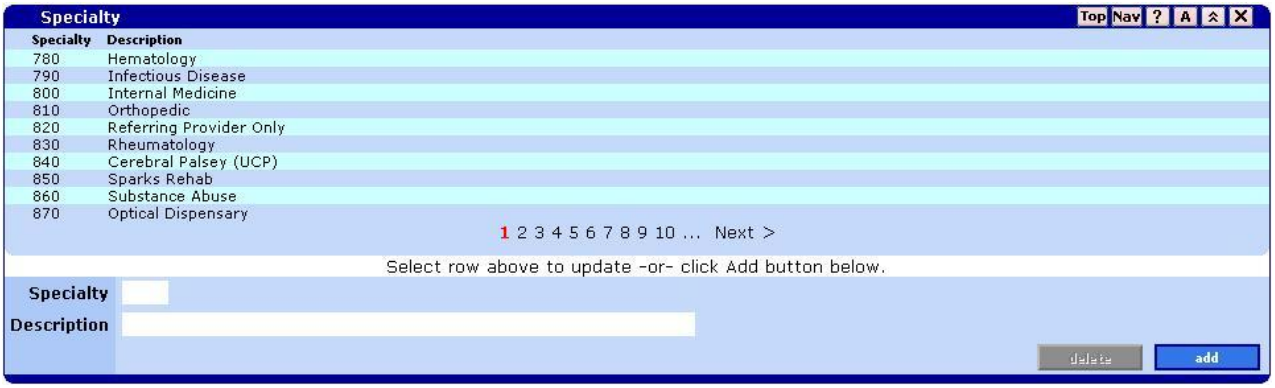
6.1.331 Specialty Panel Narrative

The Specialty panel is used to maintain specialty codes which feed into the selections applicable to the specialty field on the Provider Type Specialty panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Specialty]

6.1.332 Specialty Panel Layout



6.1.333 Specialty Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add specialty code information.	Button	N/A	0
Delete	Allows the user to remove specialty code information.	Button	N/A	0
Description	Specialty Code Description.	Field	Character	50
Specialty	Specialty Code.	Field	Number (Integer)	3

6.1.334 Specialty Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Specialty	Field	1	Specialty is required.	Enter a Specialty.
	Field	10	Specialty must be Alphanumeric.	Verify keying. Specialty must be 0-9 or A-Z.
	Field	18	Specialty must be 3 character(s) in length.	Verify keying. Specialty code must be three characters.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Specialty entered already exists.

6.1.335 Specialty Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.336 Specialty Panel Accessibility

6.1.336.1 To Access the Specialty Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Specialty.	Specialty panel displays.

6.1.336.2 To Add on Specialty Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Specialty Code.	
3	Enter **Description** of the code.	
4	Click **Save**.	Specialty information is saved.

6.1.336.3 To Update the Specialty Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Specialty information is saved.

6.1.336.4 To Delete from the Specialty Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Taxonomy Panel Overview

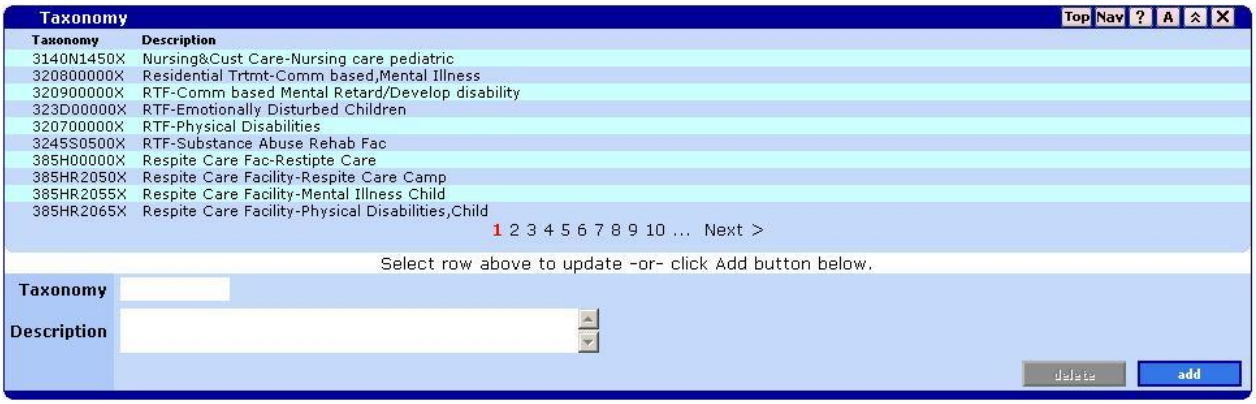
6.1.337 Taxonomy Panel Narrative

The Taxonomy panel is used to maintain taxonomy codes which feed into the selections applicable to the taxonomy field on the Provider Type Specialty panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Taxonomy]

6.1.338 Taxonomy Panel Layout



6.1.339 Taxonomy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add taxonomy code information.	Button	N/A	0
Delete	Allows the user to remove taxonomy code information.	Button	N/A	0
Description	Taxonomy Description.	Field	Character	100
Taxonomy	Taxonomy Code.	Field	Character	10

6.1.340 Taxonomy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Taxonomy	Field	1	Taxonomy is required.	Enter a Taxonomy.
	Field	10	Taxonomy must be Alphanumeric.	Verify keying. Entry must be 0-9 or A-Z.
	Field	18	Taxonomy must be 10 character(s) in length.	Verify keying. The Taxonomy code must be 10 characters.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Taxonomy code already exists.

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6.1.341 Taxonomy Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.342 Taxonomy Panel Accessibility

6.1.342.1 To Access the Taxonomy Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) display.
4	Select **Taxonomy**.	Taxonomy panel displays.

6.1.342.2 To Add on Taxonomy Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Taxonomy.	
3	Enter **Description** of the code.	
4	Click **Save**.	Taxonomy information is saved.

6.1.342.3 To Update the Taxonomy Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Taxonomy information is saved.

6.1.342.4 To Delete from the Taxonomy Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Taxonomy Group Type Panel

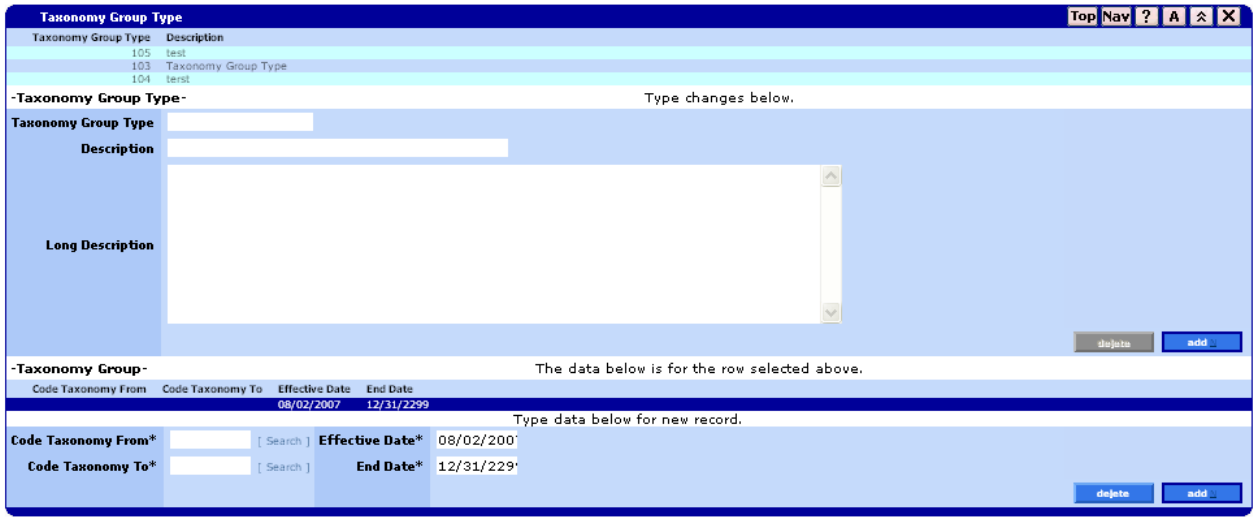
6.1.343 Taxonomy Group Type Panel Narrative

The Taxonomy Group Type panel displays the data used to group Taxonomy information into types.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Codes] - [Taxonomy Group Type]

6.1.344 Taxonomy Group Type Panel Layout



6.1.345 Taxonomy Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add [Taxonomy Group Type]	Allows the user to add taxonomy group type information.	Button	N/A	0
Add [Taxonomy Group]	Adds a new taxonomy group to the current taxonomy type.	Button	N/A	0
Code Taxonomy From	The lower range of a group of taxonomy codes.	Field	Number (Integer)	9
Code Taxonomy To	The upper range of a group of taxonomy codes.	Field	Number (Integer)	9
Delete [Taxonomy Group Type]	Allows the user to remove taxonomy group type information.	Button	N/A	0
Delete [Taxonomy Group]	Deletes the current taxonomy group from the current taxonomy type.	Button	N/A	0
Description	Describes the taxonomy type.	Field	Alphanumeric	50

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Field	Description	Field Type	Data Type	Length
Effective Date	The date that the taxonomy is to become effective for the taxonomy type in claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The last date that the taxonomy is in effect for the taxonomy type in claims processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Definition of where and/or how this taxonomy group is used.	Field	Alphanumeric	4000
Taxonomy Group Type	System assigned key for a unique taxonomy type, that represents a collection of taxonomies.	Field	Number (Integer)	9

6.1.346 Taxonomy Group Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Code Taxonomy From	Field	1	A valid Code Taxonomy From is required.	Enter a valid Code Taxonomy when adding or modifying.
Code Taxonomy To	Field	1	A valid Code Taxonomy To is required.	Enter a valid Taxonomy Code when adding or modifying.
Description	Field	1	Description is required.	Enter a Description when adding.
Effective Date	Field	1	Effective Date is required.	Enter a valid Date (MM/DD/CCYY).
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter a Date greater than or equal to 01/01/1900.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Enter a date less than or equal to 12/31/2299.
	Field	4	Effective Date [DD/MM/CCYY HH:MM:SS] must be less than or equal to End Date [DD/MM/CCYY HH:MM:SS].	Enter an Effective Date less than or equal to the End Date.
End Date	Field	1	End Date is required.	Enter a valid date (MM/DD/CCYY).
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter a date greater than or equal to 01/01/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Enter a date less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
Long Description	Field	1	Long Description is required.	Enter a description when adding.

6.1.347 Taxonomy Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.348 Taxonomy Group Type Panel Accessibility

6.1.348.1 To Access the Taxonomy Group Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) display.
4	Select Taxonomy Group Type.	Taxonomy Group Type panel displays.

6.1.348.2 To Add on Taxonomy Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Description.	
3	Enter **Long Description** of the code.	
4	Click **Save**.	Taxonomy Group Type information is saved.

6.1.348.3 To Add on Taxonomy Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [**Search**] to locate Code Taxonomy From. Enter Taxonomy, Description or select from the list of search results.	Code Taxonomy From field is populated.
3	Click [**Search**] to locate Code Taxonomy To. Enter Taxonomy, Description or select from the list of search results.	Code Taxonomy To field is populated.
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Taxonomy Group information is saved.

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6.1.348.4 To Update the Taxonomy Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Taxonomy Group Type information is saved.

6.1.348.5 To Update the Taxonomy Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Taxonomy Group information is saved.

6.1.348.6 To Delete from the Taxonomy Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.1.348.7 To Delete from the Taxonomy Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Title Panel Overview

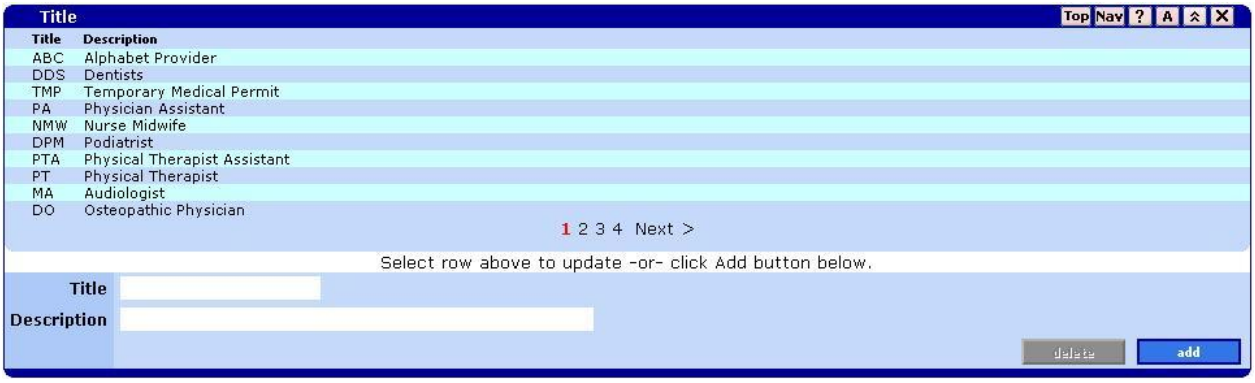
6.1.349 Title Panel Narrative

The Title panel is used to maintain title codes which feed into the selections applicable to the title field on the Provider Location Name Address panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Title]

6.1.350 Title Panel Layout



6.1.351 Title Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add title code information.	Button	N/A	0
Delete	Allows the user to remove title code information.	Button	N/A	0
Description	Title Code Description.	Field	Character	50
Title	Title Code.	Field	Character	15

6.1.352 Title Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Title	Field	1	Title is required.	Enter a Title.
	Field	10	Title must be Alphanumeric.	Verify keying. Title must be 0-9 or A-Z.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Title entered already exists.

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6.1.353 Title Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.354 Title Panel Accessibility

6.1.354.1 To Access the Title Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select **Title**.	Title panel displays.

6.1.354.2 To Add on Title Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Title**.	
3	Enter **Description** of the code.	
4	Click **Save**.	Title information is saved.

6.1.354.3 To Update the Title Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Title information is saved.

6.1.354.4 To Delete from the Title Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Type Panel Overview

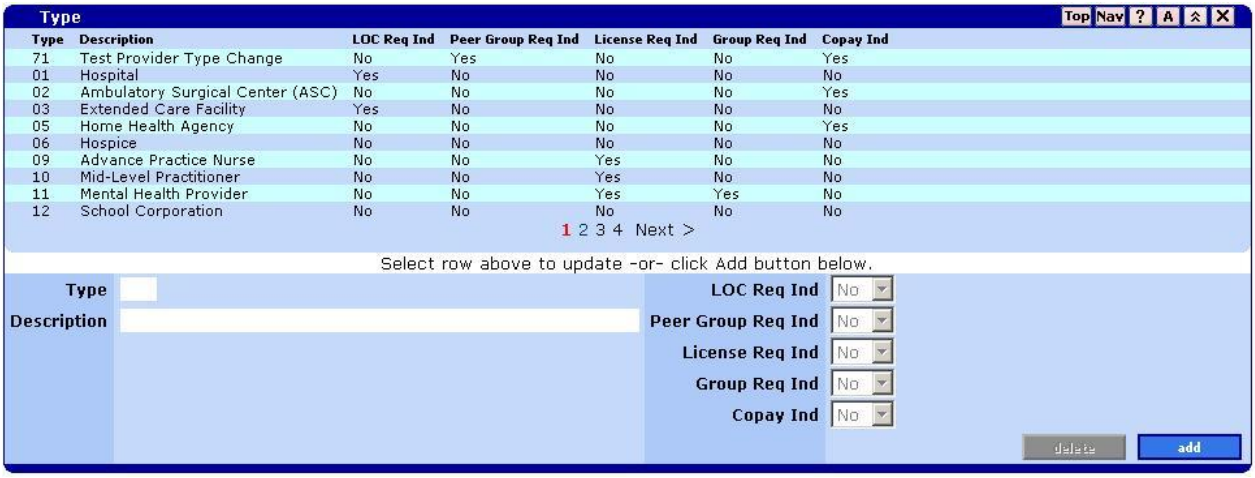
6.1.355 Type Panel Narrative

The Type panel is used to maintain type codes which feed into the selections applicable to the type field on the Provider Type Specialty panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Type]

6.1.356 Type Panel Layout



6.1.357 Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add type code information.	Button	N/A	0
Copay Ind	Copay Required Indicator. LOC Required Indicator. Valid values include: Yes and No.	Comb o Box	Drop Down List Box	0
Delete	Allows the user to remove type code information.	Button	N/A	0
Description	Type code description.	Field	Character	50
Group Req Ind	Group Required Indicator. LOC Required Indicator. Valid values include: Yes and No.	Comb o Box	Drop Down List Box	0
License Req Ind	License Required Indicator. LOC Required Indicator. Valid values include: Yes and No.	Comb o Box	Drop Down List Box	0
LOC Req Ind	LOC Required Indicator. Valid values include: Yes and No.	Comb o Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Peer Group Req Ind	Peer Group Required Indicator. LOC Required Indicator. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
Type	Type Code.	Field	Character	2

6.1.358 Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Type	Field	1	Type is required.	Enter a Type.
	Field	10	Type must be Alphanumeric.	Verify keying. Type must be 0-9 or A-Z.
	Field	18	Type must be 2 character(s) in length.	Verify keying. The Type must be two characters.
	Field	5000	A duplicate record cannot be saved.	Verify keying. The Type entered already exists.

6.1.359 Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.360 Type Panel Accessibility

6.1.360.1 To Access the Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select **Type**.	Type panel displays.

6.1.360.2 To Add on Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Type**.	
3	Enter **Description** of the code.	
4	Select **LOC Req Ind**. (Required Indicator)	

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Step	Action	Response
5	Select **Peer Group Req Ind**. (Required Indicator)	
6	Select **License Req Ind**. (Required Indicator)	
7	Select **Group Req Ind**. (Required Indicator)	
8	Select **Copay Ind**. (Required Indicator)	
9	Click **Save**.	Type information is saved.

6.1.360.3 To Update the Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Type information is saved.

6.1.360.4 To Delete from the Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Type Specialty Panel Overview

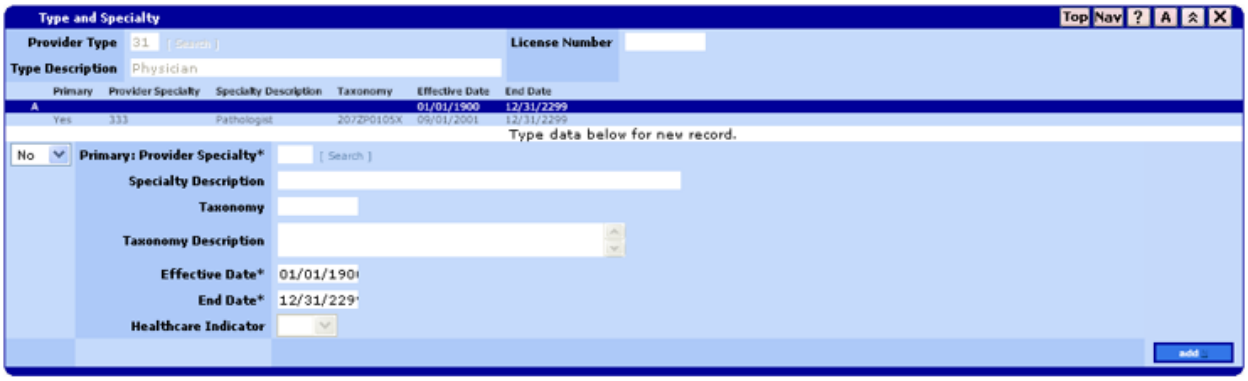
6.1.361 Type Specialty Panel Narrative

The Type Specialty panel is used to maintain the cross reference between provider type and provider specialty codes which feed into the selections applicable to the specialty field on the Provider Type Specialty panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Codes] - [Type Specialty]

6.1.362 Type Specialty Panel Layout



6.1.363 Type Specialty Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add type specialty code information.	Button	N/A	0
Delete	Allows the user to remove type specialty code information.	Button	N/A	0
Description	Provider Type Code Description.	Field	Character	50
Healthcare Indicator	Indicator showing specialty is a healthcare specialty.	Comb o Box	Drop Down List Box	0
Provider Specialty	Provided specialty.	Field	Character	50
Provider Taxonomy	Provider taxonomy.	Field	Character	100
Provider Type	Provider type code.	Field	Character	3
Specialty	Specialty code.	Field	Character	3
Specialty Description	Description of the specialty code.	Field	Character	50
Taxonomy	Taxonomy code.	Field	Number (Integer)	9
Taxonomy Description	Description of the taxonomy code.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Type	Provider type code.	Field	Character	50

6.1.364 Type Specialty Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than the 01/01/1900 default date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same specialty code.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than the 01/01/1900 default date.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be before the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap for the same specialty code.
License Number	Field	10	Provider License Number must be Alphanumeric.	Verify keying. License can only contain A-Z and/or 0-9 characters.
	Field	5000	Warning: Provider License Number is not on file.	This is a warning message. The License Number entered is not on the license file. Choose OK to save, otherwise Cancel.
	Field	5001	Warning: Provider License Number is assigned to another provider.	This is a warning message. This License Number is already assigned to another provider in the system. Choose OK to save, otherwise Cancel.
	Field	5002	Warning: Provider License Number is required for this provider type.	This is a warning message. This provider type requires a license. Choose OK to save, otherwise Cancel.

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Field	Field Type	Error Code	Error Message	To Correct
Primary: Provider Specialty	Field	100	Select one Provider Specialty as Primary.	Verify keying. Select one primary specialty checkbox.
		101	Specialty 113 not allowed without specialty 860.	Enter a valid specialty 860.
		102	Specialty 860 date range not within specialty 113 date range.	Change the date range of the specialty 860.
Provider Type	Field	100	Verify keying. The chosen specialty is not valid for this provider type.	Provider Type and Provider Specialty combination is invalid.

6.1.365 Type Specialty Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.366 Type Specialty Panel Accessibility

6.1.366.1 To Access the Type Specialty Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Codes**.	A list of hyperlinks to panel(s) displays.
4	Select Type Specialty.	Type Specialty panel displays.

6.1.366.2 To Add on Type Specialty Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Title Code.	
3	Enter **Description** of the code.	
4	Click **Save**.	Type Specialty information is saved.

6.1.366.3 To Update the Type Specialty Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Type Specialty information is saved.

6.1.366.4 To Delete from the Type Specialty Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Provider Related Data Other Page Overview

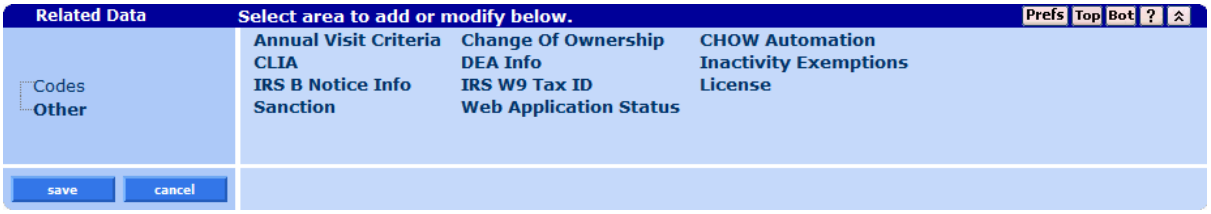
6.1.367 Provider Related Data Other Page Narrative

The Provider Related Data Other page displays the CLIA, Inactivity Exemptions, IRS B Notice Info, IRS W9 Tax ID, License and Sanction panels.

This panel is utilized as a navigation tool to access related data panels.

Navigation Path: [Provider] – [Related Data] - [Other]

6.1.368 Provider Related Data Other Page Layout



6.1.369 Provider Related Data Other Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Related Data-Other panel.	Button	N/A	0
Change of Ownership	Link to the Change Of Ownership Maintenance panel.	Hyperlink	N/A	0
CHOW Automation	Link to the CHOW Automation panel	Hyperlink	N/A	0
CLIA	Link to the CLIA panel.	Hyperlink	N/A	0
DEA Info	Link to the DEA Info panel.	Hyperlink	N/A	0
Inactivity Exemptions	Link to the Inactivity Exemptions panel.	Hyperlink	N/A	0
IRS B Notice Info	Link to the IRS B Notice Info panel.	Hyperlink	N/A	0
IRS W9 Tax ID	Link to the IRS W9 Tax ID panel.	Hyperlink	N/A	0
License	Link to the License panel.	Hyperlink	N/A	0
Sanction	Link to the Sanction panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for Related Data-Other.	Button	N/A	0
Web Application Status	Link to Web Application Status Panel	Hyperlink	N/A	0

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6.1.370 Provider Related Data Other Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.1.371 Provider Related Data Other Page Extra Features

Field	Field Type
No extra features found for this page.	

6.1.372 Provider Related Data Other Page Accessibility

6.1.372.1 To Access the Provider Related Data Other Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Click **Other** link on Related Data panel.	Provider Related Data Other page displays.

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Annual Visit Criteria Panel

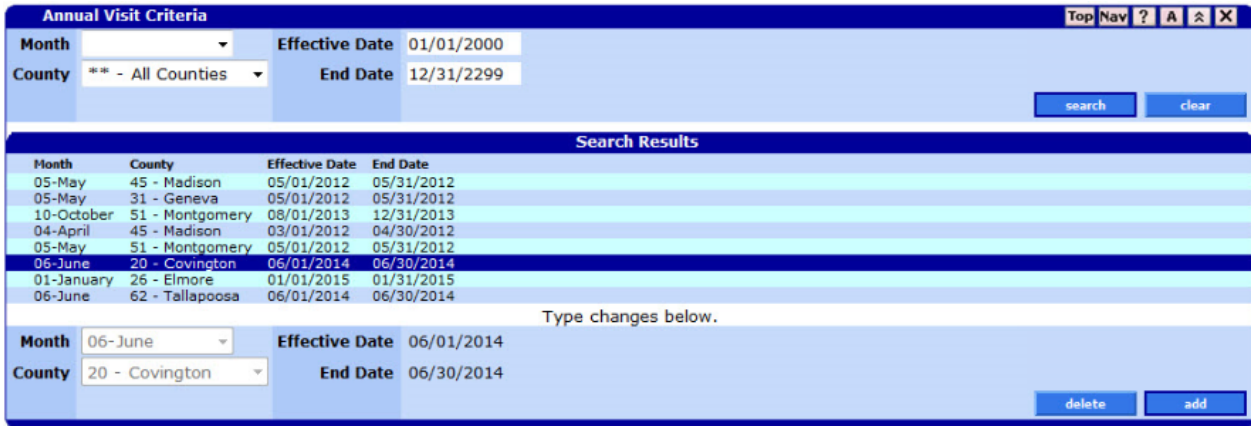
6.1.373 Annual Visit Criteria Panel Narrative

The Annual Visit Criteria panel allows the user to search and view Annual Visit Criteria information.

This panel is needed so visits to providers in the same or neighboring counties can be organized into the same months to minimize travel and avoid travel to northern counties in winter months. Uses Table T_PR_ANNUAL_VISIT_CRIT.

Navigation Path: [Provider - Related Data] - [Other] - [Annual Visit Criteria]

6.1.374 Annual Visit Criteria Panel Layout



6.1.375 Annual Visit Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Annual Visit Criteria record.	Button	N/A	0
Clear	Clears the search fields.	Button	N/A	0
Delete	Deletes the Annual Visit Criteria record.	Button	N/A	0
Search	Initiates the Search by Month or County or Date.	Button	N/A	0
County	The county code used to identify a geographical/political area in the state.	Field	Drop Down List Box	10
Effective Date	Start date of timeframe for visits to this county in this month.	Field	Date (MM/DD/CCYY)	8
End Date	End date of timeframe for visits to this county in this month.	Field	Date (MM/DD/CCYY)	8
Month	Month in which providers in a county should be visited.	Field	Drop Down List Box	2

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6.1.376 Annual Visit Criteia Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date / End Date overlapping with another segment.	Select a Different month from the Month dropdown list.

6.1.377 Annual Visit Criteria Extra Feature

Field	Field Type
No extra features found for this panel.	

6.1.378 Annual Visit Criteria Panel Accessibility

6.1.378.1 To Access the Annual Visit Criteria Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **Annual Visit Criteria.**	Annual Visit Criteria panel displays.

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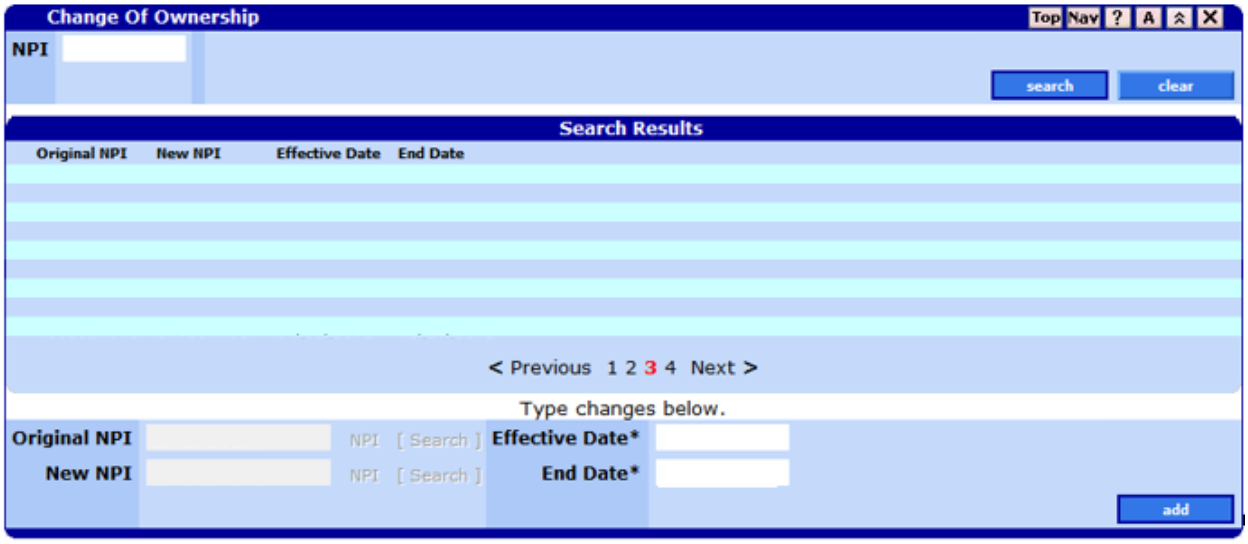
Change of Ownership Panel Overview

6.1.380 Change of Ownership Panel Narrative

The Change of Ownership panel displays CHOW data. This panel serves as a maintenance tool to access, review and edit CHOW information.

Navigation Path: [Provider] – [Related Data] - [Other] - [Change of Ownership]

6.1.381 Change of Ownership Panel Layout



6.1.382 Change of Ownership Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Change of Ownership record.	Button	N/A	0
Effective Date	Start date of timeframe for the Change of Ownership record.	Field	Date	8
End Date	End date of timeframe for the Change of Ownership record.	Field	Date	8
NPI	National Provider Identifier.	Field	Character	15
New NPI	New National Provider Identifier.	Field	Character	15
Original NPI	Original National Provider Identifier.	Field	Character	15

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6.1.383 Change of Ownership Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Date	1	Invalid date. Format is mm/dd/ccyy.	Enter a valid date in the field.
	Date	2	Effective Date must be greater than or equal to 1/1/1900.	Enter a valid date in the field.
	Date	3	Effective Date must be less than or equal to 12/31/2299.	Enter a valid date in the field.
	Date	4	Effective date is required.	Enter a valid date in the field.
	Date	5	Effective Date must be less than or equal to End Date.	Enter a valid date in the field.
End Date	Date	1	Invalid date. Format is mm/dd/ccyy.	Enter a valid date in the field.
	Date	2	End Date must be greater than or equal to 1/1/1900.	Enter a valid date in the field.
	Date	3	End Date must be less than or equal to 12/31/2299.	Enter a valid date in the field.
	Date	4	End date is required.	Enter a valid date in the field.
	Date	5	Effective Date must be less than or equal to End Date.	Enter a valid date in the field.
New NPI	Field	1	A valid New NPI is required.	Enter a valid NPI in the field.
	Field	2	Original NPI must be not Equal to New NPI.	Enter a different NPI in the field.
	Field	3	A duplicate record cannot be saved.	Enter criteria that is not currently listed.
	Field	4	ID entered must be NPI.	Enter a valid NPI in the field.
Original NPI	Field	1	A valid Original NPI is required.	Enter a valid NPI in the field.
	Field	2	Original NPI must be not Equal to New NPI.	Enter a different NPI in the field.
	Field	3	A duplicate record cannot be saved.	Enter criteria that is not currently listed.
	Field	4	ID entered must be NPI.	Enter a valid NPI in the field.

6.1.384 Change of Ownership Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.385 Change of Ownership Panel Accessibility

6.1.385.1 To Access the Change of Ownership Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **Change of Ownership**.	Change of Ownership panel displays the list of CHOW data.

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CHOW Automation Panel Overview

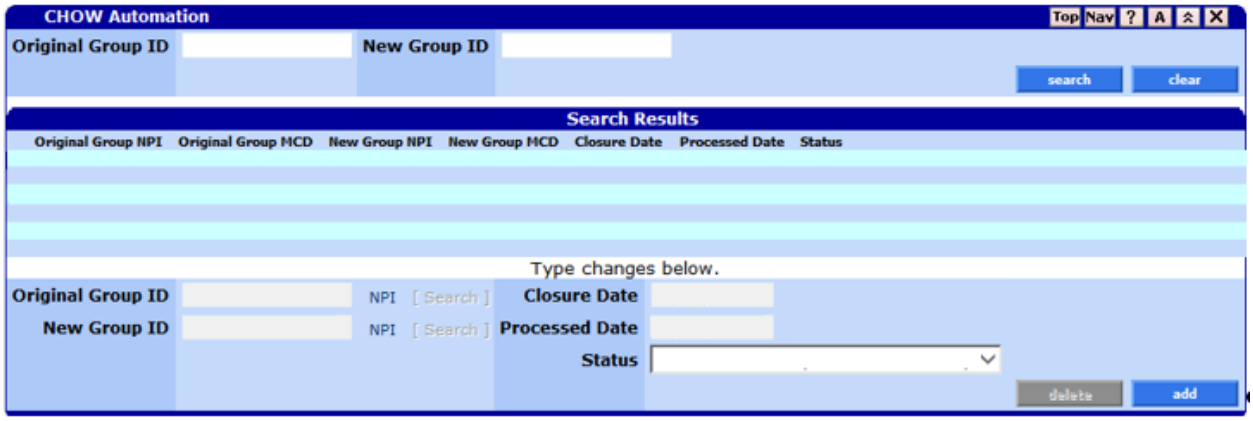
6.1.386 Change of Ownership Panel Narrative

The CHOW Automation panel displays CHOW data. This panel serves as a maintenance tool to access, review and edit CHOW information.

Navigation Path: [Provider - Related Data] - [Other] - [CHOW Automation]

Table: T_PR_CHOW_GRP_MBR

6.1.387 CHOW Automation Panel Layout



6.1.388 CHOW Automation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new CHOW Automation record.	Button	N/A	0
Clear	Allows the user to clear any changes on search panel.	Button	N/A	0
Closure Date	Date that the provider is setup for CHOW group member association.	Field	Date	8
Delete	Allows the user to delete a CHOW Automation record.	Button	N/A	0
New Group ID	New Group ID that uniquely identifies the provider enrollment tracking.	Field	Character	15
New Group MCD	New group Medicaid provider ID.	Field	Character	15
New Group NPI	New group National Provider ID.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Original Group ID	Original Group ID that uniquely identifies the provider enrollment tracking.	Field	Character	15
Original Group MCD	Original group Medicaid provider ID.	Field	Character	15
Original Group NPI	Original group National Provider ID.	Field	Character	15
Processed Date	Date the batch process completed the member move.	Field	Date	8
Search	Allows user to search by Original Group ID or New Group ID.	Button	N/A	0
Status	Status of the membership move. Accepted Values: R -> Ready to be processed, C -> Process completed successfully, E -> Error processing record.	Field	Character	1

6.1.389 CHOW Automation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Closure Date	Field	1	Closure Date must be greater than or equal to today.	Verify keying. Closure date must be greater than or equal to today.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid closure date (MM/DD/CCYY).
	Field	3	Closure Date must be greater than or equal to 1/1/1900.	Verify keying. Closure date must be greater than 1/1/1900.
	Field	4	Closure Date must be less than or equal to 12/31/2299.	Verify keying. Closure date must be less than 12/31/2299.
	Field	5	Closure Date is required.	Enter a closure date.
New Group ID	Field	1	A valid New Group ID is required.	Enter a valid new group ID.
	Field	3	New Group ID must be NPI.	Enter a valid NPI in the field.
Original Group ID	Field	1	A valid Original Group ID is required.	Enter a valid original group ID.
	Field	2	Original Group ID must be NPI.	Enter a valid NPI in the field.
	Field	4	Original Group ID and New Group ID cannot be same.	Verify keying. Original group ID and new group ID cannot be same.

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6.1.390 CHOW of Automation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.391 CHOW Automation Panel Accessibility

6.1.391.1 To Access the CHOW Automation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **CHOW Automation**.	CHOW Ownership panel displays the list of CHOW data.

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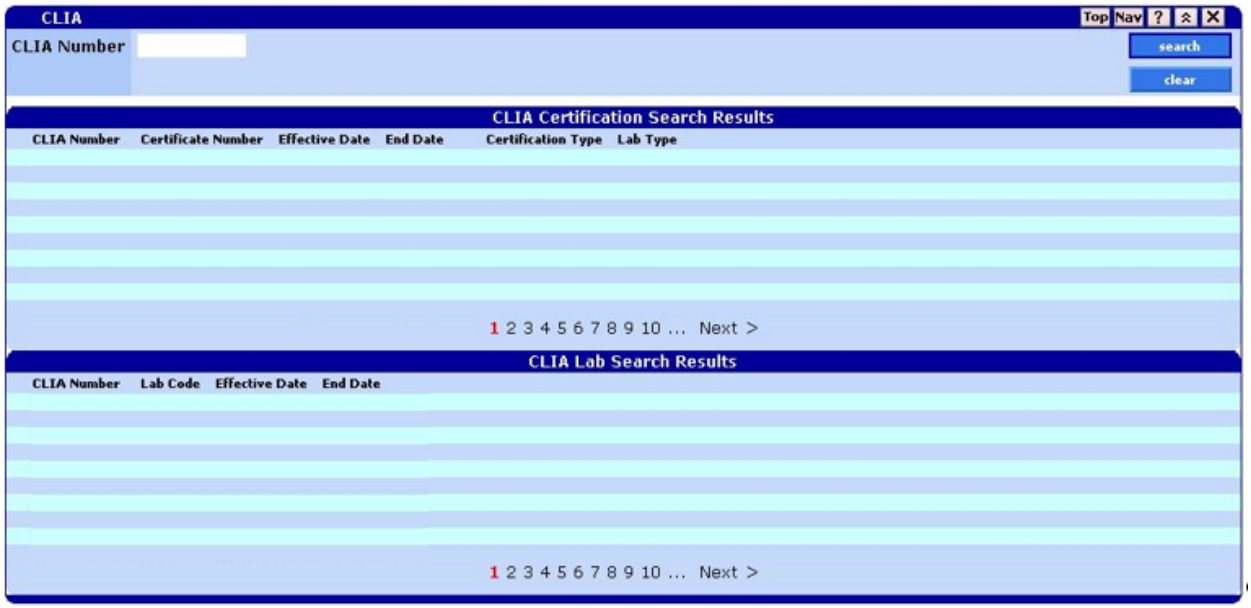
CLIA Panel Overview

6.1.392 CLIA Panel Narrative

The CLIA panel displays CLIA data from CMS as read only. This panel serves as a navigation tool to access and review CLIA information provided by CMS.

Navigation Path: [Provider] – [Related Data] - [Other] - [CLIA]

6.1.393 CLIA Panel Layout



6.1.394 CLIA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Certificate Number [CLIA Certification Search Results]	Similar to a sak short, this is a certificate number of the Clinical Laboratory Improvement Act (CLIA) number, 1 should be the most current.	Field	Character	2
Certification Type [CLIA Certification Search Results]	Provider certification type.	Field	Character	20
Clear	Allows the user to clear any changes on the CLIA panel.	Button	N/A	0
CLIA Number [CLIA Certification Search Results]	Provider's Clinical Laboratory Improvement Act (CLIA) identification number.	Field	Character	10
CLIA Number [CLIA Lab Search Results]	Provider's Clinical Laboratory Improvement Act (CLIA) identification number.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
CLIA Number [Search]	Provider's Clinical Laboratory Improvement Act (CLIA) identification number.	Field	Character	10
Effective Date [CLIA Certification Search Results]	Effective date for certificate and lab codes.	Field	Date (MM/DD/CCYY)	8
Effective Date [CLIA Lab Search Results]	Provider's effective date of certification.	Field	Date (MM/DD/CCYY)	8
End Date [CLIA Certification Search Results]	End date for certificate and lab codes.	Field	Date (MM/DD/CCYY)	8
End Date [CLIA Lab Search Results]	End date of Clinical Laboratory Improvement Act (CLIA) number.	Field	Date (MM/DD/CCYY)	8
Lab Code [CLIA Lab Search Results]	Valid Lab codes for this Clinical Laboratory Improvement Act (CLIA) number.	Field	Number (Integer)	3
Lab Type [CLIA Certification Search Results]	Lab type code.	Field	Character	1
Search	Initiates the Search by CLIA Number.	Button	N/A	0

6.1.395 CLIA Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.396 CLIA Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.397 CLIA Panel Accessibility

6.1.397.1 To Access the CLIA Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **CLIA**.	CLIA panel displays.
5	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of CLIA data to display.

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DEA Info Panel OverviewDEA Info Panel Narrative

6.68.1 DEA Info Panel Narrative

The DEA Info panel is used to view from T_PR_DEA_LIC.

Navigation Path: [Provider] – [Related Data] - [Other] - [DEA Info]

6.1.2 DEA Info Panel Layout

6.68.3 DEA Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Business Activity	Business activity code.	Field	Character	1
Business Activity Sub	Business activity subcode.	Field	Character	1
Clear	Allows the user to clear any changes on the DEA Info panel.	Button	N/A	0
Date Added	Date of original registration.	Field	Date (MM/DD/CCYY)	8
DEA Number	Drug Enforcement Administration identification number for a provider.	Field	Character	9
Degree Name	Provider Degree.	Field	Character	3
Drug Schedule	Drug Schedules.	Field	Character	12
Expiration Date	Provider License Expiration Date.	Field	Date (MM/DD/CCYY)	8
Provider CS License Number	Provider State CS License Number.	Field	Character	15
Provider License Number	Provider State License Number.	Field	Character	15
Provider Name	Provider Name.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Search	Initiates the Search by DEA Number or Provider Name.	Button	N/A	0
SSN	Provider Social Security Number.	Field	Character	9
Tax ID	Provider Tax ID.	Field	Character	13

6.68.4 DEA Info Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edit error codes.				

6.68.5 DEA Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 DEA Info Panel Accessibility

6.1.6.1 To Access the DEA Info Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **DEA Info**.	DEA Info panel displays.
5	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of DEA data to display.

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Inactivity Exemptions Panel Overview

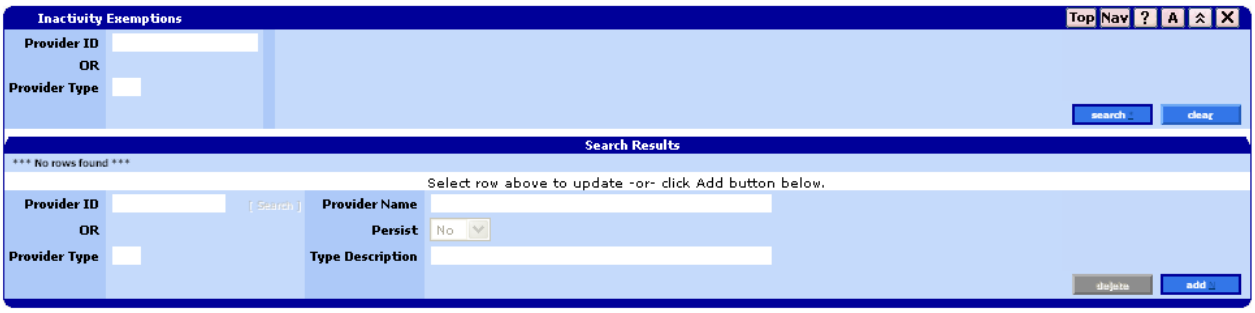
6.1.7 Inactivity Exemptions Panel Narrative

The Inactivity Exemptions panel is used to view, modify, add and delete Provider/Service Locations and Provider Types from T_PR_INACTV_EXMPT.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Other] - [Inactivity Exemptions]

6.1.8 Inactivity Exemptions Panel Layout



6.1.9 Inactivity Exemptions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add inactivity exemptions information.	Button	N/A	0
Clear	Allows the user to clear any changes on the Inactivity Exemptions panel.	Button	N/A	0
Delete	Allows the user to remove inactivity exemptions information.	Button	N/A	0
Persist	Will keep the record from being removed from the table after every Inactive Provider Deactivation process runs. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
Provider ID	Provider identification to be exempt from Inactive Provider Deactivation process.	Field	Character	9
Provider Name	Provider name to be exempt from Inactive Provider Deactivation process.	Field	Alphanumeric	50
Provider Type	Provider type to be exempt from the Inactive Provider Deactivation process.	Field	Character	2
Search	Initiates the Search by Provider ID or Provider Type.	Button	N/A	0
Type Description	Type to be exempt from the Inactive Provider Deactivation process.	Field	Alphanumeric	0

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6.1.10 Inactivity Exemptions Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Provider ID	Field	2910	Provider ID or Provider Type is required.	Enter either a Provider ID or a provider type as exemption criteria.
	Field	2930	A duplicate cannot be saved.	Enter criteria that is not currently listed.
Provider Type	Field	2920	Provider ID or Provider Type is required.	Enter either a Provider ID or a Provider Type as exemption criteria.
	Field	2930	A duplicate cannot be saved.	Enter criteria that is not currently listed.
	Field	2940	Provider Type is invalid.	Enter a Provider Type that is recognized in the system.

6.1.11 Inactivity Exemptions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.12 Inactivity Exemptions Panel Accessibility

6.1.12.1 To Access the Inactivity Exemptions Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select Inactivity Exemptions.	Inactivity Exemptions panel displays.
5	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of Inactivity Exemptions data to display.

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IRS B Notice Info Panel Overview

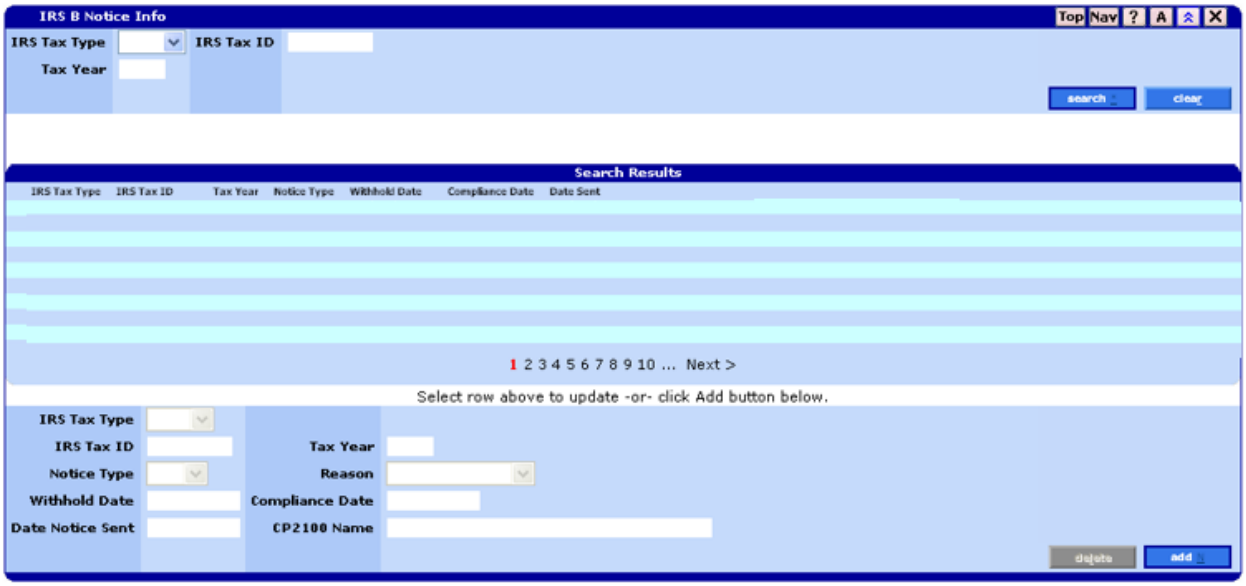
6.1.13 IRS B Notice Info Panel Narrative

The IRS B Notice Information panel is used to maintain B Notice information.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Other] - [IRS B Notice Info]

6.1.14 IRS B Notice Info Panel Layout



6.1.15 IRS B Notice Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add IRS B Notice information.	Button	N/A	0
Clear	Allows the user to clear any changes on the IRS B Notice Info panel.	Button	N/A	0
Compliance Date	Date the provider complied with the requirements of the B Notice.	Field	Date (MM/DD/CCYY)	8
CP2100 Name	Name that came in on the CP2100 file.	Field	Character	40
Date Notice Sent	Date the B Notice was sent out.	Field	Date (MM/DD/CCYY)	8
Date Sent	List field for the Notice Sent Date.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove IRS B Notice information.	Button	N/A	0
IRS Tax ID	Tax identification number assigned to a provider by the Internal Revenue Service.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
IRS Tax ID [Search]	Search field for the Tax ID Number.	Field	Character	10
IRS Tax Type	Indicates whether the tax ID is a Social Security Number or an FEIN. The valid values are "S" (SSN) and "F" (FEIN).	Combo Box	Drop Down List Box	0
IRS Tax Type [Search]	Search field for the IRS Tax Type.	Combo Box	Drop Down List Box	0
Notice Type	1st or 2nd Notice Indicator. Valid values are "1" (for 1st Notice) and "2" (for 2nd Notice).	Combo Box	Drop Down List Box	0
Reason	Reason for the CP2100 Record. Valid values are "1"(TIN Missing), "2" (TIN Not Issued), and "3" (TIN is Incorrect).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by IRS Tax Type, IRS Tax ID or Tax Year.	Button	N/A	0
Tax Year	Tax year for the CP2100.	Field	Character	4
Tax Year [Search]	Search field for the Tax Year.	Field	Character	4
Withhold Date	Date to begin withholding a percentage from the provider's payment due to sending the 1st B Notice.	Field	Date (MM/DD/CCYY)	8

6.1.16 IRS B Notice Info Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
IRS Tax Type	Combo Box	1	IRS Tax Type is required.	Select a valid value.
	Combo Box	100	The Tax ID Number/Tax ID Type does NOT exist on the T_IRS_W9_INFO table. Check on the IRS W9 Tax ID panel.	You must have a valid Tax ID/Type combination that exists on the T_IRS_W9_INFO table.
Notice Type	Combo Box	1	Notice Type is required.	Enter a valid Notice Type.
Reason	Combo Box	1	Reason is required.	Select a valid Reason.
CP2100 Name	Field	1	CP2100 Name is required.	Enter a Name.
Compliance Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
	Field	2	Withhold Date[MM/DD/YYYY 12:00:00 AM] must be less than or equal to Compliance Date[MM/DD/YYYY 12:00:00 AM].	Enter a date that is greater than the Withhold Date.
Date Notice Sent	Field	1	Date Notice Sent is required.	Enter a valid date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter a valid IRS Tax ID.
	Field	2	IRS Tax ID must be 9 character(s) in length.	Enter 9 digits.
	Field	100	The Tax ID Number/Tax ID Type does NOT exist on the T_IRS_W9_INFO table. Check on the IRS W9 Tax ID panel.	You must have a valid Tax ID/Type combination that exists on the T_IRS_W9_INFO table.
Tax Year	Field	1	Tax Year is required.	Enter a valid Tax Year.
	Field	2	Tax Year must be 4 character(s) in length.	Enter 4 digits.
	Field	3	Tax Year must be Numeric.	Enter 4 numeric digits.
Withhold Date	Field	1	Withhold Date is required.	Enter a valid date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
	Field	3	Withhold Date [MM/DD/YYYY 12:00:00 AM] must be less than or equal to Compliance Date[MM/DD/YYYY 12:00:00 AM].	Enter a date that is less than the Compliance date.

6.1.17 IRS B Notice Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.18 IRS B Notice Info Panel Accessibility

6.1.18.1 To Access the IRS B Notice Info Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select IRS B Notice Info.	IRS B Notice Info panel displays.
5	Enter search criteria and click **Search**; Or click **Search**.	Entering search criteria and clicking search allows results to display that are based on the criteria entered; Clicking search allows a list of IRS B Notice Info data to display.

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IRS W9 Tax ID Panel Overview

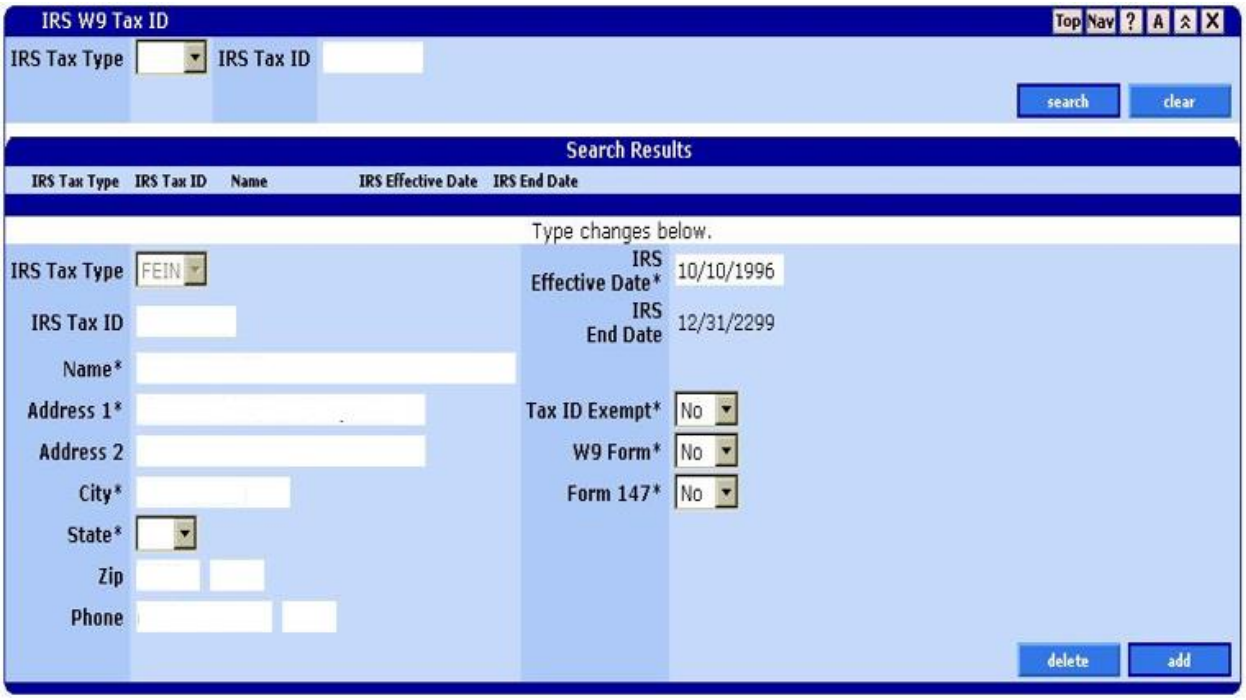
6.1.19 IRS W9 Tax ID Panel Narrative

The IRS W9 Tax ID panel is used to maintain IRS tax data which feeds data into the Tax ID panel.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Other] - [IRS W9 Tax ID]

6.1.20 IRS W9 Tax ID Panel Layout



6.1.21 IRS W9 Tax ID Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add IRS W9 Tax ID information.	Button	N/A	0
Address 1	Provider's first street Address.	Field	Character	30
Address 2	Provider's second street address.	Field	Character	30
City	Provider's city.	Field	Character	15
Clear	Allows the user to clear any changes on the IRS W9 Tax ID panel.	Button	N/A	0
Delete	Allows the user to remove IRS W9 Tax ID information.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Form 147	Provider has submitted form 147, stating his name and tax ID. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
IRS Effective Date	Effective date of tax identification number.	Field	Date (MM/DD/CCYY)	8
IRS End Date	End date of the tax identification number.	Field	Date (MM/DD/CCYY)	8
IRS Tax ID	IRS Tax identification number.	Field	Character	9
IRS Tax ID [Search]	Provider tax identification number.	Field	Character	9
IRS Tax Type	Internal Revenue Service Tax Type.	Combo Box	Drop Down List Box	0
IRS Tax Type [Search]	Provider tax identification type. Valid values include: FEIN and SSN.	Combo Box	Drop Down List Box	0
Name	Provider's name.	Field	Character	40
Phone	Provider's phone number and extension.	Field	Character	10
Search	Initiates the Search by IRS Tax ID Type or IRS Tax ID.	Button	N/A	0
State	Provider's state.	Combo Box	Drop Down List Box	0
Tax ID Exempt	Provider is exempt from receiving a 1099. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
W9 Form	Provider W9 form. Valid values include: Yes and No.	Combo Box	Drop Down List Box	0
Zip	Provider's zip code.	Field	Character	5
Zip + 4	Provider's zip + 4.	Field	Character	4

6.1.22 IRS W9 Tax ID Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter the Address 1.
City	Field	1	City is required.	Enter the City.
IRS Effective Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Date entered must have format of MM/DD/CCYY.
	Field	2	IRS Effective Date must be greater than or equal to 01/01/1900.	Enter a date greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to the End Date.
	Field	17	Date segments cannot overlap.	Verify keying. Date segments cannot overlap. A provider can only have one Tax ID per date segment.
	Field	5000	New IRS Effective Date must be less than or equal to old IRS Effective Date.	Verify keying. In an update transaction only Effective dates less than or equal to the current Effective Date can be added to prevent gaps in coverage.
IRS Effective Date	Field	3	New IRS Effective Date must be greater than the most current IRS Effective Date.	Enter date greater than the IRS current date.
IRS End Date	Field	1	Effective date and end date range overlap an existing record.	Verify and try again.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter the IRS Tax ID.
	Field	10	Tax ID must be numeric.	Verify keying. Verify the Tax ID is numeric.
	Field	18	Tax ID must be 9 character(s) in length.	Verify keying. Tax ID must be 9 numeric characters.
	Field	19	Tax ID contains an invalid value.	Verify keying. The Tax ID cannot be nine repeating numbers, for example 111111111 is not a valid tax ID.
IRS Tax ID [Search]	Field	1	Effective date and end date range overlap an existing record.	Verify information and try again.
IRS Tax Type	Field	1	IRS Tax Type is required.	Select an IRS Tax Type.
Name	Field	1	Name is required.	Enter the Name.
Phone	Field	1	Enter a valid value.	Phone Number must be numeric.
	Field	2	Phone must be 10 character(s) in length.	Enter a Phone Number with 10 characters.
State	Field	29	A valid State is required.	Choose a State code.
Zip	Field	1	Zip is required.	Enter a Zip Code.

6.1.23 IRS W9 Tax ID Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.1.24 IRS W9 Tax ID Panel Accessibility

6.1.24.1 To Access the IRS W9 Tax ID Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select IRS W9 Tax ID.	IRS W9 Tax ID Panel displays.

6.1.24.2 To Add on IRS W9 Tax ID Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select IRS Tax Type.	
3	Enter IRS Tax ID.	
4	Enter **Name**.	
5	Enter **Address 1** information.	
6	Enter **Address 2** information.	
7	Enter **City**.	
8	Select **State** from drop down list.	
9	Enter Zip Code.	
10	Enter Zip Code extension.	
11	Enter **Phone and extension**, if applicable.	
12	Enter **IRS Effective date** in MM/DD/CCYY format.	IRS End Date defaults to 12/31/2299.
13	Select **Tax ID Exempt** indicator from drop down list.	
14	Select **W9 Form** indicator from drop down list.	
15	Select **Form 147** indicator from drop down list.	
16	Click **Save**.	IRS W9 Tax ID information is saved.

6.1.24.3 To Update the IRS W9 Tax ID Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	IRS W9 Tax ID information is saved.

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6.1.24.4 To Delete from the IRS W9 Tax ID Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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License Panel Overview

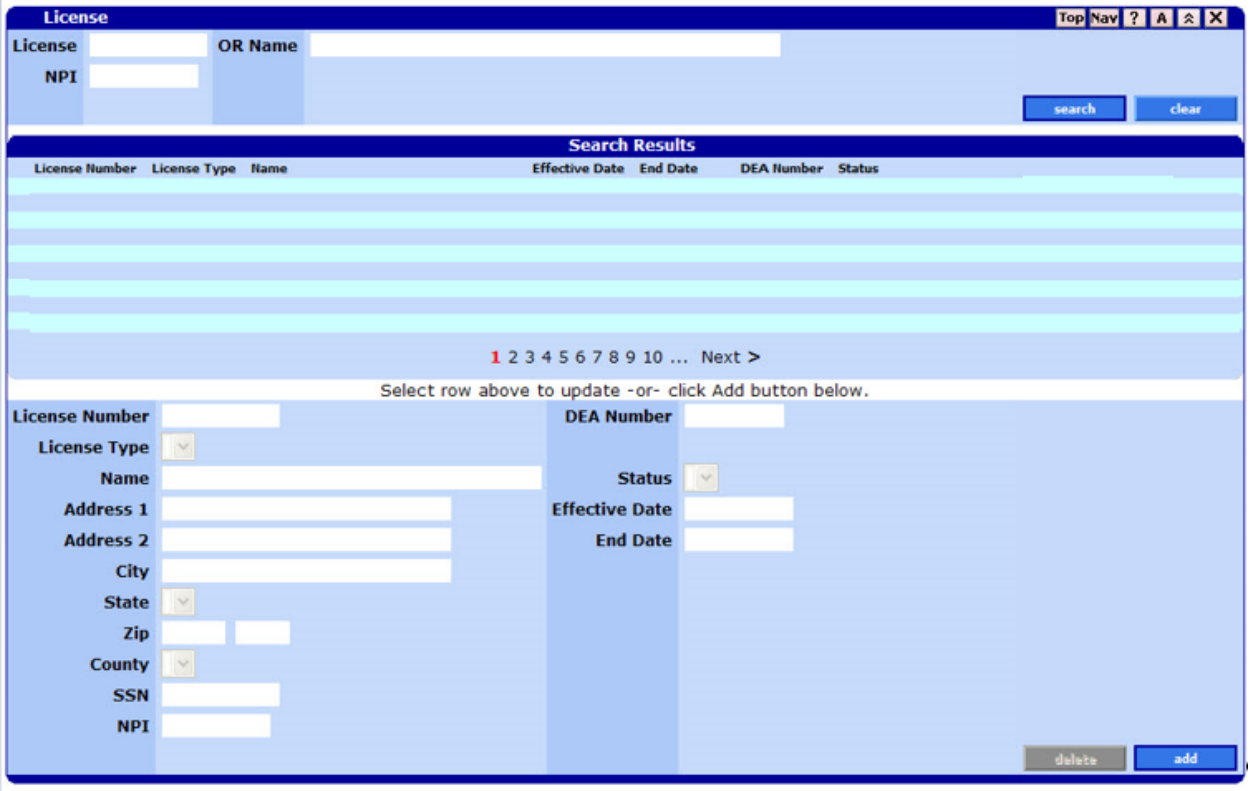
6.1.25 License Panel Narrative

The License panel allows the user to maintain license information.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] - [Other] - [License]

6.1.26 License Panel Layout



6.1.27 License Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add license information.	Button	N/A	0
Address 1	Street address this license was issued on.	Field	Character	30
Address 2	Second street address field.	Field	Character	30
City	City of the provider.	Field	Character	23
Clear	Allows the user to clear any changes on the License panel.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
County	County the license was issued in. Valid values are selected from a drop down list.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove License information.	Button	N/A	0
Effective Date	Date this license went into effect.	Field	Date (MM/DD/CCYY)	8
End Date	Date this license expired.	Field	Date (MM/DD/CCYY)	8
License Number	License number assigned to the provider.	Field	Character	10
License [Search]	License number assigned to the provider.	Field	Character	10
License Type	Type of license issued to the provider. Valid values are 'H' for Health Board and 'P' for Prescriber.	Combo Box	Drop Down List Box	0
Name	Name of the provider holding this license.	Field	Character	50
Name [Search]	Name of the provider holding this license.	Field	Character	50
NPI	National Provider Identifier (NPI).	Field	Character	15
NPI [Search]	National Provider Identifier (NPI) search field.	Field	Character	15
Search	Initiates the Search by License, Number or NPI.	Button	N/A	0
SSN	Social Security Number of the provider.	Field	Number (Integer)	9
State	State of the provider. Valid values are selected from a drop down list.	Combo Box	Drop Down List Box	0
Status	Current known status of the provider's license. Valid values are 'A' for Active and 'I' for Inactive.	Combo Box	Drop Down List Box	0
Zip	Zip code of the provider.	Field	Number (Integer)	9

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6.1.28 License Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address	Field	1	Address 1 is required.	Enter the Address 1.
City	Field	1	City is required.	Enter the City.
County	Field	29	A valid County is required.	Choose a County Code.
Effective Date	Field	1	Effective Date is required.	Enter the Effective Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Effective Date and End Date range overlap an existing record.	Verify keying. Date segments cannot overlap for the same license number and license type.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	15	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to the End Date.
	Field	17	Effective date and end date range overlap an existing record.	Verify keying. Date segments cannot overlap for the same license number and license type.
License Number	Field	1	License Number is required.	Enter the License Number.
	Field	10	License Number must be at least 4 characters in length.	Verify keying. The License Number must be between four and ten characters.
	Field	5000	License Number must be alphanumeric.	Verify keying. Entry must be 0-9 or A-Z.
License Type	Field	1	License Type is required.	Choose the License Type.
Name	Field	1	Name is required.	Enter the Name.
SSN	Field	1	SSN is required.	Enter the SSN.
State	Field	29	A valid State is required.	Choose a State code.
Status	Field	1	Status is required.	Choose a Status.
Zip	Field	1	Zip is required.	Enter the Zip Code.

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6.1.29 License Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.30 License Panel Accessibility

6.1.30.1 To Access the License Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays
4	Select **License**.	License panel displays.

6.1.30.2 To Add on License Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter License Number.	
3	Select **License Type** from drop down list.	
4	Enter **Name**.	
5	Enter **Address 1** information.	
6	Enter **Address 2** information.	
7	Enter **City**.	
8	Select **State**.	
9	Enter Zip Code.	
10	Enter Zip Code extension.	
11	Enter **County**.	
12	Enter **SSN** (Social Security Number).	
13	Enter **NPI** (National Provider Identifier), if applicable.	
14	Select **Status** from drop down menu.	
15	Enter **Effective Date** in MM/DD/CCYY format.	
16	Enter **End Date** in MM/DD/CCYY format.	
17	Click **Save**.	License information is saved.

6.1.30.3 To Update the License Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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2	Click in field(s) to update and perform update.	
3	Click **Save**.	License information is saved.

6.1.30.4 To Delete from the License Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Sanction Panel Overview

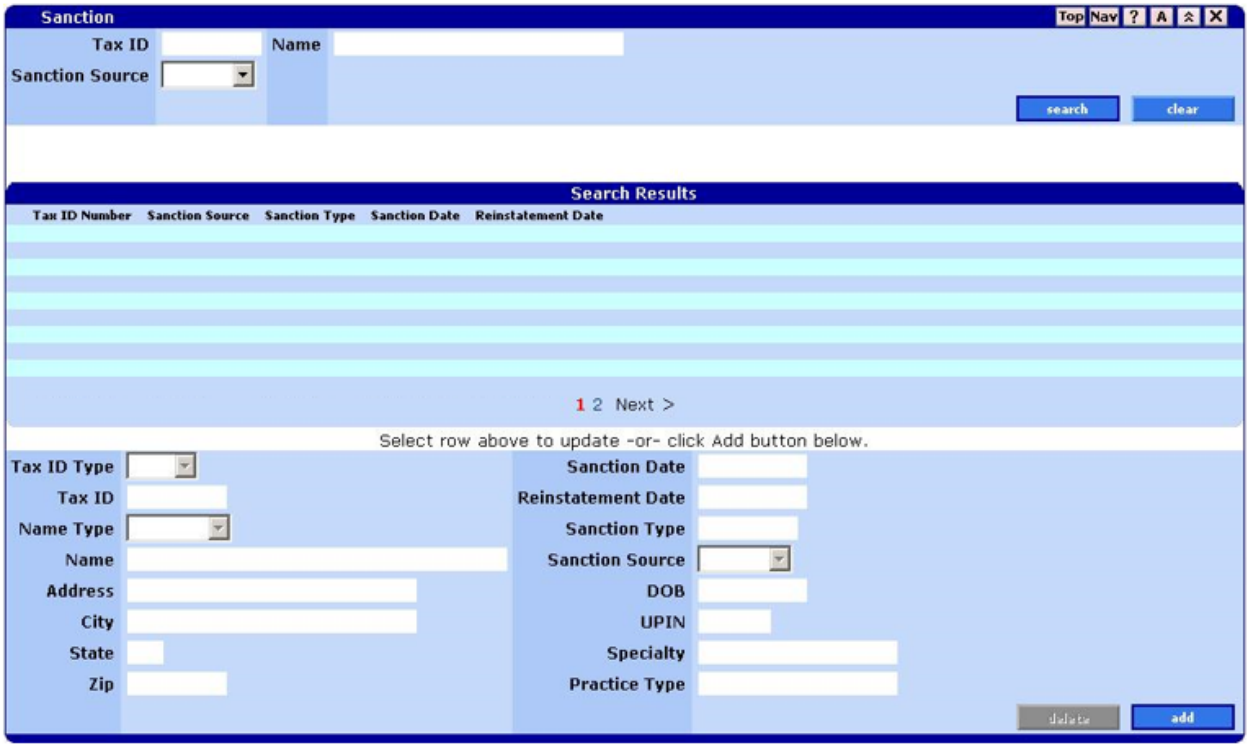
6.1.31 Sanction Panel Narrative

The Sanction panel is used to view and update Sanctioned Providers.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Related Data] – [Other] – [Sanction]

6.1.32 Sanction Panel Layout



6.1.33 Sanction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add sanctioned provider information.	Button	N/A	0
Address	Sanctioned provider's address.	Field	Character	30
City	Sanctioned provider's city.	Field	Character	30
Clear	Allows the user to clear any changes on the Sanctioned Provider panel.	Button	N/A	0
DOB	Sanctioned provider's date of birth.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to remove sanctioned provider information.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Name	Name of provider.	Field	Character	50
Name [Search]	Name of provider.	Field	Character	50
Name Type	Personal or business.	Combo Box	Drop Down List Box	0
Practice Type	Sanctioned provider's practice type.	Field	Character	20
Reinstatement Date	Date of reinstatement.	Field	Date (MM/DD/CCYY)	8
Sanction Date	Date of the sanction.	Field	Date (MM/DD/CCYY)	8
Sanction Source	Source of sanction. Valid values include: Federal and State.	Combo Box	Drop Down List Box	0
Sanction Source [Search]	Source of sanction. Valid values include: Federal and State.	Combo Box	Drop Down List Box	0
Sanction Type	Sanction type code.	Field	Alphanumeric	10
Search	Initiates the Search by Tax ID, Name or Sanctioned Source.	Button	N/A	0
Specialty	Sanctioned Provider's Specialty Description.	Field	Character	20
State	Sanctioned provider's state.	Field	Character	2
Tax ID	Tax identification number of sanctioned provider.	Field	Character	9
Tax ID [Search]	Tax identification number of sanctioned provider.	Field	Character	9
Tax ID Number	Tax identification number of the sanctioned provider.	Field	Character	9
Tax ID Type	FEIN or Social Security Number.	Combo Box	Drop Down List Box	0
UPIN	Sanctioned provider's Universal Provider Identification Number.	Field	Alphanumeric	10
Zip	Sanctioned provider's zip code.	Field	Number (Integer)	9

6.1.34 Sanction Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Name Type	Combo Box	1	Name Type is Required.	Verify keying. Select Name Type appropriate for the name entered.
Name	Field	1	Name is Required.	Verify keying. Enter Name of business or person being sanctioned.

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Field	Field Type	Error Code	Error Message	To Correct
Reinstatement Date	Field	1	Reinstatement Date must be greater than or equal to 01/01/1900.	Verify keying. Enter Reinstatement Date greater than or equal to 01/01/1900.
	Field	2	Reinstatement Date must be less than or equal to 12/31/2299.	Verify keying. Enter Reinstatement Date less than or equal to 12/31/2299.
	Field	3	Sanction Date and/or Reinstatement Date overlaps an existing record's date range.	Verify keying. Sanction Date and/or Reinstatement Date overlaps the date range of an existing record for this Tax ID, Sanction Source and Sanction Type.
Sanction Date	Field	1	Sanction Date is Required.	Verify keying. Enter date of sanction.
	Field	2	Sanction Date must be greater than or equal to 01/01/1900.	Verify keying. Enter sanction date greater than or equal to 1/1/1900.
	Field	3	Sanction Date must be less than or equal to 12/31/2299.	Verify keying. Enter sanction date less than or equal to 12/31/2299.
	Field	4	Sanction Date must be less than or equal to Reinstatement Date.	Verify keying. Sanction Date cannot be greater than Reinstatement Date entered.
	Field	5	Sanction Date and/or Reinstatement Date overlaps an existing records date range.	Verify keying. Sanction Date and/or Reinstatement Date overlaps the date range of an existing record for this Tax ID, Sanction Source and Sanction Type.
Sanction Source	Field	1	An open sanction already exists for this Tax ID, Sanction Source and Sanction Type.	Verify keying. User cannot enter a record containing the same Tax ID, Sanction Source and Sanction Type as an open existing record.
Sanction Type	Field	1	Sanction Type is Required.	Verify keying. Enter Sanction Type.
	Field	2	An open sanction already exists for this Tax ID, Sanction Source and Sanction Type.	Verify keying. User cannot enter a record containing the same Tax ID, Sanction Source and Sanction Type as an open existing record.
Tax ID	Field	1	Tax ID is Required.	Verify keying. Enter SSN or Tax ID of business or person being sanctioned.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	An open sanction already exists for this Tax ID, Sanction Source and Sanction Type.	Verify keying. User cannot enter a record containing the same Tax ID, Sanction Source and Sanction Type as an open existing record.
Tax ID Type	Field	1	Tax ID Type is Required.	Verify keying. Select Tax ID Type appropriate for Tax ID entered.
Zip	Field	1	Zip must be Numeric.	Verify keying. Enter numeric values only as zip code.

6.1.35 Sanction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.36 Sanction Panel Accessibility

6.1.36.1 To Access the Sanction Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Related Data**.	Related Data panel displays.
3	Select **Other**.	A list of hyperlinks to panel(s) displays.
4	Select **Sanction**.	Sanction Panel displays.

6.1.36.2 To Add on Sanction Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Tax ID Type** from drop down list.	
3	Enter **Tax ID**.	
4	Select **Name Type** from drop down list.	
5	Enter **Name**.	
6	Enter **Address**.	
7	Enter **City**.	
8	Select **State**.	
9	Enter Zip Code +4 digit extension.	
11	Enter **Sanction Date** in MM/DD/CCYY format.	

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Step	Action	Response
12	Enter **Reinstatement Date** in MM/DD/CCYY format, if applicable.	
13	Enter Sanction Type.	
14	Select **Sanction Source** from drop down menu.	
15	Enter **DOB** (date of birth) in MM/DD/CCYY format, if applicable.	
16	Enter **UPIN** (Universal Provider Identifier Number).	
17	Enter Specialty.	
18	Enter Practice Type.	
19	Click **Save**.	Sanction information is saved.

6.1.36.3 To Update the Sanction Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Sanction information is saved.

6.1.36.4 To Delete from the Sanction Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Web Application Status Panel

6.1.37 Web Application Status Panel Narrative

MMIS UI panel where HPE PE staff can update the status of web enrollment application submitted via the web portal product. Statuses on this panel may be applied via user interaction and/or batch processes. Statuses and dates posted to this panel will drive batch process activities such as moving application data from temp table to production tables, etc.

Fields for this panel are Application Tracking Number (ATN), Provider Name, Provider ID and Status. Date will be displayed on the panel. The date displayed is associated to the system date at the time the current status was applied. Fields other than Status are not updatable by the user. The Application Tracking Number (ATN), Provider Name and Provider ID are based on the information submitted by the provider on the application through the HPE Provider Enrollment portal product.
Status values are:

System Validation Occurring
Agency Review Required
Ready for Review
Under Review
Data Corrections Required
Corrections Applied
Rejected by Reviewer
Response Time Passed
Override
Denied
Approved
Moved to Production
Waiting on Documentation

UI editing will prevent the application or usage of an inappropriate status by a user.

Navigation Path: [Provider] – [Related Data] – [Other] – [Web Application Status]

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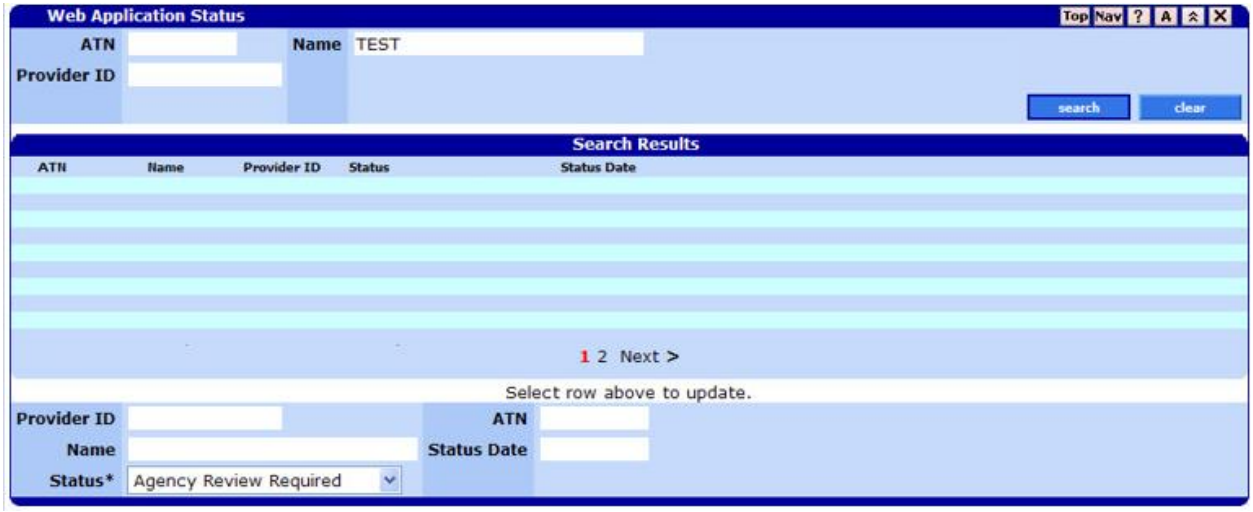
6.1.38 Web Application Status Panel Layout



6.1.39 Web Application Status Field Descriptions

Field	Description	Field Type	Data Type	Length
ATN	Application Tracking Number (ATN).	Field	Integer	15
Clear	Clear all search criteria entered.	Button	N/A	0
Name	Name of provider from application submitted through the web portal product.	Field	Character	50
Provider ID	Provider's NPI submitted via the web portal product.	Field	Alphanumeric	10
Status	Status of the provider application. Valid options include: Agency Review Required, Approved, Corrections Applied, Data Corrections Required, Denied, Incomplete, Moved to Production, Override, Primary Facsimile, Ready for Review, Rejected by Reviewer, Response Time Passed, Resubmit Application, Secondary Facsimile, System Validation Occurring, Under Review and Waiting for Documentation	Field	Drop Down List Box	30
Status Date	Current system date as of the time the current status was applied to an application.	Field	Date (MM/DD/CCYY)	8
Search	Initiate the Provider Application Status.	Button	N/A	0

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6.1.40 Web Application Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Status	Drop Down List Box	1	Previous Status must be Agency Review Required.	Prior Status should be Agency Review Required.
	Drop Down List Box	2	User does not have clearance to post status.	User will need to cancel transaction, have an unrestricted user apply this status and/or select an appropriate status.
	Drop Down List Box	3	Previous Status must be Override.	Prior Status should be Override.
	Field	4	Previous Status must be Under Review.	Prior Status should be Under Review.

6.1.41 Web Application Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.42 Web Application Status Panel Accessibility

6.1.42.1 To Access the Sanction Panel

Step	Action	Response
1	Navigate to **Provider** and click **Related Data**.	Related Data panel displays.
2	Select **Other**.	A list of hyperlinks to panel(s) displays.
3	Select Web **Application Status.**	Web Application Status Panel displays.

6.1.42.2 To Update the Web Application Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Web Application Status information is saved.

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Provider Financial Payment Summary Panel Overview

6.1.43 Provider Financial Payment Summary Panel Narrative

The Provider Financial Payment Summary panel allows the entry of search criteria regarding a provider's payment information from the Provider subsystem. This panel is inquiry only.

Navigation Path: [Provider] – [Financial Summary]

6.1.44 Provider Financial Payment Summary Panel Layout

6.1.45 Provider Financial Payment Summary Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Provider Financial Payment Summary panel.	Button	N/A	0
Month	Month to search for the financial payment summary.	Combo Box	Drop Down List Box	0
Provider ID	Unique provider identification number.	Field	Character	9
Provider Name	Provider name.	Field	Character	50
Search	Initiates the Search by Provider ID.	Button	N/A	0
[Search]	Allows user to locate a Provider by Provider ID, Business OR Last Name and First, MI.	Hyperlink	N/A	0
Year	Year to search for the financial payment summary.	Field	Date (CCYY)	4

6.1.46 Provider Financial Payment Summary Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Provider ID	Field	1	There is no Provider in the system with that ID.	Enter or search for a valid Provider ID.

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6.1.47 Provider Financial Payment Summary Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.48 Provider Financial Payment Summary Panel Accessibility

6.1.48.1 To Access the Provider Financial Payment Summary Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Provider and click Financial Summary.	Provider Financial Payment Summary Panel displays.

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Provider Financial Summary Search Results Panel Overview

6.1.49 Provider Financial Summary Search Results Panel Narrative

This panel provides the search results for Provider Financial Summary. This panel is display only.

Navigation Path: [Provider] – [Financial Summary] - [enter search criteria]

6.1.50 Provider Financial Summary Search Results Panel Layout

Search Results

Category	Claims Paid Count	Claims Denied Count	Adjustment Paid Count	Total Payment Amount
Year to Date:	3	1	0	$527.0(
Month to Date:	2	1	0	$277.0(
Current Cycle:	0	0	0	$0.0(
State Year to Date:	3	1	0	$93,010.77

6.1.51 Provider Financial Summary Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment Paid Count [Year to Date]	The number of year to date paid adjusted claims.	Field	Number (Integer)	5
Adjustment Paid Count [Month to Date]	The number of month to date paid adjusted claims.	Field	Number (Integer)	5
Adjustment Paid Count [Current Cycle]	The number of paid adjusted claims for the cycle date displayed.	Field	Number (Integer)	5
Adjustment Paid Count [State Year to Date]	The number of state fiscal year to date paid adjusted claims.	Field	Number (Integer)	5
Category	Category under which numbers fall under, for example, Claims Paid Count Year to Date.	Field	Character	0
Claims Denied Count [Year to Date]	The number of year to date denied claims.	Field	Number (Integer)	5
Claims Denied Count [Month to Date]	The number of month to date denied claims.	Field	Number (Integer)	5
Claims Denied Count [Current Cycle]	The number of denied claims for the cycle date displayed.	Field	Number (Integer)	5
Claims Denied Count [State Year to Date]	The number of state fiscal year to date denied claims.	Field	Number (Integer)	5
Claims Paid Count [Year to Date]	The number of year to date paid claims.	Field	Number (Integer)	5
Claims Paid Count [Month to Date]	The number of month to date paid claims.	Field	Number (Integer)	5

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Field	Description	Field Type	Data Type	Length
Claims Paid Count [Current Cycle]	The number of paid claims for the cycle date displayed.	Field	Number (Integer)	5
Claims Paid Count [State Year to Date]	The number of state fiscal year to date paid claims.	Field	Number (Integer)	5
Total Payment Amount [Year to Date]	The year to date total payment amount.	Field	Number (Decimal)	6
Total Payment Amount [Month to Date]	The month to date total payment amount.	Field	Number (Decimal)	6
Total Payment Amount [Current Cycle]	The total payment amount for the cycle date displayed.	Field	Number (Decimal)	6
Total Payment Amount [State Year to Date]	The state fiscal year total payment amount.	Field	Number (Decimal)	6

6.1.52 Provider Financial Summary Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.1.53 Provider Financial Summary Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.54 Provider Financial Summary Search Results Panel Accessibility

6.1.54.1 To Access the Provider Financial Summary Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Provider and click Financial Summary.	Provider Financial Payment Summary Panel displays.
3	Enter search criteria and click **Search.**	Provider Financial Summary Search Results Panel displays.

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Provider - Reports Page Overview

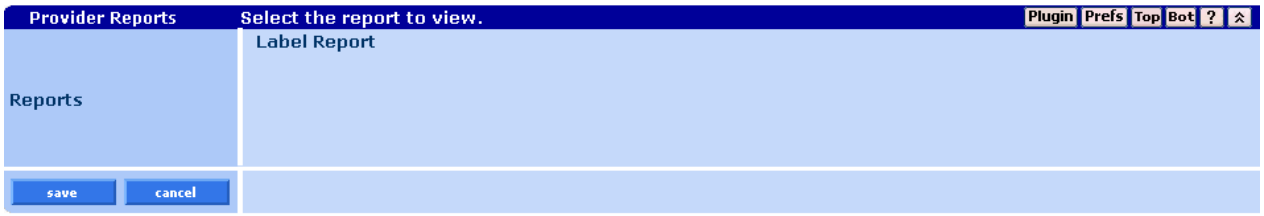
6.1.55 Provider - Reports Page Narrative

The Reports page displays the Provider Reports panel which contains a link to the Label Report panel.

This panel is inquiry only.

Navigation Path: [Provider] – [Rpts] – [Reports]

6.1.56 Provider - Reports Page Layout



6.1.57 Provider - Reports Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes on the Provider - Reports page.	Button	N/A	0
Label Report	Link to the Label Report panel.	Hyperlink	N/A	0
Save	Allows the user to save a record.	Button	N/A	0

6.1.58 Provider - Reports Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.1.59 Provider - Reports Page Extra Features

Field	Field Type
No extra features found for this page.	

6.1.60 Provider - Reports Page Accessibility

6.1.60.1 To Access the Provider - Reports Page

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Rpts**.	Provider Reports panel displays.
3	Click **Reports** hyperlink.	Hyperlinks associated to reports appear.

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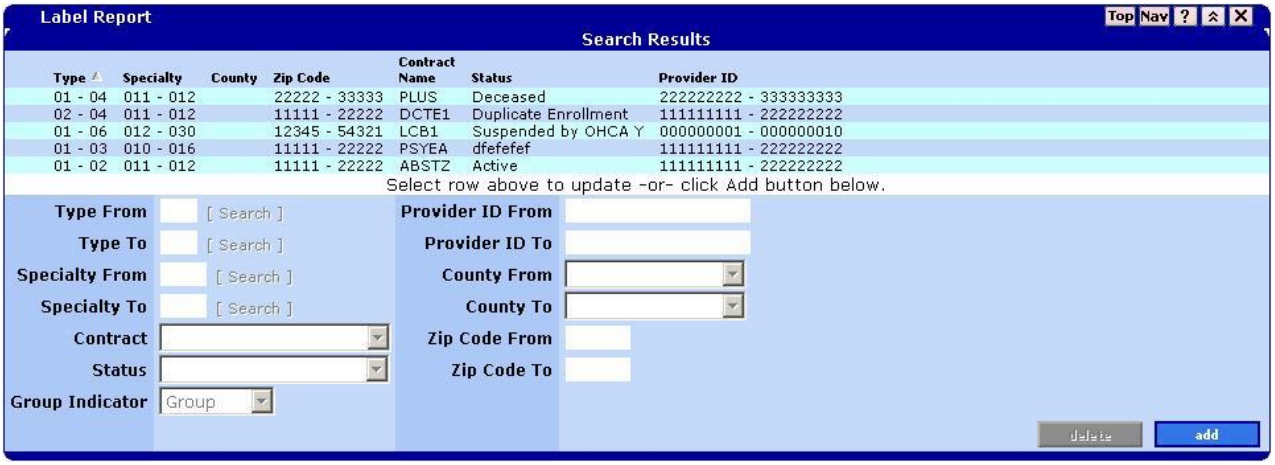
Label Report Panel Overview

6.1.61 Label Report Panel Narrative

The Label Report allows the user to enter a request for labels to be printed. Only users with update authority are allowed to modify this panel.

Navigation Path: [Provider] – [Rpts] - [Label Report]

6.1.62 Label Report Panel Layout



6.1.63 Label Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add label report information.	Button	N/A	0
Contract	User can choose to only produce labels for a specific provider contract by choosing a value from the drop down.	Combo Box	Drop Down List Box	0
Contract Name	Provider contract name.	Field	Character	20
County	Provider county range.	Field	Character	7
County From	Provider county from value.	Combo Box	Drop Down List Box	0
County To	Provider county to value.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove label report information.	Button	N/A	0
Group Indicator	User can choose to only produce labels for a groups or individual providers by choosing a value from the drop down.	Combo Box	Drop Down List Box	0
Provider ID	Provider identification number range.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
Provider ID From	Provider identification number from value.	Field	Character	9
Provider ID To	Provider identification number to value.	Field	Character	9
Specialty	Provider specialty range.	Field	Character	9
Specialty From	Provider specialty from value.	Field	Character	3
Specialty To	Provider specialty to value.	Field	Character	3
Status	User can choose to only produce labels for a specific provider status by choosing a value from the drop down.	Comb o Box	Drop Down List Box	0
Type	Provider type range.	Field	Character	7
Type From	Provider type from value.	Field	Character	2
Type To	Provider type to value.	Field	Character	2
Zip Code	Provider zip code range.	Field	Character	13
Zip Code From	Provider zip code from value.	Field	Character	5
Zip Code To	Provider zip code to value.	Field	Character	5

6.1.64 Label Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
County To	Field	145	County To cannot be less than County From.	Verify keying. County To must be greater than or equal to County From.
Provider ID From	Field	1	Provider ID From must be 9 character(s) in length.	Enter a Provider ID From with 9 characters.
	Field	148	Provider From ID cannot be greater than Provider ID To.	Verify keying. Provider ID From must be less than or equal to Provider ID To.
Provider ID To	Field	1	Provider ID To must be 9 character(s) in length.	Enter a Provider ID To with 9 characters.
Specialty From	Field	146	From Specialty Code cannot be greater than To Specialty Code.	Verify keying. Specialty From must be less than or equal to Specialty To.
	Field	5000	Specialty From not valid.	Verify keying. Enter or search for a valid Specialty code.
Specialty To	Field	5000	Specialty To not valid.	Verify keying. Enter or search for a valid Specialty code.

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Field	Field Type	Error Code	Error Message	To Correct
Type From	Field	147	Provider Type From Code cannot be greater than To Provider Type Code.	Verify keying. Provider Type From must be less than or equal to Provider Type To.
	Field	5000	Type From not valid.	Verify keying. Enter or search for a valid Provider Type.
Type To	Field	5000	Type To not valid.	Verify keying. Enter or search for a valid Provider Type.
Zip Code From	Field	149	Zip Code From cannot be greater than Zip Code To.	Verify keying. Zip Code From must be less than or equal to Zip Code To.

6.1.65 Label Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.66 Label Report Panel Accessibility

6.1.66.1 To Access the Label Report Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **Provider** and click **Rpts**.	Provider Reports panel displays.
3	Click **Label Report** hyperlink.	Label Report Panel displays.

6.1.66.2 To Add on the Label Report Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter designated label criteria.	
3	Click **Save**.	Label criteria is saved.

6.1.66.3 To Update the Label Report Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Label Report information is saved.

6.1.66.4 To Delete from the Label Report Panel

Step	Action	Response

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1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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7. Provider Reports

The Provider Reports section provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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PRV-0002-M -- License Expiration Report

7.1.1 PRV-0002-M -- License Expiration Report Narrative

The License Expiration report is a monthly report that lists all active providers whose health board license expires in 30 days or is expired. This report is produced monthly.

7.1.2 PRV-0002-M -- License Expiration Report Layout

```
Report   : PRV-0002-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process  : PRVJM410                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVP400M                           LICENSE EXPIRATION REPORT                                     Page:    999,999
                                                                                 REPORT PERIOD: MM/CCYY

   PROVIDER                  PROVIDER                                    LICENSE EXPIRATION      LICENSE      LICENSE     LICENSE
    NUMBER                     NAME                                            DATE               NUMBER       STATE       TYPE
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX
    XXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       MM/DD/CCYY        XXXXXXXXXX       XX         XXXXX


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

7.1.3 PRV-0002-M -- License Expiration Report Field Descriptions

Field	Description	Length	Data Type
License Expiration Date	Date the provider's health board license expired.	10	Date (MM/DD/CCYY)
License Number	Provider's health board license number.	10	Character
License State	State the provider’s license is held.	2	Character
License Type	Provider’s license type.	5	Character
Provider Name	Provider's name.	38	Character
Provider Number	Provider's ten digit identification number.	10	Character

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PRV-0010-R -- Label Print Request Summary Information Report

7.1.4 PRV-0010-R -- Label Print Request Summary Information Report Narrative

This report has the Label Print Request Summary Information. This report is produced by request.

7.1.5 PRV-0010-R -- Label Print Request Summary Information Report Layout

```
Report  : PRV-0010-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJD010                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVP010D                            PROVIDER MAILING LABELS                                      Page:    999,999



                                        ** Label Print Request Information
                                             User Id       : XXXXXXXX
                                   Requestor Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                              Date Requested: MM/DD/CCYY


                                        Print Request Selection Criteria
                          Type From      = XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          Type To        = XX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          Specialty from = XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          Specialty to   = XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                        County from    = XX XXXXXXXXXXXX
                                        County to      = XX XXXXXXXXXXXX
                                             Zip code from  = XXXXX
                                             Zip code to    = XXXXX
                       Contract Code/Name  = XX XXXXXXXXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
County to	End of the range of provider's county that was selected for print.	2	Character
Date Requested	Date of the request for the mailing labels.	10	Date (MM/DD/CCYY)
Order by zip code 9 digits	Field that describes what order the mailing labels were requested to be printed.	20	Character
Contract Code/Name	Contract that the label are being printed for.	2	Character
Requestor Name	Name of the clerk that made the provider mailing label request.	39	Character
Specialty from	Start of the range of provider specialties that were selected for print.	3	Character
Specialty to	End of the range of provider specialties that were selected for print.	3	Character
Status	Enrollment status of the provider.	50	Character
Type From	Start of the range of provider types that were selected for print.	2	Character
Type To	End of the range of provider types that were selected for print.	2	Character
User Id	User Identification number of the clerk that made the request for the labels.	8	Character
Zip code from	Start of the range of provider's zip code that was selected for print.	5	Character
Zip code to	End of the range of provider's zip code that was selected for print.	5	Character

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PRV-0010-R 2 -- Provider Mailing Labels Report

7.1.7 PRV-0010-R 2 -- Provider Mailing Labels Report Narrative

These are the provider mailing labels that are requested by the user. These labels are generated in the nightly batch cycle, and are fed with input from the t_pr_label_crit table, which is populated by the Provider Label Maintenance panel This report is produced by request.

7.1.8 PRV-0010-R 2 -- Provider Mailing Labels Report Layout

```
PROVIDER NAME
STREET 1
STREET 2
CITY, STATE ZIP-ZIP4
```

7.1.9 PRV-0010-R 2 -- Provider Mailing Labels Report Field Descriptions

Field	Description	Length	Data Type
City	Provider mailing address city.	15	Character
Provider Name	Provider name.	50	Character
State	Provider mailing address state code.	2	Character
Street 1	First line of the provider mailing address, street.	30	Character
Street 2	Optional second line of the provider mailing address, street.	30	Character
Zip	Provider mailing address zip code.	5	Character
Zip 4	Optional 4 digit mailing address zip code extension.	4	Character

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PRV-0011-R -- Provider Listing by Flexible Criteria Report

7.1.10 PRV-0011-R -- Provider Listing by Flexible Criteria Report Narrative

The Provider Listing by Flexible Criteria report is generated utilizing the on-line Provider Listing Report panel The user accesses the Provider Listing Report panel through the Provider Search Window by choosing the Provider List selection option from the OPTIONS pull down menu bar. The contract allows the user to choose multiple selection criteria. The valid values for selection criteria are 'provider type range', 'provider specialty range'(per service location), 'county', 'zip code'(per service location), 'contract', and 'enrollment status'. Any combination of the listed criteria, including all criteria, may be selected. The user may choose the sort sequence; alphabetically (by provider name) or numerically (by provider number). To execute the contract, the user clicks on the 'Save' option button. The report displays information from each service location on the provider's file that met the criteria selected. This report is produced by request.

7.1.11 PRV-0011-R -- Provider Listing by Flexible Criteria Report Layout

```
Report  : PRV-0011-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJD011                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: PRVP011D                      PROVIDER LISTING BY FLEXIBLE CRITERIA                                Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

                                                   User Id       : XXXXXXXX
                                         Requestor Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                   Date Requested: MM/DD/CCYY

                                                   Report selection criteria:

                                                         PROVIDER TYPE
                                FROM   XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                TO     XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                       PROVIDER SPECIALTY
                                FROM   XXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                TO     XXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                             COUNTY
                                            FROM   XX      XXXXXXXXXXXXX
                                            TO     XX      XXXXXXXXXXXXX

                                              CITY   XXXXXXXXXXXXXXXX

                                                      ZIP CODE
                                                    FROM   XXXXX
                                                    TO     XXXXX

                            CONTRACT XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                           STATUS   X       XXXXXXXXXXXXXXXXXXXXX
```


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7.1.12 PRV-0011-R -- Provider Listing by Flexible Criteria Report Field Descriptions

Field	Description	Length	Data Type
City	City requested by the analysts to search on.	15	Character
Contract	Public health contract entered by the analyst as search criteria.	9	Number (Integer)
County From	County code requested by the analysts to start the search from.	2	Character
County To	County code requested by the analyst to end the search at.	2	Character
Date Requested	Date the report was requested.	8	Date (MM/DD/CCYY)
Provider Specialty From	Provider specialty requested by the analyst to start the search from.	3	Character
Provider Specialty To	Provider specialty entered by the analyst to end the search at.	3	Character
Provider Type From	Provider type specified by the analyst to start the search from.	2	Character
Provider Type To	Provider type specified by the analyst to end the search at.	2	Character
Requestor Name	Name of the analyst who is requesting the report.	30	Character
Status	Status indicator entered by the analyst as search criteria.	1	Character
User Id	Analyst Identification number who is requesting the provider report.	8	Character
Zip Code From	Zip code requested by the analyst to start the search from.	5	Character
Zip Code To	Zip code requested by the analyst to end the search at.	5	Character

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PRV-0015-M -- Provider FEIN-SSN Cross Reference Report

7.1.13 PRV-0015-M -- Provider FEIN-SSN Cross Reference Report Narrative

The Provider FEIN SSN Cross Reference Report is a monthly report used to view providers selected by parameters other than the provider identification number. This report is sorted by FEIN/SSN. Any changes made to this report need to also be made to PRV-0016-M and PRV-0017-M. PRV-0016-M displays the same data sorted by license/certification number, and PRV-0017-M displays the same data sorted by CLIA number. This report is produced monthly.

7.1.14 PRV-0015-M -- Provider FEIN-SSN Cross Reference Report Layout

```
Report  : PRV-0015-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRV0015M                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVJM015                            PROVIDER CROSS REFERENCE                                     Page:    999,999
                                               REPORT PERIOD: MM/CCYY

                                             SORT CRITERIA:  FEIN/SSN**
                            FEIN/SSN        PROV                   LICENSE              PROVIDER NAME
                                                                     NUMBER

            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXX      XXXXXXXXXX            XXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```


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7.1.15 PRV-0015-M -- Provider FEIN-SSN Cross Reference Report Field Descriptions

Field	Description	Length	Data Type
FEIN/SSN	This field contains either the Federal Employer Identification Number or the Social Security Number for the provider.	9	Character
License	License number for the provider.	10	Character
Prov Number	Provider number for the system.	10	Character
Provider Name	Name of the provider.	50	Character

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PRV-0016-M -- Provider License Number Cross Reference Report

7.1.16 PRV-0016-M -- Provider License Number Cross Reference Report Narrative

The Provider License Number Cross Reference Report is a monthly report that allows the user to view provider listings by license number. In addition to license number, the provider name, provider ID number and SSN/FEIN are printed on the report. Any changes made to this report need to also be made to PRV-0015-M and PRV-0017-M. PRV-0015-M displays the same data sorted by FEIN/SSN, and PRV-0017-M displays the same data sorted by CLIA number.

7.1.17 PRV-0016-M -- Provider License Number Cross Reference Report Layout

```
Report  : PRV-0016-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRV0016M                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: PRVJM016                             PROVIDER CROSS REFERENCE                                      Page:    999,999
                                               REPORT PERIOD: MM/CCYY

                                                   SORT CRITERIA:  license**

                                LICENSE     PROV                  FEIN/SSN            PROVIDER NAME
                                                                    NUMBER
            XXXXXXXXXX XXXXXXXXXX              XXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX XXXXXXXXXX              XXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX XXXXXXXXXX              XXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```


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7.1.18 PRV-0016-M -- Provider License Number Cross Reference Report Field Descriptions

Field	Description	Length	Data Type
FEIN/SSN	This field contains either the Federal Employer Identification Number or the Social Security Number for the provider.	9	Character
License	License/certification number for the provider.	10	Character
Prov Number	Provider number.	10	Character
Provider Name	Name of the provider.	50	Character

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PRV-0017-M -- Provider CLIA Cross Reference Report

7.1.19 PRV-0017-M -- Provider CLIA Cross Reference Report Narrative

The Provider CLIA Cross Reference Report is a monthly report that shows all CLIA numbers in the system, grouped by CLIA number, to show relationships between providers using the same CLIA number and also possible problems with providers using the same CLIA certification. This report is ran monthly and sorted by CLIA number. Any changes made to this report need to also be made to PRV-0015-M and PRV-0016-M. PRV-0015-M displays the same data sorted by FEIN/SSN, and PRV-0016-M displays the same data sorted by license/certification number. It is modeled after the existing PRV-0015-R and PRV-0016-R reports in the current base system. The CLIA numbers in the system are pulled from the T_PR_CLIA_STAT table.

7.1.20 PRV-0017-M -- Provider CLIA Cross Reference Report Layout

```
Report  : PRV-0017-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : PRV0017M                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVJM017                          PROVIDER CLIA CROSS REFERENCE                                   Page:    999,999
                                               REPORT PERIOD: MM/CCYY


                                                 SORT CRITERIA:  CLIA**

                              CLIA              PROVIDER                            PROVIDER NAME
                                                                     NUMBER

            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
            XXXXXXXXXX        XXXXXXXXXX                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



                                              *** END OF REPORT ***
                                            *** NO DATA THIS RUN ***
```


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7.1.21 PRV-0017-M -- Provider CLIA Cross Reference Report Field Descriptions

Field	Description	Length	Data Type
CLIA	Clinical Laboratory Improvement Act Number used by the listed provider(s). The same field name are pulled from the t_pr_CLIA_stat. table.	10	Character
Provider Number	Provider's identification number.	10	Character
Provider Name	Provider's name.	50	Character

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PRV-0032-W -- Provider Pre-Notification Report

7.1.22 PRV-0032-W -- Provider Pre-Notification Report Narrative

The Provider Pre-Notification report lists providers that want to start using electronic funds transfer (EFT). This report is produced weekly.

7.1.23 PRV-0032-W -- Provider Pre-Notification Report Layout

```
Report  : PRV-0032-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJW010                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: FNIO0700                        PROVIDER PRE-NOTIFICATION REPORT                                   Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

                                                      Electronic Claims
          Provider        Provider Name                                   ABA Number      Account Number          Amount Paid

          XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXX       XXXXXXXXXXXXXXXX      $999,999,999.99
          XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXX       XXXXXXXXXXXXXXXX      $999,999,999.99
          XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXX       XXXXXXXXXXXXXXXX      $999,999,999.99
          XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXX       XXXXXXXXXXXXXXXX      $999,999,999.99
          XXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXX       XXXXXXXXXXXXXXXX      $999,999,999.99

                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

7.1.24 PRV-0032-W -- Provider Pre-Notification Report Field Descriptions

Field	Description	Length	Data Type
ABA Number	Transit routing number to the bank.	9	Character
Account Number	Number for the providers account.	15	Character
Amount Paid	Dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the third party liability amount.	15	Number (Decimal)
Electronic Claims Provider	Number that identifies a provider.	10	Character
Provider Name	Name of the provider requesting electronic funds transfer.	40	Character

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PRV-0100-W -- Active Providers with Invalid ABA Numbers Report

7.1.25 PRV-0100-W -- Active Providers with Invalid ABA Numbers Report Narrative

The Active Providers with Invalid ABA Numbers report produces a lists all active providers with invalid ABA numbers. The report is generated every Tuesday night (weekly) and sent to the Agency for evaluation and correction.

7.1.26 PRV-0100-W -- Active Providers with invalid ABA Numbers Report Layout

```
Report  : PRV-0100-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJW100                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRV0100W                    ACTIVE PROVIDERS WITH INVALID ABA NUMBERS                            Page:    999,999
                                             REPORT PERIOD: MM/DD/CCYY
                                                                                   Type of
          Provider ID                  Bank Account Number ERROR    ABA Number ERROR    Account     Effective Date     End Date

        XXXXXXXXXX                        XXXXXXXXXXXXXXXXXX           XXXXXXXXX          X           MM/DD/CCYY        MM/DD/CCYY
        XXXXXXXXXX                        XXXXXXXXXXXXXXXXXX           XXXXXXXXX          X           MM/DD/CCYY        MM/DD/CCYY
        XXXXXXXXXX                        XXXXXXXXXXXXXXXXXX           XXXXXXXXX          X           MM/DD/CCYY        MM/DD/CCYY
        XXXXXXXXXX                        XXXXXXXXXXXXXXXXXX           XXXXXXXXX          X           MM/DD/CCYY        MM/DD/CCYY

                                           Total Providers with Invalid ABA Numbers : 9,999


                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```


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7.1.27 PRV-0100-W -- Active Providers with Invalid ABA Numbers Report Field Descriptions

Field	Description	Length	Data Type
ABA Number Error	Bank Account Routing Number (ABA) error.	9	Character
Bank Account Number Error	Bank Account Number error.	17	Character
Effective Date	Effective start date of the ABA error.	10	Date (MM/DD/CCYY)
End Date	End date of the ABA error.	10	Date (MM/DD/CCYY)
Provider ID	Provider Identification Number.	10	Character
Total Providers with Invalid ABA Numbers	Displays the total number of providers that have invalid Account Routing Numbers.	5	Number (Decimal)
Type of Account	Type of the bank account that a provider is using for Electronic Funds Transfers.	1	Character

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PRV-0300-D -- Newly Enrolled Providers Report

7.1.28 PRV-0300-D -- Newly Enrolled Providers Report Narrative

The Newly Enrolled Providers report lists newly enrolled providers along with their associated information. It is sorted by county code, application finalized date, and provider number. This report is produced daily.

7.1.29 PRV-0300-D -- Newly Enrolled Providers Report Layout

```
Report  : PRV-0300-D                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : PRV0300D                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: PRVJD300                             NEWLY ENROLLED PROVIDERS                                            Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
  PROVIDER        ECC PROVIDER NAME                                      ID  ADDRESS                          PHONE      CNTY  FINALIZED
TYP      NUMBER       CONTACT                                            TYP                                    NUMBER     CODE    DATE

XXX XXXXXXXXXX     X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999)999-9999  99   MMDDCCYY
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXXXXXXXXXXX  XX XXXXX-XXXX
XXX XXXXXXXXXX     X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999)999-9999  99   MMDDCCYY
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXXXXXXXXXXX  XX XXXXX-XXXX
XXX XXXXXXXXXX     X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999)999-9999  99   MMDDCCYY
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXXXXXXXXXXX  XX XXXXX-XXXX
XXX XXXXXXXXXX     X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999)999-9999  99   MMDDCCYY
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXXXXXXXXXXX  XX XXXXX-XXXX
XXX XXXXXXXXXX     X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX (999)999-9999  99   MMDDCCYY
                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                            XXXXXXXXXXXXXXX  XX XXXXX-XXXX

                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```


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7.1.30 PRV-0300-D -- Newly Enrolled Providers Report Field Descriptions

Field	Description	Length	Data Type
City	This is the city of the provider.	Character	15
Contact	This is the contact name that was on the provider enrollment application.	Character	30
Cnty Code	This is the code of the county that the provider is in.	Character	2
ECC	This is the indicator tell whether the provider uses Electronic Claims submission currently.	Character	1
Finalized Date	This is the date that the enrollment was finalized.	Date (MM/DD/CCYY)	8
Phone Number	This is the phone number of the provider.	Character	12
Provider ID	This is the provider's ID number.	Character	9
Provider Name	This is the provider's personal or business name.	Character	50
Provider Typ	This is the provider type of the provider.	Character	2
Street Address1	This is the street address of the provider.	Character	30
Street Address2	This is the optional 2nd street address of the provider.	Character	30
Zip Code	This is the zip code of the provider.	Character	5

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PRV-0500-M -- Provider Activity - Inactivity Report

7.1.31 PRV-0500-M -- Provider Activity - Inactivity Report Narrative

The Provider Activity-Inactivity report displays a listing of providers that have not submitted claims in the last 12 months but are still currently enrolled in a contract with an Active status. An active status is defined as having an open contract eligibility segment on the t_pr_php_elig table.

This report is sorted by provider ID, then service location. This report is produced monthly.

7.1.32 PRV-0500-M -- Provider Activity - Inactivity Report Layout

```
Report  : PRV-0500-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJM500                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: PRVPM500                      PROVIDER ACTIVITY - INACTIVITY REPORT                                Page:    999,999
                                         REPORT PERIOD: MM/CCYY - MM/CCYY

PROVIDER                  PROVIDER                                                PROGRAM                 STATUS
NUMBER                    NAME

XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
                                                                                  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
                                                                                  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
XXX XXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX
                                                                                  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```

7.1.33 PRV-0500-M -- Provider Activity - Inactivity Report Field Descriptions

Field	Description	Length	Data Type
Program	The provider program.	Character	50
Provider Number	The provider's identification number.	Number	9
Provider Name	The name of the provider.	Character	50
Status	The status of the provider.	Character	1

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PRV-0510-M -- Provider Termination Report

7.1.34 PRV-0510-M -- Provider Termination Report Narrative

The Provider Termination report provides a summary listing of providers by type of the providers that were updated to the status of Term by not Enroll because the provider has past their one month grace period. This report is produced monthly.

7.1.35 PRV-0510-M -- Provider Termination Report Layout

```
Report  : PRV-0510-M                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : PRVJM051                MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: PRVP051M                      Provider Termination Report                          Page:    999,999
                                         REPORT PERIOD: MM/CCYY

                                            PROVIDER TYPE          COUNT
                                             XX                    99999
                                             XX                    99999
                                             XX                    99999
                                             XX                    99999

                                            TOTAL                  999999


                                              *** END OF REPORT ***
                                            *** NO DATA THIS RUN ***
```

7.1.36 PRV-0510-M -- Provider Termination Report Field Descriptions

Field	Description	Length	Data Type
Count	Number of records that were changed from Recertification to Term. By Provider.	5	Number (Integer)
Provider Type	Type that the provider is contracted by.	2	Number (Integer)
Total	Total number of records that were changed from Recertification to Term. By Provider.	6	Number (Integer)

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PRV-0530-W -- Provider Changes By Clerk ID Weekly Summary Report

7.1.37 PRV-0530-W -- Provider Changes By Clerk ID Weekly Summary Report Narrative

The Provider Changes by Clerk ID Weekly Summary report displays the weekly changes made by Clerk IDs in a grid format. The left hand columns contain the Clerk ID and the various tables/information they can update. The upper row lists whether the clerk added, changed, or deleted information from these elements. Where the column and row intersect a number, which represents the number of actions (e.g. adds) the listed Clerk ID performed on the matching table/information. Sub-totals are given for each Clerk ID's set of changes, which are then totaled up at the bottom of the report. The report is sorted by Clerk ID.

7.1.38 PRV-0530-W -- Provider Changes By Clerk ID Weekly Summary Report Layout

```
Report  : PRV-0530-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJW530                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: PRVP530W                    PROVIDER CHANGES BY CLERK ID WEEKLY SUMMARY                            Page:    999,999
                                                                 REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

                                                                                   ADD       CHANGE       DELETE
                    CLERK ID: XXXXXXX       Prov Base Info                         XXX         XXX          XXX
                                            Prov Serv Location Rec                 XXX         XXX          XXX
                                            Prov Name Info                         XXX         XXX          XXX
                                            Prov Address Info                      XXX         XXX          XXX
                                            Prov Grp Mbrshp Info                   XXX         XXX          XXX
                                            Prov Type Info                         XXX         XXX          XXX
                                            Prov Specialty Info                    XXX         XXX          XXX
                                            Prov Medicare Info                     XXX         XXX          XXX
                                            Prov DEA Info                          XXX         XXX          XXX
                                            Prov CLIA Info                         XXX         XXX          XXX
                                            Prov Lic/Prscbr Info                   XXX         XXX          XXX
                                            Prov EFT Info                          XXX         XXX          XXX
                                            Prov Tax ID Info                       XXX         XXX          XXX
                                            Prov Prog Elig Info                    XXX         XXX          XXX
                                            Prov LOC Rate Changes                  XXX         XXX          XXX
                                            Prov UCC Rate Changes                  XXX         XXX          XXX
                                            Prov Other                             XXX         XXX          XXX
                                            ---------------------------------------------------------------------
                                            SUB-TOTALS                            9999        9999         9999
```


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```
Report  : PRV-0530-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJW530                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: PRVP530W                    PROVIDER CHANGES BY CLERK ID WEEKLY SUMMARY                            Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

                                                                                ADD      CHANGE       DELETE
                    CLERK ID: XXXXXXX       Prov Base Info                      XXX         XXX         XXX
                                            Prov Serv Location Rec              XXX         XXX         XXX
                                            Prov Name Info                      XXX         XXX         XXX
                                            Prov Address Info                   XXX         XXX         XXX
                                            Prov Grp Mbrshp Info                XXX         XXX         XXX
                                            Prov Type Info                      XXX         XXX         XXX
                                            Prov Specialty Info                 XXX         XXX         XXX
                                            Prov Medicare Info                  XXX         XXX         XXX
                                            Prov DEA Info                       XXX         XXX         XXX
                                            Prov CLIA Info                      XXX         XXX         XXX
                                            Prov Lic/Prscbr Info                XXX         XXX         XXX
                                            Prov EFT Info                       XXX         XXX         XXX
                                            Prov Tax ID Info                    XXX         XXX         XXX
                                            Prov Prog Elig Info                 XXX         XXX         XXX
                                            Prov LOC Rate Changes               XXX         XXX         XXX
                                            Prov UCC Rate Changes               XXX         XXX         XXX
                                            Prov Other                          XXX         XXX         XXX
                                            ---------------------------------------------------------------
                                            SUB-TOTALS                         9999        9999        9999
```


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7.1.39 PRV-0530-W -- Provider Changes By Clerk ID Weekly Summary Report Field Descriptions

Field	Description	Length	Data Type
Clerk ID	Clerk identification for the user who made the listed table/information changes.	32	Character
Prov Address Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Address Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Address Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Base Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Base Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Base Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov CLIA Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov CLIA Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov CLIA Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov DEA Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov DEA Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov DEA Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov EFT Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov EFT Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov EFT Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Grp Mbrshp Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)

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Field	Description	Length	Data Type
Prov Grp Mbrshp Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Grp Mbrshp Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Rate Changes ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Rate Changes CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Rate Changes DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Lic/Prscrbr Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Lic/Prscrbr Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Lic/Prscrbr Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Medicare Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Medicare Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Medicare Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Name Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Name Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Name Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Other ADD	Number of adds the clerk performed on all other provider tables/information.	3	Number (Integer)
Prov Name Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Other CHANGE	Number of changes the clerk performed on all other provider tables/information.	3	Number (Integer)

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Field	Description	Length	Data Type
Prov Other DELETE	Number of deletes the clerk performed on all other provider tables/information.	3	Number (Integer)
Prov Prog Elig Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Prog Elig Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Prog Elig Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Serv Location Rec ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Serv Location Rec CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Serv Location Rec DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Specialty Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Specialty Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Specialty Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Tax ID Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Tax ID Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Tax ID Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov Type Info ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)
Prov Type Info CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov Type Info DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Prov UCC Rate Changes ADD	Number of adds the clerk performed on this table/information.	3	Number (Integer)

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Field	Description	Length	Data Type
Prov UCC Rate Changes CHANGE	Number of changes the clerk performed on this table/information.	3	Number (Integer)
Prov UCC Rate Changes DELETE	Number of deletes the clerk performed on this table/information.	3	Number (Integer)
Sub-totals ADD	Total number of adds entered in by the listed clerk.	4	Number (Integer)
Sub-totals CHANGE	Total number of changes entered in by the listed clerk.	4	Number (Integer)
Sub-totals DELETE	Total number of deletes entered in by the listed clerk.	4	Number (Integer)

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PRV-0550-M -- Active Provider Type Trend Information Report

7.1.40 PRV-0550-M -- Active Provider Type Trend Information Report Narrative

The Active Provider Type Trend Information report tracks the number of providers actively enrolled with the state agency. The information is for a one month period and is divided up by program, then provider type; with subtotals after each program break, and a grand total for all programs at the end of the report. This report is produced monthly.

7.1.41 PRV-0550-M -- Active Provider Type Trend Information Report Layout

```
Report  : PRV-0550-M                    ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJM550                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVP550M                          TYPE TREND REPORT                                        Page:    999,999
                                     REPORT PERIOD: MM/CCYY - MM/CCYY


                                          PROGRAM = XXXXXXXXXXXXXXXXX

      PROVIDER                    PREVIOUS     ENROLLMENTS    RE-ENROLLMENTS   TERMINATIONS    CURRENT     CURRENT      CURRENT
        TYPE                       TOTAL       DURING MONTH    DURING MONTH    DURING MONTH    ACTIVE      INACTIVE      TOTAL


  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999
  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999
  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999

       * S U B T O T A L S *        99,999          9,999           9,999           9,999        99,999      99,999      99,999


                                          PROGRAM = XXXXXXXXXXXXXXXXX

      PROVIDER                    PREVIOUS     ENROLLMENTS    RE-ENROLLMENTS   TERMINATIONS    CURRENT     CURRENT      CURRENT
        TYPE                       TOTAL       DURING MONTH    DURING MONTH    DURING MONTH    ACTIVE      INACTIVE      TOTAL


  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999
  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999
  XX  XXXXXXXXXXXXXXXXXXXX          99,999          9,999           9,999           9,999        99,999      99,999      99,999

       * S U B T O T A L S *        99,999          9,999           9,999           9,999        99,999      99,999      99,999
```


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ALL PROGRAMS

PROVIDER TYPE		PREVIOUS TOTAL	ENROLLMENTS DURING MONTH	RE-ENROLLMENTS DURING MONTH	TERMINATIONS DURING MONTH	CURRENT ACTIVE	CURRENT INACTIVE	CURRENT TOTAL
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
	* T O T A L S *	99,999	9,999	9,999	9,999	99,999	99,999	99,999

*** END OF REPORT ***
*** NO DATA THIS RUN ***

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7.1.42 PRV-0550-M -- Active Provider Type Trend Information Report Field Descriptions

Field	Description	Length	Data Type
Current Active	Total number of current providers that have claim activity in the last 12 months. This number is derived by querying against claims history.	5	Number (Decimal)
Current Inactive	Total number of current providers that DO NOT have claim activity in the last 12 months. This number is derived by querying against claims history.	5	Number (Decimal)
Current Total	Total number of providers currently enrolled. The current total can be found by querying the t_pr_php_elig table and figuring out which providers' effective date is less than the end of the reporting period when their end date is also greater than the end of the reporting period.	5	Number (Decimal)
Enrollments During Month	Total number of providers enrolled during this month's reporting period. Can be determined by querying the t_pr_php_elig table and figuring out which providers have their effective date between the beginning and end of this month's reporting period.	4	Number (Decimal)
Previous Total	Total number of enrolled providers for the previous month. Can be calculated by subtracting the terminations from the enrollments, then subtracting that result from the current total of enrolled providers. The current total can be found by querying the t_pr_php_elig table and figuring out which providers' effective date is less than the end of the reporting period when their end date is also greater than the end of the reporting period.	5	Number (Decimal)
Program	Health program for the listed providers. A 2 character code identifies each program description, this code is what must be matched with in programs in order to pull the program code description.	20	Character
Provider Type Code	Code which uniquely identifies each provider type description.	2	Character
Provider Type Description	Description for a specific provider type.	50	Character

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Field	Description	Length	Data Type
Re-Enrollments During Month	Total number of providers re-enrolled during this month's reporting period. Can be determined by querying the t_pr_php_elig table and figuring out which providers have their effective date between the beginning and end of this month's reporting period and have a previous segment.	4	Number (Decimal)
Subtotal Current Active	Total number of active providers.	5	Number (Decimal)
Subtotal Current Inactive	Total number of inactive providers.	5	Number (Decimal)
Subtotal Current Total	Total number of providers currently enrolled during this month, for a given program.	5	Number (Decimal)
Subtotal Enrollments During Month	Total number of providers enrolled during this month, for a given program.	4	Number (Decimal)
Subtotal Previous Total	Total number of providers enrolled at the end of the previous month, for a given program.	5	Number (Decimal)
Subtotal Re-Enrollments During Month	Total number of providers re-enrolled during this month, for a given program.	4	Number (Decimal)
Subtotal Termination During Month	Total number of providers terminated during this month, for a given program.	4	Number (Decimal)
Terminations During Month	Total number of providers terminated during this month's reporting period. Can be determined by querying the t_pr_php_elig table and figuring out which providers have their end date between the beginning and end of this month's reporting period.	4	Number (Decimal)
Total Current Active	Total number of active providers.	5	Number (Decimal)
Total Current Inactive	Total number of inactive providers.	5	Number (Decimal)
Total Current Total	Total number of providers currently enrolled during this month, for all programs.	5	Number (Decimal)
Total Enrollments During Month	Total number of providers enrolled during this month, for all programs.	4	Number (Decimal)

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Field	Description	Length	Data Type
Total Previous Total	Total number of providers enrolled at the end of the previous month, for all programs.	5	Number (Decimal)
Total Re-Enrollments During Month	Total number of providers re-enrolled during this month, for all programs.	4	Number (Decimal)
Total Termination During Month	Total number of providers terminated during this month, for all programs .	4	Number (Decimal)

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PRV-0551-M -- Active Provider Specialty Trend Information Report

7.1.43 PRV-0551-M -- Active Provider Specialty Trend Information Report Narrative

The Active Provider Specialty Trend Information report tracks the number of providers actively enrolled with the Agency. The information is for a one month period and is divided up by program, then provider specialty; with subtotals after each program break, and a grand total for all programs at the end of the report. This report is produced monthly.

7.1.44 PRV-0551-M -- Active Provider Specialty Trend Information Report Layout

```
Report  : PRV-0551-M                    ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJM551                MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVP551M                        SPECIALTY TREND REPORT                                     Page:    999,999
                                    REPORT PERIOD: MM/CCYY - MM/CCYY


                                          PROGRAM = XXXXXXXXXXXXXXXXX

        PROVIDER                    PREVIOUS     ENROLLMENTS    RE-ENROLLMENTS   TERMINATIONS    CURRENT      CURRENT      CURRENT
        SPECIALTY                    TOTAL       DURING MONTH    DURING MONTH    DURING MONTH    ACTIVE      INACTIVE      TOTAL


   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999
   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999
   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999

         * S U B T O T A L S *      99,999          9,999          9,999           9,999        99,999       99,999      99,999


                                          PROGRAM = XXXXXXXXXXXXXXXXX

        PROVIDER                    PREVIOUS     ENROLLMENTS    RE-ENROLLMENTS   TERMINATIONS    CURRENT      CURRENT      CURRENT
        SPECIALTY                    TOTAL       DURING MONTH    DURING MONTH    DURING MONTH    ACTIVE      INACTIVE      TOTAL


   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999
   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999
   XXX  XXXXXXXXXXXXXXXXXXXX         99,999          9,999          9,999           9,999        99,999       99,999      99,999

         * S U B T O T A L S *      99,999          9,999          9,999           9,999        99,999       99,999      99,999
```


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ALL PROGRAMS

	PROVIDER SPECIALTY	PREVIOUS TOTAL	ENROLLMENTS DURING MONTH	RE-ENROLLMENTS DURING MONTH	TERMINATIONS DURING MONTH	CURRENT ACTIVE	CURRENT INACTIVE	CURRENT TOTAL
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
XXX	XXXXXXXXXXXXXXXXXXXX	99,999	9,999	9,999	9,999	99,999	99,999	99,999
	* T O T A L S *	99,999	9,999	9,999	9,999	99,999	99,999	99,999

*** END OF REPORT ***
*** NO DATA THIS RUN ***

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7.1.45 PRV-0551-M -- Active Provider Specialty Trend Information Report Field Descriptions

Field	Description	Length	Data Type
Current Active	Number of current active providers.	4	Number (Decimal)
Current Inactive	Number of current inactive providers.	4	Number (Decimal)
Current Total	Total number of providers currently enrolled. The current total can be found by querying the t_pr_php_elig table and figuring out which providers' effective date is less than the end of the reporting period when their end date is also greater than the end of the reporting period.	5	Number (Decimal)
Enrollments During Month	Total number of providers enrolled during this month's reporting period. Can be determined by querying the t_pr_php_elig table and figuring out which providers have their effective date between the beginning and end of this month's reporting period.	4	Number (Decimal)
Previous Total	Total number of enrolled providers for the previous month. Can be calculated by subtracting the terminations from the enrollments, then subtracting that result from the current total of enrolled providers. The current total can be found by querying the t_pr_php_elig table and figuring out which providers' effective date is less than the end of the reporting period when their end date is also greater than the end of the reporting period.	5	Number (Decimal)
Program	Health program for the listed providers. A 2 character code identifies each program description, this code is what must be matched with in programs in order to pull the program code description.	50	Character
Provider Specialty Code	Code which uniquely identifies each provider specialty description.	3	Character
Provider Specialty Description	Description for a specific provider specialty.	50	Character
Subtotal Current Active	Total number of providers active during this month.	5	Number (Decimal)
Subtotal Current Inactive	Total number of providers inactive during this month.	5	Number (Decimal)
Subtotal Current Total	Total number of providers currently enrolled during this month, for a given program.	5	Number (Decimal)

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Field	Description	Length	Data Type
Subtotal Enrollments During Month	Total number of providers enrolled during this month, for a given program.	4	Number (Decimal)
Subtotal Previous Total	Total number of providers enrolled at the end of the previous month, for a given program.	5	Number (Decimal)
Subtotal Re-Enrollments During Month	Total number of providers re-enrolled during this month, for a given program.	4	Number (Decimal)
Subtotal Termination During Month	Total number of providers terminated during this month, for a given program.	4	Number (Decimal)
Terminations During Month	Total number of providers terminated during this month's reporting period. Can be determined by querying the t_pr_php_elig table and figuring out which providers have their end date between the beginning and end of this month's reporting period.	4	Number (Decimal)
Total Current Total	Total number of providers currently enrolled during this month, for all programs.	5	Number (Decimal)
Total Enrollments During Month	Total number of providers enrolled during this month, for all programs.	4	Number (Decimal)
Total Previous Total	Total number of providers enrolled at the end of the previous month, for all programs.	5	Number (Decimal)
Total Termination During Month	Total number of providers terminated during this month, for all programs.	4	Number (Decimal)

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PRV-0600-M – Provider Change of Address report

7.1.46 PRV-0600-M – Provider Change of Address report - Narrative

Address on T_PR_ADR table should be standardized once a month and also the change of addresses should be reported on a monthly basis for the Provider enrollment team to be able to make these changes periodically on T_PR_ADR table.

7.1.47 PRV-0600-M – Provider Change of Address report - Report Layout

```
REPORT  : PRV-0600-M                                  ALABAMA MEDICAID AGENCY                                          RUN DATE:  MM/DD/CCYY
PROCESS : PRVJM600                              MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME:    HH:MM:SS
LOCATION: PRVPM600                                 PROVIDER CHANGE OF ADDRESS REPORT                                      PAGE:        XXXX
                                                       REPORT PERIOD:  MM/DD/CCYY
                                                                                   OLD                                 NEW
GROUP MCD         PROVIDER MCD      PROVIDER NAME                            ADDRESS  STREET ADDRESS1/                 STREET ADDRESS1/
                                                                              TYPE    STREET ADDRESS2                  STREET ADDRESS2/
                                                                                      CITY/                            CITY/
                                                                                      STATE/                           STATE/
                                                                                      ZIP - ZIP4                       ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX

XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX

XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX

XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX

XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX

XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                       XXXXXXXXXXXXXXXX                   XXXXXXXXXXXXXXXX
                                                                                       XX                                 XX
                                                                                       XXXXX - XXXX                       XXXXX - XXXX
```


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```
XXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                                  XXXXXXXXXXXXXXXXX                      XXXXXXXXXXXXXXXXX
                                                                                                  XX                                     XX
                                                                                                  XXXXX - XXXX                           XXXXX - XXXX

TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE M :  XXXXXX
TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE P :  XXXXXX
TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE S :  XXXXXX


                                                 ***  END OF REPORT  ***
                                                 *** NO DATA THIS RUN ***
```

7.1.48 PRV-0600-M - Provider Change of Address report - Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-0600-M – Provider Change of Address report.

Field	Description	Data Type	Length
Address Type	A one character code that identifies the type of address.	Character	1
City	Mailing address city. This is the city where a provider would receive business mail.	Character	15
Group MCD	Provider Group MCD.	Character	15
Provider MCD	Provider ID value.	Character	15
Provider Name	This is the name associated with an organization or person.	Character	40
State	Mailing address state. This is the state where a provider would receive business mail.	Character	2
Street Address1	Mailing address street 1. This is the street address for a provider.	Character	30
Street Address2	Mailing address street 2. This is the mailing address for a provider.	Character	30
TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE M	Number of providers that have an address type as M.	Number (Integer)	6

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PRV-0602-M – Provider Change of Tax Addresses Report

7.1.49 PRV-0602-M – Provider Change of Tax Addresses Report - Narrative

Address on T_IRS_W9_INFO table should be standardized once a month and also the change of addresses should be reported on a monthly basis for the Provider enrollment team to be able to make these changes periodically on T_IRS_W9_INFO table.

7.1.50 PRV-0602-M – Provider Change of Tax Addresses Report - Report Layout

```
REPORT  : PRV-0602-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : PRVJM602                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:    HH:MM:SS
LOCATION: PRVPM602                    PROVIDER CHANGE OF TAX ADDRESSES REPORT                              PAGE:        XXXX
                                            REPORT PERIOD:  MM/DD/CCYY


                                                                 OLD                              NEW
TAX ID           PROVIDER NAME                                   STREET ADDRESS1/                 STREET ADDRESS1/
                                                                 STREET ADDRESS2                  STREET ADDRESS2/
                                                                 CITY/                            CITY/
                                                                 STATE/                           STATE/
                                                                 ZIP - ZIP4                       ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX  XXXXXXXXXXXXXX
```

```
                                                    XXXXXXXXXXXXXXXX              XXXXXXXXXXXXXXXX
                                                    XX                            XX
                                                    XXXXX - XXXX                  XXXXX - XXXX


TOTAL NUMBER OF PROVIDERS WITH CHANGE TAX ADDRESSES:        XXXXXX


                                          ***  END OF REPORT  ***
                                          *** NO DATA THIS RUN ***
```

7.1.51 PRV-0062-M - Provider Change of Tax Addresses report - Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-0062-M – Provider Change of Tax Addresses Report.

Field	Description	Data Type	Length
City	Mailing address city. This is the city where a provider would receive business mail.	Character	15
Provider Name	This is the name associated with an organization or person.	Character	50
State	Mailing address state. This is the state where a provider would receive business mail.	Character	2
Street Address1	Mailing address street 1. This is the street address for a provider.	Character	30
Street Address2	Mailing address street 2. This is the mailing address for a provider.	Character	30
TAX ID	Provider TAX ID value.	Character	15
Total Number of Providers with Change of Tax Address	Number of Providers with change of address.	Number (Integer)	6
Zip	Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.	Character	5
Zip4	Mailing address zip code + 4. This is the last 4 digits of a zip code.	Character	4

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PRV-0604-O – Provider Invalid Addresses Report

7.1.52 PRV-0604-O – Provider Invalid Addresses Report – Narrative

PRV-0604-O is an on request report generated to facilitate cleanup of invalid addresses on T_PR_ADR, T_PR_HB_LIB, and T_IRA_W9_INFO.

7.1.53 PRV-0604-O – Provider Invalid Addresses Report - Report Layout

```
Report  : PRV-0604-O                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : PRVJO604                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVPO604                         PROVIDER INVALID ADDRESSES REPORT                                Page:      99999
                                              REPORT PERIOD:  MM/DD/CCYY

PROVIDER ADDRESS MASTER
=======================

GROUP MCD.............PROVIDER MCD.......PROVIDER NAME.........................ADDRESS...STREET ADDRESS1/                ERROR DESCRIPTION
                                                                               TYPE     STREET ADDRESS2/
                                                                                        CITY/
                                                                                        STATE/
                                                                                        ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX
```

```
Report  : PRV-0604-O                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJO604                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVPO604                        PROVIDER INVALID ADDRESSES REPORT                               Page:      99999
                                             REPORT PERIOD:  MM/DD/CCYY


PROVIDER ADDRESS LICENSE
========================

LICENSE NUMBER...PROVIDER NAME..............................STREET ADDRESS1/                  ERROR DESCRIPTION
                                             STREET ADDRESS2/
                                             CITY/
                                             STATE/
                                             ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX
```

Field	Description	Data Type	Length
Mailing Address Count	Number of providers who have an invalid mailing address.	Number (Integer)	6
Pay To Address Count	Number of providers who have an invalid Pay To address.	Number (Integer)	6
Provider MCD	Provider MCD	Character	15
Provider Name	Name associated with an organization or person.	Character	50
Service Location Address Count	Number of providers who have an invalid service location address.	Number (Integer)	6
State	Mailing address state. This is the state where a provider would receive business mail.	Character	2
Street Address1	Mailing address street 1. This is the street address for a provider.	Character	30
Street Address2	Optional mailing address street 2. This is the mailing address for a provider.	Character	30
Tax Address Count	Number of providers who have an invalid tax address.	Number (Integer)	6
Tax ID	Tax identification number assigned to a provider by the Internal Revenue Service.	Character	9
Zip Code	Mailing address zip code in the format xxxx-xxxx. This field includes all available zip code information.	Character	10

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PRV-0700-M -- Business Rules Change Of Address Report

7.1.55 PRV-0700-M -- Business Rules Change Of Address Report Narrative

All Change of addresses will be reviewed against business rules and any that were found invalid will be reported on the Business Rules Changes of Address report.

7.1.56 PRV-0700-M -- Business Rules Change of Address Layout

```
Report  : PRV-0700-M                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : PRVJM700                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: PRVPM700                                BUSINESS RULES CHANGE OF ADDRESS                                      Page:      99999
                                                   REPORT PERIOD:  MM/DD/CCYY

GROUP MCD         PROVIDER MCD     PROVIDER NAME                                ADDRESS  NEW                            ERROR DESCRIPTION
                                                                                TYPE     STREET ADDRESS2/
                                                                                         STREET ADDRESS2/
                                                                                         CITY/
                                                                                         STATE/
                                                                                         ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                         XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                         XX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                                         XXXXX-XXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


        TOTAL NUMBER OF PROVIDERS WITH ADDRESS TYPE M  :      999,999
        TOTAL NUMBER OF PROVIDERS WITH ADDRESS TYPE P  :      999,999
        TOTAL NUMBER OF PROVIDERS WITH ADDRESS TYPE S  :      999,999


Report  : PRV-0700-M                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : PRVJM700                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: PRVPM700                                BUSINESS RULES CHANGE OF ADDRESS                                      Page:      99999
                                                     REPORT PERIOD: MM/DD/CCYY

TAX INFORMATION
-----------------
                                                                                         NEW                            ERROR DESCRIPTION
TAX ID            PROVIDER NAME                                                          STREET ADDRESS1/
                                                                                         STREET ADDRESS2/
                                                                                         CITY/
                                                                                         STATE/
                                                                                         ZIP - ZIP4
-------------------------------------------------------------------------------------------------------------------------------------------------
```


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```
XXXXXXXXXXXXXXX  XXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE P	Number of providers that have an address type as P.	6	Number (Integer)
TOTAL NUMBER OF PROVIDER WITH ADDRESS TYPE S	Number of providers that have an address type as S.	6	Number (Integer)
Tax ID	Provider Tax ID value.	15	Character
Total Number of Providers with Change Tax Addresses	Number of Providers with change of address.	6	Number (Integer)
Zip	Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.	5	Character
Zip4	Mailing address zip code + 4. This is the last 4 digits of a zip code.	4	Character

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PRV-0771-O -- Provider CMS Medicare Revocation Verification Review Report

7.1.58 PRV-0771-O -- Provider CMS Medicare Revocation Verification Review Report Narrative

Report will compare the Medicare Revocation list provided by CMS to the provider MMIS data with the following values (Provider NPI/SSN/TAX ID) and report any matching IDs that has an active/inactive contracts.

7.1.59 PRV-0771-O -- Provider CMS Medicare Revocation Verification Review Report Layout

```
Report  : PRV-0771-O                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : PRVJO771                                  MEDICAID MANAGEMENT INFORMATION SYSTEM                                         Run Time:   HH:MM:SS
Location: PRVPO771                               MEDICARE REVOCATION TO PROVIDER FILE COMPARISON                                       Page:     999999
                                                         REPORT PERIOD: MM/DD/CCYY

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME
-------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

BOARD MEMBER ACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

BOARD MEMBER ACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
```


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```
INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME
-------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

BOARD MEMBER INACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

BOARD MEMBER INACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

TOTAL NUMBER OF ACTIVE PROVIDERS NPI          :  999,999
TOTAL NUMBER OF ACTIVE PROVIDERS SSN          :  999,999
TOTAL NUMBER OF ACTIVE PROVIDERS TAX ID       :  999,999
TOTAL NUMBER OF ACTIVE BOARD MEMBERS SSN      :  999,999
TOTAL NUMBER OF ACTIVE BOARD MEMBERS TAX ID   :  999,999
TOTAL NUMBER OF INACTIVE PROVIDERS NPI        :  999,999
TOTAL NUMBER OF INACTIVE PROVIDERS SSN        :  999,999
TOTAL NUMBER OF INACTIVE PROVIDER TAX ID      :  999,999

TOTAL NUMBER OF INACTIVE BOARD MEMBERS SSN    :  999,999
TOTAL NUMBER OF INACTIVE BOARD MEMBERS TAX ID :  999,999

                                                   ** End of Report **
```

7.1.60 PRV-0771-O -- Provider CMS Medicare Revocation Verification Review Report Field Descriptions

Field	Description	Length	Data Type
ACTIVE PROVIDER:	List all the providers who have active contracts below this section.	50	Character

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Field	Description	Length	Data Type
INACTIVE PROVIDER:	List all the providers who have active contracts below this section.	50	Character
PROVIDER MCD	Medicaid ID of the provider.	15	Character
PROVIDER NAME	This is the name associated with an organization or person.	50	Character
PROVIDER NPI	National Provider Identifier of the provider.	15	Character
PROVIDER SSN	Social Security Number of the provider.	9	Character
PROVIDER TAX ID	Tax ID of the provider.	9	Character
TOTAL NUMBER OF ACTIVE BOARD MEMBERS SSN	Total number of board member provider SSNs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE BOARD MEMBERS TAX ID	Total number of board member provider TAX IDs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS NPI	Total number of NPIs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS SSN	Total number of provider SSNs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS TAX ID	Total number of provider TAX IDs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE BOARD MEMBERS SSN	Total number of board member provider SSNs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)

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Field	Description	Length	Data Type
TOTAL NUMBER OF INACTIVE BOARD MEMBERS TAX ID	Total number of board member provider TAX IDs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS NPI	Total number of NPIs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS SSN	Total number of provider SSNs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS TAX ID	Total number of provider TAX IDs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)

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PRV-0772-O -- Provider CMS Medicare Termination Verification Review Report

7.1.61 PRV-0772-O -- Provider CMS Medicare Termination Verification Review Report Narrative

Report will compare the Medicare Termination list provided by CMS to the provider MMIS data with the following values (Provider NPI/SSN/TAX ID) and report any matching IDs that has an active/inactive contracts.

7.1.62 PRV-0772-O -- Provider CMS Medicare Termination Verification Review Report Layout

```
Report  : PRV-0772-O                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : PRVJO772                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: PRVPO772                              MEDICARE TERMINATION TO PROVIDER FILE COMPARISON                                      Page:     999999
                                                             REPORT PERIOD: MM/DD/CCYY

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME
-------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                  PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

ACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                  PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

BOARD MEMBER ACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                  PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX

BOARD MEMBER ACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                  PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          XXXXXXXXX
```


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```
INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME
-------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

INACTIVE PROVIDER:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

BOARD MEMBER INACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER SSN
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

BOARD MEMBER INACTIVE AFFILIATE:

PROVIDER NPI           PROVIDER MCD           PROVIDER NAME                                                PROVIDER TAX ID
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX
XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         XXXXXXXXX

TOTAL NUMBER OF ACTIVE PROVIDERS NPI          :  999,999
TOTAL NUMBER OF ACTIVE PROVIDERS SSN          :  999,999
TOTAL NUMBER OF ACTIVE PROVIDERS TAX ID       :  999,999
TOTAL NUMBER OF ACTIVE BOARD MEMBERS SSN      :  999,999
TOTAL NUMBER OF ACTIVE BOARD MEMBERS TAX ID   :  999,999
TOTAL NUMBER OF INACTIVE PROVIDERS NPI        :  999,999
TOTAL NUMBER OF INACTIVE PROVIDERS SSN        :  999,999
TOTAL NUMBER OF INACTIVE PROVIDER TAX ID      :  999,999

TOTAL NUMBER OF INACTIVE BOARD MEMBERS SSN    :  999,999
TOTAL NUMBER OF INACTIVE BOARD MEMBERS TAX ID :  999,999

                                                   ** End of Report **
```

7.1.63 PRV-0772-O -- Provider CMS Medicare Termination Verification Review Report Field Descriptions

Field	Description	Length	Data Type
ACTIVE PROVIDER:	List all the providers who have active contracts below this section.	50	Character

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Field	Description	Length	Data Type
INACTIVE PROVIDER:	List all the providers who have active contracts below this section.	50	Character
PROVIDER MCD	Medicaid ID of the provider.	15	Character
PROVIDER NAME	This is the name associated with an organization or person.	50	Character
PROVIDER NPI	National Provider Identifier of the provider.	15	Character
PROVIDER SSN	Social Security Number of the provider.	9	Character
PROVIDER TAX ID	Tax ID of the provider.	9	Character
TOTAL NUMBER OF ACTIVE BOARD MEMBERS SSN	Total number of board member provider SSNs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE BOARD MEMBERS TAX ID	Total number of board member provider TAX IDs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS NPI	Total number of NPIs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS SSN	Total number of provider SSNs who have active contract that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF ACTIVE PROVIDERS TAX ID	Total number of provider TAX IDs who have active contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE BOARD MEMBERS SSN	Total number of board member provider SSNs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)

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Field	Description	Length	Data Type
TOTAL NUMBER OF INACTIVE BOARD MEMBERS TAX ID	Total number of board member provider TAX IDs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS NPI	Total number of NPIs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS SSN	Total number of provider SSNs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)
TOTAL NUMBER OF INACTIVE PROVIDERS TAX ID	Total number of provider TAX IDs who have inactive contracts that matched against the database from CMS Medicaid termination list provided.	6	Number (Integer)

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PRV-0820-R - Provider PDF RA End Date Forecast Report

7.1.64 PRV-0820-R - Provider PDF RA End Date Forecast Report Narrative

This report shows provider and mailing addresses where the PDF end date has not been reached. It also shows a summary of percent by provider for active and inactive PDF dates and a grand total across all providers.

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7.1.65 PRV-0820-R - Provider PDF RA End Date Forecast Report Layout

```
Report  :  PRV-0820-R                          ALABAMA MEDICAID AGENCY                          Run Date:  MM/DD/CCYY
Process :  PRV820                        MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:       9,999
Location:  PRV820D                     PROVIDERS PDF RA END DATE FORECAST REPORT                    Page:       9,999

                                  PROVIDER NAME                                          PROV      RA         RA END        RA MAX
PROVIDER MCD       PROVIDER NPI   ADDRESS                                                TYPE      COUNT      PDF DATE      PDF DATE
XXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XX       999        MM/DD/CCYY    MM/DD/CCYY
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                  XXXXXXXXXXXXXXXX XX XXXXX-XXXX

TOTALS FOR PROVIDER TYPE                           PROVIDER PDF ACTIVE  PROVIDERS PDF INACTIVE   PERCENT ACTIVE
XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999            999,999,999          999.9%

GRAND TOTALS FOR ALL PROVIDER TYPES                    999,999,999            999,9999,999         999.9%

                                                       *** END OF REPORT ***
                                                     *** NO DATA THIS RUN ***
```

7.1.66 PRV-0820-R - Provider PDF RA End Date Forecast Report Field Descriptions

Field	Description	Data Type	Length
City	The third address line for city of provider.	Character	30
Description of Provider Type	This is the corresponding description for this provider type	Character	50
Five Digit Zip Code	The 5 digit zip code that corresponds to provider's address.	Number (Integer)	5
Four Digit Zip Code	The 4 digit extension zip code that corresponds to provider's address. This field is optional.	Number (Integer)	4
Grand Total For All Provider Types - Providers PDF Active	The grand total of all providers from PROVIDERS PDF ACTIVE. Calculated	Number (Integer)	12
Grand Totals for All Provider Types – Percent Active	Calculated from GRAND TOTAL PROVIDERS PDF ACTIVE and GRAND TOTAL PROVIDERS PDF INACTIVE. The percent active for all providers.	Number (Decimal)	5
Grand Totals For All Provider Types - Providers PDF Inactive	The grand total of all providers from PROVIDERS PDF INACTIVE. Calculated	Number (Integer)	12

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Field	Description	Data Type	Length
Mailing Address line 1	The mailing address of this provider.	Character	30
Mailing Address line 2	The second address line for provider--optional--such as Suite # for example.	Character	30
PROV Type	Provider's type, a value from 0 to 99. Corresponds to a description in t_pr_type_cde.	Character	2
Provider MCD	Providers Medicaid ID.	Character	15
Provider Name	Provider's name taken from T_PR_NAME.NAME.	Character	50
Provider NPI	Provider's National Provider Identifier (NPI).	Character	15
Provider Type	A description that corresponds to a type.	Number (Integer)	2
RA Count	Count of RA from T_PR_SVC_LOC.CNT_PDF_RA.	Number (Integer)	999
RA End PDF Date	The PDF RA End Date for this provider	Date (MM/DD/CCYY)	12
RA MAX PDF Date	The PDF RA MAX Date for this provider	Date (MM/DD/CCYY)	12
State	Continuing third address line. The state (location) of provider.	Character	2
Totals For All Provider Type – Percent Active	Calculated from PROVIDERS PDF ACTIVE and PROVIDERS PDF INACTIVE. The percent active for this provider.	Number (Decimal)	5
Totals For All Provider Type – Providers PDF Active	A count by all provider types of all PDF ACTIVE.	Number (Integer)	12
Totals For All Provider Type – Providers PDF Inactive	A count by all provider types of all PDF INACTIVE.	Number (Integer)	12

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PRV-0900-O -- Providers Receiving Change In Taxonomy Code Letter Report

7.1.67 PRV-0900-O -- Providers Receiving Change In Taxonomy Code Letter Report Narrative

An entry in this report is created for every provider that had a change in their taxonomy code as specified in the state agency's Change in Taxonomy Code spreadsheet. Each entry contains enough information to verify that the letter should have been created. Some of this information comes from the original Agency spreadsheet (Provider Type, Provider Specialty, Old taxonomy code and New taxonomy code) while the rest of the information is supplied from exiting tables.

This report is associated with letter PRV-9900-O in that every letter sent out also has an entry in this report. This report is output in both modes of this process (Test and Production). In Test mode no updates are made to the database and no letters are sent out. Therefore, you can use this report in Test mode to validate the process before any updates are made or letters created. In Production mode this report is sent to FEITH so that it can be referred to at a later date. This report is produced on-demand.

7.1.68 PRV-0900-O -- Providers Receiving Change In Taxonomy Code Letter Report Layout

```
Report  : PRV-0900-O                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJO900                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVPO900                  PROVIDERS RECEIVING CHANGE IN TAXONOMY CODE LETTER                       Page:    999,999
                                                                     REPORT PERIOD: MM/DD/CCYY
 ---------------------------------------------------------------------------------------------------------------------------
            PROVIDER ID      PROV TYPE   OLD CDE     NEW CDE      OLD SAK       NEW SAK                          PROVIDER
                             & SPEC      TAXONOMY    TAXONOMY      TAXONOMY       TAXONOMY                          NAME
 ---------------------------------------------------------------------------------------------------------------------------

XXXXXXXXXX      XX XXX      XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX      XX XXX      XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXX      XX XXX      XXXXXXXXXX   XXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                      *** END OF REPORT ***
                                                    *** NO DATA THIS RUN ***
```

7.1.69 PRV-0900-O -- Providers Receiving Change In Taxonomy Code Letter Report Field Descriptions

Field	Description	Length	Data Type
New Cde Taxonomy	New 10 character CDE taxonomy code - This information comes from the Office of Health Care Access (OHCAs) Change in Taxonomy Code spreadsheet.	10	Character
New Sak Taxonomy	New 12 character SAK taxonomy code - This information is obtained from existing table information.	12	Character

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Field	Description	Length	Data Type
Old Cde Taxonomy	Old 10 character CDE taxonomy code - This information comes from OHCA's Change in Taxonomy Code spreadsheet.	10	Character
Old Sak Taxonomy	Old 12 character SAK taxonomy code - This information is obtained from existing table information.	12	Character
Prov Type & Spec	Provider Type and Specialty - This information comes from OHCA's Change in Taxonomy Code spreadsheet.	5	Character
Provider ID	Provider ID - This information is obtained from existing table information.	10	Character
Provider Name	Provider Name - This information is obtained from existing table information.	50	Character

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PRV-A030-Q - Potential Provider Deactivation Report

7.1.70 PRV-A030-Q - Potential Provider Deactivation Report Narrative

Potential Provider Deactivation Report. It is sorted by Provider Type.

7.1.71 PRV-A030-Q - Potential Provider Deactivation Report Layout

```
Report  : PRV-A030-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJQA30                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVDEACTPOT                   POTENTIAL PROVIDER DEACTIVATION                              Page    :    999,999
                                           REPORT PERIOD: MM/DD/CCYY


PROVIDER   PROVIDER NAME/                                    PROVIDER MCD/     PROVIDER NPI/     EFF DATE
TYPE       GROUP NAME                                        GROUP MCD         GROUP NPI

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX
XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX

TOTAL POTENTIAL PROVIDERS TO BE DEACTIVATED                 999,999,999


NOTE:  If provider is not part of a group, the 2nd detail line will not print.
```


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7.1.72 PRV-A030-Q - Potential Provider Deactivation Report - Field Descriptions

Field	Description	Data Type	Length
Eff Date	Date last enrolled.	Date (MM/DD/CCYY)	10
Group MCD	Group provider's Medicaid ID.	Character	15
Group NPI	Group provider's National Provider ID.	Character	15
Group Name	Group provider's service location name.	Character	50
Provider MCD	Provider's Medicaid ID.	Character	15
Provider NPI	Provider's National Provider ID.	Character	15
Provider Name	Provider's service location name.	Character	50
Provider Type	This is the type that the provider is contracted by.	Character	2
Total Potential Providers to be Deactivated	Count of total number of Potential Providers to be Deactivated and displayed on the report.	Number	11

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PRV-A031-O - Actual Providers Deactivated Report

7.1.73 PRV-A031-O - Actual Providers Deactivated Report Narrative

Actual Providers Deactivated Report. It is sorted by Provider Type.

7.1.74 PRV-A031-O - Actual Providers Deactivated Report Layout

```
Report  : PRV-A031-O                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : PRVJOA31                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVDEACTRPT                       ACTUAL PROVIDERS DEACTIVATED                               Page    :    999,999
                                             REPORT PERIOD: MM/DD/CCYY


PROVIDER   PROVIDER NAME/                                    PROVIDER MCD/     PROVIDER NPI/     EFF DATE/
TYPE       GROUP NAME                                        GROUP MCD         GROUP NPI         END DATE

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   MM/DD/CCYY

TOTAL PROVIDERS DEACTIVATED                          999,999,999
```


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7.1.75 PRV-A031-O - Actual Providers Deactivated Report - Field Descriptions

Field	Description	Data Type	Length
Eff Date	Date last enrolled.	Date (MM/DD/CCYY)	10
End Date	Date provider disenrolled.	Date (MM/DD/CCYY)	10
Group MCD	Group provider's Medicaid ID.	Character	15
Group NPI	Group provider's National Provider ID.	Character	15
Group Name	Group provider's service location name.	Character	50
Provider MCD	Provider's Medicaid ID.	Character	15
Provider NPI	Provider's National Provider ID.	Character	15
Provider Name	Provider's service location name.	Character	50
Provider Type	This is the type that the provider is contracted by.	Character	2
Total Providers Deactivated	Total number of providers deactivated and displayed on the report.	Number	11

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PRV-A032-M – PROVIDER CLOSURE REPORT

This report will list all the providers closed for the following scenarios:

- Scenario#1 - List all the provider members closed from the group, if the group contract has already been closed.
- Scenario#2 - List the group provider, if all the group members' contract has already been closed.

7.1.76 PRV-A032-M – PROVIDER CLOSURE REPORT Layout

```
Report  : PRV-A032-M                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : PRVJM032                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:mm:ss
Location: PRVPM032                            PROVIDER CLOSURE REPORT                                      Page:    999,999
                                             REPORT PERIOD: MM/DD/YYYY

PROVIDER MCD     PROVIDER NPI           PROVIDER NAME                                                CLOSURE COMMENT
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXTOTAL NUMBER OF MEMBERS CLOSED DUE TO GROUP PROVIDER CLOSURE : 999,999,999
TOTAL NUMBER OF GROUP PROVIDER CLOSED DUE TO MEMBER CLOSURE  : 999,999,999
-------------------------------------------------------------------------------------------------------------------------------

                                                  ** End of Report **
                                              ** No Data This Report **
```

7.1.77 PRV-A032-M – PROVIDER CLOSURE REPORT Field Descriptions

Field	Description	Data Type	Length
CLOSURE COMMENT	Holds the reason for the provider contract closure for the following 4 reasons.	Character	31

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Field	Description	Data Type	Length
	GROUP PROVIDER CLOSURE - Group provider causing member contract closure. CLOSED DUE TO GROUP PROVIDER - Group member closed due to Group provider contract closure. GROUP MEMBER PROVIDER CLOSURE - Group member provider causing group provider contract closure. CLOSED DUE TO MEMBER PROVIDERS - Group provider closed due to group member contract closure.		
PROVIDER MCD	MCD ID of the provider contract closed or the providers who caused the contract closure.	Character	15
PROVIDER NAME	This is the provider's personal or business name.	Character	50
PROVIDER NPI	NPI ID of the provider contract closed or the providers who caused the contract closure.	Character	15
TOTAL NUMBER OF GROUP PROVIDER CLOSED DUE TO MEMBER CLOSURE	Total number of group providers, whose contracts were closed due to group member providers.	Number (Integer)	9
TOTAL NUMBER OF MEMBERS CLOSED DUE TO GROUP PROVIDER CLOSURE	Total number of provider members, whose contracts were closed due to group provider.	Number (Integer)	9

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PRV-A034-M – State Agencies Needing to Reenroll Report

7.1.78 PRV-A034-M – State Agencies Needing to Reenroll Report Narrative

Report includes only State Agencies needing to re-enroll. It is sorted by Group Name, Provider Type, Provider Name and Provider MCD. It will page break after each Group Name.

7.1.79 PRV-A034-M – State Agencies Needing to Reenroll Report Layout

```
Report  : PRV-A034-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : PRVJMA35                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRVRENRLSTAG                   STATE AGENCIES NEEDING TO REENROLL                                Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

PROVIDER   PROVIDER NAME/                                     PROVIDER MCD/     PROVIDER NPI/     EFF DATE/
TYPE       GROUP NAME                                         GROUP MCD         GROUP NPI

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX

XX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   MM/DD/CCYY
           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX


TOTAL NUMBER OF PROVIDERS REPORTED                          99,999,999

                                                   *** NO DATA THIS RUN ***


                                                    *** END OF REPORT ***
```

7.1.80 PRV-A034-M – State Agencies Needing to Reenroll Report Field Descriptions

Field	Description	Data Type	Length
Eff Date	Date last enrolled	Date (MM/DD/CCYY)	10
Group MCD	Groups provider's Medicaid ID	Character	15
Group NPI	Groups provider's National Provider ID	Character	15
Group Name	Groups provider's service location name	Character	50

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Field	Description	Data Type	Length
Provider MCD	Provider's Medicaid ID	Character	15
Provider NPI	Provider's National Provider ID	Character	15
Provider Name	Provider's service location name	Character	50
Provider Type	This is the type that the provider is contracted by	Character	2
Total Number of Providers Reported	This is the total number of providers that are being displayed in the report	Number	8

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PRV-A035-M – Provider Reenrollment Facsimile

7.1.81 PRV-A035-M – Provider Reenrollment Facsimile Narrative

Provider Reenrollment Facsimile which is produced for all providers who must re-enroll regardless of the provider's frequency. Facsimile is to be downloaded from the current Alabama web portal in a manner similar to RAs and Managed Care reports.

7.1.82 PRV-A035-M – Provider Reenrollment Facsimile Layout

```
Report  : PRV-A035-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJMA35                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRVRENRLFAC                            PROVIDER REENROLLMENT FACSIMILE                           Page    :    999,999
                                                    REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------------
NPI               MCD ID                 NAME
999999999999999   999999999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------------
Below is the information Alabama Medicaid currently has on file for the above named provider.  As an Alabama Medicaid provider you
MUST review this information to determine the accuracy.  If all information is accurate, please print and sign this report and
submit along with any required supplemental documentation.  If this information is not accurate, take action as needed based on
directions below.  All providers MUST take action in order for the provider number shown below to remain active.

ALL REPORTS, WHETHER CHANGED OR NOT, MUST BE SIGNED AND SUBMITTED WITH SUPPLEMENTAL DOCUMENTATION TO HPE,
ATTN: PROVIDER ENROLLMENT AT: PO BOX 242577, MONTGOMERY, AL 36124

ALL DOCUMENTS/FORMS/LISTS MENTIONED IN THIS DOCUMENT THAT YOU MAY NEED TO COMPLETE OR REFER TO FOR GUIDANCE CAN BE FOUND AT:
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx

-------------------------------------------------------------------------------------------------------------------------------------
A change to data in this section constitutes the need for a new enrollment application and closure of this provider number.  To
close this provider number, indicate the reason for closure and the date (mm/dd/ccyy) on this form prior to submission.  To complete
a new enrollment application visit: www.medicaidhcp.alabamaservices.org/ProviderEnrollment

TAX ID            XXXXXXXXX

PROVIDER TYPE
XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------------
Changes are not allowed for the data in this section.  This information is displayed for validation purposes only.  If this
HPE Provider Enrollment Staff at (888) 223-3630 (nationwide):


GROUP NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
GROUP NPI         XXXXXXXXXXXXXXXX
GROUP MCD ID      XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------------
```


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```
Changes to data in this section require the provider to print this report, notate corrections and supply any additionally required
supporting documentation to HPE Provider Enrollment Staff:

SERVICE LOCATION INFORMATION:
ADDRESS 1        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 2        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE            XX
ZIP              99999-9999

TAX NAME         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Service Location and/or Tax Name changes require a completed W-9.
```

<page break>

```
Report  : PRV-A035-M                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJMA35                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRVRENRLFAC                            PROVIDER REENROLLMENT FACSIMILE                           Page    :    999,999
                                                    REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------------
NPI               MCD ID                 NAME
999999999999999   999999999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------------
DEA #            XXXXXXXXX
CLIA #           XXXXXXXXXX
CLIA and/or DEA changes require a copy of the certificate.

MEDICARE #       XXXXXXXXXX
Medicare Number changes require a copy of the Medicare Letter for this provider at this location.

PROVIDER SPECIALTY
XXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Specialties you may indicate must be appropriate for your provider type.  Refer to the Type Specialty Chart and/or forms (as needed)
on the website mentioned below.

EFT INDICATOR    X
If the EFT indicator immediately above is 'Y', you must complete an Electronic Funds Transfer (EFT) Enrollment and submit along with
a copy of a voided check or letter from the bank.

Providers who have been assigned a trading partner ID, to receive Electronic Remittance Advices (ERAs)/835 transactions, must
complete and submit along with this document an updated Electronic Remittance Advice (ERA) Authorization Agreement.  For
providers already enrolled to receive Electronic Remittance Advices (ERAs)/835 transactions, the data will be verified and/or
updated based on the updated form submitted.  For providers NOT already enrolled to receive Electronic Remittance Advices
(ERAs)/835 transactions, qualified providers will be enrolled based on the updated form submitted.

EFT and ERA enrollment may be accomplished via the electronic enrollment functionality available on the Electronic Provider
Enrollment Portal at https://medicaidhcp.alabamaservices.org/provider/ OR via the Forms available at:
```


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```
http://medicaid.alabama.gov/CONTENT/5.0 Resources/5.4 Forms Library/5.4.6 Provider Enrollment Forms.aspx
-------------------------------------------------------------------------------------------------------------------------------
License data is displayed as is stored by Alabama Medicaid.  With the required additions of information such as state abbreviations,
the entire license may not reflect the exact information on your license.  Please verify only the numeric values shown below as they
must be the same as is reflected on your professional license.  If an update is required please be sure to print this report, notate
changes and submit to HPE Provider Enrollment Staff.

License #     XXXXXXXXXX        License State   XX      License Effective Date  MM/DD/CCYY       License End Date  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
Changes to data in this section should be made via the Web Portal panels located under the Provider menu.  Upon doing so, indicate
in this section that changes were applied via the Web Portal:

CONTACT INFORMATION:
NAME            XXXXXXXXX
```

```
_____                                   _____
Signature                               Date
Signature must that of the individual enrolled.  For groups/facilities the signature must be that of an authorized representative.

_____                                   _____                   _____
PRINTED NAME                            POSITION/TITLE                  PHONE
-------------------------------------------------------------------------------------------------------------------------------
ALL required supplemental documentation, in addition to the items listed below, must be also received along with this document.
```

7.1.83 PRV-A035-M – Provider Reenrollment Facsimile Field Descriptions

Field	Description	Data Type	Length
CLIA #	Provider's CLIA number.	Character	10
CONTACT INFORMATION: E-MAIL	E-mail address of contact person.	Character	50
CONTACT INFORMATION: EXT	Extension associated to the contact person phone number.	Character	4
CONTACT INFORMATION: FAX	Fax number of contact person.	Character	13
CONTACT INFORMATION: NAME	Name of contact person.	Character	50
CONTACT INFORMATION: PHONE	Phone number of contact person.	Character	13
DEA #	DEA certification number of the provider.	Character	9
EFT INDICATOR	If EFT Indicator = Y, provider must complete an Electronic Funds Transfer (EFT) Form and submit along with a copy of a voided check.	Character	1
GROUP MCD ID	Medicaid number of the group/practice with which the provider is associated.	Character	15
GROUP NAME	Name of the group/practice with which the provider is associated.	Character	50
GROUP NPI	National provider identifier of the group/practice with which the provider is associated.	Character	15
LICENSE #	Number of the professional license of the provider.	Character	10

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Field	Description	Data Type	Length
LICENSE EFFECTIVE DATE	Effective date of the provider's professional license.	Date (MM/DD/CCYY)	10
LICENSE END DATE	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
LICENSE STATE	State in which the provider's professional license was issued.	Character	2
MAIL TO INFORMATION: ADDRESS 1	Provider's mail to address.	Character	30
MAIL TO INFORMATION: ADDRESS 2	Provider's mail to address, line 2.	Character	30
MAIL TO INFORMATION: CITY	Mail to city of the provider's mail to address.	Character	30
MAIL TO INFORMATION: E-MAIL	Mail to e-mail address of the provider's mail to address.	Character	50
MAIL TO INFORMATION: EXT	Ext of mail to phone number of the mail to address.	Character	4
MAIL TO INFORMATION: FAX	Mail to fax number of the mail to address.	Character	13
MAIL TO INFORMATION: PHONE	Mail to phone number of the mail to address.	Character	13
MAIL TO INFORMATION: STATE	Mail to state of the provider's mail to address.	Character	2
MAIL TO INFORMATION: ZIP	Mail to zip +4 of the provider's mail to address.	Character	10
MCD ID	Provider's Medicaid number.	Character	15
MEDICARE #	Provider's Medicare Number.	Character	10
NAME	Provider's Name, either business or personal.	Character	50
NPI	Provider's National Provider Identifier number.	Character	15

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Field	Description	Data Type	Length
PAY TO INFORMATION: ADDRESS 1	Provider's pay to address.	Character	30
PAY TO INFORMATION: ADDRESS 2	Provider's pay to address, line 2.	Character	30
PAY TO INFORMATION: CITY	Pay to city of provider's pay to address.	Character	30
PAY TO INFORMATION: E-MAIL	E-mail address associated to the provider's physical service location.	Character	50
PAY TO INFORMATION: EXT	Extension for both Phone and Toll Free numbers.	Character	4
PAY TO INFORMATION: FAX	Fax number associated to the provider's pay to address.	Character	13
PAY TO INFORMATION: PHONE	Phone number associated to the provider's pay to address.	Character	13
PAY TO INFORMATION: STATE	Pay to state of the provider's pay to address.	Character	2
PAY TO INFORMATION: TOLL FREE	Toll free number associated to the provider's pay to address.	Character	13
PAY TO INFORMATION: ZIP	Pay to zip +4 of the provider's pay to address.	Character	10
PROVIDER SPECIALTY	Provider specialty and description.	Character	56
PROVIDER TYPE	Provider type and description.	Character	55
SERVICE LOCATION INFORMATION: ADDRESS 1	Provider's physical service location.	Character	30

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Field	Description	Data Type	Length
SERVICE LOCATION INFORMATION: ADDRESS 2	Provider's physical service location, address line 2.	Character	30
SERVICE LOCATION INFORMATION: CITY	City of the provider's physical service location.	Character	30
SERVICE LOCATION INFORMATION: E-MAIL	E-mail address associated to the provider's physical service location.	Character	50
SERVICE LOCATION INFORMATION: EXT	Extension for both Phone and Toll Free numbers.	Character	4
SERVICE LOCATION INFORMATION: FAX	Provider's physical service location fax number.	Character	13
SERVICE LOCATION INFORMATION: PHONE	Phone number associated to the provider's physical service location.	Character	13
SERVICE LOCATION INFORMATION: STATE	State of the provider's physical service location.	Character	2
SERVICE LOCATION INFORMATION: TOLL FREE	Toll free number of the provider's physical service location.	Character	13
SERVICE LOCATION INFORMATION: ZIP	Zip +4 of the provider's physical service location address.	Character	10
TAX ID	Provider's tax identification number.	Character	9
TAX NAME	Tax name.	Character	30

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PRV-A039-W - Reenrollment Statistics

7.1.84 PRV-A039-W - Reenrollment Statistics Narrative

Statistics report for re-enrollment based upon the data in T_PR_ENROLL_INFO. 12 months of data is presented and grouped by the Providers' enrollment frequency and date the letters were generated. A percentage by month is also shown which is calculated based upon the number of Providers who are either State Providers or other providers who must re-enroll every five years divided by the total number of those providers as of October 2011.

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7.1.85 PRV-A039-W - Reenrollment Statistics Layout

Report for Enrollment Frequency of Every Year:

```
Report  : PRV-A039-W                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : PRVJWA39                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: PRVRENRLSTAT                         REENROLLMENT STATISTICS                          Page    :    999,999
                                              REPORT PERIOD: MM/DD/CCYY

ENROLLMENT FREQUENCY              Yearly, Visits Required

DATE LETTER SENT                        MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY

TOTAL PROVIDERS                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL VISITS                            999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RE-ENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

DATE LETTER SENT                        MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY
TOTAL PROVIDERS                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL VISITS                            999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RE-ENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999
```


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Report for Enrollment Frequency of Every 5 Years:

ENROLLMENT FREQUENCY	Every 5 years					
DATE LETTER SENT	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY
TOTAL PROVIDERS	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL RESPONSES	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL WHO WERE SENT 2ND LETTER	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL DISENROLLED	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL RE-ENROLLED	999,999	999,999	999,999	999,999	999,999	999,999
DATE LETTER SENT	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY
TOTAL PROVIDERS	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL RESPONSES	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL WHO WERE SENT 2ND LETTER	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL DISENROLLED	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL RE-ENROLLED	999,999	999,999	999,999	999,999	999,999	999,999
<Page Break>						

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```
Report  : PRV-A039-W                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : PRVJWA39                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: PRVRENRLSTAT                          REENROLLMENT STATISTICS                        Page    :    999,999
                                              REPORT PERIOD: MM/DD/CCYY

ENROLLMENT FREQUENCY            State Agency, Every 5 years

DATE LETTER SENT                        MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY

TOTAL PROVIDERS                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RE-ENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

DATE LETTER SENT                        MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY

TOTAL PROVIDERS                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RE-ENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999

ENROLLMENT FREQUENCY            5 years, Visits Required

DATE LETTER SENT                        MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY

TOTAL PROVIDERS                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                         999,999       999,999       999,999       999,999       999,999       999,999

TOTAL VISITS                            999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                       999,999       999,999       999,999       999,999       999,999       999,999
```


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```
TOTAL RE-ENROLLED                        999,999       999,999       999,999       999,999       999,999       999,999

DATE LETTER SENT                         MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY

TOTAL PROVIDERS                          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RESPONSES                          999,999       999,999       999,999       999,999       999,999       999,999

TOTAL VISITS                             999,999       999,999       999,999       999,999       999,999       999,999

TOTAL WHO WERE SENT 2ND LETTER           999,999       999,999       999,999       999,999       999,999       999,999

TOTAL DISENROLLED                        999,999       999,999       999,999       999,999       999,999       999,999

TOTAL RE-ENROLLED                        999,999       999,999       999,999       999,999       999,999       999,999

TOTAL PROVIDERS AS OF MM/DD/CCYY        9,999,999
DATE LETTER SENT                         MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY
PERCENTAGE OF PROVIDERS CONTACTED **      9.99 %        9.99 %        9.99 %        9.99 %        9.99 %        9.99 %
DATE LETTER SENT                         MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY       MM/CCYY
PERCENTAGE OF PROVIDERS CONTACTED  **     9.99 %        9.99 %        9.99 %        9.99 %        9.99 %        9.99 %

** Calculated from the sum of Total Providers for Every 5 Years, Total Providers for State Agency and Total Providers for 5 years,
Visits Required divided by Total Providers as of MM/DD/CCYY.
```

7.1.86 PRV-A039-W Field Descriptions

Field	Description	Data Type	Length
DATE LETTER SENT	Month in which the first re-enrollment letter was sent to the provider.	Date (MM/CCYY)	7
ENROLLMENT FREQUENCY	Type of enrollment frequency provider has. Values are 1=Every year, 5=Every five years, S=State Agency, Q=QMB Only, V=Visit required every year, F=Visit required every five years.	Character	30
PERCENTAGE OF PROVIDERS CONTACTED	Number of providers in the frequency categories of Every five years (5), State Agency (S) and Visit required every five years, who were sent a letter divided by the total number of providers in those frequency categories in October 2011.	Number (Decimal)	4

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Field	Description	Data Type	Length
TOTAL PROVIDERS	Number of providers that received letters for date specified.	Number (Integer)	7
TOTAL RESPONSES	Number of providers who responded to letters for date specified.	Number (Integer)	7
TOTAL VISITS	Number of providers last visited for the specified date.	Number (Integer)	7
TOTAL WHO WERE SENT 2ND LETTER	Number of providers who have not responded to letter for date specified and have been sent a 2nd reminder notice.	Number (Integer)	7
TOTAL DISENROLLED	Number of providers who never responded to letters for specified date and have been disenrolled.	Number (Integer)	7
TOTAL RE-ENROLLED	Number of providers who responded to letters for specified date and have been re-enrolled.	Number (Integer)	7

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PRV-A040-M – Provider Fee Collection Report

7.1.87 PRV-A040-M – Provider Fee Collection Report Narrative

Provider Collection Report which includes for all providers who have enrolled and/or re-enrolled in the last week and any fees that were collected.

7.1.88 PRV-A040-M – Provider Fee Collection Layout

```
Report  : PRV-A040-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : PRVJW040                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: PRV_FEE_COLL                         PROVIDER FEE COLLECTION                                       Page:    999,999
                                       REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
NPI/                PROVIDER NAME                                          EXEMPT    -- FEE COLLECTION INFORMATION --
MCD                                                                        IND       SRC       DATE          AMOUNT

XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X         XX    MM/DD/CCYY   999,999,999.99
XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X         XX    MM/DD/CCYY   999,999,999.99
XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X         XX    MM/DD/CCYY   999,999,999.99
XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X         XX    MM/DD/CCYY   999,999,999.99
XXXXXXXXXXXXXXX


                                                  *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```

7.1.89 PRV-A040-M – Provider Fee Collection Report - Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A040-W - Provider Fee Collection Report.

Field	Description	Data Type	Length
EXEMPT IND	Exception Indicator: H - Hardship, exempt from paying fee N - Not Exempt for paying fee Y - Exempt from paying fee	Character	1
FEE COLLECTION INFORMATION - AMOUNT	Amount of fee paid to State/Federal Agency.	Number (Decimal)	14

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Field	Description	Data Type	Length
FEE COLLECTION INFORMATION - DATE	Date fee was paid to the State/Federal Agency.	Date (MM/DD/CCYY)	10
FEE COLLECTION INFORMATION - SRC	Code associated to the State/Federal Agency to whom the fee was paid. Valid values are: AM - Alabama Medicaid CH - CHIP MC - Medicare XX - Other State Medicaid, where XX is the state abbreviation.	Character	2
MCD	Provider's Medicaid Provider ID.	Character	15
NPI	Provider's National Provider ID.	Character	15
Provider Name	Provider's Name	Character	50

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PRV-A070-M - Portal Performance Report

7.1.90 PRV-A070-M - Portal Performance Report Narrative

The Report shows the number of applications in each status applicable to the applications status on the WEB portal product.

7.1.91 PRV-A070-M—Portal Performance Report Layout

```
Report  : PRV-A070-M                          ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJM601                  MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_PRTL_PERF                            PORTAL PERFORMANCE                                 Page:        999,999
                                               REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------
AGENCY REVIEW REQUIRED                                                    999,999

APPROVED                                                                  999,999

CORRECTIONS APPLIED                                                       999,999

DATA CORRECTIONS REQUIRED                                                 999,999

DENIED                                                                    999,999

INCOMPLETE                                                                999,999

MOVED TO PRODUCTION                                                       999,999

OVERRIDE                                                                  999,999

PRIMARY FACSIMILE                                                         999,999

READY FOR REVIEW                                                          999,999

REJECTED BY REVIEWER                                                      999,999

RESPONSE TIME PASSED                                                      999,999

SECONDARY FACSIMILE                                                       999,999

SYSTEM VALIDATION OCCURRING                                               999,999

UNDER REVIEW                                                              999,999

WAITING FOR DOCUMENTATION                                                 999,999

TOTAL APPLICATIONS                                                    999,999,999

                                                   *** END OF REPORT ***
```


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```
*** NO DATA THIS RUN ***
```

7.1.92 PRV-A070-M—Portal Performance Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A070-M Portal Performance Report.

Field	Description	Data Type	Length
AGENCY REVIEW REQUIRED	Total number of applications with status of AGENCY REVIEW REQUIRED.	Number (Integer)	6
APPROVED	Total number of applications with status of APPROVED.	Number (Integer)	6
CORRECTIONS APPLIED	Total number of applications with status of CORRECTIONS APPLIED.	Number (Integer)	6
DATA CORRECTIONS REQUIRED	Total number of applications with status of DATA CORRECTIONS REQUIRED.	Number (Integer)	6
DENIED	Total number of applications with status of DENIED.	Number (Integer)	6
INCOMPLETE	Total number of applications with status of INCOMPLETE.	Number (Integer)	6
MOVED TO PRODUCTION	Total number of applications with status of MOVED TO PRODUCTION.	Number (Integer)	6
OVERRIDE	Total number of applications with status of OVERRIDE.	Number (Integer)	6
PRIMARY FACSIMILE	Total number of applications with status of PRIMARY FACSIMILE.	Number (Integer)	6
READY FOR REVIEW	Total number of applications with status of READY FOR REVIEW.	Number (Integer)	6
REJECTED BY REVIEWER	Total number of applications with status of REJECTED BY REVIEWER.	Number (Integer)	6
RESPONSE TIME PASSED	Total number of applications with status of RESPONSE TIME PASSED.	Number (Integer)	6
SECONDARY FACSIMILE	Total number of applications with status of SECONDARY FACSIMILE.	Number (Integer)	6

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Field	Description	Data Type	Length
SYSTEM VALIDATION OCCURRING	Total number of applications with status of SYSTEM VALIDATION OCCURRING.	Number(Integer)	6
TOTAL APPLICATIONS	Total number of applications in each status on the report.	Number (Integer)	6
UNDER REVIEW	Total number of applications with status of UNDER REVIEW.	Number (Integer)	6
WAITING FOR DOCUMENTATION	Total number of applications with status of WAITING FOR DOCUMENTATION.	Number (Integer)	6

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PRV-A071-D - Portal Statistics Report

7.1.93 PRV-A071-D - Portal Statistics Report Narrative

The Report shows the number of abandoned applications. Abandoned means an application was started but never submitted through the web portal product. Statuses included in the total are: Agency Review Required, Data Corrections Required, Response Time Passed, and Waiting on Documentation.

7.1.94 PRV-A071-D - Portal Statistics Report Layout

```
Report  : PRV-A071-D                          ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD301                      MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_PRTL_STATS                          PORTAL STATISTICS                                    Page:        999,999
                                               REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------

APPLICATIONS ABANDONED                 999,999

                                                *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```

7.1.95 PRV-A071-D—Portal Statistics Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A071-D Portal Statistics Report.

Field	Description	Data Type	Length
APPLICATIONS ABANDONED	Web portal applications not completed.	Number (Integer)	6

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PRV-A072-D - Provider Web App Facsimile – Facility Report

7.1.96 PRV-A072-D - Provider Web App Facsimile – Facility Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for a facility enrollment.

7.1.97 PRV-A072-D - Provider Web App Facsimile – Facility Report Layout

```
Report  : PRV-A072-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_APP_FACS                     PROVIDER WEB APP FACSIMILE - FACILITY                           Page    :    999,999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER TYPE                       TAX ID              LAST NAME             FIRST NAME        MI
XX                                  XXXXXXXXX           XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX   X
-------------------------------------------------------------------------------------------------------------------------------
ENROLLMENT TYPE                        X                                 AGENCY REVIEW INDICATOR     X
REQUESTING ENROLLMENT EFFECTIVE DATE   MM/DD/CCYY

CLIA #          XXXXXXXXXX
CLIA EFF DATE   MM/DD/CCYY

TAX NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TAX ID          XXXXXXXXX
TAX ID TYPE     X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DEA #                           XXXXXXXXX
DEA EFFECTIVE DATE              MM/DD/CCYY

PROVIDER TYPE   XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COUNTY          XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SPECIALTY      SPECIALTY DESCRIPTION                                 PRIMARY         TAXONOMY
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X               XXXXXXXXXX
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X               XXXXXXXXXX

ADDITIONAL TAXONOMY                     XXXXXXXXXX
DECERTIFYING PHARMACY NAME              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DECERTIFYING PHARMACY NPI               999999999999999
ORGANIZATIONAL TYPE                     X  - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


MEDICARE #                              XXXXXXXXXX
MEDICARE EFFECTIVE DATE                 MM/DD/CCYY
MEDICARE TYPE                           X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CONTACT INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      TITLE        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           (999)999-9999       EXT   9999                          FAX          (999)999-9999


SERVICE lOCATION INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


PAY TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


MAIL TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE           XX
ZIP             99999-9999


BANK INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          PHONE            (999)999-9999        EXT
9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          EFT TYPE          X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          ACCOUNT TYPE      X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE           XX                                      ABA ROUTING NBR   XXXXXXXXX
ZIP             99999-9999                              ACCOUNT NBR       XXXXXXXXXXXXXXXXXX


MEDICAID SURETY BOND INFORMATION:
NUMBER                EFFECTIVE DATE      END DATE
999999999999999       MM/DD/CCYY          MM/DD/CCYY


MEDICARE SURETY BOND INFORMATION:
NUMBER                EFFECTIVE DATE      END DATE
999999999999999       MM/DD/CCYY          MM/DD/CCYY

ACC EFFECTIVE DATE    MM/DD/CCYY
```


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```
ACC END DATE          MM/DD/CCYY

AFFILIATE SSN    AFFILIATE NAME                            AFFILIATE DOB
999-99-9999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY
999-99-9999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY

TRADING PARTNER ID     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

METHOD OF RETRIEVAL    X

PROVIDER AGENT INFORMATION - EFT:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION - EFT:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE            (999)999-9999

PROVIDER AGENT INFORMATION - ERA:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION - ERA:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE            (999)999-9999

CLEARINGHOUSE INFORMATION:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      E-MAIL  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTACT NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      PHONE   (999)999-9999

VENDOR INFORMATION:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      E-MAIL  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTACT NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      PHONE   (999)999-9999


< … PROVIDER AGREEMENT  …>

PROVIDER SIGNATURE : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TITLE:               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

7.1.98 PRV-A072-D—Provider Web App Facsimile – Facility Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A072-D - Provider Web App Facsimile – Facility Report.

Field	Description	Data Type	Length
ACC Effective Date	ACC effective date of a DME provider's accreditation.	Date (MM/DD/CCYY)	10
ACC End Date	ACC end date of a DME provider's accreditation.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Additional Taxonomy	Additional Taxonomy code	Character	10
Affiliate DOB	Date of Birth of listed affiliate.	Date (MM/DD/CCYY)	10
Affiliate Name	Name of affiliate, such as an owner, partner, etc.	Character	35
Affiliate SSN	Social Security Number of the listed affiliate.	Character	11
Agency Review Indicator	Indicates the application needs to be sent to the Agency for review purposes. Valued values: Y = Yes or Blank = No.	Character	1
Application Tracking Number	Tracking Number generated by the web portal product.	Character	10
Bank Information: ABA Routing NBR	Bank routing number associated to the EFT information indicated on the web application.	Character	9
Bank Information: Account NBR	Bank account number associated to the EFT information on the web application.	Character	17
Bank Information: Account Type	Type of account associated to the EFT information indicated on the web application. C = Checking S = Savings	Character	1
Bank Information: Address 1	Bank address line 1.	Character	30
Bank Information: Address 2	Bank address line 2.	Character	30
Bank Information: City	Name of city for the bank.	Character	30
Bank Information: EFT Type	EFT Type as indicated on the web application. D = Deposit W = Withdrawal	Character	1

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Field	Description	Data Type	Length
Bank Information: Ext	Extension number for the given phone.	Character	4
Bank Information: Name	Name of the bank associated to the provider's EFT information indicated on the web application.	Character	39
Bank Information: Phone	Phone number for the bank.	Character	13
Bank Information: State	State code corresponding to the address.	Character	2
Bank Information: Submission DT	The date that enrollment agreement was signed on.	Date (MM/DD/CCYY)	10
Bank Information: Zip	Complete Postal code for the address. (Zip - +4)	Character	10
Business Name	Name of facility or group indicated on the web portal product application.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Clearinghouse Information: Contact Name	Name of contact at Clearinghouse.	Character	50
Clearinghouse Information: E-mail	An electronic mail address at which the health plan might contact the provider's clearinghouse	Character	50
Clearinghouse Information: Name	Official name of the provider's clearinghouse.	Character	50
Clearinghouse Information: Phone	Telephone number of contact.	Character	13
Contact Information: E-mail	E-mail address of contact person.	Character	50

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Field	Description	Data Type	Length
Contact Information: Ext	Extension associated to contact person phone number.	Character	4
Contact Information: Fax	The contact fax number of the applicant as provided on the enrollment application.	Character	13
Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13
Contact Information: Title	Title of contact person.	Character	40
County	County code based on service location.	Character	2
DEA #	DEA certification number of the individual enrolling provider.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual enrolling provider.	Date (MM/DD/CCYY)	10
Decertifying Pharmacy NPI	NPI of the pharmacy to be decertified based on the new enrollment.	Character	15
Decertifying Pharmacy Name	Name of the pharmacy to be decertified based on the new enrollment.	Character	50
Enrollment Type	Type of Enrollment selected on the web portal product application, such as Individual, Group, etc.	Character	1
First Name	First name of the individual provider enrolling. N/A for this report.	Character	15
Last Name	Last name of individual provider enrolling. N/A for this report.	Character	20
MI	Middle initial of individual provider enrolling. N/A for this report.	Character	1
Mail To Information: Address 1	Provider's mail to address as indicated on the web application.	Character	30
Mail To Information: Address 2	Provider's mail to address, line 2, as indicated on the web application.	Character	30

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Field	Description	Data Type	Length
Mail To Information: City	Mail to city of the provider's mail to address as indicated on the web application.	Character	30
Mail To Information: E-mail	Mail To E-mail address of the provider's mail to address as indicated on the web application.	Character	50
Mail To Information: Ext	Ext of mail to phone number as indicated on the web application.	Character	4
Mail To Information: Phone	Mail to phone number of the mail to address as indicated on the web application.	Character	13
Mail To Information: State	Mail to state of the provider's mail to address as indicated on the web application.	Character	2
Mail To Information: Zip	Mail to zip +4 of the provider's mail to address as indicated on the web application.	Character	10
Medicaid Surety Bond Information: Effective Date	Effective date of a DME provider's Medicaid Surety Bond.	Date (MM/DD/CCYY)	10
Medicaid Surety Bond Information: End Date	End date of a DME provider's Medicaid Surety Bond.	Date (MM/DD/CCYY)	10
Medicaid Surety Bond Information: Number	DME provider's Medicaid Surety Bond Number.	Character	15
Medicare #	Provider's Medicare Number indicated on the web portal product application.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification as indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Medicare Surety Bond Information: Effective Date	Effective date of DME provider's Medicare Surety Bond.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Medicare Surety Bond Information: End Date	End date of a DME provider's Medicare Surety Bond.	Date (MM/DD/CCYY)	10
Medicare Surety Bond Information: Number	DME provider's Medicare Surety Bond Number.	Character	15
Medicare Type	Type of Medicare certification. M - Medicare D - DMERC	Character	2
Method of Retrieval	The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15

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Field	Description	Data Type	Length
Organizational Type	Type of organization: A = Individual Practitioner B = Sole Proprietorship C = Government Owned D = Business Corporation, for profit E = Business Corporation, non-profit F = Private, for profit G = Private, non-profit H = Partnership I = Trust J = Chain	Character	1
Pay To Information: Address 1	Provider's pay to address as indicated on the web application.	Character	30
Pay To Information: Address 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Pay To Information: City	Pay to city of provider's pay to address as indicated on the web application.	Character	30
Pay To Information: E-mail	E-mail address associated to the provider's pay to address as indicated on the web application.	Character	50
Pay To Information: Ext	Extension number for the given phone.	Character	4
Pay To Information: Fax	Fax number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Phone	Phone number associated to the provider's pay to address as indicated on the web application.	Character	13

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Field	Description	Data Type	Length
Pay To Information: State	Pay to state of the provider's pay to address as indicated on the web application.	Character	2
Pay To Information: Toll Free	Toll free number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Zip	Pay to zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Provider Agent Contact Information-EFT: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-EFT: Name	Name of a contact in agent office for handling EFT issues.	Character	50
Provider Agent Contact Information-EFT: Phone	Phone number associated with contact person.	Character	13
Provider Agent Contact Information-ERA: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-ERA: Name	Name of a contact in agent office for handling ERA issues.	Character	50
Provider Agent Contact Information-ERA: Phone	Phone number associated with contact person.	Character	13
Provider Agent Information-EFT: Name	Name of provider's authorized agent.	Character	50

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Field	Description	Data Type	Length
Provider Agent Information-ERA: Name	Name of provider's authorized agent.	Character	50
Provider Signature	This name represents the electronic signature for a provider.	Character	50
Provider Type	Provider's type selected on the web portal product application.	Character	2
Requesting Enrollment Effective Date	Requested Enrollment Effective Date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Service Location Information: Address 1	Provider's physical service location.	Character	30
Service Location Information: Address 2	Provider's physical service location, address line 2.	Character	30
Service Location Information: City	City of provider's physical service location.	Character	30
Service Location Information: E-mail	E-mail address associated to the provider's physical service location.	Character	50
Service Location Information: Ext	Extension number for the given phone.	Character	4
Service Location Information: Fax	Provider's physical service location fax number.	Character	13
Service Location Information: Phone	Phone number associated to the provider's physical service location.	Character	13
Service Location Information: State	State of provider's physical service location.	Character	2

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Field	Description	Data Type	Length
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
Service Location Information: Zip	Zip +4 of the provider's physical service location.	Character	10
Specialty	Provider's specialty selected on the web portal product application.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Tax ID	Tax Identification number as indicated on the web application.	Character	9
Tax ID Type	Tax Identification number type (FEIN = F or SSN = S) as indicated on the web application.	Character	1
Tax Name	Tax name as indicated on the web application.	Character	30
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title	Printed Title of Person Submitting Enrollment	Character	40
Title (at bottom)	Printed Title of Person Submitting Enrollment	Character	40
Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.	Character	35
Vendor Information: Contact Name	Name of a contact in vendor office for handling ERA issues.	Character	50
Vendor Information: E-mail	An electronic mail address at which the health plan might contact the provider's vendor.	Character	50
Vendor Information: Name	Name of vendor office for handling ERA issues.	Character	50
Vendor Information: Phone	Telephone number of vendor.	Character	13

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PRV-A073-D - Provider Web App Facsimile – Individual within a Group Report

7.1.99 PRV-A073-D - Provider Web App Facsimile – Individual within a Group Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for an individual provider within a group.

7.1.100 PRV-A073-D - Provider Web App Facsimile – Individual within a Group Report Layout

```
Report  : PRV-A073-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                           MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: PRV_APP_FACS               PROVIDER WEB APP FACSIMILE - INDIVIDUAL WITHIN A GROUP              Page    :    999,999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER TYPE                       TAX ID              LAST NAME             FIRST NAME        MI
XX                                  XXXXXXXXX           XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX   X
-------------------------------------------------------------------------------------------------------------------------------
ENROLLMENT TYPE                        X                                AGENCY REVIEW INDICATOR     X
REQUESTING ENROLLMENT EFFECTIVE DATE   MM/DD/CCYY                       TITLE    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLIA #          XXXXXXXXXX
CLIA EFF DATE   MM/DD/CCYY

TAX NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TAX ID          XXXXXXXXX
TAX ID TYPE     X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SSN           999-99-9999       GENDER          x       BIRTH DATE              MM/DD/CCYY
LICENSE #     XXXXXXXXXX        LICENSE STATE   xx      LICENSE EFFECTIVE DATE  MM/DD/CCYY       LICENSE END DATE  MM/DD/CCYY

GROUP NAME                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
GROUP MCD ID                    XXXXXXXXXXXXXXXX
GROUP NPI                       XXXXXXXXXXXXXXXX

DEA #                           XXXXXXXXX
DEA EFFECTIVE DATE              MM/DD/CCYY

PROVIDER TYPE   XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COUNTY          XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SPECIALTY      SPECIALTY DESCRIPTION                                    PRIMARY         TAXONOMY
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X               XXXXXXXXXX
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      X               XXXXXXXXXX


ADDITIONAL TAXONOMY                     XXXXXXXXXX
COLLABORATING PHYSICIAN NAME            xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```


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```
COLLABORATING PHYSICIAN NPI              XXXXXXXXXXXXXX
ORGANIZATIONAL TYPE                      X  -
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MEDICARE #                               XXXXXXXXXX
MEDICARE EFFECTIVE DATE                  MM/DD/CCYY
MEDICARE TYPE                            X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

```
CONTACT INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      TITLE        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           (999)999-9999       EXT   9999                          FAX          (999)999-9999


SERVICE lOCATION INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


PAY TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


MAIL TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE           XX
ZIP             99999-9999


Disclosure QUESTION AND Answers (Y or N indicator and free form text entered for Y answers.)
1         XXXXXXXXXXXXXXXXXXXX
```

```
    X    XXXX
```

```
15          XXXX
```

Field	Description	Data Type	Length
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	50
Contact Information: E-mail	E-mail address of contact person.	Character	50
Contact Information: Ext	Extension associated to the contact person phone number.	Character	4
Contact Information: Fax	The contact fax number of the applicant as provided on the enrollment application.	Character	13
Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13
Contact Information: Title	Title of Contact person.	Character	40
County	County code based on service location.	Character	2
DEA #	DEA certification number of the individual enrolling provider.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual enrolling provider.	Date (MM/DD/CCYY)	10
Disclosure Answers - 1-19 Indicator	Answer indicators to disclosure questions on the web application.	Character	1
Disclosure Answers - 1-19 Text	Answers to disclosure questions on the web application.	Character	500
Disclosure Questions - 1 -19 Text	Disclosure questions from the web application.	Character	1500

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Field	Description	Data Type	Length
Enrollment Type	Type of Enrollment selected on the web portal product application, such as Individual, Group, etc.	Character	1
First Name	First name of the individual provider enrolling.	Character	15
Gender	Gender of individual provider enrolling.	Character	1
Group MCD ID	Medicaid number of the group/practice with which the enrolling individual provider is associated.	Character	15
Group NPI	National provider identifier of the group/practice with which the enrolling individual provider is associated.	Character	15
Group Name	Name of the group/practice with which the individual enrolling provider is associated.	Character	50
Last Name	Last name of individual provider enrolling.	Character	20
License #	Number of the professional license of the individual provider enrolling.	Character	10
License Effective Date	Effective date of the provider's professional license.	Date (MM/DD/CCYY)	10
License End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
License State	State in which the provider's professional license was issued.	Character	2
MI	Middle initial of individual provider enrolling.	Character	1
Mail To Information: Address 1	Provider's mail to address as indicated on the web application.	Character	30
Mail To Information: Address 2	Provider's mail to address, line 2, as indicated on the web application.	Character	30
Mail To Information: City	Mail to city of the provider's mail to address as indicated on the web application.	Character	30
Mail To Information: E-mail	Mail to e-mail address of the provider's mail to address as indicated on the web application.	Character	50

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Field	Description	Data Type	Length
Mail To Information: Ext	Ext of mail to phone number as indicated on the web application.	Character	4
Mail To Information: Phone	Mail to phone number of the mail to address as indicated on the web application.	Character	13
Mail To Information: State	Mail to state of the provider's mail to address as indicated on the web application.	Character	2
Mail To Information: Zip	Mail to zip +4 of the provider's mail to address as indicated on the web application.	Character	10
Medicare #	Provider's Medicare Number indicated on the web portal product application.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification as indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Medicare Type	Type of Medicare certification. Valid values include: M - Medicare D - DMERC	Character	2
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15

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Field	Description	Data Type	Length
Organizational Type	Type of organization: A = Individual Practitioner B = Sole Proprietorship C = Government Owned D = Business Corporation, for profit E = Business Corporation, non-profit F = Private, for profit G = Private, non-profit H = Partnership I = Trust J = Chain	Character	1
Pay To Information: Address 1	Provider's pay to address as indicated on the web application.	Character	30
Pay To Information: Address 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Pay To Information: City	Pay to city of provider's pay to address as indicated on the web application.	Character	30
Pay To Information: E-mail	E-mail address associated to the provider's pay to address as indicated on the web application.	Character	50
Pay To Information: Ext	Extension number for the given phone.	Character	4
Pay To Information: Fax	Fax number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Phone	Phone number associated to the provider's pay to address as indicated on the web application.	Character	13

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Field	Description	Data Type	Length
Pay To Information: State	Pay to state of the provider's pay to address as indicated on the web application.	Character	2
Pay To Information: Toll Free	Toll free number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Zip	Pay to zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Provider Signature	This name represents the electronic signature for a provider.	Character	50
Provider Type	Provider's type selected on the web portal product application.	Character	2
Requesting Enrollment Effective Date	Requesting Enrollment Effective Date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
SSN	Social Security Number of individual provider enrolling.	Character	11
Service Location Information: E-mail	E-mail address associated to the provider's physical service location.	Character	50
Service Location Information: State	State of the provider's physical service location.	Character	2
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
Service Location Information: Zip	Zip +4 of the provider's physical service location.	Character	10
Service Location Information: Address 1	Provider's physical service location.	Character	30

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Field	Description	Data Type	Length
Service Location Information: Address 2	Provider's physical service location, address line 2.	Character	30
Service Location Information: City	City of the provider's physical service location.	Character	30
Service Location Information: Ext	Extension number for the given phone.	Character	4
Service Location Information: Fax	Provider's physical service location fax number.	Character	13
Service Location Information: Phone	Phone number associated to the provider's physical service location.	Character	13
Specialty	Provider's specialty selected on the web portal product application.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Tax ID	Tax identification number as indicated on the web application.	Character	9
Tax ID Type	Tax identification number type (FEIN = F or SSN = S) as indicated on the web application.	Character	1
Tax Name	Tax name as indicated on the web application.	Character	30
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title	Title of the individual provider enrolling.	Character	50
Title (at bottom)	Printed Title of Person Submitting Enrollment.	Character	40

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PRV-A074-D - Provider Web App Facsimile – Individual Report

7.1.1 PRV-A074-D - Provider Web App Facsimile – Individual Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for an individual not in a group enrollment.

7.1.2 PRV-A074-D - Provider Web App Facsimile – Individual Report Layout

```
Report  : PRV-A074-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                             MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: PRV_APP_FACS                     PROVIDER WEB APP FACSIMILE - INDIVIDUAL                         Page    :    999,999
                                                     REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER TYPE                       TAX ID              LAST NAME             FIRST NAME        MI
XX                                  XXXXXXXXX           XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX    X
-------------------------------------------------------------------------------------------------------------------------------
ENROLLMENT TYPE                        X                                AGENCY REVIEW IND     X
REQUESTING ENROLLMENT EFFECTIVE DATE   MM/DD/CCYY                       TITLE    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLIA #          XXXXXXXXXX
CLIA EFF DATE   MM/DD/CCYY

TAX NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TAX ID          XXXXXXXXX
TAX ID TYPE     X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SSN           999-99-9999       GENDER          x       BIRTH DATE              MM/DD/CCYY
LICENSE #     XXXXXXXXXX        LICENSE STATE   xx      LICENSE EFFECTIVE DATE  MM/DD/CCYY       LICENSE END DATE  MM/DD/CCYY

DEA #                           XXXXXXXXX
DEA EFFECTIVE DATE              MM/DD/CCYY

PROVIDER TYPE   XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COUNTY          XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SPECIALTY      SPECIALTY DESCRIPTION                                    PRIMARY         TAXONOMY
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       X               XXXXXXXXXX
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       X               XXXXXXXXXX

ADDITIONAL TAXONOMY                      XXXXXXXXXX
DECERTIFYING PHARMACY NAME               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DECERTIFYING PHARMACY NPI                999999999999999
ORGANIZATIONAL TYPE                      X  - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MEDICARE #                               XXXXXXXXXX
MEDICARE EFFECTIVE DATE                  MM/DD/CCYY
MEDICARE TYPE                            X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
CONTACT INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      TITLE        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           (999)999-9999       EXT   9999                          FAX          (999)999-9999

SERVICE lOCATION INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


PAY TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
ZIP             99999-9999


MAIL TO INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE           XX
ZIP             99999-9999


BANK INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          PHONE            (999)999-9999        EXT
9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          EFT TYPE          X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          ACCOUNT TYPE      X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE           XX                                      ABA ROUTING NBR   XXXXXXXXX
ZIP             99999-9999                              ACCOUNT NBR       XXXXXXXXXXXXXXXXX

Disclosure QUESTION AND Answers (Y or N indicator and free form text entered for Y answers.)
 1         XXXXXXXXXXXXXXXXXXXX
```

```
    X    XXXX
```

```
15         XXXX
```

```
PROVIDER SIGNATURE : xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
TITLE:               xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
```

7.1.3 PRV-A074-D—Provider Web App Facsimile – Individual Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A074-D - Provider Web App Facsimile – Individual Report.

Field	Description	Data Type	Length
Additional Taxonomy	Additional Taxonomy code	Character	10
Application Tracking Number	Tracking Number generated by the web portal product.	Character	10
Agency Review Indicator	Indicates the application needs to be sent to the Agency for review purposes. Valued values: Y = Yes or Blank = No.	Character	1
Bank Information: ABA Routing NBR	Bank routing number associated to the EFT information indicated on the web application.	Character	9
Bank Information: Account NBR	Bank account number associated to the EFT information on the web application.	Character	17
Bank Information: Account Type	Type of account associated to the EFT information indicated on the web application. C = Checking S = Savings	Character	1
Bank Information: Address 1	Bank address line 1	Character	30
Bank Information: Address 2	Bank address line 2.	Character	30
Bank Information: City	Name of city for the bank.	Character	30

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Field	Description	Data Type	Length
Bank Information: EFT Type	EFT Type as indicated on the web application. D = Deposit W = Withdrawal	Character	1
Bank Information: Ext	Extension number for the given phone.	Character	4
Bank Information: Name	Name of the bank associated to the provider's EFT information indicated on the web application.	Character	39
Bank Information: Phone	Phone number for the bank.	Character	13
Bank Information: State	State code corresponding to the address.	Character	2
Bank Information: Zip	Complete Postal code for the address. (Zip - +4)	Character	10
Birth Date	Date of birth of the individual provider enrolling.	Date (MM/DD/CCYY)	10
Business Name	Name of group indicated on the web portal product application. N/A for this report.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Clearinghouse Information: Contact Name	Name of contact at Clearinghouse.	Character	50
Clearinghouse Information: E-mail	An electronic mail address at which the health plan might contact the provider's clearinghouse	Character	50
Clearinghouse Information: Name	Official name of the provider's clearinghouse.	Character	50

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Field	Description	Data Type	Length
Clearinghouse Information: Phone	Telephone number of contact.	Character	13
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	50
Contact Information: E-mail	E-mail address of contact person.	Character	50
Contact Information: Ext	Extension associated to the contact person phone number.	Character	4
Contact Information: Fax	The contact fax number of the applicant as provided on the enrollment application.	Character	13
Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13
Contact Information: Title	Title of contact person.	Character	40
County	County code based on service location.	Character	2
DEA #	DEA certification number of the individual provider enrolling.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual enrolling provider.	Date (MM/DD/CCYY)	10
Disclosure Answers - 1-19 Text	Answers to disclosure questions on the web application.	Character	500

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Field	Description	Data Type	Length
Disclosure Answers 1-19 Indicator	Answer indicators to disclosure questions on the web application. Valid values will be Y = Yes, and N = No.	Character	1
Disclosure Questions - 1 -19 Text	- Disclosure questions from the web application.	Character	1500
Enrollment Type	Type of Enrollment selected on the web portal product application, such as Individual, Group, etc.	Character	1
First Name	First name of the individual provider enrolling.	Character	15
Gender	Gender of individual provider enrolling.	Character	1
Last Name	Last name of individual provider enrolling.	Character	20
License #	Number of the professional license of the individual provider enrolling.	Character	10
License Effective Date	Effective date of the provider's professional license.	Date (MM/DD/CCYY)	10
License End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
License State	State in which the provider's professional license was issued.	Character	2
MI	Middle initial of individual provider enrolling.	Character	1
Mail To Information: Address 1	Provider's mail to address as indicated on the web application.	Character	30
Mail To Information: Address 2	Provider's mail to address, line 2, as indicated on the web application.	Character	30
Mail To Information: City	Mail to city of the provider's mail to address as indicated on the web application.	Character	30

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Field	Description	Data Type	Length
Mail To Information: E-mail	Mail to e-mail address of the provider's mail to address as indicated on the web application.	Character	50
Mail To Information: Ext	Ext of mail to phone number as indicated on the web application.	Character	4
Mail To Information: Phone	Mail to phone number of the mail to address as indicated on the web application.	Character	13
Mail To Information: State	Mail to state of the provider's mail to address as indicated on the web application.	Character	2
Mail To Information: Zip	Mail to zip +4 of the provider's mail to address as indicated on the web application.	Character	10
Medicare #	Provider's Medicare Number indicated on the web portal product application.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification as indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Medicare Type	Type of Medicare certification. M = Medicare D = DMERC	Character	10
Method of Retrieval	The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15

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Field	Description	Data Type	Length
Organizational Type	Type of organization: A = Individual Practitioner B = Sole Proprietorship C = Government Owned D = Business Corporation, for profit E = Business Corporation, non-profit F = Private, for profit G = Private, non-profit H = Partnership I = Trust J = Chain	Character	1
Pay To Information: Address 1	Provider's pay to address as indicated on the web application.	Character	30
Pay To Information: Address 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Pay To Information: City	Pay to city of provider's pay to address as indicated on the web application.	Character	30
Pay To Information: E-mail	E-mail address associated to the provider's pay to address as indicated on the web application.	Character	50
Pay To Information: Ext	Extension number for the given phone.	Character	4
Pay To Information: Fax	Fax number associated to the provider's pay to address as indicated on the web application.	Character	13

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Field	Description	Data Type	Length
Pay To Information: Phone	Phone number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: State	Pay to state of the provider's pay to address as indicated on the web application.	Character	2
Pay To Information: Toll Free	Toll free number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Zip	Pay to zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Provider Agent Contact Information-EFT: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-EFT: Name	Name of a contact in agent office for handling EFT issues.	Character	50
Provider Agent Contact Information-EFT: Phone	Phone number associated with contact person.	Character	13
Provider Agent Contact Information-ERA: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-ERA: Name	Name of a contact in agent office for handling ERA issues.	Character	50
Provider Agent Contact Information-ERA: Phone	Phone number associated with contact person.	Character	13

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Field	Description	Data Type	Length
Provider Agent Information-EFT: Name	Name of provider's authorized agent.	Character	50
Provider Agent Information-ERA: Name	Name of provider's authorized agent.	Character	50
Provider Signature	This name represents the electronic signature for a Provider.	Character	50
Provider Type	Provider's type selected on the web portal product application.	Character	2
Requesting Enrollment Effective Date	Requesting Enrollment Effective Date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
SSN	Social Security Number of individual provider enrolling.	Character	11
Service Location Information: Address 1	Provider's physical service location.	Character	30
Service Location Information: Address 2	Provider's physical service location, address line 2.	Character	30
Service Location Information: City	City of the provider's physical service location.	Character	30
Service Location Information: E-mail	E-mail address associated to the provider's physical service location.	Character	50
Service Location Information: Ext	Extension of the pay to phone number.	Character	4
Service Location Information: Fax	Provider's physical service location fax number.	Character	13

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Field	Description	Data Type	Length
Service Location Information: Phone	Phone number associated to the provider's physical service location.	Character	13
Service Location Information: State	State of the provider's physical service location.	Character	2
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
Service Location Information: Zip	Zip +4 of the provider's physical service location.	Character	10
Specialty	Provider's specialty selected on the web portal product application.	Character	3
Specialty Description -	Provider's specialty description selected on the web portal product application.	Character	50
Tax ID	Tax identification number as indicated on the web application.	Character	9
Tax ID Type	Tax identification number type (FEIN = F or SSN = S) as indicated on the web application.	Character	1
Tax Name	Tax name as indicated on the web application.	Character	30
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title	Tile of the individual provider enrolling.	Character	50
Title (at bottom)	Printed Title of Person Submitting Enrollment	Character	40
Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.	Character	35
Vendor Information: Contact Name	Name of a contact in vendor office for handling ERA issues.	Character	50

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Field	Description	Data Type	Length
Vendor Information: E-mail	An electronic mail address at which the health plan might contact the provider's vendor.	Character	50
Vendor Information: Name	Name of vendor office for handling ERA issues.	Character	50
Vendor Information: Phone	Telephone number of vendor.	Character	13

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PRV-A075-D - Provider Web App Secondary Facsimile - Facility Report

7.1.4 PRV-A075-D - Provider Web App Secondary Facsimile - Facility Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for a facility enrollment that has been modified.

7.1.5 PRV-A075-D - Provider Web App Secondary Facsimile - Facility Report Layout

```
Report  : PRV-A075-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD310                           MEDICAID MANAGEMENT INFORMATION SYSTEM                      Run Time:   HH:MM:SS
Location: PRV_SEC_FACS                   PROVIDER WEB APP SECONDARY FACSIMILE - FACILITY                 Page    :    999,999
-------------------------------------------------------------------------------------------------------------------------------
Application Tracking Number         NPI                 Business Name
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        LAST NAME             FIRST NAME        MI         TITLE
                                                        XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   X          XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
SPECIALTY       SPECIALTY DESCRIPTION                                   PRIMARY             TAXONOMY CODE
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X                   XXXXXXXXXX
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X                   XXXXXXXXXX

CLIA #          XXXXXXXXXX          CLIA Eff Date   MM/DD/CCYY

Decertifying Pharmacy Name          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Decertifying Pharmacy NPI           999999999999999

Medicare #                          9999999999
Medicare Effective Date             MM/DD/CCYY
MEDICARE TYPE                       X - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MEDICAID SURETY BOND INFORMATION:
Number                Effective Date      End Date
999999999999999       MM/DD/CCYY          MM/DD/CCYY


MEDICARE SURETY BOND INFORMATION:
Number                Effective Date      End Date
999999999999999       MM/DD/CCYY          MM/DD/CCYY

ACC Effective Date    MM/DD/CCYY
ACC End Date          MM/DD/CCYY
```


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7.1.6 PRV-A075-D—Provider Web App Secondary Facsimile - Facility Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A075-D - Provider Web App Secondary Facsimile - Facility Report.

Field	Description	Data Type	Length
ACC Effective Date	ACC effective date of a DME provider's accreditation.	Date (MM/DD/CCYY)	10
ACC End Date	ACC end date of a DME provider's accreditation.	Date (MM/DD/CCYY)	10
Application Tracking Number	Tracking number generated by the web portal product.	Character	10
Business Name	Name of facility or group indicated on the web portal product application.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Decertifying Pharmacy NPI	NPI of the pharmacy to be decertified based on the new enrollment.	Character	15
Decertifying Pharmacy Name	Name of the pharmacy to be decertified based on the new enrollment.	Character	50
First Name	First name of the individual provider enrolling. N/A for this report.	Character	15
Last Name	Last name of individual provider enrolling. N/A for this report.	Character	20
MI	Middle initial of individual provider enrolling. N/A for this report.	Character	1
Medicaid Surety Bond Information: Effective Date	Effective date of a DME provider's Medicaid Surety Bond.	Date (MM/DD/CCYY)	10
Medicaid Surety Bond Information: End Date	End date of a DME provider's Medicaid Surety Bond.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Medicaid Surety Bond Information: Number	DME provider's Medicaid Surety Bond Number.	Character	15
Medicare #	Provider's Medicare Number indicated on the web portal product application.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification as indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Medicare Surety Bond Information: Effective Date	Effective date of DME provider's Medicare Surety Bond.	Date (MM/DD/CCYY)	10
Medicare Surety Bond Information: End Date	End date of a DME provider's Medicare Surety Bond.	Date (MM/DD/CCYY)	10
Medicare Surety Bond Information: Number	DME provider's Medicare Surety Bond Number.	Character	15
Medicare Type	Type of Medicare certification, both code and description are displayed.. M - Medicare D - DMERC	Character	54
NPI	National Provider Identifier of the enrolling provider.	Character	15
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Specialty	Provider's specialty code.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title	Title of the individual provider enrolling. N/A for this report.	Character	15

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PRV-A076-D - Provider Web App Secondary Facsimile - Individual within a Group Report

7.1.7 PRV-A076-D - Provider Web App Secondary Facsimile - Individual within a Group Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for an individual enrollment that has been modified.

7.1.8 PRV-A076-D - Provider Web App Secondary Facsimile - Individual within a Group Report Layout

```
Report  : PRV-A076-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD310                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_SEC_FACS            PROVIDER WEB APP SECONDARY FACSIMILE - INDIVIDUAL WITHIN A GROUP         Page    :    999,999
-------------------------------------------------------------------------------------------------------------------------------
Application Tracking Number         NPI                 Business Name
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        LAST NAME              FIRST NAME        MI         TITLE
                                                        XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   X          XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
SPECIALTY       SPECIALTY DESCRIPTION                                      PRIMARY             TAXONOMY CODE
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX X                   XXXXXXXXXX
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX X                   XXXXXXXXXX

CLIA #          XXXXXXXXXX          CLIA Eff Date   mm/DD/CCYY

LICENSE INFORMATION:
License #     9999999999            Effective Date  mm/DD/CCYY
STATE         XX                    End Date        mm/DD/CCYY

DEA #                               99AA99999
DEA Effective Date                  mm/DD/CCYY

Collaborating Physician Name        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CollaborAting Physician NPI         999999999999999

Medicare #                          9999999999
Medicare Effective Date             mm/DD/CCYY
MEDICARE TYPE                       X - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

GROUP NAME                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
GROUP MCD ID                        999999999999999
GROUP NPI                           999999999999999
```


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7.1.9 PRV-A076-D—Provider Web App Secondary Facsimile - Individual within a Group Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A076-D - Provider Web App Secondary Facsimile - Individual within a Group Report.

Field	Description	Data Type	Length
Application Tracking Number	Tracking number generated by the web portal product.	Character	10
Business Name	Name of facility or group indicated on the web portal product application.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the nurse practitioner.	Character	50
DEA #	DEA certification number of the individual provider.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual provider.	Date (MM/DD/CCYY)	10
First Name	First name of the individual provider.	Character	15
Group MCD ID	Medicaid number of the group/practice with which the provider is associated.	Character	15
Group NPI	National provider identifier of the group/practice with which the individual provider is associated.	Character	15
Group Name	Name of the group/practice with which the individual is associated.	Character	50
Last Name	Last name of the individual provider.	Character	20
License Information: End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
License Information: Effective Date	Effective date of provider's professional license.	Date (MM/DD/CCYY)	10
License Information: License #	Number of the professional license of the individual provider.	Character	10
License Information: State	State in which the provider's professional license was issued.	Character	2
MI	Middle initial of the individual provider.	Character	1
Medicare #	Provider's Medicare Number.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification.	Date (MM/DD/CCYY)	10
Medicare Type	Type of Medicare certification, both code and description are displayed.. M - Medicare D - DMERC	Character	54
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Primary	Primary indicator related to the provider specialty.	Character	1
Specialty	Provider's specialty code.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Taxonomy Code	Provider's taxonomy code.	Character	10

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PRV-A077-D - Provider Web App Secondary Facsimile - Individual Report

7.1.10 PRV-A077-D - Provider Web App Secondary Facsimile - Individual Report Narrative

This report details the facsimile information of provider enrollment data coming from the web portal for an individual non-group enrollment that has been modified.

7.1.11 PRV-A077-D - Provider Web App Secondary Facsimile - Individual Report Layout

```
Report  : PRV-A077-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD310                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_SEC_FACS                   PROVIDER WEB APP SECONDARY FACSIMILE - INDIVIDUAL                 Page    :    999,999
-------------------------------------------------------------------------------------------------------------------------------
Application Tracking Number         NPI                 Business Name
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        LAST NAME              FIRST NAME        MI         TITLE
                                                        XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   X          XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
SPECIALTY       SPECIALTY DESCRIPTION                                      PRIMARY             TAXONOMY CODE
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X                   XXXXXXXXXX
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X                   XXXXXXXXXX

CLIA #          XXXXXXXXXX          CLIA Eff Date   MM/DD/CCYY

LICENSE INFORMATION:
License #     9999999999            Effective Date  MM/DD/CCYY
STATE         XX                    End Date        MM/DD/CCYY

DEA #                               99XX99999
DEA Effective Date                  MM/DD/CCYY

Collaborating Physician Name        AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
CollaborAting Physician NPI         999999999999999

Medicare #                          9999999999
Medicare Effective Date             MM/DD/CCYY
MEDICARE TYPE                       X - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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7.1.12 PRV-A077-D—Provider Web App Secondary Facsimile - Individual Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A077-D - Provider Web App Secondary Facsimile - Individual Report.

Field	Description	Data Type	Length
Application Tracking Number	Tracking number generated by the web portal product.	Character	10
Business Name	Name of group indicated on the web portal product application. N/A for this report.	Character	50
CLIA #	Provider's CLIA certification number.	Character	10
CLIA Eff Date	CLIA certification effective date.	Date (MM/DD/CCYY)	10
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the nurse practitioner.	Character	50
DEA #	DEA certification number of the individual provider.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual provider.	Date (MM/DD/CCYY)	10
First Name	First name of the individual provider.	Character	15
Last Name	Last name of the individual provider.	Character	20
License Information: Effective Date	Effective date of provider's professional license.	Date (MM/DD/CCYY)	10
License Information: End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
License Information: License #	Number of the professional license of the individual provider.	Character	10
License Information: State	State in which the provider's professional license was issued.	Character	2

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Field	Description	Data Type	Length
MI	Middle initial of the individual provider.	Character	1
Medicare #	Provider's Medicare Number.	Character	10
Medicare Effective Date	Effective date of provider's Medicare certification.	Date (MM/DD/CCYY)	10
Medicare Type	Type of Medicare certification, both code and description are displayed.. M - Medicare D - DMERC	Character	54
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Primary	Primary indicator related to the provider specialty.	Character	1
Specialty	Provider's specialty code.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Taxonomy Code	Provider's taxonomy code.	Character	10
Title	Title of the individual provider enrolling.	Character	15

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PRV-A078-D - Provider Maintenance Facsimile

7.1.13 PRV-A078-D - Provider Maintenance Facsimile

Facsimile of provider enrollment data coming from the existing web portal when updates are made to specific information. The total page can be accessed in Feith by entering 999999999999999 as the provider number.

7.1.14 PRV-A078-D - Provider Maintenance Facsimile

```
Report  : PRV-A078-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD216                        MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: PRVPD###                            PROVIDER MAINTENANCE FACSIMILE                             Page    :    999,999
                                                REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
NPI                      NAME
999999999999999          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
BEFORE                                                                  AFTER

CONTACT INFORMATION:                                                    CONTACT INFORMATION:
NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       E-MAIL   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE            EXT         FAX                                        PHONE            EXT         FAX
(999)999-9999    9999        (999)999-9999                              (999)999-9999    9999        (999)999-9999

SERVICE LOCATION INFORMATION:                                           SERVICE LOCATION INFORMATION:
E-MAIL   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     E-MAIL   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           EXT    FAX             TOLL FREE       TF EXT          PHONE           EXT    FAX             TOLL FREE       TF EXT
(999)999-9999   9999   (999)999-9999   (999)999-9999   9999            (999)999-9999   9999   (999)999-9999   (999)999-9999   9999

-------------------------------------------------------------------------------------------------------------------------------

PAY TO INFORMATION:                                                     PAY TO INFORMATION:
ADDRESS 1   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              ADDRESS 1   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 2   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              ADDRESS 2   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              CITY        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE       AA                                                          STATE       XX
ZIP         99999-9999                                                  ZIP         99999-9999
E-MAIL      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   E-MAIL      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           EXT    FAX             TOLL FREE       TF EXT          PHONE           EXT    FAX             TOLL FREE       TF EXT
(999)999-9999   9999   (999)999-9999   (999)999-9999   9999            (999)999-9999   9999   (999)999-9999   (999)999-9999   9999

-------------------------------------------------------------------------------------------------------------------------------

MAIL TO INFORMATION:                                                    MAIL TO INFORMATION:
ADDRESS 1   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              ADDRESS 1   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 2   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              ADDRESS 2   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              CITY        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
STATE       AA                                                      STATE       AA
ZIP         99999-9999                                              ZIP         99999-9999
E-MAIL      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  E-MAIL      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           EXT    FAX                                          PHONE           EXT    FAX
(999)999-9999   9999   (999)999-9999                                (999)999-9999   9999   (999)999-9999

<page break>

Report  : PRV-A078-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD216                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRVPD###                                PROVIDER MAINTENANCE FACSIMILE                           Page    :    999,999
                                                    REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
NPI                      NAME
999999999999999
-------------------------------------------------------------------------------------------------------------------------------------


TOTAL PROVIDER UPDATES            999,999,999


                                                     *** END OF REPORT ***
```

7.1.15 PRV-A078-D—Provider Maintenance Facsimile

This section describes, in detail, the characteristics, and fields of the PRV-A078-D - Provider Maintenance Facsimile Report.

Field	Description	Data Type	Length
Contact Information: E-mail	E-mail of the contact person.	Character	50
Contact Information: Ext	Extension associated to contact person's phone number.	Character	4
Contact Information: Fax	Fax number of contact person.	Character	13
Contact Information: Name	Name of contact person.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13

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Field	Description	Data Type	Length
Mail To Information: Address 1	Provider's mail to address.	Character	30
Mail To Information: Address 2	Provider's mail to address, line 2.	Character	30
Mail To Information: City	City of the provider's mail to address.	Character	30
Mail To Information: E-mail	E-mail of the provider's mail to address.	Character	50
Mail To Information: Ext	Ext of the mail to phone number.	Character	4
Mail To Information: Fax	Fax number associated to the mail to address.	Character	13
Mail To Information: Phone	Phone number associated to the mail to address.	Character	13
Mail To Information: State	State of the provider's mail to address.	Character	2
Mail To Information: Zip	Zip +4 of the provider's mail to address.	Character	10
NAME	Name of provider for which changes were submitted.	Character	50
NPI	Provider's National Provider Identifier.	Character	15
Pay To Information: Address 1	Provider's pay to address.	Character	30
Pay To Information: Address 2	Provider's pay to address, line 2.	Character	30
Pay To Information: City	City of provider's pay to address.	Character	30

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Field	Description	Data Type	Length
Pay To Information: E-mail	E-mail address of the provider's pay to address.	Character	50
Pay To Information: Ext	Extension of phone number associated to the provider's pay to address.	Character	4
Pay To Information: Fax	Fax number associated to the provider's pay to address.	Character	13
Pay To Information: Phone	Phone number associated to the provider's pay to address.	Character	13
Pay To Information: State	State of the provider's pay to address.	Character	2
Pay To Information: TF Ext	Extension associated with the Toll free number that is associated to the provider's pay to address.	Character	4
Pay To Information: Toll Free	Toll free number associated to the provider's pay to address.	Character	13
Pay To Information: Zip	Zip +4 of the provider's pay to address.	Character	10
Service Location Information: E-mail	E-mail address associated to the provider's physical service location.	Character	50
Service Location Information: Ext	Extension associated to the phone of the provider's physical service location.	Character	4
Service Location Information: Fax	Provider's physical service location fax number.	Character	13
Service Location Information: Phone	Phone number associated to the provider's physical service location.	Character	13
Service Location Information: TF Ext	Extension associated with the Toll free number that is associated to the provider's physical service location.	Character	4

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Field	Description	Data Type	Length
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
TOTAL PROVIDER UPDATES	Total number of web changes done on date reported.	Character	11

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PRV-A079-D - Provider Web App Facsimile – Group Report

7.1.16 PRV-A079-D - Provider Web App Facsimile – Group Report Narrative

This report details facsimile information on provider enrollment data coming from the web portal for a group enrollment.

7.1.17 PRV-A079-D - Provider Web App Facsimile – Group Report Layout

```
Report  : PRV-A079-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_APP_FACS                       PROVIDER WEB APP FACSIMILE - GROUP                            Page    :    999,999
                                                    REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER TYPE                       TAX ID              LAST NAME             FIRST NAME        MI
XX                                  XXXXXXXXX           XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX   X
-------------------------------------------------------------------------------------------------------------------------------
ENROLLMENT TYPE                        X                                AGENCY REVIEW INDICATOR     X
REQUESTING ENROLLMENT EFFECTIVE DATE   MM/DD/CCYY

CLIA #          XXXXXXXXXX
CLIA EFF DATE   MM/DD/CCYY

TAX NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TAX ID          XXXXXXXXX
TAX ID TYPE     X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


PROVIDER TYPE   XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COUNTY          XX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SPECIALTY      SPECIALTY DESCRIPTION                                  PRIMARY         TAXONOMY
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X               XXXXXXXXXX
XXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X               XXXXXXXXXX


ADDITIONAL TAXONOMY                      XXXXXXXXXX
ORGANIZATIONAL TYPE                      X  - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


CONTACT INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      TITLE        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           (999)999-9999       EXT   9999                         FAX          (999)999-9999


SERVICE LOCATION INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                           PHONE        (999)999-9999       EXT     9999
```


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```
ADDRESS 2        XXXXXXXXXXXXXXXXXXXXXXXXXXXX                        FAX          (999)999-9999       EXT     9999
CITY             XXXXXXXXXXXXXXXXXXXXXXXXXXXX                        TOLL FREE    (999)999-9999       EXT     9999
STATE            XX
ZIP              99999-9999


PAY TO INFORMATION:
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       PHONE        (999)999-9999       EXT     9999
ADDRESS 2        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       FAX          (999)999-9999       EXT     9999
CITY             XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       TOLL FREE    (999)999-9999       EXT     9999
STATE            XX
ZIP              99999-9999


MAIL TO INFORMATION:
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       PHONE        (999)999-9999       EXT     9999
ADDRESS 2        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY             XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE            XX
ZIP              99999-9999


BANK INFORMATION:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX          PHONE            (999)999-9999     EXT
XXXX
ADDRESS 2        XXXXXXXXXXXXXXXXXXXXXXXXXXXXX          EFT TYPE          X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY             XXXXXXXXXXXXXXXXXXXXXXXXXXXXX          ACCOUNT TYPE      X  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE            XX                                     ABA ROUTING NBR   XXXXXXXXX
ZIP              99999-9999                             ACCOUNT NBR       XXXXXXXXXXXXXXXXX


AFFILIATE SSN    AFFILIATE NAME                         AFFILIATE DOB
999-99-9999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY
999-99-9999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY
999-99-9999      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/CCYY

TRADING PARTNER ID     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

METHOD OF RETRIEVAL    X

PROVIDER AGENT INFORMATION - EFT:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION - EFT:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE            (999)999-9999
```


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```
PROVIDER AGENT INFORMATION - ERA:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION - ERA:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE            (999)999-9999

CLEARINGHOUSE INFORMATION:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      E-MAIL  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTACT NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      PHONE   (999)999-9999

VENDOR INFORMATION:
NAME             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      E-MAIL  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTACT NAME     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      PHONE   (999)999-9999


< … PROVIDER AGREEMENT  …>

PROVIDER SIGNATURE : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TITLE:               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

7.1.18 PRV-A079-D—Provider Web App Facsimile – Group Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A079-D - Provider Web App Facsimile – Group Report.

Field	Description	Data Type	Length
Additional Taxonomy	Additional Taxonomy code	Character	10
Affiliate Name	Name of affiliate, such as an owner, partner, etc.	Character	35
Affiliate SSN	Social Security Number of the listed affiliate.	Character	11
Affiliate DOB	Date of Birth of listed affiliate.	Date (MM/DD/CCYY)	10
Agency Review Indicator	Indicates the application needs to be sent to the Agency for review purposes. Valued values: Y = Yes or Blank = No.	Character	1
Application Tracking Number	Tracking Number generated by the web portal product.	Character	10
Bank Information: ABA Routing NBR	Bank routing number associated to the EFT information indicated on the web application.	Character	9

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Field	Description	Data Type	Length
Bank Information: Account NBR	Bank account number associated to the EFT information on the web application.	Character	17
Bank Information: ABA Routing Number	Bank routing number associated to the EFT information indicated on the web application.	Character	9
Bank Information: Account Number	Bank account number associated to the EFT information on the web application.	Character	17
Bank Information: Account Type	Type of account associated to the EFT information indicated on the web application. C = Checking S = Savings	Character	1
Bank Information: Address 1	Bank address line 1.	Character	30
Bank Information: Address 2	Bank address line 2.	Character	30
Bank Information: City	Name of city for the bank.	Character	30
Bank Information: EFT Type	EFT Type as indicated on the web application. D = Deposit W = Withdrawal	Character	1
Bank Information: Name	Name of the bank associated to the provider's EFT information indicated on the web application.	Character	39
Bank Information: Phone	Phone number for the bank.	Character	13
Bank Information: State	State of Bank address.	Character	2

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Field	Description	Data Type	Length
Bank Information: Zip	Complete Postal code for the address. (Zip - +4)	Character	4
Business Name	Name of group indicated on the web portal product application.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Clearinghouse Information: Contact Name	Name of contact at Clearinghouse.	Character	50
Clearinghouse Information: E-mail	An electronic mail address at which the health plan might contact the provider's clearinghouse.	Character	50
Clearinghouse Information: Name	Official name of the provider's clearinghouse.	Character	50
Clearinghouse Information: Phone	Telephone number of contact.	Character	13
Contact Information: E-mail	E-mail address of contact person.	Character	50
Contact Information: Ext	Extension associated to contact person phone number.	Character	4
Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13
Contact Information: Title	Title of contact person.	Character	40
County	County code based on service location.	Character	2
Enrollment Type	Type of Enrollment selected on the web portal product application, such as Individual, Group, etc.	Character	1

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Field	Description	Data Type	Length
First Name	First name of the individual provider enrolling. N/A for this report.	Character	15
Last Name	Last name of individual provider enrolling. N/A for this report.	Character	20
MI	Middle initial of individual provider enrolling. N/A for this report.	Character	1
Mail To Information: Address 1	Provider's mail to address as indicated on the web application.	Character	30
Mail To Information: Address 2	Provider's mail to address, line 2, as indicated on the web application.	Character	30
Mail To Information: City	City of provider's mail to address as indicated on the web application.	Character	30
Mail To Information: E-mail	E-mail address of the provider's mail to address as indicated on the web application.	Character	50
Mail To Information: Ext	Ext of mail to phone number as indicated on the web application.	Character	4
Mail To Information: Phone	Mail to phone number of the mail to address as indicated on the web application.	Character	13
Mail To Information: State	State of the provider's mail to address as indicated on the web application.	Character	2
Mail To Information: Zip	Zip +4 of the provider's mail to address as indicated on the web application.	Character	10
Method of Retrieval	The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15

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Field	Description	Data Type	Length
Organizational Type	Type of organization: A = Individual Practitioner B = Sole Proprietorship C = Government Owned D = Business Corporation, for profit E = Business Corporation, non-profit F = Private, for profit G = Private, non-profit H = Partnership I = Trust J = Chain	Character	1
Pay To Information: Address 1	Provider's pay to address as indicated on the web portal product application.	Character	30
Pay To Information: Address 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Pay To Information: City	City of provider's pay to address as indicated on the web application.	Character	30
Pay To Information: E-mail	E-mail address associated to the provider's pay to address as indicated on the web application.	Character	50
Pay To Information: Ext	Extension number for the given phone.	Character	4
Pay To Information: Fax	Fax number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Phone	Phone number associated to the provider's pay to address as indicated on the web application.	Character	13

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Field	Description	Data Type	Length
Pay To Information: State	State of the provider's pay to address as indicated on the web application.	Character	2
Pay To Information: Toll Free	Toll free number associated to the provider's pay to address as indicated on the web application.	Character	13
Pay To Information: Zip	Zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Provider Agent Contact Information-EFT: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-EFT: Name	Name of a contact in agent office for handling EFT issues.	Character	50
Provider Agent Contact Information-EFT: Phone	Phone number associated with contact person.	Character	13
Provider Agent Contact Information-ERA: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information-ERA: Name	Name of a contact in agent office for handling ERA issues.	Character	50
Provider Agent Contact Information-ERA: Phone	Phone number associated with contact person.	Character	13
Provider Agent Information-EFT: Name	Name of provider's authorized agent.	Character	50

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Field	Description	Data Type	Length
Provider Agent Information-ERA: Name	Name of provider's authorized agent.	Character	50
Provider Signature	This name represents the electronic signature for a provider.	Character	50
Provider Type	Provider's type selected on the web portal product application.	Character	2
Requesting Enrollment Effective Date	Requested Enrollment Effective Date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
Service Location Information: Address 1	Provider's physical service location.	Character	30
Service Location Information: Address 2	Provider's physical service location, address line 2.	Character	30
Service Location Information: City	City of provider's physical service location.	Character	30
Service Location Information: E-mail	E-mail address associated to the provider's physical service location.	Character	50
Service Location Information: Ext	Extension number for the given phone.	Character	4
Service Location Information: Fax	Provider's physical service location fax number.	Character	13
Service Location Information: Phone	Phone number associated to the provider's physical service location.	Character	13
Service Location Information: State	State of provider's physical service location.	Character	2

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Field	Description	Data Type	Length
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
Service Location Information: Zip	Zip +4 of the provider's physical service location.	Character	10
Specialty	Provider's specialty selected on the web portal product application.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Tax ID	Tax Identification number as indicated on the web application.	Character	9
Tax ID Type	Tax Identification number type (FEIN = F or SSN = S) as indicated on the web application.	Character	1
Tax Name	Tax name as indicated on the web application.	Character	40
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title	Printed Title of Person Submitting Enrollment	Character	40
Title (at bottom)	Printed Title of Person Submitting Enrollment	Character	40
Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.	Character	35
Vendor Information: Contact Name	Name of a contact in vendor office for handling ERA issues.	Character	50
Vendor Information: E-mail	An electronic mail address at which the health plan might contact the provider's vendor.	Character	50
Vendor Information: Name	Name of vendor office for handling ERA issues.	Character	50
Vendor Information: Phone	Telephone number of vendor.	Character	13

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PRV-A080-D - Provider Web App Secondary Facsimile - Group Report

7.1.19 PRV-A080-D - Provider Web App Secondary Facsimile - Group Report Narrative

This report details the facsimile information of provider enrollment data coming from the web portal for a group enrollment that has been modified.

7.1.20 PRV-A080-D - Provider Web App Secondary Facsimile - Group Report Layout

```
Report  : PRV-A080-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD310                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_SEC_FACS                     PROVIDER WEB APP SECONDARY FACSIMILE - GROUP                    Page    :    999,999
-------------------------------------------------------------------------------------------------------------------------------
Application Tracking Number         NPI                 Business Name
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        LAST NAME              FIRST NAME        MI         TITLE
                                                        XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   X          XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
SPECIALTY       SPECIALTY DESCRIPTION                                      PRIMARY             TAXONOMY CODE
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX X                   XXXXXXXXXX
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX X                   XXXXXXXXXX

CLIA #          XXXXXXXXXX          CLIA Eff Date   mm/DD/CCYY
```

7.1.21 PRV-A080-D—Provider Web App Secondary Facsimile - Group Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A080-D - Provider Web App Secondary Facsimile - Group Report.

Field	Description	Data Type	Length
Application Tracking Number	Tracking Number generated by the web portal product.	Character	10
Business Name	Name of the facility or group indicated on the web portal product application.	Character	50
CLIA #	Provider's CLIA number indicated on the web portal product application.	Character	10
CLIA Eff Date	CLIA certification effective date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
First Name	First name of the individual provider enrolling. N/A for this report.	Character	15
Last Name	Last name of individual provider enrolling. N/A for this report.	Character	20

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Field	Description	Data Type	Length
MI	Middle initial of individual provider enrolling. N/A for this report.	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	1
Specialty	Provider's specialty code.	Character	3

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PRV-A081-D - Provider Web App Facsimile – OPR Report

7.1.22 PRV-A081-D - Provider Web App Facsimile – OPR Report Narrative

This report details facsimile information of provider enrollment data coming from the web portal for a provider who is either Ordering, Prescribing, or Referring.

7.1.23 PRV-A081-D - Provider Web App Facsimile – OPR Report Layout

```
Report  : PRV-A081-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_APP_FACS                          PROVIDER WEB APP FACSIMILE - OPR                           Page    :    999,999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER TYPE                       TAX ID              LAST NAME             FIRST NAME        MI          TITLE
XX                                  XXXXXXXXX           XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX   X           XXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
ENROLLMENT TYPE                         X                                 AGENCY REVIEW INDICATOR     X
REQUESTING ENROLLMENT EFFECTIVE DATE    MM/DD/CCYY

SSN           999-99-9999                           BIRTH DATE              MM/DD/CCYY
LICENSE #     XXXXXXXXXX        LICENSE STATE   XX  LICENSE EFFECTIVE DATE  MM/DD/CCYY       LICENSE END DATE  MM/DD/CCYY

DEA #                           XXXXXXXXX
DEA EFFECTIVE DATE              MM/DD/CCYY

PROVIDER TYPE   XX - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

SPECIALTY   SPECIALTY DESCRIPTION                                         PRIMARY         TAXONOMY CODE
XXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          X               XXXXXXXXXX
XXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          X               XXXXXXXXXX

COLLABORATING PHYSICIAN NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COLLABORATING PHYSICIAN NPI             XXXXXXXXXXXXXXXX

CONTACT INFORMATION:
NAME            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      TITLE        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE           (999)999-9999       EXT   9999                            FAX          (999)999-9999


SERVICE LOCATION INFORMATION:
E-MAIL          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS 1       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            PHONE        (999)999-9999       EXT     9999
ADDRESS 2       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            FAX          (999)999-9999       EXT     9999
CITY            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                            TOLL FREE    (999)999-9999       EXT     9999
STATE           XX
```


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```
ZIP              99999-9999

DISCLOSURE QUESTION AND ANSWERS (Y OR N INDICATOR AND FREE FORM TEXT ENTERED FOR Y ANSWERS.)
 1         XXXX
```

```
      X    XXXX
```

Field	Description	Data Type	Length
Birth Date	Date of birth of the individual provider enrolling.	Date (MM/DD/CCYY)	10
Business Name	Name indicated on the web portal product application.	Character	50
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the enrolling nurse practitioner.	Character	50
Contact Information: E-mail	E-mail address of contact person.	Character	50
Contact Information: Ext	Extension associated to the contact person's phone number.	Character	4
Contact Information: Fax	Fax number of contact person.	Character	13
Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Contact Information: Phone	Phone number of contact person.	Character	13
Contact Information: Title	Printed Title of Person Submitting Enrollment.	Character	40
DEA #	DEA certification number of the individual provider enrolling.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual enrolling provider.	Date (MM/DD/CCYY)	10
Date	Date the application agreement was signed.	Date (MM/DD/CCYY)	10
Disclosure Answers - 1-19 Text	Answers to disclosure questions on the web application.	Character	500
Disclosure Answers 1-19 Indicator	Answer indicators to disclosure questions on the web application. Valid values will be Y = Yes, and N = No.	Character	1

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Field	Description	Data Type	Length
Disclosure Questions - 1 -19 Text	Disclosure questions from the web application.	Character	1500
Enrollment Type	Type of Enrollment selected on the web portal product application, such as Individual, Group, OPR, etc.	Character	10
First Name	First name of the individual provider enrolling.	Character	15
Last Name	Last name of individual provider enrolling.	Character	20
License #	Number of the professional license of the individual provider enrolling.	Character	10
License Effective Date	Effective date of the provider's professional license.	Date (MM/DD/CCYY)	10
License End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
License State	State in which the provider's professional license was issued.	Character	2
MI	Middle initial of individual provider enrolling.	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Primary	Primary indicator related to the provider specialty selected by provider on the web portal product application.	Character	10
Provider Signature	This name represents the electronic signature for a provider.	Character	50
Provider Type	Provider's type selected on the web portal product application. Only the provider type code is displayed in the index area of the report but both the code and description is displayed in the body of the report.	Character	55
Requesting Enrollment Effective Date	Requesting Enrollment Effective Date indicated on the web portal product application.	Date (MM/DD/CCYY)	10
SSN	Social Security Number of individual provider enrolling.	Character	11

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Field	Description	Data Type	Length
Service Location Information: Address 1	Provider's service location address as indicated on the web application.	Character	30
Service Location Information: Address 2	Provider's service location address, line 2, as indicated on the web application.	Character	30
Service Location Information: City	City of the provider's service location address as indicated on the web application.	Character	30
Service Location Information: E-mail	E-mail address of the provider's service location address as indicated on the web application.	Character	50
Service Location Information: Ext	Extension number for the given phone.	Character	4
Service Location Information: Fax	Fax number associated to the provider's service location address as indicated on the web application.	Character	13
Service Location Information: Phone	Phone number of the service location address as indicated on the web application.	Character	13
Service Location Information: State	State on the provider's service location address as indicated on the web application.	Character	2
Service Location Information: Toll Free	Toll free number of the provider's physical service location.	Character	13
Service Location Information: Zip	Zip +4 of the provider's service location address as indicated on the web application.	Character	10
Specialty	Provider's specialty code.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Tax ID	Tax identification number as indicated on the web application.	Character	9

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Field	Description	Data Type	Length
Taxonomy Code	Provider's taxonomy code selected on the web portal product application.	Character	10
Title (at bottom)	Printed Title of Person Submitting Enrollment.	Character	40

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PRV-A082-D - Provider Web App Secondary Facsimile – OPR Report

7.1.25 PRV-A082-D - Provider Web App Secondary Facsimile – OPR Report Narrative

This report details the facsimile information of provider enrollment data coming from the web portal for an OPR enrollment that has been modified.

7.1.26 PRV-A082-D - Provider Web App Secondary Facsimile – OPR Report Layout

```
Report  : PRV-A082-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD310                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_SEC_FACS                      PROVIDER WEB APP SECONDARY FACSIMILE - OPR                     Page    :    999,999
-------------------------------------------------------------------------------------------------------------------------------
APPLICATION TRACKING NUMBER         NPI                 BUSINESS NAME
9999999999                          999999999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                        LAST NAME              FIRST NAME        MI
                                                        XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   X
-------------------------------------------------------------------------------------------------------------------------------
SPECIALTY       SPECIALTY DESCRIPTION                                      PRIMARY             TAXONOMY CODE
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         X                   XXXXXXXXXX
999             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         X                   XXXXXXXXXX

LICENSE INFORMATION:
LICENSE #     9999999999            EFFECTIVE DATE  MM/DD/CCYY
STATE         XX                    END DATE        MM/DD/CCYY


DEA #                               99AA99999
DEA EFFECTIVE DATE                  MM/DD/CCYY

COLLABORATING PHYSICIAN NAME        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
COLLABORATING PHYSICIAN NPI         XXXXXXXXXXXXXXX
```

7.1.27 PRV-A082-D—Provider Web App Secondary Facsimile – OPR Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the PRV-A082-D - Provider Web App Secondary Facsimile – OPR Report.

Field	Description	Data Type	Length
Application Tracking Number	Tracking number generated by the web portal product.	Character	10
Business Name	Name of group indicated on the web portal product application. N/A for this report.	Character	50

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Field	Description	Data Type	Length
Collaborating Physician NPI	National Provider Identifier of the collaborating (supervising) physician of the nurse practitioner.	Character	15
Collaborating Physician Name	Name of the collaborating (supervising) physician of the nurse practitioner.	Character	50
DEA #	DEA certification number of the provider.	Character	9
DEA Effective Date	Effective date of the DEA certification of the individual provider.	Date (MM/DD/CCYY)	10
First Name	First name of the provider.	Character	15
Last Name	Last name of the provider.	Character	20
License Information: Effective Date	Effective date of provider's professional license.	Date (MM/DD/CCYY)	10
License Information: End Date	End date of the provider's professional license.	Date (MM/DD/CCYY)	10
License Information: License #	Number of the professional license of the provider.	Character	10
License Information: State	State in which the provider's professional license was issued.	Character	2
MI	Middle initial of the provider.	Character	1
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Primary	Primary indicator related to the provider specialty.	Character	1
Specialty	Provider's specialty code selected on the web portal product application.	Character	3
Specialty Description	Provider's specialty description selected on the web portal product application.	Character	50
Taxonomy Code	Provider's taxonomy code.	Character	10

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PRV-A083-D – Provider EFT Facsimile Report

7.1.28 PRV-A083-D – Provider EFT Facsimile Report Narrative

This report details facsimile information of provider maintenance data coming from the web portal for EFT changes.

7.1.29 PRV-A083-D – Provider EFT Facsimile Report Layout

```
Report  : PRV-A083-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_EFTERA_FACS                            PROVIDER EFT FACSIMILE                                Page    :    999,999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
NPI               MCD ID              PROVIDER NAME                           APPLICATION TRACKING NUMBER     TAX ID
XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999                      XXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------

OTHER IDENTIFIER       XXXXXXXXXXXXXXX
ASSIGNING AUTHORITY    XXXXXXXX

PROVIDER ADDRESS:
STREET 1               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STREET 2               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE                  XX
ZIP                    99999-9999

PROVIDER CONTACT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TITLE   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                  (999)999-9999       EXT  9999                          FAX     (999)999-9999

PROVIDER AGENT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                  (999)999-9999

FINANCIAL INSTITUTION INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STREET 1               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PHONE     (999)999-9999      EXT     9999
STREET 2               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE                  XX
ZIP                    99999-9999
```


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```
TYPE OF ACCOUNT        X - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ABA ROUTING NUMBER     XXXXXXXXX
ACCOUNT NUMBER         XXXXXXXXXXXXXXXXX
ACCOUNT LINKAGE NPI    XXXXXXXXXXXXXXXXX
SUBMISSION CD          X

< Provider Agreement >
ELECTRONIC SIGNATURE:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TITLE:                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

7.1.30 PRV-A083-D – Provider EFT Facsimile Report Field Descriptions

Field	Description	Data Type	Length
ABA Routing Number	Financial institution routing number associated to the EFT information indicated on the web application.	Character	9
Account Linkage NPI	National Provider Identifier to which EFT account is linked.	Character	15
Account Number	Financial institution account number associated to the EFT information on the web application.	Character	17
Application Tracking Number	Tracking number generated by the web portal product.	Character	10
Assigning Authority	Assigning Authority of ‘Other Identifier – Medicaid’ is the default value for the enrollment portal page.	Character	2
Electronic Signature	This name represents the electronic signature for a provider.	Character	50
Financial Institution Information: City	Name of city for the financial institution.	Character	30
Financial Institution Information: Ext	Extension number for the given phone.	Character	4
Financial Institution Information: Name	Name of the financial institution associated to the provider's EFT information indicated on the web application.	Character	39
Financial Institution Information: Phone	Phone number for the financial institution.	Character	13
Financial Institution Information: State	State code corresponding to the address.	Character	2

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Field	Description	Data Type	Length
Financial Institution Information: Street 1	Financial Institution's address line 1.	Character	30
Financial Institution Information: Street 2	Financial Institution's address line 2.	Character	30
Financial Institution Information: Zip	Complete postal code for the address. (Zip - +4)	Character	10
MCD ID	Provider's Medicaid number.	Character	15
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Other Identifier	Other identifier provider may enter for EFT/ERA enrollments. Usually the MCD ID.	Character	15
Provider Address: City	Pay to city of provider's pay to address as indicated on the web application.	Character	30
Provider Address: State	Pay to state of the provider's pay to address as indicated on the web application.	Character	2
Provider Address: Street 1	Provider's pay to address as indicated on the web application.	Character	30
Provider Address: Street 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Provider Address: Zip	Pay to zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Provider Agent Contact Information: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information: Name	Name of a contact in agent office for handling ERA issues.	Character	50
Provider Agent Contact Information: Phone	Phone number associated with contact person.	Character	13
Provider Agent Information: Name	Title of contact person indicated on the web portal product application.	Character	40
Provider Contact Information: Email	An electronic mail address at which the health plan might contact the provider.	Character	50

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Field	Description	Data Type	Length
Provider Contact Information: Ext	Extension associated to contact person phone number.	Character	4
Provider Contact Information: Fax	The contact fax number of the applicant as provided on the enrollment application.	Character	13
Provider Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Provider Contact Information: Phone	Phone number of contact person.	Character	13
Provider Contact Information: Title	Title of contact person indicated on the web portal product application.	Character	40
Provider Name	Provider's Name, either business or personal.	Character	35
Submission CD	Code that indicates if submission was for following reasons: • N=New • C=Change • X=Cancel	Character	1
Tax ID	Tax Identification number as indicated on the web application.	Character	9
Title	Printed Title of Person Submitting Enrollment.	Character	40
Type of Account	Type of account associated to the EFT information indicated on the web application. Code and description. • C - Checking • S - Savings	Character	51

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PRV-A084-D – Provider ERA Facsimile Report

7.1.31 PRV-A084-D – Provider ERA Facsimile Report Narrative

This report details facsimile information of provider maintenance data coming from the web portal for ERA changes.

7.1.32 PRV-A084-D – Provider ERA Facsimile Report Layout

```
Report  : PRV-A084-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : PRVJD215                            MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: PRV_EFTERA_FACS                            PROVIDER ERA FACSIMILE                                Page    :    999,999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
NPI               MCD ID              PROVIDER NAME                           APPLICATION TRACKING NUMBER     TAX ID
XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     9999999999                      XXXXXXXXX

-------------------------------------------------------------------------------------------------------------------------------

OTHER IDENTIFIER       XXXXXXXXXXXXXXX
ASSIGNING AUTHORITY    XXXXXXXX

PROVIDER ADDRESS:
STREET 1               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STREET 2               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITY                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
STATE                  XX
ZIP                    99999-9999

PROVIDER CONTACT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    TITLE   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                  (999)999-9999       EXT  9999                          FAX     (999)999-9999

PROVIDER AGENT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER AGENT CONTACT INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                  (999)999-9999

SUBMISSION CD          X
TRADING PARTNER ID     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
AGGREGATION NPI        XXXXXXXXXXXXXXX
ERA DOWNLOAD METHOD    X

CLEARINGHOUSE INFORMATION:
NAME                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTRACT NAME          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
E-MAIL                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                   (999)999-9999
```

```
VENDOR INFORMATION:
NAME                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CONTRACT NAME           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
E-MAIL                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PHONE                   (999)999-9999

< Provider Agreement >

ELECTRONIC SIGNATURE:   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
TITLE:                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

7.1.33 PRV-A084-D – Provider ERA Facsimile Report Field Descriptions

Field	Description	Data Type	Length
Application Tracking Number	Tracking Number generated by the web portal product.	Character	10
Aggregation NPI	NPI to which ERAs are aggregated.	Character	15
Assigning Authority	Assigning Authority of 'Other Identifier – Medicaid' is the default value for the enrollment portal page.	Character	2
Clearinghouse Information: Email	An electronic mail address at which the health plan might contact the provider's clearinghouse.	Character	50
Clearinghouse Information: Contact Name	Name of contact at clearinghouse.	Character	50
Clearinghouse Information: Name	Official name of the provider's clearinghouse.	Character	50
Clearinghouse Information: Phone	Telephone number of contact.	Character	13
ERA Download Method	The method in which the provider will receive the ERA from the health plan. Valid values are: • 1-Web Download from Health Plan-Software Vendor • 2-Web Download from Health Plan-Clearinghouse • 3-Web Download from Health Plan-Direct Access/Download • 4-State Agency Main Office Connect Direct	Character	1

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Field	Description	Data Type	Length
	• 5-State Agency Provider Disbursement from Main Office • 6-Other		
Electronic Signature	This name represents the electronic signature for a provider.	Character	50
MCD ID	Provider's Medicaid number.	Character	15
NPI	Provider's National Provider Identifier number indicated on the web portal product application.	Character	15
Other Identifier	Other identifier provider may enter for EFT/ERA enrollments. Usually the MCD ID.	Character	15
Provider Address: City	Pay to city of provider's pay to address as indicated on the web application.	Character	30
Provider Address: State	Pay to state of the provider's pay to address as indicated on the web application.	Character	2
Provider Address: Street 1	Provider's pay to address as indicated on the web application.	Character	30
Provider Address: Street 2	Provider's pay to address, line 2, as indicated on the web application.	Character	30
Provider Address: Zip	Pay to zip +4 of the provider's pay to address as indicated on the web application.	Character	10
Provider Agent Contact Information: E-mail	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Agent Contact Information: Name	Name of a contact in agent office for handling ERA issues.	Character	50
Provider Agent Contact Information: Phone	Phone number associated with contact person.	Character	13
Provider Agent Information: Name	Title of contact person indicated on the web portal product application.	Character	40
Provider Contact Information: Email	An electronic mail address at which the health plan might contact the provider.	Character	50
Provider Contact Information: Ext	Extension associated to contact person phone number.	Character	4

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Field	Description	Data Type	Length
Provider Contact Information: Fax	The contact fax number of the applicant as provided on the enrollment application.	Character	13
Provider Contact Information: Name	Name of contact person indicated on the web portal product application.	Character	50
Provider Contact Information: Phone	Phone number of contact person.	Character	13
Provider Contact Information: Title	Title of contact person indicated on the web portal product application.	Character	40
Provider Name	Provider's Name, either business or personal.	Character	35
Submission CD	Code that indicates if submission was for following reasons: • N=New • C=Change • X=Cancel	Character	1
Tax ID	Tax Identification number as indicated on the web application.	Character	9
Title	Printed Title of person submitting enrollment	Character	40
Trading Partner ID	The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.	Character	35
Vendor Information: Contact Name	Name of a contact in vendor office for handling ERA issues.	Character	50
Vendor Information: E-mail	An electronic mail address at which the health plan might contact the provider's vendor.	Character	50
Vendor Information: Name	Name of vendor office for handling ERA issues.	Character	50
Vendor Information: Phone	Telephone number of contact.	Character	13

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AMMIS Recipient Call Center Operations Manual

01/15/2015

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

HP Enterprise Services
301 Technacenter Drive
Montgomery, Alabama 36117

Version 1.1

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Recipient Call Center Operations Manual
Version:	1.1
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/RCC
Owner:	HPES/Agency
Author:	
Approved by:	
Approval Date:	10/06/2011

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
09/06/2011	0.1		Updated due to EIP - Recipient Web Portal enhancement	
09/27/2011	0.2		Responded to Agency comments received on 09/16/2011.	
10/06/2011	1.0		Agency approved	
01/15/2015	1.1		General updates	

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 INTRODUCTION

The Recipient Call Center (RCC) functional area provides assistance to current and prospective recipients in the Alabama Medicaid program. RCC answers calls regarding:

- Patient 1st
- Program policies
- Non-Emergency Transportation
- General inquiries and information
- Claim and prior authorization status
- Recipient eligibility
- Medicaid ID card requests
- Demographic information updates
- Requests for applications
- Recipient Web Portal

Callers contact RCC via the toll-free number (1-800-362-1504) or, for hearing impaired recipients, through Telecommunications Device for the Deaf/Teletype (TDD/TTY) equipment over the toll-free number (1-800-253-0791) used to accommodate this equipment.

2.1 RECIPIENT CALL CENTER UNIT FUNCTIONS

The Recipient Call Center unit consists of the following:

- Recipient Inquiry Unit (RIU)
- Customer Service Unit (CSU)

2.2 RECIPIENT CALL CENTER FORMS

All forms referenced in this document can be found on the ALXIX account website at http://eds-alxix/ in the Recipient Call Center Team page.

2.3 RECIPIENT CALL CENTER TASKS

The following list identifies the tasks most frequently performed by the Recipient Call Center functional unit:

1. Process Patient 1st forms (Form 349).
2. Process Patient 1st county code reassignments.
3. Process Patient 1st exemptions.
4. Remove Medicare recipients assigned to Patient 1st (Medicare recipients are not eligible to receive Patient 1st).
5. Discuss the status of a claim as it applies to each program.
6. Provide Medicaid coverage information for prescription drugs based on a National Drug Code (NDC) lookup.
7. Perform program eligibility verification.
8. Answer basic eligibility questions for all aid categories including eligibility requirements and how to apply for aid.
9. Discuss benefit limits for each program.

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10. Initiate voucher requests for Non-Emergency Transportation (NET). The following information is obtained and forwarded to the NET office:
    - Date of request
    - Requester's name
    - Requester's relationship
    - Requester's phone number
    - Recipient Social Security Number
    - Recipient name
    - Recipient date of birth
    - Recipient address
    - Recipient phone number
    - Recipient information on file
    - Recipient's doctor's First and Last Name
    - Doctor's address
    - Doctor's phone number
    - Appointment date
    - Appointment time
    - Reason for appointment
    - Mode of transport
    - If recipient is confined to a wheelchair or uses a cane
    - Diagnostic reason for use of wheelchair or cane
    - If special transportation assistance is required
11. Answer basic questions regarding NET EBT card and its usage.
12. Transfer recipient calls about the NET EBT card to the EBT help desk at 1-877-391-4757.
13. Refer all calls regarding the Medicare Part D program or Low Income Subsidy Program to either the Social Security Administration (SSA) or the local Area Agencies on Aging.
15. Process replacement Medicaid ID card requests.
16. Process replacement ID card requests for recipients from out-stationed workers.
17. Process requests for temporary Medicaid ID cards.
18. Fulfill requests for Medicaid program applications received via the call center and voice mail.
19. For Family Certification cases, update eligibility screen MSSBR to change name, address, phone number, county code, marital status, date of birth, race, and/or sex for Medicaid for Low-Income Families (MLIF), SOBRA, and Plan First certified cases.
20. For District Office cases, update eligibility file to change the beneficiary's primary or secondary address, county code, applicant's marital status and date of marriage or divorce, sponsor's address and phone number on the MSAPU screen. Update spouse's name, address, DOB, SSN, and/or phone number on the MSAPU screen.
21. For recipients who are unable to log into the Recipient Portal, if they have registered on the portal in the past, explain how to request the user ID be emailed to them and how they can request a password reset. If they are unable to do these actions, transfer the recipient to a team leader or supervisor for assistance in resetting their password. If the recipient/user is unable to log in and the RCC Agent determines that the user has been BLOCKED, RCC will instruct the user to contact the Medicaid Agency Privacy and Security department to discuss the conditions with that department. (Currently they are to be given the names to contact as Clay Gaddis or Katharine Sisk.)
22. Notify a recipient's assigned worker of a requested change in the event an error message is returned when attempting to update the eligibility file.
23. Screen calls for District Offices by answering eligibility questions for the following Medicaid programs:

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- Nursing Home eligibility
- Intermediate Care Facility/Mentally Retarded (ICF/MR) eligibility
- Home and Community-Based Services (HCBS) eligibility
- Post-extended hospital care eligibility
- Medicare Savings Programs (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Income Groups (QI1), and Qualified Disabled Working Individuals (QDWI)) eligibility
- Supplemental Security Income (SSI) related cases, such as Disabled Adult Child (DACs), Retroactive SSI, PICKLE, and widow/widower eligibility

24. Receive, log, and file returned Medicaid ID cards that were not delivered to the recipient.

- HPES stores these cards for 6 months in case the recipient calls for the card. After 6 months, the card is destroyed in a chipper-style shredder and discarded in the trash.

25. Address policy questions for the following programs: (Detailed information regarding policy is available in the Medicaid Provider Manual: (http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx)

- Ambulance (Ground and Air)
- Ambulatory Surgical Centers (ASC)
- Anesthesiology
- Audiology/Hearing Services
- Children's Specialty Clinics
- Chiropractor
- Comprehensive Outpatient Rehabilitative Facilities (CORF)
- Dental
- Durable Medical Equipment (DME)
- Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)
- Eye Care Services
- Family Planning
- Federally Qualified Health Centers (FQHC)
- Health Departments
- Home Health
- Hospice
- Hospital
- Independent Certified Registered Nurse Practitioner (CRNP)
- Independent Laboratory
- Independent Radiology
- Independent Rural Health Clinics (RHC)
- Licensed Social Workers
- Maternity Care Program
- Nurse Midwife
- Nursing Homes
- Patient 1st
- Pharmacy
- Physician Services
- Plan First
- Podiatrist

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- Preventative Health
- Private Duty Nursing
- Prior Authorization
- Provider Based Rural Health Clinics
- Psychologist
- Targeted Case Management (TCM)
- Therapy (Occupational, Physical, and Speech)
- Third Party Liability (TPL)
- Vaccines for Children
- Elderly & Disabled Wavier
- Living-at-Home Waiver
- Mentally Retarded Waiver
- State of Alabama Independent Living Waiver (SAIL)
- Technology Assisted Waiver for Adults (TA)
- Auto-Immune Deficiency Syndrome (AIDS) Waiver

2.4 INPUT, PROCESSES, AND OUTPUT

2.4.1 Input

The table below documents the requests to the Recipient Call Center functional area:

Common Recipient Call Center Input

Input	Source	Purpose
Agency correspondence	Agency	To request information and status on the Recipient Call Center. To provide requested answers to the Recipient Call Center.
Recipient correspondence	Recipient	To request information about Alabama Medicaid. To provide updated information on the Recipient, such as name or address change.
Recipient requests	Potential recipients	To request enrollment materials and other information on the Alabama Medicaid program.
Provider requests	Provider	To request information about Alabama Medicaid. To provide Patient 1st update information regarding recipient assignments.

2.4.2 Processes

Processes accomplished in the Recipient Call Center functional unit include the following:

- Recipient calls
- Patient 1st updates
- NET requests
- Written correspondence
- Caseworker requests
- Power of Attorney documents
- Medicaid correspondence
- Returned Medicaid Cards

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Recipient Calls

The RCC Agents handle inbound and outbound calls from the recipient community regarding the following:

- Patient 1st
- Program Policy
- Non-Emergency Transportation
- General Inquiries and Information
- Claim and Prior Authorization Status
- Recipient Eligibility
- Medicaid ID Card Requests
- Demographic Information Updates
- Recipient Web Portal Assistance

Patient 1st Updates

RCC handles written requests to change a recipient's Patient 1st provider. These requests are submitted by recipients, providers, or care coordinators. The purpose of these requests is to link Medicaid recipients with a Primary Medical Provider (PMP). The PMP acts as the coordinator to provide and arrange for most of the recipient's health care needs.

To be considered for Patient 1st exemption, a Patient 1st Medical Exemption Request Form must be completed by the enrollee's physician. If the physician believes the recipient has a medical condition which excludes him/her from participating in the program, the form is then submitted for review and approval. RCC forwards these forms to the Agency to be approved. Also, exemptions are submitted when a recipient is a foster child, is institutionalized, or is in a group home. These requests are handled by RCC supervisors.

A PMP may request removal of a recipient from his panel due to good cause, according to the guidelines listed in the 1915(b) (i) waiver of the Social Security Act which allows the operation of the Patient 1st program. Good cause can be described as behavior on the part of the recipient which is disruptive, unruly, abusive, or uncooperative where the ability of the provider to administer services to the recipient or other affected recipients is seriously impaired. Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or fraudulent use of the Medicaid ID card also applies. Additionally, a Patient 1st enrollee may be removed for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice and prior written notice has been provided to the enrollee. RCC receives the requests for patients to be removed from a PMP's panel. These requests are forwarded to the Agency for processing.

RCC provides written responses to recipients who request Patient 1st changes that cannot be completed. The written response includes a letter detailing why the request cannot be completed, a copy of the original Patient 1st change form, and, when necessary, a list of Patient 1st providers for the recipient's area.

When a provider submits a Patient 1st change request that cannot be completed, the RCC staff faxes the provider's office detailing why the request cannot be completed.

NET Requests

RCC processes NET requests that provide reimbursement for necessary non-ambulance transportation services to Medicaid recipients. These requests are forwarded to the NET department via FEITH Forms iQ and Workflow applications.

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Written/Email Correspondence

Recipients submit written/email requests for responses to issues such as claim status, applications, card requests, and address updates. RCC responds to these requests with outbound calls and written or email correspondences.

Insurance companies submit or request information regarding Third Party Liability (TPL). This information is forwarded to the TPL Unit at the Agency for handling.

Caseworker Requests

Agency caseworkers can request new or replacement cards be sent out to recipients once the recipient's file has been updated. Caseworkers perform this task by sending a request through online mail (MSMM transaction) or e-mail in the Alabama Medicaid Agency Eligibility Screens (AMAES) system.

Power of Attorney Requests

Often, a recipient's Power of Attorney (POA) contacts RCC requesting information or assistance regarding the recipient's file. The RCC staff does not divulge information without proof that the caller has POA over the recipient. The RCC staff instructs the person holding POA to either fax or mail copies of POA documentation to the attention of the Recipient Call Center at HPES. RCC supervisors or team leaders then update a spreadsheet containing such information and distribute to all RCC staff.

Medicaid Correspondence

The Agency forwards generated reports based on system updates and status of recipient files. These reports include:

- Eligible Recipients who have not received a Medicaid ID card (the RCC staff issues a card to eligible recipients).
- Recipients who are deceased or whose card was returned 6 months ago or more (the RCC staff destroys these cards).
- Report of Recipients with returned plastic cards with address changes, Re-issuances and Reactivations (the RCC staff updates recipient information and send a replacement card).

The Agency's Third Party Liability (TPL) unit also forwards returned TPL letters to RCC for staff members to complete address updates when possible.

2.4.3 Output

The table below documents the outputs from the Recipient Call Center functional area:

Common Recipient Call Center Output

Output	Source	Purpose
HPES correspondence	Recipient Call Center	To communicate a response to Agency correspondence. To communicate a response to recipient correspondence. To provide updated information to the Agency and to recipients.
Medicaid Program Applications	Recipient Call Center	To provide potential recipients with the information and resources necessary to apply for Medicaid programs.
Medicaid ID cards	Recipient Call Center	To provide Medicaid ID cards that were returned to Medicaid for various reasons, such as insufficient address, to active recipients.

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2.5 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Recipient Call Center functional unit were extracted from section 3.03 of the Invitation To Bid (ITB):

1. Maintain and staff a Recipient Call Center function to include toll-free lines that are staffed from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday (excluding State observed holidays). New calls are not accepted after 4:30 p.m.; however, staff will utilize the remaining 30 minutes to clear the call queue. This is in accordance with section 3.03.097 of the ITB.
2. Maintain three staff members that are bilingual (English and Spanish).
3. Provide a call management system that supplies reports of all call center activities including hold time, abandonment rate, calls received, and calls answered.
4. Provide the State with monthly reports summarizing all calls received, answered, abandonment rates, and hold times.
5. Train all Contractor Recipient Call Center staff in Alabama Medicaid program policy, recipient eligibility criteria, claims processing procedures, and inquiry/update procedures for recipient eligibility files.
6. Install and operate a call recording system for use in quality monitoring in the Recipient Call Center.
7. Accept and resolve calls previously answered by State personnel in the Recipient Inquiry Unit, Customer Service Unit, Long-Term Care Unit, and District Offices. Transfer calls to Agency personnel that cannot be answered by HP staff.
8. Accept calls from recipients requesting non-emergency transportation (NET). Perform intake procedures on these calls and initiate a transportation assistance request to be transferred to the State NET unit via Feith Forms iQ and Workflow applications.
9. Submit to the State NET unit via Feith Forms iQ and Workflow requests for changes, cancellations to previously requested vouchers or the reporting of lost vouchers.
10. Process Patient 1st requests including: Patient 1st change requests (form 349), county code reassignments, exemptions, doctor assignment requests.
11. Accept and resolve calls from recipients related to claim status.
12. Accept and resolve calls from recipients related to eligibility inquiries.
13. Accept and resolve calls from recipients related to benefit limits for all programs.
14. Accept and resolve calls from recipients related to lost Medicaid ID cards and replacement card requests.
15. Accept and resolve calls from recipients for temporary Medicaid ID cards.
16. Accept and resolve calls for recipient eligibility file errors (e.g., address or county errors).
17. Accept and resolve calls for the recipient web portal (e.g. user ID resets, password resets, or basic user assistance).
18. Fulfill requests for Medicaid program applications.
19. Establish four voice mail boxes for callers to utilize after hours to request program applications.
20. Receive, log, and file returned Medicaid cards that were undeliverable. Retain cards for six months, and then destroy the cards.
21. Implement an Automated Voice Response System (AVRS) for recipients with functionality similar to the current Agency system and operating redundantly with the current Provider AVRS.
22. Implement a Frequently Asked Questions function within the telephone system.

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2.6 PERFORMANCE EXPECTATIONS

The following performance expectations for the Recipient Call Center functional unit were extracted from section 3.03 of the Invitation To Bid (ITB):

1. Mail all requests for program applications within 5 business days of request.
2. Staff Recipient Call Center phone lines from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday on all State business days.
3. Staffing levels for the RCC should be maintained to achieve a three minute or less hold time with a 10% or less abandonment rate after fifteen seconds and therefore an answer rate of 91.5% or greater.
4. Provide the State with monthly reports on all calls received, answered, abandoned, and hold times for the prior month's activities.

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3 RECIPIENT CALL CENTER PROCEDURES

A Recipient Call Center (RCC) Agent is an individual who is knowledgeable about the Alabama Medicaid program through extensive training, study of the RCC manuals, user documentation, and on-the-job experience. The RCC Agent interacts with the recipient community through verbal and written communication regarding the following:

1. Patient 1st
2. Program Policy
3. Non-Emergency Transportation
4. General Inquiries and Information
5. Claim and Prior Authorization Status
6. Recipient Eligibility
7. Medicaid ID Card Request
8. Demographic Information Updates
9. Recipient Web Portal Inquiries

Each RCC Agent has access to a desktop computer. This equipment allows the Agent to provide accurate and timely answers during telephone conversations through immediate online research of numerous AMMIS panels and AMAES screens.

3.1 RECIPIENT CALL CENTER SUPPORT

The RCC maintains a minimum of 25 incoming toll-free lines. The Alabama Medicaid recipient community uses the toll-free telephone lines to obtain Claim and Prior Authorization status, Patient 1st information, Non-Emergency Transportation requests, Recipient eligibility, Medicaid ID cards, program policy information, and benefits information.

> To meet both the expectations of the recipient community and contract obligations, RCC telephone lines are staffed from 8:00 am until 5:00 pm CST time on Monday through Friday. The staffing requirement excludes HPES/Medicaid-observed holidays.

All RCC Agents are on an Automated Call Distribution (ACD) system, which distributes a call to the next available RCC Agent. If a RCC Agent is completing research, the Agent can be excluded from the ACD system by a using a specific touch-tone telephone command.

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3.1.1 Telephone Etiquette

The RCC unit is, in most cases, the first contact the recipient has with Medicaid. Because first impressions with the recipient community are critical to the success of the Medicaid process, a RCC Agent must follow the telephone etiquette rules outlined in the table below:

Telephone Etiquette

Appropriate	Inappropriate
Alabama Medicaid, Good Morning/Afternoon, this is (your name), How may I help you?	Alabama Medicaid.
Let's work together to resolve the issue.	That's the (other parties') fault, not ours.
May I put you on hold, please?	Hold on.
I understand why you are upset.	I am so sorry, I feel so badly.
I'm sorry, I did not understand you.	I can't hear you--huh?
Yes ma'am/sir.	Uh-huh.
Thank you for calling, Good-bye.	Bye.

A RCC Agent must adhere to the following:

1. Do not leave a caller on hold for more than one minute without following up with the holding caller.
2. Do not lay the telephone down without first placing the caller on hold or using the mute feature on the telephone, so the caller cannot listen to other conversations in the call center while waiting for an answer from the Agent.

NOTE:

Refer to the Avaya 4620, 4621, 4625, 5620 and 5621 Phone User Guide for additional information on the basic telephone functions.

3.1.2 Telephone Research

The following section indicates the type of calls that are received by RCC Agents and the steps and actions taken to complete the calls.

A RCC Agent is committed to complete all telephone inquiries requiring follow-up or a return call by the end of the next business day.

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Alabama Medicaid Application and Eligibility System (AMAES)

Answer Basic Eligibility Questions for all Aid Category Groups Including Eligibility Requirements and How and Where to Apply

Recipients, Caseworkers, and Physician Offices may contact RCC to verify eligibility or to ask basic eligibility questions. The RCC Agent answers eligibility questions in regards to eligibility status and coverage limitations by using the steps below:

Step	Action
1	From the main menu, choose the **MSIQ1** screen (AMAES).
2	Enter the recipient's Medicaid ID number.
3	Press <Enter>.
4	Verify name and date of birth. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee refer to section **"Verification of Payee"** below.
5	Review Eligibility Status - Eligibility status alerts the RCC Agent to the recipient being eligible or not. A Active O Payee only, not eligible 1 Application denied 2 Application pending 3 Death deletion 4 Regular deletion 5 Suspended
6	Confirm Eligibility dates. Ensure you determine which month they are questioning eligibility. Review the Eligibility field. An "X" under eligibility indicates eligibility for Medicaid for the entire month indicated.
7	Review Certifying Agency. By reviewing the certifying agency, the RCC Agent knows who certified/enrolled the recipient. Many times a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment. D District Office H DHR M Medicaid Family Certification or Certification Support Division S SSI Y DYS Foster care
8	Review Aid Category - Refer to Aid Category descriptions. 1 Aged 2 Blind 3 Medicaid for Low Income Families 4 Disabled 5 SOBRA 6 Refugee 7 Foster Care-Federal 8 Foster Care-State 9 Child of SSI Mother L SLMB-only or QI-1 Q QMB-only

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Step	Action
9	Review county of residence Many times, a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment and has to contact the agency in their county. In addition, this should be reviewed when there is an issue with their PMP, due to their county code being assigned incorrectly.
10	Answer relevant questions regarding eligibility.

In The Centralized Alabama Recipient Eligibility System (CARES):

Step	Action
1	Access the CARES System. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and Date of Birth • Application ID
3	Select< Search>.
4	Verify name and date of birth. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee they will be identified as "Self" under the Relationship column in Cares.
5	Confirm Eligibility dates. Ensure you determine which month they are questioning eligibility.
6	Review the certifying Agency by looking under the State Aid Category. By reviewing the State Aid Category, the RCC Agent knows who certified/enrolled the recipient. Many times a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment.
7	Review county of residence Many times, a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment and has to contact the agency in their county. In addition, this should be reviewed when there is an issue with their PMP, due to their county code being assigned incorrectly.
8	Answer relevant questions regarding eligibility.

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RCC Agents can also perform the following procedures to access eligibility information:

Step	Action
1.	From the main menu, click **Recipient/Search** (AMMIS).
2.	Enter the recipient ID. Press <Enter> or click search. Results: **Recipient Information** panel displays.
3.	Verify name, date of birth and complete address on file. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee refer to section **"Verification of Payee"** below.
4.	Review Eligibility Segments for the proper dates of coverage via the **Benefit Plan** panel and the **Aid Category** panel accessed on the **Recipient Maintenance** panel.
5.	When a recipient's question involves Patient 1st, review the Managed Care segment (**Recipient PMP Assignment History** panel) to verify if the recipient is assigned a Patient 1st physician. If a recipient is not assigned to a Patient 1st physician they are not required to have a referral for services.
6.	When a recipient's question involves other insurance, review the (TPL) Third Party Liability field and Medicare coverage field on the **Recipient Information** panel to verify if the recipient has other insurance.
7.	If other insurance exists, the user can access the TPL **Information** panel **or Medicare A and/or B** panels for detailed information.
8.	Answer relevant questions regarding eligibility.

RCC Agents can perform the following procedures to provide specific eligibility information, such as remaining physician visits and eye care benefits:

Step	Action
1	From the Home page, access the **Recipient Subsystem**.
2	Click **Service Usage Search** to access the **Service Usage** panel.
3	Enter either a Medicaid ID and a Service Year or a Social Security Number (SSN) and a Service Year.
4	Press <Enter> or click search.
5	Review Benefit Limits.

RCC Agents should remember, although a quantity used may appear in a specific month's column, there can be other claims in process that have not been updated to a "paid" status, and therefore does not appear in that month's column. This information should always be conveyed to a recipient when quoting benefit limits.

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Verification of Payee

Recipients may have an Agent payee listed who takes care of their information for them. The following steps will show how to find the recipient's Agent payee.

For SOBRA Certified Recipients

Step	Action
1	From the **MSIQ1** screen, locate the Payee Number (AMAES).
2	Choose the **MSIQ1** screen again and enter the Payee Number.
3	Press <Enter>.
4	Verify the payee's name, date of birth, and at least the last four digits of the payee's social security number.

For District Office Certified Recipients

Step	Action
1	From the main menu, choose the **MSAPU** screen (AMAES).
2	Enter the recipient's Medicaid ID number.
3	Press <Enter>.
4	Verify the sponsor's name and address.

For SSI Certified Recipients

Step	Action
1	From the **MSIQ1** screen, locate the social security number for recipient (AMAES).
2	Choose the **MSDXI** screen and enter the social security number.
3	Press <Enter>.
4	Press <pf6>.
5	Verify the payee's name and address.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>
4	View application list to verify the authorized person.
5	The authorized person on the account will be listed as "Self" in the household list.
6	Children under the age of nineteen cannot be an authorized person.
7	If the recipient is nineteen or older, verify the authorized person field under the application list is blank. If blank, the recipient is the authorized person for the account. Otherwise, an authorized person's name should be listed in the application list under the authorized person field.

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Centralized Alabama Recipient Eligibility System (CARES)

View Notes

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
4	Select Notes tab.
5	View Notes History.

To Add Notes

Step	Action
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
5	Select the plus sign next to notes.
6	Select the name of the recipient/recipients for which a note should be added.
7	Enter notes
8	Select <Save>.

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interChange

Discuss the Status of a Claim for all Programs

Recipients, Caseworkers, and Physician Offices may contact the RCC to verify claim status and to answer basic claim questions. The RCC Agent reviews claim status and provide information to the caller by following the procedures below:

Step	Action
1	Request Recipient ID (RID).
2	Access the **Recipient Information** panel within the AMMIS system.
3	Enter the RID into the Recipient ID Field.
4	Press <Enter> or click search.
5	Request the date of service.
6	Verify recipient eligibility for the date of service.
7	Access the **Claims Search** panel within the AMMIS system.
8	Enter RID, the date of service and any other information available (ex. Provider ID, procedure code, etc.).
9	Claims appear, including: Internal Control Number (ICN), Provider ID, Date of Service (DOS), Claim type, Status, Date Paid, Amount billed.
10	Request the amount of the claim (or the amount of the bill). If the caller does not know or does not have the bill, proceed to the next step. If the caller does know the amount of the claim, proceed to step 12.
11	Request the following based on the type of caller: Physician's Office: Request the provider number. Recipient/Caseworker: Request the name of the provider. Access the **Provider Search** page **or Provider Mini-Search** panel screen to obtain the provider's Medicaid ID number. Enter the provider's Last Name in the last name field and the provider's first letter of the first name into the First, MI field. This reveals providers with the same last name and first initial. Locate the specific provider by requesting the city in which the provider is located.
12	If the claim is identified on file, you may select individual claims to view by clicking on a search result item.
13	If all lines of service were accepted and paid, advise the caller of the date in which all services were paid.
14	If any portion of the claim denied, access the **Reference Error Disposition Search-Error Disposition** Panel.
15	Advise the caller of the reason for denial. If the caller is a recipient/caseworker, advise that he/she should contact the Provider's office for correction or that no further action can be taken on the claim.
16	If there is no record of the claim, explain there is no record on file. If the caller is a recipient/caseworker, advise that they should contact the Provider's office. If the caller is a Provider's office, advise them to re-submit the claim or contact their Provider Agent for further information (if it denied on the audit trail).

Determining Reimbursement/Coverage for Procedure Codes

Step	Action
1	From the main menu, point to **Reference** and click **Procedure**. Results: The **Reference Procedure Search** panel displays.
2	Enter procedure code. Make sure the Search Type button for Healthcare Common Procedure Coding System (HCPCS) is chosen.

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Step	Action
3	The RCC Agents answer questions regarding procedure code coverage using the **Procedure Information** panel and relevant panels that may be accessed through the **Procedure Maintenance** panel.

Provide Medicaid Coverage Information for Rx Drugs Based on NDC Lookup

Recipients, Caseworkers, and Physician Offices may contact the RCC to review prescription drugs when determining coverage for a recipient. RCC Agents can review drug information using the NDC associated with a prescription drug. Recipients can obtain the NDC from their prescription label or by contacting the pharmacy where the prescription was processed.

RCC Agents perform the following procedures below to provide Medicaid coverage information for RX drugs based on NDC lookup:

Step	Action
1	Verify recipient eligibility.
2	From the main menu, access the **Drug Information-Drug** panel by clicking **Reference/Drug**.
3	Enter the NDC in the NDC field.
4	Press <Enter> or click search.
5	User can access drug information via the **Drug Maintenance** panel such as: Max Unit — Allows the user to view the maximum number of units to be allowed without override. Age — Allows the user to review age limits for the drug. Sex — Valid values are M (male), F (female), or B (either male or female). FP Ind — Displays whether or not the drug is a Family Planning Drug (FP). OTC — Displays whether or not the drug is an Over-the-Counter (OTC) drug.
6	To determine if a Prior Authorization for a drug is required, access **Benefit Plan Coverage Rules - Drug** panel. (Note – **Benefit Plan Coverage Rules - Drug** panel are accessible from the **Drug Maintenance** panel).
7	To determine whether a drug is preferred or not, access **Preferred Drug List (PDL) History** panel. (Note - PDL History panel are accessible from the **Drug Maintenance** panel).

Process Patient 1st Assignment Changes (Form 349 or Telephone)

Recipients, Caseworkers, and Physician Offices may request a change of the Patient 1st physician assignment via phone, fax, email or letter. Changes made prior to the 15th of the month become effective on the first day of the month after the change is made. Changes made after the 15th of the month become effective on the first day of the second month after the change is made.

Step	Action
1	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
2	Press <Enter> or click search.
3	Verify Eligibility. **Note**: Refer to procedures on Answering Basic Eligibility Questions for information on verifying eligibility for recipients.
4	Refer to form 349, email, letter, or recipient to verify which new doctor or clinic the recipient would like as the assigned provider.
5	Select **Managed Care** in AMMIS and click on the tab from the drop list **PMP Search**.
6	Enter the name of the doctor or clinic and click the Search button on the right side of the screen. **Note:** If you have the provider number, you can enter it in this screen and click Search.

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	If no information is found, select **Provider Search** in AMMIS. Enter the name of the doctor or clinic and click the Search button. **Note**: There are doctors that are listed under a Clinic that is a Patient 1st provider. Also, there are clinics that are not Patient 1st, but they have providers working for them that are Patient 1st providers. If you are able to find the doctor, proceed to Step 7. If you are unable to find the doctor, return to recipient or form for a second choice and repeat the previous steps to try and find the doctor. If you still cannot find the requested doctor, refer to section: **What to Do When You are Unable to Process a Patient 1st Request.**
7	Go to the **PMP Maintenance** menu and select **PMP Panel Restrictions** to check availability for the provider. You have to make sure that the doctor's panel is not full, the recipient's age is within the age limit for the provider, and the provider does not have a panel hold. See the following example: **EX:** **Restriction Gender Min.Age Max. Age Min Panel Size Max Panel size Current Panel Size Future Panel Size Panel Hold** **Inclusive Both 0 999 0 11987 4113 4437 No** With the provider panel showing above, this provider accepts newborns to elderly people. They accept both male and female patients. Their panel is not full. **Note**: When checking to see if the doctor's panel is full, you have to make sure that the future panel size does not exceed the maximum panel size. Also, if the Panel Hold field says Yes, then you won't be able to assign that particular doctor without the doctor requesting the recipient be added to them. If the panel is available, proceed to Step 8. If the requested doctor is not available based on the panel information above refer to section: **What to Do When You are Unable to Process a Patient 1st Request**.
8	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
9	Press <Enter> or click search.
10	Scroll down the page until you see the Recipient Maintenance panel, click on Managed Care.
11	Once you click on **Managed Care**, several options will appear on the right side of the screen. Click on the **PMP Assignment History**.
12	Scroll down to the bottom of the page and verify that the recipient has a current Patient 1st segment.
13	Click on the active PMP assignment segment.
14	When the information populates below, click in the field by the End Date and enter the date that the current segment will end. If the change occurs before Bit Shift or up to two days after, the end date will be the last day of the month. EX: If you receive a call on 8/5/11 to change the doctor, the end date for the current segment will be 8/31/11 since the new segment will be 9/1/11. If the change occurs three days after Bit Shift up until the end of that month, the end date will be the last day of the following month. EX: If you receive a call on 8/25/11 to change the doctor, the end date for the current segment will be 9/30/11 since the new segment will begin 10/1/11.
15	After entering the end date, select a stop reason from the drop list. This information you should get from the recipient or form. **Note 1**: RCC should only use the "numbered" reasons, unless otherwise instructed. **Note 2**: If reason code 50 is selected then you must enter a note in the **MC Notes** panel under **Managed Care** in **Recipient Maintenance** giving a detailed explanation for the change.
16	After entering the stop reason, look at the status panel. If the Effective Date of the PMP assignment is a future date (EX. If today is 08/05/11 and the Effective Date of the segment is 9/01/11 or 10/1/11), then you would need to change the status from active to history.

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	If the segment is current (Ex. 7/31/2007-12/31/2299), then leave the status active.
17	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.
18	Scroll back down to the **PMP assignment** panel and click on the <Add> button on the left side of the screen at the bottom of the panel.
19	If the effective date of the segment in Step 12 is a future date, then you will need to change the effective date of the segment you are adding to reflect that same future date (EX. If today is 08/05/11 and the Effective Date of the segment in Step 12 is 10/01/11, the Effective Date of the new segment must also be 10/01/11.)
20	When the information populates below, click in the field next to start reason and choose a start reason from the drop list. The reasons in Step 14 will also be the primary reasons for this step. **Note**: The stop reason used to end the active segment will be used as the start reason for the new segment.
21	Enter the requested provider's number into the Direct PMP Entry field and click anywhere on the panel to populate the information. If you don't have the provider number, you can click on [Available PMPs] and choose the doctor from the list that populated.
22	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.
23	Explain to the Recipient that if they would like to change their Patient First provider in the future for themselves or a family member, they can use the Recipient "My Medicaid" website available from the "Recipient" section of the Alabama Medicaid website.

What to do when you are unable to process a Patient 1st request.

There are a number of instances when a requested PMP may not be available for assignment.

RCC Agents will perform the following procedures for these cases:

Requests by phone:

Step	Action
1	Notify the recipient that the provider they have chosen is not available for assignment and see if they have another provider they would like to be assigned.
2	If neither doctor has available space on their panel, refer the caller to the Medicaid website (http://medicaid.alabama.gov) or offer to send a Patient 1st List (refer to the procedures on How to send a Patient 1st provider list from the following website, (https://www.medicaid.alabamaservices.org/ALPortal/default.aspx). **Note**: You may give the recipient up to 3 names from the Patient 1st provider list to see if they would like to be assigned to them. If they wish to be assigned to one of the providers given then follow the steps 8-21 of **Process Patient 1st Assignment Changes (Form 349 or Telephone)** Explain to the Recipient they can use the Recipient "My Medicaid" website available from the "Recipient" section of the Alabama Medicaid website to see a list of all available providers within a 75 mile radius.

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Requests by Form 349:

Step	Action
1	Initial the upper right hand corner of the form.
2	Below initials write the number that corresponds to the reason recipient cannot be assigned to PMP. See the chart below: 1. Max Caseload 2. Distance Restriction 3. Age Restriction 4. Recipient Medicaid Coverage Ending 5. Missing Information 6. PMP Not Located 7. Panel Hold 8. Lock-In Recipient 9. Requested PMP Not Patient 1st 10. Recipient Dismissed from PMP Panel 11. Recipient Not Found 12. Requestor Not Recipient or Payee 13. Recipient Not on Patient 1st Program a.) DHR b.) Medicare A&B c.) Exempt Status 14. Provider Contract Issue 15. Information Does Not Match 16. Recipient Requested Different PMP
3	All incomplete requests should be returned to the Team Leader for verification.
4	Once the Team Leader verifies request cannot be completed requests will be forwarded to RCC Clerks.
5	RCC Clerks will then send response letters and available provider lists to the requesting recipients. These letters will explain the reason the recipients Patient 1st request could not be processed.

Process Patient 1st Doctor Assignment Requests

These requests are from the PMP that closed their panel or restricted their age/count criteria.

Physicians may submit requests to change or add to their case load or add/remove a recipient on their panel. The request should **be submitted in writing** and must include the Medicaid Provider Number or NPI, Recipient Name and Recipient ID.

When a request is received, the RCC Agent will complete the following process:

Step	Action
1	Verify eligibility (if the request is specific to a particular recipient).
2	Verify the Provider's current caseload/panel on the MP screen in AMMIS. This will include reviewing the county, effective dates, and current versus maximum caseload.
3	Note in the upper right hand corner of the request the appropriate information based on the request: ▪ Is the recipient eligible?

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Step	Action
	▪ Does the recipient have a current PMP/PCP? If the recipient is already assigned to the PMP making the request, no further action is required. If the recipient is assigned to another PMP the update will be necessary. If the recipient is not assigned a PMP, they are not required to have a Patient 1st physician; therefore no change should be made. ▪ Is the Provider's current case load at the maximum allowed? (View the future versus the maximum case load)
4	Forward the written request to the supervisor for updating.
5	Supervisor will review the form and determine if the update is from the requesting provider and panel restrictions can therefore be overridden or if the update is from the another provider who is not authorized to override the requested provider's panel. **Note:** If the update is from someone not authorized to override the provider's panel restriction the form will be returned to the provider via the steps in What to Do When You are Unable to Process a Patient 1st Request.
6	If the update is from the requesting provider then Supervisor will follow steps 8 -22 in Process Patient 1st Assignment Changes section.
7	For Supervisor Overrides once you click save in step 22 of Process Patient 1st Assignment Changes section, you will receive edit messages listing the panel restriction/s requiring override.
8	Check the box next to each edit message and click continue.
9	Override of update request should now be complete.

Process removal Patient 1st Exemptions

The following steps should be taken when a recipient has been identified as enrolled in Patient 1st and should not be, such as DYS, Foster Children, Mental Health, Nursing Home and any institutionalized recipient. During the time that a recipient is considered "exempt" and should not be enrolled in Patient 1st.

The RCC supervisor should perform the following steps to "exempt" a recipient from Patient 1st:

Step	Action
1	The request must be presented in writing from the institution where the recipient currently resides. The letter must contain: o Name of recipient o Medicaid number o Date of placement in the facility o A Facility Contact Name and Phone Number
2	Access the MSMTU screen in AMAES.
3	Find the PCCM field on the screen. Enter the proper exemption code. Valid values include: FC Foster Child IN Institution OT Other (such as Group Home, DYS and Rehab)
4	Press (<F5) to save the change.
5	Log into the AMMIS system
6	Select Recipient Search and enter the RID in the **Current ID** Field.
7	Press <Enter> or click search.
8	Scroll down the page until you see the **Recipient Maintenance** panel, click on **Managed Care**.
9	Once you click on **Managed Care**, several options will appear on the right side of the screen. Click on the **PMP Assignment History**.

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Step	Action
10	Scroll down to the bottom of the page and verify that the recipient has a current Patient 1st segment.
11	Click on the active **PMP Assignment** segment.
12	Check the exemption request for the Facility Entry Date to determine end date for Patient 1st PMP segment. **Note:** Patient 1st assignments run for an entire month at a time. This means that the PMP assignment must be ended on the last day of the month PRIOR to the month that the recipient entered the facility. **Example: Entry Date into Facility 4/21/2008. Current PMP Assignment should be end dated 3/31/2008**
13	Enter the end date for the applicable PMP segment in the **End Date** Field. Note: PMP segments dated for a future date must also be placed into a history status in the **Status** Field.
14	Enter Reason Code 09 – Exempt in the **Stop Reason** Field.
15	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.

Once a recipient is no longer considered exempt, such as a release from an institution, the recipient's exemption status should be lifted. The RCC Supervisor performs the following steps to remove the exemption status form a recipient file (to delete):

Step	Action
1	The request must be presented in writing from the institution where the recipient currently resides. The letter must contain:: ▪ Name of recipient ▪ Medicaid number ▪ Date of discharge from the facility ▪ A Facility Contact Name and Phone Number
2	Access the MSMTU screen in AMAES.
3	Find the PCCM field and delete the current exemption code.
4	Press (<F5) to save the change.

Note: If necessary, a PMP will be assigned in the following PMP cycle.

Note: There is no current Process for Removal of Patient 1st Exemptions for the CARES system.

Process removal of Medicare recipients assigned to Patient 1st

Medicare recipients should not be assigned a Patient 1st physician.

In the event that a Medicare recipient is assigned a PMP, RCC Agents will perform the following procedures:

Step	Action
1	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
2	Press <Enter> or click search.
3	Verify Eligibility
4	Scroll down the age until you see the **Recipient Maintenance** panel. Click on **Medicare**.
5	Once you click on **Medicare** several options will appear on the right side of the screen. Click on **Medicare A Coverage** and **Medicare B Coverage.**

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Step	Action
6	Scroll down and view the **Medicare A Panel** and **Medicare B Panel** to ensure that the recipient is currently listed as enrolled in Medicare.
7	Review the **Last Changed Date** field to see if Medicare coverage was applied as Retro. If Retro was recently applied, verify they are assigned a PMP via the **PMP Assignment History** panel in **Managed Care.** Then forward the information to a supervisor to make the proper changes to the recipient.
8	The RCC Supervisor should follow steps 6 – 13 on the Process Removal of Patient 1st Exemptions step Action.
9	Enter Reason Code FM –Recipient is Receiving Medicare in the **Stop Reason** Field
10.	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.

Note: There is no current Process for Removal of Patient 1st Exemptions for the CARES system.

How to Handle Care Coordinator Requests to Update Recipient Patient 1st Assignment

Call Center Agents occasionally receive calls/requests from a Care Coordinator to update a recipient's Patient 1st provider. The Alabama Department of Public Health (ADPH) Care Coordinators (social workers) provide assistance to recipients to ensure adequate health care coverage.

RCC Agents use the procedures below:

Step	Action
1	Access recipient files as normal.
2	Confirm the ADPH Care Coordinator information, found on One Note, Recipient Call Center page, for the Care Coordinator list.
3	Once the Care Coordinator is confirmed, follow the normal procedure for updating a Patient 1st physician.

Process Patient 1st County Code Updates

If the recipient does not actually live in the county on file, the information needs to be updated. The RCC Agents perform the following steps to process the change request for county codes:

Step	Action
1	Verify eligibility of recipient.
2	Check the **MSIQ1** screen in AMAES to see if the address was entered correctly. Check the city, zip code, and county code. If the Social Security Administration Office enrolled the recipient, email a request to the RCC Supervisor to review and submit a county code correction. The SSI County Code Form should be completed, this includes: ▪ Recipient's name ▪ Recipient's SSN ▪ Recipient's address ▪ Recipient's phone number ▪ County code – incorrect and correct Inform the recipient to contact his/her local Social Security Administration Office for correction, to ensure that it was updated, or to determine if there is another issue he/she is required to have updated themselves. If the recipient was not enrolled by the Social Security Administration Office, update the county code in the MSSBR or MSAPU screens in AMAES.

Note: County codes are automatically updated when the address is changed in the CARES system.

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Perform Program Eligibility Verification Requests

An Eligibility Verification letter is requested by recipients for a variety of reasons. For example, some utility companies, such as Bell South, offer Medicaid recipients a discount on their utility bill or their physician may request a copy of their eligibility information for proof of coverage.

NOTE:

Recipients may contact the RCC to verify eligibility over the phone. Refer to the procedures on Answering Eligibility Questions to assist those callers.

RCC Agents perform the following steps to process the eligibility verification requests:

Step	Action
1	Access the **MSMTU** in AMAES screen and verify recipient eligibility.
2	Enter <E> in the “Send Medicaid ID card” field.
3	Press <Enter>.
4	Press (<F5) to update.

NOTE:

If eligibility verification is processed using the above steps, the program to print this request only runs on Monday and Thursday nights, unless Monday is a holiday then it runs Tuesday and Thursday nights, counsel recipients appropriately.

The recipient may also retrieve and print a proof of eligibility document from the Recipient Web Portal.

RCC Agents may also send an eligibility verification request by using the following steps:

Step	Action
1	Access the **MSEV** in AMAES screen and verify recipient eligibility.
2	Click <Print>.
3	Mail the eligibility verification request to the address on file.

If the address is different than the address on file, the caller should be referred to their certifying agency for updates to the file. If the recipient is SOBRA/MLIF or certified through a District Office, the RCC Agent can complete the address change.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
5	Select Plastic Card
4	Select Issue Paper Card under the Paper Card Column
6	Select Print

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NOTE:

Eligibility Verification letters cannot be faxed to recipients as it is a violation of the Health Insurance Portability and Accountability Act (HIPAA).

Refer All Calls regarding the Medicare Part D Program or Low Income Subsidy Program to either SSA or the Local Area Agencies on Aging

Recipients may contact the RCC to request information on the Medicare Part D or Low Income Subsidy Programs. These recipients can be referred to Medicare, their area Agency on Aging, or Senior Services for assistance.

The RCC Agent performs the following steps when a recipient is interested in Medicare Part D or Low Income Subsidy Programs:

Step	Action
1	Verify recipient eligibility.
2	Verify the county in which the recipient resides.
3	Provide the recipient with the contact information for the area Agency on Aging/Senior Services or transfer them to the appropriate office.

Accessing Caseworker Information

The RCC may need to refer recipients to case workers for further assistance. RCC Agents handle these situations using the procedures below:

Step	Action
1	Access the **MSIQE** in AMAES screen, enter the RID number and press <Enter>.
2	Look for the SBR or DO Location code that identifies the assigned case worker. The SBR or DO Location code is the first two sets of two digit codes (four digits total) in the SBR or DO Location.
3	Note the four digit code.
4	Go to the top of the screen and type "**MSCWI** in AMAES, ####" and press <Enter>. Note: #### represents the four digit code documented in step 3.
5	Give the recipient the caseworker's name and contact information. Note: RCC Agents may also offer to transfer the recipient to the caseworker as well.

Handling Requests to Resend a Returned Medicaid ID Card

Recipients may call stating they never received their card or it was lost, destroyed, or stolen. RCC Agents handle requests to resend returned Medicaid ID cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect or if the recipient is in a nursing home. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before an ID card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through the District Office, refer to the procedures on Processing Elderly & Disabled Updates for more information.

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Step	Action
	If the recipient is certified through another agency such as SSI or DHR, inform the recipient to contact his/her certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
3	Access the **MSPCI** screen in AMAES, enter the Medicaid RID number, and press enter.
4	If the card was returned to the Agency, there is a code in the "RET" field indicating the reason the card was returned.
5	Ask the recipient to verify the address. If the address is not correct on our file, we can issue a Medicaid ID card **ONLY** after the certifying agency has changed the address on our file (SSI recipients for example). It is the recipient's responsibility to contact the certifying agency regarding the change.
6	Inform the caller the card is on file and document the correct address on a Request to Resend a Returned Plastic Card form.
7	While on the line with the recipient, complete the Request to Resend a Returned Plastic Card form and email it to a RCC Clerk for processing. Inform the caller he/she should receive the card within 7 – 10 business days.

Requests to Reissue a Plastic Card

Recipients may call and state they never received their card or that it was lost, destroyed, or stolen. A recipient may need to change their name, sex, race, or date of birth. Assist the recipient with their request but inform them that they may request cards for themselves and their family members from the Recipient "My Medicaid" website which is available from the Alabama Medicaid website in the Recipient area.

NOTE:

Recipients requesting an excessive number of cards may have their file referred to Program Integrity before another card is issued.

RCC Agents handle requests to send replacement Medicaid ID Cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect or if the recipient is in a nursing home. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through the District Office, refer to the procedures on Processing Elderly & Disabled Updates for more information. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact his/her certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete (2 – 3 weeks).
3	Access the **MSPCI** screen in AMAES and verify the recipient's demographic information.
4	If the card was issued within the last two weeks, tell the caller it takes approximately two to three weeks to receive the card. Ask the recipient to call back one month from the issue date. We will be glad to send another card if he/she still has not received it within that timeframe.
5	Verify the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures on Handling Requests to Resend a Returned Medicaid ID card.
6	If the address on **MSPCI** is correct, go to the **MSPCQ** screen, enter the RID number and press <Enter>.

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Step	Action
	If the address is **not correct**, go to the **MSPCU** screen, enter the RID number, press <Enter> and move the cursor to the Address Change Indicator field and enter "Y". This action places a flag in the system to send a new card once an address update has been received from the certifying agency.
7	Enter a valid reason code from the list below:
	A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in sex H – Change in race I – Change in date of birth J – Change in Medicaid ID number
8	Press <F5>.
9	If you need to send the recipient a **MSEV** paper card to use until they receive the plastic card, move the cursor to "Issue MSEV Paper Card" and enter a "Y".
10	Press <F5>.

Handling Requests to Send a Paper Card

Recipients may call stating they need a Medicaid ID card for a newborn (no valid name or date of birth). A paper card is sent to the recipient in this situation.

RCC Agents handle requests for paper Medicaid ID cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact the certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
3	Access the **MSPCQ** screen.
4	Move the cursor to the "Issue Pseudo Paper Card" or "MSEV" field. *Note: Pseudo cards are **ONLY** issued for unborn/newborn recipients. MSEV paper cards may be issued for all other recipients.*
5	Enter "Y" into the appropriate field.
6	Press <F5>.
7	Advise the recipient that the paper card should arrive in a few days.

Processing SOBRA/MLIF/FP Updates to Recipient Information

Active SOBRA/MLIF/FP Recipients (Aid Category 3 or 5) may call needing to change their name, address, telephone number, county of residence, date of birth, sex or race. Assist the recipient, but inform them that this can be submitted via the Recipient 'My Medicaid' website available on the Alabama Medicaid website Recipient area.

RCC Agents handle these requests using the procedures below:

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Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Prior to making changes to the record, verify that the caller is a beneficiary, payee, state agency, or Agent of another state. Ask the caller to provide a Medicaid ID number/SSN and DOB of the recipient on which the update is to take place. The caller must provide a SSN and at least one other element of identification of the claimant. This process assures he/she is the person or the Agent of the person for whom the change is to be made (i.e. SSN and DOB).
3	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. Incorrect demographic information must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If the beneficiary is SOBRA/MLIF/FP and wants to make an update, proceed to step 4. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact their certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
4	Access the **MSSBR** screen in AMAES and enter the SSN – Press <Enter>. ***Note: You must use the Payee's 9-digit social security number only.*** **DO NOT** update cases when the following circumstances are present. Refer any cases to caseworker involving: Miscarriage Death Cases in a deleted status Cases on unborn/newborns – reporting birth of baby Recipients reporting SSN changes
5	Type changes and press <Enter> - ***Be sure to verify the county code and update when necessary.*** Note: Any cases at any point and time which reveal a message at the bottom of the **MSSBR** screen, when RCC staff tries to update, should be referred to the worker. Include a copy of the screen print with the message as well as a note stating the information the caller wanted to update. An example of an error message is: "'Unborn' Invalid Name—Check DOB".
6	Press <F5> for update.

Processing Elderly & Disabled District Office (DO) Updates to Recipient Information

For District Office cases, update eligibility file to change the beneficiary's primary or secondary address, name, date of birth, sex, county or residence code, applicant's marital status and date of marriage or divorce, sponsor's address and phone number on the MSAPU screen. Update spouse's name, address, DOB, SSN, and/or phone number on the MSAPU screen. Assist the recipient, but inform them that this can be submitted via the Recipient 'My Medicaid' website available on the Alabama Medicaid website Recipient area.

RCC Agents handle these requests using the procedures below:

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Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Prior to making changes to the record, verify that the caller is a beneficiary, payee, state agency, or Agent of another state. Ask the caller to provide a Medicaid ID number/SSN and DOB of the recipient on which the update is to take place. The caller must provide a SSN and at least one other element of identification of the claimant. This process assures he/she is the person or the Agent of the person for whom the change is to be made (i.e. SSN and DOB).
3	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. Incorrect demographic information must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If the beneficiary is certified by the DO and wants to make an update, proceed to step 4. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact their certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
4	Access the **MSAPU** screen in AMAES and enter the RID number – Press <Enter>.
5	Type changes and press <F5> - ***Be sure to verify the county code***. *If you encounter any errors, send the DO a screen print with a note explaining what the recipient wanted to update.*
6	Press <F5> to update.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
4	Under Person List, select the name of the person whose address needs to be changed.
4	Under the Personal Information Category select mailing address, name, gender etc. that needs to be updated.
6	Update all date. If address remember to follow up with the call to ensure whether both home and mailing addresses need to be updated.
7	Select Save

Processing Non-Emergency Transportation Requests

RCC processes NET requests that provide reimbursement to recipients or transportation companies for necessary non-ambulance transportation for medical services. These requests are forwarded to the NET department via FEITH Forms iQ and Workflow applications.

RCC Agents handle these requests using the procedures below:

Step	Action
1	Access the **NET Forms iQ** portal, through an icon on the RCC Agent's desktop.
2	Choose the link to "*Create a New Net Request*"

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Step	Action
3	Verify the recipient's eligibility information through the **MSTE** screen in AMAES or through the CARES system. This is important to ensure they are actually eligible to receive transportation assistance (recipients with Family Planning, QMB, SLMB, QI1 are not eligible for NET vouchers). Verify if benefits have been exhausted. This is done in the **Service Usage** panel through the AMMIS system.
4	Enter the recipient's SSN into the NET form then press <tab> or click elsewhere on the screen.
5	Click the "Appointment History" link to ensure a duplicate request has not already been submitted.
6	Complete entire NET form. **Note 1:** The Provider the recipient has an appointment with should be the provider's full name and the facility name should be included if necessary. **Note 2:** City Names should never be abbreviated. Always type out the entire city name. Confirm spellings if unsure. **Note 3:** If the recipient is confined to a wheelchair and/or requires special assistance list the diagnostic reason for this. **Note 4:** If the recipient's address is a PO Box or a different address than what is on file, enter the recipients address information in the additional addresses section.
7	Click <Submit>
8	Advise the caller you have submitted the request for processing. Also, advise the caller that processing will take from 30 to 90 days.

A recipient may request restricted information. The RCC Agent is not allowed to convey any confidential information and must decline to answer the request due to Medicaid policy provisions.

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3.1.3 Call Reporting

The Recipient Call Center has several reports generated daily from the telephone system. These reports are utilized to monitor the total number of calls into the center, the number of calls each Agent accepted, total hold time, number of abandoned calls, and number of calls transferred into the center. These numbers are captured and are delivered to the Medicaid Agency in the form of a monthly status report.

3.1.4 Additional Tasks

When there are no incoming calls, an RCC Agent works on research and completes the following tasks:

1. Process written Patient 1st request forms.
2. Answer Patient 1st and recipient correspondence.
3. Research all call backs.

The following section indicates the types of tasks performed by the RCC clerks and Agents and the actions taken to complete the tasks.

Receiving Returned Medicaid ID Cards

Returned Medicaid ID plastic cards may be received for a variety of reasons. Undeliverable cards are retrieved from the Medicaid Agency and delivered to the Recipient Call Center (by the mailroom team). The ID cards are coded into the system and batched alphabetically (by date received). This filing process enables the RCC to know exactly which cards are “stale” on any given day.

The RCC Agent process returned cards using the procedures below:

Step	Action
1	Mailroom team delivers Medicaid ID cards.
2	Open the letter then stamp the envelope with the date stamp.
3	Access the **MSPCR** screen in AMAES, enter the RID number, and press <Enter>. Note: Take note of the card count number and the date. If another card has been issued to replace the one that was returned, destroy the returned card (refer to the procedures on how to destroy a card).
4	The system prompts the operator for a return code. At the prompt, enter a return code from the list below: E – Returned card resent K – Insufficient Address (K is the most frequently used code) N – Recipient deceased S – Name change requested T – Sent to wrong person U – No longer eligible for Medicaid V – Sent replacement card
5	Press <F5>.
6	Batch all envelopes processed alphabetically by last name and bundle them together with a rubber band. Place the batch in the designated filing cabinet (according to process date).

NOTE

Cards received in a bulk shipment (such as cards collected and returned by pharmacies) must be placed in an envelope with the recipient name clearly written on the outside.

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Destroying Returned Medicaid ID Cards

Returned plastic cards are destroyed after they have been on file for 6 months. The RCC clerks destroy returned cards 2 – 3 times a week using the procedures below:

Step	Action
1	Pull the entire batch of cards to be destroyed from the returned card file.
2	Access the **MSPCR** screen in AMAES, and enter the RID number.
3	Press <Enter>.
4	The system prompts the operator for a return code. At the prompt, enter return code "Z" – Returned card destroyed by RCC.
5	Press <Enter>. The destroyed date is updated automatically.
6	Repeat steps 2 – 5 for each card to be destroyed.
7	Take the entire batch of cards to the shredder, and destroy them immediately.

Processing Requests to Resend a Returned Plastic Card

Once the call center Agent has submitted a request to resend a returned card, the RCC clerk processes the request using the following procedures:

Step	Action
1	Verify the address on the request form matches the **MSPCI** screen in AMAES. If the address does not match, return the form (with comments) to the supervisor. Return the Medicaid ID card **ONLY** after the certifying agency has changed the address on file (SSI recipients, for example).
2	Go to the appropriate batch and retrieve the returned card.
3	Access the **MSPCM** screen in AMAES and enter the RID number.
4	Press <Enter>.
5	Enter a return code – use the same return code displayed in the reason column. If no code is present, enter an "A".
6	Press <F5>.
7	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form.
8	Place the Medicaid ID card in a card jacket, and then insert it inside an envelope along with an "About Your Medicaid Card" letter. *Be sure to use an envelope labeled "PHI Open By Addressee Only".*
9	Seal the envelope with 3 pieces of tape.
10	Write the correct address on the envelope and place it in the basket for outgoing mail.

Reissuing a Plastic Card that Cannot be Found

Returned cards that cannot be found in the file of return cards may be reissued by "forcing out a card."

Once the RCC Agent has submitted a request to resend a returned card, and the RCC clerk has attempted to locate the card, the request is processed using the following procedures:

Step	Action
1	If the card cannot be located, access the **MSPCX** screen in AMAES and enter the RID number.
2	The system prompts the operator for a return code. At the prompt, enter the return code "A".
3	Press <F5>.
4	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form (with comments).

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Processing Requests from SOBRA workers to Reissue a Plastic Card

SOBRA workers send the Agency requests to issue replacement Medicaid ID cards. The Agency staff sends requests to RCC through AMAES online mail (MSMM transaction) or e-mail for processing.

RCC clerks handle requests to send replacement Medicaid ID cards using the procedures documented below:

Step	Action
1	Retrieve the requests from the RCC printer.
2	Access the **MSPCI** screen in AMAES and verify the recipient's demographic information.
3	Verify that the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures for Handling Requests to Resend a Returned Medicaid ID card.
4	Access the **MSPCQ** screen, enter the RID number and press <Enter>.
5	Enter a valid return code from the list below: A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in sex H – Change in race I – Change in date of birth J – Change in Medicaid ID number L -- Disaster Loss
6	Press <F5>.
7	If you need to send the recipient a **MSEV** paper card to use until they receive the plastic card, move the cursor to "Issue **MSEV** Paper Card" and enter a "Y".
8	Press <F5>.

Receiving Returned Medicaid ID Cards in CARES

Step	Action
1	Mailroom team delivers Medicaid ID cards.
2	Open the letter then stamp the envelope with the date stamp.
3	Access the **main** screen in CARES, enter the RID number, and click <Search>. Note: Take note of the date. If another card has been issued to replace the one that was returned, destroy the returned card (refer to the procedures on how to destroy a card).
4	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient that you are returning the card for. Once the name has been selected, look below at the Plastic Card History section to ensure that another returned card is not on file. If another card is on file, refer to Step #3 above. Down from the Name column is the Return Reason column. Click the drop down box and select the appropriate return reason below: Card Returned Due to Address Problem Card Returned- Recipient Deceased Card Returned- Name Change Requested Card Returned- Sent to Wrong Person Card Returned- No Longer Medicaid Eligible Card Returned- Sent Replacement Card
5	Select the green <Save> button below the name(s). A black box with Data Saved will briefly appear.

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Destroying Returned Medicaid ID Cards in CARES

Step	Action
1	Pull the entire batch of cards to be destroyed from the returned card file.
2	Access the **main** screen in CARES, and enter the RID number.
3	Select <Search>.
4	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient whose card is being destroyed. Click the drop down box and select Returned Card Destroyed by RCC.
5	Select <Save>. The destroyed date is updated automatically.
6	Repeat steps 2 – 5 for each card to be destroyed.
7	Take the entire batch of cards to the shredder, and destroy them immediately.

Processing Requests to Resend a Returned Plastic Card in CARES

Step	Action
1	Verify the address on the request form matches the **mailing address in the main CARES** screen. If the address does not match, return the form (with comments) to the supervisor. Return the Medicaid ID card **ONLY** after the certifying agency has changed the address on file (SSI recipients, for example).
2	Go to the appropriate batch and retrieve the returned card.
3	Access the **main** screen in CARES and enter the RID number.
4	Select <Search>.
5	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient that you are resending the card for. Click the drop down box and select Returned Card Resent.
6	Select <Save>.
7	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form.
8	Place the Medicaid ID card in a card jacket, and then insert it inside an envelope along with an “About Your Medicaid Card” letter. *Be sure to use an envelope labeled “PHI Open By Addressee Only”.*
9	Seal the envelope with 3 pieces of tape.
10	Print the correct address on the envelope and place it in the basket for outgoing mail.

Reissuing a Plastic Card that Cannot be Found in CARES

Step	Action
1	If the card cannot be located, access the **main** screen in CARES and enter the RID number.
2	Select <Search>.
3	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient whose card cannot be found. Click the drop down box and select Returned Card Destroyed.
4	Select <Save>.
5	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form (with comments).

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Processing Requests from SOBRA workers to Reissue a Plastic Card in CARES

Step	Action
1	Retrieve the requests from the RCC printer.
2	Access the **main** screen in CARES and verify the recipient's demographic information.
3	Verify that the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures for Handling Requests to Resend a Returned Medicaid ID card.
4	Access the **main CARES** screen, enter the RID number and press <Search>.
5	Select a valid reason from the list below: A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in gender H – Change in race I – Change in date of birth J – Change in Medicaid ID number
6	Select <Save>.
7	If you need to send the recipient an **MSEV** paper card to use until they receive the plastic card, select Issue Paper Card from the Paper Card column.
8	Select <Print>.

Application Requests for the SOBRA, MLIF, All Kids and Child Caring Foundation (Form 291/291S/291B)

Individuals have the ability to leave voice messages requesting the SOBRA, MLIF, and All Kids application.

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application.
3	If caller leaves name and address only: In AMAES, type in MSIQ2 last name, first name of caller. If MSIQ2 pulls the caller's information, then place "X" in the far right corner of the screen under EFP field to replace question mark to pull up the inquiry screen for the person. Then follow steps 4 thru 7 as you would for any other caller.
4	Access **MSIQ1** and enter the RID number or **MSIQ3** and enter the SSN and press <Enter>. If **MSIQ1** indicates "No Medicaid Number Found," mail Form 291.
5	Check the aid category. If the aid category = 3 or 5, Deprivation (DEP) code is not "FP" and eligibility status = "Active," then the recipient is currently on MLIF or SOBRA. Do not mail an application (Form 291). Instead, send Form Letter A1. If the aid category = 3 or 5, DEP code = "FP" and eligibility status = "Active," then mail Form 291, MLIF/SOBRA handout, and an ALL Kids brochure.
6	If caller requests a yellow Renewal Form, send Form 291B. *To request additional Form 291, 291S, MLIF/SOBRA handouts and ALL Kids brochures, contact Janice Brown at 242-1746 (see HPES Forms/Handouts – Order Form)*
7	Retrieve and mail the requested documents.

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Application Requests for Medicare Savings Programs (Form 211)

Individuals have the ability to leave voice messages requesting applications for the Medicare Savings Programs.

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application.
3	Access **MSIQ1** in AMAES and enter the RID number or **MSIQ3** and enter the SSN and press <Enter>. If **MSIQ1** indicates "No Medicaid Number Found," mail a Form 211 handout – "Medicare Savings Programs in Alabama," and attached Form Letter B.
4	Check the aid category. If the aid category = 92, 93, 95, 96, 97, or R2, and the eligibility status = "Active," then the recipient is currently on one of the Medicare Savings Programs. Do not mail an application (Form 211). Instead, mail Form Letter A. (*Note: Form Letter A acknowledges the receipt of a request for application and informs the recipient that according to Medicaid files, he/she is already enrolled in one of the Medicare Savings Programs.*) If the aid category does not equal 92, 93, 95, 96, 97, or R2, mail a Form 211, handout - "Medicare Savings Programs in Alabama," and attached Form Letter B.
5	Retrieve and mail the requested documents.
6	*To request additional Form 211 and "Medicare Savings Programs in Alabama" contact mailroom coordinator at (334)242-1736.*

Application Requests for Elderly and Disabled Programs/Nursing Home Care (Form 204/205)

Individuals have the ability to leave voice messages requesting applications for the Elderly and Disabled Programs/Nursing Home Care (Form 204/205).

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application. Note: If caller leaves enough information, check to see if caller is currently active on Medicaid with certifying agency D and the aid category is not L or Q. If caller is currently active with this criteria, then do not send application.
3	Mail Form 204/205, handout – "Medicaid for the Elderly and Disabled," and Form Letter C.
4	Retrieve and mail the requested documents.
5	*To request additional Form 204/205 and "Medicaid for the Elderly and Disabled," contact mailroom coordinator (242-1736).*

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Application Requests for the Medicaid Plan First Program (Form 357)

Individuals have the ability to leave voice messages requesting applications for the Medicaid Plan First Program (Form 357).

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application. Note: If caller leaves enough information, check to see if they are currently active on Medicaid. If active with Plan First or full Medicaid, do not send application.
3	Mail Form 357 with a Medicaid return postage paid envelope.
4	*To request a supply of Form 357, contact Vicki Wilson 242-1766.*

Administrative Portal Password Resets and Blocked Users

The Administrative Web Portal allows users to create a user login to gain access to the Alabama Medicaid Recipient Administrative Web Portal. It will then allow corrective actions to be taken on My Medicaid user accounts depending on the Administrative Role of the user. If a recipient has been **Blocked** out of the portal and they contact the RCC to get unblocked, RCC will instruct the recipient to call 334-242-5010 and ask to speak with the Privacy and Security Department at Medicaid (Clay Gaddis or Katherine Sisk). If they are unavailable, the recipient should be instructed to leave a message on their voicemail. If one of them agrees to have the recipient **Unblocked**, he/she will send an email to the LAN Team and Supervisors to **Unblock** the recipient. An email will be sent “Reply to ALL” to inform everyone on the original email that the action was taken.

To Block/Unblock a My Medicaid User ID

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Select **Block User** ***Note****: Before blocking a User ID, the user/recipient must contact Clay Gaddis or Katherine Sisk at 334-242-5010. Clay Gaddis or Katherine Sisk will then send an email to Block the User ID.*
8	To Unblock the user select **Unblock User** ***Note****: Before unblocking a User ID that has been previously Blocked, the user/recipient must contact Clay Gaddis or Katherine Sisk at 334-242-5010. If they are unavailable, the user/recipient should be instructed to leave a message on their voicemail. Clay Gaddis or Katherine Sisk will then send an email to Unblock the User ID.*

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To Reset Password of a My Medicaid User ID

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Verify User's Email address that appears on screen with the user
8	Select **Reset User's Password**
9	Select **Submit** ***Note:*** *A new password will be sent to the user's email on file. However, if the user would like the password sent to an alternate email because their email address has changed, the alternate email must be entered and confirmed in the appropriate fields. The user should be reminded to update their email address on the My Medicaid website in the My Account section.*

To Release Locked User Account

Locked accounts are automatically released after five minutes; therefore, Agents should have the caller try logging in again. However, if the user has been waiting longer than five minutes and is still unable to log in use the steps below.

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Select **Release Lock**

3.1.5 HIPAA Procedures

All RCC Agents have been trained on HIPAA privacy standards. When a recipient phones into the call center, the individual is asked to verify their name (first and last), date of birth, and address. If it is not the recipient calling, the RCC Agent verifies if the caller is the recipient's payee or sponsor. If the caller is not the payee or sponsor, the RCC Agent then tries to obtain verbal permission from the recipient to discuss his/her information with the caller. If all of these options have been exhausted, but the caller insists they have Power of Attorney or guardianship, the RCC Agent instructs the person with POA to either fax or mail copies of POA documentation to the attention of the Recipient Call Center at HPES. RCC supervisors or team leaders updates a spreadsheet containing the information and distribute it to all RCC staff to use as a reference for future calls.

When a provider calls into the center, the provider NPI number is verified against the provider file for validation. If a provider enrollment has expired, RCC Agents are not allowed to release recipient information to the provider.

If a suspicious call is received in the call center, the information is forwarded to the HIPAA Privacy Officer for investigation.

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4 GLOSSARY

The table below defines the terms used in the Recipient Call Center functional area:

Recipient Call Center Functional Area Terms

Term	Definition
AMAES	Alabama Medicaid Agency Eligibility System; used by RCC staff to perform various job tasks such as verifying eligibility, updating recipient demographic information, and requesting Medicaid ID cards.
AMMIS	Alabama Medicaid Management Information System; used to describe the interChange system.
CARES	Centralized Alabama Recipient Eligibility System; used by RCC staff to perform various job tasks such as verifying eligibility, updating recipient demographic information, and requesting Medicaid ID Cards For recipients who applied for Medicaid after January 1, 2014 and forward.
FEITH Forms iQ and Workflow	The application used by the RCC to forward Non- Emergency Transportation voucher requests to the Agency.
HCBS	Home and Community-Based Services; these include waiver services Medicaid covers.
ICF	Intermediate Care Facility.
MLIF	Medicaid for Low Income Families
MR	Mentally Retarded.
Non-Emergency Transportation (NET)	Unit of the Medicaid Agency responsible for reviewing transportation assistance requests and issuing assistance payments for recipients to be reimbursed for travel expenses incurred for medical services.
Plan First	Program available to women (age 19-55) which provides family planning services such as Birth Control Pills, Depo Provera shots, a yearly family planning exam, and other tests and lab work.
PMP	Primary Medical Provider; used when referring to a Medicaid recipient's Patient 1st provider.
Power of Attorney (POA)	A written instrument authorizing a person to act as an agent on behalf of another person to the extent indicated in the instrument.
QDWI	Qualified Disabled Working Individuals.
QI1	Qualified Income Groups; income may not exceed 135% of the federal poverty level.
QMB	Qualified Medicare Beneficiary; a Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100% of the federal poverty level plus $20.00.
Recipient Call Center (RCC)	Unit responsible for the recipient’s first point of contact with the Medicaid Agency regarding various programs or issues.
SLMB	Specified Low-Income Medicare Beneficiaries; income may not exceed 120% of the Federal Poverty Level (FPL).
SOBRA	Program which provides Medicaid services for pregnant women and children. SOBRA may also be used to describe a pregnant woman's type of eligibility (pregnancy only services.
Stale cards	The term used to refer to Medicaid ID cards that have been returned and are to be kept on file for six months; these cards are then destroyed.
TDD/TTY	A Telecommunications Device for the Deaf/Teletype.

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AMMIS Recipient Call Center Operations Manual

01/15/2015

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

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Version 1.1

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1 DOCUMENT CONTROL

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Recipient Call Center Operations Manual
Version:	1.1
Location:	https://pwb.alxix.slg.eds.com/ALXIX/Subsystem/utils/DocDescription.asp?Folder=../../Business%20Design/OperatingProcs/RCC
Owner:	HPES/Agency
Author:	
Approved by:	
Approval Date:	10/06/2011

1.2 AMENDMENT HISTORY

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
09/06/2011	0.1		Updated due to EIP - Recipient Web Portal enhancement	
09/27/2011	0.2		Responded to Agency comments received on 09/16/2011.	
10/06/2011	1.0		Agency approved	
01/15/2015	1.1		General updates	

1.3 RELATED DOCUMENTATION

Document	Description	url

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2 INTRODUCTION

The Recipient Call Center (RCC) functional area provides assistance to current and prospective recipients in the Alabama Medicaid program. RCC answers calls regarding:

- Patient 1st
- Program policies
- Non-Emergency Transportation
- General inquiries and information
- Claim and prior authorization status
- Recipient eligibility
- Medicaid ID card requests
- Demographic information updates
- Requests for applications
- Recipient Web Portal

Callers contact RCC via the toll-free number (1-800-362-1504) or, for hearing impaired recipients, through Telecommunications Device for the Deaf/Teletype (TDD/TTY) equipment over the toll-free number (1-800-253-0791) used to accommodate this equipment.

2.1 RECIPIENT CALL CENTER UNIT FUNCTIONS

The Recipient Call Center unit consists of the following:

- Recipient Inquiry Unit (RIU)
- Customer Service Unit (CSU)

2.2 RECIPIENT CALL CENTER FORMS

All forms referenced in this document can be found on the ALXIX account website at http://eds-alxix/ in the Recipient Call Center Team page.

2.3 RECIPIENT CALL CENTER TASKS

The following list identifies the tasks most frequently performed by the Recipient Call Center functional unit:

1. Process Patient 1st forms (Form 349).
2. Process Patient 1st county code reassignments.
3. Process Patient 1st exemptions.
4. Remove Medicare recipients assigned to Patient 1st (Medicare recipients are not eligible to receive Patient 1st).
5. Discuss the status of a claim as it applies to each program.
6. Provide Medicaid coverage information for prescription drugs based on a National Drug Code (NDC) lookup.
7. Perform program eligibility verification.
8. Answer basic eligibility questions for all aid categories including eligibility requirements and how to apply for aid.
9. Discuss benefit limits for each program.

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10. Initiate voucher requests for Non-Emergency Transportation (NET). The following information is obtained and forwarded to the NET office:
    - Date of request
    - Requester's name
    - Requester's relationship
    - Requester's phone number
    - Recipient Social Security Number
    - Recipient name
    - Recipient date of birth
    - Recipient address
    - Recipient phone number
    - Recipient information on file
    - Recipient's doctor's First and Last Name
    - Doctor's address
    - Doctor's phone number
    - Appointment date
    - Appointment time
    - Reason for appointment
    - Mode of transport
    - If recipient is confined to a wheelchair or uses a cane
    - Diagnostic reason for use of wheelchair or cane
    - If special transportation assistance is required
11. Answer basic questions regarding NET EBT card and its usage.
12. Transfer recipient calls about the NET EBT card to the EBT help desk at 1-877-391-4757.
13. Refer all calls regarding the Medicare Part D program or Low Income Subsidy Program to either the Social Security Administration (SSA) or the local Area Agencies on Aging.
15. Process replacement Medicaid ID card requests.
16. Process replacement ID card requests for recipients from out-stationed workers.
17. Process requests for temporary Medicaid ID cards.
18. Fulfill requests for Medicaid program applications received via the call center and voice mail.
19. For Family Certification cases, update eligibility screen MSSBR to change name, address, phone number, county code, marital status, date of birth, race, and/or sex for Medicaid for Low-Income Families (MLIF), SOBRA, and Plan First certified cases.
20. For District Office cases, update eligibility file to change the beneficiary's primary or secondary address, county code, applicant's marital status and date of marriage or divorce, sponsor's address and phone number on the MSAPU screen. Update spouse's name, address, DOB, SSN, and/or phone number on the MSAPU screen.
21. For recipients who are unable to log into the Recipient Portal, if they have registered on the portal in the past, explain how to request the user ID be emailed to them and how they can request a password reset. If they are unable to do these actions, transfer the recipient to a team leader or supervisor for assistance in resetting their password. If the recipient/user is unable to log in and the RCC Agent determines that the user has been BLOCKED, RCC will instruct the user to contact the Medicaid Agency Privacy and Security department to discuss the conditions with that department. (Currently they are to be given the names to contact as Clay Gaddis or Katharine Sisk.)
22. Notify a recipient's assigned worker of a requested change in the event an error message is returned when attempting to update the eligibility file.
23. Screen calls for District Offices by answering eligibility questions for the following Medicaid programs:

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- Nursing Home eligibility
- Intermediate Care Facility/Mentally Retarded (ICF/MR) eligibility
- Home and Community-Based Services (HCBS) eligibility
- Post-extended hospital care eligibility
- Medicare Savings Programs (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Income Groups (QI1), and Qualified Disabled Working Individuals (QDWI)) eligibility
- Supplemental Security Income (SSI) related cases, such as Disabled Adult Child (DACs), Retroactive SSI, PICKLE, and widow/widower eligibility

24. Receive, log, and file returned Medicaid ID cards that were not delivered to the recipient.

- HPES stores these cards for 6 months in case the recipient calls for the card. After 6 months, the card is destroyed in a chipper-style shredder and discarded in the trash.

25. Address policy questions for the following programs: (Detailed information regarding policy is available in the Medicaid Provider Manual: (http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx)

- Ambulance (Ground and Air)
- Ambulatory Surgical Centers (ASC)
- Anesthesiology
- Audiology/Hearing Services
- Children's Specialty Clinics
- Chiropractor
- Comprehensive Outpatient Rehabilitative Facilities (CORF)
- Dental
- Durable Medical Equipment (DME)
- Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)
- Eye Care Services
- Family Planning
- Federally Qualified Health Centers (FQHC)
- Health Departments
- Home Health
- Hospice
- Hospital
- Independent Certified Registered Nurse Practitioner (CRNP)
- Independent Laboratory
- Independent Radiology
- Independent Rural Health Clinics (RHC)
- Licensed Social Workers
- Maternity Care Program
- Nurse Midwife
- Nursing Homes
- Patient 1st
- Pharmacy
- Physician Services
- Plan First
- Podiatrist

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- Preventative Health
- Private Duty Nursing
- Prior Authorization
- Provider Based Rural Health Clinics
- Psychologist
- Targeted Case Management (TCM)
- Therapy (Occupational, Physical, and Speech)
- Third Party Liability (TPL)
- Vaccines for Children
- Elderly & Disabled Wavier
- Living-at-Home Waiver
- Mentally Retarded Waiver
- State of Alabama Independent Living Waiver (SAIL)
- Technology Assisted Waiver for Adults (TA)
- Auto-Immune Deficiency Syndrome (AIDS) Waiver

2.4 INPUT, PROCESSES, AND OUTPUT

2.4.1 Input

The table below documents the requests to the Recipient Call Center functional area:

Common Recipient Call Center Input

Input	Source	Purpose
Agency correspondence	Agency	To request information and status on the Recipient Call Center. To provide requested answers to the Recipient Call Center.
Recipient correspondence	Recipient	To request information about Alabama Medicaid. To provide updated information on the Recipient, such as name or address change.
Recipient requests	Potential recipients	To request enrollment materials and other information on the Alabama Medicaid program.
Provider requests	Provider	To request information about Alabama Medicaid. To provide Patient 1st update information regarding recipient assignments.

2.4.2 Processes

Processes accomplished in the Recipient Call Center functional unit include the following:

- Recipient calls
- Patient 1st updates
- NET requests
- Written correspondence
- Caseworker requests
- Power of Attorney documents
- Medicaid correspondence
- Returned Medicaid Cards

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Recipient Calls

The RCC Agents handle inbound and outbound calls from the recipient community regarding the following:

- Patient 1st
- Program Policy
- Non-Emergency Transportation
- General Inquiries and Information
- Claim and Prior Authorization Status
- Recipient Eligibility
- Medicaid ID Card Requests
- Demographic Information Updates
- Recipient Web Portal Assistance

Patient 1st Updates

RCC handles written requests to change a recipient's Patient 1st provider. These requests are submitted by recipients, providers, or care coordinators. The purpose of these requests is to link Medicaid recipients with a Primary Medical Provider (PMP). The PMP acts as the coordinator to provide and arrange for most of the recipient's health care needs.

To be considered for Patient 1st exemption, a Patient 1st Medical Exemption Request Form must be completed by the enrollee's physician. If the physician believes the recipient has a medical condition which excludes him/her from participating in the program, the form is then submitted for review and approval. RCC forwards these forms to the Agency to be approved. Also, exemptions are submitted when a recipient is a foster child, is institutionalized, or is in a group home. These requests are handled by RCC supervisors.

A PMP may request removal of a recipient from his panel due to good cause, according to the guidelines listed in the 1915(b) (i) waiver of the Social Security Act which allows the operation of the Patient 1st program. Good cause can be described as behavior on the part of the recipient which is disruptive, unruly, abusive, or uncooperative where the ability of the provider to administer services to the recipient or other affected recipients is seriously impaired. Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or fraudulent use of the Medicaid ID card also applies. Additionally, a Patient 1st enrollee may be removed for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice and prior written notice has been provided to the enrollee. RCC receives the requests for patients to be removed from a PMP's panel. These requests are forwarded to the Agency for processing.

RCC provides written responses to recipients who request Patient 1st changes that cannot be completed. The written response includes a letter detailing why the request cannot be completed, a copy of the original Patient 1st change form, and, when necessary, a list of Patient 1st providers for the recipient's area.

When a provider submits a Patient 1st change request that cannot be completed, the RCC staff faxes the provider's office detailing why the request cannot be completed.

NET Requests

RCC processes NET requests that provide reimbursement for necessary non-ambulance transportation services to Medicaid recipients. These requests are forwarded to the NET department via FEITH Forms iQ and Workflow applications.

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Written/Email Correspondence

Recipients submit written/email requests for responses to issues such as claim status, applications, card requests, and address updates. RCC responds to these requests with outbound calls and written or email correspondences.

Insurance companies submit or request information regarding Third Party Liability (TPL). This information is forwarded to the TPL Unit at the Agency for handling.

Caseworker Requests

Agency caseworkers can request new or replacement cards be sent out to recipients once the recipient's file has been updated. Caseworkers perform this task by sending a request through online mail (MSMM transaction) or e-mail in the Alabama Medicaid Agency Eligibility Screens (AMAES) system.

Power of Attorney Requests

Often, a recipient's Power of Attorney (POA) contacts RCC requesting information or assistance regarding the recipient's file. The RCC staff does not divulge information without proof that the caller has POA over the recipient. The RCC staff instructs the person holding POA to either fax or mail copies of POA documentation to the attention of the Recipient Call Center at HPES. RCC supervisors or team leaders then update a spreadsheet containing such information and distribute to all RCC staff.

Medicaid Correspondence

The Agency forwards generated reports based on system updates and status of recipient files. These reports include:

- Eligible Recipients who have not received a Medicaid ID card (the RCC staff issues a card to eligible recipients).
- Recipients who are deceased or whose card was returned 6 months ago or more (the RCC staff destroys these cards).
- Report of Recipients with returned plastic cards with address changes, Re-issuances and Reactivations (the RCC staff updates recipient information and send a replacement card).

The Agency's Third Party Liability (TPL) unit also forwards returned TPL letters to RCC for staff members to complete address updates when possible.

2.4.3 Output

The table below documents the outputs from the Recipient Call Center functional area:

Common Recipient Call Center Output

Output	Source	Purpose
HPES correspondence	Recipient Call Center	To communicate a response to Agency correspondence. To communicate a response to recipient correspondence. To provide updated information to the Agency and to recipients.
Medicaid Program Applications	Recipient Call Center	To provide potential recipients with the information and resources necessary to apply for Medicaid programs.
Medicaid ID cards	Recipient Call Center	To provide Medicaid ID cards that were returned to Medicaid for various reasons, such as insufficient address, to active recipients.

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2.5 FUNCTIONAL AREA RESPONSIBILITIES

The following responsibilities for the Recipient Call Center functional unit were extracted from section 3.03 of the Invitation To Bid (ITB):

1. Maintain and staff a Recipient Call Center function to include toll-free lines that are staffed from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday (excluding State observed holidays). New calls are not accepted after 4:30 p.m.; however, staff will utilize the remaining 30 minutes to clear the call queue. This is in accordance with section 3.03.097 of the ITB.
2. Maintain three staff members that are bilingual (English and Spanish).
3. Provide a call management system that supplies reports of all call center activities including hold time, abandonment rate, calls received, and calls answered.
4. Provide the State with monthly reports summarizing all calls received, answered, abandonment rates, and hold times.
5. Train all Contractor Recipient Call Center staff in Alabama Medicaid program policy, recipient eligibility criteria, claims processing procedures, and inquiry/update procedures for recipient eligibility files.
6. Install and operate a call recording system for use in quality monitoring in the Recipient Call Center.
7. Accept and resolve calls previously answered by State personnel in the Recipient Inquiry Unit, Customer Service Unit, Long-Term Care Unit, and District Offices. Transfer calls to Agency personnel that cannot be answered by HP staff.
8. Accept calls from recipients requesting non-emergency transportation (NET). Perform intake procedures on these calls and initiate a transportation assistance request to be transferred to the State NET unit via Feith Forms iQ and Workflow applications.
9. Submit to the State NET unit via Feith Forms iQ and Workflow requests for changes, cancellations to previously requested vouchers or the reporting of lost vouchers.
10. Process Patient 1st requests including: Patient 1st change requests (form 349), county code reassignments, exemptions, doctor assignment requests.
11. Accept and resolve calls from recipients related to claim status.
12. Accept and resolve calls from recipients related to eligibility inquiries.
13. Accept and resolve calls from recipients related to benefit limits for all programs.
14. Accept and resolve calls from recipients related to lost Medicaid ID cards and replacement card requests.
15. Accept and resolve calls from recipients for temporary Medicaid ID cards.
16. Accept and resolve calls for recipient eligibility file errors (e.g., address or county errors).
17. Accept and resolve calls for the recipient web portal (e.g. user ID resets, password resets, or basic user assistance).
18. Fulfill requests for Medicaid program applications.
19. Establish four voice mail boxes for callers to utilize after hours to request program applications.
20. Receive, log, and file returned Medicaid cards that were undeliverable. Retain cards for six months, and then destroy the cards.
21. Implement an Automated Voice Response System (AVRS) for recipients with functionality similar to the current Agency system and operating redundantly with the current Provider AVRS.
22. Implement a Frequently Asked Questions function within the telephone system.

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2.6 PERFORMANCE EXPECTATIONS

The following performance expectations for the Recipient Call Center functional unit were extracted from section 3.03 of the Invitation To Bid (ITB):

1. Mail all requests for program applications within 5 business days of request.
2. Staff Recipient Call Center phone lines from 8:00 a.m. to 5:00 p.m. local time, Monday through Friday on all State business days.
3. Staffing levels for the RCC should be maintained to achieve a three minute or less hold time with a 10% or less abandonment rate after fifteen seconds and therefore an answer rate of 91.5% or greater.
4. Provide the State with monthly reports on all calls received, answered, abandoned, and hold times for the prior month's activities.

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3 RECIPIENT CALL CENTER PROCEDURES

A Recipient Call Center (RCC) Agent is an individual who is knowledgeable about the Alabama Medicaid program through extensive training, study of the RCC manuals, user documentation, and on-the-job experience. The RCC Agent interacts with the recipient community through verbal and written communication regarding the following:

1. Patient 1st
2. Program Policy
3. Non-Emergency Transportation
4. General Inquiries and Information
5. Claim and Prior Authorization Status
6. Recipient Eligibility
7. Medicaid ID Card Request
8. Demographic Information Updates
9. Recipient Web Portal Inquiries

Each RCC Agent has access to a desktop computer. This equipment allows the Agent to provide accurate and timely answers during telephone conversations through immediate online research of numerous AMMIS panels and AMAES screens.

3.1 RECIPIENT CALL CENTER SUPPORT

The RCC maintains a minimum of 25 incoming toll-free lines. The Alabama Medicaid recipient community uses the toll-free telephone lines to obtain Claim and Prior Authorization status, Patient 1st information, Non-Emergency Transportation requests, Recipient eligibility, Medicaid ID cards, program policy information, and benefits information.

> To meet both the expectations of the recipient community and contract obligations, RCC telephone lines are staffed from 8:00 am until 5:00 pm CST time on Monday through Friday. The staffing requirement excludes HPES/Medicaid-observed holidays.

All RCC Agents are on an Automated Call Distribution (ACD) system, which distributes a call to the next available RCC Agent. If a RCC Agent is completing research, the Agent can be excluded from the ACD system by a using a specific touch-tone telephone command.

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3.1.1 Telephone Etiquette

The RCC unit is, in most cases, the first contact the recipient has with Medicaid. Because first impressions with the recipient community are critical to the success of the Medicaid process, a RCC Agent must follow the telephone etiquette rules outlined in the table below:

Telephone Etiquette

Appropriate	Inappropriate
Alabama Medicaid, Good Morning/Afternoon, this is (your name), How may I help you?	Alabama Medicaid.
Let's work together to resolve the issue.	That's the (other parties') fault, not ours.
May I put you on hold, please?	Hold on.
I understand why you are upset.	I am so sorry, I feel so badly.
I'm sorry, I did not understand you.	I can't hear you--huh?
Yes ma'am/sir.	Uh-huh.
Thank you for calling, Good-bye.	Bye.

A RCC Agent must adhere to the following:

1. Do not leave a caller on hold for more than one minute without following up with the holding caller.
2. Do not lay the telephone down without first placing the caller on hold or using the mute feature on the telephone, so the caller cannot listen to other conversations in the call center while waiting for an answer from the Agent.

NOTE:

Refer to the Avaya 4620, 4621, 4625, 5620 and 5621 Phone User Guide for additional information on the basic telephone functions.

3.1.2 Telephone Research

The following section indicates the type of calls that are received by RCC Agents and the steps and actions taken to complete the calls.

A RCC Agent is committed to complete all telephone inquiries requiring follow-up or a return call by the end of the next business day.

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Alabama Medicaid Application and Eligibility System (AMAES)

Answer Basic Eligibility Questions for all Aid Category Groups Including Eligibility Requirements and How and Where to Apply

Recipients, Caseworkers, and Physician Offices may contact RCC to verify eligibility or to ask basic eligibility questions. The RCC Agent answers eligibility questions in regards to eligibility status and coverage limitations by using the steps below:

Step	Action
1	From the main menu, choose the **MSIQ1** screen (AMAES).
2	Enter the recipient's Medicaid ID number.
3	Press <Enter>.
4	Verify name and date of birth. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee refer to section **"Verification of Payee"** below.
5	Review Eligibility Status - Eligibility status alerts the RCC Agent to the recipient being eligible or not. A Active O Payee only, not eligible 1 Application denied 2 Application pending 3 Death deletion 4 Regular deletion 5 Suspended
6	Confirm Eligibility dates. Ensure you determine which month they are questioning eligibility. Review the Eligibility field. An "X" under eligibility indicates eligibility for Medicaid for the entire month indicated.
7	Review Certifying Agency. By reviewing the certifying agency, the RCC Agent knows who certified/enrolled the recipient. Many times a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment. D District Office H DHR M Medicaid Family Certification or Certification Support Division S SSI Y DYS Foster care
8	Review Aid Category - Refer to Aid Category descriptions. 1 Aged 2 Blind 3 Medicaid for Low Income Families 4 Disabled 5 SOBRA 6 Refugee 7 Foster Care-Federal 8 Foster Care-State 9 Child of SSI Mother L SLMB-only or QI-1 Q QMB-only

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Step	Action
9	Review county of residence Many times, a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment and has to contact the agency in their county. In addition, this should be reviewed when there is an issue with their PMP, due to their county code being assigned incorrectly.
10	Answer relevant questions regarding eligibility.

In The Centralized Alabama Recipient Eligibility System (CARES):

Step	Action
1	Access the CARES System. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and Date of Birth • Application ID
3	Select< Search>.
4	Verify name and date of birth. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee they will be identified as "Self" under the Relationship column in Cares.
5	Confirm Eligibility dates. Ensure you determine which month they are questioning eligibility.
6	Review the certifying Agency by looking under the State Aid Category. By reviewing the State Aid Category, the RCC Agent knows who certified/enrolled the recipient. Many times a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment.
7	Review county of residence Many times, a recipient has to contact their certifying agency to make updates and/or corrections to their enrollment and has to contact the agency in their county. In addition, this should be reviewed when there is an issue with their PMP, due to their county code being assigned incorrectly.
8	Answer relevant questions regarding eligibility.

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RCC Agents can also perform the following procedures to access eligibility information:

Step	Action
1.	From the main menu, click **Recipient/Search** (AMMIS).
2.	Enter the recipient ID. Press <Enter> or click search. Results: **Recipient Information** panel displays.
3.	Verify name, date of birth and complete address on file. Note: If the recipient is unable to provide the correct information or does not know the required information, do not provide information. If he/she is calling on behalf of someone that he/she is not guardian of or payee for, the RCC Agent should ask to speak with the recipient to get permission to discuss the case with the initial caller. To verify if he/she is the Agent payee refer to section **"Verification of Payee"** below.
4.	Review Eligibility Segments for the proper dates of coverage via the **Benefit Plan** panel and the **Aid Category** panel accessed on the **Recipient Maintenance** panel.
5.	When a recipient's question involves Patient 1st, review the Managed Care segment (**Recipient PMP Assignment History** panel) to verify if the recipient is assigned a Patient 1st physician. If a recipient is not assigned to a Patient 1st physician they are not required to have a referral for services.
6.	When a recipient's question involves other insurance, review the (TPL) Third Party Liability field and Medicare coverage field on the **Recipient Information** panel to verify if the recipient has other insurance.
7.	If other insurance exists, the user can access the TPL **Information** panel **or Medicare A and/or B** panels for detailed information.
8.	Answer relevant questions regarding eligibility.

RCC Agents can perform the following procedures to provide specific eligibility information, such as remaining physician visits and eye care benefits:

Step	Action
1	From the Home page, access the **Recipient Subsystem**.
2	Click **Service Usage Search** to access the **Service Usage** panel.
3	Enter either a Medicaid ID and a Service Year or a Social Security Number (SSN) and a Service Year.
4	Press <Enter> or click search.
5	Review Benefit Limits.

RCC Agents should remember, although a quantity used may appear in a specific month's column, there can be other claims in process that have not been updated to a "paid" status, and therefore does not appear in that month's column. This information should always be conveyed to a recipient when quoting benefit limits.

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Verification of Payee

Recipients may have an Agent payee listed who takes care of their information for them. The following steps will show how to find the recipient's Agent payee.

For SOBRA Certified Recipients

Step	Action
1	From the **MSIQ1** screen, locate the Payee Number (AMAES).
2	Choose the **MSIQ1** screen again and enter the Payee Number.
3	Press <Enter>.
4	Verify the payee's name, date of birth, and at least the last four digits of the payee's social security number.

For District Office Certified Recipients

Step	Action
1	From the main menu, choose the **MSAPU** screen (AMAES).
2	Enter the recipient's Medicaid ID number.
3	Press <Enter>.
4	Verify the sponsor's name and address.

For SSI Certified Recipients

Step	Action
1	From the **MSIQ1** screen, locate the social security number for recipient (AMAES).
2	Choose the **MSDXI** screen and enter the social security number.
3	Press <Enter>.
4	Press <pf6>.
5	Verify the payee's name and address.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>
4	View application list to verify the authorized person.
5	The authorized person on the account will be listed as "Self" in the household list.
6	Children under the age of nineteen cannot be an authorized person.
7	If the recipient is nineteen or older, verify the authorized person field under the application list is blank. If blank, the recipient is the authorized person for the account. Otherwise, an authorized person's name should be listed in the application list under the authorized person field.

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Centralized Alabama Recipient Eligibility System (CARES)

View Notes

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
4	Select Notes tab.
5	View Notes History.

To Add Notes

Step	Action
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
5	Select the plus sign next to notes.
6	Select the name of the recipient/recipients for which a note should be added.
7	Enter notes
8	Select <Save>.

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interChange

Discuss the Status of a Claim for all Programs

Recipients, Caseworkers, and Physician Offices may contact the RCC to verify claim status and to answer basic claim questions. The RCC Agent reviews claim status and provide information to the caller by following the procedures below:

Step	Action
1	Request Recipient ID (RID).
2	Access the **Recipient Information** panel within the AMMIS system.
3	Enter the RID into the Recipient ID Field.
4	Press <Enter> or click search.
5	Request the date of service.
6	Verify recipient eligibility for the date of service.
7	Access the **Claims Search** panel within the AMMIS system.
8	Enter RID, the date of service and any other information available (ex. Provider ID, procedure code, etc.).
9	Claims appear, including: Internal Control Number (ICN), Provider ID, Date of Service (DOS), Claim type, Status, Date Paid, Amount billed.
10	Request the amount of the claim (or the amount of the bill). If the caller does not know or does not have the bill, proceed to the next step. If the caller does know the amount of the claim, proceed to step 12.
11	Request the following based on the type of caller: Physician's Office: Request the provider number. Recipient/Caseworker: Request the name of the provider. Access the **Provider Search** page **or Provider Mini-Search** panel screen to obtain the provider's Medicaid ID number. Enter the provider's Last Name in the last name field and the provider's first letter of the first name into the First, MI field. This reveals providers with the same last name and first initial. Locate the specific provider by requesting the city in which the provider is located.
12	If the claim is identified on file, you may select individual claims to view by clicking on a search result item.
13	If all lines of service were accepted and paid, advise the caller of the date in which all services were paid.
14	If any portion of the claim denied, access the **Reference Error Disposition Search-Error Disposition** Panel.
15	Advise the caller of the reason for denial. If the caller is a recipient/caseworker, advise that he/she should contact the Provider's office for correction or that no further action can be taken on the claim.
16	If there is no record of the claim, explain there is no record on file. If the caller is a recipient/caseworker, advise that they should contact the Provider's office. If the caller is a Provider's office, advise them to re-submit the claim or contact their Provider Agent for further information (if it denied on the audit trail).

Determining Reimbursement/Coverage for Procedure Codes

Step	Action
1	From the main menu, point to **Reference** and click **Procedure**. Results: The **Reference Procedure Search** panel displays.
2	Enter procedure code. Make sure the Search Type button for Healthcare Common Procedure Coding System (HCPCS) is chosen.

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Step	Action
3	The RCC Agents answer questions regarding procedure code coverage using the **Procedure Information** panel and relevant panels that may be accessed through the **Procedure Maintenance** panel.

Provide Medicaid Coverage Information for Rx Drugs Based on NDC Lookup

Recipients, Caseworkers, and Physician Offices may contact the RCC to review prescription drugs when determining coverage for a recipient. RCC Agents can review drug information using the NDC associated with a prescription drug. Recipients can obtain the NDC from their prescription label or by contacting the pharmacy where the prescription was processed.

RCC Agents perform the following procedures below to provide Medicaid coverage information for RX drugs based on NDC lookup:

Step	Action
1	Verify recipient eligibility.
2	From the main menu, access the **Drug Information-Drug** panel by clicking **Reference/Drug**.
3	Enter the NDC in the NDC field.
4	Press <Enter> or click search.
5	User can access drug information via the **Drug Maintenance** panel such as: Max Unit — Allows the user to view the maximum number of units to be allowed without override. Age — Allows the user to review age limits for the drug. Sex — Valid values are M (male), F (female), or B (either male or female). FP Ind — Displays whether or not the drug is a Family Planning Drug (FP). OTC — Displays whether or not the drug is an Over-the-Counter (OTC) drug.
6	To determine if a Prior Authorization for a drug is required, access **Benefit Plan Coverage Rules - Drug** panel. (Note – **Benefit Plan Coverage Rules - Drug** panel are accessible from the **Drug Maintenance** panel).
7	To determine whether a drug is preferred or not, access **Preferred Drug List (PDL) History** panel. (Note - PDL History panel are accessible from the **Drug Maintenance** panel).

Process Patient 1st Assignment Changes (Form 349 or Telephone)

Recipients, Caseworkers, and Physician Offices may request a change of the Patient 1st physician assignment via phone, fax, email or letter. Changes made prior to the 15th of the month become effective on the first day of the month after the change is made. Changes made after the 15th of the month become effective on the first day of the second month after the change is made.

Step	Action
1	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
2	Press <Enter> or click search.
3	Verify Eligibility. **Note**: Refer to procedures on Answering Basic Eligibility Questions for information on verifying eligibility for recipients.
4	Refer to form 349, email, letter, or recipient to verify which new doctor or clinic the recipient would like as the assigned provider.
5	Select **Managed Care** in AMMIS and click on the tab from the drop list **PMP Search**.
6	Enter the name of the doctor or clinic and click the Search button on the right side of the screen. **Note:** If you have the provider number, you can enter it in this screen and click Search.

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	If no information is found, select **Provider Search** in AMMIS. Enter the name of the doctor or clinic and click the Search button. **Note**: There are doctors that are listed under a Clinic that is a Patient 1st provider. Also, there are clinics that are not Patient 1st, but they have providers working for them that are Patient 1st providers. If you are able to find the doctor, proceed to Step 7. If you are unable to find the doctor, return to recipient or form for a second choice and repeat the previous steps to try and find the doctor. If you still cannot find the requested doctor, refer to section: **What to Do When You are Unable to Process a Patient 1st Request.**
7	Go to the **PMP Maintenance** menu and select **PMP Panel Restrictions** to check availability for the provider. You have to make sure that the doctor's panel is not full, the recipient's age is within the age limit for the provider, and the provider does not have a panel hold. See the following example: **EX:** **Restriction Gender Min.Age Max. Age Min Panel Size Max Panel size Current Panel Size Future Panel Size Panel Hold** **Inclusive Both 0 999 0 11987 4113 4437 No** With the provider panel showing above, this provider accepts newborns to elderly people. They accept both male and female patients. Their panel is not full. **Note**: When checking to see if the doctor's panel is full, you have to make sure that the future panel size does not exceed the maximum panel size. Also, if the Panel Hold field says Yes, then you won't be able to assign that particular doctor without the doctor requesting the recipient be added to them. If the panel is available, proceed to Step 8. If the requested doctor is not available based on the panel information above refer to section: **What to Do When You are Unable to Process a Patient 1st Request**.
8	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
9	Press <Enter> or click search.
10	Scroll down the page until you see the Recipient Maintenance panel, click on Managed Care.
11	Once you click on **Managed Care**, several options will appear on the right side of the screen. Click on the **PMP Assignment History**.
12	Scroll down to the bottom of the page and verify that the recipient has a current Patient 1st segment.
13	Click on the active PMP assignment segment.
14	When the information populates below, click in the field by the End Date and enter the date that the current segment will end. If the change occurs before Bit Shift or up to two days after, the end date will be the last day of the month. EX: If you receive a call on 8/5/11 to change the doctor, the end date for the current segment will be 8/31/11 since the new segment will be 9/1/11. If the change occurs three days after Bit Shift up until the end of that month, the end date will be the last day of the following month. EX: If you receive a call on 8/25/11 to change the doctor, the end date for the current segment will be 9/30/11 since the new segment will begin 10/1/11.
15	After entering the end date, select a stop reason from the drop list. This information you should get from the recipient or form. **Note 1**: RCC should only use the "numbered" reasons, unless otherwise instructed. **Note 2**: If reason code 50 is selected then you must enter a note in the **MC Notes** panel under **Managed Care** in **Recipient Maintenance** giving a detailed explanation for the change.
16	After entering the stop reason, look at the status panel. If the Effective Date of the PMP assignment is a future date (EX. If today is 08/05/11 and the Effective Date of the segment is 9/01/11 or 10/1/11), then you would need to change the status from active to history.

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	If the segment is current (Ex. 7/31/2007-12/31/2299), then leave the status active.
17	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.
18	Scroll back down to the **PMP assignment** panel and click on the <Add> button on the left side of the screen at the bottom of the panel.
19	If the effective date of the segment in Step 12 is a future date, then you will need to change the effective date of the segment you are adding to reflect that same future date (EX. If today is 08/05/11 and the Effective Date of the segment in Step 12 is 10/01/11, the Effective Date of the new segment must also be 10/01/11.)
20	When the information populates below, click in the field next to start reason and choose a start reason from the drop list. The reasons in Step 14 will also be the primary reasons for this step. **Note**: The stop reason used to end the active segment will be used as the start reason for the new segment.
21	Enter the requested provider's number into the Direct PMP Entry field and click anywhere on the panel to populate the information. If you don't have the provider number, you can click on [Available PMPs] and choose the doctor from the list that populated.
22	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.
23	Explain to the Recipient that if they would like to change their Patient First provider in the future for themselves or a family member, they can use the Recipient "My Medicaid" website available from the "Recipient" section of the Alabama Medicaid website.

What to do when you are unable to process a Patient 1st request.

There are a number of instances when a requested PMP may not be available for assignment.

RCC Agents will perform the following procedures for these cases:

Requests by phone:

Step	Action
1	Notify the recipient that the provider they have chosen is not available for assignment and see if they have another provider they would like to be assigned.
2	If neither doctor has available space on their panel, refer the caller to the Medicaid website (http://medicaid.alabama.gov) or offer to send a Patient 1st List (refer to the procedures on How to send a Patient 1st provider list from the following website, (https://www.medicaid.alabamaservices.org/ALPortal/default.aspx). **Note**: You may give the recipient up to 3 names from the Patient 1st provider list to see if they would like to be assigned to them. If they wish to be assigned to one of the providers given then follow the steps 8-21 of **Process Patient 1st Assignment Changes (Form 349 or Telephone)** Explain to the Recipient they can use the Recipient "My Medicaid" website available from the "Recipient" section of the Alabama Medicaid website to see a list of all available providers within a 75 mile radius.

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Requests by Form 349:

Step	Action
1	Initial the upper right hand corner of the form.
2	Below initials write the number that corresponds to the reason recipient cannot be assigned to PMP. See the chart below: 1. Max Caseload 2. Distance Restriction 3. Age Restriction 4. Recipient Medicaid Coverage Ending 5. Missing Information 6. PMP Not Located 7. Panel Hold 8. Lock-In Recipient 9. Requested PMP Not Patient 1st 10. Recipient Dismissed from PMP Panel 11. Recipient Not Found 12. Requestor Not Recipient or Payee 13. Recipient Not on Patient 1st Program a.) DHR b.) Medicare A&B c.) Exempt Status 14. Provider Contract Issue 15. Information Does Not Match 16. Recipient Requested Different PMP
3	All incomplete requests should be returned to the Team Leader for verification.
4	Once the Team Leader verifies request cannot be completed requests will be forwarded to RCC Clerks.
5	RCC Clerks will then send response letters and available provider lists to the requesting recipients. These letters will explain the reason the recipients Patient 1st request could not be processed.

Process Patient 1st Doctor Assignment Requests

These requests are from the PMP that closed their panel or restricted their age/count criteria.

Physicians may submit requests to change or add to their case load or add/remove a recipient on their panel. The request should **be submitted in writing** and must include the Medicaid Provider Number or NPI, Recipient Name and Recipient ID.

When a request is received, the RCC Agent will complete the following process:

Step	Action
1	Verify eligibility (if the request is specific to a particular recipient).
2	Verify the Provider's current caseload/panel on the MP screen in AMMIS. This will include reviewing the county, effective dates, and current versus maximum caseload.
3	Note in the upper right hand corner of the request the appropriate information based on the request: ▪ Is the recipient eligible?

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Step	Action
	▪ Does the recipient have a current PMP/PCP? If the recipient is already assigned to the PMP making the request, no further action is required. If the recipient is assigned to another PMP the update will be necessary. If the recipient is not assigned a PMP, they are not required to have a Patient 1st physician; therefore no change should be made. ▪ Is the Provider's current case load at the maximum allowed? (View the future versus the maximum case load)
4	Forward the written request to the supervisor for updating.
5	Supervisor will review the form and determine if the update is from the requesting provider and panel restrictions can therefore be overridden or if the update is from the another provider who is not authorized to override the requested provider's panel. **Note:** If the update is from someone not authorized to override the provider's panel restriction the form will be returned to the provider via the steps in What to Do When You are Unable to Process a Patient 1st Request.
6	If the update is from the requesting provider then Supervisor will follow steps 8 -22 in Process Patient 1st Assignment Changes section.
7	For Supervisor Overrides once you click save in step 22 of Process Patient 1st Assignment Changes section, you will receive edit messages listing the panel restriction/s requiring override.
8	Check the box next to each edit message and click continue.
9	Override of update request should now be complete.

Process removal Patient 1st Exemptions

The following steps should be taken when a recipient has been identified as enrolled in Patient 1st and should not be, such as DYS, Foster Children, Mental Health, Nursing Home and any institutionalized recipient. During the time that a recipient is considered "exempt" and should not be enrolled in Patient 1st.

The RCC supervisor should perform the following steps to "exempt" a recipient from Patient 1st:

Step	Action
1	The request must be presented in writing from the institution where the recipient currently resides. The letter must contain: o Name of recipient o Medicaid number o Date of placement in the facility o A Facility Contact Name and Phone Number
2	Access the MSMTU screen in AMAES.
3	Find the PCCM field on the screen. Enter the proper exemption code. Valid values include: FC Foster Child IN Institution OT Other (such as Group Home, DYS and Rehab)
4	Press (<F5) to save the change.
5	Log into the AMMIS system
6	Select Recipient Search and enter the RID in the **Current ID** Field.
7	Press <Enter> or click search.
8	Scroll down the page until you see the **Recipient Maintenance** panel, click on **Managed Care**.
9	Once you click on **Managed Care**, several options will appear on the right side of the screen. Click on the **PMP Assignment History**.

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Step	Action
10	Scroll down to the bottom of the page and verify that the recipient has a current Patient 1st segment.
11	Click on the active **PMP Assignment** segment.
12	Check the exemption request for the Facility Entry Date to determine end date for Patient 1st PMP segment. **Note:** Patient 1st assignments run for an entire month at a time. This means that the PMP assignment must be ended on the last day of the month PRIOR to the month that the recipient entered the facility. **Example: Entry Date into Facility 4/21/2008. Current PMP Assignment should be end dated 3/31/2008**
13	Enter the end date for the applicable PMP segment in the **End Date** Field. Note: PMP segments dated for a future date must also be placed into a history status in the **Status** Field.
14	Enter Reason Code 09 – Exempt in the **Stop Reason** Field.
15	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.

Once a recipient is no longer considered exempt, such as a release from an institution, the recipient's exemption status should be lifted. The RCC Supervisor performs the following steps to remove the exemption status form a recipient file (to delete):

Step	Action
1	The request must be presented in writing from the institution where the recipient currently resides. The letter must contain:: ▪ Name of recipient ▪ Medicaid number ▪ Date of discharge from the facility ▪ A Facility Contact Name and Phone Number
2	Access the MSMTU screen in AMAES.
3	Find the PCCM field and delete the current exemption code.
4	Press (<F5) to save the change.

Note: If necessary, a PMP will be assigned in the following PMP cycle.

Note: There is no current Process for Removal of Patient 1st Exemptions for the CARES system.

Process removal of Medicare recipients assigned to Patient 1st

Medicare recipients should not be assigned a Patient 1st physician.

In the event that a Medicare recipient is assigned a PMP, RCC Agents will perform the following procedures:

Step	Action
1	Select **Recipient Search** in AMMIS and enter the RID in the Current ID field.
2	Press <Enter> or click search.
3	Verify Eligibility
4	Scroll down the age until you see the **Recipient Maintenance** panel. Click on **Medicare**.
5	Once you click on **Medicare** several options will appear on the right side of the screen. Click on **Medicare A Coverage** and **Medicare B Coverage.**

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Step	Action
6	Scroll down and view the **Medicare A Panel** and **Medicare B Panel** to ensure that the recipient is currently listed as enrolled in Medicare.
7	Review the **Last Changed Date** field to see if Medicare coverage was applied as Retro. If Retro was recently applied, verify they are assigned a PMP via the **PMP Assignment History** panel in **Managed Care.** Then forward the information to a supervisor to make the proper changes to the recipient.
8	The RCC Supervisor should follow steps 6 – 13 on the Process Removal of Patient 1st Exemptions step Action.
9	Enter Reason Code FM –Recipient is Receiving Medicare in the **Stop Reason** Field
10.	Scroll up to the **Recipient Maintenance** panel, click the <Save> button to save the changes that you have made.

Note: There is no current Process for Removal of Patient 1st Exemptions for the CARES system.

How to Handle Care Coordinator Requests to Update Recipient Patient 1st Assignment

Call Center Agents occasionally receive calls/requests from a Care Coordinator to update a recipient's Patient 1st provider. The Alabama Department of Public Health (ADPH) Care Coordinators (social workers) provide assistance to recipients to ensure adequate health care coverage.

RCC Agents use the procedures below:

Step	Action
1	Access recipient files as normal.
2	Confirm the ADPH Care Coordinator information, found on One Note, Recipient Call Center page, for the Care Coordinator list.
3	Once the Care Coordinator is confirmed, follow the normal procedure for updating a Patient 1st physician.

Process Patient 1st County Code Updates

If the recipient does not actually live in the county on file, the information needs to be updated. The RCC Agents perform the following steps to process the change request for county codes:

Step	Action
1	Verify eligibility of recipient.
2	Check the **MSIQ1** screen in AMAES to see if the address was entered correctly. Check the city, zip code, and county code. If the Social Security Administration Office enrolled the recipient, email a request to the RCC Supervisor to review and submit a county code correction. The SSI County Code Form should be completed, this includes: ▪ Recipient's name ▪ Recipient's SSN ▪ Recipient's address ▪ Recipient's phone number ▪ County code – incorrect and correct Inform the recipient to contact his/her local Social Security Administration Office for correction, to ensure that it was updated, or to determine if there is another issue he/she is required to have updated themselves. If the recipient was not enrolled by the Social Security Administration Office, update the county code in the MSSBR or MSAPU screens in AMAES.

Note: County codes are automatically updated when the address is changed in the CARES system.

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Perform Program Eligibility Verification Requests

An Eligibility Verification letter is requested by recipients for a variety of reasons. For example, some utility companies, such as Bell South, offer Medicaid recipients a discount on their utility bill or their physician may request a copy of their eligibility information for proof of coverage.

NOTE:

Recipients may contact the RCC to verify eligibility over the phone. Refer to the procedures on Answering Eligibility Questions to assist those callers.

RCC Agents perform the following steps to process the eligibility verification requests:

Step	Action
1	Access the **MSMTU** in AMAES screen and verify recipient eligibility.
2	Enter <E> in the “Send Medicaid ID card” field.
3	Press <Enter>.
4	Press (<F5) to update.

NOTE:

If eligibility verification is processed using the above steps, the program to print this request only runs on Monday and Thursday nights, unless Monday is a holiday then it runs Tuesday and Thursday nights, counsel recipients appropriately.

The recipient may also retrieve and print a proof of eligibility document from the Recipient Web Portal.

RCC Agents may also send an eligibility verification request by using the following steps:

Step	Action
1	Access the **MSEV** in AMAES screen and verify recipient eligibility.
2	Click <Print>.
3	Mail the eligibility verification request to the address on file.

If the address is different than the address on file, the caller should be referred to their certifying agency for updates to the file. If the recipient is SOBRA/MLIF or certified through a District Office, the RCC Agent can complete the address change.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
5	Select Plastic Card
4	Select Issue Paper Card under the Paper Card Column
6	Select Print

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NOTE:

Eligibility Verification letters cannot be faxed to recipients as it is a violation of the Health Insurance Portability and Accountability Act (HIPAA).

Refer All Calls regarding the Medicare Part D Program or Low Income Subsidy Program to either SSA or the Local Area Agencies on Aging

Recipients may contact the RCC to request information on the Medicare Part D or Low Income Subsidy Programs. These recipients can be referred to Medicare, their area Agency on Aging, or Senior Services for assistance.

The RCC Agent performs the following steps when a recipient is interested in Medicare Part D or Low Income Subsidy Programs:

Step	Action
1	Verify recipient eligibility.
2	Verify the county in which the recipient resides.
3	Provide the recipient with the contact information for the area Agency on Aging/Senior Services or transfer them to the appropriate office.

Accessing Caseworker Information

The RCC may need to refer recipients to case workers for further assistance. RCC Agents handle these situations using the procedures below:

Step	Action
1	Access the **MSIQE** in AMAES screen, enter the RID number and press <Enter>.
2	Look for the SBR or DO Location code that identifies the assigned case worker. The SBR or DO Location code is the first two sets of two digit codes (four digits total) in the SBR or DO Location.
3	Note the four digit code.
4	Go to the top of the screen and type "**MSCWI** in AMAES, ####" and press <Enter>. Note: #### represents the four digit code documented in step 3.
5	Give the recipient the caseworker's name and contact information. Note: RCC Agents may also offer to transfer the recipient to the caseworker as well.

Handling Requests to Resend a Returned Medicaid ID Card

Recipients may call stating they never received their card or it was lost, destroyed, or stolen. RCC Agents handle requests to resend returned Medicaid ID cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect or if the recipient is in a nursing home. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before an ID card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through the District Office, refer to the procedures on Processing Elderly & Disabled Updates for more information.

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Step	Action
	If the recipient is certified through another agency such as SSI or DHR, inform the recipient to contact his/her certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
3	Access the **MSPCI** screen in AMAES, enter the Medicaid RID number, and press enter.
4	If the card was returned to the Agency, there is a code in the "RET" field indicating the reason the card was returned.
5	Ask the recipient to verify the address. If the address is not correct on our file, we can issue a Medicaid ID card **ONLY** after the certifying agency has changed the address on our file (SSI recipients for example). It is the recipient's responsibility to contact the certifying agency regarding the change.
6	Inform the caller the card is on file and document the correct address on a Request to Resend a Returned Plastic Card form.
7	While on the line with the recipient, complete the Request to Resend a Returned Plastic Card form and email it to a RCC Clerk for processing. Inform the caller he/she should receive the card within 7 – 10 business days.

Requests to Reissue a Plastic Card

Recipients may call and state they never received their card or that it was lost, destroyed, or stolen. A recipient may need to change their name, sex, race, or date of birth. Assist the recipient with their request but inform them that they may request cards for themselves and their family members from the Recipient "My Medicaid" website which is available from the Alabama Medicaid website in the Recipient area.

NOTE:

Recipients requesting an excessive number of cards may have their file referred to Program Integrity before another card is issued.

RCC Agents handle requests to send replacement Medicaid ID Cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect or if the recipient is in a nursing home. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through the District Office, refer to the procedures on Processing Elderly & Disabled Updates for more information. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact his/her certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete (2 – 3 weeks).
3	Access the **MSPCI** screen in AMAES and verify the recipient's demographic information.
4	If the card was issued within the last two weeks, tell the caller it takes approximately two to three weeks to receive the card. Ask the recipient to call back one month from the issue date. We will be glad to send another card if he/she still has not received it within that timeframe.
5	Verify the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures on Handling Requests to Resend a Returned Medicaid ID card.
6	If the address on **MSPCI** is correct, go to the **MSPCQ** screen, enter the RID number and press <Enter>.

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Step	Action
	If the address is **not correct**, go to the **MSPCU** screen, enter the RID number, press <Enter> and move the cursor to the Address Change Indicator field and enter "Y". This action places a flag in the system to send a new card once an address update has been received from the certifying agency.
7	Enter a valid reason code from the list below:
	A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in sex H – Change in race I – Change in date of birth J – Change in Medicaid ID number
8	Press <F5>.
9	If you need to send the recipient a **MSEV** paper card to use until they receive the plastic card, move the cursor to "Issue MSEV Paper Card" and enter a "Y".
10	Press <F5>.

Handling Requests to Send a Paper Card

Recipients may call stating they need a Medicaid ID card for a newborn (no valid name or date of birth). A paper card is sent to the recipient in this situation.

RCC Agents handle requests for paper Medicaid ID cards using the procedures below:

Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. A card cannot be issued if the address is incorrect. Incorrect names, addresses, and dates of birth must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If you find an error and the recipient is SOBRA or MLIF, refer to the procedures on Processing SOBRA/MLIF Updates for more information. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact the certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
3	Access the **MSPCQ** screen.
4	Move the cursor to the "Issue Pseudo Paper Card" or "MSEV" field. *Note: Pseudo cards are **ONLY** issued for unborn/newborn recipients. MSEV paper cards may be issued for all other recipients.*
5	Enter "Y" into the appropriate field.
6	Press <F5>.
7	Advise the recipient that the paper card should arrive in a few days.

Processing SOBRA/MLIF/FP Updates to Recipient Information

Active SOBRA/MLIF/FP Recipients (Aid Category 3 or 5) may call needing to change their name, address, telephone number, county of residence, date of birth, sex or race. Assist the recipient, but inform them that this can be submitted via the Recipient 'My Medicaid' website available on the Alabama Medicaid website Recipient area.

RCC Agents handle these requests using the procedures below:

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Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Prior to making changes to the record, verify that the caller is a beneficiary, payee, state agency, or Agent of another state. Ask the caller to provide a Medicaid ID number/SSN and DOB of the recipient on which the update is to take place. The caller must provide a SSN and at least one other element of identification of the claimant. This process assures he/she is the person or the Agent of the person for whom the change is to be made (i.e. SSN and DOB).
3	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. Incorrect demographic information must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If the beneficiary is SOBRA/MLIF/FP and wants to make an update, proceed to step 4. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact their certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
4	Access the **MSSBR** screen in AMAES and enter the SSN – Press <Enter>. ***Note: You must use the Payee's 9-digit social security number only.*** **DO NOT** update cases when the following circumstances are present. Refer any cases to caseworker involving: Miscarriage Death Cases in a deleted status Cases on unborn/newborns – reporting birth of baby Recipients reporting SSN changes
5	Type changes and press <Enter> - ***Be sure to verify the county code and update when necessary.*** Note: Any cases at any point and time which reveal a message at the bottom of the **MSSBR** screen, when RCC staff tries to update, should be referred to the worker. Include a copy of the screen print with the message as well as a note stating the information the caller wanted to update. An example of an error message is: "'Unborn' Invalid Name—Check DOB".
6	Press <F5> for update.

Processing Elderly & Disabled District Office (DO) Updates to Recipient Information

For District Office cases, update eligibility file to change the beneficiary's primary or secondary address, name, date of birth, sex, county or residence code, applicant's marital status and date of marriage or divorce, sponsor's address and phone number on the MSAPU screen. Update spouse's name, address, DOB, SSN, and/or phone number on the MSAPU screen. Assist the recipient, but inform them that this can be submitted via the Recipient 'My Medicaid' website available on the Alabama Medicaid website Recipient area.

RCC Agents handle these requests using the procedures below:

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Step	Action
1	Access the **MSIQE** screen in AMAES, enter the RID number and press <Enter>.
2	Prior to making changes to the record, verify that the caller is a beneficiary, payee, state agency, or Agent of another state. Ask the caller to provide a Medicaid ID number/SSN and DOB of the recipient on which the update is to take place. The caller must provide a SSN and at least one other element of identification of the claimant. This process assures he/she is the person or the Agent of the person for whom the change is to be made (i.e. SSN and DOB).
3	Verify the recipient's demographic and eligibility information. Be sure to ask for the recipient's CURRENT address. Incorrect demographic information must be updated by the certifying agency before a card can be issued. It is the recipient's responsibility to contact the certifying agency regarding the change. If the beneficiary is certified by the DO and wants to make an update, proceed to step 4. If the recipient is certified through another agency such as SSI or DHR, tell the recipient to contact their certifying agency to get the information updated. Recipients with card requests should call back once the update process is complete.
4	Access the **MSAPU** screen in AMAES and enter the RID number – Press <Enter>.
5	Type changes and press <F5> - ***Be sure to verify the county code***. *If you encounter any errors, send the DO a screen print with a note explaining what the recipient wanted to update.*
6	Press <F5> to update.

Centralized Alabama Recipient Eligibility System (CARES)

Step	Action
1	Access the CARES system. https://alabamacares.alabama.gov/AlabamaExpress/
2	From the main menu, enter one of the following: • Recipient Medicaid Number • Social Security Number (SSN) • Name and DOB • Application ID
3	Select< Search>.
4	Under Person List, select the name of the person whose address needs to be changed.
4	Under the Personal Information Category select mailing address, name, gender etc. that needs to be updated.
6	Update all date. If address remember to follow up with the call to ensure whether both home and mailing addresses need to be updated.
7	Select Save

Processing Non-Emergency Transportation Requests

RCC processes NET requests that provide reimbursement to recipients or transportation companies for necessary non-ambulance transportation for medical services. These requests are forwarded to the NET department via FEITH Forms iQ and Workflow applications.

RCC Agents handle these requests using the procedures below:

Step	Action
1	Access the **NET Forms iQ** portal, through an icon on the RCC Agent's desktop.
2	Choose the link to "*Create a New Net Request*"

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Step	Action
3	Verify the recipient's eligibility information through the **MSTE** screen in AMAES or through the CARES system. This is important to ensure they are actually eligible to receive transportation assistance (recipients with Family Planning, QMB, SLMB, QI1 are not eligible for NET vouchers). Verify if benefits have been exhausted. This is done in the **Service Usage** panel through the AMMIS system.
4	Enter the recipient's SSN into the NET form then press <tab> or click elsewhere on the screen.
5	Click the "Appointment History" link to ensure a duplicate request has not already been submitted.
6	Complete entire NET form. **Note 1:** The Provider the recipient has an appointment with should be the provider's full name and the facility name should be included if necessary. **Note 2:** City Names should never be abbreviated. Always type out the entire city name. Confirm spellings if unsure. **Note 3:** If the recipient is confined to a wheelchair and/or requires special assistance list the diagnostic reason for this. **Note 4:** If the recipient's address is a PO Box or a different address than what is on file, enter the recipients address information in the additional addresses section.
7	Click <Submit>
8	Advise the caller you have submitted the request for processing. Also, advise the caller that processing will take from 30 to 90 days.

A recipient may request restricted information. The RCC Agent is not allowed to convey any confidential information and must decline to answer the request due to Medicaid policy provisions.

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3.1.3 Call Reporting

The Recipient Call Center has several reports generated daily from the telephone system. These reports are utilized to monitor the total number of calls into the center, the number of calls each Agent accepted, total hold time, number of abandoned calls, and number of calls transferred into the center. These numbers are captured and are delivered to the Medicaid Agency in the form of a monthly status report.

3.1.4 Additional Tasks

When there are no incoming calls, an RCC Agent works on research and completes the following tasks:

1. Process written Patient 1st request forms.
2. Answer Patient 1st and recipient correspondence.
3. Research all call backs.

The following section indicates the types of tasks performed by the RCC clerks and Agents and the actions taken to complete the tasks.

Receiving Returned Medicaid ID Cards

Returned Medicaid ID plastic cards may be received for a variety of reasons. Undeliverable cards are retrieved from the Medicaid Agency and delivered to the Recipient Call Center (by the mailroom team). The ID cards are coded into the system and batched alphabetically (by date received). This filing process enables the RCC to know exactly which cards are “stale” on any given day.

The RCC Agent process returned cards using the procedures below:

Step	Action
1	Mailroom team delivers Medicaid ID cards.
2	Open the letter then stamp the envelope with the date stamp.
3	Access the **MSPCR** screen in AMAES, enter the RID number, and press <Enter>. Note: Take note of the card count number and the date. If another card has been issued to replace the one that was returned, destroy the returned card (refer to the procedures on how to destroy a card).
4	The system prompts the operator for a return code. At the prompt, enter a return code from the list below: E – Returned card resent K – Insufficient Address (K is the most frequently used code) N – Recipient deceased S – Name change requested T – Sent to wrong person U – No longer eligible for Medicaid V – Sent replacement card
5	Press <F5>.
6	Batch all envelopes processed alphabetically by last name and bundle them together with a rubber band. Place the batch in the designated filing cabinet (according to process date).

NOTE

Cards received in a bulk shipment (such as cards collected and returned by pharmacies) must be placed in an envelope with the recipient name clearly written on the outside.

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Destroying Returned Medicaid ID Cards

Returned plastic cards are destroyed after they have been on file for 6 months. The RCC clerks destroy returned cards 2 – 3 times a week using the procedures below:

Step	Action
1	Pull the entire batch of cards to be destroyed from the returned card file.
2	Access the **MSPCR** screen in AMAES, and enter the RID number.
3	Press <Enter>.
4	The system prompts the operator for a return code. At the prompt, enter return code "Z" – Returned card destroyed by RCC.
5	Press <Enter>. The destroyed date is updated automatically.
6	Repeat steps 2 – 5 for each card to be destroyed.
7	Take the entire batch of cards to the shredder, and destroy them immediately.

Processing Requests to Resend a Returned Plastic Card

Once the call center Agent has submitted a request to resend a returned card, the RCC clerk processes the request using the following procedures:

Step	Action
1	Verify the address on the request form matches the **MSPCI** screen in AMAES. If the address does not match, return the form (with comments) to the supervisor. Return the Medicaid ID card **ONLY** after the certifying agency has changed the address on file (SSI recipients, for example).
2	Go to the appropriate batch and retrieve the returned card.
3	Access the **MSPCM** screen in AMAES and enter the RID number.
4	Press <Enter>.
5	Enter a return code – use the same return code displayed in the reason column. If no code is present, enter an "A".
6	Press <F5>.
7	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form.
8	Place the Medicaid ID card in a card jacket, and then insert it inside an envelope along with an "About Your Medicaid Card" letter. *Be sure to use an envelope labeled "PHI Open By Addressee Only".*
9	Seal the envelope with 3 pieces of tape.
10	Write the correct address on the envelope and place it in the basket for outgoing mail.

Reissuing a Plastic Card that Cannot be Found

Returned cards that cannot be found in the file of return cards may be reissued by "forcing out a card."

Once the RCC Agent has submitted a request to resend a returned card, and the RCC clerk has attempted to locate the card, the request is processed using the following procedures:

Step	Action
1	If the card cannot be located, access the **MSPCX** screen in AMAES and enter the RID number.
2	The system prompts the operator for a return code. At the prompt, enter the return code "A".
3	Press <F5>.
4	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form (with comments).

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Processing Requests from SOBRA workers to Reissue a Plastic Card

SOBRA workers send the Agency requests to issue replacement Medicaid ID cards. The Agency staff sends requests to RCC through AMAES online mail (MSMM transaction) or e-mail for processing.

RCC clerks handle requests to send replacement Medicaid ID cards using the procedures documented below:

Step	Action
1	Retrieve the requests from the RCC printer.
2	Access the **MSPCI** screen in AMAES and verify the recipient's demographic information.
3	Verify that the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures for Handling Requests to Resend a Returned Medicaid ID card.
4	Access the **MSPCQ** screen, enter the RID number and press <Enter>.
5	Enter a valid return code from the list below: A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in sex H – Change in race I – Change in date of birth J – Change in Medicaid ID number L -- Disaster Loss
6	Press <F5>.
7	If you need to send the recipient a **MSEV** paper card to use until they receive the plastic card, move the cursor to "Issue **MSEV** Paper Card" and enter a "Y".
8	Press <F5>.

Receiving Returned Medicaid ID Cards in CARES

Step	Action
1	Mailroom team delivers Medicaid ID cards.
2	Open the letter then stamp the envelope with the date stamp.
3	Access the **main** screen in CARES, enter the RID number, and click <Search>. Note: Take note of the date. If another card has been issued to replace the one that was returned, destroy the returned card (refer to the procedures on how to destroy a card).
4	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient that you are returning the card for. Once the name has been selected, look below at the Plastic Card History section to ensure that another returned card is not on file. If another card is on file, refer to Step #3 above. Down from the Name column is the Return Reason column. Click the drop down box and select the appropriate return reason below: Card Returned Due to Address Problem Card Returned- Recipient Deceased Card Returned- Name Change Requested Card Returned- Sent to Wrong Person Card Returned- No Longer Medicaid Eligible Card Returned- Sent Replacement Card
5	Select the green <Save> button below the name(s). A black box with Data Saved will briefly appear.

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Destroying Returned Medicaid ID Cards in CARES

Step	Action
1	Pull the entire batch of cards to be destroyed from the returned card file.
2	Access the **main** screen in CARES, and enter the RID number.
3	Select <Search>.
4	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient whose card is being destroyed. Click the drop down box and select Returned Card Destroyed by RCC.
5	Select <Save>. The destroyed date is updated automatically.
6	Repeat steps 2 – 5 for each card to be destroyed.
7	Take the entire batch of cards to the shredder, and destroy them immediately.

Processing Requests to Resend a Returned Plastic Card in CARES

Step	Action
1	Verify the address on the request form matches the **mailing address in the main CARES** screen. If the address does not match, return the form (with comments) to the supervisor. Return the Medicaid ID card **ONLY** after the certifying agency has changed the address on file (SSI recipients, for example).
2	Go to the appropriate batch and retrieve the returned card.
3	Access the **main** screen in CARES and enter the RID number.
4	Select <Search>.
5	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient that you are resending the card for. Click the drop down box and select Returned Card Resent.
6	Select <Save>.
7	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form.
8	Place the Medicaid ID card in a card jacket, and then insert it inside an envelope along with an “About Your Medicaid Card” letter. *Be sure to use an envelope labeled “PHI Open By Addressee Only”.*
9	Seal the envelope with 3 pieces of tape.
10	Print the correct address on the envelope and place it in the basket for outgoing mail.

Reissuing a Plastic Card that Cannot be Found in CARES

Step	Action
1	If the card cannot be located, access the **main** screen in CARES and enter the RID number.
2	Select <Search>.
3	Select the appropriate Application ID from the Application List, and then click the Plastic Card option in the column on the left. Scroll down to the Plastic Card Request Section and select the name of the recipient whose card cannot be found. Click the drop down box and select Returned Card Destroyed.
4	Select <Save>.
5	Complete the RCC clerk section of the Requests to Resend a Returned Plastic Card form (with comments).

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Processing Requests from SOBRA workers to Reissue a Plastic Card in CARES

Step	Action
1	Retrieve the requests from the RCC printer.
2	Access the **main** screen in CARES and verify the recipient's demographic information.
3	Verify that the requested card is **NOT** in a returned status. If the card is in a returned status, refer to the procedures for Handling Requests to Resend a Returned Medicaid ID card.
4	Access the **main CARES** screen, enter the RID number and press <Search>.
5	Select a valid reason from the list below: A – Never received card B – Lost card C – Card was stolen D – Card was damaged/destroyed F – Change in name G – Change in gender H – Change in race I – Change in date of birth J – Change in Medicaid ID number
6	Select <Save>.
7	If you need to send the recipient an **MSEV** paper card to use until they receive the plastic card, select Issue Paper Card from the Paper Card column.
8	Select <Print>.

Application Requests for the SOBRA, MLIF, All Kids and Child Caring Foundation (Form 291/291S/291B)

Individuals have the ability to leave voice messages requesting the SOBRA, MLIF, and All Kids application.

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application.
3	If caller leaves name and address only: In AMAES, type in MSIQ2 last name, first name of caller. If MSIQ2 pulls the caller's information, then place "X" in the far right corner of the screen under EFP field to replace question mark to pull up the inquiry screen for the person. Then follow steps 4 thru 7 as you would for any other caller.
4	Access **MSIQ1** and enter the RID number or **MSIQ3** and enter the SSN and press <Enter>. If **MSIQ1** indicates "No Medicaid Number Found," mail Form 291.
5	Check the aid category. If the aid category = 3 or 5, Deprivation (DEP) code is not "FP" and eligibility status = "Active," then the recipient is currently on MLIF or SOBRA. Do not mail an application (Form 291). Instead, send Form Letter A1. If the aid category = 3 or 5, DEP code = "FP" and eligibility status = "Active," then mail Form 291, MLIF/SOBRA handout, and an ALL Kids brochure.
6	If caller requests a yellow Renewal Form, send Form 291B. *To request additional Form 291, 291S, MLIF/SOBRA handouts and ALL Kids brochures, contact Janice Brown at 242-1746 (see HPES Forms/Handouts – Order Form)*
7	Retrieve and mail the requested documents.

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Application Requests for Medicare Savings Programs (Form 211)

Individuals have the ability to leave voice messages requesting applications for the Medicare Savings Programs.

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application.
3	Access **MSIQ1** in AMAES and enter the RID number or **MSIQ3** and enter the SSN and press <Enter>. If **MSIQ1** indicates "No Medicaid Number Found," mail a Form 211 handout – "Medicare Savings Programs in Alabama," and attached Form Letter B.
4	Check the aid category. If the aid category = 92, 93, 95, 96, 97, or R2, and the eligibility status = "Active," then the recipient is currently on one of the Medicare Savings Programs. Do not mail an application (Form 211). Instead, mail Form Letter A. (*Note: Form Letter A acknowledges the receipt of a request for application and informs the recipient that according to Medicaid files, he/she is already enrolled in one of the Medicare Savings Programs.*) If the aid category does not equal 92, 93, 95, 96, 97, or R2, mail a Form 211, handout - "Medicare Savings Programs in Alabama," and attached Form Letter B.
5	Retrieve and mail the requested documents.
6	*To request additional Form 211 and "Medicare Savings Programs in Alabama" contact mailroom coordinator at (334)242-1736.*

Application Requests for Elderly and Disabled Programs/Nursing Home Care (Form 204/205)

Individuals have the ability to leave voice messages requesting applications for the Elderly and Disabled Programs/Nursing Home Care (Form 204/205).

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application. Note: If caller leaves enough information, check to see if caller is currently active on Medicaid with certifying agency D and the aid category is not L or Q. If caller is currently active with this criteria, then do not send application.
3	Mail Form 204/205, handout – "Medicaid for the Elderly and Disabled," and Form Letter C.
4	Retrieve and mail the requested documents.
5	*To request additional Form 204/205 and "Medicaid for the Elderly and Disabled," contact mailroom coordinator (242-1736).*

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Application Requests for the Medicaid Plan First Program (Form 357)

Individuals have the ability to leave voice messages requesting applications for the Medicaid Plan First Program (Form 357).

RCC clerks fulfill these requests using the procedures below:

Step	Action
1	Retrieve the name, address, and SSN from the voice mail box.
2	If the caller leaves the street address and zip code, but fails to include the city, then look up the zip code on the internet at www.switchboard.com. Disregard the message if the caller did not leave adequate information to send an application. Note: If caller leaves enough information, check to see if they are currently active on Medicaid. If active with Plan First or full Medicaid, do not send application.
3	Mail Form 357 with a Medicaid return postage paid envelope.
4	*To request a supply of Form 357, contact Vicki Wilson 242-1766.*

Administrative Portal Password Resets and Blocked Users

The Administrative Web Portal allows users to create a user login to gain access to the Alabama Medicaid Recipient Administrative Web Portal. It will then allow corrective actions to be taken on My Medicaid user accounts depending on the Administrative Role of the user. If a recipient has been **Blocked** out of the portal and they contact the RCC to get unblocked, RCC will instruct the recipient to call 334-242-5010 and ask to speak with the Privacy and Security Department at Medicaid (Clay Gaddis or Katherine Sisk). If they are unavailable, the recipient should be instructed to leave a message on their voicemail. If one of them agrees to have the recipient **Unblocked**, he/she will send an email to the LAN Team and Supervisors to **Unblock** the recipient. An email will be sent “Reply to ALL” to inform everyone on the original email that the action was taken.

To Block/Unblock a My Medicaid User ID

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Select **Block User** ***Note****: Before blocking a User ID, the user/recipient must contact Clay Gaddis or Katherine Sisk at 334-242-5010. Clay Gaddis or Katherine Sisk will then send an email to Block the User ID.*
8	To Unblock the user select **Unblock User** ***Note****: Before unblocking a User ID that has been previously Blocked, the user/recipient must contact Clay Gaddis or Katherine Sisk at 334-242-5010. If they are unavailable, the user/recipient should be instructed to leave a message on their voicemail. Clay Gaddis or Katherine Sisk will then send an email to Unblock the User ID.*

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To Reset Password of a My Medicaid User ID

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Verify User's Email address that appears on screen with the user
8	Select **Reset User's Password**
9	Select **Submit** ***Note:*** *A new password will be sent to the user's email on file. However, if the user would like the password sent to an alternate email because their email address has changed, the alternate email must be entered and confirmed in the appropriate fields. The user should be reminded to update their email address on the My Medicaid website in the My Account section.*

To Release Locked User Account

Locked accounts are automatically released after five minutes; therefore, Agents should have the caller try logging in again. However, if the user has been waiting longer than five minutes and is still unable to log in use the steps below.

Step	Action
1	Log into the Administrative Portal
2	Select the **Tools** Tab
3	Select **User Management**
4	Enter User ID in **User ID** Field or Select the **Search By Name** tab and enter name
5	Select Search
6	Click on User ID in the **Search Results** field
7	Select **Release Lock**

3.1.5 HIPAA Procedures

All RCC Agents have been trained on HIPAA privacy standards. When a recipient phones into the call center, the individual is asked to verify their name (first and last), date of birth, and address. If it is not the recipient calling, the RCC Agent verifies if the caller is the recipient's payee or sponsor. If the caller is not the payee or sponsor, the RCC Agent then tries to obtain verbal permission from the recipient to discuss his/her information with the caller. If all of these options have been exhausted, but the caller insists they have Power of Attorney or guardianship, the RCC Agent instructs the person with POA to either fax or mail copies of POA documentation to the attention of the Recipient Call Center at HPES. RCC supervisors or team leaders updates a spreadsheet containing the information and distribute it to all RCC staff to use as a reference for future calls.

When a provider calls into the center, the provider NPI number is verified against the provider file for validation. If a provider enrollment has expired, RCC Agents are not allowed to release recipient information to the provider.

If a suspicious call is received in the call center, the information is forwarded to the HIPAA Privacy Officer for investigation.

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4 GLOSSARY

The table below defines the terms used in the Recipient Call Center functional area:

Recipient Call Center Functional Area Terms

Term	Definition
AMAES	Alabama Medicaid Agency Eligibility System; used by RCC staff to perform various job tasks such as verifying eligibility, updating recipient demographic information, and requesting Medicaid ID cards.
AMMIS	Alabama Medicaid Management Information System; used to describe the interChange system.
CARES	Centralized Alabama Recipient Eligibility System; used by RCC staff to perform various job tasks such as verifying eligibility, updating recipient demographic information, and requesting Medicaid ID Cards For recipients who applied for Medicaid after January 1, 2014 and forward.
FEITH Forms iQ and Workflow	The application used by the RCC to forward Non- Emergency Transportation voucher requests to the Agency.
HCBS	Home and Community-Based Services; these include waiver services Medicaid covers.
ICF	Intermediate Care Facility.
MLIF	Medicaid for Low Income Families
MR	Mentally Retarded.
Non-Emergency Transportation (NET)	Unit of the Medicaid Agency responsible for reviewing transportation assistance requests and issuing assistance payments for recipients to be reimbursed for travel expenses incurred for medical services.
Plan First	Program available to women (age 19-55) which provides family planning services such as Birth Control Pills, Depo Provera shots, a yearly family planning exam, and other tests and lab work.
PMP	Primary Medical Provider; used when referring to a Medicaid recipient's Patient 1st provider.
Power of Attorney (POA)	A written instrument authorizing a person to act as an agent on behalf of another person to the extent indicated in the instrument.
QDWI	Qualified Disabled Working Individuals.
QI1	Qualified Income Groups; income may not exceed 135% of the federal poverty level.
QMB	Qualified Medicare Beneficiary; a Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100% of the federal poverty level plus $20.00.
Recipient Call Center (RCC)	Unit responsible for the recipient’s first point of contact with the Medicaid Agency regarding various programs or issues.
SLMB	Specified Low-Income Medicare Beneficiaries; income may not exceed 120% of the Federal Poverty Level (FPL).
SOBRA	Program which provides Medicaid services for pregnant women and children. SOBRA may also be used to describe a pregnant woman's type of eligibility (pregnancy only services.
Stale cards	The term used to refer to Medicaid ID cards that have been returned and are to be kept on file for six months; these cards are then destroyed.
TDD/TTY	A Telecommunications Device for the Deaf/Teletype.

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AMMIS Recipient User Manual

Date Modified: 05/01/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

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1. Document Control

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1.1 Document Information Page

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1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

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12/20/2017	15.0		Application of CO 14498	6.6 Recipient Maintenance panel updates- UPDATE panel layout to reflect removal of RCO Assignment History
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1.3 Related documentation

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N/A		

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2. Recipient Introduction

2.1 Recipient User Manual Overview

The AMMIS has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Recipient functional area.

This manual covers the following:

- Recipient Overview
- Recipient System Navigation
- System Wide Common Terminology and Layouts
- Recipient Pages/Panels
- Recipient Reports

2.2 Recipient User Manual Objective

The objective of the AMMIS Recipient User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

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3. Recipient Overview

3.1 Introduction to Recipient

The primary purpose of the Recipient Data Maintenance function is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance, and to support analysis of the data contained within the recipient data maintenance system. The maintenance of recipient data is required to support claim processing in batch and online mode, reporting functions, and eligibility verification. Additional recipient related data is also maintained in other functional areas such as Third Party Liability (TPL), Long Term Care (LTC), and Managed Care.

The main source of eligibility data for the AMMIS is a daily file extract from the Alabama Medicaid Agency's Alabama Medicaid Application and Eligibility System (AMAES). This daily data is processed through the Recipient PS/2 function which maintains eligibility data for all medical assistance programs.

Another important function of the Recipient Data Maintenance is providing recipient information to other external systems, such as Health Information Designs (HID) and Centers for Medicare and Medicaid Services (CMS).

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4. Recipient System Navigation

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 System Security

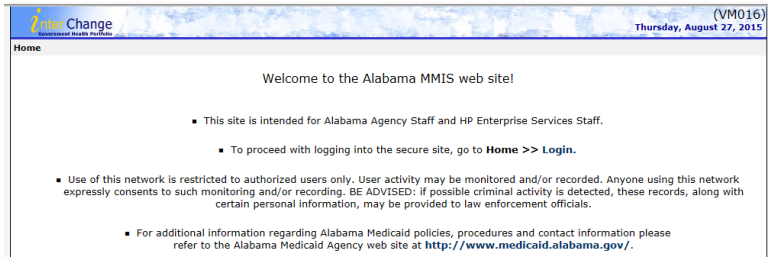
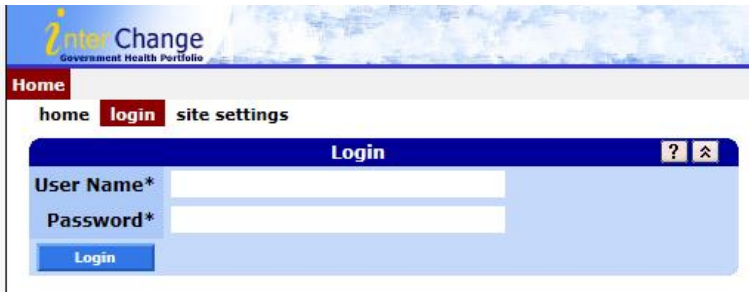
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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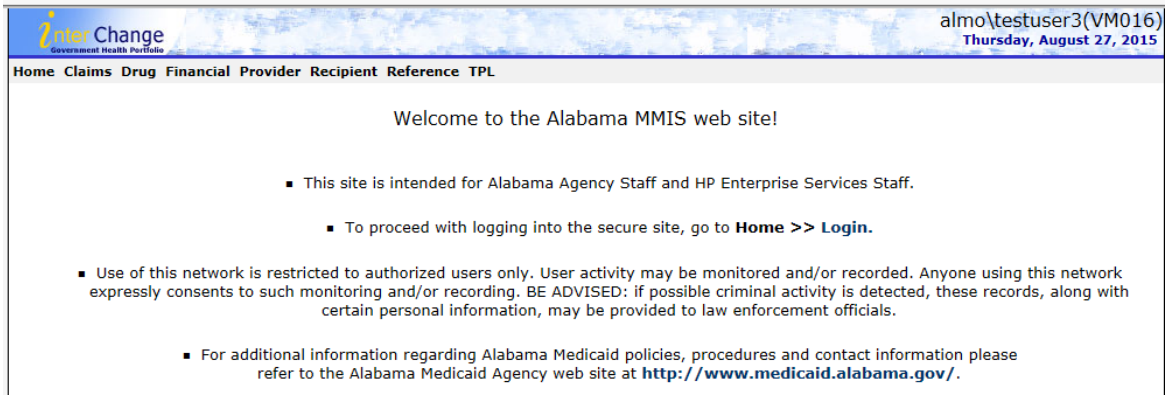
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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4.4 Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. DXC employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact the Assistant MMIS Coordinator.

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4.5 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into **AMMIS**.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or more importantly, documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

5.1 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

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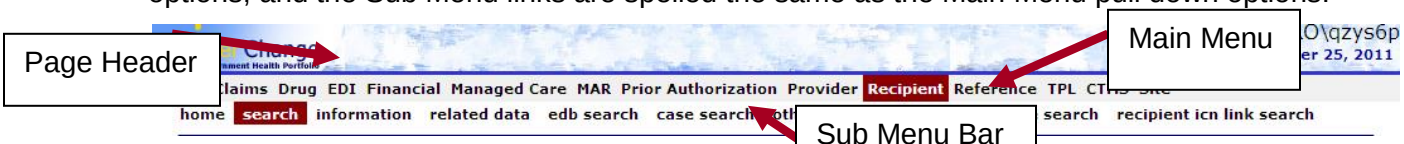
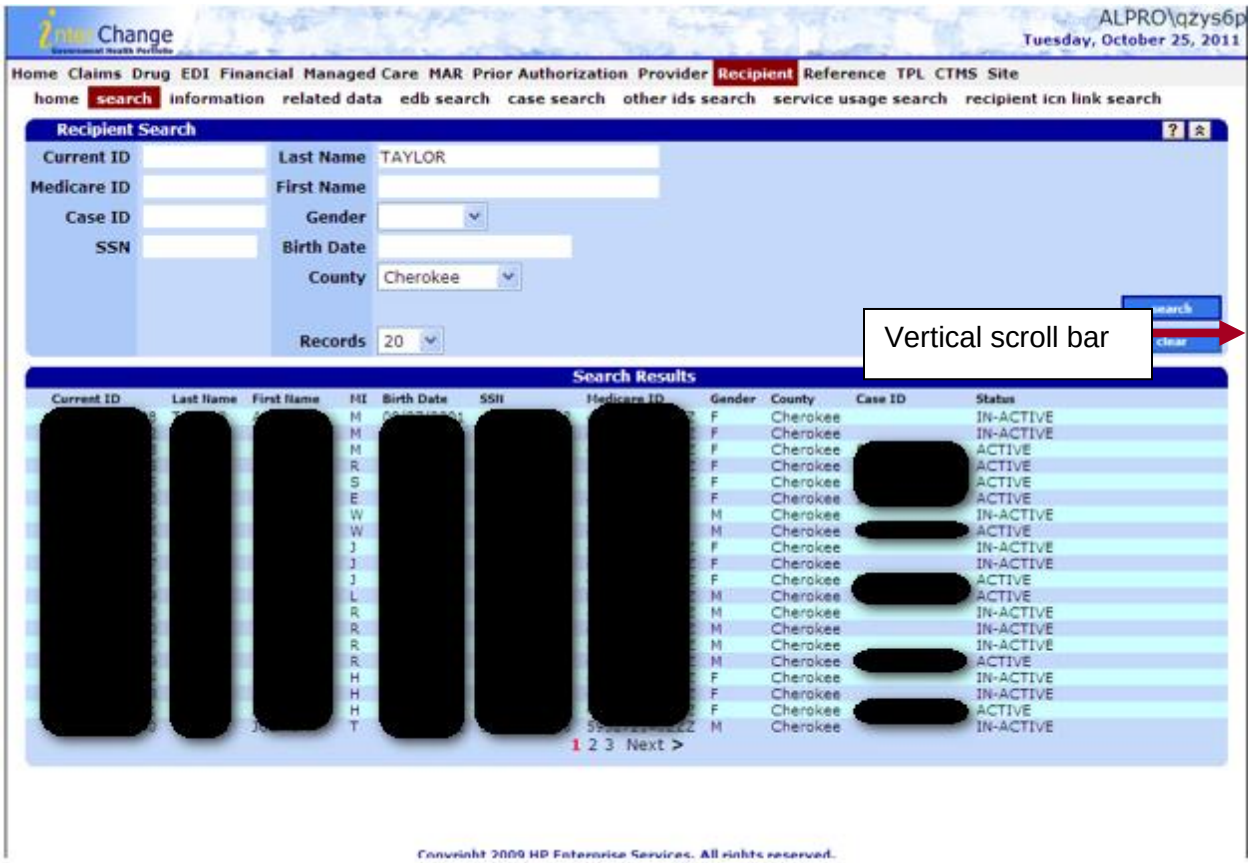
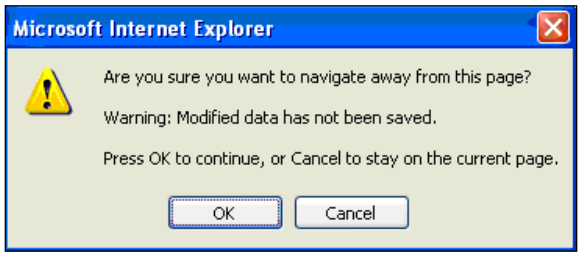
Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical sc the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



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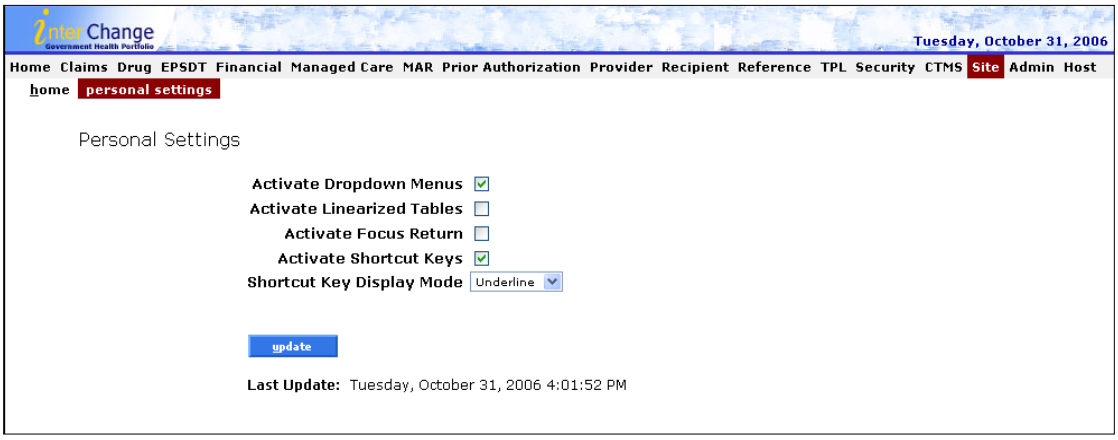
5.1.1 Shortcut Keys

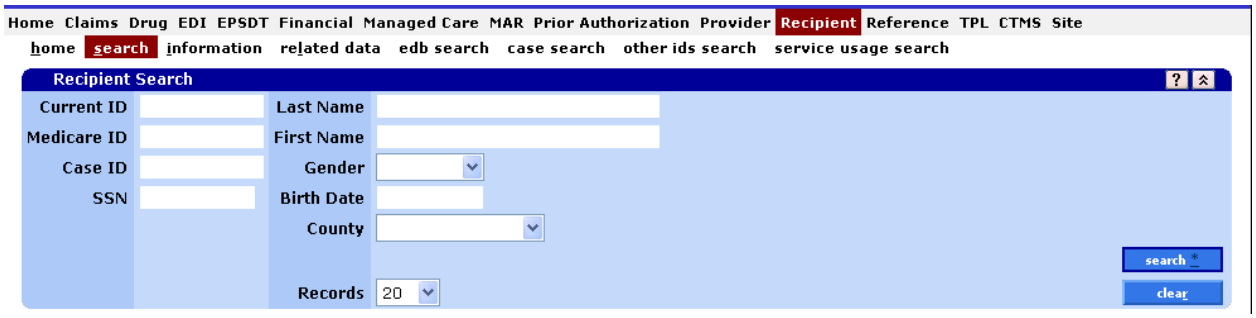
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + letter) to quickly open the associated page.

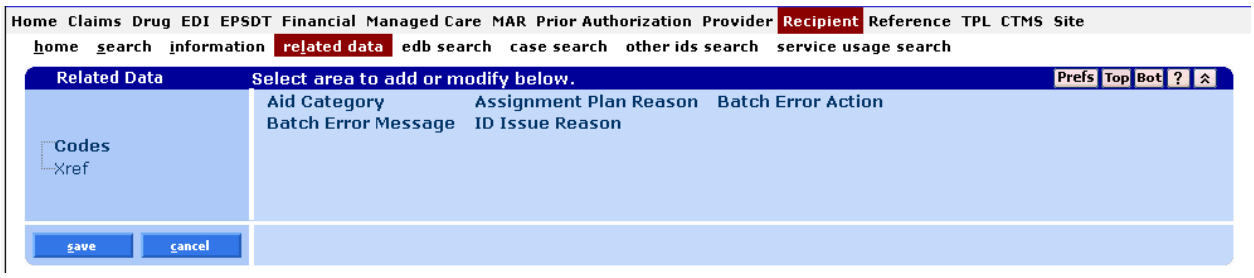
To active the shortcut key, click on the Site link, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar above and below it is the shortcut key letter.

Within the Recipient Sub Menu, the user can use the shortcut keys to quickly navigate from the Recipient Search panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter “L” is found within the horizontal bars on the Sub Menu Related Data link.





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5.2 Search Options

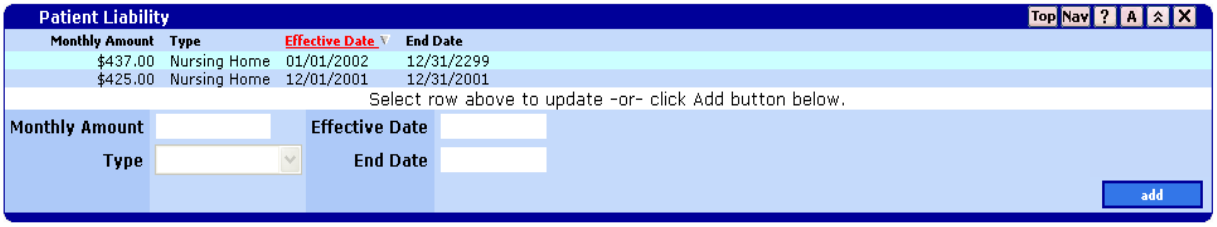
There are several search options available within the AMMIS.

5.2.1 Search Panels

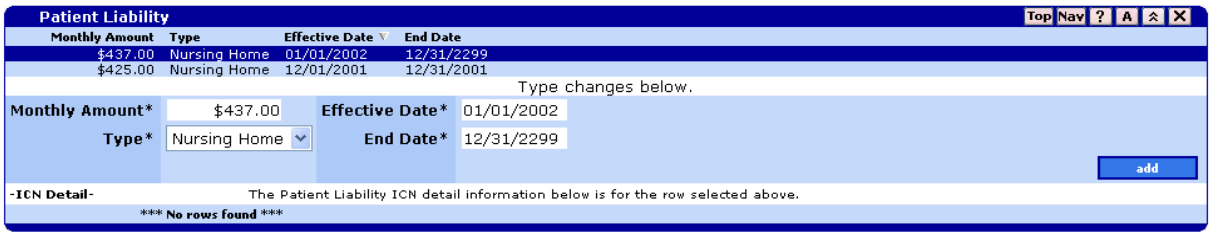
The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Recipient subsystem contain a search panel without an advanced search button included on the panel.

5.2.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicks the first row of the Recipient Patient Liability panel and detailed information displays at the bottom of the panel.



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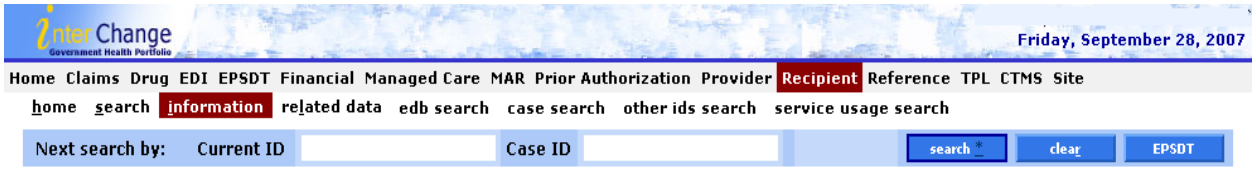
5.2.3 Mini Search

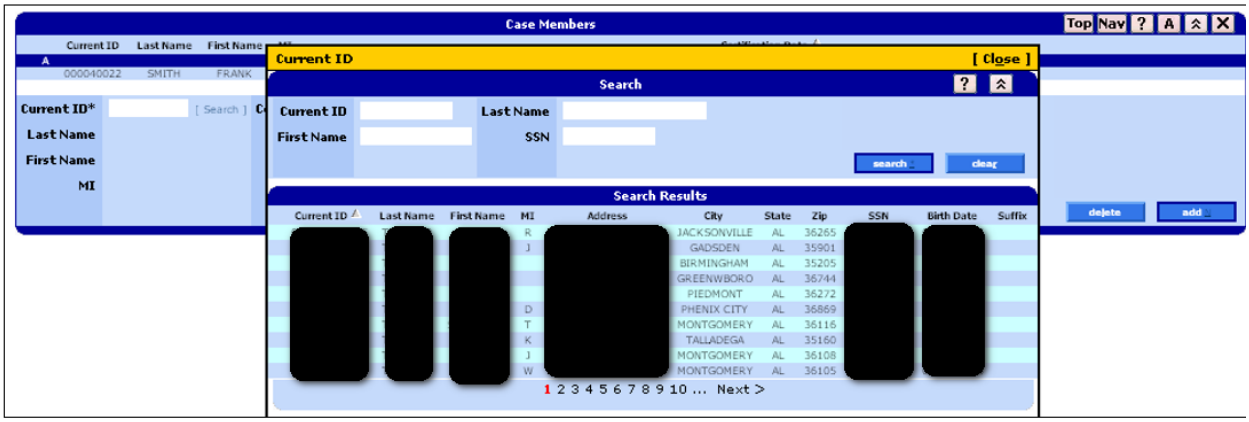
After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.



5.2.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user can access the search panel associated with that particular field.



5.3 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.3.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.

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Name	Icon	Description
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Maintain Button	maintain	Maintains a selected data record.
Preferences Button	Prefs	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

Among the panel types are the following:

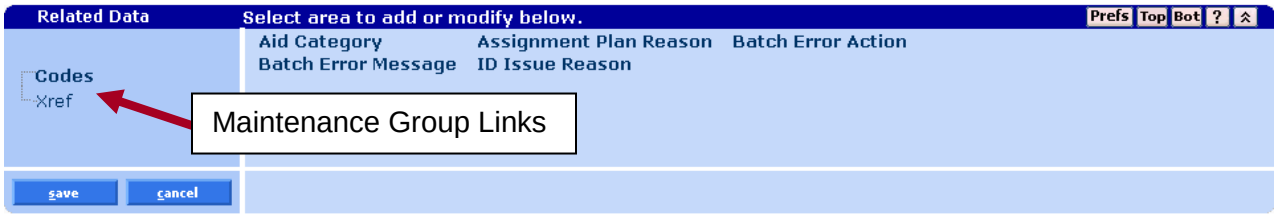
- Maintenance panel
- Task List panel
- Maintenance Item panel
- Audit panel

5.3.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page.

The following image demonstrates Maintenance Group Links (Codes and Xref) and the associated Maintenance Item links.



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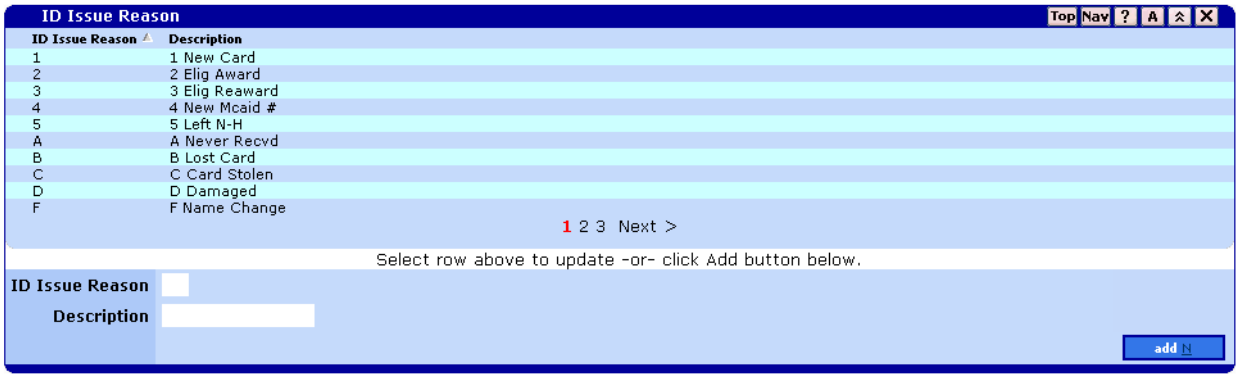
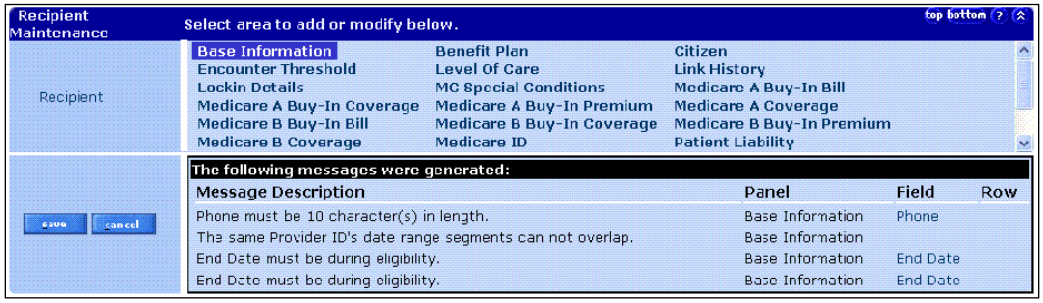
By clicking on a Maintenance Item Link (such as ID Issue Reason), the associated panel opens.

Results: ID Issue Reason Panel displays



5.3.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.



The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

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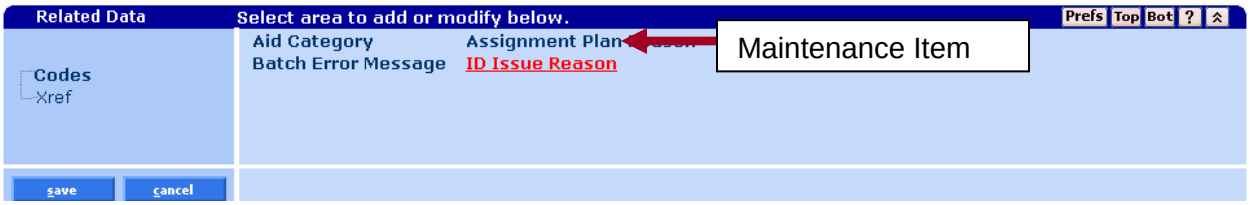
5.3.4 Maintenance Item Panel

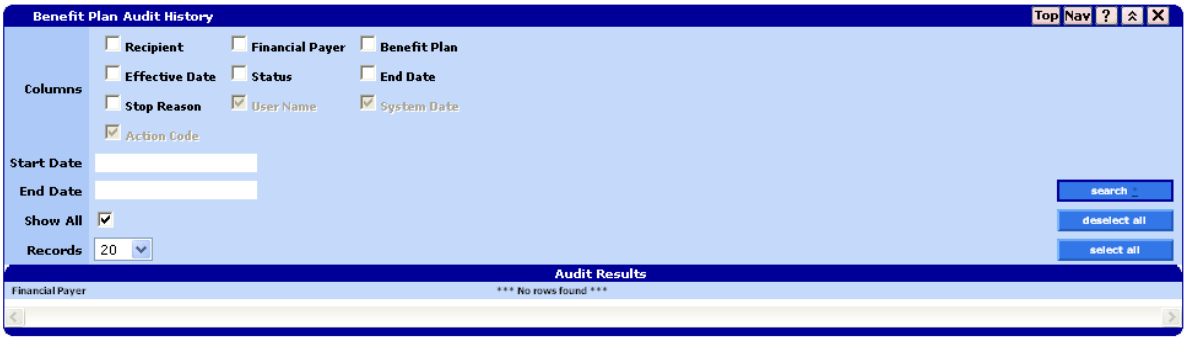
A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.3.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updateable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



5.4 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.1 Question Mark Icon

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

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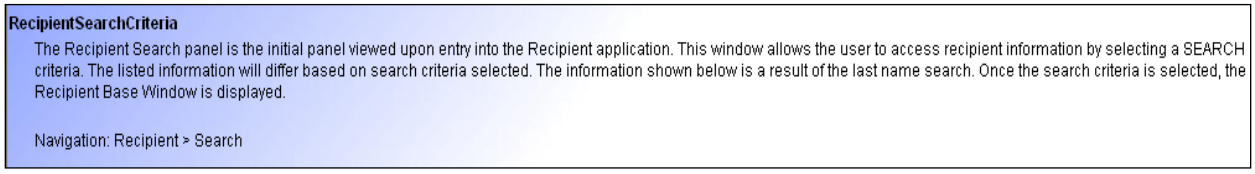
5.4.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Search	Click button to initiate a search	Button	N/A	0
Sounds-like	Sounds-like search indicator	Check Box	Check Box	0
County	Search by recipient's County	Combo Box	Character	18
Gender	Search by recipient's Gender	Combo Box	Character	10
Records Returned	Number of search items displayed on each page	Combo Box	Integer	2
Birth Date	Search by recipient's Birth Date	Field	Date (MM/DD/CCYY)	10
Case ID	Search by recipient's Case number	Field	Character	10
Current ID	Search by recipient's Medicaid number	Field	Integer	12
First Name	Search by recipient's First Name	Field	Character	13
Last Name	Search by recipient's Last Name	Field	Character	15
Medicare ID	Search by recipient's Medicare number	Field	Integer	12
SSN	Search by recipient's Social Security Number	Field	Integer	9

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	9000	At least one search field should be entered for search criteria	An entry is required to search for a recipient. Type in the Current ID or enter additional search criteria.
Sounds-like	Check Box	9000	At least one search field should be entered for search criteria	Enter additional search criteria
Birth Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify entry. Date must be in MM/DD/CCYY or MMDDCCYY format. Try again.
Current ID	Field	5010	Current ID must be numeric.	Enter a numeric ID.
Medicare ID	Field	5010	Medicare ID must be numeric.	Verify entry. The Medicare identification must contain only numerics
SSN	Field	5500	Enter a valid value	Verify entry. Social security number must be 9 characters numeric; you may input dashes (i.e., 999-99-9999).

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

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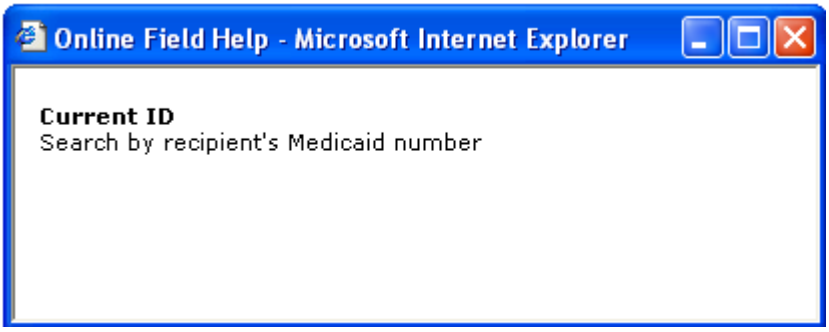
5.4.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up panel that contains information on the field selected.

5.4.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **Current ID**, a question mark appears as part of the cursor .

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6. Recipient Pages/Panels

This section gives a brief description of each window, shows a sample, and describes all associated window fields and field edits.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each window covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 Recipient Search Panel Overview

6.1.1 Recipient Search Panel Narrative

The Recipient Search panel is the initial panel viewed upon entry into the Recipient application. This panel allows the user to access recipient information by selecting Search By criteria. The listed information differs based on search criteria selected. This panel is inquiry only.

Navigation Path: [Recipient] - [Recipient Search]

6.1.2 Recipient Search Panel Layout

6.1.3 Recipient Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date	Search by recipient's Birth Date.	Field	Date (MM/DD/CCYY)	8
Case ID	Search by recipient's Case ID.	Field	Character	12
Clear	Allows the user to clear any changes on the Recipient Search panel.	Button	N/A	0
County	Search by recipient's County.	Combo Box	Drop Down List Box	0
Current ID	Search by recipient's Medicaid identification number.	Field	Character	12
First Name	Search by recipient's First Name.	Field	Character	13
Gender	Search by recipient's Gender.	Combo Box	Drop Down List Box	0
Last Name	Search by recipient's Last Name.	Field	Character	15
Medicare ID	Search by recipient's Medicare identification number.	Field	Character	12
Records	Number of search items displayed on each page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Search	Initiates the Search by Current ID, Medicare ID, Case ID, SSN or Last Name. First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.	Button	N/A	0
SSN	Search by recipient's Social Security Number.	Field	Number (Integer)	9

6.1.4 Recipient Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	9000	At least one search field should be entered for search criteria.	An entry is required to search for a recipient. Type in the Current ID or enter additional search criteria.
County	Combo Box	5505	Please enter at least the Last Name.	Enter Last Name. When searching by County only, the panel requires the Last Name as well.
Gender	Combo Box	5504	Please enter at least the Last Name.	Enter Last Name. When searching by Gender only, the panel requires the Last Name as well.
Birth Date	Field	5501	Please enter at least the Last Name.	Enter Last Name. When searching by Birth Date only, the panel requires the Last Name as well.
Current ID	Field	5010	Current ID must be numeric.	Enter a numeric ID.
First Name	Field	5506	Last Name is required when searching by First Name.	Enter Last Name. When searching by First Name only, the panel requires the Last Name as well.
Last Name	Field	5507	First Name must be 2 characters or longer if Last Name is shorter than 5 characters.	Enter additional information. When searching by Last Name only and the Last Name is shorter than 5 characters, First Name should at least be two characters long.
Medicare ID	Field	5502	Medicare ID must be Alpha Numeric.	Verify entry. Medicare ID should not contain strange symbols. Only characters A-Z and digits 0-9 are allowed in this field.
	Field	5503	Medicare ID must be at least 10 characters long.	Verify entry. Medicare ID should be at least 10 characters long.
SSN	Field	5500	Enter a valid value.	Verify entry. Social security number must be 9 characters numeric; you may input dashes (i.e., 999-99-9999).

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6.1.5 Recipient Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Recipient Search Panel Accessibility

6.1.6.1 To Access the Recipient Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Search**.	Recipient Search panel displays.

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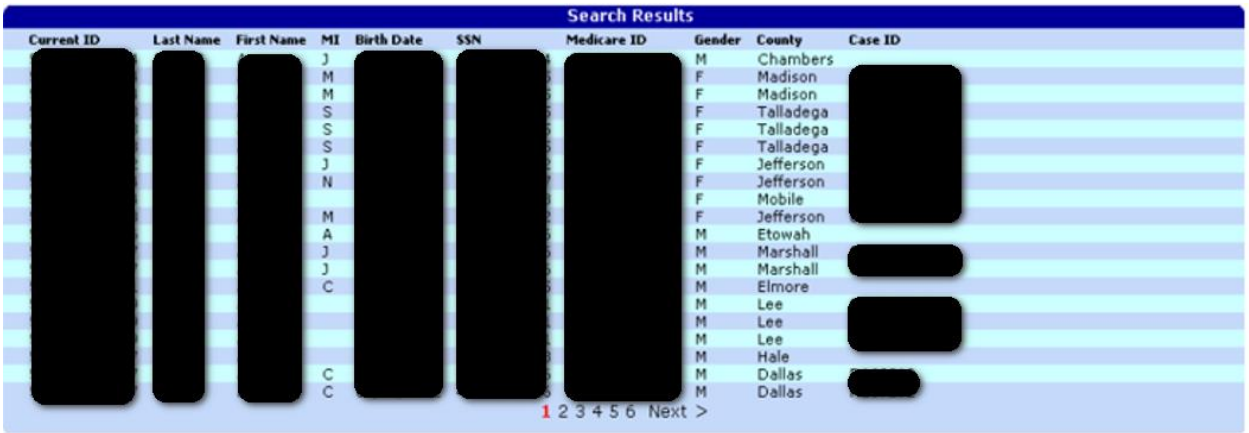
6.2 Recipient Search Results Panel Overview

6.2.1 Recipient Search Results Panel Narrative

The Recipient Search Results panel displays the outcome of the criteria entered on the Recipient Search panel 'if' there is more than one record matching the criteria. The "Recipient Information panel is displayed if only one record matches the criteria entered on the Recipient Search panel. If an 'inactive' ID is used on the Recipient Search panel, a message is displayed to inform the user that the ID is linked and is not the 'active' ID for the recipient.

Navigation Path: [Recipient] - [Recipient Search] – [Recipient Search Results]

6.2.2 Recipient Search Results Panel Layout



6.2.3 Recipient Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date	Recipient's Birth Date.	Listview	Date (MM/DD/CCYY)	8
Case ID	Recipient's Case (Payee) ID.	Listview	Character	12
County	Recipient's County of residence.	Listview	Character	18
Current ID	Recipient's Medicaid ID.	Listview	Character	12
First Name	Recipient's First Name.	Listview	Character	13
Gender	Recipient's Gender.	Listview	Character	1
Last Name	Recipient's Last Name.	Listview	Character	15
MI	Recipient's Middle Initial.	Listview	Character	1
Medicare ID	Recipient's Medicare identification number.	Listview	Character	12
SSN	Recipient's Social Security Number.	Listview	Number (Integer)	9

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6.2.4 Recipient Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Recipient Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Recipient Search Results Panel Accessibility

6.2.6.1 To Access the Recipient Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Search**.	Recipient Search panel displays.
3	Enter **Current ID**, **Medicare ID**, **Case ID**, **SSN** or **Last Name**. Note: First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.	
4	Click **Search**.	Recipient Search Results panel displays.

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6.3 Recipient Mini Search Panel Overview

6.3.1 Recipient Mini Search Panel Narrative

The Recipient Mini Search panel allows the user to search Recipient records based on Case ID and/or Medicaid ID.

This panel is inquiry only.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search]

6.3.2 Recipient Mini Search Panel Layout

6.3.3 Recipient Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case ID	Case identification number for next search.	Field	Character	12
Clear	Allows the user to clear any changes on the Recipient Mini Search panel.	Button	N/A	0
Current ID	Medicaid ID for next recipient search.	Field	Character	12
EPSDT	Allows the user to search for an EPSDT Screening History by Recipient identification number.	Button	N/A	0
Search	Initiates the Search by Current ID or Case ID.	Button	N/A	0
	The Back Button initiates a return back to the search results page	Button	N/A	0

6.3.4 Recipient Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 Recipient Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Recipient Mini Search Panel Accessibility

6.3.6.1 To Access the Recipient Mini Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.

6.3.6.2 To Navigate the Recipient Mini Search Panel

Step	Action	Response
1	Enter **Current ID** or **Case ID** into search field.	
2	Click **Search**.	Recipient Information panel displays.

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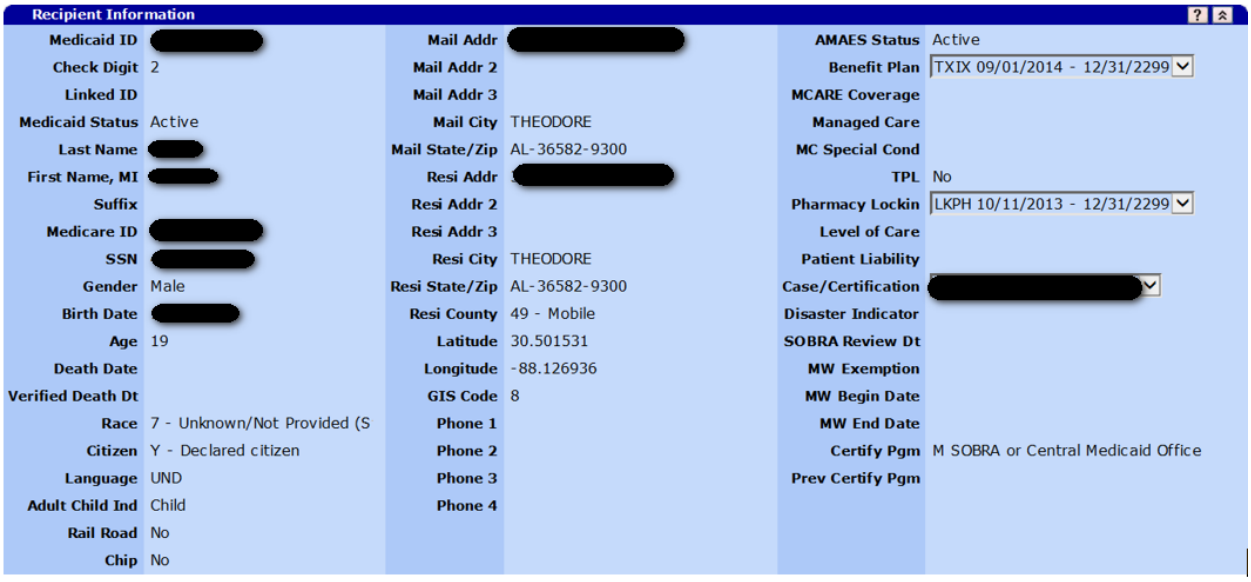
6.4 Recipient Information Panel Overview

6.4.1 Recipient Information Panel Narrative

The Recipient Information panel contains basic information about a recipient. A Recipient is a person who receives benefits from the State. Since most Base information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted. This panel is accessed to view information related to a recipient, such as demographic information and type of eligibility.

Navigation Path: [Recipient] – [Information] - [Enter Current ID or Case ID—click Search]

6.4.2 Recipient Information Panel Layout



Effective January 1, 2014 the Recipient's Citizenship code was changed from being set to a Default value = 'C – Unknown' to display values transmitted from the Alabama Medicaid Agency. The acceptable codes and descriptions for citizenship are:

Code	Descriptions
B	Battered Immigrant
C	Citizen
D1	Documented C/I
D2	Documented C/I
D3	Documented C/I
D4	Documented C/I

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D5 Medicare Exempt

D6 SSI Exempt

D7 SSDI Exempt

D8 Foster Care exempt

DA Citizen

DC Citizen deceased

DN Deemed newborn

E Conditional Entrant

F Parolee

G Afghan Immigrant

I Amer/Canadian Indian

L Lawful perm resident

M Amerasians

N Non-Qualif Non-citizen

P0 Pending documentation

P2 Pending only identity

P3 Pending only identity

P4 Pending only identity

P5 Pending citizenship

P6 Pending child <1 C/I

P7 Pending child >1 ID

P8 Pending citizenship<1

PR Awarded pending C/I

Q Iraqi Immigrant Status

R Refugee

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S Verified Alien

U Undocumented

UB Undocumented

UD Deceased undocumented

V Military, vet, DP

W Deportation withheld

X Unknown

Y Declared citizen

6.4.3 Recipient Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adult Child Ind	Identifies the recipient as either an adult ('A') or a child ('C').	Field	Character	1
Age	Recipient's Age. Calculated from the birth date to the current date.	Field	Number (Integer)	3
AMAES Status	Alabama Medicaid Agency's Status. Values: 0 = SOBRA Payee only 1 = Denied DO or SOBRA Application 2 = Pending Appl or Future Eligibility 3 = Death Deletion 4 = Regular Deletion 5 = Suspended Space = Active *Note –The numerical representation is not displayed on the panel.	Field	Character	100
Benefit Plan	Identifies the most current Benefit Plan and dates the recipient is enrolled. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0
Birth Date	Recipient's Birth Date.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Case/Certification	Identifies the recipient's Case ID and the date the recipient became certified in the Case. Certification Date is the date the Case was added to the system.	Combo Box	Drop Down List Box	0
Certify Pgm	Source of Recipient's Certification. Valid values: H = Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS Foster Care	Field	Character	102
Check Digit	The 13th or last digit for the recipient's Medicaid identification number.	Field	Character	1
Chip	Recipient's Chip Indicator. CHIP = Children's Health Insurance Program. Valid Values include: Spaces No Yes	Field	Character	3
Citizen	Recipient's Citizenship code. Prior to January 1, 2014 a default value = 'C – Unknown' was used in Alabama. After January 1, 2014 the Citizenship code will be updated to the new codes for active recipients as supplied by the Agency.	Field	Character	2
Death Date	Recipient's Date of Death, if applicable.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Disaster Indicator	Disaster Indicator is used to indicate survivors of natural disasters who have evacuated to Alabama and are temporarily receiving Medicaid Coverage. Field had originally been used for the Bay Exemption Indicator. Valid Values: RT = Rita - Texas YA = Katrina - Alabama YL = Katrina - Louisiana YM = Katrina Mississippi Spaces = None *Note – The expanded descriptions are not displayed on the panel.	Field	Character	2
First Name, Mid Init	Recipient's first name and middle initial.	Field	Character	30
Gender	Recipient's Gender. Valid values are Male Female Unknown	Field	Character	8
GIS Code	Geographical Information System code - indicates quality of the calculated longitude/latitude. Used in conjunction with Latitude and Longitude to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	4
Language	Recipient's Language. Default = 'UND' (Undetermined). Field is not currently used in Alabama.	Field	Character	15
Last Name	Recipient's last name.	Field	Character	30
Latitude	Recipient's calculated latitude. Latitude is used in conjunction with Longitude and GIS Code to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	11
Level of Care	Recipient's most current Level of Care information and dates active.	Combo Box	Drop Down List Box	0
Linked ID	If the Recipient has been linked to another Recipient, the "linked" recipient's number is displayed.	Field	Character	12

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Field	Description	Field Type	Data Type	Length
Longitude	Recipient's calculated longitude. Longitude is used in conjunction with Latitude and GIS Code to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	11
Mail Addr	Recipient's mailing street address.	Field	Character	30
Mail Addr 2	Additional Recipient mailing street address information, if applicable.	Field	Character	30
Mail Addr 3	Additional Recipient mailing street address information, if applicable. This field is not currently used in Alabama.	Field	Character	30
Mail City	Recipient's mailing address City.	Field	Character	18
Mail State/Zip	Recipient's mailing address State and 5-digit Zip Code and optional 4-digit Zip Extension (Zeroes if not known).	Field	Character	2
Managed Care	Recipient's most current Managed Care information and dates enrolled.	Combo Box	Drop Down List Box	0
Cond	Lists the Recipient's current and historical Managed Care Special Condition codes along with its enrollment periods.	Combo Box	Drop Down List Box	0
Medicaid ID	Recipient's Medicaid identification number.	Field	Character	12
Medicaid Status	Indicates if the recipient is "Active" or is a "Previous Number", meaning that the recipient ID keyed is not the Current ID.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
MCARE Coverage	Recipient's most current Medicare Coverage information. Valid Values: A = Part A B = Part B D = Part D Spaces = No Medicare Coverage NOTE: A Part D value displayed indicates the recipient is enrolled in a Part D plan. Claims editing for Part D is based on Medicare A and/or B dates displayed on the system.	Field	Character	40
Medicare ID	Recipient's Medicare ID (HIC Number).	Field	Character	12
MW Begin Date	Begin Date for Maternity Waiver Exemption, if applicable (Dependent on the Maternity Waiver Exemption field).	Field	Date (MM/DD/CCYY)	10
MW End Date	End Date for Maternity Waiver Exemption, if applicable (Dependent on the Maternity Waiver Exemption field).	Field	Date (MM/DD/CCYY)	10
MW Exemption	Identifies if the Recipient is exempt from the Maternity Waiver Program. Valid values: blank = not exempt 3 = Exempt for the Dates shown, provider may bill fee-for-service 4 = Not Exempt from MW Services, provider may bill fee-for-service *Note – The expanded descriptions are not displayed on the panel.	Field	Character	1
Patient Liability	Recipient's most current Patient Liability information and dates active.	Combo Box	Drop Down List Box	0
Pharmacy Lockin	Recipient's most current Pharmacy Lockin information and dates active (Physician Lockin can be found on the "Capitated Lock-in Assignment History" panel.)	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Phone 1	Recipient's Phone Number one with the designation of the type of phone.	Field	Character	20
Phone 2	Recipient's Phone Number two with the designation of the type of phone.	Field	Character	20
Phone 3	Recipient's Phone Number three with the designation of the type of phone.	Field	Character	20
Phone 4	Recipient's Phone Number four with the designation of the type of phone.	Field	Character	20
Phone Type	Location associated with recipient's phone number. Default value = 'Unknown'. Not currently used in Alabama.	Field	Character	15
Prev Certify Pgm	Previous Certifying Agency. Valid values: H= Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS FOSTER CARE	Field	Character	102
Race	Recipient's Race code. Valid values: A - Asian or Pacific Islander (State Value = A) E - Other Race or Ethnicity (State Value = O) B - Black (State Value = B) H - Hispanic (State Value = H) I - American Indian or Alaskan Native (State Value = I) C - Caucasian (State Value = W) 7 - Unknown/Not Provided (State Value = U)	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Rail Road	Railroad Indicator. Used exclusively by Third Party Liability. Indicates whether the Recipient is a Railroad retiree. Valid values: Yes No	Field	Character	3
Resi Addr	Recipient's residence street address.	Field	Character	30
Resi Addr 2	Additional Recipient's residence street address information. If applicable.	Field	Character	30
Resi Addr 3	Additional Recipient's residence street address information. If applicable.	Field	Character	30
Resi City	Recipient's residence address City.	Field	Character	18
Resi County	Recipient's current county of residence. Field includes County Code and corresponding description.	Field	Character	22
Resi State/Zip	Recipient's State of residence and 5-digit Zip Code and optional 4-digit Zip Extension (Zeroes if not known).	Field	Number (Integer)	13
SOBRA Review Dt	Date that the case worker needs to review the SOBRA case.	Field	Date (MM/DD/CCYY)	10
SSN	Recipient's Social Security Number.	Field	Number (Integer)	9
Suffix	Suffix of Recipient Name -- JR, SR for example. Not currently used in Alabama.	Field	Character	4
TPL	Indicates whether the recipient has TPL coverage. Valid values: Yes No	Field	Character	3
Verified Death Dt	Date the Recipient's Date of Death was verified. Not currently used in Alabama.	Field	Date (MM/DD/CCYY)	8

6.4.4 Recipient Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

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6.4.5 Recipient Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Recipient Information Panel Accessibility

6.4.6.1 To Access the Recipient Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	**Recipient Information** and Recipient Maintenance panels display.

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6.5 Base Information Panel Overview

The Base Information panel contains information about a Recipient that may be not updated. This includes Birth Date, Death Date, Ethnicity and Marital Status.

Navigation Path: [Recipient] – [Information] - [Enter Current ID or Case ID—click Search]

6.5.1 Base Information Panel Layout

6.5.2 Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date:	The date of birth for the recipient.	Field	Date (MM/DD/CCYY)	10
Death Date:	The date of death for the recipient.	Field	Date (MM/DD/CCYY)	10
Ethnicity:	The ethnicity of the recipient. Value of 01 means Hispanic. Value of 00 means not Hispanic.	Combo Box	Drop Down List Box	20
Marital Status:	Marital Status of Recipient.	Combo Box	Drop Down List Box	10

6.5.3 Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.5.4 Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.5 Base Information Panel Accessibility

6.5.5.1 To Access the Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	**Base Information** and Recipient Maintenance panels display.

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6.6 Recipient Maintenance Panel Overview

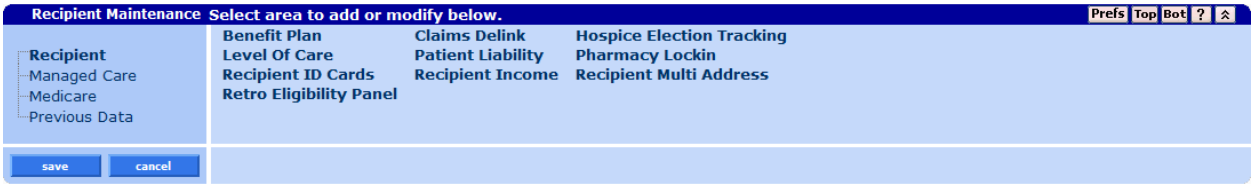
6.6.1 Recipient Maintenance Panel Narrative

The Recipient Maintenance panel is the access point for maintenance within the Recipient system. Users can choose from a list of panels on each of the following submenus: 'Recipient', 'Managed Care', 'Medicare', and 'Previous Data'. This panel is inquiry only.

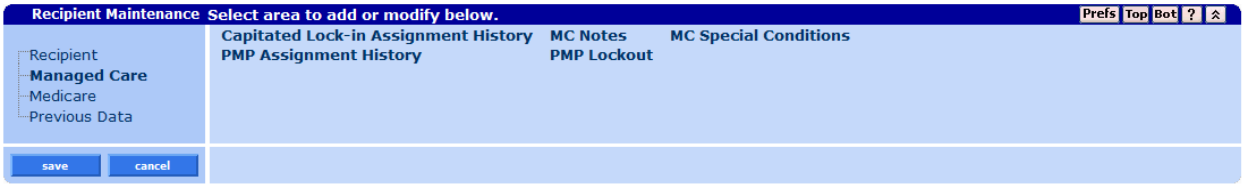
Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance]

6.6.2 Recipient Maintenance Panel Layout

Recipient

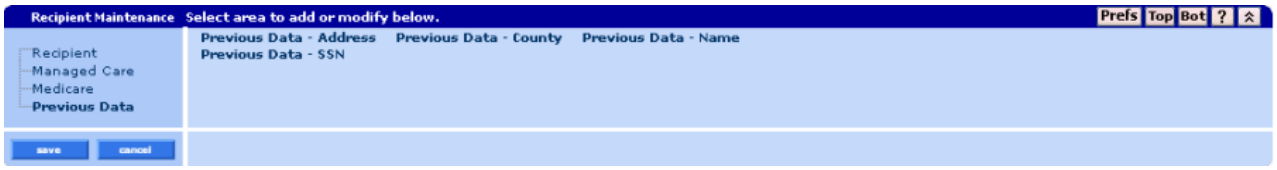


Managed Care



Medicare

Previous Data



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6.6.3 Recipient Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Recipient				
Benefit Plan	Link to the Recipient Benefit Plan panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel changes on the Recipient panels.	Button	N/A	0
Hospice Election Tracking	Link to the Hospice Election Tracking panel.	Hyperlink	N/A	0
Level of Care	Link to the Recipient Level Of Care panel.	Hyperlink	N/A	0
Pharmacy Lockin	Link to the Recipient Pharmacy Lockin panel.	Hyperlink	N/A	0
Patient Liability	Link to the Recipient Patient Liability panel.	Hyperlink	N/A	0
Recipient ID Cards	Link to the Recipient ID Cards panel.	Hyperlink	N/A	0
Recipient Income	Link to the Recipient Income panel.	Hyperlink	N/A	0
Recipient Multi Address	Link to the Recipient Multi Address panel.	Hyperlink	N/A	0
Retro Eligibility Panel	Link to the Retro Eligibility panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Recipient panels.	Button	N/A	0
Managed Care				
Cancel	Allows the user to cancel changes on the Managed Care panels.	Button	N/A	0
Capitated Lock-in Assignment History	Link to the Capitated Lock-in Assignment History panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
MC Notes Panel	Link to MC Notes Panel.	Hyperlink	N/A	0
MC Special Conditions	Link to the MC Special Conditions panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
PMP Assignment History	Link to the PMP Assignment History panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
PMP Lockout	Link to the PMP Lockout panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Managed Care panels.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Medicare				
Cancel	Allows the user to cancel changes on the Medicare panels.	Button	N/A	0
Medicare A Coverage	Link to the Medicare A Coverage panel.	Hyperlink	N/A	0
Medicare B Coverage	Link to the Medicare B Coverage panel.	Hyperlink	N/A	0
Medicare ID	Link to the Medicare ID panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Medicare panels.	Button	N/A	0
Previous Data				
Cancel	Allows the user to cancel changes on the Previous Data panels.	Button	N/A	0
Previous Data – Address	Link to the Previous Data – Address panel.	Hyperlink	N/A	0
Previous Data – County	Link to the Previous Data – County panel.	Hyperlink	N/A	0
Previous Data – Name	Link to the Previous Data – Name panel.	Hyperlink	N/A	0
Previous Data – SSN	Link to the Previous Data – SSN panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Previous Data panels.	Button	N/A	0

6.6.4 Recipient Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.5 Recipient Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 Recipient Maintenance Panel Accessibility

6.6.6.1 To Access the Recipient Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	

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Step	Action	Response
4	Click **Search**.	Recipient Information and **Recipient Maintenance** panels display.

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6.7 Benefit Plan Panel Overview

6.7.1 Benefit Plan Panel Narrative

The Benefit Plan panel is used to view eligibility segment information. This panel displays current and historical eligibility periods, Aid Categories, and other State programs. The eligibility periods are used to perform basic recipient editing in claims processing, TPL, etc. Since eligibility segment information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Benefit Plan]

6.7.2 Benefit Plan Panel Layout

6.7.3 Benefit Plan Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add benefit plan information. This button is not utilized by Alabama.	Button	N/A	0
Aid Category	Entity identifies the type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Aid Category Effective Date	Date that the recipient became eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Aid Category End Date	Date that the recipient is no longer eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Benefit Plan	Benefit Plan associated with the corresponding aid category. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Certifying Agency	Source of Recipient's Certification associated with the corresponding eligibility segment. Valid values: H = Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS Foster Care	Combo Box	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Benefit Plan panel.	Button	N/A	0
County	County Code and Description associated with the corresponding eligibility segment. Field includes County Code and corresponding description.	Combo Box	Drop Down List Box	0
D C Tracking	Data Control Tracking code associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete benefit plan information. This button will not be utilized by Alabama.	Button	N/A	0
Deprivation Code	Deprivation Code associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
DO Program Code	District Office Program associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
Effective Date	Date the recipient becomes eligible for the corresponding Benefit Plan.	Field	Date (MM/DD/CCYY)	8
End Date	Date the recipient is no longer eligible for the corresponding Benefit Plan.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Contains Financial Payer types. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Record Status	Status code for the program eligibility segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Status or Benefit Plan.	Button	N/A	0
Status	Status code for the program eligibility segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Stop Reason	Explains the termination of an eligibility period for a recipient. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0

6.7.4 Benefit Plan Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.7.5 Benefit Plan Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Benefit Plan Panel Accessibility

6.7.6.1 To Access the Benefit Plan Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Benefit Plan**.	Benefit Plan panel displays.

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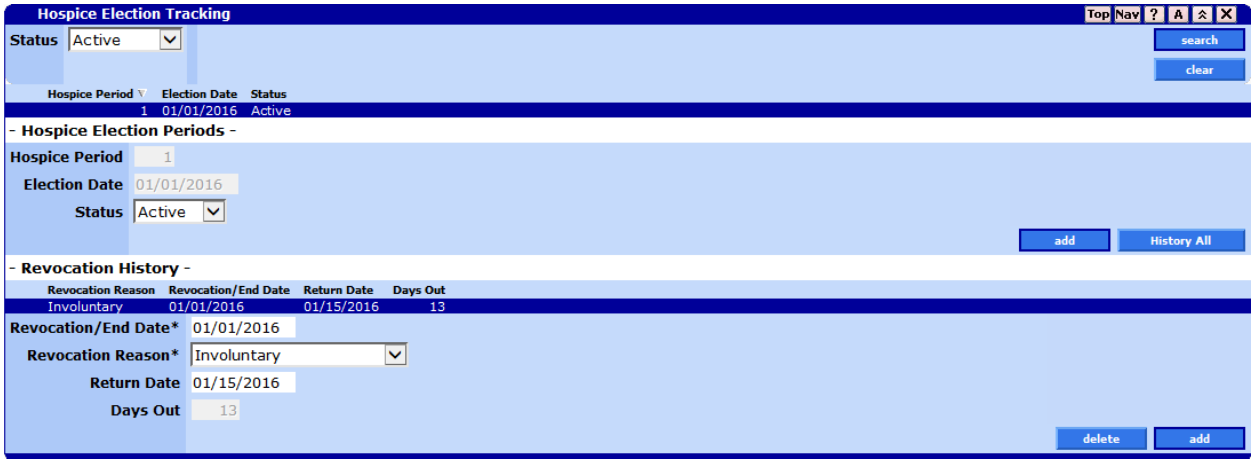
6.8 Hospice Election Tracking Panel Overview

6.8.1 Hospice Election Tracking Panel Narrative

The Hospice Election Tracking panel displays the hospice election tracking information for a recipient. This panel is updatable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance] - [Hospice Election Tracking]

6.8.2 Hospice Election Tracking Panel Layout



6.8.3 Hospice Election Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to update fields and add a new level of care record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Days Out	Number of day's recipient was out of hospice.	Field	Number (Integer)	3
Delete	Allows the user to delete a revocation record.	Button	N/A	0
Election Date	Election Date.	Field	Date (MM/DD/CCYY)	8
History All	Allows the user to update status to history for all active records.	Button	N/A	0
Hospice Period	Hospice Period.	Field	Number (Integer)	2
Return Date	Date in which recipient returned to the Hospice Election Tracking.	Field	Date (MM/DD/CCYY)	8
Revocation/End Date	Date in which recipient Hospice Election Tracking Revoked/Ended.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Revocation Reason	Revocation reason. Possible values are, V – Voluntary, I – Involuntary, R - Release Plan, C - Calculated by period end and D - Death.	Field	Drop Down List Box	1
Search	Clicking the Search button filters displayed segments by status.	Button	N/A	0
Status	Status for the Hospice Election Tracking. Possible values are A - Active, H - History, P - Previous.	Field	Drop Down List Box	1

6.8.4 Hospice Election Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Days Out	Field	1	Days Out must be less than or equal to 999.	Enter appropriate return date.
Election Date	Field	1	Election Date is required.	Enter Election Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter valid Election Date.
	Field	3	Election Date must be less than or equal to today's date.	Enter an election date less than or equal to today's date.
	Field	4	Election Date should not be within 90 days of care. However if this is revocation/return date then please add at detail. Based on current information entered, the next election date should be [M/D/YYYY].	This is just information message for 90 days calculation. If agree click save otherwise modify the election date.
	Field	5	Election Date should not be within 60 days of care. However if this is revocation/return date then please add at detail. Based on current information entered, the next election date should be [M/D/YYYY].	This is just information message for 60 days calculation. If agree click save otherwise modify the election date.
	Field	6	Are you sure about election date? If you click save it will recalculate all election periods. Please enter Revocation Date and Reason on detail panel.	This is just information message. If agree click save otherwise modify the election date.
	Field	7	Election Date must be greater than or equal to 1/1/1900.	Enter an election date greater than or equal to 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	8	Election Date must be less than or equal to 12/31/2299.	Enter an election date less than or equal to 12/31/2299.
	Field	9	You are trying to insert a previous election period between existing previous periods, you need to be inserting period prior to M/D/YYYY. If you need to insert date between these dates contact the LTC TFAL.	Enter an election date less than last previous election date or update the election date to make it active.
History All	Button	1	Are you sure you want to update the status to History for all records?	If you are sure click ok otherwise click cancel.
Return Date	Field	1	Please enter Return Date for hospice period [Number].	Enter return date for previous hospice period.
	Field	2	Return date cannot be removed once added.	Do not remove return date.
	Field	3	Invalid date. Format is mm/dd/ccyy.	Enter valid Return Date.
	Field	4	Return Date must be greater than or equal to 1/1/1900.	Enter a return date greater than or equal to 1/1/1900.
	Field	5	Return Date must be less than or equal to today's date.	Enter return date less than or equal to today's date.
	Field	6	The Revocation history date range segments cannot overlap.	Enter non-overlapping date range.
	Field	7	Return Date must be less than or equal to 12/31/2299.	Enter return date less than or equal to 12/31/2299.
Revocation/End Date	Field	1	Revocation date should not be less than Election Date for that period.	Enter revocation date greater then election date for that period.
	Field	2	Revocation date should not overlap over other record.	Enter non-overlapping date range.
	Field	3	Revocation date/reason systematically updated based on revocation date you entered. If you agree, click save.	This is notification message. If agree click save otherwise modify the revocation date.
	Field	4	Please enter Revocation Date and Reason.	Enter revocation date and reason.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Revocation Date should not be less than current election date.	Enter revocation date greater than current election date.
	Field	6	Revocation Date should not be greater than first election date.	Enter revocation date less than first election date.
	Field	7	Revocation/End Date must be greater than or equal to 1/1/1900.	Enter revocation date greater than or equal to 1/1/1900.
	Field	8	Invalid date. Format is mm/dd/ccyy.	Enter valid revocation date.
	Field	9	Revocation/End Date is required.	Enter Revocation/End Date.
Revocation Reason	Field	1	Revocation Reason is required.	Select a revocation reason.
	Field	2	'Calculated By Period End' Revocation reason is not valid for user entry.	Select appropriate revocation reason.
Search	Button	1	Please save or cancel any changes before searching hospice records.	Click Save or Cancel.
Status	Field	1	'Previous' status is not valid for user entry.	Select appropriate status.

6.8.5 Hospice Election Tracking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.8.6 Hospice Election Tracking Panel Accessibility

6.8.6.1 To Access the Hospice Election Tracking Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient**.	
6	Click **Hospice Election Tracking**.	Hospice Election Tracking panel displays.

6.8.6.2 To Add the Hospice Election Tracking Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter an **Election Date** in MM/DD/CCYY format.	
3	Click **Save**.	Hospice Election Tracking information is saved.

6.8.6.3 To Update the Hospice Election Tracking Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Hospice Election Tracking information is saved.

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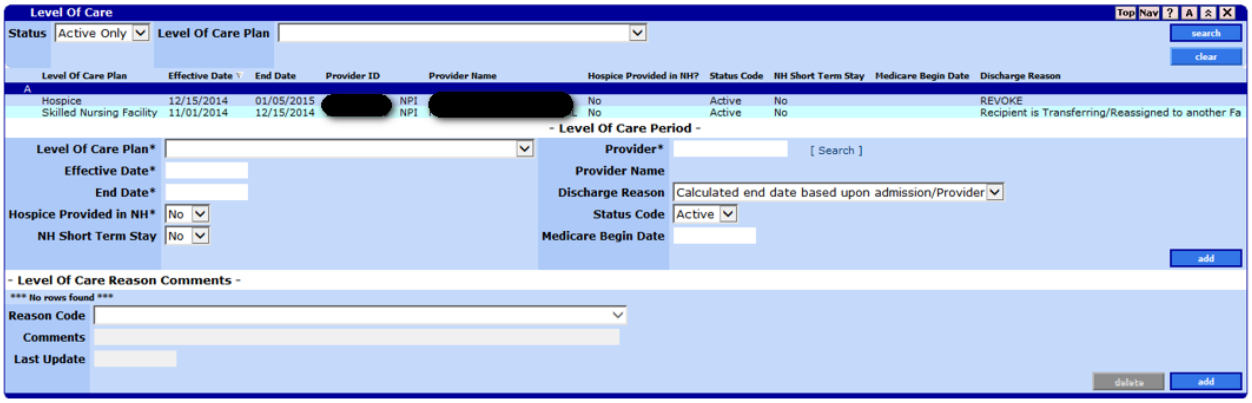
6.9 Level Of Care Panel Overview

6.9.1 Level Of Care Panel Narrative

The Level of Care panel displays the level of care information for a recipient. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance] - [Level of Care]

6.9.2 Level Of Care Panel Layout



6.9.3 Level Of Care Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to update fields and add a new Level of Care record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Comments	Free form area for comments about the Level of Care segment.	Field	Character	100
Delete	Allows the user to delete a level of care record.	Button	N/A	0
Discharge Reason	Specifies a reason to discharge a Level of Care plan. Default value will be “Calculated End Date based upon admission/provider”.	Combo Box	Drop Down List Box	0
Effective Date	Date that the recipient becomes eligible for the corresponding Level of Care plan.	Field	Date (MM/DD/CCYY)	8
End Date	Date the recipient is no longer eligible for the corresponding Level of Care plan.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Hospice Provided in NH	Indicates that Hospice is being provided in a facility.	Field	Drop Down List Box	0
Last Update	Last date record was updated	Field	Date (MM/DD/CCYY)	8
Level Of Care Plan	Level of Care plan authorized for the recipient.	Combo Box	Drop Down List Box	0
Medicare Begin Date	This date signifies that the recipient had Medicare covered days prior to this nursing facility segment.	Field	Date (MM/DD/CCYY)	8
NH Short Term Stay	Indicates when Nursing Home stay is anticipated to be less than 90 days. If Y = short term, if N means Not short term or Not Applicable	Combo Box	Drop Down List Box	1
Provider	Identification number assigned to a group or individual that provides medical services to recipients.	Field	Alphanumeric	9
Provider ID Type	Provider service location business identifier information that is assigned to the recipient.	List	Character	9
Reason Code	Reason for the Level of Care segment.	Combo Box	Drop Down List Box	0
Search	Clicking the Search button filters displayed segments by status and/or Level of Care plan.	Button	N/A	0
[Search]	Allows a user to locate a Provider by searching by Provider ID, Business OR Last Name and First, MI.	Hyperlink	N/A	0
Status	Status code for the Level of Care segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Status Code	Status code for the program eligibility segment. A blank means the segment is active and an 'H' means that the segment is history and no longer valid (Cancelled).	Combo Box	Drop Down List Box	0

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6.9.4 Level Of Care Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	4214	Overlapping segments cannot contain the same provider.	Enter non-overlapping date range or different provider.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
	Field	91232	Overlapping segments cannot contain the same LOC plan.	Enter non-overlapping date range or different LOC plan.
End Date	Field	4214	Overlapping segments cannot contain the same provider.	Enter non-overlapping date range or different provider.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
	Field	91232	Overlapping segments cannot contain the same LOC plan.	Enter non-overlapping date range or different LOC plan.
Level Of Care Plan	Field	91006	Level of Care field is required.	Verify keying.
Medicare Begin Date	Field	1001	Medicare Begin Date must be greater than or equal to 1/1/1900.	Enter an end date greater than or equal to 1/1/1900.
	Field	1002	Invalid Date (MM/DD/CCYY	Verify keying.
Provider	Field	91006	Provider ID is required.	Verify keying.
	Field	91007	Provider ID record not found. Please try again.	Verify and re-enter Provider.
Provider ID Type	Field	5176	Service Location invalid for this Provider.	Verify and re-enter location.

6.9.5 Level Of Care Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.9.6 Level Of Care Panel Accessibility

6.9.6.1 To Access the Level of Care Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient**.	
6	Click **Level of Care**.	Level of Care panel displays.

6.9.6.2 To Add the Level of Care Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Level of Care Plan** from the drop down list box.	
3	Enter an **Effective Date** in MM/DD/CCYY format.	
4	Enter an **End Date** in MM/DD/CCYY format.	
5	Select **Status Code** from the drop down list box.	
6	Enter **Provider**.	If Provider is unknown select [Search] to search by Provider ID, Business OR Last Name and First, MI.
7	Click **Save**.	Level of Care information is saved.

6.9.6.3 To Update the Level of Care Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Level of Care information is saved.

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6.10 Patient Liability Panel Overview

6.10.1 Patient Liability Panel Narrative

The Patient Liability panel is used to view a recipient's patient liability information. Since Patient Liability information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Patient Liability]

6.10.2 Patient Liability Panel Layout

6.10.3 Patient Liability Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Patient Liability information. This button is not utilized by Alabama.	Button	N/A	0
Amount Withheld	Amount withheld on the claim due to the Recipient's financial Patient Liability.	Field	Number (Decimal)	8
Date	Date the claim adjudicated in the system.	Field	Date (CCYY/MM)	6
Effective Date	Date that the patient's financial liability amount becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the patient's financial liability amount is no longer effective in a long term facility.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
ICN	Unique internal control number assigned to the claim when processed that indicates when the claim was received and whether it was sent by paper or through electronic media. The ICN is used to track the claim throughout processing.	Field	Character	13
Monthly Amount	Patient's financial liability amount that must be paid by the recipient before the State makes payment on the claim.	Field	Number (Decimal)	11
Type	Indicates which program to apply patient obligation. N = Nursing Home; P = Personal Care. Default is N = Nursing Home.	Combo Box	Drop Down List Box	0
Record Reference No	Unique identifier for patient liability.	Field	Number	9

6.10.4 Patient Liability Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.10.5 Patient Liability Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Patient Liability Panel Accessibility

6.10.6.1 To Access the Recipient Patient Liability Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Patient Liability**.	Patient Liability panel displays.

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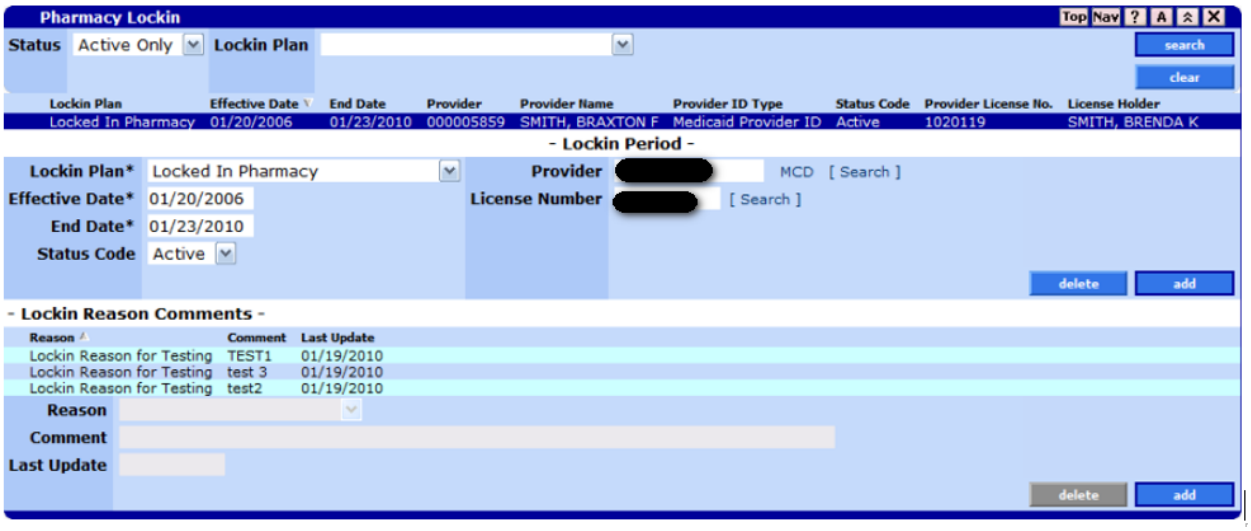
6.11 Pharmacy Lockin Panel Overview

6.11.1 Pharmacy Lockin Panel Narrative

The Pharmacy Lockin panel is used to view a recipient's pharmacy Lockin (restriction) segments. This panel is updateable for users with proper security access. Physician Lockin information can be found using the “Capitated Lock-in Assignment History” panel. This panel is described in more detail within the Managed Care subsystem.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Pharmacy Lockin]

6.11.2 Pharmacy Lockin Panel Layout



6.11.3 Pharmacy Lockin Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Pharmacy Lockin record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Comment	Free form area for comments about the Lockin segment.	Field	Character	100
Delete	Allows the user to delete a Pharmacy Lockin record.	Button	N/A	0
Effective Date	Effective Date establishes the start date of the time frame being restricted.	Field	Date (MM/DD/CCYY)	8
End Date	End Date establishes the end date of the time frame being restricted.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Last Update	Last date record was updated	Field	Date (MM/DD/CCYY)	8
License Number	Provider service location business identifier information that is assigned to the recipient.	Field	Character	10
Lockin Plan	Lockin Plan authorized for the recipient.	Combo Box	Drop Down List Box	0
Provider	Identification number assigned to a group or individual that provides medical services to recipients.	Field	Alphanumeric	15
Provider ID Type	Indicates what type of Provider ID was entered: Medicaid Provider ID or National Provider Identifier (NPI).	Listview	Character	20
Provider License No.	Provider service location business identifier information that is assigned to the recipient. Field automatically appears once the correct Provider ID is selected in Provider Field.	Listview	Character	10
Provider Name	Provider name associated with the provider identification number.	Listview	Character	40
Reason	Reason due to which recipient is Locked into the above Lockin Plan.	Field	Character	3
Search	Allows the user to filter displayed segments by status and/or Lockin Plan.	Button	N/A	0
[Search]	Allows a user to locate a Provider by searching by Provider ID, Business OR Last Name and First, MI. Allows a user to locate a License Number by searching by Provider License Number or Provider Name.	Hyperlink	N/A	0
Status	Status code for the Lockin segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Status Code	Status code for the Lockin segment. Allows users to choose what status the segment should be in: Active or History (Cancelled).	Combo Box	Drop Down List Box	0

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6.11.4 Pharmacy Lockin Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comments	Field	91006	Comment is Required.	Verify keying.
Effective Date	Field	1	Please select another prescriber or enter dates that are between the provider's program eligibility start and end date, or use an open end date.	Select another prescriber or enter dates that are between the provider's program eligibility start and end date or enter an open end date.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
End Date	Field	1	Please select another prescriber or enter dates that are between the provider's program eligibility start and end date, or use an open end date.	Select another prescriber or enter dates that are between the provider's program eligibility start and end date or enter an open end date.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
Lockin Plan	Combo Box	91006	A valid Lockin Plan is required.	Verify keying.
Provider	Field	1	A Lockin Plan for this provider already exists for the Effective Date.	Verify and re-enter provider or Effective Date.
	Field	4146	Invalid Provider.	Verify and re-enter Provider.
Reason	Combo Box	91006	A valid Reason Code is required.	Verify keying.

6.11.5 Pharmacy Lockin Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Pharmacy Lockin Panel Accessibility

6.11.6.1 To Access the Pharmacy Lockin Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Pharmacy Lockin**.	Pharmacy Lockin panel displays.

6.11.6.2 To Add the Pharmacy Lockin Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select a response from the **Lockin Plan** drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Select a response from the **Status Code** drop down list box.	
6	Enter **Provider number**.	
7	Enter **Provider License number**.	
8	Click **Save**.	Recipient Lockin Details information is saved.

6.11.6.3 To Update the Pharmacy Lockin Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Pharmacy Lockin information is saved.

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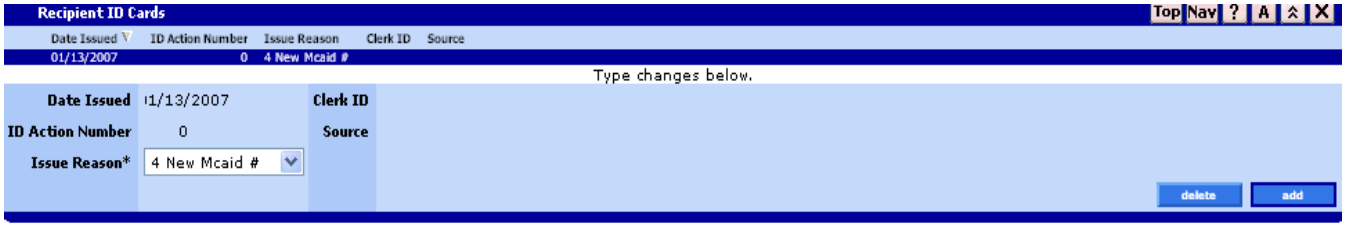
6.12 Recipient ID Cards Panel Overview

6.12.1 Recipient ID Cards Panel Narrative

The Recipient ID Cards panel is used to view and verify all ID card issuances for a recipient. This panel allows the user to view all the ID cards that were issued to a recipient as well as a corresponding reason as to why the card was issued. This panel allows the user to see a potential problem if a recipient has been issued too many ID cards. Since Plastic ID Card information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] –[Recipient Mini Search] – [Recipient Maintenance] - [Recipient ID Cards]

6.12.2 Recipient ID Cards Panel Layout



6.12.3 Recipient ID Cards Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient ID Card information. This button is not utilized by Alabama.	Button	N/A	0
Clerk ID	Clerk identification of the requester. All Plastic ID Cards information is supplied by the nightly AMAES update file.	Field	Character	8
Date Issued	Date that the ID card was issued to the recipient.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete Recipient ID Card information. This button is not utilized by Alabama.	Button	N/A	0
ID Action Number	Number of ID cards issued to the recipient.	Field	Character	2
Issue Reason	Reason the ID card was issued. The issue reason codes are converted to their actual description for readability. Valid values: Spaces = n/a A = Never Received B = Lost C = Stolen	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
	D = Damaged or Destroyed F = Changed Name G = Changed Gender H = Changed Race I = Change DOB J = Changed Med# 1 = New 2 = Awarded Eligibility 3 = Eligibility Re-Awarded 4 = New Medicaid# 5 = Left Nursing Home *Note: Only expanded description information is displayed on the panel.			
Source	Identifies the source that initiated the ID card. All Plastic ID Cards information is supplied by the nightly AMAES update file.	Field	Character	6

6.12.4 Recipient ID Cards Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.12.5 Recipient ID Cards Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 Recipient ID Cards Panel Accessibility

6.12.6.1 To Access the Recipient ID Cards Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Recipient ID Cards**.	Recipient ID Cards panel displays.

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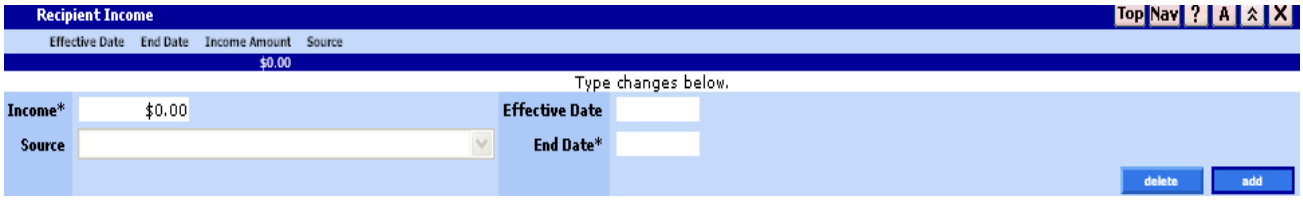
6.13 Recipient Income Panel Overview

6.13.1 Recipient Income Panel Narrative

The Recipient Income panel is used to display a recipient's income. Since income information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Recipient Income]

6.13.2 Recipient Income Panel Layout



6.13.3 Recipient Income Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient Income information. This button is not utilized by Alabama.	Button	N/A	0
Delete	Allows the user to delete Recipient Income information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Effective date of the income for the recipient. This field is not utilized by Alabama.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the income for the recipient. This field is not utilized by Alabama.	Field	Date (MM/DD/CCYY)	8
Income Amount	Recipient's income for a specified period of time. Field comes from the Gross Unearned income field via the nightly AMAES update field.	Field	Number (Decimal)	10
Source	Source of the income for the recipient. All Income information is supplied by the nightly AMAES update file.	Combo Box	Drop Down List Box	0

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6.13.4 Recipient Income Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.13.5 Recipient Income Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Recipient Income Panel Accessibility

6.13.6.1 To Access the Recipient Income Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient Income**.	Recipient Income panel displays.

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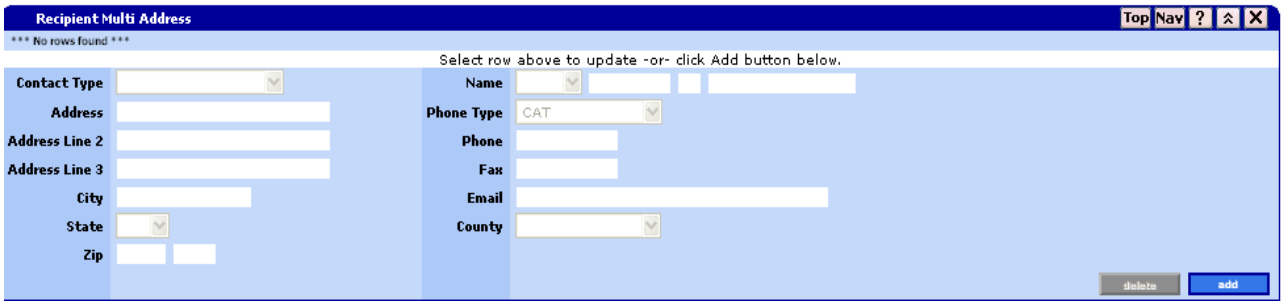
6.14 Recipient Multi Address Panel Overview

6.14.1 Recipient Multi Address Panel Narrative

The Recipient Multi Address panel is used to inquire on alternate addresses and contact information for a recipient. This panel displays Secondary, Sponsor and Spouse address information. The recipient's current address information is displayed on the Recipient Information panel. Previous addresses for a recipient can be found on the "Previous Data – Address" panel. Since all information on this panel comes from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Recipient Multi Address]

6.14.2 Recipient Multi Address Panel Layout



6.14.3 Recipient Multi Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient Multi-Address information. This button is not utilized by Alabama.	Button	N/A	0
Address	Secondary/Sponsor/Spouse primary street address.	Field	Character	30
Address Line 2	Secondary/Sponsor/Spouse street address line two, if applicable.	Field	Character	30
Address Line 3	Secondary/Sponsor/Spouse street address information, if additional space is needed. This field is not utilized by Alabama.	Field	Character	30
City	Secondary/Sponsor/Spouse city of residence.	Field	Character	15
Contact Type	Type of address. Valid values: SP = Spouse Address SE = Secondary Address SN = for Sponsor Address *Note: Only expanded description is displayed.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
County	Secondary/Sponsor/Spouse county of residence. Field includes County Code and corresponding description.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete Recipient Multi-Address information. This button is not utilized by Alabama.	Button	N/A	0
Email	Secondary/Sponsor/Spouse email address. This field is not utilized by Alabama.	Field	Character	50
Fax	Secondary/Sponsor/Spouse fax number. This field is not utilized by Alabama.	Field	Number (Integer)	10
Name	Secondary/Sponsor/Spouse name in first name/middle initial/last name format.	Field	Character	30
Phone	Secondary/Sponsor/Spouse phone number and extension. This field is not utilized by Alabama.	Field	Number (Integer)	17
Phone Type	Secondary/Sponsor/Spouse Telephone type. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0
State	Secondary/Sponsor/Spouse State of residence.	Combo Box	Drop Down List Box	0
Zip	Secondary/Sponsor/Spouse Zip Code + 4.	Field	Number (Integer)	9

6.14.4 Recipient Multi Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only in Alabama.				

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6.14.5 Recipient Multi Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Recipient Multi Address Panel Accessibility

6.14.6.1 To Access the Recipient Multi Address Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Recipient Multi Address**.	Recipient Multi Address panel displays.

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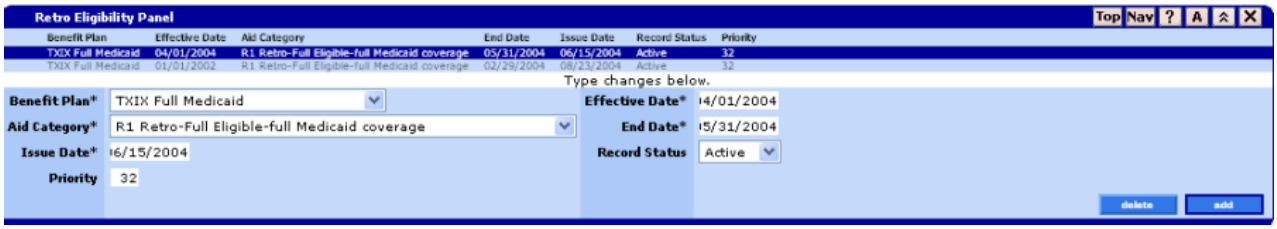
6.15 Retro Eligibility Panel Overview

6.15.1 Retro Eligibility Panel Narrative

The Retro Eligibility panel is used to view retro eligibility segment information. The retro segments are copied directly from the nightly AMAES update file and are also used to create the eligibility segments found on the Benefit Plan panel. The Issue Date is used directly in claims processing. Since all information on this panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Retro Eligibility Panel]

6.15.2 Retro Eligibility Panel Layout



6.15.3 Retro Eligibility Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Retro Eligibility information. This button is not utilized by Alabama.	Button	N/A	0
Aid Category	Entity identifies the type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Benefit Plan	Benefit Plan associated with the corresponding aid cat(s). Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove Retro Eligibility information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Date that the recipient became eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the recipient is no longer eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Issue Date	Date the Retro Eligibility segment was issued for the recipient.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Priority	Assigns importance of Aid Category. This field is not utilized by Alabama.	Field	Character	2
Record Status	Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0

6.15.4 Retro Eligibility Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.15.5 Retro Eligibility Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Retro Eligibility Panel Accessibility

6.15.6.1 To Access the Retro Eligibility Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Retro Eligibility panel**.	Retro Eligibility panel displays.

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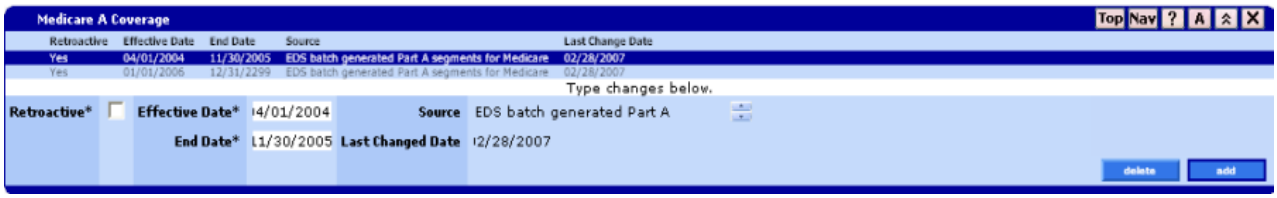
6.16 Medicare A Coverage Panel Overview

6.16.1 Medicare A Coverage Panel Narrative

The Medicare A Coverage panel is used to view or update Medicare Part A segments. The Medicare A Coverage panel contains the effective dates, end dates, Retroactive flag, and the last change date. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Medicare] - [Medicare A Coverage]

6.16.2 Medicare A Coverage Panel Layout



6.16.3 Medicare A Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare A Coverage information.	Button	N/A	0
Delete	Allows the user to delete Medicare A Coverage information. NOTE: Medicare coverage segments that are deleted will no longer display on the coverage panel, but can be viewed in the audit panel.	Button	N/A	0
Effective Date	Effective date for Medicare Part A.	Field	Date (MM/DD/CCYY)	8
End Date	End date for Medicare Part A.	Field	Date (MM/DD/CCYY)	8
Last Changed Date	Date the segment was last updated (system assigned).	Field	Date (MM/DD/CCYY)	8
Retroactive	Medicare Retroactive Determination Flag. This field is not utilized by Alabama.	Combo Box	Check Box	0
Source	Source of the transaction. Valid values: E = EDB M = AMAES (Medicaid) O = Online System X = EDS *Note: Only extended description is displayed on the panel.	Field	Character	25

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6.16.4 Medicare A Coverage Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1001	Effective Date must be first day of the month.	Enter an Effective Date that is the first day of the month.
	Field	5001	Effective Date is required.	Enter valid date or cancel transaction.
	Field	5015	Effective Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
End Date	Field	1002	End Date must be last day of the month.	Enter an End Date that is the last day of the month.
	Field	5001	End Date is required.	Enter valid date or cancel transaction.
	Field	5015	End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
Retroactive	Check Box	5001	Retroactive is required.	Field is default to 'no' (unchecked) when Effective and End dates are populated. Enter dates and check/uncheck box appropriately.

6.16.5 Medicare A Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Medicare A Coverage Panel Accessibility

6.16.6.1 To Access the Medicare A Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays

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Step	Action	Response
6	Select **Medicare A Coverage**.	Medicare A Coverage panel displays.

6.16.6.2 To Add the Medicare A Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Retroactive** checkbox, if applicable.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Recipient Medicare A Coverage information is saved.

6.16.6.3 To Update the Medicare A Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Recipient Medicare A Coverage information is saved.

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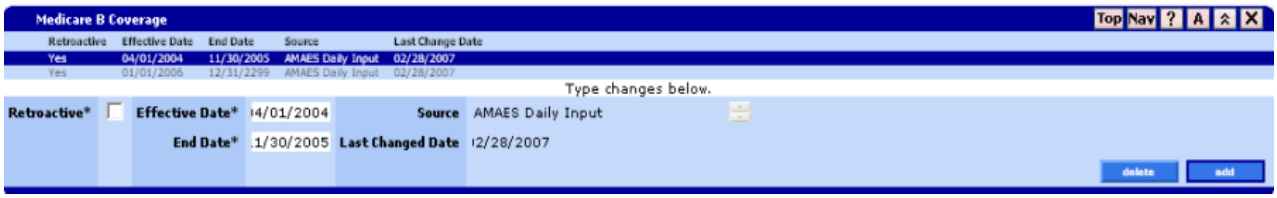
6.17 Medicare B Coverage Panel Overview

6.17.1 Medicare B Coverage Panel Narrative

The Medicare B Coverage panel is used to view or update Medicare Part B segments. The Medicare B Coverage panel contains the effective dates, end dates, Retroactive flag, and the last change date. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Medicare] - [Medicare B Coverage]

6.17.2 Medicare B Coverage Panel Layout



6.17.3 Medicare B Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare B Coverage information.	Button	N/A	0
Delete	Allows the user to delete Medicare B Coverage information. NOTE: Medicare coverage segments that are deleted will no longer display on the coverage panel, but can be viewed in the audit panel.	Button	N/A	0
Effective Date	Effective date for Medicare Part B.	Field	Date (MM/DD/CCYY)	8
End Date	End date for Medicare Part B.	Field	Date (MM/DD/CCYY)	8
Last Changed Date	Date the segment was last updated (system assigned).	Field	Date (MM/DD/CCYY)	8
Retroactive	Medicare Retroactive Determination Flag. This field is not utilized by Alabama.	Combo Box	Check Box	0
Source	Source of the transaction. Valid values: E = EDB M = AMAES (Medicaid) O = Online System X = EDS *Note: Only extended description is displayed on the panel.	Field	Character	25

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6.17.4 Medicare B Coverage Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1001	Effective Date must be first day of the month.	Ensure Effective Date is the first day of the month.
	Field	5001	Effective Date is required.	Enter valid date or cancel transaction.
	Field	5015	Effective Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
End Date	Field	1002	End Date must be last day of the month.	Ensure End Date is the last day of the month.
	Field	5001	End Date is required.	Enter valid date or cancel transaction.
	Field	5015	End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/1/01900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
Medicare B Coverage item	Field	1	Medicare ID (HIC) must be present when there is Medicare B enrollment.	If entering a Medicare B Coverage record, ensure that the recipient has a Medicare ID entered.
Retroactive	Check Box	5001	Retroactive is required.	Field is default to 'no' (unchecked) when Effective and End dates are populated. Enter dates and check/uncheck box appropriately.

6.17.5 Medicare B Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 Medicare B Coverage Panel Accessibility

6.17.6.1 To Access the Medicare B Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.

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2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays.
6	Select **Medicare B Coverage**.	Medicare B Coverage panel displays.

6.17.6.2 To Add the Medicare B Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Retroactive** checkbox, if applicable.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Recipient Medicare B Coverage information is saved.

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6.17.6.3 To Update the Medicare B Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Recipient Medicare B Coverage information is saved.

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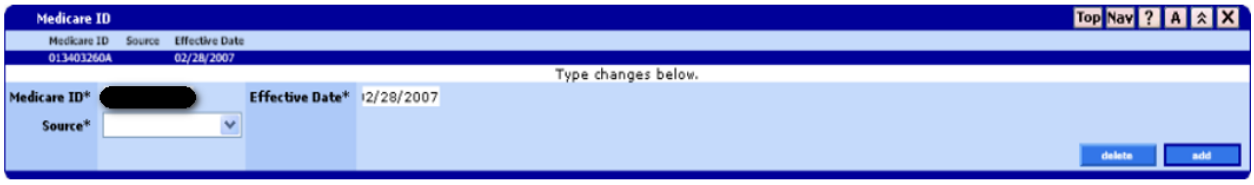
6.18 Medicare ID Panel Overview

6.18.1 Medicare ID Panel Narrative

The Medicare ID panel contains the Medicare ID, Source, and Effective Date for a recipient. Since Medicare ID information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted. Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Medicare] - [Medicare ID]

6.18.2 Medicare ID Panel Layout



6.18.3 Medicare ID Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare ID information. This button is not utilized by Alabama.	Button	N/A	0
Delete	Allows the user to delete Medicare ID information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Date the new Medicare ID was added and became effective. In Alabama, this is the date the Medicare ID was added to the EDS system.	Field	Date (MM/DD/CCYY)	8
Medicare ID	Recipient's current or previous Medicare ID (HIC).	Field	Character	12
Source	1 byte source indicator that specifies the external entity that triggered a HIC addition or update. All Medicare ID information in Alabama comes from the nightly AMAES update file.	Combo Box	Drop Down List Box	0

6.18.4 Medicare ID Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

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6.18.5 Medicare ID Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 Medicare ID Panel Accessibility

6.18.6.1 To Access the Medicare ID Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays.
6	Select **Medicare ID**.	Medicare ID panel displays.

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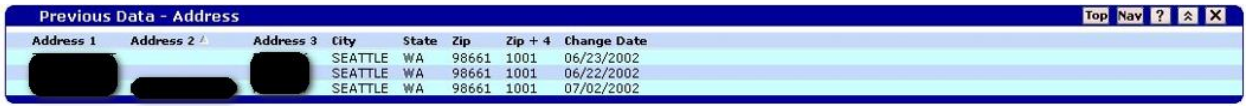
6.19 Previous Data - Address Panel Overview

6.19.1 Previous Data - Address Panel Narrative

The Previous Address panel is used to view previous known addresses for a recipient. If the main address for a recipient is changed, the previous address information is displayed here. If a recipient has more than one previous address, more than one row of data is displayed. The Address panel is inquiry only and is accessed through the Previous Data panel. The recipient's current address information is displayed on the Recipient Information panel.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - Address]

6.19.2 Previous Data - Address Panel Layout



6.19.3 Previous Data - Address Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Address line 1 of the recipient's previous address.	Listview	Character	30
Address 2	Address line 2 of the recipient's previous address.	Listview	Character	30
Address 3	Address line 3 of the recipient's previous address. This field is not utilized by Alabama.	Listview	Character	30
Change Date	Date the recipient's address changed.	Listview	Date (MM/DD/CCYY)	8
City	Previous city of the recipient.	Listview	Character	18
State	Previous state of the recipient.	Listview	Character	2
Zip	Recipient's previous zip code.	Listview	Number (Integer)	5
Zip +4	Recipient's previous zip code +4.	Listview	Number (Integer)	4

6.19.4 Previous Data - Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.19.5 Previous Data - Address Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 Previous Data - Address Panel Accessibility

6.19.6.1 To Access the Previous Data-Address Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-Address**.	Previous Data-Address panel displays.

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6.20 Previous Data - County Panel Overview

6.20.1 Previous Data - County Panel Narrative

The Previous County panel is used to view previous known counties for a recipient. If a recipient has more than one previous county, more than one row of data is displayed. The Previous County panel is inquiry only and is accessed through the Previous Data panel.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - County]

6.20.2 Previous Data - County Panel Layout

6.20.3 Previous Data - County Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Change Date	Date the recipient's county changed.	Listview	Date (MM/DD/CCYY)	8
County Code	Counties of prior residence.	Listview	Character	2
Office Code	County office of prior residence. This field is not utilized by Alabama..	Listview	Character	1

6.20.4 Previous Data - County Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.20.5 Previous Data - County Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Previous Data - County Panel Accessibility

6.20.6.1 To Access the Previous Data-County Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.

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Step	Action	Response
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-County**.	Previous Data-County panel displays.

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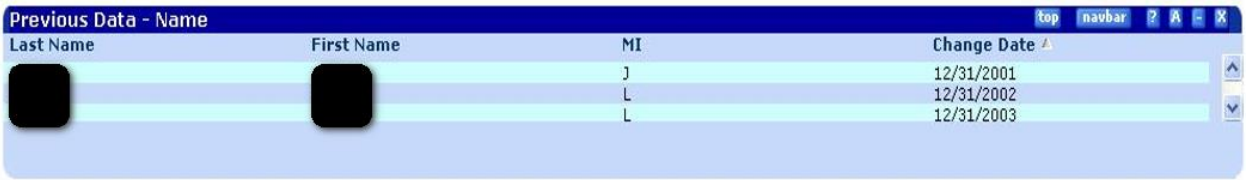
6.21 Previous Data - Name Panel Overview

6.21.1 Previous Data - Name Panel Narrative

The Previous Name panel is used to view previous known names for a recipient. The Previous Name panel is inquiry only and is accessed through the Previous Data panel. If a recipient has more than one previous name, more than one row of data is displayed.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - Name]

6.21.2 Previous Data - Name Panel Layout



6.21.3 Previous Data - Name Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Change Date	Date the recipient's name was changed.	Listview	Date (MM/DD/CCYY)	8
First Name	Previous first name of a recipient.	Listview	Character	13
Last Name	Previous last name of a recipient.	Listview	Character	15
MI	Previous middle initial of the recipient.	Listview	Character	1

6.21.4 Previous Data - Name Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.21.5 Previous Data - Name Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Previous Data - Name Panel Accessibility

6.21.6.1 To Access the Previous Data-Name Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.

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Step	Action	Response
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-Name**.	Previous Data-Name panel displays.

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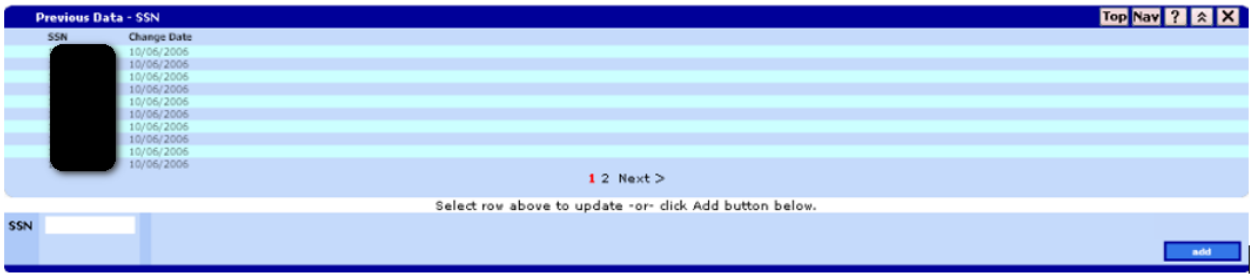
6.22 Previous Data - SSN Panel Overview

6.22.1 Previous Data - SSN Panel Narrative

The Previous SSN panel is used to view previous known Social Security Numbers for a recipient. The Previous SSN panel is inquiry only and is accessed through the Previous Data panel. If a recipient has more than one previous SSN, more than one row of data is displayed.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - SSN]

6.22.2 Previous Data - SSN Panel Layout



6.22.3 Previous Data - SSN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add SSN information for a recipient. This button is not utilized by Alabama.	Button	N/A	0
Change Date	Date the recipient's SSN was changed.	Listview	Date (MM/DD/CCYY)	8
SSN	Social Security Number of the Recipient.	Listview	Number (Integer)	9

6.22.4 Previous Data - SSN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.22.5 Previous Data - SSN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.22.6 Previous Data - SSN Panel Accessibility

6.22.6.1 To Access the Recipient Previous Data-SSN Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-SSN**.	Previous Data-SSN panel displays.

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6.23 Related Data Page Overview

6.23.1 Related Data Page Narrative

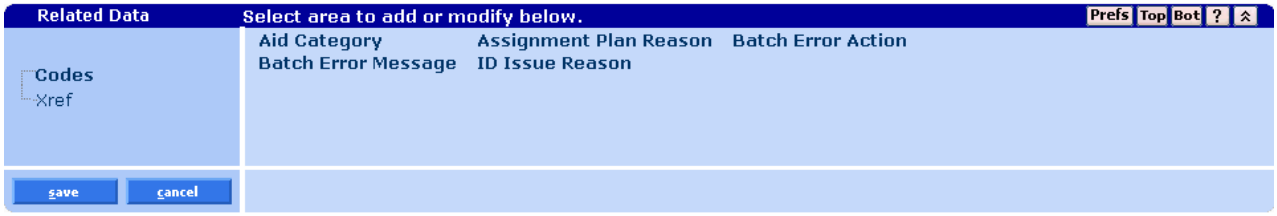
The Related Data page serves as a menu to Related Data panels. Sub-menu options include 'Codes and 'Xref'. The 'Codes' menu is the first to display. Users have the options of selecting 'Xref'.

This page is inquiry only.

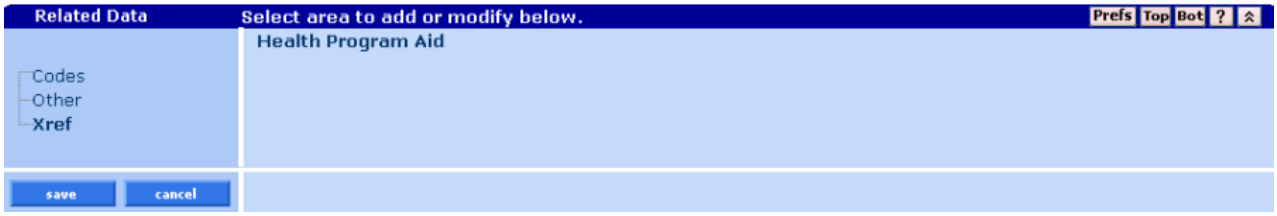
Navigation Path: [Recipient] - [Related Data]

6.23.2 Related Data Page Layout

Codes



Xref



6.23.3 Related Data Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Codes				
Aid Category	Link to the Aid Category panel.	Hyperlink	N/A	0
Assignment Plan Reason	Link to the Assignment Plan Reason panel.	Hyperlink	N/A	0
Batch Error Action	Link to the Batch Error Action panel. Used by DXC only.	Hyperlink	N/A	0
Batch Error Message	Link to the Batch Error Message panel. Used by DXC only.	Hyperlink	N/A	0
ID Issue Reason	Link to the ID Issue Reason panel.	Hyperlink	N/A	0
Xref				
Health Program Aid	Link to the Health Program Aid panel.	Hyperlink	N/A	0

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6.23.4 Related Data Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.23.5 Related Data Page Extra Features

Field	Field Type
No extra features found for this page.	

6.23.6 Related Data Page Accessibility

6.23.6.1 To Access the Related Data Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.

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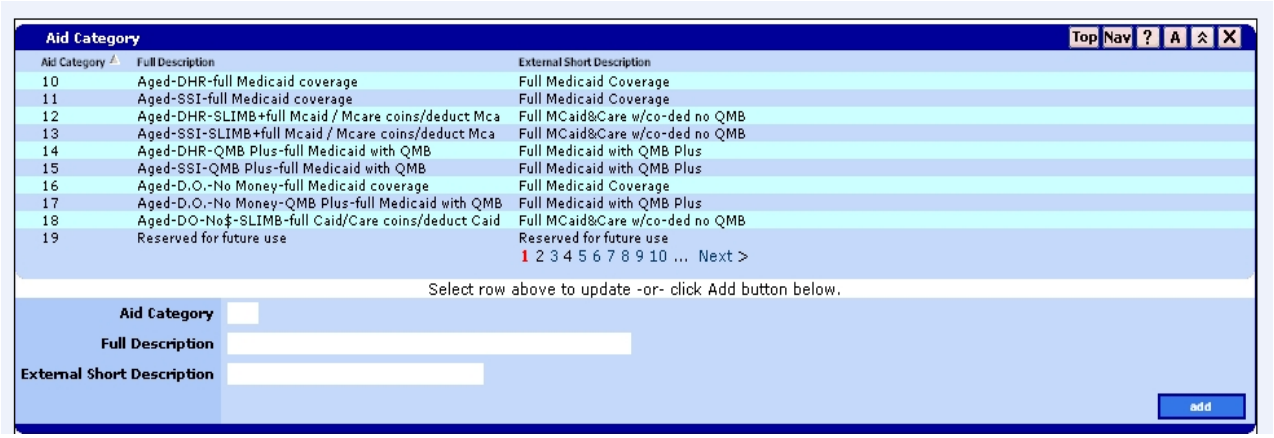
6.24 Aid Category Panel Overview

6.24.1 Aid Category Panel Narrative

The Aid Category panel stores the valid aid category codes and associated descriptions for Alabama. This is a code table panel that is updateable to those with the proper security access.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Aid Category]

6.24.2 Aid Category Panel Layout



6.24.3 Aid Category Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Aid Category record.	Button	N/A	0
Aid Category	Identifies the type of aid for which a recipient is eligible.	Field	Character	2
External Short Description	This description is used for display for providers and other external entities.	Field	Character	31
Full Description	Describes the type of aid for which a recipient is eligible. This is the full description that is used internally.	Field	Character	50

6.24.4 Aid Category Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Category	Field	5001	Aid Category is required.	Enter value or cancel transaction.
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.

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Field	Field Type	Error Code	Error Message	To Correct
Full Description	Field	5001	Full Description is required.	Enter Full Description or cancel transaction.

6.24.5 Aid Category Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Aid Category Panel Accessibility

6.24.6.1 To Access the Aid Category Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Click the **Aid Category** hyperlink.	Aid Category panel displays.

6.24.6.2 To Add Aid Category Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Aid Category**.	
3	Enter **Full Description**.	
4	Enter **External Short Description**.	
5	Click **Save**.	Aid Category information is saved.

6.24.6.3 To Update Aid Category Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in **Full Description or External Short Description** field to update and perform update.	
3	Click **Save**.	Aid Category information is saved.

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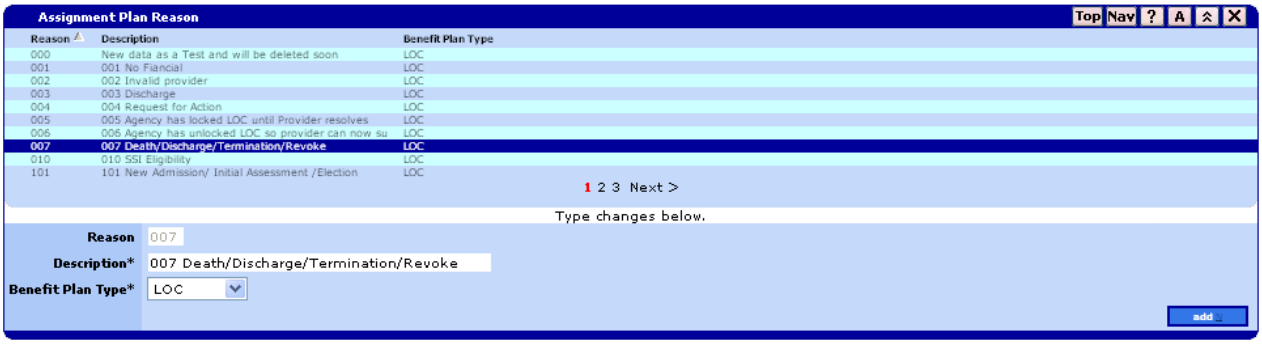
6.25 Assignment Plan Reason Panel Overview

6.25.1 Assignment Plan Reason Panel Narrative

The Assignment Plan Reason panel stores the valid assignment plan reason codes and associated descriptions and benefit plan types for Alabama. This is a code table panel that is updateable to those with the proper security access.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Assignment Plan Reason]

6.25.2 Assignment Plan Reason Panel Layout



6.25.3 Assignment Plan Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Assignment Plan Reason information.	Button	N/A	0
Benefit Plan Type	Benefit Plan Type associated with the reason code. Valid Values: Hospice LOC Lockin Waiver	Combo Box	Drop Down List Box	0
Description	Description associated with the reason code.	Field	Character	50
Reason	Code indicating the reason for the assignment plan.	Field	Character	3

6.25.4 Assignment Plan Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Type	Combo Box	N/A	A valid Benefit Plan Type is required	Select a Benefit Plan Type from the dropdown box.
Description	Field	N/A	Description is required.	Enter a Description.

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Field	Field Type	Error Code	Error Message	To Correct
Reason	Field	N/A	Reason is required.	Enter a Reason.

6.25.5 Assignment Plan Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Assignment Plan Reason Panel Accessibility

6.25.6.1 To Access the Assignment Plan Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Assignment Plan Reason**.	Assignment Plan Reason panel displays.

6.25.6.2 To Add Assignment Plan Reason Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Reason**.	
3	Enter **Description**.	
4	Select **Benefit Plan Type** from drop down list box.	
5	Click **Save**.	Assignment Plan Reason information is saved.

6.25.6.3 To Update Assignment Plan Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Assignment Plan Reason information is updated.

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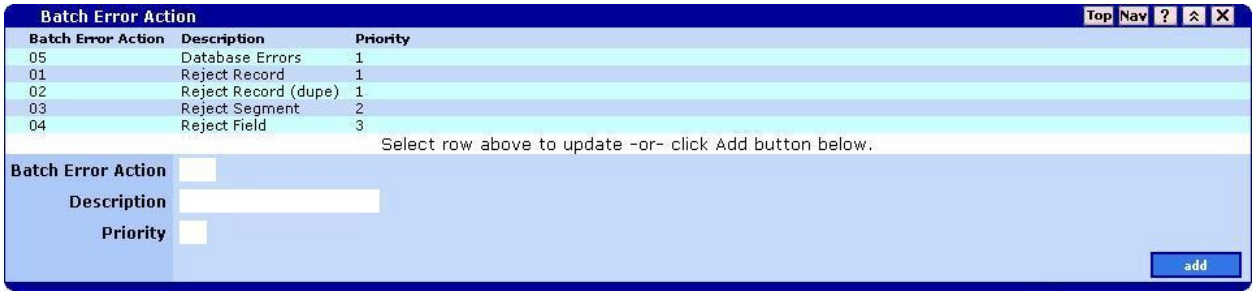
6.26 Batch Error Action Panel Overview

6.26.1 Batch Error Action Panel Narrative

The Batch Error Action panel contains the valid action codes, descriptions, and priorities that can be used when setting up batch errors for PS/2 processing. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Batch Error Action]

6.26.2 Batch Error Action Panel Layout



6.26.3 Batch Error Action Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Batch Error Action record.	Button	N/A	0
Batch Error Action	Indicates the action to be taken when an error fails on the PS/2 transaction.	Field	Number (Integer)	2
Description	Verbal description of the action to be taken when the error fails. This is used on the error report.	Field	Character	20
Priority	Indicates the report priority for the error. Valid values are 1-5. A priority of 1 has the highest and is fatal. Priorities of 2-4 are non-fatal.	Field	Number (Integer)	1

6.26.4 Batch Error Action Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Error Action	Field	5001	Batch Error Action is required.	Enter value or cancel transaction.
	Field	5010	Batch Error Action must be Numeric.	Edit entry to a numeric value or cancel transaction.
	Field	5018	Batch Error Action must be 2 character(s) in length.	Enter value of the correct length or cancel transaction.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
Description	Field	5001	Description is required.	Enter Description or cancel transaction.
Priority	Field	5001	Priority is required.	Enter value or cancel transaction.
	Field	5010	Priority must be Numeric.	Edit entry to a numeric value or cancel transaction.

6.26.5 Batch Error Action Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Batch Error Action Panel Accessibility

6.26.6.1 To Access the Batch Error Action Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Batch Error Action**.	Batch Error Action panel displays.

6.26.6.2 To Add Batch Error Action Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Batch Error Action**.	
3	Enter **Description**.	
4	Enter **Priority**.	
5	Click **Save**.	Batch Error Action information is saved.

6.26.6.3 To Update Batch Error Action Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Batch Error Action information is saved.

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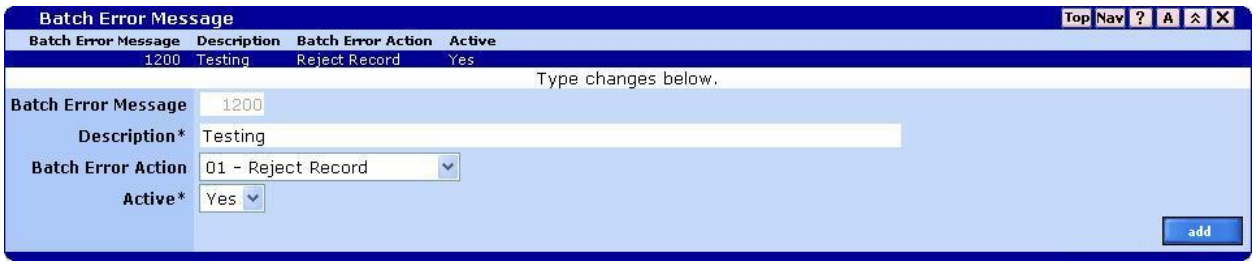
6.27 Batch Error Message Panel Overview

6.27.1 Batch Error Message Panel Narrative

The Batch Error Message panel contains error number and messages for use in the PS/2 Update Process. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Batch Error Message]

6.27.2 Batch Error Message Panel Layout



6.27.3 Batch Error Message Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active	Indicates status of error message, either a Yes or No.	Combo Box	Drop Down List Box	0
Add	Allows the user to add a new Batch Error Message record.	Button	N/A	0
Batch Error Action	Indicates the action to be taken when an error fails on the PS/2 transaction.	Combo Box	Drop Down List Box	0
Batch Error Message	Error number for a batch edit error.	Field	Character	4
Description	Describes the edit error for batch processing.	Field	Character	75

6.27.4 Batch Error Message Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Error Message	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
	Field	5500	Enter a valid value.	Verify entry is numeric.
Description	Field	5001	Description is required.	Enter Description or cancel transaction.

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6.27.5 Batch Error Message Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Batch Error Message Panel Accessibility

6.27.6.1 To Access the Batch Error Message Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Batch Error Message**.	Batch Error Message panel displays.

6.27.6.2 To Add the Batch Error Message Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Batch Error Message**.	
3	Enter **Description**.	
4	Select a **Batch Error Action** code from the drop down list box.	
5	Select an **Active** code from the drop down list box.	
6	Click **Save**.	Batch Error Message information is saved.

6.27.6.3 To Update the Batch Error Message Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Batch Error Message information is saved.

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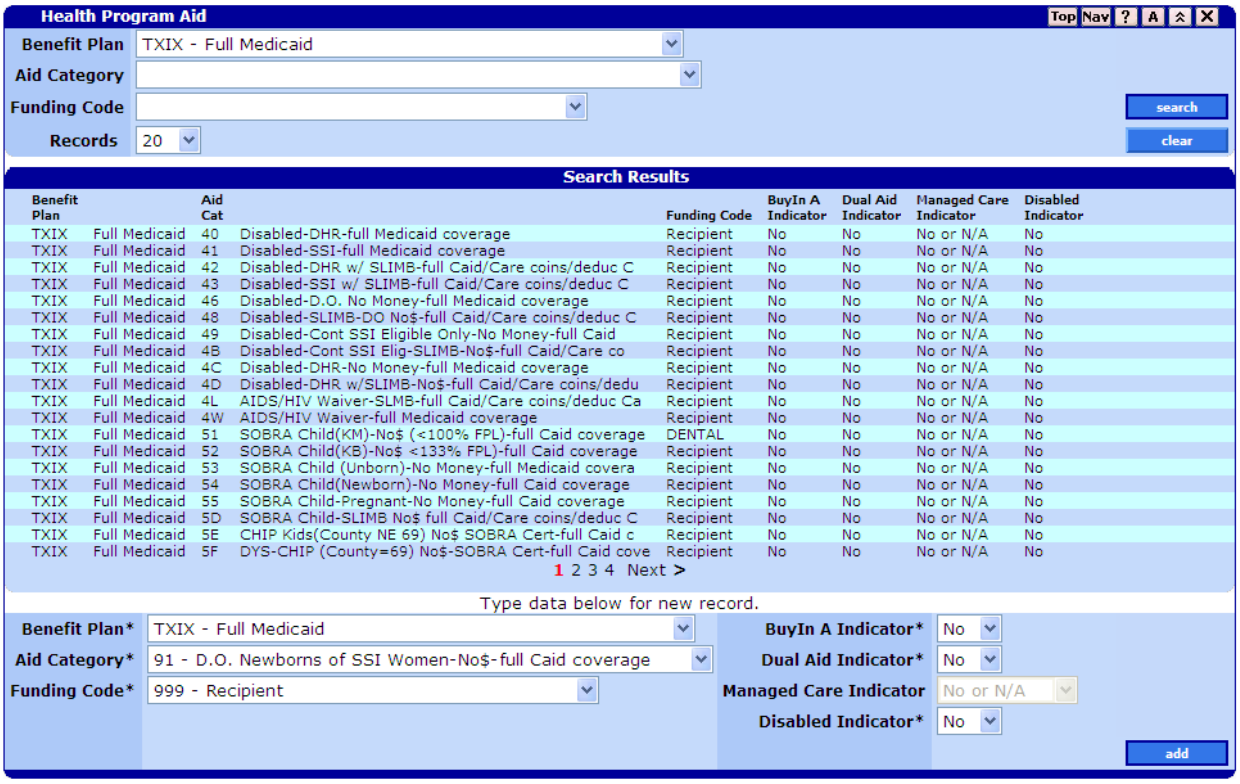
6.28 Health Program Aid Panel Overview

6.28.1 Health Program Aid Panel Narrative

The Health Program Aid panel maintains the list of valid health plan programs and aid category combinations. Users have the ability to 'filter' results by benefit plan or aid category. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Xref] - [Health Program Aid]

6.28.2 Health Program Aid Panel Layout



6.28.3 Health Program Aid Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Health Program Aid information.	Button	N/A	0
Aid Category	Type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Benefit Plan	Benefit Plan associated with the corresponding health program. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Buy In A Indicator	Buy-In A Indicator. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Health Program Aid panel.	Button	N/A	0
Disabled Indicator	Disabled Indicator. Field not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Dual Aid Indicator	Dual Aid Indicator. Field not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Funding Code	Financial fund code. This field is not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Managed Care Indicator	Managed Care Indicator. Indicates which aid cats are valid for which recipients within Patient 1st. Valid values are: B = Both, H = Health Home, P = Patient 1st, and N = N/A (should be used on all other plans).	Combo Box	Drop Down List Box	0
Records	Number of search items displayed on each page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Benefit Plan, Aid Category and/or Funding Code.	Button	N/A	0

6.28.4 Health Program Aid Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Category	Combo Box	5029	A valid Aid Category is required.	Select a valid item or cancel transaction.
Benefit Plan	Combo Box	5029	A valid Benefit Plan is required.	Select a valid item or cancel transaction.
	Combo Box	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
Buy In A Indicator	Combo Box	5001	Buy-In A Indicator is required.	Select indicator from list.
Disabled Indicator	Combo Box	5001	Disabled Indicator is required.	Select indicator from list.
Dual Aid Indicator	Combo Box	5001	Dual Aid Indicator is required.	Select indicator from list.

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Field	Field Type	Error Code	Error Message	To Correct
Funding Code	Combo Box	5029	A valid Funding Code is required.	Select a valid item or cancel transaction.
		1001	Fund code selected is inactive	Select a fund code that is active
Managed Care Indicator	Combo Box	5001	Managed Care Indicator is required.	Select indicator from list.

6.28.5 Health Program Aid Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Health Program Aid Panel Accessibility

6.28.6.1 To Access the Health Program Aid Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the **Related Data** page.	
4	Select **Health Program Aid**.	Health Program Aid panel displays.

6.28.6.2 To Add the Health Program Aid Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select a response from the **Benefit Plan** drop down list box.	
3	Select a response from the **Aid Category** drop down list box.	
4	Select a response from the **Funding Code** drop down list box.	
5	Select a response from the **Buy-In A Indicator** drop down list box.	
6	Select a response from the **Dual Aid Indicator** drop down list box.	
7	Select a response from the **Managed Care Indicator** drop down list box.	
8	Select a response from the **Disabled Indicator** drop down list box.	

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Step	Action	Response
9	Click **Save**.	Health Program Aid information is saved.

6.28.6.3 To Update the Health Program Aid Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Health Program Aid information is saved.

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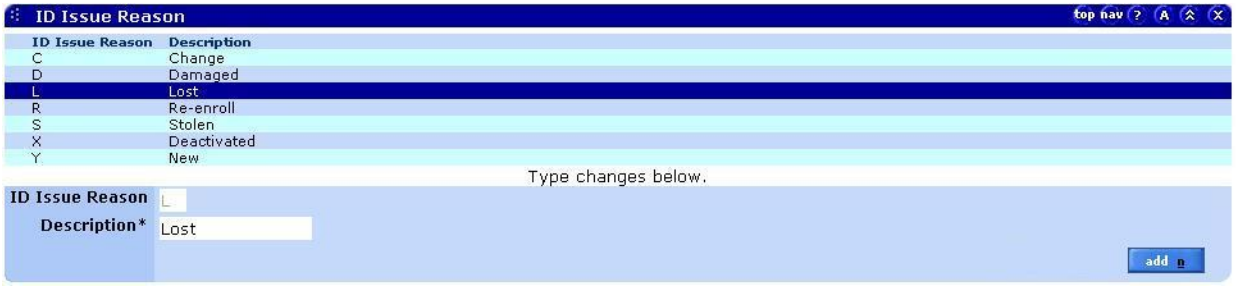
6.29 ID Issue Reason Panel Overview

6.29.1 ID Issue Reason Panel Narrative

The ID Issue Reason panel stores the reason codes and descriptions for issuing an ID card. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [ID Issue Reason]

6.29.2 ID Issue Reason Panel Layout



6.29.3 ID Issue Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an ID Issue Reason code.	Button	N/A	0
Description	Actual description the ID card was issued.	Field	Character	15
ID Issue Reason	Reason Code for issuing the Recipient's ID Card.	Field	Character	1

6.29.4 ID Issue Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	5001	Description is required.	Enter description or cancel transaction.
ID Issue Reason	Field	5001	ID Issue Reason is required.	Enter value or cancel transaction.
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.

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6.29.5 ID Issue Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 ID Issue Reason Panel Accessibility

6.29.6.1 To Access the ID Issue Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the **Related Data** panel.	
4	Select **ID Issue Reason**.	ID Issue Reason panel displays.

6.29.6.2 To Add the ID Issue Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ID Issue Reason**.	
3	Enter **Description**.	
4	Click **Save**.	ID Issue Reason information is saved.

6.29.6.3 To Update the ID Issue Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	ID Issue Reason information is saved.

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6.30 EDB Search Panel Overview

6.30.1 EDB Search Panel Narrative

The EDB Search panel allows a user to search for EDB information from the EDB (Enrollment Database) file for a recipient. The search criteria includes Medicaid ID, SSN and HIC numbers. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information are displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search]

6.30.2 EDB Search Panel Layout

6.30.3 EDB Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear out all fields from the search fields.	Button	N/A	0
Date Processed	Date updated by AMMIS.	Listview	Date (MM/DD/CCYY)	8
DOB	Date of Birth of a recipient.	Listview	Date (MM/DD/CCYY)	8
First Name	First Name of a recipient.	Listview	Character	15
HIC	Recipient Medicare ID.	Field/Listview	Character	11
Last Name	Last Name of a recipient.	Listview	Character	24
Medicaid ID	State Recipient ID Number.	Field/Listview	Character	12
MI	Middle Initial of a recipient.	Listview	Character	1
Records	Records - Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Search	Allows the user to return search results based on the entered search criteria.	Button	N/A	0
Sex	Gender code for a recipient.	Listview	Character	1
SSN	Social Security Number of a recipient.	Field/Listview	Number (Integer)	9

6.30.4 EDB Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 EDB Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 EDB Search Panel Accessibility

6.30.6.1 To Access the EDB Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.

6.30.6.2 To Navigate the EDB Search Panel

Step	Action	Response
1	Enter **Medicaid ID**, **SSN** or **HIC**.	
2	Click **Search**.	EDB Entitlement Information and EDB Maintenance panels display.

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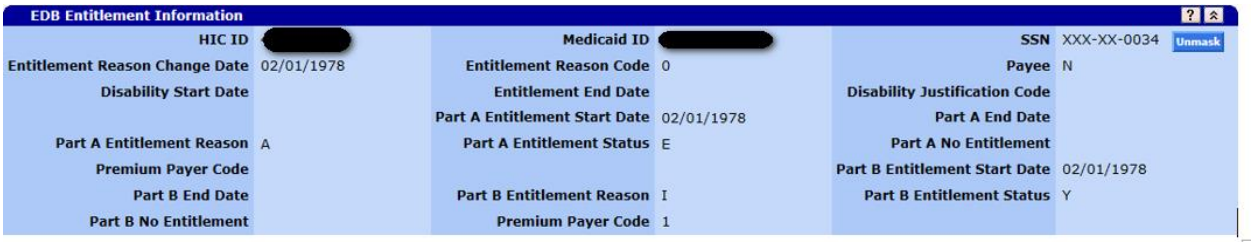
6.31 EDB Entitlement Information Panel Overview

6.31.1 EDB Entitlement Information Panel Narrative

The EDB Entitlement Information panel allows the user to view the EDB base information from the EDB (Enrollment Database) file for a member. Information from this panel is used to help assign Medicare Part A and B coverage to recipients. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] - [EDB Entitlement Information]

6.31.2 EDB Entitlement Information Panel Layout



6.31.3 EDB Entitlement Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Disability Justification Code	The justification for a beneficiary's Part A and/or Part B Medicare entitlement dates based upon his/her disability insurance benefits (DIB) status.	Field	Character	1
Disability Start Date	Date a beneficiary became entitled to Disability Insurance Benefits.	Field	Date (MM/DD/CCYY)	8
Entitlement End Date	Last date through which a beneficiary is entitled to Disability Insurance Benefits.	Field	Date (MM/DD/CCYY)	8
Entitlement Reason Change Date	Date the Reason for Entitlement or Termination of Entitlement for a Beneficiary was changed according to the EDB file from CMS.	Field	Date (MM/DD/CCYY)	8
Entitlement Reason Code	Reason for Entitlement or Termination of Entitlement for a Beneficiary.	Field	Character	1
HIC ID	Recipient's Medicare ID.	Field	Character	11

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Field	Description	Field Type	Data Type	Length
Medicaid ID	Recipient’s Medicaid ID.	Field	Character	25
Part A End Date	Last date through which a beneficiary is entitled to Part A benefits. After this date, the Part A benefits are terminated. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Part A Entitlement Reason	Reason code for a Beneficiary's Enrollment to Part A Benefits.	Field	Character	1
Part A Entitlement Start Date	Date a beneficiary became entitled to Part A Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Part A Entitlement Status	Reason for Entitlement or Termination of a Beneficiary's Part A Benefits during a period of coverage. (Source: SSA / RRB).	Field	Character	1
Part A No Entitlement	Code that occurs when there is No Part A Entitlement Date.	Field	Character	1
Part B End Date	Last date through which a beneficiary is entitled to Part B benefits. After this date, the Part B benefits are terminated. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Part B Entitlement Reason	Reason code for a Beneficiary's Enrollment to Part B Benefits.	Field	Character	1
Part B Entitlement Start Date	Date a beneficiary became entitled to Part B Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Part B Entitlement Status	Reason for Entitlement or Termination of a Beneficiary's Part B Benefits during a period of coverage. (Source: SSA / RRB).	Field	Character	1
Part B No Entitlement	Code that occurs when there is No Part B Entitlement Date.	Field	Character	1
Payee	Yes or No (Y or N) indicator specifying if the beneficiary has a Representative Payee.	Field	Character	1
Premium Payer Code (Part A)	Identifier for the Third Party Agency responsible for paying a Medicare beneficiary's Part A premiums.	Field	Character	1
Premium Payer Code (Part B)	Identifier for the Third Party Agency responsible for paying a Medicare beneficiary's Part B premiums.	Field	Character	1
SSN	Recipient’s Social Security Number.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
Unmask	Unmask button helps to unmask SSN field.	Button	N/A	0

6.31.4 EDB Entitlement Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.31.5 EDB Entitlement Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 EDB Entitlement Information Panel Accessibility

6.31.6.1 To Access the EDB Entitlement Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	**EDB Entitlement Information** and EDB Maintenance panels display.

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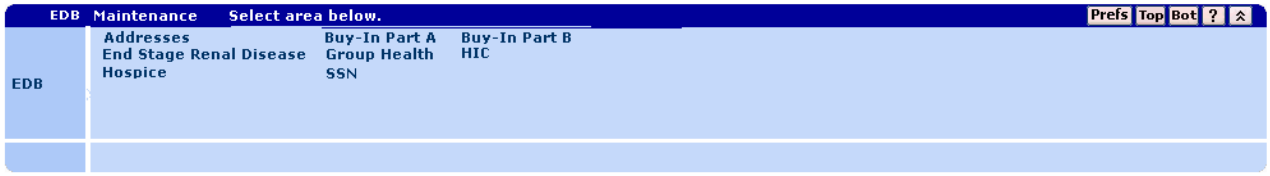
6.32 EDB Entitlement Maintenance Panel Overview

6.32.1 EDB Entitlement Maintenance Panel Narrative

The EDB Entitlement Maintenance panel is the access point for EDB maintenance within the Recipient system. Users can choose from a list of panels. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] -[EDB Search Results] - [EDB Entitlement Maintenance]

6.32.2 EDB Entitlement Maintenance Panel Layout



6.32.3 EDB Entitlement Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Addresses	Link to the Addresses panel.	Hyperlink	N/A	0
Buy-In Part A	Link to the Buy-In Part A panel.	Hyperlink	N/A	0
Buy-In Part B	Link to the Buy-In Part B panel.	Hyperlink	N/A	0
End Stage Renal Disease	Link to the End Stage Renal Disease panel.	Hyperlink	N/A	0
Group Health	Link to the Group Health panel.	Hyperlink	N/A	0
HIC	Link to the HIC panel.	Hyperlink	N/A	0
Hospice	Link to the Hospice panel.	Hyperlink	N/A	0
SSN	Link to the SSN panel.	Hyperlink	N/A	0

6.32.4 EDB Entitlement Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.32.5 EDB Entitlement Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 EDB Entitlement Maintenance Panel Accessibility

6.32.6.1 To Access the EDB Entitlement Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Maintenance panel displays.

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6.33 EDB Addresses Panel Overview

6.33.1 EDB Addresses Panel Narrative

The EDB Addresses panel allows the user to view the address as listed on the EDB (Enrollment Database) file. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Addresses]

6.33.2 EDB Addresses Panel Layout

6.33.3 EDB Addresses Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Mailing address #1 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 2	Mailing address #2 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 3	Mailing address #3 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 4	Mailing address #4 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 5	Mailing address #5 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 6	Mailing address #6 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22

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Field	Description	Field Type	Data Type	Length
Change Date	Date on which the beneficiary's Zip Code, State Code, County Code, or District Office last changed. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Zip Code	Zip Code of the Mailing Address where the beneficiary may be contacted. (Source: SSA /RRB).	Field	Character	9

6.33.4 EDB Addresses Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 EDB Addresses Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 EDB Addresses Panel Accessibility

6.33.6.1 To Access the EDB Addresses Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Addresses**.	EDB Addresses panel displays.

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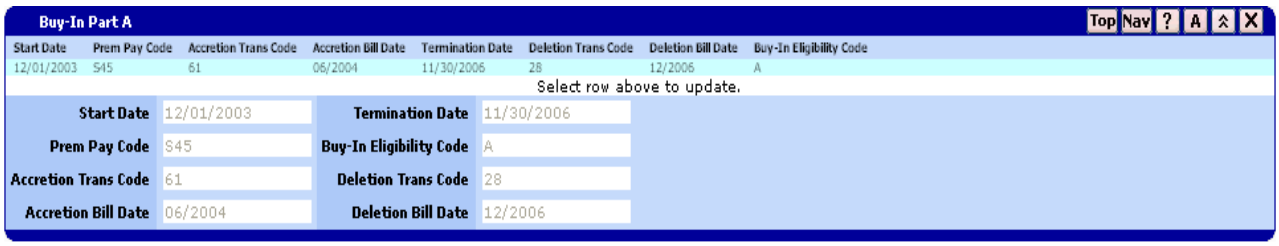
6.34 EDB Buy-In Part A Panel Overview

6.34.1 EDB Buy-In Part A Panel Narrative

The EDB Buy-In Part A panel allows the user to view the Buy-In Part A information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Buy-In Part A]

6.34.2 EDB Buy-In Part A Panel Layout



6.34.3 EDB Buy-In Part A Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accretion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency's Part A Accretion.	Field	Date (MM/CCYY)	6
Accretion Trans Code	Numeric code indicating the accretion of a beneficiary to a Third Party Agency that is responsible for paying the Part A Medicare premium.	Field	Character	4
Buy In Eligibility Code	Code that indicates the reason for State Buy-In Eligibility.	Field	Character	1
Deletion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency Part A Deletion Action.	Field	Date (MM/CCYY)	6
Deletion Trans Code	Code that indicates the reason for Deletion of a Beneficiary from a Third Party Part A Agency.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
Prem Pay Code	Identifier for a Third Party Agency (Either a Private Group or a State Buy-In Agency) responsible for paying a Medicare beneficiary's Part A premiums.	Field	Character	3
Start Date	Day a beneficiary became entitled to Part A Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Termination Date	Last date of a Private Third Party Group's or State's liability for a beneficiary's Part A premium.	Field	Date (MM/DD/CCYY)	8

6.34.4 EDB Buy-In Part A Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.34.5 EDB Buy-In Part A Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 EDB Buy-In Part A Panel Accessibility

6.34.6.1 To Access the EDB Buy-In Part A Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Buy-In Part A**.	EDB Buy-In Part A panel displays.

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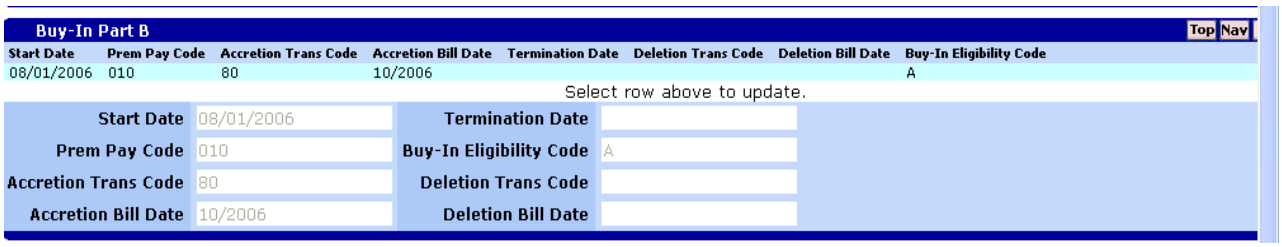
6.35 EDB Buy-In Part B Panel Overview

6.35.1 EDB Buy-In Part B Panel Narrative

The EDB Buy-In Part B panel allows the user to view the Buy-In Part B information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Buy-In Part B]

6.35.2 EDB Buy-In Part B Panel Layout



6.35.3 EDB Buy-In Part B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accretion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency's Part B Accretion.	Field	Date (MM/CCYY)	6
Accretion Trans Code	Numeric code indicating the accretion of a beneficiary to a Third Party Agency that is responsible for paying the Part B Medicare premium.	Field	Character	4
Buy In Eligibility Code	Code that indicates the reason for State Buy-In Eligibility.	Field	Character	1
Deletion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency Part B Deletion Action.	Field	Date (MM/CCYY)	6
Deletion Trans Code	Code that indicates the reason for Deletion of a Beneficiary from a Third Party Part B Agency.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
Prem Pay Code	Identifier for a Third Party Agency (Either a Private Group or a State Buy-In Agency) responsible for paying a Medicare beneficiary's Part B premiums.	Field	Character	3
Start Date	Day a beneficiary became entitled to Part B Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Termination Date	Last date of a Private Third Party Group's or State's liability for a beneficiary's Part B premium.	Field	Date (MM/DD/CCYY)	8

6.35.4 EDB Buy-In Part B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.35.5 EDB Buy-In Part B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 EDB Buy-In Part B Panel Accessibility

6.35.6.1 To Access the EDB Buy-In Part B Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID, SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Buy-In Part B**.	EDB Buy-In Part B panel displays.

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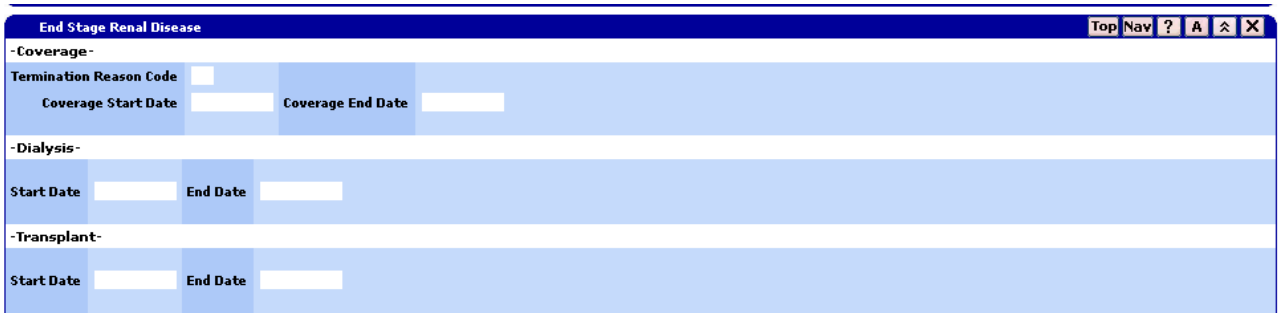
6.36 EDB End Stage Renal Disease Panel Overview

6.36.1 EDB End Stage Renal Disease Panel Narrative

The EDB End Stage Renal Disease panel allows the user to view the End Stage Renal Disease (ESRD) information from the EDB (Enrollment Database) file for a specific member. The information includes the start and termination dates for coverage, dialysis, and transplant information, plus the reason for coverage termination. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [End Stage Renal Disease]

6.36.2 EDB End Stage Renal Disease Panel Layout



6.36.3 EDB End Stage Renal Disease Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coverage End Date	Date on which the Beneficiary is no longer Entitled to Medicare under ESRD provisions.	Field	Date (MM/DD/CCYY)	8
Coverage Start Date	Date on which the Beneficiary is Entitled to Medicare in some part, because of a diagnosis of End Stage Renal Disease.	Field	Date (MM/DD/CCYY)	8
Dialysis Start Date	Date that indicates when ESRD Dialysis started.	Field	Date (MM/DD/CCYY)	8
Dialysis End Date	Date that indicates when ESRD Dialysis ended.	Field	Date (MM/DD/CCYY)	8
Termination Reason Code	Code that indicates the reason Medicare-Based End Stage Renal Disease Coverage was Terminated.	Field	Character	1
Transplant Start Date	Date that indicates when a Kidney Transplant Operation occurred.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Transplant End Date	Date that indicates when a Kidney Transplant Failed.	Field	Date (MM/DD/CCYY)	8

6.36.4 EDB End Stage Renal Disease Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.36.5 EDB End Stage Renal Disease Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 EDB End Stage Renal Disease Panel Accessibility

6.36.6.1 To Access the EDB End Stage Renal Disease Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **End Stage Renal Disease**.	EDB End Stage Renal Disease panel displays.

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6.37 EDB Group Health Panel Overview

6.37.1 EDB Group Health Panel Narrative

The EDB Group Health panel allows the user to view Group Health information from the EDB (Enrollment Database) file for a member. This Group Health information includes both enrollment and personal benefits. Information on this panel is used in Medicare Advantage enrollment as part of Managed Care. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Group Health]

6.37.2 EDB Group Health Panel Layout

6.37.3 EDB Group Health Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Contract #	Number identifying a particular GHO Enrollment. Use CMS's Online Systems to associate the Contractor Number with a GHO Plan Name.	Listview	Character	5
Disenrollment Date	Date that a Beneficiary's Enrollment in a Group Health Organization Terminates.	Listview	Date (MM/DD/CCYY)	8
Enrollment Start Date	Date of a Beneficiary's Enrollment in a GHO.	Listview	Date (MM/DD/CCYY)	8
GHP Enrollment Effective Date	Date the beneficiary's Group Health Program (GHP) Enrollment becomes effective.	Field	Date (MM/DD/CCYY)	8
PBP Coverage TypeCode	Beneficiary's Personal Benefits Package Type Code.	Field	Character	2
PBP End Date	Date the beneficiary's Personal Benefits Package ends.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
PBP Number	The beneficiary's Personal Benefits Package Number.	Field	Character	3
PBP Start Date	Date the beneficiary starts their Personal Benefits Package.	Field	Date (MM/DD/CCYY)	8

6.37.4 EDB Group Health Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.37.5 EDB Group Health Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 EDB Group Health Panel Accessibility

6.37.6.1 To Access the EDB Group Health Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Group Health**.	EDB Group Health panel displays**.**

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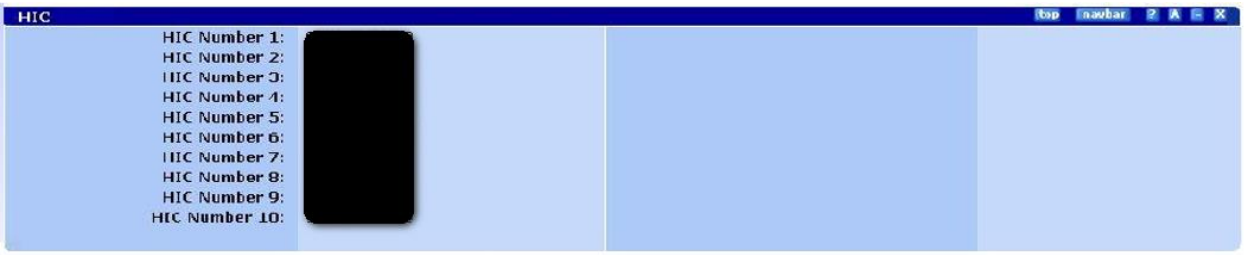
6.38 EDB HIC Panel Overview

6.38.1 EDB HIC Panel Narrative

The EDB HIC panel allows the user to view the HIC number (Medicare ID) information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [HIC]

6.38.2 EDB HIC Panel Layout



6.38.3 EDB HIC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
HIC Number	Benefit claim number. Occurs up to 10 times.	Listview	Character	1

6.38.4 EDB HIC Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.38.5 EDB HIC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.38.6 EDB HIC Panel Accessibility

6.38.6.1 To Access the EDB HIC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **HIC**.	EDB HIC panel displays.

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6.39 EDB Hospice Panel Overview

6.39.1 EDB Hospice Panel Narrative

The EDB Hospice panel allows the user to view Hospice information from the EDB (Enrollment Database) file for a Buy-In member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Maintenance] - [Hospice]

6.39.2 EDB Hospice Panel Layout

6.39.3 EDB Hospice Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coverage Processing Date	Date the Hospice Relation was updated on the EDB.	Listview	Date (MM/DD/CCYY)	8
Coverage Start Date	Elected start date of a Beneficiary's period of Hospice Coverage.	Listview	Date (MM/DD/CCYY)	8
Coverage Termination Date	Termination date of a Beneficiary's period of Hospice Coverage.	Listview	Date (MM/DD/CCYY)	8

6.39.4 EDB Hospice Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.39.5 EDB Hospice Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.39.6 EDB Hospice Panel Accessibility

6.39.6.1 To Access the EDB Hospice Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Hospice**.	EDB Hospice panel displays.

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6.40 EDB SSN Panel Overview

6.40.1 EDB SSN Panel Narrative

The EDB SSN panel allows the user to view the list of past Social Security Number information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [SSN]

6.40.2 EDB SSN Panel Layout

6.40.3 EDB SSN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
SSN Number	Social Security number of a member. Occurs up to 5 times.	Listview	Number (Integer)	9

6.40.4 EDB SSN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.40.5 EDB SSN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 EDB SSN Panel Accessibility

6.40.6.1 To Access the EDB SSN Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	

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Step	Action	Response
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **SSN**.	EDB SSN panel displays.

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6.41 Case Search Panel Overview

6.41.1 Case Search Panel Narrative

The Case Search panel allows the user to locate Case (Payee) information by selecting Search By criteria. The listed information differs based on search criteria selected. Users may search by Case Number (Payee ID) or Current ID.

Navigation Path: [Recipient] - [Case Search]

6.41.2 Case Search Panel Layout

6.41.3 Case Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the ID number given to the responsible party-guardian.	Field	Number (Integer)	12
Clear	Allows the user to clear any changes made on the Case Search panel.	Button	N/A	0
Current ID	Case head's Medicaid identification number.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Case Number or Current ID.	Button	N/A	0

6.41.4 Case Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Case Number	Field	9000	Case ID must be Alpha Numeric.	Enter an alphanumeric value.
Search	Button	9000	At least one search field should be entered for search criteria.	An entry is required to search for a case. Type in the Case ID or Current ID.

6.41.5 Case Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.41.6 Case Search Panel Accessibility

6.41.6.1 To Access the Case Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.

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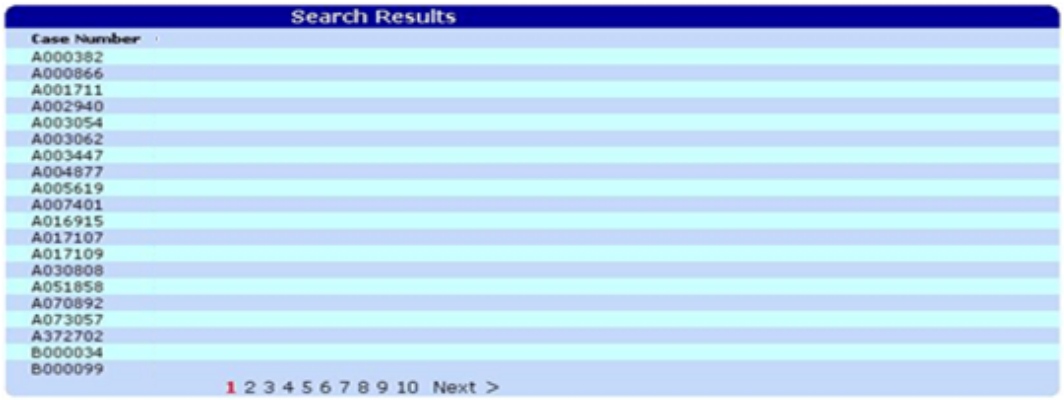
6.42 Case Search Results Panel Overview

6.42.1 Case Search Results Panel Narrative

The Case Search Results data list is displayed as a result of the user clicking the search button on the Case Search panel. If, based on the criteria entered, there are multiple records that match the user's search criteria, the data list is displayed listing all the matching records. If only one match is found, the data list is not displayed. Instead, the Case Information panel for the selected record is displayed.

Navigation Path: [Recipient] – [Case Search] – [Case Search Results]

6.42.2 Case Search Results Panel Layout



6.42.3 Case Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the ID number given to the responsible party-guardian.	Listview	Character	12

6.42.4 Case Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.42.5 Case Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.42.6 Case Search Results Panel Accessibility

6.42.6.1 To Access the Case Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name**, or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.

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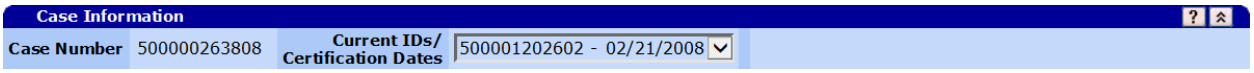
6.43 Case Information Panel Overview

6.43.1 Case Information Panel Narrative

The Case Information panel contains basic information about a Case (Payee). All Case information displayed on the panel comes directly from the nightly eligibility update file. Update access will not be granted. This panel is display only.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results] – [Case Information]

6.43.2 Case Information Panel Layout



6.43.3 Case Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the identification number given to the responsible party-guardian.	Field	Character	12
Current IDs/Certification Dates	List of all the recipients who have belonged to the Case and the dates they became certified in the Case. Certification Date is the date the Case was added to the system.	Combo Box	Drop Down List Box	0

6.43.4 Case Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.43.5 Case Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Case Information Panel Accessibility

6.43.6.1 To Access the Case Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.

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Step	Action	Response
5	Click to highlight the row.	**Case Information** and Case Maintenance panels display.

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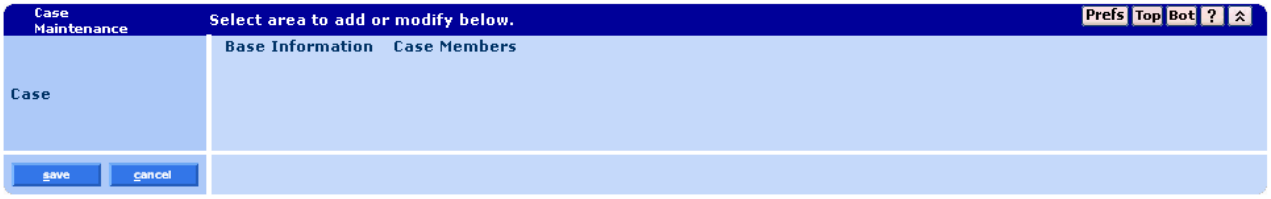
6.44 Case Maintenance Panel Overview

6.44.1 Case Maintenance Panel Narrative

The Case Maintenance Panel is used to navigate to Case (Payee) maintenance panels. The right-hand portion of this panel contains hyperlinks that open individual panels: Base Information, Case Members, and Case Spenddown. This panel is inquiry only.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results]

6.44.2 Case Maintenance Panel Layout



6.44.3 Case Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Links to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Case Maintenance panels. This button is not available in Alabama.	Button	N/A	0
Case Members	Links to the Case Members panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for Case Maintenance. This button is not available in Alabama.	Button	N/A	0

6.44.4 Case Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.44.5 Case Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.44.6 Case Maintenance Panel Accessibility

6.44.6.1 To Access the Case Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.

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6.45 Case Base Information Panel Overview

6.45.1 Case Base Information Panel Narrative

The Case Base Information panel contains additional information about a Case (Payee). Though the panel was originally built for update purposes, the panel is inquiry only in Alabama. Since Case information displayed on the panel comes directly from the nightly eligibility update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results] - [Case Maintenance] – [Base Information]

6.45.2 Case Base Information Panel Layout

6.45.3 Case Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the identification number given to the responsible party-guardian.	Field	Character	12
Source Code	Source of the Case record. All Case information comes directly from the nightly AMAES update file.	Combo Box	Drop Down List box	0

6.45.4 Case Base Information Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is Inquiry only.				

6.45.5 Case Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Case Base Information Panel Accessibility

6.45.6.1 To Access the Case Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.

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Step	Action	Response
3	Enter **Case Number** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.
6	Select **Base Information**.	Case Base Information panel displays.

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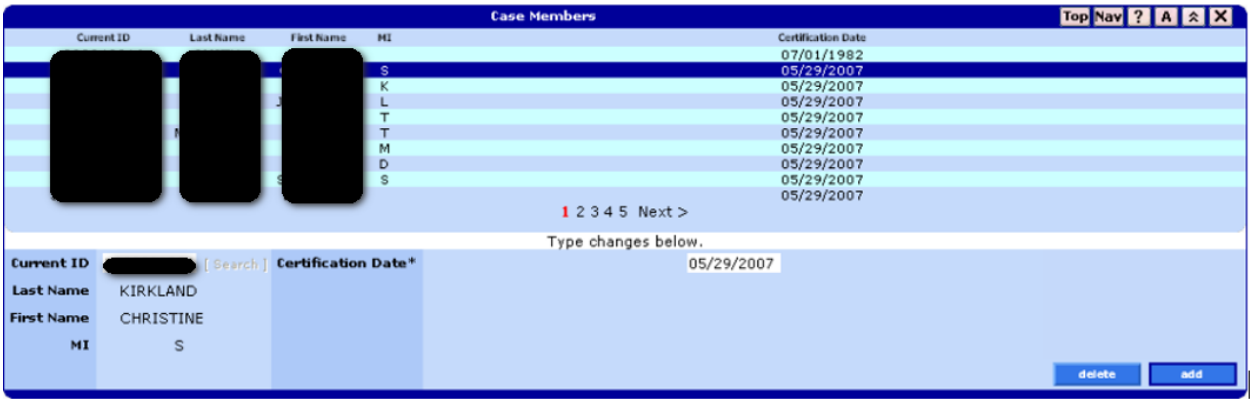
6.46 Case Members Panel Overview

6.46.1 Case Members Panel Narrative

The Case Members panel is used to view the members of a Case (Payee). Since Case information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Case Search] –[Case Search Results] - [Case Maintenance] – [Case Members]

6.46.2 Case Members Panel Layout



6.46.3 Case Members Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Case Member information. This button is not utilized by Alabama.	Button	N/A	0
Certification Date	Date the recipient became certified in the case. Certification Date is the date the Case was added to the system.	Field	Date (MM/DD/CCYY)	8
Current ID	The Medicaid ID assigned to a Recipient.	Field	Character	12
First name	Recipient's first name.	Field	Character	13
Delete	Allows the user to delete Case Member information. This field is not utilized by Alabama.	Button	N/A	0
Last Name	Recipient's last name.	Field	Character	15
MI	Recipient's middle initial.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
[Search]	Initiates the Search by Current ID, Medicare ID, Case ID, SSN or Last Name. First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.		N/A	0

6.46.4 Case Members Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is Inquiry only.				

6.46.5 Case Members Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 Case Members Panel Accessibility

6.46.6.1 To Access the Case Members Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name**, or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.
6	Select **Case Members**.	Case Members panel displays.

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6.47 Recipient Other IDs Search Panel Overview

6.47.1 Recipient Other IDs Search Panel Narrative

The Recipient Other IDs Search allows a search by recipient ID. This panel is used to display all Medicaid numbers associated with the recipient ID entered. The results of the search are displayed on the "Recipient Other IDs" panel.

Navigation Path: [Recipient] – [Other IDs Search]

6.47.2 Recipient Other IDs Search Panel Layout

6.47.3 Recipient Other IDs Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient Other IDs Search panel.	Button	N/A	0
Medicaid ID	Used to capture the ID entered by the user for which information is retrieved.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Medicaid ID.	Button	N/A	0

6.47.4 Recipient Other IDs Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Medicaid ID	Field	1	Medicaid ID is required	Enter a valid Medicaid ID number.
	Field	2	Medicaid ID must be numeric	Enter a valid numeric Medicaid ID number.

6.47.5 Recipient Other IDs Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.47.6 Recipient Other IDs Search Panel Accessibility

6.47.6.1 To Access the Recipient Other IDs Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Other IDs Search**.	Recipient Other IDs Search panel displays.

6.47.6.2 To Navigate the Recipient Other IDs Search Panel

Step	Action	Response
1	Enter **Medicaid ID**.	
2	Click **Search**.	Search Results Other IDs are displayed, if applicable.

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6.48 Recipient Other IDs Panel Overview

6.48.1 Recipient Other IDs Panel Narrative

The Recipient Other IDs panel is used to determine all the Medicaid IDs that have been associated with a different ID (see what IDs have been linked together using the "rekey" process). The Recipient Other IDs panel is an expanded version of the Recipient Previous IDs panel and is inquiry only.

Navigation Path: [Recipient] - [Other IDs Search]

6.48.2 Recipient Other IDs Panel Layout

Search Results

Current Active ID	Source File	Last Name	First Name	MI	Date Processed	Check Digit
[redacted]	Base	[redacted]	PHRA	B	02/13/2007	6

Search Results

ID	Source File	Last Name	First Name	MI	Date Processed	Check Digit
[redacted]	Link	[redacted]	[redacted]	A	02/13/2007	7
[redacted]	Link				02/05/2007	8

6.48.3 Recipient Other IDs Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Check Digit	The 13th or last digit for the recipient's Medicaid identification number.	Listview	Character	1
Current Active ID	ID that is currently active and contains the active eligibility information that is used for eligibility verification and claims processing.	Listview	Character	12
Date Processed	Date that the Recipient Link was received and processed.	Listview	Date (MM/DD/CCYY)	8
First Name	First name of recipient.	Listview	Character	15
ID	Lists all Recipient Medicaid IDs linked to the 'active' Current ID.	Listview	Character	12
Last Name	Last name of recipient.	Listview	Character	20
MI	Middle Initial of recipient.	Listview	Character	1
Source File	Indicates which table the recipient was found on.	Listview	Character	10

6.48.4 Recipient Other IDs Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.48.5 Recipient Other IDs Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Recipient Other IDs Panel Accessibility

6.48.6.1 To Access Recipient Other IDs Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and **click Other IDs Search**.	Recipient Other IDs Search panel displays.
3	Enter **Medicaid ID**.	
4	Click **Search**.	Search Results for Other IDs is displayed, if applicable.

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6.49 Service Usage Search Panel Overview

6.49.1 Service Usage Search Panel Narrative

The Service Usage Search panel (Benefit Limits) allows a user to enter Medicaid ID and Service Year or SSN and Service Year (Note: Service Year, in CCYY format, MUST be entered in order for the panel to function correctly). The search returns service usage associated with that recipient.

This panel is inquiry only.

Navigation Path: [Recipient] - [Service Usage Search]

6.49.2 Service Usage Search Panel Layout

6.49.3 Service Usage Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient Service Usage Search panel.	Button	N/A	0
Current ID	Recipient's Medicaid identification number.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the search by Current ID and Service Year, or Social Security Number and Service Year.	Button	N/A	0
Service Year	The year when the Recipient received services.	Field	Date (CCYY)	4
Soc Sec No	The recipient's Social Security Number.	Field	Number (Integer)	9

6.49.4 Service Usage Search Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.49.5 Service Usage Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Service Usage Search Panel Accessibility

6.49.6.1 To Access the Service Usage Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.

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6.50 Service Usage Search Results Panel Overview

6.50.1 Service Usage Search Results Panel Narrative

The Service Usage Search Results panel (Benefit Limits) is used to show service usage for a recipient, returned from the Recipient Service Usage Search panel. This panel is inquiry only.

Navigation: [Recipient] – [Service Usage Search] – [Service Usage Search Results]

6.50.2 Service Usage Search Results Panel Layout

Search Results

Service Limt	Service Limit Description	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Total
10	Inpatient Hospital Visits-PD													0
11	Outpatient Hospital Visits-PD													0
12	Physician Visits-PD							1	1			1		3
13	Home Health Visits-PD													0
14	Ambulatory Surgical Center-PD													0
15	Dialysis Service-PD													0
16	Eyeglass Frames-PD													0
17	Eyeglass Lens-PD													0
18	Eyeglass Fitting-PD													0
19	Eyeglass Exam-PD													0

1 2 3 4 Next >

6.50.3 Service Usage Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Apr	The benefit limit count for a recipient for April.	Field	Number (Integer)	6
Aug	The benefit limit count for a recipient for August.	Field	Number (Integer)	6
Dec	The benefit limit count for a recipient for December.	Field	Number (Integer)	6
Feb	The benefit limit count for a recipient for February.	Field	Number (Integer)	6
Jan	The benefit limit count for a recipient for January.	Field	Number (Integer)	6
July	The benefit limit count for a recipient for July.	Field	Number (Integer)	6
Jun	The benefit limit count for a recipient in June.	Field	Number (Integer)	6
Mar	The benefit limit count for a recipient for March.	Field	Number (Integer)	6
May	The benefit limit count for a recipient for May.	Field	Number (Integer)	6
Nov	The benefit limit count for a recipient in November.	Field	Number (Integer)	6
Oct	The benefit limit count for a recipient in October.	Field	Number (Integer)	6

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Field	Description	Field Type	Data Type	Length
Sep	The benefit limit count for a recipient in September.	Field	Number (Integer)	6
Service Limit	The category key for the benefit limit.	Field	Character	2
Service Limit Description	The description of the benefit limit category.	Field	Character	30
Total	The benefit limit count for a member in the Service Year.	Field	Number (Integer)	6

6.50.4 Service Usage Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.50.5 Service Usage Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.50.6 Service Usage Search Results Panel Accessibility

6.50.6.1 To Access the Service Usage Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.
3	Enter **Current ID** and **Service Year**, or **Social Security Number** and **Service Year**.	
4	Click **Search**.	Service Usage Search Results panel displays.

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6.51 Service Usage ICN Search Results Panel Overview

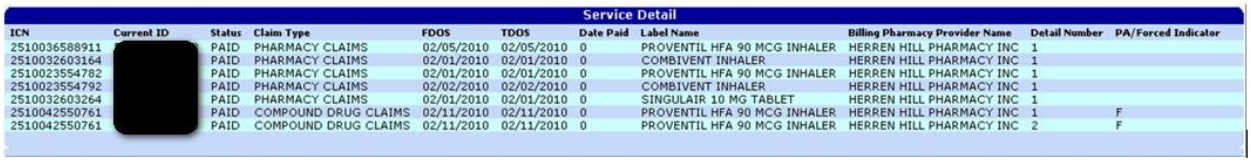
6.51.1 Service Usage ICN Search Results Panel Narrative

The Service Usage ICN Search Results panel is used to show claim information for a service limit chosen on the Recipient Service Usage Search Result panel.

This panel is display only.

Navigation: [Recipient] – [Service Usage Search] – [Service Usage Search Results] – [Service Usage ICN Search Results]

6.51.2 Service Usage ICN Search Results Panel Layout



Service Detail

ICN	Current ID	Status	Claim Type	FDOS	TDOS	Date Paid	Label Name	Billing Pharmacy Provider Name	Detail Number	PA/Forced Indicator
2510036588911	[redacted]	PAID	PHARMACY CLAIMS	02/05/2010	02/05/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	
2510032603164		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	COMBIVENT INHALER	HERREN HILL PHARMACY INC	1	
2510023554782		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	
2510023554792		PAID	PHARMACY CLAIMS	02/02/2010	02/02/2010	0	COMBIVENT INHALER	HERREN HILL PHARMACY INC	1	
2510032603264		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	SINGULAIR 10 MG TABLET	HERREN HILL PHARMACY INC	1	
2510042550761		PAID	COMPOUND DRUG CLAIMS	02/11/2010	02/11/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	F
2510042550761		PAID	COMPOUND DRUG CLAIMS	02/11/2010	02/11/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	2	F

6.51.3 Service Usage ICN Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Billing Pharmacy Provider Name	The name of the Billing Provider.	Field	Character	25
Claim Type	Description of the value assigned to a specific claim type.	Field	Character	50
Current ID	Recipient's Medicaid identification number.	Field	Character	12
Date Paid	Date on which the claim was paid.	Field	Date (MM/DD/CCYY)	8
Detail Number	The number of the detail on a claim record which counts toward this particular service usage category.	Field	Number (Integer)	4
FDOS	Date on which service began.	Field	Date (MM/DD/CCYY)	8
ICN	Internal Control Number associated with the claim.	Field	Number (Integer)	13
Label Name	The name of the drug labeler.	Field	Character	35
PA/Forced indicator	Indicates if a claim's detail paid as the result of a PA or having a benefit limit audit forced. Valid values are: P - dtl paid as the result of a PA, F - dtl paid as the result of a forced benefit limit audit, Space - Default value - dtl paid through normal	Field	Character	1
Status	Description of Claim Status.	Field	Character	20

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Field	Description	Field Type	Data Type	Length
TDOS	Last service date covered by claim.	Field	Date (MM/DD/CCYY)	8

6.51.4 Service Usage ICN Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.51.5 Service Usage ICN Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 Service Usage ICN Search Results Panel Accessibility

6.51.6.1 To Access the Service Usage ICN Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.
3	Enter **Current ID**, **Social Security Number** or **Service Year**.	
4	Click **Search**.	Service Usage Search Results panel displays.
5	Click on **Service Limit** row to view ICN details.	Service Usage ICN Search Results panel displays.

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6.52 Recipient ICN Link Search Panel Overview

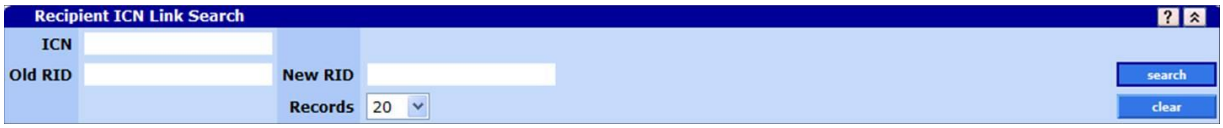
6.52.1 Recipient ICN Link Search Panel Narrative

The Recipient ICN Link Search panel allows the user to search by either ICN, Old RID or New RID or a combination of any of the three fields. The search returns the results associated with the combination of search criteria entered by the user.

This panel is inquiry only.

Navigation Path: [Recipient] - [Recipient ICN Link Search]

6.52.2 Recipient ICN Link Search Panel Layout



5.50.1 Recipient ICN Link Search Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient ICN Link Search panel.	Button	N/A	0
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the search by ICN and Old RID and New RID.	Button	N/A	0

6.52.3 Recipient ICN Link Search Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.52.4 Recipient ICN Link Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.5 Recipient ICN Link Search Panel Accessibility

6.52.5.1 To Access the Recipient ICN Link Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Recipient ICN Link Search.**	Recipient ICN Link Search panel displays.

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6.53 Recipient ICN Link Search Results Panel Overview

6.53.1 Recipient ICN Link Search Results Panel Narrative

The Recipient ICN Link Search Results panel is used to show the results returned based upon the search criteria entered by the user on the Recipient ICN Link Search panel.

This panel is inquiry only.

Navigation: [Recipient] – [Recipient ICN Link Search] – [Recipient ICN Link Search Results]

6.53.2 Recipient ICN Link Search Results Panel Layout

Recipient ICN List Results

ICN	Old RID	Old Recipient Name	Old Recipient DOB	New RID	New Recipient Name	New Recipient DOB	Date	Time
1108064216006	[redacted]	[redacted]	09/11/1965	[redacted]	[redacted]	07/22/1959	10/16/2010	15:59:21
1108064216006			07/22/1959			06/19/1963	10/15/2010	16:13:57
1108064216006			07/26/1943			09/11/1965	10/15/2010	15:54:57

6.53.3 Recipient ICN Link Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the claim was moved to the new recipient.	Field	Date (MM/DD/CCYY)	8
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
New Recipient DOB	Date of birth of the new recipient assigned to the claim.	Field	Date (MM/DD/CCYY)	8
New Recipient Name	Name of the new recipient assigned to the claim.	Field	Character	36
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Old Recipient DOB	Date of birth of the recipient formerly assigned to the claim.	Field	Date (MM/DD/CCYY)	8
Old Recipient Name	Name of the recipient formerly assigned to the claim.	Field	Character	36
Time	Time the claim was moved to the new recipient.	Field	Number(Integer)	8

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6.53.4 Recipient ICN Link Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.53.5 Recipient ICN Link Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Recipient ICN Link Search Results Panel Accessibility

6.53.6.1 To Access the Recipient ICN Link Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Recipient ICN Link Search**.	Recipient ICN Link Search panel displays.
3	Enter **ICN** or **Old RID** or **New RID**.	
4	Click **Search**.	Recipient ICN Link Search Results panel displays.

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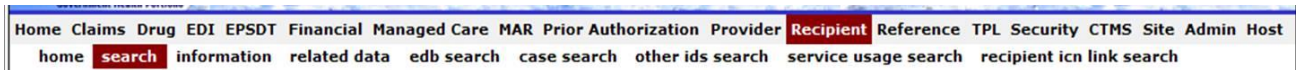
6.54 Recipient Sub Menu Panel Overview

6.54.1 Recipient Sub Menu Panel Narrative

This panel has list of sub menus for Recipient Data Maintenance Subsystems

Navigation Path: Recipient menu option

6.54.2 Recipient Sub Menu Panel Layout



6.54.3 Recipient Sub Menu Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Search	A link to Recipient Data Maintenance Case Search Page.	Hyperlink	N/A	0
EDB Search	A link to Recipient Data Maintenance EDB Search Page.	Hyperlink	N/A	0
Information	A link to Recipient Data Maintenance Information Page.	Hyperlink	N/A	0
Other ID's Search	A link to Recipient Data Maintenance Other ID's Search Page.	Hyperlink	N/A	0
Preferences	Link to Preferences	Hyperlink	N/A	0
Recipient ICN Link Search	A link to Recipient Data Maintenance Recipient ICN Link Search Page.	Hyperlink	N/A	0
Related Data	A link to Recipient Data Maintenance Related data page.	Hyperlink	N/A	0
Search	A link to Recipient Data Maintenance Search Page.	Hyperlink	N/A	0
Service Usage Search	A link to Recipient Data Maintenance Service Usage Search Page.	Hyperlink	N/A	0

6.54.4 Recipient Sub Menu Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.54.5 Recipient Sub Menu Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.54.6 Recipient Sub Menu Panel Accessibility

6.54.6.1 To Access the Recipient Sub Menu Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click any link from the menu.	Recipient Sub menu will get displayed.

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7. Reports

The Recipient User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage.

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.

Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 ELG-0001-D -- Total ID Card Counts by County Report

7.1.1 ELG-0001-D -- Total ID Card Counts by County Report Narrative

The Total ID Card Counts by County report (ELG-0001-D) lists each of the counties alphabetically with the total number of ID cards that were issued for the county each day. This number includes all replacement cards or new cards.

A "Total" column at the end of report displays the number of cards printed for the State of Alabama for that day. This number is calculated by adding all county card totals together for a grand total. This report is produced daily.

7.1.2 ELG-0001-D -- Total ID Card Counts by County Report Layout

```
 Report  : ELG-0001-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
 Process : ELGJD040                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD04C                        TOTAL ID CARD COUNTS BY COUNTY                                      Page:  9,999
                                               REPORT PERIOD: MM/DD/CCYY
        ---------------------------------------------------------------------------------------------------------------------
                                                                          NUMBER OF
                                                COUNTY                  CARDS ISSUED
        ---------------------------------------------------------------------------------------------------------------------
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999

                                                TOTAL:                   999,999,999

                                                       ** END OF REPORT **
                                                     ** NO DATA THIS RUN **
```


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7.1.3 ELG-0001-D -- Total ID Card Counts by County Report Field Descriptions

Field	Description	Length	Data Type
County	Recipient's county name.	12	Character
Number of Cards Issued	Lists the total number of plastic ID cards issued to recipients in that county for that day.	11	Number (Decimal)
Total	Total number of plastic ID cards issued for the counties.	11	Number (Decimal)

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7.2 ELG-0002-D -- ID Card Summary Report

7.2.1 ELG-0002-D -- ID Card Summary Report Narrative

The ID Card Summary report lists the total number of ID cards generated according to the reason codes sent by the AMAES system. The reasons are listed as follows:

- Never Received Card
- Lost Card
- Card was Stolen
- Damaged or Destroyed
- Change in Name
- Change in Sex
- Change in Race
- Change in DOB
- Change In Medicaid Number
- Disaster Loss
- New Card
- Awarded Eligibility
- Eligibility Re-Awarded
- New Medicaid Number
- Left Nursing Home

A Total line displays how many cards were actually generated for the day.

The purpose of the ID Card Summary report is to allow the AMMIS client to view the number of ID cards created or re-issued, and the reason for the ID Card. This report is produced daily.

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7.2.2 ELG-0002-D -- ID Card Summary Report Layout

```
Report  : ELG-0002-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : ELGJD040                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD04A                                ID CARD SUMMARY                                         Page:    999,999
                                            REPORT PERIOD: MM/DD/CCYY

                 ---------------------------------------------------------------------------------------------------------
                                                                AMAES
                 ---------------------------------------------------------------------------------------------------------
                                         NEVER RECEIVED CARD:                 999,999,999
                                         LOST CARD:                           999,999,999
                                         CARD WAS STOLEN:                     999,999,999
                                         DAMAGED OR DESTROYED:                999,999,999
                                         CHANGE IN NAME:                      999,999,999
                                         CHANGE IN SEX:                       999,999,999
                                         CHANGE IN RACE:                      999,999,999
                                         CHANGE IN DOB:                       999,999,999
                                         CHANGE IN MEDICAID NUMBER:           999,999,999
                                         DISASTER LOSS                        999,999,999
                                         NEW CARD:                            999,999,999
                                         AWARDED ELIGIBILITY:                 999,999,999
                                         ELIGIBILITY RE-AWARDED:              999,999,999
                                         NEW MEDICAID NUMBER:                 999,999,999
                                         LEFT NURSING HOME:                   999,999,999


                                         TOTAL:                               999,999,999

                                                      ** END OF REPORT **
                                                     ** NO DATA THIS RUN **
```


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7.2.3 ELG-0002-D -- ID Card Summary Report Field Descriptions

Field	Description	Length	Data Type
Awarded Eligibility	Total number of cards printed for recipients who had eligibility awarded.	11	Number (Integer)
Card was Stolen	Total number of cards printed for recipients whose cards were stolen.	11	Number (Integer)
Change in DOB	Total number of cards printed for recipients that had date of birth information that was incorrect on the card.	11	Number (Integer)
Change in Medicaid Number	Total number of cards printed for recipients who changed their Medicaid number or had information that was incorrect on the card.	11	Number (Integer)
Change in Name	Total number of cards printed for recipients who changed their name or information was incorrect on the card.	11	Number (Integer)
Change in Race	Total number of cards printed for recipients that had race information that was incorrect on the card.	11	Number (Integer)
Change in Sex	Total number of cards printed for recipients who changed their sex or information was incorrect on the card.	11	Number (Integer)
Damaged or Destroyed	Total number of cards printed for recipients who had a damaged card that needed to be replaced.	11	Number (Integer)
Disaster Loss	Total number of cards printed for recipients whose card was lost due to a significant natural disaster.	11	Number (Integer)
Eligibility Re-Awarded	Total number of cards printed for recipients who had eligibility re-awarded.	11	Number (Integer)
Left Nursing Home	Total number of cards printed for recipients who left a nursing home.	11	Number (Integer)
Lost Card	Total number of cards printed for recipients who lost their cards.	11	Number (Integer)
Never Received Card	Total number of recipients who had a card issued, but never received the card.	11	Number (Integer)

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Field	Description	Length	Data Type
New Card	Total number of cards printed for recipients who had a new card issued.	11	Number (Integer)
New Medicaid Number	Total number of cards printed for recipients who received a new Medicaid number.	11	Number (Integer)
Total	Total number of cards generated daily for all counties.	11	Number (Integer)

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7.3 ELG-0003CL-D--AMACL Daily Error Report

7.3.1 ELG-0003CL-D--AMACL Daily Error Report Narrative

This report will provide a complete listing of all errors produced from the AMAES Closure transactions received and processed Monday thru Friday from the Agency.

7.3.2 ELG-0003CL-D--AMACL Daily Error Report Layout

```
Report  : ELG-0003CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD013C                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: ELGPD013                           AMAES DAILY CLOSURE ERROR REPORT                             Page:     999,999
                                                  PERIOD:  MM/DD/CCYY


 TCD    MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
 ERROR FIELD                                           ERROR DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------------

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


          TOTAL ERRORS FOR REPORT:           99,999,999


                                                 ***   END OF REPORT   ***
                                            ***   NO DATA THIS REPORT   ***
```

7.3.3 ELG-0003CL-D--AMACL Daily Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of Error.	70	Character
Error Field	Data that is causing the error.	15	Character

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Field	Description	Length	Data Type
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character
Medicaid ID	Medicaid identification number of the recipient.	12	Character
Middle Initial	Middle Initial of the recipient	1	Character
SSN	Recipient's Social Security Number.	9	Character
Source	Identifies the process source code AMACL.	5	Character
TCD	External Transaction Code (Not used for AMAES data).	4	Character
Total Errors for Report	Total number of errors reported.	10	Number (Integer)

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7.4 ELG-0003-D –Complete Error Report

7.4.1 ELG-0003-D – Complete Error Report Narrative

The Complete Error report provides a complete listing of all errors produced from the application of AMAES data to the AMMIS databases.

7.4.2 ELG-0003-D – Complete Error Report Layout

```
Report  : ELG-0003-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD013                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD013                            COMPLETE ERROR REPORT                                       Page:    999,999
                                                REPORT PERIOD:  MM/DD/CCYY


                  TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                      ERROR DESCRIPTION
    ---------------------------------------------------------------------------------------------------------------------------
                    XXXX   XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
                                                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XXXX   XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
                                                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                            TOTAL ERRORS FOR REPORT: 99,999,999


                                                ** END OF REPORT **
                                          ***   NO DATA THIS REPORT   ***
```

7.4.3 ELG-0003-D – Complete Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of error message.	70	Character

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Field	Description	Length	Data Type
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character
Medicaid ID	The Medicaid identification number of the recipient.	12	Character
M	The middle initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Number (Integer)
Source	Identifies the recipient's source code.	5	Character
TCD	External Transaction Code (not used for AMAES data).	4	Character
Total Errors for this Report	Total number of errors reported.	10	Number (Decimal)

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7.5 ELG-0003DR-D--AMADR Daily Error Report

7.5.1 ELG-0003DR-D-- AMADR Daily Error Report Narrative

This report will provide a complete listing of all errors produced from the AMAES Drastic transactions which are produced and processed Monday thru Friday as generated by the Agency update transactions.

7.5.2 ELG-0003DR-D-- AMADR Daily Error Report Layout

```
Report  : ELG-0003DR-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD013D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: ELGPD013                           AMAES DAILY DRASTIC CHANGE ERROR REPORT                         Page:     999,999
                                                REPORT PERIOD:  MM/DD/CCYY


 TCD    MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
 ERROR FIELD                                           ERROR DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------------

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


          TOTAL ERRORS FOR REPORT:           99,999,999


                                                 ***   END OF REPORT   ***
                                             ***   NO DATA THIS REPORT   ***
```

7.5.3 ELG-0003DR-D-- AMADR Daily Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of Error.	70	Character
Error Field	Data that is causing the error.	15	Character
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character

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Field	Description	Length	Data Type
Medicaid ID	Medicaid identification number of the recipient.	12	Character
Middle Initial	Middle Initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Character
Source	Identifies the process source code AMADR.	5	Character
TCD	External Transaction Code (Not used for AMAES data).	4	Character
Total Errors for Report	Total number of errors reported.	10	Number (Integer)

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7.6 ELG-0004CL-D--AMACL Daily Transaction Report Count

7.6.1 ELG-0004CL-D--AMACL Daily Transaction Count Report Narrative

This daily report lists the total number of AMACL Closure transactions received and processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is used to determine the total AMACL transactions received and processed on the AMMIS.

7.6.2 ELG-0004CL-D--AMACL Daily Transaction Count Report Layout

```
Report  : ELG-0004CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD012C                        MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD012                     AMAES DAILY CLOSURE TRANSACTION COUNT REPORT                          Page:    999,999
                                                     REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------

  AMACL   AMAES Closure Transactions

             TOTAL TRANSACTIONS RECEIVED:                                        99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                        99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:                 99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:               99,999,999


                                                        ** END OF REPORT **
                                                 ***   NO DATA THIS REPORT   ***
```

7.6.3 ELG-0004CL-D--AMACL Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Integer)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Integer)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Integer)
Total Transactions Received	Total number of transactions received.	10	Number (Integer)

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7.7 ELG-0004-D -- AMAES Daily Transaction Count Report

7.7.1 ELG-0004-D -- AMAES Daily Transaction Count Report Narrative

The AMAES Daily Transaction Count report lists the total number of AMAES transactions received, processed with no errors, processed with non-fatal errors, and not processed due to fatal errors.

This report is used to confirm that all AMAES transactions sent that day from interChange clients were received and processed on the MMIS.

7.7.2 ELG-0004-D -- AMAES Daily Transaction Count Report Layout

```
Report  : ELG-0004-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD012                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD012                        AMAES DAILY TRANSACTION COUNT REPORT                         Page:        999,999
                                               REPORT PERIOD:  MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------

  AMAES   AMAES Daily Input

             TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999


                                                   ** END OF REPORT **
```

7.7.3 ELG-0004-D -- AMAES Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.8 ELG-0004DR-D--AMADR Daily Transaction Count Report

7.8.1 ELG-0004DR-D--AMADR Daily Transaction Count Report Narrative

This daily report lists the total number of AMADR Drastic change transactions received and processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is used to determine the total AMADR transactions received and processed on the AMMIS.

7.8.2 ELG-0004DR-D--AMADR Daily Transaction Count Report Layout

```
Report  : ELG-0004DR-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD012D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELGPD012                   AMAES DAILY DRASTIC CHANGE TRANSACTION COUNT REPORT            Page:    999,999
                                                   REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------

  AMADR   AMAES Drastic Eligibility Change Transactions

             TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999


                                                   ** END OF REPORT **
                                          ***   NO DATA THIS REPORT   ***
```

7.8.3 ELG-0004DR-D--AMADR Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.9 ELG-0007CL-D--AMACL Daily Error Count Report

7.9.1 ELG-0007CL-D--AMACL Daily Error Count Report Narrative

This report prints a summary of all errors produced from the AMAES Closure transactions received and processed Monday thru Friday from the Agency. The report includes the error number, the number of times the error occurred, the action taken when the error failed, and a description of the error.

The purpose of this report is to summarize the AMACL errors that occurred during the process.

7.9.2 ELG-0007CL-D--AMACL Daily Error Count Report Layout

```
Report  : ELG-0007CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD020C                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPDC12                        AMAES DAILY CLOSURE ERROR COUNT REPORT                             Page:    999,999
                                               REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*
-------------------------------------------------------------------------------------------------------------------------------

   7777               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   8888               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   9999               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX




                                                         ** END OF REPORT **

                                                  ***   NO DATA THIS REPORT   ***
```

7.9.3 ELG-0007CL-D--AMACL Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	The action taken when the error occurred.	1	Character
Error Code	Error Code.	4	Character

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Field	Description	Length	Data Type
Error Description	Description of the Error Code.	75	Character
Failure Count	Number of times Error occurred.	7	Character

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7.10 ELG-0007-D -- AMAES Daily Error Count Report

7.10.1 ELG-0007-D -- AMAES Daily Error Count Report Narrative

The AMAES Daily Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error.

The purpose of this report is to summarize the AMAES errors that occurred during the day.

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7.10.2 ELG-0007-D -- AMAES Daily Error Count Report Layout

```
Report  : ELG-0007-D                          ALABAMA MEDICAID AGENCY                                  Run Date:   MM/DD/CCYY
Process : ELGJD020                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:     HH:MM:SS
Location: ELGPDC12                         AMAES DAILY ERROR COUNT REPORT                                 Page:      999,999
                                              REPORT PERIOD: MM/DD/CCYY



-------------------------------------------------------------------------------------------------------------------------------

     ERROR    FAILURE COUNT      ACTION CODE     *-----------------------------ERROR DESCRIPTION-----------------------------------*

-------------------------------------------------------------------------------------------------------------------------------


    9999       999,999                  9            XXXX
```

7.10.3 ELG-0007-D – AMAES Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error code.	4	Character
Error Description	Text description of the message.	75	Character
Failure Count	Number of times error occurred.	7	Number (Decimal)

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7.11 ELG-0007DR-D--AMADR Daily Error Count Report

7.11.1 ELG-0007DR-D--AMADR Daily Error Count Report Narrative

This report prints a summary of all errors produced from the AMAES Drastic change transactions received and processed Monday thru Friday from the Agency. The report includes the error number, the number of times the error occurred, the action taken when the error failed, and a description of the error.

The purpose of this report is to summarize the AMADR errors that occurred during the process.

7.11.2 ELG-0007DR-D--AMADR Daily Error Count Report Layout

```
Report  : ELG-0007DR-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD020D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELGPDC12                      AMAES DAILY DRASTIC CHANGE ERROR COUNT REPORT                Page:    999,999
                                                REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*
-------------------------------------------------------------------------------------------------------------------------

   7777               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   8888               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   9999               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX




                                                        ** END OF REPORT **

                                                 ***   NO DATA THIS REPORT   ***
```

7.11.3 ELG-0007DR-D--AMADR Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error code.	4	Character

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Field	Description	Length	Data Type
Error Description	Text description of the message.	75	Character
Failure Count	Number of times error occurred.	7	Number (Decimal)

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7.12 ELG-0009-D -- Eligible ID Card Recipients Report

7.12.1 ELG-0009-D -- Eligible ID Card Recipients Report Narrative

The Eligible ID Card Recipients report lists the recipient names and IDs that appear on the plastic ID cards created that day.

This report is used to identify which recipients had a plastic ID card created that day.

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7.12.2 ELG-0009-D -- Eligible ID Card Recipients Report Layout

```
Report  : ELG-0009-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD040                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD04B                          ELIGIBLE ID CARD RECIPIENTS                                    Page:    999,999
                                             REPORT PERIOD: MM/DD/CCYY

                                                                                  COUNTY:   XXXXXXXXXXXX

     ---------------------------------------------------------------------------------------------------------------------
              RECIPIENT NAME           RECIPIENT ID                                RECIPIENT NAME            RECIPIENT ID
     ---------------------------------------------------------------------------------------------------------------------

     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX

                                     TOTAL RECIPIENTS FOR COUNTY XXXXXXXXXXXX:       999,999

                                        TOTAL RECIPIENTS FOR REPORT:                    999,999
                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.12.3 ELG-0009-D -- Eligible ID Card Recipients Report Field Descriptions

Field	Description	Length	Data Type
County	County of residence for a group of recipients.	12	Character
Recipient ID	Recipient's Medicaid ID that is printed on the plastic ID card.	12	Character
Recipient Name	Recipient's last name, first name, and middle initial format.	31	Character
Total Recipients for County XXXXXXXXXXXX	Total number of recipients issued ID cards within a specified county.	7	Number (Decimal)
Total Recipients for Report	Total number of recipients issued ID cards for all counties included in this report.	7	Number (Decimal)

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7.13 ELG-0011-W -- Potential Duplicate InterChange Recipient Report

7.13.1 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Narrative

The Potential Duplicate interChange Recipient report lists all recipients who were identified as a potential duplicate during the process. The report shows the recipient ID, name, SSN, and DOB for both recipients. All active (non/linked) recipients are considered during the reporting process.

This report shows only those pairs of recipients, one of whom have not been recently eligible and therefore are most likely no longer on the AMAES system. Recently eligible is defined as having eligibility within the current 3 year eligibility period or for the three years prior to that. Because the AMAES system grants eligibility only for full years, if the current eligibility is being granted for January 2010, a recipient would be listed on this report if they had not been eligible on or after January 1st, 2005. Recipients who have not been eligible will have an asterisk beside their information on the report. Either one or both of the recipients could have an asterisk. Recipients who have been eligible sometime during that period are listed on the ELG-0012-W report.

This report is used to identify recipients who are potentially duplicates. These recipient IDs should be researched further to determine if a duplicate actually exists or not. The report is sorted by SSN and recipient ID. This report is produced weekly.

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7.13.2 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Layout

```
Report  : ELG-0011-W                                    ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJW012                                  MEDICAID INFORMATION MANAGEMENT SYSTEM                       Run Time:   HH:MM:SS
Location: ELGPW020                              POTENTIAL DUPLICATE INTERCHANGE RECIPIENT REPORT                     Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------------
*-------------------- RECIPIENT 1 ------------------------------*      *-----------------------RECIPIENT 2 ------------------------------*
RECIPIENT ID        RECIPIENT NAME               SSN       DOB          RECIPIENT ID         RECIPIENT NAME             SSN       DOB
-------------------------------------------------------------------------------------------------------------------------------------


XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
                                                          ** END OF REPORT **
                                                        ** NO DATA THIS RUN **
```

7.13.3 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Field Descriptions

Field	Description	Length	Data Type
Asterisk	An asterisk is placed on a line for an MMIS recipient who is no longer on the State Agency's AMAES file. This is determined based upon the most recent eligibility date on the recipient. As of 9/4/2009, a recipient is assumed to have been removed from the State Agency's AMAES file if they do not have eligibility on or after January 1, 2004.	1	Character
DOB	Recipient date of birth.	10	Date (MM/DD/CCYY)
Recipient ID	Recipient ID.	12	Character
Recipient Name	Recipient first and last name	31	Character
SSN	Recipient social security number	9	Number (Integer)

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7.14 ELG-0012-W -- Potential Duplicate AMAES Recipient Report

7.14.1 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Narrative

The Potential Duplicate AMAES Recipient report lists all recipients who were identified as a potential duplicate during the process. The report shows the recipient ID, name, SSN, and DOB for both recipients.. All active (non/linked) recipients are considered during the reporting process.

This report shows only those pairs of recipients, both of whom have been recently eligible and therefore are most likely on the AMAES system. Recently eligible is defined as having eligibility within the current 3 year eligibility period or for the three years prior to that. Because the AMAES system grants eligibility only for full years, if the current eligibility is being granted for January 2010, a recipient would be listed on this report only if they had been eligible on or after January 1st, 2005. Recipients who have not been eligible sometime during that period are listed on the ELG-0011-W report.

This report is used to identify recipients who are potentially duplicates. These recipient IDs should be researched further to determine if a duplicate actually exists or not. The report is sorted by SSN and recipient ID. This report is produced weekly.

7.14.2 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Layout

```
Report  : ELG-0012-W                                    ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJW012                                MEDICAID INFORMATION MANAGEMENT SYSTEM                       Run Time:   HH:MM:SS
Location: ELGPW020                              POTENTIAL DUPLICATE AMAES RECIPIENT REPORT                         Page:    999,999
-------------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------------
*-------------------- RECIPIENT 1 ------------------------------*      *-----------------------RECIPIENT 2 ------------------------------*
RECIPIENT ID        RECIPIENT NAME               SSN       DOB          RECIPIENT ID         RECIPIENT NAME             SSN       DOB
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
                                                          ** END OF REPORT **
                                                        ** NO DATA THIS RUN **
```


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7.14.3 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Field Descriptions

Field	Description	Length	Data Type
DOB	Recipient date of birth.	10	Date (MM/DD/CCYY)
Recipient ID	Recipient ID.	12	Character
Recipient Name	Recipient first and last name	31	Character
SSN	Recipient social security number	9	Number (Integer)

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7.15 ELG-0014-D – AMAES Part A B Error Count Report

7.15.1 ELG-0014-D – AMAES Part A B Error Count Report Narrative

The AMAES Part A B Error Count report is a summary of the AMAES Part A B error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error. This report is produced daily.

7.15.2 ELG-0014-D – AMAES Part A B Error Count Report Layout

```
     Report  : ELG-0014-D                        ALABAMA MEDICAID AGENCY                                          Run Date:
                                                      MM/DD/CCYY
Process : ELGJD080                    MEDICAID MANAGEMENT INFORMATION SYSTEM                              Run Time:   HH:MM:SS
Location: ELGPDC12                        AMAES PART A B ERROR COUNT REPORT                                   Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY

  ---------------------------------------------------------------------------------------------------------------------------------

   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*

  ---------------------------------------------------------------------------------------------------------------------------------

   9999                 999,999         9              XXXX
```

7.16 ELG-0020-D – AMAES Part A B Updates Error Report

7.16.1 ELG-0020-D – AMAES Part A B Updates Error Report Narrative

The AMAES Part A B Updates Error report provides a complete listing of the AMAES PART A B errors that occurred during the nightly update process. This report is produced daily.

7.16.2 ELG-0020-D – AMAES Part A B Updates Error Report Layout

```
     Report  : ELG-0020-D                        ALABAMA MEDICAID AGENCY                                          Run Date:
                                                          MM/DD/CCYY
Process : ELGJD018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD013                         AMAES PART A B UPDATES ERROR REPORT                               Page:    999,999
                                                 REPORT PERIOD: MM/DD/CCYY



                  TCD       MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
                                                                                      ERROR DESCRIPTION
 ---------------------------------------------------------------------------------------------------------------------------

                    XXXX       XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX               XXXXX   XXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                    XXXX       XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX               XXXXX   XXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                TOTAL ERRORS FOR REPORT:           99,999,999

                                                       ** END OF REPORT **

                                                      ** NO DATA THIS RUN **
```

7.16.3 ELG-0020-D – AMAES Part A B Updates Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error number for a batch Edit Error.	4	Character
Error Description	Description of the error message.	70	Character
First Name	First name of the recipient.	15	Character
Last Name	Last name of the recipient.	20	Character

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Field	Description	Length	Data Type
Medicaid ID	Medicaid identification number of the recipient.	12	Character
M	Middle Initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Number (Integer)
Source	Identifies the recipient's source code.	5	Character
TCD	External Transaction Code (not used for AMAES data).	4	Character
Total Errors for this Report	Total number of errors reported.	10	Number (Decimal)

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7.17 ELG-0021-D -- AMAES PART A B Transaction Count Report

7.17.1 ELG-0021-D -- AMAES Part A B Transaction Count Report Narrative

The AMAES Part A B Transaction Count report lists the total number of AMAES Part A B transactions received, processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is produced daily.

7.17.2 ELG-0021-D -- AMAES Part A B Transaction Count Report Layout

```
Report  : ELG-0021-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD021                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD012                      AMAES PART A B TRANSACTION COUNT REPORT                          Page:     999,999
                                              REPORT PERIOD:  MM/DD/CCYY
 ---------------------------------------------------------------------------------------------------------------------------

                                         PRTAB   Part A/B Updates from AMAES file

                                TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
                                TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
                                TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
                                TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999

                                                  ** END OF REPORT **
```

7.17.3 ELG-0021-D -- AMAES Part A B Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.18 ELG-0032-D -- Link Requests Processed Report

7.18.1 ELG-0032-D -- Link Requests Processed Report Narrative

The Link Requests Processed report lists all recipient link requests that were processed successfully. Types of information that the system was not able to determine how to handle are included on the report.

The purpose of this report is to identify recipients who have been linked, as well as types of information that needs to be reviewed to see if a manual linking needs to take place. This report is produced daily.

7.18.2 ELG-0032-D -- Link Requests Processed Report Layout

```
Report  : ELG-0032-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGPD017                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGJD017                         LINK REQUESTS PROCESSED REPORT                                  Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   LINK RECIP ID    TO RECIP ID      NAME OF 'TO RECIP ID'               *--------------DATA NOT LINKED--------------*
-------------------------------------------------------------------------------------------------------------------------------

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```


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7.18.3 ELG-0032-D -- Link Requests Processed Report Field Descriptions

Field	Description	Length	Data Type
Data Not Linked	List of the types of information that was not systematically linked due to overlapping rows between the two recipient IDs.	20	Character
Link Recipient ID	ID being linked in with another ID. This ID is no longer an active ID after the link is completed.	12	Character
Name of 'To Recip ID'	Name of the recipient listed in the 'To Recip ID' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
To Recip ID	ID that another ID was linked to. This ID remains an active ID.	12	Character

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7.19 ELG-0033-D -- Unlink Requests Processed Report

7.19.1 ELG-0033-D -- Unlink Requests Processed Report Narrative

The Unlink Requests Processed report lists all recipient unlink requests that were processed successfully. Types of information that the system was not able to determine how to handle are included on the report.

The purpose of this report is to identify recipients who have been unlinked, as well as types of information that needs to be reviewed to see if a manual unlinking needs to take place. This report is produced daily.

7.19.2 ELG-0033-D -- Unlink Requests Processed Report Layout

```
Report  : ELG-0033-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGPD017                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: ELGJD017                         UNLINK REQUESTS PROCESSED REPORT                                  Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   UNLINK RECIP ID FROM RECIP ID         NAME OF 'FROM RECIP ID'      *--------------DATA NOT UNLINKED--------------*
-------------------------------------------------------------------------------------------------------------------------------
   XXXXXXXXXXXX      XXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X
   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXX       XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX


                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.19.3 ELG-0033-D -- Unlink Requests Processed Report Field Descriptions

Field	Description	Length	Data Type
Data Not Unlinked	List of the types of information that was not systematically unlinked due to the system not being able to determine which rows belonged to the ID being unlinked.	20	Character
From Recip ID	Recipient ID that had an ID unlinked from it. This ID remains an active ID.	12	Character
Name of 'From Recip ID'	Recipient name listed in the 'From Recip ID' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Unlink Recip ID	Deactivated recipient ID that was unlinked from a recipient ID and activated again.	12	Character

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7.20 ELG-0036-D – Automatic Unlink Warning Report

7.20.1 ELG-0036-D – Automatic Unlink Warning Report Narrative

This report displays the recipients that were automatically unlinked because a recipient was received from AMAES that was inactive in the AMMIS. If no recipients are automatically unlinked during a daily AMAES update cycle, no report is created.

Frequency: Daily

7.20.2 ELG-0036-D – Fund Code Assignment Criteria Report Layout

```
Report  : ELG-0036-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD036                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD036                         AUTOMATIC UNLINK WARNING REPORT                                 Page:          1
                                               REPORT PERIOD: 05/20/2010


   UNLINKED RECIP  NAME OF UNLINKED RECIP          FROM RECIP          NAME OF RECIP                      ORIG LINK DATE

   999999999999    MOUSE, MINNIE, D                    888888888888    MOUSE, MICKEY, D                     MM/DD/CCYY


                                                  *** END OF REPORT ***
```

7.20.3 ELG-0036-D – Automatic Unlink Warning Report Field Descriptions

Field	Description	Length	Data Type
Name of Recip	Name of the recipient listed in the 'RECIP' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Name of Unlinked Recip	Name of the recipient listed in the 'UNLINKED RECIP' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Orig Link Date	Date the link was originally processed.	10	Date (MM/DD/CCYY)
Recip	Recipient ID that the unlinked recipient was originally linked to.	12	Character

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Field	Description	Length	Data Type
Unlinked Recip	Recipient ID of recipient that was automatically unlinked and is now active.	12	Character

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7.21 ELG-0050-D – AMAES Unlinking Transaction Count Report

7.21.1 ELG-0050-D – AMAES Unlinking Transaction Count Report Narrative

The AMAES Unlinking Transaction Count report lists the counts of all the recipient unlinking transactions that were processed in the cycle. This report is produced daily.

7.21.2 ELG-0050-D – AMAES Unlinking Transaction Count Report Layout

```
Report  : ELG-0050-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD050                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD012                     AMAES UNLINKING TRANSACTION COUNT REPORT                          Page:    999,999
                                                 REPORT PERIOD: MM/DD/CCYY

 ---------------------------------------------------------------------------------------------------------------------------------------------------


                                                   UNLNK   Unlinking Requests


                                   TOTAL TRANSACTIONS RECEIVED:                                  999,999,999

                                   TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                  999,999,999

                                   TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:           999,999,999

                                   TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:         999,999,999


                                                   ** END OF REPORT **
```

7.21.3 ELG-0050-D – AMAES Unlinking Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due to Fatal Errors	Total number of transactions not processed due to fatal errors.	11	Number (Decimal)
Total Transactions Processed with No Errors	Total number of transactions processed with no errors.	11	Number (Decimal)
Total Transactions Processed with Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	11	Number (Decimal)

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Field	Description	Length	Data Type
Total Transactions Received	Total number of transactions received.	11	Number (Decimal)

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7.22 ELG-0052-D -- Unlinking Error Count Report

7.22.1 ELG-0052-D -- Unlinking Error Count Report Narrative

The Unlinking Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error with code source 'UNLNK'.

The purpose of this report is to summarize the errors that occurred during the day. This report is produced daily.

7.22.2 ELG-0052-D -- Unlinking Error Count Report Layout

```
Report  : ELG-0052-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD052                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: ELGPDC12                          UNLINKING ERROR COUNT REPORT                                     Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY


 ---------------------------------------------------------------------------------------------------------------------------------
   ERROR    FAILURE COUNT          ACTION CODE     *-----------------------------ERROR DESCRIPTION-------------------------*
 ---------------------------------------------------------------------------------------------------------------------------------

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                         ** END OF REPORT **
                                                       ** NO DATA THIS RUN **
```


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7.22.3 ELG-0052-D -- Unlinking Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error Code.	4	Character
Error Description	Text description of the error message.	75	Character
Failure Count	Number of times the error occurred.	7	Number (Decimal)

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7.23 ELG-0055-D -- Unlinking Error Report

7.23.1 ELG-0055-D -- Unlink Error Report Narrative

The Unlinking Error report lists all errors that occurred during the daily update process for AMAES unlink transactions. The report displays the fields in error, as well as the invalid data and a brief message explaining each error.

The purpose of the Eligibility Update Error Report is to provide EDS and the Medicaid Agency with information regarding transactions which error off. This report is produced daily.

7.23.2 ELG-0055-D -- Unlinking Error Report Layout

```
Report  : ELG-0055-D                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJD055                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: ELGPD055                              UNLINKING ERROR REPORT                                             Page:    999,999
                                                  PERIOD: MM/DD/CCYY


                    TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                        ERROR DESCRIPTION
     ---------------------------------------------------------------------------------------------------------------------------------
                      XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                                         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                      XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                        ** END OF REPORT **
                                                 ***   NO DATA THIS REPORT   ***
```

7.23.3 ELG-0055-D -- Unlinking Error Field Report Descriptions

Field	Description	Length	Data Type
Error Code	Error Code.	5	Character
Error Description	Description of the error code.	80	Character
First Name	First name of the recipient.	15	Character

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Field	Description	Length	Data Type
Last Name	Last name of the recipient.	20	Character
Medicaid ID	Medicaid identification number of the recipient.	12	Character
M	Middle initial of the recipient.	1	Character
SSN	Social Security Number of the recipient.	9	Number (Integer)
Source	Identifies source code for the data. For Alabama, this is always UNLNK.	5	Character
TCD	External Transaction Code. Not used for Alabama.	4	Character

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7.24 ELG-0060-D – AMAES Linking Transaction Count Report

7.24.1 ELG-0060-D – AMAES Linking Transaction Count Report Narrative

The AMAES Linking Transaction Count report lists the counts of all the recipient linking transactions that were processed in the cycle. This report is produced daily.

7.24.2 ELG-0060-D – AMAES Linking Transaction Count Report Layout

```
Report  : ELG-0060-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD060                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD012                        AMAES LINKING TRANSACTION COUNT REPORT                           Page:    999,999
                                               REPORT PERIOD: MM/DD/CCYY
   ------------------------------------------------------------------------------------------------------------------------------

                                                        LINK    Linking Requests

                                      TOTAL TRANSACTIONS RECEIVED:                              999,999,999
                                      TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:              999,999,999
                                      TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:       999,999,999
                                      TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:     999,999,999


                                                      ** END OF REPORT **
```

7.24.3 ELG-0060-D – AMAES Linking Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	11	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	11	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	11	Number (Decimal)
Total Transactions Received	Total number of transactions received.	11	Number (Decimal)

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7.25 ELG-0062-D -- Linking Error Count Report

7.25.1 ELG-0062-D -- Linking Error Count Report Narrative

The Linking Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error for code source 'LINK'.

The purpose of this report is to summarize the errors that occurred during the day. This report is produced daily.

7.25.2 ELG-0062-D -- Linking Error Count Report Layout

```
Report  : ELG-0062-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : ELGJD062                   MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPDC12                         LINKING ERROR COUNT REPORT                                     Page:    999,999
                                            REPORT PERIOD: MM/DD/CCYY


-------------------------------------------------------------------------------------------------------------------------
       ERROR    FAILURE COUNT      ACTION CODE     *------------------------------ERROR DESCRIPTION-------------------------*
-------------------------------------------------------------------------------------------------------------------------

       XXXX       999,999                9            XXXX
```

7.25.3 ELG-0062-D -- Linking Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error Code.	4	Character
Error Description	Text description of the error message.	75	Character
Failure Count	Number of times the error occurred.	7	Number (Decimal)

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7.26 ELG-0065-D -- Linking Error Report

7.26.1 ELG-0065-D -- Linking Error Report Narrative

The Linking Error report lists all errors that occurred during the daily update process for AMAES Link transactions; the fields in error, as well as the invalid data and a brief message explaining each error. This report is produced daily.

7.26.2 ELG-0065-D -- Linking Error Report Layout

```
Report  : ELG-0065-D                          ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : ELGJD065                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: ELGPD065                            LINKING ERROR REPORT                                               Page:    999,999
                                           REPORT PERIOD:  MM/DD/CCYY


                  TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                        ERROR DESCRIPTION
    ---------------------------------------------------------------------------------------------------------------------------
                     XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                             XXXXXXXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
SSN	Social Security Number of the recipient.	9	Number (Integer)
Source	Identifies the source code for the data. For Alabama, this is always LINK.	5	Character
TCD	External Transaction Code. Not used for Alabama.	4	Character

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7.27 ELG-0070-D – Recipient Portal Demographic Updates Daily Report

7.27.1 ELG-0070-D – Recipient Portal Demographic Updates Daily Report Narrative

This report will contain updates submitted by the Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC.

RCC will apply the updates to the AMAES CICS screens for the data on this report.

ELG-0070-D is indexed by Recipient ID in COLD and is a duplicate copy of the ELG-0071-D report.

7.27.2 ELG-0070-D – Recipient Portal Demographic Updates Daily Report Layout

```
Report  : ELG-0070-D                                ALABAMA MEDICAID AGENCY                      Run Date:
MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:
HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT           Page:
999,999


RECIPIENT ID:  XXXXXXXXXXXX            CERTIFYING AGENCY   X
                           RECIPIENT INFORMATION
                           RECIPIENT FIRST NAME XXXXXXXXXXXXXXXXX
                           RECIPIENT LAST  NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           DATE OF BIRTH MM/DD/CCYY
                           SEX X
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           RESIDENCE COUNTY XX
                           HOME PHONE (999) 999-9999 OTHER PHONE (999) 999-9999

                           RECIPIENT'S SPOUSE INFORMATION
                           DATE OF SPOUSE CHANGE MM/DD/CCYY
                           MARITIAL STATUS X
                           SPOUSE FIRST NAME XXXXXXXXXXXXXXX
                           SPOUSE LAST  NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           SPOUSE DATE OF BIRTH  MM/DD/CCYY
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           SPOUSE PHONE NUMBER (999) 999-9999
                           SPOUSE SSN 999-99-9999

                           RECIPIENT'S SPONSOR INFORMATION
```


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```
                          SPONSOR ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          SPONSOR ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          CITY XXXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                          ZIP CODE XXXXX   ZIP+4 XXXX
                          SPONSOR PHONE NUMBER (999) 999-9999

                          NAME OF PERSON REPORTING UPDATES
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON REPORTING UPDATES (999) 999-9999
                          CERTIFIED APPLICATION ASSISTER X
                          NAME OF PERSON ASSISTING
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON ASSISTING (999) 999-9999

<page break>

Report  : ELG-0070-D                                ALABAMA MEDICAID AGENCY                        Run Date:
MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:
HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT             Page:
999,999

RECIPIENT ID:  999999999999

NUMBER OF RECIPIENTS PROCESSED  99,999,999

                                              ** END OF REPORT **
                                              ** NO DATA THIS RUN **
```

7.27.3 ELG-0070-D – Recipient Portal Demographic Updates Report Field Descriptions

Field	Description	Length	Data Type
ADDRESS 1	First line of the recipient's street address.	30	Character
ADDRESS 2	Second line of the recipient's street address.	30	Character
CERTIFIED APPLICATION ASSISTER	Indicator for Certified Application Assister.	1	Character
CERTIFYING AGENCY	Certifying Agency.	1	Character
CITY	City where the recipient resides.	25	Character
DATE OF BIRTH	Date of birth of the recipient.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
DATE OF SPOUSE CHANGE	Date of marital status change.	8	Date (MM/DD/CCYY)
HOME PHONE	Home phone number of the recipient.	10	Character
MARITIAL STATUS	Indicates the marital status of a recipient.	1	Character
NAME OF PERSON ASSISTING	Name of the person assisting the update.	60	Character
NAME OF PERSON REPORTING UPDATES	Name of person reporting the update.	60	Character
NUMBER OF RECIPIENTS PROCESSED	Total number of recipients requesting updates.	10	Number (Integer)
OTHER PHONE	An additional phone number for contacting the recipient.	10	Character
PHONE NUMBER OF PERSON ASSISTING	Phone number of the person assisting the update.	10	Character
PHONE NUMBER OF PERSON REPORTING UPDATES	Phone number of person reporting the update.	10	Character
RECIPIENT FIRST NAME	First name of a recipient.	15	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
RECIPIENT LAST NAME	Last name of a recipient.	30	Character
RESIDENCE COUNTY	County code of Residence.	2	Character
SEX	Indicates the gender of the recipient.	1	Character
SPONSOR ADDRESS 1	First line of the sponsor's street address.	30	Character
SPONSOR ADDRESS 2	Second line of the sponsor's street address.	30	Character
SPONSOR CITY	City where the sponsor resides.	25	Character
SPONSOR PHONE NUMBER	Phone number of the sponsor.	10	Character

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Field	Description	Length	Data Type
SPONSOR STATE	State where the sponsor resides.	2	Character
SPONSOR ZIP CODE	The five character zip code for the sponsor.	5	Character
SPONSOR ZIP+4	The zip plus four of the sponsor.	4	Character
SPOUSE ADDRESS 1	First line of the spouse's street address.	30	Character
SPOUSE ADDRESS 2	Second line of the spouse's street address.	30	Character
SPOUSE CITY	City where the spouse resides.	25	Character
SPOUSE DATE OF BIRTH	Date of birth of the spouse.	8	Date (MM/DD/CCYY)
SPOUSE FIRST NAME	First name of the spouse.	15	Character
SPOUSE LAST NAME	Last name of the spouse.	30	Character
SPOUSE PHONE NUMBER	Phone number of the spouse.	10	Character
SPOUSE SSN	Social security number of the spouse.	9	Character
SPOUSE STATE	State where the spouse resides.	2	Character
SPOUSE ZIP CODE	The five character zip code of the spouse.	5	Character
SPOUSE ZIP+4	The zip plus four of the spouse.	4	Character
STATE	State where the recipient resides.	2	Character
ZIP CODE	The five character zip code for the recipienrecipient.t	5	Character
ZIP+4	The zip plus four of the recipient.	4	Character

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7.28 ELG-0071-D – Recipient Portal Demographic Updates Daily Report

7.28.1 ELG-0071-D – Recipient Portal Demographic Updates Daily Report Narrative

This report will contain updates submitted by the Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC.

RCC will apply the updates to the AMAES CICS screens for the data on this report.

7.28.2 ELG-0071-D – Recipient Portal Demographic Updates Daily Report Layout

```
Report  : ELG-0071-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT                   Page:    999,999


RECIPIENT ID:  XXXXXXXXXXXX            CERTIFYING AGENCY   X
                           RECIPIENT INFORMATION
                           RECIPIENT FIRST  NAME XXXXXXXXXXXXXXX
                           RECIPIENT MIDDLE NAME XXXXXXXXXXXXXXX
                           RECIPIENT LAST   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           RECIPIENT SUFFIX NAME XXXX

                           DATE OF BIRTH MM/DD/CCYY
                           SEX X
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           RESIDENCE COUNTY XX
                           HOME PHONE (999) 999-9999 OTHER PHONE (999) 999-9999

                           RECIPIENT'S SPOUSE INFORMATION
                           DATE OF SPOUSE CHANGE MM/DD/CCYY
                           MARITIAL STATUS X
                           SPOUSE FIRST  NAME XXXXXXXXXXXXXXX
                           SPOUSE MIDDLE NAME XXXXXXXXXXXXXXX
                           SPOUSE LAST   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           SPOUSE SUFFIX NAME XXXX
                           SPOUSE DATE OF BIRTH  MM/DD/CCYY
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           SPOUSE PHONE NUMBER (999) 999-9999
                           SPOUSE SSN 999-99-9999
                           RECIPIENT'S SPONSOR INFORMATION
                           SPONSOR ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
                          SPONSOR ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                          ZIP CODE XXXXX   ZIP+4 XXXX
                          SPONSOR PHONE NUMBER (999) 999-9999

                          NAME OF PERSON REPORTING UPDATES
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON REPORTING UPDATES (999) 999-9999
                          CERTIFIED APPLICATION ASSISTER X
                          NAME OF PERSON ASSISTING
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON ASSISTING (999) 999-9999

<page break>

Report  : ELG-0071-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: ELG_RECIP_UPDS                RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT                  Page:    999,999


RECIPIENT ID:  999999999999

NUMBER OF RECIPIENTS PROCESSED  99,999,999

                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.28.3 ELG-0071-D – Recipient Portal Demographic Updates Report Field Descriptions

Field	Description	Length	Data Type
ADDRESS 1	First line of the recipient's street address.	30	Character
ADDRESS 2	Second line of the recipient's street address.	30	Character
CERTIFIED APPLICATION ASSISTER	Indicator for Certified Application Assister.	1	Character
CERTIFYING AGENCY	Certifying Agency.	1	Character
CITY	City where the recipient resides.	25	Character
DATE OF BIRTH	Date of birth of the recipient.	8	Date (MM/DD/CCYY)
DATE OF SPOUSE CHANGE	Date of marital status change.	8	Date (MM/DD/CCYY)
HOME PHONE	Home phone number of the recipient.	10	Character
MARITIAL STATUS	Indicates the marital status of a recipient.	1	Character
NAME OF PERSON ASSISTING	Name of the person assisting the update.	60	Character
NAME OF PERSON REPORTING UPDATES	Name of person reporting the update.	60	Character
NUMBER OF RECIPIENTS PROCESSED	Total number of recipients requesting updates.	10	Number (Integer)
OTHER PHONE	An additional phone number for contacting the recipient.	10	Character
PHONE NUMBER OF PERSON ASSISTING	Phone number of the person assisting the update.	10	Character

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Field	Description	Length	Data Type
PHONE NUMBER OF PERSON REPORTING UPDATES	Phone number of person reporting the update.	10	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
RECIPIENT FIRST NAME	First name of a recipient.	15	Character
RECIPIENT MIDDLE NAME	Middle name of a recipient.	15	Character
RECIPIENT LAST NAME	Last name of a recipient.	30	Character
RECIPIENT SUFFIX NAME	Suffix name of a recipient.	4	Character
RESIDENCE COUNTY	County code of Residence.	2	Character
SEX	Indicates the gender of the recipient.	1	Character
SPONSOR ADDRESS 1	First line of the sponsor's street address.	30	Character
SPONSOR ADDRESS 2	Second line of the sponsor's street address.	30	Character
SPONSOR CITY	City where the sponsor resides.	25	Character
SPONSOR PHONE NUMBER	Phone number of the sponsor.	10	Character
SPONSOR STATE	State where the sponsor resides.	2	Character
SPONSOR ZIP CODE	The five character zip code for the sponsor.	5	Character
SPONSOR ZIP+4	The zip plus four of the sponsor.	4	Character
SPOUSE ADDRESS 1	First line of the spouse's street address.	30	Character
SPOUSE ADDRESS 2	Second line of the spouse's street address.	30	Character
SPOUSE CITY	City where the spouse resides.	25	Character
SPOUSE DATE OF BIRTH	Date of birth of the spouse.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
SPOUSE FIRST NAME	First name of the spouse.	15	Character
SPOUSE MIDDLE NAME	Middle name of the spouse.	15	Character
SPOUSE LAST NAME	Last name of the spouse.	30	Character
SPOUSE SUFFIX NAME	Suffix name of the spouse.	4	Character
SPOUSE PHONE NUMBER	Phone number of the spouse.	10	Character
SPOUSE SSN	Social security number of the spouse.	9	Character
SPOUSE STATE	State where the spouse resides.	2	Character
SPOUSE ZIP CODE	The five character zip code of the spouse.	5	Character
SPOUSE ZIP+4	The zip plus four of the spouse.	4	Character
STATE	State where the recipient resides.	2	Character
ZIP CODE	The five character zip code for the recipient.	5	Character
ZIP+4	The zip plus four of the recipient.	4	Character

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7.29 ELG-0072-D – Plastic Card ID Updates Report

7.29.1 ELG-0072-D – Plastic Card ID Update Report Narrative

This report will show all plastic ID cards requested by Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC. RCC will apply the requests to the AMAES CICS screens. The report is sorted by the Certifying Agency column.

7.29.2 ELG-0072-D – Plastic Card ID Updates Report Layout

```
Report  : ELG-0072-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD072                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELG_CARDRQST                          PLASTIC CARD ID UPDATES                            Page:    999,999
                                               REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------
   RECIPIENT ID     REASON FOR REQUEST  CERTIFYING AGENCY  DATE REQUESTED   TIME REQUESTED
-------------------------------------------------------------------------------------------------------------------

   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT


TOTAL CARD UPDATES            999,999,999


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

7.29.3 ELG-0072-D -- Plastic Card ID Updates Report Field Descriptions

Field	Description	Length	Data Type
CERTIFYING AGENCY	Certifying Agency	1	Character
DATE REQUESTED	Date plastic card ID update requested.	8	Date (MM/DD/CCYY)
REASON FOR REQUEST	Reason for the request.	1	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
TIME REQUESTED	Time update requested. In HHMMSSMM format.	8	Character

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Field	Description	Length	Data Type
TOTAL CARD UPDATES	Total number of card updates	11	Number (Integer)

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7.30 ELG-0134-M—Monthly Date of Death Returned to Zero Report

7.30.1 ELG-0134-M—Monthly Date of Death Returned to Zero Report Narrative

The ELG-0134-M is a report of death dates that were changed from a 'real' date to zero throughout the month. The report contains the recipient's ID, last name, first name, ssn, and previous date of death. The report is sorted by recipient ID.

This report is a summary of all deaths that were changed from a 'real' date to zero during the month. The information is sorted by recipient ID.

7.30.2 ELG-0134-M—Monthly Date of Death Returned to Zero Report Layout

```
Report  : ELG-0134-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJM025                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MI:SS
Location: ELGPM025                       DATE OF DEATH RETURNED TO ZERO REPORT                            Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
                        RECIPIENT ID      LAST NAME             FIRST NAME       SSN          PREVIOUS DATE OF DEATH
-------------------------------------------------------------------------------------------------------------------------

                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY


                            TOTAL NUMBER OF DATES OF DEATHS CHANGED THIS PERIOD:         999,999


                                                   ** END OF REPORT **
```

7.30.3 ELG-0134-M—Monthly Date of Death Returned to Zero Report Field Descriptions

Field	Description	Data Type	Length
(Heading Date Range - from)	This is the beginning date in the date range used to determine which date of deaths to report. The ones received during the date range are reported.	Date (MM/DD/CCYY)	10
(Heading Date Range - to)	This is the ending date in the date range used to determine which date of deaths to report. The ones received during the date range are reported.	Date (MM/DD/CCYY)	10
First Name	First name of the Recipient.	Character	15

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Field	Description	Data Type	Length
Last Name	Last Name of the Recipient.	Character	20
Previous Date of Death	The recipient's previous date of death prior to changing to zero.	Date (MM/DD/CCYY)	10
Recipient ID	Medicaid ID of the client that died.	Character	12
SSN	SSN of Recipient.	Number (Integer)	9
Total Number of Recips	Total Number of Recipients whose date of death was changed from a 'real' date to zero during the month.	Number (Integer)	7

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7.31 ELG-0135-M -- Lockin Eligibility Status Report

7.31.1 ELG-0135-M -- Lockin Eligibility Status Report Narrative

The Lockin Eligibility Status report is used to identify all recipients who have had a change of AMAES eligibility status during the month.

The purpose of the Eligibility Status Report is to provide EDS and the Alabama Medicaid Agency with information regarding changed AMAES status of lockin recipients once a month. This report is produced monthly.

7.31.2 ELG-0135-M -- Lockin Eligibility Status Report Layout

```
Report  : ELG-0135D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJM135                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPM135                LOCK-IN RECIPIENTS WHOSE ELIGIBILITY STATUS HAS CHANGED                 Page:    999,999
                                                 REPORT PERIOD: MM/CCYY


       RECIPIENT ID    ****** RECIPIENT NAME  ******  STATUS    ******   PHYSICIAN   ******          ******   PHARMACY   ******
        BASE ID      FIRST          M  LAST          CURR PREV  PROV #       PROVIDER  NAME          PROV #      PROVIDER  NAME
*****************************************************************************************************************************************

XXXXXXXXXXXX   XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX 9   9   XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX 9   9   XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN ***
```

7.31.3 ELG-0135-M -- Lockin Eligibility Status Report Field Descriptions

Field	Description	Length	Data Type
Pharmacy Prov #	Recipient's current pharmacy number. Up to two active pharmacy providers can be listed.	9	Character
Pharmacy Provider Name	Recipient's current pharmacy, that matches the pharmacy provider number entered.	25	Character
Physician Prov #	Current physician's provider number.	9	Character
Physician Provider Name	Physician's name that matches the physician listed.	25	Character
Recipient Name First	First name of the recipient.	15	Character

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Field	Description	Length	Data Type
Recipient ID/ Base ID	Recipient's original Base identification number.	12	Character
Recipient Name Last	Last name of the recipient.	20	Character
Recipient Name M	Middle initial of the recipient.	1	Character
Status Current	Current AMAES status of the recipient.	1	Number (Integer)
Status Previous	Previous AMAES status of the recipient, before the change.	1	Number (Integer)

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7.32 ELG-0151-M -- EDB Processing Report

7.32.1 ELG-0151-M -- EDB Processing Report Narrative

The EDB Processing report is a monthly report that lists the status of EDB processing that was completed.

7.32.2 ELG-0151-M -- EDB Processing Report Layout

```
 Report  : ELG-0151-M                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJM150                       MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: ELGPM151                              EDB PROCESSING REPORT                                             Page:    999,999
                                               REPORT PERIOD: MM/CCYY

                                                                                  ----- ADDS -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE   END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                               ----- BYPASSED -----
                                   ----------- PART A ------------  ----------- PART B ------------
                    RECIPIENT     PAYOR OPT BEG DATE  END DATE    PAYOR OPT BEG DATE    END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                                ----- DENIED -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE END DATE    PAYOR OPT BEG DATE    END DATE     HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                               ----- SHUTDOWN -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE  END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                                ----- UPDATES -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE   END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
```


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```
                                        ----- ERRORS -----
                              ----------- PART A ------------  ----------- PART B ------------
 RECIPIENT    PAYOR OPT BEG DATE    END DATE   PAYOR OPT BEG DATE   END DATE    HIC ID        COMMENT
999999999999  XXX    X  MM/DD/CCYY MM/DD/CCYY   XXX    X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999  XXX    X  MM/DD/CCYY MM/DD/CCYY   XXX    X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                          SUMMARY
                                TOTAL RECORDS PROCESSED:  999,999,999
                                TOTAL ADDS:                99,999,999
                                TOTAL BYPASSED:            99,999,999
                                TOTAL DENIED:              99,999,999
                                TOTAL SHUTDOWN:            99,999,999
                                TOTAL UPDATES:             99,999,999
                                TOTAL ERRORS:              99,999,999


                              ***   END OF REPORT   ***
                            ***   NO DATA THIS RUN   ***
```

7.32.3 ELG-0151-M -- EDB Processing Report Field Descriptions

Field	Description	Length	Data Type
Beg Date	Begin date for EDB.	10	Date (MM/DD/CCYY)
End Date	End date for EDB.	10	Date (MM/DD/CCYY)
HIC ID	HIC Number provided by CMS on the EDB file.	12	Number (Integer)
OPT	EDB Status Code.	1	Character
Payor	Premium Payor Code on the EDB File.	3	Character
Recipient	Recipient’s original Medicaid Base identification number.	12	Number (Integer)

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Field	Description	Length	Data Type
Total Adds	Total Number of EDB Records which caused Part A or B data to be added.	10	Number (Decimal)
Total Bypassed	Total Number of EDB Records with a status of Bypassed. (These are records for which there was no Part A or B data on the EDB file.)	10	Number (Integer)
Total Denied	Total Number of EDB records with a status of denied. (Note: We do not generate denials from the EDB file.)	10	Number (Integer)
Total Errors	Total Number of EDB records with a status of Error. (Note: Part A and B EDB updates do not generate errors.)	10	Number (Integer)
Total Records Processed	Total number of EDB Records Processed.	11	Number (Decimal)
Total Shutdown	Number of EDB Records with an incoming EDB Status of Shutdown. (Note: Alabama does not calculate shutdowns. These would be reflected as updates.)	10	Number (Integer)
Total Updates	Total Number of EDB Records which caused an update to Part A or B information.	10	Number (Integer)

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7.33 ELG-0612-M – CMS Eligibility Error Report

7.33.1 ELG-0612-M – CMS Eligibility Error Report Narrative

The CMS Eligibility Error Report lists the Recipients returned on the CMS Eligibility Response File with reportable BO Errors. Reportable errors are listed on the tables, T_REF_CDE_VALUE_TYPE and T_REF_CDE_VALUE_GROUP. The purpose of this report is to assist in research of crossover claims errors. This report is produced monthly after the CMS Eligibility Response File has been received from CMS.

7.33.2 ELG-0612-M – CMS Eligibility Error Report Layout

```
Report  : ELG-0612-M                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJM612                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: ELG_CMS_ERF                       CMS ELIGIBILITY ERROR REPORT                                           Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------------
 BENEFICIARY   BENEFICIARY   BENEFICIARY                BENEFICIARY   SUPP ELIG   SUPP ELIG   BO1   BO2   BO3   BO4   FILE UPDATE
 HIC #         MEDICAID ID   SURNAME                    FIRST         FROM DATE   TO DATE                           INDICATOR
-------------------------------------------------------------------------------------------------------------------------------------

                                                   Date Processed:  MM/DD/CCYY

 Reportable Errors and Descriptions:
      XXXX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X
 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X
 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X

 Total Rows Reported:                999999999
 Total Unique Recipients Reported:   999999999
 Totals Per Error Reported:
      XXXX  -  999999999


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

7.33.3 ELG-0612-M – CMS Eligibility Error Report Field Descriptions

Field	Description	Length	Data Type
Beneficiary HIC #	Recipient Medicare ID Number	12	Character
Beneficiary Medicaid ID	Recipient Medicaid ID Number	12	Character

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Field	Description	Length	Data Type
Beneficiary Surname	Recipient Last Name	24	Character
Beneficiary First	Recipient First Name	12	Character
Supp Elig From Date	Medicare Supplemental From Date	8	Character
Supp Elig To Date	Medicare Supplemental To Date	8	Character
BO1	BO Error 1	4	Character
BO2	BO Error 2	4	Character
BO3	BO Error 3	4	Character
BO4	BO Error 4	4	Character
File Update Indicator	Type of Update Values: A – Add, C – Change/Update, D - Delete	1	Character

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7.34 ELG-1095-M -- IRS 1095-B Form Report

7.34.1 ELG-1095-M -- IRS 1095-B Form Report Narrative

A viewable version of the 1095-B form will be stored in Feith, indexed by Recipient ID, Tax Year, and Run Date, for recipients covered by Medicaid. This will assist the RCC on any inquiries they may receive. *Note: Part II of the form will be empty because the 1095 forms created for these recipients are not employed by Medicaid.

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7.34.2 ELG-1095-M -- IRS 1095-B Form Report Layout

560115

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ **Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b*.**

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2015

Part I **Responsible Individual**

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ▶ ☐		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II **Employer Sponsored Coverage** (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III **Issuer or Other Coverage Provider** (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV **Covered Individuals** (Enter the information for each covered individual(s).)

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B** (2015)

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7.34.3 ELG-1095-M -- IRS 1095-B Form Report Field Descriptions

Field	Description	Length	Data Type
Box 1: Name Of Responsible Individual	Name of the responsible individual for whom the form is created for.	50	Character
Box 16: Name	Name of the issuer or other coverage provider.	23	Character
Box 17: Employer Identification Number	IRS assigned identification number.	9	Number (Integer)
Box 18: Contact Telephone Number	Telephone number of the coverage provider.	14	Character
Box 19: Street Address	Address of the coverage provider.	13	Character
Box 2: Social Security Number	Social Security Number of the responsible individual for whom the form is created for. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box 20: City or Town	City of the coverage provider.	10	Character
Box 21: State or Province	State of the coverage provider.	2	Character
Box 22: Country and Zip or Foreign Postal Code	Zip code of the coverage provider.	10	Character
Box 3: Date of Birth	Date of birth of the responsible individual for whom the form is created for.	10	Date (MM/DD/CCYY)
Box 4: Street Address	Address of the responsible individual for whom the form is created for.	30	Character
Box 5: City or Town	City of the responsible individual for whom the form is created for.	30	Character

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Field	Description	Length	Data Type
Box 6: State or Province	State of the responsible individual for whom the form is created for.	2	Character
Box 7: Country and Zip or Foreign Postal Code	Zip code of the responsible individual for whom the form is created for.	10	Character
Box 8: Origin Of The Policy	This is the code for the type of coverage in which the individual or other covered individuals were enrolled. Valid values are: A. Small Business Health Options Program (SHOP) B. Employer-sponsored coverage C. Government-sponsored program D. Individual market insurance E. Multiemployer plan F. Other designated minimum essential coverage	1	Character
Box A (PART IV): Name Of Covered Individual(s)	Name of the covered individual.	24	Character
Box B (PART IV): SSN	Social Security Number of the covered individual. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box C (PART IV): DOB	Date of birth of the covered individual.	10	Date (MM/DD/CCYY)
Box D (PART IV): Covered All 12 Months	Indicator if the individual was covered for at least one day in every month of the year.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Apr)	Indicator if the individual was covered for at least one day in the month of April.	1	Character
BOX E: Months of coverage (PART IV - Aug)	Indicator if the individual was covered for at least one day in the month of August.	1	Character
BOX E: Months of coverage (PART IV - Dec)	Indicator if the individual was covered for at least one day in the month of December.	1	Character
BOX E: Months of coverage (PART IV - Feb)	Indicator if the individual was covered for at least one day in the month of February.	1	Character
BOX E: Months of coverage (PART IV - Jan)	Indicator if the individual was covered for at least one day in the month of January.	1	Character
BOX E: Months of coverage (PART IV - Jul)	Indicator if the individual was covered for at least one day in the month of July.	1	Character
BOX E: Months of coverage (PART IV - Jun)	Indicator if the individual was covered for at least one day in the month of June.	1	Character
BOX E: Months of coverage (PART IV - Mar)	Indicator if the individual was covered for at least one day in the month of March.	1	Character
BOX E: Months of coverage (PART IV - May)	Indicator if the individual was covered for at least one day in the month of May.	1	Character
BOX E: Months of coverage (PART IV - Nov)	Indicator if the individual was covered for at least one day in the month of November.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Oct)	Indicator if the individual was covered for at least one day in the month of October.	1	Character
BOX E: Months of coverage (PART IV - Sep)	Indicator if the individual was covered for at least one day in the month of September.	1	Character

7.35 ELG-1095-M-16-- IRS 1095-B Form Report

7.35.1 ELG-1095-M-16-- IRS 1095-B Form Report Narrative

A viewable version of the 2016 1095-B form will be stored in Feith, indexed by Recipient ID, Tax Year, and Run Date, for recipients covered by Medicaid. This will assist the RCC on any inquiries they may receive. *Note: Part II of the form will be empty because the 1095 forms created for these recipients are not employed by Medicaid.

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7.35.2 ELG-1095-M-16-- IRS 1095-B Form Report Layout

560116

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

☒ Do not attach to your tax return. Keep for your records
☒ Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

20 16

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN or other TIN)	3 Date of birth (If SSN or other TIN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ☒ ☐		9 Reserved	

Part II Information about Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form 1095-B (2016)

7.35.3

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7.35.3 ELG-1095-M-16-- IRS 1095-B Form Report Field Descriptions

Field	Description	Length	Data Type
Box 1: Name Of Responsible Individual	Name of the responsible individual for whom the form is created for.	50	Character
Box 16: Name	Name of the issuer or other coverage provider.	23	Character
Box 17: Employer Identification Number	IRS assigned identification number.	9	Number (Integer)
Box 18: Contact Telephone Number	Telephone number of the coverage provider.	14	Character
Box 19: Street Address	Address of the coverage provider.	13	Character
Box 2: Social Security Number	Social Security Number of the responsible individual for whom the form is created for. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box 20: City or Town	City of the coverage provider.	10	Character
Box 21: State or Province	State of the coverage provider.	2	Character
Box 22: Country and Zip or Foreign Postal Code	Zip code of the coverage provider.	10	Character
Box 3: Date of Birth	Date of birth of the responsible individual for whom the form is created for.	10	Date (MM/DD/CCYY)
Box 4: Street Address	Address of the responsible individual for whom the form is created for.	30	Character
Box 5: City or Town	City of the responsible individual for whom the form is created for.	18	Character
Box 6: State or Province	State of the responsible individual for whom the form is created for.	2	Character
Box 7: Country and Zip or Foreign Postal Code	Zip code of the responsible individual for whom the form is created for.	10	Character
Box 8: Origin Of The Health Coverage	This is the code for the type of coverage in which the individual or other covered individuals were enrolled. Valid values are:	1	Character

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Field	Description	Length	Data Type
	A. Small Business Health Options Program (SHOP) B. Employer-sponsored coverage C. Government-sponsored program D. Individual market insurance E. Multiemployer plan F. Other designated minimum essential coverage		
Box A (PART IV): Name Of Covered Individual(s)	Name of the covered individual.	23	Character
Box B (PART IV): SSN	Social Security Number of the covered individual. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box C (PART IV): DOB	Date of birth of the covered individual.	10	Date (MM/DD/CCYY)
Box D (PART IV): Covered All 12 Months	Indicator if the individual was covered for at least one day in every month of the year.	1	Character
BOX E: Months of coverage (PART IV - Apr)	Indicator if the individual was covered for at least one day in the month of April.	1	Character
BOX E: Months of coverage (PART IV - Aug)	Indicator if the individual was covered for at least one day in the month of August.	1	Character
BOX E: Months of coverage (PART IV - Dec)	Indicator if the individual was covered for at least one day in the month of December.	1	Character
BOX E: Months of coverage (PART IV - Feb)	Indicator if the individual was covered for at least one day in the month of February.	1	Character
BOX E: Months of coverage (PART IV - Jan)	Indicator if the individual was covered for at least one day in the month of January.	1	Character
BOX E: Months of coverage (PART IV - Jul)	Indicator if the individual was covered for at least one day in the month of July.	1	Character
BOX E: Months of coverage (PART IV - Jun)	Indicator if the individual was covered for at least one day in the month of June.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Mar)	Indicator if the individual was covered for at least one day in the month of March.	1	Character
BOX E: Months of coverage (PART IV - May)	Indicator if the individual was covered for at least one day in the month of May.	1	Character
BOX E: Months of coverage (PART IV - Nov)	Indicator if the individual was covered for at least one day in the month of November.	1	Character
BOX E: Months of coverage (PART IV - Oct)	Indicator if the individual was covered for at least one day in the month of October.	1	Character
BOX E: Months of coverage (PART IV - Sep)	Indicator if the individual was covered for at least one day in the month of September.	1	Character

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7.36 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report

7.36.1 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Narrative

Users access LTC and Waiver Monthly Activity Report (LTC-0007-M) to identify recipients who have had any admission notification other than a discharge accepted and written to the LOC database. The frequency for this report is monthly.

This report's program will purge records from the T_RE_LTC_REQUEST table that were added prior to the begin run date of the monthly report. For example, if the reporting date is from 12/01/2008 to 12/31/2008, all records that were added prior to 12/01/2008 will be purged from the table prior to the generation of the December 2008 report.
Report is sorted in such a manner where provider belonging to the same specialty are grouped together and they are are further sorted grouping provider belonging to the same entity displaying NPI id's first followed by the MCD id of the same NPI. Waivers are sorted first.

7.36.2 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Layout

```
REPORT  : LTC-0007-M                    ALABAMA MEDICAID AGENCY                    RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM007               MEDICAID MANAGEMENT INFORMATION SYSTEMS           RUN TIME   :   HH:MM:SS
LOCATION: LTCPM007               LTC AND WAIVER MONTHLY ACTIVITY REPORT            PAGE       :      99999


PROVIDER SUBMITTING APPLICATION:        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER NUMBER OF SUBMITTING PROVIDER: XXXXXXXXX
START DATE:  MM/DD/CCYY                 END DATE:  MM/DD/CCYY                              XXXXXXXXXXXXXXXXXXXXXX
RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXXXXXXX,XXXXXXXXXXXXXXXXXXXX
RECIPIENT NUMBER:  XXXXXXXXXXXX                                SSN:  XXX-XX-XXXX   MCARE:  XXX



                                  **  END OF REPORT  **
                          * * N O   D A T A   T H I S   R E P O R T * *
```

7.36.3 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Field Descriptions

Field	Description	Length	Data Type
ADMISSION TYPE	Admission type - Note the field name is not displayed on the report since the information is self-evident.	Character	22
END DATE	End date of services added to the LTC or Waiver file.	Date (MM/DD/CCYY)	8

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Field	Description	Length	Data Type
MCARE	Indicates if recipient had any Medicare A or B coverage at time of admission.	Character	3
PROVIDER NUMBER OF SUBMITTING PROVIDER	Medicaid provider number.	Character	10
PROVIDER SUBMITTING APPLICATION	Provider name submitted on application	Character	50
RECIPIENT NAME	Last and first name of Medicaid recipient.	Character	50
RECIPIENT NUMBER	Recipient’s Medicaid number.	Character	12
SSN	Recipient's Social Security number.	Character	9
START DATE	Start date of services added to the LTC or Waiver file.	Date (MM/DD/CCYY)	8

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7.37 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT

7.37.1 LTC-0008-M – LTC AND TRADING PARTNER ERROR ACTIVITY REPORT Narrative

This program creates the LTC Daily Submitter Error Activity Report.

7.37.2 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT Layout

```
REPORT  : LTC-0008-M                    ALABAMA MEDICAID AGENCY                  RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM008               MEDICAID MANAGEMENT INFORMATION SYSTEMS         RUN TIME   :   HH:MM:SS
LOCATION: LTCPM008               LTC TRADING PARTNER ERROR ACTIVITY REPORT       PAGE       :      99999
                                            DATE: MM/DD/CCYY


TRADING PARTNER IDENTIFICATION:          XXXXXXXXX
PROVIDER SUBMITTING APPLICATION:        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER NUMBER OF SUBMITTING PROVIDER: XXXXXXXXXX
RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXXXXXXX,XXXXXXXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXX
RECIPIENT NUMBER:  XXXXXXXXXXXX                              SSN:  XXX-XX-XXXX


                          **  END OF REPORT  **
                  * * N O   D A T A   T H I S   R E P O R T * *
```

7.37.3 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT Field Descriptions

Field	Description	Length	Data Type
LTC ADMISSION TYPE DESCRIPTION	The description for the type of LTC ADMISSION.	Character	22
PROVIDER SUBMITTING APPLICATION	Provider name submitted on application.	Character	50
PROVIDER NUMBER OF SUBMITTING PROVIDER	PROVIDER NUMBER OF SUBMITTING PROVIDER - Medicaid provider number.	Character	15
SSN	Recipient's Social Security number.	Character	9
RECIPIENT NAME	Last and first name of Medicaid recipient.	Character	50
RECIPIENT NUMBER	Recipient’s Medicaid number.	Character	12

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Field	Description	Length	Data Type
TRADING PARTNER IDENTIFICATION	Trading partner id that is entered into the LTC admission notification via LTC software.	Character	9

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7.38 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY REPORT

7.38.1 LTC-0011-M – LTC AN PACE PROGRAM MONTHLY DISCHARGE ACTIVITY REPORT Narrative

This report will generate report of all recipients discharge from PACE program and moved to Nursing home

7.38.2 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY Report Layout

```
REPORT  : LTC-0011-M                    ALABAMA MEDICAID AGENCY                    RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM011               MEDICAID MANAGEMENT INFORMATION SYSTEMS          RUN TIME   :   HH:MM:SS
LOCATION: LTCPM011             LTC PACE PROGRAM DISCHARGE ACTIVITY REPORT            PAGE    :      99999


RECIPIENT NAME:         @<<<<<<<<<<<<<<<<<<<   , @<<<<<<<<<<<<<<
RECIPIENT NUMBER:       @<<<<<<<<<<<<<<                 SSN:  @<<-@<-@<<<
DISCHARGE DATE FROM PACE PROGRAM:  @<<<<<<<<<
PROVIDER DISCHARGING RECIPIENT @<<<<<<<<<<<<<<<<<<
```

7.38.3 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY Report Field Descriptions

Field	Description	Length	Data Type
DISCHARGE DATE FROM PACE PROGRAM	Discharge date from PACE program.	Character	10
LEVEL OF CARE SEGMENT OF RECIPIENT IN NURSING HOME START DATE END DATE	LEVEL OF CARE SEGMENT OF RECIPIENT IN NURSING HOME.	Character	20
NURSING HOME PROVIDER	NURSING HOME PROVIDER.	Character	50
NURSING HOME PROVIDER NUMBER	NURSING HOME PROVIDER NUMBER.	Character	15
PROVIDER DISCHARGING RECIPIENT	Provider name: Provider who discharge recipient from PACE program.	Character	50
PROVIDER NUMBER	Provider ID of provider who discharge recipient from PACE program.	Character	15
RECIPIENT NAME	Name of the recipient.	Character	40
RECIPIENT NUMBER	Recipient number.	Character	16
SSN	Social security number.	Character	11

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7.39 LTC-0012-W – LTC Weekly Discharge Explanation Report

7.39.1 LTC-0012-W – LTC Weekly Discharge Explanation Report Narrative

LTC Weekly Discharge Explanation Report (LTC-0012-W) - This is a weekly report to be used by the District Office to monitor recipients exiting level of care program.

This report only provides the weekly discharge activity for District Office (DO) certified recipients. It provides which DO they are associated and the reason code for the discharge. H for Recipient Discharged Home, D for Recipient Dead and T for recipient Terminated from the program. Need report narrative

7.39.2 LTC-0012-W – LTC Weekly Discharge Explanation Report Layout

```
Report  : LTC-0012-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : LTCJW012                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: LTCPW012                    LTC WEEKLY DISCHARGE EXPLANATION REPORT                              Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------
 RECIPIENT        DO #     REVIEWER #     DISCHARGE
 ID                                       EXPLANATION
-------------------------------------------------------------------------------------------------------------------------------

 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

7.39.3 LTC-0012-W – LTC Weekly Discharge Explanation Report Field Description

Field	Description	Data Type	Length
DO #	District Office #	Character	2
Discharge Explanation Code	Discharge explanation code	Character	1
Discharge Explanation Code Description	Discharge explanation code description	Character	50

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Field	Description	Data Type	Length
Recipient ID	Recipient's Medicaid ID	Character	12
Reviewer #	Reviewer ID number	Character	2

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AMMIS Recipient User Manual

Date Modified: 05/01/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technologies
301 Technacenter Drive
Montgomery, Alabama 36117

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1. Document Control

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1.1 Document Information Page

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10/27/2016	9.0		Application of CO 13778 and 13399	CO 13778 Section 4.4 Changing Passwords
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08/23/2017	13.0		Application of CO 14326	**CO 14326** Update 6.31 – EDB Entitlement Information panel layout and field descriptions
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12/20/2017	15.0		Application of CO 14498	6.6 Recipient Maintenance panel updates- UPDATE panel layout to reflect removal of RCO Assignment History
05/01/2018	16.0		General Updates	

1.3 Related documentation

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2. Recipient Introduction

2.1 Recipient User Manual Overview

The AMMIS has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Recipient functional area.

This manual covers the following:

- Recipient Overview
- Recipient System Navigation
- System Wide Common Terminology and Layouts
- Recipient Pages/Panels
- Recipient Reports

2.2 Recipient User Manual Objective

The objective of the AMMIS Recipient User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

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3. Recipient Overview

3.1 Introduction to Recipient

The primary purpose of the Recipient Data Maintenance function is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance, and to support analysis of the data contained within the recipient data maintenance system. The maintenance of recipient data is required to support claim processing in batch and online mode, reporting functions, and eligibility verification. Additional recipient related data is also maintained in other functional areas such as Third Party Liability (TPL), Long Term Care (LTC), and Managed Care.

The main source of eligibility data for the AMMIS is a daily file extract from the Alabama Medicaid Agency's Alabama Medicaid Application and Eligibility System (AMAES). This daily data is processed through the Recipient PS/2 function which maintains eligibility data for all medical assistance programs.

Another important function of the Recipient Data Maintenance is providing recipient information to other external systems, such as Health Information Designs (HID) and Centers for Medicare and Medicaid Services (CMS).

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4. Recipient System Navigation

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within the AMMIS.

4.2 System Security

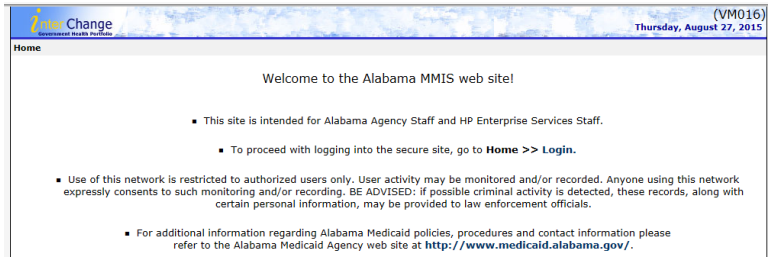
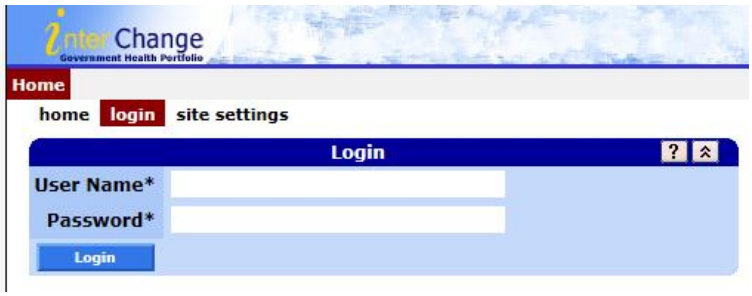
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS website in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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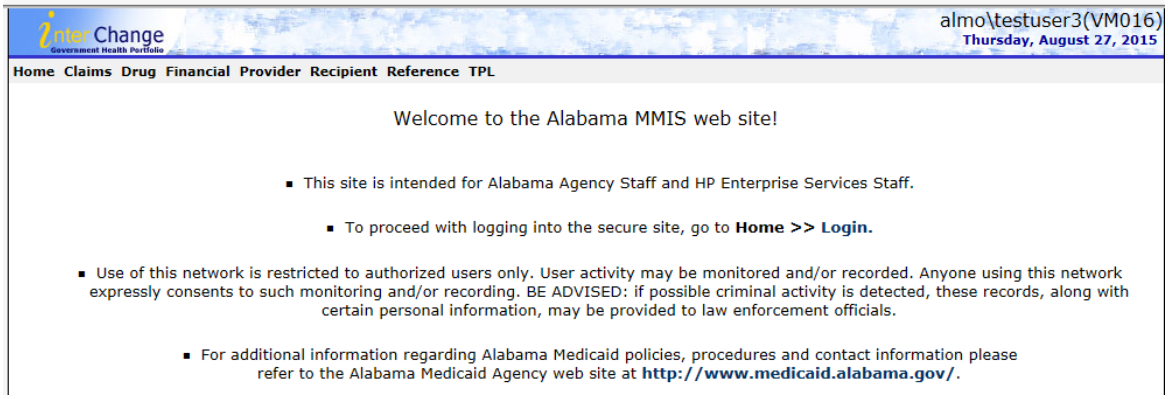
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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4.4 Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. DXC employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact the Assistant MMIS Coordinator.

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4.5 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into **AMMIS**.	Home page displays.
2	Select **View**.	View menu displays.
3	Point to **Text Size** and click **Smaller**.	Default text size is set to medium. After the user selects smaller, the system objects will appear smaller.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or more importantly, documenting, aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

5.1 Page Layout

A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu, and any associated panels.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

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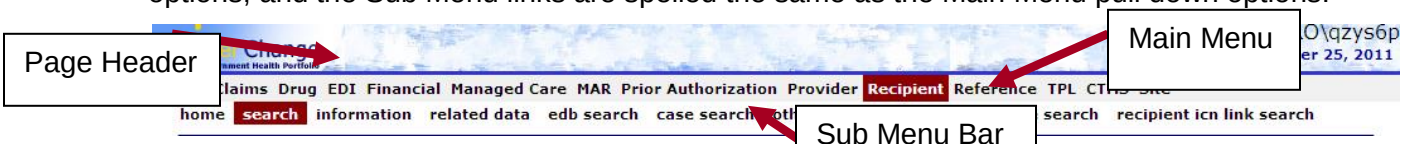
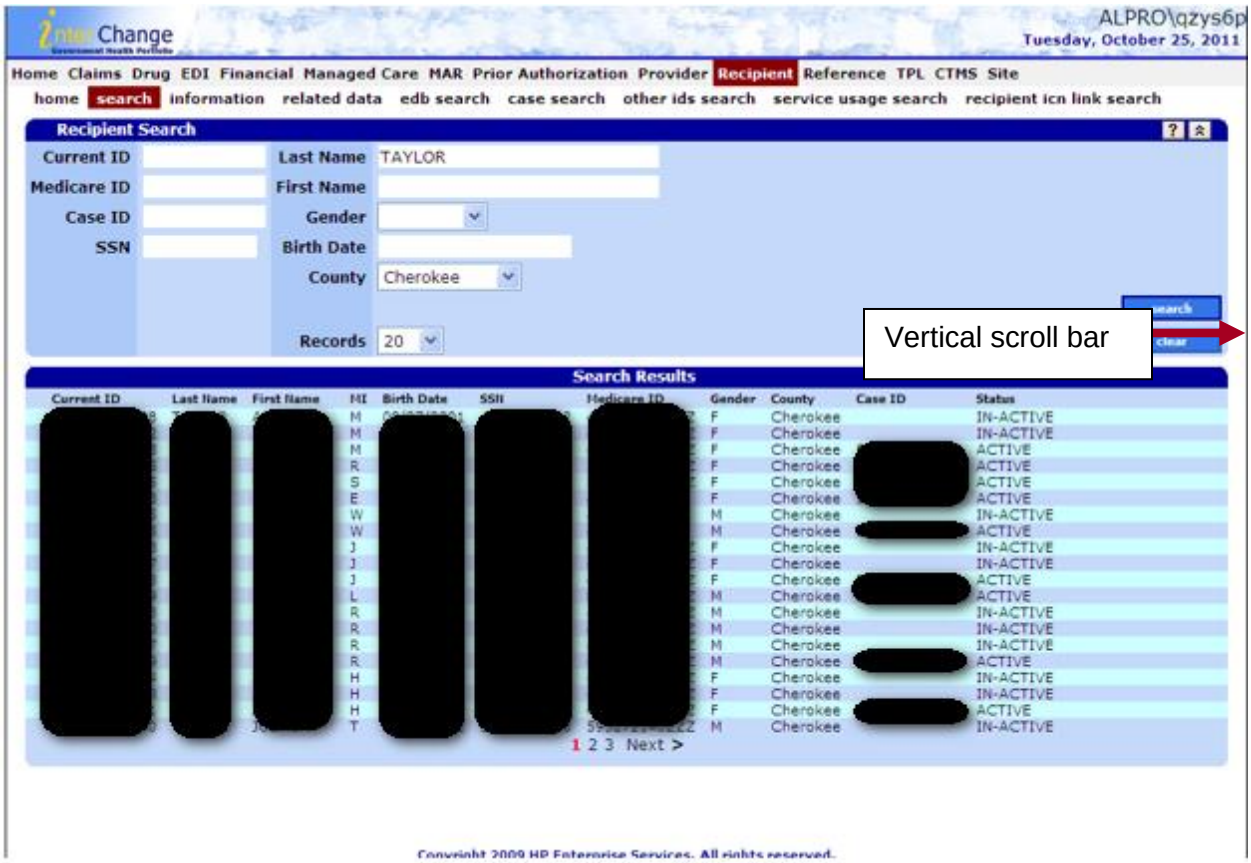
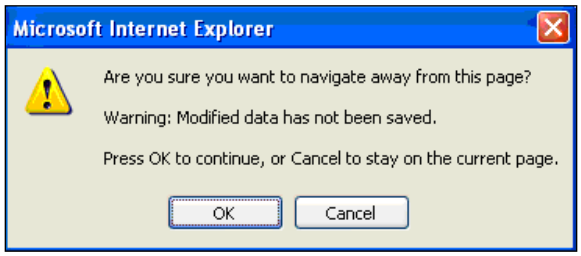
Beneath the Main Menu bar is the Sub Menu of horizontal links that open an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical sc the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page, then prior to navigating away from the page, the system prompts the user with a pop-up window message. When the system generates the message, the detail panels are locked open, and navigation away from the page is not permitted until changes are either correctly saved or cancelled.



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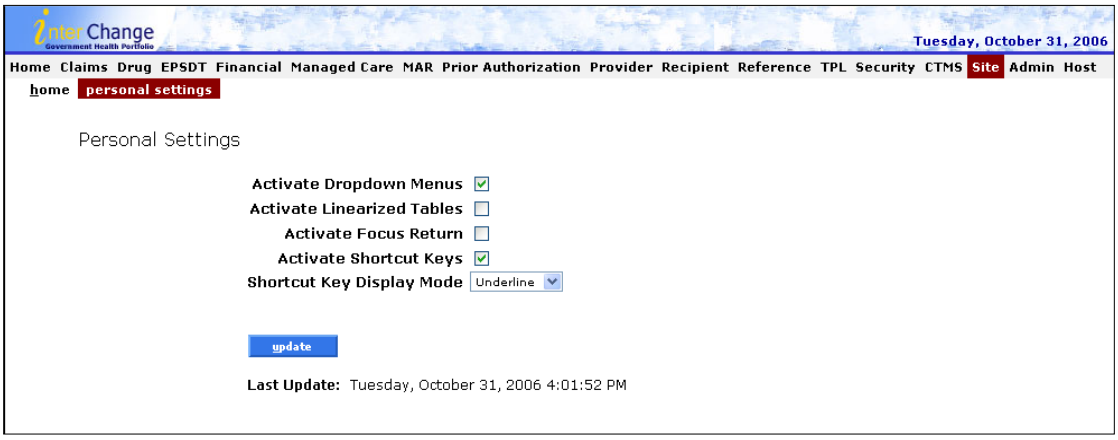
5.1.1 Shortcut Keys

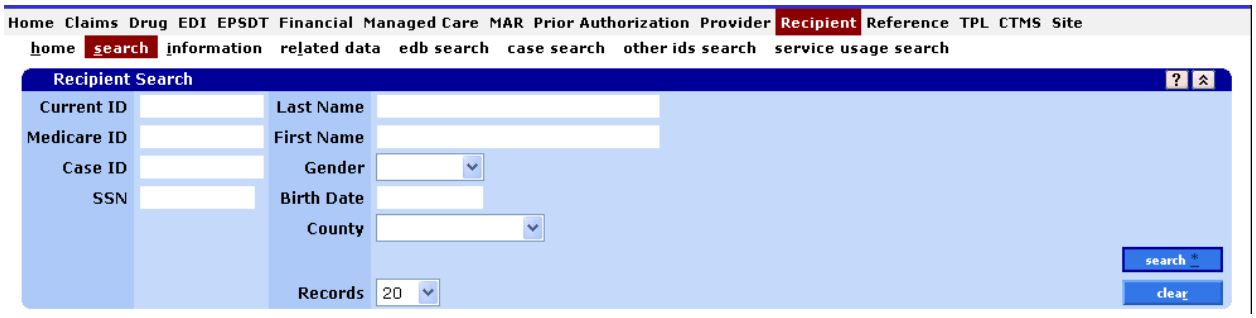
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + letter) to quickly open the associated page.

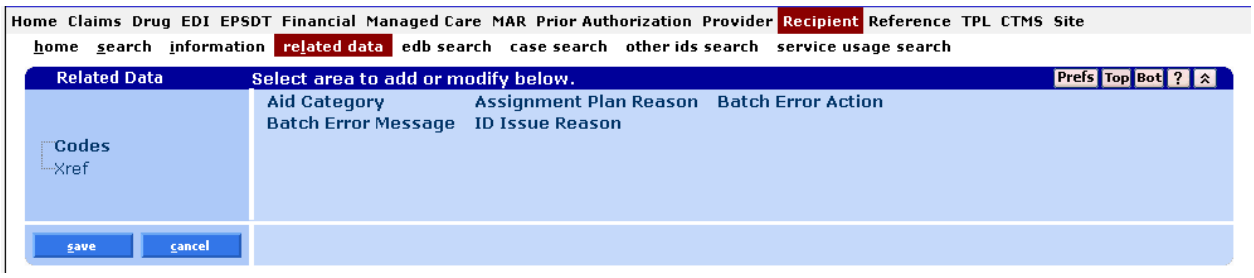
To active the shortcut key, click on the Site link, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar above and below it is the shortcut key letter.

Within the Recipient Sub Menu, the user can use the shortcut keys to quickly navigate from the Recipient Search panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter “L” is found within the horizontal bars on the Sub Menu Related Data link.





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5.2 Search Options

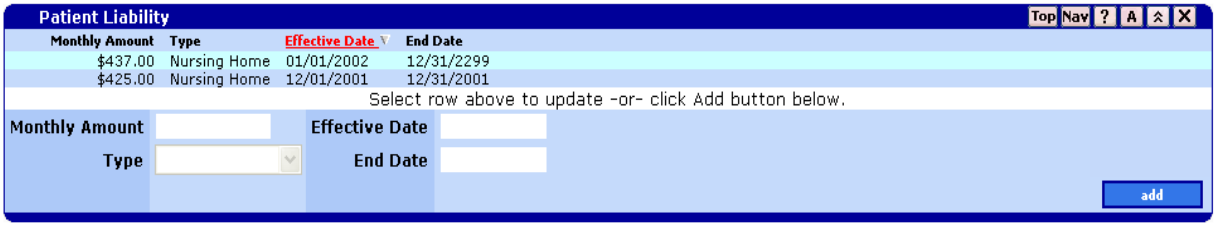
There are several search options available within the AMMIS.

5.2.1 Search Panels

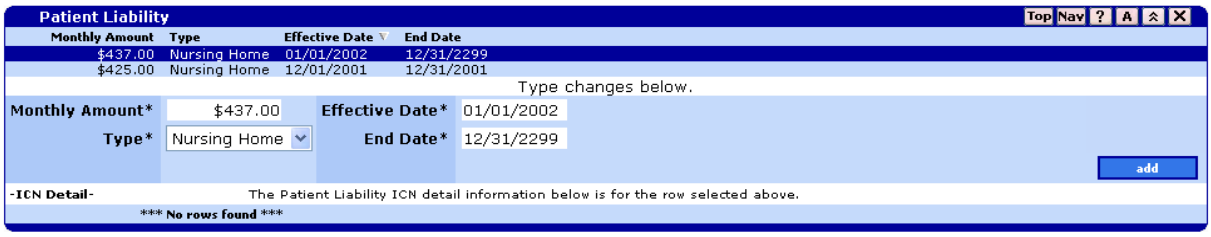
The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Recipient subsystem contain a search panel without an advanced search button included on the panel.

5.2.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicks the first row of the Recipient Patient Liability panel and detailed information displays at the bottom of the panel.



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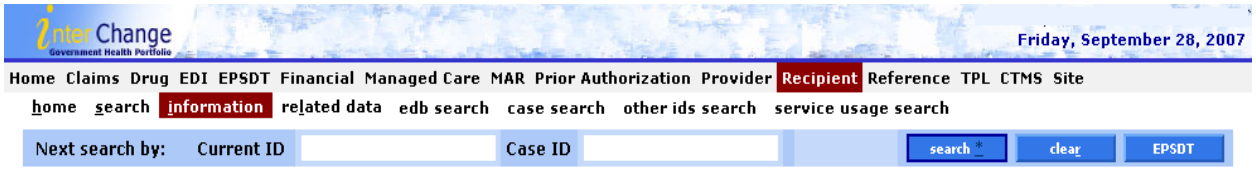
5.2.3 Mini Search

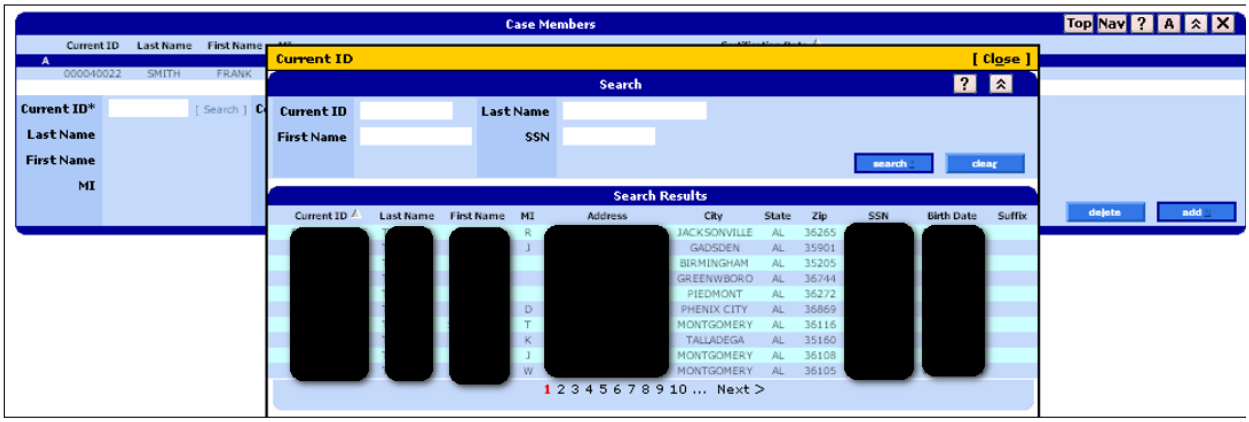
After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result.

Mini Search panels contain one or two primary search fields related to the business process.



5.2.4 Pop-Up Search

A Pop-Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user can access the search panel associated with that particular field.



5.3 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.3.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.

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Name	Icon	Description
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
Maintain Button	maintain	Maintains a selected data record.
Preferences Button	Prefs	Displays a checkmark box next to each Navigator Item link. By checking the box, the link automatically opens whenever the user browses the page. To hide the boxes, click on the button a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

Among the panel types are the following:

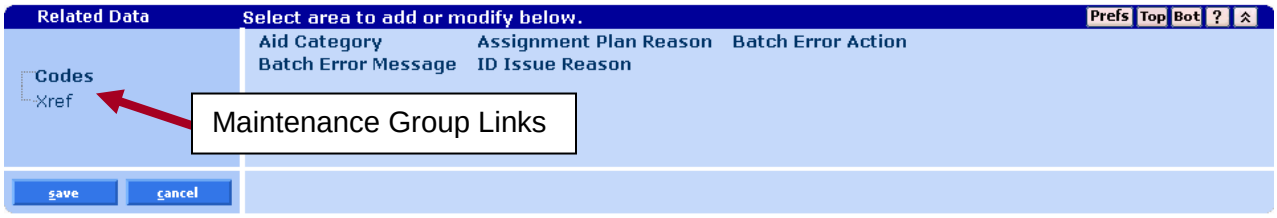
- Maintenance panel
- Task List panel
- Maintenance Item panel
- Audit panel

5.3.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page.

The following image demonstrates Maintenance Group Links (Codes and Xref) and the associated Maintenance Item links.



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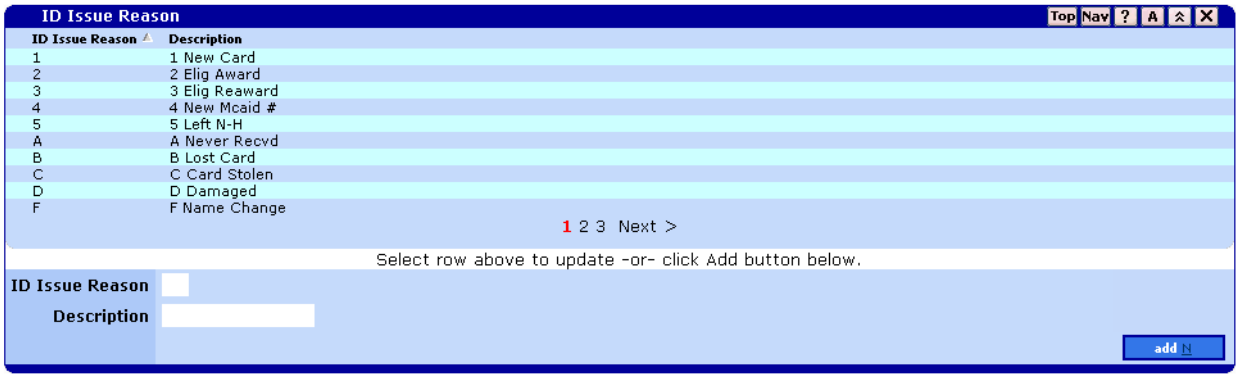
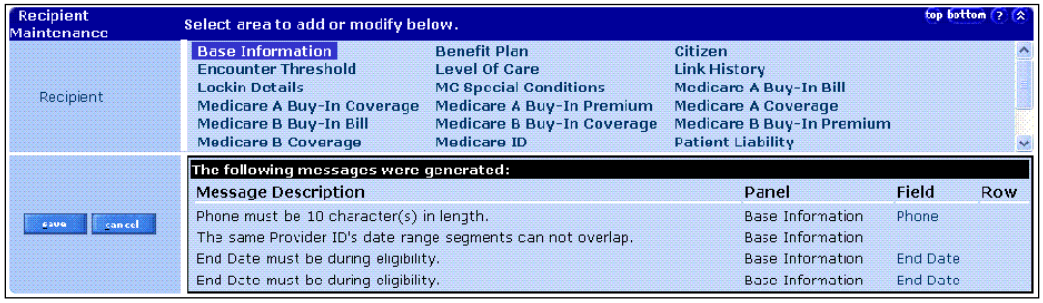
By clicking on a Maintenance Item Link (such as ID Issue Reason), the associated panel opens.

Results: ID Issue Reason Panel displays



5.3.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.



The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

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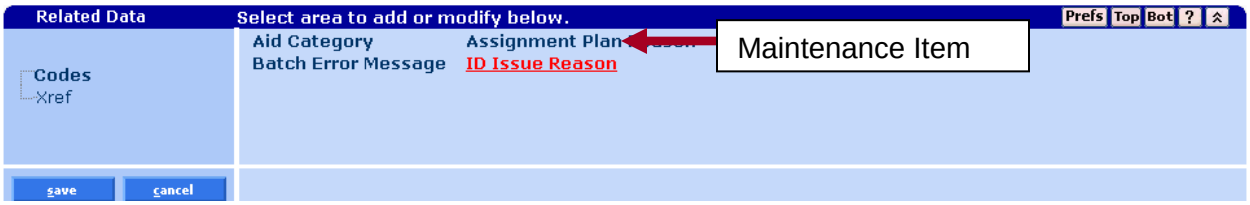
5.3.4 Maintenance Item Panel

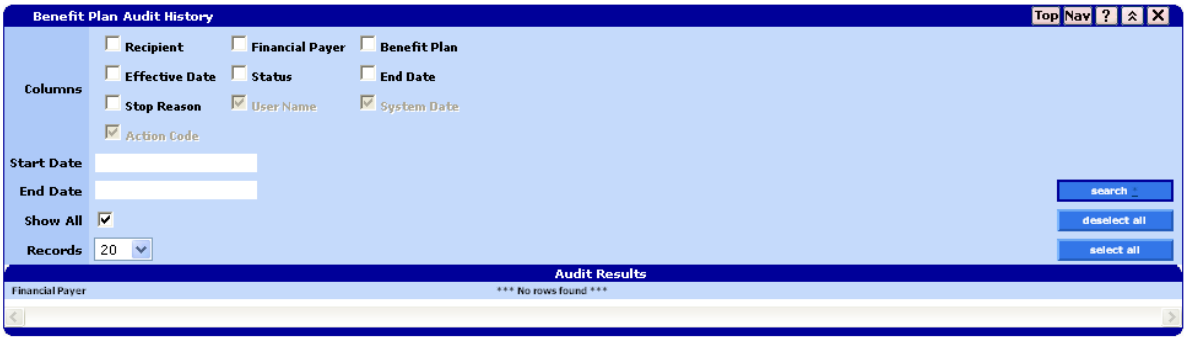
A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.3.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updateable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



5.4 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.4.1 Question Mark Icon

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

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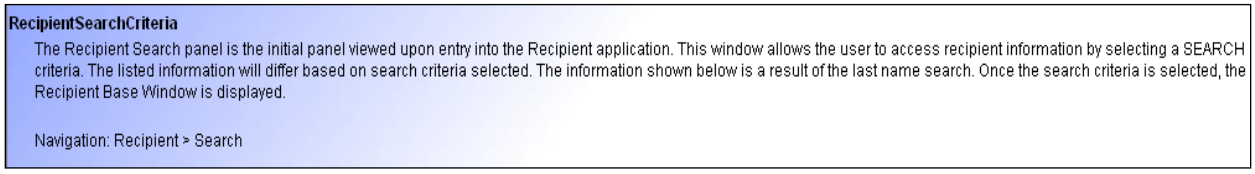
5.4.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



The second item displayed is the **Panel Layout**:

The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
Search	Click button to initiate a search	Button	N/A	0
Sounds-like	Sounds-like search indicator	Check Box	Check Box	0
County	Search by recipient's County	Combo Box	Character	18
Gender	Search by recipient's Gender	Combo Box	Character	10
Records Returned	Number of search items displayed on each page	Combo Box	Integer	2
Birth Date	Search by recipient's Birth Date	Field	Date (MM/DD/CCYY)	10
Case ID	Search by recipient's Case number	Field	Character	10
Current ID	Search by recipient's Medicaid number	Field	Integer	12
First Name	Search by recipient's First Name	Field	Character	13
Last Name	Search by recipient's Last Name	Field	Character	15
Medicare ID	Search by recipient's Medicare number	Field	Integer	12
SSN	Search by recipient's Social Security Number	Field	Integer	9

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	9000	At least one search field should be entered for search criteria	An entry is required to search for a recipient. Type in the Current ID or enter additional search criteria.
Sounds-like	Check Box	9000	At least one search field should be entered for search criteria	Enter additional search criteria
Birth Date	Field	5501	Invalid date. Format is mm/dd/yyyy.	Verify entry. Date must be in MM/DD/CCYY or MMDDCCYY format. Try again.
Current ID	Field	5010	Current ID must be numeric.	Enter a numeric ID.
Medicare ID	Field	5010	Medicare ID must be numeric.	Verify entry. The Medicare identification must contain only numerics
SSN	Field	5500	Enter a valid value	Verify entry. Social security number must be 9 characters numeric; you may input dashes (i.e., 999-99-9999).

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

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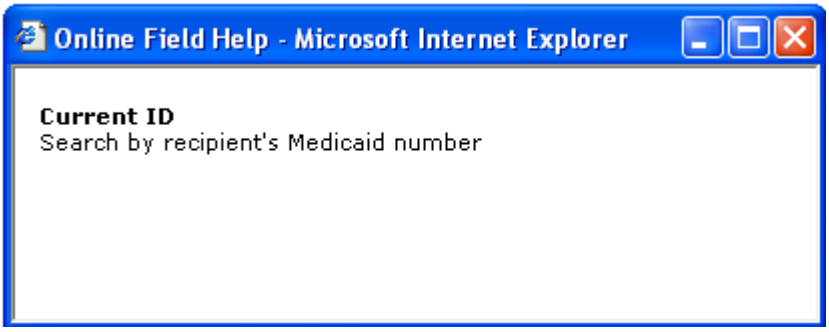
5.4.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up panel that contains information on the field selected.

5.4.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **Current ID**, a question mark appears as part of the cursor .

Click once on the text area of the field and a pop-up window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6. Recipient Pages/Panels

This section gives a brief description of each window, shows a sample, and describes all associated window fields and field edits.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each window covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 Recipient Search Panel Overview

6.1.1 Recipient Search Panel Narrative

The Recipient Search panel is the initial panel viewed upon entry into the Recipient application. This panel allows the user to access recipient information by selecting Search By criteria. The listed information differs based on search criteria selected. This panel is inquiry only.

Navigation Path: [Recipient] - [Recipient Search]

6.1.2 Recipient Search Panel Layout

6.1.3 Recipient Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date	Search by recipient's Birth Date.	Field	Date (MM/DD/CCYY)	8
Case ID	Search by recipient's Case ID.	Field	Character	12
Clear	Allows the user to clear any changes on the Recipient Search panel.	Button	N/A	0
County	Search by recipient's County.	Combo Box	Drop Down List Box	0
Current ID	Search by recipient's Medicaid identification number.	Field	Character	12
First Name	Search by recipient's First Name.	Field	Character	13
Gender	Search by recipient's Gender.	Combo Box	Drop Down List Box	0
Last Name	Search by recipient's Last Name.	Field	Character	15
Medicare ID	Search by recipient's Medicare identification number.	Field	Character	12
Records	Number of search items displayed on each page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Search	Initiates the Search by Current ID, Medicare ID, Case ID, SSN or Last Name. First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.	Button	N/A	0
SSN	Search by recipient's Social Security Number.	Field	Number (Integer)	9

6.1.4 Recipient Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	9000	At least one search field should be entered for search criteria.	An entry is required to search for a recipient. Type in the Current ID or enter additional search criteria.
County	Combo Box	5505	Please enter at least the Last Name.	Enter Last Name. When searching by County only, the panel requires the Last Name as well.
Gender	Combo Box	5504	Please enter at least the Last Name.	Enter Last Name. When searching by Gender only, the panel requires the Last Name as well.
Birth Date	Field	5501	Please enter at least the Last Name.	Enter Last Name. When searching by Birth Date only, the panel requires the Last Name as well.
Current ID	Field	5010	Current ID must be numeric.	Enter a numeric ID.
First Name	Field	5506	Last Name is required when searching by First Name.	Enter Last Name. When searching by First Name only, the panel requires the Last Name as well.
Last Name	Field	5507	First Name must be 2 characters or longer if Last Name is shorter than 5 characters.	Enter additional information. When searching by Last Name only and the Last Name is shorter than 5 characters, First Name should at least be two characters long.
Medicare ID	Field	5502	Medicare ID must be Alpha Numeric.	Verify entry. Medicare ID should not contain strange symbols. Only characters A-Z and digits 0-9 are allowed in this field.
	Field	5503	Medicare ID must be at least 10 characters long.	Verify entry. Medicare ID should be at least 10 characters long.
SSN	Field	5500	Enter a valid value.	Verify entry. Social security number must be 9 characters numeric; you may input dashes (i.e., 999-99-9999).

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6.1.5 Recipient Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Recipient Search Panel Accessibility

6.1.6.1 To Access the Recipient Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Search**.	Recipient Search panel displays.

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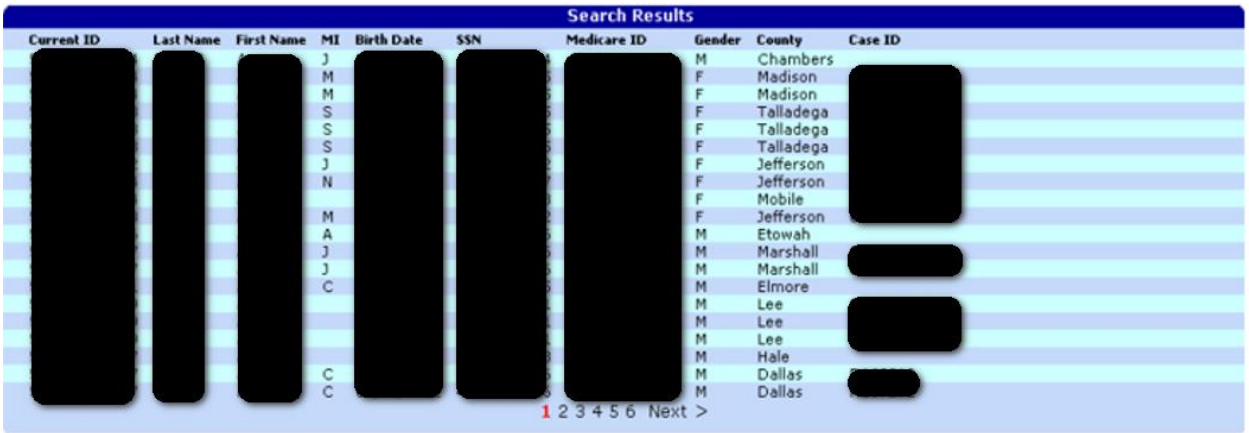
6.2 Recipient Search Results Panel Overview

6.2.1 Recipient Search Results Panel Narrative

The Recipient Search Results panel displays the outcome of the criteria entered on the Recipient Search panel 'if' there is more than one record matching the criteria. The "Recipient Information panel is displayed if only one record matches the criteria entered on the Recipient Search panel. If an 'inactive' ID is used on the Recipient Search panel, a message is displayed to inform the user that the ID is linked and is not the 'active' ID for the recipient.

Navigation Path: [Recipient] - [Recipient Search] – [Recipient Search Results]

6.2.2 Recipient Search Results Panel Layout



6.2.3 Recipient Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date	Recipient's Birth Date.	Listview	Date (MM/DD/CCYY)	8
Case ID	Recipient's Case (Payee) ID.	Listview	Character	12
County	Recipient's County of residence.	Listview	Character	18
Current ID	Recipient's Medicaid ID.	Listview	Character	12
First Name	Recipient's First Name.	Listview	Character	13
Gender	Recipient's Gender.	Listview	Character	1
Last Name	Recipient's Last Name.	Listview	Character	15
MI	Recipient's Middle Initial.	Listview	Character	1
Medicare ID	Recipient's Medicare identification number.	Listview	Character	12
SSN	Recipient's Social Security Number.	Listview	Number (Integer)	9

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6.2.4 Recipient Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Recipient Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Recipient Search Results Panel Accessibility

6.2.6.1 To Access the Recipient Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Search**.	Recipient Search panel displays.
3	Enter **Current ID**, **Medicare ID**, **Case ID**, **SSN** or **Last Name**. Note: First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.	
4	Click **Search**.	Recipient Search Results panel displays.

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6.3 Recipient Mini Search Panel Overview

6.3.1 Recipient Mini Search Panel Narrative

The Recipient Mini Search panel allows the user to search Recipient records based on Case ID and/or Medicaid ID.

This panel is inquiry only.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search]

6.3.2 Recipient Mini Search Panel Layout

6.3.3 Recipient Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case ID	Case identification number for next search.	Field	Character	12
Clear	Allows the user to clear any changes on the Recipient Mini Search panel.	Button	N/A	0
Current ID	Medicaid ID for next recipient search.	Field	Character	12
EPSDT	Allows the user to search for an EPSDT Screening History by Recipient identification number.	Button	N/A	0
Search	Initiates the Search by Current ID or Case ID.	Button	N/A	0
	The Back Button initiates a return back to the search results page	Button	N/A	0

6.3.4 Recipient Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 Recipient Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.3.6 Recipient Mini Search Panel Accessibility

6.3.6.1 To Access the Recipient Mini Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.

6.3.6.2 To Navigate the Recipient Mini Search Panel

Step	Action	Response
1	Enter **Current ID** or **Case ID** into search field.	
2	Click **Search**.	Recipient Information panel displays.

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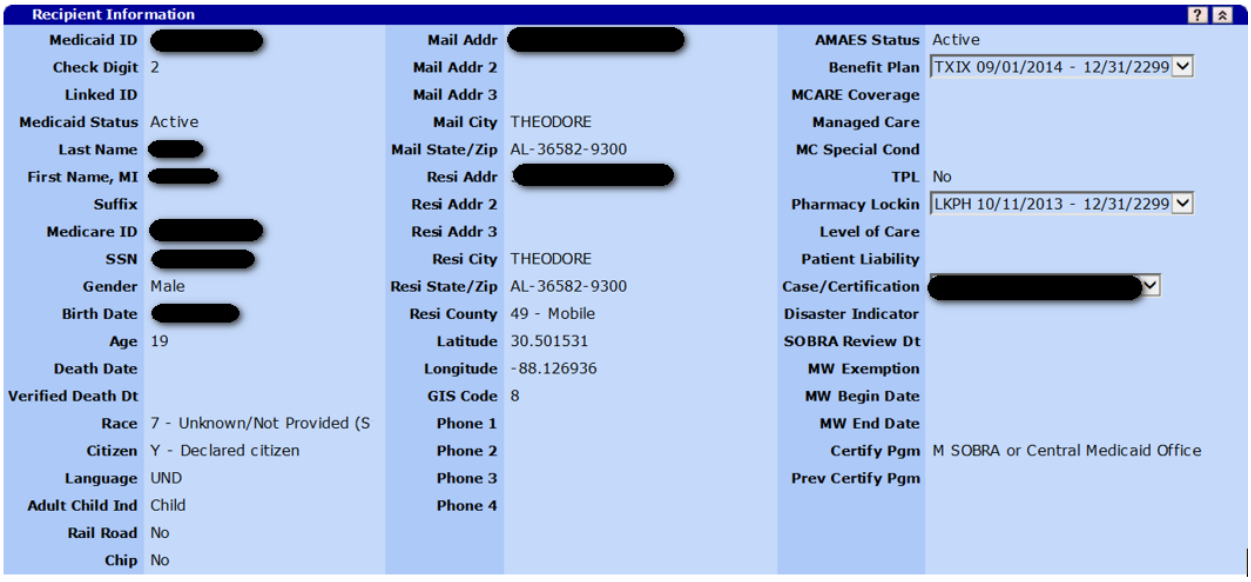
6.4 Recipient Information Panel Overview

6.4.1 Recipient Information Panel Narrative

The Recipient Information panel contains basic information about a recipient. A Recipient is a person who receives benefits from the State. Since most Base information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted. This panel is accessed to view information related to a recipient, such as demographic information and type of eligibility.

Navigation Path: [Recipient] – [Information] - [Enter Current ID or Case ID—click Search]

6.4.2 Recipient Information Panel Layout



Effective January 1, 2014 the Recipient's Citizenship code was changed from being set to a Default value = 'C – Unknown' to display values transmitted from the Alabama Medicaid Agency. The acceptable codes and descriptions for citizenship are:

Code	Descriptions
B	Battered Immigrant
C	Citizen
D1	Documented C/I
D2	Documented C/I
D3	Documented C/I
D4	Documented C/I

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D5 Medicare Exempt

D6 SSI Exempt

D7 SSDI Exempt

D8 Foster Care exempt

DA Citizen

DC Citizen deceased

DN Deemed newborn

E Conditional Entrant

F Parolee

G Afghan Immigrant

I Amer/Canadian Indian

L Lawful perm resident

M Amerasians

N Non-Qualif Non-citizen

P0 Pending documentation

P2 Pending only identity

P3 Pending only identity

P4 Pending only identity

P5 Pending citizenship

P6 Pending child <1 C/I

P7 Pending child >1 ID

P8 Pending citizenship<1

PR Awarded pending C/I

Q Iraqi Immigrant Status

R Refugee

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S Verified Alien

U Undocumented

UB Undocumented

UD Deceased undocumented

V Military, vet, DP

W Deportation withheld

X Unknown

Y Declared citizen

6.4.3 Recipient Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adult Child Ind	Identifies the recipient as either an adult ('A') or a child ('C').	Field	Character	1
Age	Recipient's Age. Calculated from the birth date to the current date.	Field	Number (Integer)	3
AMAES Status	Alabama Medicaid Agency's Status. Values: 0 = SOBRA Payee only 1 = Denied DO or SOBRA Application 2 = Pending Appl or Future Eligibility 3 = Death Deletion 4 = Regular Deletion 5 = Suspended Space = Active *Note –The numerical representation is not displayed on the panel.	Field	Character	100
Benefit Plan	Identifies the most current Benefit Plan and dates the recipient is enrolled. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0
Birth Date	Recipient's Birth Date.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Case/Certification	Identifies the recipient's Case ID and the date the recipient became certified in the Case. Certification Date is the date the Case was added to the system.	Combo Box	Drop Down List Box	0
Certify Pgm	Source of Recipient's Certification. Valid values: H = Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS Foster Care	Field	Character	102
Check Digit	The 13th or last digit for the recipient's Medicaid identification number.	Field	Character	1
Chip	Recipient's Chip Indicator. CHIP = Children's Health Insurance Program. Valid Values include: Spaces No Yes	Field	Character	3
Citizen	Recipient's Citizenship code. Prior to January 1, 2014 a default value = 'C – Unknown' was used in Alabama. After January 1, 2014 the Citizenship code will be updated to the new codes for active recipients as supplied by the Agency.	Field	Character	2
Death Date	Recipient's Date of Death, if applicable.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Disaster Indicator	Disaster Indicator is used to indicate survivors of natural disasters who have evacuated to Alabama and are temporarily receiving Medicaid Coverage. Field had originally been used for the Bay Exemption Indicator. Valid Values: RT = Rita - Texas YA = Katrina - Alabama YL = Katrina - Louisiana YM = Katrina Mississippi Spaces = None *Note – The expanded descriptions are not displayed on the panel.	Field	Character	2
First Name, Mid Init	Recipient's first name and middle initial.	Field	Character	30
Gender	Recipient's Gender. Valid values are Male Female Unknown	Field	Character	8
GIS Code	Geographical Information System code - indicates quality of the calculated longitude/latitude. Used in conjunction with Latitude and Longitude to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	4
Language	Recipient's Language. Default = 'UND' (Undetermined). Field is not currently used in Alabama.	Field	Character	15
Last Name	Recipient's last name.	Field	Character	30
Latitude	Recipient's calculated latitude. Latitude is used in conjunction with Longitude and GIS Code to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	11
Level of Care	Recipient's most current Level of Care information and dates active.	Combo Box	Drop Down List Box	0
Linked ID	If the Recipient has been linked to another Recipient, the "linked" recipient's number is displayed.	Field	Character	12

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Field	Description	Field Type	Data Type	Length
Longitude	Recipient's calculated longitude. Longitude is used in conjunction with Latitude and GIS Code to assist in calculating proximity for Managed Care PMP assignments.	Field	Number (Integer)	11
Mail Addr	Recipient's mailing street address.	Field	Character	30
Mail Addr 2	Additional Recipient mailing street address information, if applicable.	Field	Character	30
Mail Addr 3	Additional Recipient mailing street address information, if applicable. This field is not currently used in Alabama.	Field	Character	30
Mail City	Recipient's mailing address City.	Field	Character	18
Mail State/Zip	Recipient's mailing address State and 5-digit Zip Code and optional 4-digit Zip Extension (Zeroes if not known).	Field	Character	2
Managed Care	Recipient's most current Managed Care information and dates enrolled.	Combo Box	Drop Down List Box	0
Cond	Lists the Recipient's current and historical Managed Care Special Condition codes along with its enrollment periods.	Combo Box	Drop Down List Box	0
Medicaid ID	Recipient's Medicaid identification number.	Field	Character	12
Medicaid Status	Indicates if the recipient is "Active" or is a "Previous Number", meaning that the recipient ID keyed is not the Current ID.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
MCARE Coverage	Recipient's most current Medicare Coverage information. Valid Values: A = Part A B = Part B D = Part D Spaces = No Medicare Coverage NOTE: A Part D value displayed indicates the recipient is enrolled in a Part D plan. Claims editing for Part D is based on Medicare A and/or B dates displayed on the system.	Field	Character	40
Medicare ID	Recipient's Medicare ID (HIC Number).	Field	Character	12
MW Begin Date	Begin Date for Maternity Waiver Exemption, if applicable (Dependent on the Maternity Waiver Exemption field).	Field	Date (MM/DD/CCYY)	10
MW End Date	End Date for Maternity Waiver Exemption, if applicable (Dependent on the Maternity Waiver Exemption field).	Field	Date (MM/DD/CCYY)	10
MW Exemption	Identifies if the Recipient is exempt from the Maternity Waiver Program. Valid values: blank = not exempt 3 = Exempt for the Dates shown, provider may bill fee-for-service 4 = Not Exempt from MW Services, provider may bill fee-for-service *Note – The expanded descriptions are not displayed on the panel.	Field	Character	1
Patient Liability	Recipient's most current Patient Liability information and dates active.	Combo Box	Drop Down List Box	0
Pharmacy Lockin	Recipient's most current Pharmacy Lockin information and dates active (Physician Lockin can be found on the "Capitated Lock-in Assignment History" panel.)	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Phone 1	Recipient's Phone Number one with the designation of the type of phone.	Field	Character	20
Phone 2	Recipient's Phone Number two with the designation of the type of phone.	Field	Character	20
Phone 3	Recipient's Phone Number three with the designation of the type of phone.	Field	Character	20
Phone 4	Recipient's Phone Number four with the designation of the type of phone.	Field	Character	20
Phone Type	Location associated with recipient's phone number. Default value = 'Unknown'. Not currently used in Alabama.	Field	Character	15
Prev Certify Pgm	Previous Certifying Agency. Valid values: H= Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS FOSTER CARE	Field	Character	102
Race	Recipient's Race code. Valid values: A - Asian or Pacific Islander (State Value = A) E - Other Race or Ethnicity (State Value = O) B - Black (State Value = B) H - Hispanic (State Value = H) I - American Indian or Alaskan Native (State Value = I) C - Caucasian (State Value = W) 7 - Unknown/Not Provided (State Value = U)	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Rail Road	Railroad Indicator. Used exclusively by Third Party Liability. Indicates whether the Recipient is a Railroad retiree. Valid values: Yes No	Field	Character	3
Resi Addr	Recipient's residence street address.	Field	Character	30
Resi Addr 2	Additional Recipient's residence street address information. If applicable.	Field	Character	30
Resi Addr 3	Additional Recipient's residence street address information. If applicable.	Field	Character	30
Resi City	Recipient's residence address City.	Field	Character	18
Resi County	Recipient's current county of residence. Field includes County Code and corresponding description.	Field	Character	22
Resi State/Zip	Recipient's State of residence and 5-digit Zip Code and optional 4-digit Zip Extension (Zeroes if not known).	Field	Number (Integer)	13
SOBRA Review Dt	Date that the case worker needs to review the SOBRA case.	Field	Date (MM/DD/CCYY)	10
SSN	Recipient's Social Security Number.	Field	Number (Integer)	9
Suffix	Suffix of Recipient Name -- JR, SR for example. Not currently used in Alabama.	Field	Character	4
TPL	Indicates whether the recipient has TPL coverage. Valid values: Yes No	Field	Character	3
Verified Death Dt	Date the Recipient's Date of Death was verified. Not currently used in Alabama.	Field	Date (MM/DD/CCYY)	8

6.4.4 Recipient Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

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6.4.5 Recipient Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 Recipient Information Panel Accessibility

6.4.6.1 To Access the Recipient Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	**Recipient Information** and Recipient Maintenance panels display.

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6.5 Base Information Panel Overview

The Base Information panel contains information about a Recipient that may be not updated. This includes Birth Date, Death Date, Ethnicity and Marital Status.

Navigation Path: [Recipient] – [Information] - [Enter Current ID or Case ID—click Search]

6.5.1 Base Information Panel Layout

6.5.2 Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date:	The date of birth for the recipient.	Field	Date (MM/DD/CCYY)	10
Death Date:	The date of death for the recipient.	Field	Date (MM/DD/CCYY)	10
Ethnicity:	The ethnicity of the recipient. Value of 01 means Hispanic. Value of 00 means not Hispanic.	Combo Box	Drop Down List Box	20
Marital Status:	Marital Status of Recipient.	Combo Box	Drop Down List Box	10

6.5.3 Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.5.4 Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.5 Base Information Panel Accessibility

6.5.5.1 To Access the Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	**Base Information** and Recipient Maintenance panels display.

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6.6 Recipient Maintenance Panel Overview

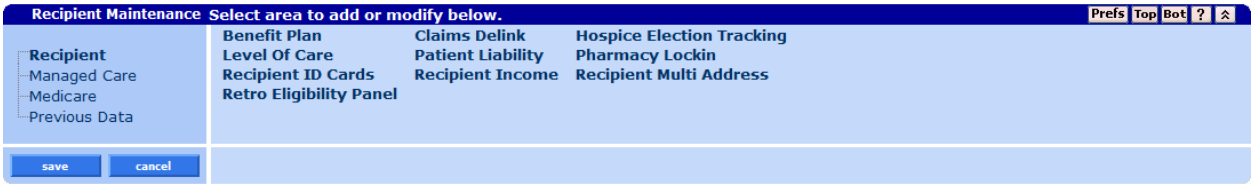
6.6.1 Recipient Maintenance Panel Narrative

The Recipient Maintenance panel is the access point for maintenance within the Recipient system. Users can choose from a list of panels on each of the following submenus: 'Recipient', 'Managed Care', 'Medicare', and 'Previous Data'. This panel is inquiry only.

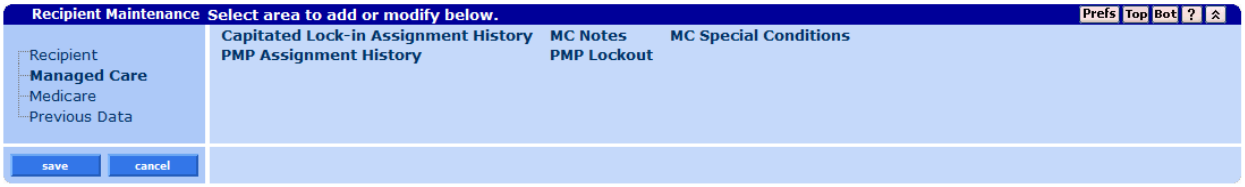
Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance]

6.6.2 Recipient Maintenance Panel Layout

Recipient

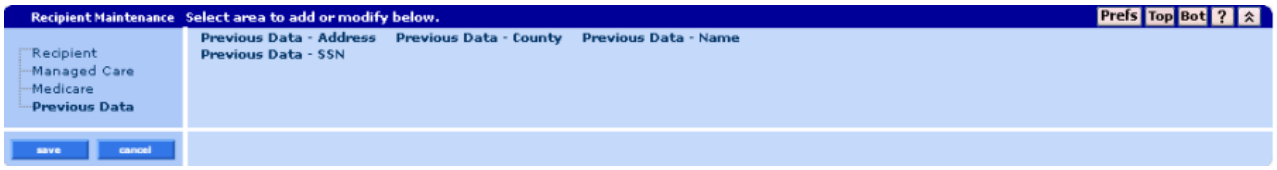


Managed Care



Medicare

Previous Data



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6.6.3 Recipient Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Recipient				
Benefit Plan	Link to the Recipient Benefit Plan panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel changes on the Recipient panels.	Button	N/A	0
Hospice Election Tracking	Link to the Hospice Election Tracking panel.	Hyperlink	N/A	0
Level of Care	Link to the Recipient Level Of Care panel.	Hyperlink	N/A	0
Pharmacy Lockin	Link to the Recipient Pharmacy Lockin panel.	Hyperlink	N/A	0
Patient Liability	Link to the Recipient Patient Liability panel.	Hyperlink	N/A	0
Recipient ID Cards	Link to the Recipient ID Cards panel.	Hyperlink	N/A	0
Recipient Income	Link to the Recipient Income panel.	Hyperlink	N/A	0
Recipient Multi Address	Link to the Recipient Multi Address panel.	Hyperlink	N/A	0
Retro Eligibility Panel	Link to the Retro Eligibility panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Recipient panels.	Button	N/A	0
Managed Care				
Cancel	Allows the user to cancel changes on the Managed Care panels.	Button	N/A	0
Capitated Lock-in Assignment History	Link to the Capitated Lock-in Assignment History panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
MC Notes Panel	Link to MC Notes Panel.	Hyperlink	N/A	0
MC Special Conditions	Link to the MC Special Conditions panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
PMP Assignment History	Link to the PMP Assignment History panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
PMP Lockout	Link to the PMP Lockout panel. See Managed Care User Manual for more details.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Managed Care panels.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Medicare				
Cancel	Allows the user to cancel changes on the Medicare panels.	Button	N/A	0
Medicare A Coverage	Link to the Medicare A Coverage panel.	Hyperlink	N/A	0
Medicare B Coverage	Link to the Medicare B Coverage panel.	Hyperlink	N/A	0
Medicare ID	Link to the Medicare ID panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Medicare panels.	Button	N/A	0
Previous Data				
Cancel	Allows the user to cancel changes on the Previous Data panels.	Button	N/A	0
Previous Data – Address	Link to the Previous Data – Address panel.	Hyperlink	N/A	0
Previous Data – County	Link to the Previous Data – County panel.	Hyperlink	N/A	0
Previous Data – Name	Link to the Previous Data – Name panel.	Hyperlink	N/A	0
Previous Data – SSN	Link to the Previous Data – SSN panel.	Hyperlink	N/A	0
Save	Allows the user to save changes on the Previous Data panels.	Button	N/A	0

6.6.4 Recipient Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.6.5 Recipient Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.6.6 Recipient Maintenance Panel Accessibility

6.6.6.1 To Access the Recipient Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	

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Step	Action	Response
4	Click **Search**.	Recipient Information and **Recipient Maintenance** panels display.

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6.7 Benefit Plan Panel Overview

6.7.1 Benefit Plan Panel Narrative

The Benefit Plan panel is used to view eligibility segment information. This panel displays current and historical eligibility periods, Aid Categories, and other State programs. The eligibility periods are used to perform basic recipient editing in claims processing, TPL, etc. Since eligibility segment information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Benefit Plan]

6.7.2 Benefit Plan Panel Layout

6.7.3 Benefit Plan Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add benefit plan information. This button is not utilized by Alabama.	Button	N/A	0
Aid Category	Entity identifies the type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Aid Category Effective Date	Date that the recipient became eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Aid Category End Date	Date that the recipient is no longer eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Benefit Plan	Benefit Plan associated with the corresponding aid category. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Certifying Agency	Source of Recipient's Certification associated with the corresponding eligibility segment. Valid values: H = Department of Human Resources D = Medicaid District Office M = SOBRA or Central Medicaid Office S = SSI/Social Security Administration Y = DYS Foster Care	Combo Box	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Benefit Plan panel.	Button	N/A	0
County	County Code and Description associated with the corresponding eligibility segment. Field includes County Code and corresponding description.	Combo Box	Drop Down List Box	0
D C Tracking	Data Control Tracking code associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete benefit plan information. This button will not be utilized by Alabama.	Button	N/A	0
Deprivation Code	Deprivation Code associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
DO Program Code	District Office Program associated with the corresponding eligibility segment. A list of valid codes can be found in iTRACE.	Combo Box	Drop Down List Box	0
Effective Date	Date the recipient becomes eligible for the corresponding Benefit Plan.	Field	Date (MM/DD/CCYY)	8
End Date	Date the recipient is no longer eligible for the corresponding Benefit Plan.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Contains Financial Payer types. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Record Status	Status code for the program eligibility segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Status or Benefit Plan.	Button	N/A	0
Status	Status code for the program eligibility segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Stop Reason	Explains the termination of an eligibility period for a recipient. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0

6.7.4 Benefit Plan Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.7.5 Benefit Plan Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Benefit Plan Panel Accessibility

6.7.6.1 To Access the Benefit Plan Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Benefit Plan**.	Benefit Plan panel displays.

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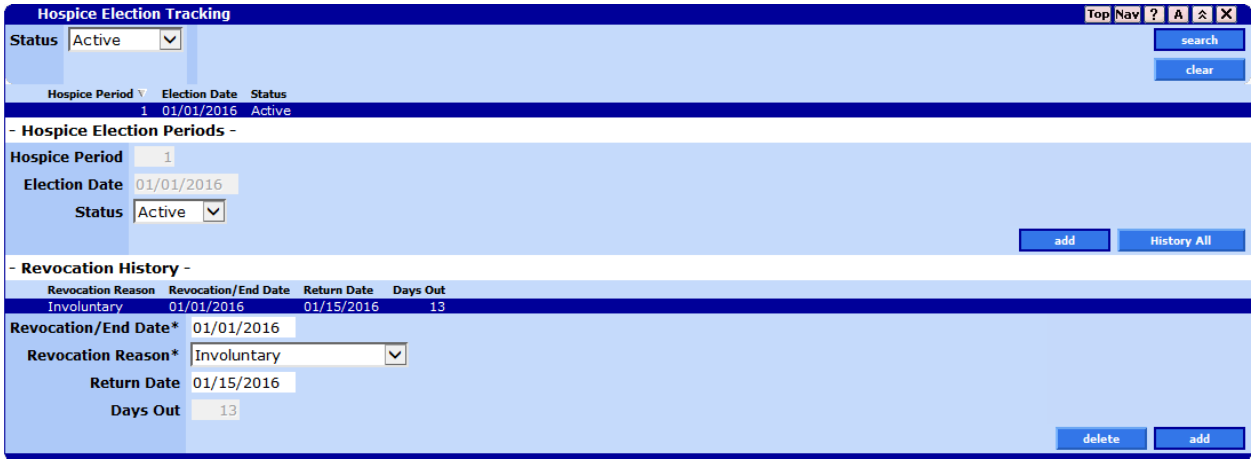
6.8 Hospice Election Tracking Panel Overview

6.8.1 Hospice Election Tracking Panel Narrative

The Hospice Election Tracking panel displays the hospice election tracking information for a recipient. This panel is updatable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance] - [Hospice Election Tracking]

6.8.2 Hospice Election Tracking Panel Layout



6.8.3 Hospice Election Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to update fields and add a new level of care record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Days Out	Number of day's recipient was out of hospice.	Field	Number (Integer)	3
Delete	Allows the user to delete a revocation record.	Button	N/A	0
Election Date	Election Date.	Field	Date (MM/DD/CCYY)	8
History All	Allows the user to update status to history for all active records.	Button	N/A	0
Hospice Period	Hospice Period.	Field	Number (Integer)	2
Return Date	Date in which recipient returned to the Hospice Election Tracking.	Field	Date (MM/DD/CCYY)	8
Revocation/End Date	Date in which recipient Hospice Election Tracking Revoked/Ended.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Revocation Reason	Revocation reason. Possible values are, V – Voluntary, I – Involuntary, R - Release Plan, C - Calculated by period end and D - Death.	Field	Drop Down List Box	1
Search	Clicking the Search button filters displayed segments by status.	Button	N/A	0
Status	Status for the Hospice Election Tracking. Possible values are A - Active, H - History, P - Previous.	Field	Drop Down List Box	1

6.8.4 Hospice Election Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Days Out	Field	1	Days Out must be less than or equal to 999.	Enter appropriate return date.
Election Date	Field	1	Election Date is required.	Enter Election Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter valid Election Date.
	Field	3	Election Date must be less than or equal to today's date.	Enter an election date less than or equal to today's date.
	Field	4	Election Date should not be within 90 days of care. However if this is revocation/return date then please add at detail. Based on current information entered, the next election date should be [M/D/YYYY].	This is just information message for 90 days calculation. If agree click save otherwise modify the election date.
	Field	5	Election Date should not be within 60 days of care. However if this is revocation/return date then please add at detail. Based on current information entered, the next election date should be [M/D/YYYY].	This is just information message for 60 days calculation. If agree click save otherwise modify the election date.
	Field	6	Are you sure about election date? If you click save it will recalculate all election periods. Please enter Revocation Date and Reason on detail panel.	This is just information message. If agree click save otherwise modify the election date.
	Field	7	Election Date must be greater than or equal to 1/1/1900.	Enter an election date greater than or equal to 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	8	Election Date must be less than or equal to 12/31/2299.	Enter an election date less than or equal to 12/31/2299.
	Field	9	You are trying to insert a previous election period between existing previous periods, you need to be inserting period prior to M/D/YYYY. If you need to insert date between these dates contact the LTC TFAL.	Enter an election date less than last previous election date or update the election date to make it active.
History All	Button	1	Are you sure you want to update the status to History for all records?	If you are sure click ok otherwise click cancel.
Return Date	Field	1	Please enter Return Date for hospice period [Number].	Enter return date for previous hospice period.
	Field	2	Return date cannot be removed once added.	Do not remove return date.
	Field	3	Invalid date. Format is mm/dd/ccyy.	Enter valid Return Date.
	Field	4	Return Date must be greater than or equal to 1/1/1900.	Enter a return date greater than or equal to 1/1/1900.
	Field	5	Return Date must be less than or equal to today's date.	Enter return date less than or equal to today's date.
	Field	6	The Revocation history date range segments cannot overlap.	Enter non-overlapping date range.
	Field	7	Return Date must be less than or equal to 12/31/2299.	Enter return date less than or equal to 12/31/2299.
Revocation/End Date	Field	1	Revocation date should not be less than Election Date for that period.	Enter revocation date greater then election date for that period.
	Field	2	Revocation date should not overlap over other record.	Enter non-overlapping date range.
	Field	3	Revocation date/reason systematically updated based on revocation date you entered. If you agree, click save.	This is notification message. If agree click save otherwise modify the revocation date.
	Field	4	Please enter Revocation Date and Reason.	Enter revocation date and reason.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Revocation Date should not be less than current election date.	Enter revocation date greater than current election date.
	Field	6	Revocation Date should not be greater than first election date.	Enter revocation date less than first election date.
	Field	7	Revocation/End Date must be greater than or equal to 1/1/1900.	Enter revocation date greater than or equal to 1/1/1900.
	Field	8	Invalid date. Format is mm/dd/ccyy.	Enter valid revocation date.
	Field	9	Revocation/End Date is required.	Enter Revocation/End Date.
Revocation Reason	Field	1	Revocation Reason is required.	Select a revocation reason.
	Field	2	'Calculated By Period End' Revocation reason is not valid for user entry.	Select appropriate revocation reason.
Search	Button	1	Please save or cancel any changes before searching hospice records.	Click Save or Cancel.
Status	Field	1	'Previous' status is not valid for user entry.	Select appropriate status.

6.8.5 Hospice Election Tracking Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.8.6 Hospice Election Tracking Panel Accessibility

6.8.6.1 To Access the Hospice Election Tracking Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient**.	
6	Click **Hospice Election Tracking**.	Hospice Election Tracking panel displays.

6.8.6.2 To Add the Hospice Election Tracking Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter an **Election Date** in MM/DD/CCYY format.	
3	Click **Save**.	Hospice Election Tracking information is saved.

6.8.6.3 To Update the Hospice Election Tracking Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Hospice Election Tracking information is saved.

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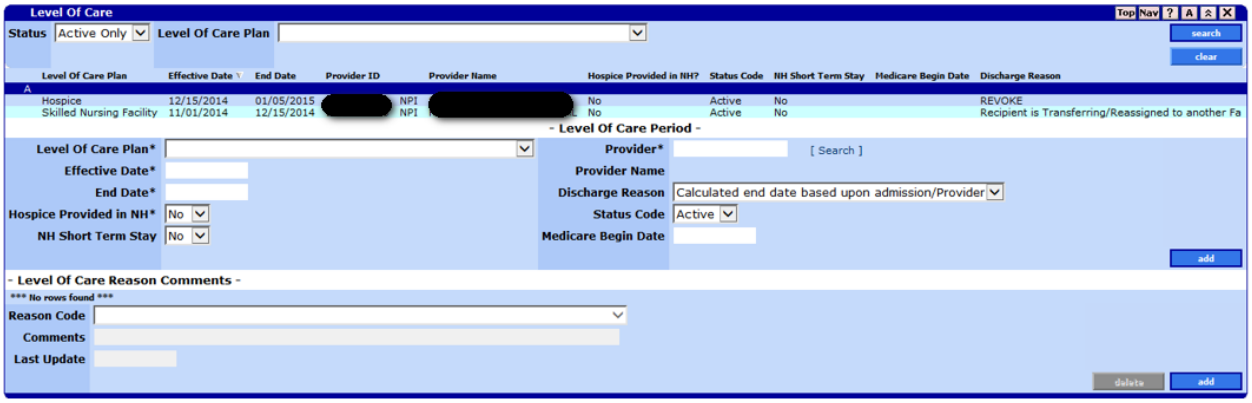
6.9 Level Of Care Panel Overview

6.9.1 Level Of Care Panel Narrative

The Level of Care panel displays the level of care information for a recipient. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Recipient Maintenance] - [Level of Care]

6.9.2 Level Of Care Panel Layout



6.9.3 Level Of Care Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to update fields and add a new Level of Care record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Comments	Free form area for comments about the Level of Care segment.	Field	Character	100
Delete	Allows the user to delete a level of care record.	Button	N/A	0
Discharge Reason	Specifies a reason to discharge a Level of Care plan. Default value will be “Calculated End Date based upon admission/provider”.	Combo Box	Drop Down List Box	0
Effective Date	Date that the recipient becomes eligible for the corresponding Level of Care plan.	Field	Date (MM/DD/CCYY)	8
End Date	Date the recipient is no longer eligible for the corresponding Level of Care plan.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Hospice Provided in NH	Indicates that Hospice is being provided in a facility.	Field	Drop Down List Box	0
Last Update	Last date record was updated	Field	Date (MM/DD/CCYY)	8
Level Of Care Plan	Level of Care plan authorized for the recipient.	Combo Box	Drop Down List Box	0
Medicare Begin Date	This date signifies that the recipient had Medicare covered days prior to this nursing facility segment.	Field	Date (MM/DD/CCYY)	8
NH Short Term Stay	Indicates when Nursing Home stay is anticipated to be less than 90 days. If Y = short term, if N means Not short term or Not Applicable	Combo Box	Drop Down List Box	1
Provider	Identification number assigned to a group or individual that provides medical services to recipients.	Field	Alphanumeric	9
Provider ID Type	Provider service location business identifier information that is assigned to the recipient.	List	Character	9
Reason Code	Reason for the Level of Care segment.	Combo Box	Drop Down List Box	0
Search	Clicking the Search button filters displayed segments by status and/or Level of Care plan.	Button	N/A	0
[Search]	Allows a user to locate a Provider by searching by Provider ID, Business OR Last Name and First, MI.	Hyperlink	N/A	0
Status	Status code for the Level of Care segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Status Code	Status code for the program eligibility segment. A blank means the segment is active and an 'H' means that the segment is history and no longer valid (Cancelled).	Combo Box	Drop Down List Box	0

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6.9.4 Level Of Care Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	4214	Overlapping segments cannot contain the same provider.	Enter non-overlapping date range or different provider.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
	Field	91232	Overlapping segments cannot contain the same LOC plan.	Enter non-overlapping date range or different LOC plan.
End Date	Field	4214	Overlapping segments cannot contain the same provider.	Enter non-overlapping date range or different provider.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
	Field	91232	Overlapping segments cannot contain the same LOC plan.	Enter non-overlapping date range or different LOC plan.
Level Of Care Plan	Field	91006	Level of Care field is required.	Verify keying.
Medicare Begin Date	Field	1001	Medicare Begin Date must be greater than or equal to 1/1/1900.	Enter an end date greater than or equal to 1/1/1900.
	Field	1002	Invalid Date (MM/DD/CCYY	Verify keying.
Provider	Field	91006	Provider ID is required.	Verify keying.
	Field	91007	Provider ID record not found. Please try again.	Verify and re-enter Provider.
Provider ID Type	Field	5176	Service Location invalid for this Provider.	Verify and re-enter location.

6.9.5 Level Of Care Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.9.6 Level Of Care Panel Accessibility

6.9.6.1 To Access the Level of Care Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient**.	
6	Click **Level of Care**.	Level of Care panel displays.

6.9.6.2 To Add the Level of Care Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Level of Care Plan** from the drop down list box.	
3	Enter an **Effective Date** in MM/DD/CCYY format.	
4	Enter an **End Date** in MM/DD/CCYY format.	
5	Select **Status Code** from the drop down list box.	
6	Enter **Provider**.	If Provider is unknown select [Search] to search by Provider ID, Business OR Last Name and First, MI.
7	Click **Save**.	Level of Care information is saved.

6.9.6.3 To Update the Level of Care Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Level of Care information is saved.

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6.10 Patient Liability Panel Overview

6.10.1 Patient Liability Panel Narrative

The Patient Liability panel is used to view a recipient's patient liability information. Since Patient Liability information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Patient Liability]

6.10.2 Patient Liability Panel Layout

6.10.3 Patient Liability Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Patient Liability information. This button is not utilized by Alabama.	Button	N/A	0
Amount Withheld	Amount withheld on the claim due to the Recipient's financial Patient Liability.	Field	Number (Decimal)	8
Date	Date the claim adjudicated in the system.	Field	Date (CCYY/MM)	6
Effective Date	Date that the patient's financial liability amount becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the patient's financial liability amount is no longer effective in a long term facility.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
ICN	Unique internal control number assigned to the claim when processed that indicates when the claim was received and whether it was sent by paper or through electronic media. The ICN is used to track the claim throughout processing.	Field	Character	13
Monthly Amount	Patient's financial liability amount that must be paid by the recipient before the State makes payment on the claim.	Field	Number (Decimal)	11
Type	Indicates which program to apply patient obligation. N = Nursing Home; P = Personal Care. Default is N = Nursing Home.	Combo Box	Drop Down List Box	0
Record Reference No	Unique identifier for patient liability.	Field	Number	9

6.10.4 Patient Liability Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.10.5 Patient Liability Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Patient Liability Panel Accessibility

6.10.6.1 To Access the Recipient Patient Liability Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Patient Liability**.	Patient Liability panel displays.

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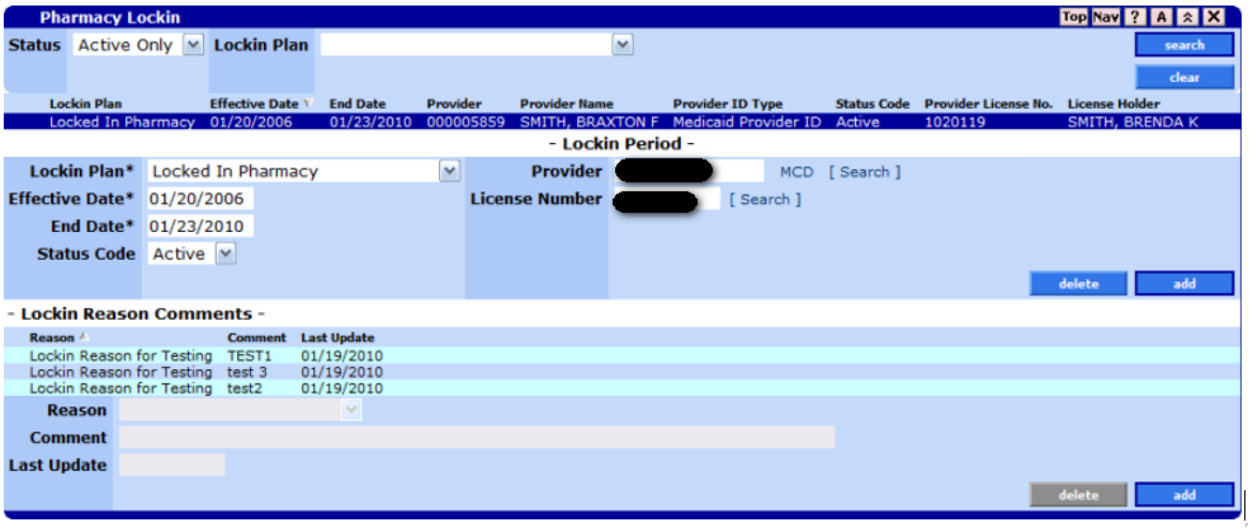
6.11 Pharmacy Lockin Panel Overview

6.11.1 Pharmacy Lockin Panel Narrative

The Pharmacy Lockin panel is used to view a recipient's pharmacy Lockin (restriction) segments. This panel is updateable for users with proper security access. Physician Lockin information can be found using the “Capitated Lock-in Assignment History” panel. This panel is described in more detail within the Managed Care subsystem.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Pharmacy Lockin]

6.11.2 Pharmacy Lockin Panel Layout



6.11.3 Pharmacy Lockin Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Pharmacy Lockin record.	Button	N/A	0
Clear	Allows the user to reset the search filter criteria.	Button	N/A	0
Comment	Free form area for comments about the Lockin segment.	Field	Character	100
Delete	Allows the user to delete a Pharmacy Lockin record.	Button	N/A	0
Effective Date	Effective Date establishes the start date of the time frame being restricted.	Field	Date (MM/DD/CCYY)	8
End Date	End Date establishes the end date of the time frame being restricted.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Last Update	Last date record was updated	Field	Date (MM/DD/CCYY)	8
License Number	Provider service location business identifier information that is assigned to the recipient.	Field	Character	10
Lockin Plan	Lockin Plan authorized for the recipient.	Combo Box	Drop Down List Box	0
Provider	Identification number assigned to a group or individual that provides medical services to recipients.	Field	Alphanumeric	15
Provider ID Type	Indicates what type of Provider ID was entered: Medicaid Provider ID or National Provider Identifier (NPI).	Listview	Character	20
Provider License No.	Provider service location business identifier information that is assigned to the recipient. Field automatically appears once the correct Provider ID is selected in Provider Field.	Listview	Character	10
Provider Name	Provider name associated with the provider identification number.	Listview	Character	40
Reason	Reason due to which recipient is Locked into the above Lockin Plan.	Field	Character	3
Search	Allows the user to filter displayed segments by status and/or Lockin Plan.	Button	N/A	0
[Search]	Allows a user to locate a Provider by searching by Provider ID, Business OR Last Name and First, MI. Allows a user to locate a License Number by searching by Provider License Number or Provider Name.	Hyperlink	N/A	0
Status	Status code for the Lockin segment. Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0
Status Code	Status code for the Lockin segment. Allows users to choose what status the segment should be in: Active or History (Cancelled).	Combo Box	Drop Down List Box	0

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6.11.4 Pharmacy Lockin Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Comments	Field	91006	Comment is Required.	Verify keying.
Effective Date	Field	1	Please select another prescriber or enter dates that are between the provider's program eligibility start and end date, or use an open end date.	Select another prescriber or enter dates that are between the provider's program eligibility start and end date or enter an open end date.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
End Date	Field	1	Please select another prescriber or enter dates that are between the provider's program eligibility start and end date, or use an open end date.	Select another prescriber or enter dates that are between the provider's program eligibility start and end date or enter an open end date.
	Field	9074	Effective Date must be <= End Date.	Verify keying.
	Field	91001	Invalid Date (MM/DD/CCYY).	Verify keying.
	Field	91003	Date is required.	Verify keying.
Lockin Plan	Combo Box	91006	A valid Lockin Plan is required.	Verify keying.
Provider	Field	1	A Lockin Plan for this provider already exists for the Effective Date.	Verify and re-enter provider or Effective Date.
	Field	4146	Invalid Provider.	Verify and re-enter Provider.
Reason	Combo Box	91006	A valid Reason Code is required.	Verify keying.

6.11.5 Pharmacy Lockin Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.11.6 Pharmacy Lockin Panel Accessibility

6.11.6.1 To Access the Pharmacy Lockin Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Pharmacy Lockin**.	Pharmacy Lockin panel displays.

6.11.6.2 To Add the Pharmacy Lockin Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select a response from the **Lockin Plan** drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Select a response from the **Status Code** drop down list box.	
6	Enter **Provider number**.	
7	Enter **Provider License number**.	
8	Click **Save**.	Recipient Lockin Details information is saved.

6.11.6.3 To Update the Pharmacy Lockin Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Pharmacy Lockin information is saved.

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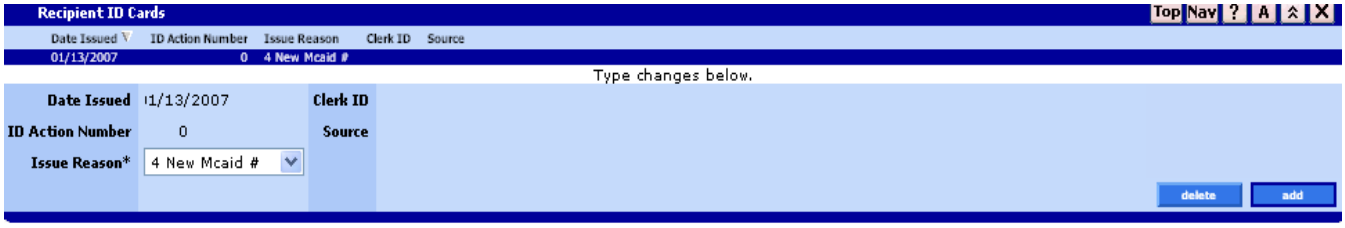
6.12 Recipient ID Cards Panel Overview

6.12.1 Recipient ID Cards Panel Narrative

The Recipient ID Cards panel is used to view and verify all ID card issuances for a recipient. This panel allows the user to view all the ID cards that were issued to a recipient as well as a corresponding reason as to why the card was issued. This panel allows the user to see a potential problem if a recipient has been issued too many ID cards. Since Plastic ID Card information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] –[Recipient Mini Search] – [Recipient Maintenance] - [Recipient ID Cards]

6.12.2 Recipient ID Cards Panel Layout



6.12.3 Recipient ID Cards Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient ID Card information. This button is not utilized by Alabama.	Button	N/A	0
Clerk ID	Clerk identification of the requester. All Plastic ID Cards information is supplied by the nightly AMAES update file.	Field	Character	8
Date Issued	Date that the ID card was issued to the recipient.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete Recipient ID Card information. This button is not utilized by Alabama.	Button	N/A	0
ID Action Number	Number of ID cards issued to the recipient.	Field	Character	2
Issue Reason	Reason the ID card was issued. The issue reason codes are converted to their actual description for readability. Valid values: Spaces = n/a A = Never Received B = Lost C = Stolen	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
	D = Damaged or Destroyed F = Changed Name G = Changed Gender H = Changed Race I = Change DOB J = Changed Med# 1 = New 2 = Awarded Eligibility 3 = Eligibility Re-Awarded 4 = New Medicaid# 5 = Left Nursing Home *Note: Only expanded description information is displayed on the panel.			
Source	Identifies the source that initiated the ID card. All Plastic ID Cards information is supplied by the nightly AMAES update file.	Field	Character	6

6.12.4 Recipient ID Cards Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.12.5 Recipient ID Cards Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 Recipient ID Cards Panel Accessibility

6.12.6.1 To Access the Recipient ID Cards Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Recipient ID Cards**.	Recipient ID Cards panel displays.

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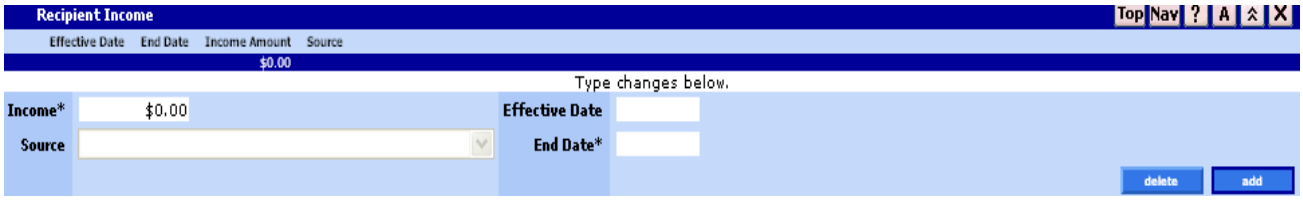
6.13 Recipient Income Panel Overview

6.13.1 Recipient Income Panel Narrative

The Recipient Income panel is used to display a recipient's income. Since income information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Recipient Income]

6.13.2 Recipient Income Panel Layout



6.13.3 Recipient Income Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient Income information. This button is not utilized by Alabama.	Button	N/A	0
Delete	Allows the user to delete Recipient Income information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Effective date of the income for the recipient. This field is not utilized by Alabama.	Field	Date (MM/DD/CCYY)	8
End Date	End date of the income for the recipient. This field is not utilized by Alabama.	Field	Date (MM/DD/CCYY)	8
Income Amount	Recipient's income for a specified period of time. Field comes from the Gross Unearned income field via the nightly AMAES update field.	Field	Number (Decimal)	10
Source	Source of the income for the recipient. All Income information is supplied by the nightly AMAES update file.	Combo Box	Drop Down List Box	0

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6.13.4 Recipient Income Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.13.5 Recipient Income Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Recipient Income Panel Accessibility

6.13.6.1 To Access the Recipient Income Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Click **Recipient Income**.	Recipient Income panel displays.

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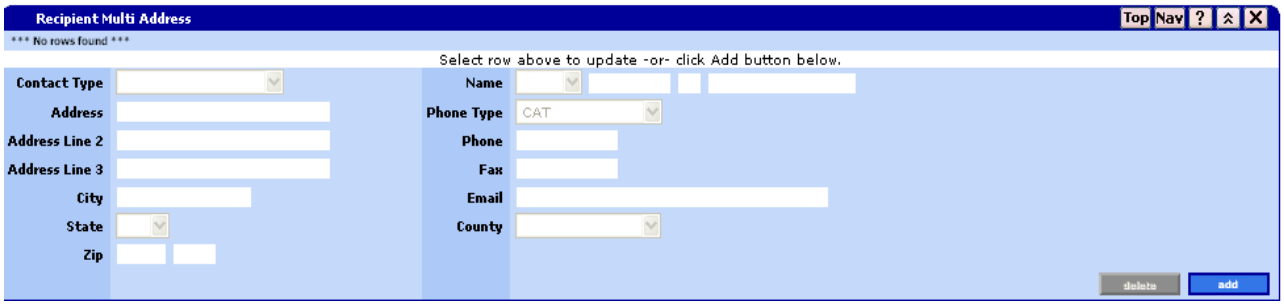
6.14 Recipient Multi Address Panel Overview

6.14.1 Recipient Multi Address Panel Narrative

The Recipient Multi Address panel is used to inquire on alternate addresses and contact information for a recipient. This panel displays Secondary, Sponsor and Spouse address information. The recipient's current address information is displayed on the Recipient Information panel. Previous addresses for a recipient can be found on the "Previous Data – Address" panel. Since all information on this panel comes from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Recipient Multi Address]

6.14.2 Recipient Multi Address Panel Layout



6.14.3 Recipient Multi Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Recipient Multi-Address information. This button is not utilized by Alabama.	Button	N/A	0
Address	Secondary/Sponsor/Spouse primary street address.	Field	Character	30
Address Line 2	Secondary/Sponsor/Spouse street address line two, if applicable.	Field	Character	30
Address Line 3	Secondary/Sponsor/Spouse street address information, if additional space is needed. This field is not utilized by Alabama.	Field	Character	30
City	Secondary/Sponsor/Spouse city of residence.	Field	Character	15
Contact Type	Type of address. Valid values: SP = Spouse Address SE = Secondary Address SN = for Sponsor Address *Note: Only expanded description is displayed.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
County	Secondary/Sponsor/Spouse county of residence. Field includes County Code and corresponding description.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete Recipient Multi-Address information. This button is not utilized by Alabama.	Button	N/A	0
Email	Secondary/Sponsor/Spouse email address. This field is not utilized by Alabama.	Field	Character	50
Fax	Secondary/Sponsor/Spouse fax number. This field is not utilized by Alabama.	Field	Number (Integer)	10
Name	Secondary/Sponsor/Spouse name in first name/middle initial/last name format.	Field	Character	30
Phone	Secondary/Sponsor/Spouse phone number and extension. This field is not utilized by Alabama.	Field	Number (Integer)	17
Phone Type	Secondary/Sponsor/Spouse Telephone type. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0
State	Secondary/Sponsor/Spouse State of residence.	Combo Box	Drop Down List Box	0
Zip	Secondary/Sponsor/Spouse Zip Code + 4.	Field	Number (Integer)	9

6.14.4 Recipient Multi Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only in Alabama.				

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6.14.5 Recipient Multi Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Recipient Multi Address Panel Accessibility

6.14.6.1 To Access the Recipient Multi Address Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Recipient Multi Address**.	Recipient Multi Address panel displays.

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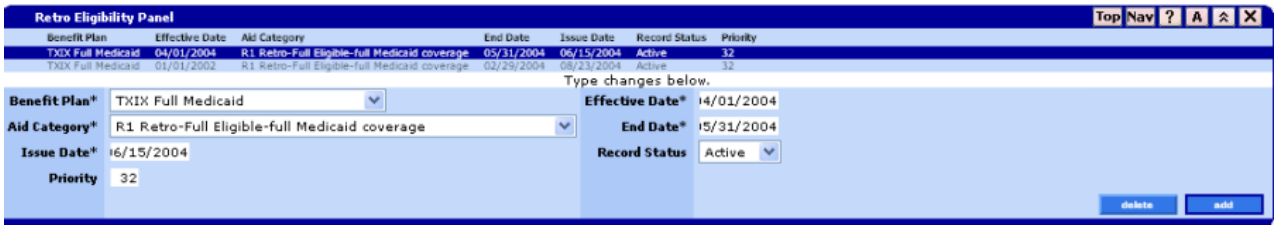
6.15 Retro Eligibility Panel Overview

6.15.1 Retro Eligibility Panel Narrative

The Retro Eligibility panel is used to view retro eligibility segment information. The retro segments are copied directly from the nightly AMAES update file and are also used to create the eligibility segments found on the Benefit Plan panel. The Issue Date is used directly in claims processing. Since all information on this panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] – [Information] – [Recipient Mini Search] – [Recipient Maintenance] - [Retro Eligibility Panel]

6.15.2 Retro Eligibility Panel Layout



6.15.3 Retro Eligibility Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Retro Eligibility information. This button is not utilized by Alabama.	Button	N/A	0
Aid Category	Entity identifies the type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Benefit Plan	Benefit Plan associated with the corresponding aid cat(s). Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove Retro Eligibility information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Date that the recipient became eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the recipient is no longer eligible for the corresponding aid category.	Field	Date (MM/DD/CCYY)	8
Issue Date	Date the Retro Eligibility segment was issued for the recipient.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Priority	Assigns importance of Aid Category. This field is not utilized by Alabama.	Field	Character	2
Record Status	Allows users to choose which segments they would like to view: Active Only, History Only, or All. *Note: Active segments refer to those segments that are 'not' cancelled. History segments are also referred to as cancelled segments.	Combo Box	Drop Down List Box	0

6.15.4 Retro Eligibility Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

6.15.5 Retro Eligibility Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Retro Eligibility Panel Accessibility

6.15.6.1 To Access the Retro Eligibility Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Retro Eligibility panel**.	Retro Eligibility panel displays.

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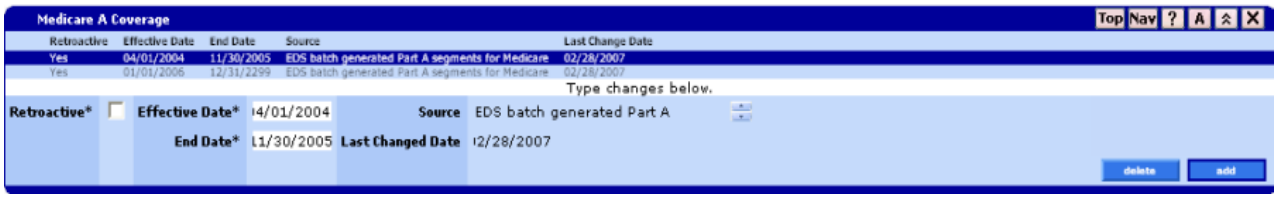
6.16 Medicare A Coverage Panel Overview

6.16.1 Medicare A Coverage Panel Narrative

The Medicare A Coverage panel is used to view or update Medicare Part A segments. The Medicare A Coverage panel contains the effective dates, end dates, Retroactive flag, and the last change date. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] – [Medicare] - [Medicare A Coverage]

6.16.2 Medicare A Coverage Panel Layout



6.16.3 Medicare A Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare A Coverage information.	Button	N/A	0
Delete	Allows the user to delete Medicare A Coverage information. NOTE: Medicare coverage segments that are deleted will no longer display on the coverage panel, but can be viewed in the audit panel.	Button	N/A	0
Effective Date	Effective date for Medicare Part A.	Field	Date (MM/DD/CCYY)	8
End Date	End date for Medicare Part A.	Field	Date (MM/DD/CCYY)	8
Last Changed Date	Date the segment was last updated (system assigned).	Field	Date (MM/DD/CCYY)	8
Retroactive	Medicare Retroactive Determination Flag. This field is not utilized by Alabama.	Combo Box	Check Box	0
Source	Source of the transaction. Valid values: E = EDB M = AMAES (Medicaid) O = Online System X = EDS *Note: Only extended description is displayed on the panel.	Field	Character	25

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6.16.4 Medicare A Coverage Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1001	Effective Date must be first day of the month.	Enter an Effective Date that is the first day of the month.
	Field	5001	Effective Date is required.	Enter valid date or cancel transaction.
	Field	5015	Effective Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
End Date	Field	1002	End Date must be last day of the month.	Enter an End Date that is the last day of the month.
	Field	5001	End Date is required.	Enter valid date or cancel transaction.
	Field	5015	End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
Retroactive	Check Box	5001	Retroactive is required.	Field is default to 'no' (unchecked) when Effective and End dates are populated. Enter dates and check/uncheck box appropriately.

6.16.5 Medicare A Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.16.6 Medicare A Coverage Panel Accessibility

6.16.6.1 To Access the Medicare A Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays

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Step	Action	Response
6	Select **Medicare A Coverage**.	Medicare A Coverage panel displays.

6.16.6.2 To Add the Medicare A Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Retroactive** checkbox, if applicable.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Recipient Medicare A Coverage information is saved.

6.16.6.3 To Update the Medicare A Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Recipient Medicare A Coverage information is saved.

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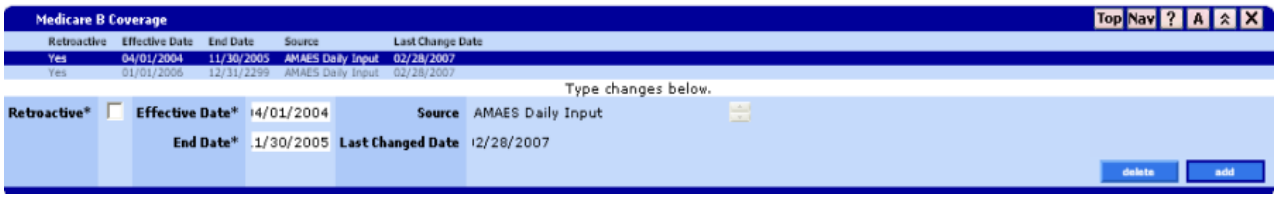
6.17 Medicare B Coverage Panel Overview

6.17.1 Medicare B Coverage Panel Narrative

The Medicare B Coverage panel is used to view or update Medicare Part B segments. The Medicare B Coverage panel contains the effective dates, end dates, Retroactive flag, and the last change date. This panel is updateable for users with proper security access.

Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Medicare] - [Medicare B Coverage]

6.17.2 Medicare B Coverage Panel Layout



6.17.3 Medicare B Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare B Coverage information.	Button	N/A	0
Delete	Allows the user to delete Medicare B Coverage information. NOTE: Medicare coverage segments that are deleted will no longer display on the coverage panel, but can be viewed in the audit panel.	Button	N/A	0
Effective Date	Effective date for Medicare Part B.	Field	Date (MM/DD/CCYY)	8
End Date	End date for Medicare Part B.	Field	Date (MM/DD/CCYY)	8
Last Changed Date	Date the segment was last updated (system assigned).	Field	Date (MM/DD/CCYY)	8
Retroactive	Medicare Retroactive Determination Flag. This field is not utilized by Alabama.	Combo Box	Check Box	0
Source	Source of the transaction. Valid values: E = EDB M = AMAES (Medicaid) O = Online System X = EDS *Note: Only extended description is displayed on the panel.	Field	Character	25

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6.17.4 Medicare B Coverage Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1001	Effective Date must be first day of the month.	Ensure Effective Date is the first day of the month.
	Field	5001	Effective Date is required.	Enter valid date or cancel transaction.
	Field	5015	Effective Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
End Date	Field	1002	End Date must be last day of the month.	Ensure End Date is the last day of the month.
	Field	5001	End Date is required.	Enter valid date or cancel transaction.
	Field	5015	End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/1/01900.
	Field	5016	Effective Date must be less than or equal to End Date.	Verify and re-key dates.
	Field	5501	Invalid date.	Enter date in appropriate format or cancel transaction.
Medicare B Coverage item	Field	1	Medicare ID (HIC) must be present when there is Medicare B enrollment.	If entering a Medicare B Coverage record, ensure that the recipient has a Medicare ID entered.
Retroactive	Check Box	5001	Retroactive is required.	Field is default to 'no' (unchecked) when Effective and End dates are populated. Enter dates and check/uncheck box appropriately.

6.17.5 Medicare B Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 Medicare B Coverage Panel Accessibility

6.17.6.1 To Access the Medicare B Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.

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2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays.
6	Select **Medicare B Coverage**.	Medicare B Coverage panel displays.

6.17.6.2 To Add the Medicare B Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Retroactive** checkbox, if applicable.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Recipient Medicare B Coverage information is saved.

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6.17.6.3 To Update the Medicare B Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Recipient Medicare B Coverage information is saved.

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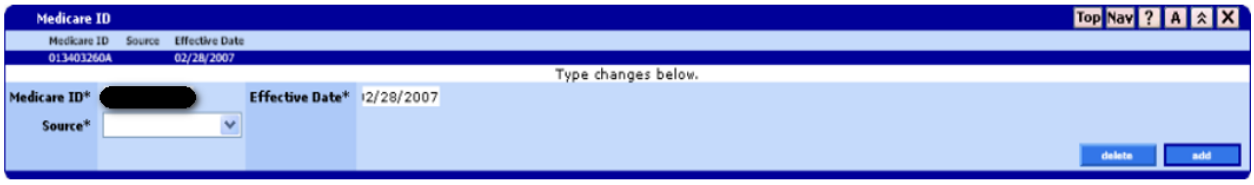
6.18 Medicare ID Panel Overview

6.18.1 Medicare ID Panel Narrative

The Medicare ID panel contains the Medicare ID, Source, and Effective Date for a recipient. Since Medicare ID information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted. Navigation Path: [Recipient] - [Information] - [Recipient Mini Search] – [Medicare] - [Medicare ID]

6.18.2 Medicare ID Panel Layout



6.18.3 Medicare ID Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Medicare ID information. This button is not utilized by Alabama.	Button	N/A	0
Delete	Allows the user to delete Medicare ID information. This button is not utilized by Alabama.	Button	N/A	0
Effective Date	Date the new Medicare ID was added and became effective. In Alabama, this is the date the Medicare ID was added to the EDS system.	Field	Date (MM/DD/CCYY)	8
Medicare ID	Recipient's current or previous Medicare ID (HIC).	Field	Character	12
Source	1 byte source indicator that specifies the external entity that triggered a HIC addition or update. All Medicare ID information in Alabama comes from the nightly AMAES update file.	Combo Box	Drop Down List Box	0

6.18.4 Medicare ID Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is inquiry only.				

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6.18.5 Medicare ID Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 Medicare ID Panel Accessibility

6.18.6.1 To Access the Medicare ID Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Medicare**.	A list of hyperlinks to panel(s) displays.
6	Select **Medicare ID**.	Medicare ID panel displays.

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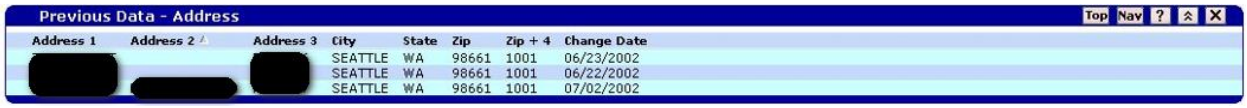
6.19 Previous Data - Address Panel Overview

6.19.1 Previous Data - Address Panel Narrative

The Previous Address panel is used to view previous known addresses for a recipient. If the main address for a recipient is changed, the previous address information is displayed here. If a recipient has more than one previous address, more than one row of data is displayed. The Address panel is inquiry only and is accessed through the Previous Data panel. The recipient's current address information is displayed on the Recipient Information panel.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - Address]

6.19.2 Previous Data - Address Panel Layout



6.19.3 Previous Data - Address Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Address line 1 of the recipient's previous address.	Listview	Character	30
Address 2	Address line 2 of the recipient's previous address.	Listview	Character	30
Address 3	Address line 3 of the recipient's previous address. This field is not utilized by Alabama.	Listview	Character	30
Change Date	Date the recipient's address changed.	Listview	Date (MM/DD/CCYY)	8
City	Previous city of the recipient.	Listview	Character	18
State	Previous state of the recipient.	Listview	Character	2
Zip	Recipient's previous zip code.	Listview	Number (Integer)	5
Zip +4	Recipient's previous zip code +4.	Listview	Number (Integer)	4

6.19.4 Previous Data - Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.19.5 Previous Data - Address Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 Previous Data - Address Panel Accessibility

6.19.6.1 To Access the Previous Data-Address Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-Address**.	Previous Data-Address panel displays.

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6.20 Previous Data - County Panel Overview

6.20.1 Previous Data - County Panel Narrative

The Previous County panel is used to view previous known counties for a recipient. If a recipient has more than one previous county, more than one row of data is displayed. The Previous County panel is inquiry only and is accessed through the Previous Data panel.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - County]

6.20.2 Previous Data - County Panel Layout

6.20.3 Previous Data - County Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Change Date	Date the recipient's county changed.	Listview	Date (MM/DD/CCYY)	8
County Code	Counties of prior residence.	Listview	Character	2
Office Code	County office of prior residence. This field is not utilized by Alabama..	Listview	Character	1

6.20.4 Previous Data - County Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.20.5 Previous Data - County Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.20.6 Previous Data - County Panel Accessibility

6.20.6.1 To Access the Previous Data-County Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.

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Step	Action	Response
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-County**.	Previous Data-County panel displays.

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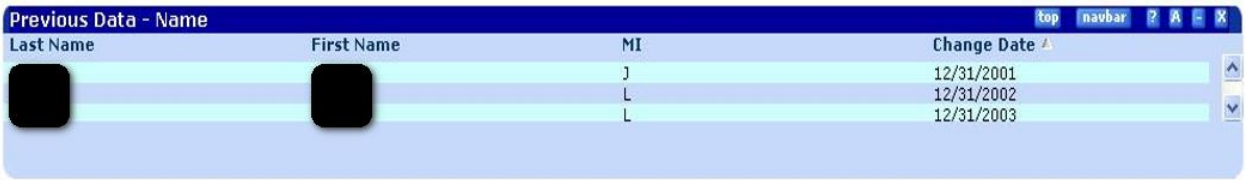
6.21 Previous Data - Name Panel Overview

6.21.1 Previous Data - Name Panel Narrative

The Previous Name panel is used to view previous known names for a recipient. The Previous Name panel is inquiry only and is accessed through the Previous Data panel. If a recipient has more than one previous name, more than one row of data is displayed.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - Name]

6.21.2 Previous Data - Name Panel Layout



6.21.3 Previous Data - Name Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Change Date	Date the recipient's name was changed.	Listview	Date (MM/DD/CCYY)	8
First Name	Previous first name of a recipient.	Listview	Character	13
Last Name	Previous last name of a recipient.	Listview	Character	15
MI	Previous middle initial of the recipient.	Listview	Character	1

6.21.4 Previous Data - Name Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.21.5 Previous Data - Name Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 Previous Data - Name Panel Accessibility

6.21.6.1 To Access the Previous Data-Name Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.

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Step	Action	Response
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-Name**.	Previous Data-Name panel displays.

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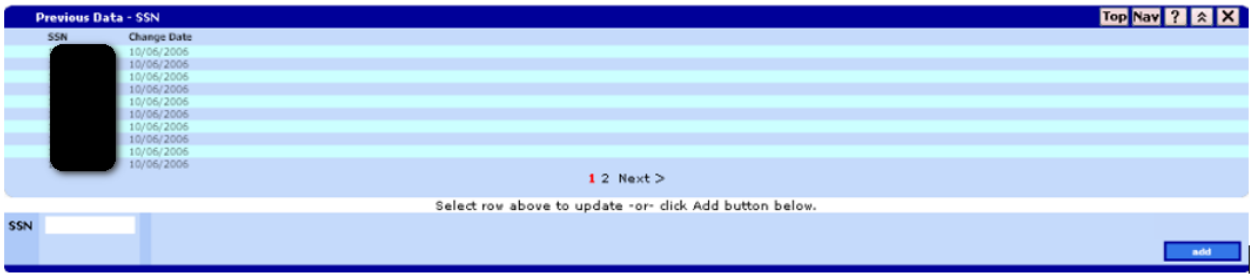
6.22 Previous Data - SSN Panel Overview

6.22.1 Previous Data - SSN Panel Narrative

The Previous SSN panel is used to view previous known Social Security Numbers for a recipient. The Previous SSN panel is inquiry only and is accessed through the Previous Data panel. If a recipient has more than one previous SSN, more than one row of data is displayed.

Navigation Path: [Recipient] - [Information] – [Recipient Mini Search] - [Previous Data] – [Previous Data - SSN]

6.22.2 Previous Data - SSN Panel Layout



6.22.3 Previous Data - SSN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add SSN information for a recipient. This button is not utilized by Alabama.	Button	N/A	0
Change Date	Date the recipient's SSN was changed.	Listview	Date (MM/DD/CCYY)	8
SSN	Social Security Number of the Recipient.	Listview	Number (Integer)	9

6.22.4 Previous Data - SSN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.22.5 Previous Data - SSN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.22.6 Previous Data - SSN Panel Accessibility

6.22.6.1 To Access the Recipient Previous Data-SSN Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Information**.	Recipient Mini Search panel displays.
3	Enter **Current ID** or **Case ID**.	
4	Click **Search**.	Recipient Information and Recipient Maintenance panels display.
5	Select **Previous Data**.	A list of hyperlinks to panel(s) displays.
6	Select **Previous Data-SSN**.	Previous Data-SSN panel displays.

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6.23 Related Data Page Overview

6.23.1 Related Data Page Narrative

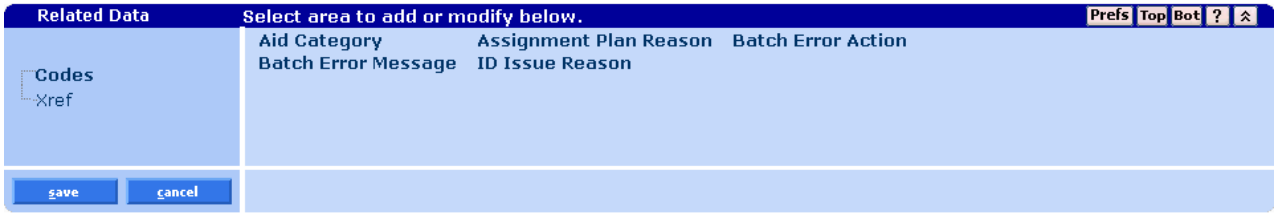
The Related Data page serves as a menu to Related Data panels. Sub-menu options include 'Codes and 'Xref'. The 'Codes' menu is the first to display. Users have the options of selecting 'Xref'.

This page is inquiry only.

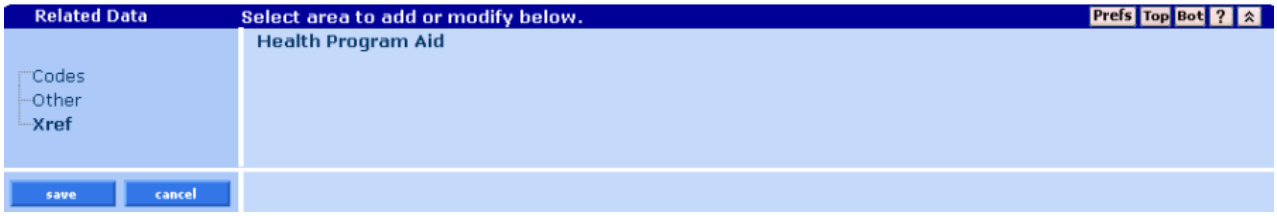
Navigation Path: [Recipient] - [Related Data]

6.23.2 Related Data Page Layout

Codes



Xref



6.23.3 Related Data Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Codes				
Aid Category	Link to the Aid Category panel.	Hyperlink	N/A	0
Assignment Plan Reason	Link to the Assignment Plan Reason panel.	Hyperlink	N/A	0
Batch Error Action	Link to the Batch Error Action panel. Used by DXC only.	Hyperlink	N/A	0
Batch Error Message	Link to the Batch Error Message panel. Used by DXC only.	Hyperlink	N/A	0
ID Issue Reason	Link to the ID Issue Reason panel.	Hyperlink	N/A	0
Xref				
Health Program Aid	Link to the Health Program Aid panel.	Hyperlink	N/A	0

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6.23.4 Related Data Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.23.5 Related Data Page Extra Features

Field	Field Type
No extra features found for this page.	

6.23.6 Related Data Page Accessibility

6.23.6.1 To Access the Related Data Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.

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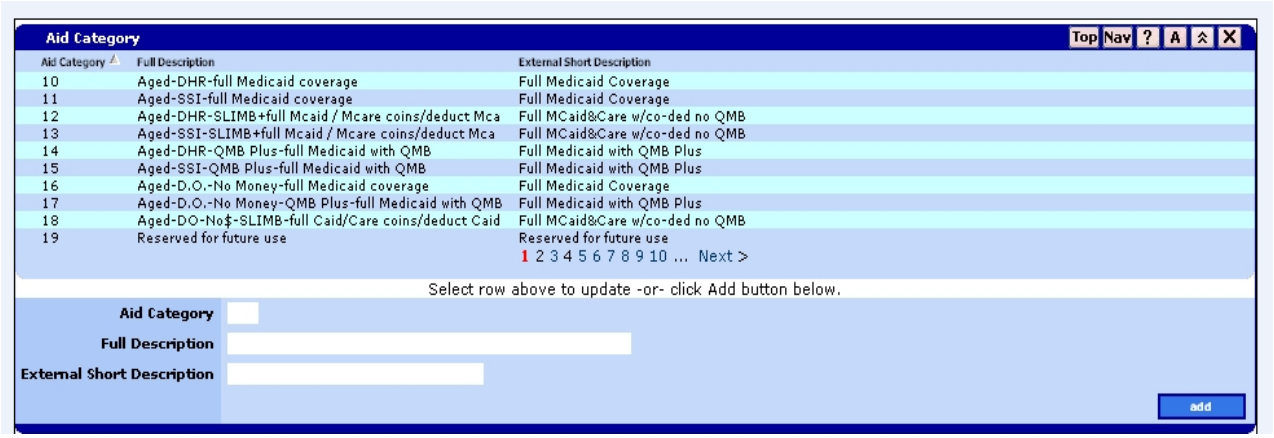
6.24 Aid Category Panel Overview

6.24.1 Aid Category Panel Narrative

The Aid Category panel stores the valid aid category codes and associated descriptions for Alabama. This is a code table panel that is updateable to those with the proper security access.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Aid Category]

6.24.2 Aid Category Panel Layout



6.24.3 Aid Category Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Aid Category record.	Button	N/A	0
Aid Category	Identifies the type of aid for which a recipient is eligible.	Field	Character	2
External Short Description	This description is used for display for providers and other external entities.	Field	Character	31
Full Description	Describes the type of aid for which a recipient is eligible. This is the full description that is used internally.	Field	Character	50

6.24.4 Aid Category Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Category	Field	5001	Aid Category is required.	Enter value or cancel transaction.
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.

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Field	Field Type	Error Code	Error Message	To Correct
Full Description	Field	5001	Full Description is required.	Enter Full Description or cancel transaction.

6.24.5 Aid Category Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.24.6 Aid Category Panel Accessibility

6.24.6.1 To Access the Aid Category Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Click the **Aid Category** hyperlink.	Aid Category panel displays.

6.24.6.2 To Add Aid Category Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Aid Category**.	
3	Enter **Full Description**.	
4	Enter **External Short Description**.	
5	Click **Save**.	Aid Category information is saved.

6.24.6.3 To Update Aid Category Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in **Full Description or External Short Description** field to update and perform update.	
3	Click **Save**.	Aid Category information is saved.

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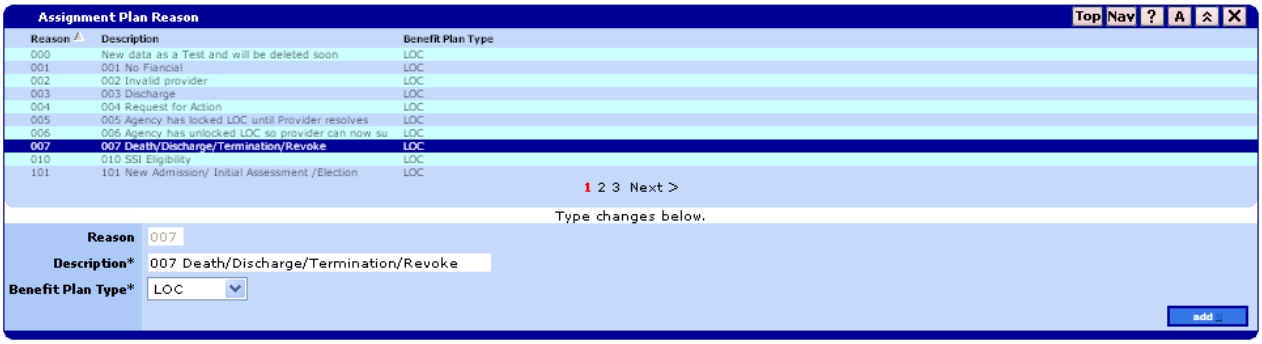
6.25 Assignment Plan Reason Panel Overview

6.25.1 Assignment Plan Reason Panel Narrative

The Assignment Plan Reason panel stores the valid assignment plan reason codes and associated descriptions and benefit plan types for Alabama. This is a code table panel that is updateable to those with the proper security access.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Assignment Plan Reason]

6.25.2 Assignment Plan Reason Panel Layout



6.25.3 Assignment Plan Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Assignment Plan Reason information.	Button	N/A	0
Benefit Plan Type	Benefit Plan Type associated with the reason code. Valid Values: Hospice LOC Lockin Waiver	Combo Box	Drop Down List Box	0
Description	Description associated with the reason code.	Field	Character	50
Reason	Code indicating the reason for the assignment plan.	Field	Character	3

6.25.4 Assignment Plan Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Type	Combo Box	N/A	A valid Benefit Plan Type is required	Select a Benefit Plan Type from the dropdown box.
Description	Field	N/A	Description is required.	Enter a Description.

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Field	Field Type	Error Code	Error Message	To Correct
Reason	Field	N/A	Reason is required.	Enter a Reason.

6.25.5 Assignment Plan Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 Assignment Plan Reason Panel Accessibility

6.25.6.1 To Access the Assignment Plan Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Assignment Plan Reason**.	Assignment Plan Reason panel displays.

6.25.6.2 To Add Assignment Plan Reason Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Reason**.	
3	Enter **Description**.	
4	Select **Benefit Plan Type** from drop down list box.	
5	Click **Save**.	Assignment Plan Reason information is saved.

6.25.6.3 To Update Assignment Plan Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Assignment Plan Reason information is updated.

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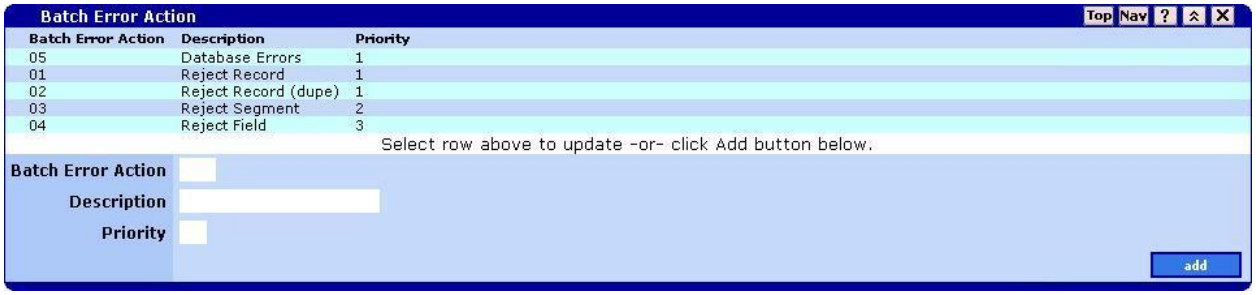
6.26 Batch Error Action Panel Overview

6.26.1 Batch Error Action Panel Narrative

The Batch Error Action panel contains the valid action codes, descriptions, and priorities that can be used when setting up batch errors for PS/2 processing. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Batch Error Action]

6.26.2 Batch Error Action Panel Layout



6.26.3 Batch Error Action Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Batch Error Action record.	Button	N/A	0
Batch Error Action	Indicates the action to be taken when an error fails on the PS/2 transaction.	Field	Number (Integer)	2
Description	Verbal description of the action to be taken when the error fails. This is used on the error report.	Field	Character	20
Priority	Indicates the report priority for the error. Valid values are 1-5. A priority of 1 has the highest and is fatal. Priorities of 2-4 are non-fatal.	Field	Number (Integer)	1

6.26.4 Batch Error Action Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Error Action	Field	5001	Batch Error Action is required.	Enter value or cancel transaction.
	Field	5010	Batch Error Action must be Numeric.	Edit entry to a numeric value or cancel transaction.
	Field	5018	Batch Error Action must be 2 character(s) in length.	Enter value of the correct length or cancel transaction.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
Description	Field	5001	Description is required.	Enter Description or cancel transaction.
Priority	Field	5001	Priority is required.	Enter value or cancel transaction.
	Field	5010	Priority must be Numeric.	Edit entry to a numeric value or cancel transaction.

6.26.5 Batch Error Action Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.26.6 Batch Error Action Panel Accessibility

6.26.6.1 To Access the Batch Error Action Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Batch Error Action**.	Batch Error Action panel displays.

6.26.6.2 To Add Batch Error Action Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Batch Error Action**.	
3	Enter **Description**.	
4	Enter **Priority**.	
5	Click **Save**.	Batch Error Action information is saved.

6.26.6.3 To Update Batch Error Action Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Batch Error Action information is saved.

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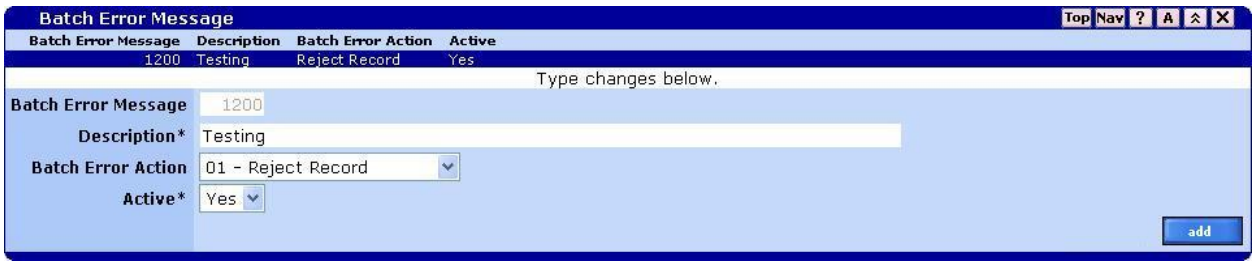
6.27 Batch Error Message Panel Overview

6.27.1 Batch Error Message Panel Narrative

The Batch Error Message panel contains error number and messages for use in the PS/2 Update Process. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [Batch Error Message]

6.27.2 Batch Error Message Panel Layout



6.27.3 Batch Error Message Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active	Indicates status of error message, either a Yes or No.	Combo Box	Drop Down List Box	0
Add	Allows the user to add a new Batch Error Message record.	Button	N/A	0
Batch Error Action	Indicates the action to be taken when an error fails on the PS/2 transaction.	Combo Box	Drop Down List Box	0
Batch Error Message	Error number for a batch edit error.	Field	Character	4
Description	Describes the edit error for batch processing.	Field	Character	75

6.27.4 Batch Error Message Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Batch Error Message	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
	Field	5500	Enter a valid value.	Verify entry is numeric.
Description	Field	5001	Description is required.	Enter Description or cancel transaction.

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6.27.5 Batch Error Message Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Batch Error Message Panel Accessibility

6.27.6.1 To Access the Batch Error Message Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	
4	Select **Batch Error Message**.	Batch Error Message panel displays.

6.27.6.2 To Add the Batch Error Message Panel

Step	Action	Response
1	Click **Add.**	Activates fields for entry of data or selection from lists.
2	Enter **Batch Error Message**.	
3	Enter **Description**.	
4	Select a **Batch Error Action** code from the drop down list box.	
5	Select an **Active** code from the drop down list box.	
6	Click **Save**.	Batch Error Message information is saved.

6.27.6.3 To Update the Batch Error Message Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Batch Error Message information is saved.

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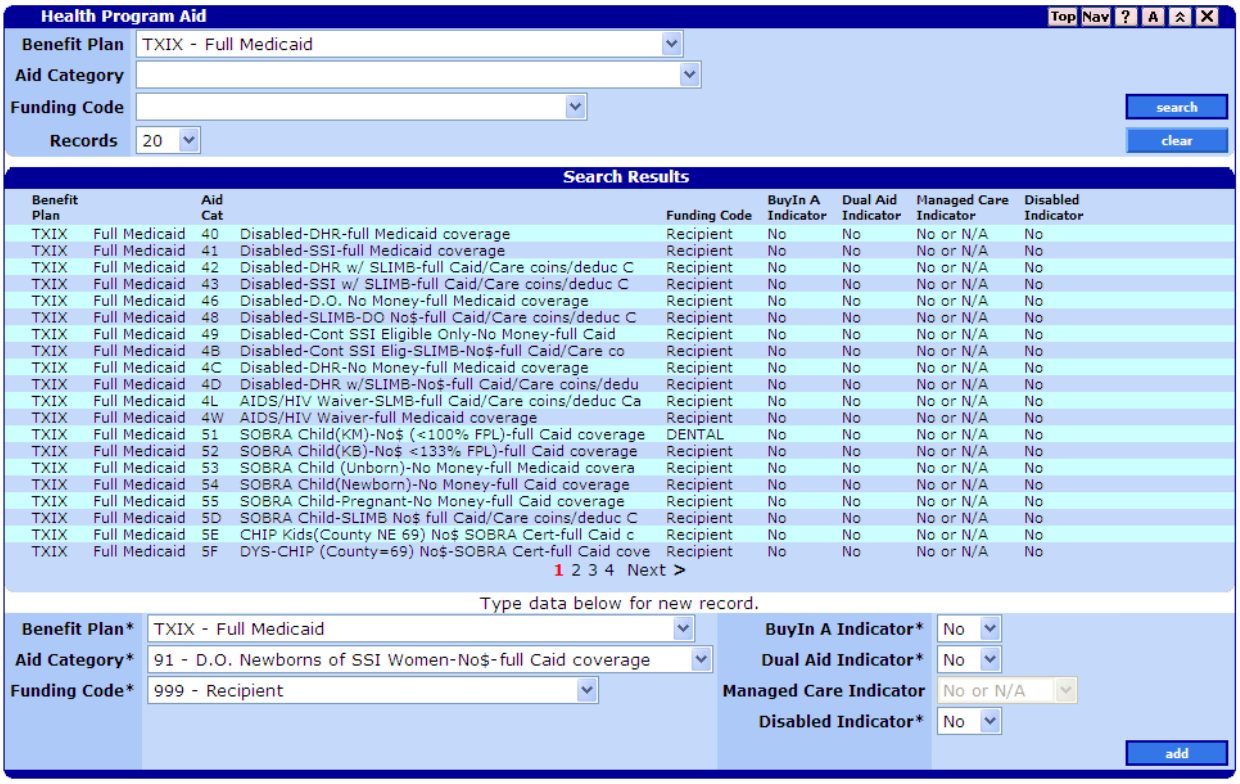
6.28 Health Program Aid Panel Overview

6.28.1 Health Program Aid Panel Narrative

The Health Program Aid panel maintains the list of valid health plan programs and aid category combinations. Users have the ability to 'filter' results by benefit plan or aid category. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Xref] - [Health Program Aid]

6.28.2 Health Program Aid Panel Layout



6.28.3 Health Program Aid Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Health Program Aid information.	Button	N/A	0
Aid Category	Type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	0
Benefit Plan	Benefit Plan associated with the corresponding health program. Benefit Plan is a classification of benefits a recipient can receive.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Buy In A Indicator	Buy-In A Indicator. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0
Clear	Allows the user to clear any changes on the Health Program Aid panel.	Button	N/A	0
Disabled Indicator	Disabled Indicator. Field not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Dual Aid Indicator	Dual Aid Indicator. Field not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Funding Code	Financial fund code. This field is not utilized by Alabama. Indicator will always default to 'N'.	Combo Box	Drop Down List Box	0
Managed Care Indicator	Managed Care Indicator. Indicates which aid cats are valid for which recipients within Patient 1st. Valid values are: B = Both, H = Health Home, P = Patient 1st, and N = N/A (should be used on all other plans).	Combo Box	Drop Down List Box	0
Records	Number of search items displayed on each page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Benefit Plan, Aid Category and/or Funding Code.	Button	N/A	0

6.28.4 Health Program Aid Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Category	Combo Box	5029	A valid Aid Category is required.	Select a valid item or cancel transaction.
Benefit Plan	Combo Box	5029	A valid Benefit Plan is required.	Select a valid item or cancel transaction.
	Combo Box	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.
Buy In A Indicator	Combo Box	5001	Buy-In A Indicator is required.	Select indicator from list.
Disabled Indicator	Combo Box	5001	Disabled Indicator is required.	Select indicator from list.
Dual Aid Indicator	Combo Box	5001	Dual Aid Indicator is required.	Select indicator from list.

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Field	Field Type	Error Code	Error Message	To Correct
Funding Code	Combo Box	5029	A valid Funding Code is required.	Select a valid item or cancel transaction.
		1001	Fund code selected is inactive	Select a fund code that is active
Managed Care Indicator	Combo Box	5001	Managed Care Indicator is required.	Select indicator from list.

6.28.5 Health Program Aid Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Health Program Aid Panel Accessibility

6.28.6.1 To Access the Health Program Aid Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the **Related Data** page.	
4	Select **Health Program Aid**.	Health Program Aid panel displays.

6.28.6.2 To Add the Health Program Aid Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select a response from the **Benefit Plan** drop down list box.	
3	Select a response from the **Aid Category** drop down list box.	
4	Select a response from the **Funding Code** drop down list box.	
5	Select a response from the **Buy-In A Indicator** drop down list box.	
6	Select a response from the **Dual Aid Indicator** drop down list box.	
7	Select a response from the **Managed Care Indicator** drop down list box.	
8	Select a response from the **Disabled Indicator** drop down list box.	

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Step	Action	Response
9	Click **Save**.	Health Program Aid information is saved.

6.28.6.3 To Update the Health Program Aid Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	Health Program Aid information is saved.

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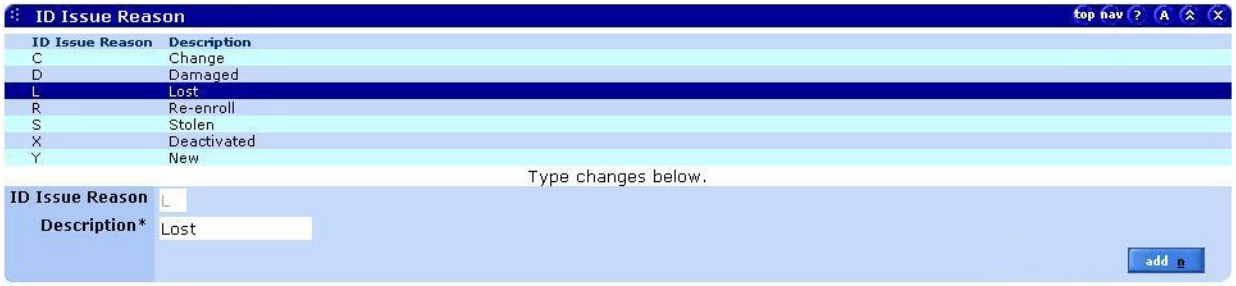
6.29 ID Issue Reason Panel Overview

6.29.1 ID Issue Reason Panel Narrative

The ID Issue Reason panel stores the reason codes and descriptions for issuing an ID card. This panel is used and maintained by DXC users only.

Navigation Path: [Recipient] - [Related Data] - [Codes] - [ID Issue Reason]

6.29.2 ID Issue Reason Panel Layout



6.29.3 ID Issue Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an ID Issue Reason code.	Button	N/A	0
Description	Actual description the ID card was issued.	Field	Character	15
ID Issue Reason	Reason Code for issuing the Recipient's ID Card.	Field	Character	1

6.29.4 ID Issue Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	5001	Description is required.	Enter description or cancel transaction.
ID Issue Reason	Field	5001	ID Issue Reason is required.	Enter value or cancel transaction.
	Field	5200	A duplicate record cannot be saved.	Verify entries and edit appropriately to create a unique entry.

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6.29.5 ID Issue Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 ID Issue Reason Panel Accessibility

6.29.6.1 To Access the ID Issue Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the **Related Data** panel.	
4	Select **ID Issue Reason**.	ID Issue Reason panel displays.

6.29.6.2 To Add the ID Issue Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ID Issue Reason**.	
3	Enter **Description**.	
4	Click **Save**.	ID Issue Reason information is saved.

6.29.6.3 To Update the ID Issue Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	ID Issue Reason information is saved.

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6.30 EDB Search Panel Overview

6.30.1 EDB Search Panel Narrative

The EDB Search panel allows a user to search for EDB information from the EDB (Enrollment Database) file for a recipient. The search criteria includes Medicaid ID, SSN and HIC numbers. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information are displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search]

6.30.2 EDB Search Panel Layout

6.30.3 EDB Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear out all fields from the search fields.	Button	N/A	0
Date Processed	Date updated by AMMIS.	Listview	Date (MM/DD/CCYY)	8
DOB	Date of Birth of a recipient.	Listview	Date (MM/DD/CCYY)	8
First Name	First Name of a recipient.	Listview	Character	15
HIC	Recipient Medicare ID.	Field/Listview	Character	11
Last Name	Last Name of a recipient.	Listview	Character	24
Medicaid ID	State Recipient ID Number.	Field/Listview	Character	12
MI	Middle Initial of a recipient.	Listview	Character	1
Records	Records - Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Search	Allows the user to return search results based on the entered search criteria.	Button	N/A	0
Sex	Gender code for a recipient.	Listview	Character	1
SSN	Social Security Number of a recipient.	Field/Listview	Number (Integer)	9

6.30.4 EDB Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 EDB Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 EDB Search Panel Accessibility

6.30.6.1 To Access the EDB Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.

6.30.6.2 To Navigate the EDB Search Panel

Step	Action	Response
1	Enter **Medicaid ID**, **SSN** or **HIC**.	
2	Click **Search**.	EDB Entitlement Information and EDB Maintenance panels display.

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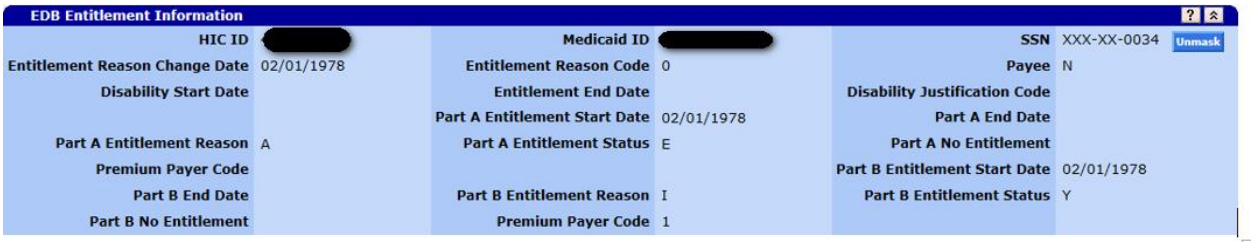
6.31 EDB Entitlement Information Panel Overview

6.31.1 EDB Entitlement Information Panel Narrative

The EDB Entitlement Information panel allows the user to view the EDB base information from the EDB (Enrollment Database) file for a member. Information from this panel is used to help assign Medicare Part A and B coverage to recipients. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] - [EDB Entitlement Information]

6.31.2 EDB Entitlement Information Panel Layout



6.31.3 EDB Entitlement Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Disability Justification Code	The justification for a beneficiary's Part A and/or Part B Medicare entitlement dates based upon his/her disability insurance benefits (DIB) status.	Field	Character	1
Disability Start Date	Date a beneficiary became entitled to Disability Insurance Benefits.	Field	Date (MM/DD/CCYY)	8
Entitlement End Date	Last date through which a beneficiary is entitled to Disability Insurance Benefits.	Field	Date (MM/DD/CCYY)	8
Entitlement Reason Change Date	Date the Reason for Entitlement or Termination of Entitlement for a Beneficiary was changed according to the EDB file from CMS.	Field	Date (MM/DD/CCYY)	8
Entitlement Reason Code	Reason for Entitlement or Termination of Entitlement for a Beneficiary.	Field	Character	1
HIC ID	Recipient's Medicare ID.	Field	Character	11

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Field	Description	Field Type	Data Type	Length
Medicaid ID	Recipient’s Medicaid ID.	Field	Character	25
Part A End Date	Last date through which a beneficiary is entitled to Part A benefits. After this date, the Part A benefits are terminated. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Part A Entitlement Reason	Reason code for a Beneficiary's Enrollment to Part A Benefits.	Field	Character	1
Part A Entitlement Start Date	Date a beneficiary became entitled to Part A Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Part A Entitlement Status	Reason for Entitlement or Termination of a Beneficiary's Part A Benefits during a period of coverage. (Source: SSA / RRB).	Field	Character	1
Part A No Entitlement	Code that occurs when there is No Part A Entitlement Date.	Field	Character	1
Part B End Date	Last date through which a beneficiary is entitled to Part B benefits. After this date, the Part B benefits are terminated. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Part B Entitlement Reason	Reason code for a Beneficiary's Enrollment to Part B Benefits.	Field	Character	1
Part B Entitlement Start Date	Date a beneficiary became entitled to Part B Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Part B Entitlement Status	Reason for Entitlement or Termination of a Beneficiary's Part B Benefits during a period of coverage. (Source: SSA / RRB).	Field	Character	1
Part B No Entitlement	Code that occurs when there is No Part B Entitlement Date.	Field	Character	1
Payee	Yes or No (Y or N) indicator specifying if the beneficiary has a Representative Payee.	Field	Character	1
Premium Payer Code (Part A)	Identifier for the Third Party Agency responsible for paying a Medicare beneficiary's Part A premiums.	Field	Character	1
Premium Payer Code (Part B)	Identifier for the Third Party Agency responsible for paying a Medicare beneficiary's Part B premiums.	Field	Character	1
SSN	Recipient’s Social Security Number.	Field	Character	9

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Field	Description	Field Type	Data Type	Length
Unmask	Unmask button helps to unmask SSN field.	Button	N/A	0

6.31.4 EDB Entitlement Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.31.5 EDB Entitlement Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 EDB Entitlement Information Panel Accessibility

6.31.6.1 To Access the EDB Entitlement Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	**EDB Entitlement Information** and EDB Maintenance panels display.

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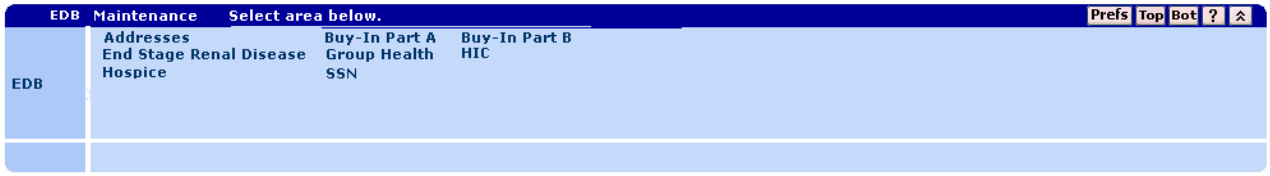
6.32 EDB Entitlement Maintenance Panel Overview

6.32.1 EDB Entitlement Maintenance Panel Narrative

The EDB Entitlement Maintenance panel is the access point for EDB maintenance within the Recipient system. Users can choose from a list of panels. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] -[EDB Search Results] - [EDB Entitlement Maintenance]

6.32.2 EDB Entitlement Maintenance Panel Layout



6.32.3 EDB Entitlement Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Addresses	Link to the Addresses panel.	Hyperlink	N/A	0
Buy-In Part A	Link to the Buy-In Part A panel.	Hyperlink	N/A	0
Buy-In Part B	Link to the Buy-In Part B panel.	Hyperlink	N/A	0
End Stage Renal Disease	Link to the End Stage Renal Disease panel.	Hyperlink	N/A	0
Group Health	Link to the Group Health panel.	Hyperlink	N/A	0
HIC	Link to the HIC panel.	Hyperlink	N/A	0
Hospice	Link to the Hospice panel.	Hyperlink	N/A	0
SSN	Link to the SSN panel.	Hyperlink	N/A	0

6.32.4 EDB Entitlement Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.32.5 EDB Entitlement Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.32.6 EDB Entitlement Maintenance Panel Accessibility

6.32.6.1 To Access the EDB Entitlement Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Maintenance panel displays.

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6.33 EDB Addresses Panel Overview

6.33.1 EDB Addresses Panel Narrative

The EDB Addresses panel allows the user to view the address as listed on the EDB (Enrollment Database) file. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Addresses]

6.33.2 EDB Addresses Panel Layout

6.33.3 EDB Addresses Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	Mailing address #1 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 2	Mailing address #2 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 3	Mailing address #3 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 4	Mailing address #4 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 5	Mailing address #5 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22
Address 6	Mailing address #6 where the beneficiary or the beneficiary's representative payee can be contacted.	Field	Character	22

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Field	Description	Field Type	Data Type	Length
Change Date	Date on which the beneficiary's Zip Code, State Code, County Code, or District Office last changed. (Source: SSA / RRB).	Field	Date (MM/DD/CCYY)	8
Zip Code	Zip Code of the Mailing Address where the beneficiary may be contacted. (Source: SSA /RRB).	Field	Character	9

6.33.4 EDB Addresses Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 EDB Addresses Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 EDB Addresses Panel Accessibility

6.33.6.1 To Access the EDB Addresses Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Addresses**.	EDB Addresses panel displays.

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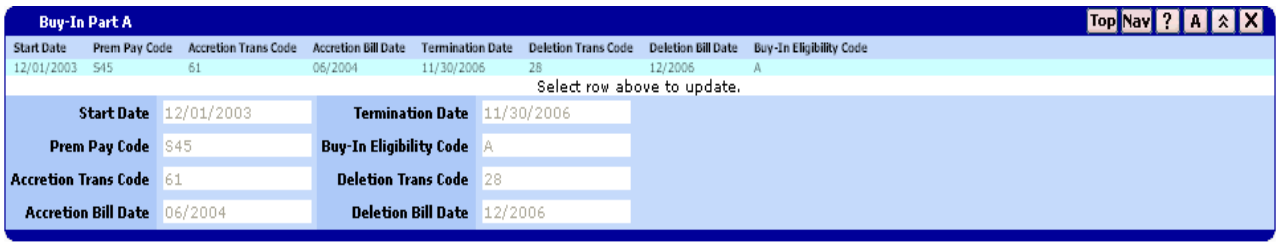
6.34 EDB Buy-In Part A Panel Overview

6.34.1 EDB Buy-In Part A Panel Narrative

The EDB Buy-In Part A panel allows the user to view the Buy-In Part A information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Buy-In Part A]

6.34.2 EDB Buy-In Part A Panel Layout



6.34.3 EDB Buy-In Part A Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accretion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency's Part A Accretion.	Field	Date (MM/CCYY)	6
Accretion Trans Code	Numeric code indicating the accretion of a beneficiary to a Third Party Agency that is responsible for paying the Part A Medicare premium.	Field	Character	4
Buy In Eligibility Code	Code that indicates the reason for State Buy-In Eligibility.	Field	Character	1
Deletion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency Part A Deletion Action.	Field	Date (MM/CCYY)	6
Deletion Trans Code	Code that indicates the reason for Deletion of a Beneficiary from a Third Party Part A Agency.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
Prem Pay Code	Identifier for a Third Party Agency (Either a Private Group or a State Buy-In Agency) responsible for paying a Medicare beneficiary's Part A premiums.	Field	Character	3
Start Date	Day a beneficiary became entitled to Part A Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Termination Date	Last date of a Private Third Party Group's or State's liability for a beneficiary's Part A premium.	Field	Date (MM/DD/CCYY)	8

6.34.4 EDB Buy-In Part A Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.34.5 EDB Buy-In Part A Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 EDB Buy-In Part A Panel Accessibility

6.34.6.1 To Access the EDB Buy-In Part A Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Buy-In Part A**.	EDB Buy-In Part A panel displays.

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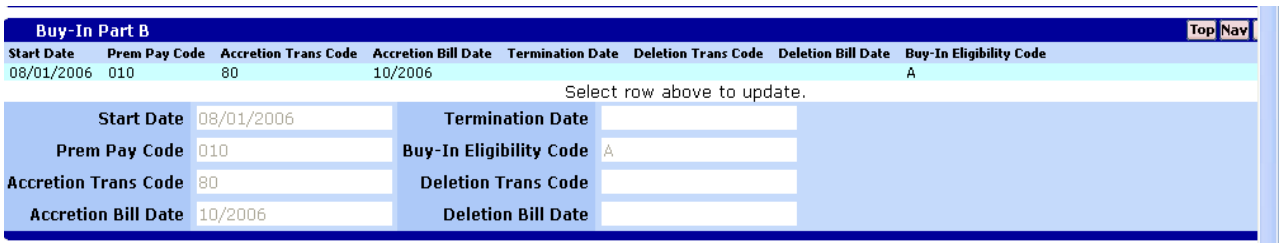
6.35 EDB Buy-In Part B Panel Overview

6.35.1 EDB Buy-In Part B Panel Narrative

The EDB Buy-In Part B panel allows the user to view the Buy-In Part B information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Buy-In Part B]

6.35.2 EDB Buy-In Part B Panel Layout



6.35.3 EDB Buy-In Part B Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accretion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency's Part B Accretion.	Field	Date (MM/CCYY)	6
Accretion Trans Code	Numeric code indicating the accretion of a beneficiary to a Third Party Agency that is responsible for paying the Part B Medicare premium.	Field	Character	4
Buy In Eligibility Code	Code that indicates the reason for State Buy-In Eligibility.	Field	Character	1
Deletion Bill Date	Date indicating the year and month that the Third Party System processed a Third Party Agency Part B Deletion Action.	Field	Date (MM/CCYY)	6
Deletion Trans Code	Code that indicates the reason for Deletion of a Beneficiary from a Third Party Part B Agency.	Field	Character	4

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Field	Description	Field Type	Data Type	Length
Prem Pay Code	Identifier for a Third Party Agency (Either a Private Group or a State Buy-In Agency) responsible for paying a Medicare beneficiary's Part B premiums.	Field	Character	3
Start Date	Day a beneficiary became entitled to Part B Medicare benefits.	Field	Date (MM/DD/CCYY)	8
Termination Date	Last date of a Private Third Party Group's or State's liability for a beneficiary's Part B premium.	Field	Date (MM/DD/CCYY)	8

6.35.4 EDB Buy-In Part B Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.35.5 EDB Buy-In Part B Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 EDB Buy-In Part B Panel Accessibility

6.35.6.1 To Access the EDB Buy-In Part B Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID, SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Buy-In Part B**.	EDB Buy-In Part B panel displays.

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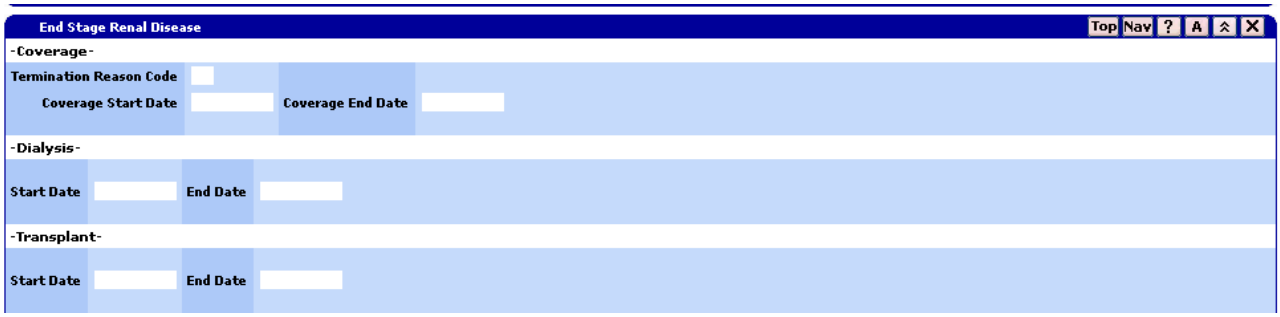
6.36 EDB End Stage Renal Disease Panel Overview

6.36.1 EDB End Stage Renal Disease Panel Narrative

The EDB End Stage Renal Disease panel allows the user to view the End Stage Renal Disease (ESRD) information from the EDB (Enrollment Database) file for a specific member. The information includes the start and termination dates for coverage, dialysis, and transplant information, plus the reason for coverage termination. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [End Stage Renal Disease]

6.36.2 EDB End Stage Renal Disease Panel Layout



6.36.3 EDB End Stage Renal Disease Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coverage End Date	Date on which the Beneficiary is no longer Entitled to Medicare under ESRD provisions.	Field	Date (MM/DD/CCYY)	8
Coverage Start Date	Date on which the Beneficiary is Entitled to Medicare in some part, because of a diagnosis of End Stage Renal Disease.	Field	Date (MM/DD/CCYY)	8
Dialysis Start Date	Date that indicates when ESRD Dialysis started.	Field	Date (MM/DD/CCYY)	8
Dialysis End Date	Date that indicates when ESRD Dialysis ended.	Field	Date (MM/DD/CCYY)	8
Termination Reason Code	Code that indicates the reason Medicare-Based End Stage Renal Disease Coverage was Terminated.	Field	Character	1
Transplant Start Date	Date that indicates when a Kidney Transplant Operation occurred.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Transplant End Date	Date that indicates when a Kidney Transplant Failed.	Field	Date (MM/DD/CCYY)	8

6.36.4 EDB End Stage Renal Disease Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.36.5 EDB End Stage Renal Disease Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 EDB End Stage Renal Disease Panel Accessibility

6.36.6.1 To Access the EDB End Stage Renal Disease Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **End Stage Renal Disease**.	EDB End Stage Renal Disease panel displays.

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6.37 EDB Group Health Panel Overview

6.37.1 EDB Group Health Panel Narrative

The EDB Group Health panel allows the user to view Group Health information from the EDB (Enrollment Database) file for a member. This Group Health information includes both enrollment and personal benefits. Information on this panel is used in Medicare Advantage enrollment as part of Managed Care. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [Group Health]

6.37.2 EDB Group Health Panel Layout

6.37.3 EDB Group Health Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Contract #	Number identifying a particular GHO Enrollment. Use CMS's Online Systems to associate the Contractor Number with a GHO Plan Name.	Listview	Character	5
Disenrollment Date	Date that a Beneficiary's Enrollment in a Group Health Organization Terminates.	Listview	Date (MM/DD/CCYY)	8
Enrollment Start Date	Date of a Beneficiary's Enrollment in a GHO.	Listview	Date (MM/DD/CCYY)	8
GHP Enrollment Effective Date	Date the beneficiary's Group Health Program (GHP) Enrollment becomes effective.	Field	Date (MM/DD/CCYY)	8
PBP Coverage TypeCode	Beneficiary's Personal Benefits Package Type Code.	Field	Character	2
PBP End Date	Date the beneficiary's Personal Benefits Package ends.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
PBP Number	The beneficiary's Personal Benefits Package Number.	Field	Character	3
PBP Start Date	Date the beneficiary starts their Personal Benefits Package.	Field	Date (MM/DD/CCYY)	8

6.37.4 EDB Group Health Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.37.5 EDB Group Health Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 EDB Group Health Panel Accessibility

6.37.6.1 To Access the EDB Group Health Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Group Health**.	EDB Group Health panel displays**.**

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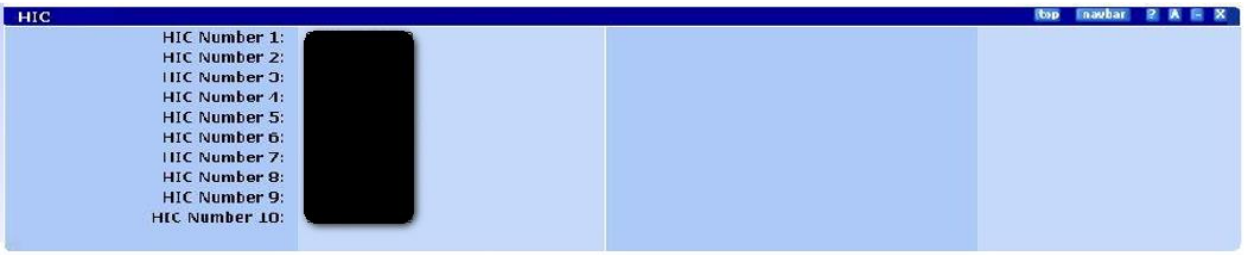
6.38 EDB HIC Panel Overview

6.38.1 EDB HIC Panel Narrative

The EDB HIC panel allows the user to view the HIC number (Medicare ID) information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, "Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment." Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [HIC]

6.38.2 EDB HIC Panel Layout



6.38.3 EDB HIC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
HIC Number	Benefit claim number. Occurs up to 10 times.	Listview	Character	1

6.38.4 EDB HIC Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.38.5 EDB HIC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.38.6 EDB HIC Panel Accessibility

6.38.6.1 To Access the EDB HIC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **HIC**.	EDB HIC panel displays.

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6.39 EDB Hospice Panel Overview

6.39.1 EDB Hospice Panel Narrative

The EDB Hospice panel allows the user to view Hospice information from the EDB (Enrollment Database) file for a Buy-In member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Maintenance] - [Hospice]

6.39.2 EDB Hospice Panel Layout

6.39.3 EDB Hospice Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Coverage Processing Date	Date the Hospice Relation was updated on the EDB.	Listview	Date (MM/DD/CCYY)	8
Coverage Start Date	Elected start date of a Beneficiary's period of Hospice Coverage.	Listview	Date (MM/DD/CCYY)	8
Coverage Termination Date	Termination date of a Beneficiary's period of Hospice Coverage.	Listview	Date (MM/DD/CCYY)	8

6.39.4 EDB Hospice Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.39.5 EDB Hospice Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.39.6 EDB Hospice Panel Accessibility

6.39.6.1 To Access the EDB Hospice Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **Hospice**.	EDB Hospice panel displays.

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6.40 EDB SSN Panel Overview

6.40.1 EDB SSN Panel Narrative

The EDB SSN panel allows the user to view the list of past Social Security Number information from the EDB (Enrollment Database) file for a member. EDB information is transmitted from the Alabama Medicaid Agency bi-monthly, as received from CMS. Per the CMS website, “Medicare's Enrollment Database (EDB) is the authoritative source for all Medicare entitlement information. This database contains information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.” Only those recipients who have EDB information will have data displayed on this panel. This panel is inquiry only.

Navigation Path: [Recipient] - [EDB Search] – [EDB Search Results] – [EDB Entitlement Maintenance] - [SSN]

6.40.2 EDB SSN Panel Layout

6.40.3 EDB SSN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
SSN Number	Social Security number of a member. Occurs up to 5 times.	Listview	Number (Integer)	9

6.40.4 EDB SSN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.40.5 EDB SSN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 EDB SSN Panel Accessibility

6.40.6.1 To Access the EDB SSN Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **EDB Search**.	EDB Search panel displays.
3	Enter **Medicaid ID**, **SSN** or **HIC**.	

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Step	Action	Response
4	Select **Search**.	EDB Entitlement Information and EDB Maintenance panels display.
5	Select **SSN**.	EDB SSN panel displays.

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6.41 Case Search Panel Overview

6.41.1 Case Search Panel Narrative

The Case Search panel allows the user to locate Case (Payee) information by selecting Search By criteria. The listed information differs based on search criteria selected. Users may search by Case Number (Payee ID) or Current ID.

Navigation Path: [Recipient] - [Case Search]

6.41.2 Case Search Panel Layout

6.41.3 Case Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the ID number given to the responsible party-guardian.	Field	Number (Integer)	12
Clear	Allows the user to clear any changes made on the Case Search panel.	Button	N/A	0
Current ID	Case head's Medicaid identification number.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Case Number or Current ID.	Button	N/A	0

6.41.4 Case Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Case Number	Field	9000	Case ID must be Alpha Numeric.	Enter an alphanumeric value.
Search	Button	9000	At least one search field should be entered for search criteria.	An entry is required to search for a case. Type in the Case ID or Current ID.

6.41.5 Case Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.41.6 Case Search Panel Accessibility

6.41.6.1 To Access the Case Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.

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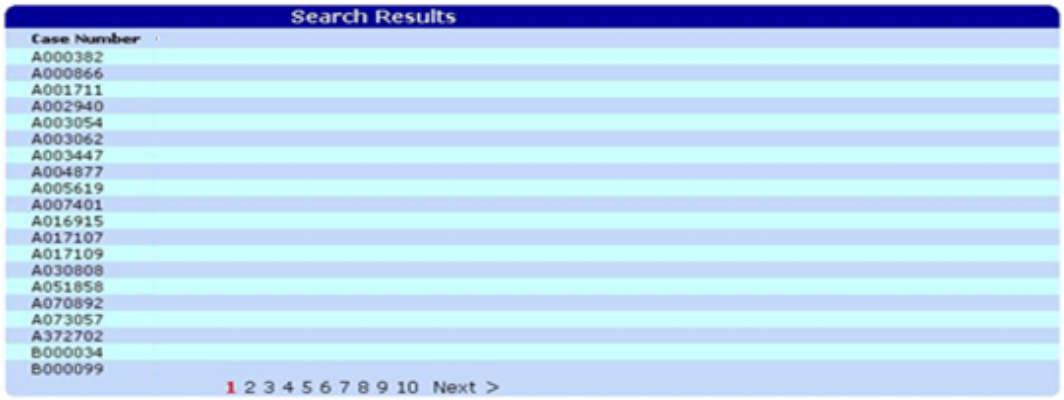
6.42 Case Search Results Panel Overview

6.42.1 Case Search Results Panel Narrative

The Case Search Results data list is displayed as a result of the user clicking the search button on the Case Search panel. If, based on the criteria entered, there are multiple records that match the user's search criteria, the data list is displayed listing all the matching records. If only one match is found, the data list is not displayed. Instead, the Case Information panel for the selected record is displayed.

Navigation Path: [Recipient] – [Case Search] – [Case Search Results]

6.42.2 Case Search Results Panel Layout



6.42.3 Case Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the ID number given to the responsible party-guardian.	Listview	Character	12

6.42.4 Case Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.42.5 Case Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.42.6 Case Search Results Panel Accessibility

6.42.6.1 To Access the Case Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name**, or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.

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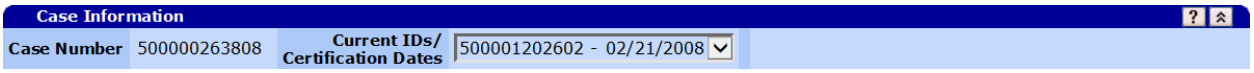
6.43 Case Information Panel Overview

6.43.1 Case Information Panel Narrative

The Case Information panel contains basic information about a Case (Payee). All Case information displayed on the panel comes directly from the nightly eligibility update file. Update access will not be granted. This panel is display only.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results] – [Case Information]

6.43.2 Case Information Panel Layout



6.43.3 Case Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the identification number given to the responsible party-guardian.	Field	Character	12
Current IDs/Certification Dates	List of all the recipients who have belonged to the Case and the dates they became certified in the Case. Certification Date is the date the Case was added to the system.	Combo Box	Drop Down List Box	0

6.43.4 Case Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.43.5 Case Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Case Information Panel Accessibility

6.43.6.1 To Access the Case Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.

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Step	Action	Response
5	Click to highlight the row.	**Case Information** and Case Maintenance panels display.

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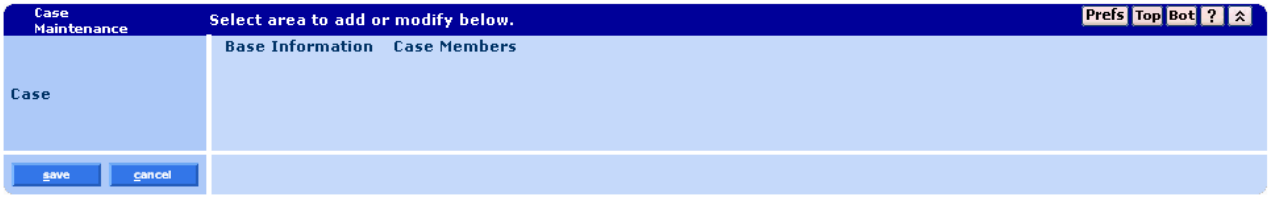
6.44 Case Maintenance Panel Overview

6.44.1 Case Maintenance Panel Narrative

The Case Maintenance Panel is used to navigate to Case (Payee) maintenance panels. The right-hand portion of this panel contains hyperlinks that open individual panels: Base Information, Case Members, and Case Spenddown. This panel is inquiry only.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results]

6.44.2 Case Maintenance Panel Layout



6.44.3 Case Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Links to the Base Information panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Case Maintenance panels. This button is not available in Alabama.	Button	N/A	0
Case Members	Links to the Case Members panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for Case Maintenance. This button is not available in Alabama.	Button	N/A	0

6.44.4 Case Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.44.5 Case Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.44.6 Case Maintenance Panel Accessibility

6.44.6.1 To Access the Case Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.

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6.45 Case Base Information Panel Overview

6.45.1 Case Base Information Panel Narrative

The Case Base Information panel contains additional information about a Case (Payee). Though the panel was originally built for update purposes, the panel is inquiry only in Alabama. Since Case information displayed on the panel comes directly from the nightly eligibility update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Case Search] – [Case Search Results] - [Case Maintenance] – [Base Information]

6.45.2 Case Base Information Panel Layout

6.45.3 Case Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The Case Number indicates the identification number given to the responsible party-guardian.	Field	Character	12
Source Code	Source of the Case record. All Case information comes directly from the nightly AMAES update file.	Combo Box	Drop Down List box	0

6.45.4 Case Base Information Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is Inquiry only.				

6.45.5 Case Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Case Base Information Panel Accessibility

6.45.6.1 To Access the Case Base Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.

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Step	Action	Response
3	Enter **Case Number** or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.
6	Select **Base Information**.	Case Base Information panel displays.

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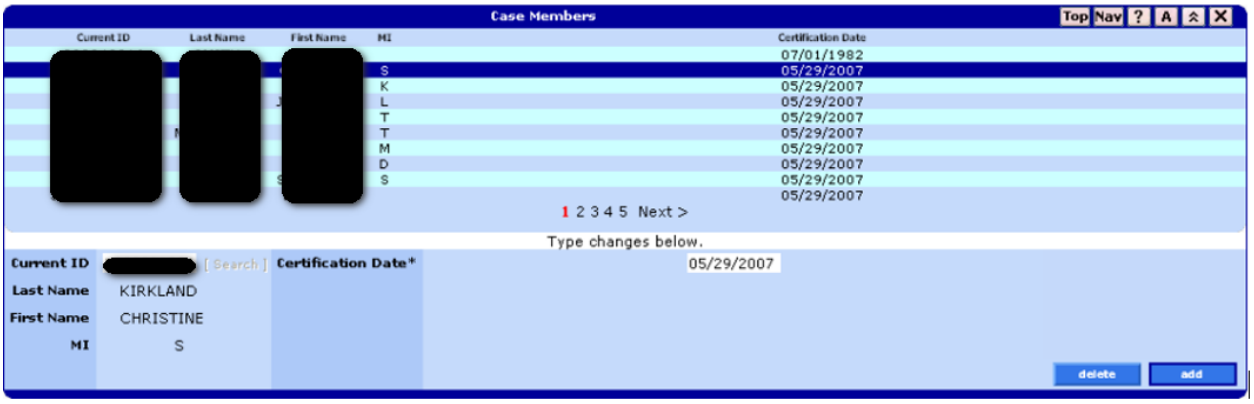
6.46 Case Members Panel Overview

6.46.1 Case Members Panel Narrative

The Case Members panel is used to view the members of a Case (Payee). Since Case information displayed on the panel comes directly from the nightly AMAES update file, the panel is inquiry only in the production environment. Update access will not be granted.

Navigation Path: [Recipient] - [Case Search] –[Case Search Results] - [Case Maintenance] – [Case Members]

6.46.2 Case Members Panel Layout



6.46.3 Case Members Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add Case Member information. This button is not utilized by Alabama.	Button	N/A	0
Certification Date	Date the recipient became certified in the case. Certification Date is the date the Case was added to the system.	Field	Date (MM/DD/CCYY)	8
Current ID	The Medicaid ID assigned to a Recipient.	Field	Character	12
First name	Recipient's first name.	Field	Character	13
Delete	Allows the user to delete Case Member information. This field is not utilized by Alabama.	Button	N/A	0
Last Name	Recipient's last name.	Field	Character	15
MI	Recipient's middle initial.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
[Search]	Initiates the Search by Current ID, Medicare ID, Case ID, SSN or Last Name. First Name, Gender, Birth Date and County must have at least the Last Name entered to perform a search.		N/A	0

6.46.4 Case Members Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel. Panel is Inquiry only.				

6.46.5 Case Members Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 Case Members Panel Accessibility

6.46.6.1 To Access the Case Members Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Case Search**.	Case Search panel displays.
3	Enter **Case Number**, **Last Name**, or **Current ID**.	
4	Click **Search**.	Case Search Results panel displays.
5	Click to highlight the row.	Case Information and Case Maintenance panels display.
6	Select **Case Members**.	Case Members panel displays.

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6.47 Recipient Other IDs Search Panel Overview

6.47.1 Recipient Other IDs Search Panel Narrative

The Recipient Other IDs Search allows a search by recipient ID. This panel is used to display all Medicaid numbers associated with the recipient ID entered. The results of the search are displayed on the "Recipient Other IDs" panel.

Navigation Path: [Recipient] – [Other IDs Search]

6.47.2 Recipient Other IDs Search Panel Layout

6.47.3 Recipient Other IDs Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient Other IDs Search panel.	Button	N/A	0
Medicaid ID	Used to capture the ID entered by the user for which information is retrieved.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the Search by Medicaid ID.	Button	N/A	0

6.47.4 Recipient Other IDs Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Medicaid ID	Field	1	Medicaid ID is required	Enter a valid Medicaid ID number.
	Field	2	Medicaid ID must be numeric	Enter a valid numeric Medicaid ID number.

6.47.5 Recipient Other IDs Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.47.6 Recipient Other IDs Search Panel Accessibility

6.47.6.1 To Access the Recipient Other IDs Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Other IDs Search**.	Recipient Other IDs Search panel displays.

6.47.6.2 To Navigate the Recipient Other IDs Search Panel

Step	Action	Response
1	Enter **Medicaid ID**.	
2	Click **Search**.	Search Results Other IDs are displayed, if applicable.

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6.48 Recipient Other IDs Panel Overview

6.48.1 Recipient Other IDs Panel Narrative

The Recipient Other IDs panel is used to determine all the Medicaid IDs that have been associated with a different ID (see what IDs have been linked together using the "rekey" process). The Recipient Other IDs panel is an expanded version of the Recipient Previous IDs panel and is inquiry only.

Navigation Path: [Recipient] - [Other IDs Search]

6.48.2 Recipient Other IDs Panel Layout

Search Results

Current Active ID	Source File	Last Name	First Name	MI	Date Processed	Check Digit
[redacted]	Base	[redacted]	PHRA	B	02/13/2007	6

Search Results

ID	Source File	Last Name	First Name	MI	Date Processed	Check Digit
[redacted]	Link	[redacted]	[redacted]	A	02/13/2007	7
[redacted]	Link				02/05/2007	8

6.48.3 Recipient Other IDs Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Check Digit	The 13th or last digit for the recipient's Medicaid identification number.	Listview	Character	1
Current Active ID	ID that is currently active and contains the active eligibility information that is used for eligibility verification and claims processing.	Listview	Character	12
Date Processed	Date that the Recipient Link was received and processed.	Listview	Date (MM/DD/CCYY)	8
First Name	First name of recipient.	Listview	Character	15
ID	Lists all Recipient Medicaid IDs linked to the 'active' Current ID.	Listview	Character	12
Last Name	Last name of recipient.	Listview	Character	20
MI	Middle Initial of recipient.	Listview	Character	1
Source File	Indicates which table the recipient was found on.	Listview	Character	10

6.48.4 Recipient Other IDs Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.48.5 Recipient Other IDs Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Recipient Other IDs Panel Accessibility

6.48.6.1 To Access Recipient Other IDs Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and **click Other IDs Search**.	Recipient Other IDs Search panel displays.
3	Enter **Medicaid ID**.	
4	Click **Search**.	Search Results for Other IDs is displayed, if applicable.

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6.49 Service Usage Search Panel Overview

6.49.1 Service Usage Search Panel Narrative

The Service Usage Search panel (Benefit Limits) allows a user to enter Medicaid ID and Service Year or SSN and Service Year (Note: Service Year, in CCYY format, MUST be entered in order for the panel to function correctly). The search returns service usage associated with that recipient.

This panel is inquiry only.

Navigation Path: [Recipient] - [Service Usage Search]

6.49.2 Service Usage Search Panel Layout

6.49.3 Service Usage Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient Service Usage Search panel.	Button	N/A	0
Current ID	Recipient's Medicaid identification number.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the search by Current ID and Service Year, or Social Security Number and Service Year.	Button	N/A	0
Service Year	The year when the Recipient received services.	Field	Date (CCYY)	4
Soc Sec No	The recipient's Social Security Number.	Field	Number (Integer)	9

6.49.4 Service Usage Search Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.49.5 Service Usage Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Service Usage Search Panel Accessibility

6.49.6.1 To Access the Service Usage Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.

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6.50 Service Usage Search Results Panel Overview

6.50.1 Service Usage Search Results Panel Narrative

The Service Usage Search Results panel (Benefit Limits) is used to show service usage for a recipient, returned from the Recipient Service Usage Search panel. This panel is inquiry only.

Navigation: [Recipient] – [Service Usage Search] – [Service Usage Search Results]

6.50.2 Service Usage Search Results Panel Layout

Search Results

Service Limt	Service Limit Description	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Total
10	Inpatient Hospital Visits-PD													0
11	Outpatient Hospital Visits-PD													0
12	Physician Visits-PD							1	1			1		3
13	Home Health Visits-PD													0
14	Ambulatory Surgical Center-PD													0
15	Dialysis Service-PD													0
16	Eyeglass Frames-PD													0
17	Eyeglass Lens-PD													0
18	Eyeglass Fitting-PD													0
19	Eyeglass Exam-PD													0

1 2 3 4 Next >

6.50.3 Service Usage Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Apr	The benefit limit count for a recipient for April.	Field	Number (Integer)	6
Aug	The benefit limit count for a recipient for August.	Field	Number (Integer)	6
Dec	The benefit limit count for a recipient for December.	Field	Number (Integer)	6
Feb	The benefit limit count for a recipient for February.	Field	Number (Integer)	6
Jan	The benefit limit count for a recipient for January.	Field	Number (Integer)	6
July	The benefit limit count for a recipient for July.	Field	Number (Integer)	6
Jun	The benefit limit count for a recipient in June.	Field	Number (Integer)	6
Mar	The benefit limit count for a recipient for March.	Field	Number (Integer)	6
May	The benefit limit count for a recipient for May.	Field	Number (Integer)	6
Nov	The benefit limit count for a recipient in November.	Field	Number (Integer)	6
Oct	The benefit limit count for a recipient in October.	Field	Number (Integer)	6

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Field	Description	Field Type	Data Type	Length
Sep	The benefit limit count for a recipient in September.	Field	Number (Integer)	6
Service Limit	The category key for the benefit limit.	Field	Character	2
Service Limit Description	The description of the benefit limit category.	Field	Character	30
Total	The benefit limit count for a member in the Service Year.	Field	Number (Integer)	6

6.50.4 Service Usage Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.50.5 Service Usage Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.50.6 Service Usage Search Results Panel Accessibility

6.50.6.1 To Access the Service Usage Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.
3	Enter **Current ID** and **Service Year**, or **Social Security Number** and **Service Year**.	
4	Click **Search**.	Service Usage Search Results panel displays.

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6.51 Service Usage ICN Search Results Panel Overview

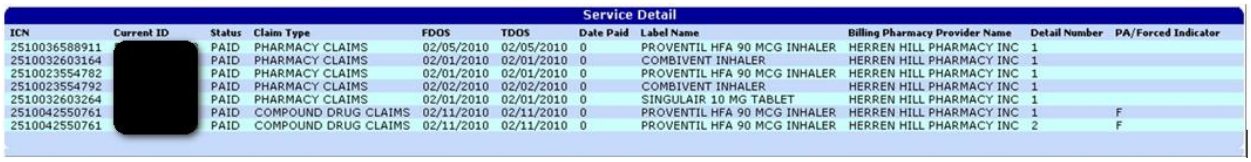
6.51.1 Service Usage ICN Search Results Panel Narrative

The Service Usage ICN Search Results panel is used to show claim information for a service limit chosen on the Recipient Service Usage Search Result panel.

This panel is display only.

Navigation: [Recipient] – [Service Usage Search] – [Service Usage Search Results] – [Service Usage ICN Search Results]

6.51.2 Service Usage ICN Search Results Panel Layout



Service Detail

ICN	Current ID	Status	Claim Type	FDOS	TDOS	Date Paid	Label Name	Billing Pharmacy Provider Name	Detail Number	PA/Forced Indicator
2510036588911	[redacted]	PAID	PHARMACY CLAIMS	02/05/2010	02/05/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	
2510032603164		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	COMBIVENT INHALER	HERREN HILL PHARMACY INC	1	
2510023554782		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	
2510023554792		PAID	PHARMACY CLAIMS	02/02/2010	02/02/2010	0	COMBIVENT INHALER	HERREN HILL PHARMACY INC	1	
2510032603264		PAID	PHARMACY CLAIMS	02/01/2010	02/01/2010	0	SINGULAIR 10 MG TABLET	HERREN HILL PHARMACY INC	1	
2510042550761		PAID	COMPOUND DRUG CLAIMS	02/11/2010	02/11/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	1	F
2510042550761		PAID	COMPOUND DRUG CLAIMS	02/11/2010	02/11/2010	0	PROVENTIL HFA 90 MCG INHALER	HERREN HILL PHARMACY INC	2	F

6.51.3 Service Usage ICN Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Billing Pharmacy Provider Name	The name of the Billing Provider.	Field	Character	25
Claim Type	Description of the value assigned to a specific claim type.	Field	Character	50
Current ID	Recipient's Medicaid identification number.	Field	Character	12
Date Paid	Date on which the claim was paid.	Field	Date (MM/DD/CCYY)	8
Detail Number	The number of the detail on a claim record which counts toward this particular service usage category.	Field	Number (Integer)	4
FDOS	Date on which service began.	Field	Date (MM/DD/CCYY)	8
ICN	Internal Control Number associated with the claim.	Field	Number (Integer)	13
Label Name	The name of the drug labeler.	Field	Character	35
PA/Forced indicator	Indicates if a claim's detail paid as the result of a PA or having a benefit limit audit forced. Valid values are: P - dtl paid as the result of a PA, F - dtl paid as the result of a forced benefit limit audit, Space - Default value - dtl paid through normal	Field	Character	1
Status	Description of Claim Status.	Field	Character	20

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Field	Description	Field Type	Data Type	Length
TDOS	Last service date covered by claim.	Field	Date (MM/DD/CCYY)	8

6.51.4 Service Usage ICN Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.51.5 Service Usage ICN Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 Service Usage ICN Search Results Panel Accessibility

6.51.6.1 To Access the Service Usage ICN Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Service Usage Search**.	Service Usage Search panel displays.
3	Enter **Current ID**, **Social Security Number** or **Service Year**.	
4	Click **Search**.	Service Usage Search Results panel displays.
5	Click on **Service Limit** row to view ICN details.	Service Usage ICN Search Results panel displays.

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6.52 Recipient ICN Link Search Panel Overview

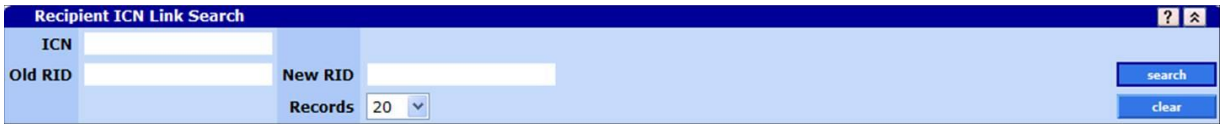
6.52.1 Recipient ICN Link Search Panel Narrative

The Recipient ICN Link Search panel allows the user to search by either ICN, Old RID or New RID or a combination of any of the three fields. The search returns the results associated with the combination of search criteria entered by the user.

This panel is inquiry only.

Navigation Path: [Recipient] - [Recipient ICN Link Search]

6.52.2 Recipient ICN Link Search Panel Layout



5.50.1 Recipient ICN Link Search Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to clear any changes on the Recipient ICN Link Search panel.	Button	N/A	0
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Records	Allows the user to specify how many records should be returned per page (5, 10, 20, 50, or 100).	Combo Box	Drop Down List Box	0
Search	Initiates the search by ICN and Old RID and New RID.	Button	N/A	0

6.52.3 Recipient ICN Link Search Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.52.4 Recipient ICN Link Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.5 Recipient ICN Link Search Panel Accessibility

6.52.5.1 To Access the Recipient ICN Link Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Recipient ICN Link Search.**	Recipient ICN Link Search panel displays.

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6.53 Recipient ICN Link Search Results Panel Overview

6.53.1 Recipient ICN Link Search Results Panel Narrative

The Recipient ICN Link Search Results panel is used to show the results returned based upon the search criteria entered by the user on the Recipient ICN Link Search panel.

This panel is inquiry only.

Navigation: [Recipient] – [Recipient ICN Link Search] – [Recipient ICN Link Search Results]

6.53.2 Recipient ICN Link Search Results Panel Layout

Recipient ICN List Results

ICN	Old RID	Old Recipient Name	Old Recipient DOB	New RID	New Recipient Name	New Recipient DOB	Date	Time
1108064216006	[redacted]	[redacted]	09/11/1965	[redacted]	[redacted]	07/22/1959	10/16/2010	15:59:21
1108064216006			07/22/1959			06/19/1963	10/15/2010	16:13:57
1108064216006			07/26/1943			09/11/1965	10/15/2010	15:54:57

6.53.3 Recipient ICN Link Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date	Date the claim was moved to the new recipient.	Field	Date (MM/DD/CCYY)	8
ICN	Number assigned to a claim processed in the system.	Field	Character	13
New RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.	Field	Character	12
New Recipient DOB	Date of birth of the new recipient assigned to the claim.	Field	Date (MM/DD/CCYY)	8
New Recipient Name	Name of the new recipient assigned to the claim.	Field	Character	36
Old RID	Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.	Field	Character	12
Old Recipient DOB	Date of birth of the recipient formerly assigned to the claim.	Field	Date (MM/DD/CCYY)	8
Old Recipient Name	Name of the recipient formerly assigned to the claim.	Field	Character	36
Time	Time the claim was moved to the new recipient.	Field	Number(Integer)	8

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6.53.4 Recipient ICN Link Search Results Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.53.5 Recipient ICN Link Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Recipient ICN Link Search Results Panel Accessibility

6.53.6.1 To Access the Recipient ICN Link Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click **Recipient ICN Link Search**.	Recipient ICN Link Search panel displays.
3	Enter **ICN** or **Old RID** or **New RID**.	
4	Click **Search**.	Recipient ICN Link Search Results panel displays.

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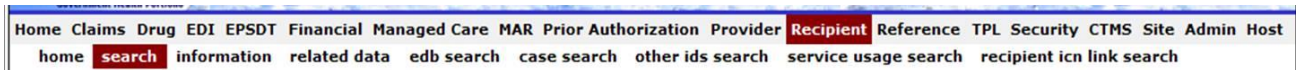
6.54 Recipient Sub Menu Panel Overview

6.54.1 Recipient Sub Menu Panel Narrative

This panel has list of sub menus for Recipient Data Maintenance Subsystems

Navigation Path: Recipient menu option

6.54.2 Recipient Sub Menu Panel Layout



6.54.3 Recipient Sub Menu Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Search	A link to Recipient Data Maintenance Case Search Page.	Hyperlink	N/A	0
EDB Search	A link to Recipient Data Maintenance EDB Search Page.	Hyperlink	N/A	0
Information	A link to Recipient Data Maintenance Information Page.	Hyperlink	N/A	0
Other ID's Search	A link to Recipient Data Maintenance Other ID's Search Page.	Hyperlink	N/A	0
Preferences	Link to Preferences	Hyperlink	N/A	0
Recipient ICN Link Search	A link to Recipient Data Maintenance Recipient ICN Link Search Page.	Hyperlink	N/A	0
Related Data	A link to Recipient Data Maintenance Related data page.	Hyperlink	N/A	0
Search	A link to Recipient Data Maintenance Search Page.	Hyperlink	N/A	0
Service Usage Search	A link to Recipient Data Maintenance Service Usage Search Page.	Hyperlink	N/A	0

6.54.4 Recipient Sub Menu Panel Field Edit Errors

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.54.5 Recipient Sub Menu Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.54.6 Recipient Sub Menu Panel Accessibility

6.54.6.1 To Access the Recipient Sub Menu Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Recipient** and click any link from the menu.	Recipient Sub menu will get displayed.

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7. Reports

The Recipient User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage.

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.

Field Descriptions: Lists the fields included on the report, with a definition of each field.

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7.1 ELG-0001-D -- Total ID Card Counts by County Report

7.1.1 ELG-0001-D -- Total ID Card Counts by County Report Narrative

The Total ID Card Counts by County report (ELG-0001-D) lists each of the counties alphabetically with the total number of ID cards that were issued for the county each day. This number includes all replacement cards or new cards.

A "Total" column at the end of report displays the number of cards printed for the State of Alabama for that day. This number is calculated by adding all county card totals together for a grand total. This report is produced daily.

7.1.2 ELG-0001-D -- Total ID Card Counts by County Report Layout

```
 Report  : ELG-0001-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
 Process : ELGJD040                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD04C                        TOTAL ID CARD COUNTS BY COUNTY                                      Page:  9,999
                                               REPORT PERIOD: MM/DD/CCYY
        ---------------------------------------------------------------------------------------------------------------------
                                                                          NUMBER OF
                                                COUNTY                  CARDS ISSUED
        ---------------------------------------------------------------------------------------------------------------------
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999
                                                XXXXXXXXXXXX             999,999,999

                                                TOTAL:                   999,999,999

                                                       ** END OF REPORT **
                                                     ** NO DATA THIS RUN **
```


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7.1.3 ELG-0001-D -- Total ID Card Counts by County Report Field Descriptions

Field	Description	Length	Data Type
County	Recipient's county name.	12	Character
Number of Cards Issued	Lists the total number of plastic ID cards issued to recipients in that county for that day.	11	Number (Decimal)
Total	Total number of plastic ID cards issued for the counties.	11	Number (Decimal)

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7.2 ELG-0002-D -- ID Card Summary Report

7.2.1 ELG-0002-D -- ID Card Summary Report Narrative

The ID Card Summary report lists the total number of ID cards generated according to the reason codes sent by the AMAES system. The reasons are listed as follows:

- Never Received Card
- Lost Card
- Card was Stolen
- Damaged or Destroyed
- Change in Name
- Change in Sex
- Change in Race
- Change in DOB
- Change In Medicaid Number
- Disaster Loss
- New Card
- Awarded Eligibility
- Eligibility Re-Awarded
- New Medicaid Number
- Left Nursing Home

A Total line displays how many cards were actually generated for the day.

The purpose of the ID Card Summary report is to allow the AMMIS client to view the number of ID cards created or re-issued, and the reason for the ID Card. This report is produced daily.

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7.2.2 ELG-0002-D -- ID Card Summary Report Layout

```
Report  : ELG-0002-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : ELGJD040                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD04A                                ID CARD SUMMARY                                         Page:    999,999
                                            REPORT PERIOD: MM/DD/CCYY

                 ---------------------------------------------------------------------------------------------------------
                                                                AMAES
                 ---------------------------------------------------------------------------------------------------------
                                         NEVER RECEIVED CARD:                 999,999,999
                                         LOST CARD:                           999,999,999
                                         CARD WAS STOLEN:                     999,999,999
                                         DAMAGED OR DESTROYED:                999,999,999
                                         CHANGE IN NAME:                      999,999,999
                                         CHANGE IN SEX:                       999,999,999
                                         CHANGE IN RACE:                      999,999,999
                                         CHANGE IN DOB:                       999,999,999
                                         CHANGE IN MEDICAID NUMBER:           999,999,999
                                         DISASTER LOSS                        999,999,999
                                         NEW CARD:                            999,999,999
                                         AWARDED ELIGIBILITY:                 999,999,999
                                         ELIGIBILITY RE-AWARDED:              999,999,999
                                         NEW MEDICAID NUMBER:                 999,999,999
                                         LEFT NURSING HOME:                   999,999,999


                                         TOTAL:                               999,999,999

                                                      ** END OF REPORT **
                                                     ** NO DATA THIS RUN **
```


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7.2.3 ELG-0002-D -- ID Card Summary Report Field Descriptions

Field	Description	Length	Data Type
Awarded Eligibility	Total number of cards printed for recipients who had eligibility awarded.	11	Number (Integer)
Card was Stolen	Total number of cards printed for recipients whose cards were stolen.	11	Number (Integer)
Change in DOB	Total number of cards printed for recipients that had date of birth information that was incorrect on the card.	11	Number (Integer)
Change in Medicaid Number	Total number of cards printed for recipients who changed their Medicaid number or had information that was incorrect on the card.	11	Number (Integer)
Change in Name	Total number of cards printed for recipients who changed their name or information was incorrect on the card.	11	Number (Integer)
Change in Race	Total number of cards printed for recipients that had race information that was incorrect on the card.	11	Number (Integer)
Change in Sex	Total number of cards printed for recipients who changed their sex or information was incorrect on the card.	11	Number (Integer)
Damaged or Destroyed	Total number of cards printed for recipients who had a damaged card that needed to be replaced.	11	Number (Integer)
Disaster Loss	Total number of cards printed for recipients whose card was lost due to a significant natural disaster.	11	Number (Integer)
Eligibility Re-Awarded	Total number of cards printed for recipients who had eligibility re-awarded.	11	Number (Integer)
Left Nursing Home	Total number of cards printed for recipients who left a nursing home.	11	Number (Integer)
Lost Card	Total number of cards printed for recipients who lost their cards.	11	Number (Integer)
Never Received Card	Total number of recipients who had a card issued, but never received the card.	11	Number (Integer)

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Field	Description	Length	Data Type
New Card	Total number of cards printed for recipients who had a new card issued.	11	Number (Integer)
New Medicaid Number	Total number of cards printed for recipients who received a new Medicaid number.	11	Number (Integer)
Total	Total number of cards generated daily for all counties.	11	Number (Integer)

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7.3 ELG-0003CL-D--AMACL Daily Error Report

7.3.1 ELG-0003CL-D--AMACL Daily Error Report Narrative

This report will provide a complete listing of all errors produced from the AMAES Closure transactions received and processed Monday thru Friday from the Agency.

7.3.2 ELG-0003CL-D--AMACL Daily Error Report Layout

```
Report  : ELG-0003CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD013C                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: ELGPD013                           AMAES DAILY CLOSURE ERROR REPORT                             Page:     999,999
                                                  PERIOD:  MM/DD/CCYY


 TCD    MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
 ERROR FIELD                                           ERROR DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------------

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


          TOTAL ERRORS FOR REPORT:           99,999,999


                                                 ***   END OF REPORT   ***
                                            ***   NO DATA THIS REPORT   ***
```

7.3.3 ELG-0003CL-D--AMACL Daily Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of Error.	70	Character
Error Field	Data that is causing the error.	15	Character

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Field	Description	Length	Data Type
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character
Medicaid ID	Medicaid identification number of the recipient.	12	Character
Middle Initial	Middle Initial of the recipient	1	Character
SSN	Recipient's Social Security Number.	9	Character
Source	Identifies the process source code AMACL.	5	Character
TCD	External Transaction Code (Not used for AMAES data).	4	Character
Total Errors for Report	Total number of errors reported.	10	Number (Integer)

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7.4 ELG-0003-D –Complete Error Report

7.4.1 ELG-0003-D – Complete Error Report Narrative

The Complete Error report provides a complete listing of all errors produced from the application of AMAES data to the AMMIS databases.

7.4.2 ELG-0003-D – Complete Error Report Layout

```
Report  : ELG-0003-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD013                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD013                            COMPLETE ERROR REPORT                                       Page:    999,999
                                                REPORT PERIOD:  MM/DD/CCYY


                  TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                      ERROR DESCRIPTION
    ---------------------------------------------------------------------------------------------------------------------------
                    XXXX   XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
                                                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XXXX   XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
                                                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                            TOTAL ERRORS FOR REPORT: 99,999,999


                                                ** END OF REPORT **
                                          ***   NO DATA THIS REPORT   ***
```

7.4.3 ELG-0003-D – Complete Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of error message.	70	Character

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Field	Description	Length	Data Type
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character
Medicaid ID	The Medicaid identification number of the recipient.	12	Character
M	The middle initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Number (Integer)
Source	Identifies the recipient's source code.	5	Character
TCD	External Transaction Code (not used for AMAES data).	4	Character
Total Errors for this Report	Total number of errors reported.	10	Number (Decimal)

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7.5 ELG-0003DR-D--AMADR Daily Error Report

7.5.1 ELG-0003DR-D-- AMADR Daily Error Report Narrative

This report will provide a complete listing of all errors produced from the AMAES Drastic transactions which are produced and processed Monday thru Friday as generated by the Agency update transactions.

7.5.2 ELG-0003DR-D-- AMADR Daily Error Report Layout

```
Report  : ELG-0003DR-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD013D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: ELGPD013                           AMAES DAILY DRASTIC CHANGE ERROR REPORT                         Page:     999,999
                                                REPORT PERIOD:  MM/DD/CCYY


 TCD    MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
 ERROR FIELD                                           ERROR DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------------

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 X      XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX              XXXXX   XXXX
 XXXXXXXXXXXXXXX                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


          TOTAL ERRORS FOR REPORT:           99,999,999


                                                 ***   END OF REPORT   ***
                                             ***   NO DATA THIS REPORT   ***
```

7.5.3 ELG-0003DR-D-- AMADR Daily Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error Number for a batch Edit Error.	4	Character
Error Description	Description of Error.	70	Character
Error Field	Data that is causing the error.	15	Character
First Name	First Name of the recipient.	15	Character
Last Name	Last Name of the recipient.	20	Character

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Field	Description	Length	Data Type
Medicaid ID	Medicaid identification number of the recipient.	12	Character
Middle Initial	Middle Initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Character
Source	Identifies the process source code AMADR.	5	Character
TCD	External Transaction Code (Not used for AMAES data).	4	Character
Total Errors for Report	Total number of errors reported.	10	Number (Integer)

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7.6 ELG-0004CL-D--AMACL Daily Transaction Report Count

7.6.1 ELG-0004CL-D--AMACL Daily Transaction Count Report Narrative

This daily report lists the total number of AMACL Closure transactions received and processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is used to determine the total AMACL transactions received and processed on the AMMIS.

7.6.2 ELG-0004CL-D--AMACL Daily Transaction Count Report Layout

```
Report  : ELG-0004CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD012C                        MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD012                     AMAES DAILY CLOSURE TRANSACTION COUNT REPORT                          Page:    999,999
                                                     REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------

  AMACL   AMAES Closure Transactions

             TOTAL TRANSACTIONS RECEIVED:                                        99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                        99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:                 99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:               99,999,999


                                                        ** END OF REPORT **
                                                 ***   NO DATA THIS REPORT   ***
```

7.6.3 ELG-0004CL-D--AMACL Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Integer)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Integer)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Integer)
Total Transactions Received	Total number of transactions received.	10	Number (Integer)

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7.7 ELG-0004-D -- AMAES Daily Transaction Count Report

7.7.1 ELG-0004-D -- AMAES Daily Transaction Count Report Narrative

The AMAES Daily Transaction Count report lists the total number of AMAES transactions received, processed with no errors, processed with non-fatal errors, and not processed due to fatal errors.

This report is used to confirm that all AMAES transactions sent that day from interChange clients were received and processed on the MMIS.

7.7.2 ELG-0004-D -- AMAES Daily Transaction Count Report Layout

```
Report  : ELG-0004-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD012                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD012                        AMAES DAILY TRANSACTION COUNT REPORT                         Page:        999,999
                                               REPORT PERIOD:  MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------

  AMAES   AMAES Daily Input

             TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999


                                                   ** END OF REPORT **
```

7.7.3 ELG-0004-D -- AMAES Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.8 ELG-0004DR-D--AMADR Daily Transaction Count Report

7.8.1 ELG-0004DR-D--AMADR Daily Transaction Count Report Narrative

This daily report lists the total number of AMADR Drastic change transactions received and processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is used to determine the total AMADR transactions received and processed on the AMMIS.

7.8.2 ELG-0004DR-D--AMADR Daily Transaction Count Report Layout

```
Report  : ELG-0004DR-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD012D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELGPD012                   AMAES DAILY DRASTIC CHANGE TRANSACTION COUNT REPORT            Page:    999,999
                                                   REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------

  AMADR   AMAES Drastic Eligibility Change Transactions

             TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
             TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
             TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999


                                                   ** END OF REPORT **
                                          ***   NO DATA THIS REPORT   ***
```

7.8.3 ELG-0004DR-D--AMADR Daily Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.9 ELG-0007CL-D--AMACL Daily Error Count Report

7.9.1 ELG-0007CL-D--AMACL Daily Error Count Report Narrative

This report prints a summary of all errors produced from the AMAES Closure transactions received and processed Monday thru Friday from the Agency. The report includes the error number, the number of times the error occurred, the action taken when the error failed, and a description of the error.

The purpose of this report is to summarize the AMACL errors that occurred during the process.

7.9.2 ELG-0007CL-D--AMACL Daily Error Count Report Layout

```
Report  : ELG-0007CL-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD020C                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPDC12                        AMAES DAILY CLOSURE ERROR COUNT REPORT                             Page:    999,999
                                               REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*
-------------------------------------------------------------------------------------------------------------------------------

   7777               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   8888               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   9999               9,999,999         9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX




                                                         ** END OF REPORT **

                                                  ***   NO DATA THIS REPORT   ***
```

7.9.3 ELG-0007CL-D--AMACL Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	The action taken when the error occurred.	1	Character
Error Code	Error Code.	4	Character

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Field	Description	Length	Data Type
Error Description	Description of the Error Code.	75	Character
Failure Count	Number of times Error occurred.	7	Character

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7.10 ELG-0007-D -- AMAES Daily Error Count Report

7.10.1 ELG-0007-D -- AMAES Daily Error Count Report Narrative

The AMAES Daily Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error.

The purpose of this report is to summarize the AMAES errors that occurred during the day.

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7.10.2 ELG-0007-D -- AMAES Daily Error Count Report Layout

```
Report  : ELG-0007-D                          ALABAMA MEDICAID AGENCY                                  Run Date:   MM/DD/CCYY
Process : ELGJD020                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:     HH:MM:SS
Location: ELGPDC12                         AMAES DAILY ERROR COUNT REPORT                                 Page:      999,999
                                              REPORT PERIOD: MM/DD/CCYY



-------------------------------------------------------------------------------------------------------------------------------

     ERROR    FAILURE COUNT      ACTION CODE     *-----------------------------ERROR DESCRIPTION-----------------------------------*

-------------------------------------------------------------------------------------------------------------------------------


    9999       999,999                  9            XXXX
```

7.10.3 ELG-0007-D – AMAES Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error code.	4	Character
Error Description	Text description of the message.	75	Character
Failure Count	Number of times error occurred.	7	Number (Decimal)

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7.11 ELG-0007DR-D--AMADR Daily Error Count Report

7.11.1 ELG-0007DR-D--AMADR Daily Error Count Report Narrative

This report prints a summary of all errors produced from the AMAES Drastic change transactions received and processed Monday thru Friday from the Agency. The report includes the error number, the number of times the error occurred, the action taken when the error failed, and a description of the error.

The purpose of this report is to summarize the AMADR errors that occurred during the process.

7.11.2 ELG-0007DR-D--AMADR Daily Error Count Report Layout

```
Report  : ELG-0007DR-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD020D                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELGPDC12                      AMAES DAILY DRASTIC CHANGE ERROR COUNT REPORT                Page:    999,999
                                                REPORT PERIOD:  MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*
-------------------------------------------------------------------------------------------------------------------------

   7777               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   8888               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   9999               9,999,999        9              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX




                                                        ** END OF REPORT **

                                                 ***   NO DATA THIS REPORT   ***
```

7.11.3 ELG-0007DR-D--AMADR Daily Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error code.	4	Character

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Field	Description	Length	Data Type
Error Description	Text description of the message.	75	Character
Failure Count	Number of times error occurred.	7	Number (Decimal)

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7.12 ELG-0009-D -- Eligible ID Card Recipients Report

7.12.1 ELG-0009-D -- Eligible ID Card Recipients Report Narrative

The Eligible ID Card Recipients report lists the recipient names and IDs that appear on the plastic ID cards created that day.

This report is used to identify which recipients had a plastic ID card created that day.

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7.12.2 ELG-0009-D -- Eligible ID Card Recipients Report Layout

```
Report  : ELG-0009-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD040                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: ELGPD04B                          ELIGIBLE ID CARD RECIPIENTS                                    Page:    999,999
                                             REPORT PERIOD: MM/DD/CCYY

                                                                                  COUNTY:   XXXXXXXXXXXX

     ---------------------------------------------------------------------------------------------------------------------
              RECIPIENT NAME           RECIPIENT ID                                RECIPIENT NAME            RECIPIENT ID
     ---------------------------------------------------------------------------------------------------------------------

     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX
     XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX                       XXXXXXXXXXXXXXXX XXXXXXXXXXXXXX X   XXXXXXXXXXXX

                                     TOTAL RECIPIENTS FOR COUNTY XXXXXXXXXXXX:       999,999

                                        TOTAL RECIPIENTS FOR REPORT:                    999,999
                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.12.3 ELG-0009-D -- Eligible ID Card Recipients Report Field Descriptions

Field	Description	Length	Data Type
County	County of residence for a group of recipients.	12	Character
Recipient ID	Recipient's Medicaid ID that is printed on the plastic ID card.	12	Character
Recipient Name	Recipient's last name, first name, and middle initial format.	31	Character
Total Recipients for County XXXXXXXXXXXX	Total number of recipients issued ID cards within a specified county.	7	Number (Decimal)
Total Recipients for Report	Total number of recipients issued ID cards for all counties included in this report.	7	Number (Decimal)

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7.13 ELG-0011-W -- Potential Duplicate InterChange Recipient Report

7.13.1 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Narrative

The Potential Duplicate interChange Recipient report lists all recipients who were identified as a potential duplicate during the process. The report shows the recipient ID, name, SSN, and DOB for both recipients. All active (non/linked) recipients are considered during the reporting process.

This report shows only those pairs of recipients, one of whom have not been recently eligible and therefore are most likely no longer on the AMAES system. Recently eligible is defined as having eligibility within the current 3 year eligibility period or for the three years prior to that. Because the AMAES system grants eligibility only for full years, if the current eligibility is being granted for January 2010, a recipient would be listed on this report if they had not been eligible on or after January 1st, 2005. Recipients who have not been eligible will have an asterisk beside their information on the report. Either one or both of the recipients could have an asterisk. Recipients who have been eligible sometime during that period are listed on the ELG-0012-W report.

This report is used to identify recipients who are potentially duplicates. These recipient IDs should be researched further to determine if a duplicate actually exists or not. The report is sorted by SSN and recipient ID. This report is produced weekly.

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7.13.2 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Layout

```
Report  : ELG-0011-W                                    ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJW012                                  MEDICAID INFORMATION MANAGEMENT SYSTEM                       Run Time:   HH:MM:SS
Location: ELGPW020                              POTENTIAL DUPLICATE INTERCHANGE RECIPIENT REPORT                     Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------------
*-------------------- RECIPIENT 1 ------------------------------*      *-----------------------RECIPIENT 2 ------------------------------*
RECIPIENT ID        RECIPIENT NAME               SSN       DOB          RECIPIENT ID         RECIPIENT NAME             SSN       DOB
-------------------------------------------------------------------------------------------------------------------------------------


XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY *    XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY *
                                                          ** END OF REPORT **
                                                        ** NO DATA THIS RUN **
```

7.13.3 ELG-0011-W -- Potential Duplicate InterChange Recipient Report Field Descriptions

Field	Description	Length	Data Type
Asterisk	An asterisk is placed on a line for an MMIS recipient who is no longer on the State Agency's AMAES file. This is determined based upon the most recent eligibility date on the recipient. As of 9/4/2009, a recipient is assumed to have been removed from the State Agency's AMAES file if they do not have eligibility on or after January 1, 2004.	1	Character
DOB	Recipient date of birth.	10	Date (MM/DD/CCYY)
Recipient ID	Recipient ID.	12	Character
Recipient Name	Recipient first and last name	31	Character
SSN	Recipient social security number	9	Number (Integer)

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7.14 ELG-0012-W -- Potential Duplicate AMAES Recipient Report

7.14.1 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Narrative

The Potential Duplicate AMAES Recipient report lists all recipients who were identified as a potential duplicate during the process. The report shows the recipient ID, name, SSN, and DOB for both recipients.. All active (non/linked) recipients are considered during the reporting process.

This report shows only those pairs of recipients, both of whom have been recently eligible and therefore are most likely on the AMAES system. Recently eligible is defined as having eligibility within the current 3 year eligibility period or for the three years prior to that. Because the AMAES system grants eligibility only for full years, if the current eligibility is being granted for January 2010, a recipient would be listed on this report only if they had been eligible on or after January 1st, 2005. Recipients who have not been eligible sometime during that period are listed on the ELG-0011-W report.

This report is used to identify recipients who are potentially duplicates. These recipient IDs should be researched further to determine if a duplicate actually exists or not. The report is sorted by SSN and recipient ID. This report is produced weekly.

7.14.2 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Layout

```
Report  : ELG-0012-W                                    ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJW012                                MEDICAID INFORMATION MANAGEMENT SYSTEM                       Run Time:   HH:MM:SS
Location: ELGPW020                              POTENTIAL DUPLICATE AMAES RECIPIENT REPORT                         Page:    999,999
-------------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------------
*-------------------- RECIPIENT 1 ------------------------------*      *-----------------------RECIPIENT 2 ------------------------------*
RECIPIENT ID        RECIPIENT NAME               SSN       DOB          RECIPIENT ID         RECIPIENT NAME             SSN       DOB
-------------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999 MM/DD/CCYY      XXXXXXXXXXXX XXXXXXXXXXXXXXXXX XXXXXXXXXXXXX  999999999  MM/DD/CCYY
                                                          ** END OF REPORT **
                                                        ** NO DATA THIS RUN **
```


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7.14.3 ELG-0012-W -- Potential Duplicate AMAES Recipient Report Field Descriptions

Field	Description	Length	Data Type
DOB	Recipient date of birth.	10	Date (MM/DD/CCYY)
Recipient ID	Recipient ID.	12	Character
Recipient Name	Recipient first and last name	31	Character
SSN	Recipient social security number	9	Number (Integer)

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7.15 ELG-0014-D – AMAES Part A B Error Count Report

7.15.1 ELG-0014-D – AMAES Part A B Error Count Report Narrative

The AMAES Part A B Error Count report is a summary of the AMAES Part A B error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error. This report is produced daily.

7.15.2 ELG-0014-D – AMAES Part A B Error Count Report Layout

```
     Report  : ELG-0014-D                        ALABAMA MEDICAID AGENCY                                          Run Date:
                                                      MM/DD/CCYY
Process : ELGJD080                    MEDICAID MANAGEMENT INFORMATION SYSTEM                              Run Time:   HH:MM:SS
Location: ELGPDC12                        AMAES PART A B ERROR COUNT REPORT                                   Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY

  ---------------------------------------------------------------------------------------------------------------------------------

   ERROR            FAILURE COUNT    ACTION CODE       *---------------------------------ERROR DESCRIPTION------------------------*

  ---------------------------------------------------------------------------------------------------------------------------------

   9999                 999,999         9              XXXX
```

7.16 ELG-0020-D – AMAES Part A B Updates Error Report

7.16.1 ELG-0020-D – AMAES Part A B Updates Error Report Narrative

The AMAES Part A B Updates Error report provides a complete listing of the AMAES PART A B errors that occurred during the nightly update process. This report is produced daily.

7.16.2 ELG-0020-D – AMAES Part A B Updates Error Report Layout

```
     Report  : ELG-0020-D                        ALABAMA MEDICAID AGENCY                                          Run Date:
                                                          MM/DD/CCYY
Process : ELGJD018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD013                         AMAES PART A B UPDATES ERROR REPORT                               Page:    999,999
                                                 REPORT PERIOD: MM/DD/CCYY



                  TCD       MEDICAID ID    SSN         FIRST NAME      M  LAST NAME             SOURCE  ERROR CODE
                                                                                      ERROR DESCRIPTION
 ---------------------------------------------------------------------------------------------------------------------------

                    XXXX       XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX               XXXXX   XXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                    XXXX       XXXXXXXXXXXX   XXXXXXXXX   XXXXXXX         X  XXXXXXXX               XXXXX   XXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                TOTAL ERRORS FOR REPORT:           99,999,999

                                                       ** END OF REPORT **

                                                      ** NO DATA THIS RUN **
```

7.16.3 ELG-0020-D – AMAES Part A B Updates Error Report Field Descriptions

Field	Description	Length	Data Type
Error Code	Error number for a batch Edit Error.	4	Character
Error Description	Description of the error message.	70	Character
First Name	First name of the recipient.	15	Character
Last Name	Last name of the recipient.	20	Character

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Field	Description	Length	Data Type
Medicaid ID	Medicaid identification number of the recipient.	12	Character
M	Middle Initial of the recipient.	1	Character
SSN	Recipient's Social Security Number.	9	Number (Integer)
Source	Identifies the recipient's source code.	5	Character
TCD	External Transaction Code (not used for AMAES data).	4	Character
Total Errors for this Report	Total number of errors reported.	10	Number (Decimal)

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7.17 ELG-0021-D -- AMAES PART A B Transaction Count Report

7.17.1 ELG-0021-D -- AMAES Part A B Transaction Count Report Narrative

The AMAES Part A B Transaction Count report lists the total number of AMAES Part A B transactions received, processed with no errors, processed with non-fatal errors, and not processed due to fatal errors. This report is produced daily.

7.17.2 ELG-0021-D -- AMAES Part A B Transaction Count Report Layout

```
Report  : ELG-0021-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD021                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD012                      AMAES PART A B TRANSACTION COUNT REPORT                          Page:     999,999
                                              REPORT PERIOD:  MM/DD/CCYY
 ---------------------------------------------------------------------------------------------------------------------------

                                         PRTAB   Part A/B Updates from AMAES file

                                TOTAL TRANSACTIONS RECEIVED:                                    99,999,999
                                TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                    99,999,999
                                TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:             99,999,999
                                TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:           99,999,999

                                                  ** END OF REPORT **
```

7.17.3 ELG-0021-D -- AMAES Part A B Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	10	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	10	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	10	Number (Decimal)
Total Transactions Received	Total number of transactions received.	10	Number (Decimal)

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7.18 ELG-0032-D -- Link Requests Processed Report

7.18.1 ELG-0032-D -- Link Requests Processed Report Narrative

The Link Requests Processed report lists all recipient link requests that were processed successfully. Types of information that the system was not able to determine how to handle are included on the report.

The purpose of this report is to identify recipients who have been linked, as well as types of information that needs to be reviewed to see if a manual linking needs to take place. This report is produced daily.

7.18.2 ELG-0032-D -- Link Requests Processed Report Layout

```
Report  : ELG-0032-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGPD017                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGJD017                         LINK REQUESTS PROCESSED REPORT                                  Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   LINK RECIP ID    TO RECIP ID      NAME OF 'TO RECIP ID'               *--------------DATA NOT LINKED--------------*
-------------------------------------------------------------------------------------------------------------------------------

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                         XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```


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7.18.3 ELG-0032-D -- Link Requests Processed Report Field Descriptions

Field	Description	Length	Data Type
Data Not Linked	List of the types of information that was not systematically linked due to overlapping rows between the two recipient IDs.	20	Character
Link Recipient ID	ID being linked in with another ID. This ID is no longer an active ID after the link is completed.	12	Character
Name of 'To Recip ID'	Name of the recipient listed in the 'To Recip ID' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
To Recip ID	ID that another ID was linked to. This ID remains an active ID.	12	Character

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7.19 ELG-0033-D -- Unlink Requests Processed Report

7.19.1 ELG-0033-D -- Unlink Requests Processed Report Narrative

The Unlink Requests Processed report lists all recipient unlink requests that were processed successfully. Types of information that the system was not able to determine how to handle are included on the report.

The purpose of this report is to identify recipients who have been unlinked, as well as types of information that needs to be reviewed to see if a manual unlinking needs to take place. This report is produced daily.

7.19.2 ELG-0033-D -- Unlink Requests Processed Report Layout

```
Report  : ELG-0033-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGPD017                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: ELGJD017                         UNLINK REQUESTS PROCESSED REPORT                                  Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
   UNLINK RECIP ID FROM RECIP ID         NAME OF 'FROM RECIP ID'      *--------------DATA NOT UNLINKED--------------*
-------------------------------------------------------------------------------------------------------------------------------
   XXXXXXXXXXXX      XXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X
   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X

   XXXXXXXXXXXX      XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX

   XXXXXXXXXXX       XXXXXXXXXXXX      XXXXXXXXXXXXXXXXX XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX


                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.19.3 ELG-0033-D -- Unlink Requests Processed Report Field Descriptions

Field	Description	Length	Data Type
Data Not Unlinked	List of the types of information that was not systematically unlinked due to the system not being able to determine which rows belonged to the ID being unlinked.	20	Character
From Recip ID	Recipient ID that had an ID unlinked from it. This ID remains an active ID.	12	Character
Name of 'From Recip ID'	Recipient name listed in the 'From Recip ID' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Unlink Recip ID	Deactivated recipient ID that was unlinked from a recipient ID and activated again.	12	Character

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7.20 ELG-0036-D – Automatic Unlink Warning Report

7.20.1 ELG-0036-D – Automatic Unlink Warning Report Narrative

This report displays the recipients that were automatically unlinked because a recipient was received from AMAES that was inactive in the AMMIS. If no recipients are automatically unlinked during a daily AMAES update cycle, no report is created.

Frequency: Daily

7.20.2 ELG-0036-D – Fund Code Assignment Criteria Report Layout

```
Report  : ELG-0036-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD036                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPD036                         AUTOMATIC UNLINK WARNING REPORT                                 Page:          1
                                               REPORT PERIOD: 05/20/2010


   UNLINKED RECIP  NAME OF UNLINKED RECIP          FROM RECIP          NAME OF RECIP                      ORIG LINK DATE

   999999999999    MOUSE, MINNIE, D                    888888888888    MOUSE, MICKEY, D                     MM/DD/CCYY


                                                  *** END OF REPORT ***
```

7.20.3 ELG-0036-D – Automatic Unlink Warning Report Field Descriptions

Field	Description	Length	Data Type
Name of Recip	Name of the recipient listed in the 'RECIP' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Name of Unlinked Recip	Name of the recipient listed in the 'UNLINKED RECIP' column. It is in the order of last name (15 char), first name (13 char), and middle initial (1 char).	31	Character
Orig Link Date	Date the link was originally processed.	10	Date (MM/DD/CCYY)
Recip	Recipient ID that the unlinked recipient was originally linked to.	12	Character

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Field	Description	Length	Data Type
Unlinked Recip	Recipient ID of recipient that was automatically unlinked and is now active.	12	Character

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7.21 ELG-0050-D – AMAES Unlinking Transaction Count Report

7.21.1 ELG-0050-D – AMAES Unlinking Transaction Count Report Narrative

The AMAES Unlinking Transaction Count report lists the counts of all the recipient unlinking transactions that were processed in the cycle. This report is produced daily.

7.21.2 ELG-0050-D – AMAES Unlinking Transaction Count Report Layout

```
Report  : ELG-0050-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJD050                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD012                     AMAES UNLINKING TRANSACTION COUNT REPORT                          Page:    999,999
                                                 REPORT PERIOD: MM/DD/CCYY

 ---------------------------------------------------------------------------------------------------------------------------------------------------


                                                   UNLNK   Unlinking Requests


                                   TOTAL TRANSACTIONS RECEIVED:                                  999,999,999

                                   TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:                  999,999,999

                                   TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:           999,999,999

                                   TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:         999,999,999


                                                   ** END OF REPORT **
```

7.21.3 ELG-0050-D – AMAES Unlinking Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due to Fatal Errors	Total number of transactions not processed due to fatal errors.	11	Number (Decimal)
Total Transactions Processed with No Errors	Total number of transactions processed with no errors.	11	Number (Decimal)
Total Transactions Processed with Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	11	Number (Decimal)

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Field	Description	Length	Data Type
Total Transactions Received	Total number of transactions received.	11	Number (Decimal)

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7.22 ELG-0052-D -- Unlinking Error Count Report

7.22.1 ELG-0052-D -- Unlinking Error Count Report Narrative

The Unlinking Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error with code source 'UNLNK'.

The purpose of this report is to summarize the errors that occurred during the day. This report is produced daily.

7.22.2 ELG-0052-D -- Unlinking Error Count Report Layout

```
Report  : ELG-0052-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD052                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: ELGPDC12                          UNLINKING ERROR COUNT REPORT                                     Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY


 ---------------------------------------------------------------------------------------------------------------------------------
   ERROR    FAILURE COUNT          ACTION CODE     *-----------------------------ERROR DESCRIPTION-------------------------*
 ---------------------------------------------------------------------------------------------------------------------------------

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    XXXX       999,999                   9            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                         ** END OF REPORT **
                                                       ** NO DATA THIS RUN **
```


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7.22.3 ELG-0052-D -- Unlinking Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error Code.	4	Character
Error Description	Text description of the error message.	75	Character
Failure Count	Number of times the error occurred.	7	Number (Decimal)

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7.23 ELG-0055-D -- Unlinking Error Report

7.23.1 ELG-0055-D -- Unlink Error Report Narrative

The Unlinking Error report lists all errors that occurred during the daily update process for AMAES unlink transactions. The report displays the fields in error, as well as the invalid data and a brief message explaining each error.

The purpose of the Eligibility Update Error Report is to provide EDS and the Medicaid Agency with information regarding transactions which error off. This report is produced daily.

7.23.2 ELG-0055-D -- Unlinking Error Report Layout

```
Report  : ELG-0055-D                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJD055                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: ELGPD055                              UNLINKING ERROR REPORT                                             Page:    999,999
                                                  PERIOD: MM/DD/CCYY


                    TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                        ERROR DESCRIPTION
     ---------------------------------------------------------------------------------------------------------------------------------
                      XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                                         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                      XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                        ** END OF REPORT **
                                                 ***   NO DATA THIS REPORT   ***
```

7.23.3 ELG-0055-D -- Unlinking Error Field Report Descriptions

Field	Description	Length	Data Type
Error Code	Error Code.	5	Character
Error Description	Description of the error code.	80	Character
First Name	First name of the recipient.	15	Character

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Field	Description	Length	Data Type
Last Name	Last name of the recipient.	20	Character
Medicaid ID	Medicaid identification number of the recipient.	12	Character
M	Middle initial of the recipient.	1	Character
SSN	Social Security Number of the recipient.	9	Number (Integer)
Source	Identifies source code for the data. For Alabama, this is always UNLNK.	5	Character
TCD	External Transaction Code. Not used for Alabama.	4	Character

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7.24 ELG-0060-D – AMAES Linking Transaction Count Report

7.24.1 ELG-0060-D – AMAES Linking Transaction Count Report Narrative

The AMAES Linking Transaction Count report lists the counts of all the recipient linking transactions that were processed in the cycle. This report is produced daily.

7.24.2 ELG-0060-D – AMAES Linking Transaction Count Report Layout

```
Report  : ELG-0060-D                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJD060                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: ELGPD012                        AMAES LINKING TRANSACTION COUNT REPORT                           Page:    999,999
                                               REPORT PERIOD: MM/DD/CCYY
   ------------------------------------------------------------------------------------------------------------------------------

                                                        LINK    Linking Requests

                                      TOTAL TRANSACTIONS RECEIVED:                              999,999,999
                                      TOTAL TRANSACTIONS PROCESSED WITH NO ERRORS:              999,999,999
                                      TOTAL TRANSACTIONS PROCESSED WITH NON-FATAL ERRORS:       999,999,999
                                      TOTAL TRANSACTIONS NOT PROCESSED DUE TO FATAL ERRORS:     999,999,999


                                                      ** END OF REPORT **
```

7.24.3 ELG-0060-D – AMAES Linking Transaction Count Report Field Descriptions

Field	Description	Length	Data Type
Total Transactions Not Processed Due To Fatal Errors	Total number of transactions not processed due to fatal errors.	11	Number (Decimal)
Total Transactions Processed With No Errors	Total number of transactions processed with no errors.	11	Number (Decimal)
Total Transactions Processed With Non-Fatal Errors	Total number of transactions processed with non-fatal errors.	11	Number (Decimal)
Total Transactions Received	Total number of transactions received.	11	Number (Decimal)

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7.25 ELG-0062-D -- Linking Error Count Report

7.25.1 ELG-0062-D -- Linking Error Count Report Narrative

The Linking Error Count report is a summary of the error code failures for the day. The report includes the error number, the number of times the error occurred, the action taken when the error fails, and a description of the error for code source 'LINK'.

The purpose of this report is to summarize the errors that occurred during the day. This report is produced daily.

7.25.2 ELG-0062-D -- Linking Error Count Report Layout

```
Report  : ELG-0062-D                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : ELGJD062                   MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPDC12                         LINKING ERROR COUNT REPORT                                     Page:    999,999
                                            REPORT PERIOD: MM/DD/CCYY


-------------------------------------------------------------------------------------------------------------------------
       ERROR    FAILURE COUNT      ACTION CODE     *------------------------------ERROR DESCRIPTION-------------------------*
-------------------------------------------------------------------------------------------------------------------------

       XXXX       999,999                9            XXXX
```

7.25.3 ELG-0062-D -- Linking Error Count Report Field Descriptions

Field	Description	Length	Data Type
Action Code	Action taken when the error failed.	1	Number (Integer)
Error	Error Code.	4	Character
Error Description	Text description of the error message.	75	Character
Failure Count	Number of times the error occurred.	7	Number (Decimal)

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7.26 ELG-0065-D -- Linking Error Report

7.26.1 ELG-0065-D -- Linking Error Report Narrative

The Linking Error report lists all errors that occurred during the daily update process for AMAES Link transactions; the fields in error, as well as the invalid data and a brief message explaining each error. This report is produced daily.

7.26.2 ELG-0065-D -- Linking Error Report Layout

```
Report  : ELG-0065-D                          ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : ELGJD065                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                  Run Time:   HH:MM:SS
Location: ELGPD065                            LINKING ERROR REPORT                                               Page:    999,999
                                           REPORT PERIOD:  MM/DD/CCYY


                  TCD   MEDICAID ID    SSN          FIRST NAME       M  LAST NAME             SOURCE  ERROR CODE
                                                                                        ERROR DESCRIPTION
    ---------------------------------------------------------------------------------------------------------------------------
                     XXXX  XXXXXXXXXXXX   XXXXXXXXX    XXXXXXXXXXXXXXX  X  XXXXXXXXXXXXXXXXXXXX  XXXXX   XXXXX
                                             XXXXXXXXXXXXXXXXXXX
```

Field	Description	Length	Data Type
SSN	Social Security Number of the recipient.	9	Number (Integer)
Source	Identifies the source code for the data. For Alabama, this is always LINK.	5	Character
TCD	External Transaction Code. Not used for Alabama.	4	Character

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7.27 ELG-0070-D – Recipient Portal Demographic Updates Daily Report

7.27.1 ELG-0070-D – Recipient Portal Demographic Updates Daily Report Narrative

This report will contain updates submitted by the Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC.

RCC will apply the updates to the AMAES CICS screens for the data on this report.

ELG-0070-D is indexed by Recipient ID in COLD and is a duplicate copy of the ELG-0071-D report.

7.27.2 ELG-0070-D – Recipient Portal Demographic Updates Daily Report Layout

```
Report  : ELG-0070-D                                ALABAMA MEDICAID AGENCY                      Run Date:
MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:
HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT           Page:
999,999


RECIPIENT ID:  XXXXXXXXXXXX            CERTIFYING AGENCY   X
                           RECIPIENT INFORMATION
                           RECIPIENT FIRST NAME XXXXXXXXXXXXXXXXX
                           RECIPIENT LAST  NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           DATE OF BIRTH MM/DD/CCYY
                           SEX X
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           RESIDENCE COUNTY XX
                           HOME PHONE (999) 999-9999 OTHER PHONE (999) 999-9999

                           RECIPIENT'S SPOUSE INFORMATION
                           DATE OF SPOUSE CHANGE MM/DD/CCYY
                           MARITIAL STATUS X
                           SPOUSE FIRST NAME XXXXXXXXXXXXXXX
                           SPOUSE LAST  NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           SPOUSE DATE OF BIRTH  MM/DD/CCYY
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           SPOUSE PHONE NUMBER (999) 999-9999
                           SPOUSE SSN 999-99-9999

                           RECIPIENT'S SPONSOR INFORMATION
```


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```
                          SPONSOR ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          SPONSOR ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          CITY XXXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                          ZIP CODE XXXXX   ZIP+4 XXXX
                          SPONSOR PHONE NUMBER (999) 999-9999

                          NAME OF PERSON REPORTING UPDATES
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON REPORTING UPDATES (999) 999-9999
                          CERTIFIED APPLICATION ASSISTER X
                          NAME OF PERSON ASSISTING
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON ASSISTING (999) 999-9999

<page break>

Report  : ELG-0070-D                                ALABAMA MEDICAID AGENCY                        Run Date:
MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM               Run Time:
HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT             Page:
999,999

RECIPIENT ID:  999999999999

NUMBER OF RECIPIENTS PROCESSED  99,999,999

                                              ** END OF REPORT **
                                              ** NO DATA THIS RUN **
```

7.27.3 ELG-0070-D – Recipient Portal Demographic Updates Report Field Descriptions

Field	Description	Length	Data Type
ADDRESS 1	First line of the recipient's street address.	30	Character
ADDRESS 2	Second line of the recipient's street address.	30	Character
CERTIFIED APPLICATION ASSISTER	Indicator for Certified Application Assister.	1	Character
CERTIFYING AGENCY	Certifying Agency.	1	Character
CITY	City where the recipient resides.	25	Character
DATE OF BIRTH	Date of birth of the recipient.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
DATE OF SPOUSE CHANGE	Date of marital status change.	8	Date (MM/DD/CCYY)
HOME PHONE	Home phone number of the recipient.	10	Character
MARITIAL STATUS	Indicates the marital status of a recipient.	1	Character
NAME OF PERSON ASSISTING	Name of the person assisting the update.	60	Character
NAME OF PERSON REPORTING UPDATES	Name of person reporting the update.	60	Character
NUMBER OF RECIPIENTS PROCESSED	Total number of recipients requesting updates.	10	Number (Integer)
OTHER PHONE	An additional phone number for contacting the recipient.	10	Character
PHONE NUMBER OF PERSON ASSISTING	Phone number of the person assisting the update.	10	Character
PHONE NUMBER OF PERSON REPORTING UPDATES	Phone number of person reporting the update.	10	Character
RECIPIENT FIRST NAME	First name of a recipient.	15	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
RECIPIENT LAST NAME	Last name of a recipient.	30	Character
RESIDENCE COUNTY	County code of Residence.	2	Character
SEX	Indicates the gender of the recipient.	1	Character
SPONSOR ADDRESS 1	First line of the sponsor's street address.	30	Character
SPONSOR ADDRESS 2	Second line of the sponsor's street address.	30	Character
SPONSOR CITY	City where the sponsor resides.	25	Character
SPONSOR PHONE NUMBER	Phone number of the sponsor.	10	Character

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Field	Description	Length	Data Type
SPONSOR STATE	State where the sponsor resides.	2	Character
SPONSOR ZIP CODE	The five character zip code for the sponsor.	5	Character
SPONSOR ZIP+4	The zip plus four of the sponsor.	4	Character
SPOUSE ADDRESS 1	First line of the spouse's street address.	30	Character
SPOUSE ADDRESS 2	Second line of the spouse's street address.	30	Character
SPOUSE CITY	City where the spouse resides.	25	Character
SPOUSE DATE OF BIRTH	Date of birth of the spouse.	8	Date (MM/DD/CCYY)
SPOUSE FIRST NAME	First name of the spouse.	15	Character
SPOUSE LAST NAME	Last name of the spouse.	30	Character
SPOUSE PHONE NUMBER	Phone number of the spouse.	10	Character
SPOUSE SSN	Social security number of the spouse.	9	Character
SPOUSE STATE	State where the spouse resides.	2	Character
SPOUSE ZIP CODE	The five character zip code of the spouse.	5	Character
SPOUSE ZIP+4	The zip plus four of the spouse.	4	Character
STATE	State where the recipient resides.	2	Character
ZIP CODE	The five character zip code for the recipienrecipient.t	5	Character
ZIP+4	The zip plus four of the recipient.	4	Character

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7.28 ELG-0071-D – Recipient Portal Demographic Updates Daily Report

7.28.1 ELG-0071-D – Recipient Portal Demographic Updates Daily Report Narrative

This report will contain updates submitted by the Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC.

RCC will apply the updates to the AMAES CICS screens for the data on this report.

7.28.2 ELG-0071-D – Recipient Portal Demographic Updates Daily Report Layout

```
Report  : ELG-0071-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: ELG_RECIP_UPDS                 RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT                   Page:    999,999


RECIPIENT ID:  XXXXXXXXXXXX            CERTIFYING AGENCY   X
                           RECIPIENT INFORMATION
                           RECIPIENT FIRST  NAME XXXXXXXXXXXXXXX
                           RECIPIENT MIDDLE NAME XXXXXXXXXXXXXXX
                           RECIPIENT LAST   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           RECIPIENT SUFFIX NAME XXXX

                           DATE OF BIRTH MM/DD/CCYY
                           SEX X
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           RESIDENCE COUNTY XX
                           HOME PHONE (999) 999-9999 OTHER PHONE (999) 999-9999

                           RECIPIENT'S SPOUSE INFORMATION
                           DATE OF SPOUSE CHANGE MM/DD/CCYY
                           MARITIAL STATUS X
                           SPOUSE FIRST  NAME XXXXXXXXXXXXXXX
                           SPOUSE MIDDLE NAME XXXXXXXXXXXXXXX
                           SPOUSE LAST   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           SPOUSE SUFFIX NAME XXXX
                           SPOUSE DATE OF BIRTH  MM/DD/CCYY
                           ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                           CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                           ZIP CODE XXXXX   ZIP+4 XXXX
                           SPOUSE PHONE NUMBER (999) 999-9999
                           SPOUSE SSN 999-99-9999
                           RECIPIENT'S SPONSOR INFORMATION
                           SPONSOR ADDRESS 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
                          SPONSOR ADDRESS 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          CITY XXXXXXXXXXXXXXXXXXXXXXXXX   STATE XX
                          ZIP CODE XXXXX   ZIP+4 XXXX
                          SPONSOR PHONE NUMBER (999) 999-9999

                          NAME OF PERSON REPORTING UPDATES
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON REPORTING UPDATES (999) 999-9999
                          CERTIFIED APPLICATION ASSISTER X
                          NAME OF PERSON ASSISTING
                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                          PHONE NUMBER OF PERSON ASSISTING (999) 999-9999

<page break>

Report  : ELG-0071-D                                ALABAMA MEDICAID AGENCY                                Run Date: MM/DD/CCYY
Process : ELGJD071                            MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: ELG_RECIP_UPDS                RECIPIENT PORTAL DEMOGRAPHIC UPDATES DAILY REPORT                  Page:    999,999


RECIPIENT ID:  999999999999

NUMBER OF RECIPIENTS PROCESSED  99,999,999

                                                  ** END OF REPORT **
                                                ** NO DATA THIS RUN **
```


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7.28.3 ELG-0071-D – Recipient Portal Demographic Updates Report Field Descriptions

Field	Description	Length	Data Type
ADDRESS 1	First line of the recipient's street address.	30	Character
ADDRESS 2	Second line of the recipient's street address.	30	Character
CERTIFIED APPLICATION ASSISTER	Indicator for Certified Application Assister.	1	Character
CERTIFYING AGENCY	Certifying Agency.	1	Character
CITY	City where the recipient resides.	25	Character
DATE OF BIRTH	Date of birth of the recipient.	8	Date (MM/DD/CCYY)
DATE OF SPOUSE CHANGE	Date of marital status change.	8	Date (MM/DD/CCYY)
HOME PHONE	Home phone number of the recipient.	10	Character
MARITIAL STATUS	Indicates the marital status of a recipient.	1	Character
NAME OF PERSON ASSISTING	Name of the person assisting the update.	60	Character
NAME OF PERSON REPORTING UPDATES	Name of person reporting the update.	60	Character
NUMBER OF RECIPIENTS PROCESSED	Total number of recipients requesting updates.	10	Number (Integer)
OTHER PHONE	An additional phone number for contacting the recipient.	10	Character
PHONE NUMBER OF PERSON ASSISTING	Phone number of the person assisting the update.	10	Character

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Field	Description	Length	Data Type
PHONE NUMBER OF PERSON REPORTING UPDATES	Phone number of person reporting the update.	10	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
RECIPIENT FIRST NAME	First name of a recipient.	15	Character
RECIPIENT MIDDLE NAME	Middle name of a recipient.	15	Character
RECIPIENT LAST NAME	Last name of a recipient.	30	Character
RECIPIENT SUFFIX NAME	Suffix name of a recipient.	4	Character
RESIDENCE COUNTY	County code of Residence.	2	Character
SEX	Indicates the gender of the recipient.	1	Character
SPONSOR ADDRESS 1	First line of the sponsor's street address.	30	Character
SPONSOR ADDRESS 2	Second line of the sponsor's street address.	30	Character
SPONSOR CITY	City where the sponsor resides.	25	Character
SPONSOR PHONE NUMBER	Phone number of the sponsor.	10	Character
SPONSOR STATE	State where the sponsor resides.	2	Character
SPONSOR ZIP CODE	The five character zip code for the sponsor.	5	Character
SPONSOR ZIP+4	The zip plus four of the sponsor.	4	Character
SPOUSE ADDRESS 1	First line of the spouse's street address.	30	Character
SPOUSE ADDRESS 2	Second line of the spouse's street address.	30	Character
SPOUSE CITY	City where the spouse resides.	25	Character
SPOUSE DATE OF BIRTH	Date of birth of the spouse.	8	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
SPOUSE FIRST NAME	First name of the spouse.	15	Character
SPOUSE MIDDLE NAME	Middle name of the spouse.	15	Character
SPOUSE LAST NAME	Last name of the spouse.	30	Character
SPOUSE SUFFIX NAME	Suffix name of the spouse.	4	Character
SPOUSE PHONE NUMBER	Phone number of the spouse.	10	Character
SPOUSE SSN	Social security number of the spouse.	9	Character
SPOUSE STATE	State where the spouse resides.	2	Character
SPOUSE ZIP CODE	The five character zip code of the spouse.	5	Character
SPOUSE ZIP+4	The zip plus four of the spouse.	4	Character
STATE	State where the recipient resides.	2	Character
ZIP CODE	The five character zip code for the recipient.	5	Character
ZIP+4	The zip plus four of the recipient.	4	Character

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7.29 ELG-0072-D – Plastic Card ID Updates Report

7.29.1 ELG-0072-D – Plastic Card ID Update Report Narrative

This report will show all plastic ID cards requested by Recipients via the Recipient Portal. This report will be stored in COLD and worked by RCC. RCC will apply the requests to the AMAES CICS screens. The report is sorted by the Certifying Agency column.

7.29.2 ELG-0072-D – Plastic Card ID Updates Report Layout

```
Report  : ELG-0072-D                          ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : ELGJD072                      MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   HH:MM:SS
Location: ELG_CARDRQST                          PLASTIC CARD ID UPDATES                            Page:    999,999
                                               REPORT PERIOD: MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------
   RECIPIENT ID     REASON FOR REQUEST  CERTIFYING AGENCY  DATE REQUESTED   TIME REQUESTED
-------------------------------------------------------------------------------------------------------------------

   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT
   XXXXXXXXXXXX     X                   X                  MM/DD/CCYY       HHMMSSTT


TOTAL CARD UPDATES            999,999,999


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

7.29.3 ELG-0072-D -- Plastic Card ID Updates Report Field Descriptions

Field	Description	Length	Data Type
CERTIFYING AGENCY	Certifying Agency	1	Character
DATE REQUESTED	Date plastic card ID update requested.	8	Date (MM/DD/CCYY)
REASON FOR REQUEST	Reason for the request.	1	Character
RECIPIENT ID	Recipient identification number of the recipient.	12	Character
TIME REQUESTED	Time update requested. In HHMMSSMM format.	8	Character

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Field	Description	Length	Data Type
TOTAL CARD UPDATES	Total number of card updates	11	Number (Integer)

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7.30 ELG-0134-M—Monthly Date of Death Returned to Zero Report

7.30.1 ELG-0134-M—Monthly Date of Death Returned to Zero Report Narrative

The ELG-0134-M is a report of death dates that were changed from a 'real' date to zero throughout the month. The report contains the recipient's ID, last name, first name, ssn, and previous date of death. The report is sorted by recipient ID.

This report is a summary of all deaths that were changed from a 'real' date to zero during the month. The information is sorted by recipient ID.

7.30.2 ELG-0134-M—Monthly Date of Death Returned to Zero Report Layout

```
Report  : ELG-0134-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : ELGJM025                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MI:SS
Location: ELGPM025                       DATE OF DEATH RETURNED TO ZERO REPORT                            Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------
                        RECIPIENT ID      LAST NAME             FIRST NAME       SSN          PREVIOUS DATE OF DEATH
-------------------------------------------------------------------------------------------------------------------------

                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY
                        XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX 999999999       MM/DD/CCYY


                            TOTAL NUMBER OF DATES OF DEATHS CHANGED THIS PERIOD:         999,999


                                                   ** END OF REPORT **
```

7.30.3 ELG-0134-M—Monthly Date of Death Returned to Zero Report Field Descriptions

Field	Description	Data Type	Length
(Heading Date Range - from)	This is the beginning date in the date range used to determine which date of deaths to report. The ones received during the date range are reported.	Date (MM/DD/CCYY)	10
(Heading Date Range - to)	This is the ending date in the date range used to determine which date of deaths to report. The ones received during the date range are reported.	Date (MM/DD/CCYY)	10
First Name	First name of the Recipient.	Character	15

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Field	Description	Data Type	Length
Last Name	Last Name of the Recipient.	Character	20
Previous Date of Death	The recipient's previous date of death prior to changing to zero.	Date (MM/DD/CCYY)	10
Recipient ID	Medicaid ID of the client that died.	Character	12
SSN	SSN of Recipient.	Number (Integer)	9
Total Number of Recips	Total Number of Recipients whose date of death was changed from a 'real' date to zero during the month.	Number (Integer)	7

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7.31 ELG-0135-M -- Lockin Eligibility Status Report

7.31.1 ELG-0135-M -- Lockin Eligibility Status Report Narrative

The Lockin Eligibility Status report is used to identify all recipients who have had a change of AMAES eligibility status during the month.

The purpose of the Eligibility Status Report is to provide EDS and the Alabama Medicaid Agency with information regarding changed AMAES status of lockin recipients once a month. This report is produced monthly.

7.31.2 ELG-0135-M -- Lockin Eligibility Status Report Layout

```
Report  : ELG-0135D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : ELGJM135                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: ELGPM135                LOCK-IN RECIPIENTS WHOSE ELIGIBILITY STATUS HAS CHANGED                 Page:    999,999
                                                 REPORT PERIOD: MM/CCYY


       RECIPIENT ID    ****** RECIPIENT NAME  ******  STATUS    ******   PHYSICIAN   ******          ******   PHARMACY   ******
        BASE ID      FIRST          M  LAST          CURR PREV  PROV #       PROVIDER  NAME          PROV #      PROVIDER  NAME
*****************************************************************************************************************************************

XXXXXXXXXXXX   XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX 9   9   XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   XXXXXXXXXXXXXXX X XXXXXXXXXXXXXXXXXXXX 9   9   XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX

                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN ***
```

7.31.3 ELG-0135-M -- Lockin Eligibility Status Report Field Descriptions

Field	Description	Length	Data Type
Pharmacy Prov #	Recipient's current pharmacy number. Up to two active pharmacy providers can be listed.	9	Character
Pharmacy Provider Name	Recipient's current pharmacy, that matches the pharmacy provider number entered.	25	Character
Physician Prov #	Current physician's provider number.	9	Character
Physician Provider Name	Physician's name that matches the physician listed.	25	Character
Recipient Name First	First name of the recipient.	15	Character

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Field	Description	Length	Data Type
Recipient ID/ Base ID	Recipient's original Base identification number.	12	Character
Recipient Name Last	Last name of the recipient.	20	Character
Recipient Name M	Middle initial of the recipient.	1	Character
Status Current	Current AMAES status of the recipient.	1	Number (Integer)
Status Previous	Previous AMAES status of the recipient, before the change.	1	Number (Integer)

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7.32 ELG-0151-M -- EDB Processing Report

7.32.1 ELG-0151-M -- EDB Processing Report Narrative

The EDB Processing report is a monthly report that lists the status of EDB processing that was completed.

7.32.2 ELG-0151-M -- EDB Processing Report Layout

```
 Report  : ELG-0151-M                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJM150                       MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: ELGPM151                              EDB PROCESSING REPORT                                             Page:    999,999
                                               REPORT PERIOD: MM/CCYY

                                                                                  ----- ADDS -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE   END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                               ----- BYPASSED -----
                                   ----------- PART A ------------  ----------- PART B ------------
                    RECIPIENT     PAYOR OPT BEG DATE  END DATE    PAYOR OPT BEG DATE    END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                                ----- DENIED -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE END DATE    PAYOR OPT BEG DATE    END DATE     HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                               ----- SHUTDOWN -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE  END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX

                                                                                ----- UPDATES -----
                                   ----------- PART A ------------  ----------- PART B ------------
                     RECIPIENT    PAYOR OPT BEG DATE   END DATE    PAYOR OPT BEG DATE   END DATE    HIC ID
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
                     999999999999  XXX   X  MM/DD/CCYY MM/DD/CCYY   XXX   X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX
```


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```
                                        ----- ERRORS -----
                              ----------- PART A ------------  ----------- PART B ------------
 RECIPIENT    PAYOR OPT BEG DATE    END DATE   PAYOR OPT BEG DATE   END DATE    HIC ID        COMMENT
999999999999  XXX    X  MM/DD/CCYY MM/DD/CCYY   XXX    X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999  XXX    X  MM/DD/CCYY MM/DD/CCYY   XXX    X  MM/DD/CCYY MM/DD/CCYY  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                          SUMMARY
                                TOTAL RECORDS PROCESSED:  999,999,999
                                TOTAL ADDS:                99,999,999
                                TOTAL BYPASSED:            99,999,999
                                TOTAL DENIED:              99,999,999
                                TOTAL SHUTDOWN:            99,999,999
                                TOTAL UPDATES:             99,999,999
                                TOTAL ERRORS:              99,999,999


                              ***   END OF REPORT   ***
                            ***   NO DATA THIS RUN   ***
```

7.32.3 ELG-0151-M -- EDB Processing Report Field Descriptions

Field	Description	Length	Data Type
Beg Date	Begin date for EDB.	10	Date (MM/DD/CCYY)
End Date	End date for EDB.	10	Date (MM/DD/CCYY)
HIC ID	HIC Number provided by CMS on the EDB file.	12	Number (Integer)
OPT	EDB Status Code.	1	Character
Payor	Premium Payor Code on the EDB File.	3	Character
Recipient	Recipient’s original Medicaid Base identification number.	12	Number (Integer)

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Field	Description	Length	Data Type
Total Adds	Total Number of EDB Records which caused Part A or B data to be added.	10	Number (Decimal)
Total Bypassed	Total Number of EDB Records with a status of Bypassed. (These are records for which there was no Part A or B data on the EDB file.)	10	Number (Integer)
Total Denied	Total Number of EDB records with a status of denied. (Note: We do not generate denials from the EDB file.)	10	Number (Integer)
Total Errors	Total Number of EDB records with a status of Error. (Note: Part A and B EDB updates do not generate errors.)	10	Number (Integer)
Total Records Processed	Total number of EDB Records Processed.	11	Number (Decimal)
Total Shutdown	Number of EDB Records with an incoming EDB Status of Shutdown. (Note: Alabama does not calculate shutdowns. These would be reflected as updates.)	10	Number (Integer)
Total Updates	Total Number of EDB Records which caused an update to Part A or B information.	10	Number (Integer)

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7.33 ELG-0612-M – CMS Eligibility Error Report

7.33.1 ELG-0612-M – CMS Eligibility Error Report Narrative

The CMS Eligibility Error Report lists the Recipients returned on the CMS Eligibility Response File with reportable BO Errors. Reportable errors are listed on the tables, T_REF_CDE_VALUE_TYPE and T_REF_CDE_VALUE_GROUP. The purpose of this report is to assist in research of crossover claims errors. This report is produced monthly after the CMS Eligibility Response File has been received from CMS.

7.33.2 ELG-0612-M – CMS Eligibility Error Report Layout

```
Report  : ELG-0612-M                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : ELGJM612                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: ELG_CMS_ERF                       CMS ELIGIBILITY ERROR REPORT                                           Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------------
 BENEFICIARY   BENEFICIARY   BENEFICIARY                BENEFICIARY   SUPP ELIG   SUPP ELIG   BO1   BO2   BO3   BO4   FILE UPDATE
 HIC #         MEDICAID ID   SURNAME                    FIRST         FROM DATE   TO DATE                           INDICATOR
-------------------------------------------------------------------------------------------------------------------------------------

                                                   Date Processed:  MM/DD/CCYY

 Reportable Errors and Descriptions:
      XXXX  -  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X
 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X
 XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXX  XXXXXXXX    XXXXXXXX    XXXX  XXXX  XXXX  XXXX  X

 Total Rows Reported:                999999999
 Total Unique Recipients Reported:   999999999
 Totals Per Error Reported:
      XXXX  -  999999999


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

7.33.3 ELG-0612-M – CMS Eligibility Error Report Field Descriptions

Field	Description	Length	Data Type
Beneficiary HIC #	Recipient Medicare ID Number	12	Character
Beneficiary Medicaid ID	Recipient Medicaid ID Number	12	Character

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Field	Description	Length	Data Type
Beneficiary Surname	Recipient Last Name	24	Character
Beneficiary First	Recipient First Name	12	Character
Supp Elig From Date	Medicare Supplemental From Date	8	Character
Supp Elig To Date	Medicare Supplemental To Date	8	Character
BO1	BO Error 1	4	Character
BO2	BO Error 2	4	Character
BO3	BO Error 3	4	Character
BO4	BO Error 4	4	Character
File Update Indicator	Type of Update Values: A – Add, C – Change/Update, D - Delete	1	Character

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7.34 ELG-1095-M -- IRS 1095-B Form Report

7.34.1 ELG-1095-M -- IRS 1095-B Form Report Narrative

A viewable version of the 1095-B form will be stored in Feith, indexed by Recipient ID, Tax Year, and Run Date, for recipients covered by Medicaid. This will assist the RCC on any inquiries they may receive. *Note: Part II of the form will be empty because the 1095 forms created for these recipients are not employed by Medicaid.

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7.34.2 ELG-1095-M -- IRS 1095-B Form Report Layout

560115

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

▶ **Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b*.**

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2015

Part I **Responsible Individual**

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ▶ ☐		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II **Employer Sponsored Coverage** (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III **Issuer or Other Coverage Provider** (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV **Covered Individuals** (Enter the information for each covered individual(s).)

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B** (2015)

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7.34.3 ELG-1095-M -- IRS 1095-B Form Report Field Descriptions

Field	Description	Length	Data Type
Box 1: Name Of Responsible Individual	Name of the responsible individual for whom the form is created for.	50	Character
Box 16: Name	Name of the issuer or other coverage provider.	23	Character
Box 17: Employer Identification Number	IRS assigned identification number.	9	Number (Integer)
Box 18: Contact Telephone Number	Telephone number of the coverage provider.	14	Character
Box 19: Street Address	Address of the coverage provider.	13	Character
Box 2: Social Security Number	Social Security Number of the responsible individual for whom the form is created for. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box 20: City or Town	City of the coverage provider.	10	Character
Box 21: State or Province	State of the coverage provider.	2	Character
Box 22: Country and Zip or Foreign Postal Code	Zip code of the coverage provider.	10	Character
Box 3: Date of Birth	Date of birth of the responsible individual for whom the form is created for.	10	Date (MM/DD/CCYY)
Box 4: Street Address	Address of the responsible individual for whom the form is created for.	30	Character
Box 5: City or Town	City of the responsible individual for whom the form is created for.	30	Character

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Field	Description	Length	Data Type
Box 6: State or Province	State of the responsible individual for whom the form is created for.	2	Character
Box 7: Country and Zip or Foreign Postal Code	Zip code of the responsible individual for whom the form is created for.	10	Character
Box 8: Origin Of The Policy	This is the code for the type of coverage in which the individual or other covered individuals were enrolled. Valid values are: A. Small Business Health Options Program (SHOP) B. Employer-sponsored coverage C. Government-sponsored program D. Individual market insurance E. Multiemployer plan F. Other designated minimum essential coverage	1	Character
Box A (PART IV): Name Of Covered Individual(s)	Name of the covered individual.	24	Character
Box B (PART IV): SSN	Social Security Number of the covered individual. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box C (PART IV): DOB	Date of birth of the covered individual.	10	Date (MM/DD/CCYY)
Box D (PART IV): Covered All 12 Months	Indicator if the individual was covered for at least one day in every month of the year.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Apr)	Indicator if the individual was covered for at least one day in the month of April.	1	Character
BOX E: Months of coverage (PART IV - Aug)	Indicator if the individual was covered for at least one day in the month of August.	1	Character
BOX E: Months of coverage (PART IV - Dec)	Indicator if the individual was covered for at least one day in the month of December.	1	Character
BOX E: Months of coverage (PART IV - Feb)	Indicator if the individual was covered for at least one day in the month of February.	1	Character
BOX E: Months of coverage (PART IV - Jan)	Indicator if the individual was covered for at least one day in the month of January.	1	Character
BOX E: Months of coverage (PART IV - Jul)	Indicator if the individual was covered for at least one day in the month of July.	1	Character
BOX E: Months of coverage (PART IV - Jun)	Indicator if the individual was covered for at least one day in the month of June.	1	Character
BOX E: Months of coverage (PART IV - Mar)	Indicator if the individual was covered for at least one day in the month of March.	1	Character
BOX E: Months of coverage (PART IV - May)	Indicator if the individual was covered for at least one day in the month of May.	1	Character
BOX E: Months of coverage (PART IV - Nov)	Indicator if the individual was covered for at least one day in the month of November.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Oct)	Indicator if the individual was covered for at least one day in the month of October.	1	Character
BOX E: Months of coverage (PART IV - Sep)	Indicator if the individual was covered for at least one day in the month of September.	1	Character

7.35 ELG-1095-M-16-- IRS 1095-B Form Report

7.35.1 ELG-1095-M-16-- IRS 1095-B Form Report Narrative

A viewable version of the 2016 1095-B form will be stored in Feith, indexed by Recipient ID, Tax Year, and Run Date, for recipients covered by Medicaid. This will assist the RCC on any inquiries they may receive. *Note: Part II of the form will be empty because the 1095 forms created for these recipients are not employed by Medicaid.

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7.35.2 ELG-1095-M-16-- IRS 1095-B Form Report Layout

560116

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

☒ Do not attach to your tax return. Keep for your records
☒ Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

20 16

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN or other TIN)	3 Date of birth (If SSN or other TIN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ☒ ☐		9 Reserved	

Part II Information about Certain Employer-Sponsored Coverage (see instructions)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual.)

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form 1095-B (2016)

7.35.3

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7.35.3 ELG-1095-M-16-- IRS 1095-B Form Report Field Descriptions

Field	Description	Length	Data Type
Box 1: Name Of Responsible Individual	Name of the responsible individual for whom the form is created for.	50	Character
Box 16: Name	Name of the issuer or other coverage provider.	23	Character
Box 17: Employer Identification Number	IRS assigned identification number.	9	Number (Integer)
Box 18: Contact Telephone Number	Telephone number of the coverage provider.	14	Character
Box 19: Street Address	Address of the coverage provider.	13	Character
Box 2: Social Security Number	Social Security Number of the responsible individual for whom the form is created for. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box 20: City or Town	City of the coverage provider.	10	Character
Box 21: State or Province	State of the coverage provider.	2	Character
Box 22: Country and Zip or Foreign Postal Code	Zip code of the coverage provider.	10	Character
Box 3: Date of Birth	Date of birth of the responsible individual for whom the form is created for.	10	Date (MM/DD/CCYY)
Box 4: Street Address	Address of the responsible individual for whom the form is created for.	30	Character
Box 5: City or Town	City of the responsible individual for whom the form is created for.	18	Character
Box 6: State or Province	State of the responsible individual for whom the form is created for.	2	Character
Box 7: Country and Zip or Foreign Postal Code	Zip code of the responsible individual for whom the form is created for.	10	Character
Box 8: Origin Of The Health Coverage	This is the code for the type of coverage in which the individual or other covered individuals were enrolled. Valid values are:	1	Character

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Field	Description	Length	Data Type
	A. Small Business Health Options Program (SHOP) B. Employer-sponsored coverage C. Government-sponsored program D. Individual market insurance E. Multiemployer plan F. Other designated minimum essential coverage		
Box A (PART IV): Name Of Covered Individual(s)	Name of the covered individual.	23	Character
Box B (PART IV): SSN	Social Security Number of the covered individual. Only the last four digits will be displayed as the format will be ***-**-9999.	11	Character
Box C (PART IV): DOB	Date of birth of the covered individual.	10	Date (MM/DD/CCYY)
Box D (PART IV): Covered All 12 Months	Indicator if the individual was covered for at least one day in every month of the year.	1	Character
BOX E: Months of coverage (PART IV - Apr)	Indicator if the individual was covered for at least one day in the month of April.	1	Character
BOX E: Months of coverage (PART IV - Aug)	Indicator if the individual was covered for at least one day in the month of August.	1	Character
BOX E: Months of coverage (PART IV - Dec)	Indicator if the individual was covered for at least one day in the month of December.	1	Character
BOX E: Months of coverage (PART IV - Feb)	Indicator if the individual was covered for at least one day in the month of February.	1	Character
BOX E: Months of coverage (PART IV - Jan)	Indicator if the individual was covered for at least one day in the month of January.	1	Character
BOX E: Months of coverage (PART IV - Jul)	Indicator if the individual was covered for at least one day in the month of July.	1	Character
BOX E: Months of coverage (PART IV - Jun)	Indicator if the individual was covered for at least one day in the month of June.	1	Character

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Field	Description	Length	Data Type
BOX E: Months of coverage (PART IV - Mar)	Indicator if the individual was covered for at least one day in the month of March.	1	Character
BOX E: Months of coverage (PART IV - May)	Indicator if the individual was covered for at least one day in the month of May.	1	Character
BOX E: Months of coverage (PART IV - Nov)	Indicator if the individual was covered for at least one day in the month of November.	1	Character
BOX E: Months of coverage (PART IV - Oct)	Indicator if the individual was covered for at least one day in the month of October.	1	Character
BOX E: Months of coverage (PART IV - Sep)	Indicator if the individual was covered for at least one day in the month of September.	1	Character

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7.36 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report

7.36.1 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Narrative

Users access LTC and Waiver Monthly Activity Report (LTC-0007-M) to identify recipients who have had any admission notification other than a discharge accepted and written to the LOC database. The frequency for this report is monthly.

This report's program will purge records from the T_RE_LTC_REQUEST table that were added prior to the begin run date of the monthly report. For example, if the reporting date is from 12/01/2008 to 12/31/2008, all records that were added prior to 12/01/2008 will be purged from the table prior to the generation of the December 2008 report.
Report is sorted in such a manner where provider belonging to the same specialty are grouped together and they are are further sorted grouping provider belonging to the same entity displaying NPI id's first followed by the MCD id of the same NPI. Waivers are sorted first.

7.36.2 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Layout

```
REPORT  : LTC-0007-M                    ALABAMA MEDICAID AGENCY                    RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM007               MEDICAID MANAGEMENT INFORMATION SYSTEMS           RUN TIME   :   HH:MM:SS
LOCATION: LTCPM007               LTC AND WAIVER MONTHLY ACTIVITY REPORT            PAGE       :      99999


PROVIDER SUBMITTING APPLICATION:        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER NUMBER OF SUBMITTING PROVIDER: XXXXXXXXX
START DATE:  MM/DD/CCYY                 END DATE:  MM/DD/CCYY                              XXXXXXXXXXXXXXXXXXXXXX
RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXXXXXXX,XXXXXXXXXXXXXXXXXXXX
RECIPIENT NUMBER:  XXXXXXXXXXXX                                SSN:  XXX-XX-XXXX   MCARE:  XXX



                                  **  END OF REPORT  **
                          * * N O   D A T A   T H I S   R E P O R T * *
```

7.36.3 LTC-0007-M – LTC AND WAIVER MONTHLY ACTIVITY Report Field Descriptions

Field	Description	Length	Data Type
ADMISSION TYPE	Admission type - Note the field name is not displayed on the report since the information is self-evident.	Character	22
END DATE	End date of services added to the LTC or Waiver file.	Date (MM/DD/CCYY)	8

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Field	Description	Length	Data Type
MCARE	Indicates if recipient had any Medicare A or B coverage at time of admission.	Character	3
PROVIDER NUMBER OF SUBMITTING PROVIDER	Medicaid provider number.	Character	10
PROVIDER SUBMITTING APPLICATION	Provider name submitted on application	Character	50
RECIPIENT NAME	Last and first name of Medicaid recipient.	Character	50
RECIPIENT NUMBER	Recipient’s Medicaid number.	Character	12
SSN	Recipient's Social Security number.	Character	9
START DATE	Start date of services added to the LTC or Waiver file.	Date (MM/DD/CCYY)	8

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7.37 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT

7.37.1 LTC-0008-M – LTC AND TRADING PARTNER ERROR ACTIVITY REPORT Narrative

This program creates the LTC Daily Submitter Error Activity Report.

7.37.2 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT Layout

```
REPORT  : LTC-0008-M                    ALABAMA MEDICAID AGENCY                  RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM008               MEDICAID MANAGEMENT INFORMATION SYSTEMS         RUN TIME   :   HH:MM:SS
LOCATION: LTCPM008               LTC TRADING PARTNER ERROR ACTIVITY REPORT       PAGE       :      99999
                                            DATE: MM/DD/CCYY


TRADING PARTNER IDENTIFICATION:          XXXXXXXXX
PROVIDER SUBMITTING APPLICATION:        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
PROVIDER NUMBER OF SUBMITTING PROVIDER: XXXXXXXXXX
RECIPIENT NAME:  XXXXXXXXXXXXXXXXXXXXXXXXX,XXXXXXXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXX
RECIPIENT NUMBER:  XXXXXXXXXXXX                              SSN:  XXX-XX-XXXX


                          **  END OF REPORT  **
                  * * N O   D A T A   T H I S   R E P O R T * *
```

7.37.3 LTC-0008-M – LTC TRADING PARTNER ERROR ACTIVITY REPORT Field Descriptions

Field	Description	Length	Data Type
LTC ADMISSION TYPE DESCRIPTION	The description for the type of LTC ADMISSION.	Character	22
PROVIDER SUBMITTING APPLICATION	Provider name submitted on application.	Character	50
PROVIDER NUMBER OF SUBMITTING PROVIDER	PROVIDER NUMBER OF SUBMITTING PROVIDER - Medicaid provider number.	Character	15
SSN	Recipient's Social Security number.	Character	9
RECIPIENT NAME	Last and first name of Medicaid recipient.	Character	50
RECIPIENT NUMBER	Recipient’s Medicaid number.	Character	12

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Field	Description	Length	Data Type
TRADING PARTNER IDENTIFICATION	Trading partner id that is entered into the LTC admission notification via LTC software.	Character	9

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7.38 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY REPORT

7.38.1 LTC-0011-M – LTC AN PACE PROGRAM MONTHLY DISCHARGE ACTIVITY REPORT Narrative

This report will generate report of all recipients discharge from PACE program and moved to Nursing home

7.38.2 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY Report Layout

```
REPORT  : LTC-0011-M                    ALABAMA MEDICAID AGENCY                    RUN DATE   : MM/DD/CCYY
PROCESS : LTCJM011               MEDICAID MANAGEMENT INFORMATION SYSTEMS          RUN TIME   :   HH:MM:SS
LOCATION: LTCPM011             LTC PACE PROGRAM DISCHARGE ACTIVITY REPORT            PAGE    :      99999


RECIPIENT NAME:         @<<<<<<<<<<<<<<<<<<<   , @<<<<<<<<<<<<<<
RECIPIENT NUMBER:       @<<<<<<<<<<<<<<                 SSN:  @<<-@<-@<<<
DISCHARGE DATE FROM PACE PROGRAM:  @<<<<<<<<<
PROVIDER DISCHARGING RECIPIENT @<<<<<<<<<<<<<<<<<<
```

7.38.3 LTC-0011-M – LTC PACE PROGRAM MONTHLY DISCHARGE ACTIVITY Report Field Descriptions

Field	Description	Length	Data Type
DISCHARGE DATE FROM PACE PROGRAM	Discharge date from PACE program.	Character	10
LEVEL OF CARE SEGMENT OF RECIPIENT IN NURSING HOME START DATE END DATE	LEVEL OF CARE SEGMENT OF RECIPIENT IN NURSING HOME.	Character	20
NURSING HOME PROVIDER	NURSING HOME PROVIDER.	Character	50
NURSING HOME PROVIDER NUMBER	NURSING HOME PROVIDER NUMBER.	Character	15
PROVIDER DISCHARGING RECIPIENT	Provider name: Provider who discharge recipient from PACE program.	Character	50
PROVIDER NUMBER	Provider ID of provider who discharge recipient from PACE program.	Character	15
RECIPIENT NAME	Name of the recipient.	Character	40
RECIPIENT NUMBER	Recipient number.	Character	16
SSN	Social security number.	Character	11

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7.39 LTC-0012-W – LTC Weekly Discharge Explanation Report

7.39.1 LTC-0012-W – LTC Weekly Discharge Explanation Report Narrative

LTC Weekly Discharge Explanation Report (LTC-0012-W) - This is a weekly report to be used by the District Office to monitor recipients exiting level of care program.

This report only provides the weekly discharge activity for District Office (DO) certified recipients. It provides which DO they are associated and the reason code for the discharge. H for Recipient Discharged Home, D for Recipient Dead and T for recipient Terminated from the program. Need report narrative

7.39.2 LTC-0012-W – LTC Weekly Discharge Explanation Report Layout

```
Report  : LTC-0012-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : LTCJW012                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: LTCPW012                    LTC WEEKLY DISCHARGE EXPLANATION REPORT                              Page:    999,999

-------------------------------------------------------------------------------------------------------------------------------
 RECIPIENT        DO #     REVIEWER #     DISCHARGE
 ID                                       EXPLANATION
-------------------------------------------------------------------------------------------------------------------------------

 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################
 #############    ##       ##             # - ##################################################


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

7.39.3 LTC-0012-W – LTC Weekly Discharge Explanation Report Field Description

Field	Description	Data Type	Length
DO #	District Office #	Character	2
Discharge Explanation Code	Discharge explanation code	Character	1
Discharge Explanation Code Description	Discharge explanation code description	Character	50

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Field	Description	Data Type	Length
Recipient ID	Recipient's Medicaid ID	Character	12
Reviewer #	Reviewer ID number	Character	2

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AMMIS Reference User Manual (Part I)

Date Modified: 01/09/2019

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

Hewlett Packard Enterprise
301 Technacenter Drive
Montgomery, Alabama 36117

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1. Document control

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1.1 Document Information Page

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1.2 Amendment History

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09/27/2016	6.0		Application of RCO CO	DF 13612 Add Sections 6.14 Reference DRG Search and DRG Search Results panel Add Section 6,15 DRG Information- DRG Panel Add 6.16 DRG Maintenance - DRG Panel Add 6.17 DRG Mini Search - DRG Panel (Defect 13612, 6.17.4) Add 6.18 DRG Base Information - DRG Panel
10/27/2016	7.0		Application of CO 13778 and 14739	Added Section 4.4 - Changing Passwords Updated Reference Searcha and Search Results Panel – layout and field descriptions
09/09/2018	8.0		Application of CO 15069 and 14900	Updates to Reimburesment Rule panels Added Drug MMC Maintenance panel Update Drug Maintenance Panel
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11/28/2018	10.0		Application of CO 15264	Other-Fund Code Criteria Panel- panel layout, field descriptions updates
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1.3 Related Documentation

Document	Description	url

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2. Reference Data Maintenance Introduction

2.1 Reference Data Maintenance User Manual Overview

The AMMIS has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Reference Data Maintenance functional area.

This manual covers the following:

- Reference Data Maintenance Overview
- Reference Data Maintenance System Navigation
- Reference Maintenance Pages/Panels
- Reference Maintenance Reports

2.2 Reference Data Maintenance User Manual Objective

This section explains the objective of the AMMIS Reference Data Maintenance User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

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3. Reference Data Maintenance Overview

3.1 Introduction to Reference Data Maintenance

The Reference Data Maintenance function maintains a consolidated source of reference information that is accessed by the Alabama interChange System during performance of claims and adjustment processing functions, prior authorization functions, Third Party Liability (TPL) processing. The Reference Data Maintenance function also supports Alabama interChange System reporting functions.

The Reference Data Maintenance function maintains the following logical data groupings:

- Benefit Plan data set identifying a group of covered services (benefits) that are granted to a member who is deemed eligible for the services the benefit plan represents. Benefit Plan configuration includes:
  - Coverage Rules detailing restrictions for services within a Benefit Plan.
  - Reimbursement Rules for selecting a payment method to reimburse a Provider for services provided to an eligible member.
  - Billing Rules classifying services a Provider can bill within a contract.
- Diagnosis data set utilizing the International Classification of Diseases, Ninth Revision coding system and diagnosis coding.
- Drug data set of eleven (11) digit National Drug Codes (NDC) including descriptive and pricing information for each code.
- Edit/Audit Criteria data used to enforce State policy in adjudicating claims. The edit function verifies the accuracy, validity, required presence, format, consistency, allowable values, and integrity of data submitted. The audit function compares the data of a claim in process with other claim data in paid claims history to determine the appropriateness of the service reflected on the claim in relation to other services received by the member.
- ICD Procedure data set that contains International Classification of Diseases, Ninth Revision, Clinical Modification procedure codes used for inpatient hospital billing.
- Modifier data set that contains codes used to further describe and qualify services provided.
- Procedure data set that contains Centers for Medicare and Medicaid Services (CMS) Health Common Procedure Coding System (HCPCS) procedure codes, Common Procedure Terminology (CPT) procedure codes including descriptive and pricing information for each code.
- Revenue codes data set for use in processing claims for hospital inpatient and outpatient services including descriptive and pricing information for each code.

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4. Reference Data Maintenance System Navigation

4.1 Overview

The Alabama interChange System is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within interChange.

4.2 System Security

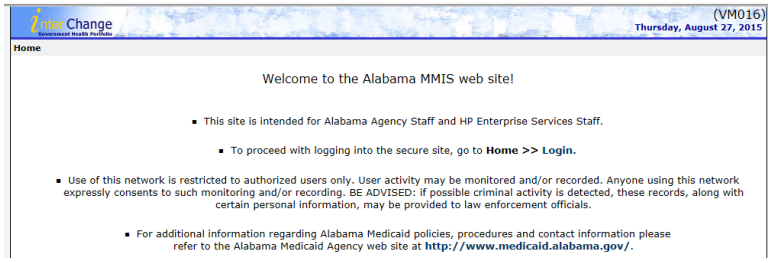
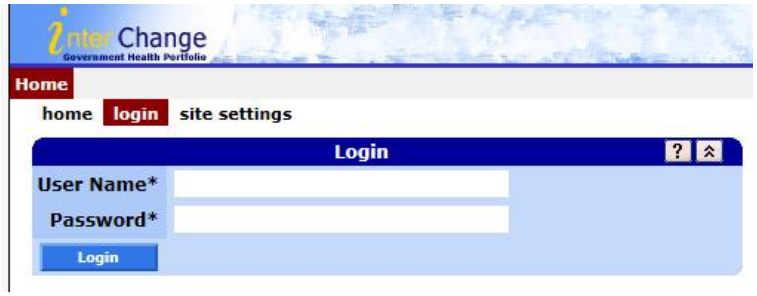
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log into the Alabama interChange website in order to utilize the services available within the secure portal.

4.3.1 Logging into the interChange System

Follow the steps below to log into the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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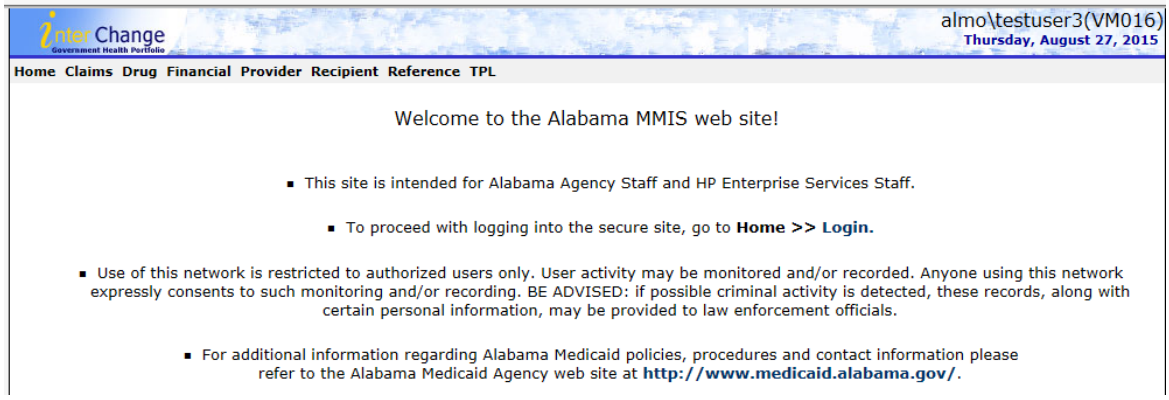
Step	Action	Response
		

4.3.2 Logging out of the interChange System

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

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4.3.3 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into interChange.	Home page displays.
2	Select View.	View menu displays.
3	Point to Text Size and click Smaller.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

4.4 Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact theAssistant MMIS Coordinator.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features, and where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms which are described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Hot Link
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

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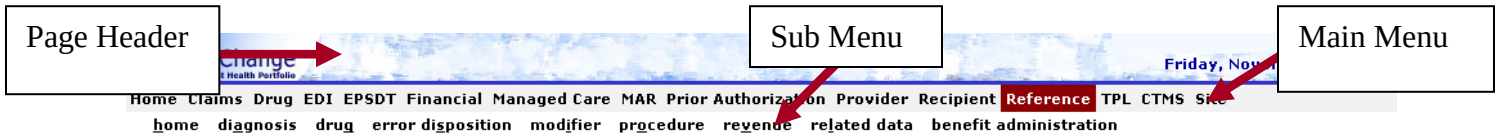
5.1 Page Layout

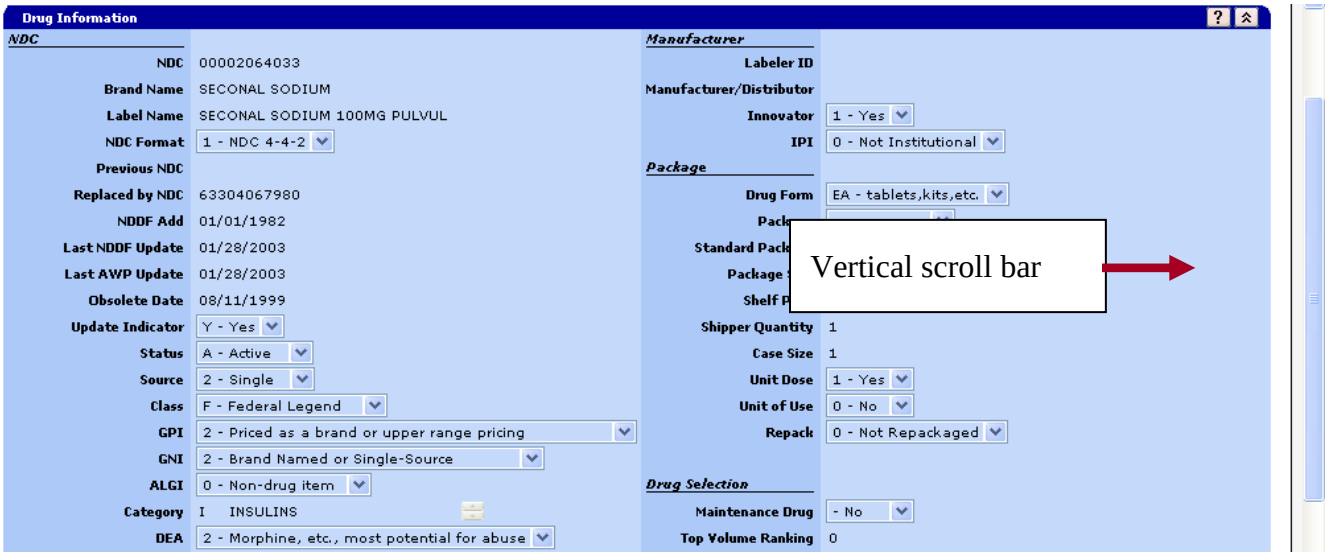
A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the EDS copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

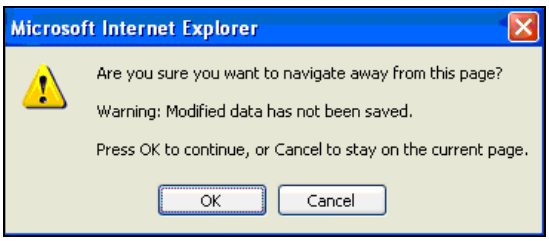
Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



If a user attempts to add, update, or delete information within the page prior to navigating away from the page, the system prompts the user with a pop-up window message. When the system generates the message detail panels are locked open, and navigating away from the page is not permitted until changes are either correctly saved or cancelled.



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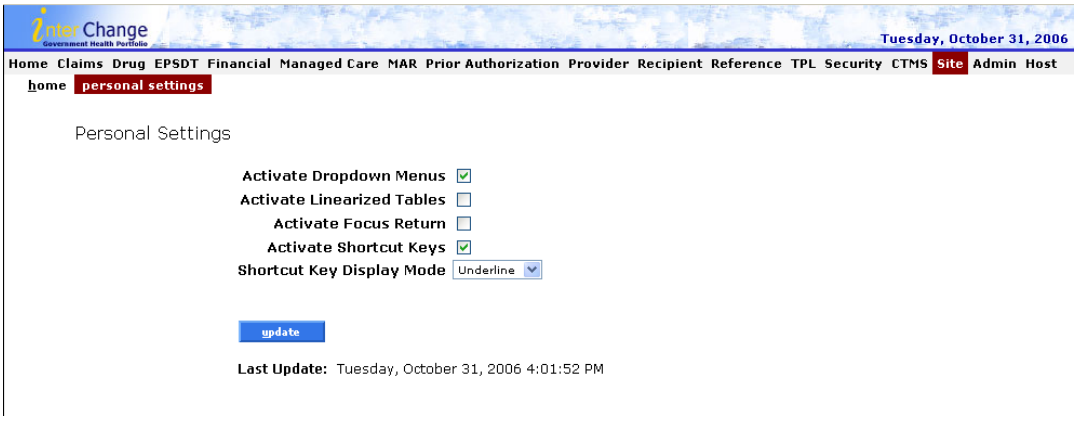
5.2 Shortcut Keys

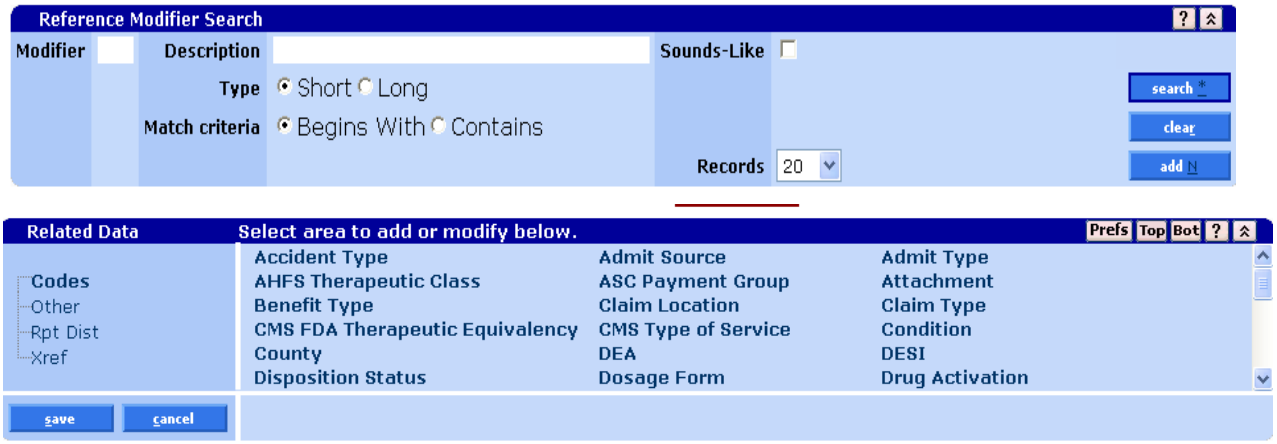
If the user activates the shortcut keys function, the Sub Menu links can be used in combination with (Ctrl +Alt + shortcut key) to quickly open the associated page.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the Reference Sub Menu, the user can use the shortcut keys to quickly navigate from the Reference Modifier panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter “L” is found within the horizontal bars on the Sub Menu related data link.



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5.3 Search Options

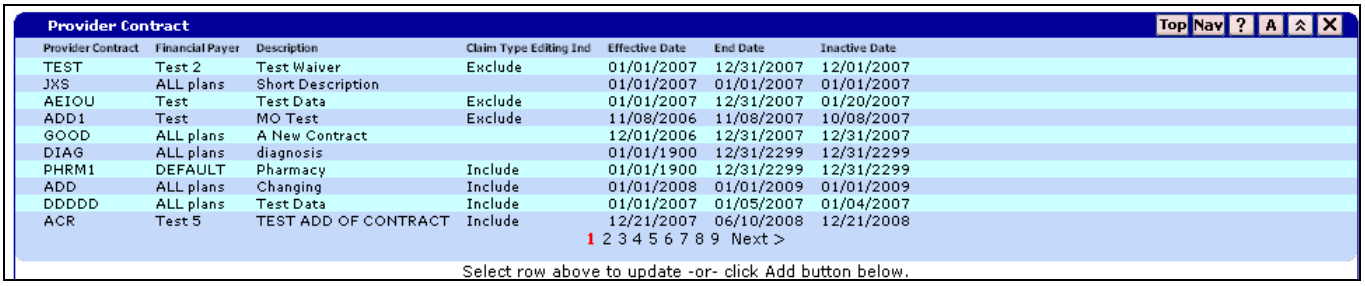
There are several search options available within interChange.

5.3.1 Search Panels

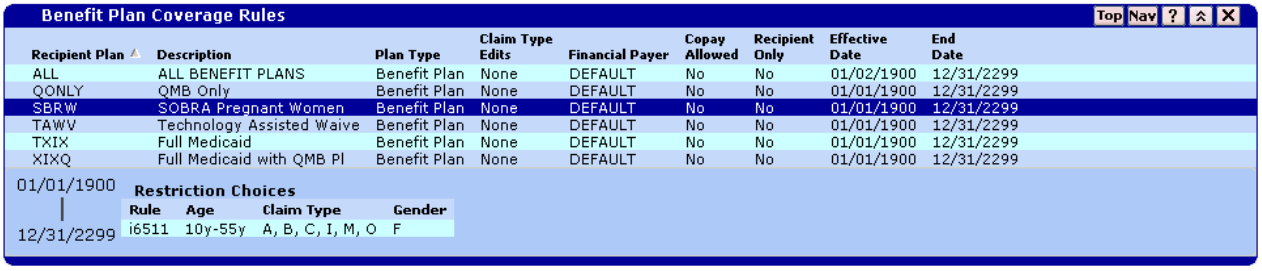
The interChange system contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the Reference subsystem contain a search panel with an advanced search button included on the panel, such as the image below.

5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated information panel opens. In the following figure, the user clicked the third row of the Benefit Plan Coverage Rules panel and detailed information displayed at the bottom of the panel.



5.3.3 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result. Mini Search panels contain one or two primary search fields related to the business process. The Reference Mini Search panel for Modifier contains one search field, as displayed below.

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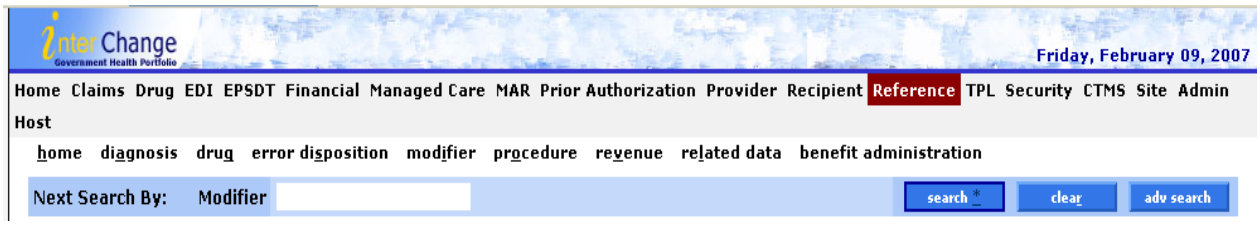
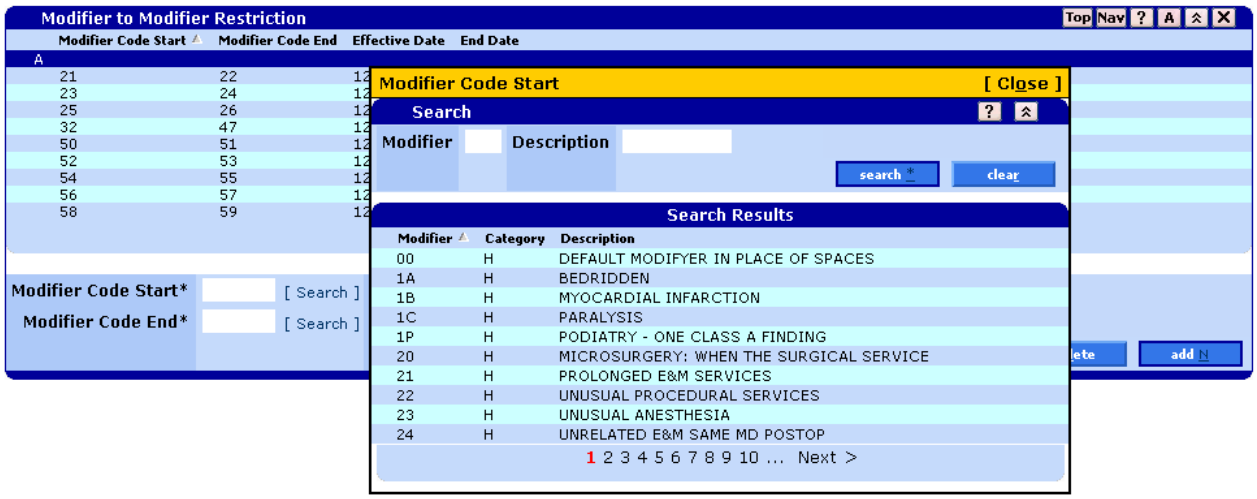


5.3.4 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.



5.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.
New	new	Allows the user to create a new record.
Preferences	Prefs	Allows user to place a checkmark next to each navigation panel they would like to see whenever they browse the Reference

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Name	Icon	Description
Button		subsystem. To hide the boxes, click the checkbox a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows a user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

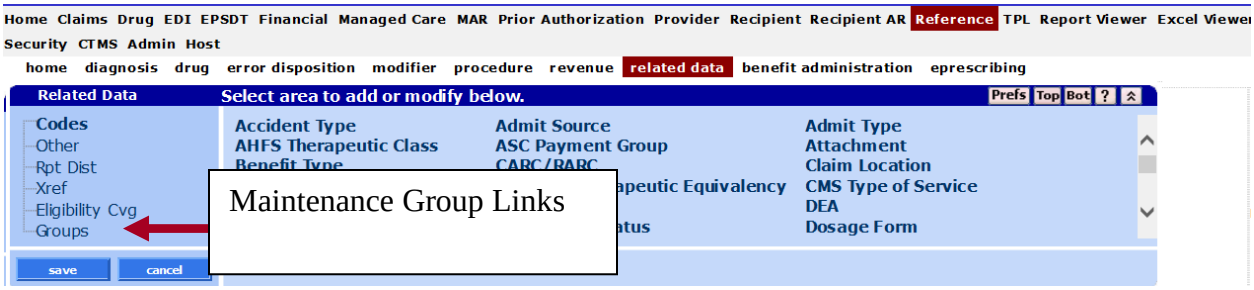
Among the panel types are the following:

- Maintenance panel
- Task List panel
- Maintenance Item Panel
- Audit panel

5.4.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page. The following image demonstrates Maintenance Group Links (Codes, Other, Rpt Dist and Xref) and the associated Maintenance Item links.



By clicking on a Maintenance Item Link (such as Benefit Type), the associated panel opens.

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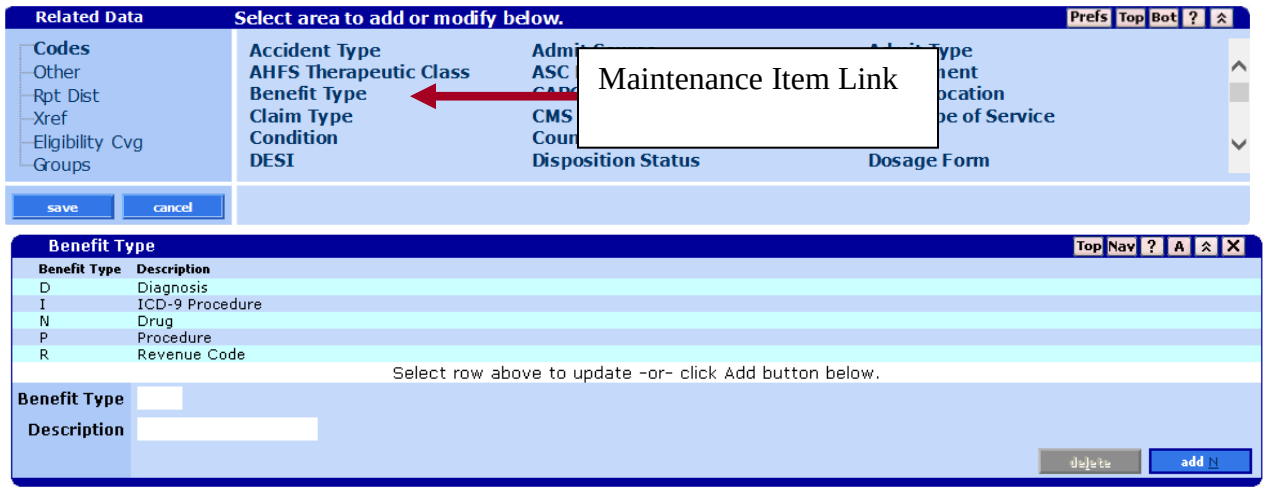
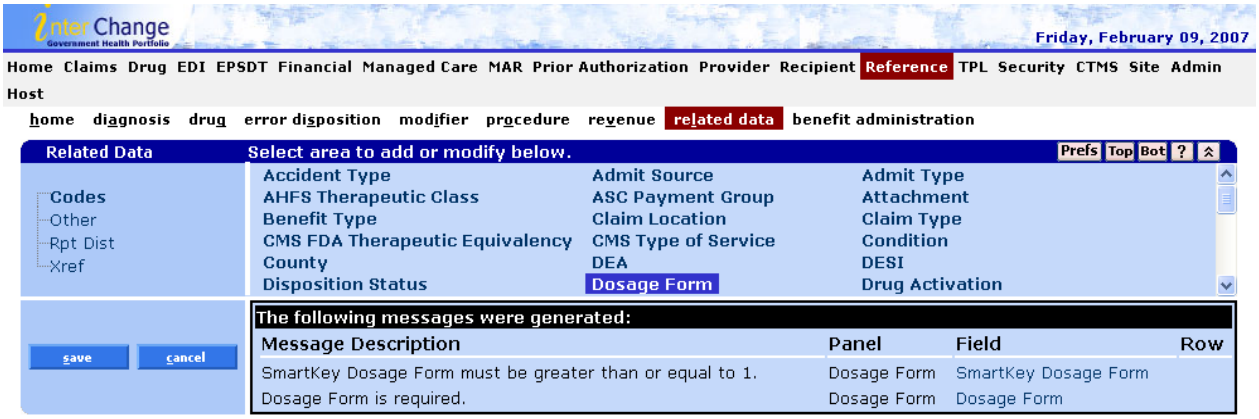


5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, or if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.



The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add, or save. For example, if the user attempts to add duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

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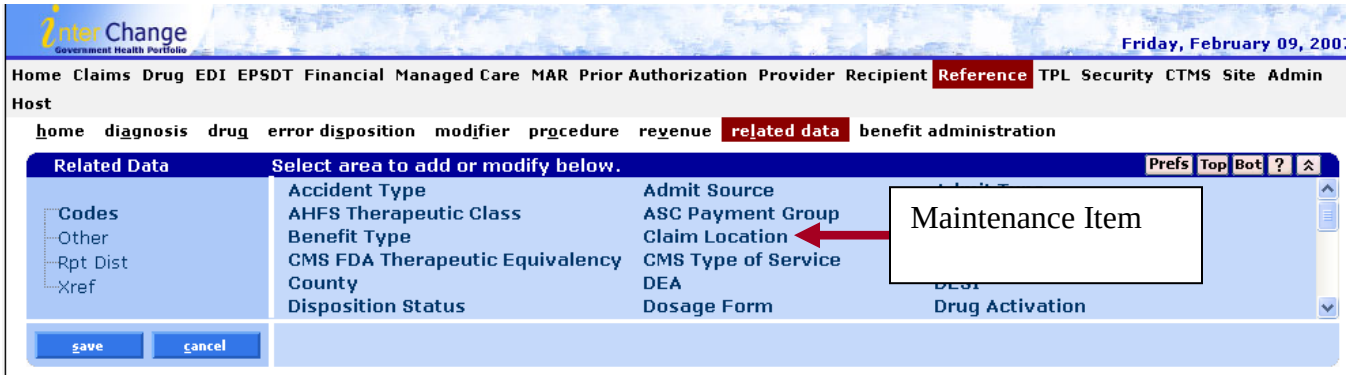
5.4.4 Maintenance Item Panel

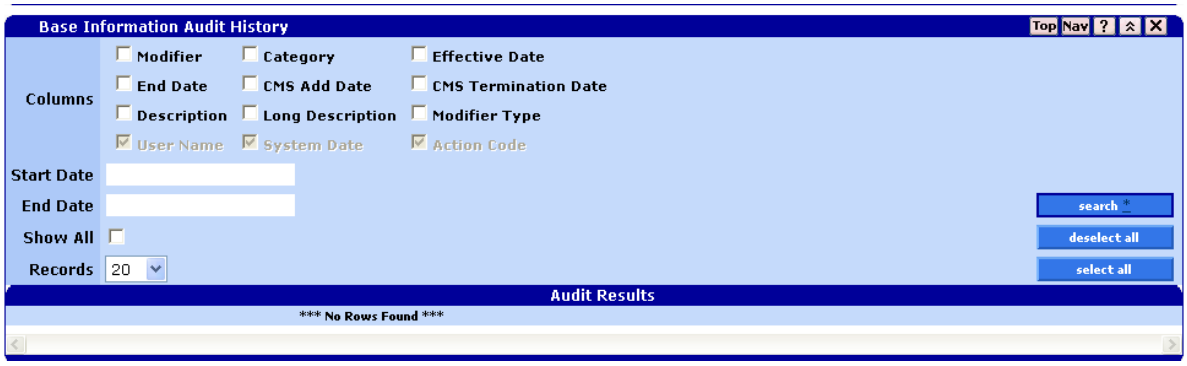
A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.4.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.



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5.5 Help Functionality

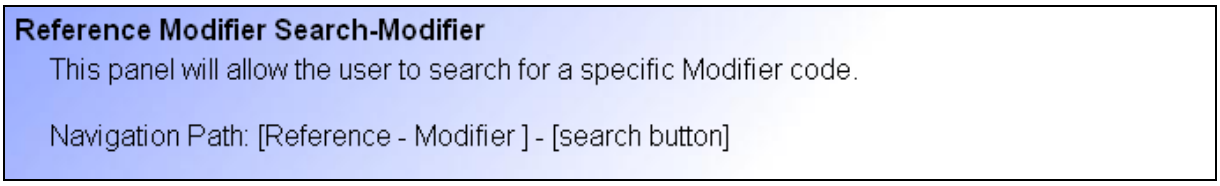
The interChange system contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon ?

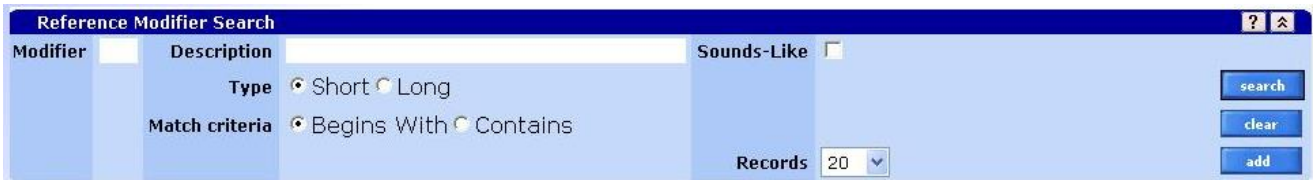
The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.5.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:



The second item displayed is the **Panel Layout**:



The third item displayed is the **Field Description** information related to the panel:

Field	Description	Field Type	Data Type	Length
add	Opens all necessary panels to allow the user to enter data and create a new Procedure Modifier in Interchange.	Button	N/A	0
clear	Clears the search criteria fields so user may key-in new criteria.	Button	N/A	0
search	Initiates 'search' for a Modifier matching the search criteria keyed-in.	Button	N/A	0
Sounds-Like	If the box is checked, phonetic search is performed and if the check box is unchecked word search is performed.	Check Box	Check Box	0
Records	Indicates the number of records to be displayed in search results.	Combo Box	Drop Down List Box	0
Description	Short text that describes the modifier, used as search criteria in the search.	Field	Character	40
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Field	Radio Button	0
Modifier	A code used to identify a procedure modifier (condition requiring medical attention), used as search criteria in the search.	Field	Character	2
Type	Allows searching on the short or the long description.	Field	Radio Button	0

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the UI.

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found.	No modifier matching the 'Description' keyed-in was found. Verify input.
Modifier	Field	1	No rows found	No modifier matching the 'Modifier' code keyed-in was found.Verify Input

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any associated documentation that relates to a panel.

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To close out of the Help panel, click the in the browser title bar.

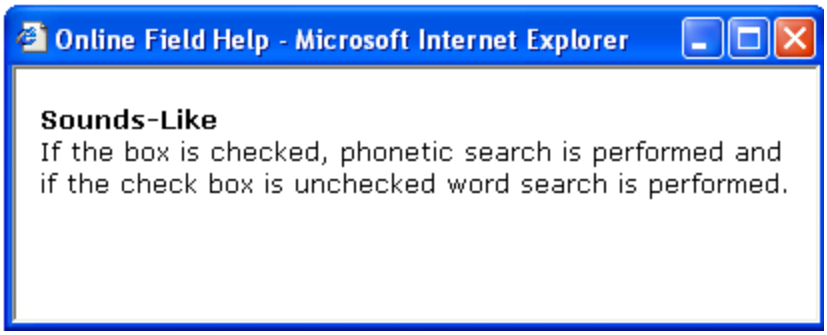
5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a popup window that contains information on the field selected.

5.5.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **Current ID**, a question mark appears as part of the cursor.

Click once on the text area of the field and a popup window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6. Reference Data Maintenance Pages/Panels

This section gives a brief description of each window, shows a sample, and describes all associated window fields and field edits.

Note: Any names, addresses, or other personal information displayed in window images are fictitious and are not representative of an actual person.

The page/panels Field Description table is sorted in alphabetical order. There may be some instances in which the publication script has altered this sort order and these anomalies were not changed during production of this document.

Each window covers the following:

- Page/Panel Narrative
- Page/Panel Layout
- Page/Panel Field Descriptions
- Page/Panel Field Edit Error Code Tables
- Page/Panel Extra Features
- Page/Panel Accessibility

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6.1 Reference Diagnosis Search Panel

6.1.1 Reference Diagnosis Search Panel Narrative

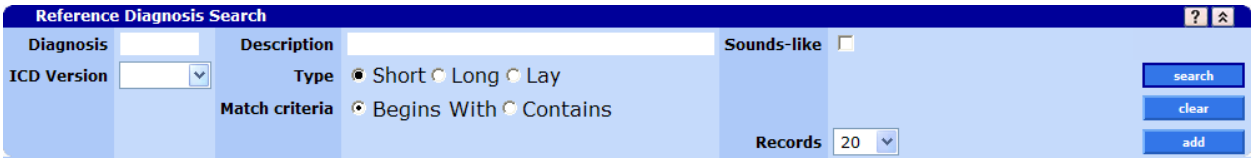
The Reference Diagnosis Search panel allows the user to search for diagnosis information based upon select criteria such as description.

This panel is positioned at the top of the Reference Diagnosis Search panel and permits the user to execute a search based upon the entered search parameters.

Additionally, security permitting, the user may opt to proceed directly to the Diagnosis Information panels to add a new Diagnosis.

Navigation Path: [Reference] – [Diagnosis] – [Reference Diagnosis Search]

6.1.2 Reference Diagnosis Search Panel Layout



6.1.3 Reference Diagnosis Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Directs the user to the Diagnosis Information panels necessary to create a new Diagnosis Code.	Button	N/A	0
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Description	Text that describes a specific Diagnosis. The user may enter all or part of the description.	Field	Character	40
Diagnosis	Code used to identify the Diagnosis (condition requiring medical attention). The user may enter all or part of the code.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Field	Radio Button	0
Records	Allows the user to specify the number of rows returned from the search.	Combo Box	Drop Down List Box	0
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Sounds Like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the check box is unchecked a literal search is performed.	Checkbox	Checkbox	0
Type	Allows searching on the short description, the long description or the lay description.	Combo Box	Radio Button	0

6.1.4 Reference Diagnosis Search Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found.	Verify keying.
Diagnosis	Field	1	No rows found.	Verify keying.

6.1.5 Reference Diagnosis Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.1.6 Reference Diagnosis Search Panel Accessibility

6.1.6.1 To Access the Reference Diagnosis Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.

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6.2 Reference Diagnosis Search Results Panel

6.2.1 Reference Diagnosis Search Results Panel Narrative

The Reference Diagnosis Search panel allows the user to search for diagnosis information based upon select criteria such as description.

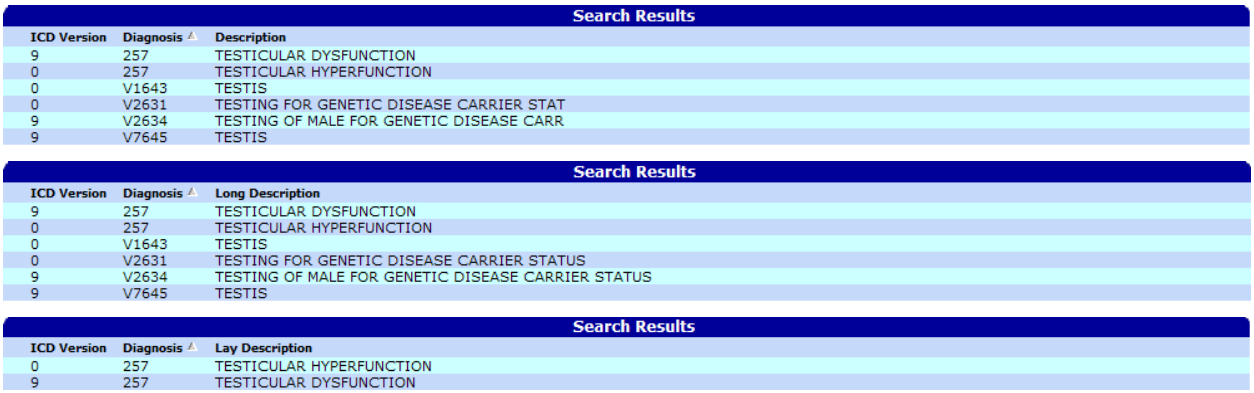
The Reference Diagnosis Search Results panel is positioned at the bottom of the Reference Diagnosis Search panel and displays a listing of Diagnosis Codes and descriptions matching the specified criteria.

Clicking/Selecting a row from the list directs the user to Diagnosis Information panel where the user may access additional diagnosis details.

This panel is inquiry only.

Navigation Path: [Reference] – [Diagnosis] - [(Enter search criteria, click on 'search' button)] - Search Results

6.2.2 Reference Diagnosis Search Results Panel Layout



Search Results

ICD Version	Diagnosis	Description
9	257	TESTICULAR DYSFUNCTION
0	257	TESTICULAR HYPERFUNCTION
0	V1643	TESTIS
0	V2631	TESTING FOR GENETIC DISEASE CARRIER STAT
9	V2634	TESTING OF MALE FOR GENETIC DISEASE CARR
9	V7645	TESTIS

Search Results

ICD Version	Diagnosis	Long Description
9	257	TESTICULAR DYSFUNCTION
0	257	TESTICULAR HYPERFUNCTION
0	V1643	TESTIS
0	V2631	TESTING FOR GENETIC DISEASE CARRIER STATUS
9	V2634	TESTING OF MALE FOR GENETIC DISEASE CARRIER STATUS
9	V7645	TESTIS

Search Results

ICD Version	Diagnosis	Lay Description
0	257	TESTICULAR HYPERFUNCTION
9	257	TESTICULAR DYSFUNCTION

6.2.3 Reference Diagnosis Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Short description of the relevant diagnosis. This is displayed if "Short" is selected from the "Type" radio buttons.	Field	Character	60
Diagnosis	Code that identifies the Diagnosis (condition requiring medical attention). Represents a medical classification of a disease or condition.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Lay Description	Lay description of the relevant diagnosis. This is displayed if "Lay" is selected from the "Type" radio buttons.	Field	Alphanumeric	100

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Field	Description	Field Type	Data Type	Length
Long Description	Long description of the relevant diagnosis. This is displayed if "Long" is selected from the "Type" radio buttons. For a lengthy description truncation occurs and only the first 100 characters are displayed.	Field	Alphanumeric	250

6.2.4 Reference Diagnosis Search Results Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 Reference Diagnosis Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 Reference Diagnosis Search Results Panel Accessibility

6.2.6.1 To Access the Reference Diagnosis Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Diagnosis Search Results panel displays.

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6.3 Diagnosis Search Panel

6.3.1 Diagnosis Search Panel Narrative

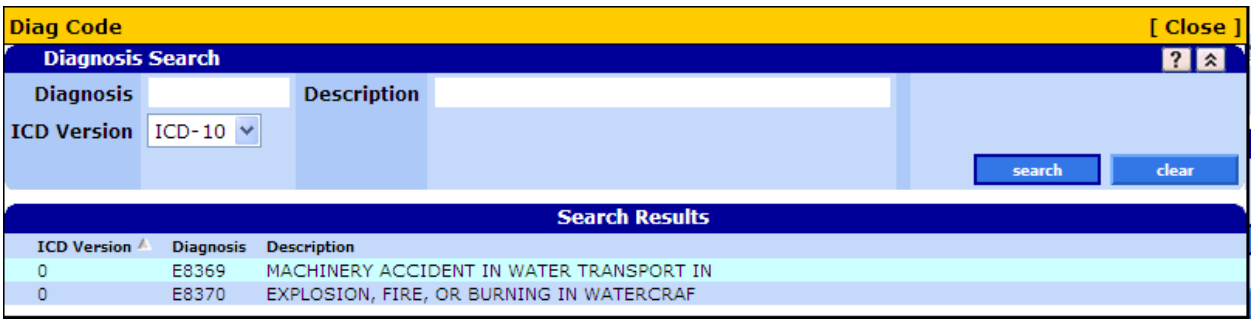
The Diagnosis Search panel allows the user to search for diagnosis information based upon select criteria such as description.

The Diagnosis Search Results panel is positioned at the bottom of the Reference Diagnosis Search panel and displays a listing of Diagnosis Codes descriptions and ICD Version matching the specified criteria.

Clicking/Selecting a row from the list directs the user to Diagnosis Information panel where the user may access additional diagnosis details.

Navigation Path: [Reference] – [Related Data] - [Other] - [Diagnosis Group Type] - [select a group] - click Diagnosis Code Range From / To

6.3.2 Diagnosis Search Panel Layout



6.3.3 Reference Diagnosis Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Description of the relevant diagnosis.	Field	Character	60
Diagnosis	Code that identifies the Diagnosis (condition requiring medical attention). Represents a medical classification of a disease or condition according to ICD-9 /ICD-10.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10	Field	Character	1
Clear	Clear the selection criteria entered.	Button	N/A	0
Search	Search for reason code using the selection criteria specified.	Button	N/A	0

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6.3.4 Reference Diagnosis Search Results Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.3.5 Reference Diagnosis Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.3.6 Diagnosis Search Panel Accessibility

6.3.6.1 To Access the Diagnosis Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to Reference and click Related Data.	Related Data Panel displays.
3	Select Other.	A list of hyperlinks to panel displays.
4	Select Diagnosis Group Type.	Diagnosis Group Panel displays.

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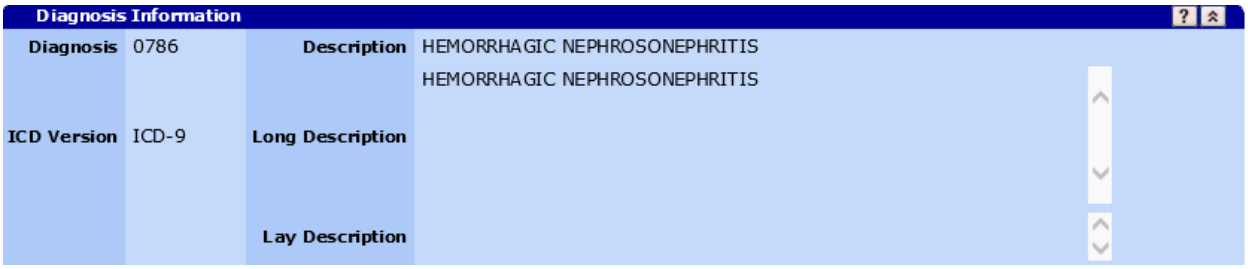
6.4 Diagnosis Information Panel

6.4.1 Diagnosis Information Panel Narrative

The Diagnosis Information panel is used to view the information for the selected Diagnosis. This panel is display only.

Navigation Path: [Reference] – [Diagnosis] - [(click on 'search' button)] - [(select row from search results)] - [Diagnosis Information]

6.4.2 Diagnosis Information Panel Layout



6.4.3 Diagnosis Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The description of the diagnosis code. The short nomenclature for a medical condition.	Field	Character	60
Diagnosis	A code used to identify a condition requiring medical attention. Represents a medical classification of a disease or condition according to ICD. (Field displays up to 7-digit ICD-10 codes for future use.)	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced.	Field	Character	1
Lay Description	A layman's description of the diagnosis.	Field	Alphanumeric	100
Long Description	The long description for the diagnosis code.	Field	Character	400

6.4.4 Diagnosis Information Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.4.5 Diagnosis Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.4.6 Diagnosis Information Panel Accessibility

6.4.6.1 To Access the Diagnosis Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.

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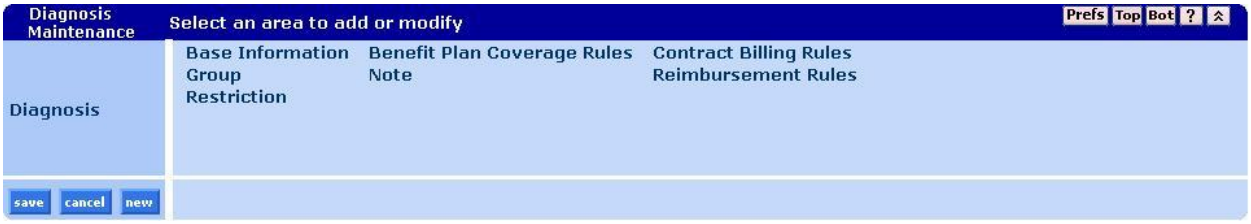
6.5 Diagnosis Maintenance Panel

6.5.1 Diagnosis Maintenance Panel Narrative

Links to the Diagnosis application information maintenance panels. This panel is inquiry only.

Navigation Path: [Reference] – [Diagnosis] - [(click on 'search' button)] - [(select row from search results)] - [Diagnosis Maintenance]

6.5.2 Diagnosis Maintenance Panel Layout



6.5.3 Diagnosis Maintenance-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Opens the Base Information panel.	Hyperlink	N/A	0
Benefit Plan Coverage Rules	Opens the Benefit Plan Coverage Rules panel.	Hyperlink	N/A	0
Cancel	Clears out ('undo') all changes made to any panel in the navigation panel links.	Button	N/A	0
Contract Billing Rules	Opens the Contract Billing Rules panel.	Hyperlink	N/A	0
Group	Opens the Group panel.	Hyperlink	N/A	0
New	Opens up required empty panels so user may enter data and create a new 'Diagnosis'.	Button	N/A	0
Note	Opens the Note panel.	Hyperlink	N/A	0
Reimbursement Rules	Opens the Reimbursement Rules panel.	Hyperlink	N/A	0
Restriction	Opens the Restriction panel.	Hyperlink	N/A	0
Save	Saves all changes made (to any panel in the Navigation panel) to the database.	Button	N/A	0

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6.5.4 Diagnosis Maintenance Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.5.5 Diagnosis Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 Diagnosis Maintenance Panel Accessibility

6.5.6.1 To Access the Diagnosis Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Maintenance panel displays.

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6.6 Diagnosis Mini Search Panel

6.6.1 Diagnosis Mini Search Panel Narrative

Diagnosis Mini-Search panel provides the user with the ability to search for a Diagnosis from the Diagnosis Information page. This panel is inquiry only.

Navigation Path: [Reference] – [Diagnosis Search] - [click on 'search' button] - (select row from search results)] - [Next Search By]

6.6.2 Diagnosis Mini Search Panel Layout

6.6.3 Diagnosis Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Opens the main 'Diagnosis Search' panel so user may set additional search criteria.	Button	N/A	0
Clear	Clears the 'Diagnosis' field.	Button	N/A	0
Diagnosis	Code used to identify the Diagnosis (condition requiring medical attention). The user must enter all of the code.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
Search	Initiates search on the database for record matching the 'Diagnosis' code keyed-in.	Button	N/A	0

6.6.4 Diagnosis Mini Search Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis	Field	2	Diagnosis number is required.	Enter a diagnosis number.
	Field	3	Diagnosis number does not exist.	Enter a valid diagnosis number.
ICD Version	Field	1	ICD Version is required	Select value from ICD Version dropdown.

6.6.5 Diagnosis Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.6.6 Diagnosis Mini Search Panel Accessibility

6.6.6.1 To Access the Diagnosis Mini Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel display.
4	Select row.	Diagnosis Mini Search panel displays.

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6.7 Base Information-Diagnosis Panel

6.7.1 Base Information-Diagnosis Panel Narrative

The Base Information-Diagnosis panel is used to maintain Diagnosis Code Information. Only users with update authority are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Diagnosis] - [Reference Search] - [(click on 'search' button)] - [(select row from search results)] - [Base Information]

6.7.2 Base Information-Diagnosis Panel Layout

6.7.3 Base Information-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Delete	Marks the 'Diagnosis' record for deletion.	Button	N/A	0
Description	The short nomenclature for a medical condition.	Field	Character	60
Diagnosis	A code for the condition requiring medical attention. The medical classification of a disease or condition according to ICD. (It holds 7 digit ICD codes, but smaller values can be entered).	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
Lay Description	A layman's description of the diagnosis.	Field	Alphanumeric	100
Long Description	The long nomenclature for a medical condition.	Field	Character	400

6.7.4 Base Information-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Diagnosis	Field	1	Diagnosis is Required.	Enter a Diagnosis Code.
	Field	2	A duplicate record cannot be saved.	Enter a non duplicate Diagnosis.

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Field	Field Type	Error Code	Error Message	To Correct
ICD Version	Combo Box	1	ICD Version is required.	Select value from ICD Version dropdown.
Long Description	Field	1	Long description is required.	Enter a Long description.

6.7.5 Base Information-Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.7.6 Base Information-Diagnosis Panel Accessibility

6.7.6.1 To Access the Base Information-Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Base Information**.	Base Information-Diagnosis panel displays.

6.7.6.2 To Add on the Base Information-Diagnosis Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Enter Diagnosis**.	
3	Enter **Description.**	
4	Select **ICD Version**.	
5	Enter **Long Description**.	
6	Enter **Lay Description**.	
7	Click **Save**.	Base Information-Diagnosis information is saved.

6.7.6.3 To Delete on the Base Information-Diagnosis Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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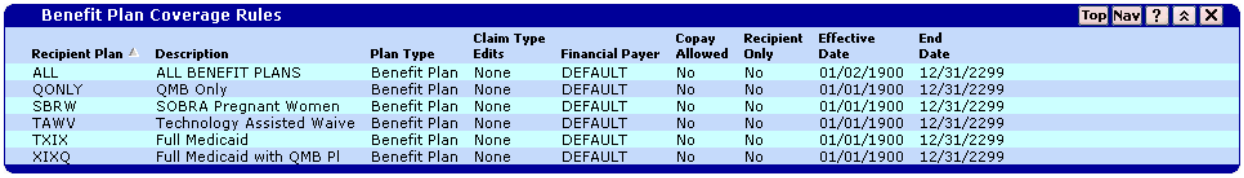
6.8 Benefit Plan Coverage Rules-Diagnosis Panel

6.8.1 Benefit Plan Coverage Rules-Diagnosis Panel Narrative

The Benefit Plan Coverage Rules-Diagnosis panel is used to view the recipient plan coverage information for a specific diagnosis code. This panel is display only.

Navigation Path: [Reference] – [Diagnosis] - (click on [search] and select row from search results) - [Diagnosis Maintenance] - [Diagnosis] - [Benefit Plan Coverage Rules]

6.8.2 Benefit Plan Coverage Rules-Diagnosis Panel Layout



Benefit Plan Coverage Rules

Recipient Plan	Description	Plan Type	Claim Type Edits	Financial Payer	Copay Allowed	Recipient Only	Effective Date	End Date
ALL	ALL BENEFIT PLANS	Benefit Plan	None	DEFAULT	No	No	01/02/1900	12/31/2299
QONLY	QMB Only	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
SBRW	SOBRA Pregnant Women	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
TAWV	Technology Assisted Waive	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
TXIX	Full Medicaid	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
XIXQ	Full Medicaid with QMB Pl	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299

6.8.3 Benefit Plan Coverage Rules-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Identifies the associated list of claim types as included or excluded for the covered benefit.	Combo Box	Drop Down List Box	0
Copay Allowed	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	Field	Character	3
Description	Description of the Recipient Plan.	Field	Character	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the end date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this benefit plan.	Field	Character	30
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Character	15
Recipient Only	Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.	Field	Character	3
Recipient Plan	Code that identifies the recipient plan that is supported in the system.	Field	Character	5

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6.8.4 Benefit Plan Coverage Rules-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.8.5 Benefit Plan Coverage Rules-Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.8.6 Benefit Plan Coverage Rules-Diagnosis Panel Accessibility

6.8.6.1 To Access the Benefit Plan Coverage Rules-Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Benefit Plan Coverage Rules**.	Benefit Plan Coverage Rules-Diagnosis panel displays.

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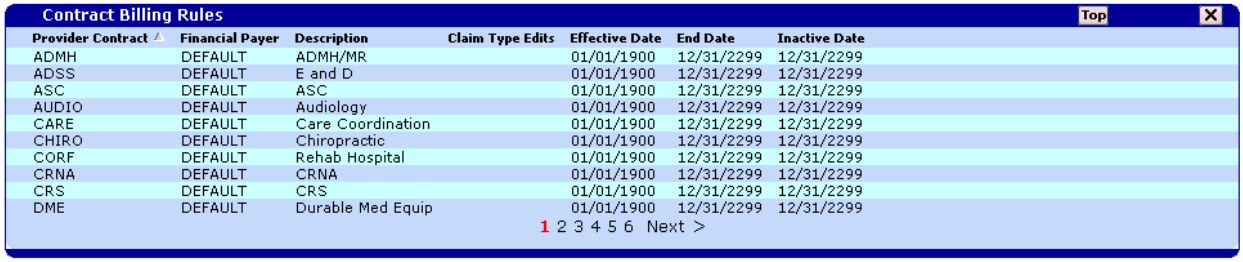
6.9 Contract Billing Rules-Diagnosis Panel

6.9.1 Contract Billing Rules-Diagnosis Panel Narrative

The Contract Billing Rules- Diagnosis panel is used to display Provider Contracts applicable to diagnosis codes. This panel is display only.

Navigation Path: [Reference] - [Diagnosis] - (Click on [Search] button) - (Select row from search results) - [Diagnosis Maintenance] - [Diagnosis] - [Contract Billing Rules]

6.9.2 Contract Billing Rules-Diagnosis Panel Layout



Contract Billing Rules

Provider Contract	Financial Payer	Description	Claim Type Edits	Effective Date	End Date	Inactive Date
ADMH	DEFAULT	ADMH/MR		01/01/1900	12/31/2299	12/31/2299
ADSS	DEFAULT	E and D		01/01/1900	12/31/2299	12/31/2299
ASC	DEFAULT	ASC		01/01/1900	12/31/2299	12/31/2299
AUDIO	DEFAULT	Audiology		01/01/1900	12/31/2299	12/31/2299
CARE	DEFAULT	Care Coordination		01/01/1900	12/31/2299	12/31/2299
CHIRO	DEFAULT	Chiropractic		01/01/1900	12/31/2299	12/31/2299
CORF	DEFAULT	Rehab Hospital		01/01/1900	12/31/2299	12/31/2299
CRNA	DEFAULT	CRNA		01/01/1900	12/31/2299	12/31/2299
CRS	DEFAULT	CRS		01/01/1900	12/31/2299	12/31/2299
DME	DEFAULT	Durable Med Equip		01/01/1900	12/31/2299	12/31/2299

1 2 3 4 5 6 Next >

6.9.3 Contract Billing Rules-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Field	Character	1
Description	Description of the provider contract.	Field	Character	30
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the end date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this provider contract.	Field	Character	30
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

6.9.4 Contract Billing Rules-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.9.5 Contract Billing Rules-Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Contract Billing Rules-Diagnosis Panel Accessibility

6.9.6.1 To Access the Contract Billing Rules-Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information and Maintenance panels display.
5	Click **Contract Billing Rules**.	Contract Billing Rules panel displays.

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6.10 Group-Diagnosis Panel

6.10.1 Group-Diagnosis Panel Narrative

The Diagnosis Group Panel is used to view the groups to which the Diagnosis belongs. These groups are then used in pricing and processing logic. The groups may be maintained on the Diagnosis Group Type panel found in Related Data.

This panel is display only.

Navigation Path: [Reference] – [Diagnosis] - [(click on 'search' button)] - [(select a row from search result list)] - [Diagnosis Maintenance] - [Group]

6.10.2 Group-Diagnosis Panel Layout

Group

Diagnosis Group Type	Description	ICD Version	Code From	Code To	Effective Date	End Date
31	PREGNANCY DIAGNOSIS CODES	9	V25	V25	01/01/1990	12/31/2299
2014	ST--Sterilization	9	V25	V25	01/01/1990	12/31/2299
2008	FP--Family Planning	9	V25	V25	01/01/1990	12/31/2299
2012	CoPay Exemptions - Pregnancy	9	V25	V25	01/01/1990	12/31/2299
1016	Sterilization - inpatient	9	V25	V25	01/01/1990	12/31/2299
3008	ALABAMA LEGACY DIAGNOSIS LIST #0008	9	V220	V259	01/01/1900	12/31/2299
5036	Patient 1st Pregnancy Exempt Diagnoses	9	V25	V269	01/01/1900	12/31/2299

6.10.3 Group-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Code From	A lower range of code which identifies a specific condition requiring medical attention. Represents a medical classification of a disease or condition according to ICD or HCPCS.	Field	Number (Integer)	7
Code To	An upper range of code which identifies a specific condition requiring medical attention. Represents a medical classification of a disease or condition according to ICD or HCPCS. This is the ending Diagnosis code value.	Field	Number (Integer)	7
Description	The description for the diagnosis Group.	Field	Character	50
Diagnosis Group Type	System assigned key for a unique diagnosis type, that represents a single or collection of diagnosis.	Field	Number (Integer)	9
Effective Date	The date that the diagnosis code is to become effective for the diagnosis type in claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The last date that the diagnosis code is in effect for the diagnosis type in claims processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1

6.10.4 Group-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.10.5 Group-Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.10.6 Group-Diagnosis Panel Accessibility

6.10.6.1 To Access the Group-Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Group**.	Group-Diagnosis panel displays.

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6.11 Note-Diagnosis Panel

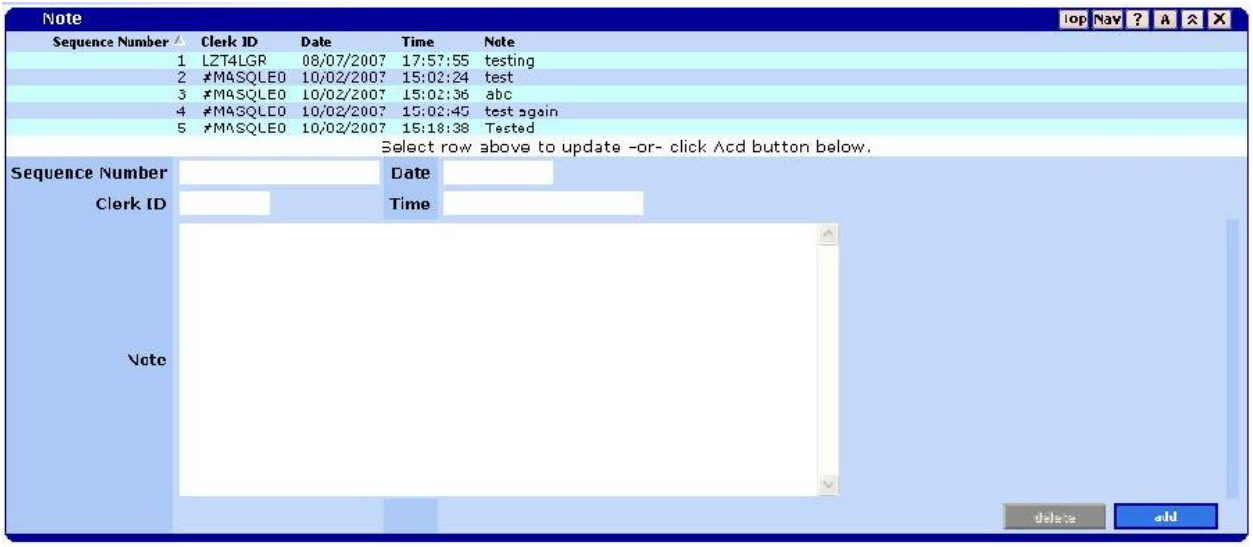
6.11.1 Note-Diagnosis Panel Narrative

The Diagnosis - Note panel is used to enter notes as to why changes were made to a specific diagnosis. The panel includes fields for date, time, clerk number, and note sequence number.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Diagnosis Search] - [(Add button) OR (select row from search results)] – [Diagnosis Maintenance] - [Note]

6.11.2 Note-Diagnosis Panel Layout



6.11.3 Note-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a note.	Button	N/A	0
Clerk ID	The identification number of the user who enters the note.	Field	Alphanumeric	8
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to delete a note.	Button	N/A	0
Note	The actual text of the note.	Field	Alphanumeric	1000
Sequence Number	Sequence number than can uniquely identify a note.	Field	Number (Integer)	9
Time	The time that the note was entered.	Field	Number (Decimal)	6

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6.11.4 Note-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add Diagnosis Note text.

6.11.5 Note-Diagnosis Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for Proc + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.11.6 Note-Diagnosis Panel Accessibility

6.11.6.1 To Access the Note-Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Note**.	Note-Diagnosis panel displays.

6.11.6.2 To Add on the Note-Diagnosis Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note-Diagnosis information is saved.

6.11.6.3 To Update on the Note-Diagnosis Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Note-Diagnosis information is saved.

6.11.6.4 To Delete on the Note-Diagnosis Panel

Step	Action	Response

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1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.12 Reimbursement Rules-Diagnosis Panel

6.12.1 Reimbursement Rules- Diagnosis Panel Narrative

The Reimbursement Rules-Diagnosis panel is used to view the Reimbursement Agreement information for a specific diagnosis code. The information displayed is retrieved from the Reimbursement Agreement tables available through the Benefit administration panels. The panel displays all reimbursement agreements associated with the specified Diagnosis.

This panel is display only.

Navigation Path: [Reference] – [Diagnosis] - [(select row from search results)] – [Diagnosis Maintenance] - [Reimbursement Rules]

6.12.2 Reimbursement Rules- Diagnosis Panel Layout

6.12.3 Reimbursement Rules- Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 – Non-drug item 1 – Generic Product 2 – Brand Product.	Field	N/A	0
Dates	These are the effective and end dates for this rule.	Field	Date (MM/DD/CCYY)	8
Dispensed As Written	It provides the Dispensed As Written value.	Field	N/A	0
Pricing Indicator	It provides the Pricing Indicator.	Field	N/A	0
Pricing Modifier	Pricing Modifier requirement for claims. Possible values are N - Pay Billed Amount,Y - Pay greater than Billed Amount & Z - Zero Pay Billed Amount.	Field	N/A	0
Rate Type	It provides the Rate Type.	Field	N/A	0
Rule	It provides the Rule identification.	Field	N/A	0

6.12.4 Reimbursement Rules- Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.12.5 Reimbursement Rules- Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.12.6 Reimbursement Rules- Diagnosis Panel Accessibility

6.12.6.1 To Access the Reimbursement Rules- Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Reimbursement Rules**.	Reimbursement Rules-Diagnosis panel displays.

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6.13 Restriction-Diagnosis Panel

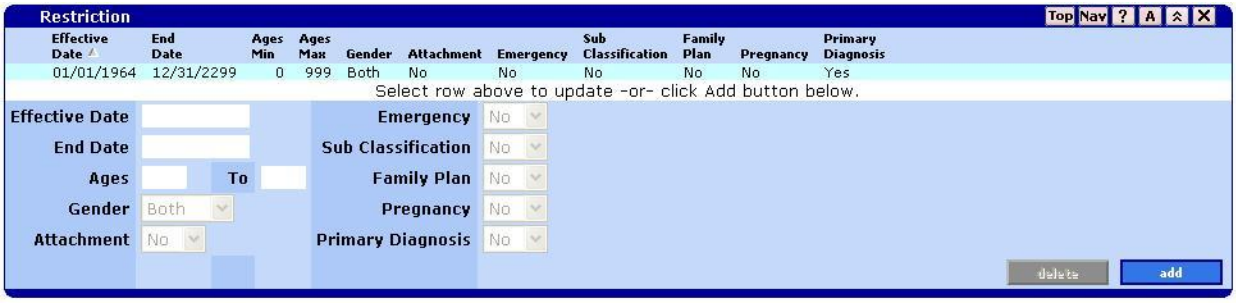
6.13.1 Restriction-Diagnosis Panel Narrative

The Diagnosis Restriction panel is used to update diagnosis restriction information.

Only authorized users with update privileges have the capability to add new information or change existing data.

Navigation Path: [Reference] – [Diagnosis] - [(click on 'search' button)] - [(select row from search results)] - [Diagnosis Maintenance] - [Restriction]

6.13.2 Restriction-Diagnosis Panel Layout



6.13.3 Restriction-Diagnosis Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new restriction to the diagnosis.	Button	N/A	0
Ages (From)	The minimum age that is valid for the diagnosis. This field is not used in AL.	Field	Number (Integer)	3
Ages (To)	The maximum age that is valid for the diagnosis. This field is not used in AL.	Field	Number (Integer)	3
Attachment	Indicates whether documentation is required for the diagnosis. The valid values are Y/N. This field is not used in AL.	Combo Box	Drop Down List Box	0
Delete	Allows the user to mark a 'restriction' to be removed from the diagnosis.	Button	N/A	0
Effective Date	The date that the limitations for the diagnosis code became effective.	Field	Date (MM/DD/CCYY)	8
Emergency	Indicates whether the diagnosis is for an emergency ASC condition. Valid values are 'Y' - yes and 'N' - no.	Combo Box	Drop Down List Box	0
End Date	The date that the limitations for the diagnosis code stopped being effective.	Field	Date (MM/DD/CCYY)	8
Family Plan	The indicator for determining whether or not	Combo	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
	this diagnosis is a Family Planning diagnosis. The valid values are Y/N. This field is not used in AL.	Box		
Gender	Indicates if the diagnosis code is gender specific. The valid values are Y/N. This field is not used in AL.	Combo Box	Drop Down List Box	0
Pregnancy	Indicates if the diagnosis is for a pregnancy. The valid values are Y/N.	Combo Box	Drop Down List Box	0
Primary Diagnosis	Indicates if the diagnosis is valid to be billed as the primary diagnosis on a claim. The valid values are Y/N.	Combo Box	Drop Down List Box	0
Sub Classification	Indicates whether the diagnosis requires further specification. The valid values are Y/N.	Combo Box	Drop Down List Box	0

6.13.4 Restriction-Diagnosis Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Ages (From)	Field	1	Enter a valid value.	Enter Age (from) for this restriction (must be numeric).
	Field	2	Age From must be less than or equal to Age To.	Age (from) must be <= Age (to).
	Field	3	Age From is required.	Enter an Age From.
Ages (To)	Field	1	Enter a valid value	Enter Age (To) for this restriction. (must be numeric).
	Field	2	Age From must be less than or equal to Age To.	Age (from) must be <= Age (to).
	Field	3	Age To is required.	Enter an Age To.
Attachment	Field	1	Attachment is required.	Choose an Attachment from drop down list.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Date range segments cannot overlap.	Verify dates against list. Date segments cannot overlap.
	Field	3	Invalid Date.	Enter an Effective Date that is numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter a valid Effective Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Verify keying. The date must be less than or equal to 12/31/2299.
Emergency	Field	1	Emergency is required.	Select an Emergency option from drop down list.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	2	Date range segments cannot overlap.	Verify dates against existing segment.
	Field	3	Invalid Date.	Enter an End Date that is numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	5	End Date is required.	Enter a valid End Date.
	Field	6	End Date must be less than or equal to 12/31/2299.	Verify keying. The date must be less than or equal to 12/31/2299.
Family Plan	Field	1	Family Plan is required.	From drop down list, select a Sub Classification for this restriction.
Gender	Field	1	Gender is required.	Select a value from the drop down list.
Pregnancy	Field	1	Pregnancy is required.	Choose a Pregnancy option from drop down list.
Primary Diagnosis	Field	1	Primary Diagnosis is required.	Select a Primary Diagnosis from drop down list.

6.13.5 Restriction-Diagnosis Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 Restriction-Diagnosis Panel Accessibility

6.13.6.1 To Access the Restriction –Diagnosis Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Diagnosis**.	Reference Diagnosis Search panel displays.

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Step	Action	Response
3	Click **Search**.	Reference Diagnosis Search Results panel displays.
4	Select row.	Diagnosis Information panel displays.
5	Click **Restriction**.	Restriction-Diagnosis panel displays.

6.13.6.2 To Add on the Restriction-Diagnosis Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Enter **End Date** in MM/DD/CCYY format.	
4	Select **Emergency** from drop down list box.	
5	Select **Sub Classification** from drop down list box.	
6	Select **Pregnancy** from drop down list box.	
7	Select **Primary Diagnosis** from drop down list box.	
8	Click **Save**.	Restriction-Diagnosis information is saved.

6.13.6.3 To Update on the Restriction-Diagnosis Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Restriction-Diagnosis information is saved.

6.13.6.4 To Delete on the Restriction-Diagnosis Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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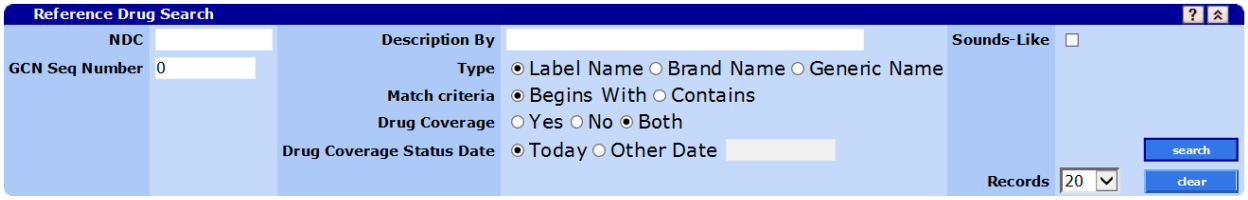
6.14 Reference Drug Search Panel

6.14.1 Reference Drug Search-Panel Narrative

The Reference Drug Search panel allows the user to enter search criteria and query for Drug records whose data matches that criteria and displays the results. This panel is inquiry only.

Navigation Path: [Reference] – [Drug]

6.14.2 Reference Drug Search Panel Layout



6.14.3 Reference Drug Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product	Field	Character	1
Brand Name	Brand name of the relevant drug. Contains only the brand name of the drug(s) returned from the search criteria. This is displayed if the 'Brand Name' radio button is selected.	Field	Character	30
Clear	Clears all fields in search criteria	Button	N/A	0
Covered	Indicates the drug is covered (Yes) or not covered (No) on the request date. The results are in 'Covered' order.	Field	Character	1
Description by	The name of the drug.	Field	Character	30
Drug	Displays the National Drug Code of the drug.	Field	Character	11

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Field	Description	Field Type	Data Type	Length
Drug Coverage	Allows the user to select search results that will display drugs that are: covered (Yes), not covered (No) or the total listing of covered and not-covered (Both) for the search criteria entered. The default value is 'Both.'	Check Box	Radio Button	0
Drug Coverage Status Date	Allows the user to select search results that will display drugs currently covered (Today), or drugs covered on a previous date (Other Date). The entry box is not available unless "Other Date" is selected. If an invalid date is entered in the date field, it will default to the current date. The default value is the current date (Today).	Check Box	Radio Button	0
GCN Seq Number	The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	9
Generic Name	Generic name of the relevant drug. Contains only the generic name of the drug(s) returned from the search criteria. This will be displayed if the 'Generic Name' radio button is selected.	Field	Character	63
Label Name	Label Name of the relevant drug. Contains name, strength, and dosage form of the drug(s) returned from the search criteria. This will be displayed if the 'Label Name' radio button is selected.	Field	Character	60
Lowest Price NDCBND	Lowest re-imbursable price of a drug which is priced using NDCBND pricing method.	Field	Number	7
Lowest Price NDCLOW	Lowest re-imbursable price of drug which is priced using NDCLOW pricing method.	Field	Number	7
Lowest Price Type NDCBND	Corresponding Lowest Price Type for NDCBND pricing method.	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Lowest Price Type NDCLOW	Corresponding Lowest Price Type for NDCLOW pricing method.	Field	Character	3
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Combo Box	Radio Button	0
Max Qty	The maximum quantity of the drug which can be dispensed.	Field	Number	10
NDC	The National Drug Code is a unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code and a 2-digit package code.	Field	Character	11
PA	PA Indicator indicates whether PA is required (Y), Not required (N) or Blank.	Field	Character	1
PDL	PDL Indicator. Indicates the PDL status of the NDC, i.e. whether the drug or drug product is preferred (Y) or non-preferred (N) and blank when PDL indicator does not exists.	Field	Character	1
Records	Allows the user to specify the number of rows returned from the search.	Combo Box	Drop Down List Box	0
Search	Initiates 'Search' of 'Drug' records based on criteria keyed-in.	Button	N/A	0
Sounds-Like	Checking this box enables the user to use the sounds-like feature to search for drug descriptions.	Combo Box	Check Box	0
TC3	For FDB implementations: Therapeutic Class Code, Specific. For MDX implementations: Therapeutic Class Code, UMC lowest detail TC available in TC1 thru TC5.	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Type	Allows the user to specify whether to search on Label, Brand or Generic Name. The corresponding description is displayed in the search results. Note: If the search is done using the ‘Brand Name’ the search results column header will be ‘Brand Name’. If the search is done by ‘Label Name’, then the search results column header will be 'Label Name'. If the search is done using the ‘Generic Name’ the search results column header will be ‘Generic Name’.	Combo Box	Radio Button	0

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6.14.4 Reference Drug Search Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Drug Coverage Status Date	Check Box	10	Future Dates are not allowed.	Enter any valid previous or current date.
	Check Box	30	As of date is not a valid date value.	Please enter a valid Drug Coverage Status Date.
	Check Box	1009	Date was invalid	Enter a valid date
Description by	Field	40	NDC, GCN Sequence Number, or Drug Description are required. Please enter a value for any of these.	Enter search values for either of these NDC, GCN Seq Number or Description By.
GCN Seq Number	Field	40	NDC, GCN Sequence Number, or Drug Description are required. Please enter a value for any of these.	Enter search values for either of these NDC, GCN Seq Number or Description By.
NDC	Field	20	NDC can only contain alphanumeric characters	Please enter an alphanumeric NDC code.
	Field	40	NDC, GCN Sequence Number, or Drug Description are required. Please enter a value for any of these.	Enter search values for either of these NDC, GCN Seq Number or Description By.

6.14.5 Reference Drug Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Reference Drug Search Panel Accessibility

6.14.6.1 To Access the Reference Drug Search Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click	Main Menu page displays.

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Step	Action	Response
	Login.	
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.

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6.15 Reference Drug Search Results Panel

6.15.1 Reference Drug Search Results Panel Narrative

The Reference Drug Search Results panel displays drug records that match the search criteria from the Drug search panel. This panel is display only.

Navigation Path: [Reference] – [Drug] - {Enter search criteria and click on 'search'}

6.15.2 Reference Drug Search Results Panel Layout

Search Results

Drug	GCN Seq Number	Generic Name	Label Name	Covered	Max Qty	ALGI	PA	PDL	Lowest Price	Lowest Price Type	AHFS	TC3	NDC Status
66992023104	66024	PHENYLEPHRINE/BROMPHENIRAMINE ORAL 10MG-6MG/5 ORAL SUSP	VAZOBID SUSPENSION	No	240	2		N	XXXXXXXXXXXX	XXXX	04042000	Z2N	R - Replace
66992023004	61679	PHENYLEPHRINE/BROMPHENIRAMIN ORAL 10MG-6MG/5 ORAL SUSP	VAZOBID SUSPENSION	No	680	2		N	XXXXXXXXXXXX	XXXX	04042000	Z2N	U - Reuse
15014023004	66024	PHENYLEPHRINE/BROMPHENIRAMINE ORAL 10MG-6MG/5 ORAL SUSP	VAZOBID SUSPENSION	No	240	1			XXXXXXXXXXXX	XXXX	04042000	Z2N	

6.15.3 Reference Drug Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product	Field	Character	1
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product	Field	Character	1
Brand Name	Brand name of the relevant drug. Contains only the brand name of the drug(s) returned from the search criteria. This is displayed if the 'Brand Name' radio button is selected.	Field	Character	30
Covered	Indicates the drug is covered (Yes) or not covered (No) on the request date. The results are in ‘Covered’ order.	Field	Character	1
Drug	Displays the National Drug Code of the drug.	Field	Character	11
GCN Seq Number	The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	5

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Field	Description	Field Type	Data Type	Length
Generic Name	Generic name of the relevant drug. Contains only the generic name of the drug(s) returned from the search criteria. This is displayed if the 'Generic Name' radio button is selected.	Field	Character	63
Label Name	Label Name of the relevant drug. Contains name, strength, and dosage form of the drug(s) returned from the search criteria. This is displayed if the 'Label Name' radio button is selected.	Field	Character	60
Max Qty	The maximum quantity of the drug which can be dispensed.	Field	Number	10
NDC Status	Displays the NDC Status for the Drug. Possible Values are R-Replace, U-Reuse, and Blank.	Field	character	13
PDL	PDL Indicator. Indicates the PDL status of the NDC, i.e. whether the drug or drug product is preferred (Y) or non-preferred (N). and blank when no PDL indicator exists.	Field	Character	1
TC3	Identifies the specific therapeutic class in which the active ingredient is classified.	Field	Character	3

6.15.4 Reference Drug Search Results Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.15.5 Reference Drug Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.15.6 Reference Drug Search Results Panel Accessibility

6.15.6.1 To Access the Reference Drug Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.

6.15.6.2 To Navigate the Reference Drug Search Results Panel

Step	Action	Response

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Step	Action	Response
1	Select row from list results.	Drug Information and Maintenance panels display.

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6.14 Reference DRG Search and DRG Search Result-DRG Panel

6.14.1 Reference DRG Search and DRG Search Result-DRG Panel Narrative

The Reference DRG Search panel allows the user to search for a specific DRG code.

Only authorized users are allowed to perform maintenance tasks. The Reference DRG Search Results panel displays DRG Codes matching the search criteria from DRG search panel

Navigation Path: [Reference] – [DRG] - [search button] - (click on [search] button)

6.14.2 Reference DRG Search and DRG Search Result-DRG Panel Layout

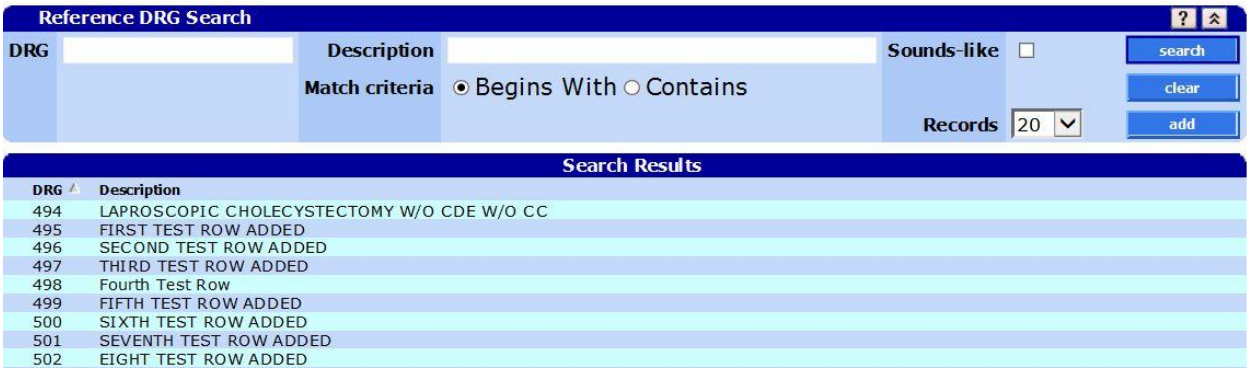

Figure 6.14.2.1 DRG Search Panel and Search Results

6.14.3 Reference DRG Search and DRG Search Results - DRG Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	This button allows the user to create a new DRG record.	Button	N/A	0
clear	This clears all fields so the user may key-in new search criteria.	Button	N/A	0
Description	This field is used to describe a unique code to tag a specific Diagnosis Related Group (DRG).	Field	Character	132
DRG	This field is used to identify a unique code to tag a specific Diagnosis Related Group (DRG). They classify hospital cases into one of approximately 500 groups, also referred to as DRGs. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities.	Field	Number (Integer)	4
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Combo Box	Radio Button	0
Records	Allows the user to specify the number of rows returned from the search.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
search	This initiates search for the DRG matching the code/description keyed-in.	Button	N/A	0
Sounds-like	Factor to retrieve records that partially match a given DRG Code and / or DRG Description.	Field	Check Box	0

6.14.4 Reference DRG Search-DRG Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found	Verify Keying. No records matching the description keyed-in were found.
DRG	Field	1	No rows found	Verify Keying. No records matching the code keyed-in were found.

6.14.5 Reference DRG Search-DRG Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 Reference DRG Search-DRG Panel Accessibility

6.14.7 To Access the Reference Search DRG and Search Results-DRG Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	Reference DRG Search panel displays.
3	Click **Search**.	Reference DRG Search Results panel displays.
4	Select row from data list.	DRG Information and Maintenance panels display.

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6.15 DRG Information-DRG Panel

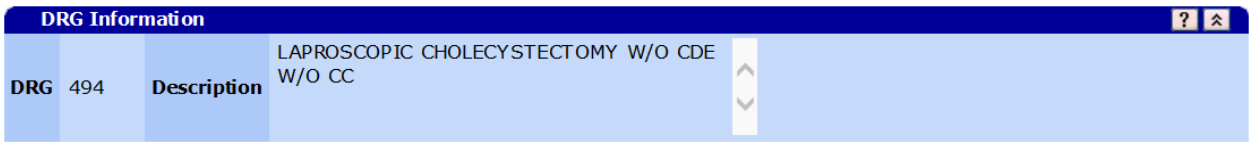
6.15.1 DRG Information-DRG Panel Narrative

The DRG Information panel is used to view DRG code data.

This panel is display only.

Navigation Path: [Reference] – [DRG] - [search] - [(select row from search results)] - [DRG Information]

6.15.2 DRG Information-DRG Panel Layout



6.15.3 DRG Information-DRG Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Text that describes the Diagnosis Related Group (DRG).	Field	Character	132
DRG	Code that uniquely identifies a Diagnosis Related Group (DRG). They classify hospital cases into one of approximately 500 groups, also referred to as DRGs. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or co morbidities.	Field	Number (Integer)	4

6.15.4 DRG Information-DRG Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.15.5 DRG Information-DRG Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.15.6 DRG Information-DRG Panel Accessibility

6.15.6.1 To Access the DRG Information-DRG Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	Reference DRG Search panel displays.
3	Click **Search**.	Reference DRG Search Results panel displays.
4	Select row from data list.	DRG Information panel displays.

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6.16 DRG Maintenance-DRG Panel

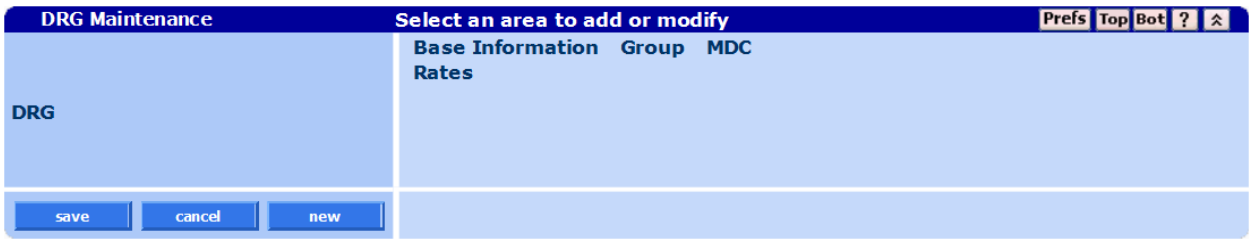
6.16.1 DRG Maintenance-DRG Panel Narrative

DRG Maintenance-DRG panel links to various DRG information maintenance panels.

This panel is inquiry only.

Navigation Path: [Reference] - [DRG (Search)] - (click on [search] button) - (select row from search results) - [DRG Maintenance] - [DRG]

6.16.2 DRG Maintenance-DRG Panel Layout



6.16.3 DRG Maintenance-DRG Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Opens the Base Information panel.	Hyperlink	N/A	0
cancel	Cancels any changes being made on the DRG Maintenance panels.	Button	N/A	0
Group	Opens the Group panel.	Hyperlink	N/A	0
MDC	Opens the MDC List panel.	Hyperlink	N/A	0
new	Clicking the New button will clear all of the DRG panels for a new record.	Button	N/A	0
Rates	Opens the Rates panel.	Hyperlink	N/A	0
save	Saves any/all changes made to any/all panels under this navigation panel.	Button	N/A	0

6.16.4 DRG Maintenance-DRG Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.16.5 DRG Maintenance-DRG Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.16.6 DRG Maintenance-DRG Panel Accessibility

6.16.6.1 To Access the DRG Maintenance-DRG Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	Reference DRG Search panel displays.
3	Click **Search**.	Reference DRG Search Results panel displays.
4	Select row from data list.	DRG Maintenance panel displays.

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6.17 DRG Mini Search-DRG Panel

6.17.1 DRG Mini Search-DRG Panel Narrative

The DRG Mini-Search allows search by DRG Code from the DRG Information page.

This panel is inquiry only.

Navigation Path: [Reference]- [DRG] - [search] - [(select row from search results)] - [Next Search By]

6.17.2 DRG Mini Search-DRG Panel Layout

6.17.3 DRG Mini Search-DRG Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
adv search	Returns the user to the main Reference DRG Search panel.	Button	N/A	0
clear	Clears the DRG field.	Button	N/A	0
DRG	This field is used to search for, and return the DRG Information panel for a specific Diagnosis Related Group (DRG) if found, or a list of any DRGs returned from the '%like%' search criteria.	Field	Character	4
search	Initiates search for a DRG record matching the 'DRG code' keyed-in DRG field.	Button	N/A	0

6.17.4 DRG Mini Search-DRG Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
DRG	Field	1	DRG Code does not exist	Enter a valid DRG code.
DRG	Field	2	DRG Code is requiered	Enter a DRG code.

6.17.5 DRG Mini Search-DRG Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 DRG Mini Search-DRG Panel Accessibility

6.17.6.1 To Access the DRG Mini Search-DRG Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	Reference DRG Search panel displays.
3	Click **Search**.	Reference DRG Search Results panel displays.

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Step	Action	Response
4	Select row from data list.	DRG Mini Search-DRG panel displays.

6.17.6.2 To Navigate the DRG Mini Search-DRG Panel

Step	Action	Response
1	Enter **DRG**.	
2	Click **Search**.	DRG Information and Maintenance panels display.

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6.18 Base Information-DRG Panel

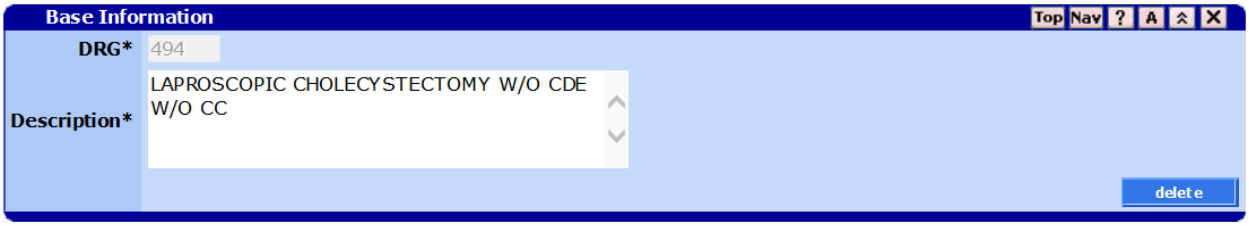
6.18.1 Base Information-DRG Panel Narrative

The DRG Code Base Information panel is used to update DRG code data.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [DRG] - [search] - [(select row from search results)] - [DRG Maintenance] - [Base Information]

6.18.2 Base Information-DRG Panel Layout



6.18.3 Base Information-DRG Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
delete	Allows the user to mark the currently open DRG record for deletion from Interchange.	Button	N/A	0
Description	This field is used to describe a unique code to tag a specific Diagnosis Related Group (DRG).	Field	Character	132
DRG	This field is used to identify a unique code to tag a specific Diagnosis Related Group (DRG). They classify hospital cases into one of approximately 500 groups, also referred to as DRGs. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities.	Field	Character	4

6.18.4 Base Information-DRG Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a description.
DRG	Field	1	DRG is required.	Enter a valid DRG code.
	Field	2	DRG code is a duplicate code.	Verify keying. The DRG code keyed is already in the system.

6.18.5 Base Information-DRG Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.18.6 Base Information-DRG Panel Accessibility

6.18.6.1 To Access the Base Information-DRG Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	Reference DRG Search panel displays.
3	Click **Search**.	Reference DRG Search Results panel displays.
4	Select row from data list.	DRG Information and Maintenance panels display.
5	Click **Base Information**.	Base Information-DRG panel displays.

6.18.6.2 To Add on the Base Information-DRG Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **DRG**.	
3	Enter **Description**.	
4	Click **Save**.	Base Information-DRG information is saved.

6.18.6.3 To Update on the Base Information-DRG Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information-DRG information is saved.

6.18.6.4 To Delete on the Base Information-DRG Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.19 Drug Maintenance Panel

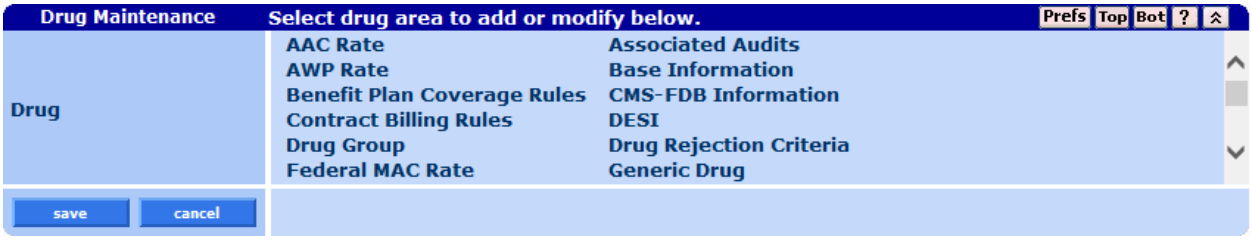
6.19.1 Drug Maintenance Panel Narrative

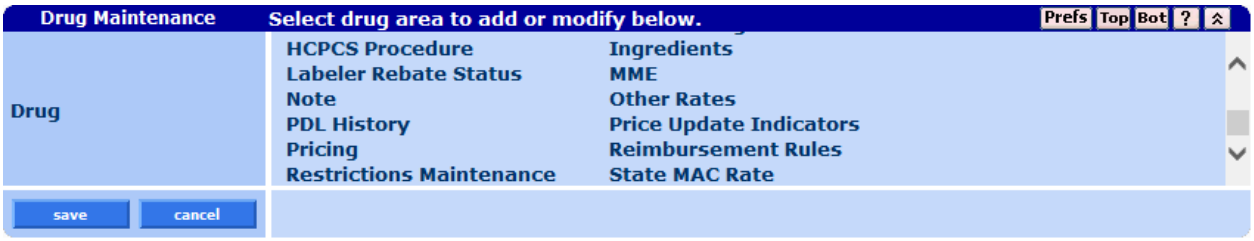
Links to the drug information maintenance panels.

This panel is inquiry only.

Navigation Path: [Reference] - [Drug] - (click on [search] and select row from search results)

6.19.2 Drug Maintenance Panel Layout





6.19.3 Drug Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AAC Rate	Provides a link which opens the Average Acquisition Cost (AAC) Rate panel.	N/A	0	N/A
Associated Audits	Provides a link which opens the Associated Audits panels.	N/A	0	N/A
AWP Rate	Provides a link which opens the Average Wholesale Price panel.	N/A	0	N/A
Base Information	Provides a link which opens the Base Information panel.	N/A	0	N/A
Benefit Plan Coverage Rules	Provides a link which opens the Benefit Plan Coverage Rules panel.	N/A	0	N/A
Cancel	Allows the user to cancel an action.	Button	N/A	0
Contract Billing Rules	Provides a link which opens the Contract Billing Rules panel.	N/A	0	N/A
DESI	Provides a link which opens the Drug Efficacy Study Implementation panel.	N/A	0	N/A

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Field	Description	Field Type	Data Type	Length
Drug Group	Provides a link which opens the Drug Group panel.	N/A	0	N/A
Drug Rejection Criteria	Provides a link which opens the Drug Rejection Criteria panel.	N/A	0	N/A
Federal MAC Rate	Provides a link which opens the Federal Maximum Allowable Cost panel.	Hyperlink	N/A	0
Generic Drug	Provides a link to the Generic Drug panel.	Hyperlink	N/A	0
HCPCS Procedure	Provides a link which opens the HCPCS Procedure - Drug panel.	Hyperlink	N/A	0
Ingredients	Provides a link to the Ingredients panel.	Hyperlink	N/A	0
Labeler Rebate Status	Provides a link which opens the Labeler Rebate Status panel.	Hyperlink	N/A	0
MME	Provides a link which opens the MME panel.	Hyperlink	N/A	0
Note	Provides a link which opens the Note panel.	Hyperlink	N/A	0
Other Rate	Provides a link which opens the Other Rate panel.	Hyperlink	N/A	0
PDL History	Provides a link which opens the PDL History panel.	Hyperlink	N/A	0
Price Update Indicators	Provides a link which opens the Price Update Indicators panel.	Hyperlink	N/A	0
Pricing	Provides a link which opens the Pricing panel.	Hyperlink	N/A	0
Reimbursement Rules	Provides a link which opens the Reimbursement Rules panel.	Hyperlink	N/A	0
Restrictions Maintenance	Provides a link which opens the Restrictions Maintenance panel.	Hyperlink	N/A	0
Save	Allows the user to save any changes made on the panel.	Button	N/A	0
State MAC Rate	Provides a link which opens the State Maximum Allowable Cost panel.	Hyperlink	N/A	0

6.19.4 Drug Maintenance Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.19.5 Drug Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.19.6 Drug Maintenance Panel Accessibility

6.19.6.1 To Access the Drug Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance panel displays.

6.19.6.2 To Navigate on the Drug Maintenance Panel

Step	Action	Response
1	Click on hyperlink to select an area to add or modify.	Selected panel displays.

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6.20 Drug Mini Search-Drug Panel

6.20.1 Drug Mini Search-Drug Panel Narrative

The Drug Mini Search panel provides the user with the ability to search for a Drug from the Drug Information page. This panel is inquiry only.

Navigation Path: [Reference] – [Drug] - (click on [search] and select row from search results)

6.20.2 Drug Mini Search-Drug Panel Layout

6.20.3 Drug Mini Search-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	This takes the user to Drug main search page where user can set more advanced search criteria.	Button	N/A	0
Clear	This 'clears' the 'Drug' field so user may key-in a new criterion.	Button	N/A	0
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code, and a 2-digit package code.	Field	Character	11
Request Date	Allows the user to enter a specific, previous date, to inquire about drug coverage for a particular NDC. If left blank, Request Date will default to the current date	Field	Date(MMDDCCYY)	8
Search	This initiates 'search' of Drug database to find a record matching the NDC Code keyed-in.	Button	N/A	0

6.20.4 Drug Mini Search-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.20.5 Drug Mini Search-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.20.6 Drug Mini Search-Drug Panel Accessibility

6.20.6.1 To Access the Drug Mini Search-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Mini Search panel displays.

6.20.6.2 To Navigate on the Drug Mini Search-Drug Panel

Step	Action	Response
1	Enter **NDC**.	
2	Click **Search**.	Drug Information and Maintenance panels display.

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6.21 Reference Drug Information Panel

6.21.1 Reference Drug Information Panel Narrative

The Drug Information panel provides an 'inquiry only' view of base drug data such as NDC (National Drug Code) and Brand Name.

First DataBank (FDB), a leading provider of electronic drug information, supplies EDS with comprehensive descriptive, pricing and clinical information on drugs.

Navigation Path: [Reference - Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - Drug Information

6.21.2 Reference Drug Information Panel Layout

Drug Information

NDC	
NDC	38396041657
Covered on 11/30/2018	No
PA	
Brand Name	ULTRA COMFORT
Label Name	DRUG MART ULTRA COMFORT SYR
NDC Format	4 - UPC 5-5
Previous NDC	
Replaced by NDC	
NDDF Add	07/17/2008
Last NDDF Update	04/09/2012
Last AWP Update	07/17/2008
Obsolete Date	
NDC status	
Update Indicator	Y - Yes
Status	A - Active
Source	1 - Multiple
Class	O - Over the Counter
GPI	9 - Indicator no longer valid
NDA	
ANDA	
GNI	0 - Non-Drug item
ALGI	1 - Generic Product
Maintenance Drug	1 - Yes
Top Volume Ranking	0
Generic Drug	
GCN Seq No	49358
Generic Name	SYRINGE & NEEDLE,INSULIN,1 ML MISCELL 30GX5/16" DISP SYRIN
HICL Seq No	23038
Ingredient List	X2BJJF
HIC4	X2BJ SYRINGE W-NDL, DISP., INSULIN
Drug Category Code	R-DISP.SYRINGES W/WO NEEDLES (INSULIN)
Therapeutic Class	
Generic	74 MISCELLANEOUS MEDICAL SUPPLIES, DEVICES,
Standard	00 MEDICAL SUPPLIES
Specific	X2B SYRINGES AND ACCESSORIES
AHFS	94000000 DEVICES
Therapeutic Equivalency	

Manufacturer	
Labeler ID	D38396
Manufacturer/Distributor	PERRIGO DIABETE
Innovator	0 - No
IPI	0 - Not Institutional
Package	
Drug Form	EA - tablets,kits,etc.
Package	Box
Standard Package	0 - No
Package Size	100.000
Shelf Pack	1
Shipper Quantity	1
Case Size	1
Unit Dose	0 - No
Unit of Use	0 - No
Repack	0 - Not Repackaged
Drug Selection	
DEA	0 - No control
Schedule Code	OC
CMS	
Unit	
CMS Package Size	0.000
Approval Date	
Market Entry Date	
Termination Date	
Category	
Orange Book Evaluation	
OBC3	ZB PARTICULAR PHARMACEUTICAL ENTITY

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6.21.3 Reference Drug Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS (Code)	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	6
AHFS (Description)	Text description of the American Hospital Formulary Service (AHFS) classification.	Field	Character	40
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 – Non-drug item 1 – Generic Product 2 – Brand Product.	Field	Character	1
Approval Date	Date the FDA approves a product for sale in the marketplace. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS by the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8
Brand Name	Name that appears on the package label provided by the manufacturer.	Field	Character	35

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Field	Description	Field Type	Data Type	Length
CMS Package Size	Indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. This column must be used in conjunction with the HCFA Unit Type to determine the appropriate number of units. Format is 99999999.999. Note: Data received from FDB and CMS. Will source from FDB update only if the package size on file is 0. Updates to this data element from the CMS quarterly update will always be applied.	Field	Number (Decimal)	11
Case Size	Number of usable units in the shipping container. First DataBank uses this number as a divisor to calculate the single package price when case pricing for the NDC is reported to First DataBank; customers can use it as a multiplier to determine the case price from the single package price. When case pricing for the NDC is not reported, the default is 1.	Field	Number (Decimal)	9
Category	Identifies single source, multi-source, or innovator status as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The data is supplied to CMS by the drug labeler.	Field	Chaacter	1
Class	Classifies a drug by its availability to the consumer according to federal specifications. e.g. Over the counter (O) or Legend (F).	Field	Character	1
Covered On	Displays the request date and coverage status of the NDC displayed on the panel. Valid values are 'Yes,' and 'No.'	Field	Character	1

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Field	Description	Field Type	Data Type	Length
DEA	Drug Enforcement Administration (DEA) Code. Denotes the degree of potential abuse and federal control of a drug. This code is subject to change by federal regulation.	Field	Character	1
Drug Category Code	The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.	Field	Character	100
Drug Form	Indicates the type of billing unit to be used for a product. E.G. Each (tablets, kits, etc.).	Field	Character	2
GCN Seq Number	Clinical Formulation ID. Represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	9
GNI	Generic Name Indicator (GNI). Specifies whether a product is a brand named product, a generically named product, or an alternative product, using the product name as the criteria.	Field	Character	1
GPI	Generic Price Indicator (GPI). Distinguishes a product as either generically priced or priced as a brand.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Generic (Code)	Generic Therapeutic Class (GTC) code. Classifies drugs according to the most common intended use. This classification provides the most general therapeutic groupings available from First DataBank. Users that need more definitive therapeutic classing should consider Standard Therapeutic Class (for example).	Field	Number (Integer)	2
Generic (Description)	Text description of the Generic Therapeutic Class.	Field	Character	40
Generic Name	Combination of active ingredient names, route of administration, dosage form, and strength.	Field	Character	63
HIC4 (Code)	Hierarchical Ingredient Code of the primary ingredient.	Field	Character	4
HIC4 (Description)	Text description of the HIC4 Code.	Field	Character	40
HICL Sequence Number	Ingredient List Identifier. A permanent numeric identifier that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.	Field	Number (Integer)	6
IPI	Identifies products sold only to selected customers, usually at a discounted price. Institutional products are manufacturer-specified; customers must meet the manufacturer's definition of an institution (for example, nursing homes, the Veteran's Administration). 0 - Not Institutional.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Ingredients	Ingredient list (commonly referred to as the HICL or HIC List), referenced by the HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.	Listview	N/A	0
Ingredient List	Ingredient list (commonly referred to as the HICL or HIC List), referenced by the HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.	Field	Character	62
Innovator	This field identifies the original innovator product for a particular generic code number. Values are: '0 - No' = non-innovator drug, and '1 - Yes' = Innovator held original patent. It is possible to have more than one product to appear to be the innovator.	Field	Character	1
Label Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Labeler ID	Code that represents the product labeler (a manufacturer, distributor, or repackager). The first character is alphabetic and represents a division within a company. The last five characters are numeric and represent the parent company. Not be confused with the five-digit labeler code that is assigned to a company by the FDA and that comprises the first five digits of an NDC.	Field	Number (Integer)	9
Last AWP Update	Date the AWP (Average Wholesale Price) was last changed according to the NDDF (National Drug Data File).	Field	Date (MM/DD/CCYY)	8
Last NDDF Update	Date on which the drug information was last changed on the NDDF from FDB.	Field	Date (MM/DD/CCYY)	8
Maintenance Drug	Identifies a drug as a maintenance drug.	Field	Character	1
Manufacturer/Distributor	Name of the product labeler (a manufacturer, distributor, or repackager).	Field	Character	15
Market Entry Date	Date a manufacturer releases the drug product to the marketplace. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is provided to CMS by the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code and a 2-digit package code.	Field	Character	11
NDC Format	Defines both the type of external identifying code (NDC, HRI, UPC, or PIN) in the NDC field and the way in which this code has been converted into the 11-digit 5-4-2 format.	Field	Character	9
NDC Status	Displays the NDC Status for the Drug. Possible Values are R-Replace, U-Reuse and Blank	Field	Character	1
NDDF Add	Date on which the drug record was added to the National Drug Data File (NDDF) from FDB.	Field	Date (MM/DD/CCYY)	8
OBC3 (Code)	Orange Book Code; 3-Byte Version (OBC3). Identifies the equivalency ratings assigned to approved prescription products according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). When there is not a three-byte code in the Orange Book, the default OBC3 is the two-byte OBC plus a trailing blank.	Field	Character	3
OBC3 (Description)	Text description of the 3-Byte Orange Book Code (OBC3).	Field	Character	30
Obsolete Date	Date when the drug product is no longer available on the market place as per the manufacturer's notification, or the best estimate of that date.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
PA	PA Indicator. Indicates whether PA is required Yes, No or Blank.	Field	Character	3
Package	Description of the container that is in direct contact with the product. First DataBank obtains the Package Description from the product package insert and abbreviates to keep package description terms within 10 characters.	Field	Character	10
Package Size	Metric quantity used to derive a unit price. The usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc. Format is 99999999.999.	Field	Number (Decimal)	11
Previous NDC	Previous/Old NDC if the current NDC is a replacement NDC.	Field	Number (Integer)	11
Repack	Identifies a product as repackaged or not repackaged. 0 - Not repackaged 1 – Repackaged.	Field	Character	1
Replaced by NDC	Replacement/New NDC if the current NDC has been changed or replaced by the labeler. An NDC must be obsolete in order for a replacement to be assigned, and the Brand Name (BN), formulation, and package size must be the same for the old and new NDC.	Field	Number (Integer)	11
Schedule Code	The unique two character code for the description of the Alabama Schedule.	Field	Character	2
Shelf Pack	Number of bundled salable units in the shipping container.	Field	Number (Integer)	9
Shipper Quantity	Number of salable units in the minimum order quantity available from the distributor; it is usually a multiple of the Shelf Pack or Case Pack.	Field	Number (Integer	9

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Field	Description	Field Type	Data Type	Length
Source	NDC-level single-source or multi-source indicator. Specifies whether a product's generic formulation (i.e. its particular active ingredient, dosage form, route of administration and strength) is only available from a single distributor or from multiple distributors.	Field	Character	1
Specific (Code)	Hierarchical Specific Therapeutic Class Code (HIC3). Identifies the specific therapeutic class in which the active ingredient is classified.	Field	Character	3
Specific (Description)	Text description of the Specific Therapeutic Class.	Field	Character	40
Standard (Code)	Standard Therapeutic Class (TC) Code. Classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system. A more comprehensive therapeutic classification is provided by Specific Therapeutic Class (for example).	Field	Number (Integer)	2
Standard (Description)	Text Description of the Standard Therapeutic Class.	Field	Character	40
Standard Package	Indicates whether the product package size is the standard package size.	Field	Character	1
Status	Identifies the status of a drug within interChange. A drug is marked as either Active (A) or Inactive (I). This information is used to allow the user to review additions and updates to a drug before it is activated for use by interChange.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Termination Date	Shelf-life expiration date of the last batch of product produced, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS from the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8
Therapeutic Equivalency (Code)	CMS FDA Therapeutic Equivalency Code. Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.	Field	Character	2
Therapeutic Equivalency (Description)	Text description of the CMS FDA Therapeutic Equivalency Code. Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.	Field	Character	100
Top Volume Ranking	Indicates if a drug is included in the list of the most frequently dispensed 200 drug products. Different package sizes and dose forms of the same drug have the same number. This field is based on pharmaceutical market research surveys and originates from First DataBank.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Unit	Indicates the unit of measure as supplied on the Health Care Financing Administration's quarterly tape. Note: Data received from FDB and CMS. Will source from FDB update only if the CMS unit file is blank. Updates from the CMS quarterly update will always be applied.	Field	Character	3
Unit Dose	Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the manufacturer. This indicator does not apply to injectable products, suppositories, or powder packets. Products labeled as Unit Dose are not sold as individual unit doses; rather, the product is sold in a package that contains several Unit Doses.	Field	Character	1
Unit of Use	Identifies products that are packaged per course of therapy. Products are labeled as Unit of Use by the manufacturer. These products are supplied with appropriate labeling and (usually) child resistant closures, and thus are appropriate to dispense as a unit.	Field	Character	1
Update Indicator	Indicates whether batch update to the NDC should be allowed.	Field	Character	1

6.21.4 Reference Drug Information Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this window.				

6.21.5 Reference Drug Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.21.6 Reference Drug Information Panel Accessibility

6.21.6.1 To Access Reference Drug Information Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information panel displays.

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6.22 AAC Rate-Drug Panel

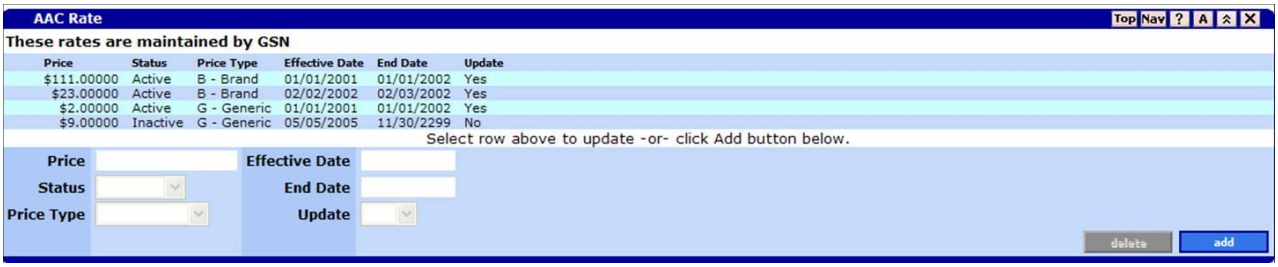
6.22.1 AAC Rate-Drug Panel Narrative

The Average Acquisition Cost (AAC) Rate panel is used to maintain the AAC Rate type at GSN level.

Only users with update authority are allowed to modify this panel.

Navigation Path: [Reference] - [Drug Search] - [(Add button) OR (Search and select row from search results)] - [Drug Maintenance] - [AAC Rate]

6.22.2 AAC Rate-Drug Panel Layout



6.22.3 AAC Rate-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an AAC pricing record to all drugs under the same GSN.	Button	N/A	0
Delete	Allows the user to delete an AAC pricing record from all drugs under the same GSN.	Button	N/A	0
Status	Indicates whether the AAC pricing segment is in an active (Y) or inactive (N) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.	Combo Box	Character	1
Effective Date	This is the date that the drug's Average Acquisition Cost takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	This is the date that the drug's Average Acquisition Cost is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Price	This is the Average Acquisition Cost for all drugs within a GSN as determined by contractor Myers & Stauffer	Field	Number	12
Price Type	Indicates if the corresponding price is for Brand or Generic drugs within	Combo Box	Character	1

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Field	Description	Field Type	Data Type	Length
	the same GSN. Valid values are: B – Brand and G – Generic.			
Update	Indicates whether batch updates to the AAC Rate file should be allowed. N = Batch updates not allowed. Y = Batch updates allowed.	Combo Box	Character	1

6.22.4 AAC Rate-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	1	The update failed because the data has been changed since it was loaded. Please reload the data, and apply your changes again.	Reload the data for AAC Rate panel.
Effective Date	Field	1	Effective Date must be less than or equal to the End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter an Effective Date in mm/DD/CCYY format.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	4	Effective Date is required.	Enter an Effective Date.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Invalid Date. Format is MM/DD/CCYY.	Enter a valid End Date in mm/DD/CCYY format.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than 01/01/1900.
	Field	3	End Date is required.	Enter an End Date.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Price	Field	1	Price is required.	Enter Price.
	Field	2	Enter a valid value.	Enter valid price(less than or equal to 9999999.99999).
	Field	3	Price must be greater than or equal to 0000.00000.	Enter valid amount in the field.

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Field	Field Type	Error Code	Error Message	To Correct
Price Type	Combo Box	1	Price Type is required.	Enter Price Type.
Status	Combo Box	1	Status is required.	Enter Status.
Update	Combo Box	1	Update is required.	Enter Update.

6.22.5 AAC Rate-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.22.6 AAC Rate-Drug Panel Accessibility

6.22.6.1 To Access the AAC Rate-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **AAC Rate**.	AAC Rate-Drug panel displays.

6.22.6.2 To Add on the AAC Rate-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Price** and **PriceType**.	
3	Select **Status** and **Update** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	AAC Rate-Drug information is saved.

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6.22.6.3 To Update on the AAC Rate-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AAC Rate-Drug information is saved.

6.22.6.4 To Delete on the AAC Rate-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.23 Drug – MME Panel

6.23.1 Drug - MME Panel Narrative

The Drug MMC Maintenance panel is used to display MME information linked to the drug.

This panel is display only.

Navigation Path: [Reference] - [Drug Search] - [(Add button) OR (Search and select row from search results)] - [Drug Maintenance] - [MME]

6.23.2 Drug – MME Panel Layout

6.23.3 Drug - MME Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active	MME Factor Available. For multi-ingredient products containing more than one opioid, this indicator will only be Yes.	Field	Character	1
Long Acting	Long Acting Opioid Indicator, product is considered to be a long acting opioid.	Field	Character	1
Morphine Equivalent	MME Strength Per Dosage Unit provides a total MME per dosage form. If the Clinical Formulation contains an ingredient with two different salts then results in this field is a sum of both.	Field	Number (Decimal)	34

6.23.4 Drug - MME Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.23.5 Drug - MME Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 Drug - MME Panel Accessibility

6.23.6.1 To Access the Drug - MME Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **MME**.	MME panel displays.

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6.24 Associated Audits-GCN Sequence Number-Drug Panel

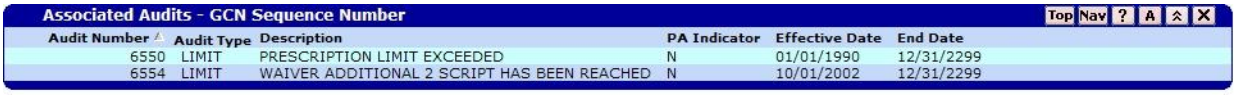
6.24.1 Associated Audits-GCN Sequence Number-Drug Panel Narrative

The Associated Audits - GCN Sequence Number panel displays a list of all table driven audits associated to a specific NDC code by GCN Sequence Number.

This panel is display only.

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Associated Audits]

6.24.2 Associated Audits-GCN Sequence Number-Drug Panel Layout



Associated Audits - GCN Sequence Number

Audit Number	Audit Type	Description	PA Indicator	Effective Date	End Date
6550	LIMIT	PRESCRIPTION LIMIT EXCEEDED	N	01/01/1990	12/31/2299
6554	LIMIT	WAIVER ADDITIONAL 2 SCRIPT HAS BEEN REACHED	N	10/01/2002	12/31/2299

6.24.3 Associated Audits-GCN Sequence Number-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Number	Code that uniquely identifies an audit.	Field	Character	4
Audit Type	Identifies the audit as limitation, contra-indicated, umbrella, etc.	Field	Character	16
Description	Text describing the audit.	Field	Character	50
Effective Date	First date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
PA Indicator	Indicates whether prior authorization is required. Valid values include: Y = Yes N = No	Field	Character	1

6.24.4 Associated Audits-GCN Sequence Number-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.24.5 Associated Audits-GCN Sequence Number-Drug Panel Extra Features

The "Associated Audit" link opens three panels:

Associated Audits - Standard Therapeutic Class
Associated Audits - NDC
Associated Audits - GCN Sequence Number

6.24.6 Associated Audits-GCN Sequence Number-Drug Panel Accessibility

6.24.6.1 To Access the Associated Audits-GCN Sequence Number-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **Associated Audits**.	Associated Audits –GCN Sequence Number panel displays.

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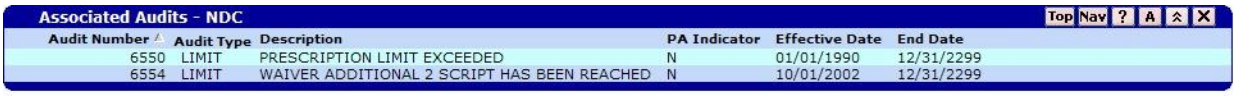
6.25 Associated Audits-NDC-Drug Panel

6.25.1 Associated Audits-NDC-Drug Panel Narrative

The Associated Audits panel displays an 'inquiry only' listing of all table driven audits associated to a specific NDC code. This panel is display only.

Navigation Path: [Reference] - [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Associated Audits]

6.25.2 Associated Audits-NDC-Drug Panel Layout



Associated Audits - NDC

Audit Number	Audit Type	Description	PA Indicator	Effective Date	End Date
6550	LIMIT	PRESCRIPTION LIMIT EXCEEDED	N	01/01/1990	12/31/2299
6554	LIMIT	WAIVER ADDITIONAL 2 SCRIPT HAS BEEN REACHED	N	10/01/2002	12/31/2299

6.25.3 Associated Audits-NDC-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Number	Code that uniquely identifies an audit.	Field	Character	4
Audit Type	Identifies the audit as limitation, contra-indicated, umbrella, etc.	Field	Character	16
Description	Text describing the audit.	Field	Character	50
Effective Date	First date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
PA Indicator	Indicates whether prior authorization is required.. Valid values include: Y = Yes N = No	Field	Character	1

6.25.4 Associated Audits-NDC-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.25.5 Associated Audits-NDC-Drug Panel Extra Features

The "Associated Audit" link opens three panels:

Associated Audits - Standard Therapeutic Class
Associated Audits - NDC
Associated Audits - GCN Sequence Number

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6.25.6 Associated Audits-NDC-Drug Panel Accessibility

6.25.6.1 To Access the Associated Audits-NDC Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **Associated Audits**.	Associated Audits-NDC Drug panel displays.

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6.26 Associated Audits-Standard Therapeutic Class-Drug Panel

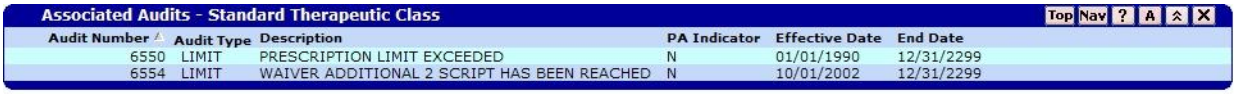
6.26.1 Associated Audits-Standard Therapeutic Class-Drug Panel Narrative

The Associated Audits - Standard Therapeutic Class panel displays a list of all table driven audits associated to a specific NDC code.

This panel is display only.

Navigation Path: [Reference - Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Associated Audits]

6.26.2 Associated Audits-Standard Therapeutic Class-Drug Panel Layout



Associated Audits - Standard Therapeutic Class

Audit Number	Audit Type	Description	PA Indicator	Effective Date	End Date
6550	LIMIT	PRESCRIPTION LIMIT EXCEEDED	N	01/01/1990	12/31/2299
6554	LIMIT	WAIVER ADDITIONAL 2 SCRIPT HAS BEEN REACHED	N	10/01/2002	12/31/2299

6.26.3 Associated Audits-Standard Therapeutic Class-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Number	Code that uniquely identifies an audit.	Field	Character	4
Audit Type	Identifies the audit as limitation, contra-indicated, umbrella, etc.	Field	Character	16
Description	Text describing the audit.	Field	Character	50
Effective Date	First date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the audit is effective within interChange.	Field	Date (MM/DD/CCYY)	8
PA Indicator	Indicates whether prior authorization is required. Valid values include: Y = Yes N = No	Field	Character	1

6.26.4 Associated Audits-Standard Therapeutic Class-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.26.5 Associated Audits-Standard Therapeutic Class-Drug Panel Extra Features

The "Associated Audit" link opens three panels:

Associated Audits - Standard Therapeutic Class
Associated Audits - NDC
Associated Audits - GCN Sequence Number

6.26.6 Associated Audits-Standard Therapeutic Class-Drug Panel Accessibility

6.26.6.1 To Access the Audits- Standard Therapeutic Class-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **Associated Audits**.	Associated Audits-Standard Therapeutic Class panel displays.

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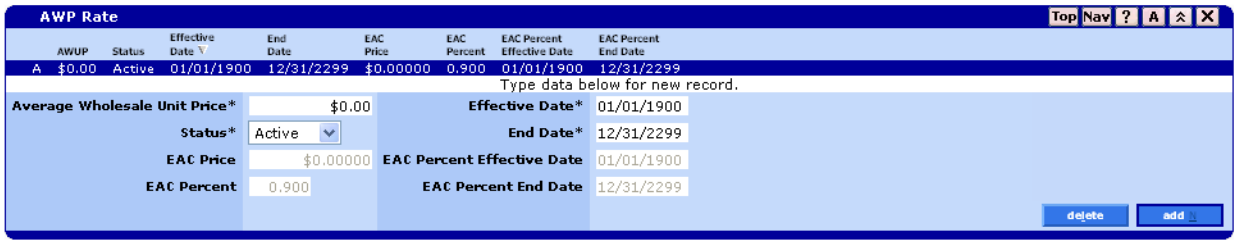
6.27 AWP Rate-Drug Panel

6.27.1 AWP Rate-Drug Panel Narrative

The Drug AWP Maintenance panel is used to maintain the drug's Blue Book Average Wholesale unit Price (AWP). The AWP represents the most common wholesaler price to the retailer or hospital and is based on actual surveys of drug wholesalers. This information is maintained on a weekly basis from First DataBank drug tapes. Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug Search] - [(Add button) OR (Search and select row from search results)] - [Drug Maintenance] - [AWP Rate]

6.27.2 AWP Rate-Drug Panel Layout



6.27.3 AWP Rate-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an AWP pricing record for this Drug.	Button	N/A	0
Average Wholesale Unit Price	Blue Book average wholesale unit price. It represents the most common wholesaler price to the retailer or hospital. This price is based on actual surveys of drug wholesalers. Format $9,999,999.99999.	Field	Number (Decimal)	12
Delete	Allows the user to delete an AWP pricing record from this Drug.	Button	N/A	0
EAC Percent	Actual percentage value to be applied to the estimated acquisition cost to determine reimbursement amount. Format 100.0.	Field	Number (Decimal)	4
EAC Percent Effective Date	First date that the associated percentage is effective.	Field	Date (MM/DD/CCYY)	8
EAC Percent End Date	Last dispense date that this percentage is applicable.	Field	Date (MM/DD/CCYY)	8
EAC Price (computed)	Contains the price representing the Estimated Acquisition Cost. Format is $9,999,999.99999. .	Field	Number (Decimal)	12

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Field	Description	Field Type	Data Type	Length
	EAC Price = (AWUP * EAC Percent).			
Effective Date	Date the Average Wholesale Price and the Estimated Acquisition Cost took effect.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Average Wholesale Price and the Estimated Acquisition Cost is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Status	Indicates whether the status of AWP pricing segment is active or inactive.	Combo Box	Drop Down List Box	0

6.27.4 AWP Rate-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Average Wholesale Unit Price	Field	1	AWP Amount must be greater than or equal to 0000.00001.	Enter valid amount in the field.
	Field	2	AWP Amount must be less than or equal to $9,999,999.99999.	Enter valid amount in the field.
	Field	3	Average Wholesale Unit Price is required.	Enter a valid AWUP.
Effective Date	Field	1	Effective Date must be less than or equal to the End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Correct overlap condition. Date segments cannot overlap.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter an Effective Date.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	Invalid Date.	Enter a valid End Date in MM/DD/CCYY format.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than 01/01/1900.
	Field	3	End Date is required.	Enter an End Date.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

6.27.5 AWP Rate-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 AWP Rate-Drug Panel Accessibility

6.27.6.1 To Access the AWP Rate-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Information and Maintenance panels display.
6	Click **AWP Rate**.	AWP Rate-Drug panel displays.

6.27.6.2 To Add on the AWP Rate-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Average Wholesale Unit price**.	
3	Select **Status** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	AWP Rate-Drug information is saved.

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6.27.6.3 To Update on the AWP Rate-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AWP Rate-Drug information is saved.

6.27.6.4 To Delete on the AWP Rate-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.28 Base Information-Drug Panel

6.28.1 Base Information-Drug Panel Narrative

The Drug Base Information panel is used to maintain base drug (NDC) data. Update privileges are controlled via Security Roles. Only users with authorized access are allowed to perform maintenance tasks.

First DataBank (FDB), a leading provider of electronic drug information, supplies EDS with comprehensive descriptive, pricing and clinical information on drugs.

NDC Note:
The NDC field contains NDCs, HRIs, UPCs, and PINs-the external identifiers representing drugs and health-related products. NDC codes are 11 digits for Alabama Medicaid purposes. NDCs, HRIs, and UPCs are ten-digit codes; a zero has been added to make them 11-digit codes, in accordance with NCPDP standards. PINs are already 11-digits. First DataBank refers to all external identifiers (NDC, HRI, UPC, and PIN) as NDCs. The NDC Format Indicator is used to determine if the value is an NDC, HRI, UPC, or PIN.

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Base Information]

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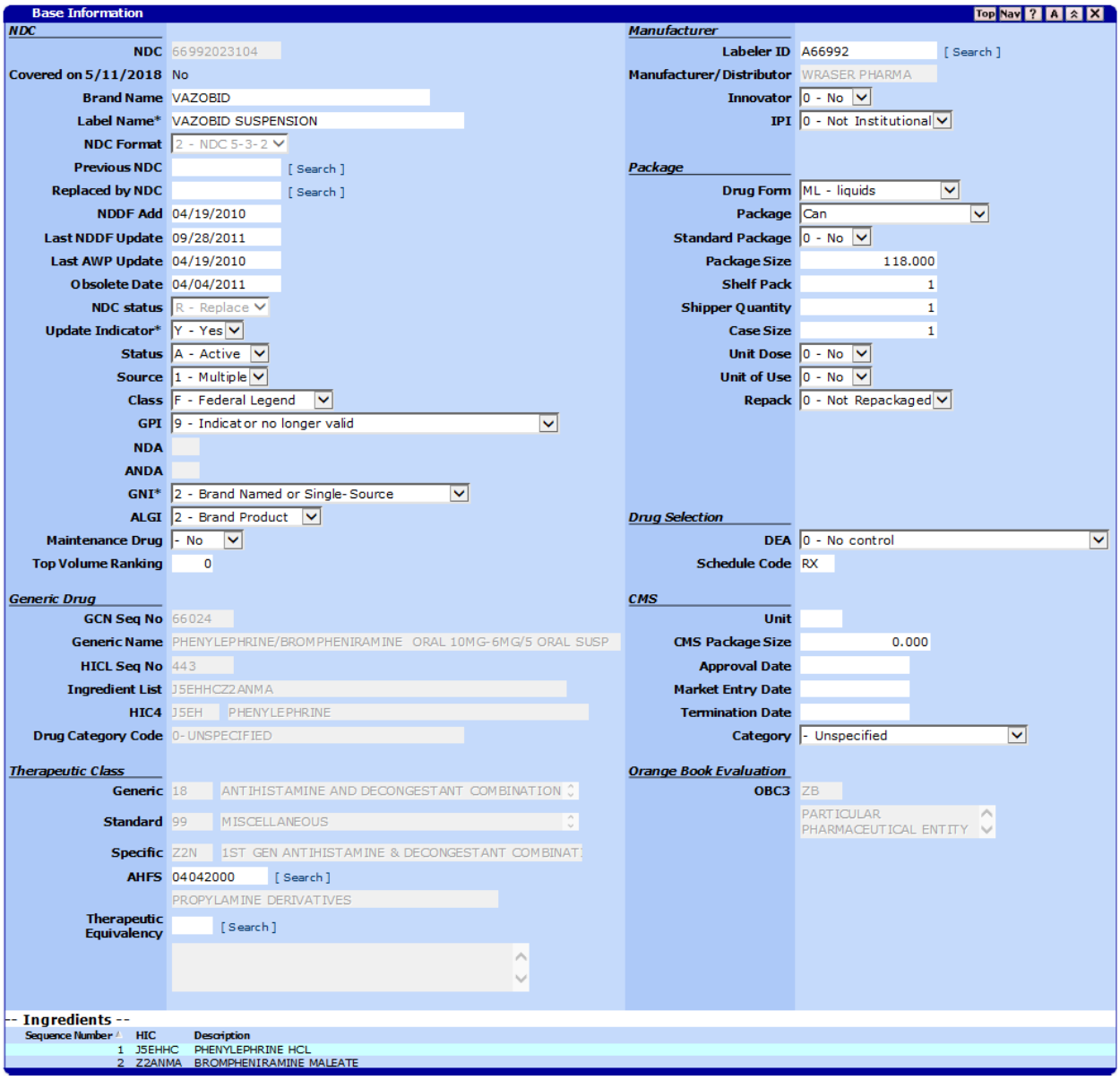
6.28.2 Base Information-Drug Panel Layout



6.28.3 Base Information-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS (Code)	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
AHFS (Description)	Text description of the American Hospital Formulary Service (AHFS) classification.	Field	Character	40
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 – Non-drug item 1 – Generic Product 2 – Brand Product.	Field	Character	1
Approval Date	Date the FDA approves a product for sale in the marketplace. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS by the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8
Brand Name	Name that appears on the package label provided by the manufacturer.	Field	Character	35
CMS Package Size	Indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. This column must be used in conjunction with the HCFA Unit Type to determine the appropriate number of units. Format is 99999999.999. Note: Data received from FDB and CMS. Will source from FDB update only if the package size on file is 0. Updates to this data element from the CMS quarterly update will always be applied.	Field	Number (Decimal)	11

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Field	Description	Field Type	Data Type	Length
Case Size	Number of usable units in the shipping container. First DataBank uses this number as a divisor to calculate the single package price when case pricing for the NDC is reported to First DataBank; customers can use it as a multiplier to determine the case price from the single package price. When case pricing for the NDC is not reported, the default is 1.	Field	Number (Decimal)	9
Category	Identifies single source, multi-source, or innovator status as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The data is supplied to CMS by the drug labeler.	Combo Box	Drop Down List Box	0
Class	Classifies a drug by its availability to the consumer according to federal specifications. e.g. Over the counter (O) or Legend (F).	Combo Box	Drop Down List Box	0
Covered On	Displays the request date and coverage status of the NDC displayed on the panel. Valid values are 'Yes,' and 'No.'	Field	Character	1
DEA	Drug Enforcement Administration (DEA) Code. Denotes the degree of potential abuse and federal control of a drug. This code is subject to change by federal regulation.	Combo Box	Drop Down List Box	0
Drug Category Code	The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.	Field	Character	100
Drug Form	Indicates the type of billing unit to be used for a product. E.G. Each (tablets, kits, etc.).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
GCN Seq Number	Clinical Formulation ID. Represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	9
GNI	Generic Name Indicator (GNI). Specifies whether a product is a brand named product, a generically named product, or an alternative product, using the product name as the criteria.	Combo Box	Drop Down List Box	0
GPI	Generic Price Indicator (GPI). Distinguishes a product as either generically priced or priced as a brand.	Combo Box	Drop Down List Box	0
Generic (Code)	Generic Therapeutic Class (GTC) code. Classifies drugs according to the most common intended use. This classification provides the most general therapeutic groupings available from First DataBank. Users that need more definitive therapeutic classing should consider Standard Therapeutic Class (for example).	Field	Number (Integer)	2
Generic (Description)	Text description of the Generic Therapeutic Class.	Field	Character	40
Generic Name	Combination of active ingredient names, route of administration, dosage form, and strength.	Field	Character	63
HIC4 (Code)	Hierarchical Ingredient Code of the primary ingredient.	Field	Character	4
HIC4 (Description)	Text description of the HIC4 Code.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
HICL Sequence Number	Ingredient List Identifier. A permanent numeric identifier that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.	Field	Number (Integer)	6
IPI	Identifies products sold only to selected customers, usually at a discounted price. Institutional products are manufacturer-specified; customers must meet the manufacturer's definition of an institution (for example, nursing homes, the Veteran's Administration). 0 - Not Institutional.	Field	Character	1
Ingredients	Ingredient list (commonly referred to as the HICL or HIC List), referenced by the HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.	Listview	N/A	0
Ingredient List	Ingredient list (commonly referred to as the HICL or HIC List), referenced by the HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.	Field	Character	62
Innovator	This field identifies the original innovator product for a particular generic code number. Values are: '0 - No' = non-innovator drug, and '1 - Yes' = Innovator held original patent. It is possible to have more than one product to appear to be the innovator.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Label Name	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	40
Labeler ID	Code that represents the product labeler (a manufacturer, distributor, or repackager). The first character is alphabetic and represents a division within a company. The last five characters are numeric and represent the parent company. Not be confused with the five-digit labeler code that is assigned to a company by the FDA and that comprises the first five digits of an NDC.	Field	Number (Integer)	9
Last AWP Update	Date the AWP (Average Wholesale Price) was last changed according to the NDDF (National Drug Data File).	Field	Date (MM/DD/CCYY)	8
Last NDDF Update	Date on which the drug information was last changed on the NDDF from FDB.	Field	Date (MM/DD/CCYY)	8
Maintenance Drug	Identifies a drug as a maintenance drug.	Field	Character	1
Manufacturer/Distributor	Name of the product labeler (a manufacturer, distributor, or repackager).	Field	Character	15
Market Entry Date	Date a manufacturer releases the drug product to the marketplace. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is provided to CMS by the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code and a 2-digit package code.	Field	Character	11
NDC Format	Defines both the type of external identifying code (NDC, HRI, UPC, or PIN) in the NDC field and the way in which this code has been converted into the 11-digit 5-4-2 format.	Field	Character	9
NDC Status	Displays the NDC Status for the Drug. Possible Values are R-Replace, U-Reuse and Blank.	Field	Character	13
NDDF Add	Date on which the drug record was added to the National Drug Data File (NDDF) from FDB.	Field	Date (MM/DD/CCYY)	8
OBC3 (Code)	Orange Book Code; 3-Byte Version (OBC3). Identifies the equivalency ratings assigned to approved prescription products according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). When there is not a three-byte code in the Orange Book, the default OBC3 is the two-byte OBC plus a trailing blank.	Field	Character	3
OBC3 (Description)	Text description of the 3-Byte Orange Book Code (OBC3).	Field	Character	30
Obsolete Date	Date when the drug product is no longer available on the market place as per the manufacturer's notification, or the best estimate of that date.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Package	Description of the container that is in direct contact with the product. First DataBank obtains the Package Description from the product package insert and abbreviates to keep package description terms within 10 characters.	Combo Box	Drop Down List Box	0
Package Size	Metric quantity used to derive a unit price. The usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc. Format is 99999999.999.	Field	Number (Decimal)	11
Previous NDC	Previous/Old NDC if the current NDC is a replacement NDC.	Field	Number (Integer)	11
Repack	Identifies a product as repackaged or not repackaged. 0 - Not repackaged 1 – Repackaged.	Field	Character	1
Replaced by NDC	Replacement/New NDC if the current NDC has been changed or replaced by the labeler. An NDC must be obsolete in order for a replacement to be assigned, and the Brand Name (BN), formulation, and package size must be the same for the old and new NDC.	Field	Number (Integer)	11
Schedule Code	The unique two character code for the description of the Alabama Schedule.	Field	Character	2
Shelf Pack	Number of bundled salable units in the shipping container.	Field	Number (Integer)	9
Shipper Quantity	Number of salable units in the minimum order quantity available from the distributor; it is usually a multiple of the Shelf Pack or Case Pack.	Field	Number (Integer	9

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Field	Description	Field Type	Data Type	Length
Source	NDC-level single-source or multi-source indicator. Specifies whether a product's generic formulation (i.e. its particular active ingredient, dosage form, route of administration and strength) is only available from a single distributor or from multiple distributors.	Combo Box	Drop Down List Box	0
Specific (Code)	Hierarchical Specific Therapeutic Class Code (HIC3). Identifies the specific therapeutic class in which the active ingredient is classified.	Field	Character	3
Specific (Description)	Text description of the Specific Therapeutic Class.	Field	Character	40
Standard (Code)	Standard Therapeutic Class (TC) Code. Classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system. A more comprehensive therapeutic classification is provided by Specific Therapeutic Class (for example).	Field	Number (Integer)	2
Standard (Description)	Text Description of the Standard Therapeutic Class.	Field	Character	40
Standard Package	Indicates whether the product package size is the standard package size.	Combo Box	Drop Down List Box	0
Status	Identifies the status of a drug within interChange. A drug is marked as either Active (A) or Inactive (I). This information is used to allow the user to review additions and updates to a drug before it is activated for use by interChange.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Termination Date	Shelf-life expiration date of the last batch of product produced, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS from the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8
Therapeutic Equivalency (Code)	CMS FDA Therapeutic Equivalency Code. Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.	Field	Character	2
Therapeutic Equivalency (Description)	Text description of the CMS FDA Therapeutic Equivalency Code. Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.	Field	Character	100
Top Volume Ranking	Indicates if a drug is included in the list of the most frequently dispensed 200 drug products. Different package sizes and dose forms of the same drug have the same number. This field is based on pharmaceutical market research surveys and originates from First DataBank.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Unit	Indicates the unit of measure as supplied on the Health Care Financing Administration's quarterly tape. Note: Data received from FDB and CMS. Will source from FDB update only if the CMS unit file is blank. Updates from the CMS quarterly update will always be applied.	Field	Character	3
Unit Dose	Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the manufacturer. This indicator does not apply to injectable products, suppositories, or powder packets. Products labeled as Unit Dose are not sold as individual unit doses; rather, the product is sold in a package that contains several Unit Doses.	Combo Box	Drop Down List Box	0
Unit of Use	Identifies products that are packaged per course of therapy. Products are labeled as Unit of Use by the manufacturer. These products are supplied with appropriate labeling and (usually) child resistant closures, and thus are appropriate to dispense as a unit.	Combo Box	Drop Down List Box	0
Update Indicator	Indicates whether batch update to the NDC should be allowed.	Combo Box	Drop Down List Box	0

6.28.4 Base Information-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS (Code)	Field	1	Enter a valid value.	Enter a numeric value.
Approval Date	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	Approval Date must be greater than or equal to 01/01/1900.	Enter an Approval Date that is greater than or equal to 01/01/1900.
	Field	3	Approval Date must be less than or equal to 12/31/2299.	Enter an Approval Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
CMS Package Size	Field	1	CMS Package Size must be greater than or equal to 00000000.000.	Enter a positive value.
	Field	2	CMS Package Size must be less than or equal to 99999999.999.	Enter a lower value.
Case Size	Field	1	Enter a valid value.	Enter a numeric value.
Labeler ID	Field	1	Enter a valid value.	Enter a numeric value.
Last AWP Update	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	Last AWP Update must be greater than or equal to 01/01/1900.	Enter a Last AWP date that is greater than or equal to 01/01/1900.
	Field	3	Last AWP Update must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Last NDDF Update	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	Last NDDF Update must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	Last NDDF Update must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Market Entry Date	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	Market Entry Date must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	Market Entry Date must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
NDDF Add	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	NDDF Add must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	NDDF Add must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Obsolete Date	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Obsolete Date must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	Obsolete Date must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Package Size	Field	1	Package Size must be greater than or equal to 00000000.000.	Enter a positive value.
	Field	2	Package Size must be less than or equal to 99999999.999.	Enter a lower value.
Shelf Pack	Field	1	Enter a valid value.	Enter a numeric value.
Shipper Quantity	Field	1	Enter a valid value.	Enter a numeric value.
Termination Date	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.
	Field	2	Termination Date must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	Termination Date must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Top Volume Ranking	Field	1	Enter a valid value.	Enter a numeric value.
Update Indicator	Field	1	Update Indicator is required.	Select a value from the drop down list.

6.28.5 Base Information-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Base Information-Drug Panel Accessibility

6.28.6.1 To Access the Base Information-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance panel displays.
6	Click **Base Information**.	Base Information-Drug panel displays.

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6.28.6.2 To Update on the Base Information-Drug Panel

Step	Action	Response
1	Click in desired field to update and perform update.	
2	Click **Save**.	Base Information -Drug information is saved.

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6.29 Benefit Plan Coverage Rules-Drug Panel

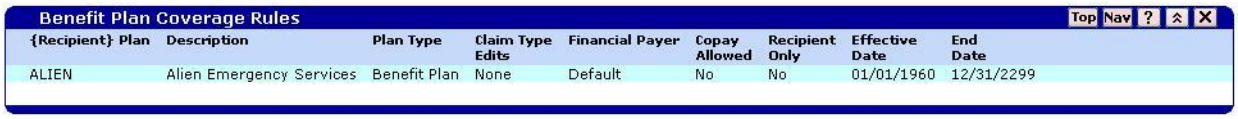
6.29.1 Benefit Plan Coverage Rules-Drug Panel Narrative

The Benefit Plan Coverage Rules-Drug panel is used to view the member plan coverage information for a specific drug code.

This panel is display only.

Navigation Path: [Reference] – [Drug] - (click on [search] and select row from search results) - [Drug Maintenance] - [Drug] - [Benefit Plan Coverage Rules]

6.29.2 Benefit Plan Coverage Rules-Drug Panel



Benefit Plan Coverage Rules

{Recipient} Plan	Description	Plan Type	Claim Type Edits	Financial Payer	Copay Allowed	Recipient Only	Effective Date	End Date
ALIEN	Alien Emergency Services	Benefit Plan	None	Default	No	No	01/01/1960	12/31/2299

6.29.3 Benefit Plan Coverage Rules- Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Identifies the associated list of claim types as included or excluded for the covered benefit.	Combo Box	Drop Down List Box	0
Copay Allowed	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	Field	Character	3
Description	Description of the Recipient Plan.	Field	Character	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this benefit plan.	Field	Character	30
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Character	15
Recipient Only	Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.	Field	Character	3
Recipient Plan	Code that identifies the recipient plan that is supported in the system.	Field	Character	5

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6.29.4 Benefit Plan Coverage Rules- Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.29.5 Benefit Plan Coverage Rules- Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.29.6 Benefit Plan Coverage Rules- Drug Panel Accessibility

6.29.6.1 To Access the Benefit Plan Coverage Rules-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Click **Search**.	Reference Drug Search Results panel displays.
4	Select row.	Drug Information panel displays.
5	Click **Benefit Plan Coverage Rules**.	Benefit Plan Coverage Rules-Drug panel displays.

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6.30 Contract Billing Rules-Drug Panel

6.30.1 Contract Billing Rules- Drug Panel Narrative

The Contract Billing Rules-Drug panel is used to display Provider Contracts applicable to drugs.

This panel is display only.

Navigation Path: [Reference] - [Drug] - (Click on [Search] button) - (Select row from search results) - [Drug Maintenance] - [Contract Billing Rules]

6.30.2 Contract Billing Rules- Drug Panel Layout

6.30.3 Contract Billing Rules- Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Field	Character	1
Description	Description of the provider contract.	Field	Character	30
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this provider contract.	Field	Character	30
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim.	Field	Date (MM/DD/CCYY)	8
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

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6.30.4 Contract Billing Rules- Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 Contract Billing Rules- Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 Contract Billing Rules- Drug Panel Accessibility

6.30.6.1 To Access the Contract Billing Rules-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Click **Search**.	Reference Drug Search Results panel displays.
4	Select row.	Drug Information panel displays.
5	Click **Contract Billing Rules**.	Contract Billing Rules panel displays.

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6.31 DESI-Drug Panel

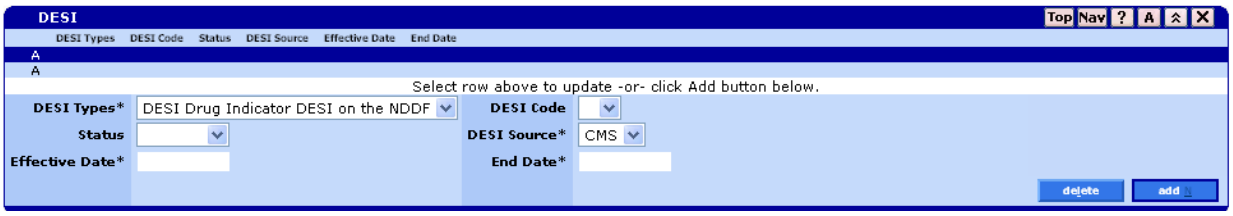
6.31.1 DESI-Drug Panel Narrative

Reference - Drug Efficacy Study Implementation panel.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug (Search)] - (click on [search] button) - (select row from search results) - [Drug Maintenance] - [Drug] - [Drug Efficacy Study Implementation] (The state DESI portion of the panel only displays if the drug has a state DESI))

6.31.2 DESI-Drug Panel Layout



6.31.3 DESI-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a 'State DESI' record to this Drug.	Button	N/A	0
Delete	Delete a 'State DESI' record from this Drug.	Button	N/A	0
DESI Code	The code identifies the DESI status of the NDC drug with current valid values of 0-6. The DESI Drug Indicator (DESI) marks a particular drug as declared less than effective by the Food and Drug Administration. The CMS DESI Code (CMS_DESI) indicates the DESI code as supplied on the CMS's quarterly tape.	Combo Box	Drop Down List Box	0
DESI Source	Indicates the source used to update the DESI: CMS or FDB.	Combo Box	Drop Down List Box	0
DESI Types	Code used to indicate the DESI (Drug Efficacy Study Implementation) type. DESI Drug Indicator DESI on the NDDF. DESI 2 Drug Indicator on the NDDF. CMS DESI code on the NDDF.	Combo Box	Drop Down List Box	0
Effective Date	The date at which the drug became Drug Efficacy Study Implementation, signified as less than effective.	Field	Date (MM/DD/CCYY)	8
End Date	The last date at which this DESI is effective; it is possible for a drug to be removed from DESI non payable status.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Status	This indicates whether the DESI segment is in an active or inactive status. Only active segments are used for claims processing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0

6.31.4 DESI-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
DESI Source	Field	1	DESI Source is required.	Select a valid DESI Source from the drop down box.
DESI Types	Field	1	DESI Types is required.	Select a DESI Types from the drop down box.
Effective Date	Field	1	Effective Date is required.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Date and DESI Type range segments can not overlap.	Enter a Date and DESI Type range segments that does not overlap.
End Date	Field	1	End Date is required.	Enter an End Date in MM/DD/CCYY format.
	Field	2	Effective Date must be less than or equal to end date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	3	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	5	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	6	Date and DESI Type range segments can not overlap.	Enter a Date and DESI Type range segments that do not overlap.

6.31.5 DESI-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.31.6 DESI-Drug Panel Accessibility

6.31.6.1 To Access the DESI-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **DESI**.	DESI-Drug panel displays.

6.31.6.2 To Add on the DESI-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **DESI Type** from drop down list box.	
3	Select **Status** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Select **DESI Code** from drop down list box.	
6	Select **DESI Source** from drop down list box.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	DESI-Drug information is saved.

6.31.6.3 To Update on the DESI-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	DESI -Drug information is saved.

6.31.6.4 To Delete on the DESI-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.32 Drug Group-Drug Panel

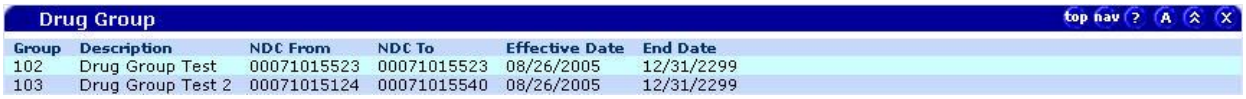
6.32.1 Drug Group-Drug Panel Narrative

The Drug Group panel is used to view all drug groups of which the selected drug is a member.

This panel is display only.

Navigation Path: [Reference] – [Drug] - [(click on 'search' button)] - [(select a row from search result list)] - [Drug Maintenance] - [Drug Group]

6.32.2 Drug Group-Drug Panel Layout



Drug Group

Group	Description	NDC From	NDC To	Effective Date	End Date
102	Drug Group Test	00071015523	00071015523	08/26/2005	12/31/2299
103	Drug Group Test 2	00071015124	00071015540	08/26/2005	12/31/2299

6.32.3 Drug Group-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Describes the drug group type.	Field	Character	50
Effective Date	The date that the drug group is to become effective for the drug type in claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date that the drug group is no longer in effect for the drug type in claims processing.	Field	Date (MM/DD/CCYY)	8
Group	System assigned key for a unique drug type that represents a collection of drug codes.	Field	Number (Integer)	9
NDC From	Drug Code Range From (relation from T_DRUG_GROUP.SAK_DRUG_FROM).	Field	Character	30
NDC To	Drug Code Range To (relation from T_DRUG_GROUP.SAK_DRUG_TO).	Field	Character	30

6.32.4 Drug Group-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for thispanel.				

6.32.5 Drug Group-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.32.6 Drug Group-Drug Panel Accessibility

6.32.6.1 To Access the Drug Group-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Drug Group**.	Drug Group-Drug panel displays.

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6.33 Drug Rejection Criteria-Drug Panel

6.33.1 Drug Rejection Criteria-Drug Panel Overview

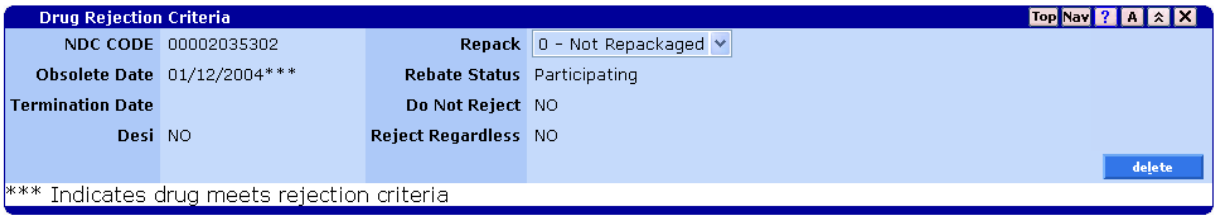
The Drug Rejection Criteria-Drug panel displays drug fields used to determine if a drug meets Alabama's rejection criteria, and is therefore, not covered. The rejection criteria is: Obsolete for more than one year; CMS Terminated for more than one year; DESI; Repackaged Products; Labeler does not participate in rebate.

Do Not Reject = YES indicates the NDC is not rejected, even if it meets other rejection criteria. Reject Regardless = YES indicates the NDC is rejected, even if it does not meet other rejection criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Drug] - [(click on 'search' button)] - [(select a row from search result list)] - [Drug Maintenance] - [Drug Rejection Criteria]

6.33.2 Drug Rejection Criteria-Drug Panel Layout



6.33.3 Drug Rejection Criteria-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
DESI	Drug Efficacy Study Implementation Code. This is the DESI Code as supplied on NDDF. The NDDF maintains three levels of DESI: DESI, DESI2, and CMS DESI. Please see NDDF documentation for current valid values and definitions. On this panel, YES indicates the drug is designated as DESI, and NO indicates it is not DESI.	Field	Alphanumeric	3
Do Not Reject	Do not reject this drug. This field indicates that the drug belongs to the "Do Not Reject" drug group.	Field	Character	3
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	Field	Number (Integer)	11

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Field	Description	Field Type	Data Type	Length
Obsolete Date	Date when the drug product is no longer available on the market place as per the manufacturer's notification, or the best estimate of that date.	Field	Date (MM/DD/CCYY)	8
Rebate Status	Indicates the drug's labeler participates in the federal rebate program.	Field	Character	30
Reject Regardless	Reject this drug regardless of the criteria. This field indicates that the drug belongs to the "Reject Regardless" drug group.	Field	Character	3
Repack	Identifies a product as repackaged or not repackaged. Valid values include: 0 - Not repackaged 1 – Repackaged	Field	Drop Down List Box	0
Termination Date	Shelf-life expiration date of the last batch of product produced, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS from the drug labeler. Note: Data received from FDB and CMS. Will source from FDB update only if a date is not already on file. Updates to this data element from the CMS quarterly update will always be applied.	Field	Date (MM/DD/CCYY)	8

6.33.4 Drug Rejection Criteria-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.33.5 Drug Rejection Criteria-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.33.6 Drug Rejection Criteria-Drug Panel Accessibility

6.33.6.1 To Access the Drug Reject Criteria-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Drug Rejection Criteria**.	Drug Rejection Criteria-Drug panel displays.

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6.34 Federal MAC Rate-Drug Panel

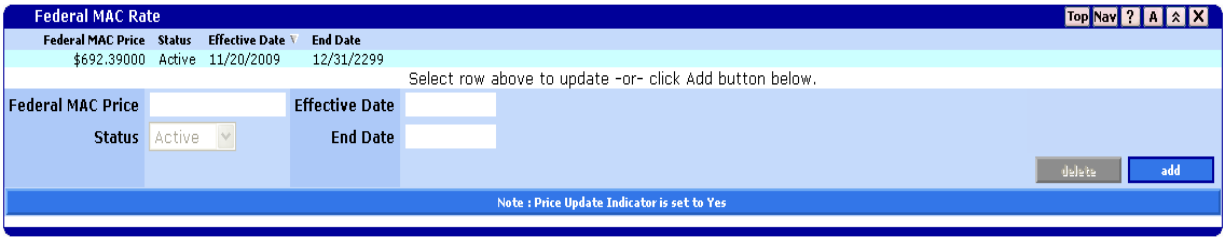
6.34.1 Federal MAC Rate-Drug Panel Narrative

The Federal MAC panel is used to maintain the Federal Maximum Allowable Cost (MAC) for a drug, along with its effective dates and status.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference]- [Drug] - [(click on 'search' and select row from search results)] - [Drug Maintenance] - [Federal MAC or Pricing]

6.34.2 Federal MAC Rate-Drug Panel Layout



6.34.3 Federal MAC Rate-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Button used to add a new MAC pricing record for this drug.	Button	N/A	0
Delete	Button used to delete an existing pricing record from this drug.	Button	N/A	0
Effective Date	The date that the drug's Federal MAC takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date that the Federal MAC is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Federal MAC Price	The Federal Maximum Allowable Cost (MAC) for a drug, also called the Federal Upper Limit (FUL). The MAC is the unit price for a drug under Federal MAC regulation. Format is $9,999,999.99999.	Field	Number (Decimal)	12
Note	Indicates weather Federal MAC rate can be updated via Batch. Default value is 'Yes.'	Button	N/A	0
Status	Indicates whether the MAC pricing segment is in an active or inactive status. Only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0

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6.34.4 Federal MAC Rate-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Verify that Effective Date and End Date do not overlap existing dates.
	Field	3	Effective date is required.	Enter a valid Effective Date.
	Field	4	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to End Date.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	91001	Invalid date.	Enter a valid date in MM/DD/CCYY format.
End Date	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Verify that Effective Date and End Date do not overlap existing dates.
	Field	3	End Date is required.	Enter an End Date.
	Field	15	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	16	End Date must be less than or equal to 12/31/2299	Enter an End Date that is less than or equal to 12/31/2299.
	Field	91001	Invalid date.	Enter a valid date in MM/DD/CCYY format.
Federal MAC Price	Field	1	Federal MAC Price must be greater than or equal to 0000.00000.	Re-enter Federal MAC price.
	Field	7	Federal MAC Price must be less than or equal to $9,999,999.99999.	Enter a valid Federal MAC Price.
	Field	8	Federal MAC price is required.	Verify keying. Enter a valid value.
	Field	9	Enter a valid value.	Enter a valid Federal MAC Price.
Status	Field	1	Status is required.	Select a Status.

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6.34.5 Federal MAC Rate-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Federal MAC Rate-Drug Panel Accessibility

6.34.6.1 To Access the Federal MAC Rate-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Federal MAC Rate**.	Federal MAC Rate -Drug panel displays.

6.34.6.2 To Add on the Federal MAC Rate-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Federal MAC Price**.	
3	Enter **Status**.	
5	Enter **Effective Date** in MM/DD/CCYY format.	
6	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	Federal MAC Rate-Drug information is saved.

6.34.6.3 To Update on the Federal MAC Rate-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Federal MAC Rate -Drug information is saved.

6.34.6.4 To Delete on the Federal MAC Rate-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

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2	Click **Delete**.	Line item is deleted.

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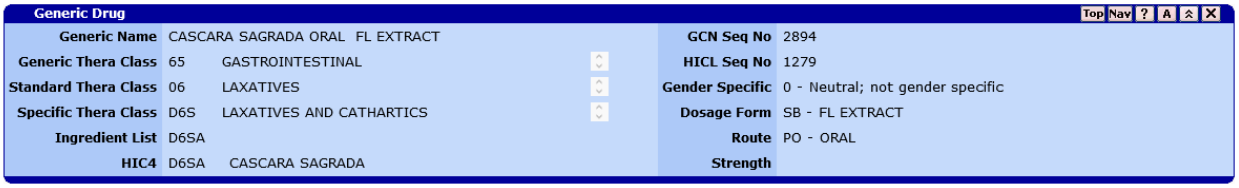
6.35 Generic Drug-Drug Panel

6.35.1 Generic Drug-Drug Panel Narrative

The Generic Drug panel displays additional 'Generic Drug' information for the NDC. This panel is inquiry only. This panel is display only.

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Drug Maintenance] - [Generic Drug]

6.35.2 Generic Drug-Drug Panel Layout



6.35.3 Generic Drug-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Dosage Form	Describes the physical presentation of a drug, such as tablet, capsule, or liquid. It may also incorporate the delivery and release mechanism of the drug.	Field	Character	2
GCN Seq No	Clinical Formulation ID.Represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	9
Gender Specific	Identifies drugs that are used for a specific gender.	Field	Character	1
Generic Name	Combination of active ingredient names, route of administration, dosage form, and strength.	Field	Character	63

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Field	Description	Field Type	Data Type	Length
Generic Thera Class (Code)	Generic Therapeutic Class Code (GTC). Classifies drugs according to the most common intended use. This classification provides the most general therapeutic groupings available from First DataBank. Users that need more definitive therapeutic classing should consider Standard Therapeutic Class, Specific Therapeutic Class or AHFS Therapeutic Class (for example).	Field	Character	3
Generic Thera Class (Description)	Text description of the Generic Therapeutic Class code.	Field	Character	50
HICL Seq No	Ingredient List Identifier. A permanent numeric identifier that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.	Field	Number (Integer)	6
HIC4 (Code)	Hierarchical Ingredient Code of the main ingredient contained in the drug.	Field	Character	4
HIC4 (Description)	Text description of the HIC4 code.	Field	Character	50
Ingredient List	Ingredient list (commonly referred to as the HICL or HIC List), referenced by the HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.	Field	Character	54
Route	Refers to the normal site or method by which a drug is administered (Route of Admin) to the body, such as oral, injection, or topical.	Field	Character	2
Specific Thera Class (Code)	Hierarchical Specific Therapeutic Class Code (GC3, Alias HIC3). Identifies the specific therapeutic class in which the active ingredient is classified.	Field	Character	3
Specific Thera Class (Description)	Text description of the Specific Therapeutic Class code.	Field	Character	50
Standard Thera Class (Code)	Standard Therapeutic Class code that classifies drugs according to the most common intended use.	Field	Character	3
Standard Thera Class (Description)	Text description of the Standard Therapeutic Class code.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Strength	Refers to the potency of the drug and is usually expressed in a metric quantity, such as 500 MG.	Field	Character	30

6.35.4 Generic Drug-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.35.5 Generic Drug-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 Generic Drug-Drug Panel Accessibility

6.35.6.1 To Access the Generic Drug-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Generic Drug**.	Generic Drug panel displays.

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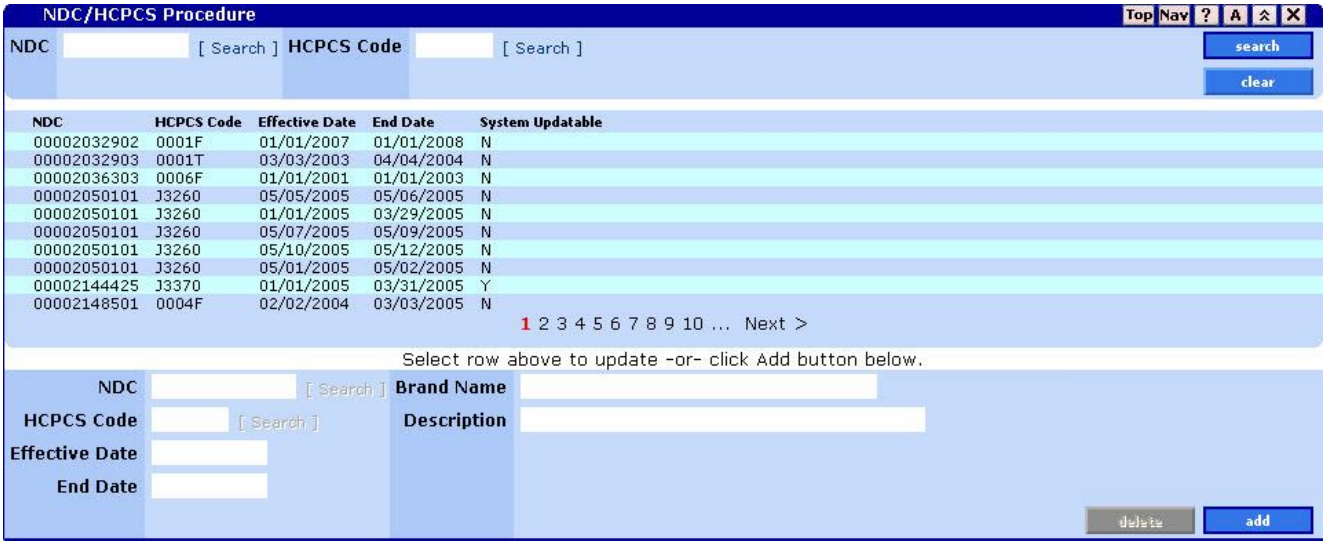
6.36 HCPCS Procedure-Drug Panel

5.29.1 HCPCS Procedure-Drug Panel Narrative

The HCPCS Procedure panel is an 'inquiry only' panel that lists the cross reference(s) between the selected NDC and associated HCPCS procedures (if applicable). HCPCS procedure codes are much more generic than NDCs and thus may have a many to 1 relationship (i.e. HCPCS to NDC).

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Drug Maintenance] - [HCPCS Procedure]

5.29.2 HCPCS Procedure-Drug Panel Layout



5.29.3 HCPCS Procedure-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows user to clear NDC and HCPCS Code text box.	Button	N/A	0
Description	Description of the HCPCS Procedure with chosen 'HCPCS Code'.	Field	Character	40
Effective Date	First date the NDC/HCPCS cross-reference is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the NDC/HCPCS cross-reference is effective.	Field	Date (MM/DD/CCYY)	8
HCPCS Code	Code that uniquely identifies a HCPCS procedure.	Field	Character	5
Search	Allows user to search records on NDC/HCPCS Procedure panel.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
System Updatable	Indicates whether record was inserted/updated from Batch or Manual/UI	Field	Character	1

6.36.1 HCPCS Procedure-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.36.2 HCPCS Procedure-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.3 HCPCS Procedure-Drug Panel Accessibility

6.36.3.1 To Access the HCPCS Procedure-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **HCPCS Procedure**.	HCPCS Procedure-Drug panel displays.

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6.37 Ingredients-Drug Panel

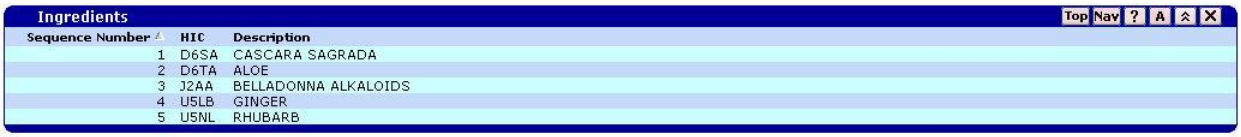
6.37.1 Ingredients-Drug Panel Narrative

The Ingredient List panel displays a list of the ingredients (commonly referred to as the HICL or HIC List) referenced by the drug's HICL Sequence Number. Each active ingredient in the list is sequenced according to its clinical importance relative to other ingredients. The relative importance of an active ingredient is based on its clinical and therapeutic use.

This panel is display only.

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Drug Maintenance] - [Base Information] or [Ingredients]

6.37.2 Ingredients-Drug Panel Ingredients-Drug Layout



6.37.3 Ingredients-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Describes the ingredient.	Field	Character	20
HIC	Hierarchical Ingredient Code that identifies the ingredient.	Field	Character	6
Sequence Number	Represents the relative order of the ingredient within the ingredient list.	Field	Number (Integer)	1

6.37.4 Ingredients-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.37.5 Ingredients-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Ingredients-Drug Panel Accessibility

6.37.6.1 To Access the Ingredients -Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Ingredients**.	Ingredients-Drug panel displays.

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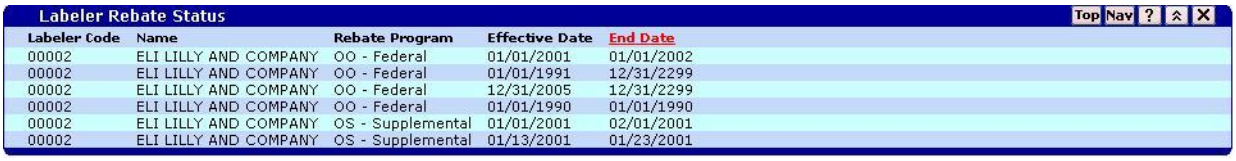
6.38 Labeler Rebate Status-Drug Panel

6.38.1 Labeler Rebate Status-Drug Panel Narrative

The Drug Labeler Rebate Status panel displays the dates the drug labeler participated in the drug rebate program. The dates are obtained from the quarterly CMS labeler contact file or from periodic CMS releases. This panel is display only.

Navigation Path: [Reference] – [Drug Search] - (click on [search] and select row from search results) - [Drug Maintenance] - [Labeler Rebate Status]

6.38.2 Labeler Rebate Status-Drug Panel Layout



Labeler Rebate Status

Labeler Code	Name	Rebate Program	Effective Date	End Date
00002	ELI LILLY AND COMPANY	OO - Federal	01/01/2001	01/01/2002
00002	ELI LILLY AND COMPANY	OO - Federal	01/01/1991	12/31/2299
00002	ELI LILLY AND COMPANY	OO - Federal	12/31/2005	12/31/2299
00002	ELI LILLY AND COMPANY	OO - Federal	01/01/1990	01/01/1990
00002	ELI LILLY AND COMPANY	OS - Supplemental	01/01/2001	02/01/2001
00002	ELI LILLY AND COMPANY	OS - Supplemental	01/13/2001	01/23/2001

6.38.3 Labeler Rebate Status-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Effective Date	This is the date that the rebate status for the drug takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	This is the date that the rebate status for the drug is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Labeler Code	This field is a FDB code used to uniquely identify the distributor.	Field	Character	5
Name	This is the name of the distributor as listed on the drug label or as indicated by the NDC code. It does not necessarily identify the actual drug fabricator.	Field	Character	39
Rebate Program	The code followed by the description of the rebate program. Valid values include: OO = Federal OS = Supplemental	Field	Alphanumeric	35

6.38.4 Labeler Rebate Status-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.38.5 Labeler Rebate Status-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.38.6 Labeler Rebate Status-Drug Panel Accessibility

6.38.6.1 To Access the Labeler Rebate Status-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Labeler Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Labeler Rebate Status**.	Labeler Rebate Status -Drug panel displays.

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6.39 Note-Drug Panel

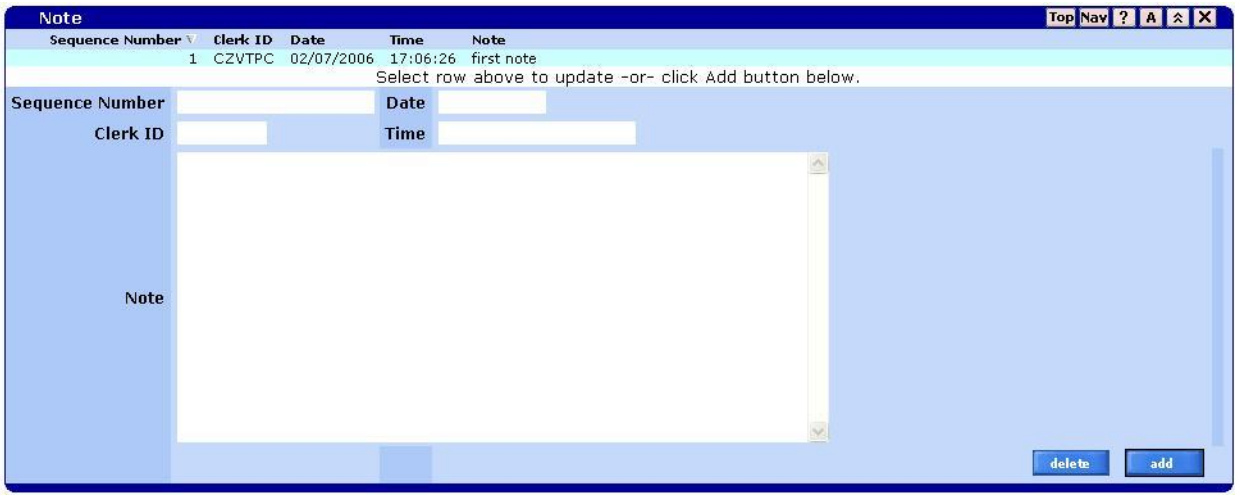
6.39.1 Note-Drug Panel Narrative

The Note-Drug panel is used to enter notes as to why changes were made to a specific NDC. Fields included are for date, time, clerk number and note sequence number.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Drug Search] - [(Add button) OR (select row from search results)] - [Drug Maintenance] - [Note]

6.39.2 Note-Drug Panel Note-Drug Layout



6.39.3 Note-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a note.	Button	N/A	0
Clerk identification	The identification of the user who enters the note.	Field	Alphanumeric	8
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to delete a note.	Button	N/A	0
Note	The actual text of the note.	Field	Alphanumeric	1000
Sequence Number	Sequence number that can uniquely identify a note.	Field	Number (Integer)	9
Time	The time that the note was entered.	Field	Number (Decimal)	6

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6.39.4 Note-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add Drug Note text.

6.39.5 Note-Drug Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for Proc + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.39.6 Note-Drug Panel Accessibility

6.39.6.1 To Access the Note-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Note**.	Note-Drug panel displays.

6.39.6.2 To Add on the Note-Drug Panel

Step	Action	Response
1	Click **Add**. Sequence Number, Date and Time automatically populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note -Drug information is saved.

6.39.6.3 To Update on the Note-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Note -Drug information is saved.

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6.39.6.4 To Delete on the Note-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.40 Other Rates-Drug Panel

6.40.1 Other Rates-Drug Panel Narrative

The Other Rates panel provides the flexibility to maintain other drug price types such as 'Direct' and 'WAC'.

Only authorized users are allowed to perform maintenance tasks.

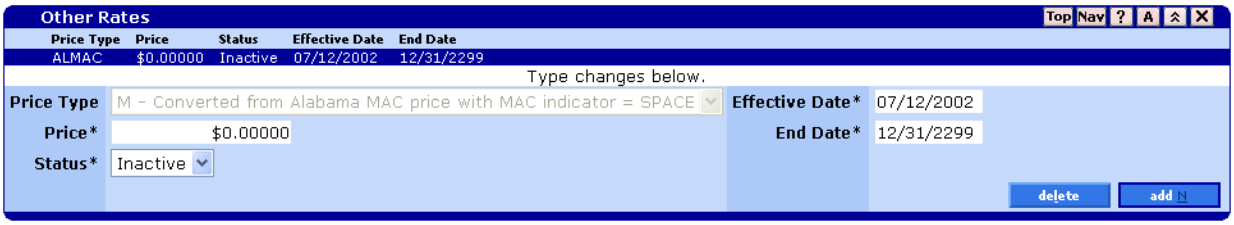
In addition to AWP and Federal MAC prices, FDB (First DataBank) supplies additional price types which may be used for pricing or for reference purposes. These additional price types include:

- 01-BB-Blue Book AWP Unit Price
- 02-BBPKG -Blue Book AWP Package Price
- 05-DIR-Direct Unit Price
- 06-DIRPKG-Direct Package Price
- 09-WHN-Wholesale Acquisition Cost (WAC) Unit Price (already includes logic of +9.2%)
- 10-WHNPKG-Wholesale Acquisition Cost (WAC) Package Price
- 11-FFPUL-Federal Financing Participation Upper Limits
- 12-ABP-Alternative Benchmark Price (ABP) Unit Price
- 13-ABPPKG-Alternative Benchmark Price (ABP) Package Price
- 99-MBBX-Medicaid Blue Book Price/Department of Justice (DOJ) Price
- AW-ALWAC-Converted from Alabama WAC (AL Selected) Price
- MA-ALMACA-Converted from Alabama MAC price with MAC indicator = A
- MW-ALMACW-Converted from Alabama MAC price with MAC indicator = W
- M-ALMAC-Converted from Alabama MAC price with MAC indicator = SPACE

Any or all of the above price types may be maintained as desired/required.

Navigation Path: [Reference] – [Drug] - [(Enter search criteria, click on 'search' button, select row from search results)] - [Drug Maintenance] - [Other Rate or Pricing]

6.40.2 Other Rates-Drug Panel Layout



6.40.3 Other Rates-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new pricing segment.	Button	N/A	0
Delete	Allows the user to mark a pricing segment for deletion.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Effective Date	First date of service the pricing segment is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the pricing segment is effective.	Field	Date (MM/DD/CCYY)	8
Price	Price amount for the relevant Price Type. E.G. Direct Unit Price. Format is $9,999,999.99999	Field	Number (Decimal)	12
Price Type	FDB (First DataBank) Price Type code and description. Indicates the type of price for the relevant pricing segment. Valid values include: ▪ 01-BB-Blue Book AWP Unit Price ▪ 02-BBPKG -Blue Book AWP Package Price ▪ 05-DIR-Direct Unit Price ▪ 06-DIRPKG-Direct Package Price ▪ 09-WHN-Wholesale Acquisition Cost (WAC) Unit Price (already includes logic of +9.2%) ▪ 10-WHNPKG-Wholesale Acquisition Cost (WAC) Package Price ▪ 11-FFPUL-Federal Financing Participation Upper Limits ▪ 12-ABP-Alternative Benchmark Price (ABP) Unit Price ▪ 13-ABPPKG-Alternative Benchmark Price (ABP) Package Price ▪ 99-MBBX-Medicaid Blue Book Price/Department of Justice (DOJ) Price ▪ AW-ALWAC-Converted from Alabama WAC (AL Selected) Price ▪ MA-ALMACA-Converted from Alabama MAC price with MAC indicator = A ▪ MW-ALMACW-Converted from Alabama MAC price with MAC indicator = W ▪ M-ALMAC-Converted from Alabama MAC price with MAC indicator = SPACE	Combo Box	Drop Down List Box	0
Status	Indicates whether the status of the pricing segment is 'Active' or 'Inactive'. Based upon date of process, only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0

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6.40.4 Other Rates-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Invalid Date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	5	Effective Date is required.	Enter an Effective Date.
End Date	Field	1	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	2	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	3	End Date is required.	Enter an End Date.
	Field	4	Invalid Date.	Enter an End Date in MM/DD/CCYY format.
Price	Field	1	Price is required.	Select a value from the Price drop down box.
	Field	2	Price must be less than or equal to 9999999.99999.	Enter a price that is less than or equal to 9999999.99999.
Price Type	Field	1	A valid Price Type is required.	Select a value from the Price Type drop down box.
Status	Field	1	Active Pricing Segments may not overlap for the same Price Type.	Enter an Active Pricing Segment that does not overlap an existing Price Type.
	Field	2	Status is required.	Select a valid Status from the drop down box.

6.40.5 Other Rates-Drug Panel Extra Features

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.40.6 Other Rates-Drug Panel Accessibility

6.40.6.1 To Access the Other Rates-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click	Main Menu page displays.

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Step	Action	Response
	Login.	
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Other Rate**.	Other Rates -Drug panel displays.

6.40.6.2 To Add on the Other Rates-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Price Type** from drop down list box.	
3	Enter **Price**.	
4	Select **Status** from drop down list box.	
5	Enter **Effective Date** in MM/DD/CCYY format.	
6	Enter **End Date** in MM/DD/CCYY format.	
7	Click **Save**.	Other Rates-Drug information is saved.

6.40.6.3 To Update on the Other Rates-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Other Rates-Drug information is saved.

6.40.6.4 To Delete on the Other Rates-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.41 PDL History Panel

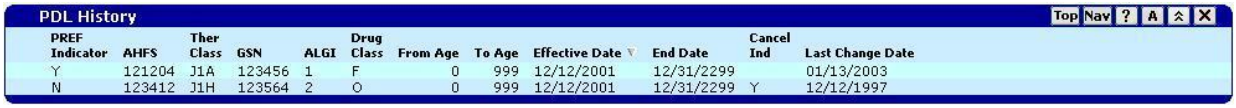
6.41.1 PDL History Panel Narrative

PDL (Preferred Drug List) History Panel is accessible from the Drug Maintenance Panel. PDL History Panel includes the viewing of the PDL History of a drug (NDC).

This panel is display only.

Navigate to [Reference] – [Drug]-[{click on Search button}]- [Drug Maintenance] –[Base Information] –[PDL History]

6.41.2 PDL History Panel Layout



PDL History

PREF Indicator	AHFS	Ther Class	GSN	ALGI	Drug Class	From Age	To Age	Effective Date	End Date	Cancel Ind	Last Change Date
Y	121204	J1A	123456	1	F	0	999	12/12/2001	12/31/2299		01/13/2003
N	123412	J1H	123564	2	O	0	999	12/12/2001	12/31/2299	Y	12/12/1997

6.41.3 PDL History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 – Non-drug item 1 – Generic Product 2 – Brand Product.	Field	Character	1
Cancel Ind	Indicates the PDL status for the NDC. If the status for the Cancel Indicator is Yes, record is cancelled from PDL.	Field	Character	1
Drug Class	Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Federal Legend. A prescription is required per the product labeling.	Field	Character	1
Effective Date	First date the PDL status is effective for the NDC.	Field	Date (MM/DD/CCYY)	8
End Date	Date that PDL status is no longer effective.	Field	Date (MM/DD/CCYY)	8
From Age	The minimum age on the date of service that the NDC is covered with the PDL.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
GSN	The Generic Code Number Sequence Number is a unique number representing a generic formulation. It is specific to the generic ingredient(s), route of administration, and drug strength. It is the same across manufacturers.	Field	Number (Integer)	6
Last Change Date	Date when the last changes for the line segment were made.	Field	Date (MM/DD/CCYY)	8
PREF Indicator	Preferred Indicator. Indicates the PDL Status of the NDC. Example: Whether the drug or drug product is preferred (Y) or non-preferred (N).	Field	Character	1
Ther Class	Therapeutic Class Code, Specific (GC3, Alias HIC3) The most specific therapeutic class code offered by First DataBank intended for users who need a very definitive therapeutic classification system.	Field	Character	3
To Age	The maximum age on the date of service that the NDC is covered within the PDL.	Field	Number (Integer)	3

6.41.4 PDL History Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.41.5 PDL History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 PDL History Panel Accessibility

6.41.6.1 To Access the PDL History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **PDL History**.	PDL History panel displays.

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6.42 Price Update Indicators Panel

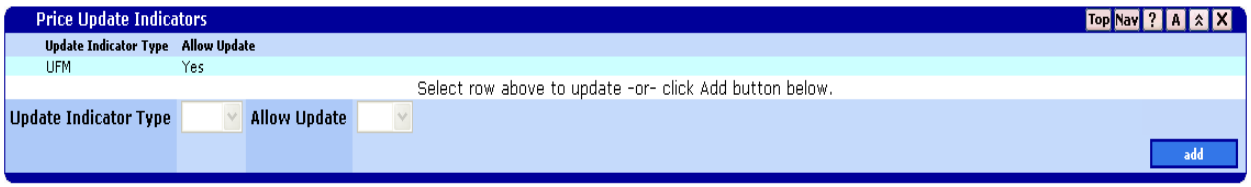
6.42.1 Price Update Indicators Panel Narrative

The purpose of Price Update Indicators panel is to create the indicator which will allow / disallow updating of State / Federal MAC rate of the particular Drug.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug] - click 'search' and select row from search results)] - [Drug Maintenance] - [Price Update Indicators]

6.42.2 Price Update Indicators Panel Layout



6.42.3 Price Update Indicators Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Button used to add a new Price Update Indicator record	Button	N/A	0
Update Indicator Type	Indicates the drug pricing type affected by the value in the Allow Update field. Valid values are: UFM (Update Federal MAC) and USM (Update State MAC).	Combo Box	Drop Down List Box	0
Allow Update	Indicates whether batch updating is allowed for the associated drug pricing type	Combo Box	Drop Down List Box	0

6.42.4 Price Update Indicators Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Update Indicator Type	Field	1	Indicator Type is required.	Select Update Indicator Type.
Allow Update	Field	2	Allow Update value is required.	Select Allow Update value.
	Field	3	Indicator Type is Duplicate.	Update the existing record for the specific Indicator type.

6.42.5 Price Update Indicators Panel Extra Features

Field	Field Type

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Field	Field Type
No extra features found for this panel.	

6.42.6 Price Update Indicators Panel Accessibility

6.42.6.1 To Access the Price Update Indicators Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Price Update Indicators**.	Price Update Indicators panel displays.

6.42.6.2 To Add on the Price Update Indicators Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Update Indicator Type**.	
3	Enter **Allow Update**.	
4	Click **Save**.	Price Update Indicators -Drug information is saved.

6.42.6.3 To Update on the Price Update Indicators Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Price Update Indicators -Drug information is saved.

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6.43 Pricing-Drug Panel

6.43.1 Pricing-Drug Panel Narrative

The Pricing Drug panel is composed of four other panels: AWP, Federal MAC, State MAC and Other Rates.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug] - (Click on [Search] button) - (Select row from search results) - [Drug Maintenance] - [Drug] - [Pricing]

6.43.2 Pricing-Drug Panel Layout

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6.43.3 Pricing-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
	AWP Rate Field Description			
Add	Allows the user to add AWP Rate information.	Button	N/A	0
Average Wholesale Unit Price	Blue Book average wholesale unit price. It represents the most common wholesaler price to the retailer or hospital. This price is based on actual surveys of drug wholesalers. Format $9,999,999.99999.	Field	Number (Decimal)	12
Delete	Allows the user to remove AWP Rate information.	Button	N/A	0
EAC Percent	Actual percentage value to be applied to the estimated acquisition cost to determine reimbursement amount.	Field	Number (Decimal)	4
EAC Percent Effective Date	First date of service the associated percentage is effective.	Field	Date (MM/DD/CCYY)	8
EAC Percent End Date	Last date of service, or dispense date, this percentage is applicable.	Field	Date (MM/DD/CCYY)	8
EAC Price	Contains the price representing the Estimated Acquisition Cost. Format Format $9,999,999.99999. EAC Price = (AWUP * EAC Percent)	Field	Number (Decimal)	12
Effective Date	The date that the average wholesale unit price takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date that the average wholesale unit price ends.	Field	Date (MM/DD/CCYY)	8
Status	This indicates whether the Average Wholesale Price segment is in an 'Active' or 'Inactive' status. Based upon date of process, only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0
	Federal MAC Rate Field Descriptions			
Add	Allows the user to add Federal MAC Rate information.	Button	N/A	0
Delete	Allows the user to remove Federal MAC Rate information.	Button	N/A	0
Effective Date	The date that the Federal MAC takes effect.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	The date that the Federal MAC ends.	Field	Date (MM/DD/CCYY)	8
Federal MAC Price	The Federal Maximum Allowable Cost (MAC) for a drug. The MAC is the unit price for a drug under Federal MAC regulation. Format $9,999,999.99999	Field	Number (Decimal)	12
Status	This indicates whether the Federal MAC Price segment is in an 'Active' or 'Inactive' status. Based upon the date of process, only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down Lists Box	8
	State MAC Rate Field Descriptions			
Add	Allows the user to add State MAC Rate information.	Button	N/A	0
Delete	Allows the user to remove State MAC Rate information.	Button	N/A	0
Effective Date	The date that the State MAC takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date that the State MAC no longer is in effect.	Field	Date (MM/DD/CCYY)	8
Rate Type	The Rate Type for this State MAC.	Combo Box	Drop Down List Box	0
State MAC Price	The Maximum Allowable Cost for a drug as determined by the State. Format $9,999,999.99999.	Field	Number (Decimal)	12
Status	This indicates whether the State MAC Price segment is in an 'Active' or 'Inactive' status. Based upon date of process, only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0
	Other Rates Field Descriptions			
Add	Allows the user to add Other Rate information.	Button	N/A	0
Delete	Allows the user to remove Other Rate information.	Button	N/A	0
Effective Date	First date of service the pricing segment is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the pricing segment is effective.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Price	Price amount for the relevant Price Type. Format is $9,999,999.99999.	Field	Number (Decimal)	12
Price Type	FDB (First DataBank) Price Type code and description. Indicates the type of price for the relevant pricing segment.	Combo Box	Drop Down List Box	0
Status	This indicates whether the associated price segment is in an 'Active' or 'Inactive' status. Based upon date of process, only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0

6.43.4 Pricing-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Field edits for the AWP Rate-Drug panel can be found in section 5.20.4.				

Field	Field Type	Error Code	Error Message	To Correct
Field edits for the Federal MAC Rate -Drug panel can be found in section 5.27.4.				

Field	Field Type	Error Code	Error Message	To Correct
Field edits for the State MAC Rate-Drug panel can be found in section 5.38.4.				

Field	Field Type	Error Code	Error Message	To Correct
Field edits for the Other Rates-Drug panel can be found in section 5.33.4.				

6.43.5 Pricing-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Pricing-Drug Panel Accessibility

6.43.6.1 To Access the Pricing-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	

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Step	Action	Response
4	Click **Search**.	Search Results display.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Pricing**.	Pricing -Drug panel displays. (AWP Rate, Federal MAC Rate, State MAC Rate and Other Rates panels display)

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6.44 Reimbursement Rules-Drug Panel

6.44.1 Reimbursement Rules- Drug Panel Narrative

The Reimbursement Rules-Drug panel is used to view the Reimbursement Agreement information for a specific drug code. This information is retrieved from the Reimbursement Agreement tables available through the Benefit administration panels. The panel displays all reimbursement agreements associated with the specified Drug.

This panel is display only.

Navigation Path: [Reference] – [Drug] - [(select row from search results)] - [Reimbursement Rules]

6.44.2 Reimbursement Rules- Drug Panel Layout

6.44.3 Reimbursement Rules- Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ALGI	Indicates whether the drug is generic according to State defined criteria. 0 – Non-drug item 1 – Generic Product 2 – Brand Product.	Field	N/A	0
Dates	These are the effective and end dates for this rule.	Field	Date (MM/DD/CCYY)	8
Dispensed As Written	It provides the Dispensed as Written values that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included. Possible values are: 0 - No product selection indicated; 1 - Substitution not allowed by provider; 2 - Substitution allowed- patient requested product dispensed; 3 - Substitution allowed- pharmacist selected product dispensed; 4 - Substitution allowed- generic drug not in stock; 5 - Substitution allowed- brand drug dispensed as generic; 6 - Override; 7 - Substitution not allowed- brand drug mandated by law; 8 - Substitution allowed- generic drug not available in marketplace; 9 – Other.	Field	N/A	0
Pricing Indicator	Indicates if there is a pricing indicator selected for this rule.	Field	N/A	0

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Field	Description	Field Type	Data Type	Length
Pricing Modifier	Pricing Modifier requirement for claims. Possible values are N - Pay Billed Amount,Y - Pay greater than Billed Amount & Z - Zero Pay Billed Amount.	Field	N/A	0
Rate Type	Indicates what type of Rate Type is selected for this rule. The Rate Type values are those found on the Codes-Rate Type panel.	Field	N/A	0
Rule	It provides the Rule identification.	Field	N/A	0

6.44.4 Reimbursement Rules- Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.44.5 Reimbursement Rules- Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.44.6 Reimbursement Rules- Drug Panel Accessibility

6.44.6.1 To Access the Reimbursement Rules-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Click **Search**.	Search Results display.
4	Select row.	Drug Information panel displays.
5	Click **Reimbursement Rules**.	Reimbursement Rules- Drug panel displays.

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6.45 Restrictions Maintenance-Drug Panel

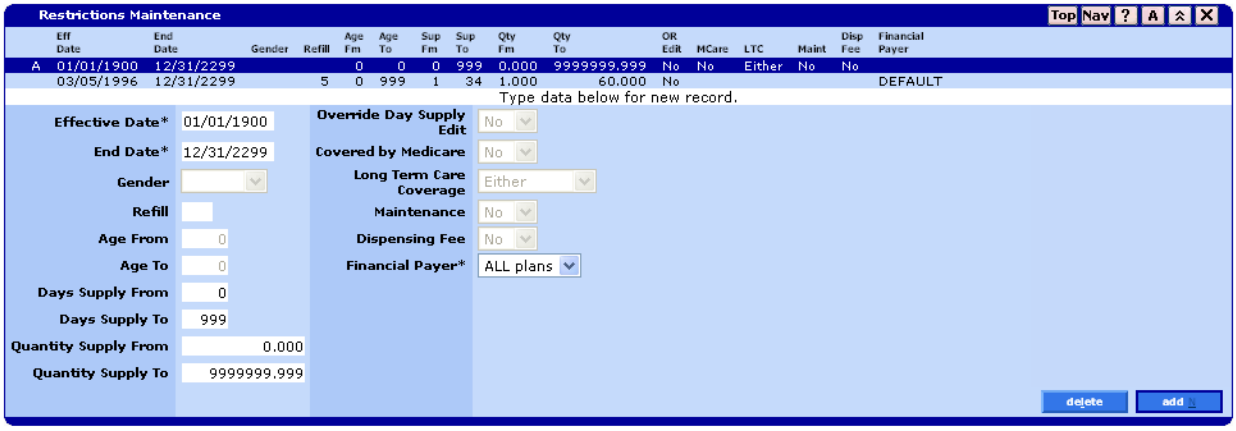
6.45.1 Restrictions Maintenance-Drug Panel Narrative

The Drug Restrictions Maintenance panel is used to update limits and restrictions for a specific NDC code. .

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug (Search)] - (click on [search] button) - (select row from search results) - [Drug Maintenance] - [Drug] - [Restrictions Maintenance]

6.45.2 Restrictions Maintenance-Drug Panel Layout



6.45.3 Restrictions Maintenance-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Restriction to this drug.	Button	N/A	0
Age From	This is a number used to indicate the lower value in an age range. It is the minimum recipient age that is valid and is entered in number of years. This is an unused field/value for AL.	Field	Number (Integer)	4
Age To	This is a number used to indicate the upper value in an age range. It is the maximum recipient age that is valid and is entered in number of years. This is an unused field/value for AL.	Field	Number (Integer)	4
Covered by Medicare	Yes/No indicator used to identify drugs covered by Medicare. A 'N' (no) indicates the drugs is not covered by Medicare. This information comes from First DataBank. This is an unused field/value for AL.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Days Supply From	The minimum number of days a prescribed drug should last a Medicaid recipient from the date it is dispensed.	Field	Number (Integer)	4
Days Supply To	The maximum number of days a prescribed drug should last a Medicaid recipient from the date it is dispensed.	Field	Number (Integer)	4
Delete	Remove a Restriction from this drug.	Button	N/A	0
Dispensing Fee	Yes/No indicator used to identify drugs that should pay a percentage of the normally calculated dispensing fee. This indicator is used with the attribute NUM_DISP_FEE_PCT to determine the dispensing fee to pay. This is an unused field/value for AL.	Combo Box	Drop Down List Box	0
Effective Date	This is the date that the drug limitations take effect.	Field	Date (MM/DD/CCYY)	8
End Date	This is the date that the drug limitations no longer are in effect.	Field	Date (MM/DD/CCYY)	8
Financial Payer	The Financial Payer for the drug Restriction.	Combo Box	Drop Down List Box	0
Gender	Identifies the sex of a person that this drug is limited to. This is an unused field/value for AL.	Combo Box	Drop Down List Box	0
Long Term Care Coverage	Indicates whether the drug is covered if the recipient lives in a long term care facility. Valid values include: 'Either' (default value), 'Not in LTC', or 'Only in LTC'. This field is not utilized by Alabama.	Combo Box	Drop Down List Box	0
Maintenance	This indicates that the drug is required for maintaining health and as such provisions have been made to provide the drug in quantities greater than the standard 34-day or monthly supply. This is an unused field/value for AL.	Combo Box	Drop Down List Box	0
Override Day Supply Edit	Yes/No indicator used to identify drugs that are not edited for a 34 day supply. An indicator of Y (yes) l bypasses editing. This is an unused field/value for AL.	Combo Box	Drop Down List Box	0
Quantity Supply From	The minimum quantity of the drug which can be dispensed. The default value is 0.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Quantity Supply To	The maximum quantity of the drug which can be dispensed. The default value is 9999999.999.	Field	Number (Decimal)	10
Refill	The number of refills available for a specific prescribed drug.	Field	Character	2

6.45.4 Restrictions Maintenance-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Days Supply From	Field	1	Days Supply From must be less than or equal to Days Supply To.	Enter a Days Supply From that is less than or equal to Days Supply To.
	Field	2	Days Supply From must be less than or equal to 999.	Enter a Days Supply From that is less than or equal to 999.
	Field	3	Enter a valid value.	Verify a valid value has been entered.
Days Supply To	Field	1	Days Supply To must be greater than or equal to Days Supply From.	Enter a Days Supply To that is greater than or equal to Days Supply From.
	Field	2	Days Supply To must be less than or equal to 999.	Enter a Days Supply To that is less than or equal to 999.
	Field	3	Enter a valid value.	Verify a valid value has been entered.
Dispensing Fee	Field	1	Disp. Fee must be one of the following values: Y = Yes, N = No.	Select a value from the drop down.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Enter an Effective Date and End Date that do not overlap existing codes.
	Field	3	Invalid Date.	Enter an Effective Date that is numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter a valid Effective Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6	End Date must be less than or equal to 12/31/2299.	Verify keying. The date must be less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #]	Enter an Effective Date and End Date that do not overlap existing codes.
	Field	3	Invalid Date.	Enter an End Date that is numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	5	End Date is required.	Enter an End Date in MM/DD/CCYY format.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter and End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a value from the drop down.
Quantity Supply From	Field	1	Quantity Supply From must be less than or equal to Quantity Supply To.	Enter a Quantity Supply From that is less than or equal to Quantity Supply To.
	Field	2	Quantity Supply From must be less than or equal to 999999.999.	Enter a Quantity Supply From that is less than or equal to 999999.999.
	Field	3	The field Quantity Supplied From has to be greater than or equal to 0.	Verify that the Quantity Supply From is greater than or equal to 0.
Quantity Supply To	Field	1	Quantity Supply From must be less than or equal to Quantity Supply To.	Enter a Quantity Supply To that is greater than or equal to Quantity Supply From.
	Field	2	Quantity Supply To must be less than or equal to 999999.999.	Enter a Quantity Supply To that is less than or equal to 999999.999.

6.45.5 Restrictions Maintenance-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.45.6 Restrictions Maintenance-Drug Panel Accessibility

6.45.6.1 To Access the Restrictions Maintenance-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **Restrictions Maintenance**.	Restrictions Maintenance-Drug panel displays.

6.45.6.2 To Add on the Restrictions Maintenance-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Enter **End Date** in MM/DD/CCYY format.	
4	Select **Gender** from drop down list box.	
5	Enter **Refill.**	
6	Enter **Age From**.	
7	Enter **Age To**.	
8	Enter **Days Supply From**.	
9	Enter **Days Supply To**.	
10	Enter **Quantity Supply From**.	
11	Enter **Quantity Supply To**.	
12	Select **Override Day Supply Edit** from drop down list box.	
13	Select **Covered by Medicare** from drop down list box.	
14	Select **Long Term Care Coverage** from drop down list box.	
15	Select **Maintenance** from drop down list box.	
16	Select **Dispensing Fee** from drop down list box.	
17	Select **Financial Payer** from drop down list	

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Step	Action	Response
	box.	
18	Click **Save**.	Restrictions Maintenance-Drug information is saved.

6.45.6.3 To Update on the Restrictions Maintenance-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Restrictions Maintenance-Drug information is saved.

6.45.6.4 To Delete on the Restrictions Maintenance-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.46 State MAC Rate-Drug Panel

6.46.1 State MAC Rate-Drug Panel Narrative

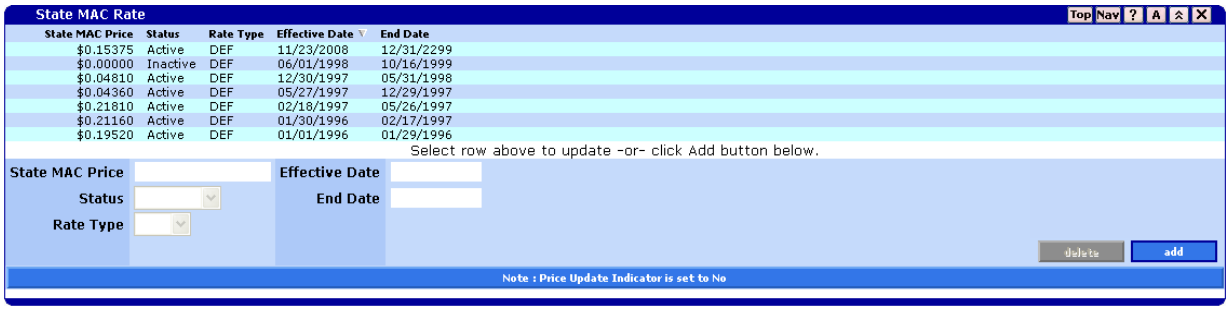
The State MAC Rate panel is used to maintain the State determined Maximum Allowable Cost (MAC) for a drug, along with its effective dates and status.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Drug (Search)] - (click on [search] button) - (select row from search results) - [Drug Maintenance] - [Drug] - [State MAC] or

Navigation Path: [Reference] - [Drug (Search)] - (click on [search] button) - (select row from search results) - [Drug Maintenance] - [Drug] - [Pricing] - (scroll to [State MAC])

6.46.2 State MAC Rate-Drug Panel Layout



6.46.3 State MAC Rate-Drug Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new State MAC pricing to this Drug.	Button	N/A	0
Delete	Remove a State MAC pricing from this Drug.	Button	N/A	0
Effective Date	This is the date that the State MAC takes effect.	Field	Date (MM/DD/CCYY)	8
End Date	This is the date that the State MAC is no longer be in effect.	Field	Date (MM/DD/CCYY)	8
Note	Indicates weather State MAC rate can be updated via Batch. Default value is 'Yes.'	Button	N/A	0
Rate Type	The Rate Type for this State MAC.	Combo Box	Drop Down List Box	0
State MAC Price	This is the Maximum Allowable Cost for a drug as determined by the State. Format $9,999,999.99999.	Field	Number (Decimal)	12

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Field	Description	Field Type	Data Type	Length
Status	Indicates whether the State MAC pricing segment is in an active or inactive status. Only active segments are used for pricing. Inactive segments are maintained for historical purposes.	Combo Box	Drop Down List Box	0

6.46.4 State MAC-Drug Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date[Field is required]	Field	1	Effective Date is required.	Enter an Effective Date in MM/DD/CCYY format.
	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Enter an Effective Date and End Date that do not overlap existing dates.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	8012	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	91001	Invalid Date.	Enter a date in MM/DD/CCYY format.
End Date[Field is required]	Field	1	End Date is required.	Enter a date in MM/DD/CCYY format.
	Field	2	The fields Effective Date and End Date from row [row #] cannot overlap with row [row #].	Enter an Effective Date and End Date that do not overlap existing dates.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	8012	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	91001	Invalid Date.	Enter a date in MM/DD/CCYY format.
Rate Type	Field	1	A valid Rate Type is required.	Select a Rate Type.
State MAC Price	Field	1	State MAC Price must be less than or equal to $9,999,999.99999.	Enter a Price is that is less than or equal to $9,999,999.99999.
	Field	2	State MAC Price is required.	Enter a State Maximum Allowable Cost price.
Status	Field	1	Status is required.	Select a value for Status.

6.46.5 State MAC Rate-Drug Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.46.6 State MAC Rate-Drug Panel Accessibility

6.46.6.1 To Access the State MAC Rate-Drug Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Drug**.	Reference Drug Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Drug Search Results panel displays.
5	Select row from list of results.	Drug Maintenance and Information panels display.
6	Click **State MAC Rate**.	State MAC Rate-Drug panel displays.

6.46.6.2 To Add on the State MAC Rate-Drug Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **State MAC Price**.	
3	Select **Status** from drop down list box.	
4	Select **Rate Type** from drop down list box.	
5	Enter **Effective Date** in MM/DD/CCYY	

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Step	Action	Response
	format.	
6	Enter **End Date** in MM/DD/CCYY format.	
7	Click **Save**.	State MAC Rate-Drug information is saved.

6.46.6.3 To Update on the State MAC-Drug Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	State MAC Rate-Drug information is saved.

6.46.6.4 To Delete on the State MAC-Drug Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.47 Reference Error Disposition Search-Error Disposition Panel

6.47.1 Reference Error Disposition Search-Error Disposition Panel Narrative

The Reference Error Disposition Search panel allows the user to enter search criteria and query for Error Disposition Codes whose data matches those criteria.

Navigation Path: [Reference] – [Error Disposition]

6.47.2 Reference Error Disposition Search-Error Disposition Panel Layout

6.47.3 Reference Error Disposition Search-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Opens up the appropriate panels necessary to create a new Edit or Audit.	Button	N/A	0
Clear	Clears the search criteria fields (Error Code, Description).	Button	N/A	0
Description	Description that is used by the search function to pull back the edit(s) and/or audit(s) that contain this description anywhere in their description.	Field	Character	50
Error Code	Code used to identify an edit or audit that is used by the search function to pull back its related data.	Field	Number (Integer)	4
Match Criteria	Specifies whether to search for matches that begin with or contain the user-entered value of the Description field.	Radio Button	N/A	0
Records	Maximum number of records that is displayed per page, based on the total number of records retuned that match the search criteria.	Combo Box	Drop Down List Box	0
Search	Initiates search on the database for a record matching the search criteria keyed-in. The search performs a %like% search on the description field and an exact match search on the error code field.	Button	N/A	0

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6.47.4 Reference Error Disposition Search-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found.	Check the input.
	Field	2	No rows found.	Check the input.

6.47.5 Reference Error Disposition Search-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.47.6 Reference Error Disposition Search-Error Disposition Panel Accessibility

6.47.6.1 To Access the Reference Error Disposition Search-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search-Error Disposition panel displays.

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6.48 Reference Error Disposition Search Results Panel

6.48.1 Reference Error Disposition Search Results Panel Narrative

The Reference Error Disposition Results panel displays Error Codes matching the selection criteria from the Error Disposition Search panel.

This panel is inquiry only.

Navigation Path: [Reference] – [Error Disposition] - [(enter search criteria, or click on 'search' button)]

6.48.2 Reference Error Disposition Search Results Panel Layout

Search Results

Error Code	Error Description	Header Detail Indicator	Overridable	Spenddown Pre-emptive
201	BILLING PROVIDER ID NUMBER MISSING	Header	No	Yes
202	BILLING PROVIDER ID IN INVALID FORMAT	Header	No	Yes
203	RECIPIENT I.D. NUMBER MISSING	Header	No	Yes
205	PRESCRIBING PRACTITIONER'S LICENSE NO. MISSING	Header	No	
206	PRESCRIBING PRACTITIONR LICENSE NO. FORMAT INVALID	Header	No	
208	PREGNANCY INDICATOR INVALID	Detail	No	
209	FACILITY PROVIDER SERVICE LOCATION IS MISSING	Header	No	No
210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	Header	No	
211	REFILL INDICATOR INVALID	Header	No	Yes
212	PRESCRIPTION NUMBER IS MISSING	Header	No	Yes
213	DATE PRESCRIBED IS MISSING	Header	No	
214	DATE PRESCRIBED IS INVALID	Header	No	
215	DATE DISPENSED IS MISSING	Header	No	
216	DATE DISPENSED IS INVALID	Header	No	No
217	NDC MISSING	Detail	No	Yes
218	NDC INVALID FORMAT	Detail	No	Yes
219	QUANTITY DISPENSED IS MISSING	Detail	No	Yes
220	QUANTITY DISPENSED IS INVALID	Detail	No	Yes
221	DAYS SUPPLY MISSING	Header	No	Yes
222	DAYS SUPPLY INVALID	Header	No	

1 2 3 4 5 6 7 8 9 10 ... Next >

6.48.3 Reference Error Disposition Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Error Code	Code used to indicate an error was discovered on a claim during processing in the MMIS system. This can be either an edit or an audit.	Field	Number (Integer)	4
Error Description	Description of an edit or an audit.	Field	Character	50
Header Detail Indicator	Indicates whether edit or audit should be set on the header.	Field	Character	1
Overridable	Indicates (Y/N) whether a clerk should be allowed to override an edit/audit upon review of the claim.	Field	Character	1
Spenddown Pre-emptive	Indicates whether the claim should be counted against spenddown if the edit is set. If the indicator is set to 'Yes' and the edit is set on the claim, the claim billed amount is not considered in Recipient spenddown.	Field	Character	1

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6.48.4 Reference Error Disposition Search Results Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.48.5 Reference Error Disposition Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 Reference Error Disposition Search Results Panel Accessibility

6.48.6.1 To Access the Reference Error Disposition Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Enter search criteria. Note: User may also click Search without entering search criteria. This displays a list of rows to select from.	Reference Error Disposition Search Results panel displays.

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6.49 Error Disposition Information-Error Disposition Panel

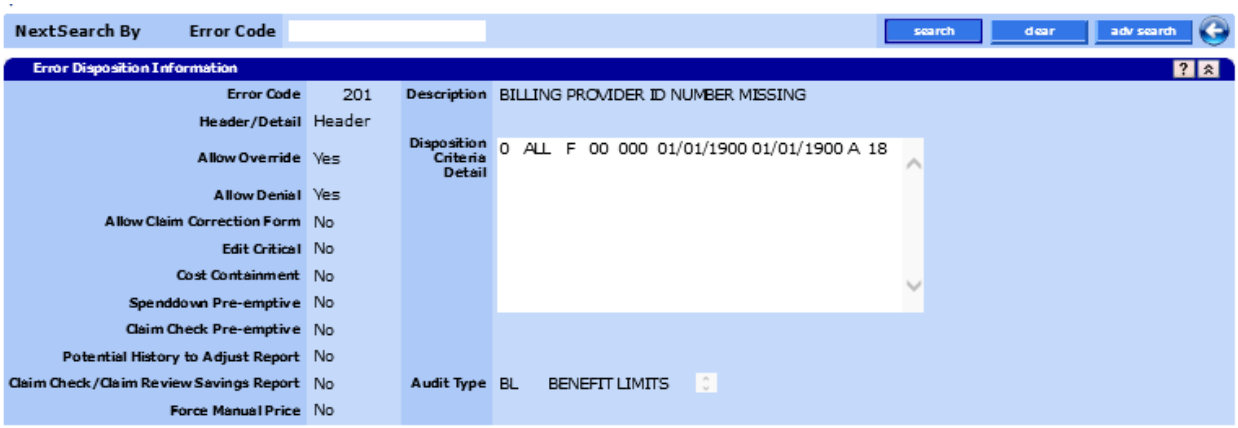
6.49.1 Error Disposition Information-Error Disposition Panel Narrative

The Error Disposition Information panel contains summary information about error disposition.

This panel is display only.

Navigation Path: [Reference] - [Error Disposition Search] - (click on 'search' and select row from search results)] - [Error Disposition Information]

6.49.2 Error Disposition Information-Error Disposition Panel Layout



6.49.3 Error Disposition Information-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allow Claim Correction Form	Indicates (Yes or No) whether a claim correction form can be generated for the specific error code.	Field	Character	1
Allow Denial	Indicates (Yes or No) whether a clerk should be allowed to set the edit/audit to deny upon review of the claim.	Field	Character	1
Allow Override	Indicates (Yes or No) whether a clerk should be allowed to override an edit/audit upon review of the claim.	Field	Character	1
Audit Type	Identifies the type of audit (i.e. limitation, conflict, negative contra, contra-indicated, step therapy, or umbrella).	Combo Box	Drop Down List Box	0
Claim Check Pre-emptive	Indicates whether Claim Check should be bypassed if the edit is set on a claim. If the indicator is set to 'Yes' and the edit is set on the claim, the claim will not go through Claim Check processing.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Claim Check/Claim Review Savings Report	Indicates if the error should be reported on the Potential History To Adjust Report.	Field	Character	1
Cost Containment	Indicates whether the error status code is a cost containment item.	Field	Character	1
Description	Description of an edit or an audit.	Field	Character	50
Disposition Criteria Detail	This provides a list view of various Error Disp Line items associated with the Error Code.	Listview	N/A	0
Edit Critical	Indicator identifying if the ESC is considered critical, and should not be inactivated, or set to pay (forced) by a clerk.	Field	Character	1
Error Code	Code used to indicate an error was discovered on a claim during processing in the MMIS system. This code can represent either an edit or an audit.	Field	Number (Integer)	4
Force Manual Price	This is used to override Edit Critical (IND_CRITICAL) when = "Y'. A 'Y' in this column means this ESC may be forced (set to pay) if the service is priced manually.	Field	Character	1
Header/Detail	Indicates whether edit or audit should be set on the header - 'H', or detail - 'D' level of a claim.	Field	Character	1
Potential History to Adjust Report	Indicates if the error should be reported on the Potential History To Adjust Report. If the box is checked, the error is included in the report.	Field	Character	1
Spenddown Pre-emptive	Indicates whether the claim should be counted against spenddown if the edit is set. If the indicator is set to 'Yes' and the edit is set on the claim, the claim billed amount is not considered in Recipient spenddown calculations.	Field	Charater	1

6.49.4 Error Disposition Information-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.49.5 Error Disposition Information-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 Error Disposition Information-Error Disposition Panel Accessibility

6.49.6.1 To Access the Error Disposition Information-Error Disposition Panel Accessibility

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Search**.	Reference Error Disposition Search Results panel displays.
4	Select row from data list.	Error Disposition Information-Error Disposition panel displays.

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6.50 Error Disposition Maintenance-Error Disposition Panel

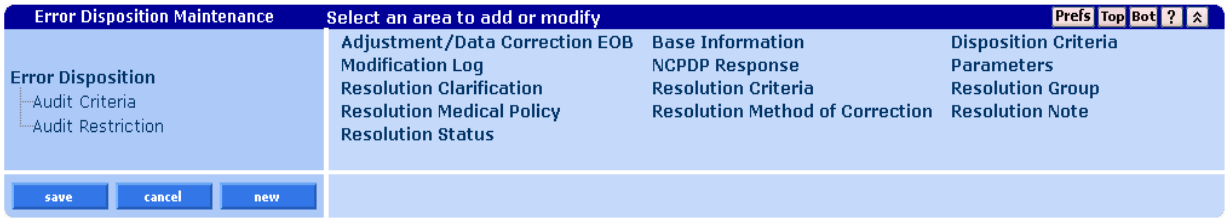
6.50.1 Error Disposition Maintenance-Error Disposition Panel Narrative

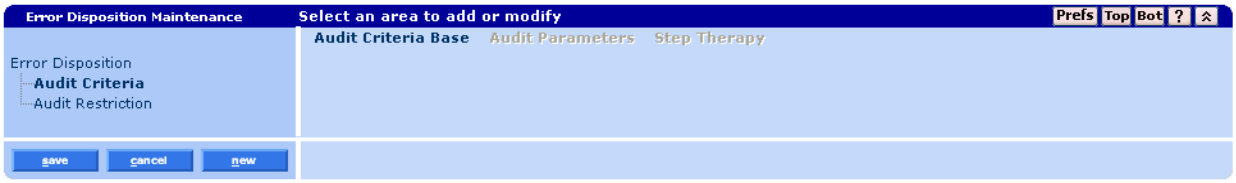
The Error Disposition Maintenance panel is used to maintain Reference Error Disposition data.

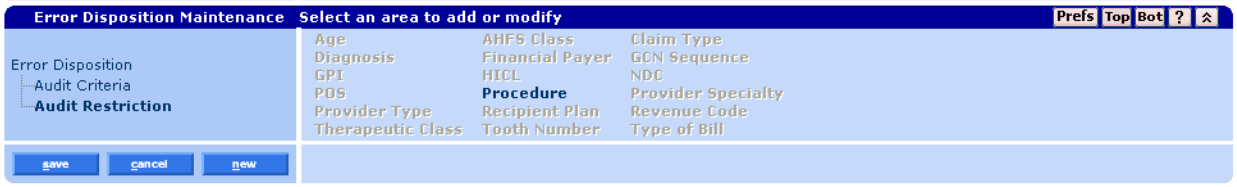
This panel is inquiry only.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance]

6.50.2 Error Disposition Maintenance-Error Disposition Panel Layout







6.50.3 Error Disposition Maintenance-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjustment/Data Correction EOB	Link to the panel containing 'Explanation of Benefits' information, associated with the Error that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Age	Link to the panel containing 'Age Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Age' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
AHFS Class	Link to the panel containing 'AHFS Class' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'AHFS Class' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Audit Criteria	This is a 'child' element under the 'tree' on the left hand side of the panel. When this is highlighted, the navigator panel on the right hand side panel contains links to sub panels under 'Audit Criteria' for the Error Disp that is open on page.	Treeview	N/A	0
Audit Criteria Base	Link to the panel containing detail information of the Audit Criteria for the Error Disposition that is open on page. This link item is available when 'Audit Criteria' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition")	Hyperlink	N/A	0
Audit Parameters	Link to the panel containing detail Audit Parameter information of the Audit Criteria for the Error Disposition that is open on page. Parameter Panel type depends upon the type of Audit. For example, for a limitation audit, it opens up Limit Parameter panel while for Contra Audit, it opens Contra Parameter panel. This link item is available when 'Audit Criteria' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition").	Hyperlink	N/A	0
Audit Restriction	This is a 'child' element under the 'tree' on the left hand side of the panel. When this is highlighted, the navigation panel on the right hand side panel contains links to sub panels under 'Audit Restrictions' for the Error Disp that is open on page.	Treeview	N/A	0
Base Information	Link to the panel containing Detail information of the Error that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Cancel	Cancels all changes to any panel in the navigation panel links.	Button	N/A	0
Claim Type	Link to the panel containing 'Claim Type Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Claim Type' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Diagnosis	Link to the panel containing 'Diagnosis Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Diagnosis' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Disposition Criteria	Link to the panel containing Line Item information of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Error Disposition	This is the 'root' element of the 'tree' on the left hand side of the panel. When this is highlighted, the navigation panel on the right hand side panel contains links to sub panels under 'Error Disposition.	Treeview	N/A	0
Financial Payer	Link to the panel containing 'Payer Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Financial Payer' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
GCN Sequence	Link to the panel containing 'GCN Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'GCN' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
GPI	Link to the panel containing 'GPI Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'GPI' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
HICL	Link to the panel containing 'HICL' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'HICL' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Modification Log	Link to the panel containing 'clerical notes' information for the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
NCPDP Response	Link to the panel containing NCPDP Response information of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
NDC	Link to the panel containing 'NDC Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'NDC' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Parameters	Link to the panel containing 'edit parameter' information for the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Procedure	Link to the panel containing 'Procedure Restriction' information (Contra for a 'contra audit') of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Procedure' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
POS	This provides a link to the panel containing 'POS'. The State and EDS use the Limit Audit POS Limitations panel to update places of service restrictions which are applicable to the error code. For example, if a limit audit applies only to services provided in the hospital, then the hospital place of service value would be entered, and displayed.	Hyperlink	N/A	0
Provider Specialty	Link to the panel containing 'Provider Specialty Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Provider Specialty' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Provider Type	Link to the panel containing 'Provider Type Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Provider Type' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Recipient Plan	Link to the panel containing 'Recipient Plan Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if Recipient Plan is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Resolution Clarification	Link to the panel containing Resolution Clarifications for the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Resolution Criteria	Link to the panel containing Resolution Criteria information for the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Resolution Group	Link to the panel containing Resolution Group information for the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Resolution Medical Policy	Link to the panel containing Medical Policy information for Resolution of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Resolution Method of Correction	Link to the panel containing Method of Correction information for Resolution of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Resolution Note	Link to the panel containing 'Notes' about Resolution of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Resolution Status	Link to the panel containing 'status' information about Resolution of the Error Disposition that is open on page. This link item is available when 'Error Disposition' is selected on the left hand side tree view.	Hyperlink	N/A	0
Revenue Code	Link to the panel containing 'Revenue Code Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Revenue Code' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Save	Saves all changes to any panel in the navigation panel links to the database.	Button	N/A	0
Step Therapy	Link to the panel containing Step Therapy information of the Audit for the Error Disposition that is open on page. This link item is available for a 'Step Therapy' type of audit, when 'Audit Criteria' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition")	Hyperlink	N/A	0
Therapeutic Class	Link to the panel containing 'Therapeutic Class Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Therapeutic Class' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Tooth Number	Link to the panel containing 'Tooth Number Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Tooth Number' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0
Type of Bill	Link to the panel containing 'Type of Bill Restriction' information of the Audit for the Error Disposition that is open on page. This link item is available when 'Audit Restriction' is selected on the left hand side tree view. (by clicking on the '+' sign next to "Error Disposition"). The link is 'grayed' out if 'Type of Bill' is 'not included' in the Audit Criteria.	Hyperlink	N/A	0

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6.50.4 Error Disposition Maintenance-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.50.5 Error Disposition Maintenance-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.50.6 Error Disposition Maintenance-Error Disposition Panel Accessibility

6.50.6.1 To Access the Disposition Maintenance-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Search**.	Reference Error Disposition Search Results panel displays.
4	Select row from data list.	Error Disposition Maintenance-Error Disposition panel displays.

6.50.6.2 To Navigate the Error Disposition Maintenance-Error Disposition Panel

Step	Action	Response
1	Select an area to add or modify by clicking desired hyperlink	Selected Error Disposition panel displays.

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6.51 Error Disposition Mini Search-Error Disposition Panel

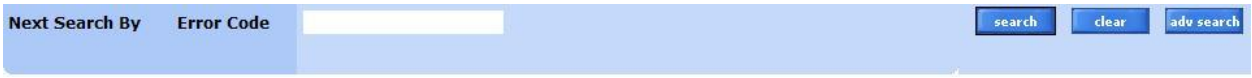
6.51.1 Error Disposition Mini Search-Error Disposition Panel Narrative

The Error Disposition Mini-Search panel provides the user with the ability to search for an Error Code from the Error Disposition Information panel.

This panel is inquiry only.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)]

6.51.2 Error Disposition Mini Search-Error Disposition Panel Layout



6.51.3 Error Disposition Mini Search-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	This takes the user to Error Disposition main search page where user can set more advanced search criteria.	Button	N/A	0
Clear	Clears the 'Error Code' field so user may key in a new Error Code to search for.	Button	N/A	0
Error Code	Code used to identify an edit or audit, used as search criteria.	Field	Number (Integer)	4
Search	Initiates database search for an Error record matching the Error Code keyed-in. If a record is found, the page is refreshed with the detail information of the Error Code keyed-in.	Button	N/A	0

6.51.4 Error Disposition Mini Search-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.51.5 Error Disposition Mini Search-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.51.6 Error Disposition Mini Search-Error Disposition Panel Accessibility

6.51.6.1 To Access the Error Disposition-Mini Search-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Error Disposition Mini Search panel displays.

6.51.6.2 To Navigate the Disposition-Mini Search-Error Disposition Panel

Step	Action	Response
1	Enter **Error Code**.	
2	Click **Search**.	Error Disposition Information and Maintenance panels display.

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6.52 Adjustment Data Correction EOB-Error Disposition Panel

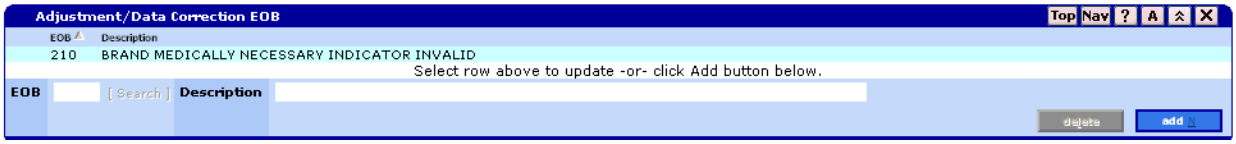
6.52.1 Adjustment Data Correction EOB-Error Disposition Panel Narrative

The Adjustment Data Correction EOB panel contains the EOB (Explanation of Benefit) code assigned to a claim header/detail for each ESC (Error Status Code) that may be posted as a result of an edit or audit. This EOB represents a meaningful message for the provider.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition Search] - [select search] -[select row from search results] - [Error Disposition Maintenance] - [Error Disposition] - [Adjustment/Data Correction EOB]

6.52.2 Adjustment Data Correction EOB-Error Disposition Panel Layout



6.52.3 Adjustment Data Correction EOB-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add an EOB assignment for the Error Status Code.	Button	N/A	0
Delete	Allows the user to delete an EOB from the Error Status Code.	Button	N/A	0
Description	Description for the Explanation of Benefits (EOB) that is printed on the remittance advice.	Field	Character	79
EOB [Search]	Code which represents a policy for Medicaid claim adjudication.	Hyperlink	N/A	0

6.52.4 Adjustment Data Correction EOB-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
EOB	Hyperlink	1	A valid EOB is required.	Enter a valid EOB code or search for an EOB Code.

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6.52.5 Adjustment Data Correction EOB-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.6 Adjustment Data Correction EOB-Error Disposition Panel Accessibility

6.52.6.1 To Access the Adjustment Data Correction EOB Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Adjustment /Data Correction EOB**.	Adjustment Data Correction EOB Error Disposition panel displays.

6.52.6.2 To Add on the Adjustment Data Correction EOB-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **EOB** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	EOB Code and description is displayed on panel.
4	Click **Save**.	Adjustment Data Correction EOB Error Disposition information is saved.

6.52.6.3 To Update on the Adjustment Data Correction EOB-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Adjustment Data Correction EOB Error Disposition information is saved.

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6.52.6.4 To Delete on the Adjustment Data Correction EOB-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.53 Base Information-Error Disposition Panel

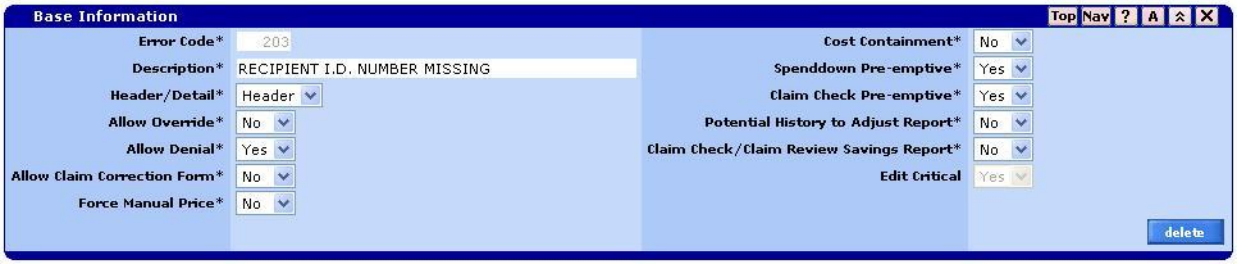
6.53.1 Base Information-Error Disposition Panel Narrative

The Base Information panel is used to view, add or update whether an edit or audit sets at the detail or header level, whether the resolutions clerk can deny or override the claim if it suspends, and to what location the claim is set for dispositioning.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition] - [Error Disposition Search] - [(Add button) OR [click on 'search' button, select row from search results) - [Error Disposition Maintenance] - [Error Disposition] - [Base Information]

6.53.2 Base Information-Error Disposition Panel Layout



6.53.3 Base Information-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Allow Claim Correction Form	Indicates (Yes or No) whether a claim correction form can be generated for the specific error code.	Combo Box	Drop Down List Box	0
Allow Denial	Indicates (Yes or No) whether a clerk should be allowed to set the edit/audit to deny upon review of the claim.	Combo Box	Drop Down List Box	0
Allow Override	Indicates (Yes or No) whether a clerk should be allowed to override an edit/audit upon review of the claim.	Combo Box	Drop Down List Box	0
Claim Check Pre-emptive	Indicates whether Claim Check should be bypassed if the edit is set on a claim. If the indicator is set to "Yes" and the edit is set on the claim, the claim will not go through Claim Check processing. This field is not used in AL, and therefore the value needs to be left at 'No'.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Claim Check/Claim Review Savings Report	Indicates if the error should be reported on the Claim Check/Claim Review Savings Report. If the box is checked, the error is included in the report. This field is not used in AL, and therefore the value needs to be left at 'No'.	Combo Box	Drop Down List Box	0
Cost Containment	Indicates whether the error status code is a cost containment item.	Combo Box	Drop Down List Box	0
Delete	Allows the user to remove the Error Code from interChange database.	Button	N/A	0
Description	Description of the edit or audit.	Field	Character	50
Edit Critical	Indicator identifying if the ESC is considered critical, and should not be inactivated, or set to pay (forced) by a clerk.	Combo Box	Drop Down List Box	0
Error Code	Code used to indicate an error was discovered on a claim during processing in the MMIS system. This code can represent either an edit or an audit.	Field	Number (Integer)	4
Force Manual Price	This is used to override Edit Critical (IND_CRITICAL) when = "Y". A 'Y' in this column means this ESC may be forced (set to pay) if the service is priced manually.	Combo Box	Drop Down List Box	0
Header/Detail	Indicates whether edit or audit should be set on the header - 'H', or detail - 'D' level of a claim.	Combo Box	Drop Down List Box	0
Potential History to Adjust Report	Indicates if the error should be reported on the Potential History To Adjust Report. If the box is checked, the error is included in the report.	Combo Box	Drop Down List Box	0
Spenddown Pre-emptive	Indicates whether the claim should be counted against spenddown if the edit is set. If the indicator is set to "Yes" and the edit is set on the claim, the claim billed amount is considered in Recipient spenddown calculations. This field is not used in AL, and therefore the value needs to be left at 'No'.	Combo Box	Drop Down List Box	0

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6.53.4 Base Information-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Error Description is required.	Enter Description.
Error Code	Field	1	Error Code is required.	Enter a 'NUMERIC' Error Code.
	Field	2	Error Code must be less than or equal to 9999.	Enter a value that is less than or equal to 9999.
Force Manual Price	Field	1	Force Manual Price Indicator can only be set if Critical Indicator is 'Y'.	Insert 'Y' only if the Critical field is 'Y'.

6.53.5 Base Information-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.53.6 Base Information-Error Disposition Panel Accessibility

6.53.6.1 To Access the Base Information-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Base Information**.	Base Information Error Disposition panel displays.

6.53.6.2 To Add on the Base Information-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Error Code**.	
3	Enter **Description**.	
4	Select **Header/Detail** from drop down list box.	
5	Select **Allow Override** from drop down list box.	
6	Select **Allow Denial** from drop down list	

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Step	Action	Response
	box.	
7	Select **Allow Claim Correction Form** from drop down list box.	
8	Select **Force Manual Price** from drop down list box.	
9	Select **Cost Containment** from drop down list box.	
10	Select **Spenddown Pre-emptive** from drop down list box. This field is not used in AL, and therefore the value needs to be left at 'No'.	
11	Select **Claim Check Pre-emptive** from drop down list box. This field is not used in AL, and therefore the value needs to be left at 'No'.	
12	Select **Potential History** to Adjust Report from drop down list box.	
13	Select **Claim Check/Claim Review Savings Report** from drop down list box. This field is not used in AL, and therefore the value needs to be left at 'No'.	
14	Select **Edit Critical** from drop down list box.	
15	Click **Save**.	Base Information Error Disposition information is saved.

6.53.6.3 To Update on the Base Information-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information Error Disposition information is saved.

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6.53.6.4 To Delete on the Base Information-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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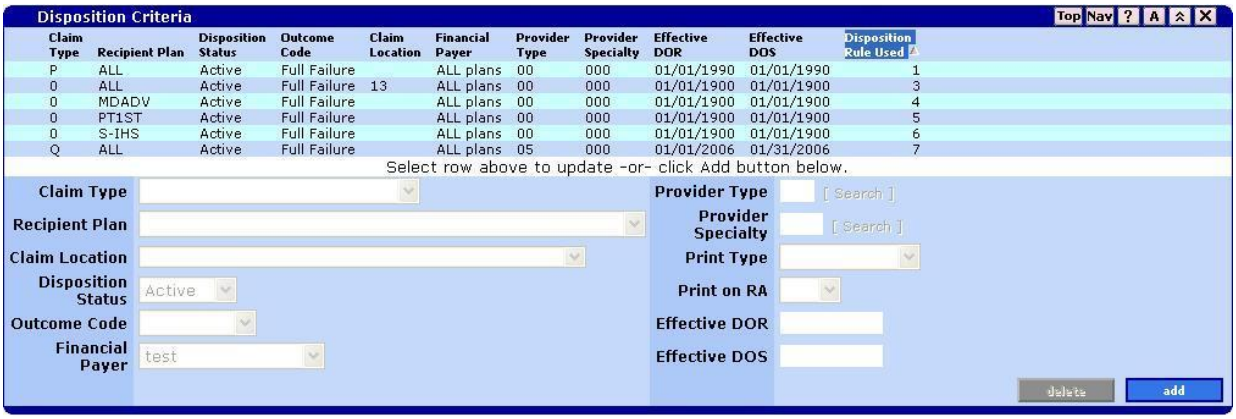
6.54 Disposition Criteria-Error Disposition Panel

6.54.1 Disposition Criteria-Error Disposition Panel Narrative

The Disposition Criteria panel contains detail dispositioning information concerning a specific edit/audit. The correct disposition detail to use for a claim is determined based on the claim type, level of care, outcome (full failure or cutback), provider specialty, date of receipt, and date of service of the claim. If there is not an exact match on claim type or provider specialty, the defaults of 0 and 00 are used. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Disposition Criteria]

6.54.2 Disposition Criteria-Error Disposition Panel Layout



6.54.3 Disposition Criteria-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new 'Disposition Criteria' to the Edit/Audit.	Button	N/A	0
Claim Location	Type of location in which a claim can be placed during processing in the MMIS system.	Combo Box	Drop Down List Box	0
Claim Type	Type of claim assigned to specified error criteria used for disposition of the claim.	Combo Box	Drop Down List Box	0
Delete	Allows the user to mark a Disposition Criteria to be removed from the edit/audit.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Disposition Rule Used	Shows the specific error disposition line number, indicated by a system assigned key used to define an occurrence of an error disposition for a specific edit/audit. The line number is retrieved from t_err_disp_line.sak_error_disp.	Field	N/A	0
Disposition Status	Indicates if a line item criterion are active or inactive. On the Region Data sub panel it relates to the code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.	Combo Box	Drop Down List Box	0
Effective DOR	Date claim processes in the system (date of receipt) for which the error should be set.	Field	Date (MM/DD/CCYY)	8
Effective DOS	Date of service for which the error should be set.	Field	Date (MM/DD/CCYY)	8
Financial Payer	The Financial payer generally represents a unique orgnization responsible for the underwriting of the claims transactions to be paid.	Combo Box	Drop Down List Box	0
Outcome Code	Indicates how to handle the possible types of failure of an edit or audit (full failure or cutback).	Combo Box	Drop Down List Box	0
Print on RA	Indicates if the error should be posted on the Remittance Advice.	Combo Box	Drop Down List Box	0
Print Type	Indicates if details that fail this edit/audit should produce a paper worksheet or appear on the edit list report.	Combo Box	Drop Down List Box	0
Provider Specialty [Search]	Specific error handling based on the specialty of the provider (billing or rendering depending on claim type). A value of "000" is used to designate any specialty.	Hyperlink	N/A	0
Provider Type [Search]	Type that a provider is licensed for. A value of "000" is used to designate any specialty.	Hyperlink	N/A	0
Recipient Plan	Code that identifies the recipient plans that are supported by the system.	Combo Box	Drop Down List Box	0

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6.54.4 Disposition Criteria-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Claim Location	Field	1	A valid Claim Location is required.	Select a 'Claim Location' from the drop down list.
	Field	2	A valid Region Disp is required.	Region Disp has to have a value.
	Field	3	Must contain at least one Region Disp.	Enter a valid Region Disposition.
Claim Type	Field	1	A valid Claim Type is required.	Enter a Claim Type.
	Field	2	Must contain at least one Region Disp.	A valid Region Disp must be added.
Effective DOR	Field	1	Must contain Effective DOR Date or Effective DOS Date.	Enter an Effective DOR.
	Field	2	Invalid date.	Enter an Effective DOR that is numeric and in MM/DD/CCYY format.
	Field	3	Effective DOR must be greater than or equal to 01/01/1900.	Enter an Effective DOR that is greater than or equal to 01/01/1900.
	Field	4	Effective DOR date must be less than or equal to 12/31/2299.	Enter an Effective DOR that is less than or equal to 12/31/2299.
Effective DOS	Field	1	Must contain Effective DOR Date or Effective DOS Date.	Enter an Effective DOS.
	Field	2	Invalid date	Enter an Effective DOS that is numeric and in MM/DD/CCYY format.
	Field	3	Effective DOS must be greater than or equal to 01/01/1900.	Enter an Effective DOS that is greater than or equal to 01/01/1900.
	Field	4	Effective DOS must be less than or equal to 12/31/2299.	Enter a date that is less than or equal to 12/31/2299.
Outcome Code	Field	1	Outcome Code is required.	Select a value from the drop down list.
Print Type	Field	1	Print Type is required.	Select a 'Print Type' from the drop down list.
Print on RA	Field	1	Print on RA is required.	Select a value from the drop down list.
Recipient Plan	Field	1	A valid Recipient Plan is required.	Select a Recipient Plan from the drop down list.

6.54.5 Disposition Criteria-Error Disposition Panel Extra Features

Field	Field Type

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Field	Field Type
No extra features found for this page/panel.	

6.54.6 Disposition Criteria-Error Disposition Panel Accessibility

6.54.6.1 To Access the Disposition Criteria- Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Disposition Criteria**.	Disposition Criteria- Error Disposition panel displays.

6.54.6.2 To Add on the Disposition Criteria- Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Claim Type** from the drop down list box.	
3	Select **Recipient Plan** from the drop down list box.	
4	Select **Claim Location** from drop down list box.	
5	Select **Disposition Status** from drop down list box.	
6	Select **Outcome Code** from drop down list box.	
7	Select **Financial Payer** from drop down list box.	
8	Enter **Provider Type**. Click [Search] if unknown.	
10	Enter **Provider Specialty**. Click [Search] if unknown.	
11	Select **Print Type** from the drop down list box.	
12	Select **Print on RA** from drop down list box.	
13	Enter **Effective DOR** in MM/DD/CCYY format.	

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Step	Action	Response
14	Enter **Effective DOS** in MM/DD/CCYY format.	
15	Click **Save**.	Disposition Criteria- Error Disposition information is saved.

6.54.6.3 To Update on the Disposition Criteria-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Disposition Criteria-Error Disposition information is saved.

6.54.6.4 To Delete on the Disposition Criteria-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.55 Disposition Criteria-Region Data-Error Disposition Panel

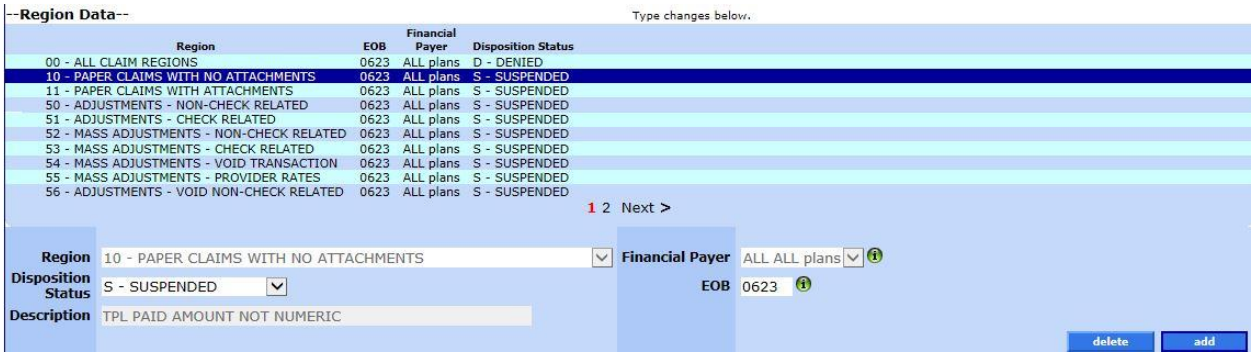
6.55.1 Disposition Criteria-Region Data-Error Disposition Panel Narrative

The Disposition Criteria - Region Data panel is used to add or update the Region Number and Disposition Status for a specific error code, Error Disposition Line Item.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Disposition Criteria (select row from the data list)]

6.55.2 Disposition Criteria-Region Data-Error Disposition Panel Layout



6.55.3 Disposition Criteria-Region Data-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add new 'Region' data to the Error Disposition line item.	Button	N/A	0
Delete	Allows the user to mark a 'Region' to be removed from the line item.	Button	N/A	0
Description	Read-only description of the specific Explanation Of Benefit for a Region and a Payer assigned to the audit for dispositioning.	Field	Character	70
Disposition Status	Code that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	Combo Box	Drop Down List Box	0
EOB [Search]	Specific Explanation Of Benefit for a Region and a Payer assigned to the audit for dispositioning.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Financial Payer	The Financial payer generally represents a unique organization responsible for the underwriting of the claims transactions to be paid.	Combo Box	Drop Down List Box	0
Region	Specific region assigned to the edit or audit line item for dispositioning.	Combo Box	Drop Down List Box	0

6.55.4 Disposition Criteria-Region Data-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Disposition Status	Field	1	A valid Disposition Status is required.	Select a Status from the drop down list.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a payer from the drop down list.
	Field	102	Financial Payer cannot be different within Region segments unless Disposition is set up for 'ALL' Financial Payers.	Select the same payer as in parent disposition line item.
Region	Field	1	A valid Region is required.	Select a Region from the drop down list.
EOB	Hyperlink	1	A valid EOB is required.	Enter an EOB code or select an EOB using the search link.
	Hyperlink	101	EOB Codes cannot be different within Region segments unless Disposition is set up for 'ALL' Recipient Plans.	Change the EOB within Region Disp records to have the same code.
	Hyperlink	1	Error Code and EOB Code must match.	Change the EOB code to the same value as the error code. If required use link to the EOB panel to allow adding a new EOB code.

6.55.5 Disposition Criteria-Region Data-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.55.6 Disposition Criteria-Region Data-Error Disposition Panel Accessibility

6.55.6.1 To Access the Disposition Criteria-Region Data-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Disposition Criteria**.	Disposition Criteria- Error Disposition Panel Accessibility information panel displays.
5	Select row from data list.	Disposition Criteria-Region Data -Error Disposition panel displays.

6.55.6.2 To Add on the Disposition Criteria-Region Data-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Region** from the drop down list box.	
3	Select **Disposition Status** from drop down list box.	
4	Enter **Description**.	
5	Select **Financial Payer** from drop down list box.	
6	Enter **EOB**. Click [Search] if unknown.	
7	Click **Save**.	Disposition Criteria- Region Data -Error Disposition information is saved.

6.55.6.3 To Update on the Disposition Criteria-Region Data-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Disposition Criteria- Region Data -Error Disposition information is saved.

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6.55.6.4 To Delete on the Disposition Criteria-Region Data-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.56 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel

6.56.1 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Narrative

This information on the Provider Type Specialty Data panel is used to include or exclude combinations of Provider type/specialty in/from participating in the disposition of the edit/audit.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Disposition Criteria (select row from the data list)]

6.56.2 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Layout

6.56.3 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new type specialty to the line item.	Button	N/A	0
Delete	Allows the user to remove a type specialty from the line item.	Button	N/A	0
Include/Exclude	Include Exclude indicator.	Combo Box	Drop Down List Box	0
Provider Role	Provider Role.	Combo Box	Drop Down List Box	0
Provider Specialty [Search]	The name of the Provider Specialty.	Hyperlink	N/A	0
Provider Type [Search]	The name of the Provider Type.	Hyperlink	N/A	0

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6.56.4 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Include/Exclude	Field	1	Include/Exclude is required.	Select an indicator value from the drop down list.
	Field	2	Include/Exclude Indicators cannot be mixed within a role - is not valid.	Modify the include/exclude indicator.
Provider Role	Field	1	Provider Role is required.	Select a Provider Role.
	Field	2	Include/Exclude Indicators cannot be mixed within a role - is not valid.	Change the Provider Role or In/Ex indicator value.
Provider Specialty	Hyperlink	3	A valid Provider Specialty is required.	Select a Provider Specialty.
Provider Type	Hyperlink	1	A valid Provider Type is required.	Select a Provider Type.

6.56.5 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel Accessibility

6.56.6.1 To Access the Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Disposition Criteria**.	Disposition Criteria- Error Disposition Panel Accessibility information panel displays.
5	Select row from data list.	Disposition Criteria-Provider Type Specialty Data-Error Disposition panel displays.

6.56.6.2 To Add on the Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from

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Step	Action	Response
		lists.
2	Select **Provider Role** from the drop down list box.	
3	Select **Provider Specialty** by clicking [Search].	
4	Enter search criteria. User may also select a row from the list of search results.	Provider Specialty information is populated.
5	Select **Provider Type** by clicking [Search].	
6	Enter search criteria. User may also select a row from the list of search results.	Provider Type information is populated.
7	Select **Include/Exclude** from drop down list box.	
8	Click **Save**.	Disposition Criteria-Provider Type Specialty Data-Error Disposition information is saved.

6.56.6.3 To Update on the Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Disposition Criteria-Provider Type Specialty Data-Error Accessibility information is saved.

6.56.6.4 To Delete on the Disposition Criteria-Provider Type Specialty Data-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.57 NCPDP Response-Error Disposition Panel

6.57.1 NCPDP Response-Error Disposition Panel Narrative

The NCPDP (National Council for Prescription Drug Pricing) Response panel is used to associate a NCPDP response code to an Error Status Code. This association would only be used for drug related edits/audits.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] – [Error Disposition] - [NCPDP Response]

6.57.2 NCPDP Response-Error Disposition Panel Layout

6.57.3 NCPDP Response-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new association of a NCPDP Response code to the Error Code.	Button	N/A	0
Delete	Allows the user to delete a NCPDP response code association from the Error Code.	Button	N/A	0
NCPDP Response Text	Read only text description associated with specific NCPDP response code value.	Field	Character	50
NCPDP Response Code	Unique code number/value assigned to a specific reject message per National Council for Prescription Drug Pricing.	[Search]	N/A	0

6.57.4 NCPDP Response-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
NCPDP Response Code	[Search]	1	A valid NCPDP Response is required.	Select a NCPDP Response using the search link.

6.57.5 NCPDP Response-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.57.6 NCPDP Response-Error Disposition Panel Accessibility

6.57.6.1 To Access the NCPDP Response-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **NCPDP Response**.	NCPDP Response-Error Disposition panel displays.

6.57.6.2 To Add on the NCPDP Response-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **NCPDP Response Code** by clicking [Search]	
3	Enter search criteria. User may also select a row from the list of search results.	NCPDP Response Code Text information is populated.
4	Click **Save**.	NCPDP Response-Error Disposition information is saved.

6.57.6.3 To Delete on the NCPDP Response-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.58 Modification Log-Error Disposition Panel

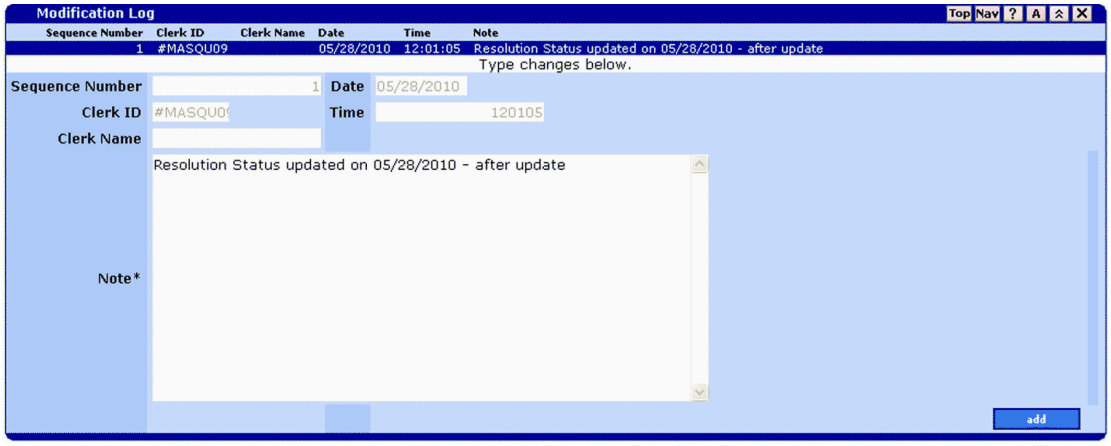
6.58.1 Modification Log -Error Disposition Panel Narrative

The Modification Log panel allows users to enter notes as to why changes were made to a specific edit or audit.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Modification Log]

6.58.2 Modification Log -Error Disposition Panel Note-Error Disposition Layout



6.58.3 Modification Log -Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Button to open an empty panel to add a new 'Log'.	Button	N/A	0
Clerk ID	Identification number of the user who enters the note. This value is set from the user's security profile.	Field	Alphanumeric	8
Clerk Name	Name of the user who enters the note. This value is set from the user's security profile.	Field	Alphanumeric	100
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Note	This is a free form text field that can be used to capture pertinent information related to the particular edit or audit error code.	Field	Character	1000
Sequence Number	System assigned Sequence number than can uniquely identify a note.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Time	The time that the note was entered.	Field	Number (Decimal)	6

6.58.4 Modification Log -Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Enter notes.

6.58.5 Modification Log -Error Disposition Panel Extra Features

Field	Field Type
Modification log is required while updating any panel for Error Disposition.	

6.58.6 Modification Log -Error Disposition Panel Accessibility

6.58.6.1 To Access the Modification Log -Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Modification Log**.	Modificaton Log-Error Disposition panel displays.

6.58.6.2 To Add on the Modification Log -Error Disposition Panel

Step	Action	Response
1	Click **Add**. Date and time populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Modification Log-Error Disposition information is saved.

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6.58.6.3 To Update on the Modification Log -Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Modification Log-Error Disposition information is saved.

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6.59 Parameters-Error Disposition Panel

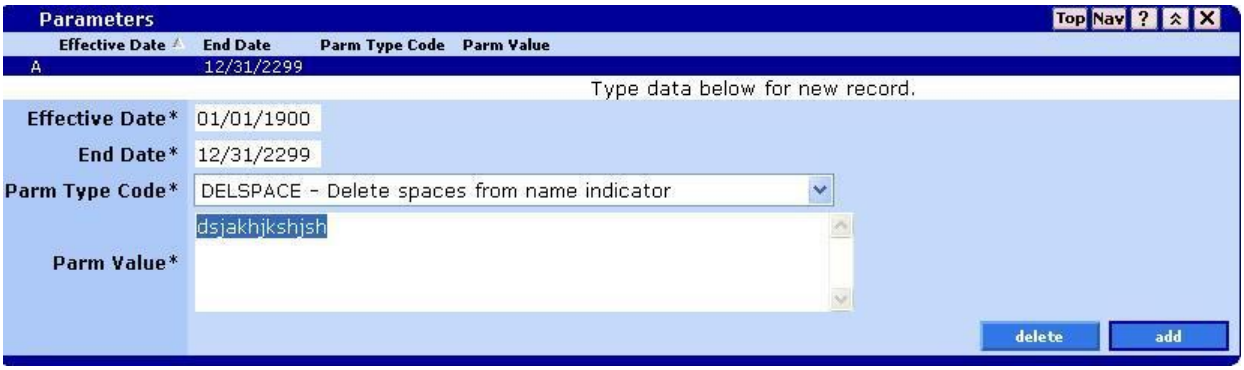
6.59.1 Parameters-Error Disposition Panel Narrative

The Parameters panel is used to provide parameter information to edits. For example, for edit 513 the panel is used to define the Recipient First Name and Recipient Last Name edit masks that the edit utilizes to compare the name on the claim to the name in the Recipient subsystem.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Parameters]

6.59.2 Parameters-Error Disposition Panel Layout



6.59.3 Parameters-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Used to add a new parameter value to the edit.	Button	N/A	0
Delete	Used to delete a parameter value from an edit.	Button	N/A	0
Effective Date	The Effective Date of the parameter value.	Field	Date (MM/DD/CCYY)	8
End Date	The End Date of the parameter value.	Field	Date (MM/DD/CCYY)	8
Parm Type Code	The parameter type; for example "RFN" for recipient first name mask.	Combo Box	Drop Down List Box	0
Parm Value	The value of the parameter; for example "XXX**********" for recipient first name (RFN) mask.	Field	Alphanumeric	4000

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6.59.4 Parameters-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	2	Edit Parm segments can not overlap.	Change the edit parm type or change the dates so no overlaps occur (the edit sets when there are overlapping date ranges for the same edit parm type).
	Field	3	Effective Date is required.	Enter an Effective Date.
	Field	4	Effective Date [MM/DD/CCYY 12:00:00 AM] must be less than or equal to End Date [MM/DD/CCYY 12:00:00 AM].	Enter an Effective Date that is less than or equal to the End Date
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Invalid date.	Enter a valid End Date in MM/DD/CCYY format.
	Field	2	End Date is required.	Enter an End Date.
	Field	3	Effective Date [MM/DD/CCYY 12:00:00 AM] must be less than or equal to End Date [MM/DD/CCYY 12:00:00 AM].	Enter an End Date that is greater than or equal to the Effective Date.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	5	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Parm Value	Field	1	Parm Value is required.	Enter a Parm Value.

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6.59.5 Parameters-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.59.6 Parameters-Error Disposition Panel Accessibility

6.59.6.1 To Access the Parameters-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Parameters.**	Parameters Error Disposition information panel displays.

6.59.6.2 To Add on the Parameters-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Enter **End Date** in MM/DD/CCYY format.	
4	Select **Parm Code** from drop down list box.	
5	Enter **Parm Value**.	
6	Click **Save**.	Parameters Error Disposition information is saved.

6.59.6.3 To Update on the Parameters-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Parameters-Error Disposition information is saved.

6.59.6.4 To Delete on the Parameters-Error Disposition Panel

Step	Action	Response

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1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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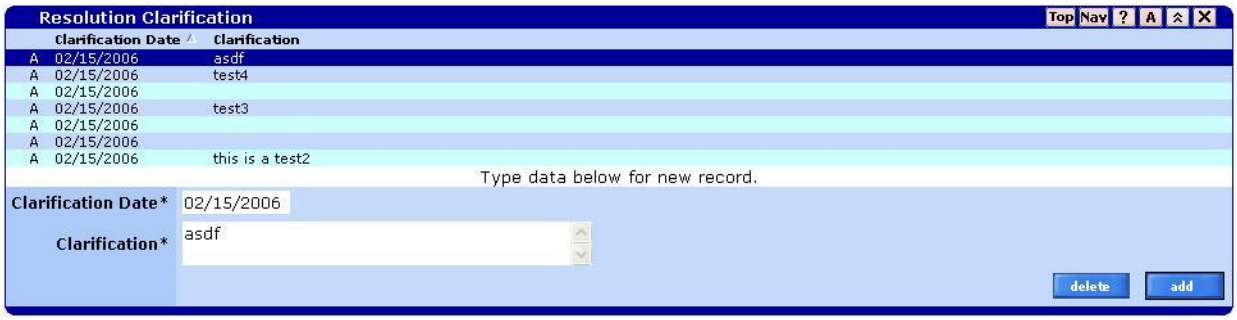
6.60 Resolution Clarification-Error Disposition Panel

6.60.1 Resolution Clarification-Error Disposition Panel Narrative

The Resolution Clarification panel is used to view, add, or update Clarifications associated with the exception. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Clarification]

6.60.2 Resolution Clarification-Error Disposition Panel Layout



6.60.3 Resolution Clarification-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new clarification to the Error Code.	Button	N/A	0
Clarification	Free form text field that allows a user to enter a clarification related to the edit or audit.	Field	Character	50
Clarification Date	Date the clarification was created.	Field	Date (MM/DD/CCYY)	10
Delete	Allows user to delete a clarification from the Error Code.	Button	N/A	0

6.60.4 Resolution Clarification-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Clarification	Field	1	Clarification is required.	Enter a clarification.
Clarification Date	Field	1	A duplicate record cannot be saved.	Enter a unique Clarification Date. There can be only one clarification for one date.
	Field	2	Clarification Date is required.	Enter Clarification Date.
	Field	3	Invalid date.	Enter a Clarification Date that is numeric and in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Clarification Date must be greater than or equal to 01/01/1900.	Enter a Clarification Date that is greater than or equal to 01/01/1900.
	Field	5	Clarification Date must be less thahn or equal to 12/31/2299.	Enter a Clarification Date that is less than or equal to 12/31/2299.

6.60.5 Resolution Clarification-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.60.6 Resolution Clarification-Error Disposition Panel Accessibility

6.60.6.1 To Access the Resolution Clarification-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Clarification.**	Resolution Clarification-Error Disposition information panel displays.

6.60.6.2 To Add on the Resolution Clarification-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Clarification Date** in MM/DD/CCYY format.	
3	Enter **Clarification**.	
4	Click **Save**.	Resolution Clarification-Error Disposition information is saved.

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6.60.6.3 To Update on the Resolution Clarification-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Clarification-Error Disposition information is saved.

6.60.6.4 To Delete on the Resolution Clarification-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.61 Resolution Criteria-Error Disposition Panel

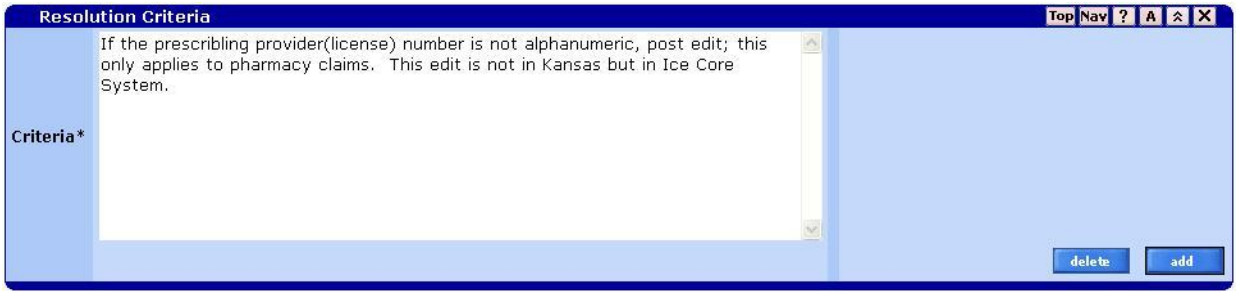
6.61.1 Resolution Criteria-Error Disposition Panel Narrative

Resolution Criteria panel describes the criteria for when the exception applies.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR ((click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Criteria]

6.61.2 Resolution Criteria-Error Disposition Panel Layout



6.61.3 Resolution Criteria-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add criteria for the Error Code if criteria does not already exist.	Button	N/A	0
Criteria	The text describing the criteria that causes the edit or audit to set.	Field	Character	999999999
Delete	Allows the user to delete the existing criteria from the Error Code.	Button	N/A	0

6.61.4 Resolution Criteria-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Criteria	Field	1	Criteria is required.	Enter criteria.

6.61.5 Resolution Criteria-Error Disposition Panel Extra Features

There is only one Resolution Criteria per Error Code. If a Resolution Criteria exists, the "Add" button is disabled.

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6.61.6 Resolution Criteria-Error Disposition Panel Accessibility

6.61.6.1 To Access the Resolution Criteria-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Criteria**.	Resolution Criteria-Error Disposition information panel displays.

6.61.6.2 To Add on the Resolution Criteria-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Criteria.**	
3	Click **Save**.	Resolution Criteria-Error Disposition information is saved.

6.61.6.3 To Update on the Resolution Criteria-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Criteria-Error Disposition information is saved.

6.61.6.4 To Delete on the Resolution Criteria-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.62 Resolution Group-Error Disposition Panel

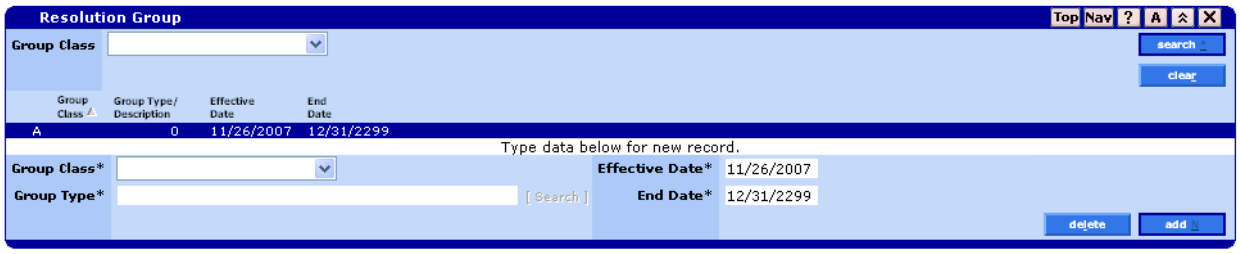
6.62.1 Resolution Group-Error Disposition Panel Narrative

The Resolution Group panel is used to view, add, or update groups associated with the exception.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition (Search)] - (Click on [Search] button) - (Select row from search results) - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Group]

6.62.2 Resolution Group-Error Disposition Panel Layout



6.62.3 Resolution Group-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to associate the Error Code with a new Resolution group.	Button	N/A	0
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Delete	Allows the user to remove a resolution group from the error code.	Button	N/A	0
Description	Description of the Group Type selection. This value is taken from one of the following tables: T_REV_TYPE, T_TYPE_SPEC_CODE, T_MOD_GROUP_TYPE, T_DIAG_TYPE, T_PROC_ICD9_TYPE, T_TOB_TYPE, T_BENEFIT_PLAN_TYPE and T_PROC_TYPE. This field usually comes from dsc_50 or dsc_25.	[Search]	Character	50

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Field	Description	Field Type	Data Type	Length
Effective Date	The date the group applies to this error code.	Field	Date (MM/DD/CCYY)	8
End Date	The last date the group applies to this error code.	Field	Date (MM/DD/CCYY)	8
Group Class	Identifies the name of the Group Class. The valid entries are: Revenue. Provider Type/Provider, Modifier, Diagnosis, ICD Procedure, Type of Bill, Benefit Plan and HCPCS Procedure.	Field	Drop Down List Box	0
Group Class (Search)	Identifies the name of the Group Class. The valid entries are: Revenue. Provider Type/Provider, Modifier, Diagnosis, ICD Procedure, Type of Bill, Benefit Plan and HCPCS Procedure.	Combo Box	Drop Down List Box	0
Group Type	Identifies the type of the group. If value is not known, click on search link.	Field	CLOB	0
Group Type/Description [Search]	Identifies the type of the group. If value is not known, click on search link.	Hyperlink	CLOB	0
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0

6.62.4 Resolution Group-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date[<Date>] must be less than or equal to End Date[<Date>].	Insert the Effective Date where the Effective Date is less than the end date.
	Field	3	Invalid date.	Enter a valid Effective Date. Date must be numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Effective Date must be greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter a valid Effective Date.
	Field	1002	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
End Date	Field	1	Effective Date[<Date>] must be less than or equal to End Date[<Date>].	Insert the End Date where the End date is grater than the Effective Date.
	Field	3	Invalid date.	Enter a valid date. Date must be numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	5	End Date is required.	Enter End Date.
	Field	1001	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Group Class	Field	1	A valid Group is required.	Select a Group from the drop down list.
	Field	2	A duplicate record cannot be saved.	Enter a Type and Group combination that is unique.
Group Type	Field	1	A duplicate record cannot be saved.	Enter a Type and Group combination that is unique.
	Field	1000	Group Type must be greater than or equal to 0.	Select a group type using the [Search] feature.

6.62.5 Resolution Group-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.62.6 Resolution Group-Error Disposition Panel Accessibility

6.62.6.1 To Access the Resolution Group-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Group**.	Resolution Group-Error Disposition information panel displays.

6.62.6.2 To Add on the Resolution Group-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from

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Step	Action	Response
		lists.
2	Select **Group Class** from the drop down list box.	
3	Select **Group Type** by clicking [Search].	
4	Enter search criteria. User may also select a row from the list of search results.	Group Type information is populated.
5	Enter **Effective Date** in MM/DD/CCYY format.	
6	Enter **End Date** in MM/DD/CCYY format.	
7	Click **Save**.	Resolution Group-Error Disposition information is saved.

6.62.6.3 To Update on the Resolution Group-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Group-Error Disposition information is saved.

6.62.6.4 To Delete on the Resolution Group-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.63 Resolution Medical Policy-Error Disposition Panel

6.63.1 Resolution Medical Policy-Error Disposition Panel Narrative

The Resolution Medical Policy panel is used to view, add, or update error disposition resolution Medical Policy numbers. This panel allows the user to tie Medical Policy identifiers directly to an error status code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR ((click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Medical Policy]

6.63.2 Resolution Medical Policy-Error Disposition Panel Layout

6.63.3 Resolution Medical Policy-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to associate the Error Code with a new Medical Policy identifier.	Button	N/A	0
Delete	Allows the user to delete a Medical Policy identifier record from the Error Code.	Button	N/A	0
Medical Policy	Identifier for the policies that apply to this Error Code.	Field	Character	80

6.63.4 Resolution Medical Policy-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Medical Policy	Field	1	Medical Policy is required.	Enter a medical policy.
	Field	2	A duplicate record cannot be saved.	Enter a unique medical policy.

6.63.5 Resolution Medical Policy-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.63.6 Resolution Medical Policy-Error Disposition Panel Accessibility

6.63.6.1 To Access the Resolution Medical Policy-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Medical Policy**.	Resolution Medical Policy-Error Disposition information panel displays.

6.63.6.2 To Add on the Resolution Medical Policy-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Medical Policy**.	
3	Click **Save**.	Resolution Medical Policy-Error Disposition information is saved.

6.63.6.3 To Update on the Resolution Medical Policy-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Medical Policy-Error Disposition information is saved.

6.63.6.4 To Delete on the Resolution Medical Policy-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.64 Resolution Method of Correction-Error Disposition Panel

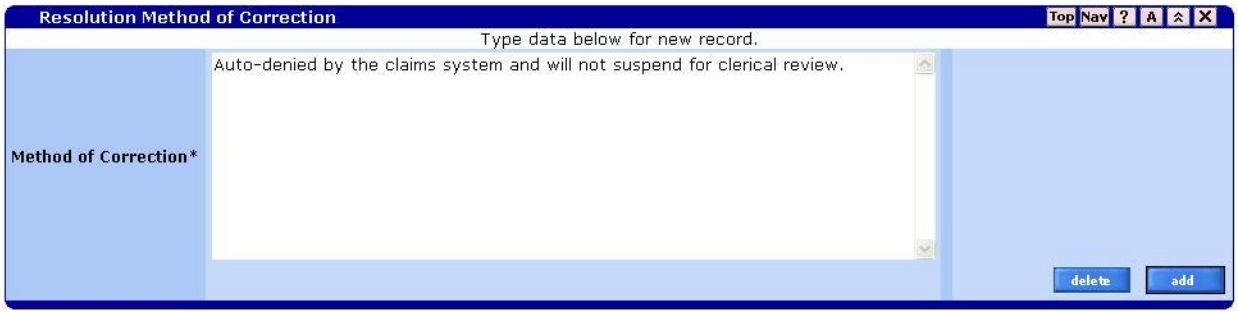
6.64.1 Resolution Method of Correction-Error Disposition Panel Narrative

The Resolution Method of Correction panel specifies the resolution method to be used in Correction.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR ((click on 'search' and select row from search results)] - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Method of Correction]

6.64.2 Resolution Method of Correction-Error Disposition Panel Layout



6.64.3 Resolution Method of Correction-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Method of Correction for the error code if one does not already exist.	Button	N/A	0
Delete	Allows the user to delete a Method of Correction from the error code if one exists.	Button	N/A	0
Method of Correction	Explanation of how the error code is resolved either manually by a clerk, or systematically.	Field	Character	999999999

6.64.4 Resolution Method of Correction-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Method of Correction	Field	1	Method of Correction is required.	Enter a Method of Correction.

6.64.5 Resolution Method of Correction-Error Disposition Panel Extra Features

There is only one Method of Correction per Error Code. If a Method of Correction exists, the "Add" button is disabled.

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6.64.6 Resolution Method of Correction-Error Disposition Panel Accessibility

6.64.6.1 To Access the Resolution Method of Correction-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Method of Correction**.	Resolution Method of Correction-Error Disposition information panel displays.

6.64.6.2 To Add on the Resolution Method of Correction-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Method of Correction**.	
3	Click **Save**.	Resolution Method of Correction-Error Disposition information is saved.

6.64.6.3 To Update on the Resolution Method of Correction -Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Method of Correction-Error Disposition information is saved.

6.64.6.4 To Delete on the Resolution Method of Correction-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.65 Resolution Note-Error Disposition Panel

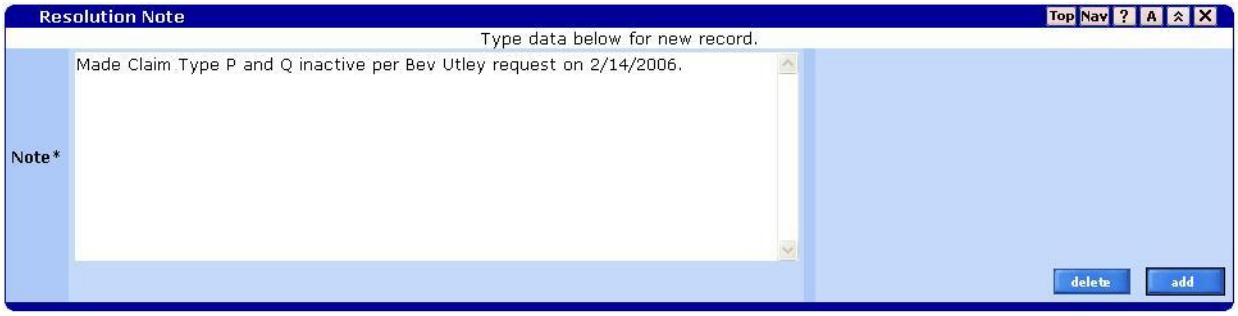
6.65.1 Resolution Note-Error Disposition Panel Narrative

The Resolution Note panel is used by the Resolution Clerk who may want to add to the handling or anything else about the error status code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition (Search)] - (Click on [Search] button) - (Select row from search results) - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Note]

6.65.2 Resolution Note-Error Disposition Panel Layout



6.65.3 Resolution Note-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a 'note' about Resolution of the error.	Button	N/A	0
Delete	Allows the user to remove a 'resolution note' from the error.	Button	N/A	0
Note	This is a note the resolution clerk may want to add to the handling or anything else about the ESC.	Field	Character	999999999

6.65.4 Resolution Note-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Enter a Resolution Note.

6.65.5 Resolution Note-Error Disposition Panel Extra Features

There is only one Resolution Note per Error Code. If a Resolution Note exists, the "Add" button is disabled.

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6.65.6 Resolution Note-Error Disposition Panel Accessibility

6.65.6.1 To Access the Resolution Note Error-Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Note**.	Resolution Note-Error Disposition information panel displays.

6.65.6.2 To Add on the Resolution Note-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Resolution Note-Error Disposition information is saved.

6.65.6.3 To Update on the Resolution Note-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Note-Error Disposition information is saved.

6.65.6.4 To Delete on the Resolution Note-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.66 Resolution Status-Error Disposition Panel

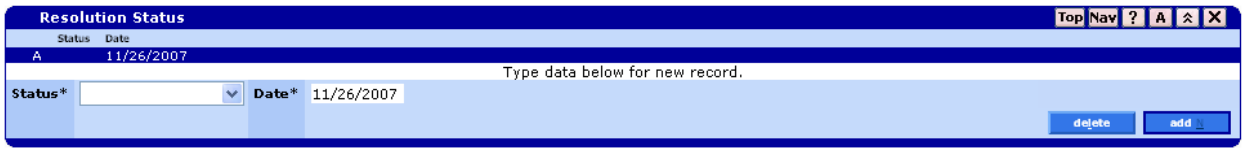
6.66.1 Resolution Status-Error Disposition Panel Narrative

The Resolution Status panel displays the information and date of status.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Error Disposition (Search)] - (click on [search] button) - (select row from search results) - [Error Disposition Maintenance] - [Error Disposition] - [Resolution Status]

6.66.2 Resolution Status-Error Disposition Panel Layout



6.66.3 Resolution Status-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a status regarding the resolution.	Button	N/A	0
Date	Date the status was associated with the resolution.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete the status of a resolution.	Button	N/A	0
Status	Identifies the status of the resolution.	Combo Box	Drop Down List Box	0

6.66.4 Resolution Status-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Date	Field	1	Date is required.	Enter a valid Date.
	Field	2	Invalid date.	Enter a Date that is numeric and in MM/DD/CCYY format.
	Field	3	Date must be greater than or equal to 01/01/1900.	Enter a Date that is greater than or equal to 01/01/1900.
	Field	4	Date must be less than or equal to 12/31/2299.	Enter a Date that is less than or equal to 12/31/2299.
Status	Field	1	A valid Status is required.	Select a status from the drop down list.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Select a unique status.

6.66.5 Resolution Status-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.66.6 Resolution Status-Error Disposition Panel Accessibility

6.66.6.1 To Access the Resolution Status-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Resolution Status**.	Resolution Status-Error Disposition information panel displays.

6.66.6.2 To Add on the Resolution Status-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Status** from the drop down list box.	
3	Enter **Date** in MM/DD/CCYY format	
4	Click **Save**.	Resolution Status-Error Disposition information is saved.

6.66.6.3 To Update on the Resolution Status-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resolution Status-Error Disposition information is saved.

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6.66.6.4 To Delete on the Resolution Status-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.67 Error Disposition - Audit Criteria Page

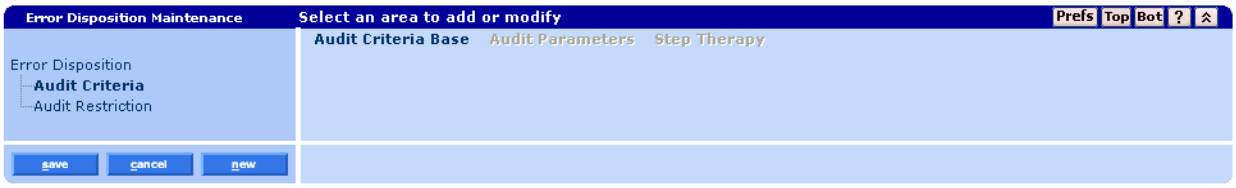
6.67.1 Error Disposition-Audit Criteria Page Narrative

The Error Disposition - Audit Criteria page is used to maintain audit criteria data.

This panel is inquiry only.

Navigation: [Reference] – [Error Disposition] – [Add] – [Audit Criteria]

6.67.2 Error Disposition - Audit Criteria Page Layout



6.67.3 Error Disposition-Audit Criteria Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Criteria Base	Link to the Audit Criteria Base panel.	Hyperlink	N/A	0
Audit Parameters	Link to the Audit Parameters panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel information related to Error Disposition.	Button	N/A	0
New	Allows the user to create information related to Error Disposition.	Button	N/A	0
Save	Allows the user to save information related to Error Disposition.	Button	N/A	0

6.67.4 Error Disposition-Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.67.5 Error Disposition-Extra Features

Field	Field Type
No extra features found for this panel.	

6.67.6 Error Disposition-Audit Criteria Page Accessibility

6.67.6.1 To Access the Error Disposition-Audit Criteria Page

Step	Action	Response

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1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Criteria**.	Audit Criteria page displays.

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6.68 Audit Criteria Base-Error Disposition Panel

6.68.1 Audit Criteria Base-Error Disposition Panel Narrative

The Audit Criteria Base panel contains a number of different indicators (Include/Exclude, Same/Different, Other) that give the user enormous flexibility by allowing them to set a variety of criteria relevant to a particular audit that causes the audit to set or be bypassed.

Include/Exclude Indicators indicate whether an attribute should be included, meaning the audit is set when those attributes are present, assuming all other criteria are met, or excluded, meaning the audit would be bypassed for those attributes, and set for all other attributes that were not excluded, assuming all other criteria are met.

Same/Different Indicators are used to determine which claims in history are used in the audit. For example, if the Procedure Same/Different indicator is set to 'Same', then a history claim is used only if the Procedure Code matches the one used on the current claim. If the indicator is set to 'Different', then a history claim is used only if the Procedure Code DOESN'T match the one used on the current claim. If the indicator is set to 'Both', then there is no limitation and history claims with all Procedure Codes is used in the audit. Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Criteria] - [Audit Criteria Base]

6.68.2 Audit Criteria Base-Error Disposition Panel Layout

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6.68.3 Audit Criteria Base-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new set of audit criteria for a specified time period for the Error Code.	Button	N/A	0
AHFS Class	Include/Exclude indicator for type of AHFS Class.	Combo Box	Drop Down List Box	0
Audit Type	Identifies the type of audit (i.e. limitation, conflict, negative contra, contra-indicated, step therapy, or umbrella).	Combo Box	Drop Down List Box	0
Billing Provider	Indication of whether the same or different provider number is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Billing Provider Location	Indication of whether the same or different Billing Provider Location is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Billing Provider Specialty	Include/Exclude indicator for provider specialty.	Combo Box	Drop Down List Box	0
Billing Provider Type	Include/Exclude indicator for provider type.	Combo Box	Drop Down List Box	0
Claim	Indication of whether the specified audit should audit against the current claim ICN that matches a history claim ICN (Same), or current claim ICN that does not match the history claim ICN (Different), or, current claim against all other history claims regardless of ICN match (Both).	Combo Box	Drop Down List Box	0
Claim Type	Include/Exclude indicator for claim type. Indicates if certain claim types should be included, meaning the audit will set for those claim types if all other criteria matches, or excluded, meaning the audit would be bypassed for those claim types.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Date of Service	Indication of whether the specified audit should audit against the current claim date of service that matches a history claim date of service, or current claim date of service that does not match the history claim date of service (Different), or, current claim date of service against all other history claims dates of service regardless of whether they match (Both).	Combo Box	Drop Down List Box	0
Diagnosis	Include/Exclude indicator for diagnosis. Indicates if certain diagnoses should be included, meaning the audit will set for those diagnoses if all other criteria matches, or excluded, meaning the audit would be bypassed for those diagnoses.	Combo Box	Drop Down List Box	0
Diagnosis Type	Indicates whether the diagnosis code(s) to be checked is (A)dmit, (D)ischarge, (E)mergency, (P)rimary, (S)econdary, (Y)Any.	Combo Box	Drop Down List Box	0
Effective Date	First day, based on date of service, on which the assigned audit criteria are valid for processing.	Combo Box	Date (MM/DD/CCYY)	8
End Date	Last day, based on date of service, that the audit criteria are valid for processing.	Combo Box	Date (MM/DD/CCYY)	8
EPSDT REF	Indicates whether EPSDT referral claims are to be included or excluded from an audit criteria.	Combo Box	Drop Down List Box	0
Financial Payer (Include/Exclude)	Include/Exclude indicator for financial payer. Indicates which financial payer should be included, meaning the audit will set for those financial payers if all other criteria are met, or excluded, meaning the audit would be bypassed for those financial payers.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Financial Payer (Same/Different Indicator)	Indication of whether the specified audit should audit against the current claim financial payer that matches a history claim financial payer, or current claim financial payer that does not match the history claim financial payer (Different), or, current claim financial payer against all other history claim's financial payer regardless of whether they match (Both).	Combo Box	Drop Down List Box	0
GCN	Include/Exclude indicator for GCN. Indicates which GCN should be included, meaning the audit will set for those GCNs if all other criteria are met, or excluded, meaning the audit would be bypassed for those GCNs.	Combo Box	Drop Down List Box	0
GCN Sequence Number	Include/Exclude indicator for GCN Sequence Number. Indicates which GCN Sequence Numbers should be included, meaning the audit will set for those GCN Sequence Numbers if all other criteria are met, or excluded, meaning the audit would be bypassed for those GCN Sequence Numbers.	Combo Box	Drop Down List Box	0
Gender	Indicates which sex (male, female, both) should be included in the audit criteria. Only history claims with the specified gender type will be assessed by the audit.	Combo Box	Drop Down List Box	0
Generic Price	Include/Exclude indicator for generic price. Indicates which generic price indicator(s) should be included, meaning the audit will set for those generic price indicator(s) if all other criteria are met, or excluded, meaning the audit would be bypassed for those generic price indicator(s).	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
HICL	Include/Exclude indicator for HICL. Indicates which HICL(s) should be included, meaning the audit will set for those HICL(s) if all other criteria are met, or excluded, meaning the audit would be bypassed for those HICL(s).	Combo Box	Drop Down List Box	0
Match J Codes	Y/N flag used only with conflict audits that says whether or not the NDC code needs to be linked with a HCPCS code. In most cases, the HCPCS code would be a J code. If the current claim is pharmacy claim, would look for a Procedure Code in history against NDC on current claim. If the current claim is not pharmacy, would look for NDC in history against procedure on current claim.	Combo Box	Drop Down List Box	0
Modifier	Include/Exclude indicator for procedure modifier.	Combo Box	Drop Down List Box	0
Modifier	Indication of whether the same or different Modifier is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
NDC	Include/Exclude indicator for NDC. Indicates which NDC(s) should be included, meaning the audit will set for those NDC(s) if all other criteria are met, or excluded, meaning the audit would be bypassed for those NDC(s).	Combo Box	Drop Down List Box	0
PA Override	Indicates whether having a prior authorization on file will override the audit. If the indicator is set to Yes, and there is PA on file, the audit will be overridden, but if the indicator is set to No, a PA on file will not override the audit.	Combo Box	Drop Down List Box	0
Performing Provider	Indication of whether the same or different Performing Provider is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Performing Provider Location	Indication of whether the same or different Performing Provider Location is to be used in the audit criteria.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Performing Provider Specialty	Indication of whether Performing Provider Specialty is included, excluded, or not in the audit criteria.	Combo Box	Drop Down List Box	0
Performing Provider Type	Indication of whether Performing Provider Type is included, excluded, or not in the audit criteria.	Combo Box	Drop Down List Box	0
Place of Service	Include/Exclude indicator for Place of Service code which indicates the place of service to which this error code is limited.	Combo Box	Drop Down List Box	0
Procedure	Indication of whether the same or different Procedure Code is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Recipient Age	Include/Exclude indicator for recipient age.	Combo Box	Drop Down List Box	0
Recipient Plan	Include/Exclude indicator for Recipient Plan.	Combo Box	Drop Down List Box	0
Referral Override	Specifies criterion for bypassing an audit based on the presence of a referring provider on the claim being audited. Values are 'A' (any), 'P' (PCCM) and space (not considered).	Combo Box	Drop Down List Box	0
Revenue Code	Include/Exclude indicator for revenue code.	Combo Box	Drop Down List Box	0
Service Limit	Indicates whether the audit is reported by EVS when the service limit enforced by the audit has been reached.	Combo Box	Drop Down List Box	0
Therapeutic Class	Include/Exclude indicator for therapeutic class.	Combo Box	Drop Down List Box	0
Tooth Number	Indication of whether the same or different tooth identification number is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Tooth Number	Indicates whether Tooth Number is included.	Combo Box	Drop Down List Box	0
Tooth Quadrant	Indication of whether the same or different Tooth Quadrant is to be used in the audit criteria.	Combo Box	Drop Down List Box	0
Tooth Surface	Indication of whether the same or different tooth surface number is to be used in the audit criteria.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Type of Bill	Include/Exclude indicator for type of bill.	Combo Box	Drop Down List Box	0

6.68.4 Audit Criteria Base-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Audit Type	Combo Box	1	Limitation Parameter information is required for this type of Audit Criteria.	Add Limitation parameter data on 'Audit Parameters' panel
	Combo Box	2	Contra Parameter information is required for this type of Audit Criteria.	Add contra parameter data on 'Audit Parameters' panel
	Combo Box	3	Umbrella Parameter information is required for this type of Audit Criteria.	Add umbrella parameter data on 'Audit Parameters' panel
	Combo Box	4	Step Therapy Group information is required for this type of Audit Criteria.	Add Step Therapy Group information on 'Step Therapy' panel
	Combo Box	5	Audit Step Therapy Level information is required.	Add Step Therapy Level information to the Step Therapy Group.
	Combo Box	6	Audit Type is required.	Select an audit type from the drop down list.
	Combo Box	7	Conflict Parameter information is required for this type of Audit Criteria.	Add Conflict parameter data on 'Audit Parameters' panel
	Combo Box	8	Negative Contra Parameter information is required for this type of Audit Criteria.	Add Negative Contra parameter data on 'Audit Parameters' panel
Effective Date	Field	1	Effective Date[] must be less than or equal to End Date[]	Insert the effective date where the effective date is less than the end date.
	Field	2	Effective Date[] is required.	Enter a date.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Date must be numeric and in MM/DD/CCYY format.
	Field	4	Effective Date[] must be greater than or equal to 1/1/1900.	Date must be more recent than 1/1/1900
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Effective Date must be greater than or equal to 1/1/1900.
End Date	Field	1	Effective Date[] must be less than or equal to End Date[]	Insert the end date where the end date is greater than the effective date.
	Field	2	End Date[] is required.	Enter a date.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Date must be numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 1/1/1900.	Date must be more recent than 1/1/1900
	Field	5	End Date must be less than or equal to 12/31/2299.	End Date must be greater than or equal to 1/1/1900.

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6.68.5 Audit Criteria Base-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.68.6 Audit Criteria Base-Error Disposition Panel Accessibility

6.68.6.1 To Access the Audit Criteria Base-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels display.
4	Click **Audit Criteria**.	Audit Criteria page displays.
5	Click **Audit Criteria Base**.	Audit Criteria Base information panel displays.

6.68.6.2 To Add on the Audit Criteria Base-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Audit Type** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Select **Recipient Plan** from drop down list box.	
6	Select **Claim Type** from drop down list box.	
7	Select **Billing Provider Type** from drop down list box.	
8	Select **Billing Provider Speciality** from drop down list box.	
9	Select **Performing Provider Type** from drop down list box.	
10	Select **Billing Provider Specialty** from drop down list box.	
11	Select **Performing Provider Specialty** from drop down list box.	
12	Select **Recipient Age** from drop down list box.	

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Step	Action	Response
13	Select **Place of Service** from drop down list box.	
14	Select **Modifier** from drop down list box.	
15	Select **Diagnosis** from drop down list box.	
16	Select **Revenue Code** from drop down list box.	
17	Select **Type of Bill** from drop down list box.	
18	Select **NDC** from drop down list box.	
19	Select **Therapeutic Class** from drop down list box.	
20	Select **Generic Price** from drop down list box.	
21	Select **GCN Sequence Number** from drop down list box.	
22	Select **HICL** from drop down list box.	
23	Select **Financial Payer** from drop down list box.	
24	Select **Tooth Number** from drop down list box.	
25	Select **AFHS Class** from drop down list box.	
Same/Indifferent Indicators		
26	Select **Claim** from drop down list box.	
27	Select **Date of Service** from drop down list box.	
28	Select **Financial Payer** from drop down list box.	
29	Select **Billing Provider** from drop down list box.	
30	Select **Performing Provider** from drop down list box.	
31	Select **Procedure** from drop down list box.	
32	Select **Diagnosis** from drop down list box.	
33	Select **Place of Service** from drop down list box.	
34	Select **Tooth Number** from drop down list box.	
35	Select **Tooth Surface** from drop down list box.	

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Step	Action	Response
36	Select **Tooth Quadrant** from drop down list box.	
37	Select **Billing Provider Location** from drop down list box.	
38	Select **Performing Provider Location** from drop down list box.	
39	Select **Modifier** from drop down list box.	
Other Indicators		
40	Select **Gender** from drop down list box.	
41	Select **PA Override** from drop down list box.	
42	Select **Match J Codes** from drop down list box.	
43	Select **Service Limit** from drop down list box.	
44	Select **Referral Override** from drop down list box.	
45	Select **Diagnosis Type** from drop down list box.	
46	Select **EPSDT REF** from drop down list box.	
47	Click **Save**.	Audit Criteria Base-Error Disposition information is saved.

6.68.6.3 To Update on the Audit Criteria Base-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Criteria Base-Error Disposition information is saved.

6.68.6.4 To Delete on the Audit Criteria Base-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.69 Audit Parameters (Conflict)-Error Disposition Panel

6.69.1 Audit Parameters (Conflict)-Error Disposition Panel Narrative

The Audit Parameters (Conflict) panel maintains information about auditing performed for services that contradict services that have already been paid for a recipient , also known as relationship auditing criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (select row from search results)] - [Audit Criteria] - [Audit Parameters (only available if the Audit Type is Conflict)]

6.69.2 Audit Parameters (Conflict)-Error Disposition Panel Layout

6.69.3 Audit Parameters (Conflict)-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a contra-indicated parameter to the audit.	Button	N/A	0
After Units	Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.	Field	Number (Integer)	4
Before / After Code	Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.	Combo Box	Drop Down List Box	0
Before Units	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	Field	Number (Integer)	4
Direction	Indicates whether the audit is a one-way or two-way audit.	Combo Box	Drop Down List Box	0
Time Unit	Indicates whether days, months, or years should be used as the unit of measure for the audit.	Combo Box	Drop Down List Box	0

6.69.4 Audit Parameters (Conflict)-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
After Units	Field	1	Enter a valid value.	Enter a numeric value from 0 to 9999.

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Field	Field Type	Error Code	Error Message	To Correct
Before Units	Field	1	Enter a valid value.	Enter a numeric value from 0 to 9999.
Time Unit	Field	1	Time Unit is Required.	Select a valid Time Unit.

6.69.5 Audit Parameters (Conflict)-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.69.6 Audit Parameters (Conflict)-Error Disposition Panel Accessibility

6.69.6.1 To Access the Audit Parameters (Conflict) -Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Criteria**.	Audit Criteria page displays.
5	Click **Audit Parameters**. Note: Only available if the Audit Type is Conflict.	Audit Parameters (Conflict) information panel displays.

6.69.6.2 To Add on the Audit Parameters (Conflict)-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Time Unit** from drop down list box.	
3	Enter **Before Units**.	
4	Enter **After Units**.	
5	Select **Before/After Code** from drop down list box.	
6	Select **Direction** from drop down list box.	
7	Click **Save**.	Audit Parameters (Conflict)-Error Disposition information is saved.

6.69.6.3 To Update on the Audit Parameters (Conflict)-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Parameters (Conflict) -Error Disposition information is saved.

6.69.6.4 To Delete on the Audit Parameters (Conflict)-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.70 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel

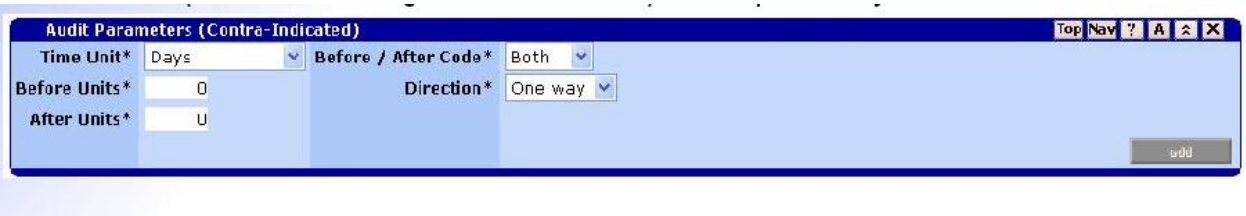
6.70.1 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Narrative

The Audit Parameters (Contra-Indicated-Negative Contra-Indicated) panel contains information about auditing performed for services that contradict services or negative contraindicated services that have already been paid for a recipient. Also known as relationship auditing criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Criteria] - [Audit Parameters (only available if the Audit Type is Contra-Indicated or negative contra-indicated)]

6.70.2 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Layout



6.70.3 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add Contra Parameter data to the audit.	Button	N/A	0
After Units	Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.	Field	Number (Integer)	4
Before / After Code	Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.	Combo Box	Drop Down List Box	0
Before Units	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	Field	Number (Integer)	4
Direction	This indicates whether the audit is a one-way or two-way audit.	Combo Box	Drop Down List Box	0
Time Unit	Indicates whether days, months, or years should be used as the unit of measure for the audit.	Combo Box	Drop Down List Box	0

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6.70.4 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
After Units	Field	1	Enter a valid value.	Enter a numeric value from 0 to 9999.
	Field	2	After Units is required.	Enter a numeric value from 0 to 9999.
	Field	3	After Units must be zero	If 'Before / After Code' is 'Before', 'After Units' must be zero.
Before Units	Field	1	Enter a valid value.	Enter a numeric value from 0 to 9999.
	Field	2	Before Units is required.	Enter a numeric value from 0 to 9999.
	Field	3	Before Units must be zero.	If 'Before / After Code' is 'After', 'Before Units' must be zero.

6.70.5 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Extra Features

Contra and Neg-Contra use the same tables. Claims uses the field in the audit criteria table (cde_error_type) to determine HOW to use the data in the table to execute the audit. The difference between the two is that Contra looks for procedures that SHOULD NOT be billed together and Negative-Contra looks for procedures that SHOULD be billed together.

6.70.6 Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel Accessibility

6.70.6.1 To Access the Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Criteria**.	Audit Criteria page displays.
5	Click **Audit Parameters**. Note: Only available if the Audit Type is Contra-Indicated or negative contra-indicated.	Audit Parameters (Contra-Indicated-Negative Contra-Indicated) information panel displays.

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6.70.6.2 To Add on the Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Time Unit** from drop down list box.	
3	Enter **Before Units**.	
4	Enter **After Units**.	
5	Select **Before/After Code** from drop down list box.	
6	Select **Direction** from drop down list box.	
7	Click **Save**.	Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition information is saved.

6.70.6.3 To Update on the Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Parameters (Contra-Indicated-Negative Contra-Indicated) -Error Disposition information is saved.

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6.70.6.4 To Delete on the Audit Parameters (Contra-Indicated-Negative Contra-Indicated)-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.71 Audit Parameters (Limitation)-Error Disposition Panel

6.71.1 Audit Parameters (Limitation)-Error Disposition Panel Narrative

The Audit Parameters (Limitation) panel contains the limitation audit parameters, including the time span audited, the number of allowed units and/or dollars, and whether the audit is restricted to particular places of service.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Criteria] - [Audit Parameters (only available if the Audit Type is Limit)]

6.71.2 Audit Parameters (Limitation)-Error Disposition Panel Layout

6.71.3 Audit Parameters (Limitation)-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add limit parameter data to Limitation Audit.	Button	N/A	0
Benefit Limit Cat	Identifies the classification of service being tracked/counted.	Combo Box	Drop Down List Box	0
Benefit Limit Cat Sus	Used for Benefit Limit audits to count visits/contacts/encounters.	Combo Box	Drop Down List Box	0
Benefit Limit Key	Identifies if the contact count is by member, both member and provider or by pharmacy.	Combo Box	Drop Down List Box	0
Money Limit	Maximum number of dollars allowed for specified services.	Field	Number (Decimal)	11
Procedure/Revenue/Drug	This code indicates whether the limitation audit limits Procedure Codes, drug or revenue codes.	Combo Box	Drop Down List Box	0
Time Span	Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Time Unit	Indicates whether days, months, or years should be used as a unit of measure for an audit.	Combo Box	Drop Down List Box	0
Unit Type	Indicates whether units, dollars, or both should be used as the unit of measure for audit.	Combo Box	Drop Down List Box	0
Units Limit	Maximum number of units allowed for specified services.	Field	Number (Decimal)	11

6.71.4 Audit Parameters (Limitation)-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Money Limit	Field	1	Enter a valid value.	Enter a valid amount.
	Field	2	Money Limits must be greater than zero.	If Unit Type is 'Both Units/Money', then you must insert a value greater than zero.
	Field	3	Money Limits must be zero.	If the Unit Type is 'Days' or 'Prescription' or 'Units', then you must insert zero in the money limit field.
	Field	5	Money Limits are required.	If Unit Type is "M", then Money Limit is required.
Time Span	Field	2	Enter a valid value	Time Span must be numeric and greater than zero.
	Field	3	Time Span is required.	Enter a valid Time Span.
Time Unit	Field	1	Time Unit is required.	Select a Time Unit from the drop down list.
Unit Type	Field	1	Unit Type is required.	Select a Unit type from the drop down list.
Units Limi	Field	1	Unit Limits must be greater than zero.	If Unit Type is 'Both Units/Money', then you must insert a value greater than zero -If unit type is "P" (prescription) or "U" (units), then you must insert a value greater than zero in Unit limit field.
	Field	2	Enter a valid value.	Unit Limits must be numeric and greater than zero.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Unit Limits are required.	If Unit Type is 'Days', or 'Prescription', or 'Units', then Unit Limit is required.
	Field	6	Unit Limits must be zero.	If Unit Type is 'Money', then you must insert zero in Unit Limit field.

6.71.5 Audit Parameters (Limitation)-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.71.6 Audit Parameters (Limitation)-Error Disposition Panel Accessibility

6.71.6.1 To Access the Audit Parameters (Limitation)-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels display.
4	Click **Audit Criteria**.	Audit Criteria page displays.
5	Click **Audit Parameters**. Note: Only available if the Audit Type is Limit.	Audit Parameters (Limitation) information panel displays.

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6.71.6.2 To Add on the Audit Parameters (Limitation)-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Unit Type** from drop down list box.	
3	Select **Time Unit** from drop down list box.	
4	Enter **Time Span**.	
5	Enter **Units Limit**.	
6	Select **Benefit Limit Cat** from drop down list box.	
7	Select **Procedure/Revenue/Drug** from drop down list box.	
8	Select **Money Limit** from drop down list box.	
9	Select **Benefit Limit Key** from drop down list box.	
10	Select **Benefit Limit Cat SUS** from drop down list box.	
11	Click **Save**.	Audit Parameters (Limitation)-Error Disposition information is saved.

6.71.6.3 To Update on the Audit Parameters (Limitation)-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Parameters (Limitation)-Error Disposition information is saved.

6.71.6.4 To Delete on the Audit Parameters (Limitation)-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.72 Error Disposition-Audit Restriction Page

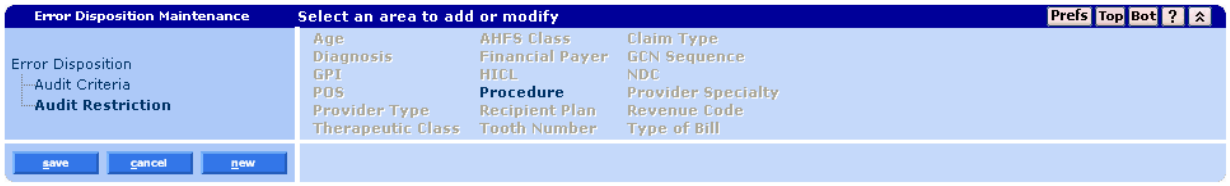
6.72.1 Error Disposition-Audit Restriction Page Narrative

The Error Disposition - Audit Restriction page is used to maintain audit restriction data.

This panel is inquiry only.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction]

6.72.2 Error Disposition-Audit Restriction Page Layout



6.72.3 Error Disposition-Audit Restriction Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Age	Link to the Age panel.	Hyperlink	N/A	0
AHFS Class	Link to the AHFS Class panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel changes.	Button	N/A	0
Claim Type	Link to the Claim Type panel.	Hyperlink	N/A	0
Diagnosis	Link to the Diagnosis panel.	Hyperlink	N/A	0
Financial Payer	Link to the Financial Payer panel.	Hyperlink	N/A	0
GCN Sequence	Link to the GCN Sequence panel.	Hyperlink	N/A	0
GPI	Link to the GPI panel.	Hyperlink	N/A	0
HICL	Link to the HICL panel.	Hyperlink	N/A	0
NDC	Link to the NDC panel.	Hyperlink	N/A	0
New	Allows the user to add information.	Button	N/A	0
POS	Link to the POS panel.	Hyperlink	N/A	0
Procedure	Link to the Procedure panel.	Hyperlink	N/A	0
Provider Specialty	Link to the Provider Specialty panel.	Hyperlink	N/A	0
Provider Type	Link to the Provider Type panel.	Hyperlink	N/A	0
Recipient Plan	Link to the Recipient Plan panel.	Hyperlink	N/A	0
Revenue Code	Link to the Revenue Code panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Save	Allows the user to save changes.	Button	N/A	0
Therapeutic Class	Link to the Therapeutic Class panel.	Hyperlink	N/A	0
Tooth Number	Link to the Tooth Number panel.	Hyperlink	N/A	0
Type of Bill	Link to the Type of Bill panel.	Hyperlink	N/A	0

6.72.4 Error Disposition-Audit Restriction - Procedure Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.72.5 Error Disposition-Audit Restriction - Procedure Page Extra Features

Field	Field Type
No extra features found for this page.	

6.72.6 Error Disposition-Audit Restriction - Procedure Page Accessibility

6.72.6.1 To Access the Error Disposition-Audit Restriction-Procedure Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.

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6.73 Audit Restriction-Age-Error Disposition Panel

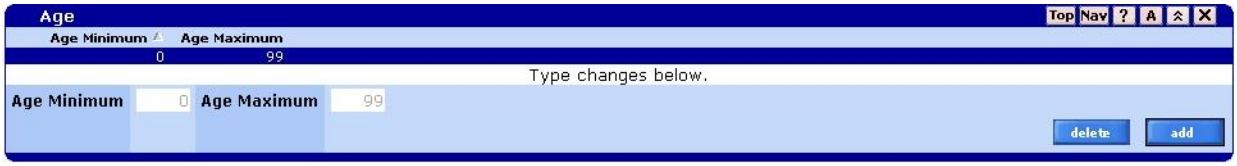
6.73.1 Audit Restriction-Age-Error Disposition Panel Narrative

The Audit Restriction –Age Error Panel is used to look-up age restriction information.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Age (only available if Recipient Age on Audit Criteria Base is 'Include' or 'exclude']

6.73.2 Audit Restriction-Age-Error Disposition Panel Layout



6.73.3 Audit Restriction-Age-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an age range restriction.	Button	N/A	0
Age Maximum	Maximum age in a range that should be included or excluded from audit criteria.	Field	Number (Integer)	4
Age Minimum	Minimum age in a range that should be included or excluded from audit criteria.	Field	Number (Integer)	4
Delete	Allows the user to delete an Age Range Restriction.	Button	N/A	0

6.73.4 Audit Restriction-Age-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Age Maximum	Field	1	Age Maximum must be less than or equal to 999.	Enter an Age Maximum that is less than or equal to 999.
	Field	2	Age Maximum must be greater than or equal to Age Minimum.	Enter an Age Maximum that is greater than or equal to Age Minimum.
	Field	3	Enter a valid value.	Age must be numeric and greater than or equal to zero.
	Field	4	Age range segments can not overlap.	Check the Age against existing records. Range cannot overlap.
Age Minimum	Field	1	Age Minimum must be less than or equal to 999.	Enter an Age Minimum that is less than or equal to 999.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Enter a valid value.	Age must be numeric and greater than or equal to zero.
	Field	3	Age range segments can not overlap.	Check the Age against existing records. Range cannot overlap.

6.73.5 Audit Restriction-Age-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.73.6 Audit Restriction-Age-Error Disposition Panel Accessibility

6.73.6.1 To Access the Audit Restriction-Age-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Age**. Note: Only available if Recipient Age on Audit Criteria Base is 'Include' or 'exclude'.	Audit Restriction-Age-Error Disposition Panel Accessibility information panel displays.

6.73.6.2 To Add on the Audit Restriction-Age-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Age Minimum**.	
3	Enter **Age Maximum**.	
4	Click **Save**.	Audit Restriction-Age-Error Disposition information is saved.

6.73.6.3 To Update on the Audit Restriction-Age-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-Age-Error Disposition

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Step	Action	Response
		information is saved.

6.73.6.4 To Delete on the Audit Restriction-Age-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.74 Audit Restriction-AHFS Class-Error Disposition Panel

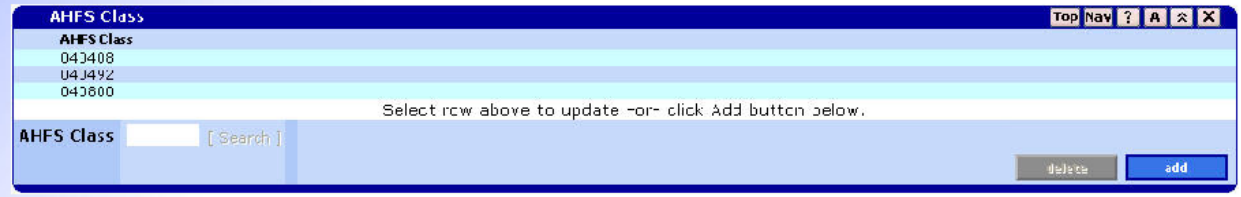
6.74.1 Audit Restriction-AHFS Class-Error Disposition Panel Narrative

The Audit Restriction-AFHS Class panel is used to look-up AHFS Class restriction information.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference - Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [(Expand Error Disposition on left by clicking +)] - [Audit Restriction] - [AHFS Class (only available if AHFS Class on Audit Criteria Base is "Include" or "Exclude"].

6.74.2 Audit Restriction-AHFS Class-Error Disposition Panel Layout



6.74.3 Audit Restriction-AHFS Class-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an AHFS class.	Button	N/A	0
Delete	Allows the user to delete an AHFS class.	Button	N/A	0
AHFS Class	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	6

6.74.4 Audit Restriction-AHFS Class-Error Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AHFS Class	Field	2	AHFS Class contains duplicates.	Enter a unique AHFS Class.
	Field	3	AHFS Class is required.	Enter a valid AHFS Class.

6.74.5 Audit Restriction-AHFS Class-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.74.6 Audit Restriction-AHFS Class-Error Disposition Panel Accessibility

6.74.6.1 To Access the Audit Restriction- AHFS Class -Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **AHFS Class**. Note: Only available if Recipient Age on Audit Criteria Base is 'Include' or 'exclude'.	Audit Restriction-AHFS Class-Error Disposition panel panel displays.

6.74.6.2 To Add on the Audit Restriction- AHFS Class -Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Age Minimum**.	
3	Enter **Age Maximum**.	
4	Click **Save**.	Audit Restriction-Age-Error Disposition information is saved.

6.74.6.3 To Update on the Audit Restriction- AHFS Class -Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-Age-Error Disposition information is saved.

6.74.6.4 To Delete on the Audit Restriction- AHFS Class -Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.75 Audit Restriction-Claim Type-Error Disposition Panel

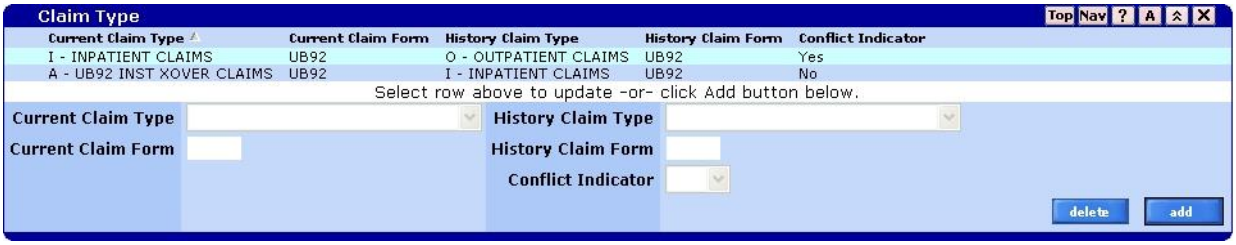
6.75.1 Audit Restriction-Claim Type-Error Disposition Panel Narrative

The Claim Type-Audit Restriction panel is used to maintain the list of claim type restrictions for conflict audits.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Claim Type (only available if Claim Type on Audit Criteria Base is "Include" or "Exclude"]

6.75.2 Audit Restriction-Claim Type-Error Disposition Panel Layout



6.75.3 Audit Restriction-Claim Type-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a claim type restriction to the audit.	Button	N/A	0
Conflict Indicator	Indicates Yes or No. If Yes, causes execution of conflict date overlap logic.	Combo Box	Drop Down List Box	0
Current Claim Form	Claim form for current claim.	Field	Alphanumeric	4
Current Claim Type	Type of claim for the current claim.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete a claim type restriction from the audit	Button	N/A	0
History Claim Form	Claim form for history claim. This field is auto-populated after a History Claim Type has been selected.	Field	Alphanumeric	4
History Claim Type	Type of claim for a past claim.	Combo Box	Drop Down List Box	0

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6.75.4 Audit Restriction-Claim Type-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Current Claim Type	Field	1	Current/History Claim Type - Invalid Combination.	Select a valid Current/History claim type combination.
	Field	2	A duplicate record cannot be saved.	Verify keying. The information entered already exists. Enter a unique Current/History claim type combination.
	Field	3	A valid Current Claim Type is required.	Select a Claim Type from the drop down field.
History Claim Type	Field	1	Current/History Claim Type - Invalid Combination.	Select a valid Current/History claim type combination.
	Field	2	A duplicate record cannot be saved.	Verify keying. The information entered already exists. Enter a unique Current/History claim type combination.
	Field	3	A valid History Claim Type is required.	Select a Claim Type from the drop down field.

6.75.5 Audit Restriction-Claim Type-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.75.6 Audit Restriction-Claim Type-Error Disposition Panel Accessibility

6.75.6.1 To Access the Audit Restriction- Claim Type-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Claim Type**. Note: Only available if Claim Type on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- Claim Type-Error Disposition Panel Accessibility information panel displays.

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6.75.6.2 To Add on the Audit Restriction- Claim Type-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Current Claim Type** from drop down list box.	
3	Enter **Current Claim Form**.	
4	Select **History Claim Type** from drop down list box.	
5	Enter **History Claim form**.	
6	Select **Conflict Indicator** from drop down list box.	
7	Click **Save**.	Audit Restriction-Claim Type-Error Disposition information is saved.

6.75.6.3 To Update on the Audit Restriction- Claim Type-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction- Claim Type-Error Disposition information is saved.

6.75.6.4 To Delete on the Audit Restriction- Claim Type-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.76 Audit Restriction-Diagnosis-Error Disposition Panel

6.76.1 Audit Restriction-Diagnosis-Error Disposition Panel Narrative

The Audit Diagnosis Limitations panel is used to add diagnosis codes to be included in or excluded from the audit criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Diagnosis (only available if Diagnosis on Audit Criteria Base is "Include" or "Exclude"]

6.76.2 Audit Restriction-Diagnosis-Error Disposition Panel Layout

6.76.3 Audit Restriction-Diagnosis-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Diagnosis restriction to the audit.	Button	N/A	0
Delete	Remove a Diagnosis restriction from the audit.	Button	N/A	0
Diagnosis From [Search]	System assigned key that uniquely identifies a specific diagnosis or the first in range of diagnosis that should be included or excluded from audit criteria.	Field	Character	7
Diagnosis To [Search]	System assigned key that identifies that last diagnosis in a range.	Field	Character	7
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.	Combo Box	Character	1

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6.76.4 Audit Restriction-Diagnosis-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis From	Field	1	A valid Diagnosis From is required.	Select a Diagnosis.
	Field	2	Diagnosis From is greater than To Diag.	Select 'Diagnosis From' where the value is less than or equal to the 'Diagnosis To'.
	Field	3	Diagnosis. range segments can not overlap.	Correct overlap condition. Diagnosis From/Diagnosis To combination cannot overlap an existing segment.
	Field	4	ICD Version of From and To code must match with version in ICD Version Dropdown.	ICD Version for Diagnosis From, To and ICD Version Dropdown should be same for a record.
Diagnosis To	Field	1	A valid Diagnosis To is required.	Select a Diagnosis.
	Field	2	From Diagnosis. is greater than To Diagnosis.	Select 'Diagnosis To' where the value is greater than or equal to the 'Diagnosis From'.
	Field	3	ICD Version of From and To code must match with version in ICD Version Dropdown.	ICD Version for Diagnosis From, To and ICD Version Dropdown should be same for a record.
ICD Version	Combo Box	1	ICD Version of From and To code must match with version in ICD Version Dropdown.	ICD Version for Diagnosis From, To and ICD Version Dropdown should be same for a record.

6.76.5 Audit Restriction-Diagnosis-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.76.6 Audit Restriction-Diagnosis-Error Disposition Panel Accessibility

6.76.6.1 To Access the Audit Restriction-Diagnosis-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.

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Step	Action	Response
5	Click **Diagnosis**. Note: Only available if Diagnosis on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- Diagnosis - Disposition Panel Accessibility information panel displays.

6.76.6.2 To Add on the Audit Restriction-Diagnosis-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Diagnosis From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Diagnosis From information is displayed on panel.
4	Select **Diagnosis To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Diagnosis To is displayed on panel.
6	Click **Save**.	Audit Restriction-Diagnosis-Disposition information is saved.

6.76.6.3 To Update on the Audit Restriction-Diagnosis-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-Diagnosis-Disposition information is saved.

6.76.6.4 To Delete on the Audit Restriction-Diagnosis-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.77 Audit Restriction-Financial Payer-Error Disposition Panel

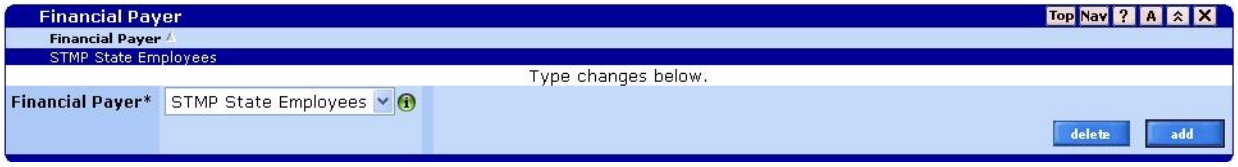
6.77.1 Audit Restriction-Financial Payer-Error Disposition Panel Narrative

The Financial Payer-Audit Restriction panel is a listing of Financial Payers that should be included or excluded from audit criteria.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Financial Payer (only available if Financial Payer on Audit Criteria Base is "Include" or "Exclude"]

6.77.2 Audit Restriction-Financial Payer-Error Disposition Panel Layout



6.77.3 Audit Restriction-Financial Payer-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a financial payer restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete a financial payer restriction from the audit.	Button	N/A	0
Financial Payer	Business code value/description used to identify the payer.	Combo Box	Drop Down List Box	0

6.77.4 Audit Restriction-Financial Payer-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Financial Payer	Field	1	A valid Financial Payer is required.	Select a Financial Payer.
	Field	2	Financial Payer is a duplicate.	Select a unique Financial Payer.

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6.77.5 Audit Restriction-Financial Payer-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.77.6 Audit Restriction-Financial Payer-Error Disposition Panel Accessibility

6.77.6.1 To Access the Audit Restriction-Financial Payer-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Financial Payer**. Note: Only available if Financial Payer on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- Financial Payer - Disposition Panel Accessibility information panel displays.

6.77.6.2 To Add on the Audit Restriction-Financial Payer-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Financial Payer** from drop down list box.	
3	Click **Save**.	Audit Restriction- Financial Payer - Disposition information is saved.

6.77.6.3 To Update on the Audit Restriction-Financial Payer-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction- Financial Payer - Disposition information is saved.

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6.77.6.4 To Delete on the Audit Restriction- Financial Payer-Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.78 Audit Restriction-GCN Sequence-Error Disposition Panel

6.78.1 Audit Restriction-GCN Sequence-Error Disposition Panel Narrative

The GCN Sequence Number-Audit Restriction panel is used to maintain GCN Sequence Number restrictions for an audit.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [GCN Sequence (only available if GCN Sequence Number on Audit Criteria Base is "Include" or "Exclude"]

6.78.2 Audit Restriction-GCN Sequence-Error Disposition Panel Layout

6.78.3 Audit Restriction-GCN Sequence-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a GCN Sequence restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete a GCN Sequence restriction from the audit.	Button	N/A	0
GCN Sequence From [Search]	Beginning GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Hyperlink	N/A	0
GCN Sequence To [Search]	Ending GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Hyperlink	N/A	0

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6.78.4 Audit Restriction-GCN Sequence-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
GCN Sequence From	Hyperlink	1	A valid GCN Sequence From is required.	Select the beginning GCN Sequence.
	Hyperlink	2	GCN Sequence To must be greater than or equal to GCN Sequence From.	Select a different GCN Sequence From.
	Hyperlink	3	GCN Sequence Numbers can not overlap.	Check against data list. Range cannot overlap.
GCN Sequence To	Hyperlink	1	A valid GCN Sequence To is required.	Select ending GCN Sequence.
	Hyperlink	2	GCN Sequence To must be greater than or equal to GCN Sequence From.	Select a different GCN Sequence To.
	Hyperlink	3	GCN Sequence Numbers can not overlap.	Check against data list. Range cannot overlap.

6.78.5 Audit Restriction-GCN Sequence-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.78.6 Audit Restriction-GCN Sequence-Error Disposition Panel Accessibility

6.78.6.1 To Access the Audit Restriction- GCN Sequence-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **GCN Sequence**. Note: Only available if GCN Sequence Number on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- GCN Sequence - Disposition Panel Accessibility information panel displays.

6.78.6.2 To Add on the Audit Restriction-GCN Sequence-Disposition Panel

Step	Action	Response

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Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **GCN Sequence From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	GCN Sequence From information is displayed on panel.
4	Select **GCN Sequence To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	GCN Sequence To is displayed on panel.
6	Click **Save**.	Audit Restriction- GCN Sequence - Disposition information is saved.

6.78.6.3 To Update on the Audit Restriction-GCN Sequence-Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction- GCN Sequence - Disposition information is saved.

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6.78.6.4 To Delete on the Audit Restriction- GCN Sequence-Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.79 Audit Restriction-GPI-Error Disposition Panel

6.79.1 Audit Restriction-GPI-Error Disposition Panel Narrative

The GPI-Audit Restriction panel is used to maintain Generic Price Indicator restrictions for an audit.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [GPI (only available if Generic Price on Audit Criteria Base is "Include" or "Exclude"]

6.79.2 Audit Restriction-GPI-Error Disposition Panel Layout

6.79.3 Audit Restriction-GPI-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a GPI Restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete a GPI Restriction from the audit.	Button	N/A	0
Generic Price Indicator	Generic Price Indicator (GPI) code and the description that is to be included/excluded in the audit.	Combo Box	Drop Down List Box	0

6.79.4 Audit Restriction-GPI-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Generic Price Indicator	Field	1	Generic Price Indicator is required.	Select a Generic Price Indicator.
	Field	2	Generic Price Indicator is a duplicate.	Select unique Generic Price Indicator.

6.79.5 Audit Restriction-GPI-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.79.6 Audit Restriction-GPI-Error Disposition Panel Accessibility

6.79.6.1 To Access the Audit Restriction- GPI-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **GPI**. Note: Only available if Generic Price on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- GPI-Error Disposition Panel Accessibility information panel displays.

6.79.6.2 To Add on the Audit Restriction- GPI-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
5	Select **Generic Price Indicator** from drop down list box.	
6	Click **Save**.	Audit Restriction-GPI-Error Disposition information is saved.

6.79.6.3 To Update on the Audit Restriction- GPI- Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-GPI-Error Disposition information is saved.

6.79.6.4 To Delete on the Audit Restriction- GPI- Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.80 Audit Restriction-HICL-Error Disposition Panel

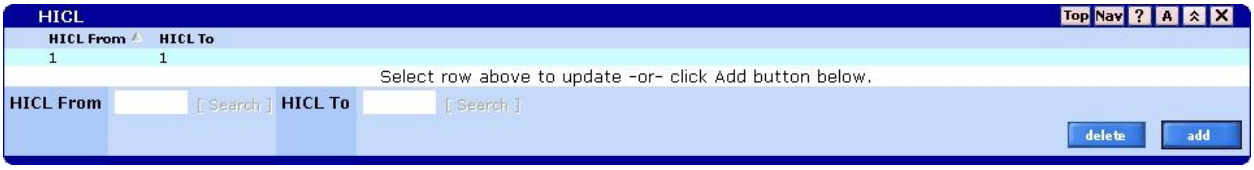
6.80.1 Audit Restriction-HICL-Error Disposition Panel Narrative

The HICL –Audit Restriction panel is used to maintain HICL restrictions for an audit.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [HICL (only available if HICL on Audit Criteria Base is "Include" or "Exclude"]

6.80.2 Audit Restriction-HICL-Error Disposition Panel Layout



6.80.3 Audit Restriction-HICL-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a HICL Restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete a HICL Restriction from the audit.	Button	N/A	0
HICL From	Beginning value for a range of HICL sequence codes to be included/excluded in the audit.	Hyperlink	N/A	0
HICL To	Ending value for a range of HICL sequence codes to be included/excluded in the audit.	Hyperlink	N/A	0

6.80.4 Audit Restriction-HICL-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
HICL From	Hyperlink	1	A valid HICL From is required.	Select a valid HICL From value.
	Hyperlink	2	From HICL value must be less than or equal to HICL To value.	Enter a HICL From value that is less than or equal to HICL To value.
	Hyperlink	3	HICL range segments can not overlap.	Correct overlap condition. The HICL segment cannot overlap.
HICL To	Hyperlink	1	A valid HICL To is required.	Select a valid HICL To value.

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6.80.5 Audit Restriction-HICL-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.80.6 Audit Restriction-HICL-Error Disposition Panel Accessibility

6.80.6.1 To Access the Audit Restriction-HICL-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **HICL**. Note: Only available if HICL on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction- HICL-Error Disposition Panel Accessibility information panel displays.

6.80.6.2 To Add on the Audit Restriction-HICL-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **HICL From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	HICL From information is displayed on panel.
4	Select **HICL To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	HICL To is displayed on panel.
6	Click **Save**.	Audit Restriction- HICL Error Disposition information is saved.

6.80.6.3 To Update on the Audit Restriction-HICL-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Audit Restriction- HICL -Error Disposition information is saved.

6.80.6.4 To Delete on the Audit Restriction-HICL-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.81 Audit Restriction-NDC-Error Disposition Panel

6.81.1 Audit Restriction-NDC-Error Disposition Panel Narrative

The NDC-Audit Restriction panel is used to maintain NDC restrictions for an audit.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [NDC (only available if NDC on Audit Criteria Base is "Include" or "Exclude"]

6.81.2 Audit Restriction-NDC-Error Disposition Panel Layout

6.81.3 Audit Restriction-NDC-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an NDC Restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete an NDC Restriction from the audit.	Button	N/A	0
NDC From [Search]	Beginning NDC for a range of NDCs to be included/excluded in the audit. This code identifies a specific drug.	Hyperlink	N/A	0
NDC To [Search]	Ending NDC for a range of NDCs to be included/excluded in the audit. This code identifies a specific drug.	Hyperlink	N/A	0

6.81.4 Audit Restriction-NDC-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
NDC From	Hyperlink	1	A valid NDC From is required.	Select a valid NDC From value.
	Hyperlink	2	NDC From value must be less than or equal to NDC To value.	Select a NDC From value that is less than or equal to the NDC To value.
	Hyperlink	3	NDC range segments can not overlap.	Verify the NDC range segments to determine where the overlap is occurring and then change the segments to avoid the overlapping of NDC code ranges.
NDC To	Hyperlink	1	A valid NDC To is required.	Select a valid NDC To value.

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6.81.5 Audit Restriction-NDC-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 Audit Restriction-NDC-Error Disposition Panel Accessibility

6.81.6.1 To Access the Audit Restriction-NDC-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **NDC**. Note: Only available if NDC on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction-NDC-Error Disposition Panel Accessibility information panel displays.

6.81.6.2 To Add on the Audit Restriction-NDC-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **NDC From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	NDC From information is displayed on panel.
4	Select **NDC To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	NDC To is displayed on panel.
6	Click **Save**.	Audit Restriction-NDC Error Disposition information is saved.

6.81.6.3 To Update on the Audit Restriction-NDC-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-NDC-Error Disposition

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Step	Action	Response
		information is saved.

6.81.6.4 To Delete on the Audit Restriction-NDC-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.82 Audit Restriction-Procedure (POS)-Error Disposition Panel

6.82.1 Audit Restriction-Procedure (POS)-Error Disposition Panel Narrative

The Audit Restrictions – POS panel is used to update places of service restrictions which are applicable to the error code. For example, if a limit audit applies only to services provided in the hospital, then the hospital place of service value would be entered, and displayed.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition] [Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [(Expand Error Disposition on left by clicking +)] - [Audit Restriction] - [POS (only available if Place of Service on Audit Criteria Base is "Include" or "Exclude"]

6.82.2 Audit Restriction-Procedure (POS)-Error Disposition Panel Layout

6.82.3 Audit Restriction-Procedure (POS)-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Place of Service Restriction to the limit audit.	Button	N/A	0
Delete	Allows the user to delete a Place of Service restriction from the limit audit.	Button	N/A	0
Description	Text description of the POS code.	Field	Character	50
Place of Service [Search]	Place of Service (POS) code which indicates the place of service to which this error code is limited.	Hyperlink	N/A	0

6.82.4 Audit Restriction-Procedure (POS)-Error Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Place of Service	Hyperlink	1	A valid Place Of Service is required.	Select a valid Place of Service.
		2	Place Of Service code is a duplicate.	Place of Service restriction already exists. Select a unique Place of Service.

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6.82.5 Audit Restriction-Procedure (POS)-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.82.6 Audit Restriction-Procedure (POS)-Error Disposition Panel Accessibiity

6.82.6.1 To Access the Audit Restriction-(POS)-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **POS**. Note: Only available if POS on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction-POS-Error Disposition Panel Accessibility information panel displays.

6.82.6.2 To Add on the Audit Restriction-POS-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **NDC From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	NDC From information is displayed on panel.
4	Select **NDC To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	NDC To is displayed on panel.
6	Click **Save**.	Audit Restriction-(POS) Error Disposition information is saved.

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6.82.6.3 To Update on the Audit Restriction-(POS)-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction-(POS)-Error Disposition information is saved.

6.82.6.4 To Delete on the Audit Restriction-(POS)-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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Audit Restriction-Procedure (Contra)-Error Disposition Panel

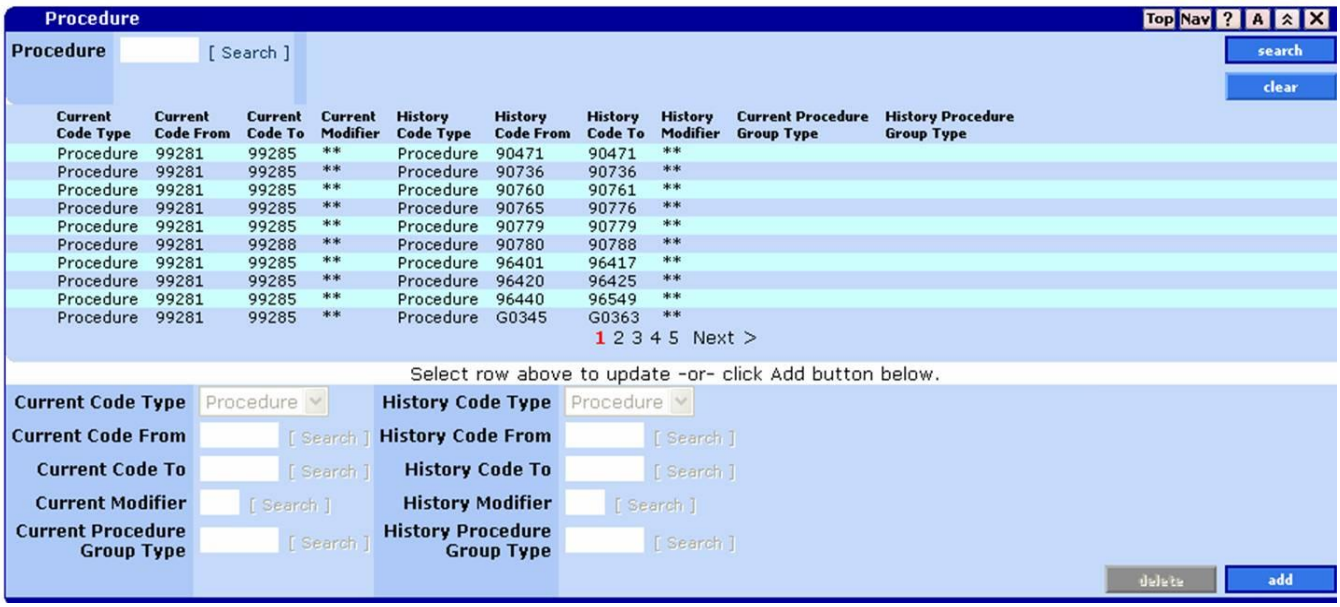
5.75.1 Audit Restriction-Procedure (Contra)-Error Disposition Panel Narrative

The Audit Procedure Restriction - Contra panel is used to maintain Procedure Codes and their modifiers or revenue codes that should be included when performing Contra-Indicated audits.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Procedure (only available if Procedure on Audit Criteria Base is "Include" or "Exclude" and Audit Type is Contra-indicated]

5.75.2 Audit Restriction-Procedure (Contra)-Error Disposition Panel Layout



5.75.3 Audit Restriction-Procedure (Contra)-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Procedure Restriction to the audit.	Button	N/A	0
Clear	Allows user to clear Procedure Code text box.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Current Code From [Search]	Related to the current claim, it is the first Procedure Code/revenue code in a range of Procedure Codes/revenue codes used to define audit criteria.	Hyperlink	N/A	0
Current Code To [Search]	Related to the current claim, it is the last Procedure Code/revenue code in a range of Procedure Codes/revenue codes used to define audit criteria.	Hyperlink	N/A	0
Current Code Type	Service Type - Procedure or Revenue.	Combo Box	Drop Down List Box	0
Current Modifier	The modifier that applies to the current Procedure Code range. Only valid if added with a Procedure Code range.	Field	Character	2
Delete	Remove a procedure Restriction from the audit.	Button	N/A	0
History Code From [Search]	Related to the claim in history, it is the first Procedure Code/revenue code in a range of Procedure Codes/revenue codes used to define audit the criteria.	Hyperlink	N/A	0
History Code To [Search]	Related to the claim in history, it is the last Procedure Code/revenue code in a range of Procedure Codes/revenue codes used to define audit the criteria.	Hyperlink	N/A	0
History Code Type	Service Type - Procedure or Revenue.	Combo Box	Drop Down List Box	0
History Modifier	The modifier that applies to the history Procedure Code range. Only valid if added with a Procedure Code range.	Field	Character	2
Procedure	Allows user to search for procedures from procedure search panel.	Field	Character	6
Search	Allows user to search records on Audit Restriction –Procedure (Contra) Procedure panel.	Button	N/A	0

5.75.4 Audit Restriction-Procedure (Contra)-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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Field	Field Type	Error Code	Error Message	To Correct
Current Code From	Hyperlink	1	A valid Current From Code is required.	Select a procedure or Revenue code.
	Hyperlink	2	From Code is greater than To Code.	Verify Keying. From Code (Revenue or Procedure) should not be greater than To code.
	Hyperlink	3	Code range segments can not overlap.	Verify Keying. Code should not overlap existing segments.
Current Code To	Hyperlink	1	A valid Current To Code is required.	Select a procedure or Revenue code.
	Hyperlink	2	From Code is greater than To Code.	Verify Keying. To Code (Revenue or Procedure) should not be less than From code.
	Hyperlink	3	Code range segments can not overlap.	Verify Keying. Code should not overlap existing segments.
History Code From	Hyperlink	1	A valid History From Code is required.	Select a Procedure or Revenue code.
	Hyperlink	2	From Code is greater than To Code.	Verify Keying. From Code (Revenue or Procedure) should not be greater than To code.
History Code To	Hyperlink	1	A valid History To Code is required.	Select a Procedure or Revenue code.
	Hyperlink	2	From Code is greater than To Code.	Verify Keying. To Code (Revenue or Procedure) should not be less than From code.

5.75.5 Audit Restriction-Procedure (Contra)-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

5.75.6 Audit Restriction-Procedure (Contra) Error Disposition Panel Accessibility

5.75.6.1 To Access the Audit Restriction (Contra) Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.

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Step	Action	Response
5	Click **Procedure**. Note: Only available if Procedure on Audit Criteria Base is "Include" or "Exclude" and Audit Type is Contra-indicated.	Audit Restriction (Contra) Error Disposition Panel Accessibility information panel displays.

5.75.6.2 To Add on the Audit Restriction (Contra) Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Current Code Type** from the drop down list box.	
3	Select **Current Code From** by clicking [Search] button.	
4	Enter search criteria. User may also select a row from the list of search results.	Current Code From is displayed on panel.
5	Select **Current Code To** by clicking [Search] button.	
6	Enter search criteria. User may also select a row from the list of search results.	Current Code To is displayed on panel.
7	Select **Current Modifier** by clicking [Search] button.	
8	Enter search criteria. User may also select a row from the list of search results.	Current Modifier is displayed on panel.
9	Select **History Code Type** from drop down list box.	
10	Select **History Code From** by clicking [Search] button.	
11	Enter search criteria. User may also select a row from the list of search results.	History Code From is displayed on panel.
12	Select **History Code To** by clicking [Search] button.	
13	Enter search criteria. User may also select a row from the list of search results.	History Code To is displayed on panel.
14	Select **History Modifier** by clicking [Search] button.	
15	Enter search criteria. User may also select a row from the list of	History Modifier is displayed on panel.

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Step	Action	Response
	search results.	
16	Click **Save**.	Audit Restriction (Contra) Error Disposition information is saved.

5.75.6.3 To Update on the Audit Restriction (Contra) Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction (Contra)Error Disposition information is saved.

5.75.6.4 To Delete on the Audit Restriction (Contra) Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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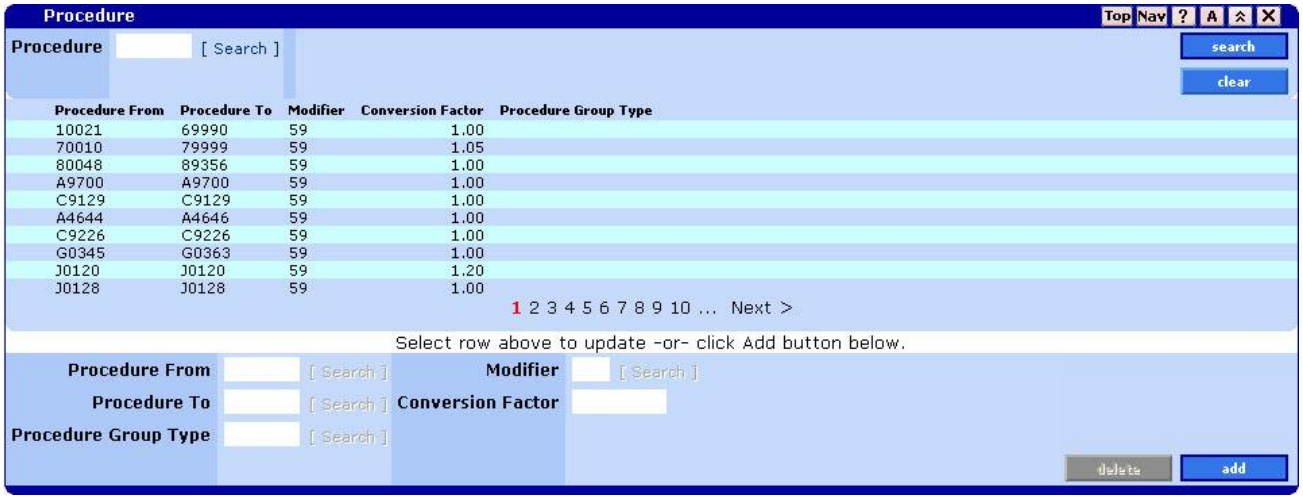
5.76 Audit Restriction-Procedure-Error Disposition Panel

5.76.1 Audit Restriction-Procedure-Error Disposition Panel Narrative

The Audit Restrictions - Procedure panel is used to maintain Procedure Codes to be included in the audit criteria. This panel is for all audits except Contra Audits. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Procedure (only available if Procedure on Audit Criteria Base is "Include" or "Exclude"]

5.76.2 Audit Restriction-Procedure-Error Disposition Panel Layout



5.76.3 Audit Restriction-Procedure-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new procedure restriction to the audit.	Button	N/A	0
Clear	Allows user to clear procedure text box.	Button	N/A	0
Conversion Factor	Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.	Field	Number (Decimal)	5
Delete	Allows the user to delete a procedure restriction from the audit.	Button	N/A	0
Modifier [Search]	Further specifies what type of Procedure Codes should be included in an audit. This code applies to both the beginning and ending procedures in the range.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Procedure From [Search]	First Procedure Code in a range of codes to be included/excluded in the audit.	Hyperlink	N/A	0
Procedure Group Type	Unique system assigned key for the Procedure Group. Represents a collection of Procedures.	Field	Number (Integer)	9
Procedure To [Search]	Last Procedure Code in a range of codes to be included/excluded in the audit.	Hyperlink	N/A	0
Procedure [Search]	List of procedure codes.	Field	Character	6
Search	Allows user to search records from the panel.	Button	N/A	0

5.76.4 Audit Restriction-Procedure-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Conversion Factor	Field	0	Conversion Factor must be greater than or equal to 0.00.	Enter a valid Conversion Factor value.
	Field	1	Conversion Factor must be less than or equal to 999.99.	Enter a valid Conversion Factor value.
	Field	2	Conversion Factor is required.	Enter a valid Conversion Factor value.
Modifier	Hyperlink	1	A valid Modifier is required.	Select a modifier.
Procedure From	Hyperlink	1	Procedure From is greater than To Procedure.	Procedure To code should be greater than or equal to Procedure From code.
	Hyperlink	2	A valid Procedure From is required.	Select a Procedure From.
	Hyperlink	3	Procedure range segments can not overlap.	Procedure code ranges cannot overlap. Please re-key.
Procedure To	Hyperlink	1	Procedure From is greater than Procedure To.	Procedure To should be greater than or equal to Procedure From.
	Hyperlink	2	A valid Procedure To is required.	Select a Procedure To.
	Hyperlink	3	Procedure Range segments can not overlap.	Procedure cCde ranges cannot overlap. Please re-key.

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5.76.5 Audit Restriction-Procedure-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

5.76.6 Audit Restriction-Procedure-Error Disposition Panel Accessibility

5.76.6.1 To Access the Audit Restriction Procedure-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Procedure**. Note: Only available if Procedure on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Procedure-Error Disposition Panel Accessibility information panel displays.

5.76.6.2 To Add on the Audit Restriction Procedure-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Provider From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Provider From is displayed on panel.
4	Select **Provider To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Provider To is displayed on panel.
6	Select **Modifier** by clicking [Search] button.	
7	Enter search criteria. User may also select a row from the list of search results.	Modifier is displayed on panel.
8	Enter **Conversion Factor**.	
9	Click **Save**.	Audit Restriction Procedure-Error Disposition information is saved.

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5.76.6.3 To Update on the Audit Restriction Procedure-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Procedure-Error Disposition information is saved.

5.76.6.4 To Delete on the Audit Restriction Procedure-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.83 Audit Restriction-Provider Specialty-Error Disposition Panel

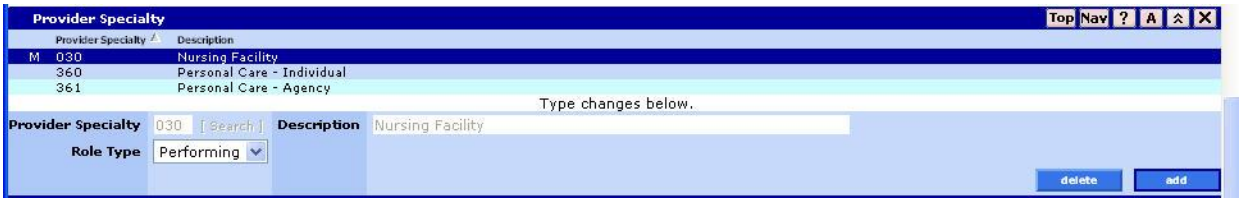
6.83.1 Audit Restriction-Provider Specialty-Error Disposition Panel Narrative

The Audit Provider Specialty Restrictions panel is used to add provider specialties to be included in or excluded from the audit criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Provider Specialty (only available if Provider Specialty on Audit Criteria Base is "Include" or "Exclude"]

6.83.2 Audit Restriction-Provider Specialty-Error Disposition Panel Layout



6.83.3 Audit Restriction-Provider Specialty-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Provider Specialty Restriction to the audit.	Button	N/A	0
Delete	Remove a Provider Specialty Restriction from the audit.	Button	N/A	0
Description	Read Only description of the provider specialty included/excluded in the audit.	Field	Character	50
Role Type	Indicate the role of provider specialty. Allowed values are space, P (Performing), B (Billing) and A (All).	Combo Box	Drop Down List Box	0
Provider Specialty [Search]	Provider Specialty Code to be included/excluded in the audit.	Hyperlink	N/A	0

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6.83.4 Audit Restriction-Provider Specialty-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Provider Specialty [Search]	Hyperlink	1	A valid Provider Specialty is required.	Select a unique provider specialty.
	Hyperlink	2	Provider Specialty is a duplicate.	Restriction for this Provider Specialty already exists. Select a unique provider specialty.
Role Type	Field	3	Role Type is required.	Select a Role Type from the list.

6.83.5 Audit Restriction-Provider Specialty-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.83.6 Audit Restriction-Provider Specialty-Error Disposition Panel Accessibility

6.83.6.1 To Access the Audit Restriction Provider Specialty-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Provider Specialty**. Note: Only available if Provider Specialty on Audit Criteria Base is "Include" or "Exclude"	Audit Restriction Provider Specialty-Error Disposition panel displays.

6.83.6.2 To Add on the Audit Restriction Provider Specialty-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Provider Specialty** by clicking [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Provider Specialty is displayed on panel.

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Step	Action	Response
4	Select **Role Type** from the drop down list box.	
5	Enter **Description**.	
6	Click **Save**.	Audit Restriction Provider Specialty-Error Disposition information is saved.

6.83.6.3 To Update on the Audit Restriction Provider Specialty-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Provider Specialty-Error Disposition information is saved.

6.83.6.4 To Delete on the Audit Restriction Provider Specialty-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.84 Audit Restriction-Provider Type-Error Disposition Panel

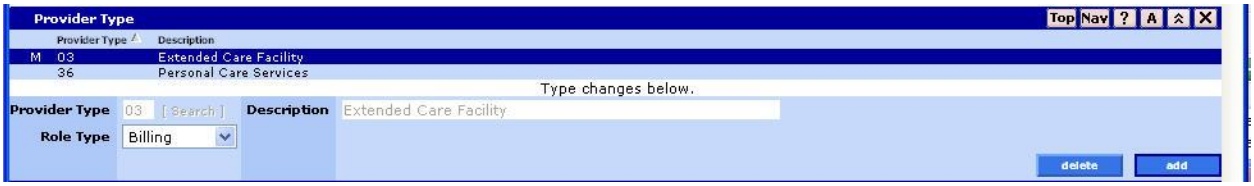
6.84.1 Audit Restriction-Provider Type-Error Disposition Panel Narrative

The Audit Provider Type Restrictions panel is used to add provider types to be included in or excluded from the audit criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Provider Type (only available if Provider Type on Audit Criteria Base is "Include" or "Exclude")]

6.84.2 Audit Restriction-Provider Type-Error Disposition Panel Layout



6.84.3 Audit Restriction-Provider Type-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add new Provider Type Restriction to the audit.	Button	N/A	0
Delete	Remove a Provider Type Restriction from the audit.	Button	N/A	0
Description	Read Only description of the provider type included/excluded in the audit.	Field	Character	50
Role Type	Indicate the role of provider type. Allowed values are space, P (Performing), B (Billing) and A (All).	Combo Box	Drop Down List Box	0
Provider Type[Search]	Provider type to be included/excluded in the audit.	Hyperlink	N/A	0

6.84.4 Audit Restriction-Provider Type-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Provider Type	Hyperlink	1	A valid Provider Type Code is required.	Select a valid provider type.
	Hyperlink	2	Provider Type is a duplicate.	Selected provider type is already restricted. Make sure that the provider type is unique.
Role Type	Field	3	Role Type is required.	Select a Role Type from the list.

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6.84.5 Audit Restriction-Provider Type-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.84.6 Audit Restriction-Provider Type-Error Disposition Panel Accessibility

6.84.6.1 To Access the Audit Restriction Provider Type-Error Disposition Panel Accessibility

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Provider Type**. Note: Only available if Provider Type on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Provider Type-Error Disposition panel displays.

6.84.6.2 To Add on the Audit Restriction Provider Type-Error Disposition Panel Accessibility

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Provider Type** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Provider Type is displayed on panel.
4	Select **Role Type** from the drop down list box.	
5	Enter **Description**.	
6	Click **Save**.	Audit Restriction Provider Type-Error Disposition information is saved.

6.84.6.3 To Update on the Audit Restriction Provider Type-Error Disposition Panel Accessibility

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Provider Type-Error Disposition information is saved.

6.84.6.4 To Delete on the Audit Restriction Provider Type-Error Disposition Panel Accessibility

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.85 Audit Restriction-Recipient Plan-Error Disposition Panel

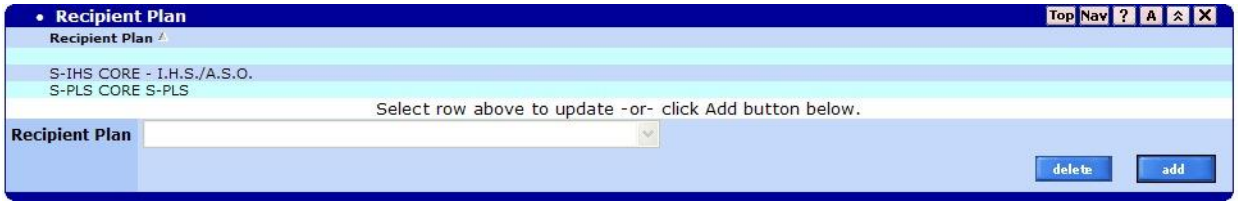
6.85.1 Audit Restriction-Recipient Plan-Error Disposition Panel Narrative

The Audit Recipient Plan Restrictions panel is used to identify which coverage programs are to be included in or excluded from the audit criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] – [Audit Restriction] - [Recipient Plan (only available if Recipient Plan on Audit Criteria Base is "Include" or "Exclude"]

6.85.2 Audit Restriction-Recipient Plan-Error Disposition Panel Layout



6.85.3 Audit Restriction-Recipient Plan-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Recipient Plan Restriction to the audit.	Button	N/A	0
Delete	Allows the user to delete a Recipient Plan Restriction from the audit.	Button	N/A	0
Recipient Plan	Recipient plan that is to be included/excluded in the audit.	Combo Box	Drop Down List Box	0

6.85.4 Audit Restriction-Recipient Plan-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Recipient Plan	Field	1	Duplicate Recipient Plan found. Recipient Plan is a duplicate.	Select a unique Recipient Plan
	Field	2	A valid Recipient Plan is required.	Select a Recipient Plan from the drop down list.

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6.85.5 Audit Restriction-Recipient Plan-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.85.6 Audit Restriction-Recipient Plan-Error Disposition Panel Accessibility

6.85.6.1 To Access the Audit Restriction Recipient Plan-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Recipient Plan**. Note: Only available if Recipient Plan on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Recipient Plan-Error Disposition panel displays.

6.85.6.2 To Add on the Audit Restriction Recipient Plan-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Recipient Plan** from the drop down list box.	
3	Click **Save**.	Audit Restriction Recipient Plan-Error Disposition information is saved.

6.85.6.3 To Update on the Audit Restriction-Recipient Plan-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Recipient Plan-Error Disposition information is saved.

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6.85.6.4 To Delete on the Audit Restriction Recipient Plan-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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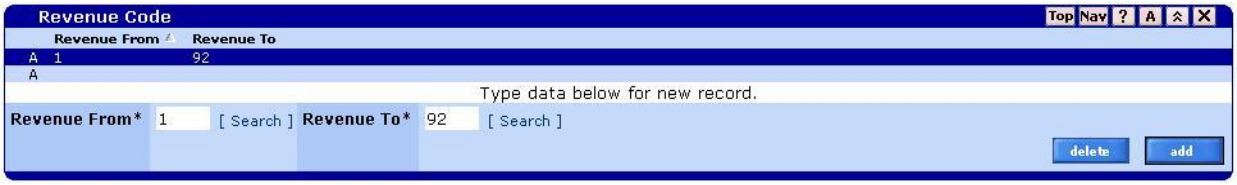
6.86 Audit Restriction-Revenue Code-Error Disposition Panel

6.86.1 Audit Restriction-Revenue Code-Error Disposition Panel Narrative

The Revenue Code-Audit Restriction panel is used to add revenue codes that are included in or excluded from audit criteria. Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Revenue Code (only available if Revenue Code on Audit Criteria Base is "Include" or "Exclude"]

6.86.2 Audit Restriction-Revenue Code-Error Disposition Panel Layout



6.86.3 Audit Restriction-Revenue Code-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Revenue Code Restriction to the audit.	Button	N/A	0
Delete	Remove a Revenue Code Restriction from the audit.	Button	N/A	0
Revenue From [Search]	The first revenue code in a range of revenue codes included/excluded in the auditing criteria.	Hyperlink	N/A	0
Revenue To [Search]	The last revenue code in a range of revenue codes included/excluded in the auditing criteria.	Hyperlink	N/A	0

6.86.4 Audit Restriction-Revenue Code-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Revenue From	Hyperlink	1	A valid Revenue From is required.	Select a Revenue Code.
	Hyperlink	3	Revenue range segments can not overlap.	Verify against list. Revenue code ranges can not overlap. Correct overlapping ranges.
	Hyperlink	8181	Revenue From is greater than Revenue To.	Revenue From must be less than Revenue To.
Revenue To	Hyperlink	1	A valid Revenue To is required.	Revenue To must be less than Revenue From.

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	Hyperlink	3	Revenue range segments can not overlap.	Verify against list. Revenue code ranges can not overlap. Correct overlapping ranges.
	Hyperlink	8181	Revenue From is greater than Revenue To.	Revenue To must be greater than or equal to Revenue From.

6.86.5 Audit Restriction-Revenue Code-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.86.6 Audit Restriction-Revenue Code-Error Disposition Panel Accessibility

6.86.6.1 To Access the Audit Restriction Revenue Code-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Revenue Code**. Note: Only available if Revenue Code on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Revenue Code-Error Disposition panel displays.

6.86.6.2 To Add on the Audit Restriction Revenue Code-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Revenue From** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Revenue From is displayed on panel.
4	Select **Revenue To** by clicking on [Search].	
5	Enter search criteria. User may also select a row from the list of search results.	Revenue To is displayed on panel.
6	Click **Save**.	Audit Restriction Revenue Code-Error Disposition

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Step	Action	Response
		information is saved.

6.86.6.3 To Update on the Audit Restriction-Revenue Code-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Revenue Code-Error Disposition information is saved.

6.86.6.4 To Delete on the Audit Restriction Revenue Code-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.87 Audit Restriction-Therapeutic Class-Error Disposition Panel

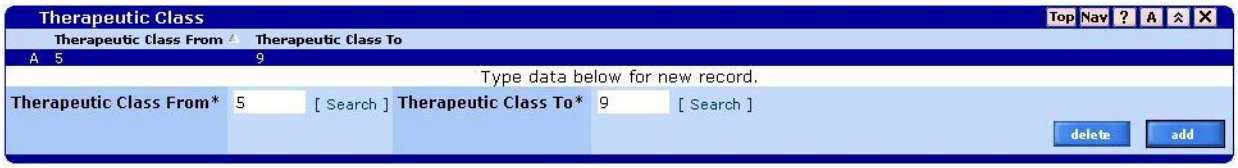
6.87.1 Audit Restriction-Therapeutic Class-Error Disposition Panel Narrative

The Therapeutic Class-Audit Restriction panel lists a range of Specific Therapeutic Classes that should be included or excluded in audit criteria for limitation and umbrella audits.

Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Therapeutic Class (only available if Therapeutic Class on Audit Criteria Base is "Include" or "Exclude"]

6.87.2 Audit Restriction-Therapeutic Class-Error Disposition Panel Layout



6.87.3 Audit Restriction-Therapeutic Class-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Therapeutic Class Restriction to the audit.	Button	N/A	0
Delete	Remove a Therapeutic Class Restriction from the audit.	Button	N/A	0
Therapeutic Class From [Search]	The start value of Therapeutic Class for a range of therapeutic classes to be included/excluded in the audit.	Hyperlink	N/A	0
Therapeutic Class To [Search]	The end value of Therapeutic Class for a range of therapeutic classes to be included/excluded in the audit.	Hyperlink	N/A	0

6.87.4 Audit Restriction-Therapeutic Class-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Therapeutic Class From [Search]	Hyperlink	1	A valid Therapeutic Class From is required.	Select a valid Therapeutic Class From value.
	Hyperlink	2	Therapeutic Class From must be less than or equal to Therapeutic Class To.	Enter a Therapeutic Class From value that is less than the Therapeutic Class To value.

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Field	Field Type	Error Code	Error Message	To Correct
	Hyperlink	3	Therapeutic Class range segments can not overlap.	Enter a Therapeutic Class range that does not overlap an existing Therapeutic Class Range Restriction.
Therapeutic Class To [Search]	Hyperlink	1	A valid Therapeutic Class To is required.	Select a valid Therapeutic Class To value.
	Hyperlink	2	Therapeutic Class From must be less than or equal to Therapeutic Class To.	Enter a Therapeutic Class From value that is less than the Therapeutic Class To value.
	Hyperlink	3	Therapeutic Class range segments can not overlap.	Enter a Therapeutic Class range that does not overlap an existing Therapeutic Class range restriction.

6.87.5 Audit Restriction-Therapeutic Class-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.87.6 Audit Restriction-Therapeutic Class-Error Disposition Panel Accessibility

6.87.6.1 To Access the Audit Restriction Therapeutic Class-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Therapeutic Class**. Note: Only available if Therapeutic Class on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Therapeutic Class-Error Disposition panel displays.

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6.87.6.2 To Add on the Audit Restriction Therapeutic Class-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Therapeutic Class From** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Therapeutic Class From is displayed on panel.
4	Select **Therapeutic Class To** by clicking on [Search].	
5	Enter search criteria. User may also select a row from the list of search results.	Therapeutic Class To is displayed on panel.
6	Click **Save**.	Audit Restriction Therapeutic Class-Error Disposition information is saved.

6.87.6.3 To Update on the Audit Restriction- Therapeutic Class-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Therapeutic Class-Error Disposition information is saved.

6.87.6.4 To Delete on the Audit Restriction Therapeutic Class-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.88 Audit Restriction-Tooth Number-Error Disposition Panel

6.88.1 Audit Restriction-Tooth Number-Error Disposition Panel Narrative

The Audit Tooth Number Restrictions panel is used to add Tooth Number to be included in or excluded from the audit criteria.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [Audit Restriction] - [Tooth Number (only available if Tooth Number on Audit Criteria Base is "Include" or "Exclude"]

6.88.2 Audit Restriction-Tooth Number-Error Disposition Panel Layout

6.88.3 Audit Restriction-Tooth Number-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Tooth Number Restriction to the audit.	Button	N/A	0
Delete	Remove a Tooth Number Restriction from the audit.	Button	N/A	0
Description	Read Only description of the provider specialty included/excluded in the audit.	Field	Character	0
Tooth Number [Search]	Tooth Number Code to be included/excluded in the audit.	Hyperlink	N/A	0

6.88.4 Audit Restriction-Tooth Number-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.88.5 Audit Restriction-Tooth Number-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.88.6 Audit Restriction-Tooth Number-Error Disposition Panel Accessibility

6.88.6.1 To Access the Audit Restriction Tooth Number-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Tooth Number**. Note: Only available if Tooth Number on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Tooth Number-Error Disposition panel displays.

6.88.6.2 To Add on the Audit Restriction Tooth Number-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Tooth Number** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Tooth Number is displayed on panel.
4	Enter **Description**.	
5	Click **Save**.	Audit Restriction Tooth Number-Error Disposition

6.88.6.3 To Update on the Audit Restriction- Tooth Number-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Tooth Number Error Disposition information is saved.

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6.88.6.4 To Delete on the Audit Restriction Tooth Number-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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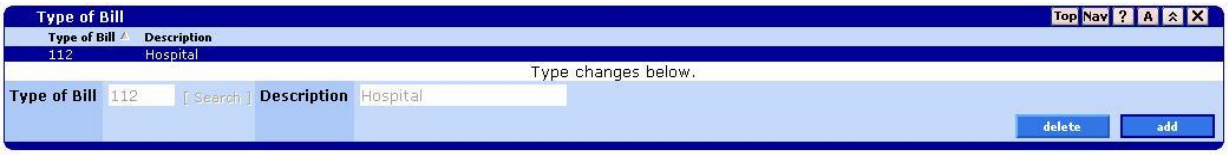
6.89 Audit Restriction-Type of Bill-Error Disposition Panel

6.89.1 Audit Restriction-Type of Bill-Error Disposition Panel Narrative

The Type of Bill-Audit Restriction panel is used to maintain type of bill restrictions for an audit. Only users with authorized access are allowed to perform maintenance tasks.

Navigation Path: [Reference - Error Disposition Search] - [(Add button) OR (click on 'search', select row from search results)] - [Error Disposition Maintenance] - [(Expand Error Disposition on left by clicking +)] - [Audit Restriction] - [Type of Bill (only available if Type of Bill on Audit Criteria Base is "Include" or "Exclude"]

6.89.2 Audit Restriction-Type of Bill-Error Disposition Panel Layout



6.89.3 Audit Restriction-Type of Bill-Error Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new Type of Bill Restriction to the audit.	Button	N/A	0
Delete	Remove a Type of Bill Restriction from the audit.	Button	N/A	0
Description	Read Only Description of Type of Bill.	Field	Character	20
Type of Bill [Search]	Code that identifies a particular bill type, to be included/excluded in the audit.	Hyperlink	N/A	0

6.89.4 Audit Restriction-Type of Bill-Error Disposition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Type of Bill [Search]	Hyperlink	1	A valid Type Of Bill is required.	Select a Type of Bill.
	Hyperlink	2	Type of Bill Code is a duplicate.	Type of Bill Restriction already exists. Select a unique Type of Bill Code.

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6.89.5 Audit Restriction-Type of Bill-Error Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.89.6 Audit Restriction-Type of Bill-Error Disposition Panel Accessibility

6.89.6.1 To Access the Audit Restriction Type of Bill-Error Disposition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Error Disposition**.	Reference Error Disposition Search panel displays.
3	Click **Add**.	Reference Error Disposition Information and Maintenance panels displays.
4	Click **Audit Restriction**.	Audit Restriction page displays.
5	Click **Type of Bill**. Note: Only available if Type of Bill on Audit Criteria Base is "Include" or "Exclude".	Audit Restriction Type of Bill-Error Disposition panel displays.

6.89.6.2 To Add on the Audit Restriction Type of Bill-Error Disposition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Type of Bill** by clicking on [Search].	
3	Enter search criteria. User may also select a row from the list of search results.	Type of Bill is displayed on panel.
4	Enter **Description**.	
5	Click **Save**.	Audit Restriction Type of Bill-Error Disposition information is saved.

6.89.6.3 To Update on the Audit Restriction-Type of Bill-Error Disposition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Restriction Type of Bill-Error Disposition information is saved.

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6.89.6.4 To Delete on the Audit Restriction Type of Bill-Error Disposition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.90 Reference Modifier Search-Modifier Panel

6.90.1 Reference Modifier Search-Modifier Panel Narrative

The Reference Modifier Search panel allows the user to search for a specific Modifier code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Modifier] - [search button]

6.90.2 Reference Modifier Search-Modifier Panel Layout

6.90.3 Reference Modifier Search-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Opens all necessary panels to allow the user to enter data and create a new Procedure Modifier in Interchange.	Button	N/A	0
Clear	Clears the search criteria fields so user may key-in new criteria.	Button	N/A	0
Description	Short text that describes the modifier, used as search criteria in the search.	Field	Character	40
Match Criteria	Allows matching based on whether the description begins with or contains the requested characters.	Combo Box	Radio Button	0
Modifier	A code used to identify a procedure modifier (condition requiring medical attention), used as search criteria in the search.	Field	Character	2
Records	Indicates the number of records to be displayed in search results.	Combo Box	Drop Down List Box	0
Search	Initiates 'search' for a Modifier matching the search criteria keyed-in.	Button	N/A	0
Sounds-Like	If the box is checked, phonetic search is performed and if the check box is unchecked word search is performed.	Combo Box	Check Box	0
Type	Allows searching on the short or the long description.	Combo Box	Radio Button	0

6.90.4 Reference Modifier Search-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct

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Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found.	No modifier matching the 'Description' keyed-in was found. Verify input.
Modifier	Field	1	No rows found.	No modifier matching the 'Modifier' code keyed-in was found. Verify Input.

6.90.5 Reference Modifier Search-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.90.6 Reference Modifier Search-Modifier Panel Accessibility

6.90.6.1 To Access the Modifier Search-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.

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6.91 Reference Modifier Search Results-Modifier Panel

6.91.1 Reference Modifier Search Results-Modifier Panel Narrative

The Reference Modifier Search Results panel displays modifier records using the criteria from the search panel.

This panel is display only.

Navigation Path: [Reference] - [Modifier (Search)]- (click on [search] button)

6.91.2 Reference Modifier Search Results-Modifier Panel Layout

Search Results

Modifier	Type	Long Description	Effective Date	End Date
54	Processing	SURGICAL CARE ONLY (SURGERY).	01/01/1990	12/31/2299
58	Processing	STAGED OR RELATED PROCEDURE BY THE SAME PHYSICIAN DURING THE POSTOPERA	01/01/1990	12/31/2299
59	Informational	SERVICE	01/01/1997	12/31/2299
EJ	Informational	SUBSEQUENT CLAIM FOR EPOETIN ALPHA (EPO) INJECTION CLAIMS ONLY	01/01/1990	12/31/2299
Q6	Informational	SERVICES FURNISHED BY A LOCUM TENENS PHYSICIAN	01/01/1990	12/31/2299
QC	Informational	SINGLE CHANNEL CARDIAC MONITORING	01/01/1990	12/31/2299
I	Informational	SITE OF TRANSFER (E.G. AIRPORT OR HELICOPTER PAD	01/01/1964	12/31/2299
S	Informational	SCENE OF ACCIDENT OR ACUTE EVENT	01/01/1964	12/31/2299
QU	Informational	SERVICES PROVIDED IN URBAN HMSA	01/01/1990	12/31/2299
WS	Informational	SAME BATTERY OF TESTS PERFORMED AT DIFFERENT TIMES ON THE SAME DAY	01/01/1990	12/31/2299
GO	Informational	SERVICES DELIVERED UNDER AN OUTPATIENT OCCUPATIONAL THERAPY PLAN OF CA	01/01/1999	12/31/2299
GN	Informational	SERVICES DELIVERED UNDER AN OUTPATIENT SPEECH LANGUAGE PATHOLOGY PLAN	01/01/1999	12/31/2299
SF	Informational	SECOND OPINION ORDERED BY A PROFESSIONAL REVIEW ORGANIZATION(PRO) PER	01/01/1964	12/31/2299
KQ	Informational	SECOND OR SUBSEQUENT DRUG OF A MULTIPLE DRUG UNIT DOSE FORMULATION	01/01/1998	12/31/2299
Y2	Informational	SECOND DIGIT OF LEFT FOOT/HAND	01/01/1990	12/31/2299
Y0	Informational	SERVICES RENDERED IN OUTPATIENT OBSERVATION UNIT	01/01/1990	12/31/2299
YC	Informational	SPECIFIC POLICY CRITERIA HAS BEEN MET	01/01/1990	12/31/2299
X2	Informational	SECOND DIGIT OF RIGHT FOOT/HAND	01/01/1990	12/31/2299
WI	Informational	SHARED INPATIENT MANAGEMENT/ITINERANT SURGERY	01/01/1990	12/31/2299
NI	Informational	SKILLED NURSING FAC/TRANSFER AIRPORT HELI PAD	01/01/1964	12/31/2002

1 2 3 Next >

6.91.3 Reference Modifier Search Results-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Short description of the relevant modifier. This is displayed if "Short" is selected from the "Type" radio buttons	Field	Character	40
Effective Dat	The date the modifier becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date the modifier is no longer valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Long description of the relevant modifier. This is displayed if "Long" is selected from the "Type" radio buttons. For a lengthy description, truncation occurs and only the first 100 characters are displayed.	Field	Alphanumeric	250
Modifier	The modifier code used to describe a procedure.	Field	Character	2
Type	Indicates that usage/type of modifier being referenced.	Field	Character	25

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6.91.4 Reference Modifier Search Results-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.91.5 Reference Modifier Search Results-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.91.6 Reference Modifier Search Results-Modifier Panel Accessibility

6.91.6.1 To Access the Reference Modifier Search Results-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search Criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance and Information panels display.

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6.92 Modifier Mini Search-Modifier Panel

6.92.1 Modifier Mini Search-Modifier Panel Narrative

The Modifier Mini-Search provides the user with the ability to search for a Modifier from the Modifier Information panel.

This panel is inquiry only.

Navigation Path: [Reference] – [Modifier] - [(select row from search results)]

6.92.2 Modifier Mini Search-Modifier Panel Layout

6.92.3 Modifier Mini Search-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Takes the user to main Modifier Search panel so user may key in advanced search criteria (Description, phonetic search etc.).	Button	N/A	0
Clear	Clears the 'Modifier' field so user can key-in new data.	Button	N/A	0
Modifier	The modifier code used to describe a procedure, used as search criteria.	Field	Character	2
Search	Initiates search for a Modifier with the Modifier Code keyed-in.	Button	N/A	0

6.92.4 Modifier Mini Search-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Modifier	Field	1	No rows found.	No Modifier records matching the code keyed in were found. Verify Keying.

6.92.5 Modifier Mini Search-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.92.6 Modifier Mini Search-Modifier Panel Accessibility

6.92.6.1 To Access the Modifier Mini Search-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search Criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Mini Search-Modifier panel displays.

6.92.6.2 To Navigate the Modifier Mini-Search-Modifier Panel

Step	Action	Response
1	Click on hyperlink to select an area to add or modify.	Select panel displays.

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6.93 Modifier Information-Modifier Panel

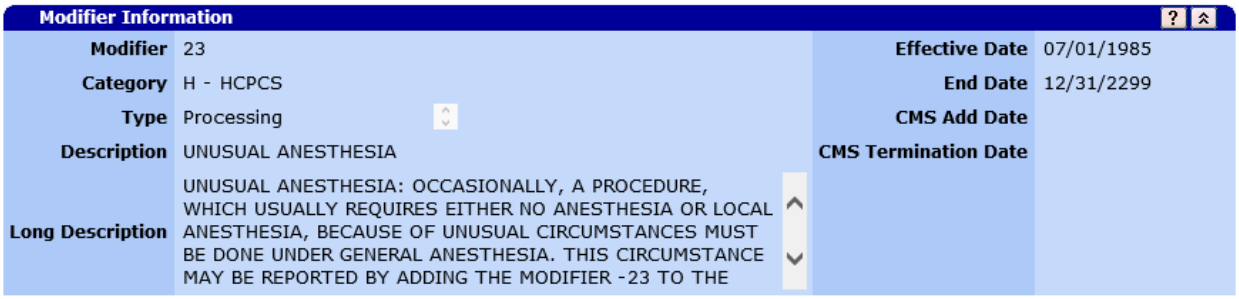
6.93.1 Modifier Information-Modifier Panel Narrative

The Modifier Information panel is used to view Modifier Information. This is a 'read-only' panel with no edit capabilities.

This panel is display only.

Navigation Path: [Reference] – [Modifier] - [Search] - [Click on any row provided on the list]

6.93.2 Modifier Information-Modifier Panel Layout



6.93.3 Modifier Information-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Category	Indicates whether the modifier is a HCPCS or Ambulance Modifier. Valid values are Ambulance and HCPCS.	Field	Character	1
CMS Add Date	Defined by CMS as the date the HCPCS code was added to the CMS common procedure coding system.	Field	Date (MM/DD/CCYY)	8
CMS Termination Date	Defined by CMS as the last date for which a procedure code may be used by providers.	Field	Date (MM/DD/CCYY)	8
Description	A short text that describes the modifier.	Field	Character	40
Effective Date	The date the modifier becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date the modifier is no longer valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Long Description of the Modifier.	Field	Character	250
Modifier	The modifier code used to describe a procedure.	Field	Character	2
Type	Indicates that usage/type of modifier being referenced.	Field	Character	25

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6.93.4 Modifier Information-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.93.5 Modifier Information-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.93.6 Modifier Information-Modifier Panel Accessibility

6.93.6.1 To Access the Modifier Information-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Information panel displays.

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6.94 Modifier Maintenance-Modifier Panel

6.94.1 Modifier Maintenance-Modifier Panel Narrative

Modifier Maintenance-Modifier panel links to the modifier information maintenance panels.

This panel is inquiry only.

Navigation Path: [Reference] – [Modifier] - [(Add button) OR (Search button and select row from search results)] - [Modifier Maintenance]

6.94.2 Modifier Maintenance-Modifier Panel Layout

6.94.3 Modifier Maintenance-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to Base Information panel.	Hyperlink	N/A	0
Cancel	Cancels any/all changes made to any/all panels under this menu.	Button	N/A	0
Group	Link to Group panel.	Hyperlink	N/A	0
Modifier to Modifier Restriction	Link to Modifier to Modifier Restriction panel.	Hyperlink	N/A	0
New	Opens appropriate panels so user may key-in data and add a new Modifier to Interchange.	Button	N/A	0
Note	Link to Note panel.	Hyperlink	N/A	0
Save	Saves any/all changes made to any/all panels under this menu.	Button	N/A	0

6.94.4 Modifier Maintenance-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.94.5 Modifier Maintenance-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.94.6 Modifier Maintenance-Modifier Panel Accessibility

6.94.6.1 To Access the Modifier Maintenance-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance panel displays.

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6.95 Base Information-Modifier Panel

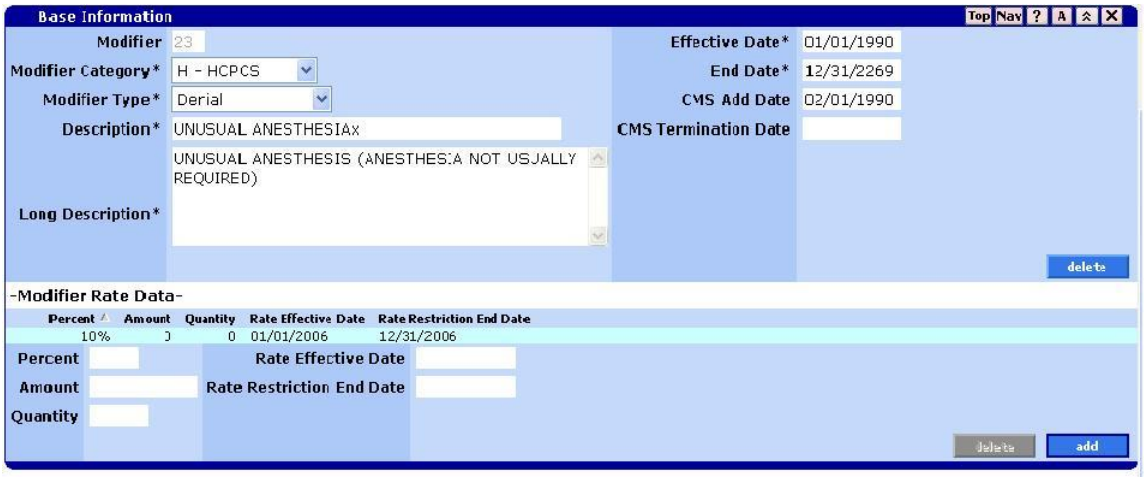
6.95.1 Base Information-Modifier Panel Narrative

The Base Information-Modifier panel is used to view or update modifier information. This panel provides the user with the capabilities of having both a long and short description of the modifier when applicable.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Modifier] - [search] - [(select row from search results)] - [Modifier-Maintenance] - [Base Information]

6.95.2 Base Information-Modifier Panel Layout



6.95.3 Base Information-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount	Dollar amount used to change the allowed amount for a procedure.	Field	Number (Decimal)	11
CMS Add Date	Date the modifier was added to CMS. Informational and applicable only to HCPCS modifiers.	Field	Date (MM/DD/CCYY)	8
CMS Termination Date	Date the modifier is terminated on CMS. Informational and applicable to HCPCS modifiers only.	Field	Date (MM/DD/CCYY)	
Delete	Marks the current Modifier for deletion from Interchange Databases.	Button	N/A	0
Description	A short text that describes the modifier.	Field	Character	40
Effective Date	The date the modifier becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	The date the modifier is no longer valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Long Description of the Modifier.	Field	Character	4000
Modifier	The modifier code used to describe a procedure.	Field	Character	2
Modifier Category	Indicates whether the modifier is a HCPCS modifier or an Ambulance modifier.	Combo Box	Drop Down List Box	0
Modifier Type	Indicates the usage/type of modifier being referenced.	Combo Box	Drop Down List Box	0
Percent	Percentage amount used to change the allowed amount for a procedure.	Field	Number (Decimal)	7
Quantity	Unit adjustment for units of service field on a detail.	Field	Number (Integer)	4
Rate Effective Date	The date that the percentage and amount for the processing modifier becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
Rate Restriction End Date	The date that the percentage and amount for the processing modifier is no longer in effect.	Field	Date (MM/DD/CCYY)	9

6.95.4 Base Information-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
CMS Add Date	Field	0	Invalid Date.	Enter valid date format.
	Field	1	CMS Add Date must be less than or equal to CMS Termination Date.	Enter a date earlier than CMS Termination Date.
	Field	11	CMS Add Date must be greater than or equal to 01/01/1900.	Enter a date later than 1900.
	Field	101	CMS Add Date is required for HCPCS Modifier.	Enter a valid date in CMS Add Date field.
	Field	111	CMS Add Date must be less than or equal to 12/31/2299.	Enter a date earlier than 12/31/2299.
CMS Termination Date	Field	0	Invalid Date.	Enter valid date format.
	Field	11	CMS Termination Date must be greater than or equal to 01/01/1900.	Enter a date later than 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	111	CMS Termination Date must be less than or equal to 12/31/2299.	Enter a date earlier than 12/31/2299.
Description	Field	1	Description is required.	Enter a Description.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be less than or equal to End Date. Effective Date must be earlier than End Date.
	Field	2	Rate Dates must be within modifier dates.	Change the Effective Dates of the modifier (on Base Information panel) or rates (on Modifier Rate Data panel).
	Field	3	Invalid Date.	Verify keying. Enter a valid date. The date must be numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Effective Date must be greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter a valid Effective Date.
	Field	6	Date ranges may not overlap for the same Modifier.	There is an existing modifier with the same code for the effective period chosen on this panel.
	Field	7	Effective Date must be less than or equal to 12/31/2299.	Enter a date earlier than 12/31/2299.
End Date	Field	0	End Date must be less than or Equal to 12/31/2299.	Enter a date earlier than 12/31/2299.
	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be >= to Effective Date.
	Field	2	Rate Dates must be within modifier dates.	Change the end date of the modifier (on Base Information panel) or rates (on Modifier Rate Data panel).
	Field	3	Invalid Date.	Verify keying. Enter a valid date. The date must be numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. End Date must be greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	End Date is required.	Enter a valid End date.
	Field	6	Date ranges may not overlap for the same Modifier.	There is an existingModifier with the same code for the effective period chosen on this panel.
Long Description	Field	1	Long Description is required.	Enter a Long Description.
	Field	7	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 4000 characters.	Limit your text to 4000 characters or less.
Modifier	Field	1	Modifier is required.	Enter a valid Modifier Code.
	Field	2	Modifier must be 2 character(s) in length.	Enter a 2 character code for the Modifier.
	Field	3	Date ranges may not overlap for the same Modifier.	There is an existing Modifier with the same code for the effective period chosen on this panel.
	Field	4	A duplicate record cannot be saved.	Verify keying. The information entered already exists. The modifier already exists.
Modifier Category	Field	1	Modifier Category is required.	Select a value from the drop down list.
Modifier Type	Field	1	A valid Modifier Type is required.	Select a Modifier Type from the drop down list.

6.95.5 Base Information-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.95.6 Base Information-Modifier Panel Accessibility

6.95.6.1 To Access the Base Information-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results panel displays.

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Step	Action	Response
5	Select row from list of results.	Modifier Maintenance and Information panels display.
6	Click **Base Information**.	Base Information-Modifier panel displays.

6.95.6.2 To Add on the Base Information-Modifier Panel Accessibility

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Enter **Modifier**.	
3	Select **Modifier Category** from drop down list box.	
4	Select **Modifier Type** from drop down list box.	
5	Enter **Description**.	
6	Enter **Long Description**.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format. Note: End Date defaults to 12/31/2299.	
9	Enter **CMS Add Date** in MM/DD/CCYY format.	
10	Enter **CMS Termination Date** in MM/DD/CCYY format.	
11	Click **Save**.	Base Information-Modifier information is saved.

6.95.6.3 To Update on the Base Information-Modifier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information-Modifier Procedure information is saved.

6.95.6.4 To Delete on the Base Information-Modifier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.96 Modifier Rate Data-Modifier Panel

6.96.1 Modifier Rate Data-Modifier Panel Narrative

The Modifier Rate Data panel is used to maintain modifier rate data. Processing modifiers are used to change or determine the allowed amount assigned to a procedure. The procedure allowed amount may be calculated or modified with the use of the percentage attribute, amount attribute or quantity attribute.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Modifier] - [search] - [(select row from search results)] - [Modifier Maintenance] - [Base Information]

6.96.2 Modifier Rate Data-Modifier Panel Layout

6.96.3 Modifier Rate Data-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to enter data and add a new Process Rate for the modifier.	Button	N/A	0
Amount	Dollar amount associated to a modifier for claims pricing. Format is 9999999.99.	Field	Number (Decimal)	9
Delete	Allows user to mark a Process Rate for deletion.	Button	N/A	0
Percent	Percentage associated to the modifier for claims pricing. Format is 9.999.	Field	Number (Decimal)	4
Quantity	Quantity associated to the modifier for claims pricing. Format is 9999.	Field	Number (Decimal)	4
Rate Effective Date	The date that the percentage and amount for the processing modifier becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
Rate End Date	The date that the percentage and amount for the processing modifier is no longer in effect.	Field	Date (MM/DD/CCYY)	8

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6.96.4 Modifier Rate Data-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Amount	Field	1	Amount must be greater than or equal to 0000.00.	Amount cannot be negative.
	Field	2	Amount, Percent, or Quantity (One Only) must be greater than zero.	Enter a valid value in any one of the three fields.
	Field	3	Amount, Percent, or Quantity (One Only) can be greater than zero.	Only one of the three fields may be entered.
	Field	4	Enter a valid value.	Amount must be a number.
	Field	5	Amount must be less than or equal to 9999999.99.	Amount cannot exceed 9999999.99.
Percent	Field	1	Percentage Modifier must be greater than or equal to 0.000.	Enter a valid percent amount.
	Field	2	Percentage Modifier must be less than or equal to 9.999.	Enter a valid percent amount.
	Field	3	Amount, Percent, or Quantity (One Only) must be greater than zero.	Enter a valid value in any one of the three fields.
	Field	4	Amount, Percent, or Quantity (One Only) can be greater than zero.	Only one of the three fields may be entered.
	Field	5	Enter a valid value.	Percent must be a numeric value.
Quantity	Field	1	Enter a valid value.	Data must be numeric and >= 0.
	Field	2	Amount, Percent, or Quantity (One Only) must be greater than zero.	Enter a valid value in any one of the three fields.
	Field	3	Amount, Percent, or Quantity (One Only) can be greater than zero.	Only one of the three fields may be entered.
Rate Effective Date	Field	1	Effective Date must be less than or equa to End Date.	Enter a valid effective date that is less than or equal to the End Date.
	Field	2	Date range segments can not overlap.	Check dates against existing Rate Data segments.
	Field	3	Invalid Date.	Date must be numeric and in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Date must be more recent than 01/01/1900.
	Field	5	Effective date is required.	Enter a valid effective date.
	Field	6	Rate Dates must be within modifier dates.	Verify Input. Rate Data Effective Period must be within Modifier effective period (on Base Information panel).
Rate End Date	Field	1	Effective Date must be less than or equal to End Date.	Enter a valid end date that is greater than or equal to the effective date.
	Field	2	Date range segments can not overlap.	Check dates against existing Rate Data segments.
	Field	3	Invalid Date.	Enter date that is numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Date must be more recent than 01/01/1900.
	Field	5	End date is required.	Enter a valid end date.
	Field	6	Rate Dates must be within modifier dates.	Verify Input. Rate Data Effective Period must be within Modifier effective period (on Base Information panel).

6.96.5 Modifier Rate Data-Modifier Panel Extra Features

Field	Field Type
No extra features found for this /panel.	

6.96.6 Modifier Rate Data-Modifier Panel Accessibility

6.96.6.1 To Access the Modifier Rate Data-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance and Information panels display.
6	Click **Base Information**.	Base Information-Modifier panel displays with

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Step	Action	Response
		Modifier Rate Data displayed at the bottom of panel.

6.96.6.2 To Add on the Modifier Rate Data-Modifier Panel

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Enter **Percent**.	
3	Enter **Amount**.	
4	Enter **Quantity**.	
5	Enter **Rate Effective Date** in MM/DD/CCYY format.	
6	Enter **Rate Restriction End Date** in MM/DD/CCYY format. Note: End Date defaults to 12/31/2299.	
7	Click **Save**.	Modifier Rate Data-Modifier information is saved.

6.96.6.3 To Update on the Modifier Rate Data-Modifier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Modifier Rate Data-Modifier information is saved.

6.96.6.4 To Delete on the Modifier Rate Data-Modifier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.97 Group-Modifier Panel

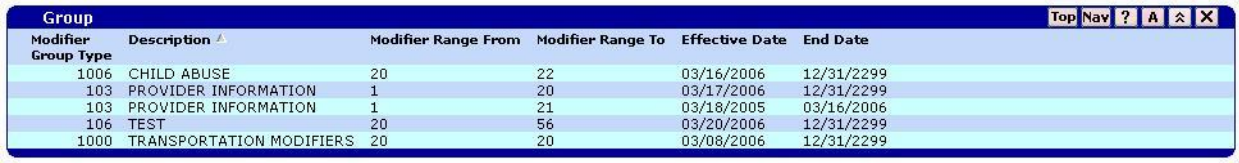
6.97.1 Group-Modifier Panel Narrative

The Group-Modifier panel is used to view Groups in which the Modifier codes are included.

This panel is display only.

Navigation Path: [Reference] – [Modifier] -[{click on 'search' button}] - [(select row from search results)] - [Modifier Maintenance-Modifier] - [Group]

6.97.2 Group-Modifier Panel Layout



Group

Modifier Group Type	Description	Modifier Range From	Modifier Range To	Effective Date	End Date
1006	CHILD ABUSE	20	22	03/16/2006	12/31/2299
103	PROVIDER INFORMATION	1	20	03/17/2006	12/31/2299
103	PROVIDER INFORMATION	1	21	03/18/2005	03/16/2006
106	TEST	20	56	03/20/2006	12/31/2299
1000	TRANSPORTATION MODIFIERS	20	20	03/08/2006	12/31/2299

6.97.3 Group-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	This is the description of the group type.	Field	Alphanumeric	0
Effective Date	This is the beginning date.	Field	Date (MM/DD/CCYY)	0
End Date	This is the end date.	Field	Date (MM/DD/CCYY)	0
Modifier Group Type	This is the number of the group type.	Field	Number (Integer)	0
Modifier Range From	This is the beginning of the range for the modifier.	Field	Alphanumeric	0
Modifier Range To	This is the end of the range for the modifier.	Field	Alphanumeric	0

6.97.4 Group-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.97.5 Group-Modifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.97.6 Group-Modifier Panel Accessibility

6.97.6.1 To Access the Group-Modifier Panel

Step	Action	Response

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Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance and Information panels display.
6	Click **Group**.	Group-Modifier panel displays.

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6.98 Modifier to Modifier Restriction-Modifier Panel

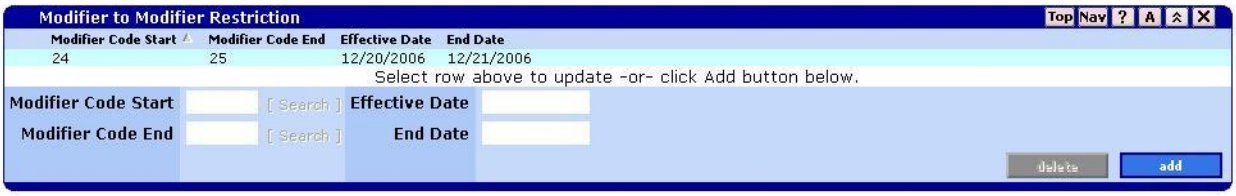
6.98.1 Modifier to Modifier Restriction-Modifier Panel Narrative

The Modifier to Modifier Restriction-Modifier panel is used to view and update modifier to modifier combinations that are invalid if billed on the same claim detail.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Modifier] - [Search] - [(select row from search results)] - [Modifier Maintenance] - [Modifier to Modifier Restriction]

6.98.2 Modifier to Modifier Restriction-Modifier Panel Layout



6.98.3 Modifier to Modifier Restriction-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to enter data and add a new restriction for the modifier.	Button	N/A	0
Delete	Allows user to mark a restriction to be removed from the modifier.	Button	N/A	0
Effective Date	The first date of service the Modifier Restriction takes effect for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The last date of service the Modifier Restriction takes effect for claims processing.	Field	Date (MM/DD/CCYY)	8
Modifier Code End	The end of the modifier range that would be invalid if billed on the same detail as the Modifier in the Modifier field.	Field	N/A	2
Modifier Code Start	The beginning of the modifier range that would be invalid if billed on the same detail as the Modifier in the Modifier field.	Field	N/A	2

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6.98.4 Modifier to Modifier Restriction-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter a valid effective date that is less than or equal to the end date.
	Field	2	Date Range segments cannot overlap.	For the chosen Modifier Start/End code combination, there is already a restriction in place for the chosen date range. Check against the data list for overlapping date segment.
	Field	3	Invalid Date.	The date must be numeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	The date must be more recent than 01/01/1900.
	Field	5	Effective Date is required.	Enter a valid Effective Date.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be >= to Effective Date.
	Field	2	Date Range segments cannot overlap.	For the chosen Modifier Start/End code combination, there is already a restriction in place for the chosen date range. Check against the data list for overlapping date segment.
	Field	3	Invalid Date.	Verify keying. The date must be numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. The date must be more recent than 01/01/1900.
	Field	5	End Date is required.	Enter a valid End Date.
Modifier Code End	[Search]	1	A Valid modifier is required.	Select a modifier using search link.
	[Search]	2	Modifier From cannot be greater than Modifier To.	Choose a different Modifier Start/End.
Modifier Code Start	[Search]	1	A Valid Modifier is required.	Select a modifier using search link.
	[Search]	2	Modifier From cannot be greater than Modifier To.	Choose a different Modifier Start/End.

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6.98.5 Modifier to Modifier Restriction-Modifier Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

6.98.6 Modifier to Modifier Restriction-Modifier Panel Accessibility

6.98.6.1 To Access the Modifier to Modifier Restriction-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance and Information panels display.
6	Click **Modifier to Modifier Restriction**.	Modifier to Modifier Restriction-Modifier panel displays.

6.98.6.2 To Add on the Modifier to Modifier Restriction-Modifier Panel

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to locate **Modifier Code Start**.	Modifier Code Start Search panel displays.
3	Enter search criteria or select from list of search results.	Modifier Code Start information is populated on panel.
4	Click [Search] to locate **Modifier Code End**.	Modifier Code End Search panel displays.
5	Enter search criteria or select from list of search results.	Modifier Code End information is populated on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	Modifier to Modifier Restriction-Modifier information is saved.

6.98.6.3 To Update on the Modifier to Modifier Restriction-Modifier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Modifier to Modifier Restriction-Modifier information is saved.

6.98.6.4 To Delete on the Modifier to Modifier Restriction-Modifier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.99 Note-Modifier Panel

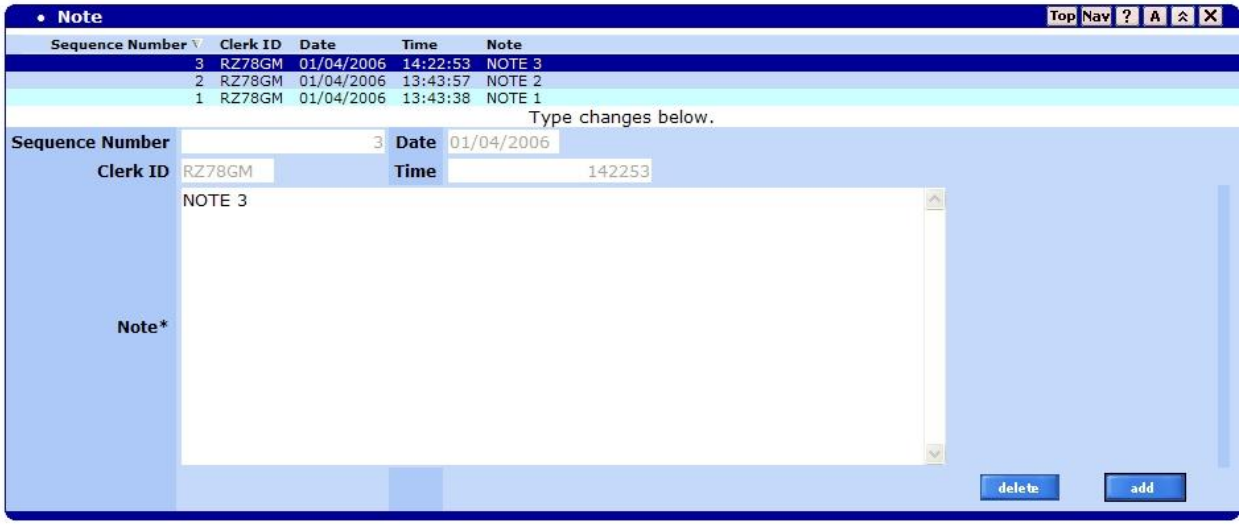
6.99.1 Note-Modifier Panel Narrative

The Note panel is used to enter notes as to why changes were made to a specific Modifier code. Fields included are for date, time, clerk number and note sequence number.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Modifier Search] - [(Add button) OR (select row from search results)] - [Note]

6.99.2 Note-Modifier Panel Layout



6.99.3 Note-Modifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a note.	Button	N/A	0
Clerk ID	Identification of the user who entered the note. This value is set from the user's security profile.	Field	Alphanumeric	8
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Delete	Delete a note.	Button	N/A	0
Note	The actual text of the note.	Field	Alphanumeric	1000
Sequence Number	Sequence number than can uniquely identify a note.	Field	Number (Integer)	9
Time	The time that the note was entered.	Field	Number (Decimal)	6

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6.99.4 Note-Modifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add Modifier Note text.

6.99.5 Note-Modifier Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for Modifier + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.99.6 Note-Modifier Panel Accessibility

6.99.6.1 To Access the Note-Modifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Modifier**.	Reference Modifier Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Modifier Search Results panel displays.
5	Select row from list of results.	Modifier Maintenance and Information panels display.
6	Click **Note**.	Note-Modifier panel displays.

6.99.6.2 To Add on the Note-Modifier Panel

Step	Action	Response
1	Click **Add**. Sequence Number, Date and Time automatically populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note-Modifier information is saved.

6.99.6.3 To Update on the Note-Modifier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Note-Modifier information is saved.

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6.99.6.4 To Delete on the Note-Modifier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.100 Reference Procedure Search-Procedure Panel

6.100.1 Reference Procedure Search-Procedure Panel Narrative

The Reference Procedure Search panel is used to search for HCPCS or ICD Procedure information (for inquiry or update) based upon select criteria such as code or description.

The Procedure Search panel is positioned at the top of the Reference Procedure Search page and permits the user to execute a search based upon the entered search parameters.

To search for a HCPCS Procedure, the 'HCPCS' radio button must first be selected. To search for an IICD Procedure, select the 'ICD' radio button and then select Blank, ICD-9 or ICD-10 from 'ICD version' dropdown.

Additionally, security permitting, the user may opt to proceed directly to either the HCPCS Procedure or ICD Procedure Information panels to add a new procedure code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] – [Procedure Search]

6.100.2 Reference Procedure Search-Procedure Panel Layout

6.100.3 Reference Procedure Search-Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Directs the user to the procedure panels necessary to create a new HCPCS or ICD procedure.	Button	N/A	0
Clear	Clears all fields so the user may enter new search criteria.	Button	N/A	0
Description	Text that describes a specific procedure. The user may enter all or part of the description.	Field	Character	40
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Combo Box	Radio Button	0
Procedure	Code that identifies a specific procedure. The user may enter all or part of the Procedure Code.	Field	Character	6
Records	Number of records to display after search is completed.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Search	Initiates the search for procedure information matching the given search criteria.	Button	N/A	0
Search Type	Allows to search for HCPCS procedures when the 'HCPCS' radio button is selected or for ICD procedures when the 'ICD' radio button is selected.	Combo Box	Radio Button	0
Sounds Like	Allows the user to perform a phonetic search on description. If the box is checked, a phonetic search is performed using the input description. If the check box is unchecked a literal search is performed.	Combo Box	Check Box	0
Type	Allows searching on the short description, the long description or the lay description.	Combo Box	Radio Button	0

6.100.4 Reference Procedure Search-Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Procedure	Field	1	No rows found.	No records matching the criteria keyed-in were found. Verify Input.

6.100.5 Reference Procedure Search-Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.100.6 Reference Procedure Search-Procedure Panel Accessibility

6.100.6.1 To Access the Reference Procedure Search-Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search-Procedure panel displays.

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6.101 Reference Procedure Search Results-Procedure Panel

6.101.1 Reference Procedure Search Results-Procedure Panel Narrative

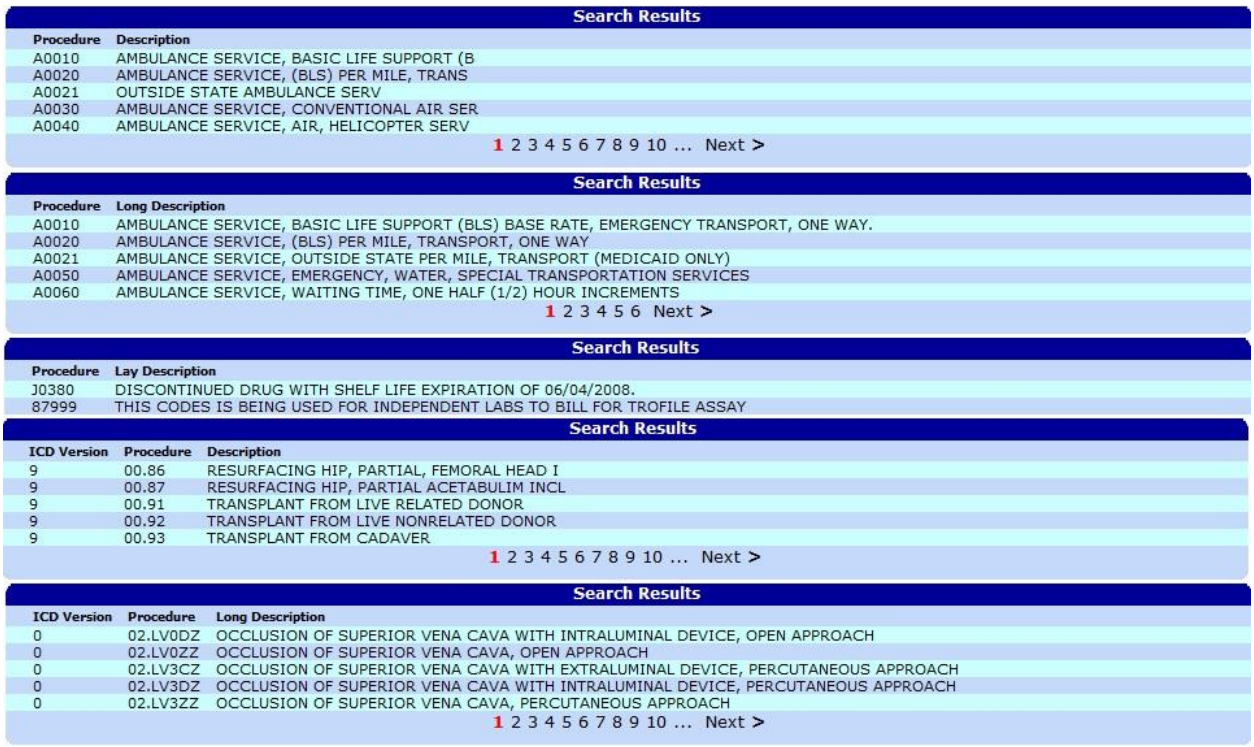
The Procedure Search Results panel displays a listing of HCPCS or ICD Procedures matching the specified criteria.

This panel is display only.

Clicking/Selecting a row from the list directs the user to either the HCPCS or ICD Procedure Information page (depending on search type) where the user may access additional procedure details.

Navigation Path: [Reference] - [Procedure] - (click on [search] button)

6.101.2 Reference Procedure Search Results-Procedure Panel Layout



Search Results

Procedure	Description
A0010	AMBULANCE SERVICE, BASIC LIFE SUPPORT (B
A0020	AMBULANCE SERVICE, (BLS) PER MILE, TRANS
A0021	OUTSIDE STATE AMBULANCE SERV
A0030	AMBULANCE SERVICE, CONVENTIONAL AIR SER
A0040	AMBULANCE SERVICE, AIR, HELICOPTER SERV

1 2 3 4 5 6 7 8 9 10 ... Next >

Search Results

Procedure	Long Description
A0010	AMBULANCE SERVICE, BASIC LIFE SUPPORT (BLS) BASE RATE, EMERGENCY TRANSPORT, ONE WAY.
A0020	AMBULANCE SERVICE, (BLS) PER MILE, TRANSPORT, ONE WAY
A0021	AMBULANCE SERVICE, OUTSIDE STATE PER MILE, TRANSPORT (MEDICAID ONLY)
A0050	AMBULANCE SERVICE, EMERGENCY, WATER, SPECIAL TRANSPORTATION SERVICES
A0060	AMBULANCE SERVICE, WAITING TIME, ONE HALF (1/2) HOUR INCREMENTS

1 2 3 4 5 6 Next >

Search Results

Procedure	Lay Description
J0380	DISCONTINUED DRUG WITH SHELF LIFE EXPIRATION OF 06/04/2008.
87999	THIS CODES IS BEING USED FOR INDEPENDENT LABS TO BILL FOR TROFILE ASSAY

Search Results

ICD Version	Procedure	Description
9	00.86	RESURFACING HIP, PARTIAL, FEMORAL HEAD I
9	00.87	RESURFACING HIP, PARTIAL ACETABULIM INCL
9	00.91	TRANSPLANT FROM LIVE RELATED DONOR
9	00.92	TRANSPLANT FROM LIVE NONRELATED DONOR
9	00.93	TRANSPLANT FROM CADAVER

1 2 3 4 5 6 7 8 9 10 ... Next >

Search Results

ICD Version	Procedure	Long Description
0	02.LV0DZ	OCCLUSION OF SUPERIOR VENA CAVA WITH INTRALUMINAL DEVICE, OPEN APPROACH
0	02.LV0ZZ	OCCLUSION OF SUPERIOR VENA CAVA, OPEN APPROACH
0	02.LV3CZ	OCCLUSION OF SUPERIOR VENA CAVA WITH EXTRALUMINAL DEVICE, PERCUTANEOUS APPROACH
0	02.LV3DZ	OCCLUSION OF SUPERIOR VENA CAVA WITH INTRALUMINAL DEVICE, PERCUTANEOUS APPROACH
0	02.LV3ZZ	OCCLUSION OF SUPERIOR VENA CAVA, PERCUTANEOUS APPROACH

1 2 3 4 5 6 7 8 9 10 ... Next >

6.101.3 Reference Procedure Search Results-Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Short description of the relevant procedure. This is displayed if "Short" is selected from the "Type" radio buttons.	Field	Character	40
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Lay Description	Lay description of the relevant procedure. This is displayed if "Lay" is selected from the "Type" radio buttons.	Field	Alphanumeric	100
Long Description	Long description of the relevant procedure. This is displayed if "Long" is selected from the "Type" radio buttons. For a lengthy description, truncation occurs and only the first 100 characters are displayed.	Field	Alphanumeric	250
Procedure	Code that identifies a specific procedure (HCPCS or ICD).	Field	Character	6

6.101.4 Reference Procedure Search Results-Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.101.5 Reference Procedure Search Results-Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.101.6 Reference Procedure Search Results-Procedure Panel Accessibility

6.101.6.1 To Access the Reference Procedure Search Results-Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results-Procedure panel displays.

6.101.6.2 To Navigate the Reference Procedure Search Results-Procedure Panel

Step	Action	Response
1	Select row from list of results.	Procedure Information and Maintenance panels display.

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6.102 Procedure Mini Search-HCPCS Procedure Panel

6.102.1 Procedure Mini Search-HCPCS Procedure Panel Narrative

The HCPCS Procedure Mini-Search panel is used to search for a HCPCS Procedure codes from the HCPCS Procedure Information panel.

This panel is inquiry only.

Navigation Path: [Reference] – [Procedure] - [{Enter search criteria, click on 'search' button}] - [(select row from search results)]

6.102.2 Procedure Mini Search-HCPCS Procedure Panel Layout

6.102.3 Procedure Mini Search-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Takes the user to Procedure Main Search page so the user can set more advanced search criteria.	Button	N/A	0
Clear	Clears the 'Procedure' field.	Button	N/A	0
Procedure	The Procedure Code used as the search criteria.	Field	Character	6
Search	Initiates 'Search' for Procedure records matching the Procedure Code keyed-in.	Button	N/A	0

6.102.4 Procedure Mini Search-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Next Search By: Procedure	Field	1	No Results found.	Verify Input.

6.102.5 Procedure Mini Search-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.102.6 Procedure Mini Search-HCPCS Procedure Panel Accessibility

6.102.6.1 To Access the Procedure Mini Search-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.

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Step	Action	Response
3	Enter search criteria.	
4	Click **Search**.	Procedure Mini Search-HCPCS Procedure panel displays.

6.102.6.2 To Navigate on the Procedure Mini Search-HCPCS Procedure Panel

Step	Action	Response
1	Enter **Procedure**.	
2	Click **Search**.	Procedure Information and Maintenance panels display.

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6.103 Procedure Information-HCPCS Procedure Panel

6.103.1 Procedure Information-HCPCS Procedure Panel Narrative

The HCPCS Procedure Information panel is used to view HCPCS procedure code information. HCPCS Procedure Codes are designed around a five-character numeric or alphanumeric coding format defined by the Centers for Medicare & Medicaid Services (CMS) called the Healthcare Common Procedure Coding System (HCPCS). The HCPCS Procedure Code data set is a collection of codes that represent procedures, supplies, products and services which may be provided to health care recipients and provide health-care providers and third party payers a common coding structure for determining claims adjudication. The codes are divided into three levels, or groups, as described below:

Level I
Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fourth edition (CPT-4). These are 5 position numeric codes representing physician and non-physician services.

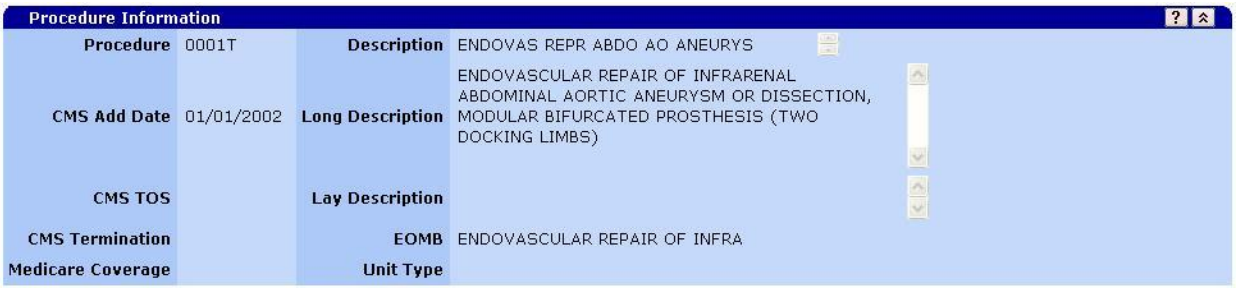
Level II
Includes codes and descriptors copyrighted by The American Dental Association's Current Dental Terminology, third edition (CDT-3). These are 5 position alpha-numeric codes comprising the D series. All other Level II codes and descriptors are approved and maintained jointly by the Alpha-Numeric Editorial Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and non-physician services that are not represented in the Level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the Level I or Level II codes.

This panel is display only.

Navigation Path: [Reference] – [Procedure] - [{Enter search criteria, click on 'search' button}] - [(select row from search results)]

6.103.2 Procedure Information-HCPCS Procedure Panel Layout



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6.103.3 Procedure Information-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CMS TOS	CMS Type of Service (TOS) Code listed on the CMS HCPCS file layout.	Field	Alphanumeric	1
Medicare Coverage	Code denoting Medicare coverage status listed on the CMS HCPCS file layout.	Field	Alphanumeric	1
CMS Add Date	Defined by CMS as the date the HCPCS code was added to the CMS common procedure coding system.	Field	Date (MM/DD/CCYY)	8
CMS Termination	Defined by CMS as the last date for which a procedure code may be used by providers.	Field	Date (MM/DD/CCYY)	8
Description	A short description of the medical procedure that was performed.	Field	Character	40
EOMB	Short description of the service performed that appears on the Recipient's Explanation of Benefits.	Field	Character	30
Long Description	A long description of the medical procedure that was performed.	Field	Character	250
Procedure	Code used to identify a medical procedure.	Field	Character	6
Unit Type	Detailed description of what one unit represents.	Field	Character	100

6.103.4 Procedure Information-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.103.5 Procedure Information-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.103.6 Procedure Information-HCPCS Procedure Panel Accessibility

6.104 Procedure Maintenance-HCPCS Procedure Panel

6.104.1 Procedure Maintenance-HCPCS Procedure Panel Narrative

The Procedure Maintenance panel provides links to the HCPCS Procedure information panels.

This panel is inquiry only.

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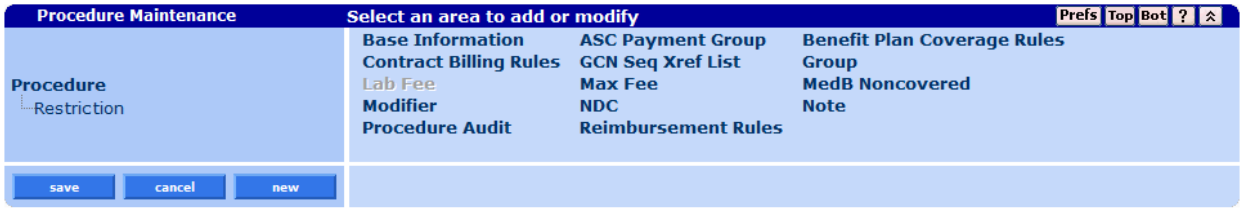
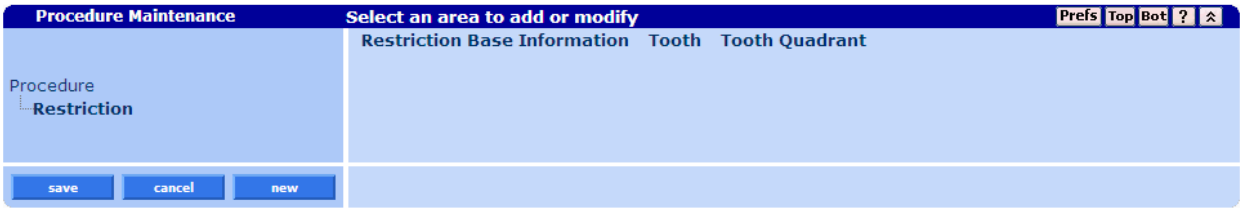
Navigation Path: [Reference] – [Procedure] - [(select HCPCS]) - {click on 'search' button} - [(select row from search results)]

6.104.2 Procedure Maintenance-HCPCS Procedure Panel Layout





6.104.3 Procedure Maintenance-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ASC Payment Group	Opens the ASC Payment Group panel.	Hyperlink	N/A	0
Base Information	Opens the Base Information panel.	Hyperlink	N/A	0
Benefit Plan Coverage Rules	Opens the Benefit Plan Coverage Rules panel.	Hyperlink	N/A	0
Cancel	Cancels all edits made so far to a panel.	Button	N/A	0
Contract Billing Rules	Opens the Contract Billing Rules panel.	Hyperlink	N/A	0
GCN Seq Xref List	Opens the GCN Seq Xref List panel.	Hyperlink	N/A	0
Group	Opens the Procedure Group panel.	Hyperlink	N/A	0
Lab Fee	Opens the Lab Fee panel. This panel is not used by Alabama.at this time).	Hyperlink	N/A	0
Max Fee	Opens the Max Fee panel.	Hyperlink	N/A	0
MedB Noncovered	Opens the MedB Noncovered panel.	Hyperlink	N/A	0
Modifier	Opens the Modifier panel.	Hyperlink	N/A	0
NDC	Opens the NDC panel.	Hyperlink	N/A	0
New	Opens a group of empty panels so a new 'Procedure' may be created.	Button	N/A	0
Note	Opens the Note panel.	Hyperlink	N/A	0
Reimbursement Rules	Opens the Reimbursement Rules panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Restriction	Sub group under 'Procedure' that displays a list of links related to procedure restrictions.	Hyperlink	N/A	0
Restriction Base Information (Restriction)	Opens the Restriction Base Information panel.	Hyperlink	N/A	0
Save	Saves all changes made so far to any panel under 'Procedure Maintenance'.	Button	N/A	0
Tooth (Restriction)	Opens the Tooth panel.	Hyperlink	N/A	0
Tooth Quadrant (Restriction)	Opens the Tooth Quadrant panel.	Hyperlink	N/A	0

6.104.4 Procedure Maintenance-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.104.5 Procedure Maintenance-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.104.6 Procedure Maintenance-HCPCS Procedure Panel Accessibility

6.104.6.1 To Access the Procedure Maintenance-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row from list of results.	Procedure Maintenance-HCPCS Procedure panel displays.

6.104.6.2 To Navigate the Procedure Maintenance-HCPCS Procedure Panel

Step	Action	Response
1	Click on hyperlink to select an area to add or modify.	Select panel displays.

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6.104.6.3 To Access the Procedure Information-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row from list of results.	Procedure Information-HCPCS Procedure panel displays.

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6.105 Base Information-HCPCS Procedure Panel

6.105.1 Base Information-HCPCS Procedure Panel Narrative

The Base Information panel is used to maintain HCPCS procedure base information. HCPCS Procedure Codes are designed around a five-character numeric or alphanumeric coding format defined by the Centers for Medicare & Medicaid Services (CMS) called the Healthcare Common Procedure Coding System (HCPCS). The HCPCS Procedure Code data set is a collection of codes that represent procedures, supplies, products and services which may be provided to health care recipients and provide health-care providers and third party payers a common coding structure for determining claims adjudication. The codes are divided into three levels, or groups, as described below:

Level I
Codes and descriptors copyrighted by the American Medical Association's current procedural terminology, fifth edition (CPT-5). These are 5 position numeric codes representing physician and non-physician services.

Level II
Includes codes and descriptors copyrighted by The American Dental Association's Current Dental Terminology, fourth edition (CDT-4). These are 5 position alpha-numeric codes comprising the D series. All other Level II codes and descriptors are approved and maintained jointly by the Alpha-Numeric Editorial Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and non-physician services that are not represented in the Level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in the Level I or Level II codes.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [{ Select [HCPCS] as Search Type and click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance] - [Base Information]

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6.105.2 Base Information-HCPCS Procedure Panel Layout

6.105.3 Base Information-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
CMS Add Date	The date that the Procedure Code was added by CMS.	Field	Date (MM/DD/CCYY)	8
CMS Termination	The date that the Procedure Code is terminated by CMS.	Field	Date (MM/DD/CCYY)	8
Delete	Delete a Procedure Code record.	Button	N/A	0
Description	A short description of the medical procedure that was performed.	Field	Character	40
EOMB	Short description of the service performed that appears on the Recipient's Explanation of Benefits.	Field	Character	30
Lay Description	The layman description of the medical procedure that was performed.	Field	Character	100
Long Description	A long description of the medical procedure that was performed.	Field	Character	250
MC Service Class	The service class indicates the type of services provided.	Combo Box	Drop Down List Box	0
Procedure	Code used to identify a medical procedure.	Field	Character	6
Unit Type	Detailed description of what one unit represents.	Field	Character	100

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6.105.4 Base Information-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
CMS Add Date	Field	1	CMS Add Date is required.	Enter a valid CMS Add Date.
	Field	2	Invalid date.	The date must be in MM/DD/CCYY format.
	Field	3	CMS Add Date must be greater than or equal to 01/01/1900.	The date must be more recent than 01/01/1900.
CMS Termination	Field	1	Invalid date.	The date must be in MM/DD/CCYY format.
	Field	2	CMS Termination Date must be greater than or equal to 01/01/1900.	The date must be more recent than 01/01/1900.
Description	Field	1	Description is required.	Verify keying.
EOMB	Field	1	EOMB is required.	Verify keying.
Long Description	Field	1	Long Description is required.	Verify keying.
Procedure	Field	1	Procedure is required.	Verify keying.
	Field	2	Procedure code must be at least 4 characters in length.	Verify keying. Procedure code must be at least 4 characters.
	Field	3	A valid Procedure Limits is required.	Key required restriction information on Restriction Base Information panel.

6.105.5 Base Information-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.105.6 Base Information-HCPCS Procedure Panel Accessibility

6.105.6.1 To Access the Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row from list of results.	Procedure Maintenance and Information panels display.
6	Click **Base Information.**	Base Information-HCPCS Procedure panel

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Step	Action	Response
		displays.

6.105.6.2 To Add on the Base Information-HCPCS Procedure Panel Accessibility

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Enter **Procedure**.	
3	Enter **Description**.	
4	Enter **Long Description**.	
5	Enter **Lay Description**.	
6	Enter **EOMB**.	
7	Select **Unit Type** from drop down list box.	
8	Enter **CMS Add Date** in MM/DD/CCYY format. **Note:** Date defaults to current date.	
9	Enter **CMS Termination Date** in MM/DD/CCYY format. Note: Date Defaults to 12/23/2299.	
10	Select **MC Service Class** from drop down list box.	
11	Click **Save**.	Base Information-HCPCS Procedure information is saved.

6.105.6.3 To Update on the Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information-HCPCS Procedure information is saved.

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6.105.6.4 To Delete on the Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.106 ASC Payment Group-HCPCS Procedure Panel

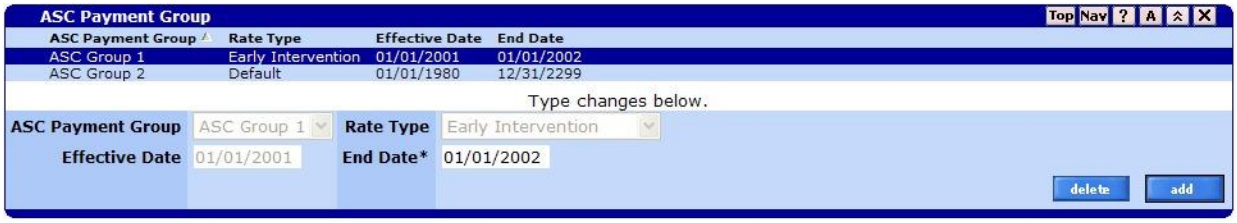
6.106.1 ASC Payment Group-HCPCS Procedure Panel Narrative

The ASC Payment Group-HCPCS Procedure panel allows the user to modify the Ambulatory Surgical Center groups assigned to a procedure. The ASC group is used to determine the ASC rate paid on a claim.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [{Select [HCPCS] as Search Type and click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [ASC Payment Group]

6.106.2 ASC Payment Group-HCPCS Procedure Panel Layout



6.106.3 ASC Payment Group-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add an ASC Pricing segment	Button	N/A	0
ASC Payment Group	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	Combo Box	Drop Down List Box	0
Delete	Delete an ASC Pricing segment.	Button	N/A	0
Effective Date	The date an Ambulatory Surgical Center rate becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date an Ambulatory Surgical Center rate is no longer in effect for claims processing.	Field	Date (MM/DD/CCYY)	8
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Combo Box	Drop Down List Box	0

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6.106.4 ASC Payment Group-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
ASC Payment Group	Field	1	A valid ASC Payment Group is required.	Select an ASC Payment Group.
	Field	2	ASC Procedure Segments may not overlap for the same ASC Payment Group and Rate Type.	Correct overlap condition. Segments may not overlap for the same ASC Payment Group and Rate Type.
Effective Date	Field	1	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	3	Effective Date must less than or equal to 12/31/2299.	Enter an Effective Date less than or equal to 12/31/2299.
	Field	4	Effective Date must be less than or equal to End Date.	Enter an Effective Date less than or equal to the End Date.
	Field	5	Effective Date is required.	Enter an Effective Date.
End Date	Field	1	Invalid date.	Enter an End Date must be in MM/DD/CCYY format.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	3	End Date must less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	4	End Date is required.	Enter an End Date.
Rate Type	Field	1	A valid Rate Type is required.	Select a valid rate Type from the list.

6.106.5 ASC Payment Group-HCPCS Procedure Panel Extra Features

Panel does not allow overlaps for the same ASC Group, Rate Type, and effective/end dates.

The same ASC Group can have overlapping date segments as long as the Rate Type is different.

6.106.6 ASC Payment Group-HCPCS Procedure Panel Accessibility

6.106.6.1 To Access the ASC Payment Group-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.

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Step	Action	Response
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **ASC Payment Group.**	ASC Payment Group-HCPCS Procedure panel displays.

6.106.6.2 To Add on the ASC Payment Group-HCPCS Procedure Panel

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Select **ASC Payment Group** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Select **Rate Type** from drop down list box.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	ASC Payment Group-HCPCS Procedure information is saved.

6.106.6.3 To Update on the ASC Payment Group-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	ASC Payment Group-HCPCS Procedure information is saved.

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6.106.6.4 To Delete on the ASC Payment Group-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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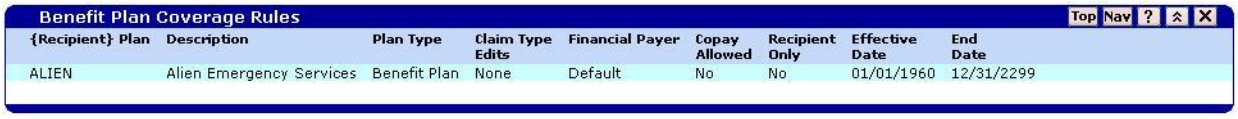
6.107 Benefit Plan Coverage Rules- HCPCS Procedure Panel

6.107.1 Benefit Plan Coverage Rules- HCPCS Procedure Panel Narrative

The Benefit Plan Coverage Rules-Drug panel is used to view the member plan coverage information for a specific procedure code. This panel is display only.

Navigation Path: [Reference] – [Procedure] - (Select [HCPCS] as Search Type and click on [search] and select row from search results) - [Procedure Maintenance] - [Procedure] - [Benefit Plan Coverage Rules]

6.107.2 Benefit Plan Coverage Rules- HCPCS Procedure Panel Layout



Benefit Plan Coverage Rules

{Recipient} Plan	Description	Plan Type	Claim Type Edits	Financial Payer	Copay Allowed	Recipient Only	Effective Date	End Date
ALIEN	Alien Emergency Services	Benefit Plan	None	Default	No	No	01/01/1960	12/31/2299

6.107.3 Benefit Plan Coverage Rules- HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Identifies the associated list of claim types as included or excluded for the covered benefit.	Combo Box	Drop Down List Box	0
Copay Allowed	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	Field	Character	3
Description	Description of the Recipient Plan.	Field	Character	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this benefit plan.	Field	Character	30
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Character	15
Recipient Only	Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.	Field	Character	3
Recipient Plan	Code that identifies the recipient plan that is supported in the system.	Field	Character	5

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6.107.4 Benefit Plan Coverage Rules- HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.107.5 Benefit Plan Coverage Rules- HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.107.6 Benefit Plan Coverage Rules- HCPCS Procedure Panel Accessibility

6.107.6.1 To Access the Benefit Plan Coverage Rules- HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Click **HCPCS**.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row.	Procedure Information and Maintenance panels display.
6	Click **Benefit Plan Coverage Rules**.	Benefit Plan Coverage Rules-HCPCS Procedure panel displays.

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6.108 Contract Billing Rules- HCPCS Procedure Panel

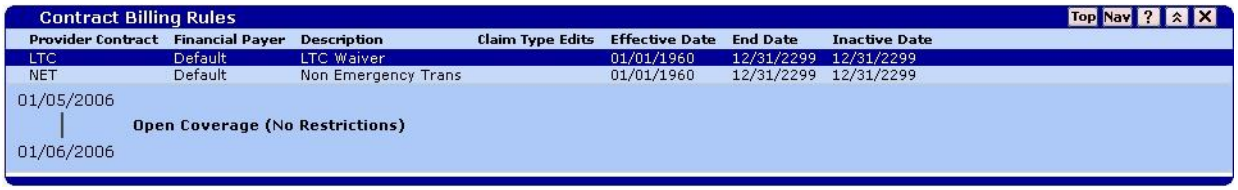
6.108.1 Contract Billing Rules- HCPCS Procedure Panel Narrative

The Contract Billing Rules- HCPCS Procedure panel is used to display Provider Contracts applicable to procedures.

This panel is display only.

Navigation Path: [Reference] - [Procedure] - (Select [HCPCS] as Search Type and click on [Search] button) - (Select row from search results) - [Procedure Maintenance] - [Procedure] - [Contract Billing Rules]

6.108.2 Contract Billing Rules- HCPCS Procedure Panel Layout



6.108.3 Contract Billing Rules- HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Attribute indicates what type of claim type program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Field	Character	1
Description	Description of the provider contract.	Field	Character	30
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this provider contract.	Field	Character	0
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

6.108.4 Contract Billing Rules- HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.108.5 Contract Billing Rules- HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.108.6 Contract Billing Rules- HCPCS Procedure Panel Accessibility

6.108.6.1 To Access the Contract Billing Rules- HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Procedure**.	Reference Procedure Search panel displays.
3	Click **Search**.	Reference Procedure Search Results panel displays.
4	Select row.	Procedure Information panel displays.
5	Click **Contract Billing Rules**.	Contract Billing Rules panel displays.

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6.109 GCN Seq Xref List

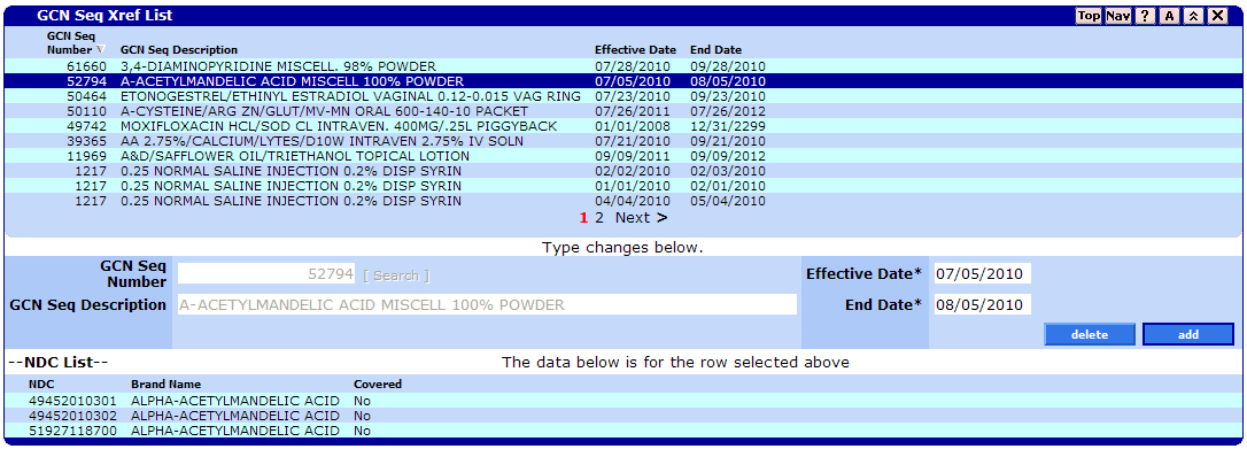
6.109.1 GCN Seq Xref List Panel Narrative

GCN Seq Xref List panel allows users to view and maintain the GSN of a procedure. In addition, there is a read-only panel that list all the NDCs associated with the NDCs that are associated with the procedure when requested.

This panel is display only.

Navigation Path: - [Reference - Procedure] - [{click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [GCN Seq Xref List]

6.109.2 GCN Seq Xref List Panel Layout



6.109.3 GCN Seq Xref List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a GCN	Button	N/A	0
Brand Name	Brand name of the relevant drug. Contains only the brand name of the drug(s) returned from the search criteria. This is displayed if the 'Brand Name' radio button is selected.	Field	Character	30
Covered	Indicates the drug is covered (Yes) or not covered (No) on the request date. The results are in ‘Covered’ order.	Field	Character	1
Delete	Allows a user to delete a GCN.	Button	N/A	
Effective Date	This is the beginning date of the GCN.	Field	Date (MM/DD/CCYY)	0
End Date	This is the end date of the GCN.	Field	Date (MM/DD/CCYY)	0

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Field	Description	Field Type	Data Type	Length
GCN Seq Description	Generic name of the relevant drug. Contains only the generic name of the drug(s) returned from the search criteria. This is displayed if the 'Generic Name' radio button is selected.	Field	Character	63
GCN Seq Number	The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Field	Number (Integer)	5
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code, and a 2-digit package code.	Field	Character	11

6.109.4 GCN Seq Xref List Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
GCN Seq Number	Field	1	A valid GCN is required.	Enter a GCN Seq Number.
GCN Seq Number	Field	4	GCN Sequence Number cannot overlap.	Correct overlapping dates.
Effective Date[Field is required]	Field	2	Effective Date is required.	Enter an Effective Date in MM/DD/CCYY format.
End Date[Field is required]	Field	3	End Date is required.	Enter an End Date in MM/DD/CCYY format.

6.109.5 GCN Seq Xref List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.109.6 GCN Seq Xref List Panel Accessibility

6.109.6.1 To Access the GCN Seq Xref List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Procedure.**	Procedure search panel displays.
3	Search for any **Procedure.**	Procedure Maintenance panel displays.
4	Point to **GCN Seq Xref List** Panel**.**	GCN Seq Xref List Panel displays.

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6.110 Group-HCPCS Procedure Panel

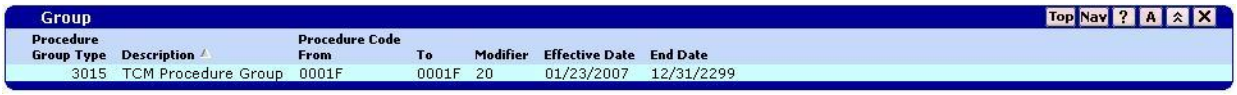
6.110.1 Group-HCPCS Procedure Panel Narrative

The Group-HCPCS Procedure panel is used to view Groups in which the Procedure Codes are included.

This panel is display only.

Navigation Path: [Reference] – [Procedure] -[{ Select [HCPCS] as Search Type and click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [Group]

6.110.2 Group-HCPCS Procedure Panel Layout



6.110.3 Group-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The description of the HCPCS procedure group.	Field	Character	50
Effective Date	The date of service the HCPCS Procedure Code becomes effective for the HCPCS procedure group.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the HCPCS Procedure Code is no longer effective for the HCPCS procedure group.	Field	Date (MM/DD/CCYY)	8
Modifier	The modifier code identified for a particular procedure code.	Field	Character	2
Procedure Code (From)	A lower range of code which identifies a medical, dental or DME procedure. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Character	5
Procedure Code (To)	A higher range of code which identifies a medical, dental or DME procedure. service. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Character	5
Procedure Group Type	Code that categorizes the HCPCS Procedure Codes into a particular group.	Field	Number (Integer)	4

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6.110.4 Group-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.110.5 Group-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.110.6 Group-HCPCS Procedure Panel Accessibility

6.110.6.1 To Access the Group-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Group**.	Group-HCPCS Procedure panel displays.

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6.111 Max Fee-HCPCS Procedure Panel

6.111.1 Max Fee-HCPCS Procedure Panel Narrative

The Max Fee panel is used to maintain the max fee allowed amount and relative value units for a Procedure Code or Procedure Code/modifier combination.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [{Select HCPCS as Search Type] and click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [Max Fee]

6.111.2 Max Fee-HCPCS Procedure Panel Layout

6.111.3 Max Fee-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new Max fee for this procedure.	Button	N/A	0
Allowed Amount	The maximum amount that may be paid for the Procedure Code. Format 9999999.99.	Field	Number (Decimal)	9
Delete	Allows user to delete a Max fee record from this procedure.	Button	N/A	0
Effective Date	Based on date of service, this is the date the Procedure Code or Procedure Code/modifier combination becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	Based on date of service, this is the last day the Procedure Code or Procedure Code/modifier combination is effective for use in claims processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Inactive Date	Date/Time the Max Fee can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Modifier	Modifier used to further describe Procedure Code. User can use the 'search' link to select a modifier.	Field	N/A	0
Modifier2	Second modifier used to further describe Procedure Code. User can use the 'search' link to select a modifier.	Field	N/A	0
Modifier3	Third modifier used to further describe Procedure Code. User can use the 'search' link to select a modifier.	Field	N/A	0
Modifier4	Fourth modifier used to further describe Procedure Code. User can use the 'search' link to select a modifier.	Field	N/A	0
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Combo Box	Drop Down List Box	0
Relative Value	The relative value unit is a grading of the relative difficulty of medical services and procedures used in determining payment. Format 999. Only whole numbers are allowed.	Field	Number (Integer)	

6.111.4 Max Fee-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Allowed Amount	Field	1	Allowed Amount must be greater than or equal to 0.	Verify keying. Allowed Amount must be >= zero.
	Field	2	Allowed Amount must be less than or equal to 9999999.99.	Verify keying. Allowed Amount can not be > 9999999.99.
	Field	3	Allowed Amount is required.	Allowed Amount must have a value.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be >= Effective Date.
	Field	2	Max Fee Pricing already active for date entered.	Verify dates with other records in the list. Dates cannot overlap.
	Field	3	Invalid Date.	Verify keying. The date must be numeric and in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter a valid Effective Date more recent than 01/01/1900.
	Field	5	Effective date is required.	Verify keying. Date must be in MM/DD/CCYY format.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. End Date must be >= to Effective Date.
	Field	2	Max Fee Pricing already active for date entered.	Verify dates against existing segment.
	Field	3	Invalid Date.	Verify keying. Date must be numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter a valid End Date more recent than 01/01/1900.
	Field	5	End Date is required.	Enter a valid End Date.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.
Modifier	Field	1	Procedure/Modifier combination is not valid.	Choose a different Modifier.
	Field	2	Modifier/Modifier combination is not valid.	Choose a different Modifier.
	Field	3	Modifier codes must be unique.	Verify keying. Make sure modifiers are Unique.
	Field	4	Modifier codes must be in ascending order.	Verify keying. Make sure modifiers are in ascending order.
Modifier2	Field	1	Modifier/Modifier combination is not valid.	Choose a different Modifier.
	Field	2	Modifier codes must be unique.	Verify keying. Make sure modifiers are Unique.
	Field	3	Modifier codes must be in ascending order.	Verify keying. Make sure modifiers are in ascending order.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Procedure/Modifier2 combination is not valid.	Choose a different Modifier.
Modifier3	Field	1	Modifier/Modifier combination is not valid.	Choose a different Modifier.
	Field	2	Modifier codes must be unique.	Verify keying. Make sure modifiers are Unique.
	Field	3	Modifier codes must be in ascending order.	Verify keying. Make sure modifiers are in ascending order.
	Field	4	Procedure/Modifier3 combination is not valid.	Choose a different Modifier.
Modifier4	Field	1	Modifier/Modifier combination is not valid.	Choose a different Modifier.
	Field	2	Modifier codes must be unique.	Verify keying. Make sure modifiers are Unique.
	Field	3	Modifier codes must be in ascending order.	Verify keying. Make sure modifiers are in ascending order.
	Field	4	Procedure/Modifier4 combination is not valid.	Choose a different Modifier.
Rate Type	Field	1	Rate Type is required.	Verify keying. Enter a valid Rate Type.
Relative Value	Field	2	Relative Value must be greater than or equal to 0.	Verify keying. Relative value must be >= zero.
	Field	3	Relative Value must be less than or equal to 999.9.	Verify keying. Relative value can not be > 999.9.
	Field	4	Relative Value is required.	Relative Value must have a value.

6.111.5 Max Fee-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.111.6 Max Fee-HCPCS Procedure Panel Accessibility

6.111.6.1 To Access the Max Fee-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.

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Step	Action	Response
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Max Fee**.	Max Fee-HCPCS Procedure panel displays.

6.111.6.2 To Add on the Max Fee-HCPCS Procedure Panel

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to locate **Modifier**.	Modifier Search panel displays.
3	Enter search criteria or select row from search results.	Modifier information populates on panel.
4	Click [Search] to locate **Modifier2**.	Modifier2 Search panel displays.
5	Enter search criteria or select row from search results.	Modifier2 information populates on panel.
6	Click [Search] to locate **Modifier3**.	Modifier3 Search panel displays.
7	Enter search criteria or select row from search results.	Modifier3 information populates on panel.
8	Click [Search] to locate **Modifier4**.	Modifier4 Search panel displays.
9	Enter search criteria or select row from search results.	Modifier4 information populates on panel.
10	Select **Rate Type** from drop down list box.	
11	Enter **Allowed Amount**.	
12	Enter **Relative Date**.	
13	Enter **Effective Date** in MM/DD/CCYY format.	
14	Enter **End Date** in MM/DD/CCYY format.	
15	Enter **Inactive Date** in MM/DD/CCYY format.	
16	Click **Save**.	Max Fee-HCPCS Procedure information is saved.

6.111.6.3 To Update on the Max Fee-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform	

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Step	Action	Response
	update.	
3	Click **Save**.	Max Fee-HCPCS Procedure information is saved.

6.111.6.4 To Delete on the Max Fee-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.112 MedB Noncovered-HCPCS Procedure Panel

6.112.1 MedB Noncovered-HCPCS Procedure Panel Narrative

The MedB Noncovered panel is used to identify a procedure to be a procedure not covered under Medicare B.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference]-[Procedure] - [Select [HCPCS] as [Search Type and click on 'search' button and select a row from the result list] - [Procedure Maintenance] - [Procedure] - [MedB Noncovered]

6.112.2 MedB Noncovered-HCPCS Procedure Layout

6.112.3 MedB Noncovered-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Procedure Code to be a procedure not covered under Medicare B.	Button	N/A	0
Delete	Delete a Procedure Code so that it is covered under Medicare B.	Button	N/A	0
Procedure Code	This identifies the procedure being defined as not covered under Medicare B. This is a Read-only field with its value being same as the Procedure Code of procedure open on the panel.	Field	Character	5

6.112.4 MedB Noncovered-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.112.5 MedB Noncovered-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.112.6 MedB Noncovered-HCPCS Procedure Panel Accessibility

6.112.6.1 To Access the MedB Noncovered-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Search Results display.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **MedB Noncovered**.	MedB Noncovered-HCPCS Procedure panel displays.

6.112.6.2 To Add on the MedB Noncovered-HCPCS Procedure Panel

Step	Action	Response
1	Click **New**.	Activates fields for entry of data or selection from lists.
2	Enter **Procedure Code**.	
3	Click **Save**.	MedB Noncovered-HCPCS Procedure information is saved.

6.112.6.3 To Update on the MedB Noncovered-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	MedB Noncovered-HCPCS Procedure information is saved.

6.112.6.4 To Delete on the MedB Noncovered-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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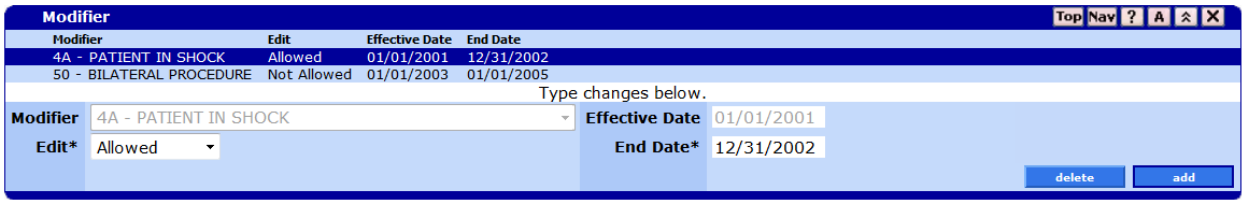
6.113 Modifier-HCPCS Procedure Panel

6.113.1 Modifier-HCPCS Procedure Panel Narrative

Valid Procedure/modifier combinations. Includes the dates that the combinations are in effect. A modifier provides the means by which the reporting physician or provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Navigation Path: [Reference - Procedure] - [{click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [Modifier]

6.113.2 Modifier-HCPCS Procedure Panel Layout



6.113.3 Modifier-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	Allows user to add data and add a modifier for this procedure	Button	N/A	0
delete	Allows user to delete a modifier record for deletion.	Button	N/A	0
Edit	Indicates the type of editing necessary for the procedure/modifier combination. Valid values are 'A' (Allowed), 'N' (Not Allowed), or 'R' (Required). An 'A' indicates the modifier is allowed to be billed with the procedure. An 'N' indicates the modifier cannot be billed with the procedure. An 'R' indicates the modifier is required to bill the procedure. If more than 1 'required' modifier exist for a procedure, the claim only needs 1 of the required modifiers be billed.	Field	Drop Down List Box	0
Effective Date	The date a modifier rule becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date a modifier rule is no longer in effect for claims processing.	Field	Date (MM/DD/CCYY)	8
Modifier	The modifier code used to further describe a procedure.	List view	N/A	0

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6.113.4 Modifier-HCPCS Procedure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Edit	Field	1	Edit is required.	Select an option for Edit from the list.
	Field	2	Allowed & Not Allowed Invalid Restriction Combination.	Allowed & Not Allowed Invalid Restriction Combination.
Effective Date	Field	1	Effective Date[] must be less than or equal to End Date[]	Verify dates. Effective Date must be <= to End Date.
	Field	3	Invalid Date. Format is mm/dd/yyyy	Verify keying. The date must be numeric and in MM/DD/CCYY format
	Field	4	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. The date must recent than 1/1/1900
	Field	5	Effective Date is required.	Enter a valid Effective Date.
	Field	6	Effective Date must be less than or equal to 12/31/2299	Verify keying. The effective date must less than or equal to 12/31/2299.
End Date	Field	1	Effective Date[] must be less than or equal to End Date[]	Verify dates. End Date must be >= to Effective Date.
	Field	3	Invalid Date. Format is MM/DD/CCYY.	Verify keying. The date must be numeric and in MM/DD/CCYY format
	Field	4	End Date must be greater than or equal to 1/1/1900.	Verify keying. The date must be recent than 1/1/1900

6.113.5 Modifier-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.113.6 Modifier-HCPCS Procedure Panel Accessibility

6.113.6.1 To Access the Modifier-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row from list of results.	Procedure Maintenance and Information panels display.
6	Click **Modifier**.	Modifier panel displays.

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6.114 NDC - HCPCS Procedure Panel

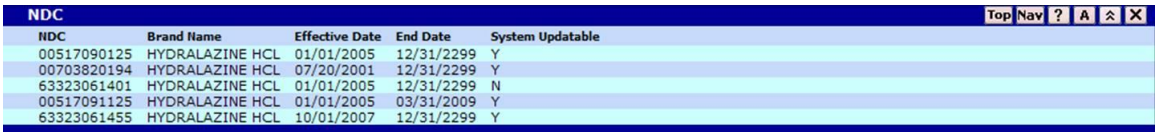
6.114.1 NDC - HCPCS Procedure Panel Narrative

The NDC panel is an 'inquiry only' panel that lists the cross reference(s) between the selected HCPCS procedure and associated NDCs (if applicable). HCPCS procedure codes are much more generic than NDCs and thus may have a many to 1 relationship (i.e. HCPCS to NDC).

This panel is display only.

Navigation Path: [Reference] – [Procedure] - [{Select [HCPCS] as [Search Type andclick on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [NDC]

6.114.2 NDC - HCPCS Procedure Panel Layout



NDC	Brand Name	Effective Date	End Date	System Updatable
00517090125	HYDRALAZINE HCL	01/01/2005	12/31/2299	Y
00703820194	HYDRALAZINE HCL	07/20/2001	12/31/2299	Y
63323061401	HYDRALAZINE HCL	01/01/2005	12/31/2299	N
00517091125	HYDRALAZINE HCL	01/01/2005	03/31/2009	Y
63323061455	HYDRALAZINE HCL	10/01/2007	12/31/2299	Y

6.114.3 NDC- HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Brand Name	Name that appears on the package label provided by the manufacturer.	Field	Character	35
Effective Date	First date of service the NDC becomes effective for this procedure.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the NDC is effective for this procedure.	Field	Date (MM/DD/CCYY)	8
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size.	Field	Character	11
System Updatable	Indicates whether record was inserted/updated from Batch or Manual/UI.	Field	Character	1

6.114.4 NDC - HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.114.5 NDC- HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.114.6 NDC- HCPCS Procedure Panel Accessibility

6.114.6.1 To Access the NDC - HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Procedure.**	Procedure search panel displays.
3	Search for any **Procedure.**	Procedure Maintenance panel disaplays.
4	Point to **NDC.**	NDC Panel displays.

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6.115 Note-HCPCS Procedure Panel

6.115.1 Note-HCPCS Procedure Panel Narrative

The Note-HCPCS Procedure panel is used to enter notes as to why changes were made to a specific Procedure Code.

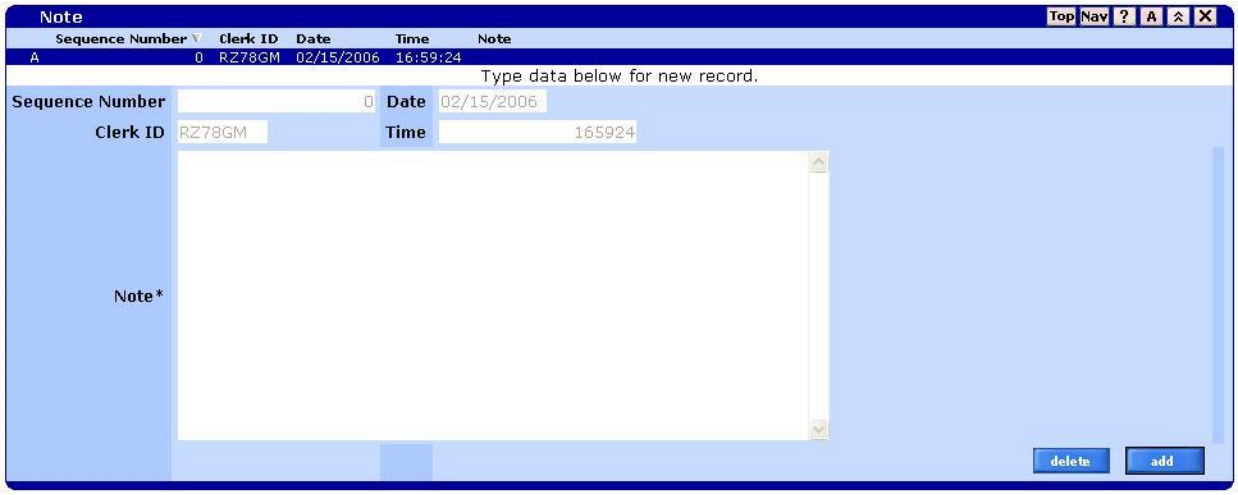
The panel consists of a note data list and a sub-panel where updates and adds are performed.

Selecting an entry from the data list l populates the sub-panel below for update/inquiry. Alternatively, new entries can be created by clicking "Add" and entering data into the update sub-panel.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [Select the 'HCPCS' radio button] - (click on [search] and select row from search results) - or (Click on [Add] button) - [Procedure Maintenance] - [Procedure] - [Note]

6.115.2 Note-HCPCS Procedure Panel Layout



6.115.3 Note-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a note for a HCPCS Procedure Code.	Button	N/A	0
Clerk ID	Identification of the user who enters the note. This value is set from the user's security profile.	Field	Alphanumeric	8
Date	Date (system date) that the note was entered.	Field	Date (MM/DD/CCYY)	8
Delete	Allows the user to delete a note from a HCPCS Procedure Code.	Button	N/A	0
Note	Free-format note text.	Field	Alphanumeric	1000

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Field	Description	Field Type	Data Type	Length
Sequence Number	System assigned sequence number to uniquely identify a Procedure note.	Field	Number (Integer)	9
Time	Time (system time) that the note was entered.	Field	Number (Decimal)	6

6.115.4 Note-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add HCPCS Procedure Note text.

6.115.5 Note-HCPCS Procedure Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:
Sequence Number - Max sequence number for Proc + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.115.6 Note-HCPCS Procedure Panel Accessibility

6.115.6.1 To Access the Note-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Note**.	Note-HCPCS Procedure panel displays.

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6.115.6.2 To Add on the Note-HCPCS Procedure Panel

Step	Action	Response
1	Click **Add**. Sequence Number, Date and Time automatically populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note-HCPCS Procedure information is saved.

6.115.6.3 To Update on the Note-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Note -HCPCS Procedure information is saved.

6.115.6.4 To Delete on the Note-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.116 Procedure Audit-HCPCS Procedure Panel

6.116.1 Procedure Audit-HCPCS Procedure Panel Narrative

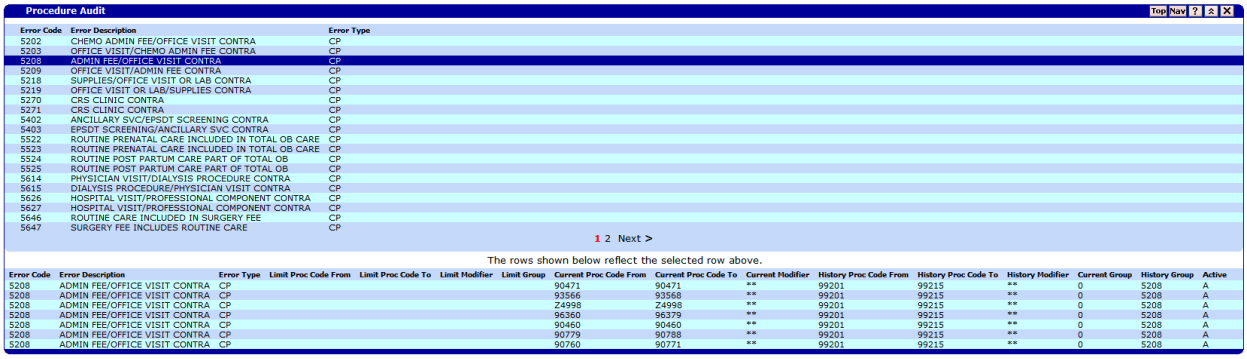
The Procedure Audit-HCPCS Procedure panels are used to view Audit Information associated with the requested procedure code. The first panel displays the Error Code (Audit), Error Description, and the Error Type. This panel displays only one row for each Error Code, consolidating multiple occurrences of a given Error Code value into that single row. When a row is selected in the Procedure Audit panel, a Details panel is then shown. It displays all the individual audit records for the selected Error Code.

The Details panel displays the Error Code (Audit), along with the Error Description, and the Error Type. Depending on the Error Type, the procedure code range and any specific modifiers will be displayed for limit audits. The current procedure code range and any specific modifiers, the history procedure code range and any specific modifiers, the group containing any exclusion for the current procedure, and the group containing any exclusion for the history procedure will be displayed for contra audits. An Active/Inactive Indicator associated with the audit is also included. This panel is similar to the E5 screen in the legacy system, but contains new functionality not found in the legacy system.

Note the first panel is sortable by clicking on column headers. The second panel is not sortable.

Navigation Path: [Reference] – [Procedure] -[{ Select [HCPCS] as Search Type and click on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [Procedure Audit] – [(select row from the Procedure Audit panel)].

6.116.2 Procedure Audit-HCPCS Procedure Panel Layout



Procedure Audit

Error Code	Error Description	Error Type
5202	CHEMO ADMIN FEE/OFFICE VISIT CONTRA	CP
5203	OFFICE VISIT/CHEMO ADMIN FEE CONTRA	CP
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP
5209	OFFICE VISIT/ADMIN FEE CONTRA	CP
5218	SUPPLIES/OFFICE VISIT OR LAB CONTRA	CP
5219	OFFICE VISIT OR LAB/SUPPLIES CONTRA	CP
5270	CRS CLINIC CONTRA	CP
5271	CRS CLINIC CONTRA	CP
5402	ANCILLARY SVC/EPSDT SCREENING CONTRA	CP
5403	EPSDT SCREENING/ANCILLARY SVC CONTRA	CP
5522	ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CARE	CP
5523	ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CARE	CP
5524	ROUTINE POST PARTUM CARE PART OF TOTAL OB	CP
5525	ROUTINE POST PARTUM CARE PART OF TOTAL OB	CP
5614	PHYSICIAN VISIT/DIALYSIS PROCEDURE CONTRA	CP
5615	DIALYSIS PROCEDURE/PHYSICIAN VISIT CONTRA	CP
5626	HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA	CP
5627	HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA	CP
5646	ROUTINE CARE INCLUDED IN SURGERY FEE	CP
5647	SURGERY FEE INCLUDES ROUTINE CARE	CP

1 2 Next >

The rows shown below reflect the selected row above.

Error Code	Error Description	Error Type	Limit Proc Code From	Limit Proc Code To	Limit Modifier	Limit Group	Current Proc Code From	Current Proc Code To	Current Modifier	History Proc Code From	History Proc Code To	History Modifier	Current Group	History Group	Active
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					90471	90471	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					93566	93568	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					Z4998	Z4998	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					96360	96379	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					90460	90460	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					90779	90788	**	99201	99215	**	0	5208	A
5208	ADMIN FEE/OFFICE VISIT CONTRA	CP					90760	90771	**	99201	99215	**	0	5208	A

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6.116.3 Procedure Audit-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active	Indicates whether the Audit is A - Active or I - Inactive. If two or more row exists for an Audit, one being Active and another being Inactive the overall status of the Audit would be Active as at least one row is active.	Field	Character	1
Current Group	Code that categorizes the HCPCS Procedure Codes into a particular Current group.	Field	Number(Integer)	9
Current Modifier	Current Modifier associated with the procedure code.	Field	Character	2
Current Proc Code From	A lower range of code which identifies current medical, dental or DME procedure. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	6
Current Proc Code To	A higher range of code which identifies a Current medical, dental or DME procedure service. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	6
Error Code	The Error Code associated with the Procedure Code.	Field	Number (Integer)	4
Error Description	The Description of Error Code.	Field	Character	50
Error Type	The type of Audit.	Field	Character	2
History Group	Code that categorizes the HCPCS Procedure Codes into a particular History group.	Field	Number(Integer)	9
History Modifier	History Modifier associated with the Procedure Code.	Field	Character	2
History Proc code From	A lower range of code which identifies History medical, dental or DME procedure. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	6
History Proc code To	A lower range of code which identifies History medical, dental or DME procedure. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	6

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Field	Description	Field Type	Data Type	Length
Limit Group	Code that categorizes the HCPCS Procedure Codes into a particular group.	Field	Number (Integer)	9
Limit Modifier	Modifier associated with the Procedure Code.	Field	Character	5
Limit Proc Code From	A lower range of code which identifies a medical, dental or DME procedure. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	5
Limit Proc Code To	A higher range of code which identifies a medical, dental or DME procedure service. If the range only covers one HCPCS Procedure Code, the From and To codes are the same.	Field	Number (Integer)	5

6.116.4 Procedure Audit-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note the first panel is sortable by clicking its column headers; the second panel is not sortable.				

6.116.5 Procedure Audit-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.116.6 Procedure Audit-HCPCS Procedure Panel Accessibility

6.116.6.1 To Access the Audit-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Procedure Audit**.	Procedure Audit-HCPCS Procedure panel displays.
8	Click any row in the Procedure Audit panel.	A detailed panel displays, showing all the Procedure Audit records for the selected Error

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Step	Action	Response
		Code in the panel above.

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6.117 Reimbursement Rules-HCPCS Procedure

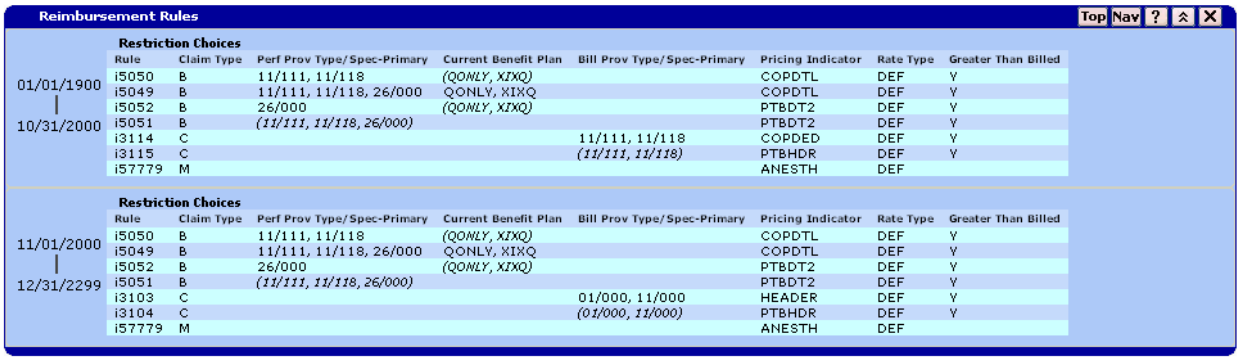
6.117.1 Reimbursement Rules- HCPCS Procedure Narrative

The Reimbursement Rules-HCPCS Procedure panel is used to view the Reimbursement Agreement information for a specific HCPCS procedure code.

This panel is display only.

Navigation Path: [Reference] – [Procedure] - [{Select [HCPCS] as [Search Type andclick on 'search' button}] - [(select row from search results)] - [Procedure Maintenance-Procedure] - [Reimbursement Rules]

6.117.2 Reimbursement Rules-HCPCS Procedure Panel Layout



6.117.3 Reimbursement Rules-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Bill Prov Type/Spec-Primary	It provides the Billing Provider Type/Specialty value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included.	Field	N/A	0
Claim Type	It provides the Claim Type values that are to be included for this rule. The possible Claim Type values are those that pulled from the Codes-Claim Type panel.	Field	N/A	0

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Field	Description	Field Type	Data Type	Length
Current Benfit Plan	It provides the Current Benefit Plan value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included. The possible Benefit Plan values are on the Recipient Plan-Benefit Administration panel.	Field	N/A	0
Dates	These are the effective and end dates for this rule.	Field	Date (MM/DD/CCYY)	8
Greater Than Billed	Indicates if the amount is greater than what was billed.	Field	Character	3
Perf Prov Type/Spec Primary	It provides the Performing Provider Type/Specialty value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included.	Field	N/A	0
Pricing Indicator	Indicates if there is a pricing indicator selected for this rule.	Field	N/A	0
Pricing Modifier	Pricing Modifier requirement for claims. Possible values are N - Pay Billed Amount,Y - Pay greater than Billed Amount & Z - Zero Pay Billed Amount.	Field	N/A	0
Rate Type	Indicates what type of Rate Type is selected for this rule. The Rate Type values are those found on the Codes-Rate Type panel.	Field	N/A	0
Rule	It provides the Rule identification.	Field	N/A	0

6.117.4 Reimbursement Rules-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.117.5 Reimbursement Rules-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.117.6 Reimbursement Rules-HCPCS Procedure Panel Accessibility

6.117.6.1 To Access the Reimbursement Rules-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS**.	
4	Click **Search**.	Reference Procedure Search Results panel displays.
5	Select row from data list.	Procedure Information and Maintenance panels display.
6	Click **Reimbursement Rules**.	Reimbursement Rules-HCPCS Procedure panel displays.

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6.118 Restriction Base Information-HCPCS Procedure Panel

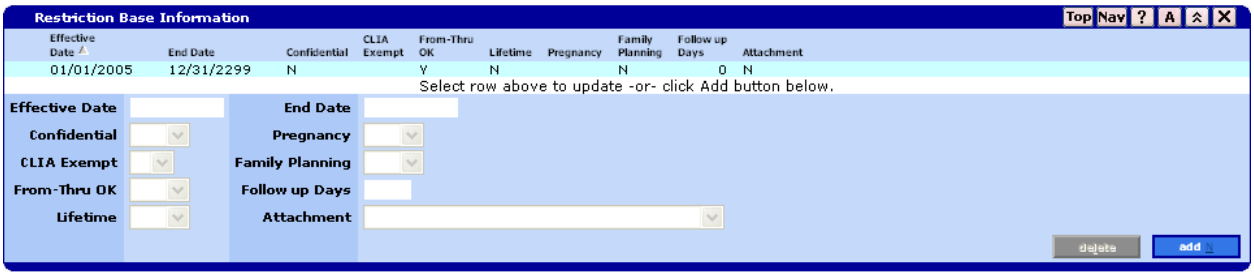
6.118.1 Restriction Base Information-HCPCS Procedure Panel Narrative

The Restriction Base Information- HCPCS Procedure panel is used to maintain HCPCS procedure code restriction information at the base code level.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Procedure (Search)] - (Select [HCPCS] as [Search Type and click on [search] button) - (select row from search results)- [Procedure Maintenance] - [Procedure] - [Restriction] - [Restriction Base Information]

6.118.2 Restriction Base Information-HCPCS Procedure Panel Layout



6.118.3 Restriction Base Information-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new restriction to this procedure.	Button	N/A	0
Attachment	Indicates whether attachments are required for the procedure.	Combo Box	Drop Down List Box	0
CLIA Indicator	Indicates if a procedure requires CLIA certification.	Combo Box	Drop Down List Box	0
Confidential	An indication that this procedure is to be confidential.	Combo Box	Drop Down List Box	0
Delete	Allows user to mark a restriction to be removed from this procedure.	Button	N/A	0
Effective Date	The date procedure limitations become effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date procedure limitations become invalid (no longer active) for claims processing.	Field	Date (MM/DD/CCYY)	8
Family Planning	Indicates if a medical procedure is related to family planning.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Follow up Days	This field represents the number of days before an E&M (visit) procedure can be paid, since it was included as part of the original surgery that was performed.	Field	Number (Integer)	4
From-Thru OK	Yes/No indicator used in claims process to determine if the procedure may be billed with From and Through dates of service.	Combo Box	Drop Down List Box	0
Lifetime	Indicates if a procedure can only occur once in the lifetime of a recipient.	Combo Box	Drop Down List Box	0
Pregnancy	Indicates if a medical procedure is related to a pregnancy.	Combo Box	Drop Down List Box	0

6.118.4 Restriction Base Information-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Attachment	Field	1	Attachment is required.	Select an option from the Attachment list.
CLIA Indicator	Field	1	CLIA exempt is required.	Select option from CLIA Exempt indicator.
Confidential	Field	1	Confidential is required.	Select option from Confidential indicator.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. Enter a valid Effective Date that is less than or equal to the end date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Verify Keying. Make sure dates do not overlap with an existing segment.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be >= 01/01/1900.
	Field	4	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	Effective date is required.	Verify keying. Entry is required.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	End Date must be >= to Effective Date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Verify keying. The date range must not overlap an existing segment.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	End Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be >= 01/01/1900.
	Field	4	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	End Date is required.	Enter a valid End Date.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Family Planning	Field	1	Family Planning is required.	Choose Yes or Nor for Family Planning.
Follow up Days	Field	1	Follow up Days is required.	Enter a valid numeric value.
	Field	2	Enter a valid value.	Enter a valid numeric value.
From-Thru OK	Field	1	From-Thru OK is required.	Pick one From-Thru OK indicator option.
Lifetime	Field	1	Lifetime is required.	Pick one from Lifetime indicator.
Pregnancy	Field	1	Pregnancy is required.	Pick one from Pregnancy indicator.

6.118.5 Restriction Base Information-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.118.6 Restriction Base Information-HCPCS Procedure Panel Accessibility

6.118.6.1 To Access the Restriction Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results display.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Restriction**.	Restriction Maintenance and Information panels display.
8	Click **Restriction Base Information**.	Restriction Base Information-HCPCS Procedure panel displays.

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6.118.6.2 To Add on the Restriction Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Select **Confidential** from drop down list box.	
4	Select **CLIA Exempt** from drop down list box.	
5	Select **From-Thru OK** from drop down list box.	
6	Select **Lifetime** from drop down list box.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Select **Pregnancy** from drop down list box.	
9	Select **Family Planning** from drop down list box.	
10	Enter F**ollow up Days**.	
11	Select **Attachment** from drop down list box.	
12	Click **Save**.	Restriction Base Information-HCPCS Procedure information is saved.

6.118.6.3 To Update on the Restriction Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Restriction Base Information-HCPCS Procedure information is saved.

6.118.6.4 To Delete on the Restriction Base Information-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.119 Tooth-HCPCS Procedure Panel

6.119.1 Tooth-HCPCS Procedure Panel Narrative

The Tooth Restriction panel is used to update procedure restrictions for tooth numbers. All entered segments are considered valid restrictions for the procedure.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Procedure] - (Select [HCPCS] as [Search Type and click on [search] button) - (select row from search results) - [Procedure Maintenance] - [Procedure] - [Restriction] - [Tooth]

6.119.2 Tooth-HCPCS Procedure Panel Layout

6.119.3 Tooth-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to enter data and create a new Tooth Restriction.	Button	N/A	0
Delete	Allows user to mark a Tooth Restriction to be removed from this procedure.	Button	N/A	0
Effective Date	Indicates the date a Tooth Restriction becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	Indicates the date a Tooth Restriction become invalid for claims processing.	Field	Date (MM/DD/CCYY)	8
Tooth Number	Drop down list that indicates the number of the tooth and its description that is restricted to a specific procedure code. Valid values include: A-T = primary 0-32 = permanent.	Combo Box	Drop Down List Box	0

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6.119.4 Tooth-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter a valid Effective Date that is less than or equal to the end date.
	Field	2	Effective Date can not overlap.	Date segments may not overlap for the same tooth number.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	4	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	Effective date is required.	Verify keying. Entry is required.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the end date.
	Field	2	Effective Date can not overlap.	Verify dates against existing segment.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	4	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	End date is required.	Verify keying. Entry is required.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Tooth Number	Field	1	A valid Tooth Number Code is required.	Select a Tooth number from the drop down list.

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6.119.5 Tooth-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.119.6 Tooth-HCPCS Procedure Panel Accessibility

6.119.6.1 To Access the Tooth-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **HCPCS** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Restriction**.	Restriction Maintenance and Information panels display.
8	Click **Tooth**.	Tooth-HCPCS Procedure panel displays.

6.119.6.2 To Add on the Tooth-HCPCS Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Tooth Number** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Tooth-HCPCS Procedure information is saved.

6.119.6.3 To Update on the Tooth-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tooth-HCPCS Procedure information is saved.

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6.119.6.4 To Delete on the Tooth-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.120 Tooth Quadrant-HCPCS Procedure Panel

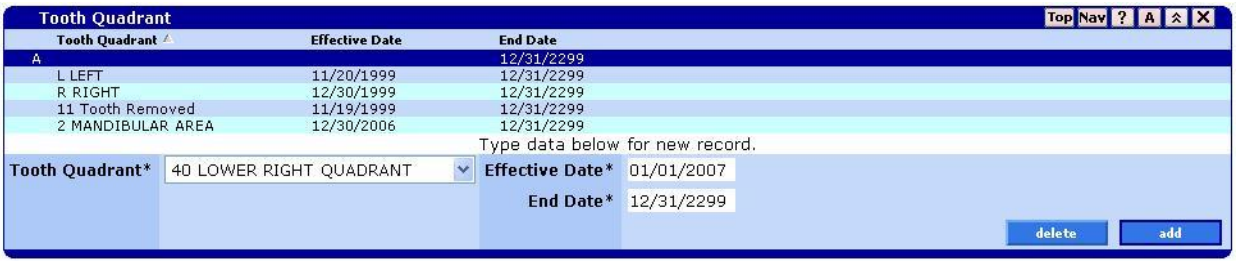
6.120.1 Tooth Quadrant-HCPCS Procedure Panel Narrative

The Tooth Quadrant panel is used to maintain tooth quadrants associated to a given procedure code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Procedure (Search)] - (Select [HCPCS] as [Search Type andclick on [search] and select row from search results)- [Procedure Maintenance] - [Procedure] - [Restriction] - [Tooth Quadrant]

6.120.2 Tooth Quadrant-HCPCS Procedure Panel Layout



6.120.3 Tooth Quadrant-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to create a new Tooth Quadrant Restriction for the procedure.	Button	N/A	0
Delete	Allows user to delete a Tooth Quadrant Restriction from the procedure.	Button	N/A	0
Effective Date	Indicates the date a Tooth Quadrant Restriction becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	Indicates the date a Tooth Quadrant Restriction become invalid for claims processing.	Field	Date (MM/DD/CCYY)	8
Tooth Quadrant	Indicates the number of the Tooth Quadrant, which was serviced, and the description.	Combo Box	Drop Down List Box	0

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6.120.4 Tooth Quadrant-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter a valid Effective Date that is less than or equal to the End date.
	Field	2	Effective Date can not overlap.	Verify Keying. Date should not overlap existing segment.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	4	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	Effective Date is required.	Verify keying. Entry is required.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the End Date.
	Field	2	Effective Date can not overlap.	Verify Keying. Date should not overlap existing segment.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	4	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	End Date is required.	Verify keying. Entry is required.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Tooth Quadrant	Field	1	A valid Tooth Quadrant is required.	Select a Tooth Quadrant from the drop down list.

6.120.5 Tooth Quadrant-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.120.6 Tooth Quadrant-HCPCS Procedure Panel Accessibility

6.120.6.1 To Access the Tooth Quadrant-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Enter search criteria.	
4	Select **HCPCS** as search type.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Restriction**.	Restriction Maintenance and Information panels display.
8	Click **Tooth Quadrant**.	Tooth Quadrant-HCPCS Procedure panel displays.

6.120.6.2 To Add on the Tooth Quadrant-HCPCS Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Tooth Quadrant** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Tooth Quadrant-HCPCS Procedure information is saved.

6.120.6.3 To Update on the Tooth Quadrant-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tooth Quadrant-HCPCS Procedure information is saved.

6.120.6.4 To Delete on the Tooth Quadrant-HCPCS Procedure Panel

Step	Action	Response

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Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.121 Procedure Mini Search-ICD Procedure Panel

6.121.1 Procedure Mini Search-ICD Procedure Panel Narrative

The Procedure ICD Mini-Search panel is used to search for ICD procedure codes from the ICD Information panel.

This panel is inquiry only.

Navigation Path:[Reference] – [Procedure] - [select ICD radio button as 'Search Type', click on ' search'] - [click on any row from the list]

6.121.2 Procedure Mini Search-ICD Procedure Panel Layout

6.121.3 Procedure Mini Search-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Takes the user back to Procedure main search page so user may enter additional search criteria.	Button	N/A	0
Clea	Clears the ICD field so user may key-in new search criteria.	Button	N/A	0
ICD	ICD procedure code to use as search criteria. The ICD Procedure Code data set contains International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification procedure codes used for inpatient hospital billing and describe procedures used for the treatment of illness and injury.	Field	Character	7
Search	Initiates the search for a ICD procedure matching the ICD code keyed in.	Button	N/A	0

6.121.4 Procedure Mini Search-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
ICD	Field	1	ICD Code does not exist.	Verify keying. Enter a valid ICD code.

6.121.5 Procedure Mini Search-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.121.6 Procedure Mini Search-ICD Procedure Panel Accessibility

6.121.6.1 To Access the Procedure Mini-Search-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click	Main Menu page displays.

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Step	Action	Response
	Login.	
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Mini-Search-ICD panel displays.

6.121.6.2 To Navigate the Procedure Mini-Search-ICD Procedure Panel

Step	Action	Response
1	Click on hyperlink to select an area to add or modify.	Select panel displays.

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6.122 Procedure Information-ICD Procedure Panel

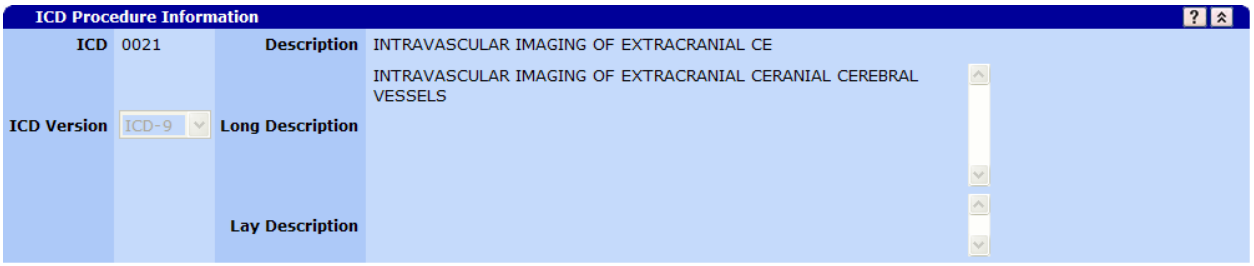
6.122.1 Procedure Information-ICD Procedure Panel Narrative

The ICD Procedure Information is used to view ICD Procedure code and descriptions. The ICD Procedure Code data set contains International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification procedure codes used for inpatient hospital billing and describe procedures used for the treatment of illness and injury. ICD procedure codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD as the heading of a category of codes that may be further subdivided by the use of third and/or fourth digits, which provide greater detail.

This panel is display only.

Navigation Path: [Reference] – [Procedure] - [select ICD radio button for 'Search Type'. Click on 'search' button] - [(select row from search results)]

6.122.2 Procedure Information-ICD Procedure Panel Layout



6.122.3 Procedure Information-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	A short medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Characters	40
ICD	The ICD procedure code used to identify therapeutic, diagnostic and prophylactic procedures that can be provided to patients in hospitals.	Field	Character	4
ICD Version	Code to denote which version of the ICD procedure code set is being referenced.	Field	Character	1
Lay Description	The layman description of the medical procedure that was performed.	Field	Character	100
Long Description	A long medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	400

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6.122.4 Procedure Information-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.122.5 Procedure Information-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.122.6 Procedure Information-ICD Procedure Panel Accessibility

6.122.6.1 To Access the Procedure Information- ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Information panel displays.

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6.123 Procedure Maintenance-ICD Procedure Panel

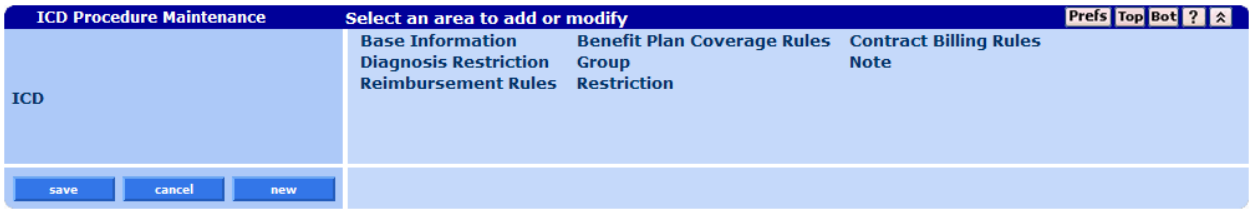
6.123.1 Procedure Maintenance-ICD Procedure Panel Narrative

The Procedure Maintenance-ICD panel contains links to various ICD Procedure panels.

This panel is inquiry only.

Navigation Path: [Reference] - [Procedure] - (Select [ICD] as [Search Type]) - (Click on [Search] button) - (Select row from search results) - [ICD Procedure Maintenance]

6.123.2 Procedure Maintenance-ICD Procedure Panel Layout



6.123.3 Procedure Maintenance-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Opens the ICD Procedure Base Information panel.	Hyperlink	N/A	0
Benefit Plan Coverage Rules	Opens the ICD Procedure Benefit Plan Coverage Rules panel.	Hyperlink	N/A	0
Cancel	Cancels all additions/deletions/changes made to any panel in the maintenance area (panels with hyperlinks on this Maintenance panel).	Button	N/A	0
Contract Billing Rules	Opens the ICD Procedure Contract Billing Rules panel.	Hyperlink	N/A	0
Diagnosis Restriction	Opens the ICD Procedure Diagnosis Restriction panel.	Hyperlink	N/A	0
Group	Opens the ICD Procedure Group panel.	Hyperlink	N/A	0
New	Opens the panels needed to create a new ICD Procedure.	Button	N/A	0
Note	Opens the ICD Procedure Note panel.	Hyperlink	N/A	0
Reimbursement Rules	Opens the ICD Procedure Reimbursement Rules panel.	Hyperlink	N/A	0
Restriction	Opens the ICD Procedure Restriction panel.	Hyperlink	N/A	0
Save	Saves all additions/deletions/changes made to any panel in the maintenance area (panels with hyperlinks on this Maintenance panel).	Button	N/A	0

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6.123.4 Procedure Maintenance-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.123.5 Procedure Maintenance-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.123.6 Procedure Maintenance-ICD Procedure Panel Accessibility

6.123.6.1 To Access the Procedure Maintenance- ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance panel displays.

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6.124 Base Information-ICD Procedure Panel

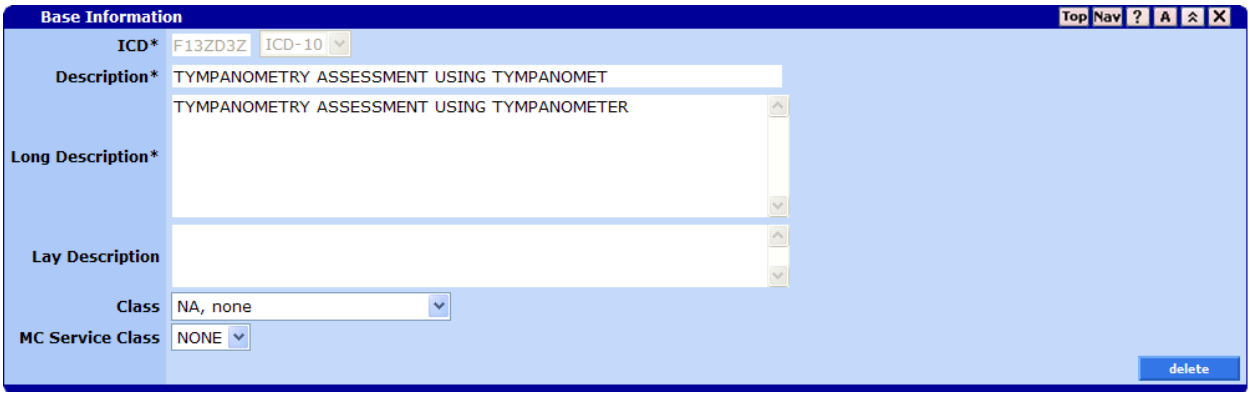
6.124.1 Base Information-ICD Procedure Panel Narrative

The Base Information-ICD 9-CM Procedure panel is used to maintain ICD Procedure base information. The ICD Procedure Code data set contains International Classification of Diseases, Ninth and Tenth Revision; Clinical Modification Procedure Codes used for inpatient hospital billing and describe procedures used for the treatment of illness and injury. ICD Procedure Codes are composed of codes with either 3 or 4 digits. Codes with two digits are included in ICD as the heading of a category of codes that may be further subdivided by the use of third and/or fourth digits, which provide greater detail.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [select ICD as 'Search Type' and click on 'search' button] - [(select row from search results)] - [ICD Procedure Maintenance] - [Base Information]

6.124.2 Base Information-ICD Procedure Panel Layout



6.124.3 Base Information-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Class	Indicates the category of procedure, operative or non operative, the Procedure Code falls within. Describes the operative or non operative class of a procedure. 1 = Class 1, surgery, 2 = Class 2, significant procedure, 3 = Class 3 significant procedure, 4 = Class 4, other.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete an ICD Procedure Code.	Button	N/A	0
Description	A short medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Characters	40

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Field	Description	Field Type	Data Type	Length
ICD	The ICD Procedure Code used to identify the therapeutic, diagnostic and prophylactic procedures that were provided to patients in hospitals.	Field	Character	7
ICD Version	Code to denote which version of the ICD procedure code set is being referenced. The valid values are BLANK, ICD-9 and ICD-10.	Combo Box	Drop Down List Box	1
Lay Description	The layman description of the medical procedure that was performed.	Field	Character	100
Long Description	A long medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.	Field	Character	400
MC Service Class	The Managed Care Service Class indicates the type of services provided.	Combo Box	Drop Down List Box	0

6.124.4 Base Information-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Verify Keying. Type in short description.
ICD	Field	1	ICD is required.	Enter a valid code for ICD.
	Field	2	Required input must be between 2 and 7 characters in length.	Verify Keying. Type in 2 digit code or more in ICD field.
	Field	3	A duplicate record cannot be saved.	A record already exists for this ICD code. Verify Keying. Enter code which is not in the database.
	Field	6	A valid Procedure ICD Lim is required.	ICD Lim must have a value.
ICD Version	Combo Box	1	ICD Version is required.	Select value from ICD Version dropdown.
Long Description	Field	1	Long Description is required.	Verify Keying. Type in long description.
MC Service Class	Field	1	A valid Mc Svc Class is required.	Select an MC Service Class from drop down list.

6.124.5 Base Information-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.124.6 Base Information-ICD Procedure Panel Accessibility

6.124.6.1 To Access the Base Information-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Base Information**.	Base Information-ICD panels display.

6.124.6.2 To Add on the Base Information- ICD Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ICD**.	
3	Enter **Description**.	
4	Enter **Long Description**.	
5	Enter **Lay Description**.	
6	Select **Class** from drop down list box.	
7	Select **MC Service Class** from drop down list box.	
8	Click **Save**.	Base Information-ICD Procedure information is saved.

6.124.6.3 To Update on the Base Information-ICD Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information-ICD Procedure information is saved.

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6.124.6.4 To Delete on the Base Information-ICD Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.125 Benfit Plan Coverage Rules-ICD Procedure Panel

6.125.1 Benfit Plan Coverage Rules-ICD-Procedure Panel Narrative

The Benefit Plan Coverage Rules-Diagnosis panel is used to view the recipient plan coverage information for a specific diagnosis code. This panel is display only.

Navigation Path: [Reference] – [Procedure] - [select ICD as 'Search Type' and click on 'search' button] - [(select row from search results)] - [ICD Procedure Maintenance] - [Benefit Plan Coverage Rules]

6.125.2 Benfit Plan Coverage Rules-ICD Procedure Panel Layout

Benefit Plan Coverage Rules

Recipient Plan	Description	Plan Type	Claim Type Edits	Financial Payer	Copay Allowed	Recipient Only	Effective Date	End Date
ALL	ALL BENEFIT PLANS	Benefit Plan	None	DEFAULT	No	No	01/02/1900	12/31/2299
QONLY	QMB Only	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
SBRW	SOBRA Pregnant Women	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
TAWV	Technology Assisted Waive	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
TXIX	Full Medicaid	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299
XIXQ	Full Medicaid with QMB Pl	Benefit Plan	None	DEFAULT	No	No	01/01/1900	12/31/2299

6.125.3 Benfit Plan Coverage Rules-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Identifies the associated list of claim types as included or excluded for the covered benefit.	Combo Box	Drop Down List Box	0
Copay Allowed	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	Field	Character	3
Description	Description of the Recipient Plan.	Field	Character	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the end date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this benefit plan.	Field	Character	30
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Character	15
Recipient Only	Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.	Field	Character	3
Recipient Plan	Code that identifies the recipient plan that is supported in the system.	Field	Character	5

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6.125.4 Benfit Plan Coverage Rules-ICD Procedure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.125.5 Benfit Plan Coverage Rules-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.125.6 Benfit Plan Coverage Rules-ICD Procedure Panel Accessibility

6.125.6.1 To Access the Benefit Plan Coverage Rules-ICD Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Benefit Plan Coverage Rules**.	Benefit Plan Coverage Rules-ICD panel displays.

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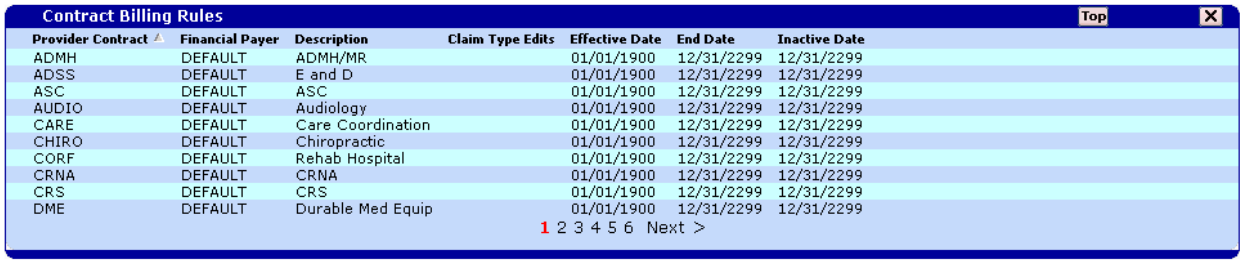
6.126 Contract Billing Rules-ICD Procedure Panel

6.126.1 Contract Billing Rules- ICD Procedure Panel Narrative

The Contract Billing Rules- ICD panel is used to display Provider Contracts applicable to procedure codes. This panel is display only.

Navigation Path: [Reference] – [Procedure] - [select ICD as 'Search Type' and click on 'search' button] - [(select row from search results)] - [ICD Procedure Maintenance] - [Contract Billing Rules]

6.126.2 Contract Billing Rules-ICD Procedure Panel Layout



Contract Billing Rules

Provider Contract	Financial Payer	Description	Claim Type Edits	Effective Date	End Date	Inactive Date
ADMH	DEFAULT	ADMH/MR		01/01/1900	12/31/2299	12/31/2299
ADSS	DEFAULT	E and D		01/01/1900	12/31/2299	12/31/2299
ASC	DEFAULT	ASC		01/01/1900	12/31/2299	12/31/2299
AUDIO	DEFAULT	Audiology		01/01/1900	12/31/2299	12/31/2299
CARE	DEFAULT	Care Coordination		01/01/1900	12/31/2299	12/31/2299
CHIRO	DEFAULT	Chiropractic		01/01/1900	12/31/2299	12/31/2299
CORF	DEFAULT	Rehab Hospital		01/01/1900	12/31/2299	12/31/2299
CRNA	DEFAULT	CRNA		01/01/1900	12/31/2299	12/31/2299
CRS	DEFAULT	CRS		01/01/1900	12/31/2299	12/31/2299
DME	DEFAULT	Durable Med Equip		01/01/1900	12/31/2299	12/31/2299

1 2 3 4 5 6 Next >

6.126.3 Contract Billing Rules- ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Field	Character	1
Description	Description of the provider contract.	Field	Character	30
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the end date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this provider contract.	Field	Character	30
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

6.126.4 Contract Billing Rules- ICD Procedure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.126.5 Contract Billing Rules-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.126.6 Contract Billing Rules-ICD Procedure Panel Accessibility

6.126.6.1 To Access the Contract Billing Rules-ICD Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Contract Billing Rules**.	Contract Billing Rules-ICD panel displays.

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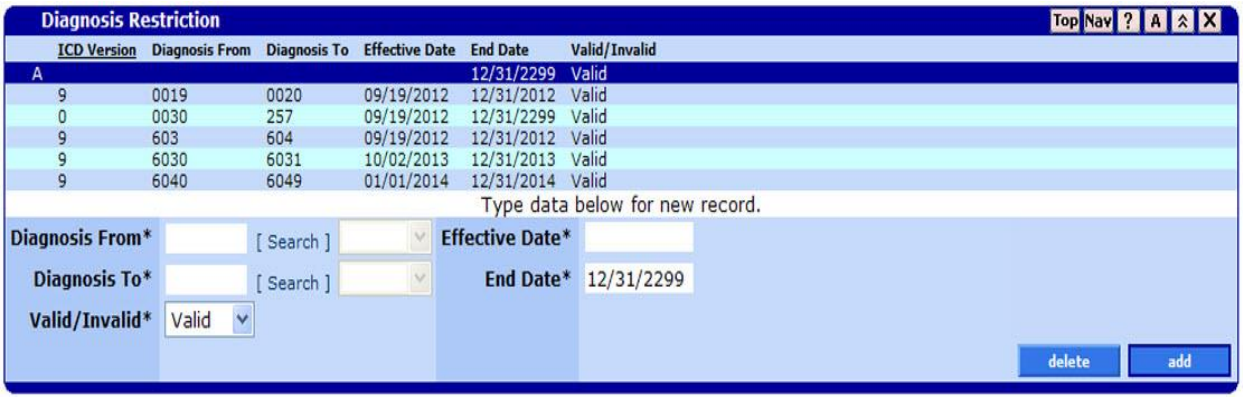
6.127 Diagnosis Restriction-ICD Procedure Panel

6.127.1 Diagnosis Restriction-ICD Procedure Panel Narrative

The ICD Procedure Diagnosis Restriction panel is used to restrict specific ICD Procedure Codes to certain diagnosis. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure] - [(Add button) OR [(select ICD as 'Search Type') and (click on 'search' button)] (select row from search results)] - [ICD Procedure Maintenance] - [Diagnosis Restriction]

6.127.2 Diagnosis Restriction-ICD Procedure Panel Layout



6.127.3 Diagnosis Restriction-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to enter data and add a new Diagnosis Restriction to this procedure.	Button	N/A	0
Delete	Allows user to mark a Diagnosis Restriction to be removed from this procedure.	Button	N/A	0
Diagnosis From [Search]	Lower limit of a range of diagnosis codes.	Field	Character	7
Diagnosis To [Seach]	Upper limit of a range of diagnosis codes.	Field	Character	7
Effective Date	The date of service a Diagnosis Code Restriction for an ICD procedure becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service a Diagnosis Code Restriction for an ICD procedure is no longer active for claims processing.	Field	Date (MM/DD/CCYY)	8
ICD Version	Displays ICD Version for the respective diagnosis code. Valid values include: '9' for ICD-9 and '0' for ICD-10.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Valid/Invalid	Indicates if diagnosis code range is valid/invalid for an ICD Procedure code.	Combo Box	Drop Down List Box	0

6.127.4 Diagnosis Restriction-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the end date.
	Field	2	Diag Range Segment Dates cannot overlap.	Verify keying. Dates cannot overlap with an existing date range and an existing ICD Version for a given Diagnosis code range.
	Field	3	Invalid Date.	Verify keying. Date must be numeric and entered in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	5	Effective Date is required.	Verify keying. Entry is required.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Date must be before 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. The Effective Date must be sequentially before the end date.
	Field	2	Diag Range Segment Dates cannot overlap.	Verify keying. Dates cannot overlap with an existing date range and an existing ICD Version date range for a given Diagnosis code range.
	Field	3	Invalid Date.	Verify keying. Date must be entered in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	5	End Date is required.	Enter a valid End Date.
	Field	6	End Date must be less than or equal to 12/31/2299.	Verify keying. Date must be before 12/31/2299.
Valid/Invalid	Field	1	Valid/Invalid is required.	Must be set to valid or invalid.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Diag Valid/Invalid Segments cannot overlap.	Verify selection. Should not overlap Diagnosis valid/invalid segments within a Diagnosis Code in an existing date range and ICD Version.
Diagnosis From	Field	1	A valid Diagnosis From is required.	Verify keying. Check the Diagnosis Selection Window for valid diagnosis.
	Field	2	'Diagnosis From' code cannot be greater than 'Diagnosis To' code.	Select a different Diagnosis From/Diagnosis To code.
	Field	3	Diagnosis From and To codes are not of same ICD Version.	Select Diagnosis From and To codes of same ICD Version.
	Field	4	Diagnosis From and To codes both must be either AlphaNumeric or Numeric.	Select Diagnosis From and To codes of same type. i.e. both should be either AlphaNumeric or Numeric.
Diagnosis To	Field	1	A valid Diagnosis To is required.	Verify keying. Check the Diagnosis Selection Window for valid diagnosis.
	Field	2	'Diagnosis From' code cannot be greater than 'Diagnosis to' Diagnosis Code.	Select a different Diagnosis From/Diagnosis To code.
	Field	3	Diagnosis From and To codes are not of same ICD Version.	Select Diagnosis From and To codes of same ICD Version.
	Field	4	Diagnosis From and To codes both must be either AlphaNumeric or Numeric.	Select Diagnosis From and To codes of same type. i.e. both should be either AlphaNumeric or Numeric.

6.127.5 Diagnosis Restriction-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.127.6 Diagnosis Restriction-ICD Procedure Panel Accessibility

6.127.6.1 To Access the Diagnosis Restriction-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	

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Step	Action	Response
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Diagnosis Restriction**.	Diagnosis Restriction-ICD panels display.

6.127.6.2 To Add on the Diagnosis Restriction-ICD Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to locate **Diagnosis From**.	Diagnosis From Search panel displays.
3	Click **Search**.	Diagnosis From information populates on panel.
4	Click [Search] to locate **Diagnosis To**.	Diagnosis To Search panel displays.
5	Click **Search**.	Diagnosis To information populates on panel.
6	Select **Valid/Invalid** from drop down list box.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	Diagnosis Restriction-ICD Procedure information is saved.

6.127.6.3 To Update on the Diagnosis Restriction-ICD Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Diagnosis Restriction-ICD Procedure information is saved.

6.127.6.4 To Delete on the Diagnosis Restriction-ICD Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.128 Group-ICD Procedure Panel

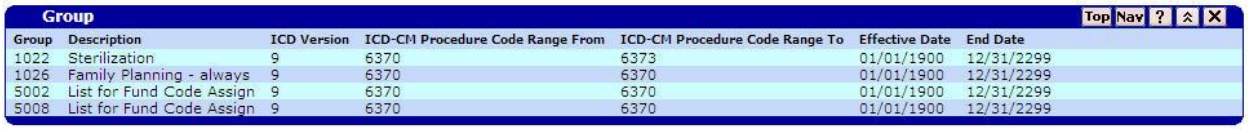
6.128.1 Group ICD Procedure Panel Narrative

The Group-ICD Procedure panel is used to view all groups to which a specific ICD Procedure code has been associated. The groups are maintained via the ICD Procedure Group panels found under Reference Related Data - Other.

This panel is display only.

Navigation Path: [Reference] – [Procedure Search] - [Select ICD as 'Search Type'. Click on 'search' button] - [(select row from search results)] - [ICD Procedure Maintenance] - [Group]

6.128.2 Group- ICD Procedure Panel Layout



Group

Group	Description	ICD Version	ICD-CM Procedure Code Range From	ICD-CM Procedure Code Range To	Effective Date	End Date
1022	Sterilization	9	6370	6373	01/01/1900	12/31/2299
1026	Family Planning - always	9	6370	6370	01/01/1900	12/31/2299
5002	List for Fund Code Assign	9	6370	6370	01/01/1900	12/31/2299
5008	List for Fund Code Assign	9	6370	6370	01/01/1900	12/31/2299

6.128.3 Group- ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The description of the ICD procedure group.	Field	Character	25
Effective Date	The date of service the Procedure Code becomes effective for that ICD type.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the Procedure Code is no longer effective for that ICD type.	Field	Date (MM/DD/CCYY)	8
Group	Code that categorizes a ICD Procedure into a particular group.	Field	Number (Integer)	9
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are BLANK, ICD-9 and ICD-10.	Field	Character	1
Procedure From	The lower range ICD Procedure Code assigned to the ICD group. If the range only covers one ICD Procedure Code, the Start and End code are the same.	Field	Character	7
Procedure To	The upper range ICD Procedure Code assigned to the ICD group. If the range only covers one ICD Procedure Code, the Start and End code are the same.	Field	Character	7

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6.128.4 Group- ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.128.5 Group- ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.128.6 Group- ICD Procedure Panel Accessibility

6.128.6.1 To Access the Group-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Search Results display.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Group**.	Group-ICD panels display.

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6.129 Note-ICD Procedure Panel

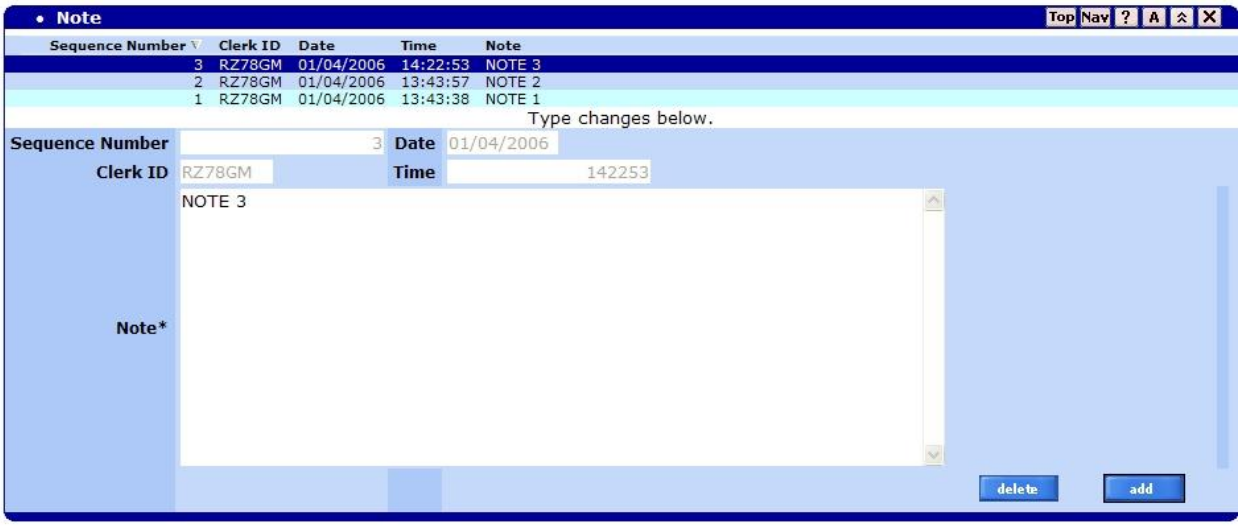
6.129.1 Note-ICD Procedure Panel Narrative

The Note panel is used to enter notes as to why changes were made to a specific ICD procedure. Includes fields for date, time, clerk number and note sequence number.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure Search] - [select ICD] - (Click on Add button) OR (click on [search] and select row from search results) - [ICD Procedure Maintenance] - [ICD] - [Note]

6.129.2 Note-ICD Procedure Panel Layout



6.129.3 Note-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clerk ID	Identification of the user who entered the note. This value is set from the user's security profile.	Field	Alphanumeric	8
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Note	The actual text of the note.	Field	Alphanumeric	1000
Sequence Number	Sequence number than can uniquely identify a note.	Field	Number (Integer)	9
Time	The time the note was entered.	Field	Number (Decimal)	6

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6.129.4 Note-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add ICD Procedure Note text.

6.129.5 Note-ICD Procedure Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for ICD Proc + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.129.6 Note-ICD Procedure Panel Accessibility

6.129.6.1 To Access the Note-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Search Results display.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Note**.	Note-ICD Procedure panel displays.

6.129.6.2 To Add on the Note-ICD Procedure Panel

Step	Action	Response
1	Click **Add**. Sequence Number, Date and Time automatically populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note-ICD Procedure information is saved.

6.129.6.3 To Update on the Note ICD Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Note-ICD Procedure information is saved.

6.129.6.4 To Delete on the Note –ICD Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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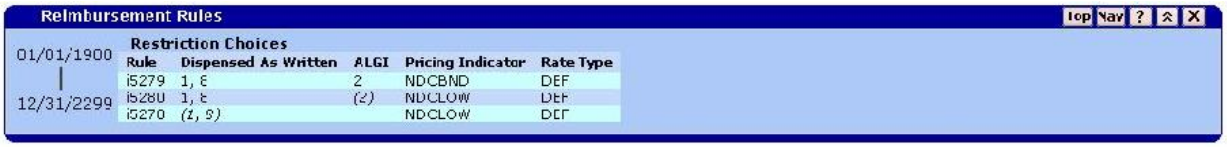
6.130 Reimbursement Rules-ICD Procedure Panel

6.130.1 Reimbursement-ICD Procedure Panel Narrative

The Reimbursement Rules-ICD Procedure panel is used to view the Reimbursement Agreement information for a specific procedure code. The information displayed is retrieved from the Reimbusement Agreement tables available through the Benefit administration panels. The panel displays all reimbursement agreements associated with the specified ICD procedure code. This panel is display only.

Navigation Path: [Reference] – [Procedure Search] - [select ICD] - (Click on Add button) OR (click on [search] and select row from search results) - [ICD Procedure Maintenance] - [ICD] - [Reimbursement Rules]

6.130.2 Reimbursement-ICD Procedure Panel Layout



6.130.3 Reimbursement-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
ALGI	It provides the ALGI value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included.	Field	N/A	0
Dates	These are the effective and end dates for this rule.	Field	Date (MM/DD/CCYY)	8
Dispensed As Written	It provides the Dispensed as Written values that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included. Possible values are: 0 - No product selection indicated; 1 - Substitution not allowed by provider; 2 - Substitution allowed- patient requested product dispensed; 3 - Substitution allowed- pharmacist selected product dispensed; 4 - Substitution allowed- generic drug not in stock; 5 - Substitution allowed- brand drug dispensed as generic; 6 - Override; 7 - Substitution not allowed- brand drug mandated by law; 8 - Substitution allowed- generic drug not available in marketplace; 9 – Other.	Field	N/A	0

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Field	Description	Field Type	Data Type	Length
Pricing Indicator	Indicates if there is a pricing indicator selected for this rule.	Field	N/A	0
Rate Type	Indicates what type of Rate Type is selected for this rule. The Rate Type values are those found on the Codes-Rate Type panel.	Field	N/A	0
Rule	It provides the Rule identification.	Field	N/A	0

6.130.4 Reimbursement-ICD Procedure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.130.5 Reimbursement-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.130.6 Reimbursement-ICD Procedure Panel Accessibility

6.130.6.1 To Access the Reimbursement Rules-ICD Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search Type.	
4	Enter search criteria.	
5	Click **Search**.	Reference Procedure Search Results panel displays.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Reimbursement Rules**.	Reimbursement Rules-ICD panel displays.

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6.131 Restriction-ICD Procedure Panel

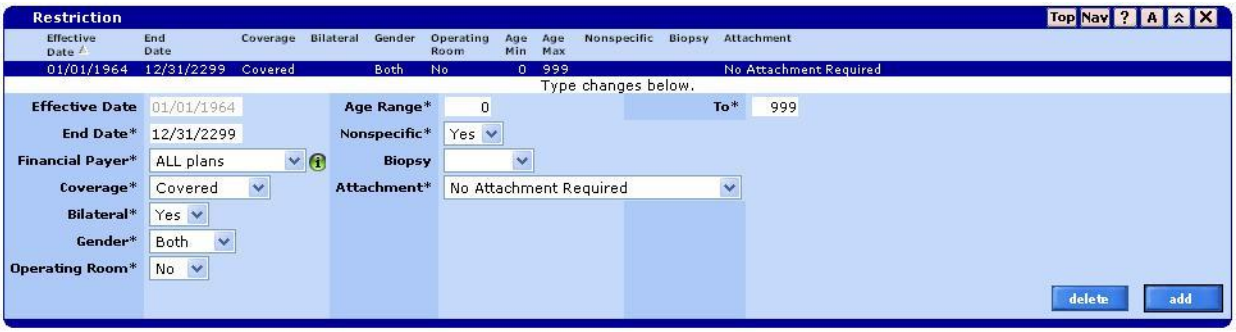
6.131.1 Restriction-ICD Procedure Panel Narrative

The Restriction-ICD Procedure panel is used to maintain ICD procedure code restriction information at the base code level.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Procedure Search] - [Select ICD as 'Search Type' and click on 'search' button] - [(select row from search results)] - [ICD Procedure Maintenance] - [Restriction]

6.131.2 Restriction-ICD Procedure Panel Layout



6.131.3 Restriction-ICD Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new restriction for an ICD procedure.	Button	N/A	0
Age Range From	The minimum age a recipient should be to receive this procedure.	Field	Number (Integer)	4
Age Range To	The maximum age a recipient should be to receive this procedure.	Field	Number (Integer)	4
Attachment	Indicates the type of attachment required for this procedure code.	Combo Box	Drop Down List Box	0
Bilateral	An indicator used to display if an ICD procedure code is a Bilateral procedure.	Combo Box	Drop Down List Box	0
Biopsy	Indicates if the procedure code is classified as an open or closed biopsy.	Combo Box	Drop Down List Box	0
Coverage	Indicates if the ICD procedure code is considered covered or non-covered.	Combo Box	Drop Down List Box	0
Delete	Allows user to delete an ICD Procedure Restriction.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Effective Date	The date of service the ICD procedure code limitations become effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the ICD procedure code limitations become invalid (no longer effective) for claims processing.	Field	Date (MM/DD/CCYY)	8
Financial Payer	The Financial payer to which this restriction applies. A Financial payer generally represents a unique organization responsible for the underwriting of the claims transactions to be paid.	Combo Box	Drop Down List Box	0
Gender	Used to indicate if a procedure is gender specific.	Combo Box	Drop Down List Box	0
Nonspecific	Indicates if the procedure code is classified as a nonspecific procedure code (a code used when more precise information is not obtainable).	Combo Box	Drop Down List Box	0
Operating Room	Used to indicate if a procedure requires the use of an operating room. This indicator is used in DRG assignment.	Combo Box	Drop Down List Box	0

6.131.4 Restriction-ICD Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Age Range From	Field	1	Enter a valid value.	Enter an Age that is numeric and greater than or equal to 0.
	Field	2	Age Min must be less than or equal to 999.	Enter a minimum age that is less than 999.
	Field	3	Age Max must be less than or equal to 999.	Enter a maximum age that is less than 999.
	Field	5	Age Range is required.	Enter a numeric age value.
Age Range To	Field	1	Age Max must be less than or equal to 999.	Enter an Age Max that is less than or equal to 999.
	Field	3	Enter a valid value.	Enter a valid Age Max value.
	Field	4	Age Range is required.	Verify keying. Enter a valid Age Max value.
Attachment	Field	1	Attachment is required.	Select an Attachment option from the list.
Bilateral	Field	1	Bilateral is required.	Choose an option from Bilateral list.

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Field	Field Type	Error Code	Error Message	To Correct
Coverage	Field	1	Coverage is required.	Select a Coverage option from the list.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is before the end date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Enter an Effective Date of the current segment that does not overlap the end date.
	Field	3	Invalid Date.	Enter a numeric Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is more recent than 01/01/1900.
	Field	5	Effective date is required.	Enter an Effective Date in MM/DD/CCYY format.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is sequentially before the end date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Enter an Effective Date of the current segment that does not overlap end date.
	Field	3	Invalid Date.	Enter an End Date that is numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is more recent than 01/01/1900.
	Field	5	End Date is required.	Enter a valid End Date.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a Financial Payer from the list.
Gender	Field	1	Gender is required.	Select Gender from the drop down list.
Nonspecific	Field	1	Nonspecific is required.	Select an option from the Nonspecific list.
Operating Room	Field	1	Operating Room is required.	Choose yes or no for the Operating Room.

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6.131.5 Restriction-ICD Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.131.6 Restriction-ICD Procedure Panel Accessibility

6.131.6.1 To Access the Restriction-ICD Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Procedure**.	Reference Procedure Search panel displays.
3	Select **ICD** as search type.	
4	Enter search criteria.	
5	Click **Search**.	Reference ICDSearch Results display.
6	Select row from list of results.	Procedure Maintenance and Information panels display.
7	Click **Restriction**.	Restriction-ICD Procedure panel displays.

6.131.6.2 To Add on the Restriction-ICD Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Enter **End Date** in MM/DD/CCYY format.	
4	Select **Coverage** from drop down list box.	
5	Select **Bilateral** from drop down list box.	
6	Select **Financial Payer** from drop down list box.	
7	Select **Gender** from drop down list box.	
8	Select **Operating Room** from drop down list box.	
9	Enter **Age Range**.	
10	Select **Nonspecific** from drop down list box.	
11	Select **Biopsy** from drop down list box.	
12	Select **Attachment** from drop down list box.	
13	Click **Save**.	Restriction-ICD Procedure information is saved.

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6.131.6.3 To Update on the Restriction-ICD Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Restriction-ICD Procedure information is saved.

6.131.6.4 To Delete on the Restriction-ICD Procedure Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.132 Reference Revenue Search-Revenue Panel

6.132.1 Reference Revenue Search-Revenue Panel Narrative

The Reference Revenue Search panel allows the user to search for a specific revenue code.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue] - [search button]

6.132.2 Reference Revenue Search-Revenue Panel Layout

6.132.3 Reference Revenue Search-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This button allows the user to create a new Revenue record.	Button	N/A	0
Clear	This clears all fields so the user may key-in new search criteria.	Button	N/A	0
Description	This describes a specific accommodation or ancillary service.	Field	Character	70
Match criteria	Allows matching based on whether the description begins with or contains the requested characters.	Combo Box	Radio Button	0
Records	This drop down list displays the number of rows returned from the search.	Combo Box	Drop Down List Box	0
Revenue	This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS.	Field	Number (Integer)	4
Search	This initiates search for the revenue matching the code/description keyed-in.	Button	N/A	0
Sounds-Like	If the box is checked, phonetic search is performs and if the check box is unchecked word search is performed.	Combo Box	Check Box	0

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6.132.4 Reference Revenue Search-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	No rows found	Verify Keying. No records matching the description keyed-in were found.
Revenue	Field	1	No rows found	Verify Keying. No records matching the code keyed-in were found.

6.132.5 Reference Revenue Search-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.132.6 Reference Revenue Search-Revenue Panel Accessibility

6.132.6.1 To Access the Reference Search Revenue-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.

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6.133 Reference Revenue Search Results-Revenue Panel

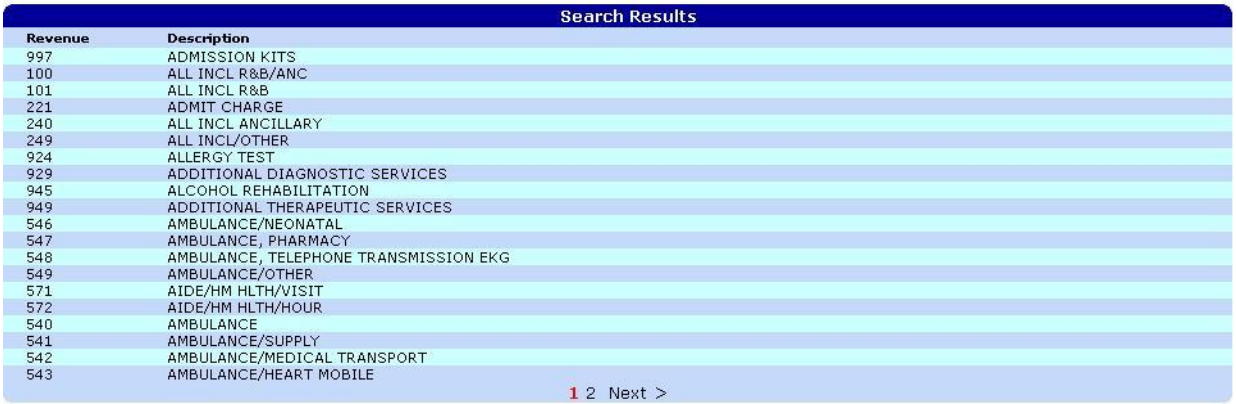
6.133.1 Reference Revenue Search Results-Revenue Panel Narrative

The Reference Revenue Search Results panel displays Revenue Codes matching the search criteria from Revenue search panel.

This panel is display only.

Navigation Path: [Reference] - [Revenue (Search)]- (click on [search] button)

6.133.2 Reference Revenue Search Results-Revenue Panel Layout



Search Results

Revenue	Description
997	ADMISSION KITS
100	ALL INCL R&B/ANC
101	ALL INCL R&B
221	ADMIT CHARGE
240	ALL INCL ANCILLARY
249	ALL INCL/OTHER
924	ALLERGY TEST
929	ADDITIONAL DIAGNOSTIC SERVICES
945	ALCOHOL REHABILITATION
949	ADDITIONAL THERAPEUTIC SERVICES
546	AMBULANCE/NEONATAL
547	AMBULANCE, PHARMACY
548	AMBULANCE, TELEPHONE TRANSMISSION EKG
549	AMBULANCE/OTHER
571	AIDE/HM HLTH/VISIT
572	AIDE/HM HLTH/HOUR
540	AMBULANCE
541	AMBULANCE/SUPPLY
542	AMBULANCE/MEDICAL TRANSPORT
543	AMBULANCE/HEART MOBILE

1 2 Next >

6.133.3 Reference Revenue Search Results-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	This describes a specific accommodation or ancillary service.	Field	Character	70
Revenue	This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS.	Field	Number (Number)	4

6.133.4 Reference Revenue Search Results-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.133.5 Reference Revenue Search Results-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.133.6 Reference Revenue Search Results-Revenue Panel Accessibility

6.133.6.1 To Access the Reference Revenue Search Results-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Base Information**.	Base Information-Revenue panel displays.

6.133.6.2 To Navigate the Revenue Reference Search Results-Revenue Panel

Step	Action	Response
1	Select row from data list.	Revenue Information and Maintenance panels display.

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6.134 Revenue Information-Revenue Panel

6.134.1 Revenue Information-Revenue Panel Narrative

The Revenue Information panel is used to view revenue code data.

This panel is display only.

Navigation Path: [Reference] – [Revenue] - [search] - [(select row from search results)] - [Revenue Information]

6.134.2 Revenue Information-Revenue Panel Layout

6.134.3 Revenue Information-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	This describes a specific accommodation or ancillary service.	Field	Character	70
Effective Date	The date of service the revenue code becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the revenue code is no longer effective.	Field	Date (MM/DD/CCYY)	8
Managed Care Service Class	The service class indicates the type of services provided.	Combo Box	Drop Down List Box	0
Revenue	This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS.	Field	Number (Integer)	4

6.134.4 Revenue Information-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.134.5 Revenue Information-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.134.6 Revenue Information-Revenue Panel Accessibility

6.134.6.1 To Access the Revenue Information-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information panel displays.

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6.135 Revenue Maintenance-Revenue Panel

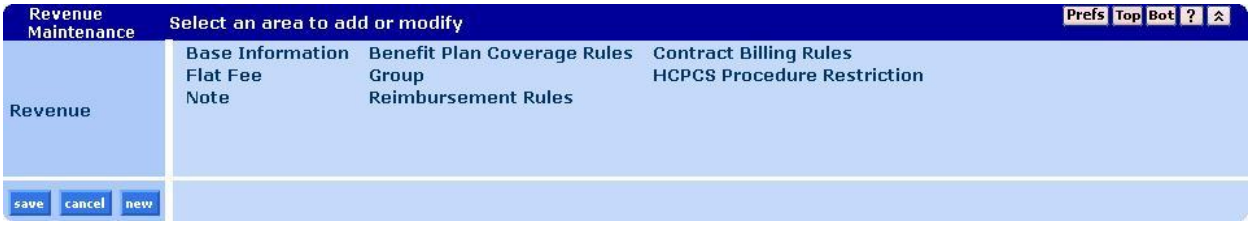
6.135.1 Revenue Maintenance-Revenue Panel Narrative

Revenue Maintenance-Revenue panel links to various Revenue information maintenance panels.

This panel is inquiry only.

Navigation Path: [Reference] - [Revenue (Search)] - (click on [search] button) - (select row from search results) - [Revenue Maintenance] - [Revenue]

6.135.2 Revenue Maintenance-Revenue Panel Layout



6.135.3 Revenue Maintenance-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Benefit Plan Coverage Rules	Link to the Benefit Plan Coverage Rules panel.	Hyperlink	N/A	0
Cancel	Cancels ('undo') any/all changes made to any/all panels under this navigation panel.	Button	N/A	0
Contract Billing Rules	Link to the Contract Billing Rules panel.	Hyperlink	N/A	0
Flat Fee	Link to the Flat Fee panel.	Hyperlink	N/A	0
Group	Link to the Group panel.	Hyperlink	N/A	0
HCPCS Procedure Restriction	Link to the HCPCS Procedure Restriction panel.	Hyperlink	N/A	0
New	Opens empty panels needed to create a new Revenue Code.	Button	N/A	0
Note	Link to the Note panel.	Hyperlink	N/A	0
Reimbursement Rules	Link to the Reimbursement Rules panel.	Hyperlink	N/A	0
Save	Saves any/all changes made to any/all panels under this navigation panel.	Button	N/A	0

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6.135.4 Revenue Maintenance-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.135.5 Revenue Maintenance-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.135.6 Revenue Maintenance-Revenue Panel Accessibility

6.135.6.1 To Access the Revenue Maintenance-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Maintenance panel displays.

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6.136 Revenue Mini Search-Revenue Panel

6.136.1 Revenue Mini Search-Revenue Panel Narrative

The Revenue Mini-Search allows search by Revenue Code from the Revenue Information page.

This panel is inquiry only.

Navigation Path: [Reference]- [Revenue] - [search] - [(select row from search results)] - [Next Search By]

6.136.2 Revenue Mini Search-Revenue Panel Layout

6.136.3 Revenue Mini Search-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adv Search	Takes the user to main Revenue Search panel so user may set more advanced search criteria (Phonetic/word search).	Button	N/A	0
Clear	Clears the 'Revenue' field so user may enter new code for searching.	Button	N/A	0
Revenue	This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS. This is the criteria used in the search.	Field	Number (Integer)	4
Search	Initiates search for a Revenue record matching the 'revenue code' keyed-in Revenue field.	Button	N/A	0

6.136.4 Revenue Mini Search-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Next Search By: Revenue	Field	1	No rows found	Enter a valid revenue code.

6.136.5 Revenue Mini Search-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.136.6 Revenue Mini Search-Revenue Panel Accessibility

6.136.6.1 To Access the Revenue Mini Search-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Mini Search-Revenue panel displays.

6.136.6.2 To Navigate the Revenue Mini Search-Revenue Panel

Step	Action	Response
1	Enter **Revenue**.	
2	Click **Search**.	Revenue Information and Maintenance panels display.

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6.137 Base Information-Revenue Panel

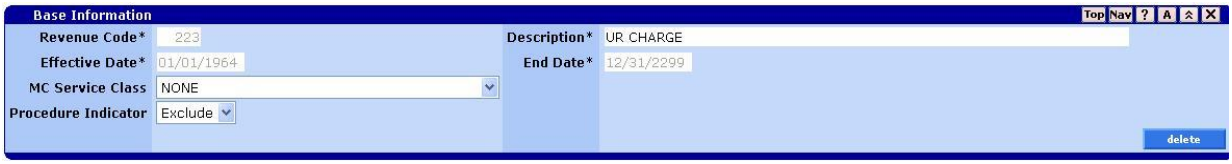
6.137.1 Base Information-Revenue Panel Narrative

The Revenue Code Base Information panel is used to update revenue code data.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue] - [search] - [(select row from search results)] - [Revenue Maintenance] - [Base Information]

6.137.2 Base Information-Revenue Panel Layout



6.137.3 Base Information-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Delete	Allows the user to mark the currently open Revenue record for deletion from Interchange.	Button	N/A	0
Description	This identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS.	Field	Character	70
Effective Date	The date of service the revenue code becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the revenue code is no longer effective.	Field	Date (MM/DD/CCYY)	8
MC Service Class	The service class indicates the type of services provided.	Field	Drop Down List Box	0
Procedure Indicator	This field indicates whether the associated drug, revenue code, or procedure range is included or excluded from the billing restrictions for a provider.	Field	Drop Down List Box	0
Revenue Code	A code which identifies a specific accommodation or ancillary service. Revenue codes are determined by CMS.	Field	Number (Integer)	4

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6.137.4 Base Information-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Key a description in the description field.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an effective date that is less than or equal to the End Date.
	Field	3	Invalid Date.	Verify keying. The Effective Date must be keyed in numeric MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	5	Effective Date is required.	Verify keying. A date must be keyed in this field.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Verify keying. Ensure the end date is greater than or equal to the effective.
	Field	3	Invalid Date.	Verify keying. The End Date must be keyed in numeric MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	5	End Date is required.	Verify keying. A date must be keyed in this field.
Revenue Code	Field	1	Revenue code is required.	Enter a valid Revenue Code.
	Field	2	Revenue code must be greater than or equal to 1.	Enter a valid Revenue Code.
	Field	3	Revenue Code must be less than or equal to 9999.	Verify keying. Revenue Code can't exceed 9999.
	Field	4	Contains duplicates.	Verify keying. The revenue code you keyed is currently on the file.

6.137.5 Base Information-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.137.6 Base Information-Revenue Panel Accessibility

6.137.6.1 To Access the Base Information-Revenue Panel

Step	Action	Response

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Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Base Information**.	Base Information-Revenue panel displays.

6.137.6.2 To Add on the Base Information-Revenue Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Revenue Code**.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Select **MC Service Class** from drop down list box.	
5	Select **Procedure Indicator** from drop down list box.	
6	Enter **Description**.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	Base Information-Revenue information is saved.

6.137.6.3 To Update on the Base Information-Revenue Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Base Information-Revenue information is saved.

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6.137.6.4 To Delete on the Base Information-Revenue Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.138 Benefit Plan Coverage Rules-Revenue Panel

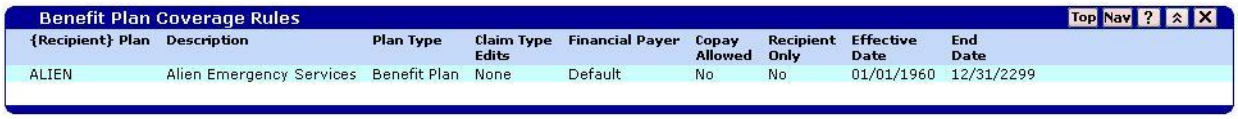
6.138.1 Benefit Plan Coverage Rules- Revenue Panel Narrative

The Benefit Plan Coverage Rules-Revenue panel is used to view the member plan coverage information for a specific revenue code.

This panel is display only.

Navigation Path: [Reference] – [Revenue] - (click on [search] and select row from search results) - [Revenue Maintenance] - [Revenue] - [Benefit Plan Coverage Rules]

6.138.2 Benefit Plan Coverage Rules-Revenue Panel Layout



Benefit Plan Coverage Rules

{Recipient} Plan	Description	Plan Type	Claim Type Edits	Financial Payer	Copay Allowed	Recipient Only	Effective Date	End Date
ALIEN	Alien Emergency Services	Benefit Plan	None	Default	No	No	01/01/1960	12/31/2299

6.138.3 Benefit Plan Coverage Rules-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Identifies the associated list of claim types as included or excluded for the covered benefit.	Combo Box	Drop Down List Box	0
Copay Allowed	Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.	Field	Character	3
Description	Description of the Recipient Plan.	Field	Character	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this benefit plan.	Field	Character	30
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Character	15
Recipient Only	Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.	Field	Character	3
Recipient Plan	Code that identifies the recipient plan that is supported in the system.	Field	Character	5

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6.138.4 Benefit Plan Coverage Rules-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.138.5 Benefit Plan Coverage Rules-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.138.6 Benefit Plan Coverage Rules-Revenue Panel Accessibility

6.138.6.1 To Access the Benefit Plan Coverage Rules- Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row.	Revenue Information and Maintenance panels display.
5	Click **Benefit Plan Coverage Rules**.	Benefit Plan Coverage Rules-Revenue panel displays.

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6.139 Contract Billing Rules-Revenue Panel

6.139.1 Contract Billing Rules- Revenue Panel Narrative

The Contract Billing Rules- Revenue panel is used to display Provider Contracts applicable to revenue codes.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] - [Revenue] - (Click on [Search] button) - (Select row from search results) - [Revenue Maintenance] - [Revenue] - [Contract Billing Rules]

6.139.2 Contract Billing Rules-Revenue Panel Layout

6.139.3 Contract Billing Rules-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Claim Type Edits	Attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Field	Character	1
Description	Description of the provider contract.	Field	Character	30
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Financial Payer for this provider contract.	Field	Character	30
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim.	Field	Date (MM/DD/CCYY)	8
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

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6.139.4 Contract Billing Rules-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.139.5 Contract Billing Rules-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.139.6 Contract Billing Rules-Revenue Panel Accessibility

6.139.6.1 To Access the Contract Billing Rules-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row.	Revenue Information and Maintenance panels display.
5	Click **Contract Billing Rules**.	Contract Billing Rules panel displays.

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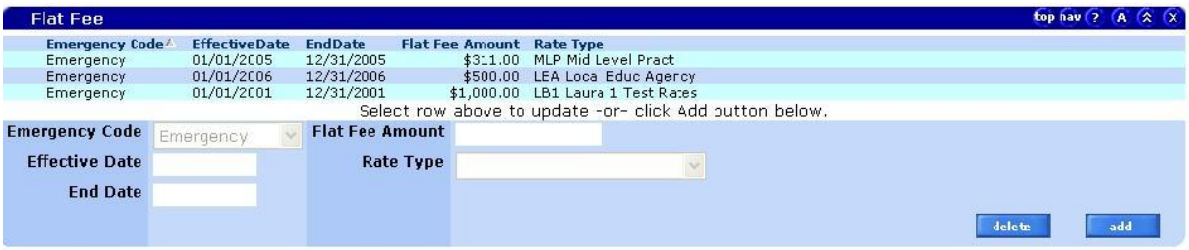
6.140 Flat Fee-Revenue Panel

6.140.1 Flat Fee-Revenue Panel Narrative

The Revenue Flat Fee panel is used to view or update specific revenue codes that have a different reimbursement rate based on emergency status. By clicking on the add button the user can add a new date segment or modify the existing one. Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue] - (click on [search] and select row from search results) - [Revenue Maintenance] - [Revenue] - [Flat Fee]

6.140.2 Flat Fee-Revenue Panel Layout



6.140.3 Flat Fee-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new 'Flat Fee' for this Revenue Code.	Button	N/A	0
Delete	Allows user to mark an existing flat fee structure to be removed from the Revenue Code.	Button	N/A	0
Effective Date	The date of service the emergency rate is effective for claims processing.	Field	Date (MM/DD/CCYY)	8
Emergency Code	A value that denotes if pricing should be computed at the emergency or non-emergency rate.	Combo Box	Drop Down List Box	0
End Date	The date of service the emergency rate is no longer effective for claims processing.	Field	Date (MM/DD/CCYY)	8
Flat Fee Amount	The amount determined to be the flat fee. Format is 9999999.99.	Field	Number (Decimal)	9
Rate Type	The description of the rate type used in determining provider reimbursement.	Combo Box	Drop Down List Box	0

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6.140.4 Flat Fee-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to the Effective Date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Verify dates with the data list. Date segments cannot overlap.
	Field	3	Invalid Date.	Enter an Effective Date that is umeric and in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is more recent than 01/01/1900.
	Field	5	Effective date is required.	Enter an Effective Date.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
Emergency Code	Field	1	Emergency Code is required.	Select an Emergency Code from the drop down list.
	Field	2	Revenue Flat Fee Segments may not overlap for the same Emergency Code and Rate Type.	Verify data. Emergency code line item must not overlap with existing line item.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an End Date that is after the Effective Date.
	Field	2	The fields Effective Date and End Date from row cannot overlap with row.	Enter an End Date range that does not overlap an existing segment.
	Field	3	Invalid Date.	Enter an End Date that is numeric and in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is more recent than 01/01/1900.
	Field	5	End Date is required.	Enter an End Date.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Flat Fee Amount	Field	1	Flat Fee Amount is required.	Enter the amount for the Flat Fee.
	Field	2	Flat Fee Amount must be greater than or equal to 0.01.	Enter a Flat Fee that is numeric field greater than or equal to 0.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Flat Fee Amount must be less than or equal to 9999999.99.	Enter a Flat Fee amount cannot exceed 9,999,999.99.
	Field	4	Enter a valid value.	Enter a Flat Fee that is a numeric field.
	Field	5	Revenue Flat Fee Segments may not overlap for the same Emergency Code and Rate Type.	Cannot enter a duplicate record.
Rate Type	Field	1	A valid Rate Type is required.	Select a Rate Type from the drop down list.

6.140.5 Flat Fee-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.140.6 Flat Fee-Revenue Panel Accessibility

6.140.6.1 To Access the Flat Fee-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Flat Fee**.	Flat Fee-Revenue panel displays.

6.140.6.2 To Add on the Flat Fee-Revenue Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Emergency Code** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Enter **Flat Fee Amount**.	
6	Select **Rate Type** from drop down list box.	
7	Click **Save**.	Flat Fee-Revenue information is saved.

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6.140.6.3 To Update on the Flat Fee-Revenue Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Flat Fee-Revenue information is saved.

6.140.6.4 To Delete on the Flat Fee-Revenue Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.141 Group-Revenue Panel

6.141.1 Group-Revenue Panel Narrative

The Revenue Group panel is used to view revenue groups a specific revenue code is part of.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue] - [search] - [(select row from search results)] - [Revenue Maintenance] - [Group]

6.141.2 Group-Revenue Panel Layout

Group

Revenue Group Type	Description	Revenue From	Code To	Effective Date	End Date
17	Accommodation	110	110	01/01/1900	12/31/2299
22	Inpatient Accommodation	110	110	01/01/1900	12/31/2299
30	Medicare A Covered	110	110	01/01/1900	06/12/2002
33	Private Room Accomodationsdfdfsdfsdfsdfd	110	110	01/01/1900	12/31/2299
36	PAS Inpatient	110	110	01/01/1900	12/31/2299
40	1 bed psych	110	110	01/01/1900	12/31/2299
1002	Outpatient Routine Care	110	179	01/01/1900	12/31/2299
1003	Accommodation	101	179	01/01/1900	12/31/2299

6.141.3 Group-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	The description of the revenue group.	Field	Character	50
Effective Date	The date of service the revenue code becomes effective for the revenue group.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the revenue code is no longer effective for the revenue group.	Field	Date (MM/DD/CCYY)	8
Revenue Code (From)	The lower limit of the revenue code range associated to a group.	Field	Number (Integer)	4
Revenue Code (To)	The upper limit of the revenue code range associated to a group.	Field	Number (Integer)	4
Revenue Group Type	A code that categorizes a revenue code into a particular group.	Field	Number (Integer)	9

6.141.4 Group-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.141.5 Group-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.141.6 Group-Revenue Panel Accessibility

6.141.6.1 To Access the Group -Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Group**.	Group-Revenue panel displays.

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6.142 HCPCS Procedure Restriction-Revenue Panel

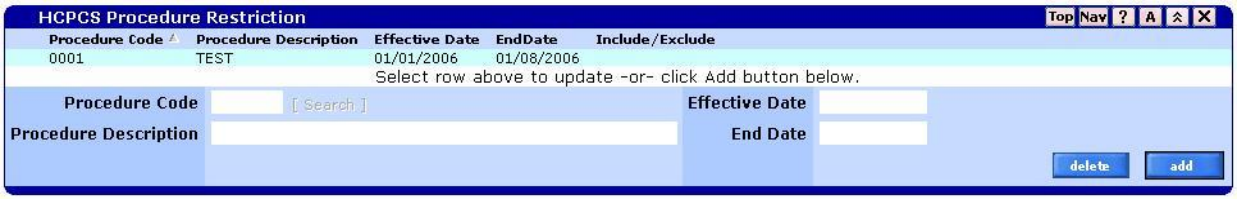
6.142.1 HCPCS Procedure Restriction-Revenue Panel Narrative

The Revenue-HCPCS Procedure Restriction panel is used to update Procedure Codes that are valid/invalid for specific revenue codes. Valid/Invalid (Include/Exclude) indicator is maintained at the Revenue Code level (Base Information panel).

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue] - [search] - [(select row from search results)] - [Revenue Maintenance] - [HCPCS Procedure Restriction]

6.142.2 HCPCS Procedure Restriction-Revenue Panel Layout



6.142.3 HCPCS Procedure Restriction-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to set up a new Procedure Restriction for this Revenue Code.	Button	N/A	0
Delete	Allows the user to mark an existing Procedure Restriction to be removed from this Revenue Code.	Button	N/A	0
Effective Date	The date of service the revenue code/HCPCS Procedure Code Restriction becomes active for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service the revenue code/HCPCS Procedure Code Restriction is no longer active for claims processing.	Field	Date (MM/DD/CCYY)	8
Include/Exclude	This is a datalist display only field. Indicates whether the Procedure Code is valid/invalid for this Revenue Code. This field is maintained at the Revenue Code level on Base Information panel.	Field	Character	7
Procedure Code [Search]	The HCPCS Procedure Code that applies to the Revenue Code Restriction.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Procedure Description	The description of the HCPCS Procedure Code.	Field	Character	40

6.142.4 HCPCS Procedure Restriction-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	3	Invalid Date.	Verify keying. The Effective Date must be keyed in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Verify keying. Date must be more recent than 01/01/1900.
	Field	5	Effective Date is required.	Verify entry. An Effective Date is required for this field.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Date must be less than or equal to 12/31/2299.
End Date	Field	3	Invalid Date.	Verify keying. The End Date must be keyed in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Verify keying. The End Date must be more recent than 01/01/1900.
	Field	5	End Date is required.	Verify entry. An End Date is required for this field.
	Field	6	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
Procedure Code	Hyperlink	1	A valid Procedure Code is required.	Entry is required for this field. Select a Procedure Code using the Search link.
	Hyperlink	2	A duplicate record cannot be saved.	Procedure Code is already used for this Revenue. Enter a non duplicated Procedure Code.

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6.142.5 HCPCS Procedure Restriction-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.142.6 HCPCS Procedure Restriction-Revenue Panel Accessibility

6.142.6.1 To Access the HCPCS Procedure Restriction-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **HCPCS Procedure Restriction**.	HCPCS Procedure Restriction-Revenue panel displays.

6.142.6.2 To Add on the HCPCS Procedure Restriction-Revenue Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to locate **Procedure Code**.	Procedure Code Search panel displays.
3	Enter search criteria or select row from list of results.	Procedure Code and Description information is populated on panel.
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	HCPCS Procedure Restriction-Revenue information is saved.

6.142.6.3 To Update on the HCPCS Procedure Restriction-Revenue Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HCPCS Procedure Restriction-Revenue information is saved.

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6.142.6.4 To Delete on the HCPCS Procedure Restriction-Revenue Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.143 Note-Revenue Panel

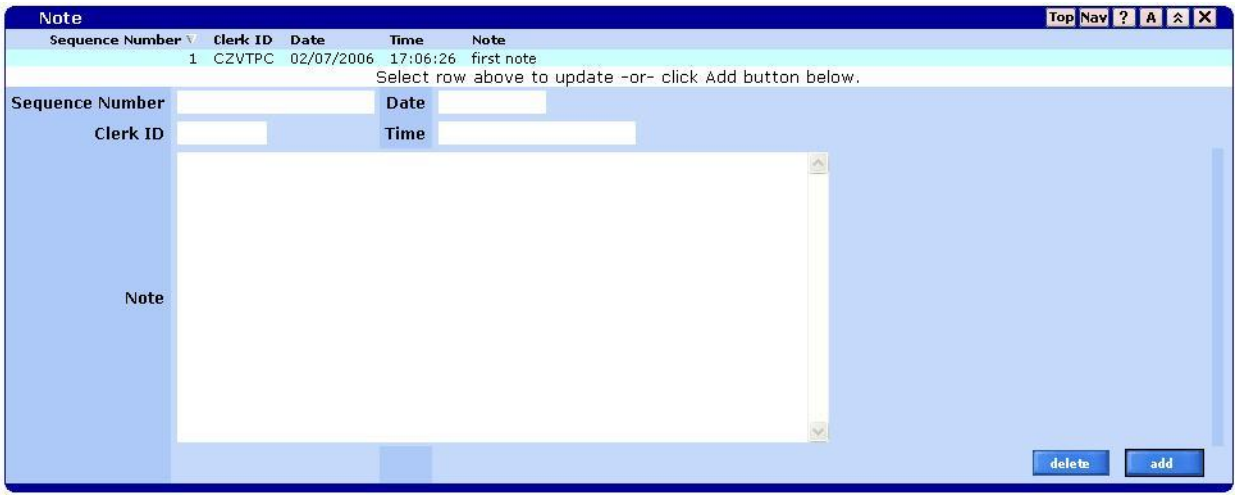
6.143.1 Note-Revenue Panel Narrative

The Note panel is used to enter notes as to why changes were made to a specific Revenue code. Includes fields for date, time, clerk number and note sequence number.

Only authorized users are allowed to perform maintenance tasks.

Navigation Path: [Reference] – [Revenue Search] - [(Add button) OR (select row from search results)] - [Note]

6.143.2 Note-Revenue Panel Layout



6.143.3 Note-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a note.	Button	N/A	0
Clerk ID	Identification of the user who enters the note. This value is set from the user's security profile.	Field	Character	8
Date	The date that the note was entered.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to delete a note.	Button	N/A	0
Note	The actual text of the note.	Field	Character	1000
Sequence Number	Sequence number than can uniquely identify a note.	Field	Number (Integer)	9
Time	The time that the note was entered.	Field	Number (Decimal)	6

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6.143.4 Note-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Add Revenue Code Note text.

6.143.5 Note-Revenue Panel Extra Features

Only the notes field is user enterable, all other fields are auto populated as follows:

Sequence Number - Max sequence number for Proc + 1
Clerk ID - System generated based on users logon id
Date - System Date (When Saved)
Time - System Time (When Saved)

6.143.6 Note-Revenue Panel Accessibility

6.143.6.1 To Access the Note-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Note**.	Note-Revenue panel displays.

6.143.6.2 To Add on the Note-Revenue Panel

Step	Action	Response
1	Click **Add**. Sequence Number, Date and Time automatically populate.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note-Revenue information is saved.

6.143.6.3 To Update on the Note Revenue Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Note-Revenue information is saved.

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6.143.6.4 To Delete on the Note-Revenue Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.144 Reimbursement Rules-Revenue

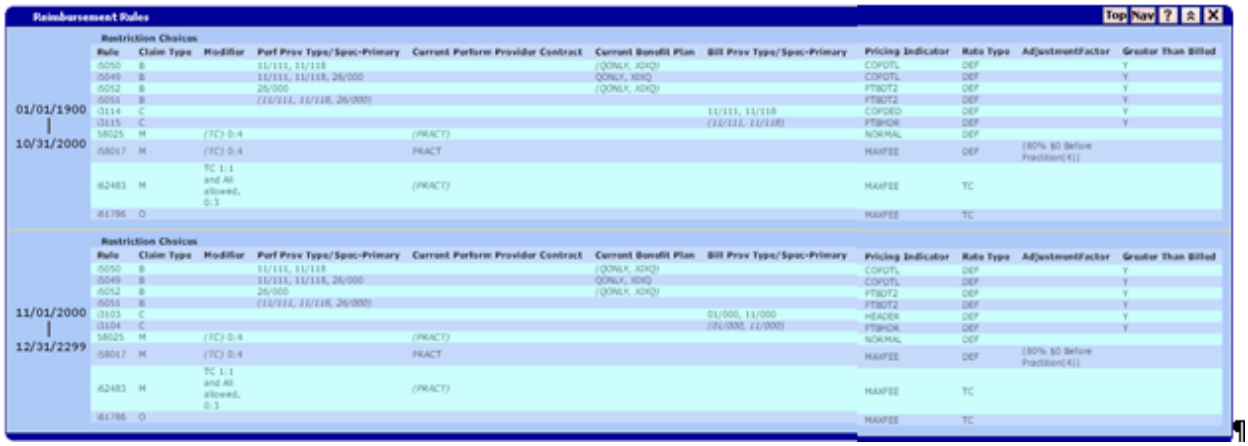
6.144.1 Reimbursement Rules-Revenue Panel Narrative

The Reimbursement Rules-Revenue panel is used to view the Reimbursement Agreement information for a specific revenue code. The information displayed is retrieved from the Reimbusement Agreement tables available through the Benefit administration panels. The panel displays all reimbursement agreements associated with the specified Revenue code.

This panel is display only.

Navigation Path: [Reference] – [Revenue] - [(select row from search results)] - [Reimbursement Rules]

6.144.2 Reimbursement Rules-Revenue Panel Layout



6.144.3 Reimbursement Rules-Revenue Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Bill Prov Type/Spec-Primary	It provides the Billing Provider Type/Specialty value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included.	Field	N/A	0
Claim Type	It provides the Claim Type values that are to be included for this rule. The possible Claim Type values are those that pulled from the Codes-Claim Type panel.	Field	N/A	0

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Field	Description	Field Type	Data Type	Length
Current Benfit Plan	It provides the Current Benefit Plan value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included. The possible Benefit Plan values are on the Recipient Plan-Benefit Administration panel.	Field	N/A	0
Dates	These are the effective and end dates for this rule.	Field	Date (MM/DD/CCYY)	8
Greater Than Billed	Indicates if the amount is greater than what was billed.	Field	Character	3
Perf Prov Type/Spec Primary	It provides the Performing Provider Type/Specialty value(s) that are to be included or excluded from this rule. If the values are in parenthesis they are to be excluded. If there are values with no parenthesis they are to be included.	Field	N/A	0
Pricing Indicator	Indicates if there is a pricing indicator selected for this rule.	Field	N/A	0
Pricing Modifier	Pricing Modifier requirement for claims. Possible values are N - Pay Billed Amount,Y - Pay greater than Billed Amount & Z - Zero Pay Billed Amount.	Field	N/A	0
Rate Type	Indicates what type of Rate Type is selected for this rule. The Rate Type values are those found on the Codes-Rate Type panel.	Field	N/A	0
Rule	It provides the Rule identification.	Field	N/A	0

6.144.4 Reimbursement Rules-Revenue Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.144.5 Reimbursement Rules-Revenue Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.144.6 Reimbursement Rules-Revenue Panel Accessibility

6.144.6.1 To Access the Reimbursement Rules-Revenue Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Revenue**.	Reference Revenue Search panel displays.
3	Click **Search**.	Reference Revenue Search Results panel displays.
4	Select row from data list.	Revenue Information and Maintenance panels display.
5	Click **Reimbursement Rules**.	Reimbursement Rules-Revenue panel displays.

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AMMIS Reference User Manual (Part II)

Date Modified: 11/28/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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6 DOCUMENT CONTROL

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6.1 DOCUMENT INFORMATION PAGE

Required Information	Definition
Document Title	AMMIS Reference User Manual
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6.2 AMENDMENT History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
11/18/2011	1.1		Application of 5010 changes for EIP enhancement	CO 8916 - Increase the length of the ICD procedure code fields from 5 to 7 characters 7.55 - REF-FCA-R – Fund Code Assignment Criteria Report CO 8540 – Increase the Health Care Entity Identifier field from 2 to 3 characters. 6.173 - Codes-Health Care Entity Identifier Panel (6.173.3 and 6.173.4) 6.208 – Other – EOB Panel (6.208.2 and 6.208.3)
			Application of EIP #1 Miscellaneous enhancement changes.	CO 8813 – Add new field 'FIPS County' to panel. 6.155 – Codes – County Panel (6.155.2 and 6.155.3)
12/12/2011	2.0		Agency approved	
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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
02/19/2013	3.0		Application of production change orders	CO 8793 – Revise layout for 7.33 REF-050A-W - Pharmacy Standard Classification Review Report and 7.33 REF-050B-W - Pharmacy Part D Classification Review Report CO 7804 – update panel layout and field descriptions for 6.214 Other-Fund Code Criteria Panel CO 7925 – Add 6.230 Other – PDL Screening Criteria Panel CO 9002 – Update field edit error message for 6.208 Other – EOB Panel. CO 9443 – Update panel layout and field descriptions for 6.207 Other-Drug Exception Panel. CO 10063 – Add Reimbursement Agreement Rule Edit Panel. CO 10815 – Add REF-0400d-C-Q - Quarterly durable medical equipment NCCI Update Report and REF-0400D-C-Q - Quarterly Durable Medical Equipment NCCI Error Report CO 11126 – Update panel layout and field description in Section 6.207 Other-Drug Exception Panel
10/09/2013	4.0		Application of ICD-10 project change orders	CO 10291 – Add the following new reports to manual: REF-0201-A -- ICD-10 Annual Update - New Procedure Codes Report 7.19 REF-0202-A -- ICD-10 Annual Update - Revised Procedure Codes Report Layout 7.21 REF-0203-A -- ICD-10 Annual Update - Discontinued Procedure Codes Report 7.22 REF-0204-A -- ICD-10 Annual Update - Procedure Error Report 7.23 REF-0205-A -- ICD-10 Annual Update - Procedure Summary Report 7.24

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				REF-0206-A -- ICD-10 Annual Update - Associated Groups For Discontinued Procedure Codes Report 7.25 CO – 10247 : Global replacement of ICD-9-CM to ICD CO 10236 Update 7.63 REF-FCA-R – Fund Code Assignment Criteria Report CO 9802: Added the following new reports: REF 0101-A ICD-10 Annual Update – New Diagnosis Codes, REF-0102-A -- ICD-10 Annual Update - Revised Diagnosis Codes Report, REF-0103-A -- ICD-10 Annual Update - Discontinued Diagnosis Codes Report, REF-0104-A -- ICD-10 Annual Update - Diagnosis Error Report, REF-0105-A -- ICD-10 Annual Update - Diagnosis Summary Report, REF-0106-A -- ICD-10 Annual Update - Diagnosis Benefit Category Groupings Report, REF-0107-A -- ICD-10 Annual Update - New Diagnosis Codes Report CO 10261- Add new panel: Benefit Hierarchy – Benefit Coverage panel. CO 10264 - Add the following new panels: Reimbursement Agreement Edit Panel Other Insurance Coverage Edit Panel Provider Contract Edit Panel Benefit Coverage Edit Panel CO 10277 –section 6.197 Related Data –Other Panel – update layout and field descriptions.

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				CO 10277 section 6.222 Other ICD Procedure Group Type- Procedure Group Panel – update layout, field descriptions and field edit error messages. CO 10283 – 6.204 Other - Diagnosis Group Type panel – update layout, field descriptions and field edit error messages. Remove Other Diagnosis Group Type Diagnosi Group Panel. CO 10262 – Add 6.278 Other Insurance Plan – Benefit Coverage Panel Add 6.276 Provider Contract – Benefit Coverage Panel Add 6.268 Recipient Plan Benefit Coverage Benefit Administration Panel Add 6.263 Recipient Plan – Benefit Administration Panel Edit 6.283 Reimbursement Agreement Panel- update layout, field descripitons, field edit error messages.
10/25/2013	5.0		Application of ACA change orders	CO 11043 Add new section 6.257 Related Data – Eligibility Coverage Panel. Add new section 6.258 – Eligibity Coverage Service Type Panel CO 11046 Add new section 6.259 – Eligibility CVG Service Coverage panel
07/21/2015	6.0		Application of ACA III production change orders	CO 12166 – Related Data Codes Page – modified to add new CARC/RARC panel. CO 12166 – Add new CARC.RARC panel. CO 12167 – Remove Other-EOB-HIPAA Adjustment Reason-EOB Xref Data Panel and Other-EOB-HIPAA Remarks-EOB Xref Data Panel CO 12168 Add Other-EOB-carc/rarc/eob Xref Data

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Panel and Other-EOB-Busc/carc/rarc Panel CO 12169 – Update Codes-HIPAA Adjustment Reason Panel and Codes – HIPAA Remark panel. CO 12187 Add new REF-0005-O - audit for EOB to BUSC/CARC/RARC/CAGC Cross Reference Complicance Report CO 12560 Add New REF-900-O CARC RARC Combinations Update Audit Report (New)
05/11/2016	7.0		Application of CO 12220	CO 12220 6.228.4 Other –PDL Maintenance Panel Fied Edit Error Messages
07/13/2016	8.0		Application of CO 13578 and 13000	CO 13578 6.193 - Codes – Type of Bill Panel – update panel layout and field description. CO 13000 Reference Related Data Code Page Related Data eligiblity Cvg Panel Reference Related DataRpt Dist Page Related Data Other Page Related Data Groups Page Groups – AFHS Group Type Panel Groups – Aid Code Group Type Panel Groups – Diagnosis Group Type Panel Groups – GCN Sequence Number Group Type Panel Groups – GCN Sequence Number Group Type – GCN Sequence Number Group Panel Groups – Group Type Panel Groups – HCPCS Procedure Group Type Panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Groups – HCPCS Procedure Group Type – HCPCS Procedure Group Panel Groups – HIC Group Type Panel Groups – ICD Procedure Group Type Panel Groups – ICD Procedure Group Type – ICD Procedure Group Panel Groups – Modifier Group Type Panel Groups – Modifier Group Type – Modifier Group panel Groups – NDC Group Type Panel Groups – NDC Group type – NDC Group Panel Groups – Provider Group Type Panel Groups – Prov Type/Prov Speciality Group Type Panel Groups – Prov Type Prov Speciality Group Type Prov Speciality Group Panel Groups – Revenue Group Type Panel Groups – Revenue Group Type – Revenue Group Panel Groups – Therapeutic Group Type Panel Groups – Therapeutic Group Type – Therapeutic Group panel Groups – Type Of Bill Group Type Panel Groups – Type of Bill Group Type – Type of Bill Group Panel
09/27/2016	9.0		Application of RCO COs	CO 13024 Add 6.280 DRG – Rates panel CO 13025 Modify Related Data - Other, Sec 6.197.2 Add link to DRG Peer Group panel Modify Related Data - Other, Sec 6.197.3 Add link to DRG Peer Group panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Add 6.206 DRG Peer Group panel CO 13023 Add section 6.279 DRG – MDC Panel Add section 6.278 DRG – Group Panel CO 13026 Modify Related Data - Other, Sec 6.170.2 Add link to DRG GroupType panel Moidfy Related Data - Other, Sec 6.170.3 Add link to DRG Peer Group panel Add Related Data - Other, Sec 6.205 Add DRG Peer Group Type panel CO 13027 Add section 6.140 Related Data Codes -MDC Panel Modify section 6.140 Related Data Codes Panel - add link to MDC panel Add 6.177 Codes - MDC Panel
09/19/2018	10.0		Application of CO 15069	Reimbursement Agreement Edit Panel, Reimbursement Rules Diagnosis Panel, Reiimbursement Rules Drug Panel, Reimbursement Rules Procedure panel, and Reimbursement Rules Revenue panel. Updated field descriptions
11/01/2018	11.0		Removal of PHI/PII	Section 6.235.2
11/28/2018	10.0		Application of CO 15264	6.217: Other-Fund Code Criteria Panel- panel layout, field descriptions updates
			Application of CO 15077	MME – Voluntary Descripiton and Source Panel MME – Set and Group Link panel MME Range Factor Group panel MME – Drug Concept Panel MME – Drugs with Potential Risk Panel MME – Designated Route Ingredient panel MME – Daily Alerting Panel MME – Concurrent Risk Set Panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				MME – Base Ingredient Panel MME – Alerts and Exceptions panels

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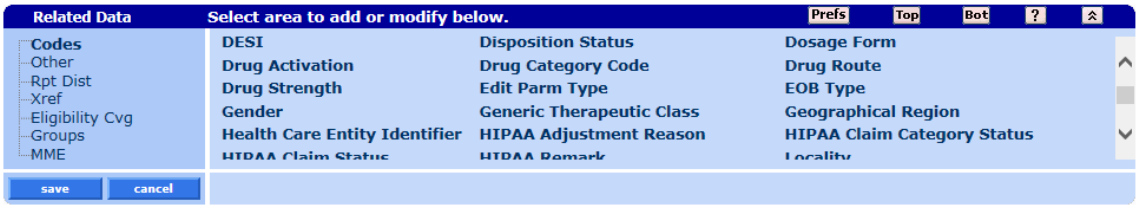
6.143 RELATED DATA CODES PAGE

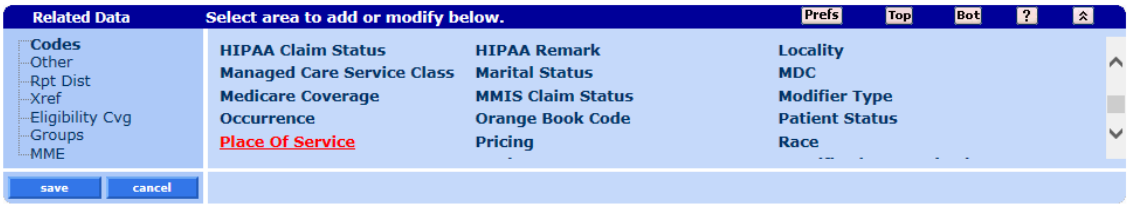
6.143.1 Related Data Codes Page Narrative

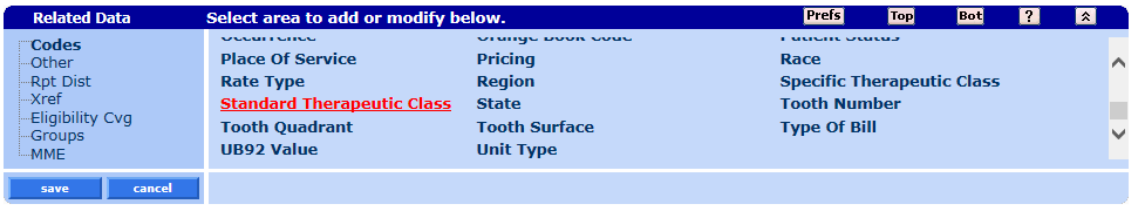
The Reference Related Data Codes page allows the user to access the various code tables maintained within the Reference Data Maintenance subsystem area. This panel is inquiry only.

Navigation: [Reference] – [Related Data] - [Codes]

6.143.2 Reference Related Data Codes Page Layout







6.143.3 Related Data Codes Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Type	Link to Accident Type panel.	Hyperlink	N/A	0
Admit Source	Link to Admit Source panel.	Hyperlink	N/A	0
Admit Type	Link to Admit Type panel.	Hyperlink	N/A	0
AHFS Therapeutic Class	Link to AHFS Therapeutic Class panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
ASC Payment Group	Link to ASC Payment Group panel.	Hyperlink	N/A	0
Attachment	Link to Attachment panel.	Hyperlink	N/A	0
Benefit Type	Link to Benefit Type panel.	Hyperlink	N/A	0
CARC/RARC	Link to CARC/RARC Panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel changes on the Related Data-Codes panel.	Button	N/A	0
Claim Location	Link to Claim Location panel.	Hyperlink	N/A	0
Claim Type	Link to Claim Type panel.	Hyperlink	N/A	0
CMS FDA Therapeutic Equivalency	Link to CMS FDA Therapeutic Equivalency panel.	Hyperlink	N/A	0
CMS Type of Service	Link to CMS Type of Service panel.	Hyperlink	N/A	0
Condition	Link to Condition panel.	Hyperlink	N/A	0
County	Link to County panel.	Hyperlink	N/A	0
DEA	Link to DEA panel.	Hyperlink	N/A	0
DESI	Link to DESI panel.	Hyperlink	N/A	0
Disposition Status	Link to Disposition Status panel.	Hyperlink	N/A	0
Dosage Form	Link to Dosage Form panel.	Hyperlink	N/A	0
Drug Activation	Link to Drug Activation panel.	Hyperlink	N/A	0
Drug Category Code	Link to Drug Category Code panel.	Hyperlink	N/A	0
Drug Route	Link to Drug Route panel.	Hyperlink	N/A	0
Drug Strength	Link to Drug Strength panel.	Hyperlink	N/A	0
Edit Parm Type	Link to Edit Parm Type panel.	Hyperlink	N/A	0
EOB Type	Link to EOB Type panel.	Hyperlink	N/A	0
Gender	Link to Gender panel.	Hyperlink	N/A	0
Generic Therapeutic Class	Link to Generic Therapeutic Class panel.	Hyperlink	N/A	0
Geographical Region	Link to Geographical Region panel.	Hyperlink	N/A	0
Health Care Entity Identifier	Link to Health Care Entity Identifier panel.	Hyperlink	N/A	0
HIPAA Adjustment Reason	Link to HIPAA Adjustment Reason panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
HIPAA Claim Category Status	Link to HIPAA Claim Category Status panel.	Hyperlink	N/A	0
HIPAA Claim Status	Link to HIPAA Claim Status panel.	Hyperlink	N/A	0
HIPAA Remark	Link to HIPAA Remark panel.	Hyperlink	N/A	0
Locality	Link to Locality panel.	Hyperlink	N/A	0
Managed Care Service Class	Link to Managed Care Service Class panel.	Hyperlink	N/A	0
Marital Status	Link to Marital Status panel.	Hyperlink	N/A	0
MDC	Link to MDC panel.	Hyperlink	N/A	0
Medicare Coverage	Link to Medicare Coverage panel.	Hyperlink	N/A	0
MMIS Claim Status	Link to MMIS Claim Status panel.	Hyperlink	N/A	0
Modifier Type	Link to Modifier Type panel.	Hyperlink	N/A	0
Occurrence	Link to Occurrence panel.	Hyperlink	N/A	0
Orange Book Code	Link to Orange Book Code panel.	Hyperlink	N/A	0
Patient Status	Link to Patient Status panel.	Hyperlink	N/A	0
Place of Service	Link to Place of Service panel.	Hyperlink	N/A	0
Pricing	Link to Pricing panel.	Hyperlink	N/A	0
Race	Link to Race panel.	Hyperlink	N/A	0
Rate Type	Link to Rate Type panel.	Hyperlink	N/A	0
Region	Link to Region panel.	Hyperlink	N/A	0
Save	Allows user to save changes on the Related Data-Codes panel.	Button	N/A	0
Specific Therapeutic Class	Link to Specific Therapeutic Class panel.	Hyperlink	N/A	0
Standard Therapeutic Class	Link to Standard Therapeutic Class panel.	Hyperlink	N/A	0
State	Link to State panel.	Hyperlink	N/A	0
Tooth Number	Link to Tooth Number panel.	Hyperlink	N/A	0
Tooth Quadrant	Link to Tooth Quadrant panel.	Hyperlink	N/A	0
Tooth Surface	Link to Tooth Surface panel.	Hyperlink	N/A	0
Type of Bill	Link to Type of Bill panel.	Hyperlink	N/A	0
UB92 Value	Link to UB92 Value panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Unit Type	Link to Unit Type panel.	Hyperlink	N/A	0

6.143.4 Related Data Codes Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.143.5 Related Data Codes Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.143.6 Related Data Codes Page Accessibility

6.143.6.1 To Access the Related Data Codes Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.

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6.144 CODES-ACCIDENT TYPE PANEL

6.144.1 Codes-Accident Type Panel Narrative

The Accident Type panel is used to maintain the HIPAA Related Causes codes pertaining to accident or employment related conditions.

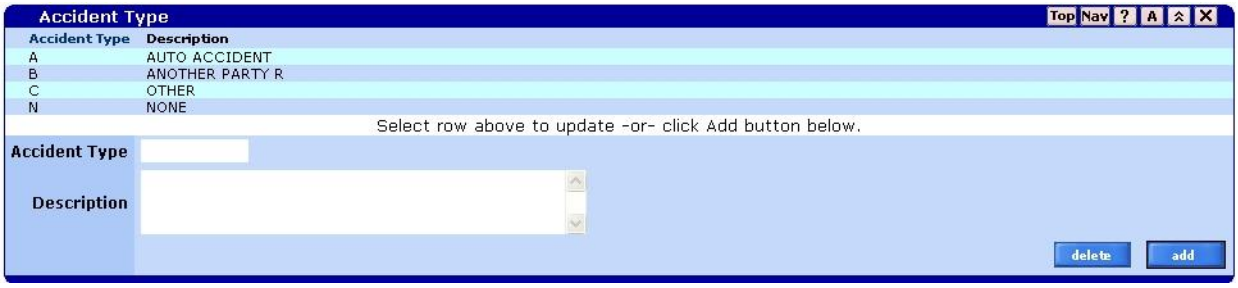
The panel consists of a data list displaying the defined Accident Types and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel. .

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference]- [Related Data] - [Codes] - [Accident Type]

6.144.2 Codes-Accident Type Panel Layout



6.144.3 Codes-Accident Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Type	Code identifying an accompanying cause of an accident, injury or illness, for example: Auto Accident.	Field	Character	1
Add	Allows the user to add an Accident Type code.	Button	N/A	0
Delete	Allows the user to delete an Accident Type.	Button	N/A	0
Description	Text description of the Accident Type code.	Field	Character	15

6.144.4 Codes-Accident Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Accident Type	Field	1	Accident Type is required.	Enter an Accident type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Accident Type code.
Description	Field	2	Description is required.	Enter a text description of the Accident Type code.

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6.144.5 Codes-Accident Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.144.6 Codes-Accident Type Panel Accessibility

6.144.6.1 To Access the Codes-Accident Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Accident Type**.	Accident Type panel displays.

6.144.6.2 To Add on the Codes-Accident Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Accident Type**.	
3	Enter **Description**.	
4	Click **Save**.	Accident Type information is saved.

6.144.6.3 To Update on the Codes-Accident Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Accident Type information is saved.

6.144.6.4 To Delete on the Codes-Accident Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.145 CODES-ADMIT SOURCE PANEL

6.145.1 Codes-Admit Source Panel Narrative

The Admit Source panel is used to maintain the NUBC Source of Admission codes.

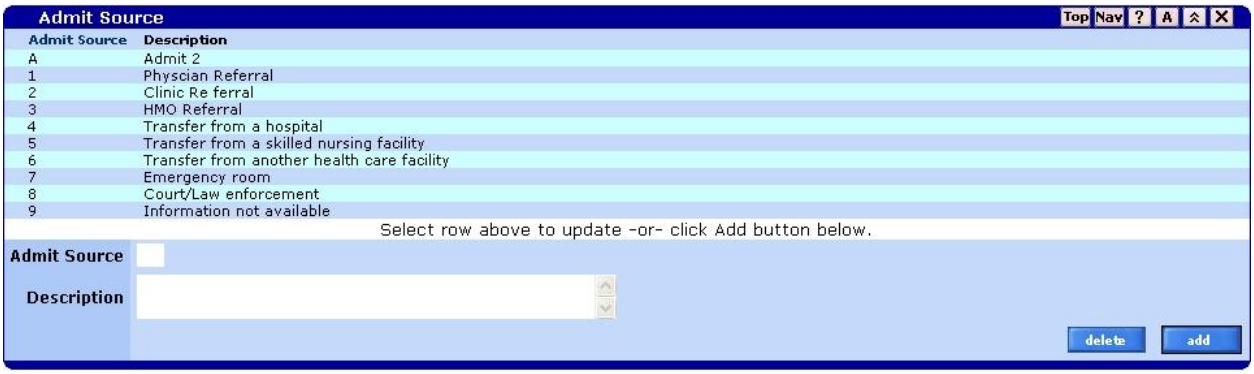
The panel consists of a data list displaying the defined Admit Sources and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference]- [Related Data] - [Codes] - [Admit Source]

6.145.2 Codes-Admit Source Panel Layout



6.145.3 Codes-Admit Source Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allow a user to add an Admit Source.	Button	N/A	0
Admit Source	Code identifying the source of admission in block 15 on the UB04 claim record for inpatient and LTC claims.	Field	Character	1
Delete	Allows the user to delete an Admit Source.	Button	N/A	0
Description	Description of the source of admission code found in block 15 on the UB04 claim record for inpatient and LTC claims.	Field	Character	50

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6.145.4 Codes-Admit Source Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admit Source	Field	1	Admit Source Code is required.	Enter an Admit Source code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Admit Source code.
Description	Field	1	Description is required.	Enter a text description of the admit source code.

6.145.5 Codes-Admit Source Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.145.6 Codes-Admit Source Panel Accessibility

6.145.6.1 To Access the Codes-Admit Source Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Admit Source**.	Admit Source panel displays.

6.145.6.2 To Add on the Codes-Admit Source Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Admit Source**.	
3	Enter **Description**.	
4	Click **Save**.	Admit Source information is saved.

6.145.6.3 To Update on the Codes-Admit Source Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Admit Source information is saved.

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6.145.6.4 To Delete on the Codes-Admit Source Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.146 CODES-ADMIT TYPE PANEL

6.146.1 Codes-Admit Type Panel Narrative

The Admit Type panel is used to maintain the NUBC Type of Admission codes. Admit Type indicates the priority of the admission/visit.

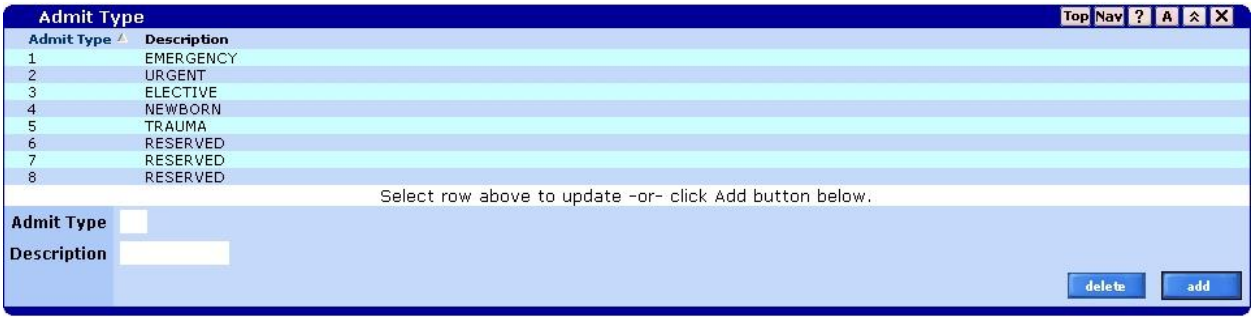
The panel consists of a data list displaying the defined Admit Types and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Admit Type]

6.146.2 Codes-Admit Type Panel Layout



6.146.3 Codes-Admit Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Admit Type code.	Button	N/A	0
Admit Type	Code which indicates the priority of the admission of a recipient for inpatient services.	Field	Character	1
Delete	Allows the user to delete an Admit Type code.	Button	N/A	0
Description	Description for the priority of the admission of a recipient for inpatient services.	Field	Character	10

6.146.4 Codes-Admit Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admit Type	Field	1	Admit Type is Required.	Enter an Admit Type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Admit Type code.
Description	Field	3	Description is Required.	Enter a text description of the admit type code.

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6.146.5 Codes-Admit Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.146.6 Codes-Admit Type Panel Accessibility

6.146.6.1 To Access the Codes-Admit Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select **Admit Type**.	Admit Type panel displays.

6.146.6.2 To Add on the Codes-Admit Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Admit Type**.	
3	Enter **Description**.	
4	Click **Save**.	Admit Type information is saved.

6.146.6.3 To Update on the Codes-Admit Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Admit Type information is saved.

6.146.6.4 To Delete on the Codes-Admit Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.147 CODES-AHFS THERAPEUTIC CLASS PANEL

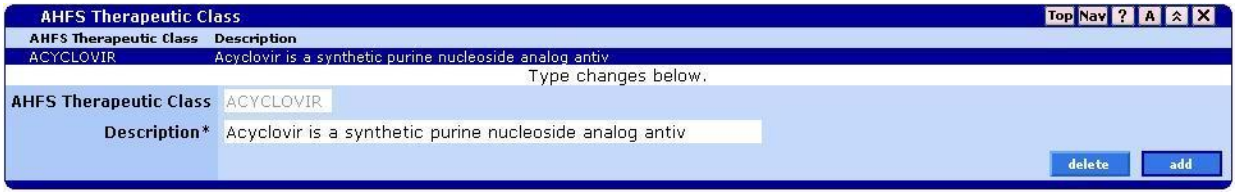
6.147.1 Codes-AHFS Therapeutic Class Panel Narrative

The AHFS Therapeutic Class panel identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path - [Reference] - [Related Data] - [Codes] - [AHFS Therapeutic Class]

6.147.2 Codes-AHFS Therapeutic Class Panel Layout



6.147.3 Codes-AHFS Therapeutic Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add an AHFS Therapeutic Class record.	Button	N/A	0
AHFS Therapeutic Class	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Alphanumeric	10
Delete	Delete an AHFS Therapeutic Class record.	Button	N/A	0
Description	Provides the text description for the AHFS Therapeutic Class code.	Field	Alphanumeric	55

6.147.4 Codes-AHFS Therapeutic Class Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS Therapeutic Class	Field	1	AHFS Therapeutic Class Code is required.	Enter AHFS Therapeutic Class Code.
Description	Field	2	Description is required.	Enter a Description.

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6.147.5 Codes-AHFS Therapeutic Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.147.6 Codes-AHFS Therapeutic Class Panel Accessibility

6.147.6.1 To Access the Codes-AHFS Therapeutic Class Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **AHFS Therapeutic Class**.	AHFS Therapeutic Class panel displays.

6.147.6.2 To Add on the Codes-AHFS Therapeutic Class Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **AHFS Therapeutic Class**.	
3	Enter **Description**.	
4	Click **Save**.	AHFS Therapeutic Class information is saved.

6.147.6.3 To Update on the Codes-AHFS Therapeutic Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AHFS Therapeutic Class information is saved.

6.147.6.4 To Delete on the Codes-AHFS Therapeutic Class Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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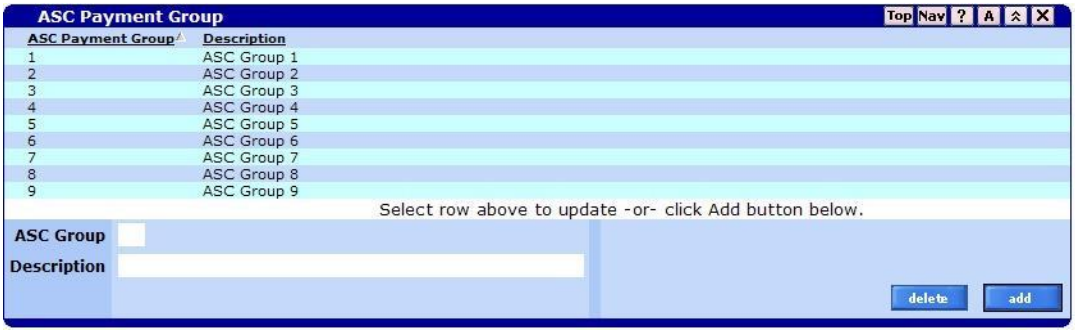
6.148 CODES-ASC PAYMENT GROUP PANEL

6.148.1 Codes-ASC Payment Group Panel Narrative

The ASC Payment Group panel allows a user to maintain the list of ASC Payment Groups and their respective descriptions. Ambulatory Surgical Center (ASC) payment groups classify procedures into different payment groups that are based on surgical procedure complexity. ASC payment groups and rates for the payment groups are established by CMS. An Ambulatory Surgical Center (ASC) is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in Medicare as an ASC. ASCs must be state licensed and Medicare certified. An ASC may be either independent (i.e., not a part of any other facility) or hospital affiliated. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [ASC Payment Group]

6.148.2 Codes-ASC Payment Group Panel Layout



6.148.3 Codes-ASC Payment Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add an ASC Payment Group record.	Button	N/A	0
ASC Payment Group	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	Field	Character	1
Delete	Delete an ASC Payment Group record.	Button	N/A	0
Description	Text describing the Ambulatory Surgical Center pricing group.	Field	Character	50

6.148.4 Codes-ASC Payment Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
ASC Payment Group	Field	1	ASC Payment Group is required.	Enter an ASC Payment Group Code.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Enter a unique ASC Payment Group.
Description	Field	1	Description is required.	Add Description text.

6.148.5 Codes-ASC Payment Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.148.6 Codes-ASC Payment Group Panel Accessibility

6.148.6.1 To Access the Codes-ASC Payment Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **ASC Payment Group**.	ASC Payment Group panel displays.

6.148.6.2 To Add on the Codes-ASC Payment Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ASC Payment Group**.	
3	Enter **Description**.	
4	Click **Save**.	ASC Payment Group information is saved.

6.148.6.3 To Update on the Codes-ASC Payment Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	ASC Payment Group information is saved.

6.148.6.4 To Delete on the Codes-ASC Payment Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

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Step	Action	Response
2	Click **Delete**.	Line item is deleted.

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6.149 CODES-ATTACHMENT PANEL

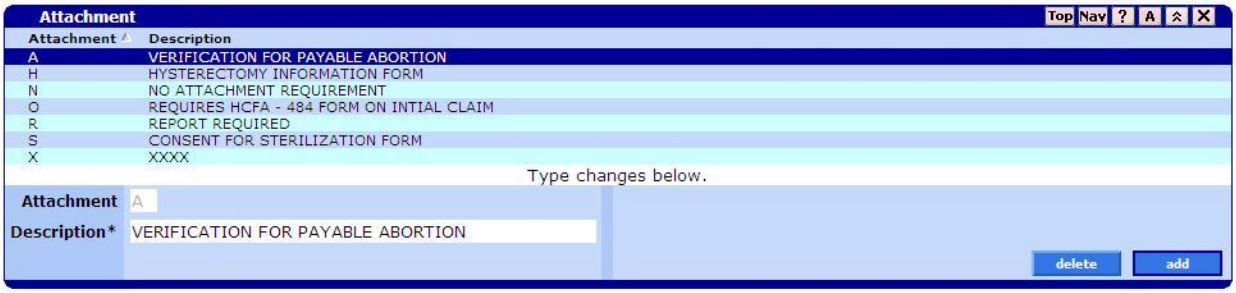
6.149.1 Codes-Attachment Panel Narrative

The Attachment panel is used to maintain the Attachment Code table which identifies and describe claims attachments.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Attachment]

6.149.2 Codes-Attachment Panel Layout



6.149.3 Codes-Attachment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Attachment code.	Button	N/A	0
Delete	Allows the user to delete an Attachment code.	Button	N/A	0
Attachment	Code used to identify the type of claims attachment.	Field	Character	1
Description	Text description of claims attachment.	Field	Character	50

6.149.4 Codes-Attachment Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Attachment	Field	1	Attachment is required.	Enter a Attachment code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Attachment code.
Description	Field	1	Description is required.	Enter a text description of the attachment code.

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6.149.5 Codes-Attachment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.149.6 Codes-Attachment Panel Accessibility

6.149.6.1 To Access the Codes-Attachment Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagedisplays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Attachment**.	Attachment panel displays.

6.149.6.2 To Add on the Codes-Attachment Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Attachment**.	
3	Enter **Description**.	
4	Click **Save**.	Attachment information is saved.

6.149.6.3 To Update on the Codes-Attachment Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Attachment information is saved.

6.149.6.4 To Delete on the Codes-Attachment Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.150 CODES-BENEFIT TYPE PANEL

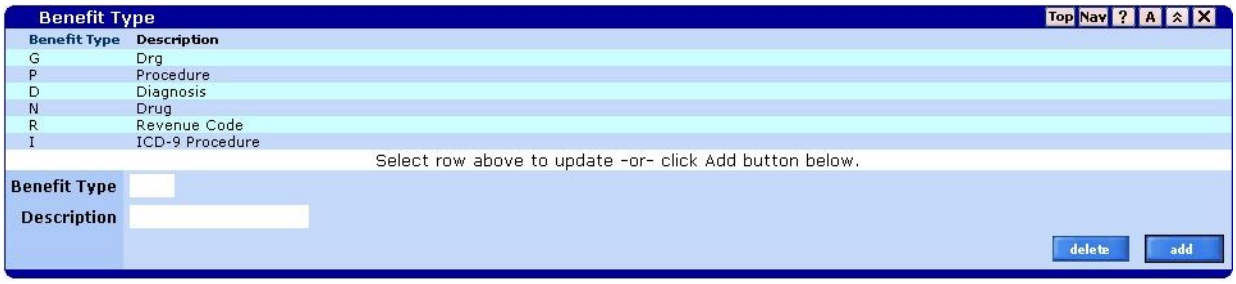
6.150.1 Codes-Benefit Type Panel Narrative

The Benefit Type panel is used to maintain the benefit type's code set.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Benefit Type]

6.150.2 Codes-Benefit Type Panel Layout



6.150.3 Codes-Benefit Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Benefit Type code.	Button	N/A	0
Delete	Allows the user to delete a Benefit Type code.	Button	N/A	0
Benefit Type	Code used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD procedures, ICD diagnosis, Revenue Code and Drug codes (NDCs).	Field	Character	3
Description	Text description of the benefit type.	Field	Character	18

6.150.4 Codes-Benefit Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Type	Field	1	Benefit Type is required.	Enter a Benefit Type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Benefit Type code.
Description	Field	1	Description is required.	Enter a text description of the Benefit Type.

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6.150.5 Codes-Benefit Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.150.6 Codes-Benefit Type Panel Accessibility

6.150.6.1 To Access the Codes-Benefit Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Benefit Type**.	Benefit Type panel displays.

6.150.6.2 To Add on the Codes-Benefit Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Benefit Type**.	
3	Enter **Description**.	
4	Click **Save**.	Benefit Type information is saved.

6.150.6.3 To Update on the Codes-Benefit Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Type information is saved.

6.150.6.4 To Delete on the Codes-Benefit Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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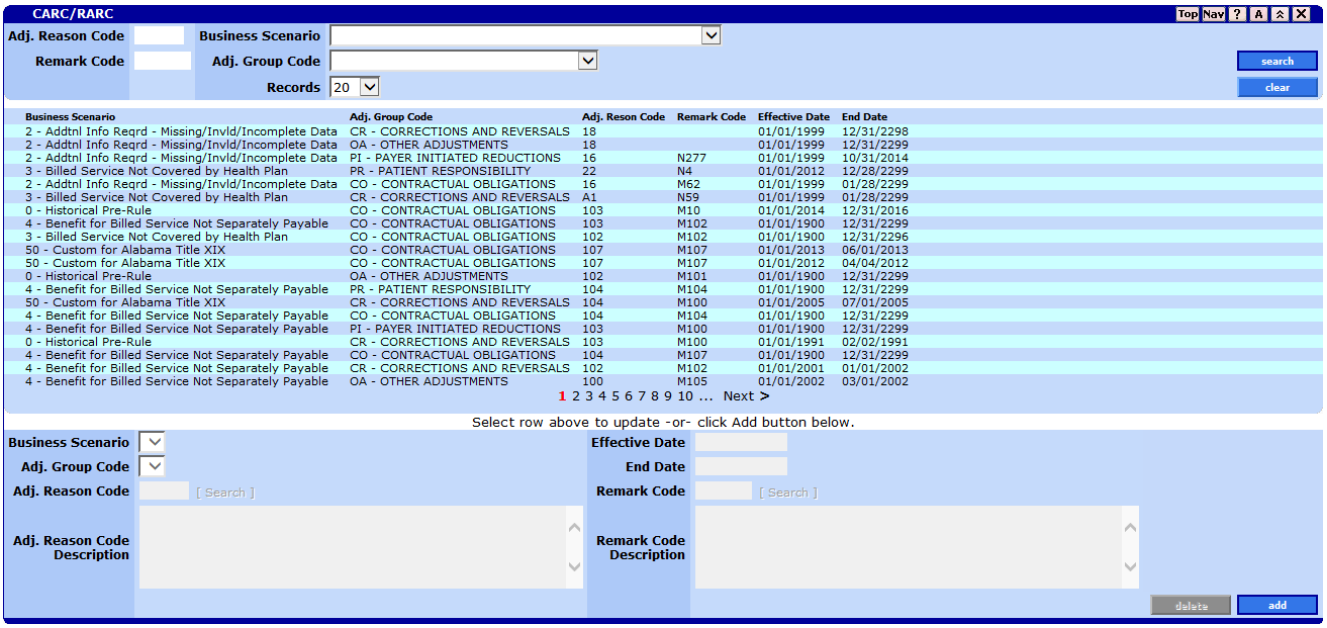
6.151 CODES - CARC/RARC PANEL OVERVIEW

6.151.1 Codes - CARC/RARC Panel Narrative

The CARC/RARC maintenance panel is used to maintain the CAQH CORE defined business scenario groups which establishes the appropriate CARC/RARC and Adjustment group code combinations for a particular business scenario. The information on this panel could potentially be updated several times a year as CAQH CORE releases a new code listing. Effective and End dates will be used to show the timeframe for which a combination is valid per CAQH CORE guidelines. This panel will also allow a Reference systems engineer and/or BA to maintain Alabama specific combinations.

Navigation: [Reference] – [Related Data] - [Codes] – [CARC/RARC]

6.151.2 Codes - CARC/RARC Panel Layout



6.151.3 Codes - CARC/RARC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a new entry.	Button	N/A	0
Adj. Group Code	Code identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code).	Combo Box	Alphanumeric	2
Adj. Reason Code	HIPAA Adjustment Reason code.	Field	Number (Integer)	9

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Adj. Reason Code Description	Description of HIPAA Adjustment Reason code.	Field	Alphanumeric	700
Business Scenario	A code to indicate the Business Scenario for the combination.	Combo Box	Alphanumeric	2
Clear	Clears the search criteria.	Button	N/A	0
Delete	Deletes the entry.	Button	N/A	0
Effective Date	The date the combination becomes valid for use in the system.	Field	Date (CCYYMMDD)	8
End Date	The last date the combination is valid for use in the system.	Field	Date (CCYYMMDD)	8
Remark Code	HIPAA Remark Code.	Field	Number (Integer)	9
Remark Code Description	Description of HIPAA Remark Code.	Field	Alphanumeric	700
Search	Triggers the panel to start a search using the provided criteria.	Button	N/A	0

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6.151.4 Codes - CARC/RARC Panel Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Adj. Group Code	Combo Box	1	A valid Adj. Group Code is required.	Please select valid Adj. Group Code from dropdown.
Business Scenario	Combo Box	1	A valid Business Scenario is required.	Please select valid Business Scenario from dropdown.
		2	A record with Business Scenario 0 is not allowed.	Select a Business Scenario other than 0.
Adj. Reason Code	Field	1	A valid Adj. Reason Code is required.	Please enter valid Adj. Reason Code.
Effective Date	Field	1	Effective Date is required.	Please enter a valid effective date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid Effective Date. Format is MM/DD/CCYY.
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Please enter Effective Date greater than or equal to 1/1/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Please enter Effective Date less than or equal to 12/31/2299.
	Field	5	Effective Date must be less than or equal to End Date.	Please enter Effective Date less than or equal to End Date.
End Date	Field	1	End Date is required.	Please enter a valid end date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid End Date. Format is MM/DD/CCYY.
	Field	3	End Date must be greater than or equal to 1/1/1900.	Please enter End Date greater than or equal to 1/1/1900.

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	Field	4	End Date must be less than or equal to 12/31/2299.	Please enter End Date less than or equal to 12/31/2299.

6.151.5 Codes - CARC/RARC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.151.6 Codes - CARC/RARC Panel Accessibility

6.151.6.1 To Access the Codes - CARC/RARC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **CARC/RARC**.	CARC/RARC panel displays.

6.151.6.2 To Add on the Codes - CARC/RARC Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Business Scenario** by clicking on the drop down list box.	
3	Enter **Effective Date**.	
4	Select **Adj. Group Code** by clicking on the drop down list box.	
5	Enter **End Date**.	
6	Enter **Adj. Reason Code**.	
7	Click **Save**.	CARC/RARC panel information is saved.

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6.151.6.3 To Update on the Codes - CARC/RARC Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in field(s) to update and perform update.	
3	Click **Save**.	CARC/RARC panel information is saved.

6.151.6.4 To Delete on the Codes - CARC/RARC Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	CARC/RARC record is deleted.

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6.152 CODES-CLAIM LOCATION PANEL

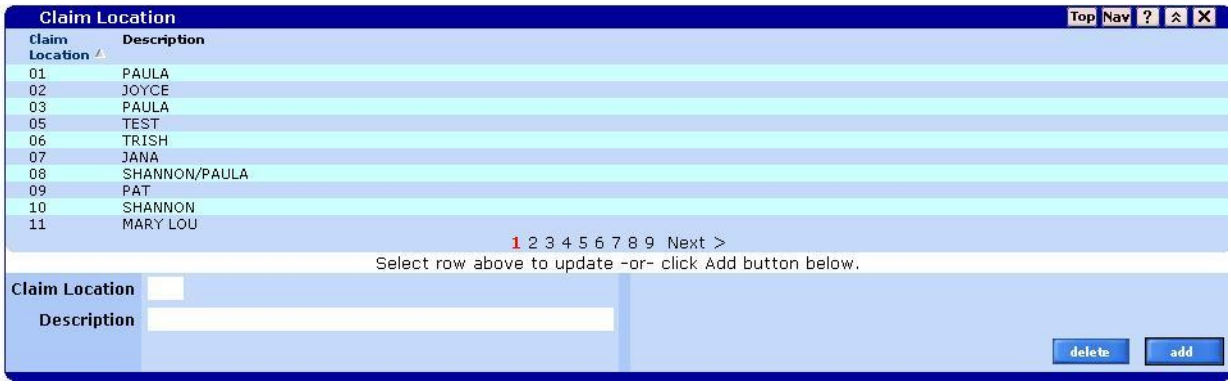
6.152.1 Codes-Claim Location Panel Narrative

The Claim Location panel is used to maintain the claim location codes, the priority for any resolution issues, whether they are sent externally for resolution, and whether they incur interest charges after a certain time period of non-resolution.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Claim Location]

6.152.2 Codes-Claim Location Panel Layout



6.152.3 Codes-Claim Location Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Claim Location code.	Button	N/A	0
Claim Location	Type of location in which a claim can be placed during processing in the MMIS system.	Field	Character	2
Delete	Allows a user to delete a Claim Location code.	Button	N/A	0
Description	Description of the type of location in which a claim can be placed during claims processing.	Field	Character	50

6.152.4 Codes-Claim Location Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Claim Location	Field	1	A duplicate record cannot be saved.	Enter a unique Claim Location code.
	Field	2	Claim Location must be Alphanumeric.	Enter a Claim Location code that contains only 0-9 and A-Z.
	Field	6	Claim Location is required.	Enter a Claim Location code.
Description	Field	6	Description is required.	Enter a Description.

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6.152.5 Codes-Claim Location Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.152.6 Codes-Claim Location Panel Accessibility

6.152.6.1 To Access the Codes-Claim Location Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Claim Location**.	Dosage Form panel displays.

6.152.6.2 To Add on the Codes-Claim Location Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Claim Location**.	
3	Enter **Description**.	
4	Click **Save**.	Claim Location information is saved.

6.152.6.3 To Update on the Codes-Claim Location Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Claim Location information is saved.

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6.152.6.4 To Delete on the Codes-Claim Location Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.153 CODES-CLAIM TYPE PANEL

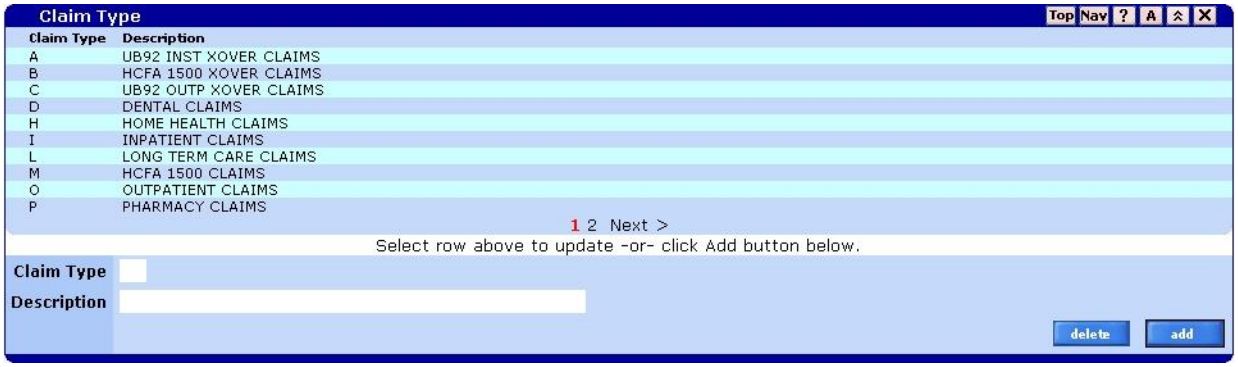
6.153.1 Codes-Claim Type Panel Narrative

The Claim Type panel is used to view and maintain the complete list of valid claim types.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - Claim Type]

6.153.2 Codes-Claim Type Panel Layout



6.153.3 Codes-Claim Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Claim Type code.	Button	N/A	0
Claim Type	The code used to identify a claim type. A claim type is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc.	Field	Character	1
Delete	Allows the user to delete a Claim Type code.	Button	N/A	0
Description	The description for the Claim Type code.	Field	Character	20

6.153.4 Codes-Claim Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	Claim Type is required.	Enter a Claim Type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique claim type.
	Field	3	Claim Type must be Alphanumeric.	Enter a claim type code that contains only 0-9 or A-Z.
Description	Field	1	Description is required.	Description is required when adding or modifying a claim type.

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6.153.5 Codes-Claim Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.153.6 Codes-Claim Type Panel Accessibility

6.153.6.1 To Access the Codes-Claim Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Claim Type**.	Claim Type panel displays.

6.153.6.2 To Add on the Codes-Claim Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Claim Type**.	
3	Enter **Description**.	
4	Click **Save**.	Claim Type information is saved.

6.153.6.3 To Update on the Codes-Claim Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Claim Type information is saved.

6.153.6.4 To Delete on the Codes-Claim Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.154 CODES-CMS FDA THERAPEUTIC EQUIVALENCY PANEL

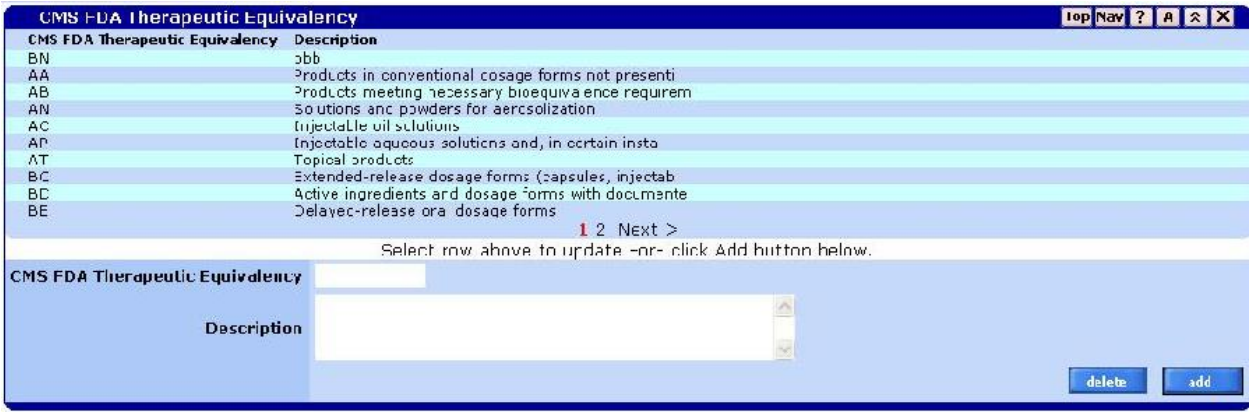
6.154.1 Codes-CMS FDA Therapeutic Equivalency Panel Narrative

The CMS FDA Therapeutic Equivalency Code (CMS_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The CMS_FDA is provided on the Health Care Financing Administration's quarterly tape.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [CMS FDA Therapeutic Equivalency]

6.154.2 Codes-CMS FDA Therapeutic Equivalency Panel Layout



6.154.3 Codes-CMS FDA Therapeutic Equivalency Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a CMS FDA Therapeutic Equivalency code.	Button	N/A	0
CMS FDA Therapeutic Equivalency	The CMS FDA Therapeutic Equivalency Code (CMS_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The CMS FDA is provided on the Health Care Financing Administration's quarterly tape.	Field	Character	100
Delete	Allows a user to delete a CMS FDA Therapeutic Equivalency code.	Button	N/A	0
Description	Text description of the CMS FDA Therapeutic Equivalency Code.	Field	Alphanumeric	100

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6.154.4 Codes-CMS FDA Therapeutic Equivalency Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
CMS FDA Therapeutic Equivalency	Field	1	CMS FDA Therapeutic Equivalency is required.	CMS FDA Therapeutic Equivalency Code required when adding or modifying CMS FDA Therapeutic Equivalency.
	Field	2	A duplicate record cannot be saved.	Enter a unique CMS FDA Therapeutic Equivalency.
Description	Field	1	Description is required.	Description required when adding or modifying CMS FDA Therapeutic Equivalency.

6.154.5 Codes-CMS FDA Therapeutic Equivalency Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.154.6 Codes-CMS FDA Therapeutic Equivalency Panel Accessibility

6.154.6.1 To Access the Codes- CMS FDA Therapeutic Equivalency Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **CMS FDA Therapeutic Equivalency**.	CMS FDA Therapeutic Equivalency panel displays.

6.154.6.2 To Add on the Codes- CMS FDA Therapeutic Equivalency Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Claim Type**.	
3	Enter **Description**.	
4	Click **Save**.	CMS FDA Therapeutic Equivalency information is saved.

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6.154.6.3 To Update on the Codes- CMS FDA Therapeutic Equivalency Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	CMS FDA Therapeutic Equivalency information is saved.

6.154.6.4 To Delete on the Codes- CMS FDA Therapeutic Equivalency Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.155 CODES-CMS TYPE OF SERVICE PANEL

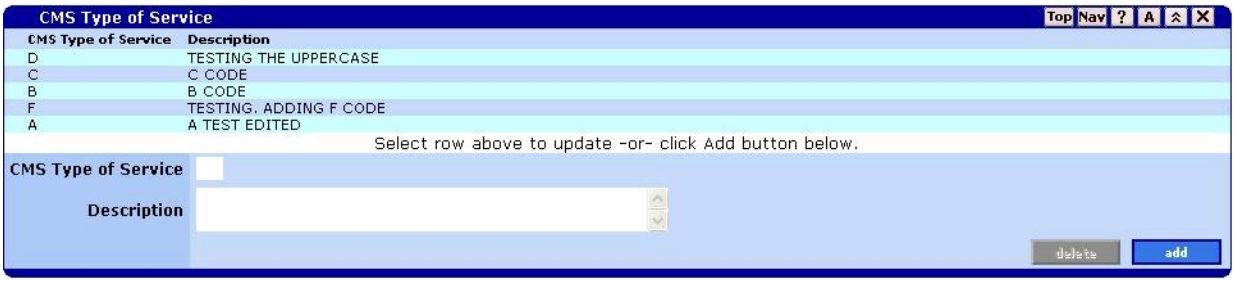
6.155.1 Codes-CMS Type of Service Panel Narrative

This panel is used to maintain CMS Type of Service Codes and Description.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [CMS Type of Service]

6.155.2 Codes-CMS Type of Service Panel Layout



6.155.3 Codes-CMS Type of Service Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a CMS Type of Service code.	Button	N/A	0
CMS Type of Service	The carrier assigned CMS Type of Service which describes the particular kind(s) of service represented.	Field	Character	1
Delete	Allows a user to delete a CMS Type of Service code.	Button	N/A	0
Description	Description of the CMS Type of Service code.	Field	Character	100

6.155.4 Codes-CMS Type of Service Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
CMS Type of Service	Field	1	CMS Type of Service is required.	Valid CMS Type of Service is required.
	Field	2	A duplicate record cannot be saved.	Verify keying. The information entered already exists. Enter a unique CMS Type of Service.
Description	Field	1	A Description is required.	Enter a Description of the TOS Code.

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6.155.5 Codes-CMS Type of Service Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.155.6 Codes-CMS Type of Service Panel Accessibility

6.155.6.1 To Access the Codes-CMS Type of Service Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagedisplays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **CMS Type of Service**.	CMS Type of Service panel displays.

6.155.6.2 To Add on the Codes-CMS Type of Service Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **CMS Type of Service**.	
3	Enter **Description**.	
4	Click **Save**.	CMS Type of Service information is saved.

6.155.6.3 To Update on the Codes-CMS Type of Service Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	CMS Type of Service information is saved.

6.155.6.4 To Delete on the Codes-CMS Type of Service Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.156 CODES-CONDITION PANEL

6.156.1 Codes-Condition Panel Narrative

The Condition panel is used to maintain the NUBC Condition codes. Condition codes are used to identify conditions relating to an Institutional claim that may affect payer processing.

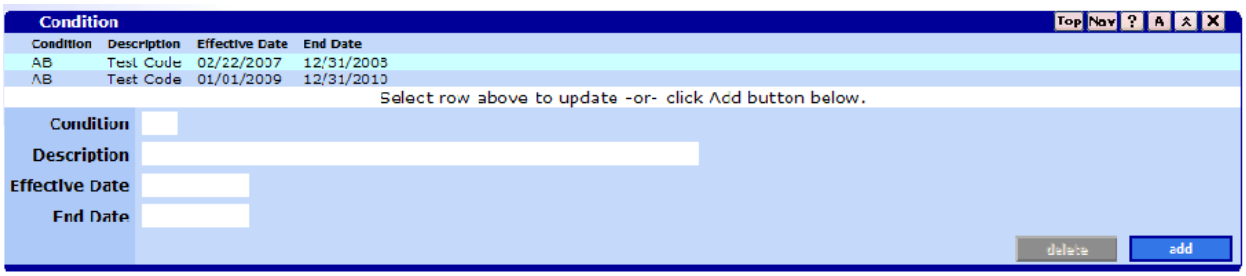
The panel consists of a data list displaying the defined Conditions and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Condition]

6.156.2 Codes-Condition Panel Layout



6.156.3 Codes-Condition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Condition code.	Button	N/A	0
Condition	Code used to identify conditions relating to a UB04 claim that may affect payer processing.	Field	Character	2
Delete	Allows the user to delete a Condition code.	Button	N/A	0
Description	Description of a conditions relating to a UB04 claim that may affect payer processing.	Field	Character	40
Effective Date	The first day this condition code is valid.	Field	Date (MM/DD/CCYY)	8
End Date	The last day this condition code is valid.	Field	Date (MM/DD/CCYY)	8

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6.156.4 Codes-Condition Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Condition	Field	1	Condition is required.	Enter a condition code.
	Field	3	Condition must be 2 character(s) in length.	Enter a unique 2 character condition code.
Description	Field	1	Description is required.	Enter a text description of the condition code.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is on or after 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is on or before 12/31/2299.
	Field	5	Effective Date[Date] must be less than or equal to End Date[Date].	Enter an Effective Date that is equal or less than the End Date.
	Field	6	Effective Date and End Date range overlap an existing condition code record.	Enter Effective Date and End Date that do not overlap a current condition code.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date in the MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is on or after 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is before or on the same date of 12/31/2299.

6.156.5 Codes-Condition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.156.6 Codes-Condition Panel Accessibility

6.156.6.1 To Access the Codes-Condition Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Condition**.	Condition panel displays.

6.156.6.2 To Add on the Codes-Condition Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Condition**.	
3	Enter **Description**.	
4	Enter **Effective Date**.	
5	Enter **End Date**.	
6	Click **Save**.	Condition information is saved.

6.156.6.3 To Update on the Codes-Condition Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Condition information is saved.

6.156.6.4 To Delete on the Codes-Condition Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.157 CODES-COUNTY PANEL

6.157.1 Codes-County Panel Narrative

The County panel is used to maintain state county information.

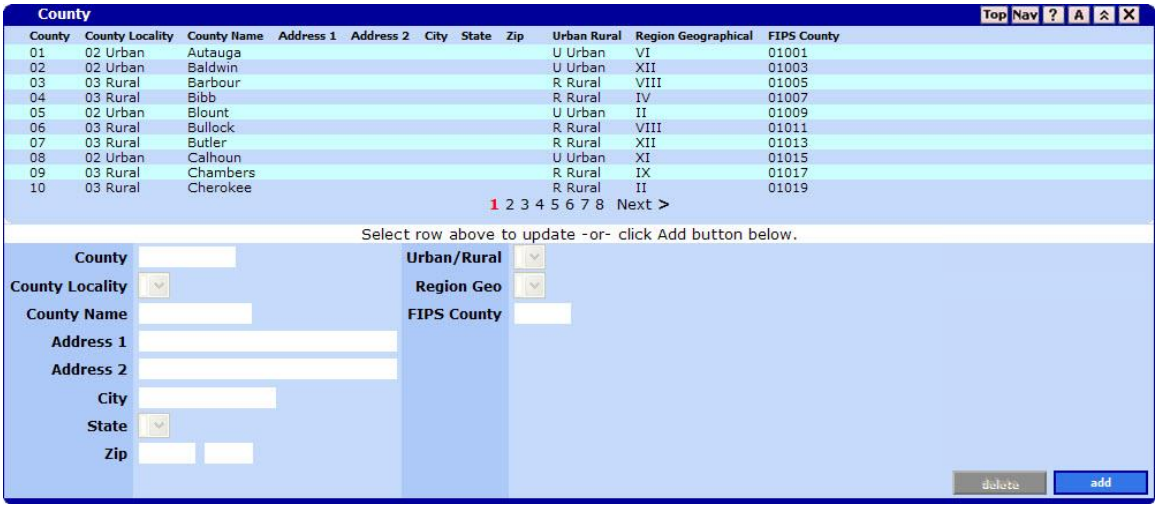
The panel consists of a data list displaying the defined Counties and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [County]

6.157.2 Codes-County Panel Layout



6.157.3 Codes-County Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a County.	Button	N/A	0
Address 1	First line of the county mailing address.	Field	Character	30
Address 2	Second line of the county mailing address.	Field	Character	30
City	City of the county mailing address.	Field	Character	15
County	The 10 digit county code used to identify a county in the state.	Field	Character	10
County Locality	A 2 digit locality code used to identify a geographical/political area in the state.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
County Name	Name of the County.	Field	Character	12
Delete	Allows the user to delete a County.	Button	N/A	0
FIPS County	The USPS county number used to identify a geographical/political area in the state.	Field	Character	5
Region Geographical	A user defined code that identifies a geographical region.	Combo Box	Drop Down List Box	0
State	State of the county mailing address.	Combo Box	Drop Down List Box	0
Urban / Rural	Indicates whether the county is urban or rural.	Combo Box	Drop Down List Box	0
Zip	Zip code of the county mailing address.	Field	Number (Integer)	9

6.157.4 Codes-County Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
County	Field	1	County is required.	Enter a 2 character county code.
	Field	2	County must be 2 character(s) in length.	Enter a 2 character county code.
	Field	3	A duplicate record cannot be saved.	Enter a unique 2 character county code.
County Name	Field	2	County Name is required.	Enter a county name.
FIPS County	Field	1	FIPS County must be 5 character(s) in length.	Enter a 5 character FIPS County code.
Region Geo	Field	3	A valid Region Geo is required.	Select a Region Geographical code from the list.

6.157.5 Codes-County Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.157.6 Codes-County Panel Accessibility

6.157.6.1 To Access the Codes-County Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **County**.	County panel displays.

6.157.6.2 To Add on the Codes-County Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **County**.	
3	Select **County Locality** from drop down list box.	
4	Enter **County Name**.	
5	Enter **Address 1**.	
6	Enter **Address 2**.	
7	Enter **City**.	
8	Select **State** from drop down list box.	
9	Enter **Zip Code+4**.	
10	Select **Urban/Rural** from drop down list box.	
11	Select **Region Geo** from drop down list box.	
12	Click **Save**.	County information is saved.

6.157.6.3 To Update on the Codes-County Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	County information is saved.

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6.157.6.4 To Delete on the Codes-County Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.158 CODES-DEA PANEL

6.158.1 Codes-DEA Panel Narrative

The Drug Enforcement Agency (DEA) panel is used to maintain DEA codes and descriptions. DEA codes denote the degree of potential abuse and federal control of a drug. This code is subject to change by federal regulation.

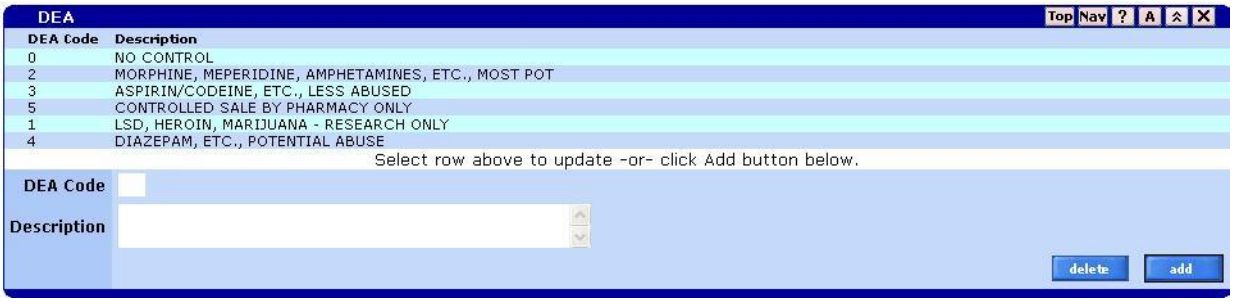
The panel consists of a data list displaying the defined DEA codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [DEA]

6.158.2 Codes-DEA Panel Layout



6.158.3 Codes-DEA Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Drug Enforcement Administration (DEA) Code.	Button	N/A	0
DEA Code	The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This is based on whether they have an accepted medical use; their relative potential for abuse; the degree of dependence that may be caused by abuse of the drug. This code is subject to change by Federal regulation.	Field	Character	1
Delete	Allows the user to delete a Drug Enforcement Administration (DEA) Code.	Button	N/A	0
Description	Text describing the Drug Enforcement Administration (DEA) code.	Field	Character	100

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6.158.4 Codes-DEA Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
DEA Code	Field	1	DEA Code is required.	Enter a Drug Enforcement Administration (DEA) Code.
	Field	6	A duplicate record cannot be saved.	Enter a unique Drug Enforcement Administration (DEA) Code.
Description	Field	1	Description is required.	Enter a text description of the Drug Enforcement Administration (DEA) Code.

6.158.5 Codes-DEA Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.158.6 Codes-DEA Panel Accessibility

6.158.6.1 To Access the Codes-DEA Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **DEA**.	DEA panel displays.

6.158.6.2 To Add on the Codes-DEA Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **DEA Code**.	
3	Enter **Description**.	
4	Click **Save**.	DEA information is saved.

6.158.6.3 To Update on the Codes-DEA Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	DEA information is saved.

6.158.6.4 To Delete on the Codes-DEA Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.159 CODES-DESI PANEL

6.159.1 Codes-DESI Panel Narrative

The DESI panel is used to maintain DESI codes. DESI codes are used to mark a particular drug as declared less than effective by the Food and Drug Administration (FDA) Drug Product Efficacy Study and Implementation program (DESI).

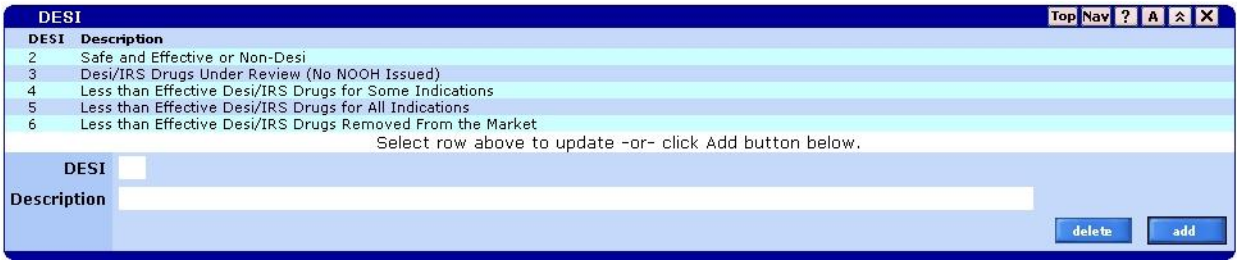
The panel consists of a data list displaying the defined DESI codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [DESI]

6.159.2 Codes-DESI Panel Layout



6.159.3 Codes-DESI Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Drug Product Efficacy Study and Implementation program (DESI) code.	Button	N/A	0
Delete	Allows a user to delete a Drug Product Efficacy Study and Implementation program (DESI) code.	Button	N/A	0
DESI	The code identifies the DESI status of the NDC drug with current valid values of 0-6. The DESI Drug Indicator (DESI) marks a particular drug as declared less than effective by the Food and Drug Administration. The CMS DESI Code (CMS_DESI) indicates the DESI code as supplied on the CMS's quarterly tape.	Field	Character	1
Description	The description of the Drug Product Efficacy Study and Implementation program (DESI) code value.	Field	Character	100

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6.159.4 Codes-DESI Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
DESI	Field	1	DESI is required.	Enter a DESI code.
	Field	2	Duplicate record cannot be saved.	Enter a unique DESI code.
Description	Field	1	Description is required.	Enter a text Description of the DESI code.

6.159.5 Codes-DESI Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.159.6 Codes-DESI Panel Accessibility

6.159.6.1 To Access the Codes-DESI Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **DESI**.	DESI panel displays.

6.159.6.2 To Add on the Codes-DESI Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **DESI**.	
3	Enter **Description**.	
4	Click **Save**.	DESI information is saved.

6.159.6.3 To Update on the Codes-DESI Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	DESI information is saved.

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6.159.6.4 To Delete on the Codes-DESI Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.160 CODES-DISPOSITION STATUS PANEL

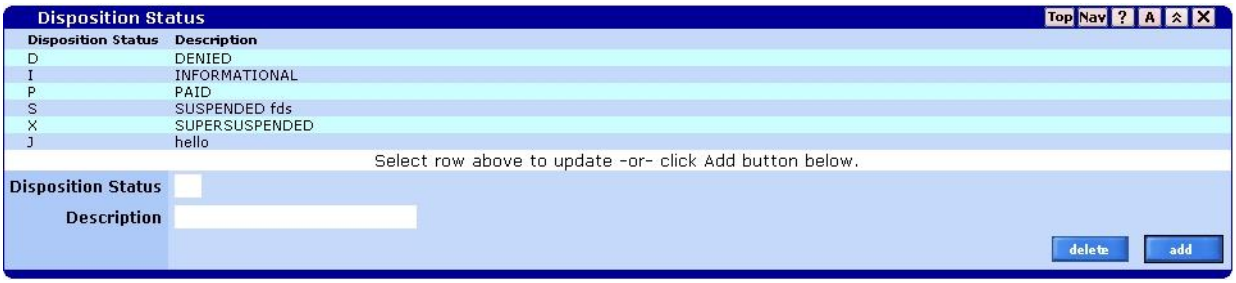
6.160.1 Codes-Disposition Status Panel Narrative

Codes-Disposition Status panel contains all the valid disposition status codes and their descriptions.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Disposition Status]

6.160.2 Codes-Disposition Status Panel Layout



6.160.3 Codes-Disposition Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Disposition Status code.	Button	N/A	0
Delete	Allows a user to delete a Disposition Status code.	Button	N/A	0
Description	Description that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	Field	Character	25
Disposition Status	Code that represents the action (pay, deny, suspend, super suspend, Pay and List) that should be taken on a claim at dispositioning time.	Field	Character	1

6.160.4 Codes-Disposition Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the disposition status code.
Disposition Status	Field	1	Disposition Status is required.	Enter a Disposition Status code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Disposition Status code.

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6.160.5 Codes-Disposition Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.160.6 Codes-Disposition Status Panel Accessibility

6.160.6.1 To Access the Codes-Disposition Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Disposition Status**.	Disposition Status panel displays.

6.160.6.2 To Add on the Codes-Disposition Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Disposition Status**.	
3	Enter **Description**.	
4	Click **Save**.	Disposition Status information is saved.

6.160.6.3 To Update on the Codes-Disposition Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Disposition Status information is saved.

6.160.6.4 To Delete on the Codes-Disposition Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.161 CODES-DOSAGE FORM PANEL

6.161.1 Codes-Dosage Form Panel Narrative

The Dosage Form panel is used to maintain Dosage Form codes as supplied by FDB (First DataBank). Dosage form describes the physical presentation of a drug, such as tablet, capsule, or liquid. It may also incorporate the delivery and release mechanism of the drug.

The Food and Drug Administration does not specify as many unique dosage forms as First DataBank; First DataBank supports all dosage forms identified by the Food and Drug Administration and observes similar naming conventions when possible. First DataBank also supplies additional dosage forms.

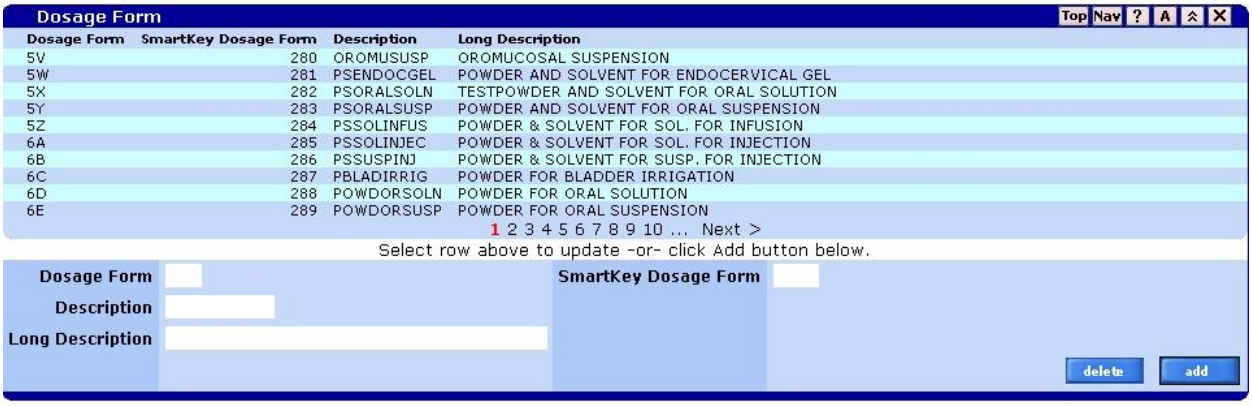
The panel consists of a data list displaying the defined Dosage Forms and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference]- [Related Data] - [Codes] - [Dosage Form]

6.161.2 Codes-Dosage Form Panel Layout



6.161.3 Codes-Dosage Form Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Dosage Form code.	Button	N/A	0
Delete	Allows the user to delete a Dosage Form code.	Button	N/A	0
Description	Abbreviated dosage form description. Describes the physical presentation of a drug, such as tablet, capsule, or liquid. It may also incorporate the delivery and release mechanism of the drug. Abbreviations may be used to conform to space requirements.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Dosage Form	Code representing the dosage form.	Field	Character	2
Long Description	Long text description of the Dosage Form code interpretation.	Field	Character	40
Smartkey Dosage Form	Smart Key Dosage Form Code.	Field	Number (Integer)	3

6.161.4 Codes-Dosage Form Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the Dosage Form code.
Dosage Form	Field	1	Dosage Form is required.	Enter a Dosage Form code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Dosage Form code.
	Field	3	Dosage Form must be 2 character(s) in length.	Enter a unique 2 digit Dosage Form code.
Long Description	Field	1	Long Description is required.	Long Description required when adding or modifying Dosage Form.
Smartkey Dosage Form	Field	1	SmartKey Dosage Form must be greater than or equal to 1.	Enter a SmartKey Dosage Form that is be greater than or equal to 1.
	Field	2	Enter a valid value.	Enter a numeric value.
	Field	3	Smartkey Dosage Form is required.	Enter a valid Smartkey Dosage Form.

6.161.5 Codes-Dosage Form Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.161.6 Codes-Dosage Form Panel Accessibility

6.161.6.1 To Access the Codes-Dosage Form Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.

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Step	Action	Response
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Dosage Form**.	Dosage Form panel displays.

6.161.6.2 To Add on the Codes-Dosage Form Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Dosage Form**.	
3	Enter **Description**.	
4	Enter **Long Description**.	
7	Click **Save**.	Dosage Form information is saved.

6.161.6.3 To Update on the Codes-Dosage Form Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Dosage Form information is saved.

6.161.6.4 To Delete on the Codes-Dosage Form Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.162 CODES-DRUG ACTIVATION PANEL

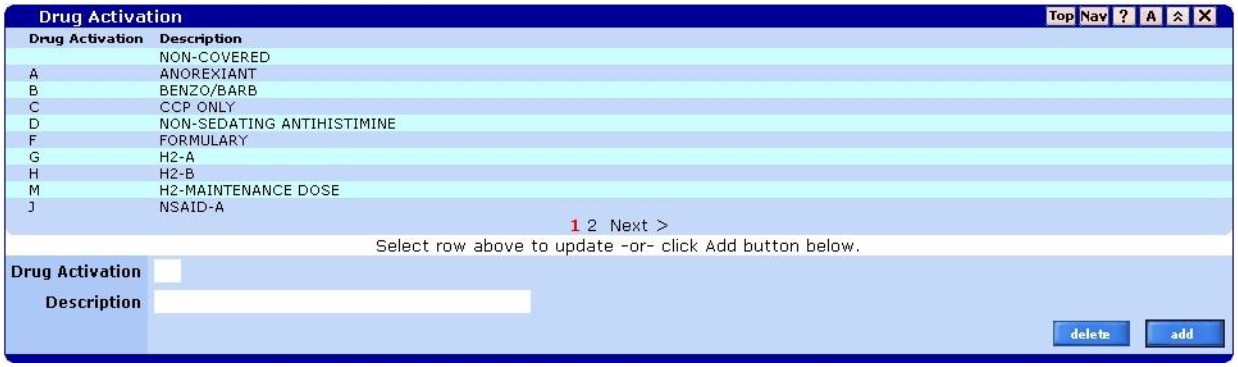
6.162.1 Codes-Drug Activation Panel Narrative

The Drug Activation panel describes the status and program coverage for a specific drug.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference]- [Related Data] - [Codes] - Drug Activation]

6.162.2 Codes-Drug Activation Panel Layout



6.162.3 Codes-Drug Activation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Drug Activation code.	Button	N/A	0
Delete	Allows the user to delete a Drug Activation code.	Button	N/A	0
Description	Text description of activation indicator.	Field	Character	40
Drug Activation	Activation indicator used to indicate what status and program coverage the drug will have. It is also used in claims editing. This attribute is determined by FDB and is part of the FDB Drug update process.	Field	Character	1

6.162.4 Codes-Drug Activation Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the drug activation code.
Drug Activation	Field	1	Drug Activation is required.	Enter a Drug Activation code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Drug Activation code.

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6.162.5 Codes-Drug Activation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.162.6 Codes-Drug Activation Panel Accessibility

6.162.6.1 To Access the Codes-Drug Activation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Drug Activation**.	Drug Activation panel displays.

6.162.6.2 To Add on the Codes-Drug Activation Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Drug Activation**.	
3	Enter **Description**.	
4	Click **Save**.	Drug Activation information is saved.

6.162.6.3 To Update on the Codes-Drug Activation Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Drug Activation information is saved.

6.162.6.4 To Delete on the Codes-Drug Activation Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.163 CODES-DRUG CATEGORY CODE PANEL

6.163.1 Codes-Drug Category Code Panel Narrative

The Drug Category Code panel is used to maintain Drug Category Codes as supplied by FDB (First DataBank). Drug Category Codes are used to indicate that a drug product belongs to a category that is commonly treated as an exception in third party plans, for example: Insulins.

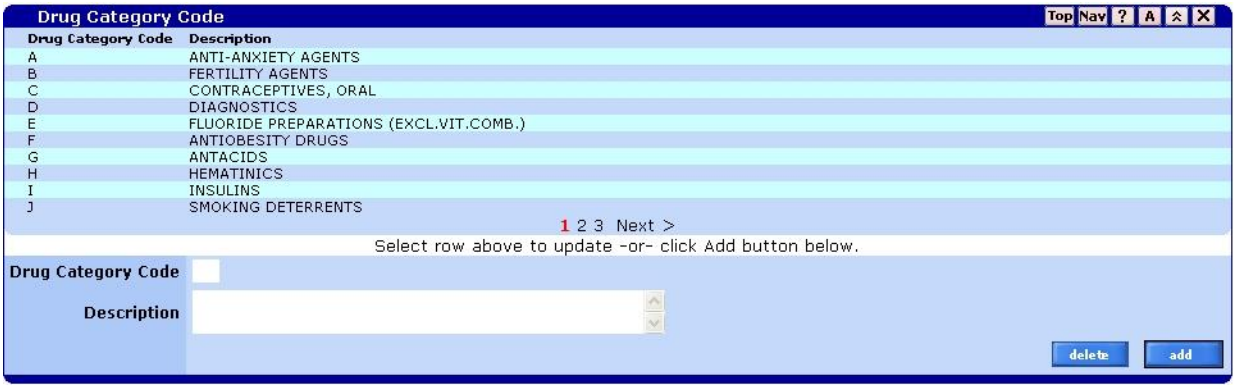
The panel consists of a data list displaying the defined Drug Categories and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - Drug Category Code]

6.163.2 Codes-Drug Category Code Panel Layout



6.163.3 Codes-Drug Category Code Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Drug Category Code.	Button	N/A	0
Delete	Allows the user to delete a Drug Category Code.	Button	N/A	0
Description	Text description of Drug Category Code.	Field	Character	100
Drug Category Code	Code representing a drug category that is commonly treated as an exception for payment by some third party plans.	Field	Character	1

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6.163.4 Codes-Drug Category Code Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description field required when adding or modifying Drug Category Code.
Drug Category Code	Field	1	Drug Category Code is required.	Drug Category Code required when adding or modifying drug category code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Drug Category Code.

6.163.5 Codes-Drug Category Code Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.163.6 Codes-Drug Category Code Panel Accessibility

6.163.6.1 To Access the Codes-Drug Category Code Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagedisplays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Drug Category Code**.	Drug Category Code panel displays.

6.163.6.2 To Add on the Codes-Drug Category Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Drug Category Code**.	
3	Enter **Description**.	
4	Click **Save**.	Drug Category Code information is saved.

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6.163.6.3 To Update on the Codes-Drug Category Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Drug Category Code information is saved.

6.163.6.4 To Delete on the Codes-Drug Category Code Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.164 CODES-DRUG ROUTE PANEL

6.164.1 Codes-Drug Route Panel Narrative

The Drug Route panel is used to maintain the Route of Administration code set as supplied by FDB (First DataBank). Route of Administration represents the normal site or method by which a drug is administered in the body, such as oral, injection, or topical.

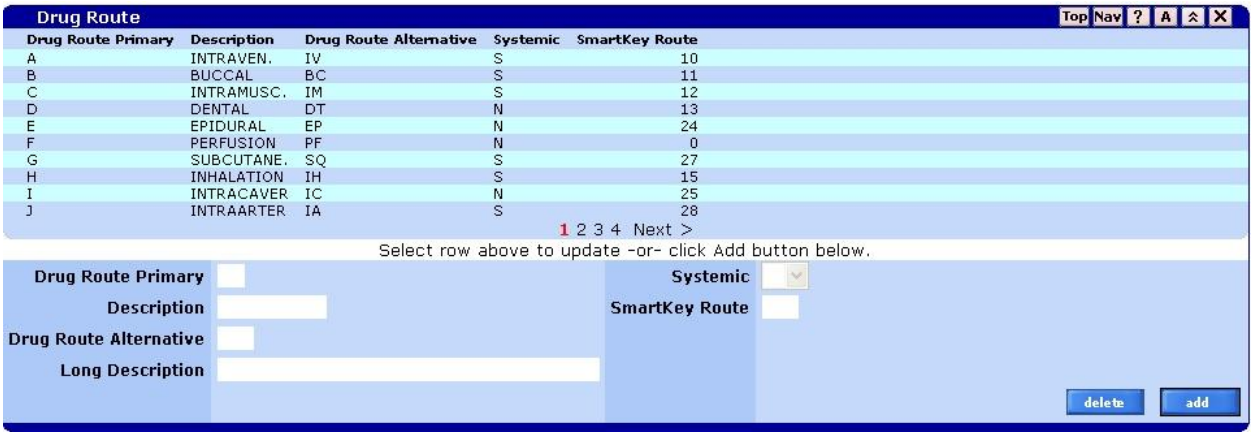
The panel consists of a data list displaying the defined Routes of Administration and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Drug Route]

6.164.2 Codes-Drug Route Panel Layout



6.164.3 Codes-Drug Route Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Drug Route code.	Button	N/A	0
Delete	Allows the user to delete a Drug Route code.	Button	N/A	0
Description	Brief/Abbreviated text description associated with a Route of Administration Code.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Drug Route Alternative	Two-character code representing the normal site or method by which a drug is administered in the body, such as oral, injection, or topical. This two character code is an abbreviation recognizable to a user such as IV, IM, SC. FDB also provides a one-character route code for applications where the description is transparent to the user. A Route of Administration Code (GCRT) is associated to each GCN_SEQNO to identify that component of the generic drug formulation.	Field	Character	2
Drug Route Primary	One-character code representing the normal site or method by which a drug is administered, such as oral, injection, or topical. This one character code is provided for applications where the description is transparent to the user.	Field	Character	1
Long Description	Extended text description for a Route of Administration. This long description is the same description for the corresponding Primary and Alternative Drug Route Codes.	Field	Character	40
SmartKey Route	Sixth component of the Smart Key is the Smart Key - Route Code (SKEY-RT), a two-digit number. An SKEY-RT code value is interpreted the same across all like NDCs.	Field	Number (Integer)	2
Systemic	Indicates if the route of administration is systemic. Valid values include: S = Systemic N = Non-systemic O = Other	Combo Box	Drop Down List Box	0

6.164.4 Codes-Drug Route Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description for the Drug Route code.
Drug Route Alternative	Field	1	Drug Route Alternative is required.	Drug Route Alternative required when adding drug route.
Drug Route Primary	Field	1	Drug Route Primary is required.	Enter a Drug Route Primary code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Drug Route Primary.

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Field	Field Type	Error Code	Error Message	To Correct
Long Description	Field	1	Long Description is required.	Enter a Long Description of the Drug Route code.
SmartKey Route	Field	1	SmartKey Route is required.	Enter a Smartkey Route number for the drug route code.
Systemic	Field	1	Systemic is required.	Select Systemic, non-systemic or other from the list.

6.164.5 Codes-Drug Route Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.164.6 Codes-Drug Route Panel Accessibility

6.164.6.1 To Access the Codes-Drug Route Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Drug Route**.	Drug Route panel displays.

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6.164.6.2 To Add on the Codes-Drug Route Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Drug Route Primary**.	
3	Enter **Description**.	
4	Enter **Long Route Alternative**.	
5	Enter **Long Description**.	
6	Select **Systemic** from drop down list box.	
7	Select **SmartKey** from drop down list box.	
8	Click **Save**.	Drug Route information is saved.

6.164.6.3 To Update on the Codes-Drug Route Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Drug Route information is saved.

6.164.6.4 To Delete on the Codes-Drug Route Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.165 CODES-DRUG STRENGTH PANEL

6.165.1 Codes-Drug Strength Panel Narrative

The Drug Strength panel is used to maintain Drug Strength information as supplied by FDB (First DataBank). The strength of a drug formulation refers to the potency of the drug.

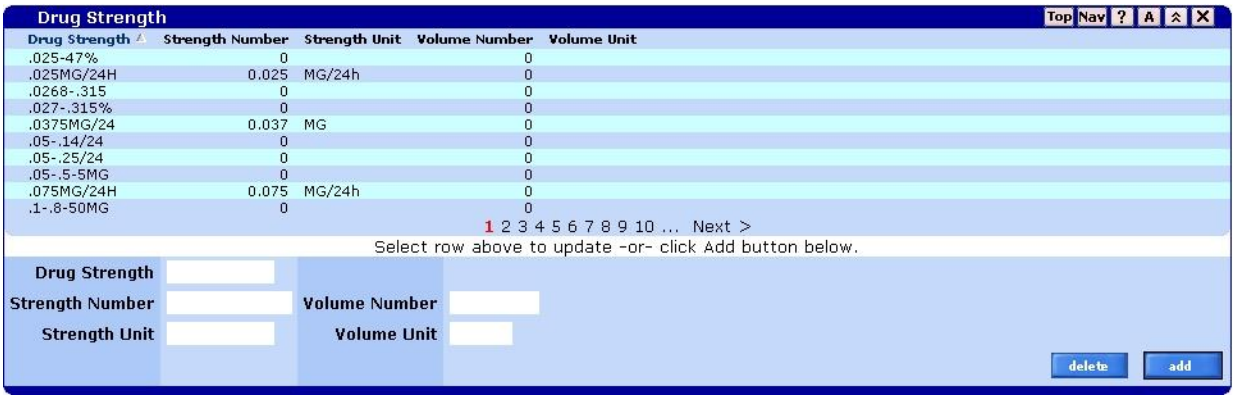
The panel consists of a data list displaying Drug Strength information and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Drug Strength]

6.165.2 Codes-Drug Strength Panel Layout



6.165.3 Codes-Drug Strength Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Drug Strength record.	Button	N/A	0
Delete	Allows the user to delete a Drug Strength record.	Button	N/A	0
Drug Strength	Drug Strength Number (STRNUM) must be used in conjunction with the Drug Strength Unit (STRUN), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression for the drug product. The strength of a drug product is usually expressed in the metric system and is not available or necessary for all drug formulations.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
Strength Number	Drug Strength Number (STRNUM) must be used in conjunction with the Drug Strength Unit (STRUN), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression for the drug product. The strength of a drug product is usually expressed in the metric system and is not available or necessary for all drug formulations.	Field	Number (Decimal)	11
Strength Unit	Drug Strength Units (STRUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system and is not available or necessary for all drug formulations.	Field	Character	10
Volume Number	Drug Strength Volume Number (VOLNUM) indicates the volume or weight of the drug product which contains the indicated amounts of active ingredients. This field must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system and is not available or necessary for all drug formulations.	Field	Number (Integer)	7
Volume Unit	Drug Strength Volume Units (VOLUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Volume Number (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system and is not available or necessary for all drug formulations.	Field	Character	5

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6.165.4 Codes-Drug Strength Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Drug Strength	Field	1	Drug Strength is required.	Enter a valid Drug Strength.
Strength Number	Field	1	Strength Number is required.	Enter a valid Strength Number.
	Field	2	Strength Number must be less than or equal to 99999999.999.	Enter a Strength Number that is less than or equal to 99999999.999.
Strength Unit	Field	1	Strength Unit is required.	Enter a valid Strength Unit when adding or modifying Drug Strength.
Volume Number	Field	1	Enter a valid value.	Enter a numeric value.
	Field	2	Volume Number must be less than or equal to 9999.999.	Enter a valid value.
	Field	3	Volume Number is required.	Must enter a value in Volume Number.
Volume Unit	Field	1	Volume Unit is required.	Enter a valid Volume Unit when adding or modifying Drug Strength.

6.165.5 Codes-Drug Strength Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.165.6 Codes-Drug Strength Panel Accessibility

6.165.6.1 To Access the Codes-Drug Strength Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Drug Strength**.	Drug Strength panel displays.

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6.165.6.2 To Add on the Codes-Drug Strength Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Drug Strength**.	
3	Enter **Strength Number**.	
4	Enter **Strength Unit**.	
5	Enter **Volume Number**.	
6	Enter **Volume Unit**.	
7	Click **Save**.	Drug Strength information is saved.

6.165.6.3 To Update on the Codes-Drug Strength Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Drug Strength information is saved.

6.165.6.4 To Delete on the Codes-Drug Strength Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.166 CODES-EDIT PARM TYPE PANEL

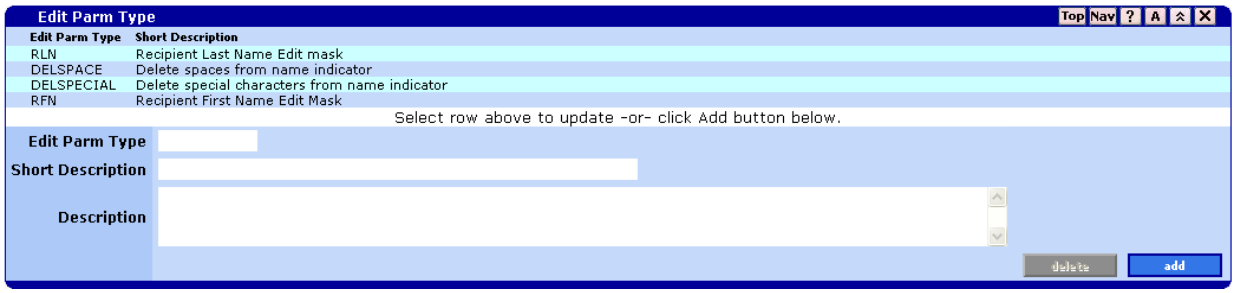
6.166.1 Codes-Edit Parm Type Panel Narrative

The Edit Parm Type contains the description of the edit parameter type.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Edit Parm Type]

6.166.2 Codes-Edit Parm Type Panel Layout



6.166.3 Codes-Edit Parm Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Edit Parameter Type.	Button	N/A	0
Delete	Allows the user to delete an Edit Parameter Type.	Button	N/A	0
Description	Description of the parameter type, for example, "Recipient First Name edit mask".	Field	Character	4000
Edit Parm Type	The parameter type, for example, "RFN" (recipient first name).	Field	Character	10
Short Description	Short Description of the Edit Parameter Type type.	Field	Character	50

6.166.4 Codes-Edit Parm Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	The Description can not be spaces; key something in the description field.
	Field	4	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 4000 characters.	Limit your text to 4000 characters or less.

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Field	Field Type	Error Code	Error Message	To Correct
Edit Parm Type	Field	1	Edit Parm Type - delete was unsuccessful. Record in use by Edit Parameter.	The Edit Parameter Type is contained on at least 1 edit parameter record. Delete the edit parm type from all edit parameters it is contained on and then delete the edit parm type.
	Field	2	A duplicate record cannot be saved.	Change the Edit Parm Type to a value that does not already exist.
	Field	3	Edit Parm Type is required.	Enter a Edit Parm Type.
Short Description	Field	0	Short Description is required.	Enter the short Description.

6.166.5 Codes-Edit Parm Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.166.6 Codes-Edit Parm Type Panel Accessibility

6.166.6.1 To Access the Codes-Edit Parm Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Edit Parm Type**.	Edit Parm Type panel displays.

6.166.6.2 To Add on the Codes-Edit Parm Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Edit Parm Type**.	
3	Enter **Short Description**.	
4	Enter **Description**.	
7	Click **Save**.	Edit Parm Type information is saved.

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6.166.6.3 To Update on the Codes-Edit Parm Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Edit Parm Type information is saved.

6.166.6.4 To Delete on the Codes-Edit Parm Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.167 CODES-EOB TYPE PANEL

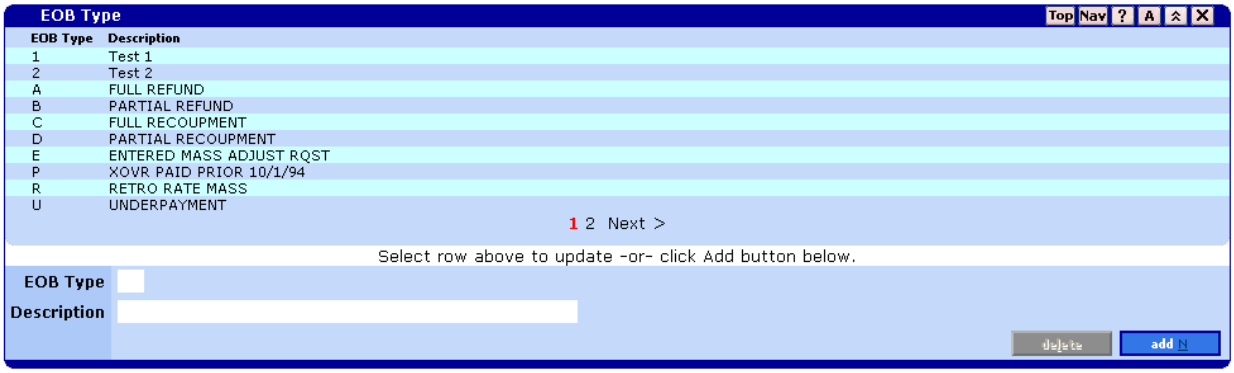
6.167.1 Codes-EOB Type Panel Narrative

The EOB Type panel is used to maintain the list of EOB types available for adjustments. The "adjustment" EOB's are used in conjunction with the error code EOB's to explain on the provider's RA why the claim hit a particular edit/audit during the adjustment process.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [EOB Type]

6.167.2 Codes-EOB Type Panel Layout



6.167.3 Codes-EOB Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Explanation of Benefit (EOB) type.	Button	N/A	0
Delete	Allows the user to delete an Explanation of Benefit (EOB) Type.	Button	N/A	0
Description	Description of the Explanation of Benefit (EOB) Type.	Field	Character	50
EOB Type	One character code used to identify the type of processing that should occur when an EOB is assigned. For example, A-full refund, U-underpayment, E-enter mass adjustment.	Field	Character	1

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6.167.4 Codes-EOB Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the EOB Type.
EOB Type	Field	1	EOB Type is required.	Enter an EOB Type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique EOB Type Code.

6.167.5 Codes-EOB Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.167.6 Codes-EOB Type Panel Accessibility

6.167.6.1 To Access the Codes-EOB Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **EOB Type**.	EOB Type panel displays.

6.167.6.2 To Add on the Codes-EOB Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **EOB Type**.	
3	Enter **Description**.	
4	Click **Save**.	EOB Type information is saved.

6.167.6.3 To Update on the Codes-EOB Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	EOB Type information is saved.

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6.167.6.4 To Delete on the Codes-EOB Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.168 CODES-GENDER PANEL

6.168.1 Codes-Gender Panel Narrative

The Gender panel is used to maintain gender code and description.

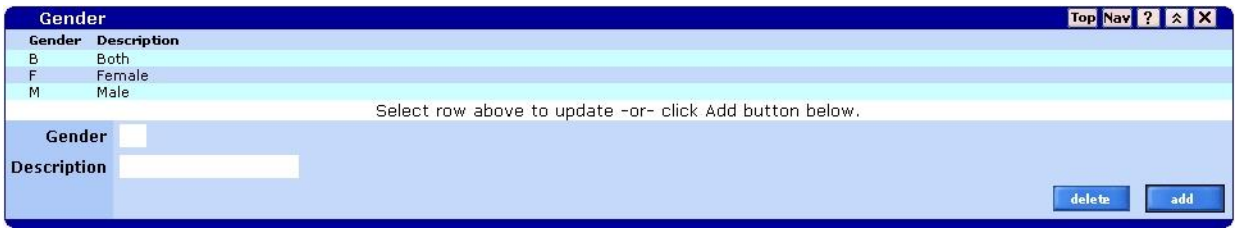
The panel consists of a data list displaying the defined Gender values and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Gender]

6.168.2 Codes-Gender Panel Layout



6.168.3 Codes-Gender Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Gender code.	Button	N/A	0
Delete	Allows the user to delete a Gender code.	Button	N/A	0
Description	Text describing the gender of an individual.	Field	Character	18
Gender	Code describing the gender of an individual.	Field	Character	1

6.168.4 Codes-Gender Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the gender code.
Gender	Field	1	Gender is required.	Enter a Gender code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Gender code.

6.168.5 Codes-Gender Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.168.6 Codes-Gender Panel Accessibility

6.168.6.1 To Access the Codes-Gender Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Gender**.	Gender panel displays.

6.168.6.2 To Add on the Codes-Gender Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Gender**.	
3	Enter **Description**.	
4	Click **Save**.	Gender information is saved.

6.168.6.3 To Update on the Codes-Gender Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Gender information is saved.

6.168.6.4 To Delete on the Codes-Gender Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.169 CODES-GENERIC THERAPEUTIC CLASS PANEL

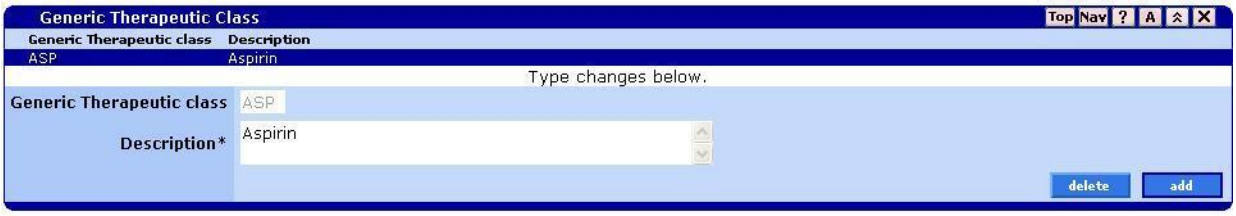
6.169.1 Codes-Generic Therapeutic Class Panel Narrative

The Generic Therapeutic Class code classifies drugs according to the most general therapeutic groupings.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation: [Reference] - [Related Data] - [Codes] - [Generic Therapeutic Class]

6.169.2 Codes-Generic Therapeutic Class Panel Layout



6.169.3 Codes-Generic Therapeutic Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Generic Therapeutic class.	Button	N/A	0
Delete	Allows the user to delete a Generic Therapeutic class.	Button	N/A	0
Description	Provides the text description for a Generic Therapeutic Class code.	Field	Alphanumeric	100
Generic Therapeutic Class	The Generic Therapeutic Class code classifies drugs according to the most general therapeutic groupings.	Field	Character	3

6.169.4 Codes-Generic Therapeutic Class Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter Description.
Generic Therapeutic Class	Field	1	Generic Therapeutic Class Code is required.	Enter Generic Therapeutic Class Code.

6.169.5 Codes-Generic Therapeutic Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.169.6 Codes-Generic Therapeutic Class Panel Accessibility

6.169.6.1 To Access the Codes-Generic Therapeutic Class Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Generic Therapeutic Class**.	Generic Therapeutic Class panel displays.

6.169.6.2 To Add on the Codes-Generic Therapeutic Class Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Generic Therapeutic Class**.	
3	Enter **Description**.	
4	Click **Save**.	Generic Therapeutic Class information is saved.

6.169.6.3 To Update on the Codes-Generic Therapeutic Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Generic Therapeutic Class information is saved.

6.169.6.4 To Delete on the Codes-Generic Therapeutic Class Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.170 CODES-GEOGRAPHICAL REGION PANEL

6.170.1 Codes-Geographical Region Panel Narrative

The Geographical Region panel is used to maintain the Geographical Region codes for the current state implementation.

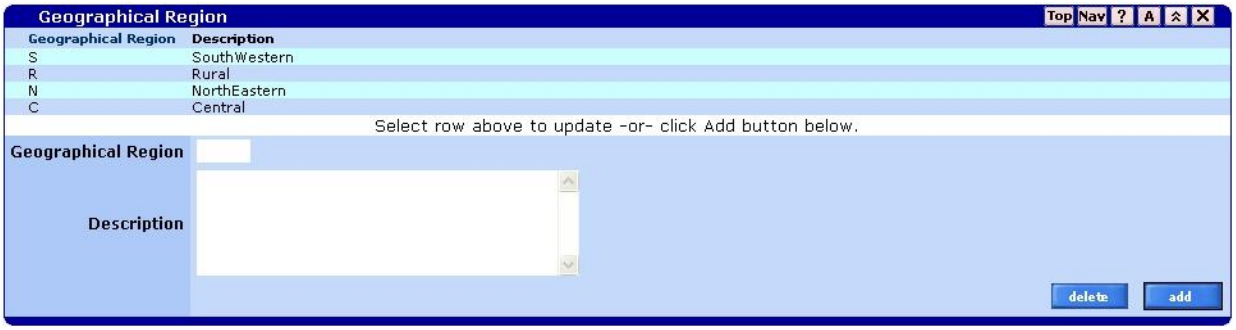
The panel consists of a data list displaying the defined Geographical Regions and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Geographical Region]

6.170.2 Codes-Geographical Region Panel Layout



6.170.3 Codes-Geographical Region Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Geographical Region code.	Button	N/A	0
Delete	Allows the user to delete a Geographical Region code.	Button	N/A	0
Description	Text describing the geographical region.	Field	Character	4000
Geographical Region	A user defined code that identifies a geographical region.	Field	Character	4

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6.170.4 Codes-Geographical Region Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is Required.	Enter a text Description of the Geographical Region.
Geographical Region	Field	1	Geographical Region is required.	Enter a Geographical Region code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Geographical Region code.

6.170.5 Codes-Geographical Region Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.170.6 Codes-Geographical Region Panel Accessibility

6.170.6.1 To Access the Codes-Geographical Region Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Geographical Region**.	Geographical Region panel displays.

6.170.6.2 To Add on the Codes-Geographical Region Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Geographical Region**.	
3	Enter **Description**.	
4	Click **Save**.	Geographical Region information is saved.

6.170.6.3 To Update on the Codes-Geographical Region Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Geographical Region information is saved.

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6.170.6.4 To Delete on the Codes-Geographical Region Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.171 CODES-HEALTH CARE ENTITY IDENTIFIER PANEL

6.171.1 Codes-Health Care Entity Identifier Panel Narrative

The Health Care Entity Identifier panel is used to maintain the Health Care Entity Identifier codes used in the Health Care Claim Status Notification/Response (277) transaction.

Entity Identifier codes are used to further modify the Health Care Status code if additional detail applicable to claim status is needed to clarify the status. The Claim Status transaction is not used as a financial transaction. Please refer to the 276/277 Transaction Set Implementation Guide for further details regarding the use of these codes.

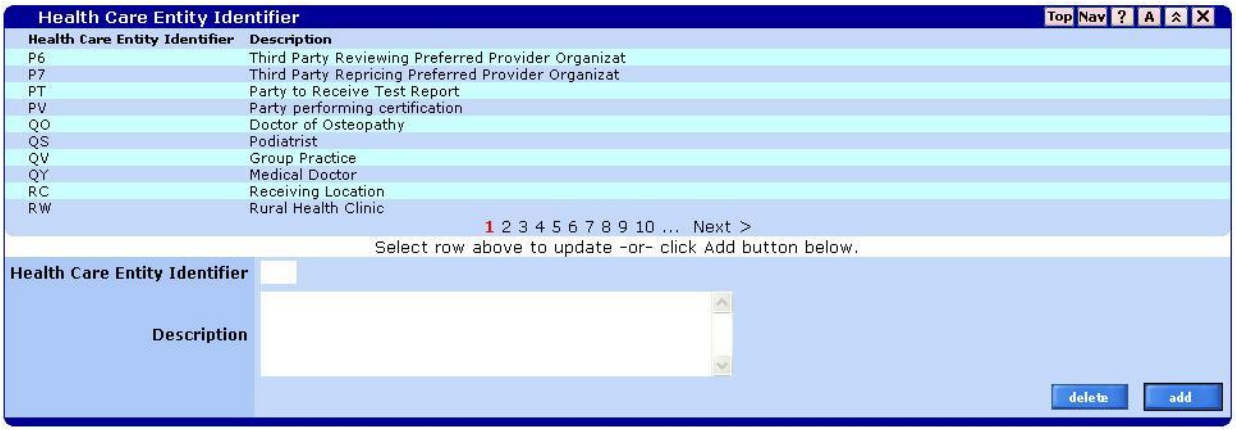
The panel consists of a data list displaying the defined Health Care Entity Identifier codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Health Care Entity Identifier]

6.171.2 Codes-Health Care Entity Identifier Panel Layout



6.171.3 Codes-Health Care Entity Identifier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Health Care Entity Identifier code.	Button	N/A	0
Delete	Delete a Health Care Entity Identifier code.	Button	N/A	0
Description	Description of Health Care Claim Status Entity Identifier code.	Field	Character	200
Health Care Entity Identifier	The HIPAA Health Care claim status entity identifier code.	Field	Character	3

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6.171.4 Codes-Health Care Entity Identifier Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description required when adding or modifying Health care entity identifier.
Health Care Entity Identifier	Field	1	Health Care Entity Identifier is required.	Health Care Entity Identifier code required when adding or modifying Health care entity identifier.
	Field	2	A duplicate record cannot be saved.	Enter a unique Health Care Entity Identifier.
	Field	3	Required input must be between 2 and 3 characters in length.	Required input must be between 2 and 3 characters in length.

6.171.5 Codes-Health Care Entity Identifier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.171.6 Codes-Health Care Entity Identifier Panel Accessibility

6.171.6.1 To Access the Codes-Health Care Entity Identifier Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Health Care Entity Identifier**.	Health Care Entity Identifier panel displays.

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6.171.6.2 To Add on the Codes-Health Care Entity Identifier Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Health Care Entity Identifier**.	
3	Enter **Description**.	
4	Click **Save**.	Codes- Health Care Entity Identifier information is saved.

6.171.6.3 To Update on the Codes-Health Care Entity Identifier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Codes- Health Care Entity Identifier information is saved.

6.171.6.4 To Delete on the Codes-Health Care Entity Identifier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.172 CODES-HIPAA ADJUSTMENT REASON PANEL

6.172.1 Codes-HIPAA Adjustment Reason Panel Narrative

The HIPAA Adjustment Reason panel is used to maintain the Claim Adjustment Reason code set.

Two HIPAA standard code sets--the reason and remark code sets--are used to report payment adjustments in remittance advice transactions (835).

Claim Adjustment Reason Codes detail the reason why an adjustment was made to a health care claim payment by the payer, while Remittance Remark Codes represent non-financial information critical to understanding the adjudication of a health insurance claim.

The HIPAA Claim Adjustment Reason Codes provide similar functionality to the current AMMIS EOB codes but lack detail. Their main purpose is to itemize the differences between the claim charges (billed amount) and the claim paid amount.

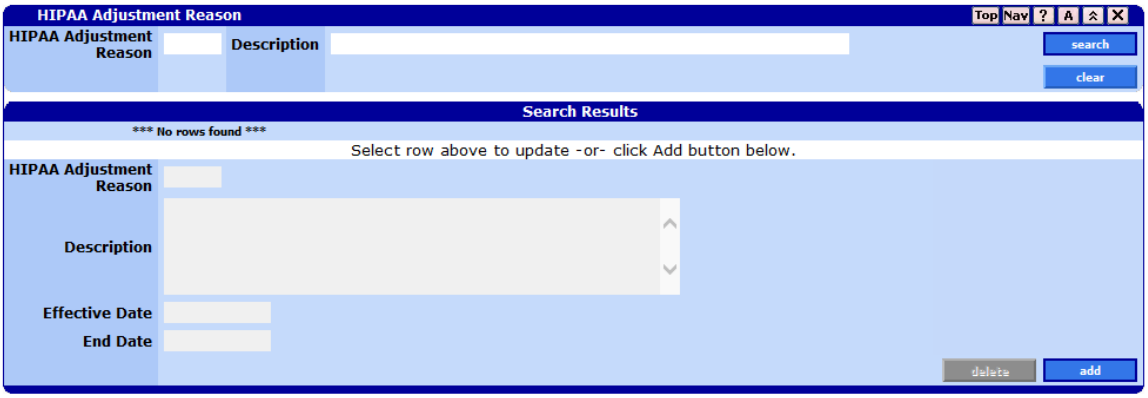
The panel consists of a data list displaying the defined Adjustment Reason codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [codes] - [HIPAA Adjustment Reason] - (click on [search])

6.172.2 Codes-HIPAA Adjustment Reason Panel Layout



6.172.3 Codes-HIPAA Adjustment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a HIPAA Adjustment Reason code.	Button	N/A	0
Clear	Clear the selection criteria entered.	Button	N/A	0
Delete	Delete a HIPAA Adjustment Reason code.	Button	N/A	0
Description	Text description of HIPAA Adjustment Reason code.	Field	Character	700

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Field	Description	Field Type	Data Type	Length
Effective Date	Date the HIPAA Adjustment Reason code becomes valid for use in the system.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the HIPAA Adjustment Reason code is valid for use in the system.	Field	Date (MM/DD/CCYY)	8
HIPAA Adjustment Reason	HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	Field	Character	4
Search	Search for reason code using the selection criteria specified.	Button	N/A	0

6.172.4 Codes-HIPAA Adjustment Reason Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description for the HIPAA Adjustment Reason.
	Field	2	You have exceeded the maximum characters allowed for this field.	The text will be truncated to the maximum 700 characters.
Effective Date	Field	1	Effective Date is required.	Enter a valid date.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to End Date.
	Field	3	Invalid date.	Enter an Effective date in MM/DD/CCYY format.
	Field	4	HIPAA Adjustment Reason Date range segments cannot overlap.	Enter HIPAA Adjustment Reason, Effective Date, and End Date that do not overlap with existing line item.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater or equal to 01/1/01900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
HIPAA Adjustment Reason	Field	1	HIPAA Adjustment Reason is required.	Enter a HIPAA Adjustment Reason code.
	Field	2	HIPAA Adjustment Reason must be Alphanumeric.	Adjustment Reason may only contain letters A-Z and numbers 0-9.

6.172.5 Codes-HIPAA Adjustment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.172.6 Codes-HIPAA Adjustment Reason Panel Accessibility

6.172.6.1 To Access the Codes-HIPAA Adjustment Reason Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **HIPAA Adjustment Reason**.	HIPAA Adjustment Reason panel displays.

6.172.6.2 To Add on the Codes-HIPAA Adjustment Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **HIPAA Adjustment Reason**.	
3	Enter **Description**.	

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Step	Action	Response
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	HIPAA Adjustment Reason information is saved.

6.172.6.3 To Update on the Codes-HIPAA Adjustment Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Adjustment Reason information is saved.

6.172.6.4 To Delete on the Codes-HIPAA Adjustment Reason Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.173 CODES-HIPAA CLAIM CATEGORY STATUS PANEL

6.173.1 Codes-HIPAA Claim Category Status Panel Narrative

The HIPAA Claim Category Status panel is used to maintain the Health Care Claim Status Category codes used in the Health Care Claim Status Notification/Response (277) transaction.

Claim Category Status codes indicate the general category of the status (accepted, rejected, additional information requested, etc.) which is then further detailed by the Health Care Claim Status codes. The Claim Status transaction is not used as a financial transaction. Please refer to the 276/277 Transaction Set Implementation Guide for further details regarding the use of these codes.

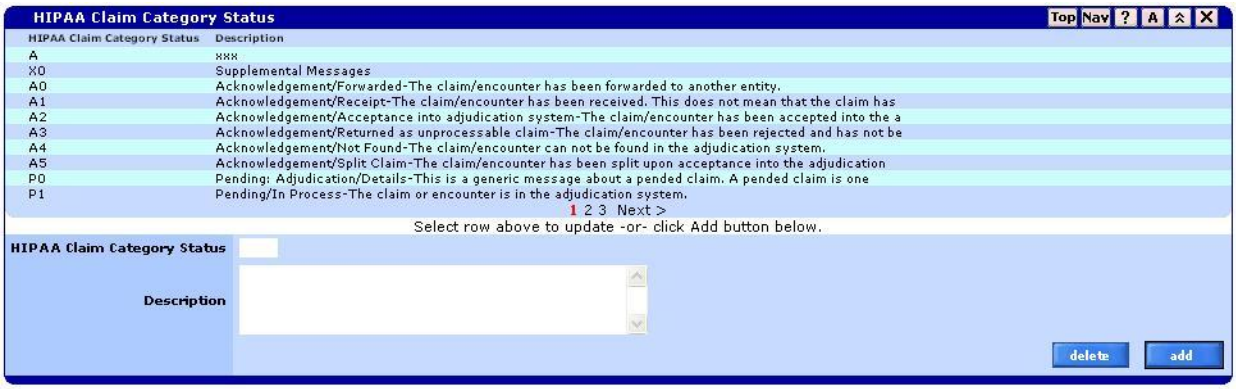
The panel consists of a data list displaying the defined Health Care Claim Category Status codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [HIPAA Claim Category Status]

6.173.2 Codes-HIPAA Claim Category Status Panel Layout



6.173.3 Codes-HIPAA Claim Category Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a HIPAA Claim Category Status Code.	Button	N/A	0
Delete	Allows the user to delete a HIPAA Claim Category Status Code.	Button	N/A	0
Description	Description of HIPAA Claim Category Status Codes.	Field	Character	200
HIPAA Claim Category Status	HIPAA Claim Category Status Code.	Field	Character	2

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6.173.4 Codes-HIPAA Claim Category Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the HIPAA Claim Category Status.
HIPAA Claim Category Status	Field	1	HIPAA Claim Category Status is required.	Enter a HIPAA Claim Category Status code.
	Field	2	A duplicate record cannot be saved.	Enter a unique HIPAA Claim Category Status Code.

6.173.5 Codes-HIPAA Claim Category Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.173.6 Codes-HIPAA Claim Category Status Panel Accessibility

6.173.6.1 To Access the Codes-HIPAA Claim Category Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **HIPAA Claim Category Status**.	HIPAA Claim Category Status panel displays.

6.173.6.2 To Add on the Codes-HIPAA Claim Category Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **HIPAA Claim Category Status**.	
3	Enter **Description**.	
4	Click **Save**.	HIPAA Claim Category Status information is saved.

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6.173.6.3 To Update on the Codes-HIPAA Claim Category Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Claim Category Status information is saved.

6.173.6.4 To Delete on the Codes-HIPAA Claim Category Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.174 CODES-HIPAA CLAIM STATUS PANEL

6.174.1 Codes-HIPAA Claim Status Panel Narrative

The HIPAA Claim Status panel is used to maintain the Claim Status codes used in the Health Care Claim Status Notification/Response (277) transaction.

Claim Status codes communicate information about the status of a claim-- e.g. whether it's been received, pended, or paid. The Claim Status transaction is not used as a financial transaction. Please refer to the 276/277 Transaction Set Implementation Guide for further details regarding the use of these codes.

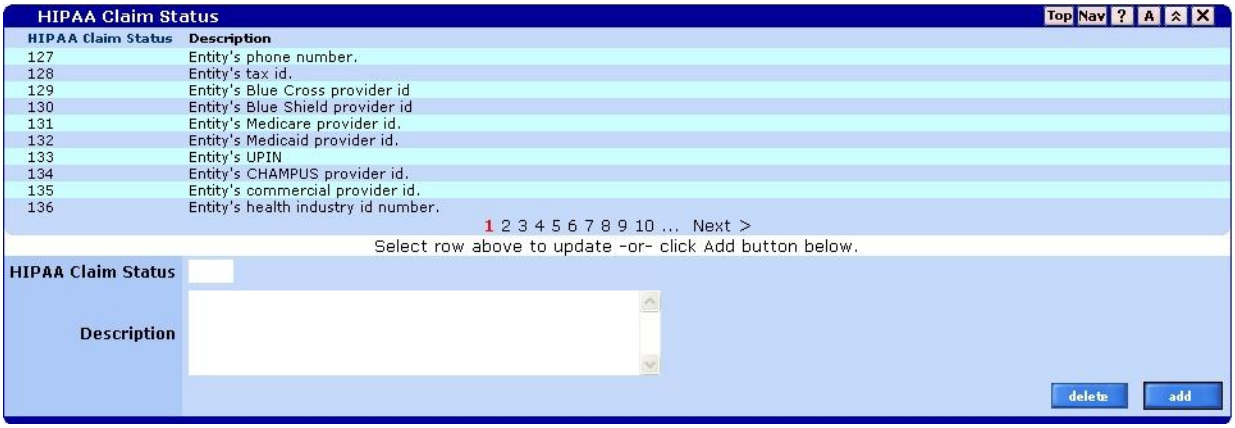
The panel consists of a data list displaying the defined Health Care Claim Status Codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [HIPAA Claim Status]

6.174.2 Codes-HIPAA Claim Status Panel Layout



6.174.3 Codes-HIPAA Claim Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a HIPAA Claim Status Codes.	Button	N/A	0
Delete	Allows a user to delete a HIPAA Claim Status Codes.	Button	N/A	0
Description	Description of the Health Care Claim Status Code.	Field	Character	200
HIPAA Claim Status	The HIPAA Health Care Claim Status Codes. Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.	Field	Character	3

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6.174.4 Codes-HIPAA Claim Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the HIPAA Claim Status.
HIPAA Claim Status	Field	1	HIPAA Claim Status is required.	Enter a HIPAA Claim Status code.
	Field	2	A duplicate record cannot be saved.	Enter a unique HIPAA Claim Status code.

6.174.5 Codes-HIPAA Claim Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.174.6 Codes-HIPAA Claim Status Panel Accessibility

6.174.6.1 To Access the Codes-HIPAA Claim Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **HIPAA Claim Status**.	HIPAA Claim Status panel displays.

6.174.6.2 To Add on the Codes-HIPAA Claim Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **HIPAA Claim Status**.	
3	Enter **Description**.	
4	Click **Save**.	HIPAA Claim Status information is saved.

6.174.6.3 To Update on the Codes-HIPAA Claim Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Claim Status information is saved.

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6.174.6.4 To Delete on the Codes-HIPAA Claim Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.175 CODES-HIPAA REMARK PANEL

6.175.1 Codes-HIPAA Remark Panel Narrative

The HIPAA Remark panel is used to maintain the Remittance Remark code set.

Two HIPAA standard code sets--the reason and remark code sets--are used to report payment adjustments in remittance advice transactions (835).

Remittance Advice Remark Codes are used within the 835 to convey information about remittance processing or to provide additional explanation for an adjustment already covered by a Claim Adjustment Reason Code. Each Remittance Advice Remark Code identifies a specific message.

For example, denied claims on HIPAA compliant 835 remittance advice returned with adjustment reason codes to characterize the overall reason for denial may also include remittance remark codes that provide a specific reason for the denial of a claim.

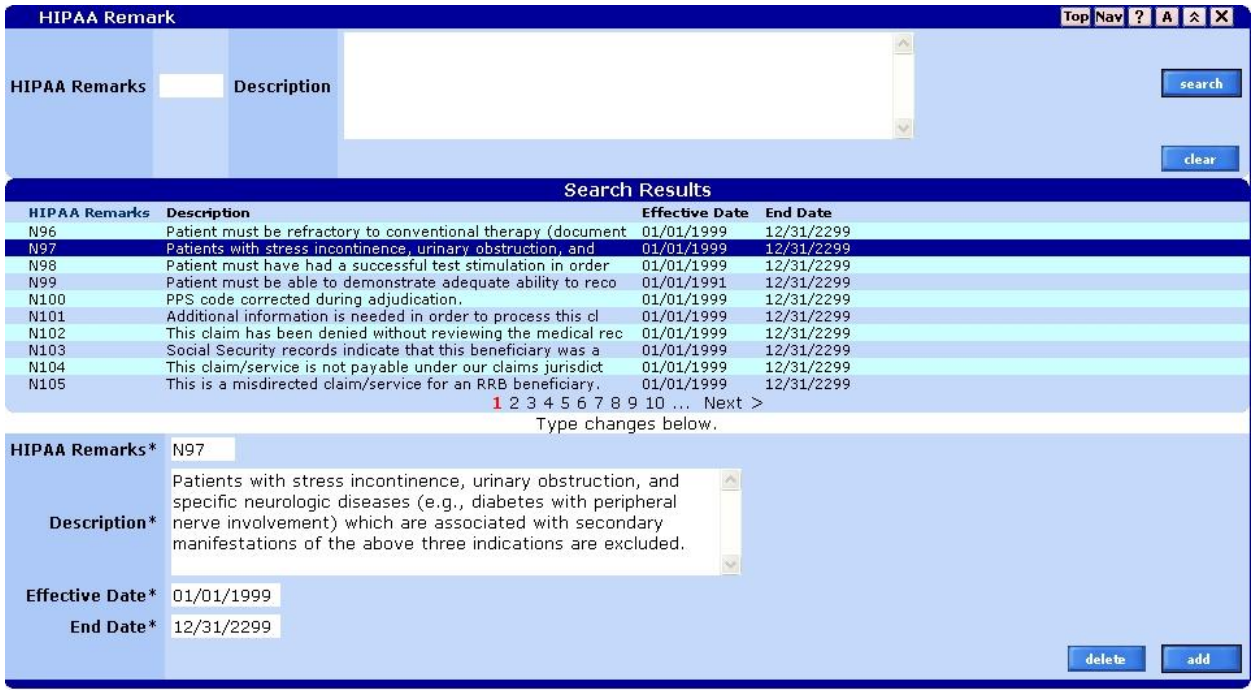
The panel consists of a data list displaying the defined Remittance Remark codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data

Navigation Path: [Reference] – [Related Data] - [Codes] - [HIPAA Remark] - (Click on Search)

6.175.2 Codes-HIPAA Remark Panel Layout



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6.175.3 Codes-HIPAA Remark Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a remarks code.	Button	N/A	0
Clear	Clears the search criteria fields so user may enter new criteria.	Button	N/A	0
Delete	Allows the user to delete a remarks code.	Button	N/A	0
Description	Text describing the remittance remark.	Field	Character	700
Effective Date	First date the remittance remark is valid for use in the system.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the remittance remark is valid for use in the system.	Field	Date (MM/DD/CCYY)	8
HIPAA Remarks	Code representing non-financial information critical to understanding the adjudication of a health insurance claim. For example: Reason for denial.	Field	Character	5
Search	Initiates search for remittance remarks matching the criteria entered.	Button	N/A	0

6.175.4 Codes-HIPAA Remark Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the HIPAA Remark code.
	Field	2	You have exceeded the maximum characters allowed for this field.	The text will be truncated to the maximum 700 characters.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Invalid date.	Enter a Effective Date in MM/DD/CCYY format.
	Field	3	Effective Date is required.	Enter a Effective Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is equal to or after 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
End Date	Field	1	Invalid date.	Enter a date in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	End Date is required.	Must enter a value in End Date.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
HIPAA Remarks	Field	1	HIPAA Remarks contains duplicates.	Enter a unique remark code.
	Field	2	HIPAA Remarks must be Alphanumeric.	Enter a HIPAA Remarks that contains only alpha or numeric characters.
	Field	3	HIPAA Remarks is required.	Enter a HIPAA Remarks code.

6.175.5 Codes-HIPAA Remark Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.175.6 Codes-HIPAA Remark Panel Accessibility

6.175.6.1 To Access the Codes-HIPAA Remark Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **HIPAA Remark**.	HIPAA Remark panel displays.

6.175.6.2 To Add on the Codes-HIPAA Remark Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **HIPAA Remark**.	
3	Enter **Description**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	

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Step	Action	Response
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	HIPAA Remark information is saved.

6.175.6.3 To Update on the Codes-HIPAA Remark Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Remark information is saved.

6.175.6.4 To Delete on the Codes-HIPAA Remark Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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CODES-LOCALITY PANEL

6.176.1 Codes-Locality Panel Narrative

The Locality panel is used to maintain Provider Locality codes. Locality codes are used to indicate whether a provider is located in an urban, rural, metropolitan, or out-of-state area.

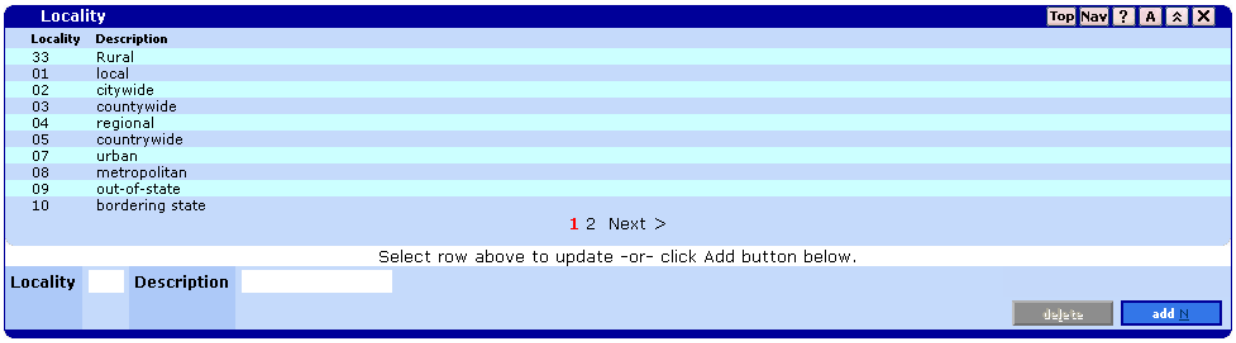
The panel consists of a data list displaying the defined Localities and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Locality]

6.176.2 Codes-Locality Panel Layout



6.176.3 Codes-Locality Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a locality.	Button	N/A	0
Delete	Allows the user to delete a locality.	Button	N/A	0
Description	Text describing the provider locality.	Field	Character	15
Locality	Code used to indicate geographical area of practice for a provider.	Field	Character	2

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6.176.4 Codes-Locality Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the Locality code.
Locality	Field	1	Locality is required.	Enter a Locality code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Locality code.
	Field	3	Locality must be 2 character(s) in length.	Enter a 2 character Locality code.

6.176.5 Codes-Locality Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.176.6 Codes-Locality Panel Accessibility

6.176.6.1 To Access the Codes-Locality Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Locality**.	Locality panel displays.

6.176.6.2 To Add on the Codes-Locality Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Locality**.	
3	Enter **Description**.	
4	Click **Save**.	Locality information is saved.

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6.176.6.3 To Update on the Codes-Locality Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Locality information is saved.

6.176.6.4 To Delete on the Codes-Locality Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.177 CODES-MANAGED CARE SERVICE CLASS PANEL

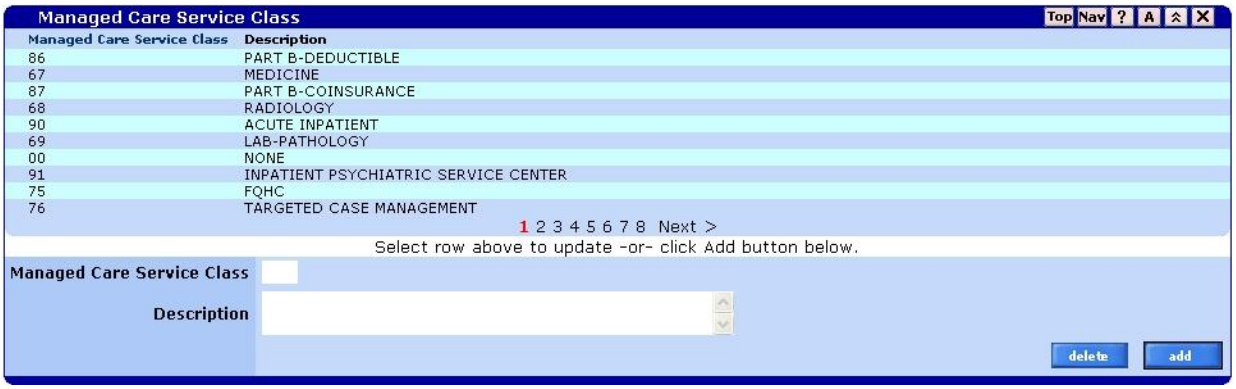
6.177.1 Codes-Managed Care Service Class Panel Narrative

The Managed Care Service class describes the type of services provided.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Codes] - [Managed Care Service Class]

6.177.2 Codes-Managed Care Service Class Panel Layout



6.177.3 Codes-Managed Care Service Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Service Class.	Button	N/A	0
Delete	Delete a Service Class.	Button	N/A	0
Description	Text description of the type of services provided.	Field	Character	100
Managed Care Service Class	The service class indicates the type of services provided.	Field	Character	2

6.177.4 Codes-Managed Care Service Class Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the Managed Care Service Class.
Managed Care Service Class	Field	1	Managed Care Service Class is required.	Enter a Managed Care Service Class code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Managed Care Service Class code.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Managed Care Service Class must be 2 character(s) in length.	Enter a 2 character value.

6.177.5 Codes-Managed Care Service Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.177.6 Codes-Managed Care Service Class Panel Accessibility

6.177.6.1 To Access the Codes-Managed Care Service Class Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Managed Care Service Class**.	Managed Care Service Class panel displays.

6.177.6.2 To Add on the Codes-Managed Care Service Class Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Managed Care Service Class**.	
3	Enter **Description**.	
4	Click **Save**.	Managed Care Service Class information is saved.

6.177.6.3 To Update on the Codes-Managed Care Service Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Managed Care Service Class information is saved.

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6.177.6.4 To Delete on the Codes-Managed Care Service Class Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.178 CODES-MARITAL STATUS PANEL

6.178.1 Codes-Marital Status Panel Narrative

The Marital Status panel is used to maintain valid marital statuses.

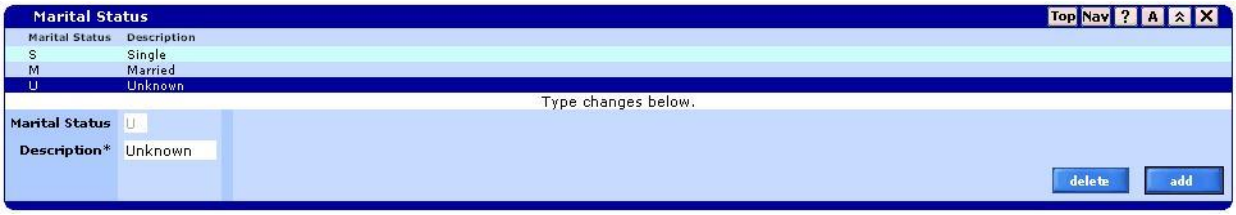
The panel consists of a data list displaying the defined Marital Statuses and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Marital Status]

6.178.2 Codes-Marital Status Panel Layout



6.178.3 Codes-Marital Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Marital Status code.	Button	N/A	0
Delete	Allows the user to delete a Marital Status code.	Button	N/A	0
Description	Text describing the marital status.	Field	Character	10
Marital Status	Code identifying/representing a marital status.	Field	Character	1

6.178.4 Codes-Marital Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the Marital Status.
Marital Status	Field	1	Marital Status is required.	Enter a Marital Status code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Marital Status code.

6.178.5 Codes-Marital Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.178.6 Codes-Marital Status Panel Accessibility

6.178.6.1 To Access the Codes-Marital Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Marital Status**.	Marital Status panel displays.

6.178.6.2 To Add on the Codes-Marital Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Marital Status**.	
3	Enter **Description**.	
4	Click **Save**.	Marital Status information is saved.

6.178.6.3 To Update on the Codes-Marital Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Marital Status information is saved.

6.178.6.4 To Delete on the Codes-Marital Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.179 CODES-MEDICARE COVERAGE PANEL

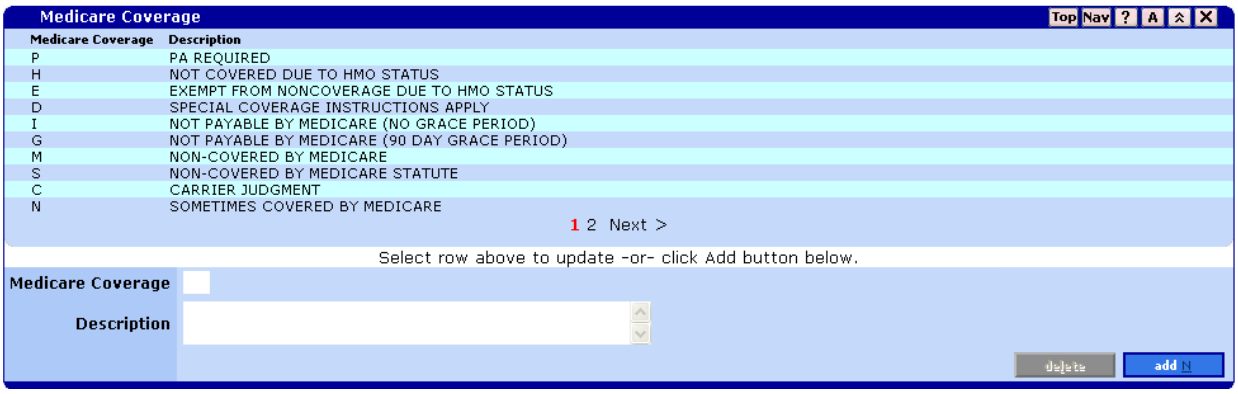
6.179.1 Codes-Medicare Coverage Panel Narrative

The Medicare Coverage panel is used to maintain Medicare Coverage Codes and Descriptions.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Medicare Coverage]

6.179.2 Codes-Medicare Coverage Panel Layout



6.179.3 Codes-Medicare Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Medicare Coverage information.	Button	N/A	0
Delete	Allows the user to delete a Medicare Coverage information.	Button	N/A	0
Description	Description of the Medicare Coverage Code.	Field	Character	100
Medicare Coverage	Code denoting Medicare coverage status listed on the CMS HCPCS file.	Field	Alphanumeric	1

6.179.4 Codes-Medicare Coverage Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Medicare Coverage	Field	1	Code is required.	Enter a Medicare code.

6.179.5 Codes-Medicare Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.179.6 Codes-Medicare Coverage Panel Accessibility

6.179.6.1 To Access the Codes-Medicare Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Medicare Coverage**.	Medicare Coverage panel displays.

6.179.6.2 To Add on the Codes-Medicare Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Medicare Coverage**.	
3	Enter **Description**.	
4	Click **Save**.	Medicare Coverage information is saved.

6.179.6.3 To Update on the Codes-Medicare Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Medicare Coverage information is saved.

6.179.6.4 To Delete on the Codes-Medicare Coverage Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.180 CODES-MDC PANEL

6.180.1 Codes-MDC Panel Narrative

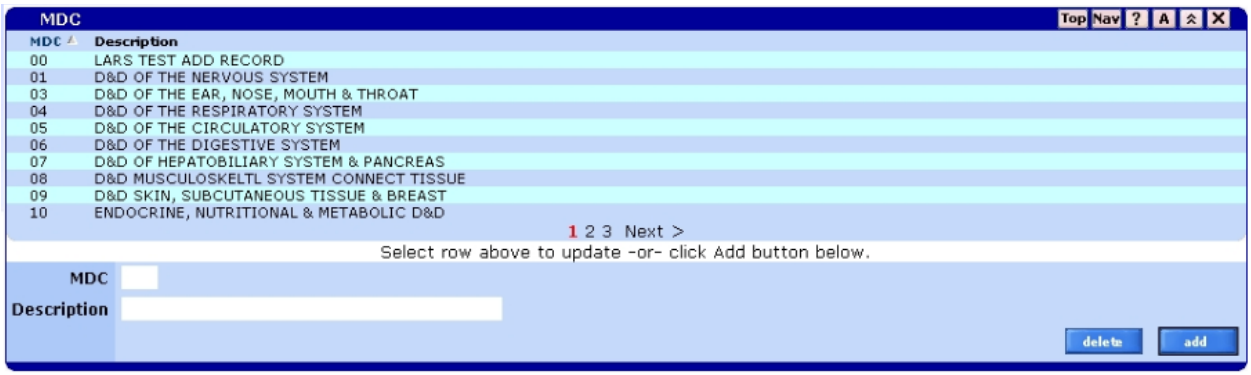
The MDC panel is used to maintain the Major Diagnostic Category (MDC) code set. Diagnostic Related Groups (DRGs) are arranged by Major Diagnostic Category (MDC).

The panel consists of a data list displaying the defined MDCs and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - MDC]

6.180.2 Codes-MDC Panel Layout



6.180.3 Codes-MDC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a MDC code.	Button	N/A	0
Delete	Allows the user to delete a MDC code.	Button	N/A	0
Description	The description for the MDC code.	Field	Character	20
MDC	The code used to identify a MDC. A MDC is a user-defined data element that refers to the kind of service being billed. For example, common MDCs are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc.	Field	Character	1

6.180.4 Codes-MDC Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
MDC	Field	1	MDC is required.	Enter a MDC code.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	100	MDC must be unique.	Enter a unique MDC.
Description	Field	1	Description is required.	Description is required when adding or modifying a MDC.

6.180.5 Codes-MDC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.180.6 Codes-MDC Panel Accessibility

6.180.6.1 To Access the Codes-MDC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **MDC**.	MDC panel displays.

6.180.6.2 To Add on the Codes-MDC Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **MDC**.	
3	Enter **Description**.	
4	Click **Save**.	MDC information is saved.

6.180.6.3 To Update on the Codes-MDC Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	MDC information is saved.

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6.180.6.4 To Delete on the Codes-MDC Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.181 CODES-MMIS CLAIM STATUS PANEL

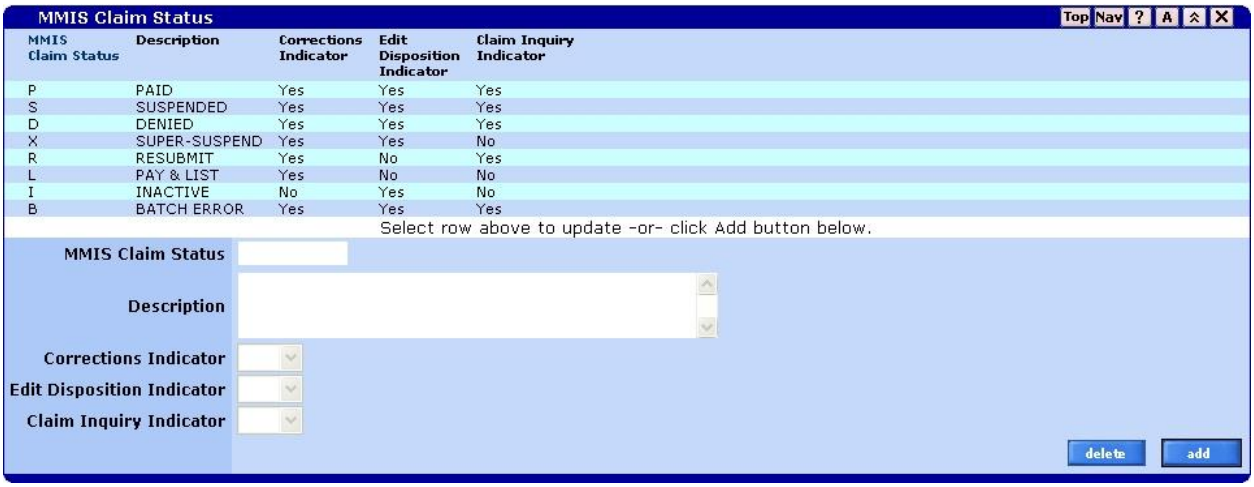
6.181.1 Codes-MMIS Claim Status Panel Narrative

The MMIS Claim Status panel is used to view claim status as defined in the MMIS.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Codes] - [MMIS Claim Status]

6.181.2 Codes-MMIS Claim Status Panel Layout



6.181.3 Codes-MMIS Claim Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a MMIS Claim Status.	Button	N/A	0
Claim Inquiry Indicator	Yes/No value used to identify Claim Status codes that are valid for use in the Claims Inquiry process.	Combo Box	Drop Down List Box	0
Corrections Indicator	Yes/No value used to identify Claim Status codes that are valid for use in the Claims Data Corrections process.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete a MMIS Claim Status.	Button	N/A	0
Description	Description of Claim Status.	Field	Character	20
Edit Disposition Indicator	Yes/No value used to identify Claim Status codes that are valid for use in the Claims Dispositioning process.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
MMIS Claim Status	The MMIS Claim Status Code that identifies the status of a claim after processing through the claims engine.	Field	Character	1

6.181.4 Codes-MMIS Claim Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Claim Inquiry Indicator	Field	1	Claim Inquiry Indicator is required.	Select a Claim Inquiry indicator from the list.
Corrections Indicator	Field	1	Corrections Indicator is required.	Select a Corrections indicator from the list.
Description	Field	1	Description is required.	Enter a text Description of the MMIS Claim Status code.
Edit Disposition Indicator	Field	1	Edit Disposition Indicator is required.	Select an Edit Disposition Indicator from the list.
MMIS Claim Status	Field	1	MMIS Claim Status is required.	Enter an MMIS Claim Status code.
	Field	2	A duplicate record cannot be saved.	Enter a unique MMIS Claim Status code.

6.181.5 Codes-MMIS Claim Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.181.6 Codes-MMIS Claim Status Panel Accessibility

6.181.6.1 To Access the Codes-MMIS Claim Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **MMIS Claim Status**.	MMIS Claim Status panel displays.

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6.181.6.2 To Add on the Codes-MMIS Claim Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **MMIS Claim Status**.	
3	Enter **Description**.	
4	Select **Corrections Indicator** from drop down list box.	
5	Select **Edit Disposition Indicator** from drop down list box.	
6	Select **Claim Inquiry Indicator** from drop down list box.	
7	Click **Save**.	MMIS Claim Status information is saved.

6.181.6.3 To Update on the Codes-MMIS Claim Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	MMIS Claim Status information is saved.

6.181.6.4 To Delete on the Codes-MMIS Claim Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.182 CODES-MODIFIER TYPE PANEL

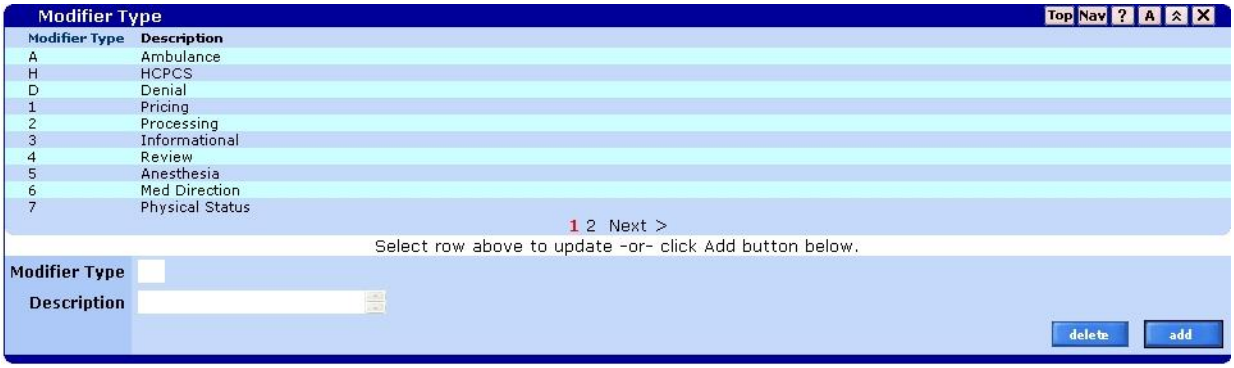
6.182.1 Codes-Modifier Type Panel Narrative

The Modifier Type panel is used for maintenance of the Modifier Type codes.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - Modifier Type]

6.182.2 Codes-Modifier Type Panel Layout



6.182.3 Codes-Modifier Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Modifier Type.	Button	N/A	0
Delete	Delete a Modifier Type.	Button	N/A	0
Description	Text Description for a Modifier Type.	Field	Character	25
Modifier Type	Code used to identify the type and/or usage of a modifier.	Field	Character	1

6.182.4 Codes-Modifier Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Description required when adding or modifying a Modifier Type.
Modifier Type	Field	1	Modifier Type must be Alphanumeric.	Enter a Modifier Type that contains only 0-9 and A-Z.
	Field	2	Modifier Type is required.	Enter a Modifier Type code.
	Field	3	A duplicate record cannot be saved.	Enter a unique Modifier Type Code.

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6.182.5 Codes-Modifier Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.182.6 Codes-Modifier Type Panel Accessibility

6.182.6.1 To Access the Codes-Modifier Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Occurrence**.	Modifier Type panel displays.

6.182.6.2 To Add on the Codes-Modifier Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Modifier Type**.	
3	Enter **Description**.	
4	Click **Save**.	Modifier Type information is saved.

6.182.6.3 To Update on the Codes-Modifier Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Modifier Type information is saved.

6.182.6.4 To Delete on the Codes-Modifier Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.183 CODES-OCCURRENCE PANEL

6.183.1 Codes-Occurrence Panel Narrative

The Occurrence panel is used to maintain the National Uniform Billing Committee (NUBC) Occurrence codes. Occurrence codes are used on Institutional claims to define a significant event relating to a claim/bill that may affect payer processing, such as an auto accident date.

Occurrence and Occurrence Span Codes are mutually exclusive. Occurrence Codes have values from 01-69 and A0-L9. Occurrence Span Codes have values from 70 through 99 and M0-Z9.

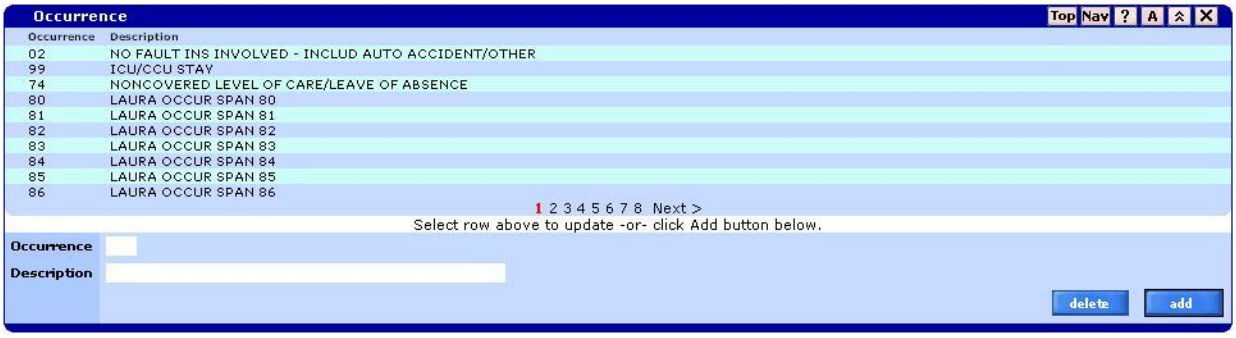
The panel consists of a data list displaying the defined Occurrence Codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Occurrence]

6.183.2 Codes-Occurrence Panel Layout



6.183.3 Codes-Occurrence Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Occurrence code.	Button	N/A	0
Delete	Allows the user to delete an Occurrence code.	Button	N/A	0
Description	The description of the occurrence code.	Field	Character	50
Occurrence	Code which defines a significant event relating to a particular UB04 claim that may affect payer processing.	Field	Character	2

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6.183.4 Codes-Occurrence Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the occurrence code.
Occurrence	Field	1	A duplicate record cannot be saved.	Enter a unique Occurrence Code.
	Field	2	Occurrence must be 2 character(s) in length.	Enter a 2 character code.
	Field	3	Occurrence is required.	Enter an Occurrence Code.

6.183.5 Codes-Occurrence Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.183.6 Codes-Occurrence Panel Accessibility

6.183.6.1 To Access the Codes-Occurrence Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Occurrence**.	Occurrence panel displays.

6.183.6.2 To Add on the Codes-Occurrence Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Occurrence**.	
3	Enter **Description**.	
4	Click **Save**.	Occurrence information is saved.

6.183.6.3 To Update on the Codes-Occurrence Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Occurrence information is saved.

6.183.6.4 To Delete on the Codes-Occurrence Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.184 CODES-ORANGE BOOK CODE PANEL

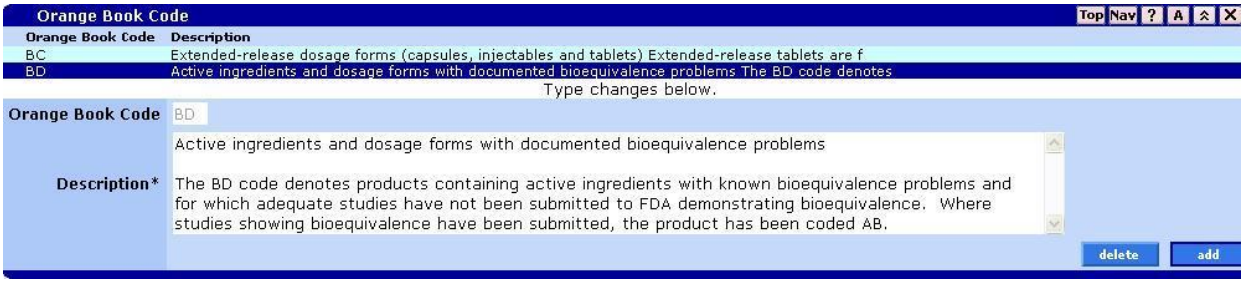
6.184.1 Codes-Orange Book Code Panel Narrative

The Orange Book Code panel identifies the equivalency ratings assigned to an approved prescription product according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation: [Reference]- [Related Data] - [Codes] - [Orange Book Code]

6.184.2 Codes-Orange Book Code Panel Layout



6.184.3 Codes-Orange Book Code Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Orange Book code.	Button	N/A	0
Delete	Allows the user to delete an Orange Book code.	Button	N/A	0
Description	Provides the text description for the Orange Book Code.	Field	Alphanumeric	500
Orange Book Code	Identifies the equivalency ratings assigned to an approved prescription product according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).	Field	Character	2

6.184.4 Codes-Orange Book Code Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter description.
Orange Book Code	Field	1	Orange Book Code is required.	Enter Orange Book Code.

6.184.5 Codes-Orange Book Code Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.184.6 Codes-Orange Book Code Panel Accessibility

6.184.6.1 To Access the Codes-Orange Book Code Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pag displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Orange Book Code**.	Orange Book Code panel displays.

6.184.6.2 To Add on the Codes-Orange Book Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Orange Book Code**.	
3	Enter **Description**.	
4	Click **Save**.	Orange Book Code information is saved.

6.184.6.3 To Update on the Codes-Orange Book Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Orange Book Code information is saved.

6.184.6.4 To Delete on the Codes-Orange Book Code Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.185 CODES-PATIENT STATUS PANEL

6.185.1 Codes-Patient Status Panel Narrative

The Patient Status panel is used to maintain the NUBC Patient Status codes. These codes are used to indicate the patient status as of the ending service date on an Institutional claim/bill.

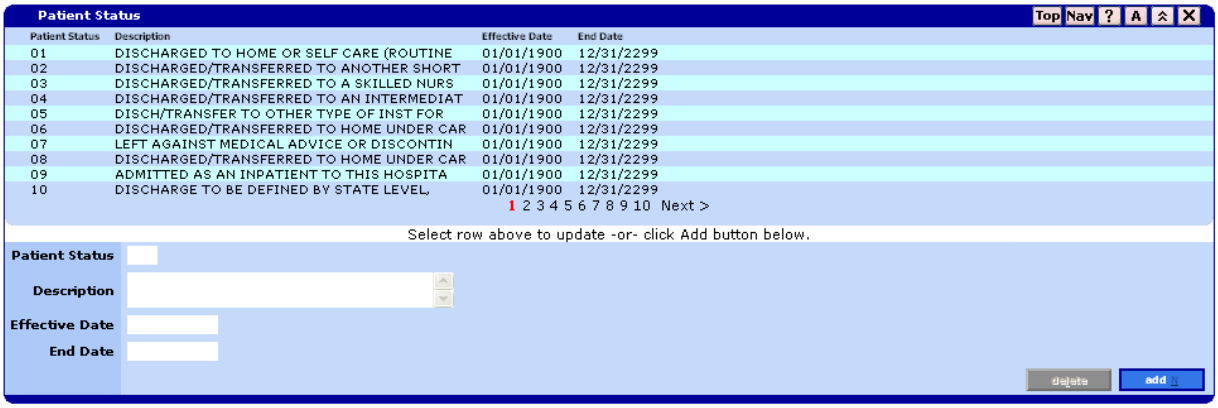
The panel consists of a data list displaying the defined Patient Statuses and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Patient Status]

6.185.2 Codes-Patient Status Panel Layout



6.185.3 Codes-Patient Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Patient Status code.	Button	N/A	0
Delete	Allows a user to delete a Patient Status code.	Button	N/A	0
Description	Description of the status of the recipient as of the ending service date of the period covered on a UB04 claim.	Field	Character	80
Effective Date	The effective date of the patient status code.	Field	Date (MM/DD/CCYY)	8
End Date	The end date of the patient status code.	Field	Date (MM/DD/CCYY)	8
Patient Status	Indicates the status of the recipient as of the ending service date of the period covered on a UB04 claim.	Field	Character	2

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6.185.4 Codes-Patient Status Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the Patient Status code.
Effective Date	Field	1	Effective date should be less than or equal to End date.	EffectiveDate should be less than or equal to End date.
	Field	3	Effective Date is required.	Enter a valid Effective Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	6	Invalid date. Format is MM/DD/CCYY.	Enter a valid Effective Date.
End Date	Field	1	End date should be greater than or equal to Effective Date.	End date should be greater than or equal to Effective Date.
	Field	2	End Date is required.	Enter a valid End Date.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	5	Invalid date. Format is MM/DD/CCYY.	Enter a valid End Date.
Patient Status	Field	1	Patient Status is required.	Enter a Patient Status code.

6.185.5 Codes-Patient Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.185.6 Codes-Patient Status Panel Accessibility

6.185.6.1 To Access the Codes-Patient Status Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.

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Step	Action	Response
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Patient Status**.	Patient Status panel displays.

6.185.6.2 To Add on the Codes-Patient Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Patient Status**.	
3	Enter **Description**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Patient Status information is saved.

6.185.6.3 To Update on the Codes-Patient Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Patient Status information is saved.

6.185.6.4 To Delete on the Codes-Patient Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.186 CODES-PLACE OF SERVICE PANEL

6.186.1 Codes-Place of Service Panel Narrative

The Place of Service panel is used to maintain the National Place of Service code set.

Place of Service Codes are two-character codes placed on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the health care industry.

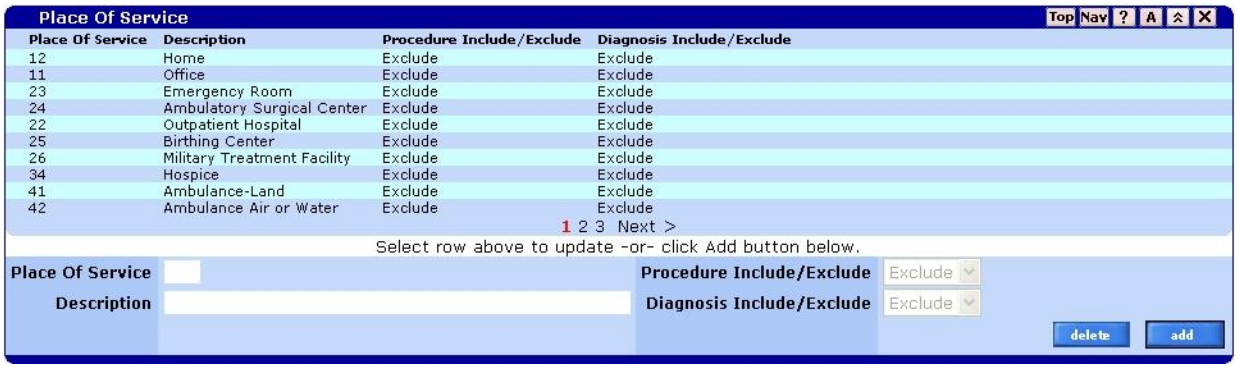
The panel consists of a data list displaying the defined Place of Service codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Place of Service]

6.186.2 Codes-Place of Service Panel Layout



6.186.3 Codes-Place of Service Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allow the user to add a place of service.	Button	N/A	0
Delete	Allow the user to delete a place of service.	Button	N/A	0
Description	Abbreviated description (name) of the place of service.	Field	Character	50
Diagnosis Include / Exclude	Indicates whether the associated list of diagnosis codes is valid or invalid for the place of service.	Combo Box	Drop Down List Box	0
Place of Service	Code indicating the entity where services were provided/rendered.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Procedure Include / Exclude	Indicates whether the associated list of Procedure Codes is valid or invalid for the place of service.	Combo Box	Drop Down List Box	0

6.186.4 Codes-Place of Service Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description (name) of Place of Service.
Diagnosis Include / Exclude	Field	1	Diagnosis Include/Exclude is required.	Select Include or Exclude from the list.
Place of Service	Field	1	Place of Service is required.	Enter a Place of Service code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Place of Service code.
Procedure Include / Exclude	Field	1	Procedure Include/Exclude is required.	Select Include or Exclude from the list.

6.186.5 Codes-Place of Service Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.186.6 Codes-Place of Service Panel Accessibility

6.186.6.1 To Access the Codes-Place of Service Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Place of Service**.	Place of Service panel displays.

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6.186.6.2 To Add on the Codes-Place of Service Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Place of Service**.	
3	Enter **Description**.	
4	Select **Procedure Include/Exclude** from drop down list box.	
5	Select **Diagnosis Include/Exclude** from drop down list box.	
6	Click **Save**.	Place of Service information is saved.

6.186.6.3 To Update on the Codes-Place of Service Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Place of Service information is saved.

6.186.6.4 To Delete on the Codes-Place of Service Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.187 CODES-PRICING PANEL

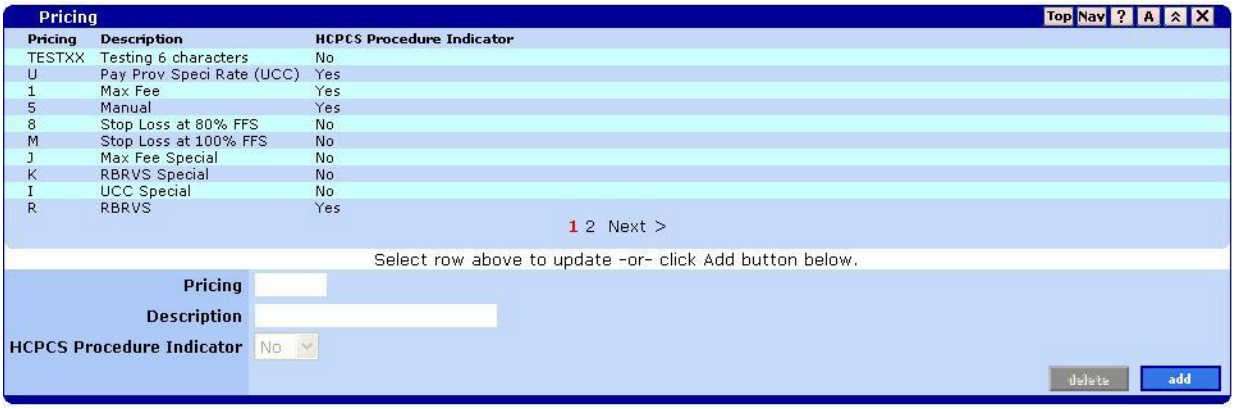
6.187.1 Codes-Pricing Panel Narrative

Pricing indicator specifies the payment methodology that should be applied or was applied when determining the payment to be made to a provider for providing a service (procedure).

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Codes] - [Pricing]

6.187.2 Codes-Pricing Panel Layout



6.187.3 Codes-Pricing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a pricing indicator.	Button	N/A	0
Delete	Allows the user to delete a pricing indicator.	Button	N/A	0
Description	Text description of the pricing indicator.	Field	Character	25
HCPCS Procedure Indicator	Indicates if the pricing indicator value is applicable for HCPCS procedures. A value of "Y" signifies the indicator is valid for HCPCS procedures and "N" says it is not.	Combo Box	Drop Down List Box	0
Pricing	Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.	Field	Character	6

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6.187.4 Codes-Pricing Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the Pricing code.
Pricing	Field	1	Pricing is required.	Enter a Pricing code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Pricing code.

6.187.5 Codes-Pricing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.187.6 Codes-Pricing Panel Accessibility

6.187.6.1 To Access the Codes-Pricing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Pricing**.	Pricing panel displays.

6.187.6.2 To Add on the Codes-Pricing Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Price**.	
3	Enter **Description**.	
4	Select **HCPCS Procedure Indicator** from the drop down list box.	
5	Click **Save**.	Pricing information is saved.

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6.187.6.3 To Update on the Codes-Pricing Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Pricing information is saved.

6.187.6.4 To Delete on the Codes-Pricing Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.188 CODES-RACE PANEL

6.188.1 Codes-Race Panel Narrative

The Race panel is used to maintain race codes and descriptions.

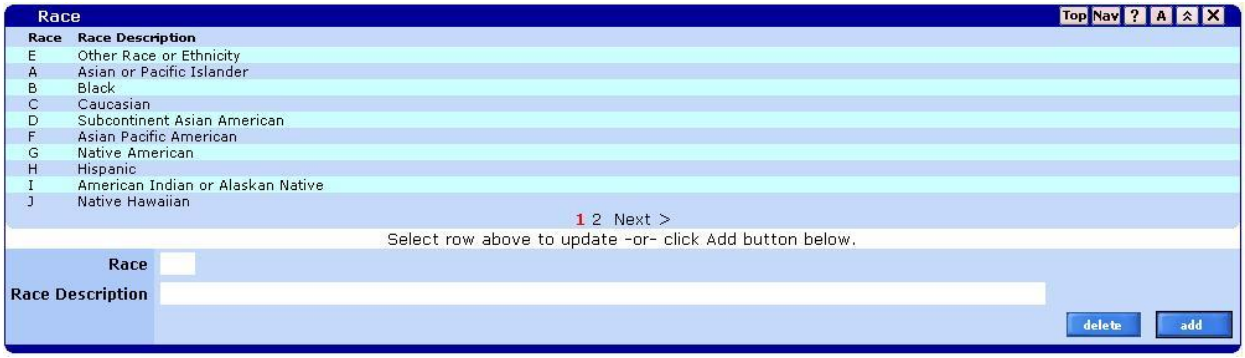
The panel consists of a data list displaying the defined Races and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Codes] - [Race]

6.188.2 Codes-Race Panel Layout



6.188.3 Codes-Race Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Race code.	Button	N/A	0
Delete	Allows the user to delete a Race code.	Button	N/A	0
Race	Code representing ethnic origin or race.	Field	Character	2
Race Description	Text describing the race code.	Field	Character	100

6.188.4 Codes-Race Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Race	Field	1	Race is required.	Enter a Race code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Race code.
Race Description	Field	1	Race Description is required.	Enter a text description Race code.

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6.188.5 Codes-Race Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.188.6 Codes-Race Panel Accessibility

6.188.6.1 To Access the Codes-Race Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Race**.	Race panel displays.

6.188.6.2 To Add on the Codes-Race Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Race**.	
3	Enter **Description**.	
4	Click **Save**.	Race information is saved.

6.188.6.3 To Update on the Codes-Race Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Race information is saved.

6.188.6.4 To Delete on the Codes-Race Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.189 CODES-RATE TYPE PANEL

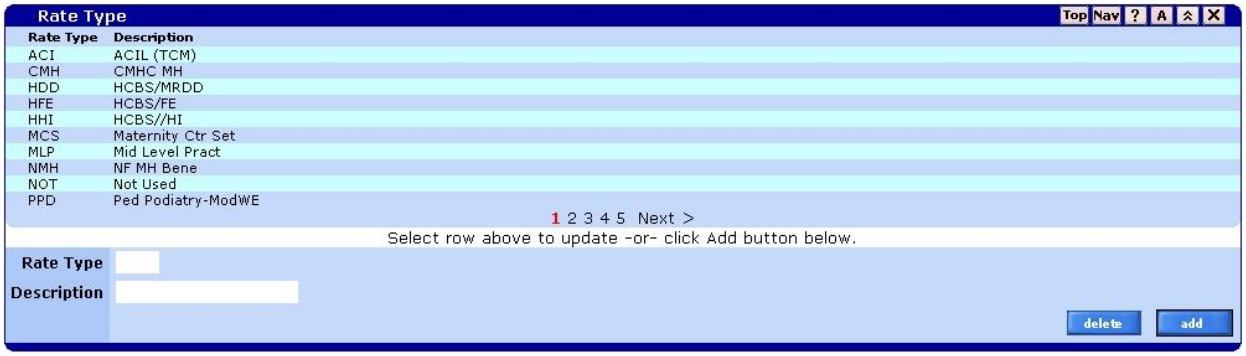
6.189.1 Codes-Rate Type Panel Narrative

The Rate Type panel is used to maintain the list of valid rate type codes used in Claims Pricing. The rate type allows different rates to be applied for various member plans.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Rate Type]

6.189.2 Codes-Rate Type Panel Layout



6.189.3 Codes-Rate Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Rate Type code.	Button	N/A	0
Delete	Allows the user to delete a Rate Type code.	Button	N/A	0
Description	Text describing the rate type.	Field	Character	18
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Field	Character	3

6.189.4 Codes-Rate Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the Rate Type code.
Rate Type	Field	1	Rate Type is required.	Enter a Rate Type code.
	Field	2	Rate Type must be at least 2 characters in length.	Enter a 2 character Rate Type code.
	Field	3	Rate Type contains duplicates.	Enter a unique Rate Type code.

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6.189.5 Codes-Rate Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.189.6 Codes-Rate Type Panel Accessibility

6.189.6.1 To Access the Codes-Rate Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Rate Type**.	Rate Type panel displays.

6.189.6.2 To Add on the Codes-Rate Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Rate Type**.	
3	Enter **Description**.	
4	Click **Save**.	Rate Type information is saved.

6.189.6.3 To Update on the Codes-Rate Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rate Type information is saved.

6.189.6.4 To Delete on the Codes-Rate Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.190 CODES-REGION PANEL

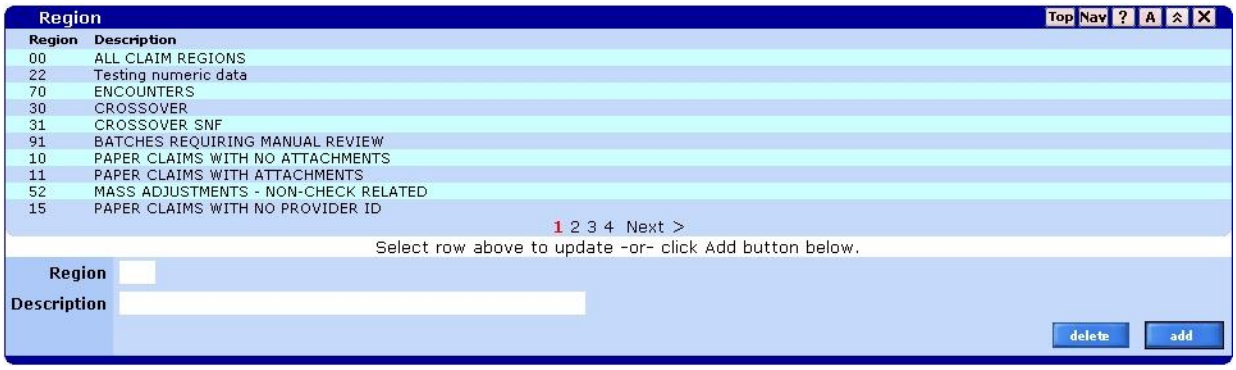
6.190.1 Codes-Region Panel Narrative

The Region panel maintains the codes and descriptions that indicate the media format of the submitted claim.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Region]

6.190.2 Codes-Region Panel Layout



6.190.3 Codes-Region Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Region code.	Button	N/A	0
Delete	Allows a user to delete a Region code.	Button	N/A	0
Description	Description of the region code.	Field	Character	50
Region	Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.	Field	Character	2

6.190.4 Codes-Region Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the Region.
Region	Field	1	Region is required.	Enter a Region code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Region code.
	Field	3	Region must be Numeric.	Enter a value that contains only 0-9 for Region.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Region must be 2 character(s) in length.	Enter a 2 digit Region code.

6.190.5 Codes-Region Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.190.6 Codes-Region Panel Accessibility

6.190.6.1 To Access the Codes-Region Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Region**.	Region panel displays.

6.190.6.2 To Add on the Codes-Region Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Region**.	
3	Enter **Description**.	
4	Click **Save**.	Region information is saved.

6.190.6.3 To Update on the Codes-Region Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Region information is saved.

6.190.6.4 To Delete on the Codes-Region Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

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Step	Action	Response
2	Click **Delete**.	Line item is deleted.

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6.191 CODES- SPECIFIC THERAPEUTIC CLASS PANEL

6.191.1 Codes- Specific Therapeutic Class Panel Narrative

The Specific Therapeutic Class panel is used to maintain Hierarchical Specific Therapeutic Class codes as supplied by FDB (First DataBank). Hierarchical Specific Therapeutic Class Codes (Alias HIC3) are used to identify a specific therapeutic class in which an active ingredient (for a drug) is classified.

The panel consists of a data list displaying the defined Specific Therapeutic Class codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Codes] - [Specific Therapeutic Class]

6.191.2 Codes-Specific Therapeutic Class Panel Layout

6.191.3 Codes- Specific Therapeutic Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Specific Therapeutic Class.	Button	N/A	0
Delete	Allows the user to delete a Specific Therapeutic Class.	Button	N/A	0
Description	A description, up to 50 characters long, of the Therapeutic Class Code.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Specific Therapeutic Class	Known also as FDB's Specific Therapeutic Class, the GC3 or the HIC3. It is a three-character alphanumeric field that identifies the specific therapeutic class in which the active ingredient is classified. It is the third position of the Hierarchical Ingredient Code (HIC).	Field	Character	3
Stage	This is the value representing the 'stage' of the entry.1= new; 2 = change; 3 = re-add; 4 = delete.	Combo Box	Drop Down List Box	0

6.191.4 Codes- Specific Therapeutic Class Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description for the Specific Therapeutic Class.
Specific Therapeutic Class	Field	1	Specific Therapeutic Class is required.	Enter a Specific Therapeutic Class code.
	Field	2	Specific Therapeutic Class is a duplicate.	Enter a unique Specific Therapeutic Class code.
	Field	3	Specific Drug Therapeutic Class Must be 3 character(s) in length.	Enter 3 characters in this field.
Stage	Field	1	Stage is required.	Enter a valid Stage when adding or modifying Specific Therapeutic Class.

6.191.5 Codes- Specific Therapeutic Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.191.6 Codes- Specific Therapeutic Class Panel Accessibility

6.191.6.1 To Access the Codes- Specific Therapeutic Class Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Specific Therapeutic Class**.	Specific Therapeutic Class panel displays.

6.191.6.2 To Add on the Codes-Specific Therapeutic Class Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Drug Therapeutic Class**.	
3	Enter **Description**.	
4	Select **Stage** from drop down list box.	
5	Click **Save**.	Specific Therapeutic Class information is saved.

6.191.6.3 To Update on the Codes-Specific Therapeutic Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Specific Therapeutic Class information is saved.

6.191.6.4 To Delete on the Codes-Specific Therapeutic Class Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.192 CODES-STANDARD THERAPEUTIC CLASS PANEL

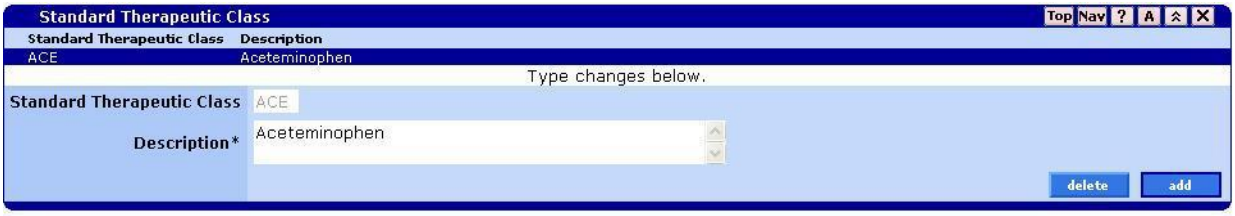
6.192.1 Codes-Standard Therapeutic Class Panel Narrative

The Standard Therapeutic Class panel classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation: [Reference] - [Related Data] - [Codes] - [Standard Therapeutic Class].

6.192.2 Codes-Standard Therapeutic Class Panel Layout



6.192.3 Codes-Standard Therapeutic Class Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Standard Therapeutic Class code.	Button	N/A	0
Delete	Allows a user to delete a Standard Therapeutic Class code.	Button	N/A	0
Description	Provides the text description for a Standard Therapeutic Class code.	Field	Alphanumeric	100
Standard Therapeutic Class	The Standard Therapeutic Class code classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system.	Field	Character	3

6.192.4 Codes-Standard Therapeutic Class Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter Description.
Standard Therapeutic Class	Field	1	Standard Therapeutic Class Code is required.	Enter Standard Therapeutic Class Code.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Enter a unique Standard Therapeutic Class code.

6.192.5 Codes-Standard Therapeutic Class Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.192.6 Codes-Standard Therapeutic Class Panel Accessibility

6.192.6.1 To Access the Codes-Standard Therapeutic Class Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Standard Therapeutic Class**.	Standard Therapeutic Class panel displays.

6.192.6.2 To Add on the Codes-Standard Therapeutic Class Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Standard Therapeutic Class**.	
3	Enter **Description**.	
4	Click **Save**.	Standard Therapeutic Class information is saved.

6.192.6.3 To Update on the Codes-Standard Therapeutic Class Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Standard Therapeutic Class information is saved.

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6.192.6.4 To Delete on the Codes-Standard Therapeutic Class Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.193 CODES-STATE PANEL

6.193.1 Codes-State Panel Narrative

The State panel is used to maintain the standard U.S. Postal Service abbreviations for States and outlying areas of the U.S.

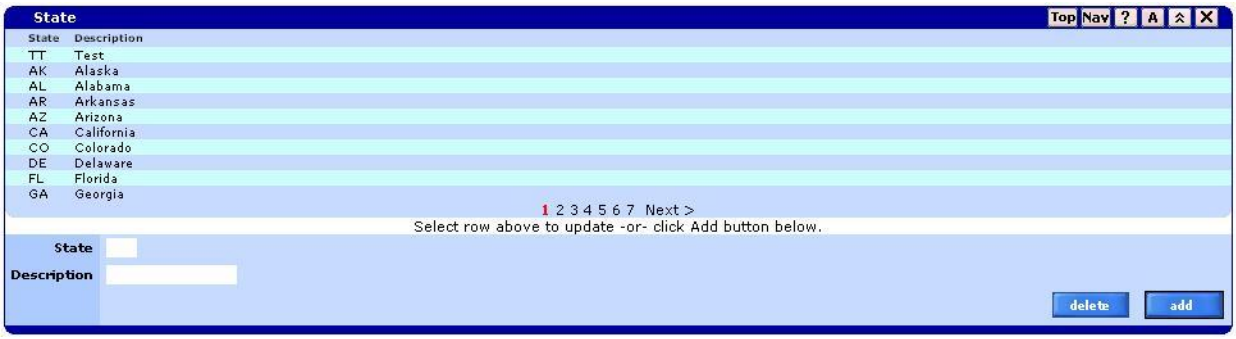
The panel consists of a data list displaying the defined States (for example) and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [State]

6.193.2 Codes-State Panel Layout



6.193.3 Codes-State Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a state code.	Button	N/A	0
Delete	Allows the user to delete a state code.	Button	N/A	0
Description	Name of state or outlying area.	Field	Character	15
State	Two character state/area abbreviation.	Field	Character	2

6.193.4 Codes-State Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter the Description (name) of the state or outlying area.
State	Field	1	State is required.	Enter a State code.
	Field	2	A duplicate record cannot be saved.	Enter a unique State code.
	Field	3	State must be 2 character(s) in length.	Enter a unique 2 character code.

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6.193.5 Codes-State Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.193.6 Codes-State Panel Accessibility

6.193.6.1 To Access the Codes-State Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **State**.	State panel displays.

6.193.6.2 To Add on the Codes-State Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **State**.	
3	Enter **Description**.	
4	Click **Save**.	State information is saved.

6.193.6.3 To Update on the Codes-State Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	State information is saved.

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6.193.6.4 To Delete on the Codes-State Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.194 CODES-TOOTH NUMBER PANEL

6.194.1 Codes-Tooth Number Panel Narrative

The Tooth Number panel is used to maintain the Tooth Number code set.

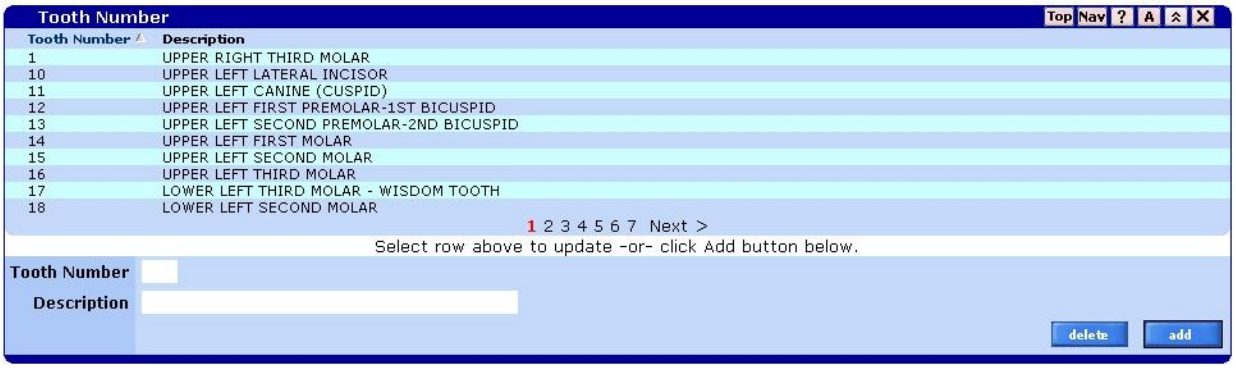
The panel consists of a data list displaying the defined Tooth Numbers and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Tooth Number]

6.194.2 Codes-Tooth Number Panel Layout



6.194.3 Codes-Tooth Number Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a tooth number.	Button	N/A	0
Delete	Allows the user to delete a tooth number.	Button	N/A	0
Description	Text description of the tooth.	Field	Character	40
Tooth Number	Code used to identify a tooth.	Field	Character	2

6.194.4 Codes-Tooth Number Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text Description of the tooth.
Tooth Number	Field	1	Tooth number is required.	Enter a Tooth Number.
	Field	2	A duplicate record cannot be saved.	Enter a unique Tooth Number.

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6.194.5 Codes-Tooth Number Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.194.6 Codes-Tooth Number Panel Accessibility

6.194.6.1 To Access the Codes-Tooth Number Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Tooth Number**.	Tooth Number panel displays.

6.194.6.2 To Add on the Codes-Tooth Number Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Tooth Number**.	
3	Enter **Description**.	
4	Click **Save**.	Tooth Number information is saved.

6.194.6.3 To Update on the Codes-Tooth Number Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tooth Number information is saved.

6.194.6.4 To Delete on the Codes-Tooth Number Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.195 CODES-TOOTH QUADRANT PANEL

6.195.1 Codes-Tooth Quadrant Panel Narrative

The Tooth Quadrant panel is used to maintain the Tooth Quadrant code set.

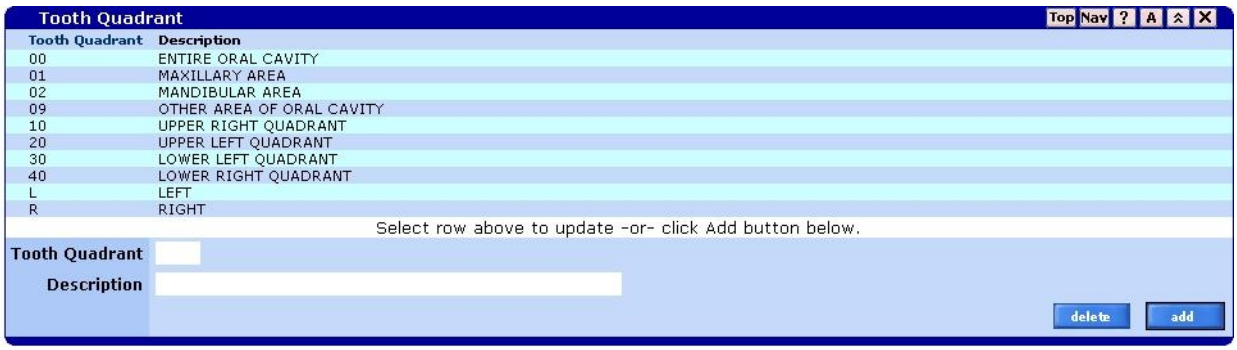
The panel consists of a data list displaying the defined Tooth Quadrants and a sub-panel where updates and adds are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Tooth Quadrant]

6.195.2 Codes-Tooth Quadrant Panel Layout



6.195.3 Codes-Tooth Quadrant Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a tooth quadrant code.	Button	N/A	0
Delete	Delete a tooth quadrant code.	Button	N/A	0
Description	Description of tooth quadrant.	Field	Character	50
Tooth Quadrant	Code identifying the tooth quadrant.	Field	Character	3

6.195.4 Codes-Tooth Quadrant Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the Tooth Quadrant.
Tooth Quadrant	Field	1	Tooth Quadrant is required.	Enter a Tooth Quadrant.
	Field	2	A duplicate record cannot be saved.	Enter a unique Tooth Quadrant.

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6.195.5 Codes-Tooth Quadrant Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.195.6 Codes-Tooth Quadrant Panel Accessibility

6.195.6.1 To Access the Codes-Tooth Quadrant Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Tooth Surface**.	Tooth Quadrant panel displays.

6.195.6.2 To Add on the Codes-Tooth Quadrant Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Tooth Quadrant**.	
3	Enter **Description**.	
4	Click **Save**.	Tooth Quadrant information is saved.

6.195.6.3 To Update on the Codes-Tooth Quadrant Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tooth Quadrant information is saved.

6.195.6.4 To Delete on the Codes-Tooth Quadrant Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.196 CODES-TOOTH SURFACE PANEL

6.196.1 Codes-Tooth Surface Panel Narrative

The Tooth Surface panel is used to maintain the Tooth Surface code set.

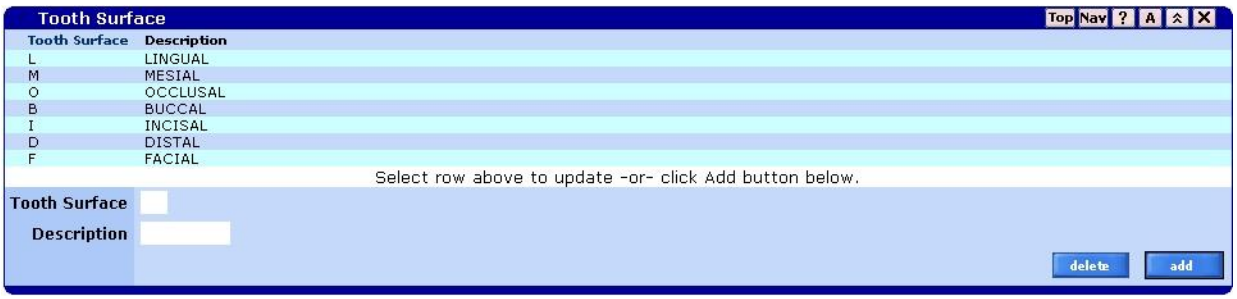
The panel consists of a data list displaying the defined Tooth Surfaces and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Tooth Surface]

6.196.2 Codes-Tooth Surface Panel Layout



6.196.3 Codes-Tooth Surface Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a tooth surface code.	Button	N/A	0
Delete	Allows the user to delete a tooth surface code.	Button	N/A	0
Description	Description of the tooth surface.	Field	Character	8
Tooth Surface	Code used to identify a surface of a tooth.	Field	Character	1

6.196.4 Codes-Tooth Surface Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the Tooth Surface.
Tooth Surface	Field	1	Tooth Surface is required.	Enter a Tooth Surface code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Tooth Surface code

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6.196.5 Codes-Tooth Surface Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.196.6 Codes-Tooth Surface Panel Accessibility

6.196.6.1 To Access the Codes-Tooth Surface Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Tooth Surface**.	Tooth Surface panel displays.

6.196.6.2 To Add on the Codes-Tooth Surface Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Tooth Surface**.	
3	Enter **Description**.	
4	Click **Save**.	Tooth Surface information is saved.

6.196.6.3 To Update on the Codes-Tooth Surface Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tooth Surface information is saved.

6.196.6.4 To Delete on the Codes-Tooth Surface Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.197 CODES-TYPE OF BILL PANEL

6.197.1 Codes-Type of Bill Panel Narrative

The Type of Bill panel is used to maintain National Uniform Billing Committee (NUBC) Type of Bill (TOB). TOB is comprised of Facility Type (first character), Bill Classification (second character), and Frequency (third character).

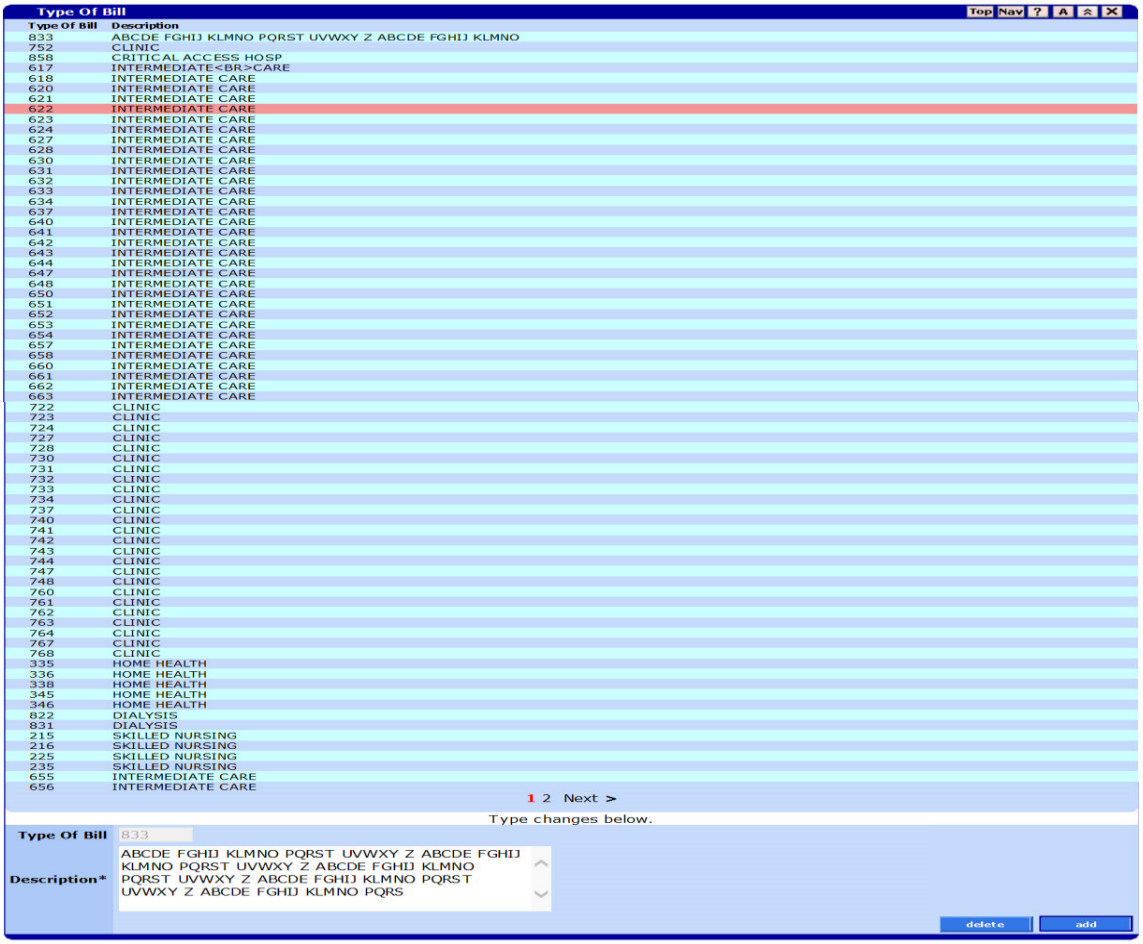
The panel consists of a data list displaying the defined Type of Bills and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [Type of Bill]

6.197.2 Codes-Type of Bill Panel Layout



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6.197.3 Codes-Type of Bill Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a type of bill.	Button	N/A	0
Delete	Allows the user to delete a type of bill.	Button	N/A	0
Description	Describes the specific Type of Bill (TOB).	Field	Character	150
Type of Bill	Code which identifies the Type of Bill (TOB). TOB is comprised of Facility Type (first character), Bill Classification (second character), and Frequency (third character).	Field	Character	3

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6.197.4 Codes-Type of Bill Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the Type of Bill.
Type of Bill	Field	1	Type of bill is required.	Enter a Type of Bill code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Type of Bill code.
	Field	3	Type of Bill must be 3 character(s) in length.	Enter a 3 character Type of Bill code.

6.197.5 Codes-Type of Bill Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.197.6 Codes-Type of Bill Panel Accessibility

6.197.6.1 To Access the Codes-Type of Bill Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Type of Bill**.	Type of Bill panel displays.

6.197.6.2 To Add on the Codes-Type of Bill Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Type of Bill**.	
3	Enter **Description**.	
4	Click **Save**.	Type of Bill information is saved.

6.197.6.3 To Update on the Codes-Type of Bill Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Type of Bill information is saved.

6.197.6.4 To Delete on the Codes-Type of Bill Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.198 CODES-UB92 VALUE PANEL

6.198.1 Codes-UB92 Value Panel Narrative

The UB92 Value panel is used to maintain the National Uniform Billing Committee (NUBC) Value codes. Value codes are used to relate amounts or values to identify data elements necessary to process an Institutional claim, such as accident hour.

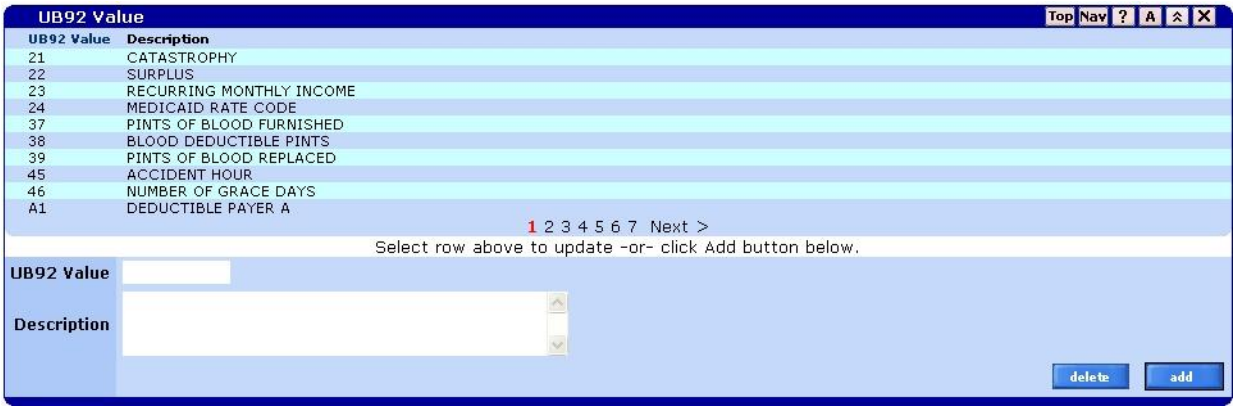
The panel consists of a data list displaying the defined Value Codes and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Codes] - [UB92 Value]

6.198.2 Codes-UB92 Value Panel Layout



6.198.3 Codes-UB92 Value Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a UB92 Value code.	Button	N/A	0
Delete	Allows a user to delete a UB92 Value code.	Button	N/A	0
Description	Description of the code used to relate values to identified data elements necessary to process a UB92 claim.	Field	Character	40
UB92 Value	Code used to relate values to identified data elements necessary to process a UB92 claim.	Field	Character	2

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6.198.4 Codes-UB92 Value Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the UB92 Value.
UB92 Value	Field	1	UB92 Value is required.	Enter a UB92 Value code.
	Field	2	A duplicate record cannot be saved.	Enter a unique UB92 Value code.
	Field	3	UB92 Value must be 2 character(s) in length.	Enter a 2 character UB92 Value code.

6.198.5 Codes-UB92 Value Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.198.6 Codes-UB92 Value Panel Accessibility

6.198.6.1 To Access the Codes-UB92 Value Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **UB92 Value**.	UB92 Value panel displays.

6.198.6.2 To Add on the Codes-UB92 Value Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **UB92 Value**.	
3	Enter **Description**.	
4	Click **Save**.	UB92 Value information is saved.

6.198.6.3 To Update on the Codes-UB92 Value Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	UB92 Value information is saved.

6.198.6.4 To Delete on the Codes-UB92 Value Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.199 CODES-UNIT TYPE PANEL

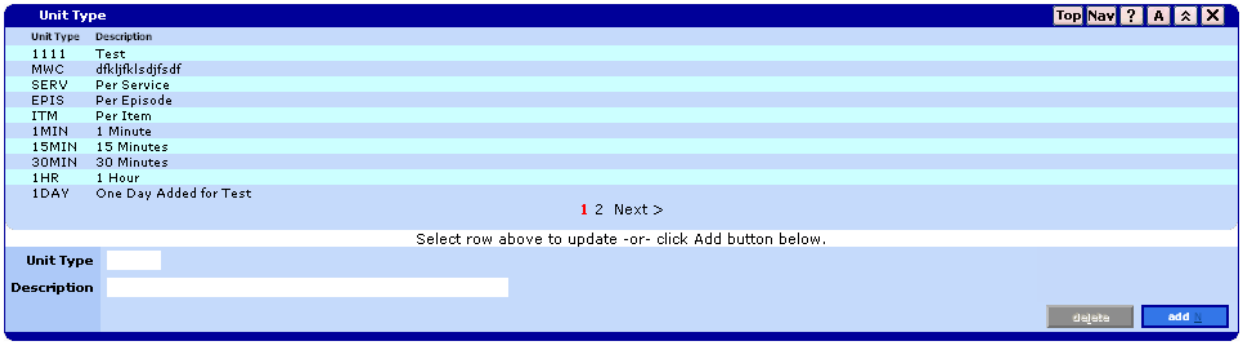
6.199.1 Codes-Unit Type Panel Narrative

The Unit Type panel allows inserts/updates/deletes to the code set Unit Type.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]-[Codes]-[Unit Type].

6.199.2 Codes-Unit Type Panel Layout



6.199.3 Codes-Unit Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This button updates the code set with the values entered in the Unit Type and description fields.	Button	N/A	0
Delete	This button removes the selected values from the code set.	Button	N/A	0
Description	Detailed description of what one unit represents.	Field	Character	100
Unit Type	Code that identifies what one unit represents for the procedure code.	Field	Character	5

6.199.4 Codes-Unit Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of the Unit Type Value.
Unit Type	Field	1	Unit Type is required.	Enter a Unit Type Value code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Unit Type Value code.

6.199.5 Codes-Unit Type Panel Extra Features

Use the Unit Type panel to insert/update/delete the records in the code set UNIT TYPE

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6.199.6 Codes-Unit Type Panel Accessibility

6.199.6.1 To Access the Codes-Unit Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes page displays.
4	Select **Unit Type**.	Unit Type panel displays.

6.199.6.2 To Add on the Codes-Unit Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Unit Type**.	
3	Enter **Description**.	
4	Click **Save**.	Unit Type information is saved.

6.199.6.3 To Update on the Codes-Unit Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Unit Type information is saved.

6.199.6.4 To Delete on the Codes-Unit Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.200 RELATED DATA OTHER PAGE

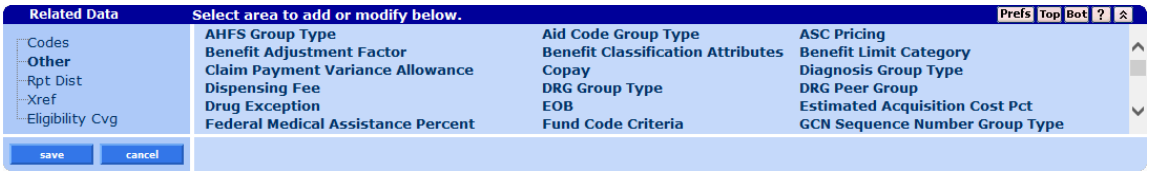
6.200.1 Related Data Other Page Narrative

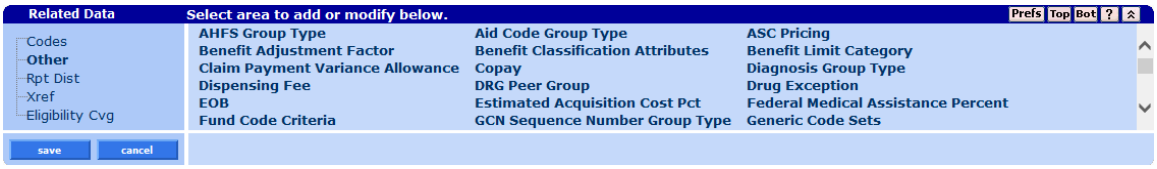
The Reference Related Data Other panel allows the user to access the various group tables maintained within the Reference Data Maintenance subsystem area.

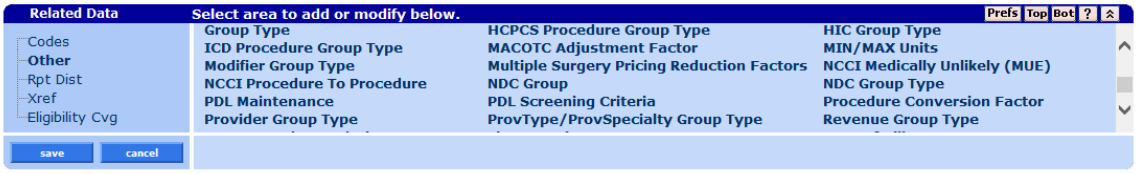
Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other]

6.200.2 Related Data Other Page Layout







6.200.3 Related Data Other Page Field Descriptions

Field	Description	Field Type	Data Type	Length
ASC Pricing	Link to the ASC Pricing panel.	Hyperlink	N/A	0
Benefit Adjustment Factor	Link to the Benefit Adjustment factor panel.	Hyperlink	N/A	0
Benefit Classification Attributes	Link to the Benefit Classification Attributes panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Benefit Limit Category	Link to the Benefit Limit Category	Hyperlink	N/A	0
Cancel	Allows the user to cancel the current action.	Button	N/A	0
Claim Payment Variance Allowance	Link to the Claim Payment Variance Allowance panel.	Hyperlink	N/A	0
Copay	Link to the Copay panel.	Hyperlink	N/A	0
Dispensing Fee	Link to the Dispensing Fee panel.	Hyperlink	N/A	0
DRG Group Type	Link to the DRG Group Type.	Hyperlink	N/A	0
Drug Exception	Link to the Drug Exception panel.	Hyperlink	N/A	0
EOB	Link to the EOB panel.	Hyperlink	N/A	0
Estimated Acquisition Cost Pct	Link to the Estimated Acquisition Cost Percent panel.	Hyperlink	N/A	0
Federal Medical Assistance Percent	Link to the Federal Medical Assistance Percent panel.	Hyperlink	N/A	0
Fund Code Criteria	Link to the Fund Code Criteria panel.	Hyperlink	N/A	0
Generic Code Sets	Link to the Generic Code Sets panel.	Hyperlink	N/A	0
Geographic Practice Cost Idx	Link to the Geographic Practice Cost Index panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
MACOTC Adjustment Factor	Link to the MACOTC Adjustment Factor panel.	Hyperlink	N/A	0
Min/Max Units	Link to the Min/Max Units panel.	Hyperlink	N/A	0
Multiple Surgery Pricing Reduction Factor	Link to the Surgery Pricing Reduction Factor panel.	Hyperlink	N/A	0
NCCI Medically Unlikely (MUE)	Link to the NCCI Medically Unlikely (MUE) panel.	Hyperlink	N/A	0
NCCI Procedure to Procedure	Link to the NCCI Procedure to Procedure panel.	Hyperlink	N/A	0
PDL Maintenance	Link to the PDL Maintenance panel	Hyperlink	N/A	0
PDL Screening Criteria	Link to the PDL Screening Criteria panel.	Hyperlink	N/A	0
Procedure Conversion Factor	Link to the Procedure Conversion Factor panel.	Hyperlink	N/A	0
Save	Allows the user to save a record.	Button	N/A	0
System Code Resolution	Link to the System Code Resolution panel.	Hyperlink	N/A	0
Yearly Medicare Rates	Link to the Yearly Medicare Rates panel.	Hyperlink	N/A	0

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6.200.4 Related Data Other Page Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.200.5 Related Data Other Page Extra Features

Field	Field Type
No extra features found for this page.	

6.200.6 Related Data Other Panel Accessibility

6.200.6.1 To Access the Related Data Other Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.

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6.202 OTHER-ASC PRICING PANEL

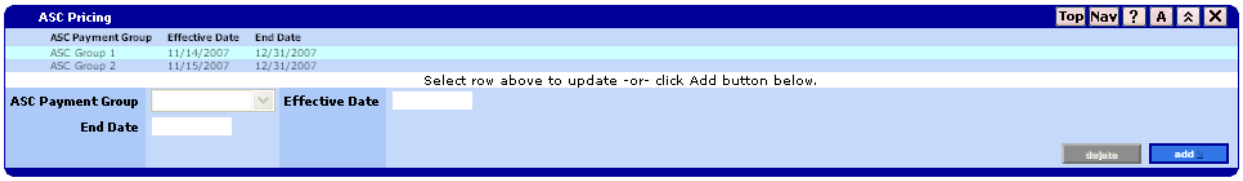
6.202.1 Other-ASC Pricing Panel Narrative

The ASC panel allows users to maintain the reimbursement rates paid to providers for a Ambulatory Surgical Center (ASC) procedure. An Ambulatory Surgical Center (ASC) is a distinct entity that operates exclusively for the purpose to providing surgical services to patients not requiring hospitalization and has an agreement with the Centers for Medicare & Medicaid Services (CMS) to participate in Medicare as an ASC. ASCs must be state licensed and Medicare certified. An ASC may be either independent (i.e., not a part of any other facility) or hospital affiliated. Ambulatory Surgical Center (ASC) facility services are reimbursed based on prospectively determined rates. The rates are based upon the classifications of procedures into different payment groups that are based on surgical procedure complexity. Rates by payment group are established by CMS.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [ASC Pricing]

6.202.2 Other-ASC Pricing Panel Layout



6.202.3 Other-ASC Pricing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add an ASC Pricing segment.	Button	N/A	0
ASC Payment Group	Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.	Combo Box	Drop Down List Box	0
Delete	Delete an ASC Pricing segment.	Button	N/A	0
Effective Date	The date an Ambulatory Surgical Center rate becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date an Ambulatory Surgical Center rate is no longer in effect for claims processing.	Field	Date (MM/DD/CCYY)	8

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6.202.4 Other-ASC Pricing Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
ASC Payment Group	Field	1	ASC Payment Group is required.	Select an ASC Payment Group.
Effective Date	Field	1	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	4	Effective Date is required.	Enter a valid effective date.
End Date	Field	1	End date must be greater than or equal to effective date.	Enter a End Date that is greater than or equal to the Effective Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is post 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

6.202.5 Other-ASC Pricing Panel Extra Features

Panel does not allow overlaps for the same ASC Group, Rate Type, and effective/end dates. The same ASC Group can have overlapping date segments as long as the Rate Type is different.

6.202.6 Other-ASC Pricing Panel Accessibility

6.202.6.1 To Access the Other-ASC Pricing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **ASC Pricing**.	ASC Pricing panel displays.

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6.202.6.2 To Add on the Other-ASC Pricing Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **ASC Payment Group** from the drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	ASC Pricing information is saved.

6.202.6.3 To Update on the Other-ASC Pricing Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	ASC Pricing information is saved.

6.202.6.4 To Delete on the Other-ASC Pricing Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.203 OTHER-BENEFIT ADJUSTMENT FACTOR PANEL

6.203.1 Other-Benefit Adjustment Factor Panel Narrative

The Benefit Adjustment Factor (BAF) panel is used to maintain valid types of AMMIS Benefit Adjustment Factors.

BAFs provide the ability to alter a service/product rate by a fixed dollar amount, percentage and/or a series of percentages to increase or decrease the allowed amount. This type of adjustment works in conjunction with a pricing methodology and allows the flexibility to alter a rate utilizing different criteria without having to create new rates.

The panel consists of a data list displaying the defined Benefit Adjustment Factor types and a sub-panel where updates and adds are performed.

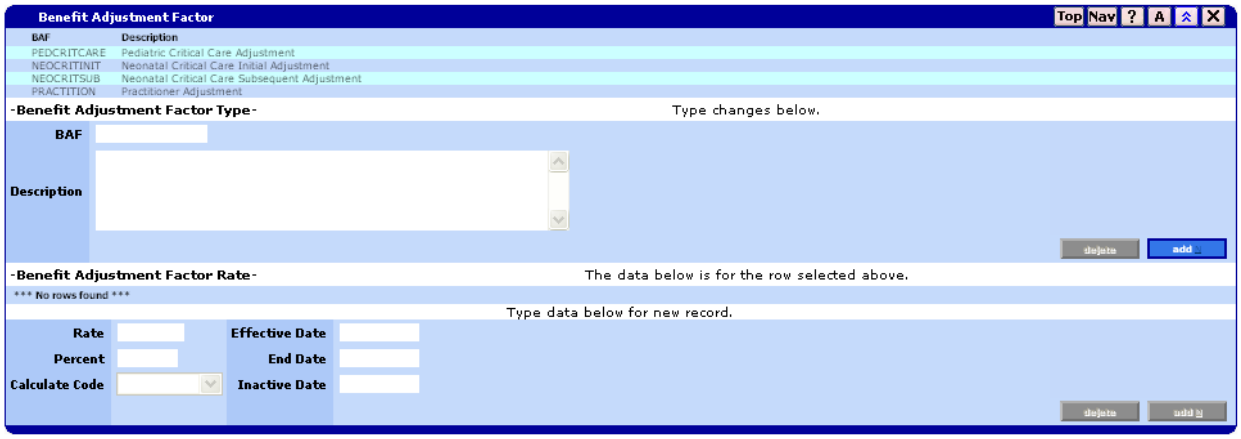
Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Benefit Adjustment Factor rates are associated to a type via the Benefit Adjustment Factor Rate child panel shown in the image below. Refer to the panel documentation for 'Benefit Adjustment Factor-Benefit Adjustment Factor Rate' for further details.

Only authorized users with update privileges have the capability to add new information or modify existing data.

[Reference] – [Related Data] - [Other] - [Benefit Adjustment Factor]

6.203.2 Other-Benefit Adjustment Factor Panel Layout



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6.203.3 Other-Benefit Adjustment Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Benefit Adjustment Factor type.	Button	N/A	0
BAF	Code that uniquely identifies the Benefit Adjustment Factor (BAF) type.	Field	Character	11
Calculate Code	Code identifying whether the BAF is applied before or after the pricing comparison step of billed vs. allowed amount. I.E. If the flag is set to After, the BAF is applied after the allowed amount is set to the lesser of the billed or allowed. Does not apply for reimbursement rules that permit payment greater than billed.	Combo Box	Drop Down List Box	0
delete	Allows the user to delete a Benefit Adjustment Factor type.	Button	N/A	0
Description	Text describing the purpose/use of the Benefit Adjustment Factor type.	Field	Character	250
Effective Date	First date of service the benefit adjustment factor is valid.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the benefit adjustment factor is valid.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Date/Time the BAF can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future inactive date restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Percent	Percentage to adjust an allowed amount using the pricing methodologies that apply to the claim/detail. Stored format is 99.999.	Field	Number (Decimal)	5
Rate	Dollar amount to adjust an allowed amount using the pricing methodology that apply to the claim/detail. Stored format is 9999.99.	Field	Number (Decimal)	6

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6.203.4 Other-Benefit Adjustment Factor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
BAF	Field	1	BAF is required.	Enter a Benefit Adjustment Factor code.
Description	Field	1	Description is required.	Enter a text description of the Benefit Adjustment Factor code.

6.203.5 Other-Benefit Adjustment Factor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.203.6 Other-Benefit Adjustment Factor Panel Accessibility

6.203.6.1 To Access the Other- Benefit Adjustment Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Benefit Adjustment Factor**.	Benefit Adjustment Factor panel displays.

6.203.6.2 To Add on the Other- Benefit Adjustment Factor Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **BAF**.	
3	Enter **Description**.	
4	Click **Save**.	Benefit Adjustment Factor information is saved.

6.203.6.3 To Update on the Other- Benefit Adjustment Factor Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Adjustment Factor information is saved.

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6.203.6.4 To Delete on the Other- Benefit Adjustment Factor Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.203.6.5 To Add on the Other- Benefit Adjustment Factor Rate Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Rate**.	
3	Enter **Percent**.	
4	Select **Calculate Code** from drop down list box.	
5	Enter **Effective Date**.	
6	Enter **End Date**.	
7	Enter **Inactive Date**.	
8	Click **Save**.	Benefit Adjustment Factor Rate information is saved.

6.203.6.6 To Update on the Other- Benefit Adjustment Factor Rate Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Adjustment Factor Rate information is saved.

6.203.6.7 To Delete on the Other- Benefit Adjustment Factor Rate Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.204 OTHER-BENEFIT CLASSIFICATION ATTRIBUTES PANEL

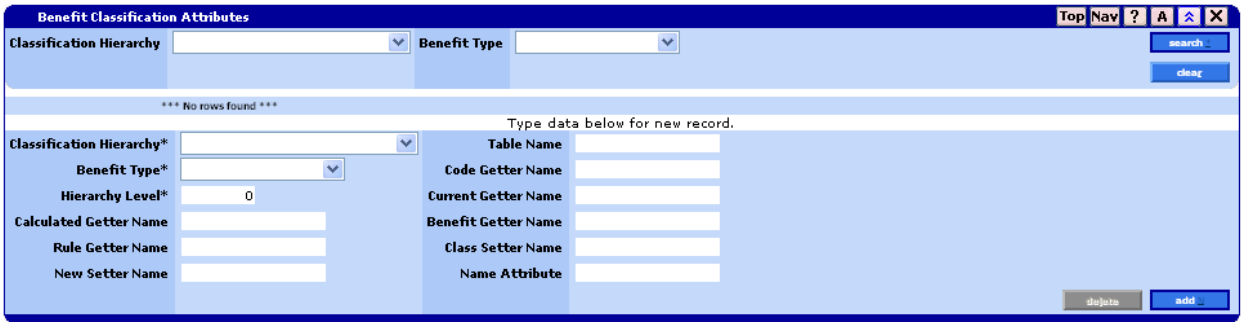
6.204.1 Other- Benefit Classification Attributes Panel Narrative

The Benefit Classification Attributes panel is needed to maintain table used by the drug classification engine. It is required for automatic classification of drugs.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path:[Reference[- [Related Data] - [Other] - [Benefit Classification] - [Attributes]

6.204.2 Other- Benefit Classification Attributes Panel Layout



6.204.3 Other- Benefit Classification Attributes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a Benefit Classification Attribute.	Button	N/A	0
Benefit Getter Name	Name of routine which determines if a detail (benefit or service) exists for the parent code being classified.	Field	Character	15
Benefit Type	The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD procedures, ICD diagnosis, Revenue Code and Drug codes (NDCs).	Combo Box	Drop Down List Box	0
Calculated Getter Name	Name of routine which retrieves the calculated or expected parent for the applicable node code.	Field	Character	15
Class Setter Name	Name of routine which updates the code descriptions.	Field	Character	15
Classification Hierarchy	It's a Unique row identifier for this table. It defines the classification Hierarchy.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Clear	It clears the criteria fields so user may enter new criteria.	Button	N/A	0
Code Getter Name	Name of routine which retrieves the codes from the node being processed.	Field	Character	15
Current Getter Name	Name of routine which retrieves the current parent for the applicable node code.	Field	Character	15
Delete	Allows user to delete a Benefit Classification Attribute.	Button	N/A	0
Hierarchy Level	Level of the node within the Classification hierarchy.	Field	Number (Decimal)	9
Name Attribute	Name of the node level.	Field	Character	15
New Setter Name	Name of routine which inserts a new row into the Classification tables.	Field	Character	15
Rule Getter Name	Name of routine which determines if a rule exists for codes belonging to the same parent as the code being classified.	Field	Character	15
Search	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Table Name	Source table for the node.	Field	Character	35

6.204.4 Other- Benefit Classification Attributes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Type	Field	1	A valid Benefit Type Hierarchy is required.	Select a value from the drop down list.
	Field	2	A valid Classification Hierarchy is required.	Select a value from the drop down list.
	Field	3	A valid Hierarchy Level Hierarchy is required.	Select a value from the drop down list.

6.204.5 Other- Benefit Classification Attributes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.204.6 Other- Benefit Classification Attributes Panel Accessibility

6.204.6.1 To Access the Other- Benefit Classification Attributes Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Benefit Classification Attributes**.	Benefit Classification Attributes panel displays.

6.204.6.2 To Add on the Other- Benefit Classification Attributes Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Classification Hierarchy** from drop down list box.	
3	Select **Benefit Type** from drop down list box.	
4	Enter **Calculated Getter Name**.	
5	Enter **Rule Getter Name**.	
6	Enter **New Setter Name**.	
7	Enter **Table Name**.	
8	Enter **Code Getter Name**.	
9	Enter **Current Getter Name**.	
10	Enter **Benefit Getter Name.**	
11	Enter **Class Setter Name**.	
12	Enter **Name Attribute**.	
13	Click **Save**.	Benefit Classification Attributes information is saved.

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6.204.6.3 To Update on the Other- Benefit Classification Attributes Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Classification Attributes information is saved.

6.204.6.4 To Delete on the Other- Benefit Classification Attributes Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.204.7 Other - Benefit Limit Category

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6.205 OTHER-CLAIM PAYMENT VARIANCE ALLOWANCE PANEL

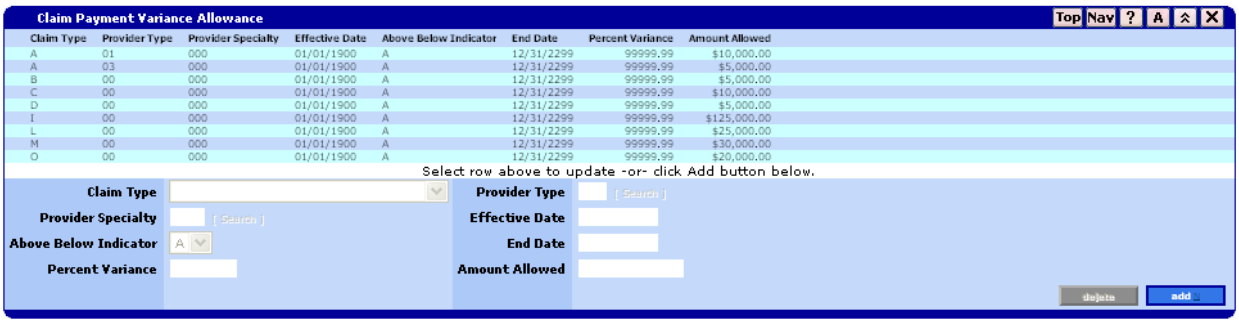
6.205.1 Other-Claim Payment Variance Allowance Panel Narrative

Provides the capability to determine if the difference between the submitted charge on the claim and the computed payment for the claim is greater than system set percentages. This panel contains the maximum values for header paid amount for each claim type/provider type/specialty. Values are used for all claim types except pharmacy.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference - Related Data] - [Other] - [Claim Payment Variance Allowance

6.205.2 Other-Claim Payment Variance Allowance Panel Layout



6.205.3 Other-Claim Payment Variance Allowance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add Claim Payment Variance Allowance.	Button	N/A	0
Above Below Indicator	Ratio indicator to specify if the percentage variance is for 'Billed to Allowed' ratio or 'Allowed to Billed' ratio. Valid values are A - Allowed to Billed rate ratio and B - Billed to Allowed rate.	Combo Box	Drop Down List Box	0
Amount Allowed	This is the Maximum or Minimum allowed amount (depending on the IND_ABOVE_BELOW) that is to be compared against the non-PH Claims Paid Amount.	Field	Number	9
Claim Type	Value for the type of claim that can be processed in the MMIS system.	Combo Box	Drop Down List Box	0
Delete	Allows user to delete Claim Payment Variance Allowance.	Button	N/A	0
Effective Date	Effective Date of percent variance record.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	End date of percent variance record.	Field	Date (MM/DD/CCYY)	8
Percent Variance	Percentage variance used in comparing if billed amount differs excessively from allowed amount.	Field	Number (Decimal)	7
Provider Specialty	A code representing the specialized area of practice for a provider.	Field	Character	3
Provider Type	Type that a provider is licensed for.	Field	Character	2

6.205.4 Other-Claim Payment Variance Allowance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required.	Select a Claim Type from the list.
Effective Date	Field	1	Effective Date is required.	Effective Date field required when adding or modifying Claim payment variance allowance.
	Field	2	Effective Date[Date] must be less than or equal to End Date[Date].	Effective Date must be less than or Equal to End Date.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	End Date field required when adding or modifying Claim payment variance allowance.
	Field	2	Effective Date[Date] must be less than or equal to End Date[Date].	Effective Date must be less than or Equal to End Date
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
Provider Specialty	Field	1	A valid Provider Specialty is required.	Enter valid Provider Specialty.
Provider Type	Field	1	A valid Provider Type is required.	Enter valid Provider Type.

6.205.5 Other-Claim Payment Variance Allowance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.205.6 Other-Claim Payment Variance Allowance Panel Accessibility

6.205.6.1 To Access the Other-Claim Payment Variance Allowance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Claim Payment Variance Allowance**.	Claim Payment Variance Allowance panel displays.

6.205.6.2 To Add on the Other-Claim Payment Variance Allowance Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Claim Type** from drop down list box.	
3	Enter **Provider Specialty**.	
4	Select **Above Below Indicator** from drop down list box.	
5	Enter **Percent Variance**.	
6	Enter **Provider Type**.	
7	Enter **Effective Date**.	
8	Enter **End Date.**	

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Step	Action	Response
9	Click **Save**.	Claim Payment Variance Allowance information is saved.

6.205.6.3 To Update on the Other Claim Payment Variance Allowance Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Claim Payment Variance Allowance information is saved.

6.205.6.4 To Delete on the Other-Claim Payment Variance Allowance Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.206 OTHER-COPAY PANEL

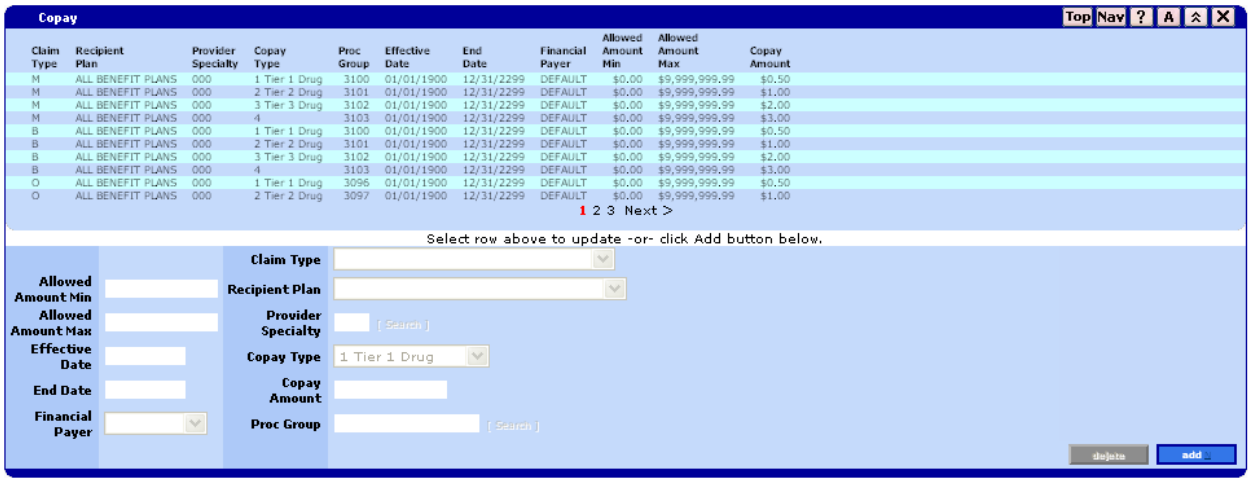
6.206.1 Other-Copay Panel Narrative

The Copay panel displays the data used to subtract the copay amount from the allowed amount for some claim types. Transportation, outpatient, and pharmacy claims will use the minimum and maximum allowed fields.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Other] - [Copay]

6.206.2 Other-Copay Panel Layout



6.206.3 Other-Copay Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Copay.	Button	N/A	0
Allowed Amount Max	This field represents the maximum allowed amount for a copay segment. It is used in transportation pricing.	Field	Number (Decimal)	11
Allowed Amount Min	This field is the minimum allowed amount. It is compared against the pricing allowed amount. If the pricing allowed amount is greater than the minimum and less than the maximum, then the copay amount is used.	Field	Number (Decimal)	11

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Field	Description	Field Type	Data Type	Length
Claim Type	Value for the type of claim that can be processed in the MMIS system.	Combo Box	Drop Down List Box	0
Copay Amount	This is the amount of copay that will be subtracted from the allowed amount. Format is 999.99.	Field	Number (Decimal)	7
Copay Type	Code identifying the type of copay. The copay type is used along with the claim type to identify the copay amount to pay on a claim.	Combo Box	Drop Down List Box	0
Delete	Allows a user to delete a Copay.	Button	N/A	0
Effective Date	This is the begin date for the copay segment.	Field	Date (MM/DD/CCYY)	8
End Date	This is the End Date for the copay segment.	Field	Date (MM/DD/CCYY)	8
Financial Payer	The code that identifies a unique payer within AMMIS.	Combo Box	Drop Down List Box	0
Proc Group [Search]	Unique system assigned key for the Procedure Group that represents a collection of Procedures. This must be a valid Procedure Group number that already exists in the database.	Hyperlink	N//A	0
Provider Specialty [Search]	A code representing the specialized area of practice for a provider.	Hyperlink	N/A	0
Recipient Plan	Identifies the medical assistance program that is supported in the system.	Combo Box	Drop Down List Box	0

6.206.4 Other-Copay Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Allowed Amount Max	Field	1	Allowed Amount Max must be greater than or equal to 1.	Enter a Max Allowed Amount that is greater than or equal to 1.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Allowed Amount Max must be less than or equal to 9999999.99.	Enter a valid amount.
	Field	4	Allowed Amount Max is Required.	Enter an Allowed Amount Max that has a value.
Allowed Amount Min	Field	1	Allowed Amount Min must be less than or equal to Allowed Amount Max.	Enter an Allowed Amount Min that is less than or equal to Allowed Amount Max .
	Field	2	Allowed Amount Min is required.	Enter a valid number.
	Field	4	Allowed Amount Min must be less than or equal to 9999999.99.	Enter a value that is less than or equal to 9999999.99.
	Field	5	Allowed Amount Min must be greater than or equal to 0.	Enter an Allowed Amount Min that is greater than or equal to 0.
Claim Type	Field	1	A valid Claim Type is required.	Select a valid clam type from the claim type drop down listing.
	Field	2	A duplicate record cannot be saved.	Enter at least one field must be unique.
Copay Amount	Field	1	Enter a valid value.	Enter a valid number.
	Field	2	Copay amount cannot be greater than 999.99.	Enter a number that is less than or equal to 999.99.
	Field	3	Copay Amount must be greater than or equal to 0.	Enter a Copay Amount that is greater than or equal to 0.
	Field	4	If COPAY was updated, please evaluate the Service Coverage Panel for possible updates.	If COPAY was updated, please evaluate the Service Coverage Panel for possible updates.
Copay Type	Field	1	Copay Type is required.	Select a valid Copay type from the copay type drop down listing.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date field when adding or modifying Copay Type.
	Field	2	Effective date must be on or before end date.	Enter an Effective Date that is less than or Equal to End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required	Enter an End Date when adding or modifying Copay Type.
	Field	3	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater or equal to 01/01/1900.
	Field	5	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a valid financial payer from the financial payer drop down listing.
Proc Group	Hyperlink	1	Must enter a valid, existing procedure group number.	Select a valid procedure group number.
Recipient Plan	Field	1	A valid Recipient Plan is required.	Select a valid Recipient Plan from the drop down listing.
Provider Specialty	Hyperlink	1	A valid Provider Specialty is required.	Select a provider specialty.

6.206.5 Other-Copay Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.206.6 Other-Copay Panel Accessibility

6.206.6.1 To Access the Other-Copay Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-page displays.
4	Select **Copay**.	Copay panel displays.

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6.206.6.2 To Add on the Other-Copay Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Allowed Amount Min**.	
3	Enter **Allowed Amount Max**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Select **Financial Payer** from drop down list box.	
7	Select **Claim Type** from drop down list box.	
8	Select **Recipient Plan** from drop down list box.	
9	Enter **Provider Specialty**. Click [Search] if unknown.	
10	Select **Copay Type** from drop down list box.	
11	Enter **Copay Amount**.	
12	Enter **Proc Group**. Click [Search] if unknown.	
13	Click **Save**.	Copay information is saved.

6.206.6.3 To Update on the Other-Copay Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Copay information is saved.

6.206.6.4 To Delete on the Other-Copay Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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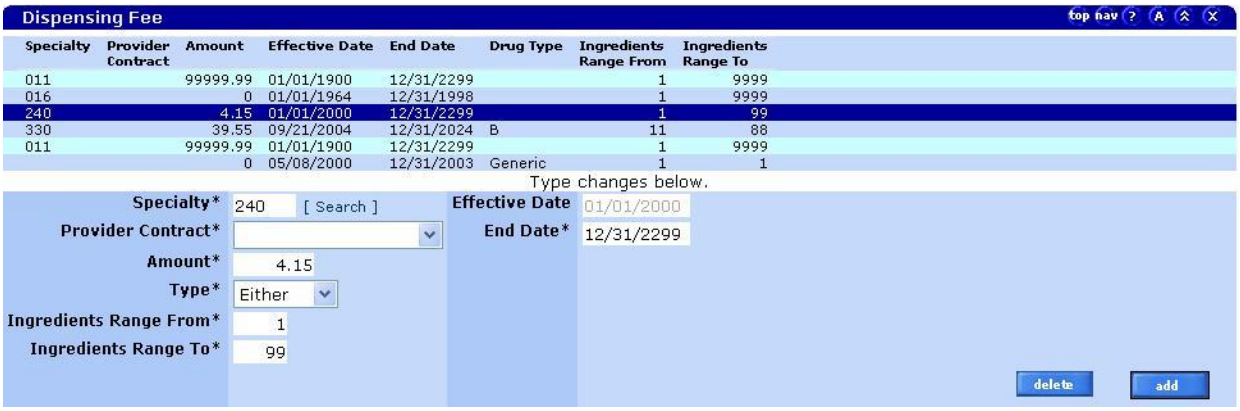
6.207 OTHER-DISPENSING FEE PANEL

6.207.1 Other-Dispensing Fee Panel Narrative

The Dispensing Fee panel is used to maintain the fee that the provider receives for dispensing a prescription legend drug when the provider has the given specialty and is certified under the given contract. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Related Data (Panel) - [Other] - [Dispensing Fee]

6.207.2 Other-Dispensing Fee Panel Layout



6.207.3 Other-Dispensing Fee Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Dispensing Fee.	Button	N/A	0
Amount	Amount that the provider receives for dispensing a prescription drug. Format is 99999.99.	Field	Number (Decimal)	7
Delete	Allows the user to delete a Dispensing Fee.	Button	N/A	0
Effective Date	Date that the Dispensing Fee for the provider specialty is in effect.	Field	Date (MM/DD/CCYY)	8
End Date	Date that the Dispensing Fee for the provider specialty is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Ingredients Range From	Number of ingredients from range (1-9999) to allow for compounds to pay varying amounts based on the number of unique ingredients in the compound.	Field	Number (Integer)	4

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Field	Description	Field Type	Data Type	Length
Ingredients Range To	Number of ingredients from range (1-9999) to allow for compounds to pay varying amounts based on the number of unique ingredients in the compound.	Field	Number (Integer)	4
Provider Contract	Description of the program the provider is enrolled in.	Combo Box	Drop Down List Box	0
Specialty	Specialty Code of the provider.	Field	Character	3
Type	Indicates Generic/Brand/Either for a provider.	Combo Box	Drop Down List Box	0

6.207.4 Other-Dispensing Fee Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Amount	Field	1	Enter a valid value.	Enter a numeric value.
	Field	2	Amount is required.	Enter a value for Amount.
Effective Date	Field	0	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to End Date.
	Field	1	Invalid date.	Enter a valid date in MM/DD/CCYY format.
	Field	2	Effective Date is required.	Enter a value for Effective Date.
End Date	Field	1	Invalid date.	Enter a valid date.
Ingredients Range From	Field	0	Ingredients Range From must be less than Ingredients Range To.	Enter an Ingredients Range From that is less than Ingredients Range To.
	Field	1	Ingredient Range From must be greater than or equal to 1.	Enter an Ingredients Range From field when adding or modifying Dispensing Fee.
	Field	2	Enter a valid value.	Enter a numeric value.
	Field	3	Ingredient Range From is required.	Enter an Ingredient Range From value.
Ingredients Range To	Field	1	Ingredient Range To must be greater than or equal to 1.	Enter an Ingredients Range To that is greater than or equal to 1.
	Field	2	Enter a valid value.	Enter a numeric value.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Ingredient Range To is required.	Enter an Ingredient Range To.
Provider Contract	Field	1	A valid Provider Contract is required.	Enter a Provider Contract field required when adding or modifying Dispensing Fee.
Specialty	Field	1	A valid Specialty is required.	Select a Specialty.

6.207.5 Other-Dispensing Fee Panel Extra Features

Field	Field Type
No extra features found for this page/panel.	

6.207.6 Other-Dispensing Fee Panel Accessibility

6.207.6.1 To Access the Other-Dispensing Fee Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select **Dispensing Fee**.	Dispensing Fee panel displays.

6.207.6.2 To Add on the Other-Dispensing Fee Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Specialty** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Specialty information is populated on panel.
4	Select **Provider Contract** from drop down list box.	
5	Enter **Amount**.	
6	Select **Type** from drop down list box.	
7	Enter **Ingredients Range From**.	

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Step	Action	Response
8	Enter **Ingredients Range To**.	
9	Enter **Effective Date** in MM/DD/CCYY format.	
10	Enter **End Date** in MM/DD/CCYY format.	
11	Click **Save**.	Dispensing Fee information is saved.

6.207.6.3 To Update on the Other-Dispensing Fee Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Dispensing Fee information is saved.

6.207.6.4 To Delete on the Other-Dispensing Fee Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.208 OTHER-DRG GROUP TYPE PANEL

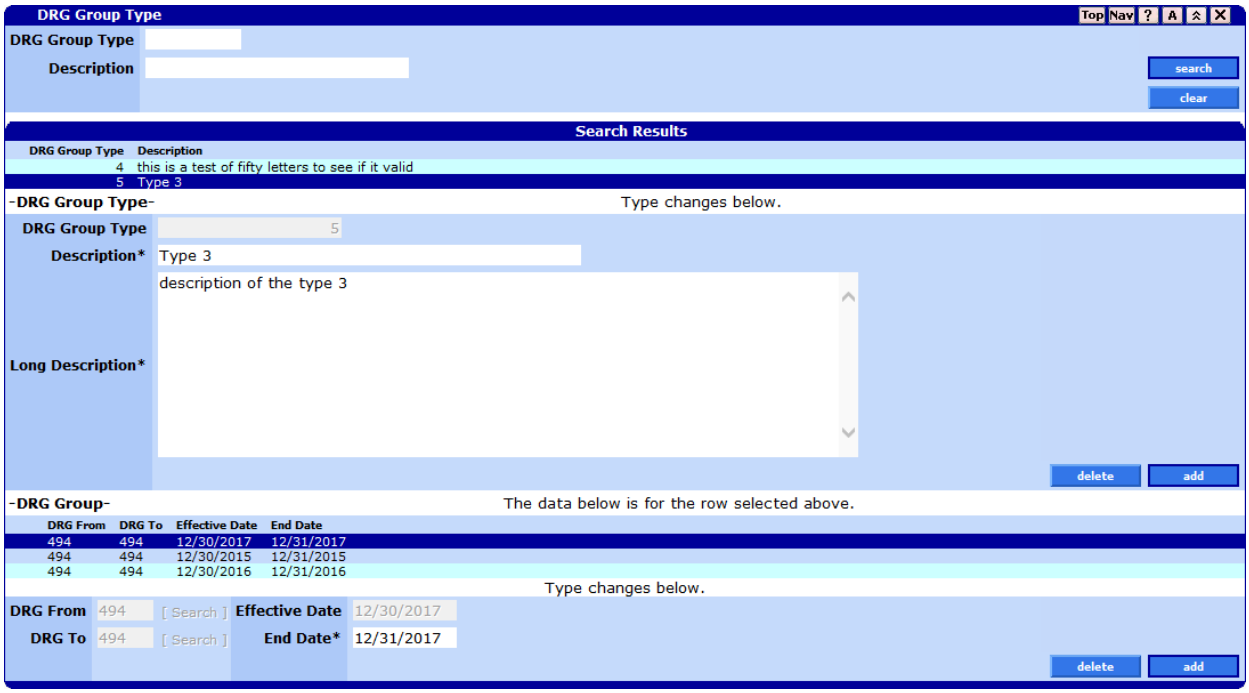
6.208.1 Other-DRG Group Type Panel Narrative

A DRG type is associated with a group of DRG codes. Used to identify DRG codes for use in certain processing methodologies.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data - Other] - [DRG Group Type]

6.208.2 Other-DRG Group Type Panel Layout



6.208.3 Other-DRG Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a DRG Group Type.	Button	N/A	0
DRG From	System assigned key for a unique DRG.	Field	Number (Integer)	9
DRG To	System assigned key for a unique DRG.	Field	Number (Integer)	9
DRG Group Type	System assigned key for a unique DRG group that represents a single or collection of DRG Group.	Field	Number (Integer)	9
Delete	Allows the user to delete a DRG Group Type.	Button	N/A	0
Description	Abbreviated definition describing DRG Group Type definition.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Description Definition	Definition of where and/or how this DRG Group Type is used.	Field	Character	4000
Effective Date	Date of service on which the DRG Group becomes valid for the DRG Group Type.	Field	Character	8
End Date	Date of service on which the DRG Group is no longer valid for the DRG Group Type.	Field	Character	8
Long Description	Group purpose. Definition of where and/or how this DRG Group is used.	Field	Character	0
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0

6.208.4 Other-DRG Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
DRG From	Field	1	A valid DRG Code Range From is required.	A valid DRG Code Range From is required.
DRG To	Field	1	A valid DRG Code Range To is required.	A valid DRG Code Range To is required.
	Field	2	DRG Code Range From cannot be greater than DRG Code Range To.	DRG Code Range From cannot be greater than DRG Code Range To.
Description	Field	1	Description is required.	Description is required.
Effective Date	Field	1	Invalid date. Format is mm/dd/yyyy.	Invalid date. Format is mm/dd/yyyy.
	Field	2	Effective Date must be greater than or equal to 1/1/1900.	Effective Date must be greater than or equal to 1/1/1900.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Effective Date must be less than or equal to 12/31/2299.
	Field	4	Effective Date is required.	Effective Date is required.
Date	Field	1	Effective date must be less than or equal to End Date.	Effective date must be less than or equal to End Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Verify keying. The date must be in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	End Date must be greater than or equal to 1/1/1900.	Enter an End Date that is post 1/1/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	5	End Date is required.	End Date is required.
Long Description	Field	1	Long Description is required.	Long Description is required.

6.208.5 Other-DRG Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.208.6 Other-DRG Group Type Panel Accessibility

6.208.6.1 To Access the Other-DRG Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **DRG Group Type**.	DRG Group Type panel displays.

6.208.6.2 To Add on the Other-DRG Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Description Definition**.	
4	Click **Save**.	DRG Group Type information is saved.

6.208.6.3 To Update on the Other- DRG Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	DRG Group Type information is saved.

6.208.6.4 To Delete on the Other-DRG Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.208.6.5 To Add on the Other-DRG Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **DRG From** or Click [Search] link to locate by DRG Code or DRG Description.	
3	Enter **DRG To** or Click [Search] link to locate by DRG Code or DRG Description.	
4	Enter **Effective Date** in MM/DD/CCYY format. Note: Defaults to current date.	
5	Enter **End Date** in MM/DD/CCYY format. Note: Defaults to 12/31/2299.	
6	Click **Save**.	DRG Group information is saved.

6.208.6.6 To Update on the Other-DRG Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	DRG Group information is saved.

6.208.6.7 To Delete on the Other-DRG Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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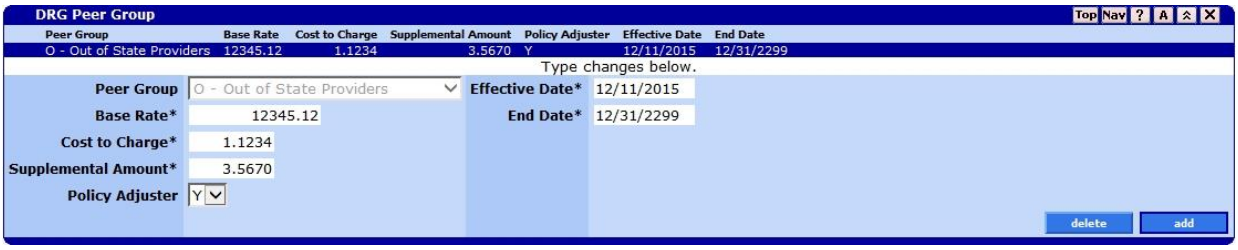
6.209 OTHER- DRG PEER GROUP PANEL

6.209.1 Other- DRG Peer Group Panel Narrative

This panel is used to update, delete and add rates for the DRG Peer Groups. .

Navigation Path: [Reference] – [Related Data] – [Other] – [DRG Peer Group]

6.209.2 Other- DRG Peer Group Panel Layout



6.209.3 Other- DRG Peer Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This button allows a user to add an entry to the DRG -Peer Group panel.	Button	N/A	0
Base Rate	This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the peer group specific calculation.	Field	Number (Decimal)	10
Cost to Charge	This is a date sensitive pricing factor represents a percentage, and is one of the primary components for the DRG calculation. This cost to charge is used for the peer group specific calculation.	Field	Number (Decimal)	5
Delete	This button allows a user to delete an entry from the DRG -Peer Group panel.	Button	N/A	0
Effective Date	The date the Peer Group DRG Rate took effect.	Field	Date (MM/DD/CCYY)	8
End Date	The date the Peer Group DRG Rate is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Peer Group	This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.	Combo Box	Drop Down List Box	1
Policy Adjuster	This one byte field represents that the current Peer group is either Vaild (Y)	Combo Box	Drop Down List Box	1

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Field	Description	Field Type	Data Type	Length
	or Invalid (N) for DRG Policy Adjusters.			
Supplemental Amount	Percentage amount of what Alabama Medicaid would pay for a supplemental payment to out of state provider.	Field	Number (Decimal)	5

6.209.4 Other- DRG Peer Group Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Base Rate	Field	1	Base Rate is required.	Enter a Base Rate.
	Field	2	Base Rate must be less than or equal to 99999999.99.	Enter a valid Base Rate.
Cost to Charge	Field	1	Cost to Charge is required.	Enter a Cost to Charge.
	Field	2	Cost to Charge must be less than or equal to 9.9999.	Enter a valid Cost to Charge.
Effective Date	Field	1	Invalid date. Format is mm/dd/yyyy.	Verify keying. The date must be in MM/DD/CCYY format
		2	Effective Date must be greater than or equal to 1/1/1900.	Enter an Effective Date that is greater than or equal to 1/1/1900.
		3	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
		4	Effective Date is required.	Enter an Effective Date.
End Date	Field	1	Effective date must be less than or equal to End Date.	Enter a date greater than or equal to the Effective Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is after or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is before or equal to 12/31/2299.
	Field	5	End Date is required	Enter a valid end date.
Peer Group	Field	1	A valid Peer Group is required	Enter a Peer Group.
Supplemental Amount	Field	1	Supplemental Amount is required.	Enter a Supplemental Amount.
	Field	2	Supplemental Amount must be less than or equal to 9.9999.	Enter a valid Supplemental Amount.

6.209.5 Other- DRG Peer Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.209.6 Other- DRG Peer Group Panel Accessibility

6.209.6.1 To Access the Other- DRG Peer Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select **DRG Peer Group.**	DRG Peer Group panel displays.

6.209.6.2 To Add on the Other DRG Peer Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Peer Group** by clicking on the drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	

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Step	Action	Response
5	Enter **Base Rate**.	
6	Enter **Cost to Charge**.	
7	Enter **Supplemental Amount**.	
8	Select **Policy Adjuster from drop down list box**.	
12	Click **Save**.	DRG Peer Group information is saved.

6.209.6.3 To Update on the Other- DRG Peer Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	DRG –Peer Group information is saved.

6.209.6.4 To Delete on the Other- DRG Peer Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.210 OTHER-DRUG EXCEPTION PANEL

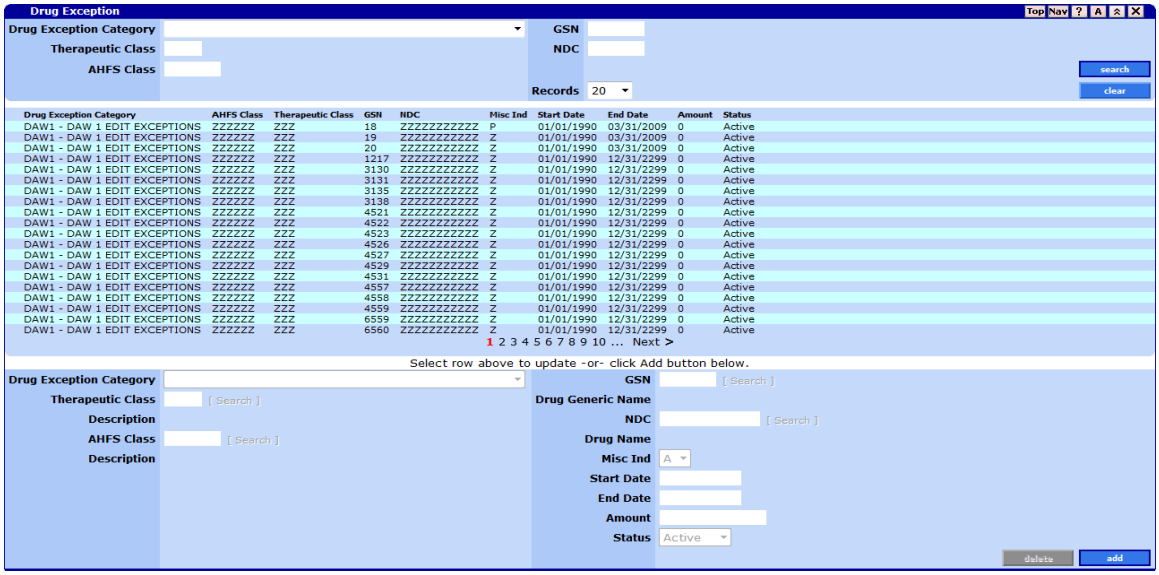
6.210.1 Other-Drug Exception Panel Narrative

The Drug Exception panel allows users to edit those Pharmacy Claims where there is no Emergency PA Number associated to them or it has not yet been determined that a PA is required. The editing required determines if the PH Claims Adjudicated Paid Amount is less than or greater than specified amounts for specific drug categories. Reasons for this panel include the necessity to specify exact combinations of drug categories or default values and not just Claim or Provider Type. If a match is found on this panel for the Pharmacy Claim and its drug categories (or their default values) and the row is ACTIVE editing is performed to compare the PH Claims Adjudicated Paid Amount against the high or low amount. If a match is found and the row is INACTIVE the editing is bypassed.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] - [Other] - [Drug Exception]

6.210.2 Other-Drug Exception Panel Layout



6.210.3 Other-Drug Exception Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS Class	First 6 digits of the CDE_THERA_CLS_AHFS or ZZZZZZ if all CDE_THERA_CLS_AHFS codes should be included. Data type change to CHAR to support ZZZZZZ entries.	Field	Character	6
Amount	This is the Maximum or Minimum allowed amount (depending on the	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
	CDE_ABOVE_BELOW) that is to be compared against the PH Claims Adjudicated Paid Amount for the specific identifying codes.			
Description (AHFS Class)	Description of the AHFS Therapeutic Class Code.	Label	Character	55
Description (Therapeutic Class)	Therapeutic Class description.	Label	Character	100
Drug Exception Category	Identifies the type of data held in the table – i.e. Is it for editing Pharmacy Claims low / high amounts? Or is it to determine if the claim for an OTC drug is exempt from editing for a long term care recipient? This field can have either of two values: P for pharmacy variance edits and X for exempt from drug edits for LTC recipients.	Combo Box	Drop Down List Box	0
Drug Generic Name	The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description (10). These fields are each separated by a space, for a total of 3 spaces.	Label	Character	100
Drug Name	Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.	Label	Character	35
End Date	End Date of Drug Exception record.	Field	Date (MM/DD/CCYY)	8
GSN	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the	Field	Number (Integer)	6

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Field	Description	Field Type	Data Type	Length
	Micromedex Generic Formulation Code.			
Misc Ind	Indicator to specify if the value in the AMT_MONETARY field is the minimum low value or the maximum high value of the PH Claim Adjudicated Paid Amount. It can also be used to indicate if preferred drug criteria should be considered for maintenance supply drug eligibility if a value of ‘P’ is indicated. Valid Values are 'A' - Above value or maximum amount or 'B' - Below value or minimum amount, ‘Z’- Default value and ‘P’ - Preferred drug criteria.	Combo Box	Drop Down List Box	0
NDC	National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and service/prior authorization. ZZZZZZZZZZZ to include all codes.	Field	Character	11
Start Date	Start Date of Drug Exception record.	Field	Date (MM/DD/CCYY)	8
Status	The Status of the Drug Exception. If the Status is INACTIVE the Drug does not require low / high value editing. If the Status is ACTIVE the Drug DOES require low / high value editing.	Combo Box	Drop Down List Box	0
Therapeutic Class	The most specific therapeutic class code offered by First DataBank, intended for users who need a very definitive therapeutic classification system. 'ZZZ'	Field	Character	3

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Field	Description	Field Type	Data Type	Length
	includes all Therapeutic class codes.			

6.210.4 Other-Drug Exception Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AHFS Class	Field	1	AHFS Class must be 6 character(s) in length.	Enter a valid AHFS Class (the first 6 digits).
	Field	2	AHFS Class is not valid. Please verify.	Enter a valid AHFS Class (the first 6 digits).
	Field	3	AHFS Class is required	Enter a valid AHFS Class (the first 6 digits).
	Field	4	A non default value for Therapeutic Class, AHFS Class, GSN, or NDC is required.	Enter a non default valid value for at least one of the fields – Therapeutic Class, AHFS Class, GSN or NDC.
Amount	Field	1	Amount must be greater than or equal to 0.00.	Enter an amount that is greater than or equal to $0.00.
	Field	2	Amount must be less than or equal to 9999999.99.	Enter an amount that is less than or equal to 9999999.99.
Drug Exception Category	Field	1	Drug Exception Category is required.	Select a Drug Exception Category from the drop down list.
End Date	Field	1	End Date is required.	Enter a valid date. Format MM/DD/CCYY.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is after or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is before or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
GSN	Field	1	GSN is not valid. Please verify.	A valid GSN is needed.
	Field	2	GSN is required.	Enter a valid GSN.
	Field	3	A non default value for Therapeutic Class, AHFS Class, GSN, or NDC is required.	Enter a non default valid value for at least one of the fields – Therapeutic Class, AHFS Class, GSN or NDC.
NDC	Field	1	National Drug Code is not valid. Please verify.	Enter a valid National Drug Code.
	Field	2	A valid NDC is required.	Enter a valid NDC.
	Field	3	A non default value for Therapeutic Class, AHFS Class, GSN, or NDC is required.	Enter a non default valid value for at least one of the fields – Therapeutic Class, AHFS Class, GSN or NDC.
Start Date	Field	1	Start Date is required.	Enter a valid End Date. Format MM/DD/CCYY.
	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid End Date. Format MM/DD/CCYY.
	Field	3	Start Date must be greater than or equal to 01/01/1900.	Enter a Start Date that is greater than or equal to 01/01/1900.
	Field	4	Start Date must be less than or equal to 12/31/2299.	Enter a Start Date that is less than or equal to 12/31/2299.
	Field	5	Start Date [Date] must be less than or equal to End Date [Date].	Enter a Start Date that is prior to or equal the End Date.
Therapeutic Class	Field	1	Therapeutic Class Code must be 3 character(s) in length.	Enter a valid Therapeutic Class. Therapeutic Class is 3 characters in length.
	Field	2	Therapeutic Class is not valid. Please verify.	Enter a valid Therapeutic Class. Therapeutic Class is

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Field	Field Type	Error Code	Error Message	To Correct
				3 characters in length.
	Field	3	Therapeutic Class is required.	Enter a valid Therapeutic Class.
	Field	4	A non default value for Therapeutic Class, AHFS Class, GSN, or NDC is required.	Enter a non default valid value for at least one of the fields – Therapeutic Class, AHFS Class, GSN or NDC.

6.210.5 Other-Drug Exception Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.210.6 Other-Drug Exception Panel Accessibility

6.210.6.1 To Access the Other-Drug Exception Fee Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select **Drug Exception**.	Drug Exception panel displays.

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6.210.6.2 To Add on the Other-Drug Exception Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Drug Exception Category** by clicking on the drop down list box.	
3	Enter **Therapeutic Class Code**.	
4	Enter **National Drug Code**.	
5	Enter **Start Date**.	
6	Enter **Amount**.	
7	Enter **AHFS First 6 Digits** .	
8	Enter **Formulation Code**.	
9	Select **Above Below Indicator** from drop down list box.	
10	Enter **End Date** in MM/DD/CCYY format.	
11	Select **Status** from drop down list box.	
12	Click **Save**.	Drug Exception information is saved.

6.210.6.3 To Update on the Other-Drug Exception Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Drug Exception information is saved.

6.210.6.4 To Delete on the Other- Drug Exception Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.211 OTHER-EOB PANEL

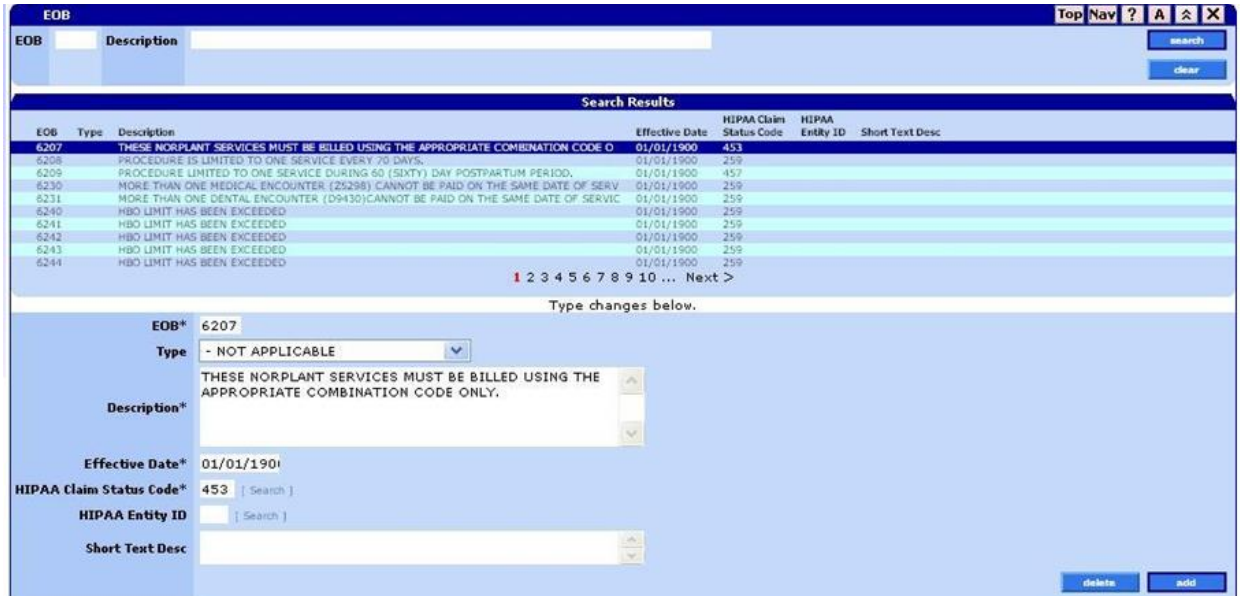
6.211.1 Other-EOB Panel Narrative

The EOB panel is used to maintain EOB Code information. The user can search for an EOB code by either entering in the specific EOB code or by typing in an EOB narrative as a search parameter. A list of all EOB codes meeting the search criteria will be displayed in the search results.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - EOB]

6.211.2 Other-EOB Panel Layout



6.211.3 Other-EOB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an EOB Code.	Button	N/A	0
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Delete	Allows the user to delete an EOB Code.	Button	N/A	0
Description	First line of the nomenclature for an Explanation of Benefits that is printed on the remittance advice.	Field	Character	395
Effective Date	Date of service that the Explanation of Benefits code became effective.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
EOB	Code which represents a policy for Medicaid claim adjudication.	Field	Number (Integer)	4
HIPAA Claim Status Code [Search]	HIPAA Health Care Claim Status Codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.	Hyperlink	N/A	0
HIPAA Entity ID [Search]	HIPAA Health Care Claim Status Entity Identifier Code.	Hyperlink	N/A	3
HIPAA Xref	Displays the HIPAA Adj Reason/EOB Xref Data and the HIPAA Remarks/EOB Xref Data panels.	Button	N/A	0
Search	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Short Text Desc	HIPAA Short Text Description representing non-financial information critical to understanding the adjudication of a health insurance claim. E.G. Reason for denial.	Field	Character	50
Type	Indication of what type of processing should be performed. This is used for processing of adjustments based on the EOB assigned as the adjustment reason.	Combo Box	Drop Down List Box	0

6.211.4 Other-EOB Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter an EOB description.
EOB	Field	1	EOB is required.	Enter a EOB when adding or modifying EOB.
	Field	2	EOB must be 4 character(s) in length.	Enter a EOB of 4 characters.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Effective Date in MM/DD/CCYY format.
HIPAA Claim Status Code	Hyperlink	1	A valid HIPAA Claim Status Code is required.	Select a valid HIPAA Claim Status Code.
HIPAA Entity ID	Hyperlink	1	A valid HIPAA Entity ID is required.	Select a valid HIPAA Entity ID.

6.211.5 Other-EOB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.211.6 Other-EOB Panel Accessibility

6.211.6.1 To Access the Other-EOB Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **EOB**.	EOB panel displays.

6.211.6.2 To Add on the Other-EOB Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **EOB**.	
3	Select **Type** from drop down list box.	
4	Enter **Description**.	
5	Enter **Amount**.	
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Select **HIPAA Claim Status Code** by clicking [Search] button.	

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Step	Action	Response
8	Enter search criteria. User may also select a row from the list of search results.	HIPAA Claim Status information is populated on panel.
9	Select **HIPAA Entity ID** by clicking [Search] button.	
10	Enter search criteria. User may also select a row from the list of search results.	HIPAA Entity ID information is populated on panel.
11	Enter **Short Text Desc**.	
11	Click **Save**.	EOB information is saved.

6.211.6.3 To Update on the Other-EOB Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	EOB information is saved.

6.211.6.4 To Delete on the Other-EOB Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.212 OTHER-EOB-RELATED ESCS PANEL

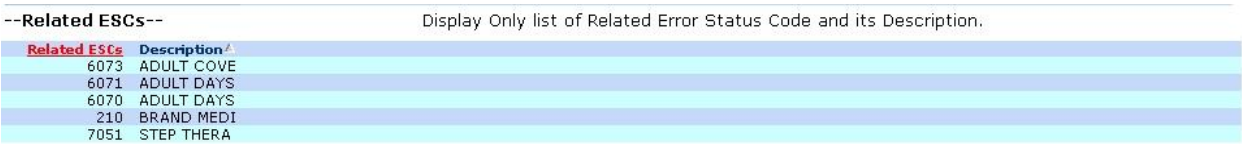
6.212.1 Other-EOB-Related ESCs Panel Narrative

The EOB Related ESCs panel is used to display Errors related to this EOB.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] – [EOB] -[select an EOB] - [Related ESCs]

6.212.2 Other-EOB-Related ESCs Panel Layout



6.212.3 Other-EOB-Related ESCs Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Text description of the Error Status Code.	Field	Character	50
Related ESCs	Error Status Code related to the EOB.	Field	Number (Integer)	4

6.212.4 Other-EOB-Related ESCs Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.212.5 Other-EOB-Related ESCs Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.212.6 Other-EOB-Related ESCs Panel Accessibility

6.212.6.1 To Access the Other-EOB Related ESCs Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other pagedisplays.
4	Select **EOB**.	Other- EOB panel displays.
5	Select a row.	EOB Related ESCs information is displayed.

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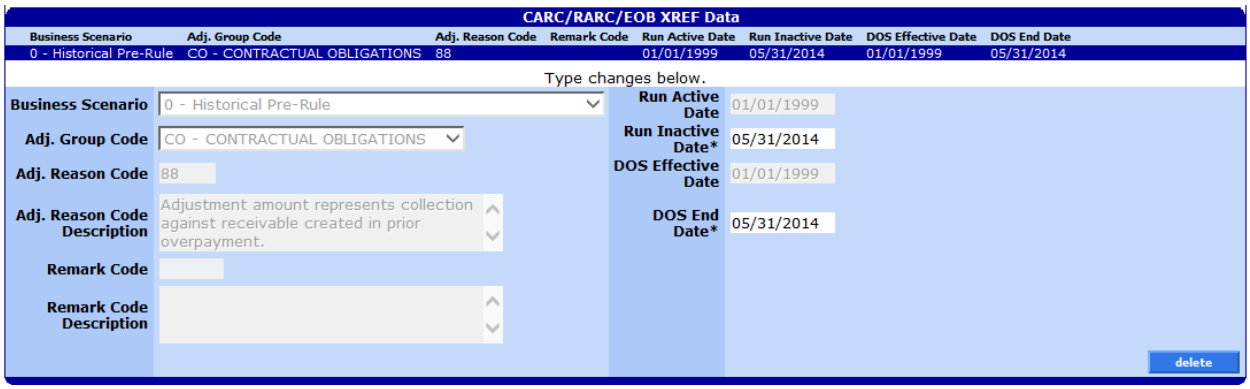
6.213 OTHER-EOB-CARC/RARC/EOB XREF DATA PANEL

6.213.1 Other-EOB-CARC/RARC/EOB Xref Data Panel Narrative

The CARC/RARC/EOB Xref panel is the third of three panels that make up the EOB system of panels. It is the cross reference panel for HIPAA Adjustment, HIPAA Remarks, CAGC and Business Scenario that are associated with an EOB code. When a row is selected from the EOB Panel, this panel will display the Business Scenario and valid CARC/RARC/CAGC combinations that were saved with an EOB. The authorized users can delete rows using the delete button or add rows using the BuSc/CARC/RARC panel above it.

Navigation Path: [Reference] - [Related Data] - [Other] - [EOB] - [Click on Search and select an EOB].

6.213.2 Other-EOB-CARC/RARC/EOB Xref Data Panel Layout



6.213.3 Other-EOB-CARC/RARC/EOB Xref Data Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adj. Group Code [Detail]	The group code and description identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code).	Combo Box	Alphanumeric	50
Adj. Reason Code	The Claims Adjustment Reason Code (CARC) communicates why a claim or service line was paid differently than it was billed.	Field	Alphanumeric	4
Adj. Reason Code Description	Text description of HIPAA Adjustment Reason code.	Field	Character	700
Business Scenario	The CAQH defined business scenario code and description (1-49) or the Alabama Medicaid specific business scenario code and description (50-99). 0 indicates historically converted records.	Combo box	Alphanumeric	2

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Field	Description	Field Type	Data Type	Length
Delete	Allows the user to delete a row on the panel.	Button	N/A	0
DOS Effective Date	The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing, applicable by date of service of the claim.	Field	Date (MM/DD/CCYY)	8
DOS End Date	The last date the relationship between MMIS EOB codes and the combination is valid for use in processing, applicable by date of service of the claim.	Field	Date (MM/DD/CCYY)	8
Remark Code	HIPAA Remittance Advice Remark Code (RARC) used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing.	Field	Alphanumeric	5
Remark Code Description	Text description of HIPAA Remittance Advice Remark Code.	Field	Character	700
Run Active Date	The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing, applicable by Financial run date.	Field	Date (MM/DD/CCYY)	8
Run Inactive Date	The last date the relationship between MMIS EOB codes and the combination is valid for use in processing, applicable by Financial run date.	Field	Date (MM/DD/CCYY)	8

6.213.4 Other-EOB-CARC/RARC/EOB Xref Data Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
DOS Effective Date	Field	1	DOS Effective Date is required.	Enter a DOS Effective date between 01/01/1900 and 12/31/2299.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	DOS Effective Date is not valid.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	4	DOS Effective Date must be greater than or equal to 1/1/1900.	Enter a valid date that is not less than 01/01/1900.
	Field	5	DOS Effective Date must be less than or equal to 12/31/2299.	Enter a valid date that is not greater than 12/31/2299.
	Field	6	DOS Effective Date [mm/dd/ccyy hr:mm:sec AM/PM] must be less than or equal to DOS End Date [mm/dd/ccyy hr:mm:sec AM/PM].	Enter a valid DOS Effective Date that is less than or equal to the DOS End Date.
	Field	7	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the DOS dates if necessary to prevent overlapping of both Run and DOS dates between rows. This cannot be done for existing rows as DOS Effective dates are non-editable for existing rows.
	Field	8	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the DOS Effective Date if necessary to prevent rows with overlapping Run dates from having non-contiguous DOS dates. This cannot be done for existing rows as DOS Effective dates are non-editable for existing rows.
	Field	9	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] should not have non-contiguous Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the Run dates if necessary to prevent rows with overlapping DOS dates from having non-contiguous Run dates. This cannot be done for existing rows as DOS Effective dates are non-editable for existing rows.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	10	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping Run dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the Run dates if necessary to prevent overlapping of both Run and DOS dates between rows. This cannot be done for existing rows as DOS Effective dates are non-editable for existing rows.
	Field	11	Please enter valid dates in row being added or modified before selecting or adding another row.	Enter a valid date between 1/1/1900 and 12/31/2299 as appropriate in date fields that do not have such dates.
DOS End Date	Field	1	DOS End Date is required.	Enter a DOS End date between 01/01/1900 and 12/31/2299.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	3	DOS End Date must be greater than or equal to 1/1/1900.	Enter a valid date that is not less than 01/01/1900.
	Field	4	DOS End Date is not valid.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	5	DOS End Date must be less than or equal to 12/31/2299.	Enter a valid date that is not greater than 12/31/2299.
	Field	6	DOS End Date [mm/dd/ccyy hr:mm:sec AM/PM] must be greater than or equal to Run Active Date [mm/dd/ccyy hr:mm:sec AM/PM].	Enter a valid DOS End Date that is greater than or equal to the Run Active Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	7	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the DOS dates if necessary to prevent overlapping of both Run and DOS dates between rows.
	Field	8	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous DOS dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the DOS Effective Date if necessary to prevent rows with overlapping Run dates from having non-contiguous DOS dates.
	Field	9	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous Run dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the Run Active Date if necessary to prevent rows with overlapping DOS dates from having non-contiguous Run dates.
	Field	10	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the Run dates if necessary to prevent overlapping of both Run and DOS dates between rows.
	Field	11	Please enter valid dates in row being added or modified before selecting or adding another row.	Enter a valid date between 1/1/1900 and 12/31/2299 as appropriate in date fields that do not have such dates.
Run Active Date	Field	1	Run Active Date is required.	Enter a Run Active date between 01/01/1900 and 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	3	Run Active Date is not valid.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	4	Run Active Date must be greater than or equal to 1/1/1900.	Enter a valid date that is not less than 01/01/1900.
	Field	5	Run Active Date must be less than or equal to 12/31/2299.	Enter a valid date that is not greater than 12/31/2299.
	Field	6	Run Active Date [mm/dd/ccyy hr:mm:sec AM/PM] must be less than or equal to Run Inactive Date [mm/dd/ccyy hr:mm:sec AM/PM].	Enter a valid Run Active Date that is less than or equal to the Run Inactive Date.
	Field	7	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy].	For new entry, modify the DOS dates if necessary to prevent overlapping of both Run and DOS dates between rows. This cannot be done for existing rows as Run Active dates are non-editable for existing rows.
	Field	8	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous DOS dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the DOS Effective Date if necessary to prevent rows with overlapping Run dates from having non-contiguous DOS dates. This cannot be done for existing rows as Run Active dates are non-editable for existing rows.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	9	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous Run dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	For new entry, modify the Run Active Date if necessary to prevent rows with overlapping DOS dates from having non-contiguous Run dates. This cannot be done for existing rows as Run Active dates are non-editable for existing rows.
	Field	10	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy].	For new entry, modify the Run dates if necessary to prevent overlapping of both Run and DOS dates between rows. This cannot be done for existing rows as Run Active dates are non-editable for existing rows.
	Field	11	Run Active Date [MM/DD/YYY] must be greater than or equal to Effective Date [MM/DD/YYYY] of the CARC/RARC/EOB combination being added.	Enter Run Active Date that is greater than or equal to the Effective Date (and also less than or equal to the End Date) of the CARC/RARC/EOB combination being added.
	Field	12	Please enter valid dates in row being added or modified before selecting or adding another row.	Enter a valid date between 1/1/1900 and 12/31/2299 as appropriate in date fields that do not have such dates.
Run Inactive Date	Field	1	Run Inactive Date is required.	Enter a Run Inactive date between 01/01/1900 and 12/31/2299.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.
	Field	3	Run Inactive Date must be greater than or equal to 1/1/1900.	Enter a valid date that is not less than 01/01/1900.
	Field	4	Run Inactive Date is not valid.	Enter a valid date between 01/01/1900 and 12/31/2299 in the mm/dd/ccyy format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Run Inactive Date must be less than or equal to 12/31/2299.	Enter a valid date that is not greater than 12/31/2299.
	Field	6	Run Inactive Date [mm/dd/ccyy hr:mm:sec AM/PM] must be greater than or equal to Run Active Date [mm/dd/ccyy hr:mm:sec AM/PM].	Enter a valid Run Inactive Date that is greater than or equal to the Run Active Date.
	Field	7	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the DOS dates if necessary to prevent overlapping of both Run and DOS dates between rows.
	Field	8	Overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous DOS dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the DOS Effective Date if necessary to prevent rows with overlapping Run dates from having non-contiguous DOS dates.
	Field	9	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have non-contiguous Run dates [[mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the Run Inactive Date if necessary to prevent rows with overlapping DOS dates from having non-contiguous Run dates.
	Field	10	Overlapping DOS dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy] cannot have overlapping Run dates [mm/dd/ccyy to mm/dd/ccyy] and [mm/dd/ccyy to mm/dd/ccyy].	Modify the Run dates if necessary to prevent overlapping of both Run and DOS dates between rows.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	11	Run Inactive Date [MM/DD/YYY] must be less than or equal to End Date [MM/DD/YYYY] of the CARC/RARC/EOB combination being added.	Enter Run Inactive Date that is less than or equal to the End Date (and also greater than or equal to the Effective Date) of the CARC/RARC/EOB combination being added.
	Field	12	Please enter valid dates in row being added or modified before selecting or adding another row.	Enter a valid date between 1/1/1900 and 12/31/2299 as appropriate in date fields that do not have such dates.

6.213.5 Other-EOB-CARC/RARC/EOB Xref Data Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.213.6 Other-EOB-CARC/RARC/EOB Xref Data Panel Accessibility

6.213.6.1 To Access the Other-CARC/RARC/EOB Xref Data Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **EOB**.	EOB panel displays.
5	Select a row on the EOB panel.	CARC/RARC/EOB/Xref panel displays.

6.213.6.2 To Add on the Other-CARC/RARC/EOB Xref Data Panel

Step	Action	Response
1	Select a row from the **BuSc/CARC/RARC** panel.	The selected row will be added to CARC/RARC/EOB Xref Datalist and Data panel. The date fields will be ready be editable.
2	Enter **Run Active Date** in MM/DD/CCYY format.	
3	Enter **Run Inactive** in MM/DD/CCYY format.	
4	Enter **DOS Effective Date** in MM/DD/CCYY format.	

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Step	Action	Response
5	Enter **DOS End Date** in MM/DD/CCYY format.	
6	Click **Save**.	CARC/RARC/EOB Xref Data information is saved.

6.213.6.3 To Update on the Other-CARC/RARC/EOB Xref Data Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update. Note: Run Inactive and DOS End dates are the only field that can be updated on this panel.	
3	Click **Save**.	CARC/RARC/EOB Xref Data information is saved.

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6.213.6.4 To Delete on the Other-CARC/RARC/EOB Xref Data Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	CARC/RARC/EOB Xref Data information is deleted from the Datalist and Data panel.

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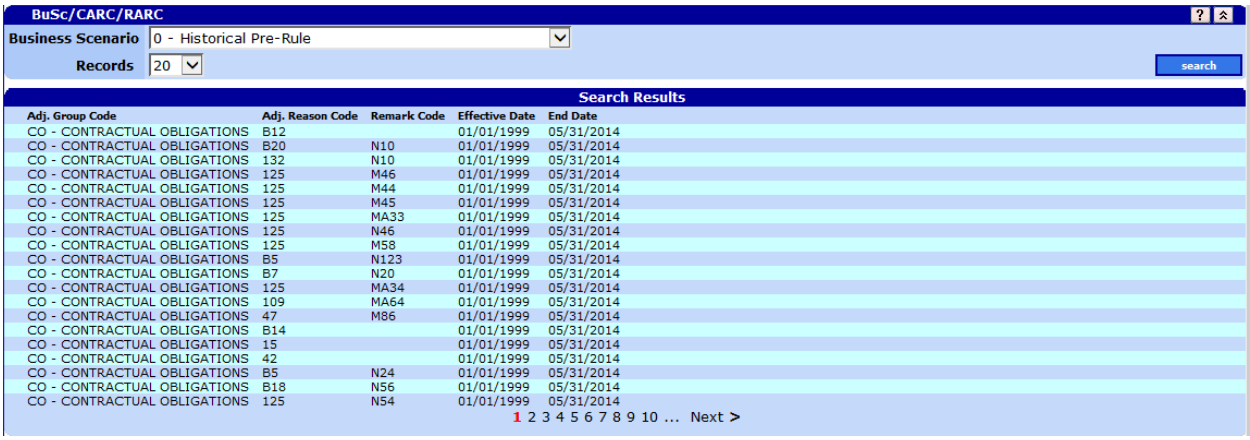
6.214 OTHER-EOB- BUSC/CARC/RARC PANEL

6.214.1 Other-EOB-BuSc/CARC/RARC Panel Narrative

The EOB-BuSc/CARC/RARC panel is the second of three panels that make up the EOB system of panels. It is used to display the valid CARC/RARC/CAGC combination for a selected Business Scenario. The user will select a Business Scenario and click on the search button to get the valid combination. When a row on the datalist is selected, that row will be added to the panel below it – the CARC/RARC/EOB Xref Data panel.

Navigation Path: [Reference] - [Related Data] - [Other] - [EOB] - (click on Search and select an EOB).

6.214.2 Other-EOB-BuSc/CARC/RARC Panel Layout



Adj. Group Code	Adj. Reason Code	Remark Code	Effective Date	End Date
CO - CONTRACTUAL OBLIGATIONS	B12		01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B20	N10	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	132	N10	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	M46	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	M44	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	M45	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	MA33	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	N46	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	M58	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B5	N123	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B7	N20	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	MA34	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	109	MA64	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	47	M86	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B14		01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	15		01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	42		01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B5	N24	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	B18	N56	01/01/1999	05/31/2014
CO - CONTRACTUAL OBLIGATIONS	125	N54	01/01/1999	05/31/2014

6.214.3 Other-EOB-BuSc/CARC/RARC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adj. Group Code	The group code and description identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code).	Field	Alphanumeric	50
Adj. Reason Code	The Claims Adjustment Reason Code (CARC) communicates why a claim or service line was paid differently than it was billed.	Field	Alphanumeric	4
Business Scenario	The CAQH defined business scenario code and description (1-49) or the Alabama Medicaid specific business scenario code and description (50-99). 0 indicates historically converted records.	Combo box	Alphanumeric	2
Effective Date	The date the combination becomes valid for use in the system.	Field	Date (MM/DD/CCYY)	8
End Date	The last date the combination is valid for use in the system.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of records to display.	Combo box	Drop Down List Box	0
Remark Code	HIPAA Remittance Advice Remark Code (RARC) used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing.	Field	Alphanumeric	5
Search	Allow the user to search for a valid CARC/RARC/CAGC combination.	Button	N/A	0

Other-EOB-BuSc/CARC/RARC Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No features for this panel.				

Other-EOB-BuSc/CARC/RARC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

Other-EOB-BuSc/CARC/RARC Panel Accessibility

To Access the Other-EOB-BuSc/CARC/RARC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **EOB**.	EOB panel displays
4	Select a row on the EOB panel.	Other-EOB-BuSc/CARC/RARC panel displays.

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6.215 OTHER-ESTIMATED ACQUISITION COST PCT PANEL

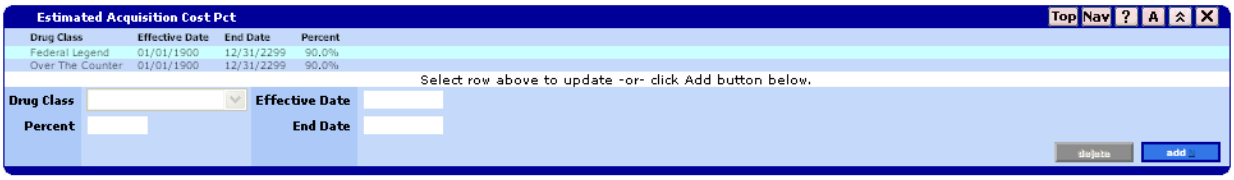
6.215.1 Other-Estimated Acquisition Cost Pct Panel Narrative

Estimated acquisition cost is a pricing factor used to price pharmacy claims. This panel contains by drug class, the EAC percentage that should be applied to result in an allowable reimbursement amount.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [Estimated Acquisition Cost Percent]

6.215.2 Other-Estimated Acquisition Cost Pct Panel Layout



6.215.3 Other-Estimated Acquisition Cost Pct Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an EAC (Estimated Acquisition Cost Percent).	Button	N/A	0
Delete	Allows the user to delete an EAC (Estimated Acquisition Cost Percent).	Button	N/A	0
Drug Class	Classifies a drug by its availability to the consumer according to federal specifications.	Combo Box	Drop Down List Box	0
Effective Date	First date of service that the associated percentage is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service, or dispense date, that this percentage is applicable.	Field	Date (MM/DD/CCYY)	8
Percent	Actual percentage value to be applied to the estimated acquisition cost to determine reimbursement amount. Format is 999.9%.	Field	Number (Decimal	4

6.215.4 Other-Estimated Acquisition Cost Pct Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Drug Class	Field	1	Drug Class is required.	Select a Drug Class from the Drug Class drop down listing.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date and End Date range overlap an existing record.	Correct overlap condition. Date segments for the same Drug Class and Ind Conv cannot overlap.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	3	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	5	End Date must be greater than or equal to 01/01/1900	Enter an End Date that is greater than or equal to 01/01/1900.
Percent	Field	1	Percent must be less than or equal to 100.000.	Enter a percent that is less than or equal to 100% using format 999.9%.
	Field	2	Enter a valid value.	Enter a percent using format 999.9%.

6.215.5 Other-Estimated Acquisition Cost Pct Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.215.6 Other-Estimated Acquisition Cost Pct Panel Accessibility

6.215.6.1 To Access the Other-Estimated Acquisition Cost Pct Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.

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Step	Action	Response
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Estimated Acquisition Cost Pct**.	Estimated Acquisition Cost Pct panel displays.

6.215.6.2 To Add on the Other-Estimated Acquisition Cost Pct Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Drug Class** from drop down list box.	
3	Enter **Percent**.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Estimated Acquisition Cost Pct information is saved.

6.215.6.3 To Update on the Other-Estimated Acquisition Cost Pct Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Estimated Acquisition Cost Pct information is saved.

6.215.6.4 To Delete on the Other-Estimated Acquisition Cost Pct Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.216 OTHER-FEDERAL MEDICAL ASSISTANCE PERCENT PANEL

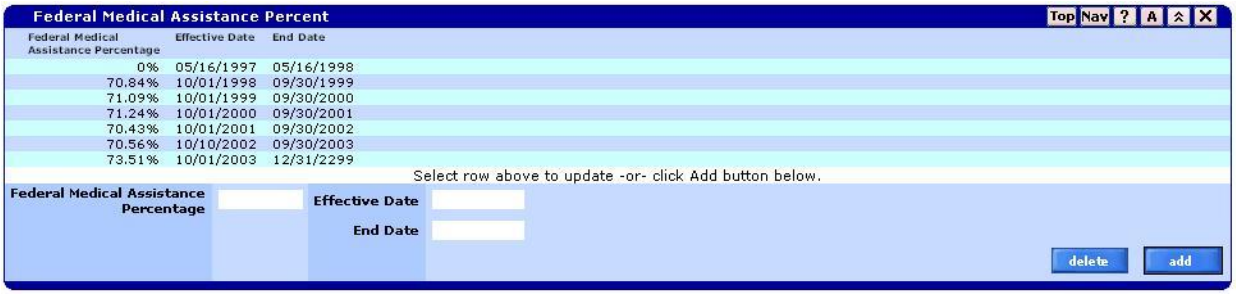
6.216.1 Other-Federal Medical Assistance Percent Panel Narrative

The Federal Medical Assistance Percentage (FMAP) Rate Type panel is used for the Federal share of benefit payments.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [Federal Medical Assistance Percent]

6.216.2 Other-Federal Medical Assistance Percent Panel Layout



6.216.3 Other-Federal Medical Assistance Percent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Federal Medical Assistance Percent rate.	Button	N/A	0
Delete	Delete a Federal Medical Assistance Percent rate.	Button	N/A	0
Effective Date	The first date of service to which this Federal Medical Assistance Percent should be applied.	Field	Date (MM/DD/CCYY)	8
End Date	The last date of service to which this particular Federal Medical Assistance Percent should be applied.	Field	Date (MM/DD/CCYY)	8
Federal Medical Assistance Percentage	The actual Federal Medical Assistance Percent amount to be applied to calculate the state share amount. Format is 9.99999.	Field	Number (Decimal)	6

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6.216.4 Other-Federal Medical Assistance Percent Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	0	Effective Date must be less than or equal to End Date.	Effective Date must be less than or equal to End Date.
	Field	1	FMAP Percentage date ranges may not overlap.	Enter a valid Date Ranges.
	Field	2	Effective Date is required.	Enter an Effective Date field when adding or modifying Federal Medical Assistance percentage.
	Field	3	Invalid date.	Enter an Effective Date n MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter a value for Effective Date that is less than or equal to 12/31/2299.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
End Date	Field	1	FMAP Percentage date ranges may not overlap.	Enter Date Ranges that do not overlap.
	Field	2	End Date is required.	Enter an End date field when adding or modifying Federal Medical Assistance Percentage.
	Field	3	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to End Date.	Enter an End Date that is greater than or equal to Effective Date.
	Field	5	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Federal Medical Assistance Percentage	Field	1	Federal Medical Assistance Percentage is required.	Enter a Federal Medical Assistance field when adding or modifying Federal Medical Assistance Percentage.
	Field	2	Federal Medical Assistance Percentage must be less than or equal to 9.99999.	Enter a percentage that is less than or equal to 9.99999.

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6.216.5 Other-Federal Medical Assistance Percent Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.216.6 Other-Federal Medical Assistance Percent Panel Accessibility

6.216.6.1 To Access the Other-Federal Medical Assistance Percent Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Federal Medical Assistance Percent**.	Federal Medical Assistance Percent panel displays.

6.216.6.2 To Add on the Other-Federal Medical Assistance Percent Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Federal Medical Assistance Percentage**.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Federal Medical Assistance Percent information is saved.

6.216.6.3 To Update on the Other-Federal Medical Assistance Percent Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Federal Medical Assistance Percent information is saved.

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6.216.6.4 To Delete on the Other-Federal Medical Assistance Percent Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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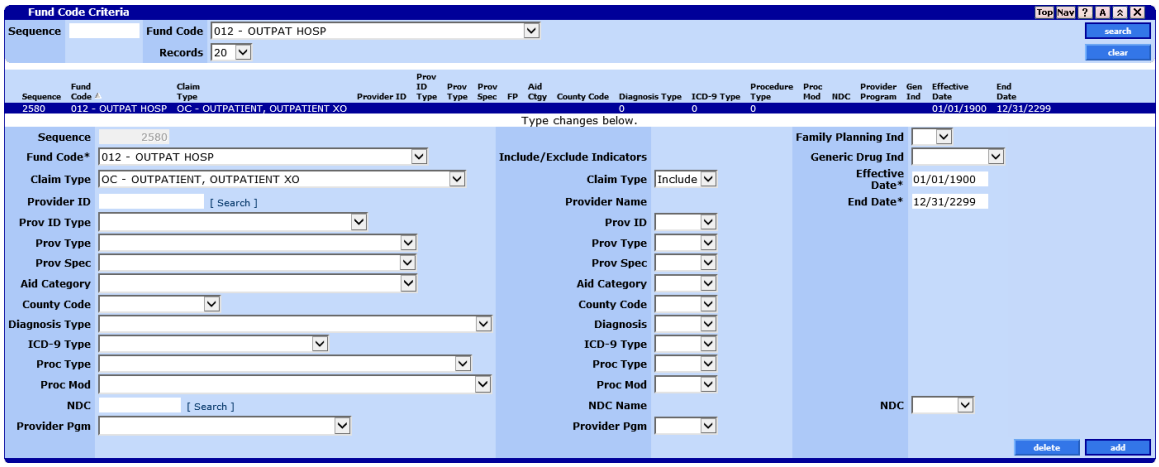
6.217 OTHER-FUND CODE CRITERIA PANEL

6.217.1 Other-Fund Code Criteria Panel Narrative

The Fund Code panel is used to create/maintain the criteria used to assign a Fund Code to a claim. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Related Data] – [Other] - [Fund Code Criteria]

6.217.2 Other-Fund Code Criteria Panel Layout



6.217.3 Other-Fund Code Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add record in Fund Code Criteria.	Button	N/A	0
Aid Category	Identifies the type of aid for which a recipient is eligible.	Combo Box	Drop Down List Box	2
Aid Category	Code identifying whether the Aid Category associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Claim Type	Up to six Claim Types that the criteria applies to. Valid Claim Types are: A, B, C, D, H, I, L, M, O, P, Q	Combo Box	Drop Down List Box	6
Claim Type	Code identifying whether the Claim Types associated with this entry are included (I) or excluded (E).	Combo Box	Drop Down List Box	1
County Code	The County Code used to identify a geographical/political area in the state.	Combo Box	Drop Down List Box	10
County Code	Code identifying whether the Recipient County associated with	Combo Box	Drop Down List Box	1

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Field	Description	Field Type	Data Type	Length
	this entry is included (I) or excluded (E).			
Delete	Allows user to delete record in Fund Code Criteria.	Button	N/A	0
Diagnosis	Code identifying whether the Diagnosis associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Diagnosis Type	System assigned key for a unique Diagnosis Type which represents a collection of Diagnosis Codes.	Combo Box	Drop Down List Box	9
Effective Date	The effective date of the Claim FCA record.	Field	Date (MM/DD/CCYY)	8
End Date	The end date of the Claim FCA record.	Field	Date (MM/DD/CCYY)	8
Family Planning Ind	A value of 'Y' indicates a family planning service.	Combo Box	Drop Down List Box	1
Fund Code	This is the fund code that is used in financial reporting to correctly categorize funds (money).	Combo Box	Drop Down List Box	3
Generic Drug Ind	Indicates whether a drug product is generic product or branded product. Values - Y or N.	Combo Box	Drop Down List Box	1
ICD-9 Type	System assigned key for a unique ICD Procedure Type, which represents a collection of ICD Procedure Codes.	Combo Box	Drop Down List Box	9
ICD-9 Type	Code identifying whether the ICD-9 Procedure associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
NDC	National Drug Code used to uniquely identify a drug. The box directly next to this is used to identify the original 10-character format of the NDC.	Field	Character	11
NDC	Code identifying whether the Drug Code associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
NDC Name	Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.	Field	Character	35

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Field	Description	Field Type	Data Type	Length
Proc Mod	The Modifier Code used to further describe a procedure.	Combo Box	Drop Down List Box	2
Proc Mod	Code identifying whether the Proc Mod associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Proc Type	System assigned key for a unique procedure type, that represents a single or collection of procedures.	Combo Box	Drop Down List Box	9
Proc Type	Code identifying whether the Procedure Code associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Prov ID	Code identifying whether the Provider ID associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Prov ID Type	Code identifying the type of Provider ID - 'MCD', 'NPI' or 'BSE'.	Combo Box	Drop Down List Box	3
Prov Spec	Code identifying whether the Provider Specialty associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Prov Spec	A code representing the specialized area of practice for a provider.	Combo Box	Drop Down List Box	3
Prov Type	Code identifying whether the Provider Type associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Prov Type	The Provider Type Code that a provider is licensed for.	Combo Box	Drop Down List Box	2
Provider ID	The Provider ID value.	Field	Character	15
Provider Name	This is the name associated with an organization or person.	Field	Character	50
Provider Pgm	A code that represents a provider enrollment program.	Combo Box	Drop Down List Box	9
Provider Pgm	Code identifying whether the Provider Program associated with this entry is included (I) or excluded (E).	Combo Box	Drop Down List Box	1
Sequence	The sequence in which the FCA rows should be processed.	Field	Number (Integer)	9

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6.217.4 Other-Fund Code Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Category	Field	2	Aid Category Indicator is required when Aid Category criteria is entered.	Enter the Aid Category Indicator when Aid Category criteria is entered.
Claim Type	Field	2	Claim Type Indicator is required when Claim Type criteria is entered.	Enter the Claim Type Indicator when Claim Type criteria is entered.
	Field	3	" " are not valid Claim Types.	Enter valid Claim Types.
County Code	Field	2	County Indicator is required when County criteria is entered.	Enter the County Indicator when County criteria is entered.
Diagnosis Type	Field	2	Diagnosis Indicator is required when Diagnosis criteria is entered.	Enter the Diagnosis Indicator when Diagnosis criteria is entered.
Effective Date	Field	1	Effective Date is required.	Enter the Effective Date.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to End Date.	Effective Date must be less than or equal to End Date.
End Date	Field	1	End Date is required.	Enter the End Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Fund Code	Field	1	A valid Fund Code is required.	Enter a valid Fund Code.
ICD-9 Type	Field	2	Procedure ICD-9 Type Indicator is required when Procedure ICD-9 Type criteria is entered.	Enter the Procedure ICD-9 Type Indicator when Procedure ICD-9 Type criteria is entered.
NDC	Field	2	NDC Indicator is required when NDC criteria is entered.	Enter the NDC Indicator when NDC criteria is entered.
	Field	3	A valid NDC is required.	Enter valid NDC.
Proc Type	Field	2	Procedure Type Indicator is required when Procedure Type criteria is entered.	Enter the Procedure Type Indicator when Procedure Type criteria is entered.

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Field	Field Type	Error Code	Error Message	To Correct
Prov ID Type	Field	2	Provider ID Indicator is required when Provider ID criteria is entered.	Enter the Provider ID Indicator when Provider ID criteria is entered.
Prov Spec	Field	2	Provider Specialty Indicator is required when Provider Specialty criteria is entered.	Enter the Provider Specialty Indicator when Provider Specialty criteria is entered.
Prov Type	Field	2	Provider Type Indicator is required when Provider Type criteria is entered.	Enter the Provider Type Indicator when Provider Type criteria is entered.
Provider ID	Field	2	Provider ID Indicator is required when Provider ID criteria is entered.	Enter Provider ID Indicator when Provider ID criteria is entered.
	Field	3	A valid Provider ID is required.	Enter a valid Provider ID.
Provider Pgm	Field	2	Provider Program Indicator is required when Provider Enroll Program criteria is entered.	Enter the Provider Program Indicator when Provider Enroll Program criteria is entered.
Sequence	Field	1	Sequence is required.	Enter the Sequence Number.
	Field	2	At least one criteria field is required.	Enter at least one criteria before saving.
	Field	3	Sequence must be greater than or equal to 1.	Enter a value that is greater than or equal to 1.

6.217.5 Other-Fund Code Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.217.6 Other-Fund Code Criteria Panel Accessibility

6.217.6.1 To Access the Other-Fund Code Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Fund Code Criteria**.	Fund Code Criteria panel displays.

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6.217.6.2 To Add on the Other Fund Code Criteria Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence.**	
3	Select **Fund Code** from drop down list box.	
4	Enter **Claim Type** in MM/DD/CCYY format.	
5	Enter **Provider ID**.	
6	Select **Provider ID Type** from drop down list box.	
7	Select **Prov Type** from drop down list box.	
8	Select **Prov Spec** from drop down list box.	
9	Enter **Aid Category**.	
10	Select **County Code** from drop down list box.	
11	Select **Diagnosis Type** from drop down list box.	
12	Select **ICD-9 Type** from drop down list box.	
13	Select **Proc Type** from drop down list box.	
14	Select **Proc Mod** from drop down list box.	
15	Enter **NDC**.	
16	Select **Provider Pgm** from drop down list box.	
Include/Exclude Indicators		
17	Select **Claim Type** from drop down list box.	
18	Select **Prov ID** from drop down list box.	
19	Select **Prov Type** from drop down list box.	
20	Select **Prov Spec** from drop down list box.	
21	Select **Aid Category** from drop down list box.	

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Step	Action	Response
22	Select **County Code** from drop down list box.	
23	Select **Diagnosis** from drop down list box.	
24	Select **ICD-9 Type** from drop down list box.	
25	Select **Proc Type** from drop down list box.	
26	Select **NDC** from drop down list box.	
27	Select **Provider Pgm** from drop down list box.	
28	Select **Family Planning Ind** from drop down list box.	
29	Select **Generic Drug Ind** from drop down list box.	
30	Enter **Effective Date**.	
31	Enter **End Date**.	
32	Click **Save**.	Fund Code Criteria information is saved.

6.217.6.3 To Update on the Other-Fund Code Criteria Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Fund Code Criteria information is saved.

6.217.6.4 To Delete on the Other-Fund Code Criteria Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.218 OTHER – GENERIC CODE SETS

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6.219 OTHER-GEOGRAPHIC PRACTICE COST IDX PANEL

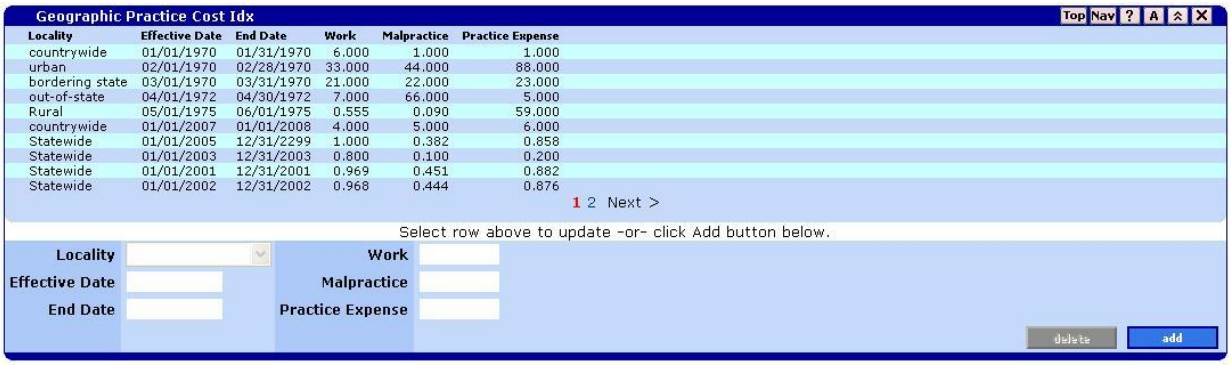
6.219.1 Other-Geographic Practice Cost Idx Panel Narrative

The Geographic Practice Cost Idx panel is used to maintain the three Geographic Practice Cost Index (GPCI) components which reflect the physician work, practice expense and malpractice expenses. This panel also allows the user to assign GPCIs based on locality. By selecting appropriate locality in the left data window, the corresponding GPCI values for that locality is displayed in the right data window.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [Geographic Practice Cost Idx]

6.219.2 Other-Geographic Practice Cost Idx Panel Layout



6.219.3 Other-Geographic Practice Cost Idx Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Geographic Practice Cost Index.	Button	N/A	0
Delete	Allows the user to delete a Geographic Practice Cost Index.	Button	N/A	0
Effective Date	Date the GPCI for a location becomes valid for use in claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	Date the GPCI for a locality is no longer valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Locality	Indicates the locality code for a provider to indicate if the provider practices in an urban, metropolitan, rural, or out-of-state location.	Combo Box	Drop Down List Box	0
Malpractice	Malpractice expense geographic adjustment factor used in computing the RBRVS fee schedule amount.	Field	Number (Decimal)	5

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Field	Description	Field Type	Data Type	Length
Practice Expense	Practice expense geographic adjustment factor used in computing the RBRVS fee schedule amount. Format 99.999.	Field	Number (Decimal)	5
Work	Work geographic adjustment factor used in computing the RBRVS fee schedule amount.	Field	Number (Decimal)	5

6.219.4 Other-Geographic Practice Cost Idx Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Effective Date is required.	Enter an Effective Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
End Date	Field	1	End Date is required.	Enter an End Date. End Date field required when adding or modifying Geographic Practice Index.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	4	Invalid date.	Enter an End Date in MM/DD/CCYY format.
Locality	Field	1	A valid Locality is required.	Select a valid locality from the Locality drop down listing.
	Field	2	GPCI date ranges may not overlap for the same Locality.	Enter GPCI date ranges that do not overlap for the same locality.

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Field	Field Type	Error Code	Error Message	To Correct
Malpractice	Field	1	Malpractice must be greater than or equal to 00.001.	Enter Malpractice that is greater than or equal to 00.001.
	Field	2	Malpractice must be less than or equal to 99.999.	Enter a Malpractice value between 00.001 and 99.999.
	Field	3	Malpractice is required.	Enter a Malpractice Value.
Practice Expense	Field	1	Practice Expense must be greater than or equal to 00.001.	Enter a Practice Expense that is greater than or equal to 00.001.
	Field	2	Practice Expense must be less than or equal to 99.999.	Key in a value less than or equal to 99.999.
	Field	3	Practice Expense is required.	Enter a Practice Expense value.
Work	Field	1	Work must be greater than or equal to 00.001.	Enter Work that is greater than or equal to 00.001.
	Field	2	Work must be less than or equal to 99.999.	Key in a value between 00.001 and 99.999.
	Field	3	Work is required.	Enter a Work value.

6.219.5 Other-Geographic Practice Cost Idx Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.219.6 Other-Geographic Practice Cost Idx Panel Accessibility

6.219.6.1 To Access the Geographic Practice Cost Idx Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Geographic Practice Cost Idx**.	Geographic Practice Cost Idx panel displays.

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6.219.6.2 To Add on the Geographic Practice Cost Idx Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Locality** from drop down list box.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Enter **Work**.	
6	Enter **Malpractice**.	
7	Enter **Practice Expense**.	
8	Click **Save**.	Geographic Practice Cost Idx information is saved.

6.219.6.3 To Update on the Geographic Practice Cost Idx Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Geographic Practice Cost Idx information is saved.

6.219.6.4 To Delete on the Geographic Practice Cost Idx Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.220 OTHER-MACOTC ADJUSTMENT FACTOR PANEL

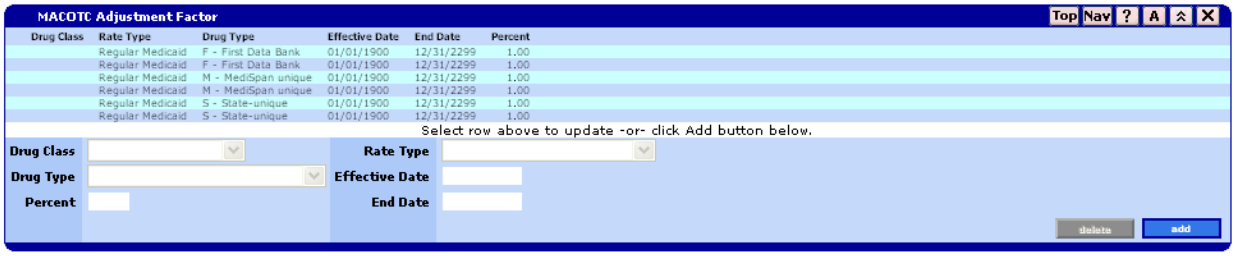
6.220.1 Other-MACOTC Adjustment Factor Panel Narrative

MAC prices for drugs with a class of "O" (Over the Counter) are multiplied by the MAC Percent to adjust payment amounts for providers. Over the Counter Drug MAC prices are normally adjusted upwards in order to persuade providers to use generic OTC drugs. (Maximum Allowed Cost Over The Counter).

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference - Related Data] - [Other] - [MACOTC Adjustment Factor]

6.220.2 Other-MACOTC Adjustment Factor Panel Layout



6.220.3 Other-MACOTC Adjustment Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Drug Class	Classifies a drug by its availability to the consumer according to federal specifications.	Combo Box	Drop Down List Box	0
Drug Type	This will indicate if the drug is State-unique (S), First Data Bank (F) supplied (is added and updated by them), MediSpan unique (M) from the old system or was added by the National Pro-DUR system (N).	Combo Box	Drop Down List Box	0
Effective Date	The date the MAC percentage becomes valid for drug pricing.	Field	Date (MM/DD/CCYY)	8
End Date	The date the MAC percentage is no longer valid for drug pricing.	Field	Date (MM/DD/CCYY)	8
Percent	Percent used to adjust the MAC price sent to us by First Data Bank for Over the Counter drugs.	Field	Number (Decimal)	3
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Combo Box	Drop Down List Box	0

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6.220.4 Other-MACOTC Adjustment Factor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Drug Class	Field	1	A valid Drug Class is required.	Select a valid Drug Class from Drop down list.
Drug Type	Field	1	Drug Type is required.	Select the Drug Type from the Drop Down list.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date. Format is MM/DD/CCYY.	Enter an Effective Date in MM/DD/CCYY format.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is post 01/01/1900.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter an End Date in MM/DD/CCYY format.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

6.220.5 Other-MACOTC Adjustment Factor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.220.6 Other-MACOTC Adjustment Factor Panel Accessibility

6.220.6.1 To Access the Other- MACOTC Adjustment Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **MACOTC Adjustment Factor**.	MACOTC Adjustment Factor panel displays.

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6.220.6.2 To Add on the Other- MACOTC Adjustment Factor Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Drug Class** from drop down list box.	
3	Select **Drug Type** from drop down list box.	
4	Enter **Percent**.	
5	Enter **Rate Type**.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date**.	
9	Click **Save**.	MACOTC Adjustment information is saved.

6.220.6.3 To Update on the Other- MACOTC Adjustment Factor Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	MACOTC Adjustment Factor information is saved.

6.220.6.4 To Delete on the Other- MACOTC Adjustment Factor Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.221 OTHER – MIN / MAX UNITS

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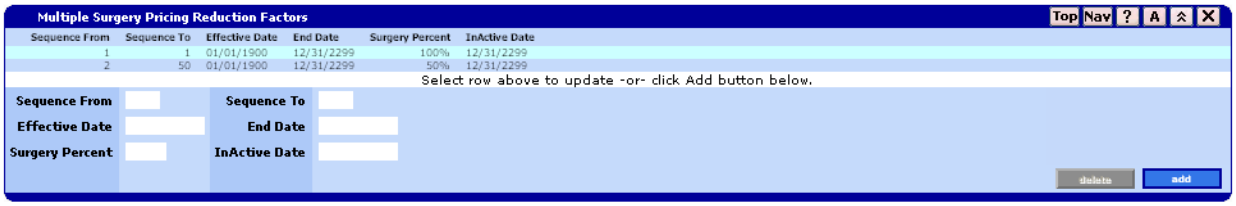
6.222 OTHER-MULTIPLE SURGERY PRICING REDUCTION FACTOR PANEL

6.222.1 Other-Multiple Surgery Pricing Reduction Factor Panel Narrative

This panel contains the records of Multiple Surgery Pricing Reduction factors. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference - Related Data] - [Other] - [Multiple Surgery Pricing Reduction Factors]

6.222.2 Other-Multiple Surgery Pricing Reduction Factor Panel Layout



6.222.3 Other-Multiple Surgery Pricing Reduction Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new record.	Button	N/A	0
Delete	Allows user to delete a record.	Button	N/A	0
Effective Date	The Effective Date when a percentage for multiple surgeries is in effect for claim processing.	Field	Date (MM/DD/CCYY)	8
End Date	The End Date when a percentage for multiple surgeries is no longer in effect for claim processing.	Field	Date (MM/DD/CCYY)	8
InActive Date	This is the date the row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than this date, the row will not be used to process the claim.	Field	Date (MM/DD/CCYY)	8
Sequence From	The beginning sequence to use to price a service for multiple surgeries.	Field	Number (Integer)	3
Sequence To	The ending sequence to use to price a service for multiple surgeries.	Field	Number (Integer)	3
Surgery Percent	The percentage to use to price a service for multiple surgeries.	Field	Number (Decimal)	3

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6.222.4 Other-Multiple Surgery Pricing Reduction Factor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is post 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
InActive Date	Field	1	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
Sequence From	Field	1	Sequence From is required.	Enter Sequence From.
Sequence To	Field	1	Sequence To is required.	Enter Sequence To.

6.222.5 Other-Multiple Surgery Pricing Reduction Factor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.222.6 Other-Multiple Surgery Pricing Reduction Factor Panel Accessibility

6.222.6.1 To Access the Other- Multiple Surgery Pricing Reduction Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.

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Step	Action	Response
4	Select **Multiple Surgery Pricing Reduction Factor**.	Multiple Surgery Pricing Reduction Factor panel displays.

6.222.6.2 To Add on the Other- Multiple Surgery Pricing Reduction Factor Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Sequence From**.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **Surgery Percent**.	
5	Enter **Sequence To**.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Enter **Inactive Date**.	
9	Click **Save**.	

6.222.6.3 To Update on the Other-Multiple Surgery Pricing Reduction Factor Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Multiple Surgery Pricing Reduction Factor information is saved.

6.222.6.4 To Delete on the Other-Multiple Surgery Pricing Reduction Factor Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.223 OTHER – NCCI MEDICALLY UNLIKELY (MUE) PANEL

6.223.1 Other – NCCI Medically Unlikely (MUE) Panel Narrative

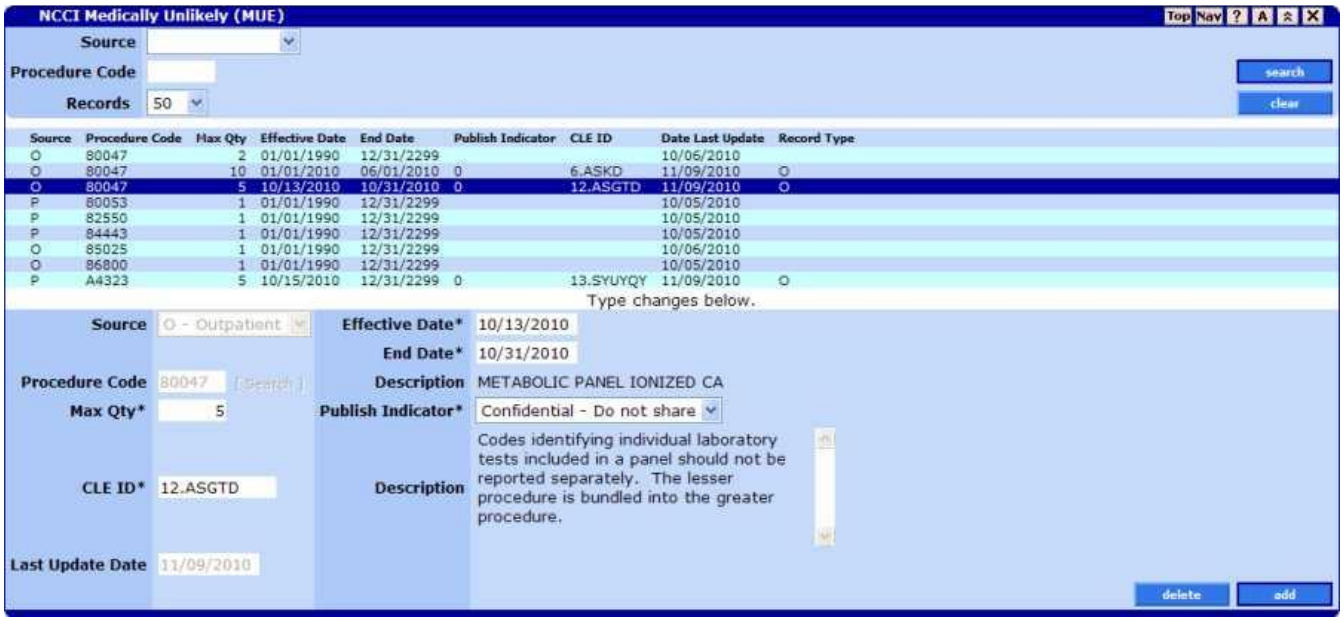
The NCCI Medically Unlikely (MUE) panel is used to view and maintain the reference NCCI MUE and NCCI MUE Override tables.

This table contains the override information for the Medicaid NCCI (National Correct Coding Information) MUE (Medically Unlikely Edits). Coupled with the information in the table T_REF_CCI_MUE_OVERRIDE, these edit pairs drive the claims NCCI MUE editing function.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [NCCI Procedure To Procedure]

6.223.2 Other – Medically Unlikely (MUE) Panel Layout



6.223.3 Other – Medically Unlikely (MUE) Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new entry.	Button	N/A	0
Clear	Clear the search criteria.	Button	N/A	0
Delete	Deletes the entry	Button	N/A	0
Search	Triggers the panel to start a search using the provided criteria.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Publish Indicator	This field corresponds to Field 5 of the NCCI MUE data, containing the publication indicator. The valid values are 0 (confidential - do not share) and 1(published - ok to share).	Combo Box	Character	1
Source	This system assigned code indicates the NCCI source file for the data.	Combo Box	Character	1
CLE ID	This field corresponds to Field 6 on the NCCI data, containing the CLE ID (Correspondence Language Example Identification Number).	Field	Character	12
Effective Date	This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.	Field	Date (MM/DD/CCYY)	8
End Date	This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.	Field	Date (MM/DD/CCYY)	8
Last Updated Date	This date shows when this row was created or last modified, due to an alteration in the NCCI data.	Field	Date (MM/DD/CCYY)	8
Max Qty	This column corresponds to Field 2 of the NCCI MUE data. This field contains the maximum units allowed for the procedure.	Field	Number (Integer)	5
Procedure Code	This column corresponds to Field 1of the NCCI MUE data. This procedure code contains the procedure code to which the MUE should be applied.	Field	Character	6
Rec Type	Record Type. This field indicates the record comes from the override table when its value is an “O”. When no value it indicates it comes from the NCCI table.	Field	Character	1

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6.223.4 Other – Medically Unlikely (MUE) Panel Field Descriptions

Field	Field Type	Error Code	Error Message	To Correct
CLEID	Field	1	CLEID must have at least the format ##.A. Where # is number, A = Alphanumeric. Please verify.	Enter a valid string. First string has to match a valid Standard Policy ID and must be Numeric. Second part must be Alphanumeric.
	Field	2	CLEID's Standard Policy does not exist. Please verify.	Enter a valid CLEID. First string has to match a valid Standard Policy ID and must be Numeric.
	Field	3	CLEID is required.	Enter a valid CLE ID.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	Sys1*	Invalid Date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	Sys2*	Effective Date must be less than or equal to 12/31/2299.	Enter Effective Date that is less than or equal to 12/31/2299.
	Field	Sys3*	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	Sys1*	Invalid Date.	Enter an End Date in MM/DD/CCYY format.
	Field	Sys2*	End Date must be less than or equal to 12/31/2299.	Enter End Date that is less than or equal to 12/31/2299.
	Field	Sys3*	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an End Date greater or equal to Effective Date.
	Field	3	Dates for records CMS Code:X, Proc Code: XXXXX cannot overlap.	Enter valid dates for the new entry. Dates cannot overlap if the fields indicated match an existing record.
Procedure Code	Field	1	Procedure Code does not exist. Please verify.	Enter a valid Procedure Code. The codes for this column come from the Procedure Panel.
	Field	2	Greater Proc Code is required.	Enter a valid Procedure Code. The codes for this column come from the Procedure Panel.

* System Generated

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6.223.5 Other – Medically Unlikely (MUE) Panel Field Descriptions

Field	Field Type
No Extra Features.	

6.223.6 Other – Medically Unlikely (MUE) Panel Accessibility

6.223.6.1 To Access the Other-Medically Unlikely (MUE) Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Medically Unlikely (MUE)**.	Medically Unlikely (MUE) panel displays.

6.223.6.2 To Add on the Other-Medically Unlikely (MUE) Panel

Step	Action	Response
1.	Click **Add**.	Activates fields for entry of data or selection from lists.
2.	Select a value from the Source Dropdown box.	
3.	Enter a valid procedure code in the Procedure Code field.	
4.	Select a valid amount in the Max Qty amount field.	
5.	Enter a valid CLE ID.	Format is ##.AAA where #=numeric, A=Alphanumeric.
6.	Enter **End Date** in MM/DD/CCYY format.	Make sure it is older or equal to Effective date.
7.	Select a value from the Publish Indicator Dropdown box.	
8.	Click **Save**. Last Update Date is automatically generated.	Medically Unlikely (MUE) information is saved.

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6.223.6.3 To Update on the Other-Medically Unlikely (MUE) Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click on desired field to update and perform the update.	
3	Click **Save**.	Medically Unlikely (MUE) information is saved.

6.223.6.4 To Delete on the Other-Medically Unlikely (MUE) Panel

Step	Action	Response
1	Click line item to be deleted*.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

* Keep in mind that items to be deleted must not have been overridden.

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6.224 OTHER – NCCI PROCEDURE TO PROCEDURE PANEL

6.225 OTHER – NCCI PROCEDURE TO PROCEDURE PANEL NARRATIVE

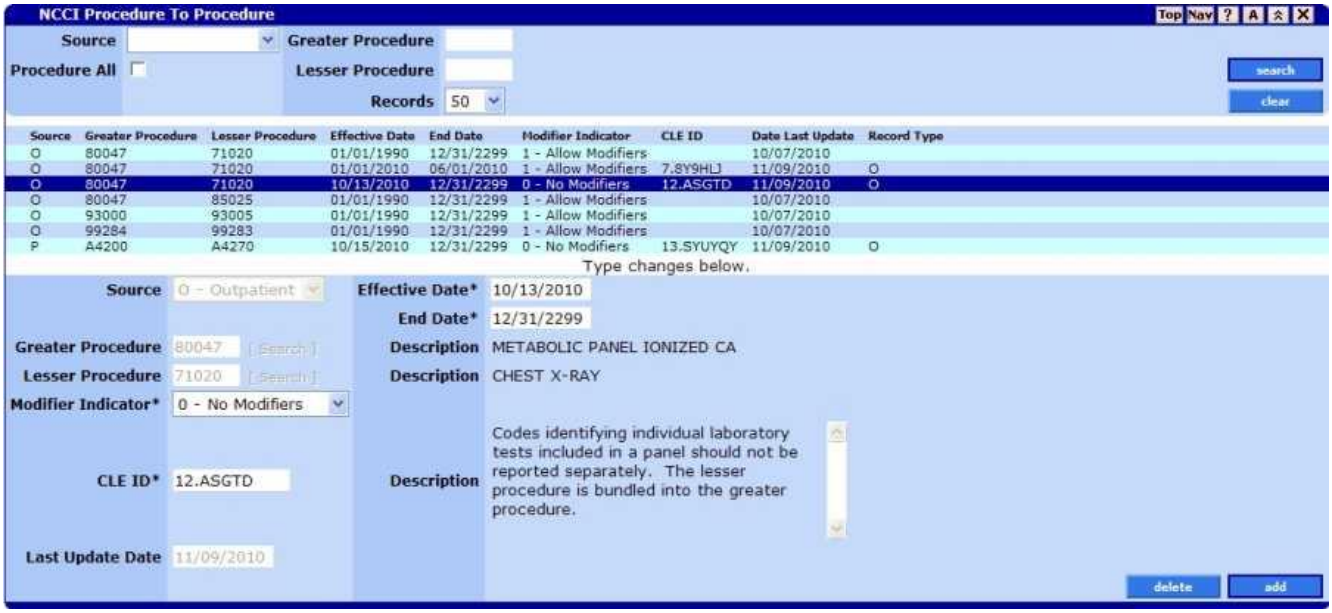
The Procedure to Procedure panel is used to view and maintain the reference NCCI and NCCI Override tables.

These tables contain the Medicaid NCCI (National Correct Coding Information) Procedure-to-Procedure data. This Data consists of Procedure code edit pairs. When coupled with the override information in T_REF_CCI_OVERRIDE, these edit pairs drive the claims NCCI editing function.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [NCCI Procedure To Procedure]

6.225.1 Other – Procedure to Procedure Panel Layout



6.225.2 Other – Procedure to Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new entry.	Button	N/A	0
Clear	Clear the search criteria.	Button	N/A	0
Delete	Deletes the entry	Button	N/A	0
Search	Triggers the panel to start a search using the provided criteria.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Procedure All	Searches Procedure codes in both, the Greater and Lesser Procedure fields.	Check Box	N/A	0
Modifier Indicator	This field corresponds to Field 7 on the NCCI database, containing the GB Modified Indicator. The valid values are: 0, 1, 9.	Combo Box	Character	1
Source	This system assigned code indicates the NCCI source file for the data.	Combo Box	Character	1
CLE ID	This field corresponds to Field 6 on the NCCI data, containing the CLE ID (Correspondence Language Example Identification Number).	Field	Character	12
Effective Date	This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.	Field	Date (MM/DD/CCYY)	8
End Date	This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.	Field	Date (MM/DD/CCYY)	8
Greater Proc Code	This column corresponds to Field 1 on the NCCI data. This procedure code represents the More Important service that should be paid when the code pair is billed together.	Field	Character	6
Last Updated Date	This date shows when this row was created or last modified, due to an alteration in the NCCI data.	Field	Date (MM/DD/CCYY)	8
Lesser Proc Code	This column corresponds to Field 2 on the NCCI data. This procedure code represents the Less Important service that should be denied when the code pair is billed together.	Field	Character	6
Rec Type	Record Type. This field indicates the record comes from the override table when its value is an “O”. When no value it indicates it comes from the NCCI table.	Field	Character	1

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6.225.3 Other-Procedure to Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Procedure All	Check Box	1	If Procedure All is selected, a valid procedure code is required.	Please enter the Procedure Code to search for.
CLEID	Field	1	CLEID must have at least the format ##.A. Where # is number, A = Alphanumeric. Please verify.	Enter a valid string. First string has to match a valid Standard Policy ID and must be Numeric. Second part must be Alphanumeric.
	Field	2	CLEID's Standard Policy does not exist. Please verify.	Enter a valid CLEID. First string has to match a valid Standard Policy ID and must be Numeric.
	Field	3	CLEID is required.	Enter a valid CLE ID.
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	Sys1*	Invalid Date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	Sys2*	Effective Date must be less than or equal to 12/31/2299.	Enter Effective Date that is less than or equal to 12/31/2299.
	Field	Sys3*	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
End Date	Field	1	End Date is required.	Enter a valid End Date.
	Field	Sys1*	Invalid Date.	Enter an End Date in MM/DD/CCYY format.
	Field	Sys2*	End Date must be less than or equal to 12/31/2299.	Enter End Date that is less than or equal to 12/31/2299.
	Field	Sys3*	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an End Date greater or equal to Effective Date.
	Field	3	Dates for records CMS Code: X, Greater Proc: XXXXX, Lesser Proc: XXXXX cannot overlap.	Enter valid dates for the new entry. Dates cannot overlap if the fields indicated match an existing record.

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Field	Field Type	Error Code	Error Message	To Correct
Greater Proc Code	Field	1	Greater Procedure Code does not exist. Please verify.	Enter a valid Procedure Code. The codes for this column come from the table t_proc.cde_proc.
	Field	2	Greater Proc Code is required.	Enter a valid Greater Proc Code.
Lesser Proc Code	Field	1	A valid Lesser Proc Code is required.	Select a procedure code.
	Field	2	Greater Proc Code is required.	Enter a valid Greater Proc Code.

* System Generated

6.225.4 Other – Procedure to Procedure Panel Extra Features

Field	Field Type
No Extra Features.	

6.225.5 Other – Procedure to Procedure Panel Accessibility

6.225.5.1 To Access the Other-Procedure to Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Procedure to Procedure**.	Procedure to Procedure panel displays.

6.225.5.2 To Add on the Other-Procedure to Procedure Panel

Step	Action	Response
1.	Click **Add**.	Activates fields for entry of data or selection from lists.
2.	Select a value from the Source Dropdown box.	
3.	Enter a valid Procedure Code in the Greater Procedure Code.	
4.	Enter a valid Procedure Code in the Lesser Procedure Code Procedure Code.	
5.	Select a Modifier Indicator from the dropdown box.	

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Step	Action	Response
6.	Enter a valid CLE ID.	Format is ##.AAA where #=numeric, A=Alphanumeric.
7.	Enter **End Date** in MM/DD/CCYY format.	Make sure it is older or equal to Effective date.
8.	Click **Save**. Last Update Date is automatically generated.	Procedure to Procedure information is saved.

5.138.1.1 To Update on the Other-Procedure to Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click on desired field to update and perform the update.	
3	Click **Save**.	Procedure to Procedure information is saved.

5.138.1.2 To Delete on the Other-Procedure to Procedure Panel

Step	Action	Response
1	Click line item to be deleted*.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

* Keep in mind that items to be deleted must not have been overridden.

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6.226 OTHER – PDL MAINTENANCE PANEL

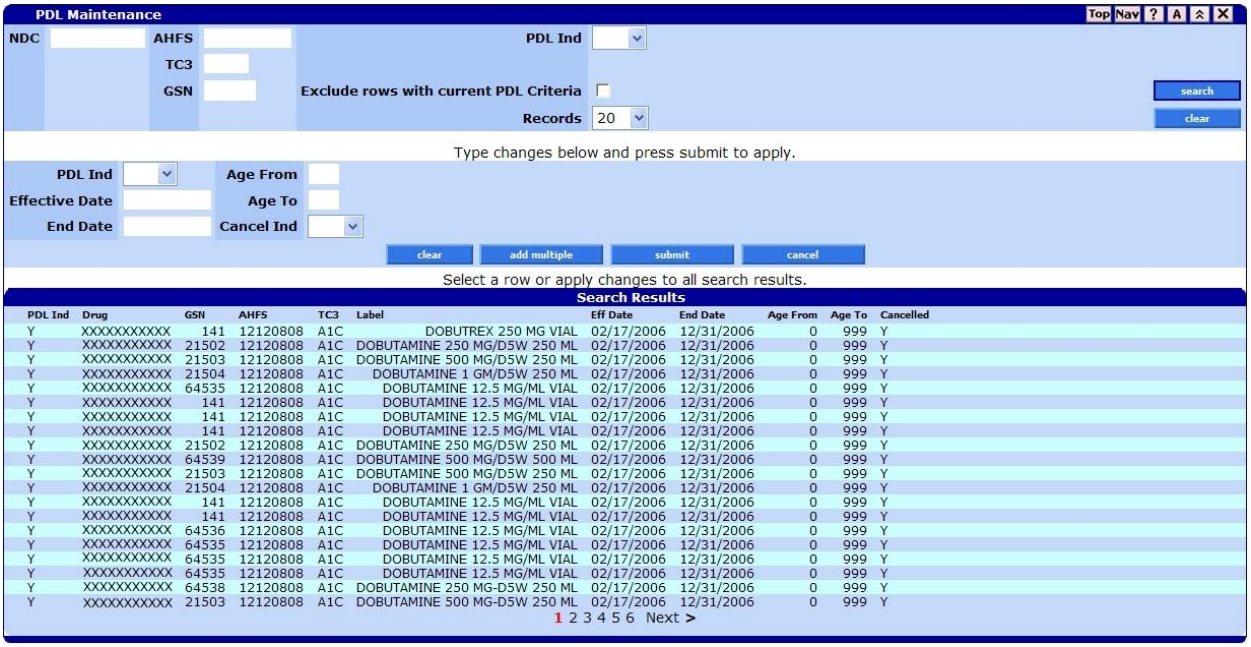
6.226.1 Other – PDL Maintenance Panel Narrative

The PDL Maintenance panel is used to maintain PDL Preferred status. With this panel the time to maintain and keep PDL drugs in order is reduced. In addition, the processing of drugs becomes more effective and accurate. This panel also helps to reduce issues when researching information about the drug.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [PDL Maintenance]

6.226.2 Other – PDL Maintenance Panel Layout



6.226.3 Other – PDL Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add Multiple	Inserts a new PDL record for each of the records displayed in the Search Results.	Button	N/A	0
Age From	The minimum age on the date of service that the NDC is covered with the PDL.	Field	Number (Integer)	3
Age To	The maximum age on the date of service that the NDC is covered within the PDL.	Field	Number (Integer)	3

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Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
Cancel	Cancels all user actions including the selection of single rows for edit.	Button	N/A	0
Cancelled/ Cancel Ind	Indicates the PDL status for the NDC. If the status for the Cancel Indicator is Yes, record is cancelled from PDL.	Combo Box	Drop Down Lists Box	1
Clear	Clears all the fields in the panel.	Button	N/A	0
Effective Date	First date the PDL status is effective for the NDC.	Field	Date (MM/DD/CCYY)	8
End Date	Date that PDL status is no longer effective.	Field	Date (MM/DD/CCYY)	8
Exclude Rows	Restricts the search to return only those drugs without any PDL History records.	Check Box	N/A	0
GSN	The Generic Code Number Sequence Number is a unique number representing a generic formulation. It is specific to the generic ingredient(s), route of administration, and drug strength. It is the same across manufacturers.	Field	Number (Integer)	6
Label	Combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.	Field	Character	40
NDC / Drug	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4-digit product code, and a 2-digit package code.	Field	Character	11
PDL Ind	Preferred Indicator. Indicates the PDL Status of the NDC. Example: Whether the drug or drug product is preferred (Y) or non-preferred (N).	Combo Box	Drop Down Lists Box	1
Search	Performs the search based on the Criteria entered.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Submit	Processes the updates or insertions of PDL records.	Button	N/A	0
TC3	Therapeutic Class Code, Specific (GC3, Alias HIC3) The most specific therapeutic class code offered by First DataBank intended for users who need a very definitive therapeutic classification system.	Field	Character	3

6.226.4 Other – PDL Maintenance Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Add Multiple	Data	1	New PDL cannot be added because its dates overlap with an existing record.	Make sure dates do not overlap with an existing non-cancelled record.
Age From	Field	1	Age From must be less or equal to Age To.	Enter an Age From less than or equal than Age To.
AHFS	Field	1	AHFS must be numeric. Please enter a valid value.	Enter a numeric AHFS.
Effective Date	Field	1	Effective Date must be earlier or the same than End Date.	Enter an Effective Date that is earlier or equal to the End Date.
GSN	Field	1	GSN must be numeric. Please enter a valid value.	Enter a numeric GSN.
Submit	Data	1	New PDL cannot be added because its dates overlap with an existing record.	Make sure dates do not overlap with an existing non-cancelled record.
		2	PDL cannot be updated because its dates overlap with an existing record.	Make sure dates do not overlap with an existing non-cancelled record.
TC3	Field	1	TC3 must be Alphanumeric. Please enter a valid value.	Do not allow strange symbols in the TC3 field.

6.226.5 Other – PDL Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.226.6 Other – PDL Maintenance Panel Accessibility

6.226.6.1 To Access the Other – PDL Maintenance Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **PDL Maintenance**	PDL Maintenance panel displays.

6.226.6.2 To Add on the Other – PDL Maintenance Panel

Step	Action	Response
1	Enter the search criteria and press the **Search** button.	Brings all records that match the criteria entered.
2	If you want to add a new PDL record for a specific drug, select the drug from the **Search Results** panel.	
3	Press the **Add Multiple** button.	The entry panel is populated with the Default values.
2	Enter the necessary information in the entry panel.	
4	Click the **Submit** button.	The new PDL record is saved.

6.226.6.3 To Update on the Other – PDL Maintenance Panel

Step	Action	Response
1	Enter the search criteria and press the **Search** button.	Brings all records that match the criteria entered.
2	If you want to modify a specific PDL record, select the record to be edited from the **Search Results** panel.	
2	Enter the necessary information in the entry panel.	
4	Click the **Submit** button.	The PDL record or records are updated.

6.226.6.4 To Delete on the Other - PDL Maintenance Panel

This panel does not delete PDL records.

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6.227 OTHER – PDL SCREENING CRITERIA PANEL

6.227.1 Other – PDL Screening Criteria Panel Narrative

The PDL Screening Criteria panel is used to maintain Drugs Screening Criteria based on their AHFS, TC3 or GSN. If the Drug's ALGI property changes to indicate the Drug should be preferred or not preferred; the PDL History logic will review if the drug matches any of these criteria, and will adjust the PDL segment accordingly.

This criteria will also be used in the batch Weekly FDB update programs to maintain the PDL master file.

This criteria should handle new drug additions, along with drug updates.

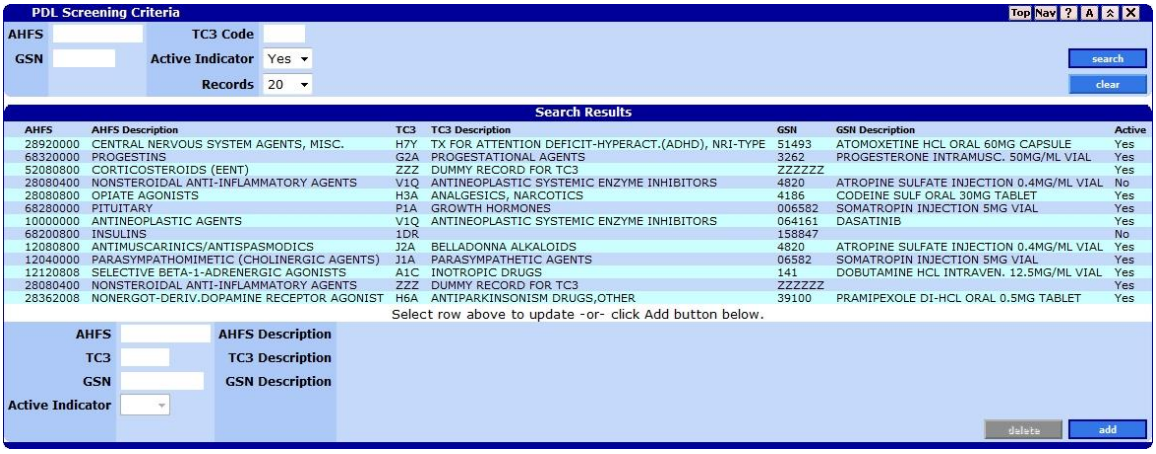
Value 'Y' indicates criteria is active and 'N' indicates criteria is no longer active.

With this panel the time to maintain and keep PDL screening Criteria is reduced.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [PDL Screening Criteria]

6.227.2 Other – PDL Screening Criteria Panel Layout



6.227.3 Other – PDL Screening Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Indicator	Indicator to identify the criteria if its active or not. Value 'Y' indicates criteria is active and 'N' indicates criteria is no longer active.	Combo Box	N/A	0
Add	Adds a new PDL Criteria record.	Button	N/A	0
AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10

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Field	Description	Field Type	Data Type	Length
AHFS Description (read-only)	Text description for AHFS Therapeutic Code.	Field	Character	40
Clear	Clears the search criteria.	Button	N/A	0
Delete	Deletes the selected PDL Criteria record from the DB.	Button	N/A	0
GSN	The Generic Code Number Sequence Number is a unique number representing a generic formulation. It is specific to the generic ingredient(s), route of administration, and drug strength. It is the same across manufacturers.	Field	Character	6
GSN Description	Text description for GSN Formulation Code.	Field	Character	60
Records	Indicates the number of records the search result panel will display in each page.	Combo Box	N/A	0
Search	Searches the PDL Screening Criteria table for records that match the AHFS provided. If AHFS is blank, it will bring all records in the table.	Button	N/A	0
TC3	Therapeutic Class Code, Specific (GC3, Alias HIC3). The most specific therapeutic class code offered by First DataBank intended for users who need a very definitive therapeutic classification system.	Field	Character	3
TC3 Description	Text description for TC3 Code.	Field	Character	60

6.227.4 Other – PDL Screening Criteria Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS	Field	1	AHFS code was not found, please verify.	Enter a valid AHFS code.
TC3	Field	1	Provided TC3 Code does not exist. Please verify.	Enter a valid Therapeutic code or ZZZ as wildcard.
TC3	Field	2	TC3 cannot be empty.	Enter a three alphanumeric Therapeutic code or ZZZ as wildcard.

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Field	Field Type	Error Code	Error Message	To Correct
TC3	Field	3	TC3 has to contain three alphanumeric characters, please verify.	Enter a three alphanumeric Therapeutic code or ZZZ as wildcard.
GSN	Field	1	Provided GSN is not on file. Please verify.	Enter a valid numeric GSN code or enter ZZZZZZ as wildcard.
GSN	Field	2	GSN cannot be empty.	Enter a valid numeric GSN code or enter ZZZZZZ as wildcard.
GSN	Field	3	GSN has to be numeric, or has to be the PDL Screening Criteria Wildcard.	Enter a valid numeric GSN code or enter ZZZZZZ as wildcard.

6.227.5 Other – PDL Screening Criteria Panel Accessibility

6.227.5.1 To Access the Other – PDL Screening Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select the **PDL Screening Criteria panel** link.	PDL Screening panel displays.

6.227.5.2 To use the search function – PDL Screening Criteria Panel

Step	Action	Response
1	Navigate to the Other – PDL Screening Criteria panel.	The Other – PDL Screening Criteria panel appears.
2	Enter a specific AHFS.	
3	Alternatively, the AHFS can be left blank.	All matching PDL Screening Criteria records will be displayed.
4	Enter a specific TC3.	
5	Alternatively, the TC3 can be left blank.	All matching PDL Screening Criteria records will be displayed.
6	Enter a specific GSN.	
7	Alternatively, the GSN can be left blank.	All matching PDL Screening Criteria records will be displayed.

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Step	Action	Response
8	Select a value for the Active Indicator, it can be Yes, No, or blank. Blank brings all values.	All matching PDL Screening Criteria records will be displayed.
9	(Optional) Select the number of rows you want to display on each page of Search Results.	The selected number or records will be displayed in the Search Results panel.
10	Click the **Search** button.	The panel brings all the records that matches the provided AHFS.

6.227.5.3 To Add on the Other – PDL Screening Criteria Panel

Step	Action	Response
1	Press the **Add** button.	A new blank record is shown.
2	Add all necessary information in all required fields.	
3	Click the **Save** button from the Related Data panel.	The new PDL Screening Criteria record is saved.

6.227.5.4 To Update on the Other – PDL Screening Criteria Panel

Step	Action	Response
1	Select a record from the Datalist.	The record's data is populated in the panel.
2	Modify the desired field(s) in the data panel.	
3	Click the **Save** button from the Related Data panel..	The PDL Screening Criteria record is updated.

6.227.5.5 To Delete on the Other - PDL Screening Criteria Panel

Step	Action	Response
1	Select a record from the Datalist.	The record's data is populated in the panel.
2	Click the **Delete** button.	A confirmation panel appears.
3	Press **OK** to confirm the deletion.	The PDL Screening Criteria record is deleted.

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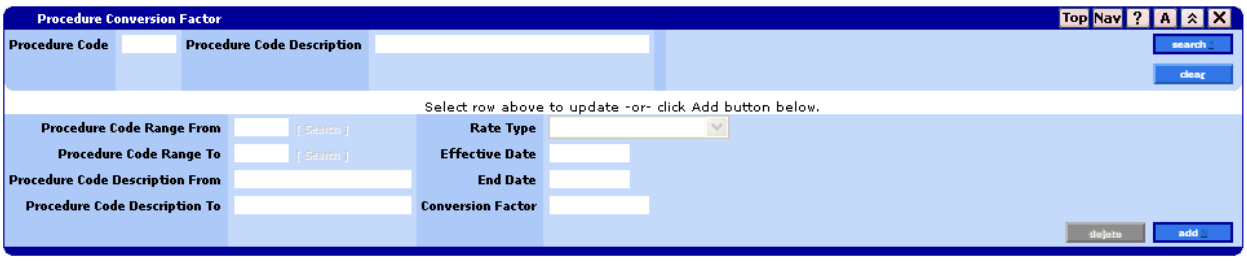
6.228 OTHER-PROCEDURE CONVERSION FACTOR PANEL

6.228.1 Other-Procedure Conversion Factor Panel Narrative

The Procedure Conversion Factor panel is used to assign a procedure specific conversion factor to be used in place of the "system-wide" conversion factor. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [Procedure Conversion Factor]

6.228.2 Other-Procedure Conversion Factor Panel Layout



6.228.3 Other-Procedure Conversion Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add assign a procedure specific conversion factor.	Button	N/A	0
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Conversion Factor	Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations. Format is 99999.9999.	Field	Number (Decimal	9
Delete	Delete a procedure specific conversion factor.	Button	N/A	0
Effective Date	Date a procedure conversion factor becomes valid for use in claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	Date a conversion factor is no longer valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Procedure Code	Code that identifies a specific procedure. The user may enter all or part of the Procedure Code.	Field	Character	6

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Field	Description	Field Type	Data Type	Length
Procedure Code Description	Text description of the Procedure Code. The user may enter all or part of the description.	Field	Character	40
Procedure Code Range Description From	Description of the Procedure Code From.	Field	Character	40
Procedure Code Range Description To	Description of the Procedure Code To.	Field	Character	40
Procedure Code Range From [Search]	Lower limit of the procedure code range for the conversion factor.	Hyperlink	N/A	0
Procedure Code Range To [Search]	Upper limit of the procedure code range for the conversion factor.	Hyperlink	N/A	0
Rate Type	Code used to identify the rate type to use in determining provider reimbursement.	Combo Box	Drop Down List Box	0
Search	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0

6.228.4 Other-Procedure Conversion Factor Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Conversion Factor	Field	1	Conversion Factor must be greater than zero.	Enter a Conversion Factor that is greater than zero.
	Field	2	Conversion Factor is required.	Conversion Factor must have a value.
Effective Date	Field	1	Procedure Range segments may not overlap.	Correct overlap condition. Code and Date ranges cannot overlap for the same rate type.
	Field	2	Effective Date is required.	Enter an Effective Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Invalid Date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to End Date.	Enter an Effective Date must be less than or equal to End Date.
	Field	5	Effective Date must be greater than or equal to 01/01/1900	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid Date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Procedure Code Range From [Search]	Hyperlink	1	A valid Procedure Code Range From is required.	Select a Procedure Code From.
	Hyperlink	2	From Procedure may not be greater than To Procedure.	Enter a valid Procedure range.
Procedure Code Range To [Search]	Hyperlink	1	A valid Procedure Code Range To is required.	Select a valid Procedure Code To.
Rate Type	Field	2	A valid Rate Type is required.	Rate Type must have a valid value.

6.228.5 Other-Procedure Conversion Factor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.228.6 Other-Procedure Conversion Factor Panel Accessibility

6.228.6.1 To Access the Other-Procedure Conversion Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other pagedisplays.
4	Select **Procedure Code Bundling**.	Procedure Conversion Factor panel displays.

6.228.6.2 To Add on the Other-Procedure Conversion Factor Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Procedure Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Procedure Code Range From information is displayed on panel.
4	Select **Procedure Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Procedure Code Range To information is displayed on panel.
6	Select **Procedure Code Description From** by clicking [Search] button.	
7	Enter search criteria. User may also select a row from the list of search results.	Procedure Code Description Range From information is displayed on panel.
8	Select **Procedure Code Description To** by clicking [Search] button.	
9	Enter search criteria. User may also select a row from the list of search results.	Procedure Code Description Range To information is displayed on panel.
10	Select **Rate Type** from drop down list box.	
11	Enter **Effective Date** in MM/DD/CCYY format.	
12	Enter **End Date** in MM/DD/CCYY format.	

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Step	Action	Response
13	Enter **Conversion Factor**.	
14	Click **Save**. Last Update Date is automatically generated.	Procedure Conversion Factor information is saved.

6.228.6.3 To Update on the Other-Procedure Conversion Factor Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Procedure Conversion Factor information is saved.

6.228.6.4 To Delete on the Other-Procedure Conversion Factor Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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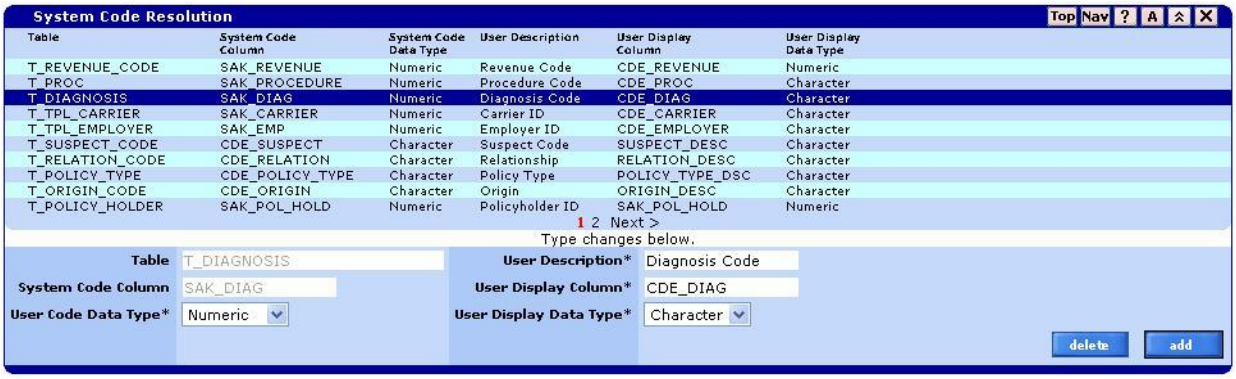
6.229 OTHER-SYSTEM CODE RESOLUTION PANEL

6.229.1 Other-System Code Resolution Panel Narrative

This System Code Resolution panel is used to maintain the valid list of all System Code Resolution records. This table is used to resolve system assigned keys to the user's online value. It is used in conjunction with the audit trail system to automate the viewing of what a SAK value is defining. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Other] - [System Code Resolution]

6.229.2 Other-System Code Resolution Panel Layout



6.229.3 Other-System Code Resolution Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a System Code Resolution.	Button	N/A	0
Delete	Allows the user to delete a code (or code range) from the selected System Code Resolution Type	Button	N/A	0
System Code Column	Key field used to retrieve a system key.	Field	Character	18
System Code Data Type	Used to identify data type of the system code.	Combo Box	Drop Down List Box	0
Table	Name of the Physical Database Table.	Field	Character	32
User Description	Description of the system key field.	Field	Character	18
User Display Column	Value that is returned.	Field	Character	18
User Display Data Type	Used to identify the data type of the user display field.	Combo Box	Drop Down List Box	0

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6.229.4 Other-System Code Resolution Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
System Code Column	Field	1	System Code Column is required.	Enter the System Code Column for the Table.
System Code Data Type	Field	1	System Code Data type is required.	Select the System Code Data Type from the Drop Down Box.
Table	Field	1	Table is required.	Enter an Oracle Table name.
User Description	Field	1	User Description is required.	Enter a User Description of the Table.
User Display Column	Field	1	User Display Column is required.	Enter the User Display column for the Table.
User Display Data Type	Field	1	User Display Data Type is required.	Select the User Display Data Type from the Drop Down Box.

6.229.5 Other-System Code Resolution Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.229.6 Other-System Code Resolution Panel Accessibility

6.229.6.1 To Access the Other-System Code Resolution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **System Code Resolution**.	System Code Resolution panel displays.

6.229.6.2 To Add on the Other-System Code Resolution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Table**.	
3	Enter **System Code Column**.	
4	Select **System Code Data Type** from drop down list box.	

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Step	Action	Response
5	Enter **User Description**.	
6	Enter **User Display Column**.	
7	Select **User Display Data Type** from drop down list box.	
8	Click **Save**.	System Code Resolution information is saved.

6.229.6.3 To Update on the Other-System Code Resolution Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	System Code Resolution information is saved.

6.229.6.4 To Delete on the Other-System Code Resolution Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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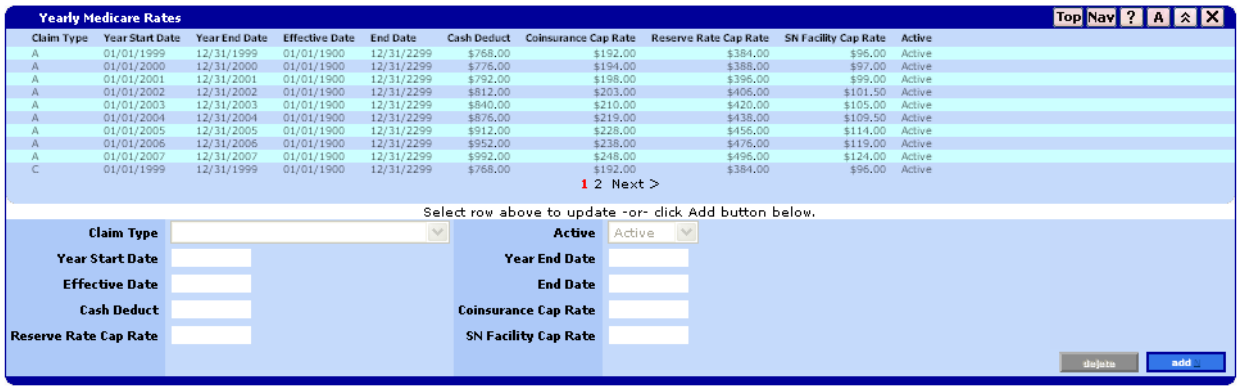
6.230 OTHER-YEARLY MEDICARE RATES PANEL

6.230.1 Other-Yearly Medicare Rates Panel Narrative

This panel contains the yearly Medicare deductible for Part A & Part B claims. It currently holds the Medicare yearly cash deductible for the specific years for a specific claim type. The changes proposed will allow for fields to hold the maximum coinsurance cap, lifetime reserve rate capitation and skilled nursing facility capitation for the specific year for the specific claim type (A or B). Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference - Related Data] - [Other] - [Yearly Medicare Rates]

6.230.2 Other-Yearly Medicare Rates Panel Layout



6.230.3 Other-Yearly Medicare Rates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active	Indicates whether the record is active or not. Only active rows are used in determining the Medicare deductible.	Combo Box	Drop Down List Box	0
Add	Allows user to add a new record in Yearly Medicare Rates panel.	Button	N/A	0
Cash Deduct	The maximum yearly cash deductible for the specified claim type.	Field	Number (Decimal)	6
Claim Type	Code that specifies the type of claim record which resides in the specified location.	Combo Box	Drop Down List Box	0
Coinsurance Cap Rate	The maximum yearly Medicare approved Inpatient Coinsurance Cap Rate.	Field	Number (Decimal)	6
Delete	Allows user to delete a record in Yearly Medicare Rates panel.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Effective Date	The first date to which the yearly deductible amount becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The last date to which the yearly deductible amount is effective.	Field	Date (MM/DD/CCYY)	8
Reserve Rate Cap Rate	The maximum yearly Medicare approved Lifetime Reserve Rate Cap Rate.	Field	Number (Decimal)	6
SN Facility Cap Rate	The maximum yearly Medicare approved Skilled Nursing Facility Cap Rate.	Field	Number (Decimal)	6
Year End Date	This field will be set to December 31 of the effected year.	Field	Date (MM/DD/CCYY)	8
Year Start Date	This field will be set to January 01 of the effected year.	Field	Date (MM/DD/CCYY)	8

6.230.4 Other-Yearly Medicare Rates Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required	Select Claim Type from Drop down list.
Effective Date	Field	1	Effective Date is required.	Enter a valid effective date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter a valid end date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is post 01/01/01900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
Year End Date	Field	1	Year End Date is required.	Enter date in Year End Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.
Year Start Date	Field	1	Year Start Date is required.	Enter date in Year Start Date.
	Field	2	Invalid date. Format is MM/DD/CCYY.	The date must be in MM/DD/CCYY format.

6.230.5 Other-Yearly Medicare Rates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.230.6 Other-Yearly Medicare Rates Panel Accessibility

6.230.6.1 To Access the Other- Yearly Medicare Rates Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.
4	Select **Yearly Medicare Rates.**	Yearly Medicare Rates panel displays.

6.230.6.2 To Add on the Other- Yearly Medicare Rates Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Claims Type** from drop down list box.	
3	Enter **Year Start Date**.	
4	Enter **Effective Date**.	
5	Enter **Cash Deduct**.	
6	Enter **Reserve Rate Cap Rate**.	
7	Select **Active** from drop down list box.	
8	Enter **Year End Date**.	
9	Enter **End Date**.	

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Step	Action	Response
10	Enter **Coinsurance Cap Rate**.	
11	Enter **SN Facility Cap Rate**.	
12	Click **Save**.	Yearly Medicare Rates information is saved.

6.230.6.3 To Update on the Other- Yearly Medicare Rates Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Yearly Medicare Rates information is saved.

6.230.6.4 To Delete on the Other- Yearly Medicare Rates Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.231 REFERENCE RELATED DATA RPT DIST PAGE

6.231.1 Reference Related Data Rpt Dist Page Narrative

The Reference Related Data Rpt Dist page allows the user to access the report routing distribution data maintained within the Reference Data Maintenance subsystem area.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Rpt Dist]

6.231.2 Reference Related Data Rpt Dist Page Layout

6.231.3 Reference Related Data Rpt Dist Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel a request.	Button	N/A	0
Report	Link to the Report panel.	Hyperlink	N/A	0
Report Control	Link to the Report Control panel.	Hyperlink	N/A	0
Report Destination	Link to the Report Destination panel.	Hyperlink	N/A	0
Report Recipient	Link to the Report Recipient panel.	Hyperlink	N/A	0
Report Route	Link to the Report Route panel.	Hyperlink	N/A	0
Save	Allows the user to save a request.	Button	N/A	0

6.231.4 Related Data Rpt Dist Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.231.5 Reference Related Data Rpt Dist Page Extra Features

Field	Field Type
No extra features found for this panel.	

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6.231.6 Reference Related Data Rpt Dist Page Accessibility

6.231.6.1 To Access the Related Data Rpt Dist Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist page displays.

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6.232 RPT DIST – REPORT PANEL

6.232.1 Rpt Dist – Report Panel Narrative

The Report panel is used to maintain the batch report file code table.

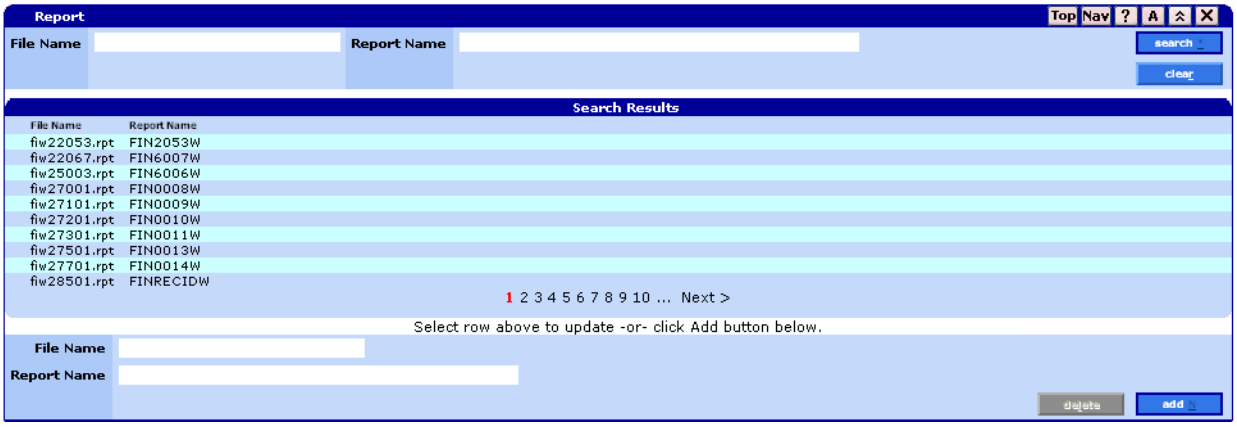
This panel consists of a search criteria sub-panel, a data list displaying the defined report files, and a sub-panel where updates and adds are performed.

The search criteria sub-panel is used to limit the entries in the data list to those matching the search criteria. Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Rpt Dist] - [Report]

6.232.2 Rpt Dist – Report Panel Layout



6.232.3 Rpt Dist – Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a report file name.	Button	N/A	0
Clear	Clears the entered search criteria.	Button	N/A	0
Delete	Allows the user to delete a report file name.	Button	N/A	0
File Name	The UNIX file name of the batch report.	Field	Character	30
Report Name	The descriptive name of the batch report.	Field	Character	50
Search	Allows the user to limit the data list entries to those matching the search criteria.	Button	N/A	0

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6.232.4 Rpt Dist – Report Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Unable to delete. Routes exist for the Report File.	You must first delete the Report Routes for this Report File.
File Name	Field	1	File Name is required.	Enter the UNIX file name of the batch report.
Report Name	Field	1	Report Name is required.	Enter the descriptive name of the batch report.

6.232.5 Rpt Dist – Report Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.232.6 Rpt Dist – Report Panel Accessibility

6.232.6.1 To Access the Rpt Dist-Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report**.	Rpt Dist-Report panel displays.

6.232.6.2 To Add on the Rpt Dist-Report Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **File Name**.	
3	Enter **Report Name**.	
4	Click **Save**.	Rpt Dist-Report information is saved.

6.232.6.3 To Update on the Rpt Dist-Report Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Rpt Dist-Report information is saved.

6.232.6.4 To Delete on the Rpt Dist-Report Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.233 RPT DIST - REPORT CONTROL PANEL

6.233.1 Rpt Dist - Report Control Panel Narrative

The Report Control panel is used to maintain the batch report control file code table.

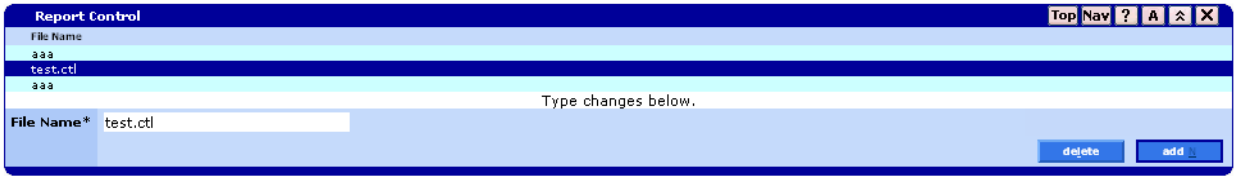
The panel consists of a search criteria sub-panel, a data list displaying the defined report files, and a sub-panel where updates and adds are performed.

The search criteria sub-panel is used to limit the entries in the data list to those matching the search criteria. Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Rpt Dist] - [Report Control]

6.233.2 Rpt Dist - Report Control Panel Layout



6.233.3 Rpt Dist - Report Control Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a report control file.	Button	N/A	0
Delete	Allows the user to delete a report file.	Button	N/A	0
File Name	The UNIX report control file name.	Field	Character	30

6.233.4 Rpt Dist - Report Control Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Unable to delete. Routes exist for the Report Control File.	You must first delete the Report Routes for this Report Control File.
File Name	Field	1	File Name is required.	Enter the UNIX report control file name.

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6.233.5 Rpt Dist - Report Control Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.233.6 Rpt Dist - Report Control Panel Accessibility

6.233.6.1 To Access the Rpt Dist-Report Control Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report Control**.	Rpt Dist-Report Control panel displays.

6.233.6.2 To Add on the Rpt Dist-Report Control Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **File Name**.	
3	Click **Save**.	Rpt Dist-Report Control information is saved.

6.233.6.3 To Update on the Rpt Dist-Report Control Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rpt Dist-Report Control information is saved.

6.233.6.4 To Delete on the Rpt Dist-Report Control Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.234 RPT DIST - REPORT DESTINATION PANEL

6.234.1 Rpt Dist - Report Destination Panel Narrative

The Report Destination panel is used to maintain the batch report control file code table.

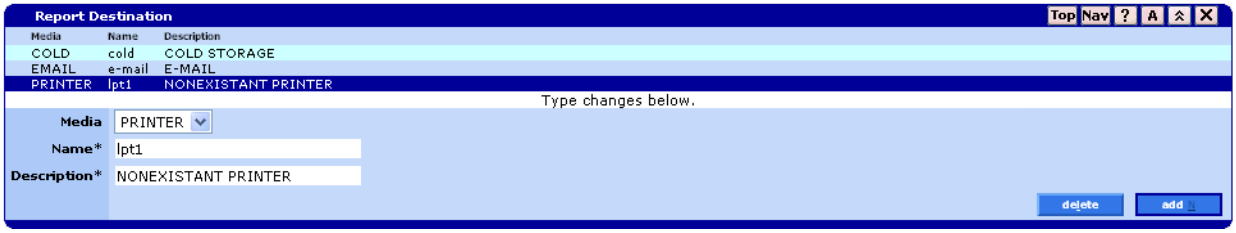
The panel consists of a data list displaying the defined report files, and a sub-panel where updates and adds are performed.

Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Rpt Dist] - [Report Destination]

6.234.2 Rpt Dist - Report Destination Panel Layout



6.234.3 Rpt Dist - Report Destination Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a destination.	Button	N/A	0
Delete	Allows the user to delete a destination.	Button	N/A	0
Description	The description of the destination.	Field	Character	30
Media	The batch report destination media type.	Combo Box	Drop Down List Box	0
Name	The name of the destination, or the UNIX printer name.	Field	Character	60

6.234.4 Rpt Dist - Report Destination Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Unable to delete. Routes exist for the Report Destination.	You must first delete the Report Routes for this Report Destination.
Description	Field	1	Description is required.	Enter the Description of the destination.
Media	Field	1	Media is required.	Enter the Media type.

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Field	Field Type	Error Code	Error Message	To Correct
Name	Field	1	Name is required.	Enter the Name of the destination, or the UNIX printer name.

6.234.5 Rpt Dist - Report Destination Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.234.6 Rpt Dist - Report Destination Panel Accessibility

6.234.6.1 To Access the Rpt Dist-Report Destination Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report Destination**.	Rpt Dist-Report Destination panel displays.

6.234.6.2 To Add on the Rpt Dist-Report Destination Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Media** from drop down list box.	
3	Enter **Name**.	
4	Enter **Description**.	
5	Click **Save**.	Rpt Dist-Report Destination information is saved.

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6.234.6.3 To Update on the Rpt Dist-Report Destination Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rpt Dist-Report Destination information is saved.

6.234.6.4 To Delete on the Rpt Dist-Report Destination Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.235 RPT DIST - REPORT RECIPIENT PANEL

6.235.1 Rpt Dist - Report Recipient Panel Narrative

The Report Recipient panel is used to maintain the recipients of batch report files.

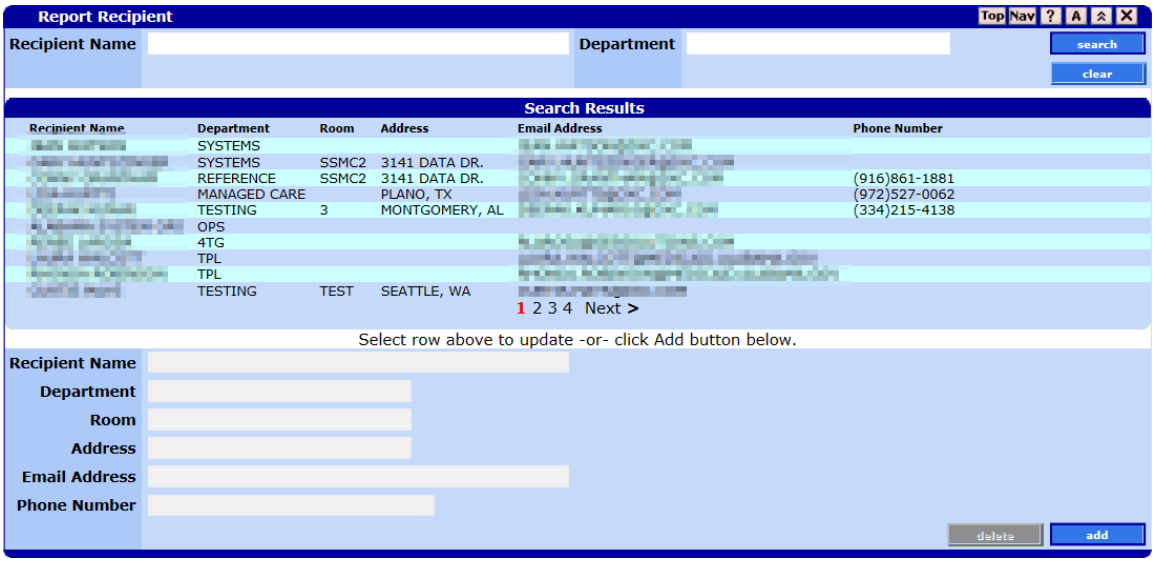
The panel consists of a search criteria sub-panel, a data list displaying the defined report files, and a sub-panel where updates and adds are performed.

The search criteria sub-panel is used to limit the entries in the data list to those matching the search criteria. Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Rpt Dist] - [Report Recipient]

6.235.2 Rpt Dist - Report Recipient Panel Layout



6.235.3 Rpt Dist - Report Recipient Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a report recipient.	Button	N/A	0
Address	The report recipient's address.	Field	Character	30
Clear	Clears the entered search criteria.	Button	N/A	0
Delete	Allows the user to delete a report recipient.	Button	N/A	0
Department	The report recipient's department.	Field	Character	30
Email Address	The report recipient's email address.	Field	Character	50
Phone Number	The report recipient's phone number.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Recipient Name	The name of the batch report distribution recipient.	Field	Character	50
Room	The report recipient's room.	Field	Character	30
Search	Limits the data list entries to those matching the search criteria.	Button	N/A	0

6.235.4 Rpt Dist - Report Recipient Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Recipient Name	Field	1	Recipient Name is required.	Enter the name of the batch report distribution recipient.

6.235.5 Rpt Dist - Report Recipient Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.235.6 Rpt Dist - Report Recipient Panel Accessibility

6.235.6.1 To Access the Rpt Dist-Report Recipient Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report Recipient**.	Rpt Dist-Report Recipient panel displays.

6.235.6.2 To Add on the Rpt Dist-Report Recipient Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Recipient Name**.	
3	Enter **Department**.	
4	Enter **Room**.	
5	Enter **Address**.	
6	Enter **Email Address**.	
7	Enter **Phone Number**.	

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Step	Action	Response
8	Click **Save**.	Rpt Dist-Report Recipient information is saved.

6.235.6.3 To Update on the Rpt Dist-Report Recipient Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rpt Dist-Report Recipient information is saved.

6.235.6.4 To Delete on the Rpt Dist-Report Recipient Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.236 RPT DIST- REPORT ROUTE PANEL

6.236.1 Rpt Dist-Report Route Panel Narrative

The Report Route panel is used to maintain the batch report distribution Report Route table. This table holds information on the routing of a report, its destination, control file, and environment. It is also used to maintain the Report Distribution table. This table associates a report route with a report recipient.

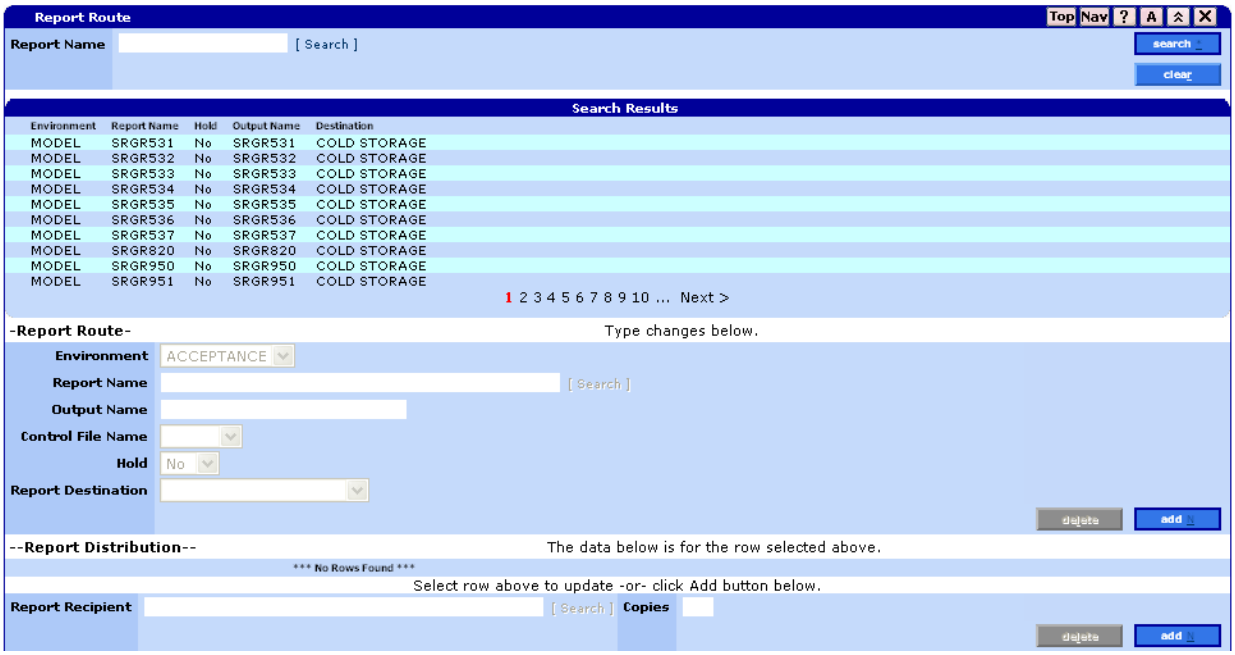
The panel consists of a search criteria sub-panel, a data list displaying the defined report routes, and a sub-panel where updates and adds are performed. When a report route is selected, a data list of recipient's is displayed below, and below that, a sub-panel where updates and adds are performed

The search criteria sub-panel is used to limit the entries in the data list to those matching the search criteria. Selecting an entry from the data list populates the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Rpt Dist] - [Report Route]

6.236.2 Rpt Dist-Report Route Panel Layout



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6.236.3 Rpt Dist-Report Route Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a report route or a report distribution.	Button	N/A	0
Clear	Clears the entered search criteria.	Button	N/A	0
Control File Name	The report control file name.	Combo Box	Drop Down List Box	0
Copies	The number of copies to be distributed.	Field	Number (Integer)	2
Delete	Allows the user to delete a report route or a report distribution.	Button	N/A	0
Destination	The report destination description.	Field	Character	60
Environment	The environment for which this report routing is valid.	Combo Box	Drop Down List Box	0
Hold	Indicates whether or not this batch report route is on hold.	Combo Box	Drop Down List Box	0
Output Name	A UNIX file name used to rename the report file name when routing to COLD.	Field	Character	30
Report Destination	The report destination description.	Combo Box	Drop Down List Box	0
Report Name	The descriptive name of the batch report.	Field	Character	30
Report Recipient	The name of the batch report distribution recipient.	Field	Character	50
Search	Limits the data list entries to those matching the search criteria.	Button	N/A	0

6.236.4 Rpt Dist-Report Route Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Environment	Field	1	Environment is required.	Enter the environment for which this report routing is valid.
Hold	Field	1	Hold is required.	Enter the batch report route hold indicator.
Report Destination	Field	1	Report Destination is required.	Use the [Search] link to search for and select the report destination.
Report Name	Field	1	The Report Name is required.	Use the [Search] link to search for and select the report name.

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6.236.5 Rpt Dist-Report Route Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.236.6 Rpt Dist - Report Route Panel Accessibility

6.236.6.1 To Access the Rpt Dist-Report Route Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report Route**.	Rpt Dist-Report Route panel displays.

6.236.6.2 To Add on the Rpt Dist-Report Route Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Environment** from drop down list box.	
3	Click [Search] to locate **Report Name**.	Report Name Search panel displays.
4	Enter search criteria or select from list of results.	Report Name information populates on panel.
5	Enter **Output Name**.	
6	Select **Control File Name** from drop down list box.	
7	Select **Hold** from drop down list box.	
8	Select **Report Destination** from drop down list box.	
9	Click **Save**.	Rpt Dist-Report Route information is saved.

6.236.6.3 To Update on the Rpt Dist-Report Route Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rpt Dist-Report Route information is saved.

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6.236.6.4 To Delete on the Rpt Dist-Report Route Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.236.6.5 To Access the Rpt Dist-Report Distribution Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data.**	Related Data page displays.
3	Click the **Rpt Dist** hyperlink located on the Related Data panel.	Related Data-Rpt Dist panel displays.
4	Click **Report Recipient**.	Rpt Dist-Report Distribution panel displays at bottom of Report Route panel.

6.236.6.6 To Add on the Rpt Dist-Report Distribution Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click [Search] to locate **Report Recipient**.	Report Recipient Search panel displays.
3	Enter search criteria or select from list of results.	Report Recipient information populates on panel.
4	Enter **Copies**.	
5	Click **Save**.	Rpt Dist-Report Distribution information is saved.

6.236.6.7 To Update on the Rpt Dist-Report Distribution Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rpt Dist-Report Distribution information is saved.

6.236.6.8 To Delete on the Rpt Dist-Report Distribution Panel

Step	Action	Response

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1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.237 RELATED DATA XREF PAGE

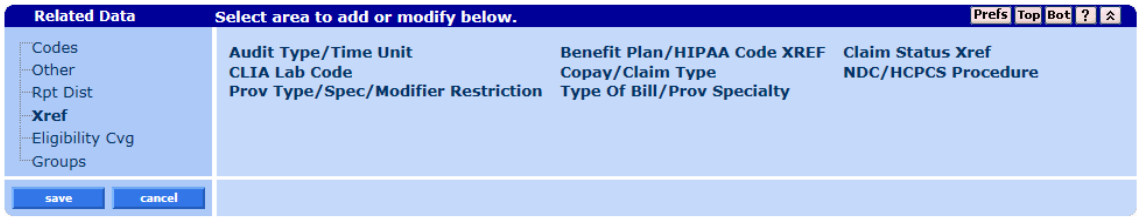
6.237.1 Related Data Xref Page Narrative

The Related Data Xref page contains the panels that are used to maintain tables that are cross referenced between two tables.

This panel is inquiry only.

Navigation Path: [Reference] - [Related Data] - [Xref]

6.237.2 Related Data Xref Page Layout



6.237.3 Related Data Xref Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Type/Time Unit	Link to the Audit Type/Time Unit panel.	Hyperlink	N/A	0
Benefit Plan/HIPAA Code XREF	This brings up the cross reference of MMIS and the HIPAA Insurance/Benefit Plan code panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel a request.	Button	N/A	0
Claim Status Xref	Link to Claim Status Xref panel.	Hyperlink	N/A	0
CLIA Lab Code	Link to CLIA Lab Code panel.	Hyperlink	N/A	0
Copay/Claim Type	Link to Copay/Claim Type panel.	Hyperlink	N/A	0
NDC/HCPCS Procedure	Link to NDC/HCPCS Procedure panel.	Hyperlink	N/A	0
Prov Type/Spec/Modifier Restriction	Link to Prov Type/Spec/Modifier Restriction panel.	Hyperlink	N/A	0
Save	Allows the user to save changes.	Button	N/A	0
Type of Bill/Prov Specialty	Link to Type of Bill/Prov Specialty panel.	Hyperlink	N/A	0

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6.237.4 Related Data Xref Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.237.5 Related Data Xref Page Extra Features

Field	Field Type
No extra features found for this page.	

6.237.6 Related Data Xref Page Accessibility

6.237.6.1 To Access the Related Data Xref Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.

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6.238 XREF-AUDIT TYPE - TIME UNIT PANEL

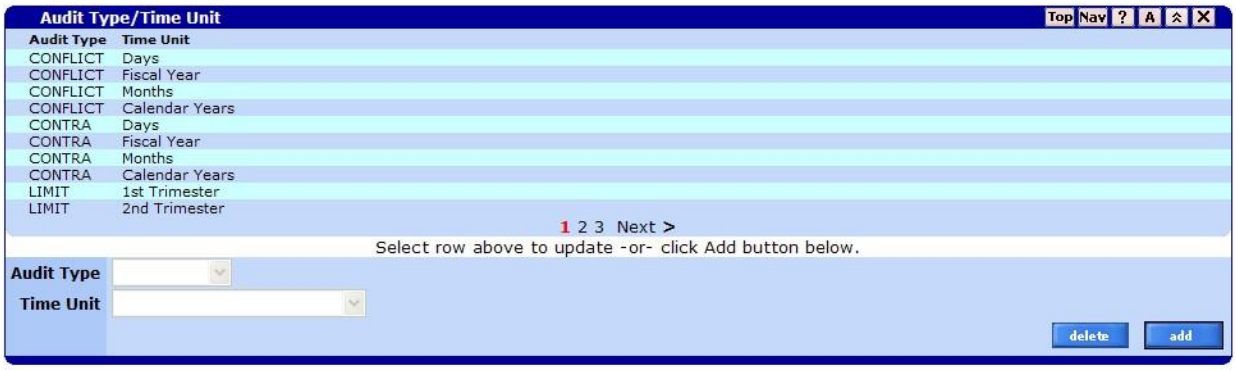
6.238.1 Xref-Audit Type-Time Unit Panel Narrative

The Audit Type-Time Unit panel maintains the list of audit time units available for each audit type on the audit parameters panels.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Xref] - [Audit Type / Time Unit]

6.238.2 Xref-Audit Type-Time Unit Panel Layout



6.238.3 Xref-Audit Type-Time Unit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add an Audit Type-Time Unit.	Button	N/A	0
Audit Type	Identifies the Audit Type.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete an Audit Type-Time Unit.	Button	N/A	0
Time Unit	Indicates the unit of time measurement to be used in auditing.	Combo Box	Drop Down List Box	0

6.238.4 Xref-Audit Type-Time Unit Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Audit Type	Field	1	A valid Audit Type is required.	Select an Audit Type.
Time Unit	Field	1	A valid Time Unit is required.	Select a Time Unit.
	Field	2	A duplicate record cannot be saved.	Enter a unique Audit Type/Time Unit combination.

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6.238.5 Xref-Audit Type-Time Unit Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.238.6 Xref-Audit Type-Time Unit Panel Accessibility

6.238.6.1 To Access the Xref- Audit Type-Time Unit Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Audit Type/Time Unit**.	Audit Type-Time Unit panel displays.

6.238.6.2 To Add on the Xref- Audit Type-Time Unit Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Audit Type** from the drop down list box.	
3	Select **Time Unit** from the drop down list box.	
4	Click **Save**.	Audit Type-Time Unit information is saved.

6.238.6.3 To Update on the Xref- Audit Type-Time Unit Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Audit Type-Time Unit information is saved.

6.238.6.4 To Delete on the Xref- Audit Type-Time Unit Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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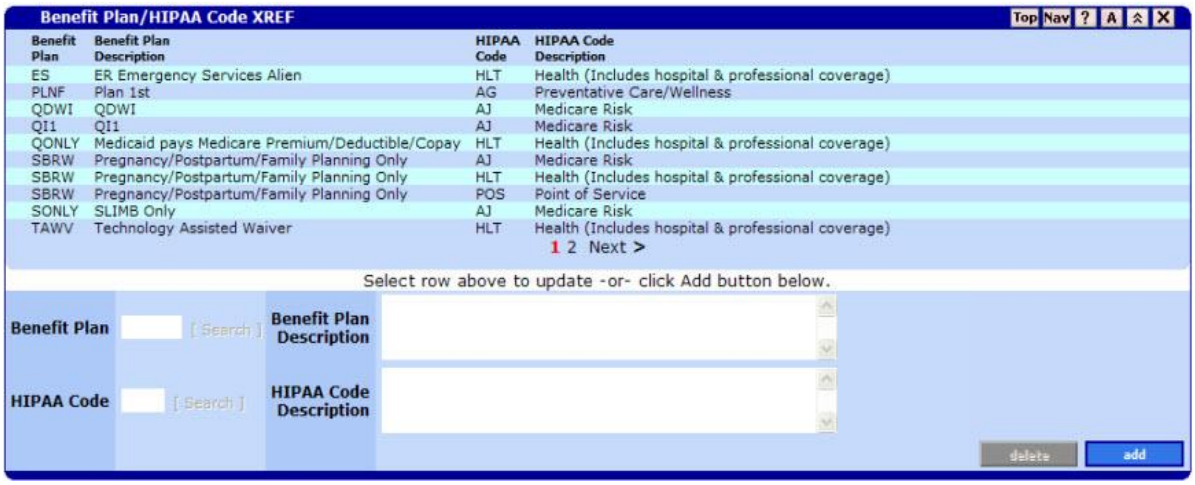
6.239 XREF-BENEFIT PLAN/HIPAA CODE XREF PANEL

6.239.1 Xref-Benefit Plan/HIPAA Code Xref Panel Narrative

The Benefit Plan/HIPAA Code Xref panel maintains cross reference of MMIS and the HIPAA Insurance/Benefit Plan codes. This table contains the Medical Assistance Program codes and HIPAA Insurance/Benefit Plan codes.

Navigation Path: [Reference] - [Related Data] - [Xref] - [Benefit Plan/HIPAA Code XREF]

6.239.2 Xref- Benefit Plan/HIPAA Code Xref Panel Layout



6.239.3 Xref-Benefit Plan/HIPAA Code Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a new entry.	Button	N/A	0
Delete	Deletes the entry.	Button	N/A	0
Benefit Plan	Identifies the medical assistance program Code that is supported in the system.	Field	Character	5
Benefit Plan Description	Identifies the medical assistance program code description that is supported in the system.	Field	Character	50
HIPAA Code	HIPAA Code identifying a group of insurance products.	Field	Character	3
HIPAA Code Description	HIPAA Code Description identifying a group of insurance products.	Field	Character	50

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6.239.4 Xref-Benefit Plan/HIPAA Code Xref Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	A valid Benefit Plan is required.	Select a Benefit Plan.
	Field	2	A duplicate record cannot be saved.	Benefit Plan and HIPAA Code combination must be unique.
HIPAA Code	Field	3	A valid HIPAA Code is required.	Select a HIPAA Code.
	Field	4	A duplicate record cannot be saved.	Benefit Plan and HIPAA Code combination must be unique.

6.239.5 Xref-Benefit Plan/HIPAA Code Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

5.246.2 Xref- Benefit Plan/HIPAA Code Xref Panel Accessibility

5.246.2.1 To Access the Xref Benefit Plan/HIPAA Code Xref Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Benefit Plan/HIPAA Code Xref**.	Benefit Plan/HIPAA Code Xref panel displays.

5.246.2.2 To Add on the Xref Benefit Plan/HIPAA Code Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Benefit Plan** by clicking [Search].	Benefit Plan search panel displays.
3	Enter search criteria. User may also select a row from the list of search results.	Benefit Plan information is populated.
4	Select **HIPAA Code** by clicking [Search].	HIPAA Code search panel displays.

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Step	Action	Response
5	Enter search criteria. User may also select a row from the list of search results.	HIPAA Code information is populated.
6	Click **Save**.	Benefit Plan/HIPAA Code Xref information is saved.

5.246.2.3 To Delete on the Xref Benefit Plan/HIPAA Code Xref Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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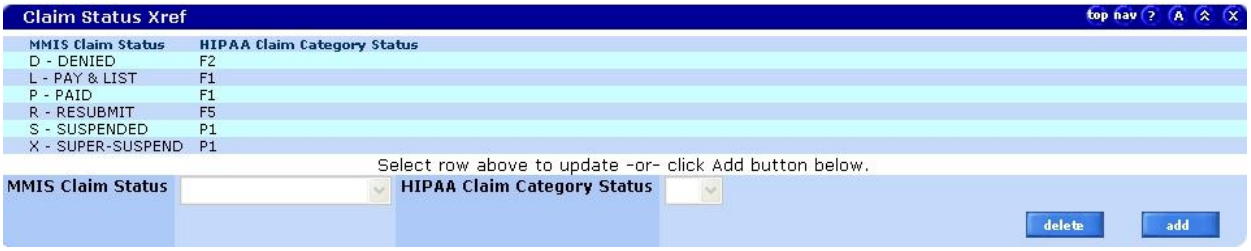
6.240 XREF-CLAIM STATUS XREF PANEL

6.240.1 Xref-Claim Status Xref Panel Narrative

The Claim Status Xref Maintains the MMIS Claim Status, and the HIPAA Claim Category Status for Claim Status Xref purposes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Xref] - [Claim Status Xref]

6.240.2 Xref-Claim Status Xref Panel Layout



6.240.3 Xref-Claim Status Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a MMIS Claim Status / HIPAA Claim Status Category association.	Button	N/A	0
Delete	Delete a MMIS Claim Status / HIPAA Claim Status Category association.	Button	N/A	0
HIPAA Claim Category Status	HIPAA Claim status codes that communicate information about the status of a claim, i.e., whether it's been received, pended, paid, etc.	Combo Box	Drop Down List Box	0
MMIS Claim Status	Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, paid, etc.	Combo Box	Drop Down List Box	0

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6.240.4 Xref-Claim Status Xref Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
HIPAA Claim Category Status	Field	1	A valid HIPAA Claim Category Status is required.	Select a HIPAA Claim Category Status.
MMIS Claim Status	Field	1	A valid MMIS Claim Status is required.	Select a MMIS Claim Status.
	Field	2	A duplicate record cannot be saved.	Enter a unique Claim Status/HIPAA Claim Status Category combination.

6.240.5 Xref-Claim Status Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.240.6 Xref-Claim Status Xref Panel Accessibility

6.240.6.1 To Access the Xref Claim Status Xref Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Claim Status Xref**.	Claim Status Xref panel displays.

6.240.6.2 To Add on the Xref Claim Status Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **MMIS Claim Status** from drop down list box.	
3	Select **HIPAA Claim Category Status** from drop down list box.	
4	Click **Save**.	Claim Status Xref information is saved.

6.240.6.3 To Update on the Xref Claim Status Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Claim Status Xref information is saved.

6.240.6.4 To Delete on the Xref Claim Status Xref Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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6.241 XREF-CLIA LAB CODE PANEL

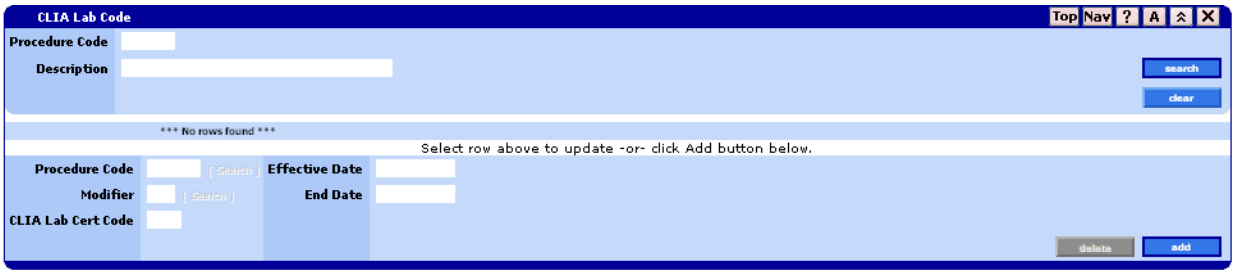
6.241.1 Xref-CLIA Lab Code Panel Narrative

The CLIA Lab Code panel contains the procedure code, modifier, and lab certification code for cross reference purposes when checking for CLIA certification during the processing of claims.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Xref] - [CLIA Lab Code]

6.241.2 Xref-CLIA Lab Code Panel Layout



6.241.3 Xref-CLIA Lab Code Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Adds a record that defines the required CLIA Lab Certification Code for the procedure/modifier combination.	Button	N/A	0
Clear	Clear CLIA Lab Certification Code information entered into the fields on the panel.	Button	N/A	0
CLIA Lab Cert Code	Clinical Laboratory Improvement Amendments (CLIA) Lab Certification Code. These codes are based on the complexity of the test method; thus, the more complicated the test, the more stringent the requirements. Three categories of tests have been established: waived complexity, moderate complexity, including the subcategory of provider-performed microscopy (PPM), and high complexity.	Field	Character	3

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Field	Description	Field Type	Data Type	Length
Delete	Deletes a record that at some point in time, identified the appropriate CLIA Lab Certification Code required for reimbursement consideration of the procedure code/modifier combination.	Button	N/A	0
Description	Description of the procedure code.	Field	Character	12
Effective Date	Date the CLIA lab code and procedure combination become effective for claims processing based on date of service on the claim.	Field	Date (MM/DD/CCYY)	8
End Date	The last day the CLIA lab code and procedure combination are effective for claims processing based on date of service on the claim.	Field	Date (MM/DD/CCYY)	8
Modifier [Search]	Modifier to be billed with the procedure code as required by the CLIA lab certification code.	Hyperlink	N/A	0
Procedure Code [Search]	Healthcare Common Procedure Coding System (HCPCS) code that identifies a particular laboratory service.	Hyperlink	N/A	0
Search	Locate CLIA Lab Code information based on the criteria entered on the panel.	Button	N/A	

6.241.4 Xref-CLIA Lab Code Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
CLIA Lab Cert Code	Field	1	CLIA Lab Cert Code is required.	Enter a 3 digit code.
	Field	2	CLIA Lab Cert Code must be 3 character(s) in length.	Enter a 3 digit code.
	Field	3	A duplicate record cannot be saved.	Enter a unique CLIA Cert code.
Effective Date	Field	1	Date ranges may not overlap for the same Procedure, Modifier and Lab Code.	Verify keying. Dates cannot for overlap for the same Procedure, Modifier and CLIA Lab Cert Code.
	Field	2	Invalid Date. Format is MM/DD/CCYY	Enter a valid date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Effective date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	4	Effective date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Effective Date must be less than or equal to End Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	3	Invalid Date. Format is MM/DD/CCYY	Enter a valid date.
	Field	4	End date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Procedure Code	Hyperlink	1	A valid Procedure Code is required.	Select a valid Procedure Code.

6.241.5 Xref-CLIA Lab Code Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.241.6 Xref-CLIA Lab Code Panel Accessibility

6.241.6.1 To Access the Xref-CLIA Lab Code Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Select **CLIA Lab Code**.	CLIA Lab Code panel displays.

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6.241.6.2 To Add on the Xref-CLIA Lab Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Procedure Code** by clicking [Search].	Procedure Code search panel displays.
3	Enter search criteria. User may also select a row from the list of search results.	Procedure Code information is populated.
4	Select **Modifier** by clicking [Search]	Modifier search panel displays.
5	Enter search criteria. User may also select a row from the list of search results.	Modifier information is populated.
6	Enter **CLIA Lab Cert Code**.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	CLIA Lab Code information is saved.

6.241.6.3 To Update on the Xref-CLIA Lab Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	CLIA Lab Code information is saved.

6.241.6.4 To Delete on the Xref-CLIA Lab Code Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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6.242 XREF-COPAY CLAIM TYPE PANEL

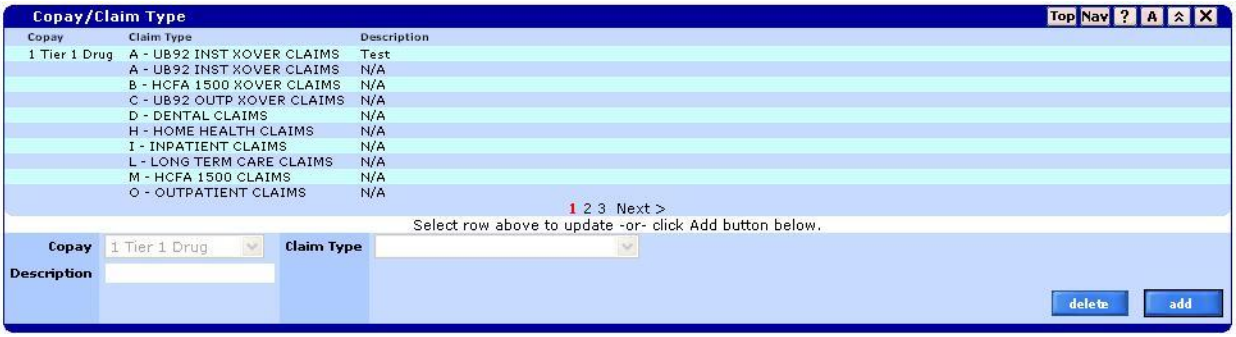
6.242.1 Xref-Copay Claim Type Panel Narrative

The Copay Type panel is used to categorize the copay for a particular claim type and program combination which ultimately determines the copay amount. Examples of uses for Copay Type are copay type codes used to identify the different copays for Tier 2 and Tier 3 drugs.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Xref] - [Copay / Claim Type]

6.242.2 Xref-Copay Claim Type Panel Layout



6.242.3 Xref-Copay Claim Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a copay / claim type association.	Button	N/A	0
Claim Type	A claims classification based on type of benefits paid.	Combo Box	Drop Down List Box	0
Copay	Code identifying the type of copay. The copay type is used along with the claim type to identify the copay amount to pay on a claim.	Combo Box	Drop Down List Box	0
Delete	Delete a copay / claim type association.	Button	N/A	0
Description	Description of copay type.	Field	Character	20

6.242.4 Xref-Copay Claim Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required.	Select a claim type from the list.
Copay	Field	1	Duplicate record cannot be saved.	Enter a valid Copay/Claim type combination.
	Field	2	Copay is required.	Select a valid copay.
Description	Field	1	Description is required.	Enter a description.

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6.242.5 Xref-Copay Claim Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.242.6 Xref-Copay Claim Type Panel Accessibility

6.242.6.1 To Access the Xref-Copay Claim Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Copay/Claim Type**.	Copay Claim Type panel displays.

6.242.6.2 To Add on the Xref-Copay Claim Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **NDC Code** from drop down list box.	
3	Enter **Description**.	
4	Select **Claim Type** from drop down list box.	
5	Click **Save**.	Copay Claim Type information is saved.

6.242.6.3 To Update on the Xref-Copay Claim Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Copay Claim Type information is saved.

6.242.6.4 To Delete on the Xref-Copay Claim Type Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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6.243 XREF-NDC-HCPCS PROCEDURE PANEL

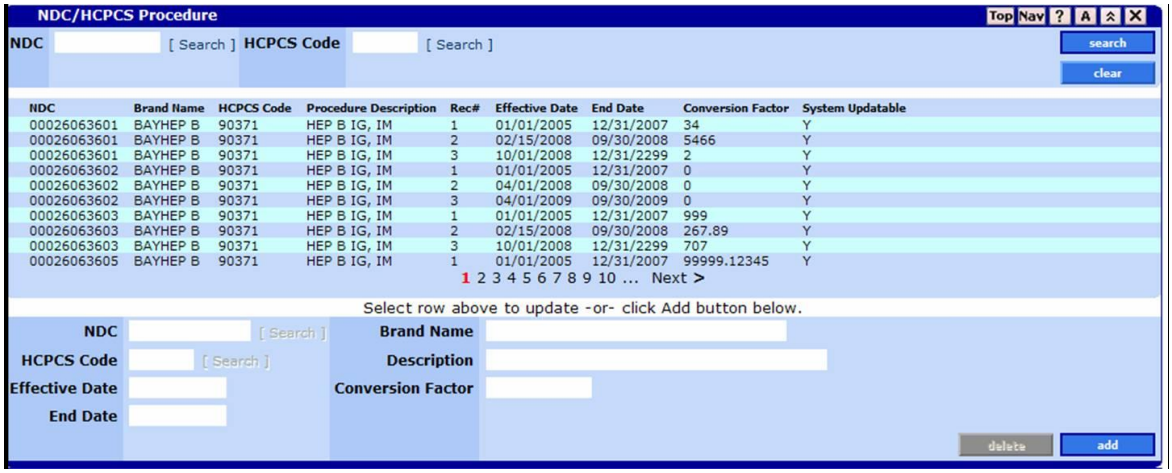
6.243.1 Xref-NDC - HCPCS Procedure Panel Narrative

The NDC/HCPCS Procedure cross walk panel is used to support the cross reference(s) between an NDC and associated HCPCS procedures (if applicable). HCPCS procedure codes are much more generic than NDCs and thus may have a many to 1 relationship (i.e. HCPCS to NDC).

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Xref] - [NDC] - HCPCS Procedure]

6.243.2 Xref-NDC-HCPCS Procedure Panel Layout



6.243.3 Xref-NDC-HCPCS Procedure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new HCPCS cross-reference to the NDC.	Button	N/A	0
Brand Name	'Read Only' name of the Drug with the chosen NDC. Name that appears on the package label provided by the manufacturer.	Field	Character	35
Brand Name [List]	Name that appears on the package label provided by the manufacturer.	Field	Character	35
Conversion Factor	It is the value used to convert HCPCS Quantity to NDC quantity for drug rebate billing purposes.	Field	Number(Decimal)	10

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Field	Description	Field Type	Data Type	Length
Conversion Factor [List]	It is the value used to convert HCPCS Quantity to NDC quantity for drug rebate billing purposes.	Field	Number(Decimal)	10
Delete	Allows user to mark a HCPCS cross-reference for deletion.	Button	N/A	0
Description	'Read Only' Description of the HCPCS Procedure with chosen 'HCPCS Code'.	Field	Character	40
Effective Date	First date the NDC/HCPCS cross-reference is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last date the NDC/HCPCS cross-reference is effective.	Field	Date (MM/DD/CCYY)	8
HCPCS Code [Search]	Code that uniquely identifies a HCPCS procedure.	Hyperlink	N/A	0
NDC [Search]	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	Hyperlink	N/A	0
Procedure Description [List]	Description of the HCPCS Procedure with chosen 'HCPCS Code'.	Field	Character	40
Rec#	It shows the record number for combination of HCPCS Code and NDC Code.	Field	Number(Integer)	4
System Updatable	Indicates whether record was inserted/updated from Batch or Manual/UI. Valid values include: ‘Y’ or ‘N’.	Field	Character	1

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6.243.4 Xref-NDC-HCPCS Procedure Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Conversion Factor	Field	1	Conversion Factor is required.	Enter an Conversion Factor.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Invalid Date.	Enter a valid date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective date must be less than or equal to 12/31/2299.	Enter an Effective date that is less than or equal to 12/31/2299.
	Field	6	NDC and HCPCS Code – Date range Segments cannot overlap	Effective Date must not overlap with End Date range in the list.
End Date	Field	1	End Date is required.	Enter an Effective Date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	3	End date must be less than or equal to 12/31/2299.	Enter an Effective date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date	Enter an Effective Date in MM/DD/CCYY format.
HCPCS Code [Search]	Hyperlink	1	A valid HCPCS Code is required.	Select a HCPCS Procedure using the search link.

6.243.5 Xref-NDC-HCPCS Procedure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.243.6 Xref-NDC-HCPCS Procedure Panel Accessibility

6.243.6.1 To Access the Xref-NDC-HCPCS Procedure Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **NDC-HCPCS Procedure**.	NDC-HCPCS Procedure panel displays.

6.243.6.2 To Add on the Xref-NDC-HCPCS Procedure Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **NDC Code** by clicking [Search]	NDC Code search panel displays.
3	Enter search criteria. User may also select a row from the list of search results.	NDC Code information is populated.
4	Select **HCPCS Code** by clicking [Search].	HCPCS Code search panel displays.
5	Enter search criteria. User may also select a row from the list of search results.	HCPCS Code information is populated.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	NDC-HCPCS Procedure information is saved.

6.243.6.3 To Update on the Xref-NDC-HCPCS Procedure Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	NDC-HCPCS Procedure information is saved.

6.243.6.4 To Delete on the Xref-NDC-HCPCS Procedure Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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6.244 XREF-PROV TYPE SPEC MODIFIER RESTRICTION PANEL

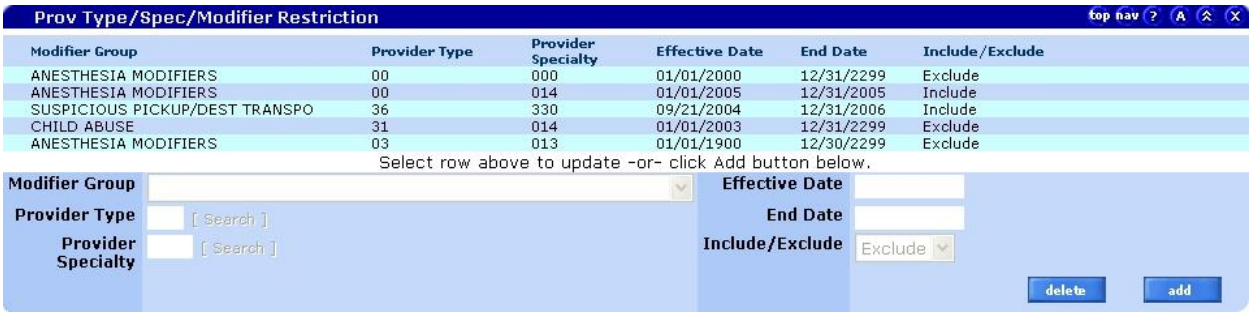
6.244.1 Xref-Prov Type Spec Modifier Restriction Panel Narrative

The Prov Type/Spec/Modifier Restriction panel provides the capability to enforce certain provider type/specialty/modifier group combinations during claims processing.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Xref] – [Prov Type/Specialty/Modifier Restriction]

6.244.2 Xref-Prov Type Spec Modifier Restriction Panel Layout



6.244.3 Xref-Prov Type Spec Modifier Restriction Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a provider type/specialty/modifier group combination.	Button	N/A	0
Delete	Delete a provider type/specialty/modifier group combination.	Button	N/A	0
Effective Date	The date this Modifier Group/Provider Type/Specialty Restriction becomes effective for claims processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date this Modifier Group/Provider Type/Specialty Restriction is no longer effective for claims processing.	Field	Date (MM/DD/CCYY)	8
Include / Exclude	Indicates if the Modifier Group is included or excluded as a requirement for the Provider Type/Specialty.	Combo Box	Drop Down List Box	0
Modifier Group	Code used to identify type of Modifier Group.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty [Search]	Provider's scope of practice.	Hyperlink	N/A	0
Provider Type [Search	Provider's type (license or certification)	Hyperlink	N/A	0

6.244.4 Xref-Prov Type Spec Modifier Restriction Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.
	Field	2	Invalid date.	Enter a valid date. Format is MM/DD/CCYY.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Effective Date must be greater than or equal to 01/01/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Effective Date must be less than or equal to 12/31/2299.
End Date	Field	1	Effective Date must be less than or equal to End Date.	Effective Date must be less than or equal to End Date.
	Field	2	Invalid date.	Enter a valid date. Format is MM/DD/CCYY.
	Field	3	End Date is required. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.
	Field	4	End Date must be greater than or equal to 01/01/1900.	End Date must be greater than or equal to 01/01/1900.
	Field	5	End Date must be less than or equal to 12/31/2299.	End Date must be less than or equal to 12/31/2299.
Include / Exclude	Field	1	Include/Exclude is required.	Select a valid Include/Exclude indicator.
Modifier Group	Field	2	A valid Modifier Group is required.	Select a Modifier Group.
	Field	5	A duplicate record cannot be saved.	Modifier Group, Provider type, Provider Specialty and effective date combination must be unique.

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Field	Field Type	Error Code	Error Message	To Correct
Provider Specialty	Hyperlink	3	A valid Provider Specialty is required.	Select a provider specialty.
Provider Type	Hyperlink	4	A valid Provider Type is required.	Select a provider type.

6.244.5 Xref-Prov Type Spec Modifier Restriction Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.244.6 Xref-Prov Type Spec Modifier Restriction Panel Accessibility

6.244.6.1 To Access the Xref-Prov Type Spec Modifier Restriction Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Prov Type/Spec/Modifier Restriction**.	Prov Type Spec Modifier Restriction panel displays.

6.244.6.2 To Add on the Xref-Prov Type Spec Modifier Restriction Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Modifier Group** from the drop down list box.	
3	Select **Provider Type** by clicking [Search]	Provider Type search panel displays.
4	Enter search criteria. User may also select a row from the list of search results.	Provider Type information is populated.
5	Select **Provider Specialty** by clicking [Search].	Provider Specialty search panel displays.
6	Enter search criteria. User may also select a row from the list of search results.	Provider Specialty information is populated.
7	Enter **Effective Date** in MM/DD/CCYY format.	

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8	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**.	Prov Type Spec Modifier Restriction information is saved.

6.244.6.3 To Update on the Xref-Prov Type Spec Modifier Restriction Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Prov Type Spec Modifier Restriction information is saved.

6.244.6.4 To Delete on the Xref-Prov Type Spec Modifier Restriction Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.245 XREF-TYPE OF BILL-PROV SPECIALTY PANEL

6.245.1 Xref-Type of Bill Prov Specialty Panel Narrative

The Type of Bill / Prov Specialty panel is used to maintain the type of facility that is billing for services on a UB92 claim form, and the specialized area of practice for a provider.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] – [Xref] - [Type of Bill / Prov Specialty]

6.245.2 Xref-Type of Bill Prov Specialty Panel Layout

6.245.3 Xref-Type of Bill Prov Specialty Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a type of bill / provider specialty association.	Button	N/A	0
Delete	Delete a type of bill / provider specialty association.	Button	N/A	0
Provider Specialty [Search]	A code representing the specialized area of practice for a provider.	Hyperlink	N/A	0
Type of Bill [Search]	Indicates the specific type of facility that is billing for services on a UB04 claim form.	Hyperlink	N/A	0

6.245.4 Xref-Type of Bill Prov Specialty Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Provider Specialty	Hyperlink	1	A valid Provider Specialty is required.	Select a provider specialty.
	Hyperlink	2	A duplicate record cannot be saved.	Select a unique provider specialty for this type of bill.
Type of Bill	Hyperlink	1	A valid Type Of Bill is required.	Select a type of bill.

6.245.5 Xref-Type of Bill Prov Specialty Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.245.6 Xref-Type of Bill Prov Specialty Panel Accessibility

6.245.6.1 To Access the Xref-Type of Bill Prov Specialty Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref page displays.
4	Select **Type of Bill/Prov Specialty**.	Type of Bill Prov Specialty panel displays.

6.245.6.2 To Add on the Xref-Type of Bill Prov Specialty Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Type of Bill** by clicking [Search] button.	Type of Bill search panel displays.
3	Enter search criteria. User may also select a row from the list of search results.	Type of Bill information is populated.
4	Select **Provider Specialty** by clicking [Search].	Provider Specialty search panel displays.
5	Enter search criteria. User may also select a row from the list of search results.	Provider Specialty information is populated.
6	Click **Save**.	Type of Bill Prov Specialty information is saved.

6.245.6.3 To Update on the Xref-Type of Bill Prov Specialty Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Type of Bill Prov Specialty information is saved.

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6.245.6.4 To Delete on the Xref-Type of Bill Prov Specialty Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected
2	Click **Delete**.	Line item is deleted

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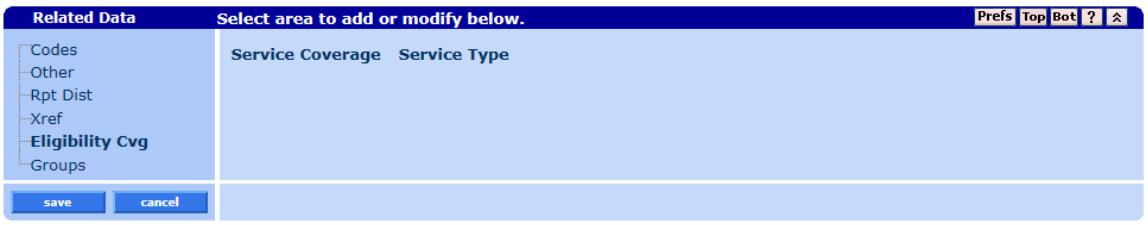
6.246 RELATED DATA ELIGIBILITY CVG PAGE

6.246.1 Related Data Eligibility Cvg Page Narrative

A panel to manage X12 service type codes. The service types panel will be used to manage a list of valid service type codes and their descriptions and identifiers. The panel should have add/delete/update functionality. This panel is inquiry only.

Navigation Path: [Reference] - [Related Data] - [Eligibility Cvg]

6.246.2 Related Data Eligibility Cvg Page Layout



6.246.2.1 Related Data Eligibility Cvg Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Service Type	Link to Service Type panel.	Hyperlink	N/A	0

6.246.2.2 Related Data Eligibility Cvg Page Field Edit Error Eligibility Cvg

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.246.2.3 Related Data Eligibility Cvg Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.246.3 Related Data Eligibility Cvg Page Accessibility

6.246.3.1 To Access the Related Data Eligibility Cvg Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Eligibility Cvg** hyperlink located on the Related Data panel.	Related Data- Eligibility Cvg page displays.

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6.247 ELIGIBILITY CVG-SERVICE TYPE PANEL

6.247.1 Eligibility Cvg-Service Type Panel Narrative

The Service Type panel is used to maintain the X12 Service Type Codes.

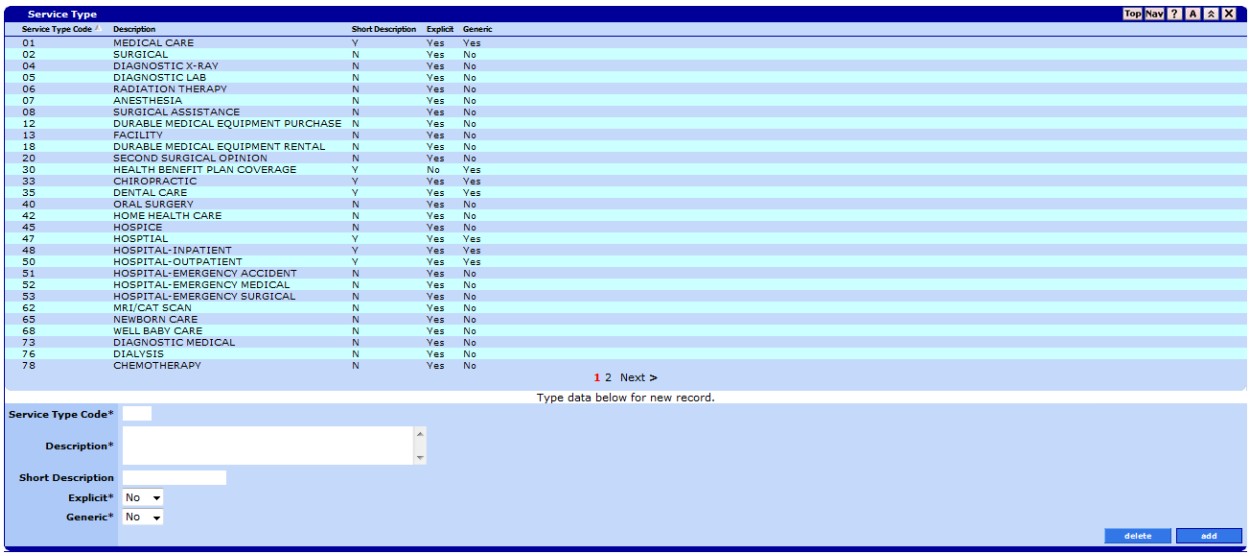
The panel consists of a data list displaying the defined Service Types and a sub-panel where updates and additions are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel. .

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Eligibility Cvg] - [Service Type]

6.247.2 Eligibility Cvg-Service Type Panel Layout



Service Type

Service Type Code	Description	Short Description	Explicit	Generic
01	MEDICAL CARE	Y	Yes	Yes
02	SURGICAL	N	Yes	No
04	DIAGNOSTIC X-RAY	N	Yes	No
05	DIAGNOSTIC LAB	N	Yes	No
06	RADIATION THERAPY	N	Yes	No
07	ANESTHESIA	N	Yes	No
08	SURGICAL ASSISTANCE	N	Yes	No
12	DURABLE MEDICAL EQUIPMENT PURCHASE	N	Yes	No
13	FACILITY	N	Yes	No
18	DURABLE MEDICAL EQUIPMENT RENTAL	N	Yes	No
20	SECOND SURGICAL OPINION	N	Yes	No
30	HEALTH BENEFIT PLAN COVERAGE	Y	No	Yes
33	CHIROPRACTIC	Y	Yes	Yes
35	DENTAL CARE	Y	Yes	Yes
40	ORAL SURGERY	N	Yes	No
42	HOME HEALTH CARE	N	Yes	No
45	HOSPICE	N	Yes	No
47	HOSPTIAL	Y	Yes	Yes
48	HOSPITAL-INPATIENT	Y	Yes	Yes
50	HOSPITAL-OUTPATIENT	Y	Yes	Yes
51	HOSPITAL-EMERGENCY ACCIDENT	N	Yes	No
52	HOSPITAL-EMERGENCY MEDICAL	N	Yes	No
53	HOSPITAL-EMERGENCY SURGICAL	N	Yes	No
62	MRI/CAT SCAN	N	Yes	No
65	NEWBORN CARE	N	Yes	No
68	WELL BABY CARE	N	Yes	No
73	DIAGNOSTIC MEDICAL	N	Yes	No
76	DIALYSIS	N	Yes	No
78	CHEMOTHERAPY	N	Yes	No

1 2 Next >

Type data below for new record.

Service Type Code*
Description*
Short Description
Explicit* No
Generic* No

delete add

6.247.3 Eligibility Cvg-Service Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Service Type.	Button	N/A	0
Delete	Allows the user to delete a Service Type.	Button	N/A	0
Description	Text description of the Service Type code.	Field	Character	50
Explicit	Indicates if the service type is explicit. Valid values include Yes or No.	Combo Box	Character	1
Generic	Indicates if the service type is generic. Valid values include Yes or No.	Combo Box	Character	1
Service Type Code	A code that indicates the type of service that a recipient may be eligible for.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Short Description	A short description that can be used in a UI with limited space or a voice response system to limit speaking time.	Field	Character	15

6.247.4 Eligibility Cvg-Service Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Service Type Code	Field	1	Service Type Code is required.	Enter a Service Type code.
	Field	2	A duplicate record cannot be saved.	Enter a unique Service Type Code.
Description	Field	3	Description is required.	Please enter a description.
Short Description	Field	4	Short Description is required.	Please enter a short description.

6.247.5 Eligibility Cvg-Service Type Panel Extra Features

Field	Field Type
This panel displays 30 records per page. This may be different from the default pagination setting	

6.247.6 Eligibility Cvg-Service Type Panel Accessibility

6.247.6.1 To Access the Eligibility Cvg-Service Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Eligibility Cvg** hyperlink located on the Related Data panel.	Related Data-Eligibility Cvg page displays.
4	Select **Service Type**.	Service Type panel displays.

6.247.6.2 To Add on the Eligibility Cvg-Service Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Service Type**.	
3	Enter **Description**.	
4	Click **Save**.	Service Type information is saved.

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6.248 ELIGIBILITY CVG-SERVICE COVERAGE PANEL

6.248.1 Eligibility Cvg-Service Coverage Panel Narrative

The Service Coverage panel is used to maintain the X12 Service Coverage details.

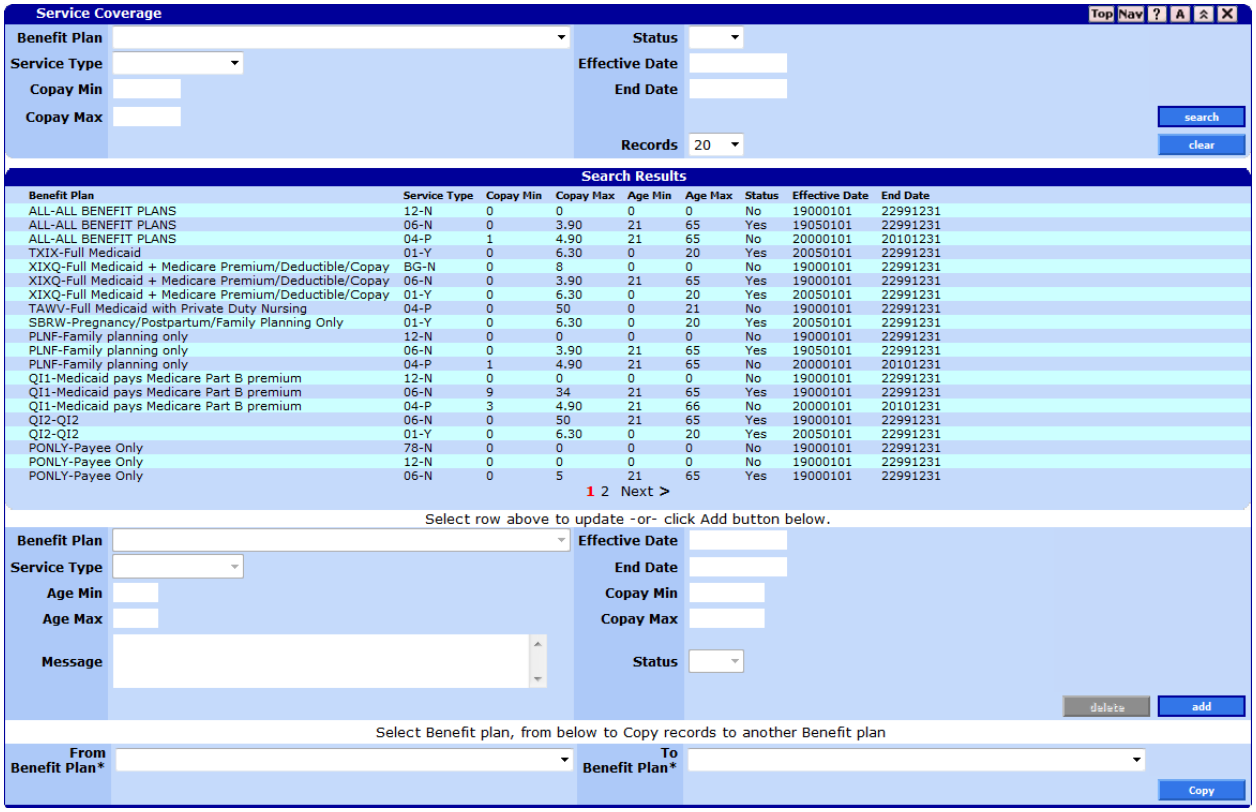
The panel consists of a data list displaying the defined service coverage and a sub-panel where updates and additions are performed.

Selecting an entry from the data list will populate the sub-panel below for update. Alternatively, new entries can be created by clicking "Add" and entering the required data into the update sub-panel.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Eligibility Cvg] - [Service Coverage]

6.248.2 Eligibility Cvg-Service Coverage Panel Layout



6.248.3 Eligibility Cvg-Service Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Service Coverage.	Button	N/A	0
Age Max	The maximum age used under the benefit plan, service type coverage.	Field	Integer	3

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Field	Description	Field Type	Data Type	Length
Age Min	The minimum age used under the benefit plan, service type coverage.	Field	Integer	3
Benefit Plan	Identifies the Medical Benefit program that is supported in the system.	Combo Box		9
Clear	Allows user to clear all search text fields.	Button	N/A	0
Copay Max	The maximum copay covered for specific plan's service coverage. This field can reflect variable minimum copay amounts.	Field	Decimal	5
Copay Min	The minimum copay amount covered for specific plan's service coverage. This field can reflect variable minimum copay amounts.	Field	Decimal	5
Copy	Allows copying records from one benefit plan to another benefit plan.	Button	N/A	0
Delete	Allows the user to delete a Service Coverage.	Button	N/A	0
Effective Date	The beginning date for the use of plan's service coverage information.	Field	Date (CCYYMMDD)	8
End Date	The last date for use of plan's service coverage information.	Field	Date (CCYYMMDD)	8
From Benefit Plan	Identifies the Medical Benefit program that is supported in the system.	Combo Box	Character	9
Message	This is text for the message that applies to the Age range -benefit Plan and service type combination. Indicates if EPDST referral required for some service types.	Field	Character	256
Search	Search for a specific criteria entered for the fields.	Button	N/A	0
Service Type	A code that indicates the type of service that a recipient may be eligible under a benefit plan.	Combo Box	Character	2
Status	Its CDE status, indicating if the service is Active, Inactive depending on the date range on the record. Character code 'Yes' means active and 'No' means inactive.	Field	Character	1
To Benefit Plan	Identifies the Medical Benefit program that is supported in the system.	Combo Box	Character	9

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6.248.4 Eligibility Cvg-Service Coverage Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Combo Box	1	Benefit plan is required.	Select a Benefit Plan.
Service Type	Combo Box	2	Service Type is required.	Select a Service Type.
Age Min	Field	1	Age Min is required.	Enter Minimum Age.
		2	Enter a valid value.	Enter values greater than 0.
		2	Age Maximum must be less than or equal to 120.	Enter Maximum Age to be less than or equal to 120.
		3	Age Minimum must be less than or equal to Age Maximum.	Enter Minimum Age less then Maximum Age.
Copay Min	Field	1	Copay Min is required.	Enter valid amount.
		2	Copay Min must be greater than or equal to 0.00.	Enter Copay Amount must be greater than or equal to 0.
		3	Copay Min must be less than or equal to 999.99.	Enter Copay Amount must be less than or equal to 999.99.
Copay Max	Field	1	Copay Max is required.	Enter Maximum copay.
		2	Copay Max must be greater than or equal to 0.00.	Enter Copay Amount must be greater than or equal to 0.
		3	Copay Max must be less than or equal to 999.99.	Enter Copay Amount must be less than or equal to 999.99.
		4	Copay Minimum must be less than or equal to Copay Maximum.	Enter Minimum copay less then Maximum copay.
Status	Combo Box	1	Status is required.	Select a Status.
Effective Date	Field	1	Effective Date is required.	Enter Effective Date.
		2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
		3	Invalid date. Format is mm/dd/ccyy.	Enter a valid date in mm/dd/ccyy format.
		4	Effective date must be greater than or equal to 1/1/1900.	Enter an Effective date that is less than or equal to 01/01/1900.
		5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is greater than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter End Date.

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Field	Field Type	Error Code	Error Message	To Correct
			Invalid Date. Format is mm/dd/ccyy.	Enter an End Date in mm/dd/ccyy format.
		2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is less than or equal to 01/01/1900.
		3	End Date must be less than or equal to 12/31/2299.	Enter an End date that is less than or equal to 12/31/2299.
Copy	button	1	Please Select both Plans, to copy records From Benefit Plan to To Benefit Plan.	Select From and To plans as both Benefit Plans are required.
		2	From and To benefit plans cannot be same,	Select 2 different benefit plans from Drop down lists.
		3	Copy failed. Either record for from Benefit Plan do not exists or Duplicate record exists.	Select a valid From benefit plan from the drop down list and a valid non existing To plan from drop down list, then Copy.

6.248.5 Eligibility Cvg-Service Coverage Panel Extra Features

Field	Field Type
Service Coverage Panel has Copy button functionality, which copies all rows specific to one Benefit plan to another Benefit plan. Its gives users the ability to add rows and edit each of them as necessary.	

6.248.6 Eligibility Cvg-Service Coverage Panel Accessibility

6.248.6.1 To Access the Eligibility Cvg-Service Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Eligibility Cvg** hyperlink located on the Related Data panel.	Related Data-Eligibility Cvg page displays.
4	Select **Service Coverage**.	Service Coverage panel displays.

6.248.6.2 To Add on the Eligibility Cvg-Service Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Enter **Service Coverage** details.	
3	Click **Save**.	Service Coverage information is saved.

6.248.6.3 To Update on the Eligibility Cvg-Service Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Service Coverage information is saved.

6.248.6.4 To Delete on the Eligibility Cvg-Service Coverage Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.248.6.5 To Copy on the Eligibility Cvg-Service Coverage Panel

Step	Action	Response
1	Select a value from, From Benefit Plan drop down list	
2	Select a different value from To Benefit Plan drop down list. The value selected should be different then From Benefit Plan value.	
3.	Click Copy.	A copy successful message displays, indicating, Copy was successful.

6.248.6.6 To Update on the Eligibility Cvg-Service Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Service Type information is saved.

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6.248.6.7 To Delete on the Eligibility Cvg-Service Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.249 RELATED DATA GROUPS PAGE

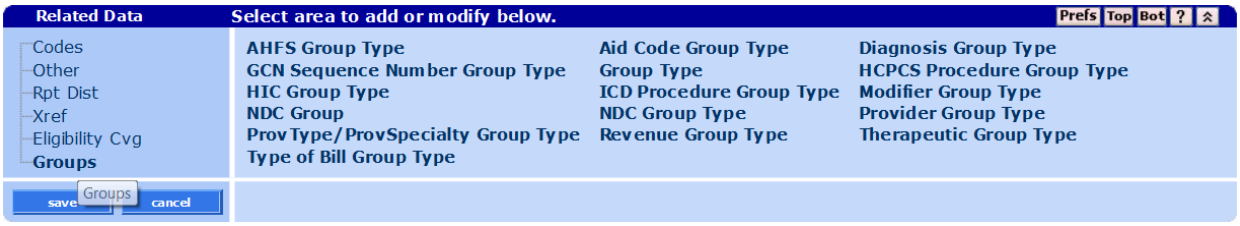
6.249.1 Related Data Groups Page Narrative

The Reference Related Data Groups panel allows the user to access the various group tables maintained within the Reference Data Maintenance subsystem area.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups]

6.249.2 Related Data Groups Page Layout



6.249.3 Related Data Groups Page Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS Group Type	Link to the AHFS Code Group Type panel.	Hyperlink	N/A	0
Aid Code Group Type	Link to the Aid Code Group Type panel.	Hyperlink	N/A	0
Diagnosis Group Type	Link to the Diagnosis Group type panel.	Hyperlink	N/A	0
Group Type	Link to the Group Type panel.	Hyperlink	N/A	0
HCPCS Procedure Group Type	Link to the HCPCS Procedure Group Type panel.	Hyperlink	N/A	0
HIC Group Type	Link to the HIC Group Type panel	Hyperlink	N/A	0
ICD Procedure Group Type	Link to the ICD Procedure Group Type panel.	Hyperlink	N/A	0
Modifier Group Type	Link to the Modifier Group Type panel.	Hyperlink	N/A	0
NDC Group	Link to the NDC Group panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
NDC Group Type	Link to the NDC Group Type panel.	Hyperlink	N/A	0
Provider Group Type	Link to the Provider Group Type panel.	Hyperlink	N/A	0
Prov Type/Prov Specialty Group Type	Link to the Prov Type/Prov Specialty Group Type panel.	Hyperlink	N/A	0
Revenue Group Type	Link to the Revenue Group Type.	Hyperlink	N/A	0
Therapeutic Group Type	Link to the Therapeutic Group Type panel.	Hyperlink	N/A	0
Type of Bill Group Type	Link to the Type of Bill Group Type panel.	Hyperlink	N/A	0

6.249.4 Related Data Groups Page Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.249.5 Related Data Groups Page Extra Features

Field	Field Type
No extra features found for this page.	

6.249.6 Related Data Groups Panel Accessibility

6.249.6.1 To Access the Related Data Groups Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.

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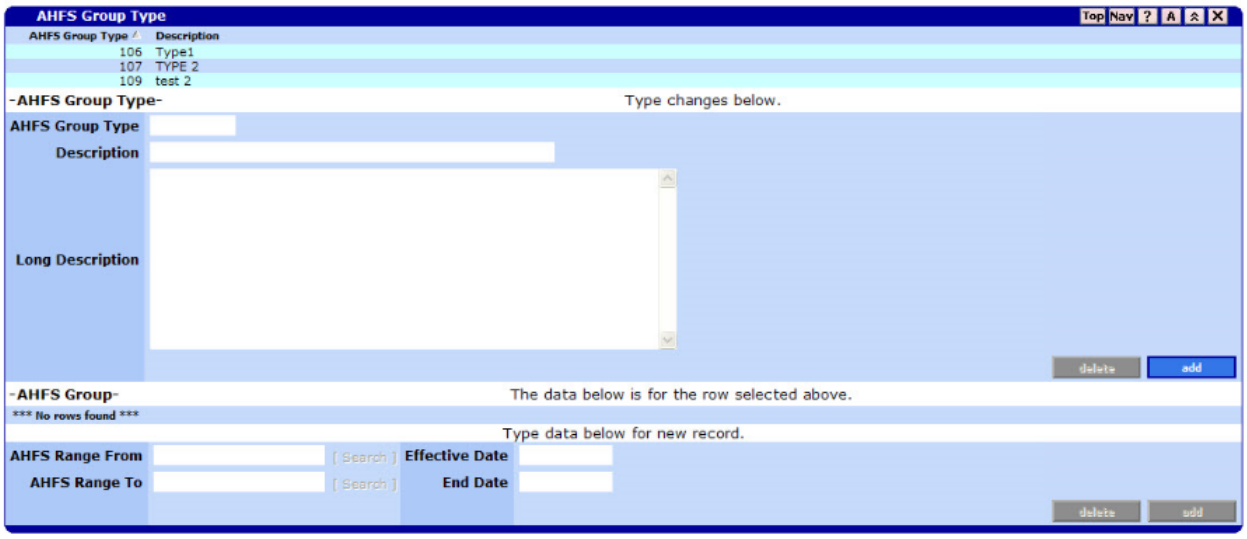
6.250 GROUPS – AFHS GROUP TYPE PANEL

6.250.1 Groups – AFHS Group Type Panel Narrative

The Agency and DXC use the AHFS Group panel to maintain AHFS groupings. The groupings allow for classifying AHFSs together for editing

Navigation Path: [Reference] - [Related Data] - [Groups] - [AHFS Group Type]

6.250.2 Groups – AFHS Group type Panel Layout



6.250.3 Groups – AFHS Group type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
add	Allow the user to add a new AHFS group type or add a new AHFS group type ranges with their Effective and end dates.	Button	N/A	0
delete	Allows the user to delete the selected record.	Button	N/A	0
AHFS Group Type [List/Detail]	System assigned key for a unique AHFS Group type, which represents a single or collection of AHFS.	Field	Number	9
AHFS Range From [List/Detail]	The first AHFS Number in the range.	Field	Alphanumeric	6
AHFS Range To [List/Detail]	The last AHFS Number in the range. If only one AHFS number is needed, this number should be the same as	Field	Character	6

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Field	Description	Field Type	Data Type	Length
	the AHFS Range From.			
Description [List/Detail]	Succinct description (name) of the AHFS Group.	Field	Character	50
Effective Date [List/Detail]	The date from which the AHFS group becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date [List/Detail]	The date on which the AHFS group becomes in-effective.	Field	Date (MM/DD/CCYY)	8
Long Description	The text description of Group purpose. Definition of where and/or how the group type is used.	Field	Character	4000

6.250.4 Groups – AFHS Group type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS Range From [List/Detail]	Field	1	AHFS Range From is required.	Select a AHFS Range From.
	Field	2	AHFS Range From[] must be less than or equal to AHFS Range To[]	Verify keying. AHFS Range From cannot be greater than AHFS Range To.
	Field	3	Date and AHFS Group Type ranges cannot overlap.	Verify keying. Date and AHFS Group Type ranges cannot overlap.
AHFS Range To [List/Detail]	Field	1	AHFS Range To is required.	Select a AHFS Range To.
Description [List/Detail]	Field	1	Description is required.	Description is required.
Effective Date [List/Detail]	Field	1	Effective Date is required.	Verify keying. Enter an Effective Date.
	Field	2	Date and AHFS Group Type Ranges cannot overlap.	Verify keying. Date and AHFS Group Type Ranges cannot overlap.
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than or equal to 1/1/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	5	Invalid date. Format is mm/dd/ccyy.	Verify keying. The date must be in

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Field	Field Type	Error Code	Error Message	To Correct
				mm/dd/ccyy format.
	Field	6	Effective Date must be less than or equal to End Date[].	Verify keying. The Effective Date must be less than or equal to End Date.
End Date [List/Detail]	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 1/1/1900.	End Date must be greater than or equal to 1/1/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	4	Invalid date. Format is mm/dd/ccyy.	Verify keying. End Date must be in mm/dd/ccyy format.
Long Description	Field	1	Long Description is required.	Long Description field is required when adding or modifying the AHFS Group Type.
	Field	2	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 4000 characters.	Long Description cannot exceed 4000 characters.

6.250.5 Groups – AFHS Group type Panel Extra Features

Field	Field Type
No extra features found for this page.	

6.250.6 Groups – AFHS Group type Panel Accessibility

6.250.6.1 To Access the Groups- AFHS Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **AFHS Group Type**.	AFHS Group Type panel displays.

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6.250.6.2 To Add on the Groups- AFHS Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**.	AFHS Group Type information is saved.

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6.251 GROUPS-AID CODE GROUP TYPE PANEL

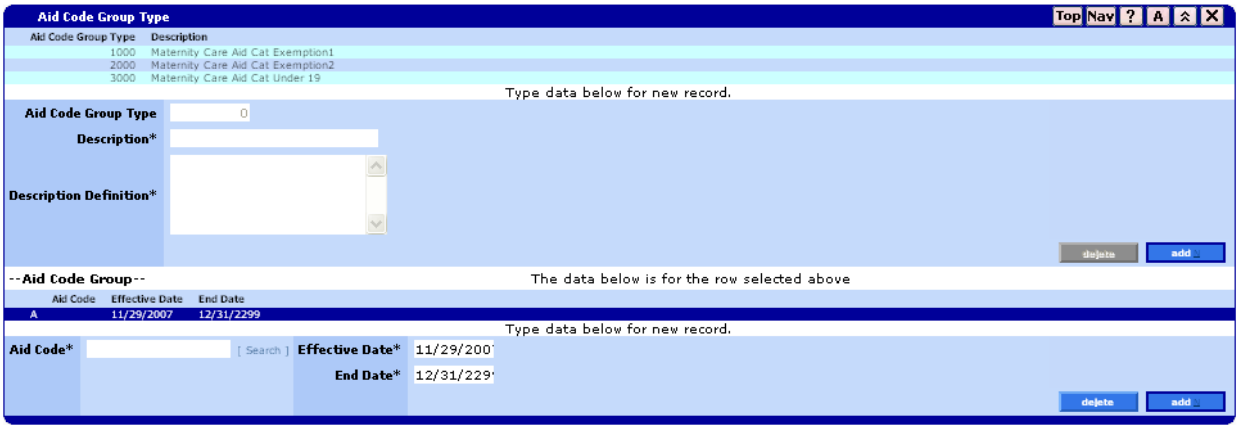
6.251.1 Groups-Aid Code Group Type Panel Narrative

The Aid Group Type panel is used to add Aid Code Group Type values.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data - Groups] - [Aid Code Group Type]

6.251.2 Groups-Aid Code Group Type Panel Layout



6.251.3 Groups-Aid Code Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add and Aid Code Group Type.	Button	N/A	0
Aid Code	Code used to identify a unique Aid Code Group.	Field	Number (Integer)	9
Aid Code Group Type	System assigned key for a unique Aid Code group that represents a single or collection of Aid Code.	Field	Number (Integer)	9
Delete	Allows the user to delete a Aid Code Group Type.	Button	N/A	0
Description	Abbreviated definition describing Aid Code Type definition.	Field	Character	50
Description Definition	Definition of where and/or how this Aid Code group is used.	Field	Character	4000
Effective Date	Date of service on which the Aid Code becomes valid for the Aid Code group.	Field	Character	8
End Date	Date of service on which the Aid Code is no longer valid for the Aid Code Group.	Field	Character	8

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6.251.4 Groups-Aid Code Group Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Description Definition	Field	1	Description Definition is required.	Enter a Description Definition.

6.251.5 Groups-Aid Code Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.251.6 Groups-Aid Code Group Type Panel Accessibility

6.251.6.1 To Access the Groups- Aid Code Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Aid Code Group Type**.	Aid Code Group Type panel displays.

6.251.6.2 To Add on the Groups- Aid Code Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Description Definition**.	
4	Click **Save**.	Aid Code Group Type information is saved.

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6.251.6.3 To Update on the Groups- Aid Code Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Aid Code Group Type information is saved.

6.251.6.4 To Delete on the Groups- Aid Code Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

6.251.6.5 To Add on the Groups- Aid Code Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Aid Code** or Click [Search] link to locate by Aid Code or Aid Description.	
3	Enter **Effective Date** in MM/DD/CCYY format. Note: Defaults to current date.	
4	Enter **End Date** in MM/DD/CCYY format. Note: Defaults to 12/31/2299.	
5	Click **Save**.	Aid Code Group information is saved.

6.251.6.6 To Update on the Groups- Aid Code Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Aid Code Group information is saved.

6.251.6.7 To Delete on the Groups- Aid Code Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

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2	Click **Delete**.	Line item is deleted.

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6.252 GROUPS-DIAGNOSIS GROUP TYPE PANEL

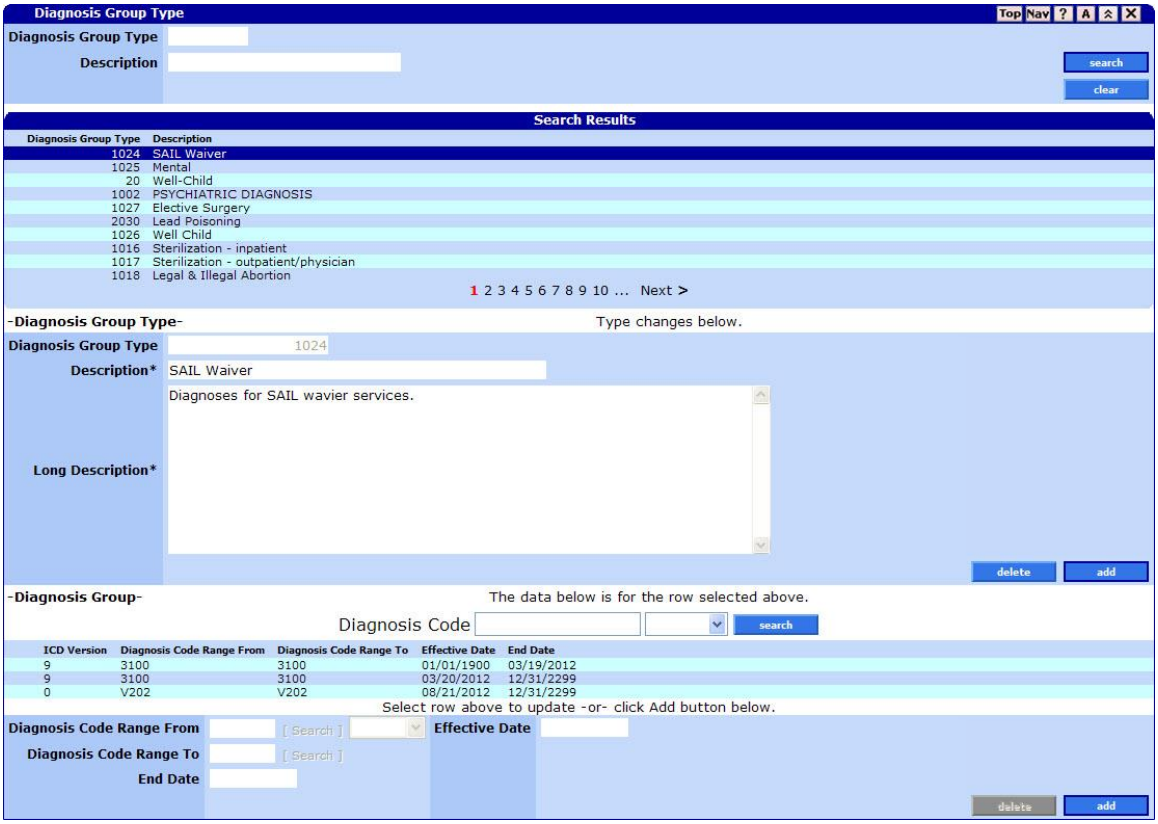
6.252.1 6.204.1 Groups-Diagnosis Group Type Panel Narrative

The Diagnosis Group Maintenance panels are used to create/update groupings of Diagnosis Codes. Groupings are used to identify/categorize services with like characteristics for varying purposes, for example: Confidential services.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]- [Groups] - [Diagnosis Group Type]

6.252.2 Groups-Diagnosis Group Type Panel Layout



6.252.3 Groups-Diagnosis Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Diagnosis Group Type and Diagnosis Group.	Button	N/A	0
Delete	Allows the user to delete a Diagnosis Group Type and Diagnosis Group.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Description	Succinct description (name) of the Diagnosis Group Type.	Field	Character	50
Diagnosis Code	It allows to search by Diagnosis code into Diagnosis group list.	Field	Alphanumeric	7
Diagnosis Code Range From	Upper limit of the diagnosis code range associated to the current group.	Field	Alphanumeric	7
Diagnosis Code Range To	Lower limit of the diagnosis code range associated to the current group.	Field	Alphanumeric	7
Diagnosis Group Type	System assigned key for a unique diagnosis type that represents a collection of diagnosis codes.	Field	Number (Integer)	9
Effective Date	First date of service the diagnosis code (or range) is effective for the Diagnosis Group.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the diagnosis code (or range) is effective for the Diagnosis Group.	Field	Date (MM/DD/CCYY)	8
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1
Long Description	Group purpose. Definition of where and/or how this Diagnosis Group is used.	Field	Character	4000

6.252.4 Groups-Diagnosis Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a description.
Diagnosis Code Range From	Field	1	A valid Diagnosis Code Range From is required.	Enter a valid code from the list.

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Field	Field Type	Error Code	Error Message	To Correct
		2	Date and Code range segments cannot overlap.	Verify keying. Codes and dates cannot overlap.
		3	Diagnosis From cannot be greater than Diagnosis To.	Enter a valid Diagnosis Code range.
Diagnosis Code Range To	Field	1	A valid Diagnosis Code Range To is required.	Enter a valid code from the list.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
		2	Effective Date must be greater than or equal to 1/1/1900.	Enter a Date greater than or equal to 1/1/1900.
		3	Effective Date must be less than or equal to 12/31/2299.	Enter a Date less than or equal to 12/31/2299.
		4	Effective Date must be less than or equal to End Date.	Enter an Effective Date less than or equal to the End Date.
		5	Date range segments cannot overlap.	Correct overlap condition. Date ranges cannot overlap for the same code.
		6	Invalid Date. Format is mm/dd/ccyy.	Enter an Effective Date in mm/dd/ccyy format.
End Date	Field	1	End Date is required.	Enter an End Date.
		2	End Date must be greater than or equal to 1/1/1900.	Enter an End Date greater than or equal to 1/1/1900.
		3	End Date must be less than or equal to 12/31/2299.	Enter an End Date less than or equal to 12/31/2299.
		4	Invalid Date. Format is mm/dd/ccyy.	Enter an End Date in mm/dd/ccyy format.
Diagnosis Group Type	Field	1	Diagnosis Group is required.	Enter a valid Diagnosis Group.
Long Description	Field	1	Long Description is required.	Enter a Long Description.

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6.252.5 Groups-Diagnosis Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.252.6 Groups-Diagnosis Group Type Panel Accessibility

6.252.6.1 To Access the Groups-Diagnosis Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Diagnosis Group Type**.	Diagnosis Group Type panel displays.

6.252.6.2 To Add on the Groups-Diagnosis Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. Diagnosis Group Type number is automatically generated.	Diagnosis Group Type information is saved.

6.252.6.3 To Update on the Groups-Diagnosis Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Diagnosis Group Type information is saved.

6.252.6.4 To Delete on the Groups-Diagnosis Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.252.6.5 To Access the Groups-Diagnosis Group Type-Diagnosis Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data panel displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups panel displays.
4	Select **Diagnosis Group Type**.	Groups- Diagnosis Group Type panel displays.
5	Select a group.	Diagnosis Group Type-Diagnosis Group panel displays.

6.252.6.6 To Add on the Groups-Diagnosis Group Type-Diagnosis Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Diagnosis Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Diagnosis Code Range From information is populated on panel.
4	Select **Diagnosis Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Diagnosis Code Range To information is populated on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	Diagnosis Group Type-Diagnosis Group information is saved.

6.252.6.7 To Update on the Groups-Diagnosis Group Type-Diagnosis Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Diagnosis Group Type-Diagnosis Group information is saved.

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6.252.6.8 To Delete on the Groups-Diagnosis Group Type-Diagnosis Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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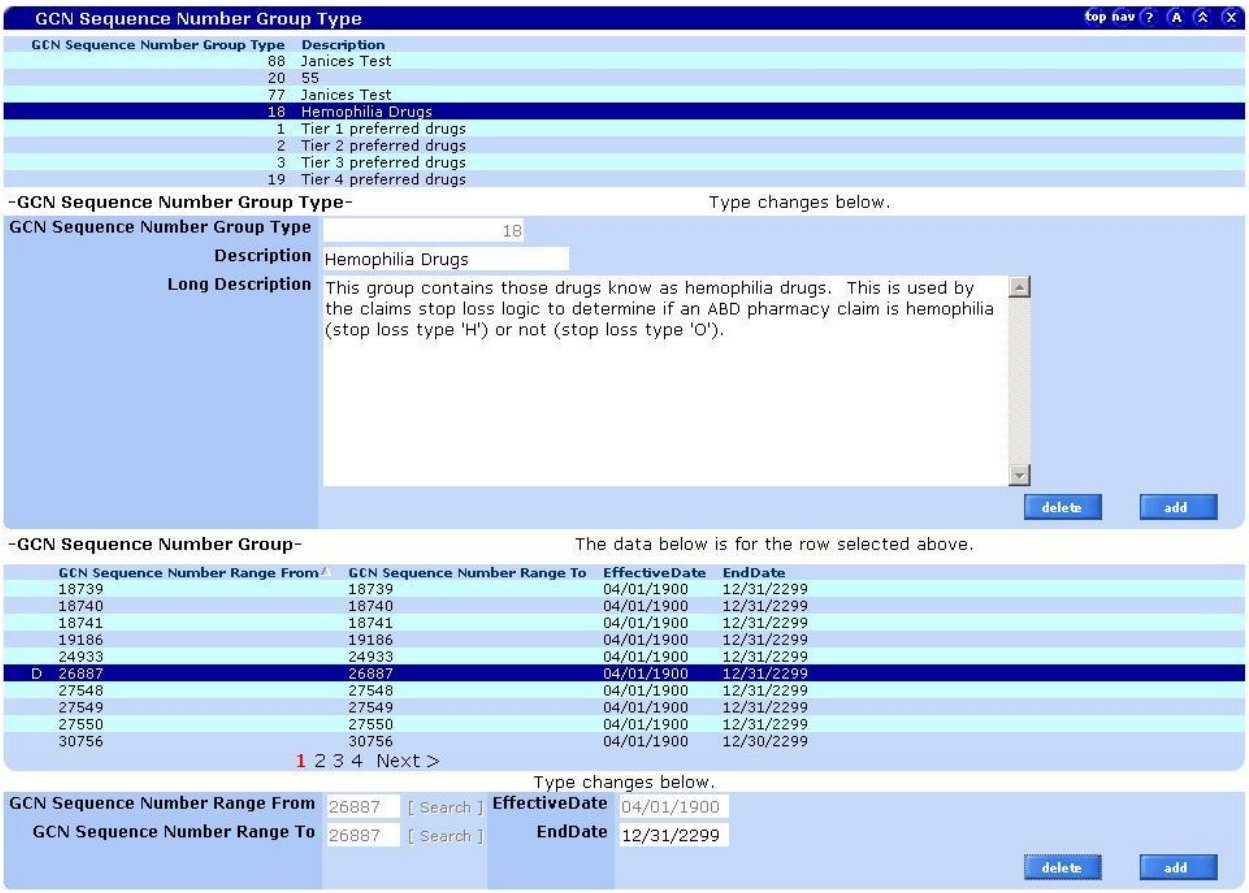
6.253 GROUPS-GCN SEQUENCE NUMBER GROUP TYPE PANEL

6.253.1 Groups-GCN Sequence Number Group Type Panel Narrative

The GCN Sequence Number Group Type panel is used to maintain GCN Sequence Number Type information used to group GCN sequence numbers together. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [GCN Sequence Number Group Type]

6.253.2 Groups-GCN Sequence Number Group Type Panel Layout



6.253.3 Groups-GCN Sequence Number Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a GCN Sequence Number Group Type.	Button	N/A	0
Delete	Delete a GCN Sequence Number Group Type.	Button	N/A	0
Description	Description of GCN Sequence number grouping.	Field	Character	25

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Field	Description	Field Type	Data Type	Length
GCN Sequence Number Group Type	System assigned key for a unique GCN sequence number type, which represents a single or collection of GCN sequence number.	Field	Number (Integer)	4
Long Description	Definition of where and/or how this GCN Sequence Number group is used.	Field	Character	4000

6.253.4 Groups-GCN Sequence Number Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a description when adding or modifying GCN Sequence Number Group Type.
Long Description	Field	1	Long Description is required.	Enter a Long Description field when adding or modifying GCN Sequence Number Group Type.

6.253.5 Groups-GCN Sequence Number Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.253.6 Groups-GCN Sequence Number Group Type Panel Accessibility

6.253.6.1 To Access the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagedisplays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **GCN Sequence Number Group Type**.	GCN Sequence Number Group Type panel displays.

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6.253.6.2 To Add on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**.	GCN Sequence Number Group Type information is saved.

6.253.6.3 To Update on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	GCN Sequence Number Group Type information is saved.

6.253.6.4 To Delete on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.254 GROUPS-GCN SEQUENCE NUMBER GROUP TYPE-GCN SEQUENCE NUMBER GROUP PANEL

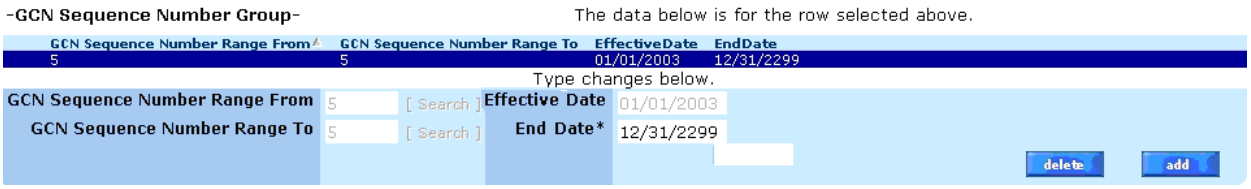
6.254.1 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Narrative

The GCN Sequence Number Group panel is used to maintain GCN Sequence Number groupings. The groupings allow for classifying GCN sequence numbers together for editing and reporting purposes.

The Generic Code Number (GCN) Sequence Number is a unique number representing the generic formulation. The GCN Sequence Number is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN Sequence Number is the same across manufacturers and/or package sizes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [GCN Sequence Number Group Type]

6.254.2 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Layout



6.254.3 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a GCN sequence number grouping.	Button	N/A	0
Delete	Delete a GCN sequence number grouping.	Button	N/A	0
Effective Date	The date that the GCN sequence number grouping is to become effective for the GCN sequence number type in processing.	Field	Date (MM/DD/CCYY)	8
End Date	The date that the GCN sequence number grouping is no longer in effect for the GCN sequence number type in processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
GCN Sequence Number Range From [Search]	This represents the starting range for the GCN Sequence Number. The Generic Code Number Sequence Number represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Hyperlink	N/A	0
GCN Sequence Number Range To [Search]	This represents the ending range for GCN sequence number. The Generic Code Number Sequence Number represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	Hyperlink	N/A	0

6.254.4 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Effective Date is required.	Enter a valid Effective Date.
	Field	12	Date and Sequence Number range segments cannot overlap.	Enter Date and Sequence Number range segments that do not overlap.
	Field	15	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	16	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	17	Effective Date cannot overlap.	Enter an Effective Date that does not overlap.
	Field	21	Invalid date. Format is MM/DD/CCYY.	Enter a valid Effective Date in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
EndDate	Field	2	End Date is required.	Enter a valid End Date in MM/DD/CCYY format.
	Field	15	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	16	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	21	Invalid date.	Enter a valid date in MM/DD/CCYY format.
GCN Sequence Number Range From	Hyperlink	1	A valid GCN Sequence Number Range From is required.	Select a valid GCN Sequence Number Range From.
GCN Sequence Number Range To	Hyperlink	1	A valid GCN Sequence Number Range To is required.	Select a valid GCN Sequence Number Range To.

6.254.5 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.254.6 Groups-GCN Sequence Number Group Type-GCN Sequence Number Group Panel Accessibility

6.254.6.1 To Access the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **GCN Sequence Number Group Type**.	GCN Sequence Number Group Type panel displays.

6.254.6.2 To Add on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click **Add**. (GCN Sequence Number Group)	Activates fields for entry of data or selection from lists.

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Step	Action	Response
2	Select [Search]**GCN Sequence Number Range From**.	
3	Enter search criteria or select row from list of results.	GCN Sequence Number Range From information is populated on panel.
4	Select [Search] **GCN Sequence Number Range To**.	
5	Enter search criteria or select row from list of results.	GCN Sequence Number Range To information is populated on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	GCN Sequence Number Group Type information is saved.

6.254.6.3 To Update on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	GCN Sequence Number Group Type information is saved.

6.254.6.4 To Delete on the GCN Sequence Number Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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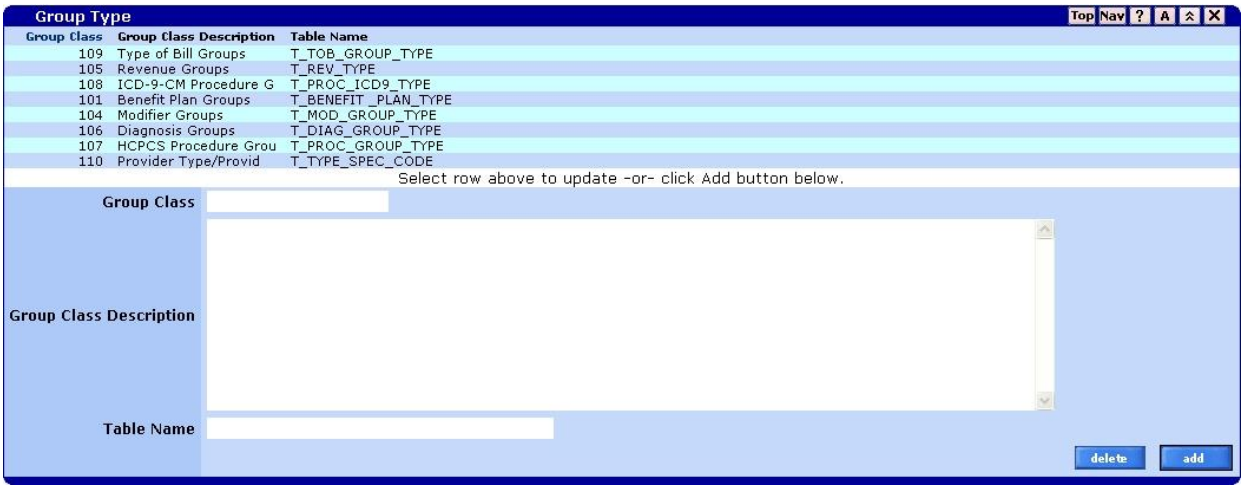
6.255 GROUPS-GROUP TYPE PANEL

6.255.1 Groups-Group Type Panel Narrative

The Group Type panel is used to maintain the group types that can be indicated that are used by claim edits and audits. The group types are displayed on the Resolution Group panel. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Group Type]

6.255.2 Groups-Group Type Panel Layout



6.255.3 Groups-Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Group Type.	Button	N/A	0
Delete	Allows the user to delete a Group Type.	Button	N/A	0
Group Class	System assigned key for a unique group type, that represents a single or collection of Group Class.	Field	Number (Integer)	8
Group Class Description	Description for the group class that will be displayed on the resolution window. Examples: This is the description for the group class that will be displayed on the resolution window. Examples: Procedure Groups, Diagnosis Groups.	Field	Character	4000
Table Name	Name of the table that contains the groups of a Group Class. For example, if the Group Class is Procedure group then the table name is T_PROC_TYPE.	Field	Character	40

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6.255.4 Groups-Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Group Class Description	Field	1	Group Class Description is required.	Add a Group Class description when adding or modifying Group Type.
Table Name	Field	1	Table Name is required.	Enter a Table Name field when adding or modifying Group Type.

6.255.5 Groups-Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.255.6 Groups-Group Type Panel Accessibility

6.255.6.1 To Access the Groups-Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Group Type**.	Group Type panel displays.

6.255.6.2 To Add on the Groups-Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Group Class Description**.	
3	Enter **Table Name**.	
4	Click **Save**. Group Class number is automatically generated.	Group Type information is saved.

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6.255.6.3 To Update on the Groups-Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Group Type information is saved.

6.255.6.4 To Delete on the Groups-Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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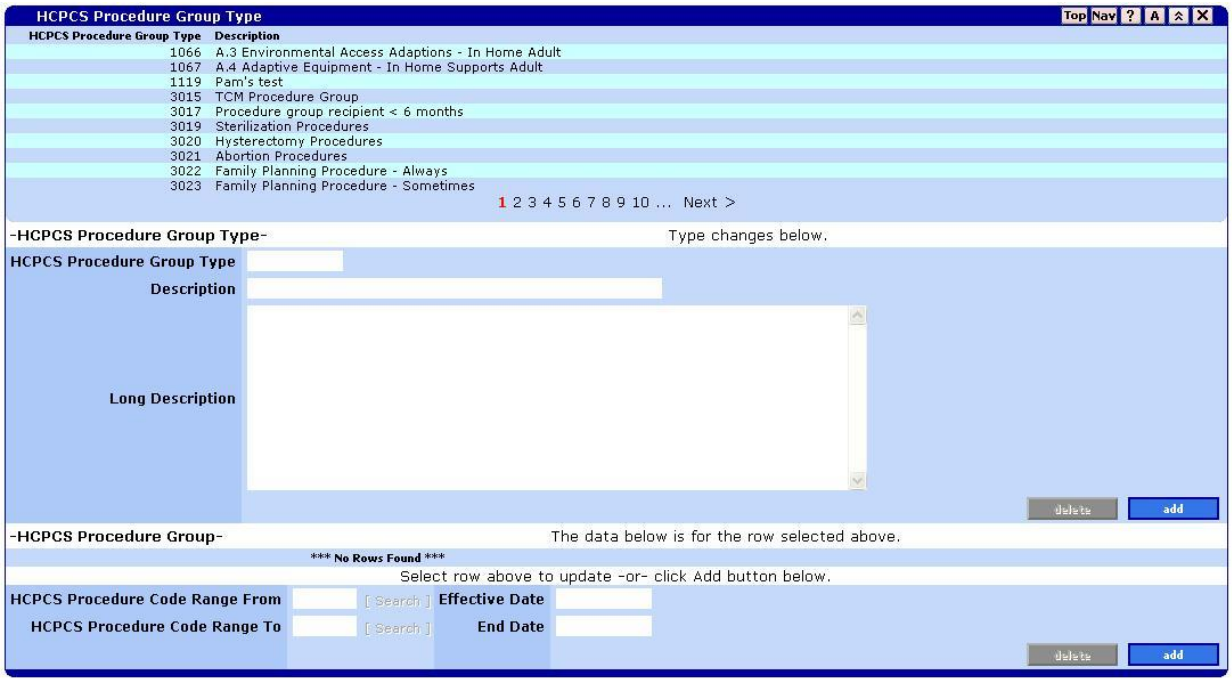
6.256 GROUPS-HCPCS PROCEDURE GROUP TYPE PANEL

6.256.1 Groups-HCPCS Procedure Group Type Panel Narrative

The HCPCS Procedure Group Type panel is used to create/update groupings of Procedure Codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. E.G. Confidential services. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [HCPCS Procedure Group Type]

6.256.2 Groups-HCPCS Procedure Group Type Panel Layout



6.256.3 Groups-HCPCS Procedure Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Procedure Group Type.	Button	N/A	0
Delete	Allows the user to delete a Procedure Group Type.	Button	N/A	0
Description	Succinct description (name) of the Procedure Group.	Field	Character	50
HCPCS Procedure Group Type	Unique system assigned key for the Procedure Group. Represents a collection of Procedures.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Long Description	Group purpose. Definition of where and/or how this Procedure Group is used.	Field	Character	4000

6.256.4 Groups-HCPCS Procedure Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description for the HCPCS Group Type.
HCPCS Procedure Group Type	Field	1	A valid Procedure Group is required.	Enter a procedure group.
Long Description	Field	1	Long Description is required.	Enter a Long Description for the HCPCS Group Type.

6.256.5 Groups-HCPCS Procedure Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.256.6 Groups-HCPCS Procedure Group Type Panel Accessibility

6.256.6.1 To Access the Groups-HCPCS Procedure Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **HCPCS Procedure Group Type**.	HCPCS Procedure Group Type panel displays.

6.256.6.2 To Add on the Groups-HCPCS Procedure Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	

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Step	Action	Response
4	Click **Save**. HCPCS Procedure Group Type number is automatically generated.	HCPCS Procedure Group Type information is saved.

6.256.6.3 To Update on the Groups-HCPCS Procedure Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HCPCS Procedure Group Type information is saved.

6.256.6.4 To Delete on the Groups-HCPCS Procedure Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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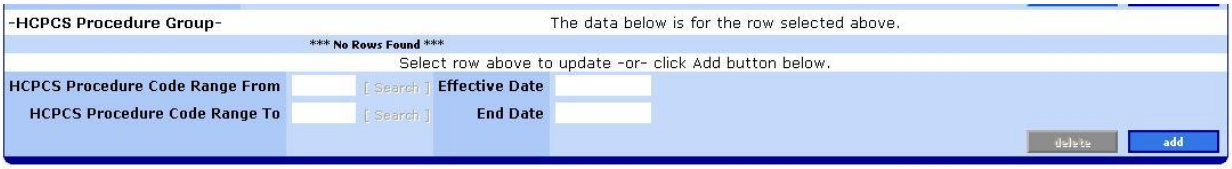
6.257 PA GROUPS-HCPCS PROCEDURE GROUP TYPE-HCPCS PROCEDURE GROUP PANEL

6.257.1 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Narrative

The HCPCS Procedure Group panel is used to view procedure groups assigned to a Procedure Code and to assign types to individual HCPCS Procedure Codes which will assist with both pricing and processing logic for that Procedure Code. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [HCPCS Procedure Group Type] - (Select a [HCPCS Procedure Group Type])

6.257.2 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Layout



6.257.3 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Procedure Code or range of codes to the selected Procedure Group Type.	Button	N/A	0
Delete	Allows a user to delete a Procedure Code (or range) from the selected Procedure Group Type.	Button	N/A	0
Effective Date	First date of service the HCPCS Procedure Code becomes effective within the Procedure Group Type.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the HCPCS Procedure Code is effective within the Procedure Group Type.	Field	Date (MM/DD/CCYY)	8
HCPCS Procedure Code Range From [Search]	Lower limit of the Procedure Code range associated to the current group.	Hyperlink	N/A	0
HCPCS Procedure Code Range To [Search]	Upper limit of the Procedure Code range associated to the current group.	Hyperlink	N/A	0

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6.257.4 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
HCPCS Procedure Code Range From	Hyperlink	1	A valid HCPCS Procedure Code Range From is required.	Select a Procedure Code.
	Hyperlink	2	Procedure From cannot be greater than Procedure To.	Select a Procedure From code that is less than or equal to the Procedure To code.
	Hyperlink	3	Date and Procedure Code range segments can not overlap.	Correct overlap condition. Date and Procedure Code ranges cannot overlap an existing segment.
HCPCS Procedure Code Range To	Hyperlink	1	A valid HCPCS Procedure Code Range To is required.	Select a procedure code.

6.257.5 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.257.6 Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel Accessibility

6.257.6.1 To Access the Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **HCPCS Procedure Group Type**.	HCPCS Procedure Group Type-HCPCS Procedure Group panel displays.

6.257.6.2 To Add on the Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **HCPCS Procedure Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	HCPCS Procedure Code Range From information is displayed on panel.
4	Select **HCPCS Procedure Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	HCPCS Procedure Code Range TO information is displayed on panel.
6	Select **Modifier** by clicking [Search] button.	
7	Enter search criteria. User may also select a row from the list of search results.	Modifier information is displayed on panel.
8	Enter **Effective Date** in MM/DD/CCYY format.	
9	Enter **End Date** in MM/DD/CCYY format.	
10	Click **Save**.	HCPCS Procedure Group Type-HCPCS Procedure Group information is saved.

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6.257.6.3 To Update on the Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HCPCS Procedure Group Type-HCPCS Procedure Group information is saved.

6.257.6.4 To Delete on the Groups-HCPCS Procedure Group Type-HCPCS Procedure Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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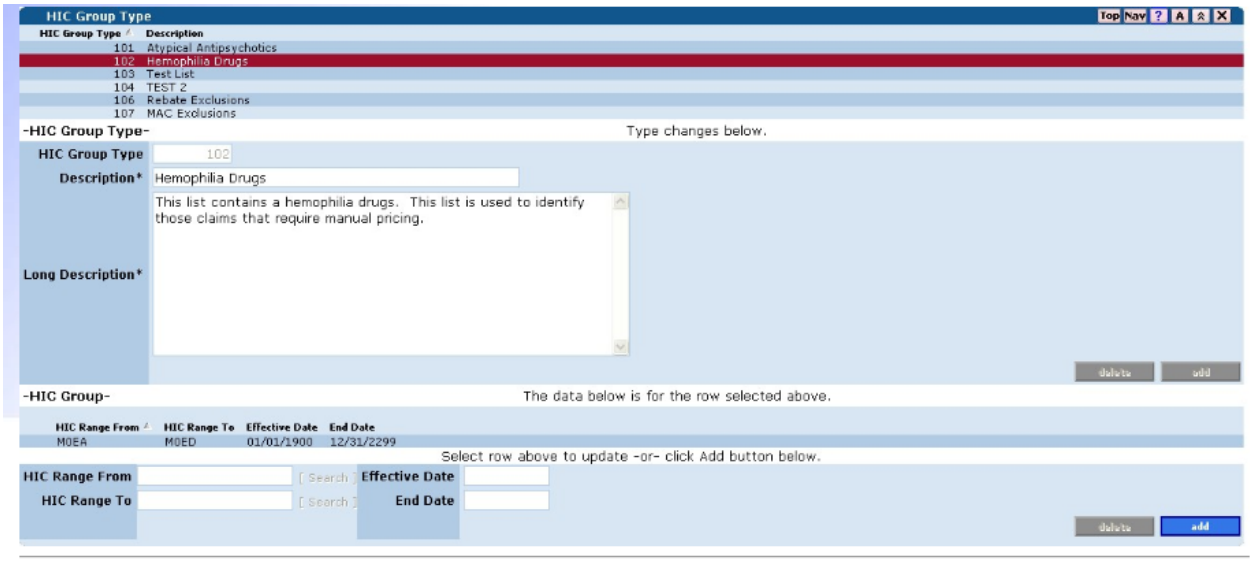
6.258 GROUPS - HIC GROUP TYPE PANEL

6.258.1 Groups – HIC Group Type Panel Narrative

The Agency and DXC use the Other-HIC Group panel to view and maintain HIC groupings. This allows for grouping HICs together for claims processing and reporting purposes.

Navigation Path: [Reference] - [Related Data] - [Groups] - [HIC Group Type]

6.258.2 Groups – HIC Group Type Panel Layout



6.258.3 Groups – HIC Group Type Panel Field Description

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new HIC group type or add a new HIC group type ranges with their Effective and End dates.	Button	N/A	0
Delete	Allows the user to Delete the selected record.	Button	N/A	0
Description [List/Detail]	Succinct description (name) of the HIC Group.	Field	Character	25
Effective Date [List/Detail]	The date from which the HIC group becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date [List/Detail]	The date on which the HIC group becomes in-effective.	Field	Date (MM/DD/CCYY)	8
HIC Group Type [List/Detail]	System assigned key for a unique HIC Group type,	Field	Number	9

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Field	Description	Field Type	Data Type	Length
	which represents a single or collection of HIC.			
HIC Range From [List/Detail]	The first HIC Number in the range.	Field	Character	6
HIC Range To [List/Detail]	The last HIC Number in the range. If only one HIC number is needed, this number should be the same as the HIC Range From.	Field	Character	6
Long Description	The text description of Group purpose. Definition of where and/or how the group type is used.	Field	Character	4000

6.258.4 Groups –HIC Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description [List/Detail]	Field	1	Description is required.	A description is required when adding or modifying the HIC Group Type.
Effective Date [List/Detail]	Field	1	Effective Date is required.	Verify keying. Enter an Effective Date.
	Field	2	Date and HIC Group Type Ranges cannot overlap.	Verify keying. Date and HIC Group Type Ranges cannot overlap.
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than or equal to 1/1/1900.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	5	Effective Date cannot overlap.	Verify keying. Effective Date cannot overlap.
	Field	6	Invalid date. Format is mm/dd/ccyy.	Verify keying. The date must be in mm/dd/ccyy format.
	Field	7	Effective Date must be less than or equal to End Date[].	Verify keying. The Effective Date must be less than or equal to End Date.
End Date [List/Detail]	Field	1	End Date is required.	Enter an End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	End Date must be greater than or equal to 1/1/1900.	Verify keying. End Date must be greater than or equal to 1/1/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	4	Invalid date. Format is mm/dd/ccyy.	Verify keying. End Date must be in mm/dd/ccyy format.
HIC Range From [List/Detail]	Field	1	A valid HIC Range From is required.	Select a HIC Range From.
	Field	2	HIC Range From cannot be greater than HIC Range To.	Verify keying. HIC Range From cannot be greater than HIC Range To.
	Field	3	Date and HIC Group Type ranges cannot overlap.	Verify keying. Date and HIC Group Type ranges cannot overlap.
	Field	4	HIC Range From Not Found	Enter valid HIC Range From.
HIC Range To [List/Detail]	Field	1	A valid HIC Range To is required.	Select a HIC Range To.
	Field	2	HIC Range To Not Found.	Enter a valid HIC Range To.
Long Description	Field	1	Long Description is required.	Long Description field is required when adding or modifying the HIC Group Type.
	Field	2	You have exceeded the maximum characters allowed for this field. Your text has been truncated to the maximum 4000 characters.	Long Description can not exceed 4000 characters.

6.258.5 Groups-HIC Group Type Panel Accessibility

6.258.5.1 To Access the Groups-HIC Group Type- Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.

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Step	Action	Response
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **HIC Group Type**.	HIC Group Type panel displays.

6.258.5.2 To Add on the Groups-HIC Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2		
3		
4		
5		
6		
7		
8		
9		
10		

6.258.5.3 To Update on the Groups- HIC Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIC Group Type Panel information is saved.

6.258.5.4 To Delete on the Groups- HIC Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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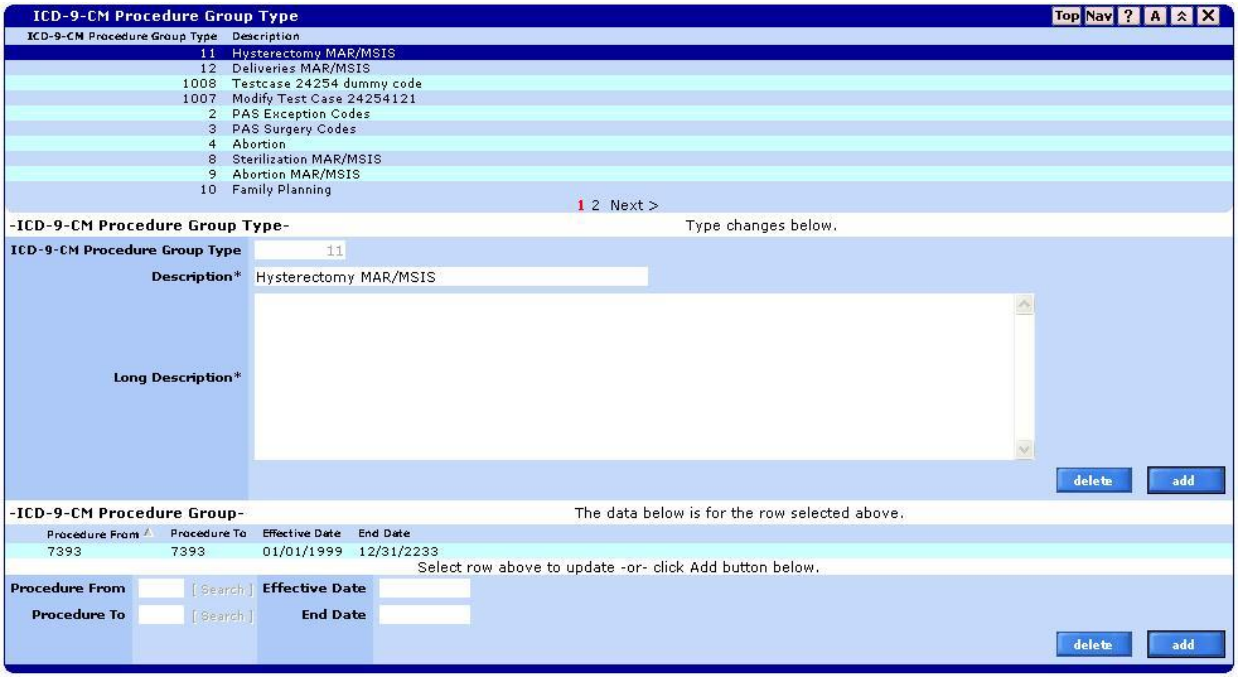
6.259 GROUPS-ICD PROCEDURE GROUP TYPE PANEL

6.259.1 Groups-ICD Procedure Group Type Panel Narrative

The ICD Procedure Type panel is used to maintain ICD Procedure Types which are associated with a group of ICD-9 CM Procedure Codes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [ICD Procedure Group Type]

6.259.2 Groups-ICD Procedure Group Type Panel Layout



6.259.3 Groups-ICD Procedure Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a new ICD Procedure Group Type.	Button	N/A	0
Delete	Delete an ICD Procedure Group Type.	Button	N/A	0
Description	Name of the Procedure Group.	Field	Character	25
ICD Procedure Group Type	Unique system assigned key for the Procedure Group. Represents a collection of Procedures.	Field	Number (Integer)	9
Long Description	Group purpose. Definition of where and/or how this Procedure Group is used.	Field	Character	4000

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6.259.4 Groups-ICD Procedure Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description field when adding or modifying ICD Procedure Group Type.
Long Description	Field	1	Long Description is required.	Enter a Long Description field when adding or modifying ICD Procedure Type.

6.259.5 Groups-ICD Procedure Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.259.6 Groups-ICD Procedure Group Type Panel Accessibility

6.259.6.1 To Access the Groups-ICD Procedure Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **ICD Procedure Group Type**.	ICD Procedure Group Type panel displays.

6.259.6.2 To Add on the Groups-ICD Procedure Group Type Panel

Step	Action	Response
1	Click **Add**. (ICD Procedure Group Type)	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. ICD Procedure Group Type number is automatically generated.	ICD Procedure Group Type information is saved.

6.259.6.3 To Update on the Groups-ICD Procedure Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	ICD Procedure Group Type information is saved.

6.259.6.4 To Delete on the Groups-ICD Procedure Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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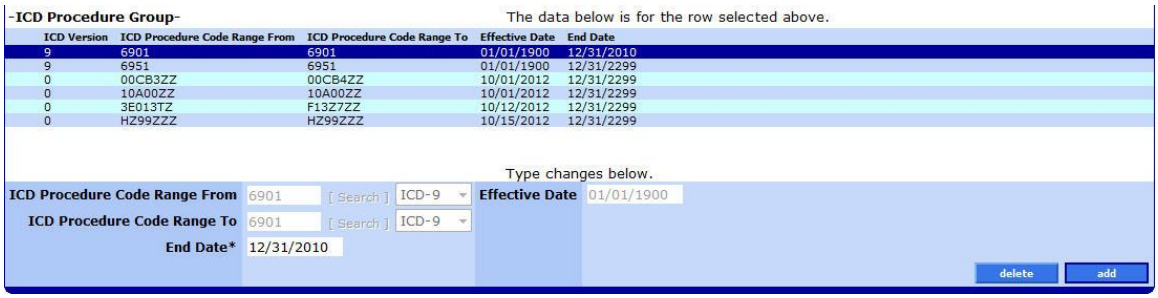
6.260 GROUPS-ICD PROCEDURE GROUP TYPE-ICD PROCEDURE GROUP PANEL

6.260.1 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Narrative

The ICD Procedure Group Maintenance panel is used to view and update ICD Procedure Codes related to a specific ICD Group. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [ICD Procedure Group Type] - (Select a [ICD Procedure Group])

6.260.2 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Layout



6.260.3 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Procedure Code or range of codes to the selected ICD Procedure Group Type.	Button	N/A	0
Delete	Allows a user to delete a Procedure Code or range of codes to the selected ICD Procedure Group Type.	Button	N/A	0
Effective Date	First date of service the ICD Procedure Code is effective within the ICD Procedure Group Type.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the ICD Procedure Code is effective within the ICD Procedure Group Type.	Field	Date (MM/DD/CCYY)	8
ICD Procedure Code Range From [Search]	Lower limit of the Procedure Code range associated to the current group.	Hyperlink	N/A	0
ICD Procedure Code Range To [Search]	Upper limit of the Procedure Code range associated to the current group.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values are '9' for ICD-9 and '0' for ICD-10.	Field	Character	1

6.260.4 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter an Effective Date in MM/DD/CCYY format.
	Field	3	Date and Code range segments cannot overlap.	Correct overlap condition. Date and Code range segments cannot overlap.
	Field	4	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date. Format is mm/dd/ccyy.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
ICD Procedure Code Range From	Field	1	Procedure Code Range From cannot be greater than Procedure To.	Select a Procedure Code Range From that is less than or equal to Procedure To.
	Field	2	A valid Procedure Code Range From is required.	Select a valid Procedure Code Range From is required.
	Field	3	ICD version of From and To codes must match.	Select a valid Procedure Code From.
	Field	4	ICD Procedure Code Range From Does Not Exist.	Select a valid Procedure Code Range From.
ICD Procedure Code Range To	Field	1	A valid Procedure Code Range To is required.	Select a valid Procedure Code Range To.
	Field	2	A valid ICD Procedure Code Range To is required.	Select a valid Procedure Code Range To.

6.260.5 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.260.6 Groups-ICD Procedure Group Type-ICD Procedure Group Panel Accessibility

6.260.6.1 To Access the Groups-ICD Procedure Group Type ICD Procedure Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **ICD Procedure Group Type**.	Groups- ICD Procedure Group Type panel displays.
5	Select a row.	ICD Procedure Group Type ICD Procedure Group panel displays.

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6.260.6.2 To Add on the Groups-ICD Procedure Group Type ICD Procedure Group Panel

Step	Action	Response
1	Click **Add**. (ICD Procedure Group Type)	Activates fields for entry of data or selection from lists.
2	Select **ICD Procedure Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	ICD Procedure Code Range From information is displayed on panel.
4	Select **ICD Procedure Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	ICD Procedure Code Range TO information is displayed on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**. ICD Procedure Group Type number is automatically generated.	ICD Procedure Group Type ICD Procedure Group information is saved.

6.260.6.3 To Update on the Groups-ICD Procedure Group Type ICD Procedure Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	ICD Procedure Group Type ICD Procedure Group information is saved.

6.260.6.4 To Delete on the Groups-ICD Procedure Group Type ICD Procedure Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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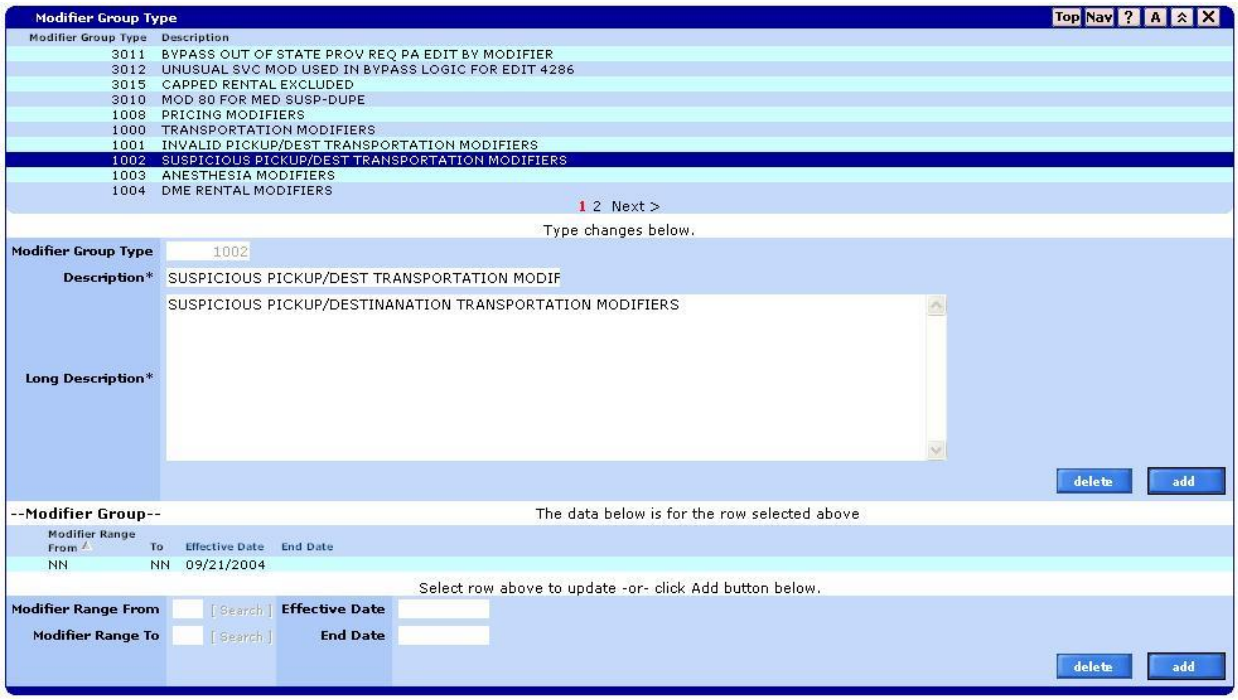
6.261 GROUPS-MODIFIER GROUP TYPE PANEL

6.261.1 Groups-Modifier Group Type Panel Narrative

The Modifier Group Type panel displays the description of modifier groups. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Modifier Group Type]

6.261.2 Groups-Modifier Group Type Panel Layout



6.261.3 Groups-Modifier Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Modifier Group Type.	Button	N/A	0
Delete	Delete a Modifier Group Type.	Button	N/A	0
Description	Describes the modifier group type.	Field	Character	50
Long Description	Long description of the modifier group type. It includes where and/or how this modifier group is used.	Field	Character	4000
Modifier Group Type	System assigned key for a unique modifier grouping type that represents a collection of modifier codes.	Field	Number (Integer)	9

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6.261.4 Groups-Modifier Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description field when adding or modifying Modifier Group Type.
Long Description	Fiel	1	Long Description is required.	Enter a Long Description field when adding or modifying Modifier Group Type.

6.261.5 Groups-Modifier Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.261.6 Groups-Modifier Group Type Panel Accessibility

6.261.6.1 To Access the Groups-Modifier Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Modifier Group Type**.	Modifier Group Type panel displays.

6.261.6.2 To Add on the Groups-Modifier Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. Modifier Group Type number is automatically generated.	Modifier Group Type information is saved.

6.261.6.3 To Update on the Groups-Modifier Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Modifier Group Type information is saved.

6.261.6.4 To Delete on the Groups-Modifier Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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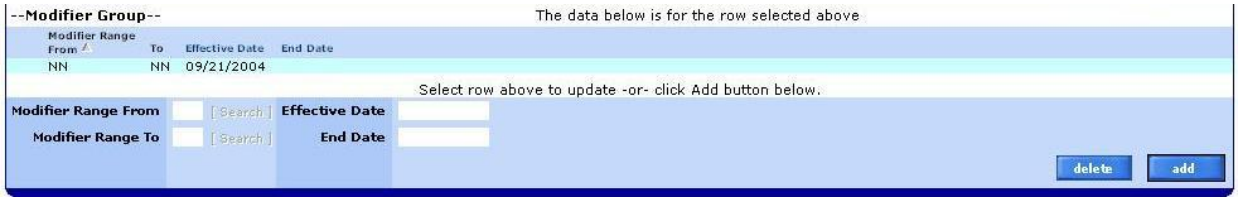
6.262 GROUPS-MODIFIER GROUP TYPE-MODIFIER GROUP PANEL

6.262.1 Groups-Modifier Group Type-Modifier Group Panel Narrative

The Modifier Group panel is used to establish and maintain groups of modifiers for claims processing. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] – [Groups] - [Modifier group Type] - (Select a [Modifier Group Type])

6.262.2 Groups-Modifier Group Type-Modifier Group Panel Layout



6.262.3 Groups-Modifier Group Type-Modifier Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a modifier group.	Button	N/A	0
Delete	Delete a modifier group.	Button	N/A	0
Effective Date	This is the date of service on which the Modifier becomes effective for the claims processing for the Modifier Group.	Field	Date (MM/DD/CCYY)	8
End Date	The last day, based on date of service, that the modifier group is valid for claims processing.	Field	Date (MM/DD/CCYY)	8
Modifier Range From [Search]	This is the lower limit of the Modifier range associated with a group.	Hyperlink	N/A	0
Modifier Range To [Search]	This is the upper limit of the Modifier range associated with a group.	Hyperlink	N/A	0

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6.262.4 Groups-Modifier Group Type-Modifier Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Invalid date.	Enter a valid effective date.
	Field	3	Date range segments cannot overlap.	Enter a valid date/range.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
End Date	Field	1	Invalid date.	Enter a valid date.
	Field	2	End Date is required.	Enter a valid End Date.
	Field	3	Date range segments cannot overlap.	Enter a valid date/range.
	Field	4	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	5	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Modifier Range From [Search]	Hyperlink	1	A valid Modifier Range From is required.	Select a valid Modifier.
	Hyperlink	2	Modifier From cannot be greater than Modifier To.	Verify keying.
Modifier Range To [Search]	Hyperlink	1	A valid Modifier Range To is required.	Select a valid modifier.

6.262.5 Groups-Modifier Group Type-Modifier Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.262.6 Groups-Modifier Group Type-Modifier Group Panel Accessibility

6.262.6.1 To Access the Groups-Modifier Group Type-Modifier Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Modifier Group Type**.	Groups- Modifier Group Type panel displays.
5	Select row.	Modifier Group Type-Modifier Group panel displays.

6.262.6.2 To Add on the Groups-Modifier Group Type-Modifier Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Modifier Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Modifier Code Range To Range From information is displayed on panel.
4	Select **Modifier Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Modifier Code Range To information is displayed on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	Modifier Group Type-Modifier Group information is saved.

6.262.6.3 To Update on the Groups-Modifier Group Type-Modifier Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	Modifier Group Type- Modifier Group information is saved.

6.262.6.4 To Delete on the Groups-Modifier Group Type-Modifier Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.263 GROUPS-NDC GROUP TYPE PANEL

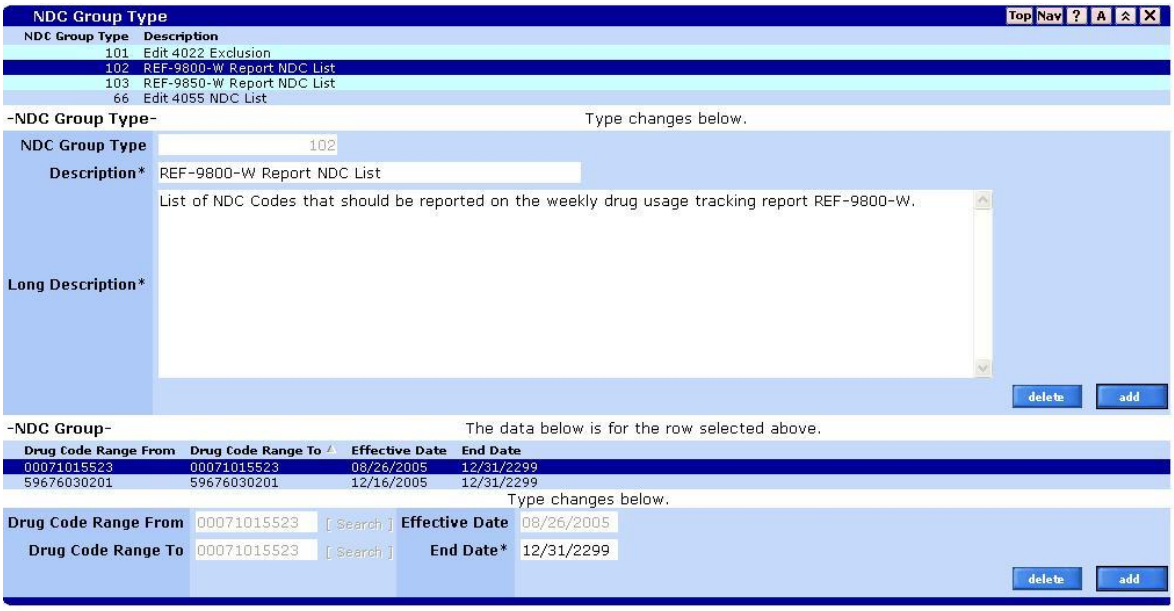
6.263.1 Groups-NDC Group Type Panel Narrative

The NDC Group maintenance panels are used to create/update groupings of NDC codes. Groupings are used to identify/categorize services with like characteristics for varying purposes.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [NDC Group Type]

6.263.2 Groups-NDC Group Type Panel Layout



6.263.3 Groups-NDC Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a NDC Group Type	Button	N/A	0
Delete	Allows the user to delete a NDC Group Type.	Button	N/A	0
Description	Succinct description (name) of the NDC Group.	Field	Character	50
Long Description	Group purpose. Definition of where and/or how this NDC Group is used.	Field	Character	4000
NDC Group Type	Unique system assigned key for the NDC Group Type that represents a collection of NDCs.	Field	Number (Integer)	9

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6.263.4 Groups-NDC Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter a Description.
Long Description	Field	1	Long Description is required.	Enter a Long Description.
NDC Group Type	Field	1	A valid Drug Group is required.	Add a NDC Group Type to the drug type.

6.263.5 Groups-NDC Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.263.6 Groups-NDC Group Type Panel Accessibility

6.263.6.1 To Access the Groups-NDC Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups pagedisplays.
4	Select **NDC Group Type**.	NDC Group Type panel displays.

6.263.6.2 To Add on the Groups-NDC Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. NDC Group Type number is automatically generated.	NDC Group Type information is saved.

6.263.6.3 To Update on the Groups-NDC Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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Step	Action	Response
3	Click **Save**.	NDC Group Type information is saved.

6.263.6.4 To Delete on the Groups-NDC Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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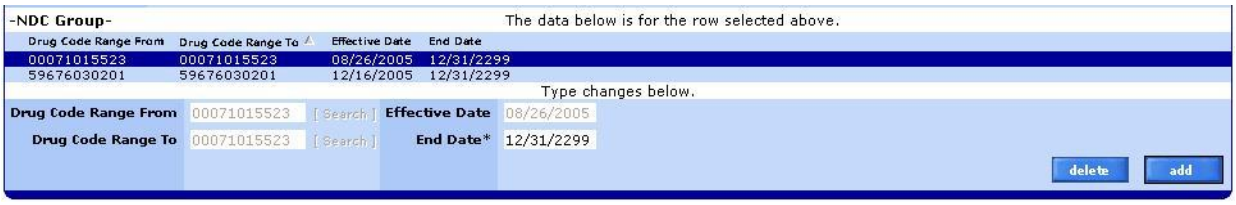
6.264 GROUPS-NDC GROUP TYPE-NDC GROUP PANEL

6.264.1 Groups-NDC Group Type-NDC Group Panel Narrative

The NDC Group maintenance panels are used to create/update groupings of NDC codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [NDC Group Type] - (Select a NDC Group Type)

6.264.2 Groups-NDC Group Type-NDC Group Panel Layout



6.264.3 Groups-NDC Group Type-NDC Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an NDC Group.	Button	N/A	0
Delete	Allows the user to delete an NDC Group.	Button	N/A	0
Effective Date	First date of service the NDC (or NDCs) is effective within the NDC Group Type.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the NDC (or NDCs) is effective within the NDC Group Type.	Field	Date (MM/DD/CCYY)	8
Drug Code Range From [Search]	Lower limit of the NDC range associated to the current group.	Hyperlink	N/A	0
Drug Code Range To [Search]	Upper limit of the NDC range associated to the current group.	Hyperlink	N/A	0

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6.264.4 Groups-NDC Group Type-NDC Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date is required.	Enter an Effective Date.
	Field	6	Date range segments cannot overlap.	Correct overlap condition. Dates cannot overlap for the same NDC codes.
End Date	Field	1	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	2	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date is required.	Enter an End Date.
Drug Code Range From [Search]	Hyperlink	1	A valid Drug Code Range From is required.	Select a valid NDC Code.
	Hyperlink	2	Drug From cannot be greater than Drug To.	Select a NDC Code Range To that is greater than or equal to the NDC Code Range From.

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Field	Field Type	Error Code	Error Message	To Correct
	Hyperlink	3	Date and Code range segments cannot overlap.	Correct overlap condition. Dates and codes cannot overlap.
Drug Code Range To [Search]	Hyperlink	1	A valid Drug Code Range To is required.	Select a valid NDC Code To.

6.264.5 Groups-NDC Group Type-NDC Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.264.6 Groups-NDC Group Type-NDC Group Panel Accessibility

6.264.6.1 To Access the Groups-NDC Group Type- NDC Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **NDC Group Type**.	Groups- NDC Group Type panel displays.
5	Select row.	NDC Group Type-NDC Group panel displays.

6.264.6.2 To Add on the Groups-NDC Group Type- NDC Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Drug Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Drug Code Range From information is displayed on panel.
4	Select **Drug Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Drug Code Range To information is displayed on panel.

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Step	Action	Response
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**.	NDC Group Type-NDC Group information is saved.

6.264.6.3 To Update on the Groups-NDC Group Type- NDC Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	NDC Group Type- NDC Group information is saved.

6.264.6.4 To Delete on the Groups-NDC Group Type- NDC Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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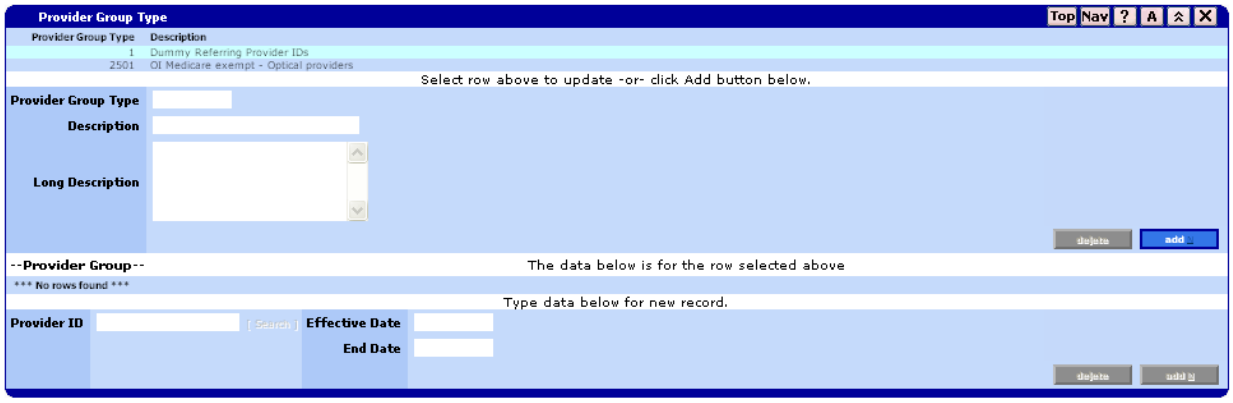
6.232 GROUPS-PROVIDER GROUP TYPE PANEL

6.232.1 Groups-Provider Group Type Panel Narrative

The Provider Group Type panel is used to create/update groupings of Providers. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data - Groups] - [Provider Group Type]

6.232.2 Groups-Provider Group Type Panel Layout



6.232.3 Groups-Provider Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allow user to add a Provider Group Type.	Button	N/A	0
Delete	Allow user to delete a Provider Group Type.	Button	N/A	0
Description	Short description for a Provider Group Type.	Field	Alphanumeric	50
Effective Date	The date of service on which the Provider becomes valid for the Provider group.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service on which the Provider becomes is no longer valid for the Provider group.	Field	Date (MM/DD/CCYY)	8
Long Description	Definition of where and/or how this Provider group is used.	Field	Alphanumeric	4000
Provider Group Type	System assigned key for unique Provider Group Type.	Field	Number (Integer)	9
Provider ID	Internal key for a unique program or provider.	Field	Character	10

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6.232.4 Groups-Provider Group Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Long Description	Field	1	Long Description is required.	Enter a Long Description.

6.232.5 Groups-Provider Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.232.6 Groups-Provider Group Type Panel Accessibility

6.232.6.1 To Access the Groups-Provider Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups pagedisplays.
4	Select **Provider Group Type**.	Provider Group Type panel displays.

6.232.6.2 To Add on the Groups-Provider Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description.**	
4	Click **Save**.	Provider Group Type information is saved.

6.232.6.3 To Update on the Groups-Provider Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Provider Group Type information is saved.

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6.232.6.4 To Delete on the Groups- Provider Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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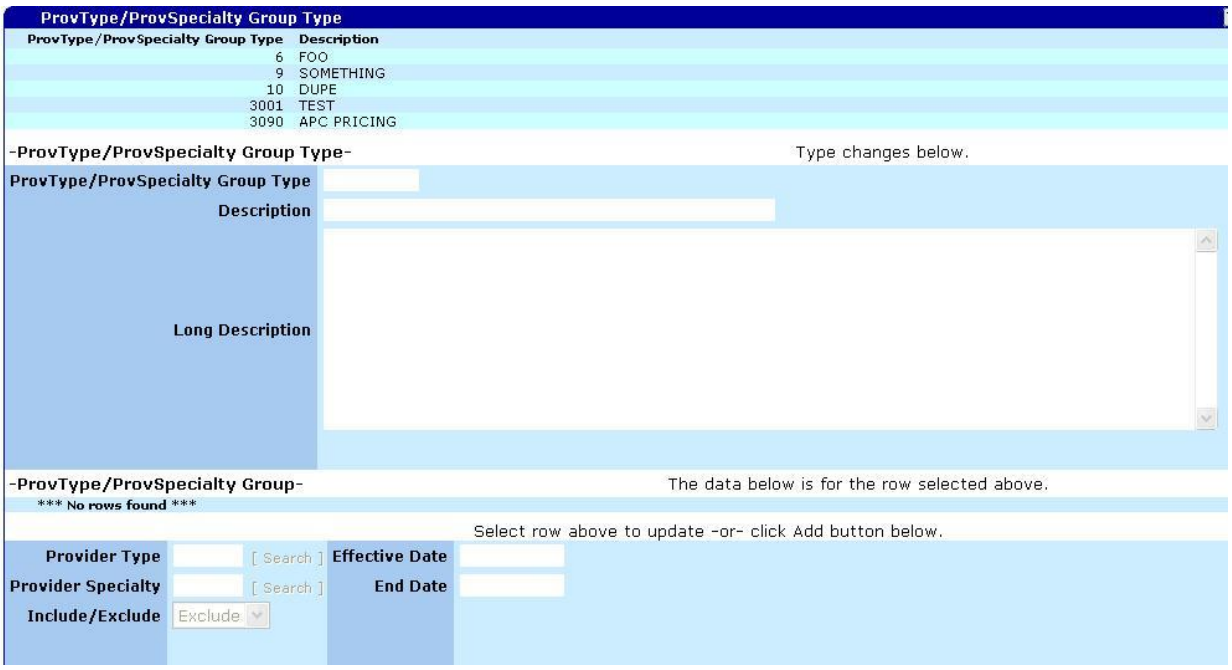
6.233 GROUPS-PROV TYPE/PROV SPECIALTY GROUP TYPE PANEL

6.233.1 Groups-Prov Type/Prov Specialty Group Type Panel Narrative

The Prov Type/Prov Specialty Group panels are used to create/update groupings of Provider Type/Provider Specialty combination. Groupings are used to identify/categorize services with like characteristics for varying purposes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data]-[Groups]-[Prov Type /Prov Specialty Group Type]

6.233.2 Groups-Prov Type/Prov Specialty Group Type Panel Layout



6.233.3 Groups-Prov Type/Prov Specialty Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Prov Type /Prov Specialty group type.	Button	N/A	0
Delete	Allows the user to delete the current Prov Type /Prov Specialty group type.	Button	N/A	0
Description	Succinct description (name) of the Prov Type/Prov Specialty Group.	Field	Character	50
Long Description	Group purpose. Definition of where and/or how the group type is used.	Field	Character	4000

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Field	Description	Field Type	Data Type	Length
Prov Type/Prov Specialty Group Type	Unique system assigned key for the Prov Type /Prov Specialty Group. Represents a collection of Specific Therapeutic Class codes. Unique system assigned key for the Therapeutic Group. Represents a collection of Provider Type/Provider specialty code combinations.	Field	Number (Integer)	0

6.233.4 Groups-Prov Type/Prov Specialty Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Descriptio	Field	1	Description is required.	Enter a text Description of the group.
Long Description	Field	1	Long Description is required.	Enter a Long Description of the group.

6.233.5 Groups-Prov Type/Prov Specialty Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.233.6 Groups-Prov Type/Prov Specialty Group Type Panel Accessibility

6.233.6.1 To Access the Groups-Prov Type/Prov Specialty Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Prov Type/Prov Specialty Group Type**.	Prov Type/Prov Specialty Group Type panel displays.

6.233.6.2 To Add on the Groups-Prov Type/Prov Specialty Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	

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Step	Action	Response
4	Click **Save**. Prov Type/Prov Specialty Group Type number is automatically generated.	Prov Type/Prov Specialty Group Type information is saved.

6.233.6.3 To Update on the Groups-Prov Type/Prov Specialty Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Prov Type/Prov Specialty Group Type information is saved.

6.233.6.4 To Delete on the Groups-Prov Type/Prov Specialty Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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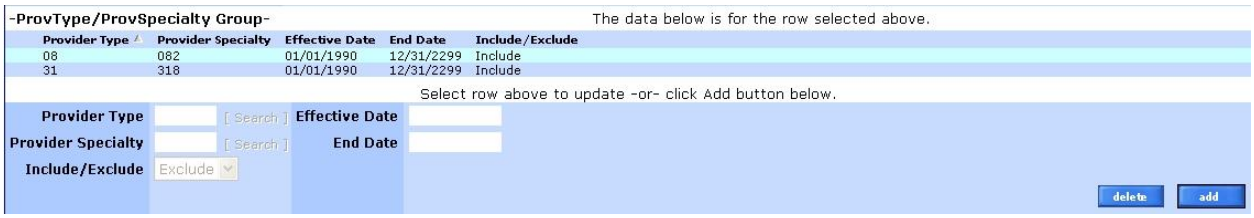
6.234 GROUPS-PROV TYPE PROV SPECIALTY GROUP TYPE-PROV TYPE PROV SPECIALTY GROUP PANEL

6.234.1 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Narrative

The Prov Type/Prov Specialty Group panels are used to create/update groupings of Prov Type and Prov Specialty Codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. E.G. Confidential services. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Groups-Prov Type Prov Specialty Group Type] - (Select a group from Prov Type /Prov Specialty Group]) -(Scroll down to [Prov Type /Prov Specialty Group])

6.234.2 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Layout



6.234.3 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Prov Type /Prov Specialty group type.	Button	N/A	0
Delete	Allows the user to delete the current Prov Type /Prov Specialty group type.	Button	N/A	0
Effective Date	Date of service the provider type and provider specialty becomes effective for the Prov Type Prov Specialty Group Type.	Field	Date (MM/DD/CCYY)	8
End Date	Date of service the provider type and provider specialty is no longer effective for the Prov Type Prov Specialty Group Type.	Field	Date (MM/DD/CCYY)	8
Include/Exclude	Indicate whether the provider type/provider specialty combination should be included or excluded.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Provider Specialty [Search]	Code that uniquely identifies the Provider Specialty.	Hyperlink	N/A	0
Provider Type [Search	Code that uniquely identifies the Provider Type.	Hyperlink	N/A	0

6.234.4 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid date.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an effective date that is less than or equal to the End Date.
	Field	3	Invalid date.	Enter a valid date in the MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter a valid date.
	Field	2	Invalid date.	Enter a valid End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Provider Specialty [Search]	Hyperlink	1	A valid Provider Specialty is required.	Select a Provider Specialty.
	Hyperlink	2	Specialty Group is a duplicate.	Enter a Provider Specialty that is not a duplicate.
Provider Type [Search]	Hyperlink	1	A valid Provider Type is required.	Select a Provider Type.

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6.234.5 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.234.6 Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel Accessibility

6.234.6.1 To Access the Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagdisplays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Modifier Group Type**.	Groups- Prov Type/Prov Specialty Group Type panel displays.
5	Select row.	Prov Type/Prov Specialty Group Type-Prov Type Prov Specialty Group panel displays.

6.234.6.2 To Add on the Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Provider Type** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Provider Type information is displayed on panel.
4	Select **Provider Specialty** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Provider Specialty information is displayed on panel.
6	Select **Include/Exclude** from drop down list box.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	

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Step	Action	Response
9	Click **Save**. Last Update Date is automatically generated.	Prov Type/Prov Specialty Group Type information is saved.

6.234.6.3 To Update on the Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Prov Type/Prov Specialty Group Type information is saved.

6.234.6.4 To Delete on the Groups-Prov Type Prov Specialty Group Type-Prov Type Prov Specialty Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.235 GROUPS-REVENUE GROUP TYPE PANEL

6.235.1 Groups-Revenue Group Type Panel Narrative

The Revenue Group Type panels are used to create/update groupings of Revenue Codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. E.G. Confidential services. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Revenue Group Type]

6.235.2 Groups-Revenue Group Type Panel Layout

6.235.3 Groups-Revenue Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Revenue Group Type.	Button	N/A	4000
Delete	Allows the user to delete a Revenue Group Type.	Button	N/A	0
Description	Name of the Revenue Group.	Field	Character	50
Long Description	Group purpose. Definition of where and/or how this Revenue Group is used.	Field	Alphanumeric	4000
Revenue Group Type	Unique system assigned key for the Revenue Group. Represents a collection of Revenue codes.	Field	Number (Integer)	9

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6.235.4 Groups-Revenue Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description for the Revenue Group Type.
Long Description	Field	1	Long description is required.	Enter a Long Description for the Revenue Group Type.

6.235.5 Groups-Revenue Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.235.6 Groups-Revenue Group Type Panel Accessibility

6.235.6.1 To Access the Revenue Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pag displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Revenue Group Type**.	Revenue Group Type panel displays.

6.235.6.2 To Add on the Revenue Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**.	Revenue Group Type information is saved.

6.235.6.3 To Update on the Revenue Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Revenue Group Type information is saved.

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6.235.6.4 To Delete on the Revenue Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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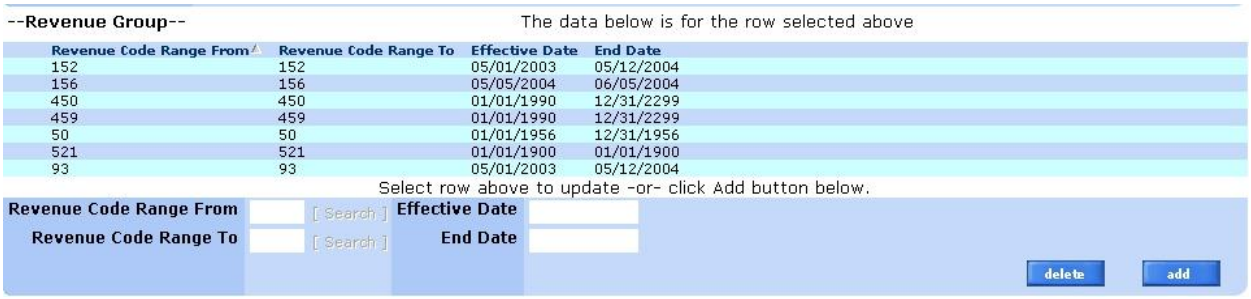
6.236 GROUPS-REVENUE GROUP TYPE-REVENUE GROUP PANEL

6.236.1 Groups-Revenue Group Type-Revenue Group Panel Narrative

The Revenue Group Type panel is used to create/update groupings of Revenue Codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. E.G. Confidential services. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Revenue Group Type] - (Select a group from [Revenue Group Type]) -(Scroll down to [Revenue Group])

6.236.2 Groups-Revenue Group Type-Revenue Group Panel Layout



6.236.3 Groups-Revenue Group Type-Revenue Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a Revenue code or range of codes to the selected Revenue Group.	Button	N/A	0
Delete	Allows a user to delete a Revenue code (or range) from the selected Revenue Group.	Button	N/A	0
Effective Date	Date of service the revenue code becomes effective for the revenue group.	Field	Date (MM/DD/CCYY)	8
End Date	Date of service the revenue code is no longer effective for the revenue group.	Field	Date (MM/DD/CCYY)	8
Revenue Code Range From [Search]	Upper limit of the revenue code range associated to a group.	Hyperlink	N/A	0
Revenue Code Range To [Search]	Lower limit of the revenue code range associated to a group.	Hyperlink	N/A	0

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6.236.4 Groups-Revenue Group Type-Revenue Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective date	Field	1	Effective Date is required.	Enter a valid date.
	Field	2	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Invalid date.	Enter a valid date in the MM/DD/CCYY format.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	6	Date range segments cannot overlap.	Correct overlap condition. Dates cannot overlap for the same From/To Revenue Code combinations.
	Field	7	Date and Code range segments cannot overlap.	Correct the overlap condition. Dates and Code ranges cannot overlap.
End Date	Field	1	End Date is required.	Enter a valid date.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter a date that is greater than or equal to 01/01/1900.
	Field	3	Invalid date.	Enter a valid date in the MM/DD/CCYY format.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Revenue Code Range From [Search]	Hyperlink	1	A valid Revenue Code Range From is required.	Select a valid Revenue Code.
	Hyperlink	2	Revenue From cannot be greater than Revenue To.	Select a revenue code from that is less that or equal to the revenue code to.
Revenue Code Range To [Search]	Hyperlink	1	A valid Revenue Code Range To is required.	Select a valid Revenue Code.

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6.236.5 Groups-Revenue Group Type-Revenue Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.236.6 Groups-Revenue Group Type-Revenue Group Panel Accessibility

6.236.6.1 To Access the Groups-Revenue Group Type-Revenue Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Revenue Group Type**.	Groups- Revenue Group Type panel displays.
5	Select row.	Revenue Group Type-Revenue Group panel displays.

6.236.6.2 To Add on the Groups-Revenue Group Type-Revenue Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Revenue Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Revenue Code Range From information is displayed on panel.
4	Select **Revenue Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Revenue Code Range To information is displayed on panel.
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	
9	Click **Save**. Last Update Date is automatically generated.	Revenue Group Type-Revenue Group information is saved.

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6.236.6.3 To Update on the Groups-Revenue Group Type-Revenue Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Revenue Group Type-Revenue Group information is saved.

6.236.6.4 To Delete on the Groups-Revenue Group Type-Revenue Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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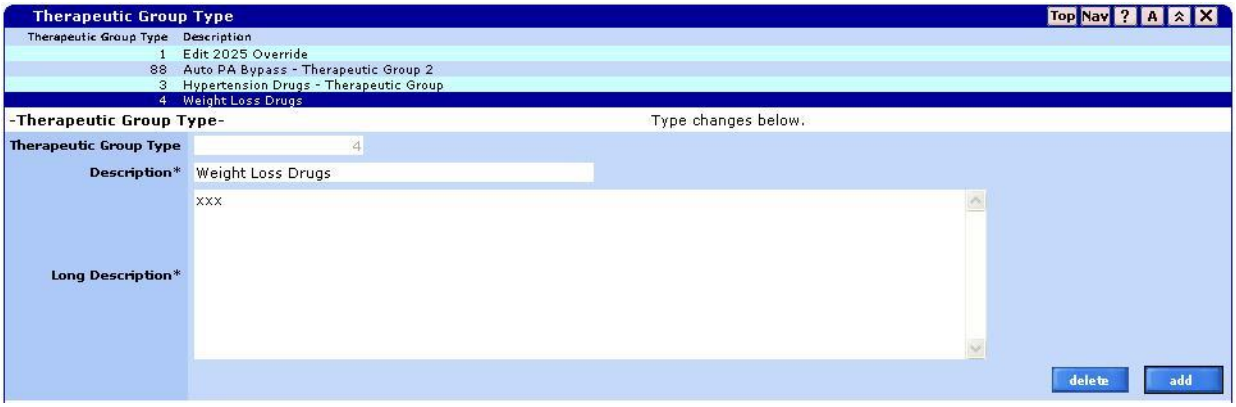
6.237 GROUPS-THERAPEUTIC GROUP TYPE PANEL

6.237.1 Groups-Therapeutic Group Type Panel Narrative

The Therapeutic Group Type panel is used to create/update groupings of Hierarchical Specific Therapeutic Class codes. Groupings are used to identify/categorize services with like characteristics for varying purposes. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Therapeutic Group Type]

6.237.2 Groups-Therapeutic Group Type Panel Layout



6.237.3 Groups-Therapeutic Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new therapeutic group type.	Button	N/A	0
Delete	Allows the user to deletes the current therapeutic group type.	Button	N/A	0
Description	Succinct description (name) of the Therapeutic Group.	Field	Alphanumeric	50
Long Description	Group purpose. Definition of where and/or how the group type is used.	Field	Alphanumeric	4000
Therapeutic Group Type	Unique system assigned key for the Therapeutic Group. Represents a collection of Specific Therapeutic Class codes.	Field	Number (Integer)	9

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6.237.4 Groups-Therapeutic Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description for the Therapeutic Group Type.
Long Description	Field	1	Long Description is required.	Enter a Long Description of the Therapeutic Group Type.

6.237.5 Groups-Therapeutic Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.237.6 Groups-Therapeutic Group Type Panel Accessibility

6.237.6.1 To Access the Groups-Therapeutic Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Therapeutic Group Type**.	Therapeutic Group Type panel displays.

6.237.6.2 To Add on the Groups-Therapeutic Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. Therapeutic Group Type is automatically generated.	Therapeutic Group Type information is saved.

6.237.6.3 To Update on the Groups-Therapeutic Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Therapeutic Group Type information is saved.

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6.237.6.4 To Delete on the Groups-Therapeutic Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.238 GROUPS-THERAPEUTIC GROUP TYPE-THERAPEUTIC GROUP PANEL

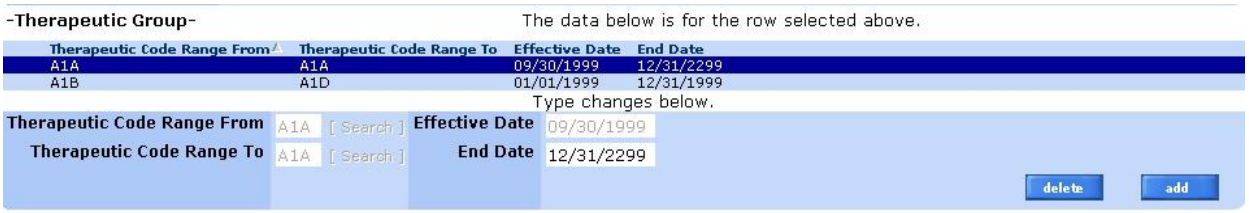
6.238.1 Groups-Therapeutic Group Type-Therapeutic Group Panel Narrative

The Therapeutic Group panel is used to view and update therapeutic codes related to a specific Therapeutic Group.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Therapeutic Group Type] - (Scroll down to [Therapeutic Group])

6.238.2 Groups-Therapeutic Group Type-Therapeutic Group Panel Layout



6.238.3 Groups-Therapeutic Group Type-Therapeutic Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a code (or code range) to the selected Therapeutic Group Type.	Button	N/A	0
Delete	Allows the user to delete a code (or code range) from the selected Therapeutic Group Type.	Button	N/A	0
Effective Date	First date of service the code (or codes) is effective within the group type.	Field	Date (MM/DD/CCYY)	8
End Date	Last date of service the code (or codes) is effective within the group type.	Field	Date (MM/DD/CCYY)	8
Therapeutic Code Range From [Search]	Lower limit of the therapeutic class code range associated to a group.	Hyperlink	N/A	0
Therapeutic Code Range To [Search]	Upper limit of the therapeutic class code range associated to a group.	Hyperlink	N/A	0

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6.238.4 Groups-Therapeutic Group Type-Therapeutic Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter a valid date.
	Field	2	Invalid date.	Enter a valid date. Format is MM/DD/CCYY.
	Field	3	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to End Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	6	Date range segments cannot overlap.	Correct overlap condition. Dates cannot overlap for the same codes.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Therapeutic Code Range From [Search]	Hyperlink	1	Therapeutic From cannot be greater than Therapeutic To.	Enter a Therapeutic that is less than or equal to Therapeutic To.
	Hyperlink	2	Date and Code range segments cannot overlap.	Correct overlap condition. Date and Code ranges cannot overlap an existing segment.
	Hyperlink	3	A valid Therapeutic Code Range From is required.	Select a Therapeutic Code Range From.
Therapeutic Code Range To [Search]	Hyperlink	1	A valid Therapeutic Code Range To is required.	Select a Therapeutic Code Range To.

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6.238.5 Groups-Therapeutic Group Type-Therapeutic Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.238.6 Groups-Therapeutic Group Type-Therapeutic Group Panel Accessibility

6.238.6.1 To Access the Groups-Therapeutic Group Type-Therapeutic Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Therapeutic Group Type**.	Therapeutic Group Type-Therapeutic Group panel displays.

6.238.6.2 To Add on the Groups-Therapeutic Group Type-Therapeutic Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Therapeutic Code Range From** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Therapeutic Code Range From information is displayed on panel.
4	Select **Therapeutic Code Range To** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Therapeutic Code Range To information is displayed on panel.
6	Enter **Effective Date** in MM/DD/CCYY format.	
7	Enter **End Date** in MM/DD/CCYY format.	
8	Click **Save**. Last Update Date is automatically generated.	Therapeutic Group Type -Therapeutic Group information is saved.

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6.238.6.3 To Update on the Groups-Therapeutic Group Type-Therapeutic Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Therapeutic Group Type Therapeutic Group information is saved.

6.238.6.4 To Delete on the Groups-Therapeutic Group Type-Therapeutic Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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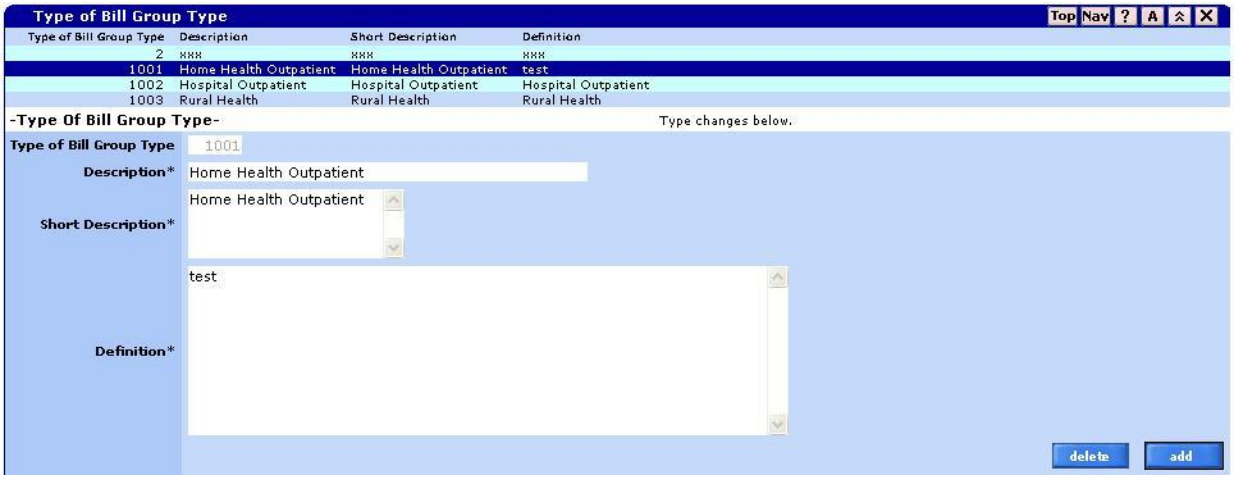
6.239 GROUPS-TYPE OF BILL GROUP TYPE PANEL

6.239.1 Groups-Type of Bill Group Type Panel Narrative

The Type of Bill Group Type panel is used in conjunction with the type of bill group. The type of bill types and their descriptions are on this entity, and the type of bill codes that correspond with each type of bill type are on the type of bill group. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Type of Bill Group Type]

6.239.2 Groups-Type of Bill Group Type Panel Layout



6.239.3 Groups-Type of Bill Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Type of Bill Group Type.	Button	N/A	0
Delete	Delete a Type of Bill Group Type.	Button	N/A	0
Definition	Definition of where and/or how this TOB groups is used.	Field	Character	4000
Description	This contains the description for the type of bill type.	Field	Character	50
Short Description	This contains the description for the type of bill type.	Field	Character	25
Type of Bill Group Type	This field is used to identify the type of bill type. It contains a number from 1 to 999 that corresponds to a range of type of bill codes.	Field	Number (Integer)	9

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6.239.4 Groups-Type of Bill Group Type Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Definition	Field	1	Definition is required.	Enter a Definition.
Description	Field	1	Description is required.	Description field is required when adding or modifying Type of Bill Group.
Short Description	Field	1	Short description is required.	Short description field is required when adding or modifying Type of Bill Group.

6.239.5 Groups-Type of Bill Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.239.6 Groups-Type of Bill Group Type Panel Accessibility

6.239.6.1 To Access the Groups-Type of Bill Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data pagedisplays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Type Of Bill Group Type**.	Type of Bill Group Type panel displays.

6.239.6.2 To Add on the Groups-Type of Bill Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Description**.	
3	Enter **Long Description**.	
4	Click **Save**. Type of Bill Group Type is automatically generated.	Type of Bill Group Type information is saved.

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6.239.6.3 To Update on the Groups-Type of Bill Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Type of Bill Group Type information is saved.

6.239.6.4 To Delete on the Groups-Type of Bill Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.240 GROUPS-TYPE OF BILL GROUP TYPE-TYPE OF BILL GROUP PANEL

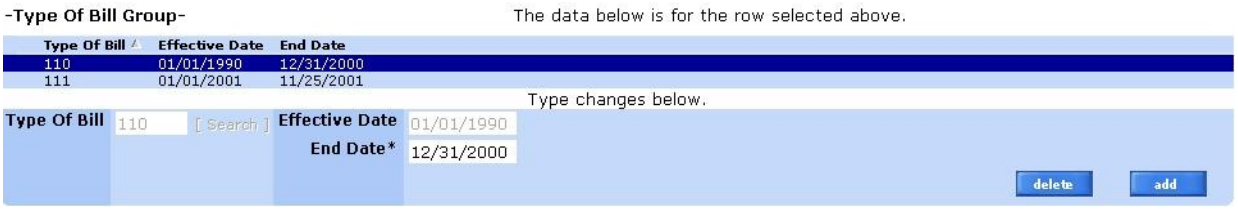
6.240.1 Groups-Type of Bill Group Type-Type of Bill Group Panel Narrative

The Type of Bill Group panel is used to create and maintain collections of Type of Bill code.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Related Data] - [Groups] - [Type of Bill Group Type] - (Scroll down to [Type of Bill Group] - (Select a group)

6.240.2 Groups-Type of Bill Group Type-Type of Bill Group Panel Layout



6.240.3 Groups-Type of Bill Group Type-Type of Bill Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Type of Bill Group.	Button	N/A	0
Delete	Delete a Type of Bill Group.	Button	N/A	0
Effective Date	Beginning date for the type of bill group entity.	Field	Date (MM/DD/CCYY)	8
End Date	Beginning date for the type of bill group entity.	Field	Date (MM/DD/CCYY)	8
Type of Bill [Search]	Type of Bill associated with the Group.	Hyperlink	N/A	0

6.240.4 Groups-Type of Bill Group Type-Type of Bill Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.
	Field	2	The fields Effective Date and End Date from row [0] cannot overlap with row [1].	The fields Effective Date and End Date must be unique.
	Field	3	Effective Date must be less than or equal to End Date.	Effective Date must be less than or equal to End Date.
End Date	Field	1	End Date is required. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.

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Field	Field Type	Error Code	Error Message	To Correct
Type of Bill	Hyperlink	1	A valid Type of Bill is required.	Enter a valid Type of Bill.

6.240.5 Groups-Type of Bill Group Type-Type of Bill Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.240.6 Groups-Type of Bill Group Type-Type of Bill Group Panel Accessibility

6.240.6.1 To Access the Groups-Type of Bill Group Type-Type of Bill Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **Groups** hyperlink located on the Related Data panel.	Related Data-Groups page displays.
4	Select **Type of Bill Group Type**.	Groups-Type of Bill Group Type panel displays.
5	Select a row from list of results.	Type of Bill Group Type-Type of Bill Group panel displays.

6.240.6.2 To Add on the Groups-Type of Bill Group Type-Type of Bill Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Type of Bill**. Note: If unknown click [Search] to locate Type of Bill.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **End Date** in MM/DD/CCYY format.	
5	Click **Save**.	Type of Bill Group Type-Type of Bill Group information is saved.

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6.240.6.3 To Update on the Groups-Type of Bill Group Type-Type of Bill Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Type of Bill Group Type-Type of Bill Group information is saved.

6.240.6.4 To Delete on the Groups-Type of Bill Group Type-Type of Bill Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other page displays.

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5.139 RELATED DATA MME PAGE

5.139.1 Related Data MME Page Narrative

The Reference Related Data MME panel allows the user to access the various MME panels.

Navigation Path: [Reference] - [Related Data] - [MME]

5.139.2 Related Data MME Page Layout

5.139.3 Related Data MME Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Alerts and Exceptions	Link to the Alerts and Exceptions panel.	Hyperlink	N/A	0
Base Ingredient	Link to the Base Ingredient panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel the current action.	Button	N/A	0
Clinical Formulation	Link to the Clinical Formulation panel.	Hyperlink	N/A	0
Concurrent Risk Set	Link to the Concurrent Risk Set panel.	Hyperlink	N/A	0
Daily Alerting	Link to the Daily Alerting panel.	Hyperlink	N/A	0
Designated Route Ingredient Info	Link to the Designated Route Ingredient Info panel.	Hyperlink	N/A	0
Drug Concept	Link to the Drug Concept panel.	Hyperlink	N/A	0
Drugs with Potential Risk	Link to the Drugs with Potential Risk panel.	Hyperlink	N/A	0
Medication Master	Link to the Medication Master panel.	Hyperlink	N/A	0
Range Factor	Link to the Range Factor panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Save	Allows the user to save a record.	Button	N/A	0
Set and Group	Link to the Set and Group panel.	Hyperlink	N/A	0
Vocabulary Description Source	Link to the Vocabulary Description Source panel.	Hyperlink	N/A	0

5.139.4 Related Data MME Page Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

5.139.5 Related Data MME Page Extra Features

Field	Field Type
No extra features found for this panel.	

5.139.6 Related Data MME Page Accessibility

5.139.6.1 To Access the Related Data MME Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.

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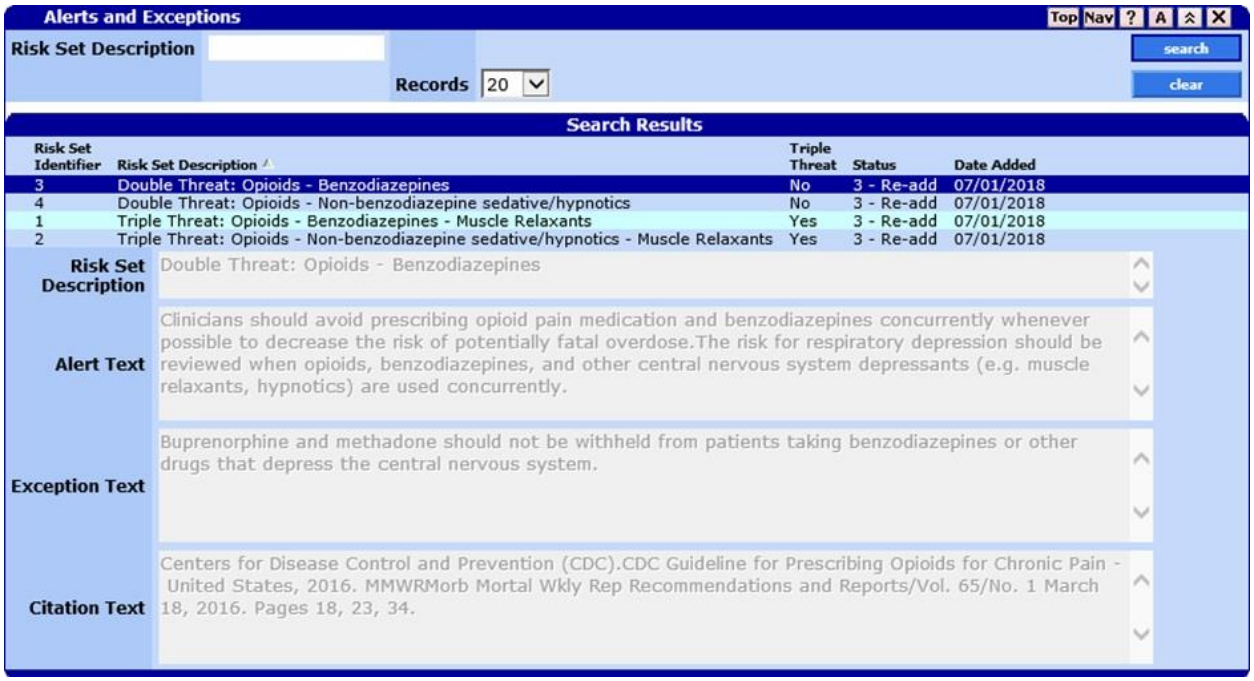
6.241 MME – ALERTS AND EXCEPTIONS PANEL

6.241.1 MME - Alerts and Exceptions Panel Narrative

This panel will display Alert Text and Alert Exception Text associated to a Concurrent Risk Set. Concurrent Risk Sets are comprised of Risk Groups and are used to identify a targeted Risk (e.g. double-threat). An indicator to identify a "Triple Threat" Risk Set is included.

Navigation Path: [Reference] - [Related Data] - [MME] - [Alerts and Exceptions]

6.241.2 MME - Alerts and Exceptions Panel Layout



6.241.3 MME - Alerts and Exceptions Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Text	Alert Text.	Field	Character	2000
Citation Text	Citation Text.	Field	Character	255
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Exception Text	Alert Exception Text.	Field	Character	2000
Risk Set Description	Concurrent Risk Set Identifier Description.	Field	Character	255
Risk Set Identifier	Concurrent Risk Set Identifier.	Field	Number	8

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Field	Description	Field Type	Data Type	Length
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1
Triple Threat	Triple Threat Indicator. 0 No triple threat present; 1 Triple threat is present.	Field	Character	1

6.241.4 MME - Alerts and Exceptions Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.241.5 MME - Alerts and Exceptions Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.241.6 MME - Alerts and Exceptions Panel Accessibility

6.241.6.1 To Access the MME - Alerts and Exceptions Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Alerts and Exceptions**.	Alerts and Exceptions panel displays.

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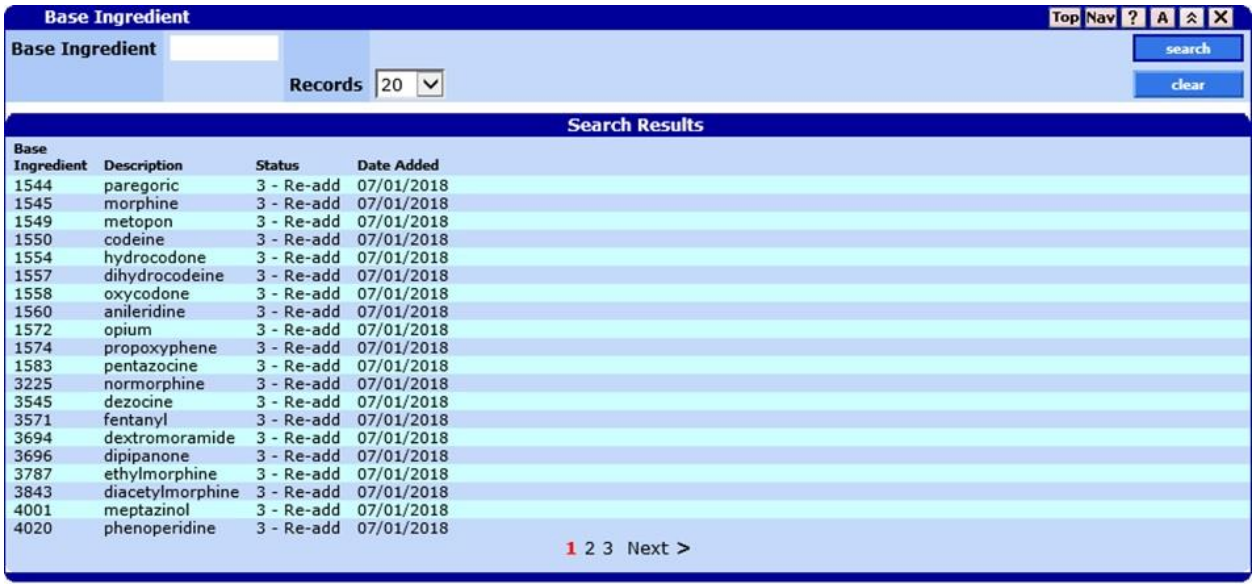
6.242 MME – BASE INGREDIENT PANEL

6.242.1 MME - Base Ingredient Panel Narrative

This panel will display text description related to Opioid Base Ingredient Identifier.

Navigation Path: [Reference] - [Related Data] - [MME] - [Base Ingredient]

6.242.2 MME - Base Ingredient Panel Layout



6.242.3 MME - Base Ingredient Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Ingredient	Opioid Base Ingredient Identifier.	Field	Number	8
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Description	Opioid Base Ingredient Identifier Description.	Field	Character	50
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

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6.242.4 MME - Base Ingredient Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.242.5 MME - Base Ingredient Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.242.6 MME - Base Ingredient Panel Accessibility

6.242.6.1 To Access the MME - Base Ingredient Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Base Ingredient**.	Base Ingredient panel displays.

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6.243 MME - CLINICAL FORMULATION PANEL

6.243.1 MME - Clinical Formulation Panel Narrative

This panel will display Clinical Formulation (GCN_SEQNO), strength of the ingredient, and MME Factor.

Navigation Path: [Reference] - [Related Data] - [MME] - [Clinical Formulation]

6.243.2 MME - Clinical Formulation Panel Layout

Clinical Formulation

GSN

Records 20

Search Results

GSN	Strength Per Dosage Unit	Opioid Base Ingredient Identifier	Opioid Strength	Opioid Strength Unit of Measure	Dosage Unit	MME Factor	Daily Dose Indicat
66634	0	4622	2	mg	mL	0	No
66635	0	4632	2	mg	film	0	No
66636	0	4632	8	mg	film	0	No
66637	6	1545	2	mg	mL	3	No
66638	0	4622	0.50	mg	mL	0	No
66643	0	4622	10	ug	mL	0	No
66764	64	3571	400	ug	spray,non-aerosol	0.16	No
66785	0.30	1550	2	mg	mL	0.15	No
66836	0.6666666666666660	1554	0.6666666666666660	mg	mL	1	No
66996	0	3571	10	ug	mL	0	No
67145	0	4622	20	ug	mL	0	No
67266	20	13168	50	mg	tablet extended release 12 hr	0.40	No
67267	40	13168	100	mg	tablet extended release 12 hr	0.40	No
67268	60	13168	150	mg	tablet extended release 12 hr	0.40	No
67270	80	13168	200	mg	tablet extended release 12 hr	0.40	No
67271	100	13168	250	mg	tablet extended release 12 hr	0.40	No
67433	0	4628	1	mg	mL	0	No
67463	3	1545	1	mg	mL	3	No
67480	1	1554	1	mg	mL	1	No
67499	0	3571	5	ug	mL	0	No

1 2 3 4 5 6 7 8 9 10 ... Next >

6.243.3 MME - Clinical Formulation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Daily Dose Indicator	Has Opioid Daily Dose Indicator, an ingredient in the product has a daily dose requirement for the MME Conv. If the product contains more than one ingredient and one of them requires a daily dose MME, this indicator is set as Yes.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Date Added	The current date that the row was added.	Field	Number (Integer)	8
Dosage Unit	Clinical Formulation Dosage Unit. For example, tablet, mL, powder, capsule, lozenge.	Field	Alphanumeric	50
GSN	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds the FDB GCN Sequence Number.	Field	Number (Integer)	6
MME Factor	Morphine Milligram Equivalent Factor provides the factor used to find the Morphine Milligram Equivalent (MME) for a dosage unit.	Field	Number (Decimal)	34
Opioid Base Ingredient Identifier	Opioid Base Ingredient Identifier that represents the base ingredient code of a given active ingredient.	Field	Number (Integer)	8
Opioid Strength	Opioid Strength provides the numeric quantity of the opioid per defined drug form. For example, 20mg tablet, the Opioid Strength value is 20.	Field	Number (Decimal)	34
Opioid Strength Unit of Measure	Opioid Strength Unit of Measure (UCUM). For example, mg, %, ug.	Field	Alphanumeric	255
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1
Strength Per Dosage Unit	MME Strength Per Dosage Unit provides a total MME per dosage form. If the Clinical Formulation contains an ingredient with two different salts then results in this field is a sum of both.	Field	Number (Decimal)	34

6.243.4 MME - Clinical Formulation Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.243.5 MME - Clinical Formulation Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.243.6 MME - Clinical Formulation Panel Accessibility

To Access the MME - Clinical Formulation Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Clinical Formulation**.	Clinical Formulation panel displays.

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6.244 MME – CONCURRENT RISK SET PANEL

6.244.1 MME - Concurrent Risk Set Panel Narrative

This panel will display text description for the Concurrent Risk Set Identifier.

Navigation Path: [Reference] - [Related Data] - [MME] - [Concurrent Risk Set]

6.244.2 MME - Concurrent Risk Set Panel Layout

6.244.3 MME - Concurrent Risk Set Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Risk Set Description	Concurrent Risk Group Identifier Description.	Field	Character	255
Risk Set Identifier	Concurrent Risk Group Identifier.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

6.244.4 MME - Concurrent Risk Set Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.244.5 MME - Concurrent Risk Set Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.244.6 MME - Concurrent Risk Set Panel Accessibility

6.244.6.1 To Access the MME - Concurrent Risk Set Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Concurrent Risk Set**.	Concurrent Risk Set panel displays.

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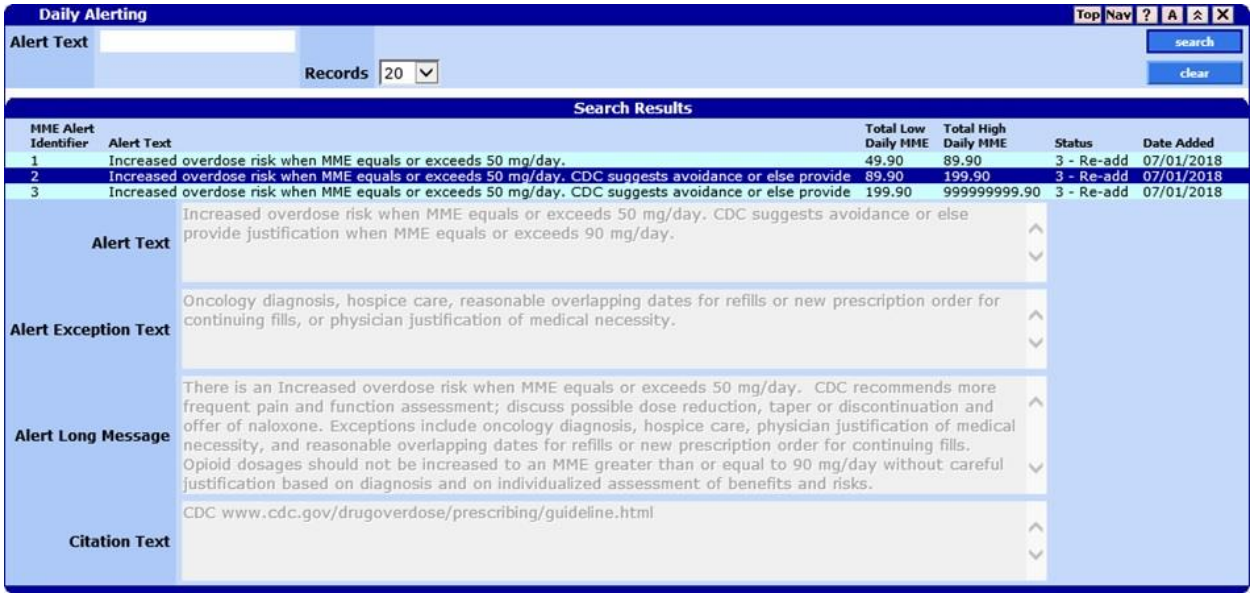
6.245 MME – DAILY ALERTING PANEL

6.245.1 MME - Daily Alerting Panel Narrative

This panel will display suggested alert text, alert negation text, and citation information based on total daily low and high thresholds.

Navigation Path: [Reference] - [Related Data] - [MME] - [Daily Alerting]

6.245.2 MME - Daily Alerting Panel Layout



6.245.3 MME - Daily Alerting Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alert Exception Text	Alert Exception Text.	Field	Character	500
Alert Long Message	Alert Long Message.	Field	Character	2000
Alert Text	Alert Text.	Field	Character	500
Citation Text	Citation Text.	Field	Character	255
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
MME Alert Identifier	MME Alert Identifier.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1
Total High Daily MME	Total High Daily MME.	Field	Number	34
Total Low Daily MME	Total Low Daily MME.	Field	Number	34

6.245.4 MME - Daily Alerting Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.245.5 MME - Daily Alerting Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.245.6 MME - Daily Alerting Panel Accessibility

6.245.6.1 To Access the MME - Daily Alerting Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Daily Alerting**.	Daily Alerting panel displays.

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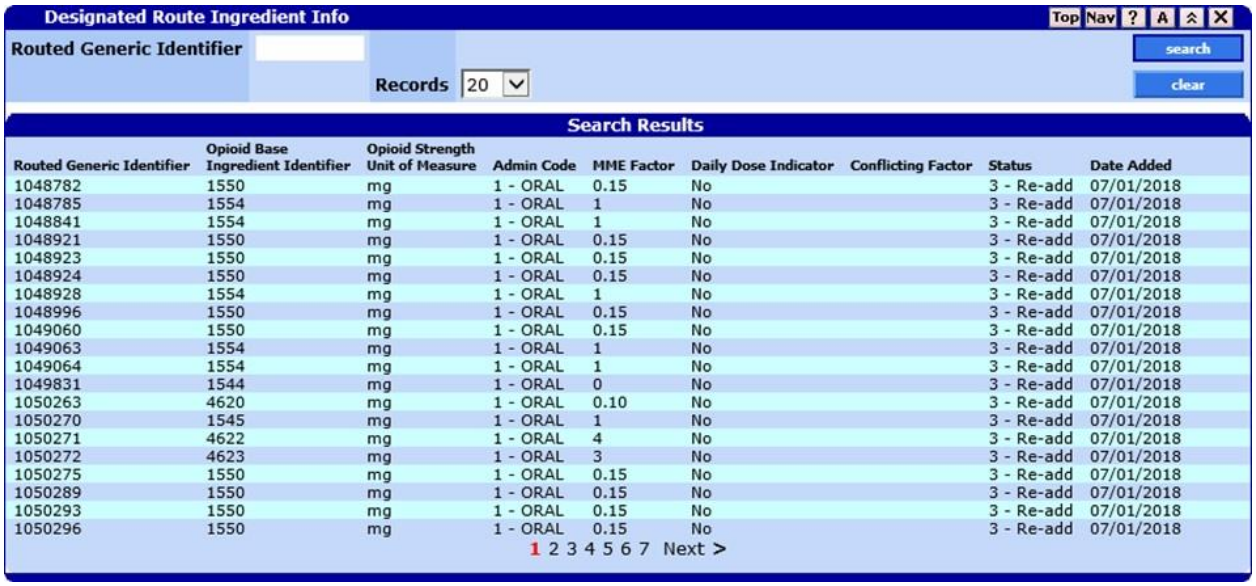
6.246 MME – DESIGNATED ROUTE INGREDIENT INFO PANEL

6.246.1 MME - Designated Route Ingredient Info Panel Narrative

This panel provides search functionality, allowing a provider to search for an ingredient's Morphine Milligram Equivalent (MME) information specific to a designated route (e.g. sublingual instead of oral). Use requires license to additional FDB files.

Navigation Path: [Reference] - [Related Data] - [MME] - [Designated Route Ingredient Info]

6.246.2 MME - Designated Route Ingredient Info Panel Layout



Routed Generic Identifier	Opioid Base Ingredient Identifier	Opioid Strength Unit of Measure	Admin Code	MME Factor	Daily Dose Indicator	Conflicting Factor	Status	Date Added
1048782	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1048785	1554	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1048841	1554	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1048921	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1048923	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1048924	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1048928	1554	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1048996	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1049060	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1049063	1554	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1049064	1554	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1049831	1544	mg	1 - ORAL	0	No		3 - Re-add	07/01/2018
1050263	4620	mg	1 - ORAL	0.10	No		3 - Re-add	07/01/2018
1050270	1545	mg	1 - ORAL	1	No		3 - Re-add	07/01/2018
1050271	4622	mg	1 - ORAL	4	No		3 - Re-add	07/01/2018
1050272	4623	mg	1 - ORAL	3	No		3 - Re-add	07/01/2018
1050275	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1050289	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1050293	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018
1050296	1550	mg	1 - ORAL	0.15	No		3 - Re-add	07/01/2018

6.246.3 MME - Designated Route Ingredient Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admin Code	Route of Administration Code, location a drug is administered. Valid values 1-ORAL, 2-INJECTION, 3-RECTAL, 4-MUCOUS MEMBRANE, 5-TOPICAL.	Field	Character	1
Clear	Clears Search Panel.	Button	N/A	0
Conflicting Factor	Conflicting MME Factor Indicator. 1=True, 0=False.	Field	Character	1
Daily Dose Indicator	Has Opioid Daily Dose Indicator. 1=True, 0=false.	Field	Character	1
Date Added	The current date that the row was added.	Field	Number	8

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Field	Description	Field Type	Data Type	Length
MME Factor	MME Dosage Unit Factor.	Field	Number	34
Opioid Base Ingredient Identifier	Opioid Base Ingredient Identifier.	Field	Number	8
Opioid Strength Unit of Measure	Opioid Strength Unit of Measure.	Field	Character	255
Routed Generic Identifier	Routed Generic Identifier.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

6.246.4 MME - Designated Route Ingredient Info Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.246.5 MME - Designated Route Ingredient Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.246.6 MME - Designated Route Ingredient Info Panel Accessibility

6.246.6.1 To Access the MME - Designated Route Ingredient Info Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Designated Route Ingredient Info**.	Designated Route Ingredient Info panel displays.

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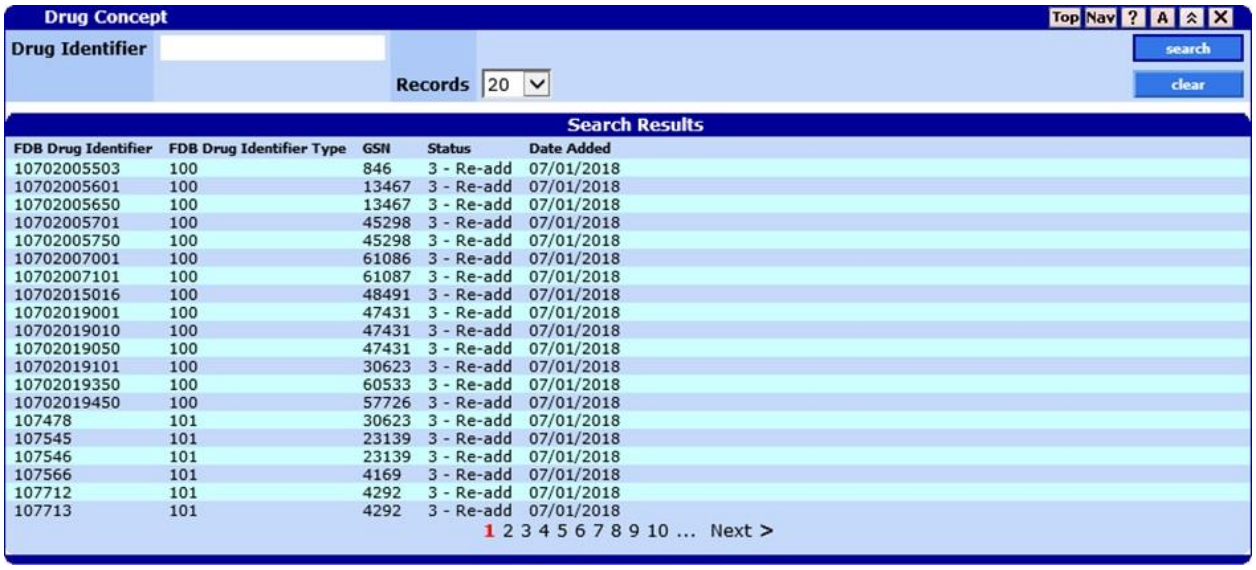
6.247 MME – DRUG CONCEPT PANEL

6.247.1 MME - Drug Concept Panel Narrative

This panel provides a link from various medication concepts and associates them to a Clinical Formulation (GCN_SEQNO). This table will only have GCN_SEQNO values for products that contain an opioid.

Navigation Path: [Reference] - [Related Data] - [MME] - [Drug Concept]

6.247.2 MME - Drug Concept Panel Layout



6.247.3 MME - Drug Concept Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Drug Identifier	FDB Drug Identifier.	Field	Character	50
Drug Identifier Type	FDB Drug Identifier Type.	Field	Number	8
GSN	Clinical Formulation ID.	Field	Number	6
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

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6.247.4 MME - Drug Concept Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.247.5 MME - Drug Concept Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.247.6 MME - Drug Concept Panel Accessibility

6.247.6.1 To Access the MME - Drug Concept Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Drug Concept**.	Drug Concept panel displays.

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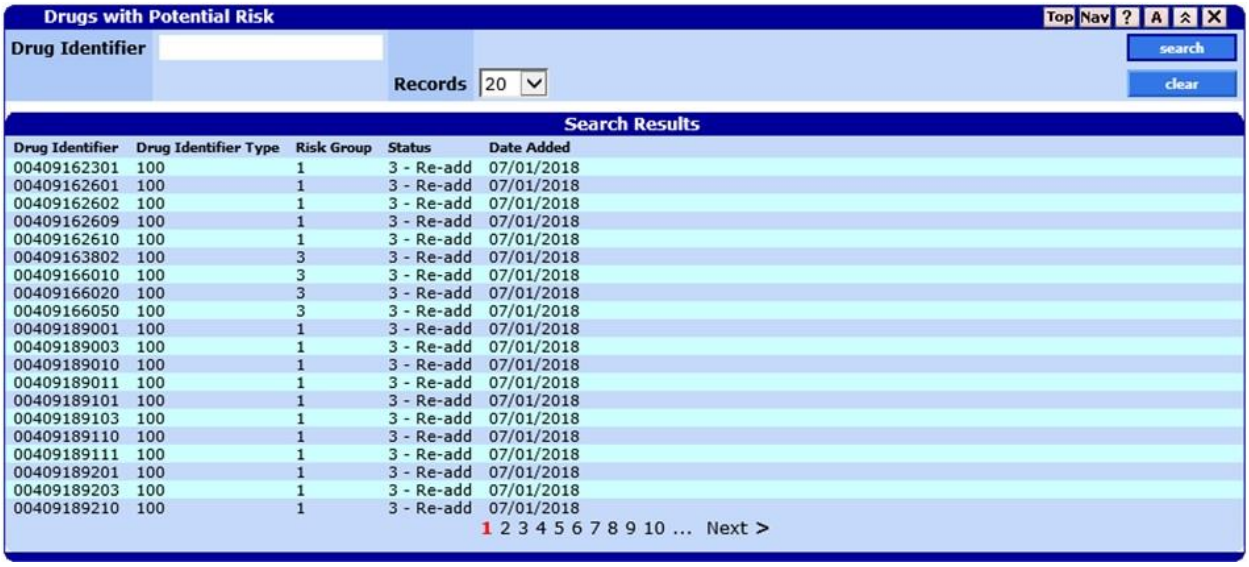
6.248 MME – DRUGS WITH POTENTIAL RISK PANEL

6.248.1 MME - Drugs with Potential Risk Panel Narrative

This panel is designed to identify specified drugs that when co-administered with Opioids create a potential risk to the patient's health.

Navigation Path: [Reference] - [Related Data] - [MME] - [Drugs with Potential Risk]

6.248.2 MME - Drugs with Potential Risk Panel Layout



Drug Identifier	Drug Identifier Type	Risk Group	Status	Date Added
00409162301	100	1	3 - Re-add	07/01/2018
00409162601	100	1	3 - Re-add	07/01/2018
00409162602	100	1	3 - Re-add	07/01/2018
00409162609	100	1	3 - Re-add	07/01/2018
00409162610	100	1	3 - Re-add	07/01/2018
00409163802	100	3	3 - Re-add	07/01/2018
00409166010	100	3	3 - Re-add	07/01/2018
00409166020	100	3	3 - Re-add	07/01/2018
00409166050	100	3	3 - Re-add	07/01/2018
00409189001	100	1	3 - Re-add	07/01/2018
00409189003	100	1	3 - Re-add	07/01/2018
00409189010	100	1	3 - Re-add	07/01/2018
00409189011	100	1	3 - Re-add	07/01/2018
00409189101	100	1	3 - Re-add	07/01/2018
00409189103	100	1	3 - Re-add	07/01/2018
00409189110	100	1	3 - Re-add	07/01/2018
00409189111	100	1	3 - Re-add	07/01/2018
00409189201	100	1	3 - Re-add	07/01/2018
00409189203	100	1	3 - Re-add	07/01/2018
00409189210	100	1	3 - Re-add	07/01/2018

1 2 3 4 5 6 7 8 9 10 ... Next >

6.248.3 MME - Drugs with Potential Risk Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Drug Identifier	FDB Drug Identifier.	Field	Character	50
Drug Identifier Type	FDB Drug Identifier Type. 3 MEDID; 6 GCN_SEQNO; 100 NDC; 101 FDB_PRODUCT_ID.	Field	Number	8
Risk Group	Concurrent Risk Group Identifier.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

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6.248.4 MME - Drugs with Potential Risk Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.248.5 MME - Drugs with Potential Risk Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.248.6 MME - Drugs with Potential Risk Panel Accessibility

6.248.6.1 To Access the MME - Drugs with Potential Risk Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Drugs with Potential Risk**.	Drugs with Potential Risk panel displays.

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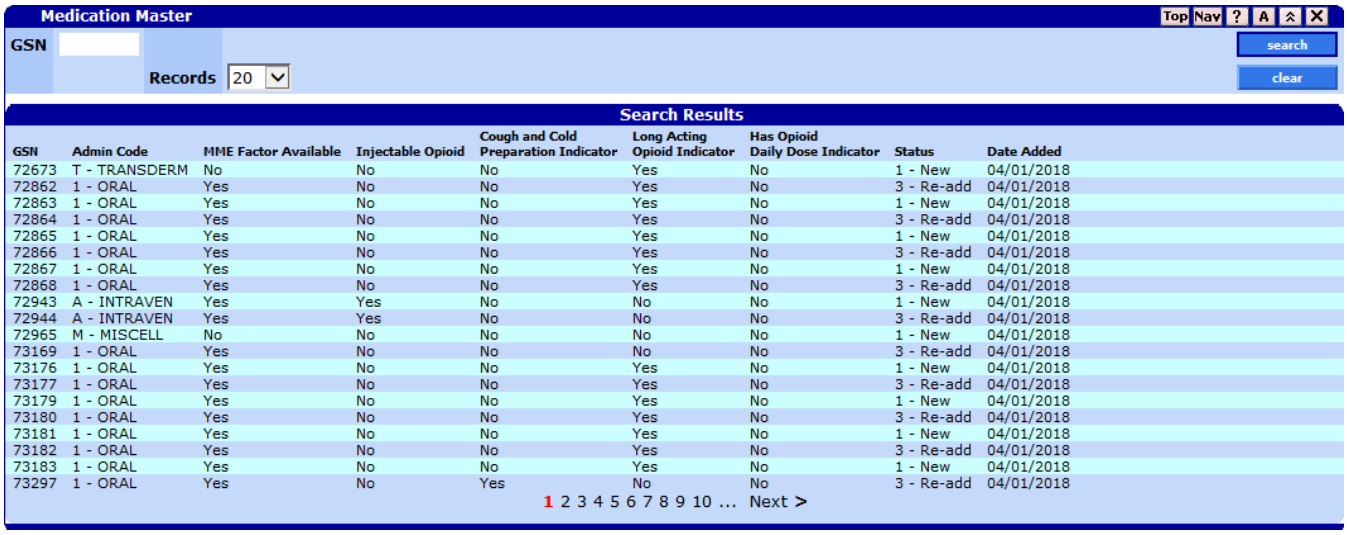
6.249 MME - MEDICATION MASTER PANEL

6.249.1 MME - Medication Master Panel Narrative

This panel provides the Route and Indicators associated to a Clinical Formulation (GCN_SEQNO) that designate: Available MME Factor, Injectable Opioid, Cough and Cold Preparation, and Long Acting Opioids. The indicators may impact continued decision making. For example, if a Morphine Milligram Equivalent (MME) is not available, then other MME functions may not be required.

Navigation Path: [Reference] - [Related Data] - [MME] - [Medication Master]

6.249.2 MME - Medication Master Panel Layout



GSN	Admin Code	MME Factor Available	Injectable Opioid	Cough and Cold Preparation Indicator	Long Acting Opioid Indicator	Has Opioid Daily Dose Indicator	Status	Date Added
72673	T - TRANSDERM	No	No	No	Yes	No	1 - New	04/01/2018
72862	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
72863	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
72864	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
72865	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
72866	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
72867	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
72868	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
72943	A - INTRAVEN	Yes	Yes	No	No	No	1 - New	04/01/2018
72944	A - INTRAVEN	Yes	Yes	No	No	No	3 - Re-add	04/01/2018
72965	M - MISCELL	No	No	No	No	No	1 - New	04/01/2018
73169	1 - ORAL	Yes	No	No	No	No	3 - Re-add	04/01/2018
73176	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
73177	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
73179	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
73180	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
73181	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
73182	1 - ORAL	Yes	No	No	Yes	No	3 - Re-add	04/01/2018
73183	1 - ORAL	Yes	No	No	Yes	No	1 - New	04/01/2018
73297	1 - ORAL	Yes	No	Yes	No	No	3 - Re-add	04/01/2018

1 2 3 4 5 6 7 8 9 10 ... Next >

6.249.3 MME - Medication Master Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admin Code	Route of Administration Code, location a drug is administered.	Field	Character	1
Clear	Clears Search Panel.	Button	N/A	0
Cough and Cold Preparation Indicator	Cough and Cold Preparation Indicator, product is considered to be a cough/cold preparation.	Field	Character	1
Date Added	The current date that the row was added.	Field	Number	8

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Field	Description	Field Type	Data Type	Length
GSN	This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds the FDB GCN Sequence Number.	Field	Number	6
Has Opioid Daily Dose Indicator	Has Opioid Daily Dose Indicator, an ingredient in the product has a daily dose requirement for the MME Conv. If the product contains more than one ingredient and one of them requires a daily dose MME, this indicator is set as Yes.	Field	Character	1
Injectable Opioid	Injectable Opioid Indicator, product is an injectable.	Field	Character	1
Long Acting Opioid Indicator	Long Acting Opioid Indicator, product is considered to be a long acting opioid.	Field	Character	1
MME Factor Available	MME Factor Available. For multi-ingredient products containing more than one opioid, this indicator will only be Yes.	Field	Character	1
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

6.249.4 MME - Medication Master Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.249.5 MME - Medication Master Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.249.6 MME - Medication Master Panel Accessibility

To Access the MME Medication Master Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Medication Master**.	Medication Master panel displays.

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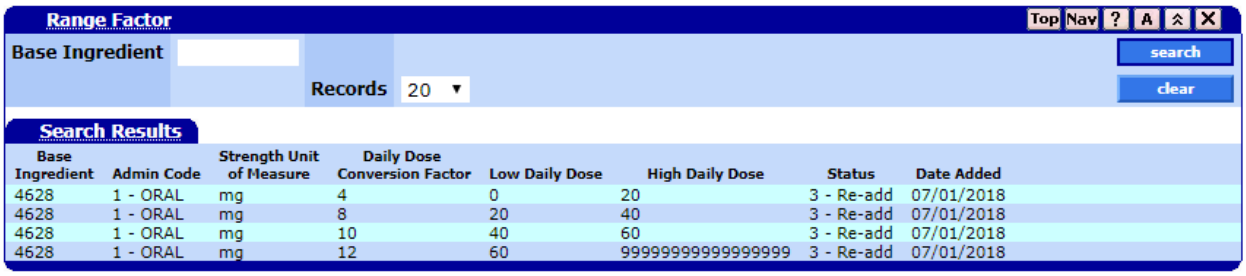
6.250 MME – RANGE FACTOR PANEL

6.250.1 MME - Range Factor Panel Narrative

This panel provides a Morphine Milligram Equivalence Daily Dose Conversion Range Factor to be used based on the total daily dose of opioid that an individual is consuming.

Navigation Path: [Reference] - [Related Data] - [MME] - [Range Factor]

6.250.2 MME - Range Factor Panel Layout



Base Ingredient	Admin Code	Strength Unit of Measure	Daily Dose Conversion Factor	Low Daily Dose	High Daily Dose	Status	Date Added
4628	1 - ORAL	mg	4	0	20	3 - Re-add	07/01/2018
4628	1 - ORAL	mg	8	20	40	3 - Re-add	07/01/2018
4628	1 - ORAL	mg	10	40	60	3 - Re-add	07/01/2018
4628	1 - ORAL	mg	12	60	99999999999999999	3 - Re-add	07/01/2018

6.250.3 MME - Range Factor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Admin Code	Route of Administration Code, location a drug is administered. Valid values 1-ORAL, 2-INJECTION, 3-RECTAL, 4-MUCOUS MEMBRANE, 5-TOPICAL.	Field	Character	1
Base Ingredient	Opioid Base Ingredient Identifier that represents the base ingredient code of a given active ingredient.	Field	Number	8
Clear	Clears Search Panel.	Button	N/A	0
Daily Dose Conversion Factor	MME Daily Dose Conversion Factor, based on low/high ttl daily range.	Field	Number	34
Date Added	The current date that the row was added.	Field	Number	8
High Daily Dose	Total High Daily MME Range per day.	Field	Number	34
Low Daily Dose	Total Low Daily MME Range per day.	Field	N/A	34
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Status	Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1
Strength Unit of Measure	Opioid Strength Unit of Measure (UCUM). For example, mg, %, ug.	Field	Character	255

6.250.4 MME - Range Factor Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.250.5 MME - Range Factor Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.250.6 MME - Range Factor Panel Accessibility

6.250.6.1 To Access the MME - Range Factor Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Range Factor**.	Range Factor panel displays.

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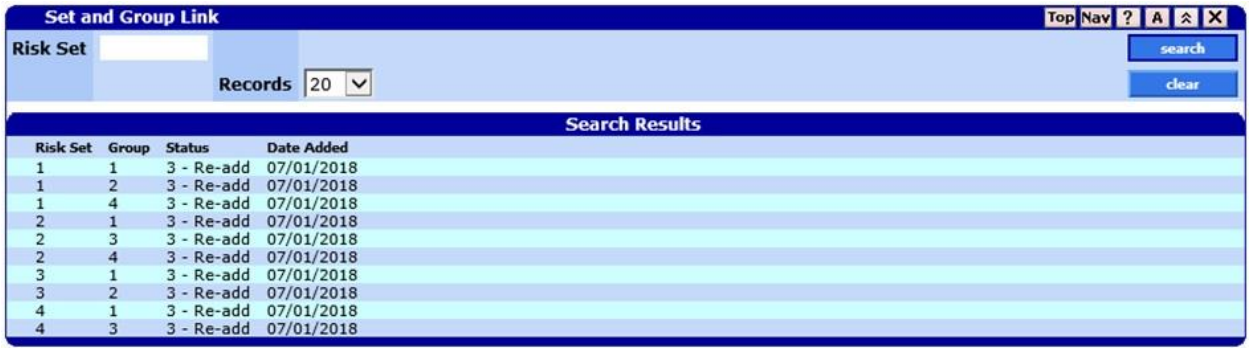
6.251 MME – SET AND GROUP LINK PANEL

6.251.1 MME - Set and Group Link Panel Narrative

This panel will link the Concurrent Risk Set Identifiers with the Concurrent Risk Group Identifiers.

Navigation Path: [Reference] - [Related Data] - [MME] - [Set and Group Link]

6.251.2 MME - Set and Group Link Panel Layout



6.251.3 MME - Set and Group Link Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Group	Concurrent Risk Group Identifier.	Field	Number	8
Risk Set	Concurrent Risk Set Identifier.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1

6.251.4 MME - Set and Group Link Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.251.5 MME - Set and Group Link Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.251.6 MME - Set and Group Link Panel Accessibility

6.251.6.1 To Access the MME - Set and Group Link Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Set and Group Link**.	Set and Group Link panel displays.

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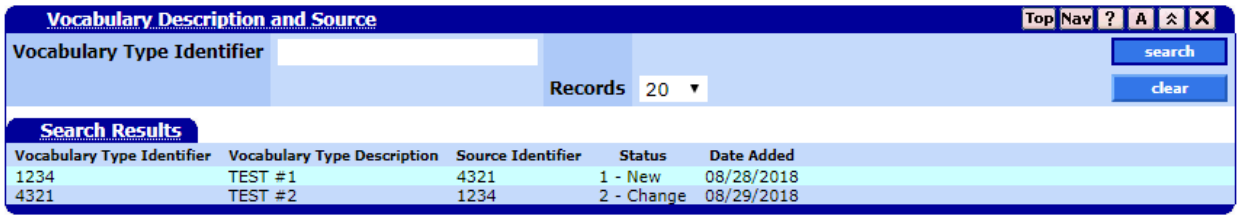
6.252 MME – VOCABULARY DESCRIPTION AND SOURCE PANEL

6.252.1 MME - Vocabulary Description and Source Panel Narrative

This panel will display the relation between the vocabulary type to its description and source.

Navigation Path: [Reference] - [Related Data] - [MME] - [Vocabulary Description and Source]

6.252.2 MME - Vocabulary Description and Source Panel Layout



6.252.3 MME - Vocabulary Description and Source Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears Search Panel.	Button	N/A	0
Date Added	The current date that the row was added.	Field	Number	8
Search	Search button. When clicked searches all records that matches the criteria. If no criteria entered, it will bring all available records.	Button	N/A	0
Source Identifier	EVD Source Identifier.	Field	Number	4
Status	Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted. Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.	Field	Character	1
Vocabulary Type Description	EVD Vocabulary Type Description.	Field	Character	50
Vocabulary Type Identifier	EVD Vocabulary Type Identifier.	Field	Number	4

6.252.4 MME - Vocabulary Description and Source Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.252.5 MME - Vocabulary Description and Source Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.252.6 MME - Vocabulary Description and Source Panel Accessibility

6.252.6.1 To Access the MME - Vocabulary Description and Source Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Related Data**.	Related Data page displays.
3	Click the **MME** hyperlink located on the Related Data panel.	Related Data-MME page displays.
4	Select **Vocabulary Description and Source**.	Vocabulary Description and Source panel displays.

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6.253 REFERENCE BENEFIT ADMINISTRATION PAGE

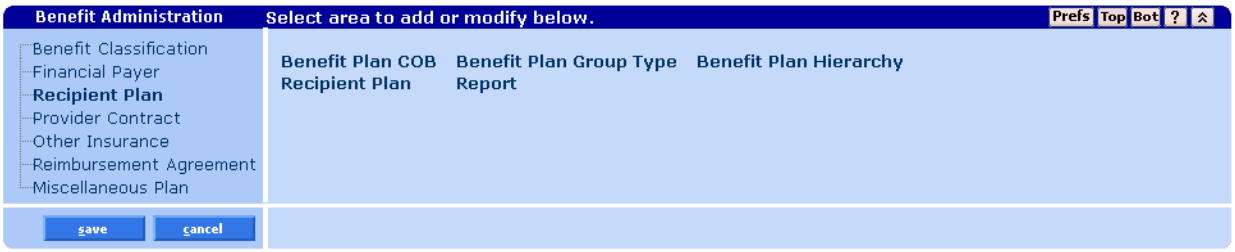
6.253.1 Reference Benefit Administration Page Narrative

The Reference Benefit Administration page allows the user to access the various miscellaneous data maintained within the Reference Data Maintenance subsystem area. This area of the user-interface includes data such as Benefit Classification, Financial Payer, Recipient Plan, Provider Contract, Other Insurance, Reimbursement Agreement and Miscellaneous Plan.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration]

6.253.2 Reference Benefit Administration Page Layout



6.253.3 Reference Benefit Administration Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Plan COB	Link to the Benefit COB panel.	Hyperlink	N/A	0
Benefit Plan Group Type	Link to the Benefit Plan Group type panel.	Hyperlink	N/A	0
Benefit Plan Hierarchy	Link to the Benefit Plan Hierarchy panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel an action.	Button	N/A	0
Recipient Plan	Link to the Recipient plan panel.	Hyperlink	N/A	0
Report	Link to the Report panel.	Hyperlink	N/A	0
Save	Allows the user to save changes.	Button	N/A	0

6.253.4 Reference Benefit Administration Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

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6.253.5 Reference Benefit Administration Page Extra Features

Field	Field Type	Error Code	Error Message	To Correct
No extra features found for this page.				

6.253.6 Reference Benefit Administration Page Accessibility

6.253.6.1 To Access the Reference Base Administration Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.

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6.254 BENEFIT PLAN COB PANEL

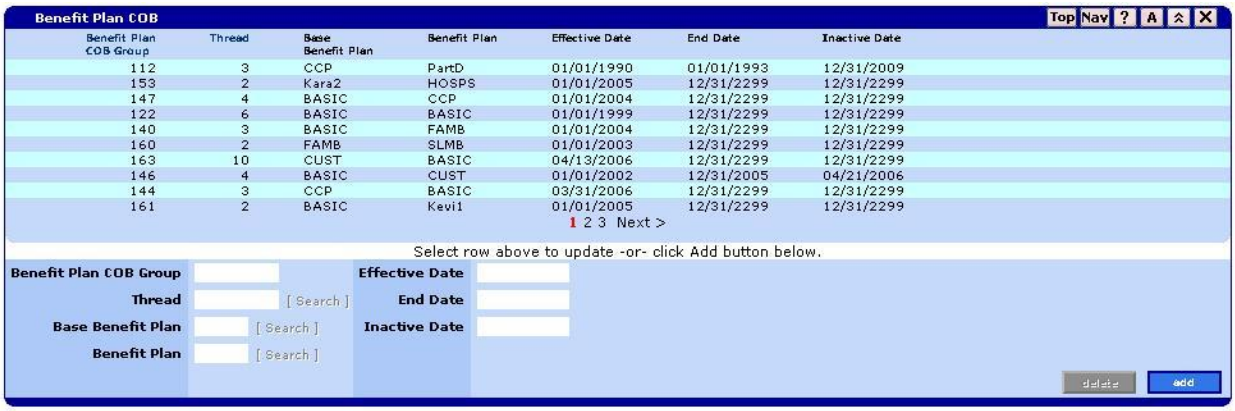
6.254.1 Benefit Plan COB Panel Narrative

The Benefit Plan Coordination of Benefit panel maintains relationships and the order of Benefit Plan as related to coordination at the Benefit Plan level. The Benefit Plan Coordination is set up by pairs considered Benefit Plan COB Groups. These groups work with the Benefit Plan Thread. Note the order of the pair is important. For example if the coordination pair is set up as BenPlan1/BenPlan2 then a Benefit Plan Hierarchy thread with BenPlan1 followed by BenPlan2 must exist to coordinate. If the first Benefit Plan in the pair does NOT pay, there will NOT be Coordination.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Benefit Plan COB]

6.254.2 Benefit Plan COB Panel Layout



6.254.3 Benefit Plan COB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a Benefit Plan COB.	Button	N/A	0
Base Benefit Plan [Search]	First Benefit Plan in the Benefit Plan COB group.	Hyperlink	N/A	0
Benefit Plan [Search]	Second Benefit Plan in the Benefit Plan COB group.	Hyperlink	N/A	0
Benefit Plan COB Group	Unique identifier for the pair of Benefit Plans to be coordinated.	Field	Number (Integer)	9
Delete	Delete a Benefit Plan COB.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Effective Date	Date the hierarchy thread becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	The last day the hierarchy thread is valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Date/Time the Benefit Plan COB can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Thread	Uniquely identifies a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiaries who are enrolled in multiple Benefit Plans of any of these types.	Field	N/A	0

6.254.4 Benefit Plan COB Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Base Benefit Plan [Search]	Hyperlink	1	A valid Base Benefit Plan is required.	Select a valid base Benefit Plan.
Benefit Plan [Search]	Hyperlink	1	A valid Benefit Plan is required.	Select a valid Benefit Plan.
	Hyperlink	2	Benefit Plan cannot equal Base Benefit Plan.	Verify keying.

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Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	0	Effective date must be on or before end date.	Effective Date must be less than or equal to End Date.
	Field	1	Date segments may not overlap.	Effective Date must not overlap with End Date range in the list.
	Field	2	Effective Date is required.	Effective Date field is required when adding or modifying Benefit Plan COB.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Insert date after 01/01/1900.
	Field	4	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Insert date less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	End Date field required when adding or modifying Benefit Plan COB
	Field	2	End date must be on or after effective date.	Verify keying. End Date must be > to Effective Date
	Field	3	Invalid date.	Verify keying. The date must be in MM/DD/CCYY format
	Field	4	Date segments may not overlap.	Verify dates against existing segment.
	Field	5	End Date must be greater than or equal to 01/01/1900.	Enter date greater than or equal to 01/01/1900.
	Field	6	End Date must be less than or equal to 12/31/2299.	Enter date less than or equal to 12/31/2299.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.
Thread [Search]	Hyperlink	1	A valid thread is required.	Insert valid thread.

6.254.5 Benefit Plan COB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.254.6 Benefit Plan COB Panel Accessibility

6.254.6.1 To Access the Benefit Plan COB Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration.**	Benefit Administration panel displays.
3	Select **Benefit Plan COB**.	Benefit COB panel displays.

6.254.6.2 To Add on the Benefit Plan COB Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Thread** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Thread information populated on panel.
4	Select **Benefit Base Plan** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Benefit Base Plan information populates on panel.

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Step	Action	Response
6	Select **Benefit Plan** by clicking [Search] button.	
7	Enter search criteria. User may also select a row from the list of search results.	Benefit Plan information populates on panel.
8	Enter **Effective Date** in MM/DD/CCYY format.	
9	Enter **End Date** in MM/DD/CCYY format.	
10	Enter **Inactive Date** in MM/DD/CCYY format.	
11	Click **Save**.	Benefit Plan COB information is saved.

6.254.6.3 To Update on the Benefit Plan COB Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Plan COB information is saved.

6.254.6.4 To Delete on the Benefit Plan COB Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.255 BENEFIT PLAN GROUP TYPE PANEL

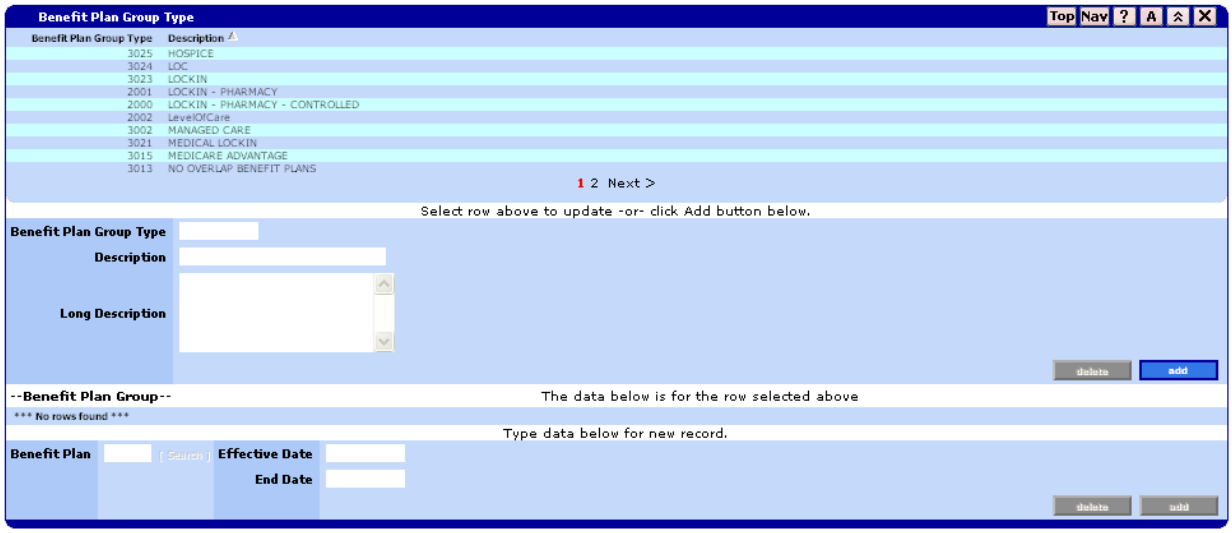
6.255.1 Benefit Plan Group Type Panel Narrative

Benefit Plan Group Type is used to add and update Benefit Plan Group types and Benefit Plan Groups.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Benefit Administration] - [Recipient Plan] - [Benefit Plan GroupType]

6.255.2 Benefit Plan Group Type Panel Layout



6.255.3 Benefit Plan Group Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Benefit Plan Group Type.	Button	N/A	0
Benefit Plan	Code used to identify a unique benefit plan.	Listview	N/A	0
Benefit Plan Group Type	System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.	Field	Number (Integer)	9
Delete	Allows the user to delete a Benefit Plan Group Type.	Button	N/A	0
Description	Abbreviated definition describing who is eligible and what types of services are provided.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Effective Date	Date of service on which the Benefit Plan becomes valid for the Benefit Plan group.	Field	Date (MM/DD/CCYY)	8
End Date	Date of service on which the Benefit Plan code is no longer valid for the Benefit Plan group.	Field	Date (MM/DD/CCYY)	8
Long Description	Text definition of program describing who is eligible and what types of services are provided.	Field	Character	4000

6.255.4 Benefit Plan Group Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Description is required.	Enter a Description.
Long Description	Field	3	Long description is required.	Enter a Long Description.

6.255.5 Benefit Plan Group Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.255.6 Benefit Plan Group Type Panel Accessibility

6.255.6.1 To Access the Benefit Plan Group Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration.**	Benefit Administration panel displays.
3	Select **Benefit Plan Group Type**.	Benefit Plan Group Type panel displays.

6.255.6.2 To Add on the Benefit Plan Group Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Thread** by clicking [Search] button.	
3	Enter search criteria. User may also select a row from the list of search results.	Thread information populated on panel.

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Step	Action	Response
4	Select **Benefit Base Plan** by clicking [Search] button.	
5	Enter search criteria. User may also select a row from the list of search results.	Benefit Base Plan information populates on panel.
6	Select **Benefit Plan** by clicking [Search] button.	
7	Enter search criteria. User may also select a row from the list of search results.	Benefit Plan information populates on panel.
8	Enter **Effective Date** in MM/DD/CCYY format.	
9	Enter **End Date** in MM/DD/CCYY format.	
10	Enter **Inactive Date** in MM/DD/CCYY format.	
11	Click **Save**.	Benefit Plan Group Type information is saved.

6.255.6.3 To Update on the Benefit Plan Group Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Plan Group Type information is saved.

6.255.6.4 To Delete on the Benefit Plan Group Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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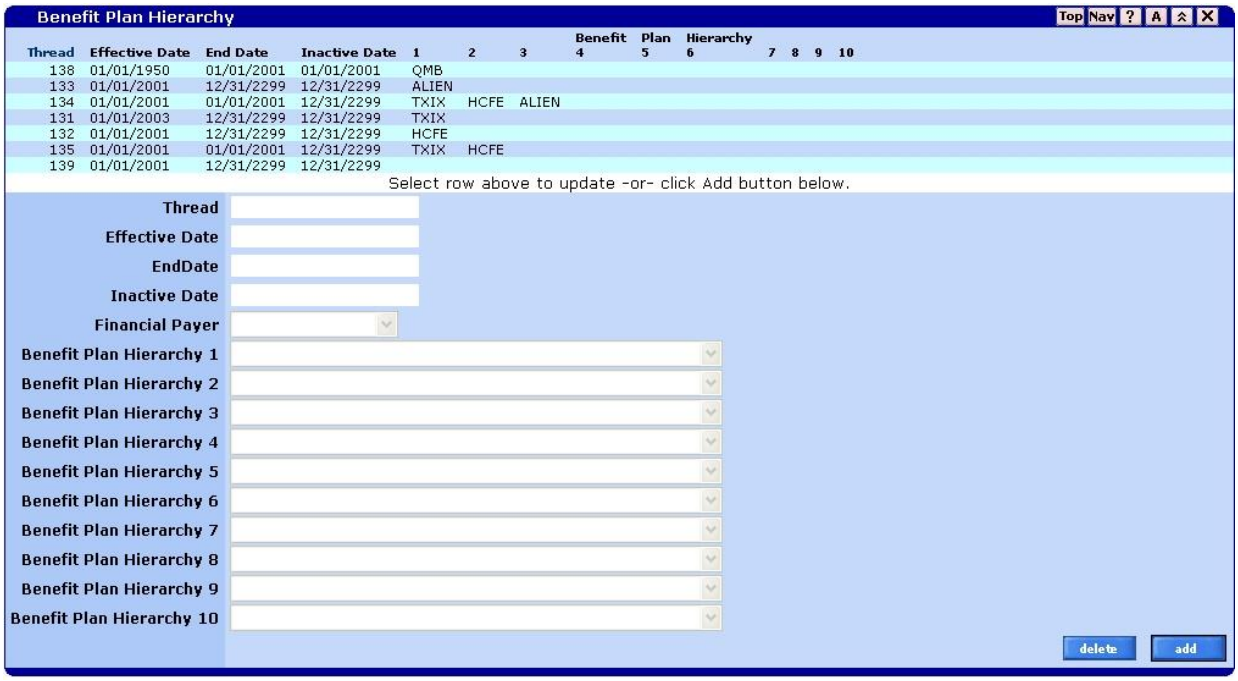
6.256 BENEFIT PLAN HIERARCHY PANEL

6.256.1 Benefit Plan Hierarchy Panel Narrative

The Benefit Plan Hierarchy panel maintains Benefit Plan Threads that are used to control Benefit Plan relationships and the order of claim adjudication at the Benefit Plan level. Benefit Plan hierarchy threads are ordered sets of Benefit Plans that may cover recipients concurrently. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Benefit Plan Hierarchy]

6.256.2 Benefit Plan Hierarchy Panel Layout



6.256.3 Benefit Plan Hierarchy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a thread.	Button	N/A	0
Benefit Plan Hierarchy 1	First Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 2	Second Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 3	Third Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 4	Fourth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Benefit Plan Hierarchy 5	Fifth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 6	Sixth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 7	Seventh Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 8	Eighth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 9	Ninth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Benefit Plan Hierarchy 10	Tenth Benefit Plan defined in the hierarchy.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete a thread.	Button	N/A	0
Effective Date	Date the hierarchy thread becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the hierarchy thread becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Dates.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Payer defined in the system. All the benefit plans defined in the thread must belong to this payer.	Combo Box	Drop Down List Box	0
Inactive Date	Date/Time the Benefit Plan Hierarchy can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Thread	System assigned identifier to be used to uniquely identify a thread. A Benefit Plan hierarchy thread is an ordered set of Benefit Plans that may cover recipients concurrently. A Benefit Plan hierarchy thread controls Benefit Plan relationships and the order of claims adjudication at the Benefit Plan level.	Field	Number (Integer)	9

6.256.4 Benefit Plan Hierarchy Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Hierarchy 1	Field	1	Duplicate Program found! Not Allowed.	Select a different Program.
	Field	2	A valid Hierarchy Node is required	Select a Program to continue.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less that or equal to the End Date.	Enter an Effective Date that is less that or equal to the End Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Overlaps thread.	Verify dates against list. Date segments cannot overlap.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a Financial Payer from the list.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.

6.256.5 Benefit Plan Hierarchy Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.256.6 Benefit Plan Hierarchy Panel Accessibility

6.256.6.1 To Access the Benefit Plan Hierarchy Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Benefit Plan Hierarchy**.	Benefit Plan Hierarchy panel displays.

6.256.6.2 To Add on the Benefit Plan Hierarchy Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date** in MM/DD/CCYY format.	
3	Enter **End Date** in MM/DD/CCYY format.	

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Step	Action	Response
4	Enter **Inactive Date** in MM/DD/CCYY format.	
5	Select **Financial Payer** from drop down list box.	
6	Select **Benefit Plan Hierarchy 1** from drop down list box.	
7	Select **Benefit Plan Hierarchy 2** from drop down list box.	
8	Select **Benefit Plan Hierarchy 3** from drop down list box.	
9	Select **Benefit Plan Hierarchy 4** from drop down list box.	
10	Select **Benefit Plan Hierarchy 5** from drop down list box.	
11	Select **Benefit Plan Hierarchy 6** from drop down list box.	
12	Select **Benefit Plan Hierarchy 7** from drop down list box.	
13	Select **Benefit Plan Hierarchy 8** from drop down list box.	
14	Select **Benefit Plan Hierarchy 9** from drop down list box.	
15	Select **Benefit Plan Hierarchy 10** from drop down list box.	
16	Click **Save**.	Benefit Plan Hierarchy information is saved.

6.256.6.3 To Update on the Benefit Plan Hierarchy Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Plan Hierarchy information is saved.

6.256.6.4 To Delete on the Benefit Plan Hierarchy Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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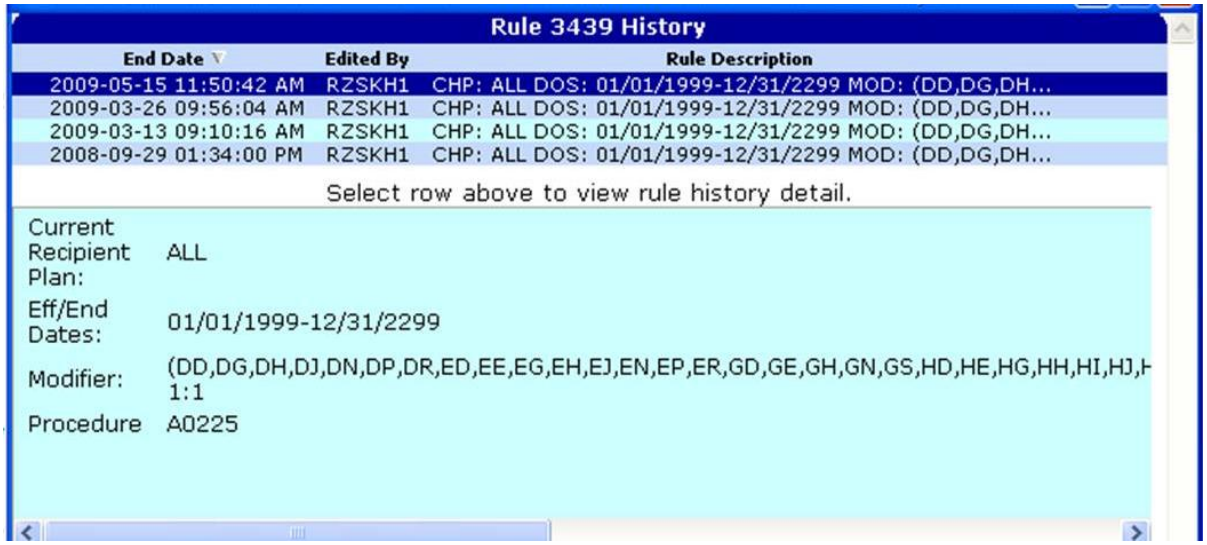
6.257 RULE HISTORY PANEL

6.257.1 Rule History Panel Narrative

The Rule History panel is used to see the history of the selected rule.

Navigation Path: [Reference] – [Benefit Administration] - [Recipient Plan] - [Benefit Coverage] - [Select rule and click view history button]

6.257.2 Rule History Panel Layout



6.257.3 Rule History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Edited By	User who updated the rule.	Field	Character	8
End Date	The Date/Time the rule was changed.	Field	Date (MM/DD/CCYY)	9
Rule Description	A string with all the rule variable information.	Field	Alphanumeric	4000

6.257.4 Rule History Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.257.5 Rule History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.257.6 Rule History Panel Accessibility

6.257.6.1 To Access the Rule History Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**; Click **Recipient Plan** link	Recipient Plan Search panel displays.
3	Select row from data list; Click **Benefit Coverage**	Benefit Coverage panels display.
4	Select any rule.	Rule panel displays.
5	Click **View History**.	Rule History Panel display.

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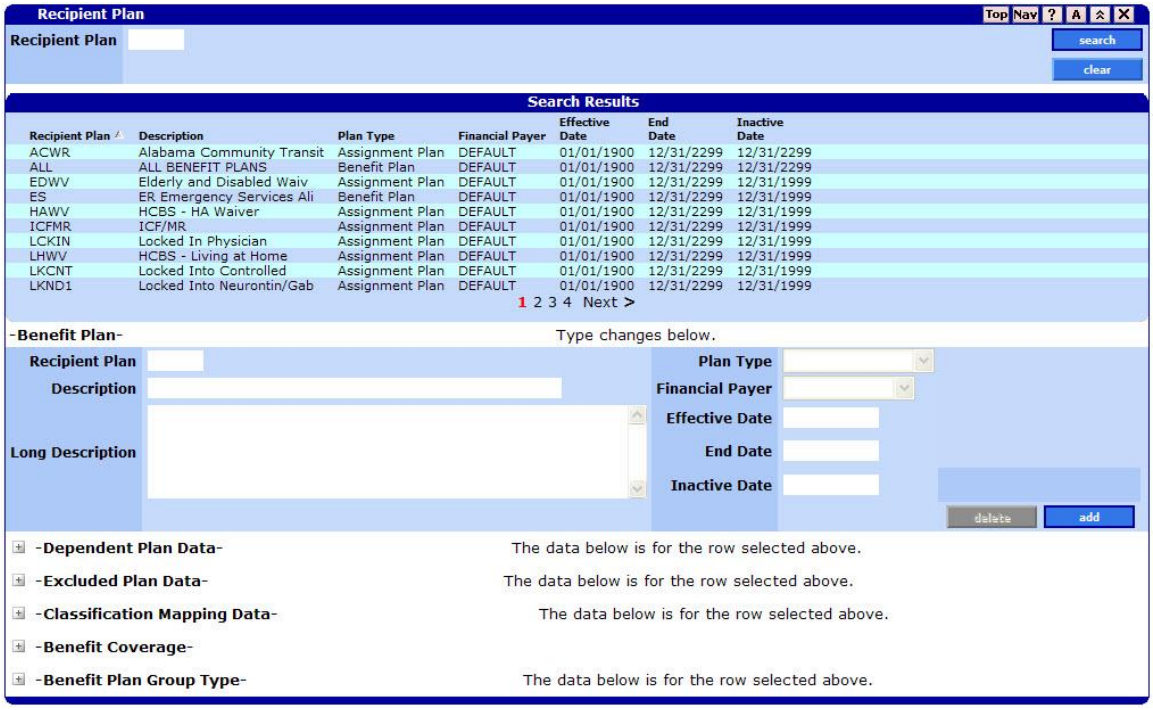
6.258 RECIPIENT PLAN- -BENEFIT ADMINISTRATION PANEL

6.258.1 Recipient Plan- -Benefit Administration Panel Narrative

The Recipient Plan- panel is used to maintain Recipient Plan. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) -

6.258.2 Recipient Plan- -Benefit Administration Panel Layout



6.258.3 Recipient Plan- -Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Recipient Plan.	Button	N/A	0
Benefit Coverage	Benefit Coverage panel.	Treeview	N/A	0
Benefit Plan Group Type	Benefit Plan Group Type panel.	Treeview	N/A	0
Classification Mapping Data	Classification Mapping Data panel.	Treeview	N/A	0
Delete	Allows the user to delete a Recipient Plan.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Dependent Plan Data	Dependent Plan Data panel.	Treeview	N/A	0
Description	Text description of the Recipient Plan.	Field	N/A	50
Effective Date	Date the Recipient Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Recipient Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Excluded Plan Data	Excluded Plan Data panel.	Treeview	N/A	0
Financial Payer	Financial Payer for this program.	Field	Drop Down List Box	0
Inactive Date	Date/Time the Recipient Plan can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Text definition of recipient plans describing who is eligible and what types of services are provided.	Field	Character	40000
Plan Type	Type of plan is either an Assignment Plan (ASGN) or a Benefit Plan (BNFT).	Field	Drop Down List Box	0
Recipient Plan	Code that identifies the recipient plans that are supported by the system.	Field	Character	5

6.258.4 Recipient Plan- -Benefit Administration Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of recipient plan.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Invalid Date. Format is mm/dd/ccyy.	Enter an Effective Date in mm/dd/ccyy format.
	Field	3	Effective Date must be less than or equal to the End Date	Enter an Effective Date that is less than or equal to the End Date.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	4	Effective Date must be greater than or equal to 1/1/1900.	Enter an Effective Date that is greater than or equal to 1/1/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299	Enter an Effective Date that is less than or equal to 12/31/2299
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 1/1/1900.	End Date that is greater than or equal to 1/1/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	A valid Financial Payer is required.	Select a Financial Payer list.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date. Format is mm/dd/ccyy.	Enter an Inactive Date in mm/dd/ccyy format.
	Field	5	Inactive Date must be greater than or equal to 1/1/1900.	Enter an Inactive Date that is greater than or equal to 1/1/1900.
Long Description	Field	1	Long Description is required.	Enter a Long Description of the Recipient Plan.
Plan Type	Field	1	Plan Type is required.	Select a Plan type from the list.
Recipient Plan	Field	1	Recipient Plan is required.	Enter a Recipient Plan code.
	Field	2	A duplicate record cannot be saved.	Enter a unique recipient plan.

6.258.5 Recipient Plan- -Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.258.6 Recipient Plan- -Benefit Administration Panel Accessibility

6.258.6.1 To Access the Recipient Plan-Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Benefit Coverage displayed at bottom.

6.267.6.2 To Add on the Recipient Plan Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Recipient Plan.	
3	Select **Financial Payer** from drop down list box.	
4	Enter **Description**.	
5	Enter **Long Description**.	
6	Select **Plan Type** from drop down list box.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	
9	Enter **Inactive Date** in MM/DD/CCYY format.	
10	Click **Save**.	Recipient Plan information is saved.

6.258.6.2 To Update on the Recipient Plan Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Recipient Plan information is saved.

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6.258.6.3 To Delete on the Recipient Plan Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.259 RECIPIENT PLAN-DEPENDENT PLAN DATA - -BENEFIT ADMINISTRATION PANEL

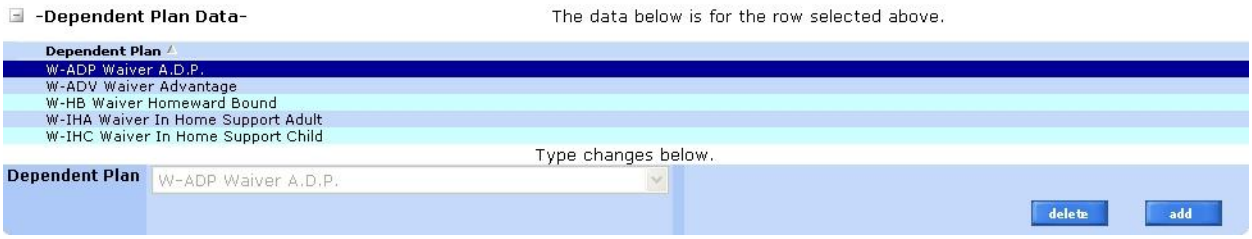
6.259.1 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Narrative

The Recipient Plan Dependent Plan Data panel maintains Recipient Plans that are dependent and must exist concurrently on Recipient Eligibility. For example, a recipient that has a waiver Recipient Plan must have Title XIX concurrently. Only authorized users with update privileges have the capability to add new information or modify existing data.

This panel is used to maintain the list of programs that can exist with the selected program.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Dependent Plan Data] by clicking on the "+")

6.259.2 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Layout



6.259.3 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a dependent plan to the Recipient Plan.	Button	N/A	0
Delete	Allows the user to delete a dependent plan from the Recipient Plan.	Button	N/A	0
Dependent Plan	Recipient plan that is dependent and must exist together on recipient eligibility.	Combo Box	Drop Down List Box	0

6.259.4 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Dependent Plan	Field	1	A valid Dependent Plan is required.	Select a Dependent Plan.
	Field	2	A duplicate record cannot be saved.	Select a unique dependent Plan.
	Field	3	The Dependent Plan cannot be the same as the parent Recipient Plan.	Select a Dependent plan that is NOT identical to the parent Recipient plan.

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6.259.5 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.259.6 Recipient Plan-Dependent Plan Data-Benefit Administration Panel Accessibility

6.259.6.1 To Access the Recipient Plan-Dependent Plan-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Dependent Plan Data displayed at bottom.

6.259.6.2 To Add on the Recipient Plan-Dependent Plan-Benefit Administration Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Dependent Plan** from drop down list box.	
3	Click **Save**.	Recipient Plan-Dependent Plan information is saved.

6.259.6.3 To Update on the Recipient Plan-Dependent Plan-Benefit Administration Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Recipient Plan-Dependent Plan information is saved.

6.259.6.4 To Delete on the Recipient Plan-Dependent Plan-Benefit Administration Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.

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2	Click **Delete**.	Line item is deleted.

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6.260 RECIPIENT PLAN-EXCLUDED PLAN DATA-BENEFIT ADMINISTRATION PANEL

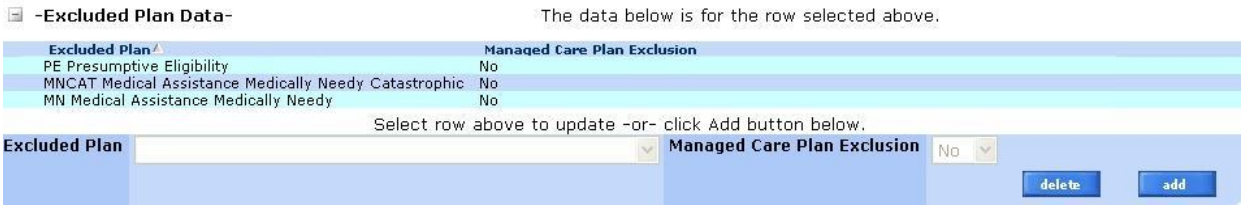
6.260.1 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Narrative

The Recipient Plan Excluded Plan Data panel maintains Recipient Plans that can not exist with a specified Recipient Plan concurrently on Recipient Eligibility. For example, a recipient can not have the Recipient Plan Presumptive Eligible concurrently with Title XIX.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Excluded Plan Data] by clicking on the "+")

6.260.2 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Layout



6.260.3 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add an Excluded Plan to the Recipient Plan.	Button	N/A	0
Delete	Allows a user to delete an Excluded Plan from the Recipient Plan.	Button	N/A	0
Excluded Plan	Recipient Plan Excluded Plan Data panel maintains Recipient Plans that cannot exist with a specified Recipient Plan concurrently on Recipient Eligibility. For example, a recipient cannot have the Recipient Plan Presumptive Eligible concurrently with TXIX.	Combo Box	Drop Down List Box	0
Managed Care Plan Exclusion	Indicates which exclusion table rows are for Managed Care exclusions specifically.	Combo Box	Drop Down List Box	0

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6.260.4 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Excluded Plan	Field	1	A duplicate record cannot be saved.	Select a unique Excluded Plan.
	Field	2	A valid Excluded Plan is required.	Select a valid Excluded Plan from the Excluded Plan Drop Down listing.
	Field	3	The Excluded Plan cannot be the same as the parent Recipient Plan.	Select an Excluded plan that is NOT identical to the parent Recipient plan.
	Field	4	Plan cannot be Exclusive of itself.	Verify Excluded Plan entry.
Managed Care Plan Exclusion	Field	1	Managed Care Plan Exclusion is required.	Select a valid Managed Care Plan Exclusion the list.

6.260.5 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.260.6 Recipient Plan-Excluded Plan Data-Benefit Administration Panel Accessibility

6.260.6.1 To Access the Recipient Plan- Excluded Plan Data-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Excluded Plan Data displayed at bottom.

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6.260.6.2 To Add on the Recipient Plan- Excluded Plan Data-Benefit Administration Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Excluded Plan** from drop down list box.	
3	Select **Managed Care Exclusion** from drop down list box.	
4	Click **Save**.	Recipient Plan- Excluded Plan Data information is saved.

6.260.6.3 To Update on the Recipient Plan- Excluded Plan Data-Benefit Administration Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Recipient Plan- Excluded Plan Data information is saved.

6.260.6.4 To Delete on the Recipient Plan- Excluded Plan Data-Benefit Administration Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.261 RECIPIENT PLAN-CLASSIFICATION MAPPING DATA-BENEFIT ADMINISTRATION PANEL

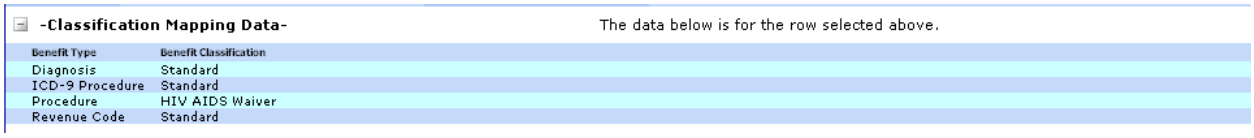
6.261.1 Recipient Plan-Classification Mapping Data-Benefit Administration Panel Narrative

The Recipient Plan Classification Mapping Data panel maintains Benefit Type and Benefit Classification.

This panel is display only.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Classification Mapping Data] by clicking on the "+")

6.261.2 Recipient Plan-Classification Mapping Data -Benefit Administration Panel Layout



6.261.3 Recipient Plan-Classification Mapping Data-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Classification	Unique row identifier for this table.	Field	Character	9
Benefit Type	The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD procedures, ICD diagnosis, Revenue Code and Drug codes (NDCs). Other allowed values may identify GROUPS of benefits such as Procedure groups etc.	Field	Character	3

6.261.4 Recipient Plan-Classification Mapping Data-Benefit Administration Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.261.5 Recipient Plan-Classification Mapping Data-Benefit Administration Panel Extra Features

Field	Field Type	Error Code	Error Message	To Correct
No extra features found for this page.				

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6.261.6 Recipient Plan-Classification Mapping Data-Benefit Administration Panel Accessibility

6.261.6.1 To Access the Recipient Plan-Dependent Plan-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Classification Mapping Data displayed at bottom.

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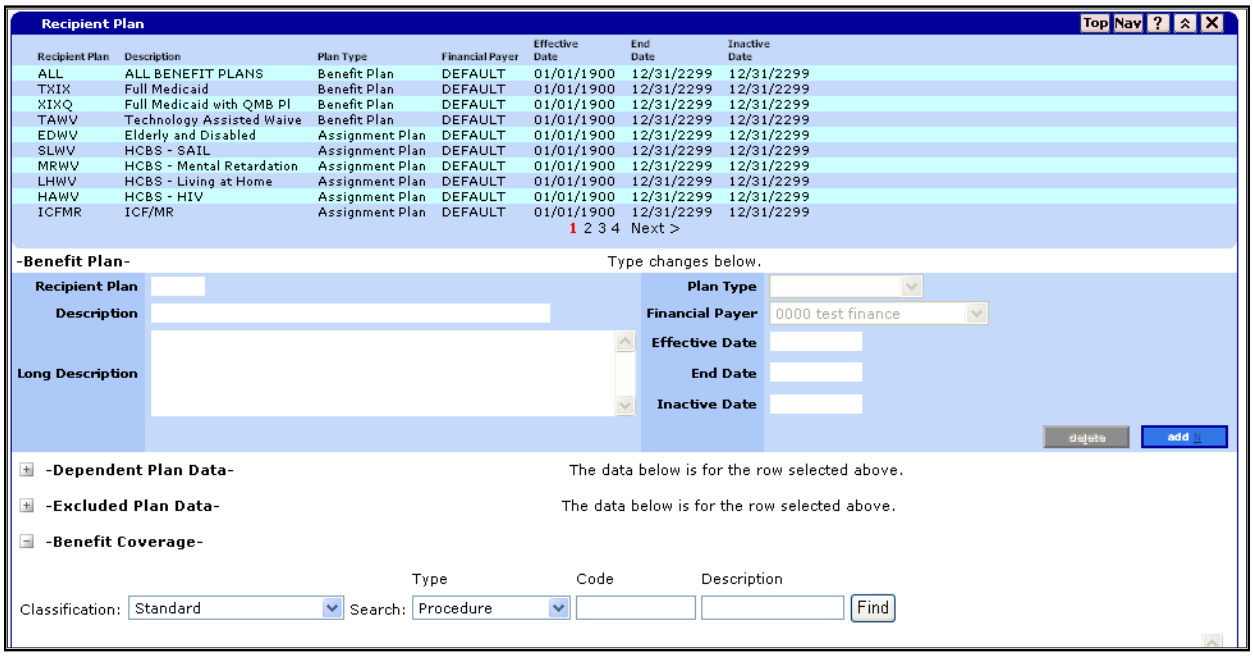
6.262 RECIPIENT PLAN-BENEFIT COVERAGE-BENEFIT ADMINISTRATION PANEL

6.262.1 Recipient Plan-Benefit Coverage-Benefit Administration Panel Narrative

The Recipient Plan-Benefit Coverage panel is used to maintain benefit coverage by Recipient Plan. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Benefit Coverage] plan by clicking on the "+")

6.262.2 Recipient Plan-Benefit Coverage-Benefit Administration Panel Layout



6.262.3 Recipient Plan-Benefit Coverage-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefits	List of Benefits.	Treeview	N/A	0
Classification	Hierarchy of groupings.	Combo Box	Drop Down List Box	0
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Search Code	Allows search for a benefit code.	Field	Character	0
Search Description	Allows search by description.	Field	Character	0
Search Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0

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6.262.4 Recipient Plan-Benefit Coverage-Benefit Administration Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.262.5 Recipient Plan-Benefit Coverage-Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.262.6 Recipient Plan-Benefit Coverage-Benefit Administration Panel Accessibility

6.262.6.1 To Access the Recipient Plan-Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Benefit Coverage displayed at bottom.

6.262.6.2 To Navigate on the Recipient Plan-Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Classification** from drop down list box.	
3	Select **Type** from drop down list box. Note: Enter code or description to narrow search down.	
4	Click **Find**.	Recipient Plan- Benefit Coverage information is displayed.

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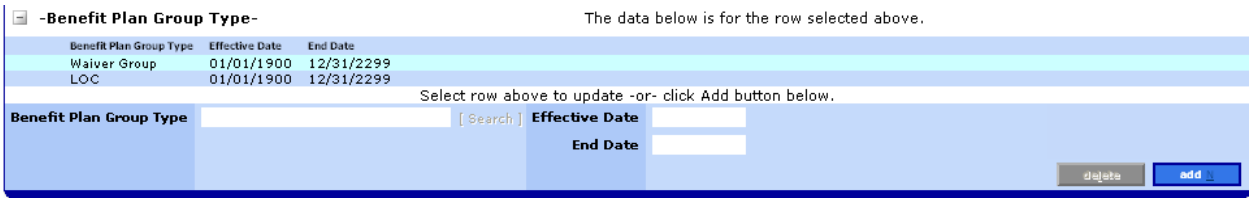
6.263 RECIPIENT PLAN-BENEFIT PLAN GROUP TYPE-BENEFIT ADMINISTRATION PANEL

6.263.1 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Narrative

The Benefit Plan Group Type panel is used to add and delete Benefit Plan Group Type for the Recipient Plan. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Benefit Plan Group Type] by clicking on the "+")

6.263.2 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Layout



6.263.3 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Benefit Plan Group Type.	Button	N/A	0
Delete	Allows the user to delete a Benefit Plan Group Type.	Button	N/A	0
Effective Date	The date of service on which the Benefit Plan becomes valid for the Benefit Plan group.	Field	Date (MM/DD/CCYY)	8
End Date	The date of service on which the Benefit Plan code is no longer valid for the Benefit Plan group.	Field	Date (MM/DD/CCYY)	8
Benefit Plan Group Type [Search]	System assigned internal key for a recipient plan.	Hyperlink	N/A	0

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6.263.4 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Group Type [Search]	Hyperlink	1	A valid Benefit Plan Group Type is required.	Select a valid Benefit Plan Group Type.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	2	Date range segments cannot overlap.	Correct the overlap condition. Date range segments cannot overlap for the same Benefit Plan.
	Field	3	Invalid date. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.
	Field	4	Effective Date is required.	Enter a valid date. Format is MM/DD/CCYY.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an effective date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an effective date that is less than or equal to 12/31/2299.
End Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid date. Format is MM/DD/CCYY.
	Field	2	End Date is required.	Enter a valid date. Format is MM/DD/CCYY.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.

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6.263.5 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.263.6 Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel Accessibility

6.263.6.1 To Access the Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Benefit Plan Group Type information displayed at bottom.

6.263.6.2 To Add on the Recipient Plan- Benefit Plan Group Type-Benefit Administration Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Benefit Plan Group Type**.	
3	Enter **Effective Date**.	
4	Enter **End Date**.	
5	Click **Save**.	Recipient Plan- Benefit Plan Group Type information is saved.

6.263.6.3 To Update on the Recipient Plan- Benefit Plan Group Type-Benefit Administration Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Recipient Plan- Benefit Plan Group Type information is saved.

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6.263.6.4 To Delete on the Recipient Plan-Benefit Plan Group Type-Benefit Administration Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.264 RECIPIENT PLAN-BENEFIT COVERAGE-BENEFIT ADMINISTRATION PANEL

6.264.1 Recipient Plan-Benefit Coverage-Benefit Administration Panel Narrative

This panel is used to maintain benefit coverage by Recipient Plan

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - (Select a Recipient Plan) - (Expand the [Benefit Coverage] plan by clicking on the "+")

6.264.2 Recipient Plan-Benefit Coverage-Benefit Administration Panel Layout

6.264.3 Recipient Plan-Benefit Coverage-Benefit Administration Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Classification	Hierarchy of groupings.	Combo Box	Drop Down List Box	0
Code	Allows search for a benefit code.	Field	Character	0
Description	Allows search by description.	Field	Character	0
Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0
Version	List of I versions. This drop down is visible only if benefit type is selected as "Diagnosis".	Combo Box	Drop Down List Box	6

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6.264.4 Recipient Plan-Benefit Coverage-Benefit Administration Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Either the code or partial description of a benefit must be specified to find it.	Enter code of a benefit and then click Find Button.
Description	Field	2	Either the code or partial description of a benefit must be specified to find it.	Enter partial description of benefit and then click Find button.

6.264.5 Recipient Plan-Benefit Coverage-Benefit Administration Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.264.6 Recipient Plan-Benefit Coverage-Benefit Administration Panel Accessibility

6.264.6.1 To Access the Recipient Plan-Benefit Coverage-Benefit Administration Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Benefit Coverage displayed at bottom.

6.264.6.2 To Navigate on the Recipient Plan- -Benefit Administration Panel

Step	Action	Response
1	Select **Classification** from drop down list box.	
2	Select **Type** from drop down list box.	
3	Select **Version** from drop down list box.	
4	Enter Code / Description or both in the text box.	
5	Click **Find**.	Recipient Plan- Benefit Coverage information is displayed.

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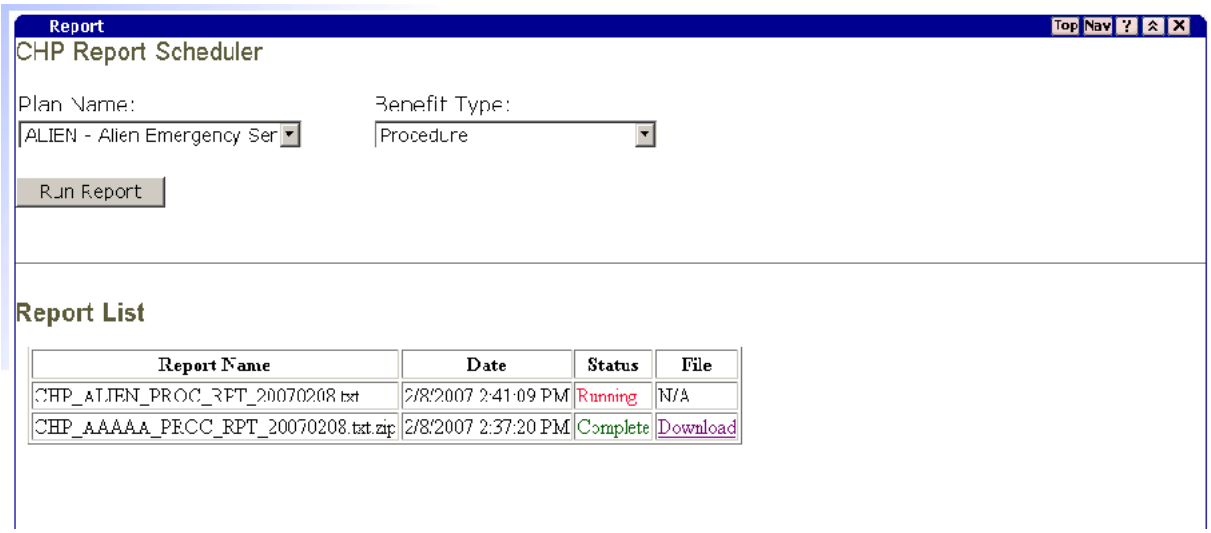
6.265 REPORT PANEL

6.265.1 Report Panel Narrative

This panel generates a report upon request that will display the rules for a selected Recipient Plan.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan] - [Report]

6.265.2 Report Panel Layout



6.265.3 Report Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Benefit Type	The 6 benefit types.	Combo Box	Drop Down List Box	0
Plan Name	User is able to select a Plan Name to filter report by.	Combo Box	Drop Down List Box	0

6.265.4 Report Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.265.5 Report Panel Extra Features

Field	Field Type	Error Code	Error Message	To Correct
No extra features found for this page.				

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6.265.6 Report Panel Accessibility

6.265.6.1 To Access the Report Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Report**.	Recipient Plan Rule panel displays.

6.265.6.2 To Navigate the Report Panel

Step	Action	Response
1	Select **Plan Name** from the drop down list box.	
2	Select **Benefit Type** from the drop down list box.	
3	Click **Run Report**.	Report displays.

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6.266 BENEFIT CLASSIFICATION PANEL

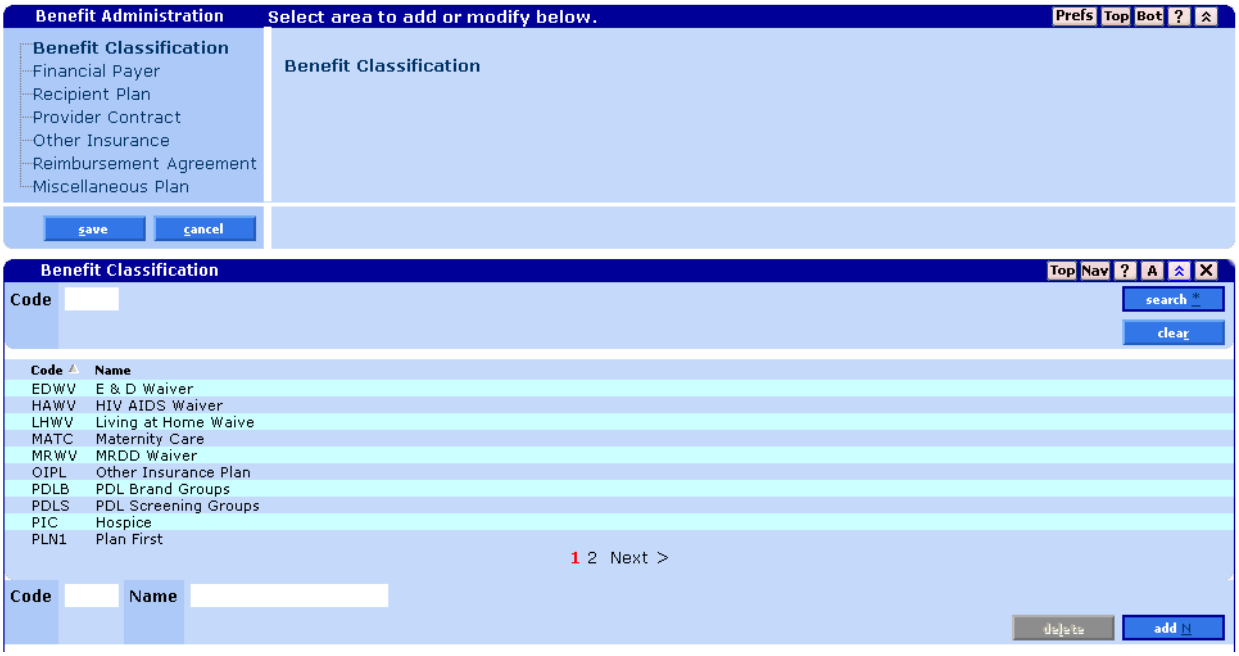
6.266.1 Benefit Classification Panel Narrative

The Benefit Classification panel is used to create and maintain benefit classification/hierarchies. The Benefit Classifications allow the user to organize or specialize benefits into hierarchies used for various system functions including, but not limited to, Benefit Plan Coverage rules, Contract Billing rules, Contract Reimbursement rules and Other Insurance rules.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Benefit Classification]

6.266.2 Benefit Classification Panel Layout



6.266.3 Benefit Classification Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Ad	Add a Benefit Classification.	Button	N/A	0
Code	A short hand code to identify the hierarchy.	Field	Character	4
Delete	Delete a Benefit Classification.	Button	N/A	0
Name	A description of the hierarchy.	Field	Character	20

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6.266.4 Benefit Classification Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Code is required.	Enter a unique code.
	Field	2	Duplicate Classification Code.	Enter a unique Classification Code.
Name	Field	1	Name is required.	Enter a description.
	Field	2	Duplicate Classification Name.	Enter a unique Classification Name.

6.266.5 Benefit Classification Panel Extra Features

The lower portion of this panel is displayed in treeview. Right clicking on the groups or benefits will display the possible actions that can be performed.

6.266.6 Benefit Classification Panel Accessibility

6.266.6.1 To Access the Benefit Classification Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Benefit Classification**.	Benefit Classification panel displays.

6.266.6.2 To Add on the Benefit Classification Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Code**.	
3	Enter **Name**.	
4	Click **Save**.	Benefit Classification information is saved.

6.266.6.3 To Update on the Benefit Classification Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Classification information is saved.

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6.266.6.4 To Delete on the Other- Benefit Classification Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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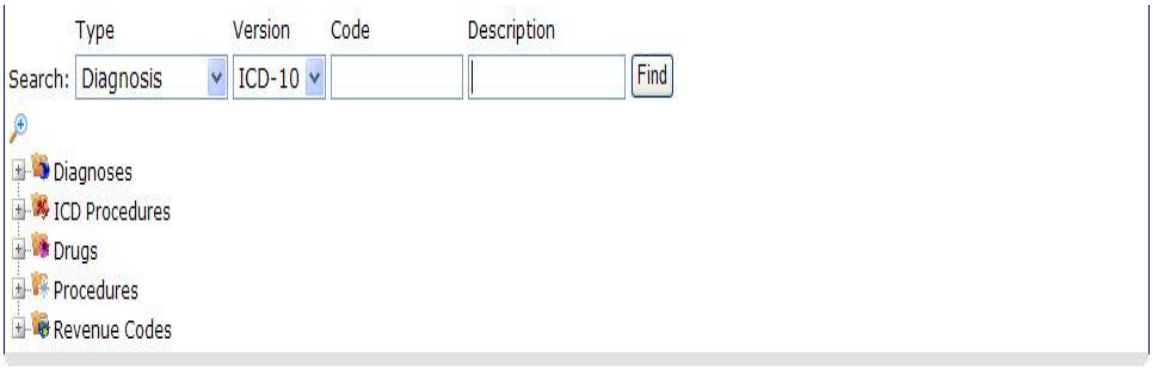
6.267 BENEFIT HIERARCHY - BENEFIT COVERAGE PANEL

6.267.1 Benefit Hierarchy - Benefit Coverage Panel Narrative

This panel is used to create/modify benefit hierarchy for any selected benefit classification.

Navigation Path: [Reference] - [Benefit Administration] - [Benefit Classification] - (Select a Benefit Classification).

6.267.2 Benefit Hierarchy - Benefit Coverage Panel Layout



6.267.3 Benefit Hierarchy - Benefit Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0
Version	List of ICD versions. This drop down is visible only if benefit type is selected as "Diagnosis".	Combo Box	Drop Down List Box	0
Code	Allows search for a benefit code.	Field	Character	0
Description	Allows search by description.	Field	Character	0

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6.267.4 Benefit Hierarchy - Benefit Coverage Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Either the code or partial description of a benefit must be specified to find it.	Enter code of a benefit and then click Find Button.
Description	Field	2	Either the code or partial description of a benefit must be specified to find it.	Enter partial description of benefit and then click Find button.

6.267.5 Benefit Hierarchy - Benefit Coverage Panel Extra Features

The lower portion of this panel is displayed in treeview. Right clicking on the groups or benefits will display the possible actions that can be performed.

6.267.6 Benefit Hierarchy - Benefit Coverage Panel Accessibility

6.267.6.1 To Access the Benefit Hierarchy - Benefit Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Benefit Classification**.	Benefit Classification panel displays.

6.267.6.2 To Navigate on the Benefit Hierarchy - Benefit Coverage Panel

Step	Action	Response
1	Select **a Classification** from the datalist	
2	Select **Type** from drop down list box.	
3	Select **Version** from drop down list box.	
4	Enter **Code / Description** or both in the text box.	
5	Click **Find**.	In Benefit Hierarchy - Benefit Coverage tree structure benefit is selected.

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6.268 FINANCIAL PAYER MAINTENANCE PAGE

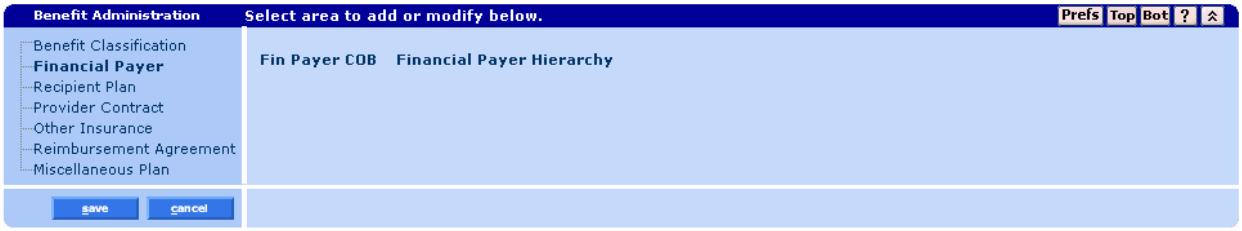
6.268.1 Financial Payer Maintenance Page Narrative

The Financial Payer Maintenance page allows the user to access the various miscellaneous data maintained within the Reference Data Maintenance subsystem area. This area of the user-interface includes data such as Fin Payer COB and Financial Hierarchy

Navigation Path: [Reference] - [Benefit Administration] - [Financial Payer]

This panel is inquiry only.

6.268.2 Financial Payer Maintenance Panel Layout



6.268.3 Financial Payer Maintenance Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel changes.	Button	N/A	0
Fin Payer COB	Link to the Fin Payer COB panel.	Hyperlink	N/A	0
Financial Payer Hierarchy	Link to the Financial Payer Hierarchy panel.	Hyperlink	N/A	0
Save	Allows the user to save changes.	Button	N/A	0

6.268.4 Financial Payer Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this page.				

6.268.5 Financial Payer Maintenance Page Extra Features

Field	Field Type	Error Code	Error Message	To Correct
No extra features found for this page.				

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6.268.6 Financial Payer Maintenance Page Accessibility

6.268.6.1 To Access the Financial Payer Maintenance Page

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Financial Payer**.	Financial Payer Maintenance page displays.

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6.269 FIN PAYER COB PANEL

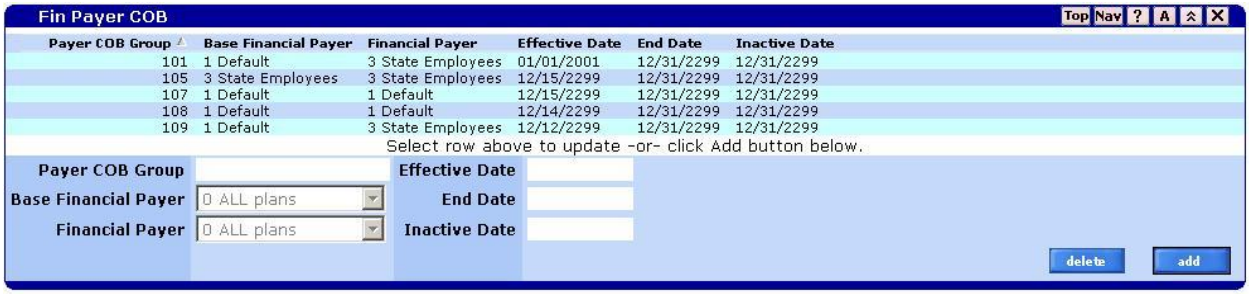
6.269.1 Fin Payer COB Panel Narrative

The Financial Payer COB panel maintains relationships and the order of Payers as related to coordination at the Payer level. The Payer Coordination is set up by pairs considered Payer COB Groups. These groups work with the Payer Thread. Note the order of the pair is important. For example if the coordination pair is set up as Payer1/Payer2 then a Payer Hierarchy thread with Payer1 followed by Payer2 must exist to coordinate. If the hierarchy thread is set up as Payer2/Payer1 the Payers will NOT coordinate. If the first Payer in the pair does NOT pay, there will NOT be Coordination.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Financial Payer] -[Fin Payer COB]

6.269.2 Fin Payer COB Panel Layout



6.269.3 Fin Payer COB Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Financial Payer COB record.	Button	N/A	0
Base Financial Payer	First Payer in the Payer COB Group.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete a Financial Payer COB record.	Button	N/A	0
Effective Date	Date the hierarchy thread becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8
End Date	Date the hierarchy thread becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Second Payer in the Payer COB Group.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Inactive Date	Date/Time the Financial Payer COB can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Payer COB Group	Unique identifier for the pair of Payers to be coordinated.	Field	Number (Integer)	9

6.269.4 Fin Payer COB Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Base Financial Payer	Field	1	Base Financial Payer and Financial Payer must be different.	Select a Base Financial Payer different from Financial Payer.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	4	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
	Field	5	Effective Date must be less than or equal to the End Date.	Enter an Effective Date that is less than or equal to the End Date.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter a valid End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Financial Payer	Field	1	Financial Payer field is required.	Select a valid financial payer from the financial payer drop down listing.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Base Financial Payer and Financial Payer must be different.	Select a Financial Payer different from Base Financial Payer.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.
Payer COB Group	Field	1	Payer COB Group is required.	Select a valid Payer COB Group from the Payer COB Group drop down listing.

6.269.5 Fin Payer COB Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.269.6 Fin Payer COB Panel Accessibility

6.269.6.1 To Access the Fin Payer COB Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Financial Payer**.	Financial Payer page displays.
4	Select **Fin Payer COB**.	Fin Payer COB panel displays.

6.269.6.2 To Add on the Fin Payer COB Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Select **Base Financial Payer** from drop down list box.	

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Step	Action	Response
3	Select **Financial Payer** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Enter **Inactive Date** in MM/DD/CCYY format.	
7	Click **Save**. Payer COB Group number is automatically generated.	Fin Payer COB information is saved.

6.269.6.3 To Update on the Fin Payer COB Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Fin Payer COB information is saved.

6.269.6.4 To Delete on the Fin Payer COB Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.270 FINANCIAL PAYER HIERARCHY PANEL

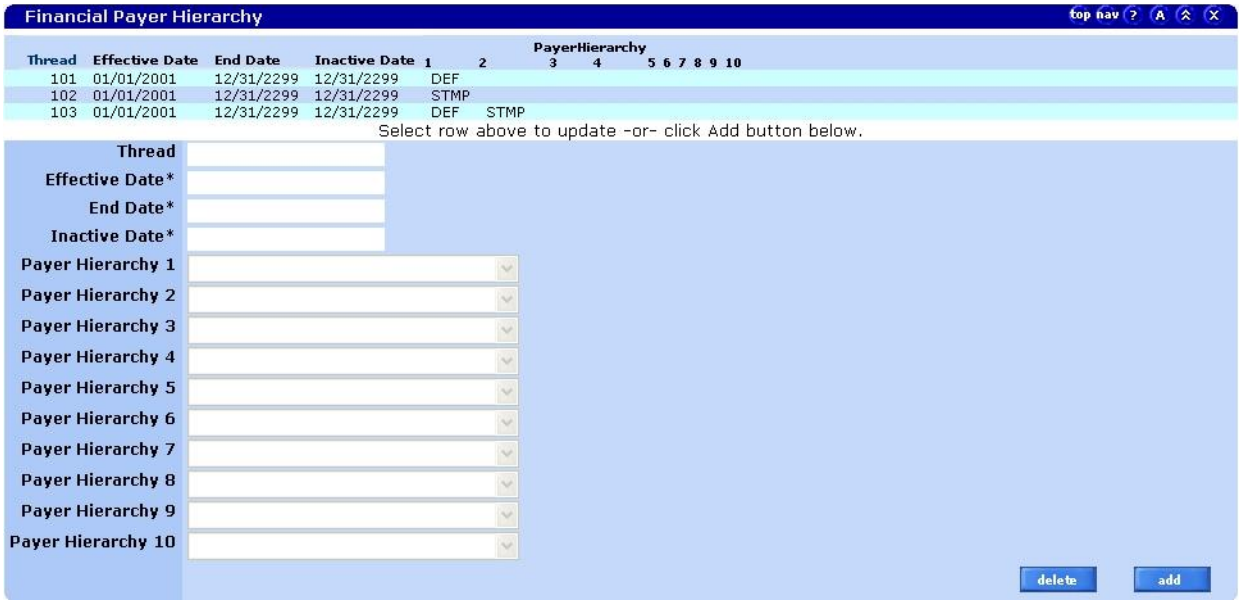
6.270.1 Financial Payer Hierarchy Panel Narrative

The Financial Payer Hierarchy panel maintains HIPAA Payer Hierarchy Threads that are used to control payer relationships and the order of claim adjudication at the Payer level. Payer hierarchy threads are ordered sets of Payers that may cover recipients concurrently.

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Benefit Administration] - [Financial Payer] - [Financial Payer Hierarchy]

6.270.2 Financial Payer Hierarchy Panel Layout



6.270.3 Financial Payer Hierarchy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a Financial Payer Hierarchy thread.	Button	N/A	0
Delete	Allows the user to delete a Financial Payer Hierarchy thread.	Button	N/A	0
Effective Date	Date the hierarchy thread becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	Date the hierarchy thread becomes invalid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. The claim FDOS/TDOS date span is used when comparing the End Dates.	Field	Date (MM/DD/CCYY)	8
Inactive Dat	Date/Time the Financial Payer Hierarchy can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Payer Hierarchy 1	First Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 2	Second Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 3	Third Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 4	Fourth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 5	Fifth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 6	Sixth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 7	Seventh Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 8	Eighth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 9	Ninth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0
Payer Hierarchy 10	Tenth Payer defined in the hierarchy.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Thread	System assigned identified to be used to uniquely identify a thread. The payer hierarchy thread is an ordered set of Payers that may cover recipients concurrently. A payer hierarchy thread controls payer relationships and the order of claim adjudication at the payer level.	Field	Number (Integer)	

6.270.4 Financial Payer Hierarchy Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to the End Date	Enter an Effective Date that is less than or equal to the End Date.
	Field	3	Invalid date.	Enter an Effective Date in MM/DD/CCYY format.
	Field	5	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	6	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.
Payer Hierarchy 1	Field	1	A valid Payer Node is required.	Select a least 1 payer.
Thread	Field	1	Duplicate payers found within a thread - is not valid.	Verify keying. Payers in the thread must be unique.

6.270.5 Financial Payer Hierarchy Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.270.6 Financial Payer Hierarchy Panel Accessibility

6.270.6.1 To Access the Financial Payer Hierarchy Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Financial Payer**.	Financial Page panel displays.
4	Select **Financial Payer Hierarchy**.	Financial Payer Hierarchy panel displays.

6.270.6.2 To Add on the Financial Payer Hierarchy Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Effective Date.**	
3	Enter **End Date**.	
4	Enter **Inactive** Date.	
5	Select **Payer Hierarchy 1** from drop down list box.	
6	Select **Payer Hierarchy 2** from drop down list box.	
7	Select **Payer Hierarchy 3** from drop down list box.	Select **Payer Hierarchy 3** from drop down list box.
8	Select **Payer Hierarchy 4** from drop down list box.	

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Step	Action	Response
9	Select **Payer Hierarchy 5** from drop down list box.	
10	Select **Payer Hierarchy 6** from drop down list box.	
11	Select **Payer Hierarchy 7** from drop down list box.	
12	Select **Payer Hierarchy 8** from drop down list box.	
13	Select **Payer Hierarchy 9** from drop down list box.	
14	Select **Payer Hierarchy 10** from drop down list box.	
15	Click **Save**. Thread number is automatically generated.	Financial Payer Hierarchy information is saved.

6.270.6.3 To Update on the Financial Payer Hierarchy Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Financial Payer Hierarchy information is saved.

6.270.6.4 To Delete on the Financial Payer Hierarchy Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.271 PROVIDER CONTRACT PANEL

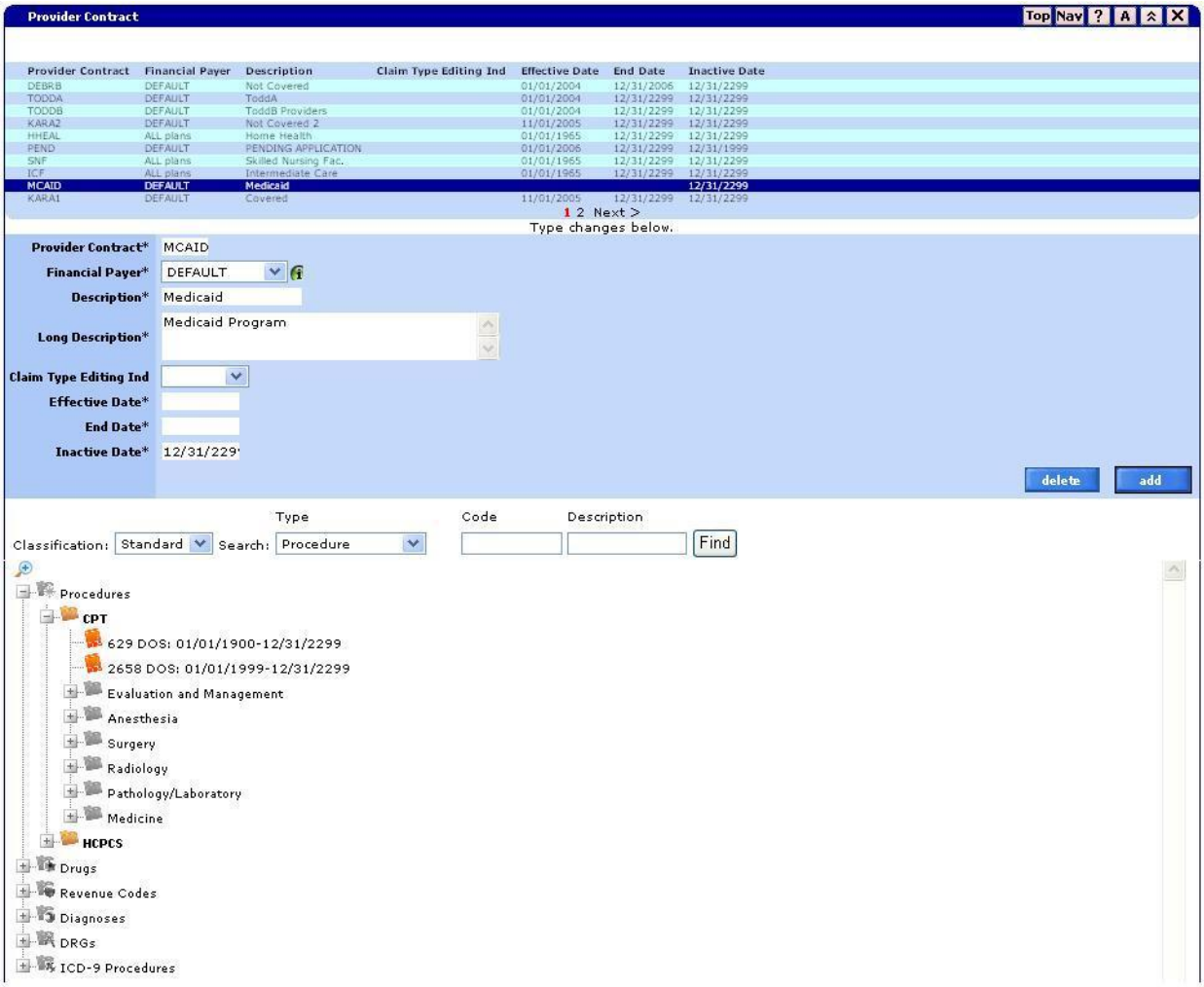
6.271.1 Provider Contract Panel Narrative

The Provider Contract panel is used to maintain Provider Contracts. Provider Contracts list benefits a provider can bill and the restrictions applicable to that benefit (billing rules).

Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] - [Benefit Administration] - [Provider Contract]

6.271.2 Provider Contract Panel Layout



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6.271.3 Provider Contract Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Ad	Allows the user to add an enrollment program.	Button	N/	0
Claim Type Edit Ind	Indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (none), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.	Combo Box	Drop Down List Box	0
Delete	Allows the user to delete an enrollment program.	Button	N/A	0
Description	Short description to the provider enrollment program.	Field	Character	20
Effective Date	Date the Provider Contract becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective dates.	Field	Date (MM/DD/CCYY)	8
End Date	Date the Provider Contract becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Financial Payer	Business code value/description used to identify the payer.	Combo Box	Drop Down List Box	0
Inactive Date	Date/Time the Provider Contract can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date Restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Long description to the provider enrollment program.	Field	Character	4000
Provider Contract	Classification of services a Provider can bill. A provider may have multiple contracts.	Field	Character	5

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6.271.4 Provider Contract Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a text description of the Enrollment Program.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Invalid date.	Enter an Effective date in MM/DD/CCYY format.
	Field	3	Effective Date must be less than or equal to the End Date.	Enter an Effective Date that is less than or equal to the End Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid date.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	Enter an End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	Enter an End Date that is less than or equal to 12/31/2299.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 01/01/1900.
Long Description	Field	1	Long description is required.	Enter a long description of the Enrollment Program.
Provider Contract	Field	1	Provider Contract is required.	Enter an provider contract.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	A duplicate record cannot be saved.	Enter a unique enrollment program.

6.271.5 Provider Contract Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.271.6 Provider Contract Panel Accessibility

6.271.6.1 To Access the Provider Contract Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Provider Contract**.	Provider Contract panel displays.

6.271.6.2 To Add on the Provider Contract Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Provider Contract**.	
3	Select **Financial Payer** from drop down list box.	
4	Enter **Description**.	
5	Enter **Long Description**.	
6	Select **Claim Type Editing Ind** from drop down list box.	
7	Enter **Effective Date** in MM/DD/CCYY format.	
8	Enter **End Date** in MM/DD/CCYY format.	
9	Enter **Inactive Date** in MM/DD/CCYY format.	
10	Click **Save**.	Provider Contract information is saved.

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6.271.6.3 To Update on the Provider Contract Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Provider Contract information is saved.

6.271.6.4 To Delete on the Provider Contract Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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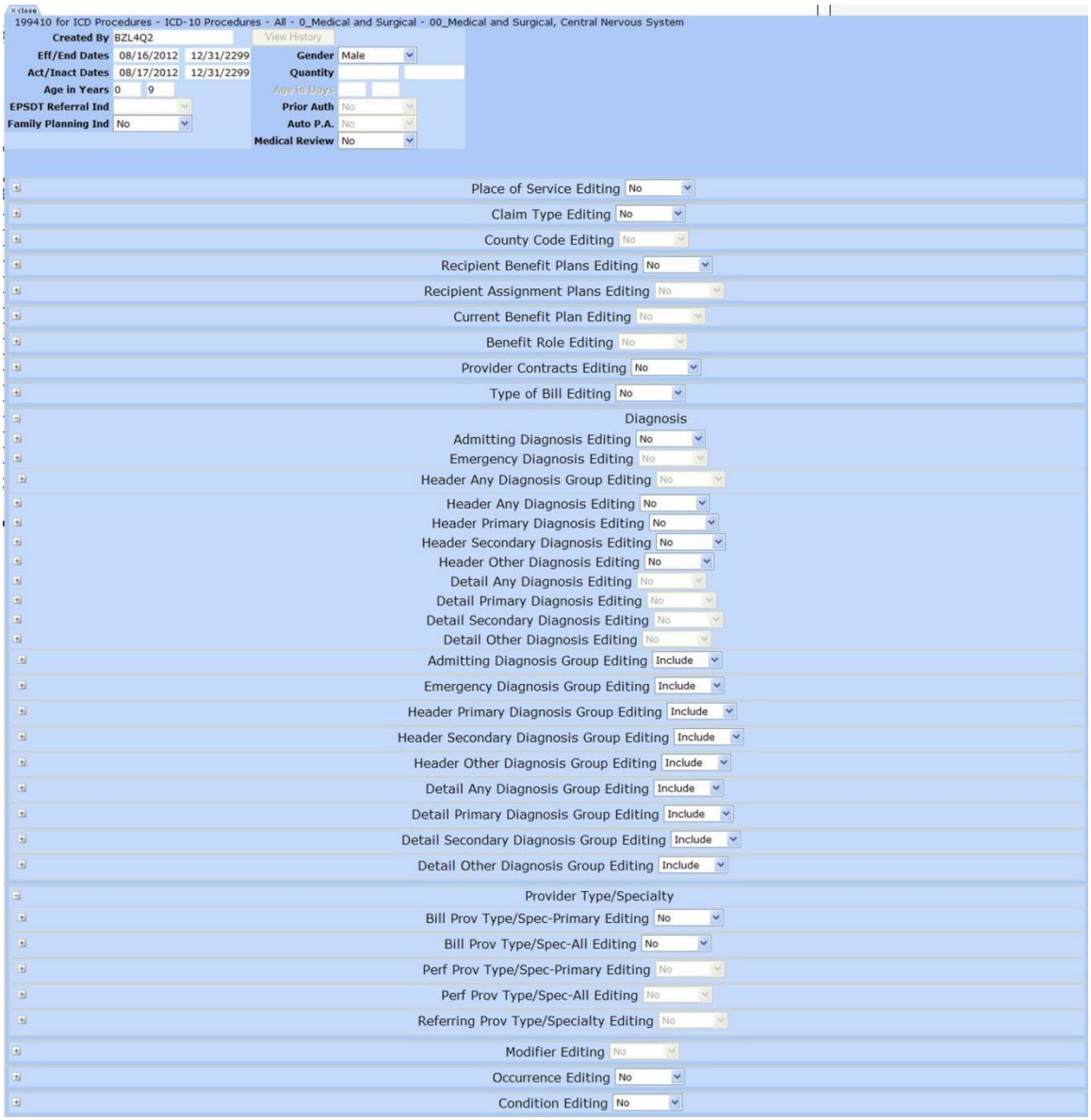
6.272 PROVIDER CONTRACT EDIT PANEL

6.272.1 Provider Contract Edit Panel Narrative

Provider Contract Edit Panel is used to create new and modify existing rule.

Navigation Path: [Reference] - [Benefit Administration] - [Provider Contract]

6.272.2 Provider Contract Edit Panel Layout



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6.272.3 Provider Contract Edit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
View History	Used to view the history of an existing rule.	Button	N/A	0
Act/Inact Dates	Active and Inactive Dates requirement for claims. The date format is MM/DD/CCYY.	Field	Character	50
Admitting Diagnosis Editing	Any Admitting Diagnosis restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Group Editing	Any Admitting Diagnosis Group restriction for claims.	Combo Box	N/A	0
Age in Days	Age in Days requirement for claims.	Field	Character	50
Age in Years	Age in Years requirement for claims.	Field	Character	50
Auto P.A.	Auto Prior Authorization requirement for claims.	Combo Box	N/A	0
Benefit Role Editing	Any Benefit Role restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-All Editing	Any bill provider all type/specialty restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-Primary Editing	Any bill provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Claim Type Editing	Any Claim Type restriction for claims.	Combo Box	N/A	0
Condition Editing	Any condition restriction for claims.	Combo Box	N/A	0
County Code Editing	Any County Code restriction for claims.	Combo Box	N/A	0
Created By	Clerk Id	Field	Character	32
Current Benefit Plan Editing	Any Current Benefit Plan restriction for claims.	Combo Box	N/A	0
Detail Any Diagnosis Editing	Any detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Any Diagnosis Group Editing	Any Detail Any Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Editing	Any other detail diagnosis restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Detail Other Diagnosis Group Editing	Any Detail Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Primary Diagnosis Editing	Any primary detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Primary Diagnosis Group Editing	Any Detail Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Editing	Any secondary detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Group Editing	Any Detail Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Diagnosis	Folder containing any diagnosis restriction for claims.	Label	N/A	0
Eff/End Dates	Effective and End Dates required for claims. The date format is MM/DD/CCYY.	Field	Character	50
EPSDT Referral Ind	EPSDT Referral requirement for claims.	Combo Box	N/A	0
Emergency Diagnosis Editing	Any Emergency Diagnosis restriction for claims.	Combo Box	N/A	0
Emergency Diagnosis Group Editing	Any Emergency Diagnosis Group restriction for claims.	Combo Box	N/A	0
Family Planning Ind	Family Planning requirement for claims.	Combo Box	N/A	0
Gender	Gender required for claims.	Combo Box	N/A	0
Header Any Diagnosis Editing	Any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Any Diagnosis Group Editing	Group containing any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Editing	Any other header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Group Editing	Any Header Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Editing	Any primary header diagnosis restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Header Primary Diagnosis Group Editing	Any Header Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Editing	Any secondary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Group Editing	Any Header Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Medical Review	Medical Review requirement for claims.	Combo Box	N/A	0
Modifier Editing	Any modifier restriction for claims.	Combo Box	N/A	0
Occurrence Editing	Any occurrence restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-All Editing	Any pref provider all type/specialty restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-Primary Editing	Any pref provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Place of Service Editing	Any Place of Service restriction for claims.	Combo Box	N/A	0
Prior Auth	Prior Authorization requirement for claims.	Combo Box	N/A	0
Provider Contract Editing	Any Provider Contract restriction for claims.	Combo Box	N/A	0
Provider Type/Specialty	Folder containing any provider type/specialty restriction for claims.	Label	N/A	0
Quantity	Quantity requirement for claims.	Field	Character	50
Recipient Assignment Plans Editing	Any Recipient Assignment Plans restriction for claims.	Combo Box	N/A	0
Recipient Benefit Plans Editing	Any Recipient Benefit Plans restriction for claims.	Combo Box	N/A	0
Referring Prov Type/Specialty Editing	Any referring provider type/specialty restriction for claims.	Combo Box	N/A	0
Type of Bill Editing	Any Type of Bill restriction for claims.	Combo Box	N/A	0

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6.272.4 Provider Contract Edit Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admitting Diagnosis Group Editing	Combo Box	14	Admitting Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Admitting Diagnosis Group" listbox. If no value needs to be added to "Admitting Diagnosis Group" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-All Editing	Combo Box	7	Bill Prov Type/Spec-All must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-Primary Editing	Combo Box	6	Bill Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Claim Type Editing	Combo Box	2	Claim Type must cover at least one value for this rule to apply.	If the value of drop down is "Include" then there must be some value in "Claim Types Assigned" list box. If no value needs to be added to "Claim Types Assigned" list box than set the value to "No" for the drop down.
Condition Editing	Combo Box	13	Condition must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
County Code Editing	Combo Box	3	County Code must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "County Codes Assigned" listbox. If no value needs to be added to "County Codes Assigned" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Current Benefit Plan Editing	Combo Box	11	Current Benefit Plan Editing must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Current Benefit Plan Editing" list box. If no value needs to be added to "Current Benefit Plan Editing" list box than set the value to "No" for the drop down.
Detail Any Diagnosis Group Editing	Combo Box	15	Detail Any Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Any Diagnosis Group" list box. If no value needs to be added to "Detail Any Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Other Diagnosis Group Editing	Combo Box	16	Detail Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Other Diagnosis Group" listbox. If no value needs to be added to "Detail Other Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Primary Diagnosis Group Editing	Combo Box	17	Detail Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Primary Diagnosis Group" list box. If no value needs to be added to "Detail Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Secondary Diagnosis Group Editing	Combo Box	18	Detail Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Secondary Diagnosis Group" list box. If no value needs to be added to "Detail Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Emergency Diagnosis Group Editing	Combo Box	20	Emergency Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Emergency Diagnosis Group" list box. If no value needs to be added to "Emergency Diagnosis

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Field	Field Type	Error Code	Error Message	To Correct
				Group" list box than set the value to "No" for the drop down.
Header Other Diagnosis Group Editing	Combo Box	19	Header Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Other Diagnosis Group" list box. If no value needs to be added to "Header Other Diagnosis Group" list box than set the value to "No" for the drop down.
Header Primary Diagnosis Group Editing	Combo Box	21	Header Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Primary Diagnosis Group" list box. If no value needs to be added to "Header Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Header Secondary Diagnosis Group Editing	Combo Box	22	Header Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Secondary Diagnosis Group" list box. If no value needs to be added to "Header Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Modifier Editing	Combo Box	10	Modifier must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value need to be added under Options than set the value to "No" for the drop down.
Occurrence Editing	Combo Box	12	Occurrence must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Perf Prov Type/Spec-All Editing	Combo Box	9	Perf Prov Type/Spec-All must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Perf Prov Type/Spec-Primary Editing	Combo Box	8	Perf Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Place of Service Editing	Combo Box	1	Place of Service must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Places Of Service Assigned" list box. If no value needs to be added to "Places Of Service Assigned" list box than set the value to "No" for the drop down.
Provider Contract Editing	Combo Box	23	Provider Contract Editing must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Provider Contract Editing" list box. If no value needs to be added to "Provider Contract Editing" list box than set the value to "No" for the drop down.
Recipient Assignment Plans Editing	Combo Box	5	Recipient Assignment Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Assignment Plans Assigned" list box. If no value needs to be added to "Recipient Assignment Plans Assigned" list box than set the value to "No" for the drop down.
Recipient Benefit Plans Editing	Combo Box	4	Recipient Benefit Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Benefit Plans Assigned" list box. If no value needs to be added to "Recipient Benefit Plans Assigned" list box than set the value to "No" for the drop down.
Type of Bill Editing	Combo Box	24	Type of Bill Editing must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type of Bill Editing" list box. If no value needs to be added to "Type of Bill Editing" list box than set the value to "No" for the drop down.

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6.272.5 Provider Contract - Benefit Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.272.6 Provider Contract Edit Panel Accessibility

6.272.7 To Access the Provider Contract Edit Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Provider Contract**.	Provider Contract panel is displayed at the bottom.

6.272.7.1 To Add on the Provider Contract Panel

Step	Action	Response
1	Select a plan and expand Benefit Coverage tree and select a Rule.	Provider Contract panel will be displayed.
2	To create a new rule right click and select “Add Rule” from the menu.	
3	Click **Save**.	Provider Contract panel is saved.

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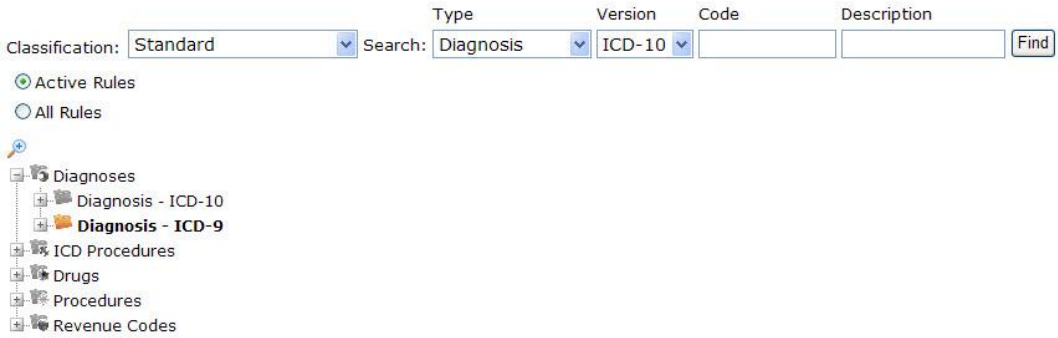
6.273 PROVIDER CONTRACT- BENEFIT COVERAGE PANEL

6.273.1 Provider Contract - Benefit Coverage Panel Narrative

This panel is used to maintain benefit coverage by Provider Contract.

Navigation Path: [Reference] - [Benefit Administration] - (Select a Provider Contract) - (Expand the plan by clicking on the "+")

6.273.2 Provider Contract - Benefit Coverage Panel Layout



6.273.3 Provider Contract - Benefit Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Classification	Hierarchy of groupings.	Combo Box	Drop Down List Box	0
Code	Allows search for a benefit code.	Field	Character	0
Description	Allows search by description.	Field	Character	0
Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0
Version	List of ICD versions. This drop down is visible only if benefit type is selected as "Diagnosis".	Combo Box	Drop Down List Box	0

6.273.4 Provider Contract - Benefit Coverage Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Either the code or partial description of a benefit must be specified to find it.	Enter code of a benefit and then click Find Button.

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Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Either the code or partial description of a benefit must be specified to find it.	Enter partial description of benefit and then click Find button.

6.273.5 Provider Contract - Benefit Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.275.6 Provider Contract - Benefit Coverage Panel Accessibility

6.273.5.1 To Access the Provider Contract - Benefit Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Provider Contract**.	Provider Contract – Benefit Coverage panel is displayed at the bottom.

6.273.5.2 To Navigate on the Provider Contract - Benefit Coverage Panel

Step	Action	Response
1	Select **Classification** from drop down list box.	
2	Select **Type** from drop down list box.	
3	Select **Version** from drop down list box.	
4	Enter Code / Description or both in the text box.	
5	Click **Find**.	Provider Contract- Benefit Coverage information is displayed.

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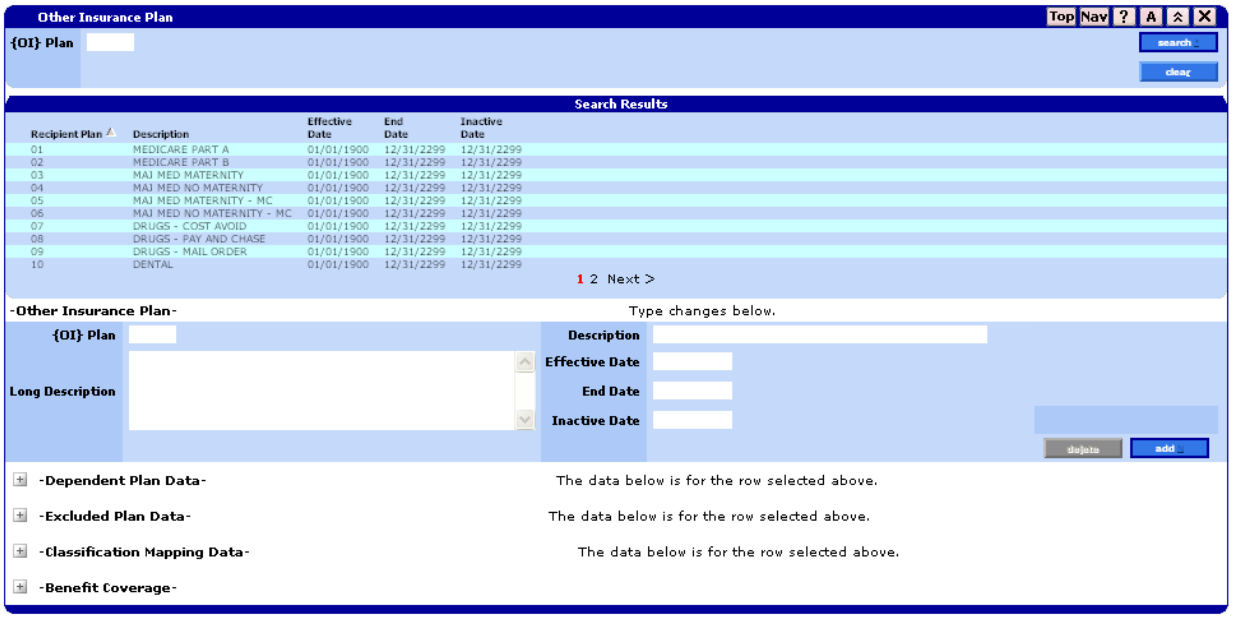
6.274 OTHER INSURANCE PLAN PANEL

6.274.1 Other Insurance Plan Panel Narrative

The Benefit Administration-Other Insurance Plan panel is used to maintain Other Insurance (OI) Plans. OI Plans identify third party health coverage for a member. There are five parts to the panel: (1) Dependent Plan Data, (2) Excluded Plan Data, (3) Classification Mapping Data, (4) Benefit Coverage. Only authorized users with update privileges have the capability to add new information or modify existing data.

Navigation Path: [Reference] – [Benefit Administration] – [Other Insurance]

6.274.2 Other Insurance Plan Panel Layout



6.274.3 Other Insurance Plan Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
{OI} Plan	Code that identifies the other insurance plan.	Field	Character	5
Add	Allows the user to add an OI plan.	Button	N/A	0
Clear	Clears all fields so the user may enter new search criteria.	Button	N/A	0
Delete	Allows the user to delete an OI Plan.	Button	N/A	0
Description	Text description of the OI Plan.	Field	Character	50
Effective Date	Date the OI Plan becomes valid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the effective date.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	Date the OI Plan becomes invalid for use in claims processing. The claim FDOS/TDOS date span is used when comparing the End Date.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Date/Time the Other Insurance Plan can no longer be used regardless of dates of service on the claim. Time is not displayed but time will be defaulted to 00:00 when selecting a date for processing. Future Inactive Date restrictions prevent inactivating a segment while claims are processing.	Field	Date (MM/DD/CCYY)	8
Long Description	Text definition of OI plans describing who is eligible and what types of services are provided.	Field	Character	4000
Search	Initiates the search for an OI matching the given search criteria.	Button	N/A	0

6.274.4 Other Insurance Plan Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description of OI Plan.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter an Effective Date in MM/DD/CCYY.
	Field	3	Effective Date must be less than or equal to the End Date.	Effective Date must be less than or equal to the End Date.
	Field	4	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date that is greater than or equal to 01/01/1900.
	Field	5	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date that is less than or equal to 12/31/2299.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter an End Date in MM/DD/CCYY format.
	Field	3	End Date must be greater than or equal to 01/01/1900.	End Date that is greater than or equal to 01/01/1900.
	Field	4	End Date must be less than or equal to 12/31/2299.	End Date that is less than or equal to 12/31/2299.

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Field	Field Type	Error Code	Error Message	To Correct
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be after the current System Date.	Enter an Inactive Date that is after the current System Date.
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Enter an Inactive Date that is less than or equal to 12/31/2299.
	Field	4	Invalid Date. Format is MM/DD/CCYY.	Enter an Inactive Date in MM/DD/CCYY format.
	Field	5	Inactive Date must be greater than or equal to 01/01/1900.	Enter an Inactive Date that is greater than or equal to 1/1/1900.
Long Description	Field	1	Long Description is required.	Enter a Long Description of the OI Plan.
{OI} Plan	Field	1	OI Plan is required.	Enter an OI Plan code.
	Field	2	A duplicate record can not be saved.	Enter a unique OI Plan.

6.274.5 Other Insurance Plan Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.274.6 Other Insurance Plan Panel Accessibility

6.274.6.1 To Access the Other Insurance Plan Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Other Insurance Plan** hyperlink.	Other Insurance Plan panel displays.

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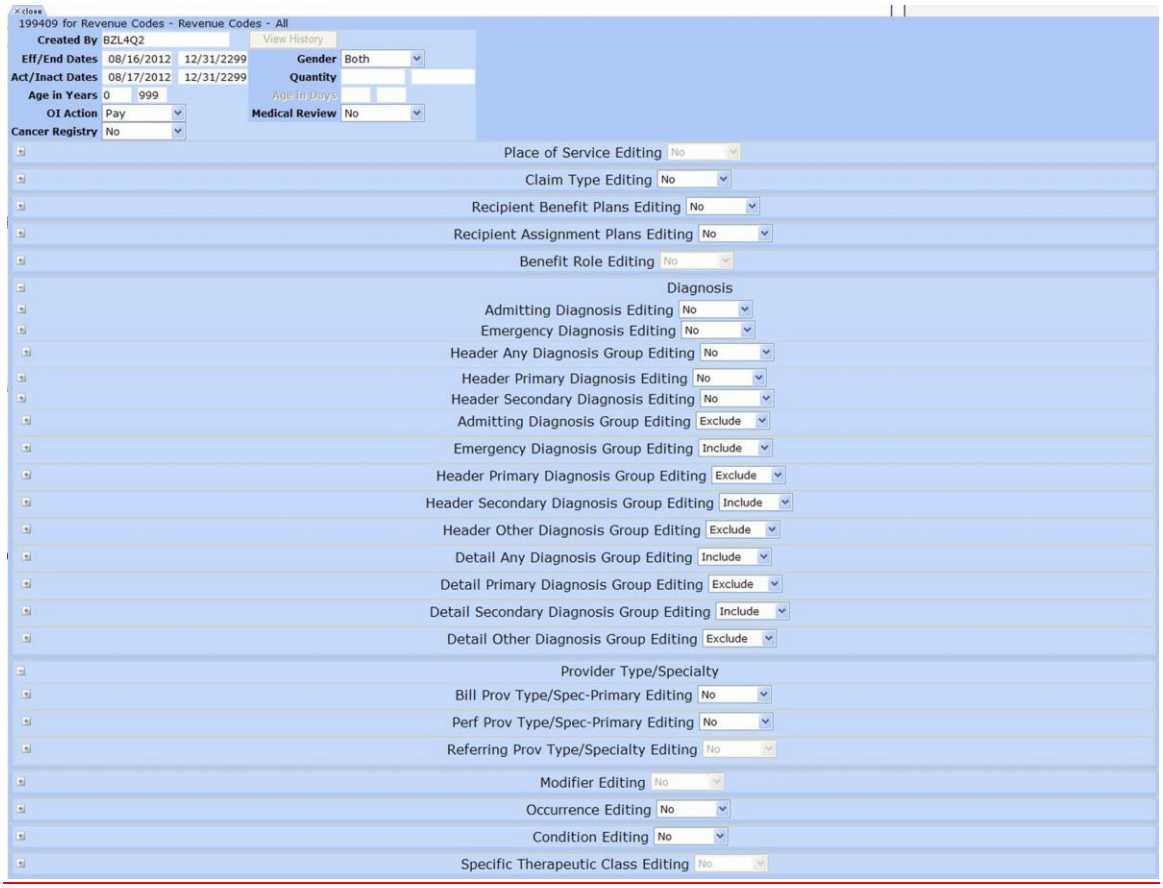
6.275 OTHER INSURANCE COVERAGE EDIT PANEL

6.275.1 Other Insurance Coverage Edit Panel Narrative

OI Coverage Edit Panel is used to create new and modify existing rule.

Navigation Path: [Reference] - [Benefit Administration] - [Other Insurance]

6.275.2 Other Insurance Coverage Edit Panel Layout



6.275.3 Other Insurance Coverage Edit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Act/Inact Dates	Active and Inactive Dates requirement for claims. The date format is MM/DD/CCYY.	Field	Character	50
Admitting Diagnosis Editing	Any Admitting Diagnosis restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Group Editing	Any Admitting Diagnosis Group restriction for claims.	Combo Box	N/A	0
Age in Days	Age in Days requirement for claims.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Age in Years	Age in Years requirement for claims.	Field	Character	50
Benefit Role Editing	Any Benefit Role restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-Primary Editing	Any bill provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Cancer Registry	Cancer Registry restriction for claims.	Combo Box	N/A	0
Claim Type Editing	Any Claim Type restriction for claims.	Combo Box	N/A	0
Condition Editing	Any condition restriction for claims.	Combo Box	N/A	0
Created By	Clerk Id	Field	Character	32
Detail Any Diagnosis Group Editing	Any Detail Any Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Group Editing	Any Detail Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Primary Diagnosis Group Editing	Any Detail Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Group Editing	Any Detail Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Diagnosis	Folder containing any diagnosis restriction for claims.	Label	N/A	0
Eff/End Dates	Effective and End Dates required for claims. The date format is MM/DD/CCYY.	Field	Character	50
Emergency Diagnosis Editing	Any Emergency Diagnosis restriction for claims.	Combo Box	N/A	0
Emergency Diagnosis Group Editing	Any Emergency Diagnosis Group restriction for claims.	Combo Box	N/A	0
Gender	Gender required for claims.	Combo Box	N/A	0
Header Any Diagnosis Group Editing	Group containing any header diagnosis restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Header Other Diagnosis Group Editing	Any Header Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Editing	Any primary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Group Editing	Any Header Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Editing	Any secondary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Group Editing	Any Header Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Medical Review	Medical Review requirement for claims.	Combo Box	N/A	0
Modifier Editing	Any modifier restriction for claims.	Combo Box	N/A	0
OI Action	OI Action restriction for claims.	Combo Box	N/A	0
Occurrence Editing	Any occurrence restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-Primary Editing	Any pref provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Place of Service Editing	Any Place of Service restriction for claims.	Combo Box	N/A	0
Quantity	Quantity requirement for claims.	Field	N/A	0
Provider Type/Specialty	Folder containing any provider type/specialty restriction for claims.	Label	N/A	0
Recipient Assignment Plans Editing	Any Recipient Assignment Plans restriction for claims.	Combo Box	N/A	0
Recipient Benefit Plans Editing	Any Recipient Benefit Plans restriction for claims.	Combo Box	N/A	0
Referring Prov Type/Specialty Editing	Any referring provider type/specialty restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Specific Therapeutic Class Editing	Any specific therapeutic class restriction for claims.	Combo Box	N/A	0
View History	Used to view the history of an existing rule.	Button	N/A	0

6.275.4 Other Insurance Coverage Edit Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admitting Diagnosis Group Editing	Combo Box	1	Admitting Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Admitting Diagnosis Group" list box. If no value needs to be added to "Admitting Diagnosis Group" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-Primary Editing	Combo Box	2	Bill Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Claim Type Editing	Combo Box	3	Claim Type must cover at least one value for this rule to apply.	If the value of drop down is "Include" then there must be some value in "Claim Types Assigned" list box. If no value needs to be added to "Claim Types Assigned" list box than set the value to "No" for the drop down.
Condition Editing	Combo Box	4	Condition must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Detail Any Diagnosis Group Editing	Combo Box	5	Detail Any Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Any Diagnosis Group" list box. If no value need to be added to "Detail Any Diagnosis Group" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Detail Other Diagnosis Group Editing	Combo Box	6	Detail Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Other Diagnosis Group" list box. If no value needs to be added to "Detail Other Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Primary Diagnosis Group Editing	Combo Box	7	Detail Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Primary Diagnosis Group" list box. If no value needs to be added to "Detail Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Secondary Diagnosis Group Editing	Combo Box	8	Detail Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Secondary Diagnosis Group" list box. If no value needs to be added to "Detail Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Emergency Diagnosis Group Editing	Combo Box	9	Emergency Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Emergency Diagnosis Group" list box. If no value needs to be added to "Emergency Diagnosis Group" list box than set the value to "No" for the drop down.
Header Other Diagnosis Group Editing	Combo Box	10	Header Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Other Diagnosis Group" list box. If no value needs to be added to "Header Other Diagnosis Group" list box than set the value to "No" for the drop down.
Header Primary Diagnosis Group Editing	Combo Box	11	Header Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Primary Diagnosis Group" list box. If no value needs to be added to "Header Primary Diagnosis Group" list box than set

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Field	Field Type	Error Code	Error Message	To Correct
				the value to "No" for the drop down.
Header Secondary Diagnosis Group Editing	Combo Box	12	Header Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Secondary Diagnosis Group" list box. If no value needs to be added to "Header Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Modifier Editing	Combo Box	13	Modifier must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Occurrence Editing	Combo Box	14	Occurrence must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Perf Prov Type/Spec-Primary Editing	Combo Box	15	Perf Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Place of Service Editing	Combo Box	16	Place of Service must cover at least one value for this rule to apply	If the value of drop down is "Include" or "Exclude" then there must be some value in "Places Of Service Assigned" list box. If no value needs to be added to "Places Of Service Assigned" list box than set the value to "No" for the drop down.
Recipient Assignment Plans Editing	Combo Box	17	Recipient Assignment Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Assignment Plans Assigned" list box. If no value needs to be added to "Recipient Assignment Plans Assigned" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Recipient Benefit Plans Editing	Combo Box	18	Recipient Benefit Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Benefit Plans Assigned" list box. If no value needs to be added to "Recipient Benefit Plans Assigned" list box than set the value to "No" for the drop down.

6.275.5 Other Insurance Coverage Edit Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.275.6 Other Insurance Coverage Edit Panel Accessibility

6.275.6.1 To Access the Other Insurance Coverage Edit Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to Reference and click Benefit Administration.	Benefit Administration panel displays.
3	Select Other Insurance.	Other Insurance Coverage Edit Plan panel displays.

6.275.6.2 To Add on the Other Insurance Coverage Edit Panel

Step	Action	Response
1	Select a plan and expand Benefit Coverage tree and select a Rule.	Other Insurance Coverage Edit Plan panel displays.
2	To create a new rule right click and select “Add Rule” from the menu.	
3	Click Save.	Other Insurance Coverage Edit Plan panel is saved.

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6.276 OTHER INSURANCE PLAN - BENEFIT COVERAGE PANEL

6.276.1 Other Insurance Plan - Benefit Coverage Panel Narrative

This panel is used to maintain benefit coverage by Other Insurance Plan.

Navigation Path: [Reference] - [Benefit Administration] – [Other Insurance] - (Select a Other Insurance Plan – Benefit Coverage) - (Expand the plan by clicking on the "+")

6.276.2 Other Insurance Plan - Benefit Coverage Panel Layout

6.276.3 Other Insurance Plan - Benefit Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Classification	Hierarchy of groupings.	Combo Box	Drop Down List Box	0
Code	Allows search for a benefit code.	Field	Character	0
Description	Allows search by description.	Field	Character	0
Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0
Version	List of ICD versions. This drop down is visible only if benefit type is selected as "Diagnosis".	Combo Box	Drop Down List Box	0

6.276.4 Other Insurance Plan - Benefit Coverage Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Either the code or partial description of a benefit must be specified to find it.	Enter code of a benefit and then click Find Button.

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Field	Field Type	Error Code	Error Message	To Correct
Description	Field	2	Either the code or partial description of a benefit must be specified to find it.	Enter partial description of benefit and then click Find button.

6.276.5 Other Insurance Plan - Benefit Coverage Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.276.6 Other Insurance Plan - Benefit Coverage Panel Accessibility

6.276.6.1 To Access the Other Insurance Plan - Benefit Coverage Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select Other Insurance.	Other Insurance Plan panel displays.

6.276.6.2 To Navigate on the Other Insurance Plan - Benefit Coverage Panel

Step	Action	Response
1	Select **Classification** from drop down list box.	
2	Select **Type** from drop down list box.	
3	Select **Version** from drop down list box.	
4	Enter Code / Description or both in the text box.	
5	Click **Find**.	Other Insurance Plan- Benefit Coverage information is displayed.

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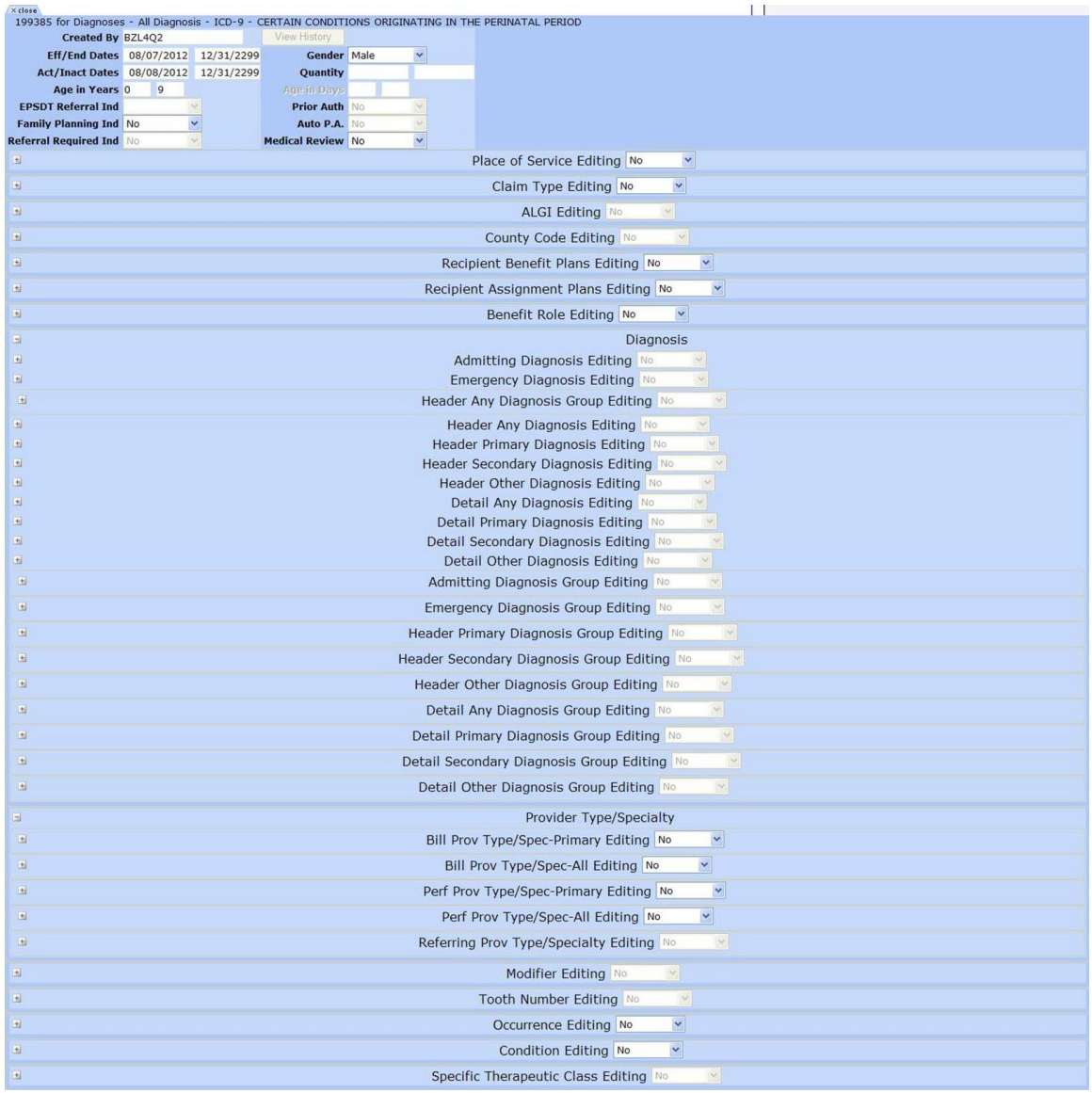
6.277 BENEFIT COVERAGE EDIT PANEL

6.277.1 Benefit Coverage Edit Panel Narrative

Benefit Coverage Edit Panel is used to create new and modify existing rule.

Navigation Path: [Reference] - [Benefit Administration] - [Recipient Plan]

6.277.2 Benefit Coverage Edit Panel Layout



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6.277.3 Benefit Coverage Edit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Act/Inact Dates	Active and Inactive Dates requirement for claims. The date format is MM/DD/CCYY.	Field	Character	50
Age in Days	Age in Days requirement for claims.	Field	Character	50
Age in Years	Age in Years requirement for claims.	Field	Character	50
ALGI Editing	Any ALGI restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Editing	Any Admitting Diagnosis restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Group Editing	Any Admitting Diagnosis Group restriction for claims.	Combo Box	N/A	0
Auto P.A.	Auto Prior Authorization requirement for claims.	Combo Box	N/A	0
Benefit Role Editing	Any Benefit Role restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-All Editing	Any bill provider all type/specialty restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-Primary Editing	Any bill provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Claim Type Editing	Any Claim Type restriction for claims.	Combo Box	N/A	0
Condition Editing	Any condition restriction for claims.	Combo Box	N/A	0
County Code Editing	Any County Code restriction for claims.	Combo Box	N/A	0
Created By	Clerk Id	Field	Character	32
Detail Any Diagnosis Editing	Any detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Any Diagnosis Group Editing	Any Detail Any Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Editing	Any other detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Group Editing	Any Detail Other Diagnosis Group restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Detail Primary Diagnosis Editing	Any primary detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Primary Diagnosis Group Editing	Any Detail Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Editing	Any secondary detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Group Editing	Any Detail Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Diagnosis	Folder containing any diagnosis restriction for claims.	Label	N/A	0
Eff/End Dates	Effective and End Dates required for claims. The date format is MM/DD/CCYY.	Field	Character	50
EPSDT Referral Ind	EPSDT Referral requirement for claims.	Combo Box	N/A	0
Emergency Diagnosis Editing	Any Emergency Diagnosis restriction for claims.	Combo Box	N/A	0
Emergency Diagnosis Group Editing	Any Emergency Diagnosis Group restriction for claims.	Combo Box	N/A	0
Family Planning Ind	Family Planning requirement for claims.	Combo Box	N/A	0
Gender	Gender required for claims.	Combo Box	N/A	0
Header Any Diagnosis Editing	Any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Any Diagnosis Group Editing	Group containing any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Editing	Any other header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Group Editing	Any Header Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Editing	Any primary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Group Editing	Any Header Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Editing	Any secondary header diagnosis restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Header Secondary Diagnosis Group Editing	Any Header Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Medical Review	Medical Review requirement for claims.	Combo Box	N/A	0
Modifier Editing	Any modifier restriction for claims.	Combo Box	N/A	0
Occurrence Editing	Any occurrence restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-All Editing	Any pref provider all type/specialty restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-Primary Editing	Any pref provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Place of Service Editing	Any Place of Service restriction for claims.	Combo Box	N/A	0
Prior Auth	Prior Authorization requirement for claims.	Combo Box	N/A	0
Provider Type/Specialty	Folder containing any provider type/specialty restriction for claims.	Label	N/A	0
Quantity	Quantity requirement for claims.	Field	Character	50
Recipient Assignment Plans Editing	Any Recipient Assignment Plans restriction for claims.	Combo Box	N/A	0
Recipient Benefit Plans Editing	Any Recipient Benefit Plans restriction for claims.	Combo Box	N/A	0
Referral Required Ind	Referral Required requirement for claims.	Combo Box	N/A	0
Referring Prov Type/Specialty Editing	Any referring provider type/specialty restriction for claims.	Combo Box	N/A	0
Specific Therapeutic Class Editing	Any specific therapeutic class restriction for claims.	Combo Box	N/A	0
Tooth Number Editing	Any tooth number restriction for claims.	Combo Box	N/A	0
View History	Used to view the history of an existing rule.	Button	N/A	0

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6.277.4 Benefit Coverage Edit Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admitting Diagnosis Group Editing	Combo Box	14	Admitting Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Admitting Diagnosis Group" list box. If no value needs to be added to "Admitting Diagnosis Group" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-All Editing	Combo Box	7	Bill Prov Type/Spec-All must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-Primary Editing	Combo Box	6	Bill Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Claim Type Editing	Combo Box	2	Claim Type must cover at least one value for this rule to apply.	If the value of drop down is "Include" then there must be some value in "Claim Types Assigned" list box. If no value needs to be added to "Claim Types Assigned" list box than set the value to "No" for the drop down.
Condition Editing	Combo Box	13	Condition must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
County Code Editing	Combo Box	3	County Code must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "County Codes Assigned" list box. If no value needs to be added to "County Codes Assigned" list box than set the

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Field	Field Type	Error Code	Error Message	To Correct
				value to "No" for the drop down.
Detail Any Diagnosis Group Editing	Combo Box	15	Detail Any Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Any Diagnosis Group" list box. If no value needs to be added to "Detail Any Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Other Diagnosis Group Editing	Combo Box	16	Detail Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Other Diagnosis Group" list box. If no value needs to be added to "Detail Other Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Primary Diagnosis Group Editing	Combo Box	17	Detail Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Primary Diagnosis Group" list box. If no value needs to be added to "Detail Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Secondary Diagnosis Group Editing	Combo Box	18	Detail Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Secondary Diagnosis Group" list box. If no value needs to be added to "Detail Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Emergency Diagnosis Group Editing	Combo Box	20	Emergency Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Emergency Diagnosis Group" list box. If no value needs to be added to "Emergency Diagnosis Group" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Header Other Diagnosis Group Editing	Combo Box	19	Header Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Other Diagnosis Group" list box. If no value needs to be added to "Header Other Diagnosis Group" list box than set the value to "No" for the drop down.
Header Primary Diagnosis Group Editing	Combo Box	21	Header Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Primary Diagnosis Group" list box. If no value needs to be added to "Header Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Header Secondary Diagnosis Group Editing	Combo Box	22	Header Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Secondary Diagnosis Group" list box. If no value needs to be added to "Header Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Modifier Editing	Combo Box	10	Modifier must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Occurrence Editing	Combo Box	12	Occurrence must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Perf Prov Type/Spec-All Editing	Combo Box	9	Perf Prov Type/Spec-All must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Perf Prov Type/Spec-Primary Editing	Combo Box	8	Perf Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Place of Service Editing	Combo Box	1	Place of Service must cover at least one value for this rule to apply	If the value of drop down is "Include" or "Exclude" then there must be some value in "Places Of Service Assigned" list box. If no value needs to be added to "Places Of Service Assigned" list box than set the value to "No" for the drop down.
Recipient Assignment Plans Editing	Combo Box	5	Recipient Assignment Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Assignment Plans Assigned" list box. If no value needs to be added to "Recipient Assignment Plans Assigned" list box than set the value to "No" for the drop down.
Recipient Benefit Plans Editing	Combo Box	4	Recipient Benefit Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Benefit Plans Assigned" list box. If no value needs to be added to "Recipient Benefit Plans Assigned" list box than set the value to "No" for the drop down.
Tooth Number Editing	Combo Box	11	Tooth Number must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Tooth Number Assigned" list box. If no value needs to be added to "Tooth Number Assigned" list box than set the value to "No" for the drop down.

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6.277.5 Benefit Coverage Edit Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.277.6 Benefit Coverage Edit Panel Accessibility

6.277.6.1 To Access the Benefit Coverage Edit Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **Benefit Administration**.	Benefit Administration panel displays.
3	Select **Recipient Plan**.	Recipient Plan panel displays with Benefit Coverage displayed at bottom.

6.277.6.2 To Add on the the Benefit Coverage Edit Panel

Step	Action	Response
1	Select a plan and expand Benefit Coverage tree and select a Rule.	Benefit Coverage Edit panel will be displayed.
2	To create a new rule right click and select “Add Rule” from the menu.	
3	Click **Save**.	Benefit Coverage Edit panel is saved.

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6.278 REIMBURSEMENT AGREEMENT PANEL

6.278.1 Reimbursement Agreement Panel Narrative

The Reimbursement Agreement panel is used to maintain the rules for which a Provider can be reimbursed for a service.

This panel is inquiry only.

Navigation Path: [Reference] - [Benefit Administration] - [Reimbursement Agreement]

6.278.2 Reimbursement Agreement Panel Layout

6.278.3 Reimbursement Agreement Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Code	Allows search for a benefit code.	Field	Alphanumeric	0
Description	Allows search by description.	Field	Alphanumeric	0
Find	Initiates search on the database table for rows matching the criteria entered.	Button	N/A	0
Type	Allows search for benefit type.	Combo Box	Drop Down List Box	0
Version	List of ICD versions. This drop down is visible only if benefit type is selected as "Diagnosis".	Combo Box	Drop Down List Box	0

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6.278.4 Reimbursement Agreement Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Either the code or partial description of a benefit must be specified to find it.	Enter code of a benefit and then click Find Button.
Description	Field	2	Either the code or partial description of a benefit must be specified to find it.	Enter partial description of benefit and then click Find button.

6.278.5 Reimbursement Agreement Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.278.6 Reimbursement Agreement Panel Accessibility

6.278.6.1 To Access the Reimbursement Agreement Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Reimbursement Agreement** hyperlink.	Reimbursement Agreement panel displays.
4	Select **Type** from drop down list box.	
5	Select **Version** from drop down list box.	
6	Enter Code / Description or both in the text box.	
7	Click **Find**.	Reimbursement Agreement - Benefit Coverage information is displayed.

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6.276 REIMBURSEMENT AGREEMENT EDIT PANEL

6.276.1 Reimbursement Agreement Edit Panel Narrative

Reimbursement Agreement Edit Panel is used to create a new or modify an existing rule for which a Provider can be reimbursed for services.

Navigation Path: [Reference] - [Benefit Administration] - [Reimbursement Agreement] – [Select a rule from any Benefit Type]

6.276.2 Reimbursement Agreement Edit Panel Layout

6.278.7 Reimbursement Agreement Edit Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Act/Inact Dates	Active and Inactive Dates requirement for claims.	Field	Date (MM/DD/CCYY)	0
AdjustmentFactor Sequence	Any adjustmentfactory sequence restriction for claims.	Listview	Character	0
Age in Days	Age in Days requirement for claims.	Field	Number (Integer)	0
Age in Years	Age in Years requirement for claims.	Field	Number (Integer)	0

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Field	Description	Field Type	Data Type	Length
ALGI Editing	Any ALGI restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Editing	Any Admitting Diagnosis restriction for claims.	Combo Box	N/A	0
Admitting Diagnosis Group Editing	Any Admitting Diagnosis Group restriction for claims.	Combo Box	N/A	0
Auto P.A.	Auto Prior Authorization requirement for claims.	Combo Box	N/A	0
Benefit Role Editing	Any Benefit Role restriction for claims.	Combo Box	N/A	0
Bill Prov Type/Spec-Primary Editing	Any bill provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Claim Type Editing	Any Claim Type restriction for claims.	Combo Box	N/A	0
Condition Editing	Any condition restriction for claims.	Combo Box	N/A	0
Created By	Clerk identification number.	Field	Character	0
Current Benefit Plan Editing	Any current benefit plan restriction for claims.	Combo Box	N/A	0
Current Billing Provider Contract Editing	Any current billing provider contract restriction for claims.	Combo Box	N/A	0
Current Perform Provider Contract Editing	Any current perform provider contract restriction for claims.	Combo Box	N/A	0
Detail Any Diagnosis Editing	Any detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Any Diagnosis Group Editing	Any Detail Any Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Editing	Any other detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Other Diagnosis Group Editing	Any Detail Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Primary Diagnosis Editing	Any primary detail diagnosis restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Detail Primary Diagnosis Group Editing	Any Detail Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Editing	Any secondary detail diagnosis restriction for claims.	Combo Box	N/A	0
Detail Secondary Diagnosis Group Editing	Any Detail Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Diagnosis	Folder containing any diagnosis restriction for claims.	Label	N/A	0
Dispensed As Written Editing	Any dispensed as written restriction for claims.	Combo Box	N/A	0
Eff/End Dates	Effective and End Dates required for claims.	Field	Date (MM/DD/CCYY)	0
Emergency Diagnosis Editing	Any Emergency Diagnosis restriction for claims.	Combo Box	N/A	0
Emergency Diagnosis Group Editing	Any Emergency Diagnosis Group restriction for claims.	Combo Box	N/A	0
Gender	Gender required for claims.	Combo Box	N/A	0
Header Any Diagnosis Editing	Any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Any Diagnosis Group Editing	Group containing any header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Editing	Any other header diagnosis restriction for claims.	Combo Box	N/A	0
Header Other Diagnosis Group Editing	Any Header Other Diagnosis Group restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Editing	Any primary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Primary Diagnosis Group Editing	Any Header Primary Diagnosis Group restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Header Secondary Diagnosis Editing	Any secondary header diagnosis restriction for claims.	Combo Box	N/A	0
Header Secondary Diagnosis Group Editing	Any Header Secondary Diagnosis Group restriction for claims.	Combo Box	N/A	0
Medical Review	Medical Review requirement for claims.	Combo Box	N/A	0
Modifier Editing	Any modifier restriction for claims.	Combo Box	N/A	0
Perf Prov Type/Spec-Primary Editing	Any pref provider primary type/specialty restriction for claims.	Combo Box	N/A	0
Place of Service Editing	Any Place of Service restriction for claims.	Combo Box	N/A	0
Pricing Modifier	Pricing Modifier requirement for claims. Possible values are N - Pay Billed Amount,Y - Pay greater than Billed Amount & Z - Zero Pay Billed Amount.	Combo Box	N/A	0
Pricing Indicator	Pricing Indicator requirement for claims.	Combo Box	N/A	0
Prior Auth	Prior Authorization requirement for claims.	Combo Box	N/A	0
Provider Type/Specialty	Folder containing any provider type/specialty restriction for claims.	Label	N/A	0
Quantity	Quantity requirement for claims.	Field	Number (Integer)	0
Rate Type	Rate Type requirement for claims.	Combo Box	N/A	0
Recipient Assignment Plans Editing	Any Recipient Assignment Plans restriction for claims.	Combo Box	N/A	0
Referring Prov Type/Specialty Editing	Any referring provider type/specialty restriction for claims.	Combo Box	N/A	0
Tooth Number Editing	Any tooth number restriction for claims.	Combo Box	N/A	0
Type of Bill Editing	Any type of bill restriction for claims.	Combo Box	N/A	0

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Field	Description	Field Type	Data Type	Length
Urban Rural Indicator Editing	Any urban rural indicator restriction for claims.	Combo Box	N/A	0
View History	Used to view the history of an existing rule.	Button	N/A	0

6.276.3 Reimbursement Agreement Edit Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Admitting Diagnosis Group Editing	Combo Box	15	Admitting Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Admitting Diagnosis Group" list box. If no value needs to be added to "Admitting Diagnosis Group" list box than set the value to "No" for the drop down.
Bill Prov Type/Spec-Primary Editing	Combo Box	10	Bill Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Claim Type Editing	Combo Box	4	Claim Type must cover at least one value for this rule to apply.	If the value of drop down is "Include" then there must be some value in "Claim Types Assigned" list box. If no value needs to be added to "Claim Types Assigned" list box than set the value to "No" for the drop down.
Condition Editing	Combo Box	14	Condition must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under Options than set the value to "No" for the drop down.
Current Benefit Plan Editing	Combo Box	6	Current Benefit Plan must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Benefit Plans Assigned" list box. If no value needs to be added to "Recipient Benefit Plans

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Field	Field Type	Error Code	Error Message	To Correct
				Assigned" list box than set the value to "No" for the drop down.
Current Billing Provider Contract Editing	Combo Box	8	Current Billing Provider Contract must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Provider Contracts Assigned" list box. If no value needs to be added to "Provider Contracts Assigned" list box than set the value to "No" for the drop down.
Current Perform Provider Contract Editing	Combo Box	9	Current Perform Provider Contract must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Provider Contracts Assigned" list box. If no value needs to be added to "Provider Contracts Assigned" list box than set the value to "No" for the drop down.
Detail Any Diagnosis Group Editing	Combo Box	16	Detail Any Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Any Diagnosis Group" list box. If no value needs to be added to "Detail Any Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Other Diagnosis Group Editing	Combo Box	17	Detail Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Other Diagnosis Group" list box. If no value needs to be added to "Detail Other Diagnosis Group" list box than set the value to "No" for the drop down.
Detail Primary Diagnosis Group Editing	Combo Box	18	Detail Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Primary Diagnosis Group" list box. If no value needs to be added to "Detail Primary Diagnosis Group" listbox than set the value to "No" for the drop down.

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Field	Field Type	Error Code	Error Message	To Correct
Detail Secondary Diagnosis Group Editing	Combo Box	19	Detail Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Detail Secondary Diagnosis Group" list box. If no value needs to be added to "Detail Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Emergency Diagnosis Group Editing	Combo Box	21	Emergency Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Emergency Diagnosis Group" list box. If no value needs to be added to "Emergency Diagnosis Group" list box than set the value to "No" for the drop down.
Header Other Diagnosis Group Editing	Combo Box	20	Header Other Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Other Diagnosis Group" list box. If no value needs to be added to "Header Other Diagnosis Group" list box than set the value to "No" for the drop down.
Header Primary Diagnosis Group Editing	Combo Box	22	Header Primary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Primary Diagnosis Group" list box. If no value needs to be added to "Header Primary Diagnosis Group" list box than set the value to "No" for the drop down.
Header Secondary Diagnosis Group Editing	Combo Box	23	Header Secondary Diagnosis Group must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Header Secondary Diagnosis Group" list box. If no value needs to be added to "Header Secondary Diagnosis Group" list box than set the value to "No" for the drop down.
Modifier Editing	Combo Box	12	Modifier must cover at least one value for this rule to apply.	If the value of drop down is "Yes" then there must be some value under Options. If no value needs to be added under

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Field	Field Type	Error Code	Error Message	To Correct
				Options than set the value to "No" for the drop down.
Perf Prov Type/Spec-Primary Editing	Combo Box	11	Perf Prov Type/Spec-Primary must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Type Specialties Assigned" list box. If no value needs to be added to "Type Specialties Assigned" list box than set the value to "No" for the drop down.
Place of Service Editing	Combo Box	3	Place of Service must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Places Of Service Assigned" list box. If no value needs to be added to "Places Of Service Assigned" list box than set the value to "No" for the drop down.
Pricing Indicator	Combo Box	1	Please choose a value for Pricing Indicator.	Select a value other than blank from for Pricing Indicator from the drop down.
Rate Type	Combo Box	2	Please choose a value for Rate Type.	Select a value other than blank from for Rate Type from the drop down.
Recipient Assignment Plans Editing	Combo Box	7	Recipient Assignment Plans must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Recipient Assignment Plans Assigned" list box. If no value needs to be added to "Recipient Assignment Plans Assigned" list box than set the value to "No" for the drop down.
Tooth Number Editing	Combo Box	13	Tooth Number must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in "Tooth Number Assigned" list box. If no values need to be added to "Tooth Number Assigned" list box than set the value to "No" for the drop down.
Urban Rural Indicator Editing	Combo Box	5	Urban rural Indicator must cover at least one value for this rule to apply.	If the value of drop down is "Include" or "Exclude" then there must be some value in

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Field	Field Type	Error Code	Error Message	To Correct
				"Urban Rural Indicators Assigned" list box. If no value needs to be added to "Urban Rural Indicators Assigned" list box than set the value to "No" for the drop down.

6.276.4 Reimbursement Agreement Edit Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.276.5 Reimbursement Agreement Edit Panel Accessibility

6.276.5.1 To Access the Reimbursement Agreement Edit Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Reimbursement Agreement** hyperlink.	Reimbursement Agreement panel displays.
4	Select a rule from any benefit type.	Reimbursement Agreement Edit Panel is displayed.

6.269.5.1 To Add on the Reimbursement Agreement Edit Panel

Step	Action	Response
1	Select a plan and expand Benefit Coverage tree and select a Rule.	Reimbursement Agreement Edit panel displays.
2	To create a new rule right click and select “Add Rule” from the menu.	
3	Click **Save**.	Reimbursement Agreement Edit Plan panel is saved.

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6.279 PLAN PDL PLAN CRITERIA PANEL

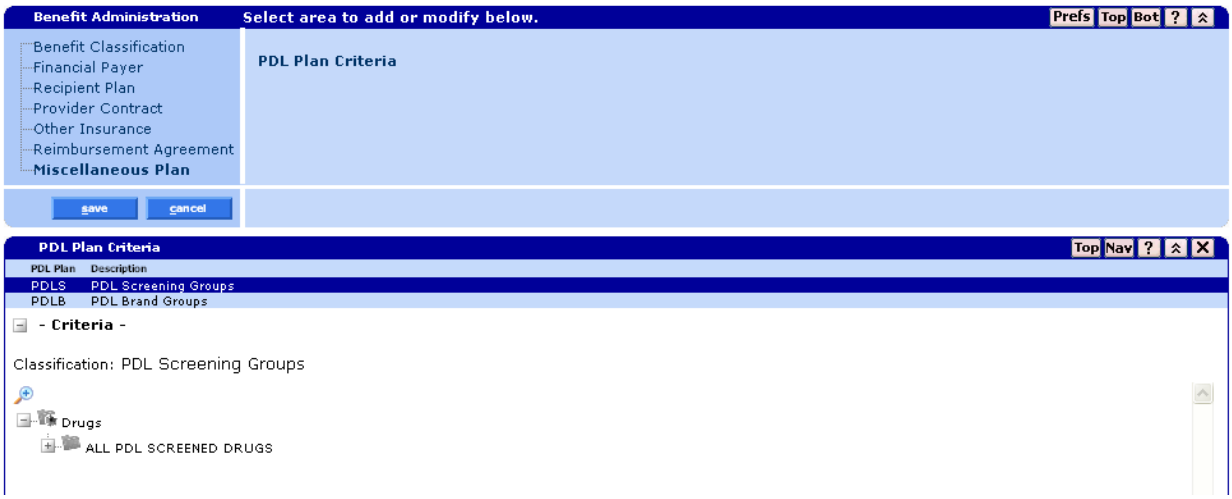
6.279.1 PDL Plan Criteria Panel Narrative

The PDL Plan Criteria panel purpose is to create the rules to be used when assigning a preferred drug status to an NDC.

This panel is display only.

Navigation Path: [Reference] - [Benefit Administration] - [Miscellaneous Plan] - [PDL Plan Criteria]

6.279.2 PDL Plan Criteria Panel Layout



6.279.3 PDL Plan Criteria Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Act/Inact Dates	The date ranges a drug can be set to active or inactive.	Field	Date (MM/DD/CCYY)	8
Brand From Date	The beginning date the brand name drug will be considered preferred.	Field	Date (MM/DD/CCYY)	8
Brand To Date	The last date the brand name drug will be considered preferred.	Field	Date (MM/DD/CCYY)	8
Cancel	Allows the user to cancel changes.	Button	N/A	0
Description	Description of the PDL Plan.	Field	Character	0
PDL Age From	The starting age range the drug will screen.	Field	Number (Integer)	3
PDL Age To	The ending age range the drug will screen.	Field	Number (Integer)	3
PDL Plan	Preferred Drug List (PDL) Plan.	Field	Character	0

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Field	Description	Field Type	Data Type	Length
PDL Plan Criteria	Link to the PDL Plan Criteria panel.	Hyperlink	N/A	0
Save	Allows the user to save changes.	Button	N/A	0
Screen To Date	The date the drug will end being screened.	Field	Date (MM/DD/CCYY)	8
Screen From Date	The date the drug will start being screened.	Listview	Date (MM/DD/CCYY)	8

6.279.4 PDL Plan Criteria Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Act/Inact Dates	Field	1	To must be greater than or equal to the From value for Act/Inact Dates.	Enter an Active date that is prior to or the same as the Inactive Date.
	Field	2	From must be less than or equal to the To value for Act/Inact Dates.	Enter an Active date that is prior to or the same as the Inactive Date.
	Field	3	Inactive Date cannot be before today.	Enter an Inactive date that is greater than today's date.
	Field	4	Invalid Date. Format is MM/DD/CCYY.	Enter date in the correct format MM/DD/CCYY.
Brand From Date	Field	1	From must be less than or equal to the To value for Brand To Date.	Enter a Brand From Date that is prior to or equal to the Brand To Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter date in the correct format MM/DD/CCYY.
Brand To Date	Field	1	To must be greater than or equal to the From value for Brand From Date.	Enter a Brand To Date that is greater or equal to the Brand From Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter date in the correct format MM/DD/CCYY.
PDL Age From	Field	1	From must be less than or equal to the To value for PDL Age To.	Enter a PDL Age From that is less than or equal to the PDL Age To.
PDL Age To	Field	1	To must be greater than or equal to the From value for PDL Age From. 5 Invalid Date. Format is MM/DD/CCYY.	Enter a PDL Age To that is greater or equal to the PDL Age From.

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Field	Field Type	Error Code	Error Message	To Correct
Screen To Date	Field	1	To must be greater than or equal to the From value for Screen From Date.	Enter a Screen Date To that is greater than or equal to the Screen From Date.
	Field	2	Invalid Date. Format is MM/DD/CCYY.	Enter date in the correct format MM/DD/CCYY.
Screen From Date	Listview	1	From must be less than or equal to the To value for Screen To Date.	Enter a Screen From Date that is prior to or equal to the Screen To Date.
	Listview	2	Invalid Date. Format is MM/DD/CCYY.	Enter date in the correct format MM/DD/CCYY.

6.279.5 PDL Plan Criteria Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.279.6 PDL Plan Criteria Panel Accessibility

6.279.6.1 To Access the PDL Plan Criteria Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Benefit Administration**.	Benefit Administration panel displays.
3	Click **Miscellaneous Plan** hyperlink.	PDL Plan Criteria panel displays.

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6.280 BENEFIT LIMIT CATEGORY PANEL.

6.280.1 Benefit Limit Category Panel Narrative

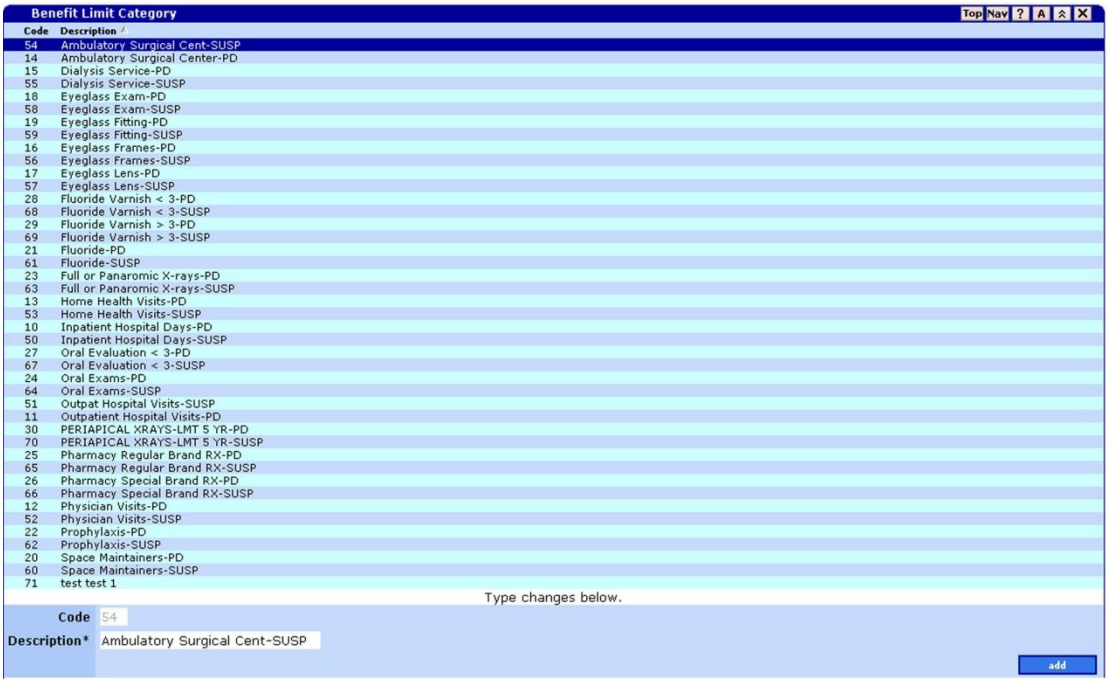
The Benefit Limit Category panel displays the list of all benefit limit categories in the system.

This panel allows adding new categories and updating the existing categories.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [Reference] - [Related Data] - [Other] - [Benefit Limit Category]

6.280.2 Benefit Limit Category Panel Layout



6.280.3 Benefit Limit Category Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Button to add new Benefit Limit Category.	Button	N/A	N/A
Code	Field for Benefit Limit Category code.	Field	Character	2
Description	Field for Benefit Limit category description.	Field	Character	30

6.280.4 Benefit Limit Category Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Code	Field	1	Code is required.	Enter a valid code.

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Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a valid Description..

6.280.5 Benefit Limit Category Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.280.6 Benefit Limit Category Panel Accessibility

6.280.6.1 To Access the Benefit Limit Category Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Related Data.**	Related data panel displays.
3	Click **Other** hyperlink.	Links under Other section displays.
4	Click **Benefit Limit Category** hyperlink.	Benefit Limit Category Panel displays.

6.280.6.2 To Add on the Benefit Limit Category Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Code**.	
3	Enter **Description**.	
4	Click **Save**.	Benefit Limit Category –Save was Successful.

6.280.6.3 To Update on the Price Update Indicators Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Benefit Limit Category –Save was Successful.

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6.281 ASSOCIATED ESC PANEL

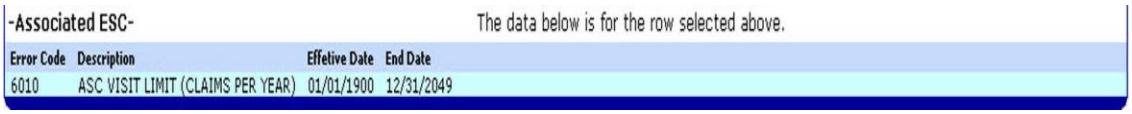
6.281.1 Associated ESC Panel Narrative

This panel lists all the associated ESCs for selected benefit limit category.

This is a view only panel.

Navigation Path: [Reference] - [Related Data] - [Other] - [Benefit Limit Category] – [Select a Benefit limit category]

6.281.2 Associated ESC Panel Layout



6.281.3 Associated ESC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	Displays the error code description for the error codes associated with the selected Benefit limit category.	Field	Character	50
Effective Date	Displays the effective date for the error codes associated with the selected Benefit limit category.	Field	Date (MM/DD/CCYY)	8
End Date	Displays the end date for the error codes associated with the selected Benefit limit category.	Field	Date (MM/DD/CCYY)	8
Error Code	Displays the error code for the error codes associated with the selected Benefit limit category.	Field	Number (Integer)	4

6.281.4 Associated ESC Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel				

6.281.5 Associated ESC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.281.6 Associated ESC Panel Accessibility

6.281.6.1 To Access the Associated ESC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference and** click **Related Data.**	Related data panel displays.
3	Click **Other** hyperlink.	Links under Other section displays.
4	Click **Benefit Limit Category** hyperlink.	Benefit Limit Category Panel displays.
5	Select a record from benefit limit category list	Associated ESC panel displays.

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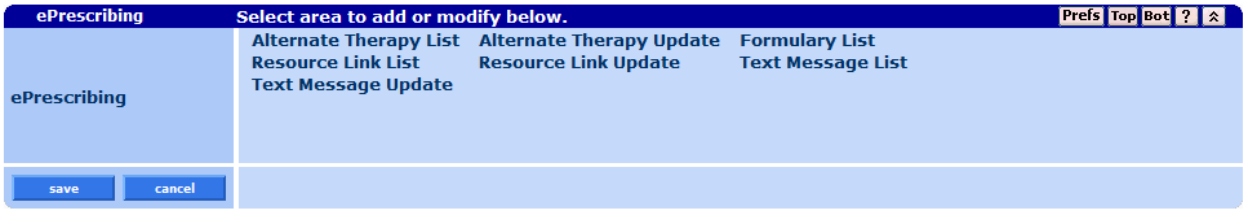
6.282 EPRESCRIBING

6.282.1 ePrescribing Panel Narrative

The ePrescribing panel provides links to other panels for maintaining tables used by the ePrescribing subsystem.

Navigation Path: [Reference] - [ePrescribing]

6.282.2 ePrescribing Panel Layout



6.282.3 ePrescribing Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alternate Therapy List	Link to the "Alternate Therapy List" panel.	Hyperlink	N/A	0
Alternate Therapy Update	Link to the "Alternate Therapy Update" panel.	Hyperlink	N/A	0
Cancel	Cancels all changes applied to all panels on the page.	Button	N/A	0
Formulary List	Link to the "Formulary List" panel.	Hyperlink	N/A	0
Resource Link List	Link to the "Resource Link List" panel.	Hyperlink	N/A	0
Resource Link Update	Link to the "Resource Link Update" panel	Hyperlink	N/A	0
Save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel.	Button	N/A	0
Text Message List	Link to the "Text Message List" panel.	Hyperlink	N/A	0
Text Message Update	Link to the "Text Message Update" panel.	Hyperlink	N/A	0

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6.282.4 ePrescribing Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.282.5 ePrescribing Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.282.6 ePrescribing Panel Accessibility

6.282.6.1 To Access the ePrescribing Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**.	Reference ePrescribing panel displays.

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6.283 ALTERNATE THERAPY LIST PANEL

6.283.1 Alternate Therapy List Panel Narrative

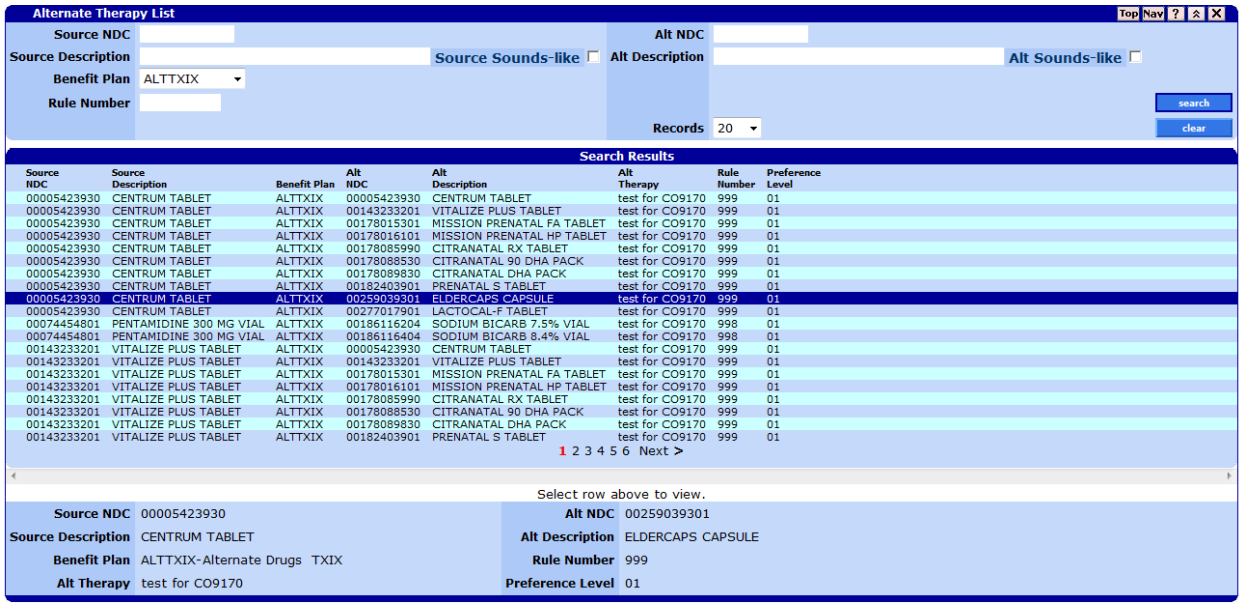
This is the ePrescribing Alternate Therapy List panel. This panel is set up to view the tables created using the Alternate Therapy Update panel.

The Benefit Plan drop down will have the following choices, Blank (for all) Medicaid, Planfirst, TXIX, and it will always default to TXIX.

This panel is inquiry only.

Navigation Path: [Reference] - [ePrescribing] - [Alternate Therapy List]

6.283.2 Alternate Therapy List Panel Layout



5.139.7 Alternate Therapy List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Alt Sounds-like	Select this checkbox to perform a SOUNDEX based phonetic search on the Alt Description.	Check Box	Check Box	1
Source Sounds-like	Select this checkbox to perform a SOUNDEX based phonetic search on the Source Description.	Check Box	Check Box	1
Alt Description	The description of the alternate NDC--Drug name and strength.	Field	Character	40

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Field	Description	Field Type	Data Type	Length
Alt NDC	Enter the National Drug Code (NDC) to search for all records for the Alternate NDC. These are NDCs that have a Y on the PDL master file.	Field	Number (Integer)	11
Alt Therapy	This field contains the Description of the Alternate Therapy Rule number from the Alternate Therapy Update panel.	Field	Character	35
Benefit Plan	The Benefit Plan.	Field	Character	50
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Preference Level	The level of preference for the alternate NDC. Right now this value is always 01 for primary preference.	Field	Number (Integer)	2
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Rule Number	This field contains the Alternate Therapy Rule number from the Alternate Therapy Update panel.	Field	Number (Integer)	9
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0
Source Description	The description of the source NDC--Drug name and strength.	Field	Character	40
Source NDC	Enter the National Drug Code (NDC) to search for all records for the Source NDC. These are NDCs that have an N on the PDL master file.	Field	Number (Integer)	11

6.283.3 Alternate Therapy List Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Alt Description	Field	1	Please enter at least one search field.	Please enter at least one search field.
Alt NDC	Field	1	Please enter at least one search field.	Please enter at least one search field.

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Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan	Field	1	Please enter at least one search field.	Please enter at least one search field.
Source Description	Field	1	Please enter at least one search field.	Please enter at least one search field.
Source NDC	Field	1	Please enter at least one search field.	Please enter at least one search field.

6.283.4 Alternate Therapy List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.283.5 Alternate Therapy List Panel Accessibility

6.283.5.1 To Access the Alternate Therapy List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing** and then click **Alternate Therapy List**.	Reference Alternate Therapy List panel displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Alternate Therapy List details gets displayed.

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6.284 ALTERNATE THERAPY UPDATEPANEL

6.284.1 Alternate Therapy Update Panel Narrative

The ePrescribing Alternate Therapy Update Panel supports the ability to maintain preferred alternatives to specific drugs. This capability allows the Agency the option to explicitly state Alabama specific drug alternatives for non – preferred NDC's.

The Alabama specified alternatives from this panel will be communicated to Surescripts in Alternative Lists. This alternatives list will be placed in a batch file that will be sent to Surescripts weekly. The processing rules to capture the data from this panel and create the batch alternatives list file can be found in PDL Alternate Therapy Batch transaction. Point of Care vendors maintain regularly scheduled processes to download this information from Surescripts so that the information can be made available to the physicians. Depending on the schedule the Point of Care vendor has to download this information, there may be a delay with the information the physician has and the information that Surescripts has in their system.

It is important to realize that this information is a guideline to the physicians.

It is also important to note that Point of Care vendors, provide their own list of alternatives to the physicians based on therapeutic equivalents within their drug file. These vendors' specified alternatives will always display below any Alabama specific alternatives when the information is being presented to the physician.

Navigation Path: [Reference] - [ePrescribing] - [Alternate Therapy Update]

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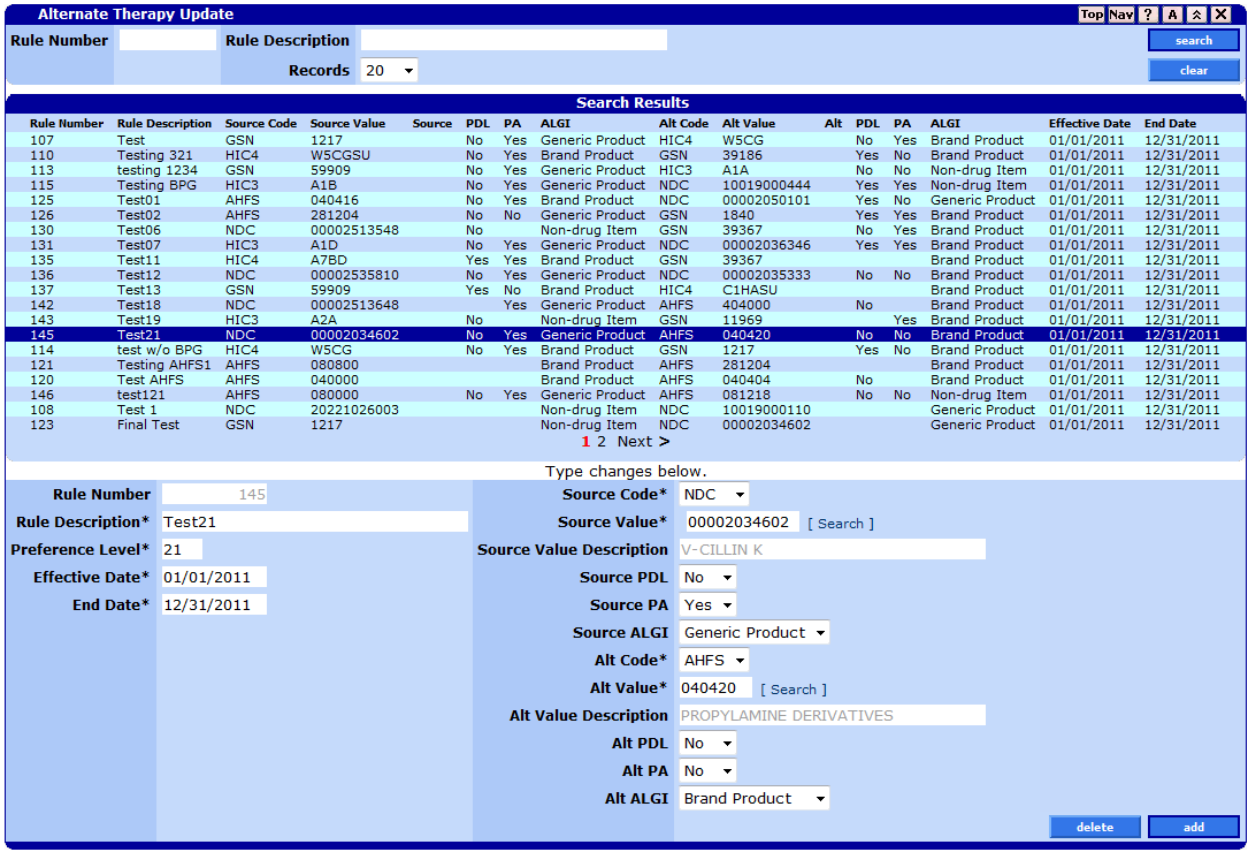
6.284.2 Alternate Therapy Update Panel Layout



6.284.3 Alternate Therapy Update Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add a new Alternate Therapy record.	Button	N/A	0
Alt ALGI	Indicates whether the alternate drug is generic according to Agency defined criteria.	Field	Drop Down List Box	1
Alt Code	The Alternate Therapy Code. Valid values are AHFS, HIC3, GSN, HIC4 or NDC.	Field	Drop Down List Box	3
Alt PA	Indicates whether the alternate requires prior authorization.	Field	Drop Down List Box	3
Alt PA	Indicates whether the alternate is in the PDL.	Field	Drop Down List Box	3
Alt Value Description	This is the label name for the currently selected Alt Value. This field is display only.	Field	Character	35
Alt Value	This is the value associated with the Alternate Therapy Code	Field	Number (Integer)	11

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Field	Description	Field Type	Data Type	Length
	selected. For example, if the Alt Code selected is HIC, then the Alt Value is the actual HIC number.			
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Delete	Allows user to delete an existing Alternate Therapy record.	Button	N/A	0
Effective Date	First day the Alternate Therapy rule is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last day the Alternate Therapy rule is effective.	Field	Date (MM/DD/CCYY)	8
Preference Level	This field is available to allow a preference level to be assigned, if needed. If there are multiple alternatives for a particular NDC and one NDC has a higher preference than another drug, this is the field to indicate the order of the preference. A higher number equals a greater preference. The preference field defaults to 01.	Field	Character	2
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Rule Description	Description of the Alternate Therapy Rule.	Field	Character	35
Rule Number	System assigned key for an Alternate Therapy rule.	Field	Number (Integer)	10
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0
Source Code	The Alternate Therapy Source Code. Valid values are AHFS, HIC3, GSN, HIC4 or NDC.	Field	Drop Down List Box	3
Source ALGI	Indicates whether the source drug is generic according to Agency defined criteria.	Field	Drop Down List Box	1
Source PA	Indicates whether the source requires prior authorization.	Field	Drop Down List Box	3
Source PDL	Indicates whether the source is in the PDL.	Field	Drop Down List Box	3

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Field	Description	Field Type	Data Type	Length
Source Value Description	This is the label name for the currently selected Source Value. This field is display only.	Field	Character	35
Source Value	This is the value associated with the Source code. For example if the Source Code selected is HIC, then the Source Value is the actual HIC number.	Field	Number (Integer)	11

6.284.4 Alternate Therapy Update Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Alt Code	Field	1	Alt Code is required.	Please select and Alt Code from the drop down list.
Alt Value	Field	1	Alt Value is required.	Please enter an Alt Value.
	Field	2	Effective Date must be less than or equal to End Date.	Please correct either the Effective Date or the End Date.
	Field	3	Effective Date is required.	Please enter an Effective Date.
End Date	Field	1	Invalid date. Format is mm/dd/ccyy.	Please enter a valid date.
	Field	2	End Date is required.	Please enter an End Date.
Preference Level	Field	1	Preference Level is required.	Please enter a preference level 01-99.
	Field	2	Required input must be 2 characters in length.	Please enter a 2 digit Preference Level between 01 and 99.
	Field	3	Preference Level must be 01-99	Please enter a 2 digit Preference Level between 01 and 99.
	Field	4	Invalid Characters.	Please enter a 2 digit Preference Level between 01 and 99.
Rule Description	Field	1	Rule Description is required.	Please enter a Rule Description.
Rule Number	Field	1	Enter a valid value.	Please enter a valid numeric Rule number to search.

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Field	Field Type	Error Code	Error Message	To Correct
Source Code	Field	1	Source Code is required.	Please select a Source Code from the drop down list.
Source Value	Field	1	Source Value is required.	Please enter a Source Value.

6.284.5 Alternate Therapy Update Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.284.6 Alternate Therapy Update Panel Accessibility

6.284.6.1 To Access the Alternate Therapy Update Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**. Then Click on **Alternate Therapy Update**.	Reference Alternate Therapy Update displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Alternate Therapy Update Search Results displays.
5	Select row from list of results.	Alternate Therapy Update Maintenance panel gets displayed.

6.284.6.2 To Add on the Alternate Therapy Update Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Rule Description**, **Preference Level**, **Source Value** and **Alt Value**.	
3	Select **Source Code, Source PDL, Source PA, Source ALGI, Alt Code, Alt PDL, Alt PA** and **Alt ALGI** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Alternate Therapy information is saved.

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6.284.6.3 To Update on the Alternate Therapy Update Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Alternate Therapy information is saved.

6.284.6.4 To Delete on the Alternate Therapy Update Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.285 FORMULARY LIST PANEL

6.285.1 Formulary List Panel Narrative

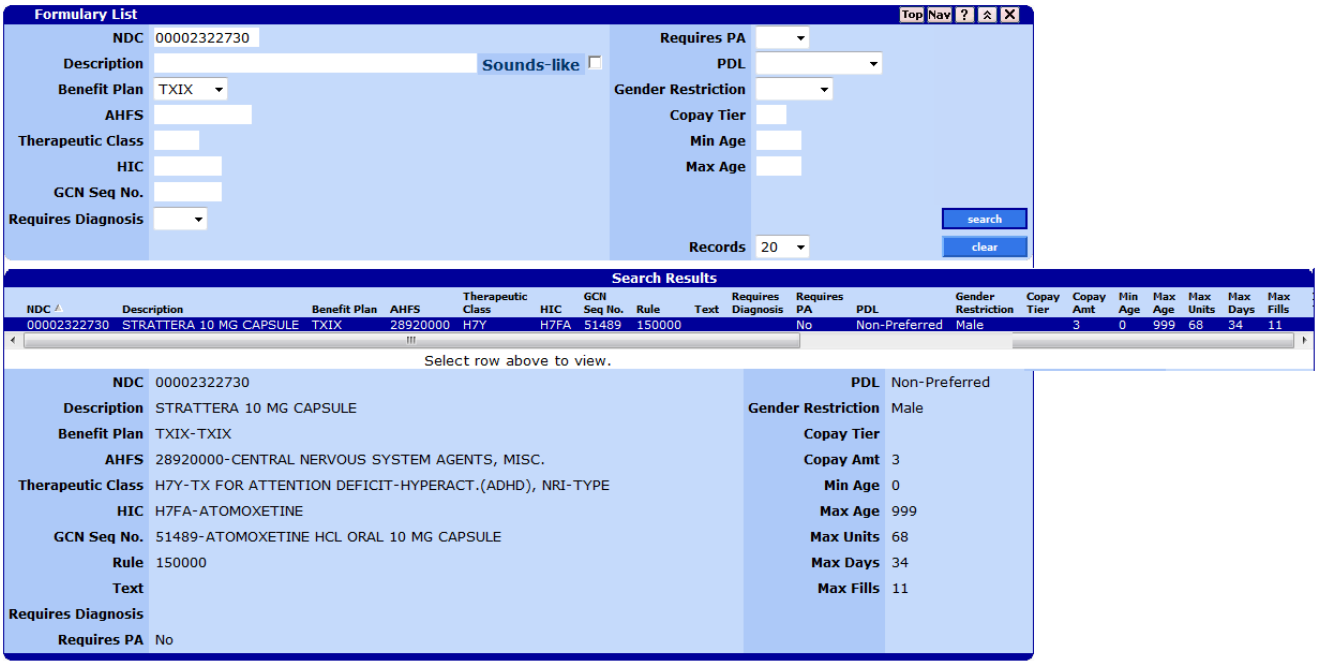
The Formulary List panel is used to view the formulary data being sent to Surescripts for ePrescribing.

The Benefit Plan drop down will have the following choices, blank (for all) Medicaid, Planfirst, TXIX, and it will always default to TXIX.

This panel is inquiry only.

Navigation Path: [Reference] - [ePrescribing] - [Formulary List]

6.285.2 Formulary List Panel Layout



6.285.3 Formulary List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
Benefit Plan	The client Benefit Plan.	Field	Character	50
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Copay Amt	Copay amount that the recipient must pay.	Field	Number (Decimal)	10

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Field	Description	Field Type	Data Type	Length
Copay Tier	Surescripts tier ID. Values are 1 to 9, from lowest copay to highest copay amounts. The AMMIS has up to three levels of copay.	Field	Number (Integer)	1
Description	The description of the National Drug Code of the resource link rule that is being searched for.	Field	Character	40
GCN Seq No.	The GCN Sequence Number.	Field	Number (Integer)	6
Gender Restriction	Specifies the gender the recipient must be to receive this drug.	Field	Character	1
HIC	The HIC.	Field	Character	6
Max Age	Maximum age the recipient can be to obtain the drug. If zero, there is no maximum age.	Field	Number (Integer)	3
Max Days	Maximum days that can be supplied at a given fill.	Field	Number (Integer)	4
Max Fills	Maximum fills for this drug.	Field	Number (Integer)	4
Max Units	Maximum units that can be dispensed at a given fill.	Field	Number (Integer)	10
Min Age	Minimum age the recipient can be to obtain the drug.	Field	Number (Integer)	3
NDC	The National Drug Code of the resource link rule that is being searched for.	Field	Number (Integer)	11
PDL	Indicates preferred drug status.	Field	Character	1
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	3
Requires Diagnosis	Indicates if the drug requires a Diagnosis. Currently this field is left blank for future use.	Field	Character	1
Requires PA	Indicates if the Drug requires a Prior Authorization.	Field	Character	1
Rule	The formulary list rule number.	Field	Number (Integer)	9
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Sounds-Like	Check this box for a search by Soundex of the string entered in the Description field.	Check Box	Check Box	1
Text	The text Message associated with the NDC. If no value in this field, then no text message is associated.	Field	Character	35
Therapeutic Class	The Therapeutic Class.	Field	Character	3

5.139.8 Formulary List Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS	Field	1	Please enter at least one search field.	Please enter at least one search field.
Benefit Plan	Field	1	Please enter at least one search field.	Please enter at least one search field.
Copay Tier	Field	1	Please enter at least one search field.	Please enter at least one search field.
Description	Field	1	Please enter at least one search field.	Please enter at least one search field.
GCN Seq No.	Field	1	Please enter at least one search field.	Please enter at least one search field.
Gender Restriction	Field	1	Please enter at least one search field.	Please enter at least one search field.
HIC	Field	1	Please enter at least one search field.	Please enter at least one search field.
Max Age	Field	1	Please enter at least one search field.	Please enter at least one search field.
Min Age	Field	1	Please enter at least one search field.	Please enter at least one search field.
NDC	Field	1	Please enter at least one search field.	Please enter at least one search field.
PDL	Field	1	Please enter at least one search field.	Please enter at least one search field.
Requires Diagnosis	Field	1	Please enter at least one search field.	Please enter at least one search field.
Requires PA	Field	1	Please enter at least one search field.	Please enter at least one search field.

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Field	Field Type	Error Code	Error Message	To Correct
Therapeutic Class	Field	1	Please enter at least one search field.	Please enter at least one search field.

6.285.4 Formulary List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.285.5 Formulary List Panel Accessibility

6.285.5.1 To Access the Formulary List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**. Click on **Formulary List**.	Formulary List panel displays.
3	Enter search criteria.	
4	Click **Search**.	Formulary List Search Results panel displays.
5	Select row from list of results.	Formulary details get displayed.

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6.286 RESOURCE LINK LIST PANEL

6.286.1 Resource Link List Panel Narrative

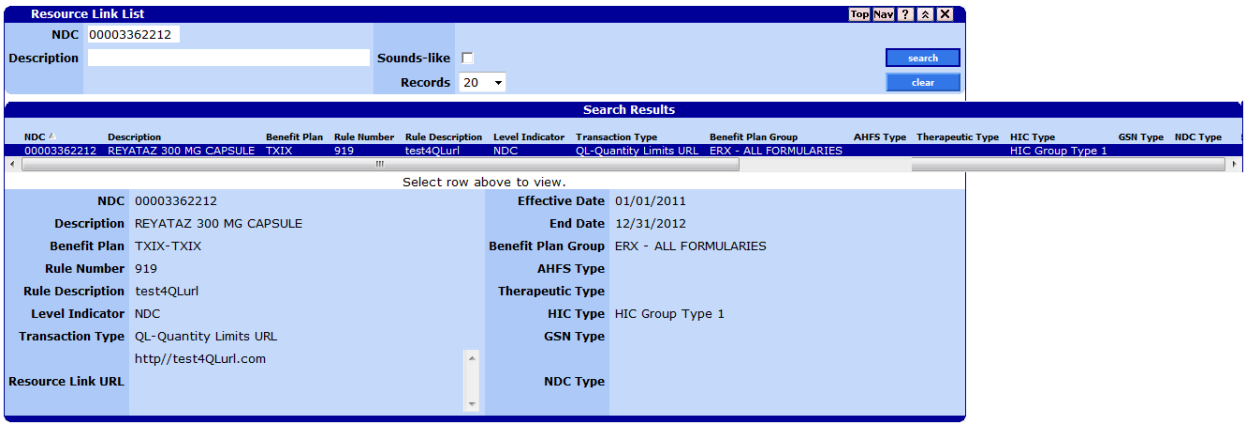
This panel is designed to view the Resource Link data set up for ePrescribing based on the Resource Link Update Panel.

The Resource Link Update panel shows the rules to apply to the NDCs on the Drug File. The Resource Link List panel shows the rules that have been applied to the NDCs on the Drug File.

This panel is inquiry only.

Navigation Path: [Reference] - [ePrescribing] - [Resource Link List]

6.286.2 Resource Link List Panel Layout



6.286.3 Resource Link List Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS Type	System assigned key for a unique AHFS type, which represents a single or collection of AHFS.	Field	Number (Integer)	9
Benefit Plan Group	The Benefit Plan Group Type selected for the rule on the Resource Link Update Panel. See Reference-->Related Data-->Benefit Plan Group Type.	Field	Character	50
Benefit Plan	Each Benefit Plan Group Type contains one or more Benefit Plans. There will be a record for each Benefit Plan in a Benefit Plan Group Type. The Benefit Plan Group Types and the Benefit Plans they contain are shown in Reference-->Related Data-->Benefit Plan Group Type. The Benefit Plan Group Type for each rule is selected on the Resource Link Update panel.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Description	Enter the National Drug Code (NDC) description (name of the drug) to search for all Resource Link rules associated with that NDC.	Field	Alphanumeric	40
Effective Date	The Effective Date of the Rule set up on the Resource Link Update panel.	Field	Date (MM/DD/CCYY)	8
End Date	The End Date of the rule set up on the Resource Link Update panel.	Field	Date (MM/DD/CCYY)	8
GCN Type	This shows the GCN Sequence Number Group Type for the rule number. A GCN Sequence Number Group Type is a list of individual GCNs to which the rule applies. GCN Sequence Number Group Types are set up at Reference-->Related Data-->Other-->GCN Sequence Number Group Type. The GCN Sequence Number Group Types are linked to rules via the Resource Link Update panel.	Field	Character	25
HIC Type	This shows the HIC Group Type for the rule number. A HIC Group Type is a list of individual HICs to which the rule applies. HIC Group Types are set up at Reference-->Related Data-->Other-->HIC Group Type. The HIC Group Types are linked to rules via the Resource Link Update panel.	Field	Character	50
Level Indicator	An indicator of whether the Resource Link rule is to be set at the Summary or NDC level.	Field	Character	1
NDC	Enter the National Drug Code (NDC) to search for all Resource Link rules associated with that NDC.	Field	Number (Integer)	11

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Field	Description	Field Type	Data Type	Length
NDC Type	This shows the NDC Group Type for the rule number. An NDC Group Type is a list of individual NDCs to which the rule applies. NDC Group Types are set up at Reference-->Related Data-->Other-->NDC Group Type. The NDC Group Types are linked to rules via the Resource Link Update panel.	Field	Character	50
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0
Resource Link URL	The Uniform Resource Locator (URL) set up for the rule. This is the URL that will be returned when the prescriber selects the associated drug.	Field	Character	0
Rule Description	The description of the Rule in effect for this Resource link record.	Field	Character	35
Rule Number	The Rule Number in effect for this Resource link record.	Field	Number (Integer)	9
Sounds-like	Check this box to search by a drug name if you are uncertain of the spelling. The spelling that you enter in the Description field must sound like the name of the drug.	Check Box	Check Box	1
Therapeutic Type	This shows the Therapeutic Group Type for the rule number. A Therapeutic Group Type is a list of individual HIC3 codes to which the rule applies. Therapeutic Group Types are set up at Reference-->Related Data-->Other-->Therapeutic Group Type. The Therapeutic Group Types are linked to rules via the Resource Link Update panel.	Field	Character	50

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Field	Description	Field Type	Data Type	Length
Transaction Type	The Surescripts Transaction Type that applies to this rule. Valid Values are: AL - Age; CP - Copay; FM - Formulary; GI - General Information; GL - Gender Limits; PA - Prior Authorization; QL - Quantity Limits.	Field	Character	25

6.286.4 Resource Link List Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	NDC or Description is required for search.	Enter NDC or Description for search.
NDC	Field	1	NDC or Description is required for search.	Enter NDC or Description for search.

6.286.5 Resource Link List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.286.6 ePrescribing - Resource Link List Panel Accessibility

6.286.6.1 To Access the Resource Link List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**.Then click on **Resource Link List**.	Resource Link List panel displays.
3	Enter search criteria.	
4	Click **Search**.	Resource Link List Search Results panel displays.

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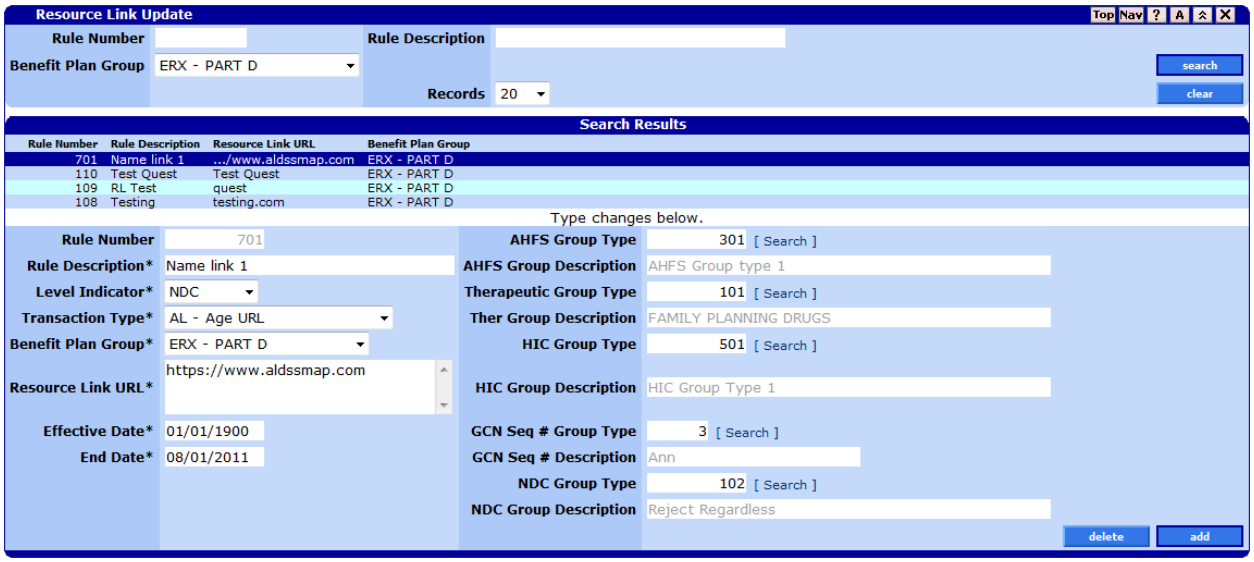
6.287 RESOURCE LINK UPDATE PANEL

6.287.1 Resource Link Update Panel Narrative

Resource Link Update panel supports entry, update and viewing of Resource Link (URL) rules. The rules explain which NDCs should have a Resource Link record in the Formulary Load to Surescripts.

Navigation Path: [Reference] - [ePrescribing] -[Resource Link Update]

6.287.2 Resource Link Update Panel Layout



5.139.9 Resource Link Update Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new Resource Link record.	Button	N/A	0
AHFS Group Description	AHFS Group Description.	Field	Character	50
AHFS Group Type	Groups of AHFS by AHFS type.	Field	Number (Integer)	9
Benefit Plan Group	Benefit Plan Group	Field	Drop Down List Box	0
Delete	Allows user to delete an existing Resource Link record.	Button	N/A	0
Effective Date	First day this Resource Link is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last day this Resource Link is effective.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
GCN Seq # Description	GCN Sequence number description.	Field	Character	30
GCN Seq # Group Type	Groups of GCN seqno by GCN sequence number type.	Field	Number (Integer)	4
HIC Group Description	HIC Group Description.	Field	Character	50
HIC Group Type	Groups of HIC by HIC type.	Field	Number (Integer)	9
Level Indicator	Indicates Resouce Link is associated with an NDC (N) or is a Summary level (S) link.	Field	Drop Down List Box	0
NDC Group Description	NDC Group description.	Field	Character	50
NDC Group Type	Groups drug by drug type. This will be used by various parts of the system for different processing methodologies.	Field	Number (Integer)	9
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Resource Link URL	The URL for this Resource Link.	Field	Character	255
Rule Description	Resource link name.	Field	Character	35
Rule Number	The Rule Number in effect for this Resource link record.	Field	Number (Integer)	9
Ther Group Description	Describes the therapeutic type.	Field	Character	50
Therapeutic Group Type	System assigned key for a unique therapeutic type, which represents a collection of therapeutic codes.	Field	Number (Integer)	9
Transaction Type	Type of Resource Link which may be associated with covered Drugs.	Field	Drop Down List Box	0

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6.287.3 Resource Link Update Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Group	Field	1	A valid Benefit Plan Group is required.	Select a valid Benefit Plan Group.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Enter an Effective Date that is greater than or equal to 1/1/1900.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	3	End Date must be greater than or equal to 1/1/1900.	Enter an End Date that is greater than or equal to 1/1/1900.
Level Indicator	Field	1	Level Indicator is required.	Select a Level Indicator.
Resource Link URL	Field	1	Resource Link URL is required.	Enter a Resource Link URL.
Rule Description	Field	1	Rule Description is required.	Enter a Rule Description.
Therapeutic Group Type	Field	1	At least one value is required in AHFS, Therapeutic, HIC, and GCN Seq Number or NDC Group Type field.	Enter a valid value in one of the following fields: AHFS Group Type, Therapeutic Group Type, HIC Group Type, GCN Seq # Group Type, or NDC Group Type.
Transaction Type	Field	1	Transaction Type is required.	Select a transaction type.

6.287.4 Resource Link Update Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.287.5 Resource Link Update Panel Accessibility

6.287.5.1 To Access the Resource Link Update Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**. Then Click on **Resource Link Update**.	Reference Resource Link Update displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Resource Link Update Search Results displays.
5	Select row from list of results.	Resource Link Update Maintenance panel gets displayed.

6.287.5.2 To Add on the Resource Link Update Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **AHFS Group Type**, **Rule Description**, **Therapeutic Group Type**, **Resource Link URL**, **GCN Seq # Group Type** and **NDC Group Type**.	
3	Select **Level Indicator**, **Transaction Type** and **Benefit Plan Group** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Resource Link information is saved.

6.287.5.3 To Update on the Resource Link Update Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Resource Link information is saved.

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6.287.5.4 To Delete on the Resource Link Update Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.288 TEXT MESSAGE LIST PANEL

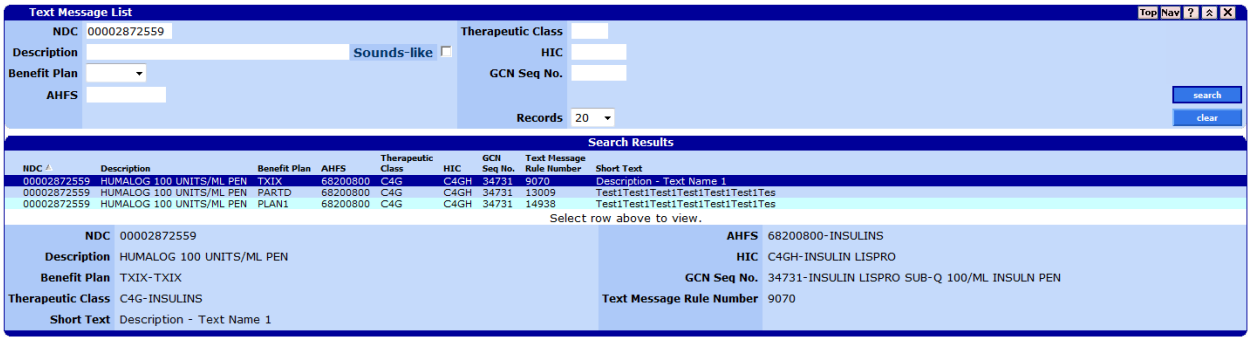
6.288.1 Text Message List Panel Narrative

ePrescribing Text Message List panel is set up to view the tables created using the Text Message Update panel.

This panel is inquiry only.

Navigation Path: [Reference] - [ePrescribing] - [Text Message List]

6.288.2 Text Message List Panel Layout



6.288.3 Text Message List Field Descriptions

Field	Description	Field Type	Data Type	Length
AHFS	Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	Field	Character	10
Benefit Plan	The Benefit Plan that the rule is applied to.	Field	Character	50
Clear	Clears the criteria fields so user may enter new criteria.	Button	N/A	0
Description	The NDC description.	Field	Character	40
GCN Seq No.	The GCN Sequence Number that the rule applies to.	Field	Number (Integer)	6
HIC	The HIC4 that the rule applies to.	Field	Character	6
NDC	The NDC (National Drug Code) that the rule applies to.	Field	Number (Integer)	11

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Search	Initiates search on the database table for records matching the criteria entered.	Button	N/A	0
Short Text	The short description of the text that will be displayed to the provider on the formulary inquiry for this drug.	Field	Character	100
Sounds-like	Select this checkbox to perform a SOUNDEX based search on the NDC Description.	Check Box	Check Box	1
Text Message Rule Number	The Text Message Rule Number.	Field	Number (Integer)	9
Therapeutic Class	The Therapeutic Class that the rule applies to.	Field	Character	3

6.288.4 Text Message List Field Edits

Field	Field Type	Error Code	Error Message	To Correct
AHFS	Field	1	Please enter at least one search field.	Please enter at least one search field.
Benefit Plan	Field	1	Please enter at least one search field.	Please enter at least one search field.
Description	Field	1	Please enter at least one search field.	Please enter at least one search field.
GCN Seq No.	Field	1	Please enter at least one search field.	Please enter at least one search field.
HIC	Field	1	Please enter at least one search field.	Please enter at least one search field.
NDC	Field	1	Please enter at least one search field.	Please enter at least one search field.
Therapeutic Class	Field	1	Please enter at least one search field.	Please enter at least one search field.

6.288.5 Text Message List Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.288.6 Text Message List Panel Accessibility

6.288.6.1 To Access the Text Message List Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **ePrescribing**. Then click on **Text Message List**.	Text Message List panel displays.
3	Enter search criteria.	
4	Click **Search**.	Text Message List Search Results panel displays.

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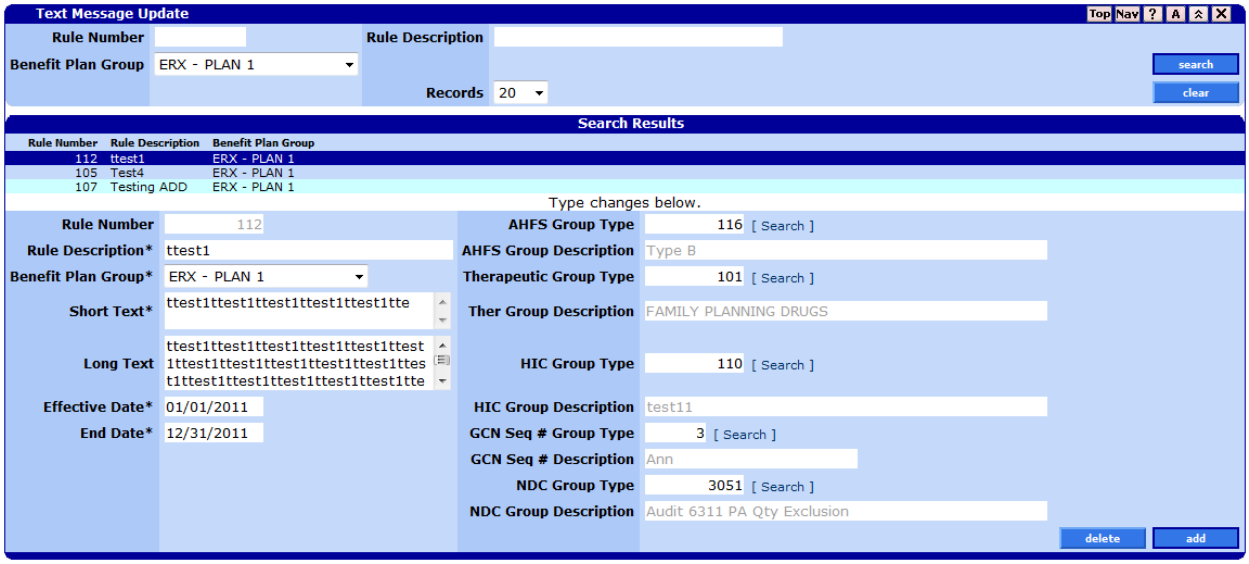
6.289 TEXT MESSAGE UPDATE PANEL

6.289.1 Text Message Update Panel Narrative

The Text Message Update panel supports entry, update and viewing of Text Messages. Text Messages are associated with NDCs or groups. Groups include AHFS, HIC3s, HIC4s, and GSNs.

Navigation Path: [Reference] - [ePrescribing] -[Text Message Update]

6.289.2 Text Message Update Panel Layout



6.289.3 Text Message Update Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows user to add a new Text Message record.	Button	N/A	0
AHFS Group Description	Succinct description (name) of the AHFS Group.	Field	Character	50
AHFS Group Type	System assigned key for a unique (FDB) AHFS Group type, which represents a single or collection of AHFS Therapeutic Class codes.	Field	Character	10
Delete	Allows user to delete an existing Text Message record.	Button	N/A	0
Benefit Plan Group	System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.	Field	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Effective Date	First day this Text Message is effective.	Field	Date (MM/DD/CCYY)	8
End Date	Last day this Text Message is effective.	Field	Date (MM/DD/CCYY)	8
GCN Seq # Group Description	GCN Sequence Number Group Description.	Field	Character	30
GCN Seq # Group Type	Groups of GCN seqno by GCN seqno type	Field	Number (Integer)	4
HIC Group Description	HIC Group Description.	Field	Character	50
HIC Group Type	Groups of HIC by HIC type.	Field	Number (Integer)	9
Long Text	The long text for the Text Message.	Field	Character	255
NDC Group Description	NDC Group Description.	Field	Character	50
NDC Group Type	NDC Group Type.	Field	Number (Integer)	9
Records	Allows the user to choose the number of records to be displayed on a page.	Field	Drop Down List Box	0
Rule Description	Resource link name.	Field	Character	35
Rule Number	System assigned key for a Text message.	Field	Number (Integer)	9
Short Text	Short text for the Text Message. If entereing both long and short text, the short text should be a summary of the long text.	Field	Character	33
Therapeutic Group Description	Therapeutic Group Description	Field	Character	35
Therapeutic Group Type	System assigned key for a unique therapeutic type that represents a collection of therapeutic codes.	Field	Number (Integer)	9

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6.289.4 Text Message Update Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Benefit Plan Group	Field	1	A valid Benefit Plan Group is required.	Select a valid Benefit Plan Group.
Effective Date	Field	1	Effective Date is required.	Enter an Effective Date.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	3	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than or equal to 1/1/1900.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	3	End Date must be greater than or equal to 1/1/1900.	Verify keying. End Date must be greater than or equal to 1/1/1900.
Rule Description	Field	1	Rule Description is required.	Enter a Rule Description.
Short Text	Field	1	Short Text is required.	Enter Short Text.
Therapeutic Group Type	Field	1	At least one value is required in Therapeutic, HIC, GCN Seq Number or NDC Group Type field.	Enter a valid value in one of the following fields: Therapeutic Group Type, HIC Group Type, GCN Seq # Group Type, or NDC Group Type. AHFS

6.289.5 Text Message Update Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.289.6 Text Message Update Panel Accessibility

6.289.6.1 To Access the Text Message Update Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.

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Step	Action	Response
2	Point to **Reference** and click **ePrescribing**. Then Click on **Resource Link Update**.	Reference Text Message Update displays.
3	Enter search criteria.	
4	Click **Search**.	Reference Text Message Update Search Results displays.
5	Select row from list of results.	Text Message Update Maintenance panel gets displayed.

6.289.6.2 To Add on the Text Message Update Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **AHFS Group Type**, **Rule Description**, **Therapeutic Group Type**, **Short Text**, **Long Text**, **GCN Seq # Group Type** and **NDC Group Type**.	
3	Select **Benefit Plan Group** from drop down list box.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Click **Save**.	Resource Link information is saved.

6.289.6.3 To Update on the Text Message Update Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Text Message information is saved.

6.289.6.4 To Delete on the Text Message Update Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.290 DRG-GROUP

6.290.1 DRG Group Panel Narrative

The Reference DRG Group Panel is used to view the groups to which the DRG belongs. These groups will then be used in pricing and processing logic. The groups are maintained on the DRG Group Type panel found in Related Data/Other.

Navigation Path: [Reference] – [DRG - Search] - [(select row from search results)] - [DRG Maintenance] - [Group]

6.290.2 DRG Group Panel Layout

Group

Group Type	Description	DRG Code From	DRG Code To	Effective Date	End Date
5	Type 3	494	494	12/30/2017	12/31/2017
5	Type 3	494	494	12/30/2015	12/31/2015
5	Type 3	494	494	12/30/2016	12/31/2016
5	Type 3	494	494	01/14/2016	12/31/2299
11	Group Type 10	494	494	01/22/2016	12/31/2299
9	New DRG Group Type 4	494	494	01/01/1900	01/01/1900
9	New DRG Group Type 4	494	497	02/05/2016	12/31/2016
9	New DRG Group Type 4	494	497	01/05/2016	01/31/2016

6.290.3 DRG Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
DRG Code From	Starting code in range of Diagnosis Related Group (DRG) Codes associated in the current Group.	Field	Character	4
DRG Code To	Ending code in range of Diagnosis Related Group (DRG) Codes associated in the current Group.	Field	Character	4
Description	Describes the current Diagnosis Related Group (DRG) Group.	Field	Character	50
Effective Date	The date the current group becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	The last date for the current group to remain effective.	Field	Date (MM/DD/CCYY)	8
Group Type	Unique code to identify a group of Diagnosis Related Group (DRGs) associated in a range of time.	Field	Number (Integer)	0

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6.290.4 DRG Group Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No extra edits found for this panel.				

6.290.5 DRG Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.290.6 DRG Group Panel Accessibility

6.290.6.1 To Access the DRG Group Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	DRG Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	DRG Search Results panel displays.
5	Select row from list of results.	DRG Information and Maintenance panels display.
6	Click **Group**.	DRG Group panel displays.

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6.291 DRG-MDC PANEL

6.291.1 DRG MDC Panel Narrative

The Reference DRG MDC Panel is used to view the MDC (Major Diagnostic Category) with which a DRG is associated. The MDCs are found in Related Data/Other.

Navigation Path: [Reference] – [DRG - Search] - [(select row from search results)] - [DRG Maintenance] - [MDC List]

6.291.2 DRG MDC Panel Layout

6.291.3 DRG MDC Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Description	This is a forty byte character field used to describe a MDC.	Field	Alphanumeric	40
MDC	This is a two byte code field used to identify a MDC.	Field	Alphanumeric	2

6.291.4 DRG MDC Panel Field Edits

Field	Field Type	Error Code	Error Message	To Correct
No extra edits found for this panel.				

6.291.5 DRG MDC Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.291.6 DRG MDC Panel Accessibility

6.291.6.1 To Access the DRG MDC Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	DRG Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	DRG Search Results panel displays.

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Step	Action	Response
5	Select row from list of results.	DRG Information and Maintenance panels display.
6	Click **MDC List**.	DRG MDC panel displays.

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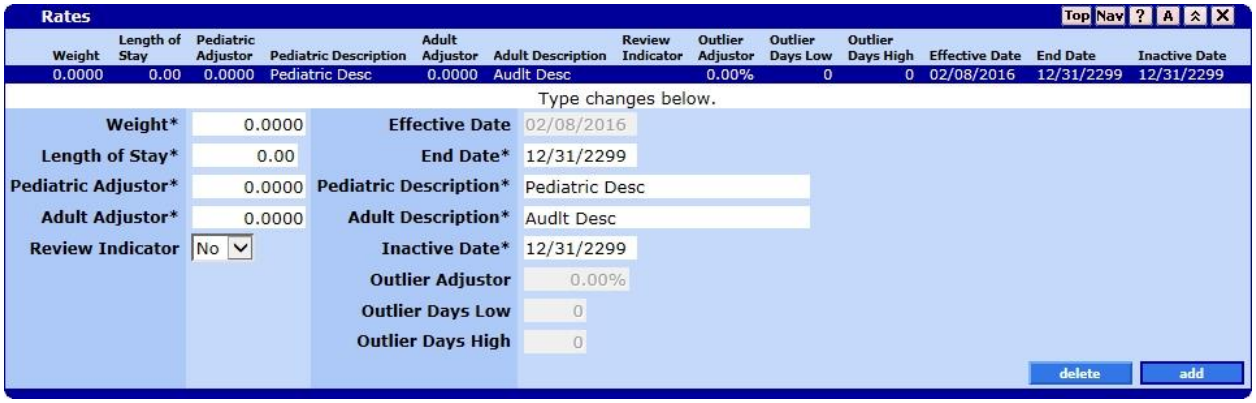
6.292 DRG-RATES

6.292.1 DRG Rates Panel Narrative

This panel is used to update, delete and add rates for the current DRG code. On an update the Effective Date cannot be changed.

Navigation Path: [Reference][- DRG - Search] - [(select row from search results)] - [Rates]

6.292.2 DRG Rates Panel Layout



6.292.3 DRG Rates Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add a DRG rate.	Button	N/A	0
Adult Adjustor	Amount we would adjust the DRG payment for adults.	Field	Number (Decimal)	7
Adult Description	Description for adjusted amount category for adults.	Field	Alphanumeric	30
Delete	Allows user to delete an existing DRG rate.	Button	N/A	0
Effective Date	The date the DRG Rate took effect. The Effective Date is not updatable.	Field	Date (MM/DD/CCYY)	8
End Date	The date the DRG Rate is no longer in effect.	Field	Date (MM/DD/CCYY)	8
Inactive Date	Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Length of Stay	This is the average length of stay associated to a particular DRG classification group.	Field	Number (Decimal)	5
Outlier Adjustor	This is the average length of stay associated to a particular DRG classification group.	Field	Number (Decimal)	5
Outlier Days High	High number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outlier's logic.	Field	Number (Integer)	3
Outlier Days Low	Low number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outlier's logic.	Field	Number (Integer)	3
Pediatric Adjustor	Amount we would adjust the DRG payment for children.	Field	Number (Decimal)	7
Pediatric Description	Description for adjusted amount for children.	Field	Alphanumeric	30
Review Indicator	Indicator for DRG should be suspended for review Poss values are Y or space (space is the default).	Field	Drop Down List Box	1
Weight	This is a date sensitive pricing factor expressed in the 9.9999 form, and is one of the primary components for the DRG calculation. Some DRGs will not be assigned weights, so for these the Level of Care pricing method will be used.	Field	Number (Decimal)	7

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6.292.4 DRG Rates Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Adult Adjustor	Field	1	Adult Adjustor is required.	Enter an Adult Adjustor.
	Field	2	Adult Adjustor must be less than or equal to 999.9999.	Enter a valid Adult Adjustor.
Adult Description	Field	1	Adult Description is required.	Enter an Adult Description.
Effective Date	Field	1	Effective Date must be greater than or equal to 1/1/1900.	Verify keying. Effective Date must be greater than or equal to 1/1/1900.
	Field	2	Effective Date is required.	Enter an Effective Date.
	Field	3	Effective Date must be less than or equal to 12/31/2299.	Verify keying. Effective Date must be less than or equal to 12/31/2299.
	Field	4	Effective Date must be less than or equal to End Date.	Verify keying. Effective Date must be less than or equal to End Date.
	Field	5	Invalid Date. Format is mm/dd/ccyy.	Enter a valid Effective Date.
	Field	6	Active Rate segments may not overlap.	Verify dates against list. Date segments cannot overlap.
End Date	Field	1	End Date is required.	Enter an End Date.
	Field	2	End Date must be greater than or equal to 1/1/1900.	Verify keying. End Date must be greater than or equal to 1/1/1900.
	Field	3	End Date must be less than or equal to 12/31/2299.	Verify keying. End Date must be less than or equal to 12/31/2299.
	Field	4	Invalid Date. Format is mm/dd/ccyy.	Enter a valid End Date.
Inactive Date	Field	1	Inactive Date is required.	Enter an Inactive Date.
	Field	2	Inactive Date must be greater than or equal to 1/1/1900.	Verify keying. Inactive Date must be greater than or equal to 1/1/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Inactive Date must be less than or equal to 12/31/2299.	Verify keying. Inactive Date must be less than or equal to 12/31/2299.
	Field	4	Invalid Date. Format is mm/dd/ccyy.	Enter a valid Inactive Date.
Length of Stay	Field	1	Length of Stay is required.	Enter a Length of Stay.
	Field	2	Length of Stay must be less than or equal to 9999.99.	Enter a valid Length of Stay.
Outlier Adjustor	Field	1	Outlier Adjustor is required.	Enter an Outlier Adjustor.
	Field	2	Percent Outlier Adjustment cannot exceed 100%.	Enter a valid Outlier Adjustment.
Outlier Days High	Field	1	Outlier Days High is required.	Enter an Outlier Days High.
	Field	2	Outlier Days High must be less than or equal to 999.	Enter a valid Outlier Days High.
Outlier Days Low	Field	1	Outlier Days Low is required.	Enter an Outlier Days Low.
	Field	2	Outlier Days Low must be less than or equal to 999.	Enter a valid Outlier Days Low.
Pediatric Adjustor	Field	1	Pediatric Adjustor is required.	Enter a Pediatric Adjustor.
	Field	2	Pediatric Adjustor must be less than or equal to 999.9999.	Enter a valid Pediatric Adjustor.
Pediatric Description	Field	1	Pediatric Description is required.	Enter an Adult Description.
Weight	Field	1	Weight is required.	Enter a Weight.
	Field	2	Weight must be less than or equal to 999.9999.	Enter a valid Weight.

6.292.5 DRG Rates Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.292.6 DRG Rates Panel Accessibility

6.292.6.1 To Access the Rates Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **Reference** and click **DRG**.	DRG Search panel displays.
3	Enter search criteria.	
4	Click **Search**.	DRG Search Results panel displays.
5	Select row from list of results.	DRG Information and Maintenance panels display.
6	Click **Rates**.	Rates-DRG panel displays.

6.292.6.2 To Add on the DRG Rates Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Weight**.	
3	Enter **Effective Date** in MM/DD/CCYY format.	
4	Enter **Length of Stay**.	
5	Enter **End Date** in MM/DD/CCYY format.	
6	Enter **Pediatric Adjustor**.	
7	Enter **Pediatric Description**.	
8	Enter **Adult Adjustor**.	
9	Enter **Adult Description**.	
10	Select **Review Indicator** from drop down list box.	
11	Enter **Inactive Date** in MM/DD/CCYY format.	
12	Enter **Outlier Adjustor**.	
13	Enter **Outlier Days Low**.	
14	Enter **Outlier Days High**.	
15	Click **Save**.	Rates information is saved.

6.292.6.3 To Update on the DRG Rates Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Rates information is saved.

6.292.6.4 To Delete on the DRG Rates Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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7 REPORTS

The Reference user manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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7.1 REF-0001-A -- CMS HCPCS UPDATE - DISCONTINUED PROCEDURE CODES REPORT

7.1.1 REF-0001-A -- CMS HCPCS Update - Discontinued Procedure Codes Report Narrative

The Centers for Medicare and Medicaid Systems (CMS) Healthcare Common Procedure Coding System (HCPCS) Update - Discontinued Procedure Codes report lists the procedure codes that are to be discontinued according to the information received on the current CMS HCPCS Update file. They have an action code of 'D' on the HCPCS file meaning 'discontinued'.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTRACE.

7.1.2 REF-0001-A -- CMS HCPCS Update - Discontinued Procedure Codes Report Layout

```
Report  : REF-0001-A                                ALABAMA MEDCAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : REFJA105                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
Location: REFP0105                   CMS HCPCS UPDATE - DISCONTINUED PROCEDURE CODES                         PAGE: 999,999
                                                    REPORT PERIOD: CCYY
-------------------------------------------------------------------------------------------------------------------------------
* HCPCS   PROCEDURE                     DATE          DATE          XREF      XREF      XREF      XREF      XREF
* CODE    DESCRIPTION                   ADDED         TERMINATED    CODE1     CODE2     CODE3     CODE4     CODE5
-------------------------------------------------------------------------------------------------------------------------------
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX
  XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY    MM/DD/CCYY    XXXXXX    XXXXXX    XXXXXX    XXXXXX    XXXXXX

                                                     * No Data This Report *
                                                        * End of Report *
```

7.1.3 REF-0001-A -- CMS HCPCS Update - Discontinued Procedure Codes Report Field Descriptions

Field	Description	Length	Data Type
Date Added	The date the HCPCS code was added to the Healthcare Common Procedure Coding System.	10	Date (MM/DD/CCYY)
Date Terminated	Last date for which the procedure code may be used by providers.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
HCPCS Code	Code that represents procedures, supplies, products and services which may be provided to individuals enrolled in health insurance programs that has been discontinued according to the current CMS HCPCS file.	5	Character
Procedure Description	Short medical description of the procedure code.	28	Character
Xref Code1	An explicit reference cross walking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes). There can be up to 5 cross reference codes for a deleted code.	6	Character
Xref Code2	An explicit reference cross walking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes). There can be up to 5 cross reference codes for a deleted code.	6	Character
Xref Code3	An explicit reference cross walking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes). There can be up to 5 cross reference codes for a deleted code.	6	Character
Xref Code4	An explicit reference cross walking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes). There can be up to 5 cross reference codes for a deleted code.	6	Character
Xref Code5	An explicit reference cross walking a deleted code or a code that is not valid for Medicare to a valid current code (or range of codes). There can be up to 5 cross reference codes for a deleted code.	6	Character

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7.2 REF-0002-A -- CMS HCPCS UPDATE - ADDED PROCEDURE CODES REPORT

7.2.1 REF-0002-A -- CMS HCPCS Update - Added Procedure Codes Report Narrative

The CMS HCPCS Update - Added Procedure Codes report lists procedure codes that are to be added according to the information received on the current CMS HCPCS Update file.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.2.2 REF-0002-A -- CMS HCPCS Update - Added Procedure Codes Report Layout

```
Report  : REF-0002-A                          ALABAMA MEDICAID AGENCY                                        RUN DATE: MM/DD/CCYY
Process : REFJA105                       MEDICAID MANAGEMENT INFORMATION SYSTEM                               RUN TIME: HH:MM:SS
Location: REFP0105                      CMS HCPCS UPDATE - ADDED PROCEDURE CODES                               PAGE    : 999,999
                                                  REPORT PERIOD: CCYY
-------------------------------------------------------------------------------------------------------------------------------------
* HCPCS   PROCEDURE                      DATE                      * HCPCS   PROCEDURE                      DATE
* CODE    DESCRIPTION                    ADDED                     * CODE    DESCRIPTION                    ADDED
-------------------------------------------------------------------------------------------------------------------------------------
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY                 XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY                 XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY                 XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY                 XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY                 XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY

                                                        No Data This Report *
                                                          * End of Report *
```

7.2.3 REF-0002-A -- CMS HCPCS Update - Added Procedure Codes Report Field Descriptions

Field	Description	Length	Data Type
Date Added	The date the HCPCS code was added to the Healthcare Common Procedure Coding System.	10	Date (MM/DD/CCYY)
HCPCS Code	Procedure code added.	5	Character
Procedure Description	Short description for the procedure code.	28	Character

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7.3 REF-0003-A -- CMS HCPCS UPDATE - ADDED MODIFIER CODES REPORT

7.3.1 REF-0003-A -- CMS HCPCS Update - Added Modifier Codes Report Narrative

The CMS HCPCS Update - Added Modifier Codes report lists the modifiers that are to be added beginning in the upcoming year according to the information received on the current CMS HCPCS Update file.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed)

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.3.2 REF-0003-A -- CMS HCPCS Update - Added Modifier Codes Report Layout

```
Report  : REF-0003-A                          ALABAMA MEDICAID AGENCY                                   RUN DATE: MM/DD/CCYY
Process : REFJA105                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
Location: REFP0105                      CMS HCPCS UPDATE - ADDED MODIFIER CODES                            PAGE   : 999,999
                                                 REPORT PERIOD : CCYY
-------------------------------------------------------------------------------------------------------------------------------
* MOD    MODIFIER                      DATE                    * MOD     MODIFIER                      DATE
* CODE   DESCRIPTION                   ADDED                    * CODE    DESCRIPTION                   ADDED
-------------------------------------------------------------------------------------------------------------------------------
  XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY                 XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY
  XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY                 XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY
  XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY                 XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY
  XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY                 XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY
  XX     XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY                 XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY


                                                   *  No Data This Report *
                                                      * End of Report *
```


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7.3.3 REF-0003-A -- CMS HCPCS Update - Added Modifier Codes Report Field Descriptions

Field	Description	Length	Data Type
Date Added	The date the modifier code was added to the Healthcare Common Procedure Coding System.	10	Date (MM/DD/CCYY)
MOD Code	Code that indicates that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. According to the current CMS HCPCS file, this code has been added to the HCPCS.	2	Character
Modifier Description	Short description of what the modifier code represents.	28	Character

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7.4 REF-0004-A -- CMS HCPCS UPDATE – SUMMARY REPORT

7.4.1 REF-0004-A -- CMS HCPCS Update - Summary Report Narrative

The CMS HCPCS Update - Summary Report summarizes what occurred during the current CMS HCPCS update process.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

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7.4.2 REF-0004-A -- CMS HCPCS Update - Summary Report Layout

```
Report  : REF-0004-A                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJA105                         MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME: HH:MM:SS
Location: REFP0105                           CMS HCPCS UPDATE - SUMMARY REPORT                              PAGE    : 999,999
                                                   REPORT PERIOD: CCYY
-------------------------------------------------------------------------------------------------------------------------------


                  *  TOTAL RECORDS READ                    ===================>       999999999




                  *  PROCEDURE RECORDS READ                ===================>       999999999
                                                                                     ==========

                  *  PROCEDURE CODES ADDED                 ===================>    =  999999999
                  *  PROCEDURE CODES DISCONTINUED          ===================>    =  999999999
                  *  PROCEDURE CODES REACTIVATED           ===================>    =  999999999
                  *  PROCEDURE CODES W/SHORT DESC CHANGE   ===================>    =  999999999
                  *  PROCEDURE CODES W/LONG DESC CHANGE    ===================>    =  999999999
                  *  PROCEDURE CODES W/NO ACTION TAKEN     ===================>    =  999999999

                  *  PROCEDURE CODE ERRORS                 ===================>    =  999999999
                                                                                     ----------
                  *  TOTAL                                 ===================>       999999999
                                                                                     ==========
                   * MODIFIER RECORDS READ                 ===================>       999999999
                                                                                     ==========

                  *  MODIFIERS ADDED                       ===================>    =  999999999
                  *  MODIDIERS DISCONTINUED                ===================>    =  999999999
                  *  MODIFIERS REACTIVATED                 ===================>    =  999999999
                  *  MODIFIERS W/SHORT DESC CHANGE         ===================>    =  999999999
                  *  MODIFIERS W/LONG DESC CHANGE          ===================>    =  999999999
                  *  MODIFIERS W/NO ACTION TAKEN           ===================>    =  999999999

                  *  MODIFIER ERRORS                       ===================>    =  999999999
                                                                                     ----------
                  *  TOTAL                                 ===================>       999999999
                                                                                     ==========

                                                   No Data This Report *
                                                     * END OF REPORT *
```


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7.4.3 REF-0004-A -- CMS HCPCS Update - Summary Report Field Descriptions

Field	Description	Length	Data Type
Modifier Errors	Number of modifier codes that encountered an error during the update process.	9	Number (Integer)
Modifier Records Read	Number of distinct modifier code records read.	9	Number (Integer)
Modifiers Added	Number of new modifier codes being added for the upcoming year.	9	Number (Integer)
Modifiers Discontinued	Number of modifier codes discontinued for the upcoming year.	9	Number (Integer)
Modifiers Reactivated	Number of modifier codes being reactivated for the upcoming year.	9	Number (Integer)
Modifiers W/Short Desc Changes	Number of modifier codes that encountered a change in their short description for the upcoming year.	9	Number (Integer)
Modifiers W/Long Desc Change	Number of modifier codes that encountered a change in their long description for the upcoming year.	9	Number (Integer)
Modifiers W/No Action Taken	Number of modifier codes with no action taken for the upcoming year.	9	Number (Integer)
Procedure Code Errors	Number of procedure codes that encountered an error during the update process.	9	Number (Integer)
Procedure Codes Added	Number of new procedure codes being added for the upcoming year.	9	Number (Integer)
Procedure Codes Discontinued	Number of procedure codes discontinued for the upcoming year.	9	Number (Integer)
Procedure Codes Reactivated	Number of procedure codes being reactivated for the upcoming year.	9	Number (Integer)
Procedure Codes W/Long Desc Change	Number of procedure codes that encountered a change in their long description for the upcoming year.	9	Number (Integer)
Procedure Codes W/No Action Taken	Number of procedure codes with no action taken for the upcoming year.	9	Number (Integer)

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Field	Description	Length	Data Type
Procedure Codes W/Short Desc Change	Number of procedure codes that encountered a change in their short description for the upcoming year.	9	Number (Integer)
Procedure Records Read	Number of distinct procedure code records read.	9	Number (Integer)
Total (Modifier)	Sum of modifier records from the above actions and errors.	9	Number (Integer)
Total (Procedure)	Sum of procedure records from the above actions and errors.	9	Number (Integer)
Total Records Read	Number of records read from HCPCS file. This number includes multiple records for the same procedure or modifier code when the long description requires multiple records.	9	Number (Integer)

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7.5 REF-0005-A -- CMS HCPCS UPDATE - ERROR

7.5.1 REF-0005-A -- CMS HCPCS Update - Error Narrative

The CMS HCPCS Update - Error report lists the errors generated during the current CMS HCPCS file update.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.5.2 REF-0005-A -- CMS HCPCS Update - Error Layout

```
Report  : REF-0005-A                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : REFJA105                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME: HH:MM:SS
Location: REFP0105                          CMS HCPCS UPDATE - ERROR REPORT                               PAGE  : 999,999
                                                   REPORT PERIOD: CCYY
-------------------------------------------------------------------------------------------------------------------------------
                                                                                                   ERROR MESSAGE
PROC/   CMS                          CMS                                ON-FILE                L = Long Description  A = Added Date
MOD      PROCEDURE            ACT   DATE      DATE    MCARE    DATE      DATE   MCARE           S = Short Description T = Term Date
CODE     DESCRIPTION          CODE  ADDED     TERM    COVRG    ADDED     TERM  COVERAGE         C = Coverage Code (Medicare Covrg)
-------------------------------------------------------------------------------------------------------------------------------

XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX  XXXXXXXXXXXXXXXXXXXX  X  MM/DD/CCYY MM/DD/CCYY  X    MM/DD/CCYY MM/DD/CCYY  X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   No Data This Report *
                                                     * End of Report *
```


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7.5.3 REF-0005-A -- CMS HCPCS Update - Error Field Descriptions

Field	Description	Length	Data Type
Act Code	Code from the CMS HCPCS file that indicates what action is to be taken for the procedure or modifier code. A=Add B=Change in Admin data and Long Description C=Change in long description D=Discontinuation of code F=Change in Admin. Data. N=No maintenance for code P=Payment change R=Re-activated code S=Change in short description T=Miscellaneous change.	1	Character
CMS - Date Added	The date the HCPCS code was added to the Healthcare Common Procedure Coding System according to the current CMS HCPCS file.	10	Date (MM/DD/CCYY)
CMS - Date Term	According to the current CMS HCPCS file, this is the last date for which a procedure or modifier code may be used by providers.	10	Date (MM/DD/CCYY)
CMS - MCARE Covrg	The code denoting Medicare coverage status on the current CMS HCPCS file. CODES: D = Special coverage instructions apply I = Not payable by Medicare (no grace period) G = Not payable by Medicare (90 day grace period) M = Non-covered by Medicare S = Non-covered by Medicare statute C = Carrier judgment	1	Character
CMS Procedure Description	Short medical description of the procedure or modifier code.	20	Character

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Field	Description	Length	Data Type
Error Message	Short explanation of the reason for the error including difference indicators if applicable. Difference indicators will be present when the data coming in on the current CMS HCPCS file does not coincide with what the State currently has on file in the database, or when the incoming CMS action indicator does not substantiate the data on the incoming CMS HCPCS file or the data the State currently has on file in the database. Difference Indicators L = Difference in long description S = Difference in short description A = Difference in Added Date T = Difference in Termination Date C = Difference in HCPCS Coverage Code (Medicare Coverage Code)	45	Character
On File– Date Added	The date the State currently has on file in the database that signifies the date the HCPCS code was added to the Healthcare Common Procedure Coding System.	10	Date (MM/DD/CCYY)
On File – Date Term	The date the State currently has on file in the database that signifies the last date for which a procedure or modifier code may be used by providers.	10	Date (MM/DD/CCYY)
On File- MCARE Coverage	The code denoting Medicare coverage status that the Agency currently has on file in the database. CODES: D = Special coverage instructions apply I = Not payable by Medicare (no grace period) G = Not payable by Medicare (90 day grace period) M = Non-covered by Medicare S = Non-covered by Medicare statute C = Carrier judgment	1	Character

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Field	Description	Length	Data Type
PROC/MOD Code	Procedure code that represents procedures, supplies, products and services which may be provided to individuals enrolled in health insurance programs or modifier code that indicates that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. These codes encountered an error during the HCPCS update process.	5	Character

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7.6 REF-0005-O - AUDIT FOR EOB TO BUSC/CARC/RARC/CAGC CROSS REFERENCE COMPLIANCE REPORT

The EOB to BUSC/CARC/RARC/CAGC Cross Reference Compliance Report shows Business Scenario/CARC/RARC combinations assigned to EOBs for which at least one issue has been detected for prospective correction. This ensures that each EOB associated to a business scenario has an active and valid code combination assigned. This report is run on request as part of the periodic maintenance of the CARC and RARC combinations and the EOB crosswalk to these combinations per procedures documented in the document entitled "Alabama ACA III EOB CARC RARC Maintenance Procedures".

The EOB code will be shown with the code and effective/end date of the currently cross-referenced CARC/RARC combination, along with verbiage identifying the detected issues / required actions.

7.6.1 REF-0005-O – Audit for EOB to BUSC/CARC/RARC/CAGC Cross Reference Compliance Report Layout

```
Report  : REF-0005-O                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJO005                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0005              EOB TO BUSC/CARC/RARC/CAGC CROSS REFERENCE COMPLIANCE AUDIT                Page:    999,999


EOB   BUS  CARC  RARC   CAGC  EFFECTIVE AND END DATE       ACTION REQUIRED
CD    SC   CD    CD     CD  RANGE FOR THE COMBINATION
XXXX  XX   XXXX  XXXXX  XX  CCYY-MM-DD - CCYY-MM-DD  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXX  XX   XXXX  XXXXX  XX  CCYY-MM-DD - CCYY-MM-DD  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                       ***   END OF REPORT   ***

                                                      ***   NO DATA THIS RUN   ***
```

7.6.2 REF-0005-O - Audit for EOB to BUSC/CARC/RARC/CAGC Cross Reference Compliance Report Descriptions

Field	Description	Data Type	Length
ACTION REQUIRED	Verbiage identifying the detected issue and required actions: Valid options can be one of 6 values per line for up to 6 lines per each EOB Code: • EOB NOT YET ASSIGNED (if no XREF found at all) • CARC/RARC COMBINATION HAS EXPIRED (XREF points to a combination that is no longer effective, i.e. the end date is before the current cycle date) • EOB TO CARC/RARC XREF HAS EXPIRED	Character	80

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Field	Description	Data Type	Length
	(if XREF record exists for the EOB but the run expiration date is before the current cycle date) • PENDING EXPIRATION OF CARC/RARC COMBINATION (if the expiration of the xref'd combination is before or equal to the upcoming compliance date and after the current cycle date) • PENDING EXPIRATION OF EOB TO CARC/RACR ASSIGNMENT (if the expiration of the cross reference to the combination is before or equal to the upcoming compliance date and after the current cycle date) • PENDING EXPIRATION OF DOS DATE RANGE • (if expiration of the usability of the xref for comparisons by date of service is before or equal to the upcoming compliance date and after the current cycle date) • **EOB TO CARC/RARC XREF ONLY FUTURE** (if the only xref that exists for the EOB is future dated) Note: Field may also be blank.		
BUS SC	A code to indicate the Business Scenario for the combination. May be empty.	Character	2
CAGC CD	Code identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code). May be empty.	Character	2
CARC CD	HIPPA adjustment code. May be empty.	Character	4
EFFECTIVE RANGE BEGIN	The beginning date range for the CARC/RARC combination associated with this EOB. May be empty	Date (CCYY-MM-DD)	10
EFFECTIVE RANGE END	The effective date range end for the CARC/RARC combination associated with this EOB. May be empty.	Date (CCYY-MM-DD)	10
EOB CD	A code which represents a policy for Medicaid claim adjudication. Cannot be empty	Character	4
RARC CD	HIPAA remarks code. May be empty.	Character	5

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7.7 REF-0007-A -- CMS HCPCS UPDATE - CHANGED PROCEDURE CODES FOR CCYY

7.7.1 REF-0007-A -- CMS HCPCS Update - Changed Procedure Codes For CCYY Narrative

The CMS HCPCS Update - Changed Procedure Codes report lists the procedure codes that encountered a change in either long or short description or procedure codes that were re-activated by CMS for the current CMS HCPCS update file.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.7.2 REF-0007-A -- CMS HCPCS Update - Changed Procedure Codes For CCYY Layout

```
Report  : REF-0007-A                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJA105                     MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
Location: REFP0105                   CMS HCPCS UPDATE - CHANGED PROCEDURE CODES                           PAGE   : 999,999
                                                     REPORT PERIOD: CCYY
-------------------------------------------------------------------------------------------------------------------------------
* HCPCS   PROCEDURE                      DATE         DATE
* CODE    DESCRIPTION                    ADDED        TERMINATED    COMMENT
-------------------------------------------------------------------------------------------------------------------------------
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                   No Data This Report *
                                                     * End of Report *
```


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7.7.3 REF-0007-A -- CMS HCPCS Update - Changed Procedure Codes For CCYY Field Descriptions

Field	Description	Length	Data Type
Comment	The field indicates whether the long or short description changed.	40	Character
Date Added	The date the HCPCS code was added to the Healthcare common procedure coding system. This data is taken from field 27 (HCPCS Code Added Date) on the CMS Update file.	10	Date (CCYY/MM/DD)
Date Terminated	Last date for which a procedure code may be used by providers. This data is taken from field 29 (HCPCS Termination Date) on the CMS Update file.	10	Date (CCYY/MM/DD)
HCPCS Code	HCPCS Procedure code that has been discontinued by CMS. This data is taken from field 1 (Healthcare Common Procedure Coding System Code) on the CMS Update file.	5	Character
Procedure Description	The short description of the procedure code. This data is taken from field 8 (HCPCS Short Description) on the CMS Update file.	28	Character

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7.8 REF-0009-A -- CMS HCPCS UPDATE - CHANGED MODIFIER CODES FOR CCYY REPORT

7.8.1 REF-0009-A -- CMS HCPCS Update - Changed Modifier Codes For CCYY Report Narrative

The CMS HCPCS Update - Changed Modifier Codes report lists the modifier codes that encountered a change in either long or short description or modifier codes that were re-activated by CMS for the current CMS HCPCS update file.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.8.2 REF-0009-A -- CMS HCPCS Update - Changed Modifier Codes For CCYY Report Layout

```
Report  : REF-0009-A                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJA105                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME: HH:MM:SS
Location: REFP0105                    CMS HCPCS UPDATE - CHANGED MODIFIER CODES                         PAGE    : 999,999
                                                   REPORT PERIOD : CCYY
-------------------------------------------------------------------------------------------------------------------------------
* MOD     MODIFIER                        DATE         DATE
* CODE    DESCRIPTION                     ADDED        TERMINATED    COMMENT
-------------------------------------------------------------------------------------------------------------------------------
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY   MM/DD/CCYY    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  * No Data This Report *
                                                     * End of Report *
```


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7.8.3 REF-0009-A -- CMS HCPCS Update - Changed Modifier Codes For CCYY Report Field Descriptions

Field	Description	Length	Data Type
Comment	Comment stating that the long description changed for the modifier code.	40	Character
Date Added	The date the HCPCS code was added to the Healthcare common procedure coding system. This data is taken from field 27 (HCPCS Code Added Date) on the CMS Update file.	10	Date (MM/DD/CCYY)
Date Terminated	Last date for which a procedure code may be used by providers. This data is taken from field 29 (HCPCS Termination Date) on the CMS Update file.	10	Date (MM/DD/CCYY)
MOD Code	Modifier to be added. This data is taken from field 4 (HCPCS Modifier Code) on the CMS Update file.	2	Character
Modifier Description	Short description of modifier. This data is taken from field 8 (HCPCS Short Description) on the CMS Update file.	28	Character

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7.9 REF-0011-A -- CMS HCPCS UPDATE - DISCONTINUED MODIFIER CODES REPORT

7.9.1 REF-0011-A -- CMS HCPCS Update - Discontinued Modifier Codes Report Narrative

The CMS HCPCS Update-Discontinued Modifier Codes report lists the modifier codes that are to be discontinued according to the information received on the current CMS HCPCS Update file. They have an action code of 'D' on the HCPCS file meaning 'discontinued'.

Data Source: CMS HCPCS Update File.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed)

The CMS HCPCS Update File record layout can be found on the Reference Input/Output Files page in iTrace.

7.9.2 REF-0011-A -- CMS HCPCS Update - Discontinued Modifier Codes Report Layout

```
Report  : REF-0011-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA105                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time: HH:MM:SS
Location: REFP0105                    CMS HCPCS UPDATE - DISCONTINUED MODIFIER CODES                          Page: 999,999
                                                     REPORT PERIOD : CCYY
-------------------------------------------------------------------------------------------------------------------------------
* MOD     MODIFIER                          DATE           DATE
* CODE    DESCRIPTION                       ADDED          TERMINATED
-------------------------------------------------------------------------------------------------------------------------------
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY     MM/DD/CCYY
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY     MM/DD/CCYY
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY     MM/DD/CCYY
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY     MM/DD/CCYY
  XX      XXXXXXXXXXXXXXXXXXXXXXXXXXXX      MM/DD/CCYY     MM/DD/CCYY


                                                  * No Data This Report *

                                                     * End of Report *
```


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7.9.3 REF-0011-A -- CMS HCPCS Update - Discontinued Modifier Codes Report Field Descriptions

Field	Description	Length	Data Type
Date Added	The date the HCPCS code was added to the Healthcare Common Procedure Coding System.	10	Date (MM/DD/CCYY)
Date Terminated	Last date for which the modifier code may be used by providers.	10	Date (MM/DD/CCYY)
MOD Code	Code that indicates that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.	2	Character
Modifier Description	Short medical description of the modifier code.	28	Character

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7.10 REF-0101-A -- ICD-10 ANNUAL UPDATE - NEW DIAGNOSIS CODES REPORT

7.10.1 REF-0101-A -- ICD-10 Annual Update - New Diagnosis Codes Report Narrative

This report lists the ICD-10 diagnosis codes and their description that are newly added as part of ICD-10 Annual Updates process for the upcoming year. Report is sorted by ICD-10 diagnosis code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.10.2 REF-0101-A -- ICD-10 Annual Update - New Diagnosis Codes Report Layout

```
Report  : REF-0101-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA001                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0101                           ICD-10: NEW DIAGNOSIS CODES                                 Page    : 999,999
                                                 REPORT PERIOD: CCYY

EFFECTIVE DATE OF CODES: MM/DD/CCYY

-------------------------------------------------------------------------------
         CODE      SHORT DESCRIPTION
-------------------------------------------------------------------------------
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------
         TOTAL NEW DIAGNOSIS CODES:   999,999

                                          ** NO DATA THIS RUN **
                                          ***  END OF REPORT  ***
```

7.10.3 REF-0101-A -- ICD-10 Annual Update - New Diagnosis Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 diagnosis code that is newly added into the system.	Character	7
EFFECTIVE DATE OF CODES	The date new ICD-10 diagnosis codes are effective.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
SHORT DESCRIPTION	A short description of ICD-10 diagnosis code that is added into the system.	Character	60
TOTAL NEW DIAGNOSIS CODES	The total number of new ICD-10 diagnosis codes added into the system for the upcoming year.	Number (Integer)	6

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7.11 REF-0102-A -- ICD-10 ANNUAL UPDATE - REVISED DIAGNOSIS CODES REPORT

7.11.1 REF-0102-A -- ICD-10 Annual Update - Revised Diagnosis Codes Report Narrative

This report lists the ICD-10 diagnosis codes that are revised for change to its description as part of ICD-10 Annual Updates process for the upcoming year.
Report is sorted by ICD-10 diagnosis code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.11.2 REF-0102-A -- ICD-10 Annual Update - Revised Diagnosis Codes Report Layout

```
Report  : REF-0102-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJA001                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: REFP0101                         ICD-10: REVISED DIAGNOSIS CODES                              Page    : 999,999
                                                 REPORT PERIOD: CCYY


-------------------------------------------------------------------------------------------------------------------------------
 CODE     BEFORE DESCRIPTION                                                AFTER DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
 TOTAL REVISED DIAGNOSIS CODES:   999,999

                                                 ** NO DATA THIS RUN **
                                                 ***  END OF REPORT  ***
```

7.11.3 REF-0102-A -- ICD-10 Annual Update - Revised Diagnosis Codes Report Field Descriptions

Field	Description	Data Type	Length
AFTER DESCRIPTION	A short description of ICD-10 diagnosis code from the system after revision.	Character	60

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Field	Description	Data Type	Length
BEFORE DESCRIPTION	A short description of ICD-10 diagnosis code from the system before revision.	Character	60
CODE	ICD-10 diagnosis code that is revised for change in code description.	Character	7
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
TOTAL REVISED DIAGNOSIS CODES	The total number of ICD-10 diagnosis codes that encountered change to their description for the upcoming year.	Number (Integer)	6

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7.12 REF-0103-A -- ICD-10 ANNUAL UPDATE - DISCONTINUED DIAGNOSIS CODES REPORT

7.12.1 REF-0103-A -- ICD-10 Annual Update - Discontinued Diagnosis Codes Report Narrative

This report lists the ICD-10 diagnosis codes that are end dated because they are marked for discontinuation as per the ICD-10 Annual Update file.
Report is sorted by ICD-10 diagnosis code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.12.2 REF-0103-A -- ICD-10 Annual Update - Discontinued Diagnosis Codes Report Layout

```
Report  : REF-0103-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJA001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: REFP0101                      ICD-10: DISCONTINUED DIAGNOSIS CODES                           Page    : 999,999
                                                 REPORT PERIOD: CCYY

END DATE OF CODES: MM/DD/CCYY

-------------------------------------------------------------------------------
         CODE      SHORT DESCRIPTION
-------------------------------------------------------------------------------
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------
         TOTAL DISCONTINUED DIAGNOSIS CODES:   999,999

                                            ** NO DATA THIS RUN **
                                            ***  END OF REPORT  ***
```

7.12.3 REF-0103-A -- ICD-10 Annual Update - Discontinued Diagnosis Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 diagnosis code that is discontinued.	Character	7

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Field	Description	Data Type	Length
END DATE OF CODES	The end date for discontinued ICD-10 diagnosis codes within the system.	Date (MM/DD/CCYY)	10
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
SHORT DESCRIPTION	A short description of discontinued ICD-10 diagnosis code from the system.	Character	60
TOTAL DISCONTINUED DIAGNOSIS CODES	The total number of ICD-10 diagnosis codes that are discontinued for the upcoming year.	Number (Integer)	6

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7.13 REF-0104-A -- ICD-10 ANNUAL UPDATE - DIAGNOSIS ERROR REPORT

7.13.1 REF-0104-A -- ICD-10 Annual Update - Diagnosis Error Report Narrative

This report lists the errors that occur during ICD-10 Annual Update process of diagnosis codes. It reports codes, its short description, an action on code while it is processed and a comment about error.
The report lists the errors on codes while it is processed for new addition, revision or discontinuation. It also lists error occurred while updating benefit classification for the diagnosis code.
Action on Code can be:
• A- ADD
• U- UPDATE
• D- DISCONTINUED

Possible comments on error description:
• Invalid Action Code
• Code is less than 3 characters in length
• ADD-Code Already Exists and is Active
• ADD-Code Already Exists and has prior End Date
• ADD-Code Already Exists and No Limits Record
• ADD-Code Already Exists and has Limits Record
• UPDATE-Code Doesn't Exist
• UPDATE-Both Old and New Record Required
• DISCONTINUE-Code Doesn't Exist
• DISCONTINUE-Code Exists but No Limits Record
• DISCONTINUE-Code Exists but has prior End Date
• DISCONTINUE-Error Updating Benefit Classification
• ADD-Error Updating Benefit Classification

Report is sorted by ICD-10 diagnosis code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

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7.13.2 REF-0104-A -- ICD-10 Annual Update - Diagnosis Error Report Layout

```
Report  : REF-0104-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJA001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: REFP0101                         ICD-10: DIAGNOSIS ERROR REPORT                              Page    : 999,999
                                                REPORT PERIOD: CCYY

-------------------------------------------------------------------------------------------------------------------------------
  CODE      SHORT DESCRIPTION                                                ACTION   COMMENT
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
  TOTAL DIAGNOSIS ERRORS: 999,999

                                                  ** NO DATA THIS RUN **
                                                  ***  END OF REPORT  ***
```

7.13.3 REF-0104-A -- ICD-10 Annual Update - Diagnosis Error Report Field Descriptions

Field	Description	Data Type	Length
ACTION	Action on ICD-10 diagnosis code while it is processed. Action on Code can be: A - ADD (for new codes) U - UPDATE (for revised codes) D - DISCONTINUED (for discontinued codes)	Character	1
CODE	ICD-10 diagnosis code for which error occurred.	Character	7
COMMENT	A description about error on code. Error description could be: • Invalid Action Code • Code is less than 3 characters in length • ADD-Code Already Exists and is Active • ADD-Code Already Exists and has prior End Date • ADD-Code Already Exists and No Limits Record • ADD-Code Already Exists and has Limits Record • UPDATE-Code Doesn't Exist • UPDATE-Both Old and New Record Required • DISCONTINUE-Code Doesn't Exist • DISCONTINUE-Code Exists but No Limits Record • DISCONTINUE-Code Exists but has prior End Date	Character	50

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Field	Description	Data Type	Length
	• DISCONTINUE-Error Updating Benefit Classification • ADD-Error Updating Benefit Classification		
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
SHORT DESCRIPTION	A short description of ICD-10 diagnosis code for which error occurred.	Character	60
TOTAL DIAGNOSIS ERRORS	The total number of diagnosis errors that are reported. This included errors while processing diagnosis code for addition, revision or discontinuation and errors while updating benefit classification for diagnosis codes.	Number (Integer)	6

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7.14 REF-0105-A -- ICD-10 ANNUAL UPDATE - DIAGNOSIS SUMMARY REPORT

7.14.1 REF-0105-A -- ICD-10 Annual Update - Diagnosis Summary Report Narrative

This report lists the summary of ICD-10 Annual Update process for diagnosis codes. It reports the number of records and transactions read from the annual update file for ICD-10 diagnosis codes, number of ICD-10 diagnosis codes added, revised for code description and discontinued. It also lists the number of codes that encountered error while processing it for new addition, revision or discontinuation and number of benefit classification errors.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.14.2 REF-0105-A -- -- ICD-10 Annual Update - Diagnosis Summary Report Layout

```
Report  : REF-0105-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA001                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0101                          ICD-10: DIAGNOSIS SUMMARY REPORT                             Page    : 999,999
                                                 REPORT PERIOD: CCYY


                    *  TOTAL RECORDS READ                    ==================>       999999999
                    *  TOTAL TRANSACTIONS READ               ==================>       999999999


                    *  NUMBER OF CODES ADDED                 ==================>    =  999999999
                    *  NUMBER OF CODES UPDATED               ==================>    =  999999999
                    *  NUMBER OF CODES DISCONTINUED          ==================>    =  999999999
                    *  NUMBER OF CODES WITH ERRORS           ==================>    =  999999999
                    *  NUMBER OF BNFT CLASSIFICATION ERRORS  ==================>    =  999999999
                                                                                     ----------
                    *  TOTAL                                 ==================>       999999999
                                                                                    ==========

                                             ** NO DATA THIS RUN **
                                             ***  END OF REPORT  ***
```


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7.14.3 REF-0105-A -- -- ICD-10 Annual Update - Diagnosis Summary Report Field Descriptions

Field	Description	Data Type	Length
NUMBER OF BNFT CLASSIFICATION ERRORS	The total number of errors when updating benefit classification for ICD-10 diagnosis codes in annual update file for the upcoming year. Note: This count is not included in count of field TOTAL on this report.	Number (Integer)	9
NUMBER OF CODES ADDED	The total number of new ICD-10 diagnosis codes added for the upcoming year.	Number (Integer)	9
NUMBER OF CODES DISCONTINUED	The total number of ICD-10 diagnosis codes that are discontinued for the upcoming year.	Number (Integer)	9
NUMBER OF CODES UPDATED	The total number of ICD-10 diagnosis codes that encountered change to their description for the upcoming year	Number (Integer)	9
NUMBER OF CODES WITH ERRORS	The total number of ICD-10 diagnosis codes that encountered error while processing it for new addition, revision to its description or discontinuation for the upcoming year.	Number (Integer)	9
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
TOTAL	The total number of ICD-10 diagnosis codes that are processed from the annual update file for the upcoming year. This count will be sum of counts from: - NUMBER OF CODES ADDED - NUMBER OF CODES UPDATED - NUMBER OF CODES DISCONTINUED - NUMBER OF CODES WITH ERRORS Note: This count doesn't include count of field NUMBER OF BNFT CLASSIFICATION ERRORS.	Number (Integer)	9
TOTAL RECORDS READ	The total number of ICD-10 diagnosis records read from the annual update file for the upcoming year.	Number (Integer)	9
TOTAL TRANSACTIONS READ	The total number of ICD-10 diagnosis transactions read from the annual update file for upcoming year.	Number (Integer)	9

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7.15 REF-0106-A -- ICD-10 ANNUAL UPDATE - DIAGNOSIS BENEFIT CATEGORY GROUPINGS REPORT

7.15.1 REF-0106-A -- ICD-10 Annual Update - Diagnosis Benefit Category Groupings Report Narrative

This report lists the diagnosis benefit category created while processing the ICD-10 diagnosis code to update the benefit classification data. It reports ICD-10 diagnosis code, action on code while it is processed and name of benefit category grouping. Report is sorted by ICD-10 diagnosis code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.15.2 REF-0106-A -- ICD-10 Annual Update - Diagnosis Benefit Category Groupings Report Layout

```
Report  : REF-0106-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJA001                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: REFP0101                   ICD-10: DIAGNOSIS BENEFIT CATEGORY GROUPINGS                      Page    : 999,999
                                                REPORT PERIOD: CCYY


-------------------------------------------------------------------------------------------------------------------------------
 CODE      ACTION      GROUPING
-------------------------------------------------------------------------------------------------------------------------------
 XXXXXXX     X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX     X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX     X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX     X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX     X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
 TOTAL OF NEW DIAGNOSIS BENEFIT CATEGORY GROUPINGS:  999,999

                                              ** NO DATA THIS RUN **
                                              ***  END OF REPORT  ***
```

7.15.3 REF-0106-A -- ICD-10 Annual Update - Diagnosis Benefit Category Groupings Report Field Descriptions

Field	Description	Data Type	Length
ACTION	Action of ICD-10 diagnosis code while it is processed. It can be: A- ADD (for new codes)	Character	1

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Field	Description	Data Type	Length
	D- DISCONTINUED (for discontinued codes)		
CODE	The ICD-10 diagnosis code for which a new diagnosis benefit category grouping is created.	Character	7
GROUPING	A diagnosis benefit category grouping that is created while processing ICD-10 diagnosis code for a given action.	Character	100
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
TOTAL OF NEW DIAGNOSIS BENEFIT CATEGORY GROUPINGS	The total number of diagnosis benefit category groupings that are created.	Number (Integer)	6

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7.16 REF-0107-A -- ICD-10 ANNUAL UPDATE - ASSOCIATED GROUPS FOR DISCONTINUED DIAGNOSIS CODES

7.16.1 REF-0107-A -- ICD-10 Annual Update - Associated Groups for Discontinued Diagnosis Codes Report Narrative

This report lists each diagnosis group that an ICD-10 diagnosis code that has been discontinued is part of. If the discontinued code is not part of any group, it is not reported. The report will contain the Group type, its long description, then each code within that group, and its short description.
Report is sorted by Group type and ICD-10 Diagnosis Code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Diagnosis Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for diagnosis codes can be found on the Reference Input/Output Files page in iTRACE.

7.16.2 REF-0107-A -- ICD-10 Annual Update - Associated Groups for Discontinued Diagnosis Codes Report Layout

```
Report  : REF-0107-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA001                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0101             ICD-10: ASSOCIATED GROUPS FOR DISCONTINUED DIAGNOSIS CODES                Page    : 999,999
                                         REPORT PERIOD: CCYY


-------------------------------------------------------------------------------------------------------------------------------
 GROUP TYPE     LONG DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                 CODE      SHORT DESCRIPTION
                 ---------------------------------------------------------------------
                 XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------

*** This report only identifies codes associated with a group ***

                                                 ** NO DATA THIS RUN **
                                                 ***  END OF REPORT  ***
```


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7.16.3 REF-0107-A -- ICD-10 Annual Update - Associated Groups for Discontinued Diagnosis Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 discontinued diagnosis code that is associated to this group.	Character	7
GROUP TYPE	Indicates the diagnosis group.	Number (Integer)	9
LONG DESCRIPTION	Definition of where and/or how this diagnosis group is used.	Character	4000
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number	4
SHORT DESCRIPTION	A short description of the ICD-10 discontinued diagnosis code.	Character	60

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7.17 REF-0120-A -- LAB FEE UPDATE EXCEPTIONS REPORT

7.17.1 REF-0120-A -- Lab Fee Update Exceptions Report Narrative

The Lab Fee Update Exceptions Report compares the Medicare Lab Fee Schedule and the Alabama Level 3 to determine matching codes. All of the procedures on the Medicare file are reported showing the equivalent Level 3 file pricing data. Asterisks on the report, flag the condition of the Medicare rate being less than the Medicaid rate.

Data Source: Cahaba Government Benefit Administration.

Frequency: Annually (Additional updates/corrections may be received throughout the year as needed).

7.17.2 REF-0120-A -- Lab Fee Update Exceptions Report Layout

```
Report  : REF-0120-A                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJA0120                     MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
Location: REFP0120                      ANNUAL LAB FEE UPDATE EXCEPTION REPORT                                   PAGE: 99999
                                                   REPORT PERIOD: CCYY

-------------------------------------------------------------------------------------------------------------------------------
PROC      MOD  CODE                                        ERROR
CODE           DESCRIPTION                                 DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------
XXXXX     XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX     XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX     XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX     XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXX     XX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                  **  END OF REPORT  **
                                                 ** NO DATA THIS RUN **
```


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7.17.3 REF-0120-A -- Lab Fee Update Exceptions Report Field Descriptions

Field	Description	Length	Data Type
Code Description	The description of the procedure code for which lab fee was being updated for.	38	Character
Error Description	Text describing the lab fee update exception.	72	Character
MOD	Procedure code modifier.	2	Character
PROC Code	HCPCS Procedure Code for which lab fee was being updated for.	5	Character

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7.18 REF-0126-Q--FEE SCHEDULE FOR LAB AND X-RAY CODES REPORT

7.18.1 REF-0126-Q--Fee Schedule for Lab and X-ray Codes Report Narrative

This Reference report is a Fee Schedule for providers for all the Lab and X-ray procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.18.2 REF-0126-Q--Fee Schedule for Lab and X-ray Codes Report Layout

```
                                MAXIMUM
      PROCEDURE CODE            ALLOWED         MAXIMUM
                                AMOUNT          QUANTITY
-------------------------------------------------------------------


         XXXXX                $999999.99          999
         XXXXX                $999999.99          999
         XXXXX                $999999.99          999
         XXXXX                $999999.99          999
         XXXXX                $999999.99          999
         XXXXX                $999999.99          999
         XXXXX                $999999.99          999


                                          ***   END OF REPORT   ***
```

7.18.3 REF-0126-Q--Fee Schedule for Lab and X-ray Codes Report Field Descriptions

Field	Description	Data Type	Length
Maximum Allowed Amount	Identifies the Medicaid maximum allowed amount.	Number (Decimal)	8
Maximum Quantity	Identifies the Medicaid maximum allowed quanitity.	Number (Decimal)	3
Procedure Code	Identifies the type of procedure.	Character	5

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7.19

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7.20 REF-0127-Q--FEE SCHEDULE FOR OUTPATIENT CODES REPORT

7.20.1 REF-0127-Q--Fee Schedule for Outpatient Codes Report Narrative

This Reference report is a Fee Schedule for providers for all the Outpatient procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.20.2 REF-0127-Q--Fee Schedule for Outpatient Codes Report Layout

```
                        MAXIMUM                      UNDER 21
      PROCEDURE         ALLOWED         REQUIRES    RESTRICTION
        CODE            AMOUNT             PA        INDICATOR
-------------------------------------------------------------------


      XXXXX             $999999.99         XXX          X
      XXXXX             $999999.99         XXX          X
      XXXXX             $999999.99         XXX          X
      XXXXX             $999999.99         XXX          X
      XXXXX             $999999.99         XXX          X
      XXXXX             $999999.99         XXX          X



                                      ***   END OF REPORT   ***
```


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7.20.3 REF-0127-Q--Fee Schedule for Outpatient Codes Report Field Descritions

Field	Description	Data Type	Length
Maximum Allowed Amount	Identifies the Medicaid maximum allowed amount.	Number (Decimal)	8
Procedure Code	Identifies the type of procedure.	Character	5
Requires PA	Indicates if a current prior authorization is required or if there was a previous prior authorization required. This indicator is either X for PA Required or Blank for No PA Required.	Character	1
Under 21 Restriction Indicator	Indicates if this procedure code has a restriction for those under the age of 21. Indicated by an X for restriction or blank if no restrictions.	Character	1

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7.21 REF-0128-Q--FEE SCHEDULE FOR DENTAL CODES REPORT

7.21.1 REF-0128-Q--Fee Schedule for Dental Codes Report Narrative

This Reference report is a Fee Schedule for providers for all the Dental procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.21.2 REF-0128-Q--Fee Schedule for Dental Codes Report Layout

```
                        MAXIMUM
      PROCEDURE         ALLOWED         REQUIRES      MAXIMUM
        CODE            AMOUNT             PA         QUANTITY
-------------------------------------------------------------------


      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9
      XXXXX              $999999.99       XXX             9


                                     ***   END OF REPORT   ***
```


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7.21.3 REF-0128-Q--Fee Schedule for Dental Codes Report Field Descriptions

Field	Description	Data Type	Length
Maximum Allowed Amount	The maximum amount that will pay.	Number (Decimal)	8
Maximum Quantity	Indicates the maximum number of units the allowable price is based.	Number (Integer)	3
Procedure Code	This field indicates the code that describes what procedure was performed by the provider.	Character	5
Requires PA	Indicates if a current prior authorization is required. This indicator is either YES for PA Required or Blank for NO PA Required.	Character	3

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7.22 REF-0129-Q--FEE SCHEDULE FOR PHYSICIAN CODES REPORT

7.22.1 REF-0129-Q--Fee Schedule for Physician Codes Report Narrative

This Reference report is a Fee Schedule for providers for all Physician procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.22.2 REF-0129-Q--Fee Schedule for Physician Codes Report Layout

```
                    MAXIMUM
       PROCEDURE          ALLOWED                    REQUIRES     MAXIMUM
         CODE             AMOUNT          MODIFIER       PA       QUANTITY
-------------------------------------------------------------------------


       XXXXX               $999999.99       XX           XXX           9
       XXXXX               $999999.99       XX           XXX           9
       XXXXX               $999999.99       XX           XXX           9
       XXXXX               $999999.99       XX           XXX           9
       XXXXX               $999999.99       XX           XXX           9
       XXXXX               $999999.99       XX           XXX           9




                                                 ***   END OF REPORT   ***
```


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7.22.3 REF-0129-Q--Fee Schedule for Physician Codes Report Fiedl Descriptions

Field	Description	Data Type	Length
Maximum Allowed Amount	Identifies the Medicaid maximum allowed amount.	Number (Decimal)	8
Maximum Quantity	Indicates the maximum number of units that the allowable price is based on.	Number (Integer)	4
Modifier	Indicates the modifier needed for this procedure code.	Character	2
Procedure Code	Identifies the type of procedure.	Character	7
Requires PA	Indicates if a current prior authorization is required. This indicator is either Y for PA Required or Blank for No PA Required.	Character	1

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7.23 REF-0130-Q--PHYSICIAN DRUG FEE SCHEDULE REPORT

7.23.1 REF-0130-Q--Physician Drug Fee Schedule Report Narrative

This Reference report is a Fee Schedule for providers for all the physician drug procedure codes.

This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.23.2 REF-0130-Q--Physician Drug Fee Schedule Report Layout

```
                                                        MAXIMUM
      PROCEDURE    PROCEDURE                            ALLOWED         REQUIRES      MAXIMUM
        CODE       DESCRIPTION                          AMOUNT             PA         QUANTITY
-------------------------------------------------------------------------------------------------------


      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999
      XXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       $999999.99        XXX           999



                                          ***   END OF REPORT   ***
```


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7.23.3 REF-0130-Q--Physician Drug Fee Schedule Report Field Descriptions

Field	Description	Data Type	Length
Maximum Allowed Amount	Identifies the Medicaid maximum allowed amount.	Number (Decimal)	8
Maximum Quantity	Indicates the number of units the allowable price is based.	Number (Integer)	3
Procedure Code	Identifies the type of procedure.	Character	5
Procedure Description	Provides a description of the procedure code.	Character	50
Requires PA	Indicates if a current prior authorization is required. This indicator is either 'YES' for PA Required or 'NO' for No PA Required.	Character	3

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7.24 REF-0131-Q--APPENDIX I REPORT

7.24.1 REF-0131-Q--Appendix I Report Narrative

This Reference report is an Appendix for providers with all the outpatient procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.24.2 REF-0131-Q--Appendix I Report Layout

```
                        MAXIMUM                                UNDER 21
      PROCEDURE         ALLOWED         REQUIRES    MAXIMUM    RESTRICTION
        CODE            AMOUNT             PA       QUANTITY    INDICATOR
-----------------------------------------------------------------------------


      XXXXX              $999999.99        XXX          9         X
      XXXXX              $999999.99        XXX          9         X
      XXXXX              $999999.99        XXX          9         X
      XXXXX              $999999.99        XXX          9         X
      XXXXX              $999999.99        XXX          9         X




                                          ***   END OF REPORT   ***
```


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7.24.3 REF-0131-Q--Appendix I Report Field Descriptions

Field	Description	Data Type	Length
Maximum Allowed Amount	Identifies the Medicaid maximum allowed amount.	Number (Decimal)	8
Maximum Quantity	Indicates the Medicaid maximum units of service allowed.	Number (Integer)	3
Procedure Code	Identifies the five digit HCPCS procedure code.	Character	5
Requires PA	Indicates if a current prior authorization is required. This indicator is either 'X' for PA Required or Blank for No PA Required.	Character	1
Under 21 Restriction Indicator	Indicates any procedure codes that have a restriction for recipients under the age of 21.	Character	1

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7.25 REF-0132-Q--FEE SCHEDULE FOR DME REPORT

7.25.1 REF-0132-Q--Fee Schedule for DME Report Narrative

This Reference report is a Fee Schedule for providers for all DME procedure codes. This report sorts in ascending order on the Procedure Code column.

Data Source: Reference

Frequency: Quarterly

7.25.2 REF-0132-Q--Fee Schedule for DME Report Layout

PROCEDURE CODE	PROCEDURE DESCRIPTION	MOD	ALLOWED AMOUNT	BENEFIT LIMIT	EPSDT REFERRAL	REQUIRES PA
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X
XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	$999,999.99	999	X	X

*** END OF REPORT ***

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7.25.3 REF-0132-Q--Fee Schedule for DME Report Field Descriptions

Field	Description	Data Type	Length
Allowed Amount	Identifies the Medicaid maximum allowed amount	Number (Decimal)	8
Benefit Limit	Indicates the number of units the allowable price is based.	Number	3
EPSDT Referral	Indicates if a current EPSDT referral is required. This indicator is either X for EPSDT referral required or blank for no EPSDT referral required	Character	1
Mod	Indicates the modifier needed for this procedure code.	Character	2
Procedure Code	Identifies the type of procedure.	Character	5
Procedure Description	Description of the procedure.	Character	30
Requires PA	Indicates if a current prior authorization is required. This indicator is either X for PA Required or Blank for No PA Required.	Character	1

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7.26 REF-0200-M -- AUDIT CRITERIA REPORT

7.26.1 REF-0200-M -- Audit Criteria Report Narrative

The Audit Criteria report lists the general audit criteria for each parameter driven audit in the system. It includes all of the different indicators that are used to define the criteria to be included and excluded on an audit such as claim type, procedure code, level of care, etc. The effective dates of the audit are also reported, as well as the type of audit.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.26.2 REF-0200-M -- Audit Criteria Report Layout

```
Report  : REF-0200-M                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
Process : REFJM200                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME: HH:MM:SS
Location: REFP0200                              AUDIT CRITERIA REPORT                                                   PAGE: 99999
                                                REPORT PERIOD: MM/CCYY

                                            --------INCLUDE/EXCLUDE ------  ---SAME/DIFF-----  --MISC--
                                                                                          T         T
                          D O                   P S     D            H P    P P P D T T Q        J D
                        P E V                 P   R P A M I R T N T G G I A  C A R R I N S U P  S   C I
ERROR            AUDT   R N E EFFECTIVE  END   G C T E G O A E O D C P C C Y  L Y O O A U F A O  E P D A
CODE DESCRIPTION TYPE LVL E Y R DATE       DATE  M T P C E D G V B C L I N L R  M R V C G M C D S  X A E G  ---REF OVERRIDE---
9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXX XXX X X X CCYY/MM/DD CCYY/MM/DD X X X X X X X X X X X X X X X X  X X X X X X X X X  X X X X  XXXXXXXXXXXXXXXXXX
9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXX XXX X X X CCYY/MM/DD CCYY/MM/DD X X X X X X X X X X X X X X X X  X X X X X X X X X  X X X X  XXXXXXXXXXXXXXXXXX
9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXX XXX X X X CCYY/MM/DD CCYY/MM/DD X X X X X X X X X X X X X X X X  X X X X X X X X X  X X X X  XXXXXXXXXXXXXXXXXX
9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXX XXX X X X CCYY/MM/DD CCYY/MM/DD X X X X X X X X X X X X X X X X  X X X X X X X X X  X X X X  XXXXXXXXXXXXXXXXXX


                                              ***   END OF REPORT   ***
                                             ***   NO DATA THIS RUN   ***
```


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7.26.3 REF-0200-M -- Audit Criteria Report Field Descriptions

Field	Description	Length	Data Type
Audit Type	Identifies the type of audit. This can be limit, contra-indicated, conflict, umbrella, bundling, unbundling, negative contra-indicated or Step Therapy.	4	Character
Deny	Indicates if the audit can be user-denied if it suspends for data correction or review.	1	Character
Description	The description of the error code.	40	Character
Effective Date	The date of service the audit criteria will apply for claims processing.	10	Date (CCYY/MM/DD)
End Date	The date of service the audit criteria ceases to apply for claims processing.	10	Date (CCYY/MM/DD)
Error Code	Indicates the error code for which the audit criteria pertains	4	Number (Integer)
Include/Exclude Age	Indicates if a recipient's age is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude CT	Indicates if a claim type is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude Diag	Indicates if a diagnosis code is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude GCN	Indicates if a GCN sequence number is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude GPI	Indicates if a generic price indicator is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude HICL	Indicates if a HICL number is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude Mod	Indicates if a procedure code is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character

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Field	Description	Length	Data Type
Include/Exclude NDC	Indicates if a National Drug Code is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude Payer	Indicates if a Payer is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude PGM	Indicates if a program is included, excluded, or not considered in the audit criteria. It also indicates if claims in history for either the same, different, or all programs should be used for auditing. The valid values are: None/Audit All Programs - blank; Include/Audit All Programs - I; Exclude/Audit All Programs - E; None/Audit Same Program - P; Include/Audit Same Program- N; Exclude/Audit Same Program - X	1	Character
Include/Exclude PRTP	Indicates if a provider type is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude REV	Indicates if a revenue code is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude SPEC	Indicates if a provider specialty is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude TCL	Indicates if a therapeutic class is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
Include/Exclude TOB	Indicates if a type of bill is included (I), excluded (E), or not considered (blank) in the audit criteria.	1	Character
LVL	Identifies whether the audit will be set at the header (HDR) or detail (DTL) level.	3	Character
Misc Jcde	Indicates if a HCPCS J code that corresponds to an NDC code is included in the audit criteria.	1	Character
Misc PA	Indicates if the audit can be overridden with a prior authorization.	1	Character
Misc Sex	Indicates which sex should be included in the audit criteria.	1	Character

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Field	Description	Length	Data Type
Misc T diag	Indicates whether the diagnosis code(s) to be checked is (A)dmit, (D)ischarge, (E)mergency, (P)rimary, (S)econdary, (space)any	1	Character
Over	Indicates if the audit can be overridden if it suspends for data correction or review.	1	Character
PRE	Indicates if the audit is considered a pre-emptive audit that will cause the system to bypass claims with this audit set for processing in Claim Check.	1	Character
Ref Override	Specifies criterion for bypassing an audit based on the presence of a referring provider on the claim being audited. Values are 'A' (any), 'P' (PCCM) and space (not considered).	18	Character
Same/Diff Clm	Indicates if auditing is performed only on details of the same claim (S), different claims (D), or both (same and different).	1	Character
Same/Diff Diag	Indication of whether the same or different primary diagnosis is to be used in the audit criteria.	1	Character
Same/Diff Payr	This code defines the Payer "scope" of the audit. A value of "S" indicates only services with the same payer as the current service are considered in the audit. A value of "D" indicates only services from different payers from the current service are considered in the audit. A value of "A" means all services are considered in the audit regardless of payer.	1	Character
Same/Diff Pos	Indication of whether same or different billing provider location is to be used in the audit criteria. The valid values are "S" - Same, "D" - Different and space - "BOTH".	1	Character
Same/Diff Proc	Indicates if the same (S) or different (D) procedure code must be on the history claim in order to be used in the audit criteria.	1	Character
Same/Diff Prov	Indicates if the same (S) or different (D) provider number must be on the history claim in order to be used in the audit criteria.	1	Character

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Field	Description	Length	Data Type
Same/Diff Tnum	Indicates if the same (S) or different (D) tooth number must be on the history claim in order to be used in the audit criteria.	1	Character
Same/Diff Tquad	Indication of whether matching should be done on quadrant between the current and history claim. Values are (C)omplete, (I)nclusive, (P)artial and (E)xclusive	1	Character
Same/Diff Tsfc	Indicates if the same (S) or different (D) tooth surface number must be on the history claim in order to be used in the audit criteria.	1	Character

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7.27 REF-0201-M -- LIMITATION AUDIT CRITERIA REPORT

7.27.1 REF-0201-M -- Limitation Audit Criteria Report Narrative

The Limitation Audit Criteria report contains the time, limitation, and procedure criteria used by limitation audits. This includes the unit type (units or dollars), time unit (months, days, years, etc), limit amounts (quantity or dollar amount), compensable day criteria for inpatient claims, and other information needed to define a limitation audit. Procedure code ranges and modifiers associated with the audit are also listed on the report. Report sorts by Error Code.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.27.2 REF-0201-M -- Limitation Audit Criteria Report Layout

```
Report  : REF-0201-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJM201                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: REFR201M                         LIMITATION AUDIT CRITERIA REPORT                                 Page:      99999
                                                   REPORT PERIOD: MM/CCYY
                 BENEFIT                                            RECALC          BENEFIT --- PROCEDURES --
ERROR              CAT  UNIT                 TIME UNITS  MONEY     COMP CONSEC 50% -LIMIT- FROM   TO            CONVERSION
CODE  DESCRIPTION  SUSP  TYPE   TIME UNIT     SPAN LIMIT  LIMIT   POS DAYS DAYS   RED CAT KEY PROC   PROC   MOD      FACTOR
9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XX  XXXXXX  XXXXXXXXXXXXXX XXXX 999999 99999999  X  X     X     X   XX X   XXXXXX XXXXXX  XX     99999.9999
9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XX  XXXXXX  XXXXXXXXXXXXXX XXXX 999999 99999999  X  X     X     X   XX X   XXXXXX XXXXXX  XX     99999.9999
9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XX  XXXXXX  XXXXXXXXXXXXXX XXXX 999999 99999999  X  X     X     X   XX X   XXXXXX XXXXXX  XX     99999.9999
9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XX  XXXXXX  XXXXXXXXXXXXXX XXXX 999999 99999999  X  X     X     X   XX X   XXXXXX XXXXXX  XX     99999.9999
9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                    XX  XXXXXX  XXXXXXXXXXXXXX XXXX 999999 99999999  X  X     X     X   XX X   XXXXXX XXXXXX  XX     99999.9999
                                                  ***   END OF REPORT   ***
                                                 ***   NO DATA THIS RUN   ***
```


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7.27.3 REF-0201-M -- Limitation Audit Criteria Report Field Descriptions

Field	Description	Length	Data Type
50% Red	Indicates if the units should be halved if first claim is after July 1. This is used by limitations applied to leave days from nursing homes.	1	Character
Benefit Limit Cat	Benefit category	2	Character
Benefit Limit Key	Benefit limit key	1	Character
Consec Days	Indicates if the number of days must be consecutive	1	Character
Conversion Factor	Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations. Format is 99999.9999.	9	Number (Decimal)
Description	The description of the error code	40	Character
Error Code	Indicates the error code for which the audit criteria pertains	4	Number (Integer)
MOD	The modifier value(s) that applies to the current procedure code range.	2	Character
Money Limit	Specifies the maximum dollar amount allowed in the time span of time units specified.	8	Number (Decimal)
POS	Indicates whether place of service will be used as a limit criteria.	1	Character
Procedures - From Proc	Related to both the current and history claims, it is the first procedure code in a range of procedure codes used to define audit the criteria.	5	Character
Procedures - Proc Mod	The modifier value(s) that applies to the current procedure code range.	2	Character
Procedures - To Proc	Related to both the current and history claims, it is the last procedure code in a range of procedure codes used to define audit the criteria.	5	Character

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Field	Description	Length	Data Type
Recalc Comp Days	Indicates if the number of compensable days should be recalculated.	1	Character
Time Span	The number of days, months, years, etc of history that needs to be examined and compared to the current detail when the audit is being performed.	4	Number (Integer)
Time Unit	Indicates which time unit of measure should be used for the audit. The values are Days, Months, Calendar Months, Years, Fiscal Year, 1st Trimester, 2nd Trimester, 3rd Trimester, Days From Discharge, and Per Pregnancy.	14	Character
Unit Type	Indicates the unit of measure to be used by the audit. The values are Units, Money, Days, Rx, and Both (units and money).	6	Character
Units Limit	Specifies the maximum number of units allowed in the time span of time units specified.	6	Number (Decimal)

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7.28 REF-0201-A -- ICD-10 ANNUAL UPDATE - NEW PROCEDURE CODES REPORT

7.28.1 REF-0201-A -- ICD-10 Annual Update - New Procedure Codes Report Narrative

This report lists the ICD-10 procedure codes and their description that are newly added as part of ICD-10 Annual Updates process for the upcoming year.

Report is sorted by ICD-10 procedure code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

7.28.2 REF-0201-A -- ICD-10 Annual Update - New Procedure Codes Report Layout

```
Report  : REF-0201-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA002                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0102                           ICD-10: NEW PROCEDURE CODES                                 Page    : 999,999
                                                 REPORT PERIOD: CCYY

EFFECTIVE DATE OF CODES: MM/DD/CCYY

-------------------------------------------------------------------------------
         CODE      SHORT DESCRIPTION
-------------------------------------------------------------------------------
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------
         TOTAL NEW PROCEDURE CODES:   999,999

                                          ** NO DATA THIS RUN **
                                          ***  END OF REPORT  ***
```

7.28.3 REF-0201-A -- ICD-10 Annual Update - New Procedure Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 procedure code that is newly added into the system	Character	7
EFFECTIVE DATE OF CODES	The date new ICD-10 procedure codes are effective.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
SHORT DESCRIPTION	A short description of ICD-10 procedure code that is added into the system.	Character	60
TOTAL NEW PROCEDURE CODES	The total number of new ICD-10 procedure codes added into the system for the upcoming year.	Number (Integer)	6

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7.29 REF-0202-M -- CONTRA-INDICATED AUDIT CRITERIA REPORT

7.29.1 REF-0202-M -- Contra-Indicated Audit Criteria Report Narrative

The Contra Indicated Audit Criteria report contains the time, units, and procedure criteria used by contra-indicated audits. This includes the time unit (months, days, years, etc), number of days before/after the current service, and direction of the audit needed to define a contra-indicated audit. Procedure code ranges and modifiers associated with the audit are also listed on the report for both the current and history claims.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.29.2 REF-0202-M -- Contra-Indicated Audit Criteria Report Layout

```
Report  : REF-0202-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : REFJM202                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
Location: REFP0202                    CONTRA-INDICATED AUDIT CRITERIA REPORT                                   PAGE: 99999
                                              REPORT PERIOD: MM/CCYY

                                                                                          ------------- PROCEDURES ------------
                                                                                          ----- CURRENT ---- ----- HISTORY ----
ERROR                                      AUDT            BEFORE BEFORE AFTER            FROM   TO     PROC FROM   TO     PROC
CODE  DESCRIPTION                          TYPE TIME UNIT  AFTER  UNITS  UNITS DIRECTION  PROC   PROC   MOD  PROC   PROC   MOD

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXX  XXXXXXXXXX  XXXXX  9999   9999   XXXXXX    XXXXX  XXXXX   XX   XXXXX  XXXXX   XX
                                                                                          XXXXX  XXXXX   XX   XXXXX  XXXXX   XX

                                                  ***   END OF REPORT   ***
                                                ***   NO DATA THIS RUN   ***
```

7.29.3 REF-0202-M -- Contra-Indicated Audit Criteria Report Field Descriptions

Field	Description	Length	Data Type
After Units	Specifies the number of units in history that should be checked after a claim's dates of service.	4	Number (Integer)
Audit Type	Identifies the type of audit. This can be either contra-indicated (CONT) or negative contra-indicated (NCON).	4	Character
Before After	Indicates when the time limit specified should be checked for the claim's dates of service in history.	6	Character

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Field	Description	Length	Data Type
Before Units	Specifies the number of units in history that should be checked before a claim's dates of service.	4	Number (Integer)
Description	The description of the error code.	40	Character
Direction	Indicates whether the audit is a one-way (history against current) or two-way audit (history against current and current against history).	7	Character
Error Code	Indicates the error code for which the audit criteria pertains.	4	Number (Integer)
Procedures - Current - From Proc	Related to the current claim, it is the first procedure code in a range of procedure codes used to define audit the criteria.	5	Character
Procedures - Current - Proc Mod	The modifier value(s) that applies to the current procedure code range.	2	Character
Procedures - Current - To Proc	Related to the current claim, it is the last procedure code in a range of procedure codes used to define audit the criteria.	5	Character
Procedures - History - From Proc	Related to the claim in history, it is the first procedure code in a range of procedure codes used to define audit the criteria.	5	Character
Procedures - History - Proc Mod	The modifier value(s) that applies to the history procedure code range.	2	Character
Procedures - History - To Proc	Related to the claim in history, it is the last procedure code in a range of procedure codes used to define audit the criteria.	5	Character
Time Unit	Indicates which unit of measure should be used for the audit. The values are Days, Months, and Years.	11	Character

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7.30 REF-0202-A -- ICD-10 ANNUAL UPDATE - REVISED PROCEDURE CODES REPORT

7.30.1 REF-0202-A -- ICD-10 Annual Update - Revised Procedure Codes Report Narrative

This report lists the ICD-10 procedure codes that are revised for change to its description as part of ICD-10 Annual Updates process for the upcoming year.

Report is sorted by ICD-10 procedure code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

7.30.2 REF-0202-A -- ICD-10 Annual Update - Revised Procedure Codes Report Layout

```
Report  : REF-0202-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA002                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0102                         ICD-10: REVISED PROCEDURE CODES                               Page    : 999,999
                                                 REPORT PERIOD: CCYY


-------------------------------------------------------------------------------------------------------------------------------
 CODE     BEFORE DESCRIPTION                                                AFTER DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
 TOTAL REVISED PROCEDURE CODES:   999,999

                                                 ** NO DATA THIS RUN **
                                                 ***  END OF REPORT  ***
```

7.30.3 REF-0202-A -- ICD-10 Annual Update - Revised Procedure Codes Report Field Descriptions

Field	Description	Data Type	Length
AFTER DESCRIPTION	A short description of ICD-10 procedure code from the system after revision.	Character	60
BEFORE DESCRIPTION	A short description of ICD-10 procedure code from the system before revision.	Character	60

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Field	Description	Data Type	Length
CODE	ICD-10 procedure code that is revised for change in code description.	Character	7
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
TOTAL REVISED PROCEDURE CODES	The total number of ICD-10 procedure codes that encountered change to their description for the upcoming year.	Number (Integer)	6

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7.31 REF-0203-A -- ICD-10 ANNUAL UPDATE - DISCONTINUED PROCEDURE CODES REPORT

7.31.1 REF-0203-A -- ICD-10 Annual Update - Discontinued Procedure Codes Report Narrative

This report lists the ICD-10 procedure codes that are end dated because they are marked for discontinuation as per the ICD-10 Annual Update file.
Report is sorted by ICD-10 procedure code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

7.31.2 REF-0203-A -- ICD-10 Annual Update - Discontinued Procedure Codes Report Layout

```
Report  : REF-0203-A                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJA002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: REFP0102                      ICD-10: DISCONTINUED PROCEDURE CODES                           Page    : 999,999
                                                 REPORT PERIOD: CCYY

END DATE OF CODES: MM/DD/CCYY

-------------------------------------------------------------------------------
         CODE      SHORT DESCRIPTION
-------------------------------------------------------------------------------
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------
         TOTAL DISCONTINUED PROCEDURE CODES:   999,999

                                                ** NO DATA THIS RUN **
                                                ***  END OF REPORT  ***
```

7.31.3 REF-0203-A -- ICD-10 Annual Update - Discontinued Procedure Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 procedure code that is discontinued.	Character	7
END DATE OF CODES	The end date for discontinued ICD-10 procedure codes within the system.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
SHORT DESCRIPTION	A short description of discontinued ICD-10 procedure code from the system.	Character	60
TOTAL DISCONTINUED PROCEDURE CODES	The total number of ICD-10 procedure codes that are discontinued for the upcoming year.	Number (Integer)	6

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7.32 REF-0204-A -- ICD-10 ANNUAL UPDATE - PROCEDURE ERROR REPORT

7.32.1 REF-0204-A -- ICD-10 Annual Update - Procedure Error Report Narrative

This report lists the errors that occur during ICD-10 Annual Update process of procedure codes. It reports codes, its short description, an action on code while it is processed and a comment about error.
The report lists the errors on codes while it is processed for new addition, revision or discontinuation. It also lists error occurred while updating benefit classification for the procedure code.
Action on Code can be:
• A- ADD
• U- UPDATE
• D- DISCONTINUED

Possible comments on error description:
• Invalid Action Code
• Code is less than 7 characters in length
• ADD-Code Already Exists and is Active
• ADD-Code Already Exists and No Limits Record
• ADD-Code Already Exists and has prior End Date
• ADD-Code Already Exists and has Limits Record
• UPDATE-Code Doesn't Exist
• UPDATE-Both Old and New Record Required
• DISCONTINUE-Code Doesn't Exist
• DISCONTINUE-Code Exists but No Limits Record
• DISCONTINUE-Code Exists but has prior End Date
• ADD-Error Updating Benefit Classification

Report is sorted by ICD-10 procedure code.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

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7.32.2 REF-0204-A -- ICD-10 Annual Update - Procedure Error Report Layout

```
Report  : REF-0204-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJA002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: HH:MM:SS
Location: REFP0102                         ICD-10: PROCEDURE ERROR REPORT                              Page    : 999,999
                                                REPORT PERIOD: CCYY

-------------------------------------------------------------------------------------------------------------------------------
  CODE      SHORT DESCRIPTION                                                ACTION   COMMENT
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------
  TOTAL PROCEDURE ERRORS: 999,999

                                                ** NO DATA THIS RUN **
                                                ***  END OF REPORT  ***
```

7.32.3 REF-0204-A -- ICD-10 Annual Update - Procedure Error Report Field Descriptions

Field	Description	Data Type	Length
ACTION	Action on ICD-10 procedure code while it is processed. Action on Code can be: A - ADD (for new codes) U - UPDATE (for revised codes) D - DISCONTINUED (for discontinued codes)	Character	1
CODE	ICD-10 procedure code for which error occurred.	Character	7
COMMENT	A description about error on code. Error description could be: • Invalid Action Code • Code is less than 7 characters in length • ADD-Code Already Exists and is Active • ADD-Code Already Exists and No Limits Record • ADD-Code Already Exists and has prior End Date • ADD-Code Already Exists and has Limits Record • UPDATE-Code Doesn't Exist • UPDATE-Both Old and New Record Required • DISCONTINUE-Code Doesn't Exist • DISCONTINUE-Code Exists but No Limits Record • DISCONTINUE-Code Exists but has prior End Date • ADD-Error Updating Benefit Classification	Character	50

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Field	Description	Data Type	Length
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
SHORT DESCRIPTION	A short description of ICD-10 procedure code for which error occurred.	Character	60
TOTAL PROCEDURE ERRORS	The total number of procedure errors that are reported. This included errors while processing procedure code for addition, revision or discontinuation and errors while updating benefit classification for procedure codes.	Number (Integer)	6

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7.33 REF-0205-A -- ICD-10 ANNUAL UPDATE - PROCEDURE SUMMARY REPORT

7.33.1 REF-0205-A -- ICD-10 Annual Update - Procedure Summary Report Narrative

This report lists the summary of ICD-10 Annual Update process for procedure codes. It reports the number of records and transactions read from the annual update file for ICD-10 procedure codes, number of ICD-10 procedure codes added, revised for code description and discontinued. It also lists the number of codes that encountered error while processing it for new addition, revision or discontinuation and number of benefit classification errors.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

7.33.2 REF-0205-A -- -- ICD-10 Annual Update - Procedure Summary Report Layout

```
Report  : REF-0205-A                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJA002                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time: HH:MM:SS
Location: REFP0102                          ICD-10: PROCEDURE SUMMARY REPORT                             Page    : 999,999
                                                 REPORT PERIOD: CCYY


                    *  TOTAL RECORDS READ                    ====================>       999999999
                    *  TOTAL TRANSACTIONS READ               ====================>       999999999


                    *  NUMBER OF CODES ADDED                 ====================>    =  999999999
                    *  NUMBER OF CODES UPDATED               ====================>    =  999999999
                    *  NUMBER OF CODES DISCONTINUED          ====================>    =  999999999
                    *  NUMBER OF CODES WITH ERRORS           ====================>    =  999999999
                    *  NUMBER OF BNFT CLASSIFICATION ERRORS  ====================>    =  999999999
                                                                                       ----------
                    *  TOTAL                                 ====================>       999999999
                                                                                       ==========

                                             ** NO DATA THIS RUN **
                                             ***  END OF REPORT  ***
```


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7.33.3 REF-0205-A -- -- ICD-10 Annual Update - Procedure Summary Report Field Descriptions

Field	Description	Data Type	Length
NUMBER OF BNFT CLASSIFICATION ERRORS	The total number of errors when updating benefit classification for ICD-10 procedure codes in annual update file for the upcoming year. Note: This count is not included in count of field TOTAL on this report.	Character	9
NUMBER OF CODES ADDED	The total number of new ICD-10 procedure codes added for the upcoming year.	Number (Integer)	9
NUMBER OF CODES DISCONTINUED	The total number of ICD-10 procedure codes that are discontinued for the upcoming year.	Number (Integer)	9
NUMBER OF CODES UPDATED	The total number of ICD-10 procedure codes that encountered change to their description for the upcoming year	Number (Integer)	9
NUMBER OF CODES WITH ERRORS	The total number of ICD-10 procedure codes that encountered error while processing it for new addition, revision to its description or discontinuation for the upcoming year.	Number (Integer)	9
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
TOTAL	The total number of ICD-10 procedure codes that are processed from the annual update file for the upcoming year. This count will be sum of counts from: - NUMBER OF CODES ADDED - NUMBER OF CODES UPDATED - NUMBER OF CODES DISCONTINUED - NUMBER OF CODES WITH ERRORS Note: This count doesn't include count of field NUMBER OF BNFT CLASSIFICATION ERRORS.	Character	9
TOTAL RECORDS READ	The total number of ICD-10 procedure records read from the annual update file for the upcoming year.	Number (Integer)	9
TOTAL TRANSACTIONS READ	The total number of ICD-10 procedure transactions read from the annual update file for upcoming year.	Number (Integer)	9

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7.34 REF-0206-A -- ICD-10 ANNUAL UPDATE - ASSOCIATED GROUPS FOR DISCONTINUED PROCEDURE CODES REPORT

7.34.1 REF-0206-A -- ICD-10 Annual Update - Associated Groups For Discontinued Procedure Codes Report Narrative

This report lists each procedure group that an ICD-10 procedure code that has been discontinued is part of. If the discontinued code is not part of any group, it is not reported. The report will contain the Group type, its long description, then each code within that group, and its short description.

Data Source: Centers for Medicare & Medicaid Services (CMS) ICD-10 Procedure Update File.
Frequency: Annual

The CMS ICD-10 Annual Update file record layout for procedure codes can be found on the Reference Input/Output Files page in iTRACE.

7.34.2 REF-0206-A -- ICD-10 Annual Update - Associated Groups For Discontinued Procedure Codes Report Layout

```
Report  : REF-0206-A                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJA002                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: REFP0102             ICD-10: ASSOCIATED GROUPS FOR DISCONTINUED PROCEDURE CODES              Page    : 999,999
                                             REPORT PERIOD: CCYY


-------------------------------------------------------------------------------------------------------------------------------
 GROUP TYPE     LONG DESCRIPTION
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                CODE      SHORT DESCRIPTION
                ---------------------------------------------------------------------
                XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                XXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------


*** This report only identifies codes associated with a group ***

                                                ** NO DATA THIS RUN **
                                                ***  END OF REPORT  ***
```


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7.34.3 REF-0206-A -- ICD-10 Annual Update - Associated Groups For Discontinued Procedure Codes Report Field Descriptions

Field	Description	Data Type	Length
CODE	ICD-10 discontinued procedure code that is associated to this group.	Character	7
GROUP TYPE	Indicates the procedure group.	Number (Integer)	9
LONG DESCRIPTION	Definition of where and/or how this procedure group is used.	Character	4000
REPORT PERIOD	Indicates the upcoming year for which Annual Update file is processed. Format is CCYY.	Number (Integer)	4
SHORT DESCRIPTION	A short description of the ICD-10 discontinued procedure code.	Character	60

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7.35 REF-0207-M -- INCLUDE-EXCLUDE AUDIT CRITERIA REPORT

7.35.1 REF-0207-M -- Include-Exclude Audit Criteria Report Narrative

The Include-Exclude Audit Criteria report contains the various parameters that are used to define the audit criteria. The include/exclude values will either be ranges of values or individual values, depending on the type of criteria being defined. The program, claim type, provider type, provider specialty, level of care, type of bill, POS, and GPI are all single values that will be listed on the report. The diagnosis, GCN, NDC, HICL, therapeutic class, age, and revenue code are represented by ranges of values. This report is sorted on the Error Code.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.35.2 REF-0207-M -- Include-Exclude Audit Criteria Report Layout

```
 Report  : REF-0207-M                          ALABAMA MEDICAID AGENCY                                        RUN DATE: MM/DD/CCYY
Process : REFJM207                           MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
Location: REFP0207                             INCLUDE/EXCLUDE AUDIT CRITERIA REPORT                                 PAGE: 99999
                                                     REPORT PERIOD: MM/CCYY


ERROR                                        AUDT INCLUDE/EXCLUDE   T
CODE  DESCRIPTION                            TYPE TYPE              P  ----------------- INCLUDE/EXCLUDE VALUES ------------------


9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXX  XXXXXXXXXXXXXXXXX  X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                 XXXXXXXXXXXXXXXXX  X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                  ***   END OF REPORT   ***
                                                ***   NO DATA THIS RUN   ***
```


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7.35.3 REF-0207-M -- Include-Exclude Audit Criteria Report Field Descriptions

Field	Description	Length	Data Type
Audit Type	Identifies the type of audit. This can be limit, contra-indicated, conflict, umbrella, bundling, unbundling, or negative contra-indicated.	4	Character
Description	The description of the error code.	50	Character
Error Code	Indicates the error code number for which the audit criteria pertains	4	Number (Integer)
Include Exclude Type	Indicates the type of audit criteria that the listed values represent. The following values will appear in this column: Program, Claim Type, Prov Type, Prov Spec, Recip Loc, Recip Age, Diagnosis, Rev Code, Type Of Bill, NDC, Thera Class, GPI, GCN Seq No, Payer and HICL.	12	Character
Include/Exclude Values	Contains the values that are associated with the audit criteria type.	59	Character
TP	Indicates if the audit criteria is set up to be included (I), excluded (E), or none (blank). For the PROGRAM audit type, the valid values are: None/Audit All Programs - blank; Include/Audit All Programs - I; Exclude/Audit All Programs - E; None/Audit Same Program - P; Include/Audit Same Program - N; Exclude/Audit Same Program - X.)	1	Character

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7.36 REF-0208-M -- PROCEDURE TO AUDIT CROSS REFERENCE REPORT

7.36.1 REF-0208-M -- Procedure to Audit Cross Reference Report Narrative

The Procedure to Audit Cross Reference report contains a listing of all procedure codes that are linked to audits. For each procedure code on the report, a list of all audits that use the procedure code is included. This report is sorted by the Procedure Code.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.36.2 REF-0208-M -- Procedure to Audit Cross Reference Report Layout

```
Report  : REF-0208-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJM208                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
Location: REFP0208                    PROCEDURE TO AUDIT CROSS REFERENCE REPORT                                 PAGE: 99999
                                                 REPORT PERIOD: MM/CCYY



PROC   ---------------------------------------- AUDITS REFERENCING PROCEDURE CODE ----------------------------------------
CODE   AUD1 AUD2 AUD3 AUD4 AUD5 AUD6 AUD7 AUD8 AUD9 AUD10 AUD11 AUD12 AUD13 AUD14 AUD15 AUD16 AUD17 AUD18 AUD19 AUD20 AUD21 AUD22

99999  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
       9999 9999 9999 9999 9999 9999 9999 9999 9999 9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999



                                                  ***   END OF REPORT   ***
                                                ***   NO DATA THIS RUN   ***
```

7.36.3 REF-0208-M -- Procedure to Audit Cross Reference Report Field Descriptions

Field	Description	Length	Data Type
AUD1	The first audit that is linked to the procedure code.	4	Number (Integer)
AUD2	The second audit that is linked to the procedure code.	4	Number (Integer)
AUD3	The third audit that is linked to the procedure code.	4	Number (Integer)
AUD4	The fourth audit that is linked to the procedure code.	4	Number (Integer)
AUD5	The fifth audit that is linked to the procedure code.	4	Number (Integer)

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Field	Description	Length	Data Type
AUD6	The sixth audit that is linked to the procedure code.	4	Number (Integer)
AUD7	The seventh audit that is linked to the procedure code.	4	Number (Integer)
AUD8	The eighth audit that is linked to the procedure code.	4	Number (Integer)
AUD9	The ninth audit that is linked to the procedure code.	4	Number (Integer)
AUD10	The tenth audit that is linked to the procedure code.	4	Number (Integer)
AUD11	The eleventh audit that is linked to the procedure code.	4	Number (Integer)
AUD12	The twelfth audit that is linked to the procedure code.	4	Number (Integer)
AUD13	The thirteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD14	The fourteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD15	The fifteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD16	The sixteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD17	The seventeenth audit that is linked to the procedure code.	4	Number (Integer)
AUD18	The eighteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD19	The nineteenth audit that is linked to the procedure code.	4	Number (Integer)
AUD20	The twentieth audit that is linked to the procedure code.	4	Number (Integer)
AUD21	The twenty-first audit that is linked to the procedure code.	4	Number (Integer)
AUD22	The twenty-second audit that is linked to the procedure code.	4	Number (Integer)
PROC Code	The procedure code that is linked to the audits listed on this report detail line.	5	Character

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7.37 REF-0209-M -- REVENUE CODE TO AUDIT CROSS REFERENCE REPORT

7.37.1 REF-0209-M -- Revenue Code to Audit Cross Reference Report Narrative

The Revenue Code to Audit Cross Reference report contains a listing of all revenue codes that are linked to audits. For each revenue code on the report, a list of all audits that use the revenue code is included.

Data Source: From the update process, information that is added, changed or deleted from the user.

Frequency: Monthly

7.37.2 REF-0209-M -- Revenue Code to Audit Cross Reference Report Layout

```
Report  : REF-0209-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
Process : REFJM209                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
Location: REFP0209                    REVENUE CODE TO AUDIT CROSS REFERENCE REPORT                              PAGE: 99999
                                            REPORT PERIOD: MM/CCYY




REV  ---------------------------------------- AUDITS REFERENCING REVENUE CODE ----------------------------------------------
CODE AUD1 AUD2 AUD3 AUD4 AUD5 AUD6 AUD7 AUD8 AUD9 AUD10 AUD11 AUD12 AUD13 AUD14 AUD15 AUD16 AUD17 AUD18 AUD19 AUD20 AUD21 AUD22

9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999
     9999 9999 9999 9999 9999 9999 9999 9999 9999 9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999  9999


                                                 ***   END OF REPORT   ***
                                               ***   NO DATA THIS RUN   ***
```

7.37.3 REF-0209-M -- Revenue Code to Audit Cross Reference Report Field Descriptions

Field	Description	Length	Data Type
AUD1	The first audit that is linked to the revenue code.	4	Number (Integer)
AUD2	The second audit that is linked to the revenue code.	4	Number (Integer)
AUD3	The third audit that is linked to the revenue code.	4	Number (Integer)
AUD4	The fourth audit that is linked to the revenue code.	4	Number (Integer)
AUD5	The fifth audit that is linked to the revenue code.	4	Number (Integer)

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Field	Description	Length	Data Type
AUD6	The sixth audit that is linked to the revenue code.	4	Number (Integer)
AUD7	The seventh audit that is linked to the revenue code.	4	Number (Integer)
AUD8	The eighth audit that is linked to the revenue code.	4	Number (Integer)
AUD9	The ninth audit that is linked to the revenue code.	4	Number (Integer)
AUD10	The tenth audit that is linked to the revenue code.	4	Number (Integer)
AUD11	The eleventh audit that is linked to the revenue code.	4	Number (Integer)
AUD12	The twelfth audit that is linked to the revenue code.	4	Number (Integer)
AUD13	The thirteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD14	The fourteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD15	The fifteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD16	The sixteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD17	The seventeenth audit that is linked to the revenue code.	4	Number (Integer)
AUD18	The eighteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD19	The nineteenth audit that is linked to the revenue code.	4	Number (Integer)
AUD20	The twentieth audit that is linked to the revenue code.	4	Number (Integer)
AUD21	The twenty-first audit that is linked to the revenue code.	4	Number (Integer)
AUD22	The twenty-second audit that is linked to the revenue code.	4	Number (Integer)
REV CODE	The revenue code that is linked to the audits listed on this report detail line.	4	Number (Integer)

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7.38 REF-04300-W -- WEEKLY DRUG UPDATE SUMMARY REPORT

7.38.1 REF-04300-W -- Weekly Drug Update Summary Report Narrative

The Weekly Drug Update Summary lists totals for errors, records read, added, updated, etc.

Data Source: First DataBank

Frequency: Weekly

7.38.2 REF-04300-W -- Weekly Drug Update Summary Report Layout

```
Report  : REFW04300                                ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : REFJW043                       MEDICAID MANAGEMENT INFORMATION SYSTEM                             RUN TIME:   HH:MM:SS
Location: REFP0043                           FDB DRUG UPDATE SUMMARY REPORT                                     PAGE:      99999
                                               REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------
                    *  AHFS THERAPEUTIC CLASS NOT FOUND  ==================>    =  9999999999
                    *  DRUG ROUTE NOT FOUND              ==================>    =  9999999999
                    *  GCN SEQUENCE NUMBER INVALID       ==================>    =  9999999999
                    *  LABELER INVALID                   ==================>    =  9999999999
                    *  MANUFACTURER INVALID              ==================>    =  9999999999
                    *  PREVIOUS NDC INVALID              ==================>    =  9999999999
                    *  NO DRUG LIMITS FOR EXISTING NDC   ==================>    =  9999999999
                                                                                  -----------

                    *  TOTAL ERRORS            ============================>    =  9999999999
                                                                                  ===========

                    *  TOTAL ADDED RECORDS     ============================>    =  9999999999

                    *  TOTAL UPDATED RECORDS   ============================>    =  9999999999

                    *  TOTAL BYPASSED RECORDS  ============================>    =  9999999999

                    *  TOTAL UNCHANGED RECORDS ============================>    =  9999999999
                                                                                  -----------

                    *  TOTAL RECORDS READ      ============================>    =  9999999999
                                                                                  ===========
                                                  *  * END OF REPORT *  *
```


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7.38.3 REF-04300-W -- Weekly Drug Update Summary Report Field Descriptions

Field	Description	Length	Data Type
AHFS Therapeutic Class Not Found	Number of records that have a therapeutic class not found on file.	10	Number (Integer)
Drug Route Not Found	Number of records with drug route not found on file.	10	Number (Integer)
GCN Sequence Number Invalid	Number of records with a general control number (GCN) sequence number not found on file. The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	10	Number (Integer)
Labeler Invalid	Number of labeler codes not found on file.	10	Number (Integer)
Manufacturer Invalid	Number of records with labeler id not found on file.	10	Number (Integer)
No Drug Limits For Existing NDC	Number of records without limit values.	10	Number (Integer)
Previous NDC Invalid	Number of records with the previous National Drug Code on the First DataBank file that differs from that currently in the database T_DRUG_PREV table.	10	Number (Integer)
Total Added Records	Total number of records added.	10	Number (Integer)
Total Bypassed Records	Total number of records bypassed.	10	Number (Integer)
Total Errors	Total number of errors identified during update.	10	Number (Integer)
Total Records Read	Total number of records read.	10	Number (Integer)
Total Unchanged Records	Total number of records from input file that did not result in a change in the database.	10	Number (Integer)
Total Updated Records	Total number of records updated.	10	Number (Integer)

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7.39 REF-04301-W -- WEEKLY DRUG UPDATE ERROR LISTING REPORT

7.39.1 REF-04301-W -- Weekly Drug Update Error Listing Report Narrative

The Weekly Drug Update Error Listing report lists all error transactions identified during the weekly First DataBank drug update process.

Data Source: First DataBank (FDBV)

Frequency: Weekly

7.39.2 REF-04301-W -- Weekly Drug Update Error Listing Report Layout

```
 Report  : REFW04301                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
 Process : REFJW043                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
 Location: REFP0043                        FDB DRUG UPDATE ERROR REPORT                                   PAGE:      99999
                                                REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------

                                                 GCN     THER   DRUG STATUS
TRX NDC           BRAND NAME                    SEQ NO   CLASS   OLD/NEW    ERROR MESSAGE
 X  XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX   XX        X/X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX   XX        X/X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX   XX        X/X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX   XX        X/X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX   XX        X/X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


 TRX Legend:                                     Totals:
     A = Added NDC                                GCN Seq No not on AHFS Thera Cls file:     999,999
     U = Updated NDC                              Drug Route not on file:                    999,999
     B = Bypassed by FDB Update                   GCN Sequence Number not on file:           999,999
     N = No Change to NDC                         Labeler code not on file:                  999,999
                                                  Drug Manufacturer not on file:             999,999
                                                  Previous NDC/nddf file do not match:       999,999
                                                  No Drug Limits for existing NDC:           999,999
                                                                     ------------------------------
                                                                     Total Exceptions:      9999,999

                                                     * * NO ERRORS THIS RUN * *
                                                       * * END OF REPORT * *
```


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7.39.3 REF-04301-W -- Weekly Drug Update Error Listing Report Field Descriptions

Field	Description	Length	Data Type
Brand Name	Commercial brand name of the drug	30	Character
Drug Status Old/New	Indicates whether a drug is active (A) or inactive (I) for payment. Old indicates the status before the drug update ran; New indicates the status after the update ran.	2	Character
Error Message	Error message- Descriptive Error Message.	52	Character
GCN Seq No.	General Control Number (GCN) sequence number- Clinical Formulation identification number. The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	6	Number (Integer)
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
Ther Class	Identifies the Standard Therapeutic Class code- This information is obtained from First DataBank.	2	Character
TRX	Transaction indicator identifies the type of action (add, change) to be applied for the National Drug Code (NDC) per the First DataBank (FDB) file.	1	Character
GCN Seq No. not on AHFS Thera Cls file	Total amount of GCN Sequence Numbers not on American Hospital Formulary Service (AHFS) Therapeutic Class file.	6	Number (Decimal)
Drug Route not on file	Total amount of drug routes not on file.	6	Number (Decimal)
GCN Sequence Number not on file	Total amount of GCN Sequence numbers not on file.	6	Number (Decimal)

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Field	Description	Length	Data Type
Labeler code not on file	Total amount of labeler codes not on file.	6	Number (Decimal)
Drug Manufacturer not on file	Total amount of manufacturers not on file.	6	Number (Decimal)
Previous NDC/NDDF file do not match	Total amount of previous National Drug Codes/ National Drug Data File (NDDF) files that do not match.	6	Number (Decimal)
No Drug Limits for existing NDC	Total amount of no drug limits for existing national drug codes.	6	Number (Decimal)
Total Exceptions	Total amount of exceptions.	7	Number (Decimal)

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7.40 REF-04302-W -- WEEKLY DRUG UPDATE REPORT

7.40.1 REF-04302-W -- Weekly Drug Update Report Narrative

The Weekly Drug Update report displays a list of individual add and update transactions performed as a result of REFP0043 FDB Drug Reference Update.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.40.2 REF-04302-W -- Weekly Drug Update Report Layout

```
 Report  : REFW04302                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
 Process : REFJW043                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:   HH:MM:SS
 Location: REFP0043                              FDB DRUG UPDATE REPORT                                       PAGE:      99999
                                                   REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------

TRX   NDC           BRAND NAME                        GENERIC NAME                      BEFORE/AFTER STATUS
X     XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X/X
X     XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X/X
X     XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X/X
X     XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X/X
X     XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    X/X


TRX Legend:                                                                Totals:
A = Added NDC                                                             Added:      999,999
U = Updated NDC                                                           Updated:    999,999
B = Bypassed by FDB Update                                                Bypassed:   999,999
N = No Change to NDC                                                      No Change:  999,999
------------------------------
Total NDCs Processed:  9999,999

                                                   * * NO ERRORS THIS RUN * *
                                                     * * END OF REPORT * *
```


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7.40.3 REF-04302-W -- Weekly Drug Update Report Field Descriptions

Field	Description	Length	Data Type
Added	Total number of records added this run.	6	Number (Decimal)
Before/After Status	Indicates whether a drug is active (A) or inactive (I) for payment, both before and after this transaction.	2	Character
Brand Name	Commercial brand name of the drug.	30	Character
Bypassed	Total number of records flagged to be bypassed by the First DataBank input file.	6	Number (Decimal)
Generic Name	Generic name of the drug.	30	Character
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
No Change	Total number of records in the input file that did not change in the database. Does not include "bypass" records.	6	Number (Decimal)
Total NDCs Processed	Total number of National Drug Codes processed this run.	7	Number (Decimal)
TRX	Transaction indicator identifies the type of action (add, change) to be applied for the National Drug Code per the First DataBank file.	1	Character
Updated	Total number of records updated this run.	6	Number (Decimal)

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7.41 REF-044U-W – DRUG PRICING UPDATE DETAIL REPORT

7.41.1 REF-044U-W – Drug Pricing Update Detail Report Narrative

This report contains the pricing updates applied during the weekly processing of the First Data Bank pricing transactions.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.41.2 REF-044U-W – Drug Pricing Update Detail Report Layout

```
Report  : REF-044U-W                          ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/YYYY
Process : REFJW044                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:
HH:MM:SS
Location: REFP0044                         DRUG PRICING UPDATE DETAIL REPORT                                 Page:
999,999
                                                REPORT PERIOD: MM/DD/YYYY

TRX TYPE     DRUG NAME                          NDC            PRICE TYPE/DESCRIPTION          EFFECTIVE DATE      COST

C            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999999999         99 - XXXXXX                  MM/DD/YYYY        999999.99999
D            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999999999         99 - XXXXXX                  MM/DD/YYYY        999999.99999
             XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
C            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999999999         99 - XXXXXX                  MM/DD/YYYY        999999.99999
C            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999999999         99 - XXXXXX                  MM/DD/YYYY        999999.99999
C            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     99999999999         99 - XXXXXX                  MM/DD/YYYY        999999.99999

     PRICE TYPE LEGEND:

     PRICE TYPE   DEFINITION
     ----------   ------------------------------------------------------------------------------------------------------
       BB         Blue Book AWP Unit Price
       WHN        Wholesale Acquisition Cost (WAC) Unit Price
       FFPUL      Federal Financing Participation Upper Limits
       MBBX       Medicaid Blue Book Price/Department of Justice (DOJ) Price

                                                   ** End of Report **

                                                 ** No Data This Report *
```


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7.41.3 REF-044U-W – Drug Pricing Update Detail Report Field Descriptions

Field	Description	Data Type	Length
Cost	The Price on the pricing transaction.	Number (Decimal)	14
Drug Name	The NDC Description. When the transaction is a Delete, there will be an additional line following the Delete line. This line will show the input file Delete record in the Drug Name column.	Character	30
Effective Date	The Effective Date of the Price on the Pricing Update transaction.	Date (MM/DD/CCYY)	10
NDC	The National Drug Code for the price being updated.	Number (Integer)	11
Price Description	The Price Type description code for the Price Type code on the pricing transaction.	Character	6
Price Type	The Price Type code for the price on the pricing transaction.	Character	2
TRX Type	Transaction Type will be 'C' to indicate Change or ‘D’ to indicate Delete on this report.	Character	1

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7.42 REF-044-W -- DRUG PRICING UPDATE SUMMARY REPORT

7.42.1 REF-044-W -- Drug Pricing Update Summary Report Narrative

The Drug Pricing Update Summary report is generated weekly with the FDB update and provide a summary of record counts related to the Federal MAC and AWP pricing update process.

Data Source: First DataBank (FDB)

Frequency: Weekly

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7.42.2 REF-044-W -- Drug Pricing Update Summary Report Layout

```
Report  : REF-044-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJW043                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: HH:MM:SS
Location: REFP044                        DRUG PRICING UPDATE SUMMARY REPORT                           Page:      99999
 ---------------------------------------------------------------------------------------------------------------------------
 ---------------------------------------------------------------------------------------------------------------------------
                              TOTAL RECORDS READ ================================>   99999999

                              TOTAL ERRORS FOUND ================================>   99999999

                                     RECORDS ADDED  RECORDS UPDATED  RECORDS NO CHANGE  RECORDS INACTIVATED

          *  AWP ====================>     9999999         9999999           9999999

          *  FEDERAL MAC ============>     9999999         9999999           9999999             9999999

          *  AWP PKG ================>     9999999         9999999           9999999

          *  DIR ====================>     9999999         9999999           9999999

          *  DIR PKG ================>     9999999         9999999           9999999

          *  WAC ====================>     9999999         9999999           9999999             9999999

          *  WAC PKG ================>     9999999         9999999           9999999

          *  DOJ ====================>     9999999         9999999           9999999

          *  ABP PKG ================>     9999999         9999999           9999999

          *  TOTAL RECORDS ==========>    99999999        99999999          99999999            99999999
                                                   ** END OF REPORT **
```


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7.42.3 REF-044-W -- Drug Pricing Update Summary Report Field Descriptions

Field	Description	Data Type	Length
ABP PKG Records Added	The total number of Alternative Benchmark Pricing Package (ABP PKG) records added.	Number (Integer)	7
ABP PKG Records No Change	The total number of Alternative Benchmark Pricing Package (ABP PKG) records not changed.	Number (Integer)	7
ABP PKG Records Updated	The total number of Alternative Benchmark Pricing Package (ABP PKG) records updated.	Number (Integer)	7
AWP PKG Records Added	The total number of Average Wholesale Price Package (AWP PKG) records added.	Number (Integer)	7
AWP PKG Records No Change	The total number of Average Wholesale Price Package (AWP PKG) records not changed.	Number (Integer)	7
AWP PKG Records Updated	The total number of Average Wholesale Price Package (AWP PKG) records updated.	Number (Integer)	7
AWP Records Added	The total number of Average Wholesale Price (AWP) records added.	Number (Integer)	7
AWP Records Updated	The total number of Average Wholesale Price (AWP) records updated.	Number (Integer)	7
AWP Records No Change	The total number of Average Wholesale Price (AWP) records not changed.	Number (Integer)	7
DIR PKG Records Added	The total number of Direct Package (DIR PKG) records added.	Number (Integer)	7
DIR PKG Records No Change	The total number of Direct Package (DIR PKG) records not changed.	Number (Integer)	7
DIR PKG Records Updated	The total number of Direct Package (DIR PKG) records updated.	Number (Integer)	7
DIR Records Added	The total number of Direct (DIR) records added.	Number (Integer)	7
DIR Records No Change	The total number of Direct (DIR) records not changed.	Number (Integer)	7
DIR Records Updated	The total number of Direct (DIR) records updated.	Number (Integer)	7
DIR Records No Change	The total number of Direct (DIR) records not changed.	Number (Integer)	7
DOJ Records Added	The total number of DOJ records added.	Number (Integer)	7

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Field	Description	Data Type	Length
DOJ Records No Change	The total number of DOJ records not changed.	Number (Integer)	7
DOJ Records Updated	The total number of DOJ records updated.	Number (Integer)	7
Federal Mac Records Added	The total number of Federal Maximum Allowable Cost (FMAC) records added.	Number (Integer)	7
Federal Mac Records Inactivated	The total number of Federal Maximum Allowable Cost (FMAC) records inactivated.	Number (Integer)	7
Federal Mac Records No Change	The total number of Federal Maximum Allowable Cost (FMAC) records not changed.	Number (Integer)	7
Federal Mac Records Updated	The total number of Federal Maximum Allowable Cost (FMAC) records updated.	Number (Integer)	7
Federal Mac Records No Change	The total number of Federal Maximum Allowable Cost (FMAC) records not changed.	Number (Integer)	7
Total Errors Found	The total number of errors encountered.	Number (Integer)	8
Total Records Added	The total number of all records added.	Number (Integer)	8
Total Records Read	The total number of records read from the file.	Number (Integer)	8
WAC PKG Records Added	The total number of Wholesale Acquisition Cost Package (WAC PKG) records added.	Number (Integer)	7
WAC PKG Records No Change	The total number of Wholesale Acquisition Cost Package (WAC PKG) records not changed.	Number (Integer)	7
WAC PKG Records Updated	The total number of Wholesale Acquisition Cost Package (WAC PKG) records updated.	Number (Integer)	7
WAC Records Added	The total number of Wholesale Acquisition Cost (WAC) records added.	Number (Integer)	7
WAC Records Inactivated	The total number of Wholesale Acquisition Cost (WAC) records inactivated.	Number (Integer)	7
WAC Records No Change	The total number of Wholesale Acquisition Cost (WAC) records not changed.	Number (Integer)	7
WAC Records Updated	The total number of Wholesale Acquisition Cost (WAC) records updated.	Number (Integer)	7

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7.43 REF-044E-W -- DRUG PRICING UPDATE ERROR REPORT

7.43.1 REF-044E-W -- Drug Pricing Update Error Report Narrative

The Drug Pricing Update Error report is generated each week with the FDB update process runs. It lists any errors encountered during the update process.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.43.2 REF-044E-W -- Drug Pricing Update Error Report Layout

```
Report  : REF-044E-W                                ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
Process : REFJW043                               MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIM: HH:MM:SS
Location: REFP0044                                  DRUG PRICING UPDATE ERROR REPORT                               PAGE:    99999

-------------------------------------------------------------------------------------------------------------------------------------
 NDC            PRICING        EFF            ERR
*CODE           TYPE           DATE           MSG
-------------------------------------------------------------------------------------------------------------------------------------

* XXXXXXXXXXX    XXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
* XXXXXXXXXXX    XXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
* XXXXXXXXXXX    XXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
* XXXXXXXXXXX    XXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXX    NDC DESC : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
* XXXXXXXXXXX    XXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  PRICE TYPE ERROR LEGEND:

  PRICE TYPE   PRICE DESC  DEFINITION
  ----------   ----------  ------------------------------------------------------------------------------------------------
   01          BB          Blue Book AWP Unit Price
   02          BBPKG       Blue Book AWP Package Price
   05          DIR         Direct Unit Price
   06          DIRPKG      Direct Package Price
   09          WHN         Wholesale Acquisition Cost (WAC) Unit Price
   10          WHNPKG      Wholesale Acquisition Cost (WAC) Package Price
   11          FFPUL       Federal Financing Participation Upper Limits
   12          ABP         Alternative Benchmark Price (ABP) Unit Price
   13          ABPPKG      Alternative Benchmark Price (ABP) Package Price
   99          MBBX        Medicaid Blue Book Price/Department of Justice (DOJ) Price
                                                        ** End of Report **
                                                    *** NO DATA THIS RUN ***
```

Note: This is a Line Type 3 line displaying an input file Delete Record.

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7.43.3 REF-044E-W -- Drug Pricing Update Error Report Field Descriptions

Field	Description	Length	Data Type
Err Msg	Description as to why the National Drug Code's rate segment could not be updated in the database.	76	Character
Eff Date	The date the rate becomes effective for claims processing.	10	Date (MM/DD/CCYY)
NDC CODE	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
Pricing Type	This indicator identifies how the National Drug Code is to be priced.	7	Character

Line Type 2 **For certain errors encountered, a second line will be printed after the first error line.** **The second line displays the NDC Description.**			
Field	**Description**	**Length**	**Data Type**
NDC CODE	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5-digit labeler code, a 4-digit product code and a 2-digit package code.	11	Character
NDC DESC	Description of the NDC.	35	Character

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Line Type 3 For errors encountered while processing an input Delete record, a second line will be printed after the first error line. The second line displays the input Delete record.			
Field	**Description**	**Length**	**Data Type**
Delete Record	The Delete Record that is currently being processed from the input file.	33	Character

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7.44 REF-046A-Q -- CMS NDC-HCPCS CROSSWALK ACTIVITY REPORT

7.44.1 REF-046A-Q -- CMS NDC-HCPCS Crosswalk Activity Report Narrative

The CMS-NDC-HCPCS Crosswalk Activity report contains the details of all database activity during the NDC/HCPCS data load process. Either a new record was added to T_DRUG_HCPCS or an existing t_drug_hcpcs record was no longer effective (end-dated).

Data Source: First DataBank (FDB)

Frequency: Quarterly

7.44.2 REF-046A-Q -- CMS NDC-HCPCS Crosswalk Activity Report Layout

```
Report  : REF0046A                                  AMMIS                                                    RUN DATE: MM/DD/CCYY
Process : REFJQ046                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                  RUN TIME:   HH:MM:SS
Location: REFP0046                  CMS NDC/HCPCS Crosswalk Update - Activity Listing                            PAGE:        999
-------------------------------------------------------------------------------------------------------------------------------------

         New Record Effective Date: MM/DD/CCYY
      End-Dated Record Ending Date: MM/DD/CCYY
-------------------------------------------------------
 NDC CODE    HCPCS CODE       ACTIVITY DESCRIPTION
-------------------------------------------------------
99999999999     XXXXX     Added new T_DRUG_HCPCS record
99999999999     XXXXX     End-dated T_DRUG_HCPCS record

                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```


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7.44.3 REF-046A-Q -- CMS NDC-HCPCS Crosswalk Activity Report Field Descriptions

Field	Description	Data Type	Length
Activity Description	The Activity Description field will either indicate a new record was added to T_DRUG_HCPCS or an existing t_drug_hcpcs record was no longer effective (end-dated).	Character	30
HCPCS Code	Code that represents procedures, supplies, products and services which may be provided to individuals enrolled in health insurance programs that has been discontinued according to the current CMS HCPCS file.	Character	5
NDC Code	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	Number (Integer)	11
New Record Effective Date	Date the new record became effective.	Date (MM/DD/CCYY)	10
End-Dated Record Ending Date	Date the record was end dated.	Date (MM/DD/CCYY)	10

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7.45 REF-046E-Q -- CMS NDC-HCPCS CROSSWALK ERROR REPORT

7.45.1 REF-046E-Q -- CMS NDC-HCPCS Crosswalk Error Report Narrative

The CMS NDC-HCPCS Crosswalk Error report contains all errors found while loading the CMS NDC/HCPCS data to the t_drug_hcpcs table.

Data Source: First DataBank

Frequency: Quarterly

7.45.2 REF-046E-Q -- CMS NDC-HCPCS Crosswalk Error Report Layout

```
Report  : REFQ046E                                  AMMIS                                                    RUN DATE: MM/DD/CCYY
Process : REFJQ046                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                RUN TIME:   HH:MM:SS
Location: REFP0046                    CMS NDC/HCPCS Crosswalk Update - Error Listing                              PAGE:        999
-------------------------------------------------------------------------------------------------------------------------------------

 NDC CODE    HCPCS CODE          ERROR DESCRIPTION
-------------------------------------------------------------

99999999999     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

99999999999     XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                     *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.45.3 REF-046E-Q -- CMS NDC-HCPCS Crosswalk Error Report Field Descriptions

Field	Description	Data Type	Length
Error Description	Description of the errors found while loading the CMS NDC/HCPCS data to the t_drug_hcpcs table.	Character	30
HCPCS Code	Code that represents procedures, supplies, products and services which may be provided to individuals enrolled in health insurance programs that has been discontinued according to the current CMS HCPCS file.	Character	5
NDC Code	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	Number (Integer)	11

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7.46 REF-048E-Q -- CMS NDC-HCPCS CROSSWALK EDIT ERROR REPORT

7.46.1 REF-048E-Q -- CMS NDC-HCPCS Crosswalk Edit Error Report Narrative

The CMS NDC-HCPCS Crosswalk Edit Error report contains all of the errors found while editing the input CMS NDC/HCPCS Crosswalk file.

Data Source: First DataBank (FDB)

Frequency: Quarterly

7.46.2 REF-048E-Q -- CMS NDC-HCPCS Crosswalk Edit Error Report Layout

```
Report  : REF0048E                                  AMMIS                                                  RUN DATE: MM/DD/CCYY
Process : REFJQ046                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                RUN TIME:   HH:MM:SS
Location: REFP0048                     CMS NDC/HCPCS Crosswalk Edit - Error Listing                             PAGE:       9999
-------------------------------------------------------------------------------------------------------------------------------------
                  All records listed below have a Non-Standard format, the expected format is HHHHH,NNNNN-NNNN-NNN.
-------------------------------------------------------------------------------------------------------------------------------------

Input Record: HHHHH,NNNNN-NNNN-NNN
Input Record: HHHHH,NNNNN-NNNN-NNN
Input Record: HHHHH,NNNNN-NNNN-NNN
                                                        *** END OF REPORT ***
                                                      *** NO DATA THIS RUN ***
```

7.46.3 REF-048E-Q -- CMS NDC-HCPCS Crosswalk Edit Error Report Field Descriptions

Field	Description	Data Type	Length
Input Record	A list of all the records that have a Non-Standard format, the expected format is HHHHH,NNNNN-NNNN-NNN.	Character	20

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7.47 REF-050A-W - PHARMACY STANDARD CLASSIFICATION REVIEW REPORT

7.47.1 REF-050A-W - Pharmacy Standard Classification Review Report Narrative

The Pharmacy Standard Classification Review Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: This report is produced out of the Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the standard drug benefit classification that is used in rule development. FDB provides updates to drug data which may affect the classification for the updated products. In addition, new products will also be introduced and will need to be classified. The groups that the new products need to go into may or may not exist in the current classification. This report will show all drugs that were ***not successfully*** classified and all updated drugs that needed to reclassified that could not be. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

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7.47.2 REF-050A-W - Pharmacy Standard Classification Review Report Layout

```
Report  : REF-050A-W                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJW050                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0050                    PHARMACY STANDARD CLASSIFICATION REVIEW REPORT                       Page:       9999


  Level Records Inserted / Updated          999             Level Records Bypassed          999

  Level Records Inserted / Updated          999             Level Records Bypassed          999

  Level Records Inserted / Updated          999             Level Records Bypassed          999

  Level Records Inserted / Updated          999             Level Records Bypassed          999

  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             Current XXXX - XX   Calculated XXXX - XX


  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             Current XXXX - XX Calculated XXXX - XX


  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                  ***   END OF REPORT   ***
```

7.47.3 REF-050A-W - Pharmacy Standard Classification Review Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Code and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Number (Integer)	100
Current	The actual group the code currently resides in.	Character	4

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Field	Description	Data Type	Length
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Number (Integer)	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number (Integer)	3
Message	Descriptive message indicating which condition this record hit which caused it to be reported.	Character	80
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.48 REF-050B-W - PHARMACY PART D CLASSIFICATION REVIEW REPORT

7.48.1 REF-050B-W - Pharmacy Part D Classification Review Report Narrative

The Pharmacy Part D Classification Review Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: This report is produced out of the Part D Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the Part D drug benefit classification that is used in rule development. FDB provides updates to Part D drug data which may affect the Part D classification for the updated products. In addition, new products will also be introduced that may need to be inserted into the Part D classification. Only drugs that meet the current Part D classification groups will be inserted into the appropriate level - This report will show all drugs that were ***not successfully*** classified. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

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7.48.2 REF-050B-W - Pharmacy Part D Classification Review Report Layout

```
Report  : REF-050B-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJW050                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:   HH:MM:SS
Location: REFP0050                    PHARMACY PART D CLASSIFICATION REVIEW REPORT                        Page:       9999


  Level Records Inserted / Updated          999            Level Records Bypassed          999


  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             Current XXXX - XX   Calculated XXXX - XX

  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                        ***   END OF REPORT   ***
```

7.48.3 REF-050B-W - Pharmacy Part D Classification Review Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Code and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Character	100
Current	The actual group the code currently resides in.	Character	4
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Number (Integer)	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number (Integer)	3
Message	Message.	Character	100
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.49 REF-050C-W – PHARMACY PDL SCREENING CLASSIFICATION REVIEW REPORT

7.49.1 REF-050C-W – Pharmacy PDL Screening Classification Review Report Narrative

The Pharmacy PDL Classification Review Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: This report is produced out of the PDL Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the PDL Screening drug benefit classification that is used in rule development for PDL. FDB provides updates to PDL drug data which may affect the PDL classification for the updated products. In addition, new products will also be introduced that may need to be inserted into the PDL screen classification. Only drugs that meet the current PDL Screened classification of drugs will be inserted into the appropriate group - This report will show all drugs that were ***not successfully*** classified. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

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7.49.2 REF-050C-W – Pharmacy PDL Screening Classification Review Report Layout

```
Report  : REF-050C-W                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : REFJW050                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0050                 PHARMACY PDL SCREENING CLASSIFICATION REVIEW REPORT                      Page:       9999


  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


  Code and Description: 99999999999 - XXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX   Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



                                                                  ***   END OF REPORT   ***
```

7.49.3 REF-050C-W – Pharmacy PDL Screening Classification Review Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Code and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Character	100
Current	The actual group the code currently resides in.	Character	4
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Number	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number	3
Message	Descriptive message indicating which condition this record hit which caused it to be reported.	Character	80

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Field	Description	Data Type	Length
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.50 REF-051A-W – PHARMACY STANDARD CLASSIFICATION UPDATE REPORT

7.50.1 REF-051A-W – Pharmacy Standard Classification Update Report Narrative

The Pharmacy Standard Classification Update Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: his report is produced out of the Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the standard drug benefit classification that is used in rule development. FDB provides updates to drug data which may affect the classification for the updated products. In addition, new products will also be introduced and will need to be classified. The groups that the new products need to go into may or may not exist in the current classification. This report will show all new drugs that were ***successfully*** classified and all updated drugs that needed to reclassified that could not be. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.50.2 REF-051A-W – Pharmacy Standard Classification Update Report Layout

```
Report  : REF-051A-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJW050                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0050                    PHARMACY STANDARD CLASSIFICATION UPDATE REPORT                        Page:       9999



  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Level Records Inserted / Updated           999

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          ***   END OF REPORT   ***
```


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7.50.3 REF-051A-W – Pharmacy Standard Classification Update Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Codes and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Character	100
Current	The actual group the code currently resides in.	Character	4
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Character	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number	3
Message	Descriptive message indicating which condition this record hit which caused it to be reported.	Character	80
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.51 REF-051B-W – PHARMACY PART D CLASSIFICATION UPDATE REPORT

7.51.1 REF-051B-W – Pharmacy Part D Classification Update Report Narrative

The Pharmacy Part D Classification Update Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: This report is produced out of the Part D Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the Part D drug benefit classification that is used in rule development. FDB provides updates to Part D drug data which may affect the Part D classification for the updated products. In addition, new products will also be introduced that may need to be inserted into the Part D classification. Only drugs that meet the current Part D classification groups will be inserted into the appropriate level - this report will show the ***successfully*** Insertion of these updates to the Part D classification. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.51.2 REF-051B-W – Pharmacy Part D Classification Update Report Layout

```
Report  : REF-051B-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJW050                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0050                   PHARMACY PART D CLASSIFICATION UPDATE REPORT                          Page:       9999



  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX      Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX      Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Level Records Inserted / Updated           999

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX      Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          ***   END OF REPORT   ***
```


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7.51.3 REF-051B-W – Pharmacy Part D Classification Update Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Code and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Number	100
Current	The actual group the code currently resides in.	Character	4
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Character	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number	3
Message	Descriptive message indicating which condition this record hit which caused it to be reported.	Character	80
Parent Code	Parent Code.	Character	4
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.52 REF-051C-W – PHARMACY PDL SCREENING CLASSIFICATION UPDATE REPORT

7.52.1 REF-051C-W – Pharmacy PDL Screening Classification Update Report Narrative

The Pharmacy PDL Classification Update Report is designed to report on codes which require additional review from the pharmacy analyst to ensure that the groupings are appropriate.

Purpose: This report is produced out of the PDL Pharmacy Classification Engine (PCE) process. The goal of the PCE process is to automatically update the PDL Screening drug benefit classification that is used in rule development for PDL. FDB provides updates to PDL drug data which may affect the PDL classification for the updated products. In addition, new products will also be introduced that may need to be inserted into the PDL screen classification. Only drugs that meet the current PDL Screened classification of drugs will be inserted into the appropriate level - this report will show the ***successfully*** Insertion of these updates to the PDL classification.. A pharmacy analyst will review this report and determine if any change to the classification is necessary.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.52.2 REF-051C-W – Pharmacy PDL Screening Classification Update Report Layout

```
Report  : REF-051C-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJW050                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: REFP0050                  PHARMACY PDL SCREENING CLASSIFICATION UPDATE REPORT                      Page:       9999



  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Level Records Inserted / Updated          999

  Code and Description: 999999999999 - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Parent Code and Desc: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  Level:  9  Action: XXXXXXXXXXXX       Message: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          ***   END OF REPORT   ***
```


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7.52.3 REF-051C-W – Pharmacy PDL Screening Classification Update Report Field Descriptions

Field	Description	Data Type	Length
Action	Field indicating if whether or not the code was added to the benefit classification group. Values are: 'Inserted' and 'Not Inserted'.	Character	12
Calculated	The group the Classification Engine has determined the code belongs in.	Character	10
Codes and Description	The current code that is being added to the classification. Examples of code types are HIC3, HIC4, GCN Sequence Number, and NDC.	Character	100
Current	The actual group the code currently resides in.	Character	4
Level	Field indicating of the level in the pharmacy classification this code belongs to.	Number (Integer)	1
Level Records Inserted/Updated	This field indicates the number of records that were inserted or updated within the specified benefit classification hierarchy level.	Number (Integer)	3
Message	Descriptive message indicating which condition this record hit which caused it to be reported.	Character	80
Parent Code and Description	The code value and description of the CALCULATED parent for the code attempting to be written to the pharmacy classification panel.	Character	100

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7.53 REF-04303-W – FDB UPDATE ADDED DRUGS DETAIL REPORT

7.53.1 REF-04303-W – FDB Update Added Drugs Detail Report Narrative

This report contains the Alabama covered drugs added to the drug file during the current First Data Bank update process.

Data Source: First DataBank (FDB)

Frequency: Weekly and Sunday

7.53.2 REF-04303-W – FDB Update Added Drugs Detail Report Layout

```
Report  : REF-04303-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : REFJW043                   MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: REFP0043                   FDB UPDATE - ADDED DRUGS DETAIL REPORT                               Page:      99999
                                            REPORT PERIOD: MM/DD/YYYY

DRUG NDC:    DRUG NAME                              CHEMICAL NAME
         GSN      AHFS       SCH  RP  PA  DC   ALGI   NDA   ANDA  GPI    PK SIZE    EFF DATE   MIN-U            MAX-U           PTD
         ------  --------  ---  --  --  --   ----   ----  ----  ---    ---------  --------   --------------   --------------  ---

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X    X      X     X    X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X    X      X     X    X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X    X      X     X    X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X    X      X     X    X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

                                                 * * END OF REPORT * *
                                               * * NO DATA THIS RUN  * *
```


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7.53.3 REF-04303-W – FDB Update Added Drugs Detail Report Field Descriptions

Field	Description	Data Type	Length
AHFS	The pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system of the drug being added.	Number (Integer)	8
ALGI	The Alabama-specific Generic Product Indicator for the drug being added.	Character	1
ANDA	The Abbreviated New Drug Application Indicator for the drug being added.	Character	1
Chemical Name	The generic drug name of the drug being added.	Character	75
DC	The Drug Class of the drug being added.	Character	1
Drug Name	The description of the drug being added.	Character	35
Drug NDC	The National Drug Code of the drug being added.	Number (Integer)	11
Eff Date	The Friday date following the weekend that the update process is run.	Date (CCYY/MM/DD)	8
GPI	The Generic Product Indicator for the drug being added.	Character	1
GSN	The GCN Sequence Number of the drug being added.	Character	6
MAX-U	The Maximum Quantity that can be dispensed for the drug being added.	Number (Decimal)	10
MIN-U	The Minimum Quantity that can be dispensed for the drug being added.	Number (Decimal)	10
NDA	The New Drug Application Indicator for the drug being added.	Character	1
PA	The Prior Authorization Indicator for the drug being added.	Character	1
PK SIZE	The Drug Package Size of the drug being added.	Number (Decimal)	11
PTD	The Part D Indicator for the drug being added. Set to 'Y' if the drug is covered under the Part D Benefit Plan for the current processing date.	Character	1
RP	The Repack Indicator of the drug being added.	Character	1
SCH	The Alabama specific drug schedule of the drug being added.	Character	2

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7.54 REF-04304-W – FDB UPDATE UPDATED DRUGS DETAIL REPORT

7.54.1 REF-04304-W – FDB Update Updated Drugs Detail Report Narrative

This report contains the Alabama covered drugs updated on the drug file during the current First Data Bank update process.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.54.2 REF-04304-W – FDB Update Updated Drugs Detail Report Layout

```
Report  : REF-04304-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : REFJW043                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0043                     FDB UPDATE - UPDATED DRUGS DETAIL REPORT                             Page:      99999
                                               REPORT PERIOD: MM/DD/YYYY

DRUG NDC:    DRUG NAME                                CHEMICAL NAME
         GSN     AHFS      SCH  RP  PA  DC   ALGI   NDA   ANDA  GPI    PK SIZE    EFF DATE   MIN-U            MAX-U           PTD
         ------  --------  ---  --  --  --   ----   ----  ----  ---    ---------  --------   --------------   --------------  ---
99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BEFORE   XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
AFTER    XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BEFORE   XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
AFTER    XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BEFORE   XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
AFTER    XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BEFORE   XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X
AFTER    XXXXXX  99999999  XX   X   X   X     X      X     X     X   99999999.999  YYYYMMDD    9999999.999      9999999.999     X

                                          * * END OF REPORT * *
                                        * * NO DATA THIS RUN  * *
```


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7.54.3 REF-04304-W – FDB Update Updated Drugs Detail Report Field Descriptions

Field	Description	Data Type	Length
AHFS	The pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system of the drug being updated.	Number (Integer)	8
ALGI	The Alabama-specific Generic Product Indicator for the drug being updated.	Character	1
ANDA	The Abbreviated New Drug Application Indicator for the drug being updated.	Character	1
Chemical Name	The generic drug name of the drug being updated.	Character	75
DC	The Drug Class of the drug being updated.	Character	1
Drug Name	The description of the drug being updated.	Character	35
Drug NDC	The National Drug Code of the drug being updated.	Number (Integer)	11
Eff Date	The current date that the update process is run.	Date (CCYY/MM/DD)	8
GPI	The Generic Product Indicator for the drug being updated.	Character	1
GSN	The GCN Sequence Number of the drug being updated.	Character	6
MAX-U	The Maximum Quantity that can be dispensed for the drug being updated.	Number (Decimal)	10
MIN-U	The Minimum Quantity that can be dispensed for the drug being updated.	Number (Decimal)	10
NDA	The New Drug Application Indicator for the drug being updated.	Character	1
PA	The Prior Authorization Indicator for the drug being updated.	Character	1
PK SIZE	The Drug Package Size of the drug being updated.	Number (Decimal)	11
PTD	The Part D Indicator for the drug being updated. Set to 'Y' if the drug is covered under the Part D Benefit Plan for the current processing date.	Character	1
RP	The Repack Indicator of the drug being updated.	Character	1
SCH	The Alabama specific drug schedule of the drug being updated.	Character	2

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7.55 REF-04305-W - FDB UPDATE REJECTED DRUGS ADDED REPORT

7.55.1 REF-04305-W - FDB Update Rejected Drugs Added Report Narrative

This report contains the Alabama non-covered drugs added to the drug file during the current First Data Bank update process.

Data Source: First DataBank (FDB)

Frequency: Weekly and Sunday

7.55.2 REF-04305-W - FDB Update Rejected Drugs Added Report Layout

```
Report  : REF-04305-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : REFJW043                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:   HH:MM:SS
Location: REFP0043                     FDB UPDATE - REJECTED DRUGS ADDED REPORT                               Page:      99999
                                               REPORT PERIOD: MM/DD/YYYY

Report  : REF-04305-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : REFJW043                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:   HH:MM:SS
Location: REFP0043                     FDB UPDATE - REJECTED DRUGS ADDED REPORT                               Page:      99999
                                               REPORT PERIOD: MM/DD/YYYY

DRUG NDC:    LABEL NAME                            CHEMICAL NAME
         GSN     AHFS      SCH  RP  PA  DC   ALGI NDA  ANDA  GPI    PK SIZE    EFF DATE   MIN-U            MAX-U           PTD  RI
         ------  --------  ---  --  --  --   ---- ---  ----  ---    ---------  --------   ---------------  ---------------  ---  ---

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X     X    X    X    X   99999999.999  YYYYMMDD      9999999.999      9999999.999  X    XXX

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X     X    X    X    X   99999999.999  YYYYMMDD      9999999.999      9999999.999  X    XXX

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X     X    X    X    X   99999999.999  YYYYMMDD      9999999.999      9999999.999  X    XXX

99999999999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         XXXXXX  99999999  XX   X   X   X     X    X    X    X   99999999.999  YYYYMMDD      9999999.999      9999999.999  X    XXX

                                                 * * END OF REPORT * *
                                               * * NO DATA THIS RUN  * *
```


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7.55.3 REF-04305-W - FDB Update Rejected Drugs Added Report Field Descriptions

Field	Description	Data Type	Length
AHFS	The pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system of the rejected drug being added.	Number (Integer)	8
ALGI	The Alabama-specific Generic Product Indicator for the rejected drug being added.	Character	1
ANDA	The Abbreviated New Drug Application Indicator for the rejected drug being added.	Character	1
CHEMICAL NAME	The generic drug name of the rejected drug being added.	Character	75
DC	The Drug Class of the rejected drug being added.	Character	1
DRUG NAME	The description of the rejected drug being added.	Character	35
DRUG NDC	The National Drug Code of the rejected drug being added.	Number (Integer)	11
EFF DATE	The Friday date following the weekend that the update process is run.	Date (CCYY/MM/DD)	8
GPI	The Generic Product Indicator for the rejected drug being added.	Character	1
GSN	The GCN Sequence Number of the rejected drug being added.	Character	6
MAX-U	The Maximum Quantity that can be dispensed for the rejected drug being added.	Number (Decimal)	10
MIN-U	The Minimum Quantity that can be dispensed for the rejected drug being added.	Number (Decimal)	10
NDA	The New Drug Application Indicator for the rejected drug being added.	Character	1
PA	The Prior Authorization Indicator for the rejected drug being added.	Character	1
PK SIZE	The Drug Package Size of the rejected drug being added.	Number (Integer)	11
PTD	The Part D Indicator for the rejected drug being added. Set to 'Y' if the drug is covered under the Part D Benefit Plan for the current processing date.	Character	1
RI	Drug Rebate Indicator. YES if the manufacturer participates in the Drug Rebate program. NO if the manufacturer does not participate in the Drug Rebate program.	Character	3
RP	The Repack Indicator of the rejected drug being added.	Character	1
SCH	The Alabama specific drug schedule of the rejected drug being added.	Character	2

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7.56 REF-05501-W -- WEEKLY AL SMAC PRICE UPDATE REPORT

7.56.1 REF-05501-W -- Weekly AL SMAC Price Update Report Narrative

The Weekly AL SMAC Price Update report displays information about the drugs that have been assigned new SMAC price or change in State Maximum Allowable Cost (SMAC) Price.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.56.2 REF-05501-W -- Weekly AL SMAC Price Update Report Layout

```
Report  : REF-05501-W                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
Process : REFJW055                   MEDICAID MANAGEMENT INFORMATION SYSTEM                     RUN TIME:   HH:MM:SS
Location: REFP0055                        STATE MAC PRICE UPDATE REPORT                              PAGE:   999,999
                                           REPORT PERIOD: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------
                                                                                        PREVIOUS          NEW
NDC           BRAND NAME                          LABEL NAME                             PRICE           PRICE
-------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99999   9999999.99999
XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99999   9999999.99999
XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99999   9999999.99999
XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99999   9999999.99999
XXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99999   9999999.99999


                                          * * END OF REPORT * *
                                        *** NO DATA THIS RUN ***
```


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7.56.3 REF-05501-W -- Weekly AL SMAC Price Update Report Field Descriptions

Field	Description	Length	Data Type
Brand Name	This field shows the brand name of the drug.	35	Character
Label Name	This field shows long description of a drug.	40	Character
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
New Price	This field shows new State Maximum Allowable Cost (SMAC) Price assigned to a drug.	13	Number (Decimal)
Previous Price	This field shows old State Maximum Allowable Cost (SMAC) Price of a drug.	13	Number (Decimal)

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7.57 REF-084B-W -- DRUG UPDATE ACCEPTANCE REPORT

7.57.1 REF-084B-W -- Drug Update Acceptance Report Narrative

The Drug Update Acceptance report shows what will happen when the process is run, and show the additional drugs that will apply when the FDB process are applied to the Production tables.

Data Source: First DataBank

Frequency: Weekly

7.57.2 REF-084B-W -- Drug Update Acceptance Report Layout

```
REPORT   :  REF-084B                                ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS  :  REFJW084                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME: HH:MM:SS
LOCATION :  REFP0084                        FIRST DATA BANK - DRUG UPDATE ACCEPTANCE REPORT                             PAGE    : 999,999
                                                      REPORT PERIOD: MM/DD/CCYY

NDC/DRUG ADDITIONS                                                      GCN                                  HCFA     HCFA
FDB ACD LABEL NAME                          NDC             AHFS       SEQNO     GPI    D/C   PA    RI    DESI     TERM DATE     OBSOLETE
X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    99999999999      XXXXXXXXXX 999999     9      X     X     X     9        MM/DD/CCYY    MM/DD/CCYY
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    PACK SIZE: 999999999.999              MIN UNITS: 999999999.999        MAX: 999999999.999

X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    99999999999      XXXXXXXXXX 999999     9      X     X     X     9        MM/DD/CCYY    MM/DD/CCYY
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    PACK SIZE: 999999999.999              MIN UNITS: 999999999.999        MAX: 999999999.999

X       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    99999999999      XXXXXXXXXX 999999     9      X     X     X     9        MM/DD/CCYY    MM/DD/CCYY
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    PACK SIZE: 999999999.999              MIN UNITS: 999999999.999        MAX: 999999999.999

                                                      * * NO ERRORS THIS RUN * *

                                                         * * END OF REPORT * *
```

7.57.3 REF-084B-W -- Drug Update Acceptance Report Field Descriptions

Field	Description	Length	Data Type
AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.	10	Character
D/C (Drug Class)	Record type indicator. Valid values include: O = OTC and F = Brand.	1	Character
FDB ACD	The transaction Code A = Add and C = Change	1	Character

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Field	Description	Length	Data Type
GCN Seq No	The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	6	Number (Integer)
GPI	Generic Price Indicator (GPI). Distinguishes a product as either generically priced or priced as a brand.	1	Number (Integer)
HCFA DESI	HCFA Drug Efficacy Study Implementation (DESI) Effective Date.	10	Date (MM/DD/CCYY)
HCFA Term Date	Centers for Medicare and Medicaid Services termination date.	10	Date (MM/DD/CCYY)
Label Name	Drug Label Name, strength and package type.	30	Character
Min Units	The minimum quantity of the drug which can be dispensed.	10	Number (Decimal)
Max	The maximum quantity of the drug which can be dispensed.	10	Number (Decimal)
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
Obsolete	The date the drug is no longer available for purchase from the manufacturer.	10	Date (MM/DD/CCYY)
PA	Prior Authorization Indicator. Valid values include: Y = Yes and N = No.	1	Character
Pack Size	Identifies the number of billing units in the labeled quantity from which the pharmacist dispenses; for example, 100 tablets, 1000 capsules, or 20 ml vial.	11	Number (Decimal)
RI (Rebate Indicator)	Rebate indicator. Valid values include: Y = Yes and N = No.	1	Character

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7.58 REF-086B-W -- DRUG PRICE UPDATE ACCEPTANCE REPORT

7.58.1 REF-086B-W -- Drug Price Update Acceptance Report Narrative

The Drug Price Update Acceptance report shows what will happen, when the process is run, and show the additional drug pricing that will apply when the FDB process are applied to the Production tables.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.58.2 REF-086B-W -- Drug Price Update Acceptance Report Layout

```
REPORT  : REF-086B-W                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : REFJW084                     MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
LOCATION: REFP084                  FIRST DATA BANK - PRICE UPDATE ACCEPTANCE REPORT                          PAGE: 999,999
                                             REPORT PERIOD: MM/DD/CCYY

FDB ACD   DRUG NAME                          NDC              PRICE TYPE    EFFECTIVE DATE                    COST
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999
X         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX      XX            MM/DD/CCYY                        9999999.99999


                                                  * * NO ERRORS THIS RUN * *

                                                    * * END OF REPORT * *
```


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7.58.3 REF-086B-W -- Drug Price Update Acceptance Report Field Descriptions

Field	Description	Length	Data Type
Cost	National Drug Code price table rate.	12	Number (Decimal)
Drug Name	Drug Brand Name- The drug name, strength and package type.	30	Character
Effective Date	Effective Price Date. The date the price becomes effective.	10	Date (MM/DD/CCYY)
FDB ACD	First DataBank record type identifier. Valid values include: C = Change A = Add D = Delete	1	Character
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
Price Type	The National Drug Code (NDC) Price Type.	2	Character

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7.59 REF-091B-W -- DRUG AND PRICING UPDATE ACCEPTANCE ERROR REPORT

7.59.1 REF-091B-W -- Drug And Pricing Update Acceptance Error Report Narrative

The Drug and Pricing Update Acceptance Error report displays all errors encountered during the actual processing of the FDB Drug and FDB Pricing files.

Data Source: First DataBank (FDB)

Frequency: Weekly

7.59.2 REF-091B-W -- Drug And Pricing Update Acceptance Error Report Layout

```
REPORT  : REF-091B-W                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : REFJW084                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
LOCATION: REFP084             FIRST DATA BANK - DRUG AND PRICING UPDATE ACCEPTANCE ERROR REPORT              PAGE: 999,999
                                             REPORT PERIOD: MM/DD/CCYY

FDB NDC          DRUG NAME                        GCN       THER    iC    DRUG     ERROR MESSAGE
ACD                                               SEQNO     CLASS   TRX   STATUS
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 X  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXX    XXX      X     X        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 * * NO ERRORS THIS RUN * *

                                                   * * END OF REPORT * *
```


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7.59.3 REF-091B-W -- Drug And Pricing Update Acceptance Error Report Field Descriptions

Field	Description	Length	Data Type
FDB ACD	First DataBank record type indicator. Valid values include: C = Change A = Add D = Delete	1	Character
Drug Name	Drug Brand Name.	30	Character
Drug Status	Indicates if Drug is A = active, I = inactive for payment.	1	Character
Error Message	Descriptive Error Message.	50	Character
GCN Seqno	The Generic Code Number Sequence Number of a drug that represents a unique combination of ingredient(s), strength, dosage form and route of administration for a generic drug formulation. Aggregates drug products that share like ingredient sets, route of administration, dosage form, and strength of drug but are marketed by multiple manufacturers.	6	Number (Integer)
iC TRX	AMMIS database type transaction update type. Valid values include: U = Update A = Add	1	Character
NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.	11	Character
Ther Class	State Specific Drug Class.	3	Character

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7.60 REF-0400D-C-Q - QUARTERLY DURABLE MEDICAL EQUIPMENT NCCI UPDATE REPORT

7.49.1 REF-0400D-C-Q - Quarterly Durable Medical Equipment NCCI Update Report

Report of updates for DME file – NCCI.

7.49.2 REF-0400D-C-Q - Quarterly Durable Medical Equipment NCCI Update Report

```
Report  : REF-0400D-C-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ400                        MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:   HH:MM:SS
Location: REFP0400                       QUARTERLY DURABLE MEDICAL EQUIPMENT NCCI UPDATE REPORT                 Page:    999,999
                                                 QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END           MOD    STATUS
 CODE 1     CODE 2     DATE         DATE          IND    MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ================================>    999,999
                              TOTAL RECORDS ADDED      ================================>    999,999
                              TOTAL RECORDS UPDATED    ================================>    999,999
                              TOTAL ERROR RECORDS      ================================>    999,999
                              TOTAL DUPLICATE RECORDS  ================================>    999,999


                                                 ** End of Report **


                                              ** No Data This Report **
```


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7.49.3 REF-0400D-C-Q - Quarterly Practitioner NCCI Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	10
MOD IND	Modifier Indicator.	Character	1
STATUS MESSAGE	Reports the status of the input record processed.	Character	74
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6

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7.61 REF-0400D-E-Q - QUARTERLY DURABLE MEDICAL EQUIPMENT NCCI ERROR REPORT

7.50.1 REF-0400D-E-Q - Quarterly Durable Medical Equipment NCCI Error Report

Report of errors for DME file – NCCI.

7.50.2 REF-0400D-E-Q - Quarterly Durable Medical Equipment NCCI Error Report

```
Report  : REF-0400D-E-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJQ400                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0400                      QUARTERLY DURABLE MEDICAL EQUIPMENT NCCI ERROR REPORT               Page:    999,999
                                              QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END          CLEID           MOD  INPUT FILE REC /
  CODE 1     CODE 2     DATE         DATE                         IND  ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.49.3 REF-0400D-E-Q - Quarterly Practitioner NCCI Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	82
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	100
CLEID	Correspondence Language Example Identification Number.	Character	12
MOD IND	Modifier Indicator.	Character	1

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7.62 REF-0400O-C-Q - QUARTERLY HOSPITAL NCCI UPDATE REPORT

7.62.1 REF-0400O-C-Q - Quarterly Hospital NCCI Update Report Narrative

Report of changes for HOS file – NCCI.

7.62.2 REF-0400O-C-Q - Quarterly Hospital NCCI Update Report Layout

```
Report  : REF-0400O-C-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJQ400                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0400                        QUARTERLY HOSPITAL NCCI UPDATE REPORT                             Page:    999,999
                                              QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END           MOD    STATUS
 CODE 1     CODE 2     DATE         DATE          IND    MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ==============================>    999,999
                              TOTAL RECORDS ADDED      ==============================>    999,999
                              TOTAL RECORDS UPDATED    ==============================>    999,999
                              TOTAL ERROR RECORDS      ==============================>    999,999
                              TOTAL DUPLICATE RECORDS  ==============================>    999,999


                                                 ** End of Report **


                                              ** No Data This Report **
```


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7.62.3 REF-0400O-C-Q - Quarterly Hospital NCCI Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	5
MOD IND	Modifier Indicator.	Character	1
STATUS MESSAGE	Reports the status of the record processed.	Character	74
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6

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7.63 REF-0400O-E-Q - QUARTERLY HOSPITAL NCCI ERROR REPORT

7.63.1 REF-0400O-E-Q - Quarterly Hospital NCCI Error Report Narrative

Report of errors for HOS file – NCCI.

7.63.2 REF-0400O-E-Q - Quarterly Hospital NCCI Error Report Layout

```
Report  : REF-0400O-E-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ400                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: REFP0400                        QUARTERLY HOSPITAL NCCI ERROR REPORT                                Page:    999,999
                                                 QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END          CLEID           MOD  INPUT FILE REC /
  CODE 1     CODE 2     DATE         DATE                         IND  ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.63.3 REF-0400O-E-Q - Quarterly Hospital NCCI Error Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	82
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	100
CLEID	Correspondence Language Example Identification Number.	Character	12
MOD IND	Modifier Indicator.	Character	1

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7.64 REF-0400P-C-Q - QUARTERLY PRACTITIONER NCCI UPDATE REPORT

7.64.1 REF-0400P-C-Q - Quarterly Practitioner NCCI Update Report

Report of updates for PR file – NCCI.

7.64.2 REF-0400P-C-Q - Quarterly Practitioner NCCI Update Report

```
Report  : REF-0400P-C-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ400                        MEDICAID MANAGEMENT INFORMATION SYSTEM                            Run Time:   HH:MM:SS
Location: REFP0400                       QUARTERLY PRACTITIONER NCCI UPDATE REPORT                              Page:    999,999
                                                 QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END           MOD    STATUS
 CODE 1     CODE 2     DATE         DATE          IND    MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX      XXXXX      MM/DD/CCYY   MM/DD/CCYY    X      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ================================>    999,999
                              TOTAL RECORDS ADDED      ================================>    999,999
                              TOTAL RECORDS UPDATED    ================================>    999,999
                              TOTAL ERROR RECORDS      ================================>    999,999
                              TOTAL DUPLICATE RECORDS  ================================>    999,999


                                                 ** End of Report **


                                              ** No Data This Report **
```


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7.64.3 REF-0400P-C-Q - Quarterly Practitioner NCCI Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	10
MOD IND	Modifier Indicator.	Character	1
STATUS MESSAGE	Reports the status of the input record processed.	Character	74
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6

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7.65 REF-0400P-E-Q - QUARTERLY PRACTITIONER NCCI ERROR REPORT

7.65.1 REF-0400P-E-Q - Quarterly Practitioner NCCI Error Report

Report of errors for PR file – NCCI.

7.65.2 REF-0400P-E-Q - Quarterly Practitioner NCCI Error Report

```
Report  : REF-0400P-E-Q                        ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJQ400                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0400                     QUARTERLY PRACTITIONER NCCI ERROR REPORT                             Page:    999,999
                                             QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HCPCS/CPT  HCPCS/CPT  EFFECTIVE    END          CLEID           MOD  INPUT FILE REC /
  CODE 1     CODE 2     DATE         DATE                         IND  ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXX   XXXXXXXX    MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXX   X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.65.3 REF-0400P-E-Q - Quarterly Practitioner NCCI Error Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	82
HCPCS/CPT CODE 1	HCPCS/CPT CODE for greater procedure.	Character	5
HCPCS/CPT CODE 2	HCPCS/CPT CODE for lesser procedure.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	100
CLEID	Correspondence Language Example Identification Number.	Character	12
MOD IND	Modifier Indicator.	Character	1

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7.66 REF-0401D-C-Q - QUARTERLY DURABLE MEDICAL EQUIPMENT MUE UPDATE REPORT

7.66.1 REF-0401D-C-Q - Quarterly Durable Medical Equipment MUE Update Report

Report of changes for the DME file - MUE.

7.66.2 REF-0401D-C-Q - Quarterly Durable Medical Equipment MUE Update Report

```
Report  : REF-0401D-C-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0401                 QUARTERLY DURABLE MEDICAL EQUIPMENT MUE UPDATE REPORT                    Page:    999,999
                                             QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT       EFFECTIVE    END            QTY  IND      STATUS
 CODE            DATE         DATE                PUBLISH  MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ================================>    999,999
                              TOTAL RECORDS ADDED      ================================>    999,999
                              TOTAL RECORDS UPDATED    ================================>    999,999
                              TOTAL ERROR RECORDS      ================================>    999,999
                              TOTAL DUPLICATE RECORDS  ================================>    999,999

                                                 ** End of Report **

                                            ** No Data This Report **
```


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7.66.3 REF-0401D-C-Q - Quarterly Durable Medical Equipment MUE Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1
QTY	Quantity of units.	Number (Integer)	5
STATUS MESSAGE	Reports the status of the record processed.	Character	72
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6

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7.67 REF-0401D-E-Q - QUARTERLY DURABLE MEDICAL EQUIPMENT MUE ERROR REPORT

7.67.1 REF-0401D-E-Q - Quarterly Durable Medical Equipment MUE Error Report

Report of Error for the DME file - MUE.

7.67.2 REF-0401D-E-Q - Quarterly Durable Medical Equipment MUE Error Report

```
Report  : REF-0401D-E-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0401                 QUARTERLY DURABLE MEDICAL EQUIPMENT MUE ERROR REPORT                      Page:    999,999
                                             QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT      QTY  CLEID            EFFECTIVE    END          IND       INPUT FILE REC /
 CODE                                 DATE         DATE         PUBLISH   ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                                                                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.67.3 REF-0401D-E-Q - Quarterly Durable Medical Equipment MUE Error Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	81
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	39
CLEID	Correspondence Language Example Identification Number.	Character	12
QTY	Quantity of units.	Number (Integer)	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1

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7.68 REF-0401O-C-Q - QUARTERLY HOSPITAL MUE UPDATE REPORT

7.68.1 REF-0401O-C-Q - Quarterly Hospital MUE Update Report

Report of changes for HOS file - MUE.

7.68.2 REF-0401O-C-Q - Quarterly Hospital MUE Update Report

```
Report  : REF-0401O-C-Q                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: REFP0401                        QUARTERLY HOSPITAL MUE UPDATE REPORT                              Page:    999,999
                                              QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT       EFFECTIVE    END            QTY  IND      STATUS
 CODE            DATE         DATE                PUBLISH  MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ==============================>    999,999
                              TOTAL RECORDS ADDED      ==============================>    999,999
                              TOTAL RECORDS UPDATED    ==============================>    999,999
                              TOTAL RECORDS UPDATED(Calculated)   ====================>    999,999
                              TOTAL ERROR RECORDS      ==============================>    999,999
                              TOTAL DUPLICATE RECORDS  ==============================>    999,999


                                                 ** End of Report **


                                              ** No Data This Report **
```


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7.68.3 REF-0401O-C-Q - Quarterly Hospital MUE Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1
QTY	Quantity units.	Number (Integer)	5
STATUS MESSAGE	Reports the status of the record processed.	Character	72
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6
TOTAL RECORDS UPDATED(Calculated)	Total input segment that end dated most recent segment and added a new segment.	Number (Integer)	6

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7.69 REF-0401O-E-Q - QUARTERLY HOSPITAL MUE ERROR REPORT

7.69.1 REF-0401O-E-Q - Quarterly Hospital MUE Error Report

Report of errors for HOS file - MUE.

7.69.2 REF-0401O-E-Q - Quarterly Hospital MUE Error Report

```
Report  : REF-0401O-E-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: REFP0401                         QUARTERLY HOSPITAL MUE ERROR REPORT                                Page:    999,999
                                                QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT      QTY  CLEID            EFFECTIVE    END          IND       INPUT FILE REC /
 CODE                                 DATE         DATE         PUBLISH   ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  ** End of Report **

                                                ** No Data This Report **
```


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7.69.3 REF-0401O-E-Q - Quarterly Hospital MUE Error Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	81
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	39
CLEID	Correspondence Language Example Identification Number.	Character	12
QTY	Quantity of units.	Number (Integer)	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1

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7.70 REF-0401P-C-Q - QUARTERLY PRACTITIONER MUE UPDATE REPORT

7.70.1 REF-0401P-C-Q - Quarterly Practitioner MUE Update Report

Report of changes for PR file - MUE.

7.70.2 REF-0401P-C-Q - Quarterly Practitioner MUE Update Report

```
Report  : REF-0401P-C-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0401                      QUARTERLY PRACTITIONER MUE UPDATE REPORT                             Page:    999,999
                                                 QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT       EFFECTIVE    END            QTY  IND      STATUS
 CODE            DATE         DATE                PUBLISH  MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX          MM/DD/CCYY    MM/DD/CCYY   99999     X     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                              TOTAL RECORDS READ       ==============================>    999,999
                              TOTAL RECORDS ADDED      ==============================>    999,999
                              TOTAL RECORDS UPDATED    ==============================>    999,999
                              TOTAL ERROR RECORDS      ==============================>    999,999
                              TOTAL DUPLICATE RECORDS  ==============================>    999,999

                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.70.3 REF-0401P-C-Q - Quarterly Practitioner MUE Update Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1
QTY	Quantity of units.	Number (Integer)	5
STATUS MESSAGE	Reports the status of the record processed.	Character	72
TOTAL DUPLICATE RECORDS	Total number of duplicated segments in input file.	Number (Integer)	6
TOTAL ERROR RECORDS	Total input segment that was errored out.	Number (Integer)	6
TOTAL RECORDS ADDED	Total segments that were added to database.	Number (Integer)	6
TOTAL RECORDS READ	Total input segments read.	Number (Integer)	6
TOTAL RECORDS UPDATED	Total input segment that caused the database update.	Number (Integer)	6

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7.71 REF-0401P-E-Q - QUARTERLY PRACTITIONER MUE ERROR REPORT

7.71.1 REF-0401P-E-Q - Quarterly Practitioner MUE Error Report

Report of errors for PR file - MUE.

7.71.2 REF-0401P-E-Q - Quarterly Practitioner MUE Error Report

```
Report  : REF-0401P-E-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : REFJQ401                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: REFP0401                       QUARTERLY PRACTITIONER MUE ERROR REPORT                             Page:    999,999
                                                QUARTER BEGINNING: MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
 HCPCS/CPT      QTY  CLEID            EFFECTIVE    END          IND       INPUT FILE REC /
 CODE                                 DATE         DATE         PUBLISH   ERROR MESSAGE  /
-------------------------------------------------------------------------------------------------------------------------------

                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                                                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXX        99999  XXXXXXXXXXXX     MM/DD/CCYY   MM/DD/CCYY   x         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 ** End of Report **

                                              ** No Data This Report **
```


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7.71.3 REF-0401P-E-Q - Quarterly Practitioner MUE Error Report Field Descriptions

Field	Description	Data Type	Length
EFFECTIVE DATE	The Effective Date of the segment.	Date (MM/DD/CCYY)	10
END DATE	The End Date of the segment.	Date (MM/DD/CCYY)	10
ERROR MESSAGE	Reports the error reason for the input record processed.	Character	81
HCPCS/CPT CODE	HCPCS/CPT CODE.	Character	5
INPUT FILE REC	Displays the input file segment causing the error.	Character	39
CLEID	Correspondence Language Example Identification Number.	Character	12
QTY	Quantity of units.	Number (Integer)	5
IND PUBLISH	Indicates whether the code can be made public.	Character	1

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7.72 REF-0900-O - CARC RARC COMBINATIONS UPDATE AUDIT REPORT

The CARC RARC Combinations Update Audit Report shows Added/Changed/Deleted values for the table of valid CARC/RARC combinations, as it is being updated from the spreadsheet from CAQH/CORE. This report was generated by the initial load of the combinations during implementation of ACA Rule 360, and then thrice-yearly on an ongoing basis as updates are received from CAQH/CORE in spreadsheet form.

7.72.1 REF-0900-O – CARC RARC Combinations Update Audit Report Layout

```
Report  : REF-0900-O                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : REFJO900                     MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time: HH:MM:SS
Location: REFP0900                       CARC RARC COMBINATIONS UPDATE AUDIT                         Page: 99999


FUNCTION (ADD/CHANGE/DELETE): XXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM ADJUSTMENT GROUP CODE: XX     CLAIM ADJUSTMENT GROUP DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  ***   END OF REPORT   ***

                                                ***   NO DATA THIS RUN   ***
```


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7.72.2 REF-0900-O - CARC RARC Combinations Update Audit Report Descriptions

Field	Description	Data Type	Length
BUSINESS SCENARIO CODE	A code to indicate the Business Scenario for the combination (BuSc).	Character	2
BUSINESS SCENARIO DESCRIPTION	Description of the Business Scenario (BuSc).	Character	50
CLAIM ADJUSTMENT GROUP CODE	Code identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code).	Character	2
CLAIM ADJUSTMENT GROUP DESCRIPTION	Description of the Claim Adjustment Group Code (CAGC).	Character	50
CLAIM ADJUSTMENT REASON CODE	HIPAA Claims Adjustment Reason Code (CARC).	Character	4
CLAIM ADJUSTMENT REASON DESCRIPTION	Description of the HIPAA Claims Adjustment Reason Code (CARC). This description comes from the thrice-yearly spreadsheet from CAQH/CORE.	Character	700
FUNCTION (ADD/CHANGE/DELETE)	Each of the three characters is "A", "C", or "D" indicating an Add, Change, or Delete action. The first character relates to CARC/RARC combination. The second character relates to the CARC/description. The third character relates to the RARC/description. An underscore means no action. **Legend:** • **A__** The combo was added, and the CARC and RARC already exist and their descriptions match, current DB value versus spreadsheet line (combo inserted into DB). • **AC_** The combo was added, and the CARC and RARC already exist and the RARC description matches, current DB value versus spreadsheet line, but not the CARC description (combo inserted, CARC updated on DB). • **A_C** The combo was added, and the CARC and RARC already exist and the CARC description matches, current DB value versus spreadsheet line, but not the RARC description (combo inserted, RARC updated on DB). • **ACC** The combo was added, and the CARC and RARC already exist and the neither the CARC nor the RARC description matches, current DB value versus spreadsheet line (combo inserted, CARC and RARC updated on DB).	Character	3

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Field	Description	Data Type	Length
	• **AA_** The combo was added, and the RARC already existed but not the CARC, which was added (combo inserted, CARC inserted into DB). • **A_A** The combo was added, and the CARC already existed but not the RARC, which was added (combo inserted, RARC inserted into DB). • **AAA** The combo was added, and neither the CARC nor the RARC already existed, so both were added (combo inserted, CARC and RARC inserted into DB). • **D__** The combo was deleted. Any updates to CARC and RARC were skipped (combo inactivated in DB). • **_C_** The combo already existed, and the CARC and RARC already exist and the RARC description matches, current DB value versus spreadsheet line, but not the CARC description (CARC updated in DB). • **__C** The combo already existed, and the CARC and RARC already exist and the CARC description matches, current DB value versus spreadsheet line, but not the RARC description (RARC updated in DB). • **_CC** The combo already existed, and the CARC and RARC already exist but neither description matches, current DB value versus spreadsheet line, but not the RARC description (CARC and RARC updated in DB). • **_A_** The combo already existed, and the RARC already existed but not the CARC, which was added (CARC inserted into DB). • **__A** The combo already existed, and the CARC already existed but not the RARC, which was added (RARC inserted into DB). • **_AA** The combo already existed, and neither the CARC nor the RARC already existed, so both were added (CARC and RARC inserted into DB). **NOTE:** If the combination is detected as duplicated on the data base, "** DUPLICATE **" will appear to the right of the FUNCTION. This is most likely caused by a UI panel entry error, and should be fixed using the UI panel.		
REMITTANCE ADVICE REMARK CODE	HIPAA Remittance Advice Remark Code (RARC). "NULL" indicates a combination without a RARC.	Character	5
REMITTANCE ADVICE REMARK DESCRIPTION	Description of the HIPAA Remittance Advice Remark Code (RARC). This description comes from the thrice-yearly spreadsheet from CAQH/CORE. "NULL" indicates a combination without a RARC.	Character	700

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7.73 REF-FCA-R – FUND CODE ASSIGNMENT CRITERIA REPORT

7.73.1 REF-FCA-R – Fund Code Assignment Criteria Report Narrative

Fund Code assignment criteria report.

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7.73.2 REF-FCA-R – Fund Code Assignment Criteria Report Layout

```
Report  : REF-FCA-R                          ALABAMA MEDICAID AGENCY                                   Run Date: 05/11/2010
Process : REFJR001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   15:53:47
Location: REFPFCAR                      FUND CODE ASSIGNMENT CRITERIA REPORT                              Page:          1
                                              REPORT PERIOD: 05/11/2010
SEQ   FC  FUND CODE DESCRIPTION
===== === ==================================================
    CLM TYPE PROVIDER ID          PT   PS    FP AID  CNTY DIAG    ICD     PROC    MOD  NDC           GI CONTRACT EFF DATE END DATE
    ======== ==================== ==== ===== == ==== ==== ======= ======= ======= ==== ============== == ======== ======== ========
   10 372 FP1115 WVR DYS ED
                                                50 I 69 I                 5010 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   20 172 FP1115 WVR ED
                                                50 I                      5010 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   30 373 FP1115 WVR DRG DYS
      PQ     I                                  50 I 69 I                                                         20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   40 173 FP1115 WVR DRG
      PQ     I                                  50 I                                                              20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   50 371 FP1115 WVR DYS
                                                50 I 69 I                                                         20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   60 171 FP1115 WVR
                                                50 I                                                              20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   70 355 STERILZ-PHYS DYS
      MB     I                                  5  I 69 I                 5000 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   80 155 STERILZ-PHYS
      MB     I                                                            5000 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
   90 224 STERILZ-HOSP DYS
      O      I                                  5  I 69 I                 5000 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  100 024 STERILZ-HOSP
      O      I                                                            5000 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  110 224 STERILZ-HOSP DYS
      IAC    I                                  5  I 69 I         5002 I                                          20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  120 024 STERILZ-HOSP
      IAC    I                                                     5002 I                                          20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  130 221 FP-FQHC DYS
                                   56 I         5  I 69 I                 5003 I                                  20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  140 221 FP-FQHC DYS
                                   56 I         5  I 69 I 5034 I          5035 I  90 I                            20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  150 221 FP-FQHC DYS
                                   56 I         5  I 69 I                 5001 I  FP I                            20000101 22991231
-----------------------------------------------------------------------------------------------------------------------------------
  160 021 FP-FQHC
                                   56 I                                   5003 I                                  20000101 22991231
                                                 * * END OF REPORT * *
```


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```
Report  : REF-FCA-R                          ALABAMA MEDICAID AGENCY                                    Run Date: 05/11/2010
Process : REFJR001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   15:53:47
Location: REFPFCAR                      FUND CODE ASSIGNMENT CRITERIA REPORT                                Page:          1
                                              REPORT PERIOD: 05/11/2010
```

PROCEDURE GROUP	PROCEDURE CODE FROM	PROCEDURE CODE TO	EFFECTIVE DATE	END DATE
5000	55250	55250	19000101	22991231
5000	55450	55450	19000101	22991231
5000	58565	58565	19000101	22991231
5000	58600	58600	19000101	22991231
5000	58605	58605	19000101	22991231
5000	58611	58611	19000101	22991231
5000	58615	58615	19000101	22991231
5000	58670	58671	19000101	22991231
5001	99205	99205	19000101	22991231
5001	99212	99212	19000101	22991231
5001	99213	99213	19000101	22991231
5001	99214	99214	19000101	22991231
5001	99347	99347	19000101	22991231
5001	S4993	S4993	19000101	22991231
5003	11975	11977	19000101	22991231
5003	11980	11980	19000101	22991231
5003	55250	55250	19000101	22991231
5003	55450	55450	19000101	22991231
5003	56302	56302	19000101	22991231
5003	57170	57170	19000101	22991231
5003	58300	58301	19000101	22991231
5003	58600	58600	19000101	22991231
5003	58605	58605	19000101	22991231
5003	58611	58611	19000101	22991231
5003	58615	58615	19000101	22991231
5003	58670	58671	19000101	22991231
5003	99401	99402	19000101	22991231
5003	J1055	J1056	19000101	22991231
5003	J7300	J7300	19000101	22991231
5003	J7302	J7304	19000101	22991231
5003	Q0111	Q0111	19000101	22991231
5032	G9008	G9008	19000101	22991231
5032	Z5385	Z5385	19000101	22991231
5033	G9002	G9002	19000101	22991231
5033	Z5393	Z5393	19000101	22991231
5035	36415	36416	19000101	22991231
5036	S9123	S9124	19000101	22991231
5036	T1019	T1019	19000101	22991231
5036	T2028	T2029	19000101	22991231
5039	H0049	H0049	19900101	22991231
5039	H0050	H0050	19900101	22991231

```
                                  * * END OF REPORT * *
```


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```
Report  : REF-FCA-R                          ALABAMA MEDICAID AGENCY                                    Run Date: 07/12/2012
Process : REFJR001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   19:13:34
Location: REFPFCAR                      FUND CODE ASSIGNMENT CRITERIA REPORT                                Page:          1
                                              REPORT PERIOD: 07/12/2012
```

DIAGNOSIS GROUP	ICD VER	DIAGNOSIS CODE FROM	DIAGNOSIS CODE TO	EFFECTIVE DATE	END DATE
2009	0	G0439	G0439	20141031	22991231
2009	0	G132	G132	20141031	22991231
2009	9	04082	04082	19900101	22991231
2009	9	0664	0664	19900101	22991231
2009	9	2501	2501	19900101	22991231
2009	9	25010	25010	19900101	22991231
2009	9	25011	25011	19900101	22991231
2009	9	25012	25012	19900101	22991231
2009	9	25013	25013	19900101	22991231
2009	9	25020	25020	19900101	22991231
2009	9	25021	25021	19900101	22991231
2009	9	25022	25022	19900101	22991231
2009	9	25023	25023	19900101	22991231
2009	9	25030	25030	19900101	22991231
2009	9	25031	25031	19900101	22991231
2009	9	25032	25032	19900101	22991231
2009	9	25033	25033	19900101	22991231
2009	9	251	251	19900101	22991231
2009	9	2510	2510	19900101	22991231
2009	9	27702	27702	19900101	22991231
2009	9	27703	27703	19900101	22991231
2009	9	27709	27709	19900101	22991231
2009	9	28262	28262	19900101	22991231
2009	9	2903	2903	19900101	22991231
2009	9	2904	2904	19900101	22991231
2009	9	29040	29040	19900101	22991231
2009	9	29041	29041	19900101	22991231
2009	9	29042	29042	19900101	22991231
2009	9	29043	29043	19900101	22991231
2009	9	2910	2910	19900101	22991231
2009	9	2912	2912	19900101	22991231
2009	9	2913	2913	19900101	22991231
2009	9	2914	2914	19900101	22991231
2009	9	2915	2915	19900101	22991231
2009	9	2918	2918	19900101	22991231
2009	9	29181	29181	19900101	22991231

```
                                        * * END OF REPORT * *
```


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```
Report  : REF-FCA-R                          ALABAMA MEDICAID AGENCY                                    Run Date: 07/12/2012
Process : REFJR001                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   19:13:34
Location: REFPFCAR                      FUND CODE ASSIGNMENT CRITERIA REPORT                                Page:          2
                                              REPORT PERIOD: 07/12/2012

                          ICD          ICD     ICD          ICD          EFFECTIVE   END
                          GROUP        VER     CODE FROM    CODE TO      DATE        DATE
                          ---------    ---     ---------    ---------    ---------   --------

                              5008      9      6652         6652         19000101    22991231
                              5008      9      6692         6692         19000101    22991231
                              5008      9      697          697          19000101    22991231
                              5008      9      9617         9617         19000101    22991231
                              5008      9      9724         9724         19000101    22991231
                              5009      9      6651         6651         19000101    22991231
                              5009      9      6652         6652         19000101    22991231
                              5009      9      6663         6663         19000101    22991231
                              5009      9      6669         6669         19000101    22991231
                              5009      9      9771         9771         19000101    22991231
                              5009      9      9773         9773         19000101    22991231
                              5013      0      0016072      0016073      20131001    22991231
                              5013      9      6909         6909         19000101    22991231
                              5013      9      7022         7022         19000101    22991231
                                                 * * END OF REPORT * *
```

7.73.3 REF-FCA-R – Fund Code Assignment Criteria Report Field Descriptions

Field	Description	Data Type	Length
AID	Identifies the Aid Category and code identifying whether the Aid Category associated with this entry is included (I) or excluded (E).	Character	4
CLM TYPE	Value for the type of claim that can be processed in the MMIS system and code identifying whether the Claim Types associated with this entry are included (I) or excluded (E).	Character	8
CNTY	The County Code used to identify a geographical/political area in the state and code identifying whether the Recipient County associated with this entry is included (I) or excluded (E).	Character	4
CONTRACT	A code that represents a provider enrollment contract and code identifying whether the Provider Contract associated with this entry is included (I) or excluded (E).	Character	8
DIAG	A Diagnosis group which represents a single or collection of Diagnosis Codes and code identifying whether the Diagnosis associated with this entry is included (I) or excluded (E).	Character	7
Diagnosis Code From	Upper limit of the diagnosis code range associated to the group.	Character	9

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Field	Description	Data Type	Length
Diagnosis Code To	Lower limit of the diagnosis code range associated to the group.	Character	9
Diagnosis Group	A Diagnosis Group which represents a single or collection of Diagnosis Codes.	Character	9
Effective Date	First date of service the corresponding Code becomes effective within the designated Group Type.	Date (MM/DD/CCYY)	8
End Date	Last date of service the corresponding Code is effective within the designated Group Type.	Date (MM/DD/CCYY)	8
FC	This is the fund code that is used in financial reporting to correctly categorize funds (money).	Character	3
FP	A value of 'Y' indicates a family planning service.	Character	1
FUND CODE DESCRIPTION	Description of the fund code that is used in financial reporting to correctly categorize funds (money).	Character	50
GI	Generic Drug Indicator - Indicates whether a drug product is generic product or branded product. Values: '0 - Non-Drug'; '1 - Generic'; '2 - Brand' and blank.	Character	1
ICD	ICD Procedure group, which represents a collection of ICD or ICD 10 Procedure Codes and Code identifying whether ICD 10 Procedure associated with this entry is included (I) or excluded (E).	Character	7
ICD Code From	Upper limit of the ICD Procedure range associated to the group.	Character	9
ICD Code To	Lower limit of the ICD Procedure range associated to the group.	Character	9
ICD Group	ICD Procedure group, which represents a collection of ICD Procedure Codes.	Character	9
ICD VER	Code to denote which version of the ICD Diagnosis or ICD Procedure code set that is being referenced. The valid values will be ‘9’ for ICD-9 and ‘0’ for ICD-10.	Character	1
MOD	The Modifier Code used to further describe a procedure and code identifying whether the Proc Mod associated with this entry is included (I) or excluded (E).	Character	4
NDC	National Drug Code used to uniquely identify a drug. The box directly next to this is used to identify the original 10-character format of the NDC and code identifying whether the Drug Code associated with this entry is included (I) or excluded (E).	Character	13

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Field	Description	Data Type	Length
PROC	Procedure group, that represents a single or collection of procedures and code identifying whether the Procedure Code associated with this entry is included (I) or excluded (E).	Character	7
PROVIDER ID	The Provider ID value and code identifying whether the Provider ID associated with this entry is included (I) or excluded (E).	Character	20
PS	A code representing the specialized area of practice for a provider and code identifying whether the Provider Specialty associated with this entry is included (I) or excluded (E).	Character	5
PT	The Provider Type Code that a provider is licensed for and code identifying whether the Provider Type associated with this entry is included (I) or excluded (E).	Character	4
Procedure Code From	Lower limit of the Procedure Code range associated to the group.	Character	9
Procedure Code To	Upper limit of the Procedure Code range associated to the group.	Character	9
Procedure Group	Represents a single or collection of procedures.	Character	9
SEQ	The sequence in which the FCA rows should be processed.	Character	5

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AMMIS SUR Case Tracking Manual

Date Modified: 07/13/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
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Montgomery, Alabama 36117

1. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 Document Information Page

Required Information	Definition
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Owner:	DXC/Agency
Author:	SUR Team

1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
12/20/2017	1.0		Final version approved	
07/13/2018	2.0		Conversion of manual from HPE to DXC	

1.3 Related documentation

Document	Description	url

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2. Introduction

2.1 Overview

This manual describes how to use the Alabama Surveillance and Utilization Review (SUR) Case Tracking windows and reports. It begins with how to log into the system and enter basic information needed throughout the system to create and update cases as they move through different phases of the process:

- Sign-on and SURS Case Tracking Navigation
- Entering/Updating Analyst Criteria
- Entering/Updating Consultant and Utilization Review Committee (URC) Member Information

The manual then continues with creating and entering SUR case information:

- Entering/Selecting New Provider Cases
- Entering/Selecting New Recipient Cases
- Entering New Referrals
- Updating Case Information

The manual finishes with follow-up case activities and how to generate letters and forms from the Letter Generator:

- Creating Hearing Notification Letters
- Creating SURS Case Tracking Letters

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3. Subsystem Overview

3.1 Overview

The Alabama Surveillance and Utilization Review (SUR) Case Tracking function replaces many of the manual operations throughout the SUR case review process with systematic approaches. Browser-based windows replace many of the manual operations such as providing auto-assignment of case reviews and online updating of case documentation. In addition, the SUR Case Tracking function allows for the viewing of imaged incoming correspondence and photocopied medical records from on-site audits.

SUR Case Tracking provides for storage of report and spreadsheet files generated within the interChange SUR and Decision Support System (DSS) areas and can link the files to related SUR cases. All case documentation, including imaged documentation, is linked to a SUR case utilizing a unique identifier called a Master Log Number. Each SUR case has an associated electronic SUR case file, which helps in identifying the steps the SUR analyst followed while researching the SUR case.

3.2 Interface with DSS to Receive or Provide Needed Data

The SURS Case Tracking function receives data from other subsystems within the Medicaid Management Information System (MMIS). The Provider Subsystem provides information directly related to the provider such as name and address. The Recipient Subsystem provides lock-in information as well as the name of the recipient.

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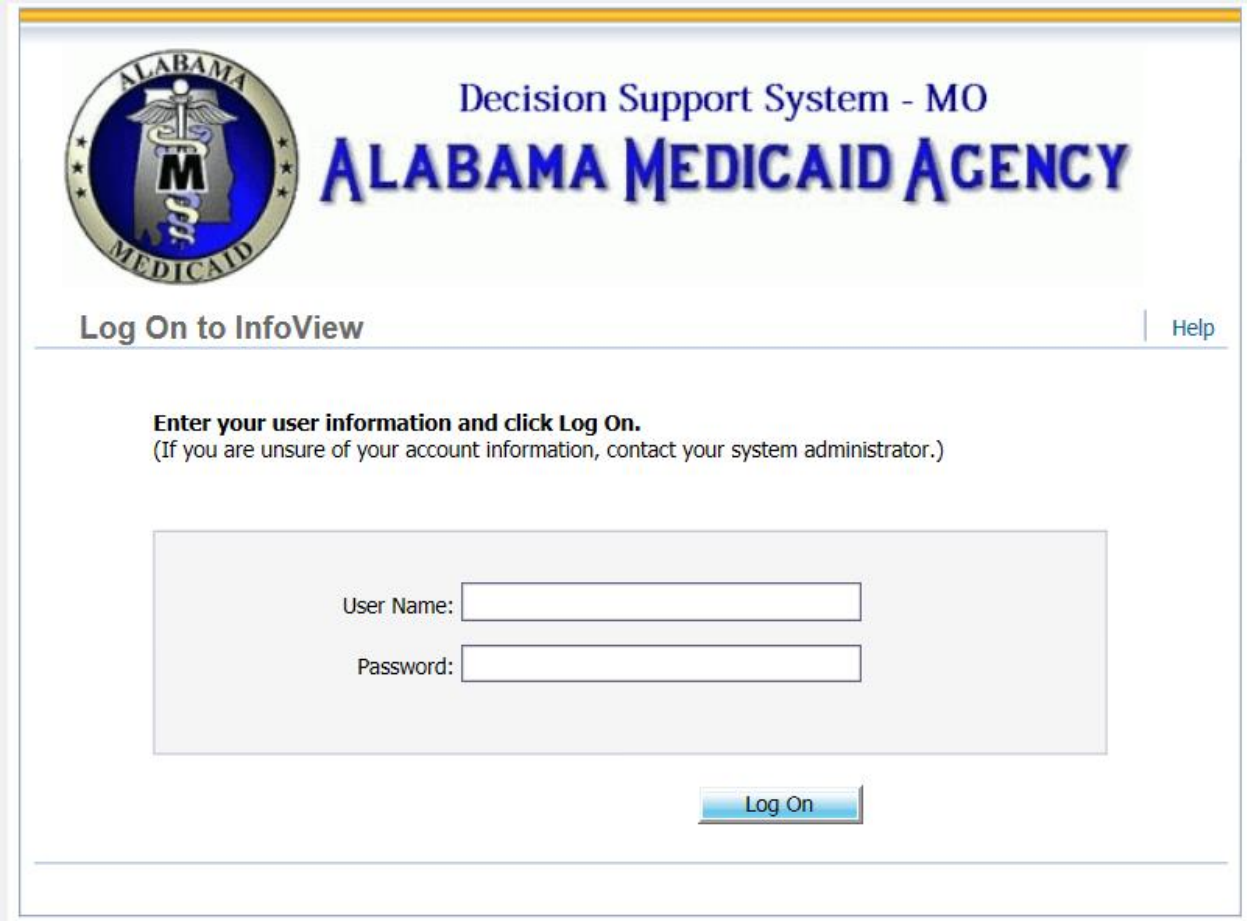
4. Sign-on and SURS Case Tracking Navigation

4.1 Overview

The SURS Case Tracking function is accessible in the same manner as the SURS*Profiler* Case Maintenance and Random Sample applications. It is a browser-based application that is available on the menus for only those users that have the SURS security clearance that includes Case Tracking. The two current levels of security within the application are SURS analyst and supervisor. The level of security clearance determines which windows can be accessed and updated. For the purpose of this manual, all functionality is shown, regardless of the security level of the user.

4.2 Sign On Window

The Sign On window is the first step in accessing any window within the SURS Case Tracking application. Access to the secure website is achieved through using the Microsoft Internet Explorer browser.



1. Launch Internet Explorer.
2. Type http://icdss-prod.alxix.slg.eds.com:20080/InfoViewApp/logon.jsp in the navigation bar.
3. Click the **Go** button or press **Enter**.
4. Enter **User ID** into the User Name text field.
5. Enter **Password** into the Password text field.
6. Click the **Log On** button.

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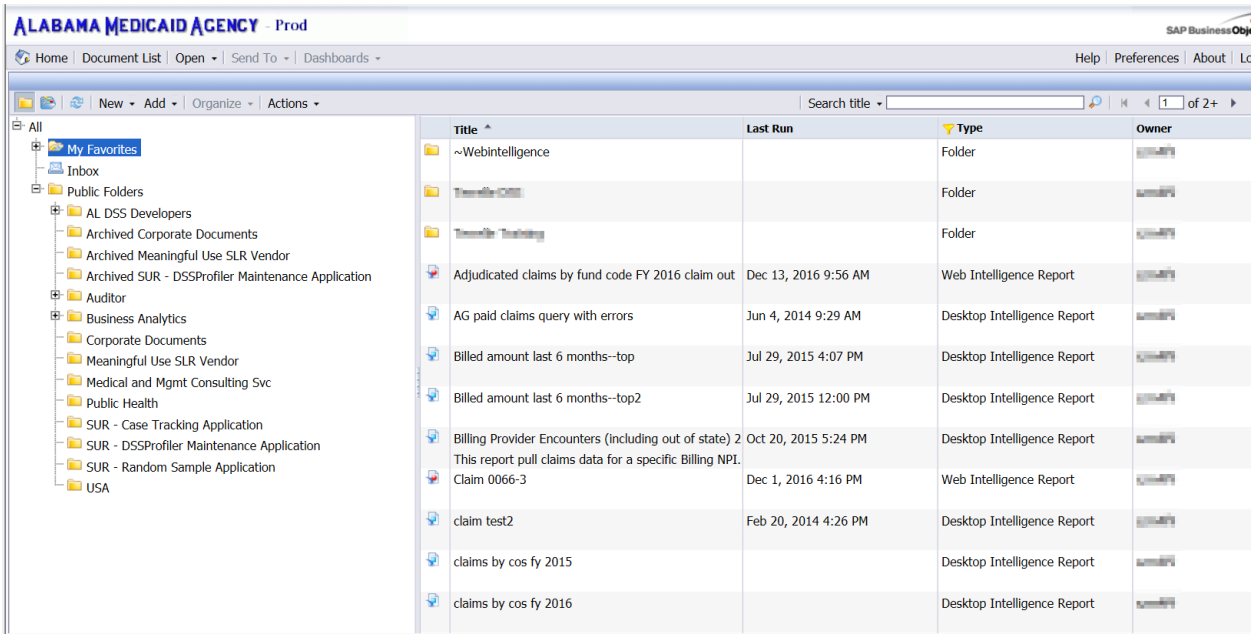
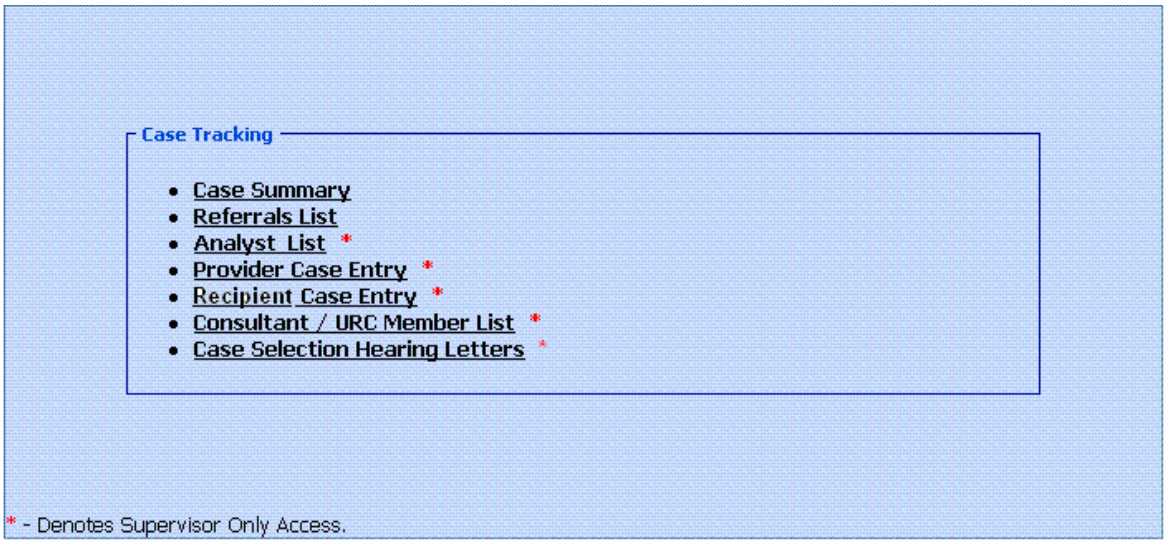
4.3 SURS Main Navigation and Case Tracking Navigation Window

To access the specific areas of the SUR Case Tracking application, utilize the links below the headings available on the lower left portion of the DSS home page:



The next window shows an example of the SURS menu accessible via the Case Tracking link:



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5. Entering/Updating Analyst Criteria

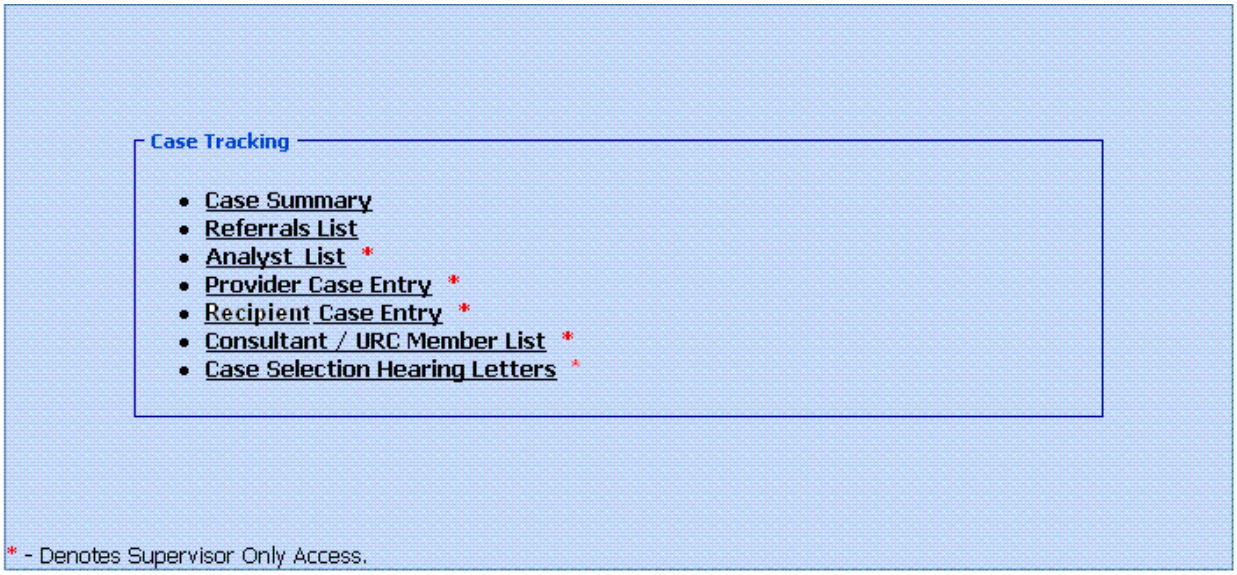
5.1 Overview

The Analyst Criteria windows are used to enter or update information for each SUR analyst who works on cases.

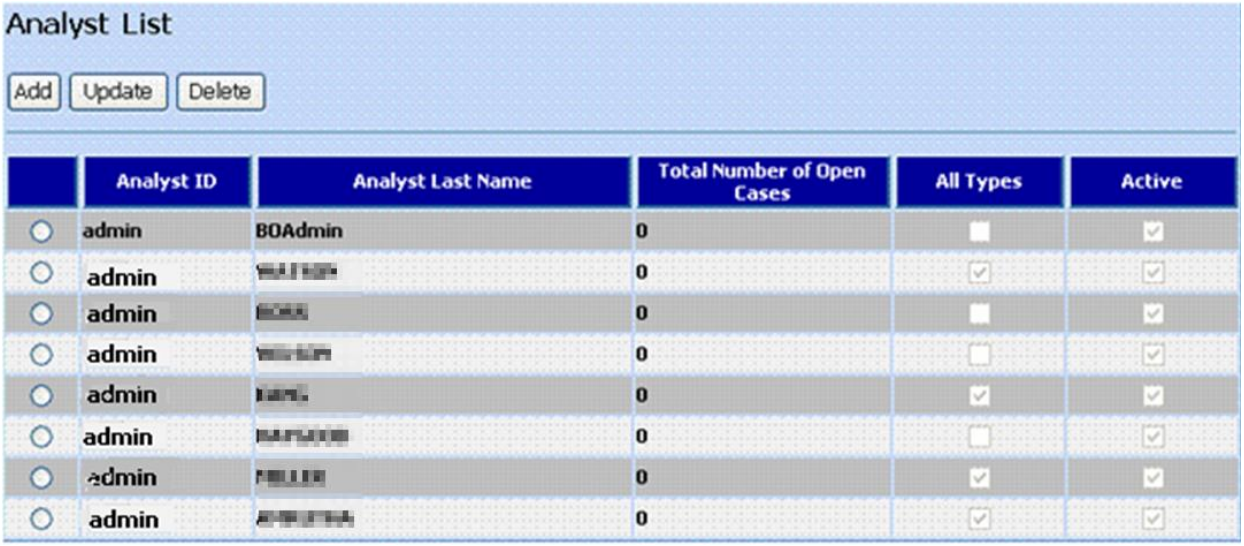
5.2 Analyst List

The Analyst List window displays all the currently entered analysts. The window displays all the active analysts first, followed by the inactive analysts.

1. On the SURS main navigation window, click the link for **Analyst List**:



2. To update an existing analyst in the Analyst List window, select the radio button to the left of the Analyst ID and click the **Update** button.



	Analyst ID	Analyst Last Name	Total Number of Open Cases	All Types	Active
○	admin	BOAdmin	0	☐	☑
○	admin	[illegible]	0	☑	☑
○	admin	[illegible]	0	☐	☑
○	admin	[illegible]	0	☐	☑
○	admin	[illegible]	0	☑	☑
○	admin	[illegible]	0	☐	☑
○	admin	[illegible]	0	☑	☑
○	admin	[illegible]	0	☑	☑

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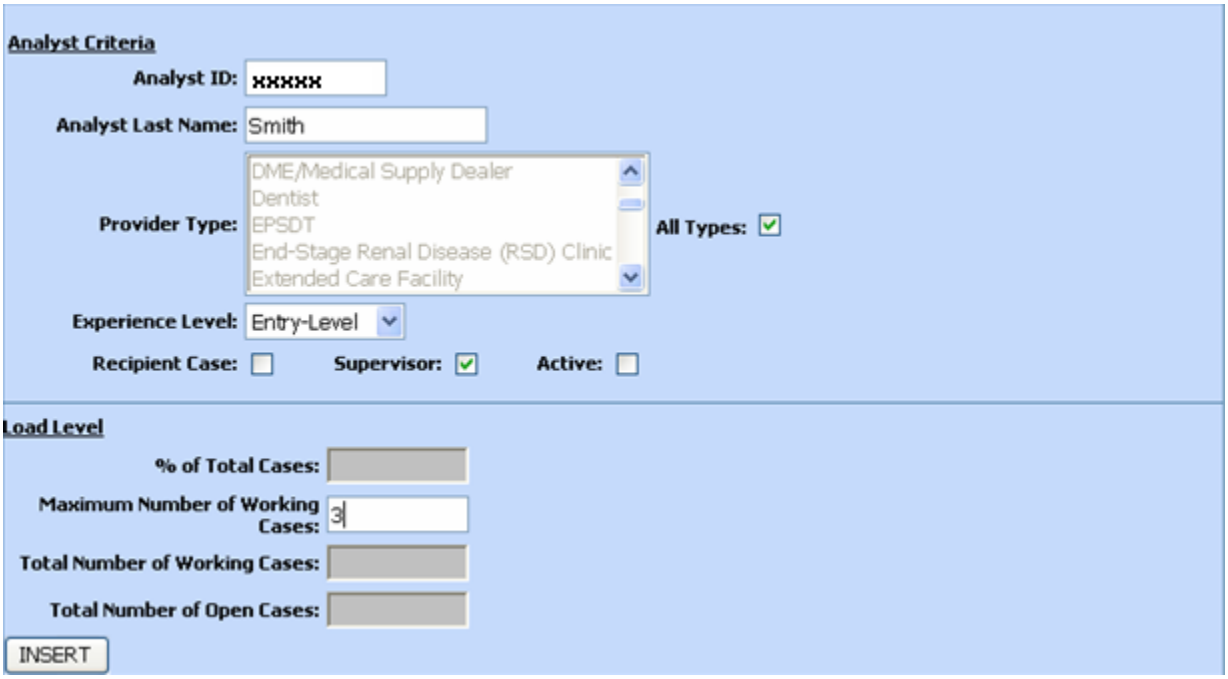
3. To add a new analyst in the Analyst List window, click the **Add** button.
4. To delete an existing analyst, select the radio button to the left of the Analyst ID and click the **Delete** button

Result: The Analyst Criteria window appears.



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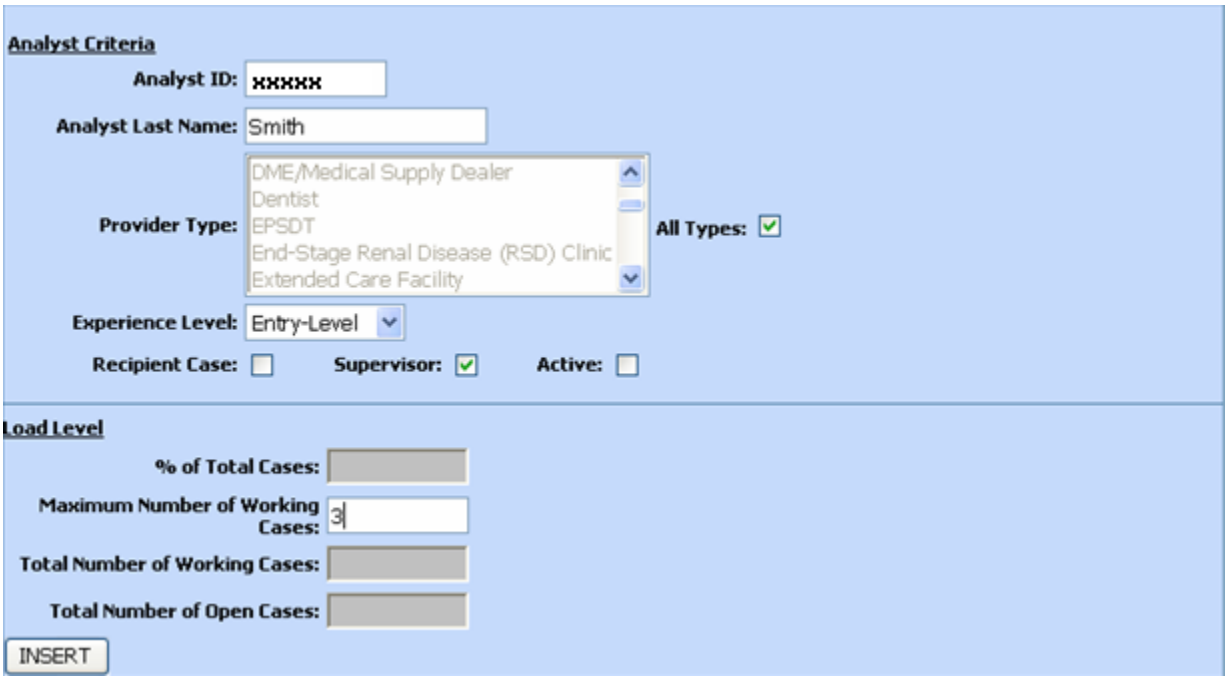
5.3 Analyst Criteria

The Analyst Criteria window allows the user to enter information regarding the analyst and their case load.



1. If adding a new analyst, enter the Analyst ID, which is usually the user ID of the analyst that is assigned for accessing interChange, DSS and other similar tools.
2. Add or update the following data items to be saved for the analyst:
   - Enter **Analyst Last Name**.
   - Select **Provider Types** for which the analyst may perform reviews. You may also select All Types if the analyst is not limited to performing reviews for specific provider types.
   - Select **Experience Level**, which can be Entry-Level, Moderate or Experienced.
   - Select **Recipient Case**, if analyst is allowed to perform such reviews. (Checked = Yes, Not Checked = No)
   - Select **Supervisor** (Checked = Yes, Not Checked = No, This field is used by the windows to only display supervisor IDs in drop-down menus. It does not give a user security access to the Supervisor Only windows.)
   - Select **Active** (Checked = Yes, Not Checked = No)
   - Enter **Maximum Number of Working Cases**.

NOTE:

The other fields listed under Load Level are system generated. These fields show a snapshot of how many cases this analyst has compared to the total cases in the system.

3. To save updated information, click the **Update** button. An Insert button is available when performing an Add. To save new information, click the **Insert** button. A Delete button is available when performing a Delete. To delete an analyst, click the **Delete** button.

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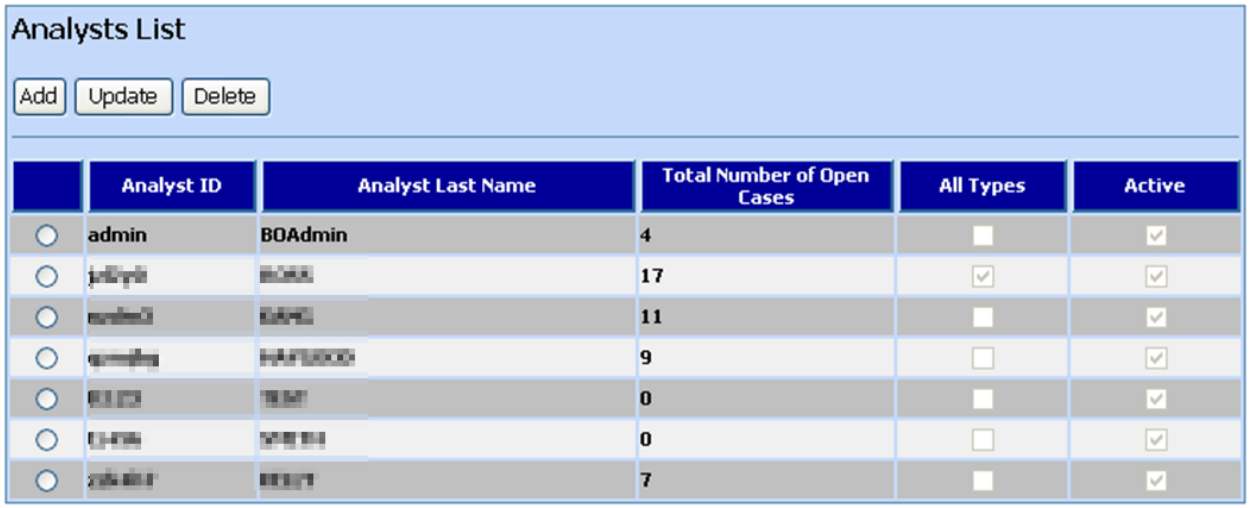
Result: The Analyst Criteria List window appears.



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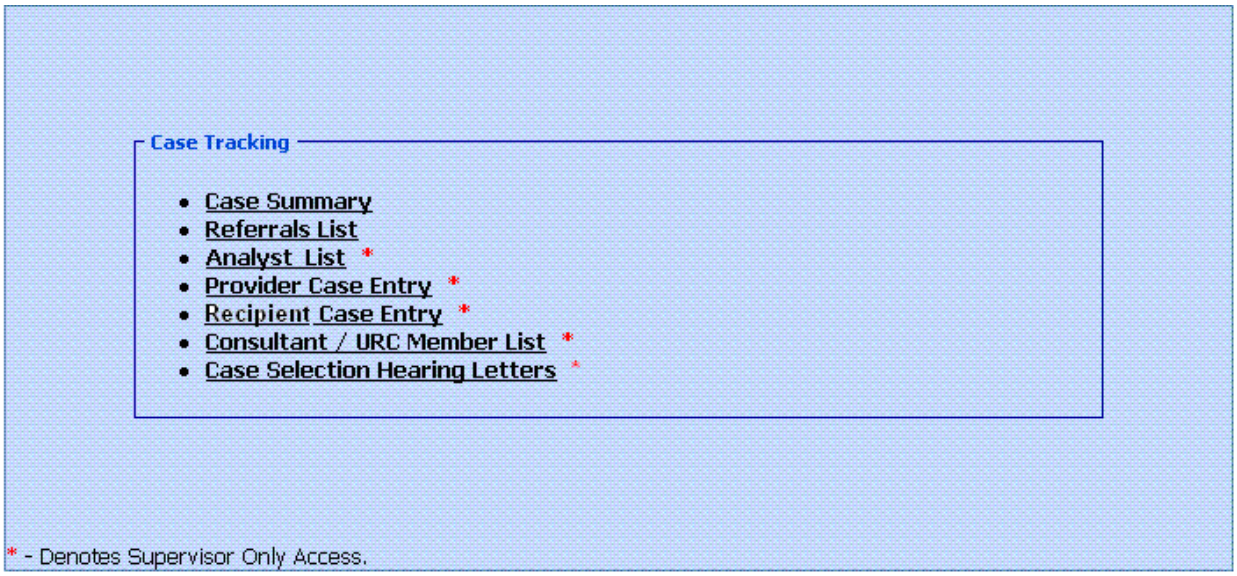
6. Entering/Updating Consultant and URC Member Information

6.1 Overview

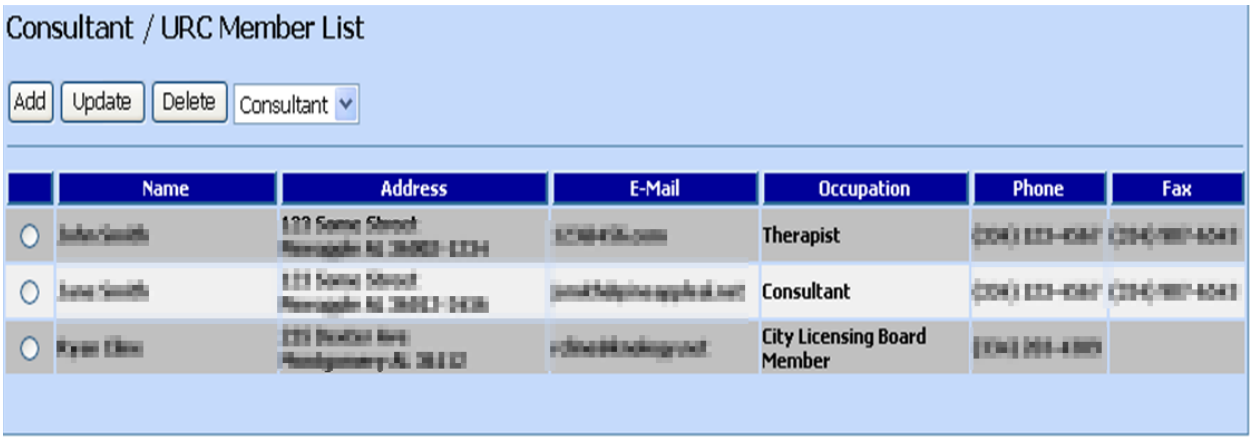
The Consultant and URC (Utilization Review Committee) member windows are used to enter or update information related to these entities. These windows are case sensitive, and the information is saved according to the case in which the information is keyed.

6.2 Consultants Listing

1. On the SURS main navigation window, click the hyperlink for **Consultant/URC Member List**:



2. Select **Consultant** from the drop-down list menu.



3. To update an existing consultant, select the radio button to the left of the Name field and click the **Update** button.

4. To add a new consultant, click the **Add** button

5. To delete an existing consultant, select the radio button to the left of the Name field and click the **Delete** button.

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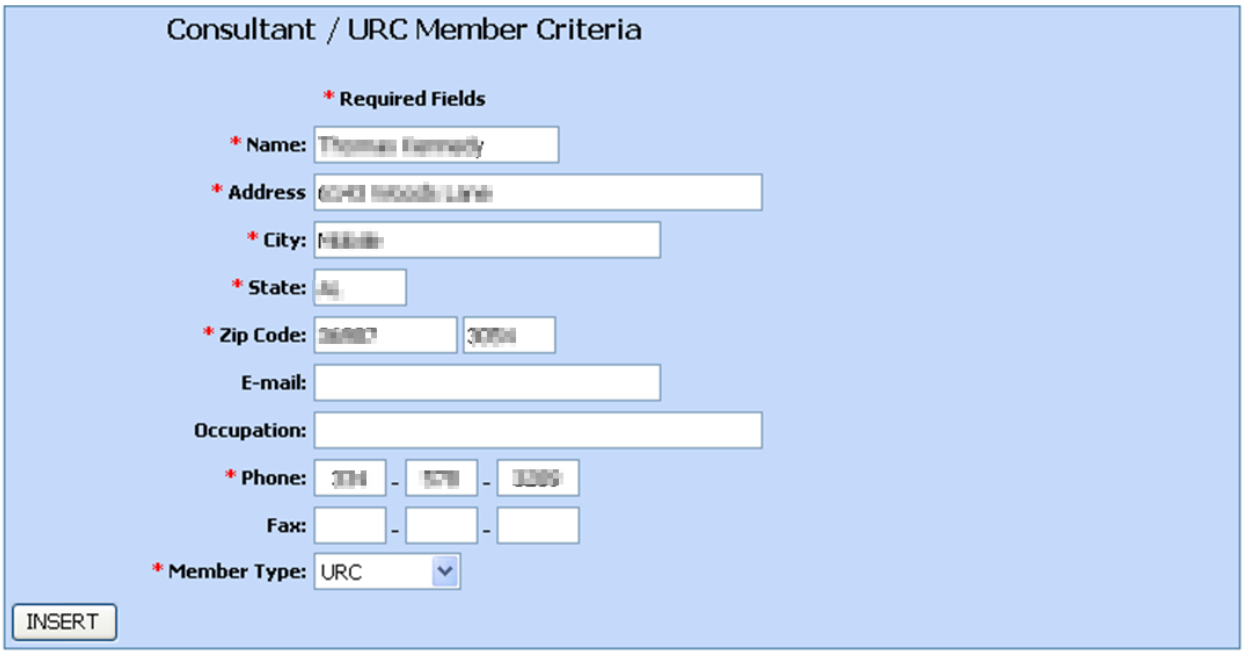
Result: The Consultant/URC Member Criteria window appears.



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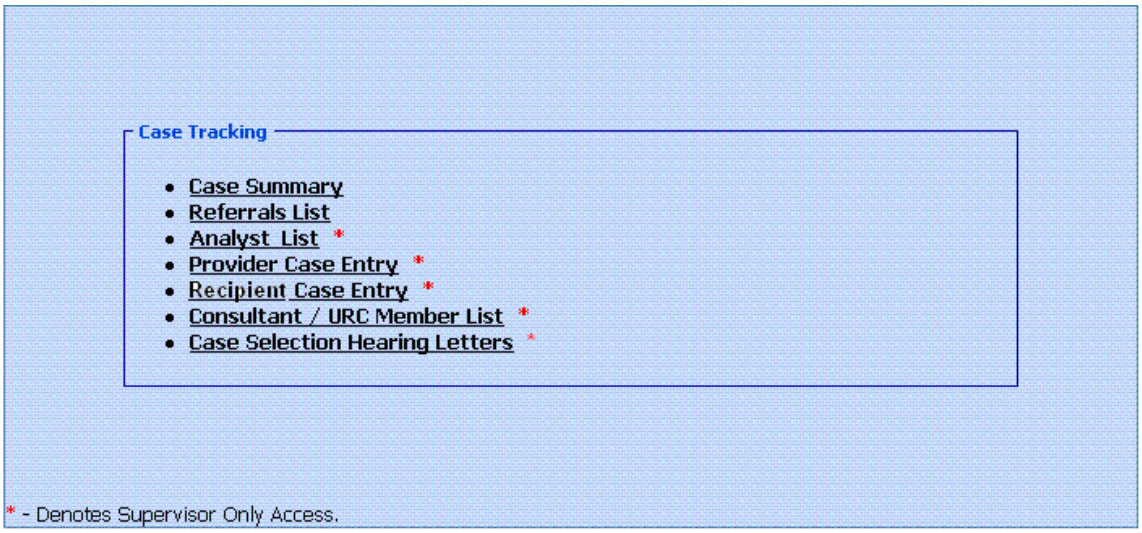
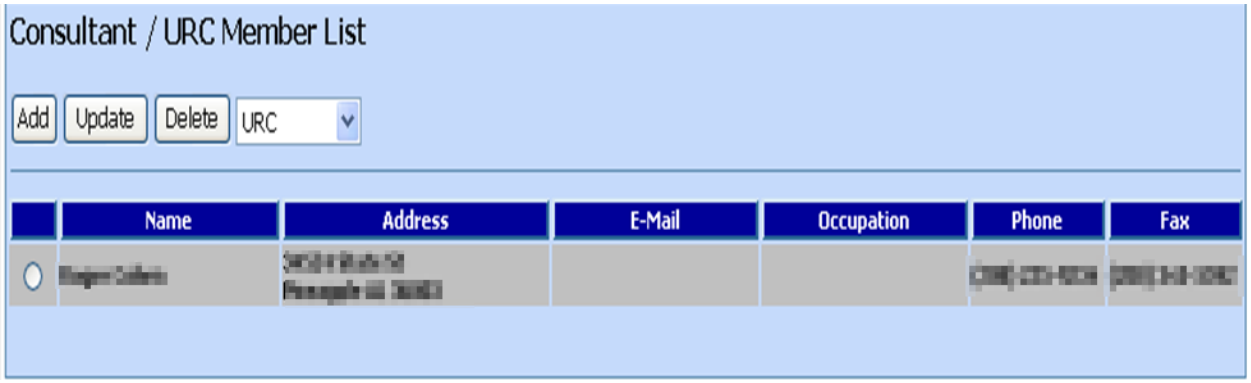
6.3 URC (Utilization Review Committee) Members Listing

1. On the SURS main navigation window, click the hyperlink for **Consultant/URC Member List**:



2. Select **URC** from the drop-down list menu.



3. To update an existing URC member, select the radio button to the left of the Name field and click the **Update** button.

4. To add a new URC member, click the **Add** button.

5. To delete an existing URC member, select the radio button to the left of the Name field and click the **Delete** button.

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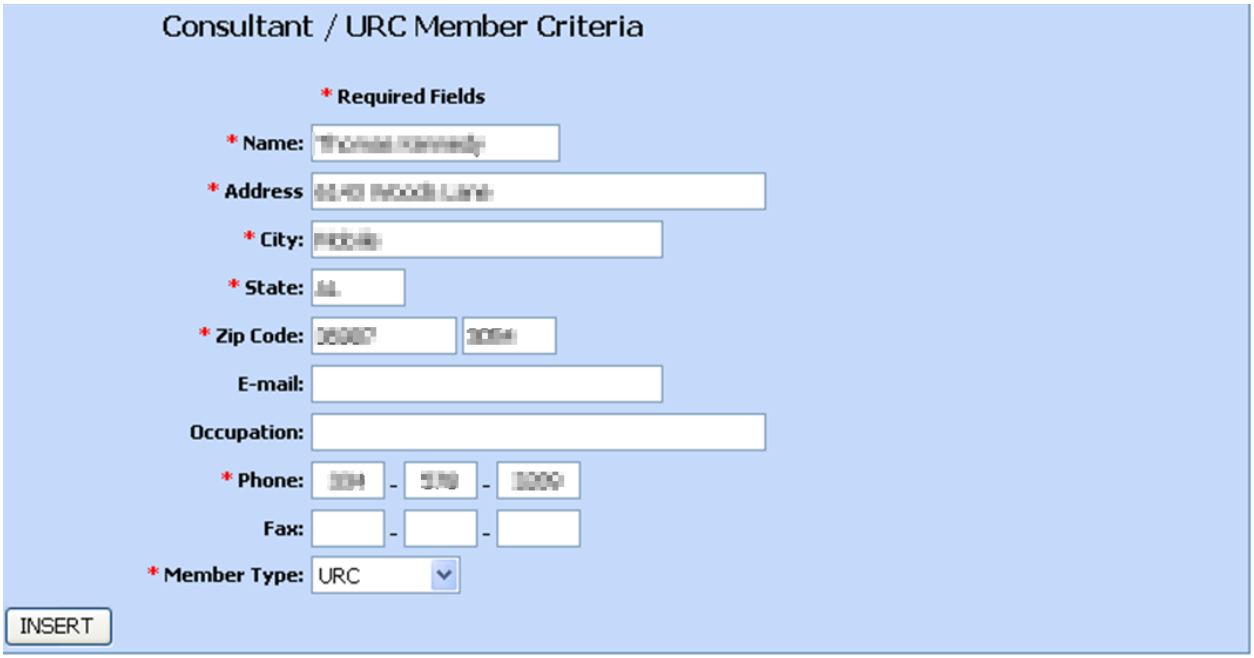
Result: The Consultant/URC Member Criteria window appears.



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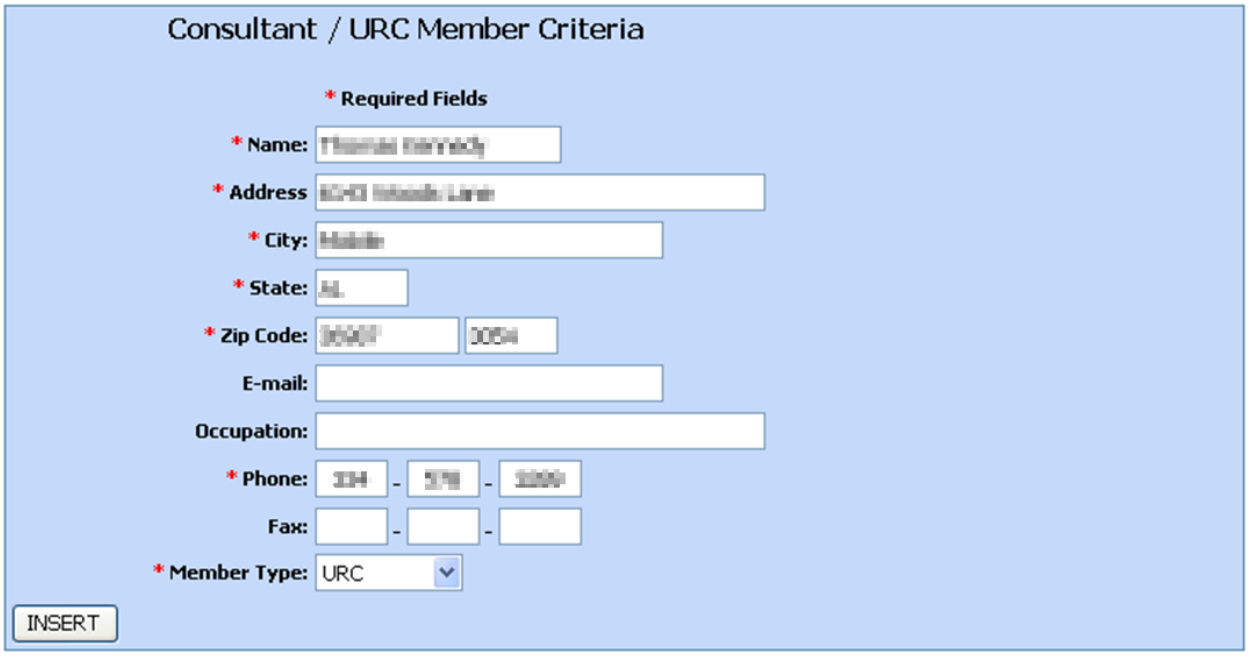
6.4 Enter Consultant/URC Member Criteria

The Consultant/URC Member Criteria window allows the user to enter contact information related to a consultant or URC member.



1. To Insert a new consultant or URC member enter the following information in the fields provided:

- Name
- Address
- City, State, Zip Code+4
- E-mail Address
- Occupation
- Phone and Fax Numbers
- Member Type (Consultant or URC)

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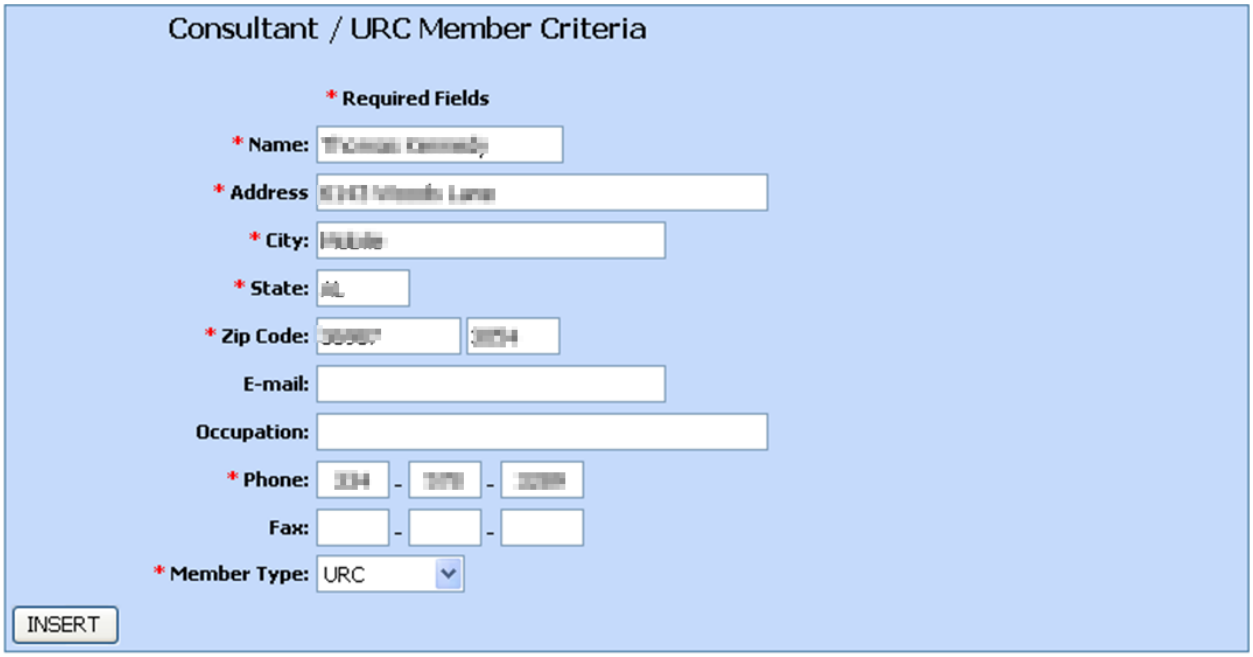
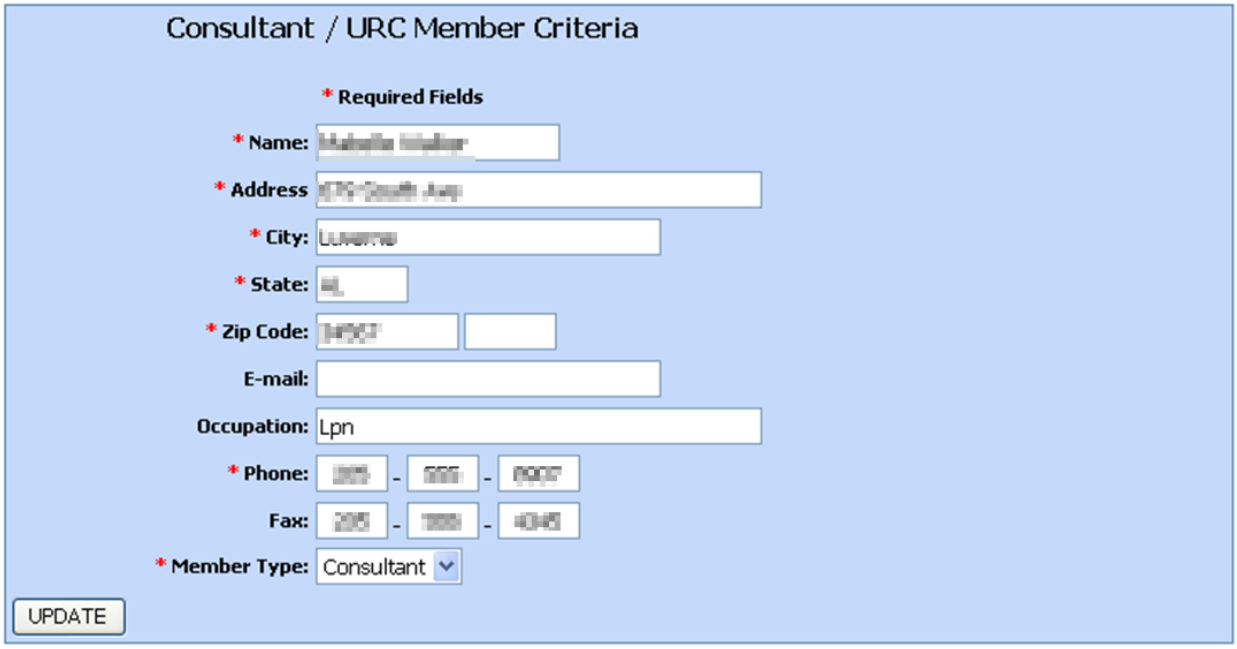
2. To save new information, click the **Insert** button.



3. To update an existing consultant or URC member, enter updates in any of the fields. To save updated information, click the **Update** button.



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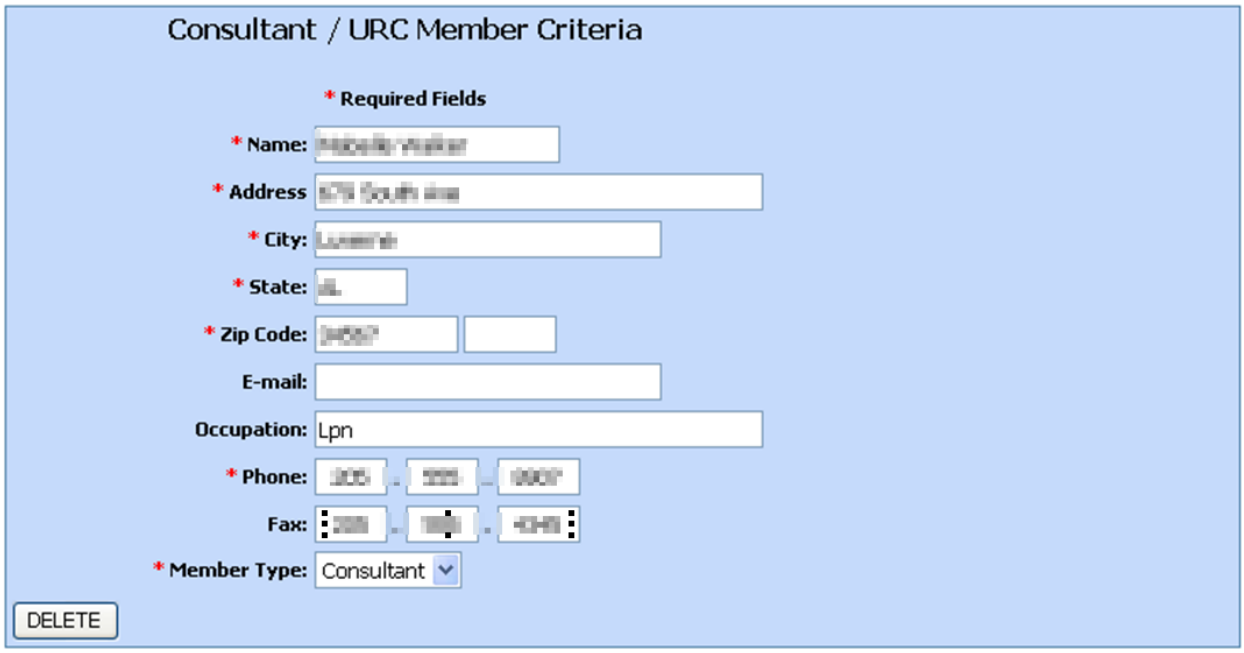
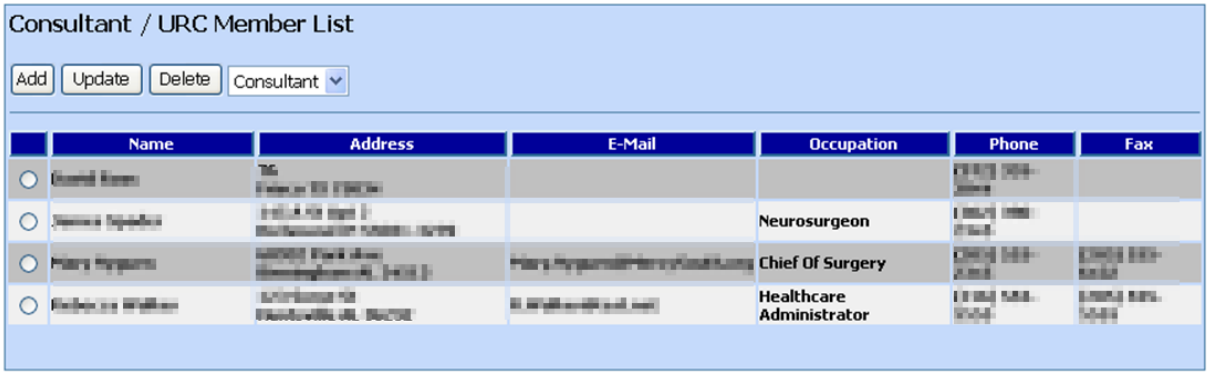
4. To delete a consultant or URC member, click the **Delete** button.



Result: When an insert, update or delete is completed the Consultants /URC Member List window is displayed.



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7. Entering/Selecting New Provider Cases

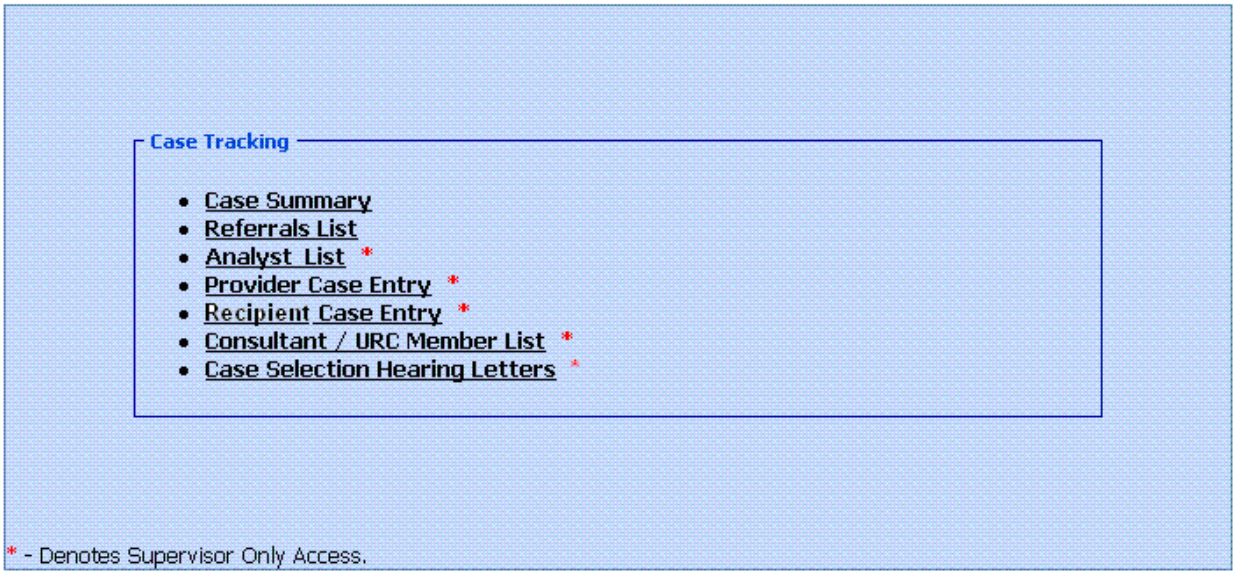
7.1 Overview

Provider case reviews can be opened for a number of reasons. DSSProfiler reports can be produced and reviewed to identify suspicious situations needing investigation or providers that have exceptions for specific cases identified by the Medicaid Agency. These cases would be entered manually into the system. Referrals can also be received from other entities that may open provider cases.

The Provider Case Entry window is the starting point for entering provider information for potential cases.

7.2 Provider Case Entry

On the SURS main navigation window, click the hyperlink for **Provider Case Entry**:



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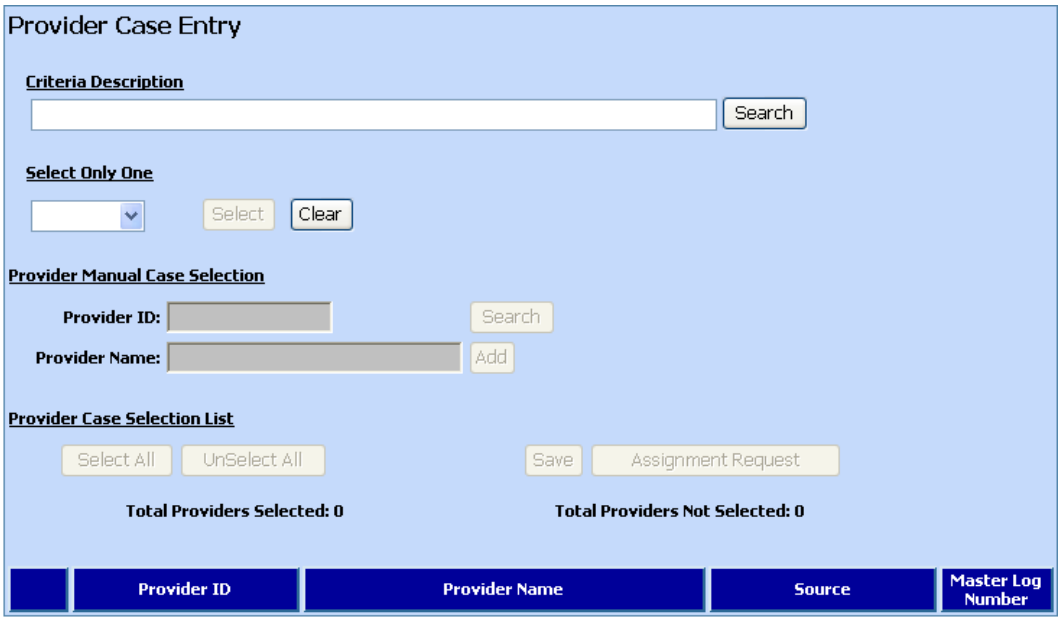
7.2.1 Provider Case Entry (by referral)

The Provider Case Entry window allows the user to create a list of potential providers that can be assigned to the case described in the Criteria Description. The case is not actually established until the assignment request button is selected. However, prior to a case opening, the user can identify and save potential providers to the list.



1. Enter a description for the new list of provider cases in the **Criteria Description** field.
2. Select **Referrals**, from the **Select Only One** drop-down menu.
3. If the Referrals selection is chosen, click the **Select** button and existing provider referrals that have not been assigned cases appear in the list at the bottom of the window. Select the applicable provider or providers by using the **Select All** button or by clicking the check box next to the applicable provider.
4. At the bottom of the window, the system returns the referral providers that were selected.
5. If too many or too few are displayed, click the **Clear** button to enter new criteria.
6. When the results are satisfactory, click the **Save** button to save the selected list along with the selected criteria. This only saves a list of the providers for the description displayed. This is a potential case list.

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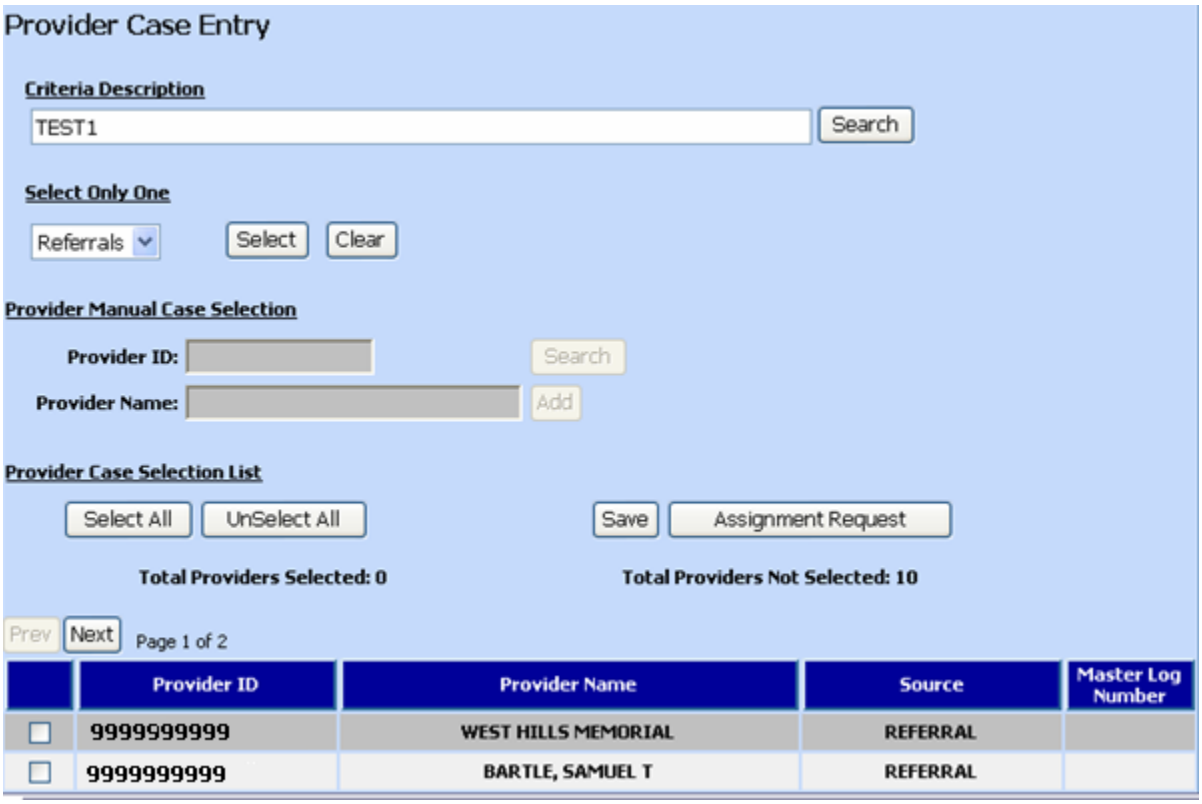
Result: The criteria and the list of providers are saved and the user remains on Provider Case Entry window.



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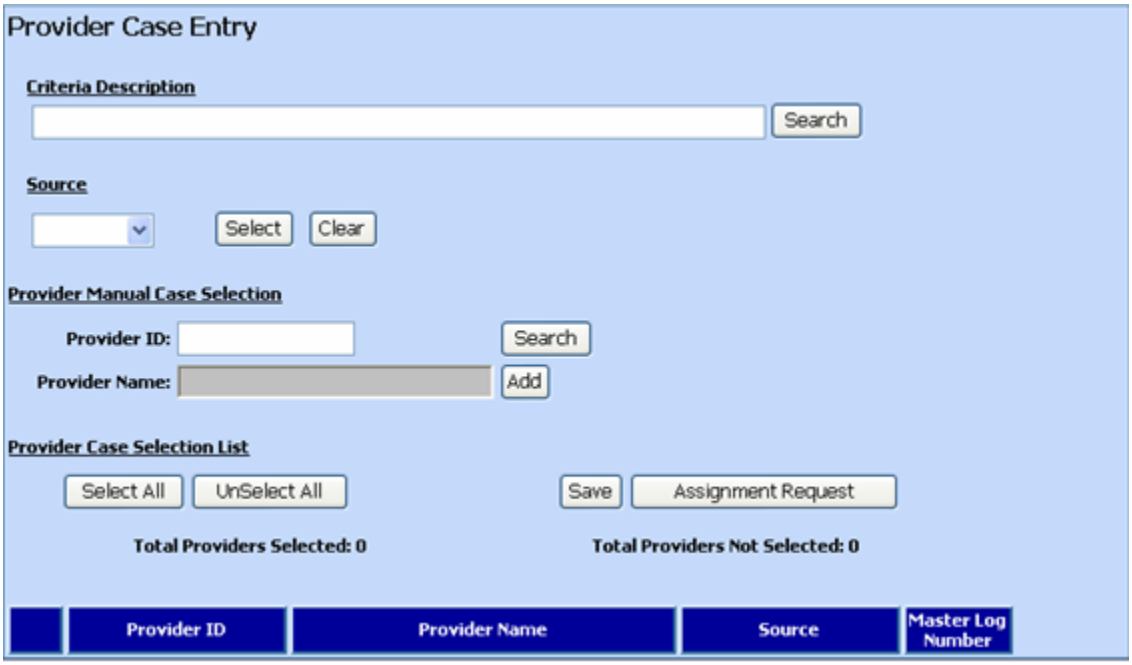
7.2.2 Provider Case Entry (manual)

Manual cases may be entered to create a new list of providers or providers may be added to an existing list for cases which do not have an assigned Master Log Number.



1. To enter a list of providers manually, enter a description for the new list of provider cases in the **Criteria Description** field and select **Manual** from the **Select Only One** drop-down menu.
2. Enter the Provider Number or Medicaid Provider number of the provider in the **Provider ID** field in the Provider Manual Case Selection area of the window and click the **Search** button.
3. If the system finds the number, the name of the provider is displayed in the **Provider Name** field. If not, an error message is displayed.
4. If the correct provider was entered, click the **Add** button to insert the provider into the list of potential provider cases.
5. Continue to add providers until results are satisfactory, then click the **Save** button to save the selected list along with the selected criteria.

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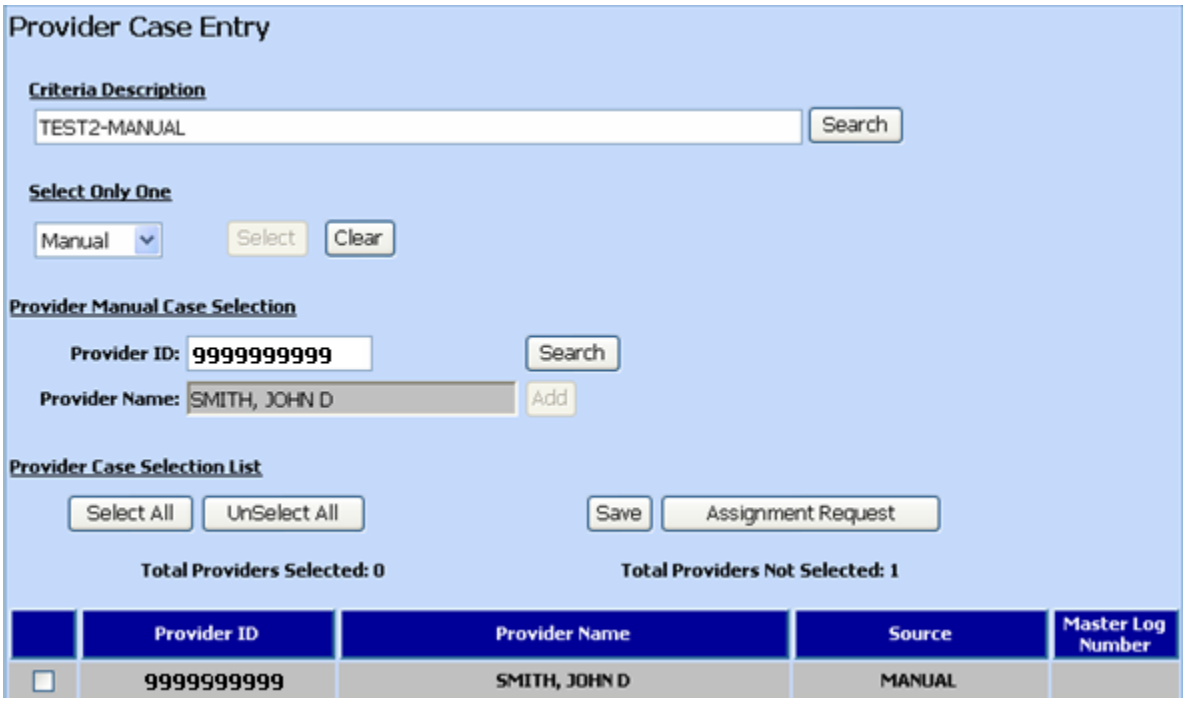
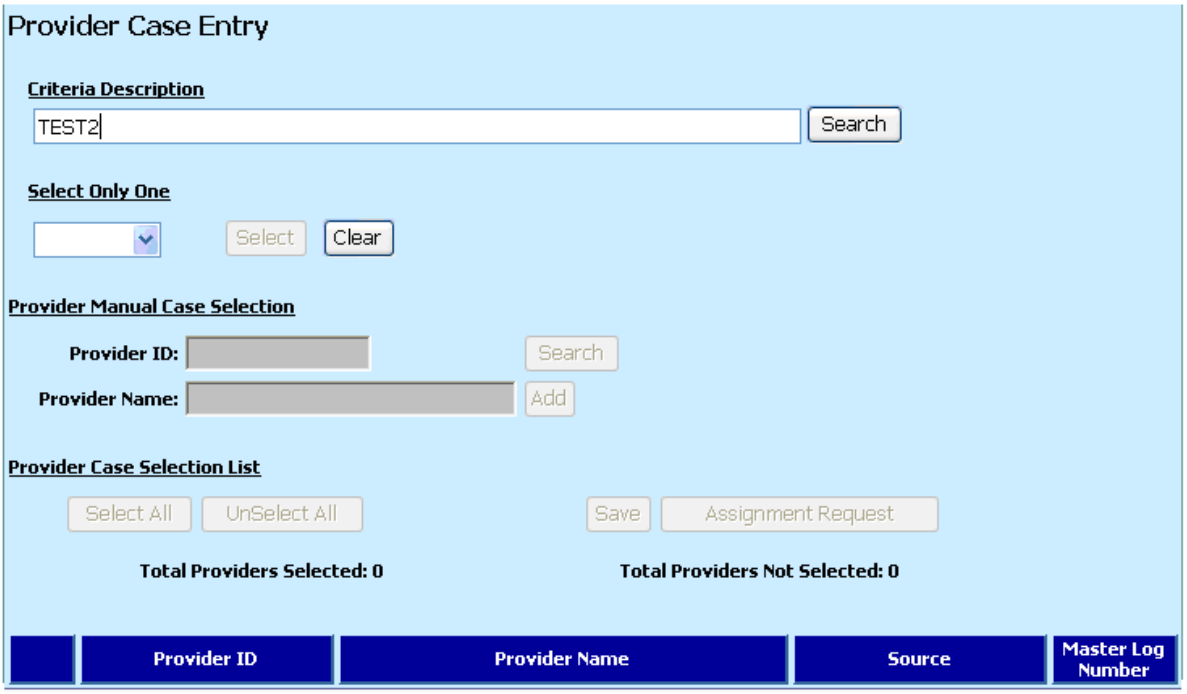
Result: The criteria and the list of providers are saved and the user remains on the Provider Case Entry window.



7.2.3 Search for Previously Saved Case List

On the Provider Case Entry window, by entering at least a portion of the criteria description and clicking the **Search** button shown beside the Criteria Description field, users can retrieve provider case criteria and the associated list of providers:



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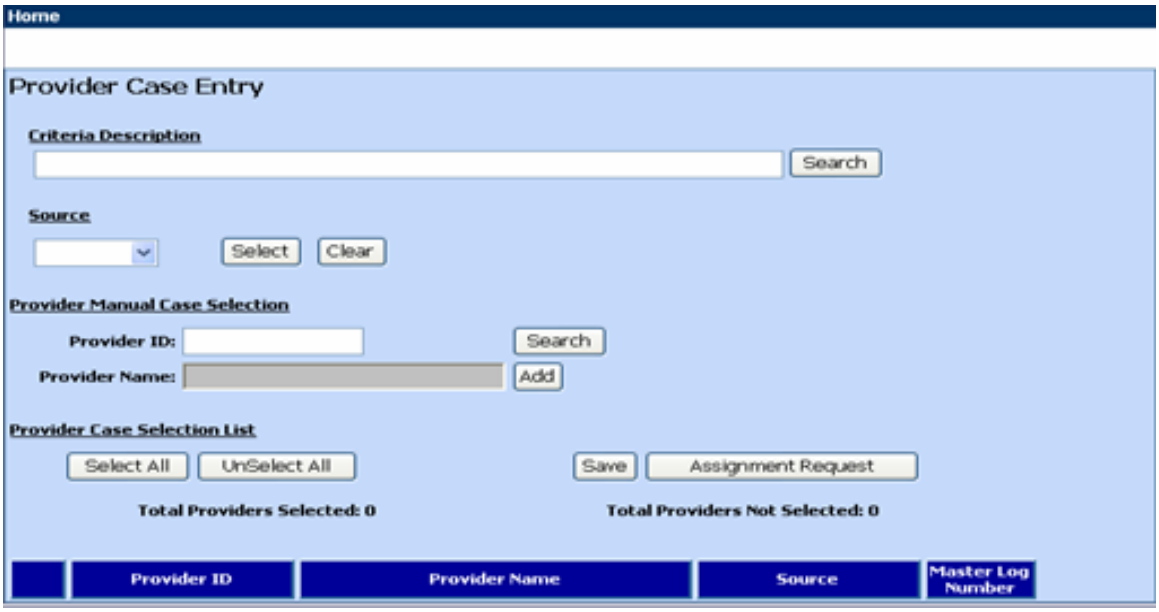
7.2.4 Provider Case Entry (select providers for case review)

Before a Master Log Number can be assigned from the Provider Case Entry window, the user must select providers for which the system is to create cases.

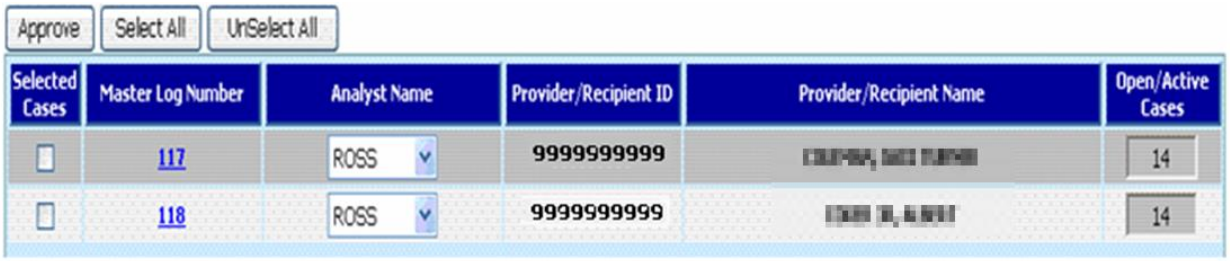


NOTE:

Only click on the Assignment Request button when you are sure you want to create the cases. After this button has been clicked, the criteria and the list of selected providers cannot be modified.

1. To individually select the providers, click the check box to the left of each **Provider ID**.
2. Click the **Select All** button to select all the providers at once or click the **UnSelect All** button to deselect all the providers at once.
3. The user may click the **Save** button to save the information entered at any time.
4. When the list has been finalized, click the **Assignment Request** button to create the case. If the list and selected providers have not been saved when the Assignment Request button is clicked, the system automatically performs a save.
5. The system assigns a Master Log Number to the selected providers and creates the appropriate directory structure used by the Case File tabs on the Case Summary window.

Result: After the cases have been created, the Case Assignment Verification window appears.



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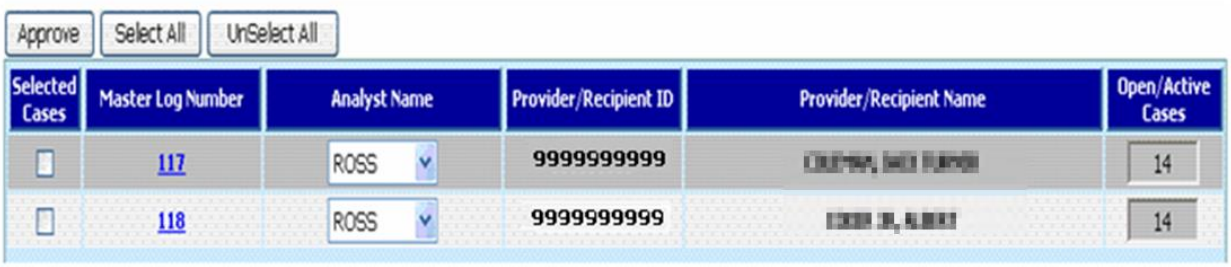
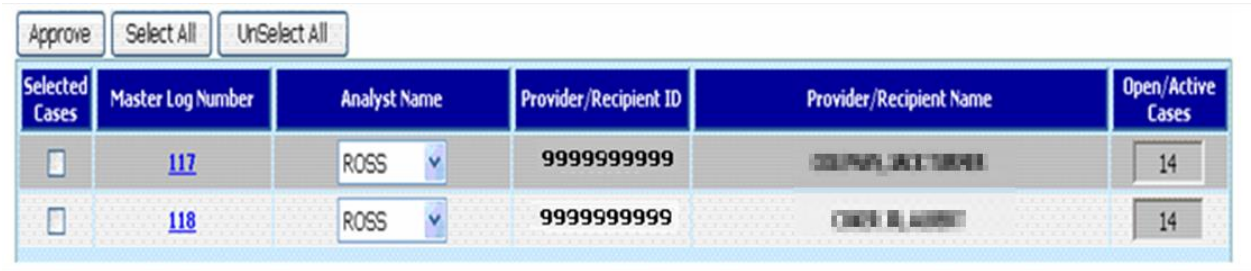
7.2.5 Case Assignment Verification

The Case Assignment Verification window displays all the cases that were automatically assigned by the system to SUR analysts:



1. The system uses the analyst criteria entered through the Analyst Criteria List windows to assign the new cases to SUR analysts.
2. The user can override these assignments by changing the name of the assigned analyst in the **Analyst Name** drop-down menu.
3. After reviewing the cases and the associated analysts, the user clicks the check box next to the **Master Log Number** hyperlink.
4. Alternately, the user may click the **Select All** button to place check marks in all the boxes, or click the **UnSelect All** button to clear all the check boxes.
5. When the assignments are finalized, the user clicks the **Approve** button to assign the appropriate cases to the selected analysts.

Result: The selected analysts are assigned to the new cases. The user remains on the Case Assignment Verification window with the check boxes grayed out for any previously assigned cases.



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8. Entering/Selecting New Recipient Cases

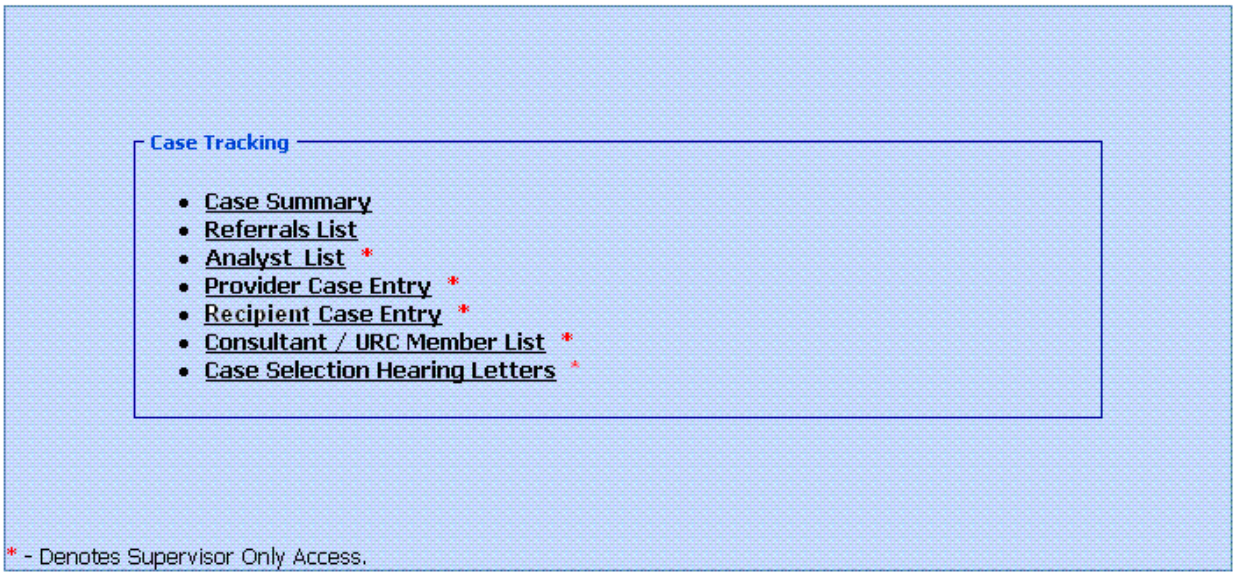
8.1 Overview

Recipient case reviews can be opened for a number of reasons. DSSProfiler reports can be produced and reviewed to display the most aberrant users of the Medicaid system. These cases would be entered manually into the system. Referrals can also be received from other entities that may open recipient cases.

The Recipient Case Entry window is the starting point for entering recipient information for potential cases.

8.2 Recipient Case Entry

On the SURS main navigation window, click the hyperlink for **Recipient Case Entry**:



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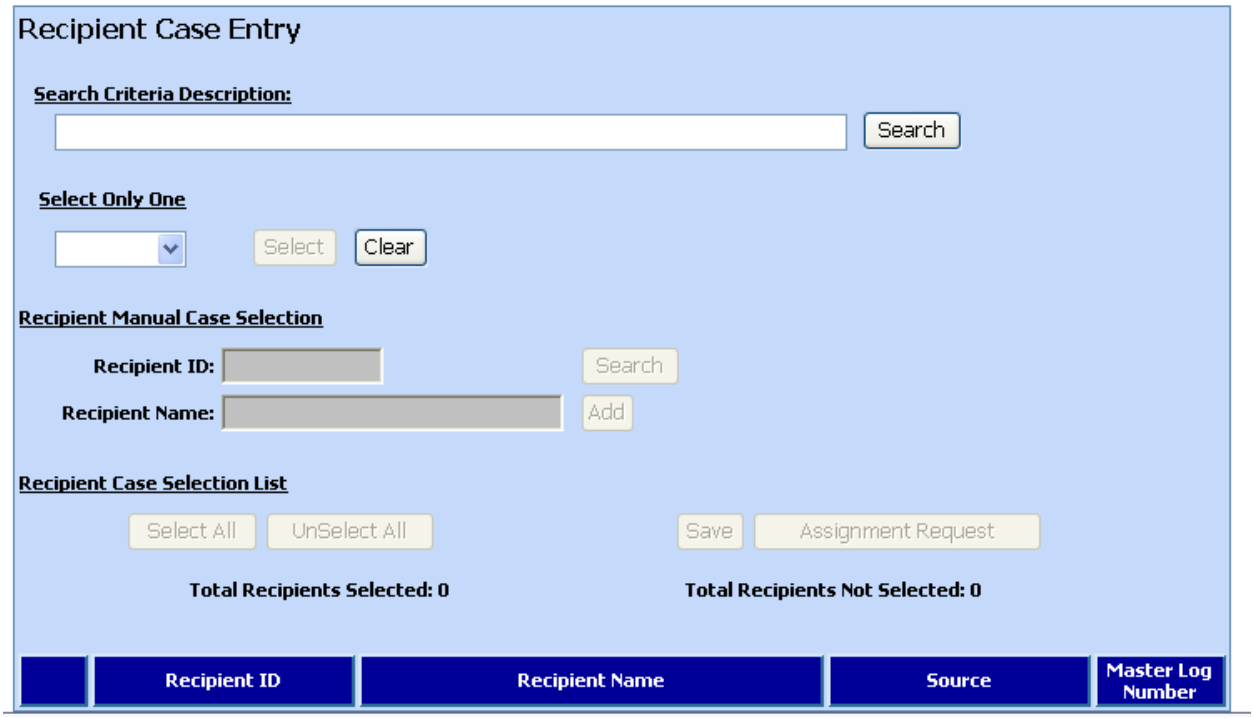
8.2.1 Recipient Case Entry (by referral)

The Recipient Case Entry window allows the user to create a list of potential recipients that can be assigned to the case described in the Search Criteria Description. The case is not actually established until the assignment request button is selected. However, prior to a case opening, the user can identify and save potential recipients to the list.



1. Enter a description for the new list of recipient cases in the **Search Criteria Description** field.
2. Select **Referrals** from the **Select Only One** drop-down menu.
3. If the Referrals selection is chosen, click the **Select** button and the existing referrals that have not been assigned cases appear in the list at the bottom of the window. Select the applicable recipient or recipients by using the **Select All** button or by clicking the check box next to the applicable recipient.
4. At the bottom of the window, the system returns the recipients that were selected.
5. If too many or too few results are displayed, click the **Clear** button to enter new criteria.
6. When the results are satisfactory, click the **Save** button to save the selected list along with the selected criteria. This only saves a list of the recipients for the description displayed; this is the potential case list.

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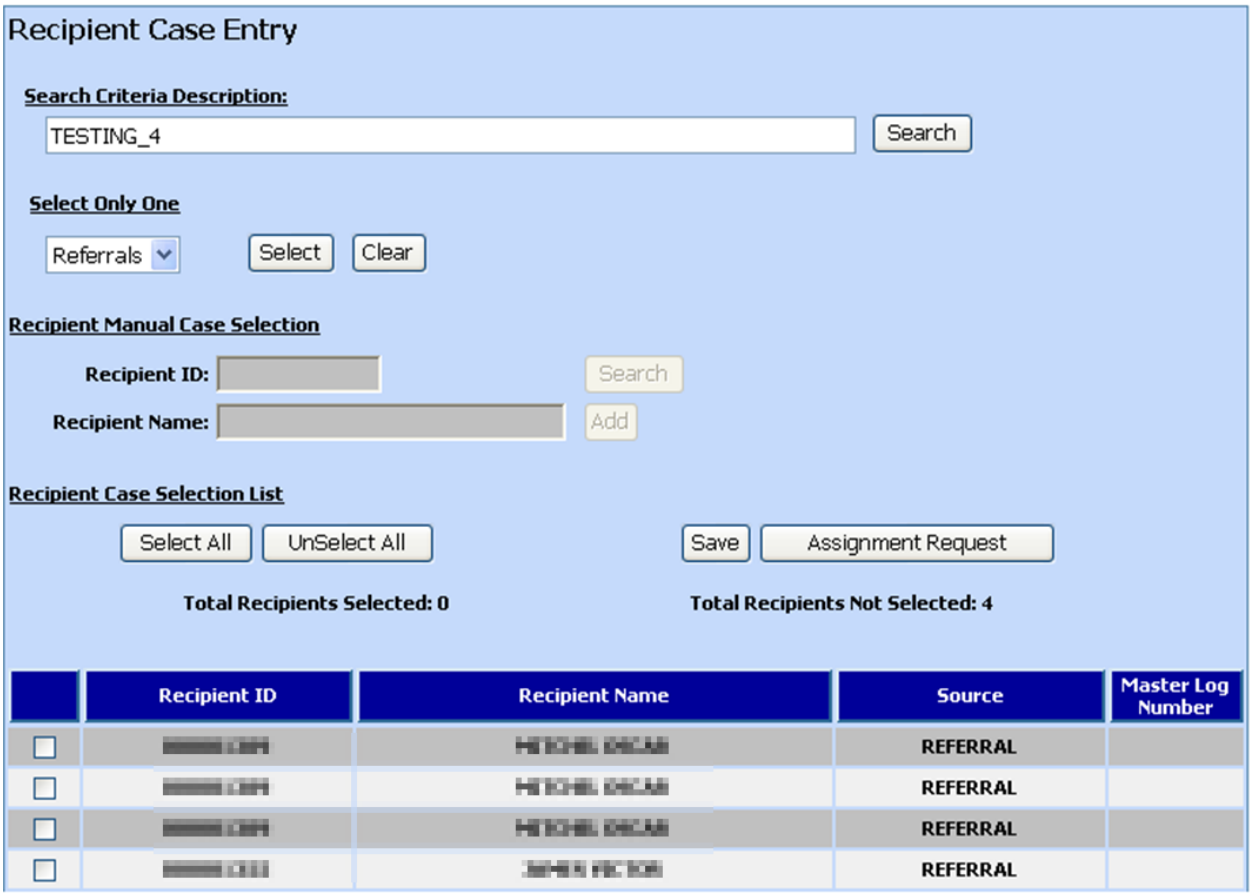
Result: The criteria and the list of recipients are saved and the user remains on the Recipient Case Entry window.



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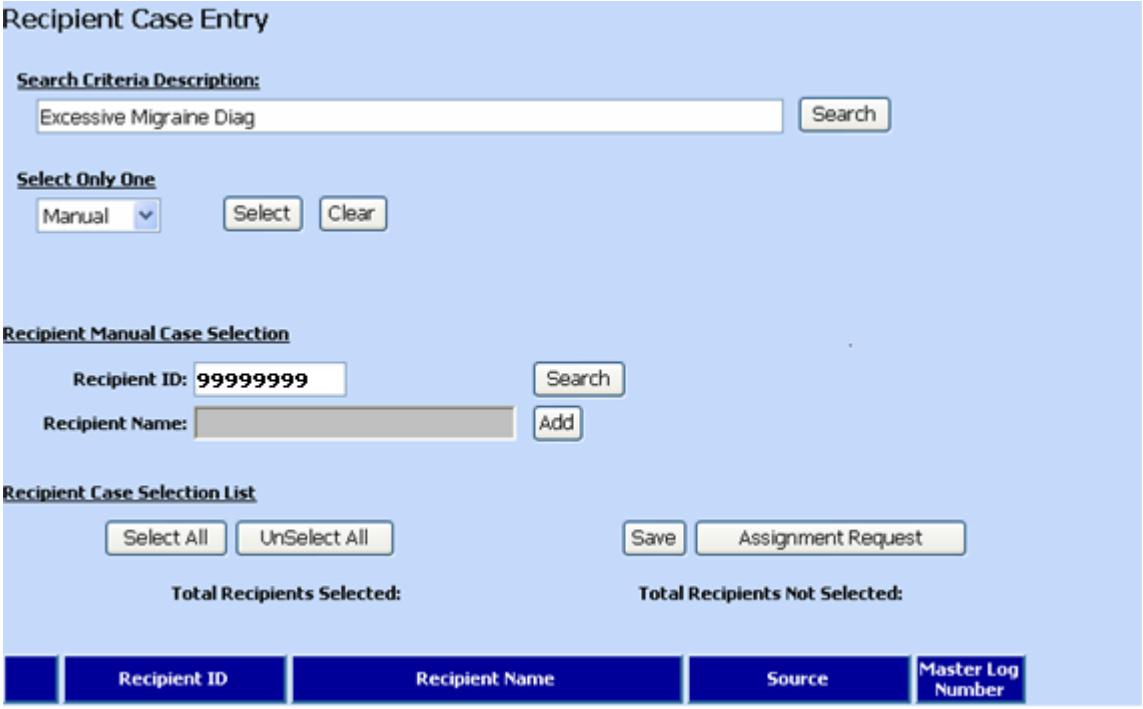
8.2.2 Recipient Case Entry (manual)

Manual cases may be entered to create a new list of recipients or recipients may be added to an existing list for cases which do not have an assigned Master Log Number.



1. Enter a description for the new list of recipient cases in the **Search Criteria Description** field.
2. To enter a new list of recipients for potential cases, select **Manual** from the **Select Only One** drop-down menu.
3. Enter the **Medicaid number** of the recipient in the **Recipient ID** field in the Recipient Manual Case Selection area of the window and click the **Search** button.
4. If the system finds the number, the name of the recipient is displayed in the **Recipient Name** field. If not, an error message is displayed.
5. If the correct recipient was entered, click the **Add** button to insert the recipient into the list of potential recipient cases.
6. Continue to add recipients until results are satisfactory, then click the **Save** button to save the select list along with the selected criteria.

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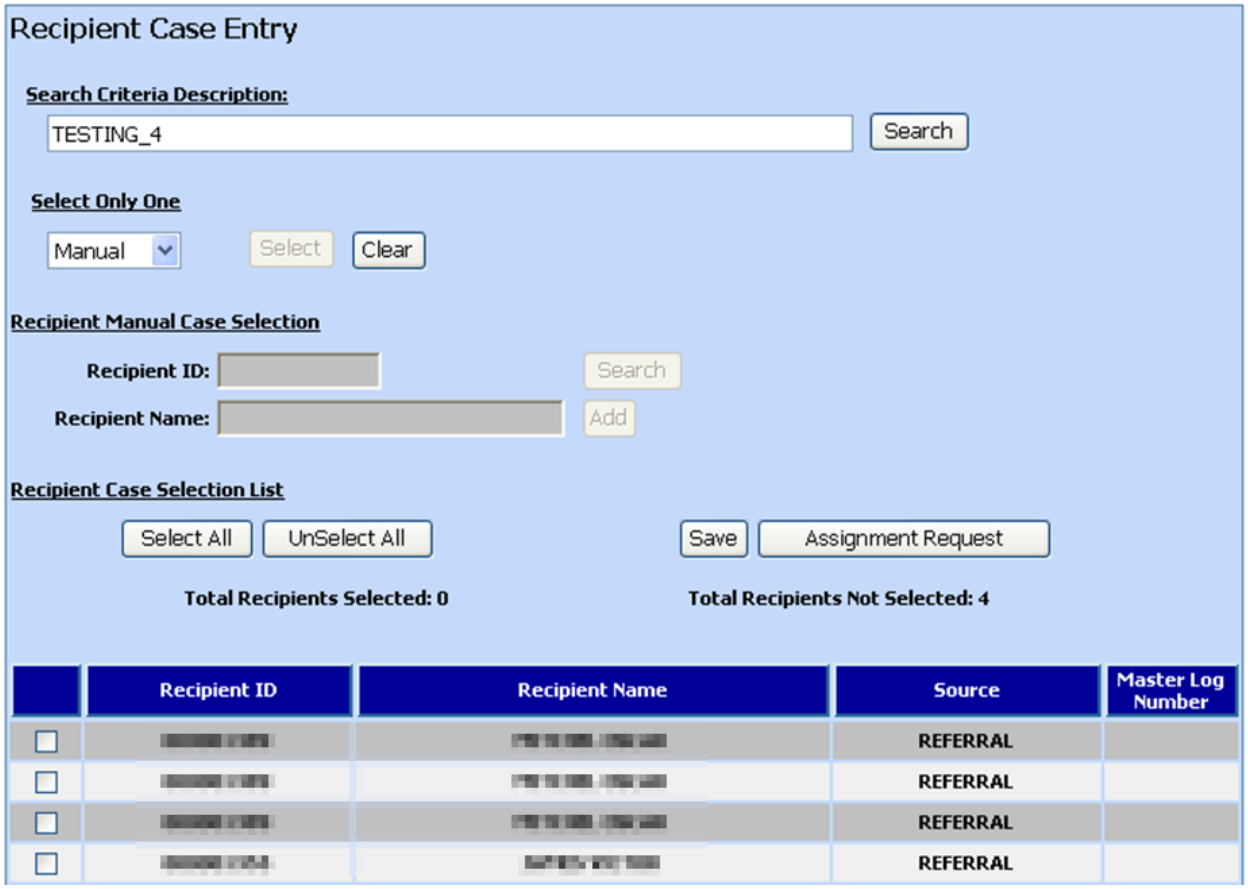
Result: The criteria and list of recipients are saved and the user remains on the Recipient Case Entry window.



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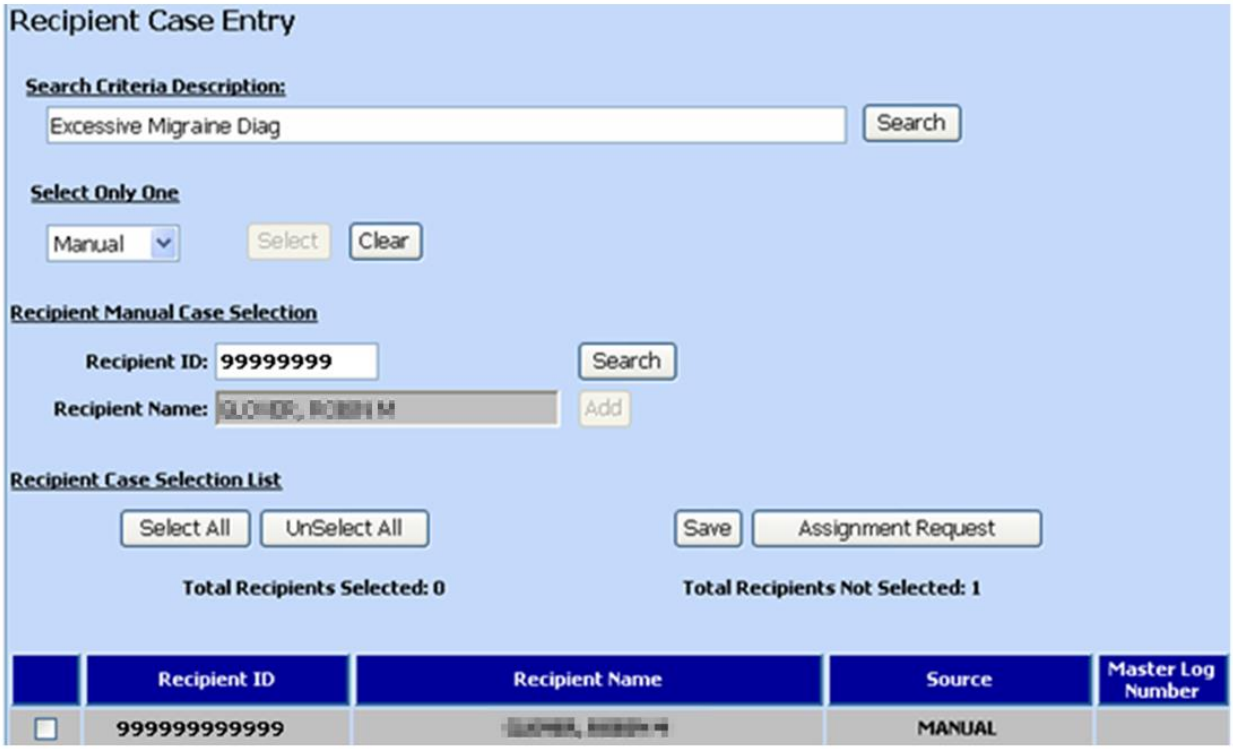
8.2.3 Search for Previously Saved Case List

By entering at least a portion of the Search Criteria Description and clicking the Search button shown beside the Search Criteria Description field, users can retrieve recipient case criteria and the associated list of recipients:



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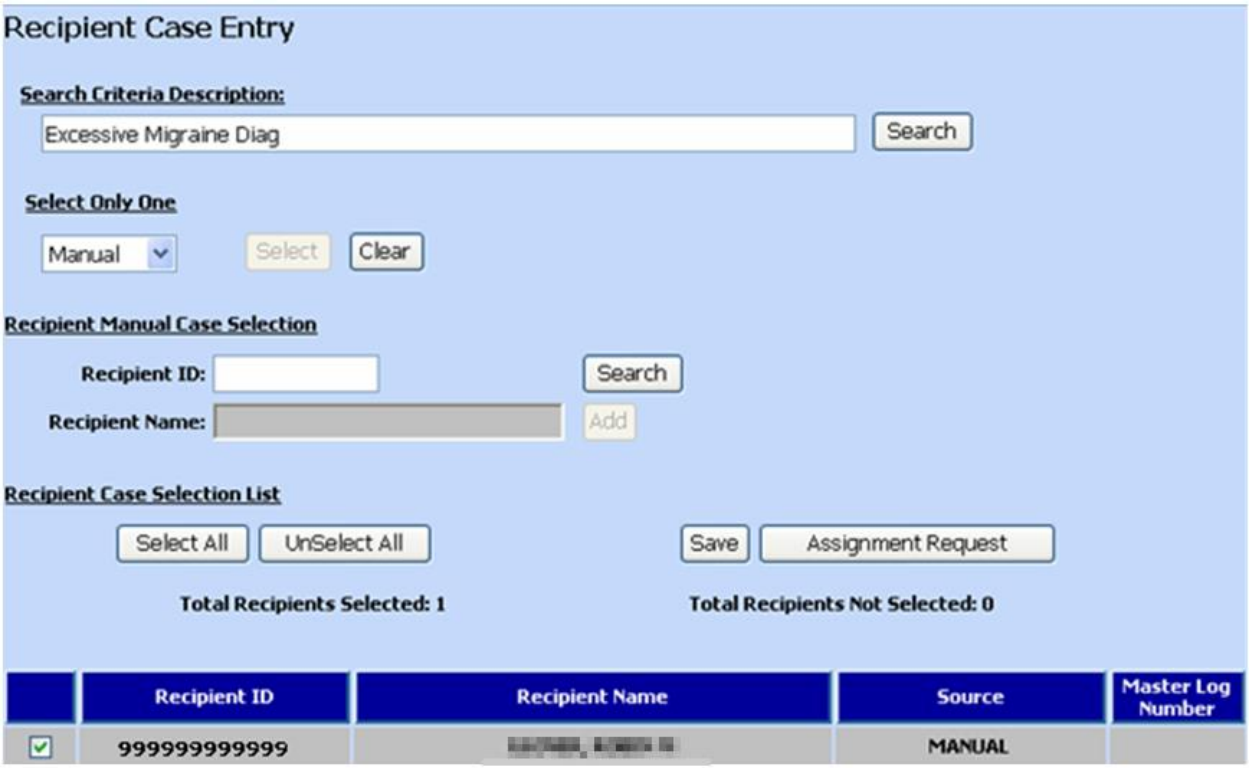
8.2.4 Recipient Case Entry (select recipients for case review)

1. Before a Master Log Number can be assigned, from the Recipient Case Entry window, the user must select recipients for which the system is to create cases.



NOTE:

Only click on the Assignment Request button when you are sure you want to create the cases. After this button has been clicked, the criteria and the list of selected recipients cannot be modified.

2. To individually select the recipients, click the check box next to the left of each **Recipient ID**.
3. Click the **Select All** button to select all the recipients at once or click the **UnSelect All** button to deselect all the recipients at once.
4. The user may click the **Save** button to save the information entered at any time.
5. When the list has been finalized, click the **Assignment Request** button to create the case. If the list and selected recipients have not been saved when the Assignment Request button is clicked, the system automatically performs a save.
6. The system assigns a Master Log Number to the selected recipients and creates the appropriate directory structure used by the Case File tabs on the Case Summary window.

Result: After the cases have been created, the Case Assignment Verification window appears.

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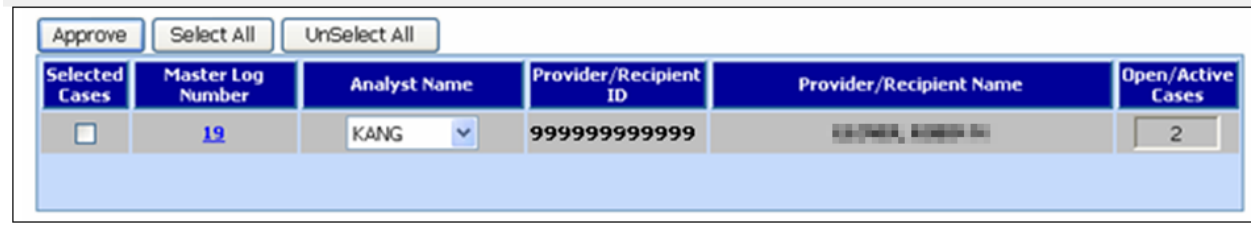
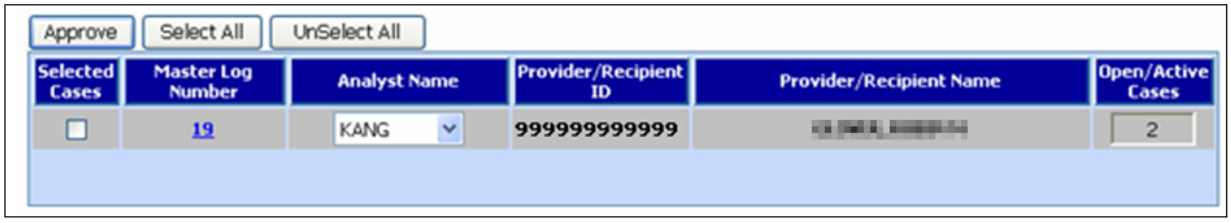


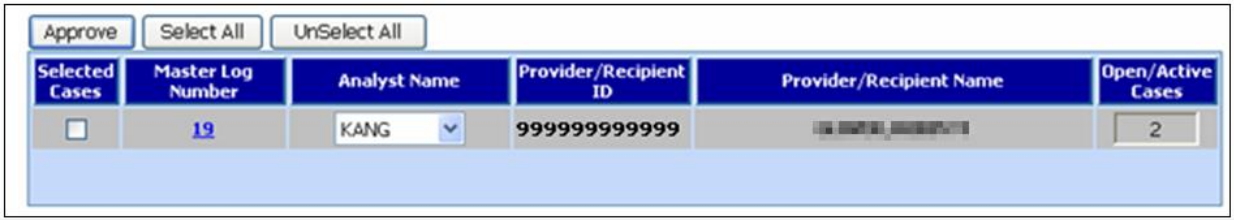
8.2.5 Case Assignment Verification

The Case Assignment Verification window displays all the cases that were automatically assigned by the system to SUR analysts.



1. The system uses the analyst criteria entered through the Analyst Criteria windows to assign the new cases to SUR analysts.
2. The user can override these assignments by changing the name of the assigned analyst in the **Analyst Name** drop-down menu.
3. After reviewing the cases and the associated analysts, the user clicks the check box next to the **Master Log Number** hyperlink.
4. Alternately, the user may click the **Select All** button to place check marks in all the boxes, or click the **UnSelect All** button to clear all the check boxes.
5. When the assignments are finalized, the user clicks the **Approve** button to assign the appropriate cases to the selected analysts.

Result: The selected analysts are assigned to the new cases. The user remains on the Case Assignment Verification window with the check boxes grayed out for any previously assigned cases.



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9. Entering New Referrals

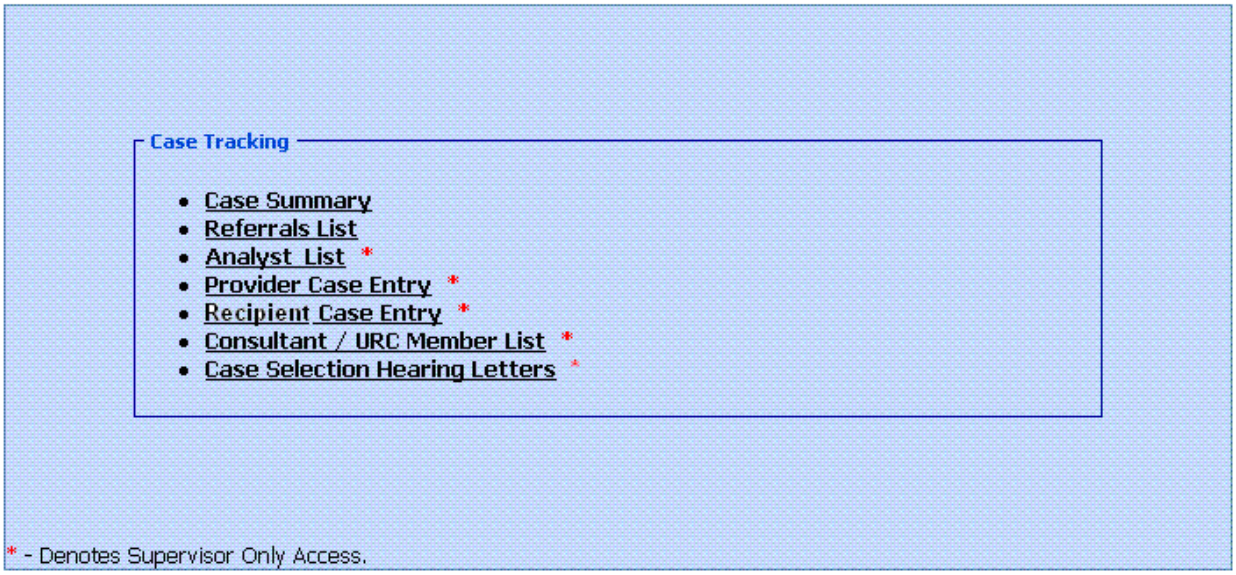
9.1 Overview

The Referral window is used to enter new referrals. These referrals may be received from other entities, such as complaints regarding a particular provider, or concerning recipients that are abusing the Medicaid system. The Referral window is also used to update and delete referrals. These functions are only available from the Referrals tab on the Case Summary window.

9.2 Referral Entry

The user may enter new referrals as they are received from other entities. Referrals are assigned to Master Log Number zero (0) until an official case has been created and the referral has been associated to a case. Referrals that are created but not assigned to a case are listed when creating a case using the referral drop down selection.

1. On the SURS main navigation window, click the hyperlink for **Referrals List**:



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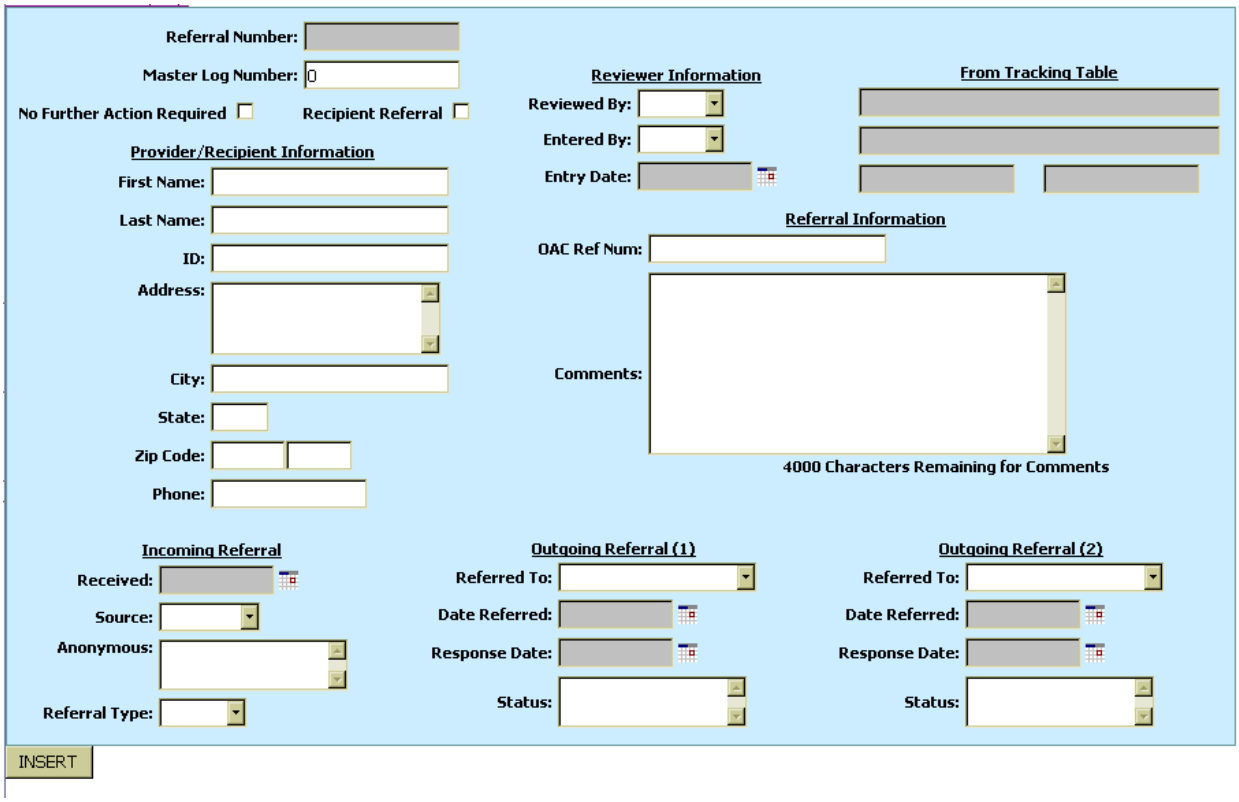

2. Enter the **Provider/Recipient** and **Referral** information into the appropriate fields.
3. Click the **Insert** button to save the information.

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Referral Number:
Master Log Number: 0
No Further Action Required
Recipient Referral
Provider/Recipient Information
First Name:
Last Name:
ID:
Address:
City:
State:
Zip Code:
Phone:
Reviewer Information
Reviewed By:
Entered By:
Entry Date:
From Tracking Table
Referral Information
OAC Ref Num:
Comments: Was reported by an unknown person as abusing the Medicaid system.
3935 Characters Remaining for Comments
Incoming Referral
Received: 3/7/2007
Source: Standard
Anonymous:
Referral Type: Phone
Outgoing Referral (1)
Referred To:
Date Referred:
Response Date:
Status:
Outgoing Referral (2)
Referred To:
Date Referred:
Response Date:
Status:
INSERT

Result: The referral information is saved along with an auto-generated referral number to be used to reference this information. After the insert, the Referrals tab of the Case Maintenance window appears to show the entire list of referrals that have not been assigned to a case (master log number is 0).

Case Summary | Lock-In | Contract Terminations | Referrals | Case File

Master Log Number: 0
Provider Name:
Analyst Name:

Add | Update | Delete

	Referral Number	Provider/Recipient ID	Provider/Recipient Name	Received	Source	Referral Type
○	1	999999999999		3/7/2007		PHONE
○	2	999999999999		3/7/2007		PHONE

The user may select a radio button for a referral and perform an update or delete. In this case the associated referral data is displayed on the Referrals List window for the user to update or delete. The user may also select the insert button to add another referral. In this case a blank Referrals List window is displayed for the user to enter referral data. From the Referrals tab shown above, the user may click on the referral number link from the 'Referral Number' column to view the related referral information. The Add, Update or Delete button must be selected from this window in order to update referral data based on the button selected.

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NOTE:

The No Further Action Required checkbox for a referral indicates if a case may potentially be opened in the future. If it is checked, the referral will not be brought into the list of selected cases on the Provider or Recipient Case Selection windows when the selected **Select Only One** drop-down value is **Referrals**. In addition, whether the checkbox is checked or not, the referral will still be listed on the Referrals tab of the Case Summary Window.

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10. Updating Case Information

10.1 Overview

The Case Summary windows display research information related to a specific Master Log Number or case. Tabs are used to display the different sets of information as they relate to the case. There are a total of five tabs including:

- Case Summary
- Lock-In
- Contract Terminations
- Referrals
- Case File

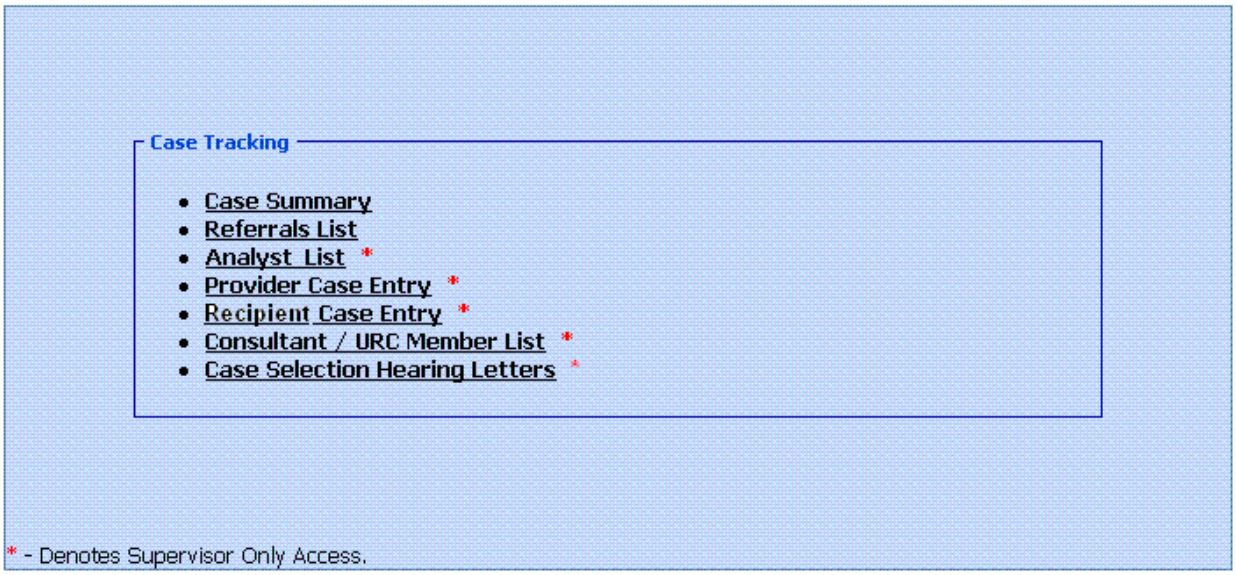
Each of these tabs are described in the sections that follow.

10.1.1 Case Summary Tab

The Case Summary tab is the main case tab. Different versions of this window have been designed for supervisors and analysts; based on their security clearances. Supervisors have greater access to view and change information than do analysts. As a case moves through different phases the related dates and amounts can be recorded, as well as analyst information and comments. The status of the case is also updated using this window.

To change information on the Case Summary tab, an authorized user follows these steps:

On the SURS main navigation window, click the hyperlink for **Case Summary**:



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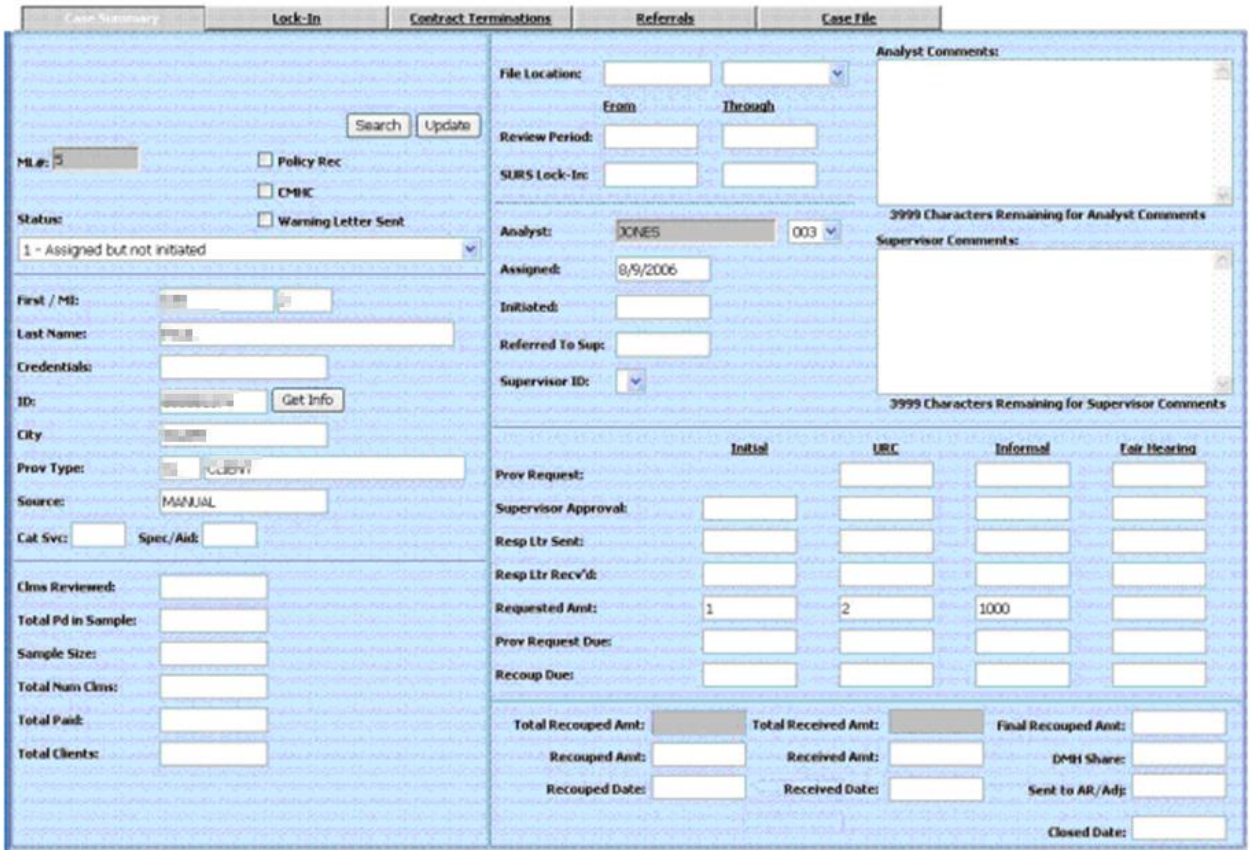
On the Case Tracking page, select the **Case Summary** tab:

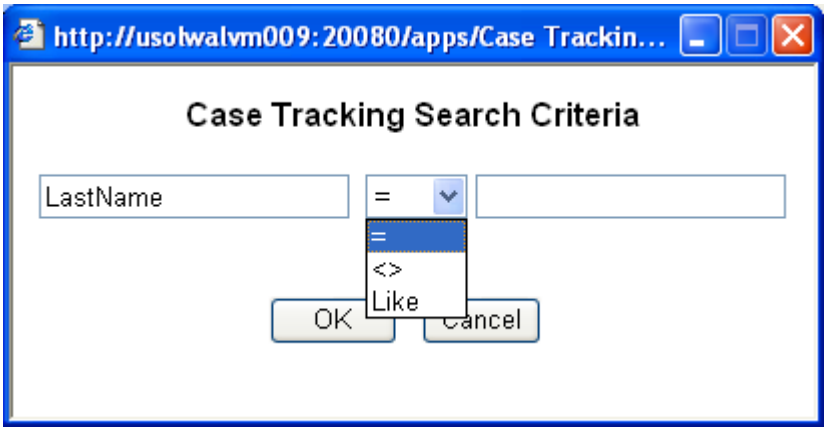


10.1.2 To Search for a Specific Case

The user can search on any field on the Case Summary tab.

1. Click in any field on the Case Summary tab. (This includes the ML# field, although it is grayed out.)
2. Click on the **Search** button.

Result: A search pop-up window appears.



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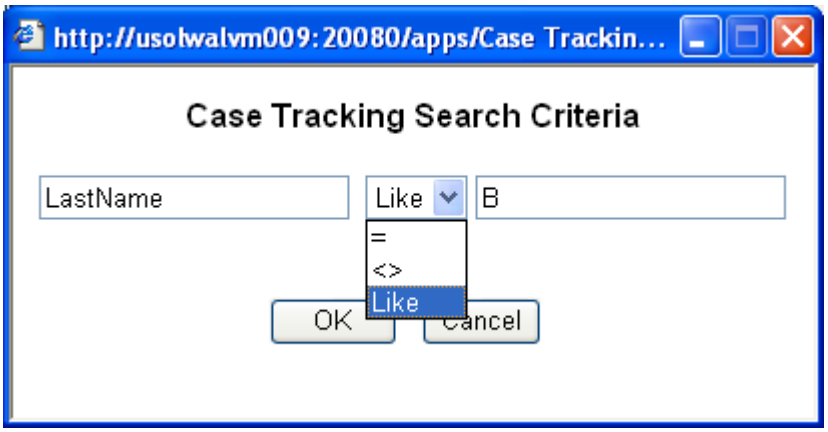
3. Select an operator from the drop-down menu to identify the condition of the search to perform, such as an equal, not equal or like condition on the search criteria.

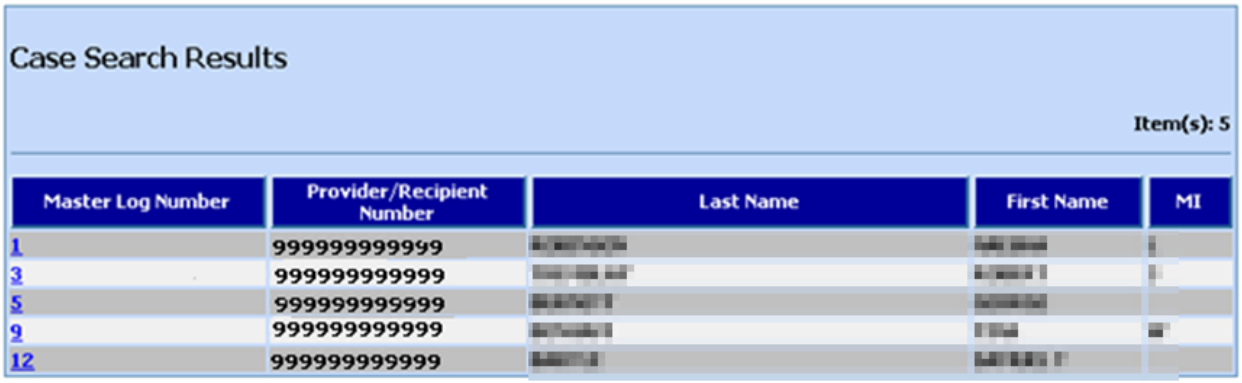
Example: In the following example, the user is searching by LastName and has selected the 'like' operator as the condition.



4. Enter the search criteria in the text box.

Example: In the example above, the search is for Last Names that contain the letter 'B'

5. Click the **OK** button or press Enter.
6. If more than one case returns from the search, the system displays all the relevant cases with the matching criteria. If only one case matches the search criteria, the user is taken directly to the Case Summary window for that case.
7. If there was more than one case returned from the search, the Case Search Results window displays. Click on the **Master Log Number** hyperlink from the displayed list to gain access to that case.



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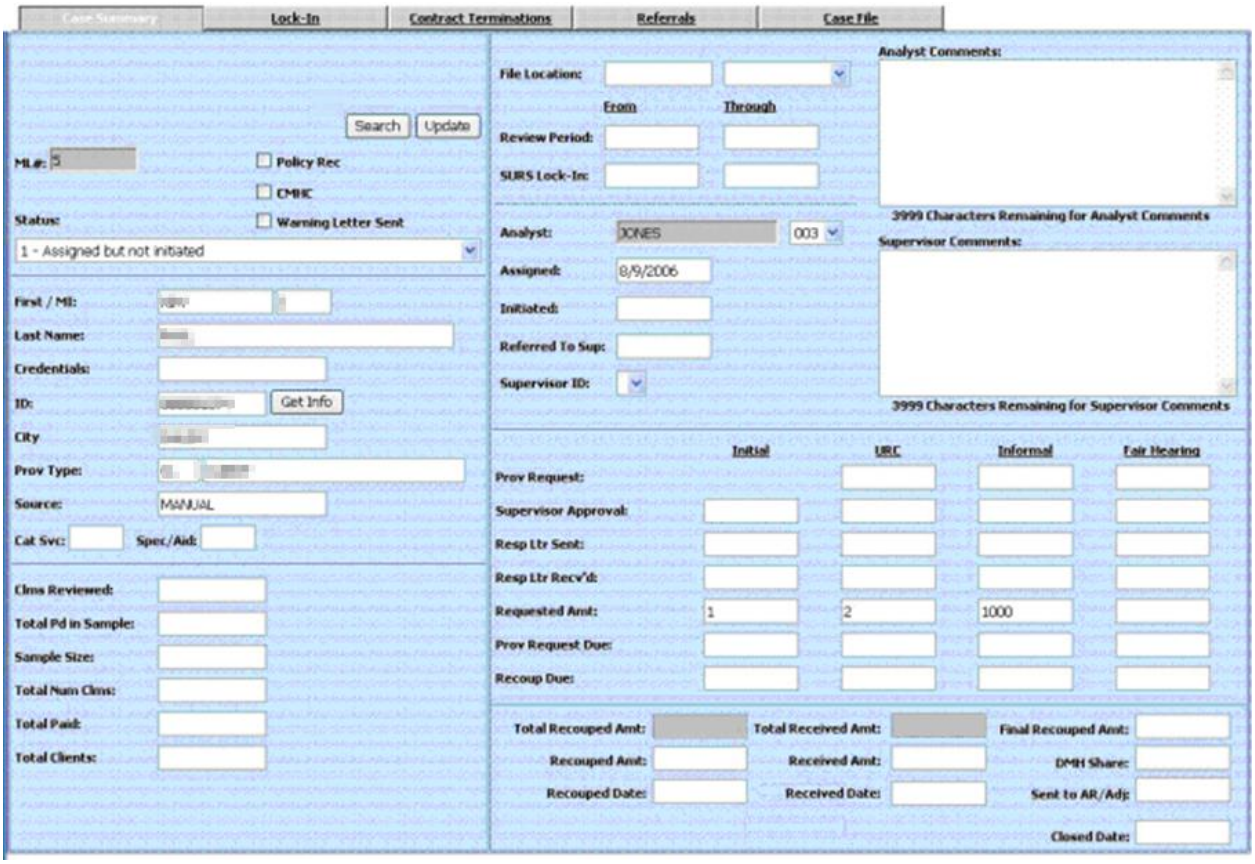
Result: The Case Summary Tab window for that specific case appears.



8. Make appropriate changes to the case data.

NOTE:

If data is grayed out that means your security clearance does not authorize you to change it.

9. To save the changes, click the **Update** button. The Update button appears on all Master Log Numbers EXCEPT zero (0). No updates are allowed on the Case Summary tab for Master Log Number 0.

Result: Information is updated on the current tab. Additionally, changes to fields shared among tabs, such as Analyst, Last Name, Comments, and SURS Lock-In dates, are updated on all tabs.

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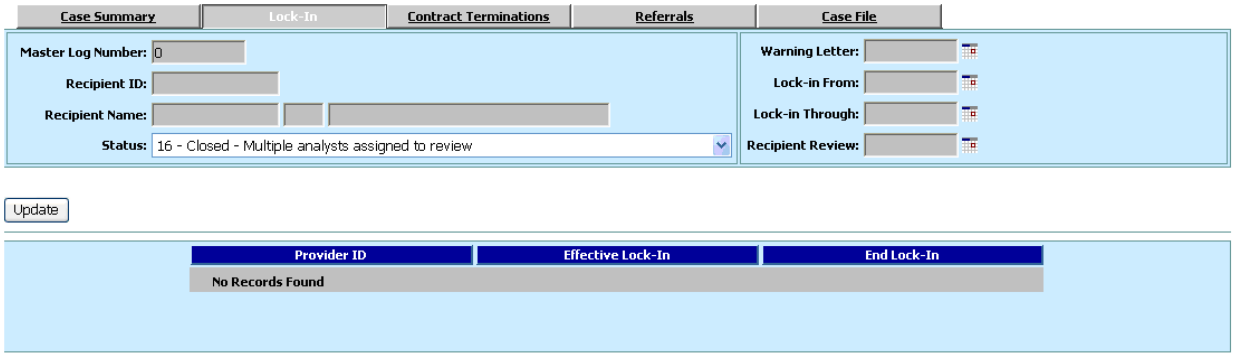
10.1.3 Lock-In Tab

The Lock-in tab displays information related to the recipient's lock-in status for a particular Master Log Number. The user maintains lock-in for a case by using this screen. Since this screen is only used to lock in a recipient to a provider, it is a one to one relationship. All information entered or displayed in the top portion of the window is related to the Case Tracking system only and is not the same lock-in data in the MMIS or DSS Recipient Subsystem. The data displayed in the bottom portion of the window is related to recipient lock-in information found in DSS data warehouse.



1. To update the existing Lock-in tab information, update the information in the top portion of the window.
2. Click the **Update** button.

Result: Saved information is displayed on the Lock-in tab and the Case Summary tab. If lock-in information exists in the DSS warehouse, it is displayed in the bottom section of the screen.

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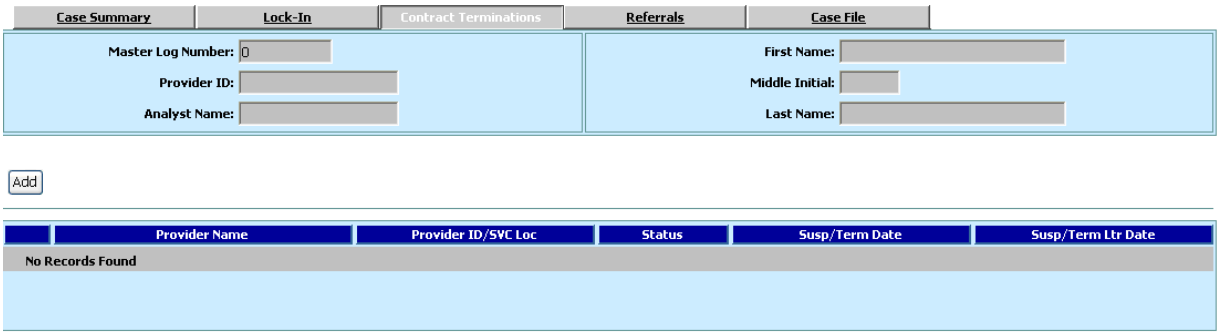
10.2 Contract Termination Tab

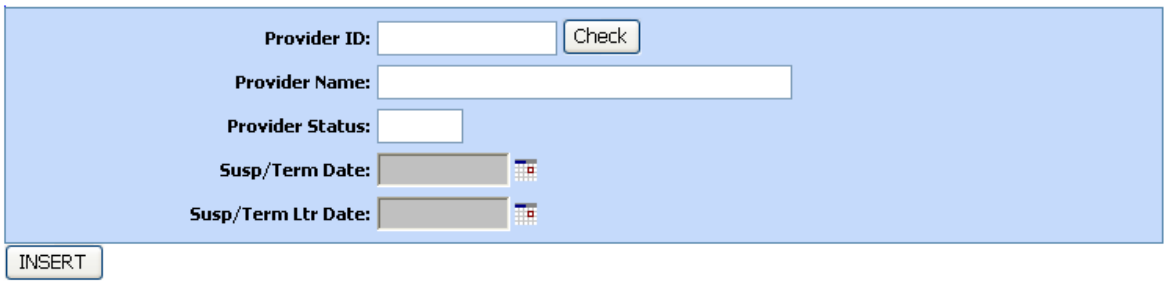
The Contract Termination Tab lists the provider numbers that have been suspended as a result of the findings of the case. This tab allows the user to enter, change, delete, or just view existing suspended provider information for a particular Master Log Number.

10.2.1 Entering a New Suspended Provider Number

1. To enter new suspended provider information, click the **Add** button from the Contract Termination Tab of the Case Summary window.



Result: The Contract Terminations Entry window appears.



2. Enter the **Provider ID**.
3. Click the **Check** button.

Result: The system verifies the Provider ID is valid. If the ID is valid, the system displays the provider's name; otherwise it displays an error message.

4. Enter the remaining information.
5. To add this provider number as a suspended number, click the **Insert** button.

Result: The system documents the number within the SURS Case Tracking system, but it does not actually suspend the provider number. Suspension of the provider number occurs within the interChange panels. The Contract Termination Tab lists the provider numbers that have been suspended as a result of the findings of the case.

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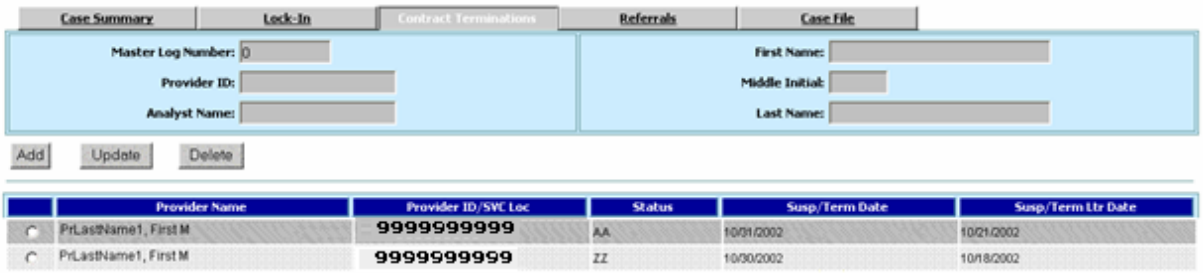
10.2.2 Changing a Suspended Provider Number

1. To change existing suspended provider information, click the radio button next to the appropriate provider number to be changed.



2. Click the **Update** button.

Result: The Contract Termination Entry window appears.

3. Change any of the appropriate information.
4. If the Provider ID changes, click the **Check** button.

Result: The system verifies the Provider ID is valid. If the ID is valid, the system displays the provider's name; otherwise it displays an error message.

5. Change any remaining information.
6. To save this information, click the **Update** button.

Result: The system documents the number within the SURS Case Tracking system, but it does not actually suspend the provider number. Suspension of the provider number occurs within the interChange panels. The Contract Termination tab lists the provider numbers that have been suspended as a result of the findings of the case.

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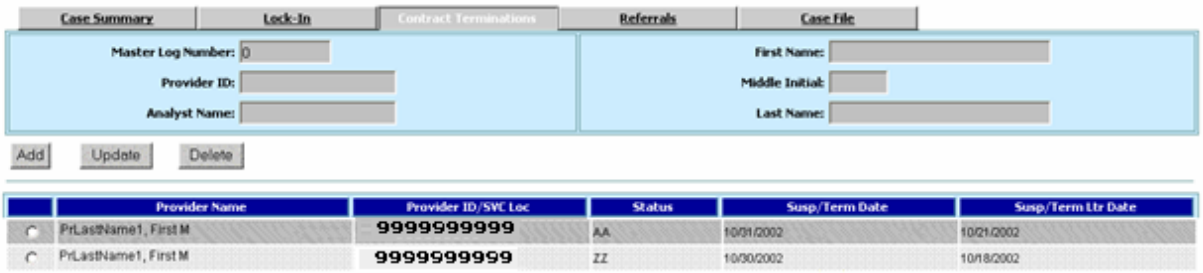
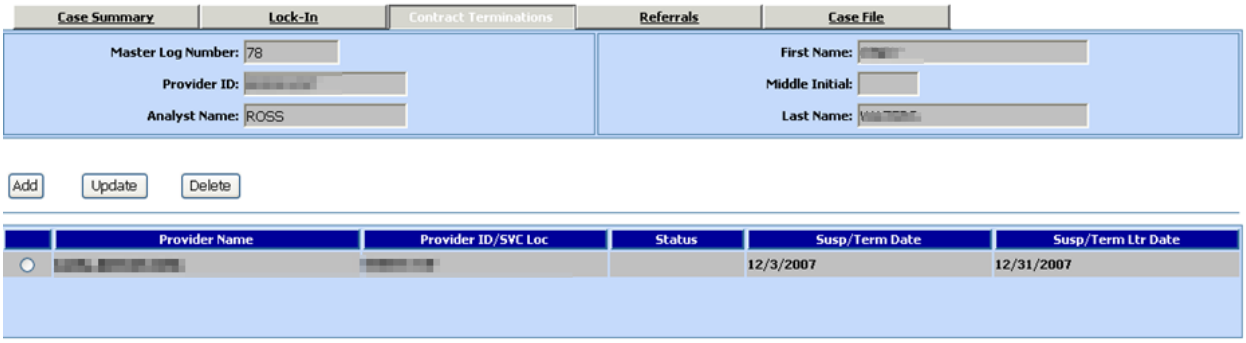
10.2.3 Deleting a Suspended Provider Number

1. To delete an existing suspended provider, click the radio button next to the appropriate **Provider Number** to be deleted.



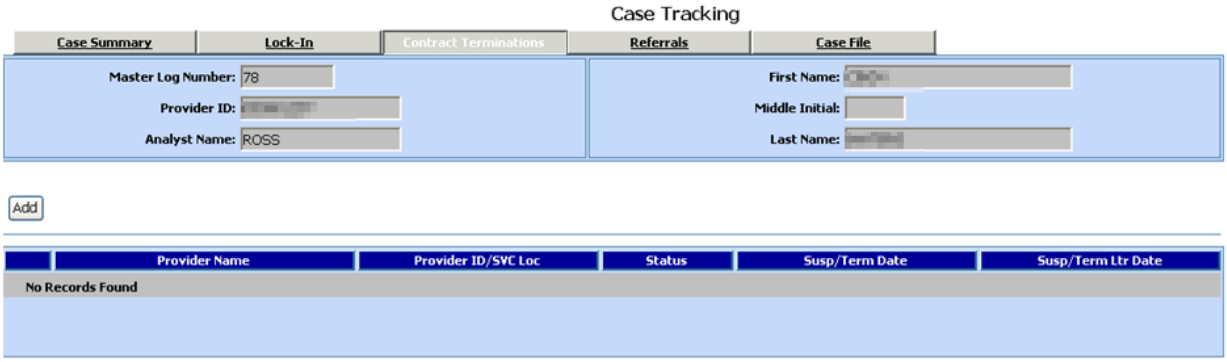
2. Click the **Delete** button.

Result: The Contract Terminations Entry window appears as a confirmation to delete the provider number.



3. If this is the appropriate provider number to be deleted, then click the **Delete** button.

Result: The contract termination information is deleted from the SURS Case Tracking system, but it does not actually remove the suspension from the provider number. Removal of the suspension of the provider number occurs within the interChange panels. The Contract Terminations tab displays an updated list of suspended providers for this case.



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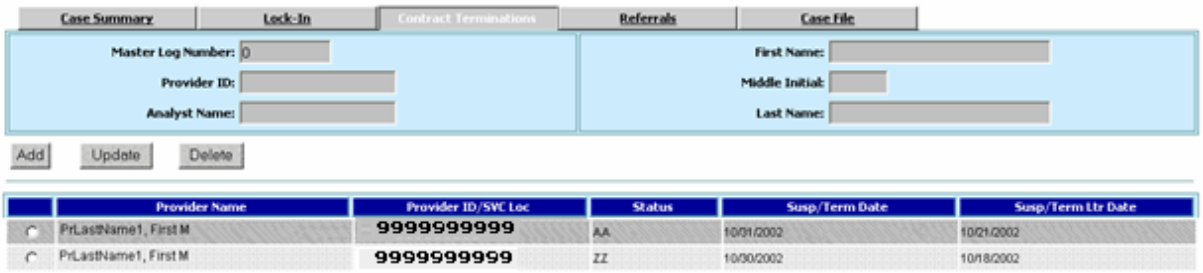
10.2.4 Viewing a Suspended Provider Number

1. To view existing suspended provider information, click the **Provider Name** hyperlink.



Result: The Contract Termination Entry window appears without an Add, Update or Delete button.

2. When finished viewing the provider information, click the **Back To Case Tracking Page** hyperlink to return to the Contract Termination Tab of the Master Log Number last visited.

Result: The Contract Termination Tab from the Case Summary window appears.

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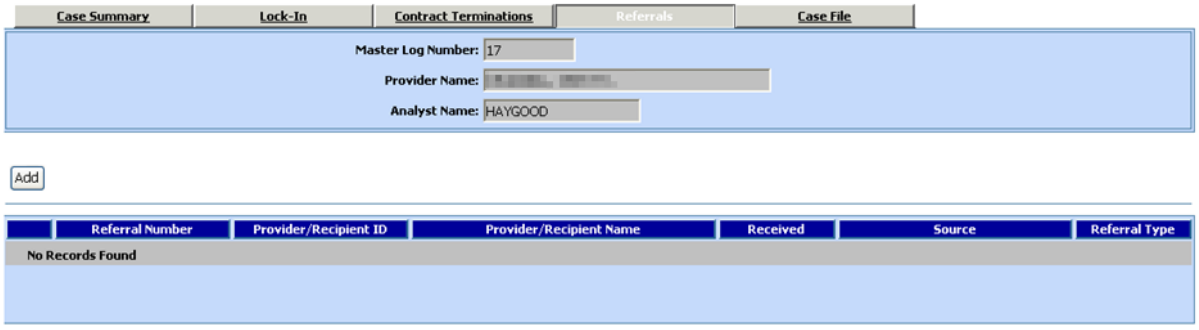
10.3 Referrals Tab

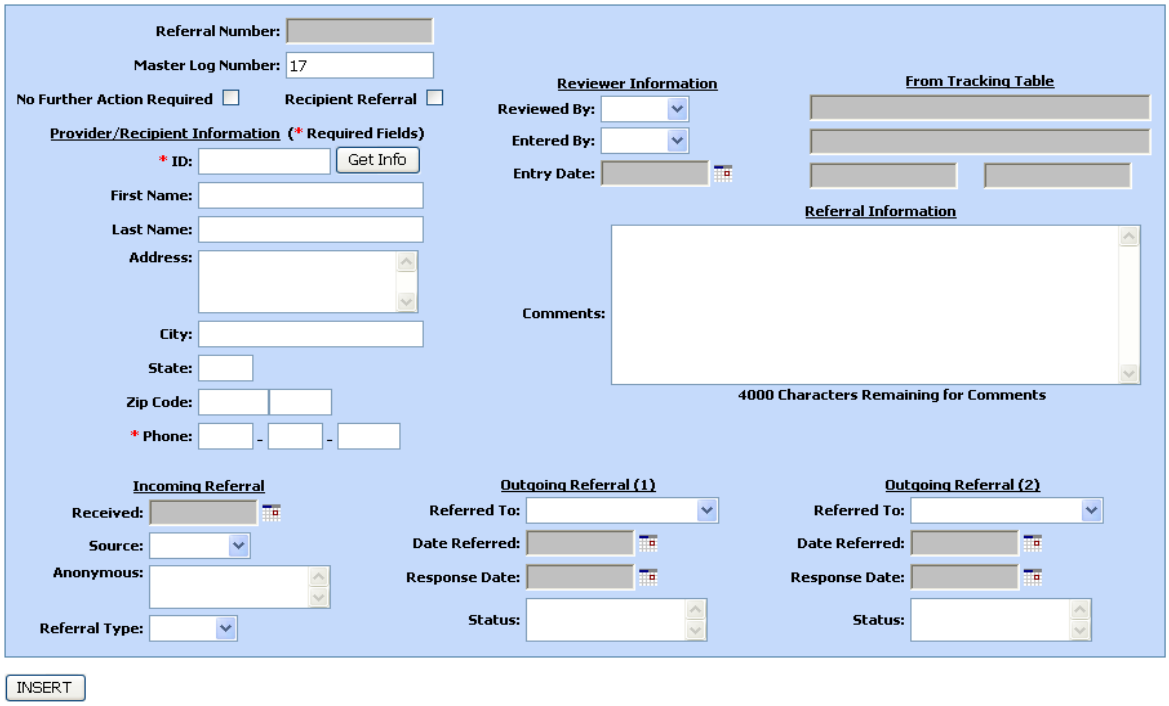
The Referrals Tab lists all the referrals associated to a Master Log Number, when a specific Master Log Number is displayed on the Case Summary window from performing a search. The Referrals Tab allows the user to add, change, or delete referral information for a specific case. It can also show referrals that have not been assigned to a case, by doing a search from the Case Summary window for Master Log Number of (zero) 0. The Referrals Tab also allows the user to add new referrals or change or delete data for referrals that have not been assigned to a case.

10.3.1 Entering a New Referral

1. To enter new referral information click the **Add** button from the referral tab.



Result: The Referrals Entry window appears.



Enter the provider/recipient and referral information into the appropriate fields.

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NOTE:

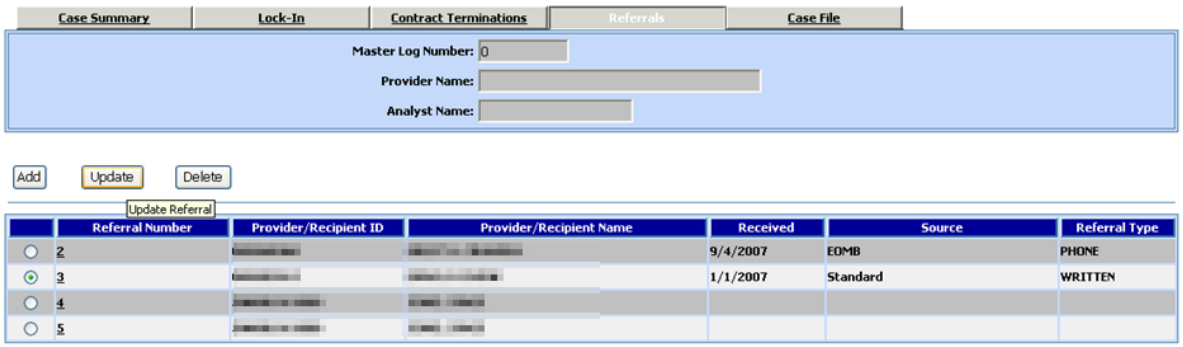
The **No Further Action Required** checkbox for a referral indicates if a case may potentially still be opened in the future. If it is checked, the referral will not be brought into the list of selected cases on the Provider or Recipient Case Selection windows when the selected **Select Only One** drop-down value is **Referrals**. In addition, whether the checkbox is checked or not, the referral will still be listed on the Referrals Tab of the Case Summary Window.

2. Click the **Insert** button to save the information.

Result: The referral information is saved along with an auto-generated referral number to be used to reference this information. After the insert, the Referral Tab from the Case Summary window, with the new referral listed at the bottom appears.

10.3.2 Changing an Existing Referral

1. Click the radio button next to the referral number to change the information. (This is located on the Referrals tab of the Case Summary window.)



2. Click the **Update** button.

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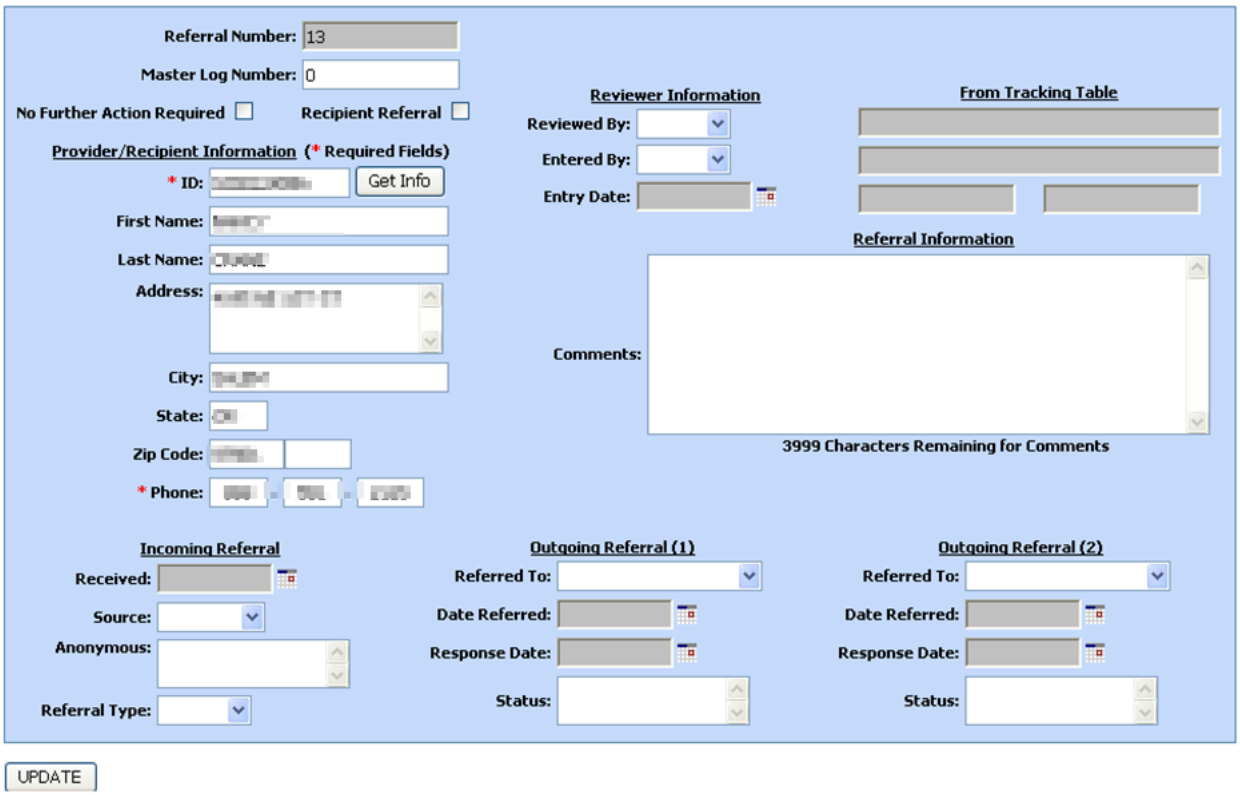
Result: The new referrals entry window appears with the associated referral data displayed.



NOTE:

The **No Further Action Required** checkbox for a referral indicates if a case may potentially still be opened in the future. If it is checked, the referral will not be brought into the list of selected cases on the Provider or Recipient Case Selection windows when the selected **Select Only One** drop-down value is **Referrals**. In addition, whether the checkbox is checked or not, the referral will still be listed on the Referrals tab of the Case Summary Window.

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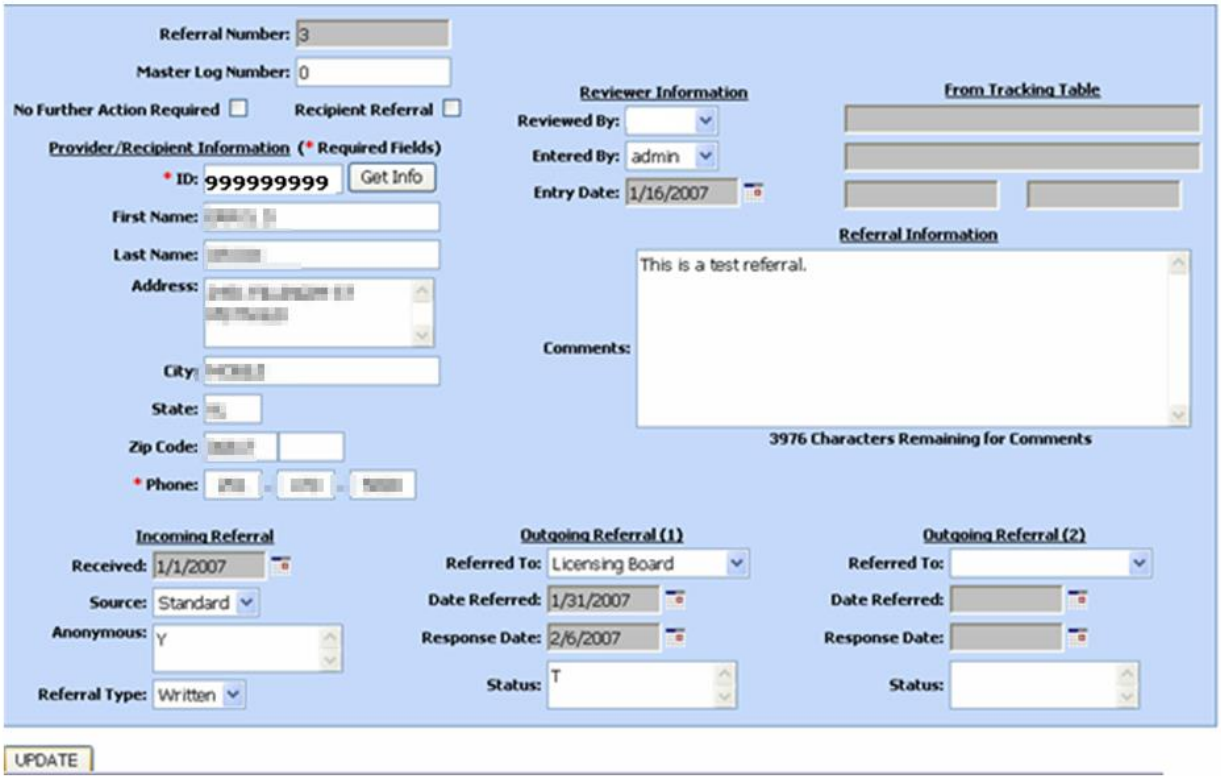
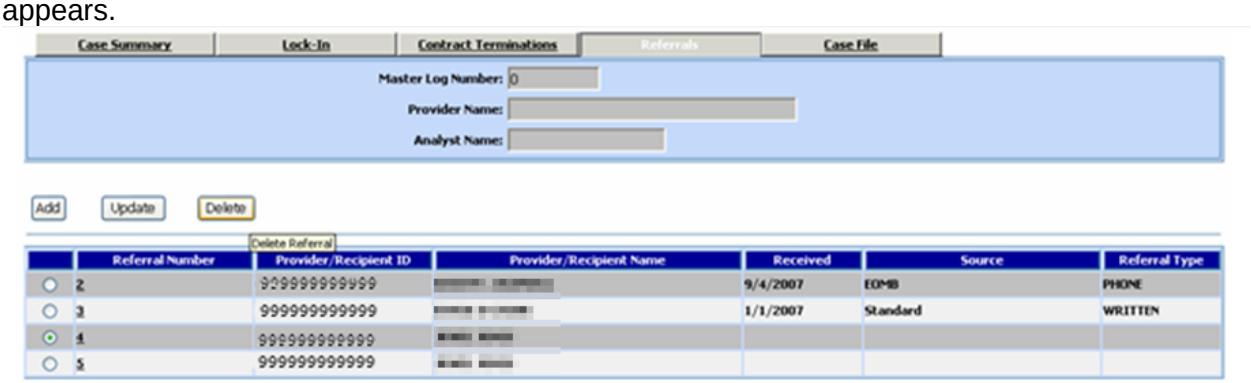
3. Change the necessary referral information in the appropriate fields.



4. Click the **Update** button to save the information.

Result: The referral information is saved and the Referral Tab from the Case Summary window appears.



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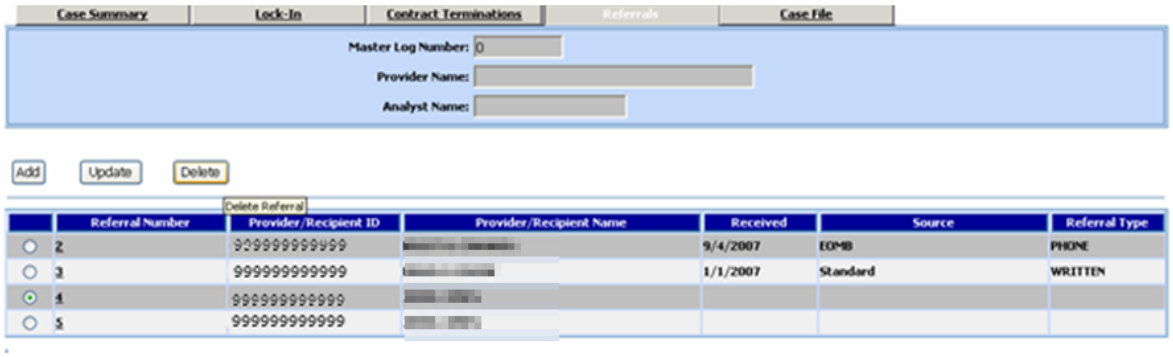
10.3.3 Deleting a Referral

1. To delete an existing referral, click the **radio button** next to the referral to be deleted.

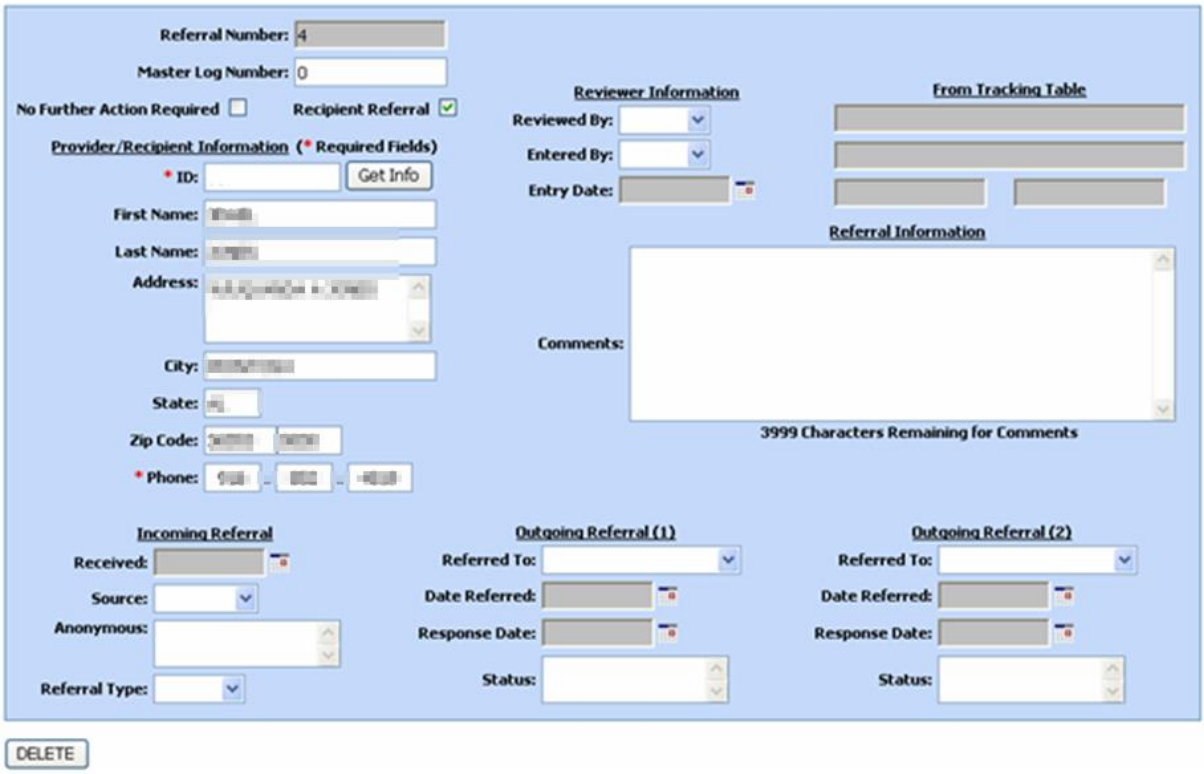


2. Click the **Delete** button.

Result: The Referrals Entry window appears with the referrals data displayed. The user confirms the deletion of the referral.

3. If this is the correct referral to delete, click the **Delete** button.

Result: The referral information is deleted from the system.



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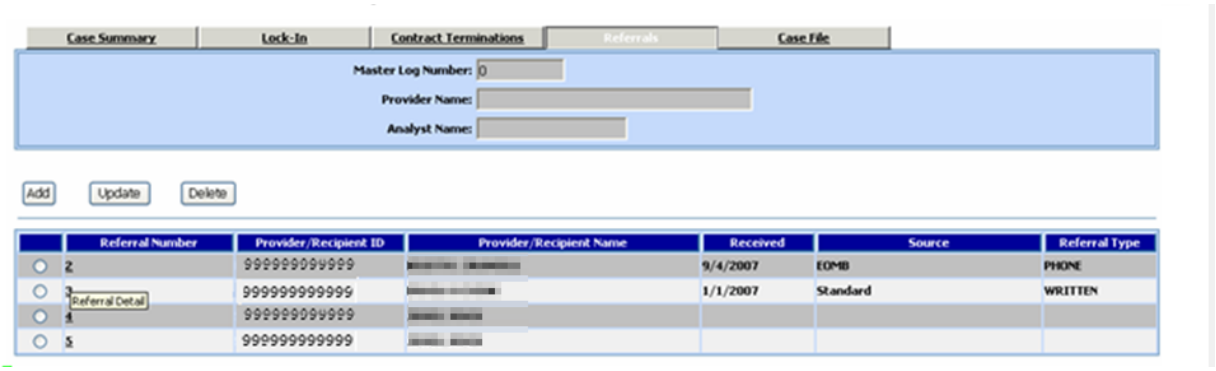
10.3.4 Viewing an existing Referral

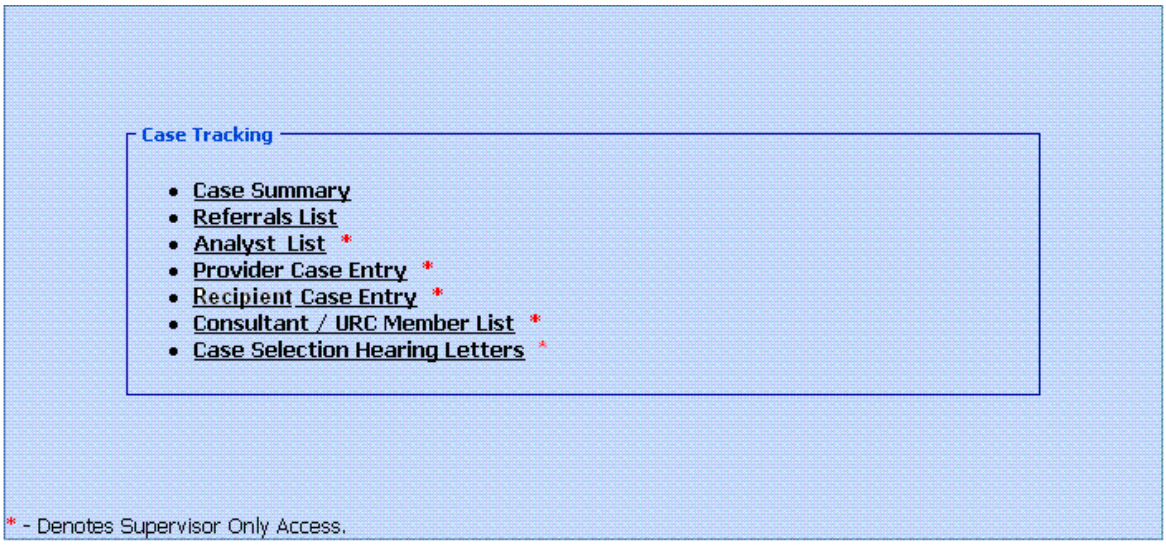
1. To view information for an existing referral, click the **Referral Number** hyperlink from the Referrals tab on the Case Summary window.



Result: The Referrals Entry window appears, showing the associated referral data. The window appears without an Add, Update, or Delete button as this is inquiry mode only.

2. When finished viewing the referral, click the **Case Tracking Main Menu** hyperlink to return to the Case Tracking Main Menu.

Result: The Case Tracking Main Menu appears.



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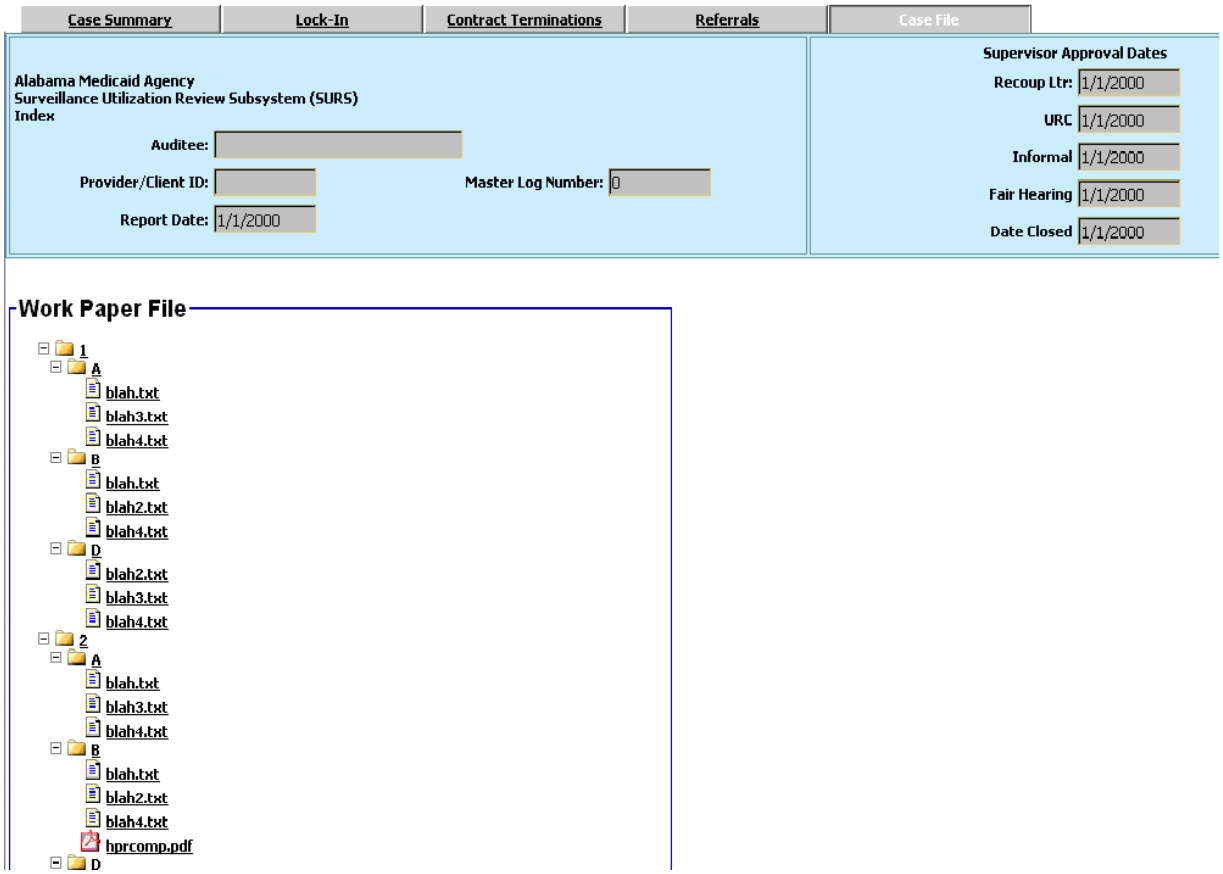
10.4 Case File Tab

The Case File Tab contains research information the analyst has associated with the Master Log Number during the review of the case. This tab makes up what is referred to as the electronic Case File. Each of the sections can contain documents, spreadsheets, scanned images, etc. depending on the research completed by the analyst.

The names of the sections as well as the names of the documents, within the sections for a particular case, are determined by the analyst. This is controlled by the names of the sub-directories and file names that are created and saved under each case number directory.

After displaying the Case File tab windows, the sections below describes how to save a document to the electronic case file to be displayed on the Case File tabs.



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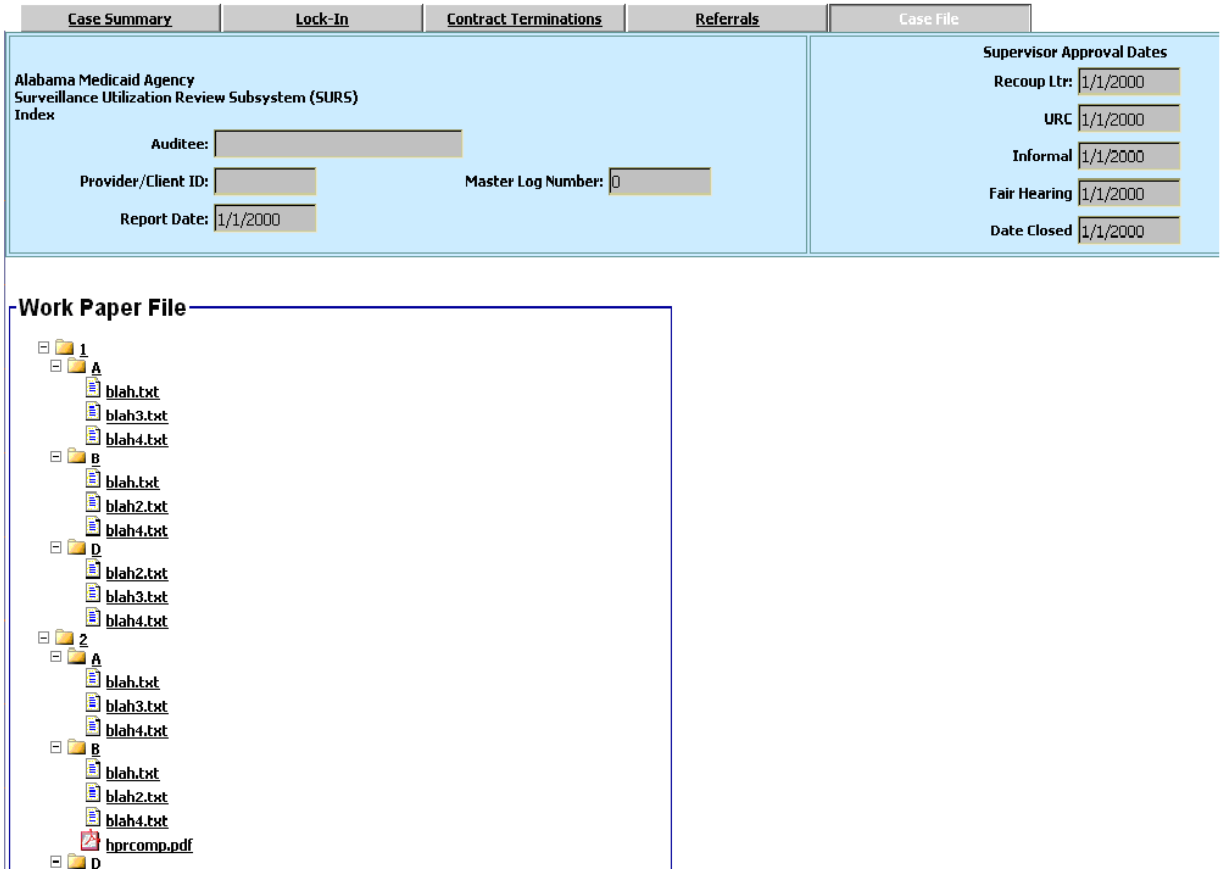
10.4.1 Saving Case File Documents

To save a document to the case file, use the following steps:

1. Open the case file.
2. Click **Save As** or **Copy**.
3. Navigate through Windows Explorer to the appropriate Master Log Number and case file folder on the server. To do this, click on the drive that is mapped to the server within the users Windows Explorer window. Then, scroll down until the appropriate Master Log Number is found. Expand the folders under that Master Log Number and click on the case file folder or one of its subfolders to which the user wants to save the document.
4. **Save** or **Paste** the document into the appropriate folder.
5. Refresh the Windows Explorer window.
6. Refresh the appropriate SURS Case Tracking Case File tab window where the document was saved.

Result: The hyperlink appears on the appropriate Case File tab.



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11. Case Selection Hearing Letters

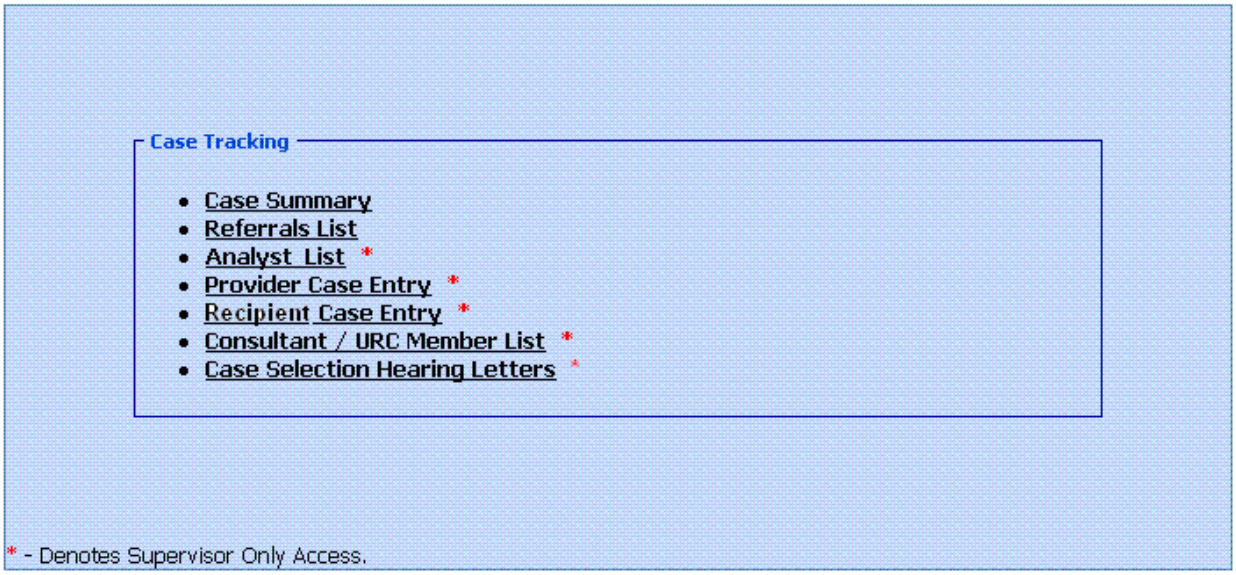
11.1 Overview

The purpose of this window is to generate letters to all the URC members for each case ready for a URC review. The letters state which providers are being taken before the URC for approval of recommendations by the analyst. The letters also state that correspondence is enclosed with the letter for their review.

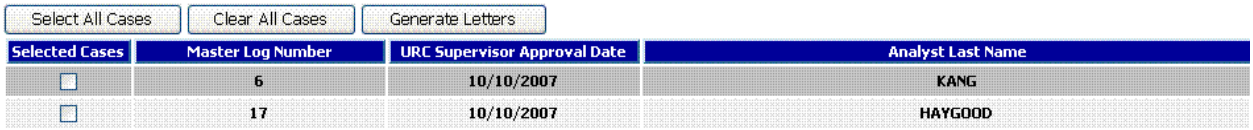
11.1.1 URC Notification Letter List

The Case Selection Hearing Letters window lists all cases that have a URC supervisor approval date on the Case Summary window.

1. On the SURS main navigation window, click the hyperlink for **Case Selection for Hearing Letters**:



2. Click on the box to the left of the **Master Log Number** to generate letters for all URC members regarding cases coming up for review.



[redacted]

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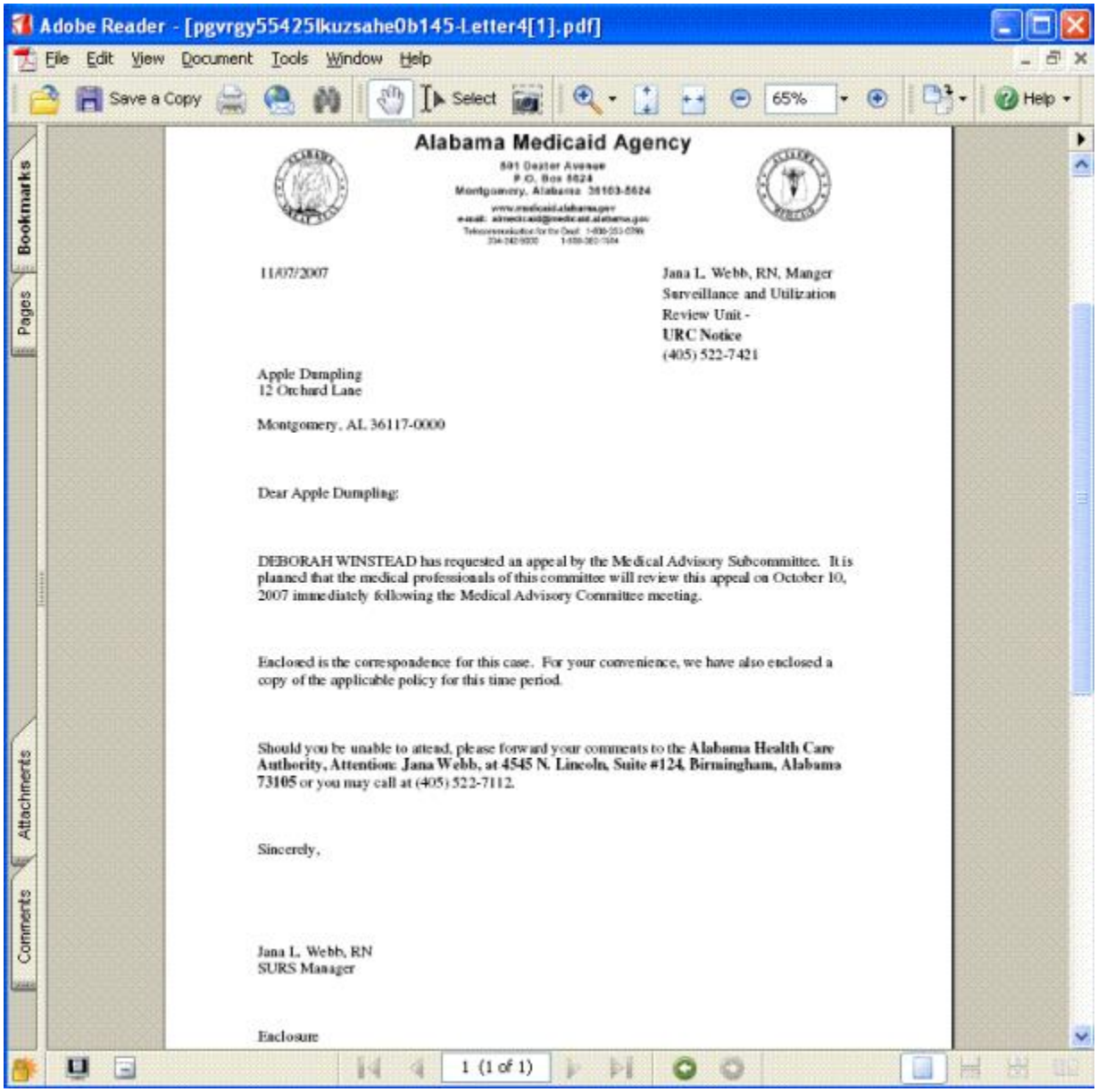
NOTE:

Users can click the Select All Cases button to check the boxes next to all listed cases. Users can also click the Clear All Cases button to uncheck the boxes next to all cases.

3. Click the **Generate Letters** button.

   Result: A PDF window is displayed with the URC letter addressed to the URC member. Select the **printer icon** in the menu bar at the top to print the letter on the local printer.



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12. Case Tracking Reports

The SUR Case Tracking User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage.

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.

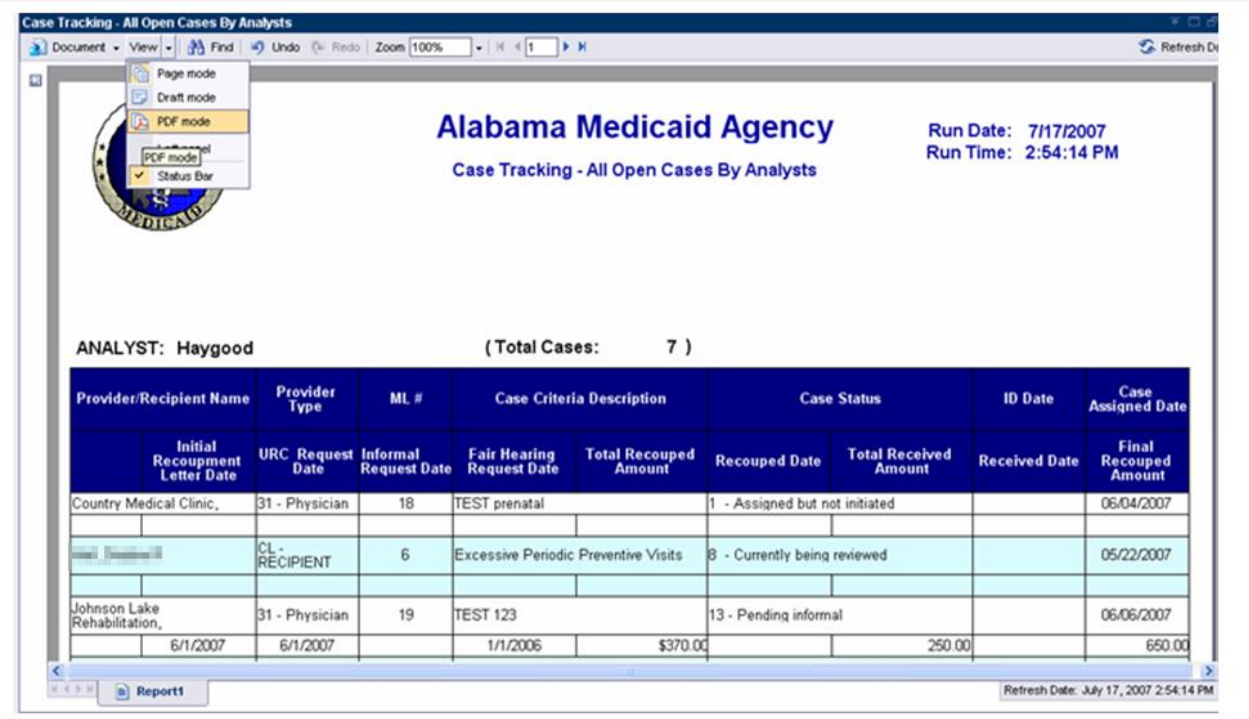
Field Descriptions: Lists the fields included on the report, with a definition of each field.

12.1 Printing Reports

All reports may be printed from DSSNavigator window by using PDF function. The report will print to the local printer.

Step 1: Select **View** from the drop down menu bar.

Step 2: Select **PDF mode**.



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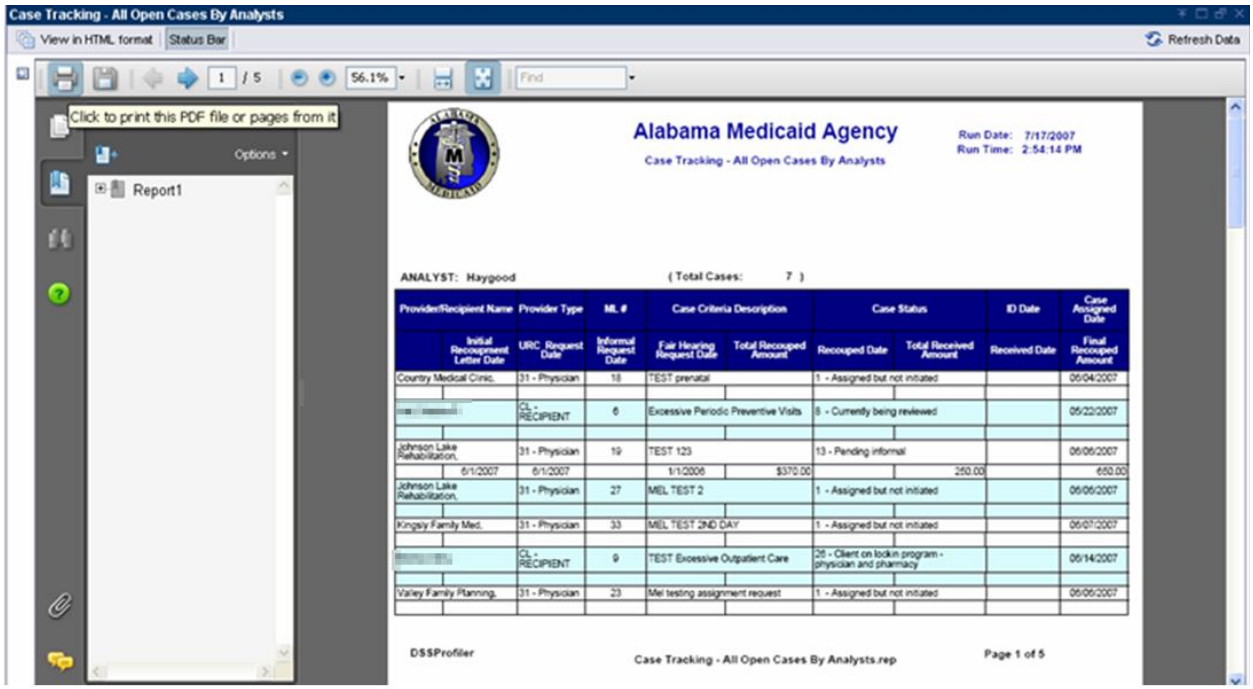
Step 3: Click the **printer icon** on the PDF menu bar. Results: Report is displayed in PDF format.



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12.2 Case Tracking – All Cases

The Case Tracking - All Cases report is generated through Business Objects. This report displays all cases in provider/recipient name order.

12.2.1 Case Tracking – All Cases Layout

Alabama Medicaid Agency

Case Tracking - All Cases
Sorted by Provider/Recipient Name
Total Cases: 5

Run Date: 9/18/2006
Run Time: 3:55:11 PM

ML #	Provider/Recipient Name	Prov/Recipient ID	Analyst	Case Assigned Date	Referred to Supervisor Date	Case Closed Date	Final Recouped Amt
1	[illegible]	999999999999	001	07/19/2006			
5	[illegible]	999999999999	003	08/09/2006			
3	[illegible]	999999999999	004	08/04/2006	08/04/2006		$3,000.00
2	[illegible]	999999999999	003	08/04/2006			
4	[illegible]	999999999999	004	08/09/2006			

End of Report

12.2.2 Case Tracking – All Cases Field Descriptions

Field	Description	Length	Data Type
Analyst	The identification of the analyst working the case.	3	Character
Case Assigned Date	Date the case was assigned to the analyst.	10	Date (MM/DD/CCYY)
Case Closed Date	Date the case was closed.	10	Date (MM/DD/CCYY)
Final Recouped Amt	The final recouped amount, as entered by the user on the Case Summary screen.	11	Number (Decimal)
ML#	Master Log Number is a unique system assigned identifier for a case.	5	Number (Integer)
Provider/Recipient Name	Name of the provider or recipient related to the case.	25	Character
Prov/Recipient ID	Identification number for the provider or recipient related to the case.	9	Character
Referred To Supervisor Date	Date the case was referred to the supervisor.	10	Date (MM/DD/CCYY)
Total Cases	Total number of cases shown on the report.	3	Number (Integer)

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12.3 Case Tracking - All Open Cases By Analysts

The Case Tracking - All Open Cases By Analysts report is created in Business Objects. This report shows all cases that are currently open for each analyst selected in the report prompt.

12.3.1 Case Tracking – All Open Cases By Analysts Layout

Alabama Medicaid Agency

Case Tracking - All Open Cases By Analysts

Run Date: 6/6/2007
Run Time: 3:14:02 PM

ANALYST: Amrutha (Total Cases: 1)

Provider/Recipient Name		Provider Type	ML #	Case Criteria Description		Case Status		ID Date	Case Assigned Date
	Initial Recoupment Letter Date	URC Request Date	Informal Request Date	Fair Hearing Request Date	Total Recouped Amount	Recouped Date	Total Received Amount	Received Date	Final Recouped Amount
[redacted]		CL - RECIPIENT	1	BLAH		2 - Pending receipt of claims detail			03/30/2007
	5/10/2007								

ANALYST: Haygood (Total Cases: 4)

Provider/Recipient Name		Provider Type	ML #	Case Criteria Description		Case Status		ID Date	Case Assigned Date
	Initial Recoupment Letter Date	URC Request Date	Informal Request Date	Fair Hearing Request Date	Total Recouped Amount	Recouped Date	Total Received Amount	Received Date	Final Recouped Amount
[redacted]		CL - RECIPIENT	12	blah		5 - Medical records requested		05/04/2007	05/01/2007
	5/5/2007								
[redacted]		CL - RECIPIENT	13	blah		2 - Pending receipt of claims detail		06/04/2007	06/01/2007
	6/4/2007				$200.50		0.00		200.50

12.3.2 Case Tracking – All Open Cases By Analysts Field Descriptions

Field	Description	Length	Data Type
Analyst	Name of the analyst with open cases.	50	Character
Case Assigned Date	Date the case was assigned to the analyst.	10	Date (MM/DD/CCYY)
Case Status	Current status of the case.	30	Character
Fair Hearing Request Date	Date the fair hearing was requested by the provider.	10	Date (MM/DD/CCYY)
Final Recouped Amount	The final recouped amount, as entered by the user on the Case Summary screen.	11	Number (Decimal)
ID Date	Date the analyst initiated the case.	10	Date (MM/DD/CCYY)
Informal Request Date	Date the informal hearing was requested by the provider.	10	Date (MM/DD/CCYY)
Initial Recoupment Letter Date	Date the letter of initial recoupment was sent.	10	Date (MM/DD/CCYY)
ML #	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)

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Field	Description	Length	Data Type
Case Criteria Description	Description of the case.	30	Character
Provider/Recipient Name	Name of the provider or recipient related to the case.	30	Character
Provider Type	Provider type for the provider identification number.	3	Character
Received Date	Date of the last recouped amount received by the agency.	10	Date (MM/DD/CCYY)
Recouped Date	Date of the last recouped amount from the system checkwrite.	10	Date (MM/DD/CCYY)
Total Cases	Total number of cases shown on the report.	3	Number (Integer)
Total Received Amount	System generated, total recouped amount received by the agency.	11	Number (Decimal)
Total Recouped Amount	System generated, total recouped amount from system checkwrite.	11	Number (Decimal)
URC Request Date	Date URC was requested by the provider.	10	Date (MM/DD/CCYY)

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12.4 Case Tracking – Cases on Hold

The Case Tracking - Cases On Hold report is created in Business Objects and shows all the cases with the status of 'on hold'. This report shows basic information related to the case on hold and more detail information related to recon dates and amounts.

12.4.1 Case Tracking – Cases on Hold Layout

Alabama Medicaid Agency

Case Tracking - Cases On Hold

Total Cases: 3

Run Date: 6/7/2007
Run Time: 7:14:30 PM

Provider/Recipient Name	Prov/Recipient ID	ML #	Analyst	Initial Recoup Letter Date	Initial Recoup Amt Requested	URC Request Date	URC Response Date	Informal Request Date	Informal Response Date
Analyst Comments	Fair Hearing Request Date	Hear Fair Response Date	Total Recouped Amount	Total Final Recouped Amount	Date Closed		Supervisor Comments		
[illegible]	[illegible]	4	[illegible]	04/15/2007	$3,025.00				
setting up test	01/02/1900								
[illegible]	[illegible]	6		05/05/2007		05/20/2007			
[illegible]	[illegible]	8		05/07/2007				05/15/2007	

12.4.2 Case Tracking – Cases on Hold Field Descriptions

Field	Description	Length	Data Type
Analyst	The identification of the analyst working the case.	3	Character
Analyst Comments	Comments related to the case.	4000	Character
Date Closed	Date the case was closed.	10	Date (MM/DD/CCYY)
Fair Hear Response Date	Due date for fair hearing request from provider.	10	Date (MM/DD/CCYY)
Fair Hearing Request Date	Date for fair hearing request from provider.	10	Date (MM/DD/CCYY)
Informal Request Date	Due date for informal request from provider.	10	Date (MM/DD/CCYY)
Informal Response Date	Date for informal request from provider.	10	Date (MM/DD/CCYY)
Initial Recoup Amt Requested	Requested amount for the initial recoupment.	11	Number (Decimal)
Initial Recoup Letter Date	Date the initial recoupment letter was sent.	10	Date (MM/DD/CCYY)
ML #	Master Log Number is a unique system assigned identifier for a case.	5	Number (Integer)
Prov/Recipient ID	The identification number of the provider	9	Character

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Field	Description	Length	Data Type
	or recipient.		
Provider/Recipient Name	The full name of the provider or recipient.	25	Character
Supervisor Comments	Supervisor comments related to the case.	4000	Character
Total Cases	Total number of cases shown on the report.	3	Number (Integer)
Total Final Recouped Amount	The final recouped amount, as entered by the user on the Case Summary screen.	11	Number (Decimal)
Total Recouped Amount	System generated, total recouped amount from system checkwrite.	11	Number (Decimal)
URC Request Date	Date for URC request from provider.	10	Date (MM/DD/CCYY)
URC Response Date	Due date for URC request from provider.	10	Date (MM/DD/CCYY)

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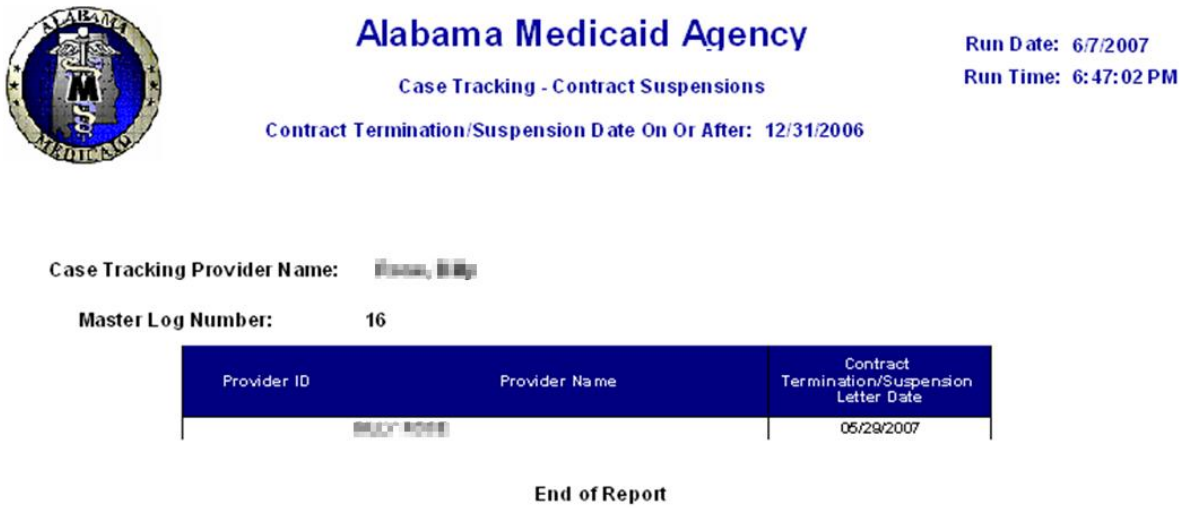
12.5 Case Tracking - Contract Suspensions

The Case Tracking - Contract Suspensions report is created in Business Objects. This report shows a list of providers that have been suspended for the termination/suspension date on the report or greater entered at the prompt.

12.5.1 Case Tracking - Contract Suspensions Layout



Alabama Medicaid Agency

Case Tracking - Contract Suspensions

Contract Termination/Suspension Date On Or After: 12/31/2006

Run Date: 6/7/2007
Run Time: 6:47:02 PM

Case Tracking Provider Name:

Master Log Number: 16

Provider ID	Provider Name	Contract Termination/Suspension Letter Date
		05/29/2007

End of Report

12.5.2 Case Tracking - Contract Suspensions Field Descriptions

Field	Description	Length	Data Type
Case Tracking Provider Name	Name of the provider associated with the contract suspension.	30	Character
Contract Termination/Suspension Date On Or After	The contract termination/suspension date based on what the user provided at the prompt.	10	Date (MM//DD/CCYY)
Contract Termination/Suspension Letter Date	Date the provider was suspended.	10	Date (MM/DD/CCYY)
Master Log Number	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)
Provider ID	The provider's identification number.	9	Character
Provider Name	The provider's full name.	25	Character

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12.6 Case Tracking - Open Closed Cases

The Case Tracking - Open Closed Cases report is created in Business Objects. This report has two tabs, one for open cases and one for closed cases within the entered date range.

12.6.1 Case Tracking - Open Cases Layout

Alabama Medicaid Agency

Case Tracking - Open Cases: 10/01/2003 - 09/30/2004

Run Date: 1/11/2007
Run Time: 3:03:11 PM

ML #	Prov/Recipient Name	Case Status	Source	ID Date	Referred to Supervisor Date	Case Assigned Date	Initial Recoup Amt Requested	URC Recoup Amt Requested	Informal Recoup Amt Requested
						Fair Hearing Recoup Amt Requested	Total Recouped Amount	Total Received Amount	Final Recouped Amount
1		16 - Closed II Multiple analysts assigned to review	MANUAL	01/01/2006	01/02/2006	07/19/2006	$5.00	$4.00	$3.00
						$2.00	$6.00	$3.00	$100.00
2		1 - Assigned but not initiated	MANUAL	08/03/2006	08/02/2006	08/04/2006			
								$1.00	
3		1 - Assigned but not initiated	MANUAL	08/04/2006	08/04/2006	08/04/2006	$3,200.00		
							$2,900.00		$3,000.00
4		1 - Assigned but not initiated	MANUAL			08/09/2006			

12.6.2 Case Tracking – Closed Cases Layout

Alabama Medicaid Agency

Case Tracking - Closed Cases: 10/01/2006 - 09/30/2007

Run Date: 6/6/2007
Run Time: 5:35:17 PM

ML#	Prov/Recipient Name	Case Status		Source	Case Assigned Date	Referred to Supervisor Date	Closed Date	Initial Recoup Amt Requested
	Physical File Location	URC Recoup Amt Requested	Informal Recoup Amt Requested	Fair Hear Recoup Amt Requested	Total Recouped Amt	Total Received Amt	Final Recouped Amt	
3		17 - Closed		MANUAL			06/06/2007	
14		17 - Closed		MANUAL	05/15/2007 $2,300.00	$0.00	06/05/2007 $2,300.00	$2,300.00

End of Report

12.6.3 Case Tracking - Open Closed Cases Field Descriptions

Field	Description	Length	Data Type
Case Assigned Date	Date the case was assigned to analyst.	10	Date (MM/DD/CCYY)
Case Status	Current status of the case.	30	Character
Case Tracking-Closed Cases	The closed cases date range based on what the user provided at the prompt.	20	Date (MM/DD/CCYY)
Closed Date (Closed Cases)	Date the case was closed.	10	Date (MM/DD/CCYY)
Fair Hearing Recoup Amt Requested	Recoupment amount requested for fair hearing.	11	Number (Decimal)
Final Recouped	The final recouped amount, as entered by the	11	Number (Decimal)

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Field	Description	Length	Data Type
Amount	user on the Case Summary screen.		
ID Date (Open Cases)	Date the analyst initiated the case.	10	Date (MM/DD/CCYY)
Informal Recoup Amt Requested	Informal recoupment amount requested.	11	Number (Decimal)
Initial Recoup Amt Requested	Amount requested for the initial recoupment.	11	Number (Decimal)
ML #	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)
Physical File Location (Closed Cases)	Location of the physical files associated with the case.	30	Character
Prov/Recipient Name	The full name of the provider or recipient.	25	Character
Referred to Supervisor Date	Date the case was referred to a supervisor.	10	Date (MM/DD/CCYY)
Source	Source of the case.	100	Character
Total Received Amount	System generated, total recouped amount received by the Agency.	11	Number (Decimal)
Total Recouped Amount	System generated, total recouped amount from system checkwrite.	11	Number (Decimal)
URC Recoup Amt Requested	Recoupment amount requested for URC.	11	Number (Decimal)

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12.7 Case Tracking - Open Cases In Work

The Case Tracking - Open Cases In Work report is created in Business Objects. This report shows all open cases that are being worked in analyst order. Cases with an assigned date and no closed date are shown on the report.

12.7.1 Case Tracking - Open Cases In Work Layout

Alabama Medicaid Agency

Case Tracking - Open Cases in Work

(cases that have an assigned date with no closed date)

Run Date: 6/6/2007
Run Time: 2:48:57 PM

ANALYST: Allison

Prov/Recipient Name		MLN	Case Status		Provider Type	Initial Amount	Total Number of Claims Reviewed	Total Paid in Sample Amount	Sample Size Number	Total Number of Claims
	Total Paid Amt	Tot Recip	Total Recouped Amt	Total Received Amt	Final Recouped Amt	Comments				
		18	8 - Currently being reviewed		CL - RECIPIENT	$6,135.33	250	$225.00	500	
	7,532.54	35.00								
		19	2 - Pending receipt of claims detail		CL - RECIPIENT	$3,211.22				

ANALYST: Amrutha

Prov/Recipient Name		MLN	Case Status		Provider Type	Initial Amount	Total Number of Claims Reviewed	Total Paid in Sample Amount	Sample Size Number	Total Number of Claims
	Total Paid Amt	Tot Recip	Total Recouped Amt	Total Received Amt	Final Recouped Amt	Comments				
		1	2 - Pending receipt of claims detail		CL - RECIPIENT	$500.00	100	$50.00	100	1000
	700.00	300.00								

12.7.2 Case Tracking - Open Cases In Work Field Descriptions

Field	Description	Length	Data Type
Analyst	Identification of the analyst associated with the case.	3	Character
Case Status	Current status of the case.	30	Character
Comments	Comments related to the case.	4000	Character
Final Recouped Amt	The final recouped amount, as entered by the user on the Case Summary screen.	11	Number (Decimal)
Initial Recoup Amount Requested	The initial recoupment amount requested.	11	Number (Decimal)
ML#	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)
Number Claims Reviewed	Number of claims reviewed.	4	Number (Integer)
Prov/Recipient Name	Name of the provider or recipient related to the case.	30	Character
Provider Type	Provider type for the provider.	3	Character
Sample Size Number	Sample size of claims reviewed.	5	Number (Integer)

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Field	Description	Length	Data Type
Tot Recip	Total number of recipients.	5	Number (Integer)
Total Number of Claims	Total number of claims.	5	Number (Integer)
Total Paid Amt	Total paid amount.	11	Number (Decimal)
Total Paid in Sample	Total paid amount for claims in the sample.	11	Number (Decimal)
Total Received Amt	System generated, total recouped amount received by the agency.	11	Number (Decimal)
Total Recouped Amt	System generated, total recouped amount from system checkwrite.	11	Number (Decimal)

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12.8 Case Tracking - Purge List

The Case Tracking - Purge List report is created in Business Objects. This report has two tabs showing a list of cases to be purged this month (based on dates entered at prompt) and showing a list of cases to be purged next month (based on dates entered at the prompt).

12.8.1 Case Tracking - Purge List Layout

Alabama Medicaid Agency
Case Tracking
Case Purge List for This Month: 05/01/2007 - 05/31/2007

Run Date: 6/7/2007
Run Time: 4:59:41 PM

ML #	Provider/Recipient Name	Case Status	Case Closed Date	Sent to AR/Adj	Recouped Date	Analyst Name	Final Recouped Amt
2	[illegible]	16 - Closed - Multiple analysts assigned to review	05/04/2001				
15	[illegible]	17 - Closed	05/15/2001				

End of Report

Alabama Medicaid Agency
Case Tracking
Case Purge List for Next Month: 06/01/2007 - 06/30/2007

Run Date: 6/7/2007
Run Time: 4:59:43 PM

ML#	Provider/Recipient Name	Case Status	Case Closed Date	Sent to AR/Adj	Recouped Date	Analyst Name	Final Recoup Amt
16	[illegible]	17 - Closed	06/23/2001				
17	[illegible]	16 - Closed - Multiple analysts assigned to review	06/17/2001				

End of Report

12.8.2 Case Tracking - Purge List Field Descriptions

Field	Description	Length	Data Type
Analyst Name	Identification of the analyst associated with the case.	3	Character
Case Closed Date	Date the case was closed.	10	Date (MM/DD/CCYY)
Case Status	Current status of the case.	30	Character
Final Recouped Amt	The final recouped amount, as entered by the user on the Case Summary screen.	11	Number (Decimal)
ML #	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)
Provider/Recipient Name	Name of the provider or recipient related to the case.	30	Character

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Field	Description	Length	Data Type
Recouped Date	Date of last recouped amount from system checkwrite.	10	Date (MM/DD/CCYY)
Sent To AR/Adj	Date sent to adjustments.	10	Date (MM/DD/CCYY)

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12.9 Case Tracking – Recipient Lock-In For Open Cases

The Case Tracking – Recipient Lock-In For Open Cases report is created in Business Objects. This report shows a list of lockin recipients, along with lockin dates, for cases currently open.

12.9.1 Case Tracking – Recipient Lock-In For Open Cases Layout

Alabama Medicaid Agency

Recipient Lock-In For Open Cases

Total Cases: 19

Run Date: 10/31/200
Run Time: 9:59:58 AI

Master Log Number	Recipient Name	Recipient ID	Case Status	Source	Analyst
Recipient Lock-In Effective Date	Recipient Lock-In End Date	Provider ID	Lock-In Provider Name	Referral Received	Warning Letter Sent
1	[illegible]	999999999999	1 - Assigned but not initiated	MANUAL	Kang
2	[illegible]	999999999999	1 - Assigned but not initiated	MANUAL	Kelly
3	[illegible]	999999999999	1 - Assigned but not initiated	MANUAL	Ross
4	[illegible]	999999999999	1 - Assigned but not initiated	MANUAL	Haygood
5	[illegible]	999999999999	26 - Client on lockin program - physician and pharmacy	MANUAL	Kang
6	[illegible]	999999999999	11 - Pending with SURS Supervisor	MANUAL	Kang
05/14/1997	12/31/2299	7191	MEDICAL CENTERPHARMACY		
7	[illegible]	999999999999	1 - Assigned but not initiated	MANUAL	Kelly
12/26/1996	12/31/2299	6969	CVS DRUG STORE# 4830		

12.9.2 Case Tracking – Recipient Lock-In For Open Cases Field Descriptions

Field	Description	Length	Data Type
Analyst	The analyst ID associated with the case.	3	Character
Case Status	Current status of the case.	30	Character
Lock-In Provider Name	The name of the lock-in provider.	25	Character
Master Log Number	Master Log Number is a unique system assigned number identifier for a case.	5	Number (Integer)
Provider ID	The provider identifier the Recipient is locked into.	25	Character
Recipient ID	The recipient's ID.	13	Character
Recipient Lock-In Effective Date	The effective date of the lock-in period.	10	Date (MM/DD/CCYY)
Recipient Lock-In	The end date of the lock-in period.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
End Date			
Recipient Name	The recipient's full name.	25	Character
Referral Received	Date the referral was received.	10	Date (MM/DD/CCYY)
Source	The source of the case – manual or referral.	15	Character
Total Cases	Total number of open cases for lock-in recipients.	5	Number(Integer)
Warning Letter Sent	Indicator showing if a warning letter has been sent.	1	Character

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AMMIS SUR User Manual

Date Modified: 04/06/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

DXC Technology
301 Technacenter Drive
Montgomery, Alabama 36117

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1 Document control

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1.1 Document Information Page

Required Information	Definition
Document Title	AMMIS SUR User Manual
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Owner:	HPE/Agency
Author:	SUR Team
Approved by:	
Approval Date:	

1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
01/28/2008	1.0		Initial Version	
10/08/2013	2.0		Application of ICD-10 project change orders and bring up-to-date all reports affected by ICD-10	CO 10209 Update section 2.4.2 Random Sample 2 – Request Filters Tab – Add ICD Version Code list Update the following sections to reflect the change from ICD-9 to ICD per COs 10227, 10228 and bring up-to-date per CO 10039: 3.2.1, 3.5.4, 3.5.5, 3.5.8, 3.5.9, 3.5.22, 3.5.23, 3.5.34, 3.5.35, 3.5.60, 3.5.61, 3.5.74, 3.5.75, 3.5.84, 3.5.85, 3.5.93, 3.5.97, 3.5.100, 3.5.108, 3.5.112

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
				CO 10210 Update section 2.4.5 Random Sample – 5 – Claim Detail window layout
03/26/2014	2.1		Update report captures to reflect latest version of ETG (8.0)	**CO 11772** Sections 3.5.93 thru 3.5.102
05/14/2014	2.2		Add missing ETG Description report and correct the verbiage for ETG Number and Description fields.	**CO 10039** New section 3.5.93 and previous sections 3.5.93 thru 3.5.102 incremented by one and ETG Number/Description verbiage corrected in these sections
04/27/2016	3.0		General Update to change HPES to HPE- updated cover page and footers	
09/27/2016	4.0		Application of RCO project change orders.	**CO 13223** Sections 3.5.8, 3.5.9, 3.5.10, 3.5.11, 3.5.24, 3.5.25, 3.5.26, 3.5.27, 3.5.38, 3.5.39, 3.5.40, 3.5.41, 3.5.66, 3.5.67, 3.5.68, 3.5.69, 3.5.82, 3.5.83, 3.5.84, 3.5.85, 3.5.94, 3.5.95, 3.5.96, 3.5.97, 3.5.136-3.5.143, 3.5.145 **CO 13228** Sections 2.4.2, 2.4.3, 2.4.5 **CO 13234** Sections 3.2.2, 3.5.106-3.5.135 Also updated screenshots of initial screens and directions for initial navigation.
01/25/2017	5.0		Application of RCO FQHC project change orders.	**CO 13693** Updated report images and field descriptions in

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised
			Note: Changes were put into production and are available in SUR, but will not be applicable until the RCO Go Live Date of 10/01/2017	Sections 3.5.66, 3.5.67, 3.5.82, 3.5.83 Updated report search criteria in Sections 3.5.136, 3.5.137, 3.5.139, 3.5.140, 3.5.142 Updated report image and field description in Sections 3.5.141 **CO 13694** Updated report images and field descriptions in Sections 3.5.106, 3.5.118, 3.5.127 **CO 13696** Update panel images for Random Sample in sections 2.4.2 and 2.4.3
04/18/2017	6.0		Application of CO 13788	**CO 13788** 3.5.143 TG- Inpatient – Related Readmissions- updated report layout and field descriptions.
12/19/2017			Application of CO 14455	**CO 14455** Update SUR UM by removing all 'RCO' related reports and updating screenshots for any panel that was modified to remove the RCO label.
4/6/2018	7.0		Updated document to remove images with PHI.	**CO 14849** Review the Alabama Medicaid Surveillance and Utilization Review (SUR) Case Tracking Manual and Alabama Medicaid Surveillance and Utilization Review (SUR) User Manual documents for PHI and PII information. Redact any PHI/ PII information found these documents and then upload them back into iTrace

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1.3 Related documentation

Document	Description	url

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1. Introduction to SUR

The Surveillance and Utilization Review (SUR) subsystem provides the capability to identify potential fraud and/or abuse candidates. The modular design of the solution enables detection components to accept data directly from the interChange DSS. The SUR Components are:

- Episode Treatment Grouper (ETG);
- Random Sample Generator; and
- DSSProfiler.

These components are accessed through the DSSNavigator. The Data Warehouse is populated with data from interChange, which allows the Data Warehouse to source data to the Random Sample application, Targeted Queries and the DSSProfiler process. Having everything contained within the Data Warehouse helps to ensure that all of the data used to identify a suspect list comes from the same source and speeds verification.

1.1 Episode Treatment Grouper (ETG)

The Episode Treatment Grouper (ETG) integrated in the SUR subsystem allows for measuring the effect of health care services on cost and quality. The ETG solution does this by identifying episodes of care, which encompass all health care services provided to an individual patient during a single illness. An episode of care is defined as all clinically related services for a single illness and a discrete diagnostic condition from the onset of symptoms until treatment is complete. Episodes of care provide a clinically meaningful unit of measuring both the cost and quality of patient care.

1.2 Random Sample Generator

The Data Warehouse also provides the ability to generate summary reports from a statistically valid random sampling process. The random sample process is initiated and accessed through browser-based windows from the Data Warehouse web site.

Through this web site, users can specify if they want to sample claims for providers or recipients, and they can specify the date ranges and other filter conditions such as specific claim types or code values. The results from the sample are stored in the Data Warehouse where the results can be reported on summary web screens or from reports generated through the Data Warehouse.

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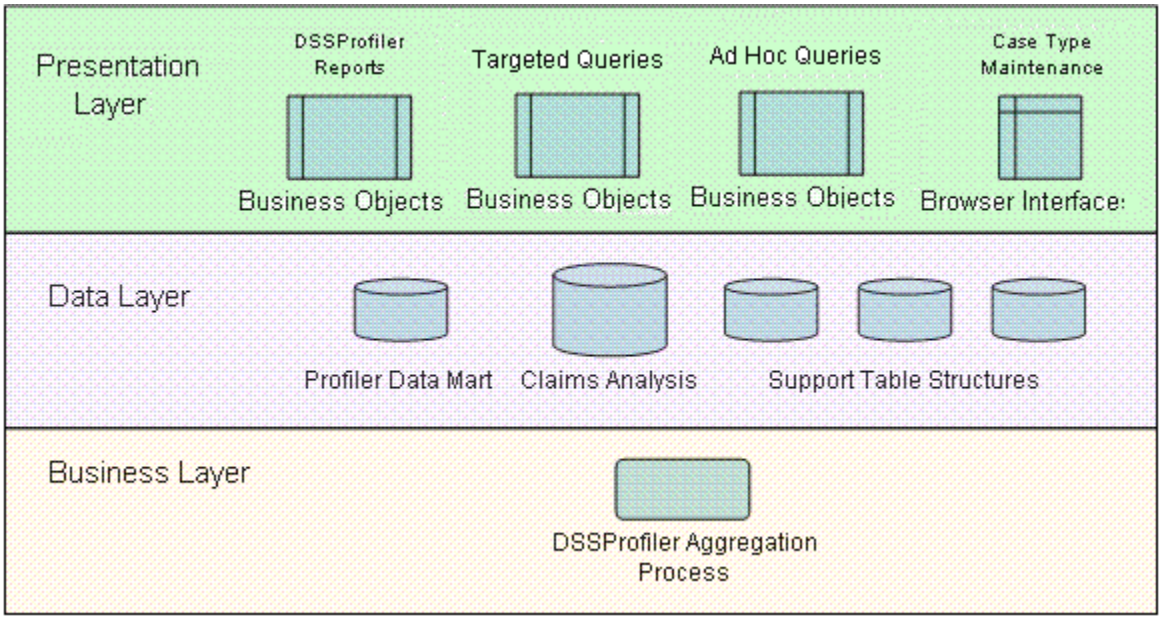
1.3 DSSProfiler

The DSSProfiler is made up of three layers: presentation, data and business. These layers interface with each other to provide the tools and data necessary for fraud and abuse monitoring.



1.3.1 Presentation Layer

The presentation layer is comprised of Business Objects and a Browser Interface.

Business Objects is the main tool used to run and review DSSProfiler reports. This tool allows the user to define many of the parameters used to create a report with the requested data. The data presented is based on the aggregation totals run during the previous quarterly process.

The Business Objects tool is also used to run targeted and ad hoc queries. Targeted queries are established reports where the user may re-fresh data when needed. Ad hoc queries allows the user to develop a query as needed.

The Browser Interface allows the user access to the Case Type Maintenance windows. Case Types can be added, deleted and updated through the Case Type Maintenance windows.

1.3.2 Data Layer

The data layer is comprised of the DSSProfiler Data Mart, Claims Analysis, and Support Table Structures.

The DSSProfiler Data Mart contains all the aggregations produced by the quarterly run of the DSSProfiler. Summaries of each Case Type within each Peer Group, Report Category (Claim Types) and Aggregation Type (Type of claim – Fee for Service (FFS), Encounter or both) are included within the tables of the data mart. By storing the aggregates at these levels, the user can run many reports looking at data in many different ways.

The Claims Analysis Data Mart is utilized to gather the claims information for the DSSProfiler to aggregate in the quarterly process.

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The Support Table Structures provide extra data for reports and queries. This data includes provider and recipient demographic data, descriptions and other data not normally found on specific claims tables.

1.3.3 Business Layer

The Business Layer is comprised of the DSSProfiler Aggregation Process.

The DSSProfiler aggregation process runs once a quarter. This process summarizes data based on claims from the previous 12 months. The aggregations are created by processing each claim against the user defined Case Types and accumulating data as necessary. The aggregations are then saved in the DSSProfiler Data Mart.

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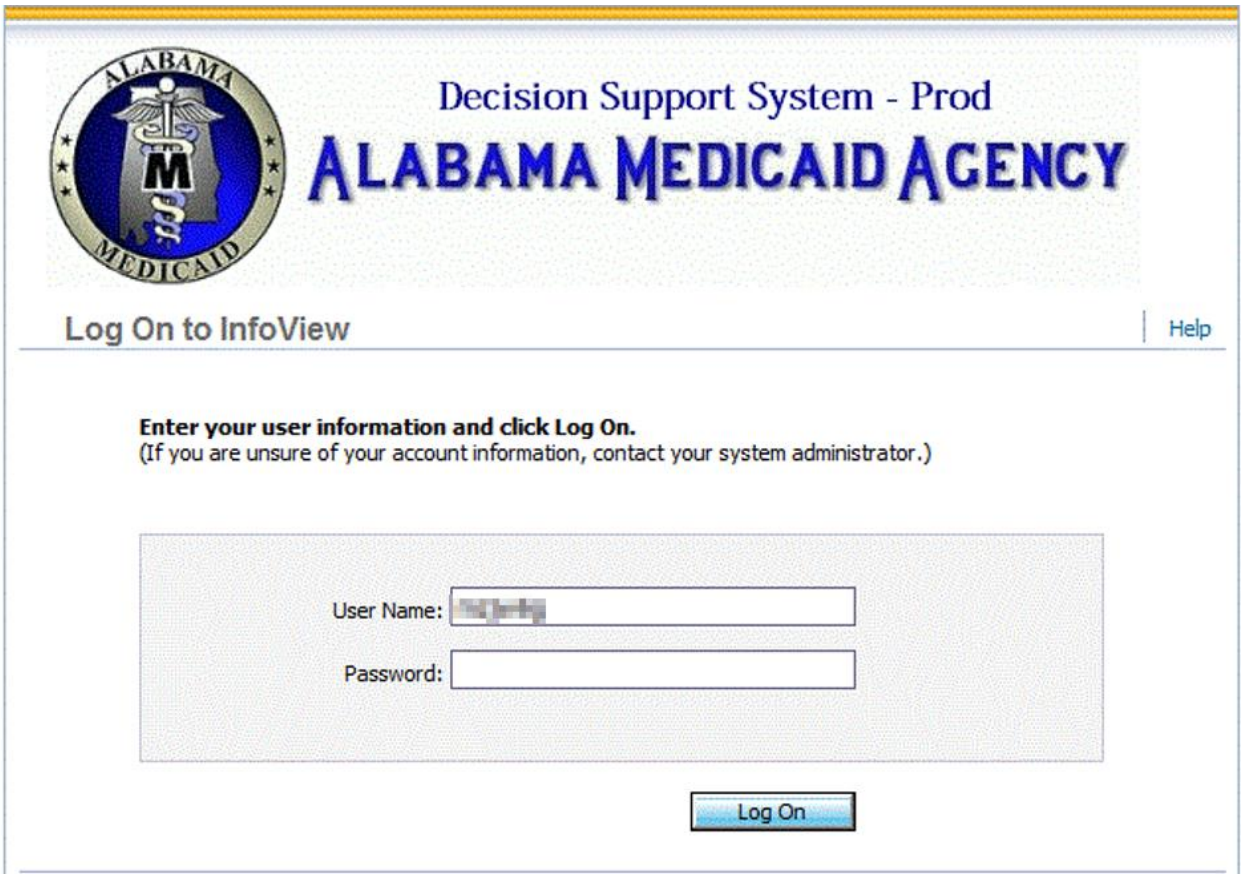
2. Internal Web Pages

2.1 Accessing the SUR DSSProfiler Application

Log on to the InfoView DSSNavigator.



A Welcome window is displayed.

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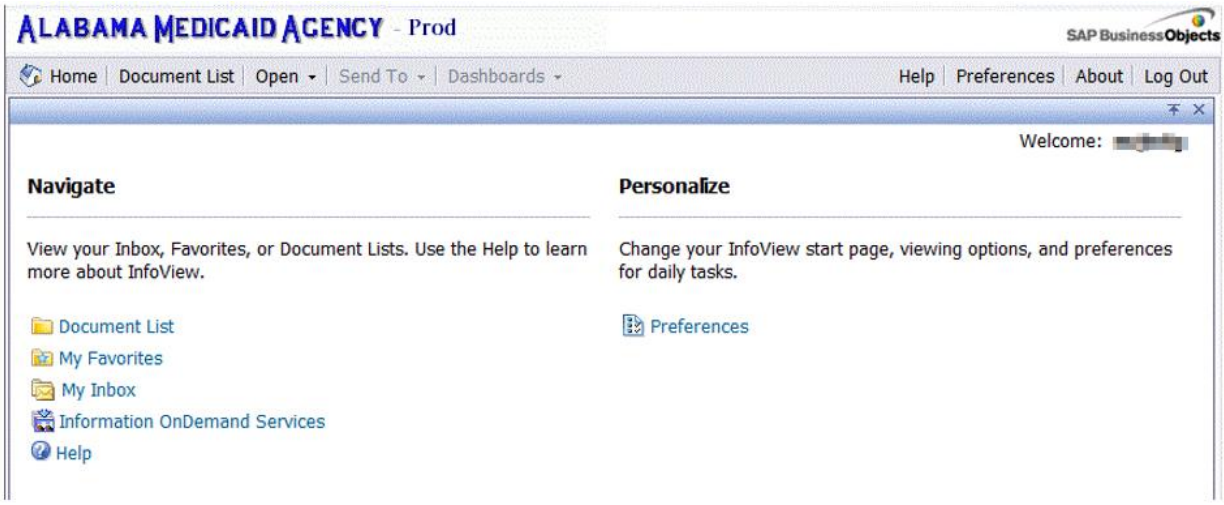
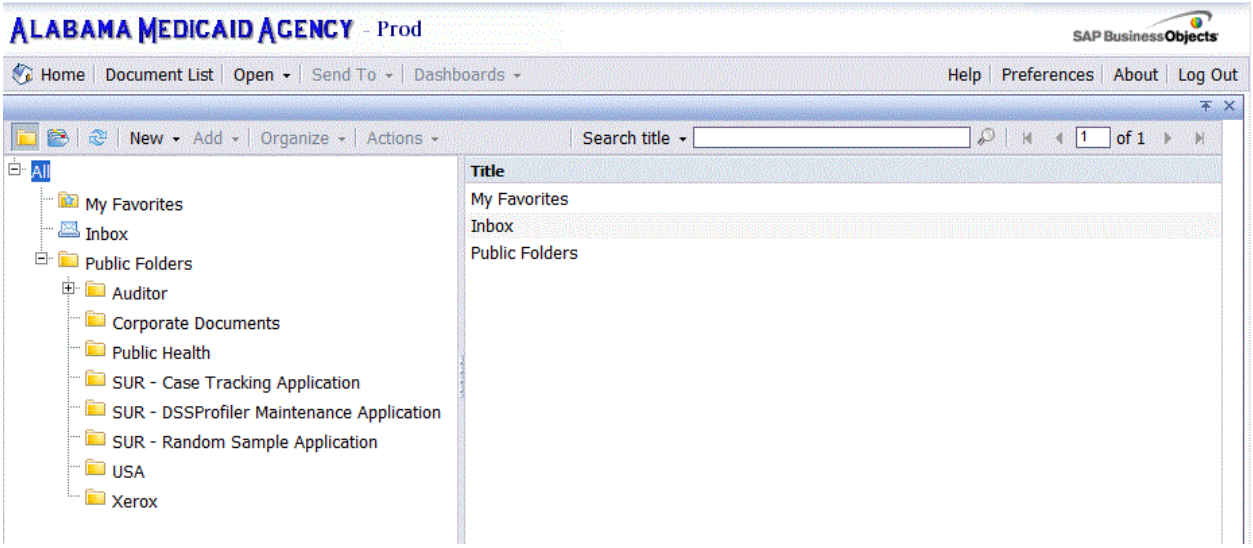


Click on “Document List” and then expand “Public Folders” and a list of applications is displayed as unopened folders.



Click on one of the folders to start an application, in this case the “SUR – DSSProfiler Maintenance Application”.

2.1.1 Case Category Maintenance

From the Document List window select the hyperlink for “Case Type Maintenance”; then select the Case Category Maintenance tab at the top. A case category is used to group or create subsets for case types and case groups within a report category. Use the Case Category Maintenance window to view, add or delete Case Categories.

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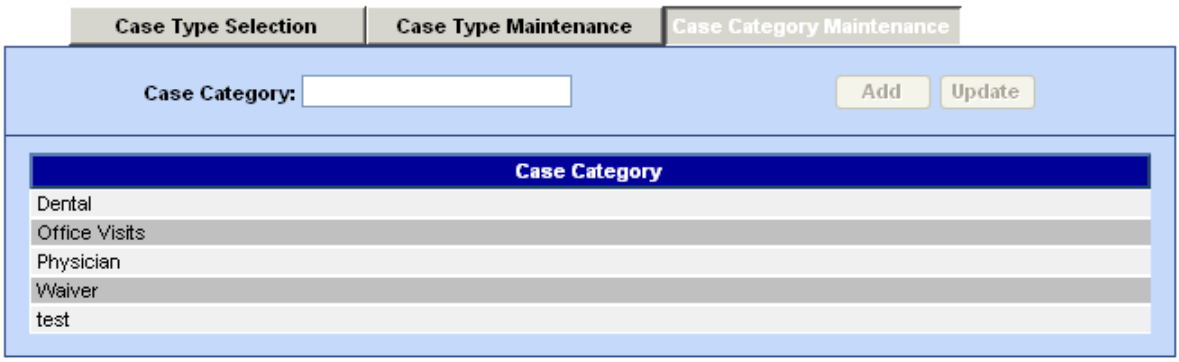
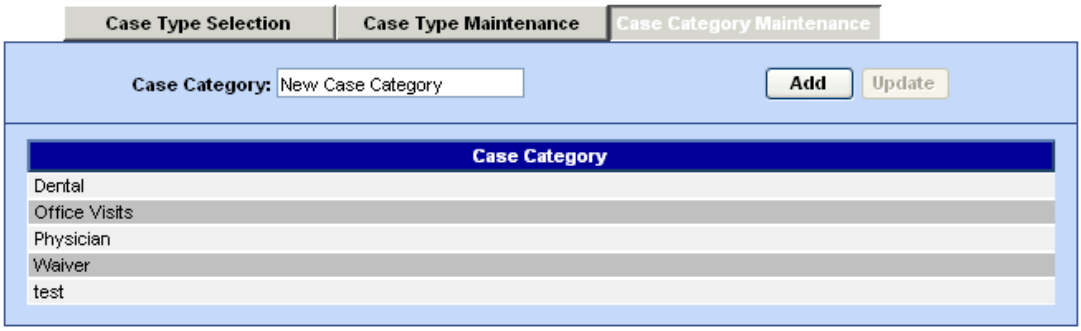


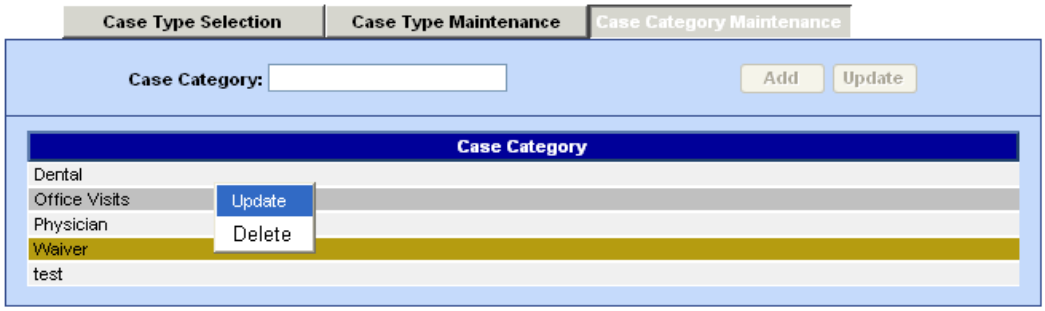
2.1.1.1 To Add a New Case Category

Place the cursor in the Case Category field and enter the name. After the first position of the name is entered, the Add button is activated. Select the **Add** button to create a new Case Category. A window displays stating the Case Category was added successfully, select **OK**. The new Case Category is added to the list.



2.1.1.2 To Update a Case Category

To make an update to an existing Case Category, highlight the Case Category and right click the mouse; then select **Update**.



The Case Category Maintenance window is re-displayed with the Update button available. The user may update the Case Category name and select **Update**. A window displays stating the Case Category was updated successfully, select **OK**.

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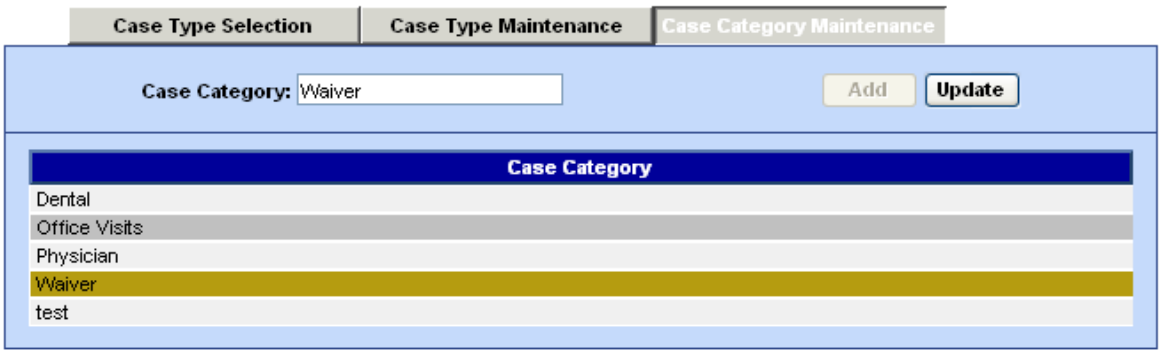
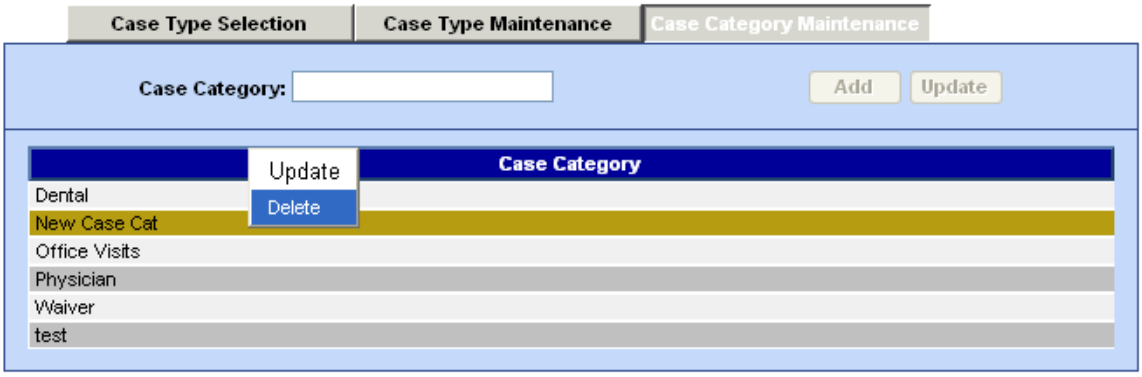


2.1.1.3 To Delete a Case Category

To delete an existing Case Category, highlight the Case Category and right click the mouse; then select **Delete**. A window displays to ensure you wish to delete the Case Category, select **OK**. The Case Category is deleted and removed from the list.



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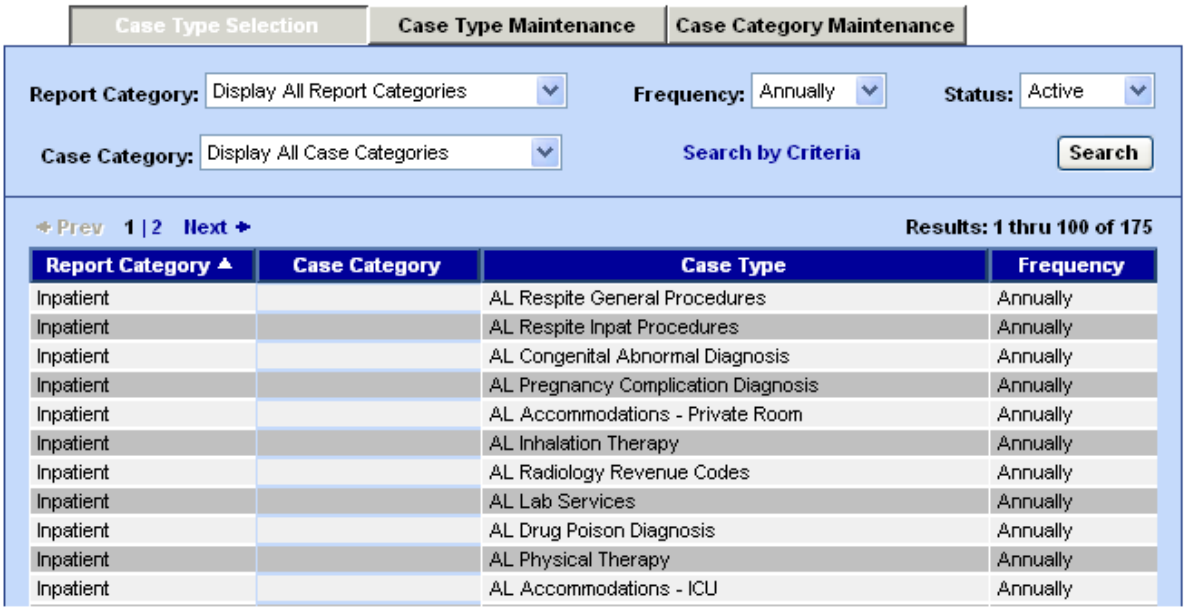
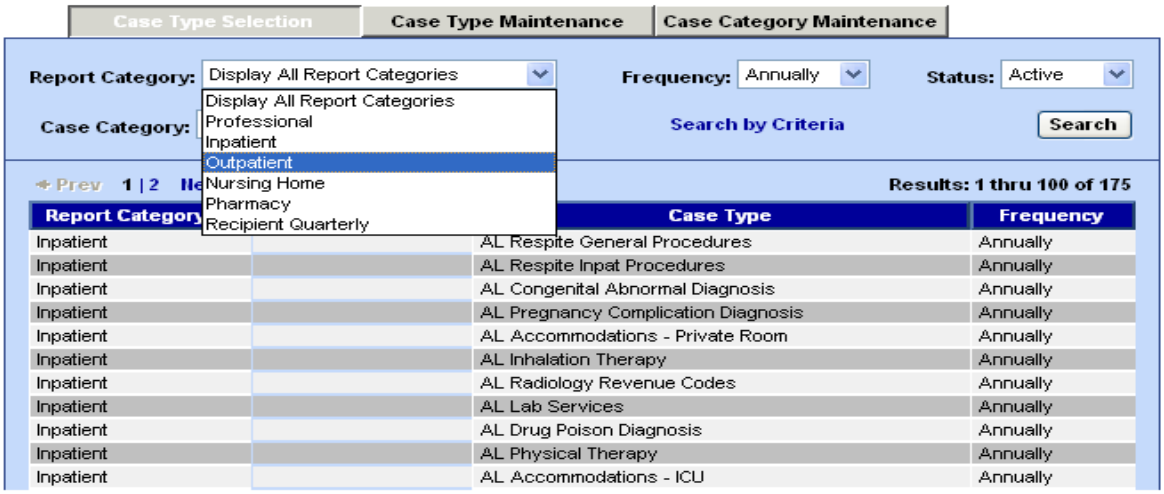
2.1.2 Case Type Maintenance

From the Document List window select the hyperlink for “Case Type Maintenance”. A case type is defined as data criteria used to group claims into different buckets that is used in evaluating peer groups and by the case group logic. Use the Case Type Selection window to view all Case Types or selected Case Types displayed as the result of a search. The Case Type Maintenance window allows the user to enter criteria for new Case Types or update existing ones.



2.1.2.1 To Search for an Existing Case Type

Use the drop down boxes for Report Category, Frequency, Status and Case Category to narrow the search criteria. Click the Search button. The Case Types meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up means ascending order.



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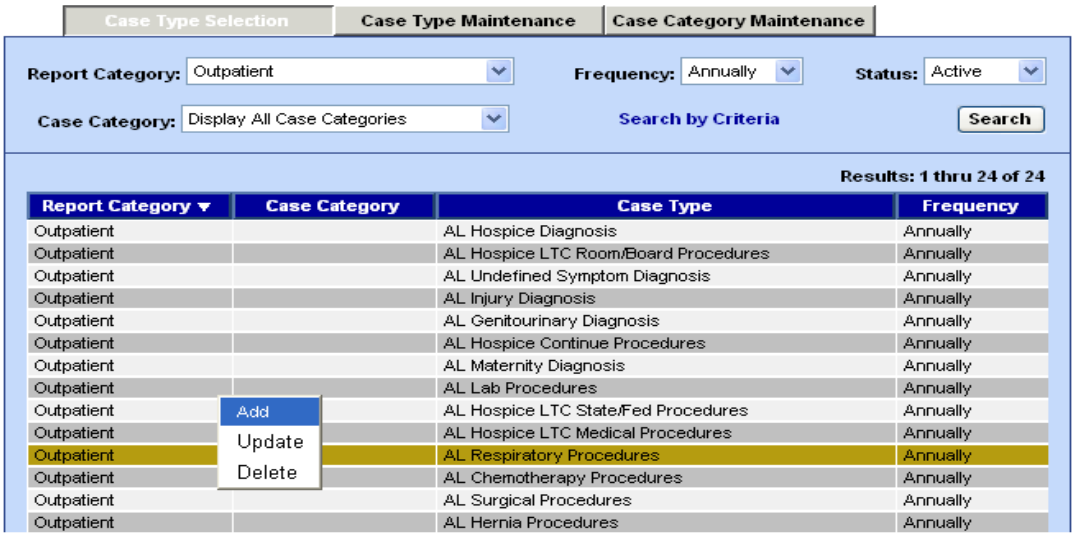
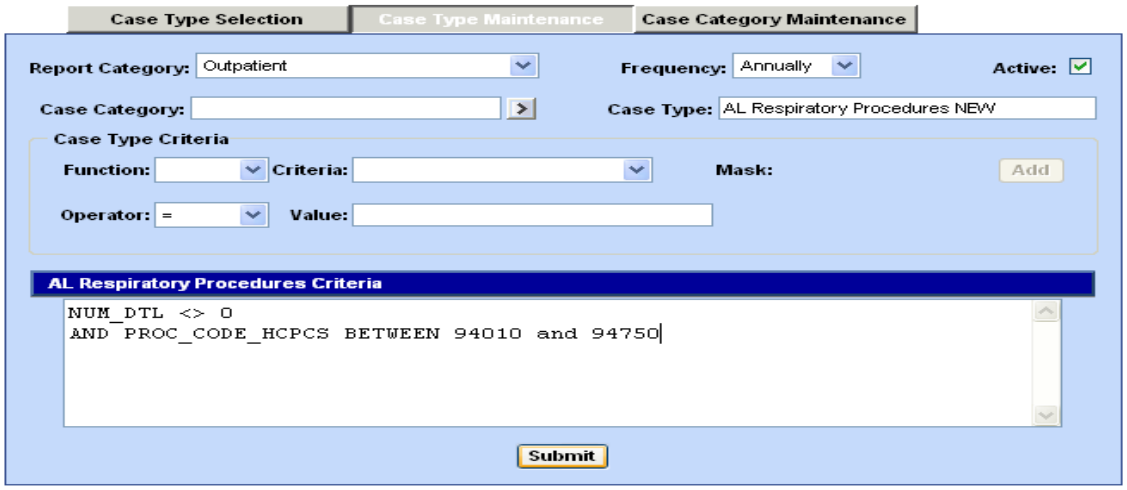
2.1.2.2 To Add a New Case Type

Highlight any Case Type, right click the mouse and select **Add**. To copy an existing Case Type in order to create a new one, locate and highlight the Case type. The Case Type Maintenance window is displayed.



The original Case Type selected on the Selection window is displayed, use the drop down boxes for Report Category, Frequency and Case Category to establish the correct criteria for the new Case Type. Change the Case Type name to represent the new one. The user must enter a new name and it must contain the prefix “AL – “. Use the Case Type Criteria items in the middle of the window to identify the criteria for the new Case Type. After the Case Type Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom.

Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. Select the Submit button to create the new Case Type. A message window displays to let the user know the Case Type was added.



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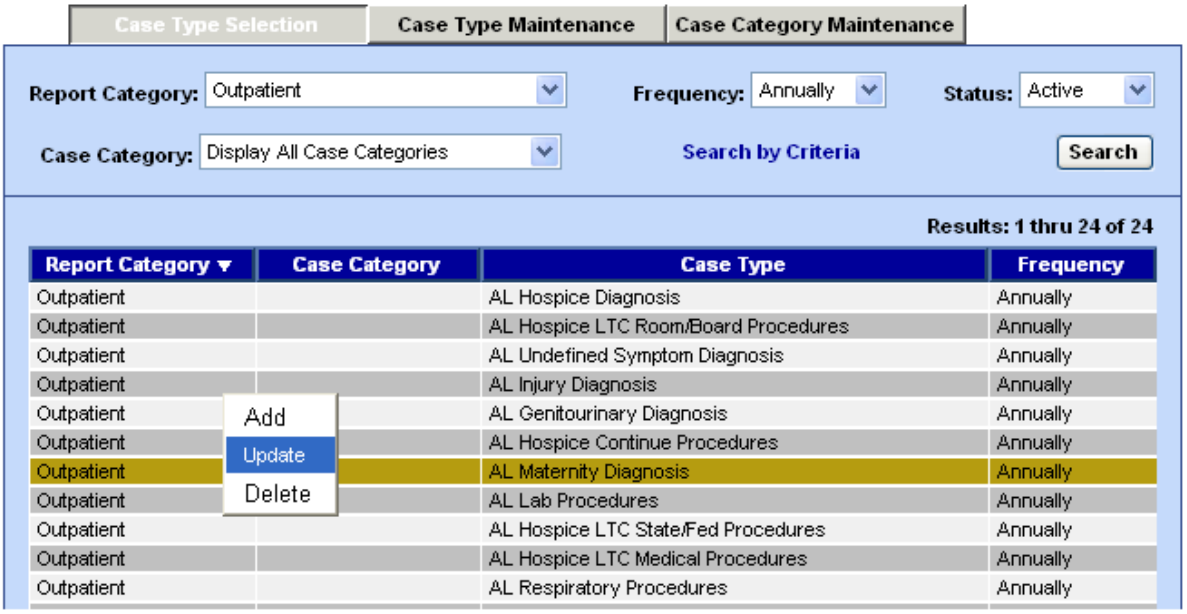
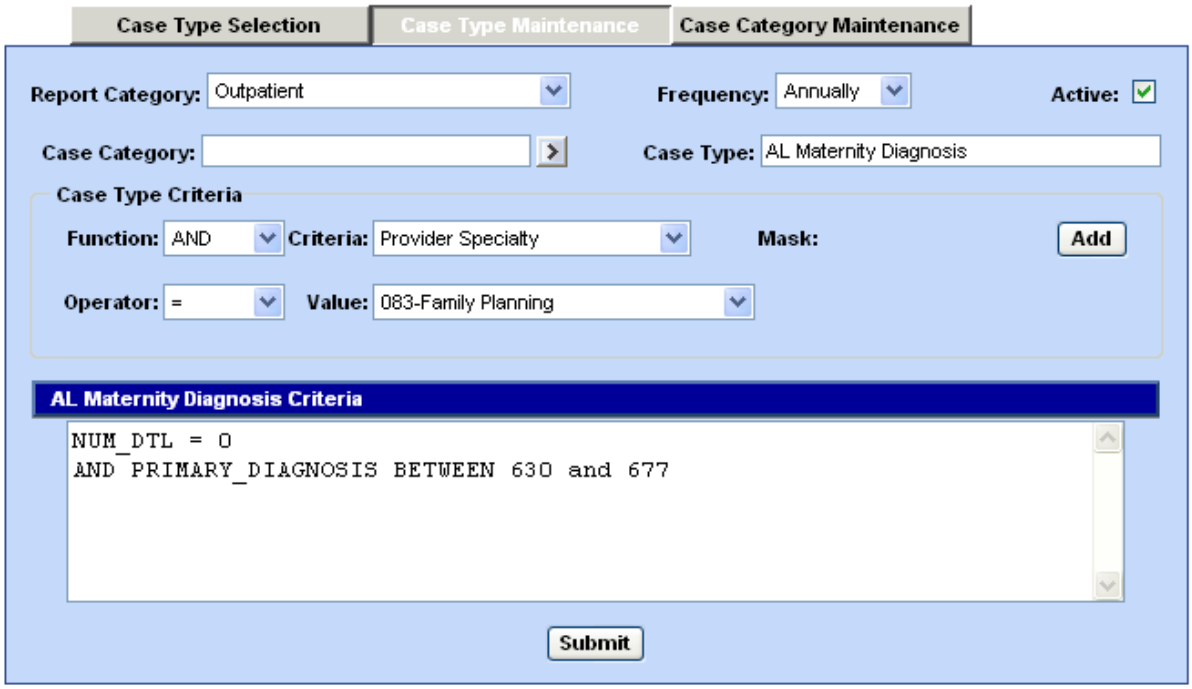
2.1.2.3 To Update a Case Type

Highlight the Case Type shown on the Case Type Selection tab, right click the mouse and select Update. Another way to select a Case Type for Update is double click on the Case Type. The criteria for the Case Type is displayed on the Case Type Maintenance window.



Use the drop down boxes for Report Category, Frequency and Case Category to update criteria for the Case Type.



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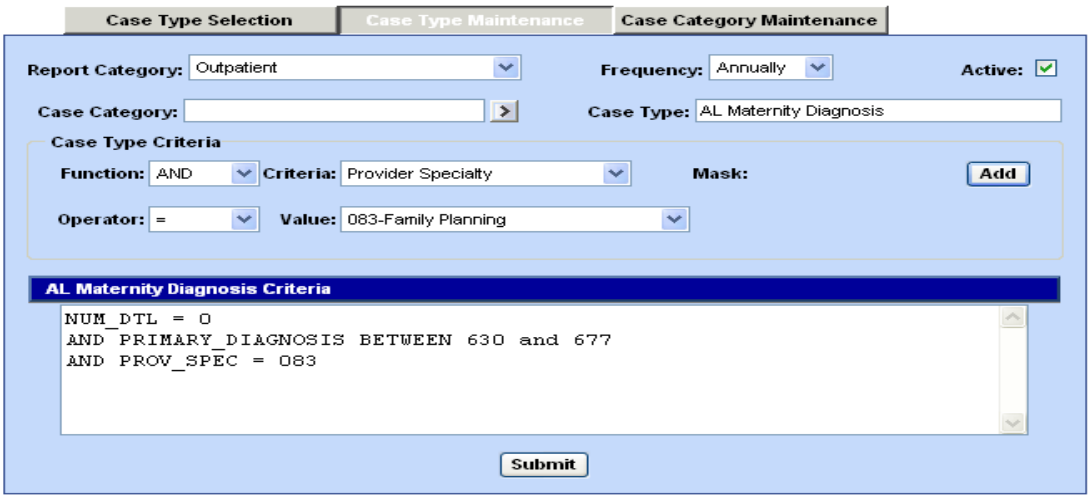
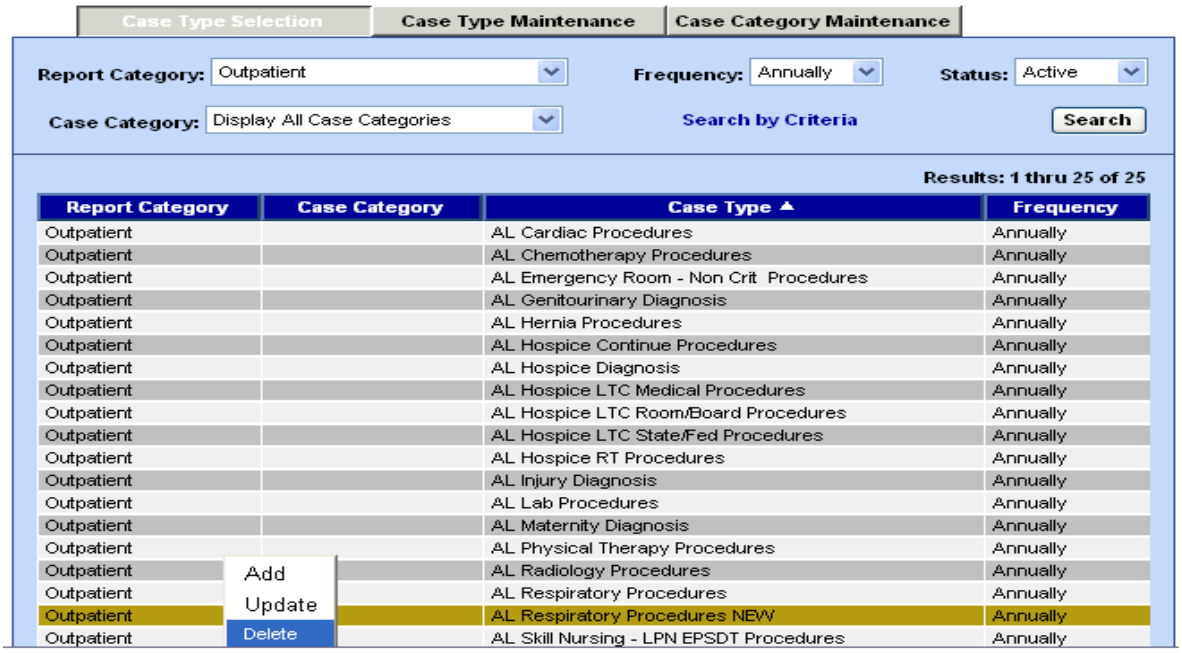
Use the Case Type Criteria items in the middle of the window to identify additional criteria. After the Case Type Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. To remove existing conditions, highlight the condition and select the keyboard delete button. When all changes have been made select the Submit button. A message window displays to let the user know the Case Type was updated.



2.1.2.4 To Delete a Case Type

Highlight the Case Type shown on the Case Type Selection tab, right click the mouse and select **Delete**. A message window displays to ensure the Case Type selected is to be deleted, select **OK**. Another message window displays to let the user know the Case Type was deleted.



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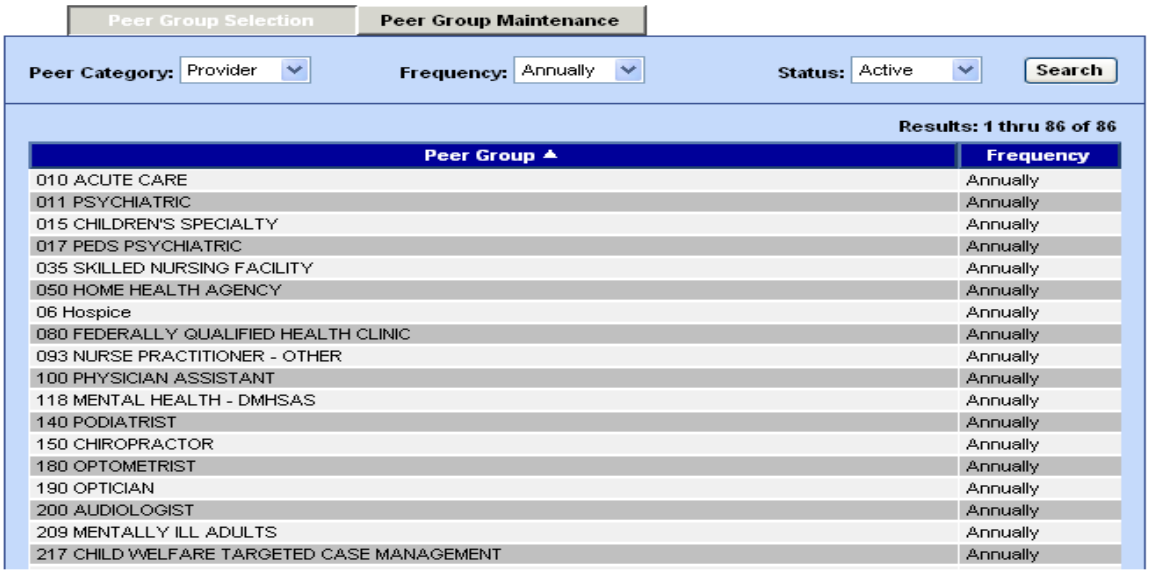
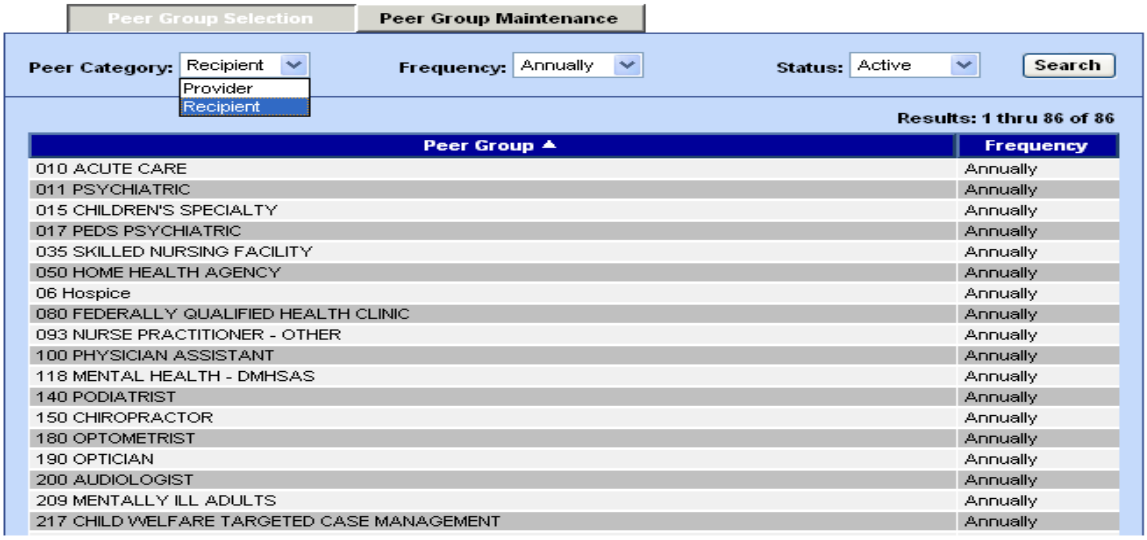
2.1.3 Peer Group Maintenance

From the Document List window select the hyperlink for “Peer Group Maintenance”. Peer group is defined as a grouping of providers or recipients that have similar characteristics, (i.e. provider type or county code). Use the Peer Group Selection window to view all Peer Groups or selected Peer Groups displayed as the result of a search. The Peer Group Maintenance window allows the user to enter criteria for new Peer Groups or make updates to existing ones.



2.1.3.1 To Search for an Existing Peer Group

Use the drop down boxes for Peer Category, Frequency and Status to narrow the search criteria. Click the Search button. The Peer Groups meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up represents ascending order.



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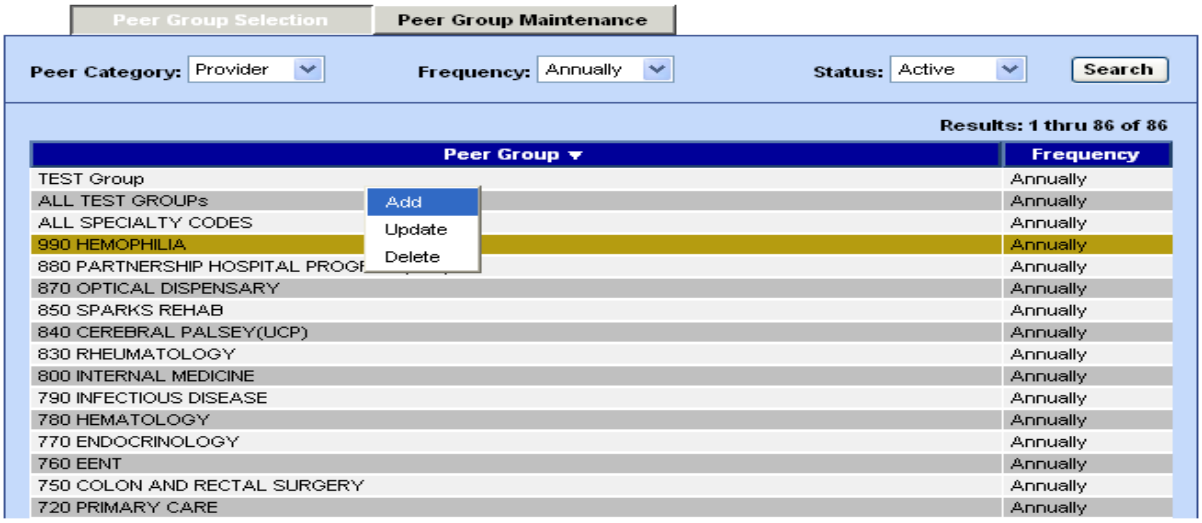
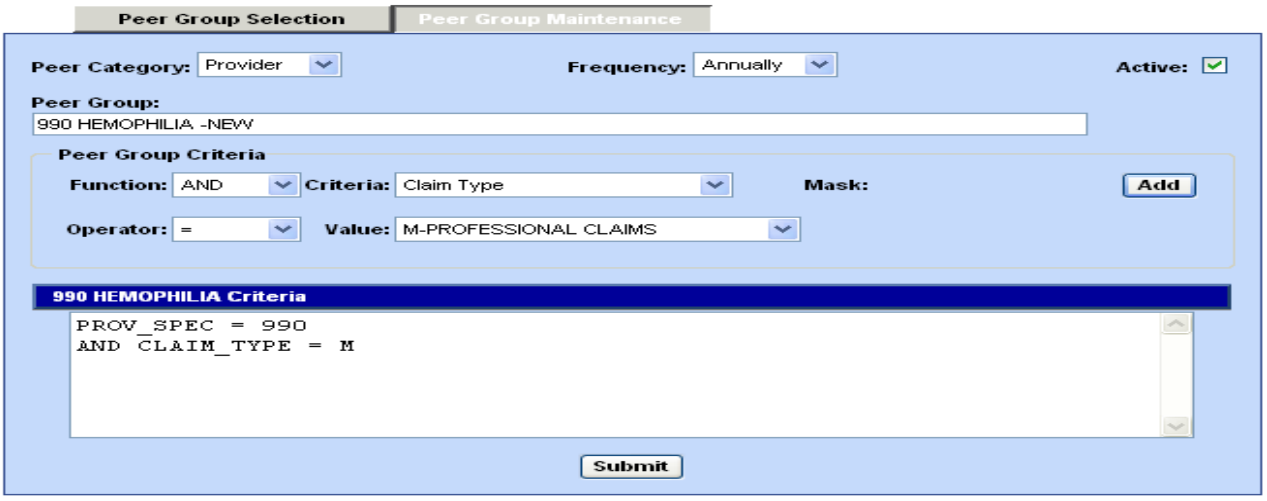
2.1.3.2 To Add a new Peer Group

Highlight any Peer Group, right click the mouse and select Add. To copy an existing Peer Group in order to create a new one, locate and highlight the Peer Group. The Peer Group Maintenance window is displayed.



The original Peer Group selected on the Selection window is displayed, use the drop down boxes for Peer Category, Frequency and Status to establish the correct criteria for the new Peer Group. Change the Peer Group name to represent the new one. You must change the name in order for a new Peer Group to be created. Use the Peer Group Criteria items in the middle of the window to identify the criteria for the new Peer Group. After the Peer Group Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. Select the Submit button to create the new Peer Group. A message window displays to let the user know the Peer Group was added.



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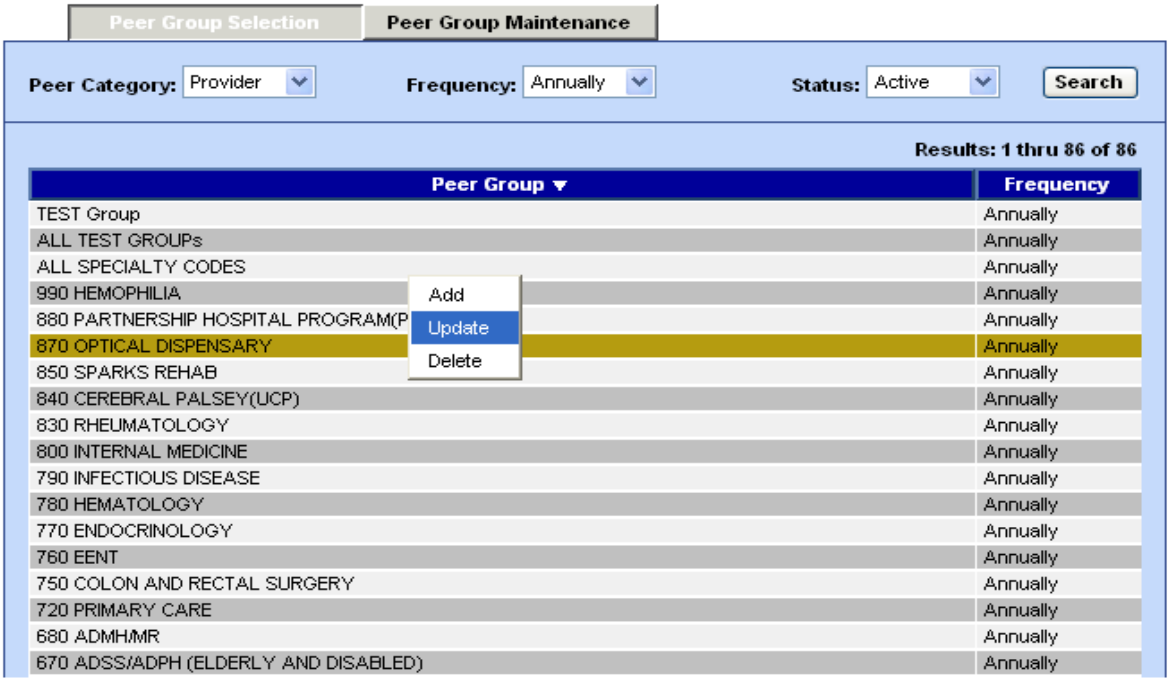
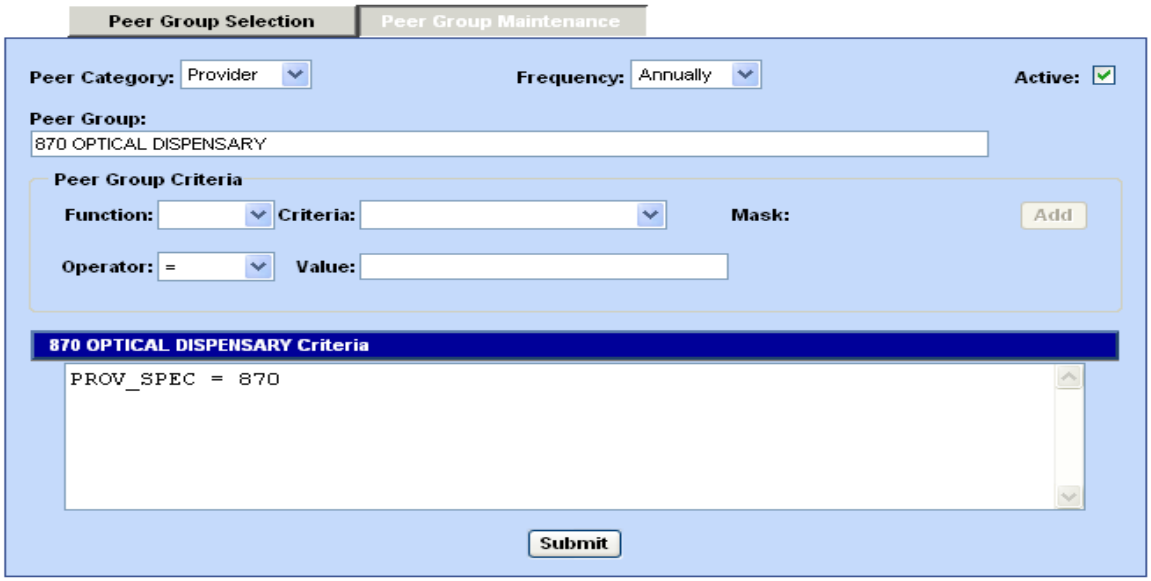
2.1.3.3 To Update a Peer Group

Highlight the Peer Group shown on the Peer Group Selection tab, right click the mouse and select Update. Another way to select a Peer Group for Update is double click on the Peer Group. The criteria for the Peer Group is displayed on the Peer Group Maintenance window.



Use the drop down boxes for Peer Category and Frequency to update criteria for the Peer Group.



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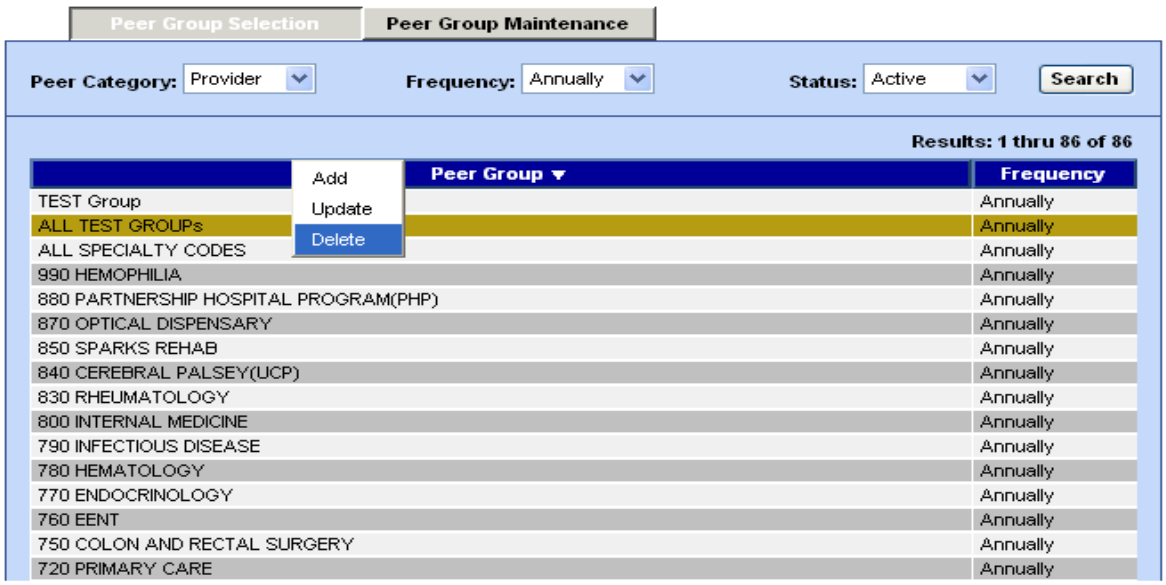
Use the Peer Group Criteria items in the middle of the window to identify additional criteria. After the Peer Group Criteria selections are made, select the Add button. The criteria will now be added to the white criteria box at the bottom. Another way to make an update is to place the cursor in the white criteria box at the bottom and type the correct conditions. NOTE: Specific field names must be used as these are database names. To remove existing conditions, highlight the condition and select the keyboard delete button. When all changes have been made select the Submit button. A message window displays to let the user know the Peer Group was updated.

2.1.3.4 To Delete a Peer Group

Highlight the Peer Group shown on the Peer Group Selection tab, right click the mouse and select Delete. A message window displays to ensure the Peer Group selected is to be deleted, select OK. Another message window displays to let the user know the Peer Group was deleted.



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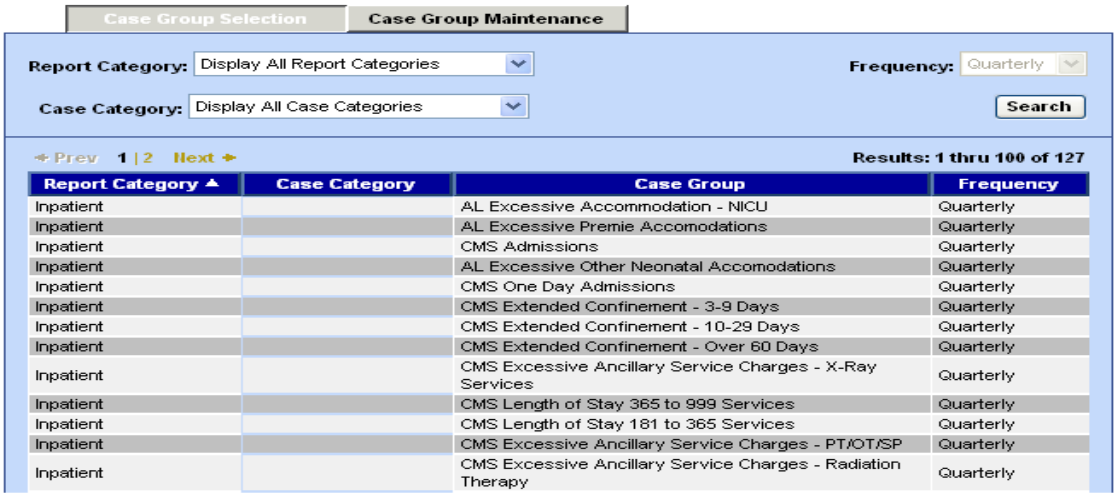
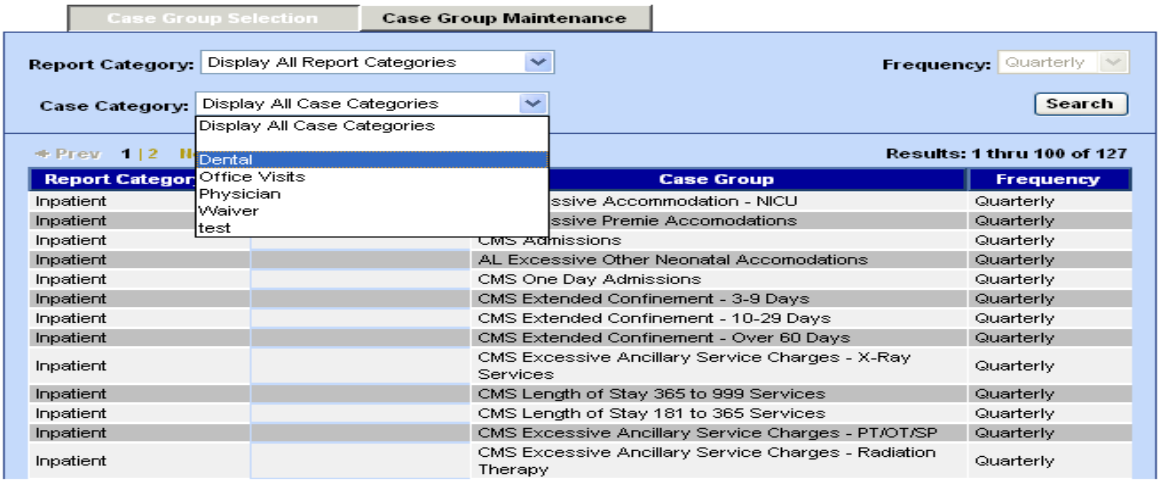
2.1.4 Case Group Maintenance

From the Document List window select the hyperlink for “Case Group Maintenance”. Case group is defined as a collection of case types used to define exception criteria for DSSProfiler reporting. Use the Case Group Selection window to view all Case Groups or selected Case Groups displayed as the result of a search. The Case Group Maintenance window allows the user to enter criteria for new Case Groups or make updates to existing ones. All Case Groups are associated with the quarterly Frequency so the Frequency selection is not available with Case Group Maintenance windows.



2.1.4.1 To Search for an Existing Case Group

Use the drop down boxes for Report Category, and Case Category to narrow the search criteria. Click the **Search** button. The Case Groups meeting the search criteria are displayed. To change the sort order, click on the column for the desired sort. The triangle pointed down represents descending order and the triangle pointed up represents ascending order.



2.1.4.2 To Add a New Case Group

Highlight any Case Group, right click the mouse and select **Add**. The Case Group Maintenance window is displayed.

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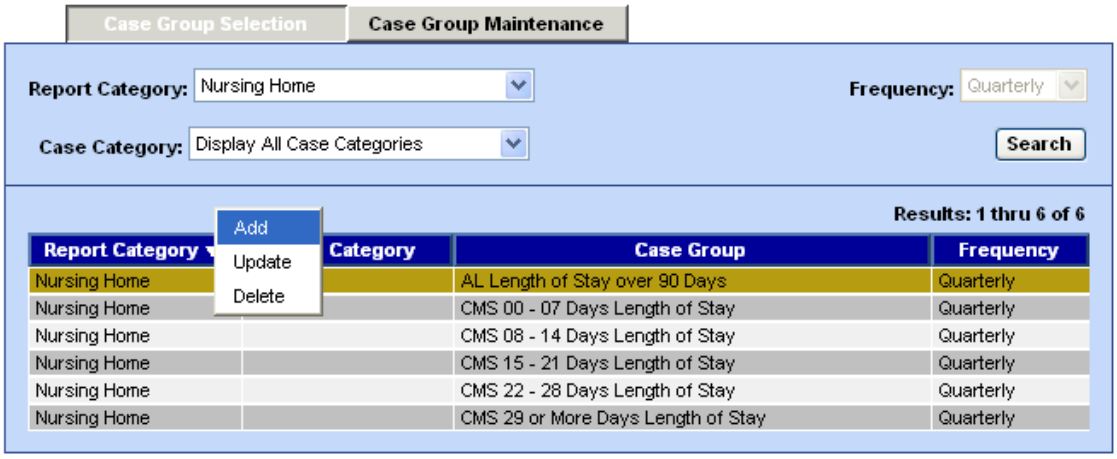
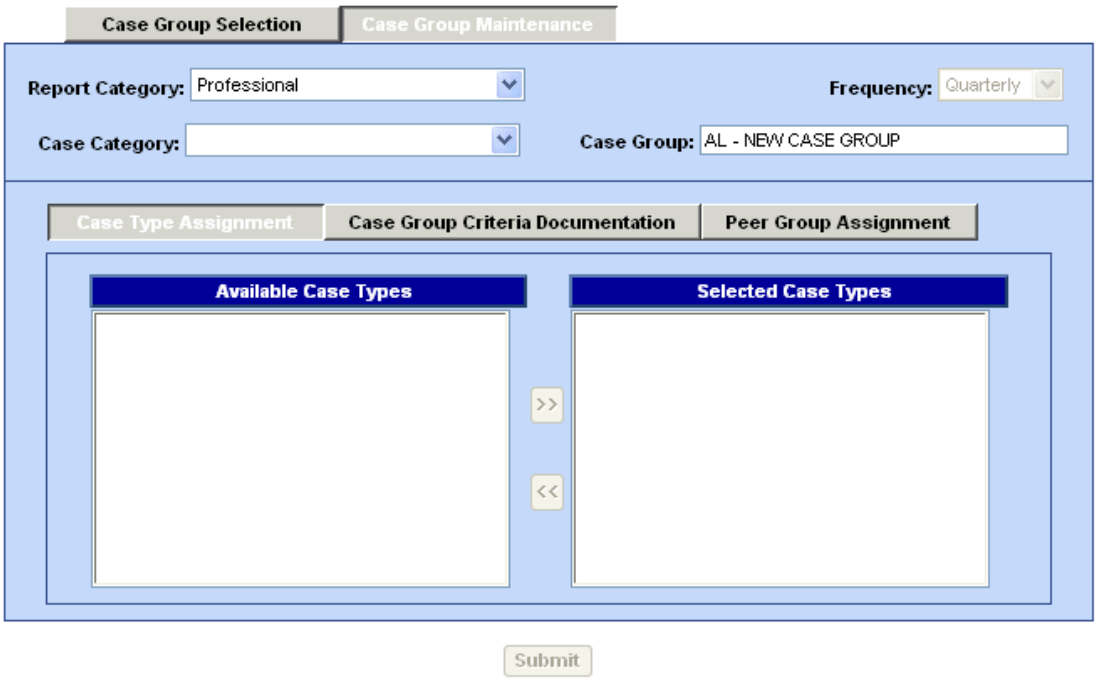


Use the drop down boxes for Report Category and Case Category to establish the correct criteria for the new Case Group. The user must enter a name and it must contain the prefix “AL – “. If the Case Types to be used in the new Case Group are associated with a specific Case Category, then select the same Case Category for the new Case Group; otherwise the list of available Case Types will not be displayed.



The user must assign Case Types to the Case Group and create the criteria before a Case Group can be saved. Click the mouse in the Available Case Types box for a list of Case Types. Use the >> and << buttons to select the correct Case Types to be used in the Case Group.

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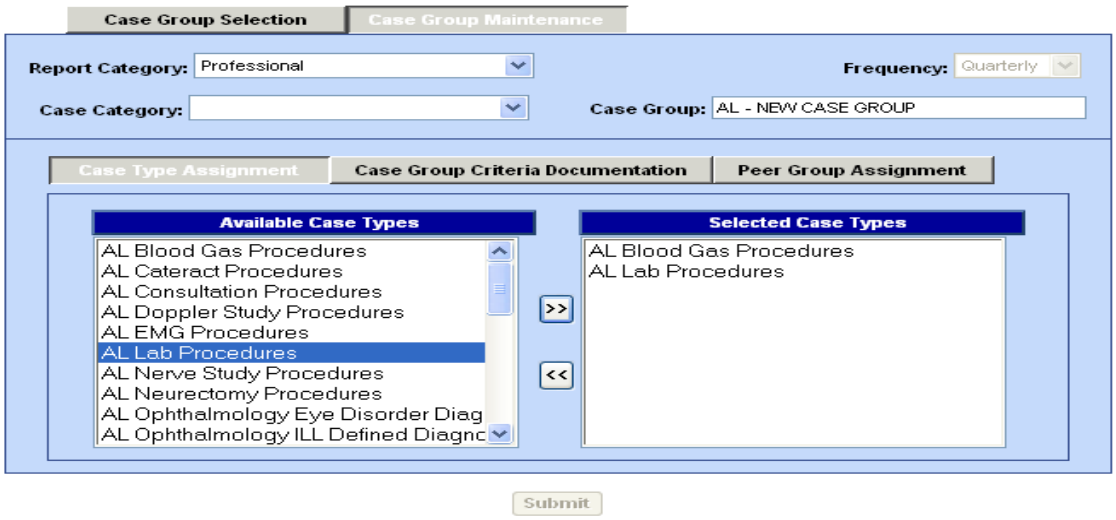
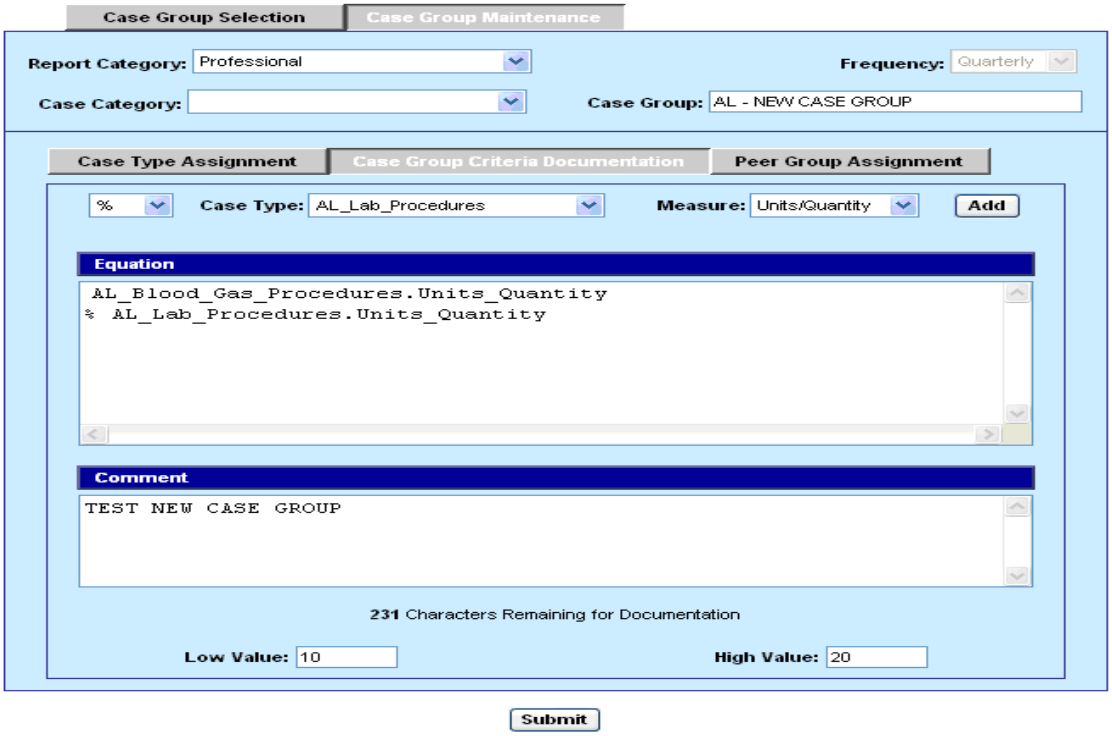


Select the Case Group Criteria Documentation tab in order to set up the equation to be used for the Case Group. Use the drop down boxes in the middle of the window to create the desired measure or equation. Select the Add button for the data to be added to the Equation box. Enter text in the Comments field and select the Low and High values to be used as default values. If the user does not need to specify a Low/High for a specific peer group, then select the Submit button to save the Case Group. A message window will display to let the user know the Case Group was added. Otherwise select the Peer Group Assignment tab.



If special limits are needed for certain peer groups, the Peer Group Assignment tab can be used to establish the limits. This tab is not required. The default limits at the bottom of the Case Group Criteria Documentation tab will be used as a default for all peer groups, unless different limits are established on this tab.

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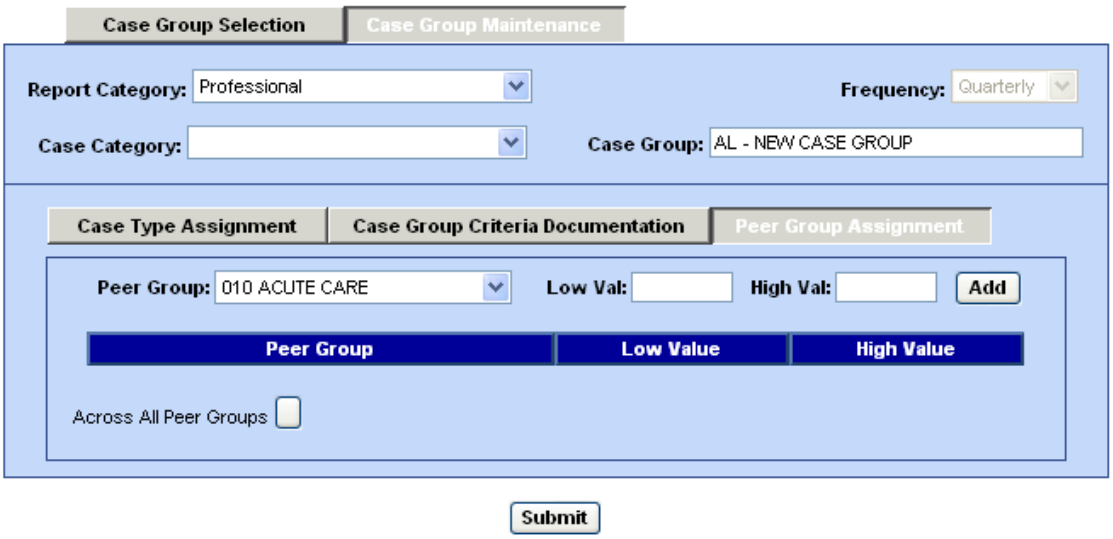
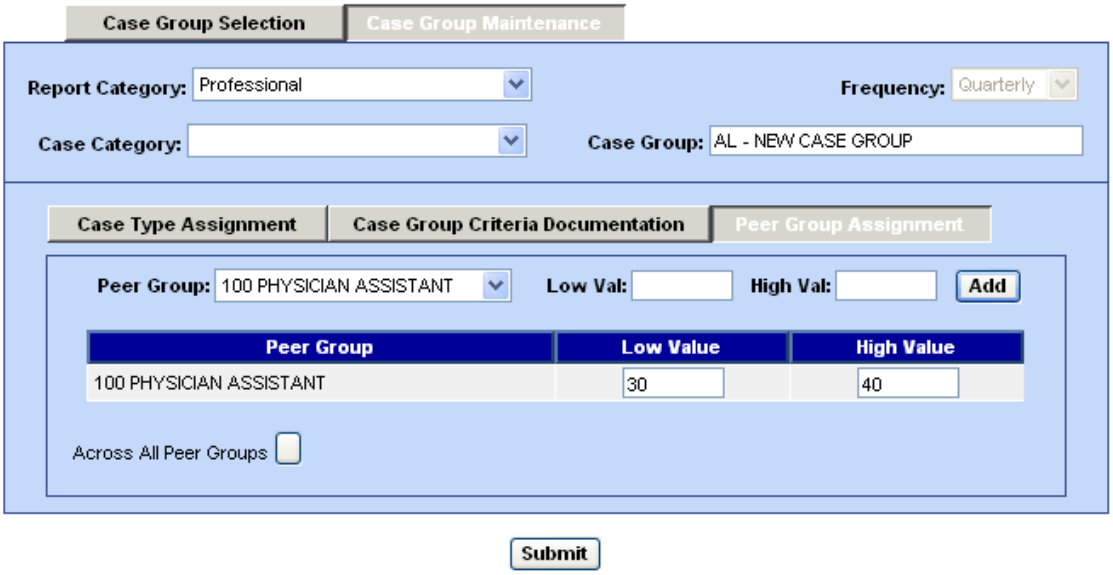


Use the drop down box to select the Peer Group. Enter the Low and High values that should apply to the selected Peer Group. Select the Add button and the limits will be added to the list at the bottom. Select the Submit button. A message window displays to let the user know the Case Group was added.



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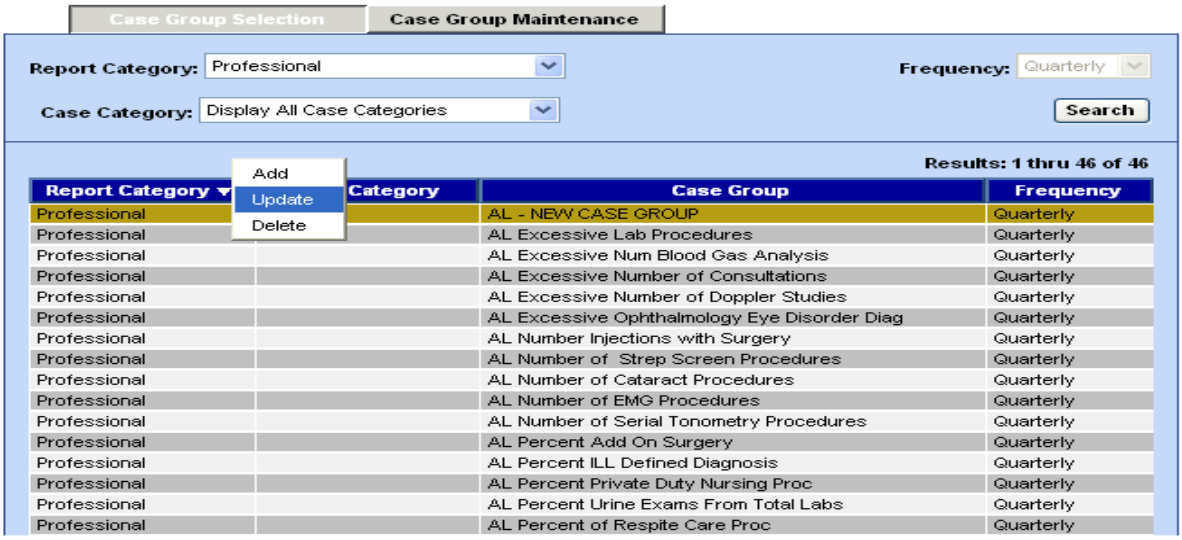
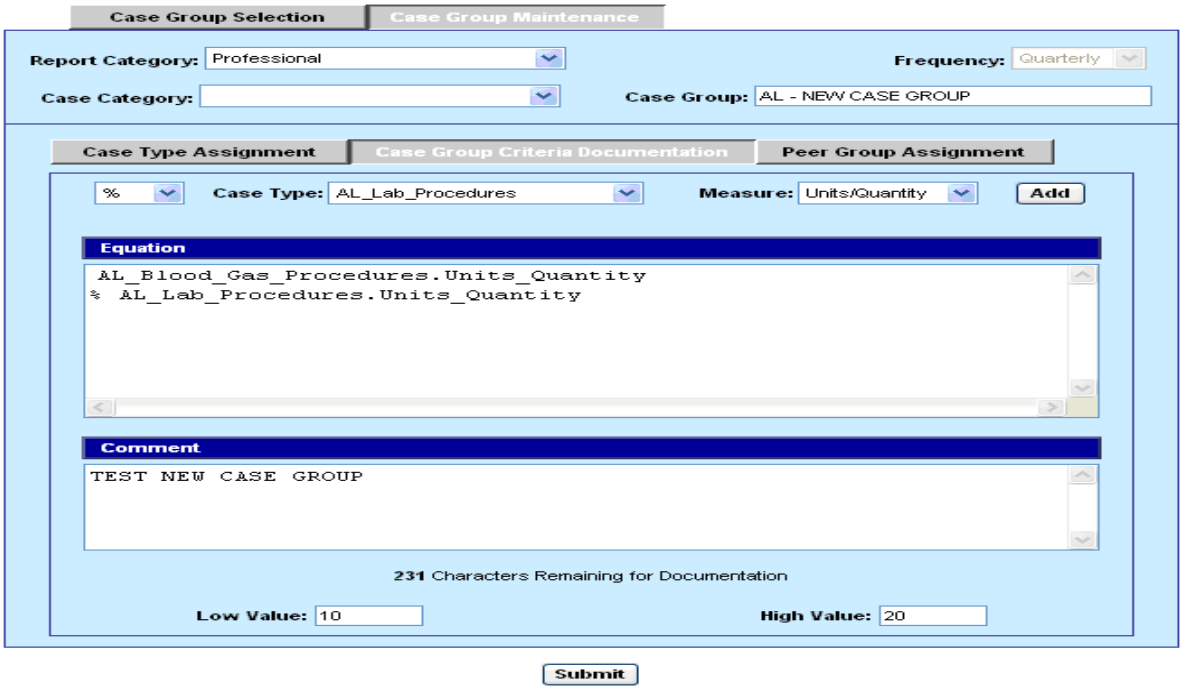
2.1.4.3 To Update a Case Group

Highlight a Case Group shown on the Case Group Selection window, right click the mouse and select Update. Another way to select a Case Group for Update is double click on the Case Group. The criteria for the Case Group is displayed on the Case Group Maintenance window.



Use the drop down boxes for Report Category and Case Category to update criteria for the Case Group. Select the Case Type Assignment tab to add or remove Case Types from the Case Group. Select the Case Group Criteria Documentation tab to update the measure or equation for the Case Group. Select the Peer Group Assignment tab to make updates to the peer group limits. Select the Submit button to save the updates. A message window displays to let the user know the Case Group was updated.



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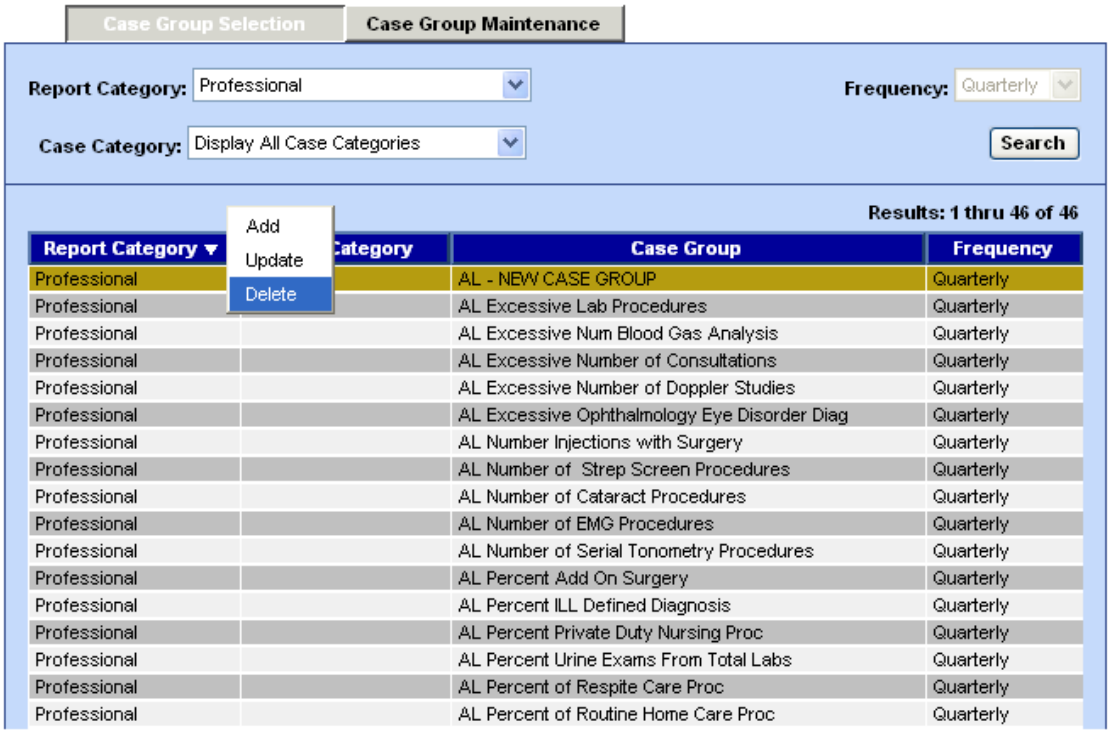
2.1.4.4 To Delete a Case Group

Highlight the Case Group shown on the Case Group Selection window, right click the mouse and select Delete. A message window displays to ensure the Case Group selected is to be deleted, select OK. Another message window displays to let the user know the Case Group was deleted.



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2.2 Case Tracking

The Alabama Surveillance and Utilization Review (SUR) Case Tracking function replaces many of the manual operations throughout the SUR case review process with systematic approaches. Browser-based windows replace many of the manual operations such as providing auto-assignment of case reviews and online updating of case documentation. In addition, the SUR Case Tracking function allows for the viewing of imaged incoming correspondence and photocopied medical records from on-site audits.

For further details related to the SUR Case Tracking function, refer to the SUR Case Tracking User Manual.

2.3 Random Sample Overview

The Random Sample Application provides the ability to generate summary reports from a statistically valid random sampling process. The random sample process is initiated and accessed through browser-based windows from the Data Warehouse web site. Through this web site, users can specify if they want to sample claims for providers or recipients, and they can specify the date ranges and other filter conditions such as specific claim types or code values. The results from the sample are stored in the Data Warehouse where the results can be reported on summary web screens or from reports generated through the Data Warehouse.

The Random Sample Application includes several windows to assist the user in either pulling a random sample of claims or 100% of the claims sorting and viewing the results. It also produces spreadsheets of the claims selected, as well as sends the results to the SUR universe in the DSS. The following pages include how to access the application, describe the windows and define the elements in the spreadsheets and SUR universe.

2.4 Accessing the Random Sample Application

Login to DSS InfoView. On the “Navigate” side of the panel, select the “Document List” folder hyperlink. Then expand the “Public Folders” folder, and select the folder entitled “SUR-Random Sample Application”. This takes you to the “Document List” window, with only the Random Sample application hyperlinks shown. Then double-click the hyperlink “Random Sample Request”.

After clicking the hyperlink, the user is taken to the Request Information window of the Random Sample application.

2.4.1 Random Sample - 1 -Request Information Tab

Use the Random Sample - 1 - Request Information Tab to generate a random claim sample for a provider or a recipient. Access this page by selecting the Random Sample link from the Navigator window. Use this first tab to set up the basic information on the request such as the provider/recipient, dates and the sample size. Other tabs described later in this document include information on filtering the request.

When the random sample request is entered, press Submit to generate the random sample request. The request is saved and a batch process runs the request. The Random Sample Log tab is available to check on the status of the request.

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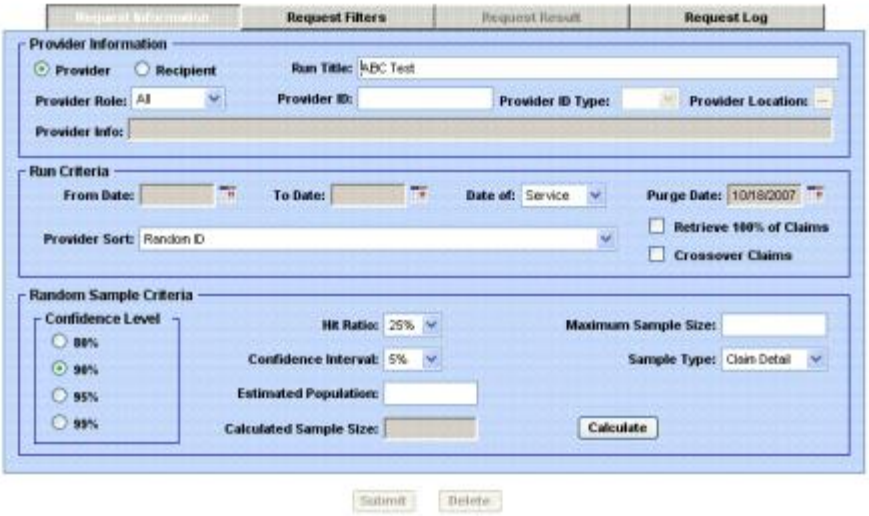
The page can be accessed in two different ways:

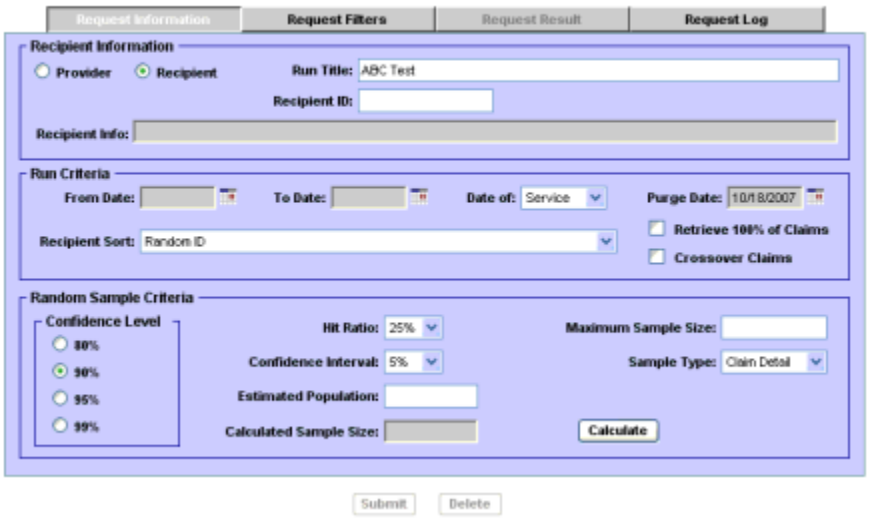
A. Open the Random Sample window and enter a provider ID and the claim criteria to restrict the results. The random sample is performed on the selected date range from at least three years plus the current year of claims data.

B. Open the Random Sample window and enter a recipient ID and the claim criteria to restrict the results. The random sample is performed on the selected date range from at least three years plus the current year of claims data.

A



B



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2.4.2 Random Sample - 2 - Request Filters Tab

Use the Random Sample - 2 - Request Filters Tab to enter specific criteria to limit the results of the Random Sample process.

Select from the following list for a Provider random sample:

- Billed Amount;
- Claim Type;
- Diagnosis Related Group (DRG) Code;
- Internal Control Number (ICN);
- Claim Indicator (‘F’ for Fee-for-Service and/or ‘E’ for Encounters; default is both);
- District Plan Code;
- National Drug Code (NDC);
- Paid Amount;
- Place of Service;
- Primary Diagnosis Code;
- ICD Version Code (9, 0, or # for "ICD-9", "ICD-10", and "undefined" respectively);
- Primary Procedure Code;
- Provider Type;
- Provider Specialty;
- Therapeutic Class;
- Prior Authorization Number;
- Lockin Indicator;
- Allowed Amount;
- Medicare Paid Amount;
- Other Insurance Amount;
- Wrap Payment Indicator

For a Recipient random sample, the following list is available:

- Billed Amount;
- Claim Type;
- DRG Code;
- ICN;
- Claim Indicator (‘F’ for Fee-for-Service and/or ‘E’ for Encounters; default is both);
- District Plan Code;
- NDC Code;
- Paid Amount;
- Place of Service;

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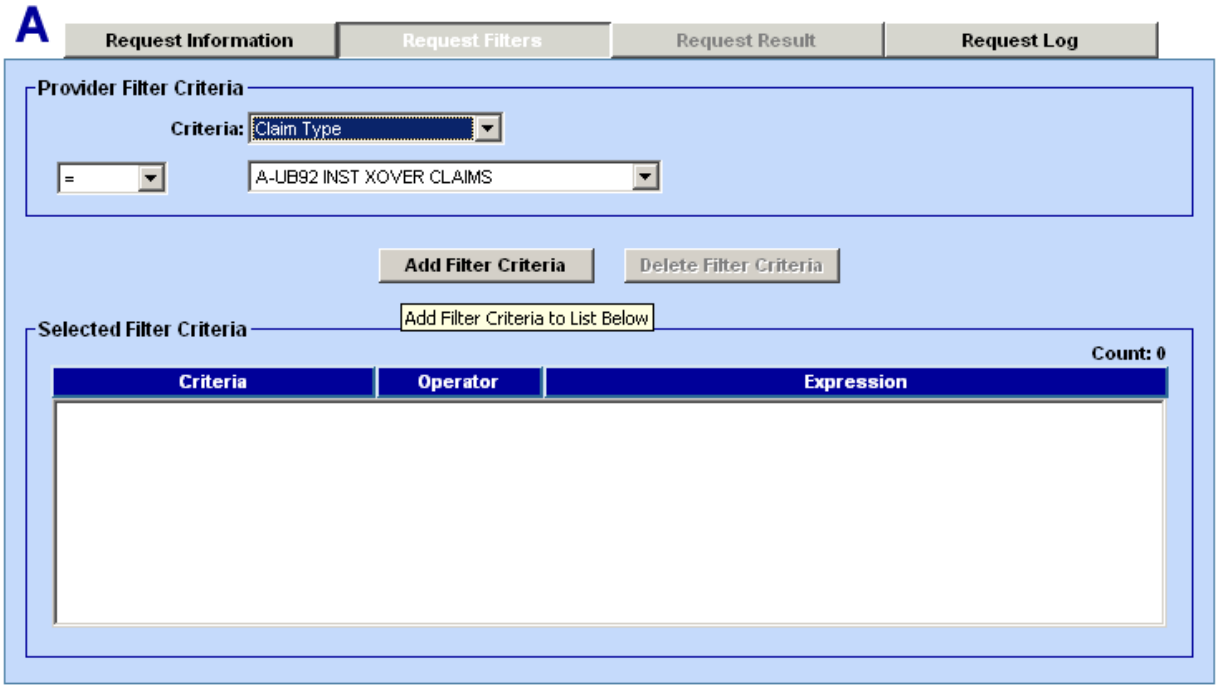
- Primary Diagnosis Code;
- ICD Version Code (9, 0, or # for "ICD-9", "ICD-10", and "undefined" respectively);
- Primary Procedure Code;
- Allowed Amount;
- Prior Authorization Number;
- Allowed Amount;
- Medicare Paid Amount;
- Other Insurance Amount;
- Referring Provider;
- Rendering Provider;
- Therapeutic Class;
- Wrap Payment Indicator

The user has the ability to add and delete from the list of filter condition codes.

There are two layouts for this window below. Layout A is the layout if a Random Sample of a Provider is selected. Layout B is for a Recipient Random Sample. The field names have a letter in front, designating the layout on which it can be found.

2.4.2.1 Random Sample - 2 - Request Filters Tab Layout A



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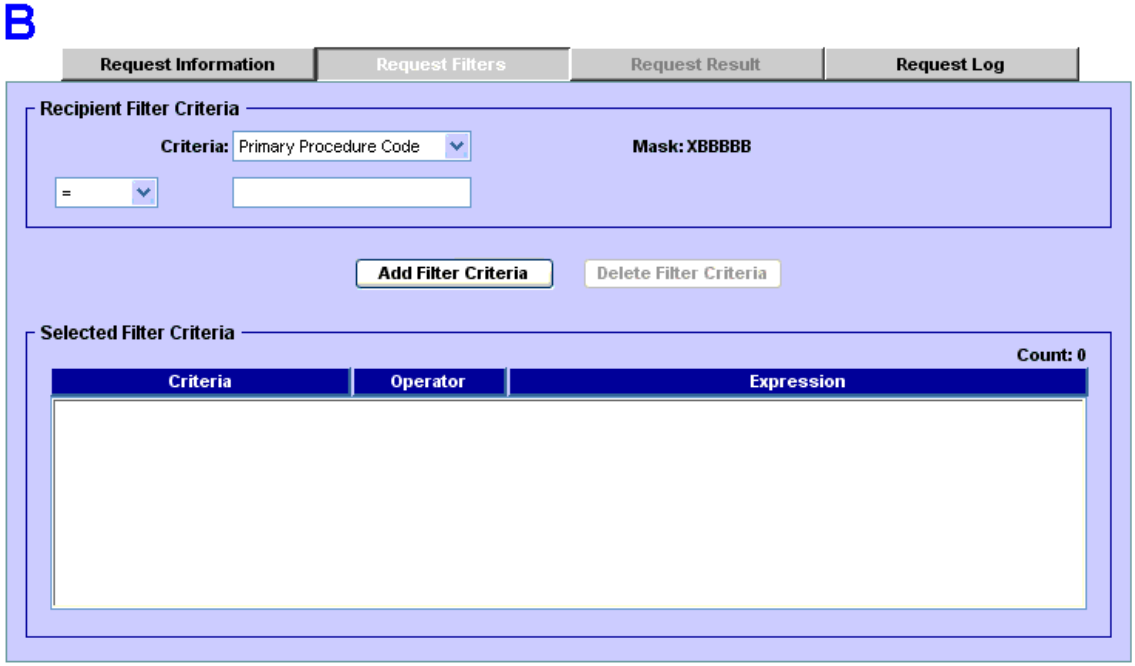
2.4.2.2 Layout B is for a Recipient Random Sample



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2.4.3 Random Sample - 3 - Request Result Tab

The Random Sample - 3 - Request Result Tab displays the Random Sample status and results. This tab displays the detail or header claim results of the Random Sample request. It displays the ICN, Detail Number (Dtl No), From Date of Service (DOS), To DOS, Amt Billed, Amt Paid, Amt MCO, Paid Date and Random ID. If the user requires more claim information, hyperlink to more claim information by clicking on the “Dtl No” associated with ICN they are interested in researching.

Two layouts for this Random Sample window are listed below. Layout A is for Provider Random Sample and layout B is for Recipient Random Sample. The field names have a letter in the front, designating the layout on which they can be found.

A

Request Information | Request Filters | Request Result | Request Log

Run Title: Prod test2
Request ID: 4096
Status: Completed
Provider Number: [redacted]
Date Type: Payment
Request User: [redacted]
Provider Info: SHERMAN, L ARMSTRONG JR. ; 1722 PINE ST STE 201 MONTGOMERY, AL 36106
All
From Date: 04/01/2017
Date/Time: 12/18/2017 09:46:54 AM
Sample Type: Details
To Date: 12/18/2017
Purge Date: 03/18/2018
Confidence Level:
Hit Ratio:
Population Size: 46
Confidence Interval:
Maximum Sample Size: 0
Sample Size: 46
Comment: Successfully completed!

Filter Criteria: Count: 0

Criteria	Operator	Expression		Expression
No Filter Criteria Found.				

Request Results: < Prev 1 Next > Results: 1 thru 46 of 46

ICN	Dtl No	Recipient ID	From DOS	To DOS	Amt Billed	Amt Paid	Amt MCO	Payment Date	Random ID	Wrap Payment
[redacted]	000	[redacted]	06/16/2016	06/16/2016	$398.40	$280.31	$0.00	04/21/2017	1	N
[redacted]	003	[redacted]	03/31/2017	03/31/2017	$7,581.57	$4,328.23	$0.00	04/21/2017	2	N
[redacted]	002	[redacted]	05/03/2017	05/03/2017	$47.00	$13.31	$0.00	05/19/2017	3	N

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B

Request Information | Request Filters | Request Result | Request Log

Run Title: Emile test
Recipient Number:
Recipient Info:
Sample Type: Details
Confidence Level:
Confidence Interval:
Comment: Successfully completed!

Request ID: 590
Date Type: Payment
From Date: 10/01/2016
To Date: 11/06/2017
Hit Ratio:
Maximum Sample Size: 0

Status: Completed
Request User:
Date/Time: 11/06/2017 03:05:10 PM
Purge Date: 02/06/2018
Population Size: 5
Sample Size: 5

Filter Criteria: Count: 0

Criteria	Operator	Expression		Expression
No Filter Criteria Found.				

Request Results: < Prev 1 Next > Results: 1 thru 5 of 5

ICN	Dtl No	Provider ID	From DOS	To DOS	Amt Billed	Amt Paid	Amt MCO	Payment Date	Random ID	Wrap Payment
	004		10/09/2016	10/09/2016	$109.40	$0.52	$0.00	10/26/2016	1	N
	005		10/09/2016	10/09/2016	$27.35	$2.11	$0.00	10/26/2016	2	N

2.4.4 Random Sample - 4 - Request Log Tab

The Random Sample - 4 - Request Log tab lets users view the status of all random sample requests. A batch process runs the random sample requests and stores the results in a table for the user to view. This page is the main entry point to view all requests.

The user may also access this window directly from the Document List window by using the hyperlink ‘Random Sample Log’.

The user has the ability to click on a request to view the following:

A. Request Information: Click the request ID hyperlink to access the Request Information tab. All fields are viewed only with the exception of the Purge Date.

B. Request Result: Click the Sample Size hyperlink to access the Request Result tab, which displays the claims that meet the criteria.

Request Information | Request Filters | Request Result | Request Log

Filter By User: Display All Users
Filter By Status: Display All Statuses

Request ID	User	ID	Request Date	Status	Run Title	Sample Size	Population	Purge Date	Delete
114			07/01/2005 01:49:59 PM	Completed	Recipient Test Case 5	4	4	10/01/2005	☐
113			07/01/2005 01:42:54 PM	Completed	Recipient Test Case 7	4	4	10/01/2005	☐
112			07/01/2005 01:41:22 PM	Completed	Recipient Test Case 6	11	11	10/01/2005	☐
110			07/01/2005 01:22:32 PM	Completed	Recipient Test Case 3	11	11	10/01/2005	☐
109			07/01/2005 01:21:09 PM	Completed	Recipient Test Case 2	11	11	10/01/2005	☐

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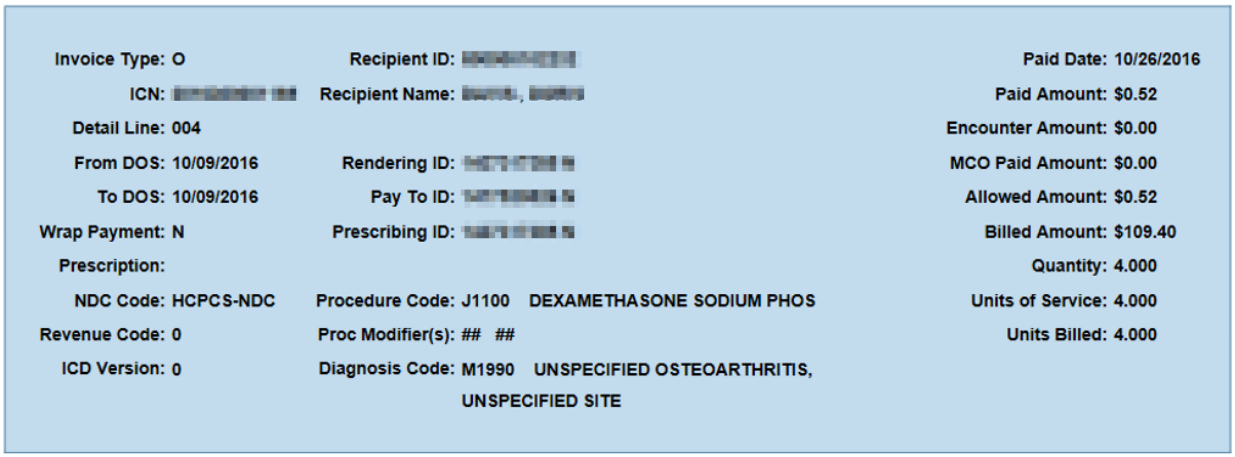
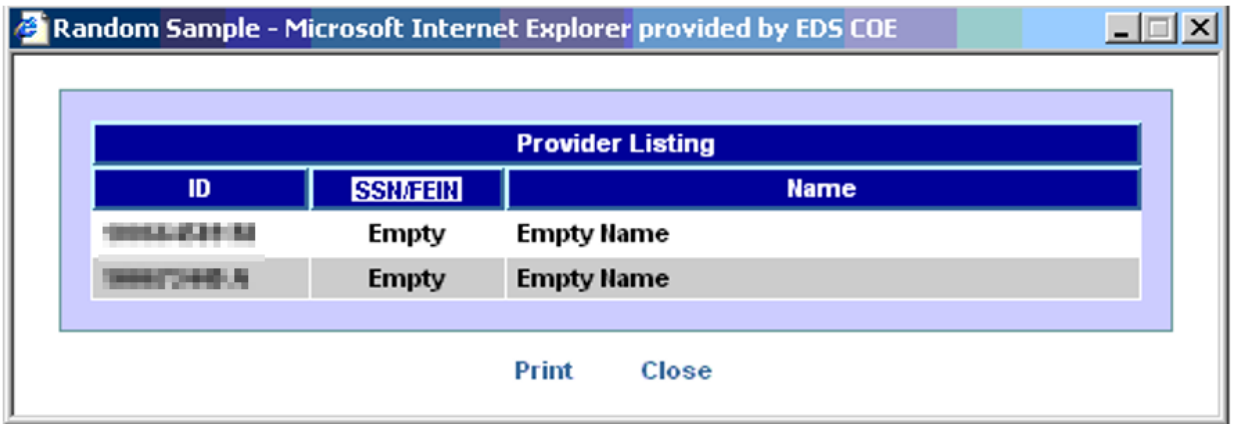
2.4.5 Random Sample - 5 - Claim Detail Window

By clicking the hyperlink ICN on the Random Sample 3 Request Results Tab the Random Sample - 5 - Claim Detail window is displayed to show the details of the selected ICN.



2.4.6 Random Sample - 6 - ID Listing Window

By clicking the hyperlink box next to the column heading for Recipient ID or Provider ID on the Random Sample 3 Request Results Tab the ID Listing window displays a listing of unique providers or recipients for a request. The list includes columns ID, Social Security Number/Federal Employer Identification Number (SSN/FEIN) and Name.



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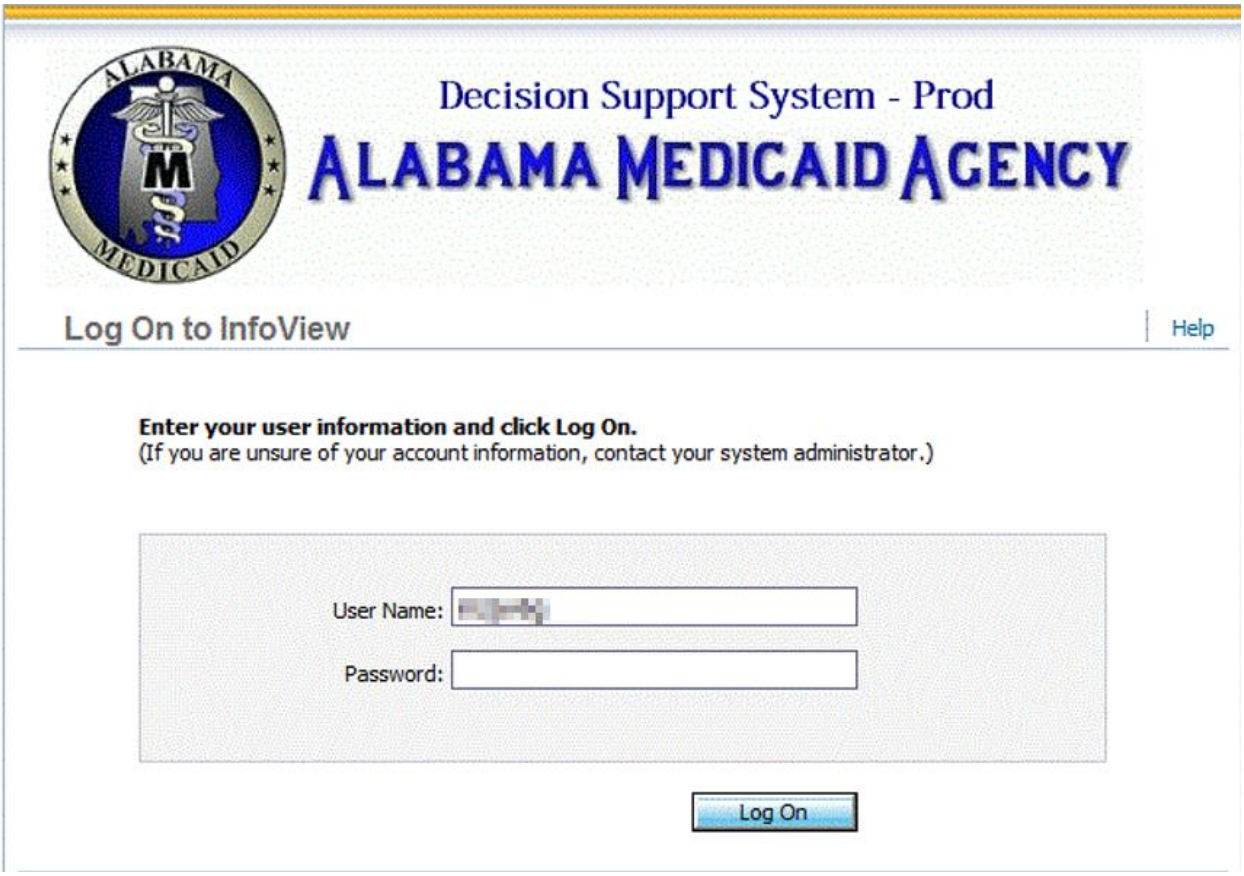
3. Reports

This manual contains a sample page for each report for this system with a short description.

3.1 Accessing the Reports from the InfoView DSSNavigator

Login to the InfoView DSSNavigator using your User Name and Password.



Results: The Welcome window displays.

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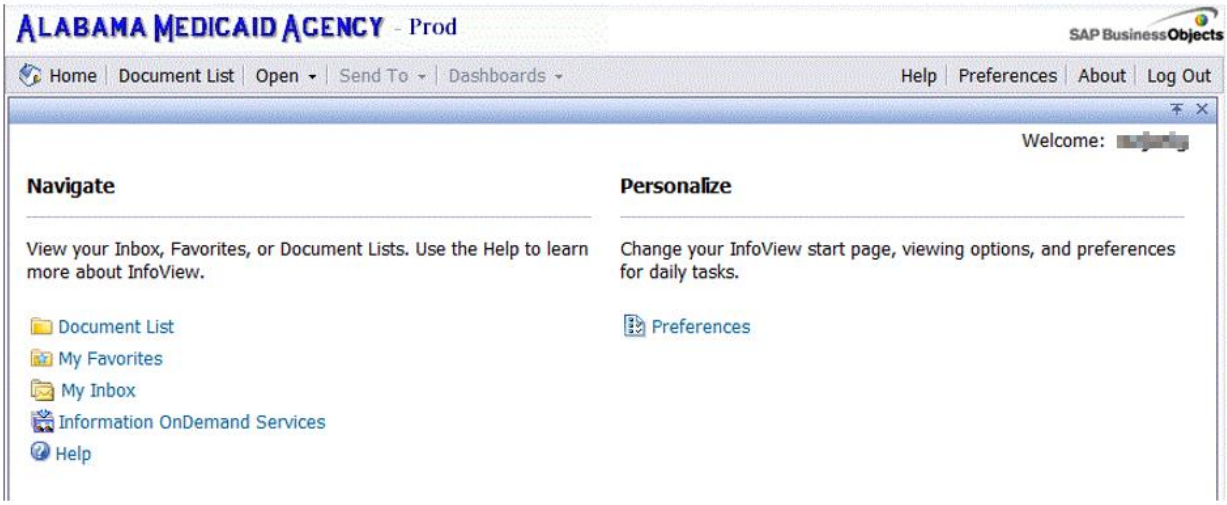

Click on “Document List”, then “Public Folders”, then double-click on “Corporate Documents”.

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3.2 List of Reports Available

3.2.1 DSSProfiler Reports

- Case Group Maintenance
- Case Type Maintenance
- Peer Group Maintenance
- Dental Claim Details by Provider
- Dental Claim Details by Provider Quarterly
- Inpatient Case Type Comparison by Peer Group
- Inpatient Case Type Comparison by Peer Group Quarterly
- Inpatient Claim Details by Provider - FFS
- Inpatient Claim Details by Provider Quarterly - FFS
- Inpatient Disease Global View
- Inpatient Disease Quick View
- Inpatient Distribution Analysis
- Inpatient Exception Quarterly
- Inpatient Frequency Distribution
- Inpatient Frequency Distribution Quarterly
- Inpatient Recipient Case Type Comparison by Peer Group
- Inpatient Recipient Case Type Comparison by Peer Group Quarterly
- Inpatient Provider Profile
- Inpatient Provider Profile Quarterly
- Nursing Facility Case Type Comparison by Peer Group
- Nursing Facility Case Type Comparison by Peer Group Quarterly
- Nursing Facility Claim Details by Provider - FFS
- Nursing Facility Claim Details by Provider Quarterly - FFS
- Nursing Facility Disease Quick View
- Nursing Facility Exception Quarterly
- Nursing Facility Frequency Distribution
- Nursing Facility Frequency Distribution Quarterly
- Nursing Facility Recipient Case Type Comparison by Peer Group
- Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly
- Nursing Facility Provider Profile
- Nursing Facility Provider Profile Quarterly
- Outpatient Case Type Comparison by Peer Group

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- Outpatient Case Type Comparison by Peer Group Quarterly
- Outpatient Claim Details by Provider - FFS
- Outpatient Claim Details by Provider Quarterly - FFS
- Outpatient Disease Quick View
- Outpatient Distribution Analysis
- Outpatient Exception Quarterly
- Outpatient Frequency Distribution
- Outpatient Frequency Distribution Quarterly
- Outpatient Recipient Case Type Comparison by Peer Group
- Outpatient Recipient Case Type Comparison by Peer Group Quarterly
- Outpatient Provider Profile
- Outpatient Provider Profile Quarterly
- Pharmacy Case Type Comparison by Peer Group
- Pharmacy Case Type Comparison by Peer Group Quarterly
- Pharmacy Claim Details by Provider
- Pharmacy Claim Details by Provider Quarterly
- Pharmacy Disease Quick View
- Pharmacy Distribution Analysis
- Pharmacy Exception Quarterly
- Pharmacy Frequency Distribution
- Pharmacy Frequency Distribution Quarterly
- Pharmacy Recipient Case Type Comparison by Peer Group
- Pharmacy Recipient Case Type Comparison by Peer Group Quarterly
- Pharmacy Provider Profile
- Pharmacy Provider Profile Quarterly
- Professional Case Type Comparison by Peer Group
- Professional Case Type Comparison by Peer Group Quarterly
- Professional Claim Details by Provider - FFS
- Professional Claim Details by Provider Quarterly - FFS
- Professional Disease Global View
- Professional Disease Quick View
- Professional Distribution Analysis
- Professional Exception Quarterly
- Professional Frequency Distribution
- Professional Frequency Distribution Quarterly

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- Professional Recipient Case Type Comparison by Peer Group
- Professional Recipient Case Type Comparison by Peer Group Quarterly
- Professional Provider Profile
- Professional Provider Profile Quarterly
- Professional Referrals Case Type Comparison by Peer Group
- Professional Referrals Case Type Comparison by Peer Group Quarterly
- Professional Referral Claim Details by Provider - FFS
- Professional Referral Claim Details by Provider Quarterly - FFS
- Professional Referral Distribution Analysis
- Professional Referral Exception Quarterly
- Professional Referral Frequency Distribution
- Professional Referral Frequency Distribution Quarterly
- Professional Referral Provider Profile
- Professional Referral Provider Profile Quarterly
- Provider Peer Group Comparison
- Provider Peer Group Comparison Quarterly
- Recipient Claim Details - FFS
- Recipient Claim Details Quarterly - FFS
- Recipient Exception Quarterly
- Recipient Frequency Distribution
- Recipient Frequency Distribution Quarterly
- Recipient Peer Group Comparison
- Recipient Peer Group Comparison Quarterly
- Recipient Profile
- Recipient Profile Quarterly

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3.2.2 ETG Reports

- ETG Details - FFS
- ETG Distribution Analysis - FFS
- ETG Episode Cross Reference - FFS
- ETG Recipient Comparison - FFS
- ETG Recipient Details - FFS
- ETG Recipient Summary - FFS
- ETG Provider Comparison - FFS
- ETG Provider Details - FFS
- ETG Provider Summary - FFS
- ETG Summary - FFS

3.2.3 Targeted Query Reports

- TQ - Facility Visits Exception
- TQ - Office Visits Exception
- TQ - Home Hospital Conflict
- TQ - Physician Office Visits
- TQ - Physician Office Visits by Recipient
- TQ – PT OT Daily Overbilling
- TQ – Emergency Room Visits
- TQ – Inpatient – Related Readmissions
- TQ – Antibiotics – 12 Months or Longer
- TQ – Delayed Surgery Summary
- TQ – Drug – Overspending Prescribers
- TQ – Drug – Recipients w-mult Pharmacies-Prescribers

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3.3 Report Layouts and Descriptions

Some information in this section is represented in table format. In order to fit information on the page, some data field information may wrap to the next line.

Within the DSSProfiler reports is a tab labeled as, Notes. This tab contains the report information which can also be found in the narrative for each report within this manual. Example A below shows the layout and narrative of DSSProfiler report, TQ – Antibiotics 12 Months or Longer. Example B below shows the Notes tab found on this report.

Example A:

TQ – Antibiotics 12 Months or Longer

This report is used to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the date of the end of From Date of Service or longer. The report looks for standard therapeutic class codes 21, 22, 24, 25, 26, and 27.

Alabama Medicaid Agency

Antibiotics 12 Months or Longer

From Date of Service: 03/31/2005

User ID:
Run Date: 09/20/2006
Run Time: 5:31:57 PM

Recipient ID	Recipient Name	USER_ID	Recipient Age	Recipient Gender	ICN	Adjusted ICN	Previous ICN	Prescriber

No Data This Report Run

Example B:

This report is to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the From Date of service entered.

Report criteria:
Claim Type = P or Q and
Claim Status = P or V and
Latest Claims Only and
All Prescribing Provider Types and
User specified From Day of Service range and
Standard Therapeutic Class Code = 21, 22, 24, 25, 26, 27 and
Fee for Service Claim only

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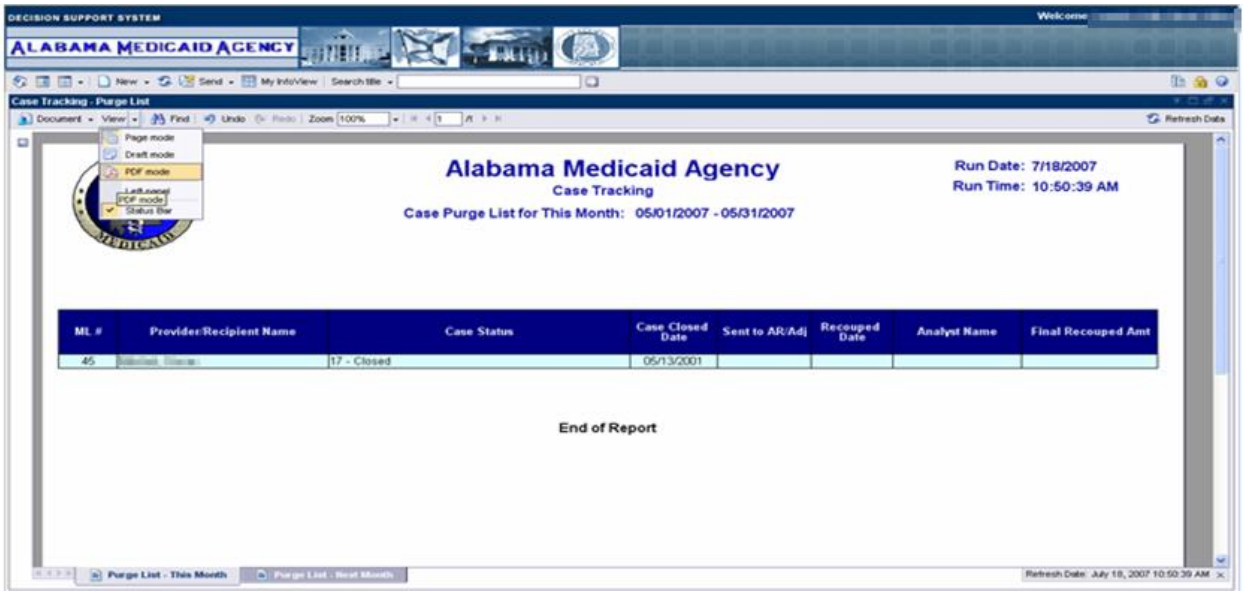
3.4 Printing Reports

All reports may be printed from InfoViewDSSNavigator window by using PDF function. The report will print to the local printer.

Step 1: Select **View** from the drop down menu bar.

Step 2: Select **PDF mode**.



Step 3: Click the printer icon on the PDF menu bar. Results: Report is displayed in PDF format.

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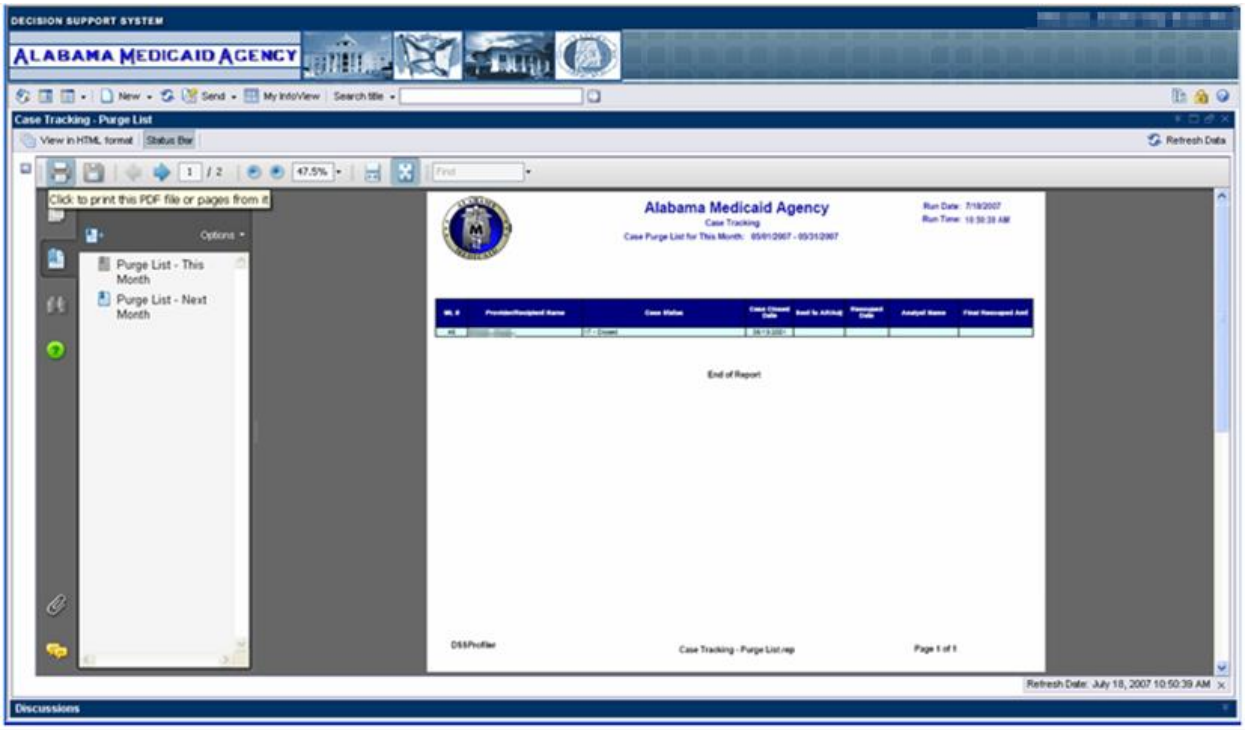

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3.5 Case Group Maintenance

This report lists all case groups that are used to run the profiler quarterly cycle. Information related to exception values, equations and measures for each case group is displayed.

```
REPORT:   SUR-8012-Q                                  Alabama Medicaid Agency                                  RUN DATE: 06/05/2006
PROCESS:  SURJQ80I                                                                                             RUN TIME: 13:45:15
LOCATION: profilecg                                 CASE GROUP MAINTENANCE REPORT                                  PAGE:     4


REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
         CASE GROUP:   Mark Test Group
      EXCEPTION VALUES:  Default                                                LOW VAL:          1    HIGH VAL:          5
                         328 OBSTETRICIAN/GYNECOLOGIST                          LOW VAL:          1    HIGH VAL:          4
     CRITERIA EQUATION:

                           Cholecystectomies.Paid Amount
                         + Coronary Artery Bypasses.Paid Amount

REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
         CASE GROUP:  Excessive Physician Office Initial Visits High Complexity
      EXCEPTION VALUES:  Default                                                LOW VAL:          5    HIGH VAL:          0
     CRITERIA EQUATION:

                           Evaluation and Management Office Visits Initial High Complexity.Units/Quantity
                         / Evaluation and Management Office Visits Initial High Complexity.Units/Quantity
                         + Evaluation and Management Office Visits Initial Low Complexity.Units/Quantity

REPORT CATEGORY:  Professional                  ***********************************************      FREQUENCY:  Quarterly

  *****CASE CATEGORY:  Not Assigned
         CASE GROUP:  Excessively High Average Days of Preoperative Stay per Incident of Surgery
      EXCEPTION VALUES:  Default                                                LOW VAL:          5    HIGH VAL:          0
     CRITERIA EQUATION:

                           Evaluation and Management Hospital Visits Initial.Units/Quantity
                         + Evaluation and Management Hospital Visits Subsequent.Units/Quantity
                         / Evaluation and Management Hospital Visits Initial.Recipient Count
```

3.5.1 Case Group Maintenance Field Descriptions

Field	Description	Length	Data Type
Case Category	The category that the Case Group is assigned to.	50	Character
Case Group	Name of the Case Group.	75	Character
Criteria Equation	The equation used to determine exceptions.	1000	Character
Frequency	Frequency of the report category - annually or quarterly.	10	Character
High Val	Highest allowed value for exception.	10	Number (Integer)
Low Val	Lowest allowed value for exception.	10	Number (Integer)
Peer Group Text	Name of Peer Group with established exception limits.	20	Character
Report Category	Report Category Description. Valid values are: Professional, Inpatient, Outpatient, Nursing Home, and Pharmacy.	30	Character
Exception Values	Documents the high and low values for specific groups. The default applies to all peer groups who do not have a specific limit identified.	50	Character

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3.5.2 Case Type Maintenance

This report lists all case types, along with the case criteria, that are used to run the profiler quarterly cycle.

```
^LREPORT:   SUR-8010-Q                                  Alabama Medicaid Agency                          RUN DATE: 08/13/2007
PROCESS:  SURJQ801                                                                                     RUN TIME: 16:23:18
LOCATION: profilect                                  CASE TYPE CRITERIA REPORT                            PAGE:    46


REPORT CATEGORY:  Inpatient                                     FREQUENCY:  Annually              STATUS:  Active
  CASE CATEGORY:  Not Assigned

      CASE TYPE:  Physical Therapy Procedures
       CRITERIA:
           Detail Number = 0
           AND ( Procedure Code - ICD9  4 bytes BETWEEN 9311 AND 9319
           OR Procedure Code - ICD9  4 bytes BETWEEN 9331 AND 9339 )

                                     ********** E N D   O F   C A S E   T Y P E **********

REPORT CATEGORY:  Inpatient                                     FREQUENCY:  Annually              STATUS:  Inactive
  CASE CATEGORY:  Not Assigned
            *********   INACTIVE   *****   INCACTIVE   *****   INACTIVE   *****   INACTIVE   *****   INACTIVE   *****   INACTIVE  ****
      CASE TYPE:  ACS-Angina
       CRITERIA:
           Detail Number = 0
           ( ( NOT Procedure Code - ICD9  4 bytes BETWEEN 3601 AND 3602
           NOT Procedure Code - ICD9  4 bytes = 3605
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3610 AND 3619
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3750 AND 3759
           NOT Procedure Code - ICD9  4 bytes BETWEEN 3770 AND 3779 )
           AND ( Primary Diagnosis BETWEEN 4111 AND 41119
           OR Primary Diagnosis BETWEEN 4118 AND 41189
           OR Primary Diagnosis BETWEEN 413 AND 41399 ) )
```

3.5.2.1 Case Type Maintenance Field Descriptions

Field	Description	Length	Data Type
Case Category	Case Category Description.	50	Character
Case Type	Case Type Description.	100	Character
Criteria	Criteria used to build the Case Type.	4000	Character
Frequency	Describes if the case type belongs to annual or quarterly reports.	10	Character
Report Category	Report Category Description.	30	Character
Status	This field shows whether the case type is active or inactive.	10	Character

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3.5.3 Peer Group Maintenance

This report lists all provider and recipient peer groups, along with the criteria, that are used to run the profiler quarterly cycle.

```
REPORT:   SUR-8010-Q                                  Alabama Medicaid Agency                          RUN DATE: 06/05/2006
PROCESS:  SURJQ801                                                                                     RUN TIME: 13:44:44
LOCATION: profilepg                              PEER GROUP MAINTENANCE REPORT                            PAGE:     1

***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  010 ACUTE CARE
            CRITERIA:
                       Provider Specialty = 010
                       AND Provider Specialty = 016
                       AND Emergency Code = 0

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  011 PSYCHIATRIC
            CRITERIA:
                       Provider Specialty = 011
                       AND Provider Specialty = 011
                       AND Provider Specialty = 015

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  012 REHABILITATION
            CRITERIA:
                       Provider Specialty = 012
                       AND Provider Specialty = 040
                       AND Provider Specialty = 110

                                   ********** E N D   O F   P E E R   G R O U P **********
***PEER CATEGORY:  Provider                                                   FREQUENCY:  Annually       STATUS:  Active
      ****PEER GROUP:  013 RESIDENTIAL TREATMENT CENTER
            CRITERIA:
                       Provider Specialty = 013
                       AND Provider Specialty = 011
                       AND Provider Specialty = 016
```

3.5.3.1 Peer Group Maintenance Field Descriptions

Field	Description	Length	Data Type
Criteria	Items that define the peer group criteria.	1000	Character
Frequency	Frequency of the peer group.	10	Character
Peer Category	Peer group - Provider or Recipient.	10	Character
Peer Group	Name of Peer Group.	40	Character
Status	Shows status of peer group - active or inactive.	10	Character

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3.5.4 DSSProfiler - Dental Claim Details by Provider

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all inpatient annual case types for a given provider and service location. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Dental Claim Details By Provider

Dental Claim Details

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 12:53:39 PM

ICN	CT	POS	Dtl #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	Proc	Proc Desc	Tooth #	SF 1	SF 2	SF 3	SF 4	SF 5	Billed Qty	Billed Amt	Alwd Amt	Paid Amt
[redacted]	D	11	1	[redacted]	[redacted]	11/12/2000	11	10/04/2012	10/04/2012	#	#######		D2393	Post 3 Srfc Resinbased Cmpst	30	M	O	B	#	#	1	$198.00	$88.00	$0.00
[redacted]	D	11	2	[redacted]	[redacted]	11/12/2000	11	10/04/2012	10/04/2012	#	#######		D9430	Office Visit During Hours	30	#	#	#	#	#	1	$0.00	$140.78	$65.78

End of Report

PHI has been covered

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B

Alabama Medicaid Agency

Dental Claim Details By Provider

Recipient Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 12:53:39 PM

Recipient ID	Recipient Full Name
5	M

C

Alabama Medicaid Agency

Dental Claim Details By Provider

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 12:53:39 PM

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
#	####### -	#	####### -	#	####### -	1	1

D

Alabama Medicaid Agency

Dental Claim Details By Provider

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 12:53:39 PM

Procedure Code & Description	ICN Count	Recipient Count
D2393 - Post 3 Srfc Resinbased Cmpst	1	1
D9430 - Office Visit During Hours	1	1

3.5.4.1 DSSProfiler - Dental Claim Details by Provider Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this	13	Number (Decimal)

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Field	Description	Length	Data Type
	particular grouping of claims for this specific recipient.		
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A)Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) SF 1	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 2	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 3	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character

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Field	Description	Length	Data Type
(A) SF 4	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 5	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 6	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A) Tooth #	A code to indicate the tooth on which the service was performed.	2	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character

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Field	Description	Length	Data Type
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.5 DSSProfiler - Dental Claim Details by Provider Quarterly

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all inpatient quarterly case types for a given provider and service location. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Dental Claim Details By Provider Qtrly
Dental Claim Details
For Dates of Service: 10/01/2012 - 09/30/2013
Provider Base, Medicaid or NPI ID: 20124
FAMILY ORIENTED PRIMARY HLTH
For Claim Types: D
Quarter: 20124

User ID:
Run Date: 11/1/2013
Run Time: 1:58:36 PM

ICN	CT	POS	DH #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	Proc	Proc Desc	Tooth #	SF 1	SF 2	SF 3	SF 4	SF 5	Billed Qty	Billed Amt	Alwd Amt	Paid Amt
	D	11	1			11/12/2000	11	10/04/2012	10/04/2012	#	#######		D2393	Post 3 Srfc Resinhased Cmpst	30	M	O	B	#	#	1	$198.00	$88.00	$0.00
	D	11	2			11/12/2000	11	10/04/2012	10/04/2012	#	#######		D9430	Office Visit During Hours	30	#	#	#	#	#	1	$0.00	$140.78	$65.78

End of Report

PHI has been covered

B

Alabama Medicaid Agency

Dental Claim Details By Provider Qtrly
Recipient Listing
For Dates of Service: 10/01/2012 - 09/30/2013
Provider Base, Medicaid or NPI ID: 20124
FAMILY ORIENTED PRIMARY HLTH
For Claim Types: D
Quarter: 20124

User ID:
Run Date: 11/1/2013
Run Time: 1:58:36 PM

Recipient ID	Recipient Full Name

End of Report

PHI has been covered

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C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 1:58:36 PM

Dental Claim Details By Provider Qtrly

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: 20124

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

Quarter: 20124

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
#	####### -	#	####### -	#	####### -	1	1

D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2013
Run Time: 1:58:36 PM

Dental Claim Details By Provider Qtrly

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: 20124

FAMILY ORIENTED PRIMARY HLTH

For Claim Types: D

Quarter: 20124

Procedure Code & Description	ICN Count	Recipient Count
D2393 - Post 3 Srfc Resinbased Cmpst	1	1
D9430 - Office Visit During Hours	1	1

End of Report

3.5.5.1 DSSProfiler – Dental Claim Details by Provider Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A)Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) SF 1	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 2	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 3	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 4	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 5	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character
(A) SF 6	A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.	1	Character

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Field	Description	Length	Data Type
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A) Tooth #	A code to indicate the tooth on which the service was performed.	2	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(A-D) Quarter (prompt)	The quarter for the claims that are displayed on the report.	4	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)

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Field	Description	Length	Data Type
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.6 DSSProfiler - Inpatient Case Type Comparison by Peer Group

The Inpatient Case Type Comparison by Peer Group report is created in DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar 'norms' on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the 'norm' for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which are the providers of asthma services who fall outside of the accepted 'norm' within the peer group.

The three tabs in this report are:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Provider Comparison
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1		NW GENERAL	$467,755.00	$234,006.54	$220,740.55	$150,904.40	$69,836.15	*
2	5	6		NW GENERAL	$3,459.38	$11,172.43	$11,172.43	$6,073.53	$5,098.90	
3	6	8		SEAMORE X-RAY CLINIC	$584.69	$2,436.84	$2,436.84	$2,436.84	$0.00	
4	9	9		NEW HORIZON REHAB CLINIC	$4,000.00	$300.00	$300.00	$1,245.37	$(945.37)	
5	8	7		SEAMORE X-RAY CLINIC	$26,745.00	$739.00	$490.00	$4,323.34	$(3,833.34)	
6	7	5		WATTSSS RE-TE ENROLL PROVIDER WITH-OUT LETTER	$6,225.00	$1,400.00	$1,400.00	$20,607.23	$(19,207.23)	
7	2	4		SEAMORE X-RAY CLINIC	$101,700.00	$72,153.69	$15,473.43	$35,718.49	$(20,245.06)	
8	3	3		MEMORIAL VALLEY MEDICAL	$12,235.00	$15,957.00	$13,271.50	$37,902.60	$(24,631.10)	
9	4	2		BAILY MEDICAL SUPPLIES	$32,285.00	$14,886.56	$12,086.56	$43,090.20	$(31,003.64)	
								2 STD DEV	$56,554.05	

End of Report

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

[redacted] - SEAMORE X-RAY CLINIC

Age Group	Gender	Recipient Count	Paid Amount Per Recipient
Age 06 - 17	M	1	$418.00
Age 65+	M	1	$72.00
		AVG:	$245.00

[redacted] - NW GENERAL

Age Group	Gender	Recipient Count	Paid Amount Per Recipient
Age 00 - 05	F	3	$3,750.75
Age 06 - 17	F	6	$2,289.80
Age 06 - 17	M	3	$2,796.17
Age 18 - 20	F	2	$12,953.16
Age 21 - 34	F	3	$33,647.12
Age 21 - 34	M	1	$2,207.55
Age 35 - 64	M	2	$23,243.70
Age 65+	F	3	$1,657.23
Age 65+	M	3	$2,282.22

C

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:55 PM

Inpatient Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	NW GENERAL	$3,750.75
[redacted]	SEAMORE X-RAY CLINIC	$4,052.57
	AVG:	$3,871.48

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	SEAMORE X-RAY CLINIC	$2,436.84
	AVG:	$2,436.84

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3.5.6.1 DSSProfiler - Inpatient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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Field	Description	Length	Data Type
(A,B,C) Provider Name	Provider's full name.	50	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(A,B,C) Provider ID	Provider identification number.	15	Character

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3.5.7 DSSProfiler - Inpatient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a quarterly inpatient peer group to determine which providers fall outside of service dollar 'norms' for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the 'norm' for the peer group are highlighted.

The three tabs in this report are:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

Inpatient Case Type Comparison by Peer Group Qtrly
Provider Comparison
For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1	[redacted]	RIDGEVIEW HEALTH CARE C	$5,154.00	$2,619.24	$2,619.24	$2,619.24	$0.00	
								2 STD DEV		

End of Report

B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

Inpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient by Age/Gender
For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

[redacted] - RIDGEVIEW HEALTH CARE C

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 00 - 05	F	1	$2,619.24
		Avg:	$2,619.24

End of Report

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C

Alabama Medicaid Agency

Inpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers
by Selected Age/Gender

User ID: [redacted]
Run Date: 8/29/2007
Run Time: 3:19:29 PM

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 127 - CMS Sunday - Thursday Admissions
Provider Peer Group: 115 - 035 SKILLED NURSING FACILITY
Aggregation Code: 2 - Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	RIDGEVIEW HEALTH CARE C	$2,619.24
	Avg:	$2,619.24

End of Report

3.5.7.1 DSSProfiler - Inpatient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Decimal)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Decimal)

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Field	Description	Length	Data Type
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Decimal)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date(CCYYQ)
(A,B,C) Provider ID	Provider identification number.	15	Character
(A,B,C) Provider Name	Provider's full name.	50	Character
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.8 DSSProfiler - Inpatient Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all inpatient annual case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Inpatient Claim Details By Provider - FFS

Inpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

ICN	CT	PCS	DB #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD 1	MD1 Desc	MD 2	MD2 Desc	MD 3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt	DRG Code & Desc	DRG Relative Weight	DRG Service Adjuster
[redacted]	I	21	1	[redacted]	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	MM/DD/YYY	0	4/1/2016	4/3/2016	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W/ HYPEROSMOSIS W/ COMA	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W/ HYPEROSMOSIS W/ COMA	[redacted]	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	2	$2,000.00	$32,481.49	$32,481.49	5202 - DIABETES	2.6	1
[redacted]	I	21	1	[redacted]	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	MM/DD/YYY	46	4/1/2016	4/1/2016	0	Z3490	ENCNTR FOR SUPVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	0	Z3490	ENCNTR FOR SUPVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	[redacted]	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	1	$832.00	$27,734.20	$27,734.20	3611 - SIGNS, SYMPTOMS AND OTH FACTORS	2.22	1
[redacted]	I	21	2	[redacted]	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	MM/DD/YYY	0	4/1/2016	4/3/2016	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W/ HYPEROSMOSIS W/ COMA	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W/ HYPEROSMOSIS W/ COMA	[redacted]	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	#	Unknown or Not Applicable	9	$999.00	$0.00	$32,481.49	5202 - DIABETES	2.6	1

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

Inpatient Claim Details By Provider - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	576

End of Report

PHI has been removed

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

Inpatient Claim Details By Provider - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
0	A419 - SEPSIS, UNSPECIFIED ORGANISM	0	L89153 - PRESSURE ULCER OF SACRAL REGION, STAGE 3	0	L89154 - PRESSURE ULCER OF SACRAL REGION, STAGE 4	1	1
0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	A259 - RAT-BITE FEVER, UNSPECIFIED	3	1
0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS	5	2
0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	0	J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS	2	1

End of Report

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D

Alabama Medicaid Agency

Inpatient Claim Details By Provider - FFS
Procedure Listing
For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: I

User ID: [redacted]
Run Date: 7/8/16
Run Time: 8:23:42 AM

Procedure Code & Description	ICN Count	Recipient Count
###### - Unknown or Not Applicable	576	526

End of Report

3.5.8.1 DSSProfiler - Inpatient Claim Details by Provider - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
(A) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A)Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A,B)Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B)Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character

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Field	Description	Length	Data Type
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.9 DSSProfiler - Inpatient Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all inpatient quarterly case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The four tabs in this report are:

A. Inpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Inpatient Claim Details By Provider Qtrly - FFS

Inpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

Quarter: 20162

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

ICN	CT	POS	Dtl #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt	DRG Code & Desc	DRG Relative Weight	DRG Service Adjuster
[redacted]	I	21	1	12345678912	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	MM/DD/YYYY	0	4/1/2016	4/3/2016	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W HYPOADDOSIS W COMA	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W HYPOADDOSIS W COMA	[redacted]	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	2	$2,000.00	$32,461.49	$32,461.49	202 - DIABETES	2.6	1
[redacted]	I	21	1	12345678912	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	MM/DD/YYYY	46	4/1/2016	4/1/2016	0	Z3490	ENCNTR FOR SUPRVISN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	0	Z3490	ENCNTR FOR SUPRVISN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	[redacted]	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	1	$832.00	$27,734.20	$27,734.20	811 - SIGNS, SYMPTOMS AND OTH FACTORS	2.22	1
[redacted]	I	21	2	12345678912	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	MM/DD/YYYY	0	4/1/2016	4/3/2016	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W HYPOADDOSIS W COMA	0	E0811	DIABETES DUE TO UNDERLYING CONDITION W HYPOADDOSIS W COMA	[redacted]	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	# #	Unknown or Not Applicable	9	$999.00	$0.00	$32,461.49	202 - DIABETES	2.6	1

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

Inpatient Claim Details By Provider Qtrly - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: I
Quarter: 20162

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	9

End of Report

PHI has been removed

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

Inpatient Claim Details By Provider Qtrly - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: I
Quarter: 20162

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	E0811 - DIABETES DUE TO UNDERLYING CONDITION W KETOACIDOSIS W COMA	0	J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS	4	2
0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	0	J708 - RESPIRATORY CONDITIONS DUE TO OTH EXTERNAL AGENTS	2	1
0	O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI	0	O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI	0	O4702 - FALSE LABOR BEFORE 37 COMPLETED WEEKS OF GEST, SECOND TRI	1	1
0	Z3490 - ENCNTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	0	Z3490 - ENCNTR FOR SUPRVSN OF NORMAL PREGNANCY, UNSP, UNSP TRIMESTER	0	O368130 - DECREASED FETAL MOVEMENTS, THIRD TRIMESTER, UNSP	2	1

End of Report

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D

Alabama Medicaid Agency

Inpatient Claim Details By Provider Qtrly - FFS

Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: I

Quarter: 20162

User ID: [redacted]
Run Date: 7/8/16
Run Time: 9:32:28 AM

Procedure Code & Description	ICN Count	Recipient Count
###### - Unknown or Not Applicable	9	5

End of Report

3.5.9.1 DSSProfiler - Inpatient Claim Details by Provider Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
(A) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A)Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character

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Field	Description	Length	Data Type
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A,B)Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B)Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) Quarter (prompt)	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)

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Field	Description	Length	Data Type
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.10 DSSProfiler - Inpatient Disease Global View

This report is created in DSSProfiler.

The Inpatient Case Type Global View report allows you to see all other services that recipients received from a selected inpatient case type. For example, you can look at all hypertension recipients who were in an inpatient facility and view all other associated services that they had.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-G in the layout below. The field names have the corresponding letter in front, identifying the tab it can be found on. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The seven tabs in this report are:

A. General Health Demographics;

B. Other Professional Services;

C. Other Inpatient Services;

D. Other Outpatient Services;

E. Other Pharmacy Services;

F. Other Nursing Facility Services; and

G. Recipients.

A

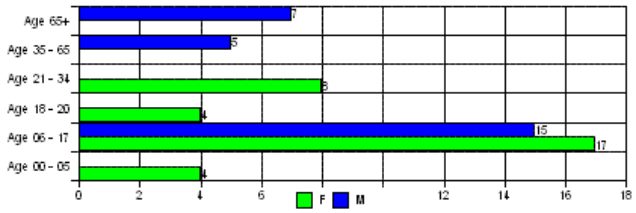
Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
General Health Demographics

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age/Gender Mix



Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$555,409.69	$307,440.20	$237,093.95	30	100.00 %

End of Report

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Professional Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$15,882.69	$6,437.99	$6,021.85	10	33.33 %
300 - FQHC Encounter Procedures	$4,724.00	$1,235.96	$1,347.71	8	26.67 %
381 - Evaluation & Management All Procedures	$2,815.00	$275.98	$346.23	7	23.33 %
245 - Injury/Poisoning Diagnosis	$1,121.00	$174.33	$150.44	5	16.67 %
237 - Infectious/Parasitic Diagnosis	$540.00	$178.16	$161.66	3	10.00 %
243 - STD, Sexual Transmitted Disease Diagnosis	$540.00	$178.16	$161.66	3	10.00 %
210 - Cholelithiasis Diagnosis	$1,420.00	$747.04	$747.04	2	6.67 %
223 - Endocrine Disease Diagnosis	$1,030.00	$161.10	$151.10	2	6.67 %
278 - Respiratory System Diagnosis	$1,420.00	$747.04	$747.04	2	6.67 %
298 - Drugs Excluding Pharmacy Procedures	$140.00	$140.00	$49.00	2	6.67 %
352 - Pathology All Procedures	$98.00	$10.00	$0.00	2	6.67 %

C

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Inpatient Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$555,409.69	$307,440.20	$237,093.95	30	100.00 %
454 - Admissions Excluding MH/SA/OB	$534,209.69	$294,036.25	$223,690.00	28	93.33 %
626 - Discharged Home codes(01 - 01)	$248,709.69	$89,223.18	$77,708.19	24	80.00 %
631 - Readmissions codes(01 - 04)	$248,709.69	$89,223.18	$77,708.19	24	80.00 %
510 - Injury/Poisoning Diagnosis	$398,290.00	$252,454.35	$182,383.10	20	66.67 %
489 - Endocrine Disease Diagnosis	$83,600.00	$17,092.15	$16,817.15	4	13.33 %
491 - Diabetes Mellitus Diagnosis	$83,600.00	$17,092.15	$16,817.15	4	13.33 %
502 - Infectious/Parasitic Diagnosis	$27,490.00	$11,819.40	$11,819.40	4	13.33 %
419 - ACS-All Ambulatory Care Sensor Conditions	$5,645.00	$3,133.00	$3,133.00	3	10.00 %
437 - ACS-Chronic	$5,645.00	$3,133.00	$3,133.00	3	10.00 %
456 - V Codes Diagnosis	$43,445.00	$16,378.80	$16,378.80	3	10.00 %
447 - ACS-Diabetes without Complication	$4,400.00	$2,407.50	$2,407.50	2	6.67 %
536 - Obstetric Diagnosis	$21,200.00	$13,403.95	$13,403.95	2	6.67 %
440 - ACS-Other Tuberculosis	$1,245.00	$725.50	$725.50	1	3.33 %
509 - Tuberculosis Diagnosis	$1,245.00	$725.50	$725.50	1	3.33 %
522 - Neoplasm Diagnosis	$584.69	$2,436.84	$2,436.84	1	3.33 %
537 - Perinatal Diagnosis	$3,000.00	$3,863.76	$3,863.76	1	3.33 %
572 - Musculoskeletal Procedures	$27,000.00	$20,275.42	$20,275.42	1	3.33 %

End of Report

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D

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Outpatient Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$21,345.60	$2,376.87	$1,655.69	8	26.67 %
687 - Endocrine Disease Diagnosis	$4,200.60	$1,336.57	$762.47	5	16.67 %
689 - Diabetes Mellitus Diagnosis	$4,200.60	$1,336.57	$762.47	5	16.67 %
656 - Circulatory System Disease Diagnosis	$10,600.00	$927.19	$780.11	4	13.33 %
661 - Heart Disease Diagnosis	$9,600.00	$827.19	$680.11	3	10.00 %
848 - Provider Type - Home Health Agency	$3,400.00	$1,225.00	$651.40	3	10.00 %
701 - Infectious/Parasitic Diagnosis	$8,000.00	$50.00	$50.00	1	3.33 %
709 - Injury/Poisoning Diagnosis	$45.00	$13.11	$13.11	1	3.33 %
736 - Obstetric Diagnosis	$500.00	$50.00	$50.00	1	3.33 %

End of Report

E

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Pharmacy Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$0.00	$0.00	$0.00	5	16.67 %

End of Report

F

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Inpatient Disease Global View
Other Nursing Facility Services
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$22,609.40	$15,747.08	$15,622.08	4	13.33 %

End of Report

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G

Alabama Medicaid Agency

Inpatient Disease Global View
Recipients

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:28 PM

Age 00 - 05

Recipient Id	Recipient Full Name
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Age 06 - 17

Recipient Id	Recipient Full Name
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

3.5.10.1 DSSProfiler - Inpatient Disease Global View Field Descriptions

Field	Description	Length	Data Type
(A) Age/Gender Mix	Bar graph that shows the actual number of recipients in each morbidity group.	0	Character
(A,G) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+.	24	Character
(A-F) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Character
(A-F) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-F) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A-F) Paid Amount	This is the total amount paid by the program for the specific claim grouping.	13	Number (Decimal)
(A-F) Percent of Recipients	Percentage of recipients in the pre-defined diagnosis group that also fall under these specific claim groupings.	8	Character

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Field	Description	Length	Data Type
(A-F) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-G) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-G) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A-G) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(G) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(G) Recipient ID	Recipient Medicaid Number.	12	Character

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3.5.11 DSSProfiler - Inpatient Disease Quick View

This report is created in the DSSProfiler and displays recipient utilization services for selected case types with totals broken out by the number of services received. The last row gives the totals for each column.

The two tabs in this report are:

A. Inpatient Disease; and

B. Inpatient Disease By Peer Group.

A

Alabama Medicaid Agency

Inpatient Disease Quick View

Inpatient Disease

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:13 PM

Each Recipient Had XX Claims	Unduplicated Recipients	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Total Paid Amount
1	19	19	19	$119,664.69	$59,060.04	$50,954.91
2	6	12	12	$90,645.00	$55,441.36	$44,100.37
4	2	8	8	$58,980.00	$37,955.65	$35,804.65
6	1	6	6	$88,000.00	$11,082.75	$11,082.75
8	1	8	8	$88,200.00	$94,280.58	$89,122.77
20	1	20	20	$109,920.00	$49,619.82	$6,028.50
Totals:			73	$555,409.69	$307,440.20	$237,093.95

End of Report

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B

Alabama Medicaid Agency

Inpatient Disease Quick View

Inpatient Disease By Peer Group

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 516 - Public Assistance, Blind

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	6	6	6	$88,000.00	$11,082.75	$11,082.75
Totals:			6	$88,000.00	$11,082.75	$11,082.75

Peer Group: 519 - Public Assistance, Disabled

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	1	1	1	$1,245.00	$725.50	$725.50
1	2	2	2	$2,200.00	$10,009.05	$10,009.05
1	4	4	4	$54,000.00	$37,555.65	$35,404.65
Totals:			7	$57,445.00	$48,290.20	$46,139.20

3.5.11.1 DSSProfiler - Inpatient Disease Quick View Field Descriptions

Field	Description	Length	Data Type
(A) Total Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Case Type	A user defined group based on the case type created in Case Maintenance. The claim grouping should be specific to the area of service.	100	Character
(A-B) Each Recipient Had XX Claims	This field shows how many claims each of the recipients had.	4	Character
(A-B) For Dates of Service	The dates for which the report is being run.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A-B) Total Claims	This is the total number of claims billed based on the number of recipients and the number of claims each recipient had.	9	Character
(A-B) Total Quantity Billed	This is the total units billed for this particular claim category.	9	Character
(A-B) Unduplicated Recipients	This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once.	9	Character
(B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(B) Peer Group	Peer Group Code and Description.	107	Character

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3.5.12 DSSProfiler - Inpatient Distribution Analysis

This report shows totals for all inpatient case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norms compared to their peers.

The five tabs of this report are:

A. Inpatient Distribution Summary;

B. TOP 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.

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A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

Inpatient Distribution Analysis
Inpatient Distribution Summary

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Paid Amount per Recip	Claims per Recip	Exception Count
1 - All Claim Groupings	59	59	30	$585,169.07	$303,592.86	$231,285.11	$19,505.64	$7,709.50	1.97	2
419 - ACS-All Ambulatory Care Sensor Conditions	4	4	3	$5,500.00	$3,208.00	$3,208.00	$1,833.33	$1,069.33	1.33	3
437 - ACS-Chronic	4	4	3	$5,500.00	$3,208.00	$3,208.00	$1,833.33	$1,069.33	1.33	3
447 - ACS-Diabetes without Complication	4	4	3	$5,500.00	$3,208.00	$3,208.00	$1,833.33	$1,069.33	1.33	3
454 - Admissions Excluding MH/SA/OB	58	58	29	$566,169.07	$300,197.96	$227,890.21	$19,523.07	$7,858.28	2.00	2
456 - V Codes Diagnosis	3	3	2	$41,245.00	$6,369.75	$6,369.75	$20,622.50	$3,184.88	1.50	6
489 - Endocrine Disease Diagnosis	9	9	5	$64,900.00	$12,268.15	$9,857.65	$12,980.00	$1,971.53	1.80	3
491 - Diabetes Mellitus Diagnosis	9	9	5	$64,900.00	$12,268.15	$9,857.65	$12,980.00	$1,971.53	1.80	3
502 - Infectious/Parasitic Diagnosis	6	6	5	$75,000.00	$28,815.15	$28,815.15	$15,000.00	$5,763.03	1.20	6
510 - Injury/Poisoning Diagnosis	38	38	18	$381,439.38	$246,444.31	$176,547.06	$21,191.08	$9,808.17	2.11	0

B

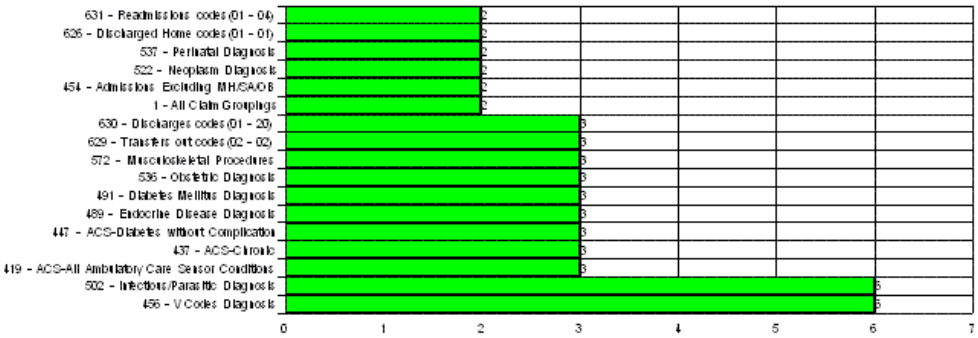
Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

Inpatient Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 Exceptions



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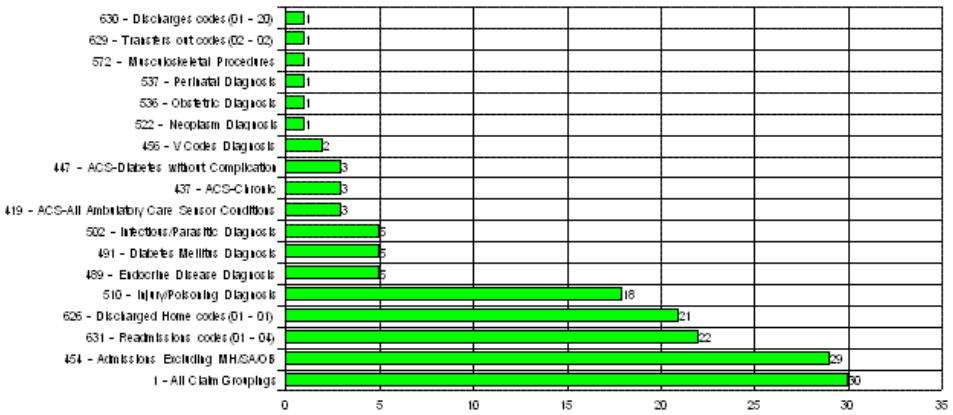
Alabama Medicaid Agency

Inpatient Distribution Analysis
Top 20

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Number of Recipients



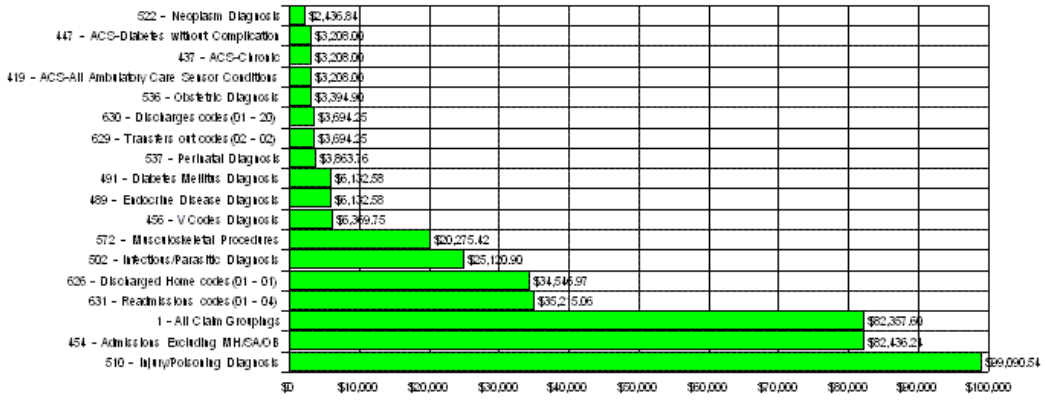
Alabama Medicaid Agency

Inpatient Distribution Analysis
Top 20

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Paid Amount per Recipient



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C

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:49:13 PM

Inpatient Distribution Analysis
By Age

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 00 - 05	6	6	6	$42,984.69	$29,899.36	$21,794.23	$7,164.12	$4,983.23	$3,632.37	1.00
Age 06 - 17	18	18	9	$179,825.00	$81,687.12	$27,203.81	$19,980.56	$9,076.35	$3,022.65	2.00
Age 18 - 20	5	5	3	$69,300.00	$33,274.62	$33,274.62	$23,100.00	$11,091.54	$11,091.54	1.67
Age 21 - 34	10	10	3	$107,200.00	$97,971.83	$92,814.02	$35,733.33	$32,657.28	$30,938.01	3.33
Age 35 - 64	12	12	4	$144,500.00	$51,849.40	$47,287.90	$36,125.00	$12,962.35	$11,821.98	3.00
Age 65+	8	8	5	$41,359.38	$8,910.53	$8,910.53	$8,271.88	$1,782.11	$1,782.11	1.60
Sum:	59	59	30	$585,169.07	$303,592.86	$231,285.11	$19,505.64	$10,119.76	$7,709.50	1.97

Case Type: 419 - ACS-All Ambulatory Care Sensor Conditions

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 06 - 17	2	2	1	$3,300.00	$1,607.00	$1,607.00	$3,300.00	$1,607.00	$1,607.00	2.00
Age 35 - 64	1	1	1	$1,100.00	$800.50	$800.50	$1,100.00	$800.50	$800.50	1.00
Age 65+	1	1	1	$1,100.00	$800.50	$800.50	$1,100.00	$800.50	$800.50	1.00
Sum:	4	4	3	$5,500.00	$3,208.00	$3,208.00	$1,833.33	$1,069.33	$1,069.33	1.33

D

Alabama Medicaid Agency

User ID: [redacted]
RunDate: 5/12/2006
Run Time: 12:49:13 PM

Inpatient Distribution Analysis
By Gender

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
F	29	29	18	$291,245.00	$184,464.82	$157,725.39	$16,180.28	$10,248.05	$8,762.52	1.61
M	30	30	12	$293,924.07	$119,128.04	$73,559.72	$24,493.67	$9,927.34	$6,129.98	2.50
Sum:	59	59	30	$585,169.07	$303,592.86	$231,285.11	$19,505.64	$10,119.76	$7,709.50	4.11

Case Type: 419 - ACS-All Ambulatory Care Sensor Conditions

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
F	1	1	1	$1,100.00	$800.50	$800.50	$1,100.00	$800.50	$800.50	1.00
M	3	3	2	$4,400.00	$2,407.50	$2,407.50	$2,200.00	$1,203.75	$1,203.75	1.50
Sum:	4	4	3	$5,500.00	$3,208.00	$3,208.00	$1,833.33	$1,069.33	$1,069.33	2.50

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E

Alabama Medicaid Agency

Inpatient Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:49:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 00 - 05	F	5	5	5	$42,400.00	$27,462.52	$19,357.39	$8,480.00	$5,492.50	$3,871.48	1.00
Age 00 - 05	M	1	1	1	$584.69	$2,436.84	$2,436.84	$584.69	$2,436.84	$2,436.84	1.00
Age 06 - 17	F	6	6	5	$68,145.00	$29,613.15	$18,547.16	$13,629.00	$5,922.63	$3,709.43	1.20
Age 06 - 17	M	12	12	4	$111,680.00	$52,073.97	$8,656.65	$27,920.00	$13,018.49	$2,164.16	3.00
Age 18 - 20	F	4	4	2	$67,000.00	$25,906.32	$25,906.32	$33,500.00	$12,953.16	$12,953.16	2.00
Age 18 - 20	M	1	1	1	$2,300.00	$7,368.30	$7,368.30	$2,300.00	$7,368.30	$7,368.30	1.00
Age 21 - 34	F	10	10	3	$107,200.00	$97,971.83	$92,814.02	$35,733.33	$32,657.28	$30,938.01	3.33
Age 35 - 64	F	1	1	1	$1,400.00	$2,410.50	$0.00	$1,400.00	$2,410.50	$0.00	1.00
Age 35 - 64	M	11	11	3	$143,100.00	$49,438.90	$47,287.90	$47,700.00	$16,479.63	$15,762.63	3.67
Age 65+	F	3	3	2	$5,100.00	$1,100.50	$1,100.50	$2,550.00	$550.25	$550.25	1.50
Age 65+	M	5	5	3	$36,259.38	$7,810.03	$7,810.03	$12,086.46	$2,603.34	$2,603.34	1.67
	Sum:	59	59	30	$585,169.07	$303,592.86	$231,285.11	$19,505.64	$10,119.76	$7,709.50	20.37

3.5.12.1 DSSProfiler - Inpatient Distribution Analysis Field Descriptions

Field	Description	Length	Data Type
(A) Exception Count	Number of exceptions identified. An exception is defined as two standard deviations from the norm.	8	Number (Integer)
(A, C-E) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A,C,D,E) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,C,D,E) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,C,D,E) Billed Amount per Recip	Total billed amount divided by the number of recipients.	12	Number (Decimal)
(A,C,D,E) Billed Quantity	Quantity billed.	14	Number (Integer)
(A,C,D,E) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A,C,D,E) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (	13	Number (Decimal)

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Field	Description	Length	Data Type
(A,C,D,E) Paid Amount per Recip	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(A,C,D,E) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A,D,E) Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(A-E) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-E) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-E) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
B) Top 20 By Number of Recipients	Graph shows Top 20 exceptions by number of recipients.	1	Character
(B) Top 20 By Paid Amound per Recipients	Graph shows Top 20 exceptions by paid amount per recipient.	1	Character
(B) Top 20 Exceptions	Graph shows Top 20 exceptions.	1	Character
(C) Average Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(C,D,E) Allowed Amt Per Recip	Total allowed amount divided by the number of recipients.	13	Number (Decimal)
(C,E) Age Description	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(D,E) Gender	Recipient's gender.	1	Character

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3.5.13 DSSProfiler - Inpatient Exception Quarterly

The Inpatient Quarterly Exception report is produced for a selected provider, provider peer group and aggregation code. This report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

Alabama Medicaid Agency

Inpatient Exception Quarterly
For Dates of Service: 07/01/2004 - 06/30/2005

User ID: [redacted]
Run Date: 5/18/2006
Run Time: 12:39:55 PM

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: TRINA O ROBERTS - ALL BSE
Type: 31 - Physician
Specialty: 316 - Family Practitioner
Address: PO BOX 3710

PORTLAND, OR 97501

Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

	20043		20044		20051	
100 - Extended Confinement - 3-9 Days; H: 002 L: 000			2.00		7.00	*
130 - Extended Confinement - Over 60 Days; H: 002 L: 000	2.00		2.00			
240 - Length of Stay 181 to 365 Services; H: 002 L: 000	2.00		2.00			
260 - Average Stays per Recipient; H: 001 L: 000	1.00		1.00		1.67	*
270 - Discharges; H: 002 L: 000	2.00		4.00	*	10.00	*

3.5.13.1 DSSProfiler - Inpatient Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Case Type Group	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Number (Integer)
Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Location Base ID	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character

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Field	Description	Length	Data Type
Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
Provider Address	The address for the provider ID.	200	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Name	The name of the provider.	63	Character
Provider NPI ID	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
Provider Specialty	The provider specialty for the provider identification number.	15	Character
Provider Type	The provider type for the provider identification number.	15	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
Service Mcaid ID	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character

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3.5.14 DSSProfiler - Inpatient Frequency Distribution

The Inpatient Frequency Distribution report is created in DSSProfiler. Based on the user-entered date range of one year, this report shows each inpatient case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 6/22/2006
Run Time: 6:51:06 PM

Inpatient Frequency Distribution

For Dates of Service: 07/01/04 - 06/30/05

Provider Peer Group Code: 1 - Inpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 419 - ACS-All Ambulatory Care Sensor Conditions

	10%	25%	50%	75%	90%	95%
Claim Count at each %	12	12	12	12	12	12

Case Type : 437 - ACS-Chronic

	10%	25%	50%	75%	90%	95%
Claim Count at each %	4	4	4	4	4	4

Case Type : 447 - ACS-Diabetes without Complication

	10%	25%	50%	75%	90%	95%
Claim Count at each %	4	4	4	4	4	4

3.5.14.1 DSSProfiler - Inpatient Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	Case type description.	100	Character

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Field	Description	Length	Data Type
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	8	Character
Provider Peer Group Code	Peer Group Type Code and Description.	54	Character

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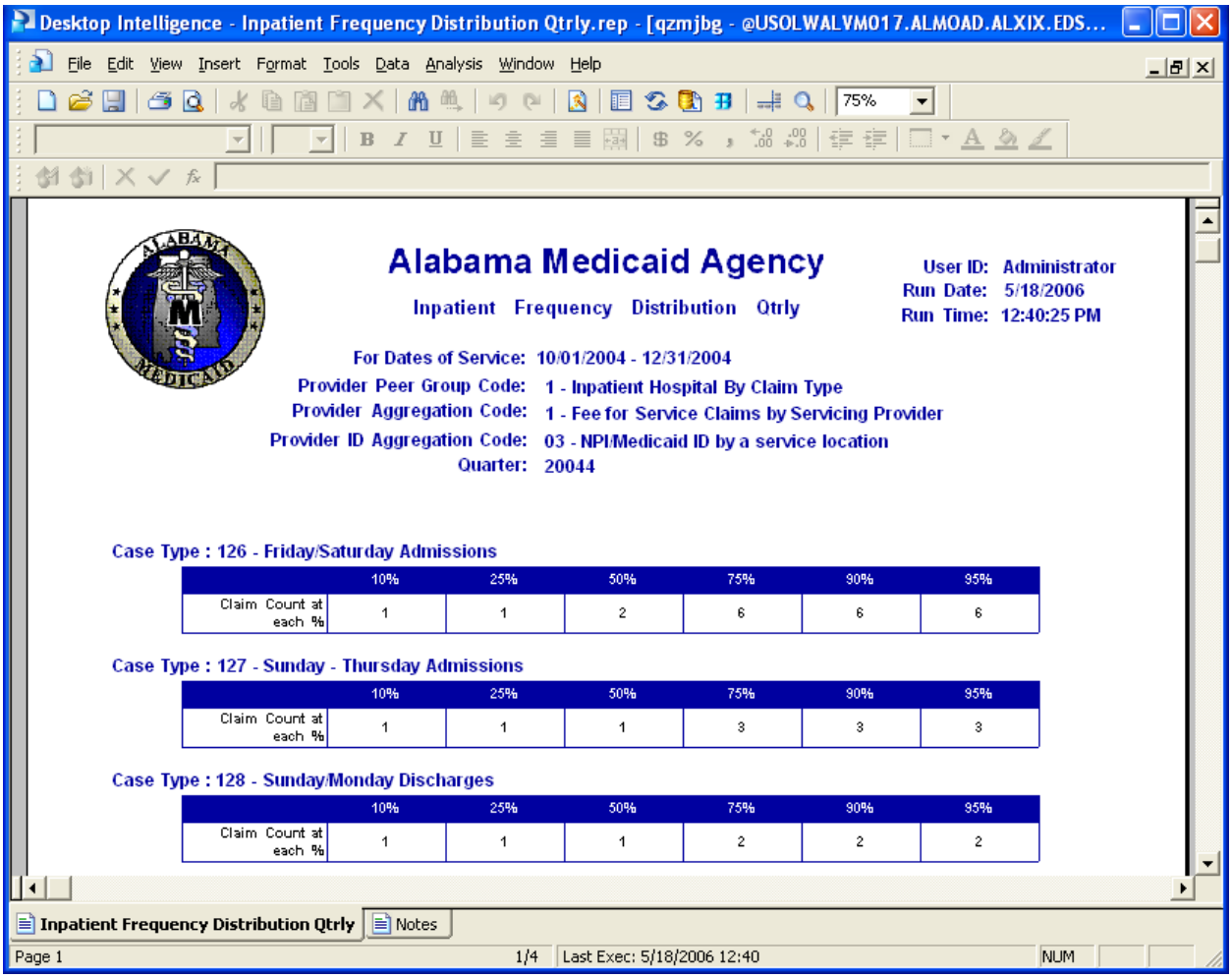
3.5.15 DSSProfiler - Inpatient Frequency Distribution Quarterly

The Inpatient Frequency Distribution Quarterly report is created in DSSProfiler. Based on the user-entered date range of one quarter, this report shows each inpatient case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



3.5.15.1 DSSProfiler - Inpatient Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)

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Field	Description	Length	Data Type
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.16 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group

The Inpatient Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

The two tabs in the report are:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

A

Alabama Medicaid Agency

Inpatient Recipient Case Type Comparison by Peer Group
Recipient Comparison
For Dates of Service: 07/01/2004 - 06/30/2005

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:38:37 AM

Case Type: 1 - All Claim Groupings
Recipient Peer Group: 526 - Medical Assistance, Categorically Needy, TANF
Recipient Aggregation: 7 - Fee for Service Claims by Recipient

Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference From Expected	Exception
1	[redacted]	[redacted]	$15,000.00	$8,127.35	$8,127.35	$3,178.22	$4,949.13	*
4	[redacted]	[redacted]	$17,000.00	$6,286.06	$6,286.06	$3,178.22	$3,107.84	
3	[redacted]	[redacted]	$12,000.00	$6,649.65	$6,649.65	$6,339.08	$310.57	
6	[redacted]	[redacted]	$3,000.00	$3,863.76	$3,863.76	$3,779.01	$84.75	
2	[redacted]	[redacted]	$2,300.00	$7,368.30	$7,368.30	$7,368.30	$0.00	
10	[redacted]	[redacted]	$10,000.00	$735.85	$735.85	$735.85	$0.00	
11	[redacted]	[redacted]	$1,245.00	$700.00	$700.00	$700.00	$0.00	
7	[redacted]	[redacted]	$13,000.00	$3,694.25	$3,694.25	$3,779.01	$(84.76)	
5	[redacted]	[redacted]	$109,920.00	$49,619.82	$6,028.50	$6,339.08	$(310.58)	
8	[redacted]	[redacted]	$1,200.00	$738.85	$738.85	$3,178.22	$(2,439.37)	
8	[redacted]	[redacted]	$1,245.00	$738.85	$738.85	$3,178.22	$(2,439.37)	
12	[redacted]	[redacted]	$15,900.00	$11,065.99	$0.00	$3,178.22	$(3,178.22)	
						2 STD DEV	$4,334.43	

End of Report

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:38:37 AM

Inpatient Recipient Case Type Comparison by Peer Group
Recipients Grouped by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005

Case Type: 1 - All Claim Groupings
Recipient Peer Group: 526 - Medical Assistance, Categorically Needy, TANF
Recipient Aggregation: 7 - Fee for Service Claims by Recipient

Age 00 - 05

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[illegible]	[illegible]	$3,000.00	$3,863.76	$3,863.76
[illegible]	[illegible]	$13,000.00	$3,694.25	$3,694.25
			Sum:	$7,558.01

Age 06 - 17

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[illegible]	[illegible]	$1,200.00	$738.85	$738.85
[illegible]	[illegible]	$15,900.00	$11,065.99	$0.00
[illegible]	[illegible]	$1,245.00	$738.85	$738.85
[illegible]	[illegible]	$15,000.00	$8,127.35	$8,127.35
[illegible]	[illegible]	$17,000.00	$6,286.06	$6,286.06

3.5.16.1 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount the provider was paid and the amount the provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group.	1	Number (Integer)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Decimal)
(A,B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the service.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Recipient Aggregation	Classification of the provider rendering health and medical services as approved under the state plan.	2	Character
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(A,B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.17 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which providers fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The two tabs in this report are:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/9/2007
Run Time: 2:34:30 PM

Inpatient Recipient Case Type Comparison
By Peer Group Qtrly

Recipient Comparison
For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 5 - Morbidity 3
Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Quarter: 20061

Rank	Expected Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	[redacted]	[redacted]	$42,147.00	$21,073.50	$42,147.00	$24,628.54	$17,518.46	
2	4	[redacted]	[redacted]	$33,118.96	$5,306.98	$31,841.88	$17,111.34	$14,730.54	
4	7	[redacted]	[redacted]	$58,219.30	$952.00	$19,844.00	$11,350.00	$8,494.00	
5	6	[redacted]	[redacted]	$33,888.00	$952.00	$15,232.00	$15,232.00	$0.00	
3	3	[redacted]	[redacted]	$61,244.64	$952.00	$22,550.00	$22,550.00	$0.00	
7	7	[redacted]	[redacted]	$12,589.50	$952.00	$2,856.00	$11,350.00	$(8,494.00)	
8	4	[redacted]	[redacted]	$28,021.24	$5,538.54	$2,380.80	$17,111.34	$(14,730.54)	
6	1	[redacted]	[redacted]	$7,110.08	$3,555.04	$7,110.08	$24,628.54	$(17,518.46)	
							2 STD DEV	$24,413.79	

End of Report

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B

Alabama Medicaid Agency

Inpatient Recipient Case Type Comparison
By Peer Group Qtrly

Recipients Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 5 - Morbidity 3
Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Quarter: 20061

User ID: [redacted]
Run Date: 10/9/2007
Run Time: 2:34:30 PM

Age 06 - 17

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$28,021.24	$5,538.54	$2,380.80
[redacted]	[redacted]	$33,118.96	$5,306.98	$31,841.88
			Sum:	**$34,222.68**

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$42,147.00	$21,073.50	$42,147.00
[redacted]	[redacted]	$7,110.08	$3,555.04	$7,110.08
			Sum:	**$49,257.08**

3.5.17.1 DSSProfiler - Inpatient Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Recipient's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Decimal)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character

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Field	Description	Length	Data Type
(A,B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.18 DSSProfiler - Inpatient Provider Profile

The Inpatient Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the inpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Inpatient Services -Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group- The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 5/30/2006
Run Time: 1:29:53 PM

Inpatient Provider Profile
Provider Summary

For Dates of Service: 07/01/2004 - 06/30/2005
Provider ID: [redacted]
Peer Group Code: 479 - 337 PLASTIC SURGEON
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider Information

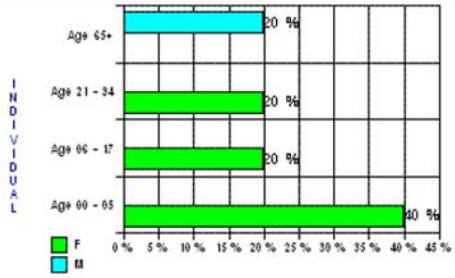
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: COUNTRY MEDICAL CLINIC
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 5888 PARK AVE

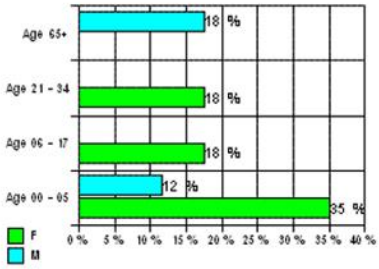
SALEM, OR 97501

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 7:30:11 AM

Inpatient Provider Profile
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 450 - 316 FAMILY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider's General Service Profile

Service Type	Recip Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
3 - Inpatient Services	5	$3,808.00	$102,383.32	$3,708.00	$4,657.77	$(949.77)	(20.39) %

End of Report

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B

Alabama Medicaid Agency

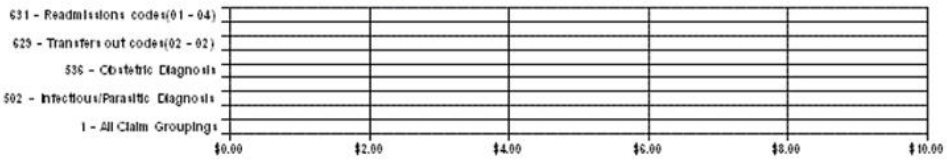
Inpatient Provider Profile

Inpatient Services

User ID: [redacted]
Run Date: 5/30/2006
Run Time: 1:29:53 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider ID: [redacted]
Peer Group Code: 479 - 337 PLASTIC SURGEON
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

Inpatient Provider Profile

Inpatient Services

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 7:30:11 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 450 - 316 FAMILY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type	Recip Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
3 - Morbidity 1	3	3	3	$2,856.00	$37,924.62	$2,756.00	$2,744.99	$11.01	0.40 %
5 - Morbidity 3	1	1	1	$952.00	$26,392.60	$952.00	$963.59	$(11.59)	(1.20) %
6 - Morbidity 4	1	1	1	$0.00	$38,066.10	$0.00	$949.20	$(949.20)	(100.00) %

End of Report

3.5.18.1 DSSProfiler - Inpatient Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Decimal)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Decimal)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and	5	Number (Decimal)

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Field	Description	Length	Data Type
	comparison of the provider's specialty peer group.		
(A) Patient Age/Gender Breakdown	It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	200	Character
(A) Provider Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on claim type, or claims can be further aggregated by recipient.	50	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group that is based on peer group norms.	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the	8	Number (Decimal)

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Field	Description	Length	Data Type
	variance of dollars from the expected value to the actual value in a percentage.		
(A-B) Provider	Provider identification number entered at the prompt.	13	Character
(A-B) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Quantity Billed.	The quantity of billed units.	8	Number (Integer)
(A-B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Top 10 Claim Groupings: Dollar Difference	Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider.	60	Character

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3.5.19 DSSProfiler - Inpatient Provider Profile Quarterly

The Inpatient Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the inpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Inpatient Services -Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.

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A

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

Inpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 102 - 010 ACUTE CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider Information

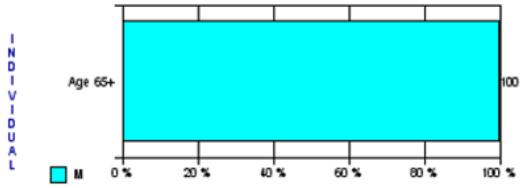
NPI ID:
Mcaid ID:
Base ID:
Name: ST JAMES HEALTHCARE - ALL BSE
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 400 SOUTH CLARK STREET

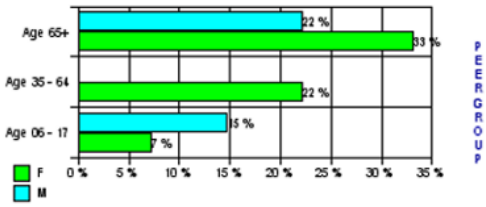
BUTTE, MT 59701

Rank

$ Paid Amount Actual	66
$ Paid Amount Expected	79
$ Billed Amount Actual	43
Recipient Rank	114
# Units Rank	161
# Claims Rank	152
Peer Group Size	184

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 3:37:34 PM

Inpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 102 - 010 ACUTE CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider's General Service Profile

Report Category	Recipient Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
3 - Inpatient Services	1	$6,664.00	$12,730.00	$952.00	$935.33	$16.67	1.78 %

End of Report

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B

Alabama Medicaid Agency

Inpatient Provider Profile Qtrly

Inpatient Services

For Dates: 01/01/2006 - 12/31/2006

Provider ID:

Provider Peer Group: 102 - 010 ACUTE CARE

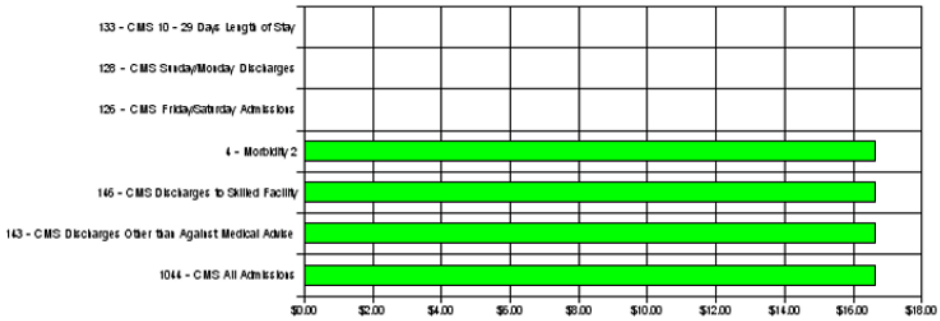
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

Provider ID Aggregation Code: 01 - Base ID all locations

Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

Inpatient Provider Profile Qtrly

Inpatient Services

For Dates: 01/01/2006 - 12/31/2006

Provider ID:

Provider Peer Group: 102 - 010 ACUTE CARE

Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

Provider ID Aggregation Code: 01 - Base ID all locations

Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 2:06:54 PM

Case Type	Recip Count	Claim Count	Billed Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
1044 - CMS All Admissions	1	1	1	$952.00	$12,730.00	$952.00	$935.33	$16.67	1.78 %
143 - CMS Discharges Other than Against Medical Advise	1	1	1	$952.00	$12,730.00	$952.00	$935.33	$16.67	1.78 %
146 - CMS Discharges to Skilled Facility	1	1	1	$952.00	$12,730.00	$952.00	$935.33	$16.67	1.78 %
4 - Morbidity 2	1	1	1	$952.00	$12,730.00	$952.00	$935.33	$16.67	1.78 %
126 - CMS Friday/Saturday Admissions	1	1	1	$952.00	$12,730.00	$952.00	$952.00	$0.00	0.00 %
128 - CMS Sunday/Monday Discharges	1	1	1	$952.00	$12,730.00	$952.00	$952.00	$0.00	0.00 %
133 - CMS 10 - 29 Days Length of Stay	1	1	1	$952.00	$12,730.00	$952.00	$952.00	$0.00	0.00 %

End of Report

3.5.19.1 DSSProfiler - Inpatient Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Decimal)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Decimal)
(A) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group that is based on peer group norms.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider ID entered at the prompt.	13	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(B) Billed Quantity	Quantity billed.	14	Number (Decimal)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Top 10 Case Types: Dollar Difference	Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character

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3.5.20 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all providers within a nursing facility peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Provider Comparison
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1	[redacted]	JOHN D SMITH - ALL NPI	$36,680.00	$32,697.27	$30,074.27	$18,497.66	$11,576.61	
2	4	4	[redacted]	GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI	$1,004.90	$1,004.90	$574.90	$574.90	$0.00	
3	2	2	[redacted]	DAVISON NW MEDICAL - ALL NPI	$2,000.00	$3,975.60	$3,975.60	$8,705.47	$(4,729.87)	
4	3	2	[redacted]	WEST HILLS MEMORIAL - ALL NPI	$3,167.15	$3,167.15	$1,858.72	$8,705.47	$(6,846.75)	
								2 STD DEV	$14,257.19	

End of Report

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

WEST HILLS MEMORIAL - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 35 - 64	M	1	$1,858.72
		SUM:	$1,858.72

GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 65+	F	1	$574.90
		SUM:	$574.90

C

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:31:18 PM

Nursing Facility Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
	JOHN D SMITH - ALL NPI	$5,570.02
	SUM:	$5,570.02

Age 06 - 17

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
	JOHN D SMITH - ALL NPI	$392.76
	SUM:	$392.76

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3.5.20.1 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Decimal)
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Decimal)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping	20	Character

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Field	Description	Length	Data Type
	variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
(A,C) Provider ID	Provider identification number.	15	Character
(A,C) Provider Name	Provider's full name.	50	Character
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.21 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a quarterly nursing facility peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

Alabama Medicaid Agency

User ID:
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Provider Comparison

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1		JOHN D SMITH - ALL NPI	$17,500.00	$19,932.57	$18,641.57	$9,973.64	$8,667.93	
2	4	4		GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI	$1,004.90	$1,004.90	$574.90	$574.90	$0.00	
3	2	2		DAVISON NW MEDICAL - ALL NPI	$2,000.00	$3,975.60	$3,975.60	$7,251.13	$(3,275.53)	
4	3	2		WEST HILLS MEMORIAL - ALL NPI	$3,167.15	$3,167.15	$1,858.72	$7,251.13	$(5,392.41)	
								2 STD DEV	12,379.56	

End of Report

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Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient by Age/Gender

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

[redacted] - WEST HILLS MEMORIAL - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 35 - 64	M	1	$1,858.72
		AVG:	$1,858.72

[redacted] - GRACE COMMUNITY PHYSICAL THERAPY - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 65+	F	1	$574.90
		AVG:	$574.90

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:22:07 PM

Nursing Facility Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20043

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	JOHN D SMITH - ALL NPI	$2,722.51
	AVG:	$2,722.51

Age 35 - 64

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	WEST HILLS MEMORIAL - ALL NPI	$1,858.72
[redacted]	DAVISON NW MEDICAL - ALL NPI	$3,975.60

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3.5.21.1 DSSProfiler - Nursing Facility Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Decimal)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Decimal)
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Decimal)
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) Provider ID	Provider identification number.	15	Character
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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Field	Description	Length	Data Type
(A,B,C) Provider Name	Provider's full name.	50	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.22 DSSProfiler - Nursing Facility Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all nursing facility case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types, additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Nursing Facility Claim Details - Shows all the claims the provider submitted.

B. Inpatient/Outpatient Claim Details - Shows the details for the claims.

C. Recipient Listing - Lists the individual recipient ID and names.

D. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes.

E. Procedure Code Listing - Lists the procedure codes and counts.

A

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider - FFS

Nursing Facility Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID:

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: I

User ID:
Run Date: 7/12/16
Run Time: 5:12:06 PM

PHI has been removed

ICN	CT	POS	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Cov Days	Billed Amt	Alwd Amt	Paid Amt
123456789012	L	31	123456789012	XXXX

C

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	74

End of Report

PHI has been removed

D

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD)	1	1
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	1	1
9	1509 - MALIGNANT NEOPLASM OF ESOPHAGUS, UNSPECI	9	78720 - DYSPHAGIA, UNSPECIFIED	9	1977 - MALIGNANT NEOPLASM OF LIVER, SPECIFIED A	1	1
9	185 - MALIGNANT NEOPLASM OF PROSTATE	9	1539 - MALIGNANT NEOPLASM OF COLON, UNSPECIFIED	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	1	1
9	185 - MALIGNANT NEOPLASM OF PROSTATE	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	1	1
9	25000 - DIABETES UNCOMPL ADULT-TYPE II	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD)	1	1
9	25000 - DIABETES UNCOMPL ADULT-TYPE II	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	3	3

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E

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider - FFS

Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID:

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

User ID:
Run Date: 7/12/16
Run Time: 5:12:06 PM

Procedure Code & Description	ICN Count	Recipient Count
	0	0

End of Report

3.5.22.1 DSSProfiler - Nursing Facility Claim Details by Provider - FFS Field Descriptions

Field	Description	Length	Data Type
(A,B) Bill Quantity	The units of service billed for payment.	15	Number (Decimal)
(A,B) Claim Type (CT)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	10	Number (Decimal)
(A,B) Place of Service (POS)	A code to indicate where the service was provided.	2	Character
(B) MD1 Desc	The description associated with the first modifier.	40	Character
(B) MD3 Desc	The description associated with the third modifier.	40	Character
(B,E) Procedure Description (Proc Desc)	The description associated with the primary procedure code.	40	Character
(A,B) Age	The age of the recipient based on the FDOS of the claim and the current eligibility date of birth rounded down to a full year.	4	Number
(A,B) Allowed Amount	Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure.	9	Number (Decimal)

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Field	Description	Length	Data Type
(A,B) Billed Amount	Amount of money requested for payment by a provider for services rendered to a recipient.	13	Character
(A,B) Covered Days	The number of days covered for the statement period of the claim.	9	Number (Decimal)
(A,B) DOB	Recipient's date of birth.	10	Date (MM/DD/YY)
(A,B) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A,B) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	70	Character
(A,B) From Date of Service (FDOS)	The date the service was incurred.	10	Date (MM/DD/CCYY)
(A,B) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A,B) To Date of Service	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)
(A,B,C) Recipient Full Name	Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name.	39	Character
(A,B,C) Recipient ID (Recip ID)	Recipient Medicaid Number	12	Character
(A,B,D) Diag	The primary ICD-CM diagnosis code.	7	Character
(A,B,D) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A,B,D) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(A,B,D) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code.	1	Character
(A-E) Claim Type(s) (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-E) Provider, Base, Medicaid or NPI ID (prompt)	Provider’s ID.	15	Character

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Field	Description	Length	Data Type
(A-E) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-E) Run Time	The time that the report was executed.	11	Character
(A-E) User ID	The id of the user that created the report.	50	Character
(B) Detail Number	Claim line number.	4	Number (Integer)
(B) MD1	The first of four possible codes that may be used to supplement the procedure code.	2	Character
(B) MD2	The second of four possible codes that may be used to supplement the procedure code.	2	Character
(B) MD2 Desc	The description associated with the second modifier.	40	Character
(B) MD3	The third of four possible codes that may be used to supplement the procedure code.	2	Character
(B, E) Procedure code (Proc)	A code from the fee schedule to indicate the service performed.	6	Character
(C,D,E) ICN Count	Unduplicated count of claims for the recipient (C), Diagnosis code (D) or Procedure code (E).	8	Number (Integer)
(D) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(D) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(D) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code.	1	Character
(D,E) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)

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3.5.23 DSSProfiler - Nursing Facility Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all nursing facility case types for a given provider ID and service location. This report displays all detailed claims information categorized by the individual case types additionally the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Nursing Facility Claim Details - Shows all the claims the provider submitted.

B. Inpatient/Outpatient Claim Details - Shows the details for the claims.

C. Recipient Listing - Lists the individual recipient ID and names.

D. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes.

E. Procedure Code Listing - Lists the procedure codes and counts.

A

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider Qtrly - FFS

Nursing Facility Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID:

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

User ID:
Run Date: 7/12/16
Run Time: 5:12:06 PM

ICN	CT	POS	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Cov Days	Billed Amt	Alwd Amt	Paid Amt
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	2/23/1957	58	8/1/2015	8/31/2015	9	319	UNSPECIFIED MENTAL RETARDATION	9	2449	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	31	$6,239.68	$6,239.68	$5,266.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	7/26/1946	69	8/1/2015	8/31/2015	9	25000	DIABETES UNCOMPL ADULT-TYPE II	9	4439	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED	31	$6,239.68	$6,239.68	$5,539.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	9/10/1941	73	8/1/2015	8/31/2015	9	25000	DIABETES UNCOMPL ADULT-TYPE II	9	78039	OTHER CONVULSIONS	31	$6,239.68	$6,239.68	$6,239.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	1/7/1936	79	8/1/2015	8/31/2015	9	40310	HYPERTENSIVE RENAL DISEASE BENIGN	9	5853	CHRONIC KIDNEY DISEASE, STAGE III	31	$6,239.68	$6,239.68	$6,239.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	9/28/1955	59	8/1/2015	8/31/2015	9	3349	SPINOCEREBELLAR DISEASE, UNSPECIFIED	9	5851	CHRONIC KIDNEY DISEASE, STAGE I	31	$6,239.68	$6,239.68	$5,322.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	12/18/1939	75	8/1/2015	8/31/2015	9	25000	DIABETES UNCOMPL ADULT-TYPE II	9	V5867	LONG-TERM (CURRENT) USE OF INSULIN	31	$6,239.68	$6,239.68	$5,509.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	9/26/1969	45	8/1/2015	8/31/2015	9	25000	DIABETES UNCOMPL ADULT-TYPE II	9	V5867	LONG-TERM (CURRENT) USE OF INSULIN	31	$6,239.68	$6,239.68	$6,239.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	11/30/1939	75	8/1/2015	8/26/2015	9	25000	DIABETES UNCOMPL ADULT-TYPE II	9	V5867	LONG-TERM (CURRENT) USE OF INSULIN	26	$5,233.28	$5,233.28	$5,233.28
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	9/26/1919	95	8/1/2015	8/31/2015	9	4439	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED	9	44023	ATHEROSCL-EXTREM W ULCERATION	31	$6,239.68	$6,239.68	$5,231.68
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	9/28/1964	50	8/1/2015	8/31/2015	9	25062	DIAB NEURO MANIF ADULT-UNCONTRLLD	9	3572	POLYNEUROPATHY IN DIABETES	31	$6,239.68	$6,239.68	$6,055.64
1234567890123	L	31	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	7/20/1952	63	8/1/2015	8/31/2015	9	4280	CONGESTIVE HEART FAILURE	9	40310	HYPERTENSIVE RENAL DISEASE BENIGN	31	$6,239.68	$6,239.68	$5,824.68

PHI has been removed

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B

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider Qtrly- FFS

Inpatient/Outpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: I;A;C;O

Calendar Year Quarter: 20153

User ID: [redacted]
Run Date: 7/12/16
Run Time: 5:12:06 PM

ICN	CT	POS	DII #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty/ Cov Days	Billed Amt	Alwd Amt	Paid Amt	DRG Code & Desc	DRG Relative Weight	DRG Service Adjuster
123456789023	I	21	0	123456789012	XXXXXXXXXX XXXXXXXXXX XX, XXXXXXXXXX XXXXXX, X	11/30/1939	75	7/2/2015	7/7/2015	9	41071	OF OTHER INTERIOR WALL	9	5188 1	RESPIRATO RY FAILURE	######	UNKNOWN or Not Applicable	# #	UNKNOWN or Not Applicable	# #	UNKNOWN or Not Applicable	# #	UNKNOWN or Not Applicable	5	$23,286.50	$4,787.30	$4,787.30	##### -	0	0

End of Report

PHI has been removed

C

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider Qtrly - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	74

End of Report

PHI has been removed

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D

Alabama Medicaid Agency

Nursing Facility Claim Details By Provider Qtrly - FFS
Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD)	1	1
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	1	1
9	1509 - MALIGNANT NEOPLASM OF ESOPHAGUS, UNSPECI	9	78720 - DYSPHAGIA, UNSPECIFIED	9	1977 - MALIGNANT NEOPLASM OF LIVER, SPECIFIED A	1	1
9	185 - MALIGNANT NEOPLASM OF PROSTATE	9	1539 - MALIGNANT NEOPLASM OF COLON, UNSPECIFIED	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	1	1
9	185 - MALIGNANT NEOPLASM OF PROSTATE	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	1	1
9	25000 - DIABETES UNCOMPL ADULT-TYPE II	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5852 - CHRONIC KIDNEY DISEASE, STAGE II (MILD)	1	1
9	25000 - DIABETES UNCOMPL ADULT-TYPE II	9	40310 - HYPERTENSIVE RENAL DISEASE BENIGN	9	5853 - CHRONIC KIDNEY DISEASE, STAGE III	3	3

E

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/12/16
Run Time: 5:12:06 PM

Nursing Facility Claim Details By Provider Qtrly - FFS
Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: CIVIC CENTER HEALTH/REHABILITION

For Claim Types: L

Calendar Year Quarter: 20153

Procedure Code & Description	ICN Count	Recipient Count
	0	0

End of Report

3.5.23.1 DSSProfiler - Nursing Facility Claim Details by Provider Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A,B) Bill Quantity	The units of service billed for payment.	15	Number
(A,B) DOB	Recipient's date of birth.	10	Date (MM/DD/YY)

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Field	Description	Length	Data Type
(A,B) Age	The age of the recipient based on the FDOS of the claim and the current eligibility date of birth rounded down to a full year.	4	Number
(A,B) Allowed Amount	Amount allowed by the specific program (Medicaid, 590, and so on.) for the procedure.	9	Number (Decimal)
(A,B) Billed Amount	Amount of money requested for payment by a provider for services rendered to a recipient.	13	Character
(A,B) Claim Type (CT)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A,B) Covered Days	The number of days covered for the statement period of the claim.	9	Number (Decimal)
(A,B) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A,B) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A,B) From Date of Service (FDOS)	The date the service was incurred.	10	Date (MM/DD/CCYY)
(A,B) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	10	Number (Decimal)
(A,B) Place of Service (POS)	A code to indicate where the service was provided.	2	Character
(A,B) To Date of Service	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)
(A,B,C) Recipient Full Name	Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name.	39	Character
(A,B,C) Recipient ID (Recip ID)	Recipient Medicaid Number	12	Character
(A,B,D) Diag	The primary ICD-CM diagnosis code.	7	Character
(A,B,D) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character

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Field	Description	Length	Data Type
(A,B,D) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(A,B,D) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code.	1	Character
(A-E) Claim Type(s) (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-E) Provider, Base, Medicaid or NPI ID (prompt)	Provider's ID.	15	Character
(A-E) Quarter (prompt)	The quarter for which the report is being run.	5	Number (Integer)
(A-E) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-E) Run Time	The time that the report was executed.	11	Character
(A-E) User ID	The id of the user that created the report.	50	Character
(B) Detail Number	Claim line number.	4	Number (Integer)
(B) MD1	The first of four possible codes that may be used to supplement the procedure code.	2	Character
(B) MD1 Desc	The description associated with the first modifier.	40	Character
(B) MD2	The second of four possible codes that may be used to supplement the procedure code.	2	Character
(B) MD2 Desc	The description associated with the second modifier.	40	Character
(B) MD3	The third of four possible codes that may be used to supplement the procedure code.	2	Character
(B) MD3 Desc	The description associated with the third modifier.	40	Character
(B,E) Procedure Description (Proc Desc)	The description associated with the primary procedure code.	40	Character
(B, E) Procedure code (Proc)	A code from the fee schedule to indicate the service performed.	6	Character
(C,D,E) ICN Count	Unduplicated count of claims for the recipient (C), Diagnosis code (D) or Procedure code (E).	8	Number (Integer)

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Field	Description	Length	Data Type
(D) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(D) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(D) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code.	1	Character
(D,E) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)

3.5.24 DSSProfiler - Nursing Facility Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can also be used for disease management for nursing facility residents. The first row gives the totals for each column.

The tabs on this report include:

A. Nursing Facility Disease; and

B. Nursing Facility Disease by Peer Group.

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:01 PM

Nursing Facility Disease Quick View
Nursing Facility Disease
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	2	1	2	$2,000.00	$3,975.60	$3,975.60
2	4	4	8	$8,000.00	$6,087.78	$5,962.78
1	6	3	6	$5,929.40	$5,829.89	$5,829.89
2	10	10	20	$11,847.15	$6,996.56	$5,688.13
1	16	8	16	$20,000.00	$22,780.08	$20,282.08
Totals:			52	$47,776.55	$45,669.91	$41,738.48

End of Report

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:35:01 PM

Nursing Facility Disease Quick View
Nursing Facility Disease By Peer Group
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 521 - Institutionalized with income < 300%, Disabled

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	2	1	2	$2,000.00	$3,975.60	$3,975.60
1	6	3	6	$5,929.40	$5,829.89	$5,829.89
1	16	8	16	$20,000.00	$22,780.08	$20,282.08
Totals:			24	$27,929.40	$32,585.57	$30,087.57

Peer Group: 525 - Public Assistance, TANF

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
2	10	10	20	$11,847.15	$6,996.56	$5,688.13
Totals:			20	$11,847.15	$6,996.56	$5,688.13

Peer Group: 526 - Medical Assistance, Categorically Needy, TANF

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount

3.5.24.1 DSSProfiler - Nursing Facility Disease Quick View Field Descriptions

Field	Description	Length	Data Type
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-B) Each Recipient Had XX Claims	This field shows us how many claims each of the recipients had.	4	Character
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A-B) Paid Amount	This is the total amount paid by the program for the specific claim grouping.	13	Number (Decimal)
(A-B) Total Claims	This is the total number of claims billed based on the number of recipients and the number of claims for each recipient.	9	Character
(A-B) Total Quantity Billed	This is the total units billed for this particular claim category.	9	Character
(A-B) Unduplicated Recipients	This is a count of all recipients that had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once.	9	Character
(B) Peer Group	Peer Group Code and Description.	7	Character

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3.5.25 DSSProfiler - Nursing Facility Exception Quarterly

The Nursing Facility Quarterly Exception report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

Alabama Medicaid Agency

Nursing Facility Quarterly Exception

For Dates of Service: 07/01/2004 - 06/30/2005

User ID:
Run Date: 5/18/2006
Run Time: 12:46:14 PM

Provider Service Location Information:
NPI ID:
Mcaid ID:
Base ID:
Name: JOHN D SMITH
Type: 03 - Extended Care Facility
Specialty: 034 - ICF/MR < 6 Beds
Address: 5975 NE 1ST ST
DROP CODE 10404
SALEM, OR 97501

Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Peer Group Code: 3 - Nursing Home By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider

	20043		20044		20051	
600 - 00 - 07 Days Length of Stay; H: 002 L: 000					6.00	*
630 - 22 - 28 Days Length of Stay; H: 002 L: 000	7.00	*	4.00	*		

End of Report

3.5.25.1 DSSProfiler - Nursing Facility Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Case Type Group Display	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Number (Integer)
Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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Field	Description	Length	Data Type
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.26 DSSProfiler - Nursing Facility Frequency Distribution

The Nursing Home Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each nursing facility case type, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type and peer grouping.

Alabama Medicaid Agency

Nursing Facility Frequency Distribution

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 3
Provider Aggregation Code: 1
Provider ID Aggregation Code: 01

User ID:
Run Date: 5/22/2006
Run Time: 11:19:48 AM

Case Type :

	10%	25%	50%	75%	90%	95%
Claim Count at each %						

3.5.26.1 DSSProfiler - Nursing Facility Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer	20	Character

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Field	Description	Length	Data Type
	group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		

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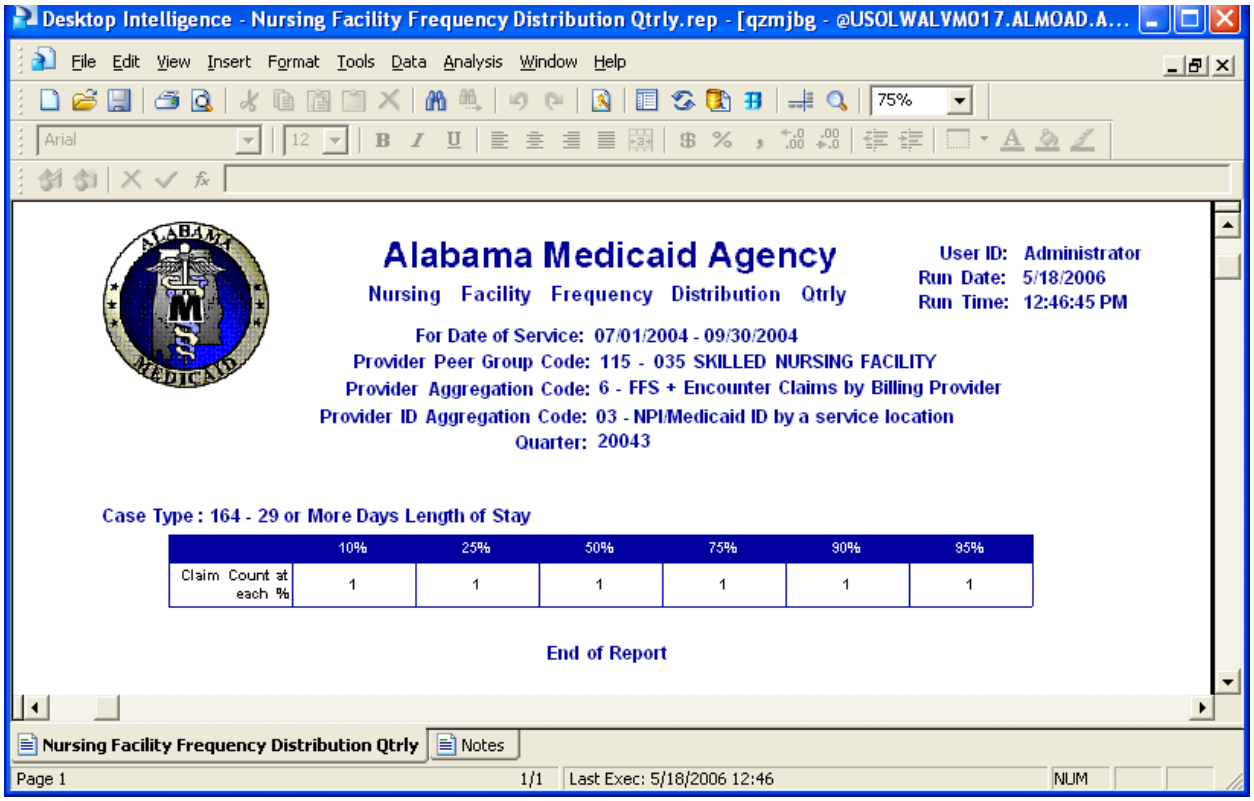
3.5.27 DSSProfiler - Nursing Facility Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays provider claim counts by percentile for nursing facility services for the selected peer group and aggregation type. Each percentile represents a percentage of the number of providers with claims in the specific claim grouping. The percentile groups are determined by ordering providers by the number of paid claims each has for the case type and then grouping the providers into the percentiles starting with the provider with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any provider falling in the percentile.



3.5.27.1 DSSProfiler - Nursing Facility Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.28 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group

The Nursing Facility Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which ones fall outside of service dollar norms for nursing home claims. All information is age and sex adjusted so that differences in patient mix do not affect the results. Individuals who have two standard deviations above the norm for the peer group are highlighted.

The tabs on this report include:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/11/2007
Run Time: 2:50:37 PM

Nursing Facility Recipient Case Type Comparison by Peer Group

Recipient Comparison
For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 906 - AL MI and MR Diagnosis
Recipient Peer Group: 1026 - 95 D.O. QMB Only with no money QMB only
Aggregation Code: 7 - Fee For Service Claims by Recipient

Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference From Expected	Exception
1	[redacted]	[redacted]	$3,689.00	$3,689.00	$3,689.00	$1,785.00	$1,904.00	
4	[redacted]	[redacted]	$1,071.00	$1,071.00	$1,071.00	$1,071.00	$0.00	
2	[redacted]	[redacted]	$5,291.93	$2,737.00	$2,737.00	$2,737.00	$0.00	
3	[redacted]	[redacted]	$2,486.30	$1,785.00	$1,785.00	$1,785.00	$0.00	
5	[redacted]	[redacted]	$5,609.13	$357.00	$357.00	$1,785.00	$(1,428.00)	
6	[redacted]	[redacted]	$238.00	$238.00	$238.00	$1,785.00	$(1,547.00)	
7	[redacted]	[redacted]	$119.00	$119.00	$119.00	$1,785.00	$(1,666.00)	
						2 STD DEV	$2,361.96	

End of Report

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B

Alabama Medicaid Agency

User ID:
Run Date: 9/11/2007
Run Time: 2:50:37 PM

Nursing Facility Recipient Case Type Comparison by Peer Group

Recipients Grouped by Age/Gender
For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 906 - AL MI and MR Diagnosis
Recipient Peer Group: 1026 - 95 D.O. QMB Only with no money QMB only
Aggregation Code: 7 - Fee For Service Claims by Recipient

Age 35 - 64
Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$2,486.30	$1,785.00	$1,785.00
			Sum:	$1,785.00

3.5.28.1 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group.	1	Number (Decimal)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the service.	13	Number (Decimal)
(A-B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A-B) Recipient ID	Recipient Medicaid Number.	12	Character
(A-B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B) Gender	Recipient's gender.	1	Character

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3.5.29 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender.

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 5/22/2006
Run Time: 9:12:12 AM

Nursing Facility Recipient Case Type Comparison
By Peer Group Qtrly
Recipient Comparison
For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Peer Group Code: 297 - Institutionalized with income < 300%, Disabled
Aggregation Code: 7 - Fee for Service Claims by Recipient
Quarter: 20043

Rank	Expected Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	[redacted]	[redacted]	$15,000.00	$17,085.06	$15,919.06	$9,947.33	$5,971.73	
3	3	[redacted]	[redacted]	$2,714.70	$2,714.70	$2,714.70	$2,714.70	$0.00	
2	1	[redacted]	[redacted]	$2,000.00	$3,975.60	$3,975.60	$9,947.33	$(5,971.73)	
							2 STD DEV	$9,751.79	

End of Report

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Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 9:12:12 AM

Nursing Facility Recipient Case Type Comparison
By Peer Group Qtrly

Recipients Grouped by Age/Gender
For Dates of Service: 07/01/2004 - 09/30/2004
Case Type: 1 - All Claim Groupings
Peer Group Code: 297 - Institutionalized with income < 300%, Disabled
Aggregation Code: 7 - Fee for Service Claims by Recipient
Quarter: 20043

Age 35 - 64

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$15,000.00	$17,085.06	$15,919.06
		$2,000.00	$3,975.60	$3,975.60
			Sum:	$9,947.33

Age 65+

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$2,714.70	$2,714.70	$2,714.70
			Sum:	$2,714.70

3.5.29.1 DSSProfiler - Nursing Facility Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Recipient's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Integer)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)

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Field	Description	Length	Data Type
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. . Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	The dates for which the report is being run.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.30 DSSProfiler - Nursing Facility Provider Profile

The Nursing Facility Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type for a nursing facility provider that exceeds the accepted norm within the provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient health status, recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Nursing Facility Services - The first section displays a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time.

The second section of the report lists all case types for which the provider was reimbursed over a particular time period. They include the following:

C. Professional Billing - This report lists all professional case types for which the profiled nursing facility was the billing provider;

D. Inpatient Billing - This report lists all inpatient case types for which the profiled nursing facility was the billing provider;

E. Outpatient Billing - This report lists all outpatient case types for which the profiled nursing facility was the billing provider; and

F. Pharmacy Billing - This report lists all pharmacy case types for which the profiled nursing facility was the billing provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code - the aggregation code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Provider Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

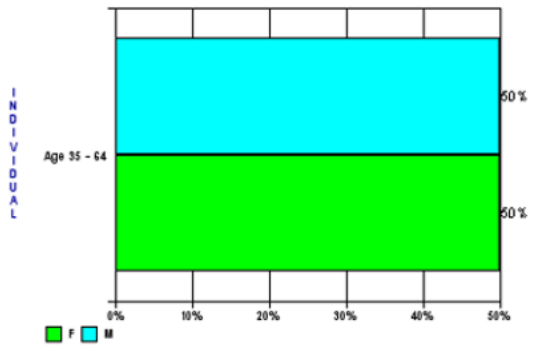
Provider Information

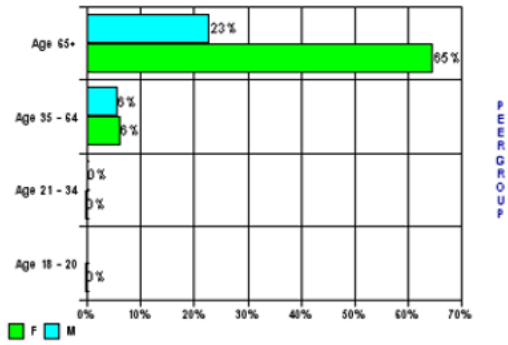
NPI ID:
Mcaid ID:
Base ID:
Name: JONES, SUSAN E
Type: 31 - Physician
Specialty: 800 - Internal Medicine
Address: 121 NORTH 20TH ST
SUITE 6
OPELIKA, AL 36801

Ranks

$ Paid Amount Actual	68
$ Paid Amount Expected	124
$ Billed Amount Actual	124
Recipient Rank	195
# Units Rank	2
# Claims Rank	64
Peer Group Size	345

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Provider Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider's General Service Profile

Report Category Code and Description	Recipient Count	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
5 - Nursing Facility Services	2	$32,102.08	$9,044.00	$31,292.46	$15,124.00	$16,168.46	106.91 %

End of Report

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B

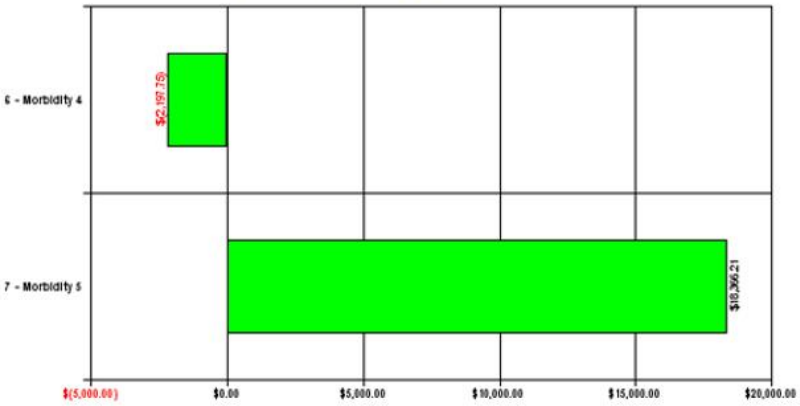
Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:15:32 AM

Nursing Facility Provider Profile
Nursing Facility Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Type Groupings: Dollar Difference



Alabama Medicaid Agency

User ID:
Run Date: 10/15/2007
Run Time: 8:31:22 AM

Nursing Facility Provider Profile
Nursing Facility Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Code and Description	Recipient Count	Claim Count	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
7 - Morbidity 5	1	19	509	$26,647.32	$8,687.00	$30,935.46	$12,569.25	$18,366.21	146.12 %
6 - Morbidity 4	1	1	1	$5,454.76	$357.00	$357.00	$2,554.75	$(2,197.75)	(86.03) %

End of Report

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C

Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:45:27 AM

Nursing Facility Provider Profile
Professional Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Code Description	Billed Amount	Allowed Amount	Paid Amount
996 - AL Consultation Procedures	$98.00	$60.00	$60.00
1000 - AL Dormicilla Procedures	$970.00	$0.00	$4.48
1031 - AL Platelet - Cell Count Procedures	$246.42	$40.00	$1,131.73
1035 - AL Injectable Drug Procedures	$11,490.82	$3,127.64	$0.00
1066 - AL Eval and Mgmt Consultation Procedures	$98.00	$60.00	$60.00
1071 - AL Hypertension Diagnosis	$65.00	$0.00	$0.00
1072 - AL Decubitus Diagnosis	$42.40	$0.00	$0.00
1118 - AL Surgery Procedures	$256.00	$66.72	$0.00

End of Report

D

Alabama Medicaid Agency

User ID:
Run Date: 10/24/2007
Run Time: 11:25:54 AM

Nursing Facility Provider Profile
Inpatient Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Code Description	Billed Amount	Allowed Amount	Paid Amount
6 - Morbidity 4	$20,095.23	$4,665.64	$4,665.64

End of Report

E

Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 8:45:27 AM

Nursing Facility Provider Profile
Outpatient Billing

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Code Description	Billed Amount	Allowed Amount	Paid Amount
3 - Morbidity 1	$700.00	$220.50	$0.00
4 - Morbidity 2	$498.50	$20.25	$20.25
5 - Morbidity 3	$585.97	$307.00	$0.00
787 - AL Emergency Room - Non Crit Procedures	$425.20	$70.29	$70.29
794 - AL Radiology Procedures	$498.50	$20.25	$20.25
1043 - AL Undefined Symptom Diagnosis	$903.39	$329.10	$0.00

End of Report

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F

Alabama Medicaid Agency

Nursing Facility Provider Profile
Pharmacy Billing

User ID:
Run Date: 10/24/2007
Run Time: 11:25:54 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 339 - 035 SKILLED NURSING FACILITY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Code Description	Billed Amount	Allowed Amount	Paid Amount
4 - Morbidity 2	$517.75	$200.31	$200.31
5 - Morbidity 3	$4,681.45	$3,018.33	$3,018.33
6 - Morbidity 4	$7,304.17	$4,815.35	$4,815.35

End of Report

3.5.30.1 DSSProfiler - Nursing Facility Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)

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Field	Description	Length	Data Type
(A-F) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-F) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-F) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-F) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-F) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-F) Provider ID	Provider's identification number.	13	Character
(A-F) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)

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Field	Description	Length	Data Type
(A) Report Category Code and Description	User-defined variables used to categorize case types into service groups.	21	Character
(B-F) Case Type Code and Description	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Billed Quantity	Quantity billed.	8	Number (Integer)
(B) Top 10 Case Type Groupings: Dollar Difference	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character
(A-F) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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3.5.31 DSSProfiler - Nursing Facility Provider Profile Quarterly

Nursing Facility Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type for a nursing facility provider that exceeds the accepted norm within the provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient health status, recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Nursing Facility Services - The first section displays a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time.

The second section of the report lists all case types for which the provider was reimbursed over a particular time period.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code is the aggregation code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Provider Summary

User ID:
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

Provider Information

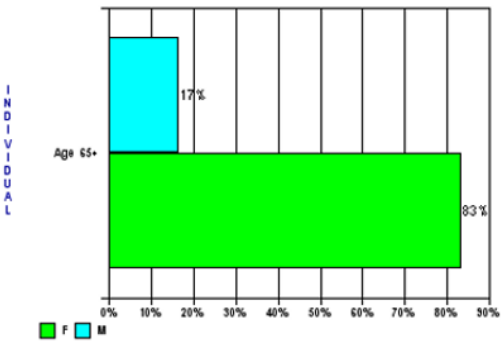
NPI ID:
Mcaid ID:
Base ID:
Name: CROWNE HLTH CARE OF GREENVIL
Type: 03 - Extended Care Facility
Specialty: 035 - Nursing Facility
Address: 408 COUNTRY CLUB DRIVE

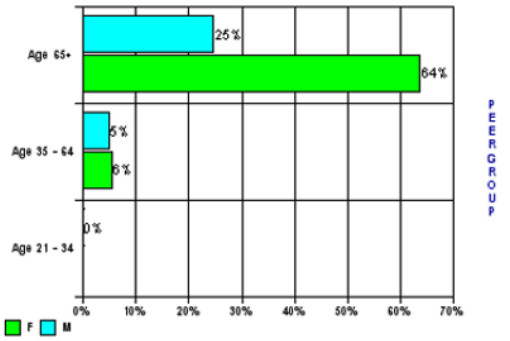
GREENVILLE, AL 36037

Ranks

$ Paid Amount Actual	113
$ Paid Amount Expected	102
$ Billed Amount Actual	152
Recipient Rank	82
# Units Rank	111
# Claims Rank	106
Peer Group Size	190

Patient Age/Gender Breakdown





Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Provider Summary

User ID:
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

Provider's General Service Profile

Service Type	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
10 - Nursing Facility Services by Billing Provider	6	$9,834.07	$10,115.00	$9,218.40	$13,033.04	$(3,814.64)	(29.27) %

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B

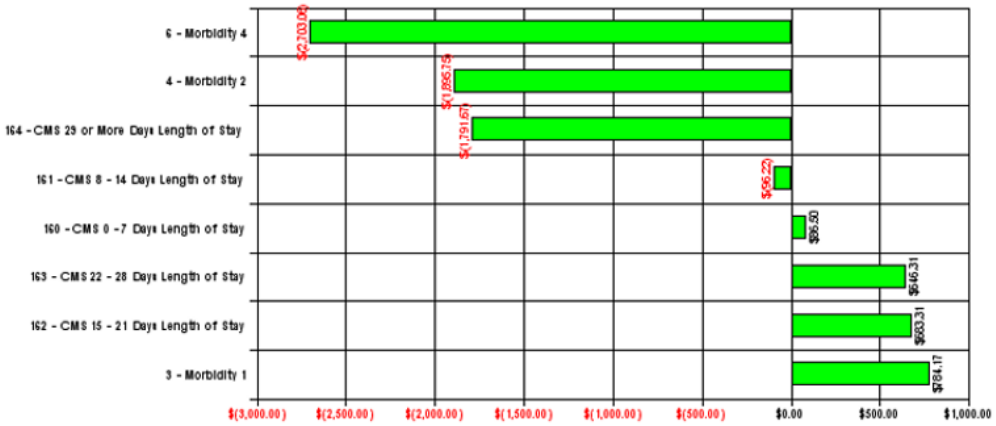
Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Nursing Facility Services

User ID: [redacted]
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

Top 10 Case Type Groupings: Dollar Difference



Alabama Medicaid Agency

Nursing Facility Provider Profile Qtrly
Nursing Facility Services

User ID: [redacted]
Run Date: 10/11/2007
Run Time: 8:08:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee For Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20063

Case Type Code and Description	Recipient Count	Claim Count	Billed Quantity	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
3 - Morbidity 1	1	1	1	$3,451.00	$3,451.00	$2,835.33	$2,051.16	$784.17	38.23 %
162 - CMS 15 - 21 Days Length of Stay	1	1	1	$2,499.00	$2,499.00	$2,499.00	$1,815.69	$683.31	37.63 %
163 - CMS 22 - 28 Days Length of Stay	2	2	2	$4,360.07	$4,641.00	$3,744.40	$3,098.09	$646.31	20.86 %
160 - CMS 0 - 7 Days Length of Stay	1	1	1	$595.00	$595.00	$595.00	$508.50	$86.50	17.01 %
161 - CMS 8 - 14 Days Length of Stay	1	1	1	$1,190.00	$1,190.00	$1,190.00	$1,286.22	$(96.22)	(7.48) %
164 - CMS 29 or More Days Length of Stay	1	1	1	$1,190.00	$1,190.00	$1,190.00	$2,981.67	$(1,791.67)	(60.09) %
4 - Morbidity 2	3	3	3	$4,598.07	$4,879.00	$4,598.07	$6,493.82	$(1,895.75)	(29.19) %
6 - Morbidity 4	2	2	2	$1,785.00	$1,785.00	$1,785.00	$4,488.06	$(2,703.06)	(60.23) %

End of Report

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3.5.31.1 DSSProfiler - Nursing Facility Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	20	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(B) Billed Quantity	Quantity billed.	14	Number (Integer)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)

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Field	Description	Length	Data Type
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-B) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Case Type Code and Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Top 10 Case Types: Dollar Difference	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character

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3.5.32 DSSProfiler - Outpatient Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all outpatient providers within a peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs on this report include:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All by Selected Age/Gender.

Alabama Medicaid Agency

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Provider Comparison

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	5	5		COUNTRY MEDICAL CLINIC	$2,100.00	$(200.00)	$0.00	$0.00	$0.00	*
2	1	1		TIM J BEAL	$400.00	$50.00	$50.00	$50.00	$0.00	*
3	1	1		GEORGE F WILSON	$15,000.00	$50.00	$50.00	$50.00	$0.00	*
4	4	4		NEW HORIZON REHAB CLINIC	$45.00	$13.11	$13.11	$13.11	$0.00	*
5	3	3	2003052195	JOHN D SMITH	$220.00	$17.00	$17.00	$17.00	$0.00	*
								2 STD DEV	$0.00	

End of Report

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Alabama Medicaid Agency

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

- COUNTRY MEDICAL CLINIC

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 18 - 20	F	1	$0.00
		AVG:	$0.00

- TIM J BEAL

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 35 - 64	M	1	$50.00
		AVG:	$50.00

Alabama Medicaid Agency

User ID:
Run Date: 10/4/2006
Run Time: 2:42:40 PM

Outpatient Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 709 - Injury/Poisoning Diagnosis
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Age 06 - 17

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
	NEW HORIZON REHAB CLINIC	$13.11
	AVG:	$13.11

Age 18 - 20

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
	COUNTRY MEDICAL CLINIC	$0.00
	AVG:	$0.00

3.5.32.1 DSSProfiler - Outpatient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this	13	Number (Decimal)

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Field	Description	Length	Data Type
	particular grouping of claims for this specific recipient.		
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Type	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	2	Character
(A,B,C) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical	20	Character

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Field	Description	Length	Data Type
	provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
(A,C) Provider ID	Provider identification number.	15	Character
(A,C) Provider Name	Provider's full name.	50	Character
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.33 DSSProfiler - Outpatient Case Type Comparison by Peer Group Quarterly

The Outpatient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which are the providers of asthma services who fall outside of the accepted 'norm' within the peer group.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All by Selected Age/Gender.

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:24:20 PM

Outpatient Case Type Comparison by Peer Group Qtrly
Provider Comparison

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1	[redacted]	TIM J BEAL - ALL NPI	$716.40	$320.21	$317.21	$264.01	$53.20	
2	3	6	[redacted]	GEORGE F WILSON - ALL NPI	$15,000.00	$50.00	$50.00	$50.00	$0.00	
3	2	2	[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$18,000.00	$150.00	$150.00	$150.00	$0.00	
4	3	4	[redacted]	NW GENERAL - ALL NPI	$525.60	$50.00	$50.00	$71.37	$(21.37)	
5	6	4	[redacted]	JILL E JANES - ALL NPI	$72.80	$21.37	$21.37	$71.37	$(50.00)	
6	5	3	[redacted]	DONALD B JONES - ALL NPI	$51.20	$25.60	$25.60	$78.80	$(53.20)	
								2 STD DEV	78.83	

End of Report

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Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:34:17 PM

Outpatient Case Type Comparison by Peer Group Qtrly

Average Amount per Recipient by Age/Gender
For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

[redacted] - TIM J BEAL - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 06 - 17	M	2	$105.40
Age 21 - 34	F	1	$36.74
Age 35 - 64	F	2	$22.08
		Avg:	$58.34

[redacted] - JILL E JANES - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 06 - 17	F	1	$21.37
		Avg:	$21.37

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Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:34:17 PM

Outpatient Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20044

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$50.00
	Avg:	$50.00

Age 06 - 17

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	JILL E JANES - ALL NPI	$21.37
[redacted]	NW GENERAL - ALL NPI	$50.00
	Avg:	$35.69

3.5.33.1 DSSProfiler - Outpatient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of provider's specialty peer group.	3	Number (Decimal)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Provider ID	Provider identification number.	15	Character
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,,C) Provider Name	Provider's full name.	50	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character

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Field	Description	Length	Data Type
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.34 DSSProfiler - Outpatient Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all outpatient case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are tabs in this report:

A. Outpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Outpatient Claim Details By Provider - FFS

Outpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

ICN	CT	POS	Dtl #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt
1234567890123	O	22	10	12345678901 2	XXXXXXXX XXXX, XXXXXXXX XXXXXXX,	MM/DD/YYYY	22	7/27/2015	7/27/2015	9	V252	STERILIZATIO N	9	75982	WARFAIN SYNDROME	58670	Laparoscopi Tubal Cauter	LT	LEFT SIDE	RT	RIGHT SIDE	# #	UNKNOWN or Not Applicable	1	########	$333.94	$333.94
1234567890123	O	22	13	12345678901 2	XXXXXXXX XXXX, XXXXXXXX XXXXXXX,	MM/DD/YYYY	24	8/8/2015	8/8/2015	9	9170	ABRASION OR FRICTION BURN OF FOOT AND TO	9	9160	ABRASION OR FRICTION BURN OF HIP, THIGH,	73630	X-Ray Exam Of Foot	LT	LEFT SIDE	RT	RIGHT SIDE	# #	UNKNOWN or Not Applicable	1	$706.00	$15.16	$15.16
1234567890123	O	22	14	12345678901 2	XXXXXXXX XXXX, XXXXXXXX XXXXXXX,	MM/DD/YYYY	24	8/8/2015	8/8/2015	9	9170	ABRASION OR FRICTION BURN OF FOOT AND TO	9	9160	ABRASION OR FRICTION BURN OF HIP, THIGH,	73610	X-Ray Exam Of Ankle	LT	LEFT SIDE	RT	RIGHT SIDE	# #	UNKNOWN or Not Applicable	1	$704.00	$15.16	$15.16

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

Outpatient Claim Details By Provider - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	3210

End of Report

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

Outpatient Claim Details By Provider - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
0	B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	0	B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	#	####### - Unknown or Not Appl.	6	6
0	B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	0	K219 - GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS	0	B20 - HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	1	1
0	B349 - VIRAL INFECTION, UNSPECIFIED	0	M791 - MYALGIA	0	R918 - OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD	1	1

End of Report

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D

Alabama Medicaid Agency

Outpatient Claim Details By Provider - FFS

Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

User ID: [redacted]
Run Date: 7/11/16
Run Time: 2:37:19 PM

Procedure Code & Description	ICN Count	Recipient Count
11043 - Deb Musc/Fascia 20 Sq Cm/<	1	1
11044 - Deb Bone 20 Sq Cm/<	1	1
11100 - Biopsy Skin Lesion	2	2
11424 - Exc H-F-Nk-Sp B9+Marg 3.1-4	1	1
13151 - Cmplx Rpr E/N/E/L 1.1-2.5 Cm	1	1
14060 - Tis Trnfr E/N/E/L 10 Sq Cm/<	1	1
17106 - Destruction Of Skin Lesions	3	3

End of Report

3.5.34.1 DSSProfiler - Outpatient Claim Details by Provider - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character

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Field	Description	Length	Data Type
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.35 DSSProfiler - Outpatient Claim Details by Provider Quarterly - FFS

Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all outpatient case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are tabs in this report:

A. Outpatient Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Outpatient Claim Details By Provider Qtrly - FFS

Outpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

Quarter: 20153

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

ICN	CT	POS	Dtl #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt
123456789012 3	O	22	4	123456789012	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXX, X	MM/DD/YYYY	64	8/14/2015	8/14/2015	9	7202	SACROILITIS, NOT ELSEWHERE CLASSIFIED	9	72252	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	27096	INJ SACROILIAC JOINT	R T	RIGHT SIDE	L T	LEFT SIDE	# #	Unknown or not Applicable	1	#######	$217.05	$217.05

End of Report

PHI has been removed

B

Alabama Medicaid Agency

Outpatient Claim Details By Provider Qtrly - FFS

Recipient Listing

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: UNIVERSITY OF ALABAMA

For Claim Types: O

Quarter: 20153

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X	3032

End of Report

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C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PM

Outpatient Claim Details By Provider Qtrly - FFS

Diagnosis Listing

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: O
Quarter: 20153

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	#	####### - Unknown or Not Appl.	50	49
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	07070 - UNSPECIFIED VIRAL HEPATITIS C W/O HEPATI	9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	1	1
9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	9	2724 - OTHER AND UNSPECIFIED HYPERLIPIDEMIA	9	042 - HUMAN IMMUNODEFINCIENCY VIRUS HIV DISEAS	1	1

End of Report

D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/11/16
Run Time: 5:44:16 PI

Outpatient Claim Details By Provider Qtrly - FFS

Procedure Listing

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: UNIVERSITY OF ALABAMA
For Claim Types: O
Quarter: 20153

Procedure Code & Description	ICN Count	Recipient Count
11043 - Deb Musc/Fascia 20 Sq Cm/<	1	1
11044 - Deb Bone 20 Sq Cm/<	1	1
11100 - Biopsy Skin Lesion	2	2
11424 - Exc H-F-Nk-Sp B9+Marg 3.1-4	1	1
13151 - Cmplx Rpr E/N/E/L 1.1-2.5 Cm	1	1
14060 - Tis Trnfr E/N/E/L 10 Sq Cm/<	1	1
17106 - Destruction Of Skin Lesions	3	3

End of Report

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3.5.35.1 DSSProfiler - Outpatient Claim Details by Provider Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character

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Field	Description	Length	Data Type
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) Quarter (prompt)	The quarter for which the report is being run.	5	Number

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Field	Description	Length	Data Type
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.36 DSSProfiler - Outpatient Disease Quick View

This report is created in the DSSProfiler. The report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can also be used for disease management. The first row gives the totals for each column.

There are tabs in this report:

A. Outpatient Disease; and

B. Outpatient Disease By Peer Group.

Alabama Medicaid Agency

User ID:
Run Date: 8/6/2006
Run Time: 9:27:01 PM

Outpatient Disease Quick View
Outpatient Disease
For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
12	1	12	12	$2,683.20	$711.45	$711.45
2	2	4	4	$156.80	$35.50	$35.50
5	3	15	15	$18,721.60	$453.74	$453.74
4	4	16	16	$5,811.20	$(95.34)	$404.66
2	5	10	10	$32,478.60	$475.94	$475.94
2	6	12	12	$8,287.80	$418.68	$194.50
1	9	9	9	$305.60	$25.19	$21.69
1	10	10	10	$2,000.00	$0.00	$0.00
1	33	33	33	$12,000.00	$1,588.39	$1,077.39
1	37	37	37	$20,200.00	$(1,600.00)	$0.00
Totals:			158	$2,683.20	$2,013.55	$3,374.87

End of Report

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Alabama Medicaid Agency

Outpatient Disease Quick View

Outpatient Disease By Peer Group

For Dates of Service: 10/01/2004 - 09/30/2005

Case Type: 1 - All Claim Groupings

Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: [redacted]
Run Date: 8/6/2006
Run Time: 9:27:01 PM

Peer Group: 504 - Blank Aid Category

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
5	1	5	5	$1,757.80	$147.46	$147.46
6	2	12	12	$12,771.20	$175.19	$275.19
2	3	6	6	$3,735.00	$50.00	$38.00
1	4	4	4	$4,800.00	$(400.00)	$0.00
1	10	10	10	$2,000.00	$0.00	$0.00
Totals:			37	$25,064.00	$(27.35)	$460.65

Peer Group: 508 - Presumptive Eligible

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	1	1	1	$115.00	$94.40	$94.40
Totals:			1	$115.00	$94.40	$94.40

3.5.36.1 DSSProfiler - Outpatient Disease Quick View Field Descriptions

Field	Description	Length	Data Type
(A-B) Paid Amount	This is the total amount paid by the program for the specific claim grouping.	13	Number (Decimal)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
(A-B) Each Recipient Had XX Claims	This field shows us how many claims each of the recipients had.	4	Character
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Total Claims	This is the total number of claims billed based on the number of recipients and the number of claims each recipient had.	9	Number (Integer)
(A-B) Total Quantity Billed	This is the total units billed for this particular claim category.	9	Number (Integer)
(A-B) Unduplicated Recipients	This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once.	9	Number (Integer)
(B) Peer Group	Peer Group Code and Description.	7	Character

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3.5.37 DSSProfiler - Outpatient Distribution Analysis

This report shows totals for all outpatient case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norms compared to their peers.

There are tabs in this report:

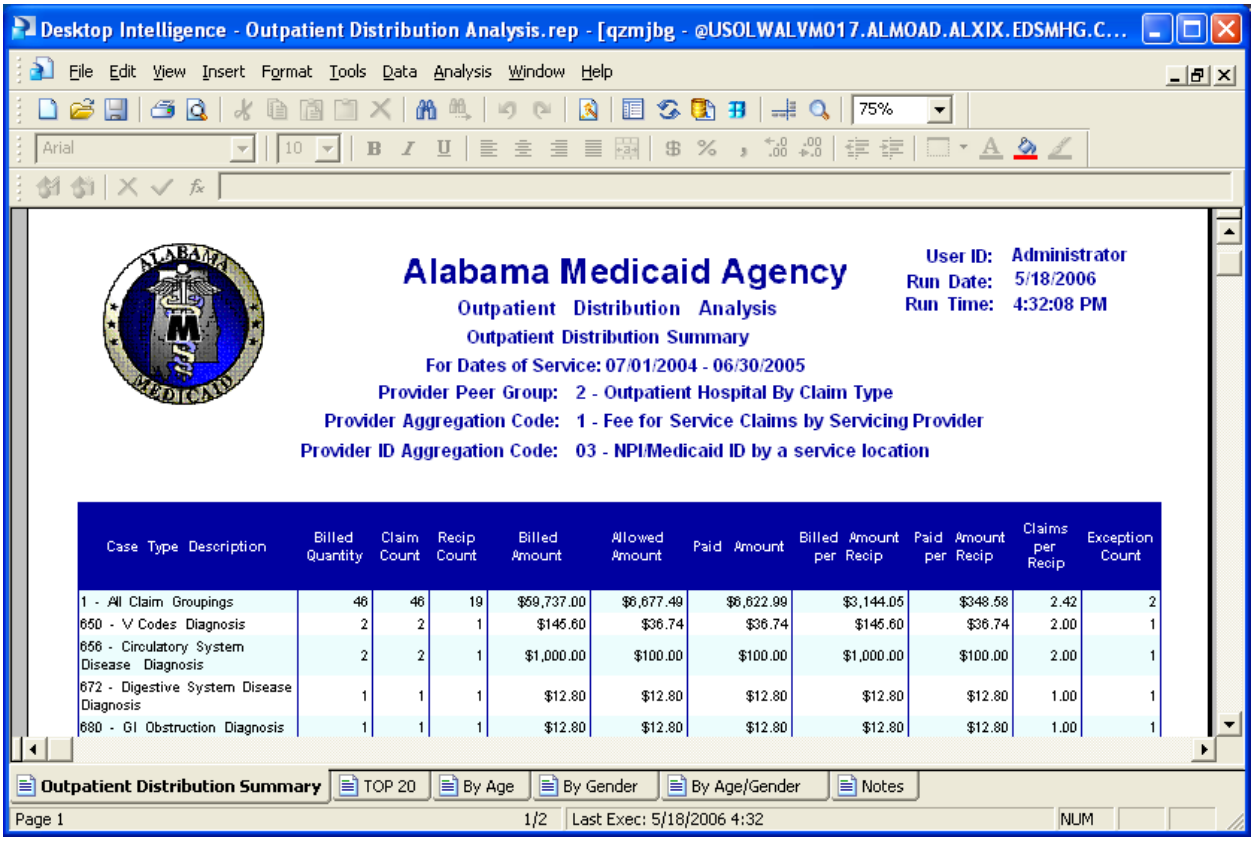
A. Outpatient Distribution Summary;

B. TOP 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.



Case Type Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Paid Amount per Recip	Claims per Recip	Exception Count
1 - All Claim Groupings	46	46	19	$59,737.00	$6,677.49	$6,622.99	$3,144.05	$348.58	2.42	2
650 - V Codes Diagnosis	2	2	1	$145.60	$36.74	$36.74	$145.60	$36.74	2.00	1
656 - Circulatory System Disease Diagnosis	2	2	1	$1,000.00	$100.00	$100.00	$1,000.00	$100.00	2.00	1
672 - Digestive System Disease Diagnosis	1	1	1	$12.80	$12.80	$12.80	$12.80	$12.80	1.00	1
680 - GI Obstruction Diagnosis	1	1	1	$12.80	$12.80	$12.80	$12.80	$12.80	1.00	1

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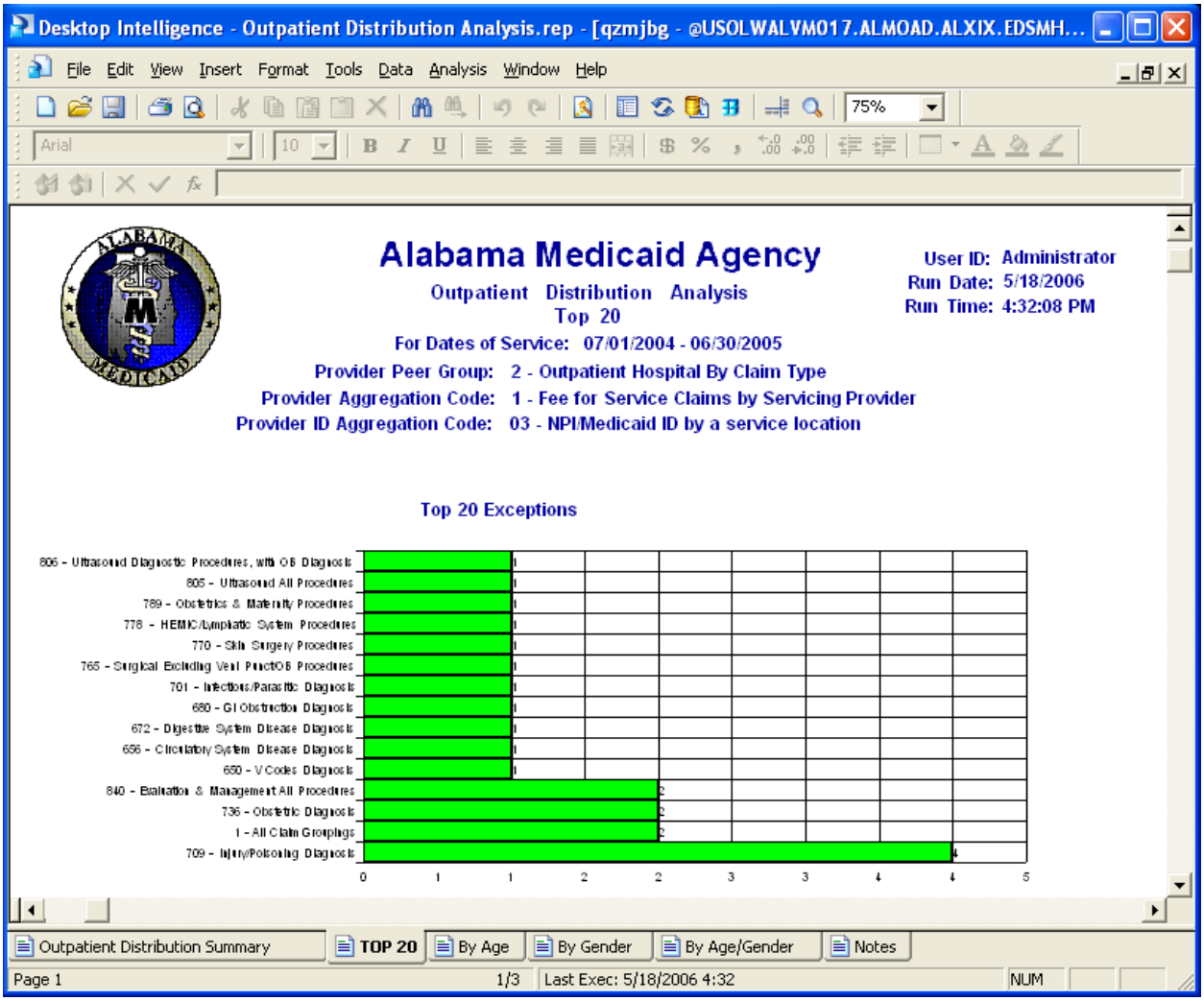

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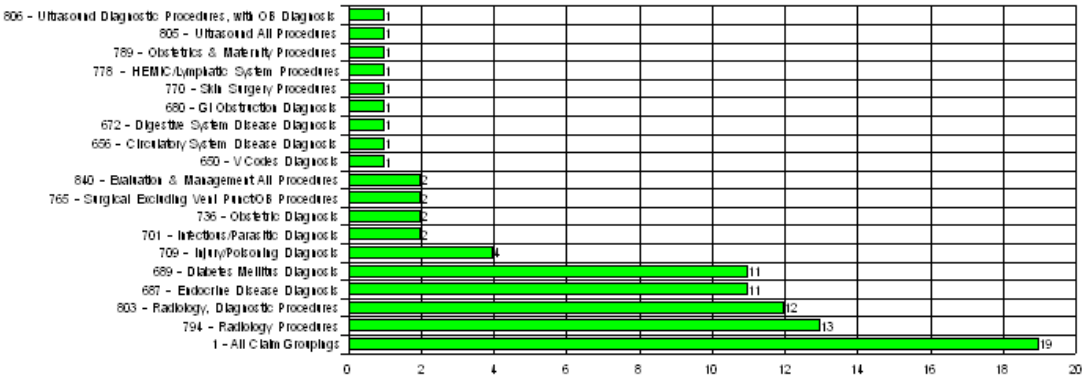
Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20
For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Number of Recipients

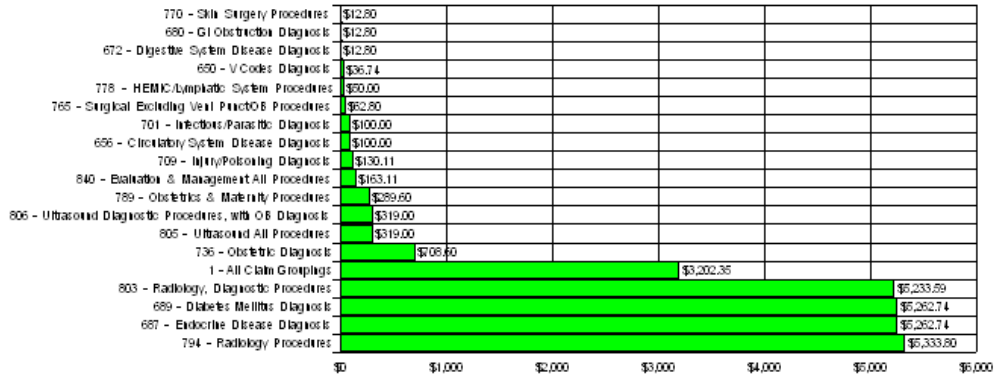


Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20
For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Paid Amount per Recipient



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File Edit View Insert Format Tools Data Analysis Window Help

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis By Age

For Dates to Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 00 - 05	9	9	5	$30,291.20	$10,320.96	$10,320.96	$6,058.24	$2,064.19	$2,064.19	1.80
Age 06 - 17	35	35	17	$5,866.80	$1,444.44	$1,444.44	$345.11	$84.97	$84.97	2.06
Age 21 - 34	32	32	13	$4,275.40	$1,667.91	$1,666.41	$328.88	$128.30	$128.19	2.46
Age 35 - 64	38	38	11	$2,262.40	$353.17	$342.67	$205.67	$32.11	$31.15	3.45
Age 65+	12	12	6	$129,375.00	$459.00	$307.50	$21,562.50	$76.50	$51.25	2.00
Sum:	126	126	52	$172,070.80	$14,245.48	$14,081.98	$28,500.40	$273.95	$2,359.75	11.77

Case Type: 650 - V Codes Diagnosis

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 21 - 34	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00
Sum:	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00

Outpatient Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

Page 1 1/10 Last Exec: 5/18/2006 4:32 NUM

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File Edit View Insert Format Tools Data Analysis Window Help

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis By Gender

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1 - All Claim Groupings

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
F	92	92	30	$85,125.80	$12,886.26	$12,874.26	$2,837.53	$429.54	$429.14	3.07
M	34	34	22	$86,945.00	$1,359.22	$1,207.72	$3,952.05	$61.78	$54.90	1.55
Sum:	126	126	52	$172,070.80	$14,245.48	$14,081.98	$6,789.57	$273.95	$484.04	4.61

Case Type: 650 - V Codes Diagnosis

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
F	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00
Sum:	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00

Outpatient Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

Page 1 1/8 Last Exec: 5/18/2006 4:32 NUM

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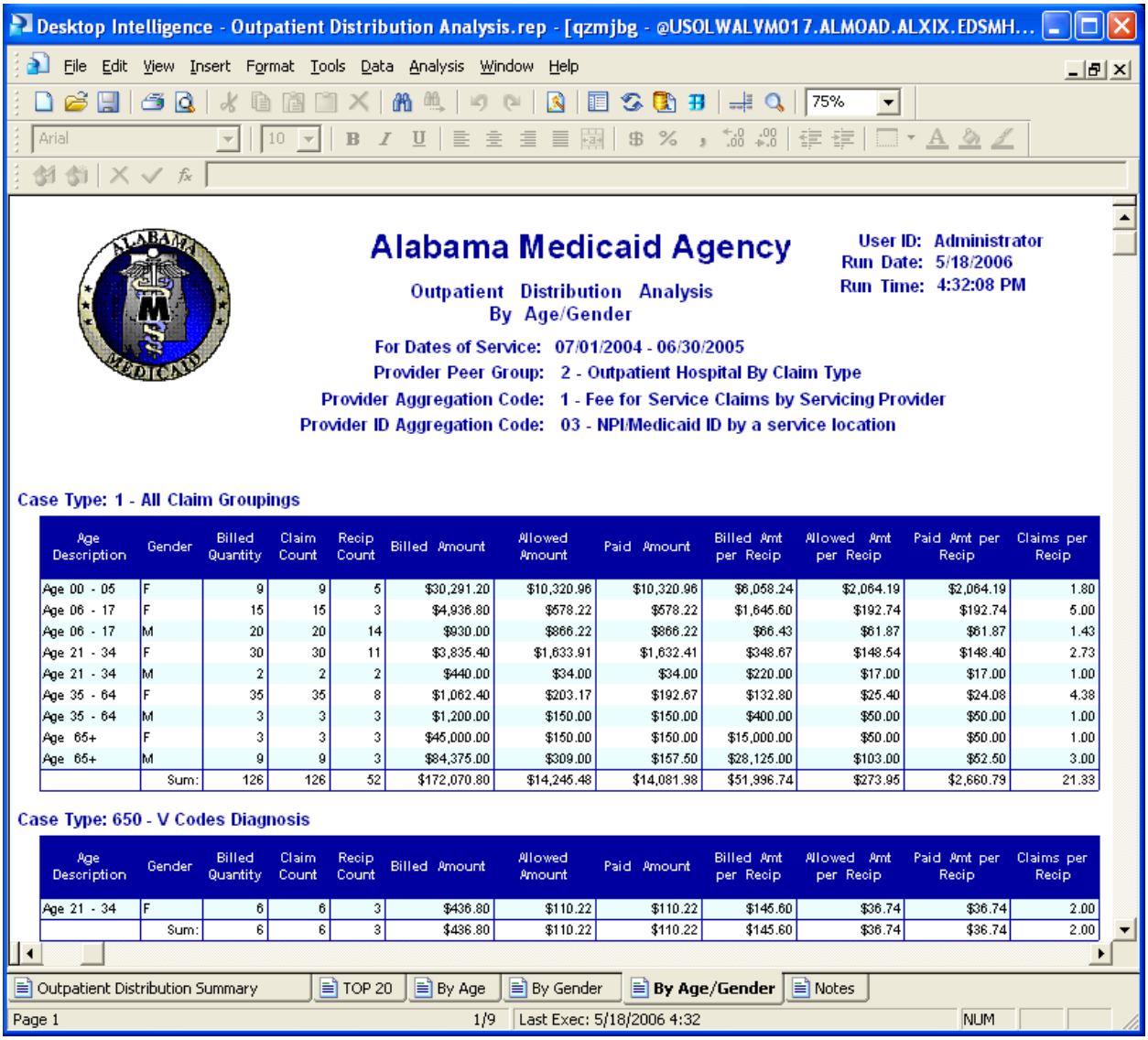

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 00 - 05	F	9	9	5	$30,291.20	$10,320.96	$10,320.96	$6,058.24	$2,064.19	$2,064.19	1.80
Age 06 - 17	F	15	15	3	$4,936.80	$578.22	$578.22	$1,645.60	$192.74	$192.74	5.00
Age 06 - 17	M	20	20	14	$930.00	$866.22	$866.22	$66.43	$61.87	$61.87	1.43
Age 21 - 34	F	30	30	11	$3,835.40	$1,633.91	$1,632.41	$348.67	$148.54	$148.40	2.73
Age 21 - 34	M	2	2	2	$440.00	$34.00	$34.00	$220.00	$17.00	$17.00	1.00
Age 35 - 64	F	35	35	8	$1,062.40	$203.17	$192.67	$132.80	$25.40	$24.08	4.38
Age 35 - 64	M	3	3	3	$1,200.00	$150.00	$150.00	$400.00	$50.00	$50.00	1.00
Age 65+	F	3	3	3	$45,000.00	$150.00	$150.00	$15,000.00	$50.00	$50.00	1.00
Age 65+	M	9	9	3	$84,375.00	$309.00	$157.50	$28,125.00	$103.00	$52.50	3.00
	Sum:	126	126	52	$172,070.80	$14,245.48	$14,081.98	$51,996.74	$273.95	$2,660.79	21.33

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 21 - 34	F	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00
	Sum:	6	6	3	$436.80	$110.22	$110.22	$145.60	$36.74	$36.74	2.00

3.5.37.1 DSSProfiler - Outpatient Distribution Analysis Field Descriptions

Field	Description	Length	Data Type
(A) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A) Exception Count	Number of exceptions identified. An exception is defined as two standard deviations from the norm.	8	Number (Integer)
(A,C,D,E) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,C,D,E) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A,C,D,E) Billed Amount per Recip	Total billed amount divided by the number of recipients.	12	Number (Decimal)
(A,C,D,E) Billed Quantity	Quantity billed.	14	Number (Integer)
(A,C,D,E) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A,C,D,E) Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,C,D,E) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,C,D,E) Paid Amount (Amt) per Recip	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(A,C,D,E) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-E) Provider Aggregation Code	Aggregation Code and Description.	100	Character
(A-E)Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-E) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Top 20 By Number of Recipients	Graph shows Top 20 exceptions by number of recipients.	1	Character
(B) Top 20 By Paid Amount per Recipient	Graph shows Top 20 exceptions by paid amount per recipient.	1	Character
(B) Top 20 Exceptions	Graph shows Top 20 exceptions.	1	Character
(C,D,E) Allowed Amt Per Recip	Total allowed amount divided by the number of recipients.	13	Number (Decimal)

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Field	Description	Length	Data Type
(C,E) Age Description	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(D,E) Gender	Recipient's gender.	1	Character

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3.5.38 DSSProfiler - Outpatient Exception Quarterly

The Outpatient Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. Case group calculations that are above the exception high value are marked as exceptions.

Alabama Medicaid Agency

Outpatient Exception Quarterly

For Dates of Service: 10/01/2004 - 09/30/2005

User ID: [redacted]
Run Date: 8/28/2006
Run Time: 10:46:36 AM

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: TIM J BEAL
Type: 31 - Physician
Specialty: 318 - General Practitioner
Address: PO BOX 3466

SALEM, OR 97501

Peer Group Code: 228 - 318 GENERAL PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

	20051	
710 - Excessive Outpatient Hospital/ER Visits; H: 002 L: 000	2.00	
720 - Excessive Outpatient Hospital/ER Visits per Recipient; H: 002 L: 000	2.00	

End of Report

3.5.38.1 DSSProfiler - Outpatient Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Case Type Group Display	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Character
Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients	20	Character

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Field	Description	Length	Data Type
	within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Service Location Information	Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID.	200	Character

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3.5.39 DSSProfiler - Outpatient Frequency Distribution

The Outpatient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each outpatient case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:31:51 PM

Outpatient Frequency Distribution

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 650 - V Codes Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Case Type : 656 - Circulatory System Disease Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	33	33	33	33	33	33

Case Type : 661 - Heart Disease Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	31	31	31	31	31	31

Case Type : 672 - Digestive System Disease Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

3.5.39.1 DSSProfiler - Outpatient Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)

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Field	Description	Length	Data Type
Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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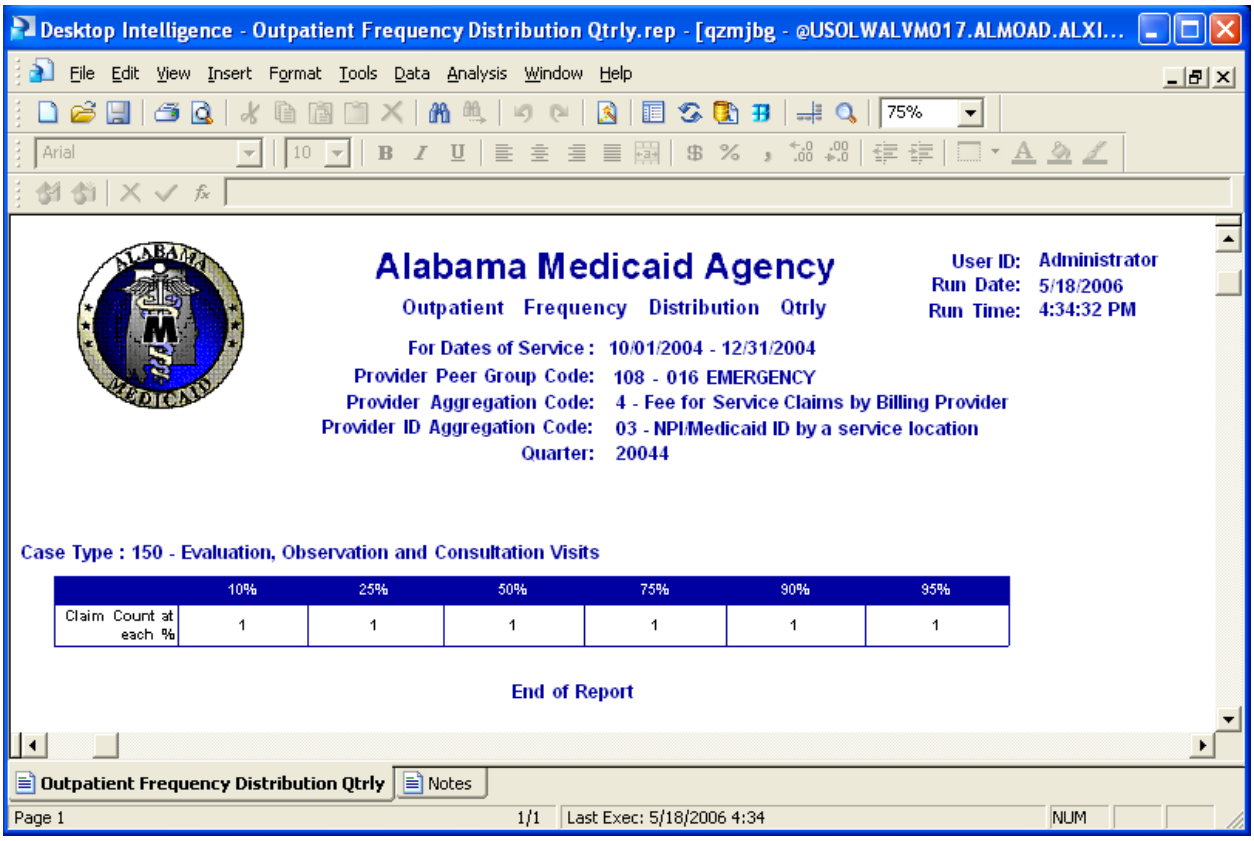
3.5.40 DSSProfiler - Outpatient Frequency Distribution Quarterly

The Outpatient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report shows for each outpatient case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th, and 95th percentiles based on the number of providers reported within a case type, peer grouping.



3.5.40.1 DSSProfiler - Outpatient Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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3.5.41 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group

Outpatient Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which ones fall outside of service dollar norms for outpatient claims. All information is age and gender adjusted so that differences in patient mix do not affect the results. Individuals who have two standard deviations above the norm for the peer group are highlighted.

There are tabs in this report:

A. Recipient Comparison; and

B. Recipient Grouped by Age/Gender.

A

Alabama Medicaid Agency

Outpatient Recipient Case Type Comparison by Peer Group
Recipient Comparison
For Dates of Service: 01/01/2006 - 12/31/2006

User ID:
Run Date: 9/20/2007
Run Time: 3:31:40 PM

Case Type: 385 - AL Hospice RT Procedures
Recipient Peer Group: 925 - 11 Aged-SSI-full Medicaid coverage
Aggregation Code: 7 - Fee For Service Claims by Recipient

Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference From Expected	Exception
2			$7,206.88	$7,206.88	$7,206.88	$5,189.46	$2,017.42	
1			$16,089.00	$10,237.44	$10,237.44	$10,237.44	$0.00	
3			$7,183.36	$7,183.36	$7,183.36	$7,402.99	$(219.63)	
4			$2,941.64	$2,941.64	$2,941.64	$6,911.81	$(3,970.17)	
						2 STD DEV	$4,324.43	

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/20/2007
Run Time: 3:31:40 PM

Outpatient Recipient Case Type Comparison by Peer Group

Recipient Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 385 - AL Hospice RT Procedures

Recipient Peer Group: 925 - 11 Aged-SSI-full Medicaid coverage

Aggregation Code: 7 - Fee For Service Claims by Recipient

Age 65+

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$7,206.88	$7,206.88	$7,206.88
[redacted]	[redacted]	$7,183.36	$7,183.36	$7,183.36
			Sum:	$14,390.24

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$2,941.64	$2,941.64	$2,941.64
[redacted]	[redacted]	$16,089.00	$10,237.44	$10,237.44
			Sum:	$13,179.08

3.5.41.1 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group.	1	Number (Integer)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(A,B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the service.	13	Number (Decimal)

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3.5.42 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Recipient Comparison; and

B. Recipient Grouped by Age/Gender.

A

Alabama Medicaid Agency

Outpatient Recipient Case Type Comparison By Peer Group Qtrly

User ID: [redacted]
Run Date: 9/20/2007
Run Time: 8:34:22 AM

Recipient Comparison

For Dates of Service: 04/01/2006 - 06/30/2006

Case Type: 1090 - AL Number of Drug Poison Diagnoses
Peer Group Code: 826 - 30 MLIF-Child + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Quarter: 20062

Rank	Expected Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	[redacted]	[redacted]	$529.00	$72.29	$72.29	$72.12	$0.17	
3	3	[redacted]	[redacted]	$82.40	$38.36	$38.36	$38.36	$0.00	
3	3	[redacted]	[redacted]	$465.30	$38.36	$38.36	$38.36	$0.00	
2	1	[redacted]	[redacted]	$719.15	$71.94	$71.94	$72.12	$(0.18)	
							2 STD DEV	$0.25	

End of Report

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B

Alabama Medicaid Agency

Outpatient Recipient Case Type Comparison By Peer Group Qtrly

Recipients Grouped by Age/Gender
For Dates of Service: 04/01/2006 - 06/30/2006

User ID: [redacted]
Run Date: 9/20/2007
Run Time: 8:34:22 AM

Case Type: 1090 - AL Number of Drug Poison Diagnoses
Peer Group Code: 826 - 30 MLIF-Child + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Quarter: 20062

Age 00 - 05

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$719.15	$71.94	$71.94
[redacted]	[redacted]	$529.00	$72.29	$72.29
			Sum:	$144.23

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$465.30	$38.36	$38.36
			Sum:	$38.36

3.5.42.1 DSSProfiler - Outpatient Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Aggregation Code and Description.	100	Character

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Field	Description	Length	Data Type
(A,B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient identification number.	8	Character
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)

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3.5.43 DSSProfiler - Outpatient Provider Profile

The Outpatient Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the outpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and genders adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Outpatient Services - Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code is the code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIOI
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Provider Information

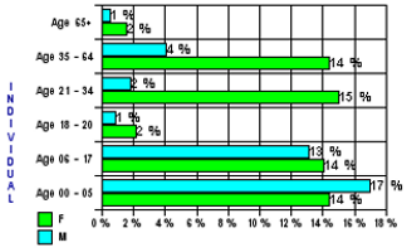
NPI ID:
Mcaid ID:
Base ID:
Name: CORRECT CARE INC - ALL BSE
Type: 31 - Physician
Specialty: 315 - Emergency Medicine Practitioner
Address: 1910 CHEROKEE AVE SW

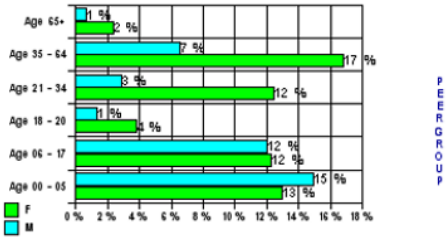
CULLMAN, AL 35055

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIOI
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Provider's General Service Profile

Service Type	Recip Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
6 - Outpatient Referrals	311	$43,940.28	$316,224.88	$20,787.14	$26,466.04	$(5,678.90)	(21.46) %

End of Report

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B

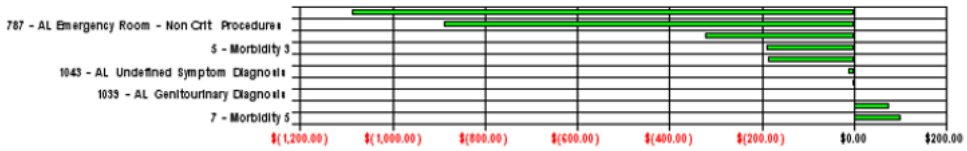
Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Outpatient Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIONER
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 12:36:38 PM

Outpatient Provider Profile
Outpatient Services

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 449 - 315 EMERGENCY MEDICINE PRACTITIONER
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type	Recip Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
7 - Morbidity 5	7	34	34	$969.78	$18,989.35	$947.68	$846.91	$100.77	11.90 %
804 - AL Surgical Procedures	1	1	1	$258.57	$1,487.00	$258.57	$181.81	$76.76	42.22 %
1039 - AL Genitourinary Diagnosis	2	2	2	$172.00	$3,440.00	$0.00	$0.00	$0.00	0.00 %
1042 - AL Injury Diagnosis	3	3	3	$538.05	$10,761.15	$0.00	$1.17	$(1.17)	(100.00) %
1043 - AL Undefined Symptom Diagnosis	5	6	6	$862.60	$17,900.05	$0.00	$11.93	$(11.93)	(100.00) %
880 - AL Lab Procedures	97	317	334	$3,176.05	$46,602.95	$3,074.41	$3,259.77	$(185.36)	(5.69) %
5 - Morbidity 3	41	146	174	$3,880.63	$40,128.58	$3,775.43	$3,965.05	$(189.62)	(4.78) %
831 - AL Respiratory Procedures	24	25	25	$175.61	$3,740.63	$175.61	$498.59	$(322.98)	(64.78) %
787 - AL Emergency Room - Non Crit Procedures	296	310	310	$11,699.14	$147,572.02	$11,592.42	$12,481.16	$(888.74)	(7.12) %
794 - AL Radiology Procedures	118	157	157	$3,418.93	$88,407.32	$3,244.90	$4,332.00	$(1,087.10)	(25.09) %
3 - Morbidity 1	137	334	334	$8,921.70	$117,631.40	$7,806.75	$8,918.76	$(1,112.01)	(12.47) %
6 - Morbidity 4	52	147	157	$4,203.70	$63,282.11	$3,188.81	$5,352.62	$(2,163.81)	(40.43) %
4 - Morbidity 2	74	201	212	$5,663.52	$76,193.44	$5,068.47	$7,382.56	$(2,314.09)	(31.35) %

End of Report

3.5.43.1 DSSProfiler - Outpatient Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) Service Type	User defined group based on the service type file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Quantity	Quantity billed.	8	Number (Integer)

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3.5.44 DSSProfiler - Outpatient Provider Profile Quarterly

The Outpatient Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the outpatient provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Outpatient Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared;
- Aggregation Code is the code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.

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A

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

Outpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Provider Information

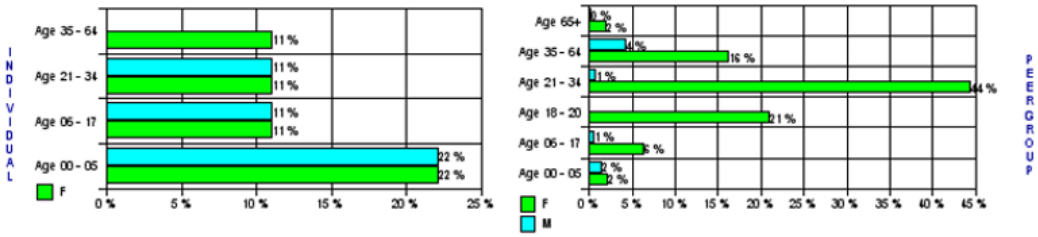
NPI ID:
Mcaid ID:
Base ID:
Name: WALTERS, WILLIAM S
Type: 31 - Physician
Specialty: 328 - Obstetrician/Gynecologist
Address: 2505 HWY 431

BOAZ, AL 35957

Rank

$ Paid Amount Actual	192
$ Paid Amount Expected	159
$ Billed Amount Actual	52
Recipient Rank	163
# Units Rank	189
# Claims Rank	121
Peer Group Size	606

Patient Age/Gender Breakdown



Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 5:00:17 PM

Outpatient Provider Profile Qtrly
Provider Summary
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Provider's General Service Profile

Report Category	Recipient Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
6 - Outpatient Referrals	9	$1,995.99	$19,290.50	$1,325.12	$1,801.55	$(476.43)	(26.45) %

End of Report

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B

Alabama Medicaid Agency

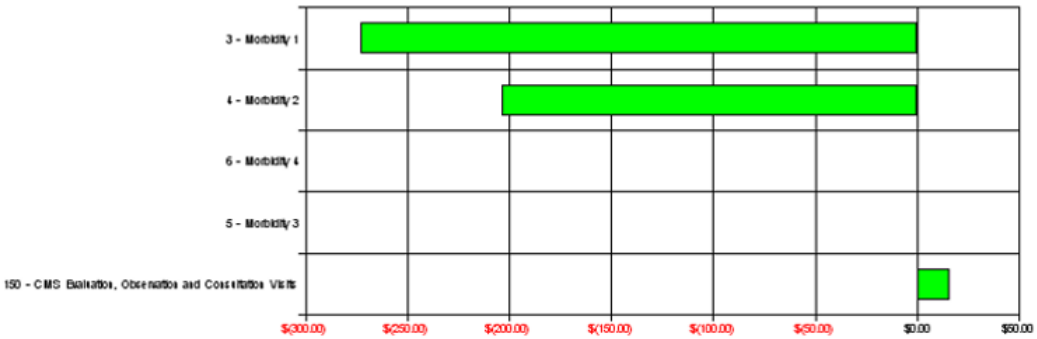
Outpatient Provider Profile Qtrly

Outpatient Services

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238 - 328 OBSTETRICIAN/GYNECOLOGIST
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

Outpatient Provider Profile Qtrly

Outpatient Services

User ID:
Run Date: 9/27/2007
Run Time: 4:09:22 PM

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 238 - 328 OBSTETRICIAN/GYNECOLOGIST
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20061

Case Type Code & Description	Recipient Count	Claim Count	Billed Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
150 - CMS Evaluation, Observation and Consultation \	9	9	9	$664.87	$3,006.50	$658.87	$642.86	$16.01	2.49 %
5 - Morbidity 3	1	11	12	$840.57	$15,991.50	$840.57	$840.57	$0.00	0.00 %
6 - Morbidity 4	1	2	2	$84.58	$475.00	$84.58	$84.58	$0.00	0.00 %
4 - Morbidity 2	2	3	3	$92.02	$638.00	$89.02	$292.48	$(203.46)	(69.56) %
3 - Morbidity 1	5	12	13	$313.95	$2,186.00	$310.95	$583.92	$(272.97)	(46.75) %

3.5.44.1 DSSProfiler - Outpatient Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the NPI ID, Mcaid ID, Base ID, Name, Type, Specialty and Address.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A-D) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Provider ID	Provider identification number.	13	Character
(A-D) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-D) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-D) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(B) Report Category	User-defined variables used to categorize case types into service groups.	21	Character

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Field	Description	Length	Data Type
(B,D) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(B,D) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(B,D) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(B,D) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(B,D) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(B,D) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(C) Top 10 Case Types: Dollar Difference	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider.	60	Character
(D) Billed Quantity	Quantity billed.	14	Number (Integer)
(D) Case Type Code Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(D) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(D) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)

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3.5.45 DSSProfiler - Pharmacy Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all pharmacy providers within a peer group to determine which providers fall outside of service dollar norms for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

Alabama Medicaid Agency

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group

Provider Comparison

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	3	4		GAVINO, REY S - ALL BSE	$218.71	$199.33	$189.33	$74.62	$114.71	
2	1	1		KRISHNASAMI, ZIPPORAH - ALL BSE	$1,076.73	$840.02	$796.34	$695.86	$100.48	
3	2	2		RETAN, J WALDEN - ALL BSE	$481.41	$361.49	$351.25	$453.87	$(102.62)	
4	4	3		UT PHYSICIANS - ALL BSE	$148.82	$114.53	$110.53	$223.11	$(112.58)	
								2 STD DEV	$248.89	

B

Alabama Medicaid Agency

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group

Average Amount per Recipient by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

- KRISHNASAMI, ZIPPORAH - ALL BSE

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 00 - 05	F	1	$69.46
Age 00 - 05	M	1	$100.33
Age 06 - 17	F	1	$31.21
Age 18 - 20	F	1	$27.12
Age 35 - 64	F	4	$117.33
Age 35 - 64	M	1	$7.80
Age 65+	F	5	$18.22
		AVG:	$56.88

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C

Alabama Medicaid Agency

User ID:
Run Date: 11/14/2007
Run Time: 8:24:43 AM

Pharmacy Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 454 - 320 GERIATRIC PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
	UT PHYSICIANS - ALL BSE	$7.25
	RETAN, J WALDEN - ALL BSE	$7.58
	KRISHNASAMI, ZIPPORAH - ALL BSE	$69.46
	AVG:	$22.97

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
	RETAN, J WALDEN - ALL BSE	$54.00
	KRISHNASAMI, ZIPPORAH - ALL BSE	$100.33
	AVG:	$77.16

3.5.45.1 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)

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Field	Description	Length	Data Type
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,C) Provider ID	Provider identification number.	15	Character
(A,C) Provider Name	Provider's full name.	50	Character
(A-C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-C) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient’s gender.	1	Character
(B,C) Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(C) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)

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3.5.46 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Quarterly

The Pharmacy Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender.

A

Alabama Medicaid Agency

User ID:
Run Date: 11/14/2007
Run Time: 8:39:54 AM

Pharmacy Case Type Comparison by Peer Group Qtrly
Provider Comparison

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	7	15		TUTEN, HARRY L - ALL BSE	$91.50	$53.16	$53.16	$26.22	$26.94	*
2	4	5		HUNTSVILLE MADISON MH C - ALL BSE	$103.90	$80.42	$80.42	$55.34	$25.08	*
3	6	6		ELRICK, WILLIAM A - ALL BSE	$59.30	$56.05	$56.04	$44.26	$11.78	
4	13	20		EVANS, ANGIE C - ALL BSE	$32.83	$23.69	$23.69	$14.36	$9.33	
5	8	12		ELLIS, DARYL A - ALL BSE	$40.25	$40.25	$40.25	$32.71	$7.54	
6	2	2		PEDIATRIC PRACTICE - ALL BSE	$372.03	$199.65	$160.55	$154.70	$5.85	
7	10	13		MEDICAL CENTERPHARMACY - ALL BSE	$41.01	$32.48	$32.48	$27.86	$4.62	
8	15	18		KAUFMAN, LORI E - ALL BSE	$25.01	$21.76	$21.76	$17.29	$4.47	
9	18	17		PILKINTON, JAMES C - ALL BSE	$27.19	$18.06	$18.06	$18.06	$0.00	
10	21	22		DECARLO, DAWN - ALL BSE	$12.99	$12.61	$12.61	$12.61	$0.00	

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 8:39:54 AM

Pharmacy Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient by Age/Gender

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

[redacted] - BARKSDALE, NANCY L - ALL BSE

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 35 - 64	F	9	$24.86
Age 35 - 64	M	2	$17.61
Age 65+	F	3	$19.14
Age 65+	M	1	$14.42
		AVG:	$22.05

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 8:39:54 AM

Pharmacy Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 01/01/2006 - 03/31/2006
Case Type: 167 - CMS Addictive Drugs by AHFS Class
Provider Peer Group: 255 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	ELLIS, DARYL A - ALL BSE	$33.46
[redacted]	JEFFERSON COUNTY DEPT OF HLT	$10.80
[redacted]	MEDICAL CENTERPHARMACY - ALL	$32.48
[redacted]	ELRICK, WILLIAM A - ALL BSE	$56.04
[redacted]	ASSAAD, SAMER - ALL BSE	$17.02
[redacted]	MORGAN, LEATHA B - ALL BSE	$32.48
[redacted]	BRIGHTSTARTS PEDIATRICS PC - A	$9.11
	AVG:	$24.36

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3.5.46.1 DSSProfiler - Pharmacy Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the service.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID	Provider identification number.	15	Character
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations	40	Character

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Field	Description	Length	Data Type
	and 03 NPI/Medicaid ID by service location.		
(A,B,C) Provider Name	Provider's full name.	50	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A.B.C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(C) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)

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3.5.47 DSSProfiler - Pharmacy Claim Details by Provider

This report lets the user drill down to the detail level for all pharmacy case types for a given provider and service location and billing provider ID. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

There are tabs in this report:

A. Pharmacy Claim Details;

B. Recipient Listing; and

C. NDC Listing.

A

Alabama Medicaid Agency

Pharmacy Claim Details By Provider
Pharmacy Claim Details

For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:14:47 PM

For Claim Types: P and Q

ICN	C T	Dtl #	Dispensed Dte	NDC	NDC Desc	DEA	GPI	GCN	AHFS	AHFS Therapeutic Class Desc	Recip ID	Recip Name	Age	POt	Dispense Qty	Billed Amt	Alwd Amt	Paid Amt
[redacted]	P	1		65162056650	IBUPROFEN	0	1	35742	28000492	OTHER NONSTEROIDAL ANTI-INFLAM. AGENTS				00	30.000	$13.75	$6.73	$6.73
[redacted]	P	1		00406053205	OXYCODONE-ACETAMIN OPHEN	2	1	70600	28000600	OPIATE AGONISTS				00	30.000	$19.86	$12.14	$12.14
[redacted]	P	1		00182402810	FERROUS SULFATE	0	1	04695	20040400	IRON PREPARATIONS				00	60.000	$4.26	$4.26	$4.26
[redacted]	P	1		55370000107	AMPICILLIN TRIHYDRATE	0	1	39272	08121608	AMINOPENICILLINS				00	28.000	$19.60	$11.55	$11.55
[redacted]	P	1		66992014616	LUSONAL	0	2	23377	48160000	EXPECTORANTS				00	120.000	$23.37	$19.89	$19.89
[redacted]	P	1		00093415573	AMOXICILLIN	0	2	39683	08121608	AMINOPENICILLINS				00	100.000	$13.02	$7.66	$7.66
[redacted]	P	1		53014046356	DELSYM	0	2	17742	48000000	ANTITUSSIVES				00	90.000	$13.20	$11.04	$11.04
[redacted]	P	1		59702081901	SUDAL 12	0	2	98129	04042000	PROPYLAMINE DERIVATIVES				00	60.000	$96.24	$80.74	$80.74
[redacted]	P	1		51991045758	POLYETHYLENE GLYCOL	0	1	86212	56120000	CATHARTICS AND LAXATIVES				00	255.000	$28.50	$22.46	$22.46
[redacted]	P	1		59762313001	AZITHROMYCIN	0	1	61199	08121292	OTHER MACROLIDES				00	22.500	$42.92	$32.59	$32.59
[redacted]	P	1		00066853302	CIPRODEX	0	2	20188	52040400	ANTIBACTERIALS (EENT)				00	7.500	$122.43	$103.62	$103.62
[redacted]	P	1		00781164366	AMOX TR-POTASSIUM CLAVULANATE	0	2	67077	08121608	AMINOPENICILLINS				00	20.000	$28.92	$66.45	$61.85
[redacted]	P	1		00006011754	SINGULAIR	0	2	94444	48102400	LEUKOTRIENE MODIFIERS				00	30.000	$131.53	$106.17	$111.57
[redacted]	P	1		00006011754	SINGULAIR	0	2	94444	48102400	LEUKOTRIENE MODIFIERS				00	30.000	$131.53	$106.17	$111.57
[redacted]	P	1		45802025735	MOMETASONE FUROATE	0	1	45860	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	30.000	$63.49	$21.99	$27.39
[redacted]	P	1		59702081901	SUDAL 12	0	2	98129	04042000	PROPYLAMINE DERIVATIVES				00	60.000	$117.24	$93.69	$89.09
[redacted]	P	1		50383059016	BROMETANE DX	0	1	96136	48000000	ANTITUSSIVES				00	240.000	$28.60	$12.57	$12.57
[redacted]	P	1		63304051504	AMOXICILLIN	0	2	39651	08121608	AMINOPENICILLINS				00	21.000	$17.72	$9.50	$9.50
[redacted]	P	1		10702001001	HYDROXYZINE HCL	0	2	13941	28249200	ANXIOLYTICS, SEDATIVES & HYPNOTICS MISC				00	30.000	$28.01	$14.59	$19.99
[redacted]	P	1		66993010702	FEXOFENADINE HCL	0	1	46693	04060000	SECOND GENERATION ANTIHISTAMINES				00	60.000	$93.91	$69.64	$75.04
[redacted]	P	1		00168033230	FLUTICASONE PROPIONATE	0	1	43951	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	60.000	$78.35	$53.37	$58.77
[redacted]	P	1		63717003412	HYLIRA	0	1	25484	94000000	DEVICES				00	340.000	$122.50	$96.26	$103.66
[redacted]	P	1		00168033230	FLUTICASONE PROPIONATE	0	1	43951	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	60.000	$78.35	$53.37	$58.77

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B

Alabama Medicaid Agency

User ID:
Run Date: 2/25/2009
Run Time: 12:14:47 PM

Pharmacy Claim Details By Provider
Recipient Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID:
VACCA DISCOUNT DRUGS
For Claim Types: P and Q

Recipient ID	Recipient Full Name

PHI has been covered

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C

Alabama Medicaid Agency

Pharmacy Claim Details By Provider

NDC Listing

For Dates of Service: 10/01/2007 - 09/30/2008

Provider Base, Medicaid or NPI ID: [redacted]

VACCA DISCOUNT DRUGS

For Claim Types: P and Q

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:14:47 PM

NDC Code & Desc	ICN Count	Recipient Count
########### -	1	1
00002322830 - STRATTERA	5	1
00002322930 - STRATTERA	6	1
00002323730 - CYMBALTA	18	4
00002323830 - STRATTERA	4	2
00002323930 - STRATTERA	7	1
00002325030 - STRATTERA	6	1
00002751001 - HUMALOG	6	1
00002821501 - HUMULIN R	2	2
00002831501 - HUMULIN N	2	2
00002850101 - HUMULIN R	1	1
00002871501 - HUMULIN 70-30	8	3
00004018682 - BONIVA	2	1
00004080085 - TAMIFLU	3	3
00004081095 - TAMIFLU	18	18
00006003144 - FOSAMAX	3	1

3.5.47.1 DSSProfiler - Pharmacy Claim Details by Provider Field Descriptions

Field	Description	Length	Data Type
(A) NDC	The national drug code for the drug dispensed.	11	Character
(A) AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification systems.	8	Number
(A) AHFS Therapeutic Class Description	Text description of the American Hospital Formulary Service (AHFS) classification	55	Character
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number
(A) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DEA	Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5.	1	Number
(A) Detail Number (Dtl#)	Detail number on the claim.	4	Number (Integer)
(A) Dispense Qty	Number of units of a drug dispensed to a member. The type of unit is expressed in Drug Form Code.	10	Number
(A) Dispensed Dte	Date the prescription was dispensed by the provider.	10	Date (MM/DD/CCYY)
(A) GCN	Generic Code Number (GCN) is a unique 5 digit number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications such as generic substitution.	5	Character
(A) GPI	Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2).	5	Character
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) NDC Description	Description/name of the prescription dispensed.	35	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (	13	Number (Decimal)

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Field	Description	Length	Data Type
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number
(A,B) Recipient Full Name (Recip Name)	Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A-C) Provider Base, Medicaid or NPI ID	Provider's ID.	13	Character
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(C)Diagnosis 1 - Code & Desc	Concatenates the National Drug Code (NDC) and the description.	63	Character
(C) ICN Count	Unduplicated count of claims for NDC listed.	8	Number (Integer)
(C) NDC Code & Desc	National Drug Code. and NDC Name/Description	49	Character
(C) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)

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3.5.48 DSSProfiler - Pharmacy Claim Details by Provider Quarterly

This report lets the user drill down to the detail level for all pharmacy case types for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

There are tabs in this report:

A. Pharmacy Claim Details;

B. Recipient Listing; and

C. NDC Listing.

A

Alabama Medicaid Agency

Pharmacy Claim Details By Provider Qtrly

Pharmacy Claim Details

For Dates of Service: 10/01/2007 - 09/30/2008

Provider Base, Medicaid or NPI ID: [redacted]

For Claim Types: P and Q

Quarter: 20083

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

ICN	CT	Dtl #	Dispensed Dte	NDC	NDC Desc	DEA	GPI	GCN	AHFS	AHFS Therapeutic Class Desc	Recip ID	Recip Name	Age	POS	Dispense Qty	Billed Amt	Alwd Amt	Paid Amt
[redacted]	P	1		60047029101	SCOPOHIST-PE	0	9	19297	04042000	PROPYLAMINE DERIVATIVES				00	60.000	$24.66	$15.79	$20.19
[redacted]	P	1		00472163016	PROMETHAZINE-DM	0	9	13975	48000000	ANTITUSSIVES				00	180.000	$13.14	$3.48	$8.38
[redacted]	P	1		00781107710	ALPRAZOLAM	4	9	14261	28240000	BENZODIAZEPINES (ANXIOLYTIC,SEDATIVE/HYP)				00	60.000	$49.37	$3.21	$8.11
[redacted]	P	1		00065401303	VIGAMOX	0	9	19542	52040400	ANTIBACTERIALS (EENT)				00	3.000	$74.43	$60.66	$66.06
[redacted]	P	1		00168000031	HYDROCORTISONE	0	9	30943	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	30.000	$16.02	$3.60	$9.00
[redacted]	P	1		00182506651	TRIAMCINOLONE ACETONIDE	0	2	31244	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	15.000	$10.89	$3.01	$8.41
[redacted]	P	1		00182506651	TRIAMCINOLONE ACETONIDE	0	2	31244	84060000	ANTI-INFLAMMATORY AGENTS (SKIN & MUCOUS)				00	15.000	$10.89	$3.01	$8.41
[redacted]	P	1		65224054501	ALDEX-CT	0	2	26967	04040400	ETHANOLAMINE DERIVATIVES				00	14.000	$24.20	$23.91	$29.31
[redacted]	P	1		64679071203	CEFPROZIL	0	1	29271	08120608	SECOND GENERATION CEPHALOSPORINS				00	20.000	$62.61	$34.85	$40.25
[redacted]	P	1		00006011731	SINGULAIR	0	9	94444	48102400	LEUKOTRIENE MODIFIERS				00	30.000	$126.54	$106.18	$111.58
[redacted]	P	1		63402051001	XOPENEX HFA	0	9	24422	12120812	SELECTIVE BETA-2-ADRENERGIC				00	15.000	$59.67	$47.76	$53.16
[redacted]	P	1		65224054501	ALDEX-CT	0	9	26967	04040400	ETHANOLAMINE DERIVATIVES				00	14.000	$24.20	$23.91	$29.31
[redacted]	P	1		65224054501	ALDEX-CT	0	9	26967	04040400	ETHANOLAMINE DERIVATIVES				00	14.000	$41.50	$23.91	$29.31
[redacted]	P	1		51672129602	KETOCONAZOLE	0	2	31850	84040000	AZOLES (SKIN & MUCOUS MEMBRANE)				00	30.000	$14.78	$14.78	$3.00
[redacted]	P	1		00168009630	KETOCONAZOLE	0	2	31850	84040000	AZOLES (SKIN & MUCOUS MEMBRANE)				00	30.000	$24.78	$21.64	$3.00
[redacted]	P	1		00093001256	PANTOPRAZOLE SODIUM	0	1	40120	56253600	PROTON-PUMP INHIBITORS				00	30.000	$127.62	$107.22	$109.62
[redacted]	P	1		60505003406	GEMFIBROZIL	0	1	25540	24060600	FIBRIC ACID DERIVATIVES				00	60.000	$76.23	$16.59	$20.99
[redacted]	P	1		00091053510	METFORMIN HCL	0	1	10857	68200400	BIGUANIDES				00	60.000	$91.71	$26.86	$30.26
[redacted]	P	1		64764045124	ACTOS	0	2	93011	68202900	THIAZOLIDINEDIONES				00	30.000	$240.39	$205.62	$208.02
[redacted]	P	1		00172206380	HYDROCHLOROTHIAZIDE	0	2	34824	40202000	THIAZIDE DIURETICS				00	30.000	$8.99	$1.34	$6.24
[redacted]	P	1		65597010430	BENICAR	0	2	17256	24320600	ANGIOTENSIN II RECEPTOR ANTAGONISTS				00	30.000	$81.18	$66.50	$68.90
[redacted]	P	1		00169183711	NOVOLIN 70-30	0	2	50001	68200000	INSULINS				00	20.000	$93.78	$27.55	$29.95
[redacted]	P	1		00881609331	MONOJECT INSULIN SYRINGE	0	0	94200	94000000	DEVICES				00	100.000	$29.07	$21.51	$24.91
[redacted]	P	1		65162062711	TRAMADOL HCL	0	1	07221	28000000	OPIATE AGONISTS				00	24.000	$25.02	$4.92	$9.32
[redacted]	P	1		11523723404	MIRALAX	0	1	86212	56120000	CATHARTICS AND LAXATIVES				00	510.000	$23.76	$16.84	$21.24
[redacted]	P	1		00472135832	CONSTULOSE	0	2	10167	40100000	AMMONIA DETOXICANTS				00	4,730.000	$332.28	$80.69	$83.09

PHI has been covered

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

Pharmacy Claim Details By Provider Qtrly
Recipient Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]
DOWNEY DRUG ALEXANDRIA
For Claim Types: P and Q
Quarter: 20083

Recipient ID	Recipient Full Name

PHI has been covered

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 2/25/2009
Run Time: 12:03:34 PM

Pharmacy Claim Details By Provider Qtrly
NDC Listing
For Dates of Service: 10/01/2007 - 09/30/2008
Provider Base, Medicaid or NPI ID: [redacted]
DOWNEY DRUG ALEXANDRIA
For Claim Types: P and Q
Quarter: 20083

NDC Code & Desc	ICN Count	Recipient Count
########### -	1	1
00002322830 - STRATTERA	5	1
00002322930 - STRATTERA	6	1
00002323730 - CYMBALTA	18	4
00002323830 - STRATTERA	4	2
00002323930 - STRATTERA	7	1
00002325030 - STRATTERA	6	1
00002751001 - HUMALOG	6	1
00002821501 - HUMULIN R	2	2

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3.5.48.1 DSSProfiler - Pharmacy Claim Details by Provider Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) NDC	The national drug code for the drug dispensed.	11	Character
(A) AHFS	Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification systems.	8	Number
(A) AHFS Therapeutic Class Description	Text description of the American Hospital Formulary Service (AHFS) classification	55	Character
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number
(A) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DEA	Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5.	1	Number
(A) Detail Number (Dtl#)	Detail number on the claim.	4	Number (Integer)
(A) Dispense Qty	Number of units of a drug dispensed to a member. The type of unit is expressed in Drug Form Code.	10	Number
(A) Dispensed Dte	Date the prescription was dispensed by the provider.	10	Date (MM/DD/CCYY)
(A) GCN	Generic Code Number (GCN) is a unique 5 digit number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications such as generic substitution.	5	Character

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Field	Description	Length	Data Type
(A) GPI	Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2).	5	Character
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) NDC Description	Description/name of the prescription dispensed.	35	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number
(A,B) Recipient Full Name (Recip Name)	Concatenates the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A-C) Provider Base, Medicaid or NPI ID	Provider's ID.	13	Character
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-C) Quarter	The quarter for which the report is being run.	5	Number
(C)Diagnosis 1 - Code & Desc	Concatenates the National Drug Code (NDC) and the description.	63	Character
(C) ICN Count	Unduplicated count of claims for NDC listed.	8	Number (Integer)
(C) NDC Code & Desc	National Drug Code and its Name/Description	49	Character
(C) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)

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3.5.49 DSSProfiler - Pharmacy Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals broken out by the number of services received. This report can be used for disease management.

There are tabs in this report:

A. Pharmacy Disease; and

B. Pharmacy Disease by Peer Group.

A

Alabama Medicaid Agency

Pharmacy Disease Quick View

Pharmacy Disease

For Dates of Service: 10/01/2004 - 09/30/2005

Case Type: 1 - All Claim Groupings

Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: [redacted]
Run Date: 8/6/2006
Run Time: 9:47:58 PM

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
7	1	0	7	$0.00	$0.00	$0.00
3	2	0	6	$0.00	$0.00	$0.00
1	3	0	3	$0.00	$0.00	$0.00
2	5	0	10	$0.00	$0.00	$0.00
1	9	0	9	$0.00	$0.00	$0.00
1	12	0	12	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
1	14	0	14	$0.00	$0.00	$0.00
Totals:			61	$0.00	$0.00	$0.00

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B

Alabama Medicaid Agency

User ID:
Run Date: 8/6/2006
Run Time: 9:47:58 PM

Pharmacy Disease Quick View
Pharmacy Disease By Peer Group

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 516 - Public Assistance, Blind

Each Recipient Had XX Claims	Unduplicated Recipients	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	1	0	1	$0.00	$0.00	$0.00
2	1	0	2	$0.00	$0.00	$0.00
Totals:			3	$0.00	$0.00	$0.00

Peer Group: 519 - Public Assistance, Disabled

Each Recipient Had XX Claims	Unduplicated Recipients	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	2	0	2	$0.00	$0.00	$0.00
Totals:			2	$0.00	$0.00	$0.00

Peer Group: 520 - Institutionalized with income less than 300%, Blnd

Each Recipient Had XX Claims	Unduplicated Recipients	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
3	1	0	3	$0.00	$0.00	$0.00
9	1	0	9	$0.00	$0.00	$0.00
Totals:			12	$0.00	$0.00	$0.00

3.5.49.1 DSSProfiler - Pharmacy Disease Quick View Field Descriptions

Field	Description	Length	Data Type
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A-B) Each Recipient Had XX Claims	This field shows us how many claims each of the recipients had.	4	Character

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Field	Description	Length	Data Type
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Total Claims	This is the total number of claims billed based on the number of recipients and the number of claims each recipient had.	9	Character
(A-B) Total Quantity Billed	This is the total units billed for this particular claim category.	9	Character
(A-B) Unduplicated Recipients	This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once.	9	Character
(B) Peer Group	Peer Group Code and Description.	107	Character

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3.5.50 DSSProfiler - Pharmacy Distribution Analysis

The Pharmacy Distribution Analysis report is created in the DSSProfiler. This report shows totals for all pharmacy case types within the selected peer group. The totals include amount reimbursed; amount billed; and number of unduplicated recipients, claim counts, units and exceptions.

This report provides a rapid method to identify which case types or service categories need to be looked at more closely with other reports within the DSS Profiler.

There are five tabs in this report:

A. Pharmacy Distribution Summary;

B. Top 20;

C. By Age;

D. By Gender; and

E. By Age/Gender.

A

Alabama Medicaid Agency

User ID:
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Pharmacy Distribution Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type Description	Billed Quantity	Recip Count	Claim Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Paid Amount per Recip	Claims per Recip	Exception Count
1060 - AL Duragesic Drug Codes	690	35	68	$36,375.67	$31,111.75	$30,907.55	$1,039.30	$883.07	1.94	0
1061 - AL Adderall Drug Codes	314,092	5989	9853	$1,598,658.05	$1,145,722.27	$1,121,202.60	$266.93	$187.21	1.65	14
1062 - AL Concerta Drug Codes	239,909	4535	7571	$1,153,097.39	$870,184.87	$849,200.65	$254.27	$187.25	1.67	15
1063 - AL Metadate Drug Codes	87,337	1769	2354	$302,148.08	$221,429.71	$219,270.13	$170.80	$123.95	1.33	19
3 - Morbidity 1	47,458,893	176398	470196	$30,214,563.44	$20,884,270.38	$20,170,357.58	$171.29	$114.35	2.67	47
4 - Morbidity 2	55,148,541	149731	596363	$54,941,237.79	$38,237,743.79	$37,061,531.92	$366.93	$247.52	3.98	28
5 - Morbidity 3	19,953,799	55718	208398	$21,200,285.98	$14,978,295.01	$14,586,911.86	$380.49	$261.80	3.74	27
6 - Morbidity 4	23,050,986	58422	220124	$20,970,986.71	$14,153,883.30	$13,856,143.03	$358.96	$237.17	3.77	33
7 - Morbidity 5	4,299,632	7380	32056	$3,868,759.58	$2,739,753.60	$2,708,409.80	$524.22	$366.99	4.34	41
945 - AL Oxycontin Drug Codes	82,058	523	1311	$494,717.56	$333,732.57	$329,708.18	$945.92	$630.42	2.51	4

End of Report

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B

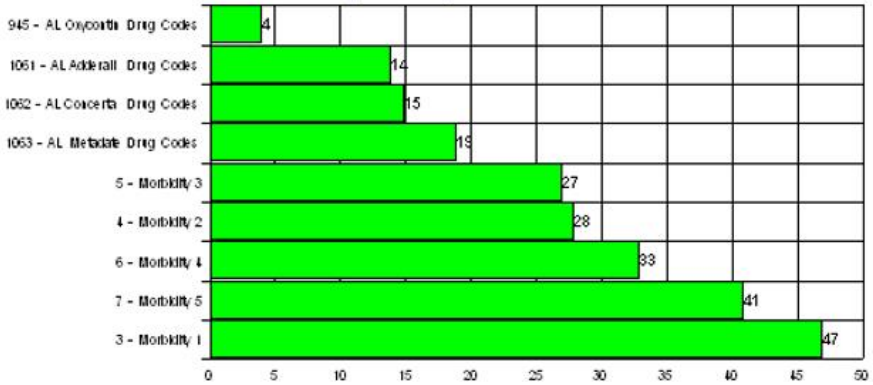
Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Top 20

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 20 Exceptions



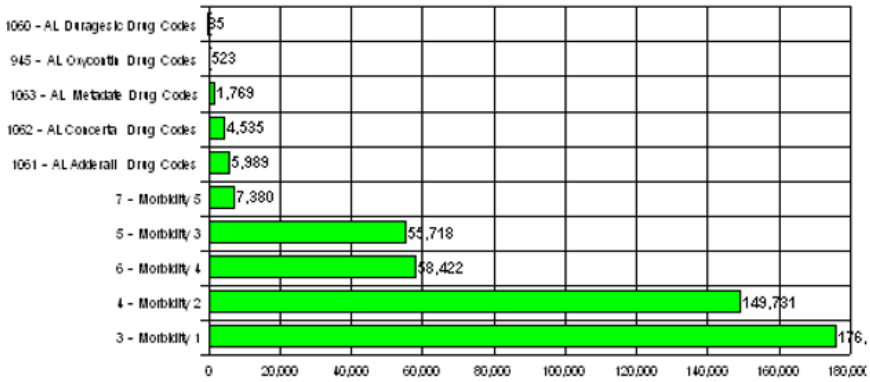
Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
Top 20

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Top 20 By Number of Recipients



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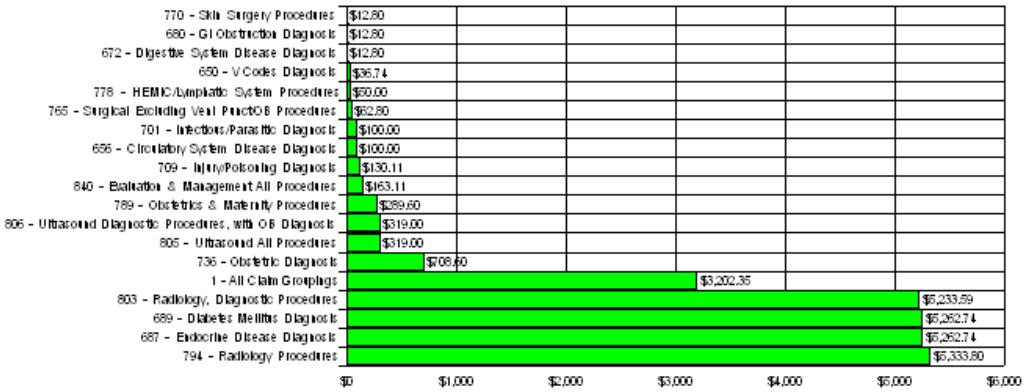
Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 4:32:08 PM

Outpatient Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 2 - Outpatient Hospital By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 20 By Paid Amount per Recipient



C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

Pharmacy Distribution Analysis
By Age

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
Age 21 - 34	90	11	4	$4,845.65	$4,230.62	$4,197.62	$1,211.41	$1,057.66	$1,049.41	2.75
Age 35 - 64	580	55	30	$30,891.24	$26,319.60	$26,154.40	$1,029.71	$877.32	$871.81	1.83
Age 65+	20	2	1	$638.78	$561.53	$555.53	$638.78	$561.53	$555.53	2.00
Sum:	690	68	35	$36,375.67	$31,111.75	$30,907.55	$2,879.90	$888.91	$2,476.75	6.58

Case Type: 1061 - AL Adderall Drug Codes

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
Age 00 - 05	11,099	368	257	$57,482.50	$40,592.49	$39,567.37	$223.67	$157.95	$153.96	1.43
Age 06 - 17	287,665	9,011	5,455	$1,467,471.59	$1,049,265.28	$1,027,642.23	$269.01	$192.35	$188.39	1.65
Age 18 - 20	7,869	239	138	$36,995.69	$28,632.70	$27,935.93	$268.08	$207.48	$202.43	1.73
Age 21 - 34	4,128	129	80	$20,043.42	$15,056.31	$14,199.58	$250.54	$188.20	$177.49	1.61
Age 35 - 64	3,331	106	59	$16,664.85	$12,175.49	$11,857.49	$282.46	$206.36	$200.97	1.80
Sum:	314,092	9,853	5,989	$1,598,658.05	$1,145,722.27	$1,121,202.60	$1,293.76	$191.30	$923.25	8.22

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D

Alabama Medicaid Agency

Pharmacy Distribution Analysis
By Gender

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
F	480	48	25	$25,185.74	$21,231.46	$21,087.26	$1,007.43	$849.26	$843.49	1.92
M	210	20	10	$11,189.93	$9,880.29	$9,820.29	$1,118.99	$988.03	$982.03	2.00
Sum:	690	68	35	$36,375.67	$31,111.75	$30,907.55	$2,126.42	$888.91	$1,825.52	3.92

Case Type: 1061 - AL Adderall Drug Codes

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
F	88,843	2,848	1,769	$462,128.35	$324,401.67	$316,112.99	$255.58	$183.38	$178.70	1.61
M	225,249	7,005	4,220	$1,146,529.70	$821,320.60	$805,089.61	$271.69	$194.63	$190.78	1.66
Sum:	314,092	9,853	5,989	$1,598,658.05	$1,145,722.27	$1,121,202.60	$527.27	$191.30	$369.48	3.27

E

Alabama Medicaid Agency

Pharmacy Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 11/14/2007
Run Time: 10:15:51 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 4 - Pharmacy By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type: 1060 - AL Duragesic Drug Codes

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
Age 21 - 34	F	50	5	2	$2,601.70	$2,269.69	$2,254.69	$1,300.85	$1,134.85	$1,127.35	2.50
Age 21 - 34	M	40	6	2	$2,243.95	$1,960.93	$1,942.93	$1,121.98	$980.47	$971.47	3.00
Age 35 - 64	F	410	41	22	$21,945.26	$18,400.24	$18,277.04	$997.51	$836.37	$830.77	1.86
Age 35 - 64	M	170	14	8	$8,945.98	$7,919.36	$7,877.36	$1,118.25	$989.92	$984.67	1.75
Age 65+	F	20	2	1	$638.78	$561.53	$555.53	$638.78	$561.53	$555.53	2.00
	Sum:	690	68	35	$36,375.67	$31,111.75	$30,907.55	$5,177.36	$888.91	$4,469.78	11.11

3.5.50.1 DSSProfiler - Pharmacy Distribution Analysis Field Descriptions

Field	Description	Length	Data Type
(A) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A) Exception Count	Number of exceptions identified. An exception is defined as two standard deviations from the norm.	8	Number (Integer)
(A,C,D,E) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular	13	Number (Decimal)

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Field	Description	Length	Data Type
	grouping of claims for this specific recipient.		
(A,D) Average Billed Amount per Recip	Total billed amount divided by the number of recipients.	12	Number (Decimal)
(AD) Average Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(A,D) Average Paid Amount per Recip	Total reimbursed amount divided by the number of recipients.	12	Number (Decimal)
(A,C,D,E) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,C,D,E) Billed Quantity	Quantity billed.	14	Number (Integer)
(A,C,D,E) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A,C,D,E) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,C,D,E) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-E) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-E) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-E) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Top 20 By Number of Recipients	Graph shows Top 20 exceptions by number of recipients.	1	Character

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Field	Description	Length	Data Type
(B) Top 20 By Paid Amount per Recipient	Graph shows Top 20 exceptions by paid amount per recipient.	1	Character
(B) Top 20 Exceptions	Graph shows Top 20 exceptions.	1	Character
(C,D,E) Allowed Amt Per Recip	Total allowed amount divided by the number of recipients.	13	Number (Decimal)
(C,E) Age Description	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(C,E) Billed Amount Per Recip	Total billed amount divided by the number of recipients.	13	Number (Decimal)
(C,E) Claims Per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(C,E) Paid Amount Per Recip	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(D,E) Gender	Recipient's gender.	1	Character

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3.5.51 DSSProfiler - Pharmacy Exception Quarterly

The Pharmacy Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations that are above the exception high value are marked as exceptions.

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/18/2006
Run Time: 5:06:36 PM

Pharmacy Exception Quarterly

For Dates of Service: 07/01/2004 - 06/30/2005

Provider Service Location Information:
NPI ID:
Mcaid ID:
Base ID:
Name: MICKEY A DALLES
Type: 24 - Pharmacy
Specialty: 240 - Pharmacy
Address: PO BOX 6042
MAIL STOP 10427
PORTLAND, OR 97501

Peer Group Code: 195 - 240 PHARMACY
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

	20043	
800 - Unusual Dispensing of Compounded Drugs; H: 002 L: 000	5.00	*
820 - Unusual Prescribing Practices; H: 002 L: 000	5.00	*
840 - Excessive Dispensing of Small Quantity Prescriptions; H: 000 L: 010	0.00	*

End of Report

3.5.51.1 DSSProfiler - Pharmacy Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Case Type Group Display	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Number (Integer)
Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The	20	Character

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Field	Description	Length	Data Type
	most common recipient peer grouping is the recipient aid category.		
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Service Location Information	Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID.	200	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.52 DSSProfiler - Pharmacy Frequency Distribution

The Pharmacy Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each pharmacy case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

Alabama Medicaid Agency

Pharmacy Frequency Distribution

User ID: [redacted]
Run Date: 5/9/2006
Run Time: 5:32:12 PM

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group: 346 - 071 MANAGED CARE ORGANIZATION
Provider Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 935 - 7600 Oxytocics

	10%	25%	50%	75%	90%	95%
Claim Count at each %	3	3	3	3	3	3

End of Report

3.5.52.1 DSSProfiler - Pharmacy Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character

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Field	Description	Length	Data Type
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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3.5.53 DSSProfiler - Pharmacy Frequency Distribution Quarterly

The Pharmacy Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report shows for each pharmacy case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.

Alabama Medicaid Agency

Pharmacy Frequency Distribution Qtrly

User ID:
Run Date: 5/12/2006
Run Time: 10:30:01 AM

For Dates of Service: 01/01/2005 - 03/31/2005
Provider Peer Group Code: 4 - Pharmacy By Claim Type
Provider Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20051

Case Type : 165 - Compounded Drugs

	10%	25%	50%	75%	90%	95%
Claim Count at each %	6	6	6	8	8	8

Case Type : 166 - Non-Compounded Drugs

	10%	25%	50%	75%	90%	95%
Claim Count at each %	7	7	14	77	105	105

End of Report

3.5.53.1 DSSProfiler - Pharmacy Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.54 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group

The Pharmacy Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which providers fall outside of service dollar norms on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the "norm" for the peer group are highlighted. This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level by utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

There are two tabs in this report:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 9:16:18 AM

Pharmacy Recipient Case Type Comparison by Peer Group
Recipient Comparison

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 6 - Morbidity 4
Recipient Peer Group: 941 - 25 Blind-SSI-full Medicaid with QMB Plus
Aggregation Code: 7 - Fee For Service Claims by Recipient

Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference From Expected	Exception
1	[redacted]	[redacted]	$250.38	$217.59	$209.59	$52.08	$157.51	*
2	[redacted]	[redacted]	$163.98	$86.79	$80.79	$52.08	$28.71	
3	[redacted]	[redacted]	$108.70	$77.76	$72.76	$57.86	$14.90	
6	[redacted]	[redacted]	$193.35	$29.61	$28.11	$13.43	$14.68	
5	[redacted]	[redacted]	$103.89	$40.93	$38.43	$31.76	$6.67	
7	[redacted]	[redacted]	$48.74	$27.09	$25.09	$31.76	$(6.67)	
13	[redacted]	[redacted]	$6.00	$5.68	$5.18	$13.43	$(8.25)	
4	[redacted]	[redacted]	$427.88	$45.95	$42.95	$57.86	$(14.91)	
8	[redacted]	[redacted]	$288.64	$25.85	$23.85	$52.08	$(28.23)	
9	[redacted]	[redacted]	$25.50	$19.86	$18.86	$52.08	$(33.22)	
10	[redacted]	[redacted]	$91.44	$12.38	$11.38	$52.08	$(40.70)	
11	[redacted]	[redacted]	$12.68	$11.36	$10.36	$52.08	$(41.72)	
12	[redacted]	[redacted]	$27.87	$10.76	$9.76	$52.08	$(42.32)	
						2 STD DEV	$101.58	

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B

Alabama Medicaid Agency

User ID:
Run Date: 9/25/2007
Run Time: 9:16:18 AM

Pharmacy Recipient Case Type Comparison by Peer Group

Recipient Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 6 - Morbidity 4

Recipient Peer Group: 941 - 25 Blind-SSI-full Medicaid with QMB Plus

Aggregation Code: 7 - Fee For Service Claims by Recipient

Age 35 - 64

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$250.38	$217.59	$209.59
		$288.64	$25.85	$23.85
		$27.87	$10.76	$9.76
		$25.50	$19.86	$18.86
		$12.68	$11.36	$10.36
		$163.98	$86.79	$80.79
		$91.44	$12.38	$11.38
			Sum:	$364.59

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$6.00	$5.68	$5.18
		$193.35	$29.61	$28.11
			Sum:	$33.29

3.5.54.1 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character

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Field	Description	Length	Data Type
(A,B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the service.	13	Number (Decimal)
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Recipient Full Name	Recipient's full name.	50	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(A,B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.55 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are two tabs in this report:

A. Recipient Comparison; and

B. Recipients Grouped by Age/Gender

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/22/2006
Run Time: 9:11:47 AM

Pharmacy Recipient Case Type Comparison
By Peer Group Qtrly
Recipient Comparison
For Dates of Service: 01/01/2005 - 03/31/2005
Case Type: 1 - All Claim Groupings
Recipient Peer Group: 302 - Medical Assistance, Categorically Needy, TANF
Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20051

Rank	Expected Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
2	2	[redacted]	[redacted]	$0.00	$0.00	$0.00	$0.00	$0.00	
2	2	[redacted]	[redacted]	$0.00	$0.00	$0.00	$0.00	$0.00	
1	1	[redacted]	[redacted]	$0.00	$0.00	$25.00	$25.00	$0.00	
							2 STD DEV	$0.00	

End of Report

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B

Alabama Medicaid Agency

Pharmacy Recipient Case Type Comparison
By Peer Group Qtrly

User ID: Administrator
Run Date: 5/22/2006
Run Time: 9:11:47 AM

Recipients Grouped by Age/Gender
For Dates of Service: 01/01/2005 - 03/31/2005
Case Type: 1 - All Claim Groupings
Recipient Peer Group: 302 - Medical Assistance, Categorically Needy, TANF
Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20051

Age 06 - 17

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$0.00	$0.00	$25.00
			Sum:	$25.00

Gender: M

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
[redacted]	[redacted]	$0.00	$0.00	$0.00
			Sum:	$0.00

3.5.55.1 DSSProfiler - Pharmacy Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character

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Field	Description	Length	Data Type
(A,B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(A,B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.56 DSSProfiler - Pharmacy Provider Profile

The Pharmacy Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the pharmacy provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Pharmacy Facility Services - Tab B has two sections. The first section of this report contains a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared; and
- Aggregation Code is the code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID:
Run Date: 9/25/2007
Run Time: 2:41:33 PM

Pharmacy Provider Profile

Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Provider Information

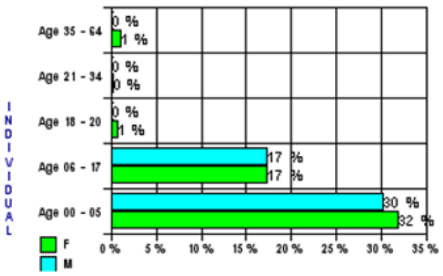
NPI ID:
Mcaid ID:
Base ID:
Name: NORTHEAST ALABAMA PEDIATRICS - ALL BSE
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 829 RIVERBEND DR

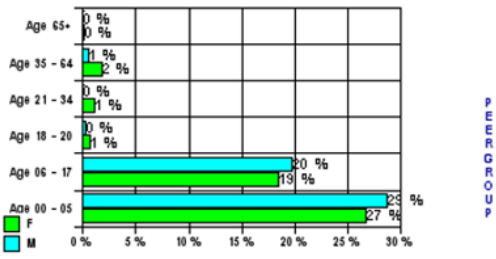
GADSDEN, AL 35901

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 10:16:50 AM

Pharmacy Provider Profile

Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Provider's General Service Profile

Service Type	Recip Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
4 - Pharmacy Services	547	$58,451.33	$88,190.39	$56,089.29	$82,105.91	$(26,016.62)	(31.69) %

End of Report

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Alabama Medicaid Agency

Pharmacy Provider Profile
Pharmacy Facility Services

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 2:41:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Case Type	Recip Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
7 - Morbidity 5	10	18	1,259	$3,978.40	$4,892.15	$3,978.40	$4,045.68	$(67.28)	(1.66) %
1061 - AL Adderall Drug Codes	1	1	30	$109.90	$244.66	$109.90	$203.44	$(93.54)	(45.98) %
1062 - AL Concerta Drug Codes	2	3	67	$246.61	$282.71	$246.61	$343.32	$(96.71)	(28.17) %
1063 - AL Metadate Drug Codes	3	3	90	$231.84	$336.67	$231.84	$356.87	$(125.03)	(35.04) %
6 - Morbidity 4	95	229	15,881	$11,084.31	$15,922.00	$11,057.01	$13,700.50	$(2,643.49)	(19.29) %
5 - Morbidity 3	29	107	9,508	$4,820.27	$5,653.83	$3,484.67	$7,585.39	$(4,100.72)	(54.06) %
3 - Morbidity 1	326	821	66,612	$28,916.57	$48,881.50	$28,527.79	$37,325.78	$(8,797.99)	(23.57) %
4 - Morbidity 2	87	225	17,022	$9,063.43	$12,840.91	$9,041.42	$19,448.49	$(10,407.07)	(53.51) %

End of Report

3.5.56.1 DSSProfiler - Pharmacy Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) Service Type	User defined group based on the service type file. The claim grouping should be specific to the area of service.	100	Character
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	10	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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Field	Description	Length	Data Type
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Quantity	Quantity billed.	8	Number (Integer)

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3.5.57 DSSProfiler - Pharmacy Provider Profile Quarterly

The Pharmacy Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the pharmacy provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown on recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Pharmacy Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.

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A

Alabama Medicaid Agency

User ID:
Run Date: 5/31/2006
Run Time: 10:49:09 AM

Pharmacy Provider Profile Qtrly

Provider Summary

For Dates: 07/01/2004 - 06/30/2005
Provider ID:
Provider Peer Group: 122 - 050 HOME HEALTH AGENCY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

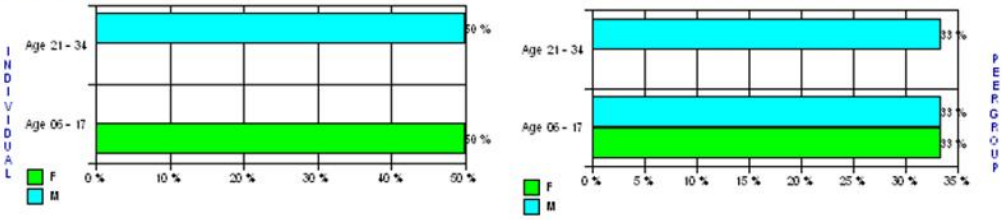
Provider Information

NPI ID:
Mcaid ID:
Base ID:
Name: NW GENERAL - ALL NPI
Type: 07 - Capitation Provider
Specialty: 071 - Managed Care Organization (MCO
Address: 3463 NE 1ST ST
MAIL STOP 9203
PORTLAND, OR 97501

Rank

$ Paid Amount Actual	3
$ Paid Amount Expected	3
$ Billed Amount Actual	3
Recipient Rank	2
# Units Rank	3
# Claims Rank	2
Peer Group Size	6

Patient Age/Gender Breakdown



Alabama Medicaid Agency

User ID:
Run Date: 8/10/2006
Run Time: 3:12:06 PM

Pharmacy Provider Profile Qtrly

Provider Summary

For Dates: 10/01/2004 - 09/30/2005
Provider ID:
Provider Peer Group: 122 - 071 MANAGED CARE ORGANIZATION
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

Provider's General Service Profile

Report Category	Recipient Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
9 - Pharmacy Services by Billing Provider	3	$0.00	$0.00	$0.00	$25.00	$(25.00)	(100.00) %

End of Report

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B

Alabama Medicaid Agency

User ID:
Run Date: 1/0/1900
Run Time: 10:49:09 AM

Pharmacy Provider Profile Qtrly
Pharmacy Services
For Dates: 07/01/2004 - 06/30/2005
Provider ID:
Provider Peer Group: 122 - 050 HOME HEALTH AGENCY
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

Top 10 Case Types: Dollar Difference

Alabama Medicaid Agency

User ID:
Run Date: 8/10/2006
Run Time: 3:12:06 PM

Pharmacy Provider Profile Qtrly
Pharmacy Services
For Dates: 10/01/2004 - 09/30/2005
Provider ID:
Provider Peer Group: 122 - 071 MANAGED CARE ORGANIZATION
Aggregation Code: 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20051

Case Type	Recipient Count	Claim Count	Billed Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
166 - Non-Compounded Drugs	3	3	0	$0.00	$0.00	$0.00	$25.00	$(25.00)	(100.00) %
1 - All Claim Groupings	3	3	0	$0.00	$0.00	$0.00	$25.00	$(25.00)	(100.00) %

End of Report

DSSProfiler - Pharmacy Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the	5	Number (Decimal)

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Field	Description	Length	Data Type
	Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.		
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Billed Quantity	Quantity billed.	14	Number (Integer)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-B) For Dates	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the	8	Number (Decimal)

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Field	Description	Length	Data Type
	expected value to the actual value in a percentage.		
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Top 10 Case Types: Dollar Difference	Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character

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3.5.58 DSSProfiler - Professional Case Type Comparison by Peer Group

Based on the user-entered date range of one year, this report displays and compares all professional providers within a peer group to determine which providers fall outside of service dollar norm for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison;

B. Average Amount per Recipient by Age/Gender; and

C. Average Amount per Recipient All Providers by Selected Age/Gender

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Provider Comparison

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	4	[redacted]	TIM J BEAL - ALL NPI	$9,003.93	$7,921.39	$7,474.73	$1,380.92	$6,093.81	*
2	2	2	[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$6,980.00	$2,930.57	$3,054.05	$2,163.55	$890.50	
3	3	17	[redacted]	JILL E JANES - ALL NPI	$15,000.00	$1,100.41	$1,100.41	$331.35	$769.06	
4	11	27	[redacted]	TRAVIS FAMILY HEALTH CENTER - ALL NPI	$290.00	$124.95	$124.95	$52.33	$72.62	
5	7	20	[redacted]	NANCY T CRANE - ALL NPI	$220.00	$220.00	$220.00	$153.90	$66.10	
6	16	28	[redacted]	JOHN D SMITH - ALL NPI	$77.00	$77.00	$77.00	$41.53	$35.47	
7	18	28	[redacted]	TRAVIS FAMILY HEALTH CENTER - ALL NPI	$111.00	$91.10	$51.10	$41.53	$9.57	
8	24	28	[redacted]	DONALD B JONES - ALL NPI	$400.00	$26.22	$26.22	$41.53	$(15.31)	
9	20	22	[redacted]	NW GENERAL - ALL NPI	$300.00	$39.33	$39.33	$55.95	$(16.62)	
10	22	22	[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$210.00	$36.22	$36.22	$55.95	$(19.73)	
11	22	22	[redacted]	BEN I CLEAVER - ALL NPI	$210.00	$36.22	$36.22	$55.95	$(19.73)	

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B

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Average Amount per Recipient by Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

[redacted] - COUNTRY MEDICAL CLINIC - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 00 - 05	F	1	$51.25
Age 06 - 17	F	2	$13.11
Age 06 - 17	M	1	$20.00
Age 21 - 34	F	2	$19.00
Age 35 - 64	F	1	$199.00
		SUM:	$47.78

[redacted] - JILL E JANES - ALL NPI

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 21 - 34	F	1	$49.00
		SUM:	$49.00

C

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:25:34 PM

Professional Case Type Comparison by Peer Group

Average Amount per Recipient All Providers by Selected Age/Gender
For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$51.25
[redacted]	TRINA O ROBERTS - ALL NPI	$0.00
[redacted]	COUNTRY MEDICAL CLINIC - ALL NPI	$18.50
	SUM:	$23.25

3.5.58.1 DSSProfiler - Professional Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-C) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-C) Provider ID	Provider identification number.	15	Character
(A-C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are	20	Character

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Field	Description	Length	Data Type
	provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
(A-C) Provider Name	Provider's full name.	50	Character
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Gender	Recipient's gender.	1	Character

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3.5.59 DSSProfiler - Professional Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range for one quarter, this report displays and compares all providers within a peer group to determine which providers range appears outside of the service dollar norms for a case type. All information is age and gender adjusted so that different patient mixes do not affect the results. Providers with two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison shows providers who fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows the age break out for the recipients; and

C. Average Amount per Recipient All Providers by Selected Age/Gender shows the recipients for each age group

A

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/19/2006
Run Time: 2:09:34 PM

Professional Case Type Comparison by Peer Group Qtrly
Provider Comparison
For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Exception
1	1	1	[redacted]	JOHN G TALYLOR	$1,871.00	$1,690.46	$1,690.46	$1,243.18	$447.28	
2	2	3	[redacted]	TRAVIS FAMILY HEALTH CENTER	$715.57	$713.08	$713.08	$366.43	$346.65	
3	5	8	[redacted]	MARK S NEWLAND	$39.56	$39.56	$39.56	$37.19	$2.37	
4	3	2	[redacted]	GEORGE F WILSON	$1,000.00	$1,000.00	$713.00	$713.00	$0.00	
5	6	7	[redacted]	GRACE COMMUNITY PHYSICAL THERAPY	$100.00	$26.37	$26.37	$79.55	$(53.18)	
6	4	5	[redacted]	MICKEY A DALLES	$180.00	$180.00	$180.00	$294.17	$(114.17)	
7	8	5	[redacted]	CLAY R MILLER	$11.87	$11.87	$11.87	$294.17	$(282.30)	
8	7	3	[redacted]	MICKEY A DALLES	$35.00	$19.78	$19.78	$366.43	$(346.65)	
								2 STD DEV	$517.66	

End of Report

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:32:39 PM

Professional Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient by Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

[redacted] - GRACE COMMUNITY PHYSICAL THERAPY

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 65+	M	1	$26.37
		AVG:	$26.37

[redacted] - JOHN G TALYLOR

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 00 - 05	M	1	$34.82
Age 18 - 20	M	2	$151.71
Age 35 - 64	F	1	$199.00
Age 35 - 64	M	3	$410.55
Age 65+	M	2	$84.21
		AVG:	$215.25

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/2/2006
Run Time: 9:32:39 PM

Professional Case Type Comparison by Peer Group Qtrly
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 10/01/2004 - 12/31/2004
Case Type: 1 - All Claim Groupings
Provider Peer Group: 6 - Dental By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location
Quarter: 20044

Age 00 - 05

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	JOHN G TALYLOR	$34.82
[redacted]	CLAY R MILLER	$11.87
[redacted]	MARK S NEWLAND	$39.56
	AVG:	$28.75

Age 06 - 17

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
[redacted]	MICKEY A DALLES	$19.78
[redacted]	TRAVIS FAMILY HEALTH CENTER	$713.08
	AVG:	$366.43

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3.5.59.1 DSSProfiler - Professional Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A,B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID	Provider identification number.	8	Character
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations	40	Character

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Field	Description	Length	Data Type
	and 03 NPI/Medicaid ID by service location.		
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,C) Provider Name	Provider's full name.	50	Character
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)

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3.5.60 DSSProfiler - Professional Claim Details by Provider - FFS

Based on the user-entered date range of one year, this report allows the user to move down to the detail level for all case type categories within the system for a given provider and service location. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients that received medical care.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are four tabs in this report:

A. Professional Claim Details;

B. Recipient Listing;

C. Diagnosis Listing; and

D. Procedure Listing.

A

Alabama Medicaid Agency

Professional Claim Details By Provider - FFS

Professional Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

For Claim Types: M FITZGERALD-PERRETT CLINIC

User ID: [redacted]
Run Date: 9/8/16
Run Time: 12:58:58 PM

ICN	CT	POS	DB #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt	Wrap Ind
[redacted]	M	11	1	12345678901 2	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	10/25/1964	50	9/4/2015	9/4/2015	9	4011	BENIGN ESSENTIAL HYPERTENSION	9	78062	OTHER HYPOXEMIA	99214	Office Outpatient Vist Est							1	$110.00	$80.72	$76.62	Y
[redacted]	M	11	2	12345678901 2	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	11/29/1958	56	9/3/2015	9/3/2015	9	7862	COUGH	9	[redacted]	Unknown or Not Appl.	70210	X-Ray, Exam Of Sinuses							1	$65.00	$21.00	$21.00	Y

End of Report

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

Professional Claim Details By Provider

Recipient Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Recipient ID	Recipient Full Name	ICN Count
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1

End of Report

PHI has been covered

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

Professional Claim Details By Provider

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
9	29630 - MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	#	####### -	#	####### -	4	4
9	29690 - UNSPECIFIED AFFECTIVE PSYCHOSIS	#	####### -	#	####### -	1	1

End of Report

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D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/25/2013
Run Time: 1:46:01 PM

Professional Claim Details By Provider

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Procedure Code & Description	ICN Count	Recipient Count
99213 - Office/Outpatient Visit Est	5	5

End of Report

3.5.60.1 DSSProfiler - Professional Claim Details by Provider - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.		
(A) Diag 2	The secondary ICD-CM diagnosis code.	60	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	7	Character

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Field	Description	Length	Data Type
(A) From Date of Service (FDOS)	Claim's first date of service.	60	Character
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	10	Date (MM/DD/CCYY)
(A) MD1	First Modifier code for the procedure code billed.	13	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	2	Character
(A) MD2	Second Modifier code for the procedure code billed.	40	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	2	Character
(A) MD3	Third Modifier code for the procedure code billed.	40	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	2	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (sent by the RCO).	40	Character
(A) Place of Service (POS)	Place of Service code for where services were rendered.	13	Number (Decimal)
(A) Proc	Procedure Code for the detail.	2	Number (Decimal)
(A) Proc Desc	Procedure Code description for the detail.	6	Character
(A) To Date of Service (TDOS)	Date on which the statement period on the claim ended	40	Character

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Field	Description	Length	Data Type
(A) Wrap Ind	Wrap Payment Indicator	1	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character

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Field	Description	Length	Data Type
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.61 DSSProfiler - Professional Claim Details by Provider Quarterly - FFS

The Professional Details by Provider reports are created in the DSSProfiler. Based on the user-entered date range of one quarter, this report lets the user tab down to the detail level for all professional case type categories within the system. This report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served. The DSSProfiler has similar reports that drill down for Professional Referrals, Inpatient, Outpatient, Nursing Facility and Pharmacy claims activity.

The detail reports are very helpful for additional analysis on exceptions or comparing the provider's claims with the medical records.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs on this report include:

A. Professional Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipients;

C. Diagnosis Listing - Lists the diagnosis codes on all claims reported; and

D. Procedure Listing - Lists the individual procedure, number of ICNs and number of recipients.

A

Alabama Medicaid Agency

Professional Claim Details By Provider Qtrly - FFS

Professional Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: SHERMAN L ARMSTRONG JR

For Claim Types: M

Quarter: 20162

User ID: [redacted]
Run Date: 9/8/16
Run Time: 1:08:54 PM

ICN	CT	POS	DB #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD1	MD1 Desc	MD2	MD2 Desc	MD3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt	Wrap Ind
[redacted]	M	11	1	123456789012	XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	4/25/2000	16	5/1/2016	5/1/2016	0	E1100	TYPE 2 DIAB W HYPRGLY W/O NONVIST HYPRGLYHYPRDS COMA (NONHC)	#	********	Unknown or Not Appl.	99394	Prev Visit Est Age 12-17	E P	MEDICAID SPEDT PROGR AND SVC					1	$40.00	$5.00	$5.00	N
[redacted]	M	11	1	123456789012	XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	3/14/1991	25	4/5/2016	4/5/2016	0	E1010	TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA	#	********	Unknown or Not Appl.	99211	Office Outpatient Visit Est							1	$50.00	$17.00	$16.70	N
[redacted]	M	11	1	123456789012	XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	9/15/2001	14	4/15/2016	4/15/2016	0	E1100	TYPE 2 DIAB W HYPRGLY W/O NONVIST HYPRGLYHYPRDS COMA (NONHC)	#	********	Unknown or Not Appl.	99394	Prev Visit Est Age 12-17	E P	MEDICAID SPEDT PROGR AND SVC					1	$40.00	$40.00	$40.00	N
[redacted]	M	11	1	123456789012	XXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	12/15/1997	18	4/17/2016	4/17/2016	0	E1010	TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA	#	********	Unknown or Not Appl.	99211	Office Outpatient Visit Est							1	$60.00	$0.00	$0.00	N

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

Professional Claim Details By Provider Qtrly

Recipient Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

Recipient ID	Recipient Full Name	ICN Count
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1
[redacted]	[redacted]	1

End of Report

PHI has been covered

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

Professional Claim Details By Provider Qtrly

Diagnosis Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
9	29630 - MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	#	####### -	#	####### -	4	4
9	29690 - UNSPECIFIED AFFECTIVE PSYCHOSIS	#	####### -	#	####### -	1	1

D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/28/2013
Run Time: 8:35:24 AM

Professional Claim Details By Provider Qtrly

Procedure Listing

For Dates of Service: 10/01/2012 - 09/30/2013

Provider Base, Medicaid or NPI ID: [redacted]

WIREGRASS WELLNESS CENTER LLC

For Claim Types: M;B

Quarter: 20131

Procedure Code & Description	ICN Count	Recipient Count
99213 - Office/Outpatient Visit Est	5	5

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3.5.61.1 DSSProfiler - Professional Claim Details by Provider Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character

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Field	Description	Length	Data Type
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	7	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A) Wrap Ind	Wrap Payment Indicator	1	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character

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Field	Description	Length	Data Type
(A-D) Quarter (prompt)	The quarter for which the report is being run for.	5	Number (Integer)
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.62 DSSProfiler - Professional Disease Global View

This set of reports is created in DSSProfiler.

This report allows you to view the services that recipients received from a selected case type. For example, you can observe diabetic or asthmatic recipients and view the associated services that they received.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-G in the layout below. The field names have the corresponding letter in front, identifying the tab it can be located. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports.

The seven tabs in this report are:

A. General Health Demographics shows the age and gender mix;

B. Other Professional Services shows the general health demographics;

C. Other Inpatient Services shows other professional services;

D. Other Outpatient Services shows other inpatient services;

E. Other Pharmacy Services shows other pharmacy services;

F. Other Nursing Facility Services shows other nursing facility services; and

G. Recipients shows the list of recipients by age groups

A

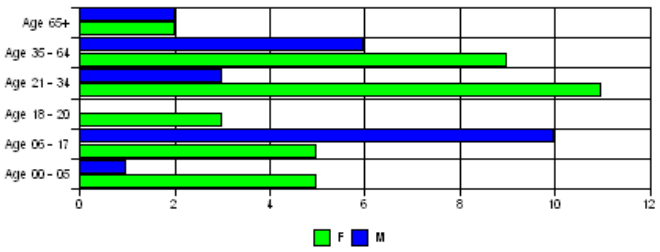
Alabama Medicaid Agency

Professional Disease Global View
General Health Demographics

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age/Gender Mix



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Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
General Health Demographics

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$55,503.64	$23,388.89	$23,388.89	57	100.00 %

End of Report

B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 8/4/2006
Run Time: 10:50:53 AM

Professional Disease Global View
Other Professional Services

For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$56,513.64	$24,075.97	$22,166.76	58	100.00 %
300 - FQHC Encounter Procedures	$33,593.34	$11,888.98	$10,916.72	33	56.90 %
381 - Evaluation & Management All Procedures	$4,072.00	$399.88	$587.63	15	25.86 %
237 - Infectious/Parasitic Diagnosis	$9,519.00	$7,660.60	$6,907.67	14	24.14 %
243 - STD, Sexual Transmitted Disease Diagnosis	$9,361.00	$7,502.60	$6,750.67	12	20.69 %
245 - Injury/Poisoning Diagnosis	$2,956.00	$583.97	$460.00	10	17.24 %
223 - Endocrine Disease Diagnosis	$1,560.00	$442.35	$431.35	9	15.52 %
225 - Diabetes Mellitus Diagnosis	$540.00	$291.25	$280.25	8	13.79 %
304 - Surgical Excluding Veni Punct/OB Procedures	$7,465.00	$6,804.07	$6,563.59	8	13.79 %
352 - Pathology All Procedures	$258.00	$146.08	$80.00	7	12.07 %
402 - Dental - C Dental Resin	$10,009.00	$4,569.82	$4,569.82	7	12.07 %
405 - Dental - F Dental Scalant	$824.25	$192.71	$192.71	6	10.34 %
298 - Drugs Excluding Pharmacy Procedures	$530.00	$331.25	$150.25	5	8.62 %
312 - Musculoskeletal Procedures	$1,710.00	$1,610.41	$1,605.41	4	6.90 %

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C

Alabama Medicaid Agency

Professional Disease Global View

Other Inpatient Services

For Dates of Service: 10/01/2004 - 09/30/2005

Case Type: 1 - All Claim Groupings

Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: [redacted]
Run Date: 8/4/2006
Run Time: 10:50:53 AM

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$274,510.00	$177,679.68	$120,550.42	11	18.97 %
454 - Admissions Excluding MH/SA/OB	$274,510.00	$177,679.68	$120,550.42	11	18.97 %
626 - Discharged Home codes(01 - 01)	$113,810.00	$40,004.00	$39,555.00	10	17.24 %
631 - Readmissions codes(01 - 04)	$113,810.00	$40,004.00	$39,555.00	10	17.24 %
510 - Injury/Poisoning Diagnosis	$214,420.00	$153,467.78	$96,613.52	7	12.07 %
489 - Endocrine Disease Diagnosis	$5,600.00	$10,442.50	$10,167.50	3	5.17 %
491 - Diabetes Mellitus Diagnosis	$5,600.00	$10,442.50	$10,167.50	3	5.17 %
419 - ACS-All Ambulatory Care Sensor Conditions	$8,800.00	$4,818.00	$4,815.00	2	3.45 %
437 - ACS-Chronic	$4,400.00	$2,407.50	$2,407.50	2	3.45 %
447 - ACS-Diabetes without Complication	$4,400.00	$2,407.50	$2,407.50	2	3.45 %
456 - V Codes Diagnosis	$41,245.00	$6,369.75	$6,369.75	2	3.45 %
502 - Infectious/Parasitic Diagnosis	$13,245.00	$7,399.65	$7,399.65	2	3.45 %

End of Report

D

Alabama Medicaid Agency

Professional Disease Global View

Other Outpatient Services

For Dates of Service: 07/01/2004 - 06/30/2005

Case Type: 1 - All Claim Groupings

Aggregation Code: 7 - Fee for Service Claims by Recipient

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$15,786.80	$2,383.42	$1,658.74	8	14.04 %
687 - Endocrine Disease Diagnosis	$4,466.20	$1,301.93	$724.33	5	8.77 %
689 - Diabetes Mellitus Diagnosis	$4,466.20	$1,301.93	$724.33	5	8.77 %
656 - Circulatory System Disease Diagnosis	$10,600.00	$927.19	$780.11	4	7.02 %
848 - Provider Type - Home Health Agency	$3,515.00	$1,319.40	$745.80	4	7.02 %
661 - Heart Disease Diagnosis	$9,600.00	$827.19	$680.11	3	5.26 %
701 - Infectious/Parasitic Diagnosis	$105.60	$9.90	$9.90	1	1.75 %
707 - STD, Sexual Transmitted Disease Diagnosis	$105.60	$9.90	$9.90	1	1.75 %
722 - Neoplasm Diagnosis	$115.00	$94.40	$94.40	1	1.75 %
736 - Obstetric Diagnosis	$500.00	$50.00	$50.00	1	1.75 %

End of Report

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E

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Other Pharmacy Services

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$0.00	$0.00	$0.00	11	19.30 %

End of Report

F

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Other Nursing Facility Services

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Case Type Description	Billed Amount	Allowed Amount	Paid Amount	Recipient Count	Percent of Recipients
1 - All Claim Groupings	$16,680.00	$0.00	$9,792.19	3	5.26 %

End of Report

G

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:32:46 PM

Professional Disease Global View
Recipients

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Age 00 - 05

Recipient Id	Recipient Full Name
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Age 06 - 17

Recipient Id	Recipient Full Name
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

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3.5.62.1 DSSProfiler - Professional Disease Global View Field Descriptions

Field	Description	Length	Data Type
(A) Age/Gender Mix	Bar graph that illustrates the number of recipients for each age group and gender mix. This graph shows the distribution of recipients based on age and gender.	0	Character
(A-F) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-F) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-F) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A-F) Paid Amount	Amount the program paid on the claim grouping of recipients in the predefined diagnosis group.	13	Number (Decimal)
(A-F) Percent of Recipients	Percentage of recipients in the pre-defined diagnosis group that also fall under these specific claim groupings.	8	Character
(A-F) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Character
(A-G) Aggregation Code	Aggregation Code and Description.	107	Character
(A-G) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-G) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(G) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+.	24	Character
(G) Recipient Full Name	Recipient's full name.	22	Character
(G) Recipient ID	Recipient Medicaid Number.	12	Character

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3.5.63 DSSProfiler - Professional Disease Quick View

This report is created in the DSSProfiler. This report displays recipient utilization services for selected case types with totals listed by the number of services received. This report can also be used for disease management. The first row gives the totals for each column.

There are two tabs in this report:

A. Professional Disease shows recipient utilization for the case type; and

B. Professional Disease by Peer Group shows recipient utilization for each peer group.

A

Alabama Medicaid Agency

Professional Disease Quick View
Professional Disease

User ID: Administrator
Run Date: 5/12/2006
Run Time: 1:38:08 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
22	1	24	22	$2,352.41	$126.04	$1,438.44
15	2	30	30	$18,243.13	$300.00	$2,593.46
3	3	9	9	$684.69	$26.04	$250.14
3	4	12	12	$119.48	$10.00	$87.48
1	5	5	5	$860.00	$0.00	$786.82
3	6	18	18	$1,337.00	$652.83	$1,238.34
2	7	14	14	$1,083.00	$21.37	$289.95
2	9	18	18	$1,170.00	$20.20	$422.44
1	10	602	10	$6,200.00	$50.00	$2,912.98
1	14	806	14	$1,231.00	$10.00	$750.00
1	19	25	19	$1,718.00	$200.00	$456.73
1	40	40	40	$4,044.00	$713.08	$1,360.59

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B

Alabama Medicaid Agency

User ID: [illegible]
Run Date: 8/12/2006
Run Time: 12:00:12 PM

Professional Disease Quick View

Professional Disease By Peer Group
For Dates of Service: 10/01/2004 - 09/30/2005
Case Type: 1 - All Claim Groupings
Aggregation Code: 7 - Fee for Service Claims by Recipient

Peer Group: 504 - Blank Aid Category

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	2	2	2	$200.00	$0.00	$7.50
Totals:			2	$200.00	$0.00	$7.50

Peer Group: 516 - Public Assistance, Blind

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
2	1	2	2	$250.00	$126.04	$124.04
1	2	2	2	$715.57	$713.08	$713.08
Totals:			4	$965.57	$839.12	$837.12

Peer Group: 519 - Public Assistance, Disabled

Unduplicated Recipients	Each Recipient Had XX Claims	Total Quantity Billed	Total Claims	Billed Amount	Allowed Amount	Paid Amount
1	1	2	1	$300.00	$300.00	$290.00
1	2	2	2	$14.00	$14.00	$14.00

3.5.63.1 DSSProfiler - Professional Disease Quick View Field Descriptions

Field	Description	Length	Data Type
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-B) Each Recipient Had XX Claims	This field shows us how many claims each of the recipients had.	4	Character
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	This is the total amount paid by the program for the specific claim grouping.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A-B) Total Claims	This is the total number of claims billed based on the number of recipients and the number of claims each recipient had.	9	Number (Integer)
(A-B) Total Quantity Billed	This is the total units billed for this particular claim category.	9	Number (Integer)
(A-B) Unduplicated Recipients	This is a count of all recipients that have had a service within this claim grouping. The count is unduplicated, meaning each recipient is only counted once.	9	Number (Integer)
(B) Peer Group	Peer Group Code and Description.	107	Character

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3.5.64 DSSProfiler - Professional Distribution Analysis

The Professional Distribution Analysis reports are created in the DSSProfiler. This report provides the totals for all professional case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types or service categories need to be observed more closely with other reports within the DSSProfiler.

The tabs in this report include:

A. Professional Distribution Summary shows professional distribution summary for different case types;

B. Professional Services Distribution top 20 shows the top 20 case types with exceptions, by number of recipients and by paid amount per recipient;

C. Professional Services Distribution by Age shows information for the age groups for each case type;

D. Professional Services Distribution by Gender shows information for the gender for each case type; and

E. Professional Services Distribution by Age/Gender shows information for the gender and age groups for each case type.

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
Professional Distribution Summary

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Paid Amt per Recip	Claims per Recip	Exception Count
1 - All Claim Groupings	3	3	1	$218.00	$0.00	$0.00	$218.00	$0.00	3.00	1
300 - FQHC Encounter Procedures	3	3	1	$218.00	$0.00	$0.00	$218.00	$0.00	3.00	1
352 - Pathology All Procedures	1	1	1	$88.00	$0.00	$0.00	$88.00	$0.00	1.00	1
381 - Evaluation & Management All Procedures	2	2	1	$130.00	$0.00	$0.00	$130.00	$0.00	2.00	1

End of Report

Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

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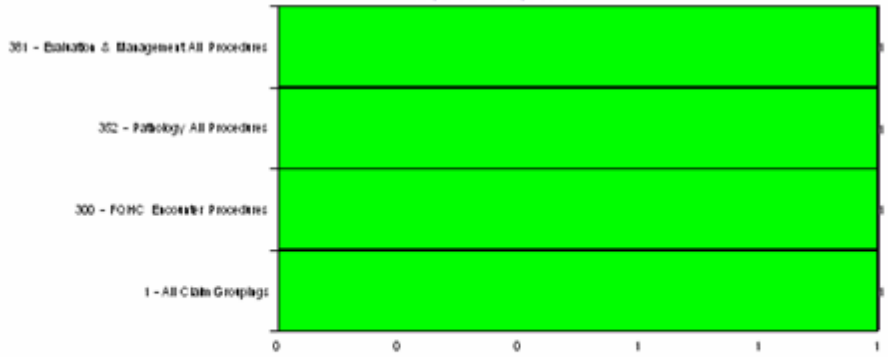
Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 Exceptions



Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/12/2006
Run Time: 12:46:10 PM

Professional Distribution Analysis
By Age

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
Age 65+	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

Case Type: 300 - FQHC Encounter Procedures

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
Age 65+	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

Professional Distribution Summary | TOP 20 | By Age | By Gender | By Age/Gender | Notes

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Alabama Medicaid Agency

Professional Distribution Analysis
By Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:46:10 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
M	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

Case Type: 300 - FQHC Encounter Procedures

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amount per Recip	Allowed Amount per Recip	Paid Amount per Recip	Claims per Recip
M	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

E

Alabama Medicaid Agency

Professional Distribution Analysis
By Age/Gender

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:46:10 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Case Type: 1 - All Claim Groupings

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 65+	M	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
	Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

Case Type: 300 - FQHC Encounter Procedures

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 65+	M	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00
	Sum:	3	3	1	$218.00	$0.00	$218.00	$0.00	$0.00	3.00

Case Type: 352 - Pathology All Procedures

Age Description	Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 65+	M	1	1	1	$88.00	$0.00	$88.00	$0.00	$0.00	1.00
	Sum:	1	1	1	$88.00	$0.00	$88.00	$0.00	$0.00	1.00

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3.5.64.1 DSSProfiler - Professional Distribution Analysis Field Descriptions

Field	Description	Length	Data Type
(A,C,D,E) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims.	13	Number (Decimal)
(A) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A) Exception Count	Number of exceptions identified. An exception is defined as two standard deviations from the norm.	8	Number (Integer)
(C,D,E) Allowed Amt Per Recipient	Total allowed amount divided by the number of recipients.	13	Number (Decimal)
(A,C,D,E) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,C,D,E) Billed Amount per Recip	Total billed amount divided by the number of recipients.	12	Number (Decimal)
(A,C,D,E) Billed Quantità	Quantity billed.	14	Number (Integer)
(A,C,D,E) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A,C,D,E) Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(A,C,D,E) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,C,D,E) Paid Amount per Recip	Total paid amount divided by the number of recipients.	12	Number (Decimal)
(A,C,D,E) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-E) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-E) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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Field	Description	Length	Data Type
(A-E) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(B) Top 20 By Number of Recipients	Graph shows Top 20 exceptions by number of recipients.	1	Character
(B) Top 20 By Paid Amount per Recipient	Graph shows Top 20 exceptions by paid amount per recipient.	1	Character
(B) Top 20 Exceptions	Graph shows Top 20 exceptions.	1	Character
(A,C,D,E) Case Type &Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(C,E) Age Description	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(D,E) Gender	Recipient's gender.	1	Character

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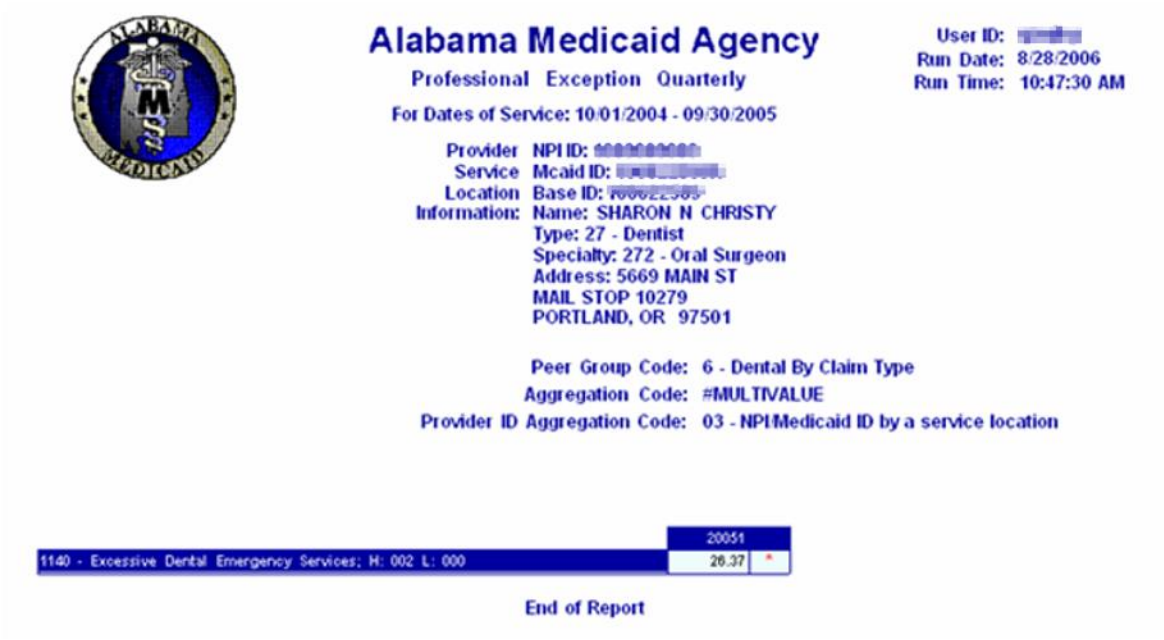
3.5.65 DSSProfiler - Professional Exception Quarterly

The Professional Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. The report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the high value are marked as exceptions.



Alabama Medicaid Agency

Professional Exception Quarterly

For Dates of Service: 10/01/2004 - 09/30/2005

User ID: [redacted]
Run Date: 8/28/2006
Run Time: 10:47:30 AM

Provider NPI ID: [redacted]
Service Mcaid ID: [redacted]
Location Base ID: [redacted]
Information: Name: SHARON N CHRISTY
Type: 27 - Dentist
Specialty: 272 - Oral Surgeon
Address: 5669 MAIN ST
MAIL STOP 10279
PORTLAND, OR 97501

Peer Group Code: 6 - Dental By Claim Type
Aggregation Code: #MULTIVALUE
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

	20051	
1140 - Excessive Dental Emergency Services; H: 002 L: 000	26.37	*

End of Report

3.5.65.1 DSSProfiler - Professional Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Calculation	Calculation to find case groups above the exception high.	14	Number (Decimal)
Case Type Group Display	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Number (Integer)
Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer	20	Character

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Field	Description	Length	Data Type
	group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Service Location Information	Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID.	200	Character

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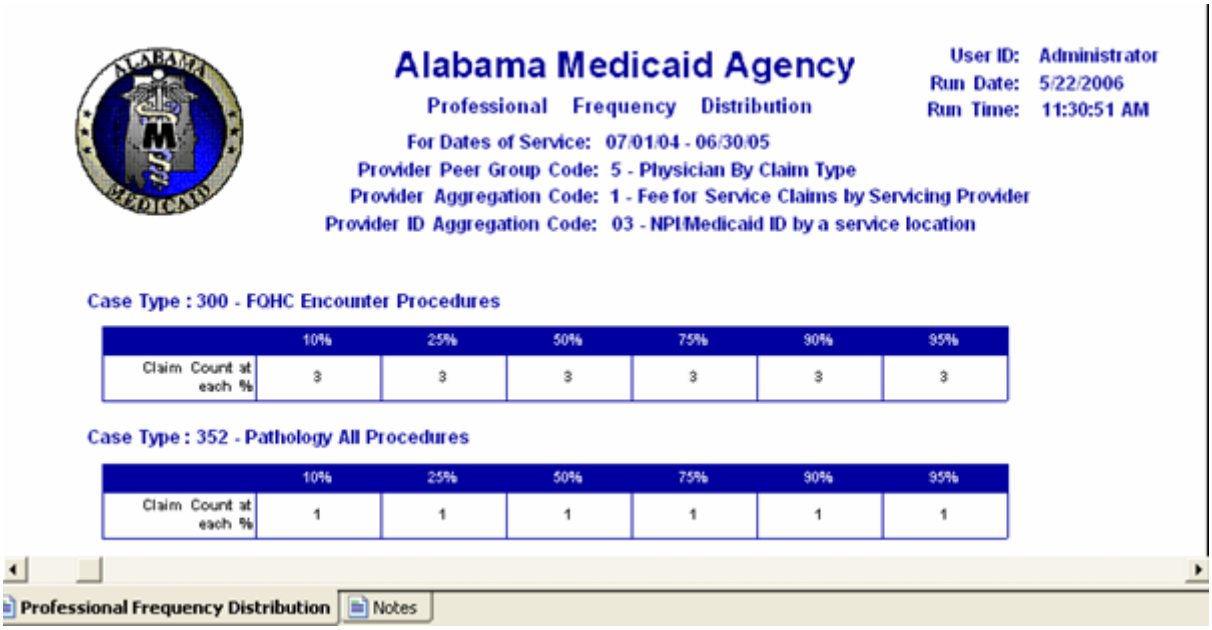
3.5.66 DSSProfiler - Professional Frequency Distribution

The Professional Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each professional case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



Alabama Medicaid Agency

Professional Frequency Distribution

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:30:51 AM

For Dates of Service: 07/01/04 - 06/30/05
Provider Peer Group Code: 5 - Physician By Claim Type
Provider Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type : 300 - FQHC Encounter Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	3	3	3	3	3	3

Case Type : 352 - Pathology All Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Professional Frequency Distribution | Notes

3.5.66.1 DSSProfiler - Professional Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02	40	Character

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Field	Description	Length	Data Type
	- NPI ID all service locations and 03 NPI/Medicaid ID by service location.		
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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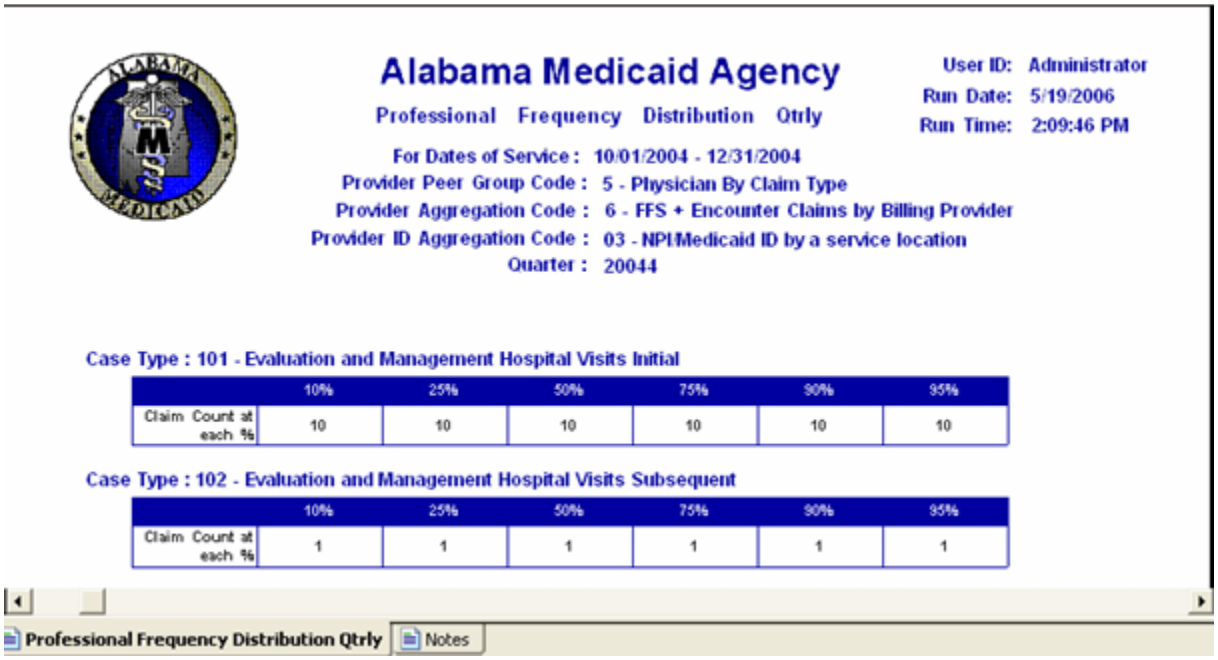
3.5.67 DSSProfiler - Professional Frequency Distribution Quarterly

The Professional Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range for one quarter, this report shows each professional case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



Alabama Medicaid Agency

Professional Frequency Distribution Qtrly

User ID: Administrator
Run Date: 5/19/2006
Run Time: 2:09:46 PM

For Dates of Service : 10/01/2004 - 12/31/2004
Provider Peer Group Code : 5 - Physician By Claim Type
Provider Aggregation Code : 6 - FFS + Encounter Claims by Billing Provider
Provider ID Aggregation Code : 03 - NPI/Medicaid ID by a service location
Quarter : 20044

Case Type : 101 - Evaluation and Management Hospital Visits Initial

	10%	25%	50%	75%	90%	95%
Claim Count at each %	10	10	10	10	10	10

Case Type : 102 - Evaluation and Management Hospital Visits Subsequent

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Professional Frequency Distribution Qtrly | Notes

3.5.67.1 DSSProfiler - Professional Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other	20	Character

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Field	Description	Length	Data Type
	providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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3.5.68 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group

The Professional Recipient Case Type Comparison by Peer Group report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norm on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely at a case type level, utilizing other reports within the DSSProfiler. This report makes it easy to see, for example, which recipients are the recipients of asthma services who fall outside of the accepted norm within the peer group.

The tabs in this report include:

A. Recipient Comparison shows which recipients fall outside the norm for the peer group; and

B. Recipients Grouped by Age/Gender shows recipients for the gender and age groups.

A

Alabama Medicaid Agency

Professional Recipient Case Type Comparison by Peer Group

Recipient Comparison

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 1071 - AL Hypertension Diagnosis

Recipient Peer Group: 959 - 38 MLIF Elig Cert by Medicaid-Adult-No Money

Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID: [redacted]
Run Date: 10/26/2007
Run Time: 9:59:35 AM

Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference From Expected	Exception
1	[redacted]	[redacted]	$160.00	$136.00	$134.00	$50.17	$83.83	*
3	[redacted]	[redacted]	$86.00	$87.00	$66.00	$37.00	$29.00	
3	[redacted]	[redacted]	$80.00	$67.00	$66.00	$43.00	$23.00	
2	[redacted]	[redacted]	$65.00	$73.77	$72.77	$72.77	$0.00	
8	[redacted]	[redacted]	$42.00	$32.00	$31.00	$31.00	$0.00	
5	[redacted]	[redacted]	$50.00	$43.00	$42.00	$50.17	$-8.17	
5	[redacted]	[redacted]	$138.00	$42.00	$42.00	$50.17	$-8.17	
7	[redacted]	[redacted]	$56.00	$42.00	$41.00	$50.17	$-9.17	
9	[redacted]	[redacted]	$48.00	$31.00	$30.00	$50.17	$-20.17	
10	[redacted]	[redacted]	$85.00	$20.00	$20.00	$43.00	$-23.00	
12	[redacted]	[redacted]	$27.00	$8.00	$8.00	$37.00	$-29.00	
11	[redacted]	[redacted]	$28.60	$12.00	$12.00	$50.17	$-38.17	
						2 STD DEV	$65.64	

End of Report

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B

Alabama Medicaid Agency

Professional Recipient Case Type Comparison by Peer Group

Recipients Grouped by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006

Case Type: 1071 - AL Hypertension Diagnosis

Recipient Peer Group: 959 - 38 MLIF Elig Cert by Medicaid-Adult-No Money

Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID:
Run Date: 10/26/2007
Run Time: 9:59:35 AM

Age 35 - 64

Gender: F

Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount
		$80.00	$67.00	$66.00
		$85.00	$73.77	$72.77
		$85.00	$20.00	$20.00
			Sum:	$158.77

3.5.68.1 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates recipients who are 2 standard deviations above or below the "norm" for the peer group.	1	Number (Integer)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Classification of the provider rendering health and medical services as approved under the state plan.	50	Character
(A,B) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (	13	Number (Decimal)
(A,B) Recipient Full Name	Recipient's full name.	50	Character
(A,B) Recipient ID	Recipient Medicaid Number.	12	Character
(A,B) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.69 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms on a user specified case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report can be analyzed. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

There are two tabs in this report:

A. Recipient Comparison shows recipients that fall outside the norm for the peer group; and

B. Recipients Grouped by Age/Gender shows recipients by gender and age groups.

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3.5.69.1 DSSProfiler - Professional Recipient Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Recipient's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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Field	Description	Length	Data Type
(A,B) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,B) Recipient ID	Recipient identification number.	8	Character
(B) Age	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Number (Integer)
(B) Gender	Recipient's gender.	1	Character

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3.5.70 DSSProfiler - Professional Provider Profile

The Professional Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A. Provider Summary - Displays basic provider demographic information, breakdown on recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B. Professional Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/25/2007
Run Time: 3:06:33 PM

Professional Provider Profile

Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider Information

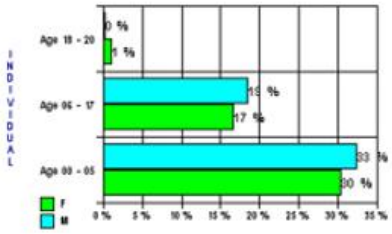
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: [redacted]
Type: 13 - Public Health Agency
Specialty: 345 - General Pediatrician
Address: 2817 30TH AVE NORTH

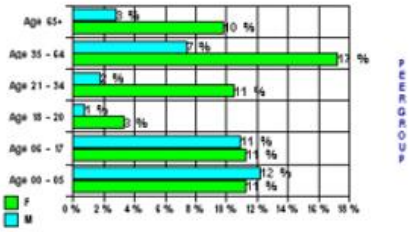
BIRMINGHAM, AL 35207

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/1/2007
Run Time: 11:42:15 AM

Professional Referral Provider Profile

Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider's General Service Profile

Service Type	Recip Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
2 - Professional Referrals	256	$111,828.75	$64,074.81	$44,595.28	$57,768.08	$(13,172.80)	(22.80) %

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B

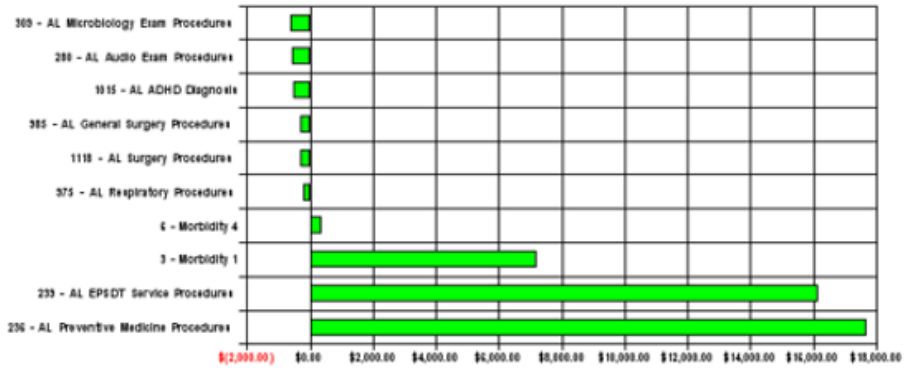
Alabama Medicaid Agency

Professional Provider Profile
Professional Services

User ID:
Run Date: 9/25/2007
Run Time: 3:06:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

Professional Provider Profile
Professional Services

User ID:
Run Date: 9/25/2007
Run Time: 3:06:33 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type	Recip Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
236 - AL Preventive Medicine Procedures	254	271	271	$36,858.00	$36,858.00	$40,898.92	$23,209.53	$17,689.39	76.22 %
239 - AL EPSDT Service Procedures	249	265	265	$36,030.00	$36,030.00	$40,026.92	$23,892.75	$16,134.17	67.53 %
3 - Morbidity 1	238	640	643	$28,613.66	$30,136.73	$28,556.66	$21,372.12	$7,184.54	33.62 %
6 - Morbidity 4	124	471	474	$21,046.66	$21,761.00	$21,046.66	$20,681.48	$365.18	1.77 %
975 - AL Respiratory Procedures	27	40	62	$576.00	$1,777.00	$0.00	$224.22	$(224.22)	(100.00) %
1118 - AL Surgery Procedures	3	3	3	$78.00	$78.00	$0.00	$281.35	$(281.35)	(100.00) %

3.5.70.1 DSSProfiler - Professional Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Patient Age/Gender Breakdown	This section compares the providers to their specialty peer group based similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A) Service Type	User defined group based on the service type file. The claim grouping should be specific to the area of service.	100	Character
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A,B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping	20	Character

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Field	Description	Length	Data Type
	variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.		
(A,B) Percent Difference	The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A,B) Provider ID	Provider identification number.	15	Character
(A,B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,B) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Quantity	Quantity billed.	8	Number (Integer)
(B) Top 10 Case Type: Dollar Difference	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character

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3.5.71 DSSProfiler - Professional Provider Profile Quarterly

The Professional Provider Profile Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Services - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - the peer group to which the profiled provider is being compared;
- Aggregation Code - the code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.

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A

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

Professional Provider Profile Qtrly

Provider Summary

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider Information

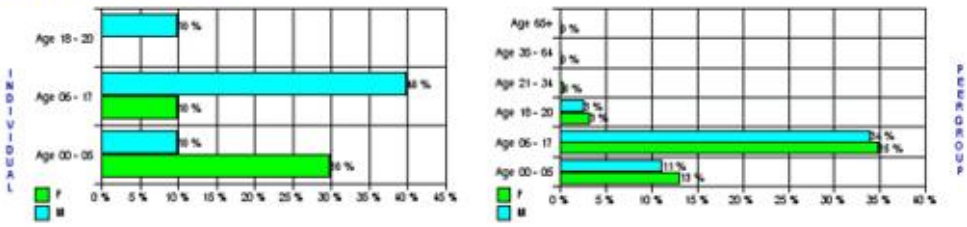
NPI ID:
Mcaid ID:
Base ID:
Name:
Type: 27 - Dentist
Specialty: 271 - General Dentistry Practitioner
Address: 1320 SUMMIT PLACE

BIRMINGHAM, AL 35243

Rank

$ Paid Amount Actual	132
$ Paid Amount Expected	83
$ Billed Amount Actual	89
Recipient Rank	65
# Units Rank	170
# Claims Rank	91
Peer Group Size	593

Patient Age/Gender Breakdown



Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 5:37:35 PM

Professional Provider Profile Qtrly

Provider Summary

For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider's General Service Profile

Report Category	Recipient Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
1 - Professional Services	10	$1,263.00	$2,046.00	$948.00	$1,483.16	$-535.16	-36.08 %

End of Report

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B

Alabama Medicaid Agency

Professional Provider Profile Qtrly
Professional Services
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

Top 10 Claim Types: Dollar Difference

Alabama Medicaid Agency

Professional Provider Profile Qtrly
Professional Services
For Dates: 01/01/2006 - 12/31/2006
Provider ID:
Provider Peer Group: 207 - 271 GENERAL DENTISTRY PRACTITIONER
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

User ID:
Run Date: 9/27/2007
Run Time: 5:02:49 PM

Case Type	Recipient Count	Claim Count	Billed Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
4 - Morbidity 2	1	2	2	$119.00	$190.00	$118.00	$169.96	$-51.96	-30.57 %
3 - Morbidity 1	6	10	10	$845.00	$1,334.00	$682.00	$853.20	$-71.20	-10.90 %
5 - Morbidity 3	1	5	5	$174.00	$304.00	$174.00	$325.33	$-151.33	-46.52 %
6 - Morbidity 4	2	4	4	$126.00	$218.00	$74.00	$334.66	$-260.66	-77.89 %

3.5.71.1 DSSProfiler - Professional Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)

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Field	Description	Length	Data Type
(A) Patient Age/Gender Breakdown	This section is similar to the health status section. It compares the providers to their specialty peer group based on the beneficiaries they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider type, specialty, name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A,B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A,B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A,B) For Dates	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,B) Percent Difference	The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A,B) Provider ID	Provider identification number.	15	Character
(A,B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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Field	Description	Length	Data Type
(A,B) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	6	Number (Integer)
(B) Billed Quantity	Quantity billed.	14	Number (Integer)
(B) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Top 10 Claim Types: Dollar Difference	Difference in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference	60	Character

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3.5.72 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group

The Professional Referrals Case Type Comparison by Peer Group report is created within the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm on a user specified service category. All information is age and gender adjusted so that differences in patient mix do not affect the results. Any of the individual case types shown in the pre-defined case types report (below) can be analyzed. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report.

A. Provider Comparison shows providers that fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows averages and recipient count for the gender and age groups for each provider; and

C. Average Amount per Recipient All Providers by Selected Age/Gender shows a lists of providers within the gender and age groups.

A

Alabama Medicaid Agency

Professional Referrals Case Type Comparison by Peer Group
Provider Comparison

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Rank	Raw Rank	Expected Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dol Diff	Exception
1	2	2		NORTHERN HEALTH, CENTER - ALL BSE	$96,345.21	$71,803.45	$71,476.46	$66,549.15	$4,927.31	
2	1	1		JEFFERSON COUNTY DEPT OF HLT - ALL BSE	$553,726.45	$443,619.74	$439,927.21	$444,858.78	$(4,931.57)	
								2 STD DEV	$13,942.56	

End of Report

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B

Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

Professional Referrals Case Type Comparison by Peer Group
Average Amount per Recipient by Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

- NORTHERN HEALTH, CENTER - ALL BSE

Age Group	Gender	Recipient Count	Paid Amount per Recipient
Age 00 - 05	F	110	$175.53
Age 00 - 05	M	109	$134.45
Age 06 - 17	F	119	$123.31
Age 06 - 17	M	114	$138.14
Age 18 - 20	F	14	$139.81
Age 18 - 20	M	4	$97.75
Age 21 - 34	F	17	$222.66
Age 35 - 64	F	4	$229.37
Age 35 - 64	M	1	$41.00
		AVG:	$145.28

C

Alabama Medicaid Agency

User ID:
Run Date: 10/10/2007
Run Time: 3:20:02 PM

Professional Referrals Case Type Comparison by Peer Group
Average Amount per Recipient All Providers by Selected Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Case Type: 3 - Morbidity 1
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations

Age 00 - 05

Gender: F

Provider ID	Provider Name	Paid Amount per Recipient
	NORTHERN HEALTH, CENTER - ALL BSE	$175.53
	JEFFERSON COUNTY DEPT OF HLT - ALL BSE	$138.79
	AVG:	$143.11

Gender: M

Provider ID	Provider Name	Paid Amount per Recipient
	NORTHERN HEALTH, CENTER - ALL BSE	$134.45
	JEFFERSON COUNTY DEPT OF HLT - ALL BSE	$143.19
	AVG:	$142.25

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3.5.72.1 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Doll Diff	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Expected Rank	Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A-C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A,C) Provider Name	Provider's full name.	50	Character
(A-C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-C) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(B-C) Paid Amount (Per Recipient)	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(A-C) Provider ID	Provider identification number.	15	Character
(A-C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(B-C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B-C) Gender	Recipient's gender.	1	Character

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3.5.73 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm for a case type. All information is age and gender adjusted so that differences in patient mix do not affect the results. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

There are three tabs in this report:

A. Provider Comparison shows providers that fall outside the norm for the peer group;

B. Average Amount per Recipient by Age/Gender shows averages and recipient count for the gender and age groups for each provider; and

C. Average Amount per Recipient All Providers by Age/Gender shows a lists of providers within the gender and age groups.

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3.5.73.1 DSSProfiler - Professional Referrals Case Type Comparison by Peer Group Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific provider.	13	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)

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Field	Description	Length	Data Type
(A) Expected Rank	Provider's rank based on the amount Provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A) Paid Amount	Actual amount the provider was paid.	13	Character
(A) Rank	Provider's rank based on the actual money paid by the program.	3	Number (Integer)
(A) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A,B,C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A,B,C) Case Type	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A.B,C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A,B,C) Provider ID	Provider identification number.	15	Character
(A,B,C) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A,B,C) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A,B,C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A,C) Provider Name	Provider's full name.	50	Character
(B) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(B,C) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64 and 65+.	24	Character
(B,C) Gender	Recipient's gender.	1	Character
(B,C) Paid Amount per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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3.5.74 DSSProfiler - Professional Referral Claim Details by Provider - FFS

The Professional Referral Claim Details by Provider report is created in the DSSProfiler. Based on the user-entered date range of one year, this report lets the user drill down to the detail level for all case type categories within the system. The Professional Referrals report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs in this report include:

A. Professional Referral Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipient ID and names;

C. Diagnosis Listing - Lists the primary, secondary, and tertiary diagnosis codes; and

D. Procedure Listing – Lists the individual procedure, number of ICNs and number of recipients.

A

Alabama Medicaid Agency

Professional Referral Claim Details By Provider - FFS

Professional Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016
Provider Base, Medicaid or NPI ID:
Billing Provider Name: SOUTHERN HEAD & NECK SRGY AL
For Claim Types: M

User ID:
Run Date: 9/8/16
Run Time: 1:14:22 PM

ICN	CTS	POS	DB #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD 1	MD1 Desc	MD 2	MD2 Desc	MD 3	MD3 Desc	Bill Qty	Billed Amt	Alwd Amt	Paid Amt	Wrap Ind
[redacted]	M	11	1	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	7/6/1999	16	8/27/2015	8/27/2015	9	4779	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	9	4770	ALLERGIC RHINITIS DUE TO POLLEN	99213	Office Outpatient Vst Est	25	B/S S&P OBN SERV SAME HO DAY					1	$80.00	$34.40	$34.40	Y
[redacted]	M	11	2	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	7/6/1999	16	8/27/2015	8/27/2015	9	4616	OTHER ACUTE SINUSITIS	9	********		J0702	Betamethasone Inj, Acetate Phosp							1	$15.00	$6.92	$6.92	Y
[redacted]	M	11	3	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	7/6/1999	16	8/27/2015	8/27/2015	9	4616	OTHER ACUTE SINUSITIS	9	********		96372	Ther/Prophy/Diag Inj Sc/Im	59	DISTINCT PROCEDURAL SERVICE					1	$29.00	$10.00	$10.00	Y
[redacted]	M	11	1	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4779	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	9	38181	DISFUNCTION OF EUSTACHIAN TUBE	99213	Office Outpatient Vst Est	25	B/S S&P OBN SERV SAME HO DAY	24	UNRELATED SERV SAME HO PROVIDER			1	$80.00	$34.40	$31.80	Y
[redacted]	M	11	2	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4738	OTHER CHRONIC SINUSITIS	9	********		J0702	Betamethasone Inj, Acetate Phosp							1	$15.00	$6.92	$6.92	Y
[redacted]	M	11	3	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4738	OTHER CHRONIC SINUSITIS	9	********		96372	Ther/Prophy/Diag Inj Sc/Im	59	DISTINCT PROCEDURAL SERVICE					1	$29.00	$10.00	$10.00	Y
[redacted]	M	11	5	1234567890 12	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	38181	DISFUNCTION OF EUSTACHIAN TUBE	9	3829	UNSPECIFIED OTITIS MEDIA	92567	Tympanometry							1	$30.00	$11.20	$11.20	Y

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:52:25 AM

Professional Referral Claim Details By Provider - FFS

Recipient Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X	205

End of Report

PHI has been removed

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:52:25 AM

Professional Referral Claim Details By Provider - FFS

Diagnosis Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
0	C07 - MALIGNANT NEOPLASM OF PAROTID GLAND	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	3	2
0	E1010 - TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	60	7
0	E109 - TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	5	2
0	E1100 - TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLY-HYPROS COMA (NKHHC)	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	62	16
0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	1	1

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D

Alabama Medicaid Agency

Professional Referral Claim Details By Provider - FFS

Procedure Listing

For Dates of Service: 04/01/2015 - 03/31/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL

For Claim Types: M

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:52:25 AM

Procedure Code & Description	ICN Count	Recipient Count
11450 - Removal Sweat Gland Lesion	1	1
11750 - Removal Of Nail Bed	8	3
11920 - Correct Skin Color 6.0 Cm/<	1	1
26010 - Drainage Of Finger Abscess	1	1
27599 - Leg Surgery Procedure	2	1
29130 - Application Of Finger Splint	12	1
59410 - Obstetrical Care	1	1

3.5.74.1 DSSProfiler - Professional Referrals Claim Details by Provider - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character

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Field	Description	Length	Data Type
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	7	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A) Wrap Ind	Wrap Payment Indicator	1	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character

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Field	Description	Length	Data Type
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character

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Field	Description	Length	Data Type
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.75 DSSProfiler - Professional Referral Claim Details by Provider Quarterly - FFS

The Professional Referral Claims Detail by Provider Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report lets the user drill down to the detail level for all case type categories within the system. The Professional Referrals report displays all detailed claims information categorized by the individual case types. Additionally, the top procedures and diagnoses are displayed, as well as a list of recipients served.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The tabs in this report include:

A. Professional Referral Claim Details - Shows all the claims the provider submitted;

B. Recipient Listing - Lists the individual recipient ID and names;

C. Diagnosis Listing - Lists the primary, secondary diagnosis as well as diagnosis 3; and

D. Procedure Listing - Lists the individual procedure, number of ICNs and number of recipients.

A

Alabama Medicaid Agency

Professional Referral Claim Details By Provider Qtrly - FFS

Professional Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: SOUTHERN HEAD & NECK SRGY AL

For Claim Types: M

Quarter: 20153

User ID: [redacted]
Run Date: 9/8/16
Run Time: 1:18:25 PM

ICN	CT	POS	DB #	Recip ID	Recip Name	DOB	Age	FDOS	TDOS	ICD	Diag	Diag Desc	ICD	Diag 2	Diag 2 Desc	Proc	Proc Desc	MD 1	MD1 Desc	MD 2	MD2 Desc	MD 3	MD3 Desc	Bill Qty	Billed Amt	Allwd Amt	Paid Amt	Wrap Ind
[redacted]	M	11	1	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	7/6/1999	16	9/27/2015	9/27/2015	9	4779	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	9	4770	ALLERGIC RHINITIS DUE TO POLLEN	99213	Other Outpatient Visit Est	2 3	B/S SKP CBN SKIN SKHS VID DAY					1	$80.00	$34.40	$34.40	N
[redacted]	M	11	2	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	7/6/1999	16	9/27/2015	9/27/2015	9	4616	OTHER ACUTE SINUSITIS	9	[redacted]		J0702	Betamethasone Acet&Sod Phosp							1	$15.00	$6.92	$6.92	N
[redacted]	M	11	3	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	7/6/1999	16	9/27/2015	9/27/2015	9	4616	OTHER ACUTE SINUSITIS	9	[redacted]		96372	Ther/Prph/Diag Inj Subcu	5 9	DISTINCT PROCEDURAL SERVICE					1	$29.00	$10.00	$10.00	N
[redacted]	M	11	1	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4779	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	9	38181	DISFUNCTION OF EUSTACHIAN TUBE	99213	Other Outpatient Visit Est	2 3	B/S SKP CBN SKIN SKHS VID DAY	0 4	UNRELATED SKIN SKHS VID POSTOP			1	$80.00	$34.40	$31.80	N
[redacted]	M	11	2	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4738	OTHER CHRONIC SINUSITIS	9	[redacted]		J0702	Betamethasone Acet&Sod Phosp							1	$15.00	$6.92	$6.92	N
[redacted]	M	11	3	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	4738	OTHER CHRONIC SINUSITIS	9	[redacted]		96372	Ther/Prph/Diag Inj Subcu	5 9	DISTINCT PROCEDURAL SERVICE					1	$29.00	$10.00	$10.00	N
[redacted]	M	11	5	12345678912	XXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX, X	8/25/1978	37	9/14/2015	9/14/2015	9	38181	DISFUNCTION OF EUSTACHIAN TUBE	9	3829	UNSPECIFIED OTITIS MEDIA	92567	Tympanometry							1	$30.00	$11.20	$11.20	N

End of Report

Pill has been removed

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

Professional Referral Claim Details By Provider Qtrly - FFS

Recipient Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M
Quarter: 20162

Recipient ID	Recipient Full Name	ICN Count
123456789012	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	203

End of Report

PHI has been removed

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

Professional Referral Claim Details By Provider Qtrly - FFS

Diagnosis Listing
For Dates of Service: 04/01/2015 - 03/31/2016
Provider Base, Medicaid or NPI ID: [redacted]
Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL
For Claim Types: M
Quarter: 20162

ICD	Diagnosis 1 - Code & Desc	ICD	Diagnosis 2 - Code & Desc	ICD	Diagnosis 3 - Code & Desc	ICN Count	Recipient Count
0	C07 - MALIGNANT NEOPLASM OF PAROTID GLAND	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	3	2
0	E1010 - TYPE 1 DIABETES MELLITUS WITH KETOACIDOSIS WITHOUT COMA	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	60	7
0	E109 - TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	5	2
0	E1100 - TYPE 2 DIAB W HYPROSM W/O NONKET HYPRGLY-HYPROS COMA (NKHHC)	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	60	16
0	E1142 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY	#	####### - Unknown or Not Appl.	#	####### - Unknown or Not Appl.	1	1

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D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/18/16
Run Time: 10:54:44 AM

Professional Referral Claim Details By Provider Qtrly - FFS

Procedure Listing

For Dates of Service: 04/01/2015 - 03/31/2016

Provider Base, Medicaid or NPI ID: [redacted]

Billing Provider Name: ST CLAIR CO HLTH DEPT.-PELL

For Claim Types: M

Quarter: 20162

Procedure Code & Description	ICN Count	Recipient Count
11450 - Removal Sweat Gland Lesion	1	1
11750 - Removal Of Nail Bed	8	3
11920 - Correct Skin Color 6.0 Cm/<	1	1
26010 - Drainage Of Finger Abscess	1	1
27599 - Leg Surgery Procedure	2	1

3.5.75.1 DSSProfiler - Professional Referrals Claim Details by Provider Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Age	The age of the recipient on the From Date of Service rounded down to a full year.	4	Number (Integer)
(A) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A) Bill Qty	Quantity billed for the service rendered.	2	Number (Decimal)
(A) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A) Claim Type (CT)	Shows what type of claim was submitted.	1	Character
(A) DOB	Recipient's Date of Birth	10	Date (MM/DD/CCYY)
(A) Detail Number (Dtl#)	Claim line number.	4	Number (Integer)
(A) Diag	The primary ICD-CM diagnosis code.	7	Character
(A) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A) Diag 2	The secondary ICD-CM diagnosis code.	7	Character
(A) Diag 2 Desc	The secondary ICD-CM diagnosis code description.	60	Character

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Field	Description	Length	Data Type
(A) From Date of Service (FDOS)	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A) MD1	First Modifier code for the procedure code billed.	2	Character
(A) MD1 Desc	Description for the First Modifier code of the procedure code billed.	40	Character
(A) MD2	Second Modifier code for the procedure code billed.	2	Character
(A) MD2 Desc	Description for the Second Modifier code of the procedure code billed.	40	Character
(A) MD3	Third Modifier code for the procedure code billed.	2	Character
(A) MD3 Desc	Description for the Third Modifier code of the procedure code billed.	40	Character
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A) Place of Service (POS)	Place of Service code for where services were rendered.	2	Number (Decimal)
(A) Proc	Procedure Code for the detail.	6	Character
(A) Proc Desc	Procedure Code description for the detail.	40	Character
(A) To Date of Service (TDOS)	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A) Wrap Ind	Wrap Payment Indicator	1	Character
(A,B) Recipient Full Name (Recip Name)	The recipient last name and first name. The format of the name will be in: last name, first name.	22	Character

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Field	Description	Length	Data Type
(A,B) Recipient ID (Recip ID)	Recipient Medicaid Number.	12	Character
(A,C) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A,C) ICD Version for Diagnosis 2	The ICD Version code for the secondary ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(A-D) Claim Types (prompt)	The code indicating the type of claim record the provider used for billing the rendered service.	1	Character
(A-D) Quarter (prompt)	The quarter for which the report is being run for.	5	Number (Integer)
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-D) Provider Base, Medicaid or NPI ID (prompt)	Lists the NPI, Medicaid, and Base ID for the attending Provider.	63	Character
(B) ICN Count	Unduplicated count of claims for the recipient within that provider.	8	Number (Integer)
(C) Diagnosis 1 - Code & Desc	The primary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 2 - Code & Desc	The secondary ICD-CM diagnosis code and its description.	70	Character
(C) Diagnosis 3 - Code & Desc	The third ICD-CM diagnosis code and its description.	70	Character

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Field	Description	Length	Data Type
(C) ICD Version for Diagnosis 3	The ICD Version code for the third ICD-CM payment level diagnosis code. (9=ICD-9; 0=ICD-10; #=N/A)	1	Character
(C) ICN Count	Unduplicated count of claims for Diagnosis codes.	8	Number (Integer)
(C,D) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(D) ICN Count	Unduplicated count of claims for procedure code.	8	Number (Integer)
(D) Procedure Code & Description	Concatenate procedure code and description into one object.	47	Character

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3.5.76 DSSProfiler - Professional Referral Distribution Analysis

This report shows totals for all professional referral case types within the selected peer group. The totals include amount paid, number of unduplicated recipients, claim counts, units and exceptions. The report also provides a rapid method to identify which case types, or service categories, need to be looked at more closely with other reports within the DSSProfiler. The exception count is the count of distinct providers who have more than two standard deviations from the norm compared to their peers.

There are five tabs in this report:

A. Professional Referral Distribution Summary shows professional distribution summary for different case types;

B. TOP 20 shows the top 20 case types with exceptions, by number of recipients and by paid amount per recipient;

C. By Age shows information for the age groups for each case type;

D. By Gender shows information for the gender for each case type; and

E. By Age/Gender shows information for the gender and age groups for each case type.

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/14/2007
Run Time: 10:42:34 AM

Professional Referral Distribution Analysis
Professional Referral Distribution Summary
For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Paid Amt per Recip	Claims per Recip	Exception Count
1000 - AL Dormicilla Procedures	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	1.00	0
1002 - AL Biospy Procedures	9	9	9	$4,359.25	$2,202.00	$1,798.00	$484.36	$199.78	1.00	0
1003 - AL Wire Removal with Surgery	1	1	1	$500.00	$500.00	$500.00	$500.00	$500.00	1.00	1
1005 - AL Open Reduction Procedures	6	6	4	$15,146.72	$5,621.50	$5,366.50	$3,786.68	$1,341.63	1.50	0
1007 - AL Retinal Procedures	1	1	1	$1,225.00	$504.00	$504.00	$1,225.00	$504.00	1.00	1
1008 - AL Psychiatric Evaluation Procedures	426	355	151	$39,439.00	$32,187.00	$27,553.00	$261.19	$182.47	2.35	0
1010 - AL Group Therapy Procedures	14	6	4	$189.00	$189.00	$81.00	$47.25	$20.25	1.50	3

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B

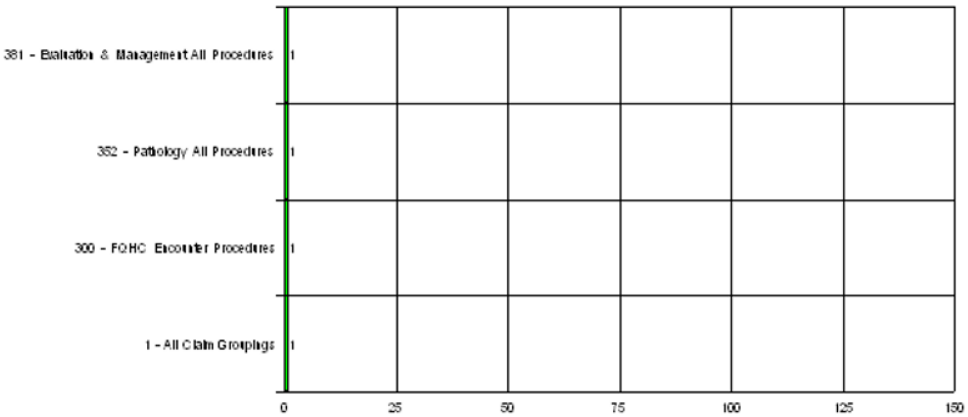
Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

Professional Referral Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 Exceptions



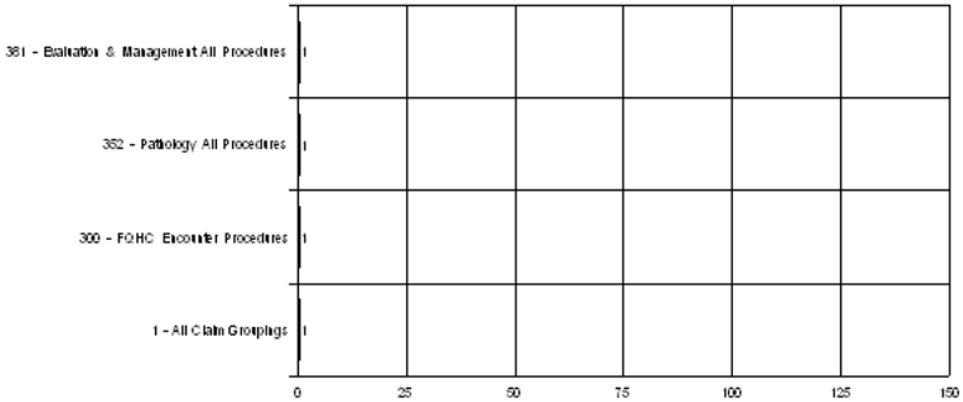
Alabama Medicaid Agency

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

Professional Referral Distribution Analysis
Top 20

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 By Number of Recipients



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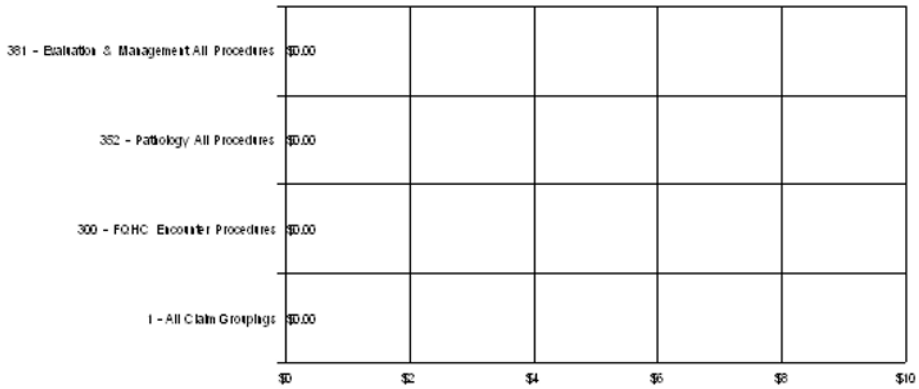
Alabama Medicaid Agency

Professional Referral Distribution Analysis
Top 20

User ID:
Run Date: 5/22/2006
Run Time: 11:31:57 AM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Top 20 By Paid Amount per Recipient



C

Alabama Medicaid Agency

Professional Referral Distribution Analysis
By Age

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

Age Description	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 35 - 64	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	$45.67	1.00
Sum:	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	$45.67	1.00

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D

Alabama Medicaid Agency

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

Professional Referral Distribution Analysis
By Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

Gender	Billed Quantity	Claim Count	Recip Count	Billed Amount	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
F	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	$45.67	1.00
Sum:	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	$45.67	1.00

E

Alabama Medicaid Agency

User ID:
Run Date: 9/14/2007
Run Time: 10:42:34 AM

Professional Referral Distribution Analysis
By Age/Gender

For Dates of Service: 01/01/2006 - 12/31/2006
Provider Peer Group: 587 - 720 PRIMARY CARE
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type: 1000 - AL Dormicilla Procedures

Age Description	Gender	Quantity Billed	Claim Count	Recip Count	Billed Amt	Allowed Amount	Paid Amount	Billed Amt per Recip	Allowed Amt per Recip	Paid Amt per Recip	Claims per Recip
Age 35 - 64	F	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	$45.67	1.00
	Sum:	2	2	2	$154.00	$91.33	$91.33	$77.00	$45.67	45.67	1.00

3.5.76.1 DSSProfiler - Professional Referrals Distribution Analysis Field Descriptions

Field	Description	Length	Data Type
(A) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character
(A) Exception Count	Number of exceptions identified. An exception is defined as two standard deviations from the norm.	8	Number (Integer)
(A,C,D,E) Allowed Amount	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A,C,D,E) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A,C,D,E) Billed Amount per Recip	Total billed amount divided by the number of recipients.	12	Number (Decimal)

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Field	Description	Length	Data Type
(A,C,D,E) Billed Quantity	Quantity billed.	14	Number (Integer)
(A,C,D,E) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A,C,D,E) Claims per Recip	Total claim count divided by the recipient count.	4	Number (Integer)
(A,C,D,E) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A,C,D,E) Paid Amount per Recip	Actual amount the provider was paid per recipient.	13	Number (Decimal)
(A,C,D,E) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-E) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-E) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-E) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
B) Top 20 By Number of Recipients	Graph shows Top 20 exceptions by number of recipients.	1	Character
(B) Top 20 By Paid Amount per Recipient	Graph shows Top 20 exceptions by paid amount per recipient.	1	Character
(B) Top 20 Exceptions	Graph shows Top 20 exceptions.	1	Character
(C,D,E) Allowed Amt Per Recip	Total allowed amount divided by the number of recipients.	13	Number (Decimal)
(C,D,E) Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
(C,E) Age Description	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(D,E) Gender	Recipient's gender.	1	Character

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3.5.77 DSSProfiler - Professional Referral Exception Quarterly

The Professional Referral Exception Quarterly report is produced for a selected provider, provider peer group and aggregation code. This report displays the number of high exceptions for case groups that occur during each reporting period. The case groups whose calculations are above the exception high value are marked as exceptions.

Alabama Medicaid Agency

Professional Referral Exception Quarterly

User ID: Administrator
Run Date: 5/19/2006
Run Time: 3:07:24 PM

For Dates of Service: 07/01/2004 - 06/30/2005

Provider Service Location Information:
NPI ID: [redacted]
Mcaid ID: [redacted]
Base ID: [redacted]
Name: GRACE COMMUNITY PHYSICAL THERAPY
Type: 27 - Dentist
Specialty: 273 - Orthodontist
Address: 3097 MAIN ST

SALEM, OR 97501

Peer Group: 6 - Dental By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

	20044	
123 - Dental Emergencies; H: 002 L: 000	26.37	*

End of Report

3.5.77.1 DSSProfiler - Professional Referrals Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Calculation	Calculation to find case groups above the exception high.	14	Number (Decimal)
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Peer Group	Peer Group Code and Description.	4	Number (Integer)
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
Provider Service Location Information	Provider's information. This includes the provider name, address, NPI ID, Medicaid ID, and Base ID.	200	Character
NPI ID	National provider identification number.	13	Character

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Field	Description	Length	Data Type
Mcaid ID	Medicaid provider identification number.	13	Character
Base ID	Provider identification number.	13	Character
Name	The provider's name.	45	Character
Type	The provider type for the provider id.	15	Character
Specialty	The provider specialty for the provider identification number.	15	Character
Provider Service Location Information	The provider address to include street address, city, state, zip code, and telephone number.	200	Character

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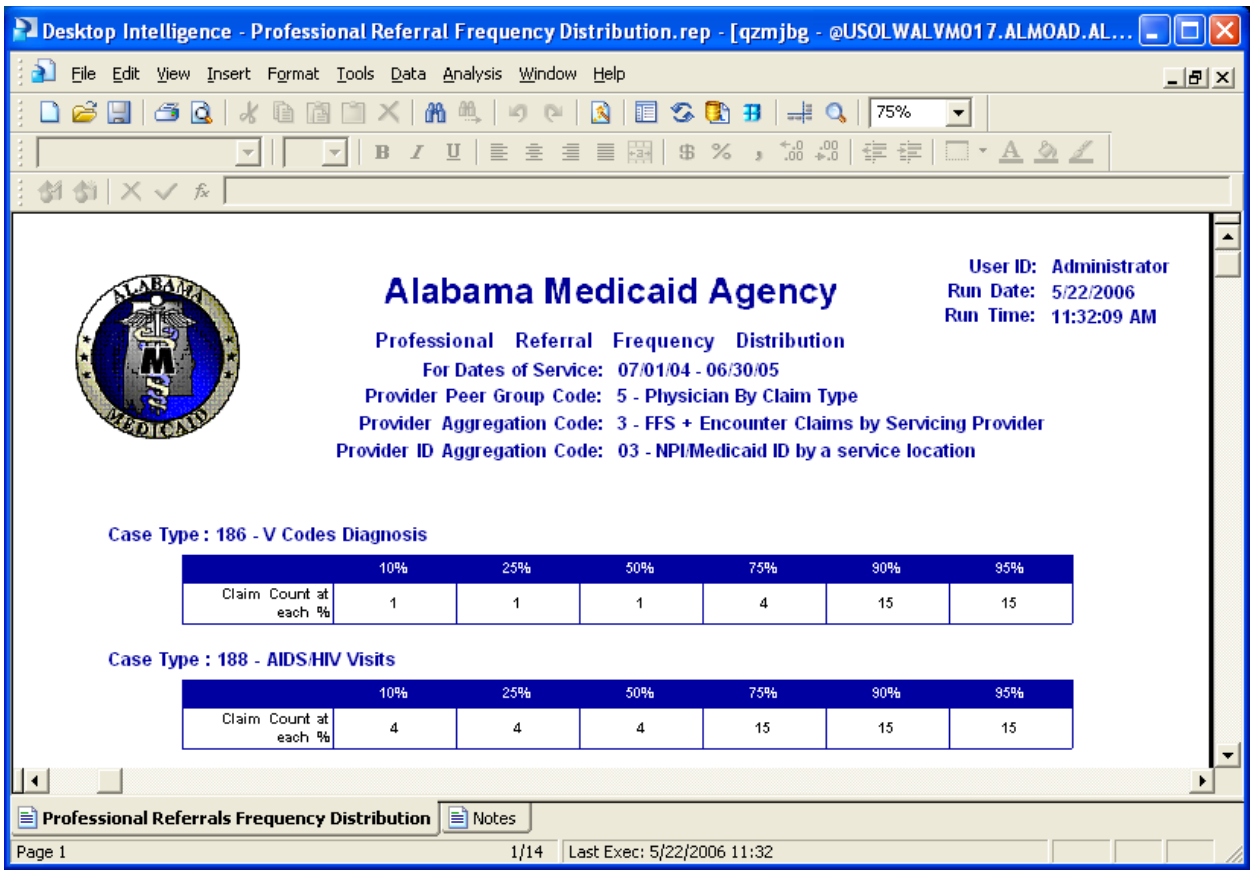
3.5.78 DSSProfiler - Professional Referral Frequency Distribution

The Professional Referral Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each professional referral case type and peer group, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of providers reported within a case type, peer grouping.



3.5.78.1 DSSProfiler - Professional Referrals Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	A user defined group based on the case mix file. The claim grouping should be specific to the area of service.	100	Character

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Field	Description	Length	Data Type
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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3.5.79 DSSProfiler - Professional Referral Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays provider claim counts for professional referral services by percentile for the selected peer group and aggregation type. Each percentile represents a percentage of the number of providers within the specific claim grouping. The percentile groups are determined by ordering providers, by the number of paid claims each has for the case type, and then grouping the providers into the percentiles starting with the provider with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any provider falling in the percentile.

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/27/2007
Run Time: 10:43:10 AM

Professional Referral Frequency Distribution Qtrly

For Dates of Service: 01/01/2006 - 03/31/2006
Provider Peer Group Code: 5 - Physician By Claim Type
Provider Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations
Quarter: 20061

Case Type : 1006 - AL Cateract Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Case Type : 101 - CMS Eval and Mgmt Hospital Visits Initial

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	2	3	5

3.5.79.1 DSSProfiler - Professional Referrals Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Provider Aggregation Code	Aggregation Code and Description.	100	Character

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Field	Description	Length	Data Type
Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character

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3.5.80 DSSProfiler - Professional Referral Provider Profile

The Professional Referral Provider Profile report is created in the DSSProfiler. Based on the user-entered date range of one year, this report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Referral - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared; and
- Aggregation Code - The code to which the profiled provider is being compared.

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A

Alabama Medicaid Agency

User ID:
Run Date: 9/26/2007
Run Time: 8:44:02 AM

Professional Referral Provider Profile
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 479 - 345 GENERAL PEDIATRICIAN
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider Information

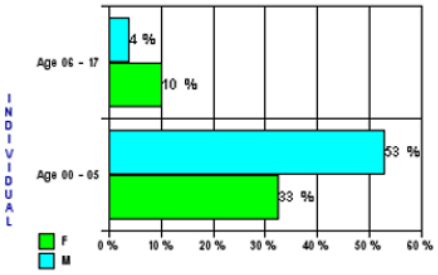
NPI ID:
Mcaid ID:
Base ID:
Name:
Type: 31 - Physician
Specialty: 345 - General Pediatrician
Address: 1022 FIRST ST NORTH #102

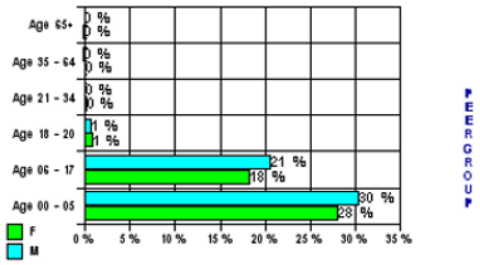
ALABASTER, AL 35007

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID:
Run Date: 11/1/2007
Run Time: 1:10:21 PM

Professional Referral Provider Profile
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID:
Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Provider's General Service Profile

Service Type	Recip Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
2 - Professional Referrals	665	$462,484.75	$242,297.56	$172,776.75	$195,600.28	$(22,823.53)	(11.67) %

End of Report

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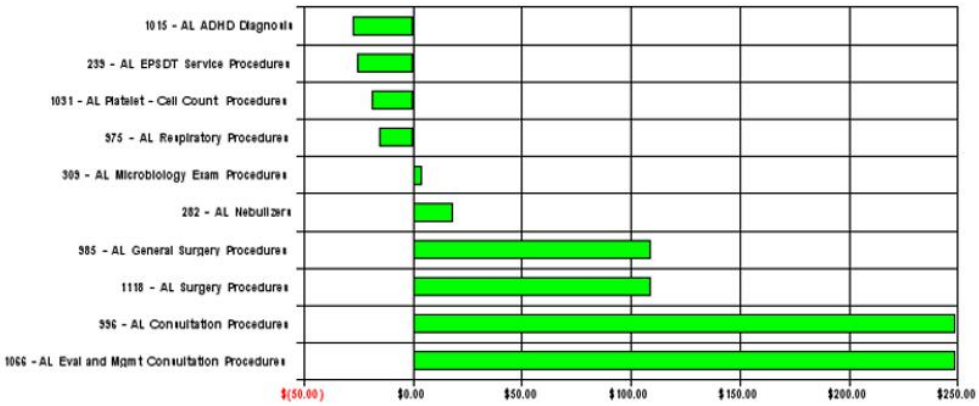
B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/26/2007
Run Time: 8:44:02 AM

Professional Referral Provider Profile
Professional Referral
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATR
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

User ID: [redacted]
Run Date: 9/26/2007
Run Time: 8:44:02 AM

Professional Referral Provider Profile
Professional Referral
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Peer Group Code: 479 - 345 GENERAL PEDIATR
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 03 - NPI/Medicaid ID by a service location

Case Type	Recip Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
1066 - AL Eval and Mgmt Consultation Procedures	5	5	5	$877.00	$1,098.00	$935.00	$686.04	$248.96	36.29 %
996 - AL Consultation Procedures	5	5	5	$877.00	$1,098.00	$935.00	$686.04	$248.96	36.29 %
1118 - AL Surgery Procedures	2	2	2	$331.00	$822.00	$331.00	$221.86	$109.14	49.19 %
985 - AL General Surgery Procedures	2	2	2	$331.00	$822.00	$331.00	$221.86	$109.14	49.19 %
282 - AL Nebulizers	1	1	1	$138.16	$150.00	$159.13	$140.54	$18.59	13.23 %
309 - AL Microbiology Exam Procedures	3	4	5	$48.00	$96.00	$14.00	$9.85	$4.15	42.13 %
975 - AL Respiratory Procedures	1	1	1	$9.00	$30.00	$0.00	$15.05	$(15.05)	(100.00) %
1031 - AL Platelet - Cell Count Procedures	2	2	2	$20.00	$43.00	$0.00	$18.82	$(18.82)	(100.00) %

3.5.80.1 DSSProfiler - Professional Referral Provider Profile Field Descriptions

Field	Description	Length	Data Type
(A) Service Type	User defined group based on the service type file. The claim grouping should be specific to the area of service.	100	Character
(A-B) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)

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Field	Description	Length	Data Type
(A-B) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A-B) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Integer)
(A-B) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Integer)
(A-B) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Integer)
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Integer)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A-B) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character

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Field	Description	Length	Data Type
(A-B) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Provider Information	Provider's demographic information. This includes the provider name, street address, city, state, zip code, and telephone number.	200	Character
(A-B) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(A-B) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(B) Quantity	Quantity billed.	8	Number (Integer)
(B) Top 10 Case Types	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character
(A) NPI ID	National provider identification number.	13	Character
(A) Mcaid ID	Medicaid provider identification number.	13	Character
(A) Base ID	Provider identification number.	13	Character
(A) Name	The provider's name.	45	Character
(A) Type	The provider type for the provider identification number.	15	Character
(A) Specialty	The provider specialty for the provider identification number.	15	Character

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3.5.81 DSSProfiler - Professional Referral Provider Profile Quarterly

The Professional Referral Provider Quarterly Profile report is created in the DSSProfiler. This report flags any category or case type that exceeds the accepted norm within the professional provider's peer group. Each category can be analyzed to identify services that are driving the total exception. All categories are age and gender adjusted so that the comparisons take into account the recipient mix of the individual provider.

The tabs on this report include:

A Provider Summary - Displays basic provider demographic information, breakdown of recipient age/gender distribution, the provider's general service profile and a comparison of recipient age/gender to the provider's peers; and

B Professional Referral - Tab B has two sections. The first sections of this report contain a graph that illustrates the top 10 case types. The case types are user defined based on the case type file. These top 10 case types are the top 10 services for which the provider received reimbursement over a specific period of time. This is an important graph because providers may be using a specific disease condition to attempt to receive additional payments. The second section of the report lists all case types for which the provider was reimbursed over a particular time period. This section is in chart form. The chart contains seven pieces of information about each claim grouping for the specific provider.

Report Prompts (Search Criteria):

- Provider ID - ID of the provider being profiled in the report;
- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - The code to which the profiled provider is being compared; and
- Quarter - Quarter of the provider being profiled in the report.

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A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: 1[redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider Information

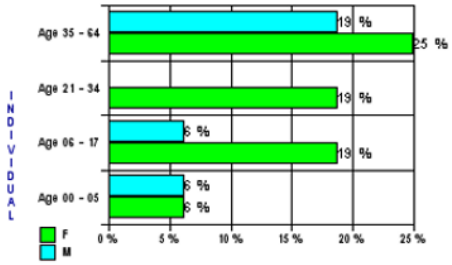
NPI ID: 1508874512
Mcaid ID: 009957890
Base ID: 10846
Name: SANDERS, STEVE M - ALL BSE
Type: 31 - Physician
Specialty: 316 - Family Practitioner
Address: 1026 GOODYEAR AVE STE 100

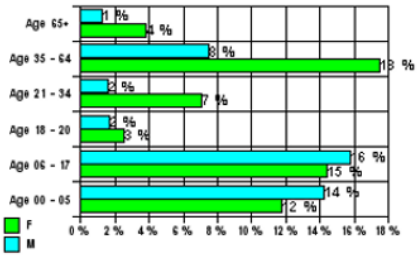
GADSDEN, AL 35903

Ranks

$ Paid Amount Actual	1
$ Paid Amount Expected	1
$ Billed Amount Actual	1
Recipient Rank	1
# Units Rank	1
# Claims Rank	1
Peer Group Size	1

Patient Age/Gender Breakdown





Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Provider Summary

For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Provider's General Service Profile

Report Category	Recipient Count	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
2 - Professional Referrals	16	$6,764.72	$24,037.97	$5,003.30	$3,439.14	$1,564.16	45.48 %

End of Report

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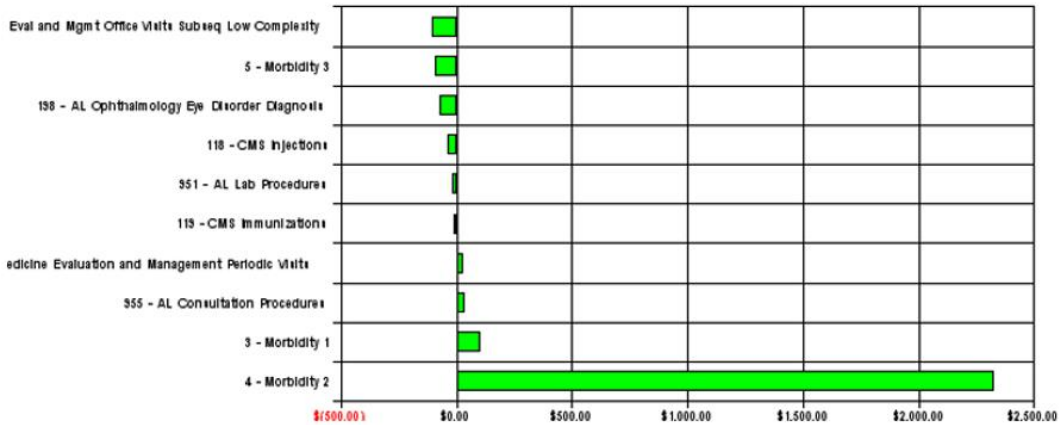
B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Top 10 Case Types: Dollar Difference



Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/8/2007
Run Time: 8:05:42 PM

Professional Referral Provider Profile Qtrly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Provider ID: [redacted]
Provider Peer Group Code: 5 - Physician By Claim Type
Aggregation Code: 1 - Fee for Service Claims by Servicing Provider
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20061

Case Type	Recipient Count	Claim Count	Quantity	Allowed Amount	Billed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
4 - Morbidity 2	6	35	38	$3,704.60	$20,464.71	$3,607.60	$1,278.30	$2,329.30	182.22 %
3 - Morbidity 1	4	9	9	$496.70	$1,119.50	$495.70	$390.63	$105.07	26.90 %
955 - AL Consultation Procedures	2	2	2	$278.00	$583.00	$326.00	$285.60	$40.40	14.15 %
121 - CMS Comprehensive Preventive Medicine Evaluation and Management Periodic Visits	2	2	2	$126.00	$140.00	$166.00	$132.34	$33.66	25.43 %
119 - CMS Immunizations	2	5	5	$40.00	$282.00	$0.00	$10.92	$(10.92)	(100.00) %
951 - AL Lab Procedures	1	1	1	$10.00	$22.00	$51.00	$66.50	$(15.50)	(23.31) %
118 - CMS Injections	2	5	5	$40.00	$282.00	$0.00	$38.91	$(38.91)	(100.00) %
198 - AL Ophthalmology Eye Disorder Diagnosis	1	3	3	$114.00	$248.00	$41.00	$112.26	$(71.26)	(63.48) %
5 - Morbidity 3	1	1	1	$100.00	$112.00	$99.00	$190.14	$(91.14)	(47.93) %
107 - CMS Eval and Mgmt Office Visits Subseq Low Complexity	3	3	3	$127.00	$173.00	$83.00	$191.65	$(108.65)	(56.69) %
108 - CMS Eval and Mgmt Office Visits Subseq High Complexity	5	5	5	$369.00	$533.00	$366.00	$520.97	$(154.97)	(29.75) %
125 - CMS Over the Counter Medical Supplies	2	3	5	$179.01	$234.47	$84.60	$241.44	$(156.84)	(64.96) %
224 - AL Ophthalmology ILL Defined Diagnosis	3	7	7	$159.00	$888.50	$135.00	$562.84	$(427.84)	(76.01) %
112 - CMS Surgeries	1	1	1	$51.00	$90.00	$11.00	$758.82	$(747.82)	(98.55) %
6 - Morbidity 4	5	19	20	$970.41	$2,341.76	$801.00	$1,580.07	$(779.07)	(49.31) %

End of Report

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3.5.81.1 DSSProfiler - Professional Referring Provider Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) # Claims Rank	Rank is based on the number of paid claims.	5	Number (Integer)
(A) # Units Rank	Rank based on the quantity billed.	5	Number (Integer)
(A) $ Billed Amount Actual	Rank based on the actual money billed by the provider.	5	Number (Decimal)
(A) $ Paid Amount Actual	Rank based on the actual money paid by the program in the specific time period.	5	Number (Decimal)
(A) $ Paid Amount Expected	Rank based on the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of the provider's specialty peer group.	5	Number (Decimal)
(A) Base ID	Provider identification number.	13	Character
(A) Mcaid ID	Medicaid provider identification number.	13	Character
(A) Name	The provider's name.	45	Character
(A) NPI ID	National provider identification number.	13	Character
(A) Patient Age/Gender Breakdown	Similar to the health status section. It compares the providers to their specialty peer group based on the recipients they serve.	10	Character
(A) Peer Group Size	Peer group size is the number of providers in the same peer group. The peer group is also the group by which the provider is compared on all rankings.	5	Number (Integer)
(A) Provider Information	Provider's demographic information. This includes the provider name, street address, city, state, zip code, and telephone number.	200	Character
(A) Recipient Rank	Rank based on the number of eligible recipients the provider served in a specific time period.	5	Number (Integer)
(A) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(A) Specialty	The provider specialty for the provider identification number.	15	Character
(A) Type	The provider type for the provider id.	15	Character
(A-B) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character

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Field	Description	Length	Data Type
(A-B) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Integer)
(A-B) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-B) Dollar Difference	Difference in the actual dollar amount and the expected dollar amount. This calculation also reflects how the claim groupings are ranked in this section (from the highest dollar difference to the lowest).	13	Number (Decimal)
(A-B) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-B) Percent Difference	Percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.	8	Number (Decimal)
(A-B) Provider ID	Provider identification number.	15	Character
(A-B) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-B) Provider Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-B) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-B) Recipient Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(B) Quantity	The quantity billed.	14	Number (Integer)
(B) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(B) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)

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Field	Description	Length	Data Type
(B) Top 10 Case Types: Dollar Difference	Different in the actual dollars and the expected dollars for the top 10 claim groupings for this provider. Graph displays Top 10 case types by dollar difference.	60	Character

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3.5.82 DSSProfiler - Provider Peer Group Comparison

The Peer Group Comparison report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient totals, outpatient referral totals and pharmacy totals. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely utilizing other reports within the DSSProfiler. The tabs in this report include:

A. Compare by Dollar Difference - contains information that is essential in comparing providers within the same specialty group;

B. Compare by Percent Difference - similar to the previous, except the difference is expressed as a percent;

C. Data - shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report; and

D. Other Rankings - shows four rankings for the providers in this particular specialty group.

Report Prompts (Search Criteria):

- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on the claim type; and
- Report Category - User-defined variables used to categorize case types into service groups.

Alabama Medicaid Agency

Provider Peer Group Comparison
Compare by Dollar Difference

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Rank	Raw Rank	Exp Rank	Provider ID	Provider Name	Dollar Difference from Expected	Number of Standard Deviations	Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $62,640.94
1	1	1	[redacted]	NW GENERAL - ALL NPI	$57,744.67	1.99	**********
2	5	5	[redacted]	NW GENERAL - ALL NPI	$5,098.90	0.18	*
3	6	7	[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	$0.00	0.00	
4	7	6	[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	$(4,213.91)	-0.15	*
5	2	4	[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	$(24,086.50)	-0.83	*****
6	3	3	[redacted]	MEMORIAL VALLEY MEDICAL - ALL NPI	$(28,661.61)	-0.99	******
7	4	2	[redacted]	BAILY MEDICAL SUPPLIES - ALL NPI	$(35,034.14)	-1.21	********

End of Report

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Alabama Medicaid Agency

User ID:
Run Date: 5/12/2006
Run Time: 12:35:13 PM

Provider Peer Group Comparison

Compare by Percent Difference

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Rank	Raw Rank	Exp Rank	Provider ID	Provider Name	Percent Difference from Expected	Number of Standard Deviations	Each * represent a 10% Difference From Center Line	
1	5	5		NW GENERAL - ALL NPI	83.95 %	1.38		* * * * * * * * *
2	1	1		NW GENERAL - ALL NPI	35.43 %	0.58		* * * *
3	6	7		SEAMORE X-RAY CLINIC - ALL NPI	0.00 %	0.00		
4	2	4		SEAMORE X-RAY CLINIC - ALL NPI	-60.89 %	-1.00	* * * * * * *	
5	3	3		MEMORIAL VALLEY MEDICAL - ALL NPI	-68.35 %	-1.12	* * * * * * *	
6	4	2		BAILY MEDICAL SUPPLIES - ALL NPI	-74.35 %	-1.22	* * * * * * * *	
7	7	6		SEAMORE X-RAY CLINIC - ALL NPI	-89.58 %	-1.47	* * * * * * * * *	

End of Report

Alabama Medicaid Agency

User ID:
Run Date: 5/12/2006
Run Time: 12:35:13 PM

Provider Peer Group Comparison
Data

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Rank	Raw RANK	Exp Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference	Recip Count	Exception
1	1	1		NW GENERAL - ALL NPI	$467,755.00	$234,006.54	$220,740.55	$162,995.88	$57,744.67	35.43 %	26	
2	5	5		NW GENERAL - ALL NPI	$3,459.38	$11,172.43	$11,172.43	$6,073.53	$5,098.90	83.95 %	2	
3	6	7		SEAMORE X-RAY CLINIC - ALL NPI	$584.69	$2,436.84	$2,436.84	$2,436.84	$0.00	0.00 %	1	
4	7	6		SEAMORE X-RAY CLINIC - ALL NPI	$26,745.00	$739.00	$490.00	$4,703.91	$(4,213.91)	-89.58 %	2	
5	2	4		SEAMORE X-RAY CLINIC - ALL NPI	$101,700.00	$72,153.69	$15,473.43	$39,559.93	$(24,086.50)	-60.89 %	5	
6	3	3		MEMORIAL VALLEY MEDICAL - ALL NPI	$12,235.00	$15,957.00	$13,271.50	$41,933.11	$(28,661.61)	-68.35 %	5	
7	4	2		BAILY MEDICAL SUPPLIES - ALL NPI	$32,285.00	$14,886.56	$12,086.56	$47,120.70	$(35,034.14)	-74.35 %	7	

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Alabama Medicaid Agency

Provider Peer Group Comparison
Other Rankings

User ID: [redacted]
Run Date: 5/12/2006
Run Time: 12:35:13 PM

For Dates of Service: 07/01/2004 - 06/30/2005
Provider Peer Group: 1 - Inpatient Hospital By Claim Type
Aggregation Code: 4 - Fee for Service Claims by Billing Provider
Report Category: 8 - Inpatient Services by Billing Provider
Provider ID Aggregation Code: 02 - NPI ID all locations

Provider ID	Provider Name	Raw Rank	Claim Rank	Recip Rank	Quantity Rank	Dollar Difference	Number of Standard Deviations
[redacted]	NW GENERAL - ALL NPI	1	1	1	1	$57,744.67	1.99
[redacted]	NW GENERAL - ALL NPI	5	6	5	6	$5,098.90	0.18
[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	6	7	7	7	$0.00	0.00
[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	7	3	5	3	$(4,213.91)	-0.15
[redacted]	SEAMORE X-RAY CLINIC - ALL NPI	2	5	3	5	$(24,086.50)	-0.83
[redacted]	MEMORIAL VALLEY MEDICAL - ALL NPI	3	4	3	4	$(28,661.61)	-0.99
[redacted]	BAILY MEDICAL SUPPLIES - ALL NPI	4	2	2	2	$(35,034.14)	-1.21

End of Report

3.5.82.1 DSSProfiler - Provider Peer Group Comparison Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Integer)
(A-B) Each * 10% difference	Each * represents a 10% Difference From Center Line.	1	Character
(A-B,D) Number of Standard Deviations	Represents the number of standard deviations that the provider's dollar difference was from the expected.	8	Number (Integer)
(A-C) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A-C) Exp Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A-D) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-D) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(A-D) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character

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Field	Description	Length	Data Type
(A-D) For Date of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Provider ID	Provider identification number.	15	Character
(A-D) Provider Name	Provider's full name.	50	Character
(A-D) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-D) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A-D) Report Category	User-defined variables used to categorize case types into service groups.	50	Character
(B) Percent Difference from Expected	Percentage number that is the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	7	Number (Integer)
(C) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Integer)
(C)Billed Amount	Amount the provider billed for the services.	13	Number (Integer)
(C) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Integer)
(C) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(C) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(C) Percent Difference	Percent number representing the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	8	Number (Decimal)
(C) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(D) Claim Rank	Number of claims rank is based on Number of claims provider billed.	3	Number (Integer)

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Field	Description	Length	Data Type
(D) Dollar Difference	Difference in the actual amount Provider was paid and the amount Provider was expected to receive (based on the ACG adjustment methodology).	13	Character
(D) Quantity Rank	Rank based on quantity billed.	3	Number (Decimal)
(D) Recip Rank	Recipient rank is a rank based on Number of eligible recipients Provider serves in a specific time period.	3	Number (Decimal)

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3.5.83 DSSProfiler - Provider Peer Group Comparison Quarterly

The Peer Group Comparison Quarterly report is created in the DSSProfiler. Based on the user-entered date range of one quarter, this report displays and compares all providers within a peer group to determine which providers fall outside of service dollar norm. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient totals, outpatient referral totals and pharmacy totals. Providers who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which providers need to be analyzed more closely utilizing other reports within the DSSProfiler. The tabs in this report include:

A. Compare by Dollar Difference - contains information that is essential in comparing providers within the same specialty group;

B. Compare by Percent Difference - similar to the previous, except the difference is expressed as a percent;

C. Data - shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report; and

D. Other Rankings - shows four rankings for the providers in this particular specialty group.

Report Prompts (Search Criteria):

- Provider Peer Group - The peer group to which the profiled provider is being compared;
- Aggregation Code - Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both. Claims can be further aggregated by billing or servicing provider where the servicing provider is the performing, referring, attending or prescribing provider, depending on claim type;
- Report Category - User-defined variables used to categorize case types into service groups; and
- Quarter - The quarter for which the report is being run. In the field description section, the fields are listed according to which tab they are found.

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Alabama Medicaid Agency

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

Provider Peer Group Comparison Qtrly
Compare By Dollar Difference

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

Rank	Raw Rank	Exp Rank	Provider ID	Provider Name	Dollar Difference from Expected	Number of Standard Deviations	Each * represent a $5000 Difference From Center Line. Rows in red indicate an Dollar Difference that is more than 2 standard deviations from the norm. 2 Standard Deviations = $10,827.26	
1	1	1	[redacted]	JOHN D SMITH - ALL BSE	$8,667.93	1.79		*
2	3	4	[redacted]	NEW HORIZON REHAB CLINIC - ALL BSE	$1,069.90	0.22		
3	5	4	[redacted]	GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE	$(1,069.90)	-0.22		
4	2	2	[redacted]	COUNTRY MEDICAL CLINIC - ALL BSE	$(3,275.53)	-0.68		
5	4	2	[redacted]	WEST HILLS MEMORIAL - ALL BSE	$(5,392.41)	-1.11	*	

End of Report

Alabama Medicaid Agency

User ID: Administrato
Run Date: 5/22/2006
Run Time: 11:13:07 AM

Provider Peer Group Comparison Qtrly
Compare By Percent Difference

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

Rank	Raw Rank	Exp Rank	Provider ID	Provider Name	Percent Difference from Expected	Number of Standard Deviations	Each * represents a 10% Difference From Center Line	
1	1	1	[redacted]	JOHN D SMITH - ALL BSE	86.91 %	1.27		* * * * * * * *
2	3	4	[redacted]	NEW HORIZON REHAB CLINIC - ALL BSE	65.05 %	0.95		* * * * * *
3	2	2	[redacted]	COUNTRY MEDICAL CLINIC - ALL BSE	-45.17 %	-0.66	* * * *	
4	5	4	[redacted]	GRACE COMMUNITY PHYSICAL THERAPY - ALL E	-65.05 %	-0.95	* * * * * *	
5	4	2	[redacted]	WEST HILLS MEMORIAL - ALL BSE	-74.37 %	-1.09	* * * * * * *	

End of Report

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Alabama Medicaid Agency

Provider Peer Group Comparison Qtrly
Data

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

Rank	Raw RANK	Exp Rank	Provider ID	Provider Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference	Recipient Count	Exception
1	1	1	1[illegible]	JOHN D SMITH - ALL BSE	$17,500.00	$19,932.57	$18,641.57	$9,973.64	$8,667.93	86.91 %	2	
2	3	4	1[illegible]	NEW HORIZON REHAB CLINIC - ALL BSE	$2,714.70	$2,714.70	$2,714.70	$1,644.80	$1,069.90	65.05 %	1	
3	5	4	1[illegible]	GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE	$1,004.90	$1,004.90	$574.90	$1,644.80	$(1,069.90)	-65.05 %	1	
4	2	2	1[illegible]	COUNTRY MEDICAL CLINIC - ALL BSE	$2,000.00	$3,975.60	$3,975.60	$7,251.13	$(3,275.53)	-45.17 %	1	
5	4	2	1[illegible]	WEST HILLS MEMORIAL - ALL BSE	$3,167.15	$3,167.15	$1,858.72	$7,251.13	$(5,392.41)	-74.37 %	1	

End of Report

Alabama Medicaid Agency

Provider Peer Group Comparison Qtrly
Other Rankings

User ID: Administrator
Run Date: 5/22/2006
Run Time: 11:13:07 AM

For Dates of Service: 07/01/2004 - 09/30/2004
Provider Peer Group: 3 - Nursing Home By Claim Type
Aggregation Code: 3 - FFS + Encounter Claims by Servicing Provider
Report Category: 5 - Nursing Facility Services
Provider ID Aggregation Code: 01 - Base ID all locations
Quarter: 20043

Provider ID	Provider Name	Raw Rank	Claim Rank	Recip Rank	Quantity Rank	Dollar Difference	Number of Standard Deviations	Exception
[illegible]	JOHN D SMITH - ALL BSE	1	1	1	1	$8,667.93	1.79	
[illegible]	NEW HORIZON REHAB CLINIC - ALL BSE	3	3	2	3	$1,069.90	0.22	
[illegible]	GRACE COMMUNITY PHYSICAL THERAPY - ALL BSE	5	3	2	3	$(1,069.90)	-0.22	
[illegible]	COUNTRY MEDICAL CLINIC - ALL BSE	2	3	2	3	$(3,275.53)	-0.68	
[illegible]	WEST HILLS MEMORIAL - ALL BSE	4	2	2	2	$(5,392.41)	-1.11	

End of Report

3.5.83.1 DSSProfiler - Provider Peer Group Comparison Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Decimal)
(B) Each * 10% difference	Each * represents a 10% Difference From Center Line.	1	Character
(A) Each * $ 5000 difference	Each * represents a $5000 Difference From Center Line. Rows in red represent a Dollar Difference that is more than 2 standard	1	Character

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Field	Description	Length	Data Type
	deviations from norm. 2 Standard Deviations = $ 10,827.26		
(A-B,D) Number of Standard Deviations	Represents the number of standard deviations that the provider's dollar difference was from the expected.	8	Number (Integer)
(A-C) Exp Rank	Provider's rank based on the amount provider should have been paid based on the Adjusted Clinical Grouping (ACG) adjustment methodology and comparison of Provider's specialty peer group.	3	Number (Integer)
(A-C) Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A-D) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-D) For Date of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Provider ID	Provider identification number.	15	Character
(A-D) Provider ID Aggregation Code	This code was added as part of NPI. The values are 01 - Base ID all service locations; 02 - NPI ID all service locations and 03 NPI/Medicaid ID by service location.	40	Character
(A-D) Provider Name	Provider's full name.	50	Character
(A-D) Provider Peer Group	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-D) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-D) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Integer)
(A-D) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(B) Percent Difference from Expected	Percentage number that is the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	7	Number (Decimal)

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Field	Description	Length	Data Type
(C) Allowed Amount	The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(C) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(C) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(C) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(C) Percent Difference	Percent number representing the difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	8	Number (Decimal)
(C) Recipient Count	An unduplicated count of recipients.	6	Number (Integer)
(C-D) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Decimal)
(C-D) Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
(D) Claim Rank	Number of claims rank is based on Number of claims provider billed.	3	Number (Integer)
(D) Quantity Rank	Rank based on quantity billed.	3	Number (Integer)
(D) Recip Rank	Recipient rank is a rank based on Number of eligible recipients Provider serves in a specific time period.	3	Number (Integer)

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3.5.84 DSSProfiler – Recipient Claim Details - FFS

Based on the user-entered date range of one year, this report shows claim details for a recipient who has been profiled. The detailed claims information is categorized by the individual case types applied to the recipient's claims. Additionally, procedures and diagnoses are displayed, as well as a list of billing and performing providers.

The detail reports are very helpful for additional analysis on individual recipients.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains five tabs:

A. The Inpatient Details tab holds claim details for inpatient claims;

B. The Professional Details tab holds claim details for professional and dental claims;

C. The Nursing Facility Details tab holds claim details for nursing facility claims;

D. The Pharmacy Details tab holds claim details for pharmacy claims; and

E. The Outpatient Details tab holds claim details for outpatient claims.

Search criteria:

- Recipient ID as specified in the user prompt; and
- Claims Indicator as specified in the user prompt.

A

Alabama Medicaid Agency

Recipient Claim Details - FFS

Inpatient Claim Details

For Dates of Service: 07/01/2015 - 06/30/2016

Recipient ID: 123456789012

Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:

Run Date: 7/7/16

Run Time: 1:19:45 PM

ICN	CT	DB #	FDOS	TDOS	Proc Cde	Proc Desc	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider IDs	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amount	DRG Code & Desc	DRG Relative Weight	DRG Service Adjuster
1234567890123	I	1	08/12/2015	08/15/2015	#####	Unknown or Not Applicable	0120	Room and board/semi-private	9	486	PNEUMONIA, ORGANISM UNSPECIFIED	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	21	3	$12,322.89	$4,011.28	$4,011.28	0481 - Nerve Disorders	0.59	1
1234567890123	I	2	08/12/2015	08/15/2015	#####	Unknown or Not Applicable	0250	Pharmacy	9	486	PNEUMONIA, ORGANISM UNSPECIFIED	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	21	10	$1,324.22	$0.00	$0.00	0481 - Nerve Disorders	0.59	1

PHI has been removed

End of Report

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B

Alabama Medicaid Agency

Recipient Claim Details - FFS
Professional Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 8/19/16
Run Time: 9:57:57 AM

ICN	CT	Dtl #	FDOS	TDOS	Proc Cde	Proc Desc	TOS	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider IDs	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amt	Wrap Ind
1234567890123	M	1	10/6/2015	10/6/2015	H0032	Mh Svc Plan Dev By Non-Md	9	####	Unknown or Not Applicable	0	F200	PARANOID SCHIZOPHRENIA	NPI ID: Medicaid ID: Base ID:	DEPT OF MNTL HLTH & MNTL RTR	11	1	$22.00	$22.00	$22.00	Y

End of Report

PHI has been removed

C

Alabama Medicaid Agency

Recipient Claim Details - FFS
Nursing Facility Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 7/11/16
Run Time: 4:54:34 PM

ICN	CT	Dtl #	FDOS	TDOS	Proc Cde	Proc Desc	TOS	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider Ids	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amt
1234567890123	L	1	1/1/2016	1/31/2016	######	Unknown or Not Applicable	#	0101	All Incl Room And Board	0	M6281	MUSCLE WEAKNESS (GENERALIZED)	NPI ID: Medicaid ID: Base ID:	RIVER CITY CARE AND REHABILITATIO N CENTER	31	31	$1,064.22	$5,541.56	$4,739.56
1234567890123	L	1	4/1/2016	4/30/2016	######	Unknown or Not Applicable	#	0101	All Incl Room And Board	0	M6281	MUSCLE WEAKNESS (GENERALIZED)	NPI ID: Medicaid ID: Base ID:	RIVER CITY CARE AND REHABILITATIO N CENTER	31	30	$1,064.22	$5,362.80	$4,560.80
1234567890123	L	1	9/25/2015	9/30/2015	######	Unknown or Not Applicable	#	0101	All Incl Room And Board	9	V5789	CARE INVOLVING OTHER SPECIFIED REHABILIT	NPI ID: Medicaid ID: Base ID:	RIVER CITY CARE AND REHABILITATIO N CENTER	31	6	$1,064.22	$1,064.22	$903.82

PHI has been removed

End of Report

D

Alabama Medicaid Agency

Recipient Claim Details - FFS
Pharmacy Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

ICN	CT	Dtl #	Dispense Date	NDC	NDC Desc	DEA	GPI	AHFS	AHFS Desc	Billing Provider IDs	Billing Provider Name	POS	Dispense Qty	Billed Amt	Allwd Amt	Paid Amt
1234567890123	P	1	01/12/2016	51672403201	WARFARIN SODIUM	0	1	2012040	COUMARIN DERIVATIVES	NPI ID: Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$23.65	$10.60	$14.59
1234567890123	P	1	01/12/2016	51672403201	HYDROCODONE-ACETAMINOPHEN	3	1	2808080	OPIATE AGONISTS	NPI ID: Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$19.10	$10.64	$14.63

End of Report

PHI has been removed

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E

Alabama Medicaid Agency

Recipient Claim Details - Encounters
Outpatient Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXX

User ID:
Run Date: 7/7/16
Run Time: 11:25:20 AM

ICN	CT	Dtl #	FDOS	TDOS	Proc Cde	Proc Desc	TOS	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider IDs	Billing Provider Name	POS	Billed Qty	Billed Amt	Alwd Amt	Paid Amount
1234567890123	O	1	6/1/2016	6/1/2016	J0690	Cefazolin Sodium Injection	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	22	2	$615.00	$1.78	$1.78
1234567890123	O	1	6/1/2016	6/1/2016	J1885	Ketorolac Tromethamine Inj	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	22	4	$510.00	$1.96	$1.96
1234567890123	O	1	6/1/2016	6/1/2016	J2250	Inj Midazolam Hydrochloride	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	22	2	$337.50	$0.26	$0.26

End of Report

PHI has been removed

3.5.84.1 DSSProfiler – Recipient Claim Details - FFS Field Descriptions

Field	Description	Length	Data Type
(A-C,E) Billed Qty	Quantity billed.	4	Number (Integer)
(A-C,E) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A-C,E) FDOS	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A-C,E) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(A-C,E) POS	Place of Service code for where service is rendered.	2	Number (Integer)
(A-C,E) Prim Diag	The primary ICD-CM diagnosis code.	7	Character
(A-C,E) Proc Cde	Procedure code on the detail.	6	Character
(A-C,E) Proc Desc	Description of the Procedure code on the detail.	40	Character
(A-C,E) Rev Cde	Revenue Code on the detail.	5	Character
(A-C,E) Rev Desc	Description of the Revenue code on the detail.	70	Character
(A-C,E) TDOS	Claim's last date of service.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A-E) Dates of Service	The Profiler dates of services.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character
(A-D) User ID	The user that created the report.	50	Character
(A-E) Allwd Amnt	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-E) Billed Amt	Amount the provider billed for the services.	13	Number (Decimal)
(A-E) Billing Provider IDs	Lists the NPI, Medicaid, and Base ID for the billing Provider.	63	Character
(A-E) Billing Provider Name	Billing Provider name.	63	Character
(A-E) CT	Shows what type of claim was submitted.	2	Character
(A-E) Dtl #	Claim line number.	4	Number (Integer)
(A-E) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
(A-E) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)
(A-E) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(A-E) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A-E) Paid Amt	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-E) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A-E) Recipient ID	Recipient Medicaid Number	12	Character
(A) Wrap Ind	Wrap Payment Indicator	1	Character
(B,CE) TOS	Claim Type of Service.	4	Number (Integer)

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Field	Description	Length	Data Type
(D) AHFS	Therapeutic class code.	8	Number (Integer)
(D) AHFS Desc	Description of the therapeutic class code.	55	Character
(D) DEA	Drug Enforcement Agency (DEA) Code	3	Character
(D) Dispense Date	Date the prescription was dispensed by the provider.	20	Date (MM/DD/CCYY)
(D) Dispense Qty	Number of units of a drug dispensed to a member.	10	Number (Integer)
(D) GPI	Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2).	1	Number (Integer)
(D) NDC	National Drug Code	11	Number (Integer)
(D) NDC Description	National Drug Code (NDC) description/name.	35	Character

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3.5.85 DSSProfiler – Recipient Claim Details Quarterly - FFS

Based on the user-entered date range of one quarter, this report shows claim details for a recipient who has been profiled. The claims are broken out by claim type and case type. The Professional Details tab includes claim details for professional or dental claims. The Outpatient Details tab included outpatient claim details. The Inpatient Details tab includes inpatient claim details. The Pharmacy Details tab includes drug claim details. Nursing Facility tab includes nursing facility claim details.

The detail reports are very helpful for additional analysis on individual recipients.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains five tabs:

A. The Professional Details tab holds claim details for professional and dental claims;

B. The Outpatient Details tab holds claim details for outpatient claims;

C. The Inpatient Details tab holds claim details for inpatient claims;

D. The Pharmacy Details tab holds claim details for pharmacy claims; and

E. The Nursing Facility Details tab holds claim details for nursing facility claims.

Search criteria:

- Recipient ID as specified in the user prompt; and
- Claims Indicator as specified in the user prompt.

A

Alabama Medicaid Agency

Recipient Claim Details Qtrly - FFS
Inpatient Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20162

User ID:
Run Date: 7/7/16
Run Time: 1:19:45 PM

ICN	CT	DB #	FDOS	TDOS	Proc Cde	Proc Desc	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider IDs	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amount	DRG Code & Desc	DRG Relative Weight	DRG Service Adjuster
123456789012	I	1	08/12/2015	08/15/2015	#####	Unknown or Not Applicable	0120	Room and board/semi-private	9	486	PNEUMONIA, ORGANISM UNSPECIFIED	NPI ID: Medicaid ID: Base ID: 1	UNIVERSITY OF ALABAMA	21	3	$12,322.89	$4,011.26	$4,011.26	0481 - Nerve Disorders	0.59	1
123456789012	I	2	08/12/2015	08/15/2015	#####	Unknown or Not Applicable	0250	Pharmacy	9	486	PNEUMONIA, ORGANISM UNSPECIFIED	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	21	10	$1,324.22	$0.00	$0.00	0481 - Nerve Disorders	0.59	1

PHI has been removed

End of Report

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B

Alabama Medicaid Agency

Recipient Claim Details Qtrly - FFS
Pharmacy Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

ICN	CT	Dtl #	Dispense Date	NDC	NDC Desc	DEA	GPI	AHFS	AHFS Desc	Billing Provider IDs	Billing Provider Name	POS	Dispense Qty	Billed Amt	Allwd Amt	Paid Amt	Wrap Ind
1234567890123	P	1	01/12/2016	51672403201	WARFARIN SODIUM	D	1	2012040	COUMARIN DERIVATIVES	NPI ID: Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$23.65	$10.60	$14.59	Y
1234567890123	P	1	01/12/2016	51672403201	HYDROCODONE-ACETAMINOPHEN	3	1	2808080	OPIATE AGONISTS	NPI ID: Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$19.10	$10.64	$14.63	N

End of Report

PHI has been removed

C

Alabama Medicaid Agency

Recipient Claim Details Qtrly - FFS
Nursing Facility Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

ICN	CT	Dtl #	FDOS	TDOS	Proc Cde	Proc Desc	TOS	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider Ids	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amt
1234567890123	L	1	1/1/2016	1/31/2016	######	Unknown or Not Applicable	#	0101	All Incl Room And Board	0	M6281	MUSCLE WEAKNESS (GENERALIZED)	NPI ID: Medicaid ID: Base ID: 1	RIVER CITY CARE AND REHABILITATIO N CENTER	31	31	$1,064.22	$5,541.56	$4,739.56

PHI has been removed

End of Report

D

Alabama Medicaid Agency

Recipient Claim Details Qtrly - FFS
Pharmacy Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X
Quarter: 20161

User ID:
Run Date: 7/11/16
Run Time: 5:26:05 PM

ICN	CT	Dtl #	Dispense Date	NDC	NDC Desc	DEA	GPI	AHFS	AHFS Desc	Billing Provider IDs	Billing Provider Name	POS	Dispense Qty	Billed Amt	Allwd Amt	Paid Amt
1234567890123	P	1	01/12/2016	51672403201	WARFARIN SODIUM	D	1	2012040	COUMARIN DERIVATIVES	NPI ID: Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$23.65	$10.60	$14.59
1234567890123	P	1	01/12/2016	51672403201	HYDROCODONE-ACETAMINOPHEN	3	1	2808080	OPIATE AGONISTS	NPI ID Medicaid ID: Base ID:	CITY PHARMACY	00	30.000	$19.10	$10.64	$14.63

End of Report

PHI has been removed

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Alabama Mediciad Agency

Recipient Claim Details Qtrly - FFS
Outpatient Claim Details
For Dates of Service: 07/01/2015 - 06/30/2016
Recipient ID: 123456789012
Recipient Full Name: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXX

User ID:
Run Date: 7/7/16
Run Time: 1:19:45 PM

ICN	CT	Dtl #	FDOS	TDOS	Proc Cde	Proc Desc	TOS	Rev Cde	Rev Desc	ICD	Prim Diag	Diag Desc	Billing Provider IDs	Billing Provider Name	POS	Billed Qty	Billed Amt	Allwd Amt	Paid Amount
1234567890123	O	1	6/1/2016	6/1/2016	J0690	Cefazolin Sodium Injection	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID	UNIVERSITY OF ALABAMA	22	2	$615.00	$1.78	$1.78
1234567890123	O	1	6/1/2016	6/1/2016	J1885	Ketorolac Tromethamine Inj	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	22	4	$510.00	$1.96	$1.96
1234567890123	O	1	6/1/2016	6/1/2016	J2250	Inj Midazolam Hydrochloride	1	0636	Drugs-Detail Coding	0	R5600	SIMPLE FEBRILE CONVULSIONS	NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	22	2	$337.50	$0.26	$0.26

PHI has been removed

End of Report

3.5.85.1 DSSProfiler – Recipient Claim Details Quarterly - FFS Field Descriptions

Field	Description	Length	Data Type
(A-C,E) Billed Qty	Quantity billed.	4	Number (Integer)
(A-C,E) Diag Desc	The primary ICD-CM diagnosis code description.	60	Character
(A-C,E) FDOS	Claim's first date of service.	10	Date (MM/DD/CCYY)
(A-C,E) ICD Version for Diagnosis 1	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(A-C,E) POS	Place of Service code for where service is rendered.	2	Number (Integer)
(A-C,E) Prim Diag	The primary ICD-CM diagnosis code.	7	Character
(A-C,E) Proc Cde	Procedure code on the detail.	5	Character
(A-C,E) Proc Desc	Description of the Procedure code on the detail.	40	Character
(A-C,E) Rev Cde	Revenue Code on the detail.	5	Character
(A-C,E) Rev Desc	Description of the Revenue code on the detail.	70	Character
(A-C,E) TDOS	Claim's last date of service.	10	Date (MM/DD/CCYY)
(A-E) Dates of Service	The Profiler dates of services.	20	Date (MM/DD/CCYY)
(A-D) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-D) Run Time	The time that the report was executed.	11	Character

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Field	Description	Length	Data Type
(A-D) User ID	The user that created the report.	50	Character
(A-E) Allwd Amnt	The amount of money allowed to the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-E) Billed Amt	Amount the provider billed for the services.	13	Number (Decimal)
(A-E) Billing Provider IDs	Lists the NPI, Medicaid, and Base ID for the billing Provider.	63	Character
(A-E) Billing Provider Name	Billing Provider name.	63	Character
(A-E) CT	Shows what type of claim was submitted.	2	Character
(A-E) Dtl #	Claim line number.	4	Number (Integer)
(A-E) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
(A-E) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)
(A-E) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(A-E) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
(A-E) Paid Amt	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-E) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A-E) Quarter (prompt)	The quarter for which the report is being run for.	5	Number (Integer)
(A-E) Recipient ID	Recipient Medicaid Number	12	Character
(B) Wrap Ind	Wrap Payment Indicator	1	Character
(B,CE) TOS	Claim Type of Service.	4	Number (Integer)
(D) AHFS	Therapeutic class code.	8	Number (Integer)
(D) AHFS Desc	Description of the therapeutic class code.	55	Character

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Field	Description	Length	Data Type
(D) DEA	Drug Enforcement Agency (DEA) Code	3	Character
(D) Dispense Date	Date the prescription was dispensed by the provider.	20	Date (MM/DD/CCYY)
(D) Dispense Qty	Number of units of a drug dispensed to a member.	10	Number (Integer)
(D) GPI	Generic Product Indicator (GPI) distinguishes a product either as a generic drug product (1) or a more expensive branded drug product (2).	1	Number (Integer)
(D) NDC	National Drug Code	11	Number (Integer)
(D) NDC Description	National Drug Code (NDC) description/name.	35	Character

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3.5.86 DSSProfiler - Recipient Exception Quarterly

The Recipient Exception Profile QTR report is created in the DSSProfiler. This report shows recipient exception trending for a period of 12 months by quarter.

The report contains six tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Nursing Facility tab holds claim details for nursing facility claims;

C. The Outpatient tab holds claim details for outpatient claims;

D. The Pharmacy tab holds claim details for pharmacy claims;

E. The Professional tab holds claim details for professional and dental claims; and

F. The Professional Referrals tab holds claim details for professional referral related claims.

A

Alabama Medicaid Agency

Recipient Exception Quarterly

Inpatient

For Dates of Service: 01/01/2006 - 12/31/2006

Recipient:

735 GABLE DRIVE
BIRMINGHAM, AL 35215-0000
37 - Jefferson

User ID:
Run Date: 11/5/2007
Run Time: 1:27:50 PM

Peer Group Code: 865 - 52 SOBRA Child(KB) with no money ! 133%FP + full Mcaid
Aggregation Code: 8 - Encounter Claims by Recipient

	20062
1835 - AL Number of Drug Poison Diagnosis H: 003 L: 000	8.00

End of Report

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B

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 3:01:01 PM

Recipient Exception Quarterly
Nursing Home
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient:
DECATUR HEALTH/REHAB
P O BOX 1821
DECATUR, AL 35602-0000
52 - Morgan
Peer Group Code: 805 - 16 Aged-D.O. with no money + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

	20061		20062		20064	
1824 - AL Number of Syncope and Collapse H: 003 L: 000	1.00		2.00		2.00	

End of Report

C

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 3:05:56 PM

Recipient Exception Quarterly
Outpatient
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient:
8810 4TH AVE N
BIRMINGHAM, AL 35206-2126

37 - Jefferson
Peer Group Code: 846 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

	20061	
1710 - CMS Number of Emergency Room Visits H: 002 L: 000	1.00	
1720 - CMS Average Number of ER Visits per Provider H: 005 L: 000	1.00	

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D

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:09:11 PM

Recipient Exception Quarterly
Pharmacy

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
P O BOX 581
BREWTON, AL 36427-0000

27 - Escambia
Peer Group Code: 864 - 51 SOBRA Child(KM) with no money ! 100%FP + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

	20064	
1610 - CMS Amount Paid for Narcotic Drugs H: 005 L: 000	36.83	*
1620 - CMS Amount Paid for Antibiotic Drugs H: 005 L: 000	9.07	*
1770 - CMS Amount Paid for All Drugs H: 005 L: 000	45.90	*
1790 - CMS Number of Prescriptions Filled H: 005 L: 000	6.00	*

End of Report

E

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:21:49 PM

Recipient Exception Quarterly
Professional

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
510 N 3RD AVE
HARTFORD, AL 36344-1904

31 - Geneva
Peer Group Code: 804 - 15 Aged-SSI with OMB Plus + full Mcaid OMB
Aggregation Code: 7 - Fee For Service Claims by Recipient

	20061	
1833 - AL Number of Headache Diagnosis H: 004 L: 000	1.00	

End of Report

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F

Alabama Medicaid Agency

Recipient Exception Quarterly
Professional Referrals
For Dates of Service: 01/01/2006 - 12/31/2006
Recipient: [redacted]
880 FREEMAN DRIVE
DADEVILLE, AL 36853-2116

62 - Tallapoosa
Peer Group Code: 832 - 36 MLIF-Adult with no money + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 3:33:49 PM

	20062
1710 - CMS Number of Emergency Room Visits H: 002 L: 000	1.00
1720 - CMS Average Number of ER Visits per Provider H: 005 L: 000	1.00
1829 - AL Number of Malaise and Fatigue H: 006 L: 000	1.00

End of Report

3.5.86.1 DSSProfiler - Recipient Exception Quarterly Field Descriptions

Field	Description	Length	Data Type
(A-F) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-F) Calculation	Calculation to find case groups above the exception high.	14	Number (Decimal)
(A-F) Case Type Group Display	Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.	4	Number (Integer)
(A-F) Exception	This column is marked with a '*' when the case group is above the exception high value.	1	Character
(A-E) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-F) Peer Group Code	User-defined criteria that will group providers and recipients to be compared against other providers and recipients within the same peer group. Typical provider peer grouping variables are provider type or provider specialty. The most common recipient peer grouping is the recipient aid category.	20	Character
(A-F) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-F) Recipient	Unique identifier for the recipient.	12	Character

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3.5.87 DSSProfiler - Recipient Frequency Distribution

The Recipient Frequency Distribution report is created in the DSSProfiler. Based on the user-entered date range of one year, this report shows for each inpatient, pharmacy, nursing facility, professional services, professional referrals and outpatient case types, peer grouping, the distribution of services within the 10th, 25th, 50th, 75th, 90th and 95th percentiles based on the number of recipients reported within a case type, peer grouping.

The report contains five tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Pharmacy tab holds claim details for pharmacy claims;

C. The Nursing Facility tab holds claim details for nursing facility claims;

D. The Professional Services tab holds claim details for professional and dental claims;

E. The Professional Referrals tab holds claim details for professional referrals; and

F. The Outpatient tab holds claim details for outpatient claims.

A

Alabama Medicaid Agency

Recipient Frequency Distribution
Inpatient
For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID: [redacted]
Run Date: 9/27/2007
Run Time: 11:19:51 AM

Case Type : 1054 - AL Drug Poison Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Case Type : 3 - Morbidity 1

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

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B

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:19:58 AM

Recipient Frequency Distribution
Pharmacy

For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 1060 - AL Duragesic Drug Codes

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	3	3	4

Case Type : 1061 - AL Adderall Drug Codes

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	3	3	4

C

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:23:35 AM

Recipient Frequency Distribution
Nursing Facility
For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 3 - Morbidity 1

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	2	3	3	6	7

Case Type : 4 - Morbidity 2

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	2	3	3	5	6

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D

Alabama Medicaid Agency

User ID:
Run Date: 9/27/2007
Run Time: 11:23:38 AM

Recipient Frequency Distribution

Professional Services

For Dates of Service: 01/01/06 - 12/31/06

Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid

Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 1000 - AL Dormicilla Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	3	4	5

Case Type : 1002 - AL Biospy Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	2

E

Alabama Medicaid Agency

User ID
Run Date: 9/27/2007
Run Time: 11:34:51 AM

Recipient Frequency Distribution

Professional Referrals

For Dates of Service: 01/01/06 - 12/31/06

Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid

Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type : 1000 - AL Dormicilla Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	3	4	4

Case Type : 1002 - AL Biospy Procedures

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	2

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F

Alabama Medicaid Agency

Recipient Frequency Distribution
Outpatient

For Dates of Service: 01/01/06 - 12/31/06
Recipient Peer Group Code: 971 - 41 Disabled-SSI- full Mcaid
Recipient Aggregation Code: 7 - Fee For Service Claims by Recipient

User ID:
Run Date: 9/27/2007
Run Time: 11:21:26 AM

Case Type : 1039 - AL Genitourinary Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	2	3	4

Case Type : 1040 - AL Maternity Diagnosis

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	3	3	3

3.5.87.1 DSSProfiler - Recipient Frequency Distribution Field Descriptions

Field	Description	Length	Data Type
(A-F) 10%	Distribution of services within 10th percentile.	4	Number (Decimal)
(A-F) 25%	Distribution of services within 25th percentile.	4	Number (Decimal)
(A-F) 50%	Distribution of services within 50th percentile.	4	Number (Decimal)
(A-F) 75%	Distribution of services within 75th percentile.	4	Number (Decimal)
(A-F) 90%	Distribution of services within 90th percentile.	4	Number (Decimal)
(A-F) 95%	Distribution of services within 95th percentile.	4	Number (Decimal)
(A-F) Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
(A-F) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-F) Recipient Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-F) Recipient Peer Group Code	Recipient Peer Group Code.	40	Character

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3.5.88 DSSProfiler - Recipient Frequency Distribution Quarterly

Based on the user-entered date range of one quarter, this report displays recipient claim counts for each claim type service by percentile for the selected peer groups and aggregation types. Each percentile represents a percentage of the number of recipients with claims in the specific case type grouping. The percentile groups are determined by ordering recipients by the number of paid claims each has for the case type and then grouping the recipients into the percentiles starting with the recipient with the least number of claims. The claim count displayed for each percentile represents the maximum number of claims for any recipient falling in the percentile.

The report contains six tabs:

A. The Inpatient tab holds claim details for inpatient claims;

B. The Pharmacy tab holds claim details for pharmacy claims;

C. The Nursing Facility tab holds claim details for nursing facility claims;

D. The Professional Services tab holds claim details for professional and dental claims;

E. The Professional Referrals tab holds claims details for professional referral related claims; and

F. The Outpatient tab holds claim details for outpatient claims.

A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 11/5/2007
Run Time: 9:18:05 AM

Recipient Frequency Distribution Qtrly
Inpatient
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 3 - Morbidity 1

	10%	25%	50%	75%	90%	95%
Claim Count at each %	8	8	9	9	11	11

Case Type: 4 - Morbidity 2

	10%	25%	50%	75%	90%	95%
Claim Count at each %	13	13	14	23	23	23

Case Type: 5 - Morbidity 3

	10%	25%	50%	75%	90%	95%
Claim Count at each %	29	29	29	29	29	29

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B

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:44 AM

Recipient Frequency Distribution Qtrly
Pharmacy
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 176 - CMS Narcotic Drugs

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	3	4	4

Case Type: 3 - Morbidity 1

	10%	25%	50%	75%	90%	95%
Claim Count at each %	4	4	4	4	4	4

Case Type: 4 - Morbidity 2

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	4	4	4

C

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:50 AM

Recipient Frequency Distribution Qtrly
Nursing Facility
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 4 - Morbidity 2

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	2	2	2

Case Type: 5 - Morbidity 3

	10%	25%	50%	75%	90%	95%
Claim Count at each %	3	3	3	3	3	3

End of Report

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D

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:51 AM

Recipient Frequency Distribution Qtrly
Professional Services
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 1078 - AL Number of Dizziness and Giddiness Diagnoses

	10%	25%	50%	75%	90%	95%
Claim Count at each %	2	2	2	2	2	2

Case Type: 1079 - AL Number of Syncope and Collapse Diagnoses

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	4	4

Case Type: 1080 - AL Number of Abdominal Pain Diagnoses

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	2	3	3

E

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:56 AM

Recipient Frequency Distribution Qtrly
Professionals Referral
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type: 1082 - AL Number of Office Visits

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	2	2

Case Type: 3 - Morbidity 1

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	1	1	1

Case Type: 4 - Morbidity 2

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	1	2	8	8

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F

Alabama Medicaid Agency

User ID:
Run Date: 11/5/2007
Run Time: 9:18:48 AM

Recipient Frequency Distribution Qtrly
Outpatient
For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group Code: 800 - 11 Aged-SSI-full Medicaid coverage
Recipient Aggregation Code: 9 - FFS + Encounter Claims by Recipient
Quarter: 20061

Case Type : 1079 - AL Number of Syncope and Collapse Diagnoses

	10%	25%	50%	75%	90%	95%
Claim Count at each %	17	17	17	17	17	17

Case Type : 1082 - AL Number of Office Visits

	10%	25%	50%	75%	90%	95%
Claim Count at each %	1	1	2	2	2	2

Case Type : 1085 - AL Number of Malaise and Fatigue Diagnoses

	10%	25%	50%	75%	90%	95%
Claim Count at each %	19	19	19	19	19	19

3.5.88.1 DSSProfiler - Recipient Frequency Distribution Quarterly Field Descriptions

Field	Description	Length	Data Type
10%	Distribution of services within 10th percentile.	4	Number (Decimal)
25%	Distribution of services within 25th percentile.	4	Number (Decimal)
50%	Distribution of services within 50th percentile.	4	Number (Decimal)
75%	Distribution of services within 75th percentile.	4	Number (Decimal)
90%	Distribution of services within 90th percentile.	4	Number (Decimal)
95%	Distribution of services within 95th percentile.	4	Number (Decimal)
Case Type	User defined group based on the case type file. The claim grouping should be specific to the area of service.	100	Character
Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Recipient Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
Recipient Peer Group Code	Recipient Peer Group Code.	40	Character

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3.5.89 DSSProfiler - Recipient Peer Group Comparison

The Recipient Peer Group Comparison report is created in the DSSProfiler. Based on the user-entered date range of one year, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service totals, professional referral totals, inpatient referral totals, outpatient referrals and pharmacy totals. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

This report provides a rapid method to find which recipients need to be analyzed more closely utilizing other reports within the DSSProfiler.

The tabs in this report include:

A. Compare by Dollar Difference - Contains information that is essential in comparing recipients within the same group;

B. Compare by Percent Difference - Similar to the previous, except the difference is expressed as a percent; and

C. Data - Shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report.

A

Alabama Medicaid Agency

Recipient Peer Group Comparison
Compare by Dollar Difference

User ID:
Run Date: 10/4/2007
Run Time: 11:26:50 AM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services

Line #	Raw Rank	Recipient ID	Recipient Full Name	Dollar Difference From Expected	Number of Standard Deviations	Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $8,755.09
1	1			$45,075.51	10.30	**********
2	2			$24,111.37	5.51	*****
3	4			$20,218.57	4.62	*****
4	5			$18,811.99	4.30	****
5	6			$16,550.78	3.78	****
6	7			$15,220.94	3.48	****
7	8			$14,082.30	3.22	***
8	9			$11,818.07	2.70	***
9	10			$11,528.42	2.63	***
10	3			$11,048.73	2.52	***
11	14			$9,284.16	2.12	**
12	12			$9,232.77	2.11	**
13	13			$9,174.25	2.10	**
14	11			$9,126.66	2.08	**
15	16			$8,178.65	1.87	**
16	15			$8,050.32	1.84	**
17	18			$7,772.09	1.78	**
18	20			$7,075.36	1.62	**

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:26:50 AM

Recipient Peer Group Comparison
Compare by Percent Difference

For Dates of Service: 01/01/2006 - 12/31/2006

Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services

Line #	Raw Rank	Recipient ID	Recipient Full Name	Percent Difference from Expected	Number of Standard Deviations	Each * represent a 10% Difference From Center Line
1	1	[redacted]	[redacted]	2033.31 %	10.74	**********
2	2	[redacted]	[redacted]	1087.64 %	5.75	**********
3	4	[redacted]	[redacted]	912.04 %	4.82	**********
4	5	[redacted]	[redacted]	848.59 %	4.48	**********
5	7	[redacted]	[redacted]	686.60 %	3.63	**********
6	99	[redacted]	[redacted]	608.84 %	3.22	**********
7	9	[redacted]	[redacted]	533.10 %	2.82	**********
8	10	[redacted]	[redacted]	520.04 %	2.75	**********
9	6	[redacted]	[redacted]	479.95 %	2.54	**********
10	8	[redacted]	[redacted]	442.94 %	2.34	**********
11	14	[redacted]	[redacted]	418.80 %	2.21	**********
12	56	[redacted]	[redacted]	373.70 %	1.97	**********
13	16	[redacted]	[redacted]	368.93 %	1.95	**********
14	18	[redacted]	[redacted]	350.59 %	1.85	**********

C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:26:50 AM

Recipient Peer Group Comparison
Data

For Dates of Service: 01/01/2006 - 12/31/2006

Recipient Peer Group: 961 - 3A Breast and Cervical Cancer + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services

Raw RANK	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
1	[redacted]	[redacted]	$105,675.80	$47,297.36	$47,292.36	$2,216.85	$45,075.51	2033.31 %
2	[redacted]	[redacted]	$68,817.70	$26,332.22	$26,328.22	$2,216.85	$24,111.37	1087.64 %
3	[redacted]	[redacted]	$77,986.04	$28,604.16	$25,780.92	$14,732.19	$11,048.73	75.00 %
4	[redacted]	[redacted]	$51,806.97	$22,503.42	$22,435.42	$2,216.85	$20,218.57	912.04 %
5	[redacted]	[redacted]	$78,276.60	$21,144.84	$21,028.84	$2,216.85	$18,811.99	848.59 %
6	[redacted]	[redacted]	$49,916.80	$20,002.23	$19,999.23	$3,448.45	$16,550.78	479.95 %
7	[redacted]	[redacted]	$55,121.00	$17,444.79	$17,437.79	$2,216.85	$15,220.94	686.60 %
8	[redacted]	[redacted]	$58,547.40	$17,372.49	$17,261.58	$3,179.28	$14,082.30	442.94 %
9	[redacted]	[redacted]	$28,704.00	$14,035.92	$14,034.92	$2,216.85	$11,818.07	533.10 %
10	[redacted]	[redacted]	$33,908.26	$14,229.27	$13,745.27	$2,216.85	$11,528.42	520.04 %
11	[redacted]	[redacted]	$16,713.12	$12,578.11	$12,575.11	$3,448.45	$9,126.66	264.66 %
12	[redacted]	[redacted]	$19,580.48	$12,447.05	$12,412.05	$3,179.28	$9,232.77	290.40 %
13	[redacted]	[redacted]	$41,604.00	$26,369.16	$12,353.53	$3,179.28	$9,174.25	288.56 %

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3.5.89.1 DSSProfiler - Recipient Peer Group Comparison Field Descriptions

Field	Description	Length	Data Type
(A) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Decimal)
(A,B) Each * Represents	(A) Each * represents a $5000 Dollar Difference From Center Line. Rows in red indicate a Dollar Difference that is more than 2 standard deviations from the norm. (B) Each * represents a 10% Difference From Center Line.	8	Number (Decimal)
(A,B) Number of Standard Deviation	Represents the number of standard deviations that the provider's dollar difference was from the expected.	8	Number (Integer)
(A,B) Line #	Line number on the report.	3	Number (Integer)
(A-C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-C) Raw Rank	Provider's rank based on the amount Provider was paid.	3	Number (Decimal)
(A-C) Recipient Full Name	Recipient's full name.	50	Character
(A-C) Recipient ID	Recipient Medicaid Number.	12	Character
(A-C) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(A-C) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(B) Percent Difference from Expected	Percentage number that is the difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology).	7	Number (Decimal)
(C) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(C) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(C) Dollar Difference	Difference in the actual amount provider was paid and the amount provider was expected to receive (based on the ACG adjustment methodology).	13	Number (Decimal)

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Field	Description	Length	Data Type
(C) Expected Amount	Amount provider was expected to receive.	13	Number (Decimal)
(C) Paid Amount	Actual amount provider was paid.	13	Number (Decimal)
(C) Percent Difference	Percent number representing the difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology).	8	Number (Decimal)

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3.5.90 DSSProfiler - Recipient Peer Group Comparison Quarterly

Based on the user-entered date range of one quarter, this report displays and compares all recipients within a peer group to determine which recipients fall outside of service dollar norms. All information is age and gender adjusted so that differences in patient mix do not affect the results. This report can look at professional service, inpatient referrals, outpatient referrals and pharmacy totals. Recipients who have two standard deviations above or below the norm for the peer group are highlighted.

The tabs in this report include:

A. Compare by Dollar Difference - Contains information that is essential in comparing recipients within the same group;

B. Compare by Percent Difference - Similar to the previous, except the difference is expressed as a percent; and

C. Individual Recipient Information - Shows the raw data for all of the equations used in the compare by dollar difference report and the compare by percent difference report.

A

Alabama Medicaid Agency

Recipient Peer Group Comparison Qtrly

Compare By Dollar Difference

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:47:04 AM

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

Line #	Raw Rank	Recipient ID	Recipient Full Name	Dollar Difference From Expected	Number of Standard Deviations	Each * represent a $5000 Difference From Center Line. Rows in red indicate a Dollar Difference that is more that 2 standard deviations from the norm. 2 Standard Deviations = $1,359.03
1	3	[redacted]	[redacted]	$4,623.80	6.80	
2	2	[redacted]	[redacted]	$3,960.18	5.83	
3	8	[redacted]	[redacted]	$3,472.56	5.11	
4	1	[redacted]	[redacted]	$3,408.00	5.02	
5	5	[redacted]	[redacted]	$3,354.95	4.94	
6	3	[redacted]	[redacted]	$3,054.24	4.49	
7	9	[redacted]	[redacted]	$2,797.07	4.12	
8	6	[redacted]	[redacted]	$2,614.31	3.85	
9	7	[redacted]	[redacted]	$2,177.24	3.20	
10	15	[redacted]	[redacted]	$1,846.30	2.72	
11	10	[redacted]	[redacted]	$1,687.21	2.48	
12	17	[redacted]	[redacted]	$1,514.24	2.23	
13	13	[redacted]	[redacted]	$1,481.00	2.18	
14	12	[redacted]	[redacted]	$1,435.21	2.11	
15	11	[redacted]	[redacted]	$1,324.21	1.95	
16	16	[redacted]	[redacted]	$1,224.58	1.80	
17	14	[redacted]	[redacted]	$1,090.80	1.61	
18	18	[redacted]	[redacted]	$964.39	1.42	

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B

Alabama Medicaid Agency

User ID:
Run Date: 10/4/2007
Run Time: 11:47:04 AM

Recipient Peer Group Comparison Qtrly
Compare By Percent Difference

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

Line #	Raw Rank	Recipient ID	Recipient Full Name	Percent Difference from Expected	Number of Standard Deviations	Each * represent a 10% Difference From Center Line
1	3			1525.00 %	10.36	**********
2	15			780.02 %	5.30	**********
3	8			739.72 %	5.02	**********
4	30			630.81 %	4.28	**********
5	9			552.79 %	3.75	**********
6	17			511.98 %	3.48	**********
7	109			441.92 %	3.00	**********
8	121			441.35 %	3.00	**********
9	5			405.41 %	2.75	**********
10	24			397.35 %	2.70	**********
11	2			376.52 %	2.56	**********
12	80			277.13 %	1.88	**********
13	26			260.43 %	1.77	**********
14	146			227.28 %	1.54	**********
15	177			224.48 %	1.52	**********

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C

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 10/4/2007
Run Time: 11:47:04 AM

Recipient Peer Group Comparison Qtrly
Individual Recipient Information

For Dates of Service: 01/01/2006 - 03/31/2006
Recipient Peer Group: 904 - R1 Retro-Full Elig + full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient
Report Category: 1 - Professional Services
Quarter: 20061

Raw Rank	Recipient ID	Recipient Full Name	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference	Exception
3	[redacted]	[redacted]	$4,927.00	$4,927.00	$4,927.00	$303.20	$4,623.80	1525.00 %	*
2	[redacted]	[redacted]	$35,267.00	$5,011.97	$5,011.97	$1,051.79	$3,960.18	376.52 %	*
8	[redacted]	[redacted]	$3,942.00	$3,942.00	$3,942.00	$469.44	$3,472.56	739.72 %	*
1	[redacted]	[redacted]	$5,130.00	$3,762.00	$5,769.00	$2,361.00	$3,408.00	144.35 %	*
5	[redacted]	[redacted]	$8,278.35	$4,182.50	$4,182.50	$827.55	$3,354.95	405.41 %	*
3	[redacted]	[redacted]	$4,927.00	$4,927.00	$4,927.00	$1,872.76	$3,054.24	163.09 %	*
9	[redacted]	[redacted]	$18,325.00	$3,303.05	$3,303.05	$505.99	$2,797.07	552.79 %	*
6	[redacted]	[redacted]	$8,794.00	$4,085.00	$4,085.00	$1,470.69	$2,614.31	177.76 %	*
7	[redacted]	[redacted]	$4,222.00	$4,050.00	$4,050.00	$1,872.76	$2,177.24	116.26 %	*
15	[redacted]	[redacted]	$6,726.80	$2,083.00	$2,083.00	$236.70	$1,846.30	780.02 %	*
10	[redacted]	[redacted]	$5,956.00	$2,868.00	$2,868.00	$1,180.79	$1,687.21	142.89 %	*
17	[redacted]	[redacted]	$2,505.00	$1,810.00	$1,810.00	$295.76	$1,514.24	511.98 %	*
13	[redacted]	[redacted]	$5,329.00	$2,254.50	$2,254.50	$773.50	$1,481.00	191.47 %	*
12	[redacted]	[redacted]	$4,516.00	$2,487.00	$2,487.00	$1,051.79	$1,435.21	136.45 %	*
11	[redacted]	[redacted]	$5,457.00	$2,506.00	$2,505.00	$1,180.79	$1,324.21	112.15 %	
16	[redacted]	[redacted]	$2,390.00	$1,932.00	$1,932.00	$707.42	$1,224.58	173.11 %	
14	[redacted]	[redacted]	$2,800.00	$2,124.00	$2,124.00	$1,033.20	$1,090.80	105.57 %	
18	[redacted]	[redacted]	$2,593.75	$1,561.17	$1,561.17	$596.78	$964.39	161.60 %	

3.5.90.1 DSSProfiler - Recipient Peer Group Comparison Quarterly Field Descriptions

Field	Description	Length	Data Type
(A,C) Dollar Difference from Expected	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A-B) Each * Represents	Each * represent a $5000 Difference From Center Line. Rows in red indicate an Dollar Difference that is more that 2 standard deviations from the norm.	8	Number (Decimal)
(A-B) Number of Standard Deviations	Represents the number of standard deviations that the provider's dollar difference was from the expected.	8	Number (Integer)
(A-C) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-C) Line #	Line number on the report.	3	Number (Integer)
(A-C) First Dates of Service	Starting and Ending range of service date selection criteria.	11	Date (MM/DD/CCYY)
(A-C) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)

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Field	Description	Length	Data Type
(A-C) Raw Rank	Recipient's rank based on the actual money paid by the program.	3	Number (Integer)
(A-C) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A-C) Recipient ID	Recipient Medicaid Number.	12	Character
(A-C) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(A-C) Report Category	User-defined variables used to categorize case types into service groups.	21	Character
(B,C) Percent Difference from Expected	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(C) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(C) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(C) Exception	Indicates providers who are 2 standard deviations above or below the "norm" for the peer group.	1	Character
(C) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(C) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)

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3.5.91 DSSProfiler - Recipient Profile

This report is created in the DSSProfiler. Based on the user-entered date range of one year, the Recipient Profile displays the aggregated case type categories for the selected recipients. This report makes it easier to see the types of services that a recipient is utilizing without the need for looking at the claim detail level. This report shows all case types including professional, inpatient, outpatient, nursing facility and pharmacy services.

There are multiple tabs on this report. For workbook documentation only, the different tabs have been lettered A-F in the layout below. The field names have the corresponding letter in front identifying the tab it can be found on. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The six tabs in this report are:

A. Recipient Demographics/Totals;

B. Professional Services;

C. Inpatient Services;

D. Outpatient Services;

E. Pharmacy Services; and

F. Nursing Facility Services.

A

Alabama Medicaid Agency

Recipient Profile
Recipient Demographics/Totals

User ID:
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID:
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Recipient County:
Birth Date:
Age Group:
Gender:

Report Category Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
1 - Professional Services	1	1	$156.00	$37.00	$37.00	$705.16	$(668.16)	-95.00 %
4 - Pharmacy Services	12	1,346	$518.67	$515.70	$515.70	$868.95	$(353.25)	-41.00 %
5 - Nursing Facility Services	3	89	$14,493.13	$14,493.13	$14,493.13	$11,942.66	$2,550.47	21.00 %

End of Report

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B

Alabama Medicaid Agency

Recipient Profile
Professional Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
4 - Morbidity 2	1	1	$156.00	$37.00	$37.00
956 - AL Radiology Procedures - All	1	1	$156.00	$37.00	$37.00

End of Report

C

Alabama Medicaid Agency

Recipient Profile
Inpatient Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount

No Data This Report Run

D

Alabama Medicaid Agency

Recipient Profile
Outpatient Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
4 - Morbidity 2	6	6	$1,345.92	$199.37	$199.37
794 - AL Radiology Procedures	2	2	$968.73	$137.38	$137.38
880 - AL Lab Procedures	4	4	$377.19	$61.99	$61.99

End of Report

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E

Alabama Medicaid Agency

Recipient Profile
Pharmacy Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

For Dates of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
4 - Morbidity 2	12	1,346	$518.67	$515.70	$515.70

End of Report

F

Alabama Medicaid Agency

Recipient Profile
Nursing Facility Services

User ID: [redacted]
Run Date: 12/12/2007
Run Time: 1:37:54 PM

Date of Service: 01/01/2006 - 12/31/2006
Recipient ID: [redacted]
Recipient Peer Group: 971 - 41 Disabled-SSI- full Mcaid
Aggregation Code: 7 - Fee For Service Claims by Recipient

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
4 - Morbidity 2	3	89	$14,493.13	$14,493.13	$14,493.13

End of Report

3.5.91.1 DSSProfiler - Recipient Profile Field Descriptions

Field	Description	Length	Data Type
(A) Age Group	Six age groups are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+.	24	Character
(A) Birth Date	Recipient's date of birth.	8	Date (MM/DD/CCYY)
(A) Dollar Difference	Difference in the actual amount recipient was paid and the amount recipient was expected to receive (based on the ACG adjustment methodology).	13	Number (Decimal)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Gender	Recipient's gender.	7	Character
(A) Percent Difference	Percent number representing the difference in the actual amount recipient was paid and the	8	Number (Decimal)

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Field	Description	Length	Data Type
	amount recipient was expected to receive (based on the ACG adjustment methodology).		
(A) Recipient County	Recipient's county of residence.	20	Character
(A) Report Category Description	User-defined variables used to categorize case types into service groups.	52	Character
(A-F) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-F) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-F) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-F) Claim Count	Number of claims the provider filed in the particular claim group for the recipient.	8	Character
(A-F) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-F) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-F) Quantity	Quantity billed.	8	Number (Integer)
(A-F) Recipient ID	Recipient Medicaid Number (plus Recipient's name).	20	Character
(A-F) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B-F) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character

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3.5.92 DSSProfiler - Recipient Profile Quarterly

Based on the user-entered date range of one quarter, this report shows a claim summary for a recipient that has been profiled. The first tab shows totals by claim type. There are also tabs for each claim type which show totals by case type.

The six tabs in this report are:

A. Recipient Demographics/Totals;

B. Professional Services;

C. Inpatient Services;

D. Outpatient Services;

E. Pharmacy Services; and

F. Nursing Facility Services.

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A

Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Recipient Demographics/Totals
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Recipient ID: [illegible]
Recipient Name: [illegible]
Birth Date: 02/13/1997
Age Group: Age 06 - 17
Gender: F

Report Category Code & Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount	Expected Amount	Dollar Difference	Percent Difference
6 - Outpatient Referrals	6	6	$1,264.10	$94.27	$94.27	$171.99	$(77.72)	-45.00 %
4 - Pharmacy Services	10	417	$511.70	$377.14	$377.14	$500.29	$(123.15)	-25.00 %
1 - Professional Services	5	5	$314.00	$171.00	$171.00	$546.39	$(375.39)	-69.00 %

End of Report

B

Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Professional Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
184 - AL Number of Emergency Room Visits	1	1	$185.00	$42.00	$42.00
4 - Morbidity 2	5	5	$314.00	$171.00	$171.00

End of Report

C

Alabama Medicaid Agency

User ID: [illegible]
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Inpatient Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID: [illegible]
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount

No Data This Report Run

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D

Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Outpatient Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
184 - AL Number of Emergency Room Visits	1	1	$440.45		$38.36
4 - Morbidity 2	6	6	$1,264.10		$94.27

End of Report

E

Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Pharmacy Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount
176 - CMS Narcotic Drugs	9	400	$176.00	$363.56	$363.56
4 - Morbidity 2	10	417	$4.00	$377.14	$377.14

End of Report

F

Alabama Medicaid Agency

User ID:
Run Date: 12/12/2007
Run Time: 2:44:21 PM

Recipient Profile Qtrly
Nursing Facility Services
For Dates of Service: 10/01/2006 - 12/31/2006
Recipient ID:
Aggregation Code: 7 - Fee For Service Claims by Recipient
Recipient Peer Group: 846 - 41 Disabled-SSI- full Mcaid
Quarter: 20064

Case Type Description	Claim Count	Quantity	Billed Amount	Allowed Amount	Paid Amount

No Data This Report Run

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3.5.92.1 DSSProfiler - Recipient Profile Quarterly Field Descriptions

Field	Description	Length	Data Type
(A) Age Group	Age range, which the recipient is grouped into. There are six age groups, 00-05, 06-17, 18-20, 21-34, 35-64, and 65+.	24	Character
(A) Birth Date	Recipient's date of birth.	8	Date (MM/DD/CCYY)
(A) Dollar Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Expected Amount	Amount provider was expected to receive based on the peer group adjustment methodology.	13	Number (Decimal)
(A) Gender	Recipient's gender.	1	Character
(A) Percent Difference	Difference in the actual amount provider was paid and the amount Provider was expected to receive (based on the peer group adjustment methodology).	13	Number (Decimal)
(A) Recipient Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A) Report Category Code Description	User-defined variables used to categorize case types into service groups.	50	Character
(A-F) Claim Count	Number of claims the provider filed for the particular claim group.	8	Number (Integer)
(A-F) Quantity	Quantity billed in the particular claim group for the recipient.	8	Number (Integer)
(A-F) Aggregation Code	Indicates the level of aggregation for claims by providers or recipients. Claims can be aggregated by FFS, Encounters or Both.	50	Character
(A-F) Allowed Amount	The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.	13	Number (Decimal)
(A-F) Billed Amount	Amount the provider billed for the services.	13	Number (Decimal)
(A-F) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-F) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(A-F) Quarter	The quarter for which the report is being run.	5	Date (CCYYQ)
(A-F) Recipient ID	Recipient Medicaid Number.	12	Character

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Field	Description	Length	Data Type
(A-F) Recipient Peer Group	Recipient Peer Group Code and Description.	40	Character
(B-F) Case Type Description	Claims groupings that were billed on the recipients within the predefined group.	100	Character

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3.5.93 ETG Descriptions

This ETG Descriptions report contains code values and descriptions for ETG major practice categories, ETG number, and ETG episode types. This is a static report based on the code table values, and other than any ETG software changes, the data in this report will not change.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-C in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The eight tabs in this report are:

A. ETGs By Major Processing Category;

B. ETGs By ETG Number & Description; and

C. ETG Episode Types.

A

Alabama Medicaid Agency

ETG Descriptions

ETG's By Major Processing Category

User ID: [redacted]
Run Date: 5/13/2014
Run Time: 11:23:54 AM

Major Processing Category: 01 - INFECTIOUS DISEASES

ETG Number	Episode Treatment Group Description
130100	130100 - AIDS, with complication, with comorbidity, with surgery
130100	130100 - AIDS, with complication, with comorbidity, w/o surgery
130100	130100 - AIDS, with complication, w/o comorbidity, with surgery
130100	130100 - AIDS, with complication, w/o comorbidity, w/o surgery
130100	130100 - AIDS, w/o complication, with comorbidity, with surgery
130100	130100 - AIDS, w/o complication, with comorbidity, w/o surgery
130100	130100 - AIDS, w/o complication, w/o comorbidity, with surgery
130100	130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery
130200	130200 - HIV sero-positive w/o AIDS, with surgery
130200	130200 - HIV sero-positive w/o AIDS, w/o surgery
130400	130400 - Septicemia, with complication, with surgery
130400	130400 - Septicemia, with complication, w/o surgery
130400	130400 - Septicemia, w/o complication, with surgery
130400	130400 - Septicemia, w/o complication, w/o surgery
130600	130600 - Other infectious diseases, with complication, with comorbidity, with surgery
130600	130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery
130600	130600 - Other infectious diseases, with complication, w/o comorbidity, with surgery
130600	130600 - Other infectious diseases, with complication, w/o comorbidity, w/o surgery

Episode Treatment Grouper (ETG) ETG Descriptions.rep Page 1 of 89

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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 5/13/2014
Run Time: 11:23:54 AM

ETG Descriptions

ETG's by ETG Number & Description

ETG Number	Episode Treatment Group Description
130100	130100 - AIDS, with complication, with comorbidity, with surgery
130100	130100 - AIDS, with complication, with comorbidity, w/o surgery
130100	130100 - AIDS, with complication, w/o comorbidity, with surgery
130100	130100 - AIDS, with complication, w/o comorbidity, w/o surgery
130100	130100 - AIDS, w/o complication, with comorbidity, with surgery
130100	130100 - AIDS, w/o complication, with comorbidity, w/o surgery
130100	130100 - AIDS, w/o complication, w/o comorbidity, with surgery
130100	130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery
130200	130200 - HIV sero-positive w/o AIDS, with surgery
130200	130200 - HIV sero-positive w/o AIDS, w/o surgery
130400	130400 - Septicemia, with complication, with surgery
130400	130400 - Septicemia, with complication, w/o surgery
130400	130400 - Septicemia, w/o complication, with surgery
130400	130400 - Septicemia, w/o complication, w/o surgery
130600	130600 - Other infectious diseases, with complication, with comorbidity, with surgery
130600	130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery
130600	130600 - Other infectious diseases, with complication, w/o comorbidity, with surgery

Episode Treatment Grouper (ETG) ETG Descriptions.rep Page 1 of 91

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Alabama Medicaid Agency

User ID:
Run Date: 5/13/2014
Run Time: 11:23:54 AM

ETG Descriptions

ETG Episode Types

Episode Type	Episode Type Description
0	0 - Complete Episode.
1	1 - A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range.
2	2 - A full year episode which has at least one anchor record within the episode's clean period from the beginning of the claims data range.
3	3 - A full year episode which has both an anchor record within the episode clean period from the beginning of the database, and another anchor record within the clean period from the end of the claims data range.
4	4 - An episode < 1 year with a clean start.
5	5 - An episode < 1 year with a clean finish.
6	6 - An episode < 1 year with neither a clean start nor a clean finish.
7	7 - Incomplete annual episode, only applies to chronic episodes.
8	8 - A record which was not grouped to an episode. This includes records with "Ongoing Rx Therapy" and Ungroupable ETG. This value may also occur for some pregnancy records.
9	9 - Orphan ancillary service, not grouped to an episode.

End of Report

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3.5.93.1 ETG Descriptions Field Descriptions

Field	Description	Length	Data Type
(A) Major Processing Category	The concatenation of The Major Practice Category and its description. The Major Practice Category - This is a high level ETG specific classification for specific disease conditions. The Major Practice Category Description. - This is a high level ETG specific classification for specific disease conditions.	105	Character
(A-B) ETG Number	The ETG identifier assigned to the episode that further identifies a disease condition.	6	Character
(A-B) Episode Treatment Group Description	The description of the ETG number.	234	Character
(C) Episode Type	This field indicates the Episode type.	2	Character
(C) Episode Type Description	This is the episode type and description.	230	Character

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3.5.94 ETG Details - FFS

The ETG Details report breaks the Episode Treatment Groups (ETGs) down to the major category levels. It displays the average episode cost, the average amount per recipient, total episodes, total recipients and total dollars.

This report contains a prompt that allows the report user to enter a specific warrant date or a range of warrant dates to extract the claim's data.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-H in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The eight tabs in this report are:

A. Details By ETG;

B. Details By Recipient;

C. Details By Servicing Provider;

D. Recipient Totals;

E. Provider Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.

A

Alabama Medicaid Agency

ETG Details - FFS
Details By ETG
For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient ID	Recipient Full Name	Recip Age	Recip County Description	Claim Indicator	Program Code Description	Provider ID - Billing	Provider ID - Referring/ Attending/ Prescribing	ICD	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
	M - PROFESSIONAL CLAIMS	0 - Complete Episode.	1234567890	XXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXX	17	22 - Cullman	F	41 - Disabled-SSI-full Medicaid coverage	NPI ID: Medicaid ID: Base ID:	NPI ID: Medicaid ID: Base ID:	9	72671 - ACHILLES BURSITIS OR TENDINITIS		N	N	-	

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	8/27/2015	8/27/2015	########### -	99213 - Office/ Outpatient Visit Est	$75.00	$34.40	$34.40	NPI ID: Medicaid ID: Base ID:	#### - Unknown or Not Applicable	N

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

ETG Details - FFS
Details By Recipient

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

123456789012

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recip Age	Recipient County Description	Claim Indicator	Program Code Description	Provider ID - Billing	Provider ID - Referring/Attending/ Prescribing	I C D	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
	M - PROFESSIONAL CLAIMS	0 - Complete Episode.	34	16 - Coffee	F	36 - MLIF-Adult-No Money-full Medicaid coverage	NPI ID: Medicaid ID: Base ID:	NPI ID: Medicaid ID: Base ID:	9	72672 - TIBIALIS TENDINITIS	N	N		-	

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	8/25/2015	8/25/2015	########### -	99214 - Office/ Outpatient Visit Est	$150.00	$68.00	$64.10	NPI ID: Medicaid ID: Base ID:	#### - Unknown or Not Applicable	Y

End of Report

C

Alabama Medicaid Agency

ETG Details - FFS
Details By Servicing Provider

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

User ID:
Run Date: 7/26/16
Run Time: 3:42:35 PM

Medicaid ID:

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient ID	Recipient Full Name	Recip Age	Recipient County Description	Claim Indicator	Program Code Description	Provider ID - Billing	Provider ID - Referring/ Attending/ Prescribing	I C D	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
	M - PROFESSIONAL CLAIMS	0 - Complete Episode.	123456789012	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	17	22 - Cullman	F	41 - Disabled-SSI-full Medicaid coverage	NPI ID: Medicaid ID: Base ID:	NPI ID: Medicaid ID: Base ID:	9	72671 - ACHILLES BURSITIS OR TENDINITIS	N	N	-		

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	8/27/2015	8/27/2015	########### -	99213 - Office/Outpatient Visit Est	$75.00	$34.40	$34.40	NPI ID: Medicaid ID: Base ID:	#### - Unknown or Not Applicable	N

End of Report

PHI has been removed

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D

Alabama Medicaid Agency

ETG Details - FFS
Recipient Totals

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 001
Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery

Recipient ID	Recipient Full Name	Paid Amount
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X	$8,075.59
Totals: 76		$8,075.59

E

Alabama Medicaid Agency

ETG Details - FFS
Provider Totals

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 001
Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery

Provider ID - Billing	Provider ID - Referring/ Attending/Prescribing	Provider ID - Rendering	Paid Amount
NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	$94.13
NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	NPI ID: Medicaid ID: Base ID:	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	$42.00

End of Report

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F

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

ETG Details - FFS

Procedure Totals

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Procedure Code & Description	Number of Providers	Percent of All Providers	Number of Recipients	Percent of All Recipients	Number of Claims	Percent of All Claims	Paid Amount
20550 - Inj Tendon Sheath/Ligament	1	1.25 %	1	1.35 %	1	0.81 %	$47.00
20605 - Drain/Inj Joint/Bursa W/O Us	2	2.50 %	2	2.70 %	2	1.61 %	$84.00
29425 - Apply Short Leg Cast	1	1.25 %	1	1.35 %	1	0.81 %	$74.00
29540 - Strapping Of Ankle And/Or Ft	2	2.50 %	2	2.70 %	2	1.61 %	$50.40
73590 - X-Ray Exam Of Lower Leg	2	2.50 %	2	2.70 %	2	1.61 %	$44.00

End of Report

G

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

ETG Details - FFS

Diagnosis Totals

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

ICD	Primary Diagnosis Code & Description	Number of Providers	Percent of All Providers	Number of Recipients	Percent of All Recipients	Number of Claims	Percent of All Claims	Paid Amount
#	####### - Unknown or Not Appl.	16	20.00 %	17	22.97 %	26	20.97 %	$375.45
0	M2550 - PAIN IN UNSPECIFIED JOINT	1	1.25 %	1	1.35 %	1	0.81 %	$42.40
0	M65871 - OTHER SYNOVITIS AND TENOSYNOVITIS, RIGHT ANKLE AND FOOT	1	1.25 %	1	1.35 %	1	0.81 %	$23.00
0	M7671 - PERONEAL TENDINITIS, RIGHT LEG	1	1.25 %	1	1.35 %	1	0.81 %	$64.27

End of Report

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H

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/26/16
Run Time: 3:42:35 PM

ETG Details - FFS

NDC Totals

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number: 714801 - Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 000
Subclass Description: Bursitis & tendinitis - foot & ankle, w/o surgery

Subclass: 001
Subclass Description: Bursitis & tendinitis - foot & ankle, with surgery

NDC & Description	Number of Providers	Percent of All Providers	Number of Recipients	Percent of All Recipients	Number of Claims	Percent of All Claims	Paid Amount
########### -	74	90.24 %	68	89.47 %	98	75.97 %	$7,549.05
00093014905 - NAPROXEN	1	1.22 %	1	1.32 %	1	0.78 %	$13.73
00093094801 - DICLOFENAC POTASSIUM	1	1.22 %	1	1.32 %	1	0.78 %	$45.24
00406012305 - HYDROCODONE-ACETAMINOPHEN	1	1.22 %	1	1.32 %	1	0.78 %	$19.22
00591544210 - PREDNISONE	1	1.22 %	1	1.32 %	1	0.78 %	$15.94

3.5.94.1 ETG Details - FFS Field Descriptions

Field	Description	Length	Data Type
(A-C) Wrap Ind	Wrap Payment Indicator	1	Character
(A,B,C,G) ICD	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(A,C,D) Recipient Full Name	Links together the recipient last name and first name into one object. The format of the name will be in: last name, first name.	22	Character
(A,C,D) Recipient ID	The recipient's Medicaid identification number.	12	Character
(A,D-H) Subclass	This field further describes the ETG number.	3	Character
(A,D-H) Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character
(A-C) Allowed Amount	The allowed amount for the detail.	11	Number (Decimal)
(A-C) Billed Amount	The billed amount for the detail.	11	Number (Decimal)

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Field	Description	Length	Data Type
(A-C) Buyin Medicare A	Medicare Buy-in in which recipient is participating in Part A.	5	Character
(A-C) Buyin Medicare B	Medicare Buy-in in which recipient is participating in Part B.	5	Character
(A-C) Claim Detail Status	The claim's status code.	1	Character
(A-C) Claim ICN	The claim's identification number.	13	Character
(A-C) Claim Indicator	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
(A-C) Claim Type & Description	Shows what type of claim was submitted and the description.	53	Character
(A-C) Date First Service	The claim's first date of service.	10	Date (MM/DD/CCYY)
(A-C) Date Last Service	The claim's last date of service.	10	Date (MM/DD/CCYY)
(A-C) Detail Number	Detail number on the claim.	3	Number (Integer)
(A-C) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	30	Character
(A-C) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)
(A-C) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(A-C) Episode Type & Description	Episode Type and the associated description.	229	Character
(A-H) ETG Number & Description	The selected ETG Number and its description.	234	Character
(A-C) Program Code & Description	State aid category.	55	Character
(A-C) Recip Age	The recipient's age.	3	Number (Integer)
(A-C) Recip County & Description	Recipient's county of residence and the associated description.	38	Character
(A-C) Revenue Code & Description	The revenue code on a detail and the associated description.	77	Character
(A-C, E) Provider ID - Referring/Attending/Prescribing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character

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Field	Description	Length	Data Type
(A-C, E) Provider ID - Billing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(A-C, E) Provider ID - Rendering	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(A-C, F) Procedure Code & Description	Procedure code on the detail and its description.	49	Character
(A-C, H) NDC Code & Description	The National Drug Code for a drug claim and its name/description	49	Character
(A-C,G) Primary Diagnosis Code & Description	Primary diagnosis code and its description.	70	Character
(A-H) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-H) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient.	11	Number (Decimal)
(D-H) Total Paid Amount	The paid (warrant) amount including the State share amount.	11	Number (Decimal)
(F-H) Number of Claims	Unduplicated count of ICNs.	8	Number (Integer)
(F-H) Number of Providers	The count of providers for the associated line.	8	Number (Integer)
(F-H) Number of Recipients	Unduplicated count of recipient IDs.	8	Number (Integer)
(F-H) Percent of All Claims	Count of ICN divided by total of all ICNs.	8	Number (Decimal)
(F-H) Percent of All Providers	The count of procedures for the provider divided by the count of all providers.	13	Number (Integer)
(F-H) Percent of All Recipients	Count of recipient id divided by total of all recipients.	8	Number (Integer)

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3.5.95

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ETG Distribution Analysis Episode Type - FFS

The ETG Distribution Analysis Episode Type report provides totals and averages for ETG Episode Types. This includes allowed amount, number of unduplicated recipients, episodes and the number of exceptions for episodes and recipients.

The Episode Type field of each record (also included in the summary record for the episode) indicates the completeness of the record's episode; see Episode Types in the Appendix for more details.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care assessed on a series of clinical and statistical algorithms.

The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for creating provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains three tabs:

A. ETG Distribution Analysis by ETG;

B. ETG Distribution Analysis by Major Practice Category (MPC); and

C. ETG Distribution Analysis Episode Type.

A

Alabama Medicaid Agency
ETG Distribution Analysis - FFS
By ETG
For Dates of Service: 10/01/2011 - 09/30/2013

User ID: [redacted]
Run Date: 5/14/2014
Run Time: 4:30:02 PM

ETG Number & Description: 130100 - AIDS, with complication, with comorbidity, with surgery

Episode Type Description	Amount Per Recipient	Amount Per Episode	Total Allowed Amount	Total Detail Paid Amount	Total Episodes	Total Recipients	Exceptions based on cost per Episode	Exceptions based on cost per Recipient
0 - Complete Episode - Full Year	$13,357.00	$13,357.00	$93,500.00	$93,500.00	7	7	0	0
7 - Unknown Start/Unknown Finish Incomplete Annual	$5,960.00	$5,960.00	$59,603.00	$59,603.00	10	10	1	1
		Totals:	$153,103.00	$153,103.00	17	17	1	1

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B

Alabama Medicaid Agency

ETG Distribution Analysis - FFS

By Major Practicing Category (MPC)

For Dates of Service: 10/01/2011 - 09/30/2013

User ID: [redacted]
Run Date: 5/14/2014
Run Time: 4:30:02 PM

ETG Number & Description	Episode Type Description	Amount Per Recipient	Amount Per Episode	Total Allowed Amount	Total Detail Paid Amount	Total Episodes	Total Recipients	Exceptions based on cost per Episode	Exceptions based on cost per Recipients
130100 - AIDS, w/o complication, with comorbidity, w/o surgery	0 - Complete Episode - Full Year	$5,949.00	$5,736.00	$803,055.00	$803,056.00	140	135	1	1
130100 - AIDS, w/o complication, with comorbidity, w/o surgery	7 - Unknown Start/Unknown Finish Incomplete Annual	$3,594.00	$3,513.00	$779,899.00	$779,899.00	222	217	1	1
130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery	0 - Complete Episode - Full Year	$6,389.00	$5,979.00	$466,363.00	$466,363.00	78	73	0	1
130100 - AIDS, w/o complication, w/o comorbidity, w/o surgery	7 - Unknown Start/Unknown Finish Incomplete Annual	$3,742.00	$3,611.00	$516,330.00	$516,330.00	143	138	0	0
130200 - HIV sero-positive w/o AIDS, w/o surgery	0 - Complete Episode - Full Year	$6,007.00	$5,062.00	$997,184.00	$997,184.00	197	166	2	3
130200 - HIV sero-positive w/o AIDS, w/o surgery	7 - Unknown Start/Unknown Finish Incomplete Annual	$2,842.00	$2,434.00	$491,613.00	$491,613.00	202	173	1	2
130400 - Septicemia, with complication, with surgery	0 - Complete Episode - Full Year	$4,064.00	$4,064.00	$8,128.00	$8,128.00	2	2	0	0
130400 - Septicemia, with complication, with surgery	1 - Clean Start/Unknown Finish - Full Year	$491.00	$491.00	$982.00	$981.00	2	2	0	0

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Alabama Medicaid Agency

ETG Distribution Analysis - FFS
By Episode Type
For Dates of Service: 10/01/2011 - 09/30/2013

User ID: [redacted]
Run Date: 5/14/2014
Run Time: 4:30:02 PM

ETG Number & Description	Amount Per Recipient	Amt Allowed Per Episode	Total Allowed Amount	Total Detail Paid Amount	Total Episodes	Total Recipients	Exceptions based on cost per Episode	Exceptions based on cost per Recipient
163400 - Non-malignant neoplasm of pituitary gland, w/o complication, with surgery	$4,591.00	$4,591.00	$27,546.00	$27,547.00	6	6	0	0
163400 - Non-malignant neoplasm of pituitary gland, w/o complication, w/o surgery	$1,646.00	$1,204.00	$390,208.00	$390,208.00	324	237	2	3
163500 - Hyper-functioning adrenal gland, with surgery	$2,720.00	$2,720.00	$2,720.00	$2,720.00	1	1	0	0
163500 - Hyper-functioning adrenal gland, w/o surgery	$647.00	$444.00	$97,634.00	$97,634.00	220	151	1	1
163600 - Hypo-functioning adrenal gland, w/o surgery	$438.00	$318.00	$100,661.00	$100,661.00	317	230	7	7
163700 - Malignant neoplasm of adrenal gland, with surgery, with active mgmt	$29,468.00	$29,468.00	$117,872.00	$117,873.00	4	4	0	0
163700 - Malignant neoplasm of adrenal gland, with surgery, w/o active mgmt	$2,951.00	$2,951.00	$2,951.00	$2,951.00	1	1	0	0
163700 - Malignant neoplasm of adrenal gland, w/o surgery, with active mgmt	$15,025.00	$11,071.00	$210,351.00	$210,350.00	19	14	1	1
163700 - Malignant neoplasm of adrenal gland, w/o surgery, w/o active mgmt	$752.00	$550.00	$36,856.00	$36,856.00	67	49	2	2

3.5.95.1 ETG Distribution Analysis Episode Type - FFS Field Descriptions

Field	Description	Length	Data Type
(A) ETG Number & Description	Episode Treatment Group (ETG) and description.	234	Character
(A,C) Episode Type & Description	Episode Type and the associated description.	229	Character
(A-B) Amount Per Episode	Total Amount allowed divided by total number of episodes. Calculation: Total Allowed Amount divided by Total Episodes.	13	Number (Decimal)
(A-C) Amount Per Recipient	Total Amount allowed divided by total number of recipients. Calculation: Total Allowed Amount divided by Total Recipients.	13	Number (Decimal)
(A-C) Exceptions based on Cost per Episode	Number of episodes whose cost falls two or more standard deviations away from the norm.	9	Number (Integer)
(A-C) Exceptions based on Cost per Recipient	Number of recipients whose cost falls two or more standard deviations away from the norm.	9	Number (Integer)

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Field	Description	Length	Data Type
(A-C) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-C) Total Allowed Amount	This is total allowed amount for an episode type.	11	Number (Decimal)
(A-C) Total Detail Paid Amount	This is the sum of the ancillary inpatient paid, ancillary outpatient paid, facility paid, Medical Services paid, Medicare paid, RX paid, and surgery paid.	11	Number (Decimal)
(A-C) Total Episodes	Total episodes for the ETG.	9	Number (Integer)
(A-C) Total Recipients	Total recipients for the ETG.	9	Number (Integer)
(B) Major Practice Category & Description	Major Practice Category and description.	50	Character
(C) Amt Allowed Per Episode	Total amount paid per ETG episode.	13	Number (Decimal)

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3.5.96 ETG Episode Cross Reference - FFS

The ETG Episode Cross Reference report provides cross reference episode information to determine if one type of disease condition is related to other episode types (for example, do asthmatics have prevalence for diabetes?) Combining episodes provides a comprehensive image of the health of recipients.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories.

ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. This date range is displayed in the header of the report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains two tabs:

A. ETG Overview - Contains an overview of the top ETGs by recipient count and the top ETGs by episode count; and

B. ETG Episodes - Contains all ETGs with the counts and amounts for each.

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A

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 3/3/16
Run Time: 11:08:02 AM

ETG Episode Cross Reference - FFS

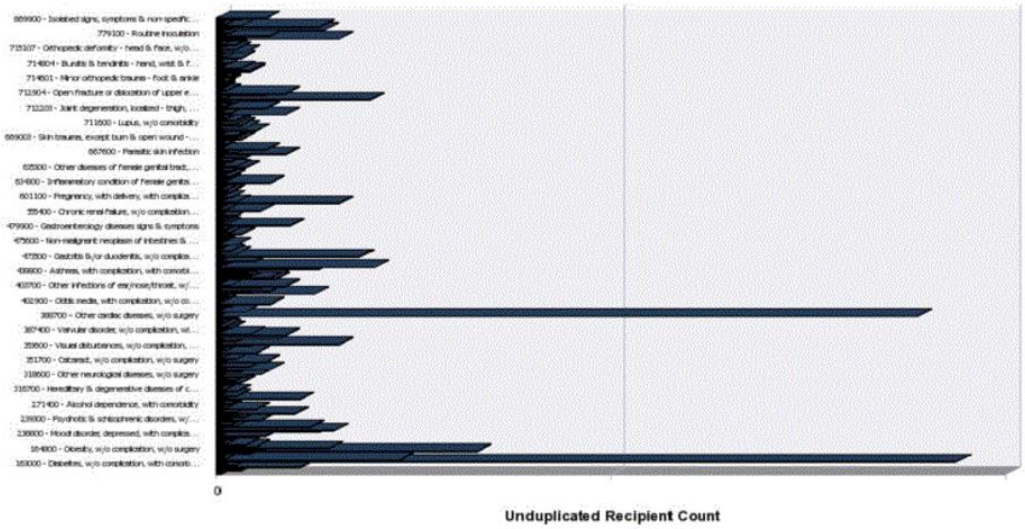
Overview

For Dates of Service: 07/01/2014 - 06/30/2016

ETG Number Entered: 163000

ETG Number Highest: 869900 - Isolated signs, symptoms & non-specific diagnoses or conditions

Top Episodes by Recipient Count



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B

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 3/3/16
Run Time: 11:08:02 AM

ETG Episode Cross Reference - FFS
All Episodes
For Dates of Service: 07/01/2014 - 06/30/2016
ETG Number entered: 163000
ETG Number Highest: 869900 - Isolated signs, symptoms & non-specific diagnoses or conditions

Episode Type & Description: 0 - Complete Episode.

Episode Count	Recipient Count	Percent of Recipients	Total Amount Paid
1,527	1,191	1063.39 %	$992,156.00
Totals: 1,527	1,191		$992,156.00

Episode Type & Description: 1 - A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range.

Episode Count	Recipient Count	Percent of Recipients	Total Amount Paid
7	7	6.25 %	$13,517.00
Totals: 7	7		$13,517.00

Episode Type & Description: 4 - An episode < 1 year with a clean start.

Episode Count	Recipient Count	Percent of Recipients	Total Amount Paid
77	77	68.75 %	$64,721.00
Totals: 77	77		$64,721.00

3.5.96.1 ETG Episode Cross Reference - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Top Episodes by Episode Count: ETG and Episode Description (Y-axis)	The ETG and Episode Description.	56	Character
(A) Top Episodes by Episode Count: Episode Count (X-axis)	Total episode count for the Episode (highest to lowest).	7	Number (Integer)
(A) Top Episodes by Recipient Count: ETG and Episode Description (Y-axis)	The ETG and Episode Description	56	Character
(A) Top Episodes by Recipient Count: Recipient Count (X-axis)	Total recipient count for the Episode (highest to lowest).	8	Number (Integer)

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Field	Description	Length	Data Type
(A,B) ETG Number entered (prompt)	The selected Episode Treatment Group (ETG) number.	6	Character
(A,B) ETG Number Highest & Description	The highest value of an Episode Treatment Group (ETG) number present in the Episode, and its description.	234	Character
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(B) Percent of Recipients	Percentage of recipients who had an episode in this ETG. Calculation: The unduplicated Recipient Count divided by the total number of recipients.	8	Number (Decimal)
(B) Recipient Count	Total recipient count for the ETG. Calculation The unduplicated Recipient Count.	8	Number (Integer)
(B) Total Amount Paid	Total amount paid for ETG.	11	Number (Decimal)
(B) Episode Type & Description	Indicates the Episode type. Values Are: 0 = Clean Start/Clean End Complete Episode. 1 = Clean Start/Unknown End A full year episode which has at least one anchor record within the episode's clean period from the end of the claims data range. 2 = Unknown Start/Clean End A full year episode which has at least one anchor record within the episode's clean period from the beginning of the claims data range. 3 = Unknown Start/Unknown End A full year episode which has both an anchor record within the episode clean period from the beginning of the database, and another anchor record within the clean period from the end of the of the claims data range. 4 = Clean Start/Unknown End An episode < 1 year with a clean start. 5 = Unknown Start/Clean End An episode < 1 year with a clean finish. 6 = Unknown Start/Unknown End An episode < 1 year with neither a clean start nor a clean finish. 7 = Incomplete annual episode, only applies to chronic episodes 8 - A record which was not grouped to an episode. This includes records with “Ongoing Rx Therapy” and Ungroupable ETG. This value may also occur for some pregnancy records.	229	Character

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Field	Description	Length	Data Type
	9 = Orphan ancillary service, not grouped to an episode.		
(B) Episode Count	Unduplicated count of episodes.	8	Number (Integer)

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3.5.97 ETG Recipient Comparison - FFS

The ETG Recipient Comparison report flags recipients with total cost per episode or per recipient that is two or more standard deviations from the norm for a given episode type. The report provides a comparison of recipient's ETG information by episode type, for a selected ETG.

Episode Treatment Groups (ETGs) are basic illness classifications similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories.

ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The ETG Recipient Comparison report flags recipients with total cost per episode of two or more standard deviations from the norm. The report allows comparing recipients ETG information by episode type for a selected ETG.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

Alabama Medicaid Agency

ETG Recipient Comparison - FFS

User ID:
Run Date: 2/11/2014
Run Time: 10:03:15 AM

For Dates of Service: 07/01/2011 - 06/30/2013

ETG Number: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Episode Type & Description: 0 - Complete Episode.

Recipient ID	Recipient Full Name	Paid Amount Per Episode	Global Paid Amount Per Episode	Difference in Episode Cost 2 std dev = $0	Episode Count	Paid Amount Per Recipient	Global Paid Amount Per Recipient	Difference in Recipient Cost 2 std dev = $0
[illegible]	[illegible]	$242.50	$2,296.00	$0.00	2	$485.00	$3,121.00	$0.00
[illegible]	[illegible]	$446.50	$2,296.00	$0.00	2	$893.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,268.00	$2,296.00	$0.00	1	$1,268.00	$3,121.00	$0.00
[illegible]	[illegible]	$301.50	$2,296.00	$0.00	2	$603.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,202.00	$2,296.00	$0.00	2	$2,404.00	$3,121.00	$0.00
[illegible]	[illegible]	$101.00	$2,296.00	$0.00	1	$101.00	$3,121.00	$0.00
[illegible]	[illegible]	$2,407.00	$2,296.00	$0.00	1	$2,407.00	$3,121.00	$0.00
[illegible]	[illegible]	$293.00	$2,296.00	$0.00	1	$293.00	$3,121.00	$0.00
[illegible]	[illegible]	$280.00	$2,296.00	$0.00	2	$560.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,331.00	$2,296.00	$0.00	2	$2,662.00	$3,121.00	$0.00
[illegible]	[illegible]	$40.00	$2,296.00	$0.00	1	$40.00	$3,121.00	$0.00
[illegible]	[illegible] A	$1,724.50	$2,296.00	$0.00	2	$3,449.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,163.00	$2,296.00	$0.00	2	$2,326.00	$3,121.00	$0.00
[illegible]	[illegible] M	$793.00	$2,296.00	$0.00	2	$1,586.00	$3,121.00	$0.00
[illegible]	[illegible]	$158.50	$2,296.00	$0.00	2	$317.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,186.50	$2,296.00	$0.00	2	$2,373.00	$3,121.00	$0.00
[illegible]	[illegible]	$556.50	$2,296.00	$0.00	2	$1,113.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,200.00	$2,296.00	$0.00	1	$1,200.00	$3,121.00	$0.00
[illegible]	[illegible] F	$2,155.00	$2,296.00	$0.00	1	$2,155.00	$3,121.00	$0.00
[illegible]	[illegible]	$1,253.00	$2,296.00	$0.00	2	$2,506.00	$3,121.00	$0.00

PHI has been covered

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3.5.97.1 ETG Recipient Comparison - FFS Field Descriptions

Field	Description	Length	Data Type
Difference in Episode Cost: 2 std dev = $0	Difference Episode Cost value which is two standard deviations (2 std dev) from the 'norm'. Provider Amount per Episode minus Global Amt per Episode. Calculation: The amount allowed for a given provider per Episode minus the global amount allowed per provider and Episode.	11	Number (Decimal)
Difference Recipient Cost: 2 std dev = $0	Difference Recipient Cost value which is two standard deviations from the 'norm'. Provider Amount per Recipient minus Global Amount per Recipient. Calculation: The amount allowed for a given recipient per Episode minus the global amount allowed per recipient and Episode. 2 Std Dev (Difference Recipient Cost)	11	Number (Decimal)
Episode Count	Unduplicated count of episodes.	8	Number (Integer)
Episode Type & Description	Episode Type and description.	229	Character
ETG Number (prompt) & Description	The selected Episode Treatment Group (ETG) code and its description.	234	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Global Paid Amount per Episode	Total amount for all providers divided by the number of episodes.	11	Number (Decimal)
Global Paid Amount per Recipient	The grand total of all paid amount per recipient.	13	Number (Decimal)
Paid Amount Per Episode	The total paid amount divided by the episode count.	13	Number (Decimal)
Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)
Recipient ID	The recipient's identification number.	12	Character
Recipient Full Name	The recipient's full name.	43	Character
Subclass	This field further describes the ETG number.	3	Character
Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character

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Field	Description	Length	Data Type
Totals	The sum of episode amounts.	13	Number (Decimal)

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3.5.98

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ETG Recipient Details - FFS

The ETG Recipient Details report shows selected recipient's detail claims information. Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The details are grouped into episode types, which provide a method of viewing specific billing patterns and practices of providers that help to determine what steps may be required to improve the health of recipients or reduce the cost of the services.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting.

The report contains eight tabs:

A. Recipient Overview;

B. Details by ETG;

C. Details by Servicing Provider;

D. Provider Totals;

E. ETG Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.

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A

Alabama Medicaid Agency

ETG Recipient Details - FFS

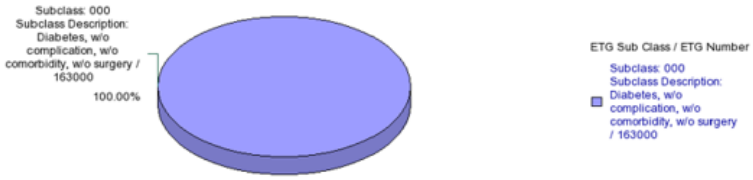
Recipient Overview

For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: 123456789012

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

Recipient Name: [redacted]
Date of Birth: [redacted]
Recipient Current Age: [redacted]
Gender: [redacted]



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B

Alabama Medicaid Agency

ETG Recipient Details - FFS

Details By ETG

For Dates of Service: 01/01/2015 - 12/31/2016

Recipient ID: 123456789012

User ID: [redacted]
Run Date: 9/8/16
Run Time: 3:28:44 PM

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient Full Name	Recipient Age	Recipient County Description	Claim Indicator	Procedure Code Description	Provider ID - Billing	Provider ID - Referring/ Attending/Prescribing	ICD	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
[redacted]	M - PROFESSIONAL CLAIMS	7 - Incomplete annual episode, only applies to chronic episodes	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	16	08 - Calhoun	E	51 - SOBRA Child(KM)-No$ (<100% FPL)-full Caid coverage	[redacted]	NPI ID: Medicaid ID: Base ID:	0	E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA	Y	Y	-		

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	4/6/2016	4/6/2016	########### -	99214 - Office/Outpatient Visit Est	$130.00	$0.00	$50.00	[redacted]	#### - Unknown or Not Applicable	N

PHI has been removed

End of Report

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C

Alabama Medicaid Agency

ETG Recipient Details - FFS
Details By Servicing Provider
For Dates of Service: 01/01/2015 - 12/31/2016
Recipient ID: 123456789012

User ID:
Run Date: 9/8/16
Run Time: 3:28:44 I

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Servicing Provider ID: NPI ID:
Medicaid ID:
Base ID:

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient Full Name	Recipient Age	Recipient County Description	Claim Indicator	Procedure Code Description	Provider ID - Billing	Provider ID - Referring/ Attending/ Prescribing	ICD	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
123456890123	M - PROFESSIONAL CLAIMS	7 - Incomplete annual episode, only applies to chronic episodes.	XXXXXXXX XXXXXXXX XXXX, XXXXXXXX XXXXXXX, X	18	09 - Calhoun	E	31 - SOBRA Child KM)-No$ (<100% FPL)-full Caid coverage	NPI ID: Medicaid ID: 1 Base ID: 100	NPI ID: Medicaid ID: Base ID:	9	E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA	Y	Y	-		

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	4/6/2016	4/6/2016	********** ** -	99214 - Office/ Outpatient Visit Est	$130.00	$0.00	$50.00	NPI ID: Medicaid ID: 1 Base ID:	**** - Unknown or Not Applicable	N

PHI has been removed

End of Report

D

Alabama Medicaid Agency

ETG Recipient Details - FFS
Provider Totals
For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

User ID:
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Provider ID	Paid Amount
NPI ID: Medicaid ID: Base ID:	$100.00
Totals: 1	$100.00

End of Report

PHI has been removed

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E

Alabama Medicaid Agency

ETG Recipient Details - FFS

ETG Totals

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Number & Description	Paid Amount
163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery	$100.00
Totals:	$100.00

End of Report

PHI has been removed

F

Alabama Medicaid Agency

ETG Recipient Details - FFS

Procedure Totals

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Number & Description: **163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery**

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Procedure Code & Description	Provider Name	Recipient ID	Recipient Full Name	Paid Amount
99214 - Office/Outpatient Visit Est	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	123456789012	XXXXXXXXXXXXX XXXXXXX, XXXXXXXXXXXXX XX, X	$100.00
Totals:	1			$100.00

End of Report

PHI has been removed

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G

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Recipient Details - FFS
Diagnosis Totals

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery
Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

ICD	Primary Diagnosis Code & Description	Provider Name	Recipient ID	Recipient Full Name	Paid Amount
0	E1165 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	123456789012	XXXXXXXXXXXXX XXXXXXX, XXXXXXXXXXXXX XX, X	$100.00
	Totals:	1			$100.00

H

Alabama Medicaid Agency

User ID: [redacted]
Run Date: 7/27/16
Run Time: 2:08:55 PM

ETG Recipient Details - FFS
NDC Totals

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: 123456789012

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

NDC & Description	Provider Name	Recipient ID	Recipient Full Name	Paid Amount
########### -	NPI ID: [redacted] Medicaid ID: [redacted] Base ID: [redacted]	123456789012	XXXXXXXXXXXXXX XXXXX, XXXXXXXXXXXXXX, X	$100.00
Totals:	1			$100.00

3.5.98.1 ETG Recipient Details - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Date of Birth	Date of birth for recipient.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A) Gender	The sex of the recipient.	1	Character
(A) Recipient Current Age	The recipient's current age.	3	Number (Integer)
(A) Recipient Name	Recipient Name.	12	Character
(A,D,F,G-H) Subclass	This field further describes the ETG number.	3	Character
(A,D,F,G-H) Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character
(A-H) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-H) Recipient ID	The recipient's Medicaid ID.	12	Character
(B) Recipient Full Name	Recipient's full name.	12	Character
(B-C) Allowed Amount	The allowed amount for the detail.	11	Number (Decimal)
(B-C) Billed Amount	The billed amount for the detail.	11	Number (Decimal)
(B-C) Claim Detail Status	The claim's status code.	1	Character
(B-C) Claim ICN	The claim's identification number.	13	Character
(B-C) Claim Type & Description	Shows what type of claim was submitted and the description.	63	Character
(B-C) Date First Service	The claim's first date of service.	10	Date (MM/DD/CCYY)
(B-C) Date Last Service	The claim's last date of service.	10	Date (MM/DD/CCYY)
(B-C) Detail Number	Detail number on the claim.	3	Number (Integer)
(B-C) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	30	Character
(B-C) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)
(B-C) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	5	Number (Decimal)

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Field	Description	Length	Data Type
(B-C) Episode Type & Description	Episode Type and the associated description.	229	Character
(B-C) Provider ID - Referring/Attending/Prescribing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(B-C) Provider ID – Billing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(B-C) Provider ID – Referring/Attending/Prescribing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(B-C) Provider ID – Rendering	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(B-C) Recipient Age	The recipient's age.	3	Number (Integer)
(B-C) Revenue Code & Description	The revenue code on a detail and the associated description.	63	Character
(B-C) Wrap Ind	Wrap Payment Indicator	1	Character
(B-C,F) Procedure Code & Description	The procedure code for the detail and the associated description.	49	Character
(B-C,H) NDC Code & Description	National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description.	49	Character
(B-H) ETG Number & Description	The ETG Number and its description.	234	Character
(B-H) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	11	Number (Decimal)
(D,F,G,H) Provider Name	Name of the provider	25	Character
(B,C,G) ICD	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(B,C,G) Primary Diagnosis Code & Description	Primary diagnosis code and its description.	47	Character

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3.5.99

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ETG Recipient Summary - FFS

The ETG Recipient Summary report rapidly displays all of the selected recipients' episodes in graphical and numeric format to assist in the identification of anomalies in service or practice. Episode Treatment Groups (ETGS) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). Based on a series of clinical and statistical algorithms, ETGs provide a medically meaningful statistical unit representing a complete episode of care. ETGs combine all routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The Episode Treatment Grouper (or ETG Profiler) allows for reporting on ETGs. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-D in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

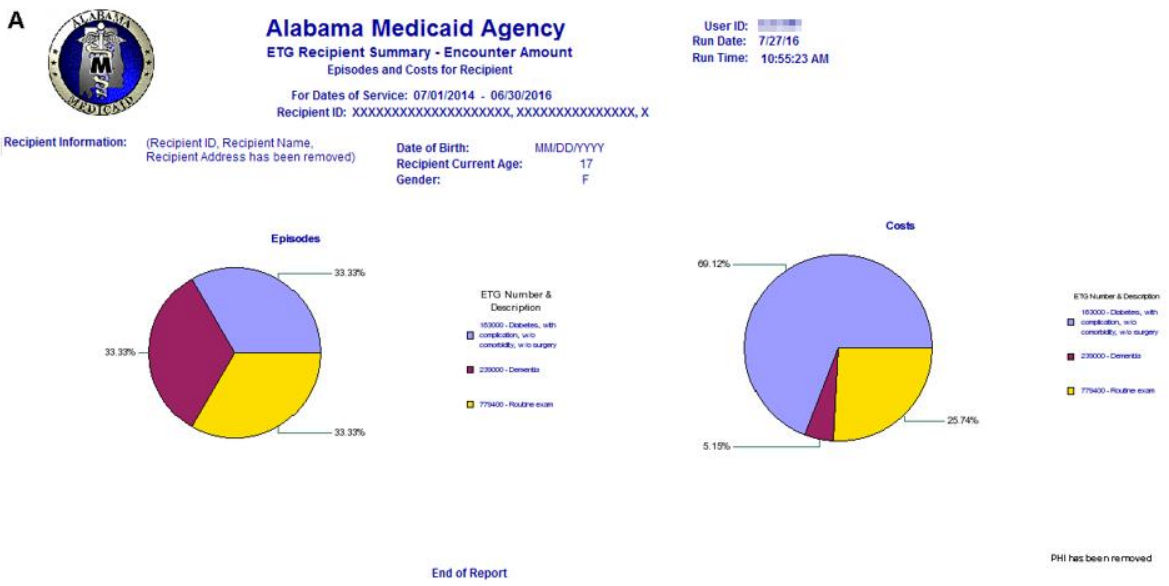
The four tabs in this report are:

A. Episodes and Costs for Recipient;

B. Recipient Summary Global Comparison;

C. Summary by ETG; and

D. Summary ETG Details by Major Practicing Category (MPC).



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B

Alabama Medicaid Agency

ETG Recipient Summary- Encounter Amount

Recipient Summary Global Comparison

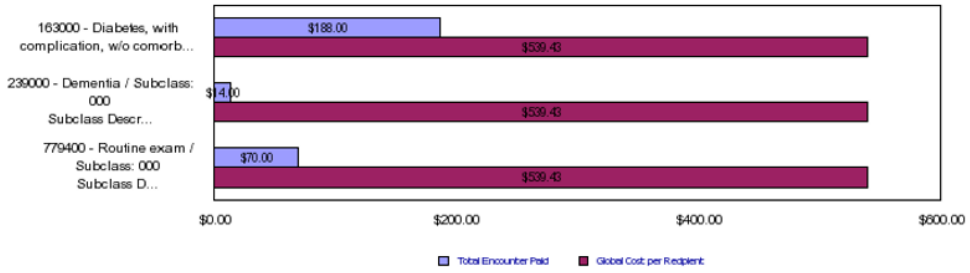
For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID: [redacted]
Run Date: 7/27/16
Run Time: 10:55:23 AM

Recipient Information

(Recipient ID, Recipient Name,
Recipient Address has been removed)



End of Report

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C

Alabama Medicaid Agency

ETG Recipient Summary - Encounter Amount

Summary By ETG

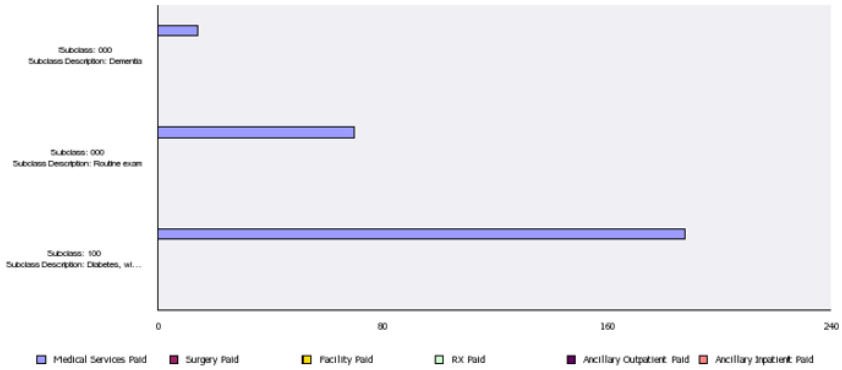
For Dates of Service: 07/01/2014 - 06/30/2016

Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID: [redacted]
Run Date: 7/27/16
Run Time: 10:55:23 AM

Recipient Information

(Recipient ID, Recipient Name, Recipient Address has been rer



Average Episode Cost:	$90.67
Average Amount per Recipient:	$90.67
Total Episodes:	3
Total Recipients:	3
Total Dollars:	$272.00

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D

Alabama Medicaid Agency

ETG Recipient Summary - Encounter Amount

Summary ETG Details by Major Practicing Category (MPC)

For Dates of Service: 07/01/2014 - 06/30/2016
Recipient ID: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X

User ID: [redacted]
Run Date: 7/27/16
Run Time: 10:55:23 AM

Recipient Information
(Recipient ID, Recipient Name, Recipient Address has been removed)

MPC & Description: 02 - ENDOCRINOLOGY

ETG Number & Description	Episode Count	Total Amount Billed	Total Encounter Amount	Global Paid Amount Per Recipient	Dollar Difference	Percent Difference	Ancillary Outpatient Paid	Facility Paid	Medical Services Paid	RX Paid	Surgery Paid	Ancillary Inpatient Paid
163000 - Diabetes, with complication, w/o comorbidity, w/o surgery	1	$525.00	$188.00	$539.43	$(351.43)	(65.15) %	$0.00	$0.00	$188.00	$0.00	$0.00	$0.00

PHI has been removed

3.5.99.1 ETG Recipient Summary - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Costs	Total amount paid for the provider.	13	Number (Decimal)
(A) Date of Birth	The recipient's birth date.	10	Date (MM/DD/CCYY)
(A) Episodes	The count of episodes for the provider.	8	Number (Integer)
(A) Gender	The sex of the recipient.	1	Character
(A) Recipient Current Age	The age of the recipient.	3	Number (Integer)
(A,B,D) Recipient Address (City, State, Zip)	The recipient's city, state, and zip code.	25	Character
(A,B,D) Recipient Address (Street)	The recipient's street address.	30	Character
(A,B,D) Recipient Name	The recipient's name.	43	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Recipient ID	Recipient Medicaid Number.	12	Character
(B) Global Cost Per Recipient	Total amount paid / unduplicated recipient count	7	Number (Decimal)
(B) Total Amount Paid	The total amount paid for the ETG.	11	Number (Decimal)
(C) Percentage	Percentage of paid amount identified in the previous report column.	8	Number (Decimal)

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Field	Description	Length	Data Type
(C) Average Amount per Recipient	Total amount paid / unduplicated recipient count.	11	Number (Decimal)
(C) Average Episode Cost	Total amount paid / episode count.	11	Number (Decimal)
(C) ETG Number	The ETG number/ID.	6	Number (Integer)
(C) Total Dollars	The summed total of all paid amounts.	13	Number (Decimal)
(C) Total Episodes	The episode count for the ETG.	6	Number (Integer)
(C) Total Recipients	The unduplicated recipient count.	6	Number (Integer)
(C,D) Ancillary Inpatient Paid	Ancillary Inpatient paid amount.	11	Number (Decimal)
(C,D) Ancillary Outpatient Paid	Ancillary Outpatient paid amount.	7	Number (Decimal)
(C,D) Facility Paid	Facility paid amount.	11	Number (Decimal)
(C,D) Medical Services Paid	Medical paid amount.	11	Number (Decimal)
(C,D) RX Paid	Prescription paid amount.	11	Number (Decimal)
(C,D) Surgery Paid	Surgery paid amount.	11	Number (Decimal)
(D) Dollar Difference	The difference between the paid and allowed amount.	7	Number (Decimal)
(D) Episode Count	Unduplicated count of episodes.	8	Number (Integer)
(D) ETG Number & Description	The ETG number and its description.	234	Character
(D) Global Paid Amount Per Recipient	Amount paid per recipient.	11	Number (Decimal)
(D) MPC & Description	The ETG defined category grouping and description.	50	Character
(D) Percent Difference	The difference between the paid and allowed amount expressed as a percent.	3	Number (Decimal)
(D) Total Amount Billed	The total amount billed for the ETG.	11	Number (Decimal)
(D) Total Amount Paid	The total amount paid for the ETG.	11	Number (Decimal)

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3.5.100 ETG Provider Comparison - FFS

The ETG Provider Comparison report flags providers with total cost per episode or per recipient that is two or more standard deviations from the norm for a given episode type. The report provides a comparison of provider's ETG information by episode type for a selected ETG.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms. The reports combine routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

Alabama Medicaid Agency

ETG Provider Comparison - FFS

For Dates of Service: 07/01/2011 - 06/30/2013

ETG Number: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

User ID: [redacted]
Run Date: 2/11/2014
Run Time: 11:15:09 AM

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Episode Type & Description: 0 - Complete Episode.

Provider ID	Provider Full Name	Paid Amount Per Episode	Global Allowed Amount Per Episode	Difference in Episode Cost: 2 std dev = $3,168	Episode Count	Paid Amount Per Recipient	Global Allowed Amount Per Recipient	Difference Recipient Cost: 2 std dev = $3,941	Recipient Count
NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted]	DAVID L SMITH	$10,552.00	$22,853.00	$(12,301.00)	1	$10,552.00	$26,175.00	$(15,623.00)	1
NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted]	BRENDELLA T MONTGOMERY	$10,123.00	$22,853.00	$(12,730.00)	1	$10,123.00	$26,175.00	$(16,052.00)	1
NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted]	BILLY J GOLDEN	$9,262.00	$22,853.00	$(13,591.00)	2	$18,524.00	$26,175.00	$(7,651.00)	1
NPI ID: [redacted] Medicaid [redacted]0 Base ID: [redacted]	CHERRIE L WAGNON	$8,349.00	$22,853.00	$(14,504.00)	1	$8,349.00	$26,175.00	$(17,826.00)	1
NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted]	JAMES O DEVANEY III	$7,682.00	$22,853.00	$(15,171.00)	1	$7,682.00	$26,175.00	$(18,493.00)	1
NPI ID: [redacted] Medicaid [redacted] Base ID: [redacted]	ANDREW M ALLEN	$7,682.00	$22,853.00	$(15,171.00)	1	$7,682.00	$26,175.00	$(18,493.00)	1
NPI ID: [redacted] Medicaid [redacted]0 Base ID: [redacted]	JOYCELYN A ATCHISON	$7,504.00	$22,853.00	$(15,349.00)	1	$7,504.00	$26,175.00	$(18,671.00)	1
NPI ID: [redacted] Medicaid [redacted]5 Base ID: [redacted]	RONNIE T CHU	$7,427.00	$22,853.00	$(15,426.00)	1	$7,427.00	$26,175.00	$(18,748.00)	1

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3.5.100.1 ETG Provider Comparison - FFS Field Descriptions

Field	Description	Length	Data Type
Difference in Episode Cost: 2 std dev = $0	Difference Episode Cost value which is two standard deviations (2 std dev) from the 'norm'. Provider Amount per Episode minus Global Amt per Episode. Calculation: The amount allowed for a given provider per Episode minus the global amount allowed per provider and Episode.	11	Number (Decimal)
Difference Recipient Cost: 2 std dev = $0	Difference Recipient Cost value which is two standard deviations from the 'norm'. Provider Amount per Recipient minus Global Amount per Recipient. Calculation: The amount allowed for a given recipient per Episode minus the global amount allowed per recipient and Episode. 2 Std Dev (Difference Recipient Cost)	11	Number (Decimal)
Episode Count	Unduplicated count of episodes.	8	Number (Integer)
Episode Type and Description	Episode Type and description.	229	Character
ETG Number (prompt) & Description	The selected ETG Number and its description.	234	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Global Allowed Amount per Episode	Paid amount per episode.	11	Number (Decimal)
Global Allowed Amount per Recipient	The allowed amount per recipient.	11	Number (Decimal)
Paid Amount Per Episode	The total paid amount divided by the episode count.	13	Number (Decimal)
Paid Amount Per Recipient	Actual amount the provider was paid per recipient.	13	Number (Decimal)

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Field	Description	Length	Data Type
Provider Full Name	The provider's full name.	50	Character
Provider ID	The provider's identification number.	9	Character
Recipient Count	The number of eligible recipients the provider served for this particular claim grouping.	6	Number (Integer)
Subclass	This field further describes the ETG number.	3	Character
Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character
Totals	The sum of episode amounts.	13	Number (Decimal)

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3.5.101 ETG Provider Details - FFS

The ETG Provider Details report shows detailed information for a selected provider. The details are grouped into episode type, which provides a convenient method of viewing specific billing patterns and practices of the provider. This information helps to determine what steps may be required to improve the health of recipients or reduce the cost of the services. Episode Treatment Groups (ETGs) are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). ETGs provide a medically meaningful statistical unit representing a complete episode of care based on a series of clinical and statistical algorithms.

The report combines routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The DSS Episode Treatment Grouper (or ETG Profiler) allows ETG reporting. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

The report contains eight tabs:

A. Provider Overview;

B. Details by ETG;

C. Details by Recipient;

D. Recipient Totals;

E. ETG Totals;

F. Procedure Totals;

G. Diagnosis Totals; and

H. NDC Totals.

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Alabama Medicaid Agency

ETG Provider Details - FFS

Provider Overview

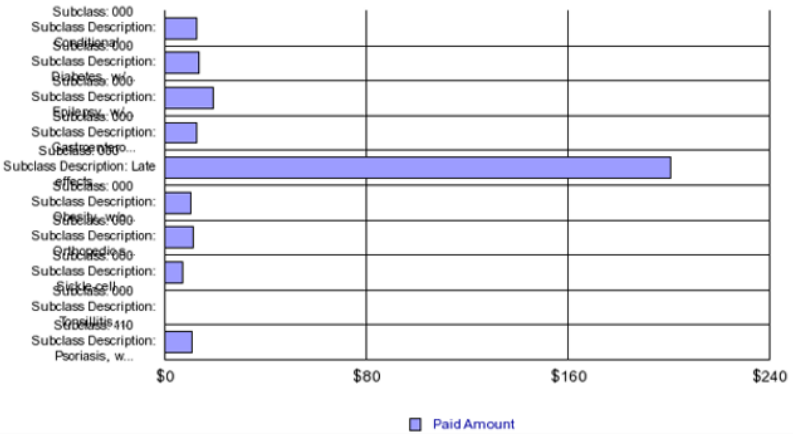
For Dates of Service: 07/01/2014 - 06/30/2016

User ID: [redacted]
Run Date: 7/21/16
Run Time: 2:15:35 PM

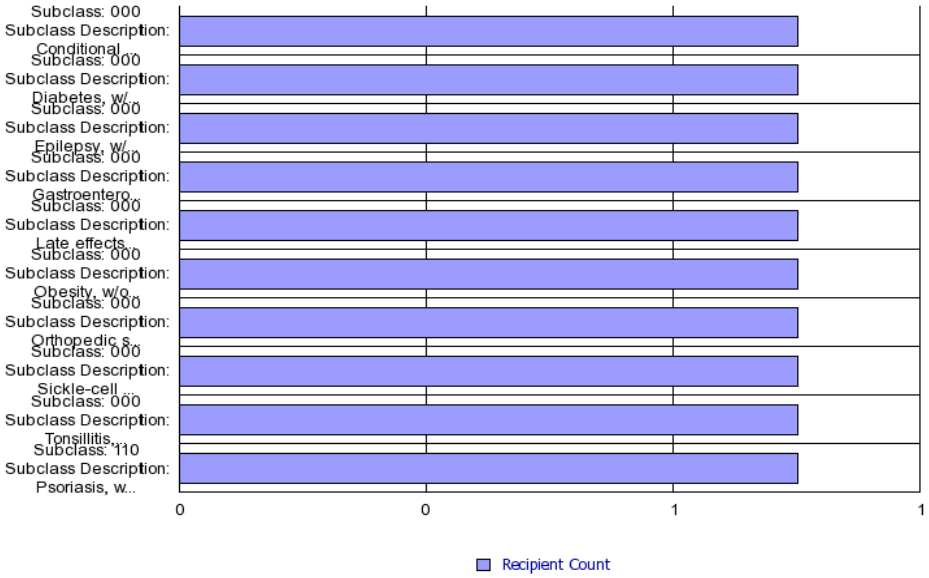
Provider Information:
NPI ID: [redacted]
Medicaid ID: [redacted]
Base ID: [redacted]
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

Top 10 ETGs based on Paid Amount



Top 10 ETGs based on Recipient Count



End of Report

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B

Alabama Medicaid Agency

ETG Provider Details - FFS

Details By ETG

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 63000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient ID	Recipient Full Name	Recip Age	Recipient County Description	Claim Indicator	Program Code Description	Provider ID - Billing	Provider ID - Referring/ Attending/ Prescribing	ICD	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
	Claim Type Code & Description	0 - Complete Episode.	123456789012	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	14	08 - Calhoun	F	41 - Disabled-SSI-full Medicaid coverage	NPI ID: Medicaid ID: Base ID:	NPI ID: Medicaid ID: Base ID:	9	25000 - DIABETES UNCOMPL ADULT-TYPE II	N	N	#### -	0	0

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	8/26/2015	8/26/2015	########### -	80053 - Comprehen Metabolic Panel	$583.30	$13.31	$13.31	NPI ID: Medicaid ID: Base ID:	0301 - Lab/ Chemistry	N

PHI has been removed

C

Alabama Medicaid Agency

ETG Provider Details - FFS

Details By Recipient

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

For Dates of Service: 07/01/2014 - 06/30/2016
Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

Recipient ID: 123456789012

Claim ICN	Claim Type Code & Description	Episode Type & Description	Recipient Full Name	Recip Age	Recipient County Description	Claim Indicator	Program Code Description	Provider ID - Billing	Provider ID - Referring/Attending/ Prescribing	ICD	Primary Diagnosis Code & Description	Buyin Medicare A	Buyin Medicare B	DRG Code & Description	DRG Relative Weight	DRG Service Adjuster
	M - PROFESSIONAL CLAIMS	0 - Complete Episode.	XXXXXXXXX XXXXXXXXX XX, XXXXXXXXX XXXXXX, X	8	63 - Tuscaloosa	F	41 - Disabled-SSI-full Medicaid coverage	NPI ID: Medicaid ID: Base ID:	NPI ID: Medicaid ID: Base ID:	9	V421 - HEART REPLACED BY TRANSPLANT	N	N	-		

Detail Number	Claim Detail Status	Date First Service	Date Last Service	NDC & Description	Procedure Code & Description	Billed Amount	Allowed Amount	Paid Amount	Provider ID - Rendering	Revenue Code & Description	Wrap Ind
1	P	8/31/2015	8/31/2015	########### -	93010 - Electrocardiogram Report	$24.00	$12.69	$12.69	NPI ID: Medicaid ID: Base ID:	#### - Unknown or Not Applicable	N

PHI has been removed

End of Report

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D

Alabama Medicaid Agency

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

ETG Provider Details - FFS

Recipient Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

Recipient ID	Recipient Full Name	ETG Number & Description	Paid Amount
123456789012	XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X	163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery	$13.31
Recipient ID	Recipient Full Name	ETG Number & Description	Paid Amount
123456789012	XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X	164800 - Obesity, w/o complication, w/o surgery	$10.11
Recipient ID	Recipient Full Name	ETG Number & Description	Paid Amount
123456789012	XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXX, X	207400 - Sickle-cell anemia, w/o surgery	$7.05

E

Alabama Medicaid Agency

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

ETG Provider Details - FFS

ETG Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description	Paid Amount
163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery	$13.31
164800 - Obesity, w/o complication, w/o surgery	$10.11
207400 - Sickle-cell anemia, w/o surgery	$7.05
315200 - Epilepsy, w/o complication, w/o comorbidity, w/o surgery	$19.10
403100 - Tonsillitis, adenoiditis or pharyngitis, w/o complication, w/o comorbidity, w/o surgery	$0.00

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F

Alabama Medicaid Agency

ETG Provider Details - FFS

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

Procedure Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

Procedure Code & Description	Recipient ID	Recipient Full Name	Claim ICN	Paid Amount
80053 - Comprehen Metabolic Panel	123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X	2015299045713	$13.31
Totals:	1		1	$13.31

PHI has been removed

G

Alabama Medicaid Agency

ETG Provider Details - FFS

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

Diagnosis Totals

For Dates of Service: 07/01/2014 - 06/30/2016

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

ICD	Primary Diagnosis Code & Description	Recipient ID	Recipient Full Name	Claim ICN	Paid Amount
9	25000 - DIABETES UNCOMPL ADULT-TYPE II	123456789012	XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX, X	2015299045713	$13.31
	Totals:	1		1	$13.31

PHI has been removed

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H

Alabama Medicaid Agency

ETG Provider Details - FFS

NDC Totals

For Dates of Service: 07/01/2014 - 06/30/2016

User ID:
Run Date: 7/21/16
Run Time: 2:15:35 PM

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: THE CHILDRENS HOSPITAL OF ALABAMA
Type: 01 - Hospital
Specialty: 010 - Acute Care
Address: 1600 7TH AVE S

BIRMINGHAM, AL 35233

ETG Number & Description: 163000 - Diabetes, w/o complication, w/o comorbidity, w/o surgery

Subclass: 000
Subclass Description: Diabetes, w/o complication, w/o comorbidity, w/o surgery

NDC & Description	Recipient ID	Recipient Full Name	Claim ICN	Paid Amount
########## -	123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX, X	2015299045713	$13.31
Totals:	1		1	$13.31

End of Report

PHI has been removed

3.5.101.1 ETG Provider Details - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Top 10 ETGs based on Paid Amount - ETG Description (X axis)	The Episode Treatment Group (ETG) description for ETGs with the highest paid amounts for this provider.	0	Character
(A) Top 10 ETGs based on Paid Amount - Paid (Y axis)	The paid amount (high to low) for Episode Treatment Groups with the highest paid amounts for this provider.	0	Number (Decimal)
(A) Top 10 ETGs based on Recipient Count (Y axis)	The recipient count (high to low) for ETGs with the highest recipient counts for this provider.	0	Number (Integer)
(A) Top 10 ETGs based on Recipient Count- ETG Description (X axis)	The ETG description for ETGs with the highest recipient counts for this provider.	0	Character
(A-H) NPI ID	The National Provider Identification number of the provider.	10	Character
(A-H) Medicaid ID	Medicaid identification number for the provider.	13	Character
(A-H) Base ID	The Medicaid identification number of the provider.	13	Character
(B,D,E,F,G,H) ETG Number & Description	The ETG number and its description.	234	Character
(A-H) Name	The provider's name.	50	Character

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Field	Description	Length	Data Type
(A-H) (Provider) Type	The provider type code and description.	55	Character
(A-H) (Provider) Specialty	The specialty and description for the provider.	56	Character
(A-H) Address (City, State, Zip)	The provider's city, state, and ZIP code.	46	Character
(A-H) Address (Street)	The provider's street address.	62	Character
(B) Servicing Provider Address (City, State, Zip)	The servicing provider's city, state, and ZIP code.	46	Character
(B) Servicing Provider Address (Street)	The servicing provider's street address.	62	Character
(D,F,G,H) Totals	The sum of episode amounts.	13	Number (Integer)
(B-H) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
(B-D, F-H) Claim ICN	The claim's identification number.	13	Character
(B-D, F-H) Recipient Full Name	Recipient Full name, including first, middle initial and last name.	39	Character
(B-D, F-H) Recipient ID	The recipient's Medicaid identification number.	11	Character
(B,C,H) NDC & Description	National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description.	49	Character
(B,C,F) Procedure Code & Description	The procedure code for the detail and the associated description.	49	Character
(B,C) Billed Amount	The billed amount for the detail.	11	Character
(B,C) Allowed Amount	The allowed amount for the detail.	11	Character
(B,C) Buy-In Medicare A	Medicare Buy-in in which recipient is participating in Part A.	5	Character
(B,C) Buy-In Medicare B	Medicare Buy-in in which recipient is participating in Part B.	5	Character
(B,C) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	30	Character
(B,C) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)

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Field	Description	Length	Data Type
(B,C) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(B,C) Provider ID-Rendering	Lists the NPI, Medicaid, and Base ID for the rendering provider.	63	Character
(B,C) Revenue Code & Description	Revenue code and description.	77	Character
(B,C,G) ICD	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
(B,C,G) Primary Diagnosis Code & Description	The primary ICD-CM diagnosis description.	70	Character
(B,C) Claim Type Code & Description	Shows what type of claim was submitted.	54	Character
(B,C) Episode Type & Description	Episode Type and the associated description.	229	Character
(B,C) Recip Age	The recipient's age.	3	Number (Integer)
(B,C) Recip County Description	Recipient's county of residence and the associated description.	38	Character
(B,C) Claim Indicator	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
(B,C) Program Code Description	State aid category.	6	Character
(B,C) Provider ID Billing	Lists the NPI, Medicaid, and Base ID for the billing provider.	63	Character
(B,C) Provider ID-Referring/Attending/Prescribing	Lists the NPI, Medicaid, and Base ID for the provider.	63	Character
(B,C) Detail Number	Detail number on the claim.	2	Number (Integer)
(B,C) Claim Detail Status	The claim's status code.	1	Character
(B,C) Date First Service	The claim's first date of service.	10	Date (MM/DD/CCYY)
(B,C) Date Last Service	The claim's last date of service.	10	Date (MM/DD/CCYY)
(B,C,F,G,H) Subclass	This field further describes the ETG number.	3	Character
(B,C) Wrap Ind	Wrap Payment Indicator	1	Character

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Field	Description	Length	Data Type
(B,C,F,G,H) Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character

3.5.102 ETG Provider Summary - FFS

This report is run through the Episode Treatment Grouper (ETG). This breaks the ETGs down to the provider level.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-D in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

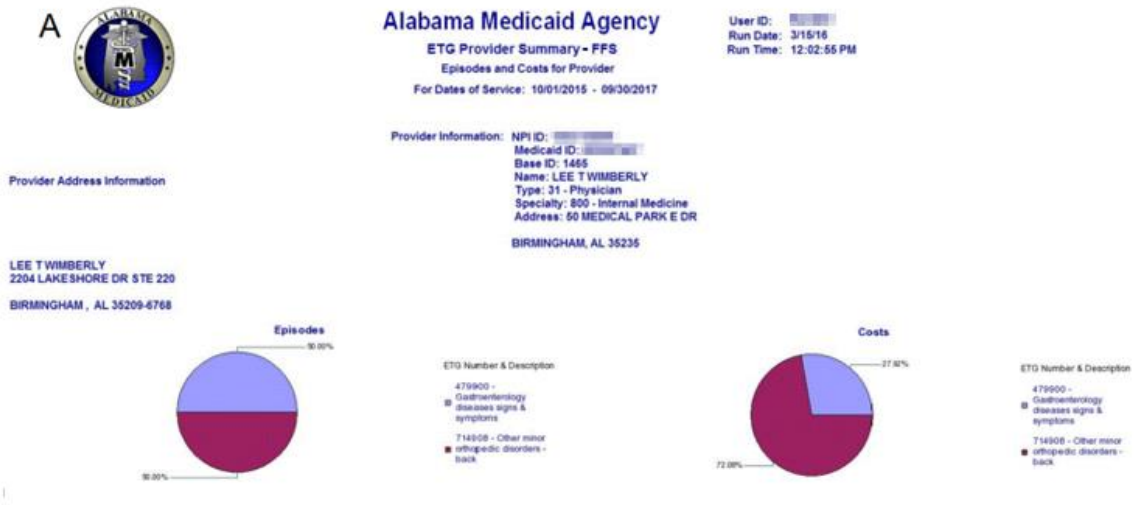
The four tabs in this report are:

A. Episodes and Costs for Provider;

B. Provider Summary Global Comparison;

C. Summary By ETG; and

D. Summary ETG Details By Major Practicing Category (MPC).



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B

Alabama Medicaid Agency

ETG Provider Summary - FFS

Provider Summary Global Comparison

For Dates of Service: 10/01/2015 - 09/30/2017

User ID:
Run Date: 3/15/16
Run Time: 12:02:55 PM

Provider Information:
NPI ID:
Medicaid ID:
Base ID:
Name: LEE T WIMBERLY
Type: 31 - Physician
Specialty: 800 - Internal Medicine
Address: 50 MEDICAL PARK E DR

BIRMINGHAM, AL 35235

Recipient Information

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C

Alabama Medicaid Agency

ETG Provider Summary - FFS

Summary By ETG

For Dates of Service: 07/01/2014 - 06/30/2016

User ID: [redacted]
Run Date: 7/25/16
Run Time: 10:41:51 AM

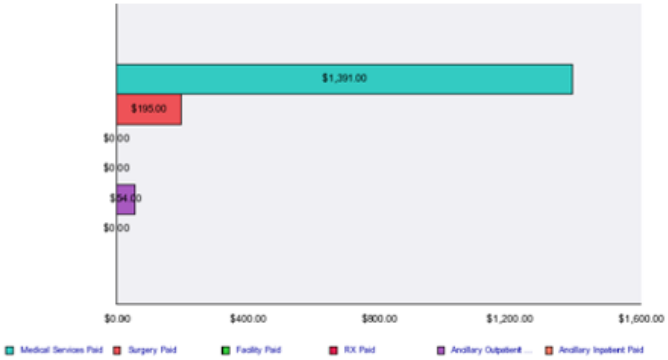
Provider Information:
NPI ID: [redacted]
Medicaid ID: [redacted]
Base ID: [redacted]
Name: SHERMAN L ARMSTRONG JR
Type: 31 - Physician
Specialty: 319 - General Surgeon
Address: 1722 PINE ST STE 201

MONTGOMERY, AL 36106

MPC Code & Description: 02 - ENDOCRINOLOGY

ETG Number & Description: 163000 - Diabetes, with complication, w/o comorbidity, w/o surgery

Episode Type & Description: 7 - Incomplete annual episode, only applies to chronic episodes.



Average Episode Cost:	$102.50
Average Amount per Recipients:	$102.50
Total Episodes:	16
Total Recipients:	16
Total Dollars:	$1,640.00

ETG Number	Ancillary Inpatient Paid	Percentage	Ancillary Outpatient Paid	Percentage	Facility Paid	Percentage	Medical Services Paid	Percentage	RX Paid	Percentage	Surgery Paid	Percentage
163000 - Diabetes, with complication, w/o comorbidity, w/o surgery	$0.00	0.00 %	$54.00	3.29 %	$0.00	0.00 %	$1,391.00	84.82 %	$0.00	0.00 %	$195.00	11.89 %

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Alabama Medicaid Agency

ETG Provider Summary - FFS

Summary ETG Details By Major Practicing Category (MPC)

For Dates of Service: 07/01/2011 - 06/30/2013

User ID: [redacted]
Run Date: 2/11/2014
Run Time: 11:42:22 AM

Provider Information: NPI ID: [redacted]
Medicaid ID: [redacted]
Base ID: [redacted]
Name: WILLIAM E TYNDALL
Type: 31 - Physician
Specialty: 315 - Emergency Medicine Practitioner
Address: 600 S 3RD ST

GADSDEN, AL 35901

Provider Address Information
WILLIAM E TYNDALL
PO BOX 538424

ATLANTA , GA 30353-

MPC & Description: 02 - ENDOCRINOLOGY

ETG Number & Description(Provider)	Recip Count	Episode Count	Total Amount Billed	Total Amount Paid	Provider Average Cost per Recip	Global Allowed Amount Per Recip	Dollar Difference	Percent Difference	Ancillary Outpatient Paid	Facility Paid	Medical Services Paid	RX Paid	Surgery Paid	Ancillary Inpatient Paid
163000 - Diabetes, w/o complication, with comorbidity, w/o surgery	2	2	$17,241.00	$4,753.00	$2,376.50	$1,925.00	$451.89	23.48 %	$2,004.00	$0.00	$1,701.00	$915.00	$133.00	$0.00

MPC & Description: 05 - CHEMICAL DEPENDENCY

ETG Number & Description(Provider)	Recip Count	Episode Count	Total Amount Billed	Total Amount Paid	Provider Average Cost per Recip	Global Allowed Amount Per Recip	Dollar Difference	Percent Difference	Ancillary Outpatient Paid	Facility Paid	Medical Services Paid	RX Paid	Surgery Paid	Ancillary Inpatient Paid
271200 - Acute alcohol intoxication	1	1	$3,498.00	$1,198.00	$1,198.00	$359.00	$838.90	233.61 %	$1,132.00	$0.00	$66.00	$0.00	$0.00	$0.00

3.5.102.1 ETG Provider Summary - FFS Field Descriptions

Field	Description	Length	Data Type
(A-D) (Provider) Specialty	The specialty and description for the provider.	63	Character
(A-D) (Provider) Type	The provider type code and description.	50	Character
(A-D) Address (City, State, Zip)	The provider's city, state, and ZIP code.	25	Character
(A-D) Address (Street)	The provider's street address.	30	Character
(A-D) Base ID	The Base identification number of the provider.	13	Character
(A-D) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-D) Medicaid ID	Medicaid identification number for the provider.	13	Character
(A-D) Name	The provider's name.	50	Character
(A-D) NPI ID	The National Provider Identification number of the provider.	10	Character
(B) Global Cost per Recipient	Total amount paid / unduplicated recipient count.	7	Number (Decimal)

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Field	Description	Length	Data Type
(B,D) Provider Average Cost per Recipient	Total amount paid per recipient.	11	Number (Decimal)
(B) Subclass	This field further describes the ETG number.	3	Character
(B) Subclass Description	The description of the subclass; for example: ETG Number 669001 is Skin trauma, subclass 000 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, w/o surgery", and subclass 001 is "except burn & open wound - foot & ankle, w/o complication, w/o comorbidity, *with* surgery".	225	Character
(C) Average Episode Cost	Total amount paid /episode cost.	11	Number (Decimal)
(C) Total Episodes	The episode count for the ETG.	6	Number (Integer)
(C) Average Amount per Recipient	Total amount paid / unduplicated recipient count.	11	Number (Decimal)
(C) Total Recipients	The unduplicated recipient count for the ETG.	6	Number (Integer)
(C) Total Dollars	The summed total of all paid amounts.	11	Number (Decimal)
(C)Percentage	Percentage of paid amount identified in the previous report column.	8	Number (Decimal)
(C) ETG Number & Description	The ETG number and its description.	234	Character
(C,D) Ancillary Inpatient Paid	Ancillary Inpatient paid amount.	11	Number (Decimal)
(C,D) Ancillary Outpatient Paid	Ancillary Outpatient paid amount.	11	Number (Decimal)
(C,D) Facility Paid	Facility paid amount.	11	Number (Decimal)
(C,D) Medical Services Paid	Medical paid amount.	11	Number (Decimal)
(C,D) RX Paid	Prescription paid amount.	11	Number (Decimal)
(C,D) Surgery Paid	Surgery paid amount.	11	Number (Decimal)
(D) Recip Count	Number of eligible recipients the provider served for this particular claim grouping.	8	Number (Integer)
(D) Episode Count	The episode count for the ETG.	6	Number (Integer)

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Field	Description	Length	Data Type
(D) Total Amount Billed	The total amount billed for the ETG.	11	Number (Decimal)
(D) Total Amount Paid	The total amount paid for the ETG.	11	Number (Decimal)
(D) Global Allowed Amount per Recip	The allowed amount per recipient.	11	Number (Decimal)
(D) Dollar Difference	The difference between the paid and allowed amount.	7	Number (Decimal)
(D) Percent Difference	The difference between the paid and allowed amount expressed as a percent.	3	Number (Decimal)

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3.5.103 ETG Summary - FFS

The ETG Summary report breaks the Episode Treatment Groups (ETGs) down to the major category levels. It displays the average episode cost, the average amount per recipient, total episodes, total recipients and total dollars.

For this particular version of the report, only FFS (Fee-for-Service) claims are used.

ETGs are basic illness classifications, similar in structure to Diagnosis Related Groupings (DRGs). Based on a series of clinical and statistical algorithms, ETGs provide a medically meaningful statistical unit representing a complete episode of care. ETGs combine all routinely collected inpatient, outpatient and ancillary claims data into mutually exclusive and exhaustive categories. ETGs successfully provide a unit of analysis for the creation of provider profiling, demand analysis and disease management strategies. The Episode Treatment Grouper (or ETG Profiler) allows for reporting on ETGs. The reports are produced quarterly with 24 months of data exclusive of the two most recent quarters.

The ETG Summary report contains two tabs. The first tab contains brief information for every ETG major processing category. The second tab allows the report user to drill down by major processing category, ETG description and episode type to view individual ETGs. The report in the second tab presents the data in chart and tabular format. A report user can select the ETG processing category, ETG description and episode type they want to see by using the drop down boxes at the top of the report.

There are multiple tabs to this report. For workbook documentation only, the different tabs have been lettered A-B in the layout below. The field names have the corresponding letter in front, identifying the tab on which it can be found. This is only to aid in verifying the report layouts. The letters are not on the actual or printed reports. For the report layouts below, only the information inside of the blue box can be found on the actual report.

The two tabs in this report are:

A. Summary By ETG; and

B. Summary ETG Details By Major Practicing Category (MPC).

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A

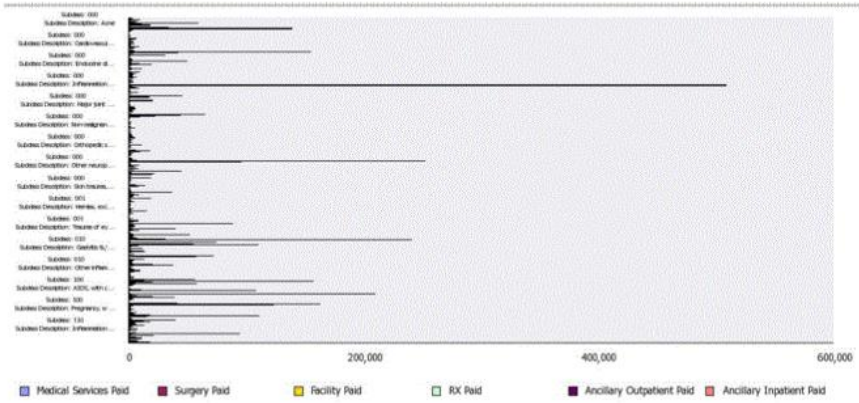
Alabama Medicaid Agency

ETG Summary - FFS

Summary By ETG

For Dates of Service: 10/01/2015 - 09/30/2017

User ID: [redacted]
Run Date: 3/21/16
Run Time: 2:51:46 PM



Average Episode Cost:	$749.50
Average Amount per Recipient:	$891.86
Total Episodes:	10,061
Total Recipients:	8,455
Total Dollars:	$7,540,709.00

ETG Number & Description	Ancillary Inpatient Paid	Percentage	Ancillary Outpatient Paid	Percentage	Facility Paid	Percentage	Medical Services Paid	Percentage	RX Paid	Percentage	Surgery Paid	Percentage
130100 - AIDS, with complication, with comorbidity, with surgery	$0.00	0.00 %	$308.00	1.36 %	$0.00	0.00 %	$1,654.00	7.31 %	$20,433.00	90.34 %	$223.00	0.99 %
130100 - AIDS, with complication, with comorbidity, w/o surgery	$0.00	0.00 %	$13,583.00	10.63 %	$0.00	0.00 %	$2,084.00	1.63 %	$111,033.00	86.88 %	$1,095.00	0.86 %
130100 - AIDS, with complication, w/o comorbidity, w/o surgery	$0.00	0.00 %	$13,419.00	18.85 %	$0.00	0.00 %	$464.00	0.65 %	$57,320.00	80.50 %	$0.00	0.00 %
130100 - AIDS, w/o complication, with comorbidity, w/o surgery	$0.00	0.00 %	$0.00	0.00 %	$0.00	0.00 %	$0.00	0.00 %	$2,459.00	100.00 %	$0.00	0.00 %
130200 - HIV sero-positive w/o AIDS, w/o surgery	$0.00	0.00 %	$248.00	71.26 %	$0.00	0.00 %	$88.00	25.29 %	$12.00	3.45 %	$0.00	0.00 %
130400 - Septicemia, with complication, w/o surgery	$0.00	0.00 %	$77.00	14.15 %	$0.00	0.00 %	$377.00	69.30 %	$90.00	16.54 %	$0.00	0.00 %
130400 - Septicemia, w/o complication, w/o surgery	$0.00	0.00 %	$689.00	46.37 %	$0.00	0.00 %	$685.00	46.10 %	$68.00	4.58 %	$44.00	2.96 %

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Alabama Medicaid Agency

ETG Summary - FFS

Summary ETG Details by Major Practicing Category (MPC)

For Dates of Service: 10/01/2014 - 09/30/2016

User ID: [redacted]
Run Date: 3/8/16
Run Time: 2:50:17 PM

MPC & Description: 01 - INFECTIOUS DISEASES

ETG Number & Description	Unduplicated Recip Count	Episode Count	Ancillary Outpatient Paid	Facility Paid	Medical Services Paid	RX Paid	Surgery Paid	Total Amount Billed	Total Amount Paid
130100 - AIDS, with complication, with comorbidity, with surgery	1	1	$308.00	$0.00	$1,654.00	$20,433.00	$223.00	$30,058.00	$22,617.00
130100 - AIDS, with complication, with comorbidity, w/o surgery	7	10	$13,583.00	$0.00	$2,084.00	$111,033.00	$1,095.00	$191,270.00	$127,796.00
130100 - AIDS, with complication, w/o comorbidity, w/o surgery	2	3	$13,419.00	$0.00	$464.00	$57,320.00	$0.00	$87,761.00	$71,204.00
130100 - AIDS, w/o complication, with comorbidity, w/o surgery	1	1	$0.00	$0.00	$0.00	$2,459.00	$0.00	$2,975.00	$2,459.00
130200 - HIV sero-positive w/o AIDS, w/o surgery	2	2	$248.00	$0.00	$88.00	$12.00	$0.00	$503.00	$348.00
130400 - Septicemia, with complication, w/o surgery	1	1	$77.00	$0.00	$377.00	$90.00	$0.00	$3,817.00	$543.00
130400 - Septicemia, w/o complication, w/o surgery	8	8	$689.00	$0.00	$685.00	$68.00	$44.00	$9,412.00	$1,486.00
130600 - Other infectious diseases, with complication, with comorbidity, w/o surgery	8	8	$260.00	$0.00	$505.00	$280.00	$0.00	$4,680.00	$1,045.00

3.5.103.1 ETG Summary - FFS Field Descriptions

Field	Description	Length	Data Type
(A) Ancillary Inpatient Paid	Ancillary Inpatient paid amount.	11	Number (Decimal)
(A) Average Amount per Recipient	Total amount paid / unduplicated recipient count.	11	Number (Decimal)
(A) Average Episode Cost	Total amount paid / episode count.	11	Number (Decimal)
(A) Percentage	Percentage of paid amount identified in the previous report column.	8	Number (Decimal)
(A) Total Dollars	The summed total of all paid amounts.	11	Number (Decimal)
(A) Total Episodes	The total count of all episodes.	6	Number (Integer)
(A) Total Recipients	The total count of all recipients.	6	Number (Integer)
(A,B) Ancillary Outpatient Paid	Ancillary Outpatient paid amount.	11	Number (Decimal)
(A,B) Facility Paid	Facility paid amount.	11	Number (Decimal)
(A,B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A,B) Medical Services Paid	Medical paid amount.	11	Number (Decimal)
(A,B) Rx Paid	Prescription paid amount.	11	Number (Decimal)
(A,B) Surgery Paid	Surgery paid amount.	11	Number (Decimal)
(A,B) ETG Number & Description	The ETG number and its description.	234	Character
(B) Episode Count	The episode count for the ETG.	6	Number (Integer)
(B) Total Amount Billed	The summed total of all billed amounts.	11	Number (Decimal)
(B) Total Amount Paid	The summed total of all paid amounts.	11	Number (Decimal)
(B) Unduplicated Recip Count	The unduplicated recipient count for the ETG.	6	Number (Integer)
(B) MPC & Description	The ETG defined category grouping.	50	Character

3.5.104 TQ - Facility Visits Exception

The Facility Visits Exception Report displays the exception professional claims submitted by a provider meeting the defined criteria for the report.

The SURS Certification Requirement met by this report:

- Physicians and other practitioners having instances of frequent multiple visits on a single day to many recipients at the same facility or location. The requirement of 'frequent' is determined by the analyst reviewing the report.

Search Criteria:

- Claim Type = M or B;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99221 and 99223 or 99231 and 99233 or 99381 and 99387 or 99391 and 99397;
- Date of Services - Date range specified by the user in the prompt; and
- Multiple Visits - Specified by the user. It is the number of visits per day by a provider to one or more recipients at the same facility or location.

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Alabama Medicaid Agency
Office Visits Exception Report

From Date of Service: 1/1/16 - 6/26/16
Multiple Visits: 1

User ID:
Run Date: 6/29/2016
Run Time: 13:58:06

Medicaid Provider ID:
Provider Name: ALABAMA COMMUNITY CARE REGION A

Recipient ID	Recipient Name	From Date of Service Date	To Date of Service Date	Claim Type	District Plan Code	ICN	Primary Procedure Code & Description	Claim Ind	Payment Date	Paid Amount	Encounter Amount	RCO Paid Amount
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X	4/5/2016	4/5/2016	M	RA1		99201 - OFFICE/OUTPATIENT VISIT NEW	E	5/9/2016	$0.00	$0.00	$7.00
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X	4/5/2016	4/5/2016	M	RA1		99201 - OFFICE/OUTPATIENT VISIT NEW	E	5/9/2016	$0.00	$0.00	$7.00

Medicaid Provider ID:
Provider Name: SHERMAN L ARMSTRONG JR

PHI has been removed

Recipient ID	Recipient Name	From Date of Service Date	To Date of Service Date	Claim Type	District Plan Code	ICN	Primary Procedure Code & Description	Claim Ind	Payment Date	Paid Amount	Encounter Amount	RCO Paid Amount
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXXX, X	4/1/2016	4/1/2016	M	RA3		99211 - OFFICE/OUTPATIENT VISIT EST	E	5/17/2016	$0.00	$15.70	$2.00

3.5.104.1 TQ - Facility Visits Exception Field Descriptions

Field	Description	Length	Data Type
Billing Provider Medicaid ID	Lists the NPI, Medicaid, and Base ID for the billing Provider.	13	Character
Billing Provider Name	The name associated with the billing provider ID.	50	Character
Claim Indicator	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
Claim Type	A code to indicate the type of medical assistance invoice used by the provider to bill OMAP for the rendered service.	1	Character
District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
Encounter Amount	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
Facility Provider Medicaid ID	Lists the NPI, Medicaid, and Base ID for the Provider.	13	Character
Facility Provider Name	The name associated with the organization or person.	50	Character
From Date of Service Date	The date the service was incurred.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
Payment Date	The date the claim was paid.	10	Number (Integer)
Provider Medicaid ID	Lists the NPI, Medicaid, and Base ID for the provider.	13	Character
Provider Name	Name of the Provider.	25	Character
Primary Procedure Code and Description	The primary procedure code and its description.	49	Character
RCO Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
Recipient ID	The unique number assigned to the recipient.	12	Character
Recipient Name	Full name of the recipient on the claim.	32	Character
Multiple Visits	User prompt to enter the limit of visits for the report data to be displayed.	2	Character
To Date of Service Date	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)

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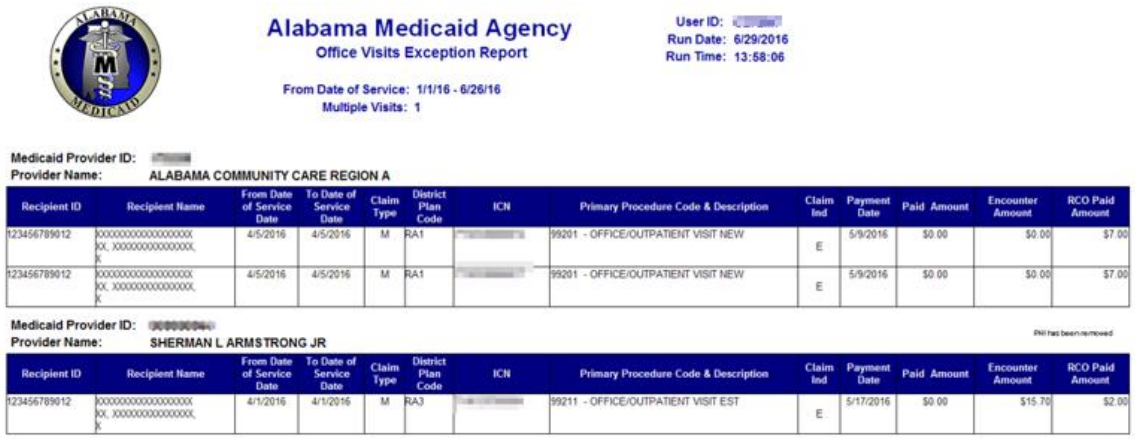
3.5.105 TQ - Office Visits Exception

The Office Visits Exception Report displays the exception professional claims submitted by a provider meeting the defined criteria for the report.

Report criteria:

- Claim Type = M or B;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99201 and 99205 or 99211 and 99215 or W0061 and W0062;
- Date of Services - Date range specified by the user in the prompt; and
- Multiple Visits - Number of Visits specified by the user in the prompt.



Alabama Medicaid Agency
Office Visits Exception Report

From Date of Service: 1/1/16 - 6/26/16
Multiple Visits: 1

User ID:
Run Date: 6/29/2016
Run Time: 13:58:06

Medicaid Provider ID:
Provider Name: ALABAMA COMMUNITY CARE REGION A

Recipient ID	Recipient Name	From Date of Service Date	To Date of Service Date	Claim Type	District Plan Code	ICN	Primary Procedure Code & Description	Claim Ind	Payment Date	Paid Amount	Encounter Amount	RCO Paid Amount
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X	4/5/2016	4/5/2016	M	RA1		99201 - OFFICE/OUTPATIENT VISIT NEW	E	5/9/2016	$0.00	$0.00	$7.00
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X	4/5/2016	4/5/2016	M	RA1		99201 - OFFICE/OUTPATIENT VISIT NEW	E	5/9/2016	$0.00	$0.00	$7.00

Medicaid Provider ID:
Provider Name: SHERMAN L ARMSTRONG JR

PHI has been removed

Recipient ID	Recipient Name	From Date of Service Date	To Date of Service Date	Claim Type	District Plan Code	ICN	Primary Procedure Code & Description	Claim Ind	Payment Date	Paid Amount	Encounter Amount	RCO Paid Amount
123456789012	XXXXXXXXXXXXXXXXXX XX, XXXXXXXXXXXXXX, X	4/1/2016	4/1/2016	M	RA3		99211 - OFFICE/OUTPATIENT VISIT EST	E	5/17/2016	$0.00	$15.70	$2.00

3.5.105.1 TQ - Office Visits Exception Field Descriptions

Field	Description	Length	Data Type
Claim Ind	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
Claim Type	Code indicating the type of claim record.	1	Character
District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
Encounter Amount	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)

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Field	Description	Length	Data Type
From Date of Service	Date on which services were first performed for a recipient.	10	Date (MM/DD/CCYY)
ICN	Internal control number of the mother claim.	13	Character
Medicaid Provider ID	Identification of the provider who performed (rendered) the service.	10	Character
Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
Payment Date	The date the claim was paid.	10	Date (MM/DD/CCYY)
Primary Procedure Code & Description	The primary procedure code and its description.	49	Character
Provider Name	Performing Prov Name.	50	Character
RCO Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
Recipient ID	The unique number assigned to the recipient by the State.	12	Character
Recipient Name	Recipient Name.	32	Number (Decimal)
Reimbursed Amount	Amount sent to a provider for payment for services rendered to a recipient	10	Date (MM/DD/CCYY)
To Date of Service	Date on which services were last performed for a recipient.	10	Date (MM/DD/CCYY)

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3.5.106 TQ – Home Hospital Conflict

This report identifies recipients receiving services from different user selected provider types on the same or overlapping dates of service. The user can enter Billing Provider Type code(s) and date of service range.

A - Overlapping Recipient Services Report is sorted by Date of First Service.

A claim is considered to overlap another claim if all of the following criteria are met: Same recipient or dates of service ranges overlap on any day except the admission and discharge date on the inpatient.

Other criteria: No voided claims; Paid Claims only; Exclude Family Planning Claims

Alabama Medicaid Agency
Home Hospital Conflict
From Date of Service: 1/1/16 - 8/1/16

User ID:
Run Date: 7/29/2016
Run Time: 13:49:31

Recipient ID	Recipient Name	Performing Provider Base ID (Inpatient)	Performing Provider Name (Inpatient)	Performing Provider Type Code & Description (Inpatient)	Performing Provider Specialty Code & Description (Inpatient)	From Date of Service (Inpatient)	To Date of Service (Inpatient)	Paid Amount (Inpatient)
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		GERALD M MACHEN	31 - Physician	316 - Family Practitioner	08/23/2015	08/26/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		GERALD M MACHEN	31 - Physician	316 - Family Practitioner	08/23/2015	08/26/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		JAMES R MOSS	31 - Physician	800 - Internal Medicine	07/01/2015	07/31/2015	$2,581.10
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		OLUDAYO B DAWODU	31 - Physician	316 - Family Practitioner	08/01/2015	08/31/2015	$2,609.96
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		BARON C MAZE	31 - Physician	800 - Internal Medicine	10/05/2015	10/12/2015	$8,323.07
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		SIMON MCCLURE	31 - Physician	339 - Psychiatrist	07/16/2015	08/20/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		PRAVEEN JETTY	31 - Physician	339 - Psychiatrist	08/12/2015	08/25/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		BHARAT K VAKHARIA	31 - Physician	800 - Internal Medicine	08/12/2015	08/18/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		TY J KREHBIEL	31 - Physician	316 - Family Practitioner	08/27/2015	08/28/2015	$630.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		FAIZULLAH SYED	31 - Physician	800 - Internal Medicine	08/17/2015	08/21/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		FAIZULLAH SYED	31 - Physician	800 - Internal Medicine	08/18/2015	08/21/2015	$1,210.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		PRITHVIRAJ R CHAVAN	31 - Physician	810 - Orthopedic	08/18/2015	08/20/2015	$1,260.00
123456789012	XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXX		PRITHVIRAJ R CHAVAN	31 - Physician	810 - Orthopedic	08/18/2015	08/20/2015	$1,260.00

PHI has been removed

ICN (Inpatient)	Detail Number (Inpatient)	Adjusted ICN (Inpatient)	Adjust/ Void Code (Inpatient)	Claim Type (Inpatient)	Performing Provider Base ID (Waiver)	Claim Indicator (Inpatient)	District Plan Code (Inpatient)	Encounter Amount (Inpatient)	RCO Paid Amount (Inpatient)	Performing Provider Name (Waiver)	Performing Provider Type Code & Description (Waiver)
	0		A	A		F		$0.00	$0.00	GERALD M MACHEN	31 - Physician
	0		A	A		F		$0.00	$0.00	GERALD M MACHEN	31 - Physician
	0		A	A		F		$0.00	$0.00	JAMES R MOSS	31 - Physician
	0		A	A		F		$0.00	$0.00	GREGORY AYERS	31 - Physician
	0		A	I		F		$0.00	$0.00	BARON C MAZE	31 - Physician
	0		A	A		F		$0.00	$0.00	SIMON MCCLURE	31 - Physician
	0		A	A		F		$0.00	$0.00	WILLIAM B SHIRAH	31 - Physician
	0		A	A		F		$0.00	$0.00	BHARAT K VAKHARIA	31 - Physician
	0		A	A		F		$0.00	$0.00	SAKINA A KAMAL	31 - Physician
	0		A	A		F		$0.00	$0.00	GEORGE A EVANS	31 - Physician
	0		A	A		F		$0.00	$0.00	KARL T HAGLER	31 - Physician
	0		A	A		F		$0.00	$0.00	GARY M RICHARDSON	31 - Physician
	0		A	A		F		$0.00	$0.00	STANLEY B WINSLOW	31 - Physician

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Performing Provider Specialty Code & Description (Waiver)	From Date of Service (Waiver)	To Date of Service (Waiver)	Reimbursed Amount (Waiver)	ICN (Waiver)	Detail Number (Waiver)	Adjusted ICN (Waiver)	Adjust/ Void Code (Waiver)	Claim Type (Waiver)	Claim Indicator (Waiver)	District Plan Code (Waiver)	Encounter Amount (Waiver)	RCO Paid Amount (Waiver)
316 - Family Practitioner	08/26/2015	08/26/2015	$0.00	[redacted]	4	[redacted]	A	B	F		$0.00	$0.00
316 - Family Practitioner	08/26/2015	08/26/2015	$0.00	[redacted]	5	[redacted]	A	B	F		$0.00	$0.00
800 - Internal Medicine	07/31/2015	07/31/2015	$0.00	[redacted]	1	[redacted]	A	B	F		$0.00	$0.00
800 - Internal Medicine	08/31/2015	08/31/2015	$0.00	[redacted]	1	[redacted]	A	B	F		$0.00	$0.00
800 - Internal Medicine	10/12/2015	10/12/2015	$58.59	[redacted]	1	[redacted]	A	M	F	C00	$0.00	$0.00
339 - Psychiatrist	08/20/2015	08/20/2015	$0.00	[redacted]	5	[redacted]	A	B	F		$0.00	$0.00
800 - Internal Medicine	08/25/2015	08/25/2015	$0.00	[redacted]	2	[redacted]	A	B	F		$0.00	$0.00
800 - Internal Medicine	08/18/2015	08/18/2015	$0.00	[redacted]	7	[redacted]	A	B	F		$0.00	$0.00
313 - Cardiovascular Surgeon	08/28/2015	08/28/2015	$16.56	[redacted]	1	[redacted]	A	B	F		$0.00	$0.00
316 - Family Practitioner	08/21/2015	08/21/2015	$0.00	[redacted]	1	[redacted]	A	B	F		$0.00	$0.00
329 - Oncologist	08/19/2015	08/21/2015	$0.00	[redacted]	2	[redacted]	A	B	F		$0.00	$0.00
318 - General Practitioner	08/20/2015	08/20/2015	$2.64	[redacted]	2	[redacted]	A	B	F		$0.00	$0.00
341 - Radiologist	08/20/2015	08/20/2015	$0.86	[redacted]	1	[redacted]	A	B	F		$0.00	$0.00

3.5.106.1 TQ – Home Hospital Conflict Field Descriptions

Field	Description	Length	Data Type
Adjust/Void Code (Inpatient)	A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).	1	Character
Adjust/Void Code (Waiver)	A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).	1	Character
Adjusted ICN (Inpatient)	Internal control number of the mother claim.	13	Character
Adjusted ICN (Waiver)	Internal control number of the mother claim.	13	Character
Claim Indicator (Inpatient)	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
Claim Indicator (Waiver)	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
Claim Type (Inpatient)	Code indicating the type of claim record.	1	Character
Claim Type (Waiver)	Code indicating the type of claim record.	1	Character
Detail Number (Inpatient)	Detail number on the claim.	22	Number (Integer)
Detail Number (Waiver)	Detail number on the claim.	22	Number (Integer)
District Plan Code (Inpatient)	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
District Plan Code (Waiver)	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character

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Field	Description	Length	Data Type
Encounter Amount (Inpatient)	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
Encounter Amount (Waiver)	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
From Date of Service (Inpatient)	Date on which services were first performed for a recipient.	10	Date (MM/DD/CCYY)
From Date of Service (Waiver)	Date on which services were first performed for a recipient.	10	Date (MM/DD/CCYY)
ICN (Inpatient)	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
ICN (Waiver)	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
Paid Amount (Inpatient)	Amount sent to a provider for payment for services rendered to a recipient	10	Date (MM/DD/CCYY)
Performing Provider Base ID (Inpatient)	Identification of the provider who performed (rendered) the service.	10	Character
Performing Provider Base ID (Waiver)	Identification of the provider who performed (rendered) the service.	10	Character
Performing Provider Name (Inpatient)	Performing Inpatient Provider Name.	50	Character
Performing Provider Name (Waiver)	Performing Waiver Provider Name.	50	Character
Performing Provider Specialty Code & Description (Inpatient)	Indicates the provider's primary specialty.	56	Character

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Field	Description	Length	Data Type
Performing Provider Specialty Code & Description (Waiver)	Indicates the provider's primary specialty.	56	Character
Performing Provider Type Code & Description (Inpatient)	Type that a provider is licensed.	55	Character
Performing Provider Type Code & Description (Waiver)	Type that a provider is licensed.	55	Character
Recipient ID	The unique number assigned to the recipient by the State.	10	Number (Decimal)
Recipient Name	Recipient Name.	10	Date (MM/DD/CCYY)
Reimbursed Amount (Waiver)	Amount sent to a provider for payment for services rendered to a recipient	10	Date (MM/DD/CCYY)
RCO Paid Amount (Inpatient)	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
RCO Paid Amount (Waiver)	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
To Date of Service (Inpatient)	Date on which services were last performed for a recipient.	13	Number (Decimal)
To Date of Service (Waiver)	Date on which services were last performed for a recipient.	10	Date (MM/DD/CCYY)

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3.5.107 TQ – Physician Office Visits

The Physician Office Visits report shows counts of physician office visits by recipient.

The SURS certification requirement met by this report is:

Excessive medical visits to a single physician or other provider unit by an AFDC family. The tabs on this report include:

A. Sorted by Provider Name

B. Sorted by Number of Visits

Search Criteria:

- Recipient Aid Category – Specified by the user
- The From Date of Service range as entered by the user at prompt
- Paid claims only
- Procedure code between 99201 and 99215
- All claims types except Pharmacy
- Exclude Family Planning Claims
- Latest Claims Only
- Exclude Wrap Payments
- Total Visits Per Family no less than number entered by user at prompt

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A

Alabama Medicaid Agency

Physician Office Visits

Sorted by Provider Name

For Dates of Service: 04/01/2016 - 06/30/2016

Total visits per family: 2

Aid Category Codes: 36;34;41

User ID:
Run Date: 6/28/16
Run Time: 7:48:11 AM

Recipient ID	Claim Indicator	District Plan Code	Performing/Attending Provider IDs	Performing/ Attending Provider Name	Performing Provider Specialty Code & Desc	Number of Visits
123456789012	E	RB1	NPI ID: Medicaid ID: Base ID:	ALABAMA ONCOLOGY HEMATOLOGY ASSOCIATES	329 - Oncologist	2
123456789012	F		NPI ID: Medicaid ID: Base ID:	DARNITA A HILL	316 - Family Practitioner	4
123456789012	E	RA1	NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	19

PHI has been removed

B

Alabama Medicaid Agency

Physician Office Visits

Sorted by Number of Visits

For Dates of Service: 04/01/2016 - 06/30/2016

Total visits per family: 2

Aid Category Codes: 36;34;41

User ID:
Run Date: 6/28/16
Run Time: 7:48:11 AM

Recipient ID	Claim Indicator	District Plan Code	Performing/Attending Provider IDs	Performing/Attending Provider Name	Performing Provider Specialty Code & Desc	Number of Visits
123456789012	E	RB1	NPI ID: Medicaid ID: Base ID:	TONIA M LONG	093 - Nurse Practitioner (Other	100
123456789012	E	RA1	NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	19
123456789012	F		NPI ID: Medicaid ID: Base ID:	DARNITA A HILL	316 - Family Practitioner	4
123456789012	E	RB1	NPI ID: Medicaid ID: Base ID:	ALABAMA ONCOLOGY HEMATOLOGY ASSOCIATES	329 - Oncologist	2
123456789012	F		NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	2
					Sum:	127

PHI has been removed

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3.5.107.1 TQ – Physician Office Visits Field Descriptions

Field	Description	Data Type	Length
(A-B) Recipient ID	The unique number assigned to the recipient.	12	Character
(A-B) Claim Indicator	“F” for Fee-for-Service, “E” for encounters.	1	Character
(A-B) District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
(A-B) Performing Provider IDs	Identification of the provider who performed (rendered) the service.	10	Character
(A-B) Performing Provider Name	Performing Provider Name.	50	Character
(A-B) Performing Provider Specialty Code & Desc	Performing Provider's primary Specialty and Description.	56	Character
(A-B) Number of Visits	Count of claims for physician office visits for the recipient/case number.	8	Number (Integer)
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Total Visits per Family	User entered value for setting the threshold for Number of Visits column.	2	Number (Integer)
(A-B) Aid Category Codes	User entered aid category codes for which the report should be run.	2	Character

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3.5.108 TQ – Physician Office Visits by Recipient

This report shows counts of physician office visits by recipient. This will help identify excessive medical visits to a single physician or other provider unit.

- Recipient Aid Category – Specified by the user
- The From Date of Service range as entered by the user at prompt
- Paid claims only
- Procedure code between 99201 and 99215
- All claims types except Pharmacy
- Exclude Family Planning Claims
- Latest Claims Only
- Exclude Wrap Payments
- Number of Office Visits no less than number entered by user at prompt

Alabama Medicaid Agency
Physician Office Visits by Recipient
For Dates of Service: 04/01/2016 - 06/30/2016
Number of Office Visits: 2

User ID:
Run Date: 7/19/16
Run Time: 11:31:46 AM

Recipient ID	Claim Indicator	District Plan Code	Recipient Name	Billing Provider IDs	Billing Provider Name	Billing Provider Specialty Code & Description	Paid Claim Count
123456789012	E	RA1	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX	NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	6
						Sum:	6
123456789012	E	RA2	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX	NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	4
						Sum:	4
123456789012	E	RB1	XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX	NPI ID: Medicaid ID: Base ID:	CARDIOVASCULAR INSTITUTE OF THE SHOALS PC	313 - Cardiovascular Surgeon	45
						Sum:	45
123456789012	F		XXXXXXXXXXXXXXXXXXX, XXXXXXXXXX	NPI ID: Medicaid ID: Base ID:	SHERMAN L ARMSTRONG JR	319 - General Surgeon	3
						Sum:	3

End of Report

3.5.108.1 TQ – Physician Office Visits by Recipient Field Descriptions

Field	Description	Length	Data Type
Billing Provider IDs	Identification that identifies the provider billing the claim.	10	Character
Billing Provider Name	The name associated with the organization or person.	50	Character

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Field	Description	Length	Data Type
Billing Provider Specialty Code & Desc	Billing Provider Specialty Code and Description.	56	Character
Claim Indicator	“F” for Fee-for-Service, “E” for encounters.	1	Character
District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
Number of Office Visits	Count of claims for office visits for the recipient/case number.	8	Number (Integer)
Paid Claim Count	Counts the financial transaction as a paid claim.	22	Number (Decimal)
Recipient ID	The unique number assigned to the recipient by the State.	12	Character
Recipient Name	The name of the recipient.	32	Character

3.5.109 TQ – PT OT Daily Overbilling

This report is to identify consumers with more than $250.00 in payments for physical, occupational, or speech therapy services performed in a single day.

Additional Criteria:

Claim type is equal to M (medical) or O (outpatient);

Payment amount is greater than zero;

Exclude adjusted claims (If claim has been adjusted, include only the final adjustment. Original claim should be excluded.); and

Procedure code is one of the following: S9129, S9131, S9128, 97001, 97002, 97003, 97004, 97010, 97012, 97014, 97016, 97018, 97020, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97504, 97520, 97530, 97532, 97533, 97535, 97537, 97542, 97545, 97546, 92507, 92508.

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Alabama Medicaid Agency

PT OT Daily Overbilling

For Dates of Service : 1/1/16 - 8/1/16

User ID:
Run Date: 7/29/16
Run Time: 1:48:30 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: CULLMAN REG MEDICAL CENTER

Recipient ID	Recipient Full Name	ICN	Claim Indicator	District Plan Code	I C D	Primary Diagnosis Code & Description	Primary Procedure Code & Description	Place of Service Code	From Date of Service	To Date of Service	Payment Date	First Modifier Code	Second Modifier Code	Performing/ Attending Provider IDs	Wrap Ind	Allowed Quantity	Sum of Paid Amount	Encounter Amount	RCO Paid Amount
123456789012	XXXXXXX XXXXXXX XXXXXX. XXXXXXX XXXXXXX K.X		F	RA2	0	M25512 - PAIN IN LEFT SHOULDER	97001 - Pt Evaluation	22	6/16/2016	6/16/2016	6/28/2016	GP	##	NPI ID: Medicaid ID: Base ID:	N	1	$40.44	$0.00	$0.00
123456789012	XXXXXXX XXXXXXX XXXXXX. XXXXXXX XXXXXXX K.X		F	RA2	0	M25512 - PAIN IN LEFT SHOULDER	97110 - Therapeutic Exercises	22	6/16/2016	6/16/2016	6/28/2016	GP	##	NPI ID: Medicaid ID: Base ID:	N	3	$50.55	$0.00	$0.00
																Sum:	$90.99	$0.00	$0.00

End of Report

PHI has been removed

3.5.109.1 TQ – PT OT Daily Overbilling Field Descriptions

Field	Description	Length	Data Type
Allowed Quantity	The units of service approved for payment.	8	Number (Decimal)
Billing Provider IDs	This object contains the Base, Medicaid and NPI IDs that identify the billing provider.	45	Character
Billing Provider Name	Name of the billing provider.	50	Character
Claim Indicator	“F” for Fee-for-Service, “E” for encounters.	1	Character
District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
Encounter Amount	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
First Modifier Code	The first of up to 2 codes that may be used to supplement the procedure-code.	2	Character
For Dates of Service (prompt)	Selected date range for which claims were selected by date of service.	23	Date (MM/DD/CCYY)
From Date of Service	The date the service was incurred.	13	Character
ICD	The ICD Version code for the primary ICD-CM payment level diagnosis code.	1	Character
ICN	Unique control number assigned to the invoice to indicate its date of receipt. The	13	Character

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Field	Description	Length	Data Type
	format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.		
Payment Date	The date the claim was paid.	10	Date (MM/DD/CCYY)
Performing Provider IDs	This object contains the Base, Medicaid and NPI IDs that identify the provider who performed (rendered) the service.	45	Character
Place of Service Code	A code to indicate where the service was provided.	2	Character
Primary Diagnosis Code & Description	The primary ICD-CM diagnosis description.	70	Character
Primary Procedure Code & Description	The code and description associated with the primary procedure code.	47	Character
RCO Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
Recipient Full Name	This field concatenates the recipient last name, first name and middle initial into one object.	39	Character
Recipient ID	The unique number assigned to the recipient by the State.	12	Character
Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
Run Time	The time that the report was executed.	11	Character
Second Modifier Code	The second of up to 2 codes that may be used to supplement the procedure-code.	2	Character
Sum	The total paid amount for the recipient.	13	Number (Decimal)
Sum of Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	10	Number (Decimal)
To Date of Service	Date on which the statement period on the claim ended.	10	Date (MM/DD/CCYY)
User ID	The id of the user that created the report.	50	Character
Wrap Ind	Wrap Payment Indicator	1	Character

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3.5.110 TQ - Emergency Room Visits

The Emergency Room Visits report displays counts of emergency room visits by the recipients in the family. The number of recipients in the family and the unduplicated number of recipients involved with the visits are shown, along with provider information.

The tabs on this report include:

A. Emergency Room Visits, sorted by Provider Name

B. Emergency Room Visits, sorted By Number of Visits

Search Criteria:

- The From Date of Service range as entered by the user at prompt;
- Paid Claims Only;
- Latest Claims Only;
- Exclude Wrap Payments;
- Procedure Code between 99281 and 99288;
- Date of Services - Date range specified by the user in the prompt;
- Minimum Visits Per Family - Specified by the user; and
- Recipient Aid Category – Specified by the user

A

Alabama Medicaid Agency

TQ - Emergency Room Visits

Sorted by Provider Name

For Dates of Service: 07/01/2016 - 09/30/2016

Minimum Visits Per Family: 1

Recipient Aid Category: 32

User ID:
Run Date: 7/21/16
Run Time: 8:37:51 AM

Recipient ID	Recipient Full Name	Performing/Attending Provider IDs	Performing/Attending Provider Name	Performing Provider Specialty Code & Desc	Number of Visits
123456789012	XXXXXXXXXXXXXXXX XXX, XXXXXXXXXXXXXX, X	NPI ID: Medicaid ID: Base ID:	JARVIS E PATTON JR.	315 - Emergency Medicine Practitioner	1

End of Report

PHI has been removed

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B

Alabama Medicaid Agency

TQ - Emergency Room Visits

Sorted by Number of Visits

For Dates of Service: 07/01/2016 - 09/30/2016
Minimum Visits Per Family: 1
Recipient Aid Category: 32

User ID:
Run Date: 7/21/16
Run Time: 8:37:51 AM

Recipient ID	Recipient Full Name	Performing/Attending Provider Name	Performing Provider Specialty Code & Desc	Performing/ Attending Provider IDs	Number of Visits
123456789012	XXXXXXXXXXXXXXXXX XXX, XXXXXXXXXXXXXXX, X	JARVIS E PATTON JR.	315 - Emergency Medicine Practitioner	NPI ID: Medicaid ID: Base ID:	1
				Total Visits:	1

End of Report

PHI has been removed

3.5.110.1 TQ - Emergency Room Visits Field Descriptions

Field	Description	Length	Data Type
(A-B) For Dates of Service	Starting and Ending range of service date selection criteria.	20	Date (MM/DD/CCYY)
(A-B) Minimum Visits Per Family	User prompt to enter the limit of visits for the report data to be displayed.	2	Number (Integer)
(A-B) Number of Visits	Count of claims for emergency room visits for the recipient/case number.	8	Number (Integer)
(A-B) Recipient ID	The unique number assigned to the recipient by the State.	12	Character
(A-B) Performing Provider IDs	Identification of the provider who performed (rendered) the service.	10	Character
(A-B) Performing Provider Name	Performing Provider Name.	50	Character
(A-B) Performing Provider Specialty Code & Desc	Performing Provider's primary Specialty and Description.	56	Character
(A-B) Recipient Aid Category	The aid category for the recipient.	2	Character
(A-B) Recip County Code	County code for the recipient head of household.	2	Character

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3.5.111 TQ – Inpatient – Related Readmissions

The Inpatient - Related Readmissions report shows recipients who have been admitted more than once to the same hospital within a seven-day period.

Alabama Medicaid Agency

Inpatient - Related Readmissions

Dates of Service within: 1/1/16 – 11/30/16

Claims Indicator(s): F

User ID: [redacted]
Run Date: 11/29/2016
Run Time: 13:55:17

Billing Provider IDs			Billing Provider Name	Recipient ID & Check Digit	Recipient Full Name		NDC Code & Description			Paid Amount			Pricing DRG Code & Description	DRG Relative Weight	DRG Service Adjustor
Claim Indicator	District Plan Code	ICN	Previous ICN	Adjusted ICN	Adjust/Void Code	Claim Type	Detail Number	Admission Date	Discharge Date	Encounter Amount	RCO Paid Amount		Readmission Alert		
Medicaid ID: [redacted]			ORLANDO HEALTH, INC.	[redacted]			########### -						$30,254.50#### -	0.0000	0.00
F					N	I	0	6/11/2016	7/6/2016	$0.00	$0.00				
Medicaid ID: [redacted]			ORLANDO HEALTH, INC.	[redacted]			########### -						$7,261.06#### -	0.0000	0.00
F					N	I	0	7/11/2016	7/17/2016	$0.00	$0.00		Possible Related Readmission!		
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$22,953.42#### -	0.0000	0.00
F					N	I	0	2/11/2016	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$37,515.58#### -	0.0000	0.00
F					N	I	0	2/11/2016	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$37,515.58#### -	0.0000	0.00
F					N	I	0	10/20/2015	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$35,095.22#### -	0.0000	0.00
F					N	I	0	10/20/2015	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$1,210.18#### -	0.0000	0.00
F					N	I	0	10/20/2015	3/2/2016	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$37,515.58#### -	0.0000	0.00
F					N	I	0	7/28/2015	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$35,095.22#### -	0.0000	0.00
F					N	I	0	7/28/2015	12/31/2299	$0.00	$0.00				
Medicaid ID: [redacted]			CUMBERLAND HOSPITAL	[redacted]			########### -						$37,515.58#### -	0.0000	0.00

3.5.111.1 TQ – Inpatient – Related Readmissions Field Descriptions

Field	Description	Length	Data Type
Adjust/Void Code	A code to indicate whether the record is for a debit or credit and adjustment.	1	Character
Adjusted ICN	Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim.	13	Number (Integer)
Claims Indicator (s)	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim (E).	1	Character
Admission Date	Date recipient was admitted.	10	Date (MM/DD/CCYY)
Claim Type	Shows what type of claim was submitted.	1	Character
Detail Number	Detail number on the claim.	63	Number (Integer)
Discharge Date	Date that the recipient was discharged by the provider for inpatient care, outpatient services or start of care.	10	Date (MM/DD/CCYY)
District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)

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Field	Description	Length	Data Type
DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
Encounter Amount	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
From Dates of Service within	Claim's first date of service.	13	Number (Integer)
ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Character
NDC Code & Description	National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description.	49	Character
Paid Amount	Amount sent to a provider for payment for services rendered to a recipient This is the amount paid by Medicaid, after TPL, copay, etc have been subtracted.	9	Number (Integer)
Previous ICN	ICN from the legacy system	13	Character
Performing Provider IDs	Lists the NPI, Medicaid, and Base ID for the performing Provider.	63	Character
Performing Provider Name	Name of the provider.	25	Character
Readmission Alert	Indicates a possible readmission within 7 days.	29	Character
RCO Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
Recipient Full Name	Name of the recipient.	13	Number (Integer)

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Field	Description	Length	Data Type
Recipient ID & Check Digit	Number used to verify recipients identification.	12	Character

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3.5.112 TQ – Antibiotics 12 Months or Longer

This report is used to identify recipients who have continuously been on any combination of antibiotics for 12 months prior to the date of the end of From Date of Service or longer. The report looks for standard therapeutic class codes 21, 22, 24, 25, 26, and 27.

Alabama Medicaid Agency

Antibiotics 12 Months or Longer

From Date of Service: 08/01/2007

User ID: [redacted]
Run Date: 10/23/2007
Run Time: 3:11:49 PM

Recipient ID	Recipient Name	Recipient Age	Recipient Gender	ICN	Adjusted ICN	Previous ICN	Prescriber Provider Base ID
[redacted]	[redacted]	34	F	[redacted]			

Recipient ID	Recipient Name	Recipient Age	Recipient Gender	ICN	Adjusted ICN	Previous ICN	Prescriber Provider Base ID
[redacted]	[redacted]	65	F	[redacted]			[redacted]

Recipient ID	Recipient Name	Recipient Age	Recipient Gender	ICN	Adjusted ICN	Previous ICN	Prescriber Provider Base ID
[redacted]	[redacted]	50	F	[redacted]			[redacted]

Recipient ID	Recipient Name	Recipient Age	Recipient Gender	ICN	Adjusted ICN	Previous ICN	Prescriber Provider Base ID
[redacted]	[redacted]	22	F	[redacted]			
[redacted]	[redacted]	22	F	[redacted]			[redacted]
[redacted]	[redacted]	22	F	[redacted]			
[redacted]	[redacted]	23	F	[redacted]			[redacted]

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Alabama Medicaid Agency

Antibiotics 12 Months or Longer

From Date of Service: 08/01/2007

User ID: [redacted]
Run Date: 10/23/2007
Run Time: 3:11:49 PM

Prescriber Provider Name	Prescriber Provider License	Prescriber Provider Type & Description	NDC Code & Description
Unknown		## - Unknown	00143992701 - CIPROFLOXACIN HCL

Prescriber Provider Name	Prescriber Provider License	Prescriber Provider Type & Description	NDC Code & Description
ST JUDE CHILDRENS RESEARCHH	[redacted]	01 - Hospital	00009022502 - CLEOCIN HCL

Prescriber Provider Name	Prescriber Provider License	Prescriber Provider Type & Description	NDC Code & Description
GWINN III, NELSON S	[redacted]	31 - Physician	00781183120 - AMOX TR-POTASSIUM CLAVULANATE

Prescriber Provider Name	Prescriber Provider License	Prescriber Provider Type & Description	NDC Code & Description
Unknown		## - Unknown	00603064450 - TRIPLE ANTIBIOTIC
PATIENTS CHOICEINC		25 - DME/Medical Supply Dealer	00603064450 - TRIPLE ANTIBIOTIC
PATIENTS CHOICEINC		25 - DME/Medical Supply Dealer	00603064450 - TRIPLE ANTIBIOTIC
CRENSHAW, ERIKA W	[redacted]	31 - Physician	00143992701 - CIPROFLOXACIN HCL

Alabama Medicaid Agency

Antibiotics 12 Months or Longer

From Date of Service: 08/01/2007

User ID: [redacted]
Run Date: 10/23/2007
Run Time: 3:11:49 PM

AHFS Therapeutic Class Code and Description	Drug Quantity	Days Supply	Control Drug Indicator	Prescription Number	Refill Indicator	From Date of Service	Payment Date	Paid Amount
08121800 - QUINOLONES	30.00	30.00	0	46651	00	11/2/2006	9/11/2007	$13.01

AHFS Therapeutic Class Code and Description	Drug Quantity	Days Supply	Control Drug Indicator	Prescription Number	Refill Indicator	From Date of Service	Payment Date	Paid Amount
08122800 - ANTIBACTERIALS, MISCELL	30.00	30.00	0	46671	00	5/7/2007	9/27/2007	$21.54

AHFS Therapeutic Class Code and Description	Drug Quantity	Days Supply	Control Drug Indicator	Prescription Number	Refill Indicator	From Date of Service	Payment Date	Paid Amount
08121608 - AMINOPENICILLINS	30.00	30.00	0	50171	00	7/7/2007	7/9/2007	$35.00

AHFS Therapeutic Class Code and Description	Drug Quantity	Days Supply	Control Drug Indicator	Prescription Number	Refill Indicator	From Date of Service	Payment Date	Paid Amount
84040400 - ANTIBACTERIALS (SKIN & M	28.00	30.00	0	46638	00	4/11/2007	4/30/2007	$8.00
84040400 - ANTIBACTERIALS (SKIN & M	28.00	30.00	0	46638	00	5/11/2007	8/7/2007	$8.00
84040400 - ANTIBACTERIALS (SKIN & M	28.00	30.00	0	46638	00	1/11/2007	8/16/2007	$7.50
08121800 - QUINOLONES	120.00	30.00	0	1000060	00	9/6/2007	9/11/2007	$4.90

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Alabama Medicaid Agency

Antibiotics 12 Months or Longer

From Date of Service: 08/01/2007

User ID:
Run Date: 10/23/2007
Run Time: 3:11:49 PM

Billing Provider Base ID	Billing Provider Name	Performing Provider Base ID	Performing Provider Name
	UNION SPRING PHARMA		UNION SPRING PHARMACY INC

Billing Provider Base ID	Billing Provider Name	Performing Provider Base ID	Performing Provider Name
	UNION SPRING PHARMA		UNION SPRING PHARMACY INC

Billing Provider Base ID	Billing Provider Name	Performing Provider Base ID	Performing Provider Name
	ADAMS PHARMACYSERV		ADAMS PHARMACYSERVICES INC

Billing Provider Base ID	Billing Provider Name	Performing Provider Base ID	Performing Provider Name
	UNION SPRING PHARMA		UNION SPRING PHARMACY INC
	UNION SPRING PHARMA		UNION SPRING PHARMACY INC
	UNION SPRING PHARMA		UNION SPRING PHARMACY INC
	NORTHWOOD PHARMAC		NORTHWOOD PHARMACY

3.5.112.1 TQ – Antibiotics 12 Months or Longer Field Descriptions

Field	Description	Length	Data Type
Adjusted ICN	Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim.	13	Character
AHFS Therapeutic Class Code and Description	American Hospital Formulary Service (AHFS) classification code and its description, identifying the pharmacological therapeutic category of the drug product.	68	Character
Billing Provider Base ID	ID which identifies the provider billing the claim.	9	Character
Billing Provider Name	The name associated with the billing provider ID.	50	Character
Control Drug Indicator	Indicates whether the drug is a controlled substance.	1	Character
Days Supply	Number of days the prescription should last.	9	Number (Integer)
Drug Quantity	Quantity dispensed for the drug claim.	9	Number (Integer)
From Date of Service	The date the service was incurred.	10	Date (MM/DD/CCYY)
ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is	13	Character

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Field	Description	Length	Data Type
	RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.		
NDC Code & Description	National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is a combination of the drug name appearing on the package label, the strength description and the dosage form description.	49	Character
Paid Amount	Amount sent to a provider for payment for services rendered to a recipient. This is the amount paid by Medicaid, after TPL, copay, etc have been subtracted.	9	Number (Decimal)
Payment Date	The date the claim was paid.	10	Date (MM/DD/CCYY)
Performing Provider Base ID	ID and Service Location which identifies the provider rendering the service.	9	Character
Performing Provider Name	The name associated with the performing provider ID.	50	Character
Prescriber Provider Base ID	ID and Service Location which identifies the provider prescribing the service.	9	Character
Prescriber Provider License	License number used to identify a person who refers recipients to other providers that perform services.	10	Character
Prescriber Provider Name	The name associated with the Prescriber ID.	50	Character
Prescriber Provider Type & Description	Provider Type and Description.	63	Character
Prescription Number	Number assigned to the prescription by the provider.	7	Character
Previous ICN	ICN from the legacy system.	22	Character
Recipient Age	Age of the recipient on the From Date of Service rounded down to a full year.	22	Character
Recipient Gender	Gender of the recipient.	1	Character
Recipient ID	Recipient's State assigned Medicaid Number or ID.	12	Character

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Field	Description	Length	Data Type
Recipient Name	Full name of the recipient on the claim.	32	Character
Refill Indicator	Reflects the number of refills. The maximum number of refills is 6.	2	Character

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3.5.113 TQ – Delayed Surgery Summary

This report lists all inpatient claims containing a surgical code where the surgical date is greater than the from date of service. This report ranks the claims based on the number of days a surgery was delayed. The delayed surgery count is calculated by determining the days between the from date of service and the surgical procedure date.

The report contains 3 report tabs:

A. The Delayed Surgery Provider List - Displays a list of providers and the delayed surgery claim count. The order is descending by delayed surgery claim count;

B. The Delayed Surgery Detail Report by Provider - Used to view a specific provider found in the Delayed Surgery Provider List. This gives you a quick view (drill) into the claims for a specific provider. Also, if you want to print the report, but don't want to print all of the other providers, use this tab to get only the selected provider; and

C. The Delayed Surgery Detail Report - All Providers displays the claims for all providers found in the Delayed Surgery Provider List tab. Use this report tab when you want to look at all of the providers' claim information at the same time.

This report is used to meet the following SUR Certification Requirement:

- Inpatient Hospitals having instances of: Frequently delayed surgery per recipient; and
- Frequently delayed surgeries are identified for billing providers having more than 3 claims with surgeries being delayed, based on the surgical procedure date, for more than 1 day from the from date of service on the claim.

Report criteria:

- Inpatient Claims Only;
- Paid Claims Only;
- From Date of Service Range prompt; and
- Surgical Procedure Date from the From Date of Service greater than 1 (one).

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A

Alabama Medicaid Agency

Delayed Surgery Provider List

From Date of Service: 4/1/16 - 6/29/16

Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time:2:52:11 PM

Billing Provider IDs	Billing Provider Name	Delayed Surgery Claim Count
NPI ID: Medicaid ID: Base ID:	SACRED HEART HOSPITAL	153
NPI ID: Medicaid ID: Base ID:	HUNTSVILLE HOSPITAL	89
NPI ID: Medicaid ID: Base ID:	THE CHILDRENS HOSPITAL OF ALABAMA	41
NPI ID: Medicaid ID: Base ID:	SOUTHEAST ALABAMA MED CTR	17
NPI ID: Medicaid ID: Base ID:	JAY HOSPITAL	6
NPI ID: Medicaid ID: Base ID:	UNIVERSITY OF ALABAMA	4

End of Report

B

Alabama Medicaid Agency

Delayed Surgery Detail Report by Provider
From Date of Service: 4/1/16 - 6/29/16
Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time: 2:52:11 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: JAY HOSPITAL

Detail Number	Claim Type	Claim Indicator	District Plan Code	Surgical Procedure Date	Paid Date	I C D	Surgical Procedure Code	Surgical Provider License Number	Paid Amount	Encounter Amount	RCO Paid Amount	Delayed Surgery Days	Pricing DRG Code & Description	DRG Relative Weight	DRG Service Adjustor
0	I	F		6/4/2016	6/1/2016	0	02H63JZ	8022	$27,421.95	$0.00	$0.00	3	1663 - CORONARY BYPASS W/O CATH	4.0194	1.00
0	I	F	RB1	6/4/2016	6/1/2016	0	02H63JZ	8022	$20,819.92	$0.00	$0.00	3	1662 - CORONARY BYPASS W/O CATH	3.0517	1.00
								Sum:	$48,241.87	$0.00	$0.00	6			

End of Report

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C

Alabama Medicaid Agency

Delayed Surgery Detail Report - All Providers
From Date of Service: 4/1/16 - 6/29/16
Number of days delayed: 1

User ID:
Run Date: 6/29/2016
Run Time: 2:52:11 PM

Billing Provider IDs: NPI ID:
Medicaid ID:
Base ID:

Billing Provider Name: UNIVERSITY OF ALABAMA

ICN	Claim Indicator	District Plan Code	Claim Type	ICD	Surgical Procedure Code	Paid Amount	Encounter Amount	RCO Paid Amount	Delayed Surgery Days	Surgical Procedure Date	Paid Date	Pricing DRG Code & Description	DRG Relative Weight	DRG Service Adjustor
	E	RB1	I	0	H22ZZZZ	$0.00	$2,000.00	$2,000.00	2	4/18/2016	5/17/2016	7532 - BIPOLAR DIS	7.1400	1.00
	E	RB1	I	0	H22ZZZZ	$0.00	$0.00	$2,000.00	2	4/18/2016	5/31/2016	7532 - BIPOLAR DIS	7.1400	1.00

3.5.113.1 TQ – Delayed Surgery Summary Field Descriptions

Field	Description	Length	Data Type
(A) Delayed Surgery Claim Count	This object will determine the number of days between the surgical procedure date and the from date of service on the inpatient claim.	9	Number (Integer)
(A-C) Billing Provider IDs	This object contains the Base, Medicaid and NPI IDs that identify a provider.	45	Character
(A-C) Billing Provider Name	The name associated with the organization or person.	50	Character
(A-C) From Date of Service (prompt)	The from date of service range entered by the user.	23	Date (MM/DD/CCYY)
(A-C) Number of days delayed (prompt)	The number of days between the surgical procedure date and the from date of service on the inpatient claim.	10	Number (Integer)
(A-C) Run Date	The date that the report was executed.	10	Date (MM/DD/CCYY)
(A-C) Run Time	The time that the report was executed.	10	Character
(A-C) User ID	The id of the user that created the report.	50	Character
(B,C) Claim Indicator	Indicates whether the claim is a Fee-for-Service (FFS) or an Encounter claim.	1	Character
(B,C) Claim Type	Shows what type of claim was submitted.	1	Character
(B,C) ICD	The ICD Version code for the surgical procedure code.	1	Character
(B,C) ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the	13	Character

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Field	Description	Length	Data Type
	batch number; and SSS is the sequence number of the invoice within the batch.		
(B,C) Delayed Surgery Days	This object will determine the number of days between the Surgical Procedure Date and the From Date of Service on the Inpatient Claim.	9	Number (Integer)
(B,C) District Plan Code	The Managed Care plan code assigned to the claim. For example:ZZZ=Medicaid	3	Character
(B,C) DRG Code and Description	Diagnosis Related Group Number assigned to the claim, and its description.	60	Character
(B,C) DRG Relative Weight	Relative weight for pricing DRG	5	Number (Decimal)
(B,C) DRG Service Adjuster	This field contains the pediatric value if recipient age at admission is less than pediatric age cut-off value. Otherwise, it will be adult service adjustor	3	Number (Decimal)
(B,C) Encounter Amount	Amount that *would have been* sent to a provider for payment for services rendered to a recipient (using Encounter “what-if" amount).	10	Number (Decimal)
(B,C) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	10	Number (Decimal)
(B,C) RCO Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (by RCO).	10	Number (Decimal)
(B,C) Paid Date	The date the claim was paid.	10	Date(MM/DD/CCYY)
(B,C) Surgical Procedure Code	The first ICD-CM code for the service performed for the recipient.	7	Character
(B,C) Surgical Procedure Date	The date the first surgical procedure was performed.	10	Date (MM/DD/CCYY)
(B,C) Surgical Provider License Number	The Medicaid physician ID of the surgeon or surgical license.	10	Character

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3.5.114 TQ – Drug – Overspending Prescribers

This report shows all prescribers that write at least 50 percent of their prescriptions for scheduled drugs.

The report contains 2 report tabs:

A: Drug - Overspending Prescribers – Drugs; and

B: Prescriber – Specialty Matchup.

Alabama Medicaid Agency

Drug - Overspending Prescribers

From Date of Service within: 12/01/2006 - 12/31/2006

User ID: [redacted]
Run Date: 10/31/2007
Run Time: 9:33:16 AM

Prescriber License	AHFS Therapeutic Class Code & Description	Claims	Paid Amount	Unique Recipients
[redacted]	04040400 - ETHANOLAMINE DERIVATIVES	3	$3.00	1
[redacted]	04041200 - PHENOTHIAZINE DERIVATIVES	7	$7.00	1
[redacted]	04042000 - PROPYLAMINE DERIVATIVES	4	$4.00	1
[redacted]	04049200 - FIRST GEN. ANTIHIST. DERIVATIVES, MISC.	2	$2.00	1
[redacted]	04080000 - SECOND GENERATION ANTIHISTAMINES	15	$15.00	1
[redacted]	08080000 - ANTHELMINTICS	1	$1.00	1
[redacted]	08120604 - FIRST GENERATION CEPHALOSPORINS	3	$3.00	1
[redacted]	08120608 - SECOND GENERATION CEPHALOSPORINS	1	$1.00	1
[redacted]	08120612 - THIRD GENERATION CEPHALOSPORINS	3	$3.00	1
[redacted]	08121292 - OTHER MACROLIDES	4	$4.00	1
[redacted]	08121608 - AMINOPENICILLINS	34	$32.00	1
[redacted]	08121800 - QUINOLONES	2	$2.00	1
[redacted]	08122000 - SULFONAMIDES (SYSTEMIC)	4	$4.00	1
[redacted]	08122800 - ANTIBACTERIALS, MISCELLANEOUS	2	$2.00	1
[redacted]	08140800 - AZOLES	4	$4.00	1
[redacted]	08149200 - ANTIFUNGALS, MISCELLANEOUS	1	$1.00	1
[redacted]	08183200 - NUCLEOSIDES AND NUCLEOTIDES	2	$2.00	1
[redacted]	08300800 - ANTIMALARIALS	1	$1.00	1
[redacted]	08309200 - ANTIPROTOZOALS, MISCELLANEOUS	1	$1.00	1
[redacted]	08360000 - URINARY ANTI-INFECTIVES	2	$2.00	1
[redacted]	12080800 - ANTIMUSCARINICS/ANTISPASMODICS	7	$5.00	1
[redacted]	12120812 - SELECTIVE BETA-2-ADRENERGIC AGONISTS	41	$36.00	1
[redacted]	12200400 - CENTRALLY ACTING SKELETAL MUSCLE RELAXNT	11	$10.00	1
[redacted]	12201200 - GABA DERIVATIVE SKELETAL MUSCLE RELAXANT	1	$1.00	1
[redacted]	20040400 - IRON PREPARATIONS	5	$5.00	1
[redacted]	20120408 - COUMARIN DERIVATIVES	1	$1.00	1
[redacted]	20121800 - PLATELET-AGGREGATION INHIBITORS	1	$1.00	1
[redacted]	24040800 - CARDIOTONIC AGENTS	2	$2.00	1
[redacted]	24060600 - FIBRIC ACID DERIVATIVES	2	$2.00	1
[redacted]	24060800 - HMG-COA REDUCTASE INHIBITORS	15	$15.00	1
[redacted]	24081600 - CENTRAL ALPHA-AGONISTS	7	$7.00	1
[redacted]	24120800 - NITRATES AND NITRITES	1	$1.00	1
[redacted]	24240000 - BETA-ADRENERGIC BLOCKING AGENTS	15	$15.00	1
[redacted]	24280800 - DIHYDROPYRIDINES	3	$3.00	1

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Alabama Medicaid Agency

Drug - Overspending Prescribers

Prescriber - Specialty Matchup

From Date of Service within: 12/01/2006 - 12/31/2006

User ID: [illegible]
Run Date: 10/31/2007
Run Time: 9:36:19 AM

Prescriber License Number	Provider Medicaid ID	Prescriber Name	Prov Primary Specialty Code & Description	Provider Specialty Code & Description
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
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[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	242 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	242 - Pharmacy	242 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
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[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
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[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy
[illegible]	[illegible]	[illegible]	240 - Pharmacy	240 - Pharmacy

3.5.114.1 TQ – Drug – Overspending Prescribers Field Descriptions

Field	Description	Length	Data Type
(A) Claims	Claim count for prescribing license number.	5	Number (Integer)
(A) Paid Amount	Amount sent to a provider for payment for services rendered to a recipient (	13	Number (Decimal)
(A) AFHS Therapeutic Class Code & Description	Therapeutic class code concatenated with a description of the therapeutic class code.	40	Character
(A) Unique Recipients	Recipient count for the prescribing license number.	5	Number (Integer)
(A,B) From Date of Service within	Claim's first date of service.	20	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
(A-B) Prescriber License (Number)	License number used to identify a person who refers recipients to other providers that perform services.	10	Character
(B) Prescriber Name	Name of the prescriber.	40	Character
(B) Prov Primary Specialty Code & Description	The primary specialty of the provider.	20	Character
(B) Prov Specialty Code & Description	A specialty of the provider.	20	Character
(B) Provider Medicaid ID	The identification number for the provider.	10	Character

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3.5.115 TQ – Drug – Recipients w-mult Pharmacies-Prescribers

The Drug - Recipients w/mult Pharmacies-Prescribers report shows recipients who visited five or more different pharmacies and obtained prescriptions from five or more prescribers in a given quarter. Note: The report layout displays the report columns being split into multiple sections. This has been done to allow for easy viewing in iTRACE and printing of the Design System Document (DSD). The actual reports in BusinessObjects will be presented in the standard report format.

Alabama Medicaid Agency

Drug - Recipients w-mult Pharmacies-Prescribers

From Date of Service Within : 01/01/2007 -03/31/2007

User ID:
Run Date: 10/25/2007
Run Time: 2:09:10 PM

Recipient ID & Check Digit	Recipient Full Name	Recipient SSN	Recipient Lockin Indicator	Previous ICN	ICN	Detail Number	Adjusted ICN	Adjust/ Void Code	Claim Type	From Date of Service	Performing Provider IDs	Performing Provider Name	Performing Provider County Code & Description
			N			0		N	P	11/19/2005	Medicaid ID:	CVS DRUG STORE# 4908	45 - Madison
			N			0		N	P	11/19/2005	Medicaid ID:	CVS DRUG STORE# 4908	45 - Madison
			N			0		N	P	11/19/2005	Medicaid ID:	CVS DRUG STORE# 4908	45 - Madison
			N			0		N	P	12/01/2005	Medicaid ID:	AMBULATORY CLINIC PHARMAC	45 - Madison
			N			0		N	P	12/02/2005	Medicaid ID:	AMBULATORY CLINIC PHARMAC	45 - Madison
			N			0		N	P	12/02/2005	Medicaid ID:	CVS DRUG STORE# 4924	45 - Madison
			N			0		N	P	12/12/2005	Medicaid ID:	MEDICINE SHOPPE	45 - Madison
			N			0		N	P	12/11/2005	Medicaid ID:	WALGREENS #06430	45 - Madison
			N			0		N	P	12/11/2005	Medicaid ID:	WALGREENS #06430	45 - Madison
			N			0		N	P	12/11/2005	Medicaid ID:	WALGREENS #06430	45 - Madison

Prescribing License	Prescribing Provider ID on Claim	NDC Code & Description	AHFS Therapeutic Class Code & Description
		00078033805 -	28129200 - Anticonvulsants, Miscellaneous
		00310027460 - SEROQUEL	28160804 - Atypical Antipsychotics
		00008083601 - EFFEXOR XR	28160416 - Sel. Serotonin & Norepi Reuptake Inhibtr
		00603401928 - IBUPROFEN	28080492 - Other Nonsteroidal Anti-Inflam. Agents
		00713052612 - PROMETHEGAN	04041200 - Phenothiazine Derivatives
		00008083601 - EFFEXOR XR	28160416 - Sel. Serotonin & Norepi Reuptake Inhibtr
		00591033505 - ACYCLOVIR	08183200 - Nucleosides And Nucleotides
		00078033805 -	28129200 - Anticonvulsants, Miscellaneous
		00173073101 - WELLBUTRIN XL	28160492 - Antidepressants, Miscellaneous
		00310027460 - SEROQUEL	28160804 - Atypical Antipsychotics

ICN Region Code & Description	Paid Amount	Quantity Dispensed
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$154.86	40.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$300.43	40.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$37.17	10.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$5.58	12.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$10.61	6.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$103.72	30.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$24.40	90.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$231.09	60.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$129.35	30.000
40 - CONVERTED REGION 05 ELECTRONIC CLAIMS	$449.45	60.000

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3.5.115.1 TQ – Drug – Recipients w-mult Pharmacies-Prescribers Field Descriptions

Field	Description	Length	Data Type
Adjust/Void Code	A code to indicate whether the record is for a debit or credit and adjustment.	1	Character
Adjusted ICN	Unique control number assigned to a claim when it has been adjusted in the system, blank if this is a non-adjusted claim.	13	Character
AHFS Therapeutic Class & Description	American Hospital Formulary Service (AHFS) classification, identifying the pharmacological therapeutic category of the drug product.	68	Character
Claim Type	Show the type of claim.	10	Character
Detail Number	Detail number on the claim.	4	Number (Integer)
Quantity Dispensed	The quantity of the drug that was dispensed to the recipient.	8	Number (Integer)
From Date of Service	For invoice types 1, the date on which services were first performed for a recipient. For invoice types 3 and 4, the first day of the billing period.	10	Date (MM/DD/CCYY
From Date of Service Within	For invoice types 1, the date on which services were first performed for a recipient. For invoice types 3 and 4, the first day of the billing period.	20	Date (MM/DD/CCYY)
ICN	Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the Julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.	13	Number (Integer)
ICN Region Code & Description	The first two positions of the ICN and associated description.	40	Character
Previous ICN	ICN from legacy system	13	Number (Integer)
NDC Code & Description	National Drug Code is comprised of a 5-Character numeric labeler code, a 4-Character numeric product code, and a 2-Character numeric package code. It identifies a drug, its labeler, and the package size of a product, and is used for pricing and prior authorization. The description is combination of the	49	Character

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Field	Description	Length	Data Type
	drug name appearing on the package label, the strength description, and the dosage form description.		
Paid Amount	Amount sent to a provider for payment for services rendered to a recipient	13	Number (Decimal)
Performing Provider County Code & Description	County in which the provider's service address is located. Out-of-state providers are also assigned a county code. The county name is associated with the county code.	30	Character
Performing Provider IDs	Identification number of the provider who performed (rendered) the service.	46	Character
Performing Provider Name	Name of the provider who performed (rendered) the service.	64	Character
Prescribing License	License number used to identify a person who refers recipients to other providers that perform services.	9	Character
Recipient Full Name	Full name of the recipient on the claim.	22	Character
Recipient ID & Check Digit	Number assigned to the recipient by the State and the recipient check digit assigned by the system with the recipient's Medicaid ID.	12	Character
Recipient Lockin Indicator	A code to indicate whether the recipient is/was "locked-in" to a specific provider to prevent utilization abuse by the recipient. Blank - No entry found for recipient on Lockin Tables, I - Recipient locked in as of date of service, O - Recipient not locked in as of date of service, but was at one time.	1	Character
Recipient SSN	Recipient Medicaid Number.	12	Character

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System Architecture (General)

The system includes multi-payer and improved benefit plan processing, as well as a state-of-the-art N-Tier architecture.

System Architecture

The Alabama Medicaid Management Information System (AMMIS) system includes multi-payer and improved benefit plan processing, as well as a state-of-the-art N-Tier architecture. The system is a highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model. It divides the application into components so that they process on different networked computers. This design and supporting architecture delivers enhanced flexibility, scalability, and reliability. The AMMIS is composed of different software components which are loosely coupled and arranged in various software and architectural patterns to enable ease of use, development, and maintainability. The core components include the AMMIS batch processing which was developed in the C programming language executing in a UNIX environment, and an N-tier web-based user interface written primarily in C#, utilizing Microsoft ASP.NET. The AMMIS data resides in an Oracle database. There are many other critical software components for AMMIS, involving letter generation, ad-hoc reports, and optical character recognition, electronic storage of paper reports and forms, and Electronic Data Interchange (EDI).

At a high level, AMMIS is comprised of a Graphical User Interface (GUI) and business entities that interact with a robust Medicaid specific data store, the AMMIS components, and any integrated third party products. As shown in Figure 1, this example of the AMMIS system is a high scaleable transaction system enabling both real-time and batch processing of data.

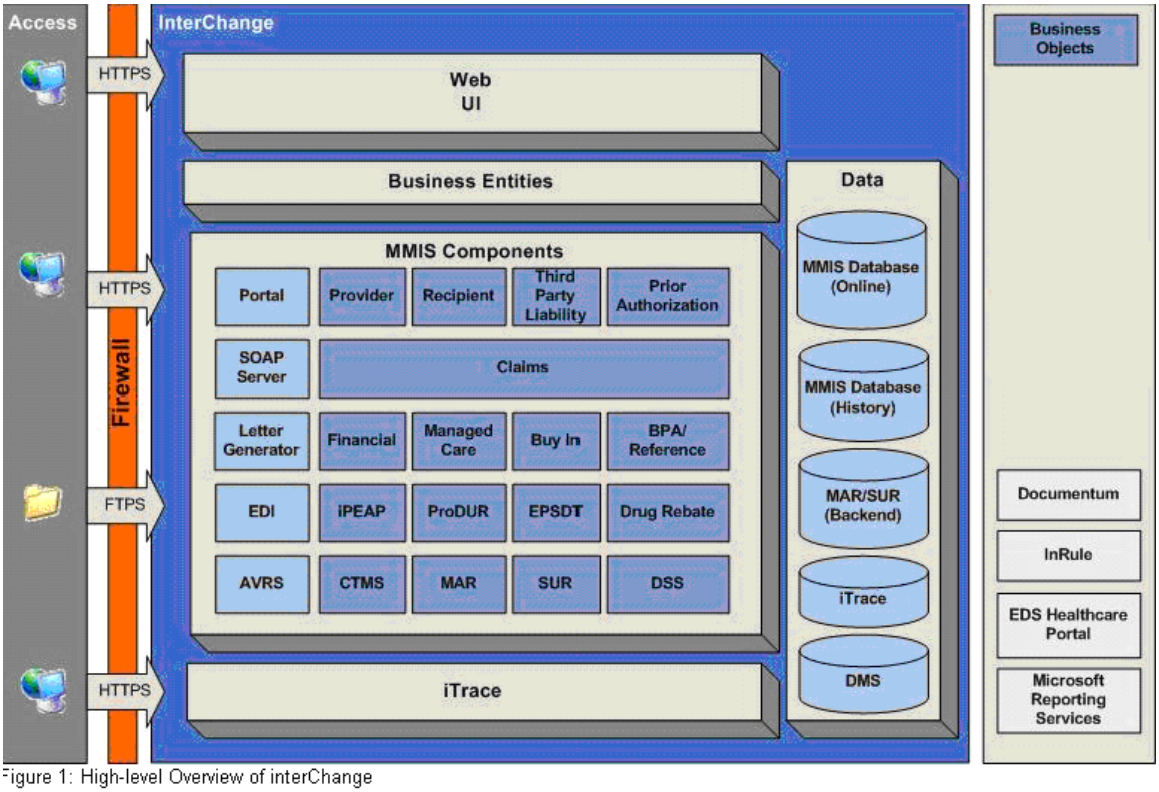


Figure 1: High-level Overview of interChange

As shown in Figure 2, this example figure of AMMIS is a multi-tiered system that provides the flexibility to interact with multiple external entities to load, filter, validate, and manage the data needed to service the stakeholders of the system. AMMIS is composed of a Presentation Layer, Technical Services Layer, Integration Services Layer, Application Layer, and a Data Layer. Each layer has a distinct role offering a scalable and extensible architecture that is sizable to any implementation.

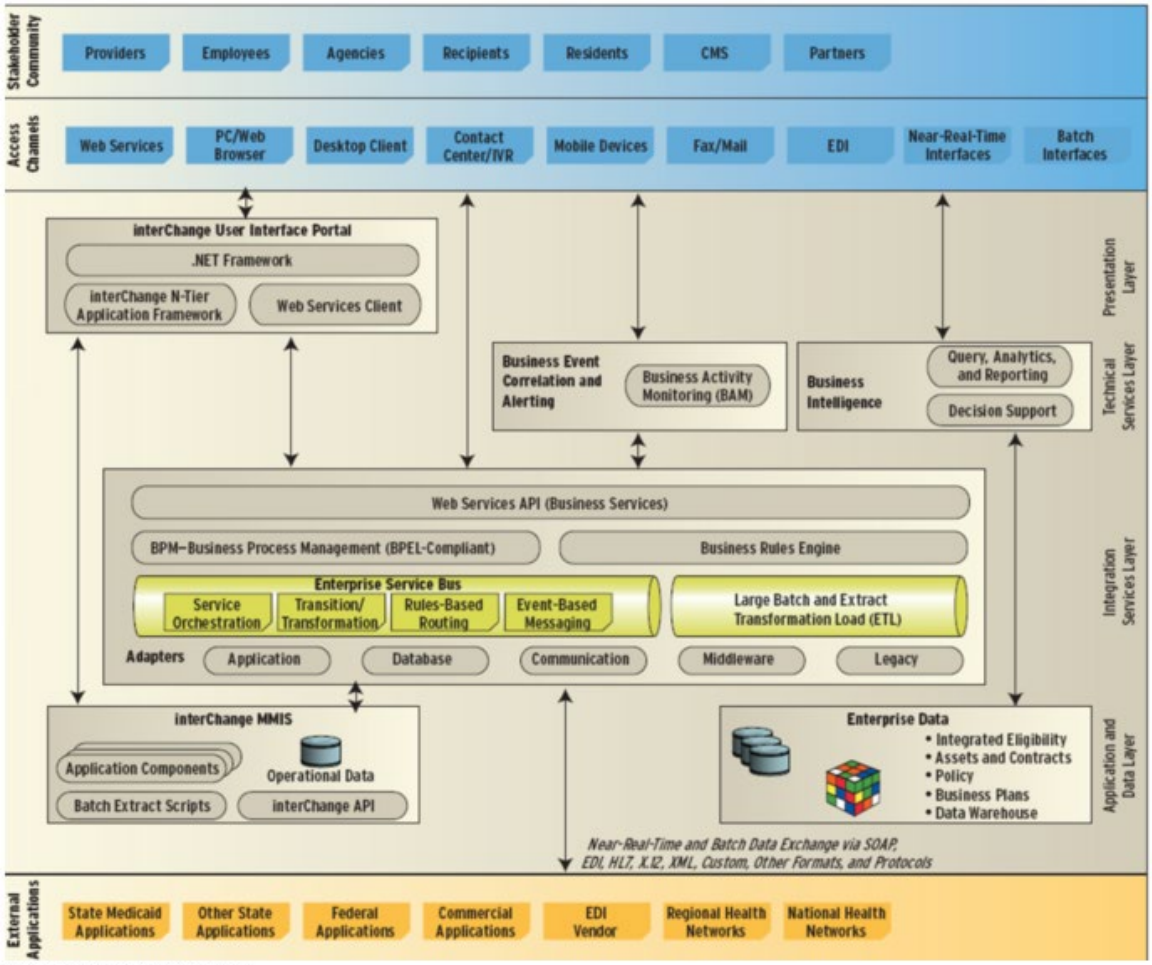
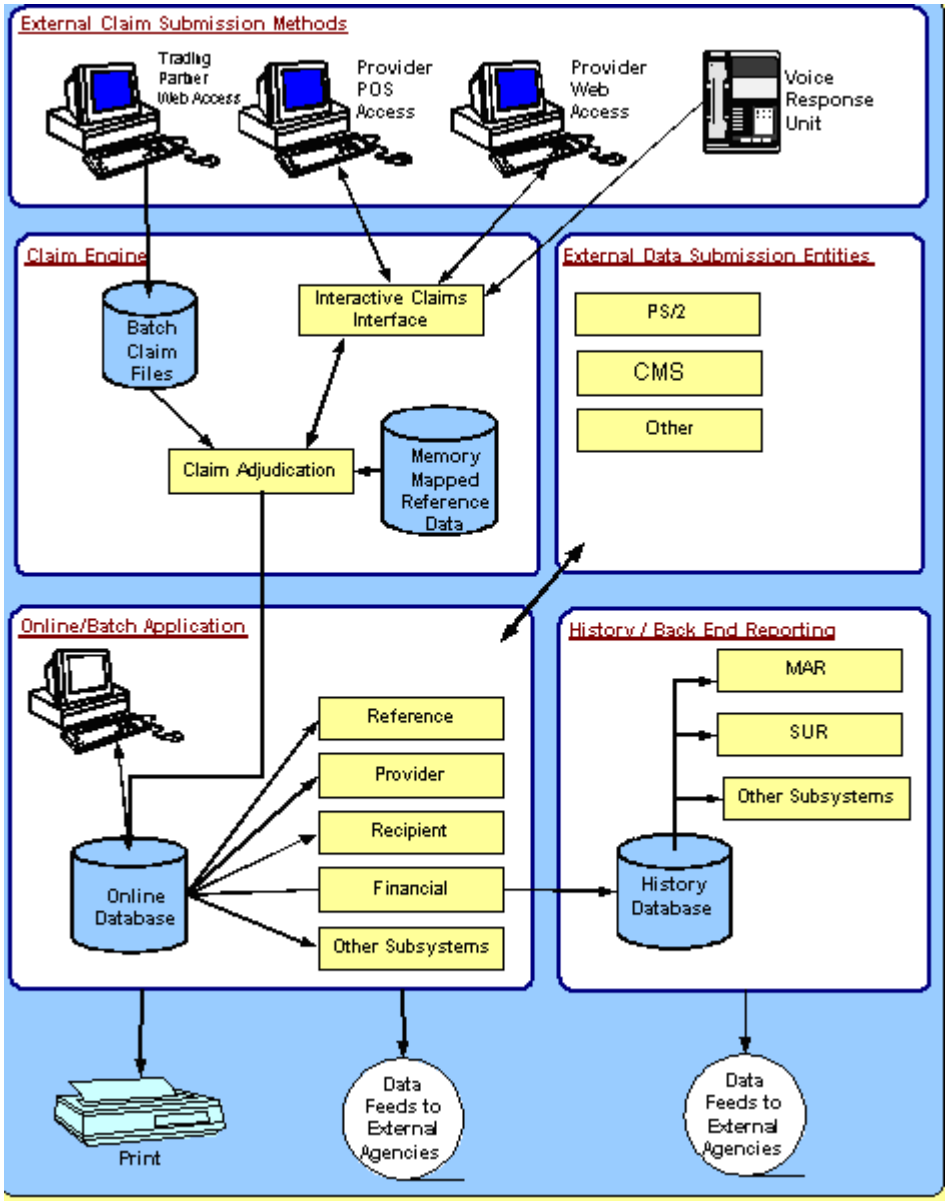


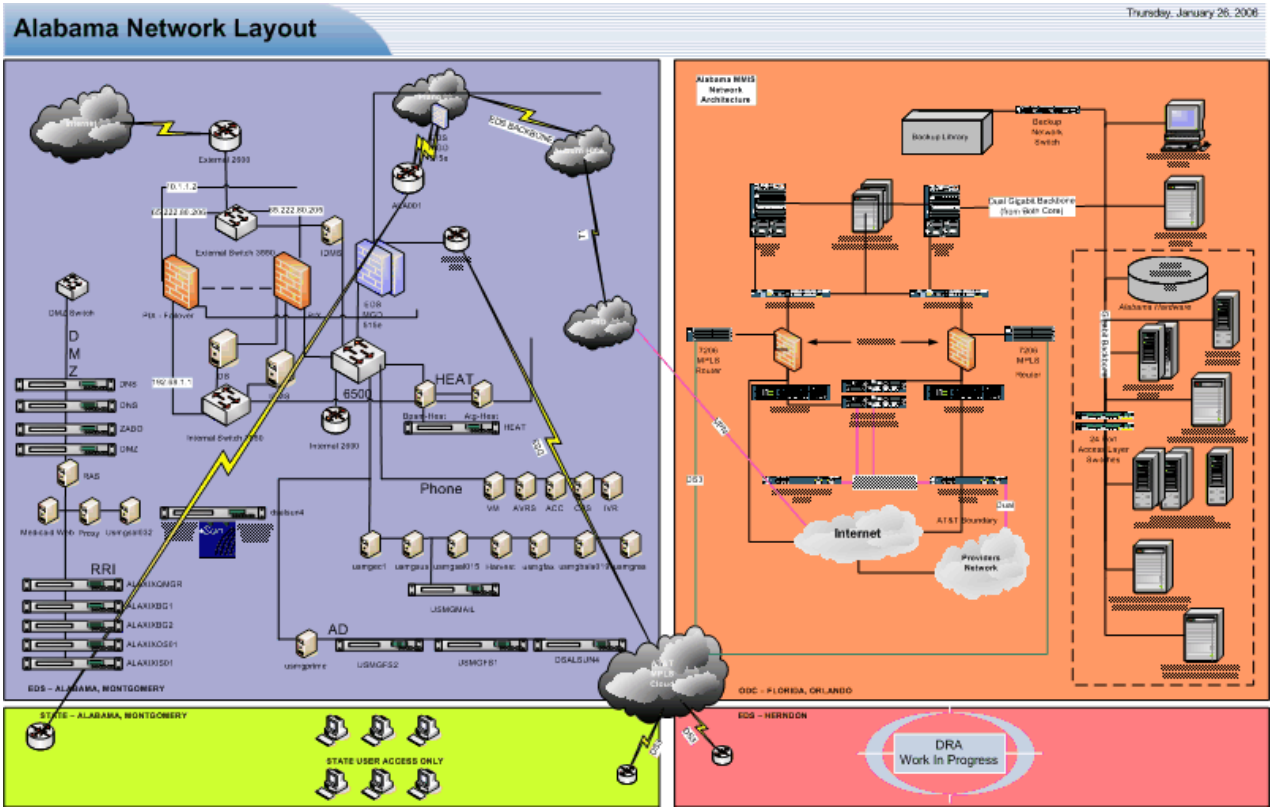
Figure 2: Multi-tiered view

The AMMIS system is logically divided into three primary components.

- The claims engine is responsible for receiving interactive transactions from external sources, adjudicating them, and returning the appropriate response (See Graph Below for an overview of claims submission methods). The online and batch components are responsible for maintaining and reporting on data contained within the online database.
- The history and back end reporting component is responsible for analyzing, reporting, and supporting the management of the activities that have occurred in the two front end systems.
- The external interfaces describe a variety of data sources which influence processing within the system. The external data submission entities are organizations that supply information to the AMMIS. PS/2 is the primary source of recipient eligibility information. CMS, for example, is a federal organization that supplies many different types of data feeds.



The existing legacy Alabama network and topology resides in Montgomery, Plano, and Auburn Hills. The AMMIS network is composed of hardware residing at the DXC account site in Montgomery, AL, and the DXC AMMIS data center in Orlando, FL. The topology is further described in the diagram below



The system supports current and future needs using proven client/server technology, industry-standard hardware, and software, and advanced communication interfaces to the State's systems. Users will become more productive because they have better and faster access to information as well as more flexibility to withdraw program information from the processing data.

A key factor in this system is its foundation on a true relational data model that is specifically designed to support Medicaid program requirements in a Relational Database Management System (RDBMS) environment. Prior to the system's original design, we defined events that are critical business functions of the Medicaid program administration. We then described those events as transactions, identified the entities (organizations or people) involved in the transactions, and the data required for the transactions.

The data model is the map used to build the system. It reinforced the model with the constraints of the database structure, which delivers strict data integrity. This "normalized" design minimizes data redundancy, and its intelligent structure yields strong referential integrity. For example, if business rules dictate that only one CLIA number occurs per provider, the unique properties defined in the database and the logic within the programs do not allow more than one Clinical Laboratory Improvement Amendments (CLIA) number per provider.

Analysis from a business perspective led the system architects to base the system on business processes and organize the data to support them. The initial design of the system, fully defined the data and each data relationship, which was critical to the success of the data model. This emphasis led to the system's data-driven or table-driven design.

For a system as complex as an AMMIS, this method is extremely important, particularly the ability to maintain such integrity over the years despite changing program and system requirements. The assured data integrity enhances the accuracy of historical data studies, fraud and abuse investigations, and program and waiver reporting. Properly designed and implemented, the relational database structure enforces data integrity and identifies anomalies in data for resolution before committing the data to the database.

Alabama Medicaid Agency
Medicaid

Let's get to work!

AMMIS System Wide Reports User Manual

10/06/2009

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

HP Enterprise Services
US Government Solutions
301 Technacenter Drive
Montgomery, Alabama 36117

06 October
2009

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Amendment History

Summary of Change

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CO 7046	1.0	10/06/2009		Initial version

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1. System Wide Reports Review Introduction

1.1 System Wide Reports Review User Manual Overview

The Alabama interChange System has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the System Wide Reports Review functional area.

This manual covers the following:

- System Wide Reports Review Overview
- System Wide Reports System Navigation
- System Wide Reports Review Pages/Panels
- System Wide Reports Review Reports

1.2 System Wide Reports Review User Manual Objective

The objective of the Alabama interChange System Wide Reports Review User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

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2. System Wide Reports Review System Navigation

2.1 Overview

The Alabama interChange System is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within FEITH.

2.2 System Security

System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

2.3 Logging In/Logging Out

Users must successfully log in to the FEITH Document Database in order to utilize the services available.

2.3.1 Logging into FEITH

Follow the steps below to log in to FEITH:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter http://dsalsun4/webfdd/login.jsp ; press **Enter** key on your keyboard.	FEITH Document Database page displays for user to enter User Name and Password.

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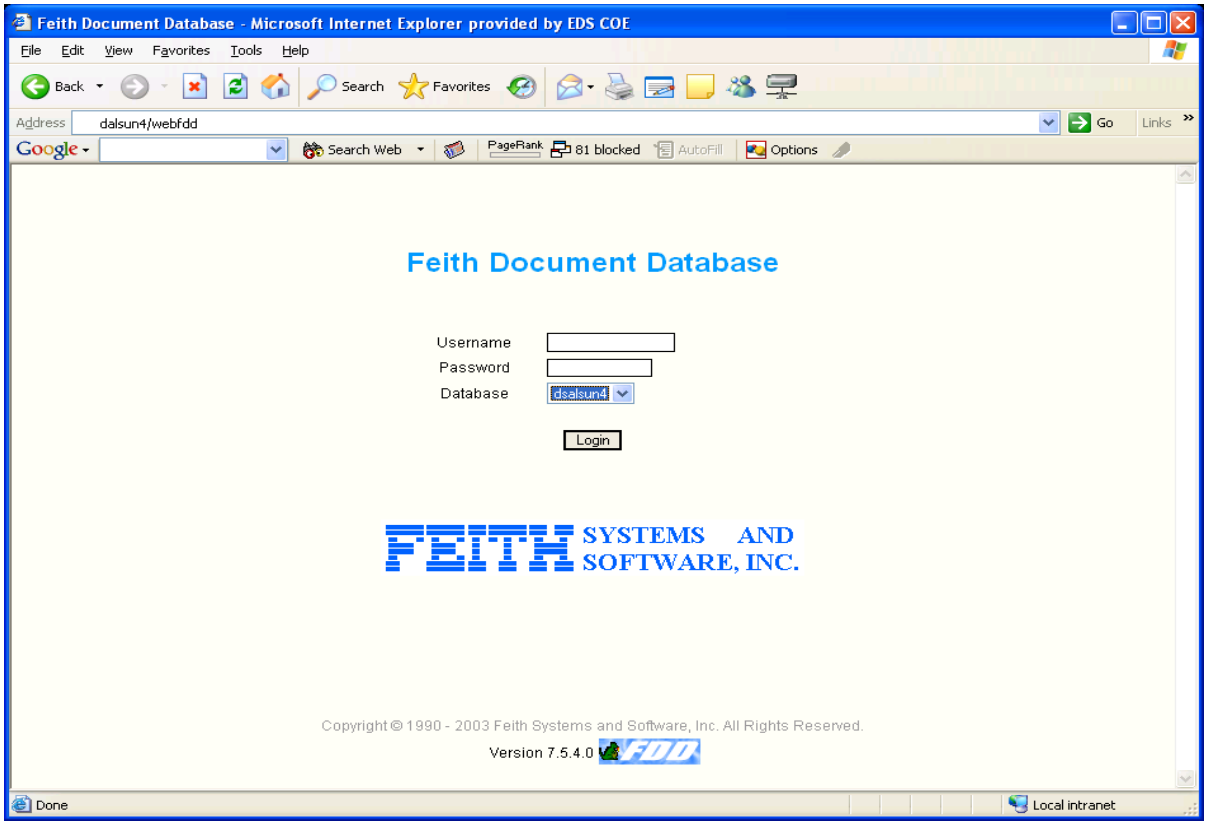

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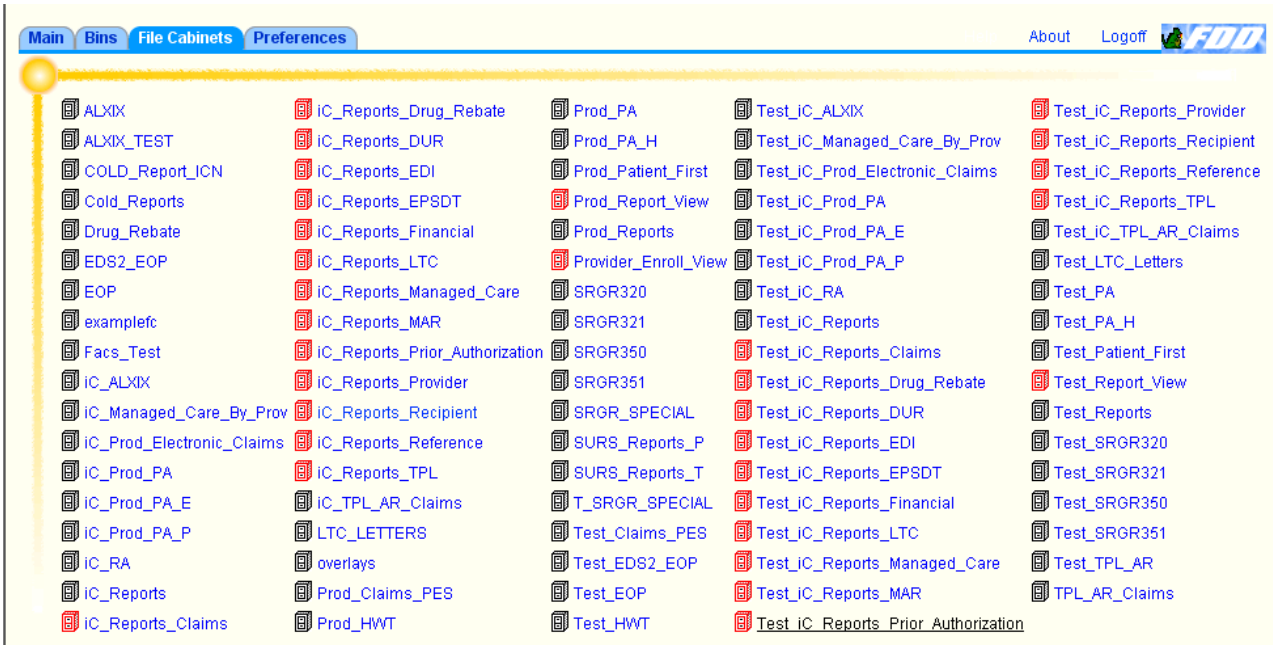
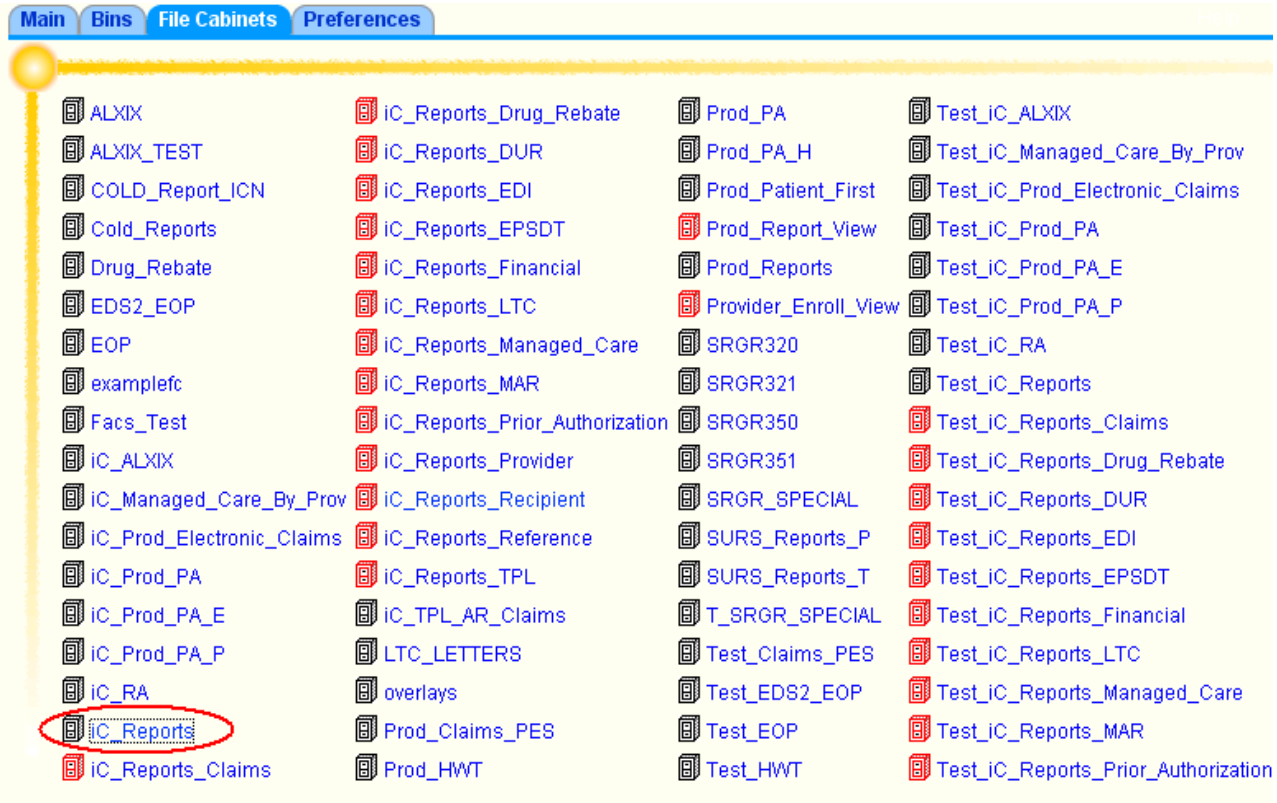
After a successful login, a list of the iC File Cabinets displays:



With the "File Cabinet" tab selected, click the desired file cabinet to search.



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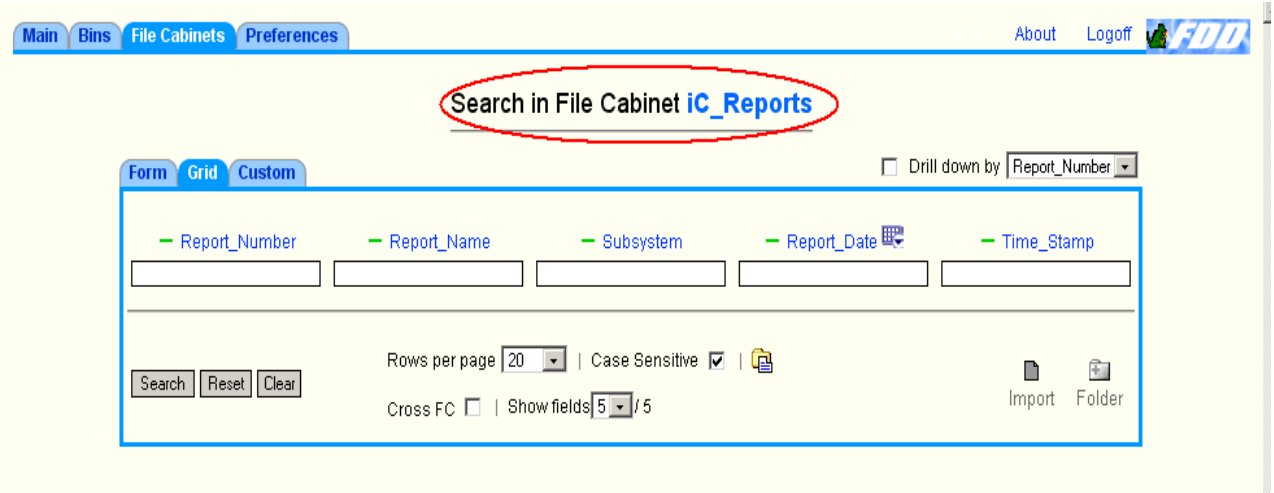
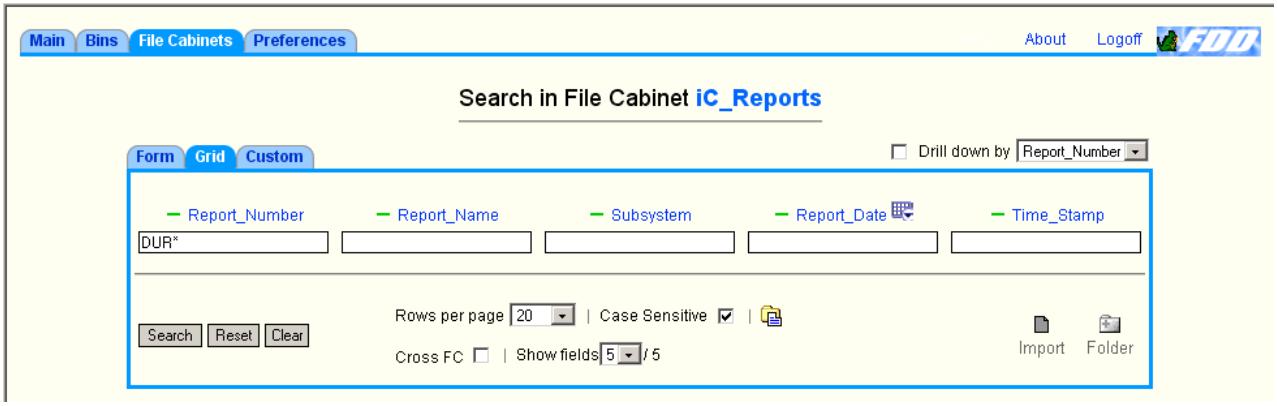
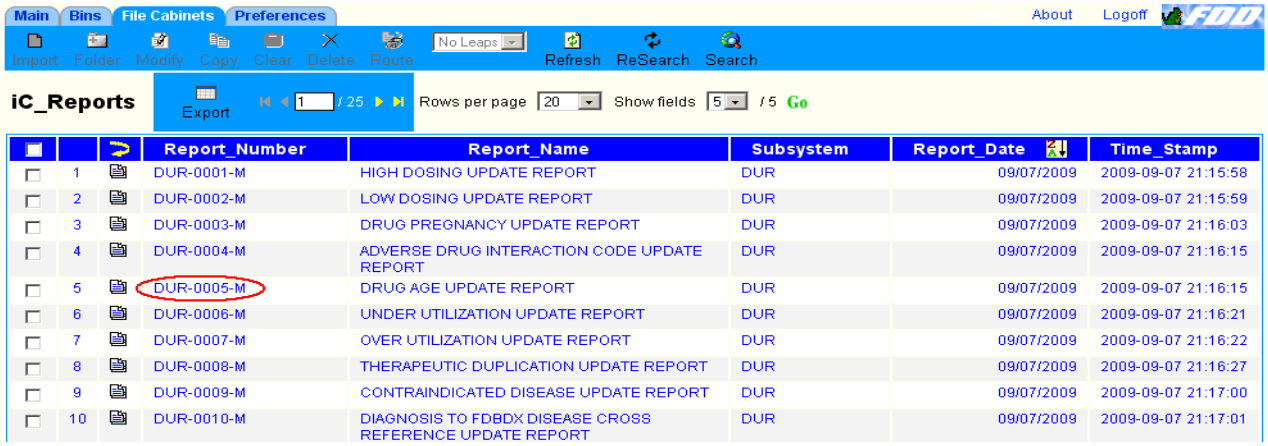
The search screen displays for the file cabinet selected.



Key the Report Number and click SEARCH. If the entire report number is not known, search using the wild-card feature by entering the First 3 characters of the report number followed by an asterisk '*,' then click SEARCH.



Search Results displays. To view the desired report, click the Report Number.



			Report_Number	Report_Name	Subsystem	Report_Date	Time_Stamp
	1		DUR-0001-M	HIGH DOSING UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:15:58
	2		DUR-0002-M	LOW DOSING UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:15:59
	3		DUR-0003-M	DRUG PREGNANCY UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:03
	4		DUR-0004-M	ADVERSE DRUG INTERACTION CODE UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:15
	5		DUR-0005-M	DRUG AGE UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:15
	6		DUR-0006-M	UNDER UTILIZATION UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:21
	7		DUR-0007-M	OVER UTILIZATION UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:22
	8		DUR-0008-M	THERAPEUTIC DUPLICATION UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:16:27
	9		DUR-0009-M	CONTRAINDICATED DISEASE UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:17:00
	10		DUR-0010-M	DIAGNOSIS TO FDBDX DISEASE CROSS REFERENCE UPDATE REPORT	DUR	09/07/2009	2009-09-07 21:17:01

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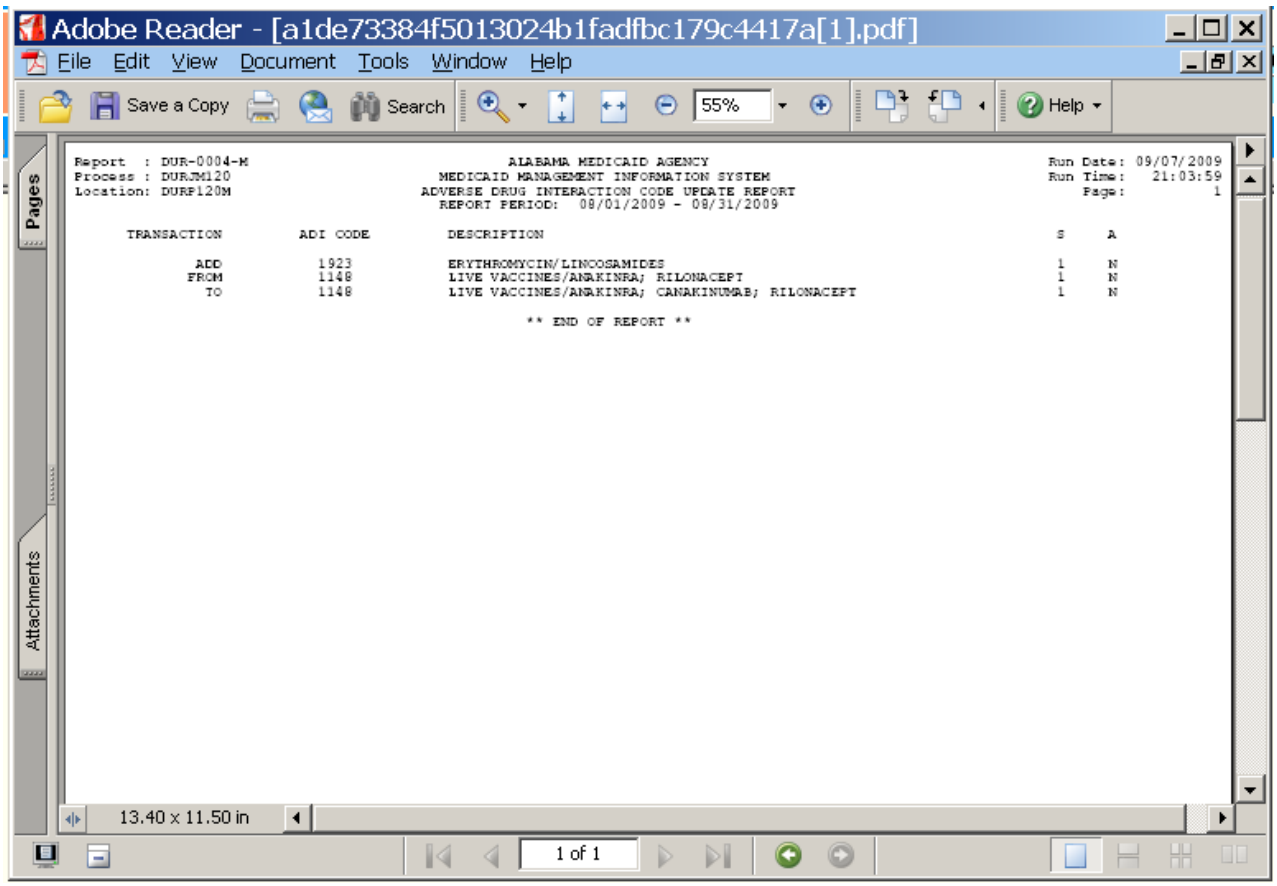
The document will be rendered in a PDF screen which can be saved, printed, magnified, copied/pasted, and rotated as Adobe Acrobat will allow.



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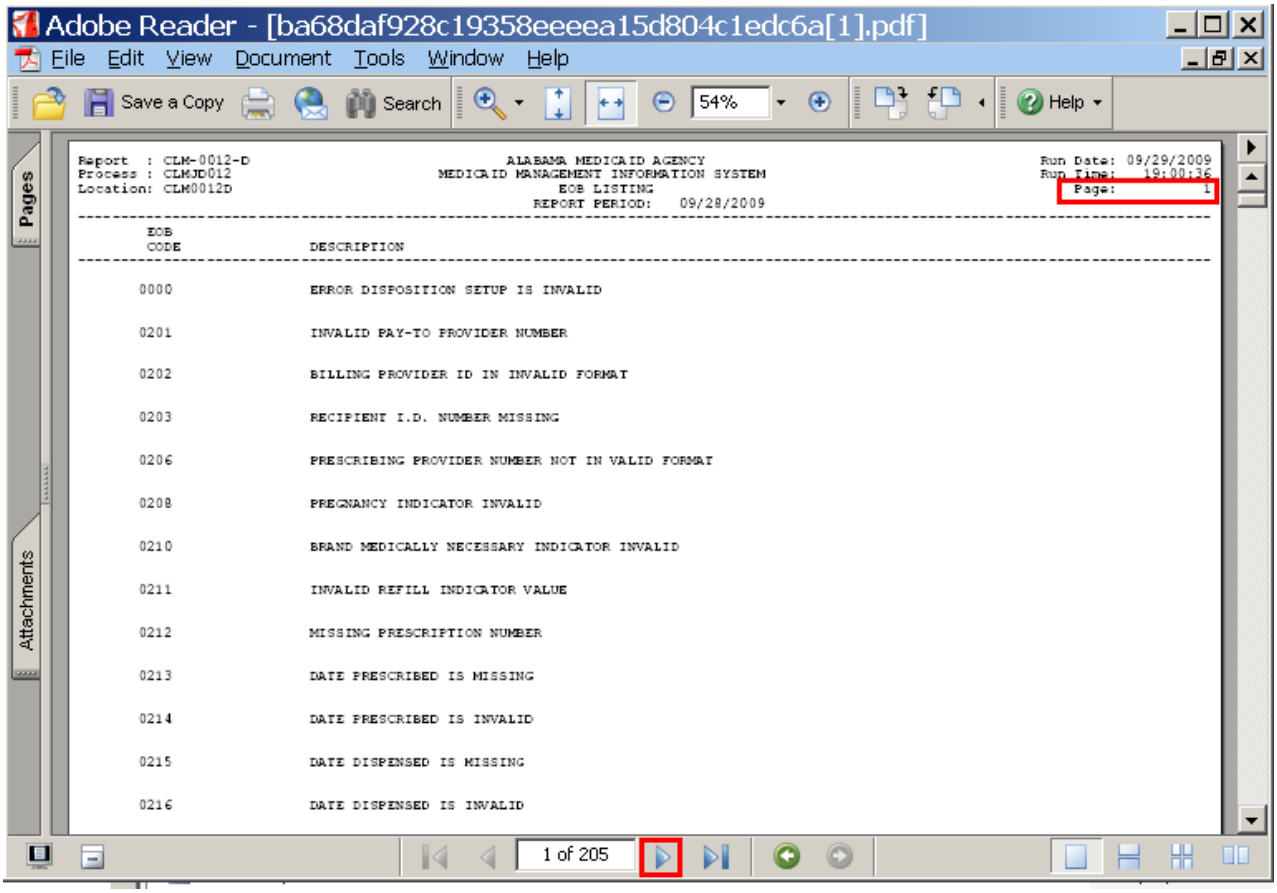
2.3.2 Reports with multiple pages

To view subsequent pages of a report with multiple pages.

On page 1, click the right arrow.



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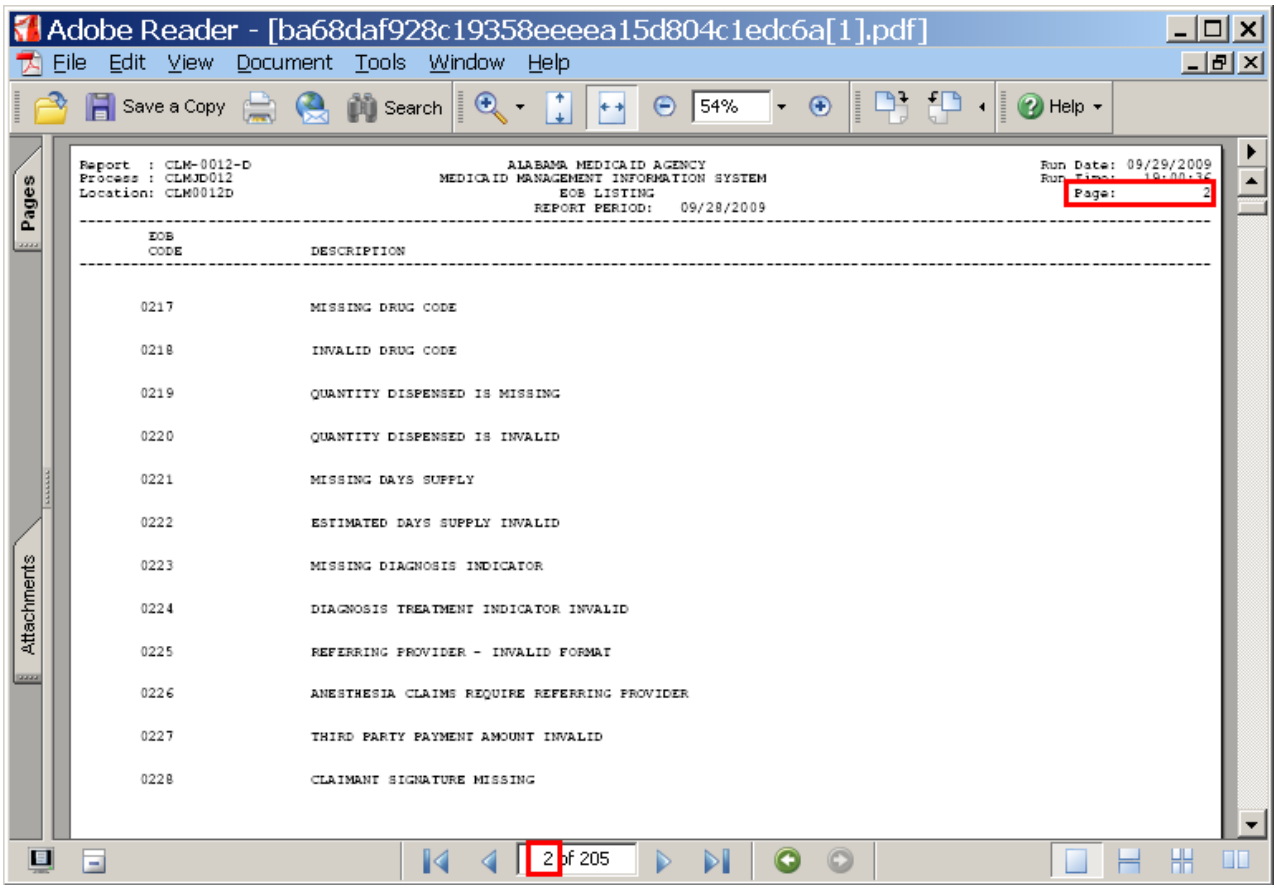
Page 2 Displays:



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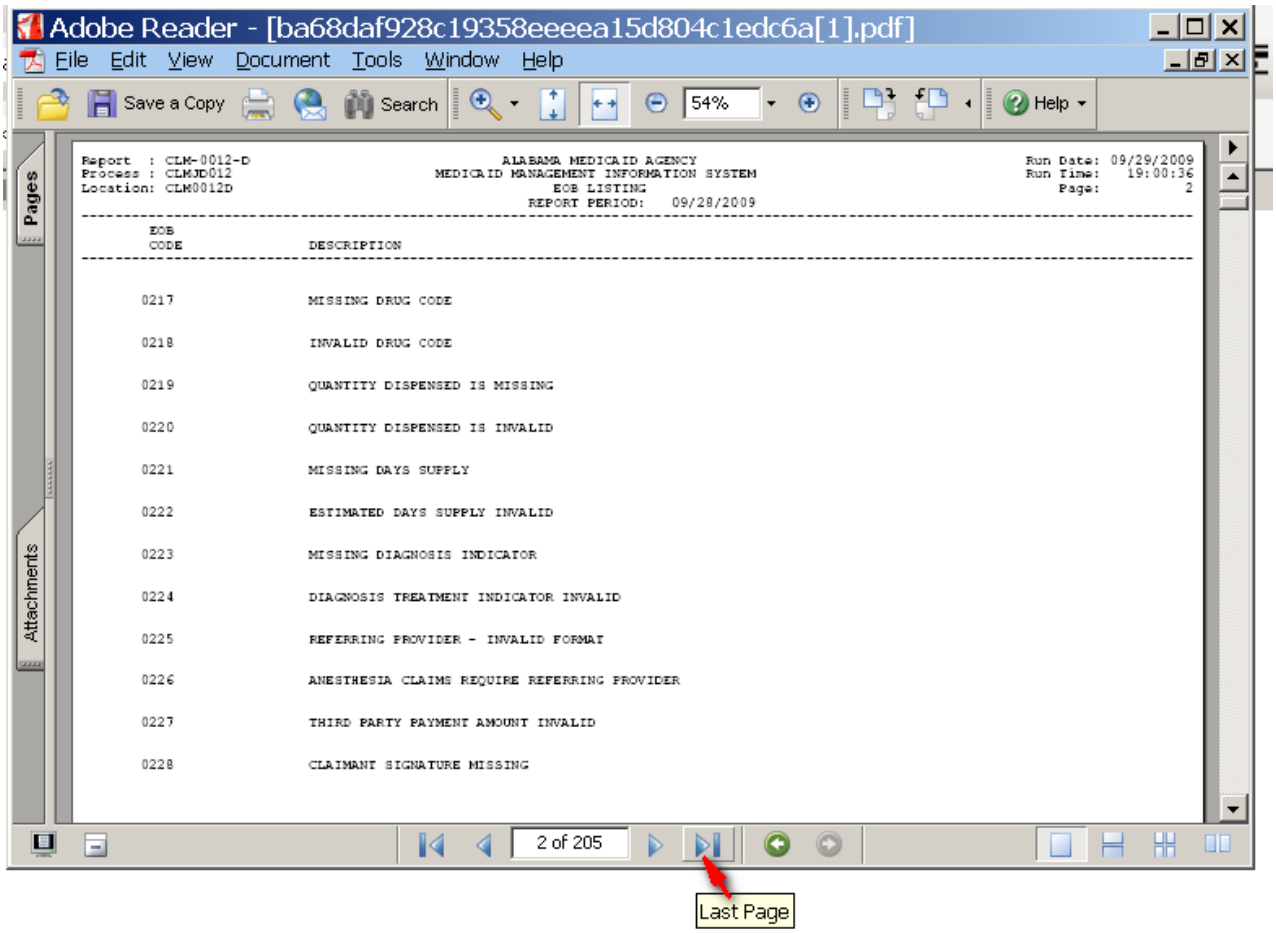
Click the LAST PAGE indicator and the last page displays.



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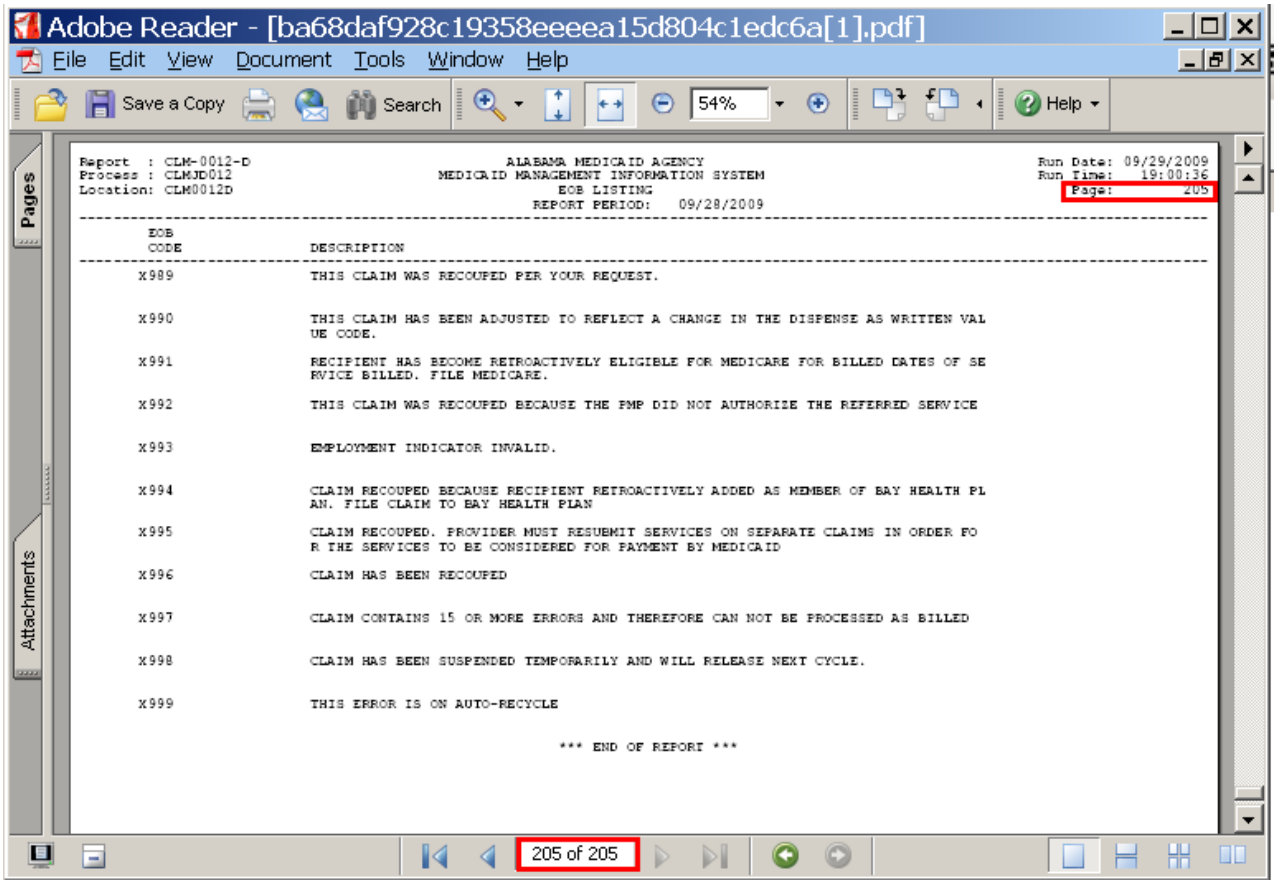
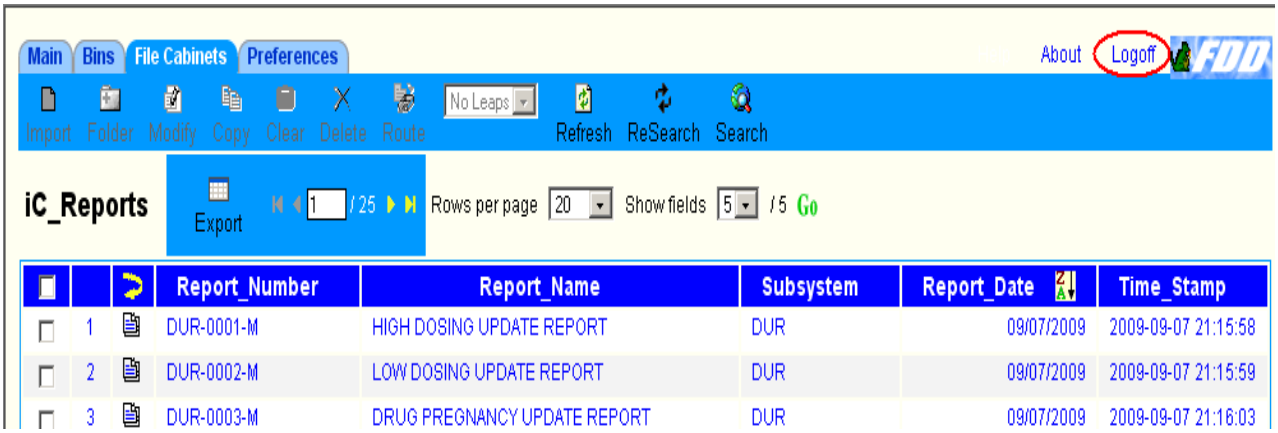


NOTE: Click the arrows on the left to reverse the process.

2.3.3 Logging out of FEITH

Click the LOGOFF button in the upper right corner of the FEITH page to exit FEITH.



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3. System Wide Reports

The System Wide Reports User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality, frequency, and usage.

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information.

Field Descriptions: Lists the fields included on the report, with a definition of each field.

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3.1 SYS-0500-D -- Report Verification Error Listing Report

3.1.1 SYS-0500-D – Report Verification Error Listing Report Narrative

This is report will be generated daily-7 days a week, and will list any reports that were unable to be verified as having been delivered to FEITH. It will also list reports that were sent to be printed and to be emailed. This is an internal report to be used by members of the Operations team, to verify report delivery.

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3.1.2 SYS-0500-D – Report Verification Error Listing Report Layout

This section presents the detail of the report.

```
Report  : SYS0500D                              ALABAMA MEDICAID AGENCY                                    Run Date: 09/17/2009
Process : SYSJDRPTVERIFY                 MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   08:24:42
Location: SYSPDRPTVERIFY                   Report Verification - Error Listing                               Page:          1
                                               REPORT PERIOD:  09/17/2009
-------------------------------------------------------------------------------------------------------------------------------

 REPORT NAME(ID)       MEDIA CODE    ERROR DESCRIPTION
-------------------------------------------------------------------------------
LTC-0008-M                E          Report sent for email.
PAU-9999-A_102            C          Report did not match to any in feith.
PAU-9999-A_103            C          Report did not match to any in feith.
LTC-0008-M                E          Report sent for email.
REF-0530-1D               C          Report did not match to any in feith.
```


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3.1.3 SYS-0500-D – Report Verification Error Listing Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the report.

Field	Description	Length	Data Type
Error Description	The message in this field indicates if a report in the listing did not match/verify to a report in FEITH, or that the report was sent to e-mail or to the printer.	50	Character
Media Code	The code in this field indicates the medium used to deliver or store the report. Valid values are: C (COLD/FEITH), E (E-mail), or P (Printer).	1	Character
Report Name/ID	This field contains the Report Name, aka alt_out. In order to show what the name of the report was, as it is listed in the report route table.	30	Character

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3.2 SYS-0501-D -- Report Verification - Confirmation Listing

3.2.1 SYS-0501-D – Report Verification – Confirmation Listing Report Narrative

This report will be generated daily-7 days a week, and will list any reports that were verified for delivery to FEITH. This is intended to be an internal report viewed only by the Operations team, to verify report delivery.

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3.2.2 SYS-0501-D – Report Verification – Confirmation Listing Report Layout

This section presents the detail of the report.

```
Report  : SYS0501D                          ALABAMA MEDICAID AGENCY                          Run Date: 09/17/2009
Process : SYSJDRPTVERIFY              MEDICAID MANAGEMENT INFORMATION SYSTEM                 Run Time:   08:24:42
Location: SYSPDRPTVERIFY            Report Verification - Confirmation Listing                   Page:          1
                                          REPORT PERIOD:  09/17/2009
-------------------------------------------------------------------------------------------------------------------

 REPORT NAME(ID)       MEDIA CODE   ACTIVITY DESCRIPTION
-------------------------------------------------------------------------------
CLM-3400-D                 C          Report matches to a report in feith.
PRV-0010-R                 C          Report matches to a report in feith.
PRV-0011-R                 C          Report matches to a report in feith.
PRV-0300-D                 C          Report matches to a report in feith.
PRV-A050-D                 C          Report matches to a report in feith.
RBT-3002-D                 C          Report matches to a report in feith.
RBT-3004-D                 C          Report matches to a report in feith.
LTC-0005-M                 C          Report matches to a report in feith.
LTC-0006-M                 C          Report matches to a report in feith.
LTC-0008-M                 C          Report matches to a report in feith.
PAU-0002-D                 C          Report matches to a report in feith.
PAU-002A-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
LTC-0005-M                 C          Report matches to a report in feith.
LTC-0006-M                 C          Report matches to a report in feith.
LTC-0008-M                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0054-D                 C          Report matches to a report in feith.
CLM-0010-D                 C          Report matches to a report in feith.
CLM-0025-D                 C          Report matches to a report in feith.
CLM-0026-D                 C          Report matches to a report in feith.
```


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3.2.3 SYS-0501-D – Report Verification – Confirmation Listing Report Field Descriptions

This section describes, in detail, the characteristics, and fields of the report.

Field	Description	Length	Data Type
Activity Description	The message in this field indicates if the report was verified against a match in FEITH.	50	Character
Media Code	The code in this field indicates the medium used to deliver or store the report. Valid values are: C (COLD/FEITH), E (E-mail), or P (Printer).	1	Character
Report Name/ID	This field contains the Report Name, aka alt_out. In order to show what the name of the report was, as it is listed in the report route table.	30	Character

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AMMIS TPL User Manual (Part II)

Date Modified: 07/13/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

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301 Technacenter Drive
Montgomery, Alabama 36117

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6. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

6.1 Document Information Page

Required Information	Definition
Document Title	AMMIS TPL User Manual – Part II
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Author:	TPL Team
Approved by:	
Approval Date:	12/12/2011 (HIPAA 5010 #4)

6.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
11/16/2011	1.1		Application of 5010 EIP Updates	CO 9008 Claims Acknowledgement reports were created for the Agency to track and review the claims submitted by TPL. Reports added include: 7.15: TPL-015R-D – 277CA Claims Acknowledgement Rejected Status Report 7.16: TPL-015S-D – 277CA Claims Acknowledgement Summary Report CO 8910 Expanded Prescription number field from 7 to 12 digits 7.27 - TPL-0026-R -- Pharmacy Billing Facsimile Report (7.27.2 and 7.27.3) CO 9445 Increased the claim number from 14 characters up to the maximum HIPAA length of 30

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				7.78 - TPL-A076-R -- TPL Credit Balance Report 7.79 - TPL-A077-R -- TPL Payments Received Not Posted Report 7.80 - TPL-A078-R -- TPL Denials Posted - Needs Research Report 7.81 - TPL-A079-R -- TPL Denials with Invalid AR Number - Not Posted Report 7.82 - TPL-A080-R -- TPL AR Payments Posted Report 7.83 - TPL-A081-R -- TPL Denials Posted Report CO 8497: Added TPL-0046-M - NCPDP Subrogation Response – Detail report CO 8498: Added TPL-0047-M: NCPDP Subrogation Response - Summary
12/12/2011	2.0		Agency approved	
10/08/2013	3.0		Application of ICD-10 project change orders	CO 10093: Update the following reports (layout and field descriptions). Section 7.6 TPL Accident Trauma Report Section 7.45 Questionnaires with No Response by Recip Report Section 7.46: Questionnaires with no Response by County Report Section 7.70 TPL Trauma Detail Claims Listing Report Section 7.30 TPL Case Tracking Report
04/16/2014	4.0		Application of CO 11711	Addition of the following reports: 7.99 TPL-A328-R -- Third Party Contractor Active Records Add Prod 7.100 TPL-A328-T -- Third Party Contractor Active Records Add Pre-Prod Report - Tricare

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Records uction Report - Tricare Records 7.101 TPL-A329-R -- Third Party Contractor Inactive Records Add Production Report - Tricare Records 7.102 TPL-A329-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Tricare Records
05/16/2014	5.0		Application of CO 11412	Additon of the following reports: 7.98 TPL-A100-R -- Third Party Contractor Active Records Add Production Report - Update Records - (Non Payable/Payable) 7.99 TPL-A100-T -- Third Party Contractor Active Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) 7.100 TPL-A101-R -- Third Party Contractor Inactive Records Add Production Report - Update Records - (Non Payable/Payable) 7.101 TPL-A101-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Update Records - (Non Payable/Payable)
09/10/2014	6.0		Application of CO 11933	Added 7.54. TPL-0321-M -- HMS MONTHLY AR AGING REPORT
1008/2014	7.0		Application of CO 11865	Updated 7.27 TPL—0026-R Pharmacy Billing Facsimile Report
1/7/2015	8.0		Application of CO 12298 and 11337	CO 12298 Addition of TPL-A098-W -- Third Party Contractor Hipp Records Add PreProd-Production Report CO 11337 Addition of TPL-A102-R -- Third Party Contractor Active Records Add Production Report – HMS Quarterly Records Report and TPL-A102-T -- Third Party Contractor Active Records Add

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Pre-Prod Report - HMS Quarterly Records Report CO 12292 Addition of TPL-0540-W -- HMS Estate Cases Summary Report and TPL-0541-W -- HMS Estate Cases Error Summary Report
7/21/2015	9.0		Application of ACA III Production Change Orders	**CO 12191** Update TPL-A077-R -- TPL Payments Received Not Posted Report and TPL-A079-R -- TPL Denials with Invalid AR Number - Not Posted Report **CO 12192** Update TPL-A076-R -- TPL Credit Balance Report, TPL-A078-R -- TPL Denials Posted - Needs Research Report and TPL-A080-R -- TPL AR Payments Posted Report and TPL-A081-R -- TPL Denials Posted Report **CO 12668** Update TPL-A075-R -- TPL Electronic Remittance Summary Report
09/27/2016	10.		Application of RCO COs	CO 13196 Include information about RCOs added to existing TPL report detailed in the TPL User Manual (Part II, Section 7). Section 7.17 - TPL-0016-M - TPL Cost Avoidance Report CO 13197 Include information about adding separate line items for the encounter recovery amounts to be displayed on existing TPL report detailed in the TPL User Manual (Part II, Section 7). Section 7.47 - TPL-0101-M -- TPL Monthly Recoveries Report CO 13194

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Include information about new TPL reports detailed in the TPL User Manual (Part II, Section 7). Section 7.69 - TPL-A036-M - TPL Medicare Claims Adjustment Report (new) Section 7.70 - TPL-A037-M - TPL Actual Medicare Claims Adjustment Report (new) - defect 13680 to add Footnote to bottom of page.
10/06/2016	11.0		Application of CO 11273	Added the following new reports to manual: 7.118 TPL-Q011-P -- Southland Policy Add/Update Report 7.119 TPL-Q011-T -- Southland Policy Add/Update Pre Prod Report 7.120 TPL-Q012-P -- Southland Not Identified - Needs Research Report 7.121 TPL-Q012-T -- Southland Not Identified - Needs Research Pre Prod Report 7.122 TPL-Q013-P -- Southland Recipient Not Found Report 7.123 TPL-Q013-T -- Southland Recipient Not Found Pre Prod Report
12/07/2016	12.0		Application of CO 13460	Added the following new reports: 7.13 - TPL-0013-P -- BCBS Policy HIPP Update Report 7.14 - TPL-0013-T -- BCBS Policy HIPP Update Report-Pre-production Report 7.111 Third Party Contractor Active Add – HIPP Update Records Report 7.112 - TPL-A104-T -- Third Party Contractor Active Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) 7.113 - Third Party Contractor Inactive Records Add Production

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Report - HIPP Update Records - (Non Payable/Payable 7.114 - TPL-A105-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable)
03/14/2017	13.0		Application of CO 14003	CO 14003 – Updated layouts and field descriptions on the followig reports: 7.98 TPL-A098-R 7.99 TPL-A098-T 7.101 TPL-A099-R 7.102 TPL A099-T 7.124 TPL-P098-E 7.125 TPL-P099-E 7.132 TPL-T098-E 7.133 TPL-T099-E
04/14/2017	14.0		Application of CO 11728. Update cover page and footers with DXC Logo and copyright informaton.	CO 11728 – 7.37 HMT-RADA-D – Dental Billing Facsimile report
11/17/2017	15.0		Application of CO 12486	Added 4 new reports: 7.60 – TPL-0401-M TPL Refund Invoice List – BCB Report 7.61 – TPL-0402-M TPL Refund Invoice Errors – BCBS Report 7.62 – TPL-0403-M TPL Refund Invoice List – HMS Report 7.63 – TPL-0404-M – TPL Refund Invoice Errors – HMS Report
01/16/2018	16.0		Application of CO 14530	7.31 Case Tracking – Certification of Authentication Report – update report layout and field descriptions 7.32 TPL Case Tracking Report - update report layout and field descriptions
07/13/2018	17.0		Conversion of manual from HPE to DXC.	General Updates

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6.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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7. TPL Reports

The TPL User Manual provides the following information for each report:

Narrative: Provides a brief description of the report functionality and usage

Layout: Provides a representation of the report and details the exact placement and format of the field names, values and heading information

Field Descriptions: Lists the fields included on the report, with a definition of each field

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7.1 TPL-0001-R -- DEERS Match - 271 Transaction Report

7.1.1 TPL-0001-R -- DEERS Match - 271 Transaction Report Narrative

Centers for Medicare and Medicaid Services (CMS) requires the TPL Unit to perform the Defense Enrollment Eligibility Reporting System (DEERS) Data Match which is an annual match of military personnel with dependents enrolled in Medicaid, and who therefore have potential eligibility for TriCare benefits. The match is performed based upon the common data elements of Sponsor Social Security Number, Sponsor name, Dependent name, Dependent Social Security Number, and Dependent Date of Birth. This match is scheduled each year by DEERS and is produced upon request.

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7.1.2 TPL-0001-R -- DEERS Match - 271 Transaction Report Layout

```
REPORT  : TPL-0001-R                        ALABAMA MEDICAID AGENCY                                          RUN DATE:  MM/DD/CCYY
PROCESS : TPLJO001                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                   RUN TIME:  HH:MM:SS
LOCATION: TPL0001O                    DEERS MATCH - 271 TRANSACTION REPORT                                        PAGE:  999,999
                                            REPORT PERIOD:  MM/DD/CCYY

REC                                                          SERVICE         GENDER REL
TYPE    SSN             NAME                                START-END        CODE   CODE     DATE OF BIRTH   IND
 X      XXX-XX-XXXX     XXXXXXXX, XXXXXXX               CCYY/MM/DD - CCYY/MM/DD  X     X        CCYY/MM/DD     X
 X      XXX-XX-XXXX     XXXXXXXX, XXXXXXX               CCYY/MM/DD - CCYY/MM/DD  X     X        CCYY/MM/DD     X
 X      XXX-XX-XXXX     XXXXXXXX, XXXXXXX               CCYY/MM/DD - CCYY/MM/DD  X     X        CCYY/MM/DD     X
 X      XXX-XX-XXXX     XXXXXXXX, XXXXXXX               CCYY/MM/DD - CCYY/MM/DD  X     X        CCYY/MM/DD     X
 X      XXX-XX-XXXX     XXXXXXXX, XXXXXXX               CCYY/MM/DD - CCYY/MM/DD  X     X        CCYY/MM/DD     X


                                                      *** END OF REPORT ***
                                                    *** NO DATA THIS RUN ***
```

7.1.3 TPL-0001-R -- DEERS Match - 271 Transaction Report Field Descriptions

Field	Description	Length	Data Type
Date of Birth	The date of birth of the sponsor or dependent.	10	Date (CCYY/MM/DD)
Gender Code	The gender code of the sponsor or dependent.	1	Character
Ind	The action indicator from the DEERS data match process. 'A' = Record inserted; 'U' = Record updated.	1	Character
Name	The name of the sponsor or dependent.	30	Character
Rec Type	Indicates (S)ponsor or (D)ependent record type.	1	Character
Rel Code	The relationship of the sponsor to the dependent.	1	Character
Service Start-End Date	The DEERS eligibility start and end dates.	21	Date (CCYY/MM/DD)
SSN	The Social Security Number of the sponsor or the dependent.	11	Character

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7.2 TPL-0002-R -- DEERS No Match - 271 Transaction Report

7.2.1 TPL-0002-R--DEERS No Match - 271 Transaction Report Narrative

CMS requires the TPL Unit to perform the DEERs No Match which is an annual match of the military personnel with dependents enrolled in Medicaid. The report lists all the coverage records that did not have an active coverage in the DEERS system. The no match logic evaluates the sponsCoverageIndicator to identify if the coverage is not active (value of 6 or V) for the sponsors sent in the 271 XML file.

7.2.2 TPL-0002-R--DEERS No Match - 271 Transaction Report Layout

```
REPORT  : TPL-0002-R                        ALABAMA MEDICAID AGENCY                                          RUN DATE:  MM/DD/CCYY
PROCESS : TPLJO001                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                  RUN TIME:  HH:MM:SS
LOCATION: TPL0001O                              DEERS NO MATCH                                                     PAGE:  999,999
                                                  YEAR CCYY

REC
TYPE   SSN             NAME                           DESCRIPTIOM

X      XXX-XX-XXXX     XXXXX, XXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X      XXX-XX-XXXX     XXXXXXXX, XXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X      XXX-XX-XXXX     XXXXXXXX, XXXXXX               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

X      XXX-XX-XXXX     XXXXXX, XXXXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
X      XXX-XX-XXXX     XXXXXX, XXXXX                  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          *** END OF REPORT ***

                                        *** NO DATA THIS RUN ***
```


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7.2.3 TPL-0002-R--DEERS No Match - 271 Transaction Report Field Descriptions

Field	Description
Description	Describe the reason why is not inactive.
Name	The name of the sponsor or dependent.
Rec. Type	Indicates (S)ponsor or (D)ependent record type
SSN	The Social Security Number of the sponsor or the dependent.

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7.3 TPL-0003-M -- TPL Monthly Casualty Composite Report

7.3.1 TPL-0003-M -- TPL Monthly Casualty Composite Report Narrative

The Monthly Casualty Composite Report contains statistics on the number of cases in an open, closed, no further pursuit, lead review, and intake status for the current date and year-to-date. This report is created in TPLJM009 and is produced monthly.

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7.3.2 TPL-0003-M -- TPL Monthly Casualty Composite Report Layout

```
REPORT  : TPL-0003-M                    ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJM009              MEDICAID MANANGEMENT INFORMATION SYSTEM                    RUN TIME:
HH:MM:SS
LOCATION: TPLC0170                TPL MONTHLY CASUALTY COMPOSITE REPORT                         PAGE: 999,999
                                      REPORT PERIOD: MM/DD/CCYY

INTAKES    Y-T-D         LEAD REVIEWS  Y-T-D     OPEN    Y-T-D        CLOSED  Y-T-D          NFP      Y-T-D

99999    999999999       99999       999999999   99999   999999999     99999   999999999     99999   99999999
I TO L    99999       999999999    L TO L   99999      999999999
I TO O    99999       999999999    L TO O   99999      999999999
I TO N    99999       999999999    L TO N   99999      999999999

                                          ***  END OF REPORT ****
                                         ***  NO DATA THIS RUN ***
```

7.3.3 TPL-0003-M -- TPL Monthly Casualty Composite Report Field Descriptions

Field	Description	Length	Data Type
Closed	Number of cases closed.	5	Character
I to L	Number of intakes to lead status.	5	Character
I to N	Number of intakes to no further pursuit.	5	Character
I to O	Number of intakes to open.	5	Character
Intakes	Number of Intakes for the time period.	5	Character
L to L	Number of leads to leads.	5	Character
L to N	Number of leads to no further pursuit.	5	Character
L to O	Number of leads to open.	5	Character
Lead Reviews	Number of reviews.	5	Character
NFP	Number of case deemed 'no further pursuit'.	5	Character
Open	Number of cases in open status.	5	Character
Report Period	Report begin date.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
YTD Closed	Number of case closed year to date.	9	Character
YTD I to L	Number of intakes to lead status year to date.	9	Character
YTD I to N	Number of intakes to no further pursuit year to date.	9	Character
YTD I to O	Number of intakes to open year to date.	9	Character
YTD Intakes	Number of Intakes year to date.	9	Character
YTD L to L	Number of leads to leads year to date.	9	Character
YTD L to N	Number of leads to no further pursuit year to date.	9	Character
YTD L to O	Number of leads to open year to date.	9	Character
YTD NFP	Number of case deemed 'no further pursuit' year to date.	9	Character
YTD Open	Number of cases in open status year to date.	9	Character
YTD Reviews	Number of reviews year to date.	9	Character

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7.4 TPL-0004-M -- TPL Case Activity Summary Report

7.4.1 TPL-0004-M -- TPL Case Activity Summary Report Narrative

The TPL Case Activity Summary report provides a summary of the number of casualty cases that have been reviewed, opened, or closed and the dollar amount collected for the reporting period. This report is produced monthly.

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7.4.2 TPL-0004-M -- TPL Case Activity Summary Report Layout

```
REPORT  : TPL-0004-M                    ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJM009                MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN TIME: HH:MM:SS
LOCATION: TPLC0180                  TPL CASE ACTIVITY SUMMARY REPORT                            PAGE: 999,999
                                        REPORT PERIOD: MM/DD/CCYY
 ANALYST: XXXXXXXX

   TOTAL INTAKE   TOTAL LEAD REVIEW   TOTAL OPEN CASE   TOTAL CLOSED CASE   TOTAL NFP   TOTAL COLLECTION
      99999            99999              99999             99999             99999       $99,999,999.99


 ANALYST: XXXXXXXX

   TOTAL INTAKE   TOTAL LEAD REVIEW   TOTAL OPEN CASE   TOTAL CLOSED CASE   TOTAL NFP   TOTAL COLLECTION
      99999            99999              99999             99999             99999       $99,999,999.99



 SUMMARY:

   TOTAL INTAKE   TOTAL LEAD REVIEW   TOTAL OPEN CASE   TOTAL CLOSED CASE   TOTAL NFP   TOTAL COLLECTION
       9999            9999               9999              9999              9999        $99,999,999.99


       TOTAL CLOSED    TOTAL COLLECTIONS      TOTAL CLOSED     TOTAL COLLECTIONS
          M-T-D              M-T-D               Y-T-D              Y-T-D

 W.C.:     99999            99999              999999999          99999999
 ACC/INJ:  99999            99999              999999999          99999999
 EST REC:  99999            99999              999999999          99999999
   TRUST:  99999            99999              999999999          99999999
      AP:  99999            99999              999999999          99999999
   OTHER:  99999            99999              999999999          99999999


                                          *** END OF REPORT  ***
                                        ***  NO DATA THIS RUN  ***
```


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7.4.3 TPL-0004-M -- TPL Case Activity Summary Report Field Descriptions

Field	Description	Length	Data Type
Analyst	The analyst assigned to work the case.	8	Character
Total Closed Case	Total number of closed cases.	5	Number (Integer)
Total Closed MTD	Four columns; W.C. (Worker's Compensation), ACC/INJ (Accident/Injury), EST REC (Estate Recovery), TRUST (Trust), AP (Absent Parent), and OTHER (Other).	5	Number (Integer)
Total Closed YTD	Four columns; W.C. (Worker's Compensation), ACC/INJ (Accident/Injury), EST REC (Estate Recovery), TRUST (Trust), AP (Absent Parent), and OTHER (Other).	9	Number (Integer)
Total Collection	Total amount collected.	14	Number (Decimal)
Total Collections MTD	Four columns; W.C. (Worker's Compensation), ACC/INJ (Accident/Injury), EST REC (Estate Recovery), TRUST (Trust), AP (Absent Parent), and OTHER (Other).	5	Number (Integer)
Total Collections YTD	Four columns; W.C. (Worker's Compensation), ACC/INJ (Accident/Injury), EST REC (Estate Recovery), TRUST (Trust), AP (Absent Parent), and OTHER (Other).	9	Number (Integer)
Total Intake	Total number of intakes.	5	Number (Integer)
Total Lead Review	Total number of reviews.	5	Number (Integer)
Total NFP	Total cases deemed no further pursuit.	5	Number (Integer)
Total Open Case	Total number of open cases.	5	Number (Integer)

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7.5 TPL-0005-M -- TPL Casualty Case Review By Analyst Report

7.5.1 TPL-0005-M -- TPL Casualty Case Review By Analyst Report Narrative

The TPL Casualty Case Review by Analyst report is a system-generated report of the total cases, which are set for follow-up review next month. It is organized by analyst for ease in distribution of case research. A summary total page is provided at the end of the report. This report is created in job TPLJM002 and is produced monthly.

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7.5.2 TPL-0005-M -- TPL Casualty Case Review By Analyst Report Layout

```
REPORT  : TPL-0005-M                          ALABAMA MEDICAID AGENCY                      RUN DATE:  MM/DD/CCYY
PROCESS : TPLJM002                       MEDICAID MANAGEMENT INFORMATION SYSTEM             RUN TIME:  HH:MM:SS
LOCATION: TPLC0190                           TPL CASUALTY CASE REVIEW BY ANALYST                 PAGE:  999,999
                                                 REPORT PERIOD:  MM/DD/CCYY


RESEARCH ANALYST:  XXXXXXXX


CASE STATUS - IN COMPROMISE

RECIPIENT NAME                      RID NO.            CASUALTY CASE NO.

XXXXXXXXXXXXXXX, XXXXXXXXXXX        999999999999        99999999


CASE STATUS - INTAKES

RECIPIENT NAME                       RID NO.            CASUALTY CASE NO.

XXXXXXXXXXXXXXX, XXXXXXXXXXX         999999999999        99999999


CASE STATUS - OPEN

RECIPIENT NAME                       RID NO.           CASUALTY CASE NO.

XXXXXXXXXXXXXXX, XXXXXXXXXXX         999999999999       99999999


CASE STATUS - LEAD REVIEW

RECIPIENT NAME                      RID NO.            CASUALTY CASE NO.

XXXXXXXXXXXXXXX, XXXXXXXXXXX        999999999999       99999999


TOTAL REVIEWS NEXT MONTH:  9999

                                 {PAGE BREAK BETWEEN CLERK ID NUMBERS}
```


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```
REPORT  : TPL-0005-M                          ALABAMA MEDICAID AGENCY                        RUN DATE: MM/DD/CCYY
PROCESS : TPLJM002                       MEDICAID MANAGEMENT INFORMATION SYSTEM               RUN TIME:  HH:MM:SS
LOCATION: TPLC0190                        TPL CASUALTY CASE REVIEW BY ANALYST                     PAGE:  999,999
                                               REPORT PERIOD:  MM/DD/CCYY


SUMMARY:


       TOTAL REVIEW: OPEN     TOTAL REVIEW: LEAD REVIEW        TOTAL INTAKE       TOTAL IN COMPROMISE    TOTAL REF
TPL INVESTIGATOR

         9999                 9999                             9999               9999                   9999

       CLERK ID    /    TOTAL

       XXXXXXXX   /      XXXX
       XXXXXXXX   /      XXXX
       XXXXXXXX   /      XXXX


                                             ***   END OF REPORT ***
                                            *** NO DATA THIS RUN ***
```


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7.5.3 TPL-0005-M -- TPL Casualty Case Review By Analyst Report Field Descriptions

Field	Description	Length	Data Type
Case Status	The status of the case tracking record.	18	Character
Casualty Case No.	System assigned number for each casualty case.	8	Number (Integer)
Clerk ID/Total	Total number of cases up for review per Research Analyst for the next month.	22	Character
Recipient Name	Alphabetical list of recipients to be reviewed for that next month.	28	Character
Research Analyst	Number assigned to an analyst.	8	Character
RID No.	The recipient's Medicaid identification number.	12	Number (Integer)
Total In Compromise	Total number of in compromise cases to be reviewed for the next month.	4	Number (Integer)
Total Intake	Total number of intake cases to be reviewed for the next month.	4	Number (Integer)
Total Lead Review	Total number of lead reviews to be reviewed for the next month.	4	Number (Integer)
Total Open	Total number of open cases to be reviewed for the next month.	4	Number (Integer)
Total Ref TPL Investigator	Total number of referrals to TPL investigator cases to be reviewed for the next month.	4	Number (Integer)
Total Reviews Next Month	Total number of cases up for review per Research Analyst for the next month.	4	Number (Integer)

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7.6 TPL-0009-W -- TPL Accident Trauma Report

7.6.1 TPL-0009-W -- TPL Accident Trauma Report Narrative

The Accident Trauma report is a weekly report. CMS requires TPL to use the accident/trauma report in order to identify and pursue possible recovery cases. The report is driven by the recipient claim history. The report accumulates and extracts paid claims with an accident related diagnosis code based on a $250.00 threshold within a 6 month period. The claims will not report until the cumulative accident/trauma claim paid amounts for the recipient exceeds the set threshold. An Accident Trauma questionnaire is automatically produced for each recipient to facilitate research and follow-up. Once a recipient is reported, they will not report again for 180 days in order to preclude redundancy. Claims are selected for this process if their primary or secondary diagnosis code is listed in the BPA CLMS & OI – TRAUMA DIAGNOSIS CODES group.

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7.6.2 TPL-0009-W -- TPL Accident Trauma Report Layout

```
REPORT  : TPL-0009-W                          ALABAMA MEDICAID AGENCY                      RUN DATE: MM/DD/CCYY
PROCESS : TPLJW001                       MEDICAID MANAGEMENT INFORMATION SYSTEM            RUN TIME:   HH:MM:SS
LOCATION: TPL0009W                             TPL ACCIDENT TRAUMA REPORT                     PAGE:    999,999
                                               REPORT PERIOD:  MM/DD/CCYY

CURRENT ID:                999999999999                   ADDRESS:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RECIPIENTS REPORTED:       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CITY:     XXXXXXXXXXXXXXXXXX
                                                          STATE:    XX      ZIP: 99999-9999

ICN             1ST DATE OF SVC  LAST DATE OF SVC   PROVIDER NO.         TOT BILLED      AMT PAID        TPL
PAYMENT     DATE PAID
XXXXXXXXXXXXX      MM/DD/CCYY       MM/DD/CCYY      XXX XXXXXXXXXXXXXX  9,999,999.99   9,999,999.99
9,999,999.99    MM/DD/CCYY
ACC IND  ICD  PRIMARY DIAG CD           DESCRIPTION
   X      X   XXXXXXX                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              SECONDARY DIAG CD
              XXXXXXX                   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          TOTAL PAID FOR CURRENT ID   XXXXXXXXXXXX : 999,999,999.99


SUMMARY:

TOTAL RECIPIENTS REPORTED:            9999              TOTAL DOLLARS PAID:           999,999,999.99


                                              *** END OF REPORT  ***
                                             *** NO DATA THIS RUN ***
```

7.6.3 TPL-0009-W -- TPL Accident Trauma Report Field Descriptions

Field	Description	Length	Data Type
1st Date of SVC	First date of service for claim.	10	Date (CCYY/MM/DD)
Acc Ind	Provider indicates on a claim whether or not the service is related to an accident.	1	Character
Address	Recipient's street address.	32	Character
Amt Paid	Amount Medicaid paid provider.	10	Number (Decimal)
City	Recipient's city.	18	Character
Current ID	Recipient Identification number assigned by interChange.	12	Character

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Field	Description	Length	Data Type
Date Paid	Date the claim was paid by Medicaid.	10	Date (CCYY/MM/DD)
Description (Primary Diag CD)	Narrative description of primary diagnosis code.	60	Character
Description (Second Diag CD)	Narrative description of secondary diagnosis code.	60	Character
ICD	Code to denote which version of the ICD diagnosis code is being reported. The valid values will be ‘9’ for ICD-9, ‘0’ for ICD-10, or blank if diagnosis is not present.	1	Character
ICN	Internal Control Number.	13	Character
Last Date of SVC	Last date of service for claim.	10	Date (CCYY/MM/DD)
Primary Diag CD	Primary diagnosis code.	7	Character
Provider No.	This is the Provider identification number.	15	Character
Provider No.Type	The Provider ID type.	3	Character
Recipients Reported	Recipient's last name, first name, middle initial.	30	Character
Secondary Diag CD	The secondary diagnosis code.	7	Character
State	Recipient's state.	2	Character
TPL Payment	Third party payment amount.	10	Number (Decimal)
Tot Billed	Total the provider billed for claim.	10	Number (Decimal)
Total Dollars Paid	Total amount paid this report period.	12	Number (Decimal)
Total Paid for Current ID	Total amount paid for recipient identification number.	12	Number (Decimal)
Total Recipients Reported	Number of recipients being reported this period.	4	Number (Integer)

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Field	Description	Length	Data Type
Zip	Recipient's zip code.	10	Number (Integer)

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7.7 TPL-0010-P -- BCBS Policy Not Identified-Needs Research Report

7.7.1 TPL-0010-P--BCBS Policy Not Identified-Needs Research Report Narrative

Report of Policies needing further research..

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7.7.2 TPL-0010-P--BCBS Policy Not Identified-Needs Research Report Layout

```
Report  : TPL-0010-R                          ALABAMA MEDICAID AGENCY                      Run Date: MM/DD/CCYY
Process : TPLJO017                      MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:   HH:MM:SS
Location: TPL0017I                    BCBS POLICY NOT IDENTIFIED - NEEDS RESEARCH             Page:         XX
                                                REPORT PERIOD: MM/DD/CCYY

MEDICAID ID      SSN           RECIPIENT NAME
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

POLICY #                         GROUP #                        SUSPECT  SUSPECT DATE  COVERAGE   EFFECTIVE    END
XXXXXXXXX                        XXXX                             X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                  X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                  X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                  X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                  X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY

*****************************************************************************************************************
*************
                                                     *NO DATA THIS RUN*
                                                      *END OF REPORT*
```

7.7.3 TPL-0010-P--BCBS Policy Not Identified-Needs Research Report Field Descriptions

Field	Description	Data Type	Length
Coverage	Coverage Code related to the recipient's policy.	Character	2
Effective	Effective Date of recipient's coverage.	Date (MM/DD/CCYY)	10
End	End date of recipient's coverage.	Date (MM/DD/CCYY)	10
Group #	Recipient's BCBS Group number.	Character	9
Medicaid ID	Medicaid ID assigned to the recipient.	Number	12
Policy #	Recipient's BCBS policy number.	Character	12
Recipient Name	Name of recipient.	Character	30

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Field	Description	Data Type	Length
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect	Suspect code related to policy.	Character	1
Suspect Date	Suspect Date related to the Suspect code.	Date (MM/DD/CCYY)	10

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7.8 TPL-0010-T -- BCBS Policy Not Identified-Needs Research Pre-Production Report

7.8.1 TPL-0010-T -- BCBS Policy Not Identified-Needs Research Pre-Production Report Narrative

Pre-production Report of Policies needing further research.

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7.8.2 TPL-0010-T -- BCBS Policy Not Identified-Needs Research Pre-Production Report Layout

```
Report  : TPL-0010-T                          ALABAMA MEDICAID AGENCY                      Run Date: MM/DD/CCYY
Process : TPLJO017                      MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:   HH:MM:SS
Location: TPL0017I                    BCBS POLICY NOT IDENTIFIED - NEEDS RESEARCH             Page:         XX
                                                REPORT PERIOD: MM/DD/CCYY



MEDICAID ID      SSN           RECIPIENT NAME
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

POLICY #                         GROUP #                         SUSPECT  SUSPECT DATE  COVERAGE   EFFECTIVE    END
XXXXXXXXX                        XXXX                              X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                   X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                   X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                   X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY
                                                                   X      MM/DD/CCYY     XX        MM/DD/CCYY
MM/DD/CCYY

*************************************************************************************************************
*************
                                              *NO DATA THIS RUN*
                                               *END OF REPORT*
```

7.8.3 TPL-0010-T -- BCBS Policy Not Identified-Needs Research Pre-Production Report Field Descriptions

Field	Description	Data Type	Length
Coverage	Coverage Code related to the recipient's policy.	Character	2
Effective	Effective Date of recipient's coverage.	Date (MM/DD/CCYY)	10
End	End Date of recipient's coverage.	Date (MM/DD/CCYY)	10
Group #	Recipient's BCBS Group number	Character	9
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Policy #	Recipient's BCBS policy number.	Character	12

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Field	Description	Data Type	Length
Recipient Name	Name of recipient.	Character	30
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect	Suspect code related to policy.	Character	1
Suspect Date	Suspect Date related to the Suspect code.	Date (MM/DD/CCYY)	10

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7.9 TPL-0011-P -- BCBS Recipient Not Found Report

7.9.1 TPL-0011-P -- BCBS Recipient Not Found Report Narrative

BCBS recipient not found report.

7.9.2 TPL-0011-P -- BCBS Recipient Not Found Report Layout

```
Report  : TPL-0011-R                          ALABAMA MEDICAID AGENCY                      Run Date: MM/DD/CCYY
Process : TPLJO017                       MEDICAID MANAGEMENT INFORMATION SYSTEM          Run Time:   HH:MM:SS
Location: TPL0017I            BCBS RECIPIENT NOT FOUND REPORT                                Page:         XX
                                              REPORT PERIOD: MM/DD/CCYY


MEDICAID ID      SSN           RECIPIENT NAME
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
*****************************************************************************************************
*************

TOTAL RECIPIENTS:   99,999,999

                                                     *END OF REPORT*
```

7.9.3 TPL-0011-P -- BCBS Recipient Not Found Report Field Descriptions

Field	Description	Data Type	Length
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Recipient Name- First Name	First Name of recipient.	Character	28
Recipient Name- Last Name	Last Name of recipient	Character	28
Recipient Name- Middle Name Initial	Middle Name Initial of recipient.	Character	1
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11

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7.10 TPL-0011-T -- BCBS Recipient Not Found Report-Pre-Production Report

7.10.1 TPL-0011-T -- BCBS Recipient Not Found Report-Pre-Production Report Narrative

Pre-production BCBS RECIPIENT NOT FOUND REPORT

7.10.2 TPL-0011-T -- BCBS Recipient Not Found Report-Pre-Production Report Layout

```
Report  : TPL-0011-T                          ALABAMA MEDICAID AGENCY                      Run Date: MM/DD/CCYY
Process : TPLJO017                      MEDICAID MANAGEMENT INFORMATION SYSTEM             Run Time:   HH:MM:SS
Location: TPL0017I                          BCBS RECIPIENT NOT FOUND REPORT                 Page:           XX
                                                REPORT PERIOD: MM/DD/CCYY


MEDICAID ID      SSN           RECIPIENT NAME
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
999999999999     999-99-9999   XXXXXXXXXXXXXXXXXXXXXXXXXXXX X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
*****************************************************************************************************
*************

TOTAL RECIPIENTS:   99,999,999

                                                  *END OF REPORT*
```

7.10.3 TPL-0011-T -- BCBS Recipient Not Found Report-Pre-Production Report Field Descriptions

Field	Description	Data Type	Length
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Recipient Name- First Name	First Name of recipient.	Character	28
Recipient Name- Last Name	Last Name of recipient	Character	28
Recipient Name- Middle Name Initial	Middle name initial of recipient	Character	1
SSN	Recipient's Social Security Number (SSN)	Number (Integer)	11

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7.11 TPL-0012-P -- BCBS Policy Add-Update Report

7.11.1 TPL-0012-P -- BCBS Policy Add-Update Report Narrative

BCBS POLICY ADD/UPDATE REPORT

7.11.2 TPL-0012-P -- BCBS Policy Add-Update Report Layout

```
Report  : TPL-0012-R                          ALABAMA MEDICAID AGENCY                    Run Date:   MM/DD/CCYY
Process : TPLJO017                      MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: TPL0017I                           BCBS POLICY ADD/UPDATE REPORT                         Page:   XX
                                             REPORT PERIOD: MM/DD/CCYY

*****************************************************************************************************************
*************
MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXX                , XXXXXXXX          X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXX                       BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB: MM/DD/CCYY

POLICY UPDATES:
BEFORE IMAGE:
CARRIER   POLICY #                      GROUP #                       SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                  XXXX                             X      X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY

AFTER IMAGE:
CARRIER   POLICY #                      GROUP #                       SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                  XXXX                             X      X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
*****************************************************************************************************************
*************
```

```
Report  : TPL-0012-R                          ALABAMA MEDICAID AGENCY                    Run Date:   MM/DD/CCYY
```


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```
Process : TPLJO017                        MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: TPL0017I                             BCBS POLICY ADD/UPDATE REPORT                             Page:   XX
                                                  REPORT PERIOD: MM/DD/CCYY


MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXX                  , XXXXXXXX          X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXX                       BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB: MM/DD/CCYY

POLICY ADDED:
CARRIER   POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                    XXXX                              X      X       XX       MM/DD/CCYY
MM/DD/CCYY
XXXXX                                                                                      XX       MM/DD/CCYY
MM/DD/CCYY
XXXXX                                                                                      XX       MM/DD/CCYY
MM/DD/CCYY
*************************************************************************************************************
*************
                                                  *NO DATA THIS RUN*
                                                   *END OF REPORT*
```

7.11.3 TPL-0012-P -- BCBS Policy Add-Update Report Field Descriptions

Field	Description	Data Type	Length
BCBS Policy #	Policy number related to recipient's BCBS insurance.	Character	12
BCBS Subscriber Name	Name of subscriber on BCBS insurance policy.	Character	30
Carrier	Carrier code added to file.	Number (Integer)	5
Carrier (after)	Carrier code placed on file after update.	Number (Integer)	5
Carrier (before)	Carrier code on file prior to policy update.	Number (Integer)	5
Coverage	Coverage code added to file that is related to recipient's policy.	Character	2
Coverage (after)	Coverage code placed on file after update.	Character	2
Coverage (before)	Coverage code on file prior to update.	Character	2
DOB (BCBS)	Date of Birth (DOB) on file for recipient according to BCBS.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
DOB (Medicaid)	Recipient's Date of Birth (DOB).	Date (MM/DD/CCYY)	10
Effective	Effective Date of recipient's coverage added to file.	Date (MM/DD/CCYY)	10
Effective (after)	Effective date placed on file after update.	Date (MM/DD/CCYY)	10
Effective (before)	Effective date on file prior to update.	Date (MM/DD/CCYY)	10
End	End date of recipient's coverage added to file.	Date (MM/DD/CCYY)	10
End (after)	End date on placed on file after update.	Date (MM/DD/CCYY)	10
End (before)	End date on file prior to update.	Date (MM/DD/CCYY)	10
Group #	Recipient's BCBS Group number added to the file.	Character	9
Group # (after)	Group number placed on file after update.	Number (Integer)	9
Group # (before)	Group number on file prior to update.	Number (Integer)	9
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Policy #	Recipient's BCBS policy number added to the file.	Character	12
Policy # (after)	Policy number placed on file after update.	Character	12
Policy # (before)	Policy number on file prior to update.	Character	12
Recipient Name	Name of recipient.	Character	30
Rel.	Relationship code added to file.	Character	1
Rel. (after)	Relationship code placed on file after update.	Character	1
Rel. (before)	Relationship code on file prior to update.	Character	1
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect	Suspect code related to policy added to the file.	Character	1
Suspect (after)	Suspect code placed on file after update.	Character	1

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Field	Description	Data Type	Length
Suspect (before)	Suspect code on file prior to update.	Character	1

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7.12 TPL-0012-T -- BCBS Policy Add-Update Report-Pre-production Report

7.12.1 TPL-0012-T -- BCBS Policy Add-Update Report-Pre-production Report Narrative

Pre-production BCBS policy add/update report

7.12.2 TPL-0012-T -- BCBS Policy Add-Update Report-Pre-production Report Layout

```
Report  : TPL-0012-T                          ALABAMA MEDICAID AGENCY                    Run Date:   MM/DD/CCYY
Process : TPLJO017                      MEDICAID MANAGEMENT INFORMATION SYSTEM            Run Time:   HH:MM:SS
Location: TPL0017I                           BCBS POLICY ADD/UPDATE REPORT                         Page:   XX
                                             REPORT PERIOD: MM/DD/CCYY

*****************************************************************************************************************
*************
MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXX                , XXXXXXXX          X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXX                       BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB: MM/DD/CCYY

POLICY UPDATES:
BEFORE IMAGE:
CARRIER   POLICY #                      GROUP #                       SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                  XXXX                             X      X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY

AFTER IMAGE:
CARRIER   POLICY #                      GROUP #                       SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                  XXXX                             X      X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                              XX       MM/DD/CCYY
MM/DD/CCYY
*****************************************************************************************************************
*************
```

```
Report  : TPL-0012-T                          ALABAMA MEDICAID AGENCY                    Run Date:   MM/DD/CCYY
```


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```
Process : TPLJO017                        MEDICAID MANAGEMENT INFORMATION SYSTEM                Run Time:   HH:MM:SS
Location: TPL0017I                             BCBS POLICY ADD/UPDATE REPORT                            Page:   XX
                                                  REPORT PERIOD: MM/DD/CCYY


MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXX                  , XXXXXXXX          X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXX                       BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB: MM/DD/CCYY

POLICY ADDED:
CARRIER   POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE    END
XXXXX     XXXXXXXXXXXX                    XXXX                              X      X       XX       MM/DD/CCYY
MM/DD/CCYY
XXXXX                                                                                      XX       MM/DD/CCYY
MM/DD/CCYY
XXXXX                                                                                      XX       MM/DD/CCYY
MM/DD/CCYY
*************************************************************************************************************
*************
                                                  *NO DATA THIS RUN*
                                                   *END OF REPORT*
```

7.12.3 TPL-0012-T -- BCBS Policy Add-Update Report-Pre-production Report Field Descriptions

Field	Description	Data Type	Length
BCBS Policy #	Policy number related to recipient's BCBS insurance.	Character	12
BCBS Subscriber Name	Name of subscriber on BCBS insurance policy.	Character	30
Carrier	Carrier code added to file.	Number (Integer)	5
Carrier (after)	Carrier code placed on file after update.	Number (Integer)	5
Carrier (before)	Carrier code on file prior to policy update.	Number (Integer)	5
Coverage	Coverage code added to file that is related to recipient's policy.	Character	2
Coverage (after)	Coverage code placed on file after update.	Character	2
Coverage (before)	Coverage code on file prior to update.	Character	2
DOB (BCBS)	Date of Birth (DOB) on file for recipient according to BCBS.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
DOB (Medicaid)	Recipient's Date of Birth (DOB).	Date (MM/DD/CCYY)	10
Effective	Effective date of recipient's coverage added to file.	Date (MM/DD/CCYY)	10
Effective (after)	Effective date placed on file after update.	Date (MM/DD/CCYY)	10
Effective (before)	Effective date on file prior to update.	Date (MM/DD/CCYY)	10
End	End date of recipient's coverage added to file.	Date (MM/DD/CCYY)	10
End (after)	End date placed on file after update.	Date (MM/DD/CCYY)	10
End (before)	End date on file prior to update.	Date (MM/DD/CCYY)	10
Group #	Recipient's BCBS Group number added to the file.	Character	9
Group # (after)	Group number placed on file after update.	Character	9
Group # (before)	Group number on file prior to update.	Character	9
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Policy #	Recipient's BCBS policy number added to the file.	Character	12
Policy # (after)	Policy number placed on file after update.	Character	12
Policy # (before)	Policy number on file prior to update.	Character	12
Recipient Name	Name of recipient.	Character	30
Rel.	Relationship code added to file.	Character	1
Rel. (after)	Relationship code placed on file after update.	Character	1
Rel. (before)	Relationship code on file prior to update.	Character	1
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect	Suspect code related to policy added to the file.	Character	1
Suspect (after)	Suspect code placed on file after update.	Character	1

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Field	Description	Data Type	Length
Suspect (before)	Suspect code on file prior to update.	Character	1

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7.13 TPL-0013-P -- BCBS Policy HIPP Update Report

7.13.1 TPL-0013-P -- BCBS Policy HIPP Update Report Narrative

BCBS Data Match Production report that will display all HIPP policies identified to be updated that have an Agency Override value of “Y”.

7.13.2 TPL-0013-P -- BCBS Policy HIPP Update Report Layout

```
Report  : TPL-0013-P                              ALABAMA MEDICAID AGENCY                                    Run
Date:   MM/DD/CCYY
Process : TPLJO018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run
Time:     HH:MM:SS
Location: TPL0018I                            BCBS POLICY HIPP UPDATE REPORT
Page:        99999
                                                  REPORT PERIOD: MM/DD/CCYY

*************************************************************************************************************
*************
MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXXXXX X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXX X
DOB: MM/DD/CCYY

POLICY UPDATES:
BEFORE IMAGE:
CARRIER      POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE
END
XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X       XX       MM/DD/CCYY
MM/DD/CCYY

AFTER IMAGE:
CARRIER      POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE
END
XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                                XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                                XX       MM/DD/CCYY
MM/DD/CCYY
*************************************************************************************************************
*************


                                                  *** NO DATA THIS RUN ***
```


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*** END OF REPORT ***

7.13.3 TPL-0013-P -- BCBS Policy HIPP Update Report Field Descriptions

Field	Description	Data Type	Length
BCBS Policy #	Policy number related to recipient's BCBS insurance.	Character	30
BCBS Subscriber Name	Name of subscriber on BCBS insurance policy.	Character	37
Carrier (After Image)	Carrier code placed on file after update.	Character	10
Carrier (Before Image)	Carrier code on file prior to policy update.	Character	5
Coverage (After Image)	Coverage code placed on file after update.	Character	2
Coverage (Before Image)	Coverage code on file prior to update.	Character	2
DOB (BCBS Data)	Date of Birth (DOB) on file for recipient according to BCBS.	Date (MM/DD/CCYY)	10
DOB (Medicaid Data)	Recipient's Date of Birth (DOB).	Date (MM/DD/CCYY)	10
Effective (After Image)	Effective date placed on file after update.	Date (MM/DD/CCYY)	10
Effective (Before Image)	Effective date on file prior to update.	Date (MM/DD/CCYY)	10
End (After Image)	End date on placed on file after update.	Date (MM/DD/CCYY)	10
End (Before Image)	End date on file prior to update.	Date (MM/DD/CCYY)	10
Group # (After Image)	Group number placed on file after update.	Character	30
Group # (Before Image)	Group number on file prior to update.	Character	30
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Policy # (After Image)	Policy number placed on file after update.	Character	30
Policy # (Before Image)	Policy number on file prior to update.	Character	30
Recipient Name	Name of recipient.	Character	50
Rel. (After Image)	Relationship code placed on file after update.	Character	1

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Field	Description	Data Type	Length
Rel. (Before Image)	Relationship code on file prior to update.	Character	1
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect (After Image)	Suspect code placed on file after update.	Character	1
Suspect (Before Image)	Suspect code on file prior to update.	Character	1

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7.14 TPL-0013-T -- BCBS Policy HIPP Update Report-Pre-production Report

7.14.1 TPL-0013-T -- BCBS Policy HIPP Update Report-Pre-production Report Narrative

BCBS Data Match Pre-Production report that will display all HIPP policies identified to be updated that have an Agency Override value of “Y”.

7.14.2 TPL-0013-T -- BCBS Policy HIPP Update Report-Pre-production Report Layout

```
Report  : TPL-0013-T                              ALABAMA MEDICAID AGENCY                                    Run
Date:   MM/DD/CCYY
Process : TPLJO018                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run
Time:     HH:MM:SS
Location: TPL0018I                            BCBS POLICY HIPP UPDATE REPORT
Page:        99999
                                                  REPORT PERIOD: MM/DD/CCYY

*************************************************************************************************************
*************
MEDICAID POLICY DATA:
MEDICAID ID: 999999999999  SSN: 999-99-9999   RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXXXXXXXX X
DOB: MM/DD/CCYY

BCBS DATA:
BCBS POLICY #: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     BCBS SUBSCRIBER NAME:  XXXXXXXXXXXXXXXXXXXX , XXXXXXXXXXX X
DOB: MM/DD/CCYY

POLICY UPDATES:
BEFORE IMAGE:
CARRIER      POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE
END
XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X       XX       MM/DD/CCYY
MM/DD/CCYY

AFTER IMAGE:
CARRIER      POLICY #                        GROUP #                        SUSPECT   REL.  COVERAGE   EFFECTIVE
END
XXXXXXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     X     X       XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                                 XX       MM/DD/CCYY
MM/DD/CCYY
                                                                                                 XX       MM/DD/CCYY
MM/DD/CCYY
*************************************************************************************************************
*************


                                                  *** NO DATA THIS RUN ***
```


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```
*** END OF REPORT ***
```

7.14.3 TPL-0013-T -- BCBS Policy HIPP Update Report-Pre-production Report Field Descriptions

Field	Description	Data Type	Length
BCBS Policy #	Policy number related to recipient's BCBS insurance.	Character	30
BCBS Subscriber Name	Name of subscriber on BCBS insurance policy.	Character	37
Carrier (After Image)	Carrier code placed on file after update.	Character	10
Carrier (Before Image)	Carrier code on file prior to policy update.	Character	5
Coverage (After Image)	Coverage code placed on file after update.	Character	2
Coverage (Before Image)	Coverage code on file prior to update.	Character	2
DOB (BCBS Data)	Date of Birth (DOB) on file for recipient according to BCBS.	Date (MM/DD/CCYY)	10
DOB (Medicaid Data)	Recipient's Date of Birth (DOB).	Date (MM/DD/CCYY)	10
Effective (After Image)	Effective date placed on file after update.	Date (MM/DD/CCYY)	10
Effective (Before Image)	Effective date on file prior to update.	Date (MM/DD/CCYY)	10
End (After Image)	End date on placed on file after update.	Date (MM/DD/CCYY)	10
End (Before Image)	End date on file prior to update.	Date (MM/DD/CCYY)	10
Group # (After Image)	Group number placed on file after update.	Character	30
Group # (Before Image)	Group number on file prior to update.	Character	30
Medicaid ID	Medicaid ID assigned to the recipient.	Number (Integer)	12
Policy # (After Image)	Policy number placed on file after update.	Character	30
Policy # (Before Image)	Policy number on file prior to update.	Character	30
Recipient Name	Name of recipient.	Character	50

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Field	Description	Data Type	Length
Rel. (After Image)	Relationship code placed on file after update.	Character	1
Rel. (Before Image)	Relationship code on file prior to update.	Character	1
SSN	Recipient's Social Security Number (SSN).	Number (Integer)	11
Suspect (After Image)	Suspect code placed on file after update.	Character	1
Suspect (Before Image)	Suspect code on file prior to update.	Character	1

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7.15 TPL-0014-R -- Carrier Data Match Error Report

7.15.1 TPL-0014-R -- Carrier Data Match Error Report Narrative

The Carrier Data Match Error report contains recipients who could not be identified in the system because the eligibility file from Blue Cross/Blue Shield of Alabama (BC/BS) did not include the Medicaid identification number or Social Security Number for these recipients. The BC/BS process is scheduled to occur once each month.

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7.15.2 TPL-0014-R -- Carrier Data Match Error Report Layout

```
REPORT  : TPL-0014-R                          ALABAMA MEDICAID AGENCY                      RUN DATE: MM/DD/CCYY
PROCESS : TPLJO018                         MEDICAID MANAGEMENT INFORMATION SYSTEM           RUN TIME: HH:MM:SS
LOCATION: TPLXXXXX                          TPL CARRIER DATA MATCH ERROR REPORT                 PAGE: 999,999
                                                 REPORT PERIOD:  MM/DD/CCYY


DATE OF BIRTH            GENDER                       NAME

CCYY/MM/DD                 X                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CCYY/MM/DD                 X                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CCYY/MM/DD                 X                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CCYY/MM/DD                 X                          XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                              *** END OF REPORT ***
                                            *** NO DATA THIS RUN ***
```

7.15.3 TPL-0014-R -- Carrier Data Match Error Report Field Descriptions

Field	Description	Length	Data Type
Date of Birth	The date of birth of the recipient.	10	Date (CCYY/MM/DD)
Gender	The gender of the recipient. Valid Values: F = Female M = Male	1	Character
Name	The last name and first name of the recipient.	42	Character

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7.16 TPL-0015-R -- Carrier Data Match Report

7.16.1 TPL-0015-R -- Carrier Data Match Report Narrative

The Carrier Data Match report contains updated recipient coverage information from the BC/BS eligibility file. The BC/BS process is scheduled to occur once each month.

7.16.2 TPL-0015-R -- Carrier Data Match Report Layout

```
REPORT  : TPL-0015-R                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJ0017                      MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN TIME: HH:MM:SS
LOCATION: TPL017I                          TPL CARRIER DATA MATCH REPORT                           PAGE: 999,999
                                              REPORT PERIOD:  MM/DD/CCYY

XXXXXXXX(CARRIER NAME)

                                                                    COVERAGE    SERVICE
IND    MEDICAID ID       NAME                                        CODE       START-END                DATE OF BIRTH
X      999999999999    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX   XX        CCYY/MM/DD - CCYY/MM/DD CCYY/MM/DD
X      999999999999    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX   XX        CCYY/MM/DD - CCYY/MM/DD CCYY/MM/DD
X      999999999999    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX   XX        CCYY/MM/DD - CCYY/MM/DD CCYY/MM/DD
X      999999999999    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX   XX        CCYY/MM/DD - CCYY/MM/DD CCYY/MM/DD
X      999999999999    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXX   XX        CCYY/MM/DD - CCYY/MM/DD CCYY/MM/DD


                                             *** END OF REPORT ***
                                            *** NO DATA THIS RUN ***
For 'U' indicator (record updated), * indicates which fields are updated.
```

7.16.3 TPL-0015-R -- Carrier Data Match Report Field Descriptions

Field	Description	Length	Data Type
Coverage Code	This code identifies the type of coverage that a TPL policy provides.	2	Character
Date of Birth	The date of birth of the recipient.	10	Date (CCYY/MM/DD)
Ind	The action indicator from the insurance company data match process. Valid values: A = Record inserted U = Record updated	1	Character
Medicaid ID	Unique identifier for the recipient.	12	Character

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Field	Description	Length	Data Type
Name	The last name and first name of the recipient.	42	Character
Service Start-End	The eligibility start and end dates.	23	Date (CCYY/MM/DD)

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7.17 TPL-015R-D – 277CA Claims Acknowledgement Rejected Status Report

7.17.1 TPL-015R-D – 277CA Claims Acknowledgement Rejected Status Report Narrative

Users access the TPL 277CA Claims Acknowledgement rejected Status Report to review the 277CA transactions that had an error on them since the previous run. This report is produced daily.

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7.17.2 TPL-015R-D – 277CA Claims Acknowledgement Rejected Status Report

```
Report  : TPL-015R-D                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJD015                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPLP015D                 277CA CLAIMS ACKNOWLEDGEMENT REJECTED STATUS REPORT                     Page:       XXXX
                                              REPORT PERIOD: MM/DD/CCYY

PAYER ID: XXXXXXXXXXXXXXX PAYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLAIM'S TRANSACTION TRACE NUMBER    : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
SUBMITTER'S TRANSACTION REFERENCE ID: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLAIMS RECEIPT DATE                 : MM/DD/CCYY
STATUS EFFECTIVE DATE               : MM/DD/CCYY
=================================================================================================================
==
REJECTED CLAIMS:
RECIPIENT ID   ICN             AR NUMBER       FROM DOS     TO DOS       POLICY NUM

XXXXXXXXXXXX   XXXXXXXXXXXXX   9999999999999   MM/DD/CCYY   MM/DD/CCYY   XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM HEADER LEVEL-----------------------------------------------

CATEGORY CODE AND DESC: XX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CATEGORY CODE AND DESC: XX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**Note that the entity line is displayed only if Entity code is received for status code.


CLAIM DETAIL LEVEL----------------------LINE CONTROL NUMBER: 99999
CATEGORY CODE AND DESC: XX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
  STATUS CODE AND DESC: XXX-
XXXX
```

```
XXXX
```

```
CLAIM DETAIL LEVEL----------------------LINE CONTROL NUMBER:  99999

CATEGORY CODE AND DESC: XX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CATEGORY CODE AND DESC: XX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXx

  STATUS CODE AND DESC: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        RELATED ENTITY: XXX-
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  *END OF REPORT*
                                                 *NO DATA THIS RUN*
```


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7.17.3 TPL-015R-D – 277CA Claims Acknowledgement Rejected Status Report Field Descriptions

Field	Description	Data Type	Length
AR NUMBER	Medicaid Accounts Receivable Number.	Character	13
CATEGORY CODE AND DESC	HC Category Code from 277CA transaction with description lookup.	Character	2
CLAIMS RECEIPT DATE	Date of receipt of 877 claims by Sender of the 277CA.	Date (MM/DD/CCYY)	10
CLAIM'S TRANSACTION TRACE NUMBER	Transaction Number sent by Sender.	Character	50
FROM DOS	First Date of Service on the claim.	Date (MM/DD/CCYY)	10
ICN	Internal control number of the claim.	Character	13
LINE CONTROL NUMBER	Claims Line Number.	Number (Integer)	4
PAYER ID	Payer ID of the Sender of the 277CA.	Character	15
Payer Name	Name of Payer.	Character	50
Policy Num	TPL Policy Number.	Character	30
RECIPIENT ID	The recipient Medicaid ID number.	Character	12
RELATED ENTITY	HC Entity code with lookup of description.	Character	3
STATUS CODE AND DESC	HC Claims Status on 277CA with lookup of description.	Character	3
STATUS EFFECTIVE DATE	Date the Sender sent the file.	Date (MM/DD/CCYY)	10
SUBMITTER'S TRANSACTION REFERENCE ID	Reference number assigned by Sender.	Character	50
TO DOS	Last Date of Service on the claim.	Date (MM/DD/CCYY)	10

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7.18 TPL-015S-D – 277CA Claims Acknowledgement Summary Report

7.18.1 TPL-015S-D – 277CA Claims Acknowledgement Summary Report Narrative

Users access the TPL 277CA Claims Acknowledgement Summary Report to review the 277CA activity since the previous run. This report is produced daily.

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7.18.2 TPL-015S-D – 277CA Claims Acknowledgement Summary Report

```
Report  : TPL-015S-D                              ALABAMA MEDICAID AGENCY                                    Run Date:
MM/DD/CCYY
Process : TPLJD015                        MEDICAID MANAGEMENT INFORMATION SYSTEM                             Run Time:
HH:MM:SS
Location: TPLP015D                      277CA CLAIMS ACKNOWLEDGEMENT SUMMARY REPORT                              Page:
XXXX
                                                 REPORT PERIOD: MM/DD/CCYY


PAYER ID: XXXXXXXXXXXXXXX PAYER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLAIM'S TRANSACTION TRACE NUMBER    : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
SUBMITTER'S TRANSACTION REFERENCE ID: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CLAIMS RECEIPT DATE                 : MM/DD/CCYY
STATUS EFFECTIVE DATE               : MM/DD/CCYY
=================================================================================================================
====

REJECTED CLAIMS:

RECIPIENT ID  ICN            AR NUMBER      FROM DOS    TO DOS      POLICY NUM

XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-----------------------------------------------------------------------------------------------------------------
---

ACCEPTED CLAIMS:

RECIPIENT ID  ICN            AR NUMBER      FROM DOS    TO DOS      POLICY NUM                      PAYER CLAIM NUMBER


XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXX  9999999999999  MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-----------------------------------------------------------------------------------------------------------------
---

TOTAL SUBMITTED CHARGES  : $ZZ,ZZZ,ZZ9.99
TOTAL REJECTED CLAIMS    :         99,999
TOTAL REJECTED AMOUNT    : $ZZ,ZZZ,ZZ9.99
```


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```
TOTAL ACCEPTED CLAIMS    :         99,999
TOTAL ACCEPTED AMOUNT    : $ZZ,ZZZ,ZZ9.99
TOTAL CLAIMS ACKNOWLEDGED:         999,99
                                                  *END OF REPORT*
                                                *NO DATA THIS RUN*
```


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7.18.3 TPL-015S-D – 277CA Claims Acknowledgement Summary Report Field Descriptions

Field	Description	Data Type	Length
AR NUMBER	Medicaid Accounts Receivable Number.	Character	13
CLAIMS RECEIPT DATE	Date of receipt of 837 claims by Sender of the 277CA.	Date (MM/DD/CCYY)	10
CLAIM'S TRANSACTION TRACE NUMBER	Trace Number from the Sender.	Character	50
FROM DOS	First Date of Service on the claim.	Date (MM/DD/CCYY)	10
ICN	Internal control number of the claim.	Character	13
PAYER CLAIM NUMBER	Control Number assigned by Payer.	Character	30
PAYER ID	Payer ID of the Sender of the 277CA.	Character	15
POLICY NUM	TPL Policy Number associated with this A/R.	Character	30
Payer Name	Name of the Payer.	Character	50
RECIPIENT ID	Recipient Medicaid ID number.	Character	12
STATUS EFFECTIVE DATE	Date the Sender sent the file.	Date (MM/DD/CCYY)	10
SUBMITTER'S TRANSACTION REFERENCE ID	Reference number assigned by Sender.	Character	50
TO DOS	Last Date of Service on the claim.	Date (MM/DD/CCYY)	10
TOTAL ACCEPTED AMOUNT	Total Charges for accepted claims. This field is taken from the transmission, not calculated.	Number (Decimal)	10
TOTAL ACCEPTED CLAIMS	Count of accepted claims as transmitted by the sender, not calculated.	Number (Integer)	5
TOTAL CLAIMS ACKNOWLEDGED	Calculated count of all claims in the transmission.	Number (Integer)	5
TOTAL REJECTED AMOUNT	Total Charges for rejected claims. This field is taken from the transmission, not calculated.	Number (Decimal)	10

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7.19 TPL-0016-M -- TPL Cost Avoidance Report

7.19.1 TPL-0016-M -- TPL Cost Avoidance Report Narrative

The TPL Cost Avoidance report provides the TPL savings for the month due to cost avoidance and provider collections. The report contains the following three sections:

- Non-Pharmacy: This section contains all data related to non-pharmacy claims.
- Pharmacy: This section contains all data related to only pharmacy claims.
- Summary: This section combines the totals for non-pharmacy and pharmacy claims.

Each section is further divided into RCO encounter claims and all other claims.

This report is produced monthly.

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7.19.2 TPL-0016-M -- TPL Cost Avoidance Report Layout

```
Report  : TPL-0016-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJM016                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0016M                            TPL COST AVOIDANCE REPORT                                    Page:    999,999
                                               REPORT PERIOD: 01/2004
NON-PHARMACY CLAIMS:
                                                          FEE FOR SERVICE CLAIMS                   ENCOUNTER CLAIMS
                                                     -------------------------------        -------------------------------
                                                           MTD            YTD                      MTD            YTD

TOTAL CLAIMS DENIED FOR MEDICARE:                    99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL AMT BILLED TO MEDICAID FOR MEDICARE:           $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR MEDICARE:                          $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL CLAIMS DENIED FOR OTHER INSURANCE:             99,999,999,999  99,999,999,999                       0               0
TOTAL AMT BILLED TO MEDICAID FOR OTHER INSURANCE:    $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR OTHER INSURANCE:                   $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL ADJUDICATED CLAIMS WITH OTHER INSURANCE PAYMENTS:  99,999,999,999  99,999,999,999    99,999,999,999  99,999,999,999
TOTAL BILLED AMOUNT TO MEDICAID WITH OTHER INSURANCE PAYMENTS:$999,999,999.99 $999,999,999.99 $999,999,999.99 $999,999,999.99
TOTAL MEDICAID PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:  $999,999,999.99 $999,999,999.99 $999,999,999.99 $999,999,999.99
TOTAL TPL PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:       $999,999,999.99 $999,999,999.99 $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH OTHER INSURANCE PAYMENTS:      $999,999,999.99 $999,999,999.99 $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH OTHER INSURANCE PAYMENTS:               $999,999,999.99 $999,999,999.99 $999,999,999.99 $999,999,999.99

TOTAL ADJUDICATED CLAIMS WITH MEDICARE PAYMENTS:     99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL MEDICAID PAID AMOUNT WITH MEDICARE PAYMENTS:   $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH MEDICARE PAYMENTS:       $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH MEDICARE PAYMENTS:                $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99


Report  : TPL-0016-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJM016                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0016M                            TPL COST AVOIDANCE REPORT                                    Page:    999,999
                                               REPORT PERIOD: 01/2004
PHARMACY CLAIMS:
                                                          FEE FOR SERVICE CLAIMS                   ENCOUNTER CLAIMS
                                                     -------------------------------        -------------------------------
                                                           MTD            YTD                      MTD            YTD

TOTAL CLAIMS DENIED FOR MEDICARE:                    99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL AMT BILLED TO MEDICAID FOR MEDICARE:           $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR MEDICARE:                          $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL CLAIMS DENIED FOR OTHER INSURANCE:             99,999,999,999  99,999,999,999                       0               0
TOTAL AMT BILLED TO MEDICAID FOR OTHER INSURANCE:    $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR OTHER INSURANCE:                   $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
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TOTAL ADJUDICATED CLAIMS WITH OTHER INSURANCE PAYMENTS:       99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL BILLED AMOUNT TO MEDICAID WITH OTHER INSURANCE PAYMENTS:$999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:     $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL TPL PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:          $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH OTHER INSURANCE PAYMENTS:         $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH OTHER INSURANCE PAYMENTS:                  $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL ADJUDICATED CLAIMS WITH MEDICARE PAYMENTS:              99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL MEDICAID PAID AMOUNT WITH MEDICARE PAYMENTS:            $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH MEDICARE PAYMENTS:                $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH MEDICARE PAYMENTS:                         $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99


Report  : TPL-0016-M                            ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM016                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0016M                              TPL COST AVOIDANCE REPORT                                    Page:    999,999
                                                REPORT PERIOD: 01/2004

SUMMARY:
                                                                 FEE FOR SERVICE CLAIMS                 ENCOUNTER CLAIMS
                                                              -------------------------------        -------------------------------
                                                                    MTD            YTD                    MTD            YTD

TOTAL CLAIMS DENIED FOR MEDICARE:                             99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL AMT BILLED TO MEDICAID FOR MEDICARE:                    $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR MEDICARE:                                   $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL CLAIMS DENIED FOR OTHER INSURANCE:                      99,999,999,999  99,999,999,999                       0               0
TOTAL AMT BILLED TO MEDICAID FOR OTHER INSURANCE:             $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS FOR OTHER INSURANCE:                            $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL ADJUDICATED CLAIMS WITH OTHER INSURANCE PAYMENTS:       99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL BILLED AMOUNT TO MEDICAID WITH OTHER INSURANCE PAYMENTS:$999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:     $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL TPL PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:          $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH OTHER INSURANCE PAYMENTS:         $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH OTHER INSURANCE PAYMENTS:                  $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99

TOTAL ADJUDICATED CLAIMS WITH MEDICARE PAYMENTS:              99,999,999,999  99,999,999,999         99,999,999,999  99,999,999,999
TOTAL MEDICAID PAID AMOUNT WITH MEDICARE PAYMENTS:            $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL MEDICAID ALLOWED WITH MEDICARE PAYMENTS:                $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99
TOTAL SAVINGS WITH MEDICARE PAYMENTS:                         $999,999,999.99 $999,999,999.99        $999,999,999.99 $999,999,999.99


                                                        **  END OF REPORT   **
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REPORT  :  TPL-0016-M                        ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS :  TPLJM016                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                  RUN TIME: HH:MM:SS
LOCATION:  TPL0016M                         TPL COST AVOIDANCE REPORT                                               PAGE: 999,999
                                            REPORT PERIOD:  MM/DD/CCYY


SUMMARY:
                                                                     MTD                   YTD

  TOTAL CLAIMS DENIED FOR MEDICARE:                                9,999,999,999       9,999,999,999,999
  TOTAL AMT BILLED TO MEDICAID FOR MEDICARE:                     $999,999,999.99     $999,999,999,999.99
  TOTAL SAVINGS FOR MEDICARE:                                    $999,999,999.99     $999,999,999.999.99

  TOTAL CLAIMS DENIED FOR OTHER INSURANCE:                         9,999,999,999       9,999,999,999,999
  TOTAL AMT BILLED TO MEDICAID FOR OTHER INSURANCE:              $999,999,999.99     $999,999,999,999.99
  TOTAL SAVINGS FOR OTHER INSURANCE:                             $999,999,999.99     $999,999,999.999.99


  TOTAL ADJUDICATED CLAIMS WITH OTHER INSURANCE PAYMENTS:          9,999,999,999       9,999,999,999,999
  TOTAL BILLED AMOUNT TO MEDICAID WITH OTHER INSURANCE PAYMENTS: $999,999,999.99     $999,999,999,999.99
  TOTAL MEDICAID PAID AMOUNT WITH OTHER INSURANCE PAYMENTS:      $999,999,999.99     $999,999,999,999.99
  TOTAL TPL PAID AMOUNT WITH OTHER INSURANCE PAYMENTS            $999,999,999.99     $999,999,999,999.99
  TOTAL MEDICAID ALLOWED WITH OTHER INSURANCE PAYMENTS           $999,999,999.99     $999,999,999,999.99
  TOTAL SAVINGS WITH OTHER INSURANCE PAYMENTS                    $999,999,999.99     $999,999,999,999.99


  TOTAL ADJUDICATED CLAIMS WITH MEDICARE PAYMENTS:                 9,999,999,999       9,999,999,999,999
  TOTAL MEDICARE PAID AMOUNT WITH MEDICARE PAYMENTS:             $999,999,999.99     $999,999,999,999.99
  TOTAL MEDICARE ALLOWED AMOUNT WITH MEDICARE PAYMENTS:          $999,999,999.99     $999,999,999,999.99
  TOTAL SAVINGS WITH MEDICARE PAYMENTS:                          $999,999,999.99     $999,999,999,999.99


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
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7.19.3 TPL-0016-M -- TPL Cost Avoidance Report Field Descriptions

Field	Description	Length	Data Type
Dollars For Claims Denied For Medicare	The amount Medicaid would have allowed on the claim if it had paid. NOTE: The entire billed amount is included in this figure whether the entire claim was denied or only a detail was denied for Medicare related edits. For this reason, the cost avoided amount is slightly overstated. (The entire billed amount is utilized in this figure because it is usually an entire claim which is denied for Medicare related edits. Also, the later process of identification of a claim which has previously been denied is difficult to do on a detail basis.)	12	Number (Decimal)
Dollars For Claims Denied For Other Insurance	The amount Medicaid would have allowed on the claim if it had paid. NOTE: The entire billed amount is included in this figure whether the entire claim was denied or only a detail was denied for TPL related edits. For this reason, the cost avoided amount is slightly overstated. (The entire billed amount is utilized in this figure because it is usually an entire claim which is denied for TPL/Medicare related edits. Also, the later process of identification of a claim which has previously been denied is difficult to do on a detail basis.)	12	Number (Decimal)
Dollars For Claims with Medicare Payments	The total Medicare payment amount submitted on the claims adjudicated during the month.	12	Number (Decimal)
Dollars For Claims with Other Insurance Payments	The total other insurance payment amount submitted on the claims adjudicated during the month.	12	Number (Decimal)
Total Adjudicated Claims with Medicare Payments (FFS and Encounters)	The total number of claims adjudicated during the month with a Medicare payment amount greater than zero.	12	Number (Decimal)
Total Adjudicated Claims with Other Insurance Payments (FFS and Encounters)	The total number of claims adjudicated during the month with another insurance payment amount greater than zero.	10	Number (Decimal)

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Field	Description	Length	Data Type
Total Amt Billed to Medicaid for Medicare (FFS and Encounters)	Total amount that was billed to Medicaid for Medicare.	12	Number (Decimal)
Total Amt Billed to Medicaid for Other Insurance (FFS and Encounters; Denied Claims)	The total amount that was billed to Medicaid with other insurance.	12	Number (Decimal)
Total Billed Amount to Medicaid with Other Insurance Payments (FFS and Encounters)	Total provider billed amount on all claims with another insurance or Medicare payment amounts greater than zero.	12	Number (Integer)
Total Claims Denied For Medicare (FFS and Encounters)	Total number of claims denied in the report month because the recipient had Medicare coverage listed on the Recipient Database, and there was no indication that Medicare was billed. A claim will be included in this figure whether the entire claim is denied or only a detail is denied for Medicare related edits.	12	Number (Decimal)
Total Claims Denied For Other Insurance (FFS and Encounters)	Total number of claims denied in the report month because the recipient had health insurance listed on the TPL Database, and there was no indication that the insurance company was billed. A claim will be included in this figure whether the entire claim is denied or only a detail is denied for TPL related edits.	10	Number (Decimal)
Total Medicaid Allowed With Other Insurance Payments (FFS and Encounters)	Total amount Medicaid allowed on the claims with another insurance or Medicare amount greater than zero.	12	Number (Decimal)
Total Medicaid Paid Amount with Other Insurance Payments (FFS and Encounters)	Total amount Medicaid paid on adjudicated claims with another insurance or Medicare amount greater than zero.	12	Number (Decimal)

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Field	Description	Length	Data Type
Total Medicaid Allowed Amount with Medicare Payments(FFS and Encounters; Adjud Claims)	Total Medicare Allowed Amount with Medicare Payments for adjudicated claims.	12	Number (Decimal)
Total Medicaid Paid Amount with Medicare Payments(FFS and Encounters; Adjud Claims)	Total Medicare amount that was paid with Medicare Payments for Adjudicated Claims.	12	Number (Decimal)
Total Savings For Medicare (FFS and Encounters; Denied Claims)	Total savings is calculated using the Medicaid allowed amount.	12	Number (Decimal)
Total Savings For Other Insurance (FFS and Encounters; Denied Claims)	Total savings is calculated using Medicaid allowed amount.	12	Number (Decimal)
Total Savings With Medicare Payments (FFS and Encounters)	Total savings is calculated using the lesser of the TPL or Medicare amount. Totals savings reflect the true savings not just TPL.	12	Number (Decimal)
Total Savings With Other Insurance Payments (FFS and Encounters; Adjudicated Claims with Medicare Payments)	Total savings is calculated using the lesser of the TPL or Medicare amount. Totals savings reflect the true savings not just TPL.	12	Number (Decimal)
Total TPL Paid Amount With Other Insurance Payments FFS and Encounters)	Total TPL amount that was paid with other insurance.	12	Number (Decimal)

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7.20 TPL-0017-R -- Carriers By Employer - Online Report

7.20.1 TPL-0017-R -- Carriers By Employer - Online Report Narrative

The TPL Carrier by Employer report is an on-line report. It is used to identify which insurance carriers an employer subscribes to. The user will specify the employer and the report will list all of carriers associated with them. To generate the report:

(1) Access the online application.

(2) From the main menu click on Third Party Liability to display the menu options for Third Party Liability.

(3) Click on the Reports link to display the reports that may be generated online.

(4) Click on the Carriers by Employer link.

(5) Enter the Employer ID in the Employer ID field or click on the Search.

(6) Enter the report format to be requested (HMTL, PDF or EXCEL)

(7) Select the View button

(8) The results will display all carriers associated with an employer.

(9) To print the report, click on FILE at the menu bar. Click on print.

This report is produced upon request.

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7.20.2 TPL-0017-R -- Carriers By Employer - Online Report Layout

Report: TPL-0017-R	ALABAMA MEDICAID AGENCY Carriers by Employer	Date: 2007/01/27 Time: 9:49 PM Page # 1 of 1

Employer ID:	E100000
Employer Name:	EDS
Employer Address:	803 NE 1ST ST SUITE 9001 SEATTLE, WA 98661 -

Carrier Number:	0000422
Carrier Name:	PRUDENTIAL INS CO OF AMERICA THE
Carrier Address:	8408 PARK AVE MAIL STOP 9047 ST LOUIS, MO 63188 -1086

7.20.3 TPL-0017-R -- Carriers By Employer - Online Report Field Descriptions

Field	Description	Length	Data Type
Carrier Address (City)	The city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	30	Character
Carrier Address (State)	The state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	2	Character
Carrier Address (Street 1)	The street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (Street 2)	The second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (ZIP + 4)	The last 4 digits of the ZIP code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.	4	Character
Carrier Address (ZIP)	The first 5 digits of the ZIP code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	15	Character

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Field	Description	Length	Data Type
Carrier Name	Name of the insurance company related to the employer.	45	Character
Carrier Number	The number Medicaid assigned to the insurance carrier.	7	Character
Employer Address (City)	The city of an employer.	30	Character
Employer Address (State)	The state of an employer.	2	Character
Employer Address (Street 1)	The street address of an employer.	55	Character
Employer Address (Street 2)	The second street address of an employer.	55	Character
Employer Address (ZIP + 4)	The last 4 digits of the ZIP code of an employer.	4	Character
Employer Address (ZIP)	The first 5 digits of the ZIP code of an employer.	15	Character
Employer ID	System assigned employer identification number.	7	Character
Employer Name	Name of the employer related to the insurance company.	39	Character

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7.21 TPL-0018-R -- Employer By Carrier - Online Report

7.21.1 TPL-0018-R -- Employer By Carrier - Online Report Narrative

The TPL Employer by Carrier report is an on-line report. This report identifies which employers subscribe to a certain insurance company. This report is produced upon request.

To generate the report:

(1) Access the online application.

(2) From the main menu click on Third Party Liability to display the menu options for Third Party Liability.

(3) Click on the Reports link to display the reports that may be generated online.

(4) Click on the Employers by Carrier button.

(5) Enter the Carrier ID in the Insurance Carrier No. field or click on Search.

(6) Enter the report format (HTML, PDF, or EXCEL)

(7) Select the View button

(8) The results will display all employers associated with the carrier.

(9) To print the report, click on FILE at the menu bar. Click on print.

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7.21.2 TPL-0018-R -- Employer By Carrier -Online Report Layout

Report: TPL-0018-R	ALABAMA MEDICAID AGENCY Employers by Carrier	Date: 2007/01/27 Time: 9:55 PM Page # 1 of 1

Carrier Number:	0000422
Carrier Name:	PRUDENTIAL INS CO OF AMERICA THE
Carrier Address:	8408 PARK AVE MAIL STOP 9047 ST LOUIS, MO 63188 -1086

Employer ID:	E100000
Employer Name:	EDS
Employer Address:	803 NE 1ST ST SUITE 9001 SEATTLE, WA 98661 -
Employer ID:	E123452
Employer Name:	GM PLANT #2
Employer Address:	805 MAIN ST SEATTLE, WA 98661 -

7.21.3 TPL-0018-R -- Employer By Carrier - Online Report Field Descriptions

Field	Description	Length	Data Type
Carrier Address (City)	The city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	30	Character
Carrier Address (State)	The state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	2	Character
Carrier Address (Street 1)	The street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (Street 2)	The second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character

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Field	Description	Length	Data Type
Carrier Address (ZIP + 4)	The last 4 digits of the Zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.	4	Character
Carrier Address (ZIP)	The first 5 digits of the Zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	15	Character
Carrier Name	Name of the insurance company.	45	Character
Carrier Number	Assigned carrier number.	7	Number (Integer)
Employer Address (City)	The city of an employer.	30	Character
Employer Address (State)	The state of an employer.	2	Character
Employer Address (Street 1)	The street address of an employer.	55	Character
Employer Address (Street 2)	The second street address of an employer.	55	Character
Employer Address (ZIP + 4)	The last 4 digits of the Zip code of an employer.	4	Number (Integer)
Employer Address (ZIP)	The first 5 digits of the Zip code of an employer.	15	Number (Integer)
Employer ID	System assigned employer identification number.	7	Character
Employer Name	Name of the employer related to the insurance company.	39	Character

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7.22 TPL-0019-R -- Recipients By Carrier - Online Report

7.22.1 TPL-0019-R -- Recipients By Carrier - Online Report Narrative

The TPL Recipients by Carrier report is an on-line report. The user specifies the insurance carrier number and all active/inactive recipients associated with the carrier will be displayed on the report. To generate the report:

(1) Access the online application.

(2) From the main menu click on Third Party Liability to display the menu options for Third Party Liability.

(3) Click on the Reports link to display the reports that may be generated online.

(4) Click on the Recipients by Carrier button.

(5) Enter the Insurance Carrier Number or Name in the Insurance Carrier Number or Name field or click on search.

(6) Enter the report format (HTML, PDF, or EXCEL)

(7) Select the View button

(8) The results will display all recipients who have coverage with the carrier. All recipients regardless of the effective dates of the coverage will be displayed.

(9) To print the report, click on FILE at the menu bar. Click on print.

This report is produced upon request.

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7.22.2 TPL-0019-R -- Recipients By Carrier - Online Report Layout

Report: TPL-0019-R

ALABAMA MEDICAID AGENCY
Recipients by Carrier

Date: 2007/01/26
Time: 10:10 AM
Page # 1 of 1

Carrier Number: 0000001
Carrier Name: CHAMPUS
Carrier Address: 10 BROOKVIEW TERRACE
MAIL STOP 9039
MADISON, WI 53713 -1234

Recipient Name	RID No	Policy Number
OWENS, ALBERT	000001110	
OWENS, ALBERT	000001110	
SMITH, HANK W	000001261	EDDDDDD
WATERS, RICK C	000001925	114556665
ROSE, BILLY	000001937	123456789
SMITH, LYLE	000001932	22999998
VAILLANCOURT, JOSEPH	000005200476	ABC
THERIAULT, ASHLEY A	000006904186	123456789
VANTOUR, AARON	000007745099	123456789
FILCH, JANET	000041423	AIR FORCE

7.22.3 TPL-0019-R -- Recipients By Carrier - Online Report Field Descriptions

Field	Description	Length	Data Type
Carrier Address (City)	The city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	30	Character
Carrier Address (State)	The state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	2	Character
Carrier Address (Street 1)	The street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character

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Field	Description	Length	Data Type
Carrier Address (Street 2)	The second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (ZIP + 4)	The last 4 digits of the Zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.	4	Number (Integer)
Carrier Address (ZIP)	The first 5 digits of the Zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	15	Number (Integer)
Carrier Name	Name of the insurance company.	45	Character
Carrier Number	Number assigned to a specific insurance company.	7	Number (Integer)
Policy Number	Number assigned to the insurance policy.	30	Alphanumeric
RID No.	Recipient identification number.	12	Number (Integer)
Recipient Name (First)	The first name of a recipient.	15	Character
Recipient Name (Last)	The last name of a recipient.	20	Character
Recipient Name (Middle Initial)	The middle initial of the recipient.	1	Character

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7.23 TPL-0020-R -- Carrier By Recipient - Online Report

7.23.1 TPL-0020-R -- Carrier By Recipient - Online Report Narrative

The TPL Carrier by Recipient report is an on-line report. It identifies a recipient's insurance policy carrier. This report is produced upon request.

To generate the report:

(1) Access the online application.

(2) From the main menu click on Third Party Liability to display the menu options for Third Party Liability.

(3) Click on the Reports link to display the reports that may be generated online.

(4) Click on the Carrier by Recipient button.

(5) Enter the RID No. of the recipient in the RID No. field or click on the search.

(6) Enter the report format (HTML, PDF, or EXCEL)

(7) Select the View button

(8) The results will display all carriers that the recipient has a policy with. All carriers regardless of the effective dates of the coverage will be displayed.

(9) To print the report, click on FILE at the menu bar. Click on print.

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7.23.2 TPL-0020-R -- Carrier By Recipient - Online Report Layout

Report: TPL-0020-R
ALABAMA MEDICAID AGENCY
Carriers by Recipient
Date: 2007/01/26
Time: 10:06 AM
Page # 1 of 1

RID Number: 000001261
Recipient Name: SMITH, HANK W

Carrier Number: 0000001
Carrier Name: CHAMPUS
Carrier Address: 10 BROOKVIEW TERRACE
MAIL STOP 9039
MADISON, WI 53713 -1234

Carrier Number: 0000101
Carrier Name: AETNA LIFE INSURANCE COMPANY
Carrier Address: 871 NE 1ST ST
HARTFORD, CT 06156 -

7.23.3 TPL-0020-R -- Carrier By Recipient - Online Report Field Descriptions

Field	Description	Length	Data Type
Carrier Address (City)	The city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	30	Character
Carrier Address (State)	The state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	2	Character

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Field	Description	Length	Data Type
Carrier Address (Street 1)	The street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (Street 2)	The second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	55	Character
Carrier Address (ZIP + 4)	The last 4 digits of the Zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.	4	Character
Carrier Address (ZIP)	The first 5 digits of the Zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	15	Character
Carrier Name	Name of the insurance company.	45	Character
Carrier Number	Number assigned to a specific insurance company.	7	Number (Integer)
RID Number	Recipient identification number.	12	Number (Integer)
Recipient Name (First)	The first name of a recipient.	15	Character
Recipient Name (Last)	The last name of a recipient.	20	Character
Recipient Name (Middle Initial)	The middle initial of the recipient.	1	Character

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7.24 TPL-0021-Q -- TPL Carrier Master File - Alpha Report

7.24.1 TPL-0021-Q -- TPL Carrier Master File - Alpha Report Narrative

The TPL Carrier Master File – Alpha report is a system generated report. This report identifies all carriers and self-insured employers currently on the TPL carrier table in alphabetical order. This report is produced quarterly.

7.24.2 TPL-0021-Q -- TPL Carrier Master File - Alpha Report Layout

```
REPORT  : TPL-0021-Q                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS : TPLJQ002                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME: HH:MM:SS
LOCATION: TPL0021Q                          TPL CARRIER MASTER FILE - ALPHA                                 PAGE: 999,999
                                               REPORT PERIOD:  MM/DD/CCYY

BILLING ADDRESS                        CORRESPONDENCE ADDRESS

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX        XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999           (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX        XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999           (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX        XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999           (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX        XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999           (XXX)XXX-XXXX  ext.  999999
                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```


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7.24.3 TPL-0021-Q -- TPL Carrier Master File - Alpha Report Field Descriptions

Field	Description	Length	Data Type
Billing Address	Billing street address, city, state and zip code of the insurance carrier.	157	Character
Correspondence Address	Correspondence street address, city, state and zip code of the insurance carrier.	157	Character
Ext	The phone number extension of the Billing Insurance carrier or Correspondence Insurance carrier.	6	Number (Integer)
Insurance Carrier Name	Name of the billing insurance carrier or correspondence insurance carrier.	32	Character
Insurance Carrier Number	Assigned carrier number (same for both billing and correspondence).	7	Number (Integer)
Insurance Carrier Phone	Phone number of the billing insurance carrier or correspondence insurance carrier.	10	Number (Integer)

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7.25 TPL-0022-Q -- TPL Carrier Master File - Numeric Report

7.25.1 TPL-0022-Q -- TPL Carrier Master File - Numeric Report Narrative

The TPL Carrier Master File - Numeric report is a system generated report. This report identifies all carriers and self-insured employers currently on the TPL Carrier table in numeric order. This report is produced quarterly.

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7.25.2 TPL-0022-Q -- TPL Carrier Master File - Numeric Report Layout

```
REPORT  : TPL-0022-Q                          ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJQ002                       MEDICAID MANAGEMENT INFORMATION SYSTEM                 RUN TIME: HH:MM:SS
LOCATION: TPL0022Q                          TPL CARRIER MASTER FILE - NUMERIC                        PAGE: 999,999
                                               REPORT PERIOD:  MM/DD/CCYY


BILLING ADDRESS                      CORRESPONDENCE ADDRESS

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX       XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999          (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX       XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999          (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX       XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999          (XXX)XXX-XXXX  ext.  999999

XXXXXXX XXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX, XX XXXXX-XXXX       XXXXXXXXXXXXXXX, XX XXXXX-XXXX
(XXX)XXX-XXXX  ext.  999999          (XXX)XXX-XXXX  ext.  999999


                                          *** END OF REPORT ***
                                       *** NO DATA THIS RUN ***
```


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7.25.3 TPL-0022-Q -- TPL Carrier Master File - Numeric Report Field Descriptions

Field	Description	Length	Data Type
Billing Address	Billing street address, city, state and zip code of the insurance carrier.	157	Character
Correspondence Address	Correspondence street address, city, state and zip code of the insurance carrier.	157	Character
Ext	The phone number extension of the Billing Insurance carrier or Correspondence Insurance carrier.	6	Number (Integer)
Insurance Carrier Name	Name of the billing insurance carrier or correspondence insurance carrier.	32	Character
Insurance Carrier Number	EDS assigned carrier number (same for both billing and correspondence).	7	Number (Integer)
Insurance Carrier Phone	Phone number of the billing insurance carrier or correspondence insurance carrier.	10	Number (Integer)

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7.26 TPL-0023-W -- Potential TPL for Follow-Up Report

7.26.1 TPL-0023-W -- Potential TPL for Follow-Up Report Narrative

The Potential TPL for Follow-up is a system generated report. This report identifies all unduplicated claims paid or denied with a TPL amount > 0 and the recipient has no insurance information on the TPL tables or the TPL amount = 0 when the claim contains TPL information, the adjustment reason code carrier indicates the recipient is covered and there is no existing policy data on the database. Once a recipient reports, they are flagged and will not report again for 60 days. The sort order for this report is by provider number and then recipients by provider. This report is produced weekly.

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7.26.2 TPL-0023-W -- Potential TPL for Follow-Up Report Layout

```
REPORT  : TPL-0023-W                          ALABAMA MEDICAID AGENCY                                          RUN DATE:  MM/DD/CCYY
PROCESS : TPLJW002                     MEDICAID MANAGEMENT INFORMATION SYSTEM                                   RUN TIME:  HH:MM:SS
LOCATION: TPL0023W                     TPL POTENTIAL TPL FOR FOLLOW-UP REPORT                                        PAGE:  999,999
                                              REPORT PERIOD:  MM/DD/CCYY



PROVIDER ID: XXX XXXXXXXXXXXXXXX  PROVIDER NAME:  XXXXXXXXXXXXXXX   X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                  FROM DATE     TO DATE                                                  MEDICAID
RID NO          ICN               OF SERVICE    OF SERVICE       TOTAL CHARGE      TPL AMOUNT          PAYMENT

999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99

PROVIDER ID: XXX XXXXXXXXXXXXXXX  PROVIDER NAME:  XXXXXXXXXXXXXXX   X  XXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                  FROM DATE     TO DATE                                                  MEDICAID
RID NO          ICN               OF SERVICE    OF SERVICE       TOTAL CHARGE      TPL AMOUNT          PAYMENT

999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99
999999999999    9999999999999     MM/DD/CCYY    MM/DD/CCYY        $99,999.99        $99,999.99        $99,999.99



                                                 ***  END OF REPORT  ***
                                               ***  NO DATA THIS RUN  ***
```


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7.26.3 TPL-0023-W -- Potential TPL for Follow-Up Report Field Descriptions

Field	Description	Length	Data Type
From Date of Service	First date of service on claim.	10	Date (MM/DD/CCYY)
ICN	Internal control number (claim number).	13	Number (Integer)
Medicaid Payment	Medicaid payment amount.	12	Integer (Decimal)
Provider ID	Pay to provider identification number.	15	Number (Integer)
Provider Name	Pay to provider first name, middle initial, and last name.	50	Character
RID No.	Assigned recipient identification number.	12	Number (Integer)
TPL Amount	Third party payment amount.	12	Number (Decimal)
To Date of Service	Last date of service on claim.	10	Date (MM/DD/CCYY)
Total Charge	Total charge on claim.	12	Number (Decimal)

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7.27 TPL-0024-M -- Verification Letter Follow-Up - Online Report

7.27.1 TPL-0024-M -- Verification Letter Follow-Up - Online Report Narrative

The Verification Letter Follow-Up online report allows the user to view or print a list of verification letters that were previously sent based on the month/year entered and are still in a non-verified status. This list includes when the letter was sent and the recipient. This report is accessed from the TPL Report Menu screen by clicking the Verification Follow-Up link. Pressing this button will display the Verification Letter Follow-Up Panel. This report is produced monthly.

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7.27.2 TPL-0024-M -- Verification Letter Follow-Up - Online Report Layout

Report: TPL-0024-M
ALABAMA MEDICAID AGENCY
Verification Letter Follow-Up
Last Activity Before: 05/01/2007
Run Date: 2007/06/05
Run Time: 3:27 PM
Page # 1 of 1

RID No.: 000003682569
Recipient Name: JONES REBECCA
Date Sent: 04/24/2007

RID No.: 000008707176
Recipient Name: HALL KRISTEN
Date Sent: 04/24/2007

RID No.: 000008762629
Recipient Name: NGUYEN TRI
Date Sent: 04/24/2007

7.27.3 TPL-0024-M - -Verification Letter Follow-Up – Online Report Field Descriptions

Field	Description	Length	Data Type
Date Sent	The date the verification letter was sent.	10	Date (CCYY/MM/DD)
RID No.	Recipient's identification number assigned by the State.	12	Number (Integer)
Recipient Name (First)	The first name of the recipient.	15	Character

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Field	Description	Length	Data Type
Recipient Name (Last)	The last name of the recipient.	20	Character
Recipient Name (Middle Initial)	The middle initial of the recipient.	1	Character

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7.28 TPL-0025-R -- Billing Summary Report

7.28.1 TPL-0025-R -- Billing Summary Report Narrative

The Billing Summary is a system generated report, which will include a pre-production as well as a production report for Rebillings, Pay and Chase, and Commercial. Each report will summarize the ARs or claims identified for billing. This report is produced upon request.

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7.28.2 TPL-0025-R -- Billing Summary Report Layout

```
REPORT:  TPL-0025-R                              ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS: TPLJM014                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:  HH:MM:SS
LOCATION: TPLF0390                               BILLING SUMMARY REPORT                                          PAGE:  9999
                                               REPORT PERIOD:  MM/CCYY
                                             XXXXXXXXXXXXXX  REPORT RUN

CARRIER NO.:   XXXXXXX
RID NO:        999999999999

  REFERENCE ICN        DATE PAID      SUBM. CHG.     PAID AMT.
  99999999999         MM/DD/CCYY      $999999.99     $999999.99
  99999999999         MM/DD/CCYY      $999999.99     $999999.99
  99999999999         MM/DD/CCYY      $999999.99     $999999.99
  99999999999         MM/DD/CCYY      $999999.99     $999999.99
  99999999999         MM/DD/CCYY      $999999.99     $999999.99

SUBTOTAL PER RID NO.                  $999999.99     $999999.999
{page break}

SUMMARY BY CARRIER

 CARRIER NUMBER               TOTAL CLAIMS BILLED           TOTAL MEDICAID PAID
 XXXXXXXXX                    999999999                     $999999999.99
 XXXXXXXXX                    999999999                     $999999999.99
 XXXXXXXXX                    999999999                     $999999999.99
 XXXXXXXXX                    999999999                     $999999999.99

   *PAGE BREAK ON CARRIER NUMBER

 *PAGE BREAK BEFORE SUMMARY OF BILLING

 SUMMARY OF BILLING


TOTAL CARRIERS BILLED         TOTAL CLAIMS BILLED           TOTAL MEDICAID PAID
999999999                     999999999                      $999999999.99

                                                          **  END OF REPORT  **
                                                         **  NO DATA THIS RUN  **
```


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7.28.3 TPL-0025-R -- Billing Summary Report Field Descriptions

Field	Description	Length	Data Type
Carrier Number	Number assigned to a specific insurance company.	7	Character
Date Paid	Date Medicaid paid the claim.	10	Date (MM/DD/CCYY)
Paid Amt.	Amount Medicaid paid on the claim.	10	Number (Decimal)
RID No.	The recipient's Medicaid identification number.	12	Number (Integer)
Reference ICN	Internal control number of claim billed.	11	Number (Integer)
Subm. Chg.	Provider submitted total claim charge.	10	Number (Decimal)
Subtotal Per RID No. - Paid Amt.	Total amount paid by Medicaid for the recipient.	10	Number (Decimal)
Subtotal Per RID No. - Subm. Chg.	Total submitted charge and Medicaid paid amounts billed to an insurance carrier for a specific recipient.	10	Number (Decimal)
Total Carriers Billed	Total carriers/employers billed this cycle.	9	Number (Integer)
Total Claims Billed (Summary by Carrier)	Unduplicated total number of claims billed to carrier.	9	Number (Integer)
Total Claims Billed (Summary of Billing)	Total number of claims billed this cycle.	9	Number (Integer)
Total Medicaid Paid (Summary by Carrier)	Total of Medicaid paid amounts for all claims billed to a carrier/employer.	13	Number (Decimal)
Total Medicaid Paid (Summary of Billing)	Total of Medicaid paid amounts billed this cycle.	13	Number (Decimal)

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7.29 TPL-0026-R -- Pharmacy Billing Facsimile Report

7.29.1 TPL-0026-R -- Pharmacy Billing Facsimile Report Narrative

The Pharmacy billing claim facsimile is system generated from the Retroactive and Rebilling processes. The facsimile is generated for all pharmacy claims where the carrier's media type code is equal to 'paper'. This report is sent to the carriers and is produced upon request.

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7.29.2 TPL-0026-R -- Pharmacy Billing Facsimile Report Layout

HMTRDRUG XXXXXXXXXXXXXXXXXXXXXXXXXX

INSURANCE

1-ID: 2-Group ID:
3-Last: 4-First:
5-Plan Name:
6-BIN #: 7-Processor Control #: 8-CMS Part D Defined Qualified Facility:

PATIENT

9-Last: 10-First 11-Person Code:
12-D.O.B. mm dd ccyy 13-Gender: 14-Relationship: 15-Patient Residence:

PHARMACY

17-Service Provider ID: 18-Qualifier:
19-Name: 20-Tel #:
21-Address:
22-City: 23-State: 24-Zip:

NCPDP
UNIVERSAL CLAIM FORM (UCF)
Version 1.2 – 02/2013
© 2013. All rights reserved.
CONTACT INSURANCE COMPANY AT LEFT FOR QUESTIONS REGARDING THIS CLAIM.

FOR OFFICE USE ONLY 16 (Document Control Number)

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

25-(Signed) 26-(Date)

ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

PRESCRIBER

27-ID: 28-Qualifier:
29-Last Name:

PHARMACIST

30-ID:
31-Qualifier:

CLAIM

32-Prescription/ Service Ref. #	33-Qual	34-Fill #	35-Date Written mm dd ccyy	36-Date Of Service mm dd ccyy	37-Submission Clarification	38-Prescription Origin	39-Pharmacy Service Type	40-Special Packaging Indicator

41-Product/Service ID	42-Qual	43-Product Description	44-Quantity Dispensed	45-Days Supply	46-DAW Code

47-Prior Auth # Submitted	48-PA Type	49-Other Coverage	50-Delay Reason	51-Level Of Service	52-Place of Service	53-Quantity Prescribed

CLINICAL 54-Diagnosis Code	55-Qual	DUR DUR / PPS CODES 56-Reason/57-Service/58-Result	59-Level Of Effort	60-Procedure Modifier

COB

COB 1 61-Other Payer ID	62-Qual	63-Other Payer Date mm dd ccyy	64-Other Payer Rejects	COB 2 65-Other Payer ID	66-Qual	67-Other Payer Date mm dd ccyy	68-Other Payer Rejects

COMPOUND

69-Dosage Form Description Code	70-Dispensing Unit Form Indicator	71-Route of Administration	72-Ingredient Component Count

	73-Product Name	74-Product ID	75-Qual	76-Ingredient Qty	77-Ingredient Drug Cost	78-Basis of Cost
1						
2						
3						
4						
5						
6						
7						

Pricing (Format (1,234.56))

79-Usual & Customary Charge	80-Basis of Cost. Det.	81-Ingredient Cost Submitted	82-Dispensing Fee Submitted	83-Prof Service Fee Submitted	84-Incentive Amount Submitted	85-Other Amount Submitted	86-Sales Tax Submitted

87-Gross Amount Due (Submitted)	88-Patient Paid Amount	89-Other Payer Amount Paid #1	90-Other Payer Amount Paid #2	91-Other Payer Patient Resp. Amount #1	92-Payer Patient Resp. Amount #2	93-Net Amount Due

Copyright 2008, 2009, 2010, 2012, 2013

**NOTE: THE AMOUNT MEDICAID PAID ON THE CLAIM IS $999,999.99.
Remit payment to: Alabama Medicaid Agency, Third Party Division, 501 Dexter Ave, PO Box 5624, Montgomery, AL 36103-5624

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7.29.3 TPL-0026-R -- Pharmacy Billing Facsimile Report Field Descriptions

Field	Description	Length	Data Type
Claim Date Of Service	Identifies date the prescription was filled or professional service rendered or subsequent payer began coverage following Part A expiration in a long-term care setting only.	10	Date (MM/DD/CCYY)
Claim Date Written	Date prescription was written.	10	Date (MM/DD/CCYY)
Claim DAW Code	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	1	Character
Claim Days Supply	Estimated number of days the prescription will last.	3	Number (Integer)
Claim Delay Reason	Code to specify the reason that submission of the transactions has been delayed.	2	Character
Claim Diagnosis Code	Code identifying the diagnosis of the patient.	15	Character
Claim DUR/PPS CODES Reason	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	2	Character
Claim DUR/PPS CODES Result	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	2	Character
Claim DUR/PPS CODES Service	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	2	Character
Claim Fill #	The code indicating whether the prescription is an original or a refill.	2	Number (Integer)
Claim Level Of Effort	Code indicating the level of effort as determined by the complexity of decision-making or resources utilized by a pharmacist to perform a professional service.	2	Character
Claim Level Of Service	Coding indicating the type of service the provider rendered.	2	Character
Claim Other Coverage	Code indicating whether or not the patient has other insurance coverage.	2	Character
Claim PA Type	Code clarifying the 'Prior Authorization Number Submitted' or benefit/plan exemption.	2	Number (Integer)

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Field	Description	Length	Data Type
Claim Pharmacy Service Type	The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.	2	Character
Claim Place Of Service	Code identifying the place where a drug or service is dispensed or administered.	2	Character
Claim Prescription Origin	Code indicating the origin of the prescription.	1	Character
Claim Prescription Service Ref.#	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	12	Number (Integer)
Claim Prior Auth # Submitted	Number submitted by the provider to identify the prior authorization.	11	Number (Integer)
Claim Procedure Modifier	Identifies special circumstances related to the performance of the service.	2	Character
Claim Product Description	Description of product being submitted.	30	Character
Claim Product/Service ID	ID of the product dispensed or service provided.	19	Character
Claim Qual (Box 33)	Indicates the type of billing submitted.	1	Character
Claim Qual (Box 42)	Code qualifying the value in 'Product/Service ID'	2	Character
Claim Qual (Box 55)	Code qualifying the 'Diagnosis Code'.	2	Character
Claim Quantity Dispensed	Quantity dispensed expressed in metric decimal units.	10	Number (Decimal)
Claim Quantity Prescribed	Amount expressed in metric decimal units.	10	Number (Decimal)
Claim Special Packaging Indicator	Code indicating the type of dispensing dose.	1	Character
Claim Submission Clarification	Code indicating that the pharmacist is clarifying the submission.	2	Character
COB 1 Other Payer Date	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	10	Date (MM/DD/CCY)

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Field	Description	Length	Data Type
COB 1 Other Payer ID	ID assigned to the payer.	10	Character
COB 1 Other Payer Rejects	The error encountered by the previous "OtherPayer" in "Reject Code". Three reject codes may be sent (each with a length of 3).	9	Character
COB 1 Qual	Code qualifying the 'Other Payer ID'.	2	Character
COB 2 Other Payer Date	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	10	Date (MM/DD/CCY)
COB 2 Other Payer ID	ID assigned to the payer.	10	Character
COB 2 Other Payer Rejects	The error encountered by the previous "OtherPayer" in "Reject Code". Three reject codes may be sent (each with a length of 3).	9	Character
COB 2 Qual	Code qualifying the 'Other Payer ID'.	2	Character
Compound Basis Of Cost	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	2	Character
Compound Dispensing Unit Form Indicator	NCPDP standard product billing codes.	1	Number (Integer)
Compound Dosage Form Description Code	Dosage form of the complete compound mixture.	2	Character
Compound Ingredient Component Count	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	2	Number (Integer)
Compound Ingredient Drug Cost	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' field.	9	Number (Decimal)
Compound Ingredient Qty	Amount expressed in metric decimal units of the product included in the compound mixture.	10	Number (Decimal)
Compound Product ID	Product identification of an ingredient used in a compound.	19	Character
Compound Product Name	Description of the ingredient being submitted.	30	Character
Compound Qual	Code qualifying the type of product dispensed.	2	Character

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Field	Description	Length	Data Type
Compound Route Of Administration	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.	11	Character
Document Control Number	Internal number used by the payer or processor to further identify the claim for imaging purposes -Document archival, retrieval and storage. Not to be used by pharmacy.	13	Character
HMTRDRUG	Title banner of MEDICAID SUBROGATION CLAIM to identify the type of claim being billed.	26	Character
Insurance BIN #	Number Card Issuer ID or Bank ID Number used for network routing.	6	Character
Insurance CMS Part D Defined Qualified Facility	Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit.	1	Character
Insurance First	First Name of Cardholder Individual.	12	Character
Insurance Group ID	ID assigned to the cardholder group or employer group.	15	Character
Insurance ID	ID assigned to the cardholder or identification number used by the plan.	20	Character
Insurance Last	Last Name of Cardholder Individual.	15	Character
Insurance Plan Name	The name of the plan.	30	Character
Insurance Processor Control #	Number assigned by the processor.	10	Character
NOTE (Medicaid Paid Amount)	The amount Medicaid paid on the claim.	10	Number (Decimal)
Patient D.O.B	Date of birth of patient.	10	Date (MM/DD/CCYY)
Patient First	Patient first name.	12	Character
Patient Gender	Code indicating the gender of the individual.	1	Character
Patient Last	Patient last name.	15	Character

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Field	Description	Length	Data Type
Patient Person Code	Code assigned to a specific person within a family.	3	Character
Patient Relationship	Code indicating relationship of patient to the cardholder.	1	Character
Patient Residence	Code identifying the patient's place of residence.	2	Character
Pharmacist ID	Unique ID assigned to the person responsible for the dispensing of the prescription or provision of the service.	15	Character
Pharmacist Qualifier	Code qualifying the 'Pharmacist ID'.	2	Character
Pharmacy Address	The street address for the pharmacy.	20	Character
Pharmacy City	City of the pharmacy.	18	Character
Pharmacy Name	Name of the pharmacy.	20	Character
Pharmacy Qualifier	Code qualifying the Service Provider ID.	2	Character
Pharmacy Service Provider ID	ID assigned to a pharmacy or provider.	15	Character
Pharmacy State	State/Province Code of the pharmacy.	2	Character
Pharmacy Tel #	Telephone number of the pharmacy.	10	Number
Prescriber ID	ID assigned to the prescriber.	15	Character
Prescriber Last Name	Prescriber's last name.	15	Character
Prescriber Qualifier	Code qualifying the 'Prescriber ID'.	2	Character
Pricing Basis of Cost. Det.	Code indicating the method by which 'Ingredient Cost Submitted' field was calculated.	2	Character
Pricing Dispensing Fee Submitted	Dispensing fee submitted by the pharmacy. This amount is included in the 'Gross Amount Due'.	10	Number (Decimal)

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Field	Description	Length	Data Type
Pricing Gross Amount Due (Submitted)	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted', 'Dispensing Fee Submitted', 'Flat Sales Tax Amount Submitted', 'Percentage Sales Tax Amount Submitted', 'Incentive Amount Submitted', 'Other Amount Claimed'. For service claim request, field represents a sum of 'Professional Services Fee Submitted', 'Flat Sales Tax Amount Submitted', 'Percentage Sales Tax Amount Submitted', 'Other Amount Claimed'.	10	Number (Decimal)
Pricing Incentive Amount Submitted	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due'.	10	Number (Decimal)
Pricing Ingredient Cost Submitted	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due'.	10	Number (Decimal)
Pricing Net Amount Due	Total of all pharmacy services amount due less any other paid amounts.	13	Number (Decimal)
Pricing Other Amount Submitted	Amount representing the additional incurred costs for a dispensed prescription or service.	10	Number (Decimal)
Pricing Other Payer Amount Paid #1	This field will be populated with a double asterisk to refer to the note at the bottom of the form indicating the Medicaid Paid Amount.	2	Character
Pricing Other Payer Amount Paid #2	Amount of any payment known by the pharmacy from other sources.	10	Number (Decimal)
Pricing Other Payer Patient Resp. Amount #1	The patient's cost share from a previous payer.	13	Number (Decimal)
Pricing Other Payer Patient Resp. Amount #2	The patient's cost share from a previous payer.	13	Number (Decimal)
Pricing Patient Paid Amount	Amount the pharmacy received from the patient for the prescription dispensed.	10	Number (Decimal)
Pricing Prof Service Fee Submitted	Amount submitted by the provider for professional services rendered.	10	Number (Decimal)

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Field	Description	Length	Data Type
Pricing Sales Tax Submitted	Flat sales tax submitted for prescription. This amount is included in the 'Gross Amount Due' or Percentage sales tax submitted.	10	Number (Decimal)
Pricing Usual & Customary Charge	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	10	Number (Decimal)
Remit Payment To:	Footer with the Alabama Medicaid Agency's Third Party Unit's complete address	118	Character
SIGNATURE OF PROVIDER Date	Current system date.	8	Date (MM/DD/YY)
SIGNATURE OF PROVIDER Signature	The words 'Signature on File' are printed in this field.	17	Character

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7.30 TPL-0027-M -- TPL Casualty Collections Report

7.30.1 TPL-0027-M -- TPL Casualty Collections Report Narrative

The Casualty Collections report is a system generated monthly report. This report lists all casualty collections from the first day of the month to the last day of the month. The totals reported is for all cases in which the date of settlement is within the reporting period. A summary total is provided at the end of the report.

NOTE:

The batch report is maintained on Feith, however, there is a TPL-0027 online report, which is accessed through the TPL Report menu.

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7.30.2 TPL-0027-M -- TPL Casualty Collections Report Layout

```
REPORT  : TPL-0027-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJM004                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:  HH:MM:SS
LOCATION: TPL0027M                          TPL CASUALTY COLLECTIONS REPORT                                   PAGE:  999,999
                                              REPORT PERIOD:  MM/DD/CCYY


CASE TYPE:   X

  CURRENT ID      RECIPIENT NAME                                          CCN           RECOVERY           CASE NUMBER

XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX

NUMBER OF CASES:     9999                                   MONTHLY RECOVERIES:  $9,999,999.99

(PAGE BREAK BEFORE NEXT CASE TYPE)

CASE TYPE:   X

  CURRENT ID      RECIPIENT NAME                                         CCN              RECOVERY           CASE NUMBER

XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X              XXXXXXXXXXX        $9,999,999.99        XXXXXXXXX

NUMBER OF CASES:     9999                                   MONTHLY RECOVERIES:  $9,999,999.99


(PAGE BREAK BEFORE SUMMARY)

SUMMARY

TOTAL MONTHLY RECOVERIES      TOTAL CASES
       $9999999.99              9999



                                                        *** END OF REPORT ***
                                                      *** NO DATA THIS RUN ***
```


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7.30.3 TPL-0027-M -- TPL Casualty Collections Report Field Descriptions

Field	Description	Length	Data Type
CCN	Cash control number of the check.	11	Number (Integer)
Case Number	Number assigned to a casualty case.	9	Character
Case Type	Type of casualty case.	1	Character
Current ID	Recipient's Medicaid identification number.	12	Character
Monthly Recoveries	Amount collected for the case type being reported.	13	Number (Decimal)
Number of Cases	Number of cases for the case type being reported.	4	Number (Integer)
Recipient Name (First)	The first name of the recipient.	15	Character
Recipient Name (Last)	The last name of the recipient.	20	Character
Recipient Name (Middle Initial)	The middle initial of the recipient.	1	Character
Recovery	Total amount received for the cash control number reported.	13	Number (Decimal)
Total Cases	Sum of all unduplicated casualty cases closed for the report month.	4	Number (Integer)
Total Monthly Recoveries	Sum of all casualty recoveries for the report month.	11	Number (Decimal)

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7.31 TPL-0028-R -- Case Tracking - Certificate of Authentication Report

7.31.1 TPL-0028-R -- Case Tracking - Certificate of Authentication Report Narrative

The Certificate of Authenticity is generated when the Case Tracking Case Detail Report (TPL-0029-R) is requested by selecting the 'batch print' button. It is used to authenticate that the data for a certain recipient within a certain time period is correct. The underscores denote where the user must supply handwritten text. This report is produced upon request.

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7.31.2 TPL-0028-R -- TPL Case Tracking - Certificate of Authentication Report Layout

CERTIFICATE OF AUTHENTICATION

NAME: (recipient name)

AMOUNT: (amount)

DATES OF SERVICE: (from dos) – (to dos)

I,_____, an agent for the State of Alabama with responsibility for maintaining records of payment on behalf of recipients of medical assistance, certify that the attached report documents payments on behalf of the above identified recipient of medical assistance and is a true and correct record of these payments.

As part of my responsibilities to the State of Alabama, this agent certifies that the amounts paid under the Medicaid program of the State of Alabama were recorded on or about the time the services were provided. These records are kept as part of the normal course of business of the State of Alabama and are available for review, subject to rules of confidentiality.

_____
Name

_____
Title

Subscribed and sworn before me this ____ day of _____, 20___.

_____
Notary Public

My commission expires
_____

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7.31.3 TPL-0028-R -- TPL Case Tracking - Certificate of Authentication Report Field Descriptions

Field	Description	Length	Data Type
Amount	This is the amount associated with the case summary.	6	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
My Comission Expires	This is the date the standard notary public's authorization expires.	8	Date (MMDD/CCYY)
Name	This is the signature of the agent for the State who has the responsibility for maintaining records of payments for recipients receiving medical assistance.	30	Character
Name (Recipient)	This is the last name, first name and middle initial of the recipient for which the case summary is generated.	32	Character
Notary Public	This is the standard notary public signature section.	30	Character
Title	This is the title of the agent who has the responsibility for maintaining records of payments for recipients receiving medical assistance.	30	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)

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7.32 TPL-0029-R -- TPL Case Tracking Report

7.32.1 TPL-0029-R -- TPL Case Tracking-Case Detail Report Narrative

The TPL Case Tracking - Case Detail Report is manually requested by selecting the 'batch print' button on the Case Tracking Base Information Panel. The certificate of authenticity (TPL-0028-R) is also printed when the user requests the print of this. This report is produced upon request.

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7.32.2 TPL-0029-R -- TPL Case Tracking Report Layout

```
REPORT  : TPL-0029-R                              ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJR029                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:  HH:MM:SS
LOCATION: TPL0029R                                TPL CASE TRACKING REPORT                                       PAGE:  999,999
                                                 REPORT PERIOD:  MM/DD/CCYY
MEMBER ID: XXXXXXXXXXXX   MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  CASE NUMBER: XXXXXXXXXX   DATE OF BIRTH: XXXXXXXXXXX

                       DATES OF SERVICE: XXXXXXXXXXXXXXXXXXXXXXXX                                REQUESTOR ID: XXXXXXXXX

PROVIDER NAME                                     DATES OF SERVICE                     PAID DATE           PAID

DX OR NDC / REASON / SETTLEMENT                   WARRANT NO/CCN                       CASE NUMBER

PAYER     / VENDOR / CARRIER                      CASE DESCRIPTION

TYPE OF CLAIM: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXX             XXXXXXXXXXXXX       XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXX                     XXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXX
```

7.32.3 TPL-0029-R -- TPL Case Tracking Report Field Descriptions

Field	Description	Length	Data Type
Member Name	This is the first name, middle initial, and last name for whom the case summary is generated.	32	Character
Case Description	This is the case type description for the associated case.	20	Character
Case Number	This is the case number of any other case for the beneficiary on an estate case. This will only appear if the report being printed is an estate recovery case.	9	Number (Integer)
Date of Birth	This is the beneficiary's date of birth.	10	Date (CCYY/MMDD)
DX or NDC/Reason/Settlement	This is the diagnosis description, drug description or reason for the paid amount or recovered amount.	60	Character
Dates of Service	This is the first and last dates of service on the case.	23	Date (CCYY/MMDD)
Paid	This is the Medicaid payment amount if amount is positive or the third party payment amount if amount is negative.	12	Number (Decimal)
Paid Date	The date of the Medicaid payment paid if the amount is positive or the date a third party payment was received if the amount is negative.	10	Date (CCYY/MMDD)
Payer/Vendor/Tortfeasor	This is the payer, vendor, or Tortfeasor name.	60	Character
Provider Name	This is the provider name.	50	Character
Requester ID	This is the clerk identification number listed on the Case Tracking Summary window.	8	Character
Dates of Service	This is the first and last dates of service on the claim.	23	Date (CCYY/MM/DD)
Total	The total dollar amount for claims paid on the case by type of claim.	9	Number (Decimal)
Type of Claim	The type of claims listed in this section of the report.	20	Character
Warrant No/CCN	This is the warrant number or cash control number associated with a settlement of expenditure.	10	Number (Integer)

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7.33 TPL-0030-Q -- TPL Recovery Activity by Coverage Type - QTD Report

7.33.1 TPL-0030-Q -- TPL Recovery Activity by Coverage Type - QTD Report Narrative

The TPL Recovery Activity by Coverage Type-QTD report is a summary of financial recovery activity categorized by insurance coverage type. This report is produced quarterly.

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7.33.2 TPL-0030-Q -- TPL Recovery Activity by Coverage Type - QTD Report Layout

```
REPORT  :  TPL-0030-Q                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS :  TPLJQ004                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
LOCATION:  TPL0030Q                    RECOVERY ACTIVITY BY COVERAGE TYPE - Q-T-D                               PAGE: 999,999
                                               REPORT PERIOD:  MM/DD/CCYY
```

COVERAGE	BILLED	NET RECV'D	UNPAID RESIDUAL	DENIED	PURGED	OUTSTAND.	NO.CLM TYPE
01 MEDICARE PART A	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
02 MEDICARE PART B	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
03 MAJOR MEDICAL MATERNITY	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
04 MAJOR MEDICAL NO MATERNITY	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
05 MAJOR MEDICAL MATERNITY-MGDCAR	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
06 MAJOR MED NO MATERNITY-MGDCARE	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
07 PRESCRIPTION DRUGS - COST AVOI	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
08 PRESCRIPTION DRUGS - PAY AND C	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
09 MAIL ORDER PRESCRIPTION DRUGS	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
10 DENTAL	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
11 DENTAL MANAGED CARE	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
12 ACCIDENT	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
13 CANCER	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
14 HOSPITAL/SURGICAL	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
15 HOSPITAL/INDEMNITY	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
16 LONG TERM CARE	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
17 LONG TERM CARE-SKILLED ONLY	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
18 OPTICAL	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
19 MEDICARE SUPPLEMENT	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999
20 MEDICARE PART D	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999.99	99999999999

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7.33.3 TPL-0030-Q -- TPL Recovery Activity by Coverage Type - QTD Report Field Descriptions

Field	Description	Length	Data Type
Outstand.	The total amount outstanding where the AR close date is equal to zero and the AR billed date is equal or less than the parm end date. This includes all outstanding ARs on the table, not just for the quarter.	11	Number (Decimal)
Billed	The total amount billed under the specified coverage type during the quarter.	11	Number (Decimal)
Coverage	The category of insurance coverage under which Medicaid paid claims were billed to private insurance.	16	Character
Denied	The total amount denied during the quarter. These are identified where the reason code is not equal A, E, M, R, U, or space and the date of last change is within the quarter.	11	Number (Decimal)
Net Recv'd	The total amount received under the specified coverage type for this quarter.	11	Number (Decimal)
NO. CLM Type	The total number of outstanding claims that are still active. This is for all ARs on the table, not just for the quarter.	11	Number (Integer)
Purged	The total amount of those ARs that were closed during the quarter due to a no response in 365 days, which is reason code 'S'.	11	Number (Decimal)
Unpaid Residual	Based on the dispositions added during the quarter, this is the difference between those disposition amounts and the total billed on the ARs.	11	Number (Decimal)

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7.34 TPL-0033-M -- TPL Cost Avoidance Summary - CMS Calculation Report

7.34.1 TPL-0033-M -- TPL Cost Avoidance Summary - CMS Calculation Report Narrative

The TPL Cost Avoidance Summary-CMS Calculation report is used to calculate the average monthly cost avoidance savings due to private insurance for the state's Medicaid program. The "Total Cost Savings" figure is summed for the three months of each quarter. This report is produced monthly.

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7.34.2 TPL-0033-M -- TPL Cost Avoidance Summary - CMS Calculation Report Layout

```
REPORT  :  TPL-0033-M                                ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS :  TPLJM005                             MEDICAID MANAGEMENT INFORMATION SYSTEM                       RUN TIME: HH:MM:SS
LOCATION:  TPL0033H                            COST AVOIDANCE SUMMARY - CMS CALCULATION                          PAGE: 999,999
                                                    REPORT PERIOD: MM/DD/CCYY

RECIPIENTS WITH MEDICARE

                              NUMBER            TOTAL EXPENDITURES           AVG EXPENDITURES

RECIPIENTS WITH MEDICARE      99999999999        $9,999,999.99                $9,999,999.99

RECIPIENTS WITHOUT MEDICARE   99999999999        $9,999,999.99                $9,999,999.99


AVERAGE SAVINGS PER RECIPIENT:     $99,999.99

TOTAL COST AVOIDANCE SAVINGS:      $99,999.99



RECIPIENTS WITH INSURANCE

                              NUMBER            TOTAL EXPENDITURES           AVG EXPENDITURES

RECIPIENTS WITH INSURANCE     99999999999        $9,999,999.99                $9,999,999.99

RECIPIENTS WITHOUT INSURANCE  99999999999        $9,999,999.99                $9,999,999.99


AVERAGE SAVINGS PER RECIPIENT:     $99,999.99

TOTAL COST AVOIDANCE SAVINGS:      $99,999.99


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.34.3 TPL-0033-M -- TPL Cost Avoidance Summary - CMS Calculation Report Field Descriptions

Field	Description	Length	Data Type
Avg Expenditures (Recipients with Insurance)	Total expenditures amount divided by number or recipients to get a dollar amount average for recipients with insurance coverage.	11	Number (Decimal)
Avg Expenditures (Recipients with Medicare)	Total expenditures amount divided by number or recipients to get a dollar amount average for recipients with Medicare coverage.	11	Number (Decimal)
Avg Expenditures (Recipients without Insurance)	Total expenditures amount divided by number or recipients to get a dollar amount average for recipients without insurance coverage.	11	Number (Decimal)
Avg Expenditures (Recipients without Medicare)	Total expenditures amount divided by number or recipients to get a dollar amount average for recipients without Medicare coverage.	11	Number (Decimal)
Avg. Savings Per Recipient (Insurance section)	Recipients without insurance coverage minus Recipients with insurance coverage.	9	Number (Decimal)
Avg. Savings Per Recipient (Medicare section)	Recipients without Medicare minus Recipients with Medicare.	9	Number (Decimal)
Number (Recipients with Insurance)	Total number of recipients report with insurance coverage.	11	Number (Integer)
Number (Recipients with Medicare)	Total number of recipients report with Medicare coverage.	11	Number (Integer)
Number (Recipients without Insurance)	Total number of recipients report without insurance coverage.	11	Number (Integer)
Number (Recipients without Medicare)	Total number of recipients report without Medicare coverage.	11	Number (Integer)
Total Cost Avoidance Savings (Insurance section)	Average Savings multiplied by the number of recipients with insurance coverage.	9	Number (Decimal)

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Field	Description	Length	Data Type
Total Cost Avoidance Savings (Medicare section)	Average Savings multiplied by the number of recipients with Medicare.	9	Number (Decimal)
Total Expenditures (Recipients with Insurance)	Total amount expended for recipients with insurance coverage.	13	Number (Decimal)
Total Expenditures (Recipients with Medicare)	Total amount expended for recipients with Medicare coverage.	13	Number (Decimal)
Total Expenditures (Recipients without Insurance)	Total amount expended for recipients without insurance coverage.	13	Number (Decimal)
Total Expenditures (Recipients without Medicare)	Total amount expended for recipients without Medicare coverage.	13	Number (Decimal)

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7.35 TPL-0034-M -- TPL Cost Recovery Summary - CMS Calculation Report

7.35.1 TPL-0034-M -- TPL Cost Recovery Summary - CMS Calculation Report Narrative

The TPL Cost Recovery Summary-CMS Calculation report is a summary of all cost recovery and collection results which are related to TPL activities. This report is produced monthly.

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7.35.2 TPL-0034-M -- TPL Cost Recovery Summary - CMS Calculation Report Layout

```
REPORT  :  TPL-0034-M                                ALABAMA MEDICAID AGENCY                                RUN DATE:   MM/DD/CCYY
PROCESS :  TPLJM008                               MEDICAID MANAGEMENT INFORMATION SYSTEM                     RUN TIME:   HH:MM:SS
LOCATION:  TPL0034M                              TPL COST RECOVERY SUMMARY - CMS CALCULATION                      PAGE:   999,999
                                                      REPORT PERIOD:  MM/DD/CCYY


CASUALTY-RELATED COLLECTIONS:                $999,999,999.99

INSURANCE COLLECTIONS                 $999,999,999.99

       MEDICARE RELATED       $999,999,999.99

       NON-MEDICARE RELATED   $999,999,999.99

PROVIDER TPL-RELATED COLLECTIONS:                    $999,999,999.99

       MEDICARE RELATED       $999,999,999.99

       NON-MEDICARE RELATED   $999,999,999.99

PROVIDER TPL-RELATED OFFSETS:                $999,999,999.99

       MEDICARE RELATED       $999,999,999.99

       NON-MEDICARE RELATED   $999,999,999.99


TOTAL TPL-RELATED RECOVERIES:                $999,999,999.99


                                                       *** END OF REPORT ***
                                                     *** NO DATA THIS RUN ***
```


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7.35.3 TPL-0034-M -- TPL Cost Recovery Summary - CMS Calculation Report Field Descriptions

Field	Description	Length	Data Type
Casualty-Related Collections	Dollar amount of casualty related TPL collections.	11	Number (Decimal)
Insurance Collections	Dollar amount of insurance TPL collections.	11	Number (Decimal)
Medicare Related (Insurance Collections)	Dollar amount of insurance collections which is Medicare related.	11	Number (Decimal)
Medicare Related (Provider TPL-Related Collections)	Dollar amount of provider TPL related collections which are Medicare related.	11	Number (Decimal)
Medicare Related (Provider TPL Related Offsets)	Dollar amount of provider TPL related offsets which are Medicare related.	11	Number (Decimal)
Non-Medicare Related (Insurance Collections)	Dollar amount of insurance collections which is non-Medicare related.	11	Number (Decimal)
Non-Medicare Related (Provider TPL Related Collections)	Dollar amount of provider TPL related collections which are non-Medicare related.	11	Number (Decimal)
Non-Medicare Related (Provider TPL Related Offsets)	Dollar amount of provider TPL related offsets which are non-Medicare related.	11	Number (Decimal)
Provider TPL-Related Collections	Dollar amount of provider TPL related collections.	11	Number (Decimal)
Provider TPL-Related Offsets	Dollar amount of provider TPL related offsets.	11	Number (Decimal)
Total TPL-Related Recoveries	Total dollar amount of TPL related recoveries.	11	Number (Decimal)

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7.36 TPL-0035-R -- UB-04 Billing Facsimile Report

7.36.1 TPL-0035-R -- UB-04 Billing Facsimile Report Narrative

The UB-04 Billing Facsimile is system generated from the TPL billing processes. The facsimile is generated for all inpatient, inpatient crossovers, and long term care claims where the carrier's media type code is equal to 'paper'. This report is produced upon request.

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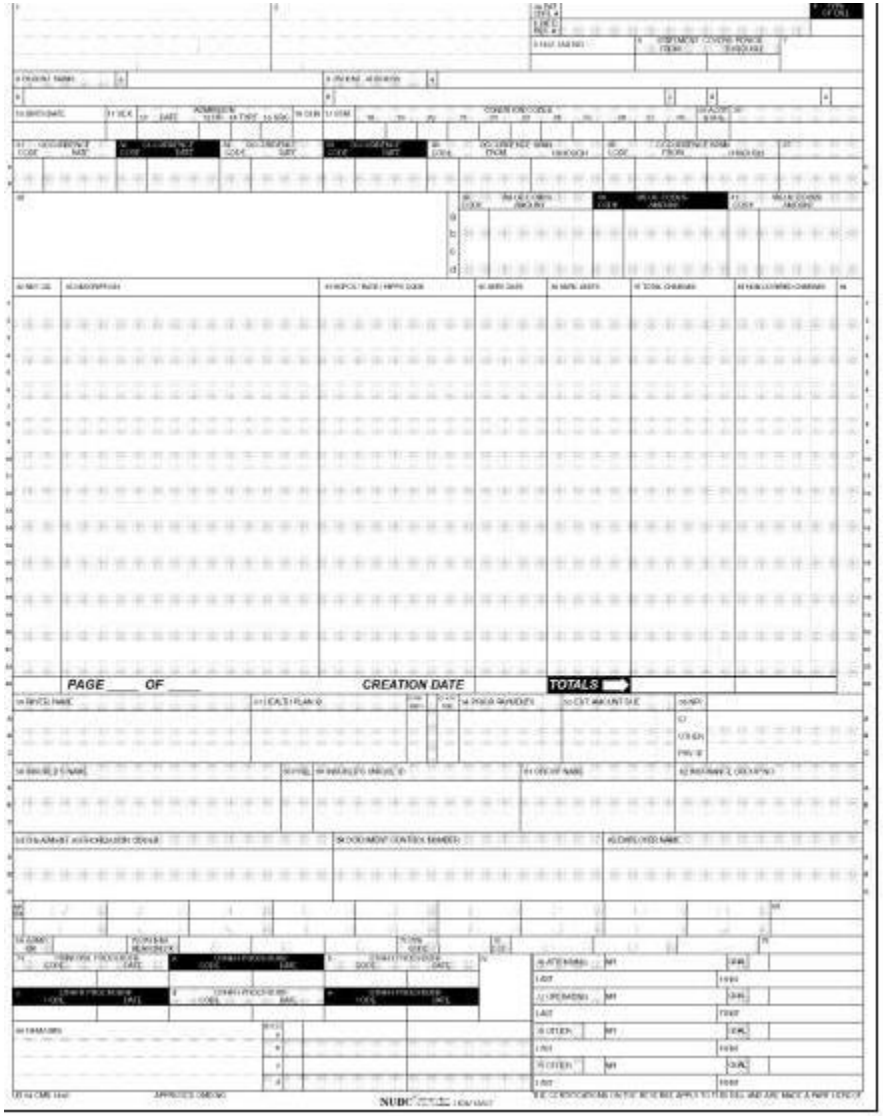
7.36.2 TPL-0035-R -- UB-04 Billing Facsimile Report Layout



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7.36.3 TPL-0035-R -- UB-04 Billing Facsimile Report Field Descriptions

Field	Description	Length	Data Type
Box 1 - Billed To	Bill To name and address.	1	Character
Box 10 - Birthdate	The recipient's date of birth.	10	Date (MM/DD/CCYY)
Box 11 - Sex	The recipient's gender.	1	Character
Box 12 - Admission Date	The date of admission.	10	Date (CCYY/MM/DD)
Box 13 - Admission Hour	The hour of admission.	2	Character
Box 14 - Type	The type of admission. Valid values: 1 = Emergency, 2 = Urgent, 3 = Elective, 4 = Newborn.	1	Number (Integer)
Box 15 - Src	The source of admission.	1	Character
Box 16 - D Hr	The hour of discharge.	2	Character
Box 17 - Stat	The patient status code.	1	Character
Box 18 - Condition Codes 1	The first condition code.	2	Character
Box 19 - Condition Codes 2	The second condition code.	2	Character
Box 2 - Remit To	Submitter name and address.	1	Character
Box 20 - Condition Codes 3	The third condition code.	2	Character
Box 21 - Condition Codes 4	The fourth condition code.	2	Character
Box 22 - Condition Codes 5	The fifth condition code.	2	Character

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Field	Description	Length	Data Type
Box 23 - Condition Codes 6	The sixth condition code.	2	Character
Box 23 - Medical Record No.	The internal control number (ICN) assigned to the Medicaid claim.	13	Number (Integer)
Box 24 - Condition Codes 7	The seventh condition code.	2	Character
Box 31 - Occurrence Code and Date 1	The first occurrence code and date.	12	Character
Box 33 - Occurrence Code and Date 2	The second occurrence code and date.	12	Character
Box 34 - Occurrence Code and Date 3	The third occurrence code and date.	12	Character
Box 35 - Occurrence Code and Date 4	The fourth occurrence code and date.	12	Character
Box 36 - Occurrence Code and Date 5	The fifth occurrence code and the from and to date.	22	Character
Box 38	The field will contain the following: Recipient ID: Medicaid Regulations - 42CFR 433.135, IC 12-1-7-24.2 MCAID Billing Number:	80	Character
Box 3a - Patient Control No.	The unique accounts receivable number associated with the claim.	12	Character
Box 3b - Medical Record Number	The unique medical record number associated with the claim.	12	Character
Box 4 - Type of Bill	The type of bill.	3	Character
Box 42 - Rev Cd	The revenue code.	3	Character
Box 43 - Description	The description of the revenue code.	25	Character

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Field	Description	Length	Data Type
Box 44 - HCPCS/Rate	The HCPCS code corresponding to Revenue Code.	6	Character
Box 45 - Serv Date	The service date.	8	Date (MM/DD/YY)
Box 46 - Serv Units	The number of units corresponding to the revenue code billed.	3	Character
Box 47 - Total Charges	The amount charged by the provider for each revenue code. The total of all lines is accumulated and reported at the end of the details under revenue code 001.	10	Number (Decimal)
Box 5 - Fed Tax No.	The State of Alabama's Medicaid Tax Identification Number.	13	Character
Box 50a - Payer	The name of any previous payer's. Valid values: Medicare or blank.	30	Character
Box 50b - Payer	The carrier's name being billed.	30	Character
Box 50c - Payer	MEDICAID is always printed in this field.	30	Character
Box 51a - Provider #	The provider number associated with the payer. This field is always blank.	9	Character
Box 51b - Provider #	The carrier code associated with the carrier being billed.	9	Character
Box 54a - Prior Payments	The payment amount paid by the payer. This field will contain either the Medicare paid amount or blanks.	12	Number (Decimal)
Box 55b - Est Amount Due	The total Medicaid paid amount or the amount being billed to the carrier.	12	Number (Decimal)
Box 58a - Insured's Name	The policyholder's last, first, and middle initial.	29	Character
Box 6 - Statement Covers Period	The claim first and last date of service.	8	Date (MM/DD/YY)
Box 60 - Cert - SSN - HIC - ID No	The policy number and policyholder's social security number.	39	Character
Box 62 - Insurance Group No	The policy group number.	30	Character

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Field	Description	Length	Data Type
Box 65 - Employer Name	The policyholder's employer name.	39	Character
Box 67 - Prin. Diag. Cd	The primary diagnosis code.	6	Character
Box 67a - Other Diag. Codes 1	The other diagnosis codes.	6	Character
Box 67b - Other Diag. Codes 2	The other diagnosis codes.	6	Character
Box 67c - Other Diag. Codes 3	The other diagnosis codes.	6	Character
Box 67d - Other Diag. Codes 4	The other diagnosis codes.	6	Character
Box 67e - Other Diag. Codes 5	The other diagnosis codes.	6	Character
Box 67f - Other Diag. Codes 6	The other diagnosis codes.	6	Character
Box 67g - Other Diag. Codes 7	The other diagnosis codes.	6	Character
Box 67h - Other Diag. Codes 8	The other diagnosis codes.	6	Character
Box 69 - Adm Diag Cd	The admitting diagnosis code.	5	Character
Box 7 - Cov Days	The number of days covered by the stay.	3	Number (Integer)
Box 70 - E-Code	The 'e' diagnosis code.	6	Character
Box 74 - Principal Procedure Code and Date	The principal surgical/obstetrical procedure code and date.	15	Character

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Field	Description	Length	Data Type
Box 74a - Other Procedure Code and Date 1	The additional surgical/obst procedure code and date.	15	Character
Box 74b - Other Procedure Code and Date	The additional surgical/obst procedure code and date.	15	Character
Box 74c - Other Procedure Code and Date	The additional surgical/obst procedure code and date.	15	Character
Box 74d - Other Procedure Code and Date	The additional surgical/obst procedure code and date.	15	Character
Box 74e - Other Procedure Code and Date	The additional surgical/obst procedure code and date.	15	Character
Box 76 - Attending Phys. Name	The provider number followed by the provider name.	48	Character
Box 8 - Patient Name	The recipient's last, first, and middle initial.	29	Character
Box 80 - Remarks	The provider's name, street address, city, state, zip code, and phone number.	97	Character
Box 85 - Provider Signature	The words 'Signature on File' are printed in this field.	17	Character
Box 86 - Date	The current system date.	8	Character
Box 9 - Patient Address	The recipient's street address, city, state, and zip code.	138	Character
Medicare Allowed	Amount Medicare allowed.	10	Number (Decimal)
Medicare Coin	Medicare coinsurance amount.	10	Number (Decimal)

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Field	Description	Length	Data Type
Medicare DED	Medicare deductible amount.	10	Number (Decimal)
Medicare Paid	Amount Medicare paid.	10	Number (Decimal)

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7.37 HMT-RADA-D -- Dental Billing Facsimile Report

7.37.1 HMT-RADA-D -- Dental Billing Facsimile Report Narrative

The Dental Billing Facsimile is system generated from the Retroactive and Rebilling processes. The facsimile is generated for all dental claims where the carrier's media type code is equal to 'paper'. This report is produced upon request.

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7.37.2 HMT-RADA-D -- Dental Billing Facsimile Report Layout

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X ____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X ____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X ____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org

7.37.3 HMT-RADA-D -- Dental Billing Facsimile Report Field Descriptions

Field	Description	Data Type	Length
Box 1 Type of Transaction	The "Statement of Actual Services" is checked.	Character	1
Box 10 Patient's Relationship to Person named in #5	The recipient's relationship to the insured. Check appropriate box.	Character	1
Box 11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and complete address for other insurance company or Dental Benefit Plan.	Character	120
Box 12 Policyholder/Subscriber Name	The insured's last, first, and middle initial. Address, City, State and Zip Code for insurance identified in box 3.	Character	120
Box 13 Date of Birth	Date of birth for policy holder in box 12.	Date (MM/DD/CCYY)	10
Box 14 Gender	Check appropriate box for policy holder in box 12.	Character	1
Box 15 Policy Holder/Subscriber ID	Policy holder identification number or social security number.	Character	15
Box 16 Plan/Group Number	Enter plan number.	Character	10
Box 17 Employer Name	The policyholder's employer name.	Character	39
Box 18 Relationship to Policy Holder/Subscriber in #12	Check appropriate box.	Character	1
Box 19 Reserved For Future Use	Leave blank and skip to Item #20. (#19 was previously used to report "Student Status.")	Character	1
Box 2 Predetermination/Preauthorization Number	Prior authorization number if applicable.	Character	10
Box 20 Patient's Name and Address	The recipient's last, first, and middle initial and their street, city, state and zip code.	Character	90
Box 21 Date of Birth	The recipient's date of birth.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Box 22 Gender	Check the appropriate box for the gender of the recipient.	Character	1
Box 23 Patient ID/Account #	Enter the AR number.	Number (Integer)	13
Box 24 Procedure Date	The detail date of service.	Date (MM/DD/CCYY)	10
Box 25 Area of Oral Cavity	1 or 2 digit code identifying the area of the oral cavity in which the service is rendered.	Character	2
Box 26 Tooth System	No description given by ADA.	Character	2
Box 27 Tooth Number(s) or Letter(S)	The tooth number/letter, may occur 12 times.	Character	2
Box 28 Tooth Surface	The tooth surface, may occur 12 times.	Character	5
Box 29 Procedure Code	The service rendered by the provider.	Number (Integer)	5
Box 29a Diag Pointer	Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.	Character	4
Box 29b Qty	Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is “01.”	Character	2
Box 3 Insurance Company/Dental Benefit Plan Information	The carrier's plan name, address, state and zip code.	Character	90
Box 30 Description	The description of service provided.	Character	24
Box 31 Fee	The line item charge submitted by the billing dentist.	Number (Decimal)	9
Box 31a Other Fee(s)	When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.	Number (Decimal)	12
Box 32 Total Fee	The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.	Number (Decimal)	12

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Field	Description	Data Type	Length
Box 33 Missing Teeth Information	Not used for rebilling, the dentist can mark any missing teeth on the claim.	Character	1
Box 34 Diagnosis Code List Qualifier	This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. B = ICD-9-CM AB = ICD-10-CM (as of October 1, 2013)	Character	2
Box 34a Diagnosis Code(s)	Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A." This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.	Character	7
Box 35 Remarks	Should contain "Medicaid Paid Amount =" and the total paid on the claim by Medicaid.	Character	30
Box 36 Authorization	Signature (Patient/Guardian) or Signature on File per Regs 42 CFR 433.135, IC 12-1-7-24.2. followed by Date claim prepared.	Character	50
Box 37 Authorization	Subscriber signature or "signature on file" follow by the date claim prepared.	Character	50
Box 38 Place of Treatment	11 for Office 22 for Hospital	Character	2
Box 39 Enclosures (Y or N)	Currently not used in Alabama.	Character	1
Box 4 Other Coverage	Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or	Character	1

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Field	Description	Data Type	Length
	medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.		
Box 40 Is Treatment for Orthodontics?	Yes or No. Currently not used in Alabama.	Character	1
Box 41 Date Appliance Placed	Date of placement. Currently not used in Alabama.	Date (MM/DD/CCYY)	10
Box 42 Months of Treatment Remaining	Number of Months remaining for treatment. Currently not used in Alabama.	Number (Integer)	3
Box 43 Replacement of Prosthesis	Check appropriate box. Currently not used in Alabama.	Character	1
Box 44 Date of Prior Placement	Date of prior placement of prosthesis. Currently not used in Alabama.	Date (MM/DD/CCYY)	10
Box 45 Treatment Resulting From	Check appropriate box if treatment is the result of occupational illness or injury, auto accident or other accident.	Character	1
Box 46 Date of Accident	The date of accident.	Date (MM/DD/CCYY)	10
Box 47 Auto Accident State	The two character state abbreviation.	Character	2
Box 48 Name, Address, City, State, Zip Code of Billing Dentist or Dental Entity	The name of the billing dentist, complete address and zip code.	Character	120
Box 49 NPI	The billing provider's NPI number.	Number (Integer)	10
Box 5 Name of Policy Holder	Last, First name and middle initial of policy holder.	Character	30
Box 50 License Number	License Number.	Character	10
Box 51 SSN or TIN	Enter the Social Security Number or the Tax Identification Number of the billing provider.	Character	12

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Field	Description	Data Type	Length
Box 52 A Additional Provider ID	Additional ID.	Character	10
Box 52 Phone Number	Billing Provider Phone number.	Character	10
Box 53 Signature (Treating Dentist)	The words 'Signature on File' are printed in the signature field followed by the Alabama Medicaid tax ID and current date.	Character	17
Box 54 NPI	The provider ID for the billing dentist.	Character	10
Box 55 License Number	Treating Provider's license number.	Character	15
Box 56 Address, City, State, Zip Code	Complete physical address.	Character	90
Box 56A Provider Specialty Code	Currently not used in Alabama.	Character	15
Box 57 Phone Number	Phone number of treating dentist.	Character	11
Box 58 Additional Provider ID	Currently not used in Alabama.	Character	10
Box 6 Date of Birth	Date of birth of policy holder	Date (MM/DD/CCYY)	10
Box 7 Gender	Check appropriate box for gender of policy holder.	Character	1
Box 8 Policy Holder/Subscriber ID	The recipient's Medicaid Number.	Number (Integer)	12
Box 9 Plan/Group Number	The policy and group number.	Character	30
Please Remit Payment To:	The Alabama Medicaid Agency's Third Party Unit's complete address and Tax ID.	Character	150

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7.38 TPL-0037-R -- CMS-1500 Billing Facsimile Report

7.38.1 TPL-0037-R -- CMS-1500 Billing Facsimile Report Narrative

The CMS-1500 Billing Facsimile is system generated from the Retroactive, Medicare Retroactive, and Rebilling processes. The facsimile is generated for all professional and professional crossover claims where the carrier's media type code is equal to 'paper'.

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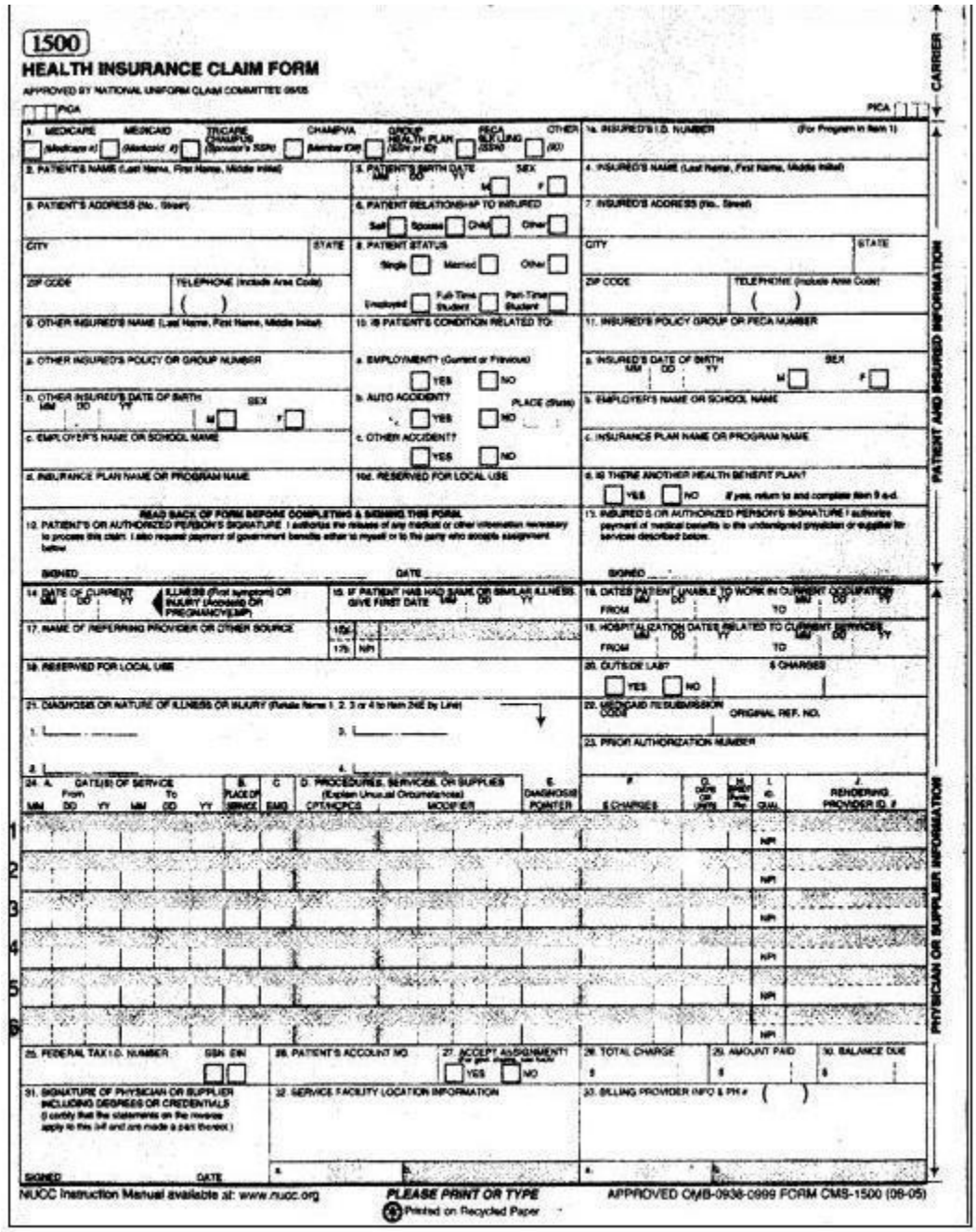
7.38.2 TPL-0037-R -- CMS-1500 Billing Facsimile Report Layout



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID#) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line) 1. 2. 3. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION a. b.
33. BILLING PROVIDER INFO & PH # ( ) a. b.

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
Printed on Recycled Paper
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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7.38.3 TPL-0037-R -- CMS-1500 Billing Facsimile Report Field Descriptions

Field	Description	Length	Data Type
Bill To:	Complete Mailing Address for entity Third Party Unit is sending the Rebilling to.	120	Character
Box 1 - Other	The type of claim being billed.	1	Character
Box 10 - Is Patient Condition Related to:	a: Employment? Y/N b: Auto Accident? Y/N :if Y then 2 letter abbreviation for state c: Other Accident? Y/N.	6	Character
Box 10d - Reserved for Local Use	The Medicaid billing number assigned by the insurance carrier.	13	Character
Box 11 - Insured's Policy Group	The group number associated with the policy being billed.	30	Character
Box 11a - Insured's Date of Birth and Gender	Insured's Date of Birth DD/MM/CCYY format and X in the appropriate box for gender.	20	Character
Box 11b - Employer's Name	The insured's employer name.	30	Character
Box 11c - Insurance Plan Name	The carrier code followed by the carrier's name.	39	Character
Box 11d - Is There Another Health Benefit Plan	X in box for Y or N.	1	Character
Box 12 - Patient's or Authorized Person's Signature	"Signature of File" pursuant to Regs 42 CFR 433.135, IC 12-1-7-24.2. and Date claim prepared.	30	Character
Box 13 - Insured's or Authorized Person's Signature	"Signature of File" pursuant to Regs 42 CFR 433.135, IC 12-1-7-24.2. and Date claim prepared.	30	Character
Box 14 - Date of Current illness or Injury or Pregnancy	Date of illness or injury or pregnancy. Currently not used in Alabama.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
Box 15 - Date of Similar Illness	If patient has had same or similar illness give first date. Currently not used in Alabama.	10	Date (MM/DD/CCYY)
Box 16 - Dates Patient Unable to Work in Current Occupation	From and through dates patient unable to work. Currently not used in Alabama.	16	Character
Box 17 - Name Of Referring Physician	The name of the referring physician.	33	Character
Box 17a - Referring Physician number	Referring number or N/A.	10	Character
Box 17b - Referring Physican's NPI	Referring Physician's NPI or blank.	10	Number (Integer)
Box 18 Hospitalization Dates Related to Current Services	To and From dates for hospital stay for services. Currently not used in Alabama.	16	Character
Box 19 - Reserved for Local use	On a cross-over claim should have "Medicare Paid Amount $##,###.##.	30	Character
Box 1a - Insureds I.D. Number	The policy number or policyholder social security number.	30	Character
Box 2 - Patient's Name	The recipient's last, first, and middle initial.	28	Character
Box 20 - Outside Lab	Check Y or N and if Y enter the amount of Charges. Currently not used in Alabama.	10	Character
Box 21.1 - Diagnosis 1	The primary diagnosis code and description.	43	Character
Box 21.2 - Diagnosis 2	The secondary diagnosis code and description.	43	Character
Box 21.3 Diagnosis 3	The third diagnosis code and description.	43	Character
Box 21.4 - Diagnosis 4	The fourth diagnosis code and description.	43	Character
Box 22 - Medicaid Resubmission Code	The internal control number (ICN) assigned to the Medicaid claim. Currently not used in Alabama.	13	Character

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Field	Description	Length	Data Type
Box 23 - Prior Authorization Number	The Prior Authorization Number.	10	Number (Integer)
Box 24a - Date(s) of Service	The 'from' and 'to' dates of service.	16	Date (MM/DD/CCYY)
Box 24b - Place of Service	The place of service.	2	Number (Integer)
Box 24c - EMG	The emergency indicator, valid values are "Y" for yes and "N" for no. Defaults to "N".	1	Character
Box 24d - Procedure, Services, or Supplies	The procedure code identifying the service followed by the appropriate modifier. The modifier may occur up to 4 times per procedure. 5 characters for procedure code and 2 characters for each modifier.	20	Character
Box 24e - Diagnosis Code	The diagnosis treated indicator - indicates which of the 4 diagnoses given in field 21 is being treated. Can occur up to 4 times.	1	Character
Box 24f - Charges	The provider submitted charges for the procedure performed.	9	Number (Decimal)
Box 24g - Days or Units	The number of days or units of service.	7	Number (Integer)
Box 24h - EPSDT/Family Plan	“1” if the procedure billed is a result of an EPSDT referral “2” if the procedure is related to Family Planning “3” if the procedure is a Patient 1st (PMP) referral Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated. “4” if the procedure is EPSDT and PMP referral.	1	Character
Box 24i - ID QUAL	The qualifier for the rendering provider number: MCD or NPI.	3	Character
Box 24j - Rendering Provider ID	The Medicaid or NPI number for the rendering provider	11	Number (Integer)
Box 25 - Federal Tax I.D. Number	The State of Alabama's Medicaid Tax Identification Number and the EIN indicator.	13	Character
Box 26 - Patient's Account Number	The unique accounts receivable number associated to the claim being billed.	12	Number (Integer)

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Field	Description	Length	Data Type
Box 27 - Accept Assignment	Y or N.	1	Character
Box 28 - Total Charge	The total of all line charges.	11	Number (Decimal)
Box 29 - Amount Paid	The Amount Medicaid paid on the claim.	9	Number (Decimal)
Box 3 - Patients Birthdate	The recipient's date of birth MM/DD/CCYY and gender has x is appropriate box.	20	Character
Box 30 - Balance Due	The difference between what the provider billed and what Medicaid had paid.	9	Number (Decimal)
Box 31 - Signature	The words 'Signature on File' are printed in the signature field followed by the current date.	17	Character
Box 32 - Name and Address of Facility	The performing providers name, street address, city, state, zip code, and tax ID.	142	Character
Box 32a	Rendering Provider's NPI number if available.	10	Number (Integer)
Box 32b	Rendering Provider's Medicaid number with MCD indicator if NPI unavailable.	13	Character
Box 33 - Billing Provider Info	The Billing provider's name and complete mailing address.	120	Character
Box 33a	Billing Provider's NPI number if available.	10	Number (Integer)
Box 33b	Billing provider's Medicaid number with MCD indicator if NPI unavailable.	13	Character
Box 4 - Insured's Name	The policyholder's last, first, and middle initial.	28	Character
Box 5 - Patient's Address	The recipient's street address, city, state, and zip code.	128	Character
Box 6 - Patient Relationship to Insured	The recipient's relationship to the insured.	1	Character
Box 7 - Insured's Address	The policyholder's street address, city, state, and zip code.	83	Character

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Field	Description	Length	Data Type
Box 8 Patient Status	Check the appropriate boxes for patient status: Single, Married, Other, Employed, Full-Time Student or Part-Time Student.	6	Character
Box 9 - Other Insured's Name	Recipient's last name, first name and middle initial.	30	Character
Box 9a - Other Insured's Policy or Group Number	Recipient's Medicaid number.	12	Number (Integer)
Box 9b - Other Insured's Date of Birth Gender	Recipient's Date of Birth DD/MM/CCYY format and X in the appropriate box for gender.	30	Character
Box 9c - Employer's Name or School Name	Employer's name or school name.	20	Character
Box 9d - Insurance Plan or Program Name	Name of Insurance Plan or Program.	8	Character
Remit Payment To:	Complete Address for the Alabama Medicaid Agency Third Party Unit.	120	Character

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7.39 TPL-0038-M -- HIPP Monthly Payment Detail Report

7.39.1 TPL-0038-M -- HIPP Monthly Payment Detail Report Narrative

The HIPP Monthly Payment Detail report is system-generated and reflects monthly Health Insurance Premium Payment (HIPP) activity on an individual recipient basis. The report details which policies are included for premium payment and the premiums paid on each. The total amount of premiums paid for HIPP recipients, the number of premiums paid and the total of reported recipients are summarized at the end of the report. This report is produced monthly.

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7.39.2 TPL-0038-M -- HIPP Monthly Payment Detail Report Layout

```
Report:  TPL-0038-M                          ALABAMA MEDICAID AGENCY                                  Run Date:   MM/DD/CCYY
Process :TPLJM038                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:     HH:MM:SS
Location:TPL0038M                           HIPP MONTHLY PAYMENT DETAIL                                  Page:        9,999
                                                 REPORT PERIOD:  MM/CCYY



RECIPIENT ID                        PAYEE ID                            AMT PAID   CHECK NO    ISSUE DT  SCHED  PERIOD    PERIOD
RECIPIENT NAME                      NAME                                                                        BEG DT    END DT
                                    POLICY NO

999999999999                        9999999                              $9,999.99  999999999  MM/DD/CCYY  XX  MM/DD/CCYY MM/DD/CCYY
XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

999999999999                        9999999                              $9,999.99  999999999  MM/DD/CCYY  XX  MM/DD/CCYY MM/DD/CCYY
XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

999999999999                        9999999                              $9,999.99  999999999  MM/DD/CCYY  XX  MM/DD/CCYY MM/DD/CCYY
XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


SUMMARY

TOTAL PAID IN PREMIUMS:         $999,999.99
NUMBER OF PREMIUMS PAID:              9,999
NUMBER OF RECIPIENTS:                 9,999


                                                   ** END OF REPORT **
                                                 ** NO DATA THIS RUN **
```


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7.39.3 TPL-0038-M -- HIPP Monthly Payment Detail Report Field Descriptions

Field	Description	Length	Data Type
Amt Paid	Amount of HIPP premium payment.	9	Decimal
Check No	Check number of premium payment.	9	Number (Integer)
Issue Dt	Date premium payment check was issued.	10	Date (MM/DD/CCYY)
Name	Carrier name from TPL Carrier table.	33	Character
Number of Premiums Paid	Total number of premium payments in the report month.	5	Number (Decimal)
Number of Recipients	Unduplicated number of recipients with HIPP premiums paid in the report month.	5	Number (Integer)
Payee ID	The employer or carrier ID the payment was issued.	7	Number (Integer)
Period Beg Dt	The premium begin date.	10	Date (MM/DD/CCYY)
Period End Dt	The premium end date.	10	Date (MM/DD/CCYY)
Policy No.	Policy number associated with this HIPP payment.	30	Character
Recipient ID	Recipient identification number.	12	Number (Integer)
Recipient Name	Recipient name - last, first, middle initial.	32	Character
Sched	Frequency schedule of premium payments for this policy: A (ANNUALLY) B (BI-WEEKLY) F (FOUR TIMES A MONTH) M (MONTHLY) Q (QUARTERLY) S (SEMI-MONTHLY) W (WEEKLY)	2	Character
Total Paid in Premiums	Total amount of premiums paid in the report month.	11	Number (Decimal)

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7.40 TPL-0039-M -- HIPP Recipients for Cost Effectiveness Review Report

7.40.1 TPL-0039-M -- HIPP Recipients for Cost Effectiveness Review Report Narrative

The HIPP Recipients for Cost Effectiveness Review report is a system-generated report. The report criteria is based upon the Review Date on the HIPP Payment panel and lists those recipients whose HIPP policies require a scheduled review, for the report month, of the cost-effectiveness of continuing premium payments. This report is produced monthly.

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7.40.2 TPL-0039-M -- HIPP Recipients for Cost Effectiveness Review Report Layout

```
REPORT  :  TPL-0039-M                          ALABAMA MEDICAID AGENCY                        RUN DATE:  MM/DD/CCYY
PROCESS :  TPLJM039                       MEDICAID MANAGEMENT INFORMATION SYSTEM              RUN TIME:  HH:MM:SS
LOCATION:  TPL0039M                  HIPP POLICYHOLDERS FOR COST EFFECTIVENESS REVIEW             PAGE:  999,999
                                               REPORT PERIOD:  MM/CCYY



POLICYHOLDER ID                       CARRIER/EMP ID    HIPP CASE #                    PREMIUM AMOUNT  SCHEDULE
POLICYHOLDER NAME                     NAME                                                             REVIEW DT


XXXXXXXXXXXX                         XXXXXXX            999999999                       $9,999.99         XX
XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                CCYY/MM/DD


XXXXXXXXXXXX                         XXXXXXX            999999999                       $9,999.99         XX
XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                CCYY/MM/DD


SUMMARY

TOTAL POLICYHOLDERS:                        9,999


                                                        *** END OF REPORT ***
                                                      *** NO DATA THIS RUN ***
```


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7.40.3 TPL-0039-M -- HIPP Recipients for Cost Effectiveness Review Report Field Descriptions

Field	Description	Length	Data Type
Carrier/Emp ID	Carrier or employer number of the insuring entity.	7	Number (Integer)
HIPP Case #	The HIPP case number assigned to the case being reported.	9	Number (Integer)
Name	Carrier/Employer name from TPL carrier table.	34	Character
Policyholder ID	The number assigned to the policyholder.	12	Number (Integer)
Policyholder Name	Policyholder name - last, first, middle initial.	26	Character
Premium Amount	Amount of HIPP premium payment.	9	Number (Decimal)
Review Dt	Date for cost-effectiveness review.	10	Date (MM/DD/CCYY)
Schedule	Frequency schedule of premium payments for this policy: A (ANNUALLY) B (BI-WEEKLY) F (FOUR TIMES A MONTH) M (MONTHLY) Q (QUARTERLY) S (SEMI-MONTHLY) W (WEEKLY)	2	Character
Total Policyholders	Total number of policyholder records reported in the reporting month.	5	Number (Integer)

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7.41 TPL-0042-Q -- HIPP Cost-Effectiveness - Quarterly Analysis Report

7.41.1 TPL-0042-Q -- HIPP Cost-Effectiveness - Quarterly Analysis Report Narrative

The HIPP Cost-effectiveness - Quarterly Analysis report provides an overview of the activity and potential cost savings impact of the HIPP Program. It includes all HIPP cases in a premium payment status (ES) and those added during the quarter. This report is produced quarterly.

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7.41.2 TPL-0042-Q -- HIPP Cost-Effectiveness - Quarterly Analysis Report Layout

```
REPORT  :  TPL-0042-Q                                ALABAMA MEDICAID AGENCY                          RUN DATE: MM/DD/CCYY
PROCESS :  TPLJQ003                             MEDICAID MANAGEMENT INFORMATION SYSTEM                 RUN TIME: HH:MM:SS
LOCATION:  TPL0042Q                          HIPP COST-EFFECTIVENESS - QUARTERLY ANALYSIS                     PAGE: 999,999
                                                   REPORT PERIOD:  MM/DD/CCYY


TOTAL NO. NEW HIPP POLICIES ENTERED                                                                    9,999
TOTAL NO. NEW HIPP POLICIES DETERMINED COST-EFFECTIVE                                                  9,999


TOTAL HIPP POLICIES IN EFFECT                                                                        999,999
TOTAL RECIPIENTS AVG ANNUAL MA EXPENDITURES FROM HIPP CALCULATIONS                                $999,999.99


POTENTIAL COST SAVINGS $                                                                     999,999,999.99



                                                     *** END OF REPORT ***
                                                    *** NO DATA THIS RUN ***
```


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7.41.3 TPL-0042-Q -- HIPP Cost-Effectiveness - Quarterly Analysis Report Field Descriptions

Field	Description	Length	Data Type
Potential Cost Savings	This is the expenditure amount minus the purchase amount on the HIPP Resource table where the HIPP cases are in a premium payment status of 'ES'.	15	Number (Decimal)
Total HIPP Policies in Effect	This is a count of all HIPP cases that are in a premium payment status of 'ES'.	7	Number (Decimal)
Total No. New HIPP Policies Determined Cost-Effective	This is the number of HIPP cases that were added within the quarter and are in a premium payment status of 'ES'.	5	Number (Decimal)
Total No. New HIPP Policies Entered	This is the number of HIPP cases that were added during the quarter, regardless of the status.	5	Number (Decimal)
Total Recipients Average Annual MA Expenditures from HIPP Calculations	This is the expenditure amount from the HIPP Resource table for all cases in a premium payment status of 'ES' and identifies the total average Medicaid expenditure amount for all individuals on these cases.	11	Number (Decimal)

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7.42 TPL-0044-W -- HIPP Policies For Follow-up Report

7.42.1 TPL-0044-W -- HIPP Policies For Follow-up Report Narrative

The HIPP Policies for Follow-up report is a system generated report. It provides a list of HIPP policies requiring additional research or information prior to purchasing a policy. All HIPP cases in a Pending Verification status (P1) that contains at least one recipient with a primary indicator = 'Y' are identified and reported. This report is produced weekly.

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7.42.2 TPL-0044-W -- HIPP Policies For Follow-up Report Layout

```
REPORT  : TPL-0044-W                          ALABAMA MEDICAID AGENCY                    RUN DATE:   MM/DD/CCYY
PROCESS : TPLJW004                     MEDICAID MANAGEMENT INFORMATION SYSTEM            RUN TIME:   HH:MM:SS
LOCATION: TPL0044W                        TPL HIPP POLICIES FOR FOLLOW-UP                    PAGE:   999,999
                                       PERIOD:  MM/DD/CCYY THROUGH MM/DD/CCYY


RECIPIENT NAME:                         XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X
RID NUMBER:                             XXXXXXXXXXXX
CARRIER NBR:                            XXXXXXX
CARRIER NAME:                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
HIPP CASE NUMBER:                       999999999

RECIPIENT NAME:                         XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X
RID NUMBER:                             XXXXXXXXXXXX
CARRIER NBR:                            XXXXXXX
CARRIER NAME:                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
HIPP CASE NUMBER:                       999999999

RECIPIENT NAME:                         XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X
RID NUMBER:                             XXXXXXXXXXXX
CARRIER NBR:                            XXXXXXX
CARRIER NAME:                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
HIPP CASE NUMBER:                       999999999

RECIPIENT NAME:                         XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X
RID NUMBER:                             XXXXXXXXXXXX
CARRIER NBR:                            XXXXXXX
CARRIER NAME:                           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
HIPP CASE NUMBER:                       999999999

                                                          *** END OF REPORT ***
                                                        *** NO DATA THIS RUN ***
```


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7.42.3 TPL-0044-W -- HIPP Policies For Follow-up Report Field Descriptions

Field	Description	Length	Data Type
Carrier NBR	The number assigned to a specific carrier who provides the potential HIPP policy.	7	Number (Integer)
Carrier Name	The name of a specific carrier who provides the potential HIPP policy.	34	Character
HIPP Case No	The unique number assigned to a HIPP case.	9	Number (Integer)
Recipient Name	Name of the Medicaid recipient.	34	Character
RID Number.	Recipient Medicaid identification number.	12	Number (Integer)

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7.43 TPL-0046-M – NCPDP Subrogation Response – Detail Status Report

7.43.1 TPL-0046-M – NCPDP Subrogation Response – Detail Status Report Narrative

The purpose of this report is to report all the drug claims that were submitted in the subrogation claim request transaction to different external entities and were rejected for different reasons.

7.43.2 TPL-0046-M – NCPDP Subrogation Response – Detail Status Report Layout

```
REPORT  : TPL-0046-M                              ALABAMA MEDICAID AGENCY                                RUN DATE:  MM/DD/CCYY
PROCESS : TPLJD100                          MEDICAID MANAGEMENT INFORMATION SYSTEM                       RUN TIME:  HH:MM:SS
LOCATION: TPL0046M                      NCPDP SUBROGATION REJECTED RESPONSE DETAILED REPORT                  PAGE:  99,999,999
                                                   REPORT PERIOD:  MM/DD/CCYY

CARRIER : XXXXXXXXXX                CARRIER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER RESPONSE STATUS: ACCEPTED
DETAIL RESPONSE STATUS: REJECTED

RECIPIENT INFORMATION:
---------------------
ID             : XXXXXXXXXXXX
FIRST NAME     : XXXXXXXXXXXXXXX
MIDDLE INITIAL : X
LAST NAME      : XXXXXXXXXXXXXXXXXXXX

DATE OF SERVICE: MM/DD/CCYY
AR NUMBER      : XXXXXXXXXXXXX

CARDHOLDER ID  : XXXXXXXXXXXXXXXXXXXX
ENTITY ICN     : XXXXXXXXXXXXXXXXXXXX

REJECTION CODES:
   1     2     3     4     5
  XXX   XXX   XXX   XXX   XXX

ADDITIONAL MESSAGE:
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<-------- page break after each rejected claim record so that each page shows a detailed rejection message received -------->
```

```
REPORT  : TPL-0046-M                          ALABAMA MEDICAID AGENCY                                RUN DATE:  MM/DD/CCYY
PROCESS : TPLJD100                       MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME:  HH:MM:SS
LOCATION: TPL0046M                  NCPDP SUBROGATION REJECTED RESPONSE DETAILED REPORT                 PAGE:  99,999,999
                                              REPORT PERIOD:  MM/DD/CCYY

RECIPIENT INFORMATION:
---------------------
ID             : XXXXXXXXXXXX
FIRST NAME     : XXXXXXXXXXXXXXX
MIDDLE INITIAL : X
LAST NAME      : XXXXXXXXXXXXXXXXXXXX

DATE OF SERVICE: MM/DD/CCYY
AR NUMBER      : XXXXXXXXXXXXX

CARDHOLDER ID  : XXXXXXXXXXXXXXXXXXXX
ENTITY ICN     : XXXXXXXXXXXXXXXXXXXX

REJECTION CODES:
   1     2     3     4     5
  XXX   XXX   XXX   XXX   XXX

ADDITIONAL MESSAGE:
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←------- page break after change in header/detail response status and same carrier;  and print header/detail status -------→
REPORT  : TPL-0046-M                            ALABAMA MEDICAID AGENCY                                RUN DATE:  MM/DD/CCYY
PROCESS : TPLJD100                         MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME:  HH:MM:SS
LOCATION: TPL0046M                     NCPDP SUBROGATION REJECTED RESPONSE DETAILED REPORT                 PAGE:  99,999,999
                                                 REPORT PERIOD:  MM/DD/CCYY

HEADER RESPONSE STATUS: REJECTED
DETAIL RESPONSE STATUS: REJECTED

RECIPIENT INFORMATION:
----------------------
ID              : XXXXXXXXXXXX
FIRST NAME      : XXXXXXXXXXXXXXX
MIDDLE INITIAL  : X
LAST NAME       : XXXXXXXXXXXXXXXXXXXX

DATE OF SERVICE: MM/DD/CCYY
AR NUMBER       : XXXXXXXXXXXXX

CARDHOLDER ID   : XXXXXXXXXXXXXXXXXXXX
ENTITY ICN      : XXXXXXXXXXXXXXXXXXXX

REJECTION CODES:
   1     2     3     4     5
  XXX   XXX   XXX   XXX   XXX

ADDITIONAL MESSAGE:
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←------- provide a sub-total when carrier code changes                                          -------→
```


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```
SUB-TOTAL FOR CARRIER                              :  XXXXXXXXXX
SUBROGATION CLAIMS WITH ACCEPTED/REJECTED STATUS   :  99,999,999
SUBROGATION CLAIMS WITH REJECTED/REJECTED STATUS   :  99,999,999
TOTAL SUBROGATION CLAIMS WITH REJECTED STATUS      :  99,999,999

←------- go to a new page for the next carrier -------→

REPORT  : TPL-0046-M                            ALABAMA MEDICAID AGENCY                                RUN DATE:  MM/DD/CCYY
PROCESS : TPLJD100                         MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME:  HH:MM:SS
LOCATION: TPL0046M                     NCPDP SUBROGATION REJECTED RESPONSE DETAILED REPORT                 PAGE:  99,999,999
                                                 REPORT PERIOD:  MM/DD/CCYY

CARRIER : XXXXXXXXXX               CARRIER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER RESPONSE STATUS: ACCEPTED
DETAIL RESPONSE STATUS: REJECTED

RECIPIENT INFORMATION:
---------------------
ID             : XXXXXXXXXXXX
FIRST NAME     : XXXXXXXXXXXXXXX
MIDDLE INITIAL : X
LAST NAME      : XXXXXXXXXXXXXXXXXXXX

DATE OF SERVICE: MM/DD/CCYY
AR NUMBER      : XXXXXXXXXXXXX

CARDHOLDER ID  : XXXXXXXXXXXXXXXXXXXX
ENTITY ICN     : XXXXXXXXXXXXXXXXXXXX

REJECTION CODES:
   1     2     3     4     5
  XXX   XXX   XXX   XXX   XXX

ADDITIONAL MESSAGE:
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←------- page break after each rejected claim record so that each page shows a detailed rejection message received -------→


←------- provide a sub-total for the last carrier                                                                  -------→

SUB-TOTAL FOR CARRIER                                :  XXXXXXXXXX
SUBROGATION CLAIMS WITH ACCEPTED/REJECTED STATUS     :  99,999,999
SUBROGATION CLAIMS WITH REJECTED/REJECTED STATUS     :  99,999,999
TOTAL SUBROGATION CLAIMS WITH REJECTED STATUS        :  99,999,999


←------- page break when EOF is reached and the grand total is being reported-------→

REPORT  : TPL-XXXX-R                              ALABAMA MEDICAID AGENCY                                RUN DATE:  MM/DD/CCYY
PROCESS : TPLJMXXXP                          MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME:  HH:MM:SS
LOCATION: TPLXXXXR                       NCPDP SUBROGATION REJECTED RESPONSE DETAILED REPORT                 PAGE:  99,999,999
                                                   REPORT PERIOD:  MM/DD/CCYY

TOTAL CARRIERS                                       :  99,999,999
SUBROGATION CLAIMS WITH ACCEPTED/REJECTED STATUS     :  99,999,999
SUBROGATION CLAIMS WITH REJECTED/REJECTED STATUS     :  99,999,999
TOTAL SUBROGATION CLAIMS WITH REJECTED STATUS        :  99,999,999


                                                        **  END OF REPORT  **
```

7.43.3 TPL-0046-M – NCPDP Subrogation Response – Detail StatusField Descriptions

Field	Description	Data Type	Length
AR Number	Number that uniquely identifies the A/R that is associated with the claim.	Character	13
Additional Message	Message received in the 526-FQ field in the AM 21 segment of the G1 detail reponse record. Up to 25 messages may be received.	Character	40
Cardholder ID	Cardholder ID received in the 302-C2 field in the AM 25 segment of the G1 detail reponse record.	Character	20
Carrier	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	Character	10
Carrier Name	The business name of an insurance carrier.	Character	45
Date of Service	Date of service received in the 401-D1 field in the Response Transaction Header Segment of the G1 detail reponse record.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
Detail Response Status	Will always indicate "Rejected" as all the claims listed had an "R" (rejected) or "D" (duplicate of paid) status in the 112-AN field of the AM21 segment in the detail response record.	Character	8
Entity ICN	Identification number assigned to the claim by the external entity.	Character	20
First Name	The first name of the recipient.	Character	15
Header Response Status	Will indicated "Accepted" if the 501-F1 field in the Response Transaction Header Segment of the G1 detail reponse record is an "A". Will indicated "Rejected" if the 501-F1 field had "R".	Character	8
ID	Unique Medicaid identifier for the recipient.	Character	12
Last Name	The last name of the recipient.	Character	20
Middle Initial	The middle initial of the recipient.	Character	1
Rejection Codes	Reject codes received in the 511-FB field in the AM 21 segment of the G1 detail reponse record. Up to 5 rejection codes may be received.	Character	3
Sub-Total for Carrier	An unique identifier used to determine the carrier.	Character	10
Subrogation Claims with Accepted/Rejected Status (Sub-Total)	Number of claims that were in accepted and rejected status by the external entity.	Number (Decimal)	8
Subrogation Claims with Accepted/Rejected Status (Total)	Total number of claims that were in accepted/rejected status by all the external entities.	Number (Decimal)	8
Subrogation Claims with Rejected/Rejected Status (Sub-Total)	Number of claims that were in rejected and rejected status by the external entity.	Number (Decimal)	8
Subrogation Claims with Rejected/Rejected Status (Total)	Total number of all claims that were in rejected/rejected status by all the external entities.	Number (Decimal)	8
Total Carriers	Total number of external entities included in the report.	Number (Decimal)	8
Total Subrogation Claims with Rejected Status (Sub-Total)	Total number of all claims that were in rejected status for the external entity.	Number (Decimal)	8

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Field	Description	Data Type	Length
Total Subrogation Claims with Rejected Status (Total)	Total number of all claims that were in rejected status for all the external entities.	Number (Decimal)	8

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7.44 TPL-0047-M - NCPDP Subrogation Response – Summary Report

7.44.1 TPL-0047-M - NCPDP Subrogation Response – Summary Report Narrative

This report list all the drug claims that were submitted in the subrogation claim request transaction to different external entities and the message and status returned by the external entity.

7.44.2 TPL-0047-M - NCPDP Subrogation Response – Summary Report Layout

```
REPORT  : TPL-0047-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJD100                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME:  HH:MM:SS
LOCATION: TPL0046M                   NCPDP SUBROGATION RESPONSE STATUS SUMMARY REPORT                      PAGE:  99,999,999
                                               REPORT PERIOD:  MM/DD/CCYY

CARRIER : XXXXXXXXXX               CARRIER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

HEADER RESPONSE: ACCEPTED
DETAIL RESPONSE: PAID

RECIPIENT ID     DATE OF SERVICE     AR NUMBER            ENTITY ICN         AMOUNT PAID              CARDHOLDER ID
RESPONSE MESSAGE

XXXXXXXXXXXX        MM/DD/CCYY     XXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXX     $999,999.99           XXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
```

```
XXXX
```

```
XXXX
```

```
SUB-TOTAL FOR CARRIER        : XXXXXXXXXX

CLAIMS BILLED                :  99,999,999
CLAIMS ACCEPTED              :  99,999,999
CLAIMS ACCEPTED AND PAID     :  99,999,999
CLAIMS ACCEPTED AND REJECTED :  99,999,999
CLAIMS REJECTED AND REJECTED :  99,999,999
AMOUNT PAID TO MEDICAID      : $ZZZZZZ9.99

←-------------   PAGE BREAK FOR A NEW CARRIER ----------------→
```

7.44.3 TPL-0047-M - NCPDP Subrogation Response – Summary Report Field Descriptions

Field	Description	Data Type	Length
AR Number	Number that uniquely identifies the A/R that is associated with the claim.	Character	13
Amount Paid	The total amount paid by the external entity as indicated in the 509-F9 field of the AM23 segment.	Number	8
Amount Paid to Medicaid	Total amount paid by the external entity to Medicaid.	Number	9
Cardholder ID	Cardholder ID received in the 302-C2 field in the AM 25 segment of the G1 detail reponse record.	Character	20
Carrier	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	Character	10
Carrier Name	The business name of an insurance carrier.	Character	45
Claims Accepted	Number of claims that were in accepted status by the external entity.	Number	8
Claims Accepted and Paid	Number of claims that were in accepted and paid status by the external entity.	Number	8
Claims Accepted and Rejected	Number of claims that were in accepted and rejected status by the external entity.	Number	8
Claims Billed	Total number of claims billed to the external entity.	Number	8
Claims Rejected and Rejected	Number of claims that were in rejected and rejected status by the external entity.	Number	8

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Field	Description	Data Type	Length
Date of Service	Date of service received in the 401-D1 field in the Response Transaction Header Segment of the G1 detail reponse record.	Date (MM/DD/CCYY)	10
Detail Response	Will indicate "Accepted" if the 112-AN field of the AM21 segment in the G1 detail reponse record is an "A". Will indicate "Rejected" if the 112-AN field of the AM21 segment had "R" (rejected) or "D" (duplicate of paid).	Character	8
Entity ICN	Identification number assigned to the claim by the external entity.	Character	20
Header Response	Will indicate "Accepted" if the 501-F1 field in the Response Transaction Header Segment of the G1 detail reponse record is an "A". Will indicate "Rejected" if the 501-F1 field had "R".	Character	8
Recipient ID	Unique Medicaid identifier for the recipient.	Character	12
Report Message	Message sent by the external entity on the F4 field of the AM20 segment. Since this field can be up to 200 characters, it will be split into two lines in the report if necessary.	Character	200
Sub-Total for Carrier	An unique identifier used to determine the carrier.	Character	10
Total Amount Paid to Medicaid	The total amount paid by all the external entities to Medicaid.	Number (Decimal)	9
Total Claims Accepted	Total number of all claims that were in accepted status by all the external entities.	Number (Decimal)	8
Total Claims Accepted and Paid	Total number of all claims that were in accepted and paid status by all the external entities.	Number (Decimal)	8
Total Claims Accepted and Rejected	Total number of all claims that were in accepted and rejected status by all the external entities.	Number (Decimal)	8
Total Claims Billed	Total number of claims billed to all the external entities.	Number (Decimal)	8
Total Claims Rejected and Rejected	Total number of all claims that were in rejected and rejected status by all the external entities.	Number (Decimal)	8
Total Number of Carriers	Total number of external entities included in the report.	Number (Decimal)	8

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7.45 TPL-0050-D -- HIPP Policy Cost Effectiveness Summary Report

7.45.1 TPL-0050-D -- HIPP Policy Cost Effectiveness Summary Report Narrative

The HIPP Policy Cost Effectiveness Summary report provides information regarding HIPP policies being evaluated for cost effectiveness for the current date. If the case was added on the current processing date and the expenditure amount is greater than zero or a case was updated on the processing date and the expenditure amount on the audit table is equal or greater than zero, these are reported. This report is produced daily.

7.45.2 TPL-0050-D -- HIPP Policy Cost Effectiveness Summary Report Layout

```
REPORT  :  TPL-0050-D                          ALABAMA MEDICAID AGENCY                                        RUN DATE:  MM/DD/CCYY
PROCESS :  TPLJD050                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                 RUN TIME:  HH:MM:SS
LOCATION:  TPL0050D                      HIPP POLICY COST-EFFECTIVENESS SUMMARY                                      PAGE:  999,999
                                                REPORT PERIOD:  MM/DD/CCYY

                                                                                EXPECTED   ANNUAL  EXPENSES
POLICYHOLDER  POLICYHOLDER NAME                 HIPP CASE #   RECOMMEND     STATUS     MEDICAID       HIPP    NET SAVINGS  CLERK ID

999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX
999999999999  XXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X  999999999   XXXXXXXXXXXXXXX   X        999,999.99   999,999.99  999,999.99  XXXXXXXX


                                      NUMBER OF POLICIES RECOMMENDED TO APPROVE:                   999,999,999
                                      NUMBER OF POLICIES RECOMMENDED TO DENY:                      999,999,999
                                      TOTAL POLICIES EVALUATED:                                    999,999,999

                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.45.3 TPL-0050-D -- HIPP Policy Cost Effectiveness Summary Report Field Descriptions

Field	Description	Length	Data Type
Clerk ID	The clerk identification number assigned to the HIPP case.	8	Character
Expected Status	The status of the HIPP case.	1	Character
HIPP	The annual premium amount for the HIPP case.	9	Number (Decimal)
HIPP Case #	The case number assigned to a HIPP case.	9	Number (Integer)
Annual Expenses Medicaid	The average Medicaid paid expenditures.	12	Number (Decimal)
Net Savings	The amount Medicaid will save if paying the premium. The annual premium amount minus the average Medicaid expenditures.	9	Number (Decimal)
Number of Policies Recommended To Deny	The total number of policies recommended to deny due to not being cost effective.	9	Number (Decimal)
Number of Policies Recommended To Approve	The total number of policies recommended for approval.	9	Number (Decimal)
Policy Number	The policy number.	30	Number (Integer)
Policyholder	The policyholder identification.	9	Character
Policyholder Name	The policyholder's first, middle, and last name.	36	Character
Recommend	The recommendation made by the system as to whether the policy is cost affective or not.	15	Character
Status	The status of the HIPP case, which includes the following values: P - Pending, Y - Approved, C - Closed, or N - Denied.	1	Character
Total Policies Evaluated	The total number of policies that were evaluated. Summary of Number of Policies Recommended To Deny and Number of Policies Recommended to Approve.	9	Number (Decimal)

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7.46 TPL-0081-W -- Questionnaires With No Response By Recip Report

7.46.1 TPL-0081-W -- Questionnaires With No Response By Recip Report Narrative

The Questionnaires with No Response by Recip report is a list of recipients to whom an accident trauma questionnaire has been sent but a response was not received within 45-90 days. This report is sorted by Recipient ID and is produced weekly.

7.46.2 TPL-0081-W -- Questionnaires With No Response By Recip Report Layout

```
REPORT  : TPL-0081-W                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS : TPLJW081                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME:   HH:MM:SS
LOCATION: TPL0081W                    QUESTIONNAIRES WITH NO RESPONSE BY RECIPIENT                         PAGE:    999,999
                                               REPORT PERIOD: MM/DD/CCYY

                                                                     PROVIDER        DATE OF            PRIMARY        DATE
  RID NO                RECIPIENT NAME                  COUNTY          ID            SERVICE      ICD   DIAGNOSIS      SENT
XXXXXXXXXXXX   XXXXXXXXXXXXXXX, XXXXXXXXXXX X         XXXXXXXXXX    XXXXXXXXXXXXXXX    MM/DD/CCYY    X     XXXXXXX      MM/DD/CCYY




                                                     *** END OF REPORT ***
                                                    *** NO DATA THIS RUN ***
```


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7.46.3 TPL-0081-W -- Questionnaires With No Response By Recip Report Field Descriptions

Field	Description	Length	Data Type
County	County code.	10	Character
Date of Service	Beginning date of service rendered by the provider.	10	Date (MM/DD/CCYY)
Date Sent	Date first letter was sent.	10	Date (MM/DD/CCYY)
ICD	Code to denote which version of the ICD diagnosis code is being reported. The valid values will be ‘9’ for ICD-9, ‘0’ for ICD-10, or blank if diagnosis is not present.	1	Character
Primary Diagnosis	Primary diagnosis code on the claim.	7	Character
Provider ID	The identification number assigned to the provider.	15	Character
RID No.	Medicaid identification number of the recipient.	12	Character
Recipient Name	Last name, first name and middle initial of the recipient.	29	Character

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7.47 TPL-0082-W -- Questionnaires With No Response By County Report

7.47.1 TPL-0082-W -- Questionnaires With No Response By County Report Narrative

The Questionnaires with No Response by County report is a list of recipients to whom a questionnaire has been sent but a response was not received within 45 - 90 days. This report is sorted by county code with totals per county code and is produced weekly.

7.47.2 TPL-0082-W -- Questionnaires With No Response By County Report Layout

```
Report  : TPL-0082-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJW082                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0082W                    QUESTIONNAIRES WITH NO RESPONSE BY COUNTY                            Page:    999,999
                                              REPORT PERIOD: MM/DD/CCYY


  COUNTY: XXXXXXXXXX
                                                      PROVIDER              DATE OF           PRIMARY      DATE
  RID NO          RECIPIENT NAME                        ID                  SERVICE    ICD    DIAGNOSIS    SENT

XXXXXXXXXXXX  XXXXXXXXXXXXXXX, XXXXXXXXXXX X         XXXXXXXXXX            MM/DD/CCYY     X      XXXXXXX     MM/DD/CCYY

  TOTAL RECIPIENTS FROM COUNTY OF XXXXXXXXXX :     999,999



                                                     *** END OF REPORT ***
                                                    *** NO DATA THIS RUN ***
```


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7.47.3 TPL-0082-W -- Questionnaires With No Response By County Report Field Descriptions

Field	Description	Length	Data Type
County	County code.	10	Character
Date of Service	Beginning date of service.	10	Date (MM/DD/CCYY)
Date Sent	Date the first letter was sent.	10	Date (MM/DD/CCYY)
ICD	Code to denote which version of the ICD diagnosis code is being reported. The valid values will be ‘9’ for ICD-9, ‘0’ for ICD-10, or blank if diagnosis is not present.	1	Character
Primary Diagnosis	Primary diagnosis code on the claim.	7	Character
Provider ID	The number assigned to the provider.	15	Character
Recipient Name	Last name, first name and middle initial of the recipient	29	Character
RID No.	Medicaid identification number of the recipient.	12	Character
Total Recipients from County	Accumulated number of recipients per county.	6	Number (Decimal)

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7.48 TPL-0101-M -- TPL Monthly Recoveries Report

7.48.1 TPL-0101-M -- TPL Monthly Recoveries Report Narrative

The TPL Monthly Recoveries report displays money recovered on a monthly basis in TPL for casualty cases and billing Fee For Service (FFS) and Encounter A/R's where the disposition date falls within the monthly parameter dates. This report is produced monthly. For casualty cases the recovery amounts for the claims will be displayed as a split based on the percentage of the number of claims that were FFS and the number that were encounters.

7.48.2 TPL-0101-M -- TPL Monthly Recoveries Report Layout

```
REPORT  : TPL-0101-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE:  MM/DD/CCYY
PROCESS : TPLJM101                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:    HH:MM:SS
LOCATION: TPL0101M                             TPL MONTHLY RECOVERIES                                        PAGE:     999,999
                                               REPORT PERIOD:  MM/CCYY

CASUALTY:

NUMBER OF CASES:  999999                          MONTHLY RECOVERIES:  $9,999,999.99

NUMBER OF FEE FOR SERVICE CLAIMS:  999999         PERCENT OF TOTAL:  999%   ESTIMATE OF FFS AMOUNT:        $9,999,999.99
NUMBER OF ENCOUNTERS CLAIMS:       999999         PERCENT OF TOTAL:  999%   ESTIMATE OF ENCOUNTER AMOUNT:  $9,999,999.99

A/R:
                                FEE FOR SERVICE        ENCOUNTERS
                                ---------------     -------------
NUMBER OF CHIP A/R'S:                    999999            999999
MONTHLY RECOVERIES:               $9,999,999.99     $9,999,999.99

NUMBER OF NON-CHIP A/R'S:                999999            999999
MONTHLY RECOVERIES:               $9,999,999.99     $9,999,999.99


SUMMARY:

TOTAL NUMBER OF CASES AND A/R's                   TOTAL MONTHLY RECOVERIES
9999999                                           $99,999,999.99



                                                     *** END OF REPORT ***
                                   Only prints if there was no data: *** NO DATA THIS RUN ***
```


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7.48.3 TPL-0101-M -- TPL Monthly Recoveries Report Field Descriptions

Field	Description	Length	Data Type
Estimate of Encounter Amount (Casualty)	Estimated recovery amount based on the percentage of the number of claims that were encounters.	9	Number (Decimal)
Estimate of FFS Amount (Casualty)	Estimated recovery amount based on the percentage of the number of claims that were FFS.	9	Number (Decimal)
Monthly Recoveries (Casualty)	Amount recovered for the month.	9	Number (Decimal)
Monthly Recoveries Chip Encounter (A/R)	Amount recovered for the month.	9	Number (Decimal)
Monthly Recoveries Chip FFS (A/R)	Amount recovered for the month.	9	Number (Decimal)
Monthly Recoveries Non-Chip Encounter (A/R)	Amount recovered for the month.	9	Number (Decimal)
Monthly Recoveries Non-Chip FFS (A/R)	Amount recovered for the month.	9	Number (Decimal)
Number of Cases (Casualty)	Number of casualty cases where money was recovered.	6	Number (Integer)
Number of Chip Encounter (A/R)	Number of A/R's where money was recovered.	6	Number(Integer)
Number of Chip FFS (A/R)	Number of A/R's where money was recovered.	6	Number (Integer)
Number of Encounter Claims (Casualty)	Number of casualty Encounter claims where money was recovered.	6	Number (Integer)
Number of FFS Claims (Casualty)	Number of casualty FFS claims where money was recovered.	6	Number (Integer)
Number of Non-Chip Encounter (A/R)	Number of A/R's where money was recovered.	6	Number (Integer)
Number of Non-Chip FFS (A/R)	Number of A/R's where money was recovered.	6	Number (Integer)
Percent of Total (Casualty)	Percentage of FFS claims that are associated to casualty cases.	3	Number
Percent of Total (Casualty)	Percentage of encounter claims that are associated to casualty cases.	3	Number
Total Monthly Recoveries	Total amount recovered for cases and A/R's for the month.	10	Number (Decimal)
Total Number of Cases and A/R's	Total number of cases and A/R's for the month.	7	Number (Integer)

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7.49 TPL-0102-M -- Estate Lien Report

7.49.1 TPL-0102-M -- Estate Lien Report Narrative

The Estate Lien report includes information about TPL liens that have been released within the current reporting month and is sorted by case type. This report is produced monthly.

7.49.2 TPL-0102-M -- Estate Lien Report Layout

```
REPORT  : TPL-0102-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE:   MM/DD/CCYY
PROCESS : TPLJM102                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
LOCATION: TPL0102M                              TPL ESTATE LIEN REPORT                                       PAGE:   999,999
                                              REPORT PERIOD:  MM/CCYY

CASE TYPE:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


CURRENT ID                RECIP NAME                            DATE LIEN           DATE LIEN
                                                                FILED               RELEASED
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY
XXXXXXXXXXXX        XXXXXXXXXXXXXXXX, XXXXXXXXXXX X             MM/DD/CCYY          MM/DD/CCYY

 TOTALS FOR ____________________:                  9,999


                                        *** END OF REPORT ***

                                      *** NO DATA THIS RUN ***
```


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7.49.3 TPL-0102-M -- Estate Lien Report Field Descriptions

Field	Description	Length	Data Type
Case Type	The case type description.	20	Character
Current ID	Medicaid ID of the recipient.	12	Character
Date Lien Filed	Date the lien was filed.	10	Date (MM/DD/CCYY)
Date Lien Released	Date the lien was released.	10	Date (MM/DD/CCYY)
Recip Name	Last name, first name and middle initial of the recipient.	29	Character
Totals For	Accumulated number of cases per case type.	4	Number (Decimal)

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7.50 TPL-0250-W -- HIPP Automated Billing Statement Creation Summary Report

7.50.1 TPL-0250-W -- HIPP Automated Billing Statement Creation Summary Report Narrative

The HIPP Automated Billing Statement Creation Summary report summarizes all billing details for the Health Insurance Premium Payments systematically generated during the weekly cycle.

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7.50.2 TPL-0250-W -- HIPP Automated Billing Statement Creation Summary Report Layout

```
REPORT  :  TPL-0250-W                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS :  TPLJW250                   MEDICAID MANAGEMENT INFORMATION SYSTEMS                          RUN TIME:   HH:MM:SS
LOCATION:  TPL0250W                       HIPP PAYMENTS PROCESSED REPORT                                   PAGE:    999,999
                                      REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


                          PAYEE  EXPENDITURE                                FREQ    NEXT        START        END         REQUEST
HIPP CASE#    PAYEE ID    TYPE       ID       DUE DATE       CHECK AMT          DUE DATE      DATE         DATE          TYPE

XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX
XXXXXXXXX    XXXXXXXXX     X      XXXXXXXXX  MM/DD/CCYY     999,999.99     X   MM/DD/CCYY   MM/DD/CCYY   MM/DD/CCYY    XXXXXX

                                                  *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.50.3 TPL-0250-W -- HIPP Automated Billing Statement Creation Summary Report Field Descriptions

Field	Description	Length	Data Type
Check Amt	This is the amount of the premium payment for a specific policy.	8	Character
Due Date	This is the date used to generate the payment.	6	Character
End Date	The premium end date that covers the check.	10	Date (MM/DD/CCYY)
Expenditure ID	This is the expenditure ID created in the financial subsystem.	9	Character
Freq	This indicates how often premium payments are due to the HIPP payee. Frequency can be: Weekly, Bi-weekly, Semi-monthly, Monthly, Quarterly, Annually, Other.	12	Character
HIPP Case #	The case number assigned to HIPP case.	9	Number (Integer)
Next Due Date	This is the calculated date the next System payment is scheduled to be generated. If the payment is requested as 'manual', this field will read "MANUAL". The program only calculates the next due date for system requested payments. Once a payment appears on this report and the payment type is 'manual', the user must access the HIPP case and update the due date, check amount, and/or premium dates before another payment will be generated.	6	Date (MM/CCYY)
Payee ID	The Payee ID.	1	Number (Integer)
Payee Type	The Payee ID Type.	9	Character
Request Type	This is the type of request, which can be Manual or System.	6	Character
Start Date	The premium period start date that covers the check.	10	Date (MM/DD/CCYY)

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7.51 TPL-0260-W -- HIPP Billing Statement Exception Report

7.51.1 TPL-0260-W -- HIPP Billing Statement Exception Report Narrative

This report identifies all payments that cannot be processed due to the following reasons:

- Payee does not have a FEIN on file

- Payee name, 1st address, city, state, or zip code missing.

- Recipient is not eligible as of the current processing date for TXIX, XIXQ, or SBRW benefit plans.

- Recipient is not associated with a policy.

- Recipient is associated with a policy but the policy is not in a Valid or Non-Verified status or the coverage dates are less than the current processing date.

- Due date is less than the parm begin date and case is in a premium payment status. This is a warning that the payment is not being processed because the due date was not updated. This needs to be researched to determine if a payment should be made. This report is produced weekly.

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7.51.2 TPL-0260-W -- HIPP Billing Statement Exception Report Layout

```
REPORT  : TPL-0260-W                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS : TPLJW260                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:   HH:MM:SS
LOCATION: TPL0260W                          HIPP REJECTED PAYMENTS REPORT                                  PAGE:    999,999
                                       REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


 HIPP CASE#   PAYEE ID      PAYEE NAME                                        CURRENT ID         CHECK AMT   ERROR MESSAGE

999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX
999999999     XXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXX      $99999.99   XXXXXXXXXXXXXXXXXXXXXX



                                                  *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```

7.51.3 TPL-0260-W -- HIPP Billing Statement Exception Report Field Descriptions

Field	Description	Length	Data Type
Check Amt	This is the amount of the premium payment for a specific policy.	8	Number (Decimal)
Current ID	The Alabama Medicaid current Recipient Identification Number.	13	Character
Error Message	This is the specific reason the billing statement could not be processed to completion. 1) Message "Recoup Not Processed" displays when the premium payment amount does not entirely cover the requested recoupment amount; 2) Message "Invalid Funding Info" displays when the program cost amount (PCA) or category of service (COS) is invalid or missing.	21	Character
HIPP Case#	The case number assigned to HIPP case.	9	Number (Integer)

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Field	Description	Length	Data Type
Payee ID	This is the carrier number or the HIPP participant ID that uniquely identifies the insurance company, employer, or HIPP participant for whom the billing statement which could not be processed to completion. This is dependent upon CDE_ENTITY in this table to determine the ID to display.	9	Character
Payee Name	This is the name of the insurance company, employer, or HIPP participant who relates to the billing statement which could not be processed to completion.	3	Character

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7.52 TPL-0270-W -- HIPP Remittance Advice Report

7.52.1 TPL-0270-W -- HIPP Remittance Advice Report Narrative

The HIPP Remittance Advice report identifies detailed premium payment information which includes premium payment, recoupment, non-cash recoupment amounts for HIPP. Remittance Advices are produced and mailed weekly.

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7.52.2 TPL-0270-W -- HIPP Remittance Advice Report Layout

```
Report  : TPL-0270-W                                    ALABAMA MEDICAID AGENCY                          Run Date: MM/DD/CCYY
Process : TPLJW270                                MEDICAID MANAGEMENT INFORMATION SYSTEM                  Run Time:   HH:MM:SS
Location: TPL0270W                                      HIPP REMITTANCE ADVICE                                Page:      99999

          PAYEE NUMBER  999999999                           DATE:MM/DD/CCYY                            CHECK # 999999999



       NOTE:  IF A CHANGE HAS OCCURRED IN EMPLOYMENT STATUS, INSURANCE COVERAGE OR
       IF YOU ARE NOT DUE THIS MONEY, PLEASE CALL THE THIRD PARTY HIPP UNIT AT 334-242-3722.



                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                 XXXXXXXXXXXX            XX XXXXX-XXXX
```


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```
Report  : TPL-0270-W                                    ALABAMA MEDICAID AGENCY                              Run Date: MM/DD/CCYY
Process : TPLJW270                                MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: TPL0270W                                      HIPP REMITTANCE ADVICE                                   Page:      99999

         PAYEE NUMBER  999999999                            DATE:MM/DD/CCYY                              CHECK # 999999999

                                      SOCIAL
        POLICYHOLDER NAME             SECURITY # POLICY #                  HIPP CASE #       PAID AMOUNT   PERIOD     PERIOD
        PARTICIPANT ID                GROUP #                                                              BEG DT     END DT
        XXXXXXXXXXXXXXX, XXXXXXXXXX X
        XXXXXXXXXXXX                  999999999  XXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXX         $9999999.99 MM/DD/CCYY MM/DD/CCYY
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Report  : TPL-0270-W                                    ALABAMA MEDICAID AGENCY                              Run Date: MM/DD/CCYY
Process : TPLJW270                                MEDICAID MANAGEMENT INFORMATION SYSTEM                     Run Time:   HH:MM:SS
Location: TPL0270W                                      HIPP REMITTANCE ADVICE                                   Page:      99999

         PAYEE NUMBER  999999999                            DATE:MM/DD/CCYY                              CHECK # 999999999

                                                         ***  PAYMENT DATA  ***

                                                PREMIUM PAYMENT AMOUNT        $    999.99
                                                RECOUPMENT AMOUNT             $    999.99
                                                TOTAL PAYMENT                 $    999.99

                                                       *** END OF REPORT ***
                                                      *** NO DATA THIS RUN ***
```


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7.52.3 TPL-0270-W -- HIPP Remittance Advice Report Field Descriptions

Field	Description	Length	Data Type
Check #	The check number assigned by Financial.	9	Number (Integer)
Date	Date of the remittance advice.	10	Date (MM/DD/CCYY)
Group #	The policy group number.	30	Character
HIPP Case #	The sak_tpl_resource number (system assigned key).	9	Character
Paid Amount	The amount paid to the payee.	9	Number (Decimal)
Participant ID	The recipient Medicaid identification number.	30	Character
Payee Number	An internal number assigned to the payee .	9	Character
Period Beg Dt	The period beginning date for the premium payment.	10	Date (MM/DD/CCYY)
Period End Dt	The period ending date for the premium.	10	Date (MM/DD/CCYY)
Policyholder Name	The name of policy holder.	44	Character
Premium Payment Amount	The amount of the premium being paid .	9	Number (Decimal)
RA #	The remittance advice number.	11	Character
Recoupment Amount	This is the amount withheld from the premium payment amount to reconcile an overpayment made to the HIPP payee.	9	Number (Decimal)
Social Security #	The policyholder’s Social Security Number.	9	Number (Integer)
Total Payment	The total amount being paid to the payee.	9	Number (Decimal)

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7.53 TPL-0280-W -- HIPP Premium Payment RA Register Report

7.53.1 TPL-0280-W -- HIPP Premium Payment RA Register Report Narrative

The HIPP Premium Payment RA Register report summarizes all HIPP premium payment, recoupment, non-cash recoupment amounts staged for a given financial cycle in sequence by HIPP payee number. One line of this report is generated for each RA/warrant. This report is produced weekly.

The report should be retained for one calendar year from the run date for informational and research purposes.

7.53.2 TPL-0280-W -- HIPP Premium Payment RA Register Report Layout

```
REPORT  :  TPL-0280-W                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS :  TPLJW280                       MEDICAID MANAGEMENT INFORMATION SYSTEMS                       RUN TIME:   HH:MM:SS
LOCATION:  TPL0280W                            HIPP PREMIUM PAYMENT RA REGISTER                            PAGE:    999,999
                                             REPORT PERIOD:   MM/DD/CCYY - MM/DD/CCYY


PAYEE NUMBER    PAYEE NAME                                    HIPP CASE #      CHECK #    PAYMENT AMT

XXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                999999999    999999999     $999999.99



                ***  GRAND TOTALS  ***                                      999999999     $999999.99


                                          *** END OF REPORT ***
                                         *** NO DATA THIS RUN ***
```

7.53.3 TPL-0280-W -- HIPP Premium Payment RA Register Report Field Descriptions

Field	Description	Length	Data Type
Check #	Number on the HIPP check.	9	Number (Integer)
HIPP Case #	The case number assigned to HIPP case.	9	Number (Integer)
Grand Totals	Total amounts of the Non-Fin Debit Amt, Non-Fin Credit Amt, Recoup Amt and Payment Amt columns.	9	Number (Decimal)
Payee Name	The name of the payee.	30	Character
Payee Number	An internal number assigned to the payee .	9	Character

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Field	Description	Length	Data Type
Payment Amt	The amount paid to the payee.	9	Number (Decimal)

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7.54 TPL-0290-M -- HIPP Monthly Clerk Cost Effective Activity Report

7.54.1 TPL-0290-M -- HIPP Monthly Clerk Cost Effective Activity Report Narrative

This report provides a list of HIPP cases added during the month, approved, and associated with a policy.

This report is primarily an Audit Trail report, but is also used to determine if the state requirement is met to review HIPP Applications within a specific period of time is met.

This report is produced monthly.

7.54.2 TPL-0290-M -- HIPP Monthly Clerk Cost Effective Activity Report Layout

```
REPORT  :  TPL-0290-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS :  TPLJM290                          MEDICAID MANAGEMENT INFORMATION SYSTEM                        RUN TIME: HH:MM:SS
LOCATION:  TPL0290M                        HIPP MONTHLY CLERK COST EFFECTIVE ACTIVITY                          PAGE: 999,999
                                                    REPORT PERIOD: MM/CCYY


 USER ID   POLICY #                          PID         CASE NO    REVAL DATE    APPR DATE   PREM BEGIN DATE
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY
XXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  999999999     999999999   MM/DD/CCYY    MM/DD/CCYY     MM/DD/CCYY

TOTAL :    9999



                                                     *** END OF REPORT ***
                                                    *** NO DATA THIS RUN***
```


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7.54.3 TPL-0290-M -- HIPP Monthly Clerk Cost Effective Activity Report Field Descriptions

Field	Description	Length	Data Type
Appr Date	The date the HIPP case was approved for payment.	10	Date (MM/DD/CCYY)
Case No	The HIPP case number.	9	Number (Integer)
PID	The policyholder ID.	9	Number (Integer)
Policy #	The policy number associated with the HIPP case recipients.	30	Character
Prem Begin Date	The premium begin date on the HIPP case.	10	Date (MM/DD/CCYY)
Reval Date	The next review date.	10	Date (MM/DD/CCYY)
Total	The total number of HIPP cases added, approved, and associated with a policy for the month.	9	Number (Decimal)
User ID	The clerk ID of the person who last updated the record.	8	Character

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7.55 TPL-0321-M -- HMS MONTHLY AR AGING REPORT

7.55.1 TPL-0321-M -- HMS MONTHLY AR AGING REPORT Narrative

This report keeps track of the outstanding balance of TPL insurance billings and TPL payments received on a monthly basis. Each month's data will reflect DXC TPL A/R stats for the fiscal year through the end of that month. The DXC TPL A/R data from the report along with HMS's A/R data will be used to produce the final report to the Agency, which in turn will be used to provide information to the Legislative fiscal office of TPL's outstanding billings.

7.55.2 TPL-0321-M -- HMS MONTHLY AR AGING REPORT Layout

```
Report  : TPL-0321-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM321                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0321M                            HMS MONTHLY AR AGING REPORT                                    Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY


AR BILLINGS AND RECOVERY                                                                                     FY CCYY
-------------------------------------------------------------------------------------------------------------------------
BEGINNING BALANCE                                                                                          $9,999,999,999.99

MEDICAID PAID AMOUNT BILLED ON NEW ARs                                                                     $9,999,999,999.99
TOTAL DOLLARS RECOVERED ON ARs POSTED                                                                      $9,999,999,999.99
TOTAL DOLLARS BILLED ON DENIED ARs POSTED                                                                  $9,999,999,999.99
DIFFERENCE BETWEEN MEDICAID PAID AND AR PAID AMOUNT (WRITE-OFF AMOUNT) FOR ARs POSTED                      $9,999,999,999.99
TOTAL AR BILLED AMOUNT ON ARs CLOSED FOR HMS FOLLOW UP                                                     $9,999,999,999.99
TOTAL AR BILLED AMOUNT ON OPEN ARs TO BE FOLLOWED BY HMS AFTER 120 DAYS                                    $9,999,999,999.99
                                                                                                           ----------------
ENDING BALANCE                                                                                             $9,999,999,999.99


                                                   *** END OF REPORT ***
```

7.55.3 TPL-0321-M -- HMS MONTHLY AR AGING REPORT Field Descriptions

Field	Description	Data Type	Length
BEGINNING BALANCE	The beginning balance of TPL insurance billings and TPL payments received for the fiscal year.	Number (Decimal)	12
DIFFERENCE BETWEEN MEDICAID PAID AND AR PAID AMOUNT (WRITE-OFF AMOUNT) FOR ARs POSTED	The difference between Medicaid Paid and AR's paid amount (Write-off Amount) for AR's posted in the fiscal year through the end of the current reporting month.	Number (Decimal)	12

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Field	Description	Data Type	Length
ENDING BALANCE	The ending balance of TPL insurance billings and TPL payments received for the fiscal year through the end of the current reporting month.	Number (Decimal)	12
MEDICAID PAID AMOUNT BILLED ON NEW ARs	The total Medicaid Paid Amount billed on New AR's in the fiscal year through the end of the current reporting month.	Number (Decimal)	12
TOTAL AR BILLED AMOUNT ON ARs CLOSED FOR HMS FOLLOW UP	The total AR billed amount on AR's closed for HMS follow up in the fiscal year through the end of the current reporting month.	Number (Decimal)	12
TOTAL AR BILLED AMOUNT ON OPEN ARs TO BE FOLLOWED BY HMS AFTER 120 DAYS	The total AR billed amount on AR's that are open in fiscal year further through the end of the current reporting month to be followed by HMS after 120 days.	Number (Decimal)	12
TOTAL DOLLARS BILLED ON DENIED ARs POSTED	The total amount billed on Denied AR's posted in the fiscal year through the end of the current reporting month.	Number (Decimal)	12
TOTAL DOLLARS RECOVERED ON ARs POSTED	The total amount recovered on AR's posted in the fiscal year through the end of the current reporting month.	Number (Decimal)	12

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7.56 TPL-0350-M -- MONTHLY POLICIES CURRENTLY ON TPL FILE Report

7.56.1 TPL-0350-M -- MONTHLY POLICIES CURRENTLY ON TPL FILE Report Narrative

Third Party Data for Application Awarded Eligibility during previous Month is received monthly. Each month, TPL would like for the policies listed on this report to be compared to our TPL file. If any of the listed policies from the report are currently on file, list them on a report titled "Policies currently on TPL file" and place it on DXC COLD.

7.56.2 TPL-0350-M -- MONTHLY POLICIES CURRENTLY ON TPL FILE Report Layout

```
Report  : TPL-0350-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM350                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0350M                          POLICIES CURRENTLY ON TPL FILE                                   Page:    999,999
                                                  PERIOD:  MM/DD/CCYY

POLICY CO NAME          CURRENT ID    POLICY NUMBER    RECIP NAME             POLICY HOLDER NAME          DOB        GOOD CAUSE
XXXXXXXXXXXXXXXXXXXXXX  999999999999  999999999999999  XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY          X




                                                 *** END OF REPORT ***
                                            ***   NO DATA THIS RUN   ***
```

7.56.3 TPL-0350-M -- MONTHLY POLICIES CURRENTLY ON TPL FILE ReportField Descriptions

Field	Description	Data Type	Length
Current ID	Medicaid Number.	Character	12
DOB	The Recipient date of birth.	Character	8
GOOD CAUSE IND	Good cause indicator.	Character	1
Policy CO Name	Policy Company Name.	Character	22
Policy Holder Name	Policy Holder name.	Character	23
Policy Number	The policy number assigned by the carrier.	Character	15

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Field	Description	Data Type	Length
Recip Name	The full name of the individual eligible for Medicaid.	Character	22

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7.57 TPL-0350-Q -- QUARTERLY POLICIES CURRENTLY ON TPL FILE Report

7.57.1 TPL-0350-Q -- QUARTERLY POLICIES CURRENTLY ON TPL FILE Report Narrative

This quarterly report is going to display the policies that were found on our system.

7.57.2 TPL-0350-Q -- QUARTERLY POLICIES CURRENTLY ON TPL FILE Report Layout

```
Report  : TPL-0350-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ350                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0350Q                           POLICIES CURRENTLY ON TPL FILE                                  Page:    999,999
                                                   PERIOD:  MM/DD/CCYY

POLICY CO NAME          CURRENT ID     POLICY NUMBER     RECIP NAME             POLICYHOLDER NAME          DOB        GOOD CAUSE IND
XXXXXXXXXXXXXXXXXXXXXX  999999999999   999999999999999   XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY          X




                                                  *** END OF REPORT ***
                                              ***   NO DATA THIS RUN   ***
```

7.57.3 TPL-0350-Q -- QUARTERLY POLICIES CURRENTLY ON TPL FILE Report Field Descriptions

Field	Description	Data Type	Length
Current ID	Medicaid Number.	Character	12
DOB	The Recipient date of birth.	Character	8
Good Cause IND	Good cause indicator.	Character	1
Policy CO Name	Policy Company Name.	Character	22
Policy Holder Name	Policy Holder name.	Character	23
Policy Number	The policy number assigned by the carrier.	Character	15
Recip Name	The full name of the individual eligible for Medicaid.	Character	22

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7.58 TPL-0351-M -- MONTHLY POLICIES NOT FOUND ON THE TPL FILE Report

7.58.1 TPL-0351-M -- MONTHLY POLICIES NOT FOUND ON THE TPL FILE Report Narrative

Third Party Data for Application Awarded Eligibility during previous Month is received monthly. Each month, TPL would like for the policies listed on this report to be compared to our TPL file. If there are other policies that are not found on the TPL file, put them on a separate report titled "Policides not found on the TPL file". This report should also be placed on DXC COLD.

7.58.2 TPL-0351-M -- MONTHLY POLICIES NOT FOUND ON THE TPL FILE Report Layout

```
Report  : TPL-0350-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM350                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0350M                    MONTHLY - POLICIES NOT FOUND ON THE TPL FILE                           Page:    999,999
                                                 PERIOD:  Month - Year

POLICY CO NAME          CURRENT ID    POLICY NUMBER    RECIP NAME             POLICY HOLDER NAME          DOB        GOOD CAUSE IND
XXXXXXXXXXXXXXXXXXXXXX  999999999999  999999999999999  XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY          X




                                                   *** END OF REPORT ***
                                              ***   NO DATA THIS RUN   ***
```

7.58.3 TPL-0351-M -- MONTHLY POLICIES NOT FOUND ON THE TPL FILE Report Field Descriptions

Field	Description	Data Type	Length
Current ID	Medicaid Number.	Character	12
DOB	The Recipient date of birth.	Character	8
Good Cause IND	Good cause indicator.	Character	1
Policy CO Name	Policy Company Name.	Character	22
Policy Holder Name	Policy Holder name.	Character	23
Policy Number	The policy number assigned by the carrier.	Character	15

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Field	Description	Data Type	Length
Recip Name	The full name of the individual eligible for Medicaid.	Character	22

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7.59 TPL-0351-Q -- QUARTERLY POLICIES NOT FOUND ON THE TPL FILE Report

7.59.1 TPL-0351-Q -- QUARTERLY POLICIES NOT FOUND ON THE TPL FILE Report Narrative

This quarterly report is going to display the policies that were not found on our system.

7.59.2 TPL-0351-Q -- QUARTERLY POLICIES NOT FOUND ON THE TPL FILE Report Layout

```
Report  : TPL-0350-Q                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ350                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0350Q                        POLICIES NOT FOUND ON THE TPL FILE                                 Page:    999,999
                                                   PERIOD:  MM/DD/CCYY

POLICY CO NAME          CURRENT ID     POLICY NUMBER     RECIP NAME             POLICYHOLDER NAME          DOB        GOOD CAUSE IND
XXXXXXXXXXXXXXXXXXXXXX  999999999999   999999999999999   XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXX   MM/DD/CCYY          X




                                                  *** END OF REPORT ***
                                              ***   NO DATA THIS RUN   ***
```

7.59.3 TPL-0351-Q -- QUARTERLY POLICIES NOT FOUND ON THE TPL FILE Report Field Descriptions

Field	Description	Data Type	Length
Current ID	Medicaid Number.	Character	12
DOB	The Recipient date of birth.	Character	8
GOOD CAUSE IND	Good cause indicator.	Character	1
Policy CO Name	Policy Company Name.	Character	22
Policy Holder Name	Policy Holder name.	Character	23
Policy Number	The policy number assigned by the carrier.	Character	15
Recip Name	The full name of the individual eligible for Medicaid.	Character	22

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7.60 TPL–0401-M ---TPL Refund Invoice List - BCBS Report

7.60.1 TPL–0401-M ---TPL Refund Invoice List - BCBS Report Narrative

This report will show all the refunds that were applied from the Blue Cross/Blue Shield refund request file.

7.60.2 TPL–0401-M ---TPL Refund Invoice List - BCBS Report Layout

```
Report  : TPL-0401-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM401                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                          TPL REFUND INVOICE LIST - BCBS                                   Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX



ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY

                 AR NUMBER: XXXXXXXXXXXXX       RECIPIENT ID:  XXXXXXXXXXXX  RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              CARRIER CODE: XXXXXXXXXX          CARRIER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                       CCN: XXXXXXXXXXX         DISP SEQUENCE: 999999999     DISP AMOUNT: 99,999,999.99

ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
```


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```
                AR NUMBER: XXXXXXXXXXXXX       RECIPIENT ID:  XXXXXXXXXXXX  RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
             CARRIER CODE: XXXXXXXXXX          CARRIER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                      CCN: XXXXXXXXXXX         DISP SEQUENCE: 999999999     DISP AMOUNT: 99,999,999.99

Report  : TPL-0401-M                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM401                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                            TPL REFUND INVOICE LIST - BCBS                                   Page:    999,999
                                          REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                  INVOICE NUMBER: XXXXXXXX



ACCOUNT NUMBER: XXXXXXXXXXXX

REFUND  REASON
 CODE   EXPLANATION
  XX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Report  : TPL-0401-M                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM401                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                            TPL REFUND INVOICE LIST - BCBS                                   Page:    999,999
                                          REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                  INVOICE NUMBER: XXXXXXXX
                                                 TOTAL REFUND BY CHECK



CASH CONTROL NUMBER         CHECK NUMBER                                  REFUND AMOUNT
-------------------         ------------------------------                -------------
```


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```
XXXXXXXXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  99,999,999.99
XXXXXXXXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  99,999,999.99
XXXXXXXXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  99,999,999.99
XXXXXXXXXXX                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                  99,999,999.99

                                                TOTAL TO BE REFUNDED:       999,999,999.99


                                                  *** NO DATA THIS RUN ***
                                                   *** END OF REPORT ***
```

7.60.3 TPL–0401-M ---TPL Refund Invoice List - BCBS Report Field Descriptions

Field	Description	Data Type	Length
ACCOUNT NUMBER	Account number associated to the refund request.	Character	12
AR NUMBER	The account receivable number that will have the refund applied to.	Character	13
BILL STAT	The billing status code.	Character	1
CARRIER CODE	The insurance carrier code.	Character	10
CARRIER NAME	The name of the insurance carrier.	Character	45
CASH CONTROL NUMBER	The cash control number of the check the refund was applied to.	Character	11
CCN	The cash control number of the check the refund was applied to.	Character	11
CHECK NUMBER	The number of the check in which the refund was applied to.	Character	30
CONTRACT	The patient's policy number.	Character	12
DISP AMOUNT	The amount being refunded from the check.	Number (Decimal)	10
DISP SEQUENCE	The number that uniquely identifies each individual disposition which was applied to a check.	Number (Integer)	9
EXTERNAL CLAIM NUMBER	The external entity's internal claim number.	Character	12

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Field	Description	Data Type	Length
INVOICE NUMBER	Invoice number associated to the refund request.	Character	8
PAID AMOUNT	The refund request amount.	Number (Decimal)	11
PATIEINT ACCT	The patient's account number associated to the refund request.	Character	12
PATIENT CONTROL NUMBER	The patient's control number associated to the refund request.	Character	13
PATIENT DOB	The patient's date of birth.	Date (MM/DD/CCYY)	10
PATIENT NAME	The patient's last name and first initial of the first and middle name.	Character	18
REASON EXPLANATION	Description of the refund.	Character	246
RECIPIENT ID	The recipient's Medicaid ID.	Character	12
RECIPIENT NAME	The recipient's name.	Character	39
REFUND AMOUNT	The total amount being refunded for each check.	Number (Decimal)	10
REFUND CODE	The refund reason code.	Character	2
REFUND REASON	The refund reason code.	Character	2
REMIT DATE	The date of the initial payment for services on the claim was submitted.	Date (MM/DD/CCYY)	10
SERVICE DATE	The date of service on the claim.	Date (MM/DD/CCYY)	10
SUBMITTED CHARGES	The payment made for the services rendered on the claim.	Number (Decimal)	10
TOTAL TO BE REFUNDED	The total amount of all refunds applied.	Number (Decimal)	11

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7.61 TPL–0402-M ---TPL Refund Invoice Errors - BCBS Report

7.61.1 TPL–0402-M ---TPL Refund Invoice Errors - BCBS Report Narrative

This report will show all the refunds that were not applied from the Blue Cross/Blue Shield refund request file due to the refund hitting one of the error reasons.

7.61.2 TPL–0402-M ---TPL Refund Invoice Errors - BCBS Report Layout

```
Report  : TPL-0402-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM401                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                         TPL REFUND INVOICE ERRORS - BCBS                                  Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX
ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                               CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                               CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
```


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```
                                                CLAIM NUMBER      DATE         CHARGES                  REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                  *** NO DATA THIS RUN ***
                                                    *** END OF REPORT ***
```

7.61.3 TPL–0402-M ---TPL Refund Invoice Errors - BCBS Report Field Descriptions

Field	Description	Data Type	Length
ACCOUNT NUMBER	Account number associated to the refund request.	Character	12
AR NUMBER	The account receivable number that will have the refund applied to.	Character	13
BILL STAT	The billing status code.	Character	1
CONTRACT	The patient's policy number.	Character	12
ERROR MESSAGE	The reason why the refund was not applied.	Character	50
EXTERNAL CLAIM NUMBER	The external entity's internal claim number.	Character	12
INVOICE NUMBER	Invoice number associated to the refund request.	Character	8
PAID AMOUNT	The refund request amount.	Number (Decimal)	11
PATIEINT ACCT	The patient's account number associated to the refund request.	Character	12
PATIENT CONTROL NUMBER	The patient's control number associated to the refund request.	Character	13
PATIENT DOB	The patient's date of birth.	Date (MM/DD/CCYY)	10
PATIENT NAME	The patient's last name and first initial of the first and middle name.	Character	18
REFUND REASON	The refund reason code.	Character	2
REMIT DATE	The date of the initial payment for services on the claim was submitted.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
SERVICE DATE	The date of service on the claim.	Date (MM/DD/CCYY)	10
SUBMITTED CHARGES	The payment made for the services rendered on the claim.	Number (Decimal)	10

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7.62 TPL–0403-M ---TPL Refund Invoice List - HMS Report

7.62.1 TPL–0403-M ---TPL Refund Invoice List - HMS Report Narrative

This report will show all the refunds that were applied from the HMS refund request file.

7.62.2 TPL–0403-M ---TPL Refund Invoice List - HMS Report Layout

```
Report  : TPL-0403-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM402                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                          TPL REFUND INVOICE LIST - HMS                                   Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX



ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY

                 AR NUMBER: XXXXXXXXXXXXX       RECIPIENT ID:  XXXXXXXXXXXX  RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
              CARRIER CODE: XXXXXXXXXX          CARRIER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                       CCN: XXXXXXXXXXX         DISP SEQUENCE: 999999999     DISP AMOUNT: 99,999,999.99

ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
```


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```
     AR NUMBER: XXXXXXXXXXXXX       RECIPIENT ID:  XXXXXXXXXXXX  RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CARRIER CODE: XXXXXXXXXX          CARRIER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         CCN: XXXXXXXXXXX         DISP SEQUENCE: 999999999     DISP AMOUNT: 99,999,999.99
```


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```
Report  : TPL-0403-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJM402                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0401M                          TPL REFUND INVOICE LIST - HMS                                  Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX
ACCOUNT NUMBER: XXXXXXXXXXXX
REFUND  REASON
 CODE   EXPLANATION
  XX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

  XX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Report  : TPL-0403-M                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJM402                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0401M                          TPL REFUND INVOICE LIST - HMS                                  Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX
                                               TOTAL REFUND BY CHECK
CASH CONTROL NUMBER         CHECK NUMBER                                    REFUND AMOUNT
-------------------         ------------------------------                  -------------
XXXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   99,999,999.99
XXXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   99,999,999.99
XXXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   99,999,999.99
XXXXXXXXXXX                 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   99,999,999.99

                                             TOTAL TO BE REFUNDED:       999,999,999.99
                                                   *** NO DATA THIS RUN ***
                                                     *** END OF REPORT ***
```


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7.62.3 TPL–0403-M ---TPL Refund Invoice List - HMS Report Field Descriptions

Field	Description	Data Type	Length
ACCOUNT NUMBER	Account number associated to the refund request.	Character	12
AR NUMBER	The account receivable number that will have the refund applied to.	Character	13
BILL STAT	The billing status code.	Character	1
CARRIER CODE	The insurance carrier code.	Character	10
CARRIER NAME	The name of the insurance carrier.	Character	45
CASH CONTROL NUMBER	The cash control number of the check the refund was applied to.	Character	11
CCN	The cash control number of the check the refund was applied to.	Character	11
CHECK NUMBER	The number of the check in which the refund was applied to.	Character	30
CONTRACT	The patient's policy number.	Character	12
DISP AMOUNT	The amount being refunded from the check.	Number (Decimal)	10
DISP SEQUENCE	The number that uniquely identifies each individual disposition which was applied to a check.	Number (Integer)	9
EXTERNAL CLAIM NUMBER	The external entity's internal claim number.	Character	12
INVOICE NUMBER	Invoice number associated to the refund request.	Character	8
PAID AMOUNT	The refund request amount.	Number (Decimal)	11
PATIEINT ACCT	The patient's account number associated to the refund request.	Character	12
PATIENT CONTROL NUMBER	The patient's control number associated to the refund request.	Character	13
PATIENT DOB	The patient's date of birth.	Date (MM/DD/CCYY)	10
PATIENT NAME	The patient's last name and first initial of the first and middle name.	Character	18
REASON EXPLANATION	Description of the refund.	Character	246

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Field	Description	Data Type	Length
RECIPIENT ID	The recipient's Medicaid ID.	Character	12
RECIPIENT NAME	The recipient's name.	Character	39
REFUND AMOUNT	The total amount being refunded for each check.	Number (Decimal)	10
REFUND CODE	The refund reason code.	Character	2
REFUND REASON	The refund reason code.	Character	2
REMIT DATE	The date of the initial payment for services on the claim was submitted.	Date (MM/DD/CCYY)	10
SERVICE DATE	The date of service on the claim.	Date (MM/DD/CCYY)	10
SUBMITTED CHARGES	The payment made for the services rendered on the claim.	Number (Decimal)	10
TOTAL TO BE REFUNDED	The total amount of all refunds applied.	Number (Decimal)	11

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7.63 TPL–0404-M ---TPL Refund Invoice Errors - HMS Report

7.63.1 TPL–0404-M ---TPL Refund Invoice Errors - HMS Report Narrative

This report will show all the refunds that were not applied from the HMS refund request file due to the refund hitting one of the error reasons.

7.63.2 TPL–0404-M ---TPL Refund Invoice Errors - HMS Report Layout

```
Report  : TPL-0404-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM402                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0401M                         TPL REFUND INVOICE ERRORS - HMS                                  Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
                                                INVOICE NUMBER: XXXXXXXX



ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACCOUNT NUMBER: XXXXXXXXXXXX

CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                              CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ACCOUNT NUMBER: XXXXXXXXXXXX
```


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```
CONTRACT      PATIENT ACCT  PATIENT NAME          EXTERNAL       SERVICE      SUBMITTED    PAID AMOUNT  REFUND  BILL     PATIENT
                                                 CLAIM NUMBER      DATE         CHARGES                   REASON  STAT  CONTROL NUMBER
XXXXXXXXXXXX  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX   MM/DD/CCYY 99,999,999.99 999,999,999.99    XX     X    XXXXXXXXXXXXX
PATIENT DOB:  MM/DD/CCYY            REMIT DATE: MM/DD/CCYY
  AR NUMBER:  XXXXXXXXXXXXX      ERROR MESSAGE: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                 *** NO DATA THIS RUN ***
                                                  *** END OF REPORT ***
```

7.63.3 TPL–0404-M ---TPL Refund Invoice Errors - HMS Report Field Descriptions

Field	Description	Data Type	Length
ACCOUNT NUMBER	Account number associated to the refund request.	Character	12
AR NUMBER	The account receivable number that will have the refund applied to.	Character	13
BILL STAT	The billing status code.	Character	1
CONTRACT	The patient's policy number.	Character	12
ERROR MESSAGE	The reason why the refund was not applied.	Character	50
EXTERNAL CLAIM NUMBER	The external entity's internal claim number.	Character	12
INVOICE NUMBER	Invoice number associated to the refund request.	Character	8
PAID AMOUNT	The refund request amount.	Number (Decimal)	11
PATIEINT ACCT	The patient's account number associated to the refund request.	Character	12
PATIENT CONTROL NUMBER	The patient's control number associated to the refund request.	Character	13
PATIENT DOB	The patient's date of birth.	Date (MM/DD/CCYY)	10
PATIENT NAME	The patient's last name and first initial of the first and middle name	Character	18
REFUND REASON	The refund reason code.	Character	2

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Field	Description	Data Type	Length
REMIT DATE	The date of the initial payment for services on the claim was submitted.	Date (MM/DD/CCYY)	10
SERVICE DATE	The date of service on the claim.	Date (MM/DD/CCYY)	10
SUBMITTED CHARGES	The payment made for the services rendered on the claim.	Number (Decimal)	10

7.64 TPL-0500-M -- HMS Case Extract Summary Report

7.64.1 TPL-0500-M -- HMS Case Extract Summary Report Narrative

This report file will summarize any update or insert performed while processing the case extract file received from HMS.

7.64.2 TPL-0500-M -- HMS Case Extract Summary Report Layout

```
Report  : TPL-0500-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJM500                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0500M                            HMS CASE SUMMARY REPORT                                        Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HMS CASE          HP CASE                   STATUS
  NUMBER            NUMBER                    MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                TOTAL RECORDS READ    ================================>    999,999
                                TOTAL RECORDS ADDED   ================================>    999,999
                                TOTAL RECORDS UPDATED ================================>    999,999
                                TOTAL ERROR RECORDS   ================================>    999,999
-------------------------------------------------------------------------------------------------------------------------------
                    RECORDS WITH SAME BASE INFORMATION ================================>    999,999

                                                   ** End of Report **
                                                 ** No Data This Report **
```

7.64.3 TPL-0500-M -- HMS Case Extract Summary Report Field Descriptions

Field	Description	Data Type	Length
HMS CASE NUMBER	Contains the case tracking number that provided by HMS.	Character	15

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Field	Description	Data Type	Length
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15
RECORDS WITH SAME BASE INFORMATION	Duplicate record- segment provided on input file is already on database.	Number (Integer)	8
STATUS MESSAGE	Description about the status of external case number update.	Character	84
TOTAL ERROR RECORDS	Total error segment in input file.	Number (Integer)	8
TOTAL RECORDS ADDED	Total number of recorded added from the file.	Number (Integer)	8
TOTAL RECORDS READ	Total Number of record read from input file provided.	Number (Integer)	8
TOTAL RECORDS UPDATED	Total number of record existing records updated in database based on the onformation in input file.	Number (Integer)	8

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7.65 TPL-0510-M -- HMS Case Extract Case Error Summary Report

7.65.1 TPL-0510-M -- HMS Case Extract Case Error Summary Report Narrative

This report file will summarize any errors generated while processing the case extract file received from HMS.

7.65.2 TPL-0510-M -- HMS Case Extract Case Error Summary Report Layout

```
Report  : TPL-0510-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJM510                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0510M                          HMS CASE ERRROR SUMMARY REPORT                                   Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
   HMS CASE          HP CASE                    ERR
   NUMBER            NUMBER                     MSG
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                   ** End of Report **
                                                ** No Data This Report **
```

7.65.3 TPL-0510-M -- HMS Case Extract Case Error Summary Report Field Descriptions

Field	Description	Data Type	Length
ERR MSG	Description as to why case segment could not be updated in the database.	Character	84
HMS CASE NUMBER	Contains the case tracking number that provided by HMS.	Character	15
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15

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7.66 TPL-0520-M -- HMS Claim Extract Summary Report

7.66.1 TPL-0520-M -- HMS Claim Extract Summary Report Narrative

This report file will summarize any update or insert performed while processing the claim extract file received from HMS.

7.66.2 TPL-0520-M -- HMS Claim Extract Summary Report Layout

```
Report  : TPL-0520-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJM520                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0520M                            HMS CLAIM SUMMARY REPORT                                       Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HMS CASE          HP CASE            NUM                    STATUS
  NUMBER            NUMBER             ICN                    MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                TOTAL RECORDS READ      ================================>    999,999
                                TOTAL RECORDS ADDED     ================================>    999,999
                                TOTAL RECORDS UPDATED   ================================>    999,999
                                TOTAL DUPLICATE RECORDS ================================>    999,999
                                TOTAL ERROR RECORDS     ================================>    999,999

                                           ** End of Report **
                                        ** No Data This Report **
```

7.66.3 TPL-0520-M -- HMS Claim Extract Summary Report Field Descriptions

Field	Description	Data Type	Length
HMS CASE NUMBER	Contains the case tracking number provided by HMS.	Character	15
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15
NUM ICN	Contains the ICN's that need to be added against the provided case number.	Character	20
STATUS MESSAGE	Description about the status of claims update.	Character	68
TOTAL DUPLICATE RECORDS	Segment provided on input file is already on database	Number (Integer)	8

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Field	Description	Data Type	Length
TOTAL ERROR RECORDS	Total error segment in input file.	Number (Integer)	8
TOTAL RECORDS ADDED	Total number of recorded added from the file.	Number (Integer)	8
TOTAL RECORDS READ	Total Number of record read from input file provided.	Number (Integer)	8
TOTAL RECORDS UPDATED	Total number of record existing records updated in database based on the onformation in input file.	Number (Integer)	8

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7.67 TPL-0530-M -- HMS Claim Extract Error Summary Report

7.67.1 TPL-0530-M -- HMS Claim Extract Error Summary Report Narrative

This report file will summarize any errors generated while processing the claim extract file received from HMS.

7.67.2 TPL-0530-M -- HMS Claim Extract Error Summary Report Layout

```
Report  : TPL-0530-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJM530                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0530M                           HMS CLAIM ERRROR SUMMARY REPORT                                 Page:    999,999
                                         REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HMS CASE          HP CASE            NUM                    ERR
  NUMBER            NUMBER             ICN                    MSG
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                   ** End of Report **
                                                 ** No Data This Report **
```

7.67.3 TPL-0530-M -- HMS Claim Extract Error Summary Report Field Descriptions

Field	Description	Data Type	Length
ERR MESSAGE	Description as to why the claims could not be updated in the database.	Character	68
HMS CASE NUMBER	Contains the case tracking number provided by HMS.	Character	15
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15
NUM ICN	Contains the ICN's that need to be added against the provided case number.	Character	20

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7.68 TPL-0540-W -- HMS Estate Cases Summary Report

7.68.1 TPL-0540-W -- HMS Estate Cases Summary Report Narrative

This report file will summarize any update or insert performed while processing the Estate Recovery case extract files received from HMS.

7.68.2 TPL-0540-W -- HMS Estate Cases Summary Report Layout

```
Report  : TPL-0540-M                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJW540                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0540W                          HMS ESTATE CASES SUMMARY REPORT                              Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HMS CASE          HP CASE                    STATUS
  NUMBER            NUMBER                     MESSAGE
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX            XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                TOTAL RECORDS READ      ================================>    999,999
                                TOTAL RECORDS ADDED     ================================>    999,999
                                TOTAL RECORDS UPDATED   ================================>    999,999
                                TOTAL ERROR RECORDS     ================================>    999,999
-------------------------------------------------------------------------------------------------------------------------------
                    RECORDS WITH SAME BASE INFORMATION  ================================>    999,999

-------------------------------------------------------------------------------------------------------------------------------
   SUMMARY COUNT INFORMATION:
-------------------------------------------------------------------------------------------------------------------------------
   CASE TYPE                              NUMBER OF CASES ADDED                      NUMBER OF CASES UPDATED
-------------------------------------------------------------------------------------------------------------------------------
   LIEN PROMISSORY                        99999999                                   99999999
   LIEN LIFE ESTATE                       99999999                                   99999999
   LIEN OTHER                             99999999                                   99999999
   ESTATE RECOVERY QIT                    99999999                                   99999999
   ESTATE RECOVERY SNT                    99999999                                   99999999
   ESTATE RECOVERY ANNUITY                99999999                                   99999999
   ESTATE RECOVERY PROBATE ESTATE         99999999                                   99999999
   ESTATE RECOVERY AFT                    99999999                                   99999999
   ESTATE RECOVERY TRUST                  99999999                                   99999999
   ESTATE RECOVERY OTHER                  99999999                                   99999999
                                                     ** End of Report **
                                                  ** No Data This Report **
```


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7.68.3 TPL-0540-M -- HMS Estate Cases Summary Report Field Descriptions

Field	Description	Data Type	Length
ESTATE RECOVERY AFT (ADDED)	Total number of Estate Recovery AFT cases added.	Number (Integer)	8
ESTATE RECOVERY AFT (UPDATED)	Total number of Estate Recovery AFT cases updated.	Number (Integer)	8
ESTATE RECOVERY ANNUITY (ADDED)	Total number of Estate Recovery ANNUITY cases added.	Number (Integer)	8
ESTATE RECOVERY ANNUITY (UPDATED)	Total number of Estate Recovery ANNUITY cases updated.	Number (Integer)	8
ESTATE RECOVERY OTHER (ADDED)	Total number of Estate Recovery OTHER cases added.	Number (Integer)	8
ESTATE RECOVERY OTHER (UPDATED)	Total number of Estate Recovery OTHER cases updated.	Number (Integer)	8
ESTATE RECOVERY PROBATE ESTATE (ADDED)	Total number of Estate Recovery Probate Estate cases added.	Number (Integer)	8
ESTATE RECOVERY PROBATE ESTATE (UPDATED)	Total number of Estate Recovery Probate Estate cases updated.	Number (Integer)	8
ESTATE RECOVERY QIT (ADDED)	Total number of Estate Recovery QIT cases added.	Number (Integer)	8
ESTATE RECOVERY QIT (UPDATED)	Total number of Estate Recovery QIT cases updated.	Number (Integer)	8
ESTATE RECOVERY SNT (ADDED)	Total number of Estate Recovery SNT cases added.	Number (Integer)	8
ESTATE RECOVERY SNT (UPDATED)	Total number of Estate Recovery SNT cases updated.	Number (Integer)	8

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Field	Description	Data Type	Length
ESTATE RECOVERY TRUST (ADDED)	Total number of Estate Recovery TRUST cases added.	Number (Integer)	8
ESTATE RECOVERY TRUST (UPDATED)	Total number of Estate Recovery TRUST cases updated.	Number (Integer)	8
HMS CASE NUMBER	Contains the case tracking number provided by HMS.	Character	15
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15
LIEN LIFE ESTATE (ADDED)	Total number of Lien Life Estate cases added.	Number (Integer)	8
LIEN LIFE ESTATE (UPDATED)	Total number of Lien Life Estate cases updated.	Number (Integer)	8
LIEN OTHER (ADDED)	Total number of Lien Other cases added.	Number (Integer)	8
LIEN OTHER (UPDATED)	Total number of Lien Other cases updated.	Number (Integer)	8
LIEN PROMISSORY (ADDED)	Total number of Lien Promissory cases added.	Number (Integer)	8
LIEN PROMISSORY (UPDATED)	Total number of Lien Promissory cases updated.	Number (Integer)	8
RECORDS WITH SAME BASE INFORMATION	Total number of records with the same base information.	Number (Integer)	8
STATUS MESSAGE	Description about the status of claims update.	Character	68
TOTAL ERROR RECORDS	Total error segment in input file.	Number (Integer)	8
TOTAL RECORDS ADDED	Total number of recorded added from the file.	Number (Integer)	8
TOTAL RECORDS READ	Total Number of record read from input file provided.	Number (Integer)	8
TOTAL RECORDS UPDATED	Total number of record existing records updated in database based on the information in input file.	Number (Integer)	8

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7.69 TPL-0541-W -- HMS Estate Cases Error Summary Report

7.69.1 TPL-0541-W -- HMS Estate Cases Error Summary Report Narrative

This report file will summarize any errors generated while processing the estate recovery case files received from HMS.

7.69.2 TPL-0541-W -- HMS Estate Cases Summary Report Layout

```
Report  : TPL-0541-W                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/YYYY
Process : TPLJW540                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0540W                      HMS ESTATE CASES ERROR SUMMARY REPORT                              Page:    999,999
                                        REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
  HMS CASE          HP CASE                   ERR
  NUMBER            NUMBER                    MSG
-------------------------------------------------------------------------------------------------------------------------------
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  XXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


                                                  ** End of Report **
                                                ** No Data This Report **
```

7.69.3 TPL-0541-W -- HMS Estate Cases Error Summary Report Field Descriptions

Field	Description	Data Type	Length
ERR MSG	Description as to why the claims could not be updated in the database.	Character	68
HMS CASE NUMBER	Contains the case tracking number provided by HMS.	Character	15
HP CASE NUMBER	Contains the HP case number created against the HMS case number.	Character	15

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7.70 TPL-1185-D -- HIPP Duplicate Active Recipient ID Report

7.70.1 TPL-1185-D -- HIPP Duplicate Active Recipient ID Report Narrative

This report identifies recipients that exist on more than 1 HIPP case and at least one of the cases are in a Premium Payment status (ES). This report is produced daily.

7.70.2 TPL-1185-D -- HIPP Duplicate Active Recipient ID Report Layout

```
REPORT  : TPL-1185-D                          ALABAMA MEDICAID AGENCY                                  RUN DATE: MM/DD/CCYY
PROCESS : TPLJD185                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
LOCATION: TPL1185D                    HIPP DUPLICATE ACTIVE RECIPIENT ID REPORT                            PAGE:    999,999

                        RECIPIENT ID        HIPP ID      STAT CD    PREM PMT BEG    PREM PMT END
                        ---------        ---------       --        --------        --------
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX
                        XXXXXXXXXXXX        999            XX        XXXXXXXX        XXXXXXXX


                                                   *** END OF REPORT ***
```

7.70.3 TPL-1185-D--HIPP Duplicate Active Recipient ID Report Field Descriptions

Field	Description	Length	Data Type
HIPP ID	A unique number assigned to each HIPP case.	9	Character
Prem Pmt Beg	The begin date for which the premiums started.	10	Date (MM/DD/CCYY)
Prem Pmt End	The last date a premium payment is made for the HIPP case.	10	Date (MM/DD/CCYY)
Recipient ID	The unique Medicaid ID assigned to a recipient.	12	Character
Stat CD	The code identifying the current status of the HIPP case.	2	Character

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7.71 TPL-3001-M -- TPL Possible Medicare Eligibles Report

7.71.1 TPL-3001-M -- TPL Possible Medicare Eligibles Report Narrative

The TPL Possible Medicare Eligibles report reads the recipient paid crossover claim files. If a recipient has a crossover claim that paid, the Medicare table in eligibility is checked to see if the recipient has Medicare A or Medicare B. The recipients who do not have Medicare A or B show up on the Possible Medicare Eligibles report. This report is produced monthly.

7.71.2 TPL-3001-M -- TPL Possible Medicare Eligibles Report Layout

```
REPORT  :   TPL-3001-M                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS :   TPLJM250                       MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:  HH:MM:SS
LOCATION:   TPLP301B                          POSSIBLE MEDICARE ELIGIBLES                                     PAGE:  999,999
                                                REPORT PERIOD: MM/DD/CCYY

SSN                LAST          FIRST             MI             HIC           DATE OF BIRTH      RID NUMBER

999999999        XXXXXXXXXXXX   XXXXXXX           X          XXXXXXXXXXXX        MM/DD/CCYY    999999999999
999999999        XXXXXXXXXXXX   XXXXXXX           X          XXXXXXXXXXXX        MM/DD/CCYY    999999999999
999999999        XXXXXXXXXXXX   XXXXXXX           X          XXXXXXXXXXXX        MM/DD/CCYY    999999999999


                                                     ***  END OF REPORT  ***
                                                    *** NO DATA THIS RUN ***
```

7.71.3 TPL-3001-M -- TPL Possible Medicare Eligibles Report Field Descriptions

Field	Description	Length	Data Type
Date of Birth	Recipient's date of birth in the recipient paid Medicare table in the recipient paid claims file.	10	Date (MM/DD/CCYY)
First	Recipient's first name in the recipient paid Medicare table in the recipient paid claims file.	7	Character
HIC	Recipient's Medicare number in the recipient paid Medicare table in the recipient paid claims file.	12	Character
Last	Recipient's last name on the recipient Medicare table in the recipient paid claims file.	12	Character
MI	Recipient's middle initial in the recipient paid Medicare table in the recipient paid claims file.	1	Character

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Field	Description	Length	Data Type
RID Number	Recipient's 12-character numeric identification number in the recipient paid Medicare table in the recipient paid claims file.	12	Number (Integer)
SSN	Recipient's Social Security Number in the recipient paid Medicare table in the recipient paid claims file.	9	Number (Integer)

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7.72 TPL-A001-M -- TPL Payment Integrity Report

7.72.1 TPL-A001-M -- TPL Payment Integrity Report Narrative

The TPL Payment Integrity Report is requested using the Decision Support System (DSS) and provides a list of all claims that have a TPL amount below a State-established percentage of the billed amount. This report is produced monthly.

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7.72.2 TPL-A001-M -- TPL Payment Integrity Report Layout

Alabama Medicaid Agency

TPL Payment Integrity Report
Report Period: 7/01/2006 - 9/30/2006

Report: TPL-A001-M
Run Date: 10/22/2007
Run Time: 9:50:58 AM

Provider:

ICN	Recipient	DOS	Billed Amount	Medicaid Amount	TPL Amount
4706279006089	5000000435948	07/20/2006	$351.00	$0.00	$3.00

Provider: 1000

ICN	Recipient	DOS	Billed Amount	Medicaid Amount	TPL Amount

Provider: 10021

ICN	Recipient	DOS	Billed Amount	Medicaid Amount	TPL Amount

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7.72.3 TPL-A001-M -- TPL Payment Integrity Report Field Descriptions

Field	Description	Length	Data Type
Billed Amount	Provider billed amount.	9	Number (Decimal)
DOS	Date of service.	10	Date (MM/DD/CCYY)
ICN	Claim internal control number.	13	Character
Medicaid Amount	Medicaid paid amount.	12	Number (Decimal)
Provider	Provider identification number.	10	Character
Recipient	Recipient identification number.	12	Character
TPL Amt	Third party liability amount.	9	Number (Decimal)

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7.73 TPL-A035-M -- TPL Billed ARs for Medicare Retroactive Report

7.73.1 TPL-A035-M -- TPL Billed ARs for Medicare Retroactive Report Narrative

The TPL Billed ARs for Medicare Retroactive report contains all the Medicare claims that were billed to the Medicare carrier during the retroactive billing process. This report is produced monthly.

7.73.2 TPL-A035-M -- TPL Billed ARs for Medicare Retroactive Report Layout

```
REPORT  :  TPL-A035-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS :  TPLJM035                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
LOCATION:  TPL0035M                      BILLED A/RS FOR MEDICARE RETROACTIVE                                   PAGE: 999,999
                                                REPORT PERIOD: MM/DD/CCYY

                                                                                SUBMITTED    TOTAL   CLM    FROM     TO    MEDICAID
  RECIP ID          RECIPIENT NAME        AR NUMBER       ICN                 CHARGES      BILLED  TYP    DOS      DOS   PROVIDER


XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXX XXXXXXXXXXXXXX    999999.99   999999.99 X  MM/DD/YY MM/DD/YY XXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXX XXXXXXXXXXXXXX    999999.99   999999.99 X  MM/DD/YY MM/DD/YY XXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXX XXXXXXXXXXXXXX    999999.99   999999.99 X  MM/DD/YY MM/DD/YY XXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXX  XXXXXXXXXXXXXX    999999.99   999999.99 X  MM/DD/YY MM/DD/YY XXXXXXXXX
XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX X XXXXXXXXXXXXX XXXXXXXXXXXXXX    999999.99   999999.99 X  MM/DD/YY MM/DD/YY XXXXXXXXX


                                                   TOTAL NUMBER OF A/RS BILLED         9999999
                                                   TOTAL $ AMOUNT SUBMITTED          99,999.99
                                                   TOTAL $ AMOUNT BILLED             99,999,99


                                                     *** END OF REPORT ***
                                                   *** NO DATA THIS RUN ***
```


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7.73.3 TPL-A035-M -- TPL Billed ARs for Medicare Retroactive Report Field Descriptions

Field	Description	Length	Data Type
AR Number	Specifies the Accounts Receivable number identifying the claim.	13	Character
CLM Type	Specifies the type of claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	Unique identification number of the claim.	13	Character
Medicaid Provider	Identifies the Medicaid billing provider.	10	Character
Recip ID	Unique identification number for the recipient.	12	Character
Recipient Name	Last, first and middle initial of the recipient.	23	Character
Submitted Charges	This field is used to display the amount of Charges actually submitted for this claim.	9	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Billed	Displays the total dollar amount billed for the report.	10	Number (Decimal)
Total $ Amount Submitted	Displays the total dollar amount submitted for the report.	10	Number (Decimal)
Total Billed	This field is used to display the amount of charges actually billed for this claim.	9	Number (Decimal)
Total Number Of A/Rs Billed	Displays the total account receivable amount billed.	7	Number (Decimal)

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7.74 TPL-A036-M -- TPL Medicare Claims Adjustment Report

7.74.1 TPL-A036-M -- TPL Medicare Claims Adjustment Report Narrative

The TPL Medicare Claims Adjustment report lists the paid amount of Medicare claims recouped (i.e., adjusted) from providers during post payment processing. This report is produced monthly.

7.74.2 TPL-A036-M -- TPL Medicare Claims Adjustment Report Layout

```
Report  : TPL-A036-M                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM036                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0036M                                   MEDICARE CLAIMS ADJUSTMENT REPORT                                 Page:    999,999
                                                        REPORT PERIOD: MM/CCYY
                                                         PRE-PRODUCTION REPORT

                                                        SUBMITTED         TOTAL     CLM    FROM        TO       MEDICAID
RECIP ID                 RECIPIENT NAME            ICN   CHARGES         RECOUPED   TYP    DOS         DOS      PROVIDER
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999
999999999999  XXXXXXXXXXXXXXXXXX,XXXXXXXXXXX X  9999999999999    99,999,999.99   99,999,999.99 X  MM/DD/CCYY  MM/DD/CCYY  9999999999

                                                        FEE FOR SERVICE     ENCOUNTERS          GRAND TOTALS
                                                        ---------------     ---------------     ---------------
                                 TOTAL NUMBER OF CLAIMS                 999,999,999         999,999,999         999,999,999
                                 TOTAL $ AMOUNT SUBMITTED            $999,999,999.99     $999,999,999.99     $999,999,999.99
                                 TOTAL $ AMOUNT RECOUPED             $999,999,999.99     $999,999,999.99     $999,999,999.99

                                                          ***END OF REPORT***
                                                       *** NO DATA THIS RUN ***
```

7.74.3 TPL-A036-M -- TPL Medicare Claims Adjustment Report Field Descriptions

Field	Description	Length	Data Type
Clm Typ	The type of claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	This field displays the internal control number of the claim.	13	Character

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Field	Description	Length	Data Type
Medicaid Provider	The Medicaid identification number of the provider who performed the service.	10	Character
Recip ID	The recipient Medicaid identification number.	12	Character
Recipient Name	The recipient's name (last, first, middle initial).	32	Character
Submitted Charges	The amount of charges submitted by the provider.	10	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Recouped (Encounters)	Total of the Total Recouped field for RCO encounters.	11	Number (Decimal)
Total $ Amount Recouped (Fee for Service)	Total of the Total Recouped field for fee for service claims.	11	Number (Decimal)
Total $ Amount Recouped (Grand Totals)	Grand total of the amount recouped for FFS and RCO encounter claims	11	Number (Decimal)
Total $ Amount Submitted (Encounters)	Total of the Submitted Charges field for RCO encounters.	11	Number (Decimal)
Total $ Amount Submitted (Fee for Service)	Total of the Submitted Charges field for fee for service claims.	11	Number (Decimal)
Total $ Amount Submitted (Grand Totals)	Grand total of the Submitted Charges for FFS and RCO encounters.	11	Number (Decimal)
Total Number of Claims (Encounters)	The number of valid RCO encounters processed.	9	Number (Interger)
Total Number of Claims (Fee for Service)	The number of valid fee for service claims processed.	9	Number (Integer)
Total Number of Claims (Grand Totals)	Grand total of the number of valid FFS and RCO encounter claims that were processed.	9	Number (Integer)
Total Recouped	This field indicates the amount that was recouped/adjusted from the provider for the claim.	10	Number (Decimal)

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7.75 TPL-A038-R -- TPL Cash Receipt and Disposition Report

7.75.1 TPL-A038-R -- TPL Cash Receipt and Disposition Report Narrative

Users access the TPL Cash Receipt and Disposition report to list the cash receipts, dispositions, and expenditures for cash receipts at the end of the deposit cycle. This report is requested using the Reports - Cash Receipt and Disposition Panel. Users are required to enter the Deposit From Date, Deposit To Date, and Report Type (Trial or Final). It includes all cash receipts and dispositions since the last deposit cycle. This report is produced upon request.

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7.75.2 TPL-A038-R -- TPL Cash Receipt and Disposition Report Layout

```
REPORT  :  TPL-A038-R                                  ALABAMA MEDICAID AGENCY                                RUN DATE: MM/DD/CCYY
PROCESS :  TPLJD010                                MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME: HH:MM:SS
LOCATION:  TPLA038R                                CASH RECEIPT AND DISPOSITION REPORT                              PAGE: 999,999
                                                      REPORT PERIOD: MM/DD/CCYY

   REPORT TYPE:  XXXXXX

   CARRIER CODE: XXXXXXXXX     CARRIER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   RECIPIENT #     A/R #         CASE #         CCN         DISP AMT     REFUND AMT     BAD CHECK AMT  DEPOSIT DATE
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD

  CARRIER TOTAL:  $9,999,999.99


   CARRIER CODE: XXXXXXXXX     CARRIER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   RECIPIENT #     A/R #         CASE #         CCN         DISP AMT     REFUND AMT     BAD CHECK AMT  DEPOSIT DATE
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD
  999999999999 9999999999999 999999999  9999999999999  $9,999,999.99  $9,999,999.99  $9,999,999.99   CCYY/MM/DD


  CARRIER TOTAL:  $9,999,999.99



                                   GRAND TOTAL       $999,999,999.99  $999,999,999.99 $999,999,999.99




                                          *** END OF REPORT ***
                                        *** NO DATA THIS RUN ***
```


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7.75.3 TPL-A038-R -- TPL Cash Receipt and Disposition Report Field Descriptions

Field	Description	Length	Data Type
A/R #	The accounts receivable number assigned to each bill.	13	Number (Integer)
Bad Check Amt	The amount returned due to bad checks.	13	Number (Decimal)
Carrier Code	The carrier code that denotes who the money was received from.	7	Character
Carrier Name	The name of the carrier the money was received from.	32	Character
Carrier Total	The total dispositions minus total refunds for a given carrier.	13	Number (Decimal)
Case #	The trauma case number.	9	Character
CCN	The check control number assigned to the check.	13	Number (Integer)
Deposit Date	The date the check was deposited.	10	Date (CCYY/MM/DD)
Disp Amount	The amount dispositioned related to the A/R record or case.	13	Number (Decimal)
Grand Total	The grand total disposition amount and grand total refund for all entities for the reporting period (calculated).	15	Number (Decimal)
Recipient ID	The recipient's Medicaid identification number.	12	Number (Integer)
Refund Amt	The amount to be refunded to the carrier.	13	Number (Decimal)
Report Type	This indicates whether the report requested is a trial or final report.	5	Character

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7.76 TPL-A046-M -- TPL Aged Detail Claims Report

7.76.1 TPL-A046-M -- TPL Aged Detail Claims Report Narrative

The TPL Aged Detail Claims report identifies all outstanding aged account receivables. Detail information is reported for those claims over 180 days from the original bill date and have not been responded too. This report is produced monthly.

7.76.2 TPL-A046-M -- TPL Aged Detail Claims Report Layout

```
REPORT  : TPL-1046-M                        ALABAMA MEDICAID AGENCY                                          RUN DATE:  MM/DD/CCYY
PROCESS : TPLJM018                           MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME:  HH:MM:SS
LOCATION: TPL0012M                           TPL AGED DETAIL CLAIMS REPORT                                         PAGE:  999,999
                                           REPORT PERIOD:  MM/DD/CCYY
SECTION 1
        CARRIER CODE:  XXXXXXX   CARRIER NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


     ** > 180 (DAYS) **

         RECIPIENT NAME                      RECIPIENT ID         A/R NUMBER          DATE BILLED        AMOUNT

  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X    XXXXXXXXXXXX        XXXXXXXXXXXXXX        MM/DD/CCYY     $999,999,999.99
  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X    XXXXXXXXXXXX        XXXXXXXXXXXXXX        MM/DD/CCYY     $999,999,999.99
  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X    XXXXXXXXXXXX        XXXXXXXXXXXXXX        MM/DD/CCYY     $999,999,999.99
  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX, X    XXXXXXXXXXXX        XXXXXXXXXXXXXX        MM/DD/CCYY     $999,999,999.99


                                               TOTAL A/R S        999,999,999            TOTAL $  999,999,999,999.99

SECTION 2

        CARRIER   *****  GRAND TOTAL-ALL CARRIERS

                                            TOTAL A/R S                                            TOTAL $ AMT
                                            -----------                                            -----------
                                            999,999,999                                      $ 999,999,999,999.99


                                                     *** END OF REPORT ***
                                                   *** NO DATA THIS RUN ***
```


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7.76.3 TPL-A046-M -- TPL Aged Detail Claims Report Field Descriptions

Field	Description	Length	Data Type
Section 1: A/R Number	The accounts receivable number assigned to each bill.	13	Character
Section 1: Amount	The billed amount of the A/R.	12	Number (Decimal)
Section 1: Carrier Code	The carrier code for which account receivables are still in an active status and the original bill date is equal or greater than 270 days.	7	Character
Section 1: Carrier Name	The carrier's name that corresponds to the carrier code.	45	Character
Section 1: Date Billed	The date on which the A/R was first billed.	10	Date (MM/DD/CCYY)
Section 1: Recipient ID	The recipient's Medicaid identification number.	12	Character
Section 1: Recipient Name	The recipient's first, middle, and last name associated with the account receivables.	32	Character
Section 1: Total $ Amt	The total dollar amount of all accounts receivables for the carrier.	15	Number (Decimal)
Section 1: Total A/R S	The total number of account receivable records reported for the carrier.	9	Number (Decimal)
Section 2: Total $	The total dollar amount outstanding for all carriers.	15	Number (Decimal)
Section 2: Total A/R S	The total number of outstanding account receivables for all carriers.	9	Number (Decimal)

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7.77 TPL-A047-R -- TPL Input Output Code Report

7.77.1 TPL-A047-R -- TPL Input Output Code Report Narrative

TPL Input/Output Code report is an on-request report generated from the Decision Support System (DSS). The report provides the user with a list of claims with an output code = J or 3. This report is produced upon request.

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7.77.2 TPL-A047-R -- TPL Input Output Code Report Layout

Alabama Medicaid Agency

TPL Input Output Code Report
Report Period: 10/01/2006

Report: TPL-A047-R
Run Date: 8/9/2007
Run Time: 1:43:35 PM

OUTPUT CODE: 3

Recipient ID	ICN	From Service Date	To Service Date	Total Charge	TPL Amount	Medicaid Payment
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00
[illegible]	[illegible]	10/01/2006	10/31/2006	[illegible]	$0.00	$0.00

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7.77.3 TPL-A047-R -- TPL Input Output Code Report Field Descriptions

Field	Description	Length	Data Type
From Service Date	The from date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	The claim internal control number.	13	Number (Integer)
Output Code	The claims containing the State specified output codes of 'J' or '3'.	1	Character
Medicaid Payment	The total Medicaid payment on the claim.	12	Number (Decimal)
Recipient ID	The recipient's Medicaid number.	12	Number (Integer)
TPL Amount	The third party liability amount reported on the claim.	9	Number (Decimal)
To Service Date	The claim to date of service.	10	Date (MM/DD/CCYY)
Total Charges	The total provider billed amount on the claim.	9	Number (Decimal)

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7.78 TPL-A052-R -- TPL Trauma Detail Claims Listing Report

7.78.1 TPL-A052-R -- TPL Trauma Detail Claims Listing Report Narrative

The TPL Trauma Detail Claims Listing report identifies each claim pertaining to a trauma case. This report lists, by recipient, detailed claim information for all claims within the trauma case. The report is generated upon request through the TPL Case Tracking Base Information panel. This report is produced upon request.

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7.78.2 TPL-A052-R -- TPL Trauma Detail Claims Listing Report Layout

```
Report  : TPL-A052-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJR052                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPLA052R                TPL TRAUMA DETAIL ONLINE AND OFFLINE CLAIMS LISTING                      Page:    999,999

CLERK ID: XXXXXXXX

RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X     RECIPIENT NUMBER: XXXXXXXXXXXX      TRAUMA CASE NUMBER: XXXXXXXXX

PERIOD COVERED: MM/DD/CCYY    MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------
PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       PROVIDER NUMBER: XXX XXXXXXXXXX

ICN: XXXXXXXXXXXXX  FDOS: MM/DD/CCYY TDOS: MM/DD/CCYY   C/T:X   BILLED:  999,999,999.99  PAID: 99,999,999.99  DT PD:MM/DD/CCYY
      ICD: X   DX CODE: XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

NDC: XXXXXXXXXXX    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    DTL XXX        BILLED     999,999.99   PAID 9,999,999.99
                   PROC CODE XXXXX         PROCEDURE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 ---------------------------------------------------------------------------------------------------------------------------

PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX       PROVIDER NUMBER: XXXXXXXXXX

ICN: XXXXXXXXXXXXX  FDOS: MM/DD/CCYY TDOS: MM/DD/CCYY   C/T: X   BILLED:  999,999,999.99  PAID: 99,999,999.99  DT PD:MM/DD/CCYY
      ICD: X   DX CODE: XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               DX CODE: XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               DX CODE: XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               DX CODE: XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
               DX CODE: XXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

NDC: XXXXXXXXXXX   NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
    DTL XXX        BILLED     999,999.99   PAID 9,999,999.99
                   PROC CODE XXXXX         PROCEDURE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    DTL XXX        BILLED     999,999.99   PAID 9,999,999.99
                   PROC CODE XXXXX         PROCEDURE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
    DTL XXX        BILLED     999,999.99   PAID 9,999,999.99
                   PROC CODE XXXXX         PROCEDURE XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------
```

```
REPORT  : TPL-A052-R                              ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
PROCESS : TPLJR052                        MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
LOCATION: TPLA052R                  TPL TRAUMA DETAIL ONLINE AND OFFLINE CLAIMS LISTING                        Page:    999,999

CLERK ID: XXXXXXXX

RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX  RECIPIENT NUMBER: XXXXXXXXXXXX      TRAUMA CASE NUMBER: XXXXXXXXX

PERIOD COVERED: MM/DD/CCYY    MM/DD/CCYY
-----------------------------------------------------------------------------------------------------------------------------

PROVIDER NUMB:  XXX XXXXXXXXXX                                          PROVIDER NUMB:  XXX XXXXXXXXXX
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                      CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-----------------------------------------------------------------------------------------------------------------------------
PROVIDER NUMB:  XXX XXXXXXXXXX                                          PROVIDER NUMB:  XXX XXXXXXXXXX
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                     NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                      CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-----------------------------------------------------------------------------------------------------------------------------
PROVIDER NUMB:  XXX XXXXXXXXXX                                          PROVIDER NUMB:  XXX XXXXXXXXXX
```


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```
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX             ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                     CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-------------------------------------------------------------------------------------------------------------------------------------
```


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```
Report  : TPL-A052-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJR052                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPLA052R                TPL TRAUMA DETAIL ONLINE AND OFFLINE CLAIMS LISTING                      Page:    999,999


CLERK ID: XXXXXXXX

RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX  RECIPIENT NUMBER: XXXXXXXXXXXX      TRAUMA CASE NUMBER: XXXXXXXXX

PERIOD COVERED: MM/DD/CCYY    MM/DD/CCYY
-------------------------------------------------------------------------------------------------------------------------------

PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     PROVIDER NUMBER: XXX XXXXXXXXXXXXXXX

OFFLINE CLAIM NUMBER: XXXXXXXXXXXXXXXXX      START DATE: MM/DD/CCYY  END DATE: MM/DD/CCYY CLAIM TYPE: X
CLAIM AMOUNT:  9,999,999.99      DATE PAID: MM/DD/CCYY
ICD: X  PRIMARY DIAGNOSIS CODE: XXXXXXX       DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
        SECONDARY DIAGNOSIS CODE: XXXXXXX     DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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```
REPORT  :  TPL-A052-R                          ALABAMA MEDICAID AGENCY                      RUN DATE: MM/DD/CCYY
PROCESS :  TPLJR052                         MEDICAID MANAGEMENT INFORMATION SYSTEM          RUN TIME: HH:MM:SS
LOCATION:  TPLA052R                           TPL TRAUMA DETAIL CLAIMS LISTING                  PAGE: 999,999




RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXX  RECIPIENT NUMBER: XXXXXXXXXXXX      SUMMARY OF ALL RECIPIENT'S PROVIDERS
-------------------------------------------------------------------------------------------------------------------------------------

PROVIDER NUMB:  XXXXXXXXXX                                                PROVIDER NUMB:  XXXXXXXXXX
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                        CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-------------------------------------------------------------------------------------------------------------------------------------
PROVIDER NUMB:  XXXXXXXXXX                                                PROVIDER NUMB:  XXXXXXXXXX
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                        CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-------------------------------------------------------------------------------------------------------------------------------------
PROVIDER NUMB:  XXXXXXXXXX                                                PROVIDER NUMB:  XXXXXXXXXX
         NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                       NAME:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
         ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              ADDR:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                        CITY/ST/ZIP:  XXXXXXXXXXXXXXXXXXXX,  XX  XXXXX-XXXX
-------------------------------------------------------------------------------------------------------------------------------------



                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.78.3 TPL-A052-R -- TPL Trauma Detail Claims Listing Report Field Descriptions

Field	Description	Length	Data Type
Addr	The provider's first address line.	30	Character
Billed	The billed amount from the associated claim.	8	Number (Decimal)
C/T	The claim type code.	1	Character
City	The provider's city.	20	Character
Clerk ID	The eight-digit TPL clerk identification number assigned to the trauma case.	8	Number (Integer)
Claim Amount	Amount entered in the Case Tracking Offline Claims panel for the claim.	9	Number (Decimal)
Claim Type	The claim type code for the offline claim.	1	Character
Date Paid	Date when claim was paid as entered in the Case Tracking Offline Claims panel.	10	Date (MM/DD/CCYY)
Description	The description associated with the diagnosis code of the offline claim.	60	Character
DTL	The detail number from the claim (numbered through 28).	2	Character
DX Code	The description associated with the diagnosis code.	60	Character
Dt Pd	The date the claim was paid by Medicaid.	10	Date (MM/DD/CCYY)
DX Code	The diagnosis code associated with the claim. All diagnosis codes submitted on the claim are printed.	7	Character
End Date	End date of service for the offline claim,	10	Date (MM/DD/CCYY)
FDOS	The from date-of-service associated with the claim.	10	Date (MM/DD/CCYY)
ICD	Code to denote which version of the ICD diagnosis code is being reported. The valid values will be ‘9’ for ICD-9, ‘0’ for ICD-10, or blank if diagnosis is not present.	1	Character
ICN	The internal control number assigned to the claim.	13	Number (Integer)
Name	The brand name of the drug associated with the NDC code.	30	Character
NDC	The national drug code associated with the claim.	11	Number (Integer)
Net Amount Paid By Medicaid	Net amount paid by Medicaid – This field is calculated by the Agency and manually entered.	11	Number (Decimal)

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Field	Description	Length	Data Type
Offline Claim Number	Number that identifies the Offline Claim entered in the Case Tracking Offline Claims panel and that is associated with a TPL Casualty Case.	17	Character
Paid	The amount paid by Medicaid for the provider's services rendered.	12	Number (Decimal)
Period Covered	Start date to end date of cover period.	10	Date (MM/DD/CCYY)
Presc Name	The prescription name or description of the NDC.	30	Character
Primary Diagnosis Code	Primary diagnosis code of the offline claim.	Character	7
Proc Code	The procedure code associated with the claim.	5	Character
Procedure	The procedure description associated with the procedure code.	30	Character
Provider Name	The Medicaid provider's name (last, first).	50	Character
Provider Numb	The Medicaid provider's number.	10	Number (Integer)
Recipient Name	The recipient's last name, first name, and middle initial.	36	Character
Recipient Number	The recipient's Medicaid identification number.	12	Number (Integer)
Secondary Diagnosis Code	Secondary diagnosis code of the offline claim.		
ST	The provider's state code.	2	Character
Start Date	Start date of service for the offline claim.	10	Date (MM/DD/CCYY)
TDOS	The to date-of-service associated with the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid By Medicaid	Total amount paid by Medicaid.	12	Number (Decimal)
Total ICN Claim Specific Refunds	Total ICN claim specific refund – This field will be calculated by the Agency and manually entered.	9	Number (Decimal)
Trauma Case Number	The trauma case number assigned by the system.	9	Character
Zip	The provider's full 9-digit zip code.	10	Character

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7.79 TPL-A056-R TPL UAIC 'HITS' With No Policy Record Found Report

7.79.1 TPL UAIC 'HITS' With No Policy Record Found Report Narrative

The TPL UAIC `Hits' with no Policy Record Found report provides all recipients from the UAIC input file that are not found on the TPL resource tables. This report is produced upon request.

7.79.2 TPL-A056-R TPL UAIC 'HITS' With No Policy Record Found Report Layout

```
REPORT  : TPL-A056-R                          ALABAMA MEDICAID AGENCY                                    RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA31                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:  HH:MM:SS
LOCATION: TPLPA315M                    TPL UAIC 'HITS' WITH NO POLICY RECORD FOUND                             PAGE:  999,999
                                                REPORT PERIOD - MM/DD/CCYY



MEDICAID NO: 999999999999    CARRIER CODE: XXXXXXX   POLICY NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   END DATE: MM/DD/CCYY

 REC-ID: XXX  NAME: XXXXXXXXXXXXXXXXXXXXXXXXX      ADDR1: XXXXXXXXXXXXXXXXXXXXXXXXXX DOB: MM/DD/CCYY IND: XXXXXXXXXXXXXXXXXXXXXXXXXXXX
   COCD: 99   HIC#: XXXXXXXXXXXX                   ADDR2: XXXXXXXXXXXXXXXXXXXXXXXXXX PDTO DT: MM/DD/CCYY
POLTYPE: 99    SSN: 999999999                      ADDR3: XXXXXXXXXXXXXXXXXXXXXXXXXX ISS DT: MM/DD/CCYY
TERM CD: X  POL NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ADDR4: XXXXXXXXXXXXXXXXXXXXXXXXXX            ELIGIBILITY
                                                                                          BEGIN DATE     END DATE
 RECIND: X    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX ADD1: XXXXXXXXXXXXXXXXXXXXXX             (MM/CCYY)       (MM/CCYY)
MTCHIND: X    DOB: MM/DD/CCYY                  ADD2: XXXXXXXXXXXXXXXXXXXXXX               (MM/CCYY)       (MM/CCYY)
              DOD: MM/DD/CCYY                   CSZ: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   (MM/CCYY)       (MM/CCYY)



                                                     *** END OF REPORT ***
                                                   *** NO DATA THIS RUN ***
```


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7.79.3 TPL-A056-R TPL UAIC 'HITS' With No Policy Record Found Report Field Descriptions

Field	Description	Length	Data Type
Add 1	The recipient's first address line.	22	Character
Add 2	The recipient's second address line.	22	Character
Addr 1	The policyholder's first address line from the UAIC input file.	25	Character
Addr 2	The policyholder's second address line from the UAIC input file.	25	Character
Addr 3	The policyholder's third address line from the UAIC input file.	25	Character
Addr 4	The policyholder's fourth address line from the UAIC input file.	25	Character
Carrier Code	The matching carrier code from the third party liability Database.	7	Character
COCD	The company code from the UAIC input file: (00, 03, 04, 56, 57, 90, 91) = United American (UAIC) (05, 06, 77) = Liberty National Claims (63) = First United American Life Claims (20, 81) = American Life & Accident Claims (60, 82, 83) = Globe Life & Accident claims (34) = American Income claims	2	Character
CSZ	The recipient's city, state and zip code.	33	Character
DOB	The recipient's date of birth.	10	Date (MM/DD/CCYY)
DOB	The policyholder's date of birth from the UAIC input file.	10	Date (MM/DD/CCYY)
DOD	The policyholder's date of death from the UAIC input file.	10	Date (MM/DD/CCYY)
Eligibility Begin	Identifies eligibility segments by begin and end dates. Shows the month and year the eligibility segment began, and the month and year it ended.	7	Date (MM/CCYY)
Eligibility End Date	The matching policy end date from the third party liability database.	7	Date (MM/CCYY)
End Date	The matching policy end date from the TPL Database.	10	Date (MM/DD/CCYY)
HIC #	The Medicare HIC Number from the UAIC input file. This is normally present on policy type 03 records.	12	Character

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Field	Description	Length	Data Type
Iss Dt	The policy effective date from the UAIC input file.	10	Date (MM/DD/CCYY)
Medicaid No	The recipient's Medicaid identification number.	12	Character
Mtchind	The indicator, which specifies the type of match. Possible values are: Blank = no match (default value) 1 = match on HIC number 2 = match on SSN	1	Character
Name	The policyholder's first, middle, and last name from the UAIC input file.	25	Character
Name	The recipient's first, middle, and last name.	27	Character
PDTO Dt	The policy paid-to-date to which the coverage is paid from the UAIC input file.	10	Date (MM/DD/CCYY)
Pol No.	The policy number assigned by the carrier from the UAIC input file.	30	Character
PolType	The policy type from the UAIC input file as follows: 00 = Hospital/Surgical/Medical 01 = cancer/ dread disease 02 = accident only 03 = Medicare supplement 04 = HMO coverage 05 = indemnity 06 = long term care/nursing home	2	Character
Policy No.	The matching policy number on the third party liability database.	30	Character

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Field	Description	Length	Data Type
Rec Ind	The indicator, which specifies one of the following: 1 =As of run date, the individual on this record is eligible to receive Medicaid. 2 =As of run date, the individual on this record is NOT eligible to receive Medicaid. 3 =As of run date, this record was not found. 4 =As of run date, the individual on this record is in a nursing home and is eligible to receive Medicaid. 5 =No match was attempted because this was a header (M00) or trailer (M99) record, or the HIC # did not begin with the Character 'A' nor end with the Character 'A' or 'M' and a valid SSN was not supplied. *****IMPORTANT***** All subsequent fields (Positions 302-492) on records with a '3' Or '5' in Am-Ind are filled with default values (Blanks Or Zeros).	1	Character
Rec-ID	The record ID from the UAIC input file as follows: M00 = header record M01= detail record M99 = trailer record	3	Character
SSN	The policyholder's Social Security Number from the UAIC input file. This is normally present on policy type 01, 02, 05, and 06 records.	9	Character
Term CD	The policy termination code from the UAIC input file as follows: H = lapsed due to hot check L or 5 = lapsed at request of policyholder R = on waiver of premium per policy terms 3 or 9 = deceased 4 = converted to another policy with same company	1	Character

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7.80 TPL-A057-R -- TPL UAIC Hits with no Match on Carrier Report

7.80.1 TPL-A057-R -- TPL UAIC Hits with no Match on Carrier Report Narrative

The TPL UAIC Hits with no Match on Carrier Report provides all the recipients from the UAIC input file that are found on the TPL Resource tables but do not match on the carrier code. The following company codes on the input file must match to the corresponding carrier code:

Company code = 00, 03, 04, 57, 90 or 91
Carrier code = 00553 or 10053

Company code = 05, 06, 70, 71, 72, 73, 74, 75, 76, or 77
Carrier code = 00306, 01508, 01792, 01826, 01857, 01867, 01868, 03307, 03429, 03489, 01365, 03409, or 00977

Company code = 63
Carrier code = 12736

Company code = 81
Carrier code = 00046, 00047, 00993, 01733, 10337, 01600

Company code = 82 or 83
Carrier code = 00231, 00863, or 00232

This report is produced upon request.

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7.80.2 TPL-A057-R -- TPL UAIC Hits with no Match on Carrier Report Layout

```
REPORT  : TPL-A057-R                                ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA31                            MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:  HH:MM:SS
LOCATION: TPLPA315M                          TPL UAIC 'HITS' WITH NO MATCH ON CARRIER                              PAGE:  999,999
                                                     REPORT PERIOD - MM/DD/CCYY

MEDICAID NO: 999999999999    CARRIER CODE: XXXXXXX   POLICY NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   END DATE: MM/DD/CCYY


REC-ID: XXX  NAME: XXXXXXXXXXXXXXXXXXXXXXXXX      ADDR1: XXXXXXXXXXXXXXXXXXXXXXXXXX DOB: MM/DD/CCYY IND: XXXXXXXXXXXXXXXXXXXXXXXXXXX
  CO CD: 99   HIC#: XXXXXXXXXXXX                   ADDR2: XXXXXXXXXXXXXXXXXXXXXXXXXX PDTO DT: MM/DD/CCYY
POLTYPE: 99    SSN: 999999999                      ADDR3: XXXXXXXXXXXXXXXXXXXXXXXXXX ISS DT: MM/DD/CCYY
TERM CD: X  POL NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ADDR4: XXXXXXXXXXXXXXXXXXXXXXXXXX              ELIGIBILITY
                                                                                              BEGIN DATE      END DATE
 RECIND: X    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX ADD1: XXXXXXXXXXXXXXXXXXXXXX              (MM/CCYY)       (MM/CCYY)
MTCHIND: X     DOB: MM/DD/CCYY                   ADD2: XXXXXXXXXXXXXXXXXXXXXX              (MM/CCYY)       (MM/CCYY)
               DOD: MM/DD/CCYY                    CSZ: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  (MM/CCYY)       (MM/CCYY)



                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.80.3 TPL-A057-R -- TPL UAIC Hits with no Match on Carrier Report Field Descriptions

Field	Description	Length	Data Type
Add 1	The recipient's first address line.	22	Character
Add 2	The recipient's second address line.	22	Character
Addr 1	The policyholder's first address line from the UAIC input file.	25	Character
Addr 2	The policyholder's second address line from the UAIC input file.	25	Character
Addr 3	The policyholder's third address line from the UAIC input file.	25	Character
Addr 4	The policyholder's fourth address line from the UAIC input file.	25	Character
Carrier Code	The matching carrier code from the third party liability database.	7	Character
COCD	The company code from the UAIC input file: (00, 03, 04, 56, 57, 90, 91) = United American (UAIC) (05, 06, 77) = Liberty National Claims (63) = First United American Life Claims (20, 81) = American Life & Accident Claims (60, 82, 83) = Globe Life & Accident claims	2	Character
CSZ	The recipient's city, state, and zip code.	33	Character
DOB	The policyholder's date of birth from the UAIC input file.	10	Date (MM/DD/CCYY)
DOB	The recipient's date of birth.	10	Date (MM/DD/CCYY)
DOD	The policyholder's date of death from the UAIC input file.	10	Date (MM/DD/CCYY)
Eligibility Begin Date	Identifies eligibility segments by begin and end dates. Shows the month and year the eligibility segment began, and the month and year it ended.	7	Date (MM/CCYY)
Eligibility End Date	The policy end date from the UAIC input file.	7	Date (MM/CCYY)
End Date	The matching policy end date from the TPL Database.	10	Date (MM/DD/CCYY)
HIC #	The Medicare HIC Number from the UAIC input file. This information is normally present on policy type 03 record.	12	Character

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Field	Description	Length	Data Type
Iss Dt	The policy effective date from the UAIC input file.	10	Date (MM/DD/CCYY)
Medicaid No.	The recipient’s Medicaid number.	12	Character
MtchInd	The indicator, which specifies the type of match. Possible values are: Blank = no match (default value) 1 = match on HIC number 2 = match on SSN	1	Character
Name	The recipient's first, middle, and last name.	27	Character
Name	The policyholder's first, middle, and last name from the UAIC input file.	25	Character
PDTO Dt	The policy paid-to-date to which the coverage is paid from the UAIC input file.	10	Date (MM/DD/CCYY)
Pol No.	The policy number assigned by the carrier from the UAIC input file.	30	Character
PolType	The policy type from the UAIC input file as follows: 00 = Hospital/Surgical/Medical 01 = Cancer/ dread disease 02 = Accident only 03 = Medicare supplement 04 = HMO coverage 05 = Indemnity 06 = Long term care/nursing home	2	Character
Policy No.	The matching policy number on the third party liability database.	30	Character

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Field	Description	Length	Data Type
Rec Ind	The indicator, which specifies one of the following: 1 =As of run date, the individual on this record is eligible to receive Medicaid. 2 = As of run date, the individual on this record is NOT eligible to receive Medicaid. 3 = As of run date, this record was not found. 4 =As of run date, the individual on this record is in a nursing home and is eligible to receive Medicaid. 5 = No match was attempted because this was a header (M00) or trailer (M99) record, or the HIC # did not begin with the character 'A' or end with the character 'A' or 'M' and a valid SSN was not supplied. *****IMPORTANT***** All subsequent fields (Positions 302-492) on records with a '3' or '5' in Am-Ind are filled with default values (Blanks Or Zeros).	1	Character
Rec-ID	The record identification from the UAIC input file as follows: M00 = header record M01= detail record M99 = trailer record	3	Character
SSN	The policyholder's Social Security Number from the UAIC input file. This is normally present on policy type 01, 02, 05, and 06 records.	9	Character
Term CD	The policy termination code from the UAIC input file as follows: H = lapsed due to hot check L or 5 = lapsed at request of policyholder R = on waiver of premium per policy terms 3 or 9 = deceased 4 = converted to another policy with same company	1	Character

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7.81 TPL-A058-R -- TPL UAIC Hits on Carrier No Match on Policy Report

7.81.1 TPL-A058-R -- TPL UAIC Hits on Carrier No Match on Policy Report Narrative

The TPL UAIC Hits on Carrier - No Match on Policy report provides all recipients from the UAIC input file that are found on the TPL resource tables with the same carrier code, but do not share the same policy number. This report is produced upon request.

7.81.2 TPL-A058-R -- TPL UAIC Hits on Carrier no Match on Policy Report Layout

```
REPORT  : TPL-A058-R                                ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA31                            MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:  HH:MM:SS
LOCATION: TPLPA315M                         TPL UAIC HITS ON CARRIER - NO MATCH ON POLICY #                        PAGE:  999,999
                                                      REPORT PERIOD - MM/DD/CCYY




MEDICAID NO: 999999999999    CARRIER CODE: XXXXXXX   POLICY NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   END DATE: MM/DD/CCYY

 REC-ID: XXX  NAME: XXXXXXXXXXXXXXXXXXXXXXXXX      ADDR1: XXXXXXXXXXXXXXXXXXXXXXXXXX DOB: MM/DD/CCYY IND: XXXXXXXXXXXXXXXXXXXXXXXXXXX
  CO CD: 99   HIC#: XXXXXXXXXXXX                   ADDR2: XXXXXXXXXXXXXXXXXXXXXXXXXX PDTO DT: MM/DD/CCYY
POLTYPE: 99    SSN: 999999999                      ADDR3: XXXXXXXXXXXXXXXXXXXXXXXXXX ISS DT: MM/DD/CCYY
TERM CD: X  POL NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ADDR4: XXXXXXXXXXXXXXXXXXXXXXXXXX              ELIGIBILITY
                                                                                        BEGIN DATE      END DATE
 RECIND: X    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX ADD1: XXXXXXXXXXXXXXXXXXXXXX             (MM/CCYY)       (MM/CCYY)
MTCHIND: X     DOB: MM/DD/CCYY                   ADD2: XXXXXXXXXXXXXXXXXXXXXX             (MM/CCYY)       (MM/CCYY)
               DOD: MM/DD/CCYY                    CSZ: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  (MM/CCYY)       (MM/CCYY)




                                                       *** END OF REPORT ***
                                                     *** NO DATA THIS RUN ***
```


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7.81.3 TPL-A058-R -- TPL UAIC Hits on Carrier no Match on Policy Report Field Descriptions

Field	Description	Length	Data Type
Add 1	The recipient's first address line.	22	Character
Add 2	The recipient's second address line.	22	Character
Addr 1	The policyholder's first address line from the UAIC input file.	25	Character
Addr 2	The policyholder's second address line from the UAIC input file.	25	Character
Addr 3	The policyholder's third address line from the UAIC input file.	25	Character
Addr 4	The policyholder's fourth address line from the UAIC input file.	25	Character
Carrier Code	The matching carrier code from the TPL database.	7	Character
COCD	The company code from the UAIC input file: (00, 03, 04, 56, 57, 90, 91) = United American (UAIC) (05, 06, 77) = Liberty National Claims (63) = First United American Life Claims (20, 81) = American Life & Accident Claims (60, 82, 83) = Globe Life & Accident claims (34) = American Income claims	2	Character
CSZ	The recipient's city, state and zip code.	33	Character
DOB	The policyholder's date of birth from the UAIC input file.	10	Date (MM/DD/CCYY)
DOB	The recipient's date of birth.	10	Date (MM/DD/CCYY)
DOD	The policyholder's date of death from the UAIC input file.	10	Date (MM/DD/CCYY)
Eligibility Begin Date	Identifies eligibility segments by begin and end dates. Shows the month and year the eligibility segment began, and the month and year it ended.	7	Date (MM/CCYY)
Eligibility End Date	The matching policy end date from the third party liability database.	7	Date (MM/CCYY)
End Date	The matching policy end date from the TPL Database.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
HIC #	The Medicare HIC Number from the UAIC input file. This is normally present on policy type 03 records.	12	Character
Iss Dt	The policy effective date from the UAIC input file.	10	Date (MM/DD/CCYY)
Medicaid No.	The recipient's Medicaid identification number.	12	Character
Mtchind	The indicator, which specifies the type of match. Possible values are: Blank = no match (default value) 1 = match on HIC number 2 = match on SSN	1	Character
Name	The recipient's first, middle, and last name.	27	Character
Name	The policyholder's first, middle, and last name from the UAIC input file.	25	Character
PDTO Dt	The policy paid-to-date to which the coverage is paid from the UAIC input file.	10	Date (MM/DD/CCYY)
Pol No.	The policy number assigned by the carrier from the UAIC input file.	30	Character
PolType	The policy type from the UAIC input file as follows: 00 = Hospital/Surgical/Medical 01 = Cancer/ dread disease 02 = Accident only 03 = Medicare supplement 04 = HMO coverage 05 = Indemnity 06 = Long term care/nursing home	2	Character
Policy No.	The matching policy number on the third party liability database.	30	Character

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Field	Description	Length	Data Type
Rec IND	The indicator, which specifies one of the following: 1 = As of run date, the individual on this record is eligible to receive Medicaid. 2 =As of run date, the individual on this record is NOT eligible to receive Medicaid. 3 =As of run date, this record was not found. 4 =As of run date, the individual on this record is in a nursing home and is eligible to receive Medicaid. 5 = No match was attempted because this was a header (M00) or trailer (M99) record, or the HIC # did not begin with the character 'A' or end with the character 'A' or 'M' and a valid SSN was not supplied. *****IMPORTANT***** All subsequent fields (Positions 302-492) on records with A '3' Or '5' in Am-Ind are filled with default values (Blanks Or Zeros).	1	Character
Rec-ID	The record ID from the UAIC input file as follows: M00 = header record M01= detail record M99 = trailer record	3	Character
SSN	The policyholder's Social Security Number from the UAIC input file. This is normally present on policy type 01, 02, 05, and 06 records.	9	Character
Term CD	The policy termination code from the UAIC input file as follows: H = lapsed due to hot check L or 5 = lapsed at request of policyholder R = on waiver of premium per policy terms 3 or 9 = deceased 4 = converted to another policy with same company	1	Character

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7.82 TPL-A059-R -- TPL UAIC Hits On Carrier Policy No Match on End Date Report

7.82.1 TPL-A059-R -- TPL UAIC Hits On Carrier Policy No Match on End Date Report Narrative

The TPL UAIC Hits On Carrier/Policy No Match on End Date report provides all recipients from the UAIC input file that are found on the TPL resource tables with a match on carrier code and policy number but no match on policy end date. This report is produced upon request.

7.82.2 TPL-A059-R -- TPL UAIC Hits On Carrier Policy no Match on End Date Report Layout

```
REPORT : TPL-A059-R                                ALABAMA MEDICAID AGENCY                                    RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA31                          MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME:  HH:MM:SS
LOCATION: TPLPA315M                  TPL UAIC HITS ON CARRIER/POLICY - NO MATCH ON END DATE                        PAGE:  999,999
                                                 REPORT PERIOD - MM/DD/CCYY




MEDICAID NO: 999999999999  CARRIER CODE: XXXXXXX  POLICY NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX END DATE:MM/DD/CCYY
 REC-ID: XXX  NAME: XXXXXXXXXXXXXXXXXXXXXXXXX      ADDR1: XXXXXXXXXXXXXXXXXXXXXXXXXX DOB: MM/DD/CCYY IND: XXXXXXXXXXXXXXXXXXXXXXXXXXXX
  CO CD: 99   HIC#: XXXXXXXXXXXX                   ADDR2: XXXXXXXXXXXXXXXXXXXXXXXXXX PDTO DT: MM/DD/CCYY
POLTYPE: 99    SSN: 999999999                      ADDR3: XXXXXXXXXXXXXXXXXXXXXXXXXX ISS DT: MM/DD/CCYY
TERM CD: X  POL NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ADDR4: XXXXXXXXXXXXXXXXXXXXXXXXXX              ELIGIBILITY
                                                                                          BEGIN DATE      END DATE
 RECIND: X    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX ADD1: XXXXXXXXXXXXXXXXXXXXXX             (MM/DD/CCYY)    (MM/DD/CCYY)
MTCHIND: X     DOB: MM/DD/CCYY                   ADD2: XXXXXXXXXXXXXXXXXXXXXX             (MM/DD/CCYY)    (MM/DD/CCYY)
               DOD: MM/DD/CCYY                    CSZ: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  (MM/DD/CCYY)    (MM/DD/CCYY)

                                                          *** END OF REPORT ***
                                                        *** NO DATA THIS RUN ***
```


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7.82.3 TPL-A059-R -- TPL UAIC Hits On Carrier Policy no Match on End Date Report Field Descriptions

Field	Description	Length	Data Type
Add 1	The recipient's first address line.	22	Character
Add 2	The recipient's second address line.	22	Character
Addr 1	The policyholder's first address line from the UAIC input file.	25	Character
Addr 2	The policyholder's second address line from the UAIC input file.	25	Character
Addr 3	The policyholder's third address line from the UAIC input file.	25	Character
Addr 4	The policyholder's fourth address line from the UAIC input file.	25	Character
Carrier Code	The matching carrier code from the third party liability database.	7	Character
COCD	The company code from the UAIC input file: (00, 03, 04, 56, 57, 90, 91) = United American (UAIC) (05, 06, 77) = Liberty National Claims (63) = First United American Life Claims (20, 81) = American Life & Accident Claims (60, 82, 83) = Globe Life & Accident claims (34) = American Income claims	2	Character
CSZ	The recipient's city, state and zip code.	33	Character
DOB	The policyholder's date of birth from the UAIC input file.	10	Date (MM/DD/CCYY)
DOB	The recipient's date of birth.	10	Date (MM/DD/CCYY)
DOD	The policyholder's date of death from the UAIC input file.	10	Date (MM/DD/CCYY)
Eligibility Begin Date	Identifies eligibility segments by begin and end dates. Shows the month and year the eligibility segment began, and the month and year it ended.	7	Date (MM/CCYY)
Eligibility End Date	The matching policy end date from the third party liability database.	10	Date (MM/DD/CCYY)
End Date	The matching policy end date from the TPL Database.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
HIC #	The Medicare HIC Number from the UAIC input file. This is normally present on policy type 03 records.	12	Character
Iss Dt	The policy effective date from the UAIC input file.	10	Date (MM/DD/CCYY)
Medicaid No.	The recipient's Medicaid identification number.	12	Character
Mtchind	The indicator, which specifies the type of match. Possible values are: Blank = no match (default value) 1 =match on HIC number 2 = match on SSN	1	Character
Name	The recipient's first, middle, and last name.	27	Character
Name	The policyholder's first, middle, and last name from the UAIC input file.	25	Character
PDTO Dt	The policy paid-to-date to which the coverage is paid from the UAIC input file.	10	Date (MM/DD/CCYY)
Pol No.	The policy number assigned by the carrier from the UAIC input file.	30	Character
PolType	The policy type from the UAIC input file as follows: 00 = Hospital/Surgical/Medical 01 = Cancer/ dread disease 02 = Accident only 03 = Medicare supplement 04 = HMO coverage 05 = Indemnity 06 = Long term care/nursing home	2	Character
Policy No.	The matching policy number on the third party liability database.	30	Character

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Field	Description	Length	Data Type
Rec IND	The indicator, which specifies one of the following: 1 = As of run date, the individual on this record is eligible to receive Medicaid. 2 = As of run date, the individual on this record is NOT eligible to receive Medicaid. 3 = As of run date, this record was not found. 4 = As of run date, the individual on this record is in a nursing home and is eligible to receive Medicaid. 5 = No match was attempted because this was a header (M00) or trailer (M99) record, or the HIC # did not begin with the character 'A' or end with the character 'A' or 'M' and a valid SSN was not supplied. *****IMPORTANT***** All subsequent fields (Positions 302-492) on records with A '3' or '5' In Am-Ind are filled with default values (Blanks Or Zeros).	1	Character
Rec-ID	The record identification from the UAIC input file as follows: M00 = header record M01= detail record M99 = trailer record	3	Character
SSN	The policyholder's Social Security Number from the UAIC input file. This is normally present on policy type 01, 02, 05, and 06 records.	9	Character
Term CD	The policy termination code from the UAIC input file as follows: H = lapsed due to hot check L or 5 = lapsed at request of policyholder R = on waiver of premium per policy terms 3 or 9 = deceased 4 = converted to another policy with same company	1	Character

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7.83 TPL-A060-R -- TPL UAIC Hits with Match on Carrier Policy and End Date Report

7.83.1 TPL-A060-R -- TPL UAIC Hits with Match on Carrier Policy and End Date Report Narrative

Users access the TPL UAIC Hits with Match on Carrier, Policy and End Date report provides all recipients from the UAIC input file that are found on the TPL resource tables with a match on carrier code, policy number, and policy end date. This report is produced upon request.

7.83.2 TPL-A060-R -- TPL UAIC Hits with Match on Carrier Policy and End Date Report Layout

```
REPORT  : TPL-A060-R                                  ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA31                             MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME:  HH:MM:SS
LOCATION: TPLPA315M                  TPL UAIC HITS WITH MATCH ON CARRIER, POLICY AND END DATE                       PAGE:  999,999
                                                   REPORT PERIOD - MM/DD/CCYY




MEDICAID NO: 999999999999    CARRIER CODE: XXXXXXX   POLICY NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   END DATE: MM/DD/CCYY


 REC-ID: XXX  NAME: XXXXXXXXXXXXXXXXXXXXXXXXX      ADDR1: XXXXXXXXXXXXXXXXXXXXXXXXXX DOB: MM/DD/CCYY IND: XXXXXXXXXXXXXXXXXXXXXXXXXXX
  CO CD: 99   HIC#: XXXXXXXXXXXX                   ADDR2: XXXXXXXXXXXXXXXXXXXXXXXXXX PDTO DT: MM/DD/CCYY
POLTYPE: 99    SSN: 999999999                      ADDR3: XXXXXXXXXXXXXXXXXXXXXXXXXX ISS DT: MM/DD/CCYY
TERM CD: X  POL NO: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX ADDR4: XXXXXXXXXXXXXXXXXXXXXXXXXX              ELIGIBILITY
                                                                                                BEGIN DATE     END DATE
 RECIND: X    NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXX ADD1: XXXXXXXXXXXXXXXXXXXXXX             (MM/CCYY)       (MM/CCYY)
MTCHIND: X     DOB: MM/DD/CCYY                   ADD2: XXXXXXXXXXXXXXXXXXXXXX             (MM/CCYY))      (MM/CCYY)
               DOD: MM/DD/CCYY                    CSZ: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  (MM/CCYY)Y)     (MM/CCYY)




                                                     *** END OF REPORT ***
                                                   *** NO DATA THIS RUN ***
```


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7.83.3 TPL-A060-R -- TPL UAIC Hits with Match on Carrier Policy and End Date Report Field Descriptions

Field	Description	Length	Data Type
Add 1	The recipient's first address line.	22	Character
Add 2	The recipient's second address line.	22	Character
Addr 1	The policyholder's first address line from the UAIC input file.	25	Character
Addr 2	The policyholder's second address line from the UAIC input file.	25	Character
Addr 3	The policyholder's third address line from the UAIC input file.	25	Character
Addr 4	The policyholder's fourth address line from the UAIC input file.	25	Character
Carrier Code	The matching carrier code from the third party liability database.	7	Character
COCD	The company code from the UAIC input file: (00, 03, 04, 56, 57, 90, 91) = United American (UAIC) (05, 06, 77) = Liberty National Claims (63) = First United American Life Claims (20, 81) = American Life & Accident Claims (60, 82, 83) = Globe Life & Accident claims (34) = American Income claims	2	Character
CSZ	The recipient's city, state and zip code.	33	Character
DOB	The policyholder's date of birth from the UAIC input file.	10	Date (MM/DD/CCYY)
DOB	The recipient's date of birth.	10	Date (MM/DD/CCYY)
DOD	The policyholder's date of death from the UAIC input file.	10	Date (MM/DD/CCYY)
Eligibility Begin Date	Identifies eligibility segments by begin and end dates. Shows the month and year the eligibility segment began, and the month and year it ended.	7	Date (MM/CCYY)
Eligibility End Date	The matching policy end date from the third party liability database.	7	Date (MM/CCYY)
End Date	The matching policy end date from the TPL Database.	10	Date (MM/DD/CCYY)

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Field	Description	Length	Data Type
HIC #	The Medicare HIC Number from the UAIC input file. This is normally present on policy type 03 records.	12	Character
Iss Dt	The policy effective date from the UAIC input file.	10	Date (MM/DD/CCYY)
Medicaid No.	The recipient's Medicaid identification number.	12	Character
Mtchind	The indicator, which specifies the type of match. Possible values are: Blank = no match (default value) 1 = match on HIC number 2 = match on SSN	1	Character
Name	The recipient's first, middle, and last name.	27	Character
Name	The policyholder's first, middle, and last name from the UAIC input file.	25	Character
PDTO DT	The policy paid-to-date to which the coverage is paid from the UAIC input file.	10	Date (MM/DD/CCYY)
Pol No.	The policy number assigned by the carrier from the UAIC input file.	30	Character
PolType	The policy type from the UAIC input file as follows: 00 = Hospital/Surgical/Medical 01 = Cancer/ dread disease 02 = Accident only 03 = Medicare supplement 04 = HMO coverage 05 = Indemnity 06 = Long term care/nursing home	2	Character
Policy No.	The matching policy number on the third party liability database.	30	Character

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Field	Description	Length	Data Type
Rec IND	The indicator, which specifies one of the following: 1 = As of run date, the individual on this record is eligible to receive Medicaid. 2 = As of run date, the individual on this record is NOT eligible to receive Medicaid. 3 = As of run date, this record was not found. 4 = As of run date, the individual on this record is in a nursing home and is eligible to receive Medicaid. 5 = No match was attempted because this was a header (M00) or trailer (M99) record, or the HIC # did not begin with the character 'A' or end with the character 'A' or 'M' and a valid SSN was not supplied. *****IMPORTANT***** All subsequent fields (Positions 302-492) on records with a '3' or '5' in Am-Ind are filled with default values (Blanks or Zeros).	1	Character
Rec-ID	The record ID from the UAIC input file as follows: M00 = header record M01= detail record M99 = trailer record	3	Character
SSN	The policyholder's Social Security Number from the UAIC input file. This is normally present on policy type 01, 02, 05, and 06 records.	9	Character
Term CD	The policy termination code from the UAIC input file as follows: H = lapsed due to hot check L or 5 = lapsed at request of policyholder R = on waiver of premium per policy terms 3 or 9 = deceased 4 = converted to another policy with same company.	1	Character

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7.84 TPL-A061-R -- TPL RSA Insurance Policy Coverage Report

7.84.1 TPL-A061-R -- TPL RSA Insurance Policy Coverage Report Narrative

The TPL RSA Insurance Policy Coverage report provides a listing of all recipients including Suspect Policy Segments on the RSA input file that are found on the TPL resource tables. This report is produced upon request.

7.84.2 TPL-A061-R -- TPL RSA Insurance Policy Coverage Report Layout

```
Report  : TPL-A061-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJA083                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0316I                         TPL RSA Insurance Policy Coverage                                 Page:    999,999

          BENEFICIARY                   MBR MBR MBR PLN
SSN       NAME                          CD  TYP CLS TYP                                                     ELIGIBILITY
999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXX XXX  XXX XXX                                                 BEGIN DATE END DATE
                                                                                                 CURRENT YEAR  MM/CCYY  MM/CCYY
    DED   DED     ENR      CNL    I  <............. POLICY FILE INFORMATION .............> 1ST PREV YEAR  MM/CCYY  MM/CCYY
    CD    AMT     DT       DT     R          POLICY NUMBER             CO#    BDATE    EDATE 2ND PREV YEAR  MM/CCYY  MM/CCYY
 9) XXX  999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999999  CCYYMMDD CCYYMMDD
 9) XXX  999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999999  CCYYMMDD CCYYMMDD
 9) XXX  999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999999  CCYYMMDD CCYYMMDD

                                              ***   END OF REPORT   ***
                                               *** NO DATA THIS RUN
```

7.84.3 TPL-A061-R -- TPL RSA Insurance Policy Coverage Report Field Descriptions

Field	Description	Length	Data Type
1st Prev Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of ‘X’ in that month’s position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of ‘X’. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character

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Field	Description	Length	Data Type
2nd Prev Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
Bdate	The policy begin date.	10	Date (MM/DD/YY)
Beneficiary Name	The beneficiary name from the RSA input file.	63	Character
CNL DT	The insurance cancellation date from the RSA input file.	10	Date (CCYYMM)
CO #	The carrier code.	7	Character
Current Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
DED AMT	The deduction amount from the RSA input file.	6	Number (Decimal)
DED CD	the deduction code from the RSA input file.	3	Character
EDate	The policy end date.	8	Date (CCYYMMDD)
Eligibility Begin Date	The month that eligibility began.	7	Date (MM/CCYY)
Eligibility End Date	The month that eligibility ended.	7	Date (MM/CCYY)

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Field	Description	Length	Data Type
ENR DT	The insurance enrollment date from the RSA input file.	8	Date (CCYYMM)
I R	The insurance rate code from the RSA input file.	1	Character
MBR CD	The member code from the RSA input file.	3	Character
MBR CLS	The member class from the RSA input file.	3	Character
MBR TYP	The member type from the RSA input file.	3	Character
PLN TYP	The insurance plan type from the RSA input file.	3	Character
Policy Number	The beneficiary policy number.	30	Character
SSN	The member Social Security Number from the RSA input file.	9	Character

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7.85 TPL-A070-R -- TPL DHR Absent Parent Military Service Report

7.85.1 TPL-A070-R -- TPL DHR Absent Parent Military Service Report Narrative

The TPL Absent Parent Military Service report is generated as a result of the data match process for the Department of Human Resources (DHR). This report is produced upon request.

7.85.2 TPL-A070-R -- TPL DHR Absent Parent Military Service Report Layout

```
REPORT  : TPL-A070-R                          ALABAMA MEDICAID AGENCY                          RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA312                     MEDICAID MANAGEMENT INFORMATION SYSTEM                  RUN TIME:  HH:MM:SS
LOCATION: TPLPA313                    TPL DHR ABSENT PARENT MILITARY SERVICE                        PAGE:  999,999
                                             REPORT PERIOD:  MM/DD/CCYY

ABSENT PARENT SSN: 999999999                       ABSENT PARENT NAME:XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ACTIVE DUTY INDICATOR: X

DEPENDENT MEDICAID NUMBER: 999999999999            DEPENDENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BRANCH OF SERVICE: XXXX                            ENLISTMENT DATE: MM/DD/CCYY

MILITARY ID NUMBER:  9999999999                    DISCHARGE DATE:  MM/DD/CCYY

                                        *** END OF REPORT ***
                                        *** NO DATA THIS RUN ***
```


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7.85.3 TPL-A070-R -- TPL DHR Absent Parent Military Service Report Field Descriptions

Field	Description	Length	Data Type
Absent Parent Name	The absent parent's name from the DHR input file.	30	Character
Absent Parent SSN	The absent parent's Social Security Number from the DHR input file.	9	Number (Integer)
Active Duty Indicator	The active military indicator from the DHR input file.	1	Character
Branch of Service	The branch of military service code from the DHR input file.	4	Character
Dependent Medicaid Number	The dependent's Medicaid identification number. This is obtained by matching the Dependent Social Security Number on the DHR input file to the Recipient Database.	12	Character
Dependent Name	The dependent's name.	30	Character
Discharge Date	The date of the military service discharge from the DHR input file.	10	Date (MM/DD/CCYY)
Enlistment Date	The date enlisted into military service from the DHR input file.	10	Date (MM/DD/CCYY)
Military ID Number	The military service number from the DHR input file.	10	Number (Integer)

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7.86 TPL-A071-R -- TPL DHR Data Report

7.86.1 TPL-A071-R -- TPL DHR Data Report Narrative

The TPL DHR Data report provides all the data received from the Department of Human Resources (DHR). This report is produced upon request.

7.86.2 TPL-A071-R -- TPL DHR Data Report Layout

```
REPORT  : TPL-A071-R                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA312                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:  HH:MM:SS
LOCATION: TPLPA313                                  TPL DHR DATA                                            PAGE:  999,999
                                             REPORT PERIOD:  MM/DD/CCYY



DEPENDENT MEDICAID NUMBER: 999999999999    TPL CARRIER CODE: XXXXX      POLICY NO.: 999999999999999
GROUP CERTIFICATION NO.: 99999             POLICY HOLDER'S NAME: XXXXX               XXXXXXX
POLICY HOLDER'S SSN: 999999999             CHILD'S NAME: XXXXXXX             XXXXXX      X

DEPENDENT MEDICAID NUMBER: 999999999999    TPL CARRIER CODE: XXXXX      POLICY NO.: 999999999999999
GROUP CERTIFICATION NO.: 99999             POLICY HOLDER'S NAME: XXXXX               XXXXXXX
POLICY HOLDER'S SSN: 999999999             CHILD'S NAME: XXXXXXX             XXXXXX      X


                                                  *** END OF REPORT ***
                                                 ** NO DATA THIS RUN ***
```


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7.86.3 TPL-A071-R -- TPL DHR Data Report Field Descriptions

Field	Description	Length	Data Type
Child's Name	Name of child.	30	Character
Dependent Medicaid Number	Medicaid number of dependent.	12	Number (Integer)
Group Certification No.	Group certification number of policy.	5	Number (Integer)
Policy Holder's Name	Name of policy holder.	30	Character
Policy Holder's SSN	Social Security Number of policy holder.	9	Number (Integer)
Policy No.	Insurance carrier policy number.	15	Character
TPL Carrier Code	The identification code of the carrier.	5	Character

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7.87 TPL-A073-R -- TPL DHR Transaction Error Report

7.87.1 TPL-A073-R -- TPL DHR Transaction Error Report Narrative

The TPL DHR Transaction Error report is generated as a result of the DHR data match process. This report is produced upon request.

7.87.2 TPL-A073-R -- TPL DHR Transaction Error Report Layout

```
REPORT  : TPL-A073-R                          ALABAMA MEDICAID AGENCY                                  RUN DATE:  MM/DD/CCYY
PROCESS : TPLJOA312                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         RUN TIME:  HH:MM:SS
LOCATION: TPLPA313                       TPL DHR TRANSACTION ERROR REPORT                                    PAGE:  999,999
                                           REPORT PERIOD :  MM/DD/CCYY

CHILDS SSN     ERROR MESSAGE

999999999      RECEIVED 800(INSURANCE) RECORD WITHOUT A CORRESPONDING 200(PARTICIPANT DEMOGRAPHICS) RECORD



999999999      RECEIVED 800(INSURANCE) RECORD WITHOUT A CORRESPONDING 200(PARTICIPANT DEMOGRAPHICS) RECORD



999999999      DHR SENT CARRIER CODE NOT FOUND



999999999      DHR SENT CARRIER CODE NOT FOUND



                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```


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7.87.3 TPL-A073-R -- TPL DHR Transaction Error Report Field Descriptions

Field	Description	Length	Data Type
Child's SSN	The dependent's Social Security Number from the DHR input file that encountered an error.	9	Number (Integer)
Error Message	The error that was encounter during the processing of the DHR input file.	104	Character

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7.88 TPL-A075-R -- TPL Electronic Remittance Summary Report

7.88.1 TPL-A075-R -- TPL Electronic Remittance Summary Report Narrative

The TPL Electronic Remittance Summary report is a summary of the claims received on an electronic remittance from an outside source and processed by the Electronic Posting batch process (an AR can represent several BCBS claims, as in the case of a drug AR). This report allows users to see:

- The number of claims reported per Claim Adjustment Reason Code (CARC)
- The sum of submitted charges per CARC
- The sum billed amount per CARC
- The sum total paid per CARC

This report also displays the following:

- The total amount paid for claims that were posted to the TPL accounts receivable's
- The total amount paid for claims that were not posted to the TPL accounts receivable's
- The number of claims that had invalid or blank CARC codes and the total billed amount, submitted charge, and paid amount for those claims
- The total number of claims that had invalid A/R numbers
- The total number of claims that were received on a remittance
- The total number of claims that were processed (i.e., the number of claims that were found on the AR table and processed by the Electronic Posting batch programs)

This report is helpful to users for providing a summary of AR posting activity and for research purposes. The report is produced upon request.

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7.88.2 TPL-A075-R -- TPL Electronic Remittance Summary Report Layout

```
Report  : TPL-A075-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0090M                    TPL ELECTRONIC REMITTANCE SUMMARY REPORT                             Page:    999,999
                                                REPORT PERIOD: MM/CCYY
                                               CHECK NUMBER:  XXXXXXXXXXXXXXX

REMITTANCE DATE: MM/DD/CCYY          CARRIER CODE: XXXXXXX

        BUSINESS     TOT CLAIMS                TOTAL                    TOTAL                       TOTAL
CARC    SCENARIO       REPORTED              SUBM CHARGE               BILLED AMT                  PAID AMT

XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
XXXX    XX              9999999              $9999999.99              $9999999.99              $9999999.99
TOTAL AMOUNT PAID AND POSTED                    :        $9999999.99
TOTAL AMOUNT PAID BUT NOT POSTED                :        $9999999.99
GRAND TOTAL PAID AGAINST REMIT                  :        $9999999.99
NUMBER OF CLAIMS WITH INVALID OR BLANK CARC     :        9999999
TOTAL BILLED AMT:       $9999999.99   TOTAL SUMBITTED CHARGE:       $9999999.99   TOTAL PAID AMT:       $9999999.99
TOTAL CLAIMS ON REMITTANCE                    :      9999999999


Report  : TPL-A075-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM0090                    MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0090M                    TPL ELECTRONIC REMITTANCE SUMMARY REPORT                             Page:    999,999
                                                REPORT PERIOD: MM/CCYY
                                               CHECK NUMBER:  XXXXXXXXXXXXXXX
                                              BUSINESS SCENARIO CODES (BUSC)

BUSINESS SCENARIO CODE: XX     BUSINESS SCENARIO DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX     BUSINESS SCENARIO DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX     BUSINESS SCENARIO DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


Report  : TPL-A075-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM0090                    MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0090M                    TPL ELECTRONIC REMITTANCE SUMMARY REPORT                             Page:    999,999
                                                REPORT PERIOD: MM/CCYY
                                               CHECK NUMBER:  XXXXXXXXXXXXXXX
                                           CLAIM ADJUSTMENT REASON CODES (CARC)

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESC: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                              XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESC: XXXX
```

Field	Description	Length	Data Type
Claim Adjustment Reason Code	The Claim Adjustment Reason Code (CARC) is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires accountability for every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Desc	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Grand Total Paid Against Remit	The total amount of money paid on the remittance.	12	Number (Decimal)
Number Of Claims with Invalid or Blank CARC	The number of claims that had an invalid or blank Claim Adjustment Reason Code.	10	Number (Integer)
Remittance Date	The date stamp on the electronic remittance.	10	Date (MM/DD/CCYY)
Total Amount Paid and Posted	The total amount that was posted to the Accounts Receivables.	12	Number (Decimal)
Total Amount Paid But Not Posted	The total amount paid by the carrier that was not posted to the account receivables.	12	Number (Decimal)
Total Billed Amt	The total billed amount for each CARC.	9	Number (Decimal)
Total Claims on Remittance	Total number of claims on the remittance.	10	Number (Integer)
Total Claims Reported	The total number of claims reported for each CARC.	10	Number (Integer)
Total Claims with Invalid AR Number	The number of claims that had an invalid AR number.	10	Number (Integer)
Total Paid Amt	The total paid amount for all invalid CARC.	14	Number (Decimal)
Total Paid Amt	The total paid amount for each CARC.	12	Number (Decimal)

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Field	Description	Length	Data Type
Total Submitted Charge	The total submitted charge for all invalid CARC.	14	Number (Decimal)
Total Subm Charge	The total submitted charge for each CARC.	9	Number (Decimal)

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7.89 TPL-A076-R -- TPL Credit Balance Report

7.89.1 TPL-A076-R -- TPL Credit Balance Report Narrative

The TPL Credit Balance Report gives a breakdown of the claims received on an electronic remittance received from an outside source. This report is created during the Electronic Posting process. The Credit Balance section displays claims that have a credit balance (i.e., a paid amount less than zero). This report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

7.89.2 TPL-A076-R -- TPL Credit Balance Report Layout

```
                                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJM090                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: TPL0094M                                  TPL CREDIT BALANCE REPORT                                            Page:    999,999
                                                     REPORT PERIOD: MM/CCYY
                                                  CHECK NUMBER:  XXXXXXXXXXXXXX

REMITTANCE DATE: MM/DD/CCYY        CARRIER CODE: XXXXXXX        DEPOSIT DATE:  MM/DD/CCYY
RID              AR NBR            CONTRACT NBR                     CLAIM #                          SUBSCRIBER NAME
XXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX,XXXXXXXXXXXX X

PATIENT NAME                         AMT BILLED         AMT PAID           MEDICAID BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X             $9999999.99        $9999999.99     MM/DD/CCYY

CLAIM      FROM         TO           DETAIL          BUSINESS                                                                  ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO   CAGC                                                CARC(S)    AMOUNT(S)
XXXX       MM/DD/CCYY   MM/DD/CCYY  $99999999.99     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
                                                     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

***** A/R 9999999999999 -TOTAL PAID:     $9999999.99
*****************************************************************************************************************************


     NUMBER OF CLAIMS  :            9999999
     TOTAL AMOUNT PAID :        $9999999.99




Report  : TPL-A076-R                                ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJM090                            MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: TPL0094M                                  TPL CREDIT BALANCE REPORT                                            Page:    999,999
                                                     REPORT PERIOD: MM/CCYY
                                                  CHECK NUMBER:  XXXXXXXXXXXXXX
                                                BUSINESS SCENARIO CODES (BUSC)

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
Report  : TPL-A076-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                       TPL CREDIT BALANCE REPORT                                     Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                       CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                   CLAIM ADJUSTMENT REASON CODES (CARC)

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

```
Report  : TPL-A076-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                       TPL CREDIT BALANCE REPORT                                     Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                       CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                 REMITTANCE ADVICE REMARK CODES (RARC)

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXX
```

Field	Description	Length	Data Type
CAGC	The group code and description that identifies the general category of the payment adjustment.	52	Character
CARC	The Claim Adjustment Reason Code(s) identifying the reason(s) the claim was adjusted.	4	Character
Carrier Code	The carrier code of the carrier the money was received from.	7	Character
Check Number	The check number associated to the refund.	9	Character
Claim #	The number assigned to the claim by the insurer.	30	Character
Claim Adjustment Reason Code	The Claim Adjustment Reason Code (CARC) is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires accountability for every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Claim Dtl #	The sequential number assigned to the claim detail (found only on the report).	3	Number (Integer)
Contract NBR	The insurer's contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid's bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	9	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid BILL DATE	The date that the third party insurer was billed by Medicaid.	10	Date (MM/DD/CCYY)
Number of Claims	Displays the number of claims documented in the report.	7	Number (Integer)

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Field	Description	Length	Data Type
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character
RARC(S)	HIPAA Remittance Advice Remarks Codes (RARCs) are used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. Note: Only the first five (5) RARCs will be reported.	5	Character
Remittance Advice Remark Code	The HIPAA Remittance Advice Remark Code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Number (Integer)
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	11	Number (Decimal)

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7.90 TPL-A077-R -- TPL Payments Received Not Posted Report

7.90.1 TPL-A077-R -- TPL Payments Received Not Posted Report Narrative

The TPL Payments Received Not Posted report gives a breakdown of the claims received on an electronic remittance received from an outside source. This report is created during the Electronic Posting process. This report displays claims that have a paid amount greater than zero but was not posted because of an invalid AR number. This report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

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7.90.2 TPL-A077-R -- TPL Payments Received Not Posted Report Layout

```
Report  : TPL-A077-R                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJD006                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0002I                                       PAYMENTS RECEIVED--NOT POSTED                                       Page:    999,999
                                                            REPORT PERIOD: MM/CCYY

                                                 CHECK NUMBER:  XXXXXXXXXXXXXXX
REMITTANCE DATE: CCYY-MM-DD           CARRIER CODE: XXXXXXX     DEPOSIT DATE: CCYY-MM-DD

CLAIM                        AR            CONTRACT                        CLAIM                           SUBSCRIBER
          RID                NBR           NBR                             NBR                             NAME
          XXXXXXXXXXXX       XXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX,XXXXXXXXXXXX X
  BUSINESS SCENARIO: XX      CAGC: XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CARC: XXXX    RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
PATIENT                                          AMT                  AMT        BEFORE   AFTER      MEDICAID
NAME                                             BILLED               PAID       CARC     CARC       BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X                    $9999999.99         $9999999.99    XXXX     XXXX       CCYY-MM-DD

CLAIM      FROM         TO           DETAIL          BUSINESS                                                                    ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO  CAGC                                                  CARC(S)     AMOUNT(S)
XXXX       CCYY-MM-DD   CCYY-MM-DD   $9999999.99     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
XXXX                                                 XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

*****A/R  9999999999999  TOTAL CLAIMS 99999     TOTAL PAID  $99,999,999,999,999.99


NUMBER OF CLAIMS:  99,999,999,999,999
TOTAL AMOUNT PAID: $99,999,999,999,999.99
```


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```
Report  : TPL-A077-R                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJD006                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0002I                                       PAYMENTS RECEIVED--NOT POSTED                                       Page:    999,999
                                                            REPORT PERIOD: MM/CCYY
                                                         BUSINESS SCENARIO CODES (BUSC)
                                                  CHECK NUMBER:  XXXXXXXXXXXXXXX

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


Report  : TPL-A077-R                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJD006                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0002I                                       PAYMENTS RECEIVED--NOT POSTED                                       Page:    999,999
                                                            REPORT PERIOD: MM/CCYY
                                                      CLAIM ADJUSTMENT REASON CODES (CARC)
                                                  CHECK NUMBER:  XXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXX
```

```
Report  : TPL-A077-R                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJD006                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: TPL0002I                                      PAYMENTS RECEIVED--NOT POSTED                                        Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                    REMITTANCE ADVICE REMARK CODES (RARC)
                                                 CHECK NUMBER:  XXXXXXXXXXXXXXX

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION: XXXXXXXXXXXXXX
```

7.90.3 TPL-A077-R -- TPL Payments Received Not Posted Report Field Descriptions

Field	Description	Length	Data Type
(CLAIM) CARC	The code that conveys the status of the A/R. This field is shown on the Payments Posted, the Denials Posted, the Denial with Invalid AR Number, and the Other sections of the report.	4	Character
Adjustment Amount(S)	The dollar amount of the claim adjustment.	11	Number (Decimal)
After CARC	The A/R status after the Electronic Posting Process is ran.	4	Character
Amt Billed	The account receivable amount billed to the third party entity.	9	Number (Decimal)
Amt Paid	The dollar amount paid against an A/R.	9	Number (Decimal)
AR NBR	Accounts receivable number assigned by the system at time of AR creation.	13	Number (Integer)
Before CARC	The A/R Status before the electronic posting process is ran. For this report, the value in this field will be N/A, since there is no valid A/R number to use to retrieve the record containing the status pre-posting from the accounts receivable file.	4	Character
Business Scenario	The CAQH CORE-defined Business Scenario code associated to the CARC. N/A if no Business Scenario was found for the CARC or more than one Business Scenario was found. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim.	2	Character
Business Scenario Code	The CAQH CORE-defined Business Scenario code that was included in the previous section of the report. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim	2	Character
Business Scenario Description	The description for the CAQH Business Scenario code.	50	Character
CAGC	The group code and description that identifies the general category of the payment adjustment.	52	Character

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Field	Description	Length	Data Type
CARC(S)	The Claim Adjustment Reason Code(s) identifying the reasons the claim was adjusted.	4	Character
Carrier Code	The carrier code of the carrier the money was received from.	7	Character
Claim Adjustment Reason Code	The CARC is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/	700	Character
Check Number	The check number associated to the refund.	9	Character
Claim NBR	The number assigned to the claim by the insurer.	30	Character
Claim DTL#	The sequential number assigned to the claim detail (found only on the report).	3	Number (Integer)
Contract NBR	The insurer’s contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid’s bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	9	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid Bill Date	The date that the third party insurer was billed by Medicaid.	10	Date (MM/DD/CCYY)
Number of Claims	Displays the number of claims documented in the report.	7	Number (Integer)
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character

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Field	Description	Length	Data Type
RARC(s)	HIPAA remarks code.Only the first five (5) RARCs will be printed out.	5	Character
Remittance Advice Remark Code	The HIPAA remark code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/	700	Character
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Number (Integer)
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	13	Number (Decimal)

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7.91 TPL-A078-R -- TPL Denials Posted - Needs Research Report

7.91.1 TPL-A078-R -- TPL Denials Posted - Needs Research Report Narrative

The Denials Posted - Needs Research Report is one of a series of reports that gives a breakdown of the claims that are received on an electronic remittance received from an outside source. This report is created during the Electronic Posting process. This report lists claims with a paid amount of zero that were posted to the accounts receivable but need research because the HIPAA Reason Code on each claim was one of the following: 18, 19, 20, 21, 22, 23, 62, 63, 71, 88, 93, 95, 100, 101, 120, 123, 124, 132, 133, 135, 136, 139, 140, 143, A7, B11, and B13. This report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

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7.91.2 TPL-A078-R -- TPL Denials Posted - Needs Research Report Layout

```
Report  : TPL-A078-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                  TPL DENIALS POSTED - NEEDS RESEARCH                                Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                       CHECK NUMBER:  XXXXXXXXXXXXXXX

REMITTANCE DATE: MM/DD/CCYY        CARRIER CODE: XXXXXXX        DEPOSIT DATE: MM/DD/CCYY
RID              AR NBR            CONTRACT NBR                     CLAIM #                        SUBSCRIBER NAME
XXXXXXXXXXXX     XXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXX       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX,XXXXXXXXXXXX X

PATIENT NAME                        AMT BILLED         AMT PAID           MEDICAID BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X            $9999999.99        $9999999.99     MM/DD/CCYY

CLAIM      FROM         TO           DETAIL          BUSINESS                                                          ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO   CAGC                                        CARC(S)    AMOUNT(S)
XXXX       MM/DD/CCYY   MM/DD/CCYY  $99999999.99     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
XXXX       MM/DD/CCYY   MM/DD/CCYY  $99999999.99     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX       $9999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX


***** A/R 9999999999999   -TOTAL PAID:  $9999999.99
*****************************************************************************************************************************



     NUMBER OF CLAIMS  :             9999999
     TOTAL AMOUNT PAID :        $9999999.99



Report  : TPL-A078-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                  TPL DENIALS POSTED - NEEDS RESEARCH                                Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                       CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                     BUSINESS SCENARIO CODES (BUSC)

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX



Report  : TPL-A078-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                  TPL DENIALS POSTED - NEEDS RESEARCH                                Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                       CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                   CLAIM ADJUSTMENT REASON CODES (CARC)

CLAIM ADJUSTMENT REASON CODE: XXXX
```


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CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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Report  : TPL-A078-R                                  ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJM090                          MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0094M                            TPL DENIALS POSTED - NEEDS RESEARCH                              Page:    999,999
                                                    REPORT PERIOD: MM/CCYY
                                                 CHECK NUMBER:  XXXXXXXXXXXXXXX
                                             REMITTANCE ADVICE REMARK CODES (RARC)

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXX
```

Field	Description	Length	Data Type
Carrier Code	The carrier code of the carrier the money was received from.	7	Character
Claim Adjustment Reason Code	The Claim Adjustment Reason Code (CARC) is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires accountability for every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Check #	The check number associated to the refund.	9	Character
Claim #	The number assigned to the claim by the insurer.	30	Character
Claim DTL #	The sequential number assigned to the claim detail (found only on the report).	2	Number (Integer)
Contract NBR	The insurer's contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid's bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	11	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid Bill Date	The date that the third party insurer was billed by Medicaid.	8	Date (MM/DD/CCYY)
Number of Claims	Displays the number of claims documented in the report.	7	Number (Integer)

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Field	Description	Length	Data Type
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character
RARC(S)	HIPAA Remittance Advice Remarks Codes (RARCs) are used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. Note: Only the first five (5) RARCs will be reported.	5	Character
Remittance Advice Remark Code	HIPAA Remittance Advice Remark Code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Character
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	13	Number (Decimal)

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7.92 TPL-A079-R -- TPL Denials with Invalid AR Number - Not Posted Report

7.92.1 TPL-A079-R -- TPL Denials with Invalid AR Number - Not Posted Report Narrative

The TPL Denials with Invalid A/R Number--Not Posted report gives a breakdown of the claims received on an electronic remittance received from an outside source. This report is created during the Electronic Posting process. This report displays claims that have a zero paid amount and an invalid AR number. This report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

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7.92.2 TPL-A079-R -- TPL Denials With Invalid AR Number - Not Posted Report Layout

```
Report  : TPL-A079-R                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : TPLJD006                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: TPL0002I                                TPL DENIALS WITH INVALID AR NUMBER-NOT POSTED                                        Page:    999,999
                                                            REPORT PERIOD: MM/CCYY

                                                  CHECK NUMBER:  XXXXXXXXXXXXXXX
REMITTANCE DATE: CCYY-MM-DD           CARRIER CODE: XXXXXXX     DEPOSIT DATE: CCYY-MM-DD

CLAIM                      AR             CONTRACT                        CLAIM                           SUBSCRIBER
          RID              NBR            NBR                             NBR                             NAME
          XXXXXXXXXXXX     XXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX,XXXXXXXXXXXX X
          CARC: N/A   RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
PATIENT                                       AMT                  AMT        BEFORE   AFTER      MEDICAID
NAME                                          BILLED               PAID       CARC     CARC       BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X                  $9999999.99         $9999999.99    XXXX     XXXX       CCYY-MM-DD

CLAIM      FROM         TO           DETAIL          BUSINESS                                                                  ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO  CAGC                                                  CARC(S)     AMOUNT(S)
XXXX       CCYY-MM-DD   CCYY-MM-DD   $9999999.99     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
          RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
XXXX                                                 XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
                                                     XX        XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXX      $9999999999.99
          RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

*****A/R 99999999999999  TOTAL CLAIMS 99999     TOTAL PAID  $99,999,999,999,999.99


NUMBER OF CLAIMS : 99,999,999,999,999
TOTAL AMOUNT PAID: $99,999,999,999,999.99



Report  : TPL-A079-R                                    ALABAMA MEDICAID AGENCY                                                    Run Date: MM/DD/CCYY
Process : TPLJD006                                 MEDICAID MANAGEMENT INFORMATION SYSTEM                                          Run Time:   HH:MM:SS
Location: TPL0002I                                TPL DENIALS WITH INVALID AR NUMBER-NOT POSTED                                        Page:    999,999
                                                            REPORT PERIOD: MM/CCYY
                                                         BUSINESS SCENARIO CODES (BUSC)
                                                  CHECK NUMBER:  XXXXXXXXXXXXXXX

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
Report  : TPL-A079-R                                    ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJD006                                MEDICAID MANAGEMENT INFORMATION SYSTEM                                 Run Time:   HH:MM:SS
Location: TPL0002I                              TPL DENIALS WITH INVALID AR NUMBER-NOT POSTED                              Page:    999,999
                                                          REPORT PERIOD: MM/CCYY
                                                   CLAIM ADJUSTMENT REASON CODES (CARC)
                                                CHECK NUMBER:  XXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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```
Location: TPL0002I                                TPL DENIALS WITH INVALID AR NUMBER-NOT POSTED                                    Page:    999,999
                                                            REPORT PERIOD: MM/CCYY
                                                     REMITTANCE ADVICE REMARK CODES (RARC)
                                                CHECK NUMBER:  XXXXXXXXXXXXXXX

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                         ***   END OF REPORT   ***
                                        ***   NO DATA THIS RUN   ***
```

7.92.3 TPL-A079-R -- TPL Denials With Invalid AR Number - Not Posted Report Field Descriptions

Field	Description	Length	Data Type
(CLAIM) CARC	This identifies the reason for denial from the insurance company. Always N/A for this report.	3	Character
Adjustment Amount(S)	The dollar amount of the claim adjustment.	11	Number (Decimal)
After CARC	The A/R Status after the electronic posting process is ran.	4	Character

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Field	Description	Length	Data Type
Amt Billed	The account receivable amount billed to the third party entity.	11	Number (Decimal)
Amt Paid	The dollar amount paid against an A/R.	9	Number (Decimal)
AR NBR	Accounts Receivable number assigned by the system at time of A/R creation.	13	Number (Integer)
Before CARC	The A/R Status before the electronic posting process is ran.	4	Character
Business Scenario	The CAQH CORE-defined Business Scenario code associated to the CARC. N/A if no Business Scenario was found for the CARC or more than one Business Scenario was found. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim.	2	Character
Business Scenario Code	The CAQH CORE-defined Business Scenario code that was included in the previous section of the report. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim	2	Character
Business Scenario Description	The description for the CAQH Business Scenario code.	50	Character
CAGC	The group code and description that identifies the general category of the payment adjustment.	52	Character
CARC(S)	The Claim Adjustment Reason Code(s) identifying the reasons the claim was adjusted.	4	Character
Carrier Code	The carrier code of the carrier the money was received from.	7	Character

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Field	Description	Length	Data Type
Claim Adjustment Reason Code	The CARC is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Check #	The check number associated to the refund.	9	Character
Claim NBR	The number assigned to the claim by the insurer.	30	Character
Claim DTL #	The sequential number assigned to the claim detail (found only on the report).	3	Number (Integer)
Contract NBR	The insurer's contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid's bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	11	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid Bill Date	The date that the third party insurer was billed by Medicaid.	10	Date (MM/DD/CCYY)
Number Of Claims	Displays the number of claims documented in the report.	7	Number (Integer)
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character
RARC(s)	HIPAA remarks code. Only the first five (5) RARCs will be printed out.	5	Character

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Field	Description	Length	Data Type
Remittance Advice Remark Code	The HIPAA remark code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/	700	Character
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Character
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	13	Number (Decimal)

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7.93 TPL-A080-R -- TPL AR Payments Posted Report

7.93.1 TPL-A080-R -- TPL AR Payments Posted Report Narrative

The TPL AR Payments Posted Report gives a breakdown of the claims received on an electronic remittance received from an outside source. This report is created during the Electronic Posting process. This report displays claims that have a paid amount greater than zero. This report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

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7.93.2 TPL-A080-R -- TPL AR Payments Posted Report Layout

```
Report  : TPL-A080-R                                        ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : TPLJM090                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0094M                                        TPL AR PAYMENTS POSTED REPORT                                        Page:    999,999
                                                             REPORT PERIOD: MM/CCYY
                                                          CHECK NUMBER: XXXXXXXXXXXXXXX

REMITTANCE DATE: MM/DD/CCYY          CARRIER CODE: XXXXXXX       DEPOSIT DATE: MM/DD/CCYYY

CLAIM                       AR            CONTRACT                        CLAIM                           SUBSCRIBER
          RID               NBR           NBR                             NBR                             NAME
          XXXXXXXXXXXX      XXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXX,XXXXXXXXXXXX X
  BUSINESS SCENARIO: XX     CAGC: XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CARC: XXXX    RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

PATIENT NAME                          AMT                          AMT     BEFORE   AFTER      MEDICAID
                                      BILLED                       PAID    CARC     CARC       BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X         $999999.99              $9999999.99    XXXX     XXXX       MM/DD/CCYY

CLAIM      FROM         TO           DETAIL          BUSINESS                                                                ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO   CAGC                                                 CARC(S)  AMOUNT(S)
XXXX       MM/DD/CCYY   MM/DD/CCYY   $99999999.99    XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX     $9999999.99
          RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

***** A/R 9999999999999 —TOTAL PAID:   $9999999.99


NUMBER OF CLAIMS:       9999999
TOTAL AMOUNT PAID:  $9999999.99


Report  : TPL-A080-R                                        ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : TPLJM090                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0094M                                        TPL AR PAYMENTS POSTED REPORT                                        Page:    999,999
                                                             REPORT PERIOD: MM/CCYY
                                                          CHECK NUMBER: XXXXXXXXXXXXXXX
                                                         BUSINESS SCENARIO CODES (BUSC)

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


Report  : TPL-A080-R                                        ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : TPLJM090                                   MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0094M                                        TPL AR PAYMENTS POSTED REPORT                                        Page:    999,999
                                                             REPORT PERIOD: MM/CCYY
                                                          CHECK NUMBER: XXXXXXXXXXXXXXX
```


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```
                                        CLAIM ADJUSTMENT REASON CODES (CARC)

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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Report  : TPL-A080-R                                  ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJM090                          MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0094M                               TPL AR PAYMENTS POSTED REPORT                                 Page:    999,999
                                                    REPORT PERIOD: MM/CCYY
                                                 CHECK NUMBER: XXXXXXXXXXXXXXX
                                             REMITANCE ADVICE REMARK CODES (RARC)

REMITANCE ADVICE REMARK CODE: XXXXX
REMITANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

REMITANCE ADVICE REMARK CODE: XXXXX
REMITANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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Field	Description	Length	Data Type
Business Scenario	The CAQH CORE-defined Business Scenario code associated to the CARC. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim. Note: N/A is displayed if a unique and valid Business Scenario was not found for the CARC.	2	Character
Business Scenario Code	The CAQH CORE-defined Business Scenario code that was included in the previous section of the report. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim.	2	Character
Business Scenario Description	The description for the CAQH-CORE Business Scenario code.	50	Character
CAGC	The group code and description that identifies the general category of the payment adjustment.	52	Character
CARC	The Claim Adjustment Reason Code(s) identifying the reasons the claim was adjusted.	4	Character
Carrier Code	The carrier code of the carrier the money was received from.	7	Character
Check Number	The check number associated to the refund.	9	Character
Claim Adjustment Reason Code	The Claim Adjustment Reason Code (CARC) is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires accountability for every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character

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Field	Description	Length	Data Type
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Claim NBR	The number assigned to the claim by the insurer.	30	Character
Claim DTL#	The sequential number assigned to the claim detail (found only on the report).	3	Number (Integer)
Contract NBR	The insurer's contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid's bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	9	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid Bill Date	The date that the third party insurer was billed by Medicaid.	10	Date (MM/DD/CCYY)
Number of Claims	Displays the number of claims documented in the report.	7	Number (Integer)
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character
RARC(S)	HIPAA Remittance Advice Remarks Codes (RARCs) are used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. Note: Only the first five (5) RARCs will be reported.	5	Character
Remittance Advice Remark Code	The HIPAA Remittance Advice Remark Code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character

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Field	Description	Length	Data Type
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Number (Integer)
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	11	Number (Decimal)

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7.94 TPL-A081-R -- TPL Denials Posted Report

7.94.1 TPL-A081-R -- TPL Denials Posted Report Narrative

The TPL Denials Posted report gives a breakdown of the claims received on an electronic remittance from an outside source. This report is created during the Electronic Posting process. This report displays claims that have a zero paid amount and were posted to the Accounts Receivable record. This report displays claims that had a zero paid amount and were posted to the Accounts Receivable record. This report excludes denied claims that have the following HIPAA Reason Codes: 18, 19, 20, 21, 22, 23, 62, 63, 71, 88, 93, 95, 100, 101, 120, 123, 124, 132, 133, 135, 136, 139, 140, 143, A7, B11, and B13. The Denials Posted Report is useful for research purposes and as a record of A/R activity for any particular remittance. This report is produced upon request.

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7.94.2 TPL-A081-R -- TPL Denials Posted Report Layout

```
Report  : TPL-A081-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                         TPL DENIALS POSTED                                          Page:    999,999
                                                        REPORT PERIOD: MM/CCYY
                                                     CHECK NUMBER:  XXXXXXXXXXXXXXX

REMITTANCE DATE: MM/DD/CCYY          CARRIER CODE:  XXXXXXX       DEPOSIT DATE:  MM/DD/CCYY

CLAIM                       AR            CONTRACT                        CLAIM                           SUBSCRIBER
          RID               NBR           NBR                             NBR                             NAME
          XXXXXXXXXXXX      XXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXX      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX,XXXXXXXXXXXX X
  BUSINESS SCENARIO: XX     CAGC: XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    CARC: XXXX    RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

PATIENT NAME                          AMT                          AMT     BEFORE   AFTER      MEDICAID
                                      BILLED                       PAID    CARC     CARC       BILL DATE
XXXXXXXXXXXX,XXXXXXXXXXXX X              $9999999.99        $9999999.99    XXXX     XXXX      MM/DD/CCYY

CLAIM      FROM         TO           DETAIL          BUSINESS                                                                  ADJUSTMENT
DTL #      DOS          DOS          PAID AMT        SCENARIO   CAGC                                                  CARC(S)   AMOUNT(S)
XXXX       MM/DD/CCYY   MM/DD/CCYY  $99999999.99     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX      $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX      $9999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX
XXXX       MM/DD/CCYY   MM/DD/CCYY  $99999999.99     XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX      $9999999.99
                                                      XX         XX- XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXX      $9999999.99
           RARC(S): XXXXX  XXXXX  XXXXX  XXXXX  XXXXX

***** A/R 9999999999999 -TOTAL PAID:     $9999999.99
*****************************************************************************************************************************


      NUMBER OF CLAIMS  :            9999999
     TOTAL AMOUNT PAID :        $9999999.99


Report  : TPL-A081-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                         TPL DENIALS POSTED                                          Page:    999,999
                                                       REPORT PERIOD: MM/CCYY
                                                     CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                   BUSINESS SCENARIO CODES (BUSC)

BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BUSINESS SCENARIO CODE: XX          BUSINESS SCENARIO DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```


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```
Report  : TPL-A081-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                         TPL DENIALS POSTED                                          Page:    999,999
                                                         REPORT PERIOD: MM/CCYY
                                                     CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                 CLAIM ADJUSTMENT REASON CODES (CARC)

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

CLAIM ADJUSTMENT REASON CODE: XXXX
CLAIM ADJUSTMENT REASON DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                      XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

```
Report  : TPL-A081-R                                    ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM090                                MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0094M                                         TPL DENIALS POSTED                                          Page:    999,999
                                                         REPORT PERIOD: MM/CCYY
                                                     CHECK NUMBER:  XXXXXXXXXXXXXXX
                                                 REMITTANCE ADVICE REMARK CODES (RARC)

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

REMITTANCE ADVICE REMARK CODE: XXXXX
```


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REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

REMITTANCE ADVICE REMARK CODE: XXXXX
REMITTANCE ADVICE REMARK DESCRIPTION:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                       XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                    *NO DATA THIS RUN*
                                                     *END OF REPORT*
```

7.94.3 TPL-A081-R – TPL Denials Posted Report Field Descriptions

Field	Description	Length	Data Type
Adjustment Amount(S)	The dollar amount of the claim adjustment.	9	Number (Decimal)
Adjustment Group Code	The code identifying the general category of payment adjustment and its description.	2	Character
After CARC	The A/R status after the electronic posting process is ran.	4	Character
Amt Billed	The account receivable amount billed to the third party entity.	9	Number (Decimal)
Amt Paid	The dollar amount paid against an A/R.	9	Number (Decimal)
AR NBR	Accounts receivable number assigned by the system at time of AR creation.	13	Number (Integer)
Before CARC	The A/R Status before the Electronic Posting process is ran.	4	Character

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Field	Description	Length	Data Type
Business Scenario	The CAQH CORE-defined Business Scenario code associated to the CARC thjat describes, at a high level, the category of the denial or payment adjustment of a claim. Note: N/A is displayed if a unique and valid Business Scenario was not found for the CARC.	2	Character
Business Scenario Code	The CAQH CORE-defined Business Scenario code that was included in the previous section of the report. The Business Scenario describes, at a high level, the category of the denial or payment adjustment of a claim.	2	Character
Business Scenario Description	The description for the CAQH-CORE Business Scenario code.	50	Character
CAGC	The group code and description that identifies the general category of the payment adjustment.	52	Character
CARC	The Claim Adjustment Reason Code(s) (CARC) identifying the reason(s) the claim was adjusted.	4	Character
Carrier Code	The carrier code of the carrier the money was received from.	7	Character
Claim Adjustment Reason Code	The Claim Adjustment Reason Code (CARC) is the HIPAA adjustment reason code that was included in the previous section of the report. HIPAA requires accountability for every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	4	Character
Claim Adjustment Reason Description	The description for the Claim Adjustment Reason Code (CARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference.	700	Character
Claim NBR	The number assigned to the claim by the insurer.	30	Character
Claim DTL #	The sequential number assigned to the claim detail (found only on the report).	3	Number (Integer)

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Field	Description	Length	Data Type
Contract NBR	The insurer's contract number.	30	Character
Deposit Date	The date on which the funds from the carrier's remittance is deposited into Medicaid's bank account.	10	Date (MM/DD/CCYY)
Detail Paid Amt	The dollar amount paid against the claim detail.	9	Number (Decimal)
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
Medicaid Bill Date	The date that the third party insurer was billed by Medicaid.	10	Date (MM/DD/CCYY)
Number of Claims	Displays the number of claims documented in the report.	7	Number (Integer)
Patient Name	The last name, first name, and middle initial of the recipient for whom medical services were rendered.	31	Character
RARC(S)	HIPAA Remittance Advice Remarks Codes (RARCs) are used to provide an additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. Note: Only the first five (5) RARCs will be reported.	5	Character
Remittance Advice Remark Code	The HIPAA Remittance Advice Remark Code (RARC) that was included in the previous section of the report.	5	Character
Remittance Advice Remark Description	The description for the Remittance Advice Remark Code (RARC). Full descriptions can be obtained from Washington Publishing: http://www.wpc-edi.com/reference/.	700	Character
Remittance Date	The date stamp on the electronic remittance received from the carrier.	10	Date (MM/DD/CCYY)
RID	The recipient identification number.	12	Number (Integer)
Subscriber Name	The last name, first name, and middle initial of the owner of the policy.	31	Character
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total Amount Paid	Displays the total dollar amount paid for the report.	13	Number (Decimal)

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7.95 TPL-A088-R -- TPL RSA Policy Record Not Added Report

7.95.1 TPL-A088-R -- TPL RSA Policy Record Not Added Report Narrative

The TPL RSA Policy Record Not Added report displays the recipients from the Retirement Systems of Alabama (RSA) input file whose policy is not in the TPL Resource tables. The recipients who appear on this report are added to the database manually. This report is produced upon request.

7.95.2 TPL-A088-R -- TPL RSA Policy Record not Added Report Layout

```
Report  : TPL-A088-R                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJA016                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   MM/HH/SS
Location: TPL0316I                         TPL RSA Policy Record not Added                                 Page:          1

          BENEFICIARY                   MBR MBR MBR PLN
SSSAN     NAME                          CD  TYP CLS TYP                                                      ELIGIBILITY
[redacted]                                                                                              BEGIN DATE END DATE
                                                                                                 CURRENT YEAR
    DED   DED     ENR      CNL    I  <............. POLICY FILE INFORMATION .............>  1ST PREV YEAR
    CD    AMT     DT       DT     R          POLICY NUMBER            CO#    BDATE    EDATE  2ND PREV YEAR
 1) P03 011000    000000   000000 D                                                   0        0
          BENEFICIARY                   MBR MBR MBR PLN
SSSAN     NAME                          CD  TYP CLS TYP                                                      ELIGIBILITY
[redacted]                                                                                              BEGIN DATE END DATE
                                                                                                 CURRENT YEAR   1/2007  12/2007
    DED   DED     ENR      CNL    I  <............. POLICY FILE INFORMATION .............>  1ST PREV YEAR   1/2006  12/2006
    CD    AMT     DT       DT     R          POLICY NUMBER            CO#    BDATE    EDATE  2ND PREV YEAR   1/2005  12/2005
 1) P09 003800    100119   000000 A  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXX         0        0

                                                   ***   END OF REPOR***
```


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7.95.3 TPL-A088-R -- TPL RSA Policy Record not Added Report Field Descriptions

Field	Description	Length	Data Type
1st Previous Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
2nd Previous Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
BDate	The policy begin date.	8	Date (MM/DD/YY)
Beneficiary NAME	The beneficiary name from the RSA input file.	63	Character
CNL DT	The insurance cancellation date from the RSA input file.	8	Character
CO #	The carrier code.	7	Character

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Field	Description	Length	Data Type
Current Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
DED AMT	The deduction amount from the RSA input file.	6	Number (Decimal)
DED CD	The deduction code from the RSA input file.	3	Character
Eligibility Begin Date	The month that eligibility began.	7	Character
Eligibility End Date	The month that eligibility ended.	7	Character
EDATE	The policy end date.	8	Date (MM/DD/YY)
ENR DT	The insurance enrollment date from the RSA input file.	8	Date (MM/DD/YY)
I R	The insurance rate code from the RSA input file.	1	Character
MBR CD	The member code from the RSA input file.	1	Character
MBR CLS	The member class from the RSA input file.	3	Character
MBR TYE	The member type from the RSA input file.	1	Character
PLN Type	The insurance plan type from the RSA input file.	3	Character
Policy Number	The beneficiary policy number.	30	Character
SSAN	The member Social Security Number from the RSA input file.	9	Number (Integer)

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7.96 TPL-A089-R -- TPL RSA Policy Record Added Report

7.96.1 TPL-A089-R -- TPL RSA Policy Record Added Report Narrative

The TPL RSA Policy Record Added report displays the recipients from the RSA input file whose policy has been automatically added to the TPL Resource tables. This report is produced upon request.

7.96.2 TPL-A089-R -- TPL RSA Policy Record Added Report Layout

```
Report  : TPL-A089-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJA083                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0316I                            TPL RSA Policy Record Added                                    Page:    999,999

          BENEFICIARY                   MBR MBR MBR PLN
SSN       NAME                          CD  TYP CLS TYP                                                      ELIGIBILITY
999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX XX  XX  XXX XXX                                                  BEGIN DATE END DATE
                                                                                                  CURRENT YEAR  MM/CCYY  MM/CCYY
    DED   DED     ENR      CNL    I  <............... POLICY FILE INFORMATION ..............>  1ST PREV YEAR  MM/CCYY  MM/CCYY
    CD    AMT     DT       DT     R          POLICY NUMBER             CO#    BDATE    EDATE  2ND PREV YEAR  MM/CCYY  MM/CCYY
 9) XXX 9999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999 CCYYMMDD CCYYMMDD
 9) XXX 9999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999 CCYYMMDD CCYYMMDD
 9) XXX 9999999   CCYYMM   CCYYMM X  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999 CCYYMMDD CCYYMMDD
                                                 ***   END OF REPORT   ***
                                                 *** NO DATA THIS RUN ***
```

7.96.3 TPL-A089-R -- TPL RSA Policy Record Added Report Field Descriptions

Field	Description	Length	Data Type
1st Prev Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character

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Field	Description	Length	Data Type
2nd PrevYear	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
BDate	The policy begin date.	8	Date (MM/DD/YY)
Begin Date	Eligibility Begin Date for the 3 yr eligibility Status.	7	Date (MM/CCYY)
Beneficiary Name	The beneficiary name from the RSA input file.	63	Character
CNL DT	The insurance cancellation date from the RSA input file.	8	Date (MM/DD/YY)
CO #	The carrier code.	7	Character
Current Year	Eligibility: Identifies months with eligibility status over a three-year period. Eligibility for a particular month is indicated by the presence of 'X' in that month's position in the field. If a particular position contains a blank, the individual was not eligible for Medicaid in that month. The 3-year span is the current year plus the 2 previous years. QMB: Identifies which months over a three-year period the individual on this record was eligible for QMB benefits under the QMB program. Eligibility for a particular month is indicated by the presence of 'X'. All position containing blanks indicate that the individual was not eligible for QMB benefits during those months. The three-year period used is the current year plus 2 previous years.	12	Character
DED AMT	The deduction amount from the RSA input file.	6	Number (Decimal)
DED CD	The deduction code from the RSA input file.	3	Character
EDATE	The policy end date.	8	Date (MM/DD/YY)

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Field	Description	Length	Data Type
End Date	Eligibility End Date for the 3 yr eligibility Status.	7	Date (MM/CCYY)
Eligibility Begin Date	The month that eligibility began.	7	Character
Eligibility End Date	The month that eligibility ended.	7	Character
ENR DT	The insurance enrollment date from the RSA input file.	8	Date (MM/DD/YY)
I R	The insurance rate code from the RSA input file.	1	Character
MBR CD	The member code from the RSA input file.	1	Character
MBR CLS	The member class from the RSA input file.	3	Character
MBR TYE	The member type from the RSA input file.	1	Character
PLN Type	The insurance plan type from the RSA input file.	3	Character
Policy Number	The beneficiary policy number.	30	Character
SSN	The member Social Security Number from the RSA input file.	9	Number (Integer)

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7.97 TPL-A090-R -- TPL Collections By Invoice Category By Fiscal Year Report

7.97.1 TPL-A090-R -- TPL Collections By Invoice Category By Fiscal Year Report Narrative

The TPL Collections by Invoice Category By Fiscal Year report provides all the TPL collections from the account receivable and case records for the current fiscal year, previous fiscal year, and previous fiscal year. The amounts are accumulated by invoice category. This report is produced upon request.

7.97.2 TPL-A090-R -- TPL Collections By Invoice Category By Fiscal Year Report Layout

```
REPORT    TPL-A090-R                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : TPLJD607                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME: HH:MM:SS
LOCATION: TPL1607D                   COLLECTIONS BY INVOICE CATEGORY BY FISCAL YEAR REPORT                     PAGE: 999,999
                                          REPORT PERIOD: MM/DD/CCYY - MM/DD/CCYY

   CURRENT FISCAL YEAR: CCYY

                  INVOICE CATEGORY          AMOUNT COLLECTED
                      999                   $9,999,999.99
                      999                   $9,999,999.99
                      999                   $9,999,999.99

                     CURRENT FISCAL YEAR XXXX TOTAL  $999,999,999.99


   1st PREVIOUS FISCAL YEAR: CCYY

                  INVOICE CATEGORY          AMOUNT COLLECTED
                      999                   $9,999,999.99
                      999                   $9,999,999.99
                      999                   $9,999,999.99

                    1st PREV FISCAL YEAR XXXX TOTAL  $999,999,999.99


   2nd PREVIOUS FISCAL YEAR: CCYY

                  INVOICE CATEGORY          AMOUNT COLLECTED
                      999                   $9,999,999.99
                      999                   $9,999,999.99
                      999                   $9,999,999.99

                    2nd PREV FISCAL YEAR XXXX TOTAL  $999,999,999.99

                                                 ***   END OF REPORT   ***
                                               ***   NO DATA THIS RUN   ***
```


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7.97.3 TPL-A090-R -- TPL Collections By Invoice Category By Fiscal Year Report Field Descriptions

Field	Description	Length	Data Type
Current Fiscal Year Amount Collected	Current Fiscal Year Amount Collected by Invoice Category.	9	Number (Decimal)
Current Fiscal Year Invoice Category	Current Fiscal Year Invoice Category Fund Code.	3	Number
Current Fiscal Year XXXX Total	Current Fiscal Year Total of all Invoice Categories.	12	Number (Decimal)
Current Fiscal Year	Current Fiscal Year.	4	Date (CCYY)
1st Prev Fiscal Amount Collected	Previous Fiscal Amount Collected by Invoice Category.	9	Number (Decimal)
1st Prev Fiscal Invoice Category	Previous Fiscal Invoice Category Fund Code.	3	Number (Integer)
1st Previous Fiscal Year XXXX Total	Previous Fiscal Year Total of all Invoice Categories.	12	Number (Decimal)
1st Previous Fiscal Year	Previous Minus One Year Fiscal Year.	4	Date (CCYY)
2nd Previous Fiscal Year Amount Collected	Previous Minus One Year Amount Collected by Invoice Category.	9	Number (Decimal)
2nd Previous Fiscal Year Invoice Category	Previous Minus One Year Invoice Category Fund Code.	3	Number (Integer)
2nd Previous Fiscal Year XXXX Total	Previous Minus One Year Fiscal Year Total of all Invoice Categories.	12	Number (Decimal)
2nd Prev Fiscal Year	Previous Fiscal Year.	4	Date (CCYY)

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7.98 TPL-A091-M -- TPL Maternity Waiver Claims Adjustment (Hospital Encounter Claims) Report

7.98.1 TPL-A091-M -- TPL Maternity Waiver Claims Adjustment (Hospital Encounter Claims) Report Narrative

The TPL Maternity Waiver Claims Adjustment (Hospital Encounter Claims) report produces a list of maternity waiver claims where the encounter indicator = Y, claim type = I (Inpatient), and the claim has a managed care plan code of P00 - P14. This report is produced monthly.

7.98.2 TPL-A091-M -- TPL Maternity Waiver Claims Adjustment (Hospital Encounter Claims) Report Layout

```
REPORT  : TPL-A091-M                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJM040                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                  RUN TIME: HH:MM:SS
LOCATION: TPLA091M                    TPL MATERNITY WAIVER CLAIMS ADJUSTMENT REPORT                                   PAGE: 999,999
                                                REPORT PERIOD:  MM/DD/CCYY
                                                HOSPITAL ENCOUNTER CLAIMS


MEDICAID                                                                SUBMITTED      TOTAL       CLM    FROM        TO
RECIP ID              RECIPIENT NAME                ICN               CHARGES       RECOUPED     TYP     DOS        DOS        PROVIDER

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX


                                                TOTAL NUMBER OF CLAIMS        999,999,999
                                                TOTAL $ AMOUNT SUBMITTED   999,999,999.99
                                                TOTAL $ AMOUNT RECOUPED    999,999,999.99


                                                      *** END OF REPORT  ***
                                                     *** NO DATA THIS RUN ***
```


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7.98.3 TPL-A091-M -- TPL Maternity Waiver Claims Adjustment (Hospital Encounter Claims) Report Field Descriptions

Field	Description	Length	Data Type
CLM TYP	The type of the claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	A unique number assigned to the claim by the system.	13	Number (Integer)
Provider	A unique identification number assigned to the provider by Medicaid.	9	Character
Medicaid Recip ID	The recipient Medicaid identification number.	12	Number (Integer)
Recipient Name	The recipient's last name, first name and middle initial.	36	Character
Submitted Charges	The amount of money charged by the provider for the service(s).	12	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Recouped	The total of the money recovered for the claims listed on the report.	14	Number (Decimal)
Total $ Amount Submitted	The total of the submitted charges for the claims listed on the report.	14	Number (Decimal)
Total Number Of Claims	The total of the claims listed on the report.	11	Number (Integer)
Total Recouped	The amount of money recovered from the provider.	12	Number (Decimal)

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7.99 TPL-A092-M -- TPL Maternity Waiver Claims Adjustment (Maternity Care Claims) Report

7.99.1 TPL-A092-M -- TPL Maternity Waiver Claims Adjustment (Maternity Care Claims) Report Narrative

The TPL Maternity Waiver Claims Adjustment report produces a list of maternity waiver claims where the provider type is equal to 61. This report is produced monthly.

7.99.2 TPL-A092-M -- TPL Maternity Waiver Claims Adjustment (Maternity Care Claims) Report Layout

```
REPORT  :  TPL-A092-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS :  TPLJA092                       MEDICAID MANAGEMENT INFORMATION SYSTEM                           RUN TIME: HH:MM:SS
LOCATION:  TPLA092M                   TPL MATERNITY WAIVER CLAIMS ADJUSTMENT REPORT                             PAGE: 999,999
                                               REPORT PERIOD:  MM/DD/CCYY
                                                 MATERNITY CARE CLAIMS


MEDICAID                                                          SUBMITTED      TOTAL       CLM    FROM        TO
RECIP ID             RECIPIENT NAME                ICN            CHARGES       RECOUPED     TYP     DOS        DOS        PROVIDER

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXX


                                                 TOTAL NUMBER OF CLAIMS        999,999,999
                                                 TOTAL $ AMOUNT SUBMITTED   999,999,999.99
                                                 TOTAL $ AMOUNT RECOUPED    999,999,999.99


                                                        *** END OF REPORT  ***
                                                       *** NO DATA THIS RUN ***
```


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7.99.3 TPL-A092-M -- TPL Maternity Waiver Claims Adjustment (Maternity Care Claims) Report Field Descriptions

Field	Description	Length	Data Type
CLM TYP	The type of the claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	A unique number assigned to the claim by the system.	13	Number (Integer)
Provider	A unique identification number assigned to the provider by Medicaid.	9	Character
Medicaid Recip ID	The recipient Medicaid identification number.	12	Number (Integer)
Recipient Name	The recipient's last name, first name and middle initial.	36	Character
Submitted Charges	The amount of money charged by the provider for the service(s).	12	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Recouped	The total of the money recovered for the claims listed on the report.	14	Number (Decimal)
Total $ Amount Submitted	The total of the submitted charges for the claims listed on the report.	14	Number (Decimal)
Total Number of Claims	The total of the claims listed on the report.	11	Number (Integer)
Total Recouped	The amount of money recovered from the provider.	12	Number (Decimal)

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7.100 TPL-A093-M -- TPL Circumcision Claims Adjustment Report

7.100.1 TPL-A093-M -- TPL Circumcision Claims Adjustment Report Narrative

The TPL Circumcision Claims Adjustment report produces a list of circumcision claims where the procedure code is 54150 or 54160. This report is produced monthly.

7.100.2 TPL-A093-M -- TPL Circumcision Claims Adjustment Report Layout

```
REPORT  : TPL-A093-M                          ALABAMA MEDICAID AGENCY                                          RUN DATE: MM/DD/CCYY
PROCESS : TPLJM040                      MEDICAID MANAGEMENT INFORMATION SYSTEM                                   RUN TIME: HH:MM:SS
LOCATION: TPLA093M                    TPL CIRCUMCISION CLAIMS ADJUSTMENT REPORT                                      PAGE: 999,999
                                            REPORT PERIOD:  MM/DD/CCYY


MEDICAID                                                          SUBMITTED      TOTAL         CLM    FROM        TO
RECIP ID             RECIPIENT NAME                ICN           CHARGES       RECOUPED       TYP     DOS        DOS        PROVIDER

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

999999999999   XXXXXXXXXXXXXXXXX, XXXXXXXXXXXX X  9999999999999  99,999,999.99  99,999,999.99   X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX


                                                 TOTAL NUMBER OF CLAIMS        999,999,999
                                                 TOTAL $ AMOUNT SUBMITTED   999,999,999.99
                                                 TOTAL $ AMOUNT RECOUPED    999,999,999.99


                                                       *** END OF REPORT  ***
                                                      *** NO DATA THIS RUN ***
```


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7.100.3 TPL-A093-M -- TPL Circumcision Claims Adjustment Report Field Descriptions

Field	Description	Length	Data Type
CLM TYP	The type of the claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	A unique number assigned to the claim by the system.	13	Number (Integer)
Medicaid Recip ID	The recipient Medicaid identification number.	12	Number (Integer)
Provider	A unique identification number assigned to the provider by Medicaid.	10	Character
Recipient Name	The recipient's last name, first name and middle initial.	36	Character
Submitted Charges	The amount of money charged by the provider for the service(s).	12	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Recouped	The total of the money recovered for the claims listed on the report.	14	Number (Decimal)
Total $ Amount Submitted	The total of the submitted charges for the claims listed on the report.	14	Number (Decimal)
Total Number of Claims	The total of the claims listed on the report.	11	Number (Integer)
Total Recouped	The amount of money recovered from the provider.	12	Number (Decimal)

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7.101 TPL-A094-M -- TPL (E) Diagnosis Claims Adjustment Report

7.101.1 TPL-A094-M -- TPL (E) Diagnosis Claims Adjustment Report Narrative

The TPL(E) Diagnosis Claims Adjustment report produces a list of claims that were recouped/adjusted during the month where the first character in the diagnosis code is ‘E’. This report is produced monthly.

7.101.2 TPL-A094-M -- TPL (E) Diagnosis Claims Adjustment Report Layout

```
REPORT  : TPL-A094-M                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : TPLJM040                      MEDICAID MANAGEMENT INFORMATION SYSTEM                            RUN TIME: HH:MM:SS
LOCATION: TPLA094M                        E-DIAGNOSIS CLAIMS ADJUSTMENT REPORT                                 PAGE: 999,999
                                              REPORT PERIOD: MM/DD/CCYY


MEDICAID                                                                  SUBMITTED     TOTAL       CLM    FROM        TO
RECIP ID      RECIPIENT NAME                                ICN           CHARGES     RECOUPED     TYP     DOS        DOS        PROVIDER

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  9999999999999  999,999.99  9,999,999.99  X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  9999999999999  999,999.99  9,999,999.99  X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  9999999999999  999,999.99  9,999,999.99  X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  9999999999999  999,999.99  9,999,999.99  X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX

XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  9999999999999  999,999.99  9,999,999.99  X   MM/DD/CCYY  MM/DD/CCYY   XXXXXXXXXX


                                         TOTAL NUMBER OF CLAIMS        999,999,999
                                         TOTAL $ AMOUNT SUBMITTED   999,999,999.99
                                         TOTAL $ AMOUNT RECOUPED    999,999,999.99


                                               *** END OF REPORT ***
                                             *** NO DATA THIS RUN ***
```


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7.101.3 TPL-A094-M -- TPL (E) Diagnosis Claims Adjustment Report Field Descriptions

Field	Description	Length	Data Type
CLM TYP	The type of the claim.	1	Character
From DOS	The first date of service on the claim.	10	Date (MM/DD/CCYY)
ICN	A unique number assigned to the claim by the system.	13	Number (Integer)
Medicaid Recip ID	The recipient Medicaid identification number.	12	Number (Integer)
Provider	A unique identification number assigned to the provider by Medicaid.	10	Character
Recipient Name	The recipient's last name, first name and middle initial.	36	Character
Submitted Charges	The amount of money charged by the provider for the service(s).	12	Number (Decimal)
To DOS	The last date of service on the claim.	10	Date (MM/DD/CCYY)
Total $ Amount Recouped	The total of the money recovered for the claims listed on the report.	14	Number (Decimal)
Total $ Amount Submitted	The total of the submitted charges for the claims listed on the report.	14	Number (Decimal)
Total Number of Claims	The total of the claims listed on the report.	11	Number (Integer)
Total Recouped	The amount of money recouped from the provider.	12	Number (Decimal)

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7.102 TPL-A098-R -- Third Party Contractor Active Records Add Production Report

7.102.1 TPL-A098-R -- Third Party Contractor Active Records Add Production Report Narrative

The Third Party Contractor Active Records Add Production report provides a listing of the policies that were active and added as a result of the match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals. This report is produced bi-monthly.

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7.102.2 TPL-A098-R -- Third Party Contractor Active Records Add Production Report Layout

```
REPORT  : TPL-A098-R                          ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : TPLJM019                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
LOCATION: TPL03190              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT                  PAGE:    999,999
                                              REPORT PERIOD - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                 AID  RECIP   RECIP
RID           LAST               FIRST        CAT  STATUS  AGE
999999999999  XXXXXXXXX          XXXXXXXX     XX     X     999

                       NEW  SEGMENTS - ADDED
POLICY                                                              POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                  START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                    DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXX        XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXX   X
*******************************************************************************************************************************
                       EXISTING  SEGMENTS
POLICY                                                              POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                  START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                    DATE        DATE        CODE IOSPWAX123HDE4M  CODE
 NONE TO REPORT

              AMOUNT BILLED = 9,999,999.99
                 AMOUNT DUE = 9,999,999.99

                 SUMMARY INFORMATION
          GRAND TOTAL ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99

COVERAGE TYPE                       RATE                 NUMBER                     AMT DUE
Major Medical                  $9,999,999.99         9,999,999,999            $9,999,999,999.99
Pharmacy                       $9,999,999.99         9,999,999,999            $9,999,999,999.99
Dental                         $9,999,999.99         9,999,999,999            $9,999,999,999.99
Medicare Supplement            $9,999,999.99         9,999,999,999            $9,999,999,999.99
Hospital Indemnity             $9,999,999.99         9,999,999,999            $9,999,999,999.99
Long Term Care                 $9,999,999.99         9,999,999,999            $9,999,999,999.99
Totals:                                              9,999,999,999            $9,999,999,999.99

                                                   *** END OF REPORT ***
```


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7.102.3 TPL-A098-R -- Third Party Contractor Active Records Add Production Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Amount Billed	This is the dollar amount HMS receives for identifying a new policy for a recipient.	12	Number (Decimal)
Amount Due	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the Amount Billed for only those policies added.	12	Number (Decimal)
Amt Due (Coverage Type)	This is the amount due per each coverage type for each active record updated.	17	Number (Decimal)
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character

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Field	Description	Length	Data Type
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character
Grand Total Added	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	9	Number (Integer)
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	12	Number (Decimal)
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the Amount Billed for only those policies added.	12	Number (Decimal)
Number (Coverage Type)	The total number of active records updated for each coverage type.	13	Number (Integer)

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Field	Description	Length	Data Type
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Rate (Coverage Type)	The payment rate per each coverage type for each Inactive record updated.	13	Number (Decimal)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	1	Character
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)

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7.103 TPL-A098-T -- Third Party Contractor Active Records Add Pre-Prod Report

7.103.1 TPL-A098-T -- Third Party Contractor Active Records Add Pre-Prod Report Narrative

This pre-production report provides the Agency with a listing of the policies that were active and added as a result of the match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.103.2 TPL-A098-T -- Third Party Contractor Active Records Add Pre-ProdReport Layout

```
REPORT  : TPL-A098-T                              ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : TPLJM019T                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
LOCATION: TPL0319O                      THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRE-PROD REPORT               PAGE:    999,999
                                                   REPORT PERIOD - MM/CCYY
-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                 AID  RECIP   RECIP
RID          LAST               FIRST        CAT  STATUS  AGE
999999999999 XXXXXXXXX          XXXXXXXX     XX     X     999

                       NEW  SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXX        XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   X
*************************************************************************************************************************************
                       EXISTING  SEGMENTS
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
 NONE TO REPORT
*************************************************************************************************************************************

             AMOUNT BILLED = $9,999,999.99
                AMOUNT DUE = $9,999,999.99

                SUMMARY INFORMATION
          GRAND TOTAL ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99

                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.103.3 TPL-A098-T -- Third Party Contractor Active Records Add Pre-Prod Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category	Character	2
AMOUNT BILLED	This is the dollar amount PCG receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due PCG for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the PCG input file	Character	7
CARRIER NAME	The name of the carrier	Character	45
CONTRACT NUMBER	The policy number assigned by the carrier from the PCG input file	Character	30
COVERAGE IND	The descriptions of the coverage indicators from the PCG input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the PCG input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the PCG datamatch.	Number (Integer)	9
GRAND TOTAL AMOUNT BILLED	This is the total dollar amount PCG receives for identifying new policies for all recipients in the PCG datamatch.	Number (Decimal)	12
GRAND TOTAL AMOUNT DUE	This is the total amount due PCG for all records that were added to the database for all recipients in the PCG datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by PCG for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by PCG is listed on a schedule mutually determined by PCG and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the PCG input file, which is used to update the policy type when adding a record	Character	2
POLICY ADD DATE	The date the policy was added	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the PCG input file	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the PCG input file	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category	Character	1
RECIPIENT NAME	The recipient's first, middle, and last name	Character	36
RID	The recipient's Medicaid ID from the PCG input file	Character	12

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7.104 TPL-A098-W -- Third Party Contractor Hipp Records Add PreProd-Production Report

7.104.1 TPL-A098-W -- Third Party Contractor Hipp Records Add PreProd-Production Report Narrative

This report is generated by the HMS HIPP Data match pre-production and production processes and contains the information Added/Updated during processing.

7.104.2 TPL-A098-W --Third Party Contractor Hipp Records Add PreProd-Production Report Layout

```
Report  : TPL-A098-W                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJW324P                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0324W              THIRD PARTY CONTRACTOR HIPP RECORDS ADD PRE-PROD/PRODUCTION REPORT              Page:    999,999
                                        REPORT PERIOD:  MM/DD/CCYY-MM/DD/CCYY


-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                        AID   RECIP   RECIP
RID          LAST                  FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XX    XX      999
                       NEW SEGMENTS - ADDED
POLICY                                                          POLICY      POLICY          COVERAGE
ADD          CARRIER      CARRIER   CONTRACT                    START       END         PLAN INDICATORS        PAY    HIPP    HIPP
DATE         CODE         NAME      NUMBER                      DATE        DATE        CODE IOSPWAX123HDE4M   CODE   CASE #  IND
MM/DD/CCYY   XXXXXXXXXX   XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   X   XXXXXXXXXXXXXXX   XX   XXXXXXXX  X
             ERROR FOUND: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 NONE TO REPORT
*************************************************************************************************************************************
                        SEGMENTS FOR HIPP UPDATE

UPDATE       CARRIER      CARRIER   CONTRACT                                                                    HIPP     HIPP
DATE         CODE         NAME      NUMBER                                                                      CASE #   IND
MM/DD/CCYY   XXXXXXXXXX   XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                             XXXXXXXX   X
 NONE TO REPORT
*************************************************************************************************************************************
```


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```
                        EXISTING SEGMENTS
POLICY                                                          POLICY      POLICY            COVERAGE
ADD          CARRIER      CARRIER   CONTRACT                    START       END          PLAN INDICATORS            HIPP     HIPP
DATE         CODE         NAME      NUMBER                      DATE        DATE         CODE IOSPWAX123HDE4M       CASE #   IND
MM/DD/CCYY   XXXXXXXXXX   XXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   X   XXXXXXXXXXXXXXX   XX   XXXXXXXX  X
 NONE TO REPORT


   RECIPIENT TOTAL ADDED = 99,999,999,999
 RECIPIENT TOTAL UPDATED = 99,999,999,999
 AMOUNT DUE FOR NEW ADDS = $99,999,999,999.99

         SUMMARY INFORMATION
       GRAND TOTAL ADDED = 99,999,999,999
     GRAND TOTAL UPDATED = 99,999,999,999
 GT AMT DUE FOR NEW ADDS = $99,999,999,999.99


                                                  *NO DATA THIS RUN*
                                                   *END OF REPORT*
```

7.104.3 TPL-A098-W -- Third Party Contractor Inactive Add Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Amount Due For New Adds	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the Amount Billed for only those policies added.	13	Number (Decimal)
Carrier Code	The carrier code from the HMS input file.	10	Character
Carrier Name	The first five letters of the name of the carrier.	5	Character

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Field	Description	Length	Data Type
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character
Error Found	Error message displayed for the error encountered with the policy.	45	Character
Grand Total Added	This is the accumulated number of policies that were added for all the recipients as a result of the HMS HIPP data match.	11	Number (Integer)
Grand Total Updated	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS HIPP data match.	11	Number (Integer)
Gt Amt Due For New Adds	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS HIPP data match. This is calculated by adding the Amount Billed for only those policies added.	13	Number (Decimal)

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Field	Description	Length	Data Type
Hipp Case #	HMS HIPP case unique identifier.	8	Character
Hipp Ind	HMS HIPP indicator to identify if the recipient is active in HIPP or not (1 = Recipient is active in HIPP, 0 = Recipient is not active in HIPP).	1	Character
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	1	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	2	Character
Recipient Name (First)	The recipient's first name.	15	Character
Recipient Name (Last)	The recipient's last name.	20	Character
Recipient Total Added	This is the number of policies that were added as a result of the HMS HIPP data match for the specific recipient.	11	Number (Integer)
Recipient Total Updated	This is the number of policies that were updated as a result of the HMS HIPP data match for the specific recipient.	11	Number (Integer)
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)
Update Date	The date the policy was updated.	10	Date (MM/DD/CCYY)

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7.105 TPL-A099-R -- Third Party Contractor Inactive Records Add Production Report

7.105.1 TPL-A099-R -- Third Party Contractor Inactive Records Add Production Report Narrative

The Third Party Contractor Inactive Records Add Production report provides a listing of the policies that were inactive and added as a result of the match with the Third Party Contractor. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals. This report is produced bi-monthly.

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7.105.2 Third Party Contractor Inactive Records Add Production Report Layout

```
Report  : TPL-A099-R                                ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM019                            MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL03190                THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRODUCTION REPORT             Page:    999,999
                                                   REPORT PERIOD - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                  AID  RECIP   RECIP
RID           LAST               FIRST         CAT  STATUS  AGE
999999999999  XXXXXXXXX          XXXXXXXX      XX     X     999

                       NEW  SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END          PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE         CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXX        XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY    XX  XXXXXXXXXXXXXX    X
*************************************************************************************************************************************
                       EXISTING  SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END          PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE         CODE IOSPWAX123HDE4M  CODE
 NONE TO REPORT


              AMOUNT BILLED = 9,999,999.99
                 AMOUNT DUE = 9,999,999.99

                 SUMMARY INFORMATION
          GRAND TOTAL ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99

COVERAGE TYPE                        RATE                 NUMBER                    AMT DUE
Major Medical                   $9,999,999.99         9,999,999,999            $9,999,999,999.99
Pharmacy                        $9,999,999.99         9,999,999,999            $9,999,999,999.99
Dental                          $9,999,999.99         9,999,999,999            $9,999,999,999.99
Medicare Supplement             $9,999,999.99         9,999,999,999            $9,999,999,999.99
Hospital Indemnity              $9,999,999.99         9,999,999,999            $9,999,999,999.99
Long Term Care                  $9,999,999.99         9,999,999,999            $9,999,999,999.99
Totals:                                               9,999,999,999            $9,999,999,999.99


                                                    *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.105.3 Third Party Contractor Inactive Records Add Production Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Amount Billed	This is the dollar amount HMS receives for identifying a new policy.	12	Number (Decimal)
Amount Due	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the Amount Billed for only those policies added.	12	Number (Decimal)
Amt Due (Coverage Type)	This is the amount due per each coverage type for each inactive record updated.	17	Number (Decimal)
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character

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Field	Description	Length	Data Type
Coverage Indicators	The descriptions of the coverage indicators from the HMS input file are as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D =Dental Coverage E =Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character
Grand Total Added	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	9	Number (Integer)
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	12	Number (Decimal)
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the Amount Billed for only those policies added.	12	Number (Decimal)
Number (Coverage Type)	The total number of Inactive records updated for each coverage type.	13	Number (Integer)

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Field	Description	Length	Data Type
Pay Code	The pay code associated with the add. This is system generated.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Rate (Coverage Type)	The payment rate per each coverage type for each Inactive record updated.	13	Number (Decimal)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	1	Character
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number.	12	Character

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7.106 TPL-A099-T Third Party Contractor Inactive Records Add Pre-Prod Report

7.106.1 TPL-A099-T Third Party Contractor Inactive Records Add Pre-Prod Report Narrative

Pre-production Report - Users access the Third Party Contractor Inactive Records Add Pre-Prod Report to provide a listing of the policies that were inactive and added as a result of the match with the Third Party Contractor. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals.

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7.106.2 TPL-A099-T Third Party Contractor Inactive Records Add Pre-Prod Report Layout

```
Report  : TPL-A099-T                                ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJM019T                           MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL03190                  THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRE-PROD REPORT                  Page:    999,999
                                                   REPORT PERIOD - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                 AID  RECIP   RECIP
RID          LAST               FIRST        CAT  STATUS  AGE
999999999999 XXXXXXXXX          XXXXXXXX     XX     X     999
                       NEW  SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXX        XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   X
*************************************************************************************************************************************
                       EXISTING  SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
 NONE TO REPORT


             AMOUNT BILLED = 9,999,999.99
                AMOUNT DUE = 9,999,999.99

                SUMMARY INFORMATION
          GRAND TOTAL ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99


                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```

7.106.3 TPL-A099-T Third Party Contractor Inactive Records Add Pre-Prod Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category	Character	2
AMOUNT BILLED	This is the dollar amount PCG receives for identifying a new policy	Number (Decimal)	12
AMOUNT DUE	This is the amount due PCG for all records that were added to the database for a recipient. This is calculated by	Number (Decimal)	12

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Field	Description	Data Type	Length
	adding the AMOUNT BILLED for only those policies added.		
CARRIER CODE	The carrier code from the PCG input file	Character	7
CARRIER NAME	The name of the carrier	Character	45
CONTRACT NUMBER	The policy number assigned by the carrier from the PCG input file	Character	30
COVERAGE IND	The descriptions of the coverage indicators from the PCG input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the PCG input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the PCG datamatch.	Number (Integer)	13

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Field	Description	Data Type	Length
GRAND TOTAL AMOUNT BILLED	This is the total dollar amount PCG receives for identifying new policies for all recipients in the PCG datamatch.	Number (Decimal)	17
GRAND TOTAL AMOUNT DUE	This is the total amount due PCG for all records that were added to the database for all recipients in the PCG datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	17
PAY CODE	The pay code associated with the add. This is system generated.	Character	2
PLAN CODE	The plan code from the PCG input file, which is used to update the policy type when adding a record	Character	2
POLICY ADD DATE	The date the policy was added	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the PCG input file	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the PCG input file	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category	Character	1
RECIPIENT NAME	The recipient's first, middle, and last name	Character	36
RID	The recipient's Medicaid ID from the PCG input file	Character	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12

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Field	Description	Data Type	Length
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED CODE	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20

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Field	Description	Data Type	Length
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.107 TPL-A100-R -- Third Party Contractor Active Records Add Production Report - Update Records Report - (Non Payable/Payable)

7.107.1 TPL-A100-R -- Third Party Contractor Active Records Add Production Report - Update Records - (Non Payable/Payable) Narrative

The Third Party Contractor Active Add – Update Records report provides the Agency with a listing of the policies that were active and updated as a result of the data match with the Third Party Contractor. The title of the report will identify the update records as either being Non Payable or Payable. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.107.2 TPL-A100-R -- Third Party Contractor Active Records Add Production Report - Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A100-R                              ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : TPLJM029                          MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: TPL0319O                THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT                        Page:    999,999
                                            HMS UPDATE RECORDS - (NON PAYABLE/PAYABLE)
                                                    REPORT PERIOD:  MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                                  POLICY      POLICY           COVERAGE
UPDATE       CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS       PAY
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*****************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*****************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99


            SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99
COVERAGE TYPE                        RATE                 NUMBER                     AMT DUE
Major Medical                   $99,999,999.99          99,999,999,99            $99,999,999,999.99
Pharmacy                        $99,999,999.99          99,999,999,99            $99,999,999,999.99
Dental                          $99,999,999.99          99,999,999,99            $99,999,999,999.99
Medicare Supplement             $99,999,999.99          99,999,999,99            $99,999,999,999.99
```


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```
Hospital Indemnity          $99,999,999.99        99,999,999,99          $99,999,999,999.99
Long Term Care              $99,999,999.99        99,999,999,99          $99,999,999,999.99
Totals:                                           99,999,999,99          $99,999,999,999.99


                                                *** END OF REPORT ***
                                              *** NO DATA THIS RUN ***
```

7.107.3 TPL-A100-R -- Third Party Contractor Active Records Add Production Report - Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Active record updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage	Character	15

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Field	Description	Data Type	Length
	D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all the recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only the policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number of Active records updated for each coverage type.	Number (Integer)	12
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Active record updated.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated in the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.108 TPL-A100-T -- Third Party Contractor Active Records Add Pre-Prod Report - Update Records - (Non Payable/Payable)

7.108.1 TPL-A100-T -- Third Party Contractor Active Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Narrative

This pre-production report provides the Agency with a listing of the policies that were active and updated as a result of the HMS Update data match with the Third Party Contractor. The title of the report will identify the update records as either being Non Payable or Payable. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.108.2 TPL-A100-T -- Third Party Contractor Active Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A100-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRE-PROD REPORT                     Page:    999,999
                                        HMS UPDATE RECORDS - (NON
PAYABLE/PAYABLE)                                                                                              REPORT
PERIOD:  MM/CCYY
-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                                  POLICY      POLICY           COVERAGE
UPDATE       CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99


            SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99


                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```


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7.108.3 TPL-A100-T -- Third Party Contractor Active Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not updated.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1

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Field	Description	Data Type	Length
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.109 TPL-A101-R -- Third Party Contractor Inactive Records Add Production Report - Update Records - (Non Payable/Payable)

7.109.1 TPL-A101-R -- Third Party Contractor Inactive Records Add Production Report - Update Records - (Non Payable/Payable) Narrative

The Third Party Contractor Inactive Update Pre-production Report - Users access the Third Party Contractor Inactive Update Report to provide a listing of the policies that were inactive and updated as a result of the data match with the Third Party Contractor. The title of the report will identify the update records as either being Non Payable or Payable. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals.

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7.109.2 TPL-A101-R -- Third Party Contractor Inactive Records Add Production Report - Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A101-R                              ALABAMA MEDICAID AGENCY                                        Run Date: MM/DD/CCYY
Process : TPLJM029                          MEDICAID MANAGEMENT INFORMATION SYSTEM                               Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRODUCTION REPORT                        Page:    999,999
                                            HMS UPDATE RECORDS - (NON-
PAYABLE/PAYABLE)                                                                                                   REPORT
PERIOD:  MM/CCYY


-------------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                   FIRST             CAT   STATUS  AGE
999999999999  XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                                  POLICY      POLICY           COVERAGE
UPDATE       CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*************************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*************************************************************************************************************************************
                        EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99

           SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99

COVERAGE TYPE                        RATE                 NUMBER                    AMT DUE
Major Medical                   $99,999,999.99         99,999,999,99           $99,999,999,999.99
Pharmacy                        $99,999,999.99         99,999,999,99           $99,999,999,999.99
```


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```
Dental                          $99,999,999.99          99,999,999,99            $99,999,999,999.99
Medicare Supplement             $99,999,999.99          99,999,999,99            $99,999,999,999.99
Hospital Indemnity              $99,999,999.99          99,999,999,99            $99,999,999,999.99
Long Term Care                  $99,999,999.99          99,999,999,99            $99,999,999,999.99
Totals:                                                 99,999,999,99            $99,999,999,999.99


                                                     *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```

7.109.3 TPL-A101-R -- Third Party Contractor Inactive Records Add Production Report - Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Inactive record updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage	Character	15

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Field	Description	Data Type	Length
	X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all the recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only the policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2

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Field	Description	Data Type	Length
NUMBER (Coverage Type)	The total number of Inactive records updated for each coverage type.	Number (Integer)	12
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Inactive record updated.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated in the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.110 TPL-A101-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Update Records - (Non Payable/Payable)

7.110.1 TPL-A101-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Narrative

Pre-production Report - Users access the Third Party Contractor Inactive Update Report to provide a listing of the policies that were inactive and added as a result of the update datamatch with the Third Party Contractor. The title of the report will identify the update records as either being Non Payable or Payable. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals.

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7.110.2 TPL-A101-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A101-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRE-PROD REPORT                  Page:    999,999
                                        HMS UPDATE RECORDS - (NON-
PAYABLE/PAYABLE)                                                                                              REPORT
PERIOD:  MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXX XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                          POLICY      POLICY           COVERAGE
UPDATE       CARRIER       CARRIER       CONTRACT               START       END         PLAN INDICATORS       PAY
DATE         CODE          NAME          NUMBER                 DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER       CARRIER       CONTRACT               START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE          NAME          NUMBER                 DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                        EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER       CARRIER       CONTRACT               START       END         PLAN INDICATORS
DATE         CODE          NAME          NUMBER                 DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99

            SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.110.3 TPL-A101-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not updated.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1

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Field	Description	Data Type	Length
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.111 TPL-A102-R -- Third Party Contractor Active Records Add Production Report – HMS Quarterly Records Report

7.111.1 TPL-A102-R -- Third Party Contractor Active Records Add Production Report - HMS Quarterly Records Report Narrative

The Third Party Contractor Active Add – HMS Quarterly Records report provides a listing of the policies that were active and added as a result of the Quarterly Data Match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

7.111.2 TPL-A102-R -- Third Party Contractor Active Records TPL-A102-R -- Third Party Contractor Active Records Add Production Report - HMS Quarterly Records Layout

Report : TPL-A102-R	ALABAMA MEDICAID AGENCY	Run Date: MM/DD/CCYY
Process : TPLJQ419	MEDICAID MANAGEMENT INFORMATION SYSTEM	Run Time: HH:MM:SS
Location: TPL0319O	THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT	Page: 999,999

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HMS QUARTERLY RECORDS

REPORT PERIOD: MM/CCYY

RECIPIENT NAME AID RECIP RECIP

RID LAST FIRST CAT STATUS AGE

999999999999 XXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXX XX XXXXXX XXX

NEW SEGMENTS - ADDED

POLICY POLICY POLICY COVERAGE

ADD CARRIER CARRIER CONTRACT START END PLAN INDICATORS PAY

DATE CODE NAME NUMBER DATE DATE CODE IOSPWAX123HDE4M CODE

MM/DD/CCYY XXXXXXXXXX XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY XX XXXXXXXXXXXXXXX XX

NONE TO REPORT

****

NEW SEGMENTS - NOT ADDED

POLICY POLICY POLICY COVERAGE

ADD CARRIER CARRIER CONTRACT START END PLAN INDICATORS PAY NOT

DATE CODE NAME NUMBER DATE DATE CODE IOSPWAX123HDE4M CODE ADDED

MM/DD/CCYY XXXXXXXXXX XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY XX XXXXXXXXXXXXXXX XX XX

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NONE TO REPORT

****

EXISTING SEGMENTS

POLICY POLICY POLICY COVERAGE

ADD CARRIER CARRIER CONTRACT START END PLAN INDICATORS

DATE CODE NAME NUMBER DATE DATE CODE IOSPWAX123HDE4M

MM/DD/CCYY XXXXXXXXXX XXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY MM/DD/CCYY XX XXXXXXXXXXXXXXX

NONE TO REPORT

RECIPIENT TOTAL ADDED = 99,999,999,999

RECIPIENT TOTAL NOT ADDED = 99,999,999,999

AMOUNT BILLED = $99,999,999,999.99

AMOUNT DUE = $99,999,999,999.99

SUMMARY INFORMATION

GRAND TOTAL ADDED = 99,999,999,999

GRAND TOTAL NOT ADDED = 99,999,999,999

GRAND TOTAL AMT BILLED = $99,999,999,999.99

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GRAND TOTAL AMT DUE = $99,999,999,999.99

COVERAGE TYPE	RATE	NUMBER	AMT DUE
Major Medical	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Pharmacy	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Dental	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Medicare Supplement	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Hospital Indemnity	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Long Term Care	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Invalid Aid Cat/Cov Type	$99,999,999.99	99,999,999,999	$99,999,999,999.99
Totals:		99,999,999,999	$99,999,999,999.99

*** END OF REPORT ***

*** NO DATA THIS RUN ***

7.111.3 TPL-A102-R -- Third Party Contractor Active Records Add Production Report - HMS Quarterly Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2

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Field	Description	Data Type	Length
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Inactive record added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED	Character	15

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Field	Description	Data Type	Length
	VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS data match.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
NUMBER (Coverage Type)	The total number or Inactive records added for each coverage type.	Number (Integer)	9
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
RATE (Coverage Type)	The payment rate per each coverage type for each Inactive record added.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS data match.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.112 TPL-A102-T -- Third Party Contractor Active Records Add Pre-Prod Report – HMS Quarterly Records Report

7.112.1 TPL-A102-T -- Third Party Contractor Active Records Add Pre-Prod Report - HMS Quarterly Records Report Narrative

This pre-production report provides the Agency with a listing of the policies that were active and added as a result of the Quarterly data match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

7.112.2 TPL-A102-T -- Third Party Contractor Active Records TPL-A102-T -- Third Party Contractor Active Records Add Pre-Prod Report - HMS Quarterly Records Layout

```
Report  : TPL-A102-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ419T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O               THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRE-PROD REPORT                  Page:    999,999
                                              HMS QUARTERLY RECORDS
                                             REPORT PERIOD:  MM/CCYY


-------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                    FIRST            CAT   STATUS  AGE
999999999999  XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


      RECIPIENT TOTAL ADDED = 99,999,999,999
```


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```
RECIPIENT TOTAL NOT ADDED = 99,999,999,999
            AMOUNT BILLED = $99,999,999,999.99
               AMOUNT DUE = $99,999,999,999.99


          SUMMARY INFORMATION
        GRAND TOTAL ADDED = 99,999,999,999
    GRAND TOTAL NOT ADDED = 99,999,999,999
   GRAND TOTAL AMT BILLED = $99,999,999,999.99
      GRAND TOTAL AMT DUE = $99,999,999,999.99


                                   *** END OF REPORT ***
                                 *** NO DATA THIS RUN ***
```

7.112.3 TPL-A102-T -- Third Party Contractor Active Records Add Pre-Prod Report - HMS Quarterly Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage	Character	15

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Field	Description	Data Type	Length
	3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS data match.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS data match.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.113 TPL-A103-R -- Third Party Contractor Inactive Records Add Production Report – HMS Quarterly Records Report

7.113.1 TPL-A103-R -- Third Party Contractor Inactive Records Add Production Report - HMS Quarterly Records Report Narrative

The Third Party Contractor Inactive Add report provides a listing of the policies that were inactive and added as a result of the Quarterly data match with the Third Party Contractor. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals.

7.113.2 TPL-A103-R -- Third Party Contractor Inactive Records Add Production Report - HMS Quarterly Records Layout

```
Report  : TPL-A103-R                          ALABAMA MEDICAID AGENCY                                          Run Date: MM/DD/CCYY
Process : TPLJQ419                       MEDICAID MANAGEMENT INFORMATION SYSTEM                                Run Time:   HH:MM:SS
Location: TPL0319O            THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRODUCTION REPORT                        Page:    999,999
                                              HMS QUARTERLY RECORDS
                                             REPORT PERIOD:  MM/CCYY


-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                   FIRST             CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*************************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*************************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT
```


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```
      RECIPIENT TOTAL ADDED = 99,999,999,999
  RECIPIENT TOTAL NOT ADDED = 99,999,999,999
              AMOUNT BILLED = $99,999,999,999.99
                 AMOUNT DUE = $99,999,999,999.99


            SUMMARY INFORMATION
          GRAND TOTAL ADDED = 99,999,999,999
      GRAND TOTAL NOT ADDED = 99,999,999,999
     GRAND TOTAL AMT BILLED = $99,999,999,999.99
        GRAND TOTAL AMT DUE = $99,999,999,999.99



COVERAGE TYPE                        RATE                 NUMBER                    AMT DUE
Major Medical                  $99,999,999.99         99,999,999,999            $99,999,999,999.99
Pharmacy                       $99,999,999.99         99,999,999,999            $99,999,999,999.99
Dental                         $99,999,999.99         99,999,999,999            $99,999,999,999.99
Medicare Supplement            $99,999,999.99         99,999,999,999            $99,999,999,999.99
Hospital Indemnity             $99,999,999.99         99,999,999,999            $99,999,999,999.99
Long Term Care                 $99,999,999.99         99,999,999,999            $99,999,999,999.99
Invalid Aid Cat/Cov Type       $99,999,999.99         99,999,999,999            $99,999,999,999.99
Totals:                                               99,999,999,999            $99,999,999,999.99


                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```

7.113.3 TPL-A103-R -- Third Party Contractor Inactive Records Add Production Report - HMS Quarterly Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12

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Field	Description	Data Type	Length
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Inactive record added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS data match.	Number (Integer)	9

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Field	Description	Data Type	Length
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
NUMBER (Coverage Type)	The total number or Inactive records added for each coverage type.	Number (Integer)	9
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Inactive record added.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3

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Field	Description	Data Type	Length
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS data match.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.114 TPL-A103-T -- Third Party Contractor Inactive Records Add Pre-Prod Report – HMS Quarterly Records Report

7.114.1 TPL-A103-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HMS Quarterly Records Report Narrative

This pre-production report provides the Agency with a listing of the policies that were inactive and added as a result of the Quarterly data match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.114.2 TPL-A103-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HMS Quarterly Records Layout

```
Report  : TPL-A103-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ419T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O             THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRE-PROD REPORT                   Page:    999,999
                                                HMS QUARTERLY RECORDS
                                               REPORT PERIOD:  MM/CCYY
-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                   FIRST             CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END          PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE         CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY    XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END          PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE         CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY    XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END          PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE         CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY    XX  XXXXXXXXXXXXXXX
NONE TO REPORT


      RECIPIENT TOTAL ADDED = 99,999,999,999
  RECIPIENT TOTAL NOT ADDED = 99,999,999,999
              AMOUNT BILLED = $99,999,999,999.99
                 AMOUNT DUE = $99,999,999,999.99


            SUMMARY INFORMATION
          GRAND TOTAL ADDED = 99,999,999,999
      GRAND TOTAL NOT ADDED = 99,999,999,999
     GRAND TOTAL AMT BILLED = $99,999,999,999.99
        GRAND TOTAL AMT DUE = $99,999,999,999.99


                                                  *** END OF REPORT ***
                                                *** NO DATA THIS RUN ***
```


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7.114.3 TPL-A103-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HMS Quarterly Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS data match.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15

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Field	Description	Data Type	Length
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS data match.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.115 TPL-A104-R -- Third Party Contractor Active Records Add Production Report - HIPP Update Records Report - (Non Payable/Payable)

7.115.1 TPL-A104-R -- Third Party Contractor Active Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Narrative

The Third Party Contractor Active Add – HIPP Update Records Report provides the Agency with a listing of the HIPP policies, with an Agency Override value of “Y”, that were identified to be updated as a result of the data match with the Third Party Contractor.

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7.115.2 TPL-A104-R -- Third Party Contractor Active Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A104-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT                  Page:    999,999
                                        HMS HIPP UPDATE RECORDS - (NON PAYABLE/PAYABLE)
                                                REPORT PERIOD:  MM/CCYY
-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                   FIRST             CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXXXXXX   XX    XXXXXX  XXX
                         SEGMENTS - UPDATED
POLICY                                                          POLICY      POLICY           COVERAGE
UPDATE       CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                         SEGMENTS - NOT UPDATED
UPDATE       CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT

    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99

            SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99

COVERAGE TYPE                        RATE                  NUMBER                     AMT DUE
Major Medical                   $99,999,999.99          99,999,999,99            $99,999,999,999.99
Pharmacy                        $99,999,999.99          99,999,999,99            $99,999,999,999.99
Dental                          $99,999,999.99          99,999,999,99            $99,999,999,999.99
Medicare Supplement             $99,999,999.99          99,999,999,99            $99,999,999,999.99
Hospital Indemnity              $99,999,999.99          99,999,999,99            $99,999,999,999.99
Long Term Care                  $99,999,999.99          99,999,999,99            $99,999,999,999.99
```


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```
Totals:                                          99,999,999,99          $99,999,999,999.99

                                                *** END OF REPORT ***
                                              *** NO DATA THIS RUN ***
```

7.115.3 TPL-A104-R -- Third Party Contractor Active Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Active record updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage	Character	15

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Field	Description	Data Type	Length
	4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all the recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only the policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number of Active records updated for each coverage type.	Number (Integer)	12
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Active record updated.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated in the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Number (Integer)	12

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7.116 TPL-A104-T -- Third Party Contractor Active Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable)

7.116.1 TPL-A104-T -- Third Party Contractor Active Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Narrative

This pre-production report provides the Agency with a listing the HIPP policies, with an Agency Override value of “Y”, that were identified to be updated as a result of the data match with the Third Party Contractor.

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7.116.2 TPL-A104-T -- Third Party Contractor Active Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A104-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRE-PROD REPORT                     Page:    999,999
                                        HMS HIPP UPDATE RECORDS - (NON PAYABLE/PAYABLE)
                                                REPORT PERIOD:  MM/CCYY


-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXX XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                            POLICY      POLICY           COVERAGE
UPDATE       CARRIER       CARRIER       CONTRACT                 START       END         PLAN INDICATORS       PAY
DATE         CODE          NAME          NUMBER                   DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER       CARRIER       CONTRACT                 START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE          NAME          NUMBER                   DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                            POLICY      POLICY           COVERAGE
ADD          CARRIER       CARRIER       CONTRACT                 START       END         PLAN INDICATORS
DATE         CODE          NAME          NUMBER                   DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99


           SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.116.3 TPL-A104-T -- Third Party Contractor Active Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not updated.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1

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Field	Description	Data Type	Length
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Number (Integer)	12

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7.117 TPL-A105-R -- Third Party Contractor Inactive Records Add Production Report - HIPP Update Records - (Non Payable/Payable)

7.117.1 TPL-A105-R -- Third Party Contractor Inactive Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Narrative

The Third Party Contractor Inactive HIPP Update Report provides a listing of the HIPP policies, with an Agency Override value of “Y”, which are inactive and identified to be updated as a result of the data match with the Third Party Contractor.

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7.117.2 TPL-A105-R -- Third Party Contractor Inactive Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A105-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O            THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRODUCTION REPORT                  Page:    999,999
                                        HMS HIPP UPDATE RECORDS - (NON PAYABLE/PAYABLE)
                                                REPORT PERIOD:  MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                                  POLICY      POLICY          COVERAGE
UPDATE       CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS       PAY
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER       CARRIER       CONTRACT                       START       END         PLAN INDICATORS
DATE         CODE          NAME          NUMBER                         DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT

    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99

            SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99

COVERAGE TYPE                        RATE                 NUMBER                     AMT DUE
Major Medical                  $99,999,999.99         99,999,999,99           $99,999,999,999.99
Pharmacy                       $99,999,999.99         99,999,999,99           $99,999,999,999.99
Dental                         $99,999,999.99         99,999,999,99           $99,999,999,999.99
Medicare Supplement            $99,999,999.99         99,999,999,99           $99,999,999,999.99
Hospital Indemnity             $99,999,999.99         99,999,999,99           $99,999,999,999.99
```


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```
Long Term Care                $99,999,999.99          99,999,999,99            $99,999,999,999.99
Totals:                                               99,999,999,99            $99,999,999,999.99

                                                     *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```

7.117.3 TPL-A105-R -- Third Party Contractor Inactive Records Add Production Report - HIPP Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Inactive record updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage	Character	15

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Field	Description	Data Type	Length
	3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all the recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only the policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number of Inactive records updated for each coverage type.	Number (Integer)	12

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Field	Description	Data Type	Length
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Inactive record updated.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated in the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Number (Integer)	12

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7.118 TPL-A105-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable)

7.118.1 TPL-A105-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Narrative

The Third Party Contractor Inactive HIPP Update Pre-Production Report provides a listing of the HIPP policies, with an Agency Override value of “Y”, which are inactive and identified to be updated as a result of the data match with the Third Party Contractor.

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7.118.2 TPL-A105-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Layout

```
Report  : TPL-A105-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM029T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRE-PROD REPORT                  Page:    999,999
                                        HMS HIPP UPDATE RECORDS - (NON PAYABLE/PAYABLE)
                                                REPORT PERIOD:  MM/CCYY


-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                    FIRST            CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXX XX    XXXXXX  XXX
                           SEGMENTS - UPDATED
POLICY                                                              POLICY      POLICY           COVERAGE
UPDATE       CARRIER       CARRIER       CONTRACT                   START       END         PLAN INDICATORS       PAY
DATE         CODE          NAME          NUMBER                     DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*************************************************************************************************************************
                           SEGMENTS - NOT UPDATED
UPDATE       CARRIER       CARRIER       CONTRACT                   START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE          NAME          NUMBER                     DATE        DATE        CODE IOSPWAX123HDE4M  CODE UPDATED
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*************************************************************************************************************************
                       EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
POLICY                                                              POLICY      POLICY           COVERAGE
ADD          CARRIER       CARRIER       CONTRACT                   START       END         PLAN INDICATORS
DATE         CODE          NAME          NUMBER                     DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX    XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL UPDATED =         99,999,999
RECIPIENT TOTAL NOT UPDATED =         99,999,999
              AMOUNT BILLED =     $99,999,999.99
                 AMOUNT DUE =     $99,999,999.99


           SUMMARY INFORMATION
        GRAND TOTAL UPDATED =         99,999,999
    GRAND TOTAL NOT UPDATED =         99,999,999
     GRAND TOTAL AMT BILLED =     $99,999,999.99
        GRAND TOTAL AMT DUE =     $99,999,999.99


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.118.3 TPL-A105-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - HIPP Update Records - (Non Payable/Payable) Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying an update on a recipient's policy.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were updated in the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The first five characters in the name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL UPDATED	This is the accumulated number of policies that were updated for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying policies needing an update for all the recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were updated in the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies updated.	Number (Decimal)	12
GRAND TOTAL NOT UPDATED	This is the accumulated number of policies for all recipients that were received from HMS but not updated in the database.	Number (Integer)	9
NOT UPDATED	The value assigned by the system that indicates the reason the policy was not updated.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when updating a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY UPDATE DATE	The date the policy was updated.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1

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Field	Description	Data Type	Length
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL UPDATED	This is the accumulated number of policies that were updated as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT UPDATED	This is the accumulated number of policies that were received from HMS but not updated to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Number (Integer)	12

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7.119 TPL-A198-R -- Third Party Contractor Active Records Add Prod Report - Absent Parent Records Report

7.119.1 TPL-A198-R -- Third Party Contractor Active Records Add Prod Report - Absent Parent Records Report Narrative

This report provides the Agency with a listing of the policies that were active and added as a result of the match with the Third Party Contractor when procesing rhe absent parent file. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.119.2 TPL-A198-R -- Third Party Contractor Active Records Add Prod Report - Absent Parent Records Report Layout

```
Report  : TPL-A198-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/YYYY
Process : TPLJM199                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O             THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT                   Page:    999,999
                                              'ABSENT PARENT RECORDS'
                                              REPORT PERIOD:  MM/CCYY
-------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                  FIRST              CAT   STATUS  AGE
999999999999  XXXXXXXXX             XXXXXXXX           41            999
                        NEW SEGMENTS - ADDED
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER   CARRIER         CONTRACT                 START       END         PLAN INDICATORS       PAY
DATE         CODE      NAME            NUMBER                   DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXX   XXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY   XX  000000500000000   P    02

MM/DD/CCYY   XXXXXXX   XXXXX           XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY  MM/DD/CCYY   XX  111111001110011   M1   02


*******************************************************************************************************************************
                        EXISTING SEGMENTS
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER   CARRIER         CONTRACT                 START       END         PLAN INDICATORS
DATE         CODE      NAME            NUMBER                   DATE        DATE        CODE IOSPWAX123HDE4M
 NONE TO REPORT


    RECIPIENT TOTAL ADDED =      999999999
RECIPIENT TOTAL NOT ADDED =      999999999
            AMOUNT BILLED =        $9999999.99
               AMOUNT DUE =        $9999999.99


          SUMMARY INFORMATION
        GRAND TOTAL ADDED =      999999999
    GRAND TOTAL NOT ADDED =      999999999
   GRAND TOTAL AMT BILLED =        $9999999.99
      GRAND TOTAL AMT DUR =        $9999999.99


                                                        *END OF REPORT*
```


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7.119.3 TPL-A198-R -- Third Party Contractor Active Records Add Prod Report - Absent Parent Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Active record added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values:	Character	15

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Field	Description	Data Type	Length
	VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number or Active records added for each coverage type.	Number (Integer)	12
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
RATE (Coverage Type)	The payment rate per each coverage type for each Active record added.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.120 TPL-A328-R -- Third Party Contractor Active Records Add Production Report - Tricare Records

7.120.1 TPL-A328-R -- Third Party Contractor Active Records Add Production Report - Tricare Records Report Narrative

The Third Party Contractor Active Add – Tricare Records report provides a listing of the policies that were active and added as a result of the Tricare datamatch with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals. This report is produced upon request.

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7.120.2 TPL-A328-R -- Third Party Contractor Active Records Add Production Report - Tricare Records Layout

```
Report  : TPL-A328-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJO329                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRODUCTION REPORT                Page:    999,999
                                             HMS TRICARE (DEERS) RECORDS
                                              REPORT PERIOD:  MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                          AID   RECIP   RECIP
RID          LAST                   FIRST             CAT   STATUS  AGE
999999999999 XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                          POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*******************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                          POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*******************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                          POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL ADDED =         99,999,999
RECIPIENT TOTAL NOT ADDED =         99,999,999
             AMOUNT BILLED =     $99,999,999.99
                AMOUNT DUE =     $99,999,999.99

           SUMMARY INFORMATION
        GRAND TOTAL ADDED =         99,999,999
    GRAND TOTAL NOT ADDED =         99,999,999
   GRAND TOTAL AMT BILLED =     $99,999,999.99
      GRAND TOTAL AMT DUE =     $99,999,999.99


COVERAGE TYPE                        RATE                 NUMBER                     AMT DUE
Major Medical                   $99,999,999.99         99,999,999,99            $99,999,999,999.99
Pharmacy                        $99,999,999.99         99,999,999,99            $99,999,999,999.99
Dental                          $99,999,999.99         99,999,999,99            $99,999,999,999.99
Medicare Supplement             $99,999,999.99         99,999,999,99            $99,999,999,999.99
Hospital Indemnity              $99,999,999.99         99,999,999,99            $99,999,999,999.99
Long Term Care                  $99,999,999.99         99,999,999,99            $99,999,999,999.99
Totals:                                                99,999,999,99            $99,999,999,999.99

                                                     *** END OF REPORT ***
                                                   *** NO DATA THIS RUN ***
```


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7.120.3 TPL-A328-R -- Third Party Contractor Active Records Add Production Report - Tricare Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Active record added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values:	Character	15

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Field	Description	Data Type	Length
	VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number or Active records added for each coverage type.	Number (Integer)	12
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
RATE (Coverage Type)	The payment rate per each coverage type for each Active record added.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Integer)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.121 TPL-A328-T -- Third Party Contractor Active Records Add Pre-Prod Report - Tricare Records

7.121.1 TPL-A328-T -- Third Party Contractor Active Records Add Pre-Prod Report - Tricare Records Report Narrative

This pre-production report provides the Agency with a listing of the policies that were active and added as a result of the Tricare data match with the Third Party Contractor. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides grand totals.

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7.121.2 TPL-A328-T -- Third Party Contractor Active Records Add Pre-Prod Report - Tricare Records Layout

```
Report  : TPL-A328-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJO329T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR ACTIVE RECORDS ADD PRE-PROD REPORT                       Page:    999,999
                                                HMS TRICARE (DEERS) RECORDS
                                                 REPORT PERIOD:  MM/CCYY
  ---------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                   FIRST             CAT   STATUS  AGE
999999999999  XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                        NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*********************************************************************************************************************************
                        NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*********************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT
     RECIPIENT TOTAL ADDED =         99,999,999
RECIPIENT TOTAL NOT ADDED =         99,999,999
            AMOUNT BILLED =     $99,999,999.99
               AMOUNT DUE =     $99,999,999.99
           SUMMARY INFORMATION
        GRAND TOTAL ADDED =         99,999,999
    GRAND TOTAL NOT ADDED =         99,999,999
   GRAND TOTAL AMT BILLED =     $99,999,999.99
      GRAND TOTAL AMT DUE =     $99,999,999.99


                                                   *** END OF REPORT ***
```

7.121.3 TPL-A328-T -- Third Party Contractor Active Records Add Pre-Prod Report - Tricare Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12

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Field	Description	Data Type	Length
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	Number (Decimal)	12

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Field	Description	Data Type	Length
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED CODE	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20

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Field	Description	Data Type	Length
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.122 TPL-A329-R -- Third Party Contractor Inactive Records Add Production Report - Tricare Records

7.122.1 TPL-A329-R -- Third Party Contractor Inactive Records Add Production Report - Tricare Records Report Narrative

The Third Party Contractor Inactive Add report provides a listing of the policies that were inactive and added as a result of the Tricare datamatch with the Third Party Contractor. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals. This report is produced upon request.

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7.122.2 TPL-A329-R -- Third Party Contractor Inactive Records Add Production Report - Tricare Records Layout

```
Report  : TPL-A329-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJO329                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0319O            THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRODUCTION REPORT                  Page:    999,999
                                                HMS TRICARE (DEERS) RECORDS
                                                 REPORT PERIOD:  MM/CCYY
 ---------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                    FIRST             CAT   STATUS  AGE
999999999999  XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*********************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*********************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL ADDED =         99,999,999
RECIPIENT TOTAL NOT ADDED =         99,999,999
            AMOUNT BILLED =     $99,999,999.99
               AMOUNT DUE =     $99,999,999.99


          SUMMARY INFORMATION
        GRAND TOTAL ADDED =         99,999,999
    GRAND TOTAL NOT ADDED =         99,999,999
   GRAND TOTAL AMT BILLED =     $99,999,999.99
      GRAND TOTAL AMT DUE =     $99,999,999.99


COVERAGE TYPE                        RATE                 NUMBER                     AMT DUE
Major Medical                   $99,999,999.99          99,999,999,99           $99,999,999,999.99
Pharmacy                        $99,999,999.99          99,999,999,99           $99,999,999,999.99
Dental                          $99,999,999.99          99,999,999,99           $99,999,999,999.99
Medicare Supplement             $99,999,999.99          99,999,999,99           $99,999,999,999.99
Hospital Indemnity              $99,999,999.99          99,999,999,99           $99,999,999,999.99
Long Term Care                  $99,999,999.99          99,999,999,99           $99,999,999,999.99
Totals:                                                 99,999,999,99           $99,999,999,999.99

                                                          *** END OF REPORT ***
                                                        *** NO DATA THIS RUN ***
```


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7.122.3 TPL-A329-R -- Third Party Contractor Inactive Records Add Production Report - Tricare Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
AMT DUE (COVERAGE TYPE)	This is the amount due per each coverage type for each Inactive record added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage	Character	15

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Field	Description	Data Type	Length
	M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID		
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED CODE	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
NUMBER (Coverage Type)	The total number or Inactive records added for each coverage type.	Number (Integer)	9
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10

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Field	Description	Data Type	Length
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RATE (Coverage Type)	The payment rate per each coverage type for each Inactive record added.	Number (Decimal)	12
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file.	Character	12

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7.123 TPL-A329-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Tricare Records

7.123.1 TPL-A329-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Tricare Records Report Narrative

Pre-production Report - Users access the Third Party Contractor Inactive Add Report to provide a listing of the policies that were inactive and added as a result of the Tricare datamatch with the Third Party Contractor. The report is sorted by Recipient ID with a page break on ID. A summary is provided on the last page of the report that provides grand totals.

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7.123.2 TPL-A329-T -- Third Party Contractor Inactive Records Add Pre-Prod Report - Tricare Records Layout

```
Report  : TPL-A329-T                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJO329T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:   HH:MM:SS
Location: TPL0319O             THIRD PARTY CONTRACTOR INACTIVE RECORDS ADD PRE-PROD REPORT                    Page:    999,999
                                             HMS TRICARE (DEERS) RECORDS
                                              REPORT PERIOD:  MM/CCYY

 ---------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                          AID   RECIP   RECIP
RID           LAST                   FIRST             CAT   STATUS  AGE
999999999999  XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXX  XX    XXXXXX  XXX
                       NEW SEGMENTS - ADDED
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX
NONE TO REPORT
*********************************************************************************************************************************
                       NEW SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY   NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE  ADDED
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX    XX
NONE TO REPORT
*********************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXXXXXXX     XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX
NONE TO REPORT


    RECIPIENT TOTAL ADDED =         99,999,999
RECIPIENT TOTAL NOT ADDED =         99,999,999
             AMOUNT BILLED =     $99,999,999.99
                AMOUNT DUE =     $99,999,999.99


          SUMMARY INFORMATION
        GRAND TOTAL ADDED =         99,999,999
    GRAND TOTAL NOT ADDED =         99,999,999
   GRAND TOTAL AMT BILLED =     $99,999,999.99
      GRAND TOTAL AMT DUE =     $99,999,999.99

                                                        *** END OF REPORT ***
                                                      *** NO DATA THIS RUN ***
```


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7.123.3 TPL-A328-R -- Third Party Contractor Inactive Records Add Pre-Prod Report - Tricare Records Report Field Descriptions

Field	Description	Data Type	Length
AID CAT	The recipient's most current aid category.	Character	2
AMOUNT BILLED	This is the dollar amount HMS receives for identifying a new policy for a recipient.	Number (Decimal)	12
AMOUNT DUE	This is the amount due HMS for all records that were added to the database for a recipient. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
CARRIER CODE	The carrier code from the HMS input file.	Character	10
CARRIER NAME	The name of the carrier.	Character	5
CONTRACT NUMBER	The policy number assigned by the carrier from the HMS input file.	Character	30
COVERAGE INDICATORS	The descriptions of the coverage indicators from the HMS input file are as follows: I – Inpatient Coverage O – Outpatient Coverage S – Surgical Coverage P – Physician Coverage W – Well Child Coverage A – Ambulance Coverage X – Prescription Drug Coverage 1 – Extended Care Coverage 2 – Mental Health Coverage 3 – DME Coverage H – Home Health Coverage D – Dental Coverage E – Vision Coverage 4 – Medicare No Policy Coverage M – Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: VALUE '0' = COVERAGE TYPE IS NOT COVERED VALUE '1' = COVERAGE TYPE IS COVERED VALUE '4' = ONLY CROSSOVER CLAIMS ARE COVERED VALUE '5' = COVERAGE TYPE IS COVERED; COST AVOID	Character	15

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Field	Description	Data Type	Length
GRAND TOTAL ADDED	This is the accumulated number of policies that were added for all the recipients as a result of the HMS datamatch.	Number (Integer)	9
GRAND TOTAL AMT BILLED	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS datamatch.	Number (Decimal)	12
GRAND TOTAL AMT DUE	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS datamatch. This is calculated by adding the AMOUNT BILLED for only those policies added.	Number (Decimal)	12
GRAND TOTAL NOT ADDED	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	Number (Integer)	9
NOT ADDED CODE	The value assigned by the system that indicates the reason the policy was not added.	Number (Integer)	2
PAY CODE	The Pay Code represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	Character	2
PLAN CODE	The plan code from the HMS input file, which is used to update the policy type when adding a record.	Character	2
POLICY ADD DATE	The date the policy was added.	Date (MM/DD/CCYY)	10
POLICY END DATE	The end date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
POLICY START DATE	The start date of the policy from the HMS input file.	Date (MM/DD/CCYY)	10
RECIP AGE	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	Number (Integer)	3
RECIP STATUS	The status of the recipient's aid category.	Character	1

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Field	Description	Data Type	Length
RECIPIENT NAME - FIRST	The recipient's first name.	Character	15
RECIPIENT NAME - LAST	The recipient's last name.	Character	20
RECIPIENT TOTAL ADDED	This is the accumulated number of policies that were added as a result of the HMS datamatch.	Number (Integer)	9
RECIPIENT TOTAL NOT ADDED	This is the accumulated number of policies that were received from HMS but not added to the database.	Number (Decimal)	9
RID	The recipient's Medicaid ID from the HMS input file	Character	12

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7.124 TPL-AR01-R -- TPL AR Created Through HMS Report

7.124.1 TPL-AR01-R -- TPL AR Created Through HMS Report Narrative

One time process report to show TPL ARs created through the HMS process.

7.124.2 TPL-AR01-R -- TPL AR Created Through HMS Report Layout

```
Report : TPL-AR01-R                          ALABAMA MEDICAID AGENCY                                   Run Date: MM/DD/CCYY
Process : TPLJO320                   MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time: MM:HH:SS
Location: TPL0320o                           TPL AR CREATED THROUGH HMS                                        Page: 1


AR NUMBER      RECIPIENT NAME                      ID MEDICAID       LEGACY ICN     ICN            CDE_CARRIER    AMT
-------------- ----------------------------------- ------------- -------------- -------------- ------------ -------------
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999
9999999999999  XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999      9999999999999 9999999999999   99999          999999999999




TOTAL NUMBER OF AR CREATED : 999999999                    TOTAL AR AMOUNT : $ 9,999,999.99

                                                         ***END OF REPORT***
```

7.124.3 TPL-AR01-R -- TPL AR Created Through HMS Report Field Descriptions

Field	Description	Data Type	Length
AMT	Amount of AR.	Number (Decimal)	12
AR Number	AR Number.	Number (Integer)	13
CDE Carrier	Carrier code.	Number (Integer)	5
ICN	Internal Control Number.	Number (Integer)	13
ID Medicaid	Medicaid ID of recipient (RID).	Number (Integer)	12

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Field	Description	Data Type	Length
Legacy ICN	Legacy assigned internal control number.	Number (Integer)	13
Recipient Name	Name of recipient	Character	30
Total Number of AR Created	Total number of accounts receivable created for this report run.	Number (Integer)	9
Total AR Amount	Total accounts receivable amounts for this report run.	Number (Decimal)	11

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7.125 TPL-AR02-R -- TPL Duplicate AR Sent By HMS Report

7.125.1 TPL-AR02-R -- TPL Duplicate AR Sent By HMS Report Narrative

One time process report to show duplicate TPL ARs sent by HMS.

7.125.2 TPL-AR02-R -- TPL Duplicate AR Sent By HMS Report Layout

```
  Report : TPL-AR02-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
  Process : TPLJO320                     MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time: MM:HH:SS
 Location: TPL0320o                            TPL Duplicate AR Sent By HMS Report                              Page: 1


DUPE AR NUMBER   RECIPIENT NAME                    ID MEDICAID       ICN            LEGACY ICN     CDE_CARRIER    AMT
-------------- ---------------------------------------- ------------- -------------- -------------- ------------ -------------
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999
9999999999999    XXXXXXXXXXXXXXX, XXXXXXXXXXXXXX X  999999999999    9999999999999 9999999999999   99999          999999999999




TOTAL NUMBER OF DUPLICATE AR : 999999999                    TOTAL AR AMOUNT : $ 9,999,999.99

                                                           ***END OF REPORT***
```

7.125.3 TPL-AR02-R -- TPL Duplicate AR Sent By HMS Report Field Descriptions

Field	Description	Data Type	Length
AMT	Amount of AR.	Number (Decimal)	12
Dupe AR Number	AR Number.	Number (Integer)	13
CDE Carrier	Carrier code.	Number (Integer)	5
ICN	Internal Control Number.	Number (Integer)	13
ID Medicaid	Medicaid ID of recipient (RID).	Number (Integer)	12

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Field	Description	Data Type	Length
Legacy ICN	Legacy assigned internal control number.	Number (Integer)	13
Recipient Name	Name of recipient	Character	30
Total Number of Duplicate AR	Total number of accounts receivable created for this report run.	Number (Integer)	9
Total AR Amount	Total accounts receivable amounts for this report run.	Number (Decimal)	11

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7.126 TPL-AR03-R -- AR'S Closed by the HMS reason code daily process Report

7.126.1 TPL-AR03-R -- AR'S Closed by the HMS reason code daily process Report Narrative

This report shows the AR information that was updated during the TPL Daily A/R Reason Code Process.

7.126.2 TPL-AR03-R -- AR'S Closed by the HMS reason code daily process Report Layout

```
Report  : TPL-AR03-R                          ALABAMA MEDICAID AGENCY                                  Run Date: MM/DD/CCYY
Process : TPLJD600                       MEDICAID MANAGEMENT INFORMATION SYSTEM                       Run Time:   HH:MM:SS
Location: TPL0600D                    AR'S CLOSED BY THE HMS REASON CODE DAILY PROCESS                  Page:       999999

                                 AR CNTL NUMBER    PREV REASON CDE   NEW REASON CDE
                                ----------------  ----------------- ----------------
                                 XXXXXXXXXXXXX          XXXX              XXXX
                                XXXXXXXXXXXXX          XXXX              XXXX
                                XXXXXXXXXXXXX          XXXX              XXXX
                                XXXXXXXXXXXXX          XXXX              XXXX

                               TOTAL NUMBER OF AR's CLOSED :         ###,###,###

                                                 *** END OF REPORT ***
```

7.126.3 TPL-AR03-R -- TPL AR Created Through HMS Report Field Descriptions

Field	Description	Data Type	Length
AR Cntl Number	A/R Control Number	Character	13
New Reason Cde	This is the reason code received in the input file from HMS and that was applied to the corresponding A/R.	Character	4
Prev Reason Cde	Reason code assigned to the A/R before applying the change.	Character	4
Total Number of Ar's Closed	Total Number of A/R that where closed during the process.	Number (Integer)	11
Total Number of Ar's Received	Total Number of records received and read.	Number (Integer)	11

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7.127 TPL-AR04-R -- AR'S Not processed by HMS reason code daily process Report

7.127.1 TPL-AR04-R -- AR'S Not processed by HMS reason code daily process Narrative

This report shows the AR information that was not processed during the TPL Daily A/R Reason Code Process.

7.127.2 TPL-AR04-R -- AR'S Not processed by HMS reason code daily process Layout

```
Report  : TPL-AR04-R                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJD600                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0600D                 AR'S NOT PROCESSED BY HMS REASON CODE DAILY PROCESS                       Page:     999999


                              SAK ACCT REC     AR CNTL NUMBER    REASON CDE RCVD        REASON
                            ----------------  ----------------  ------------------  ----------------
                                #########                              XXXX         XXXXXXXXXXXXXXXX
                                #########      XXXXXXXXXXXXXX          XXXX         XXXXXXXXXXXXXXXX

                                #########      XXXXXXXXXXXXXX          XXXX         XXXXXXXXXXXXXXXX
                                #########                              XXXX         XXXXXXXXXXXXXXXX

                                     SUBTOTAL FOR ERROR <INVALID RSN CDE>
:     ###,###,###
                                     SUBTOTAL FOR ERROR <AR NO EXISTS   >
:     ###,###,###
                                     SUBTOTAL FOR ERROR <AR DISP EXIST  >
:     ###,###,###
                                    TOTAL NUMBER OF RECORDS NOT PROCESSED
:     ###,###,###

                                                   *** END OF REPORT ***
```

7.127.3 TPL-AR02-R -- TPL Duplicate AR Sent By HMS Report Field Descriptions

Field	Description	Data Type	Length
Ar Cntl Number	A/R Control Number.	Character	13
Reason	Brief Error description. Reason why the record was not processed.	Character	20
Reason Cde Rcvd	This is the reason code received in the input file from HMS.	Character	4
Sak Acct Rec	Sak number recived and that identifies the A/R.	Number (Integer)	9
Subtotal For Error <Ar Disp Exist >	Subtotal of records not processed from reason: AR DISP EXIST .	Number (Integer)	11

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Field	Description	Data Type	Length
Subtotal For Error <Ar No Exists>	Subtotal of records not processed from reason: AR NO EXISTS.	Number (Integer)	11
Subtotal For Error <Invalid Rsn Cde>	Subtotal of records not processed from reason: INVALID RSN CDE.	Number (Integer)	11
Total Number of AR's Received	Total Number of records received.	Number (Integer)	11
Total Number of Records Not Processed	Total number of records not processed.	Number (Integer)	11

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7.128 TPL-P098-E -- Third Party Contractor Active Records Error Production Report

7.128.1 TPL-P098-E -- Third Party Contractor Active Records Error Production Report Narrative

The Third Party Contractor Active Records Error Production report provides a listing of the policies that were not added as a result of the match with the Third Party Contractor due to an error. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides the grand total. This report is produced bimonthly.

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7.128.2 TPL-P098-E -- Third Party Contractor Active Records Error Production Report Layout

```
Report  : TPL-P098-E                          ALABAMA MEDICAID AGENCY                                  Run Date:  MM/DD/CCYY
Process : TPLJM019                       MEDICAID MANAGEMENT INFORMATION SYSTEM                        Run Time:    HH:MM:SS
Location: TPL0318I               THIRD PARTY CONTRACTOR ACTIVE RECORDS ERROR PRODUCTION RPT                Page:     999,999
                                              REPORT PERIOD - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                 AID  RECIP   RECIP
RID           LAST               FIRST        CAT  STATUS  AGE
999999999999  XXXXXXXXX          XXXXXXXX     XX     X     999
                       NEW  SEGMENTS - NOT ADDED
POLICY                                                                POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                   START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                     DATE        DATE        CODE IOSPWAX123HDE4M  CODE ADDED
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX   XX
*******************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                POLICY      POLICY          COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                   START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                     DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX


                 SUMMARY INFORMATION
      GRAND TOTAL NOT ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99


COVERAGE TYPE                       RATE                 NUMBER                     AMT DUE
Major Medical                  $9,999,999.99          9,999,999,99            $9,999,999,999.99
Pharmacy                       $9,999,999.99          9,999,999,99            $9,999,999,999.99
Dental                         $9,999,999.99          9,999,999,99            $9,999,999,999.99
Medicare Supplement            $9,999,999.99          9,999,999,99            $9,999,999,999.99
Hospital Indemnity             $9,999,999.99          9,999,999,99            $9,999,999,999.99
Long Term Care                 $9,999,999.99          9,999,999,99            $9,999,999,999.99
Invalid Aid Cat/Cov Type       $9,999,999.99          9,999,999,99            $9,999,999,999.99
Totals:                                               9,999,999,99            $9,999,999,999.99


                                                 *** END OF REPORT ***
                                               *** NO DATA THIS RUN ***
```


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7.128.3 TPL-P098-E -- Third Party Contractor Active Records Error Production Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Amt Due(Coverage Type)	This is the amount due per each coverage type for each active record updated.	17	Number (Integer)
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character

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Field	Description	Length	Data Type
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	17	Number (Decimal)
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the Amount Billed for only those policies added.	17	Number (Decimal)
Grand Total Not Added	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	13	Number (Integer)
Not Added	The value assigned by the system that indicates the reason the policy was not added.	2	Number (Integer)
Number (Coverage Type)	The total number of active records updated for each coverage type.	13	Number (Integer)
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Rate (Coverage Type)	The payment rate per each coverage type for each active record updated.	13	Number (Integer)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)

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Field	Description	Length	Data Type
Recip Status	The status of the recipient's aid category.	1	Character
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)

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7.129 TPL-P099-E -- Third Party Contractor Inactive Records Error Production Report

7.129.1 TPL-P099-E -- Third Party Contractor Inactive Records Error Production Report Narrative

The Third Party Contractor Inactive Records Error Production report provides a listing of the policies that were not added as a result of the match with the Third Party Contractor due to an error. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides the grand total. This report is produced upon request.

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7.129.2 TPL-P099-E -- Third Party Contractor Inactive Records Error Production Report Layout

```
Report  : TPL-P099-E                          ALABAMA MEDICAID AGENCY                                  Run Date:  MM/DD/CCYY
Process : TPLJM019                      MEDICAID MANAGEMENT INFORMATION SYSTEM                         Run Time:    HH:MM:SS
Location: TPL0319O              THIRD PARTY CONTRACTOR INACTIVE RECORDS ERROR PRODUCTION RPT               Page:     999,999
                                             REPORT PERIOD - MM/DD/CCYY

-------------------------------------------------------------------------------------------------------------------------------
              RECIPIENT  NAME                 AID  RECIP   RECIP
RID           LAST               FIRST        CAT  STATUS  AGE
999999999999  XXXXXXXXX          XXXXXXXX     XX     X     999
                       NEW  SEGMENTS - NOT ADDED
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M  CODE ADDED
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX   XX
*******************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                          POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT              START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX


                 SUMMARY INFORMATION
      GRAND TOTAL NOT ADDED =  9,999,999,999
  GRAND TOTAL AMOUNT BILLED = $9,999,999,999.99
     GRAND TOTAL AMOUNT DUE = $9,999,999,999.99


COVERAGE TYPE                       RATE                 NUMBER                     AMT DUE
Major Medical                  $9,999,999.99          9,999,999,99            $9,999,999,999.99
Pharmacy                       $9,999,999.99          9,999,999,99            $9,999,999,999.99
Dental                         $9,999,999.99          9,999,999,99            $9,999,999,999.99
Medicare Supplement            $9,999,999.99          9,999,999,99            $9,999,999,999.99
Hospital Indemnity             $9,999,999.99          9,999,999,99            $9,999,999,999.99
Long Term Care                 $9,999,999.99          9,999,999,99            $9,999,999,999.99
Invalid Aid Cat/Cov Type       $9,999,999.99          9,999,999,99            $9,999,999,999.99
Totals:                                               9,999,999,99            $9,999,999,999.99


                                          *** END OF REPORT ***
                                        *** NO DATA THIS RUN ***
```


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7.129.3 TPL-P099-E -- Third Party Contractor Inactive Records Error Production Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Amt Due (Coverage Type)	This is the amount due per each coverage type for each inactive record updated.	17	Number (Decimal)
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character

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Field	Description	Length	Data Type
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	17	Number (Decimal)
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the Amount Billed for only those policies added.	17	Number (Decimal)
Grand Total Not Added	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	13	Number (Integer)
Not Added	The value assigned by the system that indicates the reason the policy was not added.	2	Number (Integer)
Number (Coverage Type)	The total number of inactive records updated for each coverage type.	13	Number (Integer)
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Rate (Coverage Type)	The payment rate per each coverage type for each inactive record updated.	13	Number (Integer)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	1	Character

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Field	Description	Length	Data Type
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)

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7.130 TPL-Q011-P -- Southland Policy Add/Update Report

7.130.1 TPL-Q011-P -- Southland Policy Add/Update Report Narrative

This report provides the Agency with a listing of the policies that were added and/or updated as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity. A summary is provided at the end of the report that provides totals.

7.130.2 TPL-Q011-P -- Southland Policy Add/Update Report Layout

```
Report  : TPL-Q011-P                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008                       MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0008Q                     SOUTHLAND POLICY ADD/UPDATE PRODUCTION REPORT                         Page:    999,999
                                             REPORT PERIOD: MM/CCYY - MM/CCYY

*****************************************************************************************************************************
MEDICAID POLICY DATA:
MEDICAID ID: XXXXXXXXXXXX    SSN: 999-99-9999    RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  DOB: MM/DD/CCYY   REL: X

SOUTHLAND POLICY DATA:
POLICY NUMBER: XXXXXXXXXX    SSN: 999-99-9999   SUBSCRIBER NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  DOB: MM/DD/CCYY

-----------------------------------------------------------------------------------------------------------------------------
                        NEW SEGMENTS - ADDED
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT

-----------------------------------------------------------------------------------------------------------------------------
                        SEGMENTS - UPDATED
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT

-----------------------------------------------------------------------------------------------------------------------------
                        EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT



          SUMMARY INFORMATION
      GRAND TOTAL POLICIES ADDED               =          99,999,999,999
      GRAND TOTAL POLICIES UPDATED             =          99,999,999,999
      GRAND TOTAL POLICIES NOT ADDED/UPDATED   =          99,999,999,999
      GRAND TOTAL RECIPIENTS                   =          99,999,999,999
```


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```
*** END OF REPORT ***
*** NO DATA THIS RUN ***
```

7.130.3 TPL-Q011-P -- Southland Policy Add/Update Report Field Descriptions

Field	Description	Length	Data Type
CARRIER CODE	The Southland Carrier code.	10	Character
COVERAGE	The coverage code on the Southland policy.	2	Character
DOB (MEDICAID POLICY DATA)	The recipient's Date of Birth.	10	Date (MM/DD/CCYY)
DOB (SOUTHLAND POLICY DATA)	The date of birth of the subscriber on Southland's insurance policy.	10	Date (MM/DD/CCYY)
EFFECTIVE DATE	The coverage effective date on the Southland policy.	10	Date (MM/DD/CCYY)
END DATE	The coverage end date on the Southland policy.	10	Date (MM/DD/CCYY)
GRAND TOTAL POLICIES ADDED	The total number of Southland policies added	11	Number (Integer)
GRAND TOTAL POLICIES UPDATED	The total number of Southland policies updated.	11	Number (Integer)
GRAND TOTAL RECIPIENTS	Total number of Southland recipients processed.	11	Number (Integer)
GRAND TOTAL POLICIES NOT ADDED/UPDATED	Total number of policies not added and/or updated.	11	Number (Integer)
GROUP NUMBER	The group number on the Southland policy.	30	Character
MEDICAID ID	Medicaid ID assigned to the recipient.	12	Number (Integer)
POLICY NUMBER	The Policy number related to recipient's Southland’s insurance.	30	Character
POLICY NUMBER (SOUTHLAND POLICY DATA)	The subscriber's/dependent's unique ID on the Southland Data Match file.	10	Character
RECIPIENT NAME	Last Name, First Name and Middle Initial of the recipient.	39	Character
REL	The recipient’s relationship to the Southland Subscriber.	1	Character
SSN (MEDICAID POLICY DATA)	The recipient's Social Security Number.	11	Character

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Field	Description	Length	Data Type
SSN (SOUTHLAND POLICY DATA)	The subscriber's Social Security Number on Southland's insurance policy.	11	Character
SUBSCRIBER NAME	Last Name, First Name and Middle Initial of the subscriber on Southland's insurance policy.	39	Character
SUSPECT CODE	The suspect code for the Southland policy.	1	Character

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7.131 TPL-Q011-T -- Southland Policy Add/Update Pre Prod Report

7.131.1 TPL-Q011-T -- Southland Policy Add/Update Pre Prod Report Narrative

This pre-production report provides the Agency with a listing of the policies that will be potentially added or updated as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity. A summary is provided at the end of the report that provides totals.

7.131.2 TPL-Q011-T -- Southland Policy Add/Update Pre Prod Report Layout

```
Report  : TPL-Q011-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0008Q                    SOUTHLAND POLICY ADD/UPDATE PRE PROD REPORT                            Page:    999,999
                                          REPORT PERIOD: MM/CCYY - MM/CCYY

*****************************************************************************************************************************
MEDICAID POLICY DATA:
MEDICAID ID: XXXXXXXXXXXX    SSN: 999-99-9999    RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  DOB: MM/DD/CCYY   REL: X

SOUTHLAND POLICY DATA:
POLICY NUMBER: XXXXXXXXX     SSN: 999-99-9999   SUBSCRIBER NAME: XXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXX X  DOB: MM/DD/CCYY

-----------------------------------------------------------------------------------------------------------------------------
                        NEW SEGMENTS - ADDED
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT

-----------------------------------------------------------------------------------------------------------------------------
                        SEGMENTS - UPDATED
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT

-----------------------------------------------------------------------------------------------------------------------------
                        EXISTING SEGMENTS/SEGMENTS BEFORE UPDATE
CARRIER CODE  POLICY NUMBER                   GROUP NUMBER                      SUSPECT CODE  COVERAGE    EFFECTIVE DATE    END DATE
XXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        X           XX       MM/DD/CCYY      MM/DD/CCYY
NONE TO REPORT



          SUMMARY INFORMATION
      GRAND TOTAL POLICIES ADDED               =          99,999,999,999
      GRAND TOTAL POLICIES UPDATED             =          99,999,999,999
      GRAND TOTAL POLICIES NOT ADDED/UPDATED   =          99,999,999,999
      GRAND TOTAL RECIPIENTS                   =          99,999,999,999
```


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```
*** END OF REPORT ***
*** NO DATA THIS RUN ***
```

7.131.3 TPL-Q011-T -- Southland Policy Add/Update Pre Prod Report Field Descriptions

Field	Description	Length	Data Type
CARRIER CODE	The Southland Carrier code.	10	Character
COVERAGE	The coverage code on the Southland policy.	2	Character
DOB (MEDICAID POLICY DATA)	The recipient's Date of Birth.	10	Date (MM/DD/CCYY)
DOB (SOUTHLAND POLICY DATA)	The date of birth of the subscriber on Southland's insurance policy.	10	Date (MM/DD/CCYY)
EFFECTIVE DATE	The coverage effective date on the Southland policy.	10	Date (MM/DD/CCYY)
END DATE	The coverage end date on the Southland policy.	10	Date (MM/DD/CCYY)
GRAND TOTAL POLICIES ADDED	The total number of Southland policies added.	11	Number (Integer)
GRAND TOTAL POLICIES UPDATED	The total number of Southland policies updated.	11	Number (Integer)
GRAND TOTAL RECIPIENTS	Total number of Southland recipients processed.	11	Number (Integer)
GRAND TOTAL POLICIES NOT ADDED/UPDATED	Total number of policies not added and/or updated.	11	Number (Integer)
GROUP NUMBER	The group number on the Southland policy.	30	Character
MEDICAID ID	Medicaid ID assigned to the recipient.	12	Number (Integer)
POLICY NUMBER	The Policy number related to recipient's Southland’s insurance.	30	Character
POLICY NUMBER (SOUTHLAND POLICY DATA)	The subscriber's/dependent's unique ID on the Southland Data Match file.	10	Character
RECIPIENT NAME	Last Name, First Name and Middle Initial of the recipient.	39	Character
REL	The recipient’s relationship to the Southland Subscriber.	1	Character
SSN (MEDICAID POLICY DATA)	The recipient's Social Security Number.	11	Character

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Field	Description	Length	Data Type
SSN (SOUTHLAND POLICY DATA)	The subscriber's Social Security Number on Southland's insurance policy.	11	Character
SUBSCRIBER NAME	Last Name, First Name and Middle Initial of the subscriber on Southland's insurance policy.	39	Character
SUSPECT CODE	The suspect code for the Southland policy.	1	Character

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7.132 TPL-Q012-P -- Southland Not Identified - Needs Research Report

7.132.1 TPL-Q012-P -- Southland Not Identified - Needs Research Report Narrative

This report provides the Agency with a listing of the recipients that only matched on the first three letters of the first name and date of birth, recipients who had multiple matches on the social security number, and recipients who had multiple matches on the last name, first name, and date of birth as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity. The Agency will use this report for further research.

7.132.2 TPL-Q012-P -- Southland Not Identified - Needs Research Report Layout

```
Report  : TPL-Q012-P                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008                      MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0008Q             SOUTHLAND NOT IDENTIFIED - NEEDS RESEARCH PRODUCTION REPORT                   Page:    999,999
                            MATCH ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB/MULTIPLE MATCHES
                                             REPORT PERIOD: MM/CCYY - MM/CCYY


*****************************************************************************************************************************
RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    DOB: MM/DD/CCYY    SSN: 999-99-9999    REL: X

MEDICAID ID     LAST NAME            FIRST NAME         DOB                SSN
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX

REASON: XXXXXXXXXXXXXXXXXXX
```

```
TOTAL NUMBER OF MATCHES ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB = 99,999,999,999
TOTAL NUMBER OF MULTIPLE MATCHES ON SSN                              = 99,999,999,999
TOTAL NUMBER OF MULTIPLE MATCHES ON LAST NAME, FIRST NAME, AND DOB   = 99,999,999,999
TOTAL NUMBER OF RECIPIENTS                                           = 99,999,999,999


                                        *** END OF REPORT ***
                                     *** NO DATA THIS RUN ***
```

7.132.3 TPL-Q012-P -- Southland Not Identified - Needs Research Report Field Descriptions

Field	Description	Length	Data Type
DOB	The Medicaid Recipient's Date of Birth.	10	Date (MM/DD/CCYY)
DOB:	The date of birth of the recipient on Southland's insurance policy.	10	Date (MM/DD/CCYY)
FIRST NAME	The Medicaid Recipient's First Name	15	Character
LAST NAME	The Medicaid Recipient's Last Name	20	Character
MEDICAID ID	The Medicaid ID assigned to the recipient.	12	Number (Integer)
REASON	The reason why the Southland recipient appears on the report.	50	Character
RECIPIENT NAME	Last Name and First Name of the Southland recipient.	36	Character
REL	The Southland recipient's relationship to the subscriber on Southland's insurance policy.	1	Character
SSN	The Medicaid Recipient's Social Security Number.	11	Character
SSN:	The recipient's Social Security Number on Southland's insurance policy.	11	Character
TOTAL NUMBER OF MATCHES ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB	Total number of Southland recipients that matched on the first three letters of the first name and date of birth.	11	Number (Integer)
TOTAL NUMBER OF MULTIPLE MATCHES ON LAST NAME, FIRST NAME, AND DOB	Total number of Southland recipients that multiple matches on the last name, first name, and date of birth.	11	Number (Integer)

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Field	Description	Length	Data Type
TOTAL NUMBER OF MULTIPLE MATCHES ON SSN	Total number of Southland recipients that multiple matches on the social security number.	11	Number (Integer)
TOTAL RECIPIENTS	Total number of Southland recipients displayed on the report.	11	Number (Integer)

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7.133 TPL-Q012-T -- Southland Not Identified - Needs Research Pre Prod Report

7.133.1 TPL-Q012-T -- Southland Not Identified - Needs Research Pre Prod Report Narrative

This pre production report provides the Agency with a listing of the recipients that only matched on the first three letters of the first name and date of birth, recipients who had multiple matches on the social security number, and recipients who had multiple matches on the last name, first name, and date of birth as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity. The Agency will use this report for further research.

7.133.2 TPL-Q012-T -- Southland Not Identified - Needs Research Pre Prod Report Layout

```
Report  : TPL-Q012-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008T                     MEDICAID MANAGEMENT INFORMATION SYSTEM                           Run Time:   HH:MM:SS
Location: TPL0008Q              SOUTHLAND NOT IDENTIFIED - NEEDS RESEARCH PRE PROD REPORT                    Page:    999,999
                            MATCH ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB/MULTIPLE MATCHES
                                       REPORT PERIOD: MM/CCYY - MM/CCYY


*****************************************************************************************************************************
RECIPIENT NAME: XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    DOB: MM/DD/CCYY    SSN: 999-99-9999    REL: X

MEDICAID ID     LAST NAME            FIRST NAME         DOB                SSN
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX
XXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXX    XXXXXXXXXX         XXXXXXXXXXX

REASON: XXXXXXXXXXXXXXXXXXX
```

```
TOTAL NUMBER OF MATCHES ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB = 99,999,999,999
TOTAL NUMBER OF MULTIPLE MATCHES ON SSN                              = 99,999,999,999
TOTAL NUMBER OF MULTIPLE MATCHES ON LAST NAME, FIRST NAME, AND DOB   = 99,999,999,999
TOTAL NUMBER OF RECIPIENTS                                           = 99,999,999,999


                                        *** END OF REPORT ***
                                      *** NO DATA THIS RUN ***
```

7.133.3 TPL-Q012-T -- Southland Not Identified - Needs Research Pre Prod Report Field Descriptions

Field	Description	Length	Data Type
DOB	The Medicaid Recipient's Date of Birth.	10	Date (MM/DD/CCYY)
DOB:	The date of birth of the recipient on Southland's insurance policy.	10	Date (MM/DD/CCYY)
FIRST NAME	The Medicaid Recipient's First Name	15	Character
LAST NAME	The Medicaid Recipient's Last Name	20	Character
MEDICAID ID	The Medicaid ID assigned to the recipient.	12	Number (Integer)
REASON	The reason why the Southland recipient appears on the report.	50	Character
RECIPIENT NAME	Last Name and First Name of the Southland recipient.	36	Character
REL	The Southland recipient's relationship to the subscriber on Southland's insurance policy.	1	Character
SSN	The Medicaid Recipient's Social Security Number.	11	Character
SSN:	The recipient's Social Security Number on Southland's insurance policy.	11	Character
TOTAL NUMBER OF MATCHES ON FIRST 3 LETTERS OF THE FIRST NAME AND DOB	Total number of Southland recipients that matched on the first three letters of the first name and date of birth.	11	Number (Integer)
TOTAL NUMBER OF MULTIPLE MATCHES ON LAST NAME, FIRST NAME, AND DOB	Total number of Southland recipients that multiple matches on the last name, first name, and date of birth.	11	Number (Integer)

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Field	Description	Length	Data Type
TOTAL NUMBER OF MULTIPLE MATCHES ON SSN	Total number of Southland recipients that multiple matches on the social security number.	11	Number (Integer)
TOTAL RECIPIENTS	Total number of Southland recipients displayed on the report.	11	Number (Integer)

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7.134 TPL-Q013-P -- Southland Recipient Not Found Report

7.134.1 TPL-Q013-P -- Southland Recipient Not Found Report Narrative

This report provides the Agency with a listing of the recipients that were not found as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity.

7.134.2 TPL-Q013-P -- Southland Recipient Not Found Report Layout

```
Report  : TPL-Q013-P                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008                     MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0008Q                    SOUTHLAND RECIPIENT NOT FOUND PRODUCTION REPORT                      Page:    999,999
                                          REPORT PERIOD: MM/CCYY - MM/CCYY


RECIPIENT NAME                                                  SSN             DOB              REL
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X


TOTAL RECIPIENTS:   99,999,999,999


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.134.3 TPL-Q013-P -- Southland Recipient Not Found Report Field Descriptions

Field	Description	Length	Data Type
DOB	The date of birth of the recipient on Southland's insurance policy.	10	Date (MM/DD/CCYY)
RECIPIENT NAME	Last Name, First Name and Middle Initial of the Southland recipient.	39	Character
REL	The Southland recipient’s relationship to the subscriber on Southland's insurance policy.	1	Character
SSN	The recipient’s Social Security Number on Southland's insurance policy.	11	Character
TOTAL RECIPIENTS	Total number of Southland recipients that did not match.	11	Number (Integer)

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7.135 TPL-Q013-T -- Southland Recipient Not Found Pre Prod Report

7.135.1 TPL-Q013-T -- Southland Recipient Not Found Pre Prod Report Narrative

This pre production report provides the Agency with a listing of the recipients that were not found as a result of the data match with Southland Benefit Solutions, LLC to identify Medicaid recipients enrolled in their supplemental coverage plans - vision, dental, cancer, and hospital indemnity.

7.135.2 TPL-Q013-T -- Southland Recipient Not Found Pre Prod Report Layout

```
Report  : TPL-Q013-T                          ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJQ008T                      MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0008Q                    SOUTHLAND RECIPIENT NOT FOUND PRE PROD REPORT                          Page:    999,999
                                            REPORT PERIOD: MM/CCYY - MM/CCYY


RECIPIENT NAME                                                  SSN             DOB              REL
-------------------------------------------------------------------------------------------------------------------------------
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXXXXXX X 999-99-9999     MM/DD/CCYY        X


TOTAL RECIPIENTS:   99,999,999,999


                                                   *** END OF REPORT ***
                                                 *** NO DATA THIS RUN ***
```


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7.135.3 TPL-Q013-T -- Southland Recipient Not Found Pre Prod Report Field Descriptions

Field	Description	Length	Data Type
DOB	The date of birth of the recipient on Southland's insurance policy.	10	Date (MM/DD/CCYY)
RECIPIENT NAME	Last Name, First Name and Middle Initial of the Southland recipient.	39	Character
REL	The Southland recipient’s relationship to the subscriber on Southland's insurance policy.	1	Character
SSN	The recipient’s Social Security Number on Southland's insurance policy.	11	Character
TOTAL RECIPIENTS	Total number of Southland recipients that did not match.	11	Number (Integer)

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7.136 TPL-T098-E -- Third Party Contractor Active Error Pre-Prod Report

7.136.1 TPL-T098-E -- Third Party Contractor Active Error Pre-Prod Report Narrative

This pre-production report provides the Agency with a listing of the policies that were not added as a result of the match with the Third Party Contractor due to an error. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides the grand total.

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7.136.2 TPL-T098-E -- Third Party Contractor Active Records Error Pre-Prod Report Layout

```
Report  : TPL-T098-E                              ALABAMA MEDICAID AGENCY                                    Run Date: MM/DD/CCYY
Process : TPLJM019T                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          Run Time:   HH:MM:SS
Location: TPL0319O                THIRD PARTY CONTRACTOR ACTIVE RECORDS ERROR PRE-PROD RPT                       Page:    999,999
                                                   REPORT PERIOD - MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                 AID  RECIP   RECIP
RID          LAST               FIRST        CAT  STATUS  AGE
999999999999 XXXXXXXXX          XXXXXXXX     XX     X     999
                       NEW  SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE ADDED
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX   XX
*************************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX


                 SUMMARY INFORMATION
      GRAND TOTAL NOT ADDED = 999999999
  GRAND TOTAL AMOUNT BILLED = 9,999,999.99
     GRAND TOTAL AMOUNT DUE = 9,999,999.99

                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.136.3 TPL-T098-E -- Third Party Contractor Active Records Error Pre-ProdReport Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match.	17	Number (Decimal)

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Field	Description	Length	Data Type
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the Amount Billed for only those policies added.	17	Number (Decimal)
Grand Total Not Added	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	13	Number (Integer)
Not Added	The value assigned by the system that indicates the reason the policy was not added.	2	Number (Integer)
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	1	Character
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)

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7.137 TPL-T099-E -- Third Party Contractor Inactive Error Pre-Production Report

7.137.1 TPL-T099-E -- Third Party Contractor Inactive Error Pre-Production Report Narrative

This pre-production report provides the Agency with a listing of the policies that were not added as a result of the match with the Third Party Contractor due to an error. The report is sorted by Recipient ID with a break between the different IDs. A summary is provided on the last page of the report that provides the grand total.

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7.137.2 TPL-T099-E -- Third Party Contractor Inactive Records Error Pre-Prod Report Layout

```
REPORT  : TPL-T099-E                              ALABAMA MEDICAID AGENCY                                    RUN DATE: MM/DD/CCYY
PROCESS : TPLJM019T                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME:   HH:MM:SS
LOCATION: TPL0319O                THIRD PARTY CONTRACTOR ACTIVE RECORDS ERROR PRE-PROD RPT                       PAGE:    999,999
                                                     REPORT PERIOD - MM/CCYY

-------------------------------------------------------------------------------------------------------------------------------------
             RECIPIENT  NAME                 AID  RECIP   RECIP
RID          LAST               FIRST        CAT  STATUS  AGE
999999999999 XXXXXXXXX          XXXXXXXX     XX     X     999
                        NEW  SEGMENTS - NOT ADDED
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS       PAY  NOT
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M  CODE ADDED
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX   XX   XX
*************************************************************************************************************************************
                       EXISTING SEGMENTS
POLICY                                                                  POLICY      POLICY           COVERAGE
ADD          CARRIER        CARRIER       CONTRACT                      START       END         PLAN INDICATORS
DATE         CODE           NAME          NUMBER                        DATE        DATE        CODE IOSPWAX123HDE4M
MM/DD/CCYY   XXXXX          XXXXX         XXXXXXXXXXXXXXXXXXXXXXXXXXXXX MM/DD/CCYY  MM/DD/CCYY   XX  XXXXXXXXXXXXXXX


                 SUMMARY INFORMATION
      GRAND TOTAL NOT ADDED = 999999999
  GRAND TOTAL AMOUNT BILLED = 9,999,999.99
     GRAND TOTAL AMOUNT DUE = 9,999,999.99

                                                   *** END OF REPORT ***
                                                  *** NO DATA THIS RUN ***
```


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7.137.3 TPL-T099-E -- Third Party Contractor Inactive Records Error Pre-Prod Report Field Descriptions

Field	Description	Length	Data Type
Aid Cat	The recipient's most current aid category.	2	Character
Carrier Code	The carrier code from the HMS input file.	7	Character
Carrier Name	The name of the carrier.	45	Character
Contract Number	The policy number assigned by the carrier from the HMS input file.	30	Character
Coverage Indicators	Displays the value of each coverage indicator. The value and description for each indicator is as follows: I = Inpatient Coverage O = Outpatient Coverage S = Surgical Coverage P = Physician Coverage W = Well Child Coverage A = Ambulance Coverage X = Prescription Drug Coverage 1 = Extended Care Coverage 2 = Mental Health Coverage 3 = DME Coverage H = Home Health Coverage D = Dental Coverage E = Vision Coverage 4 = Medicare No Policy Coverage M = Maternity Coverage Each of the aforementioned coverage indicators from the HMS input file can have one of the following values: Value '0' = Coverage Type is Not Covered Value '1' = Coverage Type is Covered Value '4' = Only Crossover Claims are Covered Value '5' = Coverage Type is Covered; Cost Avoid	15	Character
Grand Total Amount Billed	This is the total dollar amount HMS receives for identifying new policies for all recipients in the HMS data match..	12	Number (Decimal)

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Field	Description	Length	Data Type
Grand Total Amount Due	This is the total amount due HMS for all records that were added to the database for all recipients in the HMS data match. This is calculated by adding the Amount Billed for only those policies added.	12	Number (Decimal)
Grand Total Not Added	This is the accumulated number of policies for all recipients that were received from HMS but not added to the database.	9	Number (Integer)
Not Added	The value assigned by the system that indicates the reason the policy was not added.	2	Number (Integer)
Pay Code	Represents the types of policies provided to the Medicaid Agency by HMS for a given Medicaid recipient and their associated costs. The cost for each type of policy provided by HMS is listed on a schedule mutually determined by HMS and the Medicaid Agency. The pay code is determined by the aid category the recipient has been assigned and the types of coverage the policy provides.	2	Character
Plan Code	The plan code from the HMS input file, which is used to update the policy type when adding a record.	2	Character
Policy Add Date	The date the policy was added.	10	Date (MM/DD/CCYY)
Policy End Date	The end date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Policy Start Date	The start date of the policy from the HMS input file.	10	Date (MM/DD/CCYY)
Recip Age	The age of the recipient. The system must calculate the age based on the recipient's date of birth.	3	Number (Integer)
Recip Status	The status of the recipient's aid category.	1	Character
Recipient Name	The recipient's first, middle, and last name.	36	Character
RID	The recipient's Medicaid identification number from the HMS input file.	12	Number (Integer)

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AMMIS TPL User Manual – Part 1

Date Modified: 07/13/2018

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36104

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301 Technacenter Drive
Montgomery, Alabama 36117

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1. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 Document Information Page

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Approved by:	
Approval Date:	12/12/2011 (HIPAA 5010 #4)

1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
11/09/2011	1.1		Application of EIP 5010 changes.	CO 8790 Expanded prescription number field from 7 to 12 digits. Case Tracking Claims Search Panel (6.35.2 and 6.35.3) CO 8484 Added a new drop down box titled HIPAA Version allowing the user to manually select and save which HIPAA format the insurance carrier will accept, 4010 or 5010. Other - Carrier Panel (6.103.2, 6.103.3) Added new step action tables (6.103.7, 6.103.8 and 6.103.9)
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05/03/2012	2.1		Application of CO_7490_	Updated sections 6.8.2, 6.8.3 for the TPL Base Information Panel.
07/10/2012	3.0		Application of CO 9805	Updated section 6.70 Search - Policy Number Panel Update section 6.96 Related Data Other Panel to reflect the addition of the Nasco Policy Prefixes panel

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Date	Document Version	Author	Reason for the Change	Changes (Section, Page(s) and Text Revised)
				Add section 6. 109 Nasco Policy Prefixes Panel.
10/08/2013	4.0		Application of ICD-10 project change orders	CO 10095: Update section 6.35 Case Tracking Claims Search panel. Updates include changes to the panel layout, field descripitons and field edit error messages. Update section 6.36 Case Tracking Search Results Panel. Update include changes to the panel layout and field descriptions. CO 10101: Update section 6.41 Case Tracking Offline Claims Panel. Updates include changes to the panel layout, field descriptions and field edit error messages.
10/27/2016	5.0		Application of CO 13778 and 12819	CO 13778 - Section 4.4 Changing Passwords – updated section with new process CO 12819: - Update 4.3.1 Logging onto the AMMIS Update 4.3.2 Logging off the AMMIS
12/07/2016	6.0		Application of CO 13461	CO 13461 6.8 TPL Base Information Panel – panel layout, field descriptions, field edit error messages and step action table (add) revised.
10/13/2017	7.0		Application of CO 14433	6.40 Case Tracking Lien Information Panel – update field edit error codes
12/20/2017	8.0		Application of CO 14580 and 14373	6.35 Case Tracking Claims Search Panel 6.92 Codes-Origin Panel – Update panel layout and field descriptions.
01/16/2018	9.0		Application of CO 14640	6.26 Case Tracking Search Panel – update panel layout and field description table
07/13/2018	10.0		Conversion of manual from HPE to DXC	

1.3 Related documentation

Document	Description	url
Global Glossary and Acronyms	This document provides the user with a listing of commonly used terms and acronyms related to the Title XIX program for Alabama.	https://pwb.alxix.slg.eds.com/alxix/help/20100825%20Combined%20Acronyms.htm

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2. TPL Introduction

2.1 TPL User Manual Overview

The Alabama Medicaid Management Information System (AMMIS) has several functional areas that perform specific operations for the system users. This user manual is designed to cover the information necessary to perform the tasks associated with the Third Party Liability (TPL) functional area.

This manual covers the following:

- TPL Overview
- TPL System Navigation
- System Wide Common Terminology and Layouts
- Provider Pages/Panels
- Provider Reports

2.2 TPL User Manual Objective

The objective of the AMMIS TPL User Manual is to provide system users with detailed descriptions of the online system, including pages/panels and report field descriptions, pages/panels functionality descriptions and graphical representations of pages/panels and report layouts.

This manual contains references to current AMMIS screens, when applicable. This information will be deleted after implementation training, and is identified in the narrative text in italics.

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3. Third Party Liability (TPL) Overview

3.1 Introduction to TPL

The TPL function provides capabilities to manage the private health, Medicare, and other third party resources of Medicaid recipients, and ensures that Medicaid is the payor of last resort. This function works with a combination of cost avoidance (claim denial) and cost recovery (post-payment billing to insurers and recoupments from providers). In addition, the TPL function supports the Health Insurance Premium Payment (HIPP) process that purchases health insurance for selected beneficiaries. To the maximum extent possible, the AMMIS system uses automated processes for cost avoidance. Cost recovery shall be utilized as a backup to the avoidance process.

All input and output transmissions and formats are Health Insurance Portability and Accountability Act (HIPAA) compliant. The information maintained by the AMMIS TPL function includes beneficiary TPL resource data, insurance company data, and post-payment recovery tracking data. TPL coverage type and threshold information are used by the Claims Processing function during claims adjudication.

The primary objectives of the AMMIS TPL function are to:

- Identify third party resources available to Medicaid recipients, which may include participation in HIPP.
- Avoid paying for claims with potential third party coverage.
- Recover funds from third parties when TPL resources are identified retroactively or for mandated "pay-and-chase" payments.
- Track casualty and/or estate related cases.
- Meet federal and State TPL reporting requirements.
- Pay the premiums for health insurance for recipients when it is deemed cost-effective to do so.

The Third Party Liability subsystem consists of five major processes:

- TPL Policy - maintain TPL policy information, through accepting adds, updates or deletes from various external entities.
- HIPP - maintain and process HIPP information and payments.
- Post Pay Billing and Recoupments - recover money on Medicaid paid claims where other entities are liable due to other insurance.
- Case Tracking - recover money on Medicaid paid claims where other entities are liable.
- TPL Reports - used in the maintenance of TPL information.

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4. TPL System Navigation

4.1 Overview

The AMMIS is designed according to a set of development standards. This section is designed to introduce users to standard system navigation features within AMMIS.

4.2 System Security

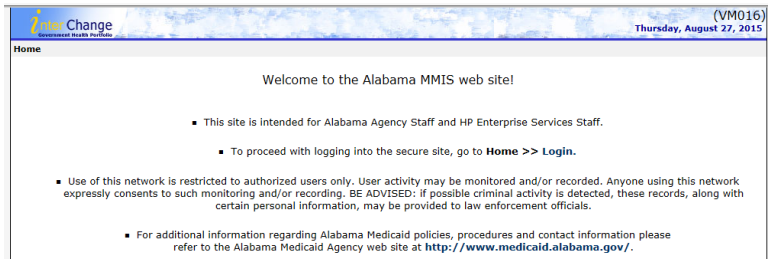
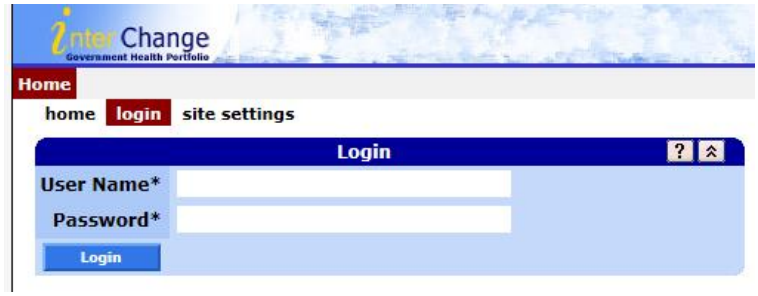
System security is handled by your system administrator. For all other security concerns with operating the system, refer to your department's business rules and practices.

4.3 Logging In/Logging Out

Users must successfully log in to the AMMIS in order to utilize the services available within the secure portal.

4.3.1 Logging into the AMMIS

Follow the steps below to log in to the website:

Step	Action	Response
1	Click **Internet Explorer** or **Netscape Communicator** browser located on your workstation.	Internet Explorer or Netscape Communicator launches.
2	Enter https://pro.alxix.slg.eds.com/alabama/default.aspx and press **Enter** key on your keyboard.	Security Alert message displays.
3	AMMIS Home page displays.  	AMMIS Authentication Home page displays.
4	Click Home -> Login  Note: All field edits are available on iTRACE for login panel.	
5	Enter **User Name** and **Password**. Click **OK**.	

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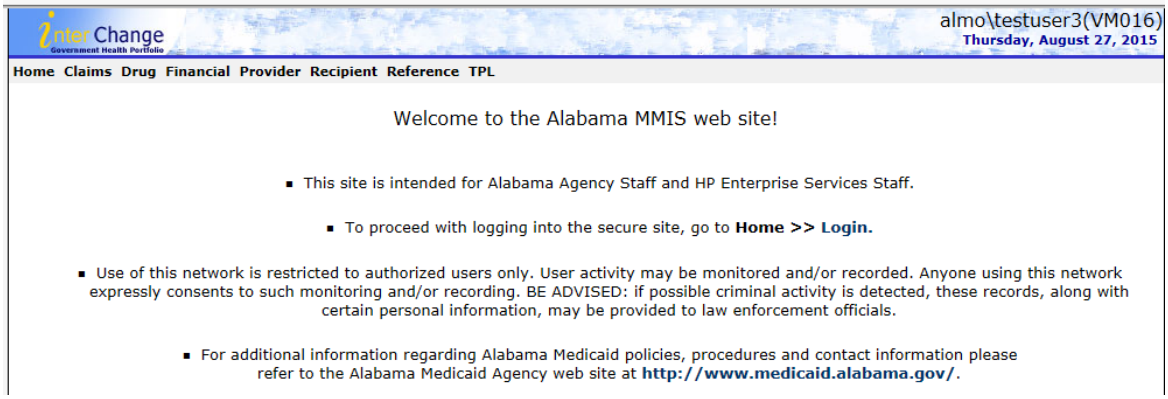
Step	Action	Response
		

4.3.2 Logging off the AMMIS

Click the Exit button on your internet browser or Click Home -> LogOff to log off the AMMIS.

4.4 Changing Passwords

The Change Password panel allows users to change their account password.

Navigation Path: [Home] – [Change Password]

NOTE:

Each field which contains an asterisk represents a required field. Therefore, the corresponding panel is not considered complete until those fields have been completed with the appropriate data.

Follow the steps below to change your password:

Step	Action	Response
1	Enter Current password.	
2	Press **Tab**.	User is taken to the New password field.
3	Enter New password.	

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Step	Action	Response
4	Press **Tab**.	User is taken to the Confirm password field.
5	Confirm password by entering it again.	
6	Press **Change Password** button.	Password successfully changed. Note: If a user enters an invalid password the system displays an error message. HPE employees with password problems will need to contact the LAN team. Agency employees with password problems will need to contact theAssistant MMIS Coordinator.

4.5 Screen Display Features

The AMMIS is designed to display within Web browser pages that fit on a personal computer (PC) desktop with a screen resolution of 1024 x 768 pixels. However, in order to fit large system objects such as panels, pages, reports, and letters into one screen print, the user has the option of resetting the text size of the Web browser so that the selected area of the system fits into a screen print.

In addition, there may be some Web browser pages that use a lower pixel configuration and cause a horizontal scroll bar to appear at the bottom of the page for viewing the left side and the right side of the information displayed. In general, pages should only require vertical scrolling.

4.5.1 To Set System Text Size

To set system text size, perform the following steps:

Step	Action	Response
1	Log into the AMMIS.	Home page displays.
2	Select View.	View menu displays.
3	Point to Text Size and click Smaller.	Default text size is set to medium. After the user selects smaller, the system objects appear smaller.

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5. System Wide Common Terminology and Layouts

The following section identifies common system terminology and features and, where applicable, an associated screen capture or design layout. This is not an all-inclusive list of common system terms and layouts; however, it is a basic foundation for the beginning user to view and understand prior to navigating the system. These terms are used by technical team members, training specialists, and help desk staff when discussing or, more importantly, documenting aspects of the system.

For information about system wide objects, instead of clicking a subsystem link within the technical design page, the user clicks the System Wide link to open documentation of system objects which are common system wide within the application.

Below is a partial list of common terms described within this document:

- Page
- Page Header
- Page Footer
- Sub Menu
- Shortcut Keys (ctrl + alt + letter)
- Main Menu bar
- Panel
- Advanced Search
- Mini Search panel
- Hot Link
- Information panel
- Navigation panel
- Task List panel
- Title Bar Icons
- Help Functionality

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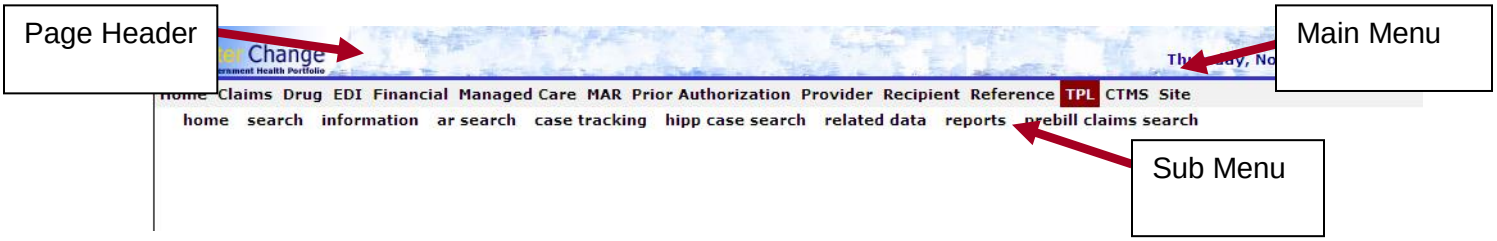
5.1 Page Layout

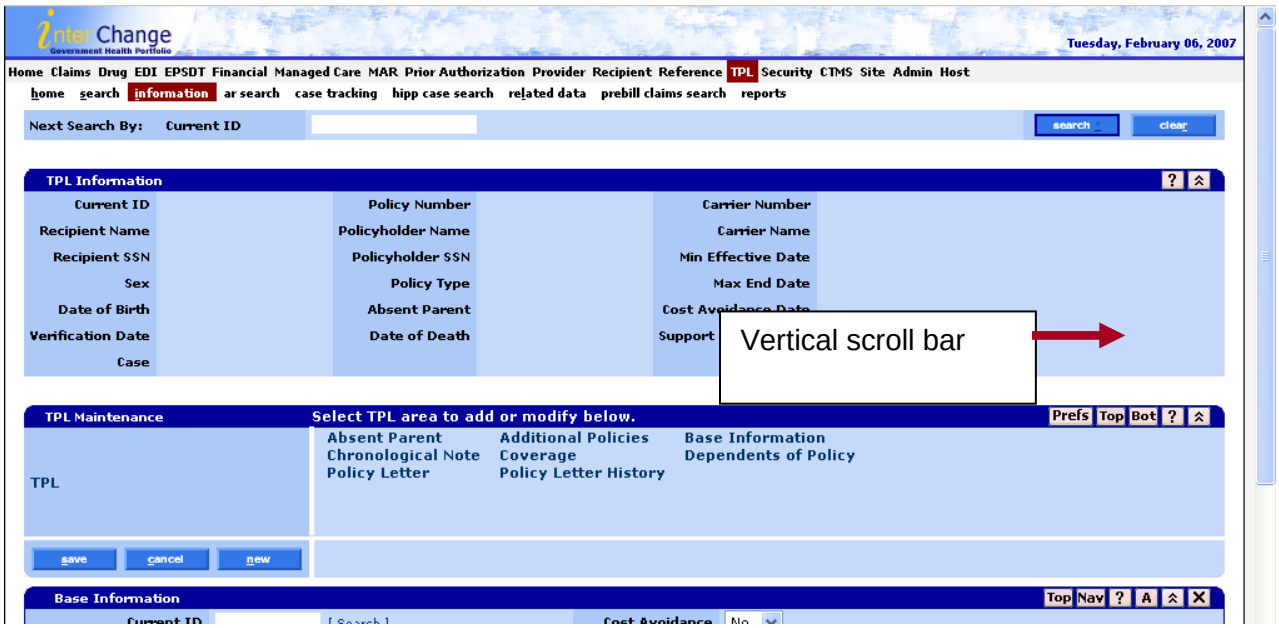
A page is defined as the entire screen that appears in the Web browser. The page contains a page header area with the day and date displayed, a Main Menu bar, a Sub Menu and any associated panels. The bottom of the page contains the Page Footer with the HP Enterprise Services copyright text displayed.

The Main Menu bar contains a horizontal set of links which display pull-down menus. Each pull down menu opens an associated page within the system.

Beneath the Main Menu bar is the Sub Menu of horizontal links that opens an associated page within the system. The Sub Menu links appear in the same order as the Main Menu pull down options, and the Sub Menu links are spelled the same as the Main Menu pull down options.



In general, when navigating a page, the vertical scroll bar should be the only scroll bar needed to view panels stacked in a vertical manner.



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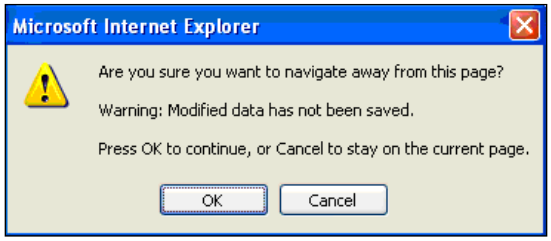
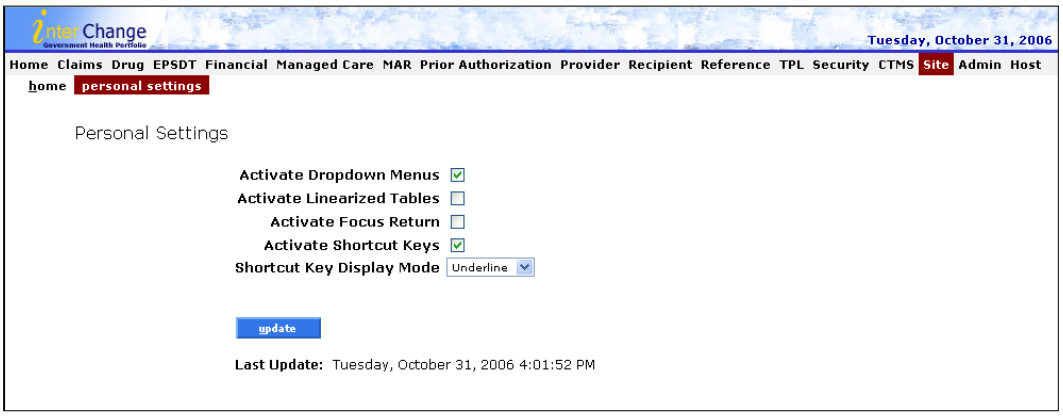
If a user attempts to add, update or delete information within the page prior to navigating away from the page, the system prompts the user with a pop-up window message. When the system generates the message the detail panels are locked open, and navigating away from the page is not permitted until changes are either correctly saved or cancelled.



5.2 Shortcut Keys

If the user activates the shortcut keys function, the Sub Menu links can be used in combination with the (Ctrl +Alt + shortcut key) to quickly open the associated page.

To activate the shortcut key, click on the Site link, select Personal Settings, check “Activate Shortcut Keys” and click the blue “Update” button.



To know which letter to use in combination with the (Ctrl + Alt) shortcut keys, the user must look at the Sub Menu name. Within the name, the letter that has a horizontal bar below it is the shortcut key letter.

Within the TPL Sub Menu, the user can use the shortcut keys to quickly navigate from the TPL Search panel to the Related Data panel by using the following shortcut key combination: (Ctrl + Alt + L) since the letter “L” is found within the horizontal bars on the Sub Menu related data link.

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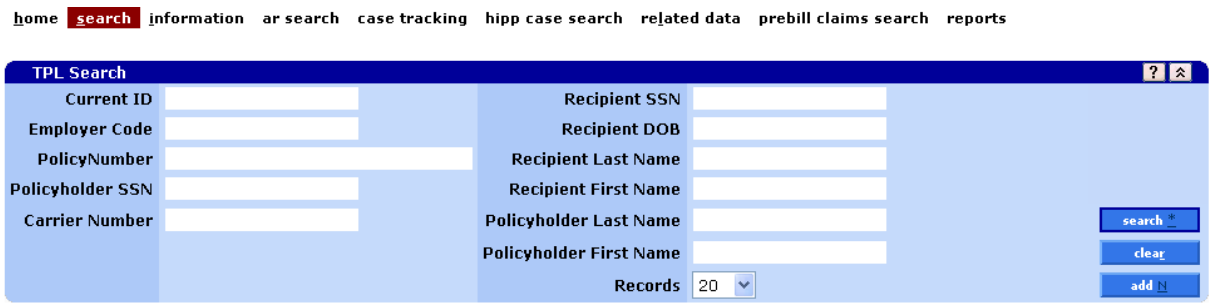
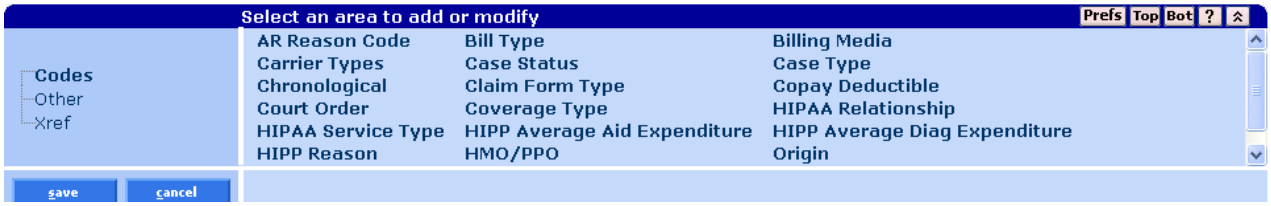


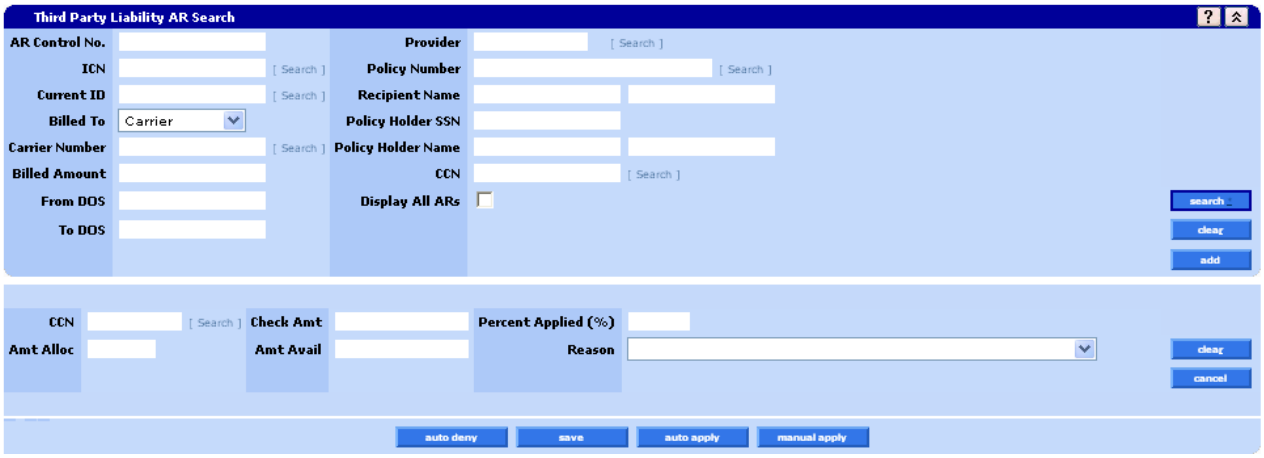


5.3 Search Options

There are several search options available within the AMMIS.

5.3.1 Search Panels

The AMMIS contains more than one type of search panel: Search and Advanced Search. Some subsystems such as the TPL subsystem contain a search panel without an advanced search button included on the panel, such as the image below.



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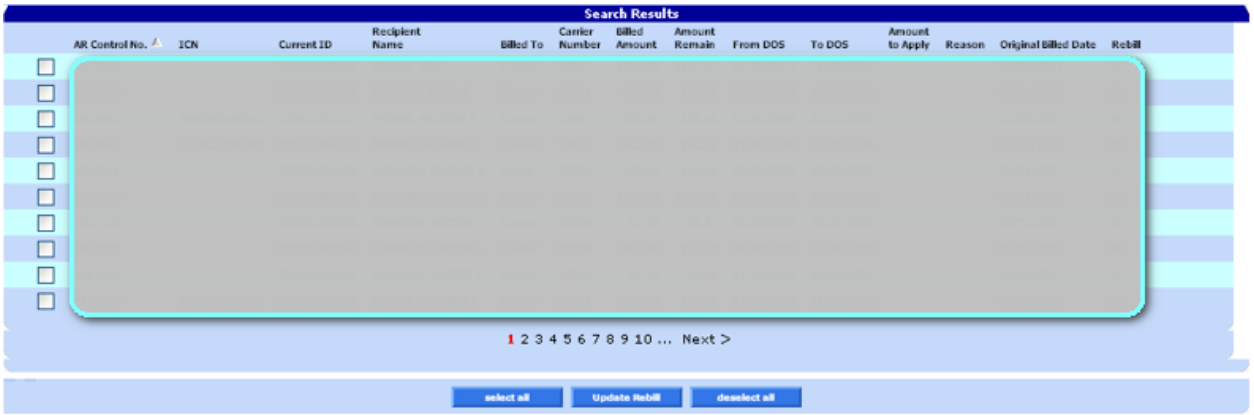
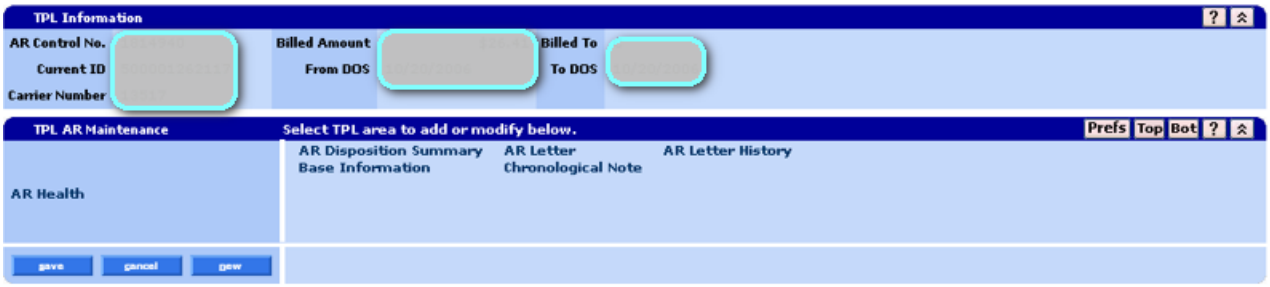
5.3.2 Search Results

Search results can be sorted in ascending or descending order by clicking the column name in the Search Results panel. All search results are resorted, not just the search results displayed on the current search result panel.



If the user clicks once on a search result row, the associated TPL Information panel opens. In the following figure, the user clicked the first row of the TPL AR Search Results panel and detailed information displayed at the bottom of the panel.



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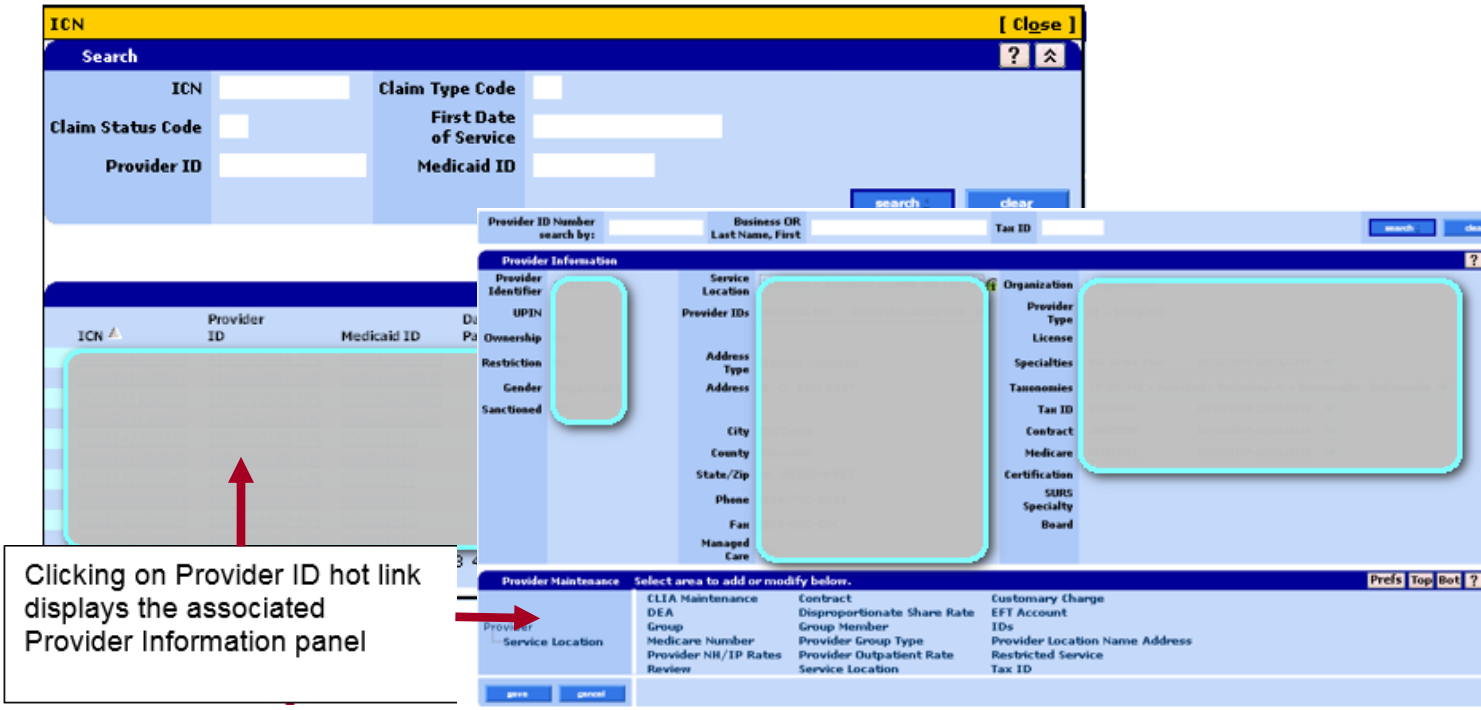
5.3.3 Hot Links

Within certain Search panels, the user can also click hot links to see additional information. If the fields in a column are underlined, there is a hot link available.



5.3.4 Mini Search

After the user has viewed at least one search result in an information panel, another search can be completed by using the primary search fields within the Mini Search panel located above the information panel containing the search result. Mini Search panels contain one or two primary search fields related to the business process.

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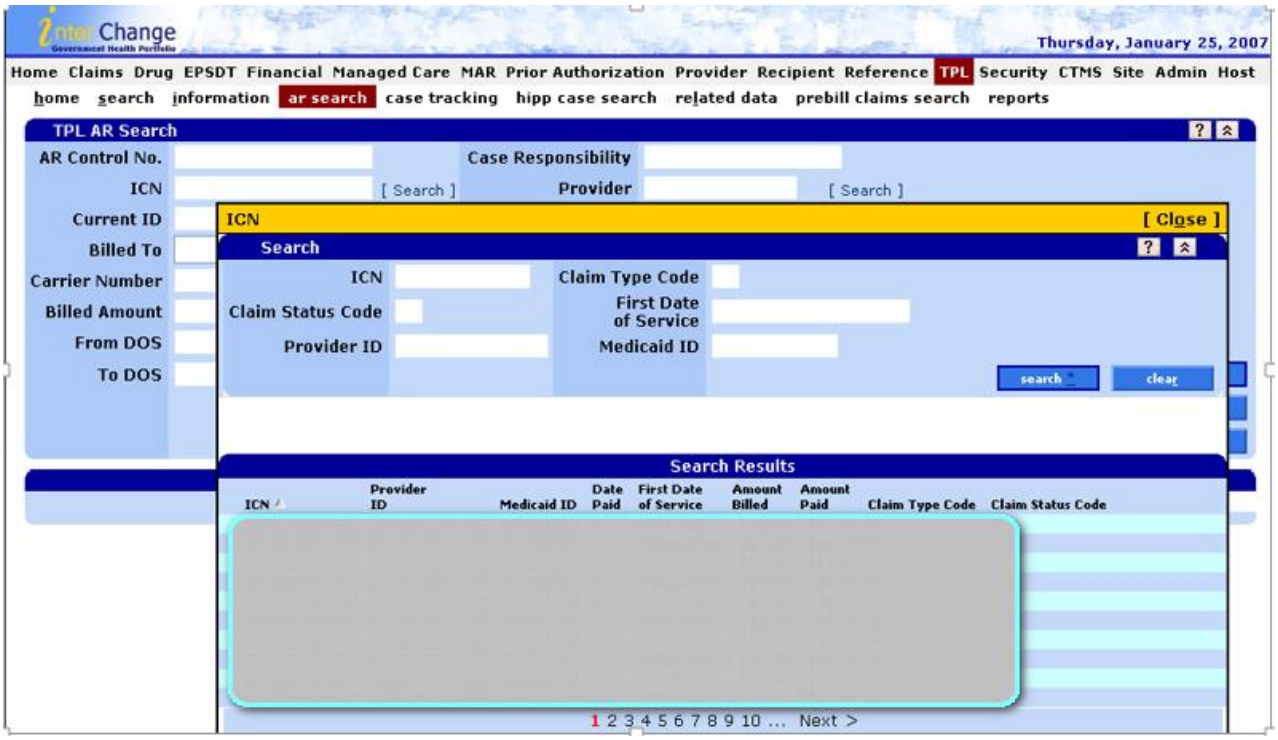
5.3.5 Pop Up Search

A Pop Up Search allows the user to search for field data without leaving the page. By clicking on the (Search) link, the user accesses the search panel that is associated with that particular field.



5.4 Panel Layout

A panel is defined as a portion of a page that performs a well-defined unit of functionality. Some panels always appear on a page, while others only appear when invoked by the user.

5.4.1 Panel Type and Functions

The system contains various panel types with specific functions for each panel type. Some panels have common icons while other panels have icons specific to their functions. Listed below are icons that can be found on one or more types of panels:

Name	Icon	Description
Add Button	add	Inserts a new data record.
Delete Button	delete	Deletes a selected data record.
Cancel Button	cancel	Cancels all changes applied to all panels on the page. Can be found on the navigation panel.
Save Button	save	Saves all changes to all panels on the page. If validation errors occur, an error message displays in the Task List panel. Can be found on the navigation panel.

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Name	Icon	Description
Maintain Button	maintain	Allows the user to manually request a letter.
Preferences Button	Prefs	Allows user to place a checkmark next to each navigation panel they would like to see whenever they browse the TPL subsystem. To hide the boxes, click the checkbox a second time. Can be found only on the Navigation panel.
Top Button	Top	Allows user to jump to the top of the page.
Bottom Button	Bot	Allows user to jump to the bottom of the page.
Help Button	?	Opens a window that displays the panel help page.
Maximize Button		Expands a panel to display all of its content.
Minimize Button		Collapses a panel.
Navigation Button	Nav	Allows a user to jump to the Navigation panel.
Audit History Button	A	Opens the Audit History Panel for a specific panel.
Close Button	X	Closes a panel.
Green Information Button		Opens information file for the associated field.

Among the panel types are the following:

Maintenance panel

Task List panel

Maintenance Item Panel

Audit panel

5.4.2 Maintenance Panel

A maintenance panel is a special control panel that uses links to open or close panels on a Web page. By clicking on a Maintenance Group Link, the associated Maintenance Item panel is displayed. Changes to Maintenance Items displayed on the page are saved or cancelled by clicking the Save or Cancel buttons on the Maintenance panel.

The Maintenance panel is used to navigate within a page, never to leave the page. The following image demonstrates Maintenance Group Links (TPL Case Tracking) and the associated Maintenance Item links.

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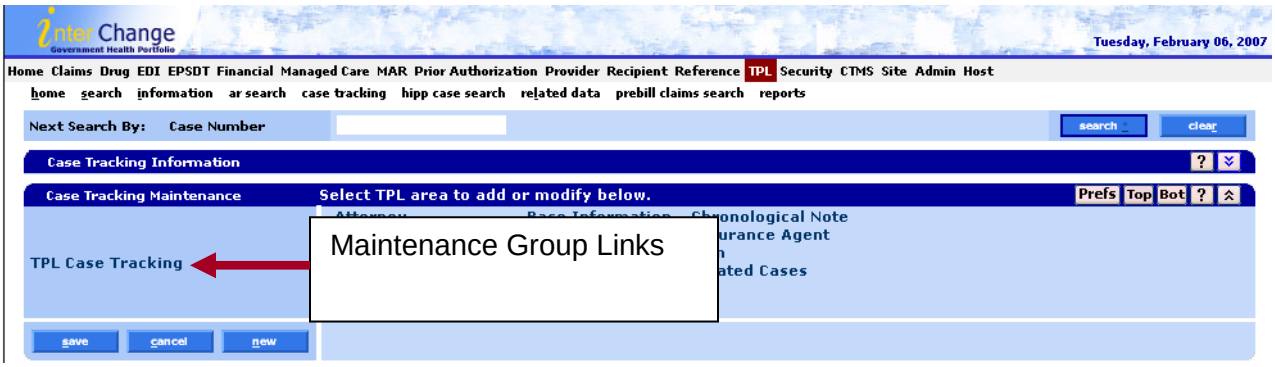
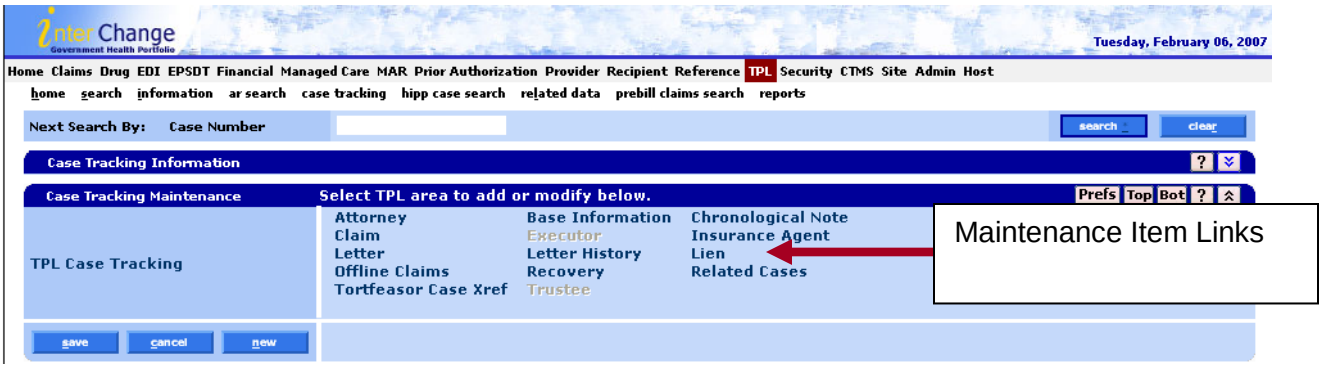
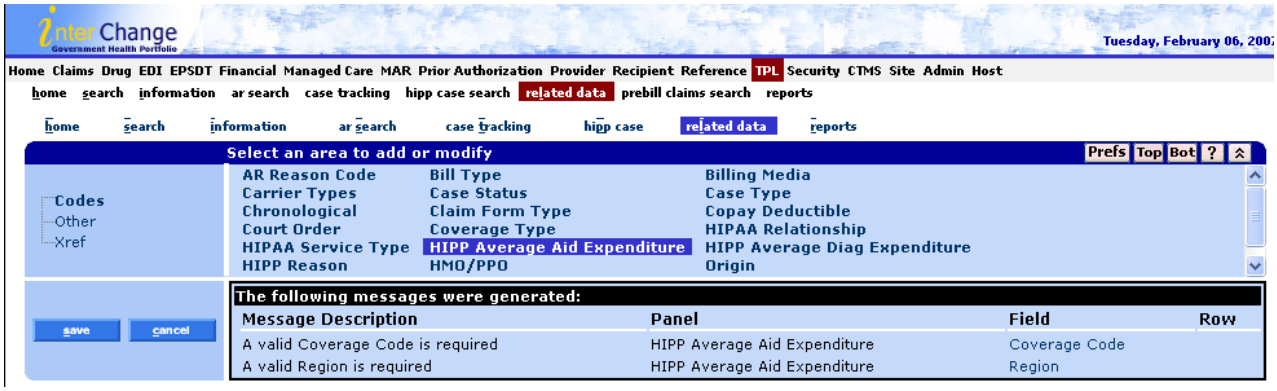




By clicking on a Maintenance Item Link (such as Lien), the associated panel opens.

5.4.3 Task List Panel

Task List panels appear within navigation panels and provide messages to the user regarding whether the data was successfully saved, if errors occurred to prevent the data from being successfully saved, or warning messages which may or may not include a radio button selection for the user to activate prior to completing the task.



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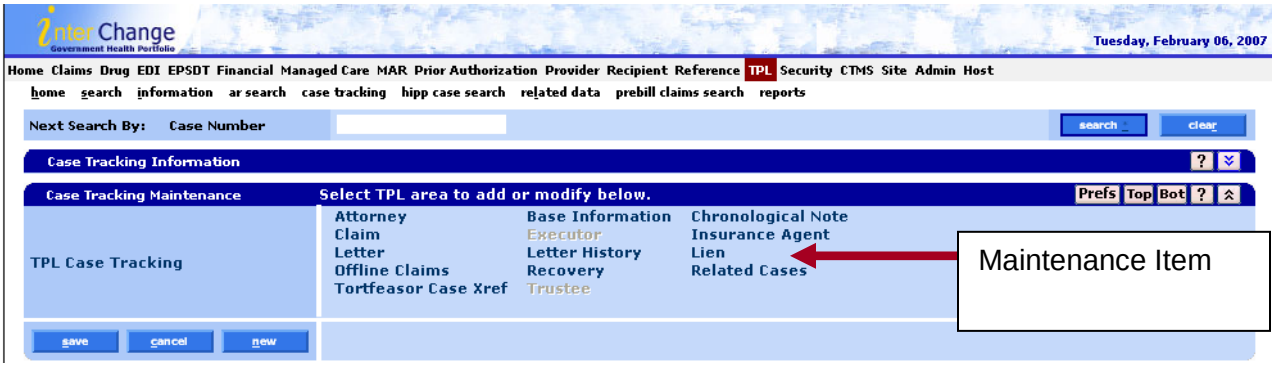
The task list contains both the name of the panel where the error occurred, and the field name or row in order to help users quickly identify key areas to correct prior to attempting another save action.

Warning messages provide users with a warning about the data they are trying to update, delete, add or save. For example, if the user attempts to add a duplicate record, the system generates a warning message.

An error message can also contain additional information which is accessed by clicking on a square node icon in the lower left side of the Task List panel.

5.4.4 Maintenance Item Panel

A Maintenance Item panel is opened by clicking a link on the Maintenance panel. Maintenance Items allow detail data to be viewed and updated. Usually a Maintenance Item has a list of data records and a panel to perform data updates. Click the Add button to enter a new data record. Or click a data record from the list to perform field updates or to delete the record. Once selected, a data record is deleted by clicking the Delete button. All adds, deletes and updates must be followed by a Save before the transaction is permanent.



5.4.5 Audit Panel

Audit panels display data change history for a given Navigator Item panel. Every insert, update or delete that is performed (on an updatable panel) in the system causes a "before" image of the data to be saved to the audit table. Users can then use the audit panel to display this information.

Audit panels are opened by clicking the button in the Navigator Item panel.

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5.5 Help Functionality

The AMMIS contains two paths to locate help: Question Mark Icon and Field Level Help.

5.5.1 Question Mark Icon ?

The Question Mark icon is used to access page/panel level help. Click the Question Mark icon to launch a separate Internet browser that contains information on the page/panel.

5.5.1.1 Panel Help Feature - Question Mark Function Description

Upon accessing the **Panel Help** function a description of the panel is displayed within the window:

Case Tracking Attorney

Use the Case Tracking Attorney panel to add/delete attorney information of the accident/injury case.

Navigation Path: [TPL] - [Case Tracking Search] - [Enter Search Criteria - Click Search] - [Select Row From Search Results] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Case Tracking Attorney]

Tables Used: T_ATTORNEY_XREF, T_ATTORNEY, T_CASUALTY_CASE

Audited: This panel is audited.

Technical Name:
TPL.CaseTrackingAttorney.ascx

Panel Name:
Case Tracking Attorney

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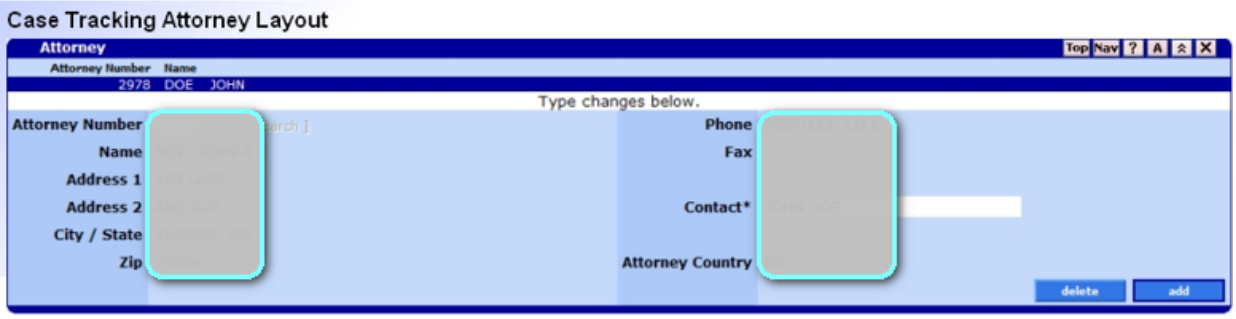
The second item displayed is the **Panel Layout**:



The third item displayed is the **Field Description** information related to the panel:

Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Add new record.	Button	N/A	0
Delete	Delete the record.	Button	N/A	0
Address 1	Address of the attorney.	Field	Character	30
Address 2	Address 2 of the attorney.	Field	Character	30
Attorney Country	Country of the attorney.	Field	Character	2
Attorney Number (List)	Unique system assigned number for each attorney.	Field	Character	8
Attorney Number (Panel)	Unique system assigned number for each attorney.	Field	Character	8
City / State	City and state of the attorney.	Field	Character	20
Contact	Attorney contact person name.	Field	Character	40
Fax	Fax machine number of the attorney.	Field	Character	10
Name (List)	Member's attorney's last name, first name and middle initial.	Field	Character	29
Name (Panel)	Member attorney's last name, first name and middle initial.	Field	Character	29
Phone	Phone number of the attorney.	Field	Character	10
Zip	The first 5 digits and the last 4 digits of the zip code for the attorney.	Field	Character	9

The fourth item displayed is the **Field Edit** information related to the panel. This portion of documentation provides the field name, the error messages associated to the field(s) and a brief explanation of how to correct the data in the field in order to bypass the error message displayed in the user interface.

Field Edits

Field	Field Type	Error Code	Error Message	To Correct
Attorney Number (List)	Field	1	A valid Attorney Number is required.	Enter or select a valid Attorney Number.
	Field	2	This Attorney is already in the list.	Enter or select a different Attorney Number.
Contact	Field	1	Contact is required.	Enter a contact name.

The information available via the Question Mark icon is virtually the same panel information accessible in iTRACE. For example, the bottom of the page contains data such as, Requirements, Test Cases, Change Orders/Defects and any Associated documentation that relates to a panel.

To close out of the Help panel, click the in the browser title bar.

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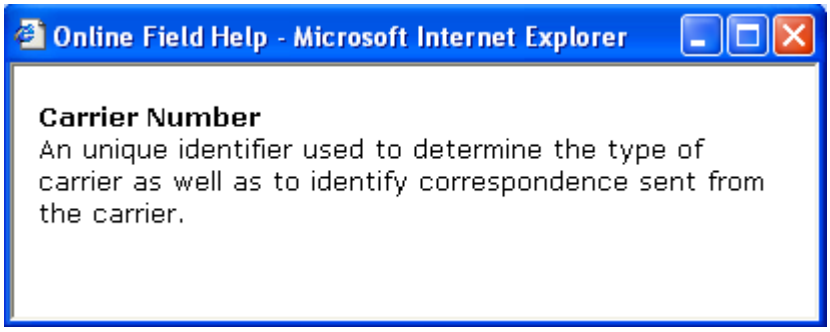
5.5.2 Field Level Help

Field Level Help is used to access field definitions related to a specific field selected. Click the Field Name to launch a pop-up window that contains information on the field selected.

5.5.2.1 Field Level Help Description

When hovering the cursor over a field name, such as **Carrier Number**, a question mark appears as part of the cursor .

Click once on the text area of the field and a popup window appears with a description of the field, such as the one provided below:



To close out of the Field Level Help window, click the in the Online Field Help title bar.

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6. TPL Pages/Panels

This section gives a brief description of each page/panel, shows a sample, and describes all associated page/panel fields and field edits.

The page/panels Field Description table is sorted in alphabetical order.

Each page/panel covers the following:

Page/Panel Narrative

Page/Panel Layout

Page/Panel Field Descriptions

Page/Panel Field Edit Error Code Tables

Page/Panel Extra Features

Page/Panel Accessibility

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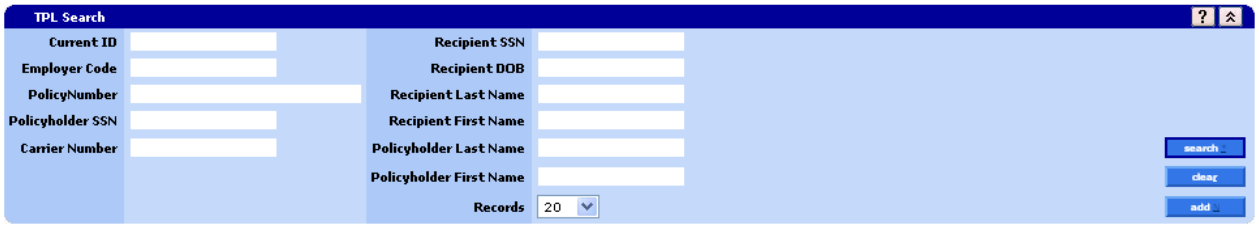
6.1 TPL Search Panel Overview

6.1.1 TPL Search Panel Narrative

The TPL Policy Search panel is used to access a client's TPL records. The user can inquire about clients with TPL. On the TPL Search panel, different combinations can be used to inquire on the client's TPL record. Once the search criterion has been entered and the search is activated by clicking on the Search button, the data is displayed in the search results section of the panel. This panel is inquiry only.

Navigation Path: [TPL] – [Search]

6.1.2 TPL Search Panel Layout



6.1.3 TPL Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the TPL Search panel.	Button	N/A	0
Carrier Number	A unique user-defined carrier identification number used on all panels and reports.	Field	Character	7
Clear	Clears the fields in the search fields.	Button	N/A	0
Current ID	Recipient's Medicaid identification number.	Field	Character	12
Employer Code	Employer's identification number.	Field	Character	7
Policyholder First Name	The first name of the holder.	Field	Character	13
Policyholder Last Name	The last name of the holder.	Field	Character	15
Policyholder SSN	The Social Security Number of the recipient.	Field	Number (Integer)	9
Policy Number	Policy number for this insurance policy.	Field	Character	30
Recipient DOB	The date of birth of a recipient.	Field	Date (MM/DD/CCYY)	8
Recipient First Name	The first name of a recipient.	Field	Character	13

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Field	Description	Field Type	Data Type	Length
Recipient Last Name	The last name of a recipient.	Field	Character	15
Recipient SSN	The Social Security Number for a recipient.	Field	Number (Integer)	9
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Initiates a search based on the criteria entered.	Button	N/A	0

6.1.4 TPL Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	91088	Current ID Not On File.	Verify entry - If correct then recipient is not in system.
Policyholder Last Name	Field	7092	Last name is required when first name is keyed.	Enter last name.
Recipient Last Name	Field	7092	Last name is required when first name is keyed.	Enter the policyholder's last name.
Search	Button	1	Please enter at least one of the following fields Current ID, Employer Code, Policy Number, Policyholder SSN, Carrier Number, Recipient SSN, Recipient Last Name, Policyholder Last Name.	Enter a value in one of the search fields.

6.1.5 TPL Search Panel Extra Features

At least one of the following fields must be entered to search: Current ID, Policy Number, Policyholder SSN, Carrier Number, Recipient SSN, Recipient Last Name, Policyholder Last Name.

If one of the following optional fields is entered, it is required to have at least one of the following fields entered with it: Recipient DOB, Recipient First Name, Policyholder First name. That is, if the recipient's first name is entered, it is required to have the last name also.

Linking Recipient IDs

If the user enters a Current ID, the panel determines if the ID entered is active. If not, the panel will retrieve and display the records based on the active ID.

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6.1.6 TPL Search Panel Accessibility

6.1.6.1 To Access the TPL Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.

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6.2 TPL Search Results Panel Overview

6.2.1 TPL Search Results Panel Narrative

The Alabama Medicaid Agency (Agency) and HP Enterprise Services (HPES) use the TPL Search Results panel to access a recipient's TPL records. This panel is display only.

Navigation Path: [TPL] – [Search] - [(Enter search criteria and click on Search)]

6.2.2 TPL Search Results Panel Layout

6.2.3 TPL Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Name	The business name of an insurance carrier.	Listview	Character	45
Carrier Number	A unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	Listview	Number (Integer)	7
Current ID	Unique identifier for the recipient.	Listview	Number (Integer)	12
Employer Code	Employer's identification number.	Field	Character	7
Group Policy Number	Policy group number. If present, gives the group number of the policy.	Listview	Character	30
Max End Date	The effective ending date of this coverage code.	Listview	Date (MM/DD/CCYY)	8
Min Effective Date	The effective begin date of this coverage code.	Listview	Date (MM/DD/CCYY)	8
Policy Number	Policy number for this insurance policy.	Listview	Character	30
Policy Type	This code identifies the type of insurance policy that the recipient is covered under.	Listview	Number (Integer)	1
Policyholder Name	The name of the policyholder.	Listview	Character	31

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Field	Description	Field Type	Data Type	Length
Policyholder SSN	The Social Security Number of the policyholder.	Field	Number (Integer)	9
Recip HIPP	Indicates whether the Recipient is enrolled in the Health Insurance Premium Payment Program (HIPP). Valid values are "Yes" and "No".	Listview	Character	3
Recipient DOB	The date of birth for a recipient.	Listview	Date (MM/DD/CCYY)	8
Recipient Name	The name of a recipient.	Listview	Character	31
Recipient SSN	The Social Security Number for a recipient.	Listview	Number (Integer)	9

6.2.4 TPL Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.2.5 TPL Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.2.6 TPL Search Results Panel Accessibility

6.2.6.1 To Access the TPL Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter **Search** criteria. Note: User must enter at least one search field to initiate search function.	
4	Click **Search**.	Results of search displays. Note: If searching by Recipient last name, Recipient first name, Policyholder Last Name or Policyholder First Name there may be multiple results.
5	Select row to view details.	TPL Information and Maintenance panels display.

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6.3 TPL Mini Search Panel Overview

6.3.1 TPL Mini Search Panel Narrative

The TPL Mini Search panel allows the user to search by Recipient ID. This panel is inquiry only.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [Search] OR [TPL - Information] - [Search]

6.3.2 TPL Mini Search Panel Layout

6.3.3 TPL Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears the value in Current identification number.	Button	N/A	0
Search	Initiates the Search by Current identification number.	Button	N/A	0
Current ID	The Recipient Medicaid identification number.	Field	Character	12

6.3.4 TPL Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	1	Current ID Not on File.	Enter a valid Current ID.
	Button	2	Please enter at least one of the following fields Current ID, Employer Code, Policy Number, Policyholder SSN, Carrier Number, Recipient SSN, Recipient Last Name, Policyholder Last Name.	Enter a valid Current ID, Employer Code, Policy Number, Policyholder SSN, Carrier Number, Recipient SSN, Recipient Last Name, or Policyholder Last Name.

6.3.5 TPL Mini Search Panel Extra Features

Based upon the number of records identified for the recipient, the next panel displayed is the TPL Information panel for a single record identified, or the TPL Search panel for multiple records. This allows the user to then select the specific TPL Policy to access.

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Linking Recipient IDs

If the user enters a Current ID, the panel determines if the ID entered is active. If not, the panel will retrieve and display the records based on the active ID.

6.3.6 TPL Mini Search Panel Accessibility

6.3.6.1 To Access the TPL Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Mini-Search panel display.

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6.4 TPL Information Panel Overview

6.4.1 TPL Information Panel Narrative

The Agency uses the TPL Information panel to view health coverage programs information and relative Medicare information that is populated from the eligibility table. This panel is display only.

Navigation Path: [TPL] – [Search] - (Select row from search results) OR
[TPL] - [Information]

6.4.2 TPL Information Panel Layout

6.4.3 TPL Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Absent Parent	Indicator of Absent Parent.	Label	Character	20
Carrier Name	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	Label	Character	45
Carrier Number	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	Label	Character	7
Case	Number used to identify a group of recipients who are in a case.	Label	Character	10
Cost Avoidance Date	The date the cost avoidance indicator was last updated.	Label	Date (MM/DD/CCYY)	8
Current ID	Unique identifier for the recipient.	Label	Number (Integer)	12
Date of Birth	The date of birth for the recipient.	Label	Date (MM/DD/CCYY)	8
Date of Death	The date of death for the recipient.	Label	Date (MM/DD/CCYY)	8
Max End Date	The effective ending date of this coverage code.	Label	Date (MM/DD/CCYY)	8
Min Effective Date	The effective begin date of this coverage code.	Label	Date (MM/DD/CCYY)	8
Policy Number	Policy number for this TPL policy.	Label	Character	30

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Field	Description	Field Type	Data Type	Length
Policy Type	This code identifies the type of insurance policy that the recipient is covered under.	Label	Character	1
Policyholder Name	The Policy holder's name.	Label	Character	30
Policyholder SSN	The Policy holder's Social Security Number.	Label	Number (Integer)	9
Recipient Name	The Recipient's name.	Label	Character	30
Recipient SSN	The Recipient's Social Security Number.	Label	Number (Integer)	9
Sex	Identifies the recipient's gender. Valid values include: F = Female M = Male	Label	Character	1
Support Enforcement	The indicator for support of enforcement.	Label	Character	1
Verification Date	The date the suspect code was last updated.	Label	Date (MM/DD/CCYY)	8

6.4.4 TPL Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.4.5 TPL Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.4.6 TPL Information Panel Accessibility

6.4.6.1 To Access the TPL Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information panel displays.

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6.5 TPL Maintenance Panel Overview

6.5.1 TPL Maintenance Panel Narrative

The TPL Maintenance panel contains links to open other panels in the TPL Information panel.

This panel is inquiry only.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] OR
[TPL - Information]

6.5.2 TPL Maintenance Panel Layout

6.5.3 TPL Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Absent Parent	Link to the Absent Parent panel.	Hyperlink	N/A	0
Additional Policies	Link to the Additional Policies panel.	Hyperlink	N/A	0
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Cancels any change made before they are saved.	Button	N/A	0
Chronological Note	Link to the Chronological Note panel.	Hyperlink	N/A	0
Coverage	Link to the Coverage panel.	Hyperlink	N/A	0
Dependents of Policy	Link to the Dependents of Policy panel.	Hyperlink	N/A	0
New	Create a new, empty base record.	Button	N/A	0
Policy Letter	Link to the Policy Letter panel.	Hyperlink	N/A	0
Policy Letter History	Link to the Policy Letter History panel.	Hyperlink	N/A	0
Save	Saves any updates.	Hyperlink	N/A	0

6.5.4 TPL Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.5.5 TPL Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.5.6 TPL Maintenance Panel Accessibility

6.5.6.1 To Access the TPL Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Maintenance panel displays.

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6.6 TPL Absent Parent Panel Overview

6.6.1 TPL Absent Parent Panel Narrative

The TPL Absent Parent panel lists the absent parent information for the TPL resource. The information is display only and cannot be modified on this panel.

This panel is display only.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [TPL Maintenance] - [Absent Parent] - OR - [TPL - Information] - [TPL Maintenance] - [Absent Parent]

6.6.2 TPL Absent Parent Panel Layout

6.6.3 TPL Absent Parent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Absent Parent Address 1	The absent parent's address line 1.	Field	Character	55
Absent Parent First Name	The absent parent's first name.	Field	Character	13
Absent Parent ID	The absent parent's identification number.	Field	Character	7
Absent Parent Last Name	The absent parent's last name.	Field	Character	15

6.6.4 TPL Absent Parent Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Absent Parent First Name (Panel)	Field	1	First Name is required.	Enter a first name.
Absent Parent Last Name (Panel)	Field	1	Last Name is required.	Enter a last name.

6.6.5 TPL Absent Parent Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.6.6 TPL Absent Parent Panel Accessibility

6.6.6.1 To Access the TPL Absent Parent Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Absent Parent.	Absent Parent panel displays.

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6.7 TPL Additional Policies Panel Overview

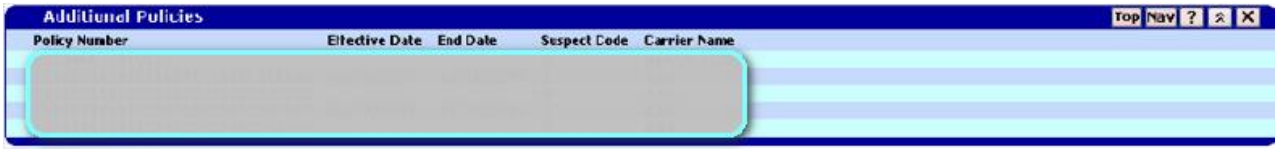
6.7.1 TPL Additional Policies Panel Narrative

The TPL Additional Policies panel contains information about TPL resource. A TPL resource is any entity other than Medicaid that could be responsible for payment of medical benefits for a Medicaid recipient. .

This panel is display only.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [TPL Maintenance] - [Additional Policies] - OR - [TPL - Information] - [TPL Maintenance] - [Additional Policies]

6.7.2 TPL Additional Policies Panel Layout



6.7.3 TPL Additional Policies Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Name	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	Label	Character	45
Effective Date	The effective begin date of this coverage code.	Label	Date (MM/DD/CCYY)	8
End Date	The effective ending date of this coverage code.	Label	Date (MM/DD/CCYY)	8
Policy Number	Policy number for this TPL policy.	Label	Number (Integer)	30
Suspect Code	This code identifies whether a TPL resource is active or suspect and, if suspect, who marked it as suspect (the system or the user).	Label	Character	1

6.7.4 TPL Additional Policies Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.7.5 TPL Additional Policies Panel Extra Features

When a policy is selected, a pop-up window displays the policy for additional maintenance.

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6.7.6 TPLAdditional Policies Panel Accessibility

6.7.6.1 To Access the TPL Additional Policies Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Additional Policies.	Additional Policies panel displays.

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6.8 TPL Base Information Panel Overview

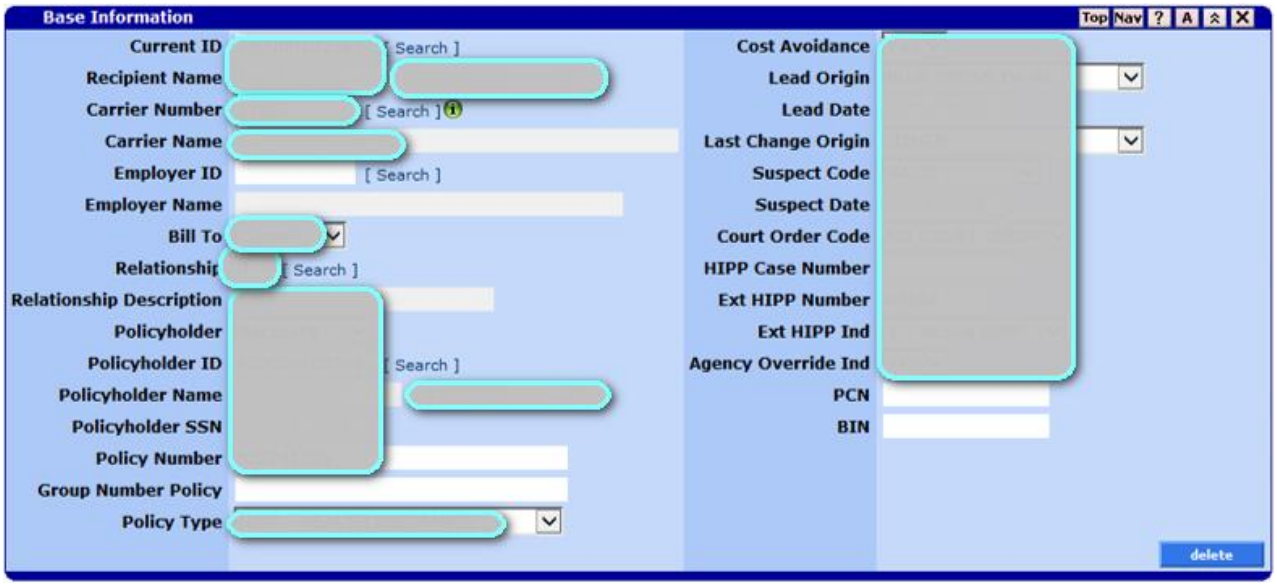
6.8.1 TPL Base Information Panel Narrative

The TPL Base Information panel lists base information about TPL Resource and links to other TPL related information.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [TPL Maintenance] - [Base Information] - OR -[TPL - Information] - [TPL Maintenance] - [Base Information]

6.8.2 TPL Base Information Panel Layout



6.8.3 TPL Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Agency Override Indicator	Yes, if a state user has manually updated Ext HIPP Number or Ext HIPP Ind., blank otherwise.	Combo Box	Drop Down List Box	1
Bill To	This code describes who TPL claim facsimiles are billed to: the employer of the policyholder or the carrier.	Combo Box	Drop Down List Box	0
BIN	Pharmacy Coverage BIN Number.	Field	Alphanumeric	15
Carrier Name	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	Field	Character	45

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Field	Description	Field Type	Data Type	Length
Carrier Number	An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.	Field	Character	7
Cost Avoidance	This code indicates if the Policy should utilize Cost Avoidance editing.	Combo Box	Drop Down List Box	0
Court Order Code	This code identifies the court ordered coverage that must be provided by an absent parent.	Combo Box	Drop Down List Box	0
Current ID	Unique identification number for the recipient.	Field	Number	12
Delete	Deletes the current record.	Button	N/A	0
Employer ID	This field is the unique, user-defined employer identification used on all screens and reports to identify the employer.	Field	Character	7
Employer Name	The business name of an employer.	Field	Character	39
Ext HIPP Ind	HMS HIPP Indicator, 1=Member is active in HIPP, 0= Member is not active in HIPP.	Field	Drop Down List Box	1
Ext HIPP Number	HMS HIPP case identifier. This will be the unique identifier for a HIPP case in the PIER system.	Field	Character	8
Group Number Policy	Policy group number. If present, gives the group number of the policy.	Field	Character	30
HIPP Case Number	This identifies the HIPP case number the policy is associated with.	Label	Character	10
Last Change Origin	This code identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.	Combo Box	Drop Down List Box	0
Lead Date	The date the resource was originally added to the system.	Field	Date (MM/DD/CCYY)	8
Lead Origin	This code identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.	Combo Box	Drop Down List Box	0
PCN	Pharmacy Coverage PCN Number.	Field	Alphanumeric	15
Policyholder Name	The last name, first name and middle initial of the policy holder.	Field	Character	19

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Field	Description	Field Type	Data Type	Length
Policy Number	Policy number for this TPL policy.	Field	Number (Integer)	30
Policy Type	This code identifies the type of insurance policy that the recipient is covered under.	Combo Box	Drop Down List Box	0
Policyholder	This code identifies whether the policy owner is a Recipient or a Policyholder.	Combo Box	Drop Down List Box	0
Policyholder ID	The identification number for the policy owner.	Field	Character	15
Policyholder SSN	The Social Security Number of the policyholder.	Field	Number (Integer)	9
Recipient Name	Recipient's last name, first name and middle initial.	Field	Character	19
Relationship	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	Field	Character	1
Relationship Description	This field contains the description associated with a specific relationship code.	Field	Character	20
Suspect Code	This field identifies the TPL suspect code which identifies whether a TPL resource is suspect and, if so, how it was determined to be suspect.	Combo Box	Drop Down List Box	0
Suspect Date	The date this resource was marked as suspect.	Field	Date (MM/DD/CCYY)	8

6.8.4 TPL Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Carrier Number	Field	1	Carrier Information is required.	Enter a valid Carrier Number or select one from the search list.
	Field	2	This Carrier Number is Inactive.	An active TPL Carrier is required. Please make sure the selected carrier is active.
Cost Avoidance	Field	1	Cost Avoid Indicator Must Be 'N'. (Dispensed when suspect code = invalid or cancelled)	Change Cost Avoidance Indicator to 'N'.
Current ID	Field	1	Recipient ID is required.	Enter a valid Medicare ID (Current ID).

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Field	Field Type	Error Code	Error Message	To Correct
HIPP Case Number	Label	1	There is a HIPP Policy associated with this policy. They must be deassociated before this policy may be deleted. Please contact the department that handles HIPP Policies.	Cannot delete HIPP Policy associated with the case.
Ext HIPP Ind	Field	58	If Ext HIPP Indicator is active, the only policy type allowed is HIPP Health Insurance.	Select HIPP Health Insurance as the policy type.
	Field	59	If EXT HIPP Indicator is inactive, the only policy type allowed is Private Pay Health Insurance.	Select Private Pay Health Insurance as the policy type.
	Field	60	Policy has been identified as HIPP recipient. Please select the appropriate policy type.	Select the appropriate policy type.
Lead Origin	Field	1	A valid Lead Origin is required.	Enter a valid Lead Origin.
Policy Type	Field	1	Policy type is required for a valid entry.	Enter a valid Policy Type.
Policyholder	Field	1	Policyholder information is required.	Select a Policyholder from the list.
Policyholder ID	Field	1	Policy Holder ID not found.	Enter a valid Policy holder number.
Policyholder Name	Field	1	Policyholder First Name Required when policyholder type = P and Suspect Code = Valid or Non-Verified.	Please change the policyholder type or enter policyholder first name.
Relationship	Field	1	Please enter a Relationship Code.	Enter a valid Relation Code or select one from the search.
Suspect Code	Field	1	Suspect Code cannot be blank.	Cannot delete HIPP Policy associated with the case.

6.8.5 TPL Base Information Panel Extra Features

Valid vs. Non-Valid Policies

When adding a policy that is not VALID, the following fields are considered required: recipient ID, lead origin and date, suspect code <> VALID.

For a policy to be saved as VALID, it must have the following: recipient id, policyholder, carrier, relationship, policy number, suspect code = VALID, policy type, and coverage with valid coverage dates.

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Duplicate Policy Checks

A unique policy is checked on recipient, carrier, and policy number.

Additionally, a check at the coverage level should occur to ensure there are no overlapping coverage dates for the same coverage type.

Possible Duplicate Policy Checks

A unique policy is checked on recipient, carrier, and policy number. If another record exist with the same information, a check against the coverage's are performed. If a match is not found with the coverage code but the dates overlap, a warning message is displayed. The user will determine whether or not to override the error and continue with the save.

Referential Integrity Checks

A policy cannot be deleted if the sak_tpl_resource is cross-referenced to a HIPP case or an AR.

Check for Managed Care

If a VALID or Non-Verified policy is added and the Policy type has a MC Disenroll status, then the Managed Care Patient first segment for that recipient is closed to the end of the current month. These are the only segments closed in this process.

To close the Managed Care segment, the following function rules apply:

The TPLResource Business Entity has a property called PolicyType.DisenrollIndicator which should contain "Y" to terminate Managed Care Patient First program.

Check to see if recip is in a Managed Care pgm that should be terminated when/if recip gets elig for HMO TPL coverage

Query Used:

```
SELECT pmp.sak_re_pmp_assign
from t_re_pmp_assign pmp, t_pub_hlth_pgm pplan
where sak_recip = '" + sak_recip + "'
and pmp.SAK_PUB_HLTH = pplan.SAK_PUB_HLTH
and pplan.cde_pgm_health = 'PT1ST'
and pmp.dte_end >= '" + DateTimeUtil.FormatYYYYMMDD(ChkDate) + "'
and cde_status1 != 'H'" /* don't count segments that were Historied off... */
```

Where sak_recip is the recipient SAK, and ChkDate is the coverage eligibility start date.

Update their PMP assignment with appropriate 'ending info'

Query Used:

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```
UPDATE t_re_pmp_assign
SET cde_rsn_mc_stop = '46', /* '46' Recipient Ineligible due to HMO coverage... */
dte_end = "' + DateTimeUtil.FormatYYYYMMDD(MCDateEnd).ToString() + "'"
dte_termed = "' + DateTimeUtil.FormatMMDDYYYY(DateTime.Today) + "'"
WHERE sak_re_pmp_assign = "' + sakPMP + "'"
```

Where MCDateEnd is the last day of the current month and sakPMP is the plan internal number.

HIPP Check for Policy Termination

When a TPL Policy is terminated that is associated to a HIPP policy, an alert message must be displayed to the user. The option should be given to terminate the HIPP policy.

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will save the information under the linked active ID.

If the Recipient subsystem receives a link request and the old sak_recip exists on the t_tpl_resource table, the sak_recip is updated in batch to the active sak_recip.

6.8.6 TPL Base Information Panel Accessibility

6.8.6.1 To Access the TPL Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Base Information.	Base Information panel displays.

6.8.6.2 To Add on the TPL Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Current ID**.	Recipient name populates on panel.
3	Enter **Carrier Number**.	Carrier name populated on panel.
4	Enter **Employer ID**.	Employer name populates on panel.
5	Select **Bill To** from drop down list box.	
6	Enter **Relationship**. If unknown click [Search].	Relationship Description populates on panel.

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Step	Action	Response
7	Select **Policyholder** from drop down list box.	
8	Enter **Policyholder ID**. If unknown click [Search].	
11	Enter **Policy Number**.	
12	Enter **Group Number Policy**.	
13	Select **Policy Type** from drop down list box.	
14	Select **Cost Avoidance** from drop down list box.	
15	Select **Lead Origin** from drop down list box.	
16	Enter **Lead Date** in MM/DD/CCYY format.	
17	Select **Last Change Origi**n from drop down list box.	
18	Select **Suspect Code** from drop down list box.	
19	Enter **Suspect Date** in MM/DD/CCYY format.	
20	Select **Court Order Code** from drop down list box.	
21	Enter **HIPP Case Numbe**r.	
22	Enter **Ext HIPP Ind**.	
23	Select **Agency Override Ind** from drop down list box.	
24	Enter **PCN**.	
25	Enter **BIN.**	
22	Click **Save**.	Base Information is saved.

6.8.6.3 To Update on the TPL Base Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	TPL Base Information is saved.

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6.8.6.4 To Delete on the TPL Base Information Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.9 TPL Chronological Note Panel Overview

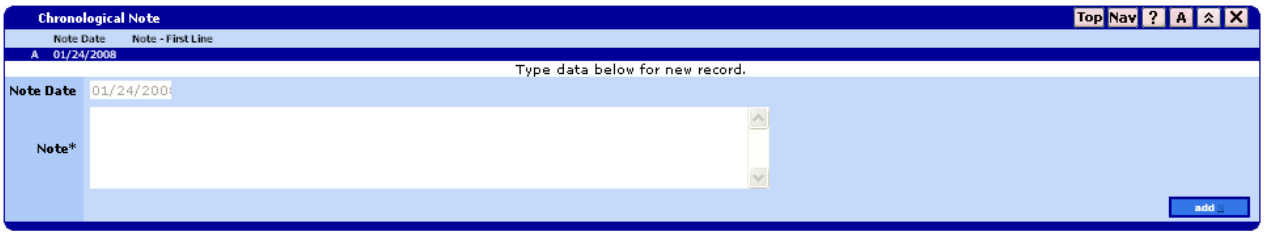
6.9.1 Chronological Note Panel Narrative

The TPL Chronological Note panel contains free-form notes entered by the user or batch processes pertaining to either the casualty case, TPL resource, HIPP Policy or TPL A/R.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [Chronological Note] OR [TPL - Information] - [Chronological Note]

6.9.2 TPL Chronological Note Panel Layout



6.9.3 Chronological Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the TPL Chronological Note panel.	Button	N/A	0
Note	This is used for free form text in the chronological notes.	Field	Character	500
Note Date	This identifies the date a particular chronological note was added to the case.	Label	Date (MM/DD/CCYY)	8
Note - First Line	Label of Note - First Line.	Label	N/A	50

6.9.4 Chronological Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Enter the first line of the note.

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6.9.5 Chronological Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.9.6 Chronological Note Panel Accessibility

6.9.6.1 To Access the Chronological Note Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Chronological Note.	Chronological Note panel displays.

6.9.6.2 To Add on the Chronological Note Panel

Step	Action	Response
1	Click **Add**. Note Date automatically populates with current date.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Chronological Note information is saved.

6.9.6.3 To Update on the Chronological Note Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Chronological Note information is saved.

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6.10 TPL Coverage Panel Overview

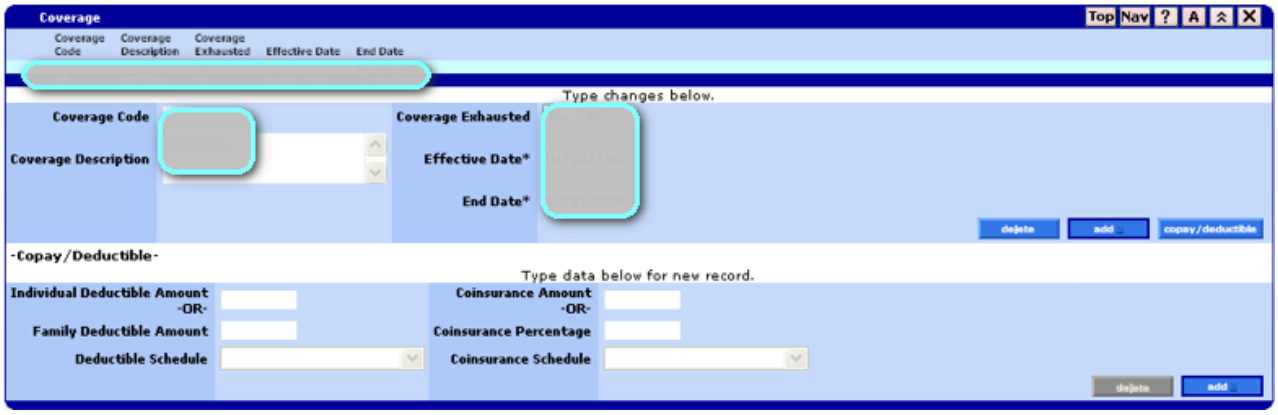
6.10.1 Coverage Panel Narrative

The TPL Coverage panel contains all possible data for TPL Coverage information.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - [(Select row from search results)] - [Coverage] OR [TPL - Information] - [Coverage]

6.10.2 TPL Coverage Panel Layout



6.10.3 TPL Coverage Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add [Copay/Deductible Panel]	Allows the user to add a record to the Copay/Deductible panel.	Button	N/A	0
Add [Coverage Panel]	Allows the user to add a record to the Coverage panel.	Button	N/A	0
Coinsurance Amount [Copay/Deductible Panel]	The coinsurance amount that a recipient is responsible for on a specific coverage type of a policy.	Field	Number (Decimal)	9
Coinsurance Percentage [Copay/Deductible Panel]	The coinsurance percentage that a recipient is responsible for on a specific coverage type of a policy." label="Coinsurance Percentage.	Field	Number (Decimal)	4
Coinsurance Schedule [Copay/Deductible Panel]	This code identifies the schedule for deductible, coinsurance, or premium payments for a specific coverage type of a policy.	Field	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Copay/Deductible	This brings up the Copay/Deductible panel.	Button	N/A	0
Coverage Code [Coverage Panel]	This code identifies the type of coverage that a TPL policy provides.	Field	Character	2
Coverage Code [Search]	This allows the user to search for a coverage code.	Hyperlink	N/A	0
Coverage Description [Coverage Panel]	This describes the type of coverage (services) a TPL resource provides.	Field	Character	120
Coverage Exhausted [Coverage Panel]	Coverage Exhausted.	Combo Box	Drop Down List Box	0
Deductible Schedule [Copay/Deductible Panel]	This code identifies the schedule for deductible, coinsurance, or premium payments for a specific coverage type of a policy.	Combo Box	Drop Down List Box	0
Delete [Copay/Deductible Panel]	This allows the user to delete a record from the Copay/Deductible panel.	Button	N/A	0
Delete [Coverage Panel]	This allows the user to delete a record from the Coverage panel.	Button	N/A	0
Effective Date [Coverage Panel]	The effective begin date of this coverage code.	Field	Date (MM/DD/CCYY)	8
End Date [Coverage Panel]	The effective ending date of this coverage code.	Field	Date (MM/DD/CCYY)	8
Family Deductible Amount [Copay/Deductible Panel]	The family deductible amount a recipient is responsible for on a specific coverage type of a policy." Label = Family Deductible Amount.	Field	Number (Decimal)	9
Individual Deductible Amount [Copay/Deductible Panel]	The individual deductible amount a recipient is responsible for on a specific coverage type of a policy.	Field	Number (Decimal)	9

6.10.4 TPL Coverage Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	1	Coverage codes 01, 02 and 20 reserved for Medicare.	Select a different coverage code.

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Field	Field Type	Error Code	Error Message	To Correct
Coinsurance Amount	Field	2	Cannot have both Coinsurance Amount and Percent.	Check the Coinsurance Percent. If it is greater than zero, then you can not declare amount for the Coinsurance amount.
Coinsurance Percentage	Field	2	Cannot have both Coinsurance Amount and Percent.	Check the Coinsurance amount. If it is greater than zero, then you can not declare a percent for the Coinsurance percent.
Coinsurance Schedule	Field	3	Coinsurance Schedule is Required. Please Enter a Value.	Verify the Coinsurance amount and Percent. If either one is greater than zero, then you must enter a value for coinsurance schedule.
Coverage Code	Field	1	A valid Coverage Code is required.	Enter a valid coverage code or click search and select one from the list.
	Field	2	Date and Code range segments for existing Coverage cannot overlap.	Change the coverage code or dates so it does not overlap with an existing span.
Deductible Schedule	Field	4	Deductible Schedule is Required. Please Enter a Value.	Verify the values of Individual Deductible Amount and Family Deductible Amount. If either one is greater than zero, then you must enter a value for the Deductible Schedule.
Effective Date	Field	1	Effective Date must be greater than or equal to 01/01/1900.	Insert date in proper format greater than or equal to 01/01/1900.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Insert date in proper format greater than or equal to 01/01/1900.
	Field	3	Effective Date [Date] must be less than or equal to End Date [Date].	Enter the effective date where its value is less than End date value.
	Field	4	End Date is required.	Enter a valid End Date.
End Date	Field	3	Effective Date [Date] must be less than or equal to End Date [Date].	Enter the End date where its value is greater than effective date value.
	Field	4	End Date is required.	Enter a valid end date.
Family Deductible Amount	Field	1	Cannot have both Ind and Family Deductible Amount.	Check the individual deductible amount. If it is greater than zero, you can not put any amount for the family deductible amount.
Individual Deductible Amount	Field	1	Cannot have both Ind and Family Deductible Amt.	Check the family deductible amount. If it is greater than zero, you can not put any amount for the individual deductible amount.

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6.10.5 TPL Coverage Panel Extra Features

For the same coverage code, dates of service cannot overlap.

The copay/deductible button expands the panel to allow the user to key additional data about the policy.

Managed Care assignment will be ended and stored historically in the following way:-

1) This logic only applies to Patient 1st.

2) MC assignment will be ended by end-of-month of the MC Effective Date if MC Effective Date is in the future and TPL coverage date overlaps the MC Effective Date.

3) MC assignment will be ended by end-of-month of current date and the MC assignment will be marked as History if MC Effective Date is in the past, MC End Date is in the future, and TPL Effective Date is less then MC Effective Date, but TPL End Date is greater than MC Effective Date.

4) MC assignment will be ended by end-of-month previous to TPL effective date if MC Effective Date is in the past, MC End Date is in future and TPL Effective Date is also in past, but is greater than MC Effective Date but less than the MC End Date.

5) MC assignment will be stored historically when the TPL Effective Date is less than the MC Effective Dates and TPL End Date is greater than or equal to the MC Effective Date.

6) No changes will be made to MC assignments already with status as history.

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6.10.6 TPL Coverage Panel Accessibility

6.10.6.1 To Access the TPL Coverage Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Coverage.	Coverage panel displays.

6.10.6.2 To Add on the TPL Coverage Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Coverage Code. If unknown, click [Search] to locate by selecting row from search results.	Coverage Code and Description are populated.
3	Select **Coverage Exhausted** from drop down list.	
4	Enter **Effective Date** in MM/DD/CCYY format.	
5	Enter **End Date** if different than date automatically populated in MM/DD/CCYY format.	
6	Click **Save**.	Coverage information is saved.

6.10.6.3 To Update on the TPL Coverage Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Coverage information is updated.

6.10.6.4 To Delete on the TPL Coverage Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.10.6.5 To Add Co-Pay/Deductible Information

Step	Action	Response
1	Click Copay/Deductible.	Copay/Deductible panel displays below Coverage panel.
2	Click **Add**.	Activates fields for entry of data or selection from lists.
3	Enter Individual Deductible Amount OR Family Deductible Amount.	
4	Select **Deductible Schedule** from drop down list.	
5	Enter Coinsurance Amount OR Coinsurance Percentage.	
6	Select **Coinsurance Schedule** from drop down list.	
7	Click **Save**.	Copay/Deductible information is saved.

6.10.6.6 To Update Co-Pay/Deductible Information

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Copay/Deductible information is updated.

6.10.6.7 To Delete Co-Pay/Deductible Information

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.11 TPL Dependents of Policy Panel Overview

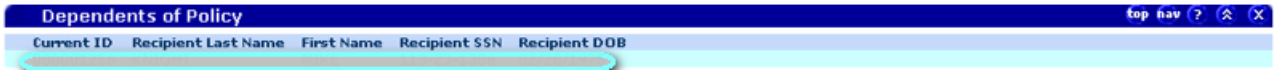
6.11.1 Dependents of Policy Panel Narrative

The TPL Dependents of Policy displays all TPL policies that exist for the same policy number and carrier.

This panel is display only.

Navigation Path: [TPL] – [Search] - [(Enter search criteria)] - [(Select row from search results)] - [TPL Maintenance] - [TPL] - [Dependents Of Policy] OR [TPL - Information] - [Dependents Of Policy]

6.11.2 TPL Dependents of Policy Panel Layout



6.11.3 TPL Dependents of Policy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Current ID	Unique identifier for the recipient.	Field	Character	12
First Name	The first name of the recipient.	Field	Character	13
Recipient DOB	The recipient's date of birth.	Field	Date (MM/DD/CCYY)	10
Recipient Last Name	The last name of the recipient.	Field	Character	15
Recipient SSN	The recipient's Social Security Number.	Field	Number (Integer)	9

6.11.4 TPL Dependents of Policy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.11.5 TPL Dependents of Policy Panel Extra Features

When selecting a row on the panel, the system pops-up into another session of the TPL Policy.

6.11.6 TPL Dependents of Policy Panel Accessibility

6.11.6.1 To Access the TPL Dependents of Policy Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search.**	TPL Search panel displays.

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Step	Action	Response
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Dependents of Policy.	Dependents of Policy panel displays.

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6.12 TPL Policy Letter Panel Overview

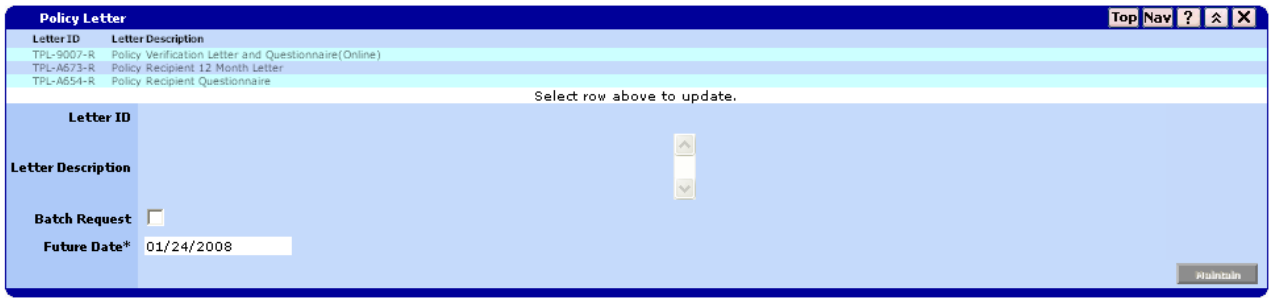
6.12.1 TPL Policy Letter Panel Narrative

The TPL Policy Letter panel allows the user to select a letter to send for the policy.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - (Select row from search results) - [TPL Maintenance] - [Policy Letter] - OR -[TPL - Information] - [TPL Maintenance] - [Policy Letter]

6.12.2 TPL Policy Letter Panel Layout



6.12.3 TPL Policy Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Batch Request	When the checkbox is clicked, the batch is requested.	Combo Box	Drop Down List Box	0
Future Date	The expected date of the letter to be batched.	Field	Date (MM/DD/CCYY)	8
Letter Description	The description of the letter.	Field	Character	4000
Letter ID	The identification number of the letter.	Field	Character	10
Maintain	Allows the user to manually request a letter.	Button	N/A	0

6.12.4 TPL Policy Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.12.5 TPL Policy Letter Panel Extra Features

As a standard, all Policy letters begin with the description of 'Pol%' and the ID of the letter begins with 'TPL-'. This allows the system to automatically pick up any newly added letters to the system.

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Based upon the schema described above, the extract for this panel is a query against the T_LG_LETTER_TEMPLATE table for the ID_LETTER and DSC_LETTER fields.

Once a letter is selected, the system passes the sak_tpl_resource to the letter generator as a parameter. This is stored on the T_LG_LETTER_REQUEST table as the ID_PEOPLE and used to retrieve the data needed to populate the letter.

6.12.6 Policy Letter Panel Accessibility

6.12.6.1 To Access the TPL Policy Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search.**	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Policy Letter.	Policy Letter panel displays.

6.12.6.2 To Maintain a Letter on the TPL Policy Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain.	Login window displays.
3	Enter User name and Password.	
4	Click **OK**.	Letter generator opens with a message requesting the user to select: To open the PDF Save the PDF Cancel

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6.13 TPL Policy Letter History Panel Overview

6.13.1 TPL Policy Letter History Panel Narrative

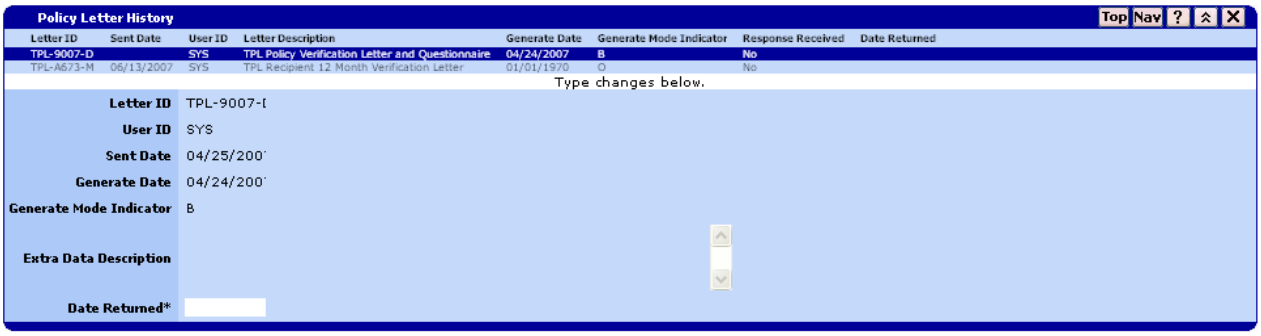
The TPL Policy Letter History panel displays the history of all letters that have been sent for this TPL policy.

This panel does not display history for HIPP, Cases or ARs, and that it only displays for this policy.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - (Select row from search results) - [TPL Maintenance] - [Policy Letter History] - OR -[TPL] – [Information] - [TPL Maintenance] - [Policy Letter History]

6.13.2 TPL Policy Letter History Panel Layout



6.13.3 TPL Policy Letter History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Returned	The date the response was returned.	Field	Date (MM/DD/CCYY)	8
Extra Data Description	Gives additional description about the request.	Field	Character	4000
Generate Date	Contains the date the letter was generated	Field	Date (MM/DD/CCYY)	8
Generate Mode Indicator	Indicates the mode in which the letter was generated (O for Online, B for Batch).	Field	Character	1
Letter Description	The description of the letter.	Listview	Character	55
Letter ID	The external identifier for this letter	Field	Character	20
Response Received	Yes or No indicator showing whether a response has or has not been received for this letter.	Listview	Character	3

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Field	Description	Field Type	Data Type	Length
Sent Date	The date the letter was created and printed.	Field	Date (MM/DD/CCYY)	8
User ID	The user who requested the letter.	Field	Character	8

6.13.4 TPL Policy Letter History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Returned	Field	1002	Date Returned is required.	Enter a valid returned date.

6.13.5 TPL Policy Letter History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.13.6 TPL Policy Letter History Panel Accessibility

6.13.6.1 To Access the TPL Policy Letter History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search.**	TPL Search panel displays.
3	Enter Search criteria.	
4	Click **Search**.	Search results displays.
5	Click row to display information.	TPL Information and Maintenance panels display.
6	Click Policy Letter History.	Policy Letter History panel displays.

6.13.6.2 To Update on the TPL Policy Letter History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Policy Letter information is updated.

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6.14 TPL AR Search Panel Overview

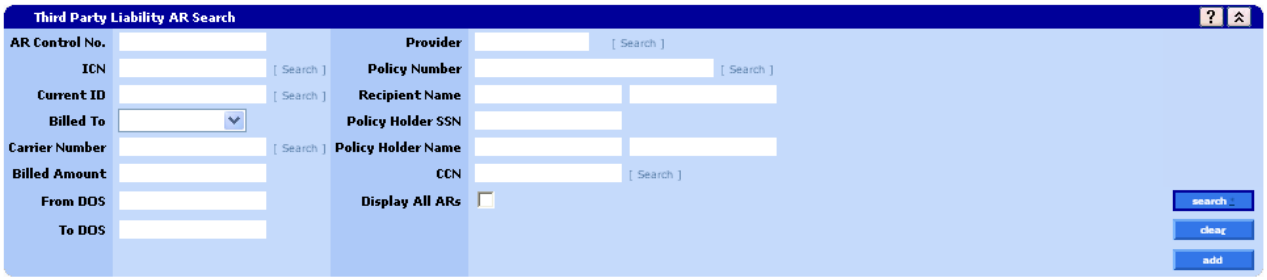
6.14.1 TPL AR Search Panel Narrative

The TPL AR Search Panel is used to search for Account Receivable records using various criteria.

This panel is inquiry on ly.

Navigation Path: [TPL] - [AR Search]

6.14.2 TPL AR Search Panel Layout



6.14.3 TPL AR Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Control No.	The internal accounts receivable control number.	Field	Character	13
Billed Amount	The amount that is expected to be received due to the A/R.	Field	Number (Decimal)	9
Billed To	The entity that was billed for the accounts receivable.	Combo Box	Drown Down List Box	1
Carrier Number	Insurance carrier identification number related to this A/R.	Field	Character	7
CCN	Cash control number of the check that has been dispositioned.	Field	Number (Integer)	11
Clear	Clears the search panel.	Button	N/A	0
Current ID	The unique identifier for the recipient.	Field	Number (Integer)	12
Display All ARs	This field is checked when the user wants all account receivable records to be displayed.	Combo Box	Checkbox	0
From DOS	The beginning date of service for the claim.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
ICN	The Internal Control Number that identifies the claim assigned to the A/R.	Field	Number (Integer)	13
Policy Holder Name (First)	The first name of the policy holder.	Field	Character	19
Policy Holder Name (Last)	The last name of the policy holder.	Field	Character	19
Policy Holder SSN	The Social Security Number of the policy holder.	Field	Number (Integer)	9
Policy Number	Policy number for the insurance policy.	Field	Character	30
Provider	The billing provider identification number.	Field	Number (Integer)	15
Recipient Name (First)	The first name of the recipient.	Field	Character	19
Recipient Name (Last)	The last name of the recipient.	Field	Character	19
Search	Searches for records based on entered criteria.	Button	N/A	0
To DOS	The ending date of service for the claim.	Field	Date (MM/DD/CCYY)	8

6.14.4 TPL AR Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	1	Please enter at least one search field.	Enter a search field in search panel before clicking search.
AR Control No	Field	5	AR Control No. must be numeric	Enter the numeric internal accounts receivable control number.
Billed Amount	Field	4	Enter a valid value.	Enter a valid dollar amount.
Carrier Number	Field	1	Carrier Number must be numeric.	Enter a numeric Carrier Number.
	Field	3	A Carrier Number is required to Display All ARs.	Please enter a Carrier Number.
Current ID	Field	6	Current ID must be numeric.	Enter a numeric ID.
From DOS	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the date in the correct format.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Both From DOS and To DOS must be entered.	Enter a value for both fields.
	Field	3	FDOS cannot be greater than TDOS.	Check values and re-enter valid dates.
ICN	Field	1	ICN must be 13 numeric digits.	Enter a valid ICN.
	Field	13	ICN must be numeric.	Enter a valid ICN.
Policy Holder Name (First)	Field	10	Policy Holder First Name contains invalid characters.	Enter a valid name.
Policy Holder Name (Last)	Field	12	Policy Holder Last Name contains invalid characters.	Enter a valid name.
	Field	15	Last Name must be used to search by Policyholder Name.	Enter a valid name.
Policy Holder SSN	Field	1	Enter a valid value.	Enter a valid SSN.
Provider	Field	1	Provider ID must be 8 numeric digits.	Enter a valid Provider ID.
Recipient Name (First)	Field	10	Recipient First Name contains invalid characters.	Enter a valid name.
Recipient Name (Last)	Field	1	Last Name must be used to search by Recipient Name.	Enter recipient's last name.
	Field	9	Recipient Last Name contains invalid characters.	Enter a valid last name.
To DOS	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the date in the correct format.
	Field	4	Both From DOS and To DOS must be entered.	Enter a value for both fields.

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6.14.5 TPL AR Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.14.6 TPL AR Search Panel Accessibility

6.14.6.1 To Access the TPL AR Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.

6.14.6.2 To Navigate on the TPL AR Search Panel

Step	Action	Response
1	Enter Search criteria.	
2	Click **Search**.	Results of search displays.
3	Select row from search results.	TPL Information and Maintenance panels display.

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6.15 TPL AR Search Results Panel Overview

6.15.1 TPL AR Search Results Panel Narrative

The TPL AR Search Results Panel is used to display the results of searches for accounts receivables.

To post cash, click the check box for all affected A/Rs. Also displayed with the search panel is the AR Allocation panel to identify the CCN to allocate against. Once the A/Rs are selected, and the CCN information has been identified, the user can allocate based upon the various options given. See the AR Allocation panel for a description of those options.

This panel is display only.

Navigation Path: [TPL] – [AR Search] - (Enter in search criteria) - (Click on search)

6.15.2 TPL AR Search Results Panel Layout

6.15.3 TPL AR Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Remain	The amount remaining for this accounts receivable.	Field	Number (Decimal)	9
Amount to Apply	The amount to be applied for this A/R.	Field	Number (Decimal)	9
AR Control No	The internal accounts receivable number assigned to the claim or transaction.	Field	Number (Integer)	13
Billed Amount	Dollar amount of the claim billed under the accounts receivable.	Field	Number (Decimal)	9
Billed To	Entity that was billed for the accounts receivable.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Carrier Number	Insurance carrier identification number related to this accounts receivable.	Field	Character	7
Current ID	The Agency assigned identification number of the recipient associated with the A/R.	Field	Character	12
Deselect All	Allows the user to unselect all records in search results.	Button	N/A	0
From DOS	The beginning date of service for the claim.	Field	Date (MM/DD/CCYY)	8
ICN	The Internal Control Number that identifies the claim assigned to the A/R.	Field	Number (Integer)	13
Original Billed Date	Shows the initial bill date.	Field	Date (MM/DD/CCYY)	8
Reason	The A/R reason code last used on the A/R.	Field	Character	4
Rebill Ind	Indicates whether a rebill has been requested for the AR.	Field	Character	1
Recipient Name	The last, first name and middle initial of the recipient.	Field	Character	29
Select All	Allows selection of all records in search results.	Button	N/A	0
To DOS	The ending date of service for the claim.	Field	Date (MM/DD/CCYY)	8
Update Rebill	Allows the user to update rebill records in the search results.	Button	N/A	0

6.15.4 TPL AR Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.15.5 TPL AR Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.15.6 TPL AR Search Results Panel Accessibility

6.15.6.1 To Access the TPL AR Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information panel displays.

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6.16 AR Disposition Selection Panel Overview

6.16.1 AR Disposition Selection Panel Narrative

The AR Disposition Selection panel displays the accounts receivables selected on the TPL AR Search panel to be dispositioned. This panel is display only.

Navigation: [TPL] - [AR Search] - [Select from Search Results] - [Identified CCN] - [Button to Disposition]

6.16.2 AR Disposition Selection Panel Layout

6.16.3 AR Disposition Selection Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Control No.	Accounts receivable that was selected from the prior panel for processing.	Field	Alphanumeric	13
Amount Remain	Amount remaining on the accounts receivable in dollars.	Field	Number (Decimal)	10
Billed Amount	Original billed amount of the accounts receivable in dollars.	Field	Number (Decimal)	10
Billed To	Billed To name for the accounts receivable.Typically carrier, provider, recipient, policyholder, etc.	Field	Character	20
Carrier Number	Carrier identification number.	Field	Number (Integer)	7
Current ID	This is the current identification number of the recipient.	Field	Number (Integer)	12
From DOS	This is the From Date of Service on the claim.	Field	Date (MM/DD/CCYY)	8
ICN	This is the internal control number for the accounts receivable.	Field	Number (Integer)	13
To DOS	This is the To Date of Service on the Claim.	Field	Date (MM/DD/CCYY)	8

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6.16.4 AR Disposition Selection Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.16.5 AR Disposition Selection Panel Extra Features

Note that for the layout, the selection panel is just the top portion displayed. The other sections are utilized through the processing of A/Rs, and become active as each A/R is selected at the top.

6.16.6 AR Disposition Selection Panel Accessibility

6.16.6.1 To Access the AR Disposition Selection Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information panel displays. AR Disposition selection panel is located directly above the TPL Information panel.

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6.17 TPL AR Information Panel Overview

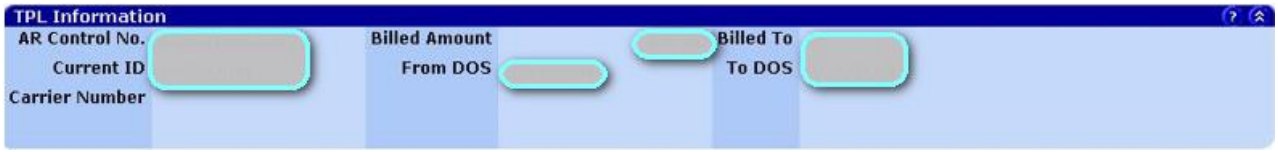
6.17.1 TPL AR Information Panel Narrative

The TPL AR Information panel describes the basic information about an accounts receivable in order to accommodate all outstanding payments from the current MMIS. A/R requires the capability of accepting a manual entry at the recipient, carrier, or policyholder level.

This panel is display only.

Navigation Path: [TPL] – [AR Search] - [(Enter search criteria)] - [(Select a record from Search Results)] - [TPL Information]

6.17.2 TPL AR Information Panel Layout



6.17.3 TPL AR Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Control No.	The internal accounts receivable control number for which dispositions are listed. (RRYYDDDBBBSSS) TPL has a region code of 61 and the batch range is 900-950 from the system generated billings or a batch range of 951-999, if a manual accounts receivable set-up.	Field	Number (Integer)	13
Billed Amount	Amount of the accounts receivable.	Field	Number (Decimal)	9
Billed To	Entity that was billed for the accounts receivable.	Field	Character	15
Carrier Number	Insurance carrier identification number related to this accounts receivable.	Field	Character	7
Current ID	The Agency assigned identification number of the recipient associated with the accounts receivable.	Field	Character	12
From DOS	The beginning date of service for the claim.	Field	Date (MM/DD/CCYY)	8
To DOS	The ending date of service for the claim	Field	Date (MM/DD/CCYY)	8

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6.17.4 TPL AR Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.17.5 TPL AR Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.17.6 TPL AR Information Panel Accessibility

6.17.6.1 To Access the TPL AR Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information panel displays.

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6.18 TPL AR Maintenance Panel Overview

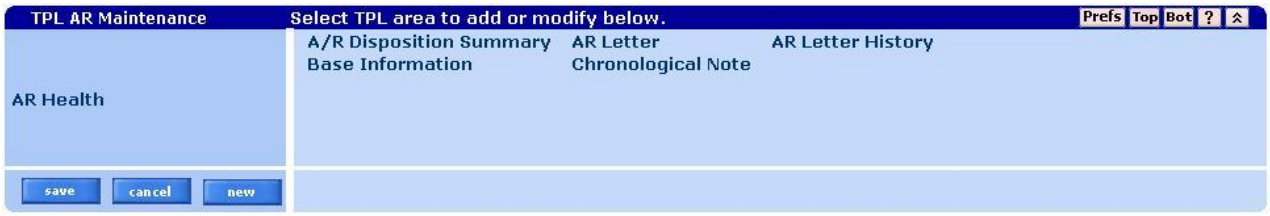
6.18.1 TPL AR Maintenance Panel Narrative

The TPL AR Maintenance panel is the point of access for TPLs requiring maintenance.

This panel is inquiry only.

Navigation Path: [TPL] – [A/R Search] - [(Enter search criteria)] - [(Select a row from Search Results)] - [TPL AR Maintenance]

6.18.2 TPL AR Maintenance Page Layout



6.18.3 TPL AR Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
A/R Disposition Summary	Link to the AR Disposition Summary panel.	Hyperlink	N/A	0
AR Letter	Link to the AR Letter hyperlink.	Hyperlink	N/A	0
AR Letter History	Link to the AR Letter History panel.	Hyperlink	N/A	0
Base Information	Link to the Base Information panel.	Hyperlink	N/A	0
Cancel	Cancels an update.	Button	N/A	0
Chronological Note	Link to the Chronological Note panel.	Hyperlink	N/A	0
New	Opens the Base Information Panel for a new accounts receivable.	Button	N/A	0
Save	Saves an update.	Button	N/A	0

6.18.4 TPL AR Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.18.5 TPL AR Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.18.6 TPL AR Maintenance Panel Accessibility

6.18.6.1 To Access the TPL AR Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Maintenance panels display.

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6.19 TPL AR Allocation Panel Overview

6.19.1 TPL AR Allocation Panel Narrative

The TPL AR Allocation panel is used to identify a Cash Control Number (CCN) in the Financial Subsystem so that it can be applied to a TPL Accounts Receivable (A/R).

Only authorized users are allowed to perform maintenance tasks on this panel.

The Auto Apply button may be used to apply money to all ARs listed on the window until the Amount Available is equal to zero. The Auto Apply feature may be used when the CCN and percentage along with a valid disposition reason code have been entered in the Allocation Panel and the ARs listed have no Disposition History and are not denied.

Money will be applied to selected (checked) ARs in the order that appears on the window. The amount of money applied is determined by: The Percent Applied based on the AR's amount remaining. If there is not enough money in the Check (CCN) to cover the required amount, the remaining available money will be applied to the AR.

The Auto Deny button may be used to deny all ARs listed on the window. A reason code is required and it cannot be a disposition or Expenditure reason code. Those AR's with Bill To = 'P' cannot be auto denied. Only ARs that have no Disposition History and have not previously been denied, are eligible for Auto Deny.

If he Check's available money exceeds the required amount to cover all selected AR's. The panel will ask the user if an Expenditure needs to be created. If the user opts to create an Expenditure, a Financial Panel will be called to complete the procedure.

Navigation Path: [TPL] – [AR Search] - [Enter Search criteria and click on Search]

6.19.2 TPL AR Allocation Panel Layout

6.19.3 TPL AR Allocation Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amt Alloc	Dollar amount of the check allocated to this point.	Field	Number (Decimal)	9
Amt Avail	Dollar amount of the check that is available at this point.	Field	Number (Decimal)	9
Auto Apply	The Auto Apply button may be used to apply money to all A/Rs listed on	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
	the panel until the Amount Available is equal to zero.			
Auto Deny	The Auto Deny button may be used to deny all A/Rs listed on the window with reason code '80' except those where the Bill To = 'P'. A/Rs that have no Disposition History are eligible for Auto Deny.	Button	N/A	0
Cancel	Cancels the current changes.	Button	N/A	0
CCN	Cash control number of the check that is to be dispositioned.	Field	Number (Integer)	11
Check Amt	Total dollar amount of the check received.	Field	Number (Decimal)	9
Clear	Clears the auto apply/deny panel.	Button	N/A	0
Manual Apply	Initiates the Manual Apply process and takes the user to the Adjustments Search panel.	Button	N/A	0
Percent Applied (%)	Percentage of the claim that the carrier has paid.	Field	Number (Decimal)	4
Reason	Reason drop down box.	Combo Box	Drop Down List Box	0
Save	Save the active record(s).	Button	N/A	0

6.19.4 TPL AR Allocation Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Auto Apply	Button	1	An A/R and a valid CCN must selected for disposition.	Select an A/R and a valid CCN.
	Button	2	AR Control number[#######] already has a disposition. For additional dispositions, use the AR Disposition Summary Panel.	The selected AR already has a disposition. AutoApply cannot be used on this AR. Use the AR Disposition Summary panel to add more dispositions.
	Button	3	AR Control number[#######] record already processed, cannot use AutoApply.	Record has already been processed. AutoApply cannot be used on this AR.
	Button	4	Available money was not enough to apply to all selected AR's.	Amount on the selected CCN was not enough to fully cover all selected ARs.
	Button	5	Would you like to create an expenditure?	After the AutoApply process completes it determines if there is amount remaining

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Field	Field Type	Error Code	Error Message	To Correct
				on the CCN. If so, the panel asks the user if an Expenditure should be created.
	Button	6	Review the amount to be applied and then press the save button to apply the monies.	This message notifies the user the Save button must be pressed to apply the changes to the affected ARs.
	Button	7	Amount must be greater than zero.	The selected AR does not have a Remaining amount greater than zero. Therefore, autoapply can not be applied to this AR.
Auto Deny	Button	1	At least one AR row must be selected.	Select an AR and repeat process.
	Button	2	Cannot have a CCN assigned on Autodeny.	CCN must be cleared before auto denying an AR.
	Button	3	Cannot have a Percent Applied on Autodeny.	Percentage must be cleared before AutoDenying an AR.
	Button	4	Please select a Reason to explain Auto Deny.	AutoDeny requires a Deny reason to apply to the AR.
	Button	5	Selected Reason cannot be applied with Auto Deny.	Reason codes A, E, M, R, & U cannot be used with AutoDeny.
	Button	6	AR Control number[#######] record already processed, cannot use Autodeny.	Record has already been denied or has a disposition. This record cannot be deny using AutoDeny.
	Button	7	AR Control number[#######] has disposition history. Auto deny cannot be applied to this TPL AR.	The selected AR already has a disposition. This AR cannot be AutoDeny.
	Button	8	Auto deny cannot be applied to TPL ARs billed to Provider.	ARs billed to the Provider cannot be AutoDenied.
	Button	9	Nothing was Auto-denied.	After the AutoDeny process completed it was determined, no AR records were updated.
	Button	10	Click on save to auto deny TPL AR payment.	This is an informational Message, the user must Save the record(s) in order for the changes to be reflected.

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Field	Field Type	Error Code	Error Message	To Correct
Percent Applied (%)	Field	1	Percent Applied is required.	Enter a valid percent value.
	Field	2	Percent Applied is not valid.	Enter a percentage between 0 and 100%.
CCN	Field	1	CCN cannot be used. It has a Non-Sufficient Fund status.	CCN has a non-sufficient funds status. This CCN cannot be used, pick another CCN.
	Field	2	CCN's Check amount must be greater than zero.	CCN's amount has been depleted. Select another CCN with enough amount to cover the AR(s) amount.
	Field	3	CCN not found or not a TPL type.	CCN does not have the correct unit of 200 for TPL or 250 for HIPP. If the CCN is correct, check with Financial determine if unit on CCN needs to be updated.
Reason	Combo Box	1	Please select a valid Reason code.	Reason Code must be selected.
	Combo Box	2	Select a valid reason code for dispositions.	For Disposition, reason codes must be R, E, M, or U. So select one of these reasons.
	Combo Box	3	Cannot use this reason code: Reason Code 'A' is exclusive for Expenditures.	A reason code is exclusive for Expenditures. Select another reason.
	Combo Box	2	Select a valid reason code for dispositions.	For Disposition, reason codes must be R, E, M, or U. So select one of these reasons.
	Combo Box	3	Cannot use this reason code: Reason Code 'A' is exclusive for Expenditures.	A reason code is exclusive for Expenditures. Select another reason.
Save	Button	1	Unable to find TPL AR Health entity for AR Control number[########].	TPL AR record does not exits.
	Button	2	A claim was adjusted and you indicated not to continue.	When a claim is adjusted the user has the chance to continue processing the AR. If the user selected No, the panel will cancel he saving process.
	Button	3	Database Transaction could not be created, please call Technical Support.	The Oracle transaction was not created successfully.

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Field	Field Type	Error Code	Error Message	To Correct
				There is a potential problem with the database.
	Button	4	Unable to find TPL AR Health entity for TPL AR Control number[#######].	AR Record could not be found.
	Button	5	Control number[#######] record already processed. Use AR Disposition Summary Panel to dispose from this AR.	The record was already either denied or autoapplied before this time. It will need to be edited from the TPL AR Maintenance Panel.
	Button	6	No reason with that code was found for reason used in AR number: #######.	AR reason selected could not be found in the reasons table.
	Button	7	Control number[######] has disposition history. Changes cannot be applied to this TPL AR.	The AR has dispositions already, the changes cannot be applied to this AR.
	Button	8	Amount must be zero for Denied AR Control number[######]. Select and press Cancel to clear amount.	During save, it was found an AR to be denied contained an amount. This must be cleared using the Cancel Button.
	Button	9	Could not update AR. Control number[#######] could not be updated.	An error occurred during the save of the indicated AR.
	Button	10	Save Failed: No TPL ARs were updated.	Errors occurred and none of the TPL ARs were saved.
	Button	11	Save Successful: ## TPL ARs were updated.	All records were updated.
	Button	12	Only ## TPL ARs were updated.	There were some errors but some TPL ARs were successfully saved.
	Button	13	Cannot Start CashRecipt Service.	Financial Service could not be started. Contact the financial Team.
	Button	14	An error occurred while updating Cash Disposition.	The Financial Disposition was not created. Contact Financial.
	Button	15	CCN information is required to persist Auto Applied records.	CCN was not provided while TPL AR records had amount to apply. CCN is required to take the money from it.
	Button	16	Cannot update AR record: [#######].	TPL AR was not saved.

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Field	Field Type	Error Code	Error Message	To Correct
	Button	17	Invalid AR disposition.	TPL AR disposition was not created. Try again.
	Button	18	TPL AR Control number [#####] already has a disposition. For additional dispositions, use the AR Disposition Summary Panel.	AR already has disposition. Verify. Add additional data via the AR Disposition Summary Panel.

6.19.5 TPL AR Allocation Panel Extra Features

[Search] Allows the user to display a pop-up search panel to search for a CCN in Financial.

CCN Search should restrict to Unit of '200' - TPL, and also for those CCNs that have not been fully dispositioned.

The CCN amount can be applied in one of the following methods:

1) Auto Apply, which begins with the first AR, dispositions fully until money runs out. This method requries the user to select one or more ARs from the result page, enter the CCN, Percentage and a valid reason code for Dispositions. Failure to enter this information will result on error messages posted by the panel.

2) Manual Apply - this method will take all selected ARs to the AR Maintenance panel so the user can enter Dispositions individually.

The only requirement for this Method is to select one or more AR from the Search results.

Other features:

Auto Deny - Auto Deny will deny the selected ARs using the selected Deny Reason. The reason code cannot be a Disposition or Expenditure reason.

Save button - this button will apply to database any changes made with the AutoApply or AutoDeny buttons. Once this button is pressed, there is no way of roll back the changes.

Clear Button - This button will clear all fields on the Allocation Panel.

Cancel Button - this button will clear the amount and reason codes applied with Autoapply. Note that existing reasons will not be cleared with this button.

Update Rebill - this button will update the Rebill indicator to the selected ARs. If this button is selected and the Rebill indicator is Y it will be set to 'N', and viceversa. Note that in contrast of the AutoApply or AutoDeny buttons, this button will update the database directly.

Select All - this button selects all records displayed on the result page. Note this function does not select all pages of results. This feature will be implemented in future releases of the panel.

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Deselect All - this button will remove the check on all selected ARs. Note this function does not select all pages of results. This feature will be implemented in future releases of the panel.

Notes:

- In this panel there is no way to dispose more money than the remaining amount in the AR. For extra dispositions, use the Disposition Summary panel from the AR Maintenance Panel.

- For ARs with disposition history, the only way to dispose more money is by going into the Disposition Summary panel from the AR Maintenance Panel.

- Note all dispositions to a TPL AR also disposition against the Financial cash receipt tables.

- While dispositioning A/Rs a check will be performed to see if the claim has been adjusted. If the claim has been adjusted a warning message will be issued and the user will answer whether or not they wish to continue.

- A/Rs that have no Disposition History are eligible for Auto Deny.

6.19.6 TPL AR Allocation Panel Accessibility

6.19.6.1 To Access the TPL AR Allocation Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	AR Allocation panel displays.

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6.20 AR Disposition Summary Panel Overview

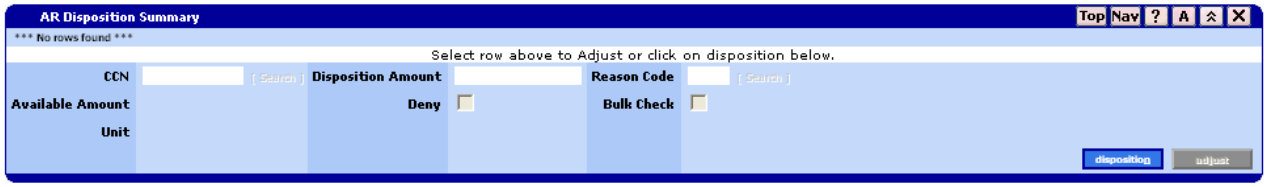
6.20.1 AR Disposition Summary Panel Narrative

The A/R Disposition Summary Panel is used to show all dispositions that have been applied against an accounts receivable. These are credits and debits applied from cash receipts, as well as dispositions for denials and write-offs.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [AR Search] - [(Enter search criteria)] - [(Select a row from Search Results)] - [TPL AR Maintenance] - [A/R Disposition Summary]

6.20.2 AR Disposition Summary Panel Layout



6.20.3 AR Disposition Summary Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjust	Opens AR Adjustment panel.	Button	N/A	0
Available Amount	The amount remaining for the CCN.	Field	Number (Decimal)	12
Bulk Check	Check box to indicate if this is a Bulk check that can be used to disposition multiple accounts receivables.	Combo Box	Checkbox	0
CCN [Search]	Check control number.	Hyperlink	N/A	0
Deny	Check box to indicate if this accounts receivable is to be denied.	Combo Box	Checkbox	0
Disposition	Creates a new A/R Disposition Record with details entered on panel.	Button	N/A	0
Disposition Amount	Amount for which the disposition is to apply to the associated A/R.	Field	Number (Decimal)	9
Reason Code [Search]	Reason code for dispositioning this A/R.	Hyperlink	N/A	0
Unit	The unit assigned to the CCN.			

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6.20.4 AR Disposition Summary Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Disposition	Button	1	Financial Disposition processing failed.	Financial disposition failed, please verify.
Deny	Check Box	11	Invalid Reason Code for deny.	Change reason code.
Otherwise, Create Expenditure	Check Box	3	Adjustment - Please enter an Add to TplAR or check the Create Expenditure checkbox.	Enter required data or check appropriate checkbox.
CCN	Field	1	Invalid CCN. Please Verify.	Enter a valid CCN or click search and select one from the list.
	Field	2	CCN is in non-sufficient funds status.	Select another CCN.
	Field	3	CCN must be numeric.	CCN must be numeric.
Disposition Amount	Field	1	Disposition amount must be greater than zero.	Enter a disposition amount greater than zero.
	Field	2	Disposition AR amount exceeds AR billed amount.	Enter a lesser disposition amount.
	Field	3	Total disposition amount is greater than the paid amount by $X.XX.	The disposition amount was bigger than the amount remaining in the CCN. Enter an amount same or less than the Amount Available in the CCN.
Reason Code	Field	1	Reason Code for disposition AR must be E, M, R or U.	Enter a vaild Reason Code.
	Field	2	Please enter a valid reason code.	Enter valid reason code.
	Field	3	Adjustment - Reason Code for Adjustment is required.TplAR.	Enter reason code.
Remove this amount	Field	1	Adjustment - Adjustment amount must be greater than zero.	Enter a valid Amount.
	Field	2	Adjustment - Adjustment amount must be less than the original disposition amount.	Amount to remove must be the same or less than the Disposition Amount.

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Field	Field Type	Error Code	Error Message	To Correct
Using Reason Code	Field	2	Adjustment - Disposition AR Reason Code is not allowed.	Verify if Reason Code is correct.

6.20.5 AR Disposition Summary Panel Extra Features

The From A/R and To A/R Reason codes have the ability to either be entered, or perform a pop-up search.

If the money is being moved from one AR to another AR, the close date on the AR the money is being moved too, is closed with the current system date.

If the full disposition amount is being adjusted from one AR and being moved to another AR or being created as an expenditure, the close date on the existing AR is reset to zero.

The A/R Number can either be entered or searched from existing TPL A/Rs.

The Create Expenditure check box will transfer the user to the create expenditure panel of the Financial Functional area.

A check is performed to see if the claim for the Add to A/R# has been adjusted. If the claim has been adjusted a warning message will be issued and the user will answer whether or not they wish to continue.

6.20.6 AR Disposition Summary Panel Accessibility

6.20.6.1 To Access the AR Disposition Summary Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information and Maintenance panels display.
6	Click AR Disposition Summary hyperlink.	AR Disposition Summary panel displays.

6.20.6.2 To Adjust on the AR Disposition Summary Panel

Step	Action	Response
1	Select row above to adjust.	Data is populated into the fields.
2	Click in desired field to update and perform adjustment.	
3	Click **Save**.	TPL AR Disposition Summary panel is updated.

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6.20.6.3 To Disposition on the AR Disposition Summary Panel

Step	Action	Response
1	Click Disposition.	Activates fields for entry of data or selection from lists.
2	Enter **CCN**. Click [Search] if CCN value is unknown.	
3	Enter Budget ID. Click [Search] if Budget ID value is unknown.	
4	Enter Amount Paid.	
5	Select **Deny**, if applicable.	
6	Enter New Reason. Click [Search] if New Reason value is unknown.	
7	Select **Bulk Check**, if applicable.	
8	Click **Save**.	AR Disposition Summary information is saved.

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6.21 TPL AR Disp - Adjustment Panel Overview

6.21.1 TPL AR Disp - Adjustment Panel Narrative

The TPL AR Disposition Adjustment Panel is used to adjust an accounts receivable disposition.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [AR Search] - [(Enter search criteria)] - [(Select from Search Results)] - [TPL AR Maintenance] - [AR Disposition Summary] - [Adjust button]

6.21.2 AR Disp - Adjustment Panel Layout

6.21.3 AR Disp - Adjustment Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount to Remove	The amount to transfer from the accounts receivable to the accounts receivable entered or expenditure.	Field	Number (Decimal)	9
Create Expenditure	Flag to indicate if the amount to removed from the Selected A/R should be added to another A/R or to create a expenditure.	Listview	Checkbox	1
Disp Amt	Disposition Amount for the selected A/R Disposition.	Field	Number (Decimal)	9
Reason	Reason code for selected accounts receivable disposition.	Field	Character	2
Reason Code for Disposition of FROM A/R	Reason code showing the status of the accounts receivable disposition from where the money is being taken.	Field	Character	2
Reason Code for Disposition of TO A/R	Reason code showing the appropriate status of the accounts receivable disposition where the money is to be applied.	Field	Character	2
Remove amount from Selected A/R and - Add to A/R No	The internal accounts receivable control number to be disposition adjusted. (RRYYDDDBBBSSS) TPL has a region code of 61 and the batch range is 900-950 from the system generated billings	Field	Number (Integer)	13

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Field	Description	Field Type	Data Type	Length
	or a batch range of 951-999, if a manual A/R set-up.			
Reason Code for Disposition of FROM A/R [Search]	This allows the user to search for Reason Code for Disposition of FROM A/R.	Hyperlink	N/A	0
Reason Code for Disposition of TO A/R [Search]	Search link allows for a more detailed search for a Reason Code for Disposition of TO A/R.	Hyperlink	N/A	0
Remove amount from Selected A/R and - Add to A/R No [Search]	This allows for a more detailed search for Remove amount from Selected A/R and - Add to A/R No.	Hyperlink	N/A	0

6.21.4 AR Disp - Adjustment Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Amount to Remove	Field	1	Record may not be over applied.	Verify keying. If necessary, review dispositions for the Add to A/R#.
	Field	2	Amount to remove may not be zero.	Verify keying and re-enter dollar amount.
	Field	3	Amount to remove must be greater than zero.	Verify keying and re-enter dollar amount.
	Field	4	Amount to remove cannot be greater than Total Amt Disp.	Review the TPL A/R Dispositions Summary window.
	Field	5	Amount to remove is greater than disposition amount.	Re-enter dollar amount which is less than or equal to the Disp Amt.
	Field	6	Amount to remove must be equal to Disp Amt for Expenditures.	Verify keying and re-enter dollar amount.
Reason Code for Disposition of FROM A/R	Field	1	Reason Code not found.	Reason code must be one of the values listed on the TPL A/R Reason Code Select window.
	Field	2	Reason code 18 may only be used with an expenditure.	Verify keying and choose a different reason code.
	Field	3	Reason code field is required.	Enter a reason code.
	Field	4	Expenditure requires Reason Code 18.	Verify keying and enter reason code 18.

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Field	Field Type	Error Code	Error Message	To Correct
Reason Code for Disposition of TO A/R	Field	1	Reason Code not found.	Reason code must be one of the values listed on the TPL A/R Reason Code Select window.
	Field	3	To reason code is not allowed with an expenditure. Please remove data.	Reason code is not valid with Created Expenditure ID.
Remove amount from Selected A/R and - Add to A/R No	Field	1	Record cannot be changed because a daughter claim exists and a new A/R has been created. Apply changes to daughter A/R.	Apply changes to daughter A/R.
	Field	2	Add to A/R not found.	Verify and re-enter correct A/R number that must already exit in A/R table.
	Field	3	Cannot have both Add to A/R# and Expenditure.	Enter either Add to A/R #.
	Field	4	Must have either Add to A/R# or Expenditure.	Enter either Add to A/R #.

6.21.5 AR Disp - Adjustment Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.21.6 AR Disp - Adjustment Panel Accessibility

6.21.6.1 To Access the AR Disp-Adjustment Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Click AR Disposition Summary hyperlink.	AR Disposition Summary panel displays.
6	Click **Adjust**.	TPL AR Disposition Adjustment panel displays.

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6.22 TPL AR Letter Panel Overview

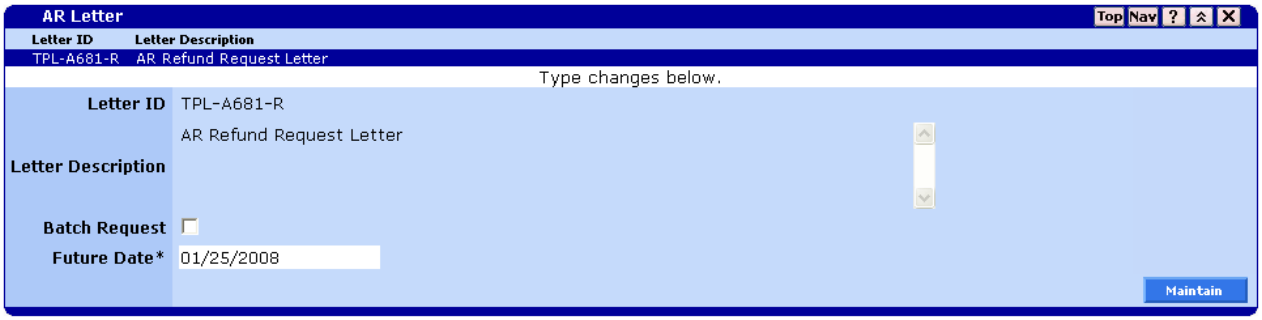
6.22.1 TPL AR Letter Panel Narrative

The TPL AR Letter panel allows the user to request an account receivable letter to send.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [AR Search] - [Search] - [Select a row from search result] - [TPL AR] - [TPL AR Maintenance] - [AR Letter]

6.22.2 TPL AR Letter Panel Layout



6.22.3 TPL AR Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Batch Request	When the checkbox is clicked, the batch is requested.	Combo Box	Checkbox	0
Future Date	The expected date of the letter to be batched.	Field	Date (MM/DD/CCYY)	8
Letter Description	The description of the letter.	Field	Character	4000
Letter ID	This is the identifier of the letter.	Field	Character	10
Maintain	Allows the user the manually print a letter.	Button	N/A	0

6.22.4 TPL AR Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.22.5 TPL AR Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.22.6 TPL AR Letter Panel Accessibility

6.22.6.1 To Access the TPL AR Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information and Maintenance panels display.
6	Click **AR Letter** hyperlink.	AR Letter panel displays.

6.22.6.2 To Update the TPL AR Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AR Letter information is saved.

6.22.6.3 To Maintain the TPL AR Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain.	Login window displays.
3	Enter User Name and Password.	
4	Click **OK**.	Letter generator opens with a message requesting the user to select: To open the PDF Save the PDF Cancel

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6.23 TPL AR Letter History Panel Overview

6.23.1 TPL AR Letter History Panel Narrative

The TPL AR Letter History shows all the letters that have been sent out for this accounts receivable.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [AR Search] - [(Enter search Criteria)] - [Search] - [(Select a row from search results)] - [AR Maintenance] - [AR Letter History]

6.23.2 TPL AR Letter History Panel Layout

6.23.3 TPL AR Letter History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Returned	Date the letter was returned.	Field	Date (MM/DD/CCYY)	8
Date Sent	This is the date the letter was created and printed.	Field	Date (MM/DD/CCYY)	8
Extra Data Description	This field contains additional text that was entered when requested by the user.	Field	Character	4000
Generate Date	Date the letter was requested	Field	Date (MM/DD/CCYY)	8
Generate Mode Indicator	The method used to produce the letter (batch or online).	Field	Character	1
Letter Description	The description of the letter.	Field	Character	55
Letter ID	This is the identifier of the letter.	Field	Character	9
Response Received	Yes or No indicator showing whether a response has or has not been received for this letter.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Return Code	An indicator used to specify if a response has been received.	Combo Box	Drop Down List Box	0
Sent Date	Date the letter was sent.	Field	Date (MM/DD/CCYY)	8
User ID	The identification number associated with the user that requested the letter.	Field	Character	8

6.23.4 TPL AR Letter History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Returned	Field	1	Return Date should be equal to or greater than 01/01/1900.	Enter Return Date of 01/01/1900 or greater.
	Field	2	Return Date should not be prior to Sent Date or Generate Date.	Enter a valid return date.
	Field	3	Return Date should be less than or equal to 12/31/2299.	Enter Return Date of 12/31/2299 or less.

6.23.5 TPL AR Letter History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.23.6 TPL AR Letter History Panel Accessibility

6.23.6.1 To Access the TPL AR Letter History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Information and Maintenance panels display.
6	Click **AR Letter History** hyperlink.	AR Letter History panel displays.

6.23.6.2 To Update the TPL AR Letter History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AR Letter History panel is updated.

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6.24 TPL AR Disp-Base Information Panel Overview

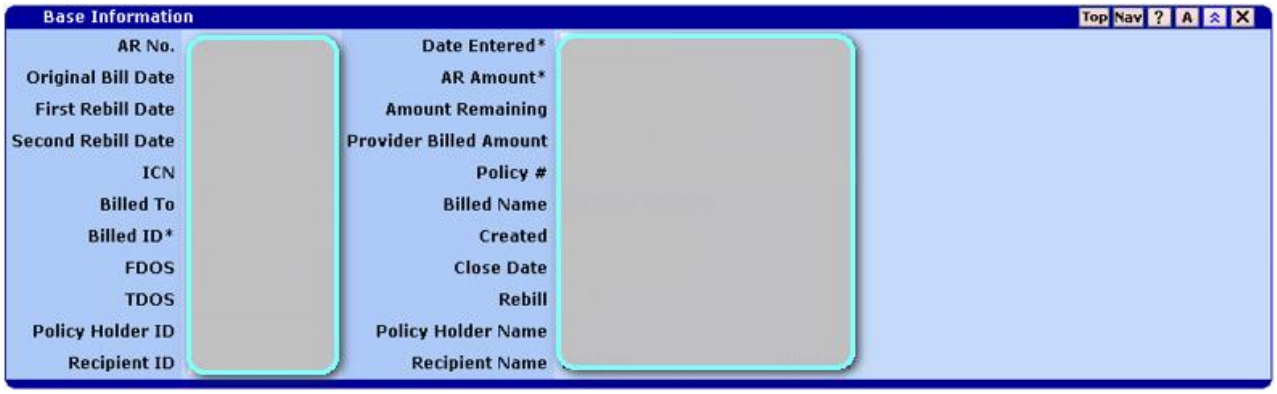
6.24.1 TPL AR Disp-Base Information Panel Narrative

The TPL AR Disp-Base Information panel is used to manually establish an accounts receivable in order to accommodate all outstanding payments from the current MMIS. A/R requires the capability of accepting a manual entry at the recipient, carrier, or policyholder level.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [AR Search] - [(Enter search criteria)] - [Select row from Search Results] - [TPL AR Maintenance] - [Base Information]

6.24.2 TPL AR Disp-Base Information Panel Layout



6.24.3 TPL AR Disp-Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR No	Accounts receivable control number.	Field	Character	13
AR Amount	Amount billed on this accounts receivable.	Field	Number (Decimal)	12
Amount Remaining	Remaining Amount on accounts receivable.	Field	Number (Decimal)	12
Billed ID	The billing identification number associated with the Billed To. This displays either the Carrier code, Employer identification number, Provider identification number or the Recipient identification number.	Field	Character	12
Billed Name	The name of the third party being billed.	Field	Character	28
Billed To	If this claim was billed to Carrier/Employer/Policyholder/Provider.	Combo Box	Drop Down List Box	0
Close Date	The date the status was changed to a closed status.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
Created	Creation method. Valid values: Manual or System.	Combo Box	Drop Down List Box	0
Date Entered	The date the account receivable was entered by the user.	Field	Date (MM/DD/CCYY)	8
FDOS	From Date of Service on the claim.	Field	Date (MM/DD/CCYY)	8
First Rebill Date	Date the first rebill was generated.	Field	Date (MM/DD/CCYY)	8
ICN	Claim associated with this accounts receivable.	Field	Character	13
Original Bill Date	Date the accounts receivable was first billed.	Field	Date (MM/DD/CCYY)	8
Policy Holder ID	The system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder ID.	Field	Character	9
Policy Holder Name	The last name, first name and middle initial of the policy holder	Field	Character	30
Policy #	The number associated with a policy.	Field	Character	30
Provider Billed Amount	The amount billed by the provider on the claim.	Field	Number (Decimal)	12
Rebill	Rebill indicator that identifies the account receivables that were manually requested by the user using the AR Search Results Panel. This field is protected from this panel.	Field	Character	1
Recipient ID	Unique identification number of the recipient.	Field	Number (Integer)	12
Recipient Name	The last name, first name and middle initial of the recipient.	Field	Character	30
Second Rebill Date	Date the second rebill was generated.	Field	Date (MM/DD/CCYY)	8
TDOS	To Date of Service on the claim.	Field	Date (MM/DD/CCYY)	8

6.24.4 TPL AR Disp-Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
AR Amount	Field	1	Amount Billed must be greater than 0.	Enter value greater than 0.
	Field	2	AR Amount is required.	Enter AR Amount.

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Field	Field Type	Error Code	Error Message	To Correct
Billed ID	Field	1	Carrier Billed ID is required.	Enter a valid Carrier Billed ID or select one from search list.
	Field	2	Policyholder Billed ID is required.	Enter a valid Policyholder Billed ID or select one from search list
	Field	3	Provider Billed ID is required.	Enter a valid Provider Billed ID or select one from search list.
	Field	4	Recipient Billed ID is required.	Enter a valid Recipient Billed ID or select one from search list.
Date Entered	Field	1	Date Entered is required.	Enter a valid date.
	Field	1	Date Entered must be greater than or equal to 1/ 1/1900.	Enter a valid Date.
FDOS	Field	1	FDOS is missing. A Manual AR requires FDOS, TDOS when no Claim is associated with it.	Please enter the FDOS.
	Field	2	FDOS must be greater than or equal to 01/01/1900.	Enter a valid date.
Original Billed Date	Field	1	Date Entered is required.	Enter a valid date.
Recipient ID	Field	1	If no recipient is assigned to this AR, a TPL Policy must be assigned.	Enter a Recipient ID or a Policy ID.
TDOS	Field	1	Invalid date. Format is MM/DD/CCYY.	Verify keying. The date must be in MM/DD/CCYY or MMDDCCYY format.
	Field	2	TDOS is missing. A Manual AR requires FDOS, TDOS when no Claim is associated with it.	Enter the TDOS.
	Field	3	TDOS must be greater than or equal to 01/01/1900.	Verify date is greater than or equal to 01/01/1900.

6.24.5 TPL AR Disp-Base Information Panel Extra Features

Required fields are AR Amount, Billed To, Billed ID, Created, Date Entered, and First Billed.

The AR Amount must be greater than zero. The Billed amount for an ICN must be greater than 0, and that ICN must be a paid ICN.

Once saved, the AR Base Information cannot be modified from this panel.

The system defaults to 'Manual' when a new AR is about to be created. Additionally, it defaults Date Entered and Original Billed Date to the current system date. If an ICN is associated with an

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AR, the system will default the Recipient ID, Provider Billed Amount, From DOS and To DOS based upon that claim.

First Rebill and Second Rebill dates are updated by the Batch System, these are read-only fields.

Close Date will be updated when dispositions are posted to the AR.

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will save the information under the linked active ID.

If the Recipient subsystem receives a link request and the old sak_recip exists on the t_tpl_ar_health table, the sak_recip is updated in batch to the active sak_recip.

6.24.6 TPL AR Disp-Base Information Panel Accessibility

6.24.6.1 To Access the TPL AR Disp-Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance page displays.
6	Click Base Information.	Base Information panel displays.

6.24.6.2 To Add on the TPLAR Disp-Base Information Panel

Step	Action	Response
1	Enter AR Amount.	
2	Select **Billed To** from the drop down list box.	
3	Enter Billed ID. Click [Search] if Billed ID is unknown.	Billed Name displays.
4	Enter Policyholder ID. Click [Search] if Policyholder ID is unknown.	Policyholder Name displays.
5	Enter Recipient ID. Click [Search] if Recipient ID is unknown.	Recipient Name displays.
6	Enter **Date Entered** in MM/DD/CCYY format. Note: Date is automatically populated with current date.	

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Step	Action	Response
7	Enter **ICN**. Click [Search] if ICN is unknown.	
8	Enter **First Billed** in MM/DD/CCYY. Note: Date is automatically populated to current date.	
9	Enter **FDOS** in MM/DD/CCYY format.	
10	Enter **TDOS** in MM/DDCCYY format.	
11	Click **Save**.	Base information is saved.

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6.25 TPL AR Disp-Chronological Note Panel Overview

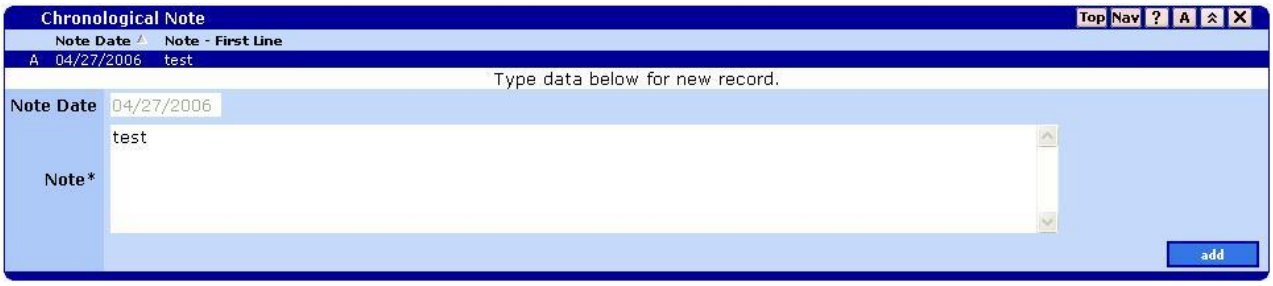
6.25.1 TPL AR Disp- Chronological Note Panel Narrative

The TPL AR Disp Chronological Note panel contains free-form notes entered by the user or batch processes pertaining to a TPL A/R.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation path: [TPL] – [AR Search]-[(Enter search criteria and click on Search)] - [(Select row from Search Results)] - [TPL AR Maintenance] - [AR Health] - [Chronological Note]

6.25.2 TPL AR Disp-Chronological Note Panel Layout



6.25.3 TPL AR Disp-Chronological Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the TPL AR Disp-Chronological Note panel.	Button	N/A	0
Note	Text field used to enter note information.	Field	Character	500
Note Date	Date the chronological note was added.	Field	Date (MM/DD/CCYY)	8
Note - First Line	Label of Note - First Line.	Label	N/A	50

6.25.4 TPL AR Disp-Chronological Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Verify keying. Enter note in the note field.
	Field	2	You have exceeded the maximum number of characters allowed for this field. Your text has been truncated to the maximum 500 characters.	Verify keying. Note entered cannot exceed 500 characters.

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6.25.5 TPL AR Disp-Chronological Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.25.6 TPL AR Disp-Chronological Note Panel Accessibility

6.25.6.1 To Access the TPL AR Disp-Chronological Note Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click Chronological Note hyperlink.	Chronological Note panel displays.

6.25.6.2 To Add on the TPL AR Disp-Chronological Note Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Note** information in free form text field.	Note Date automatically displays current date.
3	Click **Save**.	Chronological Note information is saved.

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6.26 Case Tracking Search Panel Overview

6.26.1 Case Tracking Search Panel Narrative

The State will use the Case Tracking Search panel to determine if a lead has previously been received on a specific case. Available search criteria are: Recipient ID; Recipient Last Name with Recipient First Name; Recipient Last Name with any other field; Case Number; Case Type; User ID; and Recipient Birth Date with at least one other field. Except for Recipient First Name which can only be used in conjunction with Recipient Last Name, all other search fields can be used together in any combination. If a case is found on the system matching the search criteria entered, the information pertaining to that case is displayed.

This panel is inquiry only.

Navigation Path: [TPL] - [Case Tracking Search]

6.26.2 Case Tracking Search Panel Layout

6.26.3 Case Tracking Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Search panel.	Button	N/A	0
Case Type	This indicates the type of the casualty case.	Combo Box	Drop Down List Box	0
Clear	Clears the fields in the search panel.	Button	N/A	0
Current ID [Search]	Member's identification number.	Hyperlink	N/A	0
Ext Entity Case Number	Casualty Case number provided by external entity.	Field	Number(Integer)	9
DXC Case Number[Search]	System assigned case number.	Hyperlink	N/A	0
Recipient DOB	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	10
Recipient First Name	Recipient's first name.	Field	Character	13
Recipient Last Name	Recipient's last name.	Field	Character	15
Recipient SSN	Recipient's Social Security number.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches for records based on search criteria.	Button	N/A	0
User ID	The user ID of the examiner assigned to the case.	Field	Character	8

6.26.4 Case Tracking Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Ext Entity Case Number	Field	1	Ext Entity Case Number must be numeric.	Please enter at least one search field.
Search	Button	1	Please enter at least one search field.	Please enter at least one search field.
Recipient DOB	Field	100	Invalid date. Format is MM/DD/CCYY.	Recipient Date of Birth is invalid.
Recipient First Name	Field	1	Last Name required when Recipient First Name entered.	Recipient Last Name is required when Recipient's First name is captured.
	Field	991	Invalid character in field.	Recipient's First Name Contains invalid Characters.
Recipient Last Name	Field	991	Invalid Characters in field.	Recipient's Last Name Contains invalid Characters.
Recipient SSN	Field	1	Enter a valid value.	SSN must be 9 numeric.
User ID	Field	991	Invalid character in field.	User ID contains Invalid Character.

6.26.5 Case Tracking Search Panel Extra Features

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will retrieve and display the records based on the active ID.

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6.26.6 Case Tracking Search Panel Accessibility

6.26.6.1 To Access the Case Tracking Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.

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6.27 Case Tracking Search Results Panel Overview

6.27.1 Case Tracking Search Results Panel Narrative

The Case Tracking Search results panel shows case information selected from the Case Tracking Search Panel. It is used to determine if a lead has previously been received on a specific case.

This panel is display only.

Navigation Path: [TPL] – [Case Tracking Search] - (Enter search criteria and click [Search] button)

6.27.2 Case Tracking Search Results Panel Layout

6.27.3 Case Tracking Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	This field identifies the date that the accident or injury occurred. Used to identify claims that could be used in this case.	Label	Date (MM/DD/CCYY)	8
Case Number	The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.	Label	Number (Integer)	9
Case Status	This represents the current status of the casualty case.	Label	Character	25
Case Type	This indicates the type of the casualty case.	Label	Character	25
Cur ID	The recipient's Medicare ID.	Label	Character	12
Ext Entity Case Number	Casualty Case number provided by external entity.	Label	Number(Integer)	9
Recipient DOB	The date of birth of the recipient.	Label	Date (MM/DD/CCYY)	8
Recipient Name	Recipient's last (15 characters), first name (13 characters) and middle initial (1 character).	Label	Character	31
Recipient SSN	The social security number of the recipient.	Label	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
User ID	The clerk ID of the examiner assigned to the case.	Label	Character	8

6.27.4 Case Tracking Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.27.5 Case Tracking Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.27.6 Case Tracking Search Results Panel Accessibility

6.27.6.1 To Access the Case Tracking Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.

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6.28 Case Tracking Mini Search Panel Overview

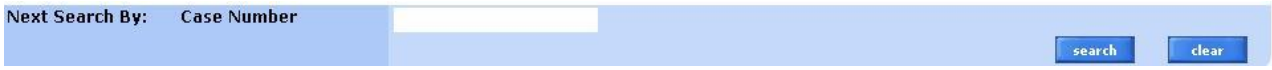
6.28.1 Case Tracking Mini Search Panel Narrative

The Case Tracking Mini Search panel allows the user to quickly change from one casualty case to another without performing a new search from the main menu system.

This panel is inquiry only.

Navigation Path: [TPL] – [Case Tracking] - [(Enter search criteria and click on [Search]) - [(Select from Search Results)] - [Case Tracking Information] - [Mini Search]

6.28.2 Case Tracking Mini Search Panel Layout



6.28.3 Case Tracking Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Case Number	The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.	Field	Number (Integer)	9
Clear	Clears out the case number field.	Button	N/A	0
Search	Searches by the entered case number.	Button	N/A	0

6.28.4 Case Tracking Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	1	Please enter at least one search field.	Enter a case number and then click search.
Case Number	Field	1	Input string was not in a correct format.	The case number is a numeric only field.

6.28.5 Case Tracking Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.28.6 Case Tracking Mini Search Panel Accessibility

6.28.6.1 To Access the Case Tracking Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.

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Step	Action	Response
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Mini Search panel displays at the top of page.

6.28.6.2 To Navigate the Case Tracking Mini-Search Panel

Step	Action	Response
1	Enter Case Number.	
2	Click **Search**.	Case Tracking Information and Maintenance panels display.

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6.29 Case Tracking Information Panel Overview

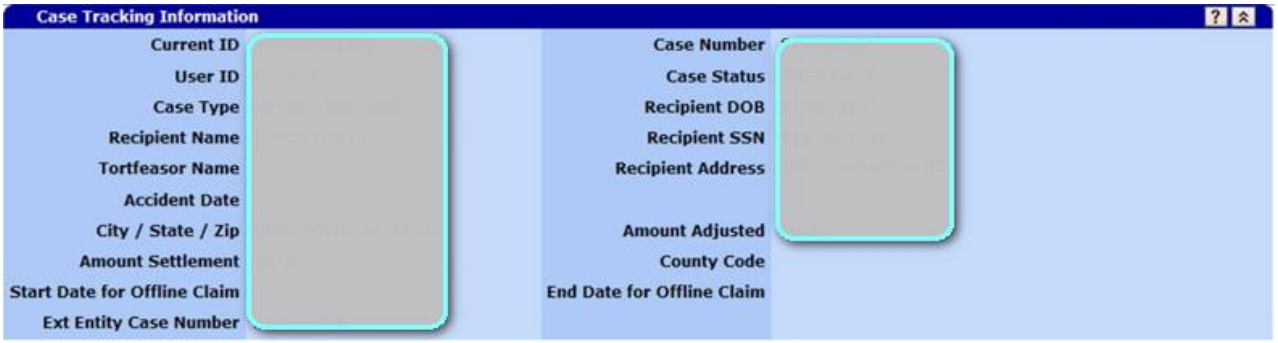
6.29.1 Case Tracking Information Panel Narrative

The Case Tracking Information panel is used to view information about a casualty case.

This panel is display only.

Navigation Path: [TPL] - [Case Tracking Search] - [Search] - [Select row from search results]

6.29.2 Case Tracking Information Panel Layout



6.29.3 Case Tracking Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	This field identifies the date that the accident or injury occurred. Used to identify claims that could be used in this case.	Field	Date (MM/DD/CCYY)	8
Amount Adjusted	The amount removed from the case since it is not actually part of the case.	Field	Number (Decimal)	9
Amount Settlement	The amount the case was settled for.	Field	Number (Decimal)	9
Case Number	The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Case Status	This field is used to identify the current status of the case. Valid values include: A = Recovered MAX-The total case amount was collected and dispositioned. This is a closed case. B = In Compromise- The responsible party is negotiating a lower settlement amount. This is an open case. F = Closed Full Amount- The full settlement amount has been received and dispositioned. This is a closed case. I = Intake-A lead has been received for potential recovery and the case has been added, but further research is needed for pursuing recoveries. This is an open case. L = Lead Review-The case has been transferred to a supervisor or designee for review. This is an open case. M = Closed Partial Recovery-The total case amount was not collected, but a partial recovery was received and dispositioned. This is a closed case. N = No Further Pursuit-After further research, it was determined the case should not be pursued. This is a closed case. O = Open Case-All research has been completed and the case should be pursued. This is an open case. X = Closed No Recovery- The case was pursued, but no money is recoverable. This is a closed case. B = REF TPL Investigator-The case has been referred to a TPL Investigator for further analysis. This is an open case.	Field	Character	1
Case Type	This indicates the type of the casualty case.	Field	Character	1
City	The city where the recipient resides.	Field	Character	18
County Code	The county code used to identify a geographical/political area in the state.	Field	Character	10
Current ID	Unique identifier for the recipient.	Field	Character	12
End Date for Offline Claim	Claim date and time when service ended.	Field	Date (MM/DD/CCYY-HH:MM:SS)	8
Ext Entity Case Number	Casualty Case number provided by external entity.	Field	Number(Integer)	9

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Field	Description	Field Type	Data Type	Length
Recipient Address	The first line of the recipient's street address.	Field	Character	30
Recipient DOB	The date of birth for the recipient.	Field	Date (MM/DD/CCYY)	8
Recipient Name [First]	The first name of a recipient.	Field	Character	15
Recipient Name [Last]	The last name of the recipient.	Field	Character	20
Recipient SSN	The Social Security Number for a recipient.	Field	Number (Integer)	9
Start Date for Offline Claim	Claim Date and time when service started.	Field	Date (MM/DD/CCYY)	8
State	The state where the recipient resides.	Field	Character	2
Tortfeasor Name [First]	The first name of the tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	13
Tortfeasor Name [Last]	The last name of the Tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	15
User ID	The clerk identification number of the examiner assigned to the case.	Field	Character	8
Zip	The five character zip code for the recipient.	Field	Number (Integer)	5

6.29.4 Case Tracking Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.29.5 Case Tracking Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.29.6 Case Tracking Information Panel Accessibility

6.29.6.1 To Access the Case Tracking Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Information panel displays.

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6.30 Case Tracking Maintenance Panel Overview

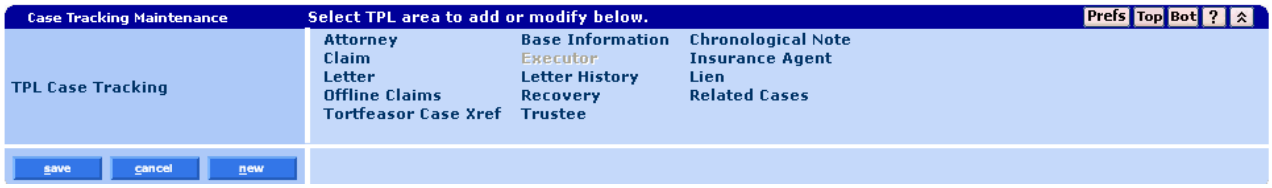
6.30.1 Case Tracking Maintenance Panel Narrative

The Case Tracking Maintenance panel contains links to open various panels for casualty case tracking maintenance.

This panel is inquiry only.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)]

6.30.2 Case Tracking Maintenance Panel Layout



6.30.3 Case Tracking Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Attorney	Link to the Case Tracking Attorney panel.	Hyperlink	N/A	0
Base Information	Link to the Case Tracking Base Information panel.	Hyperlink	N/A	0
Cancel	Cancels the current changes.	Button	N/A	0
Chronological Note	Link to the Case Chronological Note panel.	Hyperlink	N/A	0
Claim	Link to the Case Tracking Claim panel.	Hyperlink	N/A	0
Insurance Agent	Link to the Case Tracking Insurance Agent panel.	Hyperlink	N/A	0
Letter	Link to the Case Tracking Letter panel.	Hyperlink	N/A	0
Letter History	Link to the Case Tracking Letter History panel.	Hyperlink	N/A	0
Lien	Link to the Case Tracking Lien panel.	Hyperlink	N/A	0
New	Allows the user to add new Case Tracking information.	Button	N/A	0
Offline Claims	Link to the Case Tracking Offline Claims panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Recovery	Link to the Case Tracking Recovery panel.	Hyperlink	N/A	0
Related Cases	Link to the Case Tracking Related Cases panel.	Hyperlink	N/A	0
Save	Saves the current record.	Button	N/A	0
Tortfeasor Case Xref	Link to the Tortfeasor Case Xref panel.	Hyperlink	N/A	0
Trustee	Link to Case Tracking Trustee panel.	Hyperlink	N/A	0

6.30.4 Case Tracking Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.30.5 Case Tracking Maintenance Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.30.6 Case Tracking Maintenance Panel Accessibility

6.30.6.1 To Access the Case Tracking Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.

6.30.6.2 To Navigate the Case Tracking Maintenance Panel

Step	Action	Response
1	Select **TPL** area to add or modify.	Select panel displays.

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6.31 Case Tracking Attorney Panel Overview

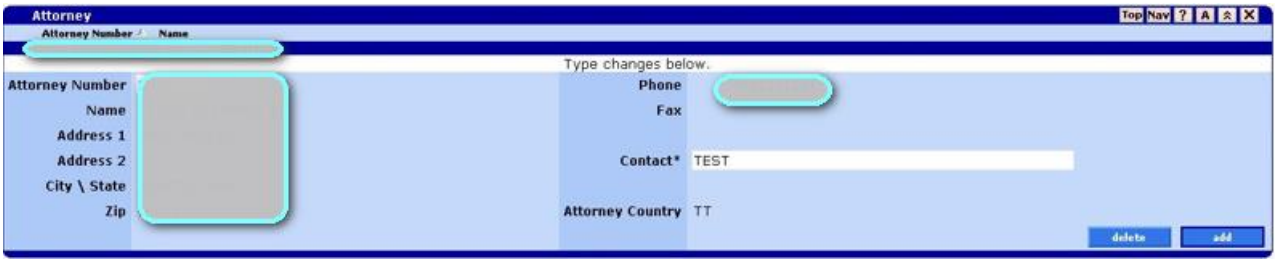
6.31.1 Case Tracking Attorney Panel Narrative

The Case Tracking Attorney panel is used to add or delete attorney information of the accident/injury case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Case Tracking Search] - [Enter Search Criteria - Click Search] - [Select Row From Search Results] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Attorney]

6.31.2 Case Tracking Attorney Panel Layout



6.31.3 Case Tracking Attorney Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Attorney panel.	Button	N/A	0
Address 1	Address of the attorney.	Field	Character	30
Address 2	Address 2 of the attorney.	Field	Character	30
Attorney Country	Country of the attorney.	Field	Character	2
Attorney Number	Unique system assigned number for each attorney.	Field	Number (Integer)	8
City \ State	Attorney city and state.	Field	Character	20
Contact	Attorney contact person name.	Field	Character	40
Delete	Deletes the record.	Button	N/A	0
Fax	Fax machine number of the attorney.	Field	Number (Integer)	10
Name	Recipient's attorney's last name, first name and middle initial.	Field	Character	29
Phone	Phone number of the attorney.	Field	Number (Integer)	10

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Field	Description	Field Type	Data Type	Length
Zip	The first 5 digits and the last 4 digits of the zip code for the attorney.	Field	Number (Integer)	9

6.31.4 Case Tracking Attorney Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Attorney Number	Field	1	A valid Attorney Number is required.	Enter or select a valid Attorney Number.
	Field	2	This Attorney is already in the list.	Enter or select a different Attorney Number.
Contact	Field	1	Contact is required.	Enter a contact name.

6.31.5 Case Tracking Attorney Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.31.6 Case Tracking Attorney Panel Accessibility

6.31.6.1 To Access the Case Tracking Attorney Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Information and Maintenance panels display.
6	Click **Attorney** hyperlink.	Case Tracking Attorney panel displays.

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6.31.6.2 To Add on the Case Tracking Attorney Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Attorney Number. If unknown, click [Search] to locate by a combination of last name, first name, country, and email. Users may also select from the list of results displayed at bottom of panel.	Name, Address 1, Address 2 (if applicable), City/State, Zip, phone and fax information populates.
3	Enter **Contact**.	
4	Click **Save**.	Case Tracking Attorney information is saved.

6.31.6.3 To Update the Case Tracking Attorney Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Tracking Attorney information is saved.

6.31.6.4 To Delete the Case Tracking Attorney Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.32 Case Tracking Base Information Panel Overview

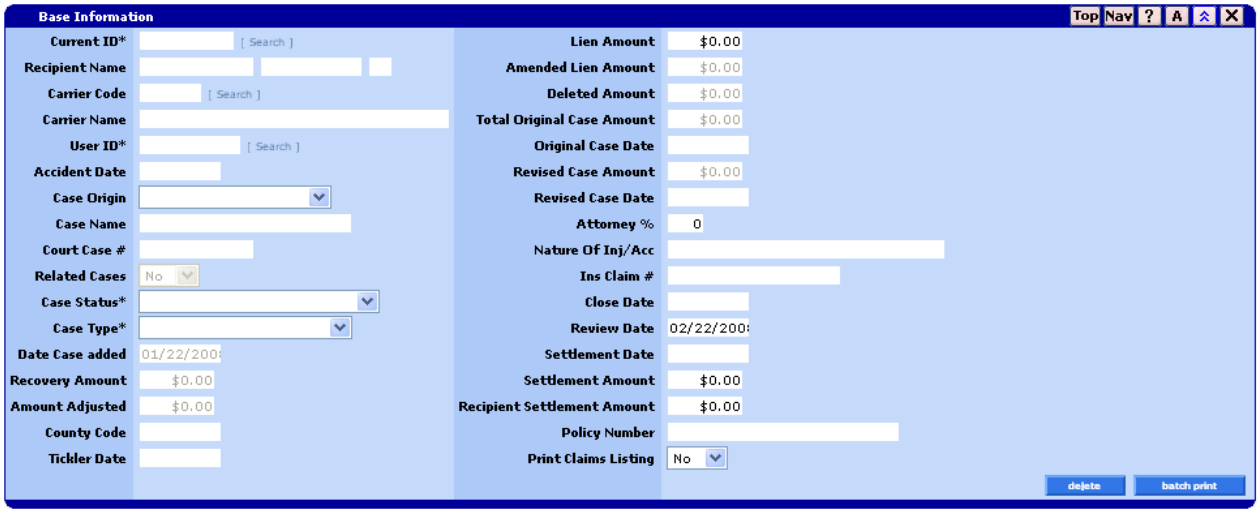
6.32.1 Case Tracking Base Information Panel Narrative

The Agency uses the Case Tracking Base Information panel to record fundamental information about a specific case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Case Tracking Search] - [Enter Search Criteria and Click on Search] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Case Tracking Base Information]

6.32.2 Case Tracking Base Information Panel Layout



6.32.3 Case Tracking Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Date	This field identifies the date that the accident occurred. Used to identify claims that could be used in this case.	Field	Date (MM/DD/CCYY)	8
Amended Lien Amount	Specifies the amended lien amount of the case.	Field	Number (Decimal)	12
Amount Adjusted	This is the amount removed from the case since it is not actually part of the case.	Field	Number (Decimal)	9
Attorney %	Specifies the attorney percentage fee.	Field	Character	6
Batch Print	This adds the sak_casualty to table T_TPL_RQST_REPORT.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Carrier Code	Specifies the insurance company carrier code associated with case.	Field	Alphanumeric	5
Carrier Name	Name of the Carrier business.	Field	Alphanumeric	45
Case Name	Specifies the court case name to be printed on the requested attorney letter. This information is not stored on the case record.	Field	Alphanumeric	20
Case Number	The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.	Field	Number (Integer)	9
Case Origin	This field identifies the party who sent the intake notification originally.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Case Status	This field is used to identify the current status of the case. Valid values include: A = Recovered MAX-The total case amount was collected and dispositioned. This is a closed case. B = In Compromise-The responsible party is negotiating a lower settlement amount. This is an open case. F = Closed Full Amount-The full settlement amount has been received and dispositioned. This is a closed case. I = Intake-A lead has been received for potential recovery and the case has been added, but further research is needed for pursuing recoveries. This is an open case. L = Lead Review-The case has been transferred to a supervisor or designee for review. This is an open case. M = Closed Partial Recovery-The total case amount was not collected, but a partial recovery was received and dispositioned. This is a closed case. N = No Further Pursuit-After further research, it was determined the case should not be pursued. This is a closed case. O = Open Case-All research has been completed and the case should be pursued. This is an open case. X = Closed No Recovery-The case was pursued, but no money is recoverable. This is a closed case. B = REF TPL Investigator-The case has been referred to a TPL Investigator for further analysis. This is an open case.	Combo Box	Drop Down List Box	0
Case Type	Type of casualty case.	Combo Box	Drop Down List Box	0
Court Case #	The legacy court case number associated with the case name.	Field	Character	12
Current ID	Recipient's identification number.	Field	Number (Integer)	12
Date Case Added	The date the case was added to the case tracking (casualty case table).	Field	Date (MM/DD/CCYY)	8
Delete	Deletes the current record.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Deleted Amount	Specifies the amount of the case that was entered.	Field	Number (Decimal)	12
Ins. Claim #	The claim number assigned by the insurance company.	Field	Character	16
Lien Amount	Specifies the amount of the lien.	Field	Number (Decimal)	12
Nature of Inj / Acc	Type of injury the recipient sustained. Free form description of the injury in a casualty case.	Field	Character	30
Original Case Date	The date the case was first billed.	Field	Date (MM/DD/CCYY)	8
Policy Number	The number associated with a policy.	Field	Character	30
Previous Review Date	This is the most recent date that this case was reviewed.	Field	Date (MM/DD/CCYY)	8
Print Claims Listing	Allows user to print a hard copy of the TPL Trauma Detail Claims Listing Report.	Combo Box	Drop Down List Box	0
Recipient Settlement Amount	Specifies the recipient settlement amount of the case.	Field	Number (Decimal)	9
Recipient Name	The Recipient's Last (15 characters) and First Name (13 characters) and Middle Initial (1 character).	Field	Character	29
Recovery Amount	The casualty case recovery amount populated from the Settlement panel.	Field	Number (Decimal)	12
Related Cases	Indicates whether there is another recipient (case) related to this case.	Combo Box	Check Box	0
Review Date	The next date the case is reviewed or the date of case closure. The last action/update date of a casualty case.	Field	Date (MM/DD/CCYY)	8
Revised Case Amount	Specifies the total claim paid amount of all claims selected for the case after it has been originally billed. This field is system populated and updated to reflect the total claim paid amount of all claims on the case if the original bill date is populated.	Field	Number (Decimal)	12
Revised Case Date	Specifies the revised date the case was billed on.	Field	Date (MM/DD/CCYY)	8
Settlement Amount	This is the amount settled in a case.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Settlement Date	Specifies the settlement date of the case.	Field	Date (MM/DD/CCYY)	8
Tickler Date	The tickler date specifies the date of when the next action should be taken on the case.	Field	Date (MM/DD/CCYY)	8
Total Original Case Amount	Specifies the total claim paid amount of all claims selected for the case before it is originally billed. This field is system populated and updated to reflect the total claim paid amount of all claims on the case as long as the case has not been billed yet.	Field	Number (Decimal)	12
User ID	The clerk identification of the examiner assigned to the case.	Field	Character	8

6.32.4 Case Tracking Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Accident Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the Accident Date in the correct format.
	Field	2	Accident Date must be greater than or equal to 01/01/1900.	Enter a date greater than 01/01/1900.
	Field	3	Accident Date must be earlier or equal than Date Case added.	Enter a date earlier or equal than the Date Case added.
	Field	4	Accident Date MM/DD/CCYY must be less than or equal to Review Date MM/DD/CCYY.	Enter an Accident Date earlier than the Review date.
Batch Print	Button	1	Report TPL-0029-R already requested for next batch cycle.	Nothing, this is an informational message.
	Button	2	Report TPL-0029-R added to next batch cycle.	Nothing, this is an informational message.
Carrier Code	Field	1	Carrier code required when dispositioning a check.	Please enter a valid carrier code or use the search option.
	Field	2	Carrier is not valid or inactive.	Enter an active valid carrier number.

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Field	Field Type	Error Code	Error Message	To Correct
Case Status	Field	1	A valid Case Status is required.	Select a Case Status from the drop down.
	Field	2	Case Status not valid – Deleted amount should be zero.	When Closed - Full Amount status is selected. Deleted amount must be zero.
	Field	3	Case status not valid – No recoveries have been posted.	When Closed - Full Amount, Closed - Partial Recovery, and Recovered Max are selected, there must be at least one Recovery.
	Field	4	Case status not valid – Partial recovery has not been posted.	When Closed - Partial Recovery is selected, there must be at least one recovery.
	Field	5	This Case must have claims associated to it, in order to have this status.	When Closed - Full Amount, Closed - Partial Recovery, and Recovered Max are selected, there must be at least one Claim associated with this case.
	Field	7	Case status not valid - Deleted amount should be zero.	When other closed status other than Closed - Full Amount is selected. The deleted amount cannot be zero.
Case Type	Field	91037	A valid Case Type is required.	Select a value for Case Type.
Current ID	Field	1	A valid Base is required.	Enter or select a Current ID.
Lien Release Date	Field	2	Lien Released Date must be greater than or equal to 01/01/1900.	Enter a Lien Released Date greater than 01/01/1900.
	Field	91001	Invalid date.	Enter a valid date (MM/DD/CCYY).
Lien Sent Date	Field	2	Lien Org Date must be greater than or equal to 01/01/1900.	Enter a Lien Sent Date greater than 01/01/1900.
	Field	91001	Invalid date. Format is MM/DD/CCYY.	Enter a valid date (MM/DD/CCYY).
Print Claims Listing	Field	1	Report TPL-A052-R already requested for next batch cycle.	Nothing, this is an informational message.
	Field	2	Report TPL-A052-R cannot be requested - No claims found.	Nothing, this is an informational message.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Claims listing report TPL-A052-R successfully requested.	Nothing, this is an informational message.
Review Date	Field	1	Review Date must be a future date.	Review Date must be greater than original case date.
Settlement Date	Field	1	Settlement Date must be equal or later than the Accident Date.	Enter a date equal or later than the accident date.
Total Original Case Amount	Field	1	Dispositioned Amount Exceeds Case Total.	Nothing, this is only an informational message.
User ID	Field	1	User ID is required.	Enter a User ID.
	Field	2	Invalid User ID. User ID is not listed in the Security Table.	Enter a valid value.

6.32.5 Case Tracking Base Information Panel Extra Features

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will save the information under the linked active ID.

If the Recipient subsystem receives a link request and the old sak_recip exists on the t_casualty_case table, the sak_recip is updated in batch to the active sak_recip.

Case Tracking Activity

If the user adds a new case or updates the status on an existing case, the panel inserts the old status and new status into the t_cas_case_act table. This data is used for the TPL-0003-M and TPL-0004-M reports.

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6.32.6 Case Tracking Base Information Panel Accessibility

6.32.6.1 To Access the Case Tracking Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Information and Maintenance panels display.
6	Click **Base Information** hyperlink.	Case Tracking Base Information panel displays.

6.32.6.2 To Add on the Case Tracking Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Current ID.	Recipient's last name, first name and middle initial automatically populate when the Current ID is entered.
3	Enter Carrier Code.	
4	Enter **User ID**.	
5	Enter **Accident Date** in MM/DD/CCYY format.	
6	Select **Case Origin** from drop down list.	
7	Enter Case Name.	
8	Enter Court Case #.	
9	Enter Ins. Claim #.	
10	Select checkbox, if applicable, if there are **Related Cases**.	
11	Select **Case Status** from drop down list.	
12	Select **Case Type** from drop down list.	
13	Enter Amount Adjusted.	
14	Enter **Tickler Date** in MM/DD/CCYY format.	
15	Enter Lien Amount.	
16	Enter Amended Lien Amount.	
17	Enter **Original Case Date** in MM/DD/CCYY format.	

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Step	Action	Response
18	Enter **Revised Case Date** in MM/DD/CCYY format.	
19	Enter Attorney %.	
20	Enter Nature of Inj/Acc.	
21	Enter **Review/Closed Date** in MM/DD/CCYY format.	
22	Enter **Settlement Date** in MM/DD/CCYY format.	
23	Enter Settlement Amount.	
24	Enter Recipient Settlement Amount.	
25	Enter Policy Number.	
26	Select **Print Claims Listing** from drop down list.	
27	Click **Save**.	Case Tracking Base Information is saved.

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6.33 Case Tracking Chronological Note Panel Overview

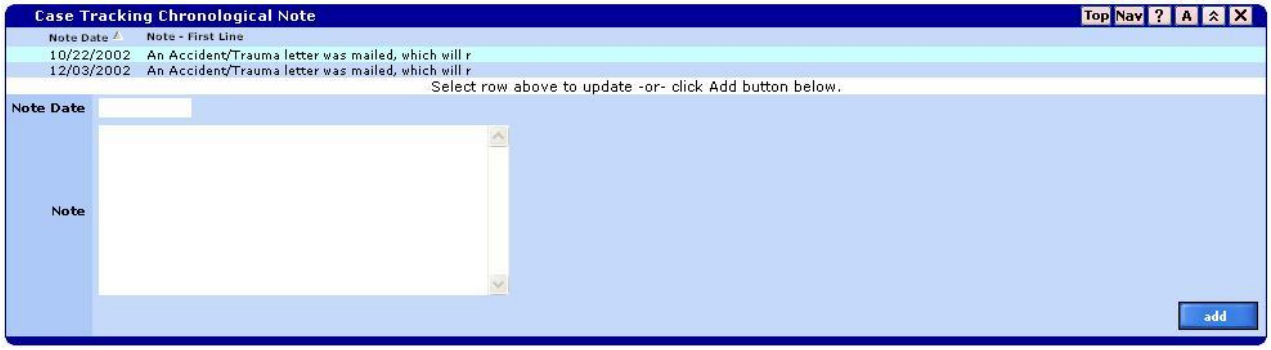
6.33.1 Case Tracking Chronological Note Panel Narrative

The Agency uses the Case Tracking Chronological Note panel to write information concerning the case (i.e. phone calls, updates, etc.).

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Case Tracking Search] - [(Enter Search Criteria and Click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Chronological Note]

6.33.2 Case Tracking Chronological Note Panel Layout



6.33.3 Case Tracking Chronological Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Caes Tracking Chronological Note panel.	Button	N/A	0
Note	This is used for free form text in the chronological notes.	Field	Character	500
Note - First Line	First line of the note that was keyed. Click Save to display the first line of the notes.	Label	Character	50
Note Date	This identifies the date a particular chronological note was added to the case.	Label	Date (MM/DD/CCYY)	8

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6.33.4 Case Tracking Chronological Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	1	Note is required.	Enter at least one line of a note.

6.33.5 Case Tracking Chronological Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.33.6 Case Tracking Chronological Note Panel Accessibility

6.33.6.1 To Access the Case Tracking Chronological Note Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL Case Tracking panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Information and Maintenance panels display.
6	Click Chronological Note hyperlink.	Case Tracking Chronological Note panel displays.

6.33.6.2 To Add on the Case Tracking Chronological Note Panel

Step	Action	Response
1	Click **Add**. Note Date defaults to current date.	Activates fields for entry of data or selection from lists.
2	Enter **Note** in free form text field.	Note Date automatically displays as current date.
3	Click **Save**.	Chronological Note information is saved.

6.33.6.3 To Update the Case Tracking Chronological Note Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Chronological Note Information is saved.

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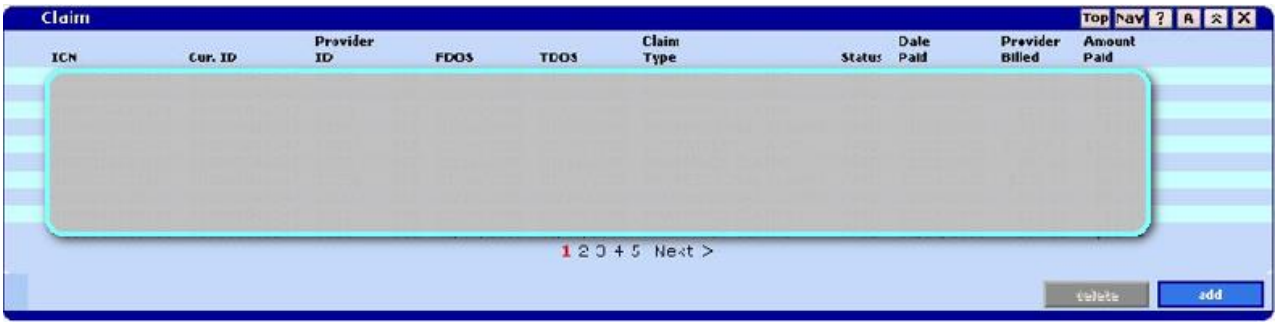
6.34 Case Tracking Claim Panel Overview

6.34.1 Case Tracking Claim Panel Narrative

The Case Tracking Claim panel provides general information about the claims associated to a case and allows the user to search for a claim in the system to associate the claim to a case.

Navigation Path: [TPL] - [Case Tracking] - [Enter Search Criteria] – [Click Search] - [Select Row From Search Results] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Claim]

6.34.2 Case Tracking Claim Panel Layout



6.34.3 Case Tracking Claim Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Claim panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Amount Paid	Amount paid on the claim.	Field	Number (Decimal)	12
Provider Billed	The amount billed by the provider.	Field	Number (Decimal)	12
Provider ID Type	The type of the Provider displayed: National Provider Identifier (NPI) or Medicaid (MCD).	Field	Character	3
Claim Type	The type of claim billed to Medicaid. Identifies the type of claim like outpatient, inpatient, dental, etc.	Label	Character	50
Current ID	Unique identifier for the recipient.	Label	Character	12
Date Paid	The date on which the claim was paid.	Label	Date (MM/DD/CCYY)	8
FDOS	Date on which service was first provided (oldest date of all details).	Label	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
ICN	Number assigned to a claim processed in the system. This is used for control purposes.	Label	Number (Integer)	13
Provider ID	Unique identifier for the provider	Label	Character	15
Status	Description of claim status.	Label	Character	20
TDOS	Last date on which service was provided to a recipient (most recent date of all details).	Label	Date (MM/DD/CCYY)	8

6.34.4 Case Tracking Claim Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.34.5 Case Tracking Claim Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.34.6 Case Tracking Claim Panel Accessibility

6.34.6.1 To Access the Case Tracking Claim Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to TPL and click Case Tracking Search.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL Case Tracking Information and Maintenance panels display.
6	Click **Claim** hyperlink.	Case Tracking Claim panel displays.

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6.35 Case Tracking Claims Search Panel Overview

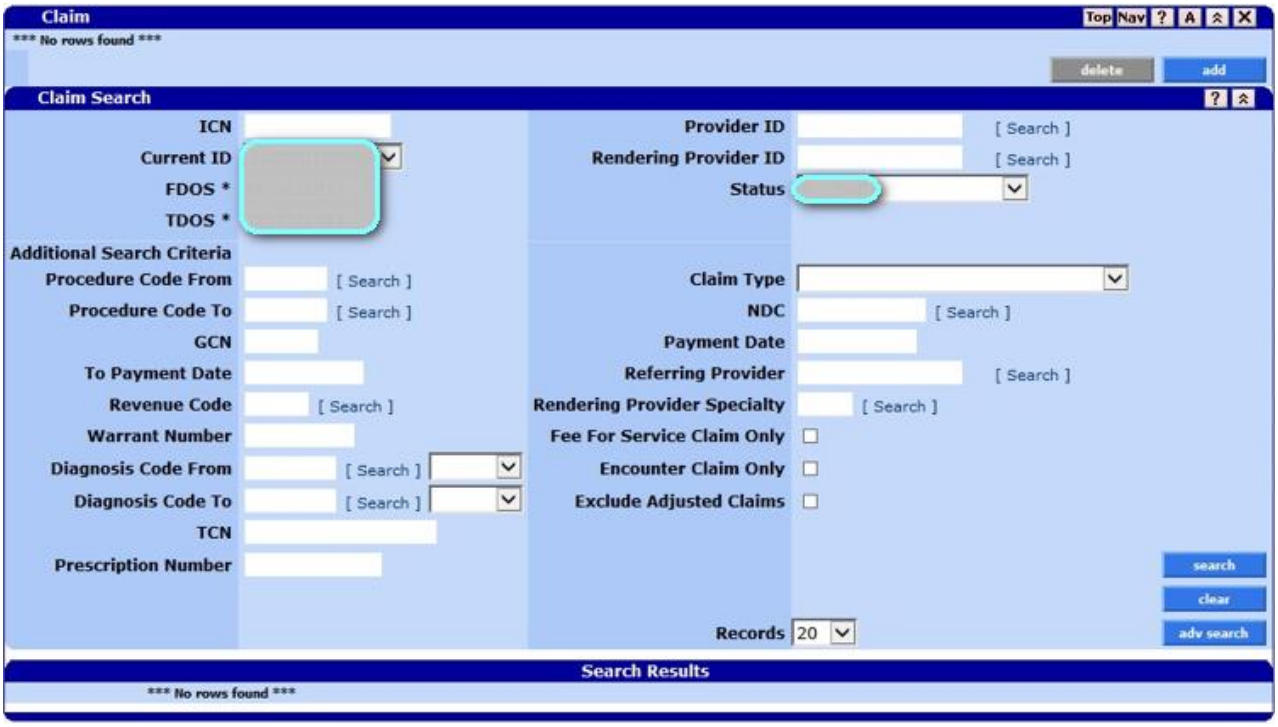
6.35.1 Case Tracking Claims Search Panel Narrative

The Agency uses the Case Tracking Claims Search panel to inquire on the itemized list of claims related to a specific case.

This panel is inquiry only.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Claim] - [Add]

6.35.2 Case Tracking Claims Search Panel Layout



6.35.3 Case Tracking Claims Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Advanced Search	Toggles between a regular search and an advanced search.	Button	N/A	0
Claim Type	The type of claim billed to Medicaid. Identifies the type of claim like outpatient, inpatient, dental, etc.	Combo Box	Drop Down List Box	0
Clear	Clears the search criteria.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Current ID	Recipient's identification number.	Combo Box	Drop Down List Box	12
Diagnosis Code From [Search]	A code for the condition requiring medical attention. This field is used in a range search with Diagnosis TO.	Hyperlink	N/A	0
Diagnosis Code To [Search]	A code for the condition requiring medical attention. This field is used in a range search with Diagnosis FROM.	Hyperlink	N/A	0
Encounter Claim Only	Returns only Encounter Claims.	Combo Box	Check Box	0
Exclude Adjusted Claims	Excludes Adjusted Claims.	Combo Box	Check Box	0
FDOS	From date of service. The first date of service that the claim was submitted for.	Field	Date (MM/DD/CCYY)	8
Fee for Service Claim Only	Returns only fee for service claims.	Combo Box	Check Box	0
GCN	The Generic Code Number is a unique number representing the generic formulation.	Field	Number (Integer)	5
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9, '0' for ICD-10, or blank if corresponding code is not present..	Combo Box	Drop Down List Box	1
ICN	Internal control number that is assigned to each claim to track activity through the claim process.	Field	Number (Integer)	13
NDC [Search]	The National Drug Code used to uniquely identify a drug.	Hyperlink	N/A	0
Payment Date	This date identifies the date on which a claim was paid.	Field	Date (MM/DD/CCYY)	8
Prescription Number	The Prescription Number associated with a claim.	Field	Number (Integer)	12
Procedure Code From [Search]	The corresponding procedure code.	Hyperlink	N/A	0
Procedure Code To [Search]	The corresponding procedure code.	Hyperlink	N/A	0
Provider ID [Search]	Identifies the provider of services.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Referring Provider [Search]	The Referring Provider identification number.	Hyperlink	N/A	0
Rendering Provider ID [Search]	The Rendering Provider identification number.	Hyperlink	N/A	0
Rendering Provider Specialty [Search]	Rendering Provider Specialty number.	Hyperlink	N/A	0
Revenue Code [Search]	This identifies a specific accommodation or ancillary service. Revenue codes are determined by the Centers for Medicare and Medicaid Services (CMS).	Hyperlink	N/A	0
Search	Searches for records based on the entered values.	Button	N/A	0
Status	The status of the claim like paid, denied, suspended, etc.	Combo Box	Drop Down List Box	0
TCN	The transaction control number used to identify claims on legacy system.	Field	Character	17
TDOS	To date of service. The last date of service that the claim was submitted for.	Field	Date (MM/DD/CCYY)	8
To Payment Date	This date identifies the date on which a claim was paid used for specifying an ending date for a range.	Field	Date (MM/DD/CCYY)	8
Warrant Number	Warrant Number.	Field	Character	9

6.35.4 Case Tracking Claims Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Diagnosis Code versions	Field	91003	From and To diagnosis code versions must be the same.	Please select the same diagnosis code versions.
Diagnosis Code From	Field	91004	Please enter the Diagnosis Code From	Please Select the Diagnosis Code From.
Diagnosis Code To	Field	91005	Please enter the Diagnosis Code To	Please Select the Diagnosis Code To.
FDOS	Field	1	FDOS is Required.	Please enter a FDOS.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	91001	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	Date must be numeric.	Verify keying. The date must be in MM/DD/CCYY format.
Fee for Service Claim Only	Field	1	Choose Fee for Service Claim or Encounter Claim.	Verify Fee for Service Claim or Encounter Claim.
ICN	Field	1	ICN must be numeric.	Re-enter numeric ICN.
Payment Date	Field	1	From Payment Date must be less than or equal to Payment Date.	Verify and re-enter From Payment Date.
	Field	91001	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	Date must be numeric.	Verify keying. The date must be in MM/DD/CCYY format.
Search	Button	1	At least one of ICN, Current ID, Provider ID, Rendering Provider ID, or ICN is required.	Enter a valid ICN, TCN, Current ID, Provider ID, or Rendering Provider ID.
TDOS	Field	91001	Invalid Date.	Verify keying. The date must be in MM/DD/CCYY format.
	Field	91002	Date must be numeric.	Verify keying. The date must be in MM/DD/CCYY format.

6.35.5 Case Tracking Claims Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.35.6 Case Tracking Claims Search Panel Accessibility

6.35.6.1 To Access the Case Tracking Claims Search Panel

Step	Action	Response
1	Enter **User Name** and **Password;** Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking Search**.	TPL AR Search panel displays.

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Step	Action	Response
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click **Claim** hyperlink.	Claim panel displays.
7	Click **Add**.	Claim Search panel displays.

6.35.6.2 To Add on the Case Tracking Claim Search Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ICN**.	
3	Enter **Current ID** if different from one currently displayed. Click [Search] if Current ID is unknown.	
4	Enter **FDOS** in MM/DD/CCYY format.	
5	Enter **TDOS** in MM/DD/CCYY format.	
6	Enter **Provider ID**. Click [Search] if Provider ID is unknown.	
7	Enter **Rendering Provider ID**. Click [Search] if Rendering Provider ID is unknown.	
8	Select **Status** from drop down list box.	
9	Select **Records** from drop down list box.	
10	Click **Save**.	Case Tracking Claim Search information is saved.

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6.36 Case Tracking Claims Search Results Panel Overview

6.36.1 Case Tracking Claims Search Results Panel Narrative

The Agency uses the Case Tracking Claims Search Results panel to view the itemized list of claims related to a specific case.

This panel is display only.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Claim] - [Add] - [Search]

6.36.2 Case Tracking Claims Search Results Panel Layout

6.36.3 Case Tracking Claims Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Billed	This dollar amount identifies the billed amount of a claim.	Listview	Number (Decimal)	8
Amount Paid	This dollar amount identifies the amount paid on a claim..	Listview	Number (Decimal)	8
Claim Type	The type of claim billed to Medicaid. Identifies the type of claim like outpatient, inpatient, dental, etc.	Listview	Character	1
Date Paid	The date the claim was paid.	Listview	Date (MM/DD/CCYY)	10
FDOS	From date of service. The beginning date of service that the claim was submitted for.	Listview	Date (MM/DD/CCYY)	10
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9, '0' for ICD-10, or blank if corresponding code is not present	Listview	Character	1
ICN	Internal control number that is assigned to each claim to track activity through the claim process.	Listview	Number (Integer)	13
Primary Diag Code	The claim primary diagnosis code.	Listview	Character	7

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Field	Description	Field Type	Data Type	Length
Primary Diag Desc	The claim primary diagnosis code description.	Listview	Character	40
Secondary Diag Code	The claim secondary diagnosis code.	Listview	Character	7
Secondary Diag Desc	The claim secondary diagnosis code description.	Listview	Character	40
Select All	Selects all claims in the search results.	Hyperlink	N/A	0
Status	The status of the claim like paid, denied, suspended, etc.	Listview	Character	1
TDOS	To date of service. The ending date of service that the claim was submitted for.	Listview	Date (MM/DD/CCYY)	10

6.36.4 Case Tracking Claims Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.36.5 Case Tracking Claims Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.36.6 Case Tracking Claims Search Results Panel Accessibility

6.36.6.1 To Access the Case Tracking Claims Search Results Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click **Claim** hyperlink.	Claim panel displays.
7	Click **Add**.	Claims Search panel displays.
8	Enter Search Criteria.	
9	Click **Search**.	Case Tracking Claims Search Results panel displays.

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6.36.6.2 To Add on the Case Tracking Claims Search Results Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **ICN**.	
3	Enter **Current ID**.	
4	Enter **FDOS** in MM/DD/CCYY format.	
5	Enter **TDOS** in MM/DD/CCYY format.	
6	Enter **Provider ID**.	
7	Enter **Rendering Provider ID**.	
8	Select **Status** from drop down list box.	
9	Select number of **Records** from drop down list box.	
10	Click **Save**.	Case Tracking Claims Search Results information is saved.

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6.37 Case Tracking Insurance Agent Panel Overview

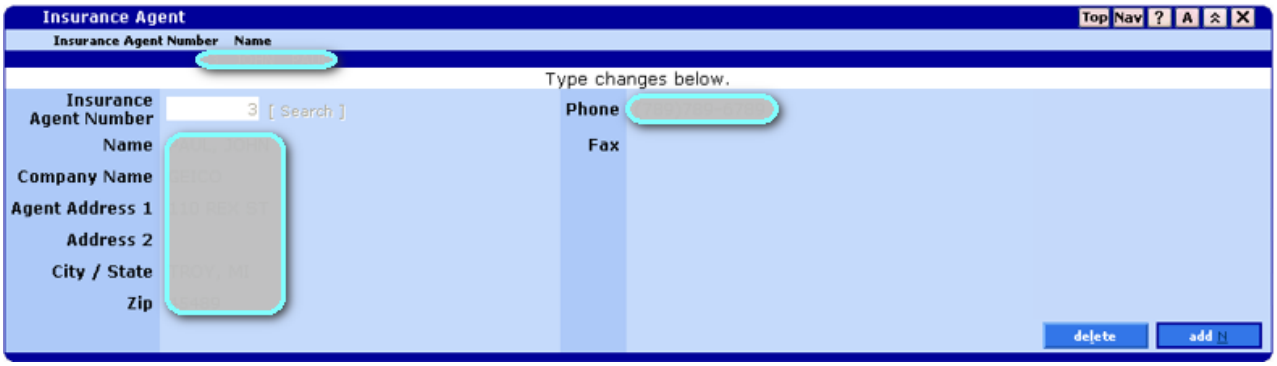
6.37.1 Case Tracking Insurance Agent Panel Narrative

The Case Tracking Insurance Agent panel is used to add or delete insurance agent information for the accident/injury case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Case Tracking Search] - [Enter Search Criteria - Click Search] - [Select Row From Search Results] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Case Tracking Insurance Agent]

6.37.2 Case Tracking Insurance Agent Panel Layout



6.37.3 Case Tracking Insurance Agent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Insurance Agent panel.	Button	N/A	0
Address 2	The second address line of the agent used for correspondence and liens.	Field	Character	55
Agent Address 1	The first address line of the agent used for correspondence and liens.	Field	Character	55
City / State	The city and state of the insurance agent where correspondence, cover letters, and liens are sent to.	Field	Character	32
Company Name	The company that the insurance agent is employed by.	Field	Character	40
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Fax	The insurance agent's fax number.	Field	Number (Integer)	15
Insurance Agent Number	Unique identifier assigned to each Insurance Agent.	Field	Number (Integer)	8

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Field	Description	Field Type	Data Type	Length
Name	The insurance agent's first name and last name used to mail correspondence, cover letters, and liens.	Field	Character	25
Phone	The phone number where the insurance agent can be reached.	Field	Number (Integer)	15
Zip	The insurance agent's zip code where the correspondence, cover letters and liens are sent to.	Field	Number (Integer)	15

6.37.4 Case Tracking Insurance Agent Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Insurance Agent Number	Field	1	A valid Insurance Agent Number is required.	Enter a valid Insurance Agent Number.
	Field	3	A duplicate record can not be saved.	Enter a valid Insurance Agent Number.

6.37.5 Case Tracking Insurance Agent Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.37.6 Case Tracking Insurance Agent Panel Accessibility

6.37.6.1 To Access the Case Tracking Insurance Agent Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click **Insurance Agent** hyperlink.	Insurance Agent panel displays.

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6.38 Case Tracking Letter Panel Overview

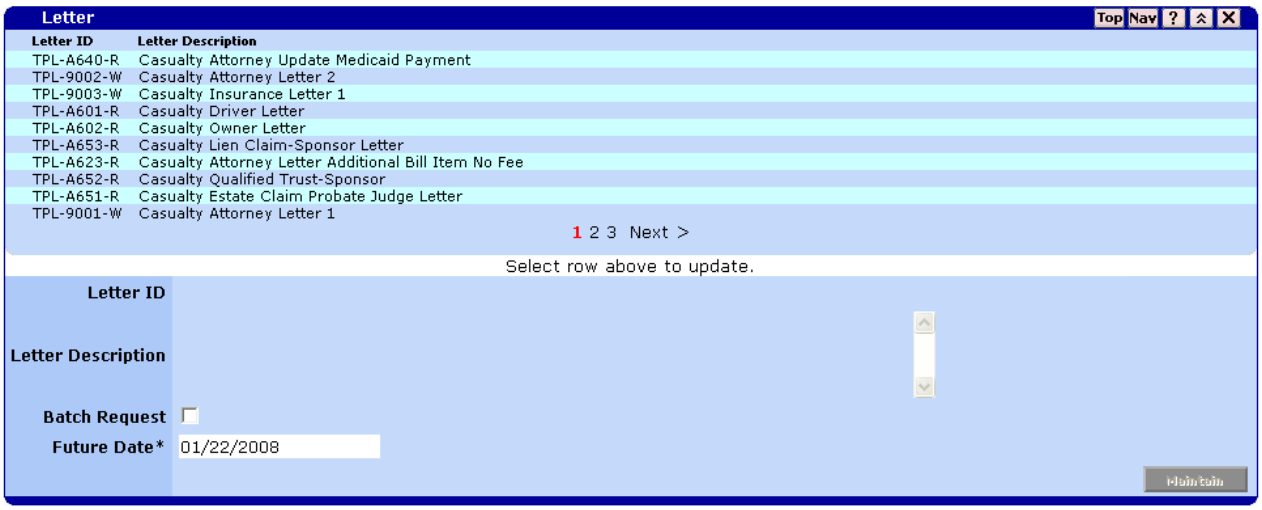
6.38.1 Case Tracking Letter Panel Narrative

The Case Tracking Letter panel allows the user to select a letter for the casualty case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Letter]

6.38.2 Case Tracking Letter Page Layout



6.38.3 Case Tracking Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Batch Request	When the checkbox is clicked, the batch is requested.	Combo Box	Checkbox	0
Future Date	The expected date of the letter to be batched.	Field	Date (MM/DD/CCYY)	8
Maintain	Allows the user to manually print a letter.	Button	N/A	0
Letter Description	The description of the letter.	Field	Character	4000
Letter ID	The identifier of the letter.	Field	Character	10

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6.38.4 Case Tracking Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.38.5 Case Tracking Letter Panel Extra Features

As a standard, all Case Tracking letters begin with the description of 'Cas%' and the ID of the letter begins with 'TPL-'. This allows the system to automatically pick up any newly added letters to the system.

Based upon the schema described above, the extract for this panel is a query against the T_LG_LETTER_TEMPLATE table for the ID_LETTER and DSC_LETTER fields.

Once a letter is selected, the system sends to the letter generate the sak_casualty for the case currently being worked on to the letter generator as a parameter.

6.38.6 Case Tracking Letter Panel Accessibility

6.38.6.1 To Access the Case Tracking Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click **Letter** hyperlink.	Case Tracking Letter panel displays.

6.38.6.2 To Update the Case Tracking Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Tracking Letter information is saved.

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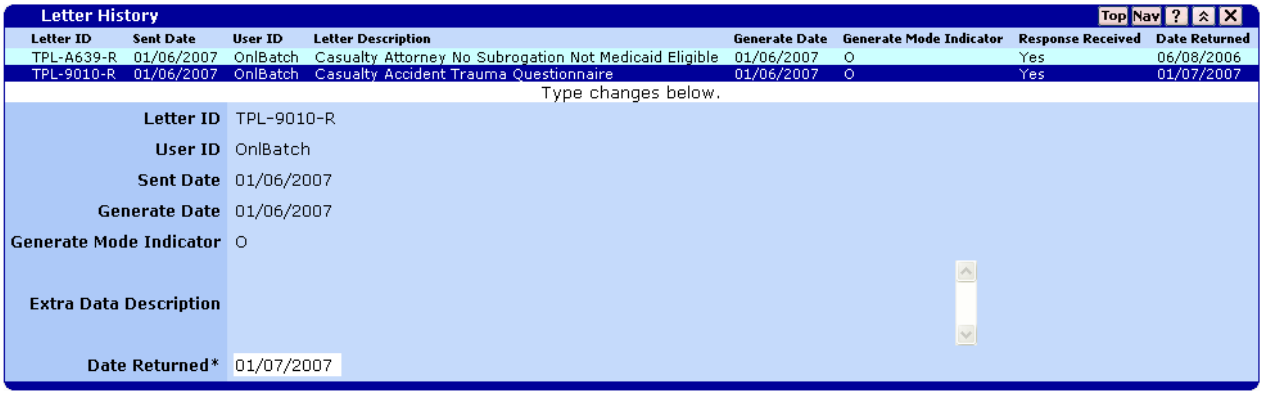
6.39 Case Tracking Letter History Panel Overview

6.39.1 Case Tracking Letter History Panel Narrative

The Case Tracking Letter History panel displays all letters sent for a casualty case.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Letter History]

6.39.2 Case Tracking Letter History Panel Layout



6.39.3 Case Tracking Letter History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Returned	The date the letter was returned.	Field	Date (MM/DD/CCYY)	8
Extra Data Description	Gives additional description about the request.	Field	Character	4000
Generate Date	Contains the date the letter was generated.	Field	Date (MM/DD/CCYY)	8
Generate Mode Indicator	Indicates the mode in which the letter was generated.	Field	Character	1
Letter Description	The description of the letter.	Field	Character	55
Letter ID	Identification of the letter available for print.	Field	Character	20
Response Received	Yes or No indicator showing if a response has or has not been received for this letter.	Field	Character	3
Sent Date	This field holds the date the letter was sent to track when letters are sent.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
User ID	The user's identification number that requested the letter.	Listview	Character	8

6.39.4 Case Tracking Letter History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Returned	Fields	1	Return Date should be less than or equal to 12/31/2299.	Enter a date of return less than or equal to 12/31/2299.
	Fields	2	Return Date should be equal to or greater than to 01/01/1900.	Enter a date of return greater than or equal to 01/01/1900.
	Fields	3	Return Date should not be prior to Sent Date or Generate Date.	Enter a date of return greater than or equal to Sent Date or Generate Date.
	Fields	4	Return Date not valid.	Enter a date or return.

6.39.5 Case Tracking Letter History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.39.6 Case Tracking Letter History Panel Accessibility

6.39.6.1 To Access the Case Tracking Letter History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click **Letter History** hyperlink.	Case Tracking Letter History panel displays.

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6.39.6.2 To Update the Case Tracking Letter History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Tracking Letter History information is saved.

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6.40 Case Tracking Lien Information Panel Overview

6.40.1 Case Tracking Lien Information Panel Narrative

The Case Tracking Lien panel is used to maintain lien information related to a case.

This panel is inquiry only.

Navigation Path: [TPL] – [Case Tracking Search] - [(Enter search criteria and click on [Search])] - [(Select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Lien]

6.40.2 Case Tracking Lien Information Panel Layout

6.40.3 Case Tracking Lien Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
City	This city of the entity that the lien was issued against.	Field	Character	25
Country [Search]	This country of the entity that the lien was issued against.	Hyperlink	N/A	0
Lien Address 1	The first address line of the entity to which a lien was issued against.	Field	Character	55
Lien Address 2	The second address line of the entity to who a lien was issued against.	Field	Character	55
Lien Released Date	The date that the lien was released.	Field	Date (MM/DD/CCYY)	8
Lien Sent Date	The date that the lien was sent.	Field	Date (MM/DD/CCYY)	8
State	The state of the entity that the lien was issued against.	Combo Box	Drop Down List Box	0
Zip	The first five digits and last four digits of the zip code of the entity that the lien was issued against.	Field	Number (Integer)	9

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6.40.4 Case Tracking Lien Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
City	Field	1	You must enter a City.	City is required when Lien Address 1 is captured.
Country	Field	1	Country is invalid.	Enter a valid code or use the search option.
Lien Address 1	Field	1	Street address 1 is Required! Please Enter a Value.	If City, Lien Address 2 or State are captured, Lien Address 1 is required.
Lien Address 2	Field	1	You must enter a Street1 before you can enter a Street 2.	If Lien Address 2 is captured, Lien Address 1 must also be captured.
Lien Released Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
Lien Sent Date	Field	2	Invalid date. Format is MM/DD/CCYY.	Enter a valid date.
Zip	Field	1	Enter a valid value.	Enter 4 Numeric Digits on the ZIP-4 code box.
	Field	2	ZIP code needs to be only numeric values.	Enter only numeric digits in the Zip code box.
	Field	3	ZIP code needs to be 5 numeric digits.	ZIP code must be 5 digits when Country is US.
	Field	4	ZIP code is required when ZIP-4 code exists.	If ZIP-4 was captured, then ZIP code must be too.
	Field	5	You must enter a Zip Code.	Enter a Zip Code.

6.40.5 Case Tracking Lien Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.40.6 Case Tracking Lien Information Panel Accessibility

6.40.6.1 To Access the Case Tracking Lien Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.

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Step	Action	Response
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click **Lien Information** hyperlink.	Lien Information panel displays.

6.40.6.2 To Add on the Case Tracking Lien Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Lien Sent Date** in MM/DD/CCYY format.	
3	Enter **Lien Release Date** in MM/DD/CCYY format.	
4	Enter Lien Address 1.	
5	Enter Lien Address 2.	
6	Enter **City**.	
7	Select **State** from the drop down list.	
8	Enter Zip Code +4.	
9	Enter **Country**. If unknown, use [Search] button to locate Country number.	
10	Click **Save**.	Lien information is saved.

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6.41 Case Tracking Offline Claims Panel Overview

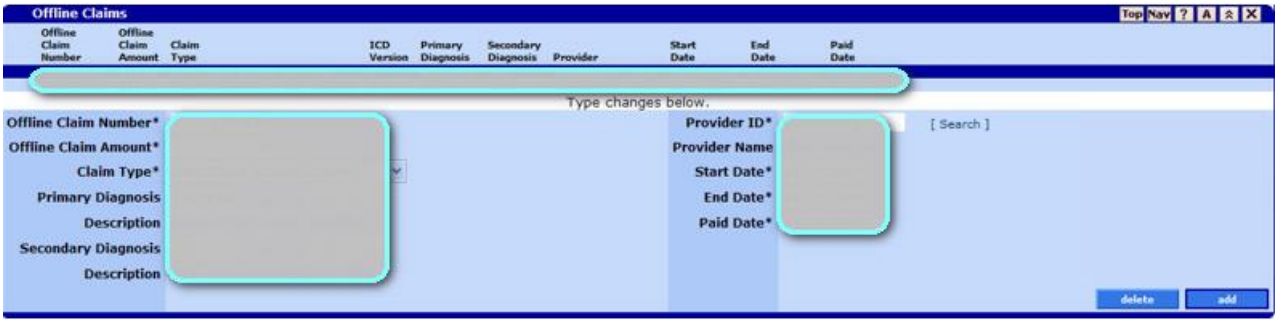
6.41.1 Case Tracking Offline Claims Panel Narrative

The Case Tracking Offline Claims panel is used by the Agency to enter and track offline claims tied to a specific case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Case Tracking Search] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL case Tracking] - [Offline Claims]

6.41.2 Case Tracking Offline Claims Panel Layout



6.41.3 Case Tracking Offline Claims Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Offline Claims panel.	Button	N/A	0
Claim Type	Code that specifies the type of claim record.	Field	Character	1
Delete	Allows the user to remove offline claim information.	Button	N/A	0
End Date	End date for service for the current offline claim.	Field	Date (MM/DD/CCYY)	8
ICD Version	Code to denote which version of the ICD diagnosis code set is being referenced.The valid values are '9' for ICD-9, '0' for ICD-10 or blank if corresponding code is not present.	Field	Character	1
Offline Claim Amount	Amount charged by provider for the current offline claim.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Offline Claim Number	Number that identifies the Offline Claim being entered and that is associated with current TPL Case.	Listview	Number (Integer)	17
Paid Date	Date when claim was paid.	Field	Date (MM/DD/CCYY)	8
Primary Diagnosis	Primary diagnosis identified when service was rendered. A code for the condition requiring medical attention.	Field	Character	7
[Primary Diagnosis] Description	The description of the primary diagnosis code.	Field	Character	60
Provider ID	Provider identification value.	Field	Character	15
Provider Name	The name associated with an organization or person.	Field	Character	50
Secondary Diagnosis	Secondary diagnosis identified when service was rendered. A code for the condition requiring medical attention.	Field	Character	7
[Secondary Diagnosis] Description	The description of the secondary diagnosis code.	Field	Character	60
Start Date	Start date of service for the current offline claim.	Field	Date (MM/DD/CCYY)	8

6.41.4 Case Tracking Offline Claims Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	1	A valid Claim Type is required.	Select a valid Claim Type.
End Date	Field	1	Invalid date.	Enter the End Date in the correct format.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter a date greater than 01/01/1900.
	Field	3	Offline Claim End Date is required.	Enter a valid End Date.
Offline Claim Amount	Field	1	Offline Claim Amount must be greater than or equal to 0.01.	Enter a claim amount.
	Field	2	Offline Claim Amount is required.	Enter a valid amount.
Paid Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the Paid Date in the correct format.
	Field	2	Paid Date must be greater than or equal to 01/01/1900.	Enter a date greater than 01/01/1900.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Paid Date is required.	Enter a valid paid date.
Primary Diagnosis	Field	1	A valid Primary Diagnosis Code is required.	Enter a valid Diagnosis Code.
	Field	2	Primary and Secondary diagnosis code versions must be the same.	Please select the same diagnosis code versions.
Provider ID	Field	1	A valid Group Provider is required.	Enter a valid Provider ID.
Secondary Diagnosis	Field	1	A valid Secondary Diagnosis Code is required.	A valid Secondary Diagnosis Code is required.
Start Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the Start Date in the correct format.
	Field	2	Offline Claim Start Date must be greater than or equal to 01/01/1900.	Enter a date greater than 01/01/1900.
	Field	3	Offline Claim Start Date is required.	Enter a valid start date.

6.41.5 Case Tracking Offline Claims Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.41.6 Case Tracking Offline Claims Accessibility

6.41.6.1 To Access the Case Tracking Offline Claims Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click **Offline Claims** hyperlink.	Offline Claims panel displays.

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6.42 Case Tracking Recovery Panel Overview

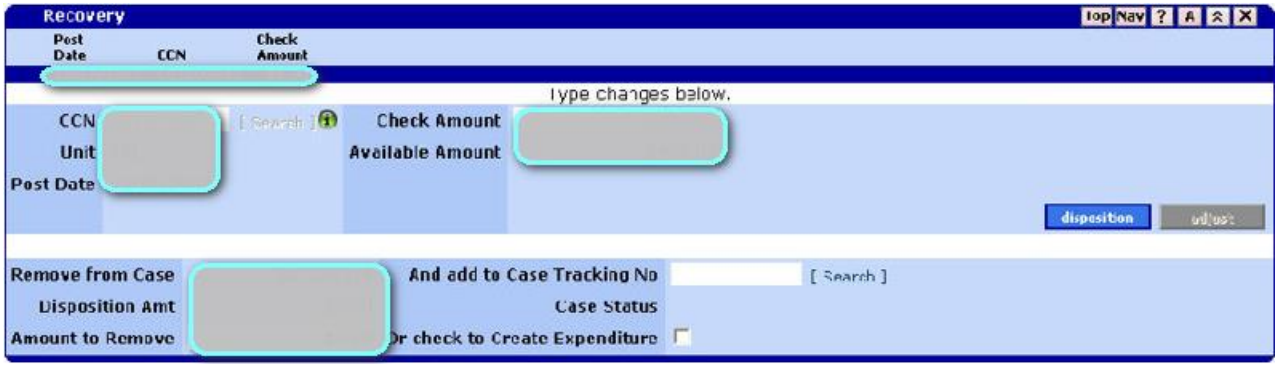
6.42.1 Case Tracking Recovery Panel Narrative

The Case Tracking Recovery panel is utilized by the Agency to enter a CCN associated with a settlement.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Recovery]

6.42.2 Case Tracking Recovery Panel Layout



6.42.3 Case Tracking Recovery Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adjust	This button navigates the user to the TPL Case Tracking Disposition Adjustment Panel.	Button	N/A	0
Amount to Remove	The amount to transfer from the case to the case entered or Expenditure.	Field	Number (Decimal)	15
And add to Case Tracking No	The case number where the money is going to be transfered. If Expenditure is selected, this field will be disabled.	Field	Character	9
Available Amount	Available amount in the selected CCN. Is the result of the Amount paid minus the dispositions to that CCN. This field is display only.	Field	Number (Decimal)	12
Case Status	This shows the status of the Case the money is being transfered to. This status cannot be any of the Closed statuses.	Label	N/A	0
CCN	Cash control number.	Field	Number (Integer)	11

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Field	Description	Field Type	Data Type	Length
Check Amount	The total dollar amount of the case settlement.	Field	Number (Decimal)	9
Disposition	This button allows the user to enter dispositions for a case.	Button	N/A	0
Disposition Amt	The total dollar amount of the disposition.	Label	N/A	0
Or check to Create Expenditure	Check this box to create an Expenditure.	Combo Box	Checkbox	0
Post Date	The date that the casualty case was posted.	Label	Date (MM/DD/CCYY)	8
Remove from Case	This is the Case Number currently being worked on. This field is display only.	Label	N/A	0
Unit	Cash recipient Unit, it can be TPL, HIPP or Non-TPL. This field is display only.	Field	Character	13

6.42.4 Case Tracking Recovery Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
And add to Case Tracking No	Field	1	Warning: Target case does not exist.	This is a warning that will post before saving. When the user enters a case that does not exist in the database.
	Field	2	Adjustment - TO Case cannot be in closed status.	The target Case cannot be in any of the closed statuses.
	Field	3	Adjustment - From Case cannot be the same as To case.	Enter a different target Case number. It cannot be the same as the sending case.
	Field	4	Adjustment - Invalid case selected. The Case must have Claims associated.	The Case that is receiving the moneys must have at least one Claim associated to it.
	Field	5	Adjustment - Must have either Add to Case Tracking or Create Expenditure.	Must have a valid destination Casualty Case or check the expenditure checkbox.
	Field	6	Warning: Target case must have Claims associated with it.	This is a warning that will post before saving. When the user enters a case that does not have Claims associated with it.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	7	Warning: Target case cannot be in closed status.	This is a warning that will post before saving. When the user enters a case that has a Closed Status. Closed Cases cannot be dispositioned anymore.
Amount to Remove	Field	1	Adjustment - must have Amount to Remove greater than 0.	Enter an Amount greater than zero.
	Field	2	Adjustment - Amount to Remove cannot exceed the Disposition amount.	Enter an amount less than the Disposition Amount.
Disposition	Button	1	Important: Disposition Amounts exceed the Original Case Amount.	Verify disposition does not exceed original case amount.
	Button	2	Carrier is required if Claims have been associated with the case.	Verify carrier is associated.
	Button	3	Invalid User ID. User ID is not listed in the security table.	Verify User ID.
CCN	Field	1	Selected CCN is not valid or does not exist.	Select a valid CCN.
	Field	2	Selected CCN does not have a TPL Unit. This CCN cannot be used for this Recovery.	Choose a CCN that has a unit of TPL (200)
	Field	3	Selected CCN is on Insufficient Funds status.	The check is in "Insufficient Funds" status. Choose another CCN.
	Field	7142	A valid Cash Receipt is required.	Click search and select one from the list.
Check Amount	Field	1	Amount is required.	Enter an amount.
	Field	2	Disposition amount exceeds case total.	This is a warning. The Check Amount in the disposition is greater than the Original Case Total or Revised Case Total (if calculated).

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	The Recovery Amount must be greater than zero.	Verify keying. Enter a Recovery Amount greater than zero.
	Field	4	Recovery Amount exceeds available check amount.	Verify keying. Enter a Recovery Amount less than the check amount.
	Field	5	Amount must be less than or equal to 9999999.99.	Enter an amount up to 9999999.99.
	Field	6	Disposition amount exceeds the Case Total.	This is a Warning. The sum of all dipositions are more than the Original Case Total or Revised Case Total (if calculated). This warning will only appear if the case is being closed.
Or check to Create Expenditure	Check Box	1	Adjustment - Must have either Add to Case Tracking or Create Expenditure.	Must have a valid destination Casualty Case or check the expenditure checkbox.

6.42.5 Case Tracking Recovery Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.42.6 Case Tracking Recovery Panel Accessibility

6.42.6.1 To Access the Case Tracking Recovery Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	TPL AR Maintenance panel displays.
6	Click **Recovery** hyperlink.	Recovery panel displays.

6.42.6.2 To Update on the Case Tracking Recovery Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Tracking Recovery information is saved.

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6.43 Case Tracking Related Cases Panel Overview

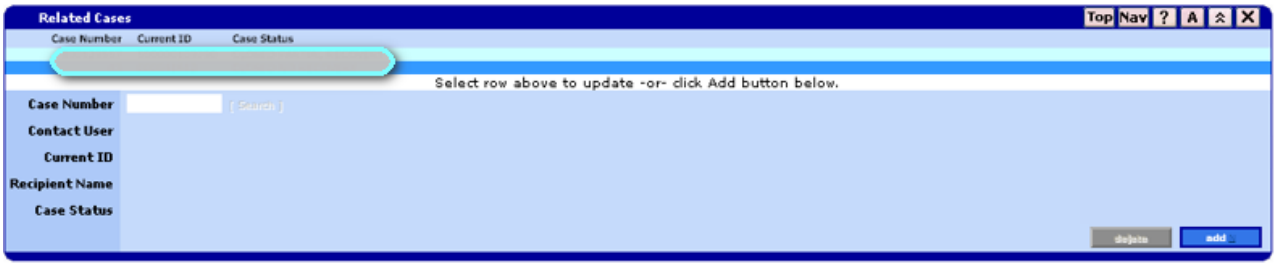
6.43.1 Case Tracking Related Cases Panel Narrative

The Case Tracking Related Case panel is utilized by the Agency to inquire about other open cases related to a recipient.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Case Tracking Search] - [(enter search criteria and click on Search)] - [(select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Related Cases]

6.43.2 Case Tracking Related Cases Panel Layout



6.43.3 Case Tracking Related Cases Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Related Cases panel.	Button	N/A	0
Case Number	The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Case Status	This field is used to identify the current status of the case. Valid values include: A = Recovered MAX-The total case amount was collected and dispositioned. This is a closed case. B = In Compromise-The responsible party is negotiating a lower settlement amount. This is an open case. F = Closed Full Amount-The full settlement amount has been received and dispositioned. This is a closed case. I = Intake-A lead has been received for potential recovery and the case has been added, but further research is needed for pursuing recoveries. This is an open case. L = Lead Review-The case has been transferred to a supervisor or designee for review. This is an open case. M = Closed Partial Recovery-The total case amount was not collected, but a partial recovery was received and dispositioned. This is a closed case. N = No Further Pursuit-After further research, it was determined the case should not be pursued. This is a closed case. O = Open Case-All research has been completed and the case should be pursued. This is an open case. X = Closed No Recovery-The case was pursued, but no money is recoverable. This is a closed case. B = REF TPL Investigator-The case has been referred to a TPL Investigator for further analysis. This is an open case.	Field	Character	0
Contact User	The user ID assigned to the related case.	Field	Character	8
Current ID	Unique identifier for the recipient.	Field	Number (Integer)	12
Delete	Deletes the current record.	Button	N/A	0
Recipient Name	The name of the responsible person for this case.	Field	Character	40

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6.43.4 Case Tracking Related Cases Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Case Number	Field	1	Enter a valid value.	Case number is a numeric only field.
	Field	2	This Related Case is already in the list.	Select another different Case Number not already listed in the Datalist.
	Field	3	Cannot relate to itself.	Select another different Case Number than the Case you are Relating Cases to.
	Field	4	A valid Casualty Case is required.	Enter or select a case number.
Current ID	Field	1	A valid Base is required.	Enter a valid Current ID.

6.43.5 Case Tracking Related Cases Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.43.6 Case Tracking Related Cases Panel Accessibility

6.43.6.1 To Access the Case Tracking Related Cases Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click **Related Cases** hyperlink.	Related Cases panel displays.

6.43.6.2 To Add on the Case Tracking Related Cases Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Case Number** or click [Search] to look for case number by Current ID, Recipient SSN, Recipient DOB, Recipient Last Name, Recipient First Name, User ID or Case Type.	Contact Name, Current ID, Recipient Name and Case Status are automatically populated.
3	Click **Save**.	Related Cases information is saved.

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6.43.6.3 To Update on the Case Tracking Related Cases Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Related Cases information is saved.

6.43.6.4 To Delete on the Case Tracking Related Cases Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.44 Case Tracking Tortfeasor Case Xref Panel Overview

6.44.1 Case Tracking Tortfeasor Case Xref Panel Narrative

The Case Tracking Tortfeasor Case Xref panel lists the Tortfeasor Cross-references associated with a case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: Navigation Path: [TPL] – [Case Tracking Search] - [(Enter search criteria and click on [Search])] - [(Select row from search results)] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Tortfeasor Case Xref]

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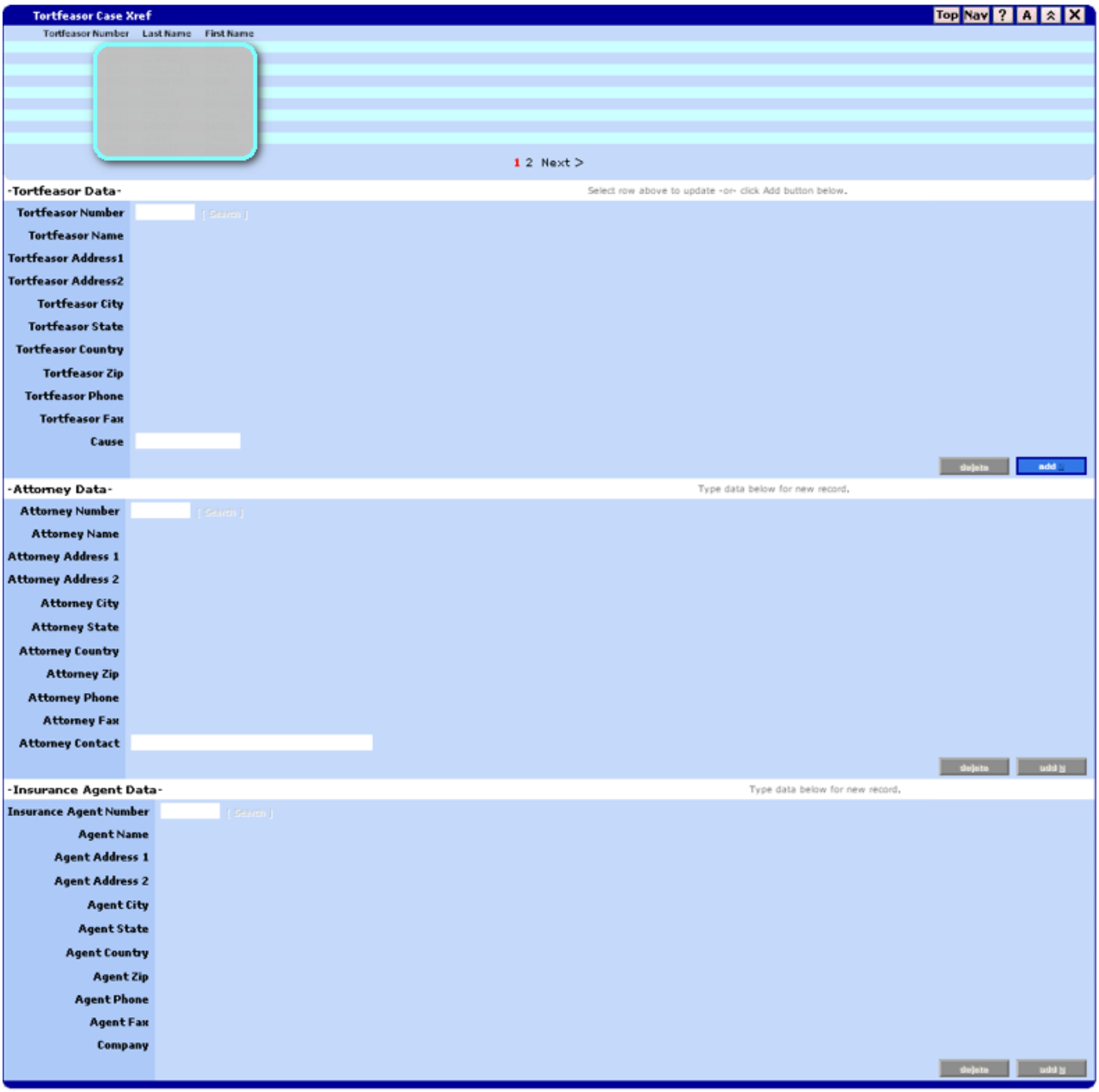
6.44.2 Case Tracking Tortfeasor Case Xref Panel Layout



6.44.3 Case Tracking Tortfeasor Case Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add (Attorney Panel)	Add a new attorney record.	Button	N/A	0
Add (Insurance Panel)	Add a new insurance record.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Add (Tortfeasor Panel)	Add a new tortfeasor record.	Button	N/A	0
Delete (Attorney Panel)	Delete an attorney record.	Button	N/A	0
Delete (Insurance Panel)	Delete an insurance record.	Button	N/A	0
Delete (Tortfeasor Panel)	Delete a tortfeasor record.	Button	N/A	0
Agent Address 1	The first street address of the insurance agent where the correspondence, cover letters, and liens are sent.	Field	Character	55
Agent Address 2	The second street address of the insurance agent where the correspondence, cover letters and liens are sent.	Field	Character	55
Agent City	The city of the insurance agent where correspondence, cover letters, and liens are sent.	Field	Character	30
Agent Country	The country of the insurance agent where correspondence, cover letters, and liens are sent.	Field	Character	2
Agent Fax	The insurance agent's fax number.	Field	Number (Integer)	15
Agent Name	The insurance agent's last, first name, middle initial used to mail correspondence, cover letters, and liens.	Field	Character	25
Agent Phone	The phone number where the insurance agent can be reached.	Field	Number (Integer)	15
Agent State	The city of the insurance agent where correspondence, cover letters, and liens are sent.	Field	Character	2
Agent Zip	The insurance agent's zip code where the correspondence, cover letters and liens are sent to.	Field	Number (Integer)	15
Attorney Address 1	The first address line of the attorney used for correspondence and liens.	Field	Character	30
Attorney Address 2	The second address line of the attorney used for correspondence and liens.	Field	Character	30
Attorney City	The attorney's city that the correspondence and liens are sent.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Attorney Contact	The name of the person that is used when contacting the attorney's office.	Field	Character	32
Attorney Country	The attorney's country code that the correspondence and liens are sent.	Field	Character	2
Attorney Fax	The fax number in the format area code + prefix + suffix.	Field	Number (Integer)	10
Attorney Name	The last, first, middle name of the attorney used for correspondence and liens.	Field	Character	29
Attorney Number	Unique identifier assigned to each attorney.	Field	Number (Integer)	8
Attorney Phone	The phone number of the attorney.	Field	Number (Integer)	10
Attorney State	The attorney's state code that the correspondence and liens are sent.	Field	Character	2
Attorney Zip	The first 5 digits and the last 4 digits of the zip code for the attorney.	Field	Number (Integer)	9
Cause	The cause number that the county courthouse puts on the lien for a torfeasor and a particular case.	Field	Character	15
Company (Insurance Panel)	The company that the insurance agent is employed by.	Field	Character	40
Insurance Agent Number	An account assigned number to an individual insurance company.	Field	Number (Integer)	8
Tortfeasor Address1	The first street address of the tortfeasor's where the correspondence, cover letters, and liens are sent to.	Field	Character	30
Tortfeasor Address2	The second street address of the tortfeasor's where the correspondence, cover letters, and liens are sent.	Field	Character	30
Tortfeasor City	The city of the tortfeasor where the correspondence, cover letters, and liens are sent.	Field	Character	15
Tortfeasor Country	The country code of the tortfeasor where the correspondence, cover letters, and liens are sent.	Field	Character	2
Tortfeasor Fax	The fax number of the tortfeasor.	Field	Number (Integer)	10
Tortfeasor Name	The last, first, middle name of the tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	29

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Field	Description	Field Type	Data Type	Length
Tortfeasor Name	The last, first, middle name of the tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	29
Tortfeasor Number	The account assigned number of the tortfeasor.	Field	Number (Integer)	8
Tortfeasor Phone	The phone number where the tortfeasor can be reached.	Field	Number (Integer)	10
Tortfeasor State	The state of the tortfeasor where the correspondence, cover letters, and liens are sent.	Field	Character	2
Tortfeasor Zip	The tortfeasor's zip code where the correspondence, cover letters, and liens are sent.	Field	Number (Integer)	5

6.44.4 Case Tracking Tortfeasor Case Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Attorney Contact	Field	44	Contact is required.	Enter a valid Contact.
Attorney Number	Field	22	A valid Attorney Number is required.	Enter or select a valid Attorney Number.
	Field	25	Attorney Number must be numeric.	Enter a valid Attorney Number.
	Field	26	Attorney does not exist, please verify.	Enter a valid Attorney Number.
Tortfeasor Number	Field	20	A valid Tortfeasor Number is required.	Enter a valid Tortfeasor Number.
	Field	22	Tortfeasor does not exist, please verify.	Enter a valid Tortfeasor Number.
	Field	23	Tortfeasor Number must be numeric.	Enter a valid Tortfeasor Number.
	Field	32	This Tortfeasor is already in the list.	Enter a different Tortfeasor Number.
Insurance Agent Number	Field	66	A valid Insurance Agent Number is required.	Enter a valid Insurance Agent Number.
	Field	67	Insurance Agent Number does not exist, please verify.	Enter a valid Insurance Agent Number.
	Field	68	Insurance Agent Number must be numeric.	Enter a valid Insurance Agent Number.

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6.44.5 Case Tracking Tortfeasor Case Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.44.6 Case Tracking Tortfeasor Case Xref Panel Accessibility

6.44.6.1 To Access the Case Tracking Tortfeasor Case Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	TPL AR Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click Tortfeasor Case Xref hyperlink.	Tortfeasor Case Xref panel displays.

6.44.6.2 To Add on the Case Tracking Tortfeasor Case Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Tortfeasor Number. If unknown, use [Search] button to locate.	Name, Address, City, State, Country, Zip, Phone and Fax of Tortfeasor are automatically populated.
3	Enter **Cause**.	
4	Click **Save**.	Tortfeasor Case Xref information is saved.

6.44.6.3 To Update on the Case Tracking Tortfeasor Case Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tortfeasor Case Xref information is saved.

6.44.6.4 To Delete on the Case Tracking Tortfeasor Case Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.45 Case Tracking Trustee Panel Overview

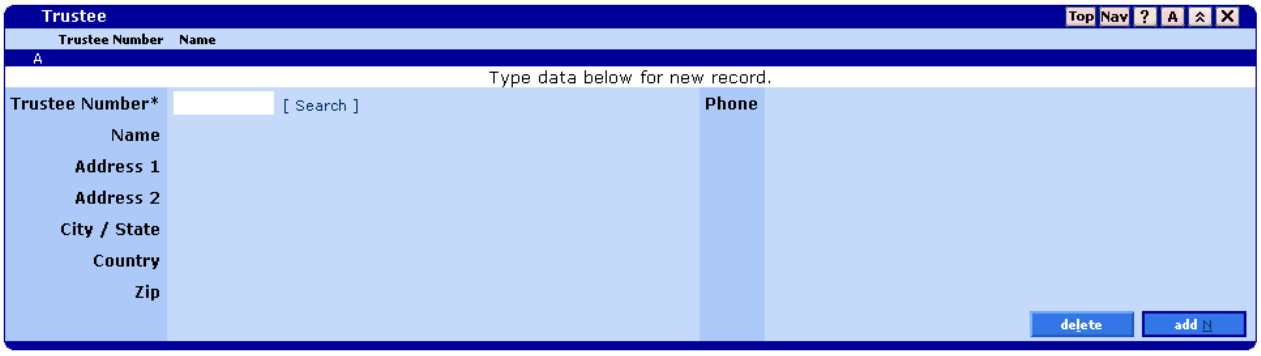
6.45.1 Case Tracking Trustee Panel Narrative

The Case Tracking Trustee panel is used to add or delete trustees associated to a trust recovery case. This panel is only enabled if the case type is equal to A, B, or C.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Case Tracking Search] - [Enter Search Criteria - Click Search] - [Select Row From Search Results] - [Case Tracking Maintenance] - [TPL Case Tracking] - [Trustee]

6.45.2 Case Tracking Trustee Panel Layout



6.45.3 Case Tracking Trustee Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Case Tracking Trustee panel.	Button	N/A	0
Address 1	Address of the trustee.	Field	Character	55
Address 2	Address 2 of the trustee.	Field	Character	55
City\State	City and state of executor.	Field	Character	32
Country	Code associated with the country.	Field	Character	3
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Name	Recipient’s trustee's last name, first name and middle initial.	Field	Character	36
Trustee Number [Search]	Unique system assigned number for each trustee.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Zip	The first 5 digits and the last 4 digits of the zip code for the trustee. It can be an international address zip code.	Field	Number (Integer)	24

6.45.4 Case Tracking Trustee Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Trustee Number	Field	1	A valid Trustee is required.	Enter or select a valid Trustee number.
	Field	2	This Trustee is already in the list.	Choose another Trustee, the one you have chosen was already associated with this case.
	Field	3	Recipient's Current ID must be selected before selecting Trustee.	Enter the recipient number in the Casualty Case Base Information Panel before trying to associate Trustees to the case.
	Field	4	Trustee Number must be numeric.	Only numeric values are allowed on Trustee Number.
	Field	5	Trustee does not exist or does not meet the requirements for this case, please verify.	There are three reasons why this message is posted. One, the Recipient ID on the Trustee panel does not match the one on the Case's Recipient Current ID. Two, the Record does not exist. This record in the T_TPL_CASE_INFO table has a Type of Trustee.

6.45.5 Case Tracking Trustee Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.45.6 Case Tracking Trustee Panel Accessibility

6.45.6.1 To Access the Case Tracking Trustee Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Case Tracking**.	Case Tracking Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	Search results display.
5	Select row from search results.	Case Tracking Maintenance panel displays.
6	Click **Trustee** hyperlink.	Case Tracking Trustee panel displays.

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Step	Action	Response
	Note: This link is only enabled if the Case Type is = A, B or C.	

6.45.6.2 To Add on the Case Tracking Trustee Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Trustee Number. If unknown, use [Search] button to locate by last name or first name.	Name, Address, City/State, Country, Phone and Zip are automatically populated.
3	Click **Save**.	Case Tracking Trustee information is saved.

6.45.6.3 To Update the Case Tracking Trustee Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Tracking Trustee information is saved.

6.45.6.4 To Delete on the Case Tracking Trustee Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.46 HIPP Case Search Panel Overview

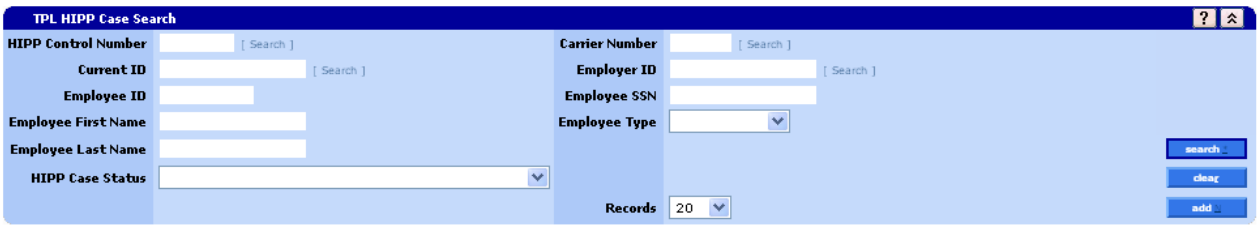
6.46.1 HIPP Case Search Panel Narrative

The HIPP Case Search panel allows the user to enter search criteria and query for HIPP Case records whose data matches that criteria.

This panel is inquiry only.

Navigation Path: [TPL] – [HIPP Case Search]

6.46.2 HIPP Case Search Panel Layout



6.46.3 HIPP Case Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the HIPP Case Search panel.	Button	N/A	0
Carrier Number	Carrier Number Identifier.	Field	Alphanumeric	7
Clear	Allows the user to remove search information from the panel.	Button	N/A	0
Current ID [Search]	This allows the user to search for a Case Number.	Hyperlink	N/A	0
Employee First Name	Search by the employee's first name.	Field	Alphanumeric	15
Employee ID	Search by an employee identification number.	Field	Number (Integer)	12
Employee Last Name	Search by the employee's last name.	Field	Alphanumeric	15
Employee SSN	Search by the employee's Social Security Number.	Field	Number (Integer)	9
Employee Type	Search by the employee type. This type can be a policyholder or recipient.	Combo Box	Drop Down List Box	0
Employer ID	Employer identification number.	Field	Alphanumeric	7
HIPP Case Status	This is the status of the HIPP Case.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
HIPP Control Number	Search by the HIPP control number assigned to a case.	Field	Alphanumeric	9
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

6.46.4 HIPP Case Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search	Button	1	Please enter at least one search field.	Need to enter a value in one of the search fields.

6.46.5 HIPP Case Search Panel Extra Features

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will retrieve and display the records based on the active ID.

6.46.6 HIPP Case Search Panel Accessibility

6.46.6.1 To Access the HIPP Case Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.

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6.47 HIPP Case Search Results Panel Overview

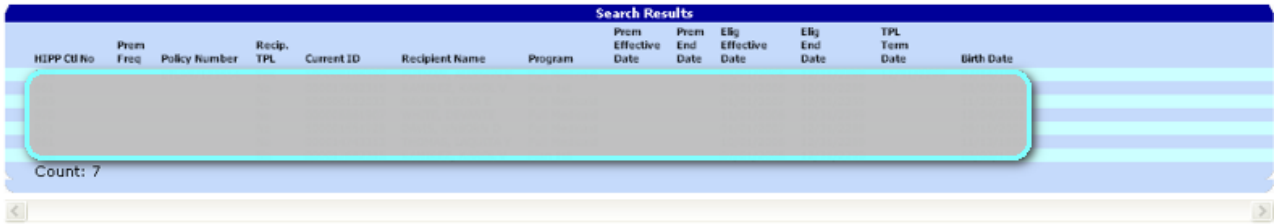
6.47.1 HIPP Case Search Results Panel Narrative

The HIPP Case Search Results panel displays HIPP Case records matching the criteria from the search panel.

This panel is display only.

Navigation Path: [TPL] – [HIPP Case Search] - [(Enter search criteria)] - [(Click on [Search])]

6.47.2 HIPP Case Search Results Panel Layout



6.47.3 HIPP Case Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Birth Date	The date of birth of the recipient (Current ID).	Field	Date (MM/DD/CCYY)	8
Current ID	Unique identifier for the recipient.	Field	Alphanumeric	12
Elig Effective Date	The effective date for the recipient (Current ID).	Field	Date (MM/DD/CCYY)	8
Elig End Date	The end date for the recipient (Current ID).	Field	Date (MM/DD/CCYY)	8
HIPP Ctrl No	The HIPP control number assigned to the HIPP case.	Field	Number (Integer)	9
Prem Effective Date	Premium Effective Date.	Field	Date (MM/DD/CCYY)	8
Prem End Date	Premium End Date.	Field	Date (MM/DD/CCYY)	8
Prem Freq	The frequency of the premium being paid.	Field	Character	1
Policy Number	The policy number associated to the HIPP case.	Field	Character	30
Program	The program the recipient is enrolled in.	Field	Alphanumeric	50
Recip. TPL	Indicates whether the Recipient has TPL. Valid values are "Yes" and "No".	Field	Character	3
Recipient Name	The name of the recipient. Format Last Name, First Name Middle Initial.	Field	Alphanumeric	31

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Field	Description	Field Type	Data Type	Length
TPL Term Date	The end date for the TPL.	Field	Date (MM/DD/CCYY)	8

6.47.4 HIPP Case Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.47.5 HIPP Case Search Results Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.47.6 HIPP Case Search Results Panel Accessibility

6.47.6.1 To Access the HIPP Case Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria.	
4	Click **Search**.	HIPP Case Search results display.

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6.48 HIPP Control Number Search Panel Overview

6.48.1 HIPP Control Number Search Panel Narrative

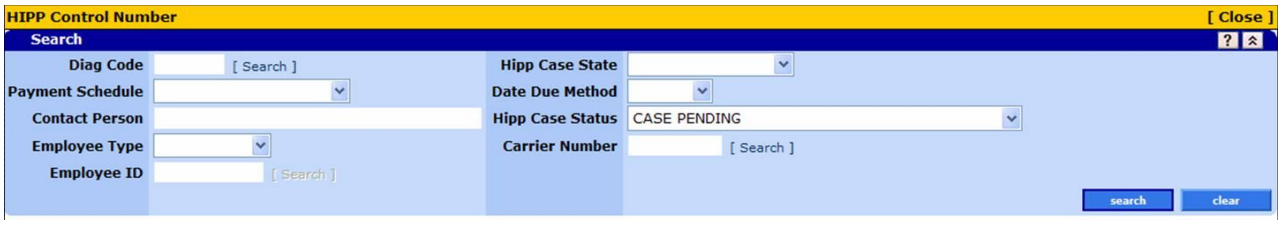
The Agency uses the HIPP Control Number Search panel to determine HIPP Control Number for HIPP Case Search panel.

The available search criteria on the panel include: Diag Code; HIPP Case State; Payment Schedule; Date Due Method; Contact Person; HIPP Case Status; Employee Code; Employee ID; Carrier Number.

This panel is inquiry only.

Navigation Path: [TPL] - [HIPP Case Search] - [HIPP Control Number search link]

6.48.2 HIPP Control Number Search Panel Layout



6.48.3 HIPP Control Number Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to remove search information from the panel.	Button	N/A	0
Carrier Number	This indicates carrier number.	Field	Alphanumeric	10
Contact Person	The name of the insurance carrier's person to contact concerning HIPP premium payments.	Field	Character	40
Date Due Method	Indicates whether the HIPP payments should be manually or systematically generated.	Field	Character	1
Diag Code	The actual high cost diagnosis code.	Field	Alphanumeric	7
Employee ID	This indicates the ID of the employee. This ID can be a policyholder ID or recipient ID.	Field	Number(Integer)	9
Employee Type	This indicates the type of the employee. This type can be a policyholder or recipient.	Field	Drop Down List Box	12
Hipp Case State	Indicates whether to purchase or not to purchase the HIPP policy.	Field	Character	1
Hipp Case Status	The code that identifies why a policy was or was not purchased.	Field	Character	2

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Field	Description	Field Type	Data Type	Length
Payment Schedule	Identifies when (monthly, quarterly, etc.) the HIPP policy must be paid.	Field	Character	1
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

6.48.4 HIPP Control Number Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Carrier Number	Button	1	Carrier Number must be numeric.	Enter numeric value in Carrier Number field.
Diag Code	Button	1	Diag Code must be numeric.	Enter numeric value in Diag Code field.

6.48.5 HIPP Control Number Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.48.6 HIPP Control Number Search Panel Accessibility

6.48.6.1 To Access the HIPP Control Number Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Click **HIPP Control Number** Search link.	HIPP Control Number search panel displays.

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6.49 HIPP Case Mini Search Panel Overview

6.49.1 HIPP Case Mini Search Panel Narrative

TPL HIPP Case Mini Search panel allows the user to enter search criteria and query for HIPP Case records whose data matches that criteria.

This panel is inquiry only.

Navigation Path: [TPL] – [HIPP Case Search] - [(Enter search criteria and click on [Search])] - [(Select row from search results)]

6.49.2 HIPP Case Mini Search Panel Layout

6.49.3 HIPP Case Mini Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clear the search information.	Button	N/A	0
HIPP Ctrl No	Unique identifier for the recipient.	Field	Alphanumeric	12
Search	Search for a HIPP Case.	Button	N/A	0

6.49.4 HIPP Case Mini Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.49.5 HIPP Case Mini Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.49.6 HIPP Case Mini Search Panel Accessibility

6.49.6.1 To Access the HIPP Case Mini Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Click **Add**.	HIPP Case Mini Search panel displays.

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6.50 HIPP Case Maintenance Panel Overview

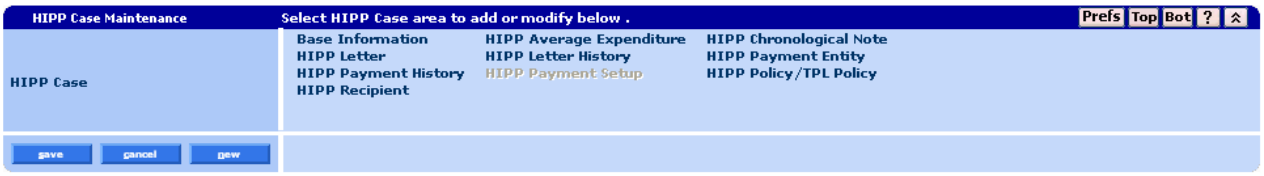
6.50.1 HIPP Case Maintenance Panel Narrative

The TPL HIPP Case Maintenance panel contains links to open other panels in the TPL HIPP Case Information panel.

This panel is inquiry only.

Navigation Path: [TPL] - [HIPP Case Search] - [(select row from search results)]

6.50.2 HIPP Case Maintenance Panel Layout



6.50.3 HIPP Case Maintenance Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Base Information	Link to the HIPP Base Information panel.	Hyperlink	N/A	0
Cancel	Cancel the changes on the HIPP Case panels.	Button	N/A	0
HIPP Average Expenditure	Link to the HIPP Average Expenditure panel.	Hyperlink	N/A	0
HIPP Chronological Note	Link to the HIPP Chronological Note panel.	Hyperlink	N/A	0
HIPP Letter	Link to the HIPP Letter panel.	Hyperlink	N/A	0
HIPP Letter History	Link to the HIPP Letter History panel.	Hyperlink	N/A	0
HIPP Payment Entity	Link to the HIPP Payment Entity panel.	Hyperlink	N/A	0
HIPP Payment History	Link to the HIPP Payment History panel.	Hyperlink	N/A	0
HIPP Payment Setup	Link to the HIPP Payment Setup panel.	Hyperlink	N/A	0
HIPP Policy/TPL Policy	Link to the HPP Policy/TPL Policy panel.	Hyperlink	N/A	0
HIPP Recipient	Link to the HIPP Recipient panel	Hyperlink	N/A	0
Save	Save the HIPP Case panels.	Button	N/A	0

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6.50.4 HIPP Case Maintenance Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.50.5 HIPP Case Maintenance Panel Extra Features

The HIPP Payment Set-up Panel link is only enabled when the following has occurred:

- At least 1 recipient has been added to the case

- At least 1 coverage has been selected

- A payment entity has been added to the case

- All required data on the HIPP Base Information Panel has been added

- The Update Expenditure button has been selected and the data saved

- HIPP case status has been changed to 'ES' (Case in a Premium Payment Status)

6.50.6 HIPP Case Maintenance Panel Accessibility

6.50.6.1 To Access the HIPP Case Maintenance Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.

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6.51 HIPP Information Panel Overview

6.51.1 HIPP Information Panel Narrative

The HIPP Information panel shows high level HIPP information for the HIPP case that the user has selected.

This panel is display only.

Navigation Path: [TPL] – [HIPP Case Search] - [Search] - [Select a row from search result] OR [TPL] – [Search] - [Add] - [TPL Information] - [HIPP Case] OR [TPL - HIPP Search] - [Add]

6.51.2 HIPP Information Panel Layout

6.51.3 HIPP Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Employee Name	This is the employee's last name, first name and middle initial.	Field	Character	29
Employee Type	The type of employee.	Field	Character	12
Employee ID	The number assigned to the employee.	Field	Number (Integer)	9
Employer ID	This is a unique, user-defined employer identification number used on all screens and reports to identify the employer.	Field	Character	9
Employer Name	This is the business name of the employer.	Field	Character	39
HIPP Case Status	This is the status of the HIPP Case.	Field	Character	40
HIPP Ctrl No.	The HIPP control number assigned to the HIPP case.	Field	Number (Integer)	9

6.51.4 HIPP Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

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6.51.5 HIPP Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.51.6 HIPP Information Panel Accessibility

6.51.6.1 To Access the HIPP Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to view details.	HIPP Information panel displays.

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6.52 HIPP Base Information Panel Overview

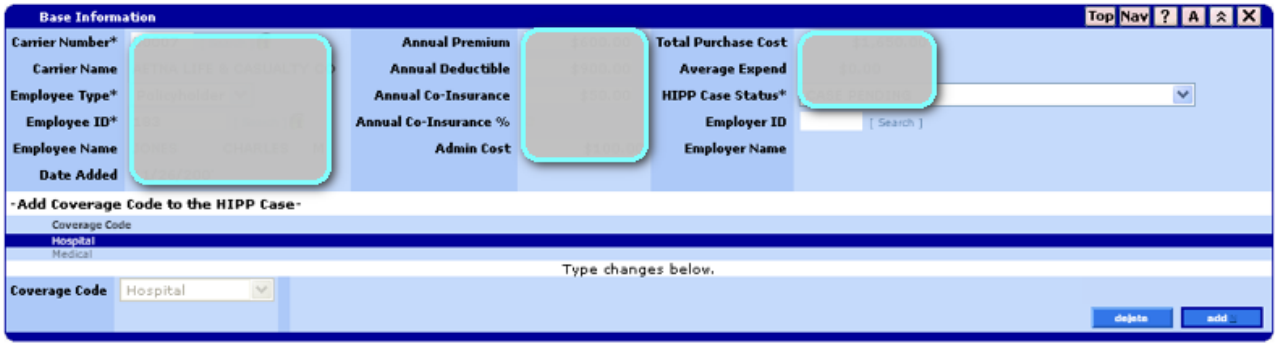
6.52.1 HIPP Base Information Panel Narrative

The HIPP Case Base Information panel is used to access and calculate the recipient's insurance policy payment benefits.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [HIPP Case Search] - [Enter Search Criteria] - [(select row from search results)] - [Base Information]

6.52.2 HIPP Base Information Panel Layout



6.52.3 HIPP Base Information Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This allows the user to add coverage groupings to the HIPP case.	Button	N/A	0
Admin Cost	Standard dollar amount of administering this network per member.	Field	Number (Decimal)	10
Annual Co-Insurance	Annual co-insurance dollar amount for the policy.	Field	Number (Decimal)	9
Annual Co-Insurance %	Annual co-insurance percentage for the policy.	Field	Number (Decimal)	3
Annual Deductible	The amount that Medicaid must meet before the insurance carrier pays for services rendered.	Field	Number (Decimal)	9
Annual Premium	Dollar amount of the premium on an annual basis.	Field	Number (Decimal)	9
Average Expend	Average dollar amount of claims paid for the member in that aid category by sex and age (and possibly diagnosis) found	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
	on the HIPP Average Expenditures window.			
Carrier Name	Name used to identify a specific Carrier.	Field	Character	28
Carrier Number	Number used to identify a specific Carrier.	Field	Character	7
Coverage Code	The coverage group that is covered under the policy. The dropdown list contains the following possible values: - 01 - Hospital - 02 - Medical - 03 - Dental - 04 - Vision - 05 - Pharmacy - 06 - Long Term Care.	Combo Box	Drop Down List Box	0
Date Added	The date the policy was identified as a HIPP resource.	Field	Date (MM/DD/CCYY)	8
Delete	Allows a user to remove a record from the data list	Button	N/A	0
Employee ID [Search]	The identification used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder ID.	Hyperlink	N/A	0
Employee Name	The policyholder's first and last name.	Field	Character	28
Employee Type	The type of employee.	Combo Box	Drop Down List Box	0
Employer ID [Search]	Allows the user to search for an Employer ID.	Hyperlink	N/A	0
Employer Name	The business name of an employer.	Field	Character	39
HIPP Case Status	Indicates whether to purchase or not to purchase the HIPP policy.	Combo Box	Drop Down List Box	0
Total Purchase Cost	System calculated cost to purchase the policy annually. This is calculated by adding the following fields: Annual Premium Amount, Annual Deductible Amount, Annual Co-Insurance Amount and the Admin Cost.	Field	Number (Decimal)	9

6.52.4 HIPP Base Information Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	1	A valid Recipient ID is required.	Verify recipient ID is valid. Re-enter.
Admin Cost	Field	1	Enter a valid value.	The Admin Cost is a numeric only value.

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Field	Field Type	Error Code	Error Message	To Correct
Annual Co-Insurance	Field	1	Enter a valid value.	The Annual Co-Insurance is a numeric only value.
	Field	2	Annual Co-Insurance must be less than or equal to 999999.99.	Correct Annual Co-Insurance amount.
Annual Deductible	Field	1	Enter a valid value.	The Annual Deductible is a numeric only value.
	Field	2	Annual Deductible must be less than or equal to 999999.99.	Correct Annual Deductible amount.
Annual Premium	Field	1	Enter a valid value.	The Annual Premium is a numeric only value.
	Field	2	Annual Premium must be less than or equal to 999999.99.	Correct Annual Premium amount.
Carrier Number	Field	1	Carrier Number must be numeric.	Please re-enter a valid value.
	Field	2	A valid Carrier Number is required.	Enter a valid Carrier Number.
Coverage Code	Field	1	A valid Coverage Code must be selected.	Select a valid coverage code.
Employee ID	Field	2	A valid Employee ID is required.	Enter a valid Employee ID.
	Field	3	Employee ID must be numeric.	Please enter a valid value.
Employer ID	Field	1	Employer ID is not valid. Please re-enter a valid value.	Please re-enter a valid value.
HIPP Case Status	Field	1	Carrier Number, Average Exp greater than zero, and HIPP Recipient(s) are required. Also, a HIPP Payment Entity must be created before attempting to change the HIPP Case Status to Premium Payment. Add required fields and create a HIPP Payment Entity, save record and try changing the HIPP Case Status again.	Add Required fields and create a HIPP Payment Entity, save record and try changing the HIPP Case Status again.
	Field	2	Warning: Update HIPP end dates to reflect eligibility change.	Verify if recipient's eligibility is current.

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Field	Field Type	Error Code	Error Message	To Correct
Total Purchase Cost	Field	1	Total Purchase Amount must be less than or equal to 99999.99.	Verify Total Purchase amount.

6.52.5 HIPP Base Information Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.52.6 HIPP Base Information Panel Accessibility

6.52.6.1 To Access the HIPP Base Information Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to view details.	HIPP Case Information panel displays.
6	Click Base Information.	HIPP Base Information panel displays.

6.52.6.2 To Add on the HIPP Base Information Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Carrier Number. If unknown, click on [Search] button to locate by Carrier Type, Carrier Name, Re-Bill Frequency, Pin Number, Active Indicator or Electronic Billing ID.	
3	Select **Employee Type** from drop down list box.	
4	Enter Employee ID. If unknown, click [Search] to locate by Policyholder ID, Last Name, First Name, SSN, Birth Date, Phone Number, Fax Number, or Phone Number Extension.	Employee Name automatically prefills based on information entered.
5	Enter Annual Premium.	
6	Enter Annual Deductible.	

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Step	Action	Response
7	Enter Annual Co-Insurance.	
8	Enter Admin Cost.	
9	Select **HIPP Case Status** from drop down list box.	
11	Enter Employer ID.	
12	Add **Coverage Code** to the HIPP Case by selecting row	
13	Click **Save**.	HIPP Base Information is saved.

6.52.6.3 To Add Coverage on the HIPP Base Information Panel

Step	Action	Response
1	Click **Add**.	
2	Select **Coverage Code** from drop down list box.	Coverage Code information is saved.

6.52.6.4 To Update the HIPP Base Information Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Base Information is saved.

6.52.6.5 To Delete on the HIPP Base Information Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.53 HIPP Average Expenditure Panel Overview

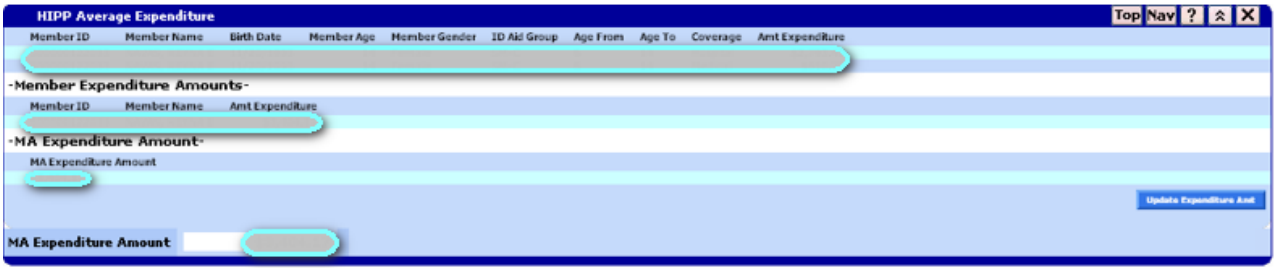
6.53.1 HIPP Average Expenditure Panel Narrative

The Agency uses the HIPP Average Expenditure Panel to calculate the average Medicaid expenditure amount for a case to determine if it is cost effective to pay the premium.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [HIPP Search] - [HIPP Case] - [HIPP Average Expenditure]

6.53.2 HIPP Average Expenditure Panel Layout



6.53.3 HIPP Average Expenditure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age From	This is the start of the recipient's age range.	Field	Number (Integer)	4
Age To	This is the end of the recipient's age range.	Field	Number (Integer)	4
Amt Expenditure	The average claim paid amount for the recipient's age, sex, and aid category.	Field	Number (Decimal)	9
Birth Date	The is the date of birth of the recipient.	Field	Date (MM/DD/CCYY)	8
Coverage	The type of coverage group.	Field	Character	14
ID Aid Group	This is the Aid Group of the recipient.	Field	Character	4
MA Expenditure Amount	The average claim paid amount of all recipients included in the HIPP case for their age, sex, and aid category.	Field	Number (Decimal)	9
Member Age	This is the age of the recipient.	Field	Number (Integer)	9
Member Gender	This is the gender of the recipient.	Field	Character	1
Member ID	The recipient's unique identifier.	Field	Character	12
Member Name	This is the name of the recipient.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Update Expenditure Amt	This button allows the user to update the expenditure amounts. If the expenditure amount on the HIPP Base Information panel is zero, the user must select this button and save the record for the expenditures to be updated on the HIPP case.	Button	N/A	0

6.53.4 HIPP Average Expenditure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.53.5 HIPP Average Expenditure Panel Extra Features

In order for the expenditure amount to be updated on the t_hipp_resource table, the user must select the Update Expenditure button and save.

6.53.6 HIPP Average Expenditure Panel Accessibility

6.53.6.1 To Access the HIPP Average Expenditure Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search.**	HIPP Case Search panel displays.
3	Click **Add**. Users may also access this panel by selecting an existing case from the HIPP Case Search results panel.	HIPP Case Maintenance panel displays.
4	Click **HIPP Expenditure** hyperlink.	HIPP Avg Expenditure panel displays.

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6.54 HIPP Chronological Note Panel Overview

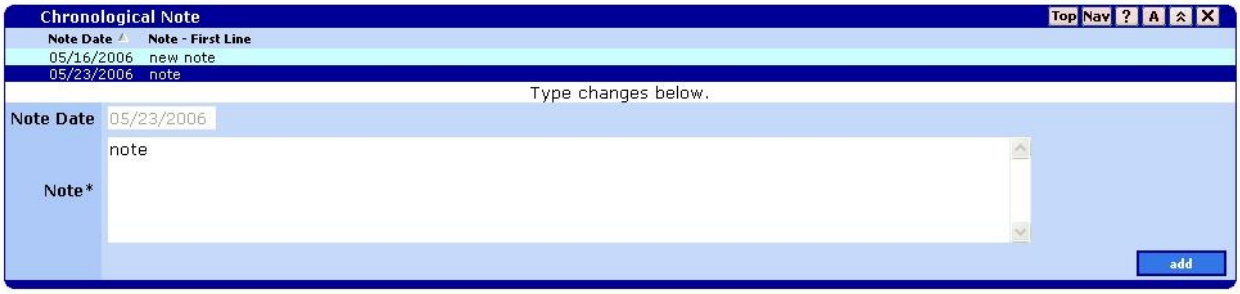
6.54.1 HIPP Chronological Note Panel Narrative

The HIPP Chronological Note panel is used to write information concerning the HIPP Policy.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [HIPP Search] - [HIPP Case] - [HIPP Chronological Note]

6.54.2 HIPP Chronological Note Panel Layout



6.54.3 HIPP Chronological Note Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the HPP Chronologial Note panel.	Button	N/A	0
Note	The note in its entirety.	Field	Character	500
Note Date	The date on which the notes were typed.	Field	Date (MM/DD/CCYY)	10
Note - First Line	This is a listing of the first line of each note that was typed.	Listview	Character	50

6.54.4 HIPP Chronological Note Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Note	Field	0	At least one line is required for the note. Enter the first line of the note.	Enter the first line of the note.

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6.54.5 HIPP Chronological Note Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.54.6 HIPP Chronological Note Panel Accessibility

6.54.6.1 To Access HIPP Chronological Note Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to view details.	HIPP Case Information panel displays.
6	Click HIPP Chronological Note.	HIPP Chronological Note panel displays.

6.54.6.2 To Add on the HIPP Chronological Note Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	HIPP Chronological Note panel information is saved.

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6.55 HIPP Letter Panel Overview

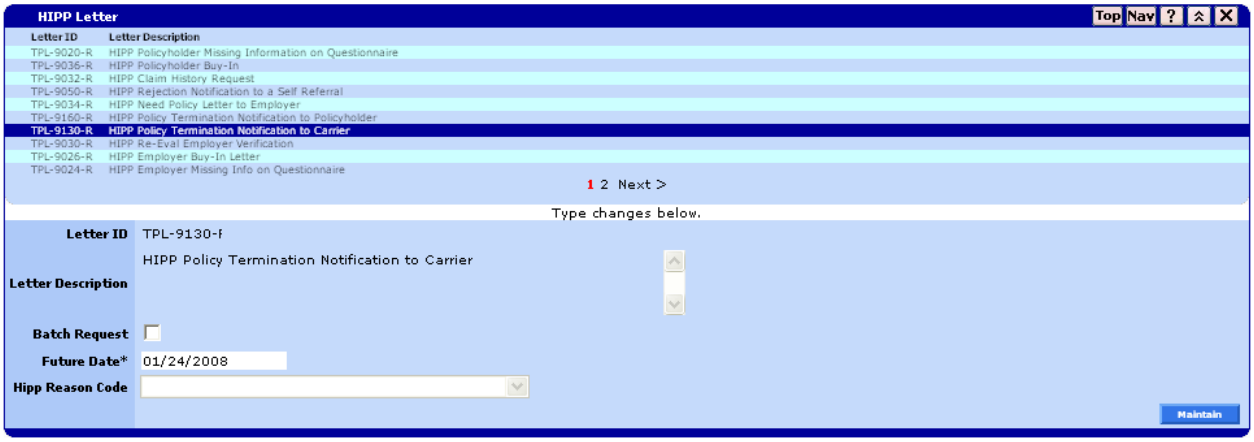
6.55.1 HIPP Letter Panel Narrative

The HIPP Letter panel allows the user to request a HIPP letter to send.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [HIPP Case Search] [(enter search criteria and click on Search)] - [(select row from search results)] [HIPP Case Maintenance] - [HIPP Case] - [HIPP Letter]

6.55.2 HIPP Letter Panel Layout



6.55.3 HIPP Letter Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Letter Description	The description of the letter.	Field	Character	1000
Letter ID	The identifier of the letter.	Field	Character	10
Maintain	Allows the user to manually request a letter.	Button	N/A	0
HIPP Reason Code	The reason for denying the HIPP case.	Combo Box	Drop Down List Box	0
Future Date	The date the batch letter request should be sent.	Field	Date (MM/DD/CCYY)	8
Batch Request	This is selected when the user would like to save the letter as a batch request.	Combo Box	Checkbox	0

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6.55.4 HIPP Letter Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.55.5 HIPP Letter Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.55.6 HIPP Letter Panel Accessibility

6.55.6.1 To Access the HIPP Letter Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Letter.	HIPP Letter panel displays.

6.55.6.2 To Maintain on the HIPP Letter Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click Maintain.	Login window displays.
3	Enter User Name and Password.	
4	Click **OK**.	Letter generator opens with a message requesting the user to select: To open the PDF Save the PDF Cancel

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6.56 HIPP Letter History Panel Overview

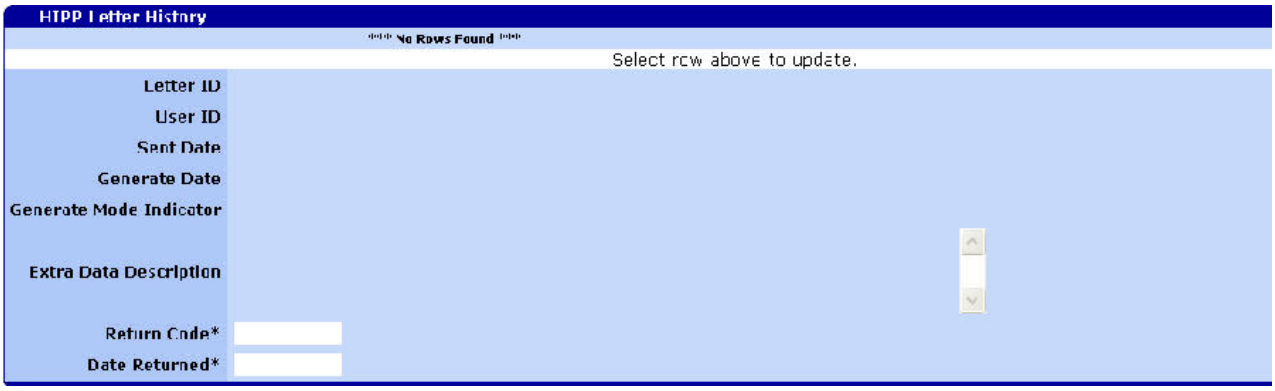
6.56.1 HIPP Letter History Panel Narrative

The HIPP Letter History shows all the letters sent out for this HIPP Policy.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [HIPP Case Search] - [(enter search criteria and click on Search)] - [(select row from Search Results)] - [HIPP Case Maintenance] - [HIPP Case] - [HIPP Letter History]

6.56.2 HIPP Letter History Panel Layout



6.56.3 HIPP Letter History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Returned	The date the response was received.	Field	Date (MM/DD/CCYY)	8
Extra Data Description	This field identifies any extra data that was requested for the letter.	Field	Character	4000
Generate Date	The date the letter was requested.	Field	Date (MM/DD/CCYY)	8
Generate Mode Indicator	The method used to produce the letter, (batch or online).	Field	Character	1
Letter ID	The identifier of the letter.	Field	Character	9
Return Code	This is a code to indicate whether a response has been received.	Combo Box	Drop Down List Box	0
Sent Date	The date the letter was created and printed.	Field	Date (MM/DD/CCYY)	8
User ID	The user identification number that requested the letter.	Field	Character	8

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6.56.4 HIPP Letter History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Returned	Field	1	Return Date should be less than or equal to 12/31/2299.	Enter a date of return less than or equal to 12/31/2299.
	Field	2	Return Date should be greater than or equal to 01/01/1900.	Enter a date of return greater than or equal to 01/01/1900.
	Field	3	Return Date should not be prior to Sent Date or Generate Date.	Enter a date of return greater than or equal to Sent Date and Generate Date.
	Field	4	Return Date not valid.	Enter valid return date.

6.56.5 HIPP Letter History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.56.6 HIPP Letter History Panel Accessibility

6.56.6.1 To Access the HIPP Letter History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Letter History.	HIPP Letter History panel displays.

6.56.6.2 To Update the HIPP Letter History Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Letter History information is saved.

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6.57 HIPP Payment Entity Panel Overview

6.57.1 HIPP Payment Entity Panel Narrative

The HIPP Payment Entity panel contains the payee information for the HIPP Case. There is not a Delete button, because this panel is a continuation of the Base Information panel.

This panel is display only.

Navigation Path: [TPL] – [HIPP Case Search] - [(Enter search criteria)] - [(Select row from search results)] - [HIPP Case Maintenance] - [HIPP Case] - [Payment Entity]

6.57.2 HIPP Payment Entity Panel Layout

6.57.3 HIPP Payment Entity Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	The street address where the contact person is located.	Field	Character	30
Address 2	The street second address where the contact person is located.	Field	Character	30
City	The city where the contact person is located.	Field	Character	18
Fax	Fax Number of the contact person associated with the HIPP Payment Entity.	Field	Character	15
FEIN	Tax ID of entity.	Field	Character	9
HIPP Identifier [Search]	The Payee Type radio button determines what value (Policyholder ID - number - 9, Employee ID - character - 7, Carrier Number - character - 7, Current ID - character - 12) is entered.	Hyperlink	N/A	0
Name	The name of the person for the HIPP identifier field.	Field	Character	40
Payee Type	The identification number assigned to the HIPP Policy. The valid radio button values are: Carrier and Employer.	Combo Box	Radio Button	0
Payment Media	This identifies the type of media to use for payment.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Phone	Phone number of the person to contact regarding this premium payment.	Field	Character	10
[Search]	This link allows for a more detailed search of a HIPP Identifier.	Hyperlink	N/A	0
State	The state where the contact person is located.	Combo Box	Drop Down List Box	0
Zip	The nine digits of the contact person's zip code.	Field	Character	9
Zip Code [4]	This lists the last 4 digits of the Zip Code.	Field	Number (Integer)	4

6.57.4 HIPP Payment Entity Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
HIPP Identifier	Field	1	HIPP Indentifier [value will display] is an invalid Carrier.	Enter a valid Carrier.
	Field	2200	HIPP Identifier [value will display] is an invalid Employer.	Enter a vaild Employer.

6.57.5 HIPP Payment Entity Panel Extra Features

The policyholder and recipient obtains have been disabled. Only a carrier or employer can be set-up as a payment entity.

6.57.6 HIPP Payment Entity Panel Accessibility

6.57.6.1 To Access the HIPP Payment Entity Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Payment Entity.	HIPP Payment Entity panel displays.

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6.57.6.2 To Update on the HIPP Payment Entity Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Payment Entity information is saved.

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6.58 HIPP Payment History Panel Overview

6.58.1 HIPP Payment History Panel Narrative

The HIPP Payment History panel shows the payment history for the HIPP Case.

This panel is display only.

Navigation Path: [TPL] - [HIPP Case] - [HIPP Case Search] - [search] - [(select row from search results)] - [HIPP Maintenance [HIPP Payment History]]

6.58.2 HIPP Payment History Panel Layout

6.58.3 HIPP Payment History Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.58.4 HIPP Payment History Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Check / Paid Amount	The amount of the check issued. Format 999999999.99.	Field	Number (Decimal)	11
Check Issue Date	The date the check was issued.	Field	Date (MM/DD/CCYY)	8
Check Number	The number of the check issued.	Field	Number (Integer)	9
Coverage End Date	The last date of coverage. This field will not be used in the AMMIS and will always be 0.	Field	Date (MM/DD/CCYY)	8
Coverage Start Date	The start date of coverage. This is not used in the AMMIS and will always contain 0.	Field	Date (MM/DD/CCYY)	8
Expend Activated Date	The date the expenditure was activated.	Field	Date (MM/DD/CCYY)	8
Expend Status	The status of the expenditure. Valid values are ‘Y ‘(processed) and ‘N’ (not processed).	Field	Character	1
Payment End Date	The end date of the payment.	Field	Date (MM/DD/CCYY)	8
Payment Start Date	The begin date for the payment.	Field	Date (MM/DD/CCYY)	8

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6.58.5 HIPP Payment History Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.58.6 HIPP Payment History Panel Accessibility

6.58.6.1 To Access the HIPP Payment History Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Payment History.	HIPP Payment History panel displays.

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6.59 HIPP Payment Setup Panel Overview

6.59.1 HIPP Payment Setup Panel Narrative

The HIPP Payment Setup displays payment information for the HIPP Case. There is not a Delete button, because this panel is a continuation of the Base Information panel.

This panel is display only.

Navigation Path: [TPL] – [HIPP Case Search] - [(Enter search criteria and click on [Search])] - [(Select row from search results)] - [HIPP Case Maintenance] - [HIPP Case] - [Payment Setup]

6.59.2 HIPP Payment Setup Panel Layout

6.59.3 HIPP Payment Setup Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Date Due	The date that the next premium payment for the policy is due.	Field	Date (MM/DD/CCYY)	8
Date Due Method	The method by which payment is made.	Combo Box	Drop Down List Box	0
HIPP Review Date	The next date when the policy should be reviewed.	Field	Date (MM/DD/CCYY)	8
Last Paid Date	The most recent date that a premium payment was issued for the policy.	Field	Date (MM/DD/CCYY)	8
Payment Schedule	Identifies when (monthly, quarterly, etc.) the HIPP policy must be paid.	Combo Box	Drop Down List Box	0
Premium Check Amt	Amount to send to the carrier, policyholder, or employer.	Field	Number (Decimal)	9
Premium End Date	If the method equals Manual, the premium begin and end dates are the period covered by the check. If the method equals System, the premium begin and end dates are on-going dates that should cover the entire period the case is active.	Field	Date (MM/DD/CCYY)	8
Premium Start Date	If the method equals Manual, the premium begin and end dates are the period covered by the check. If the method equals System,	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
	the premium begin and end dates are on-going dates that should cover the entire period the case is active.			
Refund Amount	The amount expected to be received as a result of over-payment.	Field	Number (Decimal)	9

6.59.4 HIPP Payment Setup Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Date Due	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the date in a valid format.
	Field	2	Enter a valid Due Date. MM/DD/CCYY.	Enter valid Due Date.
HIPP Review Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the date in a valid format.
	Field	2	Enter a valid HIPP Review Date. Format is MM/DD/CCYY.	HIPP review date must equal current date or greater.
Premium Check Amt	Field	1	Enter a valid value.	The Premium Check Amt is a numeric only value.
Premium End Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter a date in a valid format.
Premium Start Date	Field	1	Invalid date. Format is MM/DD/CCYY.	Enter the date in a valid format.
Refund Amount	Field	1	Enter a valid value.	Refund Amount is a numeric only value.
Payment Schedule	Combo Box	1	Payment Schedule is required.	Select Payment Schedule.

6.59.5 HIPP Payment Setup Panel Extra Features

The user can set-up a payment as a manual or system request. If the user selects Manual, a record is inserted into the t_hipp_expend_xref using sak_expenditure = -1 and will be processed in the next weekly HIPP cycle.

If the user updates a payment record and there is already a row on the t_hipp_expend_xref with a sak_expenditure = -1, the record is updated with any changes to the premium dates.

If the user updates a payment record and there is not a row on the t_hipp_expend_xref with a sak_expenditure = -1, a new record is inserted and will be processed in the next weekly HIPP cycle.

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If the user updates the Method by changing from Manual to System and a row already exists on the t_hipp_expend_xref table with a sak_expenditure = -1, an error message is displayed. This operation will not be allowed until the Manual request is processed.

If the user updates the Method by changing from Manual to System and there is no row on the table with a sak_expenditure = -1, the save will be allowed but no rows are inserted into the table. The batch program will process all System requested payments.

6.59.6 HIPP Payment Setup Panel Accessibility

6.59.6.1 To Access the HIPP Payment Setup Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Payment Setup.	HIPP Payment Setup panel displays.

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6.60 HIPP Policy/TPL Policy Panel Overview

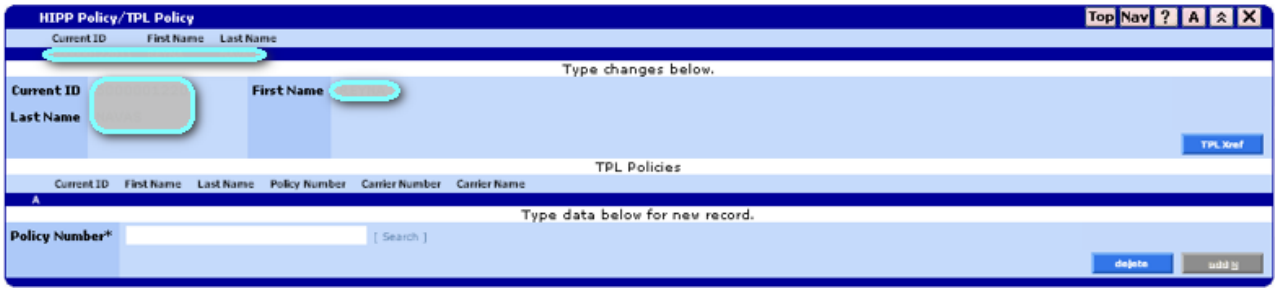
6.60.1 HIPP Policy/TPL Policy Panel Narrative

The HIPP Policy/TPL Policy panel supports the display of existing policy associations, as well as the removal of associations, to existing TPL Policies with a HIPP Case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation: [TPL]-[HIPP Case Search]-[HIPP Maintenance]-[HIPP Policy/TPL Policy]

6.60.2 HIPP Policy/TPL Policy Panel Layout



6.60.3 HIPP Policy/TPL Policy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	This button allows the user to associate a TPL policy with a recipient on the HIPP case.	Button	N/A	0
Carrier Name	This field describe about business Name.	Field	Character	45
Carrier Number	The unique identifier for the carrier.	Field	Character	7
Clear	This button clear's the fields.	Button	N/A	0
Current ID	Unique identifier for the recipient.	Field	Number	12
Delete	This button allows the user to disassociate a TPL policy with the recipient on the HIPP case.	Button	N/A	0
First Name	This is the first name of the recipient on the TPL Policy.	Field	Alphanumeric	15
Last Name	This is the last name of the recipient on the TPL Policy.	Field	Alphanumeric	15
Policy Number	The number associated with the policy.	Field	Character	30
TPL Xref	The button opens the HIPP Policy Xref Panel so the user can associate the recipient to a specific policy.	Button	N/A	0

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6.60.4 HIPP Policy/TPL Policy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
TPL Policy	Hyperlink	1	A valid TPLResource is required.	Please search for the valid TPL Policy.

6.60.5 HIPP Policy/TPL Policy Panel Extra Features

When the user clicks the [Add] button, the system displays the pop-up panel 'Search - TPL Policies'. Refer to that panel for additional information on its' functionality.

To delete an association, the user will select the row from the list and click [Delete].

The Policy Number field is hyperlinked to display a pop-up panel to the TPL Information page.

6.60.6 HIPP Policy/TPL Policy Panel Accessibility

6.60.6.1 To Access the HIPP Policy/TPL Policy Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Policy/TPL Policy.	HIPP Policy/TPL Policy panel displays.

6.60.6.2 To Update on the HIPP Policy/TPL Policy Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Payment Setup information is saved.

6.60.6.3 To Delete on the HIPP Policy/TPL Policy Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.61 HIPP Policy Xref Panel Overview

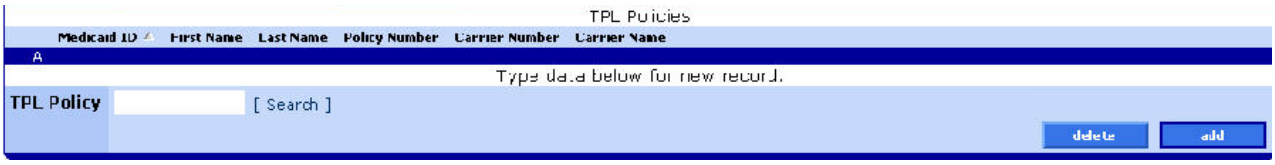
6.61.1 HIPP Policy Xref Panel Narrative

The HIPP Policy Xref panel is used to cross-reference the HIPP Policy to specific TPL Policies for the recipients on the HIPP Policy. This is needed to perform cost avoidance, and failure to set up records on this panel results in the HIPP Premium being delayed payment. .

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation: [TPL]-[HIPP Case Search]-[Enter Search Criteria] - [Search] - [Select Recipient from list] - [HIPP Policy/TPL Policy] – [TPL Xref]

6.61.2 HIPP Policy Xref Panel Layout



6.61.3 HIPP Policy Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the HIPP Policy Xref panel.	Button	N/A	0
Carrier Name	This field describe about business name.	Field	Character	45
Carrier Number	This field describe about carrier code.	Field	Character	7
Delete	This button allows the user to disassociate a TPL policy with the recipient on the HIPP case.	Field	N/A	0
First Name	The first name of member.	Field	Character	15
Last Name	The last name of member.	Field	Character	20
Medicaid ID	Used for current identification number.	Field	Number	12
Policy Number	Policy Number Identifier.	Field	Character	16
[Search]	This link allows for a more detailed search for a TPL Policy.	Button	N/A	0
TPL Policy	This allows to search for TPL Policy.	Hyperlink	N/A	0

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6.61.4 HIPP Policy Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
TPL Policy	Hyperlink	1	A valid TPL Resource is required.	Please search for the valid TPL Policy.

6.61.5 HIPP Policy Xref Panel Extra Features

When the user clicks the [Add] button, the system displays the pop-up panel 'Search - TPL Policies'. Refer to that panel for additional information on its' functionality.

To delete an association, the user selects the row from the list and click [Delete].

The Policy Number field is hyperlinked to display a pop-up panel to the TPL Information page.

6.61.6 HIPP Policy Xref Panel Accessibility

6.61.6.1 To Access the HIPP Policy Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **HIPP Case Search.**	HIPP Case Search panel displays.
3	Click **Add**.	HIPP Case Maintenance panel displays.
4	Click HIPP Policy/TPL Policy hyperlink.	HIPP Policy/TPL Policy panel displays.
5	Click **TPL Xref** button.	TPL Policies information displays below HIPP Policy information.

6.61.6.2 To Update on the HIPP Policy Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Payment Setup information is saved.

6.61.6.3 To Delete on the HIPP Policy Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.62 HIPP Recipient Panel Overview

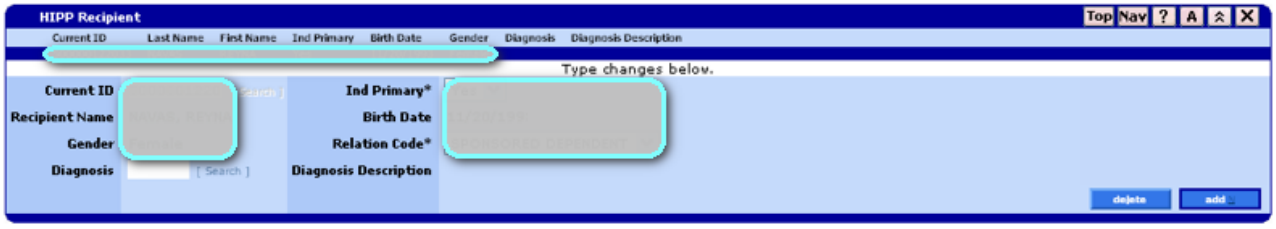
6.62.1 HIPP Recipient Panel Narrative

This panel displays information for each recipient within a HIPP Case.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [HIPP Case Search] - [(Enter search criteria and click on [Search])] - [(Select row from search results)] - [HIPP Case Maintenance] - [HIPP Case] - [HIPP Recipient]

6.62.2 HIPP Recipient Panel Layout



6.62.3 HIPP Recipient Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a recipient to the HIPP Case.	Button	N/A	0
Birth Date	This lists the Birth Date for the Current ID.	Field	Date (MM/DD/CCYY)	8
Current ID [Search]	This allows the user to search for a Current ID.	Hyperlink	N/A	0
Delete	Delete a recipient associated with the HIPP Case.	Button	N/A	0
Diagnosis [Search]	A code for the condition requiring medical attention.	Hyperlink	N/A	0
Diagnosis Description	The nomenclature for a medical condition.	Field	Character	25
Gender	The recipient's gender code.	Field	Character	1
Ind Primary	Indicates if the recipient is the primary on the HIPP Policy.	Combo Box	Drop Down List Box	0
Recipient Name	The first and last name for the Current ID.	Field	Character	35
Relation Code	This lists the Relation Code.	Combo Box	Drop Down List Box	0

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6.62.4 HIPP Recipient Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Relation Code	Combo Box	1	A valid relation code is required.	Please select a Relationship from the drop down list.
Current ID	Field	1	Recipient is a duplicate.	Verify the Current ID and re-enter.
	Field	2	A valid current ID is required.	Please enter a Recipient ID.
	Field	3	Warning: Update HIPP end dates to reflect eligibility change.	This error message appears when the user clicks save and the recipient is not eligible for today's date. This error is for a existing HIPP Case (i.e. not a new HIPP Case). Verify the recipient and the HIPP Case start and end date.
	Field	5	One or more recipients are not valid. Please verif	A recipient is required, open the "Recipient" panel and add a recipient that is eligible for today's date.
	Field	6	Recipient [ID will display] currently not eligible.	Add recipient who is currently eligible.
	Field	7	Recipient [ID will display] is not enrolled in a valid Health Program for HIPP.	Verify recipient enrolled in valid program. Enter correct recipient information.
	Field	8	Current ID must be numeric.	Enter numeric values only.
Ind Primary	Field	1	Primary Ind is required.	Please select a Ind Primary from the drop down list.

6.62.5 HIPP Recipient Panel Extra Features

Linking Recipient IDs

If the user enters a current ID, the panel determines if the ID entered is active. If not, the panel will save the information under the linked active ID.

If the Recipient subsystem receives a link request and the old sak_recip exists on the t_hipp_recip table, the sak_recip is updated in batch to the active sak_recip.

6.62.6 HIPP Recipient Panel Accessibility

6.62.6.1 To Access the HIPP Recipient Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.

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2	Point to **TPL** and click **HIPP Case Search**.	HIPP Case Search panel displays.
3	Enter Search Criteria into fields. Note: You must enter information into at least one search field.	
4	Click **Search**.	Search results display.
5	Select row to from search results.	HIPP Case Maintenance panel displays.
6	Click HIPP Recipient.	HIPP Recipient panel displays.

6.62.6.2 To Add on the HIPP Recipient Panel

Step	Action	Response
1	Enter Current ID. If unknown click [Search].	Recipient Name automatically prefills based on information entered.
2	Enter Diagnosis.	Diagnosis Decription automatically prefills based on information entered.
3	Select **Ind Primary** from the drop down list box.	
8	Select **Relation Code** from the drop down list box.	
9	Click **Save**.	HIPP Recipient information is saved.

6.62.6.3 To Update on the HIPP Recipient Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Recipient information is saved.

6.62.6.4 To Delete on the HIPP Recipient Panel

Step	Action	Response
1	Click line item to be deleted	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.63 Search - CCN Panel Overview

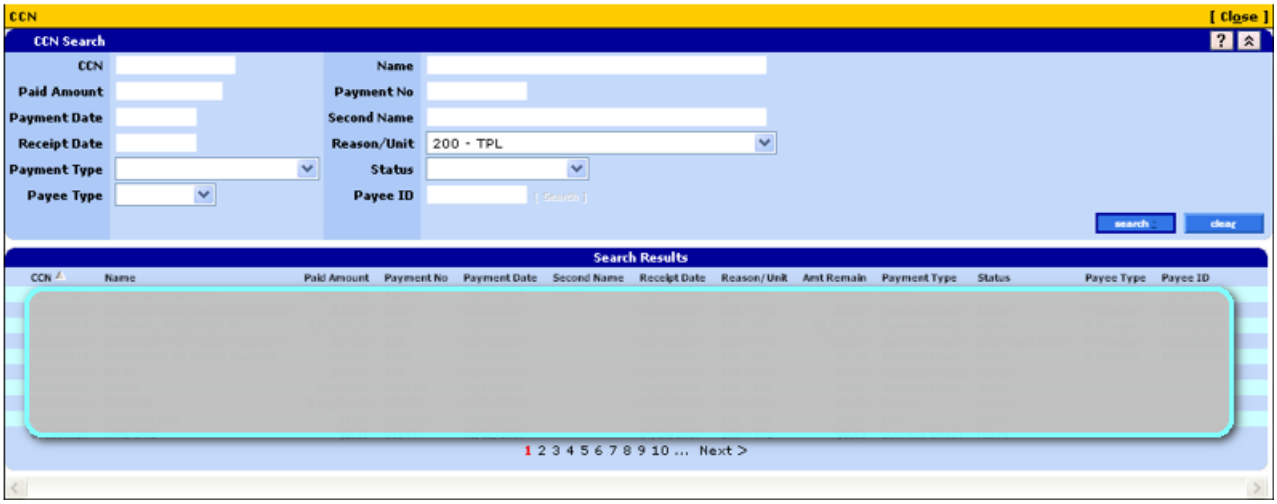
6.63.1 Search - CCN Panel Narrative

The CCN panel is used to search for TPL cash control numbers and return the selected CCN to the prior panel.

This panel is inquiry only.

Navigation Path: [TPL] – [AR Search] - (Click on [Search] next to [CCN])

6.63.2 Search - CCN Panel Layout



6.63.3 Search - CCN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amt Remain	This is the amount remaining on the check available for disposition.	Field	Number (Decimal)	9
CCN	This is the Cash Control Number.	Field	Number (Integer)	10
Check	The check number from the cash receipt.	Field	Character	13
Clear	Used to clear the search fields.	Button	N/A	0
Name	This is the name of the person that sent the cash receipt.	Field	Character	20
Paid Amount	The amount of the cash receipt.	Field	Number (Decimal)	9
Payee ID [Search]	The payee identification number that uniquely identifies the payee	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Payee Type	The type of payee.	Combo Box	Drop Down List Box	0
Payment Date	The check date.	Field	Date (MM/DD/CCYY)	8
Payment No.	The check number.	Field	Number (Integer)	10
Payment Type	The form of payment (check, money order, etc.)	Combo Box	Drop Down List Box	0
Reason/Unit	This is the unit number.	Combo Box	Drop Down List Box	0
Receipt Date	The date the cash was receipted.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Field	Checkbox	0
Search	Initiates a search based on the criteria entered in the search fields.	Button	N/A	0
Second Name	The second name associated with the cash receipt.	Field	Character	20
Status	The current status of the cash receipt.	Combo Box	Drop Down List Box	0

6.63.4 Search - CCN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.63.5 Search - CCN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.63.6 Search - CCN Panel Accessibility

6.63.6.1 To Access the Search - CCN Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search.**	AR Search panel displays.
3	Click **[Search]** located to the right of the CCN field.	CCN Search panel displays.

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6.63.6.2 To Navigate the Search - CCN Panel

Step	Action	Response
1	Enter information into fields.	
2	Click on **Search**.	CCN number populates on panel.

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6.64 Search - Carrier Number Panel Overview

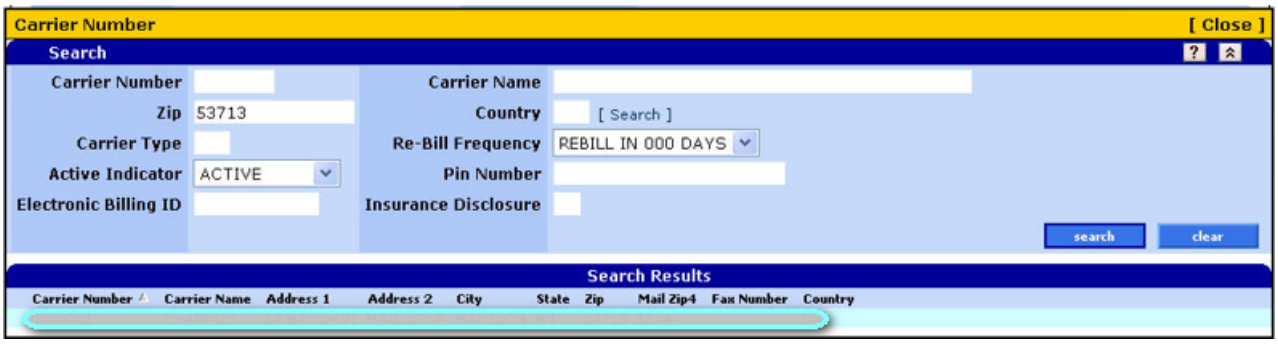
6.64.1 Search - Carrier Number Panel Narrative

The Carrier panel is used to search for carriers and return the results to the prior panel. This information is currently housed on the TT - TPL Carrier Mnemonic Inquiry screen in the legacy system.

This panel is inquiry only.

Navigation: [TPL] – [Search] - [(Click on [Add])] - [Base Information] - [(Click on [Search] next to Carrier Number)]

6.64.2 Search - Carrier Number Panel Layout



6.64.3 Search - Carrier Number Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Indicator	Indicates if the carrier is active or inactive.	Listview	Drop Down List Box	0
Address 1	This lists Address 1 of the carrier.	Field	Character	10
Address 2	This lists Address 2 of the carrier.	Field	Character	10
Carrier Name	This lists the name of the carrier.	Field	Alphanumeric	50
Carrier Number	Allows a user to search by the Carrier Number.	Field	Character	0
Carrier Type	This is the code, which identifies the type of carrier.	Field	Character	1
City	This lists the city of the carrier	Field	Character	7
Clear	Clears the information within the search fields.	Button	N/A	0
Country	Two character country abbreviation.	Field	Character	2
Electronic Billing ID	This is the electronic billing identification for the carrier.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
Fax Number	The carrier's fax number.	Field	Number (Integer)	10
Insurance Disclosure	The insurance disclosure code.	Field	Character	1
Mail Zip 4	This lists the 4 digit zip code extension.	Field	Number (Integer)	4
Pin Number	This is the pin number for the carrier's electronic billing.	Field	Number (Integer)	22
Re-Bill Frequency	This is the carrier billing frequency, in days.	Listview	Drop Down List Box	0
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0
State	This lists the state of the carrier.	Field	Character	2
Zip	This lists the zip code of the carrier.	Field	Character	5

6.64.4 Search - Carrier Number Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.64.5 Search - Carrier Number Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.64.6 Search - Carrier Number Panel Accessibility

6.64.6.1 To Access the Search-Carrier Number Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Click **Add**.	TPL Maintenance panel displays.
4	Select TPL Base Information hyperlink.	TPL Base Information panel displays.
5	Click **[Search]** located to the right of Carrier Number.	Carrier Number search panel displays.

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6.64.6.2 To Navigate on the Search-Carrier Number Panel

Step	Action	Response
1	Enter Carrier Number, Carrier Name or Zip.	
2	Click **Search**. Users may also select from the list of Search Results (if available) displayed at the bottom by clicking on a row.	Carrier Number and Carrier Name are populated in fields.

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6.65 Search - Employer Panel Overview

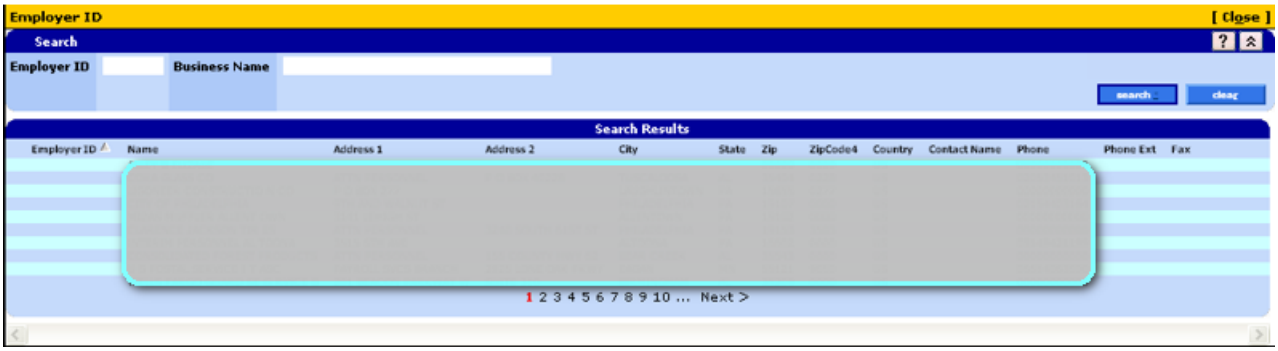
6.65.1 Search - Employer Panel Narrative

The Employer panel allows the user to search for employers and return the results to the prior panel.

This panel is inquiry only.

Navigation: [TPL] – [Search] - [(Click on [Add])] - [Base Information] - [(Click on [Search] next to Employer ID)]

6.65.2 Search - Employer Panel Layout



6.65.3 Search - Employer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	The address of the employer.	Field	Character	20
Address 2	The second address line for the employer.	Field	Character	20
Business Name	The business name of an employer.	Field	Character	39
City	The city of the employer.	Field	Character	20
Clear	Allows the user to remove employer information from the search fields	Button	N/A	0
Contact Name	The name of the employer's contact.	Field	Character	39
Country	The country code in which the employer resides.			
Employer ID	This field is the unique, user-defined employer identification used on all screens and reports to identify the employer.	Field	Number (Integer)	7
Fax	The employers fax number.	Field	Character	10
Phone	The employers phone number	Field	Number (Integer)	10
Phone Ext	The employers phone extension number.	Field	Number (Integer)	5

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Field	Description	Field Type	Data Type	Length
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0
State	The employers state code.	Field	Character	2
Zip	The zip code of the employer.	Field	Number (Integer)	5
ZipCode4	The last 4 digits of the employers zip code.	Field	Number (Integer)	4

6.65.4 Search - Employer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.65.5 Search - Employer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.65.6 Search - Employer Panel Accessibility

6.65.6.1 To Access the Search - Employer Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search.**	TPL Search panel displays.
3	Click **Add**.	TPL Maintenance panel displays.
4	Select TPL Base Information hyperlink.	TPL Base Information panel displays.
5	Click on **[Search]** located to the right of the **Employer ID** field.	Employer ID Search panel displays.

6.65.6.2 To Navigate the Search - Employer Panel

Step	Action	Response
1	Enter **Employer ID** or **Business Name** or select from the list of results displayed at the bottom of panel.	
2	Click on **Search**.	Employer ID and Employer Name information populates.

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6.66 Search - HIPAA Adjustment Reason Panel Overview

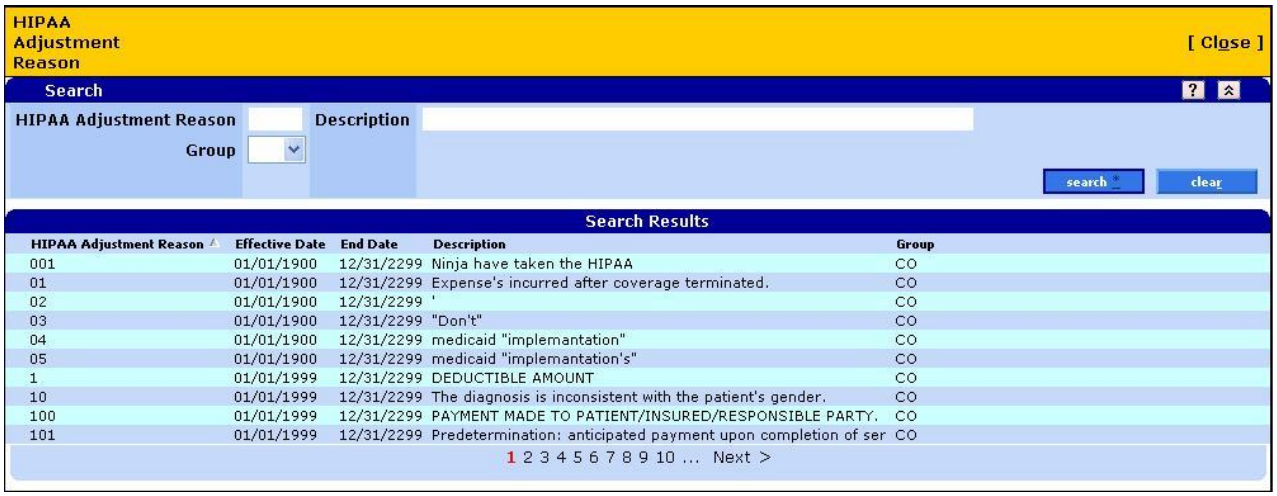
6.66.1 Search - HIPAA Adjustment Reason Panel Narrative

The HIPAA Adjustment Reason panel allows the user to search for and associate the HIPAA Adjustment reason code.

This panel is inquiry only.

Navigation: [TPL] - [Related Data]-[Xref]-[Local/HIPAA Adjustment Reason]-[Add]-[(Click on [Search] next to HIPAA Adjustment Reason)]

6.66.2 Search - HIPAA Adjustment Reason Panel Layout



6.66.3 Search - HIPAA Adjustment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to remove search criteria entered.	Button	N/A	0
Description	The text description of the Health Insurance Portability and Accountability Act (HIPAA) adjustment reason code.	Field	Character	300
Effective Date	The effective date of the HIPAA Adjustment reason, the date the HIPAA Adjustment Reason code becomes valid for use in the system.	Field	Date (MM/DD/CCYY)	10
End Date	The End Date for the HIPAA Adjustment Reason, the last date the HIPAA Adjustment Reason code is valid for use in the system.	Field	Date (MM/DD/CCYY)	10

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Field	Description	Field Type	Data Type	Length
Group	The code identifying the general category of the payment adjustment.	Field	Character	2
HIPAA Adjustment Reason	The HIPAA compliant Adjustment Reason code. HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.	Field	Character	2
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

6.66.4 Search - HIPAA Adjustment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.66.5 Search - HIPAA Adjustment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.66.6 Search - HIPAA Adjustment Reason Panel Accessibility

6.66.6.1 To Access the Search - HIPAA Adjustment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data panel displays.
4	Select the Local/HIPAA Adjustment Reason hyperlink.	Local/HIPAA Adjustment Reason panel displays.
5	Click **Add**.	Activates fields for entry of data or selection from lists.
6	Click HIPAA Adjustment Reason [Search].	HIPAA Adjustment Reason panel displays.

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6.66.6.2 To Navigate on the Search - HIPAA Adjustment Reason Panel

Step	Action	Response
1	Enter HIPAA Adjustment Reason.	
2	Select **Group** from drop down list.	
3	Enter Description.	
4	Click **Search**. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	HIPAA Adjustment Reason information is displayed.

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6.67 Search - HIPAA Service Type Panel Overview

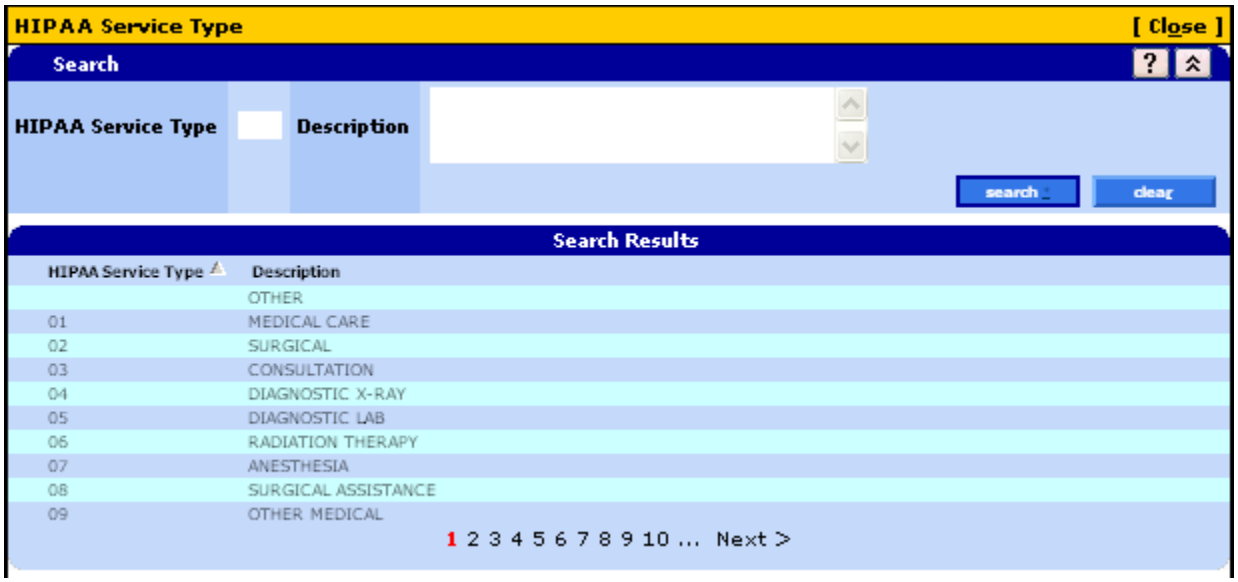
6.67.1 Search - HIPAA Service Type Panel Narrative

The HIPAA Service Type panel allows the user to search for and associate HIPAA Service Types to coverage codes.

This panel is inquiry only.

Navigation: [TPL]-[Related Data]-[Xref]-[HIPAA Service/Coverage Type]-[Add]-[(Click on [Search] next to HIPAA Service Type)]

6.67.2 Search - HIPAA Service Type Panel Layout



6.67.3 Search - HIPAA Service Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows a user to remove data entered into fields.	Button	N/A	0
Description	The HIPAA compliant description for the Service Type.	Field	Character	30
HIPAA Service Type	The HIPAA compliant code for a Service Type.	Field	Character	2
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

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6.67.4 Search - HIPAA Service Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.67.5 Search - HIPAA Service Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.67.6 Search - HIPAA Service Type Panel Accessibility

6.67.6.1 To Access the Search - HIPAA Service Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data panel displays.
4	Select the HIPAA Service /Coverage Type hyperlink.	HIPAA Service/Coverage Type panel displays.
5	Click **Add**.	Activates fields for entry of data or selection from lists.
6	Click **[Search]** located to the right of HIPAA Service Type.	HIPAA Service Type panel displays.

6.67.6.2 To Navigate on the Search- HIPAA Service Type Panel

Step	Action	Response
1	Enter HIPAA Service Type.	
2	Enter Description.	
3	Click **Search**. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	HIPAA Service Type information is displayed.

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6.68 Search - ICN Panel Overview

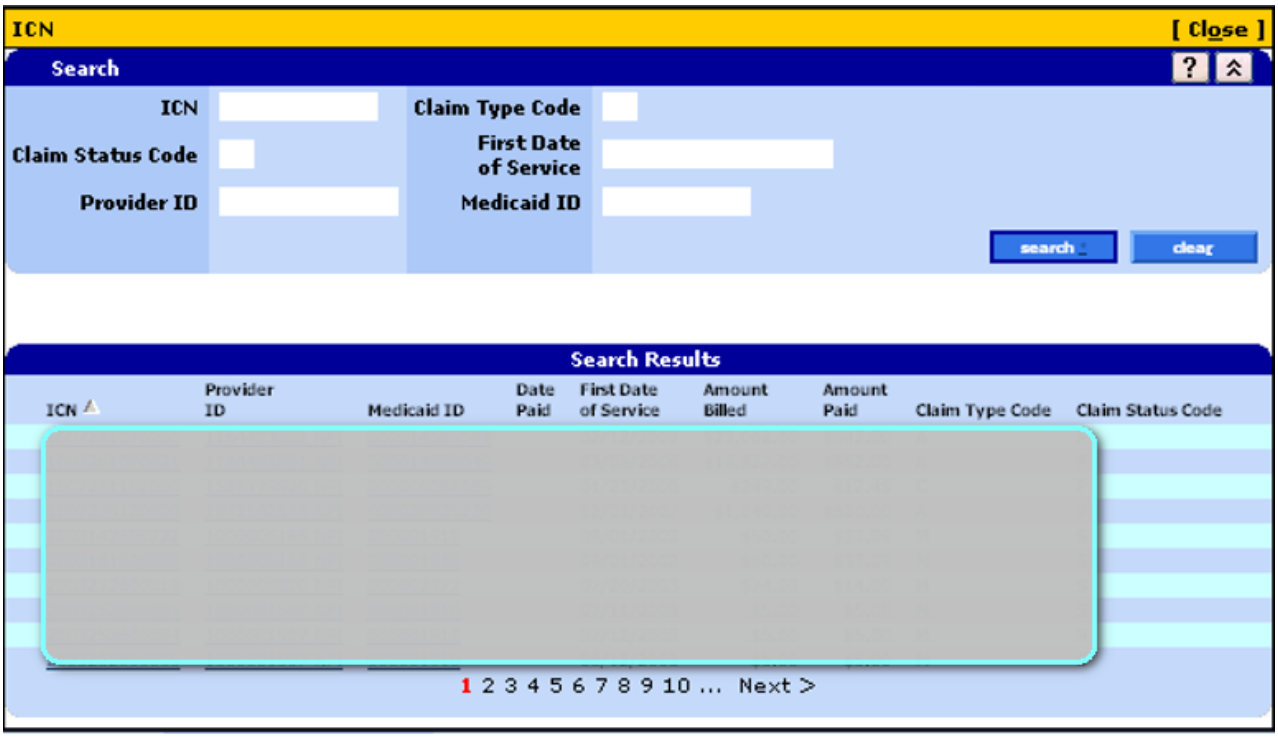
6.68.1 Search - ICN Panel Narrative

The ICN panel is used to search for internal control numbers (ICN)s and return the selected ICN to the prior panel.

This panel is inquiry only.

Navigation Path: [TPL] – [AR Search] – [(Click on [Add])] - [(Click on [Search] next to ICN)]

6.68.2 Search - ICN Panel Layout



6.68.3 Search - ICN Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount Billed	The amount the provider billed on the claim.	Label	Number (Integer)	0
Amount Paid	The amount paid on the claim.	Label	Number (Integer)	0
Claim Status Code	The status of the claim.	Field	Character	1
Claim Type Code	The type of claim.	Field	Character	1
Clear	Allows the user to remove data entered into search fields.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Date Paid	The date Medicaid paid the claim to the provider.	Label	N/A	0
First Date of Service	The first date of service on the claim.	Field	Date (MM/DD/CCYY)	8
ICN	The internal control number assigned to a claim.	Field	Number (Integer)	13
Medicaid ID	The recipient's Medicaid number.	Field	Number (Integer)	12
Provider ID	The number assigned to the provider.	Field	Number (Integer)	15
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

6.68.4 Search - ICN Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.68.5 Search - ICN Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.68.6 Search - ICN Panel Accessibility

6.68.6.1 To Access the Search - ICN Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Click **Add**.	Activates fields for entry of data or selection from lists.
4	Click **[Search]** located to the right of ICN.	ICN Search panel displays.

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6.68.6.2 To Navigate on the Search - ICN Panel

Step	Action	Response
1	Enter **ICN**.	
2	Enter Claim Status Code.	
3	Enter Provider ID.	
4	Enter Claim Type Code.	
5	Enter First Date of Service.	
6	Enter Medicaid ID.	
7	Click **Search**. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	ICN Search information is displayed.

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6.69 Search - Local Adjustment Reason Panel Overview

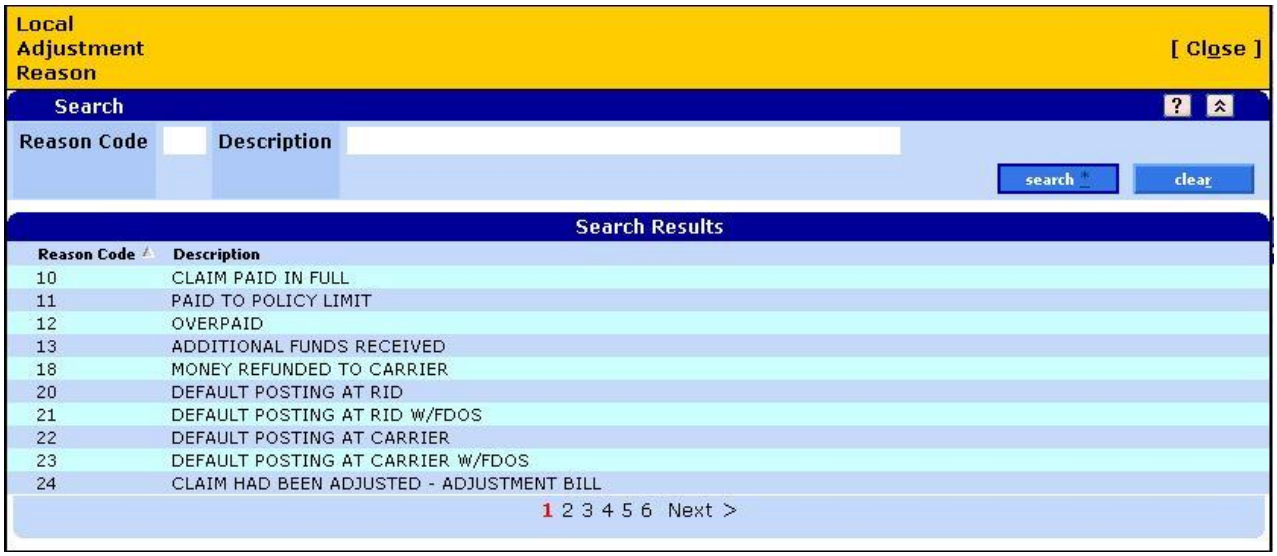
6.69.1 Search - Local Adjustment Reason Panel Narrative

The Local Adjustment Reason panel allows the user to search for and associate the Local Adjustment reason code.

This panel is inquiry only.

Navigation: [TPL] - [Related Data]-[Xref]-[Local/HIPAA Adjustment Reason]-[Add]-[(Click on [Search] next to Local Adjustment Reason)]

6.69.2 Search - Local Adjustment Reason Panel Layout



6.69.3 Search - Local Adjustment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to remove data entered into search fields.	Button	N/A	0
Description	The description for the Adjustment Reason.	Field	Character	30
Reason Code	The Adjustment Reason assigned by the system, not the HIPAA adjustment reason.	Field	Character	2
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

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6.69.4 Search - Local Adjustment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.69.5 Search - Local Adjustment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.69.6 Search - Local Adjustment Reason Panel Accessibility

6.69.6.1 To Access the Search - Local Adjustment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click **Xref**.	Xref-Related Data panel displays.
4	Select the Local/HIPAA Adjustment Reason hyperlink.	Local/HIPAA Adjustment Reason panel displays.
5	Click **Add**.	Activates fields for entry of data or selection from lists.
6	Click **[Search]** located to the right of Local Adjustment Reason.	Local Adjustment Reason search panel displays.

6.69.6.2 To Navigate on the Search - Local Adjustment Reason Panel

Step	Action	Response
1	Enter Reason Code.	
2	Enter Description.	
3	Click **Search**. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	Local Adjustment Reason search information is displayed.

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6.70 Search - Policy Number Panel Overview

6.70.1 Search - Policy Number Panel Narrative

The Policy Number panel is used to search for Policy Number and return the selected Policy Number to the prior panel.

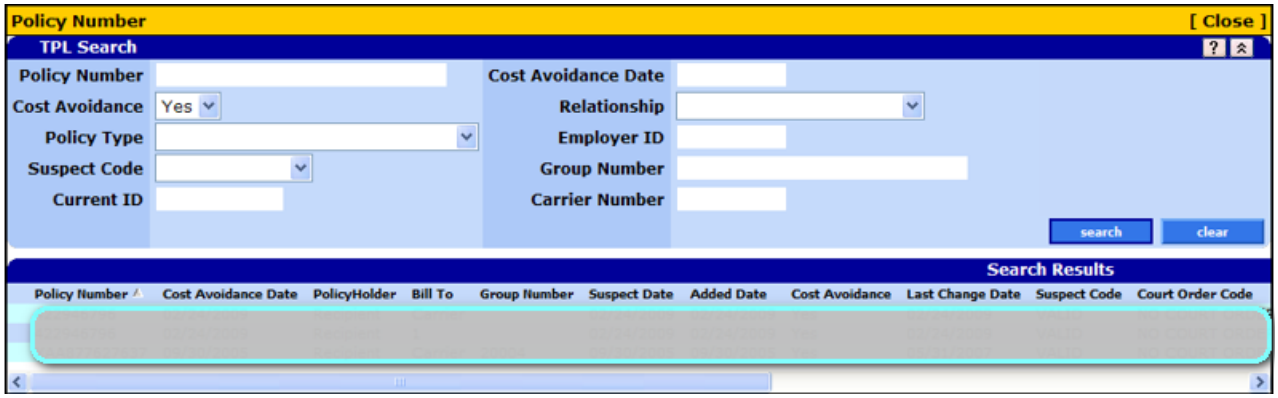
This panel is inquiry only.

Navigation Path: [TPL] – [AR Search] - (Click on [Search] next to [Policy Number])

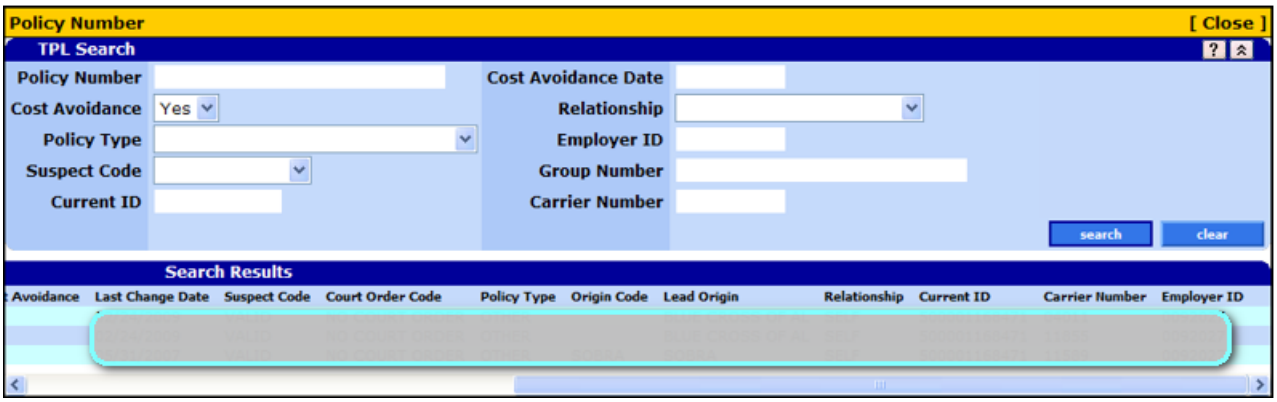
6.70.2 Search - Policy Number Panel Layout

The two layouts show all the Search Results of same panel.

Part 1



Part 2



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6.70.3 Search - Policy Number Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Added Date	The date the resource was originally added to the system.	Field	Date (MM/DD/CCYY)	8
Bill To	This code describes who the TPL claim facsimiles are billed to: the employer of the policyholder or the carrier.	Field	Character	1
Carrier Number	System assigned insurance carrier identification number.	Field	Number (Integer)	9
Clear	Allows the user to remove data entered into search fields.	Button	N/A	0
Cost Avoidance	Indicates if this is to bypass cost avoidance or not.	Combo Box	Character	1
Cost Avoidance Date	This is the date the cost avoidance indicator was last updated.	Field	Date (MM/DD/CCYY)	8
Court Order Code	This code is used to identify the court ordered code, indicating if a TPL Resource is required via a legal decision.	Field	Character	1
Current ID	Medicare identification number.	Field	Number (Integer)	9
Employer ID	Non-unique, user-defined employer identification used on all screens and reports to identify the employer.	Field	Number (Integer)	9
Group Number	Policy group number. If present, gives the group number of the policy.	Field	Character	16
Last Change Date	Contains the date that this record was last changed to help support audit trail research.	Field	Date (MM/DD/CCYY)	8
Lead Origin	Description of where the lead originated.	Field	Character	1
Origin Code	Code assigned to a specific origin.	Field	Character	1
Policy Number	Policy number for this TPL policy.	Field	Number (Integer)	16
Policy Type	This code identifies the type of insurance policy that the recipient is covered under.	Combo Box	Character	1
Policyholder	This code identifies whether the policy owner is a Recipient or a Policyholder.	Field	Character	1
Policyholder ID	A unique number assigned to a policyholder.	Field	Character	9
Relationship	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	Field	Character	1

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Field	Description	Field Type	Data Type	Length
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0
Suspect Code	This field identifies the TPL suspect code which identifies whether a TPL resource is suspect and, if so, how it was determined to be suspect.	Combo Box	Character	1
Suspect Date	The last date the suspect code was changed on the policy record.	Field	Date (MM/DD/CCYY)	8
TPL Absent Parent	Indicator of Absent Parent.	Field	Number (Integer)	9
TPLHIPPXref Data	The sak_tpl_resource that is associated with the HIPP case.	Field	Character	9

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6.70.4 Search - Policy Number Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.70.5 Search - Policy Number Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.70.6 Search - Policy Number Panel Accessibility

6.70.6.1 To Access the Search- Policy Number Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Click **[Search]** located to the right of Policy Number.	Policy Number Search panel displays.

6.70.6.2 To Navigate on the Search- Policy Number Panel

Step	Action	Response
1	Enter information in selected fields. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	
2	Click **Search**.	Policy Number information is displayed in field.

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6.71 Search - Recipient Panel Overview

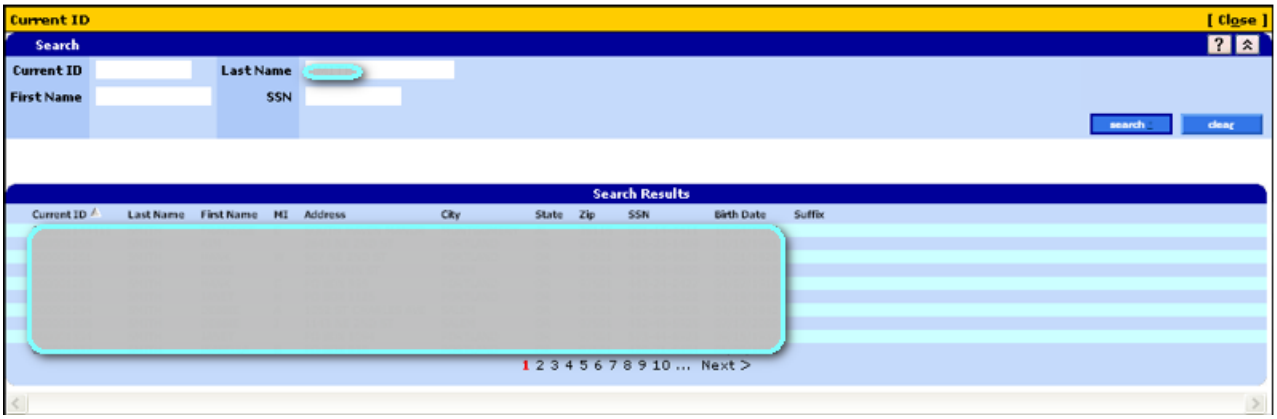
6.71.1 Search - Recipient Panel Narrative

The Recipient panel allows the user to access from a prior panel and search capability to return a needed record to the calling panel.

This panel is inquiry only.

Navigation: [TPL] – [AR Search] - [(Click on [Search] next to [Current ID])]

6.71.2 Search - Recipient Panel Layout



6.71.3 Search - Recipient Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address	This lists the address of the recipient.	Field	Alphanumeric	25
Birth Date	This lists the birth date of the recipient.	Field	Date (MM/DD/CCYY)	8
City	This lists the city the recipient resides.	Field	Character	25
Clear	Allows the user to remove data entered on the panel.	Button	N/A	0
Current ID	The recipient's Medicaid identification number.	Field	Character	12
First Name	First name of recipient.	Field	Character	15
Last Name	Last name of recipient.	Field	Character	20
MI	This lists the middle initial of the recipient.	Field	Character	1
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0
SSN	Social Security Number of recipient.	Field	Number (Integer)	9

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Field	Description	Field Type	Data Type	Length
State	This lists the state the recipient resides.	Field	Character	2
Suffix	This lists the Suffix of the recipient.	Field	Character	25
Zip	This lists the zip code of the recipient.	Field	Number (Integer)	5

6.71.4 Search - Recipient Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.71.5 Search - Recipient Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.71.6 Search - Recipient Panel Accessibility

6.71.6.1 To Access the Search - Recipient Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **AR Search**.	TPL AR Search panel displays.
3	Click **[Search]** located to the right of Current ID.	Recipient Search panel displays.

6.71.6.2 To Navigate on the Search - Recipient Panel

Step	Action	Response
1	Enter Current ID.	
2	Enter First Name.	
3	Enter Last Name.	
4	Enter **SSN**.	
5	Click **Search**. Users may also select from the list of Search Results displayed at the bottom by clicking on a row.	Recipient search information is displayed.

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6.72 Search - Relationship Panel Overview

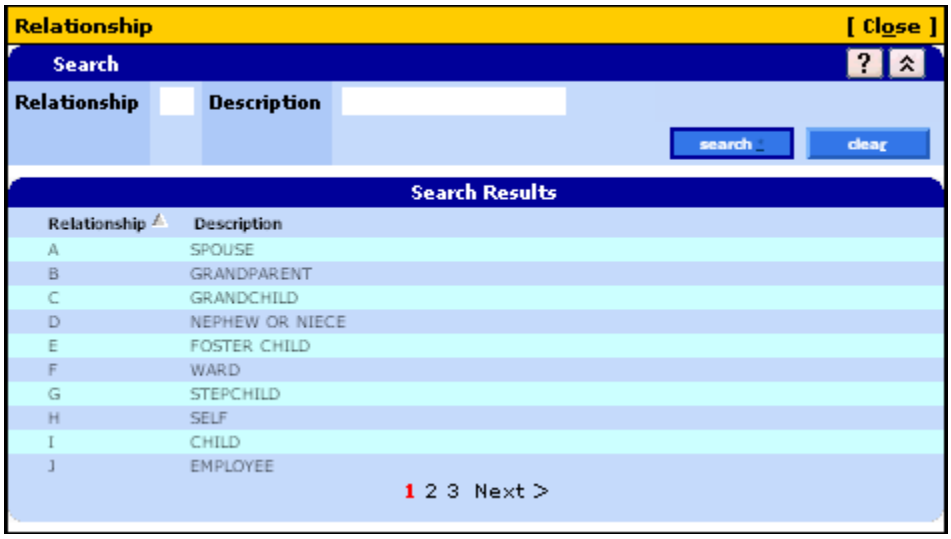
6.72.1 Search - Relationship Panel Narrative

The Relationship panel is used to search for relationship codes and return the results to the prior panel.

This panel is inquiry only.

Navigation: [TPL] – [Search] - [(Click on [Add])] - [Base Information] – [TPL] - [(Click on [Search] next to Relationship)]

6.72.2 Search - Relationship Panel Layout



6.72.3 Search - Relationship Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Allows the user to remove data entered on the panel.	Button	N/A	0
Description	This field contains the description associated with a specific relationship code.	Field	Character	20
Relationship	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	Field	Character	1
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

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6.72.4 Search - Relationship Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.72.5 Search - Relationship Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.72.6 Search - Relationship Panel Accessibility

6.72.6.1 To Access the Search - Relationship Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Search**.	TPL Search panel displays.
3	Click **Add**.	TPL Maintenance panel is displayed.
4	Select TPL Base Information hyperlink.	TPL Base Information panel displays.
5	Click **[Search]** located to the right of Relationship.	Relationship Search panel displays.

6.72.6.2 To Navigate on the Search - Relationship Panel

Step	Action	Response
1	Enter Relationship.	
2	Enter Description.	
3	Click **Search**. Users may also select from the list of Search Results (if available) displayed at the bottom by clicking on a row.	Relationship search information is displayed.

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6.73 Related Data Panel Overview

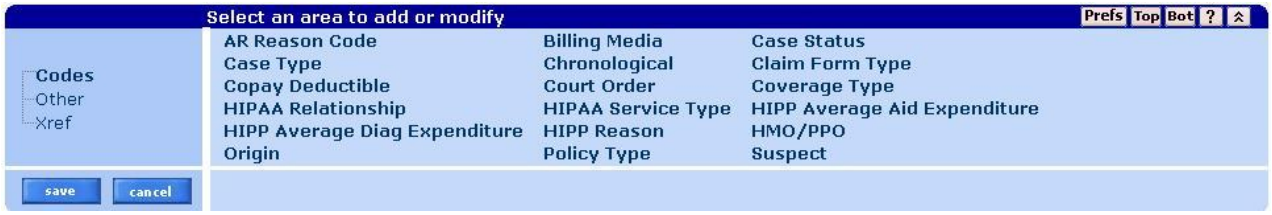
6.73.1 Related Data Panel Narrative

The point of access for the TPL Related Data panels.

This panel is inquiry only.

Navigation Path: [TPL] -[Related Data]

6.73.2 Related Data Panel Layout



6.73.3 Related Data Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes made to a panel.	Button	N/A	0
Codes	Link for Related Data Codes panels.	Hyperlink	N/A	0
Other	Link for Related Data Other panels.	Hyperlink	N/A	0
Save	Allows the user to save any changes made to a panel.	Button	N/A	0
Xref	Link for Related Data Xref panels.	Hyperlink	N/A	0

6.73.4 Related Data Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.73.5 Related Data Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.73.6 Related Data Panel Accessibility

6.73.6.1 To Access the Related Data Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.

6.73.6.2 To Navigate the Related Data Panel

Step	Action	Response
1	Select an area to view, add, or modify by clicking on a hyperlink.	Selected hyperlink displays associated panel.

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6.74 Related Data - Codes Panel Overview

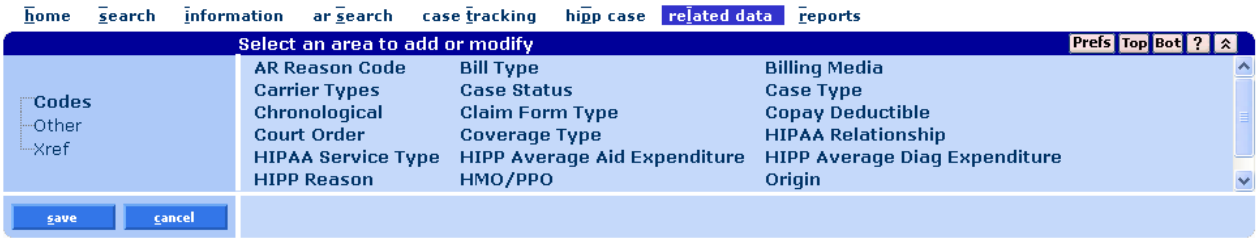
6.74.1 Related Data - Codes Panel Narrative

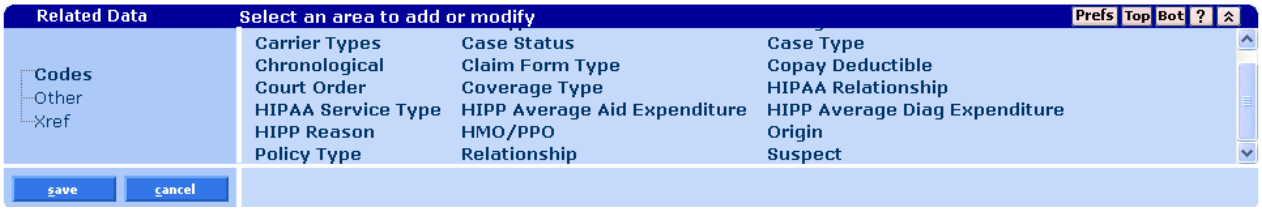
The point of access for the TPL Related Data Code panels.

This panel is inquiry onlyl.

Navigation Path: [TPL] – [Related Data] - [Codes]

6.74.2 Related Data - Codes Panel Layout





6.74.3 Related Data - Codes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR Reason Code	Link to the AR Reason Code panel.	Hyperlink	N/A	0
Bill Type	Link to the Bill Type panel.	Hyperlink	N/A	0
Billing Media	Link to the Billing Media panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes on the Codes panel.	Button	N/A	0
Carrier Types	Link to the Carrier Types panel.	Hyperlink	N/A	0
Case Status	Link to the Case Status panel.	Hyperlink	N/A	0
Case Type	Link to the Case Type panel.	Hyperlink	N/A	0
Chronological	Link to the Chronological panel.	Hyperlink	N/A	0
Claim Form Type	Link to the Claim Form Type panel.	Hyperlink	N/A	0
Copay Deductible	Link to the Copay Deductible panel.	Hyperlink	N/A	0

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Field	Description	Field Type	Data Type	Length
Court Order	Link to the Court Order panel.	Hyperlink	N/A	0
Coverage Type	Link to the Coverage Type panel.	Hyperlink	N/A	0
HIPAA Relationship	Link to the HIPAA Relationship panel.	Hyperlink	N/A	0
HIPAA Service Type	Link to the HIPAA Service Type panel.	Hyperlink	N/A	0
HIPP Average Aid Expenditure	Link to the HIPP Average Aid Expenditure panel.	Hyperlink	N/A	0
HIPP Average Diag Expenditure	Link to the HIPP Average Diagnosis Expenditure panel.	Hyperlink	N/A	0
HIPP Reason	Link to the HIPP Reason panel.	Hyperlink	N/A	0
HMO/PPO	Link to the HMO/PPO panel.	Hyperlink	N/A	0
Origin	Link to the Origin panel.	Hyperlink	N/A	0
Policy Type	Link to the Policy Type panel.	Hyperlink	N/A	0
Relationship	Link to the Relationship panel.	Hyperlink	N/A	0
Save	Allows the user to save a record for codes.	Button	N/A	0
Suspect	Link to the Suspect panel.	Hyperlink	N/A	0

6.74.4 Related Data - Codes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.74.5 Related Data - Codes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.74.6 Related Data - Codes Panel Accessibility

6.74.6.1 To Access the Related Data-Codes Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.

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6.75 Codes - AR Reason Code Panel Overview

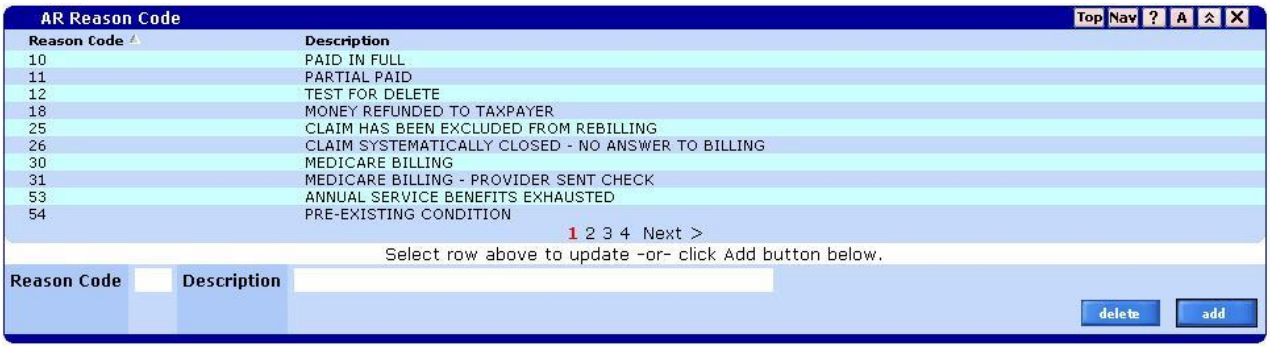
6.75.1 Codes - AR Reason Code Panel Narrative

The AR Reason Code panel is used to add, update, or delete the values and descriptions defined for A/R reasons.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation: [TPL] – [Related Data] - [Codes] - [AR Reason Code]

6.75.2 Codes - AR Reason Code Panel Layout



6.75.3 Codes - AR Reason Code Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows the user to add reason code information.	Button	N/A	0
Delete	Allows the user to remove reason code information.	Button	N/A	0
Description	Description for A/R Reason.	Field	Character	50
Reason Code	Code value for A/R Reason.	Field	Character	4

6.75.4 Codes - AR Reason Code Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
Reason Code	Field	3	Cannot delete TPL A/R Reason record. In use by an AR Disposition.	Please select a different A/R Reason record.
	Field	4	Cannot delete A/R Reason record. In use by an AR.	Please select a different A/R Reason record.
	Field	5	Reason Code is required.	Enter a Reason Code.
	Field	6	Description is required.	Enter a Description.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	7	A duplicate record cannot be saved.	Enter a valid unique.

6.75.5 Codes - AR Reason Code Panel Extra Features

Referential integrity checks need to occur on the delete from this table against the following tables:
T_HIPAA_ADJRSN_XRF
T_TPL_AR_CAS_DISPS
T_TPL_AR_DISPS
T_TPL_AR_HEALTH

6.75.6 Codes - AR Reason Code Panel Accessibility

6.75.6.1 To Access the Codes - AR Reason Code Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select AR Reason Code.	AR Reason Code panel displays.

6.75.6.2 To Add on the Codes - AR Reason Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Reason Code.	
3	Enter Description.	
4	Click **Save**.	AR Reason Code information is saved.

6.75.6.3 To Update on the Codes - AR Reason Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	AR Reason Code information is saved.

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6.75.6.4 To Delete on the Codes - AR Reason Code Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.76 Codes - Bill Type Panel Overview

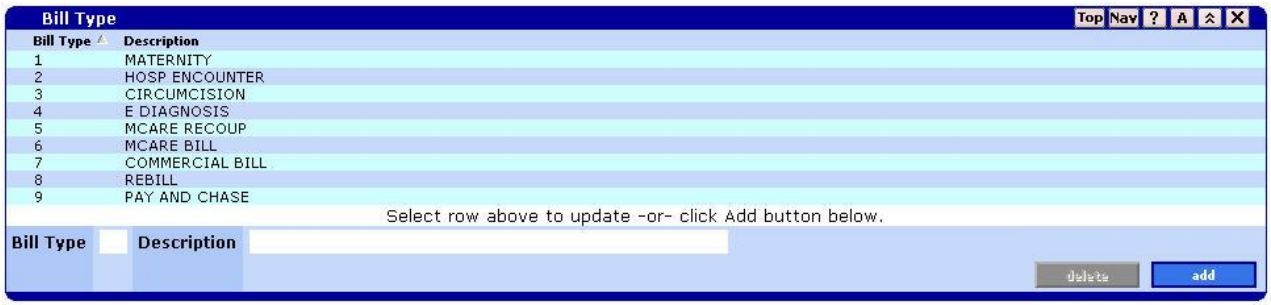
6.76.1 Codes - Bill Type Panel Narrative

The Bill Type panel establishes and maintains TPL types of billing.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Codes] - [Bill Type]

6.76.2 Codes - Bill Type Panel Layout



6.76.3 Codes - Bill Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Bill Type panel.	Button	N/A	0
Bill Type	This indicates the type of billing record.	Field	Character	1
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	This is the description of the billing type.	Field	Character	50

6.76.4 Codes - Bill Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Bill Type	Field	1	Bill Type is Required.	Please add a Billing Type.
Description	Field	1	Description is Required.	Please add a narrative Description for this billing type.

6.76.5 Codes - Bill Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.76.6 Codes - Bill Type Panel Accessibility

6.76.6.1 To Access the Codes - Bill Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Bill Type.	Bill Type panel displays.

6.76.6.2 To Add on the Codes - Bill Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Bill Type.	
3	Enter Description.	
4	Click **Save**.	Bill Type information is saved.

6.76.6.3 To Update on the Codes - Bill Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Bill Type information is saved.

6.76.6.4 To Delete on the Codes - Bill Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.77 Codes - Billing Media Panel Overview

6.77.1 Codes - Billing Media Panel Narrative

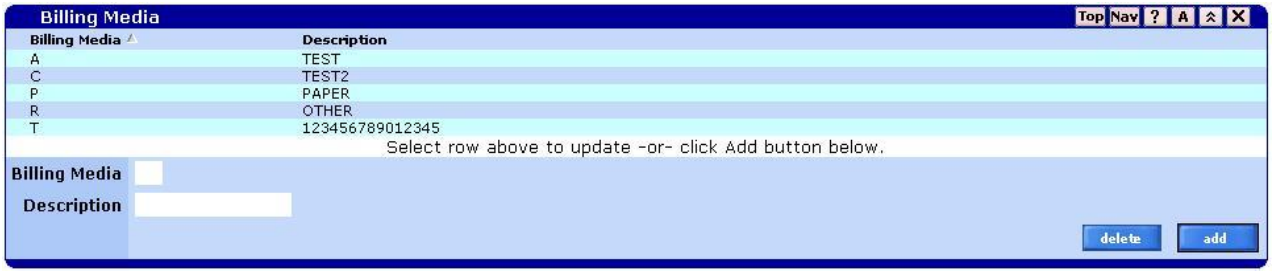
The Billing Media panel contains the possible values for the TPL billing media code and their descriptions. The data supplied by this panel is used by the Carrier panels to identify if billings should be sent as paper, electronic or none.

Delete operation now only allowed if relationship to t_tpl_carrier.cde_bill_media does not exist. If a join exists for the code, then the delete is prevented.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Billing Media]

6.77.2 Codes - Billing Media Panel Layout



6.77.3 Codes - Billing Media Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Billing Media panel.	Button	N/A	0
Billing Media	Code used to identify the billing media on which an employer or carrier wishes to receive TPL claim facsimiles.	Field	Character	1
Delete	Allows the user to remove a record from the panel.	Button	N/A	0
Description	Provides a detailed description of the associated billing media code.	Field	Character	15

6.77.4 Codes - Billing Media Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Billing Media	Field	1	Billing Media is Required.	Please add a Billing Media.
Delete	Button	1	Cannot delete Billing Media record. In use by Carrier.	Remove the Billing Media from all associated carrier records before deleting media type record.

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Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is Required.	Please add a narrative Description for this billing media.

6.77.5 Codes - Billing Media Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.77.6 Codes - Billing Media Panel Accessibility

6.77.6.1 To Access the Codes - Billing Media Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Billing Media.	Billing Media panel displays.

6.77.6.2 To Add on the Codes - Billing Media Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Billing Media.	
3	Enter Description.	
4	Click **Save**.	Billing Media information is saved.

6.77.6.3 To Update on the Codes - Billing Media Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Billing Media information is saved.

6.77.6.4 To Delete on the Codes - Billing Media Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.78 Codes- Carrier Types Panel Overview

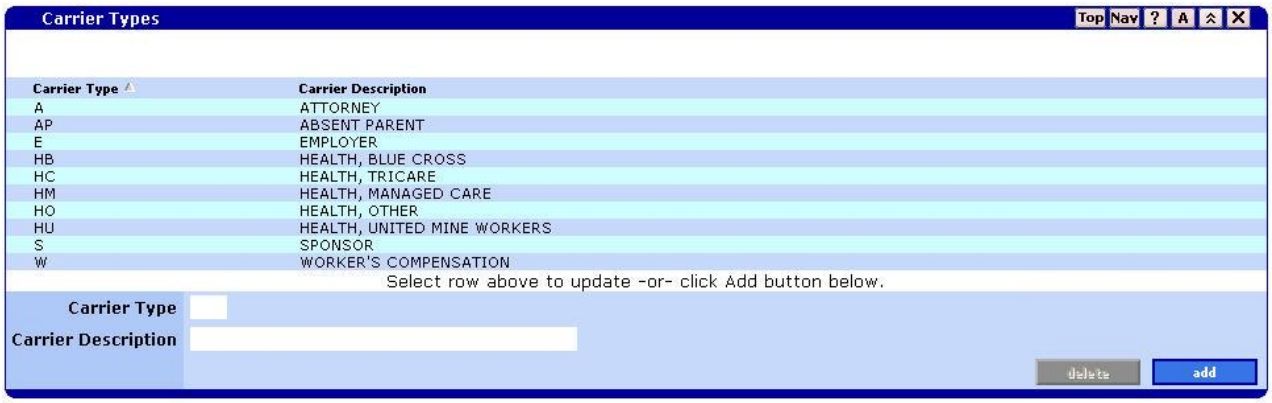
6.78.1 Codes-Carrier Types Panel Narrative

The Carrier Types panel contains the possible values for carrier types.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Carrier Types]

6.78.2 Codes-Carrier Types Panel Layout



6.78.3 Codes-Carrier Types Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Carrier Types panel.	Button	N/A	0
Carrier Type	This is the carrier type code.	Field	Character	2
Carrier Description	Description of the carrier type.	Field	Character	33
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

6.78.4 Codes-Carrier Types Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	4	Cannot add Carrier Type record. The Carrier Type already exists	Please correct the Carrier Type.
Carrier Type	Field	1	Carrier Type is Required.	Please enter a Carrier Type.
Carrier Description	Field	2	Carrier Description is Required.	Please enter a carrier Description.

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Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	3	Cannot delete Carrier Type record. In use by a carrier.	Remove the Carrier Type from all associated carrier records before deleting the carrier type record.

6.78.5 Codes-Carrier Types Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.78.6 Codes-Carrier Types Panel Accessibility

6.78.6.1 To Access the Codes - Carrier Types Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Carrier Types.	Carrier Types panel displays.

6.78.6.2 To Add on the Codes - Carrier Types Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Carrier Type.	
3	Enter Description.	
4	Click **Save**.	Carrier Types information is saved.

6.78.6.3 To Update on the Codes - Carrier Types Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier Types information is saved.

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6.78.6.4 To Delete on the Codes- Carrier Types Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.79 Codes - Case Status Panel Overview

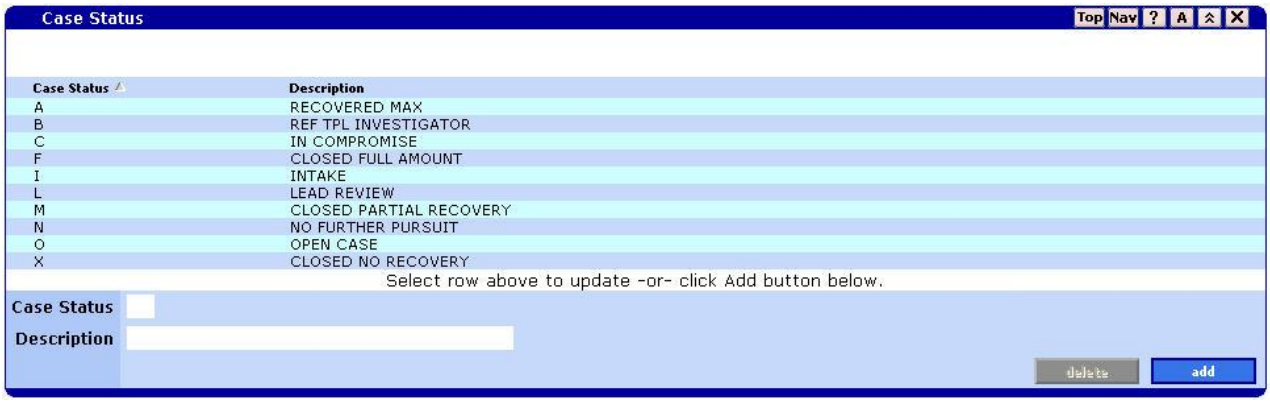
6.79.1 Codes - Case Status Panel Narrative

The Case Status panel displays the valid status codes of a TPL casualty case and its attendant description.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Case Status]

6.79.2 Codes - Case Status Panel Layout



6.79.3 Codes - Case Status Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Case Status panel.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Case Status	This represents the current status of the casualty case. Valid values include: A = Recovered MAX-The total case amount was collected and dispositioned. B = In Compromise-The responsible party is negotiating a lower settlement amount. F = Closed Full Amount-The case is being closed due to no settlement. I = Intake-A lead has been received for potential recovery and the case has been added-but further research is needed for pursuing recoveries. L = Lead Review-The case has been transferred to a supervisor or designee for review. M = Closed Partial Recovery-The total case amount was not collected, but a partial recovery was received and dispositioned. N = No Further Pursuit-After further research, it was determined the case should not be pursued. O = Open Case-All research has been completed and the case should be pursued. X = Closed No Recovery-The case was pursued but no money is recoverable. This is a closed case. B = REF TPL Investigator-The case has been referred to a TPL Investigator for further analysis.	Field	Character	1
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	This is the description of the status code.	Field	Character	40

6.79.4 Codes - Case Status Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Case Status	Field	1	Case Status is required.	Enter a Case Status code.
Delete	Button	0	Cannot delete Case Status record. In use by Casualty Case.	Cannot delete Case Status record. In use by Casualty Case.
Description	Field	1	Description is required.	Enter a Description.

6.79.5 Codes - Case Status Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.79.6 Codes - Case Status Panel Accessibility

6.79.6.1 To Access the Codes - Case Status Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Case Status.	Case Status panel displays.

6.79.6.2 To Add on the Codes - Case Status Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Case Status.	
3	Enter Description.	
4	Click **Save**.	Case Status information is saved.

6.79.6.3 To Update on the Codes - Case Status Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Status information is saved.

6.79.6.4 To Delete on the Codes - Case Status Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.80 Codes - Case Type Panel Overview

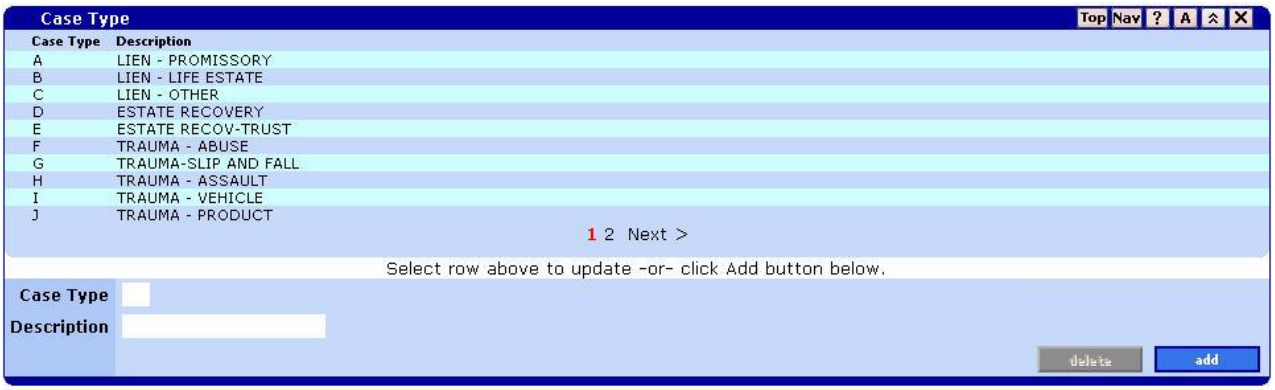
6.80.1 Codes - Case Type Panel Narrative

The Cases Type panel provides the TPL casualty case type and its' description.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Case Type]

6.80.2 Codes - Case Type Panel Layout



6.80.3 Codes - Case Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Case Type panel.	Button	N/A	0
Case Type	This indicates the type of the casualty case.	Field	Character	1
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	The description of the case type.	Field	Character	20

6.80.4 Codes - Case Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Case Type	Field	1	Case Type is required.	Enter a Case Type code.
Delete	Button	1	Delete was Unsuccessful. Cannot delete Case Types that are associated with Cases.	Case type has an associated case. Cannot delete this Case Type.
Description	Field	1	Description is required.	Enter a Description.

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6.80.5 Codes - Case Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.80.6 Codes - Case Type Panel Accessibility

6.80.6.1 To Access the Codes - Case Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Case Type.	Case Type panel displays.

6.80.6.2 To Add on the Codes - Case Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Case Type.	
3	Enter Description.	
4	Click **Save**.	Case Type information is saved.

6.80.6.3 To Update on the Codes - Case Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Type information is saved.

6.80.6.4 To Delete on the Codes - Case Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.81 Codes - Chronological Panel Overview

6.81.1 Codes - Chronological Panel Narrative

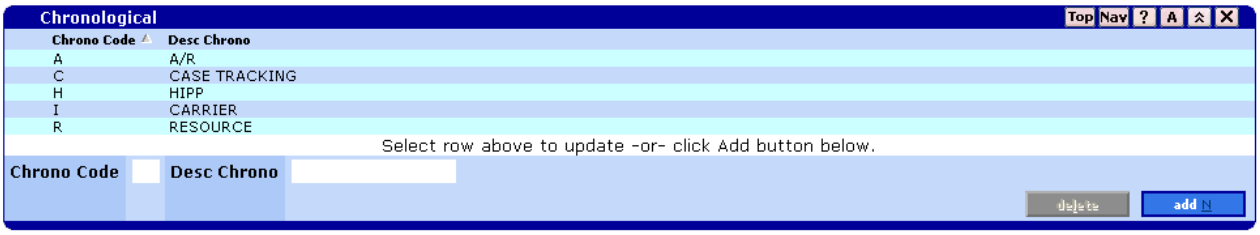
The Chronological panel contains the possible values for the TPL Chronological codes and their descriptions.

Delete operation only allowed if relationship to t_chrono_notes.cde_chrono does not exist. If a join exists for the code, then the delete is prevented.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Chronological]

6.81.2 Codes – Chronological Panel Layout



6.81.3 Codes – Chronological Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Code – Chronological panel.	Button	N/A	0
Chrono Code	This code is used to identify the chronological code, indicating if a sub area supports chronological notes.	Field	Character	1
Desc Chrono	This field provides a detailed description of the associated chronological code.	Field	Character	15
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

6.81.4 Codes – Chronological Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot delete Chrono code record. In use by a sub area.	Remove the Chrono Code record before deleting record.
Chrono Code	Label	1	A duplicate record cannot be saved.	Enter a valid unique value for Chrono Code.
	Label	2	Chrono code is Required	Please add a Chrono Code.

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Field	Field Type	Error Code	Error Message	To Correct
Description	Label	1	Description is Required.	Please add a narrative description for this chrono Code.

6.81.5 Codes – Chronological Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.81.6 Codes – Chronological Panel Accessibility

6.81.6.1 To Access Codes – Chronological Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Chronological.	Chronological panel displays.

6.81.6.2 To Add on the Codes - Chronological Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Chrono Code.	
3	Enter Desc Chrono.	
4	Click **Save**.	Chronological information is saved.

6.81.6.3 To Update on the Codes - Chronological Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Chronological information is saved.

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6.81.6.4 To Delete on the Codes - Chronological Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.82 Codes - Claim Form Type Panel Overview

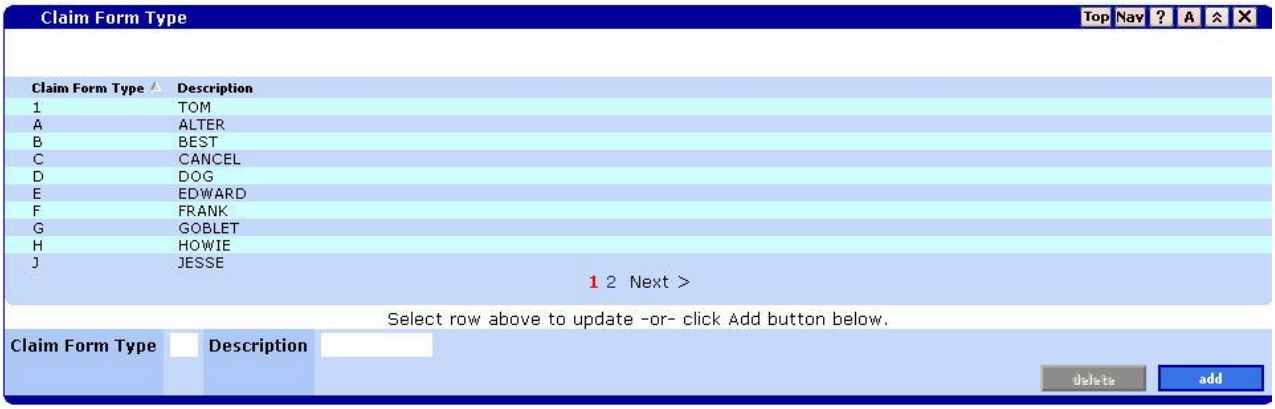
6.82.1 Codes - Claim Form Type Panel Narrative

The Claim Form Type panel contains the possible values for the TPL claim form type code. This field is used on the carrier table to indicate the type of claim form to be sent to the carrier (i.e., proprietary, universal HIPAA standard, none, etc.).

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Claim Form Type]

6.82.2 Codes - Claim Form Type Panel Layout



6.82.3 Codes - Claim Form Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Adds	Allows a user to add a new claim form type record.	Button	N/A	0
Claim Form Type	Identifies the claim form type on which a carrier wishes to receive TPL claim facsimiles.	Field	Character	1
Delete	Allows a user to remove a claim form type record.	Button	N/A	0
Description	Claim form description associated with a claim form type code.	Field	Character	10

6.82.4 Codes - Claim Form Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Claim Form Type	Field	1	Claim Form Type is required.	Enter a Claim Form Type code.
	Field	2	A duplicate record cannot be saved.	Enter a non-existing Claim Form Type code.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Cannot delete Claim Form Type record. In use by another entity.	This Claim Form Type cannot be deleted, select another claim form type.
Description	Field	1	Description is required.	Enter a Description.

6.82.5 Codes - Claim Form Type Panel Extra Features

Referential integrity is performed on deletions of this code to ensure it is not used by a carrier.

6.82.6 Codes - Claim Form Type Panel Accessibility

6.82.6.1 To Access the Codes - Claim Form Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Claim Form Type.	Claim Form Type panel displays.

6.82.6.2 To Add on the Codes - Claim Form Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Claim Form Type.	
3	Enter Description.	
4	Click **Save**.	Claim Form Type information is saved.

6.82.6.3 To Update on the Codes - Claim Form Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Claim Form Type information is saved.

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6.82.6.4 To Delete on the Codes - Claim Form Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.83 Codes - Copay Deductible Panel Overview

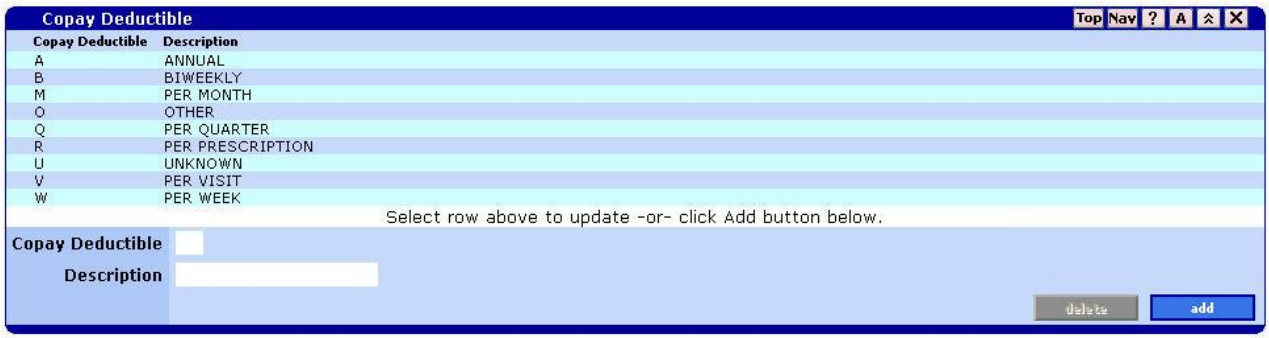
6.83.1 Codes - Copay Deductible Panel Narrative

The Copay Deductible panel describes the codes and descriptions used for copay and deductibles. The data on this panel is used on the TPL Policy Coverage panel to identify the frequency of copay and deductible.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Copay Deductible]

6.83.2 Codes - Copay Deductible Panel Layout



6.83.3 Codes - Copay Deductible Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Copay Deductible panel.	Button	N/A	0
Copay Deductible	Identifies the schedule for deductible, coinsurance, or premium payments for a specific coverage type of a policy.	Field	Character	1
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Contains the description associated with a schedule code.	Field	Character	20

6.83.4 Codes - Copay Deductible Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Copay Deductible	Field	1	Copay Deductible is required.	Enter a Copay Deductible code.
Description	Field	1	Description is required.	Enter a Description.

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6.83.5 Codes - Copay Deductible Panel Extra Features

This panel uses referential integrity to ensure deletions are cross-checked against policies. If a record is being used, the deletion is prevented.

6.83.6 Codes - Copay Deductible Panel Accessibility

6.83.6.1 To Access the Codes - Copay Deductible Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Copay Deductible.	Copay Deductible panel displays.

6.83.6.2 To Add on the Codes - Copay Deductible Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Copay Deductible.	
3	Enter Description.	
4	Click **Save**.	Copay Deductible information is saved.

6.83.6.3 To Update on the Codes - Copay Deductible Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Copay Deductible information is saved.

6.83.6.4 To Delete on the Codes - Copay Deductible Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.84 Codes - Court Order Panel Overview

6.84.1 Codes - Court Order Panel Narrative

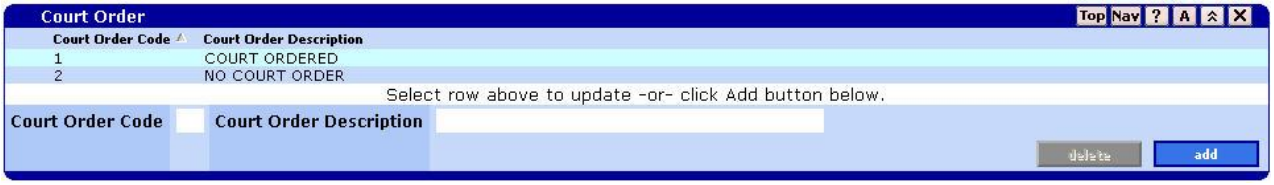
The Court Order panel contains the possible values for the TPL Court Ordered codes and their descriptions.

Delete operation only allowed if relationship to t_tpl_resource.cde_court_order does not exist. If a join exists for the code, then the delete is prevented.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Court Order]

6.84.2 Codes - Court Order Panel Layout



6.84.3 Codes - Court Order Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Court Order panel.	Button	N/A	0
Court Order Code	Used to identify the court ordered code, indicating if a TPL Resource is required via a legal decision.	Field	Character	1
Court Order Description	Provides a detailed description of the associated court ordered code.	Field	Character	15
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

6.84.4 Codes - Court Order Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Court Order Code	Field	1	Court Ordered code is Required.	Please add a Court Ordered Code.
Court Order Description	Field	1	Description is Required.	Please add a narrative Description for this court ordered code.

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Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot delete Court Ordered record. In use by a TPL Resource.	Remove the Court Ordered Code from all associated resource records before deleting record.

6.84.5 Codes - Court Order Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.84.6 Codes - Court Order Panel Accessibility

6.84.6.1 To Access the Codes - Court Order Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Court Order.	Court Order panel displays.

6.84.6.2 To Add on the Codes - Court Order Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Court Order Code.	
3	Enter Court Order Description.	
4	Click **Save**.	Court Order information is saved.

6.84.6.3 To Update on the Codes - Court Order Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Court Order information is saved.

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6.84.6.4 To Delete on the Codes - Court Order Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.85 Codes - Coverage Type Panel Overview

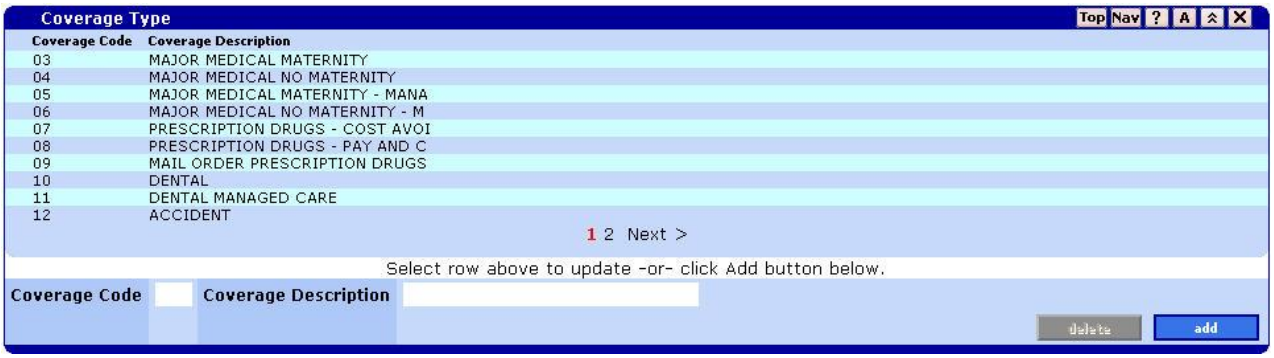
6.85.1 Codes - Coverage Type Panel Narrative

The Coverage Type panel contains the possible values for the TPL Coverage Type codes and their descriptions.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Coverage Type]

6.85.2 Codes - Coverage Type Panel Layout



6.85.3 Codes - Coverage Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Coverage Type panel.	Button	N/A	0
Coverage Code	Identifies the type of coverage that a TPL policy provides.	Field	Character	2
Coverage Description	Describes the type of coverage (services) a TPL resource provides.	Field	Character	120
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

6.85.4 Codes - Coverage Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Coverage Code	Field	1	Coverage Code is required.	Enter code for coverage type.
Coverage Description	Field	1	Coverage Description is required.	Enter Description of coverage type.

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Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Coverage Type - delete was unsuccessful. Record in use by a policy or TPL matrix.	Review entry.

6.85.5 Codes - Coverage Type Panel Extra Features

Referential integrity checks are applied when attempting deletes. A coverage code cannot be deleted if it is associated with any of the following:

Policy

Coverage to OI Plan Xref

6.85.6 Codes - Coverage Type Panel Accessibility

6.85.6.1 To Access the Codes - Coverage Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Coverage Type.	Coverage Type panel displays.

6.85.6.2 To Add on the Codes - Coverage Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Coverage Code.	
3	Enter Coverage Description.	
4	Click **Save**.	Coverage Type information is saved.

6.85.6.3 To Update on the Codes - Coverage Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Coverage Type information is saved.

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6.85.6.4 To Delete on the Codes - Coverage Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.86 Codes - HIPAA Relationship Panel Overview

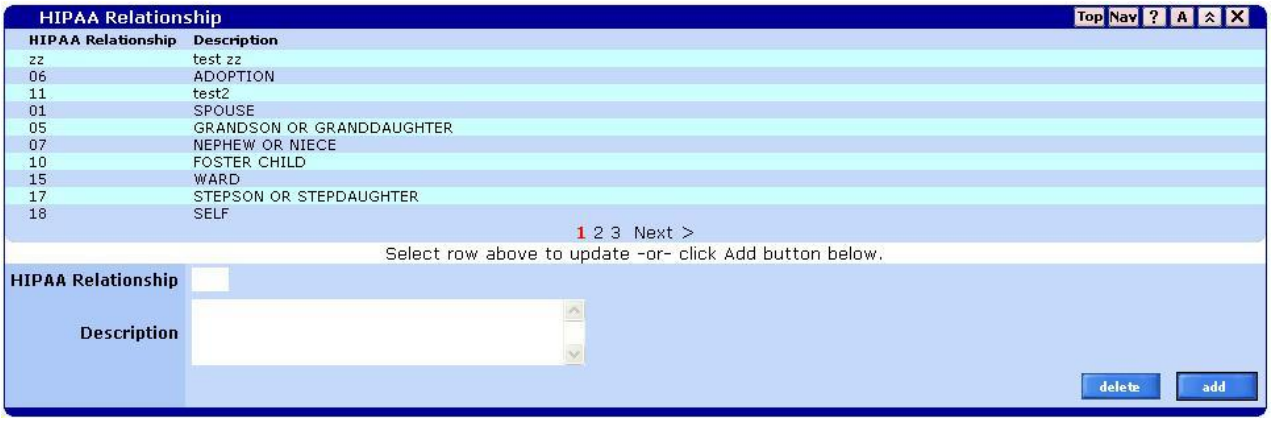
6.86.1 Codes - HIPAA Relationship Panel Narrative

The HIPAA Relationship panel contains the HIPAA relationship code values and their descriptions.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [HIPAA Relationship]

6.86.2 Codes - HIPAA Relationship Panel Layout



6.86.3 Codes - HIPAA Relationship Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Code – HIPAA Relationship panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Contains the description associated with a specific HIPAA relationship code.	Field	Character	120
HIPAA Relationship	Identifies the relationship of the recipient to the policyholder.	Field	Character	2

6.86.4 Codes - HIPAA Relationship Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot delete the HIPAA relation: Integrity with Relation Code.	Cannot delete because Relation code exists.
Description	Field	1	Description is required.	Enter a Description.

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Field	Field Type	Error Code	Error Message	To Correct
HIPAA Relationship	Field	1	HIPAA Relationship is required.	Enter a HIPAA Relationship code.
	Field	2	Cannot add a duplicated HIPAA Relationship.	Verify HIPAA Relationship Code.

6.86.5 Codes - HIPAA Relationship Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.86.6 Codes - HIPAA Relationship Panel Accessibility

6.86.6.1 To Access the Codes - HIPAA Relationship Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select HIPAA Relationship.	HIPAA Relationship panel displays.

6.86.6.2 To Add on the Codes - HIPAA Relationship Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter HIPAA Relationship.	
3	Enter Description.	
4	Click **Save**.	HIPAA Relationship information is saved.

6.86.6.3 To Update on the Codes - HIPAA Relationship Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Relationship information is saved.

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6.86.6.4 To Delete on the Codes - HIPAA Relationship Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.87 Codes - HIPAA Service Type Panel Overview

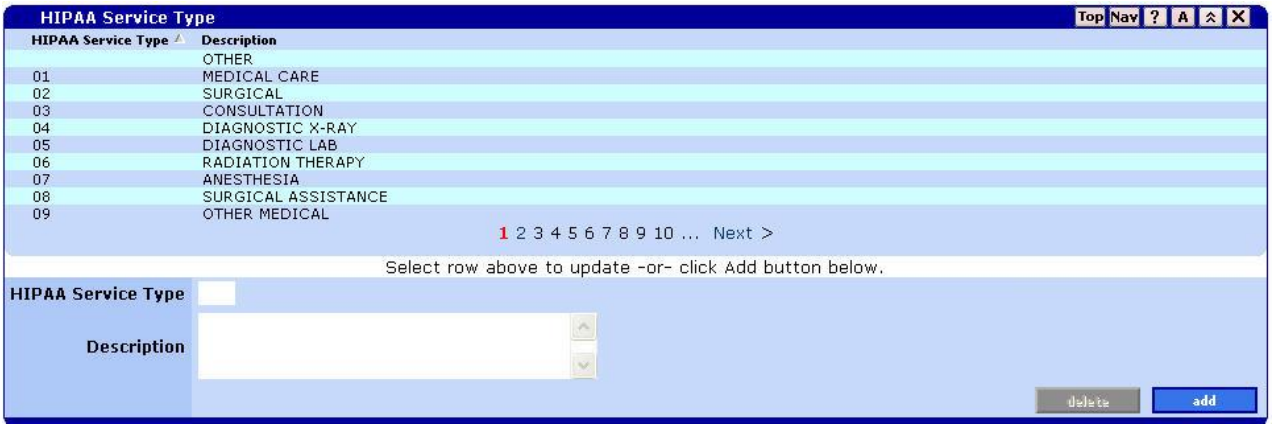
6.87.1 Codes - HIPAA Service Type Panel Narrative

The HIPAA Service Type panel contains the HIPAA service type code which describes the type of coverage a recipient has with a policy.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [HIPAA Service Type]

6.87.2 Codes - HIPAA Service Type Panel Layout



6.87.3 Codes - HIPAA Service Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – HIPAA Service Type panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	The description for the HIPAA service type code.	Field	Character	120
HIPAA Service Type	This field contains the HIPAA service type code which describes the type of coverage a recipient has with a policy.	Field	Character	2

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6.87.4 Codes - HIPAA Service Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	0	Cannot delete HIPAA Service Type Record. In use by Coverage Code - cross-reference.	Verify HIPAA Service Type.
Description	Field	1	Description is required.	Enter a Description.
HIPAA Service Type	Field	1	HIPAA Service Type is required.	Enter a HIPAA Service Type code.
	Field	2	HIPAA Service Type Code already exists.	Verify HIPAA Service Type Code.

6.87.5 Codes -HIPAA Service Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.87.6 Codes - HIPAA Service Type Panel Accessibility

6.87.6.1 To Access the Codes - HIPAA Service Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select HIPAA Service Type.	HIPAA Service Type panel displays.

6.87.6.2 To Add on the Codes - HIPAA Service Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter HIPAA Service Type.	
3	Enter Description.	
4	Click **Save**.	HIPAA Service Type information is saved.

6.87.6.3 To Update on the Codes - HIPAA Service Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Service Type information is saved.

6.87.6.4 To Delete on the Codes - HIPAA Service Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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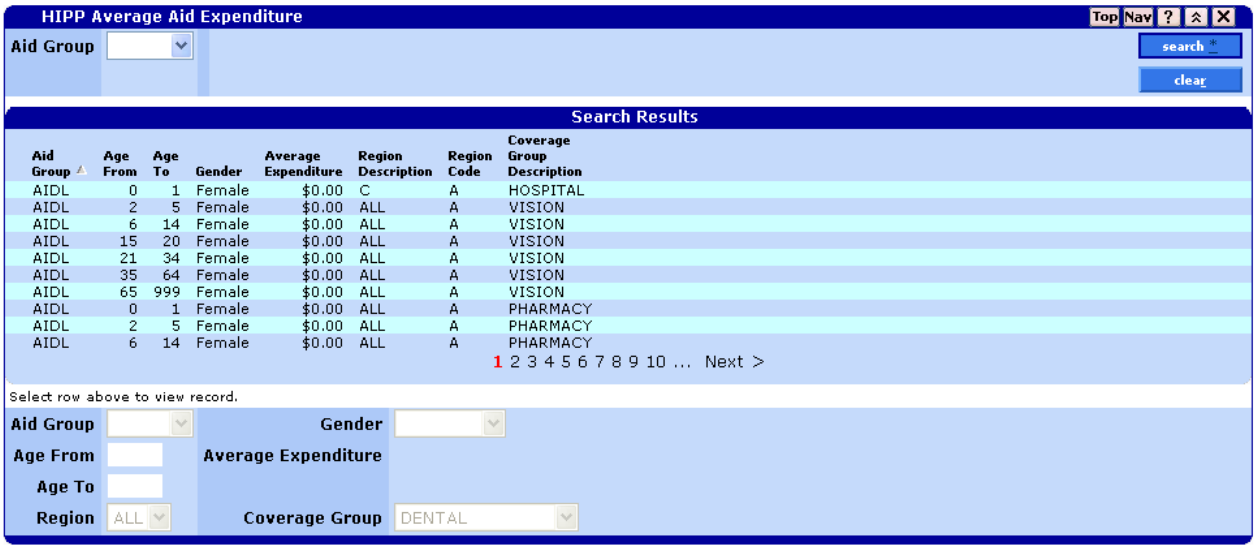
6.88 Codes - HIPP Average Aid Expenditure Panel Overview

6.88.1 Codes - HIPP Average Aid Expenditure Panel Narrative

The HIPP Average Aid Expenditure panel is used to display a list of the current HIPP average expenditure code tables, grouped by population code. It is used in the HIPP cost effectiveness calculation. This panel is display only.

Navigation Path: [TPL] - [Related Data] - [Codes] - [HIPP Average Aid Expenditure]

6.88.2 Codes - HIPP Average Aid Expenditure Panel Layout



6.88.3 Codes - HIPP Average Aid Expenditure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Age From	The starting age for the grouping.	Field	Number (Integer)	4
Age To	The ending age for the grouping.	Field	Number (Integer)	4
Aid Group	This groups aid categories into specific groups with similar characteristics.	Combo Box	Drop Down List Box	0
Average Expenditure	The dollar amount of the expenditure.	Field	Number (Decimal)	9
Clear	Clears fields of data.	Button	N/A	0
Coverage Group	This group identifies the type of coverage that a TPL policy provides.	Combo Box	Drop Down List Box	0
Coverage Group Description	Description of the coverage group.	Label	N/A	0
Gender	Identifies the sex of a person.	Combo Box	Drop Down list Box	0

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Field	Description	Field Type	Data Type	Length
Region	Geographical code for the expenditure.	Field	Alphanumeric	4
Region Description	Description of the geographical location.	Field	Alphanumeric	25
Search	Invokes search on Aid Group.	Button	N/A	0

6.88.4 Codes - HIPP Average Aid Expenditure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Age From	Field	1	Enter a valid value.	Enter a value between 0 and 9999.
	Field	2	Age From must be less than or equal to 9999.	Enter a value less than or equal to 9999.
Age To	Field	1	Enter a valid value.	Enter a value between 0 and 9999.
Aid Group	Field	1	Aid Group ID is required.	Enter a valid Aid Group ID.
Average Expenditure	Field	1	Enter a valid value.	Enter a value between $0.00 and $999,999,999.99.
Coverage Code	Field	1	A valid Coverage Code is required.	Enter a valid Coverage Code.
Gender	Field	1	Gender is required.	Enter the Gender of the person.

6.88.5 Codes - HIPP Average Aid Expenditure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.88.6 Codes - HIPP-Average Aid Expenditure Panel Accessibility

6.88.6.1 To Access the Codes - HIPP Average Aid Expenditure Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select HIPP Average Aid Expenditures.	HIPP Average Aid Expenditure panel displays.

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6.89 Codes - HIPP Average Diag Expenditure Panel Overview

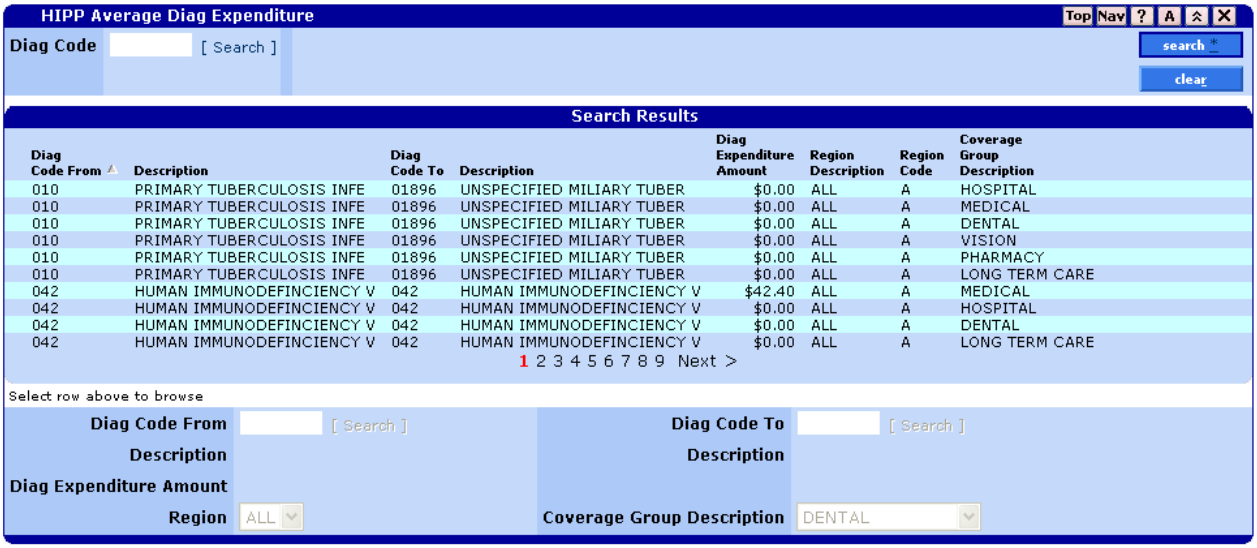
6.89.1 Codes - HIPP Average Diag Expenditure Panel Narrative

The HIPP Average Diag Expenditure panel is used to display a list of the current HIPP average diagnosis code table, grouped by diagnosis code. It is used in the HIPP cost effectiveness calculation.

This panel is display only.

Navigation Path: [TPL] - [Related Data] - [Codes] - [HIPPA Average Diag Expenditure]

6.89.2 Codes - HIPP Average Diag Expenditure Panel Layout



6.89.3 Codes - HIPP Average Diag Expenditure Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Clear	Clears fields of data.	Button	N/A	0
Coverage Group Description	Description of the coverage code. Automatically prefills based on the coverage code selected.	Field	Alphanumeric	25
Description	The short nomenclature for a medical condition.	Field	Character	25
Diag Code	A code for the condition requiring medical attention.	Combo Box	Drop Down List Box	0
Diag Code From	A code for the condition requiring medical attention.	Field	Character	7

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Field	Description	Field Type	Data Type	Length
Diag Code To	A code for the condition requiring medical attention.	Field	Character	7
Diag Expenditure Amount	The dollar amount of the expenditure.	Field	Number (Decimal)	9
Region Code	The geographical location	Combo Box	Drop Down List Box	0
Region Description	Description of the geographical location.	Field	Alphanumeric	25
Search	Invokes search on Diagnosis Code.	Button	N/A	0

6.89.4 Codes - HIPP Average Diag Expenditure Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Diag Code From	Field	1	A valid Diagnosis Code is required.	Select a valid Diagnosis Code from the list.
Diag Expenditure Amount	Field	1	Enter a valid value.	Diagnosis Expenditure Amount is numeric only.
Region	Field	1	A valid Region is required.	Enter a valid Region code.

6.89.5 Codes - HIPP Average Diag Expenditure Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.89.6 Codes - HIPP Average Diag Expenditure Panel Accessibility

6.89.6.1 To Access the Codes - HIPP Average Diag Expenditure Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select HIPP Average Diag Expenditures.	HIPP Average Diag Expenditure panel displays.

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6.90 Codes-HIPP Reason Panel Overview

6.90.1 Codes - HIPP Reason Panel Narrative

The HIPP Reason panel identifies the decision to purchase a policy or not based on the HIPP calculation.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Codes] - [HIPP Reason]

6.90.2 Codes - HIPP Reason Panel Layout

6.90.3 Codes - HIPP Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes - HIPP Reason panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Description of the code that identifies why a policy was or was not purchased.	Field	Character	40
HIPP Reason	Code that identifies why a policy was or was not purchased.	Field	Character	2
Policy Purchased	Identifies whether the policy will be purchased.	Combo Box	Drop Down List Box	0

6.90.4 Codes - HIPP Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	Enter a Description.
HIPP Reason	Field	1	HIPP Reason is required.	Enter a HIPP Reason code.

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Field	Field Type	Error Code	Error Message	To Correct
Policy Purchased	Listview	1	Policy Purchased is required.	Select a Policy Purchased value.

6.90.5 Codes - HIPP Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.90.6 Codes - HIPP Reason Panel Accessibility

6.90.6.1 To Access the Codes - HIPP Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select HIPP Reason.	HIPP Reason panel displays.

6.90.6.2 To Add on the Codes - HIPP Reason Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter HIPP Reason.	
3	Enter Description.	
4	Select **Policy Purchased** from drop down list.	
5	Click **Save**.	HIPP Reason information is saved.

6.90.6.3 To Update on the Codes - HIPP Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPP Reason information is saved.

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6.90.6.4 To Delete on the Codes - HIPP Reason Panel

Stp	Actione	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.91 Codes-HMO/PPO Panel Overview

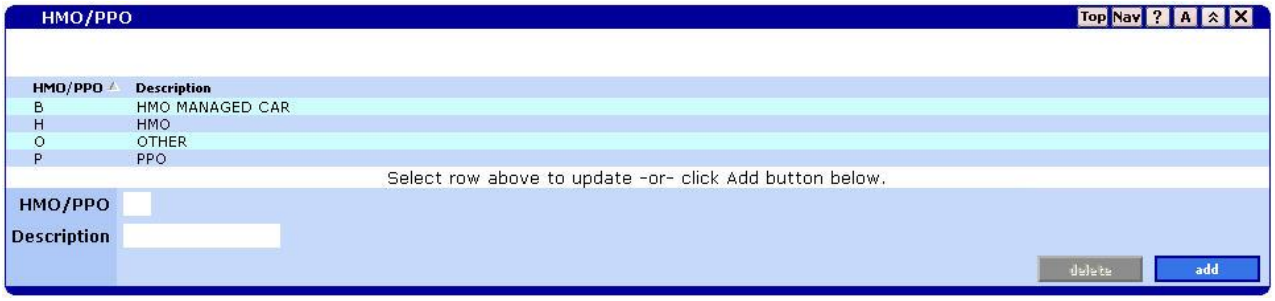
6.91.1 Codes-HMO/PPO Panel Narrative

HMO/PPO panel contains the possible values for the TPL carrier HMO indicator code. The values are used by the carrier panels to indicate additional information about a carrier.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Codes] - [HMO/PPO]

6.91.2 Codes-HMO/PPO Panel Layout



6.91.3 Codes-HMO/PPO Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – HMO/PPO panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Contains the description associated with a specific HMO indicator code.	Field	Character	15
HMO/PPO	Identifies whether a TPL carrier is an HMO or PPO.	Field	Character	1

6.91.4 Codes-HMO/PPO Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Add	Button	1	A duplicate record cannot be saved.	Enter a new different value.
Description	Field	1	Description is required.	Enter a Description.
HMO/PPO	Field	1	HMO/PPO is required.	Enter a HMO/PPO code.

6.91.5 Codes-HMO/PPO Panel Extra Features

This panel utilizes referential integrity on deletes.

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6.91.6 Codes-HMO/PPO Panel Accessibility

6.91.6.1 To Access the Codes- HMO/PPO Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select **HMO/PPO**.	HMO/PPO panel displays.

6.91.6.2 To Add on the Codes- HMO/PPO Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **HMO/PPO**.	
3	Enter Description.	
4	Click **Save**.	HMO/PPO information is saved.

6.91.6.3 To Update on the Codes - HMO/PPO Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HMO/PPO information is saved.

6.91.6.4 To Delete on the Codes - HMO/PPO Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.92 Codes - Origin Panel Overview

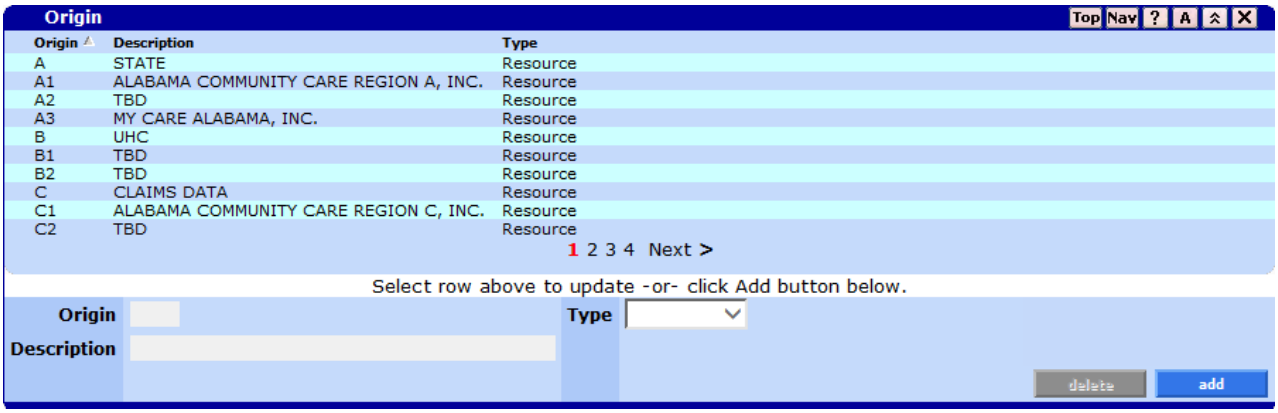
6.92.1 Codes - Origin Panel Narrative

The Origin panel identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Codes] - [Origin]

6.92.2 Codes - Origin Panel Layout



6.92.3 Codes - Origin Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Origin panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Contains the description associated with a specific TPL origin code.	Field	Character	40
Origin	Identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.	Field	Character	2
Type	Unique identifier for the resource casualty associated with the origin of this TPL.	Combo Box	Drop Down List Box	0

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6.92.4 Codes - Origin Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot delete Origin code for both types. In use by a TPL Resource and a Casualty Case.	Verify information and try again.
	Button	2	Cannot delete Origin code for the TPL Resource type. In use by a TPL resource.	Verify Information and try again.
	Button	3	Cannot delete Origin code for the Casualty Case type. In use by a Casualty Case.	Verify Information and try again.
Description	Field	1	Description is required.	Enter a Description.
Origin	Field	1	Origin is required.	Enter an Origin code.
Type	Listview	1	Type is required.	Select a Type value.

6.92.5 Codes - Origin Panel Extra Features

This panel has referential integrity checks on deletions.

6.92.6 Codes - Origin Panel Accessibility

6.92.6.1 To Access the Codes - Origin Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select **Origin**.	Origin panel displays.

6.92.6.2 To Add on the Codes - Origin Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Origin**.	
3	Enter Description.	
4	Select **Type** from the drop down list.	
5	Click **Save**.	Origin information is saved.

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6.92.6.3 To Update on the Codes - Origin Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Origin information is saved.

6.92.6.4 To Delete on the Codes - Origin Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.93 Codes - Policy Type Panel Overview

6.93.1 Codes - Policy Type Panel Narrative

The Policy Type panel identifies the type of insurance policy the recipient is covered under.

Primarily, there are three types of insurance: HMO, PPO and Other. If a policy type is HMO, then the Disenroll Managed Care indicator should typically be 'Y'. This indicator triggers the Managed Care system to automatically disenroll recipients from Managed Care.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Policy Type]

6.93.2 Codes - Policy Type Panel Layout

6.93.3 Codes - Policy Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Policy Type panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Identifies the descriptive name for a TPL policy type.	Field	Character	30
Disenroll Managed Care	Yes/No option which indicates whether the policy type should trigger disenrollment from Managed Care.	Combo Box	Drop Down List Box	0
Policy Type	Identifies the type of insurance policy that the recipient is covered under.	Field	Character	1

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6.93.4 Codes - Policy Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot delete Policy Type record. In use by a TPL Resource.	This policy type can not be deleted since it is attached to a TPL Resource.
Description	Field	1	Description is required.	Description is a required field. Enter a Description for this policy type.
Policy Type	Field	1	Policy Type is required.	Policy Type is a required field code. Enter a Policy Type for this entry.
	Field	3	A duplicate record cannot be saved.	Add a Policy Type that does not exist already.

6.93.5 Codes - Policy Type Panel Extra Features

This panel has referential integrity checks on deletes.

6.93.6 Codes - Policy Type Panel Accessibility

6.93.6.1 To Access the Codes - Policy Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Policy Type.	Policy Type panel displays.

6.93.6.2 To Add on the Codes - Policy Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Policy Type.	
3	Enter Description.	
4	Select **Disenroll Managed Care** from the drop down list.	
5	Click **Save**.	Policy Type information is saved.

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6.93.6.3 To Update on the Codes - Policy Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Policy Type information is saved.

6.93.6.4 To Delete on the Codes - Policy Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.94 Codes - Relationship Panel Overview

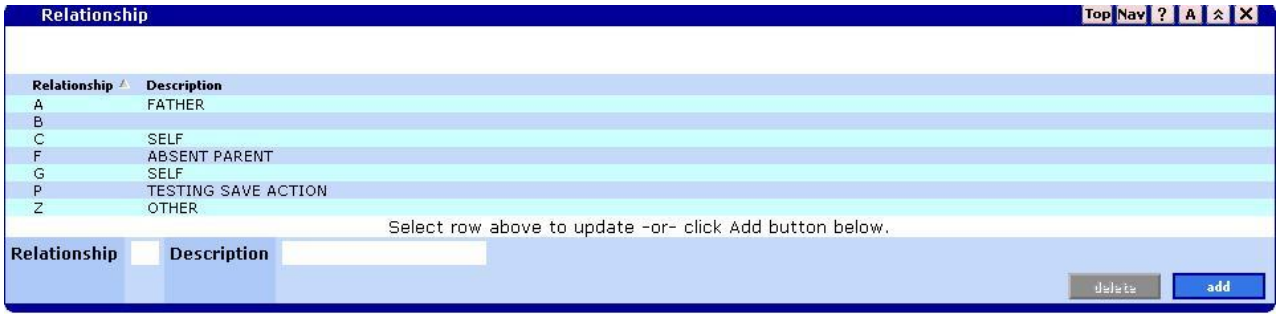
6.94.1 Codes - Relationship Panel Narrative

The Codes-Relationship panel contains the possible values for the local relationship codes and their descriptions.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Codes] - [Relationship]

6.94.2 Codes - Relationship Panel Layout



6.94.3 Codes - Relationship Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes – Relationship panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	This field contains the description associated with a specific relationship code.	Field	Alphanumeric	20
Relationship	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	Field	Alphanumeric	1

6.94.4 Codes - Relationship Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Description	Field	1	Description is required.	To enter a new record, Description for the relationship code is required.
Relationship	Field	1	A duplicate record cannot be saved.	Enter a valid Relationship code that is not already existing.
	Field	2	Delete was Unsuccessful. Cannot delete Relationship Codes with TPL Resource.	Relationship codes that are in t_tpl_resource cannot be deleted.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	3	Relationship is required.	Relationship code is required for a new record. Enter relationship code.

6.94.5 Codes - Relationship Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.94.6 Codes - Relationship Panel Accessibility

6.94.6.1 To Access the Codes - Relationship Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data.**	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select Relationship.	Relationship panel displays.

6.94.6.2 To Add on the Codes - Relationship Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Relationship.	
3	Enter Description.	
4	Click **Save**.	Relationship information is saved.

6.94.6.3 To Update on the Codes - Relationship Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Relationship information is saved.

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6.94.6.4 To Delete on the Codes - Relationship Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.95 Codes - Suspect Panel Overview

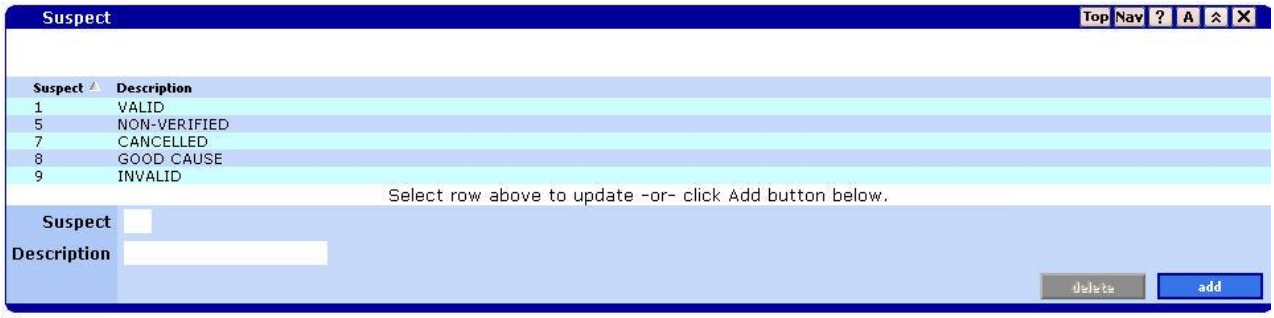
6.95.1 Codes - Suspect Panel Narrative

The Suspect panel identifies the possible values for the TPL suspect code. The suspect code is used on TPL Policies to indicate if cost avoidance should occur.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Codes] - [Suspect]

6.95.2 Codes - Suspect Panel Layout



6.95.3 Codes - Suspect Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Codes - Suspect panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Description	Contains the description associated with a specific TPL suspect code.	Field	Character	20
Suspect	Identifies the TPL suspect code which identifies whether a TPL resource is suspect and, if so, how it was determined to be suspect.	Field	Character	1

6.95.4 Codes - Suspect Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Delete	Button	1	Cannot Delete Suspect Code record. In use by TPL Resource.	Mush change the Suspect Code on all resource records before deleting.
Description	Field	1	Description is required.	Enter a Description.
Suspect	Field	1	Suspect is required.	Enter a Suspect code.

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6.95.5 Codes - Suspect Panel Extra Features

Referential integrity checks occur when deletions are attempted.

6.95.6 Codes - Suspect Panel Accessibility

6.95.6.1 To Access the Codes - Suspect Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Codes** hyperlink located on the Related Data panel.	Related Data-Codes panel displays.
4	Select **Suspect**.	Suspect panel displays.

6.95.6.2 To Add on the Codes - Suspect Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Suspect**.	
3	Enter Description.	
4	Click **Save**.	Suspect information is saved.

6.95.6.3 To Update on the Codes - Suspect Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Suspect information is saved.

6.95.6.4 To Delete on the Codes - Suspect Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.96 Related Data - Other Panel Overview

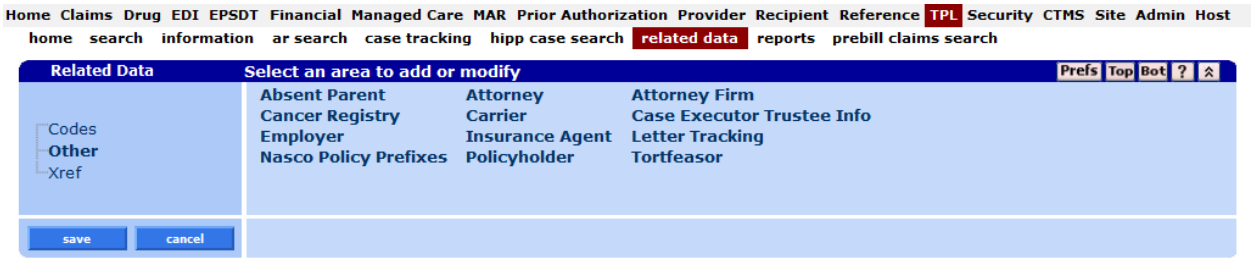
6.96.1 Related Data - Other Panel Narrative

The point of access for the TPL Related Data Other panels.

This panel is inquiry only.

Navigation Path: [TPL] – [Related Data] - [Other]

6.96.2 Related Data - Other Panel Layout



6.96.3 Related Data - Other Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Absent Parent	Link to Absent Parent panel.	Hyperlink	N/A	0
Attorney	Link to Attorney panel.	Hyperlink	N/A	0
Attorney Firm	Link to Attorney Firm panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes.	Button	N/A	0
Cancer Registry	Link to Cancer Registry panel.	Hyperlink	N/A	0
Carrier	Link to Carrier panel.	Hyperlink	N/A	0
Case Executor Trustee Info	Link to Case Trustee Info panel.	Hyperlink	N/A	0
Employer	Link to Employer panel.	Hyperlink	N/A	0
Insurance Agent	Link to Insurance Agent panel.	Hyperlink	N/A	0
Letter Tracking	Link to Letter Tracking panel.	Hyperlink	N/A	0
Nasco Policy Prefixes	Link to Nasco Policy Prefixes panel.	Hyperlink	N/A	0
Policyholder	Link to Policyholder panel.	Hyperlink	N/A	0
Save	Allows the user to save a record.	Button	N/A	0
Tortfeasor	Link to Tortfeasor panel.	Hyperlink	N/A	0

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6.96.4 Related Data - Other Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.96.5 Related Data - Other Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.96.6 Related Data - Other Panel Accessibility

6.96.6.1 To Access the Related Data – Other Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.

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6.97 Other - Absent Parent Panel Overview

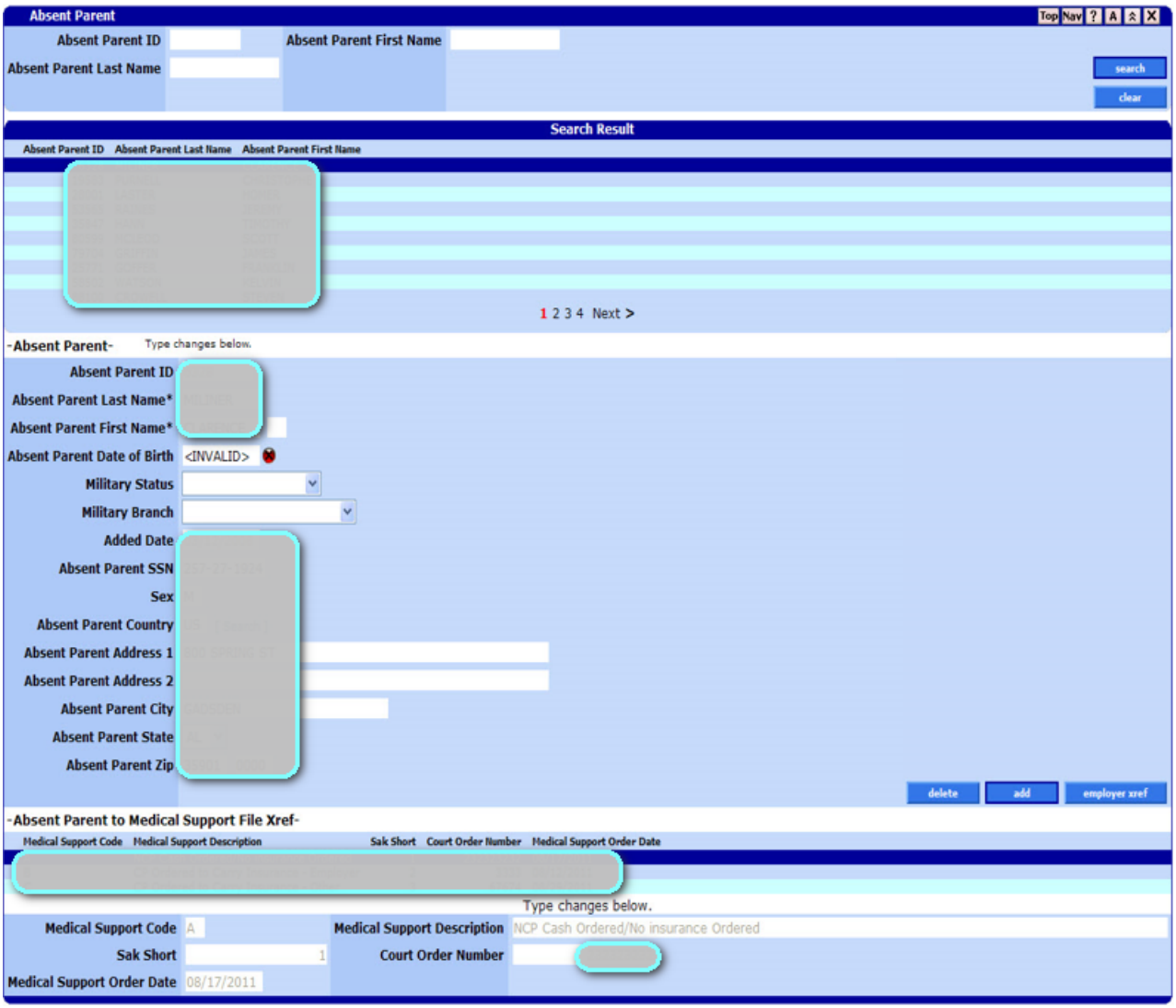
6.97.1 Other - Absent Parent Panel Narrative

The TPL Absent Parent panel allow for the creation and maintenance of Absent Parents.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Other] - [Absent Parent]

6.97.2 Other - Absent Parent Panel Layout



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6.97.3 Other - Absent Parent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Absent Parent Address 1	The first address line of the absent parent used for correspondence. Could be an international address if country code is not US.	Field	Character	55
Absent Parent Address 2	The second address line of the absent parent used for correspondence. Could be an international address if country code is not US.	Field	Character	55
Absent Parent City	The absent parent's city where the correspondence is sent.	Field	Character	30
Absent Parent Country	Two character country abbreviation.	Field	Character	2
Absent Parent Date of Birth	Absent parents date of birth.	Field	Date (MM/DD/CCYY)	10
Absent Parent First Name	The first name of the recipient's absent or custodial parent.	Field	Character	13
Absent Parent ID	The unique identifier for the recipient’s absent parent.	Field	Number (Integer)	9
Absent Parent Last Name	The last name of the recipient's absent or custodial parent.	Field	Character	15
Absent Parent Middle Initial	The middle name of the recipient's absent or custodial parent.	Field	Character	1
Absent Parent SSN	The absent parent's Social Security Number.	Field	Number (Integer)	9
Absent Parent State	The state abbreviation for the state in which the absent parent resides.	Combo Box	Drop Down List Box	0
Absent Parent Zip	The first five digits of the absent parent's zip code used for correspondence.	Field	Number (Integer)	15
Absent Parent Zip + 4	The last four digits of the zip code for correspondence of an absent parent if within the United States.	Field	Number (Integer)	4
Add	Allows a user to add a new record on the Other – Absent Parent panel.	Button	N/A	0
Added Date	The date the absent parent data was added to the table.	Field	Date (MM/DD/CCYY)	10
Court Order Number	Court Order Number.	Field	Character	16

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Field	Description	Field Type	Data Type	Length
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Employer Xref	Link to the Absent Parent to Employer Xref panel.	Button	N/A	0
Medical Support Code	Medical Support Code.	Field	Character	1
Medical Support Description	Medical Support Code Description.	Field	Character	100

6.97.4 Other - Absent Parent Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Absent Parent First Name	Field	1001	First Name is required.	Enter an Absent Parent First Name.
Absent Parent Last Name	Field	1002	Last Name is required.	Enter an Absent Parent Last Name.
Absent Parent SSN	Field	1001	Enter a Valid Value.	Social Security Number must be only numeric values. Social Security Number must be 9 numeric digits.
Absent Parent State	Field	1001	Please enter a valid state.	Please enter a valid state.
Absent Parent Zip	Field	1001	Zip Code must be only numeric values.	Enter valid ZIP code.
	Field	1002	Zip Code must be 5 numeric digits.	Enter valid ZIP Code.
Absent Parent Zip + 4	Field	1001	Cannot have Zip Plus 4 without Zip Code.	Cannot have Zip Plus 4 without Zip Code.
	Field	1002	Enter a Valid Value.	Zip Plus 4 must be only numeric values.
Employer Number	Field	1001	A valid Employer is required.	Enter or search for a valid employer.
Sex	Field	1001	Valid sex codes are be \"M\" - Male or \"F\" - Female.	Enter only valid sex codes.

6.97.5 Other - Absent Parent Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.97.6 Other - Absent Parent Panel Accessibility

6.97.6.1 To Access the Other - Absent Parent Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select Absent Parent.	Absent Parent panel displays.

6.97.6.2 To Add on the Other - Absent Parent Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Absent Parent Last Name.	
3	Enter Absent Parent First Name and Middle Initial.	
4	Enter **Date of Birth** in MM/DD/CCYY format.	
5	Select **Military Status** from drop down list.	
6	Select **Military Branch** from drop down list.	
7	Enter Absent Parent SSN.	
8	Enter **Sex**.	
9	Enter **Absent Parent Country**. Note: Search field is available if Country code is unknown.	
10	Enter Absent Parent Address 1.	
11	Enter Absent Parent Address 2.	
12	Enter Absent Parent City.	
13	Select **Absent Parent State** from drop down list.	
14	Enter Absent Parent Zip Code + 4.	
15	Click **Save**.	Absent Parent information is saved.

6.97.6.3 To Update on the Other - Absent Parent Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	

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3	Click **Save**.	Absent Parent information is saved.

6.97.6.4 To Delete on the Other - Absent Parent Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.98 Other - Absent Parent to Employer Xref Panel Overview

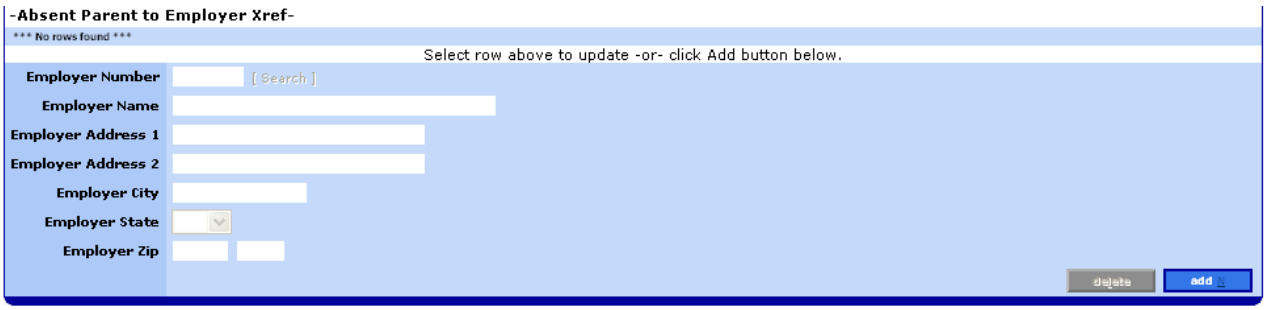
6.98.1 Other - Absent Parent to Employer Xref Panel Narrative

The Absent Parent to Employer Xref panel displays the absent parent and related employer data.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Other] - [Absent Parent] - [Employer Xref]

6.98.2 Other - Absent Parent to Employer Xref Panel Layout



6.98.3 Other - Absent Parent to Employer Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Absent Parent to Employer Xref panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Employer Address 1	This is the street address of an employer.	Field	Character	55
Employer Address 2	This is the second street address of an employer.	Field	Character	55
Employer City	This is the city of an employer.	Field	Character	30
Employer Name	This is the business name of an employer.	Field	Character	39
Employer Number	This field is the unique, user-defined employer identification number used on all screens and reports to identify the employer.	Field	Character	7
Employer State	This is the state of an employer.	Field	Character	2
Employer Zip	This is the first 5 digits of the zip code of an employer.	Field	Number (Integer)	15
Employer Zip + 4	This is the last 4 digits of the zip code of an employer.	Field	Number (Integer)	4

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6.98.4 Other - Absent Parent to Employer Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Employer Number	Field	1001	A valid Employer is required.	Enter or search for a valid employer.

6.98.5 Other - Absent Parent to Employer Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.98.6 Other - Absent Parent to Employer Xref Panel Accessibility

6.98.6.1 To Access the Other - Absent Parent to Employer Xref Panel

Step	Action	Response
1	Enter **User Name** and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select Absent Parent.	Absent Parent panel displays.
5	Click Employer Xref.	Absent Parent to Employer Xref panel displays.

6.98.6.2 To Add on the Other - Absent Parent to Employer Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Employer Number.	
3	Enter Employer Name.	
4	Enter Employer Address 1.	
5	Enter Employer Address 2.	
6	Enter Employer City.	
7	Select **Employer State** from drop down list.	
8	Enter Employer Zip Code + 4.	
9	Click **Save**.	Absent Parent to Employer Xref panel information is saved.

6.98.6.3 To Update on the Other - Absent Parent to Employer Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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2	Click in desired field to update and perform update.	
3	Click **Save**.	Absent Parent to Employer Xref panel displays.

6.98.6.4 To Delete on the Other - Absent Parent to Employer Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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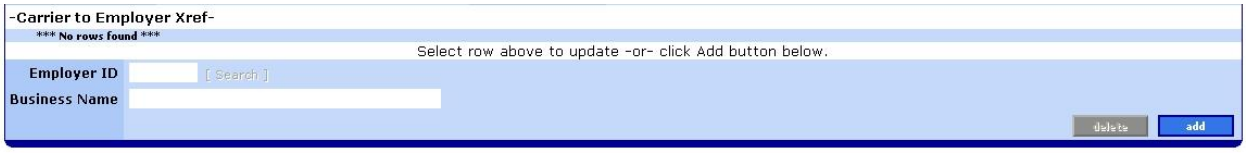
6.99 Other - Carrier to Employer Xref Panel Overview

6.99.1 Other - Carrier to Employer Xref Panel Narrative

The Carrier to Employer Xref panel is used to establish a relationship between an Employer and a Carrier. This relationship is used to support documenting Employer sponsored health coverage.

Navigation Path: [TPL] – [Related Data] - [Other] - [Carrier] - [Employer Xref]

6.99.2 Other - Carrier to Employer Xref Panel Layout



6.99.3 Other - Carrier to Employer Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Carrier to Employer Xref panel.	Button	N/A	0
Business Name	The business name of an employer.	Field	Character	39
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Employer ID	Unique, user-defined employer identification number which is used on all screens and reports to identify the employer.	Field	Character	7

6.99.4 Other - Carrier to Employer Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.99.5 Other - Carrier to Employer Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.99.6 Other - Carrier to Employer Xref Panel Accessibility

6.99.6.1 To Access the Other - Carrier to Employer Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Select **Carrier**.	Carrier panel displays.
5	Click Employer Xref.	Carrier to Employer Xref panel displays.

6.99.6.2 To Add on the Other - Carrier to Employer Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Employer ID. If unknown, click on [Search] button to locate by selecting from a list of results.	Business Name automatically prefills when Employer ID is entered.
3	Click **Save**.	Carrier to Employer Xref panel information is saved.

6.99.6.3 To Update on the Other - Carrier to Employer Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier to Employer Xref panel information is updated.

6.99.6.4 To Delete on the Other - Carrier to Employer Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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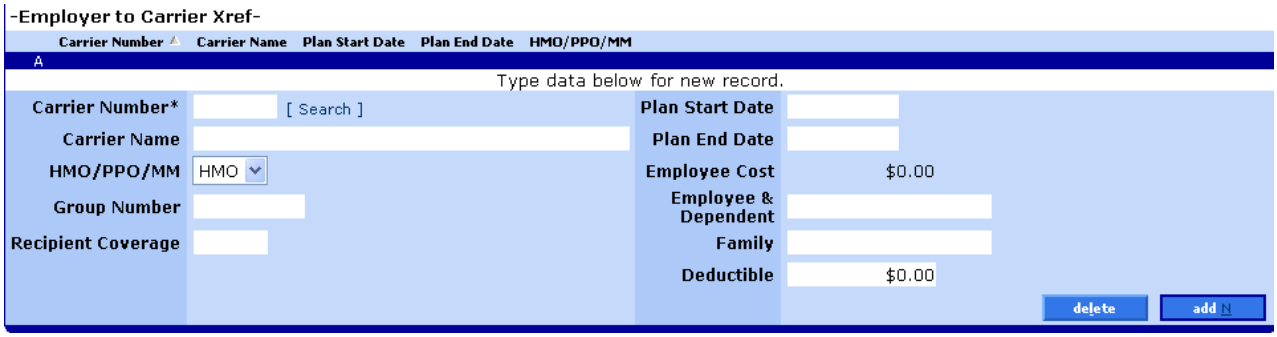
6.100 Other - Employer to Carrier Xref Panel Overview

6.100.1 Other - Employer to Carrier Xref Panel Narrative

The Employer to Carrier Xref panel is used to establish a relationship between an Employer and a Carrier. This relationship is used to support documenting Employer sponsored health coverage.

Navigation Path: [TPL] – [Related Data] - [Other] - [Employer] - [Carrier Xref]

6.100.2 Other - Employer to Carrier Xref Panel Layout



6.100.3 Other - Employer to Carrier Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Employer to Carrier Xref panel.	Button	N/A	0
Carrier Name	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	Field	Character	45
Carrier Number	The system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier identification number used on all screens and reports.	Field	Character	7
Deductible	The employee's deductible with the employer sponsored health plan with the carrier.	Field	Number (Decimal)	9
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Employee & Dependent	The employee's cost for employee and dependent for the employer sponsored health plan with the carrier.	Field	Number (Decimal)	9
Employee Cost	The employee's cost for the employer sponsored health plan with the carrier.	Field	Number (Decimal)	9

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Field	Description	Field Type	Data Type	Length
Family	The employee's cost for family for the employer sponsored health plan with the carrier.	Field	Number (Decimal)	9
Group Number	The group number of the employer sponsored health plan with the carrier.	Field	Character	30
HMO/PPO/MM	This code identifies whether a TPL carrier is an HMO or PPO.	Field	Drop Down List Box	0
Plan End Date	Date the employer sponsored plan with the carrier ends.	Field	Date (MM/DD/CCYY)	10
Plan Start Date	Date the employer sponsored plan with the carrier starts.	Field	Date (MM/DD/CCYY)	10
Recipient Coverage	The coverage level codes. Valid values include: I = Individual E = Employee Only F = Employee + Family C = Employee + Children (default) S = Employee + Spouse O = Other 1= Employee + 1	Field	Drop Down List Box	0

6.100.4 Other - Employer to Carrier Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.100.5 Other - Employer to Carrier Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.100.6 Other - Employer to Carrier Xref Panel Accessibility

6.100.6.1 To Access the Other - Employer to Carrier Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.

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Step	Action	Response
4	Select **Employer**.	Employer panel displays.
5	Click Carrier Xref.	Employer to Carrier Xref panel displays.

6.100.6.2 To Add on the Other - Employer to Carrier Xref Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Carrier Number.	
3	Enter Carrier Name.	
4	Select **HMO/PPO/MM** from drop down list.	
5	Enter Group Number.	
6	Enter Recipient Coverage.	
7	Enter **Plan Start Date** in MM/DD/CCYY format.	
8	Enter **Plan End Date** in MM/DD/CCYY format.	
9	Enter Employee & Dependent.	
10	Enter **Family**.	
11	Enter Deductible.	
12	Click **Save**.	Employer to Carrier Xref panel information is saved.

6.100.6.3 To Update on the Other - Employer to Carrier Xref Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Employer to Carrier Xref panel information is updated.

6.100.6.4 To Delete on the Other - Employer to Carrier Xref Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.101 Other - Attorney Panel Overview

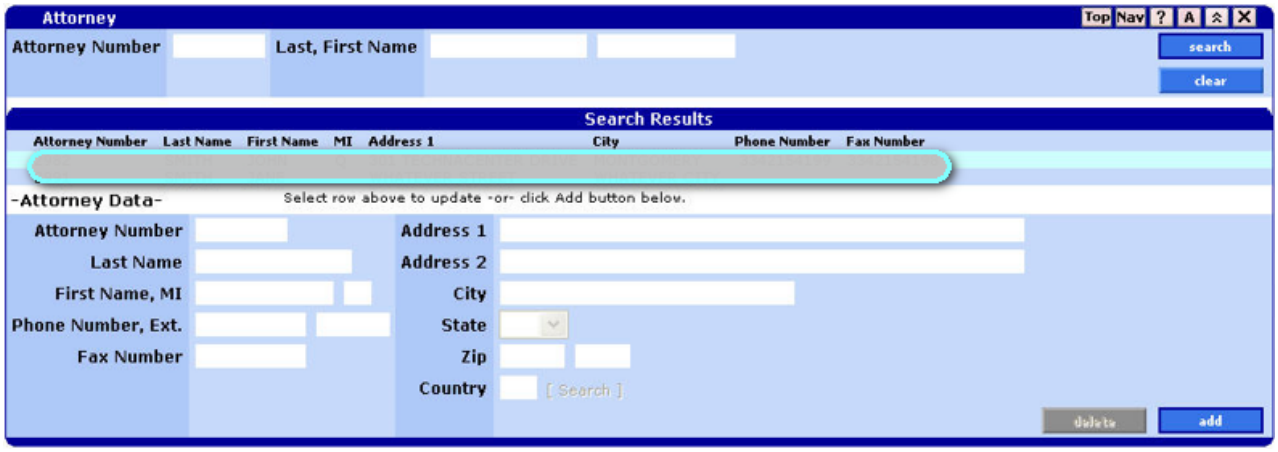
6.101.1 Other - Attorney Panel Narrative

The Attorney panel is used to search, display and update attorney information. The user has the ability to enter the attorney number, attorney name or a combination of the two fields to view the attorneys on the database.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Attorney]

6.101.2 Other - Attorney Panel Layout



6.101.3 Other - Attorney Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Attorney panel.	Button	N/A	0
Address 1	This is the first line of the street address for the attorney.	Field	Character	55
Address 2	This is the second line of the street address for the attorney.	Field	Character	55
Attorney Number	This is a unique identifier assigned to each attorney.	Field	Character	8
City	The city where the attorney resides.	Field	Character	30
Clear	Clear current search criteria.	Button	N/A	0
Countr	The country where the attorney resides.	Field	Character	2
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Fax Number	This is the United States or international fax number for the attorney.	Field	Number (Integer)	10
First Name, MI	This is the first name and middle initial of the attorney.	Field	Character	14
Last Name	The last name of the attorney.	Field	Character	15
Phone Number, Ext.	This is the US or international phone number plus the phone extension of the attorney.	Field	Number (Integer)	16
Search	Search for a record in the datalist.	Button	N/A	0
State	This is the state code where attorney resides.	Combo Box	Drop Down List Box	0
Zip	This is the first 5 digits and the last 4 digits of the zip code for the attorney if within the US. Zip can also be an international zip code.	Field	Number (Integer)	9

6.101.4 Other - Attorney Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	Enter Address 1.
City	Field	0	City is Required.	Enter a City.
Country	Field	1	Country is required.	Select a valid country value.
Fax Number	Field	1	Enter a valid value.	Enter a valid fax number.
	Field	2	Fax Number must be 10 numeric values.	If country is US, fax number must be 10 numeric values.
Last, First Name, MI	Field	0	Last Name is required.	Enter last name.
	Field	1	First Name is required.	Enter first name.
Phone Number	Field	1	Enter a valid value.	Enter a valid phone number.
	Field	2	Phone Number must be 10 numeric values.	If country is US, phone number must be 10 numeric values.
State	Field	1	A valid State is required.	Select value for state.
Zip	Field	1	Zip is required.	Enter a zip code.
	Field	2	Enter a valid value.	Enter a zip code.
	Field	3	Zip code must be 5 numeric values.	If country is US, zip code must be 5 numeric values.

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6.101.5 Other - Attorney Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.101.6 Other - Attorney Panel Accessibility

6.101.6.1 To Access the Other - Attorney Panel

Step	Action	Response
1	Enter **User Name** and Password; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
5	Click Attorney.	Attorney panel displays.

6.101.6.2 To Add on the Other - Attorney Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Attorney Number.	
3	Enter Last Name.	
4	Enter First Name, MI.	
5	Enter Phone Number, Ext.	
6	Enter Fax Number.	
7	Enter Address 1.	
8	Enter Address 2.	
9	Enter **City**.	
10	Select **State** from drop down list.	
11	Enter Zip Code +4.	
12	Enter **Country**. Note: Use Search button if country code is unknown.	
13	Click **Save**.	Attorney panel information is saved.

6.101.6.3 To Update on the Other - Attorney Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.

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Step	Action	Response
2	Click in desired field to update and perform update.	
3	Click **Save**.	Attorney panel information is updated.

6.101.6.4 To Delete on the Other - Attorney Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.102 Other - Attorney Firm Panel Overview

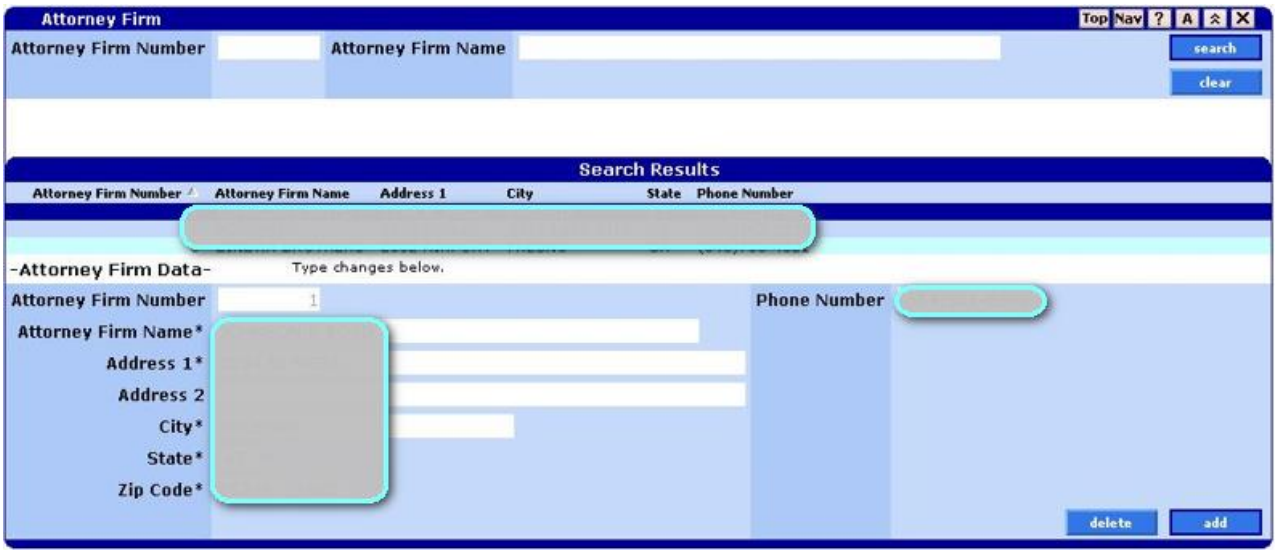
6.102.1 Other - Attorney Firm Panel Narrative

The Attorney Firm panel is used to add, update or delete an Attorney Firm Name.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Attorney Firm]

6.102.2 Other - Attorney Firm Panel Layout



6.102.3 Other - Attorney Firm Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Attorney Firm panel.	Button	N/A	0
Address 1	The first address line of the attorney firm.	Field	Character	30
Address 2	The second address line of the attorney firm.	Field	Character	30
Attorney Firm Name	The name of the attorney firm.	Field	Character	35
Attorney Firm Number	The firm number of the attorney firm.	Field	Number (Integer)	9
City	The city in which the attorney firm is located.	Field	Character	15
Clear	Clears the current search criteria.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Phone Number	The phone number of the attorney firm.	Field	Number (Integer)	13
Search	Searches datalist for attorney firm name and number.	Button	N/A	0
State	The state in which the attorney firm is located.	Combo Box	Drop Down List Box	0
Zip Code	The zip and the zip +4 of the attorney firm.	Field	Number (Integer)	9

6.102.4 Other - Attorney Firm Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1000	Address 1 is required.	Enter an address.
Attorney Firm Name	Field	1000	Attorney Firm name is required.	Enter an Attorney Firm Name.
City	Field	1000	City is required.	Enter a valid City.
State	Field	1000	A valid State is required.	Select a value for State.
Zip Code	Field	1000	Zip is required.	Enter a Zip.
	Field	1001	Enter a valid value.	Zip code is numeric only.

6.102.5 Other - Attorney Firm Panel Extra Features

The Attorney Firm panel allows the deletion of records after a referential check is performed to ensure the record is not being utilized.

6.102.6 Other - Attorney Firm Panel Accessibility

6.102.6.1 To Access the Other - Attorney Firm Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Attorney Firm.	Attorney Firm panel displays.

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6.102.6.2 To Add on the Other - Attorney Firm Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Attorney Number.	
3	Enter Last Name.	
4	Enter First Name, MI.	
5	Enter Phone Number, Ext.	
6	Enter Fax Number.	
7	Enter Address 1.	
8	Enter Address 2.	
9	Enter **City**.	
10	Select **State** from drop down list.	
11	Enter Zip Code +4.	
12	Enter **Country**. Note: Use Search button if country code is unknown.	
13	Click **Save**.	Attorney Firm panel information is saved.

6.102.6.3 To Update on the Other - Attorney Firm Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Attorney Firm panel information is updated.

6.102.6.4 To Delete on the Other - Attorney Firm Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.103 Other - Carrier Panel Overview

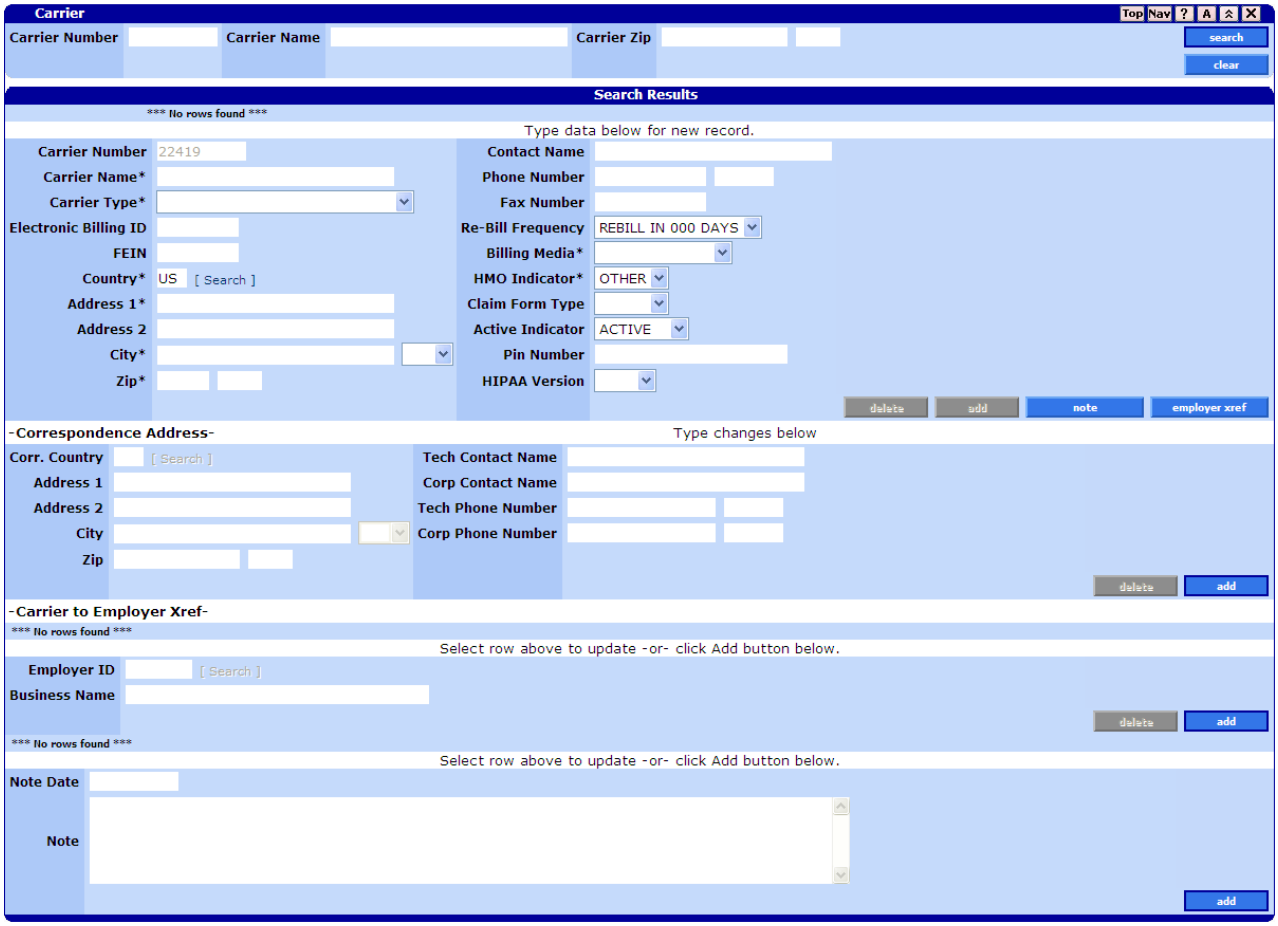
6.103.1 Other - Carrier Panel Narrative

The Carrier panel contains information about other insurance companies that may have issued policies which cover Medicaid recipients. In addition, correspondence address data, notes, and a cross-reference between the carrier and employer can also be maintained on this panel. The claim submission address is used for all claim facsimile billings. A separate correspondence address (if different than the claim submission address) is maintained within a separate section on this panel. The correspondence address is used for all non-facsimile correspondence but is not used by financial. The contact name is used to address all questions concerning the policy and carrier.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Carrier]

6.103.2 Other - Carrier Panel Layout



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6.103.3 Other - Carrier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Indicator	Indicates if the carrier is active or inactive.	Combo Box	Drop Down List Box	0
Add	Allows a user to add a new record on the Other – Carrier panel.	Button	N/A	0
Address 1	This is the street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	Field	Character	30
Address 2	This is the second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	Field	Character	30
Billing Media	This field provides a detailed description of its associated billing media code.	Combo Box	Drop Down List Box	0
Carrier Name	This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.	Field	Character	45
Carrier Number	This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier identification number used on all screens and reports.	Field	Number (Integer)	7
Carrier Type	This is the code for the carrier type.	Combo Box	Drop Down List Box	0
Carrier Zip	This is the zip code for the carrier.	Field	Number (Integer)	5
Carrier Zip +4	The last four digits of the zip code for correspondence with a carrier.	Field	Number (Integer)	4
City	This is the city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	Field	Character	15
Claim Form Type	This field is the claim form description associated with a claim form type code.	Combo Box	Drop Down List Box	0
Clear	Clears fields of data.	Button	N/A	0
Contact Name	This is the name of the carrier contact when there are questions about a policy or the carrier.	Field	Character	40
Country	Two character country abbreviation.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Electronic Billing ID	This is the electronic billing identification for the carrier.	Field	Number (Integer)	9
Employer Xref	Opens the Other - Carrier to Employer Xref panel.	Button	N/A	0
Fax Number	The fax number for the carrier in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.	Field	Number (Integer)	15
FEIN	This is the Federal Employer Identification Number (FEIN).	Field	Number (Integer)	9
HIPAA Version	HIPAA format the insurance carrier will accept, 4010 or 5010.	Combo Box	Character	4
HMO Indicator	This field contains the description associated with a specific HMO indicator code.	Combo Box	Drop Down List Box	0
Note	Opens the carrier chronological notes panel.	Button	N/A	0
Phone Number	This is the telephone number of the carrier contact.	Field	Character	10
Pin Number	This is the personal identification number for the carrier's electronic billing.	Field	Number (Integer)	10
Rebill Frequency	This is the carrier billing frequency, in days.	Combo Box	Drop Down List Box	0
Search	Invokes search on Attorney Number or Attorney Name.	Button	N/A	0
State	This is the state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	Combo Box	Drop Down List Box	0
Zip	This is the first 5 digits of the zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.	Field	Number (Integer)	5
Zip + 4	This is the zip code + 4 for the carrier.	Field	Number (Integer)	4
Corresponding Address				
Address 1	The street address for correspondence with a TPL carrier.	Field	Character	30
Address 2	The second street address for correspondence with a TPL carrier.	Field	Character	30
City	The city for correspondence with a carrier.	Field	Character	15

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Field	Description	Field Type	Data Type	Length
Corp Contact Name	The name of the corporate contact when there are questions about a policy or the carrier.	Field	Character	40
Corp Phone Number	The telephone number of the corporate contact.	Field	Number (Integer)	10
Corp Phone Number Ext.	The extension number of the corporate contact.	Field	Number (Integer)	4
Corr. Country	This code described the country, and determines whether International or Domestic style addresses are displayed.	Combo Box	Character	2
Delete	Deletes current record.	Button	N/A	0
Tech Contact Name	The name of the technical contact when there are technical questions for the carrier.	Field	Character	40
Tech Phone Number	The telephone number of the technical contact.	Field	Number (Integer)	10
Tech Phone Number Ext.	The extension number of the technical contact.	Field	Number (Integer)	4
Zip	The first five digits of the zip code for correspondence with a carrier.	Field	Number (Integer)	5
Zip + 4	The last four digits of the zip code for correspondence with a carrier.	Field	Number (Integer)	4
Carrier to Employer Xref				
Add	Allows a user to add a new record on the Other – Carrier to Employer Xref panel.	Button	N/A	0
Business Name	The business name of an employer.	Field	Character	39
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Employer ID	Unique, user-defined employer identification number which is used on all screens and reports to identify the employer.	Field	Character	7
Note				
Add	Allows a user to add a new note.	Button	N/A	0
Note	A free-form text field for notes regarding the carrier.	Field	Character	500
Note Date	The date the note was added.	Field	N/A	0

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6.103.4 Other - Carrier Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Active Indicator	Field	1001	Active indicator should be set to Active for Carriers with active Policy records.	Remove the carrier from any policies before setting indicator to inactive.
Address 1	Field	1	Address 1 is required.	Enter a valid Address 1.
	Field	2	Corresponding Address 1 is required.	Enter Correspondence Address.
Billing Media	Field	1	A valid Billing Media is required.	Select a Billing Media from the list.
Carrier Name	Field	1	Carrier Name is required.	Enter a Carrier Name.
Carrier Number	Field	1	Carrier Number is required.	Enter a valid Carrier Number.
City	Field	1	City is required.	Enter a valid City.
	Field	2	Corresponding City is required.	Enter Corresponding City.
Delete	Button	1001	Cannot delete Carrier. Carrier exists in one or more Casualty Cases.	Remove Carrier from Casualty Cases before attempting to delete Carrier.
	Button	1002	Cannot delete Carrier. Carrier exists on one or more TPL Policies.	Remove Carrier from policies before attempting to delete Carrier.
	Button	1003	Cannot delete Carrier. Carrier exists in one or more HIPP cases as Payment Entity.	Remove Carrier from HIPP Cases before attempting to delete Carrier.
	Button	1004	Cannot delete Carrier. Carrier exists in one or more TPL AR Cases.	Remove Carrier from AR Cases before attempting to delete Carrier.
	Button	1005	Cannot delete Carrier. Carrier exists in one or more HIPP Cases.	Remove carrier from HIPP Cases before attempting to delete Carrier.
Employer ID	Field	1	A valid TPL Employer ID is required.	Enter valid Employer ID.
HMO Indicator	Field	1	A valid HMO Indicator is required.	Select a HMO Indicator from the list.
Note	Field	1	Note is required.	Add note.
State	Field	1	A valid State is required.	Enter a valid State.
	Field	2	A valid Corresponding State is required.	Enter Correspondence State.
Zip	Field	1	Zip is required.	Enter a Valid Zip.
	Field	2	Corresponding Zip is required.	Enter Correspondence Zip Code.

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6.103.5 Other - Carrier Panel Extra Features

Referential integrity checks are applied when attempting deletes. A carrier cannot be deleted if it is associated with any of the following:

- Policy- AR
- Case tracking
- HIPP case

If a user changes the carrier name, address, phone numbers, or fax number and the carrier exists on a HIPP case, the panel will update the address data on the t_hipp_resource, which can then be viewed on the HIPP Payment Entity Panel.

6.103.6 Other - Carrier Panel Accessibility

6.103.6.1 To Access the Other – Carrier Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click **Carrier**.	Carrier panel displays.

6.103.6.2 To Add on the Other - Carrier Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Carrier Number**.	
3	Enter **Carrier Name**.	
4	Select **Carrier Type** from drop down list.	
5	Enter **Electronic Billing ID**.	
6	Enter **FEIN**.	
7	Enter **Country**. Note: Use Search button if country code is unknown.	
8	Enter **Address 1**.	
9	Enter **Address 2**.	
10	Enter **City**.	
11	Select **State** from drop down list.	
12	Enter **Zip Code +4**.	

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Step	Action	Response
13	Enter **Contact Name**.	
14	Enter **Phone Number**.	
15	Enter **Extension**.	
16	Select **Re-Bill Frequency** from drop down list.	
17	Select **Billing Media** from drop down list.	
18	Select **HMO Indicator** from drop down list.	
19	Select **Claim Form Type** from drop down list.	
20	Select **Active Indicator** from drop down list.	
21	Enter **PIN Number**.	
22	Click **Save**.	Carrier panel information is saved.

6.103.6.3 To Update on the Other - Carrier Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier panel information is updated.

6.103.6.4 To Delete on the Other - Carrier Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

5.103.1 Other - Carrier Panel (Correspondence Address) Accessibility

5.103.1.1 To Access the Other – Carrier Panel (Correspondence Address)

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click **Carrier**.	Carrier panel displays.
5	Click **Add** on Carrier panel.	Correspondence Address display

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5.103.1.2 To Add on the Other – Carrier Panel (Correspondence Address)

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	**Corr. Country** defaults to US.	
3	Enter **Address1**.	
4	Enter **Address 2**.	
5	Enter **City**.	
6	Select **State** from the drop down box.	
7	Enter **Zip Code**.	
8	Enter **Zip+4**.	
9	Enter **Tech Contact Name**.	
10	Enter **Corp Contact Name**.	
11	Enter **Tech Phone Number**.	
12	Enter **Corp Phone Number**.	
13	Click **Save**.	Corresponding Address is Saved.

5.103.1.3 To Update on the Other - Carrier Panel (Correspondence Address)

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier panel information is updated.

5.103.1.4 To Delete on the Other - Carrier Panel (Correspondence Address)

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

5.103.2 Other - Carrier Panel (Carrier to Employer Xref) Accessibility

5.103.2.1 To Access the Other – Carrier Panel (Carrier to Employer Xref)

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.

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Step	Action	Response
4	Click **Carrier**.	Carrier panel displays.
5	Click **Employer Xref** button.	Carrier to Employer Xref panel displays.

5.103.2.2 To Add on the Other – Carrier Panel (Carrier to Employer Xref)

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Employer ID**. If unknown, click on [Search] button to locate by selecting from a list of results.	Business Name automatically prefills when Employer ID is entered.
3	Click **Save**.	Corresponding Address is Saved.

5.103.2.3 To Update on the Other - Carrier Panel (Carrier to Employer Xref)

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier to Employer Xref panel information is updated.

5.103.2.4 To Delete on the Other - Carrier Panel (Carrier to Employer Xref)

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

5.103.3 Other - Carrier Panel (Note) Accessibility

5.103.3.1 To Access the Other – Carrier Panel (Note)

Step	Action	Response
1	Enter **User Name** and **Password**; Click **Login**.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click **Carrier**.	Carrier panel displays.
5	Click **note** button.	Note panel displays.

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5.103.3.2 To Add on the Other – Carrier Panel (Note)

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Note**.	
3	Click **Save**.	Note is Saved.

5.103.3.3 To Update on the Other - Carrier Panel (Note)

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Carrier to Employer Xref panel information is updated.

5.103.3.4 To Delete on the Other - Carrier Panel (Note)

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.104 Other - Case Executor Trustee Info Panel Overview

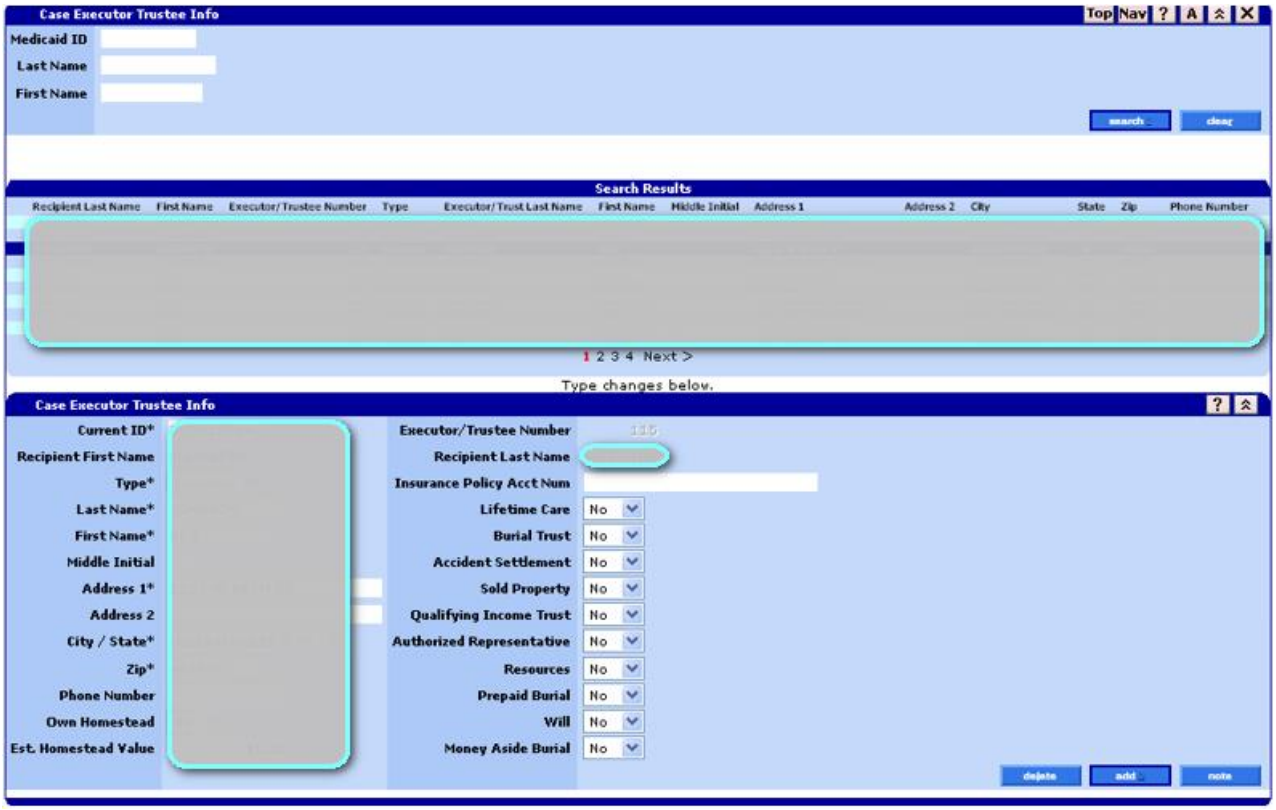
6.104.1 Other - Case Executor Trustee Info Panel Narrative

The Case Executor Trustee Info panel displays case information.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Other] - [Case Executor Trustee Info]

6.104.2 Other - Case Executor Trustee Info Panel Layout



6.104.3 Other - Case Executor Trustee Info Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Accident Settlement	Accident settlement indicator.	Combo Box	Drop Down List Box	0
Add	Allows a user to add a new record on the Other – Case Executor Trustee Info panel.	Button	N/A	0
Address1	The first address line of the Executor/Trustee.	Field	Character	55

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Field	Description	Field Type	Data Type	Length
Address2	The second address line for the Executor/Trustee.	Field	Character	55
Authorized Representative	Authorized representative indicator.	Combo Box	Drop Down List Box	0
Burial Trust	Burial trust indicator.	Combo Box	Drop Down List Box	0
City/State	This is the Executor/Trustee's city and state.	Field	Character	32
Clear	Clear search criteria.	Button	N/A	0
Current ID	The recipient's current Medicaid identification number.	Label	Character	12
Delete	Delete the case information detail.	Button	N/A	0
Est. Homestead Value	The estimated homestead value.	Field	Number (Decimal)	9
Executor/Trust Last Name	Last name of the executor/trustee.	Field	Character	20
Executor/Trustee Number	Unique identifier assigned to each Trustee.	Field	Character	9
First Name	First name of the executor/trustee.	Field	Character	15
Insurance Policy Acct Num	The account number for the insurance policy.	Field	Character	30
Lifetime Care	Lifetime care indicator.	Combo Box	Drop Down List Box	0
Middle Initial	Middle initial of the executor/trustee.	Field	Character	1
Money Aside Burial	Money set aside for burial indicator.	Combo Box	Drop Down List Box	0
Note	Opens the Notes panel	Button	N/A	0
Own Homestead	This is the Executor/Trustee's own homestead.	Combo Box	Drop Down List Box	0
Phone Number	This is the Executor/Trustee's phone.	Field	Number (Integer)	10
Prepaid Burial	Prepaid burial indicator.	Combo Box	Drop Down List Box	0
Qualifying Income Trust	Qualifying income trust indicator.	Combo Box	Drop Down List Box	0
Recipient First Name	The first name of a recipient.	Field	Character	15
Recipient Last Name	The last name of a recipient.	Field	Character	20

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Field	Description	Field Type	Data Type	Length
Resources	Resources indicator.	Combo Box	Drop Down List Box	0
Search	Start search for case information.	Button	N/A	0
Sold Property	Sold property indicator.	Combo Box	Drop Down List Box	0
Type	Executor or Trustee type.	Combo Box	Drop Down List Box	0
Will	Indicates if there is will. Valid values are: Yes and No.	Combo Box	Drop Down List Box	0
Zip	The nine digits Executor/Trustee's zip code for correspondence with a carrier.	Field	Character	9

6.104.4 Other - Case Executor Trustee Info Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address1	Field	1	Address 1 is required.	Enter executor or trustee address.
City	Field	1	City is required.	Enter a value for City.
State	Field	1	State is required.	Select a State from drop down list.
Type	Field	1	Type is required.	Select a Type from drop down list.
Zip	Field	1	Zip is required.	Enter a value for Zip Code.
	Field	2	Data must be numeric.	Enter a numeric value for Zip Code.

6.104.5 Other - Case Executor Trustee Info Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.104.6 Other - Case Executor Trustee Info Panel Accessibility

6.104.6.1 To Access the Other – Case Executor Trustee Info Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Case Information.	Case Executor Trustee Info panel displays.

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6.104.6.2 To Add on the Other - Case Executor Trustee Info Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Recipient Medicaid ID.	
3	Enter Recipient First Name.	
4	Enter Executor/Trustee Number.	
5	Select **Type** from the drop down list box.	
6	Enter Executor/Trustee Last Name.	
7	Enter First Name.	
8	Enter Middle Initial.	
9	Enter Address 1.	
10	Enter Address 2.	
11	Enter **City**.	
12	Select **State** from drop down list.	
13	Enter Zip Code +4.	
14	Enter Phone Number.	
15	Select **Own Homestead** from drop down list.	
16	Enter Est. Homestead Value.	
17	Enter Recipient Last Name.	
18	Enter Insurance Policy Acct Num.	
19	Select **Lifetime Care** from drop down list.	
20	Select **Burial Trust** from drop down list.	
21	Select **Accident Settlement** from drop down list.	
22	Select **Sold Property** from drop down list.	
23	Select **Qualifying Income Trust** from drop down list.	
24	Select **Authorized Representative** from drop down list.	
25	Select **Resources** from drop down list.	
26	Select **Prepaid Burial** from drop down list.	
27	Select **Will** from drop down list.	
28	Select **Money Aside Burial** from drop down list.	

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Step	Action	Response
29	Click **Save**.	Case Executor Trustee Info panel information is saved.

6.104.6.3 To Update on the Other - Case Executor Trustee Info Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Case Executor Trustee Info panel information is updated.

6.104.6.4 To Delete on the Other - Case Executor Trustee Info Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.105 Other - Correspondence Address Panel Overview

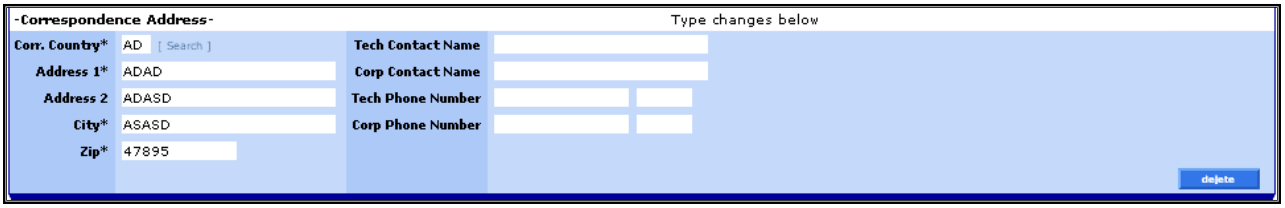
6.105.1 Other - Correspondence Address Panel Narrative

The Correspondence Address panel contains information about the other insurance company's mailing address if it is different than the billing address.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] - [Related Data] - [Other] - [Carrier] - [Search] - [Select a record].

6.105.2 Other - Correspondence Address Panel Layout



6.105.3 Other - Correspondence Address Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Address 1	The street address for correspondence with a TPL carrier.	Field	Character	30
Address 2	The second street address for correspondence with a TPL carrier.	Field	Character	30
City	The city for correspondence with a carrier.	Field	Character	15
Corp Contact Name	The name of the corporate contact when there are questions about a policy or the carrier.	Field	Character	40
Corp Phone Number	The telephone number of the corporate contact.	Field	Number (Integer)	10
Corp Phone Number Ext.	The extension number of the corporate contact.	Field	Number (Integer)	4
Corr. Country	This code described the country, and determines whether International or Domestic style addresses are displayed.	Combo Box	Character	2
Delete	Deletes current record.	Button	N/A	0
Tech Contact Name	The name of the technical contact when there are technical questions for the carrier.	Field	Character	40
Tech Phone Number	The telephone number of the technical contact.	Field	Number (Integer)	10

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Field	Description	Field Type	Data Type	Length
Tech Phone Number Ext.	The extension number of the technical contact.	Field	Number (Integer)	4
Zip	The first five digits of the zip code for correspondence with a carrier.	Field	Number (Integer)	5
Zip + 4	The last four digits of the zip code for correspondence with a carrier.	Field	Number (Integer)	4

6.105.4 Other - Correspondence Address Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address1 is required.	Enter an Address1.
City	Field	1	City is required.	Enter a City.
Zip	Field	1	Zip is required.	Enter a Zip Code.

6.105.5 Other - Correspondence Address Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.105.6 Other - Correspondence Address Panel Accessibility

6.105.6.1 To Access the Other – Correspondence Address Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data.**	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click **Carrier**.	Correspondence Address panel displays.
5	Select **Search**.	Search results display.
6	Click on desired row.	Correspondence Address panel displays at the bottom.

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6.105.6.2 To Update on the Other - Correspondence Address Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Correspondence Address panel information is updated.

6.105.6.3 To Delete on the Other - Correspondence Address Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.106 Other - Employer Panel Overview

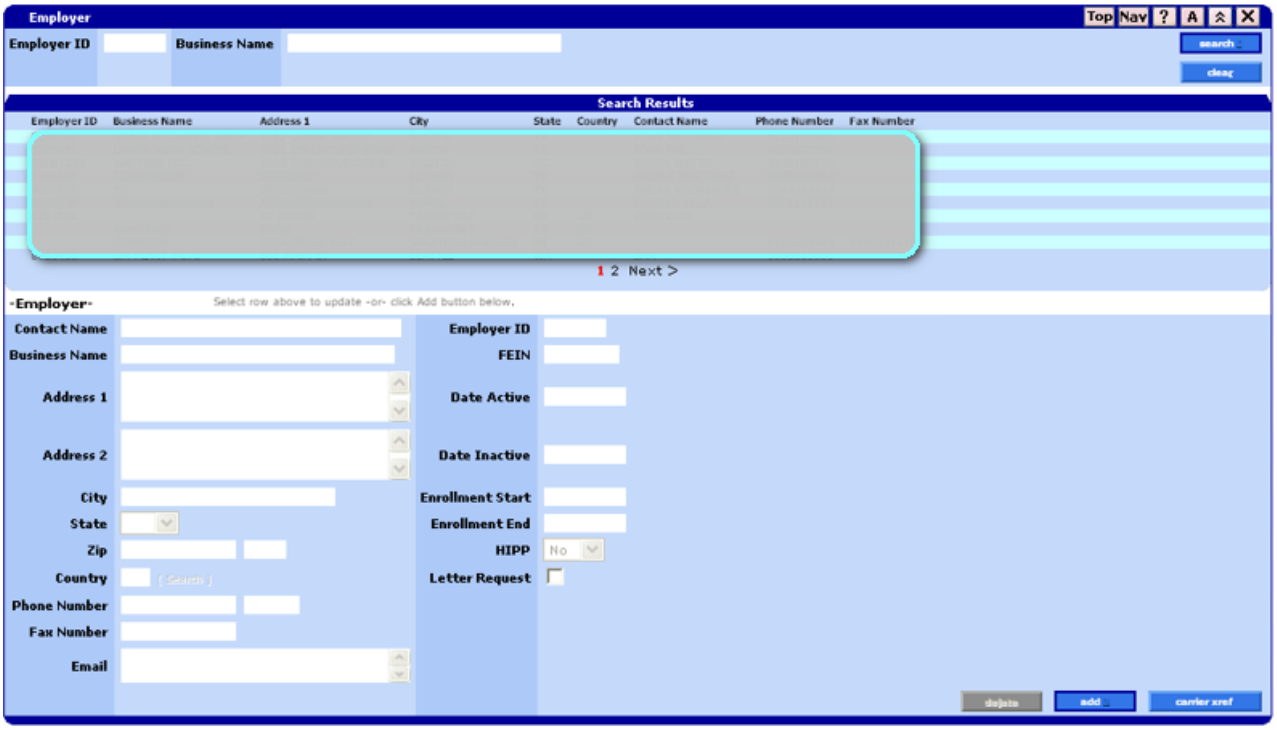
6.106.1 Other - Employer Panel Narrative

The Employer panel is used to search, display and update employer information. The user has the ability to enter the employer ID, business name or a combination of the two fields to view the employers on the database.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Employer]

6.106.2 Other-Employer Panel Layout



6.106.3 Other - Employer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Employer panel.	Button	N/A	0
Address 1	The street address of an employer.	Field	Character	30
Address 2	The second street address of an employer.	Field	Character	30
Business Name	The business name of an employer.	Field	Character	39

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Field	Description	Field Type	Data Type	Length
Carrier Xref	Link to the Carrier Xref. Panel.	Button	N/A	0
City	The city of an employer.	Field	Character	15
Clear	Clears fields of data.	Button	N/A	0
Contact Name	The employer contact name.	Field	Character	40
Country	The country code in which the employer resides.	Field	Character	2
Date Active	The date in which the employer record becomes active.	Field	Date (MM/DD/CCYY)	10
Date Inactive	The date in which the employer record is inactive.	Field	Date (MM/DD/CCYY)	10
Delete	Deletes current record.	Button	N/A	0
Email	The email address of the contact person with the employer.	Field	Character	15
Employer ID	Non-unique, user-defined employer identification number used on all screens and reports to identify the employer.	Field	Character	7
Enrollment End	The employer's end date for enrollment.	Field	Date (MM/DD/CCYY)	8
Enrollment Start	The employer's enrollment date for insurance coverage.	Field	Date (MM/DD/CCYY)	8
Extension	The employer contact telephone extension.	Field	Number (Integer)	4
Fax Number	The fax number for the employer, and is not a required field.	Field	Number (Integer)	10
FEIN	The Federal Employer Identification Number (FEIN).	Field	Character	9
HIPP	Indicates whether Health Insurance Premiums are paid for the employer group plans.	Field	Drop Down List Box	0
Letter Request	Indicates whether the user wants to request the TPL Employer Letter.	Field	Checkbox	0
Phone Number	The employer contact telephone number.	Field	Number (Integer)	10
Search	Invokes search on Employer identification number or Business Name.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
State	The state of the insurance agent where correspondence, cover letters, and liens are sent to.	Combo Box	Drop Down List Box	0
Zip 1	The first 5 digits of the zip code of an employer.	Field	Number (Integer)	5
Zip 2	The last four characters of the zip code of the employer.	Field	Number (Integer)	4

6.106.4 Other - Employer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Carrier Xref	Button	1	A valid TPL Employer Carrier Xref is required.	Add a Employer to Carrier Xref record.
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
Business Name	Field	1	Business Name is required.	Must enter a valid value for business name.
City	Field	1	City is required.	Enter a City.
Contact Name	Field	1	Contact Name is required.	Enter a Contact Name.
Delete	Button	1	Invalid Delete - Employer has Carrier Data.	Cannot delete Employer while carrier data still on file. Carrier data for this employer must be deleted first.
	Button	2	Invalid Delete - Employer has TPL Resource Data.	Can not delete Employer while TPL resource data still on file. TPL resource data for this employer must be deleted first.
Employer ID	Field	1	Employer ID must be 7 character(s) in length.	Enter a valid Employer ID.
FEIN	Field	1	FEIN is required.	Enter a valid FEIN.
Phone Number (1)	Field	1	Phone Number is required.	Enter a Phone Number.
	Field	2	Enter a valid value.	Phone Number is numeric only.
	Field	3	Phone Number must be 10 character(s) in length.	Enter a Phone Number with 10 Characters.
State	Field	1	A valid State is required.	Select a State value.
Zip 1	Field	1	Zip is required.	Enter a Zip.
	Field	2	Enter a valid value.	Zip is numeric only.

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Field	Field Type	Error Code	Error Message	To Correct
Zip 2	Field	1	Enter a valid value.	Zip (2) is numeric only.

6.106.5 Other - Employer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.106.6 Other - Employer Panel Accessibility

6.106.6.1 To Access the Other – Employer Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Employer.	Employer panel displays.

6.106.6.2 To Navigate on the Other – Employer Panel

Step	Action	Response
1	Enter Employer ID or Business Name.	
2	Click **Search**.	Employer information is displayed.

6.106.6.3 To Add on the Other - Employer Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Contact Name.	
3	Enter Business Name.	
4	Enter Address 1.	
5	Enter Address 2.	
6	Enter **City**.	
7	Select **State** from drop down list.	
8	Enter Zip Code +4.	
9	Enter **Country**. Note: Selection defaults to US.	
10	Enter Phone Number.	

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Step	Action	Response
11	Enter Fax Number.	
12	Enter **Email**.	
13	Enter Employer ID.	
14	Enter **FEIN**.	
15	Enter **Date Active** in MM/DD/CCYY format.	
16	Enter **Date Inactive** in MM/DD/CCYY format.	
17	Enter **Enrollment Start** in MM/DD/CCYY format.	
18	Enter **Enrollment End** in MM/DD/CCYY format.	
19	Select **HIPP** from drop down list.	
20	Check **Letter Request** box, if applicable.	
21	Click **Save**.	Employer panel information is saved.

6.106.6.4 To Update on the Other - Employer Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Employer panel information is updated.

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6.106.6.5 To Delete on the Other - Employer Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.107 Other - Insurance Agent Panel Overview

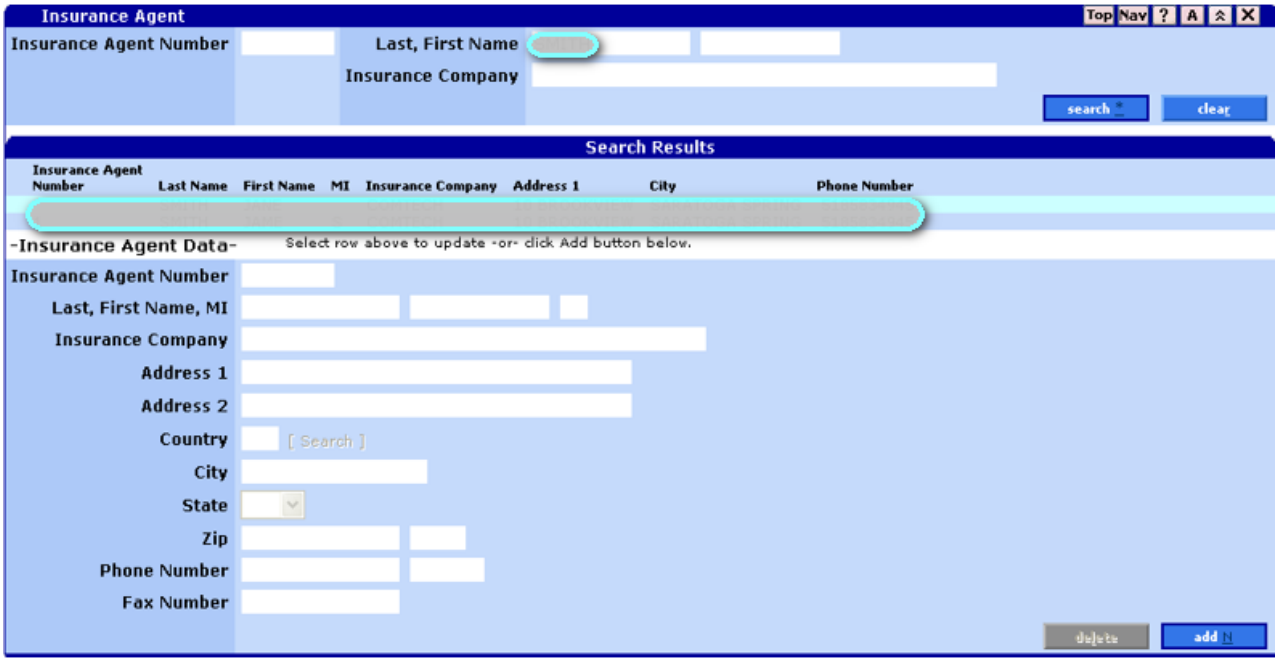
6.107.1 Other - Insurance Agent Panel Narrative

The Insurance Agent panel is used to add, update and view information on a certain insurance agent or insurance company.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Insurance Agent]

6.107.2 Other - Insurance Agent Panel Layout



6.107.3 Other - Insurance Agent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Insurance Agent panel.	Button	N/A	0
Address 1	The first street address of the insurance agent where the correspondence, cover letters, and liens are sent to.	Field	Character	30
Address 2	The second street address of the insurance agent where the correspondence, cover letters and liens are sent to.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
City	The city of the insurance agent where correspondence, cover letters, and liens are sent to.	Field	Character	15
Clear	Clears fields of data.	Button	N/A	0
Country	The country where the insurance agent resides.	Field	Character	2
Delete	Deletes current record.	Button	N/A	0
Extension Number	The extension number for the insurance agent.	Field	Number (Integer)	6
Fax Number	This is a fax number in the format area code + prefix + suffix.	Field	Number (Integer)	10
Insurance Agent Number	Unique identifier assigned to each Insurance Agent.	Field	Number (Integer)	8
Insurance Company	The company that the insurance agent is employed by.	Field	Character	40
Last, First Name, MI	The insurance agent's last name, first name and middle initial used to mail correspondence, cover letters, and liens.	Field	Character	30
Phone Number	The phone number where the insurance agent can be reached.	Field	Number (Integer)	10
Search	Invokes search on Insurance Agent Number, Agent Name or Insurance Company.	Button	N/A	0
State	The state of the insurance agent where correspondence, cover letters, and liens are sent to.	Combo Box	Drop Down List Box	0
Zip	The insurance agent's zip code where the correspondence, cover letters and liens are sent to including the last four characters of the zip code of the insurance agent used for the correspondence.	Field	Number (Integer)	9

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6.107.4 Other - Insurance Agent Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Must enter a valid value for Address 1.
City	Field	1	City is required.	Must enter a valid value for City.
Country	Field	1	Country is required.	Select a Country value.
Fax Number	Field	1	Enter a valid value.	Fax Number is numeric only.
	Field	2	Fax Number must be 10 character(s) in length.	If country is US, enter a Fax Number with 10 Characters.
	Field	3	Fax Number needs to be ten numeric values.	Enter ten valid numeric values.
Insurance Agent Name	Field	1	Last Name is required.	Enter a Last Name.
	Field	2	First Name is required.	Enter a First Name.
Phone Number	Field	1	Enter a valid value.	Phone Number is numeric only.
	Field	2	Phone Number must be 10 character(s) in length.	If country is US, enter a phone number with 10 characters.
Zip 1	Field	1	Enter a valid value.	Zip (1) is numeric only.
	Field	2	Zip is required.	Must enter a valid value for Zip.
Zip 2	Field	1	Enter a valid value.	Zip (2) is a valid value.

6.107.5 Other - Insurance Agent Panel Extra Features

Referential integrity checks are applied when attempting deletes. An insurance agent cannot be deleted if associated with a case tracking record.

6.107.6 Other - Insurance Agent Panel Accessibility

6.107.6.1 To Access the Other – Insurance Agent Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Insurance Agent.	Insurance Agent panel displays.

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6.107.6.2 To Navigate on the Other - Insurance Agent Panel

Step	Action	Response
1	Enter Insurance Agent Number, Last, First Name or Insurance Company.	
2	Click **Search**.	Insurance Agent information is populated in fields.

6.107.6.3 To Add on the Other – Insurance Agent Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Insurance Agent Number.	
3	Enter Last, First Name, MI.	
4	Enter Insurance Company.	
5	Enter Address 1.	
6	Enter Address 2.	
7	Enter **Country**. Note: Selection defaults to US.	
8	Enter **City**.	
9	Select **State** from drop down list.	
10	Enter Zip Code +4.	
11	Enter Phone Number.	
12	Enter Fax Number.	
13	Click **Save**.	Insurance Agent information is saved.

6.107.6.4 To Update on the Other – Insurance Agent Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Insurance Agent panel information is updated.

6.107.6.5 To Delete on the Other – Insurance Agent Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.108 Other - Letter Tracking Panel Overview

6.108.1 Other - Letter Tracking Panel Narrative

The Letter Tracking panel allows the user to view the history and/or update the received date for the following letters:

TPL Accident Trauma Questionnaire (Batch)

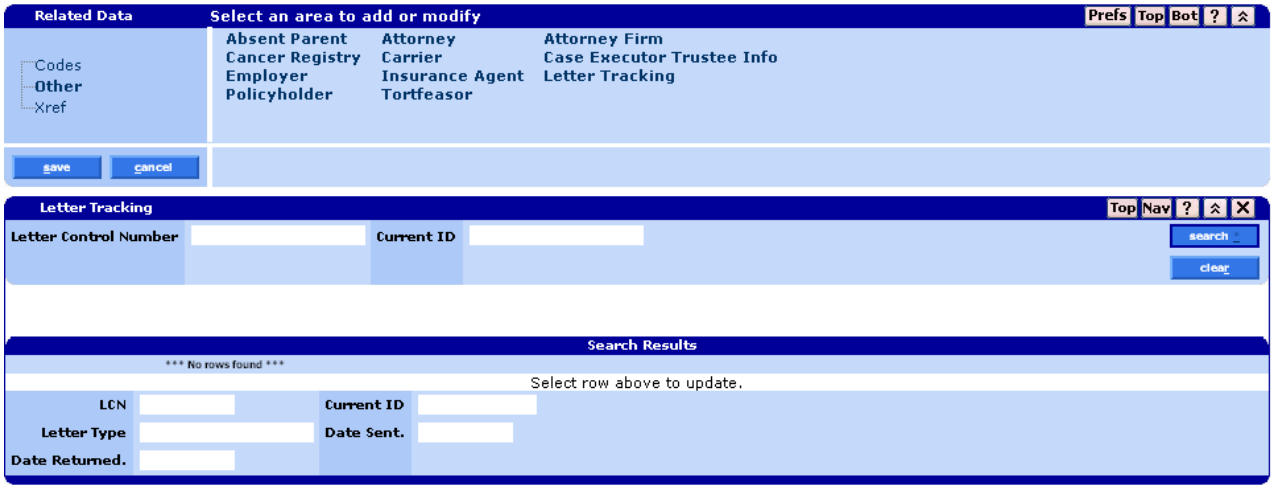
TPL Recipient Questionnaire (Batch)

TPL Absent Parent Employer Letter

TPL Absent Parent Insurance Verification Letter

Only authorized users are allowed to perform maintenance tasks on this panel.

6.108.2 Other - Letter Tracking Panel Layout



6.108.3 Other - Letter Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Cancel	Allows the user to cancel any changes.	Button	N/A	0
Clear	This button allows the user to clear the information within all letter tracking fields.	Button	N/A	0
Current ID	The recipient's current Medicaid identification number.	Label	Character	12

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Field	Description	Field Type	Data Type	Length
Date Returned	The date a response was received from the letter.	Field	Date (MM/DD/CCYY)	8
Date Sent	The date the letter was generated.	Field	Date (MM/DD/CCYY)	8
Letter Control Number (LCN)	The bar coded letter control number assigned to each letter.	Field	Character	12
Letter Type	The type of letter that was sent.	Field	Character	1
Save	Allows the user to save a record.	Button	N/A	0
Search	Invokes search on Recipient ID, Letter Control Number or Date Sent.	Button	N/A	0

6.108.4 Other - Letter Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Current ID	Field	1	Please enter at least one search field.	Enter search criteria.
Date Returned	Field	1	Date Returned is required.	Date returned is required.
Letter Control Number	Field	1	Please enter at least one search field.	Enter search criteria.

6.108.5 Other - Letter Tracking Panel Extra Features

Referential integrity checks are applied when attempting deletes. A policyholder cannot be deleted if it is associated with any of the following:

- Policy (active or inactive)
- HIPP case (active or inactive)

6.108.6 Other - Letter Tracking Panel Accessibility

6.108.6.1 To Access the Other – Letter Tracking Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Letter Tracking.	Letter Tracking panel displays.

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6.108.6.2 To Navigate on the Other - Letter Tracking Panel

Step	Action	Response
1	Enter Letter Control Number or Date Sent. Note: User must enter one search field.	
2	Click **Search**.	Letter Tracking information displays.

6.108.6.3 To Update on the Other – Letter Tracking Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Letter Tracking panel information is updated.

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6.109 Other - Nasco Policy Prefixes Panel Overview

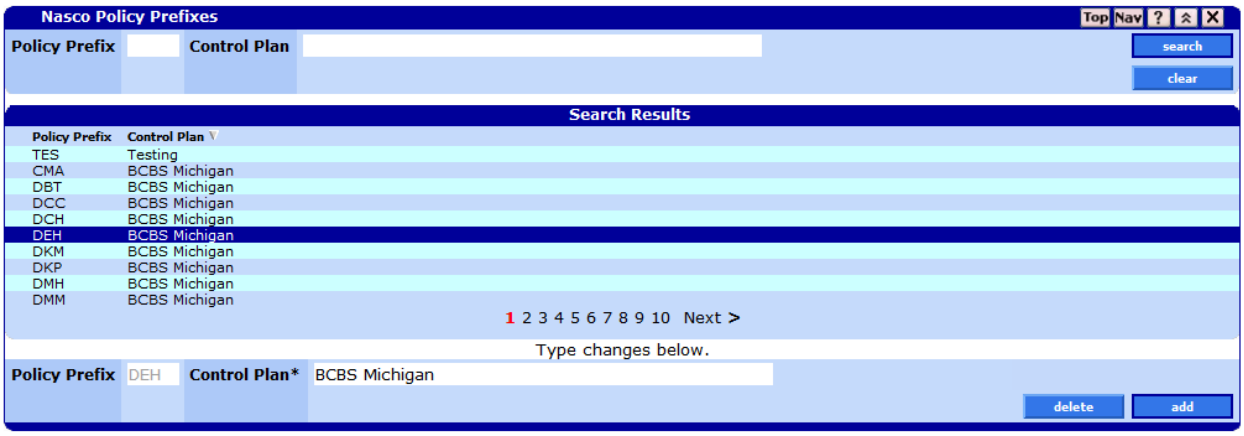
6.109.1 Other - Nasco Policy Prefixes Panel Narrative

The NASCO prefixes panel contains the list of policy prefixes that need to be excluded from the TPL Billing processes. Prefixes can be added or removed.the Control plan is the only modifiable field.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Nasco Policy Prefixes]

6.109.2 Other - Nasco Policy Prefixes Panel Layout



6.109.3 Other - Nasco Policy Prefixes Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Nasco Policy Prefixes panel.	Button	N/A	0
Clear	Clears fields of data.	Button	N/A	0
Control Plan	Description of the BCBS Control plan the prefix belongs.	Field	Character	50
Delete	Delete current record.	Button	N/A	0
Search	Invokes search on Policy Prefix or Control Plan.	Button	N/A	0
Policy Prefix	Stores the TPL policy prefix.	Field	Character	3

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6.109.4 Other - Nasco Policy Prefixes Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Control Plan	Field	1	Control Plan is required.	Enter a Control Plan.
Policy Prefix	Field	1	Policy Prefix is required.	Enter a Policy Prefix.
	Field	2	Duplicate record cannot be saved.	Enter the valid record.
	Field	3	Policy prefix should atleast contain one character (A - Z).	Policy prefix should atleast contain one character (A - Z).
	Field	4	Policy Prefix must be Alphanumeric.	Policy Prefix must be Alphanumeric.
	Field	5	Policy Prefix must be 3 characters in length	Policy Prefix must be 3 characters in length.

6.109.5 Other - Nasco Policy Prefixes Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.109.6 Other - Nasco Policy Prefixes Panel Accessibility

6.109.6.1 To Access the Other - Nasco Policy Prefixes Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click **Nasco Policy Prefixes**.	Nasco Policy Prefixes panel displays.

6.109.6.2 To Add on the Other - Nasco Policy Prefixes Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter **Policy Prefix**.	
3	Enter **Control Plan**.	
12	Click **Save**.	Nasco Policy Prefixes panel information is saved.

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6.109.6.3 To Update on the Other - Nasco Policy Prefixes Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Nasco Policy Prefixes panel information is updated.

6.109.6.4 To Delete on the Other - Nasco Policy Prefixes Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.110 Other - Policyholder Panel Overview

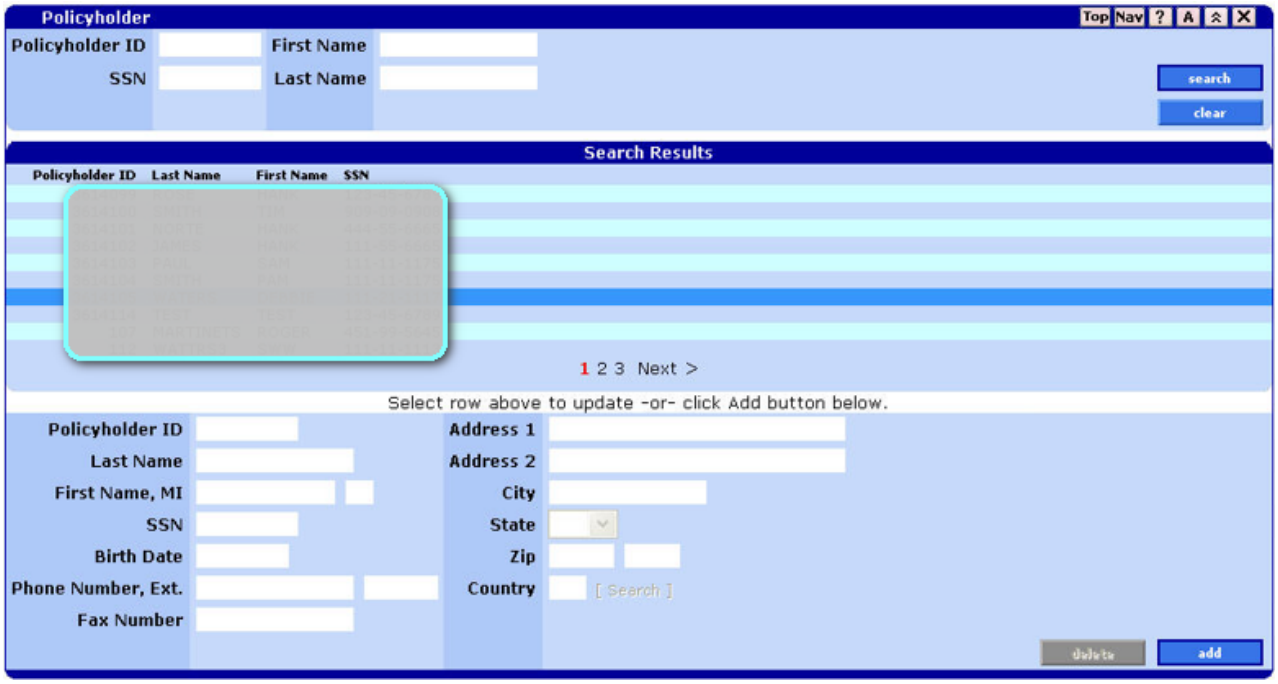
6.110.1 Other - Policyholder Panel Narrative

The Policyholder panel contains information about the non-Medicaid policyholder of a policy. A policyholder may hold a policy which covers multiple recipients. Keeping this data on a separate table allows it to be maintained once instead of for each recipient covered by the policy. If the policyholder is also a recipient, the policyholder data is obtained from the recipient table; no policyholder record is created.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Policyholder]

6.110.2 Other - Policyholder Panel Layout



6.110.3 Other - Policyholder Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Policyholder panel.	Button	N/A	0
Address 1	The street address of the policyholder. It is used to send correspondence to the policyholder.	Field	Character	30

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Field	Description	Field Type	Data Type	Length
Address 2	The second street address of the policyholder. It is used to send correspondence to the policyholder.	Field	Character	30
Birth Date	Birth date of the policy holder.	Field	Date (MM/DD/CCYY)	8
City	The city of the policyholder. It is used to send correspondence to the policyholder.	Field	Character	15
Clear	Clears fields of data.	Button	N/A	0
Country	Country code of the policy holder.	Field	Number (Integer)	2
Delete	Deletes current record.	Button	N/A	0
Fax Number	Fax number of the policy holder.	Field	Number (Integer)	15
First Name, MI	The first name and middle initial of the policyholder. It is used to send correspondence to the policyholder.	Field	Character	13
Last Name	The last name of the policyholder. It is used to send correspondence to the policyholder.	Field	Character	15
Phone Number, Ext.	Phone Number and Extension of Policy Holder.	Field	Number (Integer)	15
Policyholder ID	The system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder identification number.	Field	Number (Integer)	9
Search	Invokes search on Policyholder information.	Button	N/A	0
SSN	The Social Security Number of the policyholder.	Field	Number (Integer)	9
State	The state of the policyholder. It is used to send correspondence to the policyholder.	Combo Box	Drop Down List Box	0
Zip	The first 5 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.	Field	Number (Integer)	5
Zip + 4	The last 4 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.	Field	Number (Integer)	4

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6.110.4 Other - Policyholder Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
Birth Date	Field	1	Enter a valid Birth Date.	Birth Date must be 8 characters.
City	Field	1	City is required.	Enter a City.
Country	Field	1	Country code is invalid.	Enter a valid Country code.
Fax Number	Field	1	Enter a valid value.	Fax number is numeric only.
First Name	Field	1	First Name is required.	Enter a First Name.
Last Name	Field	1	Last Name is required.	Enter a Last Name.
Phone Number Extension	Field	1	Enter a valid value.	Phone number is numeric only.
Phone Number, Ext	Field	1	Enter a valid value.	Phone Number is numeric only.
SSN	Field	1	SSN Number is required.	Enter an SSN.
State	Field	1	A valid State is required.	Select a value for State.
Zip	Field	1	Mail Zip is required.	Enter a Zip.
	Field	2	Mail Zip must be 5 character(s) in length.	Enter a valid value.
Zip + 4	Field	1	Must be 4 character(s) in length.	Enter a valid value.

6.110.5 Other - Policyholder Panel Extra Features

Referential integrity checks are applied when a delete is attempted.

6.110.6 Other - Policyholder Panel Accessibility

6.110.6.1 To Access the Other – Policyholder Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Policyholder.	Policyholder panel displays.

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6.110.6.2 To Add on the Other – Policyholder Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Policyholder ID.	
3	Enter Last Name.	
4	Enter First Name, MI.	
5	Enter **SSN**.	
6	Enter Birthdate.	
7	Enter **Phone Number** and extension.	
8	Enter Fax Number.	
9	Enter Address 1.	
10	Enter Address 2.	
11	Enter **City**.	
12	Select **State** from drop down list box.	
13	Enter Zip Code +4.	
14	Enter **Country**. Note: Selection defaults to US. Select [Search] if unknown.	
15	Click **Save**.	Policyholder information is saved.

6.110.6.3 To Update on the Other – Policyholder Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Policyholder panel information is updated.

6.110.6.4 To Delete on the Other – Policyholder Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.111 Other - Tortfeasor Panel Overview

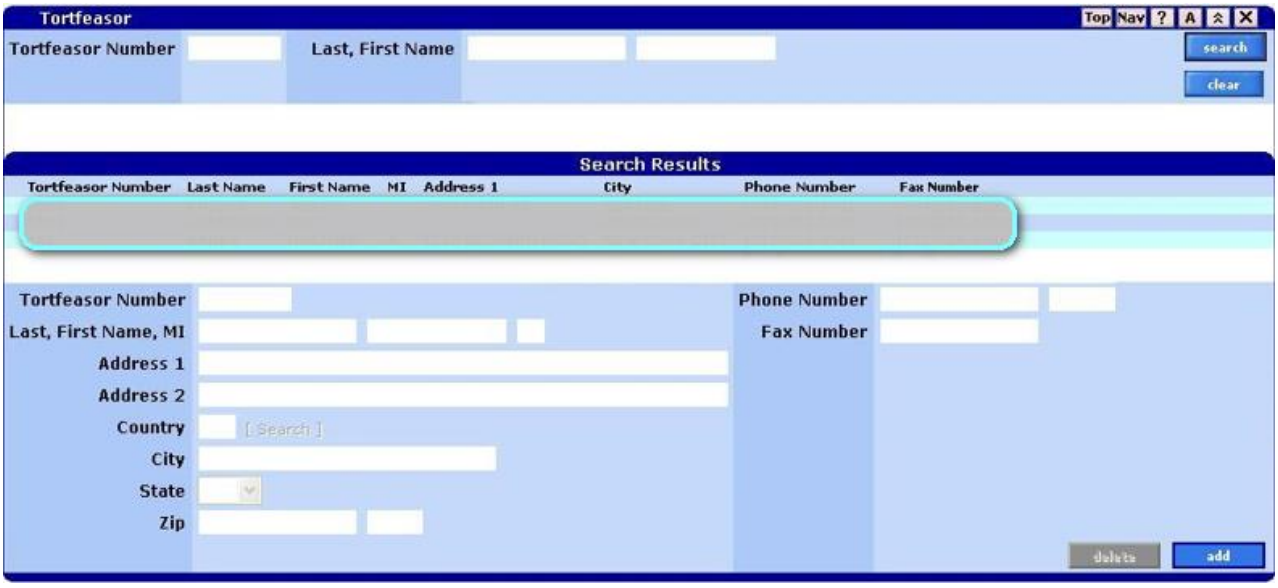
6.111.1 Other - Tortfeasor Panel Narrative

The Tortfeasor panel contains information about the person who is liable for the case. This information is used to send liens, letters and to receive payments.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Other] - [Tortfeasor]

6.111.2 Other - Tortfeasor Panel Layout



6.111.3 Other - Tortfeasor Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Other – Tortfeasor panel.	Button	N/A	0
Address 1	The first street address of the tortfeasor's where the correspondence, cover letters, and liens are sent.	Field	Character	55
Address 2	The second street address of the tortfeasor's where the correspondence, cover letters, and liens are sent.	Field	Character	55
City	The city of the tortfeasor where the correspondence, cover letters, and liens are sent.	Field	Character	30
Clear	Clears fields of data.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Country	The country where the tortfeasor resides.	Field	Character	2
Delete	Deletes current record.	Button	N/A	0
Extension Number	The extension number for the Tortfeasor phone number.	Field	Number (Integer)	6
Fax Number	The fax number for the tortfeasor. It can be an international number.	Field	Number (Integer)	10
Last, First Name, MI	The last name, first name and middle initial of the tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	29
Last, First Name [Search]	The last and first name of the tortfeasor used to address the correspondence, cover letters, and liens.	Field	Character	28
Phone Number	The phone number where the tortfeasor can be reached.	Field	Number (Integer)	10
Search	Invokes search on Tortfeasor Number or Tortfeasor Name.	Button	N/A	0
State	The state where the tortfeasor's correspondence, cover letters, and liens are sent.	Combo Box	Drop Down List Box	0
Tortfeasor Number	The account assigned number of the tortfeasor.	Field	Number (Integer)	8
Zip 1	The tortfeasor's zip code where the correspondence, cover letters, and liens are sent.	Field	Number (Integer)	9

6.111.4 Other - Tortfeasor Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Country	Field	1	A valid Country is required.	Select a valid Country value.
Fax Number	Field	1	Fax Number must be 10 character(s) in length.	If country is US, enter a Fax Number with 10 characters.
	Field	2	Fax Number is not valid.	Enter a valid value.
Last, First Name, MI	Field	1	Last Name is required.	Enter a Last Name.
	Field	2	First Name is required.	Enter a First Name.
Phone Number	Field	1	Phone Number is not valid.	Enter a valid Phone Number.

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Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Phone Number must be 10 character(s) in length.	If country is US, enter a Phone Number with 10 characters.
Zip 1	Field	1	Zip is required.	Enter a Zip Code.
	Field	2	Zip is not valid.	Enter a valid value.
	Field	3	Zip Code4 is not valid.	Enter a valid value.

6.111.5 Other - Tortfeasor Panel Extra Features

Referential integrity checks are applied when attempting deletes. A tortfeasor cannot be deleted if associated with a case tracking record.

6.111.6 Other - Tortfeasor Panel Accessibility

6.111.6.1 To Access the Other - Tortfeasor Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Other** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Tortfeasor.	Tortfeasor panel displays.

6.111.6.2 To Add on the Other - Tortfeasor Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Tortfeasor Number.	
3	Enter Last, First Name, MI.	
4	Enter Address 1.	
5	Enter Address 2.	
6	Enter **Country**. Note: Use Search button if country code is unknown.	
7	Enter **City**.	
8	Select **State** from drop down list.	
9	Enter Zip Code +4.	
10	Enter **Phone Number** plus extension.	

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Step	Action	Response
11	Enter Fax number.	
12	Click **Save**.	Tortfeasor panel information is saved.

6.111.6.3 To Update on the Other - Tortfeasor Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Tortfeasor panel information is updated.

6.111.6.4 To Delete on the Other - Tortfeasor Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.112 Related Data - Xref Panel Overview

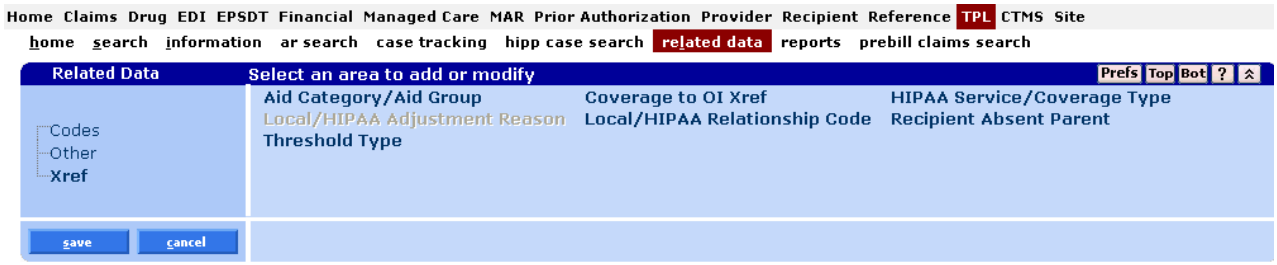
6.112.1 Related Data - Xref Panel Narrative

The point of access for the TPL Related Data Xref panels.

This panel is inquiry only.

Navigation Path: [TPL] – [Related Data] - [Xref]

6.112.2 Related Data - Xref Panel Layout



6.112.3 Related Data - Xref Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Aid Category/Aid Group	Link to the Aid Category/Aid Group panel.	Hyperlink	N/A	0
Cancel	Allows the user to cancel any changes in Xref.	Button	N/A	0
Coverage to OI Xref	Link to the Coverage to OI Xref panel.	Hyperlink	N/A	0
HIPAA Service/Coverage Type	Link to the HIPAA Service/Coverage Type panel.	Hyperlink	N/A	0
Local/HIPAA Adjustment Reason	Link to the Local/HIPAA Adjustment Reason panel.	Hyperlink	N/A	0
Local/HIPAA Relationship Code	Link to the Local/HIPAA Relationship Code panel.	Hyperlink	N/A	0
Recipient Absent Parent	Link to the to Recipient Absent Parent panel.	Hyperlink	N/A	0
Save	Allows the user to save a record in Xref.	Button	N/A	0
Threshold Type	Link to the Threshold Type panel.	Hyperlink	N/A	0

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6.112.4 Related Data - Xref Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.112.5 Related Data - Xref Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.112.6 Related Data - Xref Panel Accessibility

6.112.6.1 To Access the Related Data – Xref Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.

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6.113Xref - Aid Category/Aid Group Panel Overview

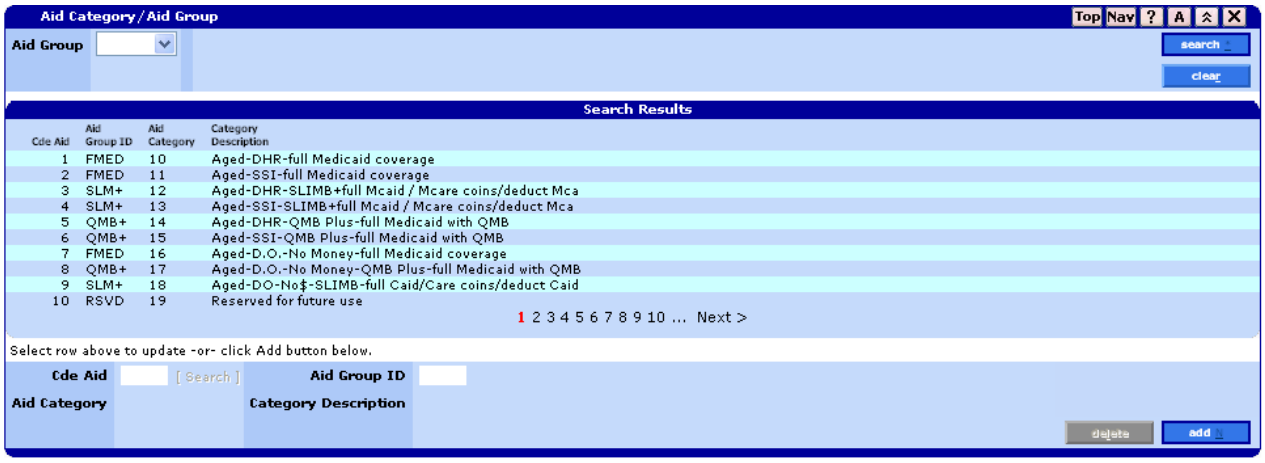
6.113.1 Xref - Aid Category/Aid Group Panel Narrative

The Xref-Aid Category/Aid Group panel is used to add or delete an Aid group, which is used to determine HIPP cost-effectiveness.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [Related Data] - [Xref] - [Aid Category/Aid Group]

6.113.2 Xref - Aid Category/Aid Group Panel



6.113.3 Xref - Aid Category/Aid Group Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Xref – Aid Category/Aid Group panel.	Button	N/A	0
Aid Category	This entity identifies the type of aid for which a recipient is eligible.	Field	Number (Integer)	9
Aid Group ID	This groups aid categories into specific groups with similar characteristics.	Field	Character	4
Category Description	Describes the type of aid for which a recipient is eligible.	Field	Character	50
Cde Aid [Search]	This is the system-assigned internal key that is 4 bytes long.	Hyperlink	N/A	0
Clear	The button clears the aid group selected.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0

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Field	Description	Field Type	Data Type	Length
Search	This button allows the user to search by aid group.	Button	N/A	0

6.113.4 Xref - Aid Category/Aid Group Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Aid Group ID	Field	1	Aid Group ID is required.	Enter a valid Aid Group ID.
Cde Aid [Search]	Hyperlink	1	A valid Cde Aid is required.	Enter a valid Aid Code

6.113.5 Xref - Aid Category/Aid Group Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.113.6 Xref - Aid Category/Aid Group Panel Accessibility

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Click Aid Category/Aid Group.	Aid Category/Aid Group panel displays.

6.113.6.1 To Navigate on the Xref - Aid Category/Aid Group Panel

Step	Action	Response
1	Select **Aid Group** from the drop down list box.	
2	Click **Search**.	Aid Category/Aid Group information displays.

6.113.6.2 To Add on the Xref - Aid Category/Aid Group Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Click **[Search]** located to right of the Cde Aid field.	Cde Aid Search panel displays.
3	Enter search criteria into fields. User may also select row from search results to display Cde Aid information.	

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Step	Action	Response
4	Click **Search**.	Cde Aid, Aid Category and Category Description fields populate.
5	Enter Aid Group ID.	
6	Click **Save**.	Aid Category/Aid Group information is saved.

6.113.6.3 To Update on the Xref - Aid Category/Aid Group Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Aid Category/Aid Group information is saved.

6.113.6.4 To Delete on the Xref - Aid Category/Aid Group Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.114Xref - Coverage to OI Panel Overview

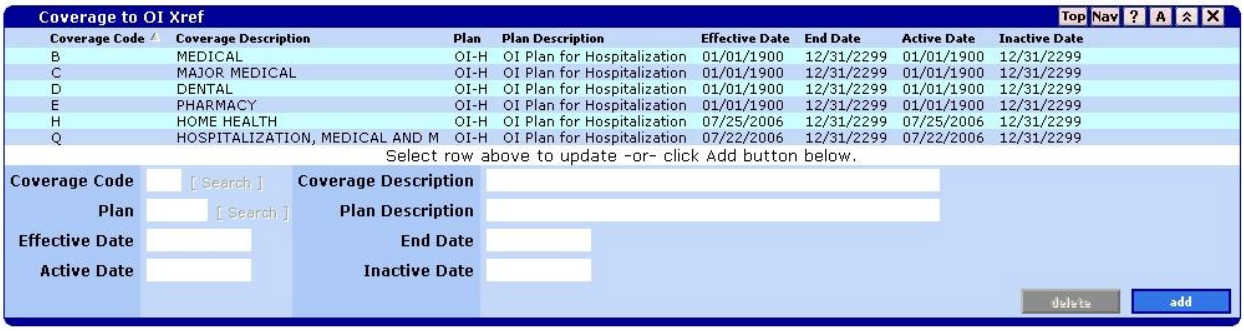
6.114.1 Xref - Coverage to OI Panel Narrative

The Xref-Coverage to OI panel is used to define relationships between Other Insurance (OI) plans and TPL coverage codes to support the TPL matrix.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [Related Data] - [Xref] - [Coverage to OI Xref]

6.114.2 Xref - Coverage to OI Panel Layout



6.114.3 Xref - Coverage to OI Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Active Date	The date that the row becomes active.	Field	Date (MM/DD/CCYY)	8
Add	Adds a new Coverage to OI Xref entry. The user is not allowed to add the same coverage and same OI plan if the same combination already exists. The user is allowed to add a new record using an existing coverage and/or plan as long as the combination doesn't already exist and the dates do not overlap.	Button	N/A	0
Coverage Code [Search]	TPL code that identifies the type of coverage linked to this OI Plan (read only).	Hyperlink	N/A	0
Coverage Description	Type of coverage description that is linked to the coverage code (read only).	Field	Character	120
Delete	Deletes the currently selected Coverage to OI Xref entry.	Button	N/A	0
Effective Date	Effective date of the row.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
End Date	End date of the row.	Field	Date (MM/DD/CCYY)	8
Inactive Date	The date that the row becomes inactive.	Field	Date (MM/DD/CCYY)	8
Plan [Search]	OI plan code linked to the coverage code.	Hyperlink	N/A	0
Plan Description	OI Plan Description linked to the OI plan code.	Listview	Character	50

6.114.4 Xref - Coverage to OI Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Active Date	Field	1	Active Date must be greater than or equal to 01/01/1900.	Enter a different active date.
Coverage Code [Search]	Hyperlink	7008	A valid Coverage Code is required.	Enter or search for a valid Coverage Code.
	Hyperlink	7010	Coverage code and plan code combination already exists.	Use a different coverage or plan or update the existing combination.
Effective Date	Field	2	Effective Date must be greater than or equal to 01/01/1900.	Enter a different Effective Date.
End Date	Field	1	End Date must be greater than or equal to 01/01/1900.	Enter a different End Date.
Inactive Date	Field	1	Inactive Date must be greater than or equal to 01/01/1900.	Enter a different Inactive Date
Plan [Search]	Hyperlink	1	A valid Plan is required.	Enter or search for a valid Plan code.
	Hyperlink	2	Coverage code and plan code combination already exists.	Use a different coverage or Plan or update the existing combination.

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6.114.5 Xref - Coverage to OI Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.114.6 Xref - Coverage to OI Panel Accessibility

6.114.6.1 To Access the Xref - Coverage to OI Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Select Coverage to OI Xref.	Xref-Coverage to OI panel displays.

6.114.6.2 To Add on the Xref - Coverage to OI Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Coverage Code. Click [Search] if Coverage Code is unknown. User can locate value by entering Coverage Code, Coverage Description or selecting a row from the search results.	Coverage Description field is populated.
3	Enter **Plan**. Click [Search] if Plan is unknown. User can locate value by entering Recipient Plan, Description or selecting a row from the search results.	Plan Description field is populated.
4	Update **Effective Date**, if needed. Note: Field automatically pre-fills with today's date.	
5	Update **Active Date**, if needed. Note: Field automatically pre-fills with today's date.	
6	Update **End Date**, if needed. Note: Field automatically pre-fills with today's date.	
7	Update **Inactive Date**, if needed. Note: Field automatically pre-fills with today's date.	
8	Click **Save**.	Xref-Coverage to OI information is saved.

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6.114.6.3 To Update on the Xref - Coverage to OI Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Xref-Coverage to OI information is saved.

6.114.6.4 To Delete on the Xref - Coverage to OI Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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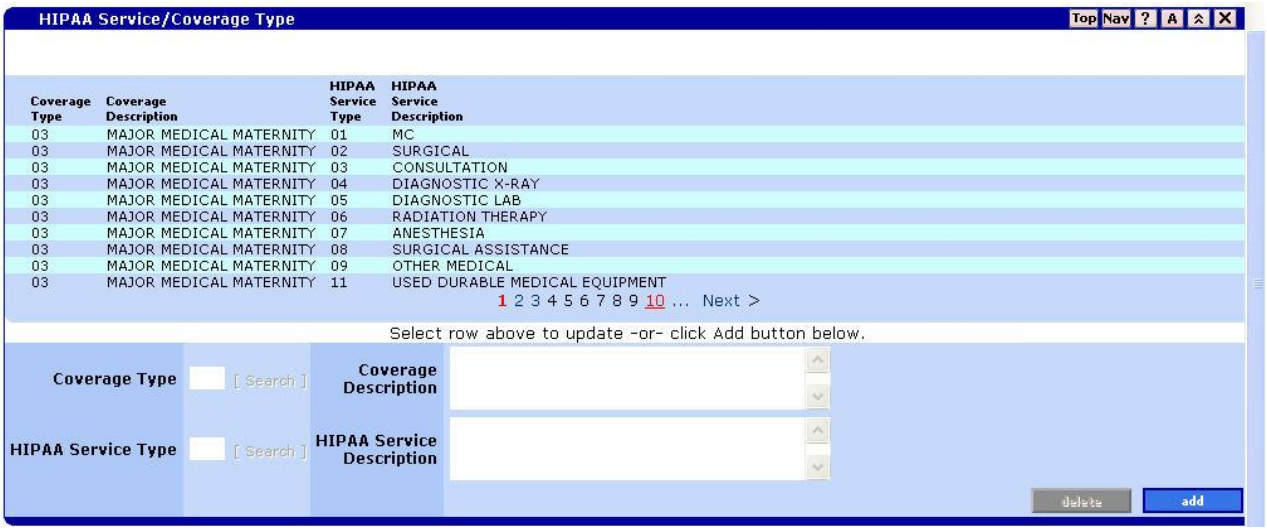
6.115Xref - HIPAA Service/Coverage Type Panel Overview

6.115.1 Xref - HIPAA Service/Coverage Type Panel Narrative

The Xref-HIPAA Service/Coverage Type panel contains the HIPAA service type code mapped to TPL coverage code. Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Xref] - [HIPAA Service/Coverage Type]

6.115.2 Xref - HIPAA Service/Coverage Type Panel Layout



6.115.3 Xref - HIPAA Service Coverage Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Xref – HIPAA Service Coverage Type panel.	Button	N/A	0
Coverage Description	This describes the type of coverage (services) a TPL resource provides.	Field	Character	120
Coverage Type [Search]	This code identifies the type of coverage that a TPL policy provides.	Hyperlink	N/A	0
Delete	Deletes the current record.	Button	N/A	0
HIPAA Service Description	This field contains the description for the HIPAA service type code.	Field	Character	120
HIPAA Service Type [Search]	This field contains the HIPAA service type code which describes the type of coverage a recipient has with a policy.	Hyperlink	N/A	0

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6.115.4 Xref - HIPAA Service/Coverage Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Coverage Type [Search]	Hyperlink	1	A valid Coverage Type is required.	Enter a valid Coverage Type.
	Hyperlink	2	Invalid Coverage Type.	Enter a valid Coverage Type or use the [Search] link to find a valid Coverage Type code.
	Hyperlink	3	A duplicate record cannot be saved.	Enter a another valid Coverage Type or use the [Search] link to find a another valid Coverage Type code.
HIPAA Service Type [Search]	Hyperlink	1	A valid HIPPA Service Type is required.	Enter a valid HIPAA Service Type or click Search and select one from the list.
	Hyperlink	2	Invalid HIPAA Service Type.	Enter a valid HIPAA Service Type or click [Search] to find a valid HIPAA Service Type code.
	Hyperlink	3	A duplicate record cannot be saved.	Enter a another valid HIPAA Service Type or click [Search] to find a another valid HIPAA Service Type code.

6.115.5 Xref - HIPAA Service/Coverage Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.115.6 Xref-HIPAA Service/Coverage Type Panel Accessibility

6.115.6.1 To Access the Xref-HIPAA Service/Coverage Type Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Select HIPAA Service/Coverage Type.	HIPAA Service/Coverage Type panel displays.

6.115.6.2 To Add on the Xref-HIPAA Service/Coverage Type Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Coverage Type. Click [Search] if Coverage Code is unknown. User can locate value by entering Coverage Code, Coverage Description or selecting a row from the search results.	Coverage Description field is populated.
3	Enter HIPAA Service Type. Click [Search] if HIPAA Service Type is unknown. User can locate value by entering HIPPA Service Type, Description or selecting a row from the search results.	HIPPA Service Description field is populated.
4	Click **Save**.	HIPAA Service/Coverage Type information is saved.

6.115.6.3 To Update on the Xref-HIPAA Service/Coverage Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	HIPAA Service/Coverage Type information is saved.

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6.115.6.4 To Delete on the Xref-HIPAA Service/Coverage Type Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.116 Xref - Local/HIPAA Adjustment Reason Panel Overview

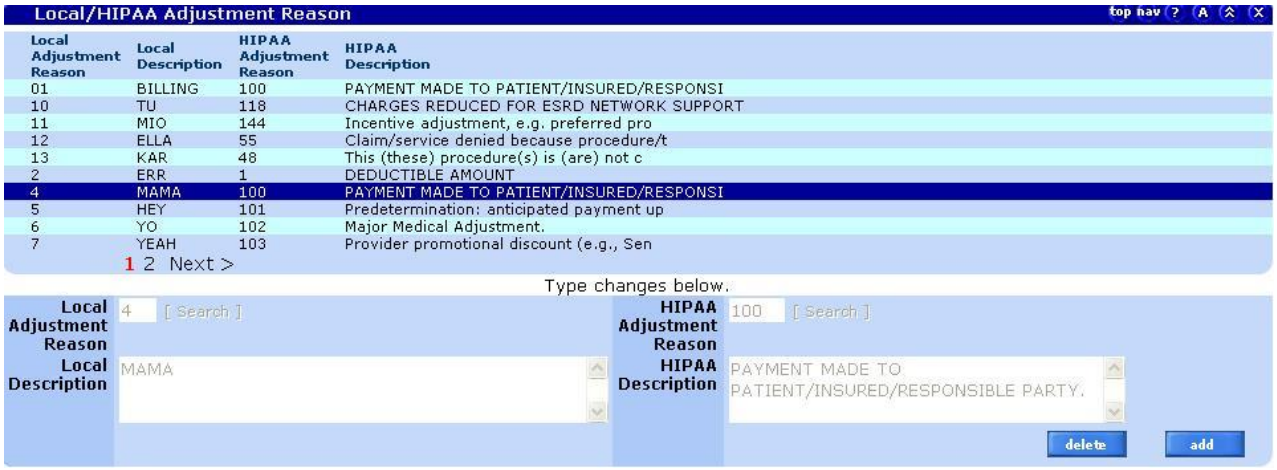
6.116.1 Xref -Local/HIPAA Adjustment Reason Panel Narrative

The Xref-Local/HIPAA Adjustment Reason panel contains data used for cross-referencing the adjustment reasons in the legacy system to the HIPAA standard adjustment reasons. This cross-reference is needed for any external data extracts.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Xref] - [Local/HIPAA Adjustment Reason]

6.116.2 Xref - Local/HIPAA Adjustment Reason Panel Layout



6.116.3 Xref - Local/HIPAA Adjustment Reason Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Xref – Local/HIPAA Adjustment Reason panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
HIPAA Adjustment Reason [Search]	This identifies the HIPAA Adjustment Reason Codes that may be received on a 835 transaction and posted to the TPL accounts receivables.	Hyperlink	N/A	0
HIPAA Description	This field contains the description associated with a specific HIPAA Adjustment Reason Code.	Field	Character	50
Local Adjustment Reason [Search]	The Alabama specific reason code that may be used to post to the TPL accounts receivables.	Hyperlink	N/A	0
Local Description	A description of the local A/R reason code.	Field	Character	50

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6.116.4 Xref - Local/HIPAA Adjustment Reason Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
HIPAA Adjustment Reason [Search]	Hyperlink	1	A valid HIPAA Adjustment Reason is required.	Enter a valid HIPAA Adjustment reason or select one from the list.
Local Adjustment Reason [Search]	Hyperlink	1	A valid Local Adjustment Reason is required.	Enter a TPL A/R Adjustment Reason.

6.116.5 Xref - Local HIPAA Adjustment Reason Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.116.6 Xref - Local Local/HIPAA Adjustment Reason Panel Accessibility

6.116.6.1 To Access the Xref - Local/HIPAA Adjustment Reason Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Select Local/HIPAA Adjustment Reason.	Local /HIPAA Adjustment Reason panel displays.

6.116.6.2 To Add Xref - Local/HIPAA Adjustment Reason on the Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Local Adjustment Reason. Click [Search] if Local Adjustment Reason is unknown. User can locate value by entering Reason Code, Description or selecting a row from the search results.	Local Description field is populated.
3	Enter HIPAA Adjustment Reason. Click [Search] if Local Adjustment Reason is unknown. User can locate value by entering HIPPA Adjustment Reason, Description, selecting Group from the drop down list box or selecting a row from the search results.	HIPPA Description field is populated.
4	Click **Save**.	Local HIPAA Adjustment Reason information is saved.

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6.116.6.3 To Update on the Xref - Local/HIPAA Adjustment Reason Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Local/HIPAA Adjustment Reason information is saved.

6.116.6.4 To Delete on the Xref - Local/HIPAA Adjustment Reason Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.117 Xref - Local HIPAA Relationship Code Panel Overview

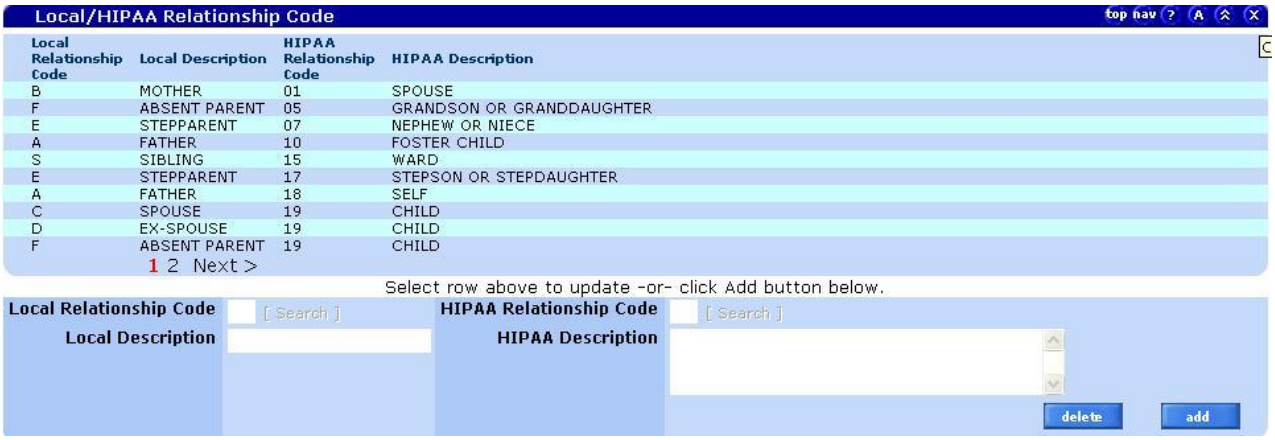
6.117.1 Xref - Local/HIPAA Relationship Code Panel Narrative

The Xref-Local/HIPAA Relationship Code panel contains the TPL relationship codes and their corresponding HIPAA relationship codes.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Related Data] - [Xref] - [Local/HIPAA Relationship Code]

6.117.2 Xref - Local/HIPAA Relationship Code Panel Layout



6.117.3 Xref - Local/HIPAA Relationship Code Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Xref – Local/HIPAA Relationship Code panel.	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
HIPAA Description	This field contains the description associated with a specific HIPAA relationship code.	Field	Character	120
HIPAA Relationship Code [Search]	This code identifies the relationship of the recipient to the policyholder.	Hyperlink	N/A	0
Local Description	This field contains the description associated with a specific relationship code.	Field	Character	21
Local Relationship Code [Search]	This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.	Hyperlink	N/A	0

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6.117.4 Xref - Local/HIPAA Relationship Code Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
HIPAA Relationship Code [Search]	Hyperlink	1	A valid HIPAA Relationship Code is required.	Enter a valid HIPAA Relationship Code or select one from the list.
	Field	2	A duplicate record cannot be saved.	Verify keying. A duplicate record cannot be saved.
Local Relationship Code [Search]	Hyperlink	1	A valid Local Relationship Code is required	Enter a valid Local Relationship Code.

6.117.5 Xref - Local/HIPAA Relationship Code Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.117.6 Xref - Local/HIPAA Relationship Code Panel Accessibility

6.117.6.1 To Access the Xref - Local/HIPAA Relationship Code Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Select Local/HIPAA Relationship Code.	Local/HIPAA Relationship Code panel displays.

6.117.6.2 To Add on the Xref - Local/HIPAA Relationship Code Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Local Relationship Code. Click [Search] if Local Relationship code is unknown.	Local Description field is populated.
3	Enter HIPAA Relationship Code. Click [Search] if HIPAA Relationship Code is unknown.	HIPAA Description field is populated.
4	Click **Save**.	Local/HIPAA Relationship Code information is saved.

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6.117.6.3 To Update on the Xref - Local/HIPAA Relationship Code Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Local/HIPAA Relationship Code information is saved.

6.117.6.4 To Delete on the Xref - Local/HIPAA Relationship Code Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.118 Xref - Recipient Absent Parent Panel Overview

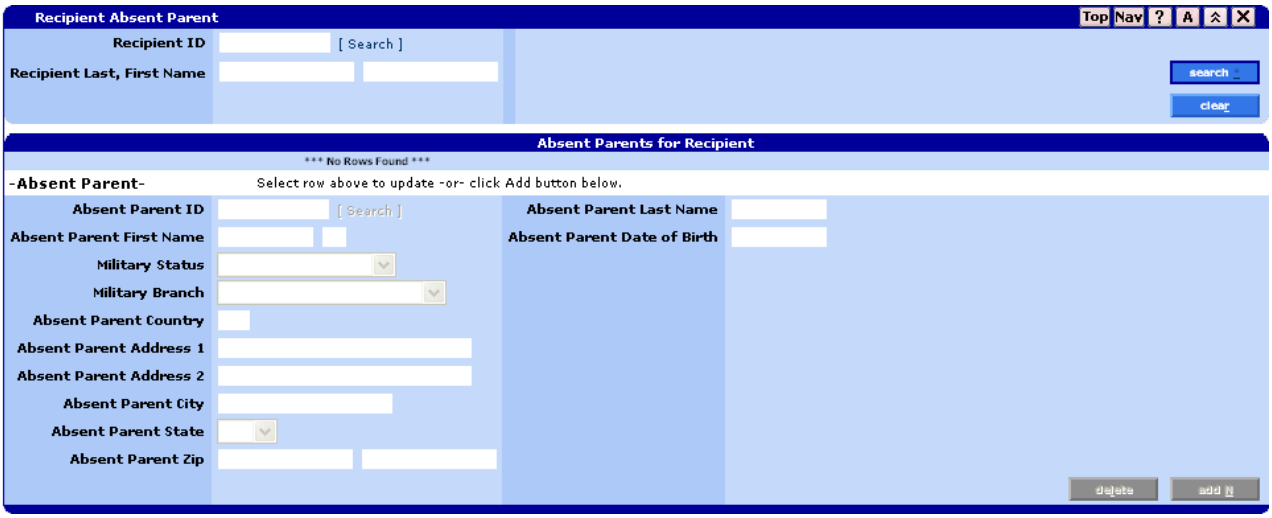
6.118.1 Xref - Recipient Absent Parent Panel Narrative

The Xref-Recipient Absent Parent panel displays a recipient's TPL absent parent data in response to an inquiry or else allows for the adding or updating of data.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Search] - (Select row from search results) - [TPL Maintenance] – [Absent Parent] - OR -[TPL] – [Related Data] - [Xref] - [Recipient Absent Parent]

6.118.2 Xref - Recipient Absent Parent Panel Layout



6.118.3 Xref - Recipient Absent Parent Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Add	Allows a user to add a new record on the Xref – Recipient Absent Parent panel.	Button	N/A	0
Absent Parent Address 1	The first address line of the absent parent used for correspondence. Could be an international address if country code is not US.	Field	Character	55
Absent Parent Address 2	The second address line of the absent parent used for correspondence. Could be an international address if country code is not US.	Field	Character	55

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Field	Description	Field Type	Data Type	Length
Absent Parent City	This is the absent parent's city where the correspondence is sent to. Could be an out of country city if country code is not US.	Field	Character	30
Absent Parent Country	Two character ISO country abbreviation.	Field	Character	2
Absent Parent Date of Birth	Absent parent's date of birth.	Field	Date (MM/DD/CCYY)	8
Absent Parent First Name, MI	This is the first name and middle initial of the member's absent or custodial parent.	Field	Character	13
Absent Parent ID	Absent parent identification number.	Field	Number (Integer)	9
Absent Parent Last Name	This is the last name of the member's absent or custodial parent.	Field	Character	15
Absent Parent State	This is the state abbreviation for the state in which the absent parent resides.	Combo Box	Drop Down List Box	0
Absent Parent Zip	This is the first five digits of the absent parent's zip code used for correspondence. Could also be an out of country zip code if country code is not US.	Field	Character	15
Absent Parent Zip + 4	This is the last four digits of the absent parent's zip code used for correspondence.	Field	Character	4
Clear	This button allows the user to clear recipient absent parent information	Button	N/A	0
Delete	Allows a user to remove a record from the data list.	Button	N/A	0
Military Branch	The absent parent’s branch of service code.	Combo Box	Drop Down List Box	0

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Field	Description	Field Type	Data Type	Length
Military Status	This is the Military status of the absent parent. Recommended values are: A =Active D = 100% DAV E = MEPCOM Enlistee N = National Guard R = Retired V = Reserve X = Other Z = Unknown Space = Not Military	Combo Box	Drop Down List Box	0
Recipient ID [Search]	Unique identifier for the recipient.	Hyperlink	Character	12
Recipient Last, First Name	The name of the recipient.	Field	Character	36
Search	This button allows the user to search by Recipient ID.	Button	N/A	0
[Search]	Allows the user to search by Absent Parent ID.	Hyperlink	N/A	0

6.118.4 Xref - Recipient Absent Parent Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Absent Parent First Name	Field	7092	First Name is required when first name is keyed.	Enter first name.
Absent Parent Last Name	Field	7093	Last name is required when last name is keyed.	Enter last name.

6.118.5 Xref - Recipient Absent Parent Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.118.6 Xref - Recipient Absent Parent Panel Accessibility

6.118.6.1 To Access the Xref – Recipient Absent Parent Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Xref panel displays.
4	Click Recipient Absent Parent.	Recipient Absent Parent panel displays.

6.118.6.2 To Add on the Xref - Recipient Absent Parent Panel

Step	Action	Response
1	Click **Add**.	Activates fields for entry of data or selection from lists.
2	Enter Absent Parent ID.	
3	Enter Absent Parent First Name.	
4	Select **Military Status** from drop down list.	
5	Select **Military Branch** from drop down list.	
6	Enter Absent Parent County.	
7	Enter Absent Parent Address 1.	
8	Enter Absent Parent Address 2.	
9	Enter Absent Parent City.	
10	Select **Absent Parent State** from drop down list.	
11	Enter Absent Parent Zip Code +4.	
12	Enter Absent Parent Last Name.	
13	Enter Absent Parent Date of Birth.	
14	Click **Save**.	Recipient Absent Parent information is saved.

6.118.6.3 To Update on the Xref - Recipient Absent Parent Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Recipient Absent Parent information is saved.

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6.118.6.4 To Delete on the Xref - Recipient Absent Parent Panel

Step	Action	Response
1	Click line item to be deleted.	Fields are populated with data related to the line selected.
2	Click **Delete**.	Line item is deleted.

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6.119 Xref - Threshold Type Panel Overview

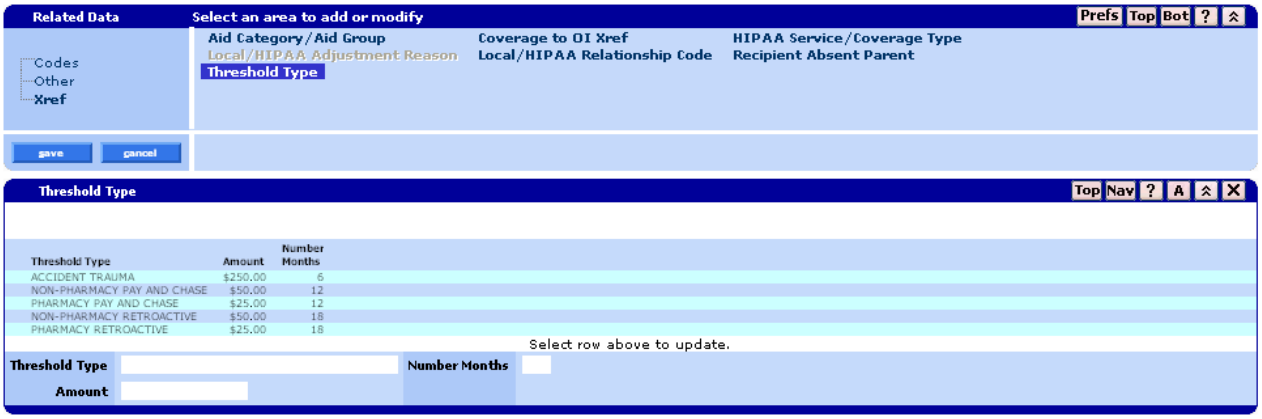
6.119.1 Xref - Threshold Type Panel Narrative

The Xref-Threshold Type panel is used to update threshold amounts and the number of months to accumulate claims. Only authorized users are allowed to perform maintenance tasks on this panel.

The Threshold Type panel should not have buttons for adds or deletes, only have the capability of updating existing threshold types. The reason for this is that the threshold types are hard-coded into the batch processes, but the dollar amounts and month durations are not hard-coded.

Navigation Path: [TPL] – [Related Data] - [XRef] - [Threshold Type]

6.119.2 Xref - Threshold Type Panel Layout



6.119.3 Xref - Threshold Type Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Amount	Dollar amount of threshold.	Field	Number (Decimal)	17
Cancel	Allows the user to cancel any changes.	Button	N/A	0
Number Months	Number of months claims are selected to accumulate to the threshold amount.	Field	Number (Integer)	2
Save	Allows the user to save a record.	Button	N/A	0
Threshold Type	Description of the type of threshold.	Field	Character	40

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6.119.4 Xref - Threshold Type Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Amount	Field	2	Amount is required.	Enter an amount.
	Field	3	Amount must be less than or equal to 999999999.99.	Enter an amount less than or equal to 999999999.99.
Number Months	Field	1	Enter a valid value.	Number Months is numeric only.

6.119.5 Xref - Threshold Type Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.119.6 Xref - Threshold Type Panel Accessibility

6.119.6.1 To Access the Xref – Threshold Type Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Related Data**.	Related Data panel displays.
3	Click the **Xref** hyperlink located on the Related Data panel.	Related Data-Other panel displays.
4	Click Threshold Type.	Threshold Type panel displays.

6.119.6.2 To Update on the Xref – Threshold Type Panel

Step	Action	Response
1	Click to highlight the row to be updated.	Data is populated in fields.
2	Click in desired field to update and perform update.	
3	Click **Save**.	Threshold Type information is updated.

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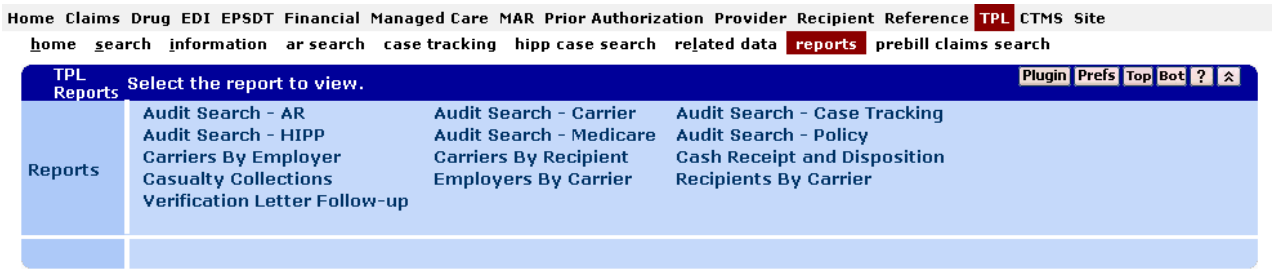
6.120 TPL Reports Page Overview

6.120.1 TPL Reports Page Narrative

The TPL Reports panel allows the user to select a report to print online. This panel is inquiry only.

Navigation Path: [TPL] – [Reports]

6.120.2 TPL Reports Page Layout



6.120.3 TPL Reports Page Field Descriptions

Field	Description	Field Type	Data Type	Length
Audit Search-AR	Link to Audit Search-AR panel.	Hyperlink	N/A	0
Audit Search-Carrier	Link to Audit Search-Carrier panel.	Hyperlink	N/A	0
Audit Search-Case Tracking	Link to Audit Search-Case Tracking panel.	Hyperlink	N/A	0
Audit Search-HIPP	Link to Audit Search-HIPP panel.	Hyperlink	N/A	0
Audit Search-Medicare	Link to Audit Search-Medicare panel.	Hyperlink	N/A	0
Audit Search-Policy	Link to Audit Search-Policy panel.	Hyperlink	N/A	0
Carriers by Recipient	Link to Carriers by Recipient panel.	Hyperlink	N/A	0
Carriers by Employer	Link to Carriers by Employer panel.	Hyperlink	N/A	0
Cash Receipt and Disposition	Link to Cash Receipt and Disposition panel.	Hyperlink	N/A	0
Casualty Collections	Link to Casualty Collections panel.	Hyperlink	N/A	0
Employers by Carrier	Link to Employers by Carrier panel.	Hyperlink	N/A	0
Recipients by Carrier	Link to Recipients by Carrier panel.	Hyperlink	N/A	0
Verification Letter Follow-Up	Link to Verification Letter Follow-Up panel.	Hyperlink	N/A	0

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6.120.4 TPL Reports Page Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for thispanel.				

6.120.5 TPL Reports Page Extra Features

Field	Field Type
No extra features found for this panel.	

6.120.6 TPL Reports Page Accessibility

6.120.6.1 To Access the TPL Reports Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports.**	TPL Reports panel displays.

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6.121 Reports – Audit Search - AR Panel Overview

6.121.1 Reports – Audit Search - AR Panel Narrative

The Reports-Audit Search –AR panel allows the user to search the System Audit Trail for Accounts Receivable Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date. Report will filter by Carrier Number, Action Code, Date range and AR Reason as selected by requester.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-AR]

6.121.2 Reports – Audit Search - AR Panel Layout

6.121.3 Reports – Audit Search - AR Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
AR Reason	This field is entered as part of the search criteria. It is only valid for searches of the audit trail for 'Accounts Receivable'. updates.	Field	Character	4
Carrier Number	Identifies TPL Carrier identification number assigned to the TPL other insurance carrier. It uniquely identifies the carrier internally to the system.	Field	Character	7
Clear	Clears out the case number field.	Button	N/A	0
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific date this field will be entered with the same value as the 'From Search Date'.	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
User ID	Identification number of the user.	Field	Character	8

6.121.4 Reports – Audit Search - AR Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
From Date	Field	1	Both dates has to be entered to filter search result by dates.	Both a From date and To date must be entered.
To Date	Field	2	Both dates has to be entered to filter search result by dates.	Both a From date and To date must be entered.
User ID	Field	3	User ID must be entered.	Enter a valid User ID

6.121.5 Reports – Audit Search - AR Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.121.6 Reports – Audit Search - AR Panel Accessibility

6.121.6.1 To Access the Reports - Audit Search – AR Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-AR.	Audit Search-AR panel displays.

6.121.6.2 To Navigate on the Reports – Audit Search - AR Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Enter AR Reason.	
7	Select number of records to retrieve from the drop down list box.	
8	Click **View**.	Audit Search-AR report is displayed.

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6.122 Reports – Audit Search - Carrier Panel Overview

6.122.1 Reports – Audit Search - Carrier Panel Narrative

The Reports –Audit Search-Carrier panel allows the user to search the System Audit Trail for Carrier Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date. The report can be filtered by Carrier Number if necessary.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-Carrier]

6.122.2 Reports – Audit Search - Carrier Panel Layout

6.122.3 Reports – Audit Search - Carrier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
Carrier Number	Identifies TPL Carrier identification assigned to the TPL other insurance carrier. It uniquely identifies the carrier internally to the system.	Field	Character	7
Clear	Clears out the case number field.	Button	N/A	0
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific date this field will be entered with the same value as the 'From Search Date'.	Field	Date (MM/DD/CCYY)	8
User ID	Identification number of the user.	Field	Character	8

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6.122.4 Reports – Audit Search - Carrier Panel Layout Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
User ID	Field	1	User ID must be entered.	Enter a valid User ID.

6.122.5 Reports – Audit Search - Carrier Panel Layout Extra Features

Field	Field Type
No extra features found for this panel.	

6.122.6 Reports – Audit Search - Carrier Panel Layout Accessibility

6.122.6.1 To Access the Reports – Audit Search – Carrier Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-Carrier.	Audit Search-Carrier panel displays.

6.122.6.2 To Navigate on the Reports – Audit Search - Case Tracking Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Select number of records to retrieve from the drop down list box.	
7	Click **View**.	Audit Search-Carrier report is displayed.

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6.123 Reports – Audit Search – Case Tracking Panel Overview

6.123.1 Reports – Audit Search – Case Tracking Panel Narrative

The Reports – Audit Search-Case Tracking panel allows the user to search the System Audit Trail for Case Tracking Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-Case Tracking]

6.123.2 Reports – Audit Search - Case Tracking Panel Layout

6.123.3 Reports – Audit Search - Case Tracking Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
Carrier Number	Identifies TPL Carrier identification assigned to the TPL other insurance carrier. It uniquely identifies the carrier internally to the system.	Field	Character	7
Clear	Clears out the case number field.	Button	N/A	0
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific date this field will be entered with the same value as the 'From Search Date'.	Field	Date (MM/DD/CCYY)	8
User ID	The identification number of the user.	Field	Character	8

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6.123.4 Reports – Audit Search - Case Tracking Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
From Date	Field	1	From Date must be before To Date.	Enter a valid From Date.
User ID	Field	1	User ID must be entered.	Enter a valid User ID.

6.123.5 Reports – Audit Search - Case Tracking Extra Features

Field	Field Type
No extra features found for this panel.	

6.123.6 Reports – Audit Search - Case Tracking Panel Accessibility

6.123.6.1 To Access the Reports – Audit Search - Case Tracking Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-Case Tracking.	Audit Search-Case Tracking panel displays.

6.123.6.2 To Navigate on the Reports – Audit Search - Case Tracking Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Select number of records to retrieve from the drop down list box.	
7	Click **View**.	Audit Search-Case Tracking report is displayed.

6.123.6.3 To Navigate on the Reports – Audit Search-Case Tracking Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	

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Step	Action	Response
5	Enter **To Date** in MM/DD/CCYY format.	
6	Select number of records to retrieve from the drop down list box.	
7	Click **View**.	Audit Search-Case Tracking report is displayed.

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6.124 Reports – Audit Search – HIPP Panel Overview

6.124.1 Reports – Audit Search - HIPP Panel Narrative

The Reports – Audit Search-HIPP panel allows the user to search the System Audit Trail for HIPP Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-HIPP]

6.124.2 Reports – Audit Search - HIPP Panel Layout

6.124.3 Reports – Audit Search – HIPP Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
Carrier Number	Identifies TPL Carrier identification assigned to the TPL other insurance carrier. It uniquely identifies the carrier internally to the system.	Field	Character	7
Clear	Clears out the case number field.	Button	N/A	0
Employer Code	Identifies the TPL Employer identification number. It uniquely identifies the employer internally to the system.	Field	Character	7
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific date this field will be entered with the same value as the 'From Search Date'.	Field	Date (MM/DD/CCYY)	8
User ID	Identification number of the user.	Field	Character	8

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6.124.4 Reports – Audit Search-HIPP Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
User ID	Field	1	User ID must be entered.	Enter a valid User ID.

6.124.5 Reports – Audit Search-HIPP Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.124.6 Reports – Audit Search-HIPP Panel Accessibility

6.124.6.1 To Access the Reports - Audit Search - HIPP Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-HIPP.	Audit Search-HIPP panel displays.

6.124.6.2 To Navigate on the Reports – Audit Search-HIPP Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Enter Employer Code.	
7	Select number of records to retrieve from the drop down list box.	
8	Click **View**.	Audit Search-HIPP report is displayed.

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6.125 Reports – Audit Search – Medicare Panel Overview

6.125.1 Reports – Audit Search - Medicare Panel Narrative

The Reports – Audit Search-Medicare panel allows the user to search the System Audit Trail for Medicare Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-Medicare]

6.125.2 Reports – Audit Search - Medicare Panel Layout

6.125.3 Reports – Audit Search - Medicare Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
Add/Chg Type	This field is entered as part of the search criteria. It only applies to Medicare Audit searches. The valid values are Manual and System.	Combo Box	Drop Down List Box	0
Clear	Clears out the case number field.	Button	N/A	0
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Medicare Type	This field is entered as part of the search criteria. Valid values are BOTH A & B (include both Medicare Part A and Part B in the search results), PART A (include only Part A in the search results), PART B (include only Part B in the search results), PART D (include only Part D in the search results) and ALL (include Part A, B, and D in the search results).	Combo Box	Drop Down List Box	0
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific	Field	Date (MM/DD/CCYY)	8

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Field	Description	Field Type	Data Type	Length
	date this field will be entered with the same value as the 'From Search Date'.			
User ID	Identification number of the user.	Field	Character	8

6.125.4 Reports – Audit Search - Medicare Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.125.5 Reports – Audit Search - Medicare Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.125.6 Reports – Audit Search - Medicare Panel Accessibility

6.125.6.1 To Access the Reports - Audit Search-Medicare Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-Medicare.	Audit Search-Medicare panel displays.

6.125.6.2 To Navigate on the Reports – Audit Search-Medicare Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Select **Medicare Type** from the drop down list box.	
7	Select number of records to retrieve from the drop down list box.	
8	Click **View**.	Audit Search-Medicare report is displayed.

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6.126 Reports – Audit Search – Policy Panel Overview

6.126.1 Reports – Audit Search - Policy Panel Narrative

The Audit Search-Policy panel allows the user to search the System Audit Trail for Policy Updates by User ID and date range. It returns records that have been added, changed or deleted for that user for the given date. This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Audit Search-Policy]

6.126.2 Reports – Audit Search - Policy Panel Layout

6.126.3 Reports – Audit Search - Policy Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Action Code	The modification action of the user. Values (Insert, Update, and Delete).	Combo Box	Drop Down List Box	0
Carrier Number	Identifies TPL Carrier identification number assigned to the TPL other insurance carrier. It uniquely identifies the carrier internally to the system.	Field	Character	7
Clear	Clears out the case number field.	Button	N/A	0
Employer Code	Identifies the TPL Employer identification number. It uniquely identifies the employer internally to the system.	Field	Character	7
From Date	The earliest date to be included in the search.	Field	Date (MM/DD/CCYY)	8
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Search	Searches by the entered case number.	Button	N/A	0
To Date	The latest date to be included in the search. When the user wishes to limit the search to a specific date this field will be entered with the same value as the 'From Search Date'.	Field	Date (MM/DD/CCYY)	8
User ID	The identification number of the user.	Field	Character	8

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6.126.4 Reports – Audit Search - Policy Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
From Date	Field	1	Both From and To dates need to be entered in order to filter by date.	Enter valid From and To Date (MM/DD/CCYY).
To Date	Field	1	Both From and To dates need to be entered in order to filter by date.	Enter valid From and To Date (MM/DD/CCYY).

6.126.5 Reports – Audit Search - Policy Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.126.6 Reports – Audit Search- Policy Panel - Accessibility

6.126.6.1 To Access the Reports - Audit Search - Policy Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Audit Search-Policy.	Audit Search-Policy panel displays.

6.126.6.2 To Navigate on the Reports –Audit Search - Policy Panel

Step	Action	Response
1	Enter **User ID**.	
2	Select **Action Code** from the drop down list box.	
3	Enter Carrier Number.	
4	Enter **From Date** in MM/DD/CCYY format.	
5	Enter **To Date** in MM/DD/CCYY format.	
6	Enter Employer Code.	
7	Select number of records to retrieve from the drop down list box.	
8	Click **View**.	Audit Search-Policy report is displayed.

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6.127 Reports - Carriers By Recipient Panel Overview

6.127.1 Reports - Carriers By Recipient Panel Narrative

The Carriers by Recipient panel allows the user to enter criteria to display the Carrier by Recipient - online report.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Carriers By Recipient]

6.127.2 Reports - Carriers By Recipient Panel Layout

6.127.3 Reports - Carriers By Recipient Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Recipient ID	Recipient's current Medicaid identification number.	Field	Character	12
Report Format	Allows the user to select the format in which to display the report.	Combo Box	Drop Down List Box	0
[Search]	Search link allows for a more detailed search for a recipient using the identification number.	Hyperlink	N/A	0
View	Button that displays the report requested.	Button	N/A	0

6.127.4 Reports - Carriers By Recipient Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Recipient ID	Field	1	Recipieint ID is required.	Enter a valid Recipient ID.
	Field	2	The Recipient does not exist, please use the [Search] button.	Enter a valid Recipient ID.

6.127.5 Reports - Carriers By Recipient Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.127.6 Reports - Carriers By Recipient Panel Accessibility

6.127.6.1 To Access the Reports - Carriers By Recipient Panel

Step	Action	Response

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1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Carriers By Recipient.	Carriers By Recipient panel displays.

6.127.6.2 To Navigate on the Reports - Carriers By Recipient Panel

Step	Action	Response
1	Enter Recipient ID. Note: Recipient ID is required. Users may utilize the [Search] field to locate ID.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Carriers By Recipient report is displayed.

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6.128 Reports - Carriers By Employer Panel Overview

6.128.1 Reports - Carriers By Employer Panel Narrative

The Carriers By Employer panel allows the user to enter criteria to display the Carriers by Employer - online report.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Carriers By Employer]

6.128.2 Reports - Carriers By Employer Panel Layout

6.128.3 Reports - Carriers By Employer Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Employer ID	This is a unique, user-defined employer identification number used on all screens and reports to identify the employer.	Field	Character	7
Report Format	Allows the user to select the format in which to display the report.	Combo Box	Drop Down List Box	0
[Search]	Search link allows for a more detailed search for an Employer ID using the identification number.	Hyperlink	N/A	0
View	Button that displays the report requested.	Button	N/A	0

6.128.4 Reports - Carriers By Employer Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Employer ID	Field	3	The Employer does not exist, please use the [Search] button.	Enter Valid Employer ID or click [Search] and Select Employer ID from list.

6.128.5 Reports - Carriers By Employer Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.128.6 Reports - Carriers By Employer Panel Accessibility

6.128.6.1 To Access the Reports - Carriers By Employer Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Carriers By Employer.	Carriers By Employer panel displays.

6.128.6.2 To Navigate on the Reports - Carriers By Employer Panel

Step	Action	Response
1	Enter Employer ID. Note: Employer ID is required. Users may utilize the [Search] field to locate ID.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Carriers by Employer report displays.

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6.129 Reports - Cash Receipt and Disposition Panel Overview

6.129.1 Reports - Cash Receipt and Disposition Panel Narrative

The Cash Receipt and Disposition panel allows the user to request the trial and final reports needed for balancing the cycle deposits against the AR dispositions and expenditures.

Only authorized users are allowed to perform maintenance tasks on this panel.

Navigation Path: [TPL] – [Reports] - [Cash Receipt and Disposition]

6.129.2 Reports - Cash Receipt and Disposition Panel Layout

6.129.3 Reports - Cash Receipt and Disposition Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Deposit From Date	The start of the deposit cycle for which the user needs to verify.	Field	Date (MM/DD/CCYY)	8
Deposit To Date	The end of the deposit cycle for which the user needs to verify.	Field	Date (MM/DD/CCYY)	8
Report Type	Indicates whether the user is requesting a trial or final run.	Combo Box	Drop Down List Box	0
Save	Allows the user to save the report request.	Button	N/A	0

6.129.4 Reports - Cash Receipt and Disposition Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Deposit From Date	Field	1	Deposit From Date is Required.	Please enter a valid Deposit From Date.
Deposit To Date	Field	1	Deposit To Date is Required.	Please enter a valid Deposit To Date.
	Field	2	Deposit To Date cannot be greater than current date.	Please correct the Deposit To Date.
Save	Button	1	Report Request Record Already Exists.	Cannot enter a new request until report is generated.

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6.129.5 Reports - Cash Receipt and Disposition Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.129.6 Reports - Cash Receipt and Disposition Panel Accessibility

6.129.6.1 To Access the Reports - Cash Receipt and Disposition Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports.**	TPL Reports panel displays.
3	Click Cash Receipt and Disposition.	Cash Receipt and Disposition panel displays.

6.129.6.2 To Navigate on the Reports - Cash Receipt and Disposition Panel

Step	Action	Response
1	Enter **Deposit From Date** in MM/DD/CCYY format.	
2	Enter **Deposit To Date** in MM/DD/CCYY format.	
3	Select **Report Type** from drop down list box.	
4	Click **View**.	Cash Receipt and Disposition report is displayed.

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6.130 Reports - Casualty Collections Panel Overview

6.130.1 Reports - Casualty Collections Panel Narrative

The Casualty Collections panel allows the user to enter criteria to display the TPL Casualty Collections (online) report.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Casualty Collections]

6.130.2 Reports - Casualty Collections Panel Layout

6.130.3 Reports - Casualty Collections Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Report Format	Allows the user to select the format in which to display the report. Valid options are: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Search Month	The date criteria on which to run the report, in CCYYMM format.	Field	Date (CCYYMM)	6
View	Button that displays the report requested.	Button	N/A	0

6.130.4 Reports - Casualty Collections Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search Month	Field	1	Search Month must be 6 character(s) in length.	Enter a 6 digit (CCYYMM) date.
	Field	2	Search Month is not Valid.	Please enter year and month CCYYMM.
	Field	3	Search Month Must be 6 character(s) in length.	Verify that all 6 characters for year and Month are entered. CCYYMM.

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6.130.5 Reports - Casualty Collections Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.130.6 Reports - Casualty Collections Panel Accessibility

6.130.6.1 To Access the Reports - Casualty Collections Panel

Step	Action	Response
1	Enter **User Name** and **Password**; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Casualty Collections.	Casualty Collections panel displays.

6.130.6.2 To Navigate on the Reports - Casualty Collections Panel

Step	Action	Response
1	Enter **Search Month** in CCYYMM format. Note: Search Month is a required field.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Casualty Collections report is displayed.

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6.131 Reports - Employers By Carrier Panel Overview

6.131.1 Reports - Employers By Carrier Panel Narrative

The Employers by Carrier panel allows the user to enter criteria to display the Employer By Carrier - online report.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Employers By Carrier]

6.131.2 Reports - Employers By Carrier Panel Layout

6.131.3 Reports - Employers By Carrier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Number	The unique user-defined carrier identification number.	Field	Character	7
Report Format	Allows the user to select the format in which to display the report. Valid options are: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
[Search]	Search link allows for a more detailed search for a carrier using the identification number.	Hyperlink	N/A	0
View	Button that displays the report requested.	Button	N/A	0

6.131.4 Reports - Employers By Carrier Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.131.5 Reports - Employers By Carrier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

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6.131.6 Reports - Employers By Carrier Panel Accessibility

6.131.6.1 To Access the Reports - Employers By Carrier Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports.**	TPL Reports panel displays.
3	Click Employers By Carrier.	Employers By Carrier panel displays.

6.131.6.2 To Navigate on the Reports - Employers By Carrier Panel

Step	Action	Response
1	Enter Carrier Number. Note: Carrier Number is a required field. Users may obtain number from [Search] field.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Employers By Carrier report is displayed.

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6.132 Reports - Recipients By Carrier Panel Overview

6.132.1 Reports - Recipients By Carrier Panel Narrative

The Recipients by Carrier panel allows the user to enter criteria to display the online report. This report identifies which recipients have coverage with a carrier. The user specifies the insurance carrier by name. All active and inactive recipients associated with the carrier are displayed on the report.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Recipients By Carrier]

6.132.2 Reports - Recipients By Carrier Panel Layout

6.132.3 Reports - Recipients By Carrier Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Carrier Number	The unique user-defined carrier identification number.	Field	Character	7
Report Format	Allows the user to select the format in which to display the report. Valid options are: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
[Search]	Search link allows for a more detailed search for a carrier number using the identification number.	Hyperlink	N/A	0
View	Button that displays the report requested.	Button	N/A	0

6.132.4 Reports - Recipients By Carrier Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Carrier Number	Field	1	The Carrier does not exist, please use the [Search] button.	Use the Search hyperlink to search for a valid carrier.

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6.132.5 Reports - Recipients By Carrier Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.132.6 Reports - Recipients By Carrier Panel Accessibility

6.132.6.1 To Access the Reports – Recipients By Carrier Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports.**	TPL Reports panel displays.
3	Click Recipients By Carrier.	Recipients By Carrier panel displays.

6.132.6.2 To Navigate on the Reports - Recipients By Carrier Panel

Step	Action	Response
1	Enter Carrier Number. Note: Carrier Number is a required field. Users may obtain number from [Search] field.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Recipients By Carrier report is displayed.

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6.133 Reports - Verification Letter Follow-Up Panel Overview

6.133.1 Reports - Verification Letter Follow-Up Panel Narrative

The Verification Letter Follow Up panel allows the user to enter criteria to display the Verification Letter Follow Up - online report. Based on the month/year entered, a list of all recipients that received a TPL-9007-D letter and are still in a non-verified status are reported.

This panel is inquiry only.

Navigation Path: [TPL] – [Reports] - [Verification Letter Follow Up]

6.133.2 Reports - Verification Letter Follow-Up Panel Layout

6.133.3 Reports - Verification Letter Follow-Up Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Report Format	Allows the user to select the format in which to display the report. Valid options are: HTML, PDF and Excel.	Combo Box	Drop Down List Box	0
Search Month	The date parameter for the report, in CCYYMM format.	Field	Date (CCYYMM)	6
View	Button that displays the report requested.	Button	N/A	0

6.133.4 Reports - Verification Letter Follow-Up Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Search Month	Field	1	Invalid Date. Format is CCYYMM.	Enter a valid Date.

6.133.5 Reports - Verification Letter Follow-Up Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.133.6

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6.133.7 Reports - Verification Letter Follow-Up Panel Accessibility

6.133.7.1 To Access the Reports – Verification Letter Follow-Up Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to **TPL** and click **Reports**.	TPL Reports panel displays.
3	Click Verification Letter Follow-Up.	Verification Letter Follow Up panel displays.

6.133.7.2 To Navigate on the Reports - Verification Letter Follow-Up Panel

Step	Action	Response
1	Enter **Search Month** in CCYYMM format. Note: Search Month is a required field.	
2	Select **Report Format** from drown down list. Valid values include: HTML, PDF and Excel. Note: Default format is HTML.	
3	Click **View**.	Verification Letter Follow-Up report is displayed.

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6.134 Prebill Claims Search Panel Overview

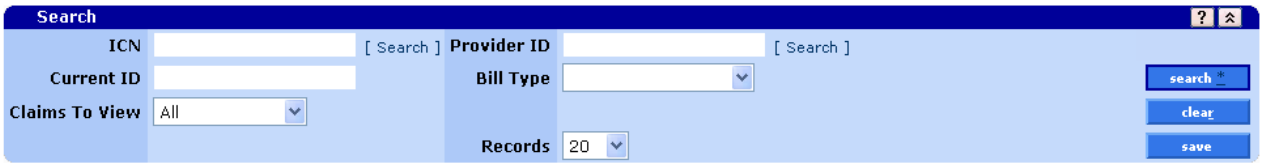
6.134.1 Prebill Claims Search Panel Narrative

The Prebill Claims Search panel allows the user to search for potential claims.

This panel is inquiry only.

Navigation Path: [TPL] – [Prebill Claims Search]

6.134.2 Prebill Claims Search Panel Layout



6.134.3 Prebill Claims Search Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
Bill Type	The type of billing the user needs to view.	Combo Box	Drop Down List Box	0
Claims to View	The claims to include in the search. Values = All, Includes Only, or Excludes Only.	Combo Box	Drop Down List Box	0
Clear	Clears the search criteria.	Button	N/A	0
Current ID	Recipient's identification number.	Field	Number (Integer)	12
ICN [Search]	Internal control number that is assigned to each claim to track activity through the claim process.	Hyperlink	N/A	0
Provider ID [Search]	Identifies the provider of services.	Hyperlink	N/A	0
Records	Allows the user to select the number of search items to display per page.	Combo Box	Drop Down List Box	0
Save	Allows the user to save changes made to the Search Results.	Button	N/A	0
Search	Button that initiates a search based on criteria entered into search fields.	Button	N/A	0

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6.134.4 Prebill Claims Search Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
Bill Type	Field	1	Bill Type is Required.	Please select a bill type from the dropdown box.
	Field	2	The combination must include the Bill Type.	Select Bill Type from the drop down list.
	Field	91024	*** No rows found ***	Verify entry - If correct then no TPL data available for that search criteria.
Current ID	Field	91024	*** No rows found ***	Verify entry - If correct then no TPL data available for that search criteria.
ICN	Field	91024	*** No rows found ***	Verify entry - If correct then no TPL data available for that search criteria.
Provider ID	Field	91024	*** No rows found ***	Verify entry - If correct then no TPL data available for that search criteria.

6.134.5 Prebill Claims Search Panel Extra Features

Field	Field Type
No extra features found for this panel.	

6.134.6 Prebill Claims Search Panel Accessibility

6.134.6.1 To Access the Prebill Claims Search Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to TPL and click Prebill Claims Search.	Prebill Claims Search panel displays.

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6.135 Prebill Claims Search Results Panel Overview

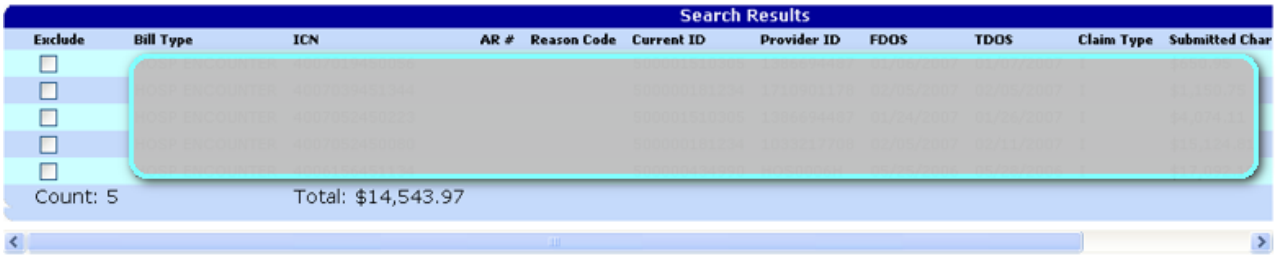
6.135.1 Prebill Claims Search Results Panel Narrative

The Prebill Claims Search Results panel provides users with the capability to view all claims selected for potential billing, rebilling or recoupments prior to the production run. .

This panel is display only.

Navigation Path: [TPL] – [Prebill Claims Search] - [Search] - [Prebill Claims Search Results] - [Add]

6.135.2 Prebill Claims Search Results Panel Layout



6.135.3 Prebill Claims Search Results Panel Field Descriptions

Field	Description	Field Type	Data Type	Length
AR #	The accounts receivable number to be closed during the production run.	Label	Character	13
Bill Type	The process that identified the claim for billing, rebilling, or recoupment.	Label	Character	20
Claim Type	The type of claim billed to Medicaid. Identifies the claim type code, not description.	Label	Character	1
Current ID	Member's identification number.	Label	Number (Integer)	12
Exclude	By checking the box the user can exclude the selected claims from the billing process.	Combo Box	Check box	0
FDOS	From date of service. This is the beginning date of service that the claim was submitted for.	Label	Date (MM/DD/CCYY)	8
ICN	Internal control number that is assigned to each claim to track activity through the claim process.	Label	Character	13
Provider ID	Identifies the provider of services.	Label	Number (Integer)	9
Reason Code	Reason code associated with the claim.	Label	Character	3

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Field	Description	Field Type	Data Type	Length
Submitted Charges	The amount the provider submitted on the claim.	Label	Number (Decimal)	12
TDOS	To date of service. This is the ending date of service that the claim was submitted for.	Label	Date (MM/DD/CCYY)	8
Total	The total amount Medicaid paid on all claims being displayed in the result list.	Label	Number (Decimal)	14

6.135.4 Prebill Claims Search Results Panel Field Edit Error Codes

Field	Field Type	Error Code	Error Message	To Correct
No field edits found for this panel.				

6.135.5 Prebill Claims Search Results Panel Extra Features

The only rebilling records that are displayed on the panel are those where the reason code = X30, X, R61, R62, R91, or C. Descriptions of all rebilling reason codes:

space - Rebill in 60 or 90 days

S - No response in 12 months
X30 - AR is closed with a disposition amount less than the billed amount and claim as been adjusted with a Medicaid paid amount greater than zero and is covered by the Matrix
X - AR is open and claim has been adjusted with a Medicaid paid amount greater than zero and is covered by the Matrix

46 - The coverage codes have been updated and the service is no longer covered by the Matrix

28 - The coverage dates have been updated and no longer cover the claim dates of service

R61 - The policy number has been updated and the AR is closed with a total disposition amount less than the AR billed amount.

R62 - The policy number has been updated and the AR is open.

31 - The suspect code has been updated to other than valid or non-verified.

R - The user has requested a manual rebill.

R91 - The carrier code has been updated and the AR is closed with a total disposition amount less than the AR billed amount.

C - The carrier code has been updated and the AR is open.

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W - The AR is open but the claim has been adjusted with either a Medicaid paid amount of zero, denied, or is not covered by the Matrix.

6.135.6 Prebill Claims Search Results Panel Accessibility

6.135.6.1 To Access the Prebill Claims Search Results Panel

Step	Action	Response
1	Enter User Name and Password; Click Login.	Main Menu page displays.
2	Point to TPL and click Prebill Claims Search.	Search panel displays.
3	Enter Search Criteria. Note: Bill Type is required.	
4	Click **Search**.	Prebill Claims Search Results display.

6.135.6.2 To Update the Prebill Claims Search Results Panel

Step	Action	Response
1	Check **Exclude**.	
2	Click **Save**.	Prebill Claims Search results information is saved.

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State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
1	System Stand-up Implementation (SSUI) Project Approach and Scheduling Phase Sch B	$ -	$ -
1	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
2			
2	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
3	SSUI Transition Plan Phase Sch B	$ -	$ -
3	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
4			
4	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
5	SSUI Transition Design Phase Sch B	$ -	$ -
5	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
6			
6	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
7	SSUI Transition Construction Phase Sch B	$ -	$ -
7	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
8			
8	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
9			
9	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
10	SSUI Transition Testing Phase Sch B-N	$ -	$ -
10	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
11	SSUI Transition Implementation Phase Deliverables Sch B	$ -	$ -
11	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
12			
12	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
13	Year 2 - Total Monthly Price from Sch C	$ -	$ -
13	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
13	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
14	Year 2 - Total Monthly Price from Sch C	$ -	$ -
14	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
14	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
15	Year 2 - Total Monthly Price from Sch C	$ -	$ -
15	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
15	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
16	Year 2 - Total Monthly Price from Sch C	$ -	$ -
16	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
16	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
17	Year 2 - Total Monthly Price from Sch C	$ -	$ -
17	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
17	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
18	Year 2 - Total Monthly Price from Sch C	$ -	$ -
18	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
18	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
19	Year 2 - Total Monthly Price from Sch C	$ -	$ -
19	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
19	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
20	Year 2 - Total Monthly Price from Sch C	$ -	$ -
20	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
20	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
21	Year 2 - Total Monthly Price from Sch C	$ -	$ -
21	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
21	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
22	Year 2 - Total Monthly Price from Sch C	$ -	$ -
22	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
22	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
23	Year 2 - Total Monthly Price from Sch C	$ -	$ -
23	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
23	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
24	Year 2 - Total Monthly Price from Sch C	$ -	$ -
24	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
24	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
25	Year 3 - Total Monthly Price from Sch C	$ -	$ -
25	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
25	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
26	Year 3 -Total Monthly Price from Sch C	$ -	$ -
26	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
26	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
27	Year 3 - Total Monthly Price from Sch C	$ -	$ -
27	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
27	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
28	Year 3 - Total Monthly Price from Sch C	$ -	$ -
28	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
28	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
29	Year 3 - Total Monthly Price from Sch C	$ -	$ -
29	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
29	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
30	Year 3 - Total Monthly Price from Sch C	$ -	$ -
30	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
30	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
31	Year 3 - Total Monthly Price from Sch C	$ -	$ -
31	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
31	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
32	Year 3 -Total Monthly Price from Sch C	$ -	$ -
32	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
32	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
33	Year 3 - Total Monthly Price from Sch C	$ -	$ -
33	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
33	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
34	Year 3 - Total Monthly Price from Sch C	$ -	$ -
34	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
34	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
35	Year 3 - Total Monthly Price from Sch C	$ -	$ -
35	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
35	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
36	Year 3 - Total Monthly Price from Sch C	$ -	$ -
36	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
36	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
37	Year 4 - Total Monthly Price from Sch C	$ -	$ -
37	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
37	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
38	Year 4 - Total Monthly Price from Sch C	$ -	$ -
38	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
38	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
39	Year 4 - Total Monthly Price from Sch C	$ -	$ -
39	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
39	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
40	Year 4 - Total Monthly Price from Sch C	$ -	$ -
40	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
40	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
41	Year 4 - Total Monthly Price from Sch C	$ -	$ -
41	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
41	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
42	Year 4 - Total Monthly Price from Sch C	$ -	$ -
42	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
42	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
43	Year 4 - Total Monthly Price from Sch C	$ -	$ -
43	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
43	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
44	Year 4 - Total Monthly Price from Sch C	$ -	$ -
44	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
44	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
45	Year 4 - Total Monthly Price from Sch C	$ -	$ -
45	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
45	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
46	Year 4 - Total Monthly Price from Sch C	$ -	$ -
46	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
46	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
47	Year 4 - Total Monthly Price from Sch C	$ -	$ -
47	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
47	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
48	Year 4 - Total Monthly Price from Sch C	$ -	$ -
48	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
48	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
49	Year 5 - Total Monthly Price from Sch C	$ -	$ -
49	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
49	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
50	Year 5 - Total Monthly Price from Sch C	$ -	$ -
50	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
50	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
51	Year 5 - Total Monthly Price from Sch C	$ -	$ -
51	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
51	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
52	Year 5 - Total Monthly Price from Sch C	$ -	$ -
52	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
52	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
53	Year 5 - Total Monthly Price from Sch C	$ -	$ -
53	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
53	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
54	Year 5 - Total Monthly Price from Sch C	$ -	$ -
54	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
54	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
55	Year 5 - Total Monthly Price from Sch C	$ -	$ -
55	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
55	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
56	Year 5 - Total Monthly Price from Sch C	$ -	$ -
56	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
56	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
57	Year 5 - Total Monthly Price from Sch C	$ -	$ -
57	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
57	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
58	Year 5 - Total Monthly Price from Sch C	$ -	$ -
58	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
58	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
59	Year 5 - Total Monthly Price from Sch C	$ -	$ -
59	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
59	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
60	Year 5 - Total Monthly Price from Sch C	$ -	$ -
60	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
60	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
61	Year 6 - Total Monthly Price from Sch C	$ -	$ -
61	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
61	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
62	Year 6 - Total Monthly Price from Sch C	$ -	$ -
62	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
62	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
63	Year 6 - Total Monthly Price from Sch C	$ -	$ -
63	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
63	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
64	Year 6 - Total Monthly Price from Sch C	$ -	$ -
64	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
64	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
65	Year 6 - Total Monthly Price from Sch C	$ -	$ -
65	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
65	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
66	Year 6 - Total Monthly Price from Sch C	$ -	$ -
66	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
66	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
67	Year 6 - Total Monthly Price from Sch C	$ -	$ -
67	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
67	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
68	Year 6 - Total Monthly Price from Sch C	$ -	$ -
68	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
68	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
69	Year 6 - Total Monthly Price from Sch C	$ -	$ -
69	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
69	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
70	Year 6 - Total Monthly Price from Sch C	$ -	$ -
70	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
70	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
71	Year 6 - Total Monthly Price from Sch C	$ -	$ -
71	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
71	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
72	Year 6 - Total Monthly Price from Sch C	$ -	$ -
72	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
72	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
73	Year 7 - Total Monthly Price from Sch C	$ -	$ -
73	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
73	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
74	Year 7 - Total Monthly Price from Sch C	$ -	$ -
74	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
74	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
75	Year 7 - Total Monthly Price from Sch C	$ -	$ -
75	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
75	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
76	Year 7 - Total Monthly Price from Sch C	$ -	$ -
76	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
76	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
77	Year 7 - Total Monthly Price from Sch C	$ -	$ -
77	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
77	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
78	Year 7 -Total Monthly Price from Sch C	$ -	$ -
78	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
78	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
79	Year 7 - Total Monthly Price from Sch C	$ -	$ -
79	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
79	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
80	Year 7 - Total Monthly Price from Sch C	$ -	$ -
80	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
80	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
81	Year 7 - Total Monthly Price from Sch C	$ -	$ -
81	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
81	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
82	Year 7 - Total Monthly Price from Sch C	$ -	$ -
82	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
82	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
83	Year 7 - Total Monthly Price from Sch C	$ -	$ -
83	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
83	Year 7 -Extra Contractual Services Sch D-1	$ -	$ -
84	Year 7 - Total Monthly Price from Sch C	$ -	$ -
84	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
84	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
	TOTAL EVALUATED PRICE		**$ 15,000,000.00**
	TOTAL FIRM AND FIXED CONTRACT PRICE	**$ 15,000,000.00**	

Note: Do not make entry in shaded area.

Signature:_____ Date:_____

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Project Approach and Scheduling Phase Deliverables	Project Plans		$ -	
	Project Organization and Staffing Plan	$ -		
	Risk Management Plan	$ -		
	Communication Plan	$ -		
	Disaster Recovery/Business Continuity Plan	$ -		
	Quality Management Plan	$ -		
	Security Plan	$ -		
	Detailed Implementation Schedule	$ -	$ -	
	Project Kick-off		$ -	
	Project Charter	$ -		
	Project Kick-off Meeting	$ -		
	Project Orientation Meeting	$ -		
	Vendor Tool Training Schedule & Material	$ -		
	Configuration Management Plan	$ -	$ -	
	Issue/Defect/Change Management Plan(s)	$ -	$ -	
	Deliverable Definition Templates	$ -	$ -	
	Project Status Reports	$ -	$ -	
	System Stand-up Approach Document	$ -	$ -	
	Acquition of Facility Space	$ -	$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Establishment of Gateway to Agency	$ -	$ -	
Total Fixed *Price of all SSUI Approach and Scheduling Deliverables (Enter amount in Schedule A, Month 1, Sch-B Price)				$ -
SSUI Transition Plan Phase Deliverables				
	Enterprise Transition Plan		$ -	
	System Interface Transition Plan	$ -		
	Ancillary Transition Plan	$ -		
	Call Center and Operations Transition Plan	$ -		
	Master Test Plan	$ -	$ -	
	Vendor Tool Training	$ -	$ -	
	Hardware and Connectivity	$ -	$ -	
	Agency Space at Facility	$ -	$ -	
	Requirements Traceability Matrix	$ -	$ -	
Total Fixed *Price of all SSUI Transition Plan Deliverables (Enter amount in Schedule A, Month 3, Sch-B Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Transition Design Phase Deliverables	System Support Design Documents		$ -	
	System Interface Document	$ -		
	Data Conversion Document	$ -		
	Software Conversion Plan	$ -		
	System Backup and Storage Plan	$ -		
	Call Center and Operations Design Documents		$ -	
	Call Center Document	$ -		
	Support and Operations Document	$ -		
	UAT Training Plan	$ -	$ -	
	Summary of Transition Changes Report	$ -	$ -	
Total Fixed *Price of all SSUI Design Deliverables (Enter amount in Schedule A, Month 5, Sch-B Price)				$ -
SSUI Transition Construction Phase Deliverables				
	Construction		$ -	
	Peer Reviews and Walk-through documents	$ -		
	Unit and Subsystem Test Results	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	SSUIP Implementation Plan	$ -	$ -	
	Draft Manuals and documentation		$ -	
	System Documentation	$ -		
	Data Model/Tables Manual	$ -		
	Data Element Dictionary	$ -		
	Hardware Configuration	$ -		
	Operating Procedures	$ -		
	Updated Provider Billing Manual	$ -		
	MMIS User Documentation	$ -		
	Draft Manuals and documentation	$ -	$ -	
	Training Plans	$ -	$ -	
	UAT Training	$ -	$ -	
	Mock Data Conversion	$ -	$ -	
	Test Plans	$ -	$ -	
	Call Center and Operations Process and Procedures	$ -	$ -	
	Vendor Certification in writing that the MMIS is ready for the test phase	$ -	$ -	
Total Fixed *Price of all SSUI Construction Deliverables (Enter amount in Schedule A, Month 7, Sch-B) Price)				$ -

	State of Alabama Medicaid Management Information System SCHEDULE B To be completed by Vendor			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Transition Test Phase Deliverables				
	System Test Results	$ -	$ -	
	Parallel Test Results	$ -	$ -	
	User Acceptance Test Support	$ -	$ -	
	Regression Test Results	$ -	$ -	
	Stress Test Results	$ -	$ -	
	Vendor Certification that the AMMIS is fully functional	$ -	$ -	
Total Fixed *Price of all SSUI Test Phase Deliverables (Enter amount in Schedule A, Month 10, Sch-B Price)				$ -
SSUI Transition Implementation Phase Deliverables				
	Final Preparations for going production		$ -	
	Production MMIS meeting all requirements defined in Section 3 - Requirements			
	Conduct final Data conversion	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Prepare and deliver notice to providers/vendors concerning transition activities	$ -		
	Conduct Provider Training	$ -		
	Conduct training for Vendor and Agency Staff	$ -		
	Distribute Alabama unique forms	$ -		
	Deliver all user, system and provider manuals and documentation	$ -		
	Final Version of all Deliverables, documentation and manuals	$ -		
	Conduct Call Center and Support Training	$ -		
	Ensure the AMMIS has the most current version of software and data	$ -		
	Completion of all activities in the training and implementation plans	$ -		
	Installation of the Manuals and Documentation System Operations Procedures on-line or on the web.	$ -		
	Begin Production Processing		$ -	
	Control and Store Transition-period claims	$ -		
	Begin Processing Claims for all claim types	$ -		
	Post Implementation Deliverables		$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Approval of AMMIS financial data and claims inventory balancing procedures	$ -		
	Approval that all claims types are processing at expected volumes and within the required time frames	$ -		
	Approval that all reports are being delivered as required	$ -		
Total Fixed *Price of all SSUI Implementation Phase Deliverables (Enter amount in Schedule A, Month 11, Sch-B Price)				$ -
Grand Total Fixed Price for SSUI and Enhancement Implementation Phase				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
* The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire System Stand-up Implementation Phase*				
	Signature:_____	Date:_____		

State of Alabama
Medicaid Management Information System
Pricing Schedule C
Operations Cost
Pricing Schedule C - To be completed by Vendor

Item	Year 2 Monthly Costs (Amounts from Line 8 and Line 19 for Year 2 are entered on Sch. A, Months 13-24, Sch-C Price)	Year 3 Monthly Costs (Amounts from Line 8 and Line 19 for Year 3 are entered on Sch. A, Months 25-36, Sch-C Price)	Year 4 Monthly Costs (Amounts from Line 8 and Line 19 for Year 4 are entered on Sch. A, Months 37-48, Sch-C Price)	Year 5 Monthly Costs (Amounts from Line 8 and Line 19 for Year 5 are entered on Sch. A, Months 49-60, Sch-C Price)	Year 6 Monthly Costs (Amounts from Line 8 and Line 19 for Year 6 are entered onSch. A, Months 61-72, Sch-C Price)	Year 7 Monthly Costs (Amounts from Line 8 and Line 19 for Year 7 are entered on Sch. A, Months 73-84, Sch-C Price)
Base Price Per Month **Total Monthly Price**	$ -	$ -	$ -	$ -	$ -	$ -
Maintenance and Modification Hours	$ -	$ -	$ -	$ -	$ -	$ -
Core System - FFS & Encounter Claims, reference, financial, Recipient Accounts Receivable, EPSDT, Electronic Data Interface (translator), supporting data and data extracts	$ -	$ -	$ -	$ -	$ -	$ -
Provider	$ -	$ -	$ -	$ -	$ -	$ -
Recipient	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefits Management	$ -	$ -	$ -	$ -	$ -	$ -
Medical Services	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Liability	$ -	$ -	$ -	$ -	$ -	$ -
Decision Support System (Data Warehouse)	$ -	$ -	$ -	$ -	$ -	$ -
Document Management and Workflow system	$ -	$ -	$ -	$ -	$ -	$ -
Managed Care	$ -	$ -	$ -	$ -	$ -	$ -
Dental Benefits Management	$ -	$ -	$ -	$ -	$ -	$ -
Pass-through Price-per-Month*	$ 208,334.00	$ 208,334.00	$ 208,333.00	$ 208,333.00	$ 208,333.00	$ 208,333.00

* The Vendor shall be compensated for pass-through expenses in accordance with Section 4.21.4 Pass-through Expenses.

Signature:_____ Date:_____

State of Alabama
Medicaid Management Information System

Pricing Schedule D
Summary Extra Contractural Services

Year 1 From Pricing Schedule D-2	$ -	Box 1
Average Monthly Cost (Divide Amount in Box 1 by 12)	$ -	Box 2
Enter Amount from Box 2 to Schedule A, Months 1-12		
Year 2 From Pricing Schedule D-3	$ -	Box 3
Average Monthly Cost (Divide Amount in Box 3 by 12)	$ -	Box 4
Enter Amount from Box 4 to Schedule A, Months 13-24		
Year 3 From Pricing Schedule D-4	$ -	Box 5
Average Monthly Cost (Divide Amount in Box 5 by 12)	$ -	Box 6
Enter Amount from Box 6 to Schedule A, Months 25-36		
Year 4 From Pricing Schedule D-5	$ -	Box 7
Average Monthly Cost (Divide Amount in Box 7 by 12)	$ -	Box 8
Enter Amount from Box 8 to Schedule A, Months 37-48		
Year 5 From Pricing Schedule D-6	$ -	Box 9
Average Monthly Cost (Divide Amount in Box 9 by 12)	$ -	Box 10
Enter Amount from Box 10 to Schedule A, Months 49-60		
Year 6 From Pricing Schedule D-7	$ -	Box 11
Average Monthly Cost (Divide Amount in Box 11 by 12)	$ -	Box 12
Enter Amount from Box 12 to Schedule A, Months 61-72		
Year 7 From Pricing Schedule D-8	$ -	Box 13
Average Monthly Cost (Divide Amount in Box 13 by 12)	$ -	Box 14
Enter Amount from Box 14 to Schedule A, Months 73-84		
TOTAL EXTRA CONTRACTURAL SERVICES COSTS (Informational Only) (Sum of Boxes 1, 3, 5, 7, 9,11, and 13)	$ -	

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-2
Extra Contractual Services - Contract Year 1

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 1.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-3
Extra Contractual Services - Contract Year 2

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 3.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-4
Extra Contractual Services - Contract Year 3

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 5.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-5
Extra Contractual Services - Contract Year 4

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 7.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-6
Extra Contractual Services - Contract Year 5

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 9.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-7
Extra Contractual Services - Contract Year 6

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 11.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-8
Extra Contractual Services - Contract Year 7

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 13.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
1	System Stand-up Implementation (SSUI) Project Approach and Scheduling Phase Sch B	$ -	$ -
1	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
2			
2	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
3	SSUI Transition Plan Phase Sch B	$ -	$ -
3	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
4			
4	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
5	SSUI Transition Design Phase Sch B	$ -	$ -
5	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
6			
6	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
7	SSUI Transition Construction Phase Sch B	$ -	$ -
7	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
8			
8	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
9			
9	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
10	SSUI Transition Testing Phase Sch B-N	$ -	$ -
10	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
11	SSUI Transition Implementation Phase Deliverables Sch B	$ -	$ -
11	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
12			
12	Year 1 - Extra Contractual Services Sch D-1	$ -	$ -
13	Year 2 - Total Monthly Price from Sch C	$ -	$ -
13	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
13	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
14	Year 2 - Total Monthly Price from Sch C	$ -	$ -
14	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
14	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
15	Year 2 - Total Monthly Price from Sch C	$ -	$ -
15	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
15	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
16	Year 2 - Total Monthly Price from Sch C	$ -	$ -
16	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
16	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
17	Year 2 - Total Monthly Price from Sch C	$ -	$ -
17	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
17	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
18	Year 2 - Total Monthly Price from Sch C	$ -	$ -
18	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
18	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
19	Year 2 - Total Monthly Price from Sch C	$ -	$ -
19	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
19	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
20	Year 2 - Total Monthly Price from Sch C	$ -	$ -
20	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
20	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
21	Year 2 - Total Monthly Price from Sch C	$ -	$ -
21	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
21	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
22	Year 2 - Total Monthly Price from Sch C	$ -	$ -
22	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
22	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
23	Year 2 - Total Monthly Price from Sch C	$ -	$ -
23	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
23	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
24	Year 2 - Total Monthly Price from Sch C	$ -	$ -
24	Year 2 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
24	Year 2 - Extra Contractual Services Sch D-1	$ -	$ -
25	Year 3 - Total Monthly Price from Sch C	$ -	$ -
25	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
25	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
26	Year 3 -Total Monthly Price from Sch C	$ -	$ -
26	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
26	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
27	Year 3 - Total Monthly Price from Sch C	$ -	$ -
27	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
27	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
28	Year 3 - Total Monthly Price from Sch C	$ -	$ -
28	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
28	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
29	Year 3 - Total Monthly Price from Sch C	$ -	$ -
29	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
29	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
30	Year 3 - Total Monthly Price from Sch C	$ -	$ -
30	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
30	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
31	Year 3 - Total Monthly Price from Sch C	$ -	$ -
31	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
31	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
32	Year 3 -Total Monthly Price from Sch C	$ -	$ -
32	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
32	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
33	Year 3 - Total Monthly Price from Sch C	$ -	$ -
33	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
33	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
34	Year 3 - Total Monthly Price from Sch C	$ -	$ -
34	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
34	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
35	Year 3 - Total Monthly Price from Sch C	$ -	$ -
35	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
35	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
36	Year 3 - Total Monthly Price from Sch C	$ -	$ -
36	Year 3 - Pass-through Price-per-Month Sch C	$ 208,334.00	$ 208,334.00
36	Year 3 - Extra Contractual Services Sch D-1	$ -	$ -
37	Year 4 - Total Monthly Price from Sch C	$ -	$ -
37	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
37	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
38	Year 4 - Total Monthly Price from Sch C	$ -	$ -
38	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
38	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
39	Year 4 - Total Monthly Price from Sch C	$ -	$ -
39	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
39	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
40	Year 4 - Total Monthly Price from Sch C	$ -	$ -
40	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
40	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
41	Year 4 - Total Monthly Price from Sch C	$ -	$ -
41	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
41	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
42	Year 4 - Total Monthly Price from Sch C	$ -	$ -
42	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
42	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
43	Year 4 - Total Monthly Price from Sch C	$ -	$ -
43	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
43	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
44	Year 4 - Total Monthly Price from Sch C	$ -	$ -
44	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
44	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
45	Year 4 - Total Monthly Price from Sch C	$ -	$ -
45	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
45	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
46	Year 4 - Total Monthly Price from Sch C	$ -	$ -
46	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
46	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
47	Year 4 - Total Monthly Price from Sch C	$ -	$ -
47	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
47	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
48	Year 4 - Total Monthly Price from Sch C	$ -	$ -
48	Year 4 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
48	Year 4 - Extra Contractual Services Sch D-1	$ -	$ -
49	Year 5 - Total Monthly Price from Sch C	$ -	$ -
49	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
49	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
50	Year 5 - Total Monthly Price from Sch C	$ -	$ -
50	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
50	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
51	Year 5 - Total Monthly Price from Sch C	$ -	$ -
51	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
51	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
52	Year 5 - Total Monthly Price from Sch C	$ -	$ -
52	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
52	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
53	Year 5 - Total Monthly Price from Sch C	$ -	$ -
53	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
53	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
54	Year 5 - Total Monthly Price from Sch C	$ -	$ -
54	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
54	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
55	Year 5 - Total Monthly Price from Sch C	$ -	$ -
55	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
55	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
56	Year 5 - Total Monthly Price from Sch C	$ -	$ -
56	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
56	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
57	Year 5 - Total Monthly Price from Sch C	$ -	$ -
57	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
57	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
58	Year 5 - Total Monthly Price from Sch C	$ -	$ -
58	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
58	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
59	Year 5 - Total Monthly Price from Sch C	$ -	$ -
59	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
59	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
60	Year 5 - Total Monthly Price from Sch C	$ -	$ -
60	Year 5 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
60	Year 5 - Extra Contractual Services Sch D-1	$ -	$ -
61	Year 6 - Total Monthly Price from Sch C	$ -	$ -
61	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
61	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
62	Year 6 - Total Monthly Price from Sch C	$ -	$ -
62	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
62	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
63	Year 6 - Total Monthly Price from Sch C	$ -	$ -
63	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
63	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
64	Year 6 - Total Monthly Price from Sch C	$ -	$ -
64	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
64	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
65	Year 6 - Total Monthly Price from Sch C	$ -	$ -
65	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
65	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
66	Year 6 - Total Monthly Price from Sch C	$ -	$ -
66	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
66	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
67	Year 6 - Total Monthly Price from Sch C	$ -	$ -
67	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
67	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
68	Year 6 - Total Monthly Price from Sch C	$ -	$ -
68	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
68	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
69	Year 6 - Total Monthly Price from Sch C	$ -	$ -
69	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
69	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
70	Year 6 - Total Monthly Price from Sch C	$ -	$ -
70	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
70	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
71	Year 6 - Total Monthly Price from Sch C	$ -	$ -
71	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
71	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
72	Year 6 - Total Monthly Price from Sch C	$ -	$ -
72	Year 6 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
72	Year 6 - Extra Contractual Services Sch D-1	$ -	$ -
73	Year 7 - Total Monthly Price from Sch C	$ -	$ -
73	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
73	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
74	Year 7 - Total Monthly Price from Sch C	$ -	$ -
74	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
74	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
75	Year 7 - Total Monthly Price from Sch C	$ -	$ -
75	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
75	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
76	Year 7 - Total Monthly Price from Sch C	$ -	$ -
76	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
76	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
77	Year 7 - Total Monthly Price from Sch C	$ -	$ -
77	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
77	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
78	Year 7 -Total Monthly Price from Sch C	$ -	$ -
78	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
78	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
79	Year 7 - Total Monthly Price from Sch C	$ -	$ -
79	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
79	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
80	Year 7 - Total Monthly Price from Sch C	$ -	$ -
80	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
80	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
81	Year 7 - Total Monthly Price from Sch C	$ -	$ -
81	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
81	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
82	Year 7 - Total Monthly Price from Sch C	$ -	$ -
82	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
82	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
83	Year 7 - Total Monthly Price from Sch C	$ -	$ -
83	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00
83	Year 7 -Extra Contractual Services Sch D-1	$ -	$ -
84	Year 7 - Total Monthly Price from Sch C	$ -	$ -
84	Year 7 - Pass-through Price-per-Month Sch C	$ 208,333.00	$ 208,333.00

State of Alabama

Medicaid Management Information System

Pricing Schedule A

Vendor Evaluated Price

Month	Contract Item	Price	Evaluated Price
84	Year 7 - Extra Contractual Services Sch D-1	$ -	$ -
	TOTAL EVALUATED PRICE		**$ 15,000,000.00**
	TOTAL FIRM AND FIXED CONTRACT PRICE	**$ 15,000,000.00**	

Note: Do not make entry in shaded area.

Signature:_____ Date:_____

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Project Approach and Scheduling Phase Deliverables	Project Plans		$ -	
	Project Organization and Staffing Plan	$ -		
	Risk Management Plan	$ -		
	Communication Plan	$ -		
	Disaster Recovery/Business Continuity Plan	$ -		
	Quality Management Plan	$ -		
	Security Plan	$ -		
	Detailed Implementation Schedule	$ -	$ -	
	Project Kick-off		$ -	
	Project Charter	$ -		
	Project Kick-off Meeting	$ -		
	Project Orientation Meeting	$ -		
	Vendor Tool Training Schedule & Material	$ -		
	Configuration Management Plan	$ -	$ -	
	Issue/Defect/Change Management Plan(s)	$ -	$ -	
	Deliverable Definition Templates	$ -	$ -	
	Project Status Reports	$ -	$ -	
	System Stand-up Approach Document	$ -	$ -	
	Acquition of Facility Space	$ -	$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Establishment of Gateway to Agency	$ -	$ -	
Total Fixed *Price of all SSUI Approach and Scheduling Deliverables (Enter amount in Schedule A, Month 1, Sch-B Price)				$ -
SSUI Transition Plan Phase Deliverables				
	Enterprise Transition Plan		$ -	
	System Interface Transition Plan	$ -		
	Ancillary Transition Plan	$ -		
	Call Center and Operations Transition Plan	$ -		
	Master Test Plan	$ -	$ -	
	Vendor Tool Training	$ -	$ -	
	Hardware and Connectivity	$ -	$ -	
	Agency Space at Facility	$ -	$ -	
	Requirements Traceability Matrix	$ -	$ -	
Total Fixed *Price of all SSUI Transition Plan Deliverables (Enter amount in Schedule A, Month 3, Sch-B Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Transition Design Phase Deliverables	System Support Design Documents		$ -	
	System Interface Document	$ -		
	Data Conversion Document	$ -		
	Software Conversion Plan	$ -		
	System Backup and Storage Plan	$ -		
	Call Center and Operations Design Documents		$ -	
	Call Center Document	$ -		
	Support and Operations Document	$ -		
	UAT Training Plan	$ -	$ -	
	Summary of Transition Changes Report	$ -	$ -	
Total Fixed *Price of all SSUI Design Deliverables (Enter amount in Schedule A, Month 5, Sch-B Price)				$ -
SSUI Transition Construction Phase Deliverables				
	Construction		$ -	
	Peer Reviews and Walk-through documents	$ -		
	Unit and Subsystem Test Results	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	SSUIP Implementation Plan	$ -	$ -	
	Draft Manuals and documentation		$ -	
	System Documentation	$ -		
	Data Model/Tables Manual	$ -		
	Data Element Dictionary	$ -		
	Hardware Configuration	$ -		
	Operating Procedures	$ -		
	Updated Provider Billing Manual	$ -		
	MMIS User Documentation	$ -		
	Draft Manuals and documentation	$ -	$ -	
	Training Plans	$ -	$ -	
	UAT Training	$ -	$ -	
	Mock Data Conversion	$ -	$ -	
	Test Plans	$ -	$ -	
	Call Center and Operations Process and Procedures	$ -	$ -	
	Vendor Certification in writing that the MMIS is ready for the test phase	$ -	$ -	
Total Fixed *Price of all SSUI Construction Deliverables (Enter amount in Schedule A, Month 7, Sch-B) Price)				$ -

	State of Alabama Medicaid Management Information System SCHEDULE B To be completed by Vendor			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
SSUI Transition Test Phase Deliverables				
	System Test Results	$ -	$ -	
	Parallel Test Results	$ -	$ -	
	User Acceptance Test Support	$ -	$ -	
	Regression Test Results	$ -	$ -	
	Stress Test Results	$ -	$ -	
	Vendor Certification that the AMMIS is fully functional	$ -	$ -	
Total Fixed *Price of all SSUI Test Phase Deliverables (Enter amount in Schedule A, Month 10, Sch-B Price)				$ -
SSUI Transition Implementation Phase Deliverables				
	Final Preparations for going production		$ -	
	Production MMIS meeting all requirements defined in Section 3 - Requirements			
	Conduct final Data conversion	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Prepare and deliver notice to providers/vendors concerning transition activities	$ -		
	Conduct Provider Training	$ -		
	Conduct training for Vendor and Agency Staff	$ -		
	Distribute Alabama unique forms	$ -		
	Deliver all user, system and provider manuals and documentation	$ -		
	Final Version of all Deliverables, documentation and manuals	$ -		
	Conduct Call Center and Support Training	$ -		
	Ensure the AMMIS has the most current version of software and data	$ -		
	Completion of all activities in the training and implementation plans	$ -		
	Installation of the Manuals and Documentation System Operations Procedures on-line or on the web.	$ -		
	Begin Production Processing		$ -	
	Control and Store Transition-period claims	$ -		
	Begin Processing Claims for all claim types	$ -		
	Post Implementation Deliverables		$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Approval of AMMIS financial data and claims inventory balancing procedures	$ -		
	Approval that all claims types are processing at expected volumes and within the required time frames	$ -		
	Approval that all reports are being delivered as required	$ -		
Total Fixed *Price of all SSUI Implementation Phase Deliverables (Enter amount in Schedule A, Month 11, Sch-B Price)				$ -
Grand Total Fixed Price for SSUI and Enhancement Implementation Phase				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B** **To be completed by Vendor**			
	SYSTEM STAND-UP IMPLEMENTATION (SSUI) PHASE DELIVERABLES			
SSUI PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
* The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire System Stand-up Implementation Phase*				
	Signature:_____	Date:_____		

State of Alabama
Medicaid Management Information System
Pricing Schedule C
Operations Cost
Pricing Schedule C - To be completed by Vendor

Item	Year 2 Monthly Costs (Amounts from Line 8 and Line 19 for Year 2 are entered on Sch. A, Months 13-24, Sch-C Price)	Year 3 Monthly Costs (Amounts from Line 8 and Line 19 for Year 3 are entered on Sch. A, Months 25-36, Sch-C Price)	Year 4 Monthly Costs (Amounts from Line 8 and Line 19 for Year 4 are entered on Sch. A, Months 37-48, Sch-C Price)	Year 5 Monthly Costs (Amounts from Line 8 and Line 19 for Year 5 are entered on Sch. A, Months 49-60, Sch-C Price)	Year 6 Monthly Costs (Amounts from Line 8 and Line 19 for Year 6 are entered onSch. A, Months 61-72, Sch-C Price)	Year 7 Monthly Costs (Amounts from Line 8 and Line 19 for Year 7 are entered on Sch. A, Months 73-84, Sch-C Price)
Base Price Per Month **Total Monthly Price**	$ -	$ -	$ -	$ -	$ -	$ -
Maintenance and Modification Hours	$ -	$ -	$ -	$ -	$ -	$ -
Core System - FFS & Encounter Claims, reference, financial, Recipient Accounts Receivable, EPSDT, Electronic Data Interface (translator), supporting data and data extracts	$ -	$ -	$ -	$ -	$ -	$ -
Provider	$ -	$ -	$ -	$ -	$ -	$ -
Recipient	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy Benefits Management	$ -	$ -	$ -	$ -	$ -	$ -
Medical Services	$ -	$ -	$ -	$ -	$ -	$ -
Third Party Liability	$ -	$ -	$ -	$ -	$ -	$ -
Decision Support System (Data Warehouse)	$ -	$ -	$ -	$ -	$ -	$ -
Document Management and Workflow system	$ -	$ -	$ -	$ -	$ -	$ -
Managed Care	$ -	$ -	$ -	$ -	$ -	$ -
Dental Benefits Management	$ -	$ -	$ -	$ -	$ -	$ -
Pass-through Price-per-Month*	$ 208,334.00	$ 208,334.00	$ 208,333.00	$ 208,333.00	$ 208,333.00	$ 208,333.00

* The Vendor shall be compensated for pass-through expenses in accordance with Section 4.21.4 Pass-through Expenses.

Signature:_____ Date:_____

State of Alabama
Medicaid Management Information System

Pricing Schedule D
Summary Extra Contractural Services

Year 1 From Pricing Schedule D-2	$ -	Box 1
Average Monthly Cost (Divide Amount in Box 1 by 12)	$ -	Box 2
Enter Amount from Box 2 to Schedule A, Months 1-12		
Year 2 From Pricing Schedule D-3	$ -	Box 3
Average Monthly Cost (Divide Amount in Box 3 by 12)	$ -	Box 4
Enter Amount from Box 4 to Schedule A, Months 13-24		
Year 3 From Pricing Schedule D-4	$ -	Box 5
Average Monthly Cost (Divide Amount in Box 5 by 12)	$ -	Box 6
Enter Amount from Box 6 to Schedule A, Months 25-36		
Year 4 From Pricing Schedule D-5	$ -	Box 7
Average Monthly Cost (Divide Amount in Box 7 by 12)	$ -	Box 8
Enter Amount from Box 8 to Schedule A, Months 37-48		
Year 5 From Pricing Schedule D-6	$ -	Box 9
Average Monthly Cost (Divide Amount in Box 9 by 12)	$ -	Box 10
Enter Amount from Box 10 to Schedule A, Months 49-60		
Year 6 From Pricing Schedule D-7	$ -	Box 11
Average Monthly Cost (Divide Amount in Box 11 by 12)	$ -	Box 12
Enter Amount from Box 12 to Schedule A, Months 61-72		
Year 7 From Pricing Schedule D-8	$ -	Box 13
Average Monthly Cost (Divide Amount in Box 13 by 12)	$ -	Box 14
Enter Amount from Box 14 to Schedule A, Months 73-84		
TOTAL EXTRA CONTRACTURAL SERVICES COSTS (Informational Only) (Sum of Boxes 1, 3, 5, 7, 9,11, and 13)	$ -	

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-2
Extra Contractual Services - Contract Year 1

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 1.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-3
Extra Contractual Services - Contract Year 2

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 3.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-4
Extra Contractual Services - Contract Year 3

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 5.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-5
Extra Contractual Services - Contract Year 4

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 7.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-6
Extra Contractual Services - Contract Year 5

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 9.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-7
Extra Contractual Services - Contract Year 6

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 11.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-8
Extra Contractual Services - Contract Year 7

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	$ -

Enter on Sch-D-1, Box 13.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

Appendix L - Business Experience Matrix

Bidder's Name:								
Project Name	Client Information (name, address, fax, phone and email)	Client Contact Information (name, address, fax, phone and email)	MMIS	Summary	Original Start Date	Actual Start Date	Original End Date	Actual End Date

Appendix L - Business Experience Matrix

Bidder's Name:						
Project Name	Original Scope and On Budget	Litigation	Contract Changes or Amendments	If the project was not on schedule at the time of contract changes or amendments, how far behind was the project?	Prime or Subcontrator	Other Information

Alabama Medicaid Quick Reference Guide

Verifying Eligibility

You can verify eligibility by any of the following methods:

1. Provider Electronic Solutions (PES)

- ❑ PC Software available from DXC at no charge
- ❑ IBM or IBM compatible PC required
- ❑ On-line real time environment ❑ The software can be downloaded at **www.medicaid.alabama.gov** or by calling **1-800-456-1242**

2. Point of Service

- ❑ Credit card terminals and receipt printers can be purchased from various companies

3. Provider Assistance Center 1-800-688-7989

- ❑ All of Alabama and within a 30 mile radius of Alabama
- ❑ Hours of Operation 8:00 A.M. – 5:00 P.M. (CST)
- ❑ Primary function of DXC Provider Relations Representatives is to assist providers with billing issues

4. Automated Voice Response System 1-800-727-7848

Touch-tone telephone 32 lines

7 days a week 21 hours a day

FAX-back

Keypad codes for letter entry:				
A - *21	G - *41	M - *61	S - *73	Y - *93
B - *22	H - *42	N - *62	T - *81	Z - *12
C - *23	I - *43	O - *63	U - *82	
D - *31	J - *51	P - *71	V- *83	
E - *32	K - *52	Q - *11	W - *91	
F - *33	L - *53	R - *72	X - *92	

AVRS "Quick Guide"
1-800-727-7848

Press 1 Check Amounts
- Press **1** To repeat the message
- Press **2** Another Provider/NPI Number

Press 2 Claim Status
- Press **1** For Pharmacy claims
- Press **2** For non-Medicare claims
- Press **3** For Medicare-related claims
  - Press **1** To repeat the message
  - Press **2** To check another claim for same recipient
  - Press **3** To check a claim for another recipient
  - Press **4** Another Provider/NPI Number

Press 3 Eligibility, Benefits, or Other Insurance
- Press **1** To receive a FAX only response
- Press **2** To receive a voice only response
- Press **3** To receive both FAX and voice response
  - Press **1** Eligibility
  - Press **2** Benefit Limits
  - Press **3** Other Insurance
    - Press **1** To repeat message
    - Press **2** To continue
      - Press **1** To check eligibility, benefits, or other insurance for same recipient
      - Press **2** Another recipient
      - Press **3** Another Provider/NPI Number

Press 4 Drug Pricing/NDC Information
- Press **1** To repeat message
- Press **2** Another Provider number
- Press **3** Another NDC for same provider
- Press **4** To verify prior authorization number

Press 5 Procedure Code Pricing Information
- Press **1** To repeat message
- Press **2** To check another procedure code for same provider
- Press **3** Another modifier for same procedure
- Press **4** Another Provider/NPI Number

Press 6 Prior Authorization Number Verification
- Press **1** To enter NDC
- Press **2** To enter procedure

Press **9** To return to the main menu

Press 7 Recipient Household Information
- Press **1** To receive a FAX only response
- Press **2** To receive a voice only response
- Press **3** To receive both FAX and voice response
  - Press **1** To repeat this information
  - Press **2** To enter another Provider/NPI Number
  - Press **3** Another Recipient Number
  - Press **4** Another Date of Birth for same parent/guardian

Press 0 Provider Assistance Center
Press * Main Menu Function
Press # To signal the end of requested data

Important Telephone Numbers for Alabama Medicaid Agency

Long Term Care

Provider Management 1-800-688-7989

Recipient Management.....1-800-362-1504

- Home and Community Based Waiver Services
- Home Health Services
- Hospice Services
- Nursing Home Care
- Private Duty Nursing (children under 21 only)
- Targeted Case Management
- Therapies, in home (children under 21 only)
- Technology Assisted Waiver for Adults

Medical Services

Provider Help Line.....1-800-688-7989
Provider/Recipient Help Line.....1-800-362-1504
Recipient Help Line FAX 334-215-4140

- Ambulance Services
- Ambulatory Surgical Centers
- Dental Program
- EPSDT (Early and Periodic Screening, Diagnosis and Treatment/Well-Child Health Checkups)
- Eye Care
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers
- Hearing Services
- Hospital Program
- Laboratory Services
- Mental Health Services
- Patient 1st Program
- Pharmacy Program
- Physicians Program
- Radiology Services
- Renal Dialysis
- Rural Health Clinics
- Therapies, not in home
- Transplants
- Transportation, air (children under 21 only)

Other Services

- Managed Care Program 334-242-5630
- Maternity Care Program 800-362-1504
- Medicare Complete 334-242-5268
- Prenatal Education 334-353-4322
- Plan First 887-737-2083
- **FAX 334-353-9356**

Suggestions or information you would like to have included in future Quick Reference Guides are welcomed. Please FAX your suggestions to 334-353-4193.

Revised 12/10/2018

Prior Authorization/Providers 1-800-688-7989
Prior Authorization/Recipients.....1-800-362-1504

- Durable Medical Equipment
- Eye care
- Home Health, additional visits (children under 21 only)
- Inpatient psychiatric admissions (children under 21 only)
- Private Duty Nursing (children under 21 only)
- Therapies, in home (children under 21 only)
- Ambulance (ground); Ambulance (air)

Prior Authorization

- Cardiology
- Dental Services (children under 21 only).....334-215-4144
- Pharmacy (HID).....1-800-748-0130

FAX 1-800-748-0116

- Radiology Services (MRI, CT, PET)

EviCore (MedSolutions) 1-888-693-3211
FAX 1-888-693-3210

Third Party Division

- To report new or cancelled health insurance:

Patient's last name begins with:

A-H 334-242-5249
I-P.....334-242-5280
Q-Z 334-242-5254

or Medicaid website:
Providers/Benefit Coordination/Third Party/Update Health Insurance Information

- Injury Questionnaires.....1-877-252-8949
- Medical Records.....1-877-252-8949

or Medicaid website:
Providers/Benefit Coordination/Third Party/Release of Information

- Subrogation Recovery.....1-877-252-8949
- Medicare premium payments (buy in).....334-242-5268
  334 353-5773
- Medicare Advantage Plans.....334-242-5257
- Dual Eligibility (Medicare/Medicaid) claim problems
  334-242-5257
- Health Insurance Premium Payment (HIPP Program)
  1-855-692-5447
- Other questions.....334-242-5269

Information/All 334-242-5000
Information/Medicaid recipients & providers regarding policies & procedures &/or administrative claim reviews
1-800-362-1504

Alabama Medicaid Website: http://medicaid.alabama.gov/

Alabama MMIS

Alabama MMIS Change Order/Defect Process

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1. Document Control

The latest version of this document is stored electronically. Any printed copy has to be considered an uncontrolled copy.

1.1 Document Information Page

Required Information	Definition
Document Title	Alabama MMIS Change Order/Defect Process
Location:	https://pwb.alxix.slg.eds.com/alxix/QA/Developer%20Processes/
Owner:	DXC
Author:	[redacted]

1.2 Amendment History

The following Amendment History log contains a record of changes made to this document:

Date	Author	Reason for Change	Changes (Section, Page(s) and Text Revised
11/05/2014	[redacted]	Addition of Documentation Process for Creating AMMIS Manual Entry for a New Panel or Report	Section 8.2.5 added
1/15/2016	[redacted]	Update references to HPES, HP, and HP Enterprise Services to HPE. Changed any references of [redacted] to [redacted] and [redacted].	All sections were updated to reflect the correct company name.
01/31/2017	[redacted]	Added note to section regarding DMRB approval.	Section 7.1
10/03/2017	[redacted]	Added information about new status 'Prod Implementation – Verification Bypassed'. Made additional updates throughout.	Section 7.4.2, number 2.
3/29/2018	[redacted]	Revamped the entire to merge the Batch and UI processes, update HPE to DXC, and to document changes/additions to the process since the last update.	All

1.3 Related documentation

Document	Description	url
Global Glossary	List of commonly used terms and acronyms associated with the Alabama MMIS.	https://pwb.alxix.slg.eds.com/alxix/ProjectPlanALXIX/Alabama%20Glossary%20and%20Acronyms.docx

Document	Description	url
iTRACE	Web-based, shared repository for documentation, change order status, communication, metrics, and process guides. The result is visibility into system changes and processes for the Agency.	https://pwb.alxix.slg.eds.com/alxix/
Alabama Interactive Portal (AIP)	Tool to generate and update Change Orders, Tasks, and Defects.	https://pwb.alxix.slg.eds.com/alxix/ZAIP/utils/PortalDefault.asp
Alabama Specific Processes	Common work processes and procedures to assist developers in performing their jobs.	https://pwb.alxix.slg.eds.com/alxix/QA/Developer%20Processes/
Alabama interChange Standards Document (UI)	User Interface (UI) operational and coding standards guide.	https://pwb.alxix.slg.eds.com/alxix/UI/interChange/Alabama%20UI%20Coding%20Standards.docx
Automated CSR Process	PowerPoint used to show the procedures Agency members and DXC leaders use to submit a CSR.	https://pwb.alxix.slg.eds.com/alxix/QA/Forms/Alabama%20Automated%20CSR%20Process.pptx
Batch – Alabama Exception Promotion Form	Form used by batch developers to request exception promotions of their code to Model Office, ACC, and/or Production outside of the normal release.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/alabama_exception%20promotion_batch.doc
Coverity Instruction Manuals	Coverity allows developers to scan their code with Coverity Static Analysis in order to find software quality issues such as resource leaks and concurrency issues.	Batch - https://pwb.alxix.slg.eds.com/alxix/help/Training/Scanners/AL%20ASQC%20-%20Coverity%20Personal%20Instructions%20-%20C.mht UI - https://pwb.alxix.slg.eds.com/alxix/help/Training/Scanners/AL%20ASQC%20-%20Coverity%20Personal%20Instructions%20-%20CSharp%20(UI).mht
Data Model Change Process	Database Promotion Procedures	https://pwb.alxix.slg.eds.com/ALXIX/help/Training/Development%20Processes/Database%20Promotion%20Procedures.htm
Estimating Excel Spreadsheet	SE/BA Estimating Tool	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/hc%20alxix%20functional%20area%20estimating%20algorithm%20tool.xlsm
Implementation Plan	Implementation steps to be taken as part of the promotion process.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/implementation%20plan.mht
Release Coordinator Instructions	Instructions utilized by release coordinators when promoting code.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/mo%20release%20procedure%20checklist.mht
Subsystem Impact Form	List of impacted subsystems associated with a CSR.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/subsystem%20impact%20form.mht
Walkthrough Form	Checklist of items that must be performed before a CO/Defect can be promoted.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/walkthrough%20form%20template.mht

Document	Description	url
UI – Alabama Exception Promotion Form	Form used by UI developers to request exception promotions of their code to Model Office, ACC, and/or Production outside of the normal release.	https://pwb.alxix.slg.eds.com/ALXIX/QA/Forms/alabama%20ui%20exception%20promotion%20form.docx

2. Definition Phase

There are four ways a system change is identified in the AMMIS:

1. **Agency Identified Change** – Customer Service Request (CSR) initiated by the Alabama Medicaid Agency (Agency) in order to add new functionality or change the criteria of existing functionality within the Alabama Medicaid Management Information System (AMMIS). Work associated with an Agency Identified Change is normally billable.
2. **DXC Identified and Agency Approved Change** – Customer Service Request (CSR) initiated by DXC and approved as billable by the Agency's MMIS office in order to add new or enhance existing functionality within the AMMIS. Work associated with a DXC Identified and Agency Approved Change is billable.
3. **DXC Identified Change** – Change Orders (COs) or Tasks initiated by DXC in order to improve system performance or maintenance. These COs primarily benefit DXC staff and are not billable.
4. **Defects** – Deficiencies identified by DXC or the Agency to correct problems with existing, agreed upon functionality. Defects are not billable.

2.1 Agency Identified Change

Customer Service Request (CSR) initiated by the Alabama Medicaid Agency (Agency) in order to add new functionality or change the criteria of existing functionality within the Alabama Medicaid Management Information System (AMMIS).

See Alabama Automated CSR Process PowerPoint presentation for Agency process.

CSR sent to DXC as a Mother CO:

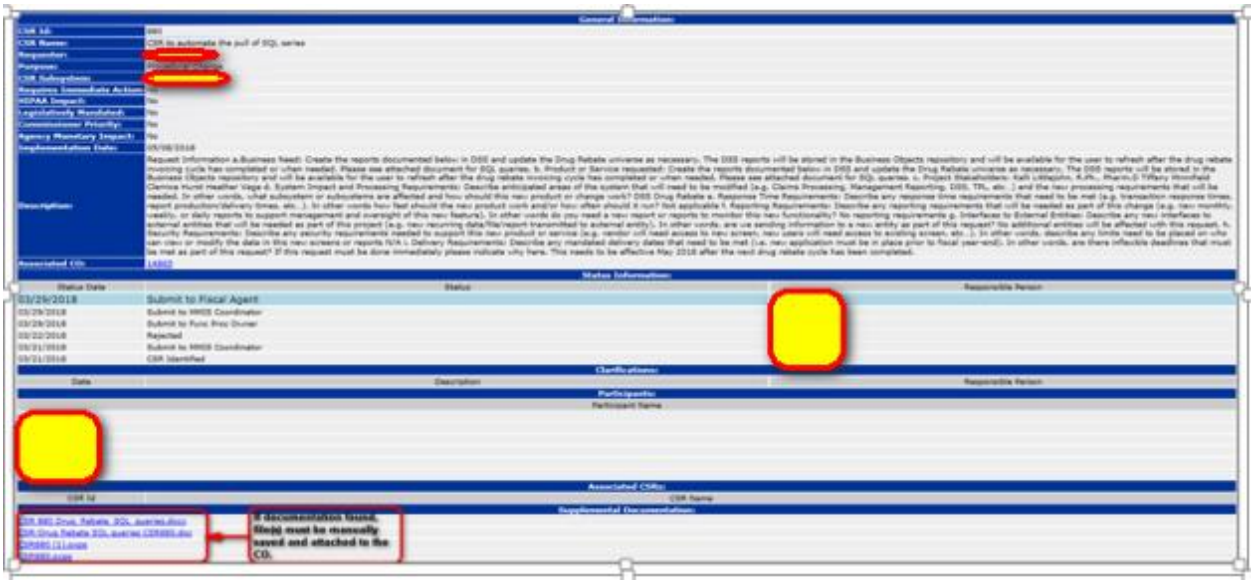
1. DXC Systems Supervisors and the Agency Base team receive email notification that a Mother CO has been written as a result of a new Agency CSR request. The default CO status is **"Change Order Written."** The Mother CO status will not be changed to "**Prod Implementation**" until ALL associated subsystem child COs are in production and approval is received from the Agency's designated approver (Currently [redacted] and/or [redacted]). Information found on the CO is Read-Only to all users, with the exception of DXC Systems Supervisors and Administrators.

   Responsible Party(s): DXC Systems Supervisors

2. Review CSR link:

   Responsible Party(s): DXC Supervisors

3. Scroll to "Supplemental Documentation:" If documentation is found, save the file and manually attach it to the Mother CO. Documentation attached to the CSR is NOT automatically transferred to the Mother CO and must be manually copied.



Responsible Party(s): DXC Systems Supervisors

4. System analysis is performed:

   I. A "Subsystem Impact Form" is attached to each Mother CO.

   Responsible Party(s): DXC Systems Supervisors

   II. Prior to an internal weekly CSR meeting, a list of new CSRs received since the last meeting is emailed to the DXC Systems team, along with the Provider Representative Supervisor and Claims Manager.

   Responsible Party(s): DXC Systems Supervisors

   III. New CSRs are reviewed in a weekly CSR meeting with the DXC Systems team. A decision is made at this time if all subsystem impacts are known, additional analysis is needed, or further clarification is needed from the Agency.

   a) All impacts are known: the impacted subsystem team(s) are instructed to update the "Subsystem Impact Form" for all subsystems.

   Responsible Party(s): DXC TFALs and BAs

   b) Additional analysis is needed: Internal meetings are scheduled, as needed. CSR is reviewed again in the following weeks CSR meeting.

   Responsible Party(s): DXC Systems Supervisors, TFALs and BAs

   c) Further clarification is needed from the Agency: A meeting request is submitted to the Agency.

   Responsible Party(s): DXC Systems Supervisors, TFALs and BAs

IV. If changes are needed in a specific subsystem, a subsystem CO (Also referred to as a "Child CO") is written using the Alabama Interactive Portal (AIP) and attached as a "Predecessor/Successor" to the original Mother CO. For each subsystem child CO (*Required):

a) *Short Name: Should be meaningful and related to the change being requested.

b) *Project: Should be "Operations CSR".

c) *Owner: Should be copied from the same field on the Mother CO.

d) *Type: Should be 'CO' or 'Task'.

e) Defect Type: Is not required and is not currently used.

f) Defect Environment: Is not required and is not currently used.

g) *Subsystem: Select from the dropdown.

h) *Grouping: Select from the dropdown.

i) *Complexity: Select from the dropdown.

j) *Severity: Select from the dropdown.

k) CO Reference: Should be copied from the same field on the Mother CO.

l) Critical Path: Is not required and is not currently used.

m) Agency Priority: Should be copied from the same field on the Mother CO. May not be known at the time the child CO is written.

n) *Billable: Will be 'Y' in most cases. A common exception would be HCPCS.

o) Start Date: Is not required and is not currently used.

p) Due Date: Is not required and is not currently used.

q) *Desired Solution Narrative: Meaningful description of what needs to be accomplished. This field may be updated several times throughout the life of the CO as more information is known.

r) Business Impact Narrative: This field may be updated several times throughout the life of the CO as more information is known.

- Two lines of information will be included for each request. Each of these will be titled as such in the Business Impact section:

  Providers/Recipients Impacted –

  Operational Team(s) Impacted -

  *NOTE: ***Providers/Recipients*** – Refers to external Alabama Medicaid providers/vendors and the recipient community.

  Operational Team(s) – Refers to internal DXC staff (i.e. Recipient Call Center, Provider Representatives, etc.)

- If there is no impact for a given line item above, the line item will still be listed, followed by "None".
- If the Provider and/or Recipient communities will be impacted, then after the first line, type in either "Providers Impacted", "Recipients Impacted", or "Both"
- If an Operational Team is impacted by the request, then after the second line, type in name of the Operational Team(s) Impacted
- As a rule of thumb, if there is an identified Impact to Providers and/or Recipients, then by default one or more Operational Team(s) will be impacted as well.
- If there is question about the impact to providers, recipients, or any one of the operational teams, the BA should consult with the Supervisor over the appropriate impacted operational areas to assist in the determination of impact. If there is a need for provider outreach, the BA will document this need in the Business Impact section.
- When completed with the "Business Impact" section, the BA will email the appropriate supervisor and operational manager, if there is an impact. They do **NOT** need to be notified if there is **NO** impact.
- The email notification, to the appropriate operational supervisor and manager, will be attached to the request in iTRACE and noted under the second line of information in the Business Impact section (see CO 7544 for example).
    - Please refer to **Section 12 Operations Impact Email** for an example of a standard e-mail notification to the operations manager and supervisor regarding potential impacts.
- The operational supervisor should review the request and work with the Agency to decide if any additional actions are required.
    - If a provider notice is needed, the Provider Representative supervisor will prepare the communication and consult with the BA if further information is needed about the request.
    - The BA and the Provider Representative supervisor will work together as the request progresses through the lifecycle of the request, to ensure the movements of the request and provider outreach communication are timed appropriately.

s) *Impact: The SE/BA is required to update the field with either Y or N, based on the information provided in the "Business Impact Narrative".

- If any of the two lines of information entered is determined to have an impact, then this field is updated with a Y.
- If both lines of information noted above is determined and noted with '**None'**, then this field is updated with a N.

- Leaving the field blank is not an option.

t) Technical Specifications: this field may be updated several times throughout the life of the CO as more information is known.

Responsible Party(s): DXC SEs and BAs

NOTE:

Database (DB) changes may or may not be identified at this time. At the point database changes are identified, a DB CO will be written.

Database changes require some additional documentation and steps. Please refer to iTRACE Data Model Change Process for those details and how to promote Data Model changes.

V. Subsystem COs are assigned to an SE and BA by the supervisors/subsystem TFALs, based on priority and/or due date. In most cases, priority will be determined in monthly subsystem meetings with the Agency. Once assigned, the status on the CO is changed to either "**SE Assigned**" or "**Const/Unit Test in Progress**". The Participants tab in AIP must also be updated to reflect the assigned team members.

Responsible Party(s): DXC Systems Supervisors and TFALs

5. Design/Construction Phase begins. Refer to Section 3 for the detailed steps involved in that phase.

2.2 DXC Identified and Agency Approved Change

Customer Service Request (CSR) initiated by DXC and approved as billable by the Agency's MMIS office in order to add new or enhance existing functionality within the AMMIS.

See Alabama Automated CSR Process PowerPoint presentation for process to submit a CSR:

The Agency approves a DXC request for a billable CSR:

1. DXC Systems Supervisors and the Agency Base team receive email notification that a Mother CO has been written as a result of a new Agency approved CSR request. The default CO status is **"Change Order Written."** The Mother CO status will not be changed to "**Prod Implementation**" until ALL associated subsystem COs are in production and approval is received from the Agency's MMIS Office. Information found on the CO is Read-Only to all users, with the exception of DXC Systems Supervisors and Administrators.

   Responsible Party(s): DXC Systems Supervisors

2. Respond to the Agency's approval to open a billable CSR with the Mother CO number. Include the Agency base distribution list ([redacted]). This step is in addition to the automated notification completed in step 1.

   Responsible Party(s): DXC Systems Supervisors

3. System analysis is performed:

   I. A "Subsystem Impact Form" is attached to each Mother CO.

      Responsible Party(s): DXC Systems Supervisors

   II. Prior to an internal weekly CSR meeting, a list of new CSRs received since the last meeting is emailed to the DXC Systems team, along with the Provider Representative Supervisor and Claims Manager.

      Responsible Party(s): DXC Systems Supervisors

   III. New CSRs are reviewed in a weekly CSR meeting with the DXC Systems team. A decision is made at this time if all subsystem impacts are known, additional analysis is needed, or further clarification is needed from the Agency.

      a) All impacts are known: the impacted subsystem teams are instructed to update the "Subsystem Impact Form" for all subsystems.

      Responsible Party(s): DXC TFALs and BAs

      b) Additional analysis is needed: Internal meetings are scheduled, as needed. CSR is reviewed again in the following weeks CSR meeting.

      Responsible Party(s): DXC Systems Supervisors, TFALs and BAs

      c) Further clarification is needed from the Agency: A meeting request is submitted to the Agency.

      Responsible Party(s): DXC Systems Supervisors, TFALs and BAs

IV. If changes are needed in a specific subsystem, a subsystem CO (Also referred to as a "Child CO") is written using the Alabama Interactive Portal (AIP) and attached as a "Predecessor/Successor" to the original Mother CO (if no changes are needed for a specific subsystem, no CO will be written). For each subsystem child CO (*Required):

a) *Short Name: Should be meaningful and related to the change being requested.

b) *Project: Should be "Operations CSR".

c) *Owner: Should be copied from the same field on the Mother CO.

d) *Type: Should be 'CO' or 'Task'.

e) Defect Type: Is not required and is not currently used.

f) Defect Environment: Is not required and is not currently used.

g) *Subsystem: Select from the dropdown.

h) *Grouping: Select from the dropdown.

i) *Complexity: Select from the dropdown.

j) *Severity: Select from the dropdown.

k) CO Reference: Should be copied from same field on the Mother CO.

l) Critical Path: Is not required and is not currently used.

m) Agency Priority: Should be copied from the same field on the Mother CO. May not be known at the time the child CO is written.

n) *Billable: Will be 'Y' in most cases. A common exception might be HCPCS.

o) Start Date: Is not required and is not currently used.

p) Due Date: Is not required and is not currently used.

q) *Desired Solution Narrative: Meaningful description of what needs to be accomplished. This field may be updated several times throughout the life of the CO as more information is known.

r) Business Impact Narrative: This field may be updated several times throughout the life of the CO as more information is known.

- Two lines of information will be included for each request. Each of these will be titled as such in the Business Impact section:

  Providers/Recipients Impacted -

  Operational Team(s) Impacted -

  *NOTE: ***Providers/Recipients*** – Refers to external Alabama Medicaid providers/vendors and the recipient community.

  Operational Team(s) – Refers to internal DXC staff (i.e. Recipient Call Center, Provider Representatives, etc.)

- If there is no impact for a given line item above, the line item will still be listed, followed by "None".
- If the Provider and/or Recipient communities will be impacted, then after the first line, type in either "Providers Impacted", "Recipients Impacted", or "Both"
- If an Operational Team is impacted by the request, then after the second line, type in name of the Operational Team(s) Impacted
- As a rule of thumb, if there is an identified Impact to Providers and/or Recipients, then by default one or more Operational Team(s) will be impacted as well.
- If there is question about the impact to providers, recipients, or any one of the operational teams, the BA should consult with the Supervisor over the appropriate impacted operational areas to assist in the determination of impact. If there is a need for provider outreach, the BA will document this need in the Business Impact section.
- When completed with the "Business Impact" section, the BA will email the appropriate supervisor and operational manager, if there is an impact. They do **NOT** need to be notified if there is **NO** impact.
- The email notification, to the appropriate operational supervisor and manager, will be attached to the request in iTRACE and noted under the second line of information in the Business Impact section (see CO 7544 for example).
    - Please refer to **Section 12 Operations Impact Email** for an example of a standard e-mail notification to the operations manager and supervisor regarding potential impacts.
- The operational supervisor should review the request and work with the Agency to decide if any additional actions are required.
    - If a provider notice is needed, the Provider Representative supervisor will prepare the communication and consult with the BA if further information is needed about the request.
    - The BA and the Provider Representative supervisor will work together as the request progresses through the lifecycle of the request, to ensure the movements of the request and provider outreach communication are timed appropriately.

s) *Impact: The lead BA is required to update the field with either Y or N, based on the information provided in the "Business Impact Narrative".

- If any of the two lines of information entered is determined to have an impact, then this field is updated with a Y.
- If both lines of information noted above is determined and noted with '**None'**, then this field is updated with a N.

- Leaving the field blank is not an option.

t) Technical Specifications: this field may be updated several times throughout the life of the CO as more information is known.

Responsible Party(s): DXC TFALs and BAs

NOTE:

Database (DB) changes may or may not be identified at this time. At the point database changes are identified, a DB CO will be written.

Database changes require some additional documentation and steps. Please refer to iTRACE Data Model Change Process for those details and how to promote Data Model changes.

V. Subsystem COs are assigned to an SE and BA by the supervisors, based on priority and/or due date. In most cases, priority will be determined in monthly subsystem meetings with the Agency. Once assigned, the status on the CO is changed to either "SE Assigned" or "Const/Unit Test in Progress". The Participants tab in AIP must also be updated to reflect the assigned team members.

Responsible Party(s): DXC Systems Supervisors

4. Design/Construction Phase begins. Refer to Section 3 for the detailed steps involved in that phase.

2.3 DXC Identified Change

Change Orders (COs) or Tasks initiated by DXC in order to improve system performance or perform maintenance. These COs primarily benefit DXC staff and are not billable.

1. Subsystem CO(s) and Tasks are entered into the AIP as non-billable. The default status for a CO is "**Change Order Written**" and for a Task is "**Issue Identified**". For each CO/Task (*Required):

a) *Short Name: Should be meaningful and related to the change being requested.

b) *Project: Should be "MNT".

c) *Owner: Should be the CO author.

d) *Type: Should be 'CO' or 'Task'.

e) Defect Type: Is not required and is not currently used.

f) Defect Environment: Is not required and is not currently used.

g) *Subsystem: Select from the dropdown.

h) *Grouping: Select from the dropdown. **NOTE:** Should never be "Operations CSR".

i) *Complexity: Select from the dropdown.

j) *Severity: Select from the dropdown.

k) CO Reference: Not required for non-billable COs unless the CO was written as a result of an Issue. If the CO created is the result of an Issue created in the Issue Management tool, the Issue number is required in BOTH the "CO Reference" field and the "Desired Solution Narrative".

l) Critical Path: Is not required and is not currently used.

m) Agency Priority: Usually not applicable for non-billable CO's. Exceptions include OIG audit findings and HCPCS.

n) *Billable: Will be 'N' in all cases.

o) Start Date: Is not required and is not currently used.

p) Due Date: Is not required and is not currently used.

q) *Desired Solution Narrative: Meaningful description of what needs to be accomplished. This field may be updated several times throughout the life of the CO as more information is known.

r) Business Impact Narrative: This field may be updated several times throughout the life of the CO as more information is known.

- Two lines of information will be included for each request. Each of these will be titled as such in the Business Impact section:

  Providers/Recipients Impacted -
  Operational Team(s) Impacted -

*NOTE: ***Providers/Recipients*** – Refers to external Alabama Medicaid providers/vendors and the recipient community.
Operational Team(s) **–** Refers to internal DXC staff (i.e. Recipient Call Center, Provider Representatives, etc.)

- If there is no impact for a given line item above, the line item will still be listed, followed by "None".
- If the Provider and/or Recipient communities will be impacted, then after the first line, type in either "Providers Impacted", "Recipients Impacted", or "Both"
- If an Operational Team is impacted by the request, then after the second line, type in name of the Operational Team(s) Impacted
- As a rule of thumb, if there is an identified Impact to Providers and/or Recipients, then by default one or more Operational Team(s) will be impacted as well.
- If there is question about the impact to providers, recipients, or any one of the operational teams, the BA should consult with the Supervisor over the appropriate impacted operational areas to assist in the determination of impact. If there is a need for provider outreach, the BA will document this need in the Business Impact section.
- When completed with the "Business Impact" section, the BA will email the appropriate supervisor and operational manager, if there is an impact. They do **NOT** need to be notified if there is **NO** impact.
- The email notification, to the appropriate operational supervisor and manager, will be attached to the request in iTRACE and noted under the second line of information in the Business Impact section (see CO 7544 for example).
    - Please refer to **Section 12 Operations Impact Email** for an example of a standard e-mail notification to the operations manager and supervisor regarding potential impacts.
- The operational supervisor should review the request and work with the Agency to decide if any additional actions are required.
    - If a provider notice is needed, the Provider Representative supervisor will prepare the communication and consult with the BA if further information is needed about the request.
    - The BA and the Provider Representative supervisor will work together as the request progresses through the lifecycle of the request, to ensure the movements of the request and provider outreach communication are timed appropriately.

s) *Impact: The lead BA is required to update the field with either Y or N, based on the information provided in the "Business Impact Narrative".

- If any of the two lines of information entered is determined to have an impact, then this field is updated with a Y.
- If both lines of information noted above is determined and noted with '**None'**, then this field is updated with a N.
- Leaving the field blank is not an option.

t) Technical Specifications: this field may be updated several times throughout the life of the CO as more information is known.

Responsible Party(s): DXC TFALs and BAs

NOTE:

Database (DB) changes may or may not be identified at this time. At the point database changes are identified, a DB CO will be written.

Database changes require some additional documentation and steps. Please refer to iTRACE Data Model Change Process for those details and how to promote Data Model changes.

2. The DXC Systems supervisors assign the CO to an SE and BA and set its priority. The priority is determined in light of the impact to the system and other system priorities. Once assigned, the status on the CO is changed to "**SE Assigned**" or "**Const/Unit Test in Progress**". The Participants tab in AIP must also be updated to reflect the assigned team members.

Responsible Party(s): DXC Systems Supervisors

3. Design/Construction Phase begins. Refer to Section 3 for the detailed steps involved in that phase.

2.4 Defects

Deficiencies identified by DXC or the Agency to correct problems with existing, agreed upon functionality.

1. Subsystem changes are entered into the AIP as a "Defect". The default CO status is "**Issue Identified**."

   a) *Short Name: Should be meaningful and related to the change being requested.

   b) *Project: Should be "MNT".

   c) *Owner: Should be the Defect author.

   d) *Type: Should be "Defect".

   e) Defect Type: Is not required and is not currently used.

   f) Defect Environment: Is not required and is not currently used.

   g) *Subsystem: Select from the dropdown.

   h) *Grouping: Select from the dropdown.

   i) *Complexity: Select from the dropdown.

   j) *Severity: Select from the dropdown.

   k) CO Reference: Not required for defects unless the defect was written as a result of an Issue or a CSR. If the defect created is the result of an Issue created in the Issue Management tool, the Issue number is required in BOTH the "CO Reference" field and the "Desired Solution Narrative". If the defect is created as a result of changes implemented as part of a CSR, the CSR number should be included in the "CO Reference" field.

   l) Critical Path: Is not required and is not currently used.

   m) Agency Priority: Usually not applicable for Defects.

   n) *Billable: Will be 'N' in all cases.

   o) Start Date: Is not required and is not currently used.

   p) Due Date: Is not required and is not currently used.

   q) *Desired Solution Narrative: Meaningful description of what needs to be accomplished. This field may be updated several times throughout the life of the CO as more information is known.

   r) Business Impact Narrative: This field may be updated several times throughout the life of the Defect as more information is known.

   - Two lines of information will be included for each request. Each of these will be titled as such in the Business Impact section:

     Providers/Recipients Impacted -

     Operational Team(s) Impacted -

     *NOTE: ***Providers/Recipients*** – Refers to external Alabama Medicaid providers/vendors and the recipient community.

Operational Team(s) **–** Refers to internal DXC staff (i.e. Recipient Call Center, Provider Representatives, etc.)

- If there is no impact for a given line item above, the line item will still be listed, followed by "None".
- If the Provider and/or Recipient communities will be impacted, then after the first line, type in either "Providers Impacted", "Recipients Impacted", or "Both"
- If an Operational Team is impacted by the request, then after the second line, type in name of the Operational Team(s) Impacted
- As a rule of thumb, if there is an identified Impact to Providers and/or Recipients, then by default one or more Operational Team(s) will be impacted as well.
- If there is question about the impact to providers, recipients, or any one of the operational teams, the BA should consult with the Supervisor over the appropriate impacted operational areas to assist in the determination of impact. If there is a need for provider outreach, the BA will document this need in the Business Impact section.
- When completed with the "Business Impact" section, the BA will email the appropriate supervisor and operational manager, if there is an impact. They do **NOT** need to be notified if there is **NO** impact.
- The email notification, to the appropriate operational supervisor and manager, will be attached to the request in iTRACE and noted under the second line of information in the Business Impact section (see CO 7544 for example).
    - Please refer to **Section 12 Operations Impact Email** for an example of a standard e-mail notification to the operations manager and supervisor regarding potential impacts.
- The operational supervisor should review the request and work with the Agency to decide if any additional actions are required.
    - If a provider notice is needed, the Provider Representative supervisor will prepare the communication and consult with the BA if further information is needed about the request.
    - The BA and the Provider Representative supervisor will work together as the request progresses through the lifecycle of the request, to ensure the movements of the request and provider outreach communication are timed appropriately.
- The following information must be included with Defects:
    - Is this Defect a result of recent changes?
    - If so, what CO/Defect?
    - If not, can we tell how long it's been going on?

s) *Impact: The lead BA is required to update the field with either Y or N, based on the information provided in the "Business Impact Narrative".

- If any of the two lines of information entered is determined to have an impact, then this field is updated with a Y.
- If both lines of information noted above is determined and noted with '**None'**, then this field is updated with a N.
- Leaving the field blank is not an option.

t) Technical Specifications: this field may be updated several times throughout the life of the CO as more information is known.

Responsible Party(s): DXC Systems Supervisors, SEs, and BAs

2. The DXC system supervisors assign the Defect to an SE and BA and set its priority. The priority is determined in light of the impact to claims payment and other system priorities. Once assigned, the status on the Defect is changed to "**SE Assigned**" or "**Const/Unit Test in Progress**". The Participants tab in AIP must also be updated to reflect the assigned team members.

   Responsible Party(s): DXC Systems Supervisors, SEs, and BAs

3. Design/Construction Phase begins. Refer to Section 3 for the detailed steps involved in that phase.

2.5 Cancellation of a "Billable CO/Task" or "Defect"

The following steps are required to request the cancellation of a billable CO/Task or Defect:

1. Status of the CO/Defect is changed to "**Under CCB Review**".

   Responsible Party(s): DXC Systems Supervisors, SEs and BAs

2. DXC Systems Supervisor will add the cancellation request to the next CCB agenda.

   Responsible Party(s): DXC Systems Supervisors

3. Request will be discussed in a CCB meeting with the Agency. The CCB has the option to approve, deny, or defer the request.

- If the CCB approves the cancellation request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the CO/Defect, indicating the Agency approved the cancellation.
  - Change the status of the CO/Defect to "**Cancelled**" in iTRACE.
  - Attach the CCB meeting minutes to the CO/Defect as verification.
- If the CCB denies the cancellation request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the request, indicating the reasons for the denial.
  - Change the CO/Defect status back to the previous setting prior to "**Under CCB Review**".
  - Attach the CCB meeting minutes, which will note the denial, to the CO/Defect.
- If the CCB defers the cancellation request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the CO/Defect, indicating the Agency has deferred the cancellation request to a future CCB meeting and note any reason given for the deferral.
  - The DXC Systems Supervisor will add the cancellation request to the next CCB agenda.
  - Repeat step 3 as necessary.

Responsible Party(s): DXC Systems Supervisors, SEs, & BAs

2.6 Changing a Non-Billable CO to a Billable CO

The following steps are required when DXC believes a non-billable CO should be changed to a billable CO:

1. Status of the CO is changed to "**Under CCB Review**".

   Responsible Party(s): DXC Systems Supervisors, SEs and BAs

2. DXC Systems Supervisor will add the change request to the next CCB agenda.

   Responsible Party(s): DXC Systems Supervisors

3. Request will be discussed in a CCB meeting with the Agency. The CCB has the option to approve, deny, or defer the request.

- If the CCB approves the change request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the CO, indicating the Agency approved the designation change.
  - Change the CO status back to the previous setting prior to "**Under CCB Review**".
  - Change the "*Billable" field from an "N" to a "Y".
  - Add "AAyyyymmddvv" to the "CO Reference" field, whereas:
    - AA = Agency Approved
    - yymmdd = the date the Agency approved the CO
    - vv = version number, (ex: 01, 02, 03, etc.)
  - Attach the CCB meeting minutes to the CO as verification.
- If the CCB denies the change request, the assigned SE/BA or DXC Systems Supervisor will log into AIP and:
  - Add a note of clarification to the CO, indicating the reasons for the denial.
  - Change the status, in iTRACE, back to the previous setting prior to "**Under CCB Review**".
  - Attach the CCB meeting minutes, which will note the denial, to the CO in iTRACE.
- If the CCB defers the change request, the assigned SE/BA or DXC Systems Supervisor will log into AIP and:
  - Add a note of clarification to the CO, indicating the Agency has deferred the change request to a future CCB meeting and note any reason given for the deferral.
  - The DXC Systems Supervisor will add the change request to the next CCB agenda.
  - Repeat step 3 as necessary.

Responsible Party(s): DXC Systems Supervisors, SEs, & BAs

2.7 Changing a Defect to a Billable CO

The following steps are required when DXC believes a Defect should be changed to a billable CO:

1. Status of the Defect is changed to "**Under CCB Review**".

   Responsible Party(s): DXC Systems Supervisors, SEs and BAs

2. DXC Systems Supervisor will add the change request to the next CCB agenda.

   Responsible Party(s): DXC Systems Supervisors

3. Request will be discussed in a CCB meeting with the Agency. The CCB has the option to approve, deny, or defer the request.

- If the CCB approves the change request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the Defect, indicating the Agency approved the designation change.
  - Change the "*Type" field from Defect to CO.
  - Change the CO status back to the previous setting prior to "**Under CCB Review**".
  - Change the "*Billable" field from an "N" to a "Y".
  - Add "AAyyyymmddvv" to the "CO Reference" field, whereas:
    - AA = Agency Approved
    - yymmdd = the date the Agency approved the CO
    - vv = version number, (ex: 01, 02, 03, etc.)
  - Add the CCB meeting minutes to the CO as verification.
- If the CCB denies the change request, the assigned SE/BA or DXC Systems Supervisor will log into AIP and:
  - Add a note of clarification to the Defect, indicating the reasons for the denial.
  - Change the CO status back to the previous setting prior to "**Under CCB Review**".
  - Attach the CCB meeting minutes, which will note the denial, to the Defect in iTRACE.
- If the CCB defers the change request, the assigned SE/BA or DXC Systems Supervisor will log into AIP and:
  - Add a note of clarification to the Defect, indicating the Agency has deferred the change request to a future CCB meeting and note any reason given for the deferral.
  - The DXC Systems Supervisor will add the change request to the next CCB agenda.
  - Repeat step 3 as necessary.

Responsible Party(s): DXC Systems Supervisors, SEs, & BAs

2.8 Changing a Defect to a Non-Billable CO

The following steps are required when DXC believes a Defect should be changed to a non-billable CO:

1. Status of Defect is changed to "**Under CCB Review**".

   Responsible Party(s): DXC Systems Supervisors, SEs and BAs

2. DXC Systems Supervisor will add the change request to the next CCB agenda.

   Responsible Party(s): DXC Systems Supervisors

3. Request will be discussed in a CCB meeting with the Agency. The CCB has the option to approve, deny, or defer the request.

- If the CCB approves the change request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the Defect, indicating the Agency approved the designation change.
  - Change the "*Type" field from Defect to CO.
  - Change the CO status back to the previous setting prior to "**Under CCB Review**" status.
  - The "*Billable" indicator should remain "N" in iTRACE.
  - Add the CCB meeting minutes to the CO as verification.
- If the CCB denies the change request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the Defect, indicating the reasons for the denial.
  - Change the Defect status back to the previous setting prior to "**Under CCB Review**" status.
  - Attach the CCB meeting minutes, which will note the denial, to the Defect.
- If the CCB defers the change request, the DXC Systems Supervisor or assigned SE/BA will log into AIP and:
  - Add a note of clarification to the Defect, indicating the Agency has deferred the change request to a future CCB meeting and note any reason given for the deferral.
  - The DXC Systems Supervisor will add the change request to the next CCB agenda.
  - Repeat step 3 as necessary.

Responsible Party(s): DXC Systems Supervisors, SEs, & BAs

3. Design/Construction Phase

3.1 CSR Status Updated

Once the CSR is reviewed in the weekly CSR meeting, a DXC Systems Supervisor will update the CSR status in AIP (Not the Mother or Child CO) from "**Submit to Fiscal Agent**" to "**CSR Work In Progress**". Changing the status will automatically generate an email to the Agency Base team and the Agency FPO(s) associated with the CSR to let them know the CSR has been started and will also automatically update the status of the Mother CO from "**Change Order Written**" to "**CO Work in Progress**".

Responsible Party(s): DXC Systems Supervisors

3.2 Complete Design

The assigned SE/BA reviews the requested changes and updates the "Desired Solution Narrative", "Business Impact Narrative" and the "Technical Design Narrative" areas of the CO/Defect as necessary.

The following steps are **required** for BILLABLE COs:

- The SE assigned to the CO is responsible for attaching the estimating excel spreadsheet to the CO in iTRACE and performing an estimate on the CO before construction begins. The estimating excel spreadsheet can be retrieved from the Forms subsection of the TRB section within iTRACE. The name of the estimating excel spreadsheet is: "HC ALXIX Functional Area Estimating Algorithm Tool". N**OTE**: It is requested the name of the estimating excel spreadsheet remain the same. Some of the internal algorithms rely on the specific name of the estimating excel spreadsheet.
- The estimating excel spreadsheet has built in historical data tables to assist the SE in the creation of the estimate for the CO. Once the estimate is generated within the estimating excel spreadsheet, the SE will manually transfer the values generated to the Estimating Metric's section of the CO in AIP. The fields in the metric section of AIP corresponds to the fields in the estimating excel spreadsheet. **NOTE:** The estimating spreadsheet is just a tool:
    - SEs can overwrite the hour estimate provided by the spreadsheet if they feel it's inaccurate based on previous experience.
    - BA's can use the estimating excel spreadsheet to plug in testing hours over and above what will be generated when the SE uses the tool initially to create the estimate. BA's are encouraged to add to the testing estimate, if it is felt the testing hours are insufficient or exceeds the initial generation.

Within iTRACE, in the TRB section, in the 'Processes' subsection, is a power point presentation on how to use the estimating tool. The power point presentation can be found by clicking on the "Estimating" link within the section titled "Alabama Specific Processes".

Responsible Party(s): DXC SEs and BAs

3.3 System Objects/UI Files are Checked Out/Created

SE confirms which system object(s)/UI File(s) need to be modified or which system object may be leveraged to produce new functionality. This step will vary depending on whether the code is batch or UI:

- Batch: SE checks the file(s) out in VCTL.
- UI: SE checks out the UI file(s) from Vault. See the Alabama interChange Standards document Vault usage standards for more information.

Retrieving and checking out the latest version of the software to be changed protects it from simultaneous update by another programmer.

NOTE: If changes do not go through the formal release process (examples include reprocessing and Install & Configuration tasks, AVRS, Feith, and PES) a separate process is in development.

Responsible Party(s): DXC SEs

3.4 Perform Initial Coverity Scan

Coverity is the tool we are using for American Society for Quality (ASQC) scans. The intent of the scans is to uncover potential security or result issues with code before it is in production. When a system object is initially checked out the assigned SE performs a scan to see what issues already exist and determine, with the TFAL, if any should be corrected as part of the new CO/Defect.

Responsible Party(s): DXC SEs

3.5 Begin Construction (Coding Changes and Unit Testing)

SE begins coding changes and unit testing. The CO/Defect status is changed to "**Const/Unit Test in Progress**." The SE notifies the assigned BA(s) that work has begun so that they can start documenting their test plan, writing their system test cases, and perform any preliminary or pre-system testing in Model Office (MO).

Responsible Party(s): DXC SEs and BAs

3.6 Perform End of Construction Coverity Scan

After each system object has been unit tested, a code scan is run to identify any new defects and security vulnerabilities potentially introduced as part of the changes. Any issues identified with the code scan must be resolved and re-testing performed before a walkthrough can be scheduled. Once each change has a clean scan and unit test results, the programmer prepares changes and documentation for a construction walkthrough.

Responsible Party(s): DXC SEs

3.7 Construction Walkthrough Preparation

Prepare walkthrough documentation and attach it to the CO/Defect. See the Walkthrough Form for all required documents.

NOTE: To associate system objects to a CO/Defect (from the iTRACE home page):

- Go to AIP
- Click on DocoTool

- Select “Change Orders” (should be selected by default)
- Type in CO/Defect number in ID CO and press “Go!”
- Select correct CO/Defect from the list
- Click on “Req/SO” (Requirements/System Objects)
- Select the SO Type from the dropdown. For UI, for example, the most likely type is ‘panel’
- Select the subsystem from the dropdown and click Find Req-SO (If you know the technical name or Requirement ID, you can type it directly)
- Find all applicable Req/SO(s) in the listing and click the + button to add it to your CO/Defect

Responsible Party(s): DXC SEs

3.8 Construction Walkthrough

After all documents are attached to the CO/Defect, the SE will either schedule a meeting or email a request to have the changes reviewed. The CO/Defect status is changed to **“Ready for Const Wthru**.” At a minimum, walkthroughs must involve at least two other SEs (including the subsystem TFAL, if applicable) and the subsystem BA. If User Manual or iTRACE changes have been made, the Technical Writer should also be invited to review. Any changes identified during the walkthrough will be noted on the Walkthrough document and resolved before going forward. If necessary a second walkthrough will be scheduled to review issues identified during the initial walkthrough. The walkthrough document includes a checklist to make sure construction is complete. The SE requesting the walkthrough is responsible for ensuring all walkthrough parties involved have responded.

NOTE: If additional coding changes are required, repeat steps 3.2 (Complete Design) through 3.8 (Construction Walkthrough) as necessary.

NOTE: In the event additional walkthrough’s are needed, the SE should create a separate folder in iTRACE to store the new walkthrough documentation. Call further folders Re-Walkthrough 2, 3, 4…, or Walkthrough 2, 3, 4... Note you have to now check item #1 as Yes in subsequent walkthrough forms.

Once the walkthrough has been completed and the walkthrough document has been signed off, the CO/Defect status is changed to “**Const Wthru Completed**” and the SE prepares to implement the change to Model Office (MO).

Responsible Party(s): DXC SEs.

3.9 Check the System Object(s)/UI File(s) back into VCTL/Vault

After all pending items have been completed and sign-off is received, SE checks the system object(s)/UI file(s) back into VCTL (batch) or Vault (UI).

UI: Ensure comments are in the correct format (following common comment standards (Example: for Change Order 14593, comment would be AL14593).

Batch: Comments, at a minimum, should include the CO or Defect number and a brief description. As needed, update the implementation plan to reflect the correct version of the checked in code.

Responsible Party(s): DXC SEs

3.10 UI: Test changes in TEST/Development Environment

UI: Request a UI TEST build to the secondary UI on-call contact. After the TEST build is successful, test changes in the Test/Development environment. This UI build takes the most current version of any code that is checked into Vault to perform the build (whether it is scheduled for a Model Office release or not).

Batch: N/A for Batch

Responsible Party(s): DXC SEs and Secondary UI On-Call

3.11 Preparing Move to Model Office

Upon completion of the construction walkthrough, the SE notifies the BA as to when the CO/Defect will be implemented in MO. The move to MO includes the following actions:

a. The status of the CO/Defect is changed to "**Ready for MO Implementation"** / "**Ready for MO Implementation EFix**" (or higher) in iTRACE.

b. The CO/Defect is associated with a MO release in iTRACE. The release number in iTRACE should be consistent with that specified for the system objects in the Implementation Plan for the CO.

   NOTE: To associate your CO/Defect to a release (from the iTRACE home page):
   - Go to AIP
   - Click on DocoTool
   - Select Releases
   - Enter the release number you want to associate the change to in the "Release Number" field.
   - Select M-Model Office from Environment dropdown and click Go!
   - Click the Release Number/ID that the CO\Defect is to be tied to
   - Select COs from the menu
   - Type in your CO\Defect number in ID CO, click Find COs
   - Click the + under Add CO to tie your CO\Defect to the release

c. For data model CO/Defects, both the CO and the tables are associated to the release in iTRACE.

d. **UI:** No additional step is needed.

   Batch: The SE must create a member in the UNIX test environment for all batch members to be moved to MO. This member will be created in /export/home/dsalmod/promotions.

   For example, to communicate DSS batch entities to be moved to MO in a release scheduled for March 21, 2018, the SE would list their batch members in the file /export/home/dsalmod/promotions/20180321/objects/DSS.

   Change the permission of the member file so others can edit the file.

Responsible Party(s): DXC SEs

4. MO Release Phase

MO releases generally occur every two weeks, on Wednesday evenings, following a checkwrite weekend. This schedule is occasionally adjusted due to holidays or other extenuating circumstances. The MO release schedule is posted on iTRACE Testing page under 'MO Promotions' on left side of the screen.

NOTE: There are three types of MO releases: batch, UI and database. All three types of changes follow the same release schedule.

4.1 Pre-MO Release Process

UI: Prior to the actual MO UI release (preferably Tuesday prior to the release or after the change has been associated to the release), SEs should check the MO release conflict promotion sites:

MMIS: https://mod.alxix.slg.eds.com/alabamarelease/Default.aspx

Web Portal: https://mod.alxix.slg.eds.com/alportalrelease/Default.aspx

This will help validate that the code that they are promoting is not going to have promotion issues and the correct version of the modules will be promoted. This site is automatically refreshed at noon and midnight. This site reviews all of the code that has been scheduled for promotion and spots promotion conflicts that could occur. Any problems that are reported on this site MUST be resolved before the MO UI promotion can begin. The UI release coordinator will monitor this site before each of the MO builds to make sure that the MO build is issue free.

Batch: N/A for Batch

Responsible Party(s): DXC SEs

4.2 MO Release Coordinator: Review CO/Defect Documentation

Before changes can be moved to MO, the MO Release Coordinator performs a final review of the CO/Defect to ensure all required documentation is attached and complete. For all COs and Defects associated to a release:

- All documentation has been completed and is up-to-date and correct. The Walkthrough form is filled out with all the needed approvals.
- The CO is associated to the correct release and is in a "**Ready For MO Implementation**" / "**Ready for MO Implementation EFix**" (or higher) status.
- **UI: N/A**
- **Batch:** All objects are checked in to source control, and those being promoted have entries in the subsystem's object move file, which should be located on mishp1ap at: /export/home/dsalmod/promotions/CCYYMMDD/objects (This is the date of the release)
- A more complete checklist to follow to ensure the CO meets the MO Release Coordinator's guidelines can be found here: MO Release Procedure Checklist

The release is "closed" as of 3:00 p.m. central time on Tuesday afternoons prior to a Wednesday MO release.

- Any issues identified by the MO Release Coordinator must be corrected by the deadline or the changes will be pulled from the release.
- CO's added to the MO release after this deadline will be removed and will require an Exception Promotion. Late exceptions are not allowed.

Responsible Party(s): DXC MO Release Coordinator, SEs

4.3 MO Release Process

UI: UI MO releases start between 12 p.m and 2:00 p.m. The UI release takes in any code scheduled for the MO release.

- Once all MO UI release conflicts have been resolved, the UI Release Coordinator is notified the final MO UI build can begin. The UI Release Coordinator will email the Alabama System Engineers and Alabama System BAs when the final build is complete.

NOTE: Any UI changes that need to be promoted with the current MO UI release "after" the MO UI release is started/completed should follow the "MO Release Phase – Exception Promotions" procedures.

Batch: N/A for Batch

Responsible Party(s): DXC UI Primary On-Call

4.4 Changes are promoted

The approved changes are promoted to the MO environment. A CO/Defect listing is generated and sent to both the DXC Team and Agency after each MO release.

Responsible Party(s): DXC MO Release Coordinator

4.5 Changes are verified

Once the MO release is complete, each SE will verify their changes are in MO and change the CO/Defect status to "**MO Implementation**." The SE communicates with the assigned BA that changes are in MO and are ready to be tested.

NOTE: Contact the subsystem technical lead if help is needed to verify changes were successfully moved to MO.

If it is found changes were not successfully moved to MO, the SE will need to either follow steps documented under "MO Release Phase – Exception Promotions" to promote their missing code or place the changes in MO override and associate the changes with the next MO release.

Responsible Party(s): DXC SEs

5. MO Testing

The following types of testing may be performed in the MO environment:

- Individual subsystem testing
- Integrated subsystem testing
- Interface testing
- Stress testing
- Regression testing

5.1 Testing begins

If the change moving to MO has been identified as having an impact to operations, the assigned BA will send an email update to the appropriate operational supervisor and manager, informing them of the move to MO and noting the potential impacts to operations, providers, and/or recipients (See Section 11. Operations Impact Email).

Once MO testing begins, the CO/Defect status is changed to "**MO Testing in Progress**." Testing continues until the BA is satisfied the system is performing as expected. Any issues identified will be communicated to the SE for resolution.

Responsible Party(s): DXC BAs

5.2 Testing complete

Once MO testing is complete, MO test results, and, if applicable, updated report(s), panel(s), and user manual updates are prepared and attached to the CO/Defect in AIP for Agency review. The CO/Defect status is changed to "**MO Testing Complete**."

Responsible Party(s): DXC BAs

5.3 ITB Requirement Review

Per 2010 ITB requirement 3.01.169: "The Vendor shall, as part of the implementation of all change orders or defects, identify and update the associated requirement(s). If there are no requirements for this change, the Vendor shall write the new requirement(s). The new or updated requirement(s) shall be submitted to the Agency for approval prior to implementation." If no requirement changes are necessary, skip to "Agency Review"

5.3.1 Change to Requirement

If the CO or Defect impacts the way an active requirement is met or verbiage changes are needed, a clarification should be added to the requirement with the proposed verbiage changes and the status set to "CCB". A monthly Change Control Board (CCB) meeting will be held with the Agency to discuss the proposed changes.

Responsible Party(s): DXC SEs and BAs

5.3.2 New Requirement

If the CO or Defect does not map to an existing, active requirement, a new requirement should be created, with the status set to "CCB". A monthly CCB meeting will be held with the Agency to discuss the proposed changes.

Responsible Party(s): DXC SEs and BAs

5.4 Agency Review

5.4.1 Contact Agency

Per 2010 ITB Requirement 3.19.001: "The Vendor shall provide at a minimum five (5) days to review test results. Any test results with less than a five (5) days review time will require the Vendor to schedule an on-site review at the Agency. All test results must have the approval of the function process owner before being moved to production."

No later than the Wednesday prior to the scheduled production release for a billable CO, an email will be sent to the Alabama Agency Base team ([redacted]), subsystem TFAL, and DXC system leaders. The Agency will always review test results for billable COs and notify DXC of their approval or disapproval, through [redacted] or [redacted] (Subject to change). For Defects and non-billable COs, if the Agency has not notified DXC of any issues or questions concerning the system changes by the Monday before the scheduled promotion, DXC will assume the Defect/non-billable CO is approved and will promote the changes as scheduled.

In most cases, the Agency can review the documentation in iTRACE. The Agency will notify DXC if a meeting is required for the walkthrough.

NOTE: There may be times when, due to the nature of the change, there is not enough time to adhere to this notification schedule. In those cases, the Agency will be informed of the change as far in advance as possible.

5.4.1.1 Format of subject line email to Agency

Subject line of the email sent to the Agency will follow the format below;

CO nnnn Requesting Agency Review & Approval of a <functional area> CO
or
Defect nnnn Requesting Agency Review of a <functional area> Defect

NOTE: If a CO is tied to a CSR number, for example: CO 6950 is tied to PR2009100901, the following subject line format is sent to the Agency;

CO nnnn (XXyyyymmddnn) Requesting Agency Review & Approval of a <functional area> CO

<u>Examples;</u>

CO 6131 Requesting Agency Review & Approval of a PA CO

CO 6950 (PR2009100901) Requesting Agency Review & Approval of a Provider CO

Defect 6783 Requesting Agency Review of a Claims Defect

5.4.1.2 Format of text in the body of email to Agency

The text used in the body of the email to request Agency Review &/or Approval will follow the format below;

Test Results for <Functional Area> <CO/Defect> nnnn - <CSR # if applicable>, <Short Description> are now in iTRACE and are available for your Review &/or Approval.

Changes associated with this request are scheduled to move to production on mm/dd/yy. Please reply with your response no later than mm/dd/yy. You may use the following link to view the test results.

https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/RequestDoco.asp?ID=nnnn

<This paragraph can contain any special instructions unique to the Defect or CO sent to the Agency.

*If the Agency does not have at least **five** business days to review test results and provide feedback, the following statement should be added to the email request (This statement will be in **bold** and placed at the beginning of the text used in the body of the e-mail;*

The requested response date below does not allow at least five business days for response. The requested date will allow this change to promote with the next scheduled move to production. DXC understands that adequate review time must be allowed. If you are unable to meet the requested timeframe, please respond indicating how much more time will be needed. In that case, the release will be adjusted or postponed to allow the required time.

This section will note approvals received from additional internal DXC teams, who, if necessary, reviewed and approved test results associated with this request, (NOTE: Email attachment of approval from the additional internal DXC team is required).

This section can be used to note where to find the test results or other documents (Example User Manual(s), Requirement changes) for review, etc.>

Please feel free to contact me if you have any questions or concerns.

Thank you!

<Signature block>

NOTE: Do not send an email which requests response within less than 24 hours. If an emergency requires response in less than 24 hours, coordinate through the Systems Supervisor who will work with the Agency to coordinate the emergency review.

Responsible Party(s): DXC BAs or SEs

5.4.2 Agency Test Case Review

After reviewing the testing documentation (which may include MO test results, updated iTRACE screenshots, and/or User Manual updates), the Agency will notify DXC of their approval for the change to be implemented or request additional information on the change. For billable COs,

approval MUST be obtained on MO test results, updated iTRACE screenshots, and/or User Manual updates.

Responsible Party(s): Agency PMO

5.4.3 Agency Approval Notification (Billable COs)

After required approval is received from the Agency, the SE is notified that the billable CO is approved and may be promoted to production. The CO status is changed to "**Ready for UAT Impl**." (or above) BA also attaches Agency approval documentation to the CO.

Responsible Party(s): DXC BAs

6. UAT/ACC Release Phase

If the CO/Defect moving to UAT has an impact to operations, the assigned BA will send an email to the appropriate supervisor and manager, informing them of the move to UAT and noting the potential impacts to operations, providers, and/or recipients (**See Section 12. Operations Impact Email**).

NOTE: COs/Defects do not need Agency approval to move to UAT.

UAT/ACC releases are generally scheduled to occur every two weeks on Wednesday evenings, six days prior to a Tuesday production release. This schedule is occasionally adjusted due to holidays or other extenuating circumstances. The UAT/ACC release schedule is posted on iTRACE at https://pwb.alxix.slg.eds.com/alxix/Testing/ under UAT Promotions on the left side of the page.

6.1 COs/Defects Associated with the UAT Release

Prior to the UAT release, DXC SEs should ensure any COs/Defects being removed or added to the release are:

- In a "**Ready for UAT Impl**" (or above) status.
- Associated with the release in AIP.

Responsible Party(s): DXC SEs

6.2 Batch & UI CO/Defect UAT promotion list

UI: On Wednesday morning, prior to the UAT release, the DXC UI Primary On-Call will send a list of UI COs/Defects associated with the release.

Batch: On Wednesday afternoon, prior to the UAT release, the DXC UAT Release Coordinator will send a list of batch system objects and all COs/Defects associated with the release and request SEs to respond with any objects that should be added or removed before 5:00 p.m. The finalized list of system objects is what will be promoted from MO to UAT. This finalized list of system objects is also the starting point for the next production list.

Responsible Party(s): DXC UI Primary On-Call & UAT Release Coordinator

6.3 Agency Notification

Per 2010 ITB Requirement 3.01.141: "The Vendor shall submit a software release list five (5) days prior to the release being applied to the production environment. The release list shall contain all changes that will be applied to the production environment as part of the release. The release list shall identify all applicable issues (issue, change orders, defects, etc.) with the associated issue number, the business area impacted, the status of the WPR (work product review) and the date Agency approval was received."

A CO/Defect listing is generated and sent to the Agency before each UAT release and five days before changes are forecasted to move to Production.

Responsible Party(s): DXC Systems Supervisors

6.4 HID Notification

Due to potential impact to the HID automated screen scraping process, HID should be notified of ANY UI changes being moved to UAT/ACC in advance of the release (email should be sent Wednesday afternoon, at the latest). HID has access to the UAT/ACC environment and can test their screen scraping process in UAT/ACC in advance of the production release. HID has asked for 3 business days to test in UAT/ACC before a production release is held, so any delay in the UAT/ACC release will also impact the production release. In addition to notifying HID of the release, any changes to the following panels should be highlighted (as these are panels used by HID as part of their screen scraping process):

Provider	
Related Data ➔ Other ➔ License	
Recipient	
Information	Medicare A
Benefit Plan	Medicare B
Reference	
Drug	Benefit Plan Coverage Rules
Federal MAC	Drug Rejection Criteria
AWP Rate	Other Rates
Pricing	State MAC Rate
PA	
Base Information	Line Item
Non-Medicaid Provider	

NOTE: Tag Name changes are controlled by the DNN framework and are completely dynamic. When we do a release, HID will have to validate/redo their scripts to pick up the new tag names. Although the additional UAT/ACC testing will reduce the chances of a tag name change being introduced to production without HID knowledge, the possibility will continue to exist.

Responsible Party(s): DXC Systems Supervisors

6.5 UAT Release Process

UI: UI UAT releases start between 12 p.m and 2:00 p.m. The UI release takes in any code scheduled for the UAT release.

Batch: N/A for Batch

Responsible Party(s): DXC UI Primary On-Call

6.6 Changes Promoted

On Wednesday evening of the UAT release, the approved CO/Defect system objects are promoted to the UAT/ACC environment. Any issues reported during this promotion are communicated to the SE team for resolution. The UAT Release Coordinator emails a list of batch system objects successfully promoted to the Alabama Systems Team distribution.

Responsible Party(s): DXC UAT Release Coordinator

6.7 Promotion Verified

On Thursday morning following the UAT release, each SE confirms their modules were correctly promoted to UAT/ACC. Status should be updated to "**UAT Implementation**".

NOTE: Contact the subsystem technical lead if help is needed to verify changes were successfully moved to UAT/ACC.

Responsible Party(s): DXC BAs & SEs

6.8 Agency and External Entity Testing

After changes are in UAT, the Agency has the option to execute their own testing before changes are scheduled to move to Production. UAT testing by the Agency is not usually required prior to production promotion.

DXC will contact any external entities or providers who are participating in testing of the promoted changes. DXC will assist, as needed, with any issues that occur during testing.

Responsible Party(s): DXC SEs & BAs, Agency & External Entities

7. Production Release Phase

If the assigned CO/Defect, moving to production, has been identified as having an impact to operations, the assigned BA will send an email update to the appropriate operational supervisor and manager, informing them of the move to production and noting the potential impacts to operations, providers, and/or recipients (**See Section 12. Operations Impact Email**).

Production releases are generally scheduled to occur every two weeks, on Tuesday evenings following a checkwrite weekend. This schedule is occasionally adjusted due to holidays or other extenuating circumstances. The production release schedule is posted on iTRACE at https://pwb.alxix.slg.eds.com/alxix/Testing/ under Production Promotions on the left side of the page.

7.1 UI Only: Pre-Verification of changes

Changes are moved to pre-deployment sites prior to officially moving to production. An email is generated when these sites are available.

Users have the same security access in these sites than they do in production.

Responsible Party(s): DXC SEs

7.2 Batch and UI CO/Defect Production Promotion List

UI: On Tuesday morning, prior to the production release, the DXC UI Primary On-Call will send a list of UI COs/Defects associated with the release.

Batch: On Tuesday afternoon, the day of the production release, the DXC Production Release Coordinator will send a list of system objects and COs/Defects associated with the release and request SEs to respond with any objects that should be added or removed before 5:00 p.m. The finalized list of system objects is what will be promoted from UAT to Production. The status for any changes expected to move to production should be "**Ready for Prod**" (or above).

NOTE: If sign-off has not been obtained for a change or if changes must be held to coordinate with other changes, the SE notifies the DXC UI Primary On-Call or Production Release Coordinator and has the affected CO/Defect/system objects pulled from the release.

Responsible Party(s): DXC SEs, UI Primary On-Call, and Production Release Coordinator

7.3 COs/Defects Associated with the Production Release

Prior to the Production release, DXC SEs should ensure any COs/Defects being added to the release are associated with the release in AIP. If a CO/Defect should not move with the release, it should also be removed from the release in AIP. The list of COs/Defects should have all their related system objects identified and listed in the previous step (Batch and UI CO/Defect Production Promotion List).

Responsible Party(s): DXC SEs

7.4 HID Notification

A courtesy reminder email is sent to HID to remind them of the Production release. The email should re-state any known impacts.

Responsible Party(s): DXC Systems Supervisors

7.5 Agency Notification

A list of all COs/Defects moving as part of the Production release is generated and sent to the Agency. This list should also include any COs/Defects/Tasks that have been placed in a "**Prod Implementation**" status since the last release.

Responsible Party(s): DXC Systems Supervisors

7.6 Changes Promoted

On the Tuesday evening of a scheduled release to Production, the approved requests are promoted to the Production environment.

UI: approved changes will be automatically re-directed to their respective Production sites (MMIS or Web Portal).

Responsible Party(s): DXC Production Release Coordinator

7.7 User Manual Updates

Technical Writer is notified of all User Manual updates (**See Section 8** for additional information on updating User Manuals). SE's/BA's will ensure any associated documentation in iTRACE is present and any updates are applied.

Responsible Party(s): DXC BAs, SEs and Technical Writer

7.8 Promotion Verified

On the day following a production release, the SE confirms the CO/Defect was successfully promoted to production.

NOTE: Contact the subsystem technical lead if help is needed to verify changes were successfully moved to Production.

There are two parts to the promotion verification:

7.8.1 Verify System Object(s)

UI: N/A

Batch: Verify system object(s) moved to production correctly.

7.8.2 Verify Change(s)

Each CO or Defect is unique in the change(s) to the application, thus the verification process will be unique as well. In the Implementation Plan, a section titled "Post Implementation Verification" provides a space to note the unique verification steps required and is to be completed prior to the construction walkthrough step. The verification steps will be reviewed

and approved, along with the rest of the Implementation Plan. Once the CO/Defect is promoted to production, the following is required to occur:

1. Verification of change(s)
   a. Change status of CO/Defect to "**Prod Verification**".
   b. Perform verification step(s) as outlined in the **Post Implementation Verification** section of the Implementation Plan.
   c. Attach supporting documentation verifying the change(s) are working as designed to the CO or Defect in iTRACE.
   d. Update the **Date Verified** field in the **Post Implementation Verification** section of the Implementation Plan.
2. If verification of change(s) will not or cannot occur within a reasonable timeframe due to the nature of change(s), then Agency approval is required to bypass the verification step:
   a. Change status of CO/Defect to "**Prod Verification**".
   b. Send an email to the Agency requesting approval to bypass the verification step (see section 7.10 Format of Agency Email Requesting Bypass).
   c. If the bypass is approved:
      i. Attach email from the Agency, approving bypass of verification, to the CO/Defect in iTRACE.
      ii. Update the **Verification Activity** and **Date Verified** fields in the **Post Implementation Verification** section of the Implementation Plan.
      iii. Change status of CO/Defect to "**Prod Implementation – Verification Bypassed**".

Responsible Party(s): DXC SEs and BAs

7.9 Subsystem CO/Defect Status Updated

The subsystem CO/Defect status is changed to "**Prod Implementation**" or "**Prod Implementation – Verification Bypassed"** only after final verification of necessary updates to User Manuals, requirements, report layouts, screen displays, and associated documents are complete in iTRACE, or the Agency has approved a formal bypass request.

Responsible Party(s): DXC SEs and BAs

7.10 Format of Agency Email Requesting Bypass

The following format of the subject line and text in the body of the email is required when sending a request to bypass the verification process noted above, to the Agency FPO of your CO or Defect with a cc to [redacted].

Subject line of the email sent to the Agency will follow the format below;

CO nnnn Verification process BYPASS request of a <*functional area*> CO

or

Defect nnnn Verification process BYPASS request of a <*functional area*> Defect

The text used in the body of the email to request Agency approval to bypass the verification process will follow the format below;

BYPASS request for <*Functional Area*> <CO/Defect> nnnn - <*CSR # if applicable*>, <*Short Description*> is requested for the following reasons;

<This section will list the reasons why the verification process is not within reasonable timeframe or effort. >

Agency's option to this request is to reply with;

1. **Approving the bypass request**
2. **Seek additional information on the bypass request**
3. **Request DXC proceed with the verification process**

Please feel free to contact me if you have any questions or concerns.

Thank you!

<Signature block>

Responsible Party(s): DXC SEs and BAs

7.11 Process for Closing out CSR's a.k.a. Mother CO's

When the last child CO of a CSR is approved and moved to a Production implementation status, leaders will:

1. Verify the Mother CO Subsystem Impact Form is complete
2. Send an email to the Agency Base team requesting closure of the Mother CO. The email will also give the Agency the option of having DXC staff provide a final end-to-end system walkthrough of changes associated with the CSR.

The email will follow the format below:

1. Email will be sent to the following;

[redacted], [redacted], and [redacted]

2. For the subject Line, it will state:

ACTION REQUIRED: CSR nnn – Mother CO xxxxx - <description of CO> ready to be CLOSED

3. Body of email will state:

DXC has completed all of the work required under CSR nnn – Mother CO xxxxx - <description of CSR>. The child CO(s), listed below are either canceled or in Production:

<Functional area> CO xxxxx - <description of CO> - <status of CO>

<Functional area> CO xxxxx - <description of CO> - <status of CO>

<Functional area> CO xxxxx - <description of CO> - <status of CO>

Etc…

The Agency has the option of having a final walkthrough of changes associated with the CSR, prior to giving approval for DXC to close the request.

<DXC systems leadership team will use this section to provide a recommendation for end-to-end testing or a reason why end-to-end testing is not necessary, (this is at the request of the Agency and the Agency has the right to decide ultimately if end-to-end testing is desired)>

Please respond with either:

Agency approves closure of CSR nnn – Mother CO xxxxx - <description of CSR>

-Or-

Agency requests a final walkthrough of changes associated with this CSR, prior to approving closure.

If the Agency requests a final end-to-end system walkthrough of the changes associated with the CSR, DXC systems leadership team will direct the BAs associated with the child CO's to request a meeting with the Agency to gather the requirements for the final walkthrough, create test cases, and present the final walkthrough of changes in a follow-up meeting.

If/when the Agency approves the final walkthrough, the Agency will submit an email follow-up to DXC approving closure of the CSR.

Once approved, DXC system leadership will:

- Change the status of the Mother CO to "**Prod Implementation**".
- Change the status of the CSR to "**Prod Implementation**". Changing the status will automatically generate an email to the Agency Base team and the Agency FPO(s) associated with the CSR to let them know the CSR has been closed.

Responsible Party(s): DXC Systems Supervisors, SEs, and BAs

7.12 Billable CSRs: Roll-up Estimate and Actual Hours

Once approval is received to close a billable CSR/Mother CO, both estimated and actual hours are rolled up from child COs associated with the CSR and manually added to the Metric section of the Mother CO in AIP:

- Estimates: Rolled-up from the individuals child COs in iTRACE. Hours were estimated as part of the "Complete design and begin coding changes and unit testing" step for billable COs.
- Actuals: Rolled up from the actual hours submitted against all the child COs associated with the CSR in TMS.

Over time, the DXC leadership team will evaluate the accuracy of estimates vs. actual hours and, if necessary, adjust the estimating tool historical data tables and the predefined percentages. Actuals will also help with future project management activities when a similar change is requested.

Responsible Party(s): DXC Systems Supervisors

8. Documentation

Documentation changes resulting from COs/Defects must be approved by the Agency. All iTRACE panel/report/letter changes and User Manuals must be presented to the Agency and approved at the same time MO test results are shown. This section contains a complete list of possible documentation updates for any given CO/Defect.

8.1 iTRACE Updates

8.1.1 UI Panels

If UI panels are affected, new screenshot(s) of the panel(s) must be prepared. In most cases, AIP must also be updated to reflect the changes.

NOTE: When creating images all PHI should be masked/redacted.

Responsible Party(s): DXC BAs and SEs

8.1.2 Reports and letters

If reports or letters are affected, new screenshot(s) of the report(s) or letter(s) must be completed. In most cases, the AIP must also be updated to reflect the changes.

NOTE: When creating images all PHI should be masked/redacted.

Responsible Party(s): DXC BAs and SEs

8.1.3 System documentation

Evaluation of the following system documentation must be made to determine any changes required as a result of the change:

- Job streams
- Job scripts
- Programs
- Data Model tables
- Code tables
- External/Internal interfaces

Responsible Party(s): DXC SEs

8.2 AMMIS Documentation Updates

Per 2010 ITB Requirement 3.01.170: "The Vendor shall as part of the implementation of any change orders or defects, update all other documentation with the new or updated requirement(s) and requirement(s) numbering. The modified documents must be presented to the Agency for approval prior to implementation".

Evaluation of the following AMMIS documents must be made to determine any changes required as a result of the change:

8.2.1 Operating Procedure User Manuals:

- Account Guidelines
- Claims Processing
- Financial Services
- Prior Authorization
- Provider Services
- Recipient Call Center

8.2.2 Subsystem User Manuals:

- Claims
- Drug Rebate
- DUR
- ePrescribe
- EPSDT
- EVCM – Web Portal, PES, Vendor Specs
- Financial
- LTC
- Managed Care
- MAR
- Prior Authorization
- Provider
- Provider Enrollment Web Portal
- Recipient
- Recipient AR
- Recipient Web Portal
- Reference
- SUR
- System Wide
- TPL

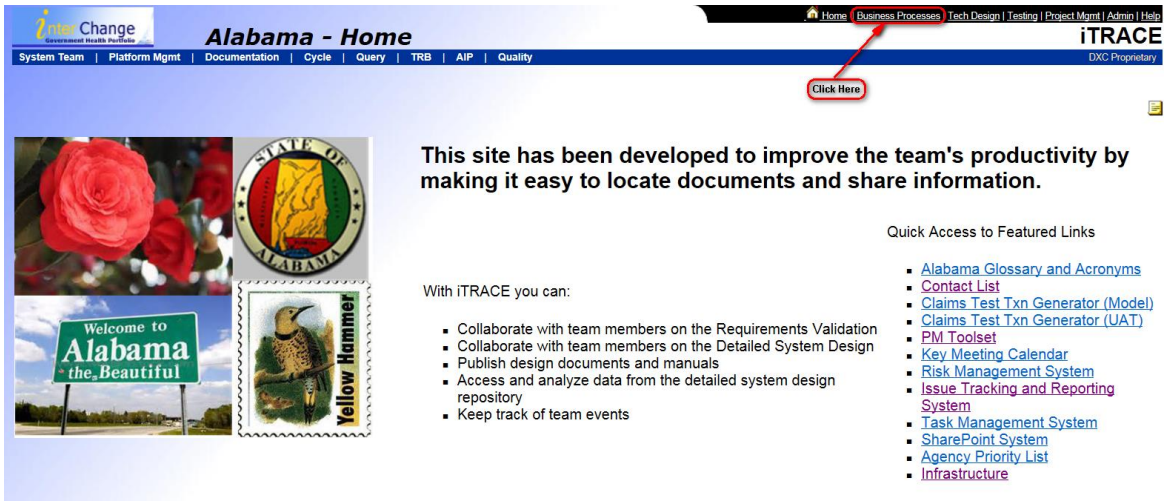
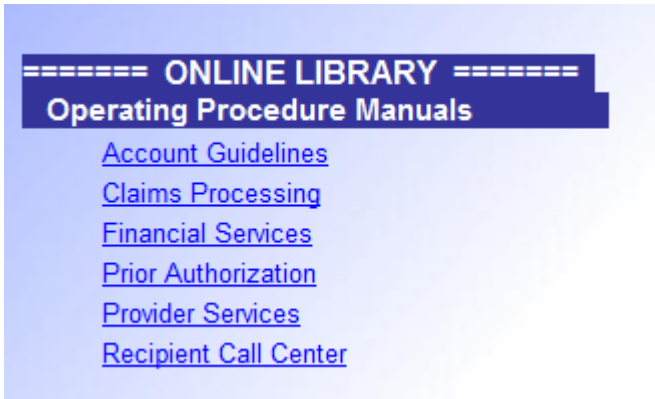
8.2.3 Additional Documentation:

- Provider Electronic Solutions (PES) User Manual
- Provider Contracts
- Provider Manual
- Recipient Benefit & Assignment Plans

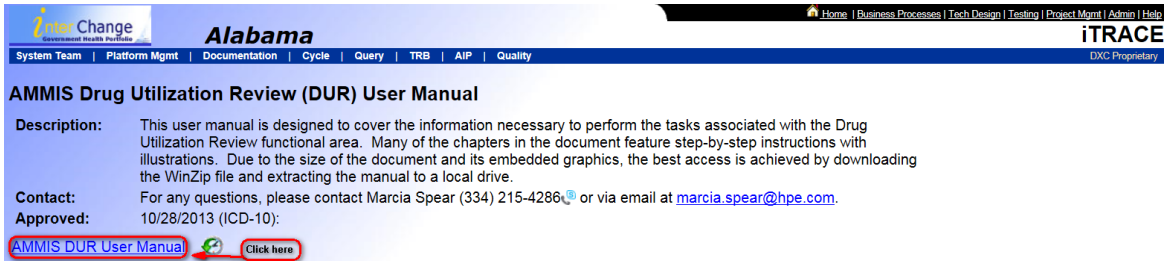
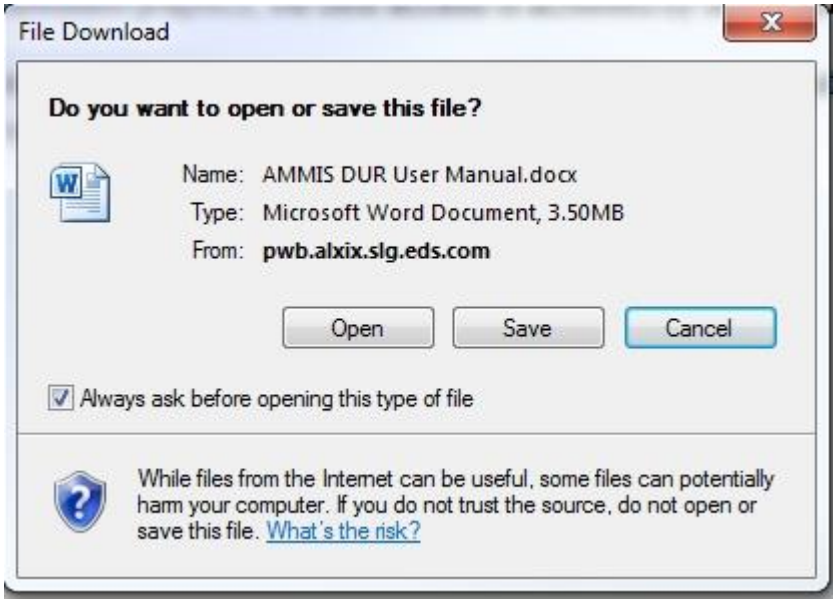
- Reimbursement Agreements

8.2.4 Documentation Process for Updating AMMIS Manuals

The following outlines the necessary steps to update the AMMIS Subsystem User Manuals, Operating Procedures, PES Manual, Web User manuals, HIPAA Companion Guide, Vendor Specifications and the NCPDP Companion Guide based on CO/Defect requirements:

Step	Action
1	Access iTRACE.
2	From the main menu. Click on **Business Processes**. 
3	Using the scroll bar locate the **Operating Procedure Manuals, User Manuals** or **Supplemental Documentation** section. 

Step	Action
	User Manuals Claims Drug Rebate DUR DSS ePrescribe EPSDT EVCM -- Web, PES, Vendor Specs Financial LTC Managed Care MAR Prior Authorization Provider Provider Enrollment Web Recipient Recipient AR Recipient Web Reference SUR System Wide TPL **Supplemental Documentation** ALXIX Network Diagram Business Processes Tec Design XREF Core iCE Business Processes Legacy Edits Provider Contracts Recipient Benefit & Assignment Plans Recipient Subsystem Documentation Reimbursement Agreements Rekey Documentation UAT Refresh
4	Click on the designated manual. Note: The AMMIS DUR User Manual was selected for the purposes of this step.

Step	Action
	 Click on the **hyperlink** to access the User Manual document.
5	 **Click Open**.
6	Locate section(s) to be updated based on CO or Defect.
7	Copy and paste section(s) into a Blank Word document.
8	Turn track changes on prior to making any updates to the new document. Note: Select Tools/Track Changes to activate.
9	Make necessary updates to section(s). Note: If this is a revision to a current panel/report include the correct heading number of the section from the master user manual. If this is a new addition of a panel/report include the heading number of where the new section will reside in the manual. For assistance contact the technical writer.
10	Save document in the following format: CO/Defect Number_(Panel/Report/Section) Name_Date. When multiple System Objects under the same subsystem are affected, a single document can be created under the name: CO/Defect Number(Subsystem Name)_Date.
11	Forward manual update(s) to Technical Writer for review prior to the internal walkthrough. Apply appropriate editing changes as indicated by Technical Writer.

Step	Action
12	Hold technical walkthrough with manual updates available for reviewers. Note: If further changes to the User Manual were suggested during the technical walkthrough, work with the Technical Writer to make the updates and verify format.
13	Notify Technical Writer via e-mail when CO/Defect moves to Production.
14	Technical Writer will update the appropriate master version of the manual and upload the revised version to iTRACE.

8.2.5 Documentation Process for Creating AMMIS Manual Entry for a New Panel or Report

Step	Action
1.	Open a blank MS Word document.
2.	Copy panel and/or report outline (provided in sections 8.2.5.1 and 8.2.5.2) into a MS Word document.
3.	Update outline with new panel and/or report information.
4.	Save document in the following format: CO/Defect Number_(Panel/Report) Name_Date. **Example:** CO 12345_Claims Search Results Panel_20140901 **Example:** DF 23456_CLM-0011-D_Clerk ID Recycle Claims Report_20140901 Note: Full panel name and/or report should be entered. When multiple System Objects under the same subsystem are affected, a single document can be created under the name: CO/Defect_Number (Subsystem Name)_Date. Note: Full subsystem name should be entered. **Example:** CO_12345 Claims_20140915
5.	Upload user manual documentation to Change Order.

8.2.5.1 New Panel Template

Use the following template as a guide to create a new user manual entry for a new panel.

New Panel Template.docx

8.2.5.2 New Report Template

Use the following template as a guide to create a new user manual entry for a new report.

New Report Template.docx

9. MO Release Phase – Exception Promotions

The Model Office (MO) Exception Promotion Process should be followed whenever changes need to be moved to MO outside of the normal MO Release schedule.

The assigned DXC SE should coordinate with the assigned BA prior to requesting an exception promotion. It is important the BA is aware of the CO/Defects progress in order to be able to obtain Agency approval.

Responsible Party(s): DXC SEs

9.1 Complete Exception Promotion Form

An Exception Promotion Form must be completed and sent to the Alabama Release Team distribution list. Any questions on how to complete this form, should be directed to the Alabama Release Team distribution list.

NOTE: There are separate forms for batch and UI.

Before sending the request for approval, set the CO/Defect status to "Ready for MO Implementation – EFix".

NOTE: All other documentation must be completed as though it were a regular promotion.

Responsible Party(s): DXC SEs

9.2 Exception Promotion Approval

Email approval from at least one Systems leader, the Solution Architect, and the DXC MO Release coordinator must be received.

NOTE: The Release coordinators and/or Solution Architect will review documentation as part of the approval. If documentation is not complete and signed off, the promotion may not proceed unless a manager overrides this decision.

Responsible Party(s): DXC Systems Supervisors, Release Coordinator, Solution Architect, SEs

9.3 Attach Exception Promotion to CO/Defect

Once you receive the required approvals, attach a copy of your completed Exception Promotion form to the CO/Defect in iTRACE.

Responsible Party(s): DXC SEs

NOTE: If Batch, skip to step 9.6. If UI, continue with step 9.4

9.4 Promote Code to the Corresponding Environment (UI)

9.4.1 Promote Code

After receiving approval, the SE will check-in the changes to the appropriate vault release repository and the UI secondary on-call will promote the code through the MO override process.

Responsible Party(s): DXC UI Secondary On-Call & SE

9.5 Request an MO Override Build (UI)

Once the modules have been checked in into the "AL Release" repository, the SE must request a MO Override build to the Alabama UI distribution list. This build will occur after COB that same day. The secondary SE will send a confirmation email so changes can be verified in MO.

Responsible Party(s): DXC UI Secondary On-Call & SE

9.6 Changes are Verified

Once the MO override build is complete, the SE will verify their changes are in MO and change the CO/Defect status to "**MO Implementation**." The SE communicates with the assigned BA that changes are in MO and are ready to be tested.

NOTE: Contact the subsystem technical lead if help is needed to verify changes were successfully moved to MO. If there are any issues promoting the code to MO, contact the Release Coordinator for investigation.

Responsible Party(s): DXC SEs

10. Production Release Phase – Exception Promotions

The Production Exception Promotion Process should be followed whenever changes need to be moved to Production outside of the normal Production Release schedule.

NOTE: Exception Promotions to Production must already have Agency approval and cannot be requested on Production Release day.

10.1 Complete Exception Promotion Form

An Exception Promotion Form must be completed and sent to the Alabama Release Team distribution list. Any questions on how to complete this form, should be directed to the Alabama Release Team distribution list.

NOTE: There are separate forms for batch and UI.

Responsible Party(s): DXC SEs

10.2 .Exception Promotion Approval

Email approval from at least one Manager, the Solution Architect, and the DXC Release coordinator must be received.

NOTE: The Release coordinators and/or Solution Architect will review documentation as part of the approval. If documentation is not complete and signed off, the promotion may not proceed.

Responsible Party(s): DXC Systems Supervisors, Release Coordinator, Solution Architect, SEs

10.3 Attach Exception Promotion to CO/Defect

Once you receive the required approvals, attach a copy of your completed Exception Promotion form to the change's folder in iTRACE.

The suggested naming is:

CO/Def <number><env> Exception Promotion Form MM-DD-YYYY.docx.

where <number> is the CO/Defect number and <env> is the environment where the changes will go into (MO/UAT/PROD)

Responsible Party(s): DXC SEs

NOTE: If Batch, skip to step 10.6. If UI, continue with step 10.4

10.4 Manually Promote Code to the Corresponding Repository (UI)

<u>These actions MUST be done before 5:00 PM Central, Monday thru Friday</u>;

10.4.1 Manually Promote Code

After receiving approval, the SE will promote the code manually to the corresponding repository, ALMXXX (where XXX is the release number currently in Production). The ALMXXX directory is located in the "AL Release" repository.

NOTE: In addition to the current MO release, the SE must also associate the changes to the next MO release (i.e. if the current MO release is 138, it would be tied to both 138 and 139).

Responsible Party(s): DXC SEs

10.4.2 Check In Code

Once the SE has copied all of the elements, they need to check in the code using the comments ALXXXX - where XXXX is the CO/Defect number.

Responsible Party(s): DXC SEs

10.5 Request a Production Override Build (UI)

Once all elements are checked in, the SE will change the status of the CO/Defect to "PROD OVERRIDE". Then a Production UI build has to be requested to the Alabama UI team. The UI Secondary On-Call SE will schedule a Production UI build that same night.

Responsible Party(s): DXC UI Secondary On-Call & SE

10.6 Changes are Verified

Each SE confirms that their modules were correctly promoted to production. It is also necessary for the team to review the automated emails to ensure the correct release was promoted. This step will help ensure a quick response to any changes promoted to production in error.

NOTE: Contact the subsystem technical lead if help is needed to verify changes were successfully moved to production. If it is found changes were not successfully moved to production, contact the release coordinator for investigation.

Responsible Party(s): DXC SEs

10.7 User Manual updates

Technical Writer is notified of all User Manual updates. See Section 8 for additional information on updating User Manuals.

Responsible Party(s): DXC SEs and BAs

10.8 Subsystem CO Status Updated

The subsystem CO/Defect status is changed to "**Prod Implementation**" or "**Prod Implementation – Verification Bypassed"** only after final verification of necessary updates to User Manuals, requirements, report layouts, screen displays, and associated documents are complete in iTRACE, or the Agency has approved a formal bypass request.

NOTE: In addition to the statuses mentioned above, the following statuses may be used as necessary at any time during the CO/Defect process:

a. "**Hold**" – If changes must wait until a later date
b. "**Cancelled**" – If changes are no longer required
c. "**Awaiting Further Definition**" – If additional information is needed from the Agency or other third party intermediary
d. "**Prod OVERRIDE**" – This is used for emergency changes which are placed in the Production Override library. This status will be changed to "**Prod Implementation**" or

"**Prod Implementation – Verification Bypassed**" once the changes have been promoted and/or verified through the normal chain of events.

Responsible Party(s): DXC SEs and BAs

11.Operations Impact Email

Standard template e-mail is to be used when e-mailing the impacted Operations team of potential impacts identified in a new BASE request.

The Subject line of the required e-mail should contain the following;

Operational Impacts in <CO, Defect, Task> ###### <CO Description>

The Body of the required e-mail should contain the following;

Good morning/afternoon,

This is an initial email on <CO, Defect, Task> #####, <CO description>, the <CO, Defect, Task> is on the books to be work at some point. Once this request is in the beginning stages of the lifecycle of a request, we will send another notification out to the team with any additional information & details as they are known.

At this time, here is what we believe is the impact to Operations, <include believed Impact>>

As always, please feel free to contact me with any questions you may have with respect to this request. In addition, as we know more details or have additional information to share, we will send additional updates, as soon as possible.

Thank you,

<BA name>

<Signature block>

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
CLAIMS SUBMISSION STATISTICS - MONTHLY
REPORT PERIOD: 10/01/2018 - 10/31/2018

Submission Type	Claim Type	Accepted Claims	Claims Suspended	Claims Paid	Claims Denied
837D	DENTAL CLAIMS	30,196	8	27,607	2,581
Total		30,196	8	27,607	2,581
837I	INPATIENT XOVER CLAIMS	2,472	18	1,863	591
	INPATIENT CLAIMS	9,228	4	7,244	1,980
	LONG TERM CARE CLAIMS	20,491	0	18,698	1,793
	OUTPATIENT CLAIMS	83,712	190	70,454	13,068
	OUTPATIENT XOVER CLAIMS	27,601	43	17,078	10,480
Total		143,504	255	115,337	27,912
837P	PROFESSIONAL CLAIMS	743,719	4,027	617,534	122,158
	PROFESSIONAL XOVER CLAIMS	185,822	2,208	115,867	67,747
Total		929,541	6,235	733,401	189,905
NON-STANDARD	DENTAL CLAIMS	312	1	258	53
	INPATIENT XOVER CLAIMS	51	1	4	46
	INPATIENT CLAIMS	248	106	34	108
	LONG TERM CARE CLAIMS	8	0	2	6
	OUTPATIENT CLAIMS	1,619	250	1,073	296
	OUTPATIENT XOVER CLAIMS	100	5	76	19
	PROFESSIONAL CLAIMS	22,845	1,347	18,703	2,795
	PROFESSIONAL XOVER CLAIMS	2,856	581	1,441	834
Total		28,039	2,291	21,591	4,157
WEB DDE	COMPOUND DRUG CLAIMS	2,363	0	1,350	1,013
	DENTAL CLAIMS	16,507	5	14,100	2,402
	INPATIENT XOVER CLAIMS	552	9	346	197
	INPATIENT CLAIMS	2,206	37	1,590	579
	LONG TERM CARE CLAIMS	4,530	4	3,697	829
	OUTPATIENT CLAIMS	9,586	67	7,225	2,294
	OUTPATIENT XOVER CLAIMS	2,087	1	1,198	888
	PHARMACY CLAIMS	804,910	0	505,207	299,703
	PROFESSIONAL CLAIMS	91,539	1,205	72,678	17,656
	PROFESSIONAL XOVER CLAIMS	15,187	186	12,600	2,401
Total		949,467	1,514	619,991	327,962
Claims Not Processed		0			
System Total		2,080,747	10,303	1,517,927	552,517

*** END OF REPORT ***

COLUMN NAME	TABLE NAME	DATA TYPE	LENGTH	PRECISION
AA_WAIT_DAYS	T_RE_MC_REASON	NUMBER	3.00	0.00
ACG	T_PF_RECIP_ACG	CHAR	4.00	0.00
ACG	T_PROFILE_ACG_WEIGHTS	CHAR	4.00	0.00
ACG	T_PROFILE_RECIP_ACG	CHAR	4.00	0.00
ACKBY_DATE	T_TRLOG	DATE	0.00	0.00
ACK_EXPECT	T_TRLOG	VARCHAR2	1.00	0.00
ACK_INTCH	T_AGREEMENTS	VARCHAR2	1.00	0.00
ACK_INTCH	T_TRADSTAT	VARCHAR2	1.00	0.00
ACK_MSG	T_AGREEMENTS	VARCHAR2	1.00	0.00
ACK_MSG	T_TRADSTAT	VARCHAR2	1.00	0.00
ACK_RQSTD	T_AGREEMENTS	VARCHAR2	1.00	0.00
ACK_RQSTD	T_TRADSTAT	VARCHAR2	1.00	0.00
ACK_RQSTD2	T_AGREEMENTS	VARCHAR2	1.00	0.00
ACK_RQSTD2	T_TRADSTAT	VARCHAR2	1.00	0.00
ACTION	T_PA_PC_UPD_HDR	CHAR	1.00	0.00
ACTION_CODE	T_PA_DDSD_UPD_HDR	CHAR	1.00	0.00
ACTION_CODE	T_PA_LTCA_UPD_HDR	CHAR	1.00	0.00
ACTION_STATUS	T_PA_HCBW_UPD_HDR	CHAR	1.00	0.00
ACTUAL_AMT	T_PROFILE_PEER_PROV_AMTS	NUMBER	10.00	2.00
ACTUAL_PERCENT	T_PERF_SUMM	NUMBER	6.00	2.00
ACTUAL_UNITS	T_PERF_SUMM	NUMBER	6.00	2.00
ACT_AMT_PER_PROV	T_PF_RECIP_CMPR	NUMBER	10.00	2.00
ACT_AMT_PER_PROV	T_PF_RE_CMPR_Q	NUMBER	10.00	2.00
ACT_AMT_PER_RECIP	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
ACW_TIME	T_PR_ATT_CMS	NUMBER	10.00	0.00
ADDR1	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
ADDR2	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
ADDR_AP_CITY	T_DS_RECIP_SOBRA_FAM_ABSNT	VARCHAR2	20.00	0.00

ADDR_AP_STATE	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	2.00	0.00
ADDR_AP_STRT1	T_DS_RECIP_SOBRA_FAM_ABSNT	VARCHAR2	22.00	0.00
ADDR_AP_STRT2	T_DS_RECIP_SOBRA_FAM_ABSNT	VARCHAR2	22.00	0.00
ADDR_AP_ZIP	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	5.00	0.00
ADDR_EMPLOYER	T_DS_RECIP_SOBRA_EMP	VARCHAR2	22.00	0.00
ADDR_EMPLOYER_CITY	T_DS_RECIP_SOBRA_EMP	VARCHAR2	20.00	0.00
ADDR_EMPLOYER_STATE	T_DS_RECIP_SOBRA_EMP	CHAR	2.00	0.00
ADDR_EMPLOYER_ZIP_PL_4	T_DS_RECIP_SOBRA_EMP	CHAR	9.00	0.00
ADDR_OTHER_CITY	T_DS_RECIP_SOBRA_APPL	VARCHAR2	20.00	0.00
ADDR_OTHER_STATE	T_DS_RECIP_SOBRA_APPL	CHAR	2.00	0.00
ADDR_OTHER_STRT1	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
ADDR_OTHER_STRT2	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
ADDR_OTHER_ZIP_PL_4	T_DS_RECIP_SOBRA_APPL	CHAR	9.00	0.00
ADD_DTE	T_LS_LVL1_PRICING	DATE	0.00	0.00
ADJ_IND	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
ADJ_IND	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
ADJ_IND	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	1.00	0.00
ADMIT_DATE	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
ADMIT_DATE	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
ADR1_RETURN_ST	T_835_CONSTANTS	CHAR	55.00	0.00
ADR1_RETURN_ST	T_FIN_CYCLE	CHAR	30.00	0.00
ADR2_RETURN_ST	T_835_CONSTANTS	CHAR	55.00	0.00
ADR2_RETURN_ST	T_FIN_CYCLE	CHAR	30.00	0.00
ADR_ADPH_CITY	T_RE_ADPH_1095	VARCHAR2	28.00	0.00
ADR_ADPH_STREET_1	T_RE_ADPH_1095	VARCHAR2	60.00	0.00
ADR_ADPH_STREET_2	T_RE_ADPH_1095	VARCHAR2	60.00	0.00
ADR_AGENT_CITY	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	30.00	0.00
ADR_AGENT_CITY	T_WEB_RECEIVER	CHAR	30.00	0.00
ADR_AGENT_CITY	T_WEB_RECEIVER_BACKUP	CHAR	30.00	0.00
ADR_AGENT_CITY_AFT	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_CITY_BEF	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STATE	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	2.00	0.00
ADR_AGENT_STATE	T_WEB_RECEIVER	CHAR	2.00	0.00

ADR_AGENT_STATE	T_WEB_RECEIVER_BACKUP	CHAR	2.00	0.00
ADR_AGENT_STATE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_AGENT_STATE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_AGENT_STRT1	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT1	T_WEB_RECEIVER	CHAR	30.00	0.00
ADR_AGENT_STRT1	T_WEB_RECEIVER_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT1_AFT	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT1_BEF	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT2	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT2	T_WEB_RECEIVER	CHAR	30.00	0.00
ADR_AGENT_STRT2	T_WEB_RECEIVER_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT2_AFT	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_STRT2_BEF	T_PR_WEB_CHG_BACKUP	CHAR	30.00	0.00
ADR_AGENT_ZIP	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	5.00	0.00
ADR_AGENT_ZIP	T_WEB_RECEIVER	CHAR	5.00	0.00
ADR_AGENT_ZIP	T_WEB_RECEIVER_BACKUP	CHAR	5.00	0.00
ADR_AGENT_ZIP_4	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	4.00	0.00
ADR_AGENT_ZIP_4	T_WEB_RECEIVER	CHAR	4.00	0.00
ADR_AGENT_ZIP_4	T_WEB_RECEIVER_BACKUP	CHAR	4.00	0.00
ADR_AGENT_ZIP_4_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_AGENT_ZIP_4_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_AGENT_ZIP_AFT	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_AGENT_ZIP_BEF	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_CARE_OF	T_CT_EOMB	VARCHAR2	50.00	0.00
ADR_CITY	T_ATTORNEY	CHAR	30.00	0.00
ADR_CITY	T_ATTORNEY_FIRM	VARCHAR2	30.00	0.00
ADR_CITY	T_BOARD_PART	CHAR	50.00	0.00
ADR_CITY	T_BORDER	VARCHAR2	30.00	0.00
ADR_CITY	T_CALL_OTHER_INFO	VARCHAR2	18.00	0.00
ADR_CITY	T_CA_PR_HB_LIC	CHAR	23.00	0.00
ADR_CITY	T_CLM_ADR_N3_N4	VARCHAR2	30.00	0.00
ADR_CITY	T_COUNTY	CHAR	15.00	0.00
ADR_CITY	T_COUNTY_OFFICE	CHAR	18.00	0.00
ADR_CITY	T_CT_EDIT_MEMBERS	VARCHAR2	18.00	0.00
ADR_CITY	T_CT_EOMB	VARCHAR2	18.00	0.00
ADR_CITY	T_CT_REFERRALS	VARCHAR2	18.00	0.00
ADR_CITY	T_DR_LBLR_CONTACT	VARCHAR2	27.00	0.00
ADR_CITY	T_FACILITY	CHAR	50.00	0.00
ADR_CITY	T_FIN_NONPROV	CHAR	15.00	0.00
ADR_CITY	T_HIPP_RESOURCE	CHAR	30.00	0.00

ADR_CITY	T_INS_AGENT	CHAR	30.00	0.00
ADR_CITY	T_MB_DEN_RECIP	CHAR	18.00	0.00
ADR_CITY	T_MB_NUM_RECIP	CHAR	18.00	0.00
ADR_CITY	T_OWNER	CHAR	50.00	0.00
ADR_CITY	T_OWNER_WI	CHAR	50.00	0.00
ADR_CITY	T_PA_HDR	VARCHAR2	30.00	0.00
ADR_CITY	T_PA_HDR_PE_TRNSP	VARCHAR2	30.00	0.00
ADR_CITY	T_PR_ADR_CASS	VARCHAR2	30.00	0.00
ADR_CITY	T_PR_APPLN	CHAR	15.00	0.00
ADR_CITY	T_PR_APPLN_WI	CHAR	15.00	0.00
ADR_CITY	T_PR_DEA_LIC	VARCHAR2	33.00	0.00
ADR_CITY	T_PR_HB_LIC	CHAR	23.00	0.00
ADR_CITY	T_PR_HB_LIC_KY	CHAR	30.00	0.00
ADR_CITY	T_PR_LABEL_CRIT	CHAR	15.00	0.00
ADR_CITY	T_PR_NAM_NPPES	VARCHAR2	40.00	0.00
ADR_CITY	T_PS_BILLING_CTR	VARCHAR2	18.00	0.00
ADR_CITY	T_PS_CASE_ADDRESS	VARCHAR2	18.00	0.00
ADR_CITY	T_PS_NONCERT_FAC	VARCHAR2	18.00	0.00
ADR_CITY	T_RE_1095	VARCHAR2	30.00	0.00
ADR_CITY	T_RE_ADDRESS	CHAR	18.00	0.00
ADR_CITY	T_RE_ADR_CASS	VARCHAR2	30.00	0.00
ADR_CITY	T_RE_BASE	CHAR	18.00	0.00
ADR_CITY	T_RE_BASE_DN	CHAR	18.00	0.00
ADR_CITY	T_RE_CHILD_HAD	CHAR	25.00	0.00
ADR_CITY	T_RE_CLOSE_MCD	CHAR	25.00	0.00
ADR_CITY	T_RE_DEMOGRAPHIC	CHAR	25.00	0.00
ADR_CITY	T_RE_EPSDT_LETTER	CHAR	15.00	0.00
ADR_CITY	T_RE_ID_CRD_ISS	CHAR	18.00	0.00
ADR_CITY	T_RE_INCOME_NEW	CHAR	25.00	0.00
ADR_CITY	T_RE_LOOKUP_PO_BOX	VARCHAR2	18.00	0.00
ADR_CITY	T_RE_MARITAL	CHAR	25.00	0.00
ADR_CITY	T_RE_MULTI_ADDRESS	CHAR	18.00	0.00
ADR_CITY	T_RE_SPONSOR	CHAR	25.00	0.00
ADR_CITY	T_STATE_ADDR	VARCHAR2	15.00	0.00
ADR_CITY	T_SUSPECT_RES	CHAR	18.00	0.00
ADR_CITY	T_TORTFEASOR	CHAR	30.00	0.00

ADR_CITY	T_TORTFEASOR_AL	CHAR	30.00	0.00
ADR_CITY	T_TP	VARCHAR2	30.00	0.00
ADR_CITY	T_TPL_AC_PARENT	CHAR	30.00	0.00
ADR_CITY	T_TPL_CASE_INFO	CHAR	30.00	0.00
ADR_CITY	T_TPL_CNTY_PROS	CHAR	15.00	0.00
ADR_CITY	T_TPL_CONTRACTOR	CHAR	15.00	0.00
ADR_CITY	T_TPL_COUNTY_PROBATE	VARCHAR	30.00	0.00
ADR_CITY	T_TPL_LIEN	CHAR	30.00	0.00
ADR_CITY_2010AC_N401	T_CLM_DNTL_HDR	VARCHAR2	30.00	0.00
ADR_CITY_2010AC_N401	T_CLM_PHYS_HDR	VARCHAR2	30.00	0.00
ADR_CITY_2010AC_N401	T_CLM_UB92_HDR	VARCHAR2	30.00	0.00
ADR_CITY_2310C_N401	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00
ADR_CITY_2310E_N401	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
ADR_CITY_2310F_N401	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
ADR_CITY_2330B_N401	T_CLM_DNTL_2320	VARCHAR2	30.00	0.00
ADR_CITY_2330B_N401	T_CLM_PHYS_2320	VARCHAR2	30.00	0.00
ADR_CITY_2420D_N401	T_CLM_DNTL_2400	VARCHAR2	30.00	0.00
ADR_CITY_2420G_N401	T_CLM_PHYS_2400	VARCHAR2	30.00	0.00
ADR_CITY_2420H_N401	T_CLM_PHYS_2400	VARCHAR2	30.00	0.00
ADR_CITY_MAIL	T_DS_RECIP_DO_APPL	VARCHAR2	25.00	0.00
ADR_CITY_MAIL	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	25.00	0.00
ADR_CITY_PHYS	T_RE_BASE	CHAR	18.00	0.00
ADR_CITY_PHYS	T_RE_BASE_DN	CHAR	18.00	0.00
ADR_CITY_RES	T_DS_RECIP_DO_APPL	VARCHAR2	25.00	0.00
ADR_CITY_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	25.00	0.00
ADR_CLM_CITY	T_TPL_CORR_ADDR	CHAR	30.00	0.00
ADR_CLM_STATE	T_TPL_CORR_ADDR	CHAR	2.00	0.00
ADR_CLM_STRT1	T_TPL_CORR_ADDR	CHAR	55.00	0.00
ADR_CLM_STRT2	T_TPL_CORR_ADDR	CHAR	55.00	0.00
ADR_CLM_ZIP	T_TPL_CORR_ADDR	CHAR	15.00	0.00
ADR_CLM_ZIP_4	T_TPL_CORR_ADDR	CHAR	4.00	0.00
ADR_CONTACT_EMAIL	T_PR_ENRL	VARCHAR2	50.00	0.00
ADR_CONTACT_EMAIL	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00

ADR_CONTACT_EMAIL	T_PR_SVC_LOC_AL	VARCHAR2	50.00	0.00
ADR_CONTACT_EMAIL_AFT	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_CONTACT_EMAIL_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_CONTACT_EMAIL_BEF	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_CONTACT_EMAIL_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_CONTACT_LOCN	T_PS_CASE	VARCHAR2	24.00	0.00
ADR_COUNTRY	T_CLM_ADR_N3_N4	CHAR	3.00	0.00
ADR_COUNTY	T_CALL_OTHER_INFO	VARCHAR2	15.00	0.00
ADR_COUNTY	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_COUNTY_LISTED	T_DS_RECIP_DO_PREV_PROP	CHAR	2.00	0.00
ADR_COUNTY_PARCEL	T_DS_RECIP_DO_REAL_EST	CHAR	2.00	0.00
ADR_COUNTY_RES	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_COUNTY_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_DEST_CITY	T_TMSIS_COT003_CLM_DTL	VARCHAR2	28.00	0.00
ADR_DEST_LN1	T_TMSIS_COT003_CLM_DTL	VARCHAR2	60.00	0.00
ADR_DEST_LN2	T_TMSIS_COT003_CLM_DTL	VARCHAR2	60.00	0.00
ADR_DEST_STATE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
ADR_DEST_ZIP	T_TMSIS_COT003_CLM_DTL	VARCHAR2	9.00	0.00
ADR_ELIGIBLE_CITY	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	28.00	0.00
ADR_ELIGIBLE_LN1	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_ELIGIBLE_LN2	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_ELIGIBLE_LN3	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_ELIGIBLE_STATE	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	2.00	0.00
ADR_ELIGIBLE_ZIP	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	9.00	0.00
ADR_EMAIL	T_ANALYST	VARCHAR2	50.00	0.00
ADR_EMAIL	T_ATTORNEY	CHAR	50.00	0.00
ADR_EMAIL	T_CLERK_PROFILE	VARCHAR2	50.00	0.00
ADR_EMAIL	T_CT_EDIT_MEMBERS	VARCHAR2	50.00	0.00
ADR_EMAIL	T_DR_LBLR_CONTACT	VARCHAR2	40.00	0.00
ADR_EMAIL	T_DS_LVX_USER_REQ	VARCHAR2	256.00	0.00
ADR_EMAIL	T_DS_RECIP_DO_APPL	VARCHAR2	40.00	0.00

ADR_EMAIL	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	40.00	0.00
ADR_EMAIL	T_INS_AGENT	CHAR	50.00	0.00
ADR_EMAIL	T_PR_ADR	VARCHAR2	50.00	0.00
ADR_EMAIL	T_PR_ADR_AL	VARCHAR2	50.00	0.00
ADR_EMAIL	T_PR_ADR_WI	VARCHAR2	50.00	0.00
ADR_EMAIL	T_PR_ENRL_LOC	VARCHAR2	50.00	0.00
ADR_EMAIL	T_RE_EMAIL	VARCHAR2	50.00	0.00
ADR_EMAIL	T_TP	VARCHAR2	100.00	0.00
ADR_EMAIL	T_TPL_CONTRACTOR	VARCHAR2	40.00	0.00
ADR_EMAIL	T_TPL_EMPLOYER	CHAR	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_PR_ENRL_EFT_ACCT	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_AGENT_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_CH_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_CH_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
ADR_EMAIL_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
ADR_EMAIL_CLEARINGHOUSE	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
ADR_EMAIL_CLEARINGHOUSE	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	40.00	0.00
ADR_EMAIL_SSA	T_DS_RECIP_DO_APPL	VARCHAR2	40.00	0.00
ADR_EMAIL_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
ADR_EMAIL_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
ADR_EMAIL_VENDOR_CONTACT	T_WEB_RECEIVER	VARCHAR2	50.00	0.00

ADR_EMAIL_VENDOR_CONTACT	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_VENDOR_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_VENDOR_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_EMAIL_VT	T_DS_RECIP_DO_APPL	VARCHAR2	40.00	0.00
ADR_FIPS_STATE	T_MR_TMSIS_STATE_XREF	CHAR	2.00	0.00
ADR_INS_CARRIER_CITY	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	28.00	0.00
ADR_INS_CARRIER_LN1	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_INS_CARRIER_LN2	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_INS_CARRIER_LN3	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	60.00	0.00
ADR_INS_CARRIER_STATE	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	2.00	0.00
ADR_INS_CARRIER_ZIP	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	9.00	0.00
ADR_IP	T_FILE_SOLICITED_TRACK	VARCHAR2	21.00	0.00
ADR_MAIL	T_CALL_OTHER_INFO	VARCHAR2	50.00	0.00
ADR_MAIL_CITY	T_FIN_INSTITUTION	CHAR	30.00	0.00
ADR_MAIL_CITY	T_IRS_W9_INFO	CHAR	15.00	0.00
ADR_MAIL_CITY	T_PA_NONMED_PROV	CHAR	15.00	0.00
ADR_MAIL_CITY	T_POLICY_HOLDER	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ADR	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ADR_AL	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ADR_WI	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ENRL_EFT_ACCT	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_ENRL_LOC	CHAR	30.00	0.00
ADR_MAIL_CITY	T_PR_FIN_INST	CHAR	15.00	0.00
ADR_MAIL_CITY	T_RE_PARTD_PDP_CARRIER	CHAR	20.00	0.00
ADR_MAIL_CITY	T_TPL_CARRIER	CHAR	30.00	0.00
ADR_MAIL_CITY	T_TPL_CARRIER_AL	CHAR	30.00	0.00
ADR_MAIL_CITY	T_TPL_EMPLOYER	CHAR	30.00	0.00
ADR_MAIL_CITY	T_TPL_SUB	CHAR	15.00	0.00
ADR_MAIL_CITY_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_CITY_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00

ADR_MAIL_CITY_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_CITY_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_MAIL_CITY_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_CNT_ZIP	T_RE_EDB	CHAR	9.00	0.00
ADR_MAIL_EMAIL_AFT	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_MAIL_EMAIL_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_MAIL_EMAIL_BEF	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_MAIL_EMAIL_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_MAIL_INT	T_PR_ADR	VARCHAR2	50.00	0.00
ADR_MAIL_INT	T_PR_ADR_AL	VARCHAR2	50.00	0.00
ADR_MAIL_INT	T_PR_ADR_WI	VARCHAR2	50.00	0.00
ADR_MAIL_STATE	T_FIN_INSTITUTION	CHAR	2.00	0.00
ADR_MAIL_STATE	T_IRS_W9_INFO	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PA_NONMED_PROV	CHAR	2.00	0.00
ADR_MAIL_STATE	T_POLICY_HOLDER	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ADR	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ADR_AL	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ADR_WI	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ENRL_EFT_ACCT	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_ENRL_LOC	CHAR	2.00	0.00
ADR_MAIL_STATE	T_PR_FIN_INST	CHAR	2.00	0.00
ADR_MAIL_STATE	T_RE_PARTD_PDP_CARRIER	CHAR	2.00	0.00
ADR_MAIL_STATE	T_TPL_CARRIER	CHAR	2.00	0.00
ADR_MAIL_STATE	T_TPL_CARRIER_AL	CHAR	2.00	0.00
ADR_MAIL_STATE	T_TPL_EMPLOYER	CHAR	2.00	0.00
ADR_MAIL_STATE	T_TPL_SUB	CHAR	2.00	0.00
ADR_MAIL_STATE_AFT	T_PR_WEB_CHG	CHAR	2.00	0.00
ADR_MAIL_STATE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_MAIL_STATE_BEF	T_PR_WEB_CHG	CHAR	2.00	0.00
ADR_MAIL_STATE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_MAIL_STATE_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	2.00	0.00
ADR_MAIL_STRT1	T_IRS_W9_INFO	CHAR	30.00	0.00

ADR_MAIL_STRT1	T_PA_NONMED_PROV	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_POLICY_HOLDER	CHAR	55.00	0.00
ADR_MAIL_STRT1	T_PR_ADR	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_PR_ADR_AL	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_PR_ADR_WI	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_PR_ENRL_LOC	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_PR_FIN_INST	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_RE_PARTD_PDP_CARRIER	CHAR	30.00	0.00
ADR_MAIL_STRT1	T_TPL_CARRIER	CHAR	55.00	0.00
ADR_MAIL_STRT1	T_TPL_CARRIER_AL	CHAR	55.00	0.00
ADR_MAIL_STRT1	T_TPL_EMPLOYER	CHAR	55.00	0.00
ADR_MAIL_STRT1	T_TPL_SUB	CHAR	30.00	0.00
ADR_MAIL_STRT1_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_STRT1_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_MAIL_STRT1_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_STRT1_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_MAIL_STRT1_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_IRS_W9_INFO	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PA_NONMED_PROV	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_POLICY_HOLDER	CHAR	55.00	0.00
ADR_MAIL_STRT2	T_PR_ADR	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PR_ADR_AL	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PR_ADR_WI	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PR_ENRL_LOC	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_PR_FIN_INST	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_RE_PARTD_PDP_CARRIER	CHAR	30.00	0.00
ADR_MAIL_STRT2	T_TPL_CARRIER	CHAR	55.00	0.00
ADR_MAIL_STRT2	T_TPL_CARRIER_AL	CHAR	55.00	0.00
ADR_MAIL_STRT2	T_TPL_EMPLOYER	CHAR	55.00	0.00

ADR_MAIL_STRT2	T_TPL_SUB	CHAR	30.00	0.00
ADR_MAIL_STRT2_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_STRT2_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_MAIL_STRT2_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_MAIL_STRT2_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_MAIL_STRT2_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	30.00	0.00
ADR_MAIL_STRT_1	T_FIN_INSTITUTION	CHAR	30.00	0.00
ADR_MAIL_STRT_1	T_PR_ENRL_EFT_ACCT	CHAR	30.00	0.00
ADR_MAIL_STRT_2	T_FIN_INSTITUTION	CHAR	30.00	0.00
ADR_MAIL_STRT_2	T_PR_ENRL_EFT_ACCT	CHAR	30.00	0.00
ADR_MAIL_ZIP	T_FIN_INSTITUTION	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_IRS_W9_INFO	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PA_NONMED_PROV	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_POLICY_HOLDER	CHAR	15.00	0.00
ADR_MAIL_ZIP	T_PR_ADR	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PR_ADR_AL	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PR_ADR_WI	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PR_ENRL_EFT_ACCT	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PR_ENRL_EFT_ERA_MAINT	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_PR_ENRL_LOC	VARCHAR2	10.00	0.00
ADR_MAIL_ZIP	T_PR_FIN_INST	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_RE_PARTD_PDP_CARRIER	CHAR	5.00	0.00
ADR_MAIL_ZIP	T_TPL_CARRIER	CHAR	15.00	0.00
ADR_MAIL_ZIP	T_TPL_CARRIER_AL	CHAR	15.00	0.00
ADR_MAIL_ZIP	T_TPL_EMPLOYER	CHAR	15.00	0.00
ADR_MAIL_ZIP	T_TPL_SUB	CHAR	5.00	0.00
ADR_MAIL_ZIP_4	T_FIN_INSTITUTION	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_IRS_W9_INFO	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PA_NONMED_PROV	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_POLICY_HOLDER	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PR_ADR	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PR_ADR_AL	CHAR	4.00	0.00

ADR_MAIL_ZIP_4	T_PR_ADR_WI	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PR_ENRL_EFT_ACCT	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PR_ENRL_EFT_ERA_MAINT	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_PR_FIN_INST	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_RE_PARTD_PDP_CARRIER	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_TPL_CARRIER	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_TPL_CARRIER_AL	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_TPL_EMPLOYER	CHAR	4.00	0.00
ADR_MAIL_ZIP_4	T_TPL_SUB	CHAR	4.00	0.00
ADR_MAIL_ZIP_4_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
ADR_MAIL_ZIP_4_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_MAIL_ZIP_4_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
ADR_MAIL_ZIP_4_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_MAIL_ZIP_4_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	4.00	0.00
ADR_MAIL_ZIP_AFT	T_PR_WEB_CHG	CHAR	5.00	0.00
ADR_MAIL_ZIP_AFT	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_MAIL_ZIP_BEF	T_PR_WEB_CHG	CHAR	5.00	0.00
ADR_MAIL_ZIP_BEF	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_MAIL_ZIP_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	5.00	0.00
ADR_MC_PLAN_CITY	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	28.00	0.00
ADR_MC_PLAN_LN1	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_MC_PLAN_LN2	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_MC_PLAN_LN3	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_MC_PLAN_STATE	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	2.00	0.00
ADR_MC_PLAN_ZIP	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	9.00	0.00
ADR_NOTIFICATION_FROM	T_TRACK_NOTIFICATION	VARCHAR2	200.00	0.00
ADR_NOTIFICATION_TO	T_TRACK_NOTIFICATION	VARCHAR2	200.00	0.00
ADR_ORIGIN_CITY	T_TMSIS_COT003_CLM_DTL	VARCHAR2	28.00	0.00
ADR_ORIGIN_LN1	T_TMSIS_COT003_CLM_DTL	VARCHAR2	60.00	0.00
ADR_ORIGIN_LN2	T_TMSIS_COT003_CLM_DTL	VARCHAR2	60.00	0.00
ADR_ORIGIN_STATE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00

ADR_ORIGIN_ZIP	T_TMSIS_COT003_CLM_DTL	VARCHAR2	9.00	0.00
ADR_PATIENT_EMAIL	T_CLM_PHRM_HDR	VARCHAR2	80.00	0.00
ADR_PAYEE_CITY	T_DS_PAYEE_NAM_ADR	VARCHAR2	50.00	0.00
ADR_PAYEE_STATE	T_DS_PAYEE_NAM_ADR	CHAR	2.00	0.00
ADR_PAYEE_STREET_1	T_DS_PAYEE_NAM_ADR	VARCHAR2	100.00	0.00
ADR_PAYEE_STREET_2	T_DS_PAYEE_NAM_ADR	VARCHAR2	100.00	0.00
ADR_PAYEE_ZIP_CODE	T_DS_PAYEE_NAM_ADR	CHAR	5.00	0.00
ADR_PAYEE_ZIP_CODE_4	T_DS_PAYEE_NAM_ADR	CHAR	4.00	0.00
ADR_PAY_CITY_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_CITY_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_CITY_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_CITY_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_EMAIL_AFT	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_PAY_EMAIL_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_PAY_EMAIL_BEF	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_PAY_EMAIL_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_PAY_STATE_AFT	T_PR_WEB_CHG	CHAR	2.00	0.00
ADR_PAY_STATE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_PAY_STATE_BEF	T_PR_WEB_CHG	CHAR	2.00	0.00
ADR_PAY_STATE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
ADR_PAY_STRT1_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_STRT1_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_STRT1_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_STRT1_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_STRT2_AFT	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_STRT2_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_STRT2_BEF	T_PR_WEB_CHG	VARCHAR2	30.00	0.00
ADR_PAY_STRT2_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	30.00	0.00
ADR_PAY_ZIP_4_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
ADR_PAY_ZIP_4_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_PAY_ZIP_4_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
ADR_PAY_ZIP_4_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
ADR_PAY_ZIP_AFT	T_PR_WEB_CHG	CHAR	5.00	0.00
ADR_PAY_ZIP_AFT	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_PAY_ZIP_BEF	T_PR_WEB_CHG	CHAR	5.00	0.00
ADR_PAY_ZIP_BEF	T_PR_WEB_CHG_BACKUP	CHAR	5.00	0.00
ADR_PRESCRB_CITY	T_CLM_PHRM_HDR	VARCHAR2	20.00	0.00

ADR_PRESCRB_STATE	T_CLM_PHRM_HDR	CHAR	2.00	0.00
ADR_PRESCRB_STREET	T_CLM_PHRM_HDR	VARCHAR2	30.00	0.00
ADR_PRESCRB_ZIP	T_CLM_PHRM_HDR	VARCHAR2	15.00	0.00
ADR_PROV_LOC_CITY	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	28.00	0.00
ADR_PROV_LOC_COUNTY	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	3.00	0.00
ADR_PROV_LOC_LN1	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_PROV_LOC_LN2	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_PROV_LOC_LN3	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	60.00	0.00
ADR_PROV_LOC_STATE	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	2.00	0.00
ADR_PROV_LOC_ZIP	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	9.00	0.00
ADR_SANC_CITY	T_PR_SANCTION_AL	VARCHAR	30.00	0.00
ADR_SANC_CITY	T_PR_SANCTION_WI	VARCHAR	30.00	0.00
ADR_SANC_STATE	T_PR_SANCTION_AL	CHAR	2.00	0.00
ADR_SANC_STATE	T_PR_SANCTION_WI	CHAR	2.00	0.00
ADR_SANC_STREET	T_PR_SANCTION_AL	VARCHAR	30.00	0.00
ADR_SANC_STREET	T_PR_SANCTION_WI	VARCHAR	30.00	0.00
ADR_SANC_ZIP	T_PR_SANCTION_AL	CHAR	9.00	0.00
ADR_SANC_ZIP	T_PR_SANCTION_WI	CHAR	9.00	0.00
ADR_SITE	T_CT_CASE_TRACK	VARCHAR2	18.00	0.00
ADR_SITE_CITY	T_PMP_SVC_LOC_KY	CHAR	30.00	0.00
ADR_SITE_ST	T_PMP_SVC_LOC_KY	CHAR	2.00	0.00
ADR_SITE_STRT1	T_PMP_SVC_LOC_KY	CHAR	30.00	0.00
ADR_SITE_STRT2	T_PMP_SVC_LOC_KY	CHAR	30.00	0.00
ADR_SITE_ZIP	T_PMP_SVC_LOC_KY	CHAR	5.00	0.00
ADR_SITE_ZIP_4	T_PMP_SVC_LOC_KY	CHAR	4.00	0.00
ADR_STATE	T_ATTORNEY	CHAR	2.00	0.00
ADR_STATE	T_ATTORNEY_FIRM	CHAR	2.00	0.00
ADR_STATE	T_BOARD_PART	CHAR	2.00	0.00
ADR_STATE	T_CALL_OTHER_INFO	CHAR	2.00	0.00
ADR_STATE	T_CA_PR_HB_LIC	CHAR	2.00	0.00
ADR_STATE	T_CLM_ADR_N3_N4	CHAR	2.00	0.00
ADR_STATE	T_COUNTY	CHAR	2.00	0.00
ADR_STATE	T_COUNTY_OFFICE	CHAR	2.00	0.00

ADR_STATE	T_CT_EDIT_MEMBERS	CHAR	2.00	0.00
ADR_STATE	T_CT_EOMB	VARCHAR2	2.00	0.00
ADR_STATE	T_CT_REFERRALS	CHAR	2.00	0.00
ADR_STATE	T_DR_LBLR_CONTACT	CHAR	2.00	0.00
ADR_STATE	T_FACILITY	CHAR	2.00	0.00
ADR_STATE	T_FIN_NONPROV	CHAR	2.00	0.00
ADR_STATE	T_HIPP_RESOURCE	CHAR	2.00	0.00
ADR_STATE	T_INS_AGENT	CHAR	2.00	0.00
ADR_STATE	T_MB_DEN_RECIP	CHAR	2.00	0.00
ADR_STATE	T_MB_NUM_RECIP	CHAR	2.00	0.00
ADR_STATE	T_OWNER	CHAR	2.00	0.00
ADR_STATE	T_OWNER_WI	CHAR	2.00	0.00
ADR_STATE	T_PA_HDR	CHAR	2.00	0.00
ADR_STATE	T_PA_HDR_PE_TRNSP	CHAR	2.00	0.00
ADR_STATE	T_PR_ADR_CASS	CHAR	2.00	0.00
ADR_STATE	T_PR_APPLN	CHAR	2.00	0.00
ADR_STATE	T_PR_APPLN_WI	CHAR	2.00	0.00
ADR_STATE	T_PR_DEA_LIC	CHAR	2.00	0.00
ADR_STATE	T_PR_HB_LIC	CHAR	2.00	0.00
ADR_STATE	T_PR_HB_LIC_KY	CHAR	2.00	0.00
ADR_STATE	T_PR_NAM_NPPES	VARCHAR2	40.00	0.00
ADR_STATE	T_RE_1095	CHAR	2.00	0.00
ADR_STATE	T_RE_ADDRESS	CHAR	2.00	0.00
ADR_STATE	T_RE_ADPH_1095	CHAR	2.00	0.00
ADR_STATE	T_RE_ADR_CASS	CHAR	2.00	0.00
ADR_STATE	T_RE_BASE	CHAR	2.00	0.00
ADR_STATE	T_RE_BASE_DN	CHAR	2.00	0.00
ADR_STATE	T_RE_CHILD_HAD	CHAR	2.00	0.00
ADR_STATE	T_RE_CLOSE_MCD	CHAR	2.00	0.00
ADR_STATE	T_RE_DEMOGRAPHIC	CHAR	2.00	0.00
ADR_STATE	T_RE_EPSDT_LETTER	CHAR	2.00	0.00
ADR_STATE	T_RE_ID_CRD_ISS	CHAR	2.00	0.00
ADR_STATE	T_RE_INCOME_NEW	CHAR	2.00	0.00
ADR_STATE	T_RE_MARITAL	CHAR	2.00	0.00
ADR_STATE	T_RE_MULTI_ADDRESS	CHAR	2.00	0.00
ADR_STATE	T_RE_SPONSOR	CHAR	2.00	0.00
ADR_STATE	T_STATE_ADDR	CHAR	2.00	0.00
ADR_STATE	T_SUSPECT_RES	CHAR	2.00	0.00

ADR_STATE	T_TORTFEASOR	CHAR	2.00	0.00
ADR_STATE	T_TORTFEASOR_AL	CHAR	2.00	0.00
ADR_STATE	T_TP	CHAR	2.00	0.00
ADR_STATE	T_TPL_AC_PARENT	CHAR	2.00	0.00
ADR_STATE	T_TPL_CASE_INFO	CHAR	2.00	0.00
ADR_STATE	T_TPL_CNTY_PROS	CHAR	2.00	0.00
ADR_STATE	T_TPL_CONTRACTOR	CHAR	2.00	0.00
ADR_STATE	T_TPL_COUNTY_PROBATE	CHAR	2.00	0.00
ADR_STATE	T_TPL_LIEN	CHAR	2.00	0.00
ADR_STATE_2010AC_N402	T_CLM_DNTL_HDR	CHAR	2.00	0.00
ADR_STATE_2010AC_N402	T_CLM_PHYS_HDR	CHAR	2.00	0.00
ADR_STATE_2010AC_N402	T_CLM_UB92_HDR	CHAR	2.00	0.00
ADR_STATE_2310C_N402	T_CLM_DNTL_2300	CHAR	2.00	0.00
ADR_STATE_2310E_N402	T_CLM_PHYS_2300	CHAR	2.00	0.00
ADR_STATE_2310F_N402	T_CLM_PHYS_2300	CHAR	2.00	0.00
ADR_STATE_2330B_N402	T_CLM_DNTL_2320	CHAR	2.00	0.00
ADR_STATE_2330B_N402	T_CLM_PHYS_2320	CHAR	2.00	0.00
ADR_STATE_2420D_N402	T_CLM_DNTL_2400	CHAR	2.00	0.00
ADR_STATE_2420G_N402	T_CLM_PHYS_2400	CHAR	2.00	0.00
ADR_STATE_2420H_N402	T_CLM_PHYS_2400	CHAR	2.00	0.00
ADR_STATE_LIC	T_PR_ENRL_IDENTIFIER	CHAR	2.00	0.00
ADR_STATE_LISTED	T_DS_RECIP_DO_PREV_PROP	CHAR	2.00	0.00
ADR_STATE_MAIL	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_STATE_MAIL	T_DS_RECIP_DO_APPL_SPONS	CHAR	2.00	0.00
ADR_STATE_PARCEL	T_DS_RECIP_DO_REAL_EST	CHAR	2.00	0.00

ADR_STATE_PHYS	T_RE_BASE	CHAR	2.00	0.00
ADR_STATE_PHYS	T_RE_BASE_DN	CHAR	2.00	0.00
ADR_STATE_RES	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_STATE_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
ADR_STREET	T_CT_EDIT_MEMBERS	VARCHAR2	30.00	0.00
ADR_STREET	T_CT_EOMB	VARCHAR2	30.00	0.00
ADR_STREET	T_CT_REFERRALS	VARCHAR2	30.00	0.00
ADR_STREET1	T_BOARD_PART	CHAR	50.00	0.00
ADR_STREET1	T_DR_LBLR_CONTACT	VARCHAR2	39.00	0.00
ADR_STREET1	T_FACILITY	CHAR	50.00	0.00
ADR_STREET1	T_OWNER	CHAR	50.00	0.00
ADR_STREET1	T_OWNER_WI	CHAR	50.00	0.00
ADR_STREET1	T_PR_NAM_NPPES	VARCHAR2	55.00	0.00
ADR_STREET1_MAIL	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET1_MAIL	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	35.00	0.00
ADR_STREET1_RES	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET1_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET2	T_BOARD_PART	CHAR	50.00	0.00
ADR_STREET2	T_DR_LBLR_CONTACT	VARCHAR2	39.00	0.00
ADR_STREET2	T_FACILITY	CHAR	50.00	0.00
ADR_STREET2	T_OWNER	CHAR	50.00	0.00
ADR_STREET2	T_OWNER_WI	CHAR	50.00	0.00
ADR_STREET2	T_PR_NAM_NPPES	VARCHAR2	55.00	0.00
ADR_STREET2_MAIL	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET2_MAIL	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	35.00	0.00
ADR_STREET2_RES	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET2_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	35.00	0.00
ADR_STREET3	T_DR_LBLR_CONTACT	VARCHAR2	39.00	0.00
ADR_STREET3_MAIL	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	35.00	0.00
ADR_STREET_1	T_ATTORNEY	CHAR	55.00	0.00
ADR_STREET_1	T_ATTORNEY_FIRM	VARCHAR2	55.00	0.00
ADR_STREET_1	T_CA_PR_HB_LIC	CHAR	30.00	0.00
ADR_STREET_1	T_CLM_ADR_N3_N4	VARCHAR2	55.00	0.00
ADR_STREET_1	T_COUNTY	CHAR	30.00	0.00
ADR_STREET_1	T_COUNTY_OFFICE	CHAR	30.00	0.00
ADR_STREET_1	T_FIN_NONPROV	CHAR	30.00	0.00
ADR_STREET_1	T_HIPP_RESOURCE	CHAR	55.00	0.00
ADR_STREET_1	T_INS_AGENT	CHAR	55.00	0.00

ADR_STREET_1	T_MB_DEN_RECIP	CHAR	30.00	0.00
ADR_STREET_1	T_MB_NUM_RECIP	CHAR	30.00	0.00
ADR_STREET_1	T_PA_HDR	VARCHAR2	55.00	0.00
ADR_STREET_1	T_PA_HDR_PE_TRNSP	VARCHAR2	55.00	0.00
ADR_STREET_1	T_PR_ADR_CASS	VARCHAR2	30.00	0.00
ADR_STREET_1	T_PR_APPLN	CHAR	30.00	0.00
ADR_STREET_1	T_PR_APPLN_WI	CHAR	30.00	0.00
ADR_STREET_1	T_PR_DEA_LIC	VARCHAR2	40.00	0.00
ADR_STREET_1	T_PR_HB_LIC	CHAR	30.00	0.00
ADR_STREET_1	T_PR_HB_LIC_KY	CHAR	30.00	0.00
ADR_STREET_1	T_PS_BILLING_CTR	VARCHAR2	26.00	0.00
ADR_STREET_1	T_PS_CASE_ADDRESS	VARCHAR2	26.00	0.00
ADR_STREET_1	T_PS_NONCERT_FAC	VARCHAR2	26.00	0.00
ADR_STREET_1	T_RE_1095	VARCHAR2	30.00	0.00
ADR_STREET_1	T_RE_ADDRESS	CHAR	30.00	0.00
ADR_STREET_1	T_RE_ADR_CASS	VARCHAR2	30.00	0.00
ADR_STREET_1	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_1	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_1	T_RE_CLOSE_MCD	CHAR	30.00	0.00
ADR_STREET_1	T_RE_DEMOGRAPHIC	CHAR	30.00	0.00
ADR_STREET_1	T_RE_EDB	CHAR	22.00	0.00
ADR_STREET_1	T_RE_EPSDT_LETTER	CHAR	30.00	0.00
ADR_STREET_1	T_RE_ID_CRD_ISS	CHAR	30.00	0.00
ADR_STREET_1	T_RE_INCOME_NEW	CHAR	30.00	0.00
ADR_STREET_1	T_RE_MARITAL	CHAR	30.00	0.00
ADR_STREET_1	T_RE_MULTI_ADDRESS	CHAR	30.00	0.00
ADR_STREET_1	T_RE_SPONSOR	CHAR	30.00	0.00
ADR_STREET_1	T_STATE_ADDR	VARCHAR2	30.00	0.00
ADR_STREET_1	T_SUSPECT_RES	CHAR	30.00	0.00
ADR_STREET_1	T_TORTFEASOR	CHAR	55.00	0.00
ADR_STREET_1	T_TORTFEASOR_AL	CHAR	55.00	0.00
ADR_STREET_1	T_TP	VARCHAR2	55.00	0.00

ADR_STREET_1	T_TPL_AC_PARENT	CHAR	55.00	0.00
ADR_STREET_1	T_TPL_CASE_INFO	CHAR	55.00	0.00
ADR_STREET_1	T_TPL_CNTY_PROS	CHAR	30.00	0.00
ADR_STREET_1	T_TPL_CONTRACTOR	CHAR	30.00	0.00
ADR_STREET_1	T_TPL_COUNTY_PROBATE	VARCHAR	55.00	0.00
ADR_STREET_1	T_TPL_LIEN	CHAR	55.00	0.00
ADR_STREET_1_PHYS	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_1_PHYS	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_2	T_ATTORNEY	CHAR	55.00	0.00
ADR_STREET_2	T_ATTORNEY_FIRM	VARCHAR2	55.00	0.00
ADR_STREET_2	T_CA_PR_HB_LIC	CHAR	30.00	0.00
ADR_STREET_2	T_CLM_ADR_N3_N4	VARCHAR2	55.00	0.00
ADR_STREET_2	T_COUNTY	CHAR	30.00	0.00
ADR_STREET_2	T_COUNTY_OFFICE	CHAR	30.00	0.00
ADR_STREET_2	T_FIN_NONPROV	CHAR	30.00	0.00
ADR_STREET_2	T_HIPP_RESOURCE	CHAR	55.00	0.00
ADR_STREET_2	T_INS_AGENT	CHAR	55.00	0.00
ADR_STREET_2	T_MB_DEN_RECIP	CHAR	30.00	0.00
ADR_STREET_2	T_MB_NUM_RECIP	CHAR	30.00	0.00
ADR_STREET_2	T_PA_HDR	VARCHAR2	55.00	0.00
ADR_STREET_2	T_PA_HDR_PE_TRNSP	VARCHAR2	55.00	0.00
ADR_STREET_2	T_PR_ADR_CASS	VARCHAR2	30.00	0.00
ADR_STREET_2	T_PR_APPLN	CHAR	30.00	0.00
ADR_STREET_2	T_PR_APPLN_WI	CHAR	30.00	0.00
ADR_STREET_2	T_PR_DEA_LIC	VARCHAR2	40.00	0.00
ADR_STREET_2	T_PR_HB_LIC	CHAR	30.00	0.00
ADR_STREET_2	T_PR_HB_LIC_KY	CHAR	30.00	0.00
ADR_STREET_2	T_PS_BILLING_CTR	VARCHAR2	26.00	0.00
ADR_STREET_2	T_PS_CASE_ADDRESS	VARCHAR2	26.00	0.00
ADR_STREET_2	T_PS_NONCERT_FAC	VARCHAR2	24.00	0.00
ADR_STREET_2	T_RE_1095	VARCHAR2	30.00	0.00

ADR_STREET_2	T_RE_ADDRESS	CHAR	30.00	0.00
ADR_STREET_2	T_RE_ADR_CASS	VARCHAR2	30.00	0.00
ADR_STREET_2	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_2	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_2	T_RE_CLOSE_MCD	CHAR	30.00	0.00
ADR_STREET_2	T_RE_DEMOGRAPHIC	CHAR	30.00	0.00
ADR_STREET_2	T_RE_EDB	CHAR	22.00	0.00
ADR_STREET_2	T_RE_EPSDT_LETTER	CHAR	30.00	0.00
ADR_STREET_2	T_RE_ID_CRD_ISS	CHAR	30.00	0.00
ADR_STREET_2	T_RE_INCOME_NEW	CHAR	30.00	0.00
ADR_STREET_2	T_RE_MARITAL	CHAR	30.00	0.00
ADR_STREET_2	T_RE_MULTI_ADDRESS	CHAR	30.00	0.00
ADR_STREET_2	T_RE_SPONSOR	CHAR	30.00	0.00
ADR_STREET_2	T_STATE_ADDR	VARCHAR2	30.00	0.00
ADR_STREET_2	T_SUSPECT_RES	CHAR	30.00	0.00
ADR_STREET_2	T_TORTFEASOR	CHAR	55.00	0.00
ADR_STREET_2	T_TORTFEASOR_AL	CHAR	55.00	0.00
ADR_STREET_2	T_TP	VARCHAR2	55.00	0.00
ADR_STREET_2	T_TPL_AC_PARENT	CHAR	55.00	0.00
ADR_STREET_2	T_TPL_CASE_INFO	CHAR	55.00	0.00
ADR_STREET_2	T_TPL_CNTY_PROS	CHAR	30.00	0.00
ADR_STREET_2	T_TPL_CONTRACTOR	CHAR	30.00	0.00
ADR_STREET_2	T_TPL_COUNTY_PROBATE	VARCHAR	55.00	0.00
ADR_STREET_2	T_TPL_LIEN	CHAR	55.00	0.00
ADR_STREET_2_PHYS	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_2_PHYS	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_3	T_PR_DEA_LIC	VARCHAR2	40.00	0.00
ADR_STREET_3	T_RE_ADDRESS	CHAR	30.00	0.00
ADR_STREET_3	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_3	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_3	T_RE_EDB	CHAR	22.00	0.00
ADR_STREET_3	T_RE_MULTI_ADDRESS	CHAR	30.00	0.00
ADR_STREET_3_PHYS	T_RE_BASE	CHAR	30.00	0.00
ADR_STREET_3_PHYS	T_RE_BASE_DN	CHAR	30.00	0.00
ADR_STREET_4	T_RE_EDB	CHAR	22.00	0.00
ADR_STREET_5	T_RE_EDB	CHAR	22.00	0.00
ADR_STREET_6	T_RE_EDB	CHAR	22.00	0.00

ADR_STREET_LISTED	T_DS_RECIP_DO_PREV_PROP	VARCHAR2	30.00	0.00
ADR_STREET_PARCEL	T_DS_RECIP_DO_REAL_EST	VARCHAR2	70.00	0.00
ADR_STRT1_2010AC_N301	T_CLM_DNTL_HDR	VARCHAR2	55.00	0.00
ADR_STRT1_2010AC_N301	T_CLM_PHYS_HDR	VARCHAR2	55.00	0.00
ADR_STRT1_2010AC_N301	T_CLM_UB92_HDR	VARCHAR2	55.00	0.00
ADR_STRT1_2310C_N301	T_CLM_DNTL_2300	VARCHAR2	55.00	0.00
ADR_STRT1_2310E_N301	T_CLM_PHYS_2300	VARCHAR2	55.00	0.00
ADR_STRT1_2310F_N301	T_CLM_PHYS_2300	VARCHAR2	55.00	0.00
ADR_STRT1_2330B_N301	T_CLM_DNTL_2320	VARCHAR2	55.00	0.00
ADR_STRT1_2330B_N301	T_CLM_PHYS_2320	VARCHAR2	55.00	0.00
ADR_STRT1_2420D_N301	T_CLM_DNTL_2400	VARCHAR2	55.00	0.00
ADR_STRT1_2420G_N301	T_CLM_PHYS_2400	VARCHAR2	55.00	0.00
ADR_STRT1_2420H_N301	T_CLM_PHYS_2400	VARCHAR2	55.00	0.00
ADR_STRT2_2010AC_N302	T_CLM_DNTL_HDR	VARCHAR2	55.00	0.00
ADR_STRT2_2010AC_N302	T_CLM_PHYS_HDR	VARCHAR2	55.00	0.00
ADR_STRT2_2010AC_N302	T_CLM_UB92_HDR	VARCHAR2	55.00	0.00
ADR_STRT2_2310C_N302	T_CLM_DNTL_2300	VARCHAR2	55.00	0.00
ADR_STRT2_2310E_N302	T_CLM_PHYS_2300	VARCHAR2	55.00	0.00
ADR_STRT2_2310F_N302	T_CLM_PHYS_2300	VARCHAR2	55.00	0.00
ADR_STRT2_2330B_N302	T_CLM_DNTL_2320	VARCHAR2	55.00	0.00
ADR_STRT2_2330B_N302	T_CLM_PHYS_2320	VARCHAR2	55.00	0.00
ADR_STRT2_2420D_N302	T_CLM_DNTL_2400	VARCHAR2	55.00	0.00
ADR_STRT2_2420G_N302	T_CLM_PHYS_2400	VARCHAR2	55.00	0.00
ADR_STRT2_2420H_N302	T_CLM_PHYS_2400	VARCHAR2	55.00	0.00
ADR_SVC_EMAIL_AFT	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_SVC_EMAIL_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_SVC_EMAIL_BEF	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
ADR_SVC_EMAIL_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
ADR_TAX_ADR1	T_FIN_CYCLE_TAX_INFO	CHAR	40.00	0.00
ADR_TAX_CITY	T_FIN_CYCLE_TAX_INFO	CHAR	40.00	0.00

ADR_TAX_STATE	T_FIN_CYCLE_TAX_INFO	CHAR	2.00	0.00
ADR_TAX_ZIP	T_FIN_CYCLE_TAX_INFO	CHAR	5.00	0.00
ADR_TAX_ZIP4	T_FIN_CYCLE_TAX_INFO	CHAR	4.00	0.00
ADR_ZIP	T_BOARD_PART	CHAR	5.00	0.00
ADR_ZIP	T_CT_EDIT_MEMBERS	CHAR	5.00	0.00
ADR_ZIP	T_CT_EOMB	CHAR	5.00	0.00
ADR_ZIP	T_CT_REFERRALS	CHAR	5.00	0.00
ADR_ZIP	T_DR_LBLR_CONTACT	CHAR	5.00	0.00
ADR_ZIP	T_FACILITY	CHAR	5.00	0.00
ADR_ZIP	T_OWNER	CHAR	5.00	0.00
ADR_ZIP	T_OWNER_WI	CHAR	5.00	0.00
ADR_ZIP	T_PR_DEA_LIC	CHAR	5.00	0.00
ADR_ZIP	T_TP	VARCHAR2	15.00	0.00
ADR_ZIP	T_TPL_AC_PARENT	CHAR	15.00	0.00
ADR_ZIP	T_TPL_CONTRACTOR	CHAR	5.00	0.00
ADR_ZIP	T_TPL_COUNTY_PROBATE	CHAR	5.00	0.00
ADR_ZIP_2010AC_N403	T_CLM_DNTL_HDR	VARCHAR2	15.00	0.00
ADR_ZIP_2010AC_N403	T_CLM_PHYS_HDR	VARCHAR2	15.00	0.00
ADR_ZIP_2010AC_N403	T_CLM_UB92_HDR	VARCHAR2	15.00	0.00
ADR_ZIP_2310C_N403	T_CLM_DNTL_2300	VARCHAR2	15.00	0.00
ADR_ZIP_2310E_N403	T_CLM_PHYS_2300	VARCHAR2	15.00	0.00
ADR_ZIP_2310F_N403	T_CLM_PHYS_2300	VARCHAR2	15.00	0.00
ADR_ZIP_2330B_N403	T_CLM_DNTL_2320	VARCHAR2	15.00	0.00
ADR_ZIP_2330B_N403	T_CLM_PHYS_2320	VARCHAR2	15.00	0.00
ADR_ZIP_2420D_N403	T_CLM_DNTL_2400	VARCHAR2	15.00	0.00

ADR_ZIP_2420G_N403	T_CLM_PHYS_2400	VARCHAR2	15.00	0.00
ADR_ZIP_2420H_N403	T_CLM_PHYS_2400	VARCHAR2	15.00	0.00
ADR_ZIP_4	T_BOARD_PART	CHAR	4.00	0.00
ADR_ZIP_4	T_CA_PR_HB_LIC	CHAR	4.00	0.00
ADR_ZIP_4	T_DR_LBLR_CONTACT	CHAR	4.00	0.00
ADR_ZIP_4	T_FACILITY	CHAR	4.00	0.00
ADR_ZIP_4	T_OWNER	CHAR	4.00	0.00
ADR_ZIP_4	T_OWNER_WI	CHAR	4.00	0.00
ADR_ZIP_4	T_PR_DEA_LIC	CHAR	4.00	0.00
ADR_ZIP_4	T_PR_HB_LIC	CHAR	4.00	0.00
ADR_ZIP_4	T_PR_HB_LIC_KY	CHAR	4.00	0.00
ADR_ZIP_4	T_RE_MULTI_ADDRESS	CHAR	4.00	0.00
ADR_ZIP_4	T_TPL_AC_PARENT	CHAR	4.00	0.00
ADR_ZIP_4	T_TPL_CASE_INFO	CHAR	4.00	0.00
ADR_ZIP_4	T_TPL_CONTRACTOR	CHAR	4.00	0.00
ADR_ZIP_4	T_TPL_COUNTY_PROBATE	CHAR	4.00	0.00
ADR_ZIP_CDE	T_PR_HB_LIC_KY	CHAR	5.00	0.00
ADR_ZIP_CODE	T_ATTORNEY	CHAR	15.00	0.00
ADR_ZIP_CODE	T_ATTORNEY_FIRM	VARCHAR2	15.00	0.00
ADR_ZIP_CODE	T_BUYA_MISMATCH	CHAR	9.00	0.00
ADR_ZIP_CODE	T_BUYB_BILL_INFO	CHAR	5.00	0.00
ADR_ZIP_CODE	T_BUYB_MISMATCH	CHAR	9.00	0.00
ADR_ZIP_CODE	T_CALL_OTHER_INFO	CHAR	5.00	0.00
ADR_ZIP_CODE	T_CA_PR_HB_LIC	CHAR	5.00	0.00
ADR_ZIP_CODE	T_CLM_ADR_N3_N4	VARCHAR2	15.00	0.00
ADR_ZIP_CODE	T_COUNTY	CHAR	5.00	0.00
ADR_ZIP_CODE	T_COUNTY_OFFICE	CHAR	5.00	0.00
ADR_ZIP_CODE	T_FIN_NONPROV	CHAR	5.00	0.00
ADR_ZIP_CODE	T_HIPP_RESOURCE	CHAR	15.00	0.00
ADR_ZIP_CODE	T_INS_AGENT	CHAR	15.00	0.00
ADR_ZIP_CODE	T_MB_DEN_RECIP	CHAR	5.00	0.00

ADR_ZIP_CODE	T_MB_NUM_RECIP	CHAR	5.00	0.00
ADR_ZIP_CODE	T_MR_TMSIS_ZIP_COUNTY	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PA_HDR	VARCHAR2	15.00	0.00
ADR_ZIP_CODE	T_PA_HDR_PE_TRNSP	VARCHAR2	15.00	0.00
ADR_ZIP_CODE	T_PR_ADR_CASS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PR_APPLN	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PR_APPLN_WI	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PR_HB_LIC	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
ADR_ZIP_CODE	T_PS_BILLING_CTR	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PS_CASE_ADDRESS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_PS_NONCERT_FAC	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_1095	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_ADDRESS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_ADPH_1095	CHAR	9.00	0.00
ADR_ZIP_CODE	T_RE_ADR_CASS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_BASE	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_BASE_DN	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_CHILD_HAD	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_CLOSE_MCD	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_DEMOGRAPHIC	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_EPSDT_LETTER	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_ID_CRD_ISS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_INCOME_NEW	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_LOOKUP_PO_BOX	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_MARITAL	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_MULTI_ADDRESS	CHAR	5.00	0.00
ADR_ZIP_CODE	T_RE_SPONSOR	CHAR	5.00	0.00
ADR_ZIP_CODE	T_STATE_ADDR	CHAR	5.00	0.00
ADR_ZIP_CODE	T_SUSPECT_RES	CHAR	5.00	0.00
ADR_ZIP_CODE	T_TORTFEASOR	CHAR	15.00	0.00
ADR_ZIP_CODE	T_TORTFEASOR_AL	CHAR	15.00	0.00
ADR_ZIP_CODE	T_TPL_CASE_INFO	VARCHAR2	20.00	0.00
ADR_ZIP_CODE	T_TPL_CNTY_PROS	CHAR	5.00	0.00

ADR_ZIP_CODE	T_TPL_LIEN	CHAR	15.00	0.00
ADR_ZIP_CODE_4	T_ATTORNEY	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_ATTORNEY_FIRM	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_CALL_OTHER_INFO	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_COUNTY	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_COUNTY_OFFICE	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_FIN_NONPROV	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_HIPP_RESOURCE	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_INS_AGENT	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_MB_DEN_RECIP	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_MB_NUM_RECIP	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PR_ADR_CASS	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PR_APPLN	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PR_APPLN_WI	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PS_BILLING_CTR	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PS_CASE_ADDRESS	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_PS_NONCERT_FAC	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_1095	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_ADDRESS	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_ADR_CASS	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_BASE	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_BASE_DN	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_CLOSE_MCD	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_DEMOGRAPHIC	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_EPSDT_LETTER	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_INCOME_NEW	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_MARITAL	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_RE_SPONSOR	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_STATE_ADDR	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_SUSPECT_RES	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_TORTFEASOR	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_TORTFEASOR_AL	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_TPL_CNTY_PROS	CHAR	4.00	0.00
ADR_ZIP_CODE_4	T_TPL_LIEN	CHAR	4.00	0.00
ADR_ZIP_CODE_4_PHYS	T_RE_BASE	CHAR	4.00	0.00
ADR_ZIP_CODE_4_PHYS	T_RE_BASE_DN	CHAR	4.00	0.00
ADR_ZIP_CODE_FROM	T_PR_LABEL_CRIT	CHAR	5.00	0.00

ADR_ZIP_CODE_PHYS	T_RE_BASE	CHAR	5.00	0.00
ADR_ZIP_CODE_PHYS	T_RE_BASE_DN	CHAR	5.00	0.00
ADR_ZIP_CODE_TO	T_PR_LABEL_CRIT	CHAR	5.00	0.00
ADR_ZIP_EXT	T_CT_EDIT_MEMBERS	CHAR	4.00	0.00
ADR_ZIP_EXT	T_CT_EOMB	CHAR	4.00	0.00
ADR_ZIP_EXT	T_CT_REFERRALS	CHAR	4.00	0.00
ADR_ZIP_PL_4_MAIL	T_DS_RECIP_DO_APPL	CHAR	9.00	0.00
ADR_ZIP_PL_4_MAIL	T_DS_RECIP_DO_APPL_SPONS	CHAR	9.00	0.00
ADR_ZIP_PL_4_RES	T_DS_RECIP_DO_APPL	CHAR	9.00	0.00
ADR_ZIP_PL_4_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	9.00	0.00
AFLD	T_TRLOG	NUMBER	10.00	0.00
AGE	T_MB_DEN_RECIP	NUMBER	3.00	0.00
AGE	T_MB_NUM_RECIP	NUMBER	3.00	0.00
AGE	T_PF_RECIP_ACG	CHAR	3.00	0.00
AGE	T_PROFILE_ASM_MM_PEER	NUMBER	4.00	0.00
AGE	T_PROFILE_ASM_MM_PROV	NUMBER	4.00	0.00
AGE	T_PROFILE_INPAT_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_INPAT_GLOBALS	NUMBER	2.00	0.00
AGE	T_PROFILE_INPAT_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_INPAT_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_INPAT_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_OUTPAT_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_OUTPAT_GLOBALS	NUMBER	2.00	0.00
AGE	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_OUTPAT_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARMREF_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARMREF_GLOBALS	NUMBER	2.00	0.00
AGE	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARMREF_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARM_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARM_GLOBALS	NUMBER	2.00	0.00

AGE	T_PROFILE_PHARM_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_PHARM_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PHARM_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PROFREF_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_PROFREF_GLOBALS	NUMBER	2.00	0.00
AGE	T_PROFILE_PROFREF_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_PROFREF_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PROFREF_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PROF_AMTS	NUMBER	4.00	0.00
AGE	T_PROFILE_PROF_GLOBALS	NUMBER	2.00	0.00
AGE	T_PROFILE_PROF_GRP_TOT	NUMBER	3.00	0.00
AGE	T_PROFILE_PROF_PROV_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_PROF_PT_TOT	NUMBER	4.00	0.00
AGE	T_PROFILE_RECIP	NUMBER	4.00	0.00
AGE	T_PROFILE_RECIP_ACG	CHAR	3.00	0.00
AGE	T_PROFILE_RPT_GRAPHS	NUMBER	4.00	0.00
AGE	T_PROFILE_TOT_CMPR	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_AVERAGE_EXPEND	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_AVE_EXP_AVGE	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_MR_AGE_GROUP	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_MR_MSIS_AID	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_STATE_COS	NUMBER	4.00	0.00
AGE_BEGIN_GROUP	T_UB92_COS	NUMBER	4.00	0.00
AGE_END_GROUP	T_AVERAGE_EXPEND	NUMBER	4.00	0.00
AGE_END_GROUP	T_AVE_EXP_AVGE	NUMBER	4.00	0.00
AGE_END_GROUP	T_MR_AGE_GROUP	NUMBER	4.00	0.00
AGE_END_GROUP	T_MR_MSIS_AID	NUMBER	4.00	0.00
AGE_END_GROUP	T_STATE_COS	NUMBER	4.00	0.00
AGE_END_GROUP	T_UB92_COS	NUMBER	4.00	0.00
AGE_GRP	T_PF_INPAT_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_INPAT_RP_TOT_Q	NUMBER	2.00	0.00

AGE_GRP	T_PF_NHOME_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_NHOME_RP_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_OUTPAT_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_OUTPAT_RP_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PHARM_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PHARM_RP_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PROF_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PROF_RP_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PRREF_RE_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_PRREF_RP_TOT_Q	NUMBER	2.00	0.00
AGE_GRP	T_PF_RECIP_CMPR	NUMBER	2.00	0.00
AGE_GRP	T_PF_RE_CMPR_Q	NUMBER	2.00	0.00
AGE_HIGH	T_ADJMS_AGE_SEX	NUMBER	3.00	0.00
AGE_LOW	T_ADJMS_AGE_SEX	NUMBER	3.00	0.00
AGE_MAX	T_EVS_SVC_COVERAGE	NUMBER	3.00	0.00
AGE_MAX	T_MC_PMP_PANEL_RESTRICT	NUMBER	3.00	0.00
AGE_MIN	T_EVS_SVC_COVERAGE	NUMBER	3.00	0.00
AGE_MIN	T_MC_PMP_PANEL_RESTRICT	NUMBER	3.00	0.00
ALIEN_ID_NUM	T_RE_ALIEN	CHAR	10.00	0.00
ALLOWED_AMT	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00

AMOUNT_ALLOWED	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_ALLOWED	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_PROV_TOTS	NUMBER	9.00	0.00

AMOUNT_BILLED	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
AMOUNT_BILLED	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
AMOUNT_BILLED	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
AMOUNT_BILLED	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
AMOUNT_BILLED	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
AMOUNT_BILLED	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMT	T_AR_DISP	NUMBER	13.00	2.00
AMT	T_ASC_PRICING	NUMBER	9.00	2.00
AMT	T_CAPITAL_COST	NUMBER	9.00	2.00

AMT	T_EDUCATION_CST	NUMBER	9.00	2.00
AMT	T_ERROR_EXTRACT	NUMBER	9.00	2.00
AMT	T_FIN_PROCESS_AR_DISP	NUMBER	13.00	2.00
AMT	T_HOSPICE_RATE	NUMBER	9.00	2.00
AMT	T_INP_LOC_RATE	NUMBER	9.00	2.00
AMT	T_MAX_FEE	NUMBER	9.00	2.00
AMT	T_OVERHEAD_FEE	NUMBER	9.00	2.00
AMT	T_PEER_GRP_CAPT	NUMBER	9.00	2.00
AMT	T_PEER_GRP_EDUC	NUMBER	9.00	2.00
AMT	T_PEER_GRP_INP_LOC	NUMBER	9.00	2.00
AMT	T_PREVAILING	NUMBER	9.00	2.00
AMT	T_PROCESS_MOD	NUMBER	9.00	2.00
AMT	T_PROFILE_INPAT_AMTS	NUMBER	10.00	2.00
AMT	T_PROFILE_INPAT_GLOBALS	NUMBER	11.00	2.00
AMT	T_PROFILE_INPAT_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_INPAT_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_INPAT_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_OUTPAT_AMTS	NUMBER	10.00	2.00
AMT	T_PROFILE_OUTPAT_GLOBALS	NUMBER	10.00	2.00
AMT	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_OUTPAT_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARMREF_AMTS	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARMREF_GLOBALS	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARMREF_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARM_AMTS	NUMBER	10.00	2.00

AMT	T_PROFILE_PHARM_GLOBALS	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARM_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARM_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARM_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	10.00	2.00
AMT	T_PROFILE_PROFREF_AMTS	NUMBER	10.00	2.00
AMT	T_PROFILE_PROFREF_GLOBALS	NUMBER	10.00	2.00
AMT	T_PROFILE_PROFREF_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PROFREF_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PROFREF_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PROF_AMTS	NUMBER	10.00	2.00
AMT	T_PROFILE_PROF_GLOBALS	NUMBER	10.00	2.00
AMT	T_PROFILE_PROF_GRP_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PROF_PROV_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_PROF_PT_TOT	NUMBER	10.00	2.00
AMT	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
AMT	T_PROFILE_RECIP	NUMBER	10.00	2.00
AMT	T_PROFILE_SELECTED_CASES	NUMBER	10.00	2.00
AMT	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
AMT	T_PR_CAPT_CST	NUMBER	9.00	2.00
AMT	T_PR_MDED_CST	NUMBER	9.00	2.00
AMT	T_PR_UB_LOC_RATE	NUMBER	9.00	2.00
AMT	T_REVENUE_FLAT_FEE	NUMBER	9.00	2.00
AMT	T_TPL_AR_CAS_DISPS	NUMBER	9.00	2.00
AMT	T_TPL_AR_DISPS	NUMBER	9.00	2.00
AMT	T_TPL_AR_DISPS_AL	NUMBER	9.00	2.00
AMT	T_TPL_AR_HEALTH	NUMBER	9.00	2.00
AMT	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	2.00

AMT	T_TPL_LAST_REPTD	NUMBER	9.00	2.00
AMT	T_VFC_ADMIN_FEE	NUMBER	9.00	2.00
AMT_2300_CN102	T_CLM_DNTL_2300	NUMBER	18.00	2.00
AMT_2300_HCP02	T_CLM_DNTL_2300	NUMBER	18.00	2.00
AMT_2300_HCP03	T_CLM_DNTL_2300	NUMBER	18.00	2.00
AMT_2300_HCP05	T_CLM_DNTL_2300	NUMBER	9.00	2.00
AMT_2320_AMT02_COB	T_CLM_PHYS_2320	NUMBER	18.00	2.00
AMT_2320_AMT02_COB_NON_COV	T_CLM_DNTL_2320	NUMBER	18.00	2.00
AMT_2320_AMT02_PAT_LIAB	T_CLM_DNTL_2320	NUMBER	18.00	2.00
AMT_2320_AMT02_PAT_LIAB	T_CLM_PHYS_2320	NUMBER	18.00	2.00
AMT_2320_AMT02_PAT_LIAB	T_CLM_UB92_2320	NUMBER	18.00	2.00
AMT_2320_MOA02	T_CLM_DNTL_2320	NUMBER	18.00	2.00
AMT_2320_MOA09	T_CLM_DNTL_2320	NUMBER	18.00	2.00
AMT_2400_CN102	T_CLM_DNTL_2400	NUMBER	18.00	2.00
AMT_2400_HCP02	T_CLM_DNTL_2400	NUMBER	18.00	2.00
AMT_2400_HCP03	T_CLM_DNTL_2400	NUMBER	18.00	2.00
AMT_2400_HCP05	T_CLM_DNTL_2400	NUMBER	9.00	2.00
AMT_2430_AMT02	T_CLM_DNTL_2430_AMT	NUMBER	18.00	2.00
AMT_2430_AMT02	T_CLM_UB92_2430	NUMBER	18.00	2.00
AMT_2430_AMT02_PAT_LIAB	T_CLM_PHYS_2430	NUMBER	18.00	2.00
AMT_60_PCT	T_LAB_FEE	NUMBER	9.00	2.00
AMT_62_PCT	T_LAB_FEE	NUMBER	9.00	2.00
AMT_AAC	T_DRUG_AAC_PRICE	NUMBER	12.00	5.00
AMT_ACCOM	T_ACCOMM_FEE	NUMBER	7.00	2.00
AMT_ACCT2_BAL	T_DS_RECIP_DO_BANK	NUMBER	8.00	2.00
AMT_ACCT3_BAL	T_DS_RECIP_DO_BANK	NUMBER	8.00	2.00
AMT_ACCT4_BAL	T_DS_RECIP_DO_BANK	NUMBER	8.00	2.00

AMT_ACCT_BAL	T_DS_RECIP_DO_BANK	NUMBER	8.00	2.00
AMT_ACC_SEQUEST	T_CA_XOVER	NUMBER	8.00	2.00
AMT_ACC_SEQUEST	T_FINAL_PHYS_XOVER	NUMBER	8.00	2.00
AMT_ACC_SEQUEST	T_FINAL_UB92_XOVER	NUMBER	8.00	2.00
AMT_ACC_SEQUEST	T_SUSP_PHYS_XOVER	NUMBER	8.00	2.00
AMT_ACC_SEQUEST	T_SUSP_UB92_XOVER	NUMBER	8.00	2.00
AMT_ACT_HOURS	T_CSR_SLC_TASK	NUMBER	9.00	0.00
AMT_ADJUSTED	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_ADJUSTED	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
AMT_ADJUSTED	T_CLM_EOB_XREF	NUMBER	9.00	2.00
AMT_ADJUSTMENT	T_CLM_CAS	NUMBER	9.00	2.00
AMT_ADJUSTMENT	T_PAYER_ADJUSTMENT	NUMBER	9.00	2.00
AMT_ADMIN_FEE	T_HIPP_RESOURCE	NUMBER	9.00	2.00
AMT_ADV_OFFSET	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_ADV_OFFSET	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_ALLOWED	T_LS_PHARMACY_OTHER	NUMBER	9.00	2.00
AMT_ALLOWED	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_ALLOWED	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_ALLOWED	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_ALLOWED	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_ALLOWED	T_TPL_COST_AVOID_SUMM	NUMBER	11.00	2.00
AMT_ALLWD	T_PROFILE_RECP_OUTLIER	NUMBER	11.00	2.00
AMT_ALLWD	T_SCOS_CLAIMS_BY_DATE	NUMBER	11.00	2.00

AMT_ALLWD	T_SCOS_CLAIMS_BY_MONTH	NUMBER	11.00	2.00
AMT_ALLWD	T_SCOS_CLAIMS_BY_QTR	NUMBER	11.00	2.00
AMT_ALLWD	T_SCOS_FIN_DATA_BY_DATE	NUMBER	11.00	2.00
AMT_ALLWD	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	11.00	2.00
AMT_ALLWD	T_SCOS_FIN_DATA_BY_QTR	NUMBER	11.00	2.00
AMT_ALWD	T_CA_DRUG	NUMBER	9.00	2.00
AMT_ALWD	T_CA_HDR_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_CC_HIST_ADJUST	NUMBER	9.00	2.00
AMT_ALWD	T_CLM_PGM_XREF	NUMBER	9.00	2.00
AMT_ALWD	T_CPAS_EXTRACT	NUMBER	9.00	2.00
AMT_ALWD	T_CPAS_SPLIT	NUMBER	9.00	2.00
AMT_ALWD	T_DR_CLMS_XREF	NUMBER	11.00	2.00
AMT_ALWD	T_DR_INVOICE_DTL	NUMBER	11.00	2.00
AMT_ALWD	T_DS_DNTL_ICN	NUMBER	10.00	2.00
AMT_ALWD	T_DS_HM_DETAIL	NUMBER	10.00	2.00
AMT_ALWD	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_ALWD	T_MEDPOL_UB92	NUMBER	9.00	2.00
AMT_ALWD	T_MPHX_DENTAL_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	2.00
AMT_ALWD	T_MPHX_PHYS_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_MR_LTC	NUMBER	12.00	2.00
AMT_ALWD	T_MR_POS	NUMBER	12.00	2.00
AMT_ALWD	T_MR_PROV	NUMBER	12.00	2.00
AMT_ALWD	T_MR_RECIP	NUMBER	12.00	2.00
AMT_ALWD	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_ALWD	T_MR_RE_CNTY	NUMBER	12.00	2.00
AMT_ALWD	T_MR_XOVER	NUMBER	12.00	2.00
AMT_ALWD	T_PD_DNTL_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_PD_PHARM_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_PD_PHYS_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_PD_UB92_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_PF_INPAT_RE_TOT_Q	NUMBER	14.00	2.00

AMT_ALWD	T_PF_INPAT_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_NHOME_RE_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_NHOME_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_OUTPAT_RE_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_OUTPAT_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PHARM_RE_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PHARM_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PROF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PROF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PRREF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_PRREF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_ALWD	T_PF_RECIP_CMPR	NUMBER	14.00	2.00
AMT_ALWD	T_PF_RE_CMPR_Q	NUMBER	14.00	2.00
AMT_ALWD	T_SUSP_DENTAL_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_SUSP_PHRM_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_SUSP_PHYS_DTL	NUMBER	9.00	2.00
AMT_ALWD	T_SUSP_UB92_DTL	NUMBER	9.00	2.00
AMT_ALWD_1	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_10	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_11	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_12	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_13	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_14	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_15	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_16	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_17	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00

AMT_ALWD_18	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_19	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_2	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_20	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_21	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_22	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_23	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_3	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_4	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_5	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_6	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_7	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_8	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_9	T_CA_HDR_DTL_DN	NUMBER	9.00	2.00
AMT_ALWD_MCARE	T_CA_XOVER	NUMBER	10.00	2.00
AMT_ALWD_MCARE	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_ALWD_MCARE	T_FINAL_UB92_XOVER	NUMBER	10.00	2.00
AMT_ALWD_MCARE	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_ALWD_MCARE	T_SUSP_UB92_XOVER	NUMBER	10.00	2.00
AMT_ALWD_OLD	T_CC_CR_SAVE	NUMBER	9.00	2.00
AMT_ALWD_REPL	T_CC_CR_SAVE	NUMBER	9.00	2.00
AMT_ALWD_TPL	T_CA_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_ALWD_TPL	T_CLM_TPL_SUMMARY	NUMBER	9.00	2.00

AMT_ANNUAL_DEDUCTIBLE	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	13.00	2.00
AMT_APPLIED_INTEREST	T_FIN_PROCESS_AR	NUMBER	9.00	2.00
AMT_APPRAISED	T_DS_RECIP_DO_REAL_EST	NUMBER	7.00	0.00
AMT_APPROVAL	T_DS_RECIP_DO_APPL	NUMBER	7.00	2.00
AMT_APPROVED	T_PHYS_DEXT_KEY	NUMBER	9.00	2.00
AMT_ATTY_FEE	T_CAS_REATT_INF	NUMBER	9.00	2.00
AMT_ATTY_WITHHELD	T_CAS_REATT_INF	NUMBER	9.00	2.00
AMT_AUTH	T_WEB_PA_DTL	NUMBER	7.00	2.00
AMT_AUTO_EQUITY	T_DS_RECIP_DO_VEHICLE	NUMBER	8.00	2.00
AMT_AVG_COST_ELIGIBLE	T_AUTO_PA_SUMMARY	NUMBER	15.00	6.00
AMT_AVG_COST_RECIP	T_AUTO_PA_SUMMARY	NUMBER	11.00	2.00
AMT_AVG_UNIT_PRICE_ACTUAL	T_AUTO_PA_SUMMARY	NUMBER	11.00	2.00
AMT_AVG_UNIT_PRICE_CALC	T_AUTO_PA_SUMMARY	NUMBER	11.00	2.00
AMT_AWP	T_DRUG_AWP	NUMBER	12.00	5.00
AMT_AWP_PRICE	T_LS_DRUG_AWP_PRICING	NUMBER	11.00	5.00
AMT_BACKUP_WHD_ADJ	T_1099_ADJUST	NUMBER	10.00	2.00
AMT_BACKUP_WHOLD	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_BACKUP_WITHHLD	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_BACKUP_WITHHLD	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_BALANCE	T_DR_DISPUTE_RESO	NUMBER	9.00	2.00
AMT_BALANCE	T_DR_LATE_NOTICE	NUMBER	9.00	2.00
AMT_BASE_DRG	T_UB92_HDR_INP_OLD	NUMBER	9.00	2.00
AMT_BENE_COINS	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COINS	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COINS	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COINS	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00

AMT_BENE_COPAY	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COPAY	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COPAY	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_COPAY	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_DEDUCT	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_DEDUCT	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_DEDUCT	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_BENE_DEDUCT	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_BILLED	T_CA_HDR_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_CA_MATERNITY_CARE	NUMBER	9.00	2.00
AMT_BILLED	T_CLM_BATCH_PROCESS	NUMBER	13.00	2.00
AMT_BILLED	T_CLM_BATCH_PROCESS_ENC	NUMBER	13.00	2.00
AMT_BILLED	T_CLM_MAT_CARE_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_CLM_MAT_CARE_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_DNTL_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_DNTL_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_PHRM_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_PHRM_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_PHYS_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_DENY_PHYS_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_DS_DNTL_ICN	NUMBER	10.00	2.00
AMT_BILLED	T_DS_HM_DETAIL	NUMBER	10.00	2.00
AMT_BILLED	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_BILLED	T_ENC_BATCH_PROCESS	NUMBER	13.00	2.00
AMT_BILLED	T_HIST_DIRECTORY	NUMBER	9.00	2.00
AMT_BILLED	T_LS_PHARMACY_OTHER	NUMBER	9.00	2.00
AMT_BILLED	T_MR_ERROR_DTL	NUMBER	12.00	2.00
AMT_BILLED	T_MR_ERROR_KY	NUMBER	12.00	2.00
AMT_BILLED	T_MR_LTC_REV	NUMBER	12.00	2.00
AMT_BILLED	T_MR_PROV_DENIED	NUMBER	12.00	2.00

AMT_BILLED	T_MR_PROV_SUSP	NUMBER	12.00	2.00
AMT_BILLED	T_MR_RECIP	NUMBER	12.00	2.00
AMT_BILLED	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_BILLED	T_MR_RE_CNTY	NUMBER	12.00	2.00
AMT_BILLED	T_PD_DNTL_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_PD_DNTL_HDR	NUMBER	8.00	2.00
AMT_BILLED	T_PD_DNTL_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_PD_PHARM_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_PD_PHARM_HDR	NUMBER	8.00	2.00
AMT_BILLED	T_PD_PHARM_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_PD_PHYS_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_PD_PHYS_HDR	NUMBER	8.00	2.00
AMT_BILLED	T_PD_PHYS_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_PF_INPAT_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_INPAT_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_NHOME_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_NHOME_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_OUTPAT_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_OUTPAT_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PHARM_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PHARM_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PROF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PROF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PRREF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_PRREF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_BILLED	T_PF_RECIP_CMPR	NUMBER	14.00	2.00
AMT_BILLED	T_PF_RE_CMPR_Q	NUMBER	14.00	2.00
AMT_BILLED	T_RETRO_SUMM_RECS	NUMBER	9.00	2.00

AMT_BILLED	T_SUSP_DENTAL_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_SUSP_DENTAL_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_SUSP_PHRM_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_SUSP_PHYS_DTL	NUMBER	9.00	2.00
AMT_BILLED	T_SUSP_PHYS_HDR	NUMBER	9.00	2.00
AMT_BILLED	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_BILLED	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_BILLED	T_TPL_COST_AVOID_SUMM	NUMBER	11.00	2.00
AMT_BILLED	T_TPL_THRESHOLD_SUMM	NUMBER	9.00	2.00
AMT_BILLED	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_BILLED_DENIED	T_MR_PROV	NUMBER	12.00	2.00
AMT_BILLED_DENIED	T_MR_RECIP	NUMBER	12.00	2.00
AMT_BILLED_DENIED	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_BILLED_DENIED	T_MR_RECIP_RANK	NUMBER	12.00	2.00
AMT_BILLED_OLD	T_CC_CR_SAVE	NUMBER	9.00	2.00
AMT_BILLED_ORIG	T_PHYS_DEXT_KEY	NUMBER	8.00	2.00
AMT_BILLED_PAID	T_MR_PROV	NUMBER	12.00	2.00
AMT_BILLED_PAID	T_MR_RECIP_RANK	NUMBER	12.00	2.00
AMT_BILLED_REPL	T_CC_CR_SAVE	NUMBER	9.00	2.00
AMT_BILLED_UB92	T_DENY_UB92_DTL	NUMBER	9.00	2.00
AMT_BILLED_UB92	T_DENY_UB92_HDR	NUMBER	9.00	2.00
AMT_BILLED_UB92	T_PD_UB92_DTL	NUMBER	9.00	2.00
AMT_BILLED_UB92	T_PD_UB92_HDR	NUMBER	9.00	2.00
AMT_BILLED_UB92	T_SUSP_UB92_DTL	NUMBER	9.00	2.00

AMT_BILLED_UB92	T_SUSP_UB92_HDR	NUMBER	9.00	2.00
AMT_BUDGET	T_FIN_BUDG_PERIOD	NUMBER	11.00	2.00
AMT_CAPITAL	T_PEER_GRP_DRGR_OLD	NUMBER	10.00	4.00
AMT_CAPITATED_PMT_REQ	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_CAPITATION	T_HIPP_CAPITATION_RATE	NUMBER	9.00	2.00
AMT_CAPITATION	T_MC_CAP_AMTS	NUMBER	9.00	2.00
AMT_CAPITATION	T_MC_CAP_AMTS_PMP	NUMBER	9.00	2.00
AMT_CAPITATION_MAX	T_MC_CAP_AMTS_RANGE	NUMBER	9.00	2.00
AMT_CAPITATION_MIN	T_MC_CAP_AMTS_RANGE	NUMBER	9.00	2.00
AMT_CAP_PAID	T_CAPITATION_ADJ	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAPITATION_ADJ_DN	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAPITATION_ADJ_WI	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAPITATION_HIST	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAPITATION_HIST_DN	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAPITATION_HIST_WI	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAP_MASS_ADJ_RST	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CAP_MASS_ADJ_RST_tmp	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CA_KICK_PYMT	NUMBER	10.00	2.00
AMT_CAP_PAID	T_CLM_KICK_PYMT	NUMBER	10.00	2.00
AMT_CASE_SETTLMNT	T_CASUALTY_REC	NUMBER	9.00	2.00
AMT_CASE_TOT_PREV	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_CASE_TOT_PREV	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
AMT_CHCK_MANUAL	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_CHCK_MANUAL	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_CHCK_MANUAL	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_CHCK_VOID	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_CHCK_VOID	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_CHCK_VOID	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_CHECK	T_FIN_PAYMENT	NUMBER	11.00	2.00

AMT_CHECK_CLEARED	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_CHG	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
AMT_CHG	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
AMT_CHG	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
AMT_CLAIM_INTEREST	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_CLAIM_INTEREST	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_CLAIM_OFFSET	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_CLAIM_OFFSET	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_CLMDED	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_CLM_CHARGE	T_AR_CLM_HDR	NUMBER	9.00	2.00
AMT_CLM_PRICE	T_LS_PHARMACY_OTHER	NUMBER	9.00	3.00
AMT_CLM_REFUND	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_CLM_REFUND	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_CLM_REFUND	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_CLOUTLR	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_CLTCHRG	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_CLTCOIN	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_CLTPYMT	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_CLTREIM	T_UB92_HDR_OUTPAT	NUMBER	9.00	2.00
AMT_COINSURANCE	T_CA_LTC	NUMBER	9.00	2.00
AMT_COINSURANCE	T_CA_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_COINSURANCE	T_CA_XOVER	NUMBER	9.00	2.00
AMT_COINSURANCE	T_CLM_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_COINSURANCE	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_COINSURANCE	T_FINAL_UB92_XOVER	NUMBER	9.00	2.00
AMT_COINSURANCE	T_HIPP_RESOURCE	NUMBER	8.00	2.00
AMT_COINSURANCE	T_MPHX_XOVER	NUMBER	9.00	2.00
AMT_COINSURANCE	T_MR_XOVER	NUMBER	12.00	2.00
AMT_COINSURANCE	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00

AMT_COINSURANCE	T_SUSP_UB92_XOVER	NUMBER	9.00	2.00
AMT_COINSURANCE	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_COMPROMISED	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_COMPROMISED	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
AMT_CONTRACT	T_CLM_CN1	NUMBER	9.00	2.00
AMT_CONT_FEE	T_TPL_CONT_FEE	NUMBER	9.00	0.00
AMT_CONV_FACTOR	T_CONV_FACTOR	NUMBER	9.00	4.00
AMT_CONV_FACTOR	T_DRUG_HCPCS	NUMBER	10.00	5.00
AMT_CONV_FACTOR	T_DR_JCODE_XWALK	NUMBER	9.00	4.00
AMT_CONV_FACTOR	T_PROC_CONV_FACTOR	NUMBER	9.00	4.00
AMT_COPAY	T_CA_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_COPAY	T_CA_XOVER	NUMBER	9.00	2.00
AMT_COPAY	T_CLM_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_COPAY	T_COPAY	NUMBER	5.00	2.00
AMT_COPAY	T_ERX_FORMULARY	NUMBER	10.00	2.00
AMT_COPAY	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_COPAY	T_FINAL_UB92_XOVER	NUMBER	9.00	2.00
AMT_COPAY	T_LS_PHARMACY_OTHER	NUMBER	9.00	2.00
AMT_COPAY	T_MAX_FEE	NUMBER	5.00	2.00
AMT_COPAY	T_MR_RECIP	NUMBER	12.00	2.00
AMT_COPAY	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_COPAY	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_COPAY	T_SUSP_UB92_XOVER	NUMBER	9.00	2.00
AMT_COPAY	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_COPAY	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_COPAY_MAX	T_EVS_SVC_COVERAGE	NUMBER	5.00	2.00
AMT_COPAY_MIN	T_EVS_SVC_COVERAGE	NUMBER	5.00	2.00
AMT_COPAY_RCO	T_CA_RCO	NUMBER	9.00	2.00
AMT_COPAY_RCO	T_CLM_RCO	NUMBER	9.00	2.00

AMT_COST_OUTLIER	T_UB92_HDR_INP_OLD	NUMBER	9.00	2.00
AMT_COST_SHARE	T_CAPITATION_ADJ_WI	NUMBER	10.00	2.00
AMT_COST_SHARE	T_CAPITATION_HIST_WI	NUMBER	10.00	2.00
AMT_COST_THD	T_CA_UB92	NUMBER	9.00	2.00
AMT_COST_THD	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_COUNTED	T_DS_RECIP_DO_RESOURCE	NUMBER	8.00	2.00
AMT_CO_PAY	T_CA_HDR_DTL	NUMBER	9.00	2.00
AMT_CO_PAY	T_CLM_PGM_XREF	NUMBER	7.00	2.00
AMT_CO_PAY	T_DENY_PHYS_HDR	NUMBER	7.00	2.00
AMT_CO_PAY	T_DS_HM_DETAIL	NUMBER	10.00	2.00
AMT_CO_PAY	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_CO_PAY	T_MR_LTC	NUMBER	12.00	2.00
AMT_CO_PAY	T_PD_DNTL_DTL	NUMBER	7.00	2.00
AMT_CO_PAY	T_PD_PHARM_HDR	NUMBER	7.00	2.00
AMT_CO_PAY	T_PD_PHYS_DTL	NUMBER	7.00	2.00
AMT_CO_PAY	T_PD_PHYS_HDR	NUMBER	7.00	2.00
AMT_CO_PAY	T_PD_UB92_DTL	NUMBER	7.00	2.00
AMT_CO_PAY	T_SUSP_PHYS_DTL	NUMBER	7.00	2.00
AMT_CO_PAY	T_SUSP_PHYS_HDR	NUMBER	7.00	2.00
AMT_CO_PAY	T_TPL_COIN_DED	NUMBER	7.00	2.00
AMT_CPAS1	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS2	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS3	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS4	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS5	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS6	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CPAS7	T_CPAS_HCFA_INFO	NUMBER	9.00	2.00
AMT_CUR_REQ	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_DAILY_RATE	T_TMSIS_CLT002_CLM_HDR	NUMBER	7.00	2.00
AMT_DAILY_RATE	T_TMSIS_COT002_CLM_HDR	NUMBER	7.00	2.00
AMT_DAY_CARE_CAP	T_DS_RECIP_SOBRA_APPL	NUMBER	7.00	2.00
AMT_DAY_OUTLIER	T_UB92_HDR_INP_OLD	NUMBER	9.00	2.00
AMT_DAY_OUTLIER_PER_DIEM	T_CA_UB92	NUMBER	9.00	2.00
AMT_DAY_OUTLIER_PER_DIEM	T_UB92_HDR_INP	NUMBER	9.00	2.00

AMT_DEDUCT	T_CA_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_DEDUCT	T_CA_XOVER	NUMBER	9.00	2.00
AMT_DEDUCT	T_CLM_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_DEDUCT	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_DEDUCT	T_FINAL_UB92_XOVER	NUMBER	9.00	2.00
AMT_DEDUCT	T_HIPP_RESOURCE	NUMBER	8.00	2.00
AMT_DEDUCT	T_HIPP_RESOURCE	NUMBER	9.00	2.00
AMT_DEDUCT	T_MPHX_XOVER	NUMBER	9.00	2.00
AMT_DEDUCT	T_MR_XOVER	NUMBER	12.00	2.00
AMT_DEDUCT	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_DEDUCT	T_SUSP_UB92_XOVER	NUMBER	9.00	2.00
AMT_DEDUCTIBLE	T_EMP_CARR_XREF	NUMBER	9.00	2.00
AMT_DEDUCTIBLE	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_DEDUCT_BLOOD	T_CA_XOVER	NUMBER	8.00	2.00
AMT_DEDUCT_BLOOD	T_FINAL_UB92_XOVER	NUMBER	8.00	2.00
AMT_DEDUCT_BLOOD	T_SUSP_UB92_XOVER	NUMBER	8.00	2.00
AMT_DEDUCT_FAM	T_TPL_COIN_DED	NUMBER	7.00	2.00
AMT_DEDUCT_INDV	T_TPL_COIN_DED	NUMBER	7.00	2.00
AMT_DETAIL_TPL	T_DENY_DNTL_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_DENY_PHRM_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_DENY_PHYS_DTL	NUMBER	9.00	2.00

AMT_DETAIL_TPL	T_DENY_UB92_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_PD_DNTL_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_PD_PHARM_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_PD_PHYS_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_PD_UB92_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_SUSP_DENTAL_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_SUSP_PHRM_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_SUSP_PHYS_DTL	NUMBER	9.00	2.00
AMT_DETAIL_TPL	T_SUSP_UB92_DTL	NUMBER	9.00	2.00
AMT_DISP	T_FIN_BUDG_DISP	NUMBER	11.00	2.00
AMT_DISP	T_FIN_PROCESS_BUDG_DISP	NUMBER	11.00	2.00
AMT_DISPENSE_FEE	T_TMSIS_CRX003_CLM_DTL	NUMBER	8.00	2.00
AMT_DISPOSITION	T_ADJ_REV_RQST	NUMBER	10.00	2.00
AMT_DISPOSITION	T_ADJ_VOID_RQST	NUMBER	10.00	2.00

AMT_DISPOSITION	T_CASH_RCPT_DISP	NUMBER	10.00	2.00
AMT_DISPOSITION	T_CASH_RCPT_DISP	NUMBER	13.00	2.00
AMT_DISPOSITION	T_FIN_PROCESS_AR	NUMBER	13.00	2.00
AMT_DISPOSITION	T_FIN_PROCESS_CASH_DISP	NUMBER	13.00	2.00
AMT_DISPOSITION	T_FIN_PROCESS_LIEN_DISP	NUMBER	10.00	2.00
AMT_DISPOSITION	T_LIEN_DISP	NUMBER	10.00	2.00
AMT_DISPOSITION_MOM	T_FIN_PROCESS_AR	NUMBER	13.00	2.00
AMT_DISPRO_PAY	T_PR_DISPRO_PAY	NUMBER	10.00	2.00
AMT_DISP_APPLIED11	T_DR_DISPUTE	NUMBER	11.00	2.00
AMT_DISP_APPLIED11	T_DR_INTEREST	NUMBER	11.00	2.00
AMT_DISP_APPLIED11	T_DR_PAYMENT_HDR	NUMBER	11.00	2.00
AMT_DISP_APPLIED11	T_DR_PAYMENT_XREF	NUMBER	11.00	2.00
AMT_DISP_SHARE	T_DENY_UB92_HDR	NUMBER	9.00	2.00
AMT_DISP_SHARE	T_PD_UB92_HDR	NUMBER	9.00	2.00
AMT_DISP_SHARE	T_SUSP_UB92_HDR	NUMBER	9.00	2.00
AMT_DISP_SHR	T_UB92_HDR_INP_OLD	NUMBER	9.00	2.00
AMT_DMH_SHARE	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_DOLLAR_ADJ	T_PR_LOC_RATE_REQ	NUMBER	8.00	2.00
AMT_DRG_OUTLIER	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_DRG_OUT_COST	T_CA_UB92	NUMBER	9.00	2.00
AMT_DRG_OUT_COST	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_DRUG_DEPOSIT	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_DRUG_UNIT_PRICE	T_CLM_NDC_DTL	NUMBER	17.00	2.00
AMT_DR_PER_UNIT_PD	T_DR_PAYMENT_XREF	NUMBER	11.00	6.00
AMT_DTL_CHARGE	T_AR_CLM_DTL	NUMBER	9.00	2.00
AMT_DTL_PMT	T_AR_CLM_DTL	NUMBER	9.00	2.00
AMT_DTL_TPL	T_CA_HDR_DTL	NUMBER	9.00	2.00

AMT_DTL_TPL	T_DS_HM_DETAIL	NUMBER	10.00	2.00
AMT_DUE_EST	T_UB92_HDR_PAYER	NUMBER	9.00	2.00
AMT_DUE_OR_REFUND	T_BUYA_MISMATCH	NUMBER	8.00	2.00
AMT_DUE_OR_REFUND	T_BUYB_MISMATCH	NUMBER	8.00	2.00
AMT_EFT_CLEARED	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_EMPLOYEE_COST	T_EMP_CARR_XREF	NUMBER	9.00	2.00
AMT_EMPLOYER_COST	T_EMP_CARR_XREF	NUMBER	9.00	2.00
AMT_EMP_DEPEND_PREMIUM	T_EMP_CARR_XREF	NUMBER	9.00	2.00
AMT_ENCOUNTER	T_CLM_PGM_XREF	NUMBER	10.00	2.00
AMT_ENCOUNTER	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_ENCOUNTER	T_MEDPOL_UB92	NUMBER	9.00	2.00
AMT_ENCOUNTER	T_MPHX_DENTAL_DTL	NUMBER	9.00	2.00
AMT_ENCOUNTER	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	2.00
AMT_ENCOUNTER	T_MPHX_PHYS_DTL	NUMBER	9.00	2.00
AMT_EQUITY	T_DS_RECIP_DO_REAL_EST	NUMBER	7.00	0.00
AMT_ERX_REDUCTION	T_CA_XOVER	NUMBER	10.00	2.00
AMT_ERX_REDUCTION	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_ERX_REDUCTION	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_ESTIMATED	T_RE_AR_OVERPAYMENT	NUMBER	11.00	2.00
AMT_EST_HOURS	T_CSR_SLC_TASK	NUMBER	9.00	0.00
AMT_EST_PROV_COST	T_CA_UB92	NUMBER	9.00	2.00
AMT_EST_PROV_COST	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_EXCLUDED	T_DS_RECIP_DO_RESOURCE	NUMBER	8.00	2.00
AMT_EXPENDITURE	T_AVERAGE_EXPEND	NUMBER	9.00	2.00
AMT_EXPENDITURE	T_AVE_EXP_AVGE	NUMBER	9.00	2.00
AMT_EXPENDITURE	T_AVE_EXP_DIAG	NUMBER	9.00	2.00
AMT_EXPENDITURE	T_HIPP_RESOURCE	NUMBER	9.00	2.00
AMT_EXPENSE	T_CASUALTY_REC	NUMBER	9.00	2.00
AMT_EXPENSE	T_CAS_REATT_INF	NUMBER	9.00	2.00
AMT_EXPENSE_PD	T_RE_EXPENSE	NUMBER	9.00	2.00
AMT_EXPENSE_TOT	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_EXPENSE_TOT	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_FAC_LV_ALW	T_CA_LTC	NUMBER	9.00	2.00
AMT_FAMILY_PREMIUM	T_EMP_CARR_XREF	NUMBER	9.00	2.00

AMT_FAM_ALLOC	T_DS_RECIP_DO_APPL	NUMBER	9.00	2.00
AMT_FEE	T_FEE_SCHEDULE	NUMBER	9.00	2.00
AMT_FEE	T_PR_ENROLL_SCRN	NUMBER	9.00	2.00
AMT_FICA	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_FICA	T_EXPENDITURE	NUMBER	9.00	2.00
AMT_FICA	T_EXPENDITURE_DN	NUMBER	9.00	2.00
AMT_FICA	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_FICA	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_FICA_ADJ	T_1099_ADJUST	NUMBER	10.00	2.00
AMT_FINAL_PAYMENT	T_CA_UB92	NUMBER	9.00	2.00
AMT_FINAL_PAYMENT	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_FLAG	T_FIN_BUDG_PERIOD	NUMBER	11.00	2.00
AMT_FULL_STAY	T_CA_UB92	NUMBER	9.00	2.00
AMT_FULL_STAY	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_FULL_STAY_DRG_PYMT	T_CA_UB92	NUMBER	9.00	2.00
AMT_FULL_STAY_DRG_PYMT	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_GENERIC_DOLLAR	T_GEN_RATES	NUMBER	9.00	2.00
AMT_GROSS	T_DS_RECIP_DO_INCOME	NUMBER	7.00	2.00
AMT_GROSS_DUE	T_CA_DRUG	NUMBER	9.00	2.00
AMT_GROSS_DUE	T_DENY_PHRM_HDR	NUMBER	9.00	2.00
AMT_GROSS_DUE	T_PD_PHARM_HDR	NUMBER	9.00	2.00
AMT_GROSS_DUE	T_PHRM_HDR_OPT	NUMBER	8.00	2.00
AMT_GROSS_DUE	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
AMT_GROSS_EARND_INC	T_DS_RECIP_CORE	NUMBER	5.00	0.00
AMT_GROSS_PAY	T_RE_INCOME_NEW	NUMBER	9.00	2.00
AMT_GROSS_UNEARND_INC	T_DS_RECIP_CORE	NUMBER	7.00	2.00
AMT_HCE_DEPOSIT	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_HELD	T_PAY_HOLD_TXN_XREF	NUMBER	13.00	2.00
AMT_HI_PREMIUM	T_RE_BNDX_BUYIN	NUMBER	5.00	2.00
AMT_HMS_DEPOSIT	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_HOMESTEAD	T_TPL_CASE_INFO	NUMBER	9.00	2.00

AMT_HOSP_ALW	T_CA_LTC	NUMBER	9.00	2.00
AMT_INCENTIVE	T_PHRM_HDR_OPT	NUMBER	8.00	2.00
AMT_INCOME	T_RE_BASE_DN	NUMBER	10.00	2.00
AMT_INCOME	T_RE_CASE	NUMBER	11.00	2.00
AMT_INCOME	T_RE_INCOME	NUMBER	10.00	2.00
AMT_INCOME	T_RE_MOVE_IN_OUT	NUMBER	9.00	2.00
AMT_INCR_CLMS_RMB	T_DR_INCR_ADJ	NUMBER	11.00	2.00
AMT_INCR_RBT_UNIT	T_DR_INCR_ADJ	NUMBER	11.00	6.00
AMT_INCR_REBATE_CLM	T_DR_INCR_ADJ	NUMBER	13.00	2.00
AMT_INSURANCE	T_LS_PHARMACY_OTHER	NUMBER	9.00	2.00
AMT_INTEREST	T_CLAIM_INTEREST	NUMBER	11.00	2.00
AMT_INTEREST	T_FIN_PROCESS_AR	NUMBER	9.00	2.00
AMT_INT_BAL	T_DR_LATE_NOTICE	NUMBER	9.00	2.00
AMT_INT_BILLED	T_DR_INCR_INT	NUMBER	11.00	2.00
AMT_INT_BILLED	T_DR_INVOICE	NUMBER	11.00	2.00
AMT_INT_DUE	T_DR_INCR_INT	NUMBER	11.00	2.00
AMT_INT_PAID	T_DR_INCR_INT	NUMBER	11.00	2.00
AMT_INT_WO	T_DR_INCR_INT	NUMBER	11.00	2.00
AMT_INT_WO	T_DR_INVOICE	NUMBER	11.00	2.00
AMT_IN_PROCESS	T_FIN_PROCESS_AR	NUMBER	13.00	2.00
AMT_IN_PROCESS_MOM	T_FIN_PROCESS_AR	NUMBER	13.00	2.00
AMT_IP_COINS_CAP	T_MCARE_DEDUCTIBLE	NUMBER	6.00	2.00
AMT_LATE_FILING	T_CA_XOVER	NUMBER	9.00	2.00
AMT_LATE_FILING	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_LATE_FILING	T_FINAL_UB92_XOVER	NUMBER	9.00	2.00
AMT_LATE_FILING	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_LATE_FILING	T_SUSP_UB92_XOVER	NUMBER	9.00	2.00
AMT_LIEN	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_LIEN	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00

AMT_LIEN_RATE	T_LIEN	NUMBER	10.00	2.00
AMT_LIFETIME_RES_CAP	T_MCARE_DEDUCTIBLE	NUMBER	6.00	2.00
AMT_LNACOIN	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	2.00
AMT_LNOUTLR	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	5.00
AMT_LNPYMT	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	2.00
AMT_LNRCOIN	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	2.00
AMT_LNREIM	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	2.00
AMT_LNTOTDEC	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	2.00
AMT_LOC_2_BED_RATE	T_PR_LOC_RATE	NUMBER	7.00	2.00
AMT_LOC_2_BED_RATE	T_PR_LOC_RATE_WI	NUMBER	7.00	2.00
AMT_LOC_ADD_RATE	T_PR_LOC_RATE	NUMBER	7.00	2.00
AMT_LOC_ADD_RATE	T_PR_LOC_RATE_WI	NUMBER	7.00	2.00
AMT_LTC_OTHR_INS	T_MR_LTC	NUMBER	12.00	2.00
AMT_LTC_PARTB_EXCL	T_DS_RECIP_DO_APPL	NUMBER	9.00	2.00
AMT_LTC_RCP_LIAB	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_MAC	T_DRUG_MAC	NUMBER	12.00	5.00
AMT_MAC	T_DRUG_OTC_MAC	NUMBER	9.00	5.00
AMT_MAC	T_DRUG_S_MAC	NUMBER	12.00	5.00
AMT_MAC_PRICE	T_LS_DRUG_MAC_PRICING	NUMBER	11.00	5.00
AMT_MARG_COST_PCT	T_CA_UB92	NUMBER	4.00	3.00
AMT_MARG_COST_PCT	T_UB92_HDR_INP	NUMBER	4.00	3.00
AMT_MAX_ALLOWED	T_COPAY	NUMBER	9.00	2.00
AMT_MAX_RECOUP	T_FIN_MAX_RECOUP	NUMBER	10.00	2.00
AMT_MAX_RECOUP	T_PR_ACCT_REC_MAX	NUMBER	10.00	2.00
AMT_MAX_RECOUP_AR	T_ACCT_REC	NUMBER	13.00	2.00
AMT_MAX_RECOUP_AR	T_ACCT_REC_DN	NUMBER	13.00	2.00
AMT_MAX_RECOUP_AR	T_FIN_PROCESS_AR	NUMBER	9.00	2.00

AMT_MCARE_PAID	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_MDCD_FFS_EQUIV	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_MDCD_FFS_EQUIV	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_MDCD_FFS_EQUIV	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_MDCD_FFS_EQUIV	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_MDCD_PD_DISP_SHARE	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_MDCR_COINS	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_MDCR_DEDUCT	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICAID_PD	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICAID_PD	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICAID_PD	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICAID_PD	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICARE_PAID	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_MEDICARE_PAID	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_MEDICARE_PD	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_MEDICARE_PD	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_MED_ED	T_PEER_GRP_DRGR_OLD	NUMBER	10.00	2.00
AMT_MIA_CLM_DISP_SHR	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_CLM_DRG	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_CLM_INDIR_TEACH	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_CLM_PPS_CAP	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_CLM_PPS_CAP_OUT	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_MSP_PASSTHRU	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_NONPAY_PROF	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_OLD_CAPITAL	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPSCAPDSHDRG	T_CLM_MIA	NUMBER	9.00	2.00

AMT_MIA_PPSCAPFSPDRG	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPSCAPHSPDRG	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPSOPFEDDRG	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPSOPHOSPDRG	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPS_CAPTIME	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIA_PPS_CAP_EX	T_CLM_MIA	NUMBER	9.00	2.00
AMT_MIN_ALLOWED	T_COPAY	NUMBER	9.00	2.00
AMT_MOA_ESRD_PAYMENT	T_CLM_MOA	NUMBER	9.00	2.00
AMT_MOA_HCPCS_PAYBL	T_CLM_MOA	NUMBER	9.00	2.00
AMT_MOA_NONPAY_PROF	T_CLM_MOA	NUMBER	9.00	2.00
AMT_MONETARY	T_CLM_AMT	NUMBER	9.00	2.00
AMT_MONETARY	T_CLM_AMT_VARIANCE	NUMBER	9.00	2.00
AMT_MONETARY	T_DRUG_EXCEPTION_AL	NUMBER	9.00	2.00
AMT_MONTHLY_INCOME	T_DS_RECIP_DO_FAMILY	NUMBER	9.00	2.00
AMT_NDC_PROFEE	T_CA_DRUG	NUMBER	9.00	2.00
AMT_NDC_PROFEE	T_DENY_PHRM_HDR	NUMBER	7.00	2.00
AMT_NDC_PROFEE	T_DISP_FEE	NUMBER	7.00	2.00
AMT_NDC_PROFEE	T_MPHX_PHRM_DTL_AL	NUMBER	7.00	2.00
AMT_NDC_PROFEE	T_PD_PHARM_HDR	NUMBER	7.00	2.00
AMT_NDC_PROFEE	T_PR_DISP_FEE	NUMBER	7.00	2.00

AMT_NDC_PROFEE	T_SUSP_PHRM_HDR	NUMBER	7.00	2.00
AMT_NEGATIVE_ADJ	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_NET	T_DS_RECIP_DO_INCOME	NUMBER	7.00	2.00
AMT_NET_BILLED	T_DENY_DNTL_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_DENY_PHRM_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_DENY_PHYS_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_PD_DNTL_HDR	NUMBER	8.00	2.00
AMT_NET_BILLED	T_PD_DNTL_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_PD_PHARM_HDR	NUMBER	8.00	2.00
AMT_NET_BILLED	T_PD_PHARM_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_PD_PHYS_HDR	NUMBER	8.00	2.00
AMT_NET_BILLED	T_PD_PHYS_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_SUSP_DENTAL_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
AMT_NET_BILLED	T_SUSP_PHYS_HDR	NUMBER	9.00	2.00
AMT_NET_VOUCHER	T_RE_NET_VOUCHER	NUMBER	7.00	2.00
AMT_NONCLM_OFFSET	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_NONCLM_OFFSET	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_NONCLM_REFUND	T_1099_DETAIL	NUMBER	10.00	2.00
AMT_NONCLM_REFUND	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_NONCLM_REFUND	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_NONC_ADJ_DRG_PYMT	T_CA_UB92	NUMBER	9.00	2.00
AMT_NONC_ADJ_DRG_PYMT	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_NONC_ADJ_FACT	T_CA_UB92	NUMBER	6.00	5.00
AMT_NONC_ADJ_FACT	T_UB92_HDR_INP	NUMBER	6.00	5.00
AMT_NONC_ADJ_OUTLIER	T_CA_UB92	NUMBER	9.00	2.00
AMT_NONC_ADJ_OUTLIER	T_UB92_HDR_INP	NUMBER	9.00	2.00

AMT_NONC_PER_DIEM	T_CA_UB92	NUMBER	9.00	2.00
AMT_NONC_PER_DIEM	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_NON_COVERED	T_CA_HDR_DTL	NUMBER	9.00	2.00
AMT_NON_COVERED	T_UB92_DTL_EXT_KEY	NUMBER	9.00	2.00
AMT_NON_COV_CHARGES	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_NON_COV_CHARGES	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_NO_ISSUE	T_FIN_NO_ISSUE	NUMBER	11.00	2.00
AMT_NPT_PRICE	T_NDDF_PRICE	NUMBER	12.00	5.00
AMT_OFFLINE_CLM	T_CASUALTY_CASE_OFFLINE	NUMBER	9.00	2.00
AMT_OPER_COST	T_PR_UB_LOC_RATE	NUMBER	9.00	2.00
AMT_OP_BENEFIT_STAGE	T_CLM_PHRM_COB_BENEFIT	NUMBER	10.00	2.00
AMT_OP_PAID	T_PHRM_COB	NUMBER	9.00	2.00
AMT_OP_PAT_RESP	T_CA_DRUG	NUMBER	10.00	2.00
AMT_OP_PAT_RESP	T_CLM_PHRM_COB_PAT_RESP	NUMBER	10.00	2.00
AMT_OP_PAT_RESP	T_DENY_PHRM_HDR	NUMBER	10.00	2.00
AMT_OP_PAT_RESP	T_PD_PHARM_HDR	NUMBER	10.00	2.00
AMT_OP_PAT_RESP	T_SUSP_PHRM_HDR	NUMBER	10.00	2.00
AMT_ORIGINAL_LIEN	T_LIEN	NUMBER	10.00	2.00
AMT_ORIG_CFY	T_RE_AR_OVERPAYMENT	NUMBER	11.00	2.00
AMT_ORIG_PFY1	T_RE_AR_OVERPAYMENT	NUMBER	11.00	2.00
AMT_ORIG_PFY2	T_RE_AR_OVERPAYMENT	NUMBER	11.00	2.00
AMT_OTHER	T_DS_RECIP_SOBRA_FAMILY	NUMBER	7.00	2.00
AMT_OTHER_CLAIMED_SUB	T_PHRM_HDR_OPT	NUMBER	8.00	2.00
AMT_OTHER_INSURANCE	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_OTHER_INSURANCE	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_OTHER_INSURANCE	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00

AMT_OTHER_INSURANCE	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_OUTLIER	T_CA_UB92	NUMBER	9.00	2.00
AMT_OUTLIER	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_OVERHEAD	T_DENY_UB92_HDR	NUMBER	9.00	2.00
AMT_OVERHEAD	T_PD_UB92_HDR	NUMBER	9.00	2.00
AMT_OVERHEAD	T_SUSP_UB92_HDR	NUMBER	9.00	2.00
AMT_PAID	T_ADJ_MASS_CLAIM	NUMBER	9.00	2.00
AMT_PAID	T_CASH_RECEIPT	NUMBER	9.00	2.00
AMT_PAID	T_CASH_RECEIPT	NUMBER	13.00	2.00
AMT_PAID	T_CAS_CLAIM_SUMM	NUMBER	9.00	2.00
AMT_PAID	T_CA_FIN	NUMBER	13.00	2.00
AMT_PAID	T_CA_MATERNITY_CARE	NUMBER	9.00	2.00
AMT_PAID	T_CHCK_CLM_XREF	NUMBER	10.00	2.00
AMT_PAID	T_CLM_BATCH_PROCESS	NUMBER	13.00	2.00
AMT_PAID	T_CLM_BATCH_PROCESS_ENC	NUMBER	13.00	2.00
AMT_PAID	T_CLM_BENEFIT_LIMITS	NUMBER	11.00	2.00
AMT_PAID	T_CLM_HIST_BALANCE	NUMBER	12.00	2.00
AMT_PAID	T_CLM_MAT_CARE_DTL	NUMBER	9.00	2.00
AMT_PAID	T_CLM_MAT_CARE_HDR	NUMBER	9.00	2.00
AMT_PAID	T_CLM_PGM_XREF	NUMBER	10.00	2.00
AMT_PAID	T_CPAS_EXTRACT	NUMBER	9.00	2.00
AMT_PAID	T_CPAS_SPLIT	NUMBER	9.00	2.00
AMT_PAID	T_CPAS_STRATA	NUMBER	12.00	2.00
AMT_PAID	T_DENY_PHYS_DTL	NUMBER	9.00	2.00
AMT_PAID	T_DS_DNTL_ICN	NUMBER	10.00	2.00
AMT_PAID	T_DS_HM_DETAIL	NUMBER	10.00	2.00
AMT_PAID	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_PAID	T_ENC_BATCH_PROCESS	NUMBER	13.00	2.00
AMT_PAID	T_EXPENDITURE	NUMBER	9.00	2.00
AMT_PAID	T_EXPENDITURE	NUMBER	13.00	2.00
AMT_PAID	T_EXPENDITURE_DN	NUMBER	13.00	2.00
AMT_PAID	T_FIN_835_TRACK	NUMBER	11.00	2.00

AMT_PAID	T_FIN_PAY_RELEASE	NUMBER	13.00	2.00
AMT_PAID	T_FIN_PROCESS_PYMT_XREF	NUMBER	10.00	2.00
AMT_PAID	T_LS_PHARMACY_CLAIMS	NUMBER	9.00	2.00
AMT_PAID	T_LS_SUMMARY_NDC	NUMBER	9.00	2.00
AMT_PAID	T_MEDPOL_UB92	NUMBER	9.00	2.00
AMT_PAID	T_MPHX_DENTAL_DTL	NUMBER	9.00	2.00
AMT_PAID	T_MPHX_INPT_HDR	NUMBER	9.00	2.00
AMT_PAID	T_MPHX_INPT_HDR2	NUMBER	9.00	2.00
AMT_PAID	T_MPHX_PHYS_DTL	NUMBER	9.00	2.00
AMT_PAID	T_MR_ERROR_DTL	NUMBER	12.00	2.00
AMT_PAID	T_MR_LTC	NUMBER	12.00	2.00
AMT_PAID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
AMT_PAID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
AMT_PAID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
AMT_PAID	T_MR_POS	NUMBER	12.00	2.00
AMT_PAID	T_MR_PROV	NUMBER	12.00	2.00
AMT_PAID	T_MR_PROV_PERFORM_KY	NUMBER	12.00	2.00
AMT_PAID	T_MR_RECIP	NUMBER	12.00	2.00
AMT_PAID	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_PAID	T_MR_RECIP_RANK	NUMBER	12.00	2.00
AMT_PAID	T_MR_RE_CNTY	NUMBER	12.00	2.00
AMT_PAID	T_MR_WVR_CLM	NUMBER	12.00	2.00
AMT_PAID	T_MR_XOVER	NUMBER	12.00	2.00
AMT_PAID	T_PD_DNTL_DTL	NUMBER	9.00	2.00
AMT_PAID	T_PD_DNTL_HDR	NUMBER	9.00	2.00
AMT_PAID	T_PD_PHARM_DTL	NUMBER	9.00	2.00
AMT_PAID	T_PD_PHYS_DTL	NUMBER	9.00	2.00
AMT_PAID	T_PD_UB92_DTL	NUMBER	9.00	2.00
AMT_PAID	T_PD_UB92_HDR	NUMBER	9.00	2.00
AMT_PAID	T_PF_INPAT_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_INPAT_RP_TOT_Q	NUMBER	14.00	2.00

AMT_PAID	T_PF_NHOME_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_NHOME_RP_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_OUTPAT_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_OUTPAT_RP_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PHARM_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PHARM_RP_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PROF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PROF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PRREF_RE_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_PRREF_RP_TOT_Q	NUMBER	14.00	2.00
AMT_PAID	T_PF_RECIP_CMPR	NUMBER	14.00	2.00
AMT_PAID	T_PF_RE_CMPR_Q	NUMBER	14.00	2.00
AMT_PAID	T_RETRO_SUMM_RECS	NUMBER	9.00	2.00
AMT_PAID	T_SCOS_CLAIMS_BY_DATE	NUMBER	11.00	2.00
AMT_PAID	T_SCOS_CLAIMS_BY_MONTH	NUMBER	11.00	2.00
AMT_PAID	T_SCOS_CLAIMS_BY_QTR	NUMBER	11.00	2.00
AMT_PAID	T_SCOS_FIN_DATA_BY_DATE	NUMBER	11.00	2.00
AMT_PAID	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	11.00	2.00
AMT_PAID	T_SCOS_FIN_DATA_BY_QTR	NUMBER	11.00	2.00
AMT_PAID	T_SUSP_DENTAL_HDR	NUMBER	9.00	3.00
AMT_PAID	T_TPL_COST_AVOID_SUMM	NUMBER	11.00	2.00
AMT_PAID	T_TPL_PREBILL	NUMBER	9.00	2.00
AMT_PAID	T_TPL_THRESHOLD_SUMM	NUMBER	9.00	2.00
AMT_PAID_2009	T_CA_PHYS	NUMBER	10.00	2.00
AMT_PAID_2009	T_CLM_PGM_XREF	NUMBER	10.00	2.00
AMT_PAID_ADJ	T_ERROR_EXTRACT	NUMBER	12.00	2.00
AMT_PAID_ADMIN	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_PAID_ADMIN	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00

AMT_PAID_CAP	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_PAID_CAP	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_PAID_FROM	T_CPAS_AMT_PAID	NUMBER	9.00	2.00
AMT_PAID_MCARE	T_CA_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_PAID_MCARE	T_FINAL_UB92_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE	T_MR_XOVER	NUMBER	12.00	2.00
AMT_PAID_MCARE	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_PAID_MCARE	T_SUSP_UB92_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE_ORIG	T_CA_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE_ORIG	T_FINAL_PHYS_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE_ORIG	T_FINAL_UB92_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE_ORIG	T_SUSP_PHYS_XOVER	NUMBER	10.00	2.00
AMT_PAID_MCARE_ORIG	T_SUSP_UB92_XOVER	NUMBER	10.00	2.00
AMT_PAID_RCO	T_CA_RCO	NUMBER	9.00	2.00
AMT_PAID_RCO	T_CLM_RCO	NUMBER	9.00	2.00
AMT_PAID_TO	T_CPAS_AMT_PAID	NUMBER	9.00	2.00
AMT_PAID_TOTAL	T_835_CK_EFT_TRCNO	NUMBER	9.00	2.00
AMT_PAID_TOT_ADJ	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_PAID_TOT_ADJ	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_PAID_TPL	T_CA_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_PAID_TPL	T_CLM_TPL_SUMMARY	NUMBER	9.00	2.00
AMT_PATIENT_RESPONS	T_AR_CLM_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_CLM_PGM_XREF	NUMBER	8.00	2.00
AMT_PATNT_LIAB	T_DENY_DNTL_HDR	NUMBER	9.00	2.00

AMT_PATNT_LIAB	T_DENY_PHRM_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_DENY_PHYS_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_PD_DNTL_HDR	NUMBER	8.00	2.00
AMT_PATNT_LIAB	T_PD_DNTL_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_PD_PHARM_HDR	NUMBER	8.00	2.00
AMT_PATNT_LIAB	T_PD_PHARM_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_PD_PHYS_HDR	NUMBER	8.00	2.00
AMT_PATNT_LIAB	T_PD_PHYS_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_RE_PAT_LIAB	NUMBER	8.00	2.00
AMT_PATNT_LIAB	T_SUSP_DENTAL_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
AMT_PATNT_LIAB	T_SUSP_PHYS_HDR	NUMBER	9.00	2.00
AMT_PAT_LIAB	T_CA_HDR_DTL	NUMBER	10.00	2.00
AMT_PAT_LIAB	T_MR_LTC	NUMBER	12.00	2.00
AMT_PAYMENT	T_AR_CLM_HDR	NUMBER	9.00	2.00
AMT_PAYMENT	T_EFT_TRACE_XREF	NUMBER	11.00	2.00
AMT_PAY_DAY_CARE	T_DS_RECIP_SOBRA_APPL	NUMBER	7.00	2.00
AMT_PAY_MTHLY	T_RE_AR_OVERPAYMENT	NUMBER	9.00	2.00
AMT_PAY_OUT	T_PAYMENT_HOLD	NUMBER	10.00	2.00
AMT_PAY_RATE	T_RE_INCOME_NEW	NUMBER	6.00	2.00
AMT_PA_AUTH	T_PA_LINE_ITEM	NUMBER	9.00	2.00
AMT_PA_REQ	T_PA_LINE_ITEM	NUMBER	9.00	2.00
AMT_PA_USED	T_PA_ITEM_DTL_XREF	NUMBER	9.00	2.00
AMT_PD	T_AUTO_PA_SUMMARY	NUMBER	11.00	2.00
AMT_PD_PAT_UB92	T_CLM_PATLIAB_X	NUMBER	9.00	2.00
AMT_PD_PAT_UB92	T_CLM_PATLIAB_X	NUMBER	10.00	2.00
AMT_PD_PAT_UB92	T_DENY_UB92_HDR	NUMBER	9.00	2.00
AMT_PD_PAT_UB92	T_PD_UB92_HDR	NUMBER	9.00	2.00
AMT_PD_PAT_UB92	T_SUSP_UB92_HDR	NUMBER	9.00	2.00

AMT_PEER	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	13.00	2.00
AMT_PEER_COST	T_PR_PEER_LEVEL	NUMBER	9.00	2.00
AMT_PERCENTAGE	T_STOP_LOSS_PARMS	NUMBER	3.00	2.00
AMT_PERCENT_FC	T_DR_FUND_CODE_PERCENT	NUMBER	5.00	2.00
AMT_PER_BRND	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	10.00	2.00
AMT_PER_BRND_PEER	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	13.00	2.00
AMT_PER_EPISODE	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
AMT_PER_EPISODE	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
AMT_PER_EPISODE	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
AMT_PER_EPISODE	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMT_PER_RECIP	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
AMT_PER_RECIP	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
AMT_PER_RECIP	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
AMT_PER_RECIP	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
AMT_PER_RECIP	T_PROFILE_PHARM_PT_TOT	NUMBER	10.00	2.00
AMT_POLICY_PREM	T_DS_RECIP_DO_HLTH_INS	NUMBER	8.00	2.00
AMT_POSITIVE_ADJ	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_PREMIUM	T_BUYA_BILL	NUMBER	8.00	2.00
AMT_PREMIUM	T_BUYB_BILL	NUMBER	8.00	2.00
AMT_PREMIUM	T_HIPP_RESOURCE	NUMBER	8.00	2.00
AMT_PREM_PAID	T_MR_BUYIN_PREM	NUMBER	12.00	2.00
AMT_PREM_PRD	T_BUYA_PERD	NUMBER	8.00	2.00
AMT_PREM_PRD	T_BUYB_PERD	NUMBER	8.00	2.00
AMT_PREM_PRD	T_HIPP_RESOURCE	NUMBER	8.00	2.00
AMT_PREM_RATE	T_BUYA_BILL	NUMBER	8.00	2.00
AMT_PREM_RATE	T_BUYA_MISMATCH	NUMBER	8.00	2.00
AMT_PREM_RATE	T_BUYB_BILL	NUMBER	8.00	2.00
AMT_PREM_RATE	T_BUYB_MISMATCH	NUMBER	8.00	2.00
AMT_PRE_XFER	T_CA_UB92	NUMBER	9.00	2.00
AMT_PRE_XFER	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_PRICE	T_DRUG_PRICE	NUMBER	12.00	5.00

AMT_PRICE_ASC	T_ASC_PRICING	NUMBER	11.00	2.00
AMT_PRICE_PER_UNIT	T_DR_TMP_SUPP_RATES	NUMBER	12.00	6.00
AMT_PRIOR_PAYMENT	T_UB92_HDR_PAYER	NUMBER	9.00	2.00
AMT_PRNT_SUPP	T_DS_RECIP_SOBRA_APPL	NUMBER	7.00	2.00
AMT_PROV_BILLED	T_TPL_AR_HEALTH	NUMBER	9.00	2.00
AMT_PROV_PER_DIEM	T_CA_LTC	NUMBER	9.00	2.00
AMT_PROV_PER_DIEM	T_CA_UB92	NUMBER	9.00	2.00
AMT_PROV_REFUNDS	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_PSYCH	T_CA_XOVER	NUMBER	9.00	2.00
AMT_PSYCH	T_FINAL_PHYS_XOVER	NUMBER	9.00	2.00
AMT_PSYCH	T_FINAL_UB92_XOVER	NUMBER	9.00	2.00
AMT_PSYCH	T_SUSP_PHYS_XOVER	NUMBER	9.00	2.00
AMT_PSYCH	T_SUSP_UB92_XOVER	NUMBER	9.00	2.00
AMT_PURCHASE	T_HIPP_RESOURCE	NUMBER	7.00	2.00
AMT_PURCHASE_DME	T_PHYS_DEXT_KEY	NUMBER	9.00	2.00
AMT_RANK	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
AMT_RATE	T_COUNTY_RATE	NUMBER	9.00	2.00
AMT_RATE	T_MC_CAP_CMF_RATES	NUMBER	5.00	2.00
AMT_RATE	T_PR_RATE_KY	NUMBER	9.00	2.00
AMT_RATE_ADJ	T_BNFT_ADJ_FACTOR	NUMBER	6.00	2.00
AMT_RATE_PERCENT	T_CA_HDR_DTL	NUMBER	7.00	2.00
AMT_RATE_PERCENT	T_CLM_PGM_XREF	NUMBER	7.00	2.00
AMT_RATE_PERCENT	T_DS_HM_DETAIL	NUMBER	7.00	2.00
AMT_RATE_PERCENT	T_DS_HM_HEADER	NUMBER	7.00	2.00
AMT_RATE_PERCENT	T_PR_INST_RATE_WI	NUMBER	5.00	2.00
AMT_RATE_PERCENT	T_PR_LOC_RATE	NUMBER	7.00	2.00
AMT_RATE_PERCENT	T_PR_LOC_RATE_WI	NUMBER	7.00	2.00

AMT_RATE_PERCENT	T_PR_OUT_RATE_AL	NUMBER	6.00	3.00
AMT_RATE_PERCENT_2009	T_CA_PHYS	NUMBER	7.00	2.00
AMT_RATE_PERCENT_2009	T_CLM_PGM_XREF	NUMBER	7.00	2.00
AMT_RATE_PER_DIEM	T_PR_INST_RATE_WI	NUMBER	9.00	2.00
AMT_RATE_PRICE	T_CA_DRUG	NUMBER	12.00	5.00
AMT_RATE_PRICE	T_PD_PHARM_DTL	NUMBER	12.00	5.00
AMT_REBATE_PD	T_DR_INCR_PAY	NUMBER	11.00	2.00
AMT_REBATE_UNIT	T_DR_CMS_TAPE	NUMBER	11.00	6.00
AMT_REBATE_UNIT	T_DR_DISPUTE_DTL	NUMBER	11.00	6.00
AMT_REBATE_UNIT	T_DR_DISPUTE_RESO	NUMBER	11.00	6.00
AMT_REBATE_UNIT	T_DR_INVOICE_DTL	NUMBER	11.00	6.00
AMT_REBATE_UNIT	T_DR_PPA_INV_DTL	NUMBER	11.00	6.00
AMT_REBATE_UNIT	T_DR_RATE	NUMBER	11.00	6.00
AMT_REBATE_UNIT_CMS	T_DR_TMP_SUPP_RATES	NUMBER	12.00	6.00
AMT_REBATE_UNIT_OFFSET	T_DR_CMS_UROA	NUMBER	11.00	6.00
AMT_REBATE_UNIT_OFFSET	T_DR_RATE_UROA	NUMBER	11.00	6.00
AMT_REBATE_UNIT_SUPP	T_DR_TMP_SUPP_RATES	NUMBER	12.00	6.00
AMT_RECOUPED	T_CT_AR_TRACKING	NUMBER	8.00	2.00
AMT_RECOUPED	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_RECOUPMENT	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_REDUCED_PREM_RATE	T_BUYA_MISMATCH	NUMBER	8.00	2.00

AMT_REDUCED_PREM_RATE	T_BUYB_MISMATCH	NUMBER	8.00	2.00
AMT_RED_PREM_RATE	T_BUYB_BILL	NUMBER	8.00	2.00
AMT_REFUND	T_CT_CASE_RECOUP	NUMBER	8.00	2.00
AMT_REFUND	T_HIPP_RESOURCE	NUMBER	7.00	2.00
AMT_REFUND_REC	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REFUND_REQ	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REFUND_REQ_CEO	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REF_REQ_APPEAL	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REF_REQ_RECON1	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REF_REQ_RECON2	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_REIM	T_MR_CMS64	NUMBER	12.00	2.00
AMT_REIM	T_MR_ERROR_DTL	NUMBER	12.00	2.00
AMT_REIM	T_MR_LTC	NUMBER	12.00	2.00
AMT_REIM	T_MR_POS	NUMBER	12.00	2.00
AMT_REIM	T_MR_PROV	NUMBER	12.00	2.00
AMT_REIM	T_MR_RECIP	NUMBER	12.00	2.00
AMT_REIM	T_MR_RECIP_KY	NUMBER	12.00	2.00
AMT_REIM	T_MR_RECIP_RANK	NUMBER	12.00	2.00
AMT_REIM	T_MR_RE_CNTY	NUMBER	12.00	2.00
AMT_REIM	T_MR_XOVER	NUMBER	12.00	2.00
AMT_REIMBURSED	T_CA_FIN	NUMBER	13.00	2.00
AMT_REIMBURSED	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_REIMBURSEMENT	T_DENY_UB92_HDR	NUMBER	9.00	2.00
AMT_REIMBURSEMENT	T_DR_CLMS_XREF	NUMBER	11.00	2.00
AMT_REIMBURSEMENT	T_EXPENDITURE	NUMBER	9.00	2.00
AMT_REIMBURSEMENT	T_EXPENDITURE	NUMBER	13.00	2.00
AMT_REIMBURSEMENT	T_EXPENDITURE_DN	NUMBER	13.00	2.00
AMT_REIMBURSEMENT	T_PD_UB92_HDR	NUMBER	9.00	2.00

AMT_REIMBURSEMENT	T_SUSP_UB92_HDR	NUMBER	9.00	2.00
AMT_RENTAL_DME	T_PHYS_DEXT_KEY	NUMBER	9.00	2.00
AMT_RETURNED_NFS	T_DAILY_FUND_TXN	NUMBER	12.00	2.00
AMT_REVENUE_CHARGE	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_REVENUE_CHARGE	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_SAVINGS	T_TPL_COST_AVOID_SUMM	NUMBER	11.00	2.00
AMT_SELF_EMP	T_DS_RECIP_SOBRA_FAMILY	NUMBER	7.00	2.00
AMT_SELF_EMP_EXCL	T_DS_RECIP_SOBRA_FAMILY	NUMBER	7.00	2.00
AMT_SERVICE_PAID	T_CLM_OTH_PYR_DTL	NUMBER	10.00	2.00
AMT_SETTLEMENT	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_SETTLEMENT	T_CASUALTY_CASE	NUMBER	9.00	2.00
AMT_SETTLEMENT	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
AMT_SETUP	T_ACCT_REC	NUMBER	13.00	2.00
AMT_SETUP	T_ACCT_REC_DN	NUMBER	13.00	2.00
AMT_SETUP	T_FIN_PROCESS_AR	NUMBER	13.00	2.00
AMT_SMI_PREMIUM	T_RE_BNDX_BUYIN	NUMBER	5.00	2.00
AMT_SNF_RATE_CAP	T_MCARE_DEDUCTIBLE	NUMBER	6.00	2.00
AMT_SPENDDOWN	T_RE_SPEND_LIAB	NUMBER	10.00	2.00
AMT_SPENDDOWN	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_SPOUSAL_IMPOV	T_DS_RECIP_DO_APPL	NUMBER	9.00	2.00
AMT_SSA_PYMT	T_DS_RECIP_CORE	NUMBER	7.00	2.00
AMT_SSI_PYMT	T_DS_RECIP_CORE	NUMBER	7.00	2.00
AMT_STAND_DEV	T_CPAS_STRATA	NUMBER	8.00	2.00
AMT_STATE_SHARE	T_CHCK_CLM_XREF	NUMBER	10.00	2.00
AMT_STATE_SHARE	T_CLM_PGM_XREF	NUMBER	10.00	2.00
AMT_STATE_SHARE	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_STATE_SHARE	T_EXPENDITURE	NUMBER	9.00	2.00
AMT_STATE_SHARE	T_EXPENDITURE	NUMBER	13.00	2.00
AMT_STATE_SHARE	T_EXPENDITURE_DN	NUMBER	13.00	2.00

AMT_STATE_SHARE	T_FIN_PROCESS_PYMT_XREF	NUMBER	10.00	2.00
AMT_STATE_SHARE	T_PR_PROV_YTD_AMT	NUMBER	10.00	2.00
AMT_STATE_SHARE	T_PR_YTD_AMT_HIST	NUMBER	10.00	2.00
AMT_SUPPLEMENTAL	T_CA_UB92	NUMBER	9.00	2.00
AMT_SUPPLEMENTAL	T_PEER_GRP_DRGR	NUMBER	5.00	4.00
AMT_SUPPLEMENTAL	T_UB92_HDR_INP	NUMBER	9.00	2.00
AMT_SUPPLEMENTAL_PCT	T_CA_UB92	NUMBER	5.00	4.00
AMT_SUPPLEMENTAL_PCT	T_UB92_HDR_INP	NUMBER	5.00	4.00
AMT_SUPP_PYMT	T_DS_RECIP_CORE	NUMBER	7.00	2.00
AMT_SVC_TRACKING_PMT	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_SVC_TRACKING_PMT	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_SVC_TRACKING_PMT	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_SVC_TRACKING_PMT	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COINS	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COINS	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COINS	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COINS	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COPAY	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COPAY	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COPAY	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_THIRD_PARTY_COPAY	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_THRESHOLD	T_DR_INVOICE_TYPE	NUMBER	8.00	2.00
AMT_THRESHOLD	T_TPL_THRESHOLD	NUMBER	11.00	2.00
AMT_THRESHOLD_FROM	T_STOP_LOSS_PARMS	NUMBER	9.00	2.00
AMT_THRESHOLD_TO	T_STOP_LOSS_PARMS	NUMBER	9.00	2.00
AMT_TOTAL	T_PAYMENT_EXTRACT	NUMBER	11.00	2.00
AMT_TOTAL_13	T_CPAS_STRATA	NUMBER	13.00	2.00
AMT_TOTAL_SD	T_CPAS_STRATA	NUMBER	12.00	2.00
AMT_TOT_ALLOWED	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_ALLOWED	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_ALLOWED	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00

AMT_TOT_ALLOWED	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_ALWD	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_ALWD	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_BILLED	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_BILLED	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_BILLED	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_BILLED	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_BILLED	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_BILLED	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_CAP_ADJ	T_CAP_MASS_ADJ_RST	NUMBER	11.00	2.00
AMT_TOT_CAP_ADJ	T_CAP_MASS_ADJ_RST_tmp	NUMBER	11.00	2.00
AMT_TOT_CAST_CROWN	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_CLM	T_PROFILE_PROV_AVERAGES	NUMBER	10.00	2.00
AMT_TOT_CLM_PEER	T_PROFILE_PROV_AVERAGES	NUMBER	11.00	2.00
AMT_TOT_COPAY	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_COPAY	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_COPAY	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_COPAY	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_CO_PAY	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_EARN_ADJ	T_1099_ADJUST	NUMBER	10.00	2.00
AMT_TOT_ENCOUNTER	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_EXAM	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_FLUORIDE_TREAT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_MCARE_PAID	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_MDCR_COINS	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_COINS	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_COINS	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00

AMT_TOT_MDCR_COINS	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_DEDUCT	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_DEDUCT	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_DEDUCT	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MDCR_DEDUCT	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MEDICAID_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MEDICAID_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MEDICAID_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MEDICAID_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_MULTI_SURFACE	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_ONE_SURFACE	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_OTH_INS_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_OTH_INS_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_OTH_INS_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_OTH_INS_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_OTH_PAID	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_TOT_PAID	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_PAID	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_TOT_PAID	T_DS_CLM_CNT_PAID_DTE	NUMBER	10.00	2.00
AMT_TOT_PAID	T_DS_CLM_CNT_SVC_DTE	NUMBER	10.00	2.00
AMT_TOT_PAID	T_DS_DNTL_PR_GRP_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID	T_DS_DNTL_PR_RE_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID_INIT	T_DS_DNTL_PR_RE_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID_INIT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID_RCALL	T_DS_DNTL_PR_RE_SUM	NUMBER	12.00	2.00
AMT_TOT_PAID_RCALL	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00

AMT_TOT_PALLIATIVE_TREAT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_PAT_LIAB	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_PD	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_TOT_PD_SAMPLE	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_TOT_PROPHY	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_PULP_CAP	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_RADIOGRAPH	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_REBATE_CLM	T_DR_DISPUTE_DTL	NUMBER	11.00	2.00
AMT_TOT_REBATE_CLM	T_DR_DISPUTE_RESO	NUMBER	11.00	2.00
AMT_TOT_REBATE_CLM	T_DR_INVOICE_DTL	NUMBER	11.00	2.00
AMT_TOT_REBATE_CLM	T_DR_PPA_INV_DTL	NUMBER	11.00	2.00
AMT_TOT_REBATE_PD	T_DR_DISPUTE_RESO	NUMBER	11.00	2.00
AMT_TOT_REBATE_PD	T_DR_INVOICE_DTL	NUMBER	11.00	2.00
AMT_TOT_REIMB	T_DR_RECOUP_LTR_ICN	NUMBER	10.00	2.00
AMT_TOT_REIMB	T_MPHX_PHRM_DTL_AL	NUMBER	10.00	2.00
AMT_TOT_REIMB	T_PD_PHARM_HDR	NUMBER	10.00	2.00
AMT_TOT_REIMB	T_PD_PHYS_HDR	NUMBER	10.00	2.00
AMT_TOT_REIMBURSED	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_REV	T_CT_CASE_TRACK	NUMBER	11.00	2.00
AMT_TOT_ROOT_CANAL	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_SEALANT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_SED_FILLING	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_SIMPLE_EXTRACT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_STATE_SHARE	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_STEEL_CROWN	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_SURG_EXTRACT	T_DS_DNTL_PR_SUM	NUMBER	12.00	2.00
AMT_TOT_TPL	T_CA_IND_AGGR	NUMBER	13.00	2.00
AMT_TOT_TPL_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_TPL_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	13.00	2.00

AMT_TOT_TPL_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_TPL_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	13.00	2.00
AMT_TOT_TRANSACTIONS	T_RE_AR_OVERPAYMENT	NUMBER	11.00	2.00
AMT_TPL	T_DR_CLMS_XREF	NUMBER	11.00	2.00
AMT_TPL	T_DS_HM_HEADER	NUMBER	10.00	2.00
AMT_TPL	T_MR_PROV	NUMBER	12.00	2.00
AMT_TPL	T_TMSIS_CIP003_CLM_DTL	NUMBER	13.00	2.00
AMT_TPL	T_TMSIS_CLT003_CLM_DTL	NUMBER	13.00	2.00
AMT_TPL	T_TMSIS_COT003_CLM_DTL	NUMBER	13.00	2.00
AMT_TPL	T_TMSIS_CRX003_CLM_DTL	NUMBER	13.00	2.00
AMT_TPL	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_TPL_HDR_ONLY	T_UB92_HDR_EXT_KEY	NUMBER	9.00	2.00
AMT_TPL_PAID	T_TPL_COST_AVOID_SUMM	NUMBER	11.00	2.00
AMT_TRANSACTION	T_RE_AR_TRANSACTION	NUMBER	11.00	2.00
AMT_TTL_CLMS_RMB	T_DR_DISPUTE_DTL	NUMBER	11.00	2.00
AMT_TTL_CLMS_RMB	T_DR_INVOICE_DTL	NUMBER	11.00	2.00
AMT_TTL_CLMS_RMB	T_DR_PPA_INV_DTL	NUMBER	11.00	2.00
AMT_TTL_REBATE_WO	T_DR_INV_WRITEOFF	NUMBER	11.00	2.00
AMT_TXN	T_FIN_EARNINGS_HIST	NUMBER	13.00	2.00
AMT_TXN	T_FIN_EARNINGS_YTD	NUMBER	13.00	2.00
AMT_UC	T_CA_DRUG	NUMBER	9.00	2.00
AMT_UC	T_DENY_PHRM_HDR	NUMBER	9.00	2.00
AMT_UC	T_PD_PHARM_HDR	NUMBER	9.00	2.00
AMT_UC	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
AMT_UCC_RATE	T_REF_UCC	NUMBER	9.00	2.00
AMT_UNEARNED	T_DS_RECIP_SOBRA_FAMILY	NUMBER	7.00	2.00
AMT_UNIT	T_DR_DISPUTE	NUMBER	13.00	3.00
AMT_UNIT_PRICE	T_DR_TMP_SUPP_RATES	NUMBER	12.00	6.00

AMT_UNIT_RATE	T_PA_DTL	NUMBER	10.00	0.00
AMT_UNIT_RATE	T_UB92_DTL_EXT_KEY	NUMBER	10.00	4.00
AMT_URA	T_DR_4002_RCPTS	NUMBER	11.00	6.00
AMT_URA_BAL	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_URA_PD	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_URA_PREV_PD	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_URA_RATIO	T_DR_4002_RCPTS	NUMBER	5.00	4.00
AMT_UROA	T_DR_4002_RCPTS	NUMBER	11.00	6.00
AMT_UROA_BAL	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_UROA_PD	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_UROA_PREV_PD	T_DR_4002_RCPTS	NUMBER	11.00	2.00
AMT_UROA_RATIO	T_DR_4002_RCPTS	NUMBER	5.00	4.00
AMT_USED	T_WEB_PA_DTL	NUMBER	7.00	2.00
AMT_VALUE	T_CA_VALUE	NUMBER	9.00	2.00
AMT_VALUE	T_UB92_HDR_VALUE	NUMBER	9.00	2.00
AMT_VALUE_1	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_10	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_11	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_12	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_2	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_3	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_4	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_5	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_6	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_7	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_8	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_VALUE_9	T_CA_VALUE_DN	NUMBER	9.00	2.00
AMT_WAGE	T_DS_RECIP_SOBRA_FAMILY	NUMBER	7.00	2.00
AMT_WARRANT	T_WEB_CLAIM_HDR	NUMBER	9.00	2.00
AMT_WARRANT	T_WEB_PAY_SUM	NUMBER	9.00	2.00
AMT_XFER_PAY	T_CA_UB92	NUMBER	9.00	2.00
AMT_XFER_PAY	T_UB92_HDR_INP	NUMBER	9.00	2.00

ANCILLARY_INPATIENT_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00

ANCILLARY_INPATIENT_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_INPATIENT_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00

ANCILLARY_OUTPATIENT_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
ANCILLARY_OUTPATIENT_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
ANSWER1	T_WEB_USER	VARCHAR2	20.00	0.00
ANSWER2	T_WEB_USER	VARCHAR2	20.00	0.00
ANS_HOLD_TIME	T_PR_ATT_CMS	NUMBER	10.00	0.00
APPL_REF	T_AGREEMENTS	VARCHAR2	14.00	0.00
APPL_REF	T_TRADSTAT	VARCHAR2	14.00	0.00
APPL_REF	T_TRLOG	VARCHAR2	14.00	0.00
APP_PSWD	T_AGREEMENTS	VARCHAR2	14.00	0.00
APP_PSWD	T_TRADSTAT	VARCHAR2	14.00	0.00
APP_PSWD	T_TRLOG	VARCHAR2	14.00	0.00
APP_RCV_CD	T_TRLOG	VARCHAR2	35.00	0.00
APP_RCV_QL	T_AGREEMENTS	VARCHAR2	4.00	0.00
APP_RCV_QL	T_TRADING_PARTNER	VARCHAR2	4.00	0.00
APP_RCV_QL	T_TRADSTAT	VARCHAR2	4.00	0.00
APP_RCV_QL	T_TRLOG	VARCHAR2	4.00	0.00
APP_SND_CD	T_TRLOG	VARCHAR2	35.00	0.00
APP_SND_QL	T_TRADING_PARTNER	VARCHAR2	4.00	0.00
APP_SND_QL	T_TRLOG	VARCHAR2	4.00	0.00

AREA_CODE	T_COUNTRY	CHAR	3.00	0.00
AREA_NUMBER	T_PA_DDSD_UPD_HDR	CHAR	1.00	0.00
AREA_NUMBER	T_PA_HCBW_UPD_HDR	CHAR	1.00	0.00
ASSIGNING_AUTHORITY	T_PR_ENRL_EFT_ERA_MAINT	CHAR	2.00	0.00
ASSIGNING_AUTHORITY	T_PR_ENRL_IDENTIFIER	CHAR	2.00	0.00
ASSIGN_CODE	T_PA_LTCA_UPD_HDR	CHAR	2.00	0.00
ASSOC_CODE	T_AGREEMENTS	VARCHAR2	6.00	0.00
ASSOC_CODE	T_TRADSTAT	VARCHAR2	6.00	0.00
ASSOC_CODE	T_TRLOG	VARCHAR2	6.00	0.00
ATTORNEY_PERCENT	T_CASUALTY_CASE	NUMBER	3.00	0.00
ATTORNEY_PERCENT	T_CASUALTY_CASE_AL	NUMBER	3.00	0.00
AUTH_CODE	T_TRADING_PARTNER	VARCHAR2	10.00	0.00
AUTH_EFF	T_PA_HCBW_UPD_HDR	CHAR	6.00	0.00
AUTH_EFF	T_PA_LTCA_UPD_DTL	CHAR	8.00	0.00
AUTH_EFFECTIVE_DATE	T_PA_DDSD_UPD_HDR	CHAR	6.00	0.00
AUTH_END	T_PA_HCBW_UPD_HDR	CHAR	6.00	0.00
AUTH_END	T_PA_LTCA_UPD_DTL	CHAR	8.00	0.00
AUTH_ENDING_DATE	T_PA_DDSD_UPD_HDR	CHAR	6.00	0.00
AUTH_NUMBER	T_PA_DDSD_UPD_DTL	CHAR	10.00	0.00
AUTH_NUMBER	T_PA_DDSD_UPD_HDR	CHAR	10.00	0.00
AUTH_QUAL	T_TRADING_PARTNER	VARCHAR2	2.00	0.00
AUTO_MAKE	T_DS_RECIP_DO_VEHICLE	VARCHAR2	10.00	0.00
AUTO_MODEL	T_DS_RECIP_DO_VEHICLE	VARCHAR2	10.00	0.00
AUTO_YEAR	T_DS_RECIP_DO_VEHICLE	NUMBER	4.00	0.00
AVG_PEER	T_PROFILE_MEASURES	NUMBER	5.00	2.00
AVG_PMP	T_PROFILE_MEASURES	NUMBER	5.00	2.00
AVR_PASSWORD	T_WEB_USER	VARCHAR2	20.00	0.00
AVR_PASS_DATE	T_WEB_USER	NUMBER	8.00	0.00
BAD_CLM_CNT	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
BANK_ADDR	T_DS_RECIP_DO_BANK	VARCHAR2	35.00	0.00
BANK_CITY	T_DS_RECIP_DO_BANK	VARCHAR2	25.00	0.00
BANK_STATE	T_DS_RECIP_DO_BANK	CHAR	2.00	0.00

BANK_ZIP_PL_4	T_DS_RECIP_DO_BANK	CHAR	9.00	0.00
BASE_RECIP_ID	T_WEB_RECIP_XREF	CHAR	12.00	0.00
BEGIN_DATE	T_PA_PC_UPD_HDR	CHAR	6.00	0.00
BEGIN_DATE	T_PROFILE_NHRECIPS	DATE	0.00	0.00
BEGIN_DATE	T_WEB_PA_DTL	DATE	0.00	0.00
BEGIN_QTR	T_DR_UNIT_CONV	NUMBER	5.00	0.00
BEG_DOS	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
BEG_DOS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
BEG_DOS	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
BEN_CAT	T_MB_DEN_RECIP	CHAR	2.00	0.00
BEN_CAT	T_MB_NUM_RECIP	CHAR	2.00	0.00
BILLIDEN	T_TRADING_PARTNER	VARCHAR2	15.00	0.00
BILLING_FILENAME	T_TXN_BILLING	VARCHAR	255.00	0.00
BILLQUAL	T_TRADING_PARTNER	VARCHAR2	2.00	0.00
BILL_COUNT	T_TRANSACTION	NUMBER	9.00	0.00
BILL_INDICATOR	T_TRANSACTION	CHAR	1.00	0.00
BILL_PROV_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
BILL_PROV_KEY	T_CA_FIN	NUMBER	9.00	0.00
BILL_PROV_KEY	T_DS_DNTL_ICN	NUMBER	9.00	0.00
BILL_PROV_KEY	T_DS_HM_HEADER	NUMBER	9.00	0.00

BIN_NUMB	T_TRADING_PARTNER	NUMBER	19.00	0.00
BRAND_NAME	T_MB_HEDIS_DRUG	VARCHAR2	100.00	0.00
BYTE_COUNT	T_TRLOG	NUMBER	19.00	0.00
B_RECV_ID	T_TRADING_PARTNER	VARCHAR2	24.00	0.00
B_SEND_ID	T_TRADING_PARTNER	VARCHAR2	24.00	0.00
CALC	T_MB_CALC	NUMBER	11.00	5.00
CALC_AMT_PER_PROV	T_PF_INPAT_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_PROV	T_PF_NHOME_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_PROV	T_PF_OUTPAT_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_PROV	T_PF_PHARM_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_PROV	T_PF_PROF_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_PROV	T_PF_PRREF_RP_TOT_Q	NUMBER	10.00	2.00
CALC_AMT_PER_RECIP	T_PROFILE_INPAT_PT_TOT	NUMBER	10.00	2.00
CALC_AMT_PER_RECIP	T_PROFILE_OUTPAT_PT_TOT	NUMBER	10.00	2.00
CALC_AMT_PER_RECIP	T_PROFILE_PHARMREF_PT_TOT	NUMBER	10.00	2.00
CALC_AMT_PER_RECIP	T_PROFILE_PROFREF_PT_TOT	NUMBER	10.00	2.00
CALC_AMT_PER_RECIP	T_PROFILE_PROF_PT_TOT	NUMBER	10.00	2.00
CALC_INGRED_COST	T_LS_PHARMACY_CLAIMS	NUMBER	9.00	2.00
CALC_INGRED_COST	T_LS_SUMMARY_NDC	NUMBER	9.00	2.00
CAP_IND	T_MB_DEN_RECIP	CHAR	1.00	0.00
CAP_IND	T_MB_NUM_RECIP	CHAR	1.00	0.00
CASE_NUM	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
CASE_TYPE_CDE	T_PF_EXP_INPAT_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_EXP_NHOME_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_EXP_OUTPAT_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_EXP_PHARM_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_EXP_PROF_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_EXP_RECIP_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_INPAT_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_INPAT_RP_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_NHOME_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_NHOME_RP_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_OUTPAT_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_OUTPAT_RP_TOT_Q	NUMBER	4.00	0.00

CASE_TYPE_CDE	T_PF_PHARM_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_PHARM_RP_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_PROF_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_PROF_RP_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_PRREF_RE_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_PRREF_RP_TOT_Q	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_RECIP_CMPR	NUMBER	4.00	0.00
CASE_TYPE_CDE	T_PF_RE_CMPR_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_INPAT_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_NHOME_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_OUTPAT_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_PHARM_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_PROF_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_CDE	T_PF_EXP_RECIP_VAL_Q	NUMBER	4.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_INPAT_VAL_Q	VARCHAR2	100.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_NHOME_VAL_Q	VARCHAR2	100.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_OUTPAT_VAL_Q	VARCHAR2	100.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_PHARM_VAL_Q	VARCHAR2	100.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_PROF_VAL_Q	VARCHAR2	100.00	0.00
CASE_TYPE_GRP_DSC	T_PF_EXP_RECIP_VAL_Q	VARCHAR2	100.00	0.00
CASH_CTL_NO	T_ADJ_MASS_CLAIM	CHAR	11.00	0.00
CASH_CTL_NO	T_ADJ_MASS_RQST	CHAR	11.00	0.00
CASH_CTL_NO	T_CASH_RECEIPT	CHAR	11.00	0.00

CASH_CTL_NO	T_TCN_XREF	CHAR	17.00	0.00
CASH_DEDUCT	T_MCARE_DEDUCTIBLE	NUMBER	6.00	2.00
CATEGORY	T_MB_HEDIS_DRUG	VARCHAR2	100.00	0.00
CATEGORY	T_WEB_MSG_CATEGORY	VARCHAR2	30.00	0.00
CDE	T_ADJMS_DATES	CHAR	1.00	0.00
CDE	T_ADJMS_ERROR	CHAR	1.00	0.00
CDE	T_CASH_RCPT_XREF	CHAR	1.00	0.00
CDE	T_CCF_ERROR_DATA	CHAR	1.00	0.00
CDE	T_CHCK_CLM_XREF	CHAR	1.00	0.00
CDE	T_COPAY	CHAR	1.00	0.00
CDE	T_CPAS_DATE_SERV	CHAR	1.00	0.00
CDE	T_CPAS_STRAT_STAT	CHAR	1.00	0.00
CDE	T_DRUG_CLASS	CHAR	1.00	0.00
CDE	T_DRUG_LIMITS	CHAR	1.00	0.00
CDE	T_EOB	CHAR	1.00	0.00
CDE	T_EOB_TYPES	CHAR	1.00	0.00
CDE	T_FIN_PROCESS_PYMT_XREF	CHAR	1.00	0.00
CDE	T_LAB_FEE	CHAR	1.00	0.00
CDE	T_LIMIT_PARM	CHAR	1.00	0.00
CDE	T_LIMIT_PARM	CHAR	1.00	0.00
CDE	T_MODIFIER	CHAR	1.00	0.00

CDE	T_MODIFIER_TYPE	CHAR	1.00	0.00
CDE	T_PDUR_OUTCOME	CHAR	1.00	0.00
CDE	T_PR_LABEL_CRIT	CHAR	1.00	0.00
CDE	T_REBATE	CHAR	1.00	0.00
CDE	T_REVENUE_FLAT_FEE	CHAR	1.00	0.00
CDE	T_RTS_COMMENT	CHAR	1.00	0.00
CDE	T_RTS_INFO	CHAR	1.00	0.00
CDE	T_SPEC_MOD	CHAR	1.00	0.00
CDE	T_SUR_RQST_DATES	CHAR	1.00	0.00
CDE	T_TPL_AC_PARENT	CHAR	1.00	0.00
CDE	T_UB92_HDR_PAYER	CHAR	1.00	0.00
CDE_1000A_TECH_CONTACT	T_TPL_1000_PYR_TECH	CHAR	2.00	0.00
CDE_1000A_WEB_CONTACT	T_TPL_835_5010	CHAR	2.00	0.00
CDE_1000B_PAYEE	T_TPL_835_5010	CHAR	3.00	0.00
CDE_1099_ADJ_RSN	T_1099_ADJUST	CHAR	2.00	0.00
CDE_1099_ADJ_RSN	T_1099_ADJ_REASON	CHAR	2.00	0.00
CDE_2	T_CPAS_HCFA_CODE	CHAR	4.00	0.00
CDE_2000B_SBR05	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_2010AA_PER01	T_CLM_DNTL_HDR	CHAR	2.00	0.00
CDE_2010AC_NM101	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_2010AC_NM101	T_CLM_PHYS_HDR	CHAR	3.00	0.00

CDE_2010AC_NM101	T_CLM_UB92_HDR	CHAR	3.00	0.00
CDE_2010BA_PER01	T_CLM_PHYS_HDR	CHAR	2.00	0.00
CDE_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	CHAR	3.00	0.00
CDE_2300_CN101	T_CLM_DNTL_2300	CHAR	2.00	0.00
CDE_2300_CRC03	T_CLM_UB92_2300	CHAR	3.00	0.00
CDE_2300_CRC04	T_CLM_UB92_2300	CHAR	3.00	0.00
CDE_2300_CRC05	T_CLM_UB92_2300	CHAR	3.00	0.00
CDE_2300_DN206	T_CLM_DNTL_2300_DN2	CHAR	3.00	0.00
CDE_2300_HCP01	T_CLM_DNTL_2300	CHAR	2.00	0.00
CDE_2300_HCP13	T_CLM_DNTL_2300	CHAR	2.00	0.00
CDE_2300_HCP14	T_CLM_DNTL_2300	CHAR	2.00	0.00
CDE_2300_HCP15	T_CLM_DNTL_2300	CHAR	2.00	0.00
CDE_2300_HI01_2	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00
CDE_2300_HI01_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI01_2_PROC	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI01_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI02_2	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00
CDE_2300_HI02_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI02_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI02_2_PAT_RSN	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI02_2_PROC	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI02_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI03_2	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00
CDE_2300_HI03_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI03_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI03_2_PAT_RSN	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI03_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI04_2	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00

CDE_2300_HI04_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI04_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI04_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI05_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI05_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI05_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI06_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI06_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI06_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI07_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI07_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI07_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI08_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI08_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI08_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI09_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI09_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI09_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI10_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI10_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI10_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI11_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00
CDE_2300_HI11_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI11_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_HI12_2_COND	T_CLM_PHYS_2300	VARCHAR2	30.00	0.00

CDE_2300_HI12_2_EXT_CAUSE	T_CLM_UB92_2300	VARCHAR2	30.00	0.00
CDE_2300_HI12_9_EXT_CAUSE	T_CLM_UB92_2300	CHAR	1.00	0.00
CDE_2300_REF02	T_CLM_UB92_2300	VARCHAR2	50.00	0.00
CDE_2300_REF02_CLM_ADJ	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
CDE_2300_REF02_REPRIC_CLM	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
CDE_2310C_PER01	T_CLM_PHYS_2300	CHAR	2.00	0.00
CDE_2310E_NM101	T_CLM_DNTL_2300	CHAR	3.00	0.00
CDE_2310E_NM101	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_2310F_NM101	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_2320_MOA03	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
CDE_2320_MOA04	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
CDE_2320_MOA05	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
CDE_2320_MOA06	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
CDE_2320_MOA07	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
CDE_2320_SBR05	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_2330B_REF02_CLM_ADJ	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
CDE_2330E_NM101	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_2330E_NM101	T_CLM_UB92_2320	CHAR	3.00	0.00
CDE_2330F_NM101	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_2330G_NM101	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_2330G_NM101	T_CLM_PHYS_2320	CHAR	3.00	0.00

CDE_2330G_NM101	T_CLM_UB92_2320	CHAR	3.00	0.00
CDE_2330H_NM101	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_2330I_NM101	T_CLM_UB92_2320	CHAR	3.00	0.00
CDE_2400_CN101	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_CN104	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_HCP01	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_HCP11	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_HCP13	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_HCP14	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_HCP15	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_PWK01	T_CLM_PHYS_2400_PWK	CHAR	2.00	0.00
CDE_2400_PWK02	T_CLM_PHYS_2400_PWK	CHAR	2.00	0.00
CDE_2400_REF04_2_CLM_ADJ	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_PAUTH_1	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_PAUTH_2	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_PAUTH_3	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_PAUTH_4	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_PAUTH_5	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_REF04_2_REPRIC_CLM	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
CDE_2400_SV311_1	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_SV311_2	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_SV311_3	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2400_SV311_4	T_CLM_DNTL_2400	CHAR	2.00	0.00
CDE_2420B_NM101	T_CLM_UB92_2400	CHAR	3.00	0.00
CDE_2420C_NM101	T_CLM_DNTL_2400	CHAR	3.00	0.00
CDE_2420C_NM101	T_CLM_UB92_2400	CHAR	3.00	0.00
CDE_2420D_NM101	T_CLM_DNTL_2400	CHAR	3.00	0.00

CDE_2420D_NM101	T_CLM_UB92_2400	CHAR	3.00	0.00
CDE_2420G_NM101	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_2420H_NM101	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_2420_NM101	T_CLM_DNTL_DTL_REF	CHAR	3.00	0.00
CDE_2420_NM101	T_CLM_PHYS_DTL_REF	CHAR	3.00	0.00
CDE_2420_NM101	T_CLM_UB92_DTL_REF	CHAR	3.00	0.00
CDE_50_PCT_APPLY	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_50_PCT_APPLY	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_AAA	T_PA_RECIP_ADH	CHAR	2.00	0.00
CDE_AAC_PRICE_TYPE	T_DRUG_AAC_PRICE	CHAR	1.00	0.00
CDE_AA_CNT	T_RE_PMP_REASON	CHAR	1.00	0.00
CDE_ABOVE_BELOW	T_DRUG_EXCEPTION_AL	CHAR	1.00	0.00
CDE_ACCIDENT_COUNTRY	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_ACCIDENT_COUNTRY	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_ACCIDENT_COUNTRY	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
CDE_ACCIDENT_ST	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
CDE_ACCIDENT_STATE	T_DENTAL_HDR_KEYS	CHAR	2.00	0.00
CDE_ACCIDENT_STATE	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_ACCOUNTING_CODE	T_WEB_ACCT_CODE	CHAR	1.00	0.00
CDE_ACCOUNTING_CODE	T_WEB_CLAIM_HDR	CHAR	1.00	0.00
CDE_ACCRED_ORG	T_TMSIS_MCR007_ACCRED_ORG	VARCHAR2	2.00	0.00
CDE_ACCT2_TYPE	T_DS_RECIP_DO_BANK	CHAR	1.00	0.00

CDE_ACCT3_TYPE	T_DS_RECIP_DO_BANK	CHAR	1.00	0.00
CDE_ACCT4_TYPE	T_DS_RECIP_DO_BANK	CHAR	1.00	0.00
CDE_ACCT_TYPE	T_DS_RECIP_DO_BANK	CHAR	1.00	0.00
CDE_ACCT_TYPE	T_FIN_BANK_ACCT	CHAR	1.00	0.00
CDE_ACCT_USAGE	T_FIN_BANK_ACCT	CHAR	1.00	0.00
CDE_ACC_PTS	T_PR_ACC_PTS_WI	CHAR	1.00	0.00
CDE_ACC_TYP	T_ACCIDENT_TYPE	CHAR	1.00	0.00
CDE_ACG	T_CM_ACG	CHAR	4.00	0.00
CDE_ACQ	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
CDE_ACQ	T_LS_PHARMACY_OTHER	CHAR	1.00	0.00
CDE_ACQ	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
CDE_ACTION	T_ADJ_RULES	CHAR	10.00	0.00
CDE_ACTION	T_BATCH_ERR_ACT	CHAR	2.00	0.00
CDE_ACTION	T_CDE_ACTION	CHAR	2.00	0.00
CDE_ACTION	T_CLM_IMAGE_BALANCE	CHAR	1.00	0.00
CDE_ACTION	T_DS_RECIP_SOBRA_FAM_HIST	CHAR	2.00	0.00
CDE_ACTION	T_SUSP_ADJ_XREF	CHAR	1.00	0.00
CDE_ACTION_1	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_ACTION_2	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00

CDE_ACTION_TAKEN	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_ACTIVE	T_DRUG_SCREEN	CHAR	1.00	0.00
CDE_ACTIVE	T_DRUG_SCREEN	CHAR	1.00	0.00
CDE_ADDR_TYPE	T_REF_CDE_DPV_GROUP	CHAR	1.00	0.00
CDE_ADDR_TYPE	T_RE_DEMOGRAPHIC	CHAR	1.00	0.00
CDE_ADDR_USAGE	T_PR_ADDR_CODE	CHAR	1.00	0.00
CDE_ADDR_USAGE	T_RE_CDE_ADR_USAGE	CHAR	2.00	0.00
CDE_ADDR_USAGE	T_RE_MULTI_ADDRESS	CHAR	2.00	0.00
CDE_ADI	T_DRUG_DRUG_CRIT_DN	CHAR	5.00	0.00
CDE_ADI	T_DRUG_INVERSE	CHAR	5.00	0.00
CDE_ADI	T_DRUG_INVERSE	NUMBER	8.00	0.00
CDE_ADI	T_INVRS_UPDT_LOG	CHAR	5.00	0.00
CDE_ADJUSTMENT	T_DR_ADJ_RSN	CHAR	1.00	0.00
CDE_ADJUSTMENT	T_DR_PAYMENT_XREF	CHAR	1.00	0.00
CDE_ADJUSTMENT2	T_DR_PAYMENT_XREF	CHAR	1.00	0.00
CDE_ADJUSTMENT3	T_DR_PAYMENT_XREF	CHAR	1.00	0.00
CDE_ADJUST_REASON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_ADJUST_REASON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_ADJUST_REASON	T_TMSIS_COT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_ADJUST_REASON	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_ADJ_ACTION	T_ADJ_MASS_CLAIM	CHAR	1.00	0.00
CDE_ADJ_RSN	T_CDE_HIPAA_ADJRSN	CHAR	4.00	0.00

CDE_ADJ_SOURCE	T_CLM_ADJ_XREF	CHAR	1.00	0.00
CDE_ADJ_VOID	T_CA_CLAIM_KEY	CHAR	1.00	0.00
CDE_ADJ_VOID	T_DS_DNTL_ICN	CHAR	1.00	0.00
CDE_ADMIT_DIAG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	7.00	0.00
CDE_ADMIT_DIAG	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	7.00	0.00
CDE_ADMIT_DIAG_FLAG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_ADMIT_DIAG_FLAG	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_ADMIT_HOUR	T_CA_UB92	NUMBER	4.00	0.00
CDE_ADMIT_HOUR	T_DENY_UB92_HDR	CHAR	4.00	0.00
CDE_ADMIT_HOUR	T_MPHX_MISC	CHAR	4.00	0.00
CDE_ADMIT_HOUR	T_PD_UB92_HDR	CHAR	4.00	0.00
CDE_ADMIT_HOUR	T_RETRO_SUMM_RECS	CHAR	2.00	0.00
CDE_ADMIT_HOUR	T_SUSP_UB92_HDR	CHAR	4.00	0.00
CDE_ADMIT_PROV_SPEC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_ADMIT_PROV_SPEC	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_ADMIT_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_ADMIT_PROV_TAXON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_ADMIT_PROV_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_ADMIT_PROV_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_ADMIT_SOURCE	T_ADMIT_SOURCE	CHAR	1.00	0.00
CDE_ADMIT_SOURCE	T_CA_LTC	CHAR	1.00	0.00
CDE_ADMIT_SOURCE	T_CA_UB92	CHAR	1.00	0.00
CDE_ADMIT_SOURCE	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_ADMIT_SOURCE	T_DRG_CROSSWALK	CHAR	1.00	0.00
CDE_ADMIT_SOURCE	T_PD_UB92_HDR	CHAR	1.00	0.00

CDE_ADMIT_SOURCE	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_ADMIT_TYPE	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_CA_UB92	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_RE_LTC_REQUEST	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_ADMIT_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_ADR_TYPE	T_PS_CASE_ADDRESS	CHAR	3.00	0.00
CDE_ADR_TYPE	T_PS_CDE_ADR_TYPE	CHAR	3.00	0.00
CDE_ADR_TYPE	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	2.00	0.00
CDE_ADULT_CHILD	T_DS_RECIP_AGGR_CNT	CHAR	1.00	0.00
CDE_ADULT_CHILD	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_ADVNT_DISP	T_PS_CDE_ADV_DISP	CHAR	2.00	0.00
CDE_ADVNT_DISP	T_PS_DETERMINATION	CHAR	2.00	0.00
CDE_ADVNT_DISP	T_PS_LTR_LEGEND	CHAR	2.00	0.00
CDE_ADVNT_DISP	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_AFFIL_PGM_TYPE	T_TMSIS_PRV009_AFFIL_PGMS	VARCHAR2	1.00	0.00
CDE_AGENCY	T_BUYA_BILL	CHAR	3.00	0.00
CDE_AGENCY	T_BUYA_DEMO_CHANGE	CHAR	3.00	0.00
CDE_AGENCY	T_BUYA_EXCEPT	CHAR	3.00	0.00
CDE_AGENCY	T_BUYA_PREM	CHAR	3.00	0.00
CDE_AGENCY	T_BUYB_BILL	CHAR	3.00	0.00

CDE_AGENCY	T_BUYB_DEMO_CHANGE	CHAR	3.00	0.00
CDE_AGENCY	T_BUYB_EXCEPT	CHAR	3.00	0.00
CDE_AGENCY	T_BUYB_PREM	CHAR	3.00	0.00
CDE_AGENCY	T_PR_STATE_AGENCY	CHAR	2.00	0.00
CDE_AGENCY	T_PR_STATE_SHARE	CHAR	2.00	0.00
CDE_AGENCY	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_AGENCY_PREV	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_AGENT_COUNTRY	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	2.00	0.00
CDE_AGENT_COUNTRY	T_WEB_RECEIVER	CHAR	2.00	0.00
CDE_AGENT_COUNTRY	T_WEB_RECEIVER_BACKUP	CHAR	2.00	0.00
CDE_AGENT_COUNTRY_AFT	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
CDE_AGENT_COUNTRY_BEF	T_PR_WEB_CHG_BACKUP	CHAR	2.00	0.00
CDE_AGE_GROUP	T_DS_CLM_CNT_PAID_DTE	CHAR	1.00	0.00
CDE_AGE_GROUP	T_DS_CLM_CNT_SVC_DTE	CHAR	1.00	0.00
CDE_AGE_GROUP	T_DS_RECIP_AGGR_CNT	CHAR	1.00	0.00
CDE_AGE_GROUP_TYPE	T_MR_AGE_GROUP	CHAR	2.00	0.00
CDE_AGE_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_AGE_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_AGE_RESTR	T_AGE_RESTRICT	CHAR	2.00	0.00
CDE_AGE_RESTR	T_PMP_SVC_LOC	CHAR	2.00	0.00
CDE_AGE_RESTR	T_PMP_SVC_LOC	CHAR	2.00	0.00
CDE_AGE_RESTR	T_PMP_SVC_LOC_KY	CHAR	2.00	0.00

CDE_AGE_RESTR	T_PMP_SVC_LOC_WI	CHAR	2.00	0.00
CDE_AGGREGATION	T_PF_AGR_TYPE	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_INPAT_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_INPAT_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_NHOME_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_NHOME_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_OUTPAT_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_OUTPAT_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PHARM_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PHARM_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PROF_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PROF_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PRREF_RE_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_PRREF_RP_TOT_Q	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_RECIP_CMPR	NUMBER	4.00	0.00
CDE_AGGREGATION	T_PF_RE_CMPR_Q	NUMBER	4.00	0.00
CDE_AHFS_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_AHFS_REL	T_THERA_AHFS	CHAR	2.00	0.00
CDE_AID_CAT	T_AID_CAT_GROUP_XREF	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CAPITATION_ADJ_DN	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CAPITATION_HIST_DN	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CA_RECIP_KEY	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CDE_AID	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CLM_FCA	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CLM_SAMPLE	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_CLM_SYS_FIELDS_DTL	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_DS_CLM_CNT_PAID_DTE	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_DS_CLM_CNT_SVC_DTE	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_DS_RECIP_AGGR_CNT	CHAR	2.00	0.00

CDE_AID_CATEGORY	T_ELIGCNT	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MB_DEN_RECIP	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MB_NUM_RECIP	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_ELIG_SAK	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_LTC	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_LTC_REV	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_MSIS_AID	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_MSIS_AID_KY	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RE	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RECIP	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RECIP_RANK	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_RE_KY	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_TMSIS_AID_CAT	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_MR_XOVER	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_RE_AID_ELIG_DN	CHAR	2.00	0.00
CDE_AID_CATEGORY	T_RE_BASE_DN	CHAR	2.00	0.00
CDE_AID_CATG	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_AID_IFSSA	T_IFSSA_AID_GROUP	CHAR	2.00	0.00
CDE_ALERT_RSN	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_ALLOWED_CHARGE_SRC	T_MR_TMSIS_PRICING	CHAR	1.00	0.00
CDE_ALLOWED_CHARGE_SRC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00

CDE_ALT	T_ERX_ALT_THERAPY	CHAR	10.00	0.00
CDE_ALT_LIST_ID	T_PGM_HIERARCHY	CHAR	10.00	0.00
CDE_ALWD_CALCULATION	T_BNFT_ADJ_FACTOR	CHAR	1.00	0.00
CDE_AL_SCHEDULE	T_CDE_AL_SCHEDULE	CHAR	2.00	0.00
CDE_AL_SCHEDULE	T_CDE_AL_SCHEDULE_AL	CHAR	2.00	0.00
CDE_AL_SCHEDULE	T_DENY_PHRM_DTL	CHAR	2.00	0.00
CDE_AL_SCHEDULE	T_DRUG_STATE_AL	CHAR	2.00	0.00
CDE_AL_SCHEDULE	T_PD_PHARM_DTL	CHAR	2.00	0.00
CDE_AL_SCHEDULE	T_SUSP_PHRM_DTL	CHAR	2.00	0.00
CDE_AMAES_BUYIN_STATUS	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_AMB_TRANSPORT	T_CLM_CR1	CHAR	1.00	0.00
CDE_AMB_TRANS_RSN	T_CLM_CR1	CHAR	1.00	0.00
CDE_ANK_FOOTNOTE	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_ANK_FOOTNOTE	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_APPL_COUNTY	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_APPL_DO	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00

CDE_APPL_OFFSET	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_APPL_PGM	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_APPL_REVIEWER	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_APPL_SOURCE	T_DS_RECIP_DO_APPL	CHAR	3.00	0.00
CDE_APPL_SRC	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_APPL_STATUS	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_APPL_STATUS	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_APPL_TYPE	T_CDE_APPL_TYPE	NUMBER	4.00	0.00

CDE_APPL_TYPE	T_NDC_APPL	NUMBER	4.00	0.00
CDE_APPL_TYPE	T_PR_APPLN	CHAR	3.00	0.00
CDE_APPL_TYPE	T_PR_APPLN_TYPE	NUMBER	3.00	0.00
CDE_APPL_TYPE	T_PR_APPLN_WI	NUMBER	3.00	0.00
CDE_APPROVAL	T_CHK_REISSUE_XREF	CHAR	1.00	0.00
CDE_AP_COOP	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	1.00	0.00
CDE_AP_RACE	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	1.00	0.00
CDE_AP_SEX	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	1.00	0.00
CDE_AREA	T_CCF_ERROR_DATA	CHAR	2.00	0.00
CDE_AREA	T_MC_AREA_RGN_XREF	CHAR	5.00	0.00
CDE_AREA	T_MC_AREA_RGN_XREF_WI	CHAR	15.00	0.00
CDE_AREA	T_PROJ_AREA_CDE	CHAR	2.00	0.00

CDE_AREA_ASSGND	T_PROJ_TRACK	CHAR	2.00	0.00
CDE_AREA_RECVD	T_PROJ_TRACK	CHAR	2.00	0.00
CDE_AREA_TYPE	T_MC_AREA_RGN_XREF	CHAR	1.00	0.00
CDE_AREA_TYPE	T_MC_AREA_RGN_XREF_WI	CHAR	1.00	0.00
CDE_AREA_TYPE	T_MC_AREA_TYPE	CHAR	1.00	0.00
CDE_ASC	T_ASC_GROUP	CHAR	1.00	0.00
CDE_ASC	T_ASC_GROUP	CHAR	2.00	0.00
CDE_ASC	T_ASC_PRICING	CHAR	1.00	0.00
CDE_ASC	T_ASC_PRICING	CHAR	2.00	0.00
CDE_ASC	T_PROC_ASC	CHAR	1.00	0.00
CDE_ASSIGN_ENT_RSN	T_RE_ASSIGNMENT	CHAR	2.00	0.00
CDE_ASSIGN_EXT_RSN	T_RE_ASSIGNMENT	CHAR	2.00	0.00
CDE_ASST_SURG	T_RBRVS	CHAR	1.00	0.00
CDE_ASST_SURG	T_RBRVS_UPDATE	CHAR	1.00	0.00
CDE_ATTACH	T_CA_ATTACH	CHAR	2.00	0.00
CDE_ATTACH	T_CDE_ATTACH	CHAR	2.00	0.00
CDE_ATTACHMENT	T_CDE_ATTACHMENT	CHAR	1.00	0.00
CDE_ATTACHMENT_CONTROL	T_ATTACHMENT_XREF	VARCHAR2	80.00	0.00
CDE_ATTACHMENT_CONTROL	T_CLM_PWK	VARCHAR2	80.00	0.00
CDE_ATTACH_1	T_CA_ATTACH_DN	CHAR	2.00	0.00
CDE_ATTACH_2	T_CA_ATTACH_DN	CHAR	2.00	0.00
CDE_ATTACH_3	T_CA_ATTACH_DN	CHAR	2.00	0.00
CDE_ATTACH_4	T_CA_ATTACH_DN	CHAR	2.00	0.00
CDE_AUDIT_DIR	T_CONFLICT_PARM	CHAR	1.00	0.00
CDE_AUDIT_DIR	T_CONTRA_PARM	CHAR	1.00	0.00

CDE_AUDIT_DIR	T_UMBRELLA_PARM	CHAR	1.00	0.00
CDE_AUTHORIZATION	T_HOSP_ANC_AUTH	CHAR	1.00	0.00
CDE_AUTHORIZATION	T_TP	VARCHAR2	10.00	0.00
CDE_AUTHORIZATION_QUALIFIER	T_TP	VARCHAR2	2.00	0.00
CDE_BASIS_OF_COST	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_BASIS_OF_COST	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_BASIS_OF_COST	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_BATCH_STATUS	T_CLM_BATCH_PROCESS	CHAR	1.00	0.00
CDE_BATCH_STATUS	T_CLM_BATCH_PROCESS_ENC	CHAR	1.00	0.00
CDE_BATCH_STATUS	T_ENC_BATCH_PROCESS	CHAR	1.00	0.00
CDE_BED_TYPE	T_PR_BEDS_KY	CHAR	2.00	0.00
CDE_BED_TYPE	T_PR_BED_TYPE_KY	CHAR	2.00	0.00
CDE_BED_TYPE	T_TMSIS_PRV010_BED_TYPE	VARCHAR2	1.00	0.00
CDE_BEF_AFT	T_CONFLICT_PARM	CHAR	1.00	0.00
CDE_BEF_AFT	T_CONTRA_PARM	CHAR	1.00	0.00
CDE_BEF_AFT	T_READMIT_PARM	CHAR	1.00	0.00
CDE_BEF_AFT	T_UMBRELLA_PARM	CHAR	1.00	0.00
CDE_BENDEX	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_BENEFIT_CATEGORY	T_BENEFIT_LIMIT_CATEGORY	CHAR	2.00	0.00
CDE_BENEFIT_CATEGORY	T_CA_BENEFIT_LIMITS	CHAR	2.00	0.00
CDE_BENEFIT_CATEGORY	T_CLM_BENEFIT_LIMITS	CHAR	2.00	0.00
CDE_BENEFIT_CATEGORY	T_LIMIT_PARM	CHAR	2.00	0.00

CDE_BENEFIT_CATEGORY_SUSP	T_LIMIT_PARM	CHAR	2.00	0.00
CDE_BENEFIT_LIMIT_KEY	T_CLM_BENEFIT_LIMITS	CHAR	1.00	0.00
CDE_BENEFIT_LIMIT_KEY	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_BENEFIT_ROLE	T_CLM_BNFT_ROLE	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_CLM_COVERED_ROLE	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_CLM_PAYABLE_ROLE	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_COV_BNFT_BNFT	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_PAY_BNFT_BNFT	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_REIMB_AGREEMENT	CHAR	4.00	0.00
CDE_BENEFIT_ROLE	T_REIMB_BNFT_BNFT	CHAR	4.00	0.00
CDE_BENEFIT_TYPE	T_BENEFIT_TYPE	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_BNFT_GROUP_STD	CHAR	3.00	0.00

CDE_BENEFIT_TYPE	T_COVERED_BENEFIT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_COV_BNFT_BNFT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_GROUP_STD_BNFT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_HIERARCHY_ATTRIBUTE	CHAR	1.00	0.00
CDE_BENEFIT_TYPE	T_MR_TMSIS_COS	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_PAYABLE_BENEFIT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_PAY_BNFT_BNFT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_REIMB_AGREEMENT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_REIMB_BNFT_BNFT	CHAR	3.00	0.00
CDE_BENEFIT_TYPE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_BENEFIT_TYPE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00

CDE_BENEFIT_TYPE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_BENEFIT_TYPE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_BILLER	T_PR_BILLER	CHAR	1.00	0.00
CDE_BILLING	T_PR_STATE_AGENCY	CHAR	1.00	0.00
CDE_BILLING_CTR	T_PS_BILLING_CTR	CHAR	2.00	0.00
CDE_BILLING_CTR	T_PS_REFERRAL	CHAR	2.00	0.00
CDE_BILLING_CTR	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_BILLING_ENTITYID	T_DENTAL_HDR_KEYS	VARCHAR2	15.00	0.00
CDE_BILLING_ENTITYID	T_PHYS_HDR_KEY	VARCHAR2	15.00	0.00
CDE_BILLING_ENTITYID	T_UB92_HDR_EXT_KEY	VARCHAR2	15.00	0.00
CDE_BILLING_REC_ID	T_TXN_BILLING	CHAR	3.00	0.00
CDE_BILLING_REC_ID	T_TXN_BILLING_DESC	CHAR	3.00	0.00
CDE_BILLING_UNIT	T_MR_TMSIS_UNIT_TYPE	CHAR	2.00	0.00
CDE_BILLING_UNIT	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_BILLING_UNIT	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_BILL_FREQUENCY	T_PHYS_DEXT_KEY	CHAR	1.00	0.00
CDE_BILL_MAN_FORMAT	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_BILL_MEDIA	T_BILLING_MEDIA	CHAR	1.00	0.00
CDE_BILL_MEDIA	T_HIPP_RESOURCE	CHAR	1.00	0.00
CDE_BILL_MEDIA	T_TPL_CARRIER	CHAR	1.00	0.00
CDE_BILL_MEDIA	T_TPL_CARRIER_AL	CHAR	1.00	0.00
CDE_BILL_PAYTO_PROVIDER	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_BILL_PAYTO_PROVIDER	T_PHYS_HDR_KEY	CHAR	3.00	0.00
CDE_BILL_PAYTO_PROVIDER	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
CDE_BILL_PROV_SPEC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_SPEC	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_SPEC	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_SPEC	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_BILL_PROV_TAXON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_BILL_PROV_TAXON	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00

CDE_BILL_PROV_TAXON	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_BILL_PROV_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_PROV_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_BILL_TO	T_CSR	CHAR	1.00	0.00
CDE_BILL_TO	T_RETRO_SUMM_RECS	CHAR	1.00	0.00
CDE_BILL_TO	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_BILL_TYPE	T_TPL_CDE_BILL_TYPE	CHAR	1.00	0.00
CDE_BILL_TYPE	T_TPL_PREBILL	CHAR	1.00	0.00
CDE_BIOPSY	T_PROC_ICD9_LIM	CHAR	1.00	0.00
CDE_BIRTH_WT_FROM	T_DRG_NEONATAL	NUMBER	1.00	0.00
CDE_BIRTH_WT_TO	T_DRG_NEONATAL	NUMBER	1.00	0.00
CDE_BI_SURG	T_PROC_ICD9_LIM	CHAR	1.00	0.00
CDE_BI_SURG	T_RBRVS	CHAR	1.00	0.00
CDE_BI_SURG	T_RBRVS_UPDATE	CHAR	1.00	0.00
CDE_BNFT_ADJ_TYPE	T_BNFT_ADJ_FACTOR_TYPE	CHAR	11.00	0.00
CDE_BOE	T_MR_MSIS_AID	CHAR	1.00	0.00
CDE_BOE	T_MR_MSIS_AID_KY	CHAR	1.00	0.00
CDE_BP_IN_EX	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
CDE_BP_OIL	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_BRANCH	T_POL_CHAMP_INFO	CHAR	1.00	0.00
CDE_BRST_CERV_CANCER	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_BUDGET	T_FIN_BUDGET	CHAR	4.00	0.00
CDE_BUDGET_TYPE	T_FIN_BUDG_DISP	CHAR	1.00	0.00
CDE_BUDGET_TYPE	T_FIN_PROCESS_BUDG_DISP	CHAR	1.00	0.00
CDE_BULLETIN_FORMAT	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_BUS_ACT	T_PR_CDE_BUS_ACT	CHAR	1.00	0.00
CDE_BUS_ACT	T_PR_DEA_LIC	CHAR	1.00	0.00

CDE_BUS_ACT_SUB	T_PR_DEA_LIC	CHAR	1.00	0.00
CDE_BUS_PROCESS	T_BUSINESS_PROCESS	CHAR	3.00	0.00
CDE_BUS_PROCESS	T_PERF_ANALYST	CHARACTER	3.00	0.00
CDE_BUS_PROCESS	T_PERF_CRIT	CHAR	3.00	0.00
CDE_BUS_PROCESS	T_PERF_SUMM	CHAR	3.00	0.00
CDE_BUS_SCENARIO	T_CDE_CARC_RARC	CHAR	2.00	0.00
CDE_BUS_UNIT	T_BUSINESS_UNIT	CHAR	3.00	0.00
CDE_BUS_UNIT	T_PERF_ANALYST	CHARACTER	3.00	0.00
CDE_BUS_UNIT	T_PERF_CRIT	CHAR	3.00	0.00
CDE_BUS_UNIT	T_PERF_SUMM	CHAR	3.00	0.00
CDE_BUYIN	T_CLM_SYS_FIELDS_HDR	CHAR	2.00	0.00
CDE_BUY_AGENCY	T_BUYA_MISMATCH	CHAR	3.00	0.00
CDE_BUY_AGENCY	T_BUYB_MISMATCH	CHAR	3.00	0.00
CDE_BUY_ELIG	T_BUYB_BILL	CHAR	2.00	0.00
CDE_BUY_ELIG	T_BUYB_EXCEPT	CHAR	2.00	0.00
CDE_BUY_ELIG	T_BUYB_MISMATCH	CHAR	2.00	0.00
CDE_BUY_ELIG	T_BUYB_PREM	CHAR	2.00	0.00
CDE_BUY_ELIG	T_CDE_BUY_ELIG	CHAR	2.00	0.00
CDE_BUY_LIV_ARNG	T_BUYB_BILL	CHAR	1.00	0.00
CDE_BUY_LIV_ARNG	T_BUYB_MISMATCH	CHAR	1.00	0.00
CDE_BUY_MODI	T_BUYA_BILL	CHAR	2.00	0.00

CDE_BUY_MODI	T_BUYA_MISMATCH	CHAR	2.00	0.00
CDE_BUY_MODI	T_BUYB_BILL	CHAR	2.00	0.00
CDE_BUY_MODI	T_BUYB_MISMATCH	CHAR	2.00	0.00
CDE_BUY_MODI	T_CDE_BUY_BILL	CHAR	2.00	0.00
CDE_BUY_SSI	T_BUYB_BILL	CHAR	1.00	0.00
CDE_BUY_SSI	T_BUYB_MISMATCH	CHAR	1.00	0.00
CDE_BUY_SUB	T_BUYA_BILL	CHAR	1.00	0.00
CDE_BUY_SUB	T_BUYA_MISMATCH	CHAR	1.00	0.00
CDE_BUY_SUB	T_BUYB_BILL	CHAR	1.00	0.00
CDE_BUY_SUB	T_BUYB_MISMATCH	CHAR	1.00	0.00
CDE_BUY_SUB	T_CDE_BUY_BILL	CHAR	1.00	0.00
CDE_BUY_TXN	T_BUYA_BILL	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYA_EXCEPT	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYA_MISMATCH	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYA_PREM	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYB_BILL	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYB_EXCEPT	CHAR	2.00	0.00
CDE_BUY_TXN	T_BUYB_MISMATCH	CHAR	2.00	0.00

CDE_BUY_TXN	T_BUYB_PREM	CHAR	2.00	0.00
CDE_BUY_TXN	T_CDE_BUY_BILL	CHAR	2.00	0.00
CDE_BUY_TXN	T_CDE_BUY_PREM	CHAR	2.00	0.00
CDE_CALC_TYPE	T_MB_CALC	CHAR	1.00	0.00
CDE_CALC_TYPE	T_MB_DESC	CHAR	1.00	0.00
CDE_CALC_TYPE	T_MM_CALC_TYPE	CHAR	1.00	0.00
CDE_CALC_TYPE	T_MM_MEASURE_BASE	CHAR	1.00	0.00
CDE_CALLER_TYPE	T_CALL_TRACK	CHAR	3.00	0.00
CDE_CALLER_TYPE	T_CDE_CALLER_TYPE	CHAR	3.00	0.00
CDE_CALL_CATEG	T_CALL_QUESTION	CHAR	3.00	0.00
CDE_CALL_CATEG	T_CDE_CALL_CATEG	CHAR	3.00	0.00
CDE_CALL_CMPLTN	T_CALL_QUESTION	CHAR	3.00	0.00
CDE_CALL_CMPLTN	T_CDE_CALL_CMPLTN	CHAR	3.00	0.00
CDE_CALL_METHOD	T_CALL_TRACK	CHAR	3.00	0.00
CDE_CALL_METHOD	T_CDE_CALL_METHOD	CHAR	3.00	0.00
CDE_CALL_PRIORITY	T_CALL_QUESTION	CHAR	3.00	0.00
CDE_CALL_PRIORITY	T_CDE_CALL_PRIORITY	CHAR	3.00	0.00
CDE_CALL_STATUS	T_CALL_QUESTION	CHAR	1.00	0.00
CDE_CALL_STATUS	T_CALL_TRACK	CHAR	1.00	0.00
CDE_CALL_STATUS	T_CDE_CALL_STATUS	CHAR	1.00	0.00
CDE_CALL_TYPE	T_CALL_QUESTION	CHAR	3.00	0.00
CDE_CALL_TYPE	T_CDE_CALL_TYPE	CHAR	3.00	0.00
CDE_CALL_UNIT	T_CALL_CLERK_UNIT	CHAR	3.00	0.00
CDE_CALL_UNIT	T_CALL_TRACK	CHAR	3.00	0.00
CDE_CALL_UNIT	T_CDE_CALL_UNIT	CHAR	3.00	0.00
CDE_CANNED_RESP	T_CALL_NOTES	CHAR	3.00	0.00
CDE_CANNED_RESP	T_CDE_CAN_RESP	CHAR	3.00	0.00
CDE_CAP_CATEGORY	T_STATE_COS	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_ADJ	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_ADJ_DN	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_ADJ_WI	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_HIST	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_HIST_DN	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAPITATION_HIST_WI	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAP_MASS_ADJ_RST	CHAR	2.00	0.00
CDE_CAP_REASON	T_CAP_MASS_ADJ_RST_tmp	CHAR	2.00	0.00

CDE_CAP_REASON	T_CAP_REASON	CHAR	2.00	0.00
CDE_CAP_STATUS	T_CA_KICK_PYMT	CHAR	1.00	0.00
CDE_CAP_STATUS	T_CLM_KICK_PYMT	CHAR	1.00	0.00
CDE_CARRIER	T_RETRO_SUMM_RECS	CHAR	10.00	0.00
CDE_CARRIER	T_TPL_CARRIER	CHAR	7.00	0.00
CDE_CARRIER	T_TPL_CARRIER	CHAR	10.00	0.00
CDE_CARRIER	T_TPL_CARRIER_AL	CHAR	10.00	0.00
CDE_CARRIER	T_TPL_CORR_ADDR	CHAR	10.00	0.00
CDE_CARRIER	T_TPL_RES_DEL	CHAR	7.00	0.00
CDE_CARRIER_ROUTE	T_PR_ADR_CASS	CHAR	4.00	0.00
CDE_CARRIER_ROUTE	T_RE_ADR_CASS	CHAR	4.00	0.00
CDE_CARRIER_STAT	T_TPL_CARRIER	CHAR	2.00	0.00
CDE_CARRIER_STAT	T_TPL_CARRIER_AL	CHAR	2.00	0.00
CDE_CARRIER_STAT	T_TPL_CDE_CARRIER_STAT	CHAR	2.00	0.00
CDE_CARRIER_TYPE	T_TPL_CARRIER	CHAR	2.00	0.00
CDE_CARRIER_TYPE	T_TPL_CARRIER_AL	CHAR	2.00	0.00
CDE_CARRIER_TYPE	T_TPL_CDE_CARRIER_TYPE	CHAR	2.00	0.00
CDE_CASE_RESP	T_TPL_CARRIER	CHAR	3.00	0.00
CDE_CASE_RESP	T_TPL_CARRIER_AL	CHAR	3.00	0.00
CDE_CASE_STATUS	T_CT_CASE_STATUS	CHAR	2.00	0.00
CDE_CASE_STATUS	T_CT_CASE_TRACK	CHAR	2.00	0.00
CDE_CASE_TYPE	T_CASUALTY_CASE	CHAR	1.00	0.00
CDE_CASE_TYPE	T_CASUALTY_CASE	CHAR	2.00	0.00
CDE_CASE_TYPE	T_CASUALTY_CASE_AL	CHAR	2.00	0.00
CDE_CASE_TYPE	T_CAS_CASE_TYPE	CHAR	2.00	0.00
CDE_CASE_TYPE	T_PS_CASE	CHAR	1.00	0.00
CDE_CASE_TYPE	T_PS_CASE_TYPE	CHAR	1.00	0.00
CDE_CASE_TYPE	T_TPL_CONT_FEE	CHAR	1.00	0.00
CDE_CASE_TYPE	T_TPL_CONT_FEE	CHAR	2.00	0.00
CDE_CASH_STATUS	T_CASH_RECEIPT	CHAR	1.00	0.00
CDE_CASH_STATUS	T_CDE_CASH_STATUS	CHAR	1.00	0.00
CDE_CAS_ORIG	T_CASUALTY_CASE	CHAR	1.00	0.00

CDE_CAS_ORIG	T_CASUALTY_CASE	CHAR	2.00	0.00
CDE_CAS_ORIG	T_CASUALTY_CASE_AL	CHAR	2.00	0.00
CDE_CATEGORY	T_CLM_CRC	CHAR	2.00	0.00
CDE_CATEGORY	T_GEN_RATES	CHAR	1.00	0.00
CDE_CATEGORY	T_MODIFIER	CHAR	1.00	0.00
CDE_CAUSE	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_CAVITY_DESIG_1	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
CDE_CAVITY_DESIG_1	T_PA_DTL	CHAR	3.00	0.00
CDE_CAVITY_DESIG_2	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
CDE_CAVITY_DESIG_2	T_PA_DTL	CHAR	3.00	0.00
CDE_CAVITY_DESIG_3	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
CDE_CAVITY_DESIG_3	T_PA_DTL	CHAR	3.00	0.00
CDE_CAVITY_DESIG_4	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
CDE_CAVITY_DESIG_4	T_PA_DTL	CHAR	3.00	0.00
CDE_CAVITY_DESIG_5	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
CDE_CAVITY_DESIG_5	T_PA_DTL	CHAR	3.00	0.00
CDE_CERTIFICATE	T_DENY_PHYS_HDR	CHAR	2.00	0.00
CDE_CERTIFICATE	T_DENY_UB92_HDR	CHAR	2.00	0.00
CDE_CERTIFICATE	T_PD_PHYS_HDR	CHAR	2.00	0.00
CDE_CERTIFICATE	T_PD_UB92_HDR	CHAR	2.00	0.00

CDE_CERTIFICATE	T_SUSP_PHYS_HDR	CHAR	2.00	0.00
CDE_CERTIFICATE	T_SUSP_UB92_HDR	CHAR	2.00	0.00
CDE_CERT_AGENCY	T_RE_AID_ELIG	CHAR	1.00	0.00
CDE_CERT_AGENCY	T_RE_AID_ELIG_DN	CHAR	1.00	0.00
CDE_CERT_AMER_IND_AK_NATIVE	T_TMSIS_ELG016_RACE_INFO	VARCHAR2	1.00	0.00
CDE_CERT_NUM	T_CLIA_CERT	CHAR	2.00	0.00
CDE_CERT_PGM	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_CERT_TYPE	T_CLIA_CERT	CHAR	1.00	0.00
CDE_CERT_TYPE	T_PR_CERT_CODE	CHAR	2.00	0.00
CDE_CERT_TYPE	T_PR_SVC_CERT	CHAR	2.00	0.00
CDE_CERT_TYPE	T_PR_SVC_CERT_WI	CHAR	2.00	0.00
CDE_CHECK_EFT_NUM	T_835_CK_EFT_TRCNO	VARCHAR2	30.00	0.00
CDE_CHILD_SUPP_COOP	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_CHIP	T_MR_TMSIS_AID_CAT	CHAR	1.00	0.00
CDE_CHIP	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
CDE_CHRONO	T_CDE_CHRONO	CHAR	1.00	0.00
CDE_CHRONO	T_CHRONO_NOTES	CHAR	1.00	0.00
CDE_CITIZEN	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_CITIZENSHIP	T_CDE_FAM_MBR_CITIZENSHIP	CHAR	1.00	0.00
CDE_CITIZEN_STAT	T_RE_BASE_DN	CHAR	2.00	0.00
CDE_CITIZEN_STAT	T_RE_CITIZEN_DSC	CHAR	2.00	0.00
CDE_CITIZEN_VER_FLAG	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
CDE_CLAIM_FILING_IND	T_CLM_SBR	CHAR	2.00	0.00
CDE_CLAIM_FORM	T_CLAIM_FRM_TYP	CHAR	1.00	0.00
CDE_CLAIM_FORM	T_FIN_PROCESS_EOMB	CHAR	1.00	0.00

CDE_CLAIM_FORM	T_TPL_CARRIER	CHAR	1.00	0.00
CDE_CLAIM_FORM	T_TPL_CARRIER_AL	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_DENY_DNTL_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_DENY_PHYS_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
CDE_CLAIM_FREQUENCY	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_CLAIM_STATUS	T_CLM_PHRM_	CHAR	1.00	0.00
CDE_CLAIM_STATUS	T_CLM_PHRM_PAPER_IMG	CHAR	1.00	0.00
CDE_CLAIM_STATUS	T_WEB_CLAIM_HDR	CHAR	1.00	0.00
CDE_CLAIM_STATUS	T_WEB_CLM_STATUS	CHAR	1.00	0.00
CDE_CLAIM_SUBMIT_RSN	T_DENTAL_HDR_KEYS	CHAR	2.00	0.00
CDE_CLAIM_TYPE	T_CLM_FCA	CHAR	6.00	0.00
CDE_CLAIM_TYPE	T_WEB_CLAIM_HDR	CHAR	1.00	0.00

CDE_CLAIM_TYPE	T_WEB_CLM_TYPE	CHAR	1.00	0.00
CDE_CLAPCRFL	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
CDE_CLARIFICATION	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_2	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_2	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_2	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_3	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_3	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_CLARIFICATION_3	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_CLASS	T_EFT_TRACE_XREF	CHAR	3.00	0.00
CDE_CLASS	T_PROC_ICD9	CHAR	1.00	0.00
CDE_CLASS_BNFT_HIER	T_CLASSIFICATION_BNFT	CHAR	4.00	0.00
CDE_CLASS_GROUP	T_CLASS_OBJECT_GROUP	VARCHAR2	10.00	0.00
CDE_CLEID	T_REF_CCI	CHAR	12.00	0.00
CDE_CLEID	T_REF_CCI_MUE	CHAR	12.00	0.00
CDE_CLEID	T_REF_CCI_MUE_OVERRIDE	CHAR	12.00	0.00

CDE_CLEID	T_REF_CCI_OVERRIDE	CHAR	12.00	0.00
CDE_CLERK_ID	T_CLM_PHRM_	CHAR	20.00	0.00
CDE_CLERK_ID	T_CLM_PHRM_PAPER_IMG	CHAR	20.00	0.00
CDE_CLMSA	T_UB92_HDR_OUTPAT	VARCHAR2	4.00	0.00
CDE_CLM_ADJ_GROUP	T_CLM_CAS	CHAR	2.00	0.00
CDE_CLM_ADJ_GROUP	T_PAYER_ADJUSTMENT	CHAR	2.00	0.00
CDE_CLM_ADJ_REASON	T_CLM_CAS	CHAR	5.00	0.00
CDE_CLM_ADJ_REASON	T_PAYER_ADJUSTMENT	VARCHAR2	5.00	0.00
CDE_CLM_CAT_STATUS	T_CLM_STATUS_XREF	CHAR	2.00	0.00
CDE_CLM_CAT_STATUS	T_HC_CLM_STAT_CAT	CHAR	2.00	0.00
CDE_CLM_FILING	T_AR_CLM_HDR	CHAR	2.00	0.00
CDE_CLM_FORM	T_AUDIT_CLAIM_FORM	CHAR	4.00	0.00
CDE_CLM_FORM_CURR	T_AUDIT_CL_TYPE_X	CHAR	4.00	0.00
CDE_CLM_FORM_HIST	T_AUDIT_CL_TYPE_X	CHAR	4.00	0.00
CDE_CLM_LINE_STATUS	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_CLM_LINE_STATUS	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_CLM_LINE_STATUS	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_CLM_LINE_STATUS	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_CLM_LOC	T_ERR_DISP_LINE	CHAR	2.00	0.00
CDE_CLM_LOCATION	T_CDE_CLM_LOC	CHAR	2.00	0.00
CDE_CLM_PMT_REM	T_TMSIS_CIP_REM_CDE	VARCHAR2	5.00	0.00
CDE_CLM_PMT_REM	T_TMSIS_CLT_REM_CDE	VARCHAR2	5.00	0.00
CDE_CLM_PMT_REM	T_TMSIS_COT_REM_CDE	VARCHAR2	5.00	0.00
CDE_CLM_PMT_REM	T_TMSIS_CRX_REM_CDE	VARCHAR2	5.00	0.00
CDE_CLM_REGION	T_CA_CLAIM_KEY	CHAR	2.00	0.00
CDE_CLM_REGION	T_DCOR_SCHEDULE	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_OP_PERFORM	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_OP_PERFORM_DTL	CHAR	2.00	0.00

CDE_CLM_REGION	T_MR_PROV	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_PROV_RE	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_RECIP	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_CLM_REGION	T_MR_XOVER	CHAR	2.00	0.00
CDE_CLM_STATUS	T_ADJ_MASS_CLAIM	CHAR	1.00	0.00
CDE_CLM_STATUS	T_AR_CLM_HDR	CHAR	2.00	0.00
CDE_CLM_STATUS	T_CA_DRUG	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CA_MATERNITY_CARE	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CLM_MAT_CARE_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CLM_MAT_CARE_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CLM_SAMPLE	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CLM_STATUS	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CLM_STATUS_XREF	CHAR	1.00	0.00
CDE_CLM_STATUS	T_CPAS_CLM_STATUS	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_DNTL_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_DNTL_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_PHRM_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_PHYS_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_UB92_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_FIN_PROCESS_DNTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_FIN_PROCESS_PHRM	CHAR	1.00	0.00
CDE_CLM_STATUS	T_FIN_PROCESS_PHYS	CHAR	1.00	0.00
CDE_CLM_STATUS	T_FIN_PROCESS_UB92	CHAR	1.00	0.00
CDE_CLM_STATUS	T_HIST_DIRECTORY	CHAR	1.00	0.00
CDE_CLM_STATUS	T_MEDPOL_UB92	CHAR	1.00	0.00
CDE_CLM_STATUS	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PBM_PHARM_EXTRACT	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_DNTL_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_PHARM_DTL	CHAR	1.00	0.00

CDE_CLM_STATUS	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_PHYS_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_UB92_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SAK_ICN_DAILY	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_DENTAL_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_PHRM_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_UB92_DTL	CHAR	1.00	0.00
CDE_CLM_STATUS	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_STATUS	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS	T_TMSIS_COT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS_CAT	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS_CAT	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS_CAT	T_TMSIS_COT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_STATUS_CAT	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_CLM_TXN_TYP	T_DENY_DNTL_HDR	CHAR	1.00	0.00

CDE_CLM_TXN_TYP	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_DENY_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TXN_TYP	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TYP	T_CLM_PGM_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_ADJMS_CT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_ADJ_MASS_CLAIM	CHAR	1.00	0.00

CDE_CLM_TYPE	T_ADJ_VOID_RQST	CHAR	1.00	0.00
CDE_CLM_TYPE	T_AUDIT_CLAIM_FORM	CHAR	1.00	0.00
CDE_CLM_TYPE	T_AUDIT_CL_FORM_X	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CASUALTY_CASE_OFFLINE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CA_CLAIM_KEY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CA_FIN	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CA_MATERNITY_CARE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CCF_ERROR_DATA	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CHK_BAN_CLM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLAIM_ERROR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLAIM_LOCAT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLAIM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_AMT_VARIANCE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_HIST_BALANCE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_MAT_CARE_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_PROCESSED_EXTRAC T	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_RESUB_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CLM_SAMPLE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COPAY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COPAY_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COS_CLM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COVERAGE_CRIT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_BILL_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_CLAIM_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_CT_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_DIAG_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_NDC_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_PROC_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_REV_XREF	CHAR	1.00	0.00

CDE_CLM_TYPE	T_COV_SPEC_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_COV_TYPE_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CPAS_CLAIM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_CT_TXN_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DCOR_QLTY_CTL	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DCOR_SCHEDULE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DENY_DNTL_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DENY_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DS_CLM_CNT_PAID_DTE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DS_CLM_CNT_SVC_DTE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DS_HM_HEADER	CHAR	1.00	0.00
CDE_CLM_TYPE	T_DUPE_AUDIT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_EDIT_RECYCLE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_ERROR_EXTRACT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_ERR_DISP_LINE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_FIN_PRU_PAY_CLM	CHAR	1.00	0.00
CDE_CLM_TYPE	T_HIST_DIRECTORY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MCARE_DEDUCTIBLE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MEDPOL_UB92	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MPHX_INPT_HDR	CHAR	1.00	0.00

CDE_CLM_TYPE	T_MPHX_INPT_HDR2	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_NONCLAIM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_OP_PERFORM	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_OP_PERFORM_DTL	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_PROV	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_PROV_RE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_PROV_SUSP	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RECIP	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RECIP_KY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RECIP_RANK	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RE_CNTY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_RE_KY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_MR_XOVER	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PAYMENT_EXTRACT	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PAY_CT_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PAY_HOLD_CLM_TYP	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PGM_CT_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PRICING_CLM_TYPE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PROV_CLM_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PR_CONTRACT_RATE_KY	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PR_PGM_CT_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_PR_RST_SVC	CHAR	1.00	0.00
CDE_CLM_TYPE	T_REIMB_RATE	CHAR	1.00	0.00

CDE_CLM_TYPE	T_RETRO_SUMM_RECS	CHAR	1.00	0.00
CDE_CLM_TYPE	T_RE_LOCKIN_INFO	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SUR_RQST_CLM_TYP	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_CLM_TYPE	T_SYS_LOCATION	CHAR	1.00	0.00
CDE_CLM_TYPE	T_TOB_CT_XREF	CHAR	1.00	0.00
CDE_CLM_TYPE	T_TPL_CONT_FEE	CHAR	1.00	0.00
CDE_CLM_TYPE	T_TPL_THRESHOLD_SUMM	CHAR	1.00	0.00
CDE_CLM_TYPE_2	T_AUDIT_CL_FORM_X	CHAR	1.00	0.00
CDE_CLM_TYPE_CURR	T_AUDIT_CL_TYPE_X	CHAR	1.00	0.00
CDE_CLM_TYPE_HIST	T_AUDIT_CL_TYPE_X	CHAR	1.00	0.00
CDE_CLM_TYP_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_CLM_TYP_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_CLM_VERSION	T_CA_CLAIM_KEY	CHAR	4.00	0.00
CDE_CLM_VERSION	T_DENTAL_HDR_KEYS	CHAR	4.00	0.00
CDE_CLM_VERSION	T_HIST_DIRECTORY	CHAR	4.00	0.00

CDE_CLM_VERSION	T_PHRM_HDR_KEYS	CHAR	4.00	0.00
CDE_CLM_VERSION	T_PHYS_HDR_KEY	CHAR	4.00	0.00
CDE_CLM_VERSION	T_UB92_HDR_EXT_KEY	CHAR	4.00	0.00
CDE_CLOSE_REASON	T_RE_CLOSE_MCD	CHAR	1.00	0.00
CDE_CLPRMETH	T_UB92_HDR_OUTPAT	VARCHAR2	2.00	0.00
CDE_CLRTC	T_UB92_HDR_OUTPAT	VARCHAR2	2.00	0.00
CDE_CMPD_DISP_FORM	T_PHRM_HDR_OPT	CHAR	1.00	0.00
CDE_CMPD_DOSE	T_CA_DRUG	CHAR	2.00	0.00

CDE_CMPD_DOSE	T_PHRM_HDR_OPT	CHAR	2.00	0.00
CDE_CMPD_INGRED_MOD	T_CLM_PHRM_CMPD_MOD	CHAR	2.00	0.00
CDE_CMPD_RTE_ADMIN	T_PHRM_HDR_OPT	CHAR	2.00	0.00
CDE_CMPD_TYPE	T_CLM_PHRM_HDR	CHAR	2.00	0.00
CDE_CMS64_CAT_FED_REIMB	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_CMS64_CAT_FED_REIMB	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_CMS64_CAT_FED_REIMB	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_CMS64_CAT_FED_REIMB	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_CMS_COD_STATUS	T_DRUG_CMSFDB_INFO	CHAR	2.00	0.00
CDE_CMS_DRUG_CATGRY	T_DRUG_CMSFDB_INFO	CHAR	1.00	0.00
CDE_CMS_FILE	T_MR_TMSIS_CMS_ERROR_FILES	CHAR	3.00	0.00
CDE_CMS_FILE	T_TMSIS_CMS_ERROR_FILES	CHAR	3.00	0.00

CDE_CMS_SOURCE_CCI	T_REF_CCI	CHAR	1.00	0.00
CDE_CMS_SOURCE_CCI	T_REF_CCI_OVERRIDE	CHAR	1.00	0.00
CDE_CMS_SOURCE_CCI_MUE	T_REF_CCI_MUE	CHAR	1.00	0.00
CDE_CMS_SOURCE_CCI_MUE	T_REF_CCI_MUE_OVERRIDE	CHAR	1.00	0.00
CDE_CMS_THERA_EQUIV	T_DRUG_CMSFDB_INFO	CHAR	2.00	0.00
CDE_CMS_TOS	T_CDE_CMS_TOS	CHAR	1.00	0.00
CDE_CMS_TOS	T_CDE_PROC	CHAR	1.00	0.00
CDE_CMS_TOS	T_PROC	CHAR	1.00	0.00
CDE_CMS_UNIT	T_DR_CMS_TAPE	CHAR	3.00	0.00
CDE_CNCRNT_RISK_GROUP_ID	T_MME_OPIOID_CONCR_RISK_DR	NUMBER	8.00	0.00
CDE_CNCRNT_RISK_GROUP_ID	T_MME_OPIOID_CONCR_RISK_LN	NUMBER	8.00	0.00
CDE_CNCRNT_RISK_GRP_ID	T_MME_CONCR_RISK_GRP_ID_DS	NUMBER	8.00	0.00
CDE_CNCRNT_RISK_SET_ID	T_MME_OPIOID_CONCR_ALERT	NUMBER	8.00	0.00
CDE_CNCRNT_RISK_SET_ID	T_MME_OPIOID_CONCR_RISK_LN	NUMBER	8.00	0.00
CDE_CNCRNT_RISK_SET_ID_DESC	T_MME_OPIOID_CONCR_ALERT	VARCHAR2	255.00	0.00
CDE_CNTY_FROM	T_PR_LABEL_CRIT	VARCHAR2	10.00	0.00
CDE_CNTY_TO	T_PR_LABEL_CRIT	VARCHAR2	10.00	0.00
CDE_CNT_CRIT	T_MM_CNT_CRIT	CHAR	1.00	0.00
CDE_CNT_CRIT	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_CODE_TYPE	T_CODE_RESOLUTION	CHAR	1.00	0.00
CDE_COLLECT_AUTH	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_COLLECT_MEDIA	T_DRUG_LBLR	CHAR	1.00	0.00
CDE_COLLECT_MEDIA	T_DR_COLLECT_MEDIA	CHAR	1.00	0.00

CDE_COLLECT_STATUS	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_COMB_PROC	T_LS_LVL1_PRICING	CHAR	18.00	0.00
CDE_COMB_PROC	T_LS_LVL3_PRICING	CHAR	18.00	0.00
CDE_COMPARISON_OP	T_RU_COMPARISON	CHAR	2.00	0.00
CDE_COMPARISON_OP	T_RU_COMPARISON_OP	CHAR	2.00	0.00
CDE_COMPOUND_DOSE_FORM	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_COMP_DAYS	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_COMP_DAYS	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_COND	T_CA_COND	CHAR	2.00	0.00
CDE_COND	T_CONDITION	CHAR	2.00	0.00
CDE_COND	T_COND_INP_LOC	CHAR	2.00	0.00
CDE_COND	T_COV_BNFT_CONDITION	CHAR	2.00	0.00
CDE_COND	T_PAY_BNFT_CONDITION	CHAR	2.00	0.00
CDE_COND	T_PHYS_COND	CHAR	2.00	0.00
CDE_COND	T_PR_LOC_RATE_WI	CHAR	2.00	0.00
CDE_COND	T_PR_PSYCH_FACI	CHAR	2.00	0.00
CDE_COND	T_REIMB_CONDITION	CHAR	2.00	0.00
CDE_COND	T_UB92_HDR_COND_X	CHAR	2.00	0.00
CDE_CONDITION	T_CLM_CRC	VARCHAR2	15.00	0.00
CDE_CONDITION	T_ERM_DEP	CHAR	1.00	0.00
CDE_COND_1	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_1	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_COND_2	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_2	T_MEDPOL_UB92	CHAR	2.00	0.00

CDE_COND_3	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_3	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_COND_4	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_4	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_COND_5	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_5	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_COND_6	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_7	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_8	T_CA_COND_DN	CHAR	2.00	0.00
CDE_COND_SEQ	T_CA_COND	CHAR	2.00	0.00
CDE_COND_SEQ	T_PHYS_COND	CHAR	2.00	0.00
CDE_COND_SEQ	T_UB92_HDR_COND_X	CHAR	2.00	0.00
CDE_CONFIRM	T_CM_CONFIRM	CHAR	1.00	0.00
CDE_CONTACT_PREF	T_PR_SVC_LOC_STATE_KY	CHAR	1.00	0.00
CDE_CONTACT_TYPE	T_DR_CONTACT_TYPE	CHAR	2.00	0.00
CDE_CONTACT_TYPE	T_DR_LBLR_CONTACT	CHAR	2.00	0.00
CDE_CONTEXT_EXT	T_TPL_CASE_XREF	CHAR	10.00	0.00
CDE_CONTRACT_ID	T_CLM_CN1	VARCHAR2	50.00	0.00
CDE_CONTRACT_TYPE	T_CLM_CN1	CHAR	2.00	0.00
CDE_CONTRACT_VERSION	T_CLM_CN1	VARCHAR2	30.00	0.00
CDE_CONTROL	T_PLOG_PARAMETER	CHAR	2.00	0.00
CDE_CONV	T_DR_CONV_UNITS	CHAR	1.00	0.00
CDE_COORDINATION_BENEFITS	T_CLM_SBR	CHAR	1.00	0.00
CDE_COPAY_STATUS	T_PHYS_DEXT_KEY	CHAR	1.00	0.00
CDE_COPAY_TYPE	T_COPAY_TYPE	CHAR	1.00	0.00

CDE_COP_LIST_ID	T_PGM_HIERARCHY	CHAR	10.00	0.00
CDE_CORE_BASED_STAT_AREA	T_TMSIS_MCR002_MAIN	VARCHAR2	1.00	0.00
CDE_COS	T_CT_CASE_TRACK	CHAR	2.00	0.00
CDE_COST_AVOID	T_TPL_COST_AVOID_SUMM	CHAR	1.00	0.00
CDE_COS_CMS21	T_COS_ASSIGN_CRIT	CHAR	4.00	0.00
CDE_COS_CMS21	T_COS_DTL_XREF	CHAR	4.00	0.00
CDE_COS_CMS64_21	T_COS_ASSIGN_CRIT	CHAR	4.00	0.00
CDE_COS_CMS64_21	T_COS_DTL_XREF	CHAR	4.00	0.00
CDE_COS_CMS64_21	T_STATE_COS	CHAR	4.00	0.00
CDE_COS_CMS64_9	T_COS_ASSIGN_CRIT	CHAR	4.00	0.00
CDE_COS_CMS64_9	T_COS_DTL_XREF	CHAR	4.00	0.00
CDE_COS_CMS64_9	T_STATE_COS	CHAR	4.00	0.00
CDE_COS_FED	T_PHARMACY_COS	CHAR	2.00	0.00
CDE_COS_FED	T_PHYSICIAN_COS	CHAR	2.00	0.00
CDE_COS_FED	T_UB92_COS	CHAR	2.00	0.00
CDE_COS_HCFA	T_PHARMACY_COS	CHAR	2.00	0.00
CDE_COS_HCFA	T_PHYSICIAN_COS	CHAR	2.00	0.00
CDE_COS_HCFA	T_UB92_COS	CHAR	2.00	0.00
CDE_COS_MSIS	T_COS_ASSIGN_CRIT	CHAR	2.00	0.00
CDE_COS_MSIS	T_COS_DTL_XREF	CHAR	2.00	0.00
CDE_COS_MSIS	T_MR_TMSIS_CDE_TOS	CHAR	2.00	0.00
CDE_COS_MSIS	T_STATE_COS	CHAR	2.00	0.00
CDE_COS_ST	T_CA_CLAIM_KEY	CHAR	2.00	0.00
CDE_COS_ST	T_CLM_SAMPLE	CHAR	2.00	0.00
CDE_COS_ST	T_COS_ASSIGN_CRIT	CHAR	2.00	0.00
CDE_COS_ST	T_COS_DTL_XREF	CHAR	2.00	0.00
CDE_COS_ST	T_MR_COPAY_CRIT	CHAR	2.00	0.00
CDE_COS_ST	T_MR_ERROR_KY	CHAR	2.00	0.00

CDE_COS_ST	T_MR_POS	CHAR	2.00	0.00
CDE_COS_ST	T_MR_POS_RE	CHAR	2.00	0.00
CDE_COS_ST	T_MR_PROV	CHAR	2.00	0.00
CDE_COS_ST	T_MR_PROV_PERFORM_KY	CHAR	2.00	0.00
CDE_COS_ST	T_MR_PROV_RE	CHAR	2.00	0.00
CDE_COS_ST	T_MR_RE	CHAR	2.00	0.00
CDE_COS_ST	T_MR_RECIP	CHAR	2.00	0.00
CDE_COS_ST	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_COS_ST	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_COS_ST	T_MR_RE_KY	CHAR	2.00	0.00
CDE_COS_ST	T_MR_TMSIS_CDE_TOS	CHAR	2.00	0.00
CDE_COS_ST	T_MR_TMSIS_COS	CHAR	2.00	0.00
CDE_COS_ST	T_MR_XOVER	CHAR	2.00	0.00
CDE_COS_ST	T_PHARMACY_COS	CHAR	2.00	0.00
CDE_COS_ST	T_PHYSICIAN_COS	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_CLAIMS_BY_DATE	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_CLAIMS_BY_MONTH	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_CLAIMS_BY_QTR	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_FIN_DATA_BY_DATE	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_FIN_DATA_BY_MONTH	CHAR	2.00	0.00
CDE_COS_ST	T_SCOS_FIN_DATA_BY_QTR	CHAR	2.00	0.00
CDE_COS_ST	T_STATE_COS	CHAR	2.00	0.00
CDE_COS_ST	T_UB92_COS	CHAR	2.00	0.00
CDE_COS_SUB	T_CA_CLAIM_KEY	CHAR	2.00	0.00

CDE_COS_SUB	T_COS_ASSIGN_CRIT	CHAR	2.00	0.00
CDE_COS_SUB	T_COS_DTL_XREF	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_COPAY_CRIT	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_ERROR_KY	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_POS	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_POS_RE	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_PROV	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_PROV_PERFORM_KY	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_PROV_RE	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_RE	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_RECIP	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_RE_KY	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_TMSIS_CDE_TOS	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_TMSIS_COS	CHAR	2.00	0.00
CDE_COS_SUB	T_MR_XOVER	CHAR	2.00	0.00
CDE_COS_SUB	T_SCOS_CLAIMS_BY_DATE	CHAR	3.00	0.00
CDE_COS_SUB	T_SCOS_CLAIMS_BY_MONTH	CHAR	3.00	0.00
CDE_COS_SUB	T_SCOS_CLAIMS_BY_QTR	CHAR	3.00	0.00

CDE_COS_SUB	T_SCOS_FIN_DATA_BY_DATE	CHAR	3.00	0.00
CDE_COS_SUB	T_SCOS_FIN_DATA_BY_MONTH	CHAR	3.00	0.00
CDE_COS_SUB	T_SCOS_FIN_DATA_BY_QTR	CHAR	3.00	0.00
CDE_COS_SUB	T_STATE_COS	CHAR	2.00	0.00
CDE_COS_SUB1	T_CLM_SAMPLE	CHAR	1.00	0.00
CDE_COS_SUB1	T_PHARMACY_COS	CHAR	1.00	0.00
CDE_COS_SUB1	T_PHYSICIAN_COS	CHAR	1.00	0.00
CDE_COS_SUB1	T_UB92_COS	CHAR	1.00	0.00
CDE_COS_SUB2	T_CLM_SAMPLE	CHAR	1.00	0.00
CDE_COS_SUB2	T_PHARMACY_COS	CHAR	1.00	0.00
CDE_COS_SUB2	T_PHYSICIAN_COS	CHAR	1.00	0.00
CDE_COS_SUB2	T_UB92_COS	CHAR	1.00	0.00
CDE_COS_TYPE	T_CDE_COS_VALUES	CHAR	5.00	0.00
CDE_COS_VALUE	T_CDE_COS_VALUES	CHAR	4.00	0.00
CDE_COUNTRY	T_ATTORNEY	CHAR	2.00	0.00
CDE_COUNTRY	T_ATTORNEY_FIRM	CHAR	2.00	0.00
CDE_COUNTRY	T_COUNTRY	CHAR	2.00	0.00
CDE_COUNTRY	T_HIPP_RESOURCE	CHAR	2.00	0.00
CDE_COUNTRY	T_INS_AGENT	CHAR	2.00	0.00
CDE_COUNTRY	T_PA_HDR	CHAR	3.00	0.00
CDE_COUNTRY	T_PA_HDR_PE_TRNSP	CHAR	3.00	0.00
CDE_COUNTRY	T_POLICY_HOLDER	CHAR	2.00	0.00
CDE_COUNTRY	T_PR_ADR	CHAR	2.00	0.00
CDE_COUNTRY	T_PR_ADR_AL	CHAR	2.00	0.00
CDE_COUNTRY	T_PR_ADR_WI	CHAR	2.00	0.00
CDE_COUNTRY	T_PR_NAM_NPPES	VARCHAR2	2.00	0.00
CDE_COUNTRY	T_TORTFEASOR	CHAR	2.00	0.00
CDE_COUNTRY	T_TORTFEASOR_AL	CHAR	2.00	0.00
CDE_COUNTRY	T_TP	CHAR	3.00	0.00
CDE_COUNTRY	T_TPL_AC_PARENT	CHAR	2.00	0.00
CDE_COUNTRY	T_TPL_CARRIER	CHAR	2.00	0.00
CDE_COUNTRY	T_TPL_CARRIER_AL	CHAR	2.00	0.00

CDE_COUNTRY	T_TPL_CASE_INFO	CHAR	2.00	0.00
CDE_COUNTRY	T_TPL_CORR_ADDR	CHAR	2.00	0.00
CDE_COUNTRY	T_TPL_EMPLOYER	CHAR	2.00	0.00
CDE_COUNTRY	T_TPL_LIEN	CHAR	2.00	0.00
CDE_COUNTRY_2010AC_N404	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_COUNTRY_2010AC_N404	T_CLM_PHYS_HDR	CHAR	3.00	0.00
CDE_COUNTRY_2010AC_N404	T_CLM_UB92_HDR	CHAR	3.00	0.00
CDE_COUNTRY_2310C_N404	T_CLM_DNTL_2300	CHAR	3.00	0.00
CDE_COUNTRY_2310E_N404	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_COUNTRY_2310F_N404	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_COUNTRY_2330B_N404	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_COUNTRY_2330B_N404	T_CLM_PHYS_2320	CHAR	3.00	0.00
CDE_COUNTRY_2420D_N404	T_CLM_DNTL_2400	CHAR	3.00	0.00
CDE_COUNTRY_2420G_N404	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_COUNTRY_2420H_N404	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_COUNTRY_CURRENCY	T_COUNTRY	CHAR	3.00	0.00
CDE_COUNTRY_SUB	T_PA_HDR_PE_TRNSP	CHAR	3.00	0.00
CDE_COUNTRY_SUB_DEP	T_PA_HDR	CHAR	3.00	0.00
CDE_COUNTRY_SUB_RQST_PROV	T_PA_HDR	CHAR	3.00	0.00
CDE_COUNTRY_SUB_SUBSCRIBER	T_PA_HDR	CHAR	3.00	0.00
CDE_COUNTY	T_BORDER	VARCHAR2	10.00	0.00
CDE_COUNTY	T_BUYA_BILL_INFO	VARCHAR2	10.00	0.00
CDE_COUNTY	T_BUYA_MISMATCH	VARCHAR2	10.00	0.00
CDE_COUNTY	T_BUYB_BILL_INFO	VARCHAR2	10.00	0.00

CDE_COUNTY	T_BUYB_MISMATCH	VARCHAR2	10.00	0.00
CDE_COUNTY	T_CASUALTY_CASE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_CASUALTY_CASE_AL	VARCHAR2	10.00	0.00
CDE_COUNTY	T_CA_PR_HB_LIC	VARCHAR2	10.00	0.00
CDE_COUNTY	T_CLM_FCA	VARCHAR2	10.00	0.00
CDE_COUNTY	T_CLM_SYS_FIELDS_DTL	VARCHAR2	10.00	0.00
CDE_COUNTY	T_COUNTY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_COUNTY_OFFICE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_COUNTY_RATE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DENY_DNTL_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DENY_PHRM_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DENY_PHYS_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DENY_UB92_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DS_CLM_CNT_PAID_DTE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DS_CLM_CNT_SVC_DTE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_DS_RECIP_AGGR_CNT	VARCHAR2	10.00	0.00
CDE_COUNTY	T_ELIGCNT	VARCHAR2	10.00	0.00
CDE_COUNTY	T_EXPENDITURE	CHAR	2.00	0.00
CDE_COUNTY	T_EXPENDITURE	CHAR	10.00	0.00
CDE_COUNTY	T_EXPENDITURE_DN	CHAR	10.00	0.00
CDE_COUNTY	T_HIPP_CAPITATION_RATE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_HOSPICE_RATE	CHAR	2.00	0.00
CDE_COUNTY	T_MC_ANNUAL_POSTCARD_C RIT	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MC_PLAN_COUNTY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MC_PMP_MASS_XFER	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_ELIG_SAK	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_ERROR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_ERROR_DTL	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_ERROR_KY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_FIPS	VARCHAR2	10.00	0.00

CDE_COUNTY	T_MR_POS	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_POS_RE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV_DENIED	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV_PERFORM	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV_PERFORM_DTL	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV_PERFORM_KY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PROV_RE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_PR_ENROL_SAK	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_RE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_RECIP_RANK	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_RE_CNTY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_MR_RE_KY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PD_DNTL_HDR	CHAR	2.00	0.00
CDE_COUNTY	T_PD_DNTL_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_COUNTY	T_PD_PHARM_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PD_PHYS_HDR	CHAR	2.00	0.00
CDE_COUNTY	T_PD_PHYS_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PD_UB92_HDR	CHAR	2.00	0.00
CDE_COUNTY	T_PD_UB92_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_ANNUAL_VISIT_CRIT	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_ENRL_LOC	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_HB_LIC	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_HB_LIC_KY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_RST_SVC_STATE_KY	VARCHAR	10.00	0.00
CDE_COUNTY	T_PR_SVC_LOC	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_SVC_LOC_AL	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PR_SVC_LOC_WI	VARCHAR2	10.00	0.00
CDE_COUNTY	T_PS_CASE	CHAR	2.00	0.00
CDE_COUNTY	T_REF_DISTRICT_PLAN	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_AID_ELIG	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_AID_ELIG_DN	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_BASE	CHAR	2.00	0.00

CDE_COUNTY	T_RE_BASE	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_BASE_DN	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_DEMOGRAPHIC	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_ID_CRD_ISS	CHAR	2.00	0.00
CDE_COUNTY	T_RE_ID_CRD_ISS	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_MULTI_ADDRESS	VARCHAR2	10.00	0.00
CDE_COUNTY	T_RE_PREV_CTY	CHAR	2.00	0.00
CDE_COUNTY	T_RE_PREV_CTY	VARCHAR2	10.00	0.00
CDE_COUNTY	T_SUSP_DENTAL_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_SUSP_PHRM_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_SUSP_PHYS_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_SUSP_UB92_HDR	VARCHAR2	10.00	0.00
CDE_COUNTY	T_TPL_CNTY_PROS	CHAR	2.00	0.00
CDE_COUNTY	T_TPL_COUNTY_PROBATE	VARCHAR2	10.00	0.00
CDE_COUNTY_DNTL	T_DS_DNTL_RECIP	VARCHAR2	10.00	0.00
CDE_COUNTY_FIPS	T_COUNTY	CHAR	5.00	0.00
CDE_COUNTY_FIPS	T_MR_TMSIS_ZIP_COUNTY	CHAR	5.00	0.00
CDE_COUNTY_FIPS	T_PR_ADR_CASS	CHAR	5.00	0.00
CDE_COUNTY_FIPS	T_RE_ADR_CASS	CHAR	5.00	0.00
CDE_COUNTY_NO	T_DS_RECIP_SOBRA_FAM_HIST	CHAR	2.00	0.00
CDE_COUNTY_SRV	T_RE_HIST_ERR	VARCHAR2	10.00	0.00
CDE_COUNTY_SRV	T_RE_HIST_LOG	VARCHAR2	10.00	0.00
CDE_COUNTY_SRV	T_RE_PS2_ERR	VARCHAR2	10.00	0.00
CDE_COUNTY_SRV	T_RE_PS2_LOG	VARCHAR2	10.00	0.00
CDE_COUNTY_SRV_PS2	T_RE_PS2_DUPE	VARCHAR2	10.00	0.00
CDE_COUNTY_WARD	T_RE_BASE	CHAR	2.00	0.00
CDE_COURT_ORDER	T_COURT_ORD_CDE	CHAR	1.00	0.00
CDE_COURT_ORDER	T_TPL_RESOURCE	CHAR	1.00	0.00

CDE_COVERAGE	T_AVE_EXP_AVGE	CHAR	2.00	0.00
CDE_COVERAGE	T_AVE_EXP_DIAG	CHAR	2.00	0.00
CDE_COVERAGE	T_CARRIER_COV_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COVERAGE_CRIT	CHAR	2.00	0.00
CDE_COVERAGE	T_COVERAGE_TYPE	CHAR	2.00	0.00
CDE_COVERAGE	T_COVERAGE_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_COV_BILL_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_BILL_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_COV_CLAIM_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_CLAIM_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_COV_DIAG_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_NDC_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_PROC_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_REV_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_SPEC_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_COV_TYPE_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_HIPAA_COV_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_HIPP_COVERAGE_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_HIPP_PENDING	CHAR	2.00	0.00
CDE_COVERAGE	T_MR_TMSIS_TPL_COV_TYPE	CHAR	2.00	0.00
CDE_COVERAGE	T_RETRO_BILLING	CHAR	1.00	0.00
CDE_COVERAGE	T_RETRO_COV_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_RETRO_SUMM_RECS	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_271_COVERAGE	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_AR_HEALTH	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_AR_HEALTH_XXX	CHAR	2.00	0.00

CDE_COVERAGE	T_TPL_COV_PLAN_XREF	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_EXEMPT	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_GROUP_COV_ASSIGN	CHAR	2.00	0.00
CDE_COVERAGE	T_TPL_MATRIX_XREF	CHAR	1.00	0.00
CDE_COVERAGE	T_TPL_PREBILL	CHAR	2.00	0.00
CDE_COVERAGE_TYPE	T_MR_TMSIS_TPL_COV_TYPE	CHAR	2.00	0.00
CDE_COVERAGE_TYPE	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	2.00	0.00
CDE_COVERAGE_TYPE	T_TMSIS_TPL004_HLTH_INS_CT	VARCHAR2	2.00	0.00
CDE_COV_ASSIGN	T_TPL_GROUP_COV_ASSIGN	CHAR	2.00	0.00
CDE_COV_CND_IE	T_COV_CND_AXIS_RANGE	CHAR	1.00	0.00
CDE_COV_ICES	T_TPL_RES_DEL	CHAR	10.00	0.00
CDE_COV_LIST_ID	T_PGM_HIERARCHY	CHAR	10.00	0.00
CDE_COV_MOD_IE	T_COV_MOD_AXIS_RANGE	CHAR	1.00	0.00
CDE_COV_OCC_IE	T_OCC_MOD_AXIS_RANGE	CHAR	1.00	0.00
CDE_CO_PAY_SCH	T_TPL_COIN_DED	CHAR	1.00	0.00
CDE_CO_SURG	T_RBRVS	CHAR	1.00	0.00
CDE_CO_SURG	T_RBRVS_UPDATE	CHAR	1.00	0.00
CDE_CRC32	T_FILE_TRACK	VARCHAR2	8.00	0.00
CDE_CSHC_STATUS	T_CDE_CSHCS_STATUS	CHAR	1.00	0.00
CDE_CSR_TEXT	T_CSR_TEXT	CHAR	1.00	0.00
CDE_CSR_TEXT	T_CSR_TEXT_CODE	CHAR	1.00	0.00
CDE_CSR_TYPE	T_CSR	CHAR	1.00	0.00
CDE_CTRL_NUM	T_TXN_BILLING	CHAR	9.00	0.00
CDE_CTZN_SOURCE	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00

CDE_CTZN_VERIFIED	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_CURR_FROM	T_CONTRA_PROC	CHAR	6.00	0.00
CDE_CURR_MOD	T_CONTRA_PROC	CHAR	2.00	0.00
CDE_CURR_MOD	T_CONTRA_PROC_EXPL	CHAR	2.00	0.00
CDE_CURR_MOD	T_CONTRA_PROC_EXPL_MIRROR	CHAR	2.00	0.00
CDE_CURR_PROC	T_CONTRA_PROC_EXPL	CHAR	6.00	0.00
CDE_CURR_PROC	T_CONTRA_PROC_EXPL_MIRROR	CHAR	6.00	0.00
CDE_CURR_TO	T_CONTRA_PROC	CHAR	6.00	0.00
CDE_CURR_TYPE	T_CONTRA_PROC	CHAR	1.00	0.00
CDE_CURR_TYPE	T_CONTRA_PROC_EXPL	CHAR	1.00	0.00
CDE_CURR_TYPE	T_CONTRA_PROC_EXPL_MIRROR	CHAR	1.00	0.00
CDE_CVRG_LVL	T_EMP_CARR_XREF	CHAR	1.00	0.00
CDE_CVRG_LVL	T_TPL_CVRG_LVL	CHAR	1.00	0.00
CDE_CVRG_LVL	T_TPL_CVRG_REL_XREF	CHAR	1.00	0.00
CDE_DATA_COLLECTED	T_TMSIS_DATA_ELEMENTS	VARCHAR2	1.00	0.00
CDE_DATA_TYPE	T_CM_CT_FILTER	CHAR	1.00	0.00
CDE_DATA_TYPE	T_CM_PG_FILTER	CHAR	1.00	0.00
CDE_DATA_TYPE	T_MM_FILTER	CHAR	1.00	0.00
CDE_DATE_RANGE	T_MM_DATE_RANGE	CHAR	1.00	0.00
CDE_DATE_RANGE	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_DATE_TYPE	T_STOP_LOSS_PARMS	CHAR	1.00	0.00
CDE_DAY	T_CM_DAY	CHAR	3.00	0.00
CDE_DAY	T_FIN_SCHEDULE	CHAR	1.00	0.00

CDE_DAY	T_FIN_SCHED_OVERRIDE	CHAR	1.00	0.00
CDE_DAYS_CONSEC	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_DAYS_CONSEC	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_DCC	T_DRUG_CAT_CODE	CHAR	1.00	0.00
CDE_DCC	T_GENERIC_DRUG	CHAR	1.00	0.00
CDE_DEA	T_CA_DRUG	CHAR	1.00	0.00
CDE_DEA	T_DEA_CODE	CHAR	1.00	0.00
CDE_DEA	T_DRUG	CHAR	1.00	0.00
CDE_DEA	T_DRUG_DN	CHAR	1.00	0.00
CDE_DEA	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_DECISION	T_CLM_RU_MATCHED	CHAR	4.00	0.00
CDE_DECISION	T_RU_DECISION	CHAR	4.00	0.00
CDE_DECISION	T_RU_DECISION_VAR	CHAR	4.00	0.00
CDE_DECISION	T_RU_RULE	CHAR	4.00	0.00
CDE_DEDUCT_SCHD	T_TPL_COIN_DED	CHAR	1.00	0.00
CDE_DEFAULT	T_DR_PROCESS	CHAR	1.00	0.00
CDE_DELAY_REASON	T_DENTAL_HDR_KEYS	CHAR	2.00	0.00

CDE_DELAY_REASON	T_PHRM_HDR_KEYS	CHAR	2.00	0.00
CDE_DELAY_REASON	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_DELAY_REASON	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
CDE_DEPOSIT	T_FIN_BUDGET	CHAR	1.00	0.00
CDE_DEPRIVATION	T_RE_AID_ELIG	CHAR	2.00	0.00
CDE_DEPRIVATION	T_RE_AID_ELIG_DN	CHAR	2.00	0.00
CDE_DEPRIVATION	T_RE_CDE_DEPRIVATION_RSN	CHAR	2.00	0.00
CDE_DEPRV_RSN	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_DESI	T_DESI	CHAR	1.00	0.00
CDE_DESI	T_DESI_CODE	CHAR	1.00	0.00
CDE_DESI_TYPE	T_DESI	CHAR	1.00	0.00
CDE_DIAG	T_CA_DIAG	CHAR	7.00	0.00
CDE_DIAG	T_CLM_DIAG_XREF	CHAR	7.00	0.00
CDE_DIAG	T_DIAGNOSIS	CHAR	7.00	0.00
CDE_DIAG	T_DIAG_DSE_XREF	CHAR	7.00	0.00
CDE_DIAG	T_HIPP_RESOURCE	CHAR	7.00	0.00
CDE_DIAG	T_TMSIS_CIP_DIAG	VARCHAR2	7.00	0.00
CDE_DIAG	T_TMSIS_CLT_DIAG	VARCHAR2	7.00	0.00
CDE_DIAG	T_TMSIS_COT_DIAG	VARCHAR2	7.00	0.00
CDE_DIAG	T_UB92_HDR_DIAG_X	CHAR	7.00	0.00
CDE_DIAG1	T_UB92_HDR_INP_OLD	CHAR	7.00	0.00
CDE_DIAG2	T_UB92_HDR_INP_OLD	CHAR	7.00	0.00

CDE_DIAGS_DSPLY	T_CA_DIAG_DN	VARCHAR2	1,024.00	0.00
CDE_DIAG_1	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_1	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_10	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_10	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_11	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_11	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_12	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_12	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_2	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_2	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_3	T_CA_DIAG_DN	CHAR	7.00	0.00

CDE_DIAG_3	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_4	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_4	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_5	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_5	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_6	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_6	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_7	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_7	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_8	T_CA_DIAG_DN	CHAR	7.00	0.00
CDE_DIAG_8	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_9	T_CA_DIAG_DN	CHAR	7.00	0.00

CDE_DIAG_9	T_CA_DIAG_MAT_CARE	CHAR	7.00	0.00
CDE_DIAG_CC	T_UB92_HDR_INP_OLD	CHAR	7.00	0.00
CDE_DIAG_CMPT_EDIT	T_PROC_LIMITS	CHAR	1.00	0.00
CDE_DIAG_COMPAT	T_CDE_DIAG_COMPAT	CHAR	3.00	0.00
CDE_DIAG_FDB	T_DIAG_DSE_XREF	CHAR	6.00	0.00
CDE_DIAG_FDB	T_DIAG_DSE_XRF_LOG	CHAR	6.00	0.00
CDE_DIAG_FDB	T_DRUG_DISEASE	CHAR	6.00	0.00
CDE_DIAG_FLAG	T_TMSIS_CIP_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_FLAG	T_TMSIS_CLT_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_FLAG	T_TMSIS_COT_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_FROM	T_AUDT_DIAG_XRF	CHAR	5.00	0.00
CDE_DIAG_FROM	T_AUDT_DIAG_XRF	CHAR	7.00	0.00
CDE_DIAG_FROM	T_AVE_EXP_DIAG	CHAR	7.00	0.00
CDE_DIAG_FROM	T_COV_DIAG_XREF	CHAR	5.00	0.00
CDE_DIAG_FROM	T_PROC_ICD9_DIA	CHAR	7.00	0.00
CDE_DIAG_FROM	T_TPL_RQST_RPT_SRCH	CHAR	7.00	0.00
CDE_DIAG_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_DIAG_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_DIAG_IN_EX	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00

CDE_DIAG_POA	T_CA_DIAG	CHAR	1.00	0.00
CDE_DIAG_POA	T_UB92_HDR_DIAG_X	CHAR	1.00	0.00
CDE_DIAG_POA_1	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_10	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_11	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_12	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_2	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_3	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_4	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_5	T_CA_DIAG_DN	CHAR	1.00	0.00

CDE_DIAG_POA_6	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_7	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_8	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_9	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_DIAG_POA_FLAG	T_TMSIS_CIP_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_POA_FLAG	T_TMSIS_CLT_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_POA_FLAG	T_TMSIS_COT_DIAG	VARCHAR2	1.00	0.00
CDE_DIAG_PRIMARY	T_CASUALTY_CASE_OFFLINE	CHAR	7.00	0.00
CDE_DIAG_PTR_1	T_PA_DTL	NUMBER	2.00	0.00
CDE_DIAG_PTR_2	T_PA_DTL	NUMBER	2.00	0.00
CDE_DIAG_PTR_3	T_PA_DTL	NUMBER	2.00	0.00
CDE_DIAG_PTR_4	T_PA_DTL	NUMBER	2.00	0.00
CDE_DIAG_SECONDARY	T_CASUALTY_CASE_OFFLINE	CHAR	7.00	0.00
CDE_DIAG_SEQ	T_CA_DIAG	CHAR	2.00	0.00
CDE_DIAG_SEQ	T_CLM_DIAG_XREF	CHAR	2.00	0.00
CDE_DIAG_SEQ	T_MEDPOL_UB92_DIAG	CHAR	2.00	0.00

CDE_DIAG_SEQ	T_MPHX_PH_DIAG	CHAR	2.00	0.00
CDE_DIAG_SEQ	T_UB92_HDR_DIAG_X	CHAR	2.00	0.00
CDE_DIAG_SEQ_CLEAN	T_CA_DIAG	CHAR	2.00	0.00
CDE_DIAG_TO	T_AUDT_DIAG_XRF	CHAR	5.00	0.00
CDE_DIAG_TO	T_AUDT_DIAG_XRF	CHAR	7.00	0.00
CDE_DIAG_TO	T_AVE_EXP_DIAG	CHAR	7.00	0.00
CDE_DIAG_TO	T_COV_DIAG_XREF	CHAR	5.00	0.00
CDE_DIAG_TO	T_PROC_ICD9_DIA	CHAR	7.00	0.00
CDE_DIAG_TO	T_TPL_RQST_RPT_SRCH	CHAR	7.00	0.00
CDE_DIAG_TREAT_IND1	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND1	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00

CDE_DIAG_TREAT_IND1	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND2	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_PD_DNTL_DTL	CHAR	2.00	0.00

CDE_DIAG_TREAT_IND3	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND3	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_DIAG_TREAT_IND4	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_DISABILITY_TYPE	T_MR_TMSIS_AID_CAT	CHAR	2.00	0.00
CDE_DISABILITY_TYPE	T_TMSIS_ELG017_DISAB_INFO	VARCHAR2	2.00	0.00
CDE_DISASTER_SURVIVOR	T_RE_BASE_STATE	CHAR	2.00	0.00
CDE_DISASTER_SURVIVOR	T_RE_CDE_DISASTER_SURVIVOR	CHAR	2.00	0.00

CDE_DISAST_SURV	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_DISCHARGE_RSN	T_RE_ASSIGN_PLAN	CHAR	1.00	0.00
CDE_DISCHARGE_RSN	T_RE_ASSIGN_PLAN_RLOC	CHAR	1.00	0.00
CDE_DISCHARGE_RSN	T_RE_LTC_REQUEST	CHAR	1.00	0.00
CDE_DISCIPLINE_TYPE	T_CLM_HH_CARE_PLAN	CHAR	2.00	0.00
CDE_DISCIPLINE_TYPE	T_CLM_HSD	CHAR	2.00	0.00
CDE_DISC_SOURCE	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_DISEASE	T_CONTRA_DISEASE	CHAR	9.00	0.00
CDE_DISEASE	T_DIAG_DSE_XREF	CHAR	9.00	0.00
CDE_DISEASE	T_DISEASE_DSC	CHAR	9.00	0.00
CDE_DISEASE	T_DISEASE_INFERRED	CHAR	9.00	0.00
CDE_DISEASE	T_MPHX_DSE_PROF	CHAR	9.00	0.00
CDE_DISEASE	T_PDUR_ADD_TOX	CHAR	9.00	0.00

CDE_DISEASE	T_THERA_DURATION	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_CONTRA_DISEASE	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_DIAG_DSE_XREF	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_DIAG_DSE_XRF_LOG	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_DISEASE_DSC	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_DISEASE_INFERRED	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_MPHX_DSE_PROF	CHAR	9.00	0.00
CDE_DISEASE_FDBDX	T_THERA_DURATION	CHAR	9.00	0.00
CDE_DISP	T_ALERT_DISP	CHAR	1.00	0.00
CDE_DISP	T_PDUR_RLHX	CHAR	1.00	0.00
CDE_DISP	T_PRODUR_WARN	CHAR	1.00	0.00
CDE_DISPENSE_STATUS	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_DISPENSE_STATUS	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
CDE_DISPENSE_STATUS	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_DISPENSE_STATUS	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_DISPUTE	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_DISPUTE	T_DR_DISPUTE_RSN	CHAR	1.00	0.00
CDE_DISPUTE2	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_DISPUTE3	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_DISPUTE_RSN	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_DISPUTE_RSN2	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_DISPUTE_RSN3	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_DISP_PROV_TAXON	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_DISP_REASON	T_AR_STATUS	CHAR	4.00	0.00

CDE_DISP_REASON	T_FIN_PROCESS_LIEN_DISP	CHAR	4.00	0.00
CDE_DISP_REASON	T_LIEN_DISP	CHAR	4.00	0.00
CDE_DISP_STATUS	T_BATCH_ERR_SUM	CHAR	1.00	0.00
CDE_DISP_STATUS	T_CA_ERROR	CHAR	1.00	0.00
CDE_DISP_STATUS	T_CDE_DISP_STATUS	CHAR	1.00	0.00
CDE_DISP_STATUS	T_CLAIM_ERROR	CHAR	1.00	0.00
CDE_DISP_STATUS	T_EOB_ERR_XREF	CHAR	1.00	0.00
CDE_DISP_STATUS	T_EOB_ERR_XREF	CHAR	1.00	0.00
CDE_DISP_STATUS	T_ERR_DISP_LINE	CHAR	1.00	0.00
CDE_DISP_STATUS	T_MR_ERROR	CHAR	1.00	0.00
CDE_DISP_STATUS	T_MR_ERROR_DTL	CHAR	1.00	0.00
CDE_DISP_STATUS	T_MR_ERROR_KY	CHAR	1.00	0.00
CDE_DISP_STATUS	T_REGION_DISP	CHAR	1.00	0.00
CDE_DISP_STATUS	T_REGION_DISP	CHAR	1.00	0.00
CDE_DISP_STATUS_1	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISP_STATUS_2	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISP_STATUS_3	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISP_STATUS_4	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISP_STATUS_5	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISP_STATUS_6	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_DISTRICT_PLAN	T_CLM_SYS_FIELDS_HDR	CHAR	3.00	0.00

CDE_DISTRICT_PLAN	T_DS_HM_HEADER	CHAR	3.00	0.00
CDE_DISTRICT_PLAN	T_REF_DISTRICT_PLAN	CHAR	3.00	0.00
CDE_DME_CERT_TYPE	T_CLM_CR3	CHAR	1.00	0.00
CDE_DME_UOM	T_CLM_CR3	CHAR	2.00	0.00
CDE_DNTL_PROC_GRP	T_DS_DNTL_ICN	CHAR	2.00	0.00
CDE_DNTL_PROC_GRP	T_DS_DNTL_PROC_GRP	CHAR	2.00	0.00
CDE_DNTL_PROC_GRP	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_DNTL_PR_PEER_GRP	T_DS_DNTL_PR_ENROLL	CHAR	2.00	0.00
CDE_DNTL_PR_PEER_GRP	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_DNTL_PR_PEER_GRP	T_DS_DNTL_PR_PEER_GRP	CHAR	2.00	0.00
CDE_DNTL_PR_PEER_GRP	T_DS_DNTL_PR_SUM	CHAR	2.00	0.00
CDE_DOC_TYPE	T_CDE_DOC_TYPE	VARCHAR2	50.00	0.00
CDE_DOD_VERIFIED	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_DOMAIN	T_RU_DOMAIN	CHAR	4.00	0.00
CDE_DOMAIN	T_RU_RELATION	CHAR	4.00	0.00
CDE_DOSAGE_FORM	T_CDE_DOSAGE_FORM	CHAR	2.00	0.00
CDE_DOSAGE_FORM	T_ERX_GCDF_NCPDP_QQ_XREF	CHAR	2.00	0.00
CDE_DOSAGE_FORM	T_ERX_NCPDP_QQ	CHAR	2.00	0.00
CDE_DOSAGE_FORM	T_GENERIC_DRUG	CHAR	2.00	0.00

CDE_DO_AID_CAT	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_DO_ED_APPL_STATUS	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_DO_ED_LOC_PGM	T_RE_BASE_STATE	CHAR	2.00	0.00
CDE_DO_MSP_APPL_STATUS	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_DO_MSP_LOC_PGM	T_RE_BASE_STATE	CHAR	2.00	0.00
CDE_DPV	T_REF_CDE_DPV_GROUP	VARCHAR2	6.00	0.00
CDE_DPV_FOOTNOTE	T_PR_ADR_CASS	VARCHAR2	6.00	0.00
CDE_DPV_FOOTNOTE	T_RE_ADR_CASS	VARCHAR2	6.00	0.00
CDE_DRG	T_CA_UB92	CHAR	4.00	0.00
CDE_DRG	T_DRG	CHAR	4.00	0.00
CDE_DRG	T_DRG_NEONATAL	CHAR	4.00	0.00
CDE_DRG	T_PA_PAUTH	NUMBER	9.00	0.00
CDE_DRG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	4.00	0.00
CDE_DRG	T_UB92_HDR_INP	CHAR	4.00	0.00
CDE_DRG_BASE_RATE_CAT	T_PR_DRG_RATE	CHAR	1.00	0.00
CDE_DRG_HIGH	T_CA_UB92	CHAR	4.00	0.00
CDE_DRG_HIGH	T_UB92_HDR_INP	CHAR	4.00	0.00
CDE_DRG_REPLACING	T_DRG_NEONATAL	CHAR	4.00	0.00
CDE_DRUG_CATG	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_DRUG_CATGRY	T_DRUG	CHAR	1.00	0.00
CDE_DRUG_CATGRY	T_DRUG_DN	CHAR	1.00	0.00
CDE_DRUG_CATGRY	T_DR_CMS_TAPE	CHAR	1.00	0.00

CDE_DRUG_CATGRY	T_GENERIC_DRUG	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_DRUG	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_DRUG_DN	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_DRUG_MAC_PCT	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_EAC	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_PDL_MASTER	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_PDL_MASTER_AL	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_PHARMACY_COS	CHAR	1.00	0.00
CDE_DRUG_CLASS	T_STATE_COS	CHAR	1.00	0.00
CDE_DRUG_COV	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_DRUG_EXCEPT_CATEGORY	T_DRUG_EXCEPTION_AL	CHAR	4.00	0.00
CDE_DRUG_FORM	T_DENY_PHRM_DTL	CHAR	2.00	0.00
CDE_DRUG_FORM	T_DRUG	CHAR	2.00	0.00
CDE_DRUG_FORM	T_DRUG_DN	CHAR	2.00	0.00

CDE_DRUG_FORM	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_DRUG_FORM	T_PD_PHARM_DTL	CHAR	2.00	0.00
CDE_DRUG_FORM	T_SUSP_PHRM_DTL	CHAR	2.00	0.00
CDE_DRUG_SOURCE	T_CA_DRUG_SOURCE	CHAR	1.00	0.00
CDE_DRUG_SOURCE	T_DRUG	CHAR	1.00	0.00
CDE_DRUG_SOURCE	T_DRUG_DN	CHAR	1.00	0.00
CDE_DRUG_STATUS	T_DRUG	CHAR	1.00	0.00
CDE_DRUG_STATUS	T_DRUG_DN	CHAR	1.00	0.00
CDE_DRUG_TYPE	T_DRUG	CHAR	1.00	0.00
CDE_DRUG_TYPE	T_DRUG_MAC_PCT	CHAR	1.00	0.00
CDE_DRUG_UTIL	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	6.00	0.00
CDE_DR_CORRECT_FLAG	T_CDE_DR_CORRECT_FLAG	CHAR	1.00	0.00
CDE_DR_UNIT_TYPE	T_CDE_DR_UNIT_TYPE	CHAR	3.00	0.00
CDE_DTE_DAY	T_CDE_DTE_DAY	NUMBER	4.00	0.00
CDE_DTE_TYPE	T_TPL_RQST_RPT_SRCH	CHAR	1.00	0.00
CDE_DTL_STATUS	T_CA_CLAIM_KEY	CHAR	1.00	0.00
CDE_DTL_STATUS	T_CA_HDR_DTL	CHAR	1.00	0.00
CDE_DTL_STATUS	T_DS_DNTL_ICN	CHAR	1.00	0.00
CDE_DTL_STATUS	T_DS_HM_DETAIL	CHAR	1.00	0.00
CDE_DTL_STATUS	T_DS_HM_HEADER	CHAR	1.00	0.00

CDE_DUAL_ELIG	T_MR_TMSIS_AID_CAT	CHAR	2.00	0.00
CDE_DUAL_ELIG	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	2.00	0.00
CDE_DUAL_STATUS	T_RE_CDE_PARTD_DUAL_STATUS	CHAR	2.00	0.00
CDE_DUAL_STATUS	T_RE_CMS_MMA_ENROLL	CHAR	2.00	0.00
CDE_DUR_CONFLICT	T_CDE_DUR_CONFLICT	CHAR	2.00	0.00
CDE_DUR_INTERVENTION	T_CDE_DUR_INTERVENTION	CHAR	2.00	0.00
CDE_DUR_INTRVNTN	T_CA_DRUG	CHAR	2.00	0.00
CDE_DUR_INTRVNTN	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_DUR_INTRVNTN	T_PDUR_FINAL_CLM	CHAR	2.00	0.00
CDE_DUR_INTRVNTN	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_DUR_INTRVNTN	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_CA_DRUG	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_CDE_DUR_OUTCOME	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_PDUR_FINAL_CLM	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_PDUR_OUTCOME	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_DUR_OUTCOME	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_D_C_TRACK	T_RE_AID_ELIG	CHAR	2.00	0.00
CDE_D_C_TRACK	T_RE_AID_ELIG_DN	CHAR	2.00	0.00

CDE_D_C_TRACK	T_RE_CDE_D_C_TRACK	CHAR	2.00	0.00
CDE_EARNINGS	T_FIN_CDE_EARNINGS	CHAR	2.00	0.00
CDE_EARNINGS	T_FIN_EARNINGS_HIST	CHAR	2.00	0.00
CDE_EARNINGS	T_FIN_EARNINGS_YTD	CHAR	2.00	0.00
CDE_EARNINGS_CATEGORY	T_FIN_CDE_EARNINGS	CHAR	2.00	0.00
CDE_EARNINGS_CATEGORY	T_FIN_CDE_EARNINGS_CAT	CHAR	2.00	0.00
CDE_EDIT	T_TPL_VALIDITY_EDITS	CHAR	3.00	0.00
CDE_EDIT	T_UB92_DTL_OUTPAT_EDIT	CHAR	2.00	0.00
CDE_EDIT	T_UB92_HDR_OUTPAT_EDIT	CHAR	2.00	0.00
CDE_ELEMENT	T_ADJ_RULES	CHAR	20.00	0.00
CDE_ELEMENT	T_CDE_HIPAA	NUMBER	9.00	0.00
CDE_ELIGIBILITY_GROUP	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	2.00	0.00
CDE_ELIGIBLE_COUNTY	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	3.00	0.00
CDE_ELIG_CHANGE_REASON	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	2.00	0.00
CDE_ELIG_GROUP	T_MR_TMSIS_AID_CAT	CHAR	2.00	0.00
CDE_ELIG_INCOMP	T_ETG_SUMMARY	CHAR	1.00	0.00
CDE_ELIG_INCOMP	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00

CDE_ELIG_INCOMP	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
CDE_ELIG_INCOMP	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
CDE_ELIG_STATUS	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_ELOT	T_PR_ADR_CASS	CHAR	5.00	0.00
CDE_ELOT	T_RE_ADR_CASS	CHAR	5.00	0.00
CDE_EMERGENCY	T_CA_IND_KEY	CHAR	1.00	0.00
CDE_EMERGENCY	T_CDE_EMERGENCY	CHAR	1.00	0.00
CDE_EMPLOYER	T_TPL_EMPLOYER	CHAR	10.00	0.00
CDE_EMP_STATUS	T_PA_HDR	CHAR	2.00	0.00
CDE_EMP_STATUS	T_TPL_AC_PARENT_EMP_XREF	CHAR	4.00	0.00
CDE_ENC_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_CA_HDR_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_DENY_DNTL_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_DENY_PHYS_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_DENY_PHYS_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_DENY_UB92_DTL	CHAR	1.00	0.00

CDE_ENC_STATUS	T_DENY_UB92_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_PHYS_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_UB92_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_UB92_DTL	CHAR	1.00	0.00
CDE_ENC_STATUS	T_SUSP_UB92_HDR	CHAR	1.00	0.00
CDE_ENRL_RATE	T_MB_DEN_RECIP	CHAR	4.00	0.00
CDE_ENRL_RATE	T_MB_NUM_RECIP	CHAR	4.00	0.00
CDE_ENRL_TYPE	T_PR_ENRL	CHAR	1.00	0.00
CDE_ENROLL_FREQ	T_PR_ENROLL_INFO	CHAR	1.00	0.00
CDE_ENROLL_RSN	T_MC_ENROLL_RSN	CHAR	2.00	0.00
CDE_ENROLL_RSN	T_MC_PMP_ENRL_RGN	CHAR	2.00	0.00

CDE_ENROLL_RSN	T_MC_PMP_ENRL_RGN_AL	CHAR	2.00	0.00
CDE_ENROLL_STATUS	T_MC_ENROLL_STATUS	CHAR	1.00	0.00
CDE_ENROLL_STATUS	T_MC_PMP_ENRL_RGN	CHAR	1.00	0.00
CDE_ENROLL_STATUS	T_MC_PMP_ENRL_RGN_AL	CHAR	1.00	0.00
CDE_ENROLL_STATUS	T_PR_ENROLL_STATUS	CHAR	1.00	0.00
CDE_ENROLL_STATUS	T_PR_PHP_ELIG	CHAR	1.00	0.00
CDE_ENROLL_STATUS	T_WEB_PROV_ENR	CHAR	2.00	0.00
CDE_ENROLL_STATUS	T_WEB_PROV_ENR_CD	CHAR	2.00	0.00
CDE_ENROLL_TYPE	T_PR_APPLN_WI	CHAR	1.00	0.00
CDE_ENROLL_TYPE	T_RE_CDE_PARTD_ENROLL_TYPE	CHAR	2.00	0.00
CDE_ENROLL_TYPE	T_RE_PARTD_PDP_ASSIGN	CHAR	2.00	0.00
CDE_ENROLL_TYPE	T_TMSIS_ELG021_ENROL_SPAN	VARCHAR2	1.00	0.00
CDE_ENTITY	T_HIPP_RESOURCE	CHAR	1.00	0.00
CDE_ENTITY	T_TPL_CDE_ENTITY_LTR	CHAR	1.00	0.00
CDE_ENTITY	T_TPL_LETTER_ENTITY	CHAR	1.00	0.00
CDE_ENTITY_AR	T_TPL_CDE_PCN_AR	VARCHAR2	13.00	0.00
CDE_ENTITY_ID	T_PA_HDR_PE_TRNSP	CHAR	3.00	0.00
CDE_ENTITY_ID	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
CDE_ENTITY_TYPE	T_CDE_CALLER_TYPE	CHAR	1.00	0.00
CDE_ENV	T_SYS_REPORT_ROUTE	CHAR	1.00	0.00
CDE_EOB	T_ALERT_DISP	CHAR	4.00	0.00
CDE_EOB	T_CA_ERROR	CHAR	4.00	0.00

CDE_EOB	T_EOB	CHAR	4.00	0.00
CDE_EOB	T_ERROR_EXTRACT	NUMBER	4.00	0.00
CDE_EOB_1	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EOB_2	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EOB_3	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EOB_4	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EOB_5	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EOB_6	T_CA_ERROR_DN	CHAR	4.00	0.00
CDE_EPSDT_FP	T_CA_IND_KEY	CHAR	1.00	0.00
CDE_EPSDT_FP	T_DENY_DNTL_HDR	CHAR	1.00	0.00
CDE_EPSDT_FP	T_DENY_PHYS_DTL	CHAR	1.00	0.00
CDE_EPSDT_FP	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_EPSDT_FP	T_PD_PHYS_DTL	CHAR	1.00	0.00
CDE_EPSDT_FP	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
CDE_EPSDT_FP	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
CDE_EPSDT_REF	T_CA_IND_KEY	CHAR	2.00	0.00
CDE_ERM_TXN	T_CLM_BATCH_RNG	NUMBER	9.00	0.00

CDE_ERM_TXN	T_CT_TXN_XREF	NUMBER	9.00	0.00
CDE_ERM_TXN	T_ERM_DEP	NUMBER	9.00	0.00
CDE_ERM_TXN	T_ERM_ENT	NUMBER	9.00	0.00
CDE_ERM_TXN	T_ERM_HDR	NUMBER	9.00	0.00
CDE_ERROR	T_BATCH_ERR_MSG	NUMBER	4.00	0.00
CDE_ERROR	T_FIN_ERROR_CODE	NUMBER	9.00	0.00
CDE_ERROR	T_FIN_MAN_REJECT	NUMBER	9.00	0.00
CDE_ERROR	T_RE_CMS_MMA_RESPONSE	NUMBER	4.00	0.00
CDE_ERROR	T_RE_EBS_CARD_RQST	CHAR	3.00	0.00
CDE_ERROR	T_RE_HIST_ERR	NUMBER	4.00	0.00
CDE_ERROR	T_RE_PS2_ERR	NUMBER	4.00	0.00
CDE_ERROR_ICES	T_ADJ_RET_RQST_ERR	CHAR	1.00	0.00
CDE_ERROR_NCPDP	T_CLM_NCPDP_MSG	CHAR	2.00	0.00
CDE_ERROR_NCPDP	T_ESC_NCPDP_XREF	CHAR	2.00	0.00
CDE_ERROR_NCPDP	T_NCPDP_RESPONSE	CHAR	2.00	0.00
CDE_ERROR_TYPE	T_AUDIT_CRIT	CHAR	2.00	0.00
CDE_ERROR_TYPE	T_AUDIT_CRIT_AL	CHAR	2.00	0.00
CDE_ERROR_TYPE	T_AUDIT_TIME_UNIT_XREF	CHAR	2.00	0.00
CDE_ERROR_TYPE	T_CDE_ERR_TYPE	CHAR	2.00	0.00
CDE_ESC	T_CA_ERROR	NUMBER	4.00	0.00
CDE_ESC	T_CC_CR_SAVE	NUMBER	4.00	0.00
CDE_ESC	T_ERROR_DISP	NUMBER	4.00	0.00
CDE_ESC	T_ERROR_DISP_MMIS	NUMBER	4.00	0.00
CDE_ESC	T_ERROR_EXTRACT	NUMBER	4.00	0.00
CDE_ESC	T_MR_ERROR	NUMBER	4.00	0.00
CDE_ESC	T_MR_ERROR_DTL	NUMBER	4.00	0.00
CDE_ESC	T_MR_ERROR_KY	NUMBER	4.00	0.00
CDE_ESC1	T_CC_HIST_ADJUST	NUMBER	4.00	0.00
CDE_ESC2	T_CC_HIST_ADJUST	NUMBER	4.00	0.00

CDE_ESC3	T_CC_HIST_ADJUST	NUMBER	4.00	0.00
CDE_ESC4	T_CC_HIST_ADJUST	NUMBER	4.00	0.00
CDE_ESC5	T_CC_HIST_ADJUST	NUMBER	4.00	0.00
CDE_ESRD_CVRG_END	T_RE_EDB	CHAR	1.00	0.00
CDE_ETHNIC	T_CA_RECIP_KEY	CHAR	2.00	0.00
CDE_ETHNIC	T_RE_BASE	CHAR	2.00	0.00
CDE_ETHNIC	T_RE_BASE_DN	CHAR	2.00	0.00
CDE_ETHNICITY	T_TMSIS_ELG015_ETHNICITY	VARCHAR2	1.00	0.00
CDE_EVENT	T_CDE_EVENT	VARCHAR2	50.00	0.00
CDE_EVENT	T_LG_CDE_HISTORY	CHAR	3.00	0.00
CDE_EVENT	T_LG_HISTORY	CHAR	3.00	0.00
CDE_EVENT	T_PLOG_EVENTS	CHAR	8.00	0.00
CDE_EVENT	T_PLOG_HEADER	CHAR	8.00	0.00
CDE_EVENT	T_PLOG_MODULES	CHAR	8.00	0.00
CDE_EVENT	T_PLOG_REPORTS	CHAR	8.00	0.00
CDE_EVENT	T_PLOG_WINDOWS	CHAR	8.00	0.00
CDE_EVENT	T_TRANSACTIONS	CHAR	8.00	0.00
CDE_EVENT_KEY	T_CDE_EVENT_KEY	VARCHAR2	50.00	0.00
CDE_EVENT_SET	T_EVENT_SETS	CHAR	8.00	0.00
CDE_EVENT_SET	T_PLOG_EVENTS	CHAR	8.00	0.00
CDE_EVENT_SET	T_PLOG_HEADER	CHAR	8.00	0.00
CDE_EVENT_SET	T_PLOG_MODULES	CHAR	8.00	0.00
CDE_EVENT_SET	T_PLOG_REPORTS	CHAR	8.00	0.00
CDE_EVENT_SET	T_PLOG_WINDOWS	CHAR	8.00	0.00
CDE_EXCEPTION_STATUS	T_WEB_CL_EXCP_STAT	CHAR	1.00	0.00
CDE_EXCL_RSN	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
CDE_EXPAND_AID	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_EXP_LEVEL	T_CT_ANALYST	CHAR	1.00	0.00
CDE_EXP_LN_ELIG	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00

CDE_EXP_LN_ELIG	T_DS_RECIP_SOBRA_FAMILY	CHAR	2.00	0.00
CDE_EXP_LN_ELIG_ACTION	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_EXP_LN_ELIG_SRC	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_FACILITY	T_DS_RECIP_DO_APPL	CHAR	4.00	0.00
CDE_FACILITY	T_RE_BASE	CHAR	3.00	0.00
CDE_FAC_GRP_INDIVIDUAL	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	2.00	0.00
CDE_FAMILY	T_BASE_ENDO_PROC	CHAR	2.00	0.00
CDE_FCBC_SOURCE	T_PR_ENROLL_SCRN	CHAR	2.00	0.00
CDE_FDB_DRUG_CATGRY	T_DRUG_CMSFDB_INFO	CHAR	1.00	0.00
CDE_FDB_DRUG_ID	T_MME_OPIOID_CONCR_RISK_DR	VARCHAR2	50.00	0.00
CDE_FDB_DRUG_ID	T_MME_OPIOID_DRG_CONCEPT_L	VARCHAR2	50.00	0.00
CDE_FDB_DRUG_ID_TYPE	T_MME_OPIOID_CONCR_RISK_DR	NUMBER	8.00	0.00
CDE_FDB_DRUG_ID_TYPE	T_MME_OPIOID_DRG_CONCEPT_L	NUMBER	8.00	0.00
CDE_FED_AID_CTG	T_FEDERAL_AID	CHAR	2.00	0.00
CDE_FEE	T_PR_ENROLL_SCRN	CHAR	2.00	0.00
CDE_FILE_DIRECTION	T_CDE_FILE_DIRECTION	VARCHAR2	50.00	0.00
CDE_FILE_ENCODE_SPEC	T_TMSIS_EXT_HDR	VARCHAR2	3.00	0.00
CDE_FILE_FORMAT	T_PMP_SVC_LOC	CHAR	1.00	0.00
CDE_FILE_FORMAT	T_PMP_SVC_LOC	CHAR	1.00	0.00
CDE_FILE_FORMAT	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00

CDE_FILE_FORMAT	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
CDE_FILE_STATUS	T_CDE_FILE_STATUS	VARCHAR2	50.00	0.00
CDE_FINAL_LOC_EVAL	T_PS_ICF_MR	CHAR	3.00	0.00
CDE_FINAL_NF	T_PS_LTR_LEGEND	CHAR	1.00	0.00
CDE_FIN_ACT	T_DS_CDE_FIN_ACT	CHAR	3.00	0.00
CDE_FIN_ACT	T_DS_FIN_DEPT_ACT_XREF	CHAR	3.00	0.00
CDE_FIN_ACT	T_DS_FIN_FUND_DEPT_XREF	CHAR	3.00	0.00
CDE_FIN_COS	T_FIN_COS	CHAR	3.00	0.00
CDE_FIN_CYCLE	T_FIN_CYCLE	CHAR	4.00	0.00
CDE_FIN_DEPT	T_DS_CDE_FIN_DEPT	CHAR	3.00	0.00
CDE_FIN_DEPT	T_DS_CLM_CNT_PAID_DTE	CHAR	3.00	0.00
CDE_FIN_DEPT	T_DS_CLM_CNT_SVC_DTE	CHAR	3.00	0.00
CDE_FIN_DEPT	T_DS_FIN_DEPT_ACT_XREF	CHAR	3.00	0.00
CDE_FIN_DEPT	T_DS_FIN_FUND_DEPT_XREF	CHAR	3.00	0.00
CDE_FIN_FUND	T_PA_PAUTH	CHAR	3.00	0.00
CDE_FIN_PAYER	T_FINANCIAL_PAYER	CHAR	4.00	0.00
CDE_FIPS	T_MR_FIPS	CHAR	3.00	0.00
CDE_FLUORIDATED	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_FLUORIDATED	T_DS_DNTL_PR_SUM	CHAR	2.00	0.00
CDE_FLUORIDATED	T_DS_DNTL_RECIP	CHAR	2.00	0.00

CDE_FNOTE_IND	T_CDE_SCH_FNOTES	CHAR	1.00	0.00
CDE_FOOTNOTE	T_CDE_SCH_FNOTES	CHAR	3.00	0.00
CDE_FOOTNOTE_KEY	T_CDE_SCH_KEYS	CHAR	1.00	0.00
CDE_FORM	T_ADJ_RULES	CHAR	4.00	0.00
CDE_FORM	T_EDI_RETURN_REASON	CHAR	1.00	0.00
CDE_FORM_TYPE	T_CDE_TAX_FORM_TYPE	CHAR	4.00	0.00
CDE_FORM_TYPE	T_CDE_TAX_REC_TYPE	CHAR	4.00	0.00
CDE_FORM_TYPE	T_FIN_CYCLE_TAX_INFO	CHAR	4.00	0.00
CDE_FORM_TYPE	T_RE_CONSENT_FORM_ACTIVITY	CHAR	1.00	0.00
CDE_FORM_TYPE	T_RE_CONSENT_FORM_MASTER	CHAR	1.00	0.00
CDE_FPL	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_FREQ	T_FIN_SCHEDULE	CHAR	2.00	0.00
CDE_FREQ	T_FIN_SCHED_OVERRIDE	CHAR	2.00	0.00
CDE_FREQUENCY	T_CM_CASE_GROUP	CHAR	1.00	0.00
CDE_FREQUENCY	T_CM_CASE_TYPE	CHAR	1.00	0.00
CDE_FREQUENCY	T_CM_FREQUENCY	CHAR	1.00	0.00
CDE_FREQUENCY	T_CM_PEER_GROUP	CHAR	1.00	0.00
CDE_FREQUENCY	T_MC_PGM_GROUP_XREF	CHAR	1.00	0.00
CDE_FREQUENCY	T_MM_FREQUENCY	CHAR	1.00	0.00
CDE_FREQUENCY	T_MM_MEASURE_BASE	CHAR	1.00	0.00
CDE_FREQUENCY	T_PDUR_ADD_TOX	CHAR	1.00	0.00

CDE_FREQUENCY	T_PDUR_ADD_TOX_FAC	CHAR	1.00	0.00
CDE_FREQ_RECOUP	T_LIEN	CHAR	1.00	0.00
CDE_FRM_LIST_ID	T_PGM_HIERARCHY	CHAR	10.00	0.00
CDE_FUNCTIONAL	T_CDE_SUPPORTED_DOC	CHAR	2.00	0.00
CDE_FUNCTIONAL	T_EDIC_PAYLOADTYPES	VARCHAR2	2.00	0.00
CDE_FUNCTIONAL_STATUS	T_CDE_FUNCTIONAL_STATUS	CHAR	1.00	0.00
CDE_FUNCTIONAL_STATUS	T_FUNCTIONAL_ACKS	CHAR	1.00	0.00
CDE_FUNC_AREA	T_CSR	CHAR	3.00	0.00
CDE_FUNDING	T_MR_TMSIS_FUND_CODE	CHAR	2.00	0.00
CDE_FUNDING	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUNDING	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUNDING	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUNDING	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUND_CODE	T_CAPITATION_ADJ_DN	CHAR	3.00	0.00
CDE_FUND_CODE	T_CAPITATION_HIST_DN	CHAR	3.00	0.00
CDE_FUND_CODE	T_CA_CLAIM_KEY	CHAR	3.00	0.00
CDE_FUND_CODE	T_CT_AR_TRACKING	CHAR	3.00	0.00
CDE_FUND_CODE	T_DS_CLM_CNT_PAID_DTE	CHAR	3.00	0.00
CDE_FUND_CODE	T_DS_CLM_CNT_SVC_DTE	CHAR	3.00	0.00
CDE_FUND_CODE	T_DS_HM_HEADER	CHAR	3.00	0.00
CDE_FUND_CODE	T_FIN_FUND_CODE	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_ERROR	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_ERROR_DTL	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_ERROR_KY	CHAR	3.00	0.00

CDE_FUND_CODE	T_MR_LTC	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_LTC_REV	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_OP_PERFORM	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_OP_PERFORM_DTL	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_POS	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_POS_RE	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV_DENIED	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV_PERFORM	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV_PERFORM_DTL	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV_PERFORM_KY	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_PROV_RE	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RE	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RECIP	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RECIP_KY	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RECIP_RANK	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RE_CNTY	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_RE_KY	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_TMSIS_FUND_CODE	CHAR	3.00	0.00
CDE_FUND_CODE	T_MR_XOVER	CHAR	3.00	0.00
CDE_FUND_PAYER	T_FUND_PAYER	CHAR	4.00	0.00
CDE_FUND_SRC	T_CDE_FUND_SRC	CHAR	1.00	0.00
CDE_FUND_SRC	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
CDE_FUND_SRC	T_COS_DTL_XREF	CHAR	1.00	0.00

CDE_FUND_SRC	T_MB_DEN_RECIP	CHAR	2.00	0.00
CDE_FUND_SRC	T_MB_NUM_RECIP	CHAR	1.00	0.00
CDE_FUND_SRC_STATE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUND_SRC_STATE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUND_SRC_STATE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_FUND_SRC_STATE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_GB_MOD	T_CLAIM_BDL_NCCD	CHAR	1.00	0.00
CDE_GCN_SEQNO	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	6.00	0.00
CDE_GCN_SEQNO	T_MME_OPIOID_DRG_CONCEPT_L	NUMBER	6.00	0.00
CDE_GCN_SEQNO	T_MME_OPIOID_MED_MASTER	NUMBER	6.00	0.00
CDE_GCRT	T_MME_MME_RANGE_FACTOR	CHAR	1.00	0.00
CDE_GCRT	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
CDE_GCRT	T_MME_OPIOID_RTD_ING_MME	CHAR	1.00	0.00
CDE_GENDER	T_DRUG_GER	CHAR	1.00	0.00
CDE_GENDER	T_DRUG_PED	CHAR	1.00	0.00
CDE_GENDER	T_DS_DNTL_RECIP	CHAR	1.00	0.00
CDE_GENDER	T_ERX_FORMULARY	CHAR	1.00	0.00
CDE_GENDER	T_GERI_DOSE	CHAR	1.00	0.00
CDE_GENDER	T_HIGH_DOSE	CHAR	1.00	0.00
CDE_GENDER	T_LOW_DOSE	CHAR	1.00	0.00
CDE_GENDER	T_PEDI_DOSE	CHAR	1.00	0.00
CDE_GENDER	T_PF_INPAT_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_INPAT_RP_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_NHOME_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_NHOME_RP_TOT_Q	CHAR	1.00	0.00

CDE_GENDER	T_PF_OUTPAT_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_OUTPAT_RP_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PHARM_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PHARM_RP_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PROF_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PROF_RP_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PRREF_RE_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_PRREF_RP_TOT_Q	CHAR	1.00	0.00
CDE_GENDER	T_PF_RECIP_ACG	CHAR	1.00	0.00
CDE_GENDER	T_PF_RECIP_CMPR	CHAR	1.00	0.00
CDE_GENDER	T_PF_RE_CMPR_Q	CHAR	1.00	0.00
CDE_GENDER	T_PR_NAM_NPPES	VARCHAR2	1.00	0.00
CDE_GENDER	T_PR_PROV	CHAR	1.00	0.00
CDE_GENDER	T_PR_RST_SVC_STATE_KY	CHAR	1.00	0.00
CDE_GENDER	T_THERA_DURATION	CHAR	1.00	0.00
CDE_GENDER_RESTR	T_MC_PMP_PANEL_RESTRICT	CHAR	1.00	0.00
CDE_GEN_CDE_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_GEN_CDE_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_GEN_CD_SQ_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_GEN_CD_SQ_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_GIS_QUALITY	T_GIS_CODES	NUMBER	4.00	0.00
CDE_GIS_QUALITY	T_RE_ADDRESS	NUMBER	4.00	0.00
CDE_GIS_QUALITY	T_RE_BASE	NUMBER	4.00	0.00
CDE_GIS_QUALITY	T_RE_BASE_DN	NUMBER	4.00	0.00
CDE_GPI_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_GPI_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_GROUP	T_CDE_CALL_CATEG	CHAR	1.00	0.00
CDE_GROUP	T_CDE_CALL_PRIORITY	CHAR	1.00	0.00
CDE_GROUP	T_CDE_CALL_UNIT	CHAR	1.00	0.00
CDE_GROUP	T_CDE_HIPAA_ADJRSN	CHAR	2.00	0.00
CDE_GROUP	T_LS_MANFAC_GROUPING	CHAR	3.00	0.00

CDE_GROUP	T_LS_SUMMARY_NDC	CHAR	3.00	0.00
CDE_GROUP	T_MM_GROUP	CHAR	1.00	0.00
CDE_GROUP	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_GROUPING	T_AID_CAT_GROUP_XREF	CHAR	3.00	0.00
CDE_GROUPING	T_CDE_GROUP	CHAR	3.00	0.00
CDE_GROUP_CAGC	T_CDE_CARC_RARC	CHAR	2.00	0.00
CDE_GROUP_D	T_CA_AID_GROUP	CHAR	3.00	0.00
CDE_GROUP_E	T_CA_AID_GROUP	CHAR	3.00	0.00
CDE_GROUP_P	T_CA_AID_GROUP	CHAR	3.00	0.00
CDE_GRP_TYPE	T_DRG_GROUPER	NUMBER	4.00	0.00
CDE_GRP_VERSION	T_DRG_GROUPER	VARCHAR2	20.00	0.00
CDE_GSA	T_MB_DEN_RECIP	CHAR	2.00	0.00
CDE_GSA	T_MB_NUM_RECIP	CHAR	2.00	0.00
CDE_GSN_DOSAGE_UNIT	T_MME_OPIOID_CF_MME_FAC TOR	VARCHAR2	50.00	0.00
CDE_GS_APPLICATION	T_TP	VARCHAR2	15.00	0.00
CDE_HANDICAP_ACC	T_PR_ADR	CHAR	1.00	0.00
CDE_HANDICAP_ACC	T_PR_ADR_AL	CHAR	1.00	0.00
CDE_HANDICAP_ACC	T_PR_ADR_WI	CHAR	1.00	0.00
CDE_HANDLING	T_835_CK_EFT_TRCNO	CHAR	1.00	0.00
CDE_HCAC_CAT	T_CA_UB92	CHAR	2.00	0.00
CDE_HCAC_CAT	T_UB92_HDR_INP	CHAR	2.00	0.00
CDE_HCBS_CHRON_NHH	T_TMSIS_ELG020_HCBS_CH_N HH	VARCHAR2	3.00	0.00
CDE_HCBS_SERVICE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	1.00	0.00
CDE_HCBS_SERVICE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	1.00	0.00
CDE_HCBS_TAXONOMY	T_TMSIS_COT003_CLM_DTL	VARCHAR2	5.00	0.00
CDE_HCBS_TAXONOMY	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	5.00	0.00
CDE_HCFA_JUST	T_RE_EDB	CHAR	1.00	0.00

CDE_HCFA_UNIT	T_DR_DISPUTE_DTL	CHAR	3.00	0.00
CDE_HCFA_UNIT	T_DR_DISPUTE_RESO	CHAR	3.00	0.00
CDE_HCFA_UNIT	T_DR_INVOICE_DTL	CHAR	3.00	0.00
CDE_HCPCS_RATE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	14.00	0.00
CDE_HCPCS_RATE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	14.00	0.00
CDE_HCPCS_RATE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	14.00	0.00
CDE_HC_CLM_STATUS	T_EOB	CHAR	3.00	0.00
CDE_HC_CLM_STATUS	T_HC_CLM_STATUS	CHAR	3.00	0.00
CDE_HC_ENTITY_ID	T_EOB	CHAR	3.00	0.00
CDE_HC_ENTITY_ID	T_HC_ENTITY_ID	CHAR	2.00	0.00
CDE_HC_ENTITY_ID	T_HC_ENTITY_ID	CHAR	3.00	0.00
CDE_HDR_DTL_LVL	T_ERROR_DISP	CHAR	1.00	0.00
CDE_HHLTH_PROGNOSIS	T_CLM_CR6	CHAR	1.00	0.00
CDE_HH_CERT_TYPE	T_CLM_CR6	CHAR	1.00	0.00
CDE_HH_CHRON_COND	T_TMSIS_ELG008_HH_CHR_CON	VARCHAR2	1.00	0.00
CDE_HH_PAT_LOCATION	T_CLM_CR6	CHAR	1.00	0.00
CDE_HH_SURGICAL_PROC	T_CLM_CR6	VARCHAR2	15.00	0.00
CDE_HIC	T_INGREDIENT	CHAR	6.00	0.00
CDE_HIC2	T_HIC3	CHAR	2.00	0.00
CDE_HIC3	T_HIC3	CHAR	3.00	0.00
CDE_HIC3_GROUP	T_HIC3	NUMBER	6.00	0.00
CDE_HIC4	T_HIC4	CHAR	4.00	0.00
CDE_HIC4	T_INGRED_DUPE	CHAR	4.00	0.00
CDE_HICL_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_HICL_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00

CDE_HIC_RRB	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_HIPAA_VERSION	T_TPL_CARRIER	CHAR	4.00	0.00
CDE_HIPAA_VERSION	T_TPL_CARRIER_AL	CHAR	4.00	0.00
CDE_HIPP	T_HIPP_RESOURCE	CHAR	2.00	0.00
CDE_HIPP	T_HIPP_RSN_CODES	CHAR	2.00	0.00
CDE_HIPP_PROCESS	T_HIPP_RESOURCE	CHAR	1.00	0.00
CDE_HIST	T_CA_KICK_PYMT	CHAR	1.00	0.00
CDE_HIST	T_CLM_KICK_PYMT	CHAR	1.00	0.00
CDE_HIST_FROM	T_CONTRA_PROC	CHAR	6.00	0.00
CDE_HIST_FROM	T_CONTRA_PROC_EXPL	CHAR	6.00	0.00
CDE_HIST_FROM	T_CONTRA_PROC_EXPL_MIRROR	CHAR	6.00	0.00
CDE_HIST_MOD	T_CONTRA_PROC	CHAR	2.00	0.00
CDE_HIST_MOD	T_CONTRA_PROC_EXPL	CHAR	2.00	0.00
CDE_HIST_MOD	T_CONTRA_PROC_EXPL_MIRROR	CHAR	2.00	0.00
CDE_HIST_TO	T_CONTRA_PROC	CHAR	6.00	0.00
CDE_HIST_TO	T_CONTRA_PROC_EXPL	CHAR	6.00	0.00
CDE_HIST_TO	T_CONTRA_PROC_EXPL_MIRROR	CHAR	6.00	0.00
CDE_HIST_TYPE	T_CONTRA_PROC	CHAR	1.00	0.00
CDE_HIST_TYPE	T_CONTRA_PROC_EXPL	CHAR	1.00	0.00
CDE_HIST_TYPE	T_CONTRA_PROC_EXPL_MIRROR	CHAR	1.00	0.00
CDE_HMO_PPO	T_EMP_CARR_XREF	CHAR	1.00	0.00
CDE_HMO_PPO	T_HMO_INDICATOR	CHAR	1.00	0.00
CDE_HMO_PPO	T_TPL_CARRIER	CHAR	1.00	0.00
CDE_HMO_PPO	T_TPL_CARRIER_AL	CHAR	1.00	0.00

CDE_HOLD_ADDL	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_HOLD_INIT	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_IAC	T_PA_IAC_TEXT	CHAR	25.00	0.00
CDE_ICD_VERSION	T_AUDT_DIAG_XRF	CHAR	1.00	0.00
CDE_ICD_VERSION	T_CASUALTY_CASE_OFFLINE	CHAR	1.00	0.00
CDE_ICD_VERSION	T_CA_DIAG	CHAR	1.00	0.00
CDE_ICD_VERSION	T_CA_ICD9_PROC	CHAR	1.00	0.00
CDE_ICD_VERSION	T_CLM_DIAG_XREF	CHAR	1.00	0.00
CDE_ICD_VERSION	T_DIAGNOSIS	CHAR	1.00	0.00
CDE_ICD_VERSION	T_DIAG_DSE_XREF	CHAR	1.00	0.00
CDE_ICD_VERSION	T_MEDPOL_UB92_DIAG	CHAR	1.00	0.00
CDE_ICD_VERSION	T_MPHX_PH_DIAG	CHAR	1.00	0.00
CDE_ICD_VERSION	T_PROC_ICD9	CHAR	1.00	0.00
CDE_ICD_VERSION	T_PROC_ICD9_DIA	CHAR	1.00	0.00
CDE_ICD_VERSION	T_UB92_HDR_DIAG_X	CHAR	1.00	0.00
CDE_ICD_VERSION	T_UB92_HDR_ICD9CM	CHAR	1.00	0.00

CDE_ICD_VERSION_1	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_ETG_SUMMARY	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_1	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	1.00	0.00
CDE_ICD_VERSION_10	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_10	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_11	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_11	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_12	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_12	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00

CDE_ICD_VERSION_2	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_ETG_SUMMARY	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_2	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	1.00	0.00
CDE_ICD_VERSION_3	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_3	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_3	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_3	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_4	T_CA_DIAG_DN	CHAR	1.00	0.00

CDE_ICD_VERSION_4	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_4	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_4	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_5	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_5	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_5	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_5	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_6	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_6	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_6	T_CA_ICD9_PROC_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_7	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_7	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_7	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00

CDE_ICD_VERSION_8	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_8	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_8	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICD_VERSION_9	T_CA_DIAG_DN	CHAR	1.00	0.00
CDE_ICD_VERSION_9	T_CA_DIAG_MAT_CARE	CHAR	1.00	0.00
CDE_ICD_VERSION_9	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
CDE_ICF_MR_FNL_APR	T_PS_CDE_ICF_FNL	CHAR	2.00	0.00
CDE_ICF_MR_FNL_APR	T_PS_ICF_MR	CHAR	2.00	0.00
CDE_ICF_MR_PRE_APR	T_PS_CDE_ICF_PRE	CHAR	2.00	0.00
CDE_ICF_MR_PRE_APR	T_PS_ICF_MR	CHAR	2.00	0.00
CDE_ICN	T_DR_CLMS_XREF	NUMBER	13.00	0.00
CDE_IDCARD_CNTL	T_COUNTY	CHAR	5.00	0.00
CDE_IDENTIFICATION	T_CDE_SUPPORTED_DOC	VARCHAR2	50.00	0.00
CDE_ID_CLERK	T_DR_INV_COMMENT	CHAR	8.00	0.00
CDE_ID_PATIENT	T_AR_CLM_HDR	VARCHAR2	30.00	0.00
CDE_ID_PROVIDER	T_AR_CLM_HDR	VARCHAR2	30.00	0.00
CDE_IEVES	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_IMAGE_TYPE	T_CLM_IMAGE_BALANCE	CHAR	3.00	0.00
CDE_IMID	T_MR_MSIS_AID_KY	CHAR	2.00	0.00
CDE_IMID	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_IMID	T_MR_RE_KY	CHAR	2.00	0.00
CDE_IMMIG_STATUS	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
CDE_IMMIG_VER_FLAG	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
CDE_IMMUNIZATION_TYPE	T_MR_TMSIS_IMMUN_TYPE	CHAR	2.00	0.00
CDE_IMMUNIZATION_TYPE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00

CDE_IMMUNIZATION_TYPE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_IMMUNIZATION_TYPE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_IMMUNIZATION_TYPE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_IMPUTED_SPEC	T_IMPUTED_SPEC	CHAR	3.00	0.00
CDE_INCOME	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	2.00	0.00
CDE_INCOME_FROM	T_DS_RECIP_DO_INCOME	CHAR	1.00	0.00
CDE_INCOME_LVL	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_INCOME_SRC	T_DS_RECIP_DO_INCOME	CHAR	2.00	0.00
CDE_INCOME_TYPE	T_RE_INCOME_LOSS	CHAR	1.00	0.00
CDE_INCOME_TYPE	T_RE_INCOME_NEW	CHAR	1.00	0.00
CDE_INC_EXC_AID_CAT	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_CLM_TYPE	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_COUNTY	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_DIAG	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_DRUG	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_ICD9	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_IND	T_TPL_PREBILL	CHAR	1.00	0.00
CDE_INC_EXC_PROC	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_PROC_MOD	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_PROV_ID	T_CLM_FCA	CHAR	1.00	0.00

CDE_INC_EXC_PROV_PGM	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_PROV_SPEC	T_CLM_FCA	CHAR	1.00	0.00
CDE_INC_EXC_PROV_TYPE	T_CLM_FCA	CHAR	1.00	0.00
CDE_INDIAN_PROV	T_PR_SVC_LOC	CHAR	1.00	0.00
CDE_INDIAN_PROV	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_INDIAN_PROV	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
CDE_INDUSTRY	T_CDE_SUPPORTED_DOC	VARCHAR2	12.00	0.00
CDE_INDUSTRY	T_EDIC_PAYLOADTYPES	VARCHAR2	40.00	0.00
CDE_IND_835	T_FIN_REMIT	CHAR	1.00	0.00
CDE_IND_RELATIONSHIP	T_CLM_SBR	CHAR	2.00	0.00
CDE_IND_RELATIONSHIP	T_PA_HDR	CHAR	2.00	0.00
CDE_IND_TYPE	T_DRUG_INDICATOR	CHAR	3.00	0.00
CDE_IND_UNITS	T_DR_DISPUTE_RESO	CHAR	2.00	0.00
CDE_INGRED_STATUS	T_INGREDIENT	CHAR	1.00	0.00
CDE_INIT_AWARD	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_INIT_LAG	T_MR_WVR_CLM	CHAR	1.00	0.00
CDE_INIT_LAG	T_MR_WVR_ELG	CHAR	1.00	0.00
CDE_INIT_ORG	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_INIT_ORG	T_TPL_RESOURCE	CHAR	2.00	0.00
CDE_INPUT	T_DRG_MAPPER	CHAR	5.00	0.00
CDE_INPUT_OUTPUT	T_CDE_TPL_IN_OUT	CHAR	1.00	0.00
CDE_INPUT_OUTPUT	T_RU_VARIABLE	CHAR	1.00	0.00
CDE_INPUT_OUTPUT	T_TRANSACTION_TYPE	CHAR	1.00	0.00
CDE_INQ_TYPE	T_PR_PHONE_TRACK	CHAR	2.00	0.00
CDE_INQ_TYPE	T_PR_PHONE_TYPE	CHAR	2.00	0.00
CDE_INQ_TYPE_2	T_PR_PHONE_TRACK	CHAR	2.00	0.00
CDE_INQ_TYPE_3	T_PR_PHONE_TRACK	CHAR	2.00	0.00
CDE_INST_TYPE	T_PR_INST_RATE_WI	CHAR	1.00	0.00

CDE_INSURANCE_TYPE	T_CLM_SBR	CHAR	3.00	0.00
CDE_INSURED_GROUP_NUMBER	T_CLM_SBR	VARCHAR2	50.00	0.00
CDE_INS_CARRIER_NAIC	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	10.00	0.00
CDE_INS_HIPAA	T_HIPAA_BP	CHAR	3.00	0.00
CDE_INS_HIPAA	T_HIPAA_BP_XREF	CHAR	3.00	0.00
CDE_INS_PLAN_TYPE	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	2.00	0.00
CDE_INS_PLAN_TYPE	T_TMSIS_TPL004_HLTH_INS_CT	VARCHAR2	2.00	0.00
CDE_INTERFACE	T_PR_INTERFACE_STATS	CHAR	3.00	0.00
CDE_INTERIM_ACTION	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_4002_RCPTS	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_CLMS_INV_XREF	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_CONTACT_TYPE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_DISPUTE_RESO	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_DRUGS_INV	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_FUND_INV_XREF	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_INVOICE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_INVOICE_TYPE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_INV_TYPE_XREF	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_LATE_NOTICE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_MAIL_DATE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_PROCESS_INV_XREF	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_RATE	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_STATUS	CHAR	2.00	0.00
CDE_INV_TYPE	T_DR_STATUS_SUPPLE	CHAR	2.00	0.00
CDE_INV_TYPE_1	T_CA_DRUG_REBATE	CHAR	2.00	0.00

CDE_INV_TYPE_2	T_CA_DRUG_REBATE	CHAR	2.00	0.00
CDE_INV_TYPE_3	T_CA_DRUG_REBATE	CHAR	2.00	0.00
CDE_INV_TYPE_4	T_CA_DRUG_REBATE	CHAR	2.00	0.00
CDE_INV_TYPE_SUPP	T_DR_INV_TYPE_XREF	CHAR	2.00	0.00
CDE_ISA_RESERVED	T_TXN_BILLING	CHAR	2.00	0.00
CDE_ISSUE_REASON	T_ID_ISSUE_RSN	CHAR	1.00	0.00
CDE_ISSUE_REASON	T_RE_EBS_CARD_RQST	CHAR	1.00	0.00
CDE_ISSUE_REASON	T_RE_ID_CARD	CHAR	1.00	0.00
CDE_ISSUE_REASON	T_RE_ID_CRD_ISS	CHAR	1.00	0.00
CDE_ISSUE_REASON	T_RE_ID_CRD_RQST	CHAR	1.00	0.00
CDE_JOIN_TYPE	T_MM_JOIN_TYPE	CHAR	1.00	0.00
CDE_JOIN_TYPE	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_KICK_PYMT	T_CLM_SYS_FIELDS_DTL	CHAR	1.00	0.00
CDE_LABELER	T_DRUG_LBLR	CHAR	5.00	0.00
CDE_LABELER	T_DRUG_REBATE_TEMP	CHAR	5.00	0.00
CDE_LABELER	T_DR_DISPUTE_RESO	CHAR	5.00	0.00
CDE_LABELER	T_LS_DRUG_MASTER	CHAR	5.00	0.00
CDE_LABELER	T_LS_MANFAC_GROUPING	CHAR	5.00	0.00
CDE_LABELER	T_LS_MANFAC_INFO	CHAR	5.00	0.00
CDE_LABELER	T_LS_PHARMACY_OTHER	CHAR	5.00	0.00
CDE_LABELER_DM	T_LS_SUMMARY_NDC	CHAR	5.00	0.00
CDE_LABELER_ID	T_DRUG_MANUF	CHAR	6.00	0.00

CDE_LAB_CODE	T_CLIA_LAB	CHAR	3.00	0.00
CDE_LAB_CODE	T_REF_CLIA_LC_PROC	CHAR	3.00	0.00
CDE_LAB_TYPE	T_CLIA_CERT	CHAR	1.00	0.00
CDE_LACS_FOOTNOTE	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_LACS_FOOTNOTE	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_LANGUAGE	T_CALL_OTHER_INFO	CHAR	3.00	0.00
CDE_LANGUAGE	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_LANGUAGE	T_DS_RECIP_DO_APPL	CHAR	3.00	0.00
CDE_LANGUAGE	T_LANGUAGE	CHAR	3.00	0.00
CDE_LANGUAGE	T_LG_CDE_LANGUAGE	CHAR	3.00	0.00
CDE_LANGUAGE	T_LG_LETTER_TEMPLATE	CHAR	3.00	0.00
CDE_LANGUAGE	T_PR_SVC_LANG	CHAR	3.00	0.00
CDE_LANGUAGE	T_RE_BASE	CHAR	3.00	0.00
CDE_LANGUAGE	T_RE_BASE_DN	CHAR	3.00	0.00
CDE_LANG_CORRESP	T_RE_BASE	CHAR	3.00	0.00
CDE_LANG_CORRESP	T_RE_BASE_DN	CHAR	3.00	0.00
CDE_LANG_HIPAA	T_HIPAA_LANGUAGE	CHAR	3.00	0.00
CDE_LANG_HIPAA	T_HIPAA_LANG_XREF	CHAR	3.00	0.00
CDE_LANG_MMIS	T_HIPAA_LANG_XREF	CHAR	1.00	0.00
CDE_LAST_TPL_ACTION	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_LETTER	T_PS_LTR_LEGEND	CHAR	3.00	0.00
CDE_LETTERHEAD	T_LG_LETTERHEAD	CHAR	1.00	0.00
CDE_LETTERHEAD	T_LG_LETTER_TEMPLATE	CHAR	1.00	0.00
CDE_LETTER_TEXT	T_TPL_CDE_LETTER	CHAR	3.00	0.00
CDE_LETTER_USED	T_PS_LTR_REQUEST	CHAR	3.00	0.00
CDE_LEVEL	T_AUDIT_ST_LEVEL	CHAR	1.00	0.00
CDE_LEVEL	T_AUDIT_ST_MEM	CHAR	1.00	0.00
CDE_LEVEL_OF_CARE	T_ADJ_RET_RQST_ERR	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_CA_RECIP_KEY	CHAR	5.00	0.00

CDE_LEVEL_OF_CARE	T_COND_INP_LOC	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_DRG_INP_LOC	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_ERR_DISP_LINE	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_MR_LTC	CHAR	5.00	0.00
CDE_LEVEL_OF_CARE	T_MR_LTC_REV	CHAR	5.00	0.00
CDE_LEVEL_OF_CARE	T_PR_LOC_CODE	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_PR_RECP_LOC_X	CHAR	2.00	0.00
CDE_LEVEL_OF_CARE	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_LEVEL_OF_SVC	T_PHRM_HDR_KEYS	CHAR	2.00	0.00
CDE_LICENSE_TYPE	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	1.00	0.00
CDE_LIC_CLASS	T_CDE_LIC_CLASS_KY	CHAR	3.00	0.00
CDE_LIC_CLASS	T_PR_HB_LIC_KY	CHAR	3.00	0.00
CDE_LIC_STATE	T_PR_APPLN	CHAR	2.00	0.00
CDE_LIC_STATE	T_PR_APPLN_WI	CHAR	2.00	0.00
CDE_LIC_TYPE	T_CA_PR_HB_LIC	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_APPLN	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_APPLN_WI	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_HB_LIC	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_HB_LIC_KY	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_PRESCRIBER	CHAR	1.00	0.00
CDE_LIC_TYPE	T_PR_TYPE	CHAR	1.00	0.00
CDE_LIMIT	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
CDE_LIMITATION	T_PR_ACC_PTS_LIMIT_WI	CHAR	1.00	0.00
CDE_LINE_ADJUST_RSN	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_LINE_ADJUST_RSN	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_LINE_ADJUST_RSN	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_LINE_ADJUST_RSN	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_LIST_ID	T_ERX_CDE_LIST_ID	CHAR	10.00	0.00
CDE_LIST_SUB_TYPE	T_ERX_CDE_LIST_ID	CHAR	2.00	0.00
CDE_LIST_TYPE	T_ERX_CDE_LIST_ID	CHAR	3.00	0.00
CDE_LIVES_WITH_FAM	T_DS_RECIP_MFP	CHAR	1.00	0.00

CDE_LIVING_ARRNGMNT	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_LIV_ARNG	T_CA_RECIP_KEY	CHAR	2.00	0.00
CDE_LIV_ARNG	T_RE_BASE_DN	CHAR	2.00	0.00
CDE_LIV_ARNG	T_RE_LIV_ARNG	CHAR	2.00	0.00
CDE_LIV_ARRNGMNT	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_LNCPT4	T_UB92_DTL_OUTPAT_GROUP	VARCHAR2	5.00	0.00
CDE_LNCPTAPC	T_UB92_DTL_OUTPAT_GROUP	VARCHAR2	5.00	0.00
CDE_LNITEMRC	T_UB92_DTL_OUTPAT_PRICE	CHAR	2.00	0.00
CDE_LNPAYAPC	T_UB92_DTL_OUTPAT_GROUP	VARCHAR2	5.00	0.00
CDE_LNPRMETH	T_UB92_DTL_OUTPAT_PRICE	CHAR	2.00	0.00
CDE_LOC	T_ADJMS_LOC	CHAR	3.00	0.00
CDE_LOC	T_AUDIT_LOC_XREF	CHAR	3.00	0.00
CDE_LOC	T_INP_LOC	CHAR	3.00	0.00
CDE_LOC	T_INP_LOC_RATE	CHAR	3.00	0.00
CDE_LOC	T_LTC_LEAVE_RATE	CHAR	3.00	0.00
CDE_LOC	T_MR_WVR_CLM	CHAR	6.00	0.00
CDE_LOC	T_MR_WVR_ELG	CHAR	6.00	0.00
CDE_LOC	T_PEER_GRP_INP_LOC	CHAR	3.00	0.00
CDE_LOC	T_PR_LOC_RATE_REQ	CHAR	3.00	0.00
CDE_LOC	T_PR_PEER_LEVEL	CHAR	3.00	0.00
CDE_LOC	T_PR_RECP_LOC_X	CHAR	3.00	0.00
CDE_LOC	T_PR_UB_LOC_RATE	CHAR	3.00	0.00
CDE_LOC	T_RE_LOC	CHAR	3.00	0.00
CDE_LOC	T_RE_LOC_CODE	CHAR	5.00	0.00

CDE_LOC	T_UB92_NH_HDR	CHAR	3.00	0.00
CDE_LOCALITY	T_COUNTY	CHAR	2.00	0.00
CDE_LOCALITY	T_GPCI	CHAR	2.00	0.00
CDE_LOCALITY	T_LOCALITY	CHAR	2.00	0.00
CDE_LOCALITY	T_PREVAILING	CHAR	2.00	0.00
CDE_LOCALITY	T_PREVAILING_CONV	CHAR	2.00	0.00
CDE_LOCAL_SUPPORT	T_PS_CASE	CHAR	3.00	0.00
CDE_LOCATION	T_CLAIM_LOCAT	CHAR	2.00	0.00
CDE_LOCATION	T_DS_RECIP_DO_APPL	CHAR	8.00	0.00
CDE_LOCATION	T_LOCATION	CHAR	2.00	0.00
CDE_LOCATION	T_SYS_LOCATION	CHAR	2.00	0.00
CDE_LOCATION_PGM	T_RE_AID_ELIG	CHAR	2.00	0.00
CDE_LOCATION_PGM	T_RE_AID_ELIG_DN	CHAR	2.00	0.00
CDE_LOCATION_PGM	T_RE_CDE_LOCATION_PGM	CHAR	2.00	0.00
CDE_LOCATION_PRCNG_GEO	T_REIMB_LOCATION	CHAR	4.00	0.00
CDE_LOCATION_PRCNG_TYPE	T_REIMB_LOCATION	CHAR	4.00	0.00
CDE_LOCKIN	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_LOCKIN_PROV_TYPE	T_TMSIS_ELG009_LOCKIN_INFO	VARCHAR2	2.00	0.00
CDE_LOCK_ENT_RSN	T_RE_LOCK_ENT	CHAR	2.00	0.00
CDE_LOCK_EXIT_RSN	T_RE_LOCK_EXIT	CHAR	2.00	0.00
CDE_LOCK_SOURCE	T_MC_RE_PMP_LKOUT	CHAR	1.00	0.00
CDE_LOC_ANALYST	T_PS_ICF_MR	CHAR	3.00	0.00
CDE_LOC_COUNTY	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_LOC_DO	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_LOC_EVAL	T_PS_CASE	CHAR	3.00	0.00
CDE_LOC_FROM	T_DCOR_SCHEDULE	CHAR	2.00	0.00

CDE_LOC_FROM	T_LOCATION_NOTE	CHAR	2.00	0.00
CDE_LOC_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_LOC_PGM	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_LOC_RVWR	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_LOC_STATUS	T_MR_TMSIS_BEN_PLAN	CHAR	3.00	0.00
CDE_LOC_STATUS	T_PR_APPLN_WI	CHAR	1.00	0.00
CDE_LOC_STATUS	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	3.00	0.00
CDE_LOC_STOP	T_RE_LOC	CHAR	3.00	0.00
CDE_LOC_STOP1	T_RE_LOC_STOP1	CHAR	1.00	0.00
CDE_LOC_STOP2	T_RE_LOC_STOP2	CHAR	2.00	0.00
CDE_LOC_TO	T_DCOR_SCHEDULE	CHAR	2.00	0.00
CDE_LOC_TO	T_LOCATION_NOTE	CHAR	2.00	0.00
CDE_LOGICAL_CONNECTIVE	T_RU_CONDITION	CHAR	3.00	0.00
CDE_LOGON_STATUS	T_AUDIT_LOGON	CHAR	1.00	0.00
CDE_LOG_STATUS	T_SW_RTI_LOG	CHAR	1.00	0.00
CDE_LOW_WT_DRG	T_CA_UB92	CHAR	1.00	0.00
CDE_LOW_WT_DRG	T_UB92_HDR_INP	CHAR	1.00	0.00
CDE_LTC_TYPE	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_LTR_CTGRY	T_PS_CDE_LTR_CTGRY	CHAR	2.00	0.00
CDE_LTR_CTGRY	T_PS_CDE_LTR_TYPE	CHAR	2.00	0.00
CDE_LTR_TYPE	T_BATCH_LETTERS	CHAR	2.00	0.00
CDE_LTR_TYPE	T_CAS_HIST_LETTERS	CHAR	2.00	0.00
CDE_LTR_TYPE	T_CAS_LTR_TYPE	CHAR	2.00	0.00

CDE_LTR_TYPE	T_PS_CDE_LTR_TYPE	VARCHAR2	60.00	0.00
CDE_LTR_TYPE	T_RE_ID_LETTER	CHAR	2.00	0.00
CDE_LTSS_LEVEL_OF_CARE	T_MR_TMSIS_BEN_PLAN	CHAR	1.00	0.00
CDE_LTSS_LEVEL_OF_CARE	T_TMSIS_ELG013_LTSS_PARTIC	VARCHAR2	1.00	0.00
CDE_LVL_CARE_NH_INST	T_PA_DTL	CHAR	1.00	0.00
CDE_LVL_CARE_NH_PROF	T_PA_DTL	CHAR	1.00	0.00
CDE_MAILING	T_DRUG_LBLR	CHAR	2.00	0.00
CDE_MAILING	T_DR_INV_MAIL	CHAR	2.00	0.00
CDE_MAINT_ASSIST_STATUS	T_MR_TMSIS_AID_CAT	CHAR	1.00	0.00
CDE_MAINT_ASSIST_STATUS	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
CDE_MAND_VOL	T_MC_REGION_WI	CHAR	1.00	0.00
CDE_MANUAL	T_CA_KICK_PYMT	CHAR	1.00	0.00
CDE_MANUAL	T_CLM_KICK_PYMT	CHAR	1.00	0.00
CDE_MAPPED	T_DRG_MAPPER	CHAR	5.00	0.00
CDE_MAPPER_TYPE	T_DRG_MAPPER	CHAR	2.00	0.00
CDE_MAP_VERSION	T_DRG_MAPPER	CHAR	3.00	0.00
CDE_MARITAL	T_CDE_MARITAL	CHAR	1.00	0.00
CDE_MARITAL	T_PS_CASE	CHAR	1.00	0.00
CDE_MARITAL	T_PS_CDE_MARITAL	CHAR	1.00	0.00
CDE_MARITAL	T_RE_BASE	CHAR	1.00	0.00

CDE_MARITAL	T_RE_BASE_DN	CHAR	1.00	0.00
CDE_MARITAL	T_RE_MARITAL	CHAR	1.00	0.00
CDE_MARITAL_STATUS	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_MARITAL_STATUS	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_MARITAL_STATUS	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	2.00	0.00
CDE_MAS	T_MR_MSIS_AID	CHAR	1.00	0.00
CDE_MAS	T_MR_MSIS_AID_KY	CHAR	1.00	0.00
CDE_MATER_WVR_EXEMPTION	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_MATH_OP	T_CM_CG_CRIT	CHAR	1.00	0.00
CDE_MATRIX_STATUS	T_TPL_MATRIX_XREF	CHAR	1.00	0.00
CDE_MAX_DOSE_UNIT	T_PEDI_DOSE	CHAR	2.00	0.00
CDE_MAX_DOSE_UNITS	T_HIGH_DOSE	CHAR	3.00	0.00
CDE_MAX_DOSE_UNITS	T_HIGH_DOSE_LOG	CHAR	3.00	0.00
CDE_MAX_UNIT_FORM	T_HIGH_DOSE	CHAR	2.00	0.00
CDE_MAX_UNIT_FORM	T_HIGH_DOSE_LOG	CHAR	2.00	0.00
CDE_MAX_UNIT_FORM	T_PEDI_DOSE	CHAR	2.00	0.00
CDE_MBR_STATUS	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_MCARE_TYPE	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_MCARE_TYPE	T_PR_ENRL_IDENTIFIER	CHAR	1.00	0.00
CDE_MCARE_TYPE	T_PR_MCARE_BILL	CHAR	1.00	0.00
CDE_MCAR_COVRG	T_CDE_MCARE_COVRG	CHAR	1.00	0.00

CDE_MCAR_COVRG	T_CDE_PROC	CHAR	1.00	0.00
CDE_MCAR_COVRG	T_PROC	CHAR	1.00	0.00
CDE_MC_ADDR_TYPE	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	1.00	0.00
CDE_MC_AID_GRP	T_MC_AID_GRP	CHAR	3.00	0.00
CDE_MC_ENTITY	T_MC_ENTITY	CHAR	3.00	0.00
CDE_MC_PGM_STATUS_GRP	T_MC_PGM_STATUS_GRP	CHAR	3.00	0.00
CDE_MC_PLAN_COUNTY	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	3.00	0.00
CDE_MC_PLAN_TYPE	T_MR_TMSIS_BEN_PLAN	CHAR	2.00	0.00
CDE_MC_PLAN_TYPE	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	2.00	0.00
CDE_MC_PLAN_TYPE	T_TMSIS_MCR002_MAIN	VARCHAR2	2.00	0.00
CDE_MC_PROFIT_STATUS	T_TMSIS_MCR002_MAIN	VARCHAR2	2.00	0.00
CDE_MC_PROGRAM	T_TMSIS_MCR002_MAIN	VARCHAR2	1.00	0.00
CDE_MC_REGION	T_CAPITATION_ADJ	CHAR	5.00	0.00
CDE_MC_REGION	T_CAPITATION_ADJ_DN	CHAR	5.00	0.00
CDE_MC_REGION	T_CAPITATION_ADJ_WI	CHAR	5.00	0.00
CDE_MC_REGION	T_CAPITATION_HIST	CHAR	5.00	0.00
CDE_MC_REGION	T_CAPITATION_HIST_DN	CHAR	5.00	0.00
CDE_MC_REGION	T_CAPITATION_HIST_WI	CHAR	5.00	0.00
CDE_MC_REGION	T_CAP_MASS_ADJ_RST	CHAR	5.00	0.00
CDE_MC_REGION	T_CAP_MASS_ADJ_RST_tmp	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_AREA_RGN_XREF	CHAR	5.00	0.00

CDE_MC_REGION	T_MC_AREA_RGN_XREF_WI	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_CAP_AMTS	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_CAP_AMTS_PMP	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_CAP_AMTS_RANGE	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_CENSUS	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_PGM_RGN_XREF	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_PMP_ENRL_RGN	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_PMP_ENRL_RGN_AL	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_REGION	CHAR	5.00	0.00
CDE_MC_REGION	T_MC_REGION_WI	CHAR	5.00	0.00
CDE_MC_REGION	T_RE_PMP_ASSIGN	CHAR	5.00	0.00
CDE_MC_REGION	T_RE_PMP_ASSIGN_WI	CHAR	5.00	0.00
CDE_MC_SERVICE_AREA	T_TMSIS_MCR002_MAIN	VARCHAR2	1.00	0.00
CDE_MC_SVC_CLASS	T_MC_SVC_CLASS	CHAR	2.00	0.00

CDE_MC_SVC_CLASS	T_PROC	CHAR	2.00	0.00
CDE_MC_SVC_CLASS	T_PROC_ICD9	CHAR	2.00	0.00
CDE_MC_SVC_CLASS	T_REVENUE_CODE	CHAR	2.00	0.00
CDE_MDC	T_CA_UB92	CHAR	2.00	0.00
CDE_MDC	T_MDC	CHAR	2.00	0.00
CDE_MDC	T_UB92_HDR_INP	CHAR	2.00	0.00
CDE_MDCD_ENROLL_STATUS	T_TMSIS_PRV007_MDCD_ENROLL	VARCHAR2	2.00	0.00
CDE_MDCD_STATE_PLAN_ENROLL	T_TMSIS_PRV007_MDCD_ENROLL	VARCHAR2	1.00	0.00
CDE_MEASUREMENT_CATEGORY	T_CLM_MEA	CHAR	2.00	0.00
CDE_MEASURE_UNIT_INST	T_PA_DTL	CHAR	2.00	0.00
CDE_MEASURE_UNIT_PROF	T_PA_DTL	CHAR	2.00	0.00
CDE_MEDIA	T_MEDIA	CHAR	1.00	0.00
CDE_MEDIA	T_SYS_DEST	CHAR	1.00	0.00
CDE_MEDIA	T_TRANSACTION	CHAR	1.00	0.00
CDE_MEDIA	T_TRANS_MEDIA_XREF	CHAR	1.00	0.00
CDE_MEDIA	T_UPLOAD	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_DRUG_LBLR	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_DR_INV_MEDIA	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_LG_CDE_MEDIA	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_LG_LETTER_REQUEST	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_PA_MEDIA	CHAR	1.00	0.00
CDE_MEDIA_TYPE	T_PA_PAUTH	CHAR	1.00	0.00
CDE_MEDICAID_BOE	T_MR_TMSIS_AID_CAT	CHAR	2.00	0.00
CDE_MEDICAID_BOE	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	2.00	0.00
CDE_MEDICAID_STATE	T_CLM_PHRM_HDR	CHAR	2.00	0.00

CDE_MEDICARE	T_CA_RECIP_KEY	CHAR	1.00	0.00
CDE_MEDICARE	T_DS_CLM_CNT_PAID_DTE	CHAR	1.00	0.00
CDE_MEDICARE	T_DS_CLM_CNT_SVC_DTE	CHAR	1.00	0.00
CDE_MEDICARE	T_DS_RECIP_AGGR_CNT	CHAR	1.00	0.00
CDE_MEDICARE	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_MEDICARE_A_B	T_RE_CMS_MMA_RESPONSE	CHAR	1.00	0.00
CDE_MEDICARE_D	T_RE_CMS_MMA_RESPONSE	CHAR	1.00	0.00
CDE_MEDICARE_ID_TYPE	T_RE_HIB	CHAR	1.00	0.00
CDE_MEDICARE_IND	T_MR_ELIG_SAK	CHAR	1.00	0.00
CDE_MEDICARE_REIM_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_MEDICARE_REIM_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_MEDICARE_REIM_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_MEDICARE_REIM_TYPE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_MED_ASSIGNMENT	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00

CDE_MED_ASSIGNMENT	T_PHYS_HDR_KEY	CHAR	1.00	0.00
CDE_MED_ASSIGNMENT	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
CDE_MED_REC_NUM	T_CA_MATERNITY_CARE	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_CLM_MAT_CARE_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_DENY_PHYS_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_DENY_UB92_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_DS_HM_HEADER	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_PD_PHYS_HDR	VARCHAR2	30.00	0.00
CDE_MED_REC_NUM	T_PD_PHYS_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_PD_UB92_HDR	VARCHAR2	30.00	0.00
CDE_MED_REC_NUM	T_PD_UB92_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_SUSP_PHYS_HDR	VARCHAR2	50.00	0.00
CDE_MED_REC_NUM	T_SUSP_UB92_HDR	VARCHAR2	50.00	0.00
CDE_MED_SUPPORT	T_TPL_AC_PARENT_MED_XREF	CHAR	1.00	0.00
CDE_MED_SUPPORT	T_TPL_CDE_MED_SUPPORT	CHAR	1.00	0.00
CDE_MESSAGE	T_SYS_ERR_MSG	NUMBER	9.00	0.00
CDE_METHOD	T_STOP_LOSS_PARMS	CHAR	1.00	0.00
CDE_MFP_LIVES_WITH_FAM	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	1.00	0.00
CDE_MFP_PART_ENDED	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	2.00	0.00
CDE_MFP_QUAL_INSTITUTE	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	2.00	0.00
CDE_MFP_QUAL_RESIDENCE	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	2.00	0.00
CDE_MFP_REINSTITUTE_RSN	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	2.00	0.00

CDE_MGD_PLAN	T_DS_RECIP_AGGR_CNT	CHAR	5.00	0.00
CDE_MIA_REMARK_1	T_CLM_MIA	VARCHAR2	50.00	0.00
CDE_MIA_REMARK_2	T_CLM_MIA	VARCHAR2	50.00	0.00
CDE_MIA_REMARK_3	T_CLM_MIA	VARCHAR2	50.00	0.00
CDE_MIA_REMARK_4	T_CLM_MIA	VARCHAR2	50.00	0.00
CDE_MIA_REMARK_5	T_CLM_MIA	VARCHAR2	50.00	0.00
CDE_MILITARY_BRANCH	T_TPL_AC_PARENT	CHAR	1.00	0.00
CDE_MILITARY_STATUS	T_TPL_AC_PARENT	CHAR	1.00	0.00
CDE_MIME_TYPE	T_DOWNLOAD	CHAR	4.00	0.00
CDE_MIME_TYPE	T_MIME_TYPE	CHAR	4.00	0.00
CDE_MIN_DOSE_UNIT	T_PEDI_DOSE	CHAR	2.00	0.00
CDE_MIN_DOSE_UNITS	T_LOW_DOSE	CHAR	3.00	0.00
CDE_MIN_DOSE_UNITS	T_LOW_DOSE_LOG	CHAR	3.00	0.00
CDE_MIN_UNIT_FORM	T_LOW_DOSE	CHAR	2.00	0.00
CDE_MIN_UNIT_FORM	T_LOW_DOSE_LOG	CHAR	2.00	0.00
CDE_MIN_UNIT_FORM	T_PEDI_DOSE	CHAR	2.00	0.00
CDE_MISC	T_CLM_MISC	VARCHAR2	11.00	0.00
CDE_MISMATCH_REASON	T_IRS_B_NOTICE_AL	CHAR	1.00	0.00
CDE_MISMATCH_REASON	T_IRS_B_NOTICE_WI	CHAR	1.00	0.00
CDE_MI_VERBAL_DTRM	T_PS_CDE_MI_DTRM	CHAR	3.00	0.00
CDE_MI_VERBAL_DTRM	T_PS_DETERMINATION	CHAR	3.00	0.00

CDE_MI_VERBAL_DTRM	T_PS_RESIDENT_RVW	CHAR	3.00	0.00
CDE_MI_VRBL_REC_BY	T_PS_DETERMINATION	CHAR	3.00	0.00
CDE_MME_ALERT_ID	T_MME_DAILY_MME_ALERTIN G	NUMBER	8.00	0.00
CDE_MOA_REMARK_1	T_CLM_MOA	VARCHAR2	50.00	0.00
CDE_MOA_REMARK_2	T_CLM_MOA	VARCHAR2	50.00	0.00
CDE_MOA_REMARK_3	T_CLM_MOA	VARCHAR2	50.00	0.00
CDE_MOA_REMARK_4	T_CLM_MOA	VARCHAR2	50.00	0.00
CDE_MOA_REMARK_5	T_CLM_MOA	VARCHAR2	50.00	0.00
CDE_MOD	T_AUDIT_PROC	CHAR	2.00	0.00
CDE_MOD	T_AUDIT_PROC_MIRROR	CHAR	2.00	0.00
CDE_MOD1	T_LS_LVL1_PRICING	CHAR	2.00	0.00
CDE_MOD1	T_LS_LVL3_PRICING	CHAR	2.00	0.00
CDE_MOD2	T_LS_LVL1_PRICING	CHAR	2.00	0.00
CDE_MOD2	T_LS_LVL3_PRICING	CHAR	2.00	0.00
CDE_MOD3	T_LS_LVL1_PRICING	CHAR	2.00	0.00
CDE_MOD3	T_LS_LVL3_PRICING	CHAR	2.00	0.00
CDE_MOD4	T_LS_LVL1_PRICING	CHAR	2.00	0.00
CDE_MOD4	T_LS_LVL3_PRICING	CHAR	2.00	0.00
CDE_MODIFIER	T_CLM_MODIFIER	CHAR	2.00	0.00
CDE_MODIFIER	T_CLM_PYR_MOD	CHAR	2.00	0.00
CDE_MODIFIER_1	T_CA_HDR_DTL	CHAR	2.00	0.00
CDE_MODIFIER_1	T_WEB_CLAIM_DTL	CHAR	2.00	0.00
CDE_MODIFIER_1	T_WEB_PA_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_ADJMS_MODIF	CHAR	2.00	0.00
CDE_MODIFIER_2	T_CA_HDR_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_REF_UCC	CHAR	2.00	0.00
CDE_MODIFIER_2	T_RE_EPS_HIST_EXT	CHAR	2.00	0.00

CDE_MODIFIER_2	T_SUR_RQST_PROCMOD	CHAR	2.00	0.00
CDE_MODIFIER_2	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_WEB_CLAIM_DTL	CHAR	2.00	0.00
CDE_MODIFIER_2	T_WEB_PA_DTL	CHAR	2.00	0.00
CDE_MODIFIER_3	T_ADJMS_MODIF	CHAR	2.00	0.00
CDE_MODIFIER_3	T_CA_HDR_DTL	CHAR	2.00	0.00
CDE_MODIFIER_3	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_3	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_3	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_3	T_REF_UCC	CHAR	2.00	0.00
CDE_MODIFIER_3	T_RE_EPS_HIST_EXT	CHAR	2.00	0.00
CDE_MODIFIER_3	T_SUR_RQST_PROCMOD	CHAR	2.00	0.00
CDE_MODIFIER_3	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_4	T_ADJMS_MODIF	CHAR	2.00	0.00
CDE_MODIFIER_4	T_CA_HDR_DTL	CHAR	2.00	0.00
CDE_MODIFIER_4	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_4	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_4	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_MODIFIER_4	T_REF_UCC	CHAR	2.00	0.00
CDE_MODIFIER_4	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_MOD_1	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_MOD_1	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_MOD_2	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_MOD_2	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_MOD_3	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_MOD_3	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_MOD_4	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_MOD_4	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_MOD_EDIT	T_PROC_MODIFIER	CHAR	1.00	0.00
CDE_MOD_FROM	T_MODIFIER_RSTN	CHAR	2.00	0.00

CDE_MOD_FROM	T_MOD_GROUP	CHAR	2.00	0.00
CDE_MOD_IND	T_REF_CCI	CHAR	1.00	0.00
CDE_MOD_IND	T_REF_CCI_OVERRIDE	CHAR	1.00	0.00
CDE_MOD_TO	T_MODIFIER_RSTN	CHAR	2.00	0.00
CDE_MOD_TO	T_MOD_GROUP	CHAR	2.00	0.00
CDE_MOVE_TYPE	T_PR_ADR_CASS	CHAR	1.00	0.00
CDE_MOVE_TYPE	T_RE_ADR_CASS	CHAR	1.00	0.00
CDE_MR_VERBAL_DTRM	T_PS_CDE_MR_DTRM	CHAR	4.00	0.00
CDE_MR_VERBAL_DTRM	T_PS_DETERMINATION	CHAR	4.00	0.00
CDE_MR_VERBAL_DTRM	T_PS_RESIDENT_RVW	CHAR	4.00	0.00
CDE_MR_VRB_RCVD_BY	T_PS_DETERMINATION	CHAR	3.00	0.00
CDE_MSG_TYPE	T_ERM_ENT	CHAR	4.00	0.00
CDE_MSG_TYPE	T_NCPDP_P4_LOG	CHAR	1.00	0.00
CDE_MSP	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_MSP_COUNTY	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_MSP_DO	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_MSP_PGM	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_MSP_REVIEWER	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_MSP_STATUS	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_MULTI_SURG	T_RBRVS	CHAR	1.00	0.00
CDE_MULTI_SURG	T_RBRVS_UPDATE	CHAR	1.00	0.00

CDE_MW_ACTION	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_NAME_TYPE	T_WEB_PROV	CHAR	1.00	0.00
CDE_NATL_HC_ENTITY_ID_TYPE	T_TMSIS_MCR008_NATL_HC_ENT	VARCHAR2	1.00	0.00
CDE_NATL_HC_ENTITY_TYPE	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	1.00	0.00
CDE_NATL_HC_ENTITY_TYPE	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	1.00	0.00
CDE_NCOA_ACTION	T_PR_ADR_CASS	CHAR	1.00	0.00
CDE_NCOA_ACTION	T_RE_ADR_CASS	CHAR	1.00	0.00
CDE_NCOA_FOOTNOTE	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_NCOA_FOOTNOTE	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_ALERT_DISP	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_CA_DRUG	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_DRUG_SCREEN	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_DRUG_SCREEN	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_NCPDP_CONFLICT	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_PDUR_FINAL_CLM	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_PDUR_FINAL_WARN	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_PDUR_RLHX	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_PRODUR_WARN	CHAR	2.00	0.00
CDE_NCPDP_CONFLICT	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_NDC	T_ADJMS_DRUG	CHAR	11.00	0.00
CDE_NDC	T_CA_DRUG	CHAR	11.00	0.00
CDE_NDC	T_CA_HDR_DTL	CHAR	11.00	0.00
CDE_NDC	T_CLM_FCA	CHARACTER	11.00	0.00
CDE_NDC	T_DRUG	CHAR	11.00	0.00
CDE_NDC	T_DRUG_DN	CHAR	11.00	0.00

CDE_NDC	T_DRUG_EXCEPTION_AL	CHAR	11.00	0.00
CDE_NDC	T_DR_CMS_TAPE	CHAR	11.00	0.00
CDE_NDC	T_DR_CMS_UROA	CHAR	11.00	0.00
CDE_NDC	T_DR_DISPUTE_RESO	CHAR	11.00	0.00
CDE_NDC	T_DR_TMP_SUPP_RATES	CHAR	11.00	0.00
CDE_NDC	T_LS_DRUG_AWP_PRICING	CHAR	11.00	0.00
CDE_NDC	T_LS_DRUG_MAC_PRICING	CHAR	11.00	0.00
CDE_NDC	T_LS_DRUG_MASTER	CHAR	11.00	0.00
CDE_NDC	T_LS_PHARMACY_CLAIMS	CHAR	11.00	0.00
CDE_NDC	T_LS_PHARMACY_OTHER	CHAR	11.00	0.00
CDE_NDC	T_LS_SUMMARY_NDC	CHAR	11.00	0.00
CDE_NDC	T_MB_HEDIS_DRUG	CHAR	11.00	0.00
CDE_NDC	T_NDC_APPL	CHAR	11.00	0.00
CDE_NDC	T_NDC_NDA_ANDA	CHAR	11.00	0.00
CDE_NDC	T_PHRM_DTL_KEYS	CHAR	11.00	0.00
CDE_NDC	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_NDC	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_NDC	T_TMSIS_COT003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_NDC	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	12.00	0.00

CDE_NDC_FORMAT	T_DRUG	CHAR	1.00	0.00
CDE_NDC_FORMAT	T_DRUG_DN	CHAR	1.00	0.00
CDE_NDC_FROM	T_AUDIT_NDC_XREF	CHAR	11.00	0.00
CDE_NDC_FROM	T_COV_NDC_XREF	CHAR	11.00	0.00
CDE_NDC_ID	T_CLM_NDC_DTL	VARCHAR2	48.00	0.00
CDE_NDC_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_NDC_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_NDC_OR_JCODE	T_DR_RECOUP_LTR_ICN	CHAR	11.00	0.00
CDE_NDC_STATUS	T_DENY_PHRM_DTL	CHAR	1.00	0.00
CDE_NDC_STATUS	T_PD_PHARM_DTL	CHAR	1.00	0.00
CDE_NDC_STATUS	T_SUSP_PHRM_DTL	CHAR	1.00	0.00
CDE_NDC_SUB	T_PHRM_DTL_KEYS	CHAR	11.00	0.00
CDE_NDC_TO	T_AUDIT_NDC_XREF	CHAR	11.00	0.00
CDE_NDC_TO	T_COV_NDC_XREF	CHAR	11.00	0.00
CDE_NDC_UNIT_OF_MEASURE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_NDC_UNIT_OF_MEASURE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_NDC_UNIT_OF_MEASURE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_NENTL_A_STAT	T_RE_EDB	CHAR	1.00	0.00
CDE_NENTL_B_STAT	T_RE_EDB	CHAR	1.00	0.00
CDE_NF_DISP	T_PS_CDE_NF_DISP	CHAR	2.00	0.00
CDE_NF_DISP	T_PS_DETERMINATION	CHAR	2.00	0.00
CDE_NF_DISP	T_PS_LTR_LEGEND	CHAR	2.00	0.00

CDE_NF_DISP	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_NH_RESIDENT_STATUS	T_PA_DTL	CHAR	1.00	0.00
CDE_NONSPEC	T_PROC_ICD9_LIM	CHAR	1.00	0.00
CDE_NOTE	T_CLM_NTE	VARCHAR2	3.00	0.00
CDE_NOTE_TYPE	T_CALL_NOTES	CHAR	3.00	0.00
CDE_NOTE_TYPE	T_CDE_NOTE_TYPE	CHAR	3.00	0.00
CDE_NOTICE_TYPE	T_IRS_B_NOTICE_AL	CHAR	1.00	0.00
CDE_NOTICE_TYPE	T_IRS_B_NOTICE_WI	CHAR	1.00	0.00
CDE_NOTIFICATION_TYPE	T_ANALYST	CHAR	1.00	0.00
CDE_NOTIFICATION_TYPE	T_CLERK_PROFILE	CHAR	1.00	0.00
CDE_NO_ISSUE_ACTIVE	T_FIN_NO_ISSUE	CHAR	1.00	0.00
CDE_NPI	T_TP	VARCHAR2	50.00	0.00
CDE_NPT_TYPE	T_NDDF_PRICE	CHAR	2.00	0.00
CDE_NPT_TYPE	T_NDDF_PRICE_TYPE	CHAR	2.00	0.00
CDE_OBC	T_CDE_OBC	CHAR	2.00	0.00
CDE_OBC3	T_DRUG	CHAR	3.00	0.00
CDE_OBC3	T_DRUG_DN	CHAR	3.00	0.00
CDE_OCCUR	T_FIN_SCHEDULE	CHAR	1.00	0.00
CDE_OCCUR	T_FIN_SCHED_OVERRIDE	CHAR	1.00	0.00
CDE_OCCURRENCE	T_CA_OCCUR	CHAR	2.00	0.00
CDE_OCCURRENCE	T_COV_BNFT_OCCURR	CHAR	2.00	0.00
CDE_OCCURRENCE	T_OCCURRENCE	CHAR	2.00	0.00

CDE_OCCURRENCE	T_OVERHEAD_FEE	CHAR	2.00	0.00
CDE_OCCURRENCE	T_PAY_BNFT_OCCURR	CHAR	2.00	0.00
CDE_OCCURRENCE	T_TMSIS_CIP_OCC_CDE	VARCHAR2	2.00	0.00
CDE_OCCURRENCE	T_TMSIS_CLT_OCC_CDE	VARCHAR2	2.00	0.00
CDE_OCCURRENCE	T_TMSIS_COT_OCC_CDE	VARCHAR2	2.00	0.00
CDE_OCCURRENCE	T_UB92_HDR_OCC	CHAR	2.00	0.00
CDE_OCCUR_1	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_2	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_3	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_4	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_5	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_6	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_7	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OCCUR_8	T_CA_OCCUR_DN	CHAR	2.00	0.00
CDE_OFFICE	T_COUNTY_OFFICE	CHAR	1.00	0.00
CDE_OFFICE	T_RE_BASE	CHAR	1.00	0.00
CDE_OFFICE	T_RE_BASE_DN	CHAR	1.00	0.00
CDE_OFFICE	T_RE_ID_CRD_ISS	CHAR	1.00	0.00
CDE_OFFICE	T_RE_PREV_CTY	CHAR	1.00	0.00
CDE_OFFICE_SRV	T_RE_HIST_ERR	CHAR	1.00	0.00
CDE_OFFICE_SRV	T_RE_HIST_LOG	CHAR	1.00	0.00
CDE_OFFICE_SRV	T_RE_PS2_ERR	CHAR	1.00	0.00
CDE_OFFICE_SRV	T_RE_PS2_LOG	CHAR	1.00	0.00
CDE_OFFICE_SRV_PS2	T_RE_PS2_DUPE	CHAR	1.00	0.00
CDE_OFF_STATUS	T_RE_OFF_STAT	CHAR	2.00	0.00
CDE_OOS	T_PR_OUT_OF_STATE	CHAR	1.00	0.00
CDE_OPER_AUTH	T_MR_TMSIS_BEN_PLAN	CHAR	2.00	0.00
CDE_OPER_AUTH	T_TMSIS_MCR005_OPER_AUTH	VARCHAR2	2.00	0.00
CDE_OPER_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00

CDE_OPIOID	T_CA_DRUG	CHAR	1.00	0.00
CDE_OPIOID	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_OPIOID	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
CDE_OPIOID	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_OPIOID	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
CDE_OPIOID_BASE_ING_ID	T_MME_MME_RANGE_FACTOR	NUMBER	8.00	0.00
CDE_OPIOID_BASE_ING_ID	T_MME_OPIOID_BASE_ING_DESC	NUMBER	8.00	0.00
CDE_OPIOID_BASE_ING_ID	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	8.00	0.00
CDE_OPIOID_BASE_ING_ID	T_MME_OPIOID_RTD_ING_MME	NUMBER	8.00	0.00
CDE_OPIOID_STRENGTH_UOM	T_MME_OPIOID_CF_MME_FACTOR	VARCHAR2	255.00	0.00
CDE_OPIOID_STRENGTH_UOM	T_MME_OPIOID_RTD_ING_MME	VARCHAR2	255.00	0.00
CDE_OP_AMT_PAID_QUAL	T_PHRM_COB	CHAR	2.00	0.00
CDE_OP_COV_TYPE	T_PHRM_COB_XREF	CHAR	2.00	0.00
CDE_ORGANIZ	T_CA_DRUG	CHAR	1.00	0.00
CDE_ORGANIZ	T_MR_TMSIS_CDE_ORGANIZ	CHAR	1.00	0.00
CDE_ORGANIZ	T_PR_SVC_LOC	CHAR	1.00	0.00
CDE_ORGANIZ	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_ORGANIZ	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
CDE_ORIGIN	T_ORIGIN_CODE	CHAR	2.00	0.00

CDE_ORIGIN	T_TPL_271_SUBSCRIBER	CHAR	2.00	0.00
CDE_ORIGIN	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_ORIGIN	T_TPL_RESOURCE	CHAR	2.00	0.00
CDE_ORIG_TXN_ID	T_EDI_INTERCHANGE	VARCHAR2	50.00	0.00
CDE_OTHER_COVERAGE	T_NCPDP_OTH_COV	CHAR	2.00	0.00
CDE_OTHER_COVERAGE	T_PHRM_HDR_KEYS	CHAR	2.00	0.00
CDE_OTHER_FREQ	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_OTHER_SOURCE	T_DS_RECIP_SOBRA_FAMILY	CHAR	2.00	0.00
CDE_OTHER_SUB_GENDER	T_DNTL_OTH_PYR_HDR	CHAR	1.00	0.00
CDE_OTHER_SUB_GENDER	T_INST_OTH_PYR_HDR	CHAR	1.00	0.00
CDE_OTHER_SUB_GENDER	T_PROF_OTH_PYR_HDR	CHAR	1.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_COT002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	3.00	0.00
CDE_OTHER_TPL_COLLECT	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_OUTCOME	T_ERR_DISP_LINE	CHAR	1.00	0.00
CDE_OUTLIER	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_OUTLIER_TYPE	T_CA_UB92	CHAR	1.00	0.00
CDE_OUTLIER_TYPE	T_UB92_HDR_INP	CHAR	1.00	0.00

CDE_OWNER	T_TPL_AR_HEALTH	CHAR	1.00	0.00
CDE_OWNER	T_TPL_AR_HEALTH_XXX	CHAR	1.00	0.00
CDE_OWNERSHIP	T_MR_TMSIS_CDE_ORGANIZ	CHAR	2.00	0.00
CDE_OWNERSHIP	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	2.00	0.00
CDE_OWNERSHIP_TYPE	T_PR_ENRL_PROV	CHAR	1.00	0.00
CDE_OXY_CERT_TYPE	T_CLM_CR5	CHAR	1.00	0.00
CDE_OXY_TEST_COND	T_CLM_CR5	CHAR	1.00	0.00
CDE_OXY_TEST_FIND	T_CLM_CR5	CHAR	1.00	0.00
CDE_OXY_TEST_FIND2	T_CLM_CR5	CHAR	1.00	0.00
CDE_OXY_TEST_FIND3	T_CLM_CR5	CHAR	1.00	0.00
CDE_PAID_DAY	T_RE_INCOME_NEW	CHAR	1.00	0.00
CDE_PAID_FREQ	T_RE_EXPENSE	CHAR	1.00	0.00
CDE_PAID_FREQ	T_RE_INCOME_NEW	CHAR	1.00	0.00
CDE_PAID_LEVEL	T_CM_PAID_LEVEL	CHAR	1.00	0.00
CDE_PANEL_HOLD_BY	T_MC_PMP_PANEL_RESTRICT	CHAR	1.00	0.00
CDE_PARENT	T_ADJ_RULES	CHAR	20.00	0.00
CDE_PARM_TYPE	T_CDE_EDIT_PARM_TYPE	CHAR	10.00	0.00
CDE_PARM_TYPE	T_EDIT_PARMS	CHAR	10.00	0.00
CDE_PART	T_MM_PART	CHAR	1.00	0.00
CDE_PART	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_PARTD_SRC	T_RE_MEDICARE_D	CHAR	1.00	0.00
CDE_PARTITION_ID	T_ADJ_MASS_CLAIM	CHAR	2.00	0.00
CDE_PARTITION_ID	T_HIST_DIRECTORY	CHAR	2.00	0.00

CDE_PARTITION_ID	T_RETRO_SUMM_RECS	CHAR	2.00	0.00
CDE_PARTY_ID	T_PARTY_IDENTIFIER	VARCHAR2	80.00	0.00
CDE_PART_A_BYN_ACCRETION	T_RE_PART_A_ACCRETION	NUMBER	4.00	0.00
CDE_PART_A_BYN_DELETION	T_RE_PART_A_ACCRETION	NUMBER	4.00	0.00
CDE_PART_B_BYN_ACCRETION	T_RE_PART_B_ACCRETION	NUMBER	4.00	0.00
CDE_PART_B_BYN_DELETION	T_RE_PART_B_ACCRETION	NUMBER	4.00	0.00
CDE_PART_ENDED	T_DS_RECIP_MFP	CHAR	2.00	0.00
CDE_PART_IND	T_MM_PART_IND	CHAR	1.00	0.00
CDE_PART_SEQ	T_MM_PART_SEQ	CHAR	1.00	0.00
CDE_PART_SEQ	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_PASRR	T_PS_CDE_PASRR	CHAR	3.00	0.00
CDE_PASRR	T_PS_DETERMINATION	CHAR	3.00	0.00
CDE_PASRR	T_PS_LTR_LEGEND	CHAR	3.00	0.00
CDE_PASRR	T_PS_RESIDENT_RVW	CHAR	3.00	0.00
CDE_PATIENT_LOCATION	T_PHRM_HDR_KEYS	CHAR	2.00	0.00

CDE_PATIENT_RESIDENCE	T_CLM_PHRM_HDR	CHAR	2.00	0.00
CDE_PATIENT_SIGNATURE	T_PHYS_HDR_KEY	CHAR	1.00	0.00
CDE_PATIENT_STATUS	T_CA_LTC	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_CA_UB92	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_DENY_UB92_HDR	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_DRG_CROSSWALK	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_PATIENT_STAT	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_PD_UB92_HDR	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_RETRO_SUMM_RECS	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_SUSP_UB92_HDR	CHAR	2.00	0.00
CDE_PATIENT_STATUS	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PATIENT_STATUS	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PAT_CONDITION	T_CLM_CR2	CHAR	1.00	0.00
CDE_PAT_SIGN_SOURCE	T_PROF_OTH_PYR_HDR	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_1099_DETAIL	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_ACCT_REC	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_ACCT_REC_DN	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_AR_DISP	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_AR_ONLINE_LETTER	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_CASH_RCPT_DISP	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_CASH_RECEIPT	CHAR	1.00	0.00

CDE_PAYEE_TYPE	T_CHECK	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_CHK_BAN_PAYEE	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_DS_PAYEE_NAM_ADR	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_EXPENDITURE	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_EXPENDITURE	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_EXPENDITURE_DN	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_AR_RQST_REPORT	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_EARNINGS_HIST	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_EARNINGS_YTD	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_EFT_ACCT	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_MAX_RECOUP	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_NONPROV	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PAYEE	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PROCESS_AR	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PROCESS_AR_DISP	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PROCESS_CASH_DISP	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PROCESS_PYMT	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_PYMT_PULL	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_REMIT	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_FIN_SCHED_CRIT_PAYEE	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_LIEN	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_NONPROV_TAX_ID	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_PAY_HOLD_PROV	CHAR	1.00	0.00
CDE_PAYEE_TYPE	T_TPL_TAX_ID	CHAR	1.00	0.00
CDE_PAYER_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_PAYER_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PAYER_RESPONSIB	T_CLM_SBR	CHAR	1.00	0.00
CDE_PAYMENT	T_DR_PAYMENT_RSN	CHAR	2.00	0.00
CDE_PAYMENT	T_DR_PAYMENT_XREF	CHAR	2.00	0.00

CDE_PAYMENT_METHOD	T_FIN_835_TRACK	CHAR	3.00	0.00
CDE_PAYMENT_TYPE	T_CASH_PYMT_TYPE	CHAR	1.00	0.00
CDE_PAYMENT_TYPE	T_CASH_RECEIPT	CHAR	1.00	0.00
CDE_PAYMENT_TYPE	T_FIN_CYCLE	CHAR	1.00	0.00
CDE_PAY_CND_IE	T_PAY_CND_AXIS_RANGE	CHAR	1.00	0.00
CDE_PAY_DAY_CARE_FREQ	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_PAY_FREQ	T_DS_RECIP_DO_HLTH_INS	CHAR	1.00	0.00
CDE_PAY_MOD_IE	T_PAY_MOD_AXIS_RANGE	CHAR	1.00	0.00
CDE_PAY_OCC_IE	T_PAY_OCC_AXIS_RANGE	CHAR	1.00	0.00
CDE_PAY_RECOUP	T_CAP_REASON	CHAR	1.00	0.00
CDE_PAY_TYPE	T_CHECK	CHAR	1.00	0.00
CDE_PAY_TYPE	T_FIN_PROCESS_PYMT	CHAR	1.00	0.00
CDE_PAY_TYPE	T_PAY_HOLD_PAY_TYP	CHAR	1.00	0.00
CDE_PA_ASSIGN	T_PA_ASSIGN_CODE	CHAR	2.00	0.00
CDE_PA_ASSIGN	T_PA_PAUTH	CHAR	2.00	0.00
CDE_PA_GRP_ASSIGN	T_PA_ASSIGN_CODE	CHAR	2.00	0.00
CDE_PA_PSY_DIAG	T_PA_1261A_PSY	CHAR	2.00	0.00
CDE_PA_PSY_DIAG	T_PA_PSY_DIAG_CODE	CHAR	2.00	0.00
CDE_PA_STATUS	T_PA_LINEITEM_STAT	CHAR	1.00	0.00
CDE_PA_STATUS	T_PA_LINE_ITEM	CHAR	1.00	0.00
CDE_PA_STATUS	T_WEB_PA_DTL	CHAR	1.00	0.00
CDE_PA_STATUS	T_WEB_PA_HDR	CHAR	1.00	0.00
CDE_PA_STATUS	T_WEB_PA_STATUS	CHAR	1.00	0.00
CDE_PA_TYPE	T_DENY_PHRM_HDR	CHAR	2.00	0.00

CDE_PA_TYPE	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_PA_TYPE	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_PA_TYPE	T_WEB_PA_DTL	CHAR	1.00	0.00
CDE_PA_TYPE	T_WEB_PA_TYPE	CHAR	1.00	0.00
CDE_PBEN_CRVG_TYPE	T_RE_EDB	CHAR	2.00	0.00
CDE_PCCM_EXEMPT	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_PC_ADDR_CHG	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_HST1	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_HST2	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_RET_HST1	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_RET_HST2	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_RSN_HST1	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PC_RSN_HST2	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PDP_TYPE	T_RE_CDE_PDP_TYPE	CHAR	2.00	0.00
CDE_PDP_TYPE	T_RE_PARTD_PDP_CARRIER	CHAR	2.00	0.00
CDE_PDP_TYPE	T_RE_PARTD_PDP_PLAN	CHAR	2.00	0.00
CDE_PD_MNEMONIC	T_PKG_DESC_MDX	CHAR	10.00	0.00
CDE_PEER_GROUP	T_PEER_GROUP	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_CAPT	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_DRGR	CHAR	1.00	0.00

CDE_PEER_GROUP	T_PEER_GRP_DRGR_OLD	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_EDUC	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_FACT	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_INP_LOC	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PEER_GRP_RTIO	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PR_PEER_GROUP	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PR_SVC_LOC	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_PEER_GROUP	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
CDE_PEER_GRP	T_PF_INPAT_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_INPAT_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_NHOME_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_NHOME_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_OUTPAT_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_OUTPAT_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PHARM_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PHARM_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PROF_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PROF_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PRREF_RE_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_PRREF_RP_TOT_Q	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_RECIP_CMPR	NUMBER	4.00	0.00
CDE_PEER_GRP	T_PF_RE_CMPR_Q	NUMBER	4.00	0.00
CDE_PERF_PR_SPC_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PERF_PR_TYP_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PERF_SVC_LOC	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_PERF_SVC_LOC	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_PERIOD_TYPE	T_FIN_PERIOD	CHAR	4.00	0.00

CDE_PERIOD_TYPE	T_FIN_PERIOD_TYPE	CHAR	4.00	0.00
CDE_PER_DOSAGE_UNIT	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	34.00	17.00
CDE_PGM_COV	T_FEE_SCHEDULE	CHAR	1.00	0.00
CDE_PGM_GROUP	T_MC_PGM_GROUP	CHAR	6.00	0.00
CDE_PGM_GROUP	T_MC_PGM_GROUP_XREF	CHAR	6.00	0.00
CDE_PGM_HEALTH	T_ADJMS_MEDAST	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_CA_CLAIM_KEY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_DS_CLM_CNT_PAID_DTE	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_DS_CLM_CNT_SVC_DTE	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_DS_RECIP_AGGR_CNT	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_HIPAA_BP_XREF	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MB_DEN_ICN	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MB_DEN_RECIP	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MB_NUM_ICN	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MB_NUM_RECIP	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_ELIG_SAK	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_ERROR	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_ERROR_DTL	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_ERROR_KY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_LTC	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_LTC_REV	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_OP_PERFORM	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_OP_PERFORM_DTL	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_POS	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_POS_RE	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_DENIED	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_PERFORM	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_PERFORM_DTL	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_PERFORM_KY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_RE	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_PROV_SUSP	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_RE	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_RECIP	CHAR	5.00	0.00

CDE_PGM_HEALTH	T_MR_RECIP_KY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_RECIP_RANK	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_RE_CNTY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_RE_KY	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_MR_XOVER	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_PUB_HLTH_PGM	CHAR	5.00	0.00
CDE_PGM_HEALTH	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_PGM_HEALTH_LI	T_CDE_PGM_HEALTH_LI	CHAR	5.00	0.00
CDE_PGM_HEALTH_LI	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_PGM_PA	T_FEE_SCHEDULE	CHAR	1.00	0.00
CDE_PGM_STATUS	T_CAPITATION_ADJ_STATE	CHAR	2.00	0.00
CDE_PGM_STATUS	T_CAPITATION_HIST_STATE	CHAR	2.00	0.00
CDE_PGM_STATUS	T_MC_CDE_AID_ENROLL	CHAR	2.00	0.00
CDE_PGM_STATUS	T_MC_PGM_STATUS_GRP_XREF	CHAR	2.00	0.00
CDE_PGM_STATUS	T_MR_MSIS_AID_KY	CHAR	2.00	0.00
CDE_PGM_STATUS	T_MR_RECIP_KY	CHAR	2.00	0.00
CDE_PGM_STATUS	T_MR_RE_KY	CHAR	2.00	0.00
CDE_PGM_STATUS	T_RE_PGM_STATUS_CODE	CHAR	2.00	0.00
CDE_PHONE	T_CDE_PHONE	CHAR	2.00	0.00
CDE_PHONE_TYPE	T_PR_ENRL_LOC_PHONE	CHAR	2.00	0.00
CDE_PHONE_TYPE	T_PS_CDE_PHONE_TYP	CHAR	1.00	0.00
CDE_PHONE_TYPE	T_PS_CNT_PHONE	CHAR	1.00	0.00
CDE_PHONE_TYPE	T_PS_PHONE_NUMBER	CHAR	1.00	0.00
CDE_PHRM_SVC_TYPE	T_CLM_PHRM_HDR	CHAR	2.00	0.00
CDE_PHS_TYPE	T_PHS_ENTITY	CHAR	9.00	0.00
CDE_PHS_TYPE	T_PHS_PROVIDER	CHAR	9.00	0.00
CDE_PICKUP_TIME	T_MPHX_MISC	CHAR	4.00	0.00
CDE_PKG_DESC	T_PKG_DESC_MDX	NUMBER	3.00	0.00

CDE_PLACE_OF_SERVICE	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_DENY_PHYS_HDR	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_PD_PHYS_HDR	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_PHRM_HDR_KEYS	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_SUSP_PHYS_HDR	CHAR	2.00	0.00
CDE_PLACE_OF_SERVICE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PLAN	T_CDE_PLAN_CDE	CHAR	3.00	0.00
CDE_PLAN	T_LS_LVL3_PRICING	CHAR	3.00	0.00
CDE_PLAN	T_MC_PLAN_COUNTY	CHAR	1.00	0.00
CDE_PLAN_DISTRICT	T_MC_PLAN_COUNTY	CHAR	1.00	0.00
CDE_PLAN_TYPE	T_HIPP_RESOURCE	CHAR	1.00	0.00
CDE_PLAN_TYPE	T_REF_DISTRICT_PLAN	CHAR	5.00	0.00
CDE_PLAN_TYPE	T_TPL_CDE_PLAN_TYPE	CHAR	1.00	0.00
CDE_PLAST_CARD	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PLAST_CARD_RET	T_DS_RECIP_CORE	CHAR	1.00	0.00

CDE_PLAST_CARD_RSN	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PLOG_STATUS	T_PLOG_HEADER	CHAR	2.00	0.00
CDE_PLOG_STATUS	T_PLOG_VERSION	CHAR	2.00	0.00
CDE_PMP_FOCUS	T_MC_PMP_FOCUS	CHAR	3.00	0.00
CDE_POLICY	T_ERR_RESO_POLICY	VARCHAR2	80.00	0.00
CDE_POLICY_OWNER	T_MR_TMSIS_TPL_REL_TYPE	CHAR	2.00	0.00
CDE_POLICY_OWNER	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	2.00	0.00
CDE_POLICY_OWNER_SSN	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	9.00	0.00
CDE_POLICY_OWNR	T_HIPP_RESOURCE	CHAR	1.00	0.00
CDE_POLICY_OWNR	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_POLICY_PREFIX	T_TPL_CDE_POLICY_PREFIX	CHAR	3.00	0.00
CDE_POLICY_TYPE	T_POLICY_TYPE	CHAR	1.00	0.00
CDE_POLICY_TYPE	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_PORT	T_CDE_PORT	CHAR	1.00	0.00
CDE_PORT	T_PORT	CHAR	1.00	0.00
CDE_POS	T_CA_CLAIM_KEY	CHAR	2.00	0.00
CDE_POS	T_CC_HIST_ADJUST	CHAR	2.00	0.00
CDE_POS	T_COV_BNFT_POS	CHAR	2.00	0.00
CDE_POS	T_DENY_DNTL_HDR	CHAR	2.00	0.00
CDE_POS	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_POS	T_DIAG_POS_LIM	CHAR	2.00	0.00
CDE_POS	T_LIMITPARM_POS	CHAR	2.00	0.00
CDE_POS	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_POS	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_POS	T_MR_POS	CHAR	2.00	0.00
CDE_POS	T_MR_POS_RE	CHAR	2.00	0.00
CDE_POS	T_PAY_BNFT_POS	CHAR	2.00	0.00
CDE_POS	T_PD_DNTL_HDR	CHAR	2.00	0.00
CDE_POS	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_POS	T_PLACE_OF_SERVICE	CHAR	2.00	0.00
CDE_POS	T_POS_TYP_BILL	CHAR	2.00	0.00
CDE_POS	T_PR_RST_SVC	CHAR	2.00	0.00
CDE_POS	T_REIMB_POS	CHAR	2.00	0.00

CDE_POS	T_SITE_OF_DIFF	CHAR	2.00	0.00
CDE_POS	T_SUSP_DENTAL_HDR	CHAR	2.00	0.00
CDE_POS	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_POSITION	T_BOARD_POSITION	CHAR	2.00	0.00
CDE_POSITION	T_PR_BOARD_MEM	CHAR	2.00	0.00
CDE_POSTAL_BC	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_POSTAL_BC	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_POS_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_POS_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_POS_SUB	T_DENTAL_HDR_KEYS	CHAR	2.00	0.00
CDE_POS_SUB	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PREF_BILLING	T_PR_ENRL_PROV	CHAR	1.00	0.00
CDE_PREF_BULLETIN	T_PR_ENRL_PROV	CHAR	1.00	0.00
CDE_PREF_COMM	T_PR_ENRL_PROV	CHAR	1.00	0.00
CDE_PREF_LEVEL	T_ERX_ALT_THERAPY	CHAR	2.00	0.00
CDE_PREF_LEVEL	T_ERX_FORM_ALT_THERAPY	CHAR	2.00	0.00
CDE_PREM	T_MR_BUYIN_PREM	CHAR	1.00	0.00
CDE_PREMPAYR_A	T_RE_EDB	CHAR	1.00	0.00
CDE_PREMPAYR_B	T_RE_EDB	CHAR	1.00	0.00
CDE_PRESCRIBER_QUAL	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_PRESCRIBER_QUAL	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_PRESCRIBER_QUAL	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_PRESCRIPTION_NUM	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_PRESCRIPT_ID	T_CLM_NDC_DTL	VARCHAR2	50.00	0.00
CDE_PRESCR_PROV_SPEC	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PRESCR_PROV_TAXON	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_PRESCR_PROV_TYPE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00

CDE_PREV_AEF_STATUS	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_PRICING_ACTION	T_LS_LVL3_PRICING	CHAR	1.00	0.00
CDE_PRIMARY_TYPE	T_FIN_PROCESS_PROV_ID	CHAR	3.00	0.00
CDE_PRIM_LANG	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	3.00	0.00
CDE_PRIM_LANG_ENGL_PROF	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
CDE_PRINT_TYPE	T_ERR_DISP_LINE	CHAR	1.00	0.00
CDE_PRIOR96	T_CLAIM_BDL_NCCD	CHAR	1.00	0.00
CDE_PRIORITY	T_DS_LVX_USER_REQ	CHAR	1.00	0.00
CDE_PRIORITY	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_PRIORITY	T_PROJ_TRACK	CHAR	1.00	0.00
CDE_PRIORITY	T_RE_AID_ELIG	CHAR	2.00	0.00
CDE_PRIORITY	T_RE_AID_ELIG_DN	CHAR	2.00	0.00
CDE_PRIORITY	T_RE_RETRO_ELIG	CHAR	2.00	0.00
CDE_PRIOR_1	T_DS_RECIP_DO_APPL_HIST	CHAR	2.00	0.00
CDE_PRIOR_2	T_DS_RECIP_DO_APPL_HIST	CHAR	2.00	0.00
CDE_PRIOR_DO	T_DS_RECIP_DO_APPL_HIST	CHAR	2.00	0.00
CDE_PRIOR_PGM	T_DS_RECIP_DO_APPL_HIST	CHAR	2.00	0.00
CDE_PRIOR_REVIEWER	T_DS_RECIP_DO_APPL_HIST	CHAR	2.00	0.00
CDE_PRIOR_STATUS	T_DS_RECIP_DO_APPL_HIST	CHAR	1.00	0.00
CDE_PRIV_MC	T_DS_RECIP_CORE	CHAR	1.00	0.00

CDE_PRNT_SUPP_FREQ	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
CDE_PROC	T_ADJMS_MODIF	CHAR	6.00	0.00
CDE_PROC	T_CA_HDR_DTL	CHAR	6.00	0.00
CDE_PROC	T_CA_MATERNITY_CARE	CHAR	6.00	0.00
CDE_PROC	T_CC_HIST_ADJUST	CHAR	6.00	0.00
CDE_PROC	T_CDE_PROC	CHAR	6.00	0.00
CDE_PROC	T_CLM_MAT_CARE_DTL	CHAR	6.00	0.00
CDE_PROC	T_DENTAL_DTL_KEYS	CHAR	6.00	0.00
CDE_PROC	T_DS_DNTL_ICN	CHAR	6.00	0.00
CDE_PROC	T_DS_HM_DETAIL	CHAR	6.00	0.00
CDE_PROC	T_FEE_SCHEDULE	CHAR	5.00	0.00
CDE_PROC	T_LS_LVL3_PRICING	CHAR	5.00	0.00
CDE_PROC	T_MEDB_NONCOVERED	CHAR	5.00	0.00
CDE_PROC	T_MR_TMSIS_IMMUN_TYPE	CHAR	6.00	0.00
CDE_PROC	T_MR_WVR_PROC	CHAR	6.00	0.00
CDE_PROC	T_PA_DTL	VARCHAR2	48.00	0.00
CDE_PROC	T_PHYS_DEXT_KEY	CHAR	6.00	0.00
CDE_PROC	T_PROC	CHAR	6.00	0.00
CDE_PROC	T_PROC_RU_COV_XREF	CHAR	6.00	0.00
CDE_PROC	T_RBRVS_UPDATE	CHAR	5.00	0.00
CDE_PROC	T_REF_CCI_MUE	CHAR	6.00	0.00
CDE_PROC	T_REF_CCI_MUE_OVERRIDE	CHAR	6.00	0.00
CDE_PROC	T_TMSIS_CIP_HDR_PROC	VARCHAR2	8.00	0.00
CDE_PROC	T_TMSIS_COT003_CLM_DTL	VARCHAR2	8.00	0.00
CDE_PROC	T_UB92_DTL_EXT_KEY	CHAR	6.00	0.00
CDE_PROC1	T_UB92_HDR_INP_OLD	CHAR	6.00	0.00

CDE_PROC2	T_UB92_HDR_INP_OLD	CHAR	6.00	0.00
CDE_PROCEDURE	T_CLM_OTH_PYR_DTL	VARCHAR2	48.00	0.00
CDE_PROCESS	T_PR_PHP_ELIG	CHAR	2.00	0.00
CDE_PROCESSED	T_RE_CLM_DELINK	CHAR	1.00	0.00
CDE_PROCESS_LEVEL	T_DR_PROCESS	CHAR	1.00	0.00
CDE_PROCESS_LEVEL	T_DR_PROCESS_INV_XREF	CHAR	1.00	0.00
CDE_PROCESS_RULE	T_FIN_REGION_RULES	CHAR	1.00	0.00
CDE_PROCESS_TYPE	T_EXPENDITURE	CHAR	1.00	0.00
CDE_PROCESS_TYPE	T_EXPENDITURE_DN	CHAR	1.00	0.00
CDE_PROCESS_TYPE	T_FIN_CDE_EFT_STATUS	CHAR	1.00	0.00
CDE_PROC_1	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_10	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_11	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_12	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_13	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_14	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_15	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_16	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_17	T_CA_HDR_DTL_DN	CHAR	6.00	0.00

CDE_PROC_18	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_19	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_2	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_20	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_21	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_22	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_23	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_3	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_4	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_5	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_6	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_7	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_8	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_9	T_CA_HDR_DTL_DN	CHAR	6.00	0.00
CDE_PROC_COL1_MI	T_REF_CCI	CHAR	6.00	0.00
CDE_PROC_COL1_MI	T_REF_CCI_OVERRIDE	CHAR	6.00	0.00
CDE_PROC_COL2_LI	T_REF_CCI	CHAR	6.00	0.00
CDE_PROC_COL2_LI	T_REF_CCI_OVERRIDE	CHAR	6.00	0.00
CDE_PROC_DEPT	T_PROCESS_DEPT	CHAR	1.00	0.00
CDE_PROC_DEPT	T_SYS_LOCATION	CHAR	1.00	0.00
CDE_PROC_FLAG	T_TMSIS_CIP_HDR_PROC	VARCHAR2	2.00	0.00
CDE_PROC_FLAG	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_PROC_FROM	T_AUDT_PROC_XRF	CHAR	5.00	0.00
CDE_PROC_FROM	T_COV_PROC_XREF	CHAR	5.00	0.00
CDE_PROC_FROM	T_DS_DNTL_PROC_GRP	CHAR	6.00	0.00
CDE_PROC_FROM	T_DUPE_AUDIT	CHAR	6.00	0.00
CDE_PROC_FROM	T_TPL_RQST_RPT_SRCH	CHAR	5.00	0.00
CDE_PROC_ICD9	T_CA_ICD9_PROC	VARCHAR2	7.00	0.00

CDE_PROC_ICD9	T_PROC_ICD9	VARCHAR2	7.00	0.00
CDE_PROC_ICD9	T_UB92_HDR_ICD9CM	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_1	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_2	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_3	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_4	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_5	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_ICD9_6	T_CA_ICD9_PROC_DN	VARCHAR2	7.00	0.00
CDE_PROC_IN_EX	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
CDE_PROC_MOD	T_ADJMS_MODIF	CHAR	2.00	0.00
CDE_PROC_MOD	T_AUDT_PROC_XRF	CHAR	2.00	0.00
CDE_PROC_MOD	T_CLM_FCA	CHAR	2.00	0.00
CDE_PROC_MOD	T_COV_BNFT_MOD	CHAR	2.00	0.00
CDE_PROC_MOD	T_DENY_PHYS_DTL	CHAR	2.00	0.00
CDE_PROC_MOD	T_FEE_SCHEDULE	CHAR	2.00	0.00
CDE_PROC_MOD	T_MAX_FEE	CHAR	2.00	0.00
CDE_PROC_MOD	T_MODIFIER	CHAR	2.00	0.00
CDE_PROC_MOD	T_MODIFIER_RSTN	CHAR	2.00	0.00
CDE_PROC_MOD	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_PROC_MOD	T_PAY_BNFT_MOD	CHAR	2.00	0.00
CDE_PROC_MOD	T_PA_DTL	CHAR	2.00	0.00
CDE_PROC_MOD	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_PROC_MOD	T_PD_PHYS_DTL	CHAR	2.00	0.00
CDE_PROC_MOD	T_PREVAILING	CHAR	2.00	0.00
CDE_PROC_MOD	T_PREVAILING_CONV	CHAR	2.00	0.00
CDE_PROC_MOD	T_PROCESS_MOD	CHAR	2.00	0.00
CDE_PROC_MOD	T_PROC_GROUP	CHAR	2.00	0.00
CDE_PROC_MOD	T_PROC_MODIFIER	CHAR	2.00	0.00
CDE_PROC_MOD	T_PR_RST_SVC	CHAR	2.00	0.00
CDE_PROC_MOD	T_RBRVS	CHAR	2.00	0.00

CDE_PROC_MOD	T_RBRVS_UPDATE	CHAR	2.00	0.00
CDE_PROC_MOD	T_REF_CLIA_LC_PROC	CHAR	2.00	0.00
CDE_PROC_MOD	T_REF_UCC	CHAR	2.00	0.00
CDE_PROC_MOD	T_REIMB_MODIFIER	CHAR	2.00	0.00
CDE_PROC_MOD	T_RE_EPS_ABNORMAL	CHAR	2.00	0.00
CDE_PROC_MOD	T_RE_EPS_HIST_EXT	CHAR	2.00	0.00
CDE_PROC_MOD	T_RE_EPS_MOD_XREF	CHAR	2.00	0.00
CDE_PROC_MOD	T_RE_EPS_TRMNT_DRG	CHAR	2.00	0.00
CDE_PROC_MOD	T_RE_EPS_TRNT_DIAG	CHAR	2.00	0.00
CDE_PROC_MOD	T_SPEC_MOD	CHAR	2.00	0.00
CDE_PROC_MOD	T_SUR_RQST_PROCMOD	CHAR	2.00	0.00
CDE_PROC_MOD	T_SUSP_PHYS_DTL	CHAR	2.00	0.00
CDE_PROC_MOD	T_TMSIS_CIP_HDR_PROC	VARCHAR2	2.00	0.00
CDE_PROC_MOD	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_PROC_MOD1	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_PROC_MOD1	T_CC_HIST_ADJUST	CHAR	2.00	0.00
CDE_PROC_MOD1	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_PROC_MOD1_ORIG	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD1_SUB	T_DENTAL_DTL_KEYS	CHAR	2.00	0.00
CDE_PROC_MOD1_SUB	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD1_SUB	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD2	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_PROC_MOD2	T_CC_HIST_ADJUST	CHAR	2.00	0.00
CDE_PROC_MOD2	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_PROC_MOD2	T_MAX_FEE	CHAR	2.00	0.00
CDE_PROC_MOD2	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_PROC_MOD2	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00

CDE_PROC_MOD2_ORIG	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD2_SUB	T_DENTAL_DTL_KEYS	CHAR	2.00	0.00
CDE_PROC_MOD2_SUB	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD2_SUB	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD3	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_PROC_MOD3	T_CC_HIST_ADJUST	CHAR	2.00	0.00
CDE_PROC_MOD3	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_PROC_MOD3	T_MAX_FEE	CHAR	2.00	0.00
CDE_PROC_MOD3	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_PROC_MOD3	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_PROC_MOD3_ORIG	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD3_SUB	T_DENTAL_DTL_KEYS	CHAR	2.00	0.00
CDE_PROC_MOD3_SUB	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD3_SUB	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD4	T_CA_MATERNITY_CARE	CHAR	2.00	0.00
CDE_PROC_MOD4	T_CC_HIST_ADJUST	CHAR	2.00	0.00
CDE_PROC_MOD4	T_CLM_MAT_CARE_DTL	CHAR	2.00	0.00
CDE_PROC_MOD4	T_MAX_FEE	CHAR	2.00	0.00
CDE_PROC_MOD4	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_PROC_MOD4	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_PROC_MOD4_ORIG	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD4_SUB	T_DENTAL_DTL_KEYS	CHAR	2.00	0.00
CDE_PROC_MOD4_SUB	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD4_SUB	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
CDE_PROC_MOD_1	T_MR_WVR_PROC	CHAR	2.00	0.00
CDE_PROC_MOD_2	T_MR_WVR_PROC	CHAR	2.00	0.00
CDE_PROC_MOD_2	T_PA_DTL	CHAR	2.00	0.00
CDE_PROC_MOD_3	T_MR_WVR_PROC	CHAR	2.00	0.00
CDE_PROC_MOD_3	T_PA_DTL	CHAR	2.00	0.00

CDE_PROC_MOD_4	T_PA_DTL	CHAR	2.00	0.00
CDE_PROC_MOD_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_PROC_MOD_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PROC_OLD	T_CC_CR_SAVE	CHAR	6.00	0.00
CDE_PROC_REPL	T_CC_CR_SAVE	CHAR	6.00	0.00
CDE_PROC_REPL	T_CC_HIST_ADJUST	CHAR	6.00	0.00
CDE_PROC_STATUS	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_PROC_STATUS	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_PROC_SUB	T_DENTAL_DTL_KEYS	CHAR	6.00	0.00
CDE_PROC_SUB	T_PHYS_DEXT_KEY	CHAR	6.00	0.00
CDE_PROC_SUB	T_UB92_DTL_EXT_KEY	CHAR	6.00	0.00
CDE_PROC_TO	T_AUDT_PROC_XRF	CHAR	5.00	0.00
CDE_PROC_TO	T_COV_PROC_XREF	CHAR	5.00	0.00
CDE_PROC_TO	T_DS_DNTL_PROC_GRP	CHAR	6.00	0.00
CDE_PROC_TO	T_DUPE_AUDIT	CHAR	6.00	0.00
CDE_PROC_TO	T_PA_DTL	VARCHAR2	48.00	0.00
CDE_PROC_TO	T_TPL_RQST_RPT_SRCH	CHAR	5.00	0.00
CDE_PROC_UOM	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_PROGRAM	T_RE_AR_OVERPAYMENT	CHAR	2.00	0.00
CDE_PROGRAM_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PROGRAM_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PROGRAM_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PROGRAM_TYPE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_PROG_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00

CDE_PROG_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PROJECTED_STATUS	T_CDE_AGENCY_STATUS	CHAR	1.00	0.00
CDE_PROJECTED_STATUS	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_PROSTHESIS	T_DENTAL_DTL_KEYS	CHAR	1.00	0.00
CDE_PROSTHESIS	T_PA_DTL	CHAR	1.00	0.00
CDE_PROVIDER_ID_TYPE	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	1.00	0.00
CDE_PROVIDER_TYPE	T_CLM_ENTITY	CHAR	3.00	0.00
CDE_PROV_ATT_ID	T_DCOR_SCHEDULE	VARCHAR2	30.00	0.00
CDE_PROV_CLASSIFICATION	T_TMSIS_PRV006_TAXON_CLASS	VARCHAR2	20.00	0.00
CDE_PROV_CLASS_TYPE	T_TMSIS_PRV006_TAXON_CLASS	VARCHAR2	1.00	0.00
CDE_PROV_ENROLL_METHOD	T_TMSIS_PRV007_MDCD_ENROLL	VARCHAR2	1.00	0.00
CDE_PROV_FACILITY_TYPE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	9.00	0.00
CDE_PROV_FACILITY_TYPE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	9.00	0.00
CDE_PROV_ID_TYPE	T_CLM_FCA	CHAR	3.00	0.00
CDE_PROV_ID_TYPE	T_PR_CHOW_GRP_MBR	CHAR	3.00	0.00
CDE_PROV_ID_TYPE	T_PR_IDENTIFIER	CHAR	3.00	0.00
CDE_PROV_ID_TYPE	T_PR_ID_TYPE	CHAR	3.00	0.00
CDE_PROV_LOC_ADR_TYPE	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	1.00	0.00
CDE_PROV_PGM	T_PR_ENROLL_PGM	CHAR	5.00	0.00
CDE_PROV_PROFIT_STATUS	T_MR_TMSIS_CDE_ORGANIZ	CHAR	2.00	0.00
CDE_PROV_PROFIT_STATUS	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	2.00	0.00
CDE_PROV_SEX	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	1.00	0.00
CDE_PROV_SPEC	T_ACCT_REC_DN	CHAR	3.00	0.00
CDE_PROV_SPEC	T_ADJMS_PRSPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_AR_SUPP_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_AUDT_SPC_XREF	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CALL_TRACK	CHAR	3.00	0.00

CDE_PROV_SPEC	T_CHK_BAN_PR_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CLM_AMT_VARIANCE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CLM_FCA	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CLM_SAMPLE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_COPAY	CHAR	3.00	0.00
CDE_PROV_SPEC	T_COS_PROV_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_COV_BNFT_TYPE_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_COV_SPEC_XREF	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CPAS_PROV_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_CPAS_SPLIT	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_DNTL_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_DNTL_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_PHRM_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_PHYS_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_PHYS_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DENY_UB92_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DISP_FEE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_DISP_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_ERR_DISP_LINE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_EXPENDITURE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_EXPENDITURE_DN	CHAR	3.00	0.00
CDE_PROV_SPEC	T_EXPENDITURE_SUPP_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_FCOS_PR_SPEC_XRF	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_ERROR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_ERROR_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_ERROR_KY	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_OP_PERFORM	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_OP_PERFORM_DTL	CHAR	3.00	0.00

CDE_PROV_SPEC	T_MR_PROV	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_DENIED	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_PERFORM	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_PERFORM_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_PERFORM_KY	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_RE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PROV_SUSP	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_PR_ENROL_SAK	CHAR	3.00	0.00
CDE_PROV_SPEC	T_MR_TMSIS_PROV_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PAY_BNFT_TYPE_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PAY_HOLD_PROV_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_DNTL_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_DNTL_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_PHARM_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_PHYS_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_PHYS_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PD_UB92_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PRCNG_TYPE_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PREVAILING	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PREVAILING_CONV	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PROC_SPEC_LIM	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PROFILE_PROV_ADDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_APPLN_WI	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_CONTRACT_TYPE_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_DISP_FEE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_ENRL_SPECIALTY	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_LOC_RATE_REQ	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_RISK_GRP_XREF	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_SPEC	CHAR	3.00	0.00

CDE_PROV_SPEC	T_PR_SPEC_CDE	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_SPEC_PRIORITY	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_SPEC_SUBSPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_SURS_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_PR_TYPE_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_RBRVS_PR_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_REV_SPEC_RSTN	CHAR	3.00	0.00
CDE_PROV_SPEC	T_RE_LOCKIN_INFO	CHAR	3.00	0.00
CDE_PROV_SPEC	T_SPEC_MOD	CHAR	3.00	0.00
CDE_PROV_SPEC	T_SPEC_TOB_XREF	CHAR	3.00	0.00
CDE_PROV_SPEC	T_SUSP_DENTAL_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_SUSP_PHYS_DTL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_SUSP_PHYS_HDR	CHAR	3.00	0.00
CDE_PROV_SPEC	T_TPL_RESTRICTION	CHAR	3.00	0.00
CDE_PROV_SPEC	T_TP_SPC_MOD_EXCL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_TYPE_SPEC_EXCL	CHAR	3.00	0.00
CDE_PROV_SPEC	T_TYPE_SPEC_GROUP	CHAR	3.00	0.00
CDE_PROV_SPEC	T_WEB_PROV_SPEC	CHAR	3.00	0.00
CDE_PROV_SPEC	T_WEB_PROV_SPEC_CD	CHAR	3.00	0.00
CDE_PROV_SPEC_1	T_MEDPOL_UB92	NUMBER	4.00	0.00
CDE_PROV_SPEC_1	T_MPHX_DENTAL_DTL	NUMBER	4.00	0.00
CDE_PROV_SPEC_1	T_MPHX_INPT_HDR	NUMBER	4.00	0.00
CDE_PROV_SPEC_1	T_MPHX_INPT_HDR2	NUMBER	4.00	0.00
CDE_PROV_SPEC_1	T_MPHX_PHYS_DTL	NUMBER	4.00	0.00
CDE_PROV_SPEC_BILL	T_MPHX_PHYS_DTL	NUMBER	4.00	0.00

CDE_PROV_SPEC_EDIT	T_PROC_LIMITS	CHAR	1.00	0.00
CDE_PROV_SPEC_PERF	T_MEDPOL_UB92	NUMBER	4.00	0.00
CDE_PROV_SPEC_PRIM	T_MR_TMSIS_HOSP_TYPE	CHAR	3.00	0.00
CDE_PROV_SPEC_PRIM	T_PR_APPLN	CHAR	3.00	0.00
CDE_PROV_SPEC_PRIM	T_PR_TYPE	CHAR	3.00	0.00
CDE_PROV_STATUS	T_CT_CONT_TERM	CHAR	2.00	0.00
CDE_PROV_SUBSPEC	T_PR_SPEC	CHAR	3.00	0.00
CDE_PROV_SUBSPEC	T_PR_SPEC_SUBSPEC	CHAR	3.00	0.00
CDE_PROV_SUBSPEC	T_PR_SUBSPEC	CHAR	3.00	0.00
CDE_PROV_SUBSPEC	T_PR_SUBSPEC_CDE	CHAR	3.00	0.00
CDE_PROV_SUPER_SPEC	T_PROFILE_PROV_SUPER_SPEC	CHAR	3.00	0.00
CDE_PROV_TAXONOMY	T_CLM_ENTITY	VARCHAR2	30.00	0.00
CDE_PROV_TYPE	T_835_CONTACTS	CHAR	2.00	0.00
CDE_PROV_TYPE	T_ACCT_REC_DN	CHAR	2.00	0.00
CDE_PROV_TYPE	T_ADJMS_PROVTYP	CHAR	2.00	0.00
CDE_PROV_TYPE	T_AR_SUPP_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_AUDIT_PR_TYPE_X	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CALL_TRACK	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CHK_BAN_PROV_TYP	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CLM_AMT_VARIANCE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CLM_FCA	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CLM_SAMPLE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_COS_PROV_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_COV_BNFT_TYPE_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_COV_TYPE_XREF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CPAS_PROV_TYPE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CPAS_SPLIT	CHAR	2.00	0.00
CDE_PROV_TYPE	T_CT_ANALYST	VARCHAR2	255.00	0.00

CDE_PROV_TYPE	T_CT_CASE_TRACK	CHAR	2.00	0.00
CDE_PROV_TYPE	T_DENY_DNTL_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_DENY_PHRM_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_DENY_PHYS_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_DENY_UB92_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_ERR_DISP_LINE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_EXPENDITURE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_EXPENDITURE_DN	CHAR	2.00	0.00
CDE_PROV_TYPE	T_EXPENDITURE_SUPP_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_FCOS_PR_SPEC_XRF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_FCOS_PR_SPEC_XRF	CHAR	3.00	0.00
CDE_PROV_TYPE	T_FCOS_PR_TYPE_XRF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_HIPAA_PT_SVC_XRF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_ERROR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_ERROR_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_ERROR_KY	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_OP_PERFORM	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_OP_PERFORM_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_DENIED	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_PERFORM	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_PERFORM_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_PERFORM_KY	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_RE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PROV_SUSP	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_PR_ENROL_SAK	CHAR	2.00	0.00
CDE_PROV_TYPE	T_MR_TMSIS_PROV_TYPE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PAY_BNFT_TYPE_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PAY_HOLD_PR_TYPE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PD_DNTL_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PD_PHARM_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PD_PHYS_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PD_UB92_HDR	CHAR	2.00	0.00

CDE_PROV_TYPE	T_PRCNG_TYPE_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PROFILE_PROV_ADDR	CHAR	3.00	0.00
CDE_PROV_TYPE	T_PROV_CLM_XREF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_APPLN	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_APPLN_WI	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_CONTRACT_TYPE_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_ENRL_PROV	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_INACTV_EXMPT_AL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_LOC_RATE_REQ	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_RISK_GRP_XREF	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_TYPE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_TYPE_CDE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_PR_TYPE_SPEC	CHAR	2.00	0.00
CDE_PROV_TYPE	T_RE_LOCKIN_INFO	CHAR	2.00	0.00
CDE_PROV_TYPE	T_SUSP_DENTAL_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_SUSP_PHYS_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_SUSP_UB92_HDR	CHAR	2.00	0.00
CDE_PROV_TYPE	T_TPL_RESTRICTION	CHAR	2.00	0.00
CDE_PROV_TYPE	T_TP_SPC_MOD_EXCL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_TYPE_SPEC_EXCL	CHAR	2.00	0.00
CDE_PROV_TYPE	T_TYPE_SPEC_GROUP	CHAR	2.00	0.00
CDE_PROV_TYPE	T_WEB_PROV	CHAR	2.00	0.00
CDE_PROV_TYPE	T_WEB_PROV_TYPE	CHAR	2.00	0.00
CDE_PROV_TYPE	T_XOVER_RATE	CHAR	2.00	0.00
CDE_PROV_TYPE_BILL	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
CDE_PROV_TYPE_PERF	T_MEDPOL_UB92	CHAR	2.00	0.00
CDE_PROV_TYPE_PRIM	T_MR_TMSIS_HOSP_TYPE	CHAR	2.00	0.00
CDE_PRSCRIP_ORIGIN	T_DENY_PHRM_HDR	CHAR	1.00	0.00
CDE_PRSCRIP_ORIGIN	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_PRSCRIP_ORIGIN	T_SUSP_PHRM_HDR	CHAR	1.00	0.00

CDE_PRV_AGREEMENT	T_PHYS_HDR_KEY	CHAR	1.00	0.00
CDE_PR_FROM_SPEC	T_PR_LABEL_CRIT	CHAR	3.00	0.00
CDE_PR_ID_END_RSN	T_PR_IDENTIFIER	CHAR	3.00	0.00
CDE_PR_ID_END_RSN	T_PR_ID_END_RSN	CHAR	3.00	0.00
CDE_PR_ROLE	T_COV_BNFT_TYPE_SPEC	CHAR	4.00	0.00
CDE_PR_ROLE	T_ERR_DISP_PT_PS_X	CHAR	1.00	0.00
CDE_PR_ROLE	T_PAY_BNFT_TYPE_SPEC	CHAR	4.00	0.00
CDE_PR_ROLE	T_PRCNG_TYPE_SPEC	CHAR	4.00	0.00
CDE_PR_ROLE	T_PR_CLAIM_ROLE	CHAR	4.00	0.00
CDE_PR_ROLE	T_PR_CONTRACT_TYPE_SPEC	CHAR	4.00	0.00
CDE_PR_SPEC	T_ERR_DISP_PT_PS_X	CHAR	3.00	0.00
CDE_PR_TO_SPEC	T_PR_LABEL_CRIT	CHAR	3.00	0.00
CDE_PR_TYPE	T_ERR_DISP_PT_PS_X	CHAR	2.00	0.00
CDE_PR_TYPE_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_PR_TYPE_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_PTA_RSN	T_RE_EDB	CHAR	1.00	0.00
CDE_PTA_STATUS	T_RE_EDB	CHAR	1.00	0.00
CDE_PTB_RSN	T_RE_EDB	CHAR	1.00	0.00
CDE_PTB_STATUS	T_RE_EDB	CHAR	1.00	0.00
CDE_PT_SPEC_EI	T_ERR_DISP_PT_PS_X	CHAR	1.00	0.00
CDE_PUB_PRIV	T_CA_IND_KEY	CHAR	1.00	0.00
CDE_PUB_PRIV	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
CDE_PUB_PRIV	T_DS_HM_HEADER	CHAR	1.00	0.00
CDE_PUB_PRIV	T_FCOS_PR_SPEC_XRF	CHAR	1.00	0.00

CDE_PUB_PRIV	T_PR_SVC_LOC	CHAR	1.00	0.00
CDE_PUB_PRIV	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
CDE_PUB_PRIV	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
CDE_PULL_REASON	T_FIN_PYMT_PULL	CHAR	2.00	0.00
CDE_PULL_REASON	T_PAY_PULL_REASON	CHAR	2.00	0.00
CDE_PULL_REASON	T_PR_PAY_PULL	CHAR	2.00	0.00
CDE_PYMT_METHOD	T_PA_LINE_ITEM	CHAR	1.00	0.00
CDE_P_ALERT_RSN	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_QUAD	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_QUAD	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_QUADRANT	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_QUADRANT	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUADRANT	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_QUADRANT	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUADRANT_2	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUADRANT_3	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUADRANT_4	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUADRANT_5	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_QUALFD_TRUST	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00

CDE_QUAL_INSTITUTE	T_DS_RECIP_MFP	CHAR	2.00	0.00
CDE_QUAL_RESIDENCE	T_DS_RECIP_MFP	CHAR	2.00	0.00
CDE_QUAL_SEQ	T_MM_QUALIFIER	NUMBER	1.00	0.00
CDE_QUAL_SEQ	T_MM_QUALIFIER_SEQ	NUMBER	1.00	0.00
CDE_QUAL_SEQ_TYPE	T_MM_QUALIFIER_SEQ	CHAR	1.00	0.00
CDE_QUAL_TYPE	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_QUAL_TYPE	T_MM_QUALIFIER_TYPE	CHAR	1.00	0.00
CDE_QUESTION_TO	T_QUES_REC_CODE	CHAR	1.00	0.00
CDE_QUESTION_TO	T_SUSPECT_RES	CHAR	1.00	0.00
CDE_RACE	T_CA_RECIP_KEY	CHAR	2.00	0.00
CDE_RACE	T_CDE_RACE	CHAR	2.00	0.00
CDE_RACE	T_CLM_SYS_FIELDS_HDR	CHAR	2.00	0.00
CDE_RACE	T_DS_CLM_CNT_PAID_DTE	CHAR	2.00	0.00
CDE_RACE	T_DS_CLM_CNT_SVC_DTE	CHAR	2.00	0.00
CDE_RACE	T_DS_DNTL_RECIP	CHAR	2.00	0.00
CDE_RACE	T_DS_RECIP_AGGR_CNT	CHAR	2.00	0.00
CDE_RACE	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_RACE	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_RACE	T_ELIGCNT	CHAR	2.00	0.00
CDE_RACE	T_MB_DEN_RECIP	CHAR	2.00	0.00
CDE_RACE	T_MB_NUM_RECIP	CHAR	2.00	0.00
CDE_RACE	T_MR_ELIG_SAK	CHAR	2.00	0.00
CDE_RACE	T_MR_RE	CHAR	2.00	0.00
CDE_RACE	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_RACE	T_MR_RE_KY	CHAR	2.00	0.00
CDE_RACE	T_PS_CASE	CHAR	1.00	0.00
CDE_RACE	T_PS_CDE_RACE	CHAR	1.00	0.00
CDE_RACE	T_RE_BASE	CHAR	2.00	0.00
CDE_RACE	T_RE_BASE_DN	CHAR	2.00	0.00
CDE_RACE	T_RE_ID_CRD_ISS	CHAR	2.00	0.00
CDE_RACE	T_TMSIS_ELG016_RACE_INFO	VARCHAR2	3.00	0.00
CDE_RACE_HIPAA	T_HIPAA_RACE	CHAR	3.00	0.00

CDE_RACE_HIPAA	T_HIPAA_RACE_XREF	CHAR	3.00	0.00
CDE_RACE_MMIS	T_HIPAA_RACE_XREF	CHAR	2.00	0.00
CDE_RACE_OTHER	T_TMSIS_ELG016_RACE_INFO	VARCHAR2	25.00	0.00
CDE_RAILROAD	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_RANGE_HI	T_PR_RST_SVC	NUMBER	9.00	0.00
CDE_RANGE_LOW	T_PR_RST_SVC	NUMBER	9.00	0.00
CDE_RANGE_TYPE	T_PMT_NUM_RNG	CHAR	1.00	0.00
CDE_RANGE_TYPE	T_PMT_RNG_TYPE	CHAR	1.00	0.00
CDE_RATE_CELL	T_MC_RATE_CELL	CHAR	5.00	0.00
CDE_RATE_TYPE	T_ASC_PRICING	CHAR	3.00	0.00
CDE_RATE_TYPE	T_CA_CLAIM_KEY	CHAR	3.00	0.00
CDE_RATE_TYPE	T_CLM_PGM_XREF	CHAR	3.00	0.00
CDE_RATE_TYPE	T_CONV_FACTOR	CHAR	3.00	0.00
CDE_RATE_TYPE	T_COUNTY_RATE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_DISP_SHARE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_DRUG_MAC_PCT	CHAR	3.00	0.00
CDE_RATE_TYPE	T_DRUG_OTC_MAC	CHAR	3.00	0.00
CDE_RATE_TYPE	T_DRUG_S_MAC	CHAR	3.00	0.00
CDE_RATE_TYPE	T_EAC	CHAR	3.00	0.00
CDE_RATE_TYPE	T_FIN_FUND_CDE_RATE	CHAR	2.00	0.00
CDE_RATE_TYPE	T_FIN_RATE_TYPE	CHAR	2.00	0.00
CDE_RATE_TYPE	T_INP_LOC_RATE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_LAB_FEE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_LTC_LEAVE_RATE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_MARG_COST	CHAR	3.00	0.00

CDE_RATE_TYPE	T_MAX_FEE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PEER_GRP_DRGR_OLD	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PROC_ASC	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PROC_CONV_FACTOR	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_DRG_RATE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_INST_RATE_WI	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_LOC_RATE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_LOC_RATE_WI	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_OUT_RATE_AL	CHAR	3.00	0.00
CDE_RATE_TYPE	T_PR_RATE_KY	CHAR	3.00	0.00
CDE_RATE_TYPE	T_RATE_TYPE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_REF_UCC	CHAR	3.00	0.00
CDE_RATE_TYPE	T_REIMB_AGREEMENT	CHAR	3.00	0.00
CDE_RATE_TYPE	T_REVENUE_FLAT_FEE	CHAR	3.00	0.00
CDE_RATE_TYPE	T_XOVER_RATE	CHAR	3.00	0.00
CDE_REASON	T_RE_AR_OVERPAYMENT_RSN	CHAR	2.00	0.00
CDE_REASON	T_RE_ASSIGN_REASON	CHAR	3.00	0.00
CDE_REASON	T_RE_ASSIGN_RSN_CODE	CHAR	3.00	0.00
CDE_REASON	T_RE_MC_RECIP	CHAR	1.00	0.00
CDE_REASON	T_RE_MC_RECIP_WI	CHAR	1.00	0.00
CDE_REASON	T_TPL_RESTRICTION	CHAR	1.00	0.00
CDE_REASON	T_TPL_REST_RSN_CDE	CHAR	1.00	0.00
CDE_REASON	T_UB92_DTL_OUTPAT_EDIT	CHAR	1.00	0.00

CDE_REASON	T_UB92_HDR_OUTPAT_EDIT	CHAR	1.00	0.00
CDE_REASON_FOUR	T_ACCT_REC	CHAR	4.00	0.00
CDE_REASON_FOUR	T_ACCT_REC_DN	CHAR	4.00	0.00
CDE_REASON_FOUR	T_AR_DISP	CHAR	4.00	0.00
CDE_REASON_FOUR	T_AR_DISP_REAS	CHAR	4.00	0.00
CDE_REASON_FOUR	T_AR_REASONS	CHAR	4.00	0.00
CDE_REASON_FOUR	T_CASH_DISP_REASON	CHAR	4.00	0.00
CDE_REASON_FOUR	T_CASH_RCPT_DISP	CHAR	4.00	0.00
CDE_REASON_FOUR	T_DR_INV_WO_RSN	CHAR	4.00	0.00
CDE_REASON_FOUR	T_DR_INV_WRITEOFF	CHAR	4.00	0.00
CDE_REASON_FOUR	T_EXPENDITURE	CHAR	4.00	0.00
CDE_REASON_FOUR	T_EXPENDITURE	CHAR	4.00	0.00
CDE_REASON_FOUR	T_EXPENDITURE_DN	CHAR	4.00	0.00
CDE_REASON_FOUR	T_EXPENDITURE_RSN	CHAR	4.00	0.00
CDE_REASON_FOUR	T_FIN_AR_RQST_REPORT	CHAR	4.00	0.00
CDE_REASON_FOUR	T_FIN_PROCESS_AR	CHAR	4.00	0.00
CDE_REASON_FOUR	T_FIN_PROCESS_AR_DISP	CHAR	4.00	0.00
CDE_REASON_FOUR	T_FIN_PROCESS_CASH_DISP	CHAR	4.00	0.00
CDE_REASON_FOUR	T_PAYMENT_HOLD	CHAR	4.00	0.00
CDE_REASON_FOUR	T_PAY_HOLD_REASONS	CHAR	4.00	0.00
CDE_REASON_FOUR	T_RTS_INFO	CHAR	4.00	0.00
CDE_REASON_FOUR	T_RTS_REASON	CHAR	4.00	0.00
CDE_REASON_LI	T_RE_BASE_DN	CHAR	3.00	0.00
CDE_REASON_LIEN	T_CDE_LIEN_RSN	CHAR	4.00	0.00
CDE_REASON_LIEN	T_LIEN	CHAR	4.00	0.00
CDE_REASON_LIEN	T_LIEN_RSN_CODE	CHAR	4.00	0.00
CDE_REASON_MC	T_RE_MC_REASON	CHAR	1.00	0.00
CDE_REASON_REISSUE	T_CHECK_VOID	CHAR	1.00	0.00

CDE_REASON_REISSUE	T_CHK_REISSUE_RSN	CHAR	1.00	0.00
CDE_REASON_REISSUE	T_CHK_REISSUE_XREF	CHAR	1.00	0.00
CDE_REASON_RLOC	T_RE_BASE_DN	CHAR	3.00	0.00
CDE_REASON_STRT	T_RE_LOC	CHAR	3.00	0.00
CDE_REASON_TWO	T_CLAIM_EXTRACT	CHAR	2.00	0.00
CDE_REASON_TWO	T_HIPAA_ADJRSN_XRF	CHAR	4.00	0.00
CDE_REASON_TWO	T_TPL_AR_CAS_DISPS	CHAR	2.00	0.00
CDE_REASON_TWO	T_TPL_AR_DISPS	CHAR	2.00	0.00
CDE_REASON_TWO	T_TPL_AR_DISPS	CHAR	4.00	0.00
CDE_REASON_TWO	T_TPL_AR_DISPS_AL	CHAR	4.00	0.00
CDE_REASON_TWO	T_TPL_AR_HEALTH	CHAR	2.00	0.00
CDE_REASON_TWO	T_TPL_AR_HEALTH	CHAR	4.00	0.00
CDE_REASON_TWO	T_TPL_AR_HEALTH_XXX	CHAR	2.00	0.00
CDE_REASON_TWO	T_TPL_AR_REASONS	CHAR	2.00	0.00
CDE_REASON_TWO	T_TPL_AR_REASONS	CHAR	4.00	0.00
CDE_REASON_TWO	T_TPL_PREBILL	CHAR	4.00	0.00
CDE_REASON_TYPE	T_AR_DISP_REAS	CHAR	1.00	0.00
CDE_REASON_TYPE	T_AR_REASONS	CHAR	1.00	0.00
CDE_REASON_TYPE	T_CDE_LIEN_RSN	CHAR	1.00	0.00
CDE_REASON_TYPE	T_EXPENDITURE_RSN	CHAR	1.00	0.00
CDE_REASON_TYPE	T_FIN_PROCESS_AR	CHAR	1.00	0.00
CDE_REASON_TYPE	T_LIEN_RSN_CODE	CHAR	1.00	0.00
CDE_REASON_TYPE	T_PAY_HOLD_REASONS	CHAR	1.00	0.00
CDE_RECIP_AGE_GRP	T_DS_DNTL_PR_GRP_SUM	CHAR	3.00	0.00

CDE_RECIP_AGE_GRP	T_DS_DNTL_PR_SUM	CHAR	3.00	0.00
CDE_RECIP_AGE_GRP	T_DS_DNTL_RECIP	CHAR	3.00	0.00
CDE_RECIP_COUNTY	T_CA_RECIP_KEY	VARCHAR2	10.00	0.00
CDE_RECIP_COUNTY	T_MB_DEN_RECIP	VARCHAR2	10.00	0.00
CDE_RECIP_COUNTY	T_MB_NUM_RECIP	VARCHAR2	10.00	0.00
CDE_RECIP_TYPE	T_DS_RECIP_DO_RESOURCE	CHAR	1.00	0.00
CDE_RECORD_CODE	T_WEB_CLAIM_HDR	CHAR	2.00	0.00
CDE_RECORD_CODE	T_WEB_RECORD_CODE	CHAR	2.00	0.00
CDE_RECORD_TYPE	T_PS_CDE_REC_TYPE	CHAR	2.00	0.00
CDE_RECORD_TYPE	T_PS_DETERMINATION	CHAR	2.00	0.00
CDE_RECORD_TYPE	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_RECOUP	T_FIN_BUDGET	CHAR	1.00	0.00
CDE_RECOUP_FREQ	T_ACCT_REC	CHAR	1.00	0.00
CDE_RECOUP_FREQ	T_ACCT_REC_DN	CHAR	1.00	0.00
CDE_RECOUP_FREQ	T_FIN_PROCESS_AR	CHAR	1.00	0.00
CDE_RECOUP_TYPE	T_ACCT_REC	CHAR	1.00	0.00
CDE_RECOUP_TYPE	T_ACCT_REC_DN	CHAR	1.00	0.00
CDE_RECOUP_TYPE	T_FIN_AR_RQST_REPORT	CHAR	1.00	0.00

CDE_RECYCLE_TYPE	T_EDIT_RECYCLE	CHAR	1.00	0.00
CDE_REC_REJD	T_RE_CMS_MMA_RESPONSE	NUMBER	6.00	0.00
CDE_REC_SRC	T_RE_EBS_CARD_RQST	CHAR	2.00	0.00
CDE_REC_TYPE	T_CDE_TAX_REC_TYPE	CHAR	1.00	0.00
CDE_REC_TYPE	T_FIN_CYCLE_TAX_INFO	CHAR	1.00	0.00
CDE_REC_TYPE	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00
CDE_REC_TYPE	T_PR_ADR_CASS	CHAR	1.00	0.00
CDE_REC_TYPE	T_RE_ADR_CASS	CHAR	1.00	0.00
CDE_REC_TYPE	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_REDETERMINATION	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_REFERRAL	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_REFERRAL	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_REFERRAL_STATUS	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_REFERRED	T_PS_CDE_REFERRED	CHAR	2.00	0.00
CDE_REFERRED	T_PS_REFERRAL	CHAR	2.00	0.00
CDE_REFERRED	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_REFER_PROV_SPEC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REFER_PROV_SPEC	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REFER_PROV_SPEC	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REFER_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_REFER_PROV_TAXON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_REFER_PROV_TAXON	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00

CDE_REFER_PROV_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REFER_PROV_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REFER_PROV_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_REF_ANS1	T_PS_REFERRAL	CHAR	1.00	0.00
CDE_REF_ANS2	T_PS_REFERRAL	CHAR	1.00	0.00
CDE_REF_ID	T_CLM_REF	VARCHAR2	50.00	0.00
CDE_REF_ID	T_PAYER_REF	VARCHAR2	30.00	0.00
CDE_REF_ID	T_PAYER_REF	VARCHAR2	50.00	0.00
CDE_REGION	T_ADJMS_REGION	CHAR	2.00	0.00
CDE_REGION	T_CLAIM_ERROR	CHAR	2.00	0.00
CDE_REGION_GEO	T_AVE_EXP_AVGE	CHAR	4.00	0.00
CDE_REGION_GEO	T_AVE_EXP_DIAG	CHAR	4.00	0.00
CDE_REGION_GEO	T_COUNTY	CHAR	4.00	0.00
CDE_REGION_GEO	T_GEOGRAPHICAL_REGION	CHAR	4.00	0.00
CDE_REGION_GEO	T_HIPP_CAPITATION_RATE	CHAR	4.00	0.00
CDE_REGION_GEO	T_REGION_GEOGRAPHICAL	CHAR	4.00	0.00
CDE_REGION_TYPE	T_MC_REGION	CHAR	1.00	0.00
CDE_REGION_TYPE	T_MC_REGION_WI	CHAR	1.00	0.00
CDE_REIMBURSE_ARRANGEMENT	T_TMSIS_MCR002_MAIN	VARCHAR2	2.00	0.00
CDE_REIMB_CND_IE	T_REIMB_CND_AXIS_RANGE	CHAR	1.00	0.00
CDE_REIMB_MOD_IE	T_REIMB_MOD_AXIS_RANGE	CHAR	1.00	0.00

CDE_REINSTITUTE_RSN	T_DS_RECIP_MFP	CHAR	2.00	0.00
CDE_REJECT	T_EVS_INQUIRY	CHAR	2.00	0.00
CDE_REJECT_REASON	T_RE_LTC_REQUEST	CHAR	2.00	0.00
CDE_RELATED_CAUSE_1	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_RELATED_CAUSE_1	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_RELATED_CAUSE_1	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
CDE_RELATED_CAUSE_2	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_RELATED_CAUSE_2	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_RELATED_CAUSE_2	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
CDE_RELATED_CAUSE_3	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_RELATED_CAUSE_3	T_PHYS_HDR_KEY	CHAR	2.00	0.00
CDE_RELATED_CAUSE_3	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
CDE_RELATION	T_HIPAA_REL_CODE	CHAR	2.00	0.00
CDE_RELATION	T_HIPAA_REL_XREF	CHAR	1.00	0.00
CDE_RELATION	T_HIPP_RECIP	CHAR	1.00	0.00
CDE_RELATION	T_MR_TMSIS_TPL_REL_TYPE	CHAR	1.00	0.00
CDE_RELATION	T_RELATION_CODE	CHAR	1.00	0.00
CDE_RELATION	T_RE_MOVE_IN_OUT	CHAR	1.00	0.00
CDE_RELATION	T_TPL_CASE_INFO	CHAR	1.00	0.00
CDE_RELATION	T_TPL_CVRG_REL_XREF	CHAR	1.00	0.00
CDE_RELATION	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_RELATIONSHIP	T_CALL_TRACK	CHAR	1.00	0.00
CDE_RELATION_TYPE	T_OWNER_REL_TYPE	CHAR	2.00	0.00
CDE_RELATION_TYPE	T_PR_OWNER	CHAR	2.00	0.00
CDE_RELEASE_INFO	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00
CDE_RELEASE_INFORMATION	T_PHYS_HDR_KEY	CHAR	1.00	0.00
CDE_RELEASE_OF_INFO	T_INST_OTH_PYR_HDR	CHAR	1.00	0.00

CDE_RELEASE_OF_INFO	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
CDE_REL_TO_APPL	T_DS_RECIP_DO_APPL_SPONS	CHAR	3.00	0.00
CDE_REL_TO_APPL	T_DS_RECIP_DO_FAMILY	CHAR	1.00	0.00
CDE_REL_TO_APPL	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_REMARK	T_CDE_HIPAA_REMRKS	CHAR	5.00	0.00
CDE_REMARK	T_PAYER_REMARK	CHAR	5.00	0.00
CDE_REPAYEE	T_RE_EDB	CHAR	1.00	0.00
CDE_REPAY_TYPE	T_ACCT_REC	CHAR	1.00	0.00
CDE_REPAY_TYPE	T_ACCT_REC_DN	CHAR	1.00	0.00
CDE_REPAY_TYPE	T_FIN_PROCESS_AR	CHAR	1.00	0.00
CDE_REPLACEMENT_TYPE	T_DRG_CROSSWALK	CHAR	1.00	0.00
CDE_REPORTING	T_PR_SUMM_TBL_LIST	CHAR	1.00	0.00
CDE_REPORT_FREQ	T_FIN_REPORT	CHAR	1.00	0.00
CDE_REPORT_FREQ	T_FIN_RPT_PARMS	CHAR	1.00	0.00
CDE_REPORT_TYPE	T_FIN_SCHEDULE	CHAR	1.00	0.00
CDE_REPRESENTS	T_ATTORNEY_XREF	CHAR	1.00	0.00
CDE_REPRESENTS	T_ATTORNEY_XREF_WI	CHAR	1.00	0.00
CDE_REPRESENTS	T_BATCH_LETTERS	CHAR	1.00	0.00
CDE_REPRESENTS	T_CAS_HIST_LETTERS	CHAR	1.00	0.00
CDE_REPRESENTS	T_INS_AGENT_XREF	CHAR	1.00	0.00
CDE_REQUEST_TYPE	T_PR_APPLN	CHAR	1.00	0.00

CDE_REQUEST_TYPE	T_PR_APPLN_WI	CHAR	1.00	0.00
CDE_REQ_TABLE	T_PR_LOC_RATE_REQ	CHAR	2.00	0.00
CDE_REQ_TABLE	T_PR_LOC_REQ_TABLE	CHAR	2.00	0.00
CDE_RESOLUTION	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_RESOLUTION	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_RESOLUTION	T_DR_RESO_CODE	CHAR	1.00	0.00
CDE_RESOLUTION2	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_RESOLUTION2	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_RESOLUTION3	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_RESOLUTION3	T_DR_DISPUTE_RESO	CHAR	1.00	0.00
CDE_RESOURCE_LVL	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_RESP_TYPE	T_CDE_CAN_RESP	CHAR	3.00	0.00
CDE_RESTRICTED_BENEFITS	T_MR_TMSIS_AID_CAT	CHAR	1.00	0.00
CDE_RESTRICTED_BENEFITS	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
CDE_RESTRICT_TYPE	T_COS_ASSIGN_CRIT	CHAR	2.00	0.00
CDE_RESTRICT_TYPE	T_MC_PMP_PANEL_RESTRICT	CHAR	1.00	0.00
CDE_RESTRICT_TYPE	T_MC_PMP_RESTRICT_TYPE	CHAR	1.00	0.00
CDE_RES_CAS	T_ORIGIN_CODE	CHAR	1.00	0.00
CDE_RETRIEVAL	T_PR_ENRL_EFT_ERA	CHAR	1.00	0.00

CDE_RETRIEVAL	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	1.00	0.00
CDE_RETRIEVAL	T_PR_ENRL_EFT_ERA_MAINT	CHAR	1.00	0.00
CDE_RETRIEVAL	T_WEB_RECEIVER	CHAR	1.00	0.00
CDE_RETRIEVAL	T_WEB_RECEIVER_BACKUP	CHAR	1.00	0.00
CDE_RETRIEVAL_AFT	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RETRIEVAL_BEF	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RETURNED	T_TPL_LTR_RESP_XREF	CHAR	1.00	0.00
CDE_RETURN_VALUE	T_CODE_RESOLUTION	CHAR	1.00	0.00
CDE_RET_PYMT	T_FIN_BUDGET	CHAR	1.00	0.00
CDE_REVC_FROM	T_AUDIT_REV_XREF	NUMBER	4.00	0.00
CDE_REVC_FROM	T_COV_REV_XREF	NUMBER	4.00	0.00
CDE_REVC_TO	T_AUDIT_REV_XREF	NUMBER	4.00	0.00
CDE_REVC_TO	T_COV_REV_XREF	NUMBER	4.00	0.00
CDE_REVENUE	T_ADJMS_REVENUE	NUMBER	4.00	0.00

CDE_REVENUE	T_CA_HDR_DTL	CHAR	4.00	0.00
CDE_REVENUE	T_CDE_REVENUE	CHAR	4.00	0.00
CDE_REVENUE	T_CLM_OTH_PYR_DTL	VARCHAR2	48.00	0.00
CDE_REVENUE	T_DENY_UB92_DTL	NUMBER	4.00	0.00
CDE_REVENUE	T_DS_HM_DETAIL	CHAR	4.00	0.00
CDE_REVENUE	T_MEDPOL_UB92	NUMBER	4.00	0.00
CDE_REVENUE	T_MR_LTC_REV	NUMBER	4.00	0.00
CDE_REVENUE	T_PD_UB92_DTL	NUMBER	4.00	0.00
CDE_REVENUE	T_REVENUE_CODE	CHAR	4.00	0.00
CDE_REVENUE	T_REVENUE_CODE	NUMBER	4.00	0.00
CDE_REVENUE	T_SUSP_UB92_DTL	NUMBER	4.00	0.00
CDE_REVENUE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_REVENUE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_REVENUE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_REVENUE_1	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_10	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_11	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_12	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_13	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_14	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_15	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_16	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_17	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_18	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_19	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_2	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_20	T_CA_HDR_DTL_DN	CHAR	4.00	0.00

CDE_REVENUE_21	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_22	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_23	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_3	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_4	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_5	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_6	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_7	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_8	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVENUE_9	T_CA_HDR_DTL_DN	CHAR	4.00	0.00
CDE_REVIEW	T_FIN_EFT_ACCT	CHAR	1.00	0.00
CDE_REVIEW_REASON	T_PR_CDE_REVIEW_REASON	CHAR	1.00	0.00
CDE_REVIEW_REASON	T_PR_RST_SVC	CHAR	1.00	0.00
CDE_REVIEW_TYPE	T_PR_CDE_REVIEW	CHAR	1.00	0.00
CDE_REVIEW_TYPE	T_PR_REVIEW	CHAR	1.00	0.00
CDE_REVIEW_TYPE	T_PR_RST_SVC	CHAR	1.00	0.00
CDE_REVOKE_RSN	T_RE_HOSPICE_DTL	CHAR	1.00	0.00
CDE_REV_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_REV_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_REV_REQ	T_RE_REV_REQ	CHAR	1.00	0.00
CDE_REV_RSN	T_RE_REV_RSN	CHAR	1.00	0.00
CDE_REV_SUB	T_UB92_DTL_EXT_KEY	NUMBER	4.00	0.00
CDE_RIC	T_BUYA_BILL	CHAR	1.00	0.00
CDE_RIC	T_BUYA_DEMO_CHANGE	CHAR	1.00	0.00
CDE_RIC	T_BUYA_EXCEPT	CHAR	1.00	0.00
CDE_RIC	T_BUYA_MISMATCH	CHAR	1.00	0.00
CDE_RIC	T_BUYA_PREM	CHAR	1.00	0.00
CDE_RIC	T_BUYB_BILL	CHAR	1.00	0.00
CDE_RIC	T_BUYB_DEMO_CHANGE	CHAR	1.00	0.00
CDE_RIC	T_BUYB_EXCEPT	CHAR	1.00	0.00

CDE_RIC	T_BUYB_MISMATCH	CHAR	1.00	0.00
CDE_RIC	T_BUYB_PREM	CHAR	1.00	0.00
CDE_RISK	T_PR_ENROLL_SCRN	CHAR	2.00	0.00
CDE_RISK_MET	T_PR_RISK_GRP_XREF	CHAR	2.00	0.00
CDE_RISK_NOT_MET	T_PR_RISK_GRP_XREF	CHAR	2.00	0.00
CDE_RLINK_TYPE	T_ERX_CDE_RLINK	CHAR	2.00	0.00
CDE_RLINK_TYPE	T_ERX_RESOURCE_LINK	CHAR	2.00	0.00
CDE_RLSE_STATUS	T_FIN_PAY_RELEASE	CHAR	1.00	0.00
CDE_ROLE_TYPE	T_AUDIT_PR_TYPE_X	CHAR	1.00	0.00
CDE_ROLE_TYPE	T_AUDT_SPC_XREF	CHAR	1.00	0.00
CDE_ROUTED_GEN_ID	T_MME_OPIOID_RTD_ING_MME	NUMBER	8.00	0.00
CDE_ROUTE_2	T_CDE_DRUG_ROUTE	CHAR	2.00	0.00
CDE_ROUTE_ADMIN	T_CDE_DRUG_ROUTE	CHAR	1.00	0.00
CDE_ROUTE_ADMIN	T_DENY_PHRM_HDR	VARCHAR2	11.00	0.00
CDE_ROUTE_ADMIN	T_GENERIC_DRUG	CHAR	2.00	0.00
CDE_ROUTE_ADMIN	T_GENERIC_DRUG	CHAR	2.00	0.00

CDE_ROUTE_ADMIN	T_PD_PHARM_HDR	VARCHAR2	11.00	0.00
CDE_ROUTE_ADMIN	T_SUSP_PHRM_HDR	VARCHAR2	11.00	0.00
CDE_ROUTE_ADMIN	T_THERA_DURATION	CHAR	2.00	0.00
CDE_ROUTE_ADMIN	T_THERA_DURATION	CHAR	2.00	0.00
CDE_ROW_TYPE	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_ROW_TYPE	T_DS_DNTL_PR_SUM	CHAR	2.00	0.00
CDE_RPT_CAT	T_CM_CASE_GROUP	CHAR	1.00	0.00
CDE_RPT_CAT	T_CM_CASE_TYPE	CHAR	1.00	0.00
CDE_RPT_CAT	T_CM_RPT_CAT	CHAR	1.00	0.00
CDE_RPT_PRIORITY	T_BATCH_ERR_ACT	CHAR	1.00	0.00
CDE_RPT_PRIORITY	T_RE_HIST_ERR	CHAR	1.00	0.00
CDE_RPT_PRIORITY	T_RE_PS2_ERR	CHAR	1.00	0.00

CDE_RPT_THFY_LYFY	T_DS_DNTL_ICN	CHAR	2.00	0.00
CDE_RPT_THFY_LYFY	T_DS_DNTL_PR_ENROLL	CHAR	2.00	0.00
CDE_RPT_THFY_LYFY	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_RPT_THFY_LYFY	T_DS_DNTL_PR_RE_SUM	CHAR	2.00	0.00
CDE_RPT_THFY_LYFY	T_DS_DNTL_PR_SUM	CHAR	2.00	0.00
CDE_RPT_THFY_LYFY	T_DS_DNTL_RECIP	CHAR	2.00	0.00
CDE_RPT_THIS_LAST	T_DS_DNTL_CDE_THIS_LAST	CHAR	2.00	0.00
CDE_RPT_THQT_LYQT	T_DS_DNTL_ICN	CHAR	2.00	0.00

CDE_RPT_THQT_LYQT	T_DS_DNTL_PR_ENROLL	CHAR	2.00	0.00
CDE_RPT_THQT_LYQT	T_DS_DNTL_PR_GRP_SUM	CHAR	2.00	0.00
CDE_RPT_THQT_LYQT	T_DS_DNTL_PR_RE_SUM	CHAR	2.00	0.00
CDE_RPT_THQT_LYQT	T_DS_DNTL_PR_SUM	CHAR	2.00	0.00
CDE_RPT_THQT_LYQT	T_DS_DNTL_RECIP	CHAR	2.00	0.00
CDE_RPT_TRANSMISSION	T_CLM_PWK	CHAR	2.00	0.00
CDE_RPT_TYPE	T_CLM_PWK	CHAR	2.00	0.00
CDE_RPT_TYPE	T_FIN_REPORT	CHAR	1.00	0.00
CDE_RPT_TYPE	T_FIN_RPT_PARMS	CHAR	1.00	0.00
CDE_RQSTR	T_PROJ_RQSTR_CDE	CHAR	1.00	0.00

CDE_RQSTR_TYPE	T_PROJ_TRACK	CHAR	1.00	0.00
CDE_RSN_DEL	T_RE_MC_RECIP	CHAR	1.00	0.00
CDE_RSN_DEL	T_RE_MC_RECIP_WI	CHAR	1.00	0.00
CDE_RSN_HIPAA	T_EXPENDITURE_RSN	CHAR	2.00	0.00
CDE_RSN_HIPAA	T_HIPAA_ASGN_XREF	CHAR	2.00	0.00
CDE_RSN_HIPAA	T_HIPAA_MC_ASSIGN	CHAR	2.00	0.00
CDE_RSN_MC_ASSIGN	T_RE_PMP_REASON	CHAR	2.00	0.00
CDE_RSN_MC_DET	T_RE_MC_RECIP	CHAR	1.00	0.00
CDE_RSN_MC_DET	T_RE_MC_RECIP_WI	CHAR	1.00	0.00
CDE_RSN_MC_START	T_RE_PMP_ASSIGN	CHAR	2.00	0.00
CDE_RSN_MC_START	T_RE_PMP_ASSIGN_WI	CHAR	2.00	0.00
CDE_RSN_MC_STOP	T_RE_PMP_ASSIGN	CHAR	2.00	0.00
CDE_RSN_MC_STOP	T_RE_PMP_ASSIGN_WI	CHAR	2.00	0.00
CDE_RSN_MMIS	T_HIPAA_ASGN_XREF	CHAR	2.00	0.00
CDE_RSN_PMP_ASSGN	T_RE_PMP_REASON	CHAR	1.00	0.00
CDE_RSN_PMP_ASSIGN	T_RE_PMP_REASON	CHAR	1.00	0.00
CDE_RSN_SUBMISSION	T_FIN_EFT_ACCT	CHAR	1.00	0.00

CDE_RSN_SUBMISSION	T_PR_ENRL_EFT_ACCT	CHAR	1.00	0.00
CDE_RSN_SUBMISSION	T_PR_ENRL_EFT_ERA_MAINT	CHAR	1.00	0.00
CDE_RSN_SUBMISSION	T_WEB_RECEIVER	CHAR	1.00	0.00
CDE_RSN_SUBMISSION	T_WEB_RECEIVER_BACKUP	CHAR	1.00	0.00
CDE_RSN_SUBMISSION_EFT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RSN_SUBMISSION_EFT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RSN_SUBMISSION_ERA_AFT	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RSN_SUBMISSION_ERA_BEF	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
CDE_RSP	T_PLOG_HEADER	CHAR	1.00	0.00
CDE_RSP	T_PLOG_VERSION	CHAR	1.00	0.00
CDE_RSRC_TYPE	T_DS_RECIP_DO_RESOURCE	CHAR	2.00	0.00
CDE_RST_TYPE	T_PR_RST_SVC	CHAR	1.00	0.00
CDE_RS_CITIZEN	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_RVWR_NO	T_DS_RECIP_SOBRA_FAM_HIST	CHAR	2.00	0.00
CDE_SAM_DIFF_MOD	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIFF_PR_ID_PERF	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIFF_PR_LOC_BILL	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIFF_PR_LOC_PERF	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIFF_PR_SPC_PERF	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIF_CLM	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SAM_DIF_CLM	T_AUDIT_CRIT_AL	CHAR	1.00	0.00

CDE_SAM_DIF_DI	T_READMIT_PARM	CHAR	1.00	0.00
CDE_SAM_DIF_DOS	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SAM_DIF_DOS	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIF_PAYER	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SAM_DIF_PAYER	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIF_POS	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIF_PR	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SAM_DIF_PR	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SAM_DIF_PRC	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SAM_DIF_PRC	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SANC_SOURCE	T_PR_SANCTION_AL	CHAR	9.00	0.00
CDE_SANC_SOURCE	T_PR_SANCTION_WI	CHAR	9.00	0.00
CDE_SANC_SOURCE	T_PR_VERIFY	CHAR	1.00	0.00
CDE_SANC_TYPE	T_PR_SANCTION_AL	CHAR	9.00	0.00
CDE_SANC_TYPE	T_PR_SANCTION_WI	CHAR	9.00	0.00
CDE_SBR_LOC_COUNTY	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_SBR_LOC_DEPR	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_SBR_LOC_WCTY	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_SBR_LOC_WKR	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_SCHEDULE_1	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_SCHEDULE_2	T_LS_DRUG_MASTER	CHAR	1.00	0.00
CDE_SCOS	T_SCOS_GROUPS	CHAR	3.00	0.00

CDE_SCOS_GROUP	T_SCOS_GROUPS	CHAR	2.00	0.00
CDE_SCOS_GROUP	T_SCOS_GROUP_DESC	CHAR	2.00	0.00
CDE_SCOS_SUBGROUP	T_SCOS_GROUPS	CHAR	3.00	0.00
CDE_SCOS_SUBGROUP	T_SCOS_SUBGROUP_DESC	CHAR	3.00	0.00
CDE_SCREEN_NAME	T_DRUG_SCREEN	CHAR	2.00	0.00
CDE_SCREEN_NAME	T_DRUG_SCREEN	CHAR	2.00	0.00
CDE_SCRIPT_QQ	T_ERX_NCPDP_QQ	CHAR	10.00	0.00
CDE_SECURED	T_WINDOW	CHAR	1.00	0.00
CDE_SECURED_CTLS	T_WINDOW	CHAR	1.00	0.00
CDE_SECURITY	T_TP	VARCHAR2	10.00	0.00
CDE_SECURITY_QUALIFIER	T_TP	VARCHAR2	2.00	0.00
CDE_SELF_DIRECTION_TYPE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_SELF_DIRECTION_TYPE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_SELF_DIRECTION_TYPE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_SELF_DIRECTION_TYPE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_SELF_EMP_FREQ	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_SENDER_ID	T_EDI_INTERCHANGE	VARCHAR2	15.00	0.00
CDE_SEND_REC_ID_GS	T_TXN_BILLING	CHAR	15.00	0.00
CDE_SEND_REC_ID_ISA	T_TXN_BILLING	CHAR	15.00	0.00
CDE_SENIORITY	T_CALL_CLERK_UNIT	CHAR	1.00	0.00
CDE_SEQ_TYPE	T_MM_QUALIFIER	CHAR	1.00	0.00
CDE_SEQ_TYPE	T_MM_SEQ_TYPE	CHAR	1.00	0.00
CDE_SERVICE_AREA	T_PS_RESIDENT_RVW	CHAR	2.00	0.00
CDE_SERVICE_LOC	T_1099_DETAIL	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_CASH_RCPT_DISP	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_CHK_BAN_PROV	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_CLAIM_INTEREST	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_DISP_SHARE	CHAR	1.00	0.00

CDE_SERVICE_LOC	T_EXPENDITURE	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_HIST_DIRECTORY	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PDUR_SUSP	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PR_DRG_RATE	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PR_PAY_PULL	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PR_PHP_ELIG	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PR_PROV_YTD_AMT	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_PR_YTD_AMT_HIST	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RE_ASSIGNMENT	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RE_LOC	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RE_LOCKIN_INFO	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RE_LOC_DATES	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RE_SPEND_PROV	CHAR	1.00	0.00
CDE_SERVICE_LOC	T_RTS_INFO	CHAR	1.00	0.00
CDE_SERVICE_LOC_MBR	T_RE_PMP_ASSIGN	CHAR	1.00	0.00
CDE_SERV_PROV_CHK	T_PA_PAUTH	CHAR	1.00	0.00
CDE_SERV_TYPE	T_HIPAA_SVC_TYPE	CHAR	2.00	0.00
CDE_SEVERITY_LEVEL	T_ALLERGY	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_CONTRA_DISEASE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_DISEASE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_GER	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_GER	CHAR	1.00	0.00

CDE_SEVERITY_LEVEL	T_DRUG_GER_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_INVERSE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_OVER_UTIL	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_PED	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_PED	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_PED_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_PREG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_PREG_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_THER_DUPE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_DRUG_UNDER_UTIL	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_HIGH_DOSE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_HIGH_DOSE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_HIGH_DOSE_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_INGRED_DUPE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_INVRS_UPDT_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_LOW_DOSE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_LOW_DOSE	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_LOW_DOSE_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_OVER_UTIL_LOG	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_PDUR_ADD_TOX	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_PDUR_ADD_TOX_FAC	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_PDUR_FINAL_WARN	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_PDUR_RLHX	CHAR	2.00	0.00
CDE_SEVERITY_LEVEL	T_PRODUR_WARN	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_THERA_DUP_LOG	CHAR	1.00	0.00

CDE_SEVERITY_LEVEL	T_THERA_DURATION	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_THERA_DURATION	CHAR	1.00	0.00
CDE_SEVERITY_LEVEL	T_UNDER_UTIL_LOG	CHAR	1.00	0.00
CDE_SEVER_LOC	T_LOCATION	CHAR	2.00	0.00
CDE_SEV_LEVEL	T_ETG_DTL	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_DTL_ENCNTR	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_DTL_FFS	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_DTL_RCO_PAID	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_SUMMARY	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
CDE_SEV_LEVEL	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
CDE_SEX	T_ADJMS_AGE_SEX	CHAR	1.00	0.00
CDE_SEX	T_AVERAGE_EXPEND	CHAR	1.00	0.00
CDE_SEX	T_AVE_EXP_AVGE	CHAR	1.00	0.00
CDE_SEX	T_BUYA_BILL_INFO	CHAR	1.00	0.00
CDE_SEX	T_BUYA_DEMO_CHANGE	CHAR	1.00	0.00
CDE_SEX	T_BUYA_EXCEPT	CHAR	1.00	0.00
CDE_SEX	T_BUYA_MISMATCH	CHAR	1.00	0.00
CDE_SEX	T_BUYB_BILL_INFO	CHAR	1.00	0.00
CDE_SEX	T_BUYB_DEMO_CHANGE	CHAR	1.00	0.00
CDE_SEX	T_BUYB_EXCEPT	CHAR	1.00	0.00
CDE_SEX	T_BUYB_MISMATCH	CHAR	1.00	0.00
CDE_SEX	T_CA_RECIP_KEY	CHAR	1.00	0.00
CDE_SEX	T_CDE_SEX	CHAR	1.00	0.00

CDE_SEX	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
CDE_SEX	T_CM_SEX	CHAR	1.00	0.00
CDE_SEX	T_COVERED_BENEFIT	CHAR	1.00	0.00
CDE_SEX	T_DIAG_LIMIT	CHAR	1.00	0.00
CDE_SEX	T_DRUG_LIMITS	CHAR	1.00	0.00
CDE_SEX	T_DS_CLM_CNT_PAID_DTE	CHAR	1.00	0.00
CDE_SEX	T_DS_CLM_CNT_SVC_DTE	CHAR	1.00	0.00
CDE_SEX	T_DS_RECIP_AGGR_CNT	CHAR	1.00	0.00
CDE_SEX	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_SEX	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_SEX	T_ELIGCNT	CHAR	1.00	0.00
CDE_SEX	T_MB_DEN_RECIP	CHAR	1.00	0.00
CDE_SEX	T_MB_NUM_RECIP	CHAR	1.00	0.00
CDE_SEX	T_MC_CAP_DEMOGRAPH	CHAR	1.00	0.00
CDE_SEX	T_MC_CAP_DEMOGRAPH_KY	CHAR	1.00	0.00
CDE_SEX	T_MC_CENSUS	CHAR	1.00	0.00
CDE_SEX	T_MR_ELIG_SAK	CHAR	1.00	0.00
CDE_SEX	T_MR_RE	CHAR	1.00	0.00
CDE_SEX	T_MR_RE_CNTY	CHAR	1.00	0.00
CDE_SEX	T_MR_RE_KY	CHAR	1.00	0.00
CDE_SEX	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
CDE_SEX	T_PROC_ICD9_LIM	CHAR	1.00	0.00
CDE_SEX	T_PROC_LIMITS	CHAR	1.00	0.00
CDE_SEX	T_PR_ENRL_PROV	CHAR	1.00	0.00
CDE_SEX	T_PS_CASE	CHAR	1.00	0.00
CDE_SEX	T_PS_CDE_SEX	CHAR	1.00	0.00
CDE_SEX	T_RE_BASE	CHAR	1.00	0.00
CDE_SEX	T_RE_BASE_DN	CHAR	1.00	0.00
CDE_SEX	T_RE_BNDX_BUYIN	CHAR	1.00	0.00
CDE_SEX	T_RE_CHILD_HAD	CHAR	1.00	0.00
CDE_SEX	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
CDE_SEX	T_RE_DEMOGRAPHIC	CHAR	1.00	0.00

CDE_SEX	T_RE_EDB	CHAR	1.00	0.00
CDE_SEX	T_RE_HIST_ERR	CHAR	1.00	0.00
CDE_SEX	T_RE_ID_CRD_ISS	CHAR	1.00	0.00
CDE_SEX	T_RE_PS2_ERR	CHAR	1.00	0.00
CDE_SEX	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	1.00	0.00
CDE_SEX	T_TPL_AC_PARENT	CHAR	1.00	0.00
CDE_SEX_EDB	T_BUYA_DEMO_CHANGE	CHAR	1.00	0.00
CDE_SEX_EDB	T_BUYB_DEMO_CHANGE	CHAR	1.00	0.00
CDE_SEX_RSTRCTN	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SEX_RSTRCTN	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SHED_RETRO	T_RETRO_COV_XREF	CHAR	1.00	0.00
CDE_SHED_RETRO	T_RETRO_SCHED	CHAR	1.00	0.00
CDE_SHIP_PATTERN	T_CLM_HSD	CHAR	2.00	0.00
CDE_SHIP_TIME	T_CLM_HSD	CHAR	1.00	0.00
CDE_SHORT_STAYS	T_PS_CDE_STAYS	CHAR	2.00	0.00
CDE_SHORT_STAYS	T_PS_REFERRAL	CHAR	2.00	0.00
CDE_SITE_STATUS	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00
CDE_SKEY_DOSG_FRM	T_DRUG_OTC_MAC	CHAR	3.00	0.00
CDE_SKEY_GEN_CLS	T_DRUG_OTC_MAC	CHAR	2.00	0.00
CDE_SKEY_HICL	T_DRUG_OTC_MAC	CHAR	5.00	0.00
CDE_SKEY_PACK_SIZ	T_DRUG_OTC_MAC	CHAR	4.00	0.00
CDE_SKEY_RT	T_CDE_DRUG_ROUTE	NUMBER	2.00	0.00
CDE_SKEY_RT	T_DRUG_OTC_MAC	CHAR	2.00	0.00
CDE_SKEY_SPEC_CLS	T_DRUG_OTC_MAC	CHAR	4.00	0.00
CDE_SKEY_STRENGTH	T_DRUG_OTC_MAC	CHAR	4.00	0.00
CDE_SKILL	T_ANALYST_SKILL	CHAR	3.00	0.00

CDE_SKILL	T_SKILL	CHAR	3.00	0.00
CDE_SKILL_LEVEL	T_ANALYST_SKILL	CHAR	1.00	0.00
CDE_SKILL_LEVEL	T_SKILL_LEVEL_CODE	CHAR	1.00	0.00
CDE_SLC_TASK	T_CSR_SLC_TASK	CHAR	4.00	0.00
CDE_SLC_TASK	T_SLC_TASK_CODE	CHAR	4.00	0.00
CDE_SMART_KEY	T_DRUG	CHAR	24.00	0.00
CDE_SMART_KEY	T_DRUG	CHAR	24.00	0.00
CDE_SMART_KEY	T_RE_EPS_DRG_TRT_N	CHAR	24.00	0.00
CDE_SMART_KEY	T_RE_EPS_TRMNT_DRG	CHAR	24.00	0.00
CDE_SMSA	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_SOBRA_APPL_STATUS	T_RE_BASE_STATE	CHAR	1.00	0.00
CDE_SOBRA_COUNTY	T_RE_BASE_STATE	VARCHAR2	10.00	0.00
CDE_SORT_ORDER	T_FIN_AR_RQST_REPORT	CHAR	1.00	0.00
CDE_SOUNDEX	T_PR_NAM	CHAR	4.00	0.00
CDE_SOUNDEX	T_RE_BASE	CHAR	4.00	0.00
CDE_SOUNDEX	T_RE_BASE_DN	CHAR	4.00	0.00
CDE_SOURCE	T_CA_CLAIM_KEY	CHAR	2.00	0.00
CDE_SOURCE	T_CLM_HIST_BALANCE	CHAR	1.00	0.00
CDE_SOURCE	T_CT_PROV_CRIT	NUMBER	1.00	0.00
CDE_SOURCE	T_CT_RE_CRIT	NUMBER	1.00	0.00
CDE_SOURCE	T_CT_SELECT_LST	NUMBER	2.00	0.00

CDE_SOURCE	T_CT_SELECT_SRC	NUMBER	2.00	0.00
CDE_SOURCE	T_DESI	CHAR	2.00	0.00
CDE_SOURCE	T_ERX_ALT_THERAPY	CHAR	10.00	0.00
CDE_SOURCE	T_MR_CDE_SOURCE	CHAR	2.00	0.00
CDE_SOURCE	T_MR_CMS64	CHAR	2.00	0.00
CDE_SOURCE	T_MR_ERROR	CHAR	2.00	0.00
CDE_SOURCE	T_MR_ERROR_DTL	CHAR	2.00	0.00
CDE_SOURCE	T_MR_ERROR_KY	CHAR	2.00	0.00
CDE_SOURCE	T_MR_LTC	CHAR	2.00	0.00

CDE_SOURCE	T_MR_LTC_REV	CHAR	2.00	0.00
CDE_SOURCE	T_MR_OP_PERFORM	CHAR	2.00	0.00
CDE_SOURCE	T_MR_OP_PERFORM_DTL	CHAR	2.00	0.00
CDE_SOURCE	T_MR_POS	CHAR	2.00	0.00
CDE_SOURCE	T_MR_POS_RE	CHAR	2.00	0.00
CDE_SOURCE	T_MR_PROV	CHAR	2.00	0.00
CDE_SOURCE	T_MR_PROV_DENIED	CHAR	2.00	0.00

CDE_SOURCE	T_MR_PROV_PERFORM	CHAR	2.00	0.00
CDE_SOURCE	T_MR_PROV_PERFORM_DTL	CHAR	2.00	0.00
CDE_SOURCE	T_MR_PROV_PERFORM_KY	CHAR	2.00	0.00
CDE_SOURCE	T_MR_PROV_RE	CHAR	2.00	0.00
CDE_SOURCE	T_MR_RE	CHAR	2.00	0.00
CDE_SOURCE	T_MR_RECIP	CHAR	2.00	0.00
CDE_SOURCE	T_MR_RECIP_KY	CHAR	2.00	0.00

CDE_SOURCE	T_MR_RECIP_RANK	CHAR	2.00	0.00
CDE_SOURCE	T_MR_RE_CNTY	CHAR	2.00	0.00
CDE_SOURCE	T_MR_RE_KY	CHAR	2.00	0.00
CDE_SOURCE	T_MR_XOVER	CHAR	2.00	0.00
CDE_SOURCE	T_RE_ADDRESS	CHAR	5.00	0.00
CDE_SOURCE	T_RE_ASSIGN_PLAN	CHAR	5.00	0.00
CDE_SOURCE	T_RE_ASSIGN_PLAN_RLOC	CHAR	5.00	0.00
CDE_SOURCE	T_RE_BASE	CHAR	5.00	0.00
CDE_SOURCE	T_RE_BASE	CHAR	5.00	0.00
CDE_SOURCE	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_SOURCE	T_RE_CASE	CHAR	5.00	0.00
CDE_SOURCE	T_RE_CDE_SOURCE	CHAR	5.00	0.00
CDE_SOURCE	T_RE_DEATH_CHG	CHAR	5.00	0.00
CDE_SOURCE	T_RE_HIST_ERR	CHAR	5.00	0.00
CDE_SOURCE	T_RE_HIST_LOG	CHAR	5.00	0.00
CDE_SOURCE	T_RE_ID_CARD	CHAR	1.00	0.00
CDE_SOURCE	T_RE_ID_CRD_ISS	CHAR	1.00	0.00
CDE_SOURCE	T_RE_INCOME	CHAR	5.00	0.00
CDE_SOURCE	T_RE_MEDICARE_A	CHAR	5.00	0.00
CDE_SOURCE	T_RE_MEDICARE_B	CHAR	5.00	0.00
CDE_SOURCE	T_RE_MULTI_ADDRESS	CHAR	5.00	0.00
CDE_SOURCE	T_RE_PS2_DUPE	CHAR	5.00	0.00
CDE_SOURCE	T_RE_PS2_ERR	CHAR	5.00	0.00

CDE_SOURCE	T_RE_PS2_LOG	CHAR	5.00	0.00
CDE_SOURCE_ADDR	T_RE_BASE	CHAR	5.00	0.00
CDE_SOURCE_ADDR	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_SOURCE_INC	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_SOURCE_LI	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_SOURCE_LOCATION	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SOURCE_LOCATION	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SOURCE_LOCATION	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SOURCE_LOCATION	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SOURCE_RLOC	T_RE_BASE_DN	CHAR	5.00	0.00
CDE_SPECIAL	T_PS_CDE_SPECIAL	CHAR	3.00	0.00
CDE_SPECIAL	T_PS_DETERMINATION	CHAR	3.00	0.00
CDE_SPECIAL	T_PS_LTR_LEGEND	CHAR	3.00	0.00
CDE_SPECIAL	T_PS_RESIDENT_RVW	CHAR	3.00	0.00
CDE_SPECIALTY	T_PR_IMPUTED_SPEC_XREF	CHAR	3.00	0.00
CDE_SPECIAL_PROGRAM	T_DENTAL_HDR_KEYS	CHAR	3.00	0.00
CDE_SPECIAL_PROGRAM	T_PHYS_HDR_KEY	CHAR	3.00	0.00
CDE_SPECIAL_PROGRAM	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
CDE_SPEC_AID_CAT	T_CT_CASE_TRACK	CHAR	3.00	0.00
CDE_SPEC_COND	T_MC_SPEC_COND	CHAR	3.00	0.00
CDE_SPEC_COND_CLASS	T_MC_SPEC_COND_CLASS	CHAR	3.00	0.00
CDE_SPEC_COND_CLASS	T_MC_SPEC_COND_CLASS_XREF	CHAR	3.00	0.00
CDE_SPEC_COND_CLASS	T_MC_SPEC_COND_EXCL	CHAR	3.00	0.00
CDE_SPEC_COND_TYPE	T_MC_SPEC_COND_TYPE	CHAR	3.00	0.00

CDE_SPEC_COND_TYPE	T_MC_SPEC_COND_TYPE_XREF	CHAR	3.00	0.00
CDE_SPEC_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_SPEC_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_SPEC_PRIORITY	T_PR_SPEC_PRIORITY	CHAR	3.00	0.00
CDE_SPONSOR_TYPE	T_DS_RECIP_DO_APPL_SPONS	CHAR	1.00	0.00
CDE_SRCE_PATNT	T_RE_LOC	CHAR	2.00	0.00
CDE_SS	T_PS_LTR_LEGEND	CHAR	1.00	0.00
CDE_SSI_STATE_SUPP_STAT	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	3.00	0.00
CDE_SSI_STATUS	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	3.00	0.00
CDE_SSN_VERIFIED	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_STATE	T_BORDER	CHAR	2.00	0.00
CDE_STATE	T_CPAS_HCFA_INFO	CHAR	2.00	0.00
CDE_STATE	T_MR_TMSIS_STATE_XREF	CHAR	2.00	0.00
CDE_STATE	T_PS_BILLING_CTR	CHAR	2.00	0.00
CDE_STATE	T_PS_CASE_ADDRESS	CHAR	2.00	0.00
CDE_STATE	T_PS_NONCERT_FAC	CHAR	2.00	0.00
CDE_STATE	T_STATE	CHAR	2.00	0.00
CDE_STATE_AGENCY	T_PR_SVC_LOC_AL	VARCHAR2	10.00	0.00
CDE_STATE_ISSUE	T_PR_HB_LIC_KY	CHAR	2.00	0.00
CDE_STATE_PLAN_OPT_TYPE	T_MR_TMSIS_BEN_PLAN	CHAR	2.00	0.00
CDE_STATE_PLAN_OPT_TYPE	T_TMSIS_ELG011_STATE_PLAN	VARCHAR2	2.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP_DIAG	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP_HDR_PROC	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP_OCC_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CIP_REM_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CLT_DIAG	VARCHAR2	50.00	0.00

CDE_STATE_RECORD_KEY	T_TMSIS_CLT_OCC_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CLT_REM_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_COT002_CLM_HDR	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_COT003_CLM_DTL	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_COT_DIAG	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_COT_OCC_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_COT_REM_CDE	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	50.00	0.00
CDE_STATE_RECORD_KEY	T_TMSIS_CRX_REM_CDE	VARCHAR2	50.00	0.00
CDE_STATE_REC_TYPE	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	2.00	0.00
CDE_STATE_REGION	T_MR_ELIG_SAK	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_ERROR	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_ERROR_DTL	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_ERROR_KY	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_POS	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_POS_RE	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV_DENIED	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV_PERFORM	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV_PERFORM_DTL	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV_PERFORM_KY	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PROV_RE	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_PR_ENROL_SAK	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_RE	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_RECIP_RANK	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_RE_CNTY	CHAR	1.00	0.00
CDE_STATE_REGION	T_MR_RE_KY	CHAR	1.00	0.00
CDE_STATE_SPEC_ELIG_GROUP	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	6.00	0.00

CDE_STATE_VAR	T_ALLERGY	CHAR	1.00	0.00
CDE_STATE_VAR	T_ALLERGY_DIAG	CHAR	1.00	0.00
CDE_STATE_VAR	T_CONTRA_DISEASE	CHAR	1.00	0.00
CDE_STATE_VAR	T_DIAG_DSE_XREF	CHAR	1.00	0.00
CDE_STATE_VAR	T_DISEASE_INFERRED	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_DISEASE	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_GER	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_GER	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_GER_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_INVERSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_OVER_UTIL	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_PED	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_PED	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_PED_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_PREG	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_PREG_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_SCREEN	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_SCREEN	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_THER_DUPE	CHAR	1.00	0.00
CDE_STATE_VAR	T_DRUG_UNDER_UTIL	CHAR	1.00	0.00
CDE_STATE_VAR	T_GENERIC_DRUG	CHAR	1.00	0.00
CDE_STATE_VAR	T_GERI_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_GFC_INGREDIENT	CHAR	1.00	0.00

CDE_STATE_VAR	T_HICL_CLASS_XREF	CHAR	1.00	0.00
CDE_STATE_VAR	T_HIGH_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_HIGH_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_HIGH_DOSE_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_INGREDIENT	CHAR	1.00	0.00
CDE_STATE_VAR	T_INGRED_DUPE	CHAR	1.00	0.00
CDE_STATE_VAR	T_INVRS_UPDT_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_LOW_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_LOW_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_LOW_DOSE_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_CONCR_RISK_GRP_ID_DS	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_DAILY_MME_ALERTING	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_MME_RANGE_FACTOR	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_BASE_ING_DESC	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_CF_MME_FACTOR	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_CONCR_ALERT	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_CONCR_RISK_DR	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_CONCR_RISK_LN	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_DRG_CONCEPT_L	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_OPIOID_RTD_ING_MME	CHAR	1.00	0.00
CDE_STATE_VAR	T_MME_VOCAB_TYPE_DEF	CHAR	1.00	0.00

CDE_STATE_VAR	T_OVER_UTIL_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_PDUR_ADD_TOX	CHAR	1.00	0.00
CDE_STATE_VAR	T_PDUR_PREG_DIAG	CHAR	1.00	0.00
CDE_STATE_VAR	T_PEDI_DOSE	CHAR	1.00	0.00
CDE_STATE_VAR	T_THERAPEUTIC	CHAR	1.00	0.00
CDE_STATE_VAR	T_THERA_DUP_LOG	CHAR	1.00	0.00
CDE_STATE_VAR	T_THERA_DURATION	CHAR	1.00	0.00
CDE_STATE_VAR	T_THERA_DURATION	CHAR	1.00	0.00
CDE_STATE_VAR	T_UNDER_UTIL_LOG	CHAR	1.00	0.00
CDE_STATUS	T_835_CK_EFT_TRCNO	CHAR	1.00	0.00
CDE_STATUS	T_ANALYST	CHAR	1.00	0.00
CDE_STATUS	T_APPLICATION	CHAR	1.00	0.00
CDE_STATUS	T_AR_COLLECTION	CHAR	1.00	0.00
CDE_STATUS	T_AUTO_PA	CHAR	1.00	0.00
CDE_STATUS	T_CAPITATION_ADJ	CHAR	1.00	0.00
CDE_STATUS	T_CAPITATION_ADJ_DN	CHAR	1.00	0.00
CDE_STATUS	T_CAPITATION_ADJ_WI	CHAR	1.00	0.00
CDE_STATUS	T_CAP_MASS_ADJ_RST	CHAR	1.00	0.00
CDE_STATUS	T_CAP_MASS_ADJ_RST_tmp	CHAR	1.00	0.00
CDE_STATUS	T_CAP_SUMMARY	CHAR	1.00	0.00
CDE_STATUS	T_CAP_SUMMARY	CHAR	1.00	0.00
CDE_STATUS	T_CAP_SUMMARY_AL	CHAR	1.00	0.00

CDE_STATUS	T_CAP_SUMMARY_WI	CHAR	1.00	0.00
CDE_STATUS	T_CAP_SUMMARY_tmp	CHAR	1.00	0.00
CDE_STATUS	T_CM_CASE_TYPE	CHAR	1.00	0.00
CDE_STATUS	T_CM_PEER_GROUP	CHAR	1.00	0.00
CDE_STATUS	T_CM_STATUS	CHAR	1.00	0.00
CDE_STATUS	T_CONTROL	CHAR	1.00	0.00
CDE_STATUS	T_DRUG_EXCEPTION_AL	CHAR	1.00	0.00
CDE_STATUS	T_DR_DISPUTE	CHAR	1.00	0.00
CDE_STATUS	T_DR_DISPUTE_DTL	CHAR	1.00	0.00
CDE_STATUS	T_DR_DISPUTE_STAT	CHAR	1.00	0.00
CDE_STATUS	T_DR_INVOICE_DTL	CHAR	1.00	0.00
CDE_STATUS	T_DS_LVX_MSG_LOG	CHAR	1.00	0.00
CDE_STATUS	T_EVS_SVC_COVERAGE	CHAR	1.00	0.00
CDE_STATUS	T_FIN_835_TRACK	CHAR	1.00	0.00
CDE_STATUS	T_FIN_PAYMENT	CHAR	1.00	0.00
CDE_STATUS	T_FIN_REMIT	CHAR	1.00	0.00
CDE_STATUS	T_FIN_SCHED_CRIT_STATUS	CHAR	1.00	0.00
CDE_STATUS	T_PC_AUTHORIZATION	CHAR	1.00	0.00
CDE_STATUS	T_POL_CHAMP_INFO	CHAR	1.00	0.00
CDE_STATUS	T_PROFILE	CHAR	1.00	0.00
CDE_STATUS	T_PR_APPLN_STATUS	CHAR	1.00	0.00
CDE_STATUS	T_PR_ENRL	CHAR	1.00	0.00
CDE_STATUS	T_PR_LOC_RATE_REQ	CHAR	1.00	0.00
CDE_STATUS	T_PR_VERIFY	CHAR	1.00	0.00
CDE_STATUS	T_PW_AUTHORIZATION	CHAR	1.00	0.00
CDE_STATUS	T_RECIP_LINK_XREF	CHAR	1.00	0.00

CDE_STATUS	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_STATUS	T_RE_ASSIGN_PLAN	CHAR	1.00	0.00
CDE_STATUS	T_RE_ASSIGN_PLAN_LI	CHAR	1.00	0.00
CDE_STATUS	T_RE_ASSIGN_PLAN_RLOC	CHAR	1.00	0.00
CDE_STATUS	T_RE_EDB	CHAR	1.00	0.00
CDE_STATUS	T_RE_HOSPICE_HDR	CHAR	1.00	0.00
CDE_STATUS	T_RE_LINK_RQST	CHAR	1.00	0.00
CDE_STATUS	T_RE_UNLINK_RQST	CHAR	1.00	0.00
CDE_STATUS	T_TPL_AR_HEALTH	CHAR	1.00	0.00
CDE_STATUS	T_TPL_AR_HEALTH	CHAR	1.00	0.00
CDE_STATUS	T_TPL_AR_HEALTH_XXX	CHAR	1.00	0.00
CDE_STATUS	T_TPL_CDE_BILLING_STATUS	CHAR	1.00	0.00
CDE_STATUS	T_UC_AUTHORIZATION	CHAR	1.00	0.00
CDE_STATUS	T_UP_AUTHORIZATION	CHAR	1.00	0.00
CDE_STATUS	T_UW_AUTHORIZATION	CHAR	1.00	0.00
CDE_STATUS	T_WEB_USER	CHAR	1.00	0.00
CDE_STATUS	T_WEB_USER_STATUS	CHAR	1.00	0.00
CDE_STATUS	T_WINDOW	CHAR	1.00	0.00
CDE_STATUS1	T_ADJ_MASS_CLAIM	CHAR	1.00	0.00
CDE_STATUS1	T_ADJ_MASS_RQST	CHAR	1.00	0.00
CDE_STATUS1	T_BANK_PD_NOISSUE	CHAR	1.00	0.00
CDE_STATUS1	T_CA_EPSDT_ABNORMAL	CHAR	1.00	0.00
CDE_STATUS1	T_CA_ERROR	CHAR	1.00	0.00
CDE_STATUS1	T_CHECK	CHAR	1.00	0.00

CDE_STATUS1	T_CHECK_STATUS_CDE	CHAR	1.00	0.00
CDE_STATUS1	T_CHECK_STATUS_HIST	CHAR	1.00	0.00
CDE_STATUS1	T_CLAIM_ERROR	CHAR	1.00	0.00
CDE_STATUS1	T_CLM_EOB_XREF	CHAR	1.00	0.00
CDE_STATUS1	T_CLM_PATLIAB_X	CHAR	1.00	0.00
CDE_STATUS1	T_CLM_PATLIAB_X	CHAR	1.00	0.00
CDE_STATUS1	T_CPAS_CLM_STATUS	CHAR	1.00	0.00
CDE_STATUS1	T_DRUG	CHAR	1.00	0.00
CDE_STATUS1	T_DRUG_DN	CHAR	1.00	0.00
CDE_STATUS1	T_DR_INVOICE	CHAR	1.00	0.00
CDE_STATUS1	T_EVS_ELIG	CHAR	1.00	0.00
CDE_STATUS1	T_FIN_PROCESS_PYMT	CHAR	1.00	0.00
CDE_STATUS1	T_LIEN	CHAR	1.00	0.00
CDE_STATUS1	T_LIEN_STATUS	CHAR	1.00	0.00

CDE_STATUS1	T_MC_FTE	CHAR	1.00	0.00
CDE_STATUS1	T_MC_PMP_SC	CHAR	1.00	0.00
CDE_STATUS1	T_PA_ITEM_DTL_XREF	CHAR	1.00	0.00
CDE_STATUS1	T_PROJ_STATUS_CDE	CHAR	1.00	0.00
CDE_STATUS1	T_PROJ_TRACK	CHAR	1.00	0.00
CDE_STATUS1	T_PR_APPLN	CHAR	1.00	0.00
CDE_STATUS1	T_PR_APPLN_STATUS_RSN	CHAR	1.00	0.00
CDE_STATUS1	T_PR_APPLN_WI	CHAR	1.00	0.00
CDE_STATUS1	T_PR_CDE_APPLN_STATUS	CHAR	1.00	0.00
CDE_STATUS1	T_PR_HB_LIC	CHAR	1.00	0.00
CDE_STATUS1	T_PR_HB_LIC_KY	CHAR	1.00	0.00
CDE_STATUS1	T_PR_LETTER_TEXT	CHAR	1.00	0.00
CDE_STATUS1	T_PR_PHONE_TRACK	CHAR	1.00	0.00
CDE_STATUS1	T_PR_RST_SVC	CHAR	1.00	0.00
CDE_STATUS1	T_RBRVS_UPDATE	CHAR	1.00	0.00
CDE_STATUS1	T_RE_AID_ELIG	CHAR	1.00	0.00
CDE_STATUS1	T_RE_AID_ELIG	CHAR	1.00	0.00
CDE_STATUS1	T_RE_AID_ELIG_DN	CHAR	1.00	0.00
CDE_STATUS1	T_RE_ELIG	CHAR	1.00	0.00
CDE_STATUS1	T_RE_ELIG_DN	CHAR	1.00	0.00
CDE_STATUS1	T_RE_EPS_ABNORMAL	CHAR	1.00	0.00
CDE_STATUS1	T_RE_HOH	CHAR	1.00	0.00
CDE_STATUS1	T_RE_PARTD_PDP_ASSIGN	CHAR	1.00	0.00

CDE_STATUS1	T_RE_PMP_ASSIGN	CHAR	1.00	0.00
CDE_STATUS1	T_RE_PMP_ASSIGN_WI	CHAR	1.00	0.00
CDE_STATUS1	T_RE_RETRO_ELIG	CHAR	1.00	0.00
CDE_STATUS1	T_SUR_RQST_EOMB	CHAR	1.00	0.00
CDE_STATUS1_1	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS1_2	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS1_3	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS1_4	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS1_5	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS1_6	T_CA_ERROR_DN	CHAR	1.00	0.00
CDE_STATUS2	T_DR_PAYMENT_HDR	CHAR	2.00	0.00
CDE_STATUS2	T_DR_PAYMENT_STAT	CHAR	2.00	0.00
CDE_STATUS2	T_DR_PAYMENT_XREF	CHAR	2.00	0.00
CDE_STATUS_1	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00

CDE_STATUS_2	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00
CDE_STATUS_3	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00
CDE_STATUS_CASE	T_CASUALTY_CASE	CHAR	1.00	0.00
CDE_STATUS_CASE	T_CASUALTY_CASE_AL	CHAR	1.00	0.00
CDE_STATUS_CASE	T_CAS_CASE_STATUS	CHAR	1.00	0.00
CDE_STATUS_CHECK	T_TPL_CHECK_HOLD	CHAR	1.00	0.00
CDE_STATUS_CSR	T_CSR	CHAR	1.00	0.00
CDE_STATUS_EFT	T_FIN_CDE_EFT_STATUS	CHAR	1.00	0.00
CDE_STATUS_EFT	T_FIN_EFT_ACCT	CHAR	1.00	0.00
CDE_STATUS_EFT	T_PR_EFT_ACCT	CHAR	1.00	0.00
CDE_STATUS_ICN	T_DR_RECOUP_LTR_ICN	CHAR	1.00	0.00
CDE_STATUS_INFO	T_TPL_CHECK_HOLD	CHAR	1.00	0.00
CDE_STATUS_TYPE	T_PA_LINEITEM_STAT	CHAR	1.00	0.00
CDE_STAT_ERROR	T_CA_ERROR	CHAR	1.00	0.00
CDE_STAT_ERROR	T_CLAIM_ERROR	CHAR	1.00	0.00
CDE_STAT_ERROR	T_CLM_EOB_XREF	CHAR	1.00	0.00
CDE_STAT_RULE	T_CLM_RU_MATCHED	CHAR	1.00	0.00

CDE_STOP	T_RE_ELIG_DN	CHAR	3.00	0.00
CDE_STOP	T_RE_ELIG_STOP	CHAR	3.00	0.00
CDE_STOP_LOSS_TYPE	T_STOP_LOSS_PARMS	CHAR	1.00	0.00
CDE_STRATA_TYPE	T_CLM_SAMPLE	CHAR	12.00	0.00
CDE_ST_CASE_NEW	T_CAS_CASE_ACT	CHAR	1.00	0.00
CDE_ST_CASE_OLD	T_CAS_CASE_ACT	CHAR	1.00	0.00
CDE_ST_ID	T_TXN_BILLING	CHAR	3.00	0.00
CDE_ST_OF_SCREEN	T_PS_CDE_SCRN_ST	CHAR	2.00	0.00
CDE_ST_OF_SCREEN	T_PS_LVL_I_TRACK	CHAR	2.00	0.00
CDE_SUBMIT	T_BATCH	VARCHAR2	15.00	0.00
CDE_SUBMIT_STATE	T_TMSIS_EXT_HDR	VARCHAR2	2.00	0.00
CDE_SUBMIT_TRANS_TYPE	T_TMSIS_EDIT_FAILURES	VARCHAR2	1.00	0.00
CDE_SUBMIT_TRANS_TYPE	T_TMSIS_EDIT_STATS	VARCHAR2	1.00	0.00
CDE_SUBMIT_TRANS_TYPE	T_TMSIS_EXT_HDR	VARCHAR2	1.00	0.00
CDE_SUBMIT_TRANS_TYPE	T_TMSIS_RUN_STATS	VARCHAR2	1.00	0.00
CDE_SUBSCRIBER_GENDER	T_PHYS_HDR_KEY	CHAR	1.00	0.00
CDE_SUB_2010AA_N407	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_SUB_2010AA_N407	T_CLM_PHYS_HDR	CHAR	3.00	0.00
CDE_SUB_2010AA_N407	T_CLM_UB92_HDR	CHAR	3.00	0.00
CDE_SUB_2010AB_N407	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_SUB_2010AB_N407	T_CLM_PHYS_HDR	CHAR	3.00	0.00
CDE_SUB_2010AB_N407	T_CLM_UB92_HDR	CHAR	3.00	0.00
CDE_SUB_2010AC_N407	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_SUB_2010AC_N407	T_CLM_PHYS_HDR	CHAR	3.00	0.00
CDE_SUB_2010AC_N407	T_CLM_UB92_HDR	CHAR	3.00	0.00

CDE_SUB_2010BA_N407	T_CLM_DNTL_HDR	CHAR	3.00	0.00
CDE_SUB_2010BA_N407	T_CLM_PHYS_HDR	CHAR	3.00	0.00
CDE_SUB_2010BA_N407	T_CLM_UB92_HDR	CHAR	3.00	0.00
CDE_SUB_2310C_N407	T_CLM_DNTL_2300	CHAR	3.00	0.00
CDE_SUB_2310C_N407	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_SUB_2310E_N407	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_SUB_2310F_N407	T_CLM_PHYS_2300	CHAR	3.00	0.00
CDE_SUB_2330A_N407	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_SUB_2330A_N407	T_CLM_PHYS_2320	CHAR	3.00	0.00
CDE_SUB_2330A_N407	T_CLM_UB92_2320	CHAR	3.00	0.00
CDE_SUB_2330B_N407	T_CLM_DNTL_2320	CHAR	3.00	0.00
CDE_SUB_2330B_N407	T_CLM_PHYS_2320	CHAR	3.00	0.00
CDE_SUB_2330B_N407	T_CLM_UB92_2320	CHAR	3.00	0.00
CDE_SUB_2420C_N407	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_SUB_2420D_N407	T_CLM_DNTL_2400	CHAR	3.00	0.00
CDE_SUB_2420E_N407	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_SUB_2420G_N407	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_SUB_2420H_N407	T_CLM_PHYS_2400	CHAR	3.00	0.00
CDE_SUB_GENDER	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00
CDE_SUB_GENDER	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
CDE_SUB_ID	T_TRANSACTION	VARCHAR2	35.00	0.00
CDE_SUITE_FOOTNOTE	T_PR_ADR_CASS	CHAR	2.00	0.00
CDE_SUITE_FOOTNOTE	T_RE_ADR_CASS	CHAR	2.00	0.00
CDE_SURFACE_1	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
CDE_SURFACE_2	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00

CDE_SURFACE_3	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
CDE_SURFACE_4	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
CDE_SURFACE_5	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
CDE_SUSPECT	T_SUSPECT_CODE	CHAR	1.00	0.00
CDE_SUSPECT	T_TPL_RESOURCE	CHAR	1.00	0.00
CDE_SVC_CATEGORY	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
CDE_SVC_LOC_FA	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_OTHER_2	T_PD_UB92_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_REF_1	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_REF_1	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_REF_2	T_PD_DNTL_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_REF_2	T_PD_PHYS_HDR	CHAR	1.00	0.00
CDE_SVC_LOC_REND	T_PD_PHARM_HDR	CHAR	1.00	0.00
CDE_SVC_PROV_SPEC	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_PROV_SPEC	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_PROV_SPEC	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_PROV_TAXON	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_SVC_PROV_TAXON	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_SVC_PROV_TAXON	T_TMSIS_COT003_CLM_DTL	VARCHAR2	12.00	0.00
CDE_SVC_PROV_TYPE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_PROV_TYPE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_PROV_TYPE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_SVC_TRACKING_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SVC_TRACKING_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SVC_TRACKING_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00

CDE_SVC_TRACKING_TYPE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_SVC_TYPE	T_EVS_CDE_SVC_TYPE	CHAR	2.00	0.00
CDE_SVC_TYPE	T_EVS_SVC_COVERAGE	CHAR	2.00	0.00
CDE_SVC_TYPE	T_PA_LINE_ITEM	CHAR	1.00	0.00
CDE_SYSTEMIC	T_CDE_DRUG_ROUTE	CHAR	1.00	0.00
CDE_S_D_DIAG	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_S_D_DIAG	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_S_D_TO_NUM	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_S_D_TO_NUM	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_S_D_TO_SURF	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_S_D_TO_SURF	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_TANF_CASH	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
CDE_TARGET_834	T_RE_RCO_834	CHAR	5.00	0.00
CDE_TAXONOMY	T_MR_TMSIS_PROV_TAXON	CHAR	10.00	0.00
CDE_TAXONOMY	T_PR_ENRL_SPECIALTY	CHAR	10.00	0.00
CDE_TAXONOMY	T_PR_TAXONOMY_CDE	CHAR	10.00	0.00
CDE_TAXONOMY_ADDNL	T_PR_ENRL_PROV	CHAR	10.00	0.00
CDE_TAX_ID_TYPE	T_PR_SANCTION_AL	CHAR	1.00	0.00
CDE_TAX_ID_TYPE	T_PR_SANCTION_WI	CHAR	1.00	0.00
CDE_TEAM_SURG	T_RBRVS	CHAR	1.00	0.00
CDE_TEAM_SURG	T_RBRVS_UPDATE	CHAR	1.00	0.00
CDE_TECH_CONTACT1	T_835_CONTACTS	CHAR	2.00	0.00
CDE_TECH_CONTACT2	T_835_CONTACTS	CHAR	2.00	0.00
CDE_TECH_CONTACT3	T_835_CONTACTS	CHAR	2.00	0.00
CDE_TEST_LEVEL	T_PLOG_HEADER	CHAR	2.00	0.00
CDE_TEST_LEVEL	T_PLOG_VERSION	CHAR	2.00	0.00

CDE_TEXT_1	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_TEXT_2	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_TEXT_3	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_TEXT_4	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_TEXT_5	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_TEXT_6	T_ADJ_RULES	VARCHAR2	100.00	0.00
CDE_THERA_AHFS	T_LS_DRUG_MASTER	CHAR	6.00	0.00
CDE_THERA_AHFS	T_LS_SUMMARY_NDC	CHAR	6.00	0.00
CDE_THERA_CLASS	T_LS_DRUG_MASTER	CHAR	7.00	0.00
CDE_THERA_CLS_AHFS	T_CA_DRUG	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_CDE_THERA_AHFS	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_DRUG	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_DRUG	NUMBER	9.00	0.00
CDE_THERA_CLS_AHFS	T_DRUG_DN	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_ERX_FORMULARY	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_GENERIC_DRUG	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_PDL_MASTER	CHAR	10.00	0.00

CDE_THERA_CLS_AHFS	T_PDL_MASTER_AL	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_PDL_SCRN_CRIT	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS	T_THERA_AHFS	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS_FIRST6	T_AUDIT_AHFS	CHAR	6.00	0.00
CDE_THERA_CLS_AHFS_FIRST6	T_DRUG_EXCEPTION_AL	CHAR	6.00	0.00
CDE_THERA_CLS_AHFS_FROM	T_AHFS_GROUP	CHAR	10.00	0.00
CDE_THERA_CLS_AHFS_TO	T_AHFS_GROUP	CHAR	10.00	0.00
CDE_THERA_CLS_FDA	T_DRUG	CHAR	2.00	0.00
CDE_THERA_CLS_FDA	T_DRUG_DN	CHAR	2.00	0.00

CDE_THERA_CLS_FDA	T_THERA_FDA	CHAR	2.00	0.00
CDE_THERA_CLS_GEN	T_CA_DRUG	CHAR	3.00	0.00
CDE_THERA_CLS_GEN	T_CDE_THERA_GEN	CHAR	3.00	0.00
CDE_THERA_CLS_GEN	T_GENERIC_DRUG	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_CA_DRUG	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_CDE_THERA_SPEC	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_DRUG_EXCEPTION_AL	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_PDL_MASTER	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_PDL_MASTER_AL	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_PDL_SCRN_CRIT	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_THERAPEUTIC	CHAR	3.00	0.00
CDE_THERA_CLS_SPEC	T_THERA_DUP_LOG	CHAR	3.00	0.00
CDE_THERA_CLS_STD	T_CA_DRUG	CHAR	3.00	0.00
CDE_THERA_CLS_STD	T_CDE_THERA_STD	CHAR	3.00	0.00

CDE_THERA_CLS_STD	T_GENERIC_DRUG	CHAR	3.00	0.00
CDE_THERA_CLS_ST_FROM	T_AUDIT_THER_CL_X	CHAR	2.00	0.00
CDE_THERA_CLS_ST_TO	T_AUDIT_THER_CL_X	CHAR	2.00	0.00
CDE_THERA_EQUIV	T_DR_CMS_TAPE	CHAR	2.00	0.00
CDE_THRESHOLD	T_TPL_THRESHOLD	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_OP_PERFORM	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_OP_PERFORM_DTL	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_PROV_PERFORM	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_PROV_PERFORM_DTL	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_PROV_PERFORM_KY	CHAR	2.00	0.00
CDE_THRUPUT_TYPE	T_MR_THRUPUT_GRP	CHAR	2.00	0.00
CDE_TH_CL_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_TH_CL_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_TIER_COPAY	T_ERX_FORMULARY	CHAR	1.00	0.00
CDE_TIME_PERIOD	T_RE_SPEND_LIAB	CHAR	1.00	0.00
CDE_TIME_UNIT	T_AUDIT_TIME_UNIT_XREF	CHAR	1.00	0.00
CDE_TIME_UNIT	T_CDE_TIME_UNIT	CHAR	1.00	0.00
CDE_TIME_UNIT	T_CONFLICT_PARM	CHAR	1.00	0.00
CDE_TIME_UNIT	T_CONTRA_PARM	CHAR	1.00	0.00
CDE_TIME_UNIT	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_TIME_UNIT	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_TIME_UNIT	T_READMIT_PARM	CHAR	1.00	0.00
CDE_TIME_UNIT	T_UMBRELLA_PARM	CHAR	1.00	0.00
CDE_TITLE	T_PR_TITLE_CODE	CHAR	15.00	0.00

CDE_TMSIS_DATA_ELEMENT	T_MR_TMSIS_CMS_ERROR_RECS	VARCHAR2	6.00	0.00
CDE_TMSIS_DATA_ELEMENT	T_MR_TMSIS_ELEMENTS_XREF	CHAR	6.00	0.00
CDE_TMSIS_DATA_ELEMENT	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	6.00	0.00
CDE_TMSIS_DATA_ELEMENT	T_TMSIS_DATA_ELEMENTS	VARCHAR2	6.00	0.00
CDE_TMSIS_DED_VER	T_TMSIS_EXT_HDR	VARCHAR2	10.00	0.00
CDE_TMSIS_DMAP_VER	T_TMSIS_EXT_HDR	VARCHAR2	9.00	0.00
CDE_TMSIS_EDIT_RULE	T_TMSIS_EDIT_RULES	VARCHAR2	10.00	0.00
CDE_TMSIS_EDIT_TIER	T_TMSIS_EDIT_RULES	VARCHAR2	5.00	0.00
CDE_TMSIS_ERR_CAT	T_TMSIS_EDIT_RULES	VARCHAR2	10.00	0.00
CDE_TMSIS_ERR_CAT	T_TMSIS_ERROR_CATEGORY	VARCHAR2	10.00	0.00
CDE_TMSIS_PROV_SPEC	T_MR_TMSIS_PROV_SPEC	CHAR	2.00	0.00
CDE_TMSIS_PROV_TYPE	T_MR_TMSIS_PROV_TYPE	CHAR	2.00	0.00
CDE_TMSIS_TYPE_OF_BILL	T_MR_TMSIS_TYPE_OF_BILL	CHAR	4.00	0.00
CDE_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES	VARCHAR2	30.00	0.00
CDE_TMSIS_VV_IN_EX_DATA_EL	T_TMSIS_DEP_ELEM_XREF	VARCHAR2	1.00	0.00
CDE_TMSIS_VV_IN_EX_DEP_EL	T_TMSIS_DEP_ELEM_XREF	VARCHAR2	1.00	0.00
CDE_TOB_IN_EX	T_AUDIT_CRIT	CHAR	1.00	0.00
CDE_TOB_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_TOOTH	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH1_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH1_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH1_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH1_SURFACE4	T_PA_DTL	CHAR	2.00	0.00

CDE_TOOTH1_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH2	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH2_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH2_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH2_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH2_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH2_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH3	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH3_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH3_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH3_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH3_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH3_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH4	T_PA_LINE_ITEM	CHAR	2.00	0.00

CDE_TOOTH4_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH4_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH4_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH4_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH4_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH5	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH5_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH5_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH5_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH5_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH5_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH6	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH6_SURFACE1	T_PA_DTL	CHAR	2.00	0.00

CDE_TOOTH6_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH6_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH6_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH6_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH7	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH7_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH7_SURFACE2	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH7_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH7_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH7_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH8	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH8_SURFACE1	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH8_SURFACE2	T_PA_DTL	CHAR	2.00	0.00

CDE_TOOTH8_SURFACE3	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH8_SURFACE4	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH8_SURFACE5	T_PA_DTL	CHAR	2.00	0.00
CDE_TOOTH_DESIG_SYSTEM	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_TOOTH_NBR	T_AUDIT_TOOTH_NBR_X_AL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_CA_DENTAL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_DENY_DNTL_DTL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_MPHX_DENTAL_DTL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_PD_DNTL_DTL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_PROC_TOOTH	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_SUSP_DENTAL_DTL	CHAR	2.00	0.00
CDE_TOOTH_NBR	T_TOOTH	CHAR	2.00	0.00
CDE_TOOTH_NBR_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
CDE_TOOTH_NUMBER	T_CLM_DN2	VARCHAR2	30.00	0.00
CDE_TOOTH_QUAD	T_PA_LINE_ITEM	CHAR	2.00	0.00
CDE_TOOTH_QUAD	T_PROC_TOOTH_QUAD	CHAR	3.00	0.00
CDE_TOOTH_QUAD	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_TOOTH_QUAD	T_TOOTH_QUADRANT	CHAR	3.00	0.00
CDE_TOOTH_STATUS	T_CLM_DN2	CHAR	2.00	0.00
CDE_TOOTH_SURFACE	T_CLM_DTL_TTH_SFC	CHAR	1.00	0.00
CDE_TOOTH_SURFACE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	1.00	0.00
CDE_TOOTH_SURFACE	T_TOOTH_SURFACE	CHAR	1.00	0.00
CDE_TOOTH_SURFACE_1	T_CA_DENTAL	CHAR	1.00	0.00
CDE_TOOTH_SURFACE_2	T_CA_DENTAL	CHAR	1.00	0.00
CDE_TOOTH_SURFACE_3	T_CA_DENTAL	CHAR	1.00	0.00
CDE_TOOTH_SURFACE_4	T_CA_DENTAL	CHAR	1.00	0.00

CDE_TOOTH_SURFACE_5	T_CA_DENTAL	CHAR	1.00	0.00
CDE_TOOTH_SURFACE_6	T_CA_DENTAL	CHAR	1.00	0.00
CDE_TOP_200	T_DRUG	NUMBER	4.00	0.00
CDE_TOS	T_LS_LVL1_PRICING	CHAR	2.00	0.00
CDE_TOS	T_LS_LVL3_PRICING	CHAR	2.00	0.00
CDE_TOS	T_MR_TMSIS_CDE_TOS	CHAR	3.00	0.00
CDE_TPL_ACTION	T_CLM_TPL_RESOURCE	CHAR	1.00	0.00
CDE_TPL_ENTITY_ADR_TYPE	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	2.00	0.00
CDE_TPL_IN	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
CDE_TPL_OUT	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
CDE_TPL_SVC_CLASS	T_TPL_MATRIX_XREF	CHAR	2.00	0.00
CDE_TPL_SVC_CLASS	T_TPL_SVC_CLASS	CHAR	2.00	0.00
CDE_TPL_UNIT	T_TPL_CDE_CLERK_UNIT	CHAR	1.00	0.00
CDE_TPL_UNIT	T_TPL_CLERK	CHAR	1.00	0.00
CDE_TP_GROUP	T_CDE_TP_GROUP	VARCHAR2	6.00	0.00
CDE_TP_GROUP	T_TP_GROUP_XREF	VARCHAR2	6.00	0.00
CDE_TP_ID	T_TELECOM_TP	CHAR	15.00	0.00
CDE_TP_ID	T_TXN_BILLING	CHAR	15.00	0.00
CDE_TP_PTA_ACTRN_TX	T_RE_EDB	CHAR	4.00	0.00
CDE_TP_PTA_BUYIN_ELIG	T_RE_EDB	CHAR	1.00	0.00
CDE_TP_PTA_DELET_TX	T_RE_EDB	CHAR	4.00	0.00
CDE_TP_PTA_PAYER	T_RE_EDB	CHAR	3.00	0.00
CDE_TP_PTB_ACTRN_TX	T_RE_EDB	CHAR	4.00	0.00
CDE_TP_PTB_BUYIN_ELIG	T_RE_EDB	CHAR	1.00	0.00
CDE_TP_PTB_DELET_TX	T_RE_EDB	CHAR	4.00	0.00
CDE_TP_PTB_PAYER	T_RE_EDB	CHAR	3.00	0.00
CDE_TP_STATUS	T_CDE_TP_STATUS	VARCHAR2	50.00	0.00
CDE_TP_TYPE	T_CDE_TP_TYPE	VARCHAR2	50.00	0.00
CDE_TRACKING_STATUS	T_ACCT_REC	CHAR	4.00	0.00
CDE_TRACKING_STATUS	T_ACCT_REC_DN	CHAR	4.00	0.00

CDE_TRANS	T_PA_ATTACH_INFO	CHAR	2.00	0.00
CDE_TRANSACT	T_PLOG_HEADER	CHAR	8.00	0.00
CDE_TRANSACT	T_PLOG_MODULES	CHAR	8.00	0.00
CDE_TRANSACT	T_PLOG_REPORTS	CHAR	8.00	0.00
CDE_TRANSACT	T_PLOG_WINDOWS	CHAR	8.00	0.00
CDE_TRANSACT	T_TRANSACTIONS	CHAR	8.00	0.00
CDE_TRANSACTION	T_CDE_SUPPORTED_DOC	CHAR	3.00	0.00
CDE_TRANSACTION	T_CLM_RU_MATCHED	CHAR	4.00	0.00
CDE_TRANSACTION	T_EDIC_PAYLOADTYPES	VARCHAR2	3.00	0.00
CDE_TRANSACTION	T_RU_DECISION	CHAR	4.00	0.00
CDE_TRANSACTION	T_RU_TRANSACTION	CHAR	4.00	0.00
CDE_TRANSACTION	T_RU_VARIABLE	CHAR	4.00	0.00
CDE_TRANSACTION_CATEGORY	T_RE_AR_TRANSACTION	CHAR	1.00	0.00
CDE_TRANSACTION_TYPE	T_RE_AR_TRANSACTION	CHAR	1.00	0.00
CDE_TRANSPORT	T_CDE_TRANSPORT	VARCHAR2	50.00	0.00
CDE_TREATMENT	T_UB92_TREATMENT	VARCHAR2	30.00	0.00
CDE_TRIPLE_THREAT_IND	T_MME_OPIOID_CONCR_ALERT	CHAR	1.00	0.00
CDE_TXN	T_AR_TXN_XREF	CHAR	1.00	0.00
CDE_TXN	T_BATCH	CHAR	2.00	0.00
CDE_TXN	T_CDE_BUY_BILL	CHAR	1.00	0.00
CDE_TXN	T_DIAG_DSE_XRF_LOG	CHAR	1.00	0.00
CDE_TXN	T_DRUG_GER_LOG	CHAR	1.00	0.00
CDE_TXN	T_DRUG_PED_LOG	CHAR	1.00	0.00
CDE_TXN	T_DRUG_PREG_LOG	CHAR	1.00	0.00
CDE_TXN	T_EXPEND_TXN_XREF	CHAR	1.00	0.00

CDE_TXN	T_FIN_BUDG_DISP	CHAR	1.00	0.00
CDE_TXN	T_FIN_NUM_COR	CHAR	1.00	0.00
CDE_TXN	T_FIN_PROCESS_BUDG_DISP	CHAR	1.00	0.00
CDE_TXN	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00
CDE_TXN	T_FIN_REMIT_TXN_XREF	CHAR	1.00	0.00
CDE_TXN	T_FIN_SCHED_CRIT_TXN	CHAR	1.00	0.00
CDE_TXN	T_FIN_TXN_TYPE	CHAR	1.00	0.00
CDE_TXN	T_HIGH_DOSE_LOG	CHAR	1.00	0.00
CDE_TXN	T_INVRS_UPDT_LOG	CHAR	1.00	0.00
CDE_TXN	T_LOW_DOSE_LOG	CHAR	1.00	0.00
CDE_TXN	T_OVER_UTIL_LOG	CHAR	1.00	0.00
CDE_TXN	T_PAY_HOLD_TXN_XREF	CHAR	1.00	0.00
CDE_TXN	T_THERA_DUP_LOG	CHAR	1.00	0.00
CDE_TXN	T_UNDER_UTIL_LOG	CHAR	1.00	0.00
CDE_TXN_MOD	T_CDE_BUY_BILL	CHAR	1.00	0.00
CDE_TXN_SECONDARY	T_FIN_TXN_TYPE	CHAR	2.00	0.00
CDE_TXN_SORT	T_FIN_TXN_TYPE	CHAR	2.00	0.00
CDE_TXN_TYPE	T_CDE_TXN_TYPE	CHAR	1.00	0.00
CDE_TXN_TYPE	T_COS_DTL_XREF	CHAR	1.00	0.00
CDE_TXN_TYPE	T_FIN_EFT_ACCT	CHAR	1.00	0.00
CDE_TXN_TYPE	T_FIN_PROCESS_SCHED	CHAR	1.00	0.00
CDE_TXN_TYPE	T_FIN_SCHED_CRIT_TXN	CHAR	1.00	0.00
CDE_TXN_TYPE	T_RE_HIST_ERR	CHAR	5.00	0.00
CDE_TXN_TYPE	T_RE_PS2_ERR	CHAR	5.00	0.00
CDE_TYPE	T_CDE_ACTION	CHAR	1.00	0.00

CDE_TYPE	T_CDE_TPL_IN_OUT	CHAR	1.00	0.00
CDE_TYPE	T_FIN_PAYMENT	CHAR	1.00	0.00
CDE_TYPE	T_MC_CAP_CLM_XREF	CHAR	1.00	0.00
CDE_TYPE	T_MC_POSTCARD_RERUN	CHAR	1.00	0.00
CDE_TYPE	T_MC_RE_ASGN_LTRS	CHAR	1.00	0.00
CDE_TYPE	T_MULT_SURG_PCT	CHAR	1.00	0.00
CDE_TYPE	T_PA_ATTACH_INFO	CHAR	2.00	0.00
CDE_TYPE	T_RE_CCHIC_TRACK	CHAR	1.00	0.00
CDE_TYPE	T_RE_PAT_LIAB	CHAR	1.00	0.00
CDE_TYPE	T_TPL_COST_AVOID_SUMM	CHAR	1.00	0.00
CDE_TYPE_834	T_RE_RCO_834	CHAR	1.00	0.00
CDE_TYPE_ASSIST	T_DS_RECIP_CORE	CHAR	2.00	0.00
CDE_TYPE_BILL_FROM	T_COV_BILL_XREF	CHAR	3.00	0.00
CDE_TYPE_BILL_TO	T_COV_BILL_XREF	CHAR	3.00	0.00
CDE_TYPE_FROM	T_PR_LABEL_CRIT	CHAR	2.00	0.00
CDE_TYPE_INCOME	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_TYPE_MEDICARE	T_TPL_PREBILL	CHAR	1.00	0.00
CDE_TYPE_NOTIFICATION	T_CALL_OTIFICATION	CHAR	2.00	0.00
CDE_TYPE_OF_BILL	T_AUDIT_TOB_XREF	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_DENY_UB92_HDR	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_MPHX_INPT_HDR	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_MPHX_INPT_HDR2	CHAR	3.00	0.00

CDE_TYPE_OF_BILL	T_MR_TMSIS_TYPE_OF_BILL	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_PAY_BNFT_TOB	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_PD_UB92_HDR	VARCHAR2	3.00	0.00
CDE_TYPE_OF_BILL	T_POS_TYP_BILL	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_REIMB_TOB	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_SPEC_TOB_XREF	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_SUSP_UB92_HDR	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	4.00	0.00
CDE_TYPE_OF_BILL	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	4.00	0.00
CDE_TYPE_OF_BILL	T_TMSIS_COT002_CLM_HDR	VARCHAR2	4.00	0.00
CDE_TYPE_OF_BILL	T_TOB_CT_XREF	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_TOB_GROUP	CHAR	3.00	0.00
CDE_TYPE_OF_BILL	T_TYPE_OF_BILL	CHAR	3.00	0.00
CDE_TYPE_OF_CLAIM	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_TYPE_OF_CLAIM	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_TYPE_OF_CLAIM	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_TYPE_OF_CLAIM	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
CDE_TYPE_OF_HOSPITAL	T_MR_TMSIS_HOSP_TYPE	CHAR	2.00	0.00
CDE_TYPE_OF_HOSPITAL	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_TYPE_OF_SCREEN	T_PS_CDE_SCREEN	CHAR	2.00	0.00
CDE_TYPE_OF_SCREEN	T_PS_LVL_I_TRACK	CHAR	2.00	0.00
CDE_TYPE_OF_SERVICE	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_TYPE_OF_SERVICE	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_TYPE_OF_SERVICE	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_TYPE_OF_SERVICE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_TYPE_ORIGIN	T_CALL_OTIFICATION	CHAR	2.00	0.00
CDE_TYPE_OTHER_TPL	T_TMSIS_TPL005_OTH_TPL_COV	VARCHAR2	1.00	0.00
CDE_TYPE_PLAN	T_PUB_HLTH_PGM	CHAR	4.00	0.00
CDE_TYPE_SPEC_EI	T_TYPE_SPEC_GROUP	CHAR	1.00	0.00
CDE_TYPE_TO	T_PR_LABEL_CRIT	CHAR	2.00	0.00

CDE_T_ALERT_RSN	T_DS_RECIP_CORE	CHAR	1.00	0.00
CDE_T_P	T_TXN_BILLING	CHAR	1.00	0.00
CDE_UNDER_DIR_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNDER_DIR_PROV_TAXON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNDER_DIR_PROV_TAXON	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNDER_SUP_PROV_TAXON	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNDER_SUP_PROV_TAXON	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNDER_SUP_PROV_TAXON	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
CDE_UNEARNED_FREQ	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_UNEARNED_SOURCE	T_DS_RECIP_SOBRA_FAMILY	CHAR	2.00	0.00
CDE_UNEARN_SRC	T_CDE_FAM_MBR_UNEARN_SRC	CHAR	2.00	0.00
CDE_UNIT	T_CDE_DOSE_UNIT	CHAR	2.00	0.00
CDE_UNIT	T_DR_CONV_UNITS	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_ACCT_REC	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_ACCT_REC_DN	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_AR_DISP	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_EXPENDITURE	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_EXPENDITURE_DN	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_FIN_CDE_UNIT	CHAR	2.00	0.00
CDE_UNIT_DEPT	T_FIN_PROCESS_AR	CHAR	2.00	0.00

CDE_UNIT_DEPT	T_FIN_PROCESS_AR_DISP	CHAR	2.00	0.00
CDE_UNIT_FROM	T_CALL_QUESTION	CHAR	18.00	0.00
CDE_UNIT_MEASURE	T_CLM_NDC_DTL	CHAR	2.00	0.00
CDE_UNIT_OF_MEASURE	T_CLM_HSD	CHAR	2.00	0.00
CDE_UNIT_OF_MEASURE	T_CLM_QTY	CHAR	2.00	0.00
CDE_UNIT_OF_MEASURE	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	2.00	0.00
CDE_UNIT_TO	T_CALL_QUESTION	CHAR	18.00	0.00
CDE_UNIT_TYPE	T_DR_TMP_SUPP_RATES	CHAR	3.00	0.00
CDE_UNIT_TYPE	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_UNIT_TYPE	T_LIMIT_PARM	CHAR	1.00	0.00
CDE_UNIT_TYPE	T_MR_TMSIS_UNIT_TYPE	CHAR	5.00	0.00
CDE_UNIT_TYPE	T_PROC	CHAR	5.00	0.00
CDE_UNIT_TYPE	T_REV_HOSPICE_XWALK	CHAR	1.00	0.00
CDE_UNIT_TYPE	T_UNIT_TYPE	CHAR	5.00	0.00
CDE_UOM	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
CDE_UOM_AMB	T_CLM_CR1	CHAR	2.00	0.00
CDE_UOM_DME	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
CDE_UPDATE_SOURCE	T_DRUG	CHAR	1.00	0.00
CDE_UPDATE_SOURCE	T_DRUG_DN	CHAR	1.00	0.00
CDE_UPDATE_TYPE	T_DRUG	CHAR	1.00	0.00
CDE_UPDATE_TYPE	T_DRUG_DN	CHAR	1.00	0.00

CDE_URBAN_RURAL	T_COUNTY	CHAR	1.00	0.00
CDE_USAGE	T_TP_CONFIG	CHAR	1.00	0.00
CDE_USER_ELIG_INCOMP	T_ETG_SUMMARY	CHAR	1.00	0.00
CDE_USER_ELIG_INCOMP	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00
CDE_USER_ELIG_INCOMP	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
CDE_USER_ELIG_INCOMP	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
CDE_USER_EPISODE_TYPE	T_ETG_SUMMARY	VARCHAR2	1.00	0.00
CDE_USER_EPISODE_TYPE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	1.00	0.00
CDE_USER_EPISODE_TYPE	T_ETG_SUMMARY_FFS	VARCHAR2	1.00	0.00
CDE_USER_EPISODE_TYPE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	1.00	0.00
CDE_USER_OUTLIER	T_ETG_SUMMARY	VARCHAR2	1.00	0.00

CDE_USER_OUTLIER	T_ETG_SUMMARY_ENCNTR	VARCHAR2	1.00	0.00
CDE_USER_OUTLIER	T_ETG_SUMMARY_FFS	VARCHAR2	1.00	0.00
CDE_USER_OUTLIER	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	1.00	0.00
CDE_VA	T_DS_RECIP_DO_INCOME	CHAR	1.00	0.00
CDE_VALUE	T_CA_VALUE	CHAR	2.00	0.00
CDE_VALUE	T_CDE_HIPAA	CHAR	10.00	0.00
CDE_VALUE	T_REF_CDE_VALUE_GROUP	CHAR	10.00	0.00
CDE_VALUE	T_RU_ACTION	VARCHAR2	50.00	0.00
CDE_VALUE	T_RU_DISCRETE_SET	VARCHAR2	50.00	0.00
CDE_VALUE	T_UB92_HDR_VALUE	CHAR	2.00	0.00
CDE_VALUE	T_VALUE	CHAR	2.00	0.00
CDE_VALUE_1	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_10	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_11	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_12	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_2	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_3	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_4	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_5	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_6	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_7	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_8	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_9	T_CA_VALUE_DN	CHAR	2.00	0.00
CDE_VALUE_CHILD	T_RU_ARRAY	VARCHAR2	50.00	0.00

CDE_VALUE_COMP	T_RU_COMPARISON	VARCHAR2	50.00	0.00
CDE_VALUE_TYPE	T_RU_ACTION	CHAR	1.00	0.00
CDE_VALUE_TYPE	T_RU_COMPARISON	CHAR	1.00	0.00
CDE_VAN_ID	T_TRANSACTION	VARCHAR2	35.00	0.00
CDE_VARIABLE	T_RU_ACTION	CHAR	4.00	0.00
CDE_VARIABLE	T_RU_COMPARISON	CHAR	4.00	0.00
CDE_VARIABLE	T_RU_DECISION_VAR	CHAR	4.00	0.00
CDE_VARIABLE	T_RU_VARIABLE	CHAR	4.00	0.00
CDE_VER_CTRL_NUM	T_TXN_BILLING	CHAR	5.00	0.00
CDE_VISIT	T_PR_ENROLL_SCRN	CHAR	2.00	0.00
CDE_VT_REL_TO_APPL	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
CDE_WAGE_FREQ	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
CDE_WAGE_TYPE	T_CDE_WAGE_TYPE	CHAR	2.00	0.00
CDE_WAIVER_TYPE	T_MR_TMSIS_BEN_PLAN	CHAR	2.00	0.00
CDE_WAIVER_TYPE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_WAIVER_TYPE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_WAIVER_TYPE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_WAIVER_TYPE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	2.00	0.00
CDE_WAIVER_TYPE	T_TMSIS_ELG012_WAIVER_PART	VARCHAR2	2.00	0.00

CDE_WARD_TYPE	T_RE_BASE	CHAR	1.00	0.00
CDE_WEIGHT_UOM	T_CLM_CR1	CHAR	2.00	0.00
CDE_WEIGHT_UOM	T_CLM_SBR	CHAR	2.00	0.00
CDE_WORKER_ACTION	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
CDE_WORK_CLASS	T_PROJ_TRK_DTL	CHAR	2.00	0.00
CDE_WORK_CLASS	T_PROJ_WORK_CLASS	CHAR	2.00	0.00
CDE_X12_VERSION	T_EDI_INTERCHANGE	VARCHAR2	12.00	0.00
CDE_XFER_REASON	T_MC_CDE_XFER_REASON	CHAR	2.00	0.00
CDE_XFER_REASON	T_MC_PMP_MASS_XFER	CHAR	2.00	0.00
CDE_XFER_STATUS	T_MC_CDE_XFER_STATUS	CHAR	1.00	0.00
CDE_XFER_STATUS	T_MC_PMP_MASS_XFER	CHAR	1.00	0.00
CDE_XIX_MBESCBES_CAT_SVC	T_MR_TMSIS_FUND_CODE	CHAR	4.00	0.00
CDE_XIX_MBESCBES_CAT_SVC	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_XIX_MBESCBES_CAT_SVC	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_XIX_MBESCBES_CAT_SVC	T_TMSIS_COT003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_XIX_MBESCBES_CAT_SVC	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	4.00	0.00
CDE_XXI_MBESCBES_CAT_SVC	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_XXI_MBESCBES_CAT_SVC	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_XXI_MBESCBES_CAT_SVC	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_XXI_MBESCBES_CAT_SVC	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
CDE_ZIP_CODE	T_BORDER	NUMBER	5.00	0.00
CD_ENTITL_CHG_RSN	T_RE_EDB	CHAR	1.00	0.00
CHECK_SAK	T_CASH_RECEIPT	NUMBER	9.00	0.00
CHECK_SAK	T_CHCK_CLM_XREF	NUMBER	9.00	0.00
CHECK_SAK	T_CHECK	NUMBER	9.00	0.00

CHECK_SAK	T_CHECK_CLEARED	NUMBER	9.00	0.00
CHECK_SAK	T_CHECK_SLIP_DATE	NUMBER	9.00	0.00
CHECK_SAK	T_CHECK_STATUS_HIST	NUMBER	9.00	0.00
CHECK_SAK	T_CHECK_VOID	NUMBER	9.00	0.00
CHECK_SAK	T_CHK_ENCODE_ERROR	NUMBER	9.00	0.00
CHECK_SAK	T_CHK_REISSUE_XREF	NUMBER	9.00	0.00
CHECK_SAK	T_CHK_STALE_DATE	NUMBER	9.00	0.00
CHECK_SAK	T_FIN_NO_ISSUE	NUMBER	9.00	0.00
CHECK_SAK	T_FIN_PAYMENT	NUMBER	9.00	0.00
CHECK_SAK	T_FIN_PROCESS_PYMT	NUMBER	9.00	0.00
CHECK_SAK	T_FIN_PROCESS_PYMT_XREF	NUMBER	9.00	0.00
CHECK_SAK	T_FIN_REMIT	NUMBER	9.00	0.00
CHILD_AUTH_IND	T_WEB_RECEIVER	CHAR	1.00	0.00
CHILD_AUTH_IND	T_WEB_RECEIVER_BACKUP	CHAR	1.00	0.00
CHK_ISS_DAY	T_FIN_CYCLE	CHAR	1.00	0.00
CHK_ISS_NUM_DAYS	T_FIN_CYCLE	NUMBER	4.00	0.00
CITY	T_TRADING_PARTNER	VARCHAR2	19.00	0.00
CITY_RETURN_ST	T_835_CONSTANTS	CHAR	30.00	0.00
CITY_RETURN_ST	T_FIN_CYCLE	CHAR	15.00	0.00
CLAIM_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
CLAIM_KEY	T_CA_CLAIM_KEY	NUMBER	9.00	0.00
CLAIM_KEY	T_CA_FIN	NUMBER	9.00	0.00
CLAIM_KEY	T_DS_HM_HEADER	NUMBER	9.00	0.00
CLAIM_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00

CLAIM_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
CLAIM_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
CLAIM_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
CLIST_VER	T_AGREEMENTS	VARCHAR2	6.00	0.00
CLIST_VER	T_TRADSTAT	VARCHAR2	6.00	0.00
CLIST_VER	T_TRLOG	VARCHAR2	6.00	0.00
CLM	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
CLMS_BILLED	T_CLAIM_EXTRACT	NUMBER	9.00	0.00
CLMS_BILLED	T_PHS_CLAIM	NUMBER	9.00	0.00
CLM_CNT	T_PF_INPAT_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_INPAT_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_NHOME_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_NHOME_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_OUTPAT_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_OUTPAT_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PHARM_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PHARM_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PROF_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PROF_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PRREF_RE_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_PRREF_RP_TOT_Q	NUMBER	8.00	0.00
CLM_CNT	T_PF_RECIP_CMPR	NUMBER	8.00	0.00
CLM_CNT	T_PF_RE_CMPR_Q	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_INPAT_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_INPAT_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_INPAT_GRP_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_INPAT_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_INPAT_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_OUTPAT_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_OUTPAT_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	8.00	0.00

CLM_CNT	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_OUTPAT_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PEER_PROV_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARMREF_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARMREF_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARMREF_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARM_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARM_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARM_GRP_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARM_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PHARM_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROFREF_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROFREF_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROFREF_GRP_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROFREF_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROFREF_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROF_AMTS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROF_GLOBALS	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROF_GRP_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROF_PROV_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROF_PT_TOT	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_PROV_NON_REFER	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_RECIP	NUMBER	4.00	0.00
CLM_CNT	T_PROFILE_SELECTED_CASES	NUMBER	8.00	0.00
CLM_CNT	T_PROFILE_TOT_CMPR	NUMBER	8.00	0.00
CLM_DISPNSE_DT	T_ADJ_REV_RQST	CHAR	8.00	0.00
CLM_LST_NAM_RECIP	T_DENTAL_HDR_KEYS	VARCHAR2	60.00	0.00
CLM_LST_NAM_RECIP	T_PHRM_HDR_KEYS	VARCHAR2	60.00	0.00

CLM_LST_NAM_RECIP	T_PHRM_HDR_KEYS	VARCHAR2	60.00	0.00
CLM_LST_NAM_RECIP	T_PHYS_HDR_KEY	VARCHAR2	60.00	0.00
CLM_LST_NAM_RECIP	T_UB92_HDR_EXT_KEY	VARCHAR2	60.00	0.00
CLM_RANK	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
CLM_RECIP_FST_NAM	T_DENTAL_HDR_KEYS	VARCHAR2	35.00	0.00
CLM_RECIP_FST_NAM	T_PHRM_HDR_KEYS	VARCHAR2	35.00	0.00
CLM_RECIP_FST_NAM	T_PHRM_HDR_KEYS	VARCHAR2	35.00	0.00
CLM_RECIP_FST_NAM	T_PHYS_HDR_KEY	VARCHAR2	35.00	0.00
CLM_RECIP_FST_NAM	T_UB92_HDR_EXT_KEY	VARCHAR2	35.00	0.00
CLM_RE_CNT	T_PROFILE_PMPM_PROV	NUMBER	5.00	0.00
CLM_RE_CNT	T_PROF_MM_PEER	NUMBER	8.00	0.00
CLM_TOT_CHG	T_CALL_QUESTION	NUMBER	8.00	2.00
CLUSTER_NUM	T_ETG_DTL	VARCHAR2	4.00	0.00
CLUSTER_NUM	T_ETG_DTL_ENCNTR	VARCHAR2	4.00	0.00
CLUSTER_NUM	T_ETG_DTL_FFS	VARCHAR2	4.00	0.00
CLUSTER_NUM	T_ETG_DTL_RCO_PAID	VARCHAR2	4.00	0.00
CMS64_COS	T_MR_CMS64	CHAR	4.00	0.00
CMS64_FUND_COL	T_MR_CMS64	NUMBER	4.00	0.00
CMS64_RPT_LINE	T_MR_CMS64	CHAR	4.00	0.00
CMS64_RPT_NUM	T_MR_CMS64	NUMBER	9.00	0.00
CMS_FILLER_17	T_PR_ATT_CMS	CHAR	17.00	0.00
CNT	T_CHK_BAN_CLM_TYPE	NUMBER	4.00	0.00
CNT	T_CHK_BAN_PROV_TYP	NUMBER	4.00	0.00

CNT	T_PAY_HOLD_CLM_TYP	NUMBER	4.00	0.00
CNT	T_PAY_HOLD_PGM_CDE	NUMBER	4.00	0.00
CNT	T_PAY_HOLD_PROV	NUMBER	4.00	0.00
CNT	T_PAY_HOLD_PR_TYPE	NUMBER	4.00	0.00
CNT_2400_PATIENT02	T_CLM_PHYS_2400	NUMBER	15.00	3.00
CNT_AG1	T_AGREEMENTS	VARCHAR2	3.00	0.00
CNT_AG1	T_TRADSTAT	VARCHAR2	3.00	0.00
CNT_AG2	T_AGREEMENTS	VARCHAR2	3.00	0.00
CNT_AG2	T_TRADSTAT	VARCHAR2	3.00	0.00
CNT_AG3	T_AGREEMENTS	VARCHAR2	3.00	0.00
CNT_AG3	T_TRADSTAT	VARCHAR2	3.00	0.00
CNT_AG4	T_AGREEMENTS	VARCHAR2	3.00	0.00
CNT_AG4	T_TRADSTAT	VARCHAR2	3.00	0.00
CNT_ATTEMPTS	T_835_CK_EFT_TRCNO	NUMBER	2.00	0.00
CNT_BAD_CLM	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_BAD_CLM	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_BED	T_TMSIS_PRV010_BED_TYPE	NUMBER	5.00	0.00
CNT_CASE_TYPE	T_CM_CASE_GROUP	NUMBER	4.00	0.00
CNT_CLAIMS	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
CNT_CLAIMS	T_DS_CLM_CNT_PAID_DTE	NUMBER	9.00	0.00
CNT_CLAIMS	T_DS_CLM_CNT_SVC_DTE	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00

CNT_CLAIMS	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
CNT_CLAIMS	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_ERROR	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_ERROR_DTL	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_ERROR_KY	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_PROV_DENIED	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_RE_CNTY	NUMBER	9.00	0.00
CNT_CLAIMS	T_MR_XOVER	NUMBER	9.00	0.00
CNT_CLAIMS_CORR	T_MR_ERROR_COUNTS	NUMBER	9.00	0.00
CNT_CLAIMS_CORR	T_MR_PROV	NUMBER	9.00	0.00
CNT_CLAIMS_CORR	T_MR_PROV_DENIED	NUMBER	9.00	0.00
CNT_CLAIMS_DENIED	T_CA_ANALYSIS	NUMBER	9.00	0.00
CNT_CLAIMS_ERROR	T_MR_ERROR_COUNTS	NUMBER	9.00	0.00
CNT_CLAIMS_ERRORS	T_MR_PROV	NUMBER	9.00	0.00
CNT_CLAIMS_ERRORS	T_MR_PROV_DENIED	NUMBER	9.00	0.00
CNT_CLAIMS_OVRD	T_MR_ERROR_COUNTS	NUMBER	9.00	0.00
CNT_CLAIMS_OVRD	T_MR_PROV	NUMBER	9.00	0.00
CNT_CLAIMS_OVRD	T_MR_PROV_DENIED	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_CA_ANALYSIS	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_CA_FIN	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_DS_DNTL_ICN	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_MR_POS	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_MR_PROV	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_MR_RECIP	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_MR_RECIP_KY	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_MR_RECIP_RANK	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_PR_PROV_YTD_AMT	NUMBER	9.00	0.00
CNT_CLAIMS_PAID	T_PR_YTD_AMT_HIST	NUMBER	9.00	0.00
CNT_CLAIMS_TPL	T_MR_PROV	NUMBER	9.00	0.00
CNT_CLAIM_LINE	T_TMSIS_CIP002_CLM_HDR	NUMBER	4.00	0.00
CNT_CLAIM_LINE	T_TMSIS_CLT002_CLM_HDR	NUMBER	4.00	0.00
CNT_CLAIM_LINE	T_TMSIS_COT002_CLM_HDR	NUMBER	4.00	0.00

CNT_CLAIM_LINE	T_TMSIS_CRX002_CLM_HDR	NUMBER	4.00	0.00
CNT_CLAIM_PAID	T_SCOS_CLAIMS_BY_DATE	NUMBER	8.00	0.00
CNT_CLAIM_PAID	T_SCOS_CLAIMS_BY_MONTH	NUMBER	8.00	0.00
CNT_CLAIM_PAID	T_SCOS_CLAIMS_BY_QTR	NUMBER	8.00	0.00
CNT_CLAIM_PAID	T_SCOS_FIN_DATA_BY_DATE	NUMBER	8.00	0.00
CNT_CLAIM_PAID	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	8.00	0.00
CNT_CLAIM_PAID	T_SCOS_FIN_DATA_BY_QTR	NUMBER	8.00	0.00
CNT_CLM	T_TPL_COST_AVOID_SUMM	NUMBER	9.00	0.00
CNT_CL_DENIED	T_MR_PROV	NUMBER	9.00	0.00
CNT_CL_DENIED	T_MR_RECIP	NUMBER	9.00	0.00
CNT_CL_DENIED	T_MR_RECIP_KY	NUMBER	9.00	0.00
CNT_CL_DENIED	T_MR_RECIP_RANK	NUMBER	9.00	0.00
CNT_CL_DENIED	T_PR_PROV_YTD_AMT	NUMBER	9.00	0.00
CNT_CL_DENIED	T_PR_YTD_AMT_HIST	NUMBER	9.00	0.00
CNT_CL_DOR_DOA	T_MR_OP_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOR_DOA	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOR_DOP	T_MR_OP_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOR_DOP	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOR_DOP	T_MR_PROV_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOR_DOP	T_MR_PROV_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOR_DOP	T_MR_PROV_PERFORM_KY	NUMBER	9.00	0.00
CNT_CL_DOS_DOA	T_MR_OP_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOS_DOA	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOS_DOP	T_MR_OP_PERFORM	NUMBER	9.00	0.00

CNT_CL_DOS_DOP	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOS_DOP	T_MR_PROV_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOS_DOP	T_MR_PROV_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOS_DOP	T_MR_PROV_PERFORM_KY	NUMBER	9.00	0.00
CNT_CL_DOS_DOR	T_MR_OP_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOS_DOR	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOS_DOR	T_MR_PROV_PERFORM	NUMBER	9.00	0.00
CNT_CL_DOS_DOR	T_MR_PROV_PERFORM_DTL	NUMBER	9.00	0.00
CNT_CL_DOS_DOR	T_MR_PROV_PERFORM_KY	NUMBER	9.00	0.00
CNT_CL_PD_ADJ	T_PR_PROV_YTD_AMT	NUMBER	9.00	0.00
CNT_CL_PD_ADJ	T_PR_YTD_AMT_HIST	NUMBER	9.00	0.00
CNT_CMPD_INGRED_MOD	T_CLM_PHRM_CMPD_MOD	NUMBER	2.00	0.00
CNT_CRITERIA	T_CM_CASE_GROUP	NUMBER	4.00	0.00
CNT_CRITERIA	T_CM_CASE_TYPE	NUMBER	4.00	0.00
CNT_CRITERIA	T_CM_PEER_GROUP	NUMBER	4.00	0.00
CNT_DAYS_OF_CARE	T_MR_LTC_REV	NUMBER	9.00	0.00
CNT_DENIED	T_CLM_HIST_BALANCE	NUMBER	9.00	0.00
CNT_DENIED_ADJ	T_CLM_HIST_BALANCE	NUMBER	9.00	0.00
CNT_DENIED_CLAIMS	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
CNT_DRUG_GEN	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
CNT_DRUG_GEN	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
CNT_ELIGIBLES	T_AUTO_PA_SUMMARY	NUMBER	8.00	0.00
CNT_ELIGIBLES	T_DS_RECIP_AGGR_CNT	NUMBER	7.00	0.00

CNT_EM_DTLS	T_PR_PCP	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
CNT_EPISODES	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_ERROR	T_BATCH_ERR_SUM	NUMBER	9.00	0.00
CNT_FILE	T_DS_LVX_MSG_LOG	NUMBER	10.00	0.00
CNT_HITS	T_PROFILE_INFO_SOLUTIONS	NUMBER	8.00	0.00
CNT_INFORMATIONAL	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_INFORMATIONAL	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_INFORMATIONAL	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_LOOKUP	T_NDC_LOOKUP_STATS	NUMBER	9.00	0.00
CNT_LTC_DAYS	T_MR_WVR_ELG	NUMBER	9.00	0.00
CNT_LTC_DAYS_CARE	T_MR_LTC	NUMBER	9.00	0.00
CNT_MIA_COSTRPT_DAYS	T_CLM_MIA	NUMBER	6.00	0.00
CNT_MIA_COVERED_DAYS	T_CLM_MIA	NUMBER	6.00	0.00
CNT_MIA_LIFE_PSYCH	T_CLM_MIA	NUMBER	6.00	0.00
CNT_MIA_LIFE_RESERVE	T_CLM_MIA	NUMBER	6.00	0.00
CNT_MMIS_UNAVAIL	T_CALL_TRACK	NUMBER	3.00	0.00
CNT_NUM_ICN	T_SCOS_CLAIMS_BY_DATE	NUMBER	8.00	0.00
CNT_NUM_ICN	T_SCOS_CLAIMS_BY_MONTH	NUMBER	8.00	0.00
CNT_NUM_ICN	T_SCOS_CLAIMS_BY_QTR	NUMBER	8.00	0.00
CNT_NUM_ICN	T_SCOS_FIN_DATA_BY_DATE	NUMBER	8.00	0.00

CNT_NUM_ICN	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	8.00	0.00
CNT_NUM_ICN	T_SCOS_FIN_DATA_BY_QTR	NUMBER	8.00	0.00
CNT_OP_AMT_PAID	T_PHRM_COB	NUMBER	4.00	0.00
CNT_OP_BENEFIT_STAGE_AMT	T_CLM_PHRM_COB_BENEFIT	NUMBER	2.00	0.00
CNT_OP_PAT_RESP_AMT	T_CLM_PHRM_COB_PAT_RESP	NUMBER	2.00	0.00
CNT_ORIG_CLM	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_ORIG_CLM	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_OTHER_PAYER	T_CLM_PHRM_COB_BENEFIT	NUMBER	4.00	0.00
CNT_OTHER_PAYER	T_CLM_PHRM_COB_PAT_RESP	NUMBER	4.00	0.00
CNT_OTHER_PAYER	T_PHRM_COB	NUMBER	4.00	0.00
CNT_OTHER_PAYER	T_PHRM_COB_XREF	NUMBER	4.00	0.00
CNT_PAID	T_CLM_HIST_BALANCE	NUMBER	9.00	0.00
CNT_PAID_ADJ	T_CLM_HIST_BALANCE	NUMBER	9.00	0.00
CNT_PC_DAYS	T_MR_OP_PERFORM	NUMBER	4.00	0.00
CNT_PC_DAYS	T_MR_OP_PERFORM_DTL	NUMBER	4.00	0.00
CNT_PC_DAYS	T_MR_PROV_PERFORM	NUMBER	4.00	0.00
CNT_PC_DAYS	T_MR_PROV_PERFORM_DTL	NUMBER	4.00	0.00
CNT_PC_DAYS	T_MR_PROV_PERFORM_KY	NUMBER	4.00	0.00
CNT_PC_HST1	T_DS_RECIP_CORE	NUMBER	3.00	0.00
CNT_PC_HST2	T_DS_RECIP_CORE	NUMBER	3.00	0.00
CNT_PDF_RA	T_PR_SVC_LOC	NUMBER	3.00	0.00
CNT_PDF_RA	T_PR_SVC_LOC_AL	NUMBER	3.00	0.00

CNT_PDF_RA	T_PR_SVC_LOC_WI	NUMBER	3.00	0.00
CNT_PEERGRP	T_CM_CASE_GROUP	NUMBER	4.00	0.00
CNT_PERF_PROV_ID	T_SCOS_CLAIMS_BY_DATE	NUMBER	8.00	0.00
CNT_PERF_PROV_ID	T_SCOS_CLAIMS_BY_MONTH	NUMBER	8.00	0.00
CNT_PERF_PROV_ID	T_SCOS_CLAIMS_BY_QTR	NUMBER	8.00	0.00
CNT_PERF_PROV_ID	T_SCOS_FIN_DATA_BY_DATE	NUMBER	8.00	0.00
CNT_PERF_PROV_ID	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	8.00	0.00
CNT_PERF_PROV_ID	T_SCOS_FIN_DATA_BY_QTR	NUMBER	8.00	0.00
CNT_PLAST_CARD	T_DS_RECIP_CORE	NUMBER	3.00	0.00
CNT_PROVS	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
CNT_PROVS	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_PROV_ID	T_SCOS_CLAIMS_BY_DATE	NUMBER	8.00	0.00
CNT_PROV_ID	T_SCOS_CLAIMS_BY_MONTH	NUMBER	8.00	0.00
CNT_PROV_ID	T_SCOS_CLAIMS_BY_QTR	NUMBER	8.00	0.00
CNT_PROV_ID	T_SCOS_FIN_DATA_BY_DATE	NUMBER	8.00	0.00
CNT_PROV_ID	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	8.00	0.00
CNT_PROV_ID	T_SCOS_FIN_DATA_BY_QTR	NUMBER	8.00	0.00
CNT_PROV_SPEC	T_PAY_HOLD_PROV_SPEC	NUMBER	4.00	0.00
CNT_RECIPIENTS	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
CNT_RECIPIENTS	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00

CNT_RECIPIENTS	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_CLAIMS_BY_DATE	NUMBER	8.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_CLAIMS_BY_MONTH	NUMBER	8.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_CLAIMS_BY_QTR	NUMBER	8.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_FIN_DATA_BY_DATE	NUMBER	8.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	8.00	0.00
CNT_RECIP_BASE_ID	T_SCOS_FIN_DATA_BY_QTR	NUMBER	8.00	0.00
CNT_REC_INSERTED	T_PR_INTERFACE_STATS	NUMBER	4.00	0.00
CNT_REC_PROCESSED	T_PR_INTERFACE_STATS	NUMBER	4.00	0.00
CNT_REJ_CLM	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_RESTRICT	T_COS_ASSIGN_CRIT	NUMBER	4.00	0.00
CNT_RESTRICT	T_STATE_COS	NUMBER	4.00	0.00
CNT_ROWS	T_DS_LVX_MSG_LOG	NUMBER	15.00	0.00
CNT_SCOS	T_PAY_HOLD_SCOS	NUMBER	4.00	0.00
CNT_SUSPENSE_CL	T_MR_PROV_SUSP	NUMBER	9.00	0.00
CNT_THRESHOLD	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_THRESHOLD	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_THRESHOLD	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_TMSIS_ERRORS	T_TMSIS_EDIT_STATS	NUMBER	9.00	0.00
CNT_TMSIS_RECORDS	T_TMSIS_RUN_STATS	NUMBER	9.00	0.00
CNT_TOT_CAST_CROWN	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_CLAIMS_DENIED	T_CA_IND_AGGR	NUMBER	9.00	0.00
CNT_TOT_CLAIMS_PAID	T_CA_IND_AGGR	NUMBER	9.00	0.00
CNT_TOT_CLAIMS_TPL	T_CA_IND_AGGR	NUMBER	9.00	0.00
CNT_TOT_CLM	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
CNT_TOT_CLM	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
CNT_TOT_CLMS_PAID	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_CLMS_PAID	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00

CNT_TOT_DTLS	T_PR_PCP	NUMBER	9.00	0.00
CNT_TOT_EXAM	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_FLUORIDE_TREAT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_MULTI_SURFACE	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_ONE_SURFACE	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_PALLIATIVE_TREAT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_PROPHY	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_PULP_CAP	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_RADIOGRAPH	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_REC	T_TMSIS_CIP001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_CLT001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_COT001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_CRX001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_ELG001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_MCR001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_PRV001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_REC	T_TMSIS_TPL001_FILE_HDR	NUMBER	11.00	0.00
CNT_TOT_ROOT_CANAL	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SEALANT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SED_FILLING	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SIMPLE_EXTRACT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_STEEL_CROWN	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SURG_EXTRACT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_INIT	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_INIT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00

CNT_TOT_SVC_PAID	T_DS_DNTL_PR_GRP_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_PAID	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_PAID	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_RCALL	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_SVC_RCALL	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_UNDUP_NPI	T_DS_DNTL_PR_GRP_SUM	NUMBER	9.00	0.00
CNT_TOT_UNDUP_NPI	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_UNDUP_RECIP	T_DS_DNTL_PR_GRP_SUM	NUMBER	9.00	0.00
CNT_TOT_UNDUP_RECIP	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_INIT	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_INIT	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_RADIO	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_RADIO	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_RCALL	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
CNT_TOT_VISITS_RCALL	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
CNT_TXN	T_FIN_EARNINGS_HIST	NUMBER	9.00	0.00

CNT_TXN	T_FIN_EARNINGS_YTD	NUMBER	9.00	0.00
CNT_TXN_1	T_TXN_BILLING	NUMBER	9.00	0.00
CNT_TXN_2	T_TXN_BILLING	NUMBER	9.00	0.00
CNT_UNDUP_CLIENTS_DENIED	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
CNT_UNDUP_RECIP	T_DS_CLM_CNT_PAID_DTE	NUMBER	9.00	0.00
CNT_UNDUP_RECIP	T_DS_CLM_CNT_SVC_DTE	NUMBER	9.00	0.00
CNT_UNITS_SERV	T_MR_PROV	NUMBER	9.00	0.00
CNT_UNITS_SERV	T_MR_RECIP	NUMBER	9.00	0.00
CNT_UNITS_SERV	T_MR_RECIP_KY	NUMBER	9.00	0.00
CNT_UNITS_SERV	T_MR_RE_CNTY	NUMBER	9.00	0.00
CNT_WVR_DAYS	T_MR_WVR_ELG	NUMBER	9.00	0.00
CODE	T_PROFILE_INPAT_MIX	NUMBER	4.00	0.00
CODE	T_PROFILE_OUTPAT_MIX	NUMBER	4.00	0.00
CODE	T_PROFILE_PHARM_MIX	NUMBER	4.00	0.00
CODE	T_PROFILE_PROF_MIX	NUMBER	4.00	0.00
COLD_NAME	T_RTE_RPT_CTL	CHAR	10.00	0.00
COLD_OPT	T_RTE_RPT_CTL	CHAR	10.00	0.00
COLOR_NAM	T_RISK_COLORS	VARCHAR2	64.00	0.00
COMMENT1	T_PR_APPLN_COMMENT	VARCHAR2	250.00	0.00
COMM_AGM	T_AGREEMENTS	VARCHAR2	35.00	0.00
COMM_AGM	T_TRADSTAT	VARCHAR2	35.00	0.00
COMM_AGM	T_TRLOG	VARCHAR2	35.00	0.00
COMPANY_NAME	T_SEC_USER	CHAR	30.00	0.00
CONFINEMENT_NUM	T_ETG_DTL	VARCHAR2	10.00	0.00
CONFINEMENT_NUM	T_ETG_DTL_ENCNTR	VARCHAR2	10.00	0.00
CONFINEMENT_NUM	T_ETG_DTL_FFS	VARCHAR2	10.00	0.00

CONFINEMENT_NUM	T_ETG_DTL_RCO_PAID	VARCHAR2	10.00	0.00
CONSULT_TIME	T_PR_ATT_CMS	NUMBER	10.00	0.00
CONTACT1	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
CONTACT1_EMAIL	T_SEC_SUPPORT	CHAR	15.00	0.00
CONTACT1_FIRST_NAME	T_SEC_SUPPORT	CHAR	15.00	0.00
CONTACT1_LAST_NAME	T_SEC_SUPPORT	CHAR	20.00	0.00
CONTACT1_PHONE	T_SEC_SUPPORT	CHAR	15.00	0.00
CONTACT2	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
CONTACT2_EMAIL	T_SEC_SUPPORT	CHAR	30.00	0.00
CONTACT2_FIRST_NAME	T_SEC_SUPPORT	CHAR	15.00	0.00
CONTACT2_LAST_NAME	T_SEC_SUPPORT	CHAR	20.00	0.00
CONTACT2_PHONE	T_SEC_SUPPORT	CHAR	15.00	0.00
CONTACT_EMAIL	T_SEC_USER	CHAR	50.00	0.00
CONTACT_FIRST_NAME	T_SEC_USER	CHAR	15.00	0.00
CONTACT_LAST_NAME	T_SEC_USER	CHAR	20.00	0.00
CONTACT_NAME	T_WEB_USER	VARCHAR2	40.00	0.00
CONTACT_PHONE	T_SEC_USER	CHAR	15.00	0.00
CONTINGENCY_PLAN_REQ	T_RISK_RANKING	CHAR	1.00	0.00
CONTINGENCY_TRIGGER	T_RISKS	VARCHAR2	4,000.00	0.00
CONTRA_DSE_IND	T_DISEASE_INFERRED	CHAR	1.00	0.00
CONTROL_NUMBER	T_DR_INCR_INT	CHAR	11.00	0.00
CONTROL_NUMBER	T_DR_INCR_PAY	CHAR	11.00	0.00
COPY_SAK	T_CORRESPOND_COPY	NUMBER	9.00	0.00
COPY_TO	T_CORRESPOND_COPY	CHAR	20.00	0.00
CORR_ACTION	T_CORRESPOND_LOG	CHAR	1.00	0.00
CORR_ASSIGNEE	T_CORRESPOND_LOG	CHAR	20.00	0.00
CORR_AUTHOR	T_CORRESPOND_LOG	CHAR	20.00	0.00
CORR_COMPLETE_DATE	T_CORRESPOND_LOG	NUMBER	8.00	0.00
CORR_FUNCTION	T_CORRESPOND_FUNC	NUMBER	9.00	0.00
CORR_FUNCTION	T_CORRESPOND_LOG	NUMBER	9.00	0.00
CORR_FUNCTION_DESC	T_CORRESPOND_FUNC	CHAR	10.00	0.00
CORR_ID	T_CORRESPOND_COPY	NUMBER	9.00	0.00
CORR_ID	T_CORRESPOND_LOG	NUMBER	9.00	0.00
CORR_ID_ACCT	T_CORRESPOND_LOG	CHAR	8.00	0.00
CORR_LETTER_DATE	T_CORRESPOND_LOG	NUMBER	8.00	0.00
CORR_NEXT_ACCTID	T_CORRESPOND_ACCT	NUMBER	9.00	0.00
CORR_RECEIVED_DATE	T_CORRESPOND_LOG	NUMBER	8.00	0.00
CORR_RECIPIENT	T_CORRESPOND_LOG	CHAR	20.00	0.00
CORR_RESPONSE_DATE	T_CORRESPOND_LOG	NUMBER	8.00	0.00
CORR_SOURCE	T_CORRESPOND_ACCT	CHAR	1.00	0.00
CORR_SOURCE	T_CORRESPOND_LOG	CHAR	1.00	0.00

CORR_SOURCE	T_CORRESPOND_SRC	CHAR	1.00	0.00
CORR_SOURCE_DESC	T_CORRESPOND_SRC	CHAR	10.00	0.00
CORR_SUBJECT	T_CORRESPOND_LOG	CHAR	120.00	0.00
CORR_TYPE	T_CORRESPOND_ACCT	CHAR	1.00	0.00
CORR_TYPE	T_CORRESPOND_LOG	CHAR	1.00	0.00
COUNTER	T_DR_DISPUTE	NUMBER	4.00	0.00
COUNTRY	T_TRADING_PARTNER	VARCHAR2	25.00	0.00
COUNTY_CDE	T_MR_MSIS_ELIGIBLE	CHAR	3.00	0.00
COURT_ORDER	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	12.00	0.00
COVERAGE_CRIT	T_COVERAGE_CRIT	CHAR	1.00	0.00
COV_DAYS	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	5.00	0.00
CRVS_UNIT	T_LS_LVL3_PRICING	NUMBER	11.00	3.00
CST_CHRG_RATE	T_PR_DRG_RATE	NUMBER	5.00	4.00
CST_CHRG_RATE	T_PR_DRG_RATE	NUMBER	6.00	5.00
CTN	T_CALL_TRACK	NUMBER	10.00	0.00
CURR_FMT	T_TRADING_PARTNER	VARCHAR2	1.00	0.00
CUSTNO	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
CUSTNO	T_TRADSTAT	VARCHAR2	35.00	0.00
CUST_AMT	T_LS_LVL1_PRICING	NUMBER	7.00	2.00
CUST_EFF_DTE	T_LS_LVL1_PRICING	DATE	0.00	0.00
CUST_END_DTE	T_LS_LVL1_PRICING	DATE	0.00	0.00
DATE_ADDED	T_SEC_USER_AUTHORITY	DATE	0.00	0.00
DATE_BIRTH	T_MR_MSIS_ELIGIBLE	CHAR	8.00	0.00
DATE_DEATH	T_MR_MSIS_ELIGIBLE	CHAR	8.00	0.00
DATE_IND	T_DATE_AGING	CHAR	1.00	0.00
DATE_INT	T_DATE_AGING	NUMBER	9.00	0.00
DATE_JUL	T_DATE_AGING	NUMBER	9.00	0.00
DATE_PAID	T_ADJ_MASS_CLAIM	NUMBER	8.00	0.00
DATE_PAID	T_CLM_SAMPLE	NUMBER	8.00	0.00
DATE_PAID	T_CPAS_EXTRACT	NUMBER	8.00	0.00
DATE_PAID	T_CPAS_SPLIT	NUMBER	8.00	0.00
DATE_PAID	T_HIST_DIRECTORY	NUMBER	8.00	0.00

DATE_PAID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
DATE_PAID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
DATE_PAID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
DATE_PAID	T_RETRO_SUMM_RECS	NUMBER	8.00	0.00
DATE_PAID	T_RE_EPS_ABNORMAL	NUMBER	8.00	0.00
DATE_PAID	T_RE_EPS_HIST_EXT	NUMBER	8.00	0.00
DATE_PARM_1	T_SYSTEM_PARMS	NUMBER	8.00	0.00
DATE_RUN	T_DR_MAIL_DATE	DATE	0.00	0.00
DATE_RUN	T_DR_MAIL_DATE	NUMBER	8.00	0.00
DATE_STAMP	T_EVS_INQUIRY	DATE	0.00	0.00
DATE_STAMP	T_EVS_INQUIRY	NUMBER	8.00	0.00
DATE_STAMP	T_RE_HIST_LOG	NUMBER	8.00	0.00
DATE_STAMP	T_RE_PS2_LOG	NUMBER	8.00	0.00
DATE_YTD	T_DATE_AGING	NUMBER	9.00	0.00
DAYS	T_AGREEMENTS	VARCHAR2	2.00	0.00
DAYS	T_TRADSTAT	VARCHAR2	2.00	0.00
DAYS_BEGIN_GRP	T_MR_THRUPUT_GRP	NUMBER	4.00	0.00
DAYS_END_GRP	T_MR_THRUPUT_GRP	NUMBER	4.00	0.00
DAY_OF_WEEK	T_CA_TIME_KEY	NUMBER	4.00	0.00
DEL_CODE	T_AGREEMENTS	VARCHAR2	1.00	0.00
DEL_CODE	T_TRADING_PARTNER	VARCHAR2	1.00	0.00
DEL_CODE	T_TRADSTAT	VARCHAR2	1.00	0.00
DEN_CNT	T_MB_CALC	NUMBER	10.00	0.00
DESCR	T_WEB_ROLE	VARCHAR2	70.00	0.00
DESCRIPTION	T_SECURITY_LEVEL	VARCHAR2	70.00	0.00
DESCRIPTION	T_WEB_MSG_CATEGORY	VARCHAR2	70.00	0.00
DESC_BATCH	T_CASH_BATCH_NUM	CHAR	30.00	0.00
DESC_CALC_TYPE	T_MM_CALC_TYPE	VARCHAR2	13.00	0.00
DESC_CDE_LETTER	T_TPL_CDE_LETTER	CHAR	200.00	0.00
DESC_CHRONO	T_CDE_CHRONO	CHAR	15.00	0.00
DESC_CNT_CRIT	T_MM_CNT_CRIT	VARCHAR2	50.00	0.00
DESC_DATA_SOURCE	T_MM_DATA_SRCE	VARCHAR2	50.00	0.00
DESC_DOMAIN	T_MM_DOMAIN	VARCHAR2	50.00	0.00
DESC_DTE_RANGE	T_MM_DATE_RANGE	VARCHAR2	50.00	0.00

DESC_INV_TYPE	T_DR_INVOICE_TYPE	CHAR	30.00	0.00
DESC_JOIN_TYPE	T_MM_JOIN_TYPE	VARCHAR2	50.00	0.00
DESC_MEASURE_SOURCE	T_MM_MEASURE_SRCE	VARCHAR2	50.00	0.00
DESC_RATE	T_FIN_RATE_TYPE	VARCHAR	80.00	0.00
DESC_REASON	T_FIN_SCHED_HOLD	VARCHAR	80.00	0.00
DESC_REASON	T_FIN_SCHED_OVERRIDE	VARCHAR	80.00	0.00
DESC_SORT_RA_PGM	T_FIN_CYCLE	CHAR	30.00	0.00
DESC_TP_GROUP	T_CDE_TP_GROUP	VARCHAR2	80.00	0.00
DESI_IND	T_DR_CMS_TAPE	CHAR	1.00	0.00
DEST	T_AGREEMENTS	VARCHAR2	100.00	0.00
DEST	T_TRADSTAT	VARCHAR2	100.00	0.00
DEVICE_TYPE	T_EVS_INQUIRY	CHAR	8.00	0.00
DIAG	T_ETG_SUMMARY	VARCHAR2	7.00	0.00
DIAG	T_ETG_SUMMARY_ENCNTR	VARCHAR2	7.00	0.00
DIAG	T_ETG_SUMMARY_FFS	VARCHAR2	7.00	0.00
DIAG	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	7.00	0.00
DIAG_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_1	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	7.00	0.00
DIAG_1	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	7.00	0.00
DIAG_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_2	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	7.00	0.00
DIAG_2	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	7.00	0.00
DIAG_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_3	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	7.00	0.00
DIAG_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_4	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	7.00	0.00

DIAG_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_5	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	7.00	0.00
DIAG_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_7	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_8	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIAG_9	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
DIALING_CODE	T_COUNTRY	CHAR	5.00	0.00
DIR	T_AGREEMENTS	VARCHAR2	3.00	0.00
DIR	T_TRADSTAT	VARCHAR2	3.00	0.00
DIR	T_TRLOG	VARCHAR2	3.00	0.00
DISPOSITION_TYPE	T_FIN_BUDG_DISP	CHAR	1.00	0.00
DISPOSITION_TYPE	T_FIN_PROCESS_BUDG_DISP	CHAR	1.00	0.00
DISP_FEE	T_LS_PHARMACY_CLAIMS	NUMBER	9.00	2.00
DISP_FEE	T_LS_SUMMARY_NDC	NUMBER	9.00	2.00
DISP_TIME	T_PR_ATT_CMS	NUMBER	10.00	0.00
DOC_WORD	T_CAS_LTR_TYPE	CHAR	12.00	0.00
DOLLDIFF	T_PF_RECIP_CMPR	NUMBER	10.00	2.00
DOLLDIFF	T_PF_RE_CMPR_Q	NUMBER	10.00	2.00
DOLLDIFF	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
DOS_TIME_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
DOS_TIME_KEY	T_CA_FIN	NUMBER	9.00	0.00
DRG	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
DRG_IND	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
DRUG_ID	T_ETG_DTL	VARCHAR2	5.00	0.00

DRUG_ID	T_ETG_DTL_ENCNTR	VARCHAR2	5.00	0.00
DRUG_ID	T_ETG_DTL_FFS	VARCHAR2	5.00	0.00
DRUG_ID	T_ETG_DTL_RCO_PAID	VARCHAR2	5.00	0.00
DSC	T_DEA_CODE	CHAR	100.00	0.00
DSC	T_DESI_CODE	CHAR	100.00	0.00
DSC	T_DRUG_CAT_CODE	VARCHAR2	100.00	0.00
DSC	T_DR_DISPUTE_RSN	CHAR	100.00	0.00
DSC	T_DR_DISPUTE_STAT	CHAR	100.00	0.00
DSC	T_DR_RESO_CODE	CHAR	100.00	0.00
DSC	T_PHARMACY_COS	CHAR	100.00	0.00
DSC	T_PHYSICIAN_COS	CHAR	100.00	0.00
DSC	T_RISK_CATEGORY	VARCHAR2	4,000.00	0.00
DSC	T_RISK_IMPACT	VARCHAR2	4,000.00	0.00
DSC	T_RISK_PLANS	VARCHAR2	4,000.00	0.00
DSC	T_RISK_PLAN_STATUS	VARCHAR2	4,000.00	0.00
DSC	T_RISK_PROBABILITY	VARCHAR2	4,000.00	0.00
DSC	T_RISK_STATUS	VARCHAR2	4,000.00	0.00
DSC	T_STATE_COS	CHAR	50.00	0.00
DSC	T_THERA_FDA	VARCHAR2	100.00	0.00
DSC	T_UB92_COS	CHAR	100.00	0.00
DSC	T_WEB_ACCT_CODE	CHAR	55.00	0.00

DSC	T_WEB_CLM_ERROR_CD	CHAR	50.00	0.00
DSC	T_WEB_CLM_STATUS	CHAR	50.00	0.00
DSC	T_WEB_CLM_TYPE	CHAR	25.00	0.00
DSC	T_WEB_CL_EXCP_STAT	CHAR	15.00	0.00
DSC	T_WEB_PA_STATUS	CHAR	15.00	0.00
DSC	T_WEB_PA_TYPE	CHAR	25.00	0.00
DSC	T_WEB_PROV_ENR_CD	CHAR	75.00	0.00
DSC	T_WEB_PROV_SPEC_CD	CHAR	65.00	0.00
DSC	T_WEB_PROV_TYPE	CHAR	100.00	0.00
DSC	T_WEB_RECORD_CODE	CHAR	40.00	0.00
DSC_1099_ADJ_RSN	T_1099_ADJ_REASON	CHAR	50.00	0.00
DSC_12	T_PROJ_STATUS_CDE	CHAR	12.00	0.00
DSC_150	T_CASH_COMMENT	CHAR	150.00	0.00
DSC_150	T_CSR	CHAR	150.00	0.00
DSC_150	T_CSR_TEXT	CHAR	150.00	0.00
DSC_150_RQST	T_PROJ_DESC	CHAR	150.00	0.00
DSC_150_STATUS	T_PROJ_STATUS	CHAR	150.00	0.00
DSC_25	T_CHK_REISSUE_RSN	CHAR	25.00	0.00
DSC_25	T_CSR_TEXT_CODE	CHAR	25.00	0.00
DSC_25	T_DIAGNOSIS	CHAR	40.00	0.00
DSC_25	T_DIAGNOSIS	VARCHAR2	60.00	0.00
DSC_25	T_DRUG_CLASS	CHAR	25.00	0.00
DSC_25	T_FEDERAL_AID	CHAR	25.00	0.00
DSC_25	T_MODIFIER_TYPE	CHAR	25.00	0.00
DSC_25	T_PDUR_OUTCOME	CHAR	25.00	0.00
DSC_25	T_PRICING_IND	CHAR	25.00	0.00
DSC_25	T_PROC_ICD9_TYPE	CHAR	25.00	0.00
DSC_25	T_PROJ_AREA_CDE	CHAR	25.00	0.00
DSC_25	T_RETRO_SCHED	CHAR	25.00	0.00
DSC_25	T_RE_EPS_MOD_XREF	CHAR	40.00	0.00
DSC_25	T_RE_EPS_XREF_N	CHAR	40.00	0.00
DSC_25	T_RTS_REASON	CHAR	25.00	0.00
DSC_25	T_SKILL	CHAR	25.00	0.00
DSC_25	T_SKILL_LEVEL_CODE	CHAR	25.00	0.00
DSC_25	T_SLC_TASK_CODE	CHAR	25.00	0.00

DSC_25	T_TOB_TYPE	CHAR	25.00	0.00
DSC_30	T_CPAS_HCFA_CODE	CHAR	30.00	0.00
DSC_30	T_IFFSA_AID_RSN	CHAR	30.00	0.00
DSC_30	T_IFSSA_AID_GROUP	CHAR	30.00	0.00
DSC_30	T_PR_PHONE_TYPE	CHAR	30.00	0.00
DSC_30	T_STATE_ADDR	VARCHAR2	30.00	0.00
DSC_30	T_SYSTEM_PARMS	CHAR	30.00	0.00
DSC_50	T_AHFS_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_AR_DISP_REAS	CHAR	50.00	0.00
DSC_50	T_AR_REASONS	CHAR	50.00	0.00
DSC_50	T_AR_STATUS	CHAR	50.00	0.00
DSC_50	T_ASC_GROUP	CHAR	50.00	0.00
DSC_50	T_ASC_GROUP	VARCHAR2	50.00	0.00
DSC_50	T_BENEFIT_PLAN_TYPE	CHAR	50.00	0.00
DSC_50	T_CAP_REASON	CHAR	50.00	0.00
DSC_50	T_CASH_DISP_REASON	CHAR	50.00	0.00
DSC_50	T_DIAG_TYPE	CHAR	50.00	0.00
DSC_50	T_DRG_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_DRUG_TYPE	CHAR	50.00	0.00
DSC_50	T_DR_ADJ_IND	CHAR	50.00	0.00
DSC_50	T_DR_INV_WO_RSN	CHAR	50.00	0.00
DSC_50	T_DR_PAYMENT_STAT	CHAR	50.00	0.00
DSC_50	T_EOB_TYPES	CHAR	50.00	0.00
DSC_50	T_ERROR_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_HICL_SEQ	CHAR	50.00	0.00
DSC_50	T_HIC_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_HIPP_RESOURCE	CHAR	50.00	0.00
DSC_50	T_MOD_GROUP_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_NCPDP_RESPONSE	CHAR	50.00	0.00
DSC_50	T_PROC_TYPE	CHAR	50.00	0.00
DSC_50	T_REF_CDE_AID_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_REF_CDE_DPV_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_REF_CDE_VALUE_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_REF_ID_PROV_TYPE	VARCHAR2	50.00	0.00
DSC_50	T_REV_TYPE	CHAR	50.00	0.00
DSC_50	T_TAXONOMY_TYPE	CHAR	50.00	0.00
DSC_50	T_THERAPEUTIC_TYPE	CHAR	50.00	0.00
DSC_50	T_THERA_DUP_LOG	CHAR	50.00	0.00
DSC_50	T_TOB_TYPE	CHAR	50.00	0.00
DSC_50	T_TPL_AR_REASONS	CHAR	50.00	0.00
DSC_50	T_TYPE_SPEC_CODE	CHAR	50.00	0.00
DSC_6	T_CA_EPSDT_ABNORMAL	CHAR	40.00	0.00

DSC_6	T_RE_EPS_ABNORMAL	CHAR	40.00	0.00
DSC_6	T_RE_EPS_MOD_XREF	CHAR	6.00	0.00
DSC_6	T_RE_EPS_XREF_N	CHAR	6.00	0.00
DSC_ACG	T_CM_ACG	VARCHAR2	80.00	0.00
DSC_ACTION	T_BATCH_ERR_ACT	CHAR	20.00	0.00
DSC_ACTION	T_CDE_ACTION	VARCHAR2	200.00	0.00
DSC_ACTION	T_RE_HIST_ERR	CHAR	20.00	0.00
DSC_ACTION	T_RE_PS2_ERR	CHAR	20.00	0.00
DSC_ADDRESS	T_SYS_REPORT_RECIP	VARCHAR2	30.00	0.00
DSC_ADDR_USAGE	T_PR_ADDR_CODE	CHAR	20.00	0.00
DSC_ADDR_USAGE	T_RE_CDE_ADR_USAGE	CHAR	30.00	0.00
DSC_ADI	T_DRUG_INVERSE	CHAR	60.00	0.00
DSC_ADI	T_DRUG_INVERSE	CHAR	200.00	0.00
DSC_ADI	T_INVRS_UPDT_LOG	CHAR	60.00	0.00
DSC_ADJUSTMENT	T_DAILY_FUND_TXN	CHAR	255.00	0.00
DSC_ADJUSTMENT	T_DR_ADJ_RSN	CHAR	100.00	0.00
DSC_ADJ_ADULT	T_DRG_RATE	CHAR	30.00	0.00
DSC_ADJ_PED	T_DRG_RATE	CHAR	30.00	0.00
DSC_ADJ_RSN	T_CDE_HIPAA_ADJRSN	VARCHAR2	300.00	0.00
DSC_ADJ_RSN	T_CDE_HIPAA_ADJRSN	VARCHAR2	700.00	0.00
DSC_ADMIT_SOURCE	T_ADMIT_SOURCE	VARCHAR2	50.00	0.00
DSC_ADMIT_TYPE	T_ADMIT_TYPE	CHAR	10.00	0.00
DSC_ADR_TYPE	T_PS_CDE_ADR_TYPE	VARCHAR	20.00	0.00
DSC_ADVNT_DISP	T_PS_CDE_ADV_DISP	VARCHAR2	40.00	0.00
DSC_AGCCS	T_ALLERGY_AGCCS	VARCHAR2	60.00	0.00
DSC_AGCSP	T_ALLERGY_AGCSP	VARCHAR2	60.00	0.00
DSC_AGE	T_CDE_PEDI_WEIGHTS	CHAR	30.00	0.00
DSC_AGENCY	T_PR_STATE_AGENCY	CHAR	50.00	0.00
DSC_AGE_GROUP	T_CA_RECIP_KEY	CHAR	15.00	0.00
DSC_AGE_GROUP	T_MR_AGE_GROUP	CHAR	15.00	0.00
DSC_AGE_RESTRICT	T_AGE_RESTRICT	CHAR	20.00	0.00
DSC_AGGREGATION	T_PF_AGR_TYPE	VARCHAR2	100.00	0.00
DSC_AID_CATEGORY	T_CA_RECIP_KEY	CHAR	50.00	0.00
DSC_AID_CATEGORY	T_CDE_AID	CHAR	50.00	0.00

DSC_AID_CATEGORY_SHORT	T_CDE_AID	CHAR	31.00	0.00
DSC_AL_SCHEDULE	T_CDE_AL_SCHEDULE	VARCHAR2	30.00	0.00
DSC_AL_SCHEDULE	T_CDE_AL_SCHEDULE_AL	VARCHAR2	30.00	0.00
DSC_ANALYST_REASON	T_PA_RULE_DECISION	VARCHAR2	4,000.00	0.00
DSC_ANALYST_REASON	T_PA_RULE_QUESTION	VARCHAR2	4,000.00	0.00
DSC_APPL_TYPE	T_CDE_APPL_TYPE	VARCHAR2	50.00	0.00
DSC_APPL_TYPE	T_PR_APPLN_TYPE	VARCHAR2	100.00	0.00
DSC_AREA_TYPE	T_MC_AREA_TYPE	CHAR	15.00	0.00
DSC_ATTACH	T_CDE_ATTACH	VARCHAR2	50.00	0.00
DSC_ATTACH	T_PA_ATTACH_INFO	VARCHAR	80.00	0.00
DSC_ATTACHMENT	T_CDE_ATTACHMENT	VARCHAR2	50.00	0.00
DSC_ATTACHMENT	T_CLM_PWK	VARCHAR2	80.00	0.00
DSC_ATTRIBUTE	T_CCF_ERROR_DATA	CHAR	20.00	0.00
DSC_AUTO_PA	T_AUTO_PA	VARCHAR2	40.00	0.00
DSC_BANK_ACCT	T_FIN_BANK_ACCT	CHAR	30.00	0.00
DSC_BANNER_TEXT	T_CHECK_BANNER	VARCHAR2	4,000.00	0.00
DSC_BED_TYPE	T_PR_BED_TYPE_KY	VARCHAR2	50.00	0.00
DSC_BENEFIT_CATEGORY	T_BENEFIT_LIMIT_CATEGORY	CHAR	30.00	0.00
DSC_BENEFIT_ROLE	T_CLM_BNFT_ROLE	VARCHAR2	100.00	0.00
DSC_BENEFIT_TYPE	T_BENEFIT_TYPE	VARCHAR2	18.00	0.00
DSC_BILL_MEDIA	T_BILLING_MEDIA	CHAR	15.00	0.00
DSC_BILL_TYPE	T_TPL_CDE_BILL_TYPE	CHAR	50.00	0.00
DSC_BNFT_ADJ_TYPE	T_BNFT_ADJ_FACTOR_TYPE	VARCHAR2	250.00	0.00
DSC_BUDGET	T_FIN_BUDGET	CHAR	30.00	0.00
DSC_BUS_ACT	T_PR_CDE_BUS_ACT	VARCHAR2	30.00	0.00
DSC_BUS_PROCESS	T_BUSINESS_PROCESS	CHAR	30.00	0.00
DSC_BUS_UNIT	T_BUSINESS_UNIT	CHAR	30.00	0.00
DSC_BUY_ELIG	T_CDE_BUY_ELIG	CHAR	256.00	0.00
DSC_BUY_TXN	T_CDE_BUY_BILL	CHAR	256.00	0.00
DSC_BUY_TXN	T_CDE_BUY_PREM	CHAR	256.00	0.00
DSC_CALLER_TYPE	T_CDE_CALLER_TYPE	CHAR	50.00	0.00

DSC_CALL_CATEG	T_CDE_CALL_CATEG	CHAR	50.00	0.00
DSC_CALL_CMPLTN	T_CDE_CALL_CMPLTN	CHAR	50.00	0.00
DSC_CALL_METHOD	T_CDE_CALL_METHOD	CHAR	50.00	0.00
DSC_CALL_PRIORITY	T_CDE_CALL_PRIORITY	CHAR	50.00	0.00
DSC_CALL_STATUS	T_CDE_CALL_STATUS	CHAR	50.00	0.00
DSC_CALL_TYPE	T_CDE_CALL_TYPE	CHAR	50.00	0.00
DSC_CALL_UNIT	T_CDE_CALL_UNIT	CHAR	50.00	0.00
DSC_CANNED_RESP	T_CDE_CAN_RESP	CHAR	50.00	0.00
DSC_CAP_CATEGORY	T_MC_RATE_CELL	CHAR	35.00	0.00
DSC_CARRIER_STAT	T_TPL_CDE_CARRIER_STAT	VARCHAR2	40.00	0.00
DSC_CARRIER_TYPE	T_TPL_CDE_CARRIER_TYPE	VARCHAR2	40.00	0.00
DSC_CASE_GROUP	T_CM_CASE_GROUP	VARCHAR2	100.00	0.00
DSC_CASE_STATUS	T_CT_CASE_STATUS	VARCHAR2	100.00	0.00
DSC_CASE_TYPE	T_CAS_CASE_TYPE	CHAR	30.00	0.00
DSC_CASE_TYPE	T_CM_CASE_TYPE	VARCHAR2	100.00	0.00
DSC_CASE_TYPE	T_PS_CASE_TYPE	VARCHAR2	40.00	0.00
DSC_CASH_STATUS	T_CDE_CASH_STATUS	VARCHAR2	30.00	0.00
DSC_CDE	T_CDE_CSHCS_STATUS	CHAR	15.00	0.00
DSC_CDE	T_CDE_HIB_SOURCE	CHAR	15.00	0.00
DSC_CDE	T_CDE_TPL_IN_OUT	VARCHAR2	100.00	0.00
DSC_CDE	T_EXPENDITURE_RSN	CHAR	15.00	0.00
DSC_CDE	T_ID_ISSUE_RSN	CHAR	15.00	0.00
DSC_CDE_ENTITY	T_TPL_CDE_ENTITY_LTR	CHAR	20.00	0.00
DSC_CERT_TYPE	T_PR_CERT_CODE	CHAR	50.00	0.00
DSC_CHG_LINE_1	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CHG_LINE_2	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CHG_LINE_3	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CHG_LINE_4	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CHG_LINE_5	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CHG_LINE_6	T_RE_OTH_CHG	CHAR	50.00	0.00
DSC_CITIZENSHIP	T_CDE_FAM_MBR_CITIZENSHIP	VARCHAR2	75.00	0.00
DSC_CITIZEN_STAT	T_RE_CITIZEN_DSC	CHAR	60.00	0.00
DSC_CLAIM_FORM	T_CLAIM_FRM_TYP	CHAR	10.00	0.00
DSC_CLARIFICATION	T_ERR_RESO_CLRFCTNS	CLOB	0.00	0.00
DSC_CLASS_GROUP	T_CLASS_OBJECT_GROUP	VARCHAR2	4,000.00	0.00
DSC_CLASS_HIERARCHY	T_CLASSIFICATION_BNFT	VARCHAR2	20.00	0.00
DSC_CLM_CAT_STATUS	T_HC_CLM_STAT_CAT	VARCHAR2	200.00	0.00
DSC_CLM_LOCATION	T_CDE_CLM_LOC	VARCHAR2	200.00	0.00
DSC_CLM_STATUS	T_CA_CLAIM_KEY	VARCHAR2	50.00	0.00
DSC_CLM_STATUS	T_CLM_STATUS	VARCHAR2	20.00	0.00

DSC_CLM_TYP	T_CLAIM_TYPE	CHAR	50.00	0.00
DSC_CLM_TYPE	T_CA_CLAIM_KEY	VARCHAR2	50.00	0.00
DSC_CLM_TYPE	T_DS_HM_HEADER	VARCHAR2	50.00	0.00
DSC_CLM_TYPE	T_MR_NONCLAIM_TYPE	CHAR	50.00	0.00
DSC_CMS_TOS	T_CDE_CMS_TOS	VARCHAR2	100.00	0.00
DSC_COLLECT_MEDIA	T_DR_COLLECT_MEDIA	CHAR	25.00	0.00
DSC_COMMENT	T_DR_INV_COMMENT	CLOB	0.00	0.00
DSC_COMMENT	T_PR_COMMENT	VARCHAR2	4,000.00	0.00
DSC_COMMENT	T_PR_ENROLL_SCRN	VARCHAR2	250.00	0.00
DSC_COMMENT	T_PR_INTERFACE_STATS	VARCHAR2	100.00	0.00
DSC_COMMENT	T_PR_VERIFY	VARCHAR2	100.00	0.00
DSC_COMMENT	T_RE_ASSIGN_REASON	VARCHAR2	100.00	0.00
DSC_COMMENT	T_RE_COMMENT	VARCHAR2	4,000.00	0.00
DSC_COMMENTS	T_PLOG_COMMENTS	VARCHAR2	254.00	0.00
DSC_COMMENTS	T_PLOG_ESTIMATE	VARCHAR2	254.00	0.00
DSC_COMPLETE_TXN	T_BUYA_ERROR	VARCHAR2	500.00	0.00
DSC_COMPLETE_TXN	T_BUYB_ERROR	VARCHAR2	500.00	0.00
DSC_COMPLETE_TXN	T_RE_HIST_LOG	VARCHAR2	4,000.00	0.00
DSC_COMPLETE_TXN	T_RE_PS2_LOG	VARCHAR2	4,000.00	0.00
DSC_COND	T_CONDITION	CHAR	40.00	0.00
DSC_CONFIRM	T_CM_CONFIRM	VARCHAR2	10.00	0.00
DSC_CONTACT_TYPE	T_DR_CONTACT_TYPE	VARCHAR2	40.00	0.00
DSC_CONTROL	T_PLOG_PARAMETER	CHAR	45.00	0.00
DSC_COPAY_TYPE	T_COPAY_TYPE	VARCHAR2	20.00	0.00
DSC_COPAY_TYPE	T_MR_COPAY_TYPE	CHAR	50.00	0.00
DSC_COS	T_CA_CLAIM_KEY	CHAR	50.00	0.00
DSC_COS_VALUE	T_CDE_COS_VALUES	CHAR	50.00	0.00
DSC_COUNTRY	T_COUNTRY	VARCHAR2	50.00	0.00
DSC_COUNTY	T_COUNTY	CHAR	12.00	0.00
DSC_COURT_ORDER	T_COURT_ORD_CDE	CHAR	40.00	0.00
DSC_COVER_TYPE	T_COVERAGE_TYPE	CHAR	120.00	0.00
DSC_CPAS1	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS1	T_CPAS_STRAT_STAT	CHAR	40.00	0.00
DSC_CPAS10	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS11	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS12	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS13	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS14	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS15	T_CPAS_HCFA_INFO	CHAR	40.00	0.00

DSC_CPAS16	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS17	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS18	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS19	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS2	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS20	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS21	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS3	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS4	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS5	T_CPAS_HCFA_INFO	CHAR	100.00	0.00
DSC_CPAS6	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS7	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS8	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPAS9	T_CPAS_HCFA_INFO	CHAR	40.00	0.00
DSC_CPASTXT	T_CPAS_HCFA_CODE	CHAR	40.00	0.00
DSC_CRIT	T_CT_PROV_CRIT	VARCHAR2	255.00	0.00
DSC_CRIT	T_CT_RE_CRIT	VARCHAR2	255.00	0.00
DSC_CRITERIA	T_ERR_RESO_CRIT	CLOB	0.00	0.00
DSC_CSE_CAT	T_CM_CSE_CAT	VARCHAR2	50.00	0.00
DSC_CVRG_LVL	T_TPL_CVRG_LVL	CHAR	30.00	0.00
DSC_DAY	T_CM_DAY	VARCHAR2	10.00	0.00
DSC_DB_FIELD	T_LG_LETTER_REQUEST_IDX	VARCHAR2	50.00	0.00
DSC_DB_FIELD	T_LG_LETTER_TEMPL_IDX	VARCHAR2	50.00	0.00
DSC_DB_FIELD_LONG	T_LG_LETTER_TEMPL_IDX	VARCHAR2	100.00	0.00
DSC_DECISION	T_RU_DECISION	VARCHAR2	80.00	0.00
DSC_DEFINITION	T_AHFS_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_BENEFIT_PLAN_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_DIAG_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_DRG_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_DRUG_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_ERROR_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_GCN_SEQNO_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_HIC_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_MOD_GROUP_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_PROC_ICD9_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_PROC_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_REF_CDE_AID_TYPE	VARCHAR2	4,000.00	0.00

DSC_DEFINITION	T_REF_CDE_DPV_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_REF_CDE_VALUE_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_REF_ID_PROV_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_REV_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_TAXONOMY_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_THERAPEUTIC_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_TOB_TYPE	VARCHAR2	4,000.00	0.00
DSC_DEFINITION	T_TYPE_SPEC_CODE	VARCHAR2	4,000.00	0.00
DSC_DEPRIVATION	T_RE_CDE_DEPRIVATION_RSN	VARCHAR2	100.00	0.00
DSC_DEPT	T_SYS_REPORT_RECIP	VARCHAR2	30.00	0.00
DSC_DEST	T_SYS_DEST	VARCHAR2	30.00	0.00
DSC_DIAG_COMPAT	T_CDE_DIAG_COMPAT	VARCHAR2	100.00	0.00
DSC_DISASTER_SURVIVOR	T_RE_CDE_DISASTER_SURVIVOR	VARCHAR2	100.00	0.00
DSC_DISEASE	T_DISEASE_DSC	VARCHAR2	100.00	0.00
DSC_DISEASE_FDBDX	T_DIAG_DSE_XRF_LOG	CHAR	56.00	0.00
DSC_DISEASE_FDBDX	T_DISEASE_DSC	CHAR	56.00	0.00
DSC_DISP_STATUS	T_CDE_DISP_STATUS	VARCHAR2	25.00	0.00
DSC_DNTL_PROC_GRP	T_DS_DNTL_PROC_GRP	VARCHAR2	100.00	0.00
DSC_DNTL_PR_PEER_GRP	T_DS_DNTL_PR_PEER_GRP	VARCHAR2	100.00	0.00
DSC_DOC_TYPE	T_CDE_DOC_TYPE	VARCHAR2	255.00	0.00
DSC_DOMAIN	T_RU_DOMAIN	VARCHAR2	40.00	0.00
DSC_DOSAGE_FORM	T_CDE_DOSAGE_FORM	VARCHAR2	10.00	0.00
DSC_DOSAGE_LONG	T_CDE_DOSAGE_FORM	VARCHAR2	40.00	0.00
DSC_DOSE_FORM	T_LS_DRUG_MASTER	CHAR	10.00	0.00
DSC_DOSE_FORM	T_LS_SUMMARY_NDC	CHAR	10.00	0.00
DSC_DPV	T_REF_CDE_DPV_GROUP	VARCHAR2	200.00	0.00
DSC_DPV_DEFINITION	T_REF_CDE_DPV_GROUP	VARCHAR2	4,000.00	0.00
DSC_DRG	T_DRG	VARCHAR2	132.00	0.00
DSC_DRG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	20.00	0.00
DSC_DRUG_GENERIC	T_CA_DRUG_GENERIC	VARCHAR2	20.00	0.00

DSC_DRUG_PACK	T_DRUG	CHAR	10.00	0.00
DSC_DRUG_PACK	T_DRUG	CHAR	10.00	0.00
DSC_DRUG_PACK	T_DRUG_DN	CHAR	10.00	0.00
DSC_DRUG_SCH	T_PR_DEA_LIC	VARCHAR2	12.00	0.00
DSC_DRUG_SOURCE	T_CA_DRUG_SOURCE	VARCHAR2	20.00	0.00
DSC_DRUG_STRGTH_U	T_CDE_STRENGTH	CHAR	10.00	0.00
DSC_DRUG_STRGTH_U	T_DRUG	CHAR	10.00	0.00
DSC_DRUG_STR_VOL_U	T_CDE_STRENGTH	CHAR	5.00	0.00
DSC_DRUG_STR_VOL_U	T_DRUG	CHAR	5.00	0.00
DSC_DR_CORRECT_FLAG	T_CDE_DR_CORRECT_FLAG	VARCHAR2	200.00	0.00
DSC_DR_UNIT_TYPE	T_CDE_DR_UNIT_TYPE	VARCHAR2	200.00	0.00
DSC_DTE_DAY	T_CDE_DTE_DAY	CHAR	20.00	0.00
DSC_DUAL_STATUS	T_RE_CDE_PARTD_DUAL_STATUS	VARCHAR2	100.00	0.00
DSC_DUR_CONFLICT	T_CDE_DUR_CONFLICT	VARCHAR2	200.00	0.00
DSC_DUR_INTERVENTION	T_CDE_DUR_INTERVENTION	VARCHAR2	200.00	0.00
DSC_DUR_OUTCOME	T_CDE_DUR_OUTCOME	VARCHAR2	200.00	0.00
DSC_D_C_TRACK	T_RE_CDE_D_C_TRACK	VARCHAR2	100.00	0.00
DSC_EARNINGS	T_FIN_CDE_EARNINGS	CHAR	30.00	0.00
DSC_EARNINGS_CATEGORY	T_FIN_CDE_EARNINGS_CAT	CHAR	30.00	0.00
DSC_EDIT	T_TPL_VALIDITY_EDITS	CHAR	120.00	0.00

DSC_EFT_STATUS	T_FIN_CDE_EFT_STATUS	VARCHAR2	30.00	0.00
DSC_EMAIL	T_RE_MULTI_ADDRESS	VARCHAR2	75.00	0.00
DSC_EMAIL	T_SYS_REPORT_RECIP	VARCHAR2	50.00	0.00
DSC_EMERGENCY	T_CDE_EMERGENCY	CHAR	10.00	0.00
DSC_ENROLL_RSN	T_MC_ENROLL_RSN	CHAR	50.00	0.00
DSC_ENROLL_STATUS	T_MC_ENROLL_STATUS	CHAR	50.00	0.00
DSC_ENROLL_STATUS	T_PR_ENROLL_STATUS	CHAR	21.00	0.00
DSC_ENROLL_TYPE	T_RE_CDE_PARTD_ENROLL_TYPE	VARCHAR2	100.00	0.00
DSC_EOB	T_CA_ERROR	CHAR	79.00	0.00
DSC_EOB	T_EOB	CHAR	79.00	0.00
DSC_EOB2	T_EOB	CHAR	79.00	0.00
DSC_EOB3	T_EOB	CHAR	79.00	0.00
DSC_EOB4	T_EOB	CHAR	79.00	0.00
DSC_EOB5	T_EOB	CHAR	79.00	0.00
DSC_EOB_SHORT	T_EOB	VARCHAR2	50.00	0.00
DSC_EOMB	T_PROC	CHAR	30.00	0.00
DSC_ERA_PGM	T_FIN_CYCLE	CHAR	30.00	0.00
DSC_ERROR	T_DS_LVX_MSG_LOG	VARCHAR2	4,000.00	0.00
DSC_ERROR	T_FIN_ERROR_CODE	CHAR	100.00	0.00
DSC_ERROR_LONG	T_FIN_ERROR_CODE	VARCHAR2	4,000.00	0.00
DSC_ERROR_MSG	T_EDIC_RESPONSES	VARCHAR2	200.00	0.00
DSC_ERROR_MSG	T_EDIC_RESPONSES_ARC	VARCHAR2	200.00	0.00
DSC_ERROR_STAT	T_ERROR_DISP	CHAR	50.00	0.00
DSC_ERROR_STAT	T_ERROR_DISP_MMIS	CHAR	50.00	0.00
DSC_ERROR_TYPE	T_CDE_ERR_TYPE	CHAR	30.00	0.00
DSC_ERROR_UPD	T_PDUR_UPD_ERROR	CHAR	20.00	0.00
DSC_ERR_CURRPROG	T_OBJECT_METH	CHAR	10.00	0.00
DSC_ERR_RESO_STATUS	T_RESO_STATUS	VARCHAR2	50.00	0.00
DSC_ESC	T_CA_ERROR	CHAR	50.00	0.00
DSC_ETHNIC	T_CA_RECIP_KEY	VARCHAR2	50.00	0.00
DSC_EVENT	T_CDE_EVENT	VARCHAR2	255.00	0.00

DSC_EVENT	T_CT_PROD_TRAIN	VARCHAR2	255.00	0.00
DSC_EVENT	T_LG_CDE_HISTORY	VARCHAR2	50.00	0.00
DSC_EVENT_EXT	T_LG_HISTORY_EXT	VARCHAR2	2,000.00	0.00
DSC_EVENT_KEY	T_CDE_EVENT_KEY	VARCHAR2	255.00	0.00
DSC_EVENT_TRACK	T_EVENT_TRACK	VARCHAR2	250.00	0.00
DSC_EVENT_TRACK_KEYS	T_EVENT_TRACK_KEYS	VARCHAR2	255.00	0.00
DSC_EXTRA_DATA	T_LG_LETTER_REQUEST	CLOB	0.00	0.00
DSC_EXTRA_DATA	T_LTR_RQST_TEMPLAT	VARCHAR2	4,000.00	0.00
DSC_FIELD	T_RE_HIST_ERR	CHAR	15.00	0.00
DSC_FIELD	T_RE_PS2_ERR	CHAR	15.00	0.00
DSC_FILENAME	T_EDIC_BATCH_MSGBOX	VARCHAR2	500.00	0.00
DSC_FILENAME	T_EDIC_BATCH_MSGBOX_ARC	VARCHAR2	500.00	0.00
DSC_FILENAME	T_LG_LETTERHEAD	CHAR	25.00	0.00
DSC_FILENAME	T_LG_LETTER_REQUEST	CHAR	25.00	0.00
DSC_FILE_DIRECTION	T_CDE_FILE_DIRECTION	VARCHAR2	255.00	0.00
DSC_FILE_INFO	T_CLM_K3	VARCHAR2	80.00	0.00
DSC_FILE_LOCATION	T_CT_FILE_LOCATION	VARCHAR2	50.00	0.00
DSC_FILE_STATUS	T_CDE_FILE_STATUS	VARCHAR2	255.00	0.00
DSC_FILTER	T_CM_CT_FILTER	VARCHAR2	30.00	0.00
DSC_FILTER	T_CM_PG_FILTER	VARCHAR2	30.00	0.00
DSC_FILTER	T_MM_FILTER	VARCHAR2	30.00	0.00
DSC_FIN_ACT	T_DS_CDE_FIN_ACT	VARCHAR2	50.00	0.00
DSC_FIN_COS	T_FIN_COS	CHAR	40.00	0.00
DSC_FIN_CYCLE	T_FIN_CYCLE	CHAR	30.00	0.00
DSC_FIN_DEPT	T_DS_CDE_FIN_DEPT	VARCHAR2	50.00	0.00
DSC_FIN_PAYER	T_FINANCIAL_PAYER	VARCHAR2	1,000.00	0.00
DSC_FIN_PAYER_SHORT	T_FINANCIAL_PAYER	VARCHAR2	30.00	0.00
DSC_FOOTNOTE	T_CDE_SCH_FNOTES	VARCHAR2	3,000.00	0.00
DSC_FOOTNOTE_KEY	T_CDE_SCH_KEYS	VARCHAR2	500.00	0.00
DSC_FORM_TYPE	T_CDE_TAX_FORM_TYPE	VARCHAR2	30.00	0.00
DSC_FREQUENCY	T_CM_FREQUENCY	VARCHAR2	10.00	0.00
DSC_FREQUENCY	T_MM_FREQUENCY	VARCHAR2	10.00	0.00

DSC_FUNCTIONAL_STATUS	T_CDE_FUNCTIONAL_STATUS	VARCHAR2	255.00	0.00
DSC_FUND	T_FIN_FUND_CODE	CHAR	50.00	0.00
DSC_FUND_CODE	T_CA_CLAIM_KEY	CHAR	50.00	0.00
DSC_FUND_GROUP	T_FUND_CDE_GRP	CHAR	50.00	0.00
DSC_FUND_LONG	T_FIN_FUND_CODE	VARCHAR2	4,000.00	0.00
DSC_FUND_PAYER	T_FUND_PAYER	VARCHAR2	1,000.00	0.00
DSC_FUND_PAYER_SHORT	T_FUND_PAYER	VARCHAR2	30.00	0.00
DSC_FUND_SRC	T_CDE_FUND_SRC	CHAR	30.00	0.00
DSC_GCN_SEQNO_TYPE	T_GCN_SEQNO_TYPE	CHAR	25.00	0.00
DSC_GENERIC	T_LS_DRUG_MASTER	VARCHAR2	30.00	0.00
DSC_GROUP	T_BNFT_GROUP_STD	VARCHAR2	4,000.00	0.00
DSC_GROUP	T_GROUP	VARCHAR2	4,000.00	0.00
DSC_GROUP	T_LG_LETTER_GROUP	VARCHAR2	1,000.00	0.00
DSC_GROUP	T_MM_GROUP	VARCHAR2	18.00	0.00
DSC_GROUPING	T_CDE_GROUP	VARCHAR2	40.00	0.00
DSC_GROUP_CLASS	T_GROUP_TYPE	VARCHAR2	4,000.00	0.00
DSC_GROUP_NAME	T_AUDIT_ST_GROUP	CHAR	30.00	0.00
DSC_GROUP_TYPE	T_TPL_GROUP_COV_ASSIGN	VARCHAR2	40.00	0.00
DSC_HC_CLM_STATUS	T_HC_CLM_STATUS	VARCHAR2	200.00	0.00
DSC_HC_ENTITY_ID	T_HC_ENTITY_ID	VARCHAR2	200.00	0.00
DSC_HELP	T_WEB_PAGE	CLOB	0.00	0.00
DSC_HIC2	T_HIC3	VARCHAR2	50.00	0.00
DSC_HIC3	T_HIC3	VARCHAR2	50.00	0.00
DSC_HIC4	T_HIC4	VARCHAR2	50.00	0.00
DSC_HIPAA	T_CDE_HIPAA	VARCHAR	500.00	0.00
DSC_HIPP	T_HIPP_RSN_CODES	CHAR	40.00	0.00
DSC_HMO_PPO	T_HMO_INDICATOR	CHAR	15.00	0.00

DSC_HOLIDAY	T_HOLIDAY_DATES	CHAR	30.00	0.00
DSC_IAC	T_PA_IAC_TEXT	VARCHAR2	500.00	0.00
DSC_IAC	T_PA_IAC_XREF	VARCHAR2	500.00	0.00
DSC_ICF_MR_FNL_APR	T_PS_CDE_ICF_FNL	VARCHAR2	40.00	0.00
DSC_ICF_MR_PRE_APR	T_PS_CDE_ICF_PRE	VARCHAR2	40.00	0.00
DSC_IMMUNIZ	T_RE_EPSDT_IMMUN	CHAR	30.00	0.00
DSC_INCOME_SRC	T_DS_RECIP_DO_INCOME	VARCHAR2	10.00	0.00
DSC_INDICATOR	T_CDE_DRUG_ACT	VARCHAR2	40.00	0.00
DSC_INS_HIPAA	T_HIPAA_BP	VARCHAR2	50.00	0.00
DSC_INV_TYPE_SHORT	T_DR_INVOICE_TYPE	CHAR	6.00	0.00
DSC_LANGUAGE	T_LANGUAGE	CHAR	100.00	0.00
DSC_LANGUAGE	T_LG_CDE_LANGUAGE	VARCHAR2	25.00	0.00
DSC_LANG_HIPAA	T_HIPAA_LANGUAGE	CHAR	50.00	0.00
DSC_LAY	T_CDE_PROC	VARCHAR2	100.00	0.00
DSC_LAY	T_DIAGNOSIS	VARCHAR2	100.00	0.00
DSC_LAY	T_PROC	VARCHAR2	100.00	0.00
DSC_LAY	T_PROC_ICD9	VARCHAR2	100.00	0.00
DSC_LENGTH_15	T_ACCIDENT_TYPE	CHAR	15.00	0.00
DSC_LENGTH_15	T_LOCALITY	CHAR	15.00	0.00
DSC_LETTER	T_LETTER	VARCHAR2	4,000.00	0.00
DSC_LETTER	T_LG_LETTER_TEMPLATE	VARCHAR2	1,000.00	0.00
DSC_LETTERHEAD	T_LG_LETTERHEAD	CHAR	25.00	0.00
DSC_LETTER_TEXT	T_PR_LETTER_TEXT	VARCHAR2	4,000.00	0.00
DSC_LEVEL	T_AUDIT_ST_LEVEL	CHAR	30.00	0.00
DSC_LEVEL_OF_CARE	T_CA_RECIP_KEY	VARCHAR2	50.00	0.00
DSC_LICENSE	T_PA_HDR	VARCHAR2	80.00	0.00
DSC_LIC_CLASS	T_CDE_LIC_CLASS_KY	VARCHAR2	50.00	0.00
DSC_LIEN_CODE	T_LIEN_RSN_CODE	CHAR	20.00	0.00

DSC_LIEN_COMMENT	T_LIEN_COMMENT	VARCHAR2	250.00	0.00
DSC_LIEN_REASON	T_CDE_LIEN_RSN	CHAR	30.00	0.00
DSC_LIMITATION	T_PR_ACC_PTS_LIMIT_WI	VARCHAR2	30.00	0.00
DSC_LINK_DATA	T_RE_LINK_PROC	CHAR	20.00	0.00
DSC_LIV_ARNG	T_CA_RECIP_KEY	VARCHAR2	50.00	0.00
DSC_LIV_ARNG	T_RE_LIV_ARNG	CHAR	50.00	0.00
DSC_LN	T_DRUG	VARCHAR2	40.00	0.00
DSC_LN	T_DRUG_DN	VARCHAR2	40.00	0.00
DSC_LOC	T_INP_LOC	CHAR	100.00	0.00
DSC_LOC	T_PR_LOC_CODE	CHAR	100.00	0.00
DSC_LOC	T_RE_LOC_CODE	VARCHAR	50.00	0.00
DSC_LOCATION_PGM	T_RE_CDE_LOCATION_PGM	VARCHAR2	100.00	0.00
DSC_LOCAT_TYPE	T_LOCATION	CHAR	50.00	0.00
DSC_LOCK_ENT_RSN	T_RE_LOCK_ENT	CHAR	20.00	0.00
DSC_LOCK_EXIT_RSN	T_RE_LOCK_EXIT	CHAR	20.00	0.00
DSC_LOC_STOP	T_RE_LOC_STOP1	CHAR	50.00	0.00
DSC_LOC_STOP	T_RE_LOC_STOP2	CHAR	50.00	0.00
DSC_LONG	T_AR_COMMENTS	CHAR	250.00	0.00
DSC_LONG	T_AR_DISP_COMM	CHAR	250.00	0.00
DSC_LONG	T_CHECK_COMMENT	VARCHAR2	250.00	0.00
DSC_LONG	T_DIAGNOSIS	CHAR	250.00	0.00
DSC_LONG	T_DIAGNOSIS	VARCHAR2	400.00	0.00
DSC_LONG	T_EVS_CDE_SVC_TYPE	VARCHAR2	50.00	0.00
DSC_LONG	T_EXPEND_COMMENT	CHAR	250.00	0.00
DSC_LONG	T_MODIFIER	VARCHAR2	4,000.00	0.00
DSC_LONG	T_PROC	VARCHAR2	4,000.00	0.00
DSC_LONG	T_PROC_ICD9	VARCHAR2	400.00	0.00

DSC_LONG	T_RTS_COMMENT	CHAR	250.00	0.00
DSC_LONG_GIS_QUALITY	T_GIS_CODES	VARCHAR2	4,000.00	0.00
DSC_LONG_VAR	T_TEST_ITEMS	VARCHAR2	2,000.00	0.00
DSC_LTR_CTGRY	T_PS_CDE_LTR_CTGRY	VARCHAR2	60.00	0.00
DSC_LTR_TYPE	T_CAS_LTR_TYPE	CHAR	30.00	0.00
DSC_LTR_TYPE	T_PS_CDE_LTR_TYPE	CHAR	60.00	0.00
DSC_MAILING	T_DR_INV_MAIL	CHAR	15.00	0.00
DSC_MARITAL	T_CDE_MARITAL	CHAR	10.00	0.00
DSC_MARITAL	T_PS_CDE_MARITAL	CHAR	9.00	0.00
DSC_MCARE_COVRG	T_CDE_MCARE_COVRG	VARCHAR2	100.00	0.00
DSC_MC_AID_GRP	T_MC_AID_GRP	CHAR	75.00	0.00
DSC_MC_AID_GRP	T_MC_AID_GRP	VARCHAR2	75.00	0.00
DSC_MC_ENTITY	T_MC_ENTITY	CHAR	100.00	0.00
DSC_MC_PGM_STATUS_GRP	T_MC_PGM_STATUS_GRP	VARCHAR2	75.00	0.00
DSC_MC_REGION	T_MC_REGION	CHAR	50.00	0.00
DSC_MC_REGION	T_MC_REGION_WI	CHAR	50.00	0.00
DSC_MC_SVC_CLASS	T_MC_SVC_CLASS	VARCHAR2	100.00	0.00
DSC_MDC	T_MDC	CHAR	40.00	0.00
DSC_MEASURE	T_CM_MEASURE	VARCHAR2	15.00	0.00
DSC_MEASURE_BASE	T_MM_MEASURE_BASE	VARCHAR2	700.00	0.00
DSC_MEDIA	T_DR_INV_MEDIA	CHAR	15.00	0.00
DSC_MEDIA	T_MEDIA	VARCHAR2	32.00	0.00
DSC_MEDIA_TYPE	T_LG_CDE_MEDIA	VARCHAR2	20.00	0.00
DSC_MEDIA_TYPE	T_PA_MEDIA	CHAR	9.00	0.00
DSC_MEDICARE	T_CA_RECIP_KEY	VARCHAR2	50.00	0.00
DSC_MED_SUPPORT	T_TPL_CDE_MED_SUPPORT	VARCHAR2	100.00	0.00
DSC_MESSAGE	T_BATCH_ERR_MSG	CHAR	75.00	0.00
DSC_MESSAGE	T_SYS_ERR_MSG	CHAR	50.00	0.00
DSC_MIME_TYPE	T_MIME_TYPE	VARCHAR2	50.00	0.00
DSC_MI_VERBAL_DTRM	T_PS_CDE_MI_DTRM	VARCHAR2	40.00	0.00
DSC_MODIFIER	T_MODIFIER	VARCHAR2	40.00	0.00
DSC_MR_VERBAL_DTRM	T_PS_CDE_MR_DTRM	VARCHAR2	60.00	0.00
DSC_MTHD_CORR	T_ERR_RESO_MTHD_CORR	CLOB	0.00	0.00
DSC_NAME	T_APPLICATION	VARCHAR2	254.00	0.00
DSC_NAME	T_CONTROL	VARCHAR2	254.00	0.00
DSC_NAME	T_PC_AUTHORIZATION	VARCHAR2	254.00	0.00
DSC_NAME	T_PROFILE	VARCHAR2	254.00	0.00

DSC_NAME	T_PW_AUTHORIZATION	VARCHAR2	254.00	0.00
DSC_NAME	T_UC_AUTHORIZATION	VARCHAR2	254.00	0.00
DSC_NAME	T_UP_AUTHORIZATION	VARCHAR2	254.00	0.00
DSC_NAME	T_UW_AUTHORIZATION	VARCHAR2	254.00	0.00
DSC_NATURE_OF_INJ	T_CASUALTY_CASE	CHAR	32.00	0.00
DSC_NATURE_OF_INJ	T_CASUALTY_CASE_AL	CHAR	32.00	0.00
DSC_NCPDP_CONFLICT	T_NCPDP_CONFLICT	VARCHAR2	50.00	0.00
DSC_NDC	T_DRUG	CHAR	30.00	0.00
DSC_NDC	T_DRUG	VARCHAR2	35.00	0.00
DSC_NDC	T_DRUG_DN	VARCHAR2	35.00	0.00
DSC_NF_DISP	T_PS_CDE_NF_DISP	VARCHAR2	40.00	0.00
DSC_NOTE	T_CALL_NOTES	VARCHAR2	4,000.00	0.00
DSC_NOTE	T_CLM_NTE	VARCHAR2	80.00	0.00
DSC_NOTE	T_DIAG_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_DRG_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_DRUG_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_ERR_DISP_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_LOCATION_NOTE	CHAR	256.00	0.00
DSC_NOTE	T_MC_NPI_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_MC_PMP_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_MC_RE_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_MODIFIER_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_PA_RULE_NOTE	VARCHAR2	4,000.00	0.00
DSC_NOTE	T_PROC_ICD9_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_PROC_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE	T_REVENUE_NOTES	VARCHAR2	1,000.00	0.00
DSC_NOTE_TYPE	T_CDE_NOTE_TYPE	CHAR	100.00	0.00
DSC_NOTICE	T_RE_EPSDT_NOTICE	CHAR	30.00	0.00
DSC_NO_ISSUE_COMMENT	T_FIN_NO_ISSUE	VARCHAR2	250.00	0.00
DSC_NPT_TYPE	T_NDDF_PRICE_TYPE	CHAR	6.00	0.00
DSC_NPT_TYPE_DEF	T_NDDF_PRICE_TYPE	VARCHAR2	100.00	0.00
DSC_OBC	T_CDE_OBC	VARCHAR2	500.00	0.00
DSC_OCCUPATION	T_CT_EDIT_MEMBERS	VARCHAR2	40.00	0.00

DSC_OCCURRENCE	T_OCCURRENCE	CHAR	50.00	0.00
DSC_OFF_STATUS	T_RE_OFF_STAT	CHAR	50.00	0.00
DSC_OTHER_COVERAGE	T_NCPDP_OTH_COV	VARCHAR2	100.00	0.00
DSC_OTHER_INCOME	T_RE_INCOME_LOSS	CHAR	35.00	0.00
DSC_OTHER_INCOME	T_RE_INCOME_NEW	CHAR	35.00	0.00
DSC_OTHER_INFO	T_CALL_OTHER_INFO	VARCHAR2	200.00	0.00
DSC_OUTGOING_REF	T_CT_OUTGOING_REF	VARCHAR2	50.00	0.00
DSC_PAID_LEVEL	T_CM_PAID_LEVEL	VARCHAR2	11.00	0.00
DSC_PAPER_RA_PGM	T_FIN_CYCLE	CHAR	30.00	0.00
DSC_PARM	T_BUY_PARMS	VARCHAR2	100.00	0.00
DSC_PARM	T_CDE_EDIT_PARM_TYPE	VARCHAR2	4,000.00	0.00
DSC_PARM	T_TMSIS_PARMS	VARCHAR2	200.00	0.00
DSC_PARM_SHORT	T_CDE_EDIT_PARM_TYPE	VARCHAR2	50.00	0.00
DSC_PARM_VALUE	T_EDIT_PARMS	VARCHAR2	4,000.00	0.00
DSC_PART	T_MM_PART	VARCHAR2	18.00	0.00
DSC_PART_IND	T_MM_PART_IND	VARCHAR2	50.00	0.00
DSC_PART_SEQ	T_MM_PART_SEQ	VARCHAR2	18.00	0.00
DSC_PASRR	T_PS_CDE_PASRR	VARCHAR2	40.00	0.00
DSC_PATIENT_CONDITION	T_CLM_CR2	VARCHAR2	80.00	0.00
DSC_PATIENT_CONDITION_2	T_CLM_CR2	VARCHAR2	80.00	0.00
DSC_PATIENT_STATUS	T_PATIENT_STAT	CHAR	80.00	0.00
DSC_PAYEE	T_FIN_PAYEE	CHAR	30.00	0.00
DSC_PAYMENT	T_DR_PAYMENT_RSN	CHAR	100.00	0.00
DSC_PAYMENT_TYPE	T_CASH_PYMT_TYPE	VARCHAR	20.00	0.00
DSC_PAYMENT_TYPE	T_CASH_PYMT_TYPE	VARCHAR2	20.00	0.00
DSC_PA_ASSIGN	T_PA_ASSIGN_CODE	CHAR	30.00	0.00
DSC_PA_TEXT	T_PA_EXT_TEXT	VARCHAR2	540.00	0.00
DSC_PA_TEXT	T_PA_INT_TEXT	VARCHAR2	900.00	0.00
DSC_PDP_TYPE	T_RE_CDE_PDP_TYPE	VARCHAR2	100.00	0.00
DSC_PEER_GROUP	T_CM_PEER_GROUP	VARCHAR2	100.00	0.00
DSC_PEER_GROUP	T_PEER_GROUP	CHAR	30.00	0.00
DSC_PERIOD	T_RE_EPSDT_PERIODS	CHAR	10.00	0.00
DSC_PERIOD_TYPE	T_FIN_PERIOD_TYPE	VARCHAR	40.00	0.00

DSC_PGM_DEFINITION	T_PUB_HLTH_PGM	VARCHAR2	4,000.00	0.00
DSC_PGM_GROUP	T_MC_PGM_GROUP	CHAR	100.00	0.00
DSC_PGM_HEALTH	T_CA_CLAIM_KEY	VARCHAR2	50.00	0.00
DSC_PGM_HEALTH	T_PUB_HLTH_PGM	VARCHAR2	50.00	0.00
DSC_PGM_HEALTH_LI	T_CDE_PGM_HEALTH_LI	VARCHAR2	50.00	0.00
DSC_PGM_STATUS	T_RE_PGM_STATUS_CODE	VARCHAR2	50.00	0.00
DSC_PHONE	T_CDE_PHONE	CHAR	15.00	0.00
DSC_PHONE	T_SYS_REPORT_RECIP	VARCHAR2	30.00	0.00
DSC_PHONE_TYPE	T_PS_CDE_PHONE_TYP	VARCHAR2	20.00	0.00
DSC_PHS_TYPE	T_PHS_ENTITY	CHAR	50.00	0.00
DSC_PKG_DESC	T_PKG_DESC_MDX	VARCHAR2	50.00	0.00
DSC_PLAN	T_CDE_PLAN_CDE	VARCHAR2	200.00	0.00
DSC_PLAN_TYPE	T_TPL_CDE_PLAN_TYPE	CHAR	120.00	0.00
DSC_PMP_FOCUS	T_MC_PMP_FOCUS	CHAR	100.00	0.00
DSC_PORT	T_CDE_PORT	VARCHAR2	255.00	0.00
DSC_POS	T_CA_CLAIM_KEY	VARCHAR2	50.00	0.00
DSC_POS	T_PLACE_OF_SERVICE	CHAR	50.00	0.00
DSC_POSITION	T_BOARD_POSITION	CHAR	50.00	0.00
DSC_PRACTICE_TYPE	T_PR_SANCTION_AL	VARCHAR	20.00	0.00
DSC_PRACTICE_TYPE	T_PR_SANCTION_WI	VARCHAR	20.00	0.00
DSC_PROBLEM	T_PLOG_HEADER	VARCHAR2	1,500.00	0.00
DSC_PROC	T_CDE_PROC	VARCHAR2	40.00	0.00
DSC_PROCEDURE	T_FEE_SCHEDULE	CHAR	25.00	0.00
DSC_PROCEDURE	T_PROC	CHAR	40.00	0.00
DSC_PROCEDURE	T_PROC_ICD9	VARCHAR2	60.00	0.00
DSC_PROCESS	T_DR_PROCESS	CHAR	100.00	0.00
DSC_PROC_DENTAL	T_PA_DTL	VARCHAR2	80.00	0.00
DSC_PROC_DEPT	T_PROCESS_DEPT	CHAR	50.00	0.00
DSC_PROC_INST	T_PA_DTL	VARCHAR2	80.00	0.00
DSC_PROC_PROF	T_PA_DTL	VARCHAR2	80.00	0.00
DSC_PRODUR_SCREEN	T_DRUG_SCREEN	CHAR	25.00	0.00
DSC_PRODUR_SCREEN	T_DRUG_SCREEN	CHAR	25.00	0.00

DSC_PROJECTED_STATUS	T_CDE_AGENCY_STATUS	VARCHAR2	100.00	0.00
DSC_PROVIDER_ROLE	T_PR_CLAIM_ROLE	VARCHAR2	50.00	0.00
DSC_PROV_ID_TYPE	T_PR_ID_TYPE	VARCHAR2	50.00	0.00
DSC_PROV_PGM	T_PR_ENROLL_PGM	CHAR	20.00	0.00
DSC_PROV_PGM_LONG	T_PR_ENROLL_PGM	VARCHAR2	4,000.00	0.00
DSC_PROV_SPEC	T_PR_SPEC_CDE	CHAR	50.00	0.00
DSC_PROV_SUBSPEC	T_PR_SUBSPEC_CDE	CHAR	50.00	0.00
DSC_PROV_SUPER_SPEC	T_PROFILE_PROV_SUPER_SPEC	VARCHAR2	50.00	0.00
DSC_PROV_TYPE	T_CT_CASE_TRACK	VARCHAR2	50.00	0.00
DSC_PROV_TYPE	T_PR_TYPE_CDE	CHAR	50.00	0.00
DSC_PR_ID_END_RSN	T_PR_ID_END_RSN	VARCHAR2	50.00	0.00
DSC_PSY_DIAG	T_PA_PSY_DIAG_CODE	CHAR	20.00	0.00
DSC_PULL_REASON	T_PAY_PULL_REASON	CHAR	50.00	0.00
DSC_QUAL	T_MM_QUALIFIER	VARCHAR2	100.00	0.00
DSC_QUAL_TYPE	T_MM_QUALIFIER_TYPE	VARCHAR2	11.00	0.00
DSC_QUERIED_DATA	T_LG_LETTER_REQUEST	CLOB	0.00	0.00
DSC_QUERY	T_DS_LVX_USER_REQ	VARCHAR2	1,000.00	0.00
DSC_QUERY	T_LG_LETTER_TEMPLATE	CLOB	0.00	0.00
DSC_QUERY	T_QUERY	VARCHAR2	4,000.00	0.00
DSC_QUESTION	T_PA_RULE_QUESTION	VARCHAR2	4,000.00	0.00
DSC_QUESTION	T_WEB_SUPPORT	VARCHAR2	2,000.00	0.00
DSC_RACE	T_CA_RECIP_KEY	VARCHAR2	100.00	0.00
DSC_RACE	T_CDE_RACE	VARCHAR2	100.00	0.00
DSC_RACE	T_PS_CDE_RACE	CHAR	9.00	0.00
DSC_RACE_HIPAA	T_HIPAA_RACE	CHAR	50.00	0.00
DSC_RANGE_TYPE	T_PMT_RNG_TYPE	CHAR	30.00	0.00
DSC_RATE_TYPE	T_RATE_TYPE	VARCHAR2	18.00	0.00
DSC_REASON	T_PAY_HOLD_REASONS	CHAR	30.00	0.00
DSC_REASON	T_PR_LETTER_TEXT	VARCHAR2	50.00	0.00
DSC_REASON	T_RE_ASSIGN_RSN_CODE	VARCHAR2	100.00	0.00
DSC_REASON	T_TPL_REST_RSN_CDE	CHAR	30.00	0.00
DSC_REASON_MC	T_RE_MC_REASON	CHAR	25.00	0.00
DSC_RECIP_COUNTY	T_CA_RECIP_KEY	VARCHAR2	25.00	0.00
DSC_RECORD_TYPE	T_PS_CDE_REC_TYPE	VARCHAR2	40.00	0.00
DSC_REC_TYPE	T_CDE_TAX_REC_TYPE	VARCHAR2	30.00	0.00
DSC_REFERRED	T_PS_CDE_REFERRED	VARCHAR	30.00	0.00

DSC_REGION	T_CA_CLAIM_KEY	VARCHAR2	50.00	0.00
DSC_REGION	T_REGION	CHAR	50.00	0.00
DSC_REGION_GEO	T_GEOGRAPHICAL_REGION	VARCHAR2	4,000.00	0.00
DSC_REGION_GEO	T_REGION_GEOGRAPHICAL	VARCHAR2	4,000.00	0.00
DSC_RELATION	T_HIPAA_REL_CODE	CHAR	120.00	0.00
DSC_RELATION_TYPE	T_OWNER_REL_TYPE	CHAR	50.00	0.00
DSC_REMARK	T_CDE_HIPAA_REMRKS	VARCHAR2	700.00	0.00
DSC_REPLACE_DENTAL	T_PA_DTL	VARCHAR2	80.00	0.00
DSC_REPLY	T_LOCATION_NOTE	CHAR	256.00	0.00
DSC_REQ_TABLE	T_PR_LOC_REQ_TABLE	CHAR	50.00	0.00
DSC_RESO_NOTES	T_ERR_RESO_NOTES	CLOB	0.00	0.00
DSC_RESTRICT_TYPE	T_MC_PMP_RESTRICT_TYPE	CHAR	30.00	0.00
DSC_REVENUE	T_CDE_REVENUE	CHAR	70.00	0.00
DSC_REVIEW_REASON	T_PR_CDE_REVIEW_REASON	VARCHAR2	50.00	0.00
DSC_REVIEW_RSN	T_FIN_EFT_ACCT	VARCHAR2	50.00	0.00
DSC_REVIEW_TYPE	T_PR_CDE_REVIEW	VARCHAR2	50.00	0.00
DSC_REV_CODE	T_REVENUE_CODE	CHAR	70.00	0.00
DSC_REV_REQ	T_RE_REV_REQ	CHAR	30.00	0.00
DSC_REV_RSN	T_RE_REV_RSN	CHAR	20.00	0.00
DSC_ROOM	T_SYS_REPORT_RECIP	VARCHAR2	30.00	0.00
DSC_ROUTE	T_CDE_DRUG_ROUTE	VARCHAR2	10.00	0.00
DSC_ROUTE_LONG	T_CDE_DRUG_ROUTE	VARCHAR2	40.00	0.00
DSC_RPT_CAT	T_CM_RPT_CAT	VARCHAR2	30.00	0.00
DSC_RPT_PRD_DESC	T_MR_RPT_PRD	CHAR	14.00	0.00
DSC_RPT_PRD_DESC	T_TPL_LAST_REPTD	CHAR	14.00	0.00
DSC_RPT_THIS_LAST	T_DS_DNTL_CDE_THIS_LAST	VARCHAR2	100.00	0.00
DSC_RQSTR	T_PROJ_RQSTR_CDE	CHAR	25.00	0.00
DSC_RSN_HIPAA	T_HIPAA_MC_ASSIGN	CHAR	50.00	0.00
DSC_RSN_MC_ASSIGN	T_RE_PMP_REASON	CHAR	100.00	0.00

DSC_RSRC	T_DS_RECIP_DO_RESOURCE	VARCHAR2	14.00	0.00
DSC_RTP_REAS	T_PR_APPLN_RTP	CHAR	250.00	0.00
DSC_RTP_REAS	T_PR_APPLN_RTP	VARCHAR2	250.00	0.00
DSC_RULE	T_RU_RULE_HISTORY	VARCHAR2	4,000.00	0.00
DSC_SAK	T_NULL_SAK	CHAR	12.00	0.00
DSC_SCOS_GROUP	T_SCOS_GROUP_DESC	VARCHAR2	40.00	0.00
DSC_SCOS_SUBGROUP	T_SCOS_SUBGROUP_DESC	VARCHAR2	40.00	0.00
DSC_SCREEN	T_RE_EPSDT_SCREEN	CHAR	30.00	0.00
DSC_SCREEN	T_RE_EPSDT_SCREEN	CHAR	50.00	0.00
DSC_SCRIPT_QQ	T_ERX_NCPDP_QQ	VARCHAR2	50.00	0.00
DSC_SEQ_TYPE	T_MM_SEQ_TYPE	VARCHAR2	50.00	0.00
DSC_SERVICE	T_CLM_OTH_PYR_DTL	VARCHAR2	80.00	0.00
DSC_SERV_TYPE	T_HIPAA_SVC_TYPE	CHAR	120.00	0.00
DSC_SEX	T_CA_RECIP_KEY	VARCHAR2	20.00	0.00
DSC_SEX	T_CDE_SEX	VARCHAR2	18.00	0.00
DSC_SEX	T_CDE_SEX	VARCHAR2	100.00	0.00
DSC_SEX	T_CM_SEX	VARCHAR2	10.00	0.00
DSC_SEX	T_PS_CDE_SEX	CHAR	6.00	0.00
DSC_SHORT	T_EVS_CDE_SVC_TYPE	VARCHAR2	15.00	0.00
DSC_SHORT	T_PLOG_HEADER	CHAR	60.00	0.00
DSC_SHORT	T_PLOG_VERSION	CHAR	60.00	0.00
DSC_SHORT	T_TEST_ITEMS	CHAR	60.00	0.00
DSC_SHORT_GIS_QUALITY	T_GIS_CODES	CHAR	40.00	0.00
DSC_SHORT_NAME	T_CDE_SUPPORTED_DOC	CHAR	24.00	0.00
DSC_SHORT_NAME	T_TRANSACTION_TYPE	CHAR	24.00	0.00
DSC_SHORT_STAYS	T_PS_CDE_STAYS	VARCHAR2	11.00	0.00
DSC_SOURCE	T_CA_CLAIM_KEY	CHAR	50.00	0.00
DSC_SOURCE	T_CT_SELECT_SRC	VARCHAR2	100.00	0.00
DSC_SOURCE	T_MR_CDE_SOURCE	CHAR	50.00	0.00
DSC_SOURCE	T_RE_CDE_SOURCE	CHAR	100.00	0.00
DSC_SPECIAL	T_PS_CDE_SPECIAL	VARCHAR2	40.00	0.00
DSC_SPECIALTY	T_PR_SANCTION_AL	VARCHAR	20.00	0.00
DSC_SPECIALTY	T_PR_SANCTION_WI	VARCHAR	20.00	0.00
DSC_SPEC_COND	T_MC_SPEC_COND	CHAR	100.00	0.00
DSC_SPEC_COND_CLASS	T_MC_SPEC_COND_CLASS	CHAR	50.00	0.00
DSC_SPEC_COND_TYPE	T_MC_SPEC_COND_TYPE	CHAR	50.00	0.00
DSC_STATE	T_STATE	CHAR	15.00	0.00

DSC_STATUS	T_CHECK_STATUS_CDE	CHAR	30.00	0.00
DSC_STATUS	T_CM_STATUS	VARCHAR2	10.00	0.00
DSC_STATUS	T_LIEN_STATUS	CHAR	20.00	0.00
DSC_STATUS	T_PA_LINEITEM_STAT	CHAR	20.00	0.00
DSC_STATUS	T_PR_CDE_APPLN_STATUS	VARCHAR2	50.00	0.00
DSC_STATUS	T_TPL_CDE_BILLING_STATUS	CHAR	30.00	0.00
DSC_STATUS	T_WEB_USER_STATUS	VARCHAR2	70.00	0.00
DSC_STATUS_CASE	T_CAS_CASE_STATUS	CHAR	40.00	0.00
DSC_STD_POLICY	T_CDE_STD_POLICY	CHAR	256.00	0.00
DSC_STOP	T_RE_ELIG_STOP	CHAR	20.00	0.00
DSC_STRENGTH	T_CDE_STRENGTH	CHAR	10.00	0.00
DSC_STRENGTH	T_GENERIC_DRUG	CHAR	10.00	0.00
DSC_STRENGTH	T_GENERIC_DRUG	VARCHAR2	60.00	0.00
DSC_STRENGTH	T_LS_DRUG_MASTER	CHAR	10.00	0.00
DSC_STRENGTH	T_LS_SUMMARY_NDC	CHAR	10.00	0.00
DSC_STRETCH_PURPOSE	T_CLM_CR1	VARCHAR2	80.00	0.00
DSC_ST_OF_SCREEN	T_PS_CDE_SCRN_ST	VARCHAR2	30.00	0.00
DSC_SUPPORTED_DOC	T_CDE_SUPPORTED_DOC	VARCHAR2	255.00	0.00
DSC_SYSTEM_KEY	T_SYSTEM_KEYS	CHAR	20.00	0.00
DSC_TABLE_NAME	T_PR_SUMM_TBL_LIST	CHAR	35.00	0.00
DSC_TAXONOMY	T_PR_TAXONOMY_CDE	CHAR	100.00	0.00
DSC_TEMPLATE	T_LG_LETTER_TEMPLATE	CLOB	0.00	0.00
DSC_TEXT	T_ERX_TEXT	VARCHAR2	100.00	0.00
DSC_TEXT_CONCAT	T_ERX_TEXT_CONCAT	VARCHAR2	100.00	0.00
DSC_TEXT_LINE	T_CHRONO_NOTES	VARCHAR2	4,000.00	0.00
DSC_TEXT_LONG	T_ERX_TEXT	VARCHAR2	200.00	0.00
DSC_THERA_CLS_AHFS	T_CDE_THERA_AHFS	VARCHAR2	55.00	0.00
DSC_THERA_CLS_GEN	T_CDE_THERA_GEN	VARCHAR2	100.00	0.00

DSC_THERA_CLS_SPEC	T_CDE_THERA_SPEC	VARCHAR2	100.00	0.00
DSC_THERA_CLS_SPEC	T_THERAPEUTIC	VARCHAR2	100.00	0.00
DSC_THERA_CLS_STD	T_CDE_THERA_STD	VARCHAR2	100.00	0.00
DSC_THRESHOLD	T_TPL_THRESHOLD	CHAR	40.00	0.00
DSC_THRUPUT_GRP	T_MR_THRUPUT_GRP	CHAR	25.00	0.00
DSC_TIME_UNIT	T_CDE_TIME_UNIT	CHAR	30.00	0.00
DSC_TITLE	T_PR_TITLE_CODE	CHAR	50.00	0.00
DSC_TITLE	T_WEB_PAGE	VARCHAR2	48.00	0.00
DSC_TMSIS_DATA_ELEMENT	T_TMSIS_DATA_ELEMENTS	VARCHAR2	4,000.00	0.00
DSC_TMSIS_EDIT_RULE	T_TMSIS_EDIT_CTL	VARCHAR2	500.00	0.00
DSC_TMSIS_ERR_CAT_NAME	T_TMSIS_ERROR_CATEGORY	VARCHAR2	100.00	0.00
DSC_TMSIS_RULE_LOGIC	T_TMSIS_EDIT_RULES	VARCHAR2	1,000.00	0.00
DSC_TMSIS_TIER_NAME	T_TMSIS_ERROR_CATEGORY	VARCHAR2	50.00	0.00
DSC_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES	VARCHAR2	4,000.00	0.00
DSC_TOOTH_NBR	T_TOOTH	CHAR	40.00	0.00
DSC_TOOTH_QUAD	T_TOOTH_QUADRANT	VARCHAR2	50.00	0.00
DSC_TOOTH_SURFACE	T_TOOTH_SURFACE	CHAR	8.00	0.00
DSC_TPL_SVC_CLASS	T_TPL_SVC_CLASS	VARCHAR2	30.00	0.00
DSC_TPL_UNIT	T_TPL_CDE_CLERK_UNIT	CHAR	120.00	0.00
DSC_TP_STATUS	T_CDE_TP_STATUS	VARCHAR2	255.00	0.00
DSC_TP_TYPE	T_CDE_TP_TYPE	VARCHAR2	255.00	0.00
DSC_TRADENAME	T_NDC_NDA_ANDA	VARCHAR2	125.00	0.00
DSC_TRANSACTION	T_PDUR_UPD_ERROR	CHAR	90.00	0.00
DSC_TRANSACTION	T_RU_TRANSACTION	VARCHAR2	4,000.00	0.00
DSC_TRANSACTION_TYPE	T_TRANSACTION_TYPE	VARCHAR2	64.00	0.00
DSC_TRANSPORT	T_CDE_TRANSPORT	VARCHAR2	255.00	0.00
DSC_TRIP_PURPOSE	T_CLM_CR1	VARCHAR2	80.00	0.00
DSC_TXN_TYPE	T_CDE_TXN_TYPE	CHAR	30.00	0.00
DSC_TXN_TYPE	T_FIN_TXN_TYPE	CHAR	18.00	0.00
DSC_TYPE_OF_BILL	T_TYPE_OF_BILL	VARCHAR2	150.00	0.00
DSC_TYPE_OF_SCREEN	T_PS_CDE_SCREEN	VARCHAR2	12.00	0.00
DSC_UNEARN_SRC	T_CDE_FAM_MBR_UNEARN_SRC	VARCHAR2	30.00	0.00
DSC_UNIT	T_CDE_DOSE_UNIT	CHAR	30.00	0.00
DSC_UNIT	T_DR_CONV_UNITS	CHAR	3.00	0.00
DSC_UNIT_DEPT	T_FIN_CDE_UNIT	VARCHAR	30.00	0.00
DSC_UNIT_TYPE	T_UNIT_TYPE	VARCHAR2	100.00	0.00
DSC_UPD_FOR_LOG	T_DIAG_DSE_XRF_LOG	CHAR	8.00	0.00

DSC_UPD_FOR_LOG	T_DRUG_GER_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_DRUG_PED_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_DRUG_PREG_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_HIGH_DOSE_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_INVRS_UPDT_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_LOW_DOSE_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_OVER_UTIL_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_THERA_DUP_LOG	CHAR	8.00	0.00
DSC_UPD_FOR_LOG	T_UNDER_UTIL_LOG	CHAR	8.00	0.00
DSC_URL	T_WEB_PAGE	VARCHAR2	500.00	0.00
DSC_VALUE	T_LG_LETTER_REQUEST_IDX	VARCHAR2	20.00	0.00
DSC_VALUE	T_VALUE	CHAR	40.00	0.00
DSC_VALUE_50	T_REF_CDE_VALUE_GROUP	VARCHAR2	50.00	0.00
DSC_VALUE_DEFINITION	T_REF_CDE_VALUE_GROUP	VARCHAR2	200.00	0.00
DSC_VARIABLE	T_RU_VARIABLE	VARCHAR2	40.00	0.00
DSC_WAGE_TYPE	T_CDE_WAGE_TYPE	VARCHAR2	200.00	0.00
DSC_WORK_CLASS	T_PROJ_WORK_CLASS	CHAR	25.00	0.00
DSC_WVR_SVC	T_MR_WVR_SVC	CHAR	50.00	0.00
DSC_X12_MSG	T_EDIC_BATCH_MSGBOX	CLOB	0.00	0.00
DSC_X12_MSG	T_EDIC_BATCH_MSGBOX_ARC	CLOB	0.00	0.00
DSC_X12_MSG	T_EDIC_REQUESTS	CLOB	0.00	0.00
DSC_X12_MSG	T_EDIC_REQUESTS_ARC	CLOB	0.00	0.00
DSC_X12_MSG	T_EDIC_RESPONSES	CLOB	0.00	0.00
DSC_X12_MSG	T_EDIC_RESPONSES_ARC	CLOB	0.00	0.00
DSC_XFER_REASON	T_MC_CDE_XFER_REASON	CHAR	50.00	0.00
DSC_XFER_STATUS	T_MC_CDE_XFER_STATUS	CHAR	50.00	0.00
DSC_XML_QUERY	T_QUERY	CLOB	0.00	0.00
DSC_XML_SCHEMA	T_WEB_PAGE	VARCHAR2	100.00	0.00
DTE_1115A_EFF	T_TMSIS_ELG018_1115A_DEMO	NUMBER	8.00	0.00
DTE_1115A_END	T_TMSIS_ELG018_1115A_DEMO	NUMBER	8.00	0.00
DTE_1261A_REC	T_PA_1261A_PSY	NUMBER	8.00	0.00

DTE_1261A_RTN	T_PA_1261A_PSY	NUMBER	8.00	0.00
DTE_2100_CLM_RCVD	T_TPL_2100_CLM_PYMT	NUMBER	8.00	0.00
DTE_2100_COVRG_EXPIRED	T_TPL_2100_CLM_PYMT	NUMBER	8.00	0.00
DTE_75_STOP	T_BUYA_PREM	DATE	0.00	0.00
DTE_75_STOP	T_BUYA_PREM	NUMBER	8.00	0.00
DTE_75_STOP	T_BUYB_PREM	DATE	0.00	0.00
DTE_75_STOP	T_BUYB_PREM	NUMBER	8.00	0.00
DTE_ACCEPTED	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_ACCIDENT	T_CAS_AT_EXCLUSIONS	NUMBER	8.00	0.00
DTE_ACCIDENT	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_ACCIDENT	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_ACCIDENT	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_ACCRED_ACHIEVED	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	8.00	0.00
DTE_ACCRED_END	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	8.00	0.00
DTE_ACTION	T_DS_RECIP_SOBRA_FAM_HIST	DATE	0.00	0.00
DTE_ACTION_TAKEN	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_ACTIVATION	T_CHK_REISSUE_XREF	DATE	0.00	0.00
DTE_ACTIVATION	T_CHK_REISSUE_XREF	NUMBER	8.00	0.00
DTE_ACTIVATION	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_ACTIVATION	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_ACTIVATION	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_ACTIVE	T_COUNTY_RATE	DATE	0.00	0.00
DTE_ACTIVE	T_PR_INST_RATE_WI	DATE	0.00	0.00
DTE_ACTIVE	T_PR_LOC_RATE_WI	DATE	0.00	0.00
DTE_ACTIVE	T_PR_OUT_RATE_AL	NUMBER	8.00	0.00
DTE_ACTIVE	T_PR_RATE_KY	DATE	0.00	0.00
DTE_ACTIVE	T_PUB_HLTH_PGM	DATE	0.00	0.00
DTE_ACTIVE	T_REV_HOSPICE_XWALK	DATE	0.00	0.00
DTE_ACTIVE	T_TPL_COV_PLAN_XREF	DATE	0.00	0.00

DTE_ACTIVE	T_TPL_EMPLOYER	DATE	0.00	0.00
DTE_ACTIVE	T_TPL_EMPLOYER	NUMBER	8.00	0.00
DTE_ACTIVE_THRU	T_RE_PARTD_PDP_ASSIGN	DATE	0.00	0.00
DTE_ACTIVE_THRU	T_RE_PARTD_PDP_ASSIGN	NUMBER	8.00	0.00
DTE_ACTIVITY	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_ACTIVITY	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_ACTUAL_MOD	T_CSR	NUMBER	8.00	0.00
DTE_ACTUAL_PROD	T_CSR	NUMBER	8.00	0.00
DTE_ADD	T_AUTO_PA_LTR	NUMBER	8.00	0.00
DTE_ADD	T_RE_CONSENT_FORM_ACTIVITY	NUMBER	8.00	0.00
DTE_ADD	T_RE_CONSENT_FORM_MASTER	DATE	0.00	0.00
DTE_ADD	T_RE_CONSENT_FORM_MASTER	NUMBER	8.00	0.00
DTE_ADD	T_TPL_POLICY_TRIGGER	NUMBER	8.00	0.00
DTE_ADDED	T_ACCT_REC	NUMBER	8.00	0.00
DTE_ADDED	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_ADDED	T_AR_COMMENTS	DATE	0.00	0.00
DTE_ADDED	T_AR_COMMENTS	NUMBER	8.00	0.00
DTE_ADDED	T_CASH_COMMENT	NUMBER	8.00	0.00
DTE_ADDED	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_ADDED	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_ADDED	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_ADDED	T_CA_KICK_PYMT	DATE	0.00	0.00
DTE_ADDED	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_ADDED	T_CHECK_COMMENT	DATE	0.00	0.00
DTE_ADDED	T_CHECK_COMMENT	NUMBER	8.00	0.00
DTE_ADDED	T_CHRONO_NOTES	DATE	0.00	0.00

DTE_ADDED	T_CHRONO_NOTES	NUMBER	8.00	0.00
DTE_ADDED	T_CLM_ADJ_XREF	DATE	0.00	0.00
DTE_ADDED	T_CLM_ADJ_XREF	NUMBER	8.00	0.00
DTE_ADDED	T_CLM_IMAGE_BALANCE	NUMBER	8.00	0.00
DTE_ADDED	T_CLM_KICK_PYMT	NUMBER	8.00	0.00
DTE_ADDED	T_CLM_LINK_UNLINK_XREF	NUMBER	8.00	0.00
DTE_ADDED	T_CLM_MAT_CARE_HDR	NUMBER	8.00	0.00
DTE_ADDED	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_ADDED	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_ADDED	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_ADDED	T_EXPEND_COMMENT	DATE	0.00	0.00
DTE_ADDED	T_EXPEND_COMMENT	NUMBER	8.00	0.00
DTE_ADDED	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_ADDED	T_FIN_PROCESS_LIEN_DISP	NUMBER	8.00	0.00
DTE_ADDED	T_FIN_PRUDENT_PAY	NUMBER	8.00	0.00
DTE_ADDED	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_ADDED	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_ADDED	T_LIEN	DATE	0.00	0.00
DTE_ADDED	T_LIEN	NUMBER	8.00	0.00
DTE_ADDED	T_LIEN_COMMENT	NUMBER	8.00	0.00
DTE_ADDED	T_LIEN_DISP	DATE	0.00	0.00
DTE_ADDED	T_LIEN_DISP	NUMBER	8.00	0.00
DTE_ADDED	T_LS_DRUG_MASTER	DATE	0.00	0.00
DTE_ADDED	T_MC_PMP_SC	DATE	0.00	0.00
DTE_ADDED	T_MC_PMP_SC	NUMBER	8.00	0.00
DTE_ADDED	T_MC_RE_PMP_SEL	NUMBER	8.00	0.00
DTE_ADDED	T_MME_CONCR_RISK_GRP_ID_DS	DATE	0.00	0.00
DTE_ADDED	T_MME_CONCR_RISK_GRP_ID_DS	NUMBER	8.00	0.00
DTE_ADDED	T_MME_DAILY_MME_ALERTING	DATE	0.00	0.00
DTE_ADDED	T_MME_DAILY_MME_ALERTING	NUMBER	8.00	0.00
DTE_ADDED	T_MME_MME_RANGE_FACTOR	DATE	0.00	0.00
DTE_ADDED	T_MME_MME_RANGE_FACTOR	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_BASE_ING_DESC	DATE	0.00	0.00

DTE_ADDED	T_MME_OPIOID_BASE_ING_DESC	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_CF_MME_FACTOR	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_ALERT	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_ALERT	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_RISK_DR	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_RISK_DR	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_RISK_LN	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_CONCR_RISK_LN	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_DRG_CONCEPT_L	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_DRG_CONCEPT_L	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_MED_MASTER	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_MED_MASTER	NUMBER	8.00	0.00
DTE_ADDED	T_MME_OPIOID_RTD_ING_MME	DATE	0.00	0.00
DTE_ADDED	T_MME_OPIOID_RTD_ING_MME	NUMBER	8.00	0.00
DTE_ADDED	T_MME_VOCAB_TYPE_DEF	DATE	0.00	0.00
DTE_ADDED	T_MME_VOCAB_TYPE_DEF	NUMBER	8.00	0.00
DTE_ADDED	T_PR_DEA_LIC	NUMBER	8.00	0.00
DTE_ADDED	T_PR_LABEL_CRIT	NUMBER	8.00	0.00
DTE_ADDED	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_ADDED	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_ADDED	T_RE_BASE	NUMBER	8.00	0.00
DTE_ADDED	T_RE_BASE_DN	DATE	0.00	0.00
DTE_ADDED	T_RE_COMMENT	DATE	0.00	0.00
DTE_ADDED	T_RE_DEATH_CHG	DATE	0.00	0.00
DTE_ADDED	T_RE_HOSPICE_HDR	NUMBER	8.00	0.00
DTE_ADDED	T_RE_LTC_REQUEST	DATE	0.00	0.00
DTE_ADDED	T_RE_MC_RECIP	DATE	0.00	0.00
DTE_ADDED	T_RE_MC_RECIP	NUMBER	8.00	0.00

DTE_ADDED	T_RE_MC_RECIP_WI	NUMBER	8.00	0.00
DTE_ADDED	T_RE_MINI_LINK_XREF	NUMBER	8.00	0.00
DTE_ADDED	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_ADDED	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_ADDED	T_SUSPECT_RES	NUMBER	8.00	0.00
DTE_ADDED	T_TEST_ITEMS	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_271_SUBSCRIBER	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AC_PARENT	DATE	0.00	0.00
DTE_ADDED	T_TPL_AC_PARENT	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AR_CAS_DISPS	DATE	0.00	0.00
DTE_ADDED	T_TPL_AR_CAS_DISPS	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AR_DISPS	DATE	0.00	0.00
DTE_ADDED	T_TPL_AR_DISPS	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AR_DISPS_AL	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_ADDED	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_AR_HEALTH_XXX	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_CANCER_REGISTRY	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_LAST_REPTD	NUMBER	8.00	0.00
DTE_ADDED	T_TPL_RESOURCE	DATE	0.00	0.00
DTE_ADDED	T_TPL_RESOURCE	NUMBER	8.00	0.00
DTE_ADDED	T_WEB_MESSAGE_USER	NUMBER	8.00	0.00
DTE_ADDITIONAL	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_ADDITIONAL	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_ADDITIONAL	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_ADDITIONAL	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_CA_RCO	DATE	0.00	0.00
DTE_ADJUDICATION	T_CA_TPL_SUMMARY	DATE	0.00	0.00
DTE_ADJUDICATION	T_CLM_RCO	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_CLM_TPL_SUMMARY	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_INST_OTH_PYR_HDR	DATE	0.00	0.00
DTE_ADJUDICATION	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_CIP003_CLM_DTL	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_CLT003_CLM_DTL	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00

DTE_ADJUDICATION	T_TMSIS_COT003_CLM_DTL	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_ADJUDICATION	T_TMSIS_CRX003_CLM_DTL	NUMBER	8.00	0.00
DTE_ADJUSTED	T_ADJ_DENT_XREF	NUMBER	8.00	0.00
DTE_ADJUSTED	T_ADJ_PHRM_XREF	NUMBER	8.00	0.00
DTE_ADJUSTED	T_ADJ_PHYS_XREF	NUMBER	8.00	0.00
DTE_ADJUSTED	T_ADJ_UB92_XREF	NUMBER	8.00	0.00
DTE_ADJUSTED	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_ADJUSTED	T_CLM_MAT_CARE_HDR	NUMBER	8.00	0.00
DTE_ADJUSTED	T_DR_RECOUP_LTR_DATES	NUMBER	8.00	0.00
DTE_ADJUSTED	T_SUSP_ADJ_XREF	NUMBER	8.00	0.00
DTE_ADMISSION	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_ADMISSION	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_ADMISSION	T_MEDPOL_UB92	NUMBER	8.00	0.00
DTE_ADMISSION	T_MPHX_INPT_HDR	NUMBER	8.00	0.00
DTE_ADMISSION	T_MPHX_INPT_HDR2	NUMBER	8.00	0.00
DTE_ADMISSION	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_ADMISSION	T_RETRO_SUMM_RECS	NUMBER	8.00	0.00
DTE_ADMISSION	T_SUSP_UB92_HDR	NUMBER	8.00	0.00
DTE_ADMIT	T_RE_LOC_DATES	DATE	0.00	0.00
DTE_ADMIT	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_ADMIT	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_ADMITTED	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_AGREEMENT	T_PR_ENRL	NUMBER	8.00	0.00
DTE_AGREEMENT	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_AGREEMENT	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_AGREEMENT_MAILED	T_TP	DATE	0.00	0.00
DTE_AGREEMENT_RECV	T_TP	DATE	0.00	0.00
DTE_ALERT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_ALERT	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_ANNUAL_DUE	T_PS_DETERMINATION	NUMBER	8.00	0.00

DTE_ANNUAL_DUE	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_APPEAL	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_APPLICATION	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_APPLICATION	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_APPLIED	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	8.00	0.00
DTE_APPL_ACCEPTED	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_APPL_OFFSET	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_APPL_RCVD	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_APPL_RVWD	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_APPL_STAT_CHG	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_APPT	T_RE_NET_VOUCHER	DATE	0.00	0.00
DTE_AP_BIRTH	T_DS_RECIP_SOBRA_FAM_ABSNT	DATE	0.00	0.00
DTE_ARA_EFF	T_FIN_PROCESS_PROV_ID	NUMBER	8.00	0.00
DTE_ARA_EFF	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_ARA_EFF	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_ARA_EFF	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_AR_LIABILITY	T_ACCT_REC	NUMBER	8.00	0.00
DTE_AR_LIABILITY	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_AR_LIABILITY	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_ASGN_END	T_MC_PMP_MASS_XFER	DATE	0.00	0.00
DTE_ASGN_END	T_MC_PMP_MASS_XFER	NUMBER	8.00	0.00
DTE_ASSESS_CMPLT	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_ASSESS_CMPLT	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_ASSESS_RCVD	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_ASSESS_RCVD	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00

DTE_ASSIGNED	T_CASH_RCPT_DISP	DATE	0.00	0.00
DTE_ASSIGNED	T_CASH_RCPT_DISP	NUMBER	8.00	0.00
DTE_ASSIGNED	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_ASSIGNED	T_FIN_PROCESS_CASH_DISP	NUMBER	8.00	0.00
DTE_ASSOC_DISPENSE	T_PHRM_HDR_OPT	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_APPLICATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_CONTROL	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_PROFILE	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_CREATE	T_WINDOW	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_APPLICATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_CONTROL	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_PROFILE	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_AUDIT_UPDATE	T_WINDOW	NUMBER	8.00	0.00
DTE_AUTHORIZATION	T_TP	DATE	0.00	0.00
DTE_AVAILABLE	T_DOWNLOAD	DATE	0.00	0.00
DTE_BATCH	T_CLAIM_EXTRACT	CHAR	5.00	0.00
DTE_BED_TYPE_EFF	T_TMSIS_PRV010_BED_TYPE	NUMBER	8.00	0.00
DTE_BED_TYPE_END	T_TMSIS_PRV010_BED_TYPE	NUMBER	8.00	0.00
DTE_BEGIN	T_ALLERGY	NUMBER	8.00	0.00
DTE_BEGIN	T_ALLERGY_DIAG	NUMBER	8.00	0.00
DTE_BEGIN	T_CONTRA_DISEASE	DATE	0.00	0.00
DTE_BEGIN	T_CONTRA_DISEASE	NUMBER	8.00	0.00
DTE_BEGIN	T_CSR	NUMBER	8.00	0.00
DTE_BEGIN	T_CT_PROD_TRACK	DATE	0.00	0.00
DTE_BEGIN	T_DIAG_DSE_XREF	NUMBER	8.00	0.00
DTE_BEGIN	T_DISEASE_INFERRED	DATE	0.00	0.00
DTE_BEGIN	T_DISEASE_INFERRED	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_DISEASE	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_GER	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_GER	NUMBER	8.00	0.00

DTE_BEGIN	T_DRUG_INVERSE	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_INVERSE	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_OVER_UTIL	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_OVER_UTIL	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_PED	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_PED	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_PREG	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_PREG	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_SCREEN	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_SCREEN	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_THER_DUPE	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_THER_DUPE	NUMBER	8.00	0.00
DTE_BEGIN	T_DRUG_UNDER_UTIL	DATE	0.00	0.00
DTE_BEGIN	T_DRUG_UNDER_UTIL	NUMBER	8.00	0.00
DTE_BEGIN	T_ERX_ALT_THERAPY	NUMBER	8.00	0.00
DTE_BEGIN	T_ERX_RESOURCE_LINK	NUMBER	8.00	0.00
DTE_BEGIN	T_ERX_TEXT	NUMBER	8.00	0.00
DTE_BEGIN	T_GENERIC_DRUG	DATE	0.00	0.00
DTE_BEGIN	T_GENERIC_DRUG	NUMBER	8.00	0.00
DTE_BEGIN	T_GERI_DOSE	NUMBER	8.00	0.00
DTE_BEGIN	T_GFC_INGREDIENT	DATE	0.00	0.00
DTE_BEGIN	T_GFC_INGREDIENT	NUMBER	8.00	0.00
DTE_BEGIN	T_HIGH_DOSE	DATE	0.00	0.00
DTE_BEGIN	T_HIGH_DOSE	NUMBER	8.00	0.00
DTE_BEGIN	T_INGREDIENT	DATE	0.00	0.00
DTE_BEGIN	T_INGREDIENT	NUMBER	8.00	0.00
DTE_BEGIN	T_INGRED_DUPE	DATE	0.00	0.00
DTE_BEGIN	T_INGRED_DUPE	NUMBER	8.00	0.00
DTE_BEGIN	T_LOW_DOSE	DATE	0.00	0.00
DTE_BEGIN	T_LOW_DOSE	NUMBER	8.00	0.00
DTE_BEGIN	T_PDUR_ADD_TOX	NUMBER	8.00	0.00
DTE_BEGIN	T_PDUR_ADD_TOX_FAC	NUMBER	8.00	0.00
DTE_BEGIN	T_PDUR_PREG_DIAG	NUMBER	8.00	0.00
DTE_BEGIN	T_PEDI_DOSE	NUMBER	8.00	0.00
DTE_BEGIN	T_THERA_DURATION	DATE	0.00	0.00
DTE_BEGIN	T_THERA_DURATION	NUMBER	8.00	0.00
DTE_BEGIN	T_WEB_PROV_ENR	DATE	0.00	0.00
DTE_BEGIN	T_WEB_PROV_SPEC	DATE	0.00	0.00
DTE_BENDEX	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_BENE_COINS_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COINS_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COINS_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COINS_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COPAY_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00

DTE_BENE_COPAY_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COPAY_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_COPAY_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_DEDUCT_PD	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_DEDUCT_PD	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_DEDUCT_PD	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BENE_DEDUCT_PD	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_DENY_DNTL_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_DENY_PHRM_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_PD_DNTL_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_PD_PHARM_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_SUSP_DENTAL_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_SUSP_PHRM_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_SUSP_UB92_HDR	NUMBER	8.00	0.00
DTE_BILLED	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_BILLED	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_BILLED	T_TPL_AR_HEALTH_XXX	NUMBER	8.00	0.00
DTE_BILLING	T_BUYA_BILL	DATE	0.00	0.00
DTE_BILLING	T_BUYA_BILL	NUMBER	8.00	0.00
DTE_BILLING	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_BILLING	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_BILLING	T_BUYB_BILL	DATE	0.00	0.00
DTE_BILLING	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_BILLING	T_BUYB_MISMATCH	DATE	0.00	0.00

DTE_BILLING	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYA_BILL_INFO	DATE	0.00	0.00
DTE_BIRTH	T_BUYA_BILL_INFO	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYA_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYA_EXCEPT	DATE	0.00	0.00
DTE_BIRTH	T_BUYA_EXCEPT	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_BIRTH	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYB_BILL_INFO	DATE	0.00	0.00
DTE_BIRTH	T_BUYB_BILL_INFO	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYB_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYB_EXCEPT	DATE	0.00	0.00
DTE_BIRTH	T_BUYB_EXCEPT	NUMBER	8.00	0.00
DTE_BIRTH	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_BIRTH	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_BIRTH	T_CLM_SYS_FIELDS_HDR	NUMBER	8.00	0.00
DTE_BIRTH	T_DS_DNTL_RECIP	DATE	0.00	0.00
DTE_BIRTH	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_BIRTH	T_DS_RECIP_SOBRA_FAMILY	DATE	0.00	0.00
DTE_BIRTH	T_ELIGCNT	DATE	0.00	0.00
DTE_BIRTH	T_MC_CENSUS	NUMBER	8.00	0.00
DTE_BIRTH	T_POLICY_HOLDER	DATE	0.00	0.00
DTE_BIRTH	T_POLICY_HOLDER	NUMBER	8.00	0.00
DTE_BIRTH	T_PR_BOARD	DATE	0.00	0.00
DTE_BIRTH	T_PR_BOARD	NUMBER	8.00	0.00
DTE_BIRTH	T_PR_ENRL_BOARD	NUMBER	8.00	0.00
DTE_BIRTH	T_PR_ENRL_PROV	NUMBER	8.00	0.00
DTE_BIRTH	T_PR_PROV	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_1095	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_ADPH_1095	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_BASE	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_BASE_DN	DATE	0.00	0.00
DTE_BIRTH	T_RE_BNDX_BUYIN	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_CHILD_HAD	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_CMS_MMA_ENROLL	DATE	0.00	0.00
DTE_BIRTH	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_DEMOGRAPHIC	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_EDB	DATE	0.00	0.00
DTE_BIRTH	T_RE_HIST_ERR	NUMBER	8.00	0.00

DTE_BIRTH	T_RE_ID_CRD_ISS	DATE	0.00	0.00
DTE_BIRTH	T_RE_ID_CRD_ISS	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_MARITAL	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_MOVE_IN_OUT	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_PS2_DUPE	NUMBER	8.00	0.00
DTE_BIRTH	T_RE_PS2_ERR	NUMBER	8.00	0.00
DTE_BIRTH	T_TPL_AC_PARENT	DATE	0.00	0.00
DTE_BIRTH	T_TPL_AC_PARENT	NUMBER	8.00	0.00
DTE_BIRTH	T_TPL_SUSP_XREF	NUMBER	8.00	0.00
DTE_BIRTH_DATE	T_PS_CASE	NUMBER	8.00	0.00
DTE_BIRTH_EDB	T_BUYA_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BIRTH_EDB	T_BUYB_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BIRTH_ELIGIBLE	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_BIRTH_ELIGIBLE	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BIRTH_ELIGIBLE	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_BIRTH_ELIGIBLE	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_BIRTH_ELIGIBLE	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	8.00	0.00
DTE_BIRTH_NEW	T_CA_RECIP_HIST	DATE	0.00	0.00
DTE_BIRTH_OLD	T_CA_RECIP_HIST	DATE	0.00	0.00
DTE_BIRTH_PROV	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	8.00	0.00
DTE_BIRTH_PS2	T_RE_PS2_DUPE	NUMBER	8.00	0.00
DTE_BIRTH_SPOUSE	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_BP_OIL	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_BILL	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_BILL	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_BILL_INFO	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_BILL_INFO	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_ERROR	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_ERROR	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_EXCEPT	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_EXCEPT	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_MISMATCH	DATE	0.00	0.00

DTE_BUY_PROC	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYA_PREM	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYA_PREM	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_BILL	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_BILL_INFO	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_BILL_INFO	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_DEMO_CHANGE	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_ERROR	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_ERROR	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_EXCEPT	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_EXCEPT	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_BUY_PROC	T_BUYB_PREM	DATE	0.00	0.00
DTE_BUY_PROC	T_BUYB_PREM	NUMBER	8.00	0.00
DTE_B_NOTICE_COMPLY	T_IRS_B_NOTICE_AL	NUMBER	8.00	0.00
DTE_B_NOTICE_COMPLY	T_IRS_B_NOTICE_WI	NUMBER	8.00	0.00
DTE_B_NOTICE_SENT	T_IRS_B_NOTICE_AL	NUMBER	8.00	0.00
DTE_B_NOTICE_WHOLD	T_IRS_B_NOTICE_AL	NUMBER	8.00	0.00
DTE_B_NOTICE_WHOLD	T_IRS_B_NOTICE_WI	NUMBER	8.00	0.00
DTE_CALL_END	T_CALL_TRACK	NUMBER	8.00	0.00
DTE_CALL_RECEIVED	T_CALL_TRACK	NUMBER	8.00	0.00
DTE_CAPITATED_PMT_REQ	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_CAPITATION	T_CAPITATION_ADJ	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAPITATION_ADJ_DN	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAPITATION_ADJ_WI	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAPITATION_HIST	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAPITATION_HIST_DN	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAPITATION_HIST_WI	NUMBER	6.00	0.00
DTE_CAPITATION	T_CAP_MASS_ADJ_RST	NUMBER	6.00	0.00
DTE_CAP_BEGIN	T_CAP_MASS_ADJ_RST_tmp	NUMBER	8.00	0.00
DTE_CAP_END	T_CAP_MASS_ADJ_RST_tmp	NUMBER	8.00	0.00
DTE_CAP_TXN	T_CAPITATION_HIST	NUMBER	8.00	0.00

DTE_CAP_TXN	T_CAPITATION_HIST_DN	DATE	0.00	0.00
DTE_CAP_TXN	T_CAPITATION_HIST_WI	NUMBER	8.00	0.00
DTE_CAP_TXN	T_CAP_SUMMARY	DATE	0.00	0.00
DTE_CAP_TXN	T_CAP_SUMMARY	NUMBER	8.00	0.00
DTE_CAP_TXN	T_CAP_SUMMARY_AL	NUMBER	8.00	0.00
DTE_CAP_TXN	T_CAP_SUMMARY_WI	NUMBER	8.00	0.00
DTE_CAP_TXN	T_CAP_SUMMARY_tmp	NUMBER	8.00	0.00
DTE_CASE_CLOSED	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_CASE_DLC	T_PS_CASE	NUMBER	8.00	0.00
DTE_CCYYMM	T_CPAS_HCFA_INFO	NUMBER	9.00	0.00
DTE_CC_PROCESSED	T_CC_CR_SAVE	DATE	0.00	0.00
DTE_CC_PROCESSED	T_CC_HIST_ADJUST	NUMBER	22.00	8.00
DTE_CEO_REQ	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_CEO_RESP	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_CERT	T_RE_CASE_XREF	DATE	0.00	0.00
DTE_CERT	T_RE_CASE_XREF	NUMBER	8.00	0.00
DTE_CERTIFIED	T_AR_COLLECTION	DATE	0.00	0.00
DTE_CERTIFIED	T_AR_COLLECTION	NUMBER	8.00	0.00
DTE_CERT_AG_CHG	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_CERT_UPDT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_CHANGED	T_LAST_PASSWORD	NUMBER	8.00	0.00
DTE_CHANGED	T_RE_MOVE_IN_OUT	NUMBER	8.00	0.00
DTE_CHANGED	T_RE_OTH_CHG	NUMBER	8.00	0.00
DTE_CHANGED	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_CHANGED	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_CHANGED	T_RE_SPONSOR	NUMBER	8.00	0.00
DTE_CHECK	T_CASH_RECEIPT	DATE	0.00	0.00
DTE_CHECK	T_CASH_RECEIPT	NUMBER	8.00	0.00
DTE_CHECK_EFF	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_CHECK_EFF	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_CHECK_EFF	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00

DTE_CHECK_EFF	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_CHPID_SHPID_REL_EFF	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	8.00	0.00
DTE_CHPID_SHPID_REL_END	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	8.00	0.00
DTE_CLAIM	T_CA_TIME_KEY	DATE	0.00	0.00
DTE_CLARIFICATION	T_ERR_RESO_CLRFCTNS	DATE	0.00	0.00
DTE_CLEARED	T_BANK_PD_NOISSUE	DATE	0.00	0.00
DTE_CLEARED	T_BANK_PD_NOISSUE	NUMBER	8.00	0.00
DTE_CLEARED	T_CHECK_CLEARED	NUMBER	8.00	0.00
DTE_CLEARED	T_FIN_NO_ISSUE	NUMBER	8.00	0.00
DTE_CLM_ADJUDICATION	T_DNTL_OTH_PYR_HDR	DATE	0.00	0.00
DTE_CLM_ADJUDICATION	T_PROF_OTH_PYR_HDR	DATE	0.00	0.00
DTE_CLM_LOCAT	T_ADJ_REV_RQST	NUMBER	8.00	0.00
DTE_CLM_LOCAT	T_CLAIM_LOCAT	NUMBER	8.00	0.00
DTE_CLM_LOCAT	T_CLM_PROCESSED_EXTRACT	NUMBER	8.00	0.00
DTE_CLM_RECIP_CHANGED	T_CLM_RECIP_HIST	NUMBER	8.00	0.00
DTE_CLM_SRV_FROM	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_CLM_SRV_TO	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_CLOSED	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_CLOSED	T_DR_DISPUTE	DATE	0.00	0.00
DTE_CLOSED	T_DR_DISPUTE	NUMBER	8.00	0.00
DTE_CLOSED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_CLOSED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_CLOSE_DATE	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_CLOSE_DATE	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_CLOSE_MCD	T_RE_CLOSE_MCD	NUMBER	8.00	0.00
DTE_CMS_ADD	T_MODIFIER	DATE	0.00	0.00
DTE_CMS_ADD	T_MODIFIER	NUMBER	8.00	0.00
DTE_CMS_ERROR_RPT	T_DR_MAIL_DATE	DATE	0.00	0.00
DTE_CMS_ERROR_RPT	T_DR_MAIL_DATE	NUMBER	8.00	0.00
DTE_CMS_HCFA_APPC	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_CMS_HCFA_APPC	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_CMS_HCFA_MRKC	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_CMS_HCFA_MRKC	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_CMS_LAST_UPDATED	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_CMS_LAST_UPDATED	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_CMS_REACTIVATION	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00

DTE_CMS_REACTIVATION	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_CMS_TAPE_RECEIVED	T_DR_MAIL_DATE	DATE	0.00	0.00
DTE_CMS_TAPE_RECEIVED	T_DR_MAIL_DATE	NUMBER	8.00	0.00
DTE_CMS_TAPE_SENT	T_DR_MAIL_DATE	DATE	0.00	0.00
DTE_CMS_TAPE_SENT	T_DR_MAIL_DATE	NUMBER	8.00	0.00
DTE_CMS_TERM	T_MODIFIER	DATE	0.00	0.00
DTE_CMS_TERM	T_MODIFIER	NUMBER	8.00	0.00
DTE_CMS_TERM_HCFA	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_CMS_TERM_HCFA	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_COLLECT_START	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_COLLECT_START	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_COMMENT	T_DR_INV_COMMENT	NUMBER	8.00	0.00
DTE_COMMENT	T_PR_APPLN_COMMENT	DATE	0.00	0.00
DTE_COMMENT	T_PR_APPLN_COMMENT	NUMBER	8.00	0.00
DTE_COMMENT	T_PR_COMMENT	DATE	0.00	0.00
DTE_COMMENT	T_PR_COMMENT	NUMBER	8.00	0.00
DTE_COMPLETE	T_PROJ_TRACK	NUMBER	8.00	0.00
DTE_COMPLIANCE	T_CLM_ARRA_STATS	NUMBER	8.00	0.00
DTE_CONFIRMED	T_CLM_IMAGE_BALANCE	NUMBER	8.00	0.00
DTE_CONFIRMED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_CONFIRMED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_CONFIRMED_FROM	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_CONFIRMED_FROM	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_CONFIRMED_TO	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_CONFIRMED_TO	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_CONTACT	T_PS_CASE	NUMBER	8.00	0.00
DTE_CONTRACT	T_WEB_PROV	DATE	0.00	0.00
DTE_CORRECTED	T_CLM_IMAGE_BALANCE	NUMBER	8.00	0.00
DTE_COST_AVOID	T_TPL_RESOURCE	DATE	0.00	0.00
DTE_COST_AVOID	T_TPL_RESOURCE	NUMBER	8.00	0.00
DTE_COST_STLMNT	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_COST_STLMNT	T_AR_SUPP_DTL	NUMBER	8.00	0.00
DTE_COST_STLMNT	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_COST_STLMNT	T_EXPENDITURE_SUPP_DTL	NUMBER	8.00	0.00
DTE_COV_END	T_HIPP_EXPEND_XREF	NUMBER	0.00	0.00

DTE_COV_END	T_HIPP_EXPEND_XREF	NUMBER	8.00	0.00
DTE_COV_START	T_HIPP_EXPEND_XREF	NUMBER	8.00	0.00
DTE_CREATE	T_CLM_BATCH_PROCESS	DATE	0.00	0.00
DTE_CREATE	T_CLM_BATCH_PROCESS_ENC	DATE	0.00	0.00
DTE_CREATE	T_EDIC_BATCH_MSGBOX	TIMESTAMP	0.00	0.00
DTE_CREATE	T_EDIC_BATCH_MSGBOX_ARC	TIMESTAMP	0.00	0.00
DTE_CREATE	T_EDIC_REQUESTS	TIMESTAMP	0.00	0.00
DTE_CREATE	T_EDIC_REQUESTS_ARC	TIMESTAMP	0.00	0.00
DTE_CREATE	T_EDIC_RESPONSES	TIMESTAMP	0.00	0.00
DTE_CREATE	T_EDIC_RESPONSES_ARC	TIMESTAMP	0.00	0.00
DTE_CREATE	T_ENC_BATCH_PROCESS	DATE	0.00	0.00
DTE_CREATED	T_CALL_OTIFICATION	NUMBER	8.00	0.00
DTE_CREATED	T_CDE_SUPPORTED_DOC	DATE	0.00	0.00
DTE_CREATED	T_CDE_TP_STATUS	DATE	0.00	0.00
DTE_CREATED	T_DOCUMENT_TRACK	DATE	0.00	0.00
DTE_CREATED	T_DOCUMENT_TRANSACTIONS	DATE	0.00	0.00
DTE_CREATED	T_DR_INCR_ADJ	DATE	0.00	0.00
DTE_CREATED	T_DR_INCR_ADJ	NUMBER	8.00	0.00
DTE_CREATED	T_DR_INCR_INT	DATE	0.00	0.00
DTE_CREATED	T_DR_INCR_INT	NUMBER	8.00	0.00
DTE_CREATED	T_DR_INCR_PAY	DATE	0.00	0.00
DTE_CREATED	T_DR_INCR_PAY	NUMBER	8.00	0.00
DTE_CREATED	T_DS_RECIP_AGGR_CNT	DATE	0.00	0.00
DTE_CREATED	T_EVENT_TRACK	TIMESTAMP	6.00	0.00
DTE_CREATED	T_EVENT_TRACK_KEYS	TIMESTAMP	6.00	0.00
DTE_CREATED	T_FILE_CORRELATION	DATE	0.00	0.00
DTE_CREATED	T_FILE_SOLICITED_TRACK	DATE	0.00	0.00
DTE_CREATED	T_FILE_TRACK	DATE	0.00	0.00
DTE_CREATED	T_FILE_TRACK_EXCEPTION	DATE	0.00	0.00
DTE_CREATED	T_FIN_REMIT	DATE	0.00	0.00
DTE_CREATED	T_FIN_REMIT	NUMBER	8.00	0.00
DTE_CREATED	T_FUNCTIONAL_ACKS	DATE	0.00	0.00
DTE_CREATED	T_NCPDP_P4_LOG	TIMESTAMP	6.00	0.00
DTE_CREATED	T_RE_1095_REJECT	NUMBER	8.00	0.00
DTE_CREATED	T_RE_1095_TRACK	NUMBER	8.00	0.00
DTE_CREATED	T_RE_ADPH_1095_REJECT	NUMBER	8.00	0.00
DTE_CREATED	T_RE_ADPH_1095_TRACK	NUMBER	8.00	0.00
DTE_CREATED	T_RE_CMS_MMA_RESPONSE	DATE	0.00	0.00
DTE_CREATED	T_RE_CMS_MMA_RESPONSE	NUMBER	8.00	0.00

DTE_CREATED	T_RE_EBS_CARD_RQST	CHAR	8.00	0.00
DTE_CREATED	T_RE_EDB	DATE	0.00	0.00
DTE_CREATED	T_RE_NET_VOUCHER	DATE	0.00	0.00
DTE_CREATED	T_RE_PARTD_PDP_ASSIGN	DATE	0.00	0.00
DTE_CREATED	T_RE_PARTD_PDP_ASSIGN	NUMBER	8.00	0.00
DTE_CREATED	T_TP	DATE	0.00	0.00
DTE_CREATED	T_TP_ALLOWED_TRANSPORT	DATE	0.00	0.00
DTE_CREATED	T_TP_CONFIG	DATE	0.00	0.00
DTE_CREATED	T_TRACK_SUPP_DOC_XREF	DATE	0.00	0.00
DTE_CREDIT_BAL_EFFECTIVE	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_CREDIT_BAL_END	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_CS_REFERRAL	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_CY	T_CA_TIME_KEY	NUMBER	4.00	0.00
DTE_CYCLE	T_1099_DETAIL	DATE	0.00	0.00
DTE_CYCLE	T_1099_DETAIL	NUMBER	8.00	0.00
DTE_CYCLE	T_CHECK	DATE	0.00	0.00
DTE_CYCLE	T_CHECK	NUMBER	8.00	0.00
DTE_CYCLE	T_FIN_EARNINGS_HIST	NUMBER	8.00	0.00
DTE_CYCLE	T_FIN_EARNINGS_YTD	NUMBER	8.00	0.00
DTE_CYCLE	T_FIN_PROCESS_PYMT	NUMBER	8.00	0.00
DTE_CYCLE	T_PR_PROV_YTD_AMT	DATE	0.00	0.00
DTE_CYCLE	T_PR_PROV_YTD_AMT	NUMBER	8.00	0.00
DTE_CYCLE	T_PR_YTD_AMT_HIST	DATE	0.00	0.00
DTE_CYCLE	T_PR_YTD_AMT_HIST	NUMBER	8.00	0.00
DTE_CYCLE	T_SW_RTI_LOG	NUMBER	8.00	0.00
DTE_DATA_COLLECTED	T_TMSIS_DATA_ELEMENTS	NUMBER	8.00	0.00
DTE_DEATH	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_DEATH	T_RE_BASE	NUMBER	8.00	0.00
DTE_DEATH	T_RE_BASE_DN	DATE	0.00	0.00
DTE_DEATH	T_RE_DEATH_CHG	NUMBER	9.00	0.00
DTE_DEATH	T_RE_DEATH_RPT	NUMBER	8.00	0.00

DTE_DEATH	T_RE_EDB	DATE	0.00	0.00
DTE_DEATH_ELIGIBLE	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	8.00	0.00
DTE_DEATH_PROV	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	8.00	0.00
DTE_DEATH_SPOUSE	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_DEFICIENCY	T_ACCT_REC	NUMBER	8.00	0.00
DTE_DEFICIENCY	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_DEFICIENCY	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_DELIVERY	T_CLM_HDR_DELIVERY	NUMBER	8.00	0.00
DTE_DEPOSITED	T_RE_AR_TRANSACTION	DATE	0.00	0.00
DTE_DEPOSITED	T_RE_AR_TRANSACTION	NUMBER	8.00	0.00
DTE_DESI_DISC	T_LS_DRUG_MASTER	DATE	0.00	0.00
DTE_DESI_EFFECT	T_LS_DRUG_MASTER	DATE	0.00	0.00
DTE_DET_EMAIL_SENT	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_DISABILITY_TYPE_EFF	T_TMSIS_ELG017_DISAB_INFO	NUMBER	8.00	0.00
DTE_DISABILITY_TYPE_END	T_TMSIS_ELG017_DISAB_INFO	NUMBER	8.00	0.00
DTE_DISAST_SURV_BEGIN	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_DISAST_SURV_END	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_DISC	T_LS_DRUG_MASTER	DATE	0.00	0.00
DTE_DISCHARGE	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_DISCHARGE	T_MPHX_INPT_HDR	NUMBER	8.00	0.00
DTE_DISCHARGE	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_DISCHARGE	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_DISCOVERED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_DISCOVERED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_DISENROLL	T_MC_PMP_ENRL_RGN	DATE	0.00	0.00
DTE_DISENROLL	T_MC_PMP_ENRL_RGN	NUMBER	8.00	0.00
DTE_DISENROLL	T_MC_PMP_ENRL_RGN_AL	NUMBER	8.00	0.00
DTE_DISENROLL	T_PR_ENROLL_INFO	DATE	0.00	0.00

DTE_DISENROLL	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_DISENROLL_PROCESSED	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_DISENROLL_PROCESSED	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_DISPENSE	T_CA_DRUG	DATE	0.00	0.00
DTE_DISPENSE	T_DENY_PHRM_HDR	NUMBER	8.00	0.00
DTE_DISPENSE	T_DR_RECOUP_LTR_ICN	NUMBER	8.00	0.00
DTE_DISPENSE	T_LS_PHARMACY_OTHER	CHAR	10.00	0.00
DTE_DISPENSE	T_MPHX_PHRM_DTL_AL	NUMBER	8.00	0.00
DTE_DISPENSE	T_PDUR_SUSP	NUMBER	8.00	0.00
DTE_DISPENSE	T_PDUR_SUSP	NUMBER	8.00	0.00
DTE_DISPENSE	T_PD_PHARM_HDR	NUMBER	8.00	0.00
DTE_DISPENSE	T_SUSP_PHRM_HDR	NUMBER	8.00	0.00
DTE_DISPENSED	T_DR_CLMS_XREF	NUMBER	8.00	0.00
DTE_DISPOSED	T_DS_RECIP_DO_PREV_PROP	DATE	0.00	0.00
DTE_DISPOSITION	T_FIN_BUDG_DISP	NUMBER	8.00	0.00
DTE_DISPOSITION	T_FIN_PROCESS_BUDG_DISP	NUMBER	8.00	0.00
DTE_DOS_EFFECTIVE	T_EOB_CARC_RARC_XREF	DATE	0.00	0.00
DTE_DOS_EFFECTIVE	T_EOB_CARC_RARC_XREF	NUMBER	8.00	0.00
DTE_DOS_END	T_EOB_CARC_RARC_XREF	DATE	0.00	0.00
DTE_DOS_END	T_EOB_CARC_RARC_XREF	NUMBER	8.00	0.00
DTE_DOS_FROM	T_EVS_INQUIRY	DATE	0.00	0.00
DTE_DOS_FROM	T_EVS_INQUIRY	NUMBER	8.00	0.00
DTE_DOS_THRU	T_EVS_INQUIRY	DATE	0.00	0.00
DTE_DOS_THRU	T_EVS_INQUIRY	NUMBER	8.00	0.00
DTE_DOWNLOADED	T_DOWNLOAD	DATE	0.00	0.00
DTE_DOWNLOADED	T_EDIC_MSG_RECEIVE	TIMESTAMP	0.00	0.00
DTE_DOWNLOADED	T_EDIC_MSG_RECEIVE_ARC	TIMESTAMP	0.00	0.00
DTE_DOWNLOADED	T_WEB_FEITH_DOWNLOAD	DATE	0.00	0.00
DTE_DOWNLOADED	T_WEB_PAY_SUM	DATE	0.00	0.00
DTE_DO_APPL_ACCEPTED	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_DO_ED_APPL_STATUS	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_DO_MSP_APPL_STATUS	T_RE_BASE_STATE	DATE	0.00	0.00

DTE_DRUG_OBSOLETE	T_DRUG	DATE	0.00	0.00
DTE_DRUG_OBSOLETE	T_DRUG	NUMBER	8.00	0.00
DTE_DRUG_OBSOLETE	T_DRUG_DN	DATE	0.00	0.00
DTE_DTRMN_RCVD	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_DTRMN_RCVD	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_DTRMN_USER_DLC	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_DUE	T_ACCT_REC	NUMBER	8.00	0.00
DTE_DUE	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_DUE	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_DUE	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_DUE	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_DUE_CHILD	T_RE_CHILD_EXPECT	NUMBER	8.00	0.00
DTE_ECC_EFF	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_ECC_EFF	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_ECC_EFF	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_EFF	T_EDIT_PARMS	NUMBER	8.00	0.00
DTE_EFF	T_PR_PHONE_TRACK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_835_CK_EFT_TRCNO	DATE	0.00	0.00
DTE_EFFECTIVE	T_ACCOMM_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_ACCT_REC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_EFFECTIVE	T_AHFS_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AR_INTEREST_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_AR_INTEREST_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_ASC_PRICING	DATE	0.00	0.00

DTE_EFFECTIVE	T_ASC_PRICING	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AUDIT_CRIT	DATE	0.00	0.00
DTE_EFFECTIVE	T_AUDIT_CRIT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AUDIT_CRIT_AL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AUDIT_ST_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_AUDIT_ST_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AUDIT_ST_MEM	DATE	0.00	0.00
DTE_EFFECTIVE	T_AUDIT_ST_MEM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_AUTO_PA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BENEFIT_PLAN_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_BENEFIT_PLAN_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BNFT_ADJ_FACTOR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BNFT_PLAN_COB	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BORDER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYA_BILL	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYA_BILL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYA_EXCEPT	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYA_EXCEPT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYA_PERD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYA_PREM	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYA_PREM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYB_BILL	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYB_EXCEPT	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYB_EXCEPT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYB_PERD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_BUYB_PREM	DATE	0.00	0.00
DTE_EFFECTIVE	T_BUYB_PREM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CAPITAL_COST	DATE	0.00	0.00
DTE_EFFECTIVE	T_CAPITAL_COST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALLER_TYPE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_CATEG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_CMPLTN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_METHOD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_PRIORITY	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_CDE_CALL_STATUS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_TYPE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CALL_UNIT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CAN_RESP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_CARC_RARC	DATE	0.00	0.00
DTE_EFFECTIVE	T_CDE_CARC_RARC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_HIPAA_ADJRSN	DATE	0.00	0.00
DTE_EFFECTIVE	T_CDE_HIPAA_ADJRSN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_HIPAA_REMRKS	DATE	0.00	0.00
DTE_EFFECTIVE	T_CDE_HIPAA_REMRKS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CDE_NOTE_TYPE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLAIM_BDL_LABPANEL	DATE	0.00	0.00
DTE_EFFECTIVE	T_CLAIM_BDL_NCCD	DATE	0.00	0.00
DTE_EFFECTIVE	T_CLAIM_BDL_OVERRIDE	DATE	0.00	0.00
DTE_EFFECTIVE	T_CLIA_CERT	DATE	0.00	0.00
DTE_EFFECTIVE	T_CLIA_CERT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLIA_LAB	DATE	0.00	0.00
DTE_EFFECTIVE	T_CLIA_LAB	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLM_AMT_VARIANCE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLM_FCA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLM_INT_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CLM_MULT_SURG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CONDITION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_COND_INP_LOC	DATE	0.00	0.00
DTE_EFFECTIVE	T_COND_INP_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_CONV_FACTOR	DATE	0.00	0.00
DTE_EFFECTIVE	T_CONV_FACTOR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_COPAY	DATE	0.00	0.00
DTE_EFFECTIVE	T_COPAY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_COUNTY_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_COVERAGE_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_COVERAGE_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_COVERED_BENEFIT	DATE	0.00	0.00
DTE_EFFECTIVE	T_COVERED_BENEFIT	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_CST_CHG_RATIO	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DESI	DATE	0.00	0.00
DTE_EFFECTIVE	T_DESI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DIAG_COMPAT_GRP	DATE	0.00	0.00
DTE_EFFECTIVE	T_DIAG_COMPAT_GRP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DIAG_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_DIAG_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DIAG_LIMIT	DATE	0.00	0.00
DTE_EFFECTIVE	T_DIAG_LIMIT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DIAG_POS_LIM	DATE	0.00	0.00
DTE_EFFECTIVE	T_DIAG_POS_LIM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DISP_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_DISP_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DISP_SHARE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_CROSSWALK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_DIAG_XWALK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRG_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_GROUPER	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRG_GROUPER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_ICD9_XWALK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_INP_LOC	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRG_INP_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_MAPPER	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRG_MAPPER	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_DRG_NEONATAL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRG_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRG_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_AAC_PRICE	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_AAC_PRICE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_ACT_COV	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_AWP	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_AWP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_HCPCS	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_HCPCS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_LIMITS	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_LIMITS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_MAC	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_MAC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_MAC_PCT	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_MAC_PCT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_PRICE	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_REBATE_TEMP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DRUG_S_MAC	DATE	0.00	0.00
DTE_EFFECTIVE	T_DRUG_S_MAC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DR_INV_TYPE_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_DR_INV_TYPE_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DR_JCODE_XWALK	DATE	0.00	0.00
DTE_EFFECTIVE	T_DR_JCODE_XWALK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DR_STATUS	DATE	0.00	0.00
DTE_EFFECTIVE	T_DR_STATUS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DR_STATUS_SUPPLE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DR_TBILL_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_DR_TBILL_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_DS_HM_PROV_FY_XREF	DATE	0.00	0.00

DTE_EFFECTIVE	T_DS_RECIP_MFP	DATE	0.00	0.00
DTE_EFFECTIVE	T_EAC	DATE	0.00	0.00
DTE_EFFECTIVE	T_EAC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EDI_COVERED_PROV_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EDI_MC_PROV_TP_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EDI_TP_834_RQST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EDUCATION_CST	DATE	0.00	0.00
DTE_EFFECTIVE	T_EDUCATION_CST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EFT_TRACE_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_EFT_TRACE_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_ENC_ERR_THRESHLD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EOB	DATE	0.00	0.00
DTE_EFFECTIVE	T_EOB	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EOB_ADJRSN_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_EOB_REMRKS_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_ERROR_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_ERROR_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EVS_ELIG	DATE	0.00	0.00
DTE_EFFECTIVE	T_EVS_ELIG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_EVS_SVC_COVERAGE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FEE_SCHEDULE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FICA_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_FICA_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FINANCIAL_PAYER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_BUDG_GRP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_CYCLE_BNK_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_EFT_ACCT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_MAX_RECOUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_PAYER_COB	NUMBER	0.00	0.00
DTE_EFFECTIVE	T_FIN_PROCESS_AR	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_FIN_PRUDENT_PAY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_PYMT_PULL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_SCHED_HOLD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FIN_SCHED_OVERRIDE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FMAP_PCT	DATE	0.00	0.00
DTE_EFFECTIVE	T_FMAP_PCT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_FUND_PAYER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_GCN_SEQNO_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_GCN_SEQNO_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_GEN_RATES	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_GPCI	DATE	0.00	0.00
DTE_EFFECTIVE	T_GPCI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_HIC_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_EFFECTIVE	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_HOSPICE_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_HOSPICE_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_HOSP_ANC_AUTH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_INP_LOC_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_INP_LOC_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_IRS_W9_INFO	DATE	0.00	0.00
DTE_EFFECTIVE	T_IRS_W9_INFO	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_LAB_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_LAB_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_LIMIT_PARM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_LS_DRUG_AWP_PRICING	DATE	0.00	0.00
DTE_EFFECTIVE	T_LS_DRUG_MAC_PRICING	DATE	0.00	0.00
DTE_EFFECTIVE	T_LS_LVL3_PRICING	DATE	0.00	0.00
DTE_EFFECTIVE	T_LTC_LEAVE_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MARG_COST	DATE	0.00	0.00
DTE_EFFECTIVE	T_MARG_COST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MAX_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_MAX_FEE	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_MCARE_DEDUCTIBLE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_AID_GRP	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_AID_GRP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_AID_GRP_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_AID_GRP_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_AREA_RGN_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_AREA_RGN_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_AREA_RGN_XREF_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_AMTS	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_CAP_AMTS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_AMTS_PMP	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_CAP_AMTS_PMP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_AMTS_RANGE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_CMF_RATES	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_CAP_CMF_RATES	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_DEMOGRAPH	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_CAP_DEMOGRAPH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CAP_DEMOGRAPH_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CDE_AID_ENROLL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CENSUS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_CENSUS_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_DIAG_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_DIAG_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_FTE	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_FTE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PGM_LIV_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PGM_LIV_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PGM_RGN_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PGM_RGN_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PGM_STATUS_GRP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PGM_STATUS_GRP_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PLAN_COUNTY	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PLAN_COUNTY	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_MC_PMP_EDB_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PMP_EDB_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PMP_ENRL_RGN	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PMP_ENRL_RGN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PMP_ENRL_RGN_AL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PMP_GRP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PMP_PANEL_RESTRICT	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PMP_PANEL_RESTRICT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_PMP_SC	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_PMP_SC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_RATE_CELL	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_RATE_CELL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_RE_PMP_LKOUT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_RE_SPEC_COND	DATE	0.00	0.00
DTE_EFFECTIVE	T_MC_RE_SPEC_COND	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MC_SPEC_COND_EXCL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MODIFIER	DATE	0.00	0.00
DTE_EFFECTIVE	T_MODIFIER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MODIFIER_RSTN	DATE	0.00	0.00
DTE_EFFECTIVE	T_MODIFIER_RSTN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MOD_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_MOD_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MR_ELIG	DATE	0.00	0.00
DTE_EFFECTIVE	T_MR_PR_ENROL	DATE	0.00	0.00
DTE_EFFECTIVE	T_MR_WVR_PROC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MR_WVR_SVC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_MULT_SURG_PCT	DATE	0.00	0.00
DTE_EFFECTIVE	T_MULT_SURG_PCT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_NDDF_PRICE	DATE	0.00	0.00
DTE_EFFECTIVE	T_NDDF_PRICE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_NONPROV_TAX_ID	DATE	0.00	0.00

DTE_EFFECTIVE	T_NONPROV_TAX_ID	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_OUTLIER_THRESHLD	DATE	0.00	0.00
DTE_EFFECTIVE	T_OUTLIER_THRESHLD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_OVERHEAD_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_OVERHEAD_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PATIENT_STAT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PAYABLE_BENEFIT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PAYER_HIERARCHY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_EFFECTIVE	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PA_ASSIGN_CODE	DATE	0.00	0.00
DTE_EFFECTIVE	T_PA_ASSIGN_CODE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PDL_MASTER	DATE	0.00	0.00
DTE_EFFECTIVE	T_PDL_MASTER_AL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_CAPT	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_CAPT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_DRGR	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_DRGR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_DRGR_OLD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_EDUC	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_EDUC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_FACT	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_FACT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_INP_LOC	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_INP_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_RTIO	DATE	0.00	0.00
DTE_EFFECTIVE	T_PEER_GRP_RTIO	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PERF_ANALYST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PERF_CRIT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PERF_SUMM	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_PGM_CT_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_PGM_CT_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PGM_HIERARCHY	DATE	0.00	0.00
DTE_EFFECTIVE	T_PGM_HIERARCHY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PHS_DATES	DATE	0.00	0.00
DTE_EFFECTIVE	T_PHS_DATES	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_AUTOASSGN	DATE	0.00	0.00
DTE_EFFECTIVE	T_PMP_AUTOASSGN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_PANEL_SIZE	DATE	0.00	0.00
DTE_EFFECTIVE	T_PMP_PANEL_SIZE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_SVC_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_SVC_LOC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_SVC_LOC_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PMP_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PREVAILING	DATE	0.00	0.00
DTE_EFFECTIVE	T_PREVAILING	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PREVAILING_CONV	DATE	0.00	0.00
DTE_EFFECTIVE	T_PREVAILING_CONV	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROCESS_MOD	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROCESS_MOD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_ASC	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_ASC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_CONV_FACTOR	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_CONV_FACTOR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_DIAG_LIM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_DIAG_LIM	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_PROC_DIAG_PA	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_DIAG_PA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_GSN_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_GSN_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_ICD9_DIA	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_ICD9_DIA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_ICD9_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_ICD9_GROUP	NUMBER	8.00	0.00
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DTE_EFFECTIVE	T_PROC_ICD9_LIM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_LIMITS	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_LIMITS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_MCO_LIM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_MCO_LIM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_MODIFIER	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_MODIFIER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_SPEC_LIM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_SPEC_LIM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_TOOTH	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_TOOTH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PROC_TOOTH_QUAD	DATE	0.00	0.00
DTE_EFFECTIVE	T_PROC_TOOTH_QUAD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ACCT_REC_MAX	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ANNUAL_VISIT_CRIT	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_ANNUAL_VISIT_CRIT	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_PR_APPLN_STATUS_RSN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_BEDS_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_BILLER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_BOARD	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_BOARD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_BOARD_MEM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_CAPT_CST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_CHOW_GRP_MBR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_CHOW_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_CHOW_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_CLIA_STAT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_COVERED_PGM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_COVERED_PGM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_CST_CHRG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_DEA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_DISP_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_DRG_RATE	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_DRG_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_DRG_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_EDIT_EXEMPT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_EFT_ACCT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENRL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENRL_CLIA	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENRL_SPECIALTY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENRL_TAX_ID	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENROLL_PGM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_ENROLL_PGM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_FACILITY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_GRP_MBR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_GRP_MBR	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_HB_LIC	DATE	0.00	0.00

DTE_EFFECTIVE	T_PR_HB_LIC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_HB_LIC_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_INST_RATE_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_LICENSE_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_LOC_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_LOC_RATE_REQ	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_LOC_RATE_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_MARG_CST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_MCARE_BILL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_MDED_CST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_OUT_OF_STATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_OUT_RATE_AL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_OWNER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PAY_PULL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PCP	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_PCP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PEER_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PEER_LEVEL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PGM_CT_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_PGM_CT_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PHP_ELIG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PHYS_ASST	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PHYS_SUPV	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_PHYS_SUPV	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_PSYCH_FACI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_RATE_KY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_RECP_LOC_X	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_RECP_LOC_X	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_REVIEW	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_REVIEW	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_RISK_GRP_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_RST_SVC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_SPEC	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_PR_STATE_SHARE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_SURS_SPEC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_SVC_CERT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_SVC_CERT_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_SVC_LANG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_TAXONOMY	DATE	0.00	0.00
DTE_EFFECTIVE	T_PR_TAXONOMY	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_TAX_ID	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PR_UB_LOC_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PUB_HLTH_PGM	DATE	0.00	0.00
DTE_EFFECTIVE	T_PUB_HLTH_PGM	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RBRVS	DATE	0.00	0.00
DTE_EFFECTIVE	T_RBRVS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RBRVS_PR_SPEC	DATE	0.00	0.00
DTE_EFFECTIVE	T_RBRVS_PR_SPEC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REBATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RECIP_REVIEW	DATE	0.00	0.00
DTE_EFFECTIVE	T_RECIP_REVIEW	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CCI	DATE	0.00	0.00
DTE_EFFECTIVE	T_REF_CCI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CCI_MUE	DATE	0.00	0.00
DTE_EFFECTIVE	T_REF_CCI_MUE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CCI_MUE_OVERRIDE	DATE	0.00	0.00
DTE_EFFECTIVE	T_REF_CCI_MUE_OVERRIDE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CCI_OVERRIDE	DATE	0.00	0.00
DTE_EFFECTIVE	T_REF_CCI_OVERRIDE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CDE_AID_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CDE_VALUE_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_REF_CDE_VALUE_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_CLIA_LC_PROC	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_REF_DISTRICT_PLAN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_ID_PROV_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REF_UCC	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REIMB_AGREEMENT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REIMB_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REVENUE_CODE	DATE	0.00	0.00
DTE_EFFECTIVE	T_REVENUE_CODE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REVENUE_FLAT_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_REVENUE_FLAT_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REV_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_REV_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REV_HOSPICE_XWALK	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REV_PROC_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_REV_PROC_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_REV_SPEC_RSTN	DATE	0.00	0.00
DTE_EFFECTIVE	T_REV_SPEC_RSTN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_AID_ELIG	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_AID_ELIG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_AID_ELIG_DN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_ASSIGN_PLAN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_ASSIGN_PLAN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_ASSIGN_PLAN_LI	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_ASSIGN_PLAN_RLOC	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_CLM_DELINK	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_CMS_MMA_ENROLL	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_CUST_STATUS	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_CUST_STATUS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_ELIG	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_ELIG	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_ELIG_DN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_HIB	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_HIB	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_RE_HOH	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_HOH	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_INCOME	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_LOC	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_LOCKIN_INFO	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_LOCKIN_PERIOD	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_LTC_REQUEST	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_MEDICARE_A	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_MEDICARE_A	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_MEDICARE_B	DATE	0.00	0.00
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DTE_EFFECTIVE	T_RE_MEDICARE_D	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_MEDICARE_D	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_OLD_PCN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_OLD_PCN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_PARTD_PDP_ASSIGN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_PARTD_PDP_ASSIGN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_PARTD_PDP_PLAN	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_PARTD_PDP_PLAN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_PAT_LIAB	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_PAT_LIAB	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_RE_RETRO_ELIG	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_SPEND_LIAB	DATE	0.00	0.00
DTE_EFFECTIVE	T_RE_SPEND_LIAB	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_SITE_OF_DIFF	DATE	0.00	0.00
DTE_EFFECTIVE	T_SITE_OF_DIFF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_SPEC_MOD	DATE	0.00	0.00
DTE_EFFECTIVE	T_SPEC_MOD	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_STATE_ADDR	NUMBER	8.00	0.00

DTE_EFFECTIVE	T_STATE_DESI	DATE	0.00	0.00
DTE_EFFECTIVE	T_STATE_DESI	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_STOP_LOSS_PARMS	DATE	0.00	0.00
DTE_EFFECTIVE	T_STOP_LOSS_PARMS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_SYSTEM_PARMS	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TAXONOMY_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TELECOM_TP	DATE	0.00	0.00
DTE_EFFECTIVE	T_THERAPEUTIC_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TOB_GROUP	DATE	0.00	0.00
DTE_EFFECTIVE	T_TOB_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_AC_PARENT_EMP_XREF	DATE	0.00	0.00
DTE_EFFECTIVE	T_TPL_AC_PARENT_EMP_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_CARRIER	DATE	0.00	0.00
DTE_EFFECTIVE	T_TPL_CARRIER	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_CARRIER_AL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_CAR_SUB_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_CONT_FEE	DATE	0.00	0.00
DTE_EFFECTIVE	T_TPL_CONT_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_COV_PLAN_XREF	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_EXEMPT	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_RESTRICTION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_RES_DEL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TPL_TAX_ID	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TP_SPC_MOD_EXCL	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_TYPE_SPEC_GROUP	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_VFC_ADMIN_FEE	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_WINDOW	NUMBER	8.00	0.00
DTE_EFFECTIVE	T_XOVER_RATE	NUMBER	8.00	0.00
DTE_EFFECTIVE_ACC	T_PR_BOND	DATE	0.00	0.00
DTE_EFFECTIVE_ACC	T_PR_BOND	NUMBER	8.00	0.00

DTE_EFFECTIVE_ACC	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_EFFECTIVE_DEA	T_PR_ENRL_IDENTIFIER	NUMBER	8.00	0.00
DTE_EFFECTIVE_EFT_AFT	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_EFFECTIVE_EFT_BEF	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_EFFECTIVE_EFT_ERA	T_FIN_EFT_ACCT	NUMBER	8.00	0.00
DTE_EFFECTIVE_EFT_ERA	T_WEB_RECEIVER	NUMBER	8.00	0.00
DTE_EFFECTIVE_EFT_ERA	T_WEB_RECEIVER_BACKUP	NUMBER	8.00	0.00
DTE_EFFECTIVE_ERA_AFT	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_EFFECTIVE_ERA_BEF	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_EFFECTIVE_FROM	T_CHECK_BANNER	DATE	0.00	0.00
DTE_EFFECTIVE_FROM	T_CHECK_BANNER	NUMBER	8.00	0.00
DTE_EFFECTIVE_FROM	T_FIN_AR_RQST_REPORT	NUMBER	8.00	0.00
DTE_EFFECTIVE_FROM	T_LIEN	DATE	0.00	0.00
DTE_EFFECTIVE_FROM	T_LIEN	NUMBER	8.00	0.00
DTE_EFFECTIVE_LIC	T_PR_ENRL_IDENTIFIER	NUMBER	8.00	0.00
DTE_EFFECTIVE_MCAID	T_PR_BOND	DATE	0.00	0.00
DTE_EFFECTIVE_MCAID	T_PR_BOND	NUMBER	8.00	0.00
DTE_EFFECTIVE_MCAID	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_EFFECTIVE_MCARE	T_PR_BOND	DATE	0.00	0.00
DTE_EFFECTIVE_MCARE	T_PR_BOND	NUMBER	8.00	0.00
DTE_EFFECTIVE_MCARE	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_EFFECTIVE_MCARE	T_PR_ENRL_IDENTIFIER	NUMBER	8.00	0.00
DTE_EFFECTIVE_THRU	T_CHECK_BANNER	DATE	0.00	0.00
DTE_EFFECTIVE_THRU	T_CHECK_BANNER	NUMBER	8.00	0.00
DTE_EFFECTIVE_THRU	T_FIN_AR_RQST_REPORT	NUMBER	8.00	0.00
DTE_EFFECTIVE_THRU	T_LIEN	DATE	0.00	0.00
DTE_EFFECTIVE_THRU	T_LIEN	NUMBER	8.00	0.00
DTE_EFFECTIVE_THRU	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_EFFECTIVE_THRU	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_EFFEC_DOR	T_ERR_DISP_LINE	DATE	0.00	0.00
DTE_EFFEC_DOR	T_ERR_DISP_LINE	NUMBER	8.00	0.00
DTE_EFFEC_DOS	T_ERR_DISP_LINE	DATE	0.00	0.00
DTE_EFFEC_DOS	T_ERR_DISP_LINE	NUMBER	8.00	0.00
DTE_EFT_REQUEST_AFT	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00

DTE_EFT_REQUEST_BEF	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_ELECTION	T_RE_HOSPICE_HDR	NUMBER	8.00	0.00
DTE_ELIGIBLE_ADR_EFF	T_TMSIS_ELG004_CONTACT_INF	NUMBER	8.00	0.00
DTE_ELIGIBLE_ADR_END	T_TMSIS_ELG004_CONTACT_INF	NUMBER	8.00	0.00
DTE_ELIG_DETERM_EFF	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	8.00	0.00
DTE_ELIG_DETERM_END	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	8.00	0.00
DTE_ELIG_EFF	T_RE_BASE_DN	DATE	0.00	0.00
DTE_ELIG_END	T_RE_BASE_DN	DATE	0.00	0.00
DTE_ELIG_EXPIRED	T_CLM_SYS_FIELDS_DTL	NUMBER	8.00	0.00
DTE_ELIG_PRSN_MAIN_EFF	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	8.00	0.00
DTE_ELIG_PRSN_MAIN_END	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	8.00	0.00
DTE_EMAIL_CHANGED	T_RE_EMAIL	NUMBER	8.00	0.00
DTE_EMAIL_SENT	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_EMAIL_SENT	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_END	T_ACCOMM_FEE	NUMBER	8.00	0.00
DTE_END	T_AHFS_GROUP	NUMBER	8.00	0.00
DTE_END	T_ALLERGY	NUMBER	8.00	0.00
DTE_END	T_ALLERGY_DIAG	NUMBER	8.00	0.00
DTE_END	T_ASC_PRICING	DATE	0.00	0.00
DTE_END	T_ASC_PRICING	NUMBER	8.00	0.00
DTE_END	T_AUDIT_CRIT	DATE	0.00	0.00
DTE_END	T_AUDIT_CRIT	NUMBER	8.00	0.00
DTE_END	T_AUDIT_CRIT_AL	NUMBER	8.00	0.00
DTE_END	T_AUDIT_ST_GROUP	DATE	0.00	0.00
DTE_END	T_AUDIT_ST_GROUP	NUMBER	8.00	0.00
DTE_END	T_AUDIT_ST_MEM	DATE	0.00	0.00
DTE_END	T_AUDIT_ST_MEM	NUMBER	8.00	0.00
DTE_END	T_AUTO_PA	NUMBER	8.00	0.00

DTE_END	T_BENEFIT_PLAN_GROUP	DATE	0.00	0.00
DTE_END	T_BENEFIT_PLAN_GROUP	NUMBER	8.00	0.00
DTE_END	T_BNFT_ADJ_FACTOR	NUMBER	8.00	0.00
DTE_END	T_BNFT_PLAN_COB	NUMBER	8.00	0.00
DTE_END	T_BORDER	NUMBER	8.00	0.00
DTE_END	T_BUYA_PERD	NUMBER	8.00	0.00
DTE_END	T_BUYB_PERD	NUMBER	8.00	0.00
DTE_END	T_CAPITAL_COST	DATE	0.00	0.00
DTE_END	T_CAPITAL_COST	NUMBER	8.00	0.00
DTE_END	T_CDE_CALLER_TYPE	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_CATEG	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_CMPLTN	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_METHOD	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_PRIORITY	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_STATUS	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_TYPE	NUMBER	8.00	0.00
DTE_END	T_CDE_CALL_UNIT	NUMBER	8.00	0.00
DTE_END	T_CDE_CAN_RESP	NUMBER	8.00	0.00
DTE_END	T_CDE_CARC_RARC	DATE	0.00	0.00
DTE_END	T_CDE_CARC_RARC	NUMBER	8.00	0.00
DTE_END	T_CDE_HIPAA_ADJRSN	DATE	0.00	0.00
DTE_END	T_CDE_HIPAA_ADJRSN	NUMBER	8.00	0.00
DTE_END	T_CDE_HIPAA_REMRKS	DATE	0.00	0.00
DTE_END	T_CDE_HIPAA_REMRKS	NUMBER	8.00	0.00
DTE_END	T_CDE_NOTE_TYPE	NUMBER	8.00	0.00
DTE_END	T_CLAIM_BDL_LABPANEL	DATE	0.00	0.00
DTE_END	T_CLAIM_BDL_NCCD	DATE	0.00	0.00
DTE_END	T_CLAIM_BDL_OVERRIDE	DATE	0.00	0.00
DTE_END	T_CLIA_CERT	DATE	0.00	0.00
DTE_END	T_CLIA_CERT	NUMBER	8.00	0.00
DTE_END	T_CLIA_LAB	DATE	0.00	0.00
DTE_END	T_CLIA_LAB	NUMBER	8.00	0.00
DTE_END	T_CLM_AMT_VARIANCE	NUMBER	8.00	0.00
DTE_END	T_CLM_FCA	NUMBER	8.00	0.00
DTE_END	T_CLM_INT_RATE	NUMBER	8.00	0.00
DTE_END	T_CLM_MULT_SURG	NUMBER	8.00	0.00
DTE_END	T_CONDITION	NUMBER	8.00	0.00

DTE_END	T_COND_INP_LOC	DATE	0.00	0.00
DTE_END	T_COND_INP_LOC	NUMBER	8.00	0.00
DTE_END	T_CONTRA_DISEASE	DATE	0.00	0.00
DTE_END	T_CONTRA_DISEASE	NUMBER	8.00	0.00
DTE_END	T_CONV_FACTOR	DATE	0.00	0.00
DTE_END	T_CONV_FACTOR	NUMBER	8.00	0.00
DTE_END	T_COPAY	DATE	0.00	0.00
DTE_END	T_COPAY	NUMBER	8.00	0.00
DTE_END	T_COUNTY_RATE	NUMBER	8.00	0.00
DTE_END	T_COVERAGE_XREF	DATE	0.00	0.00
DTE_END	T_COVERAGE_XREF	NUMBER	8.00	0.00
DTE_END	T_COVERED_BENEFIT	DATE	0.00	0.00
DTE_END	T_COVERED_BENEFIT	NUMBER	8.00	0.00
DTE_END	T_CSR	NUMBER	8.00	0.00
DTE_END	T_CST_CHG_RATIO	NUMBER	8.00	0.00
DTE_END	T_DESI	DATE	0.00	0.00
DTE_END	T_DESI	NUMBER	8.00	0.00
DTE_END	T_DIAG_COMPAT_GRP	DATE	0.00	0.00
DTE_END	T_DIAG_COMPAT_GRP	NUMBER	8.00	0.00
DTE_END	T_DIAG_DSE_XREF	NUMBER	8.00	0.00
DTE_END	T_DIAG_GROUP	DATE	0.00	0.00
DTE_END	T_DIAG_GROUP	NUMBER	8.00	0.00
DTE_END	T_DIAG_LIMIT	DATE	0.00	0.00
DTE_END	T_DIAG_LIMIT	NUMBER	8.00	0.00
DTE_END	T_DIAG_POS_LIM	DATE	0.00	0.00
DTE_END	T_DIAG_POS_LIM	NUMBER	8.00	0.00
DTE_END	T_DISEASE_INFERRED	DATE	0.00	0.00
DTE_END	T_DISEASE_INFERRED	NUMBER	8.00	0.00
DTE_END	T_DISP_FEE	DATE	0.00	0.00
DTE_END	T_DISP_FEE	NUMBER	8.00	0.00
DTE_END	T_DISP_SHARE	NUMBER	8.00	0.00
DTE_END	T_DRG_CROSSWALK	NUMBER	8.00	0.00

DTE_END	T_DRG_DIAG_XWALK	NUMBER	8.00	0.00
DTE_END	T_DRG_GROUP	DATE	0.00	0.00
DTE_END	T_DRG_GROUP	NUMBER	8.00	0.00
DTE_END	T_DRG_GROUPER	DATE	0.00	0.00
DTE_END	T_DRG_GROUPER	NUMBER	8.00	0.00
DTE_END	T_DRG_ICD9_XWALK	NUMBER	8.00	0.00
DTE_END	T_DRG_INP_LOC	DATE	0.00	0.00
DTE_END	T_DRG_INP_LOC	NUMBER	8.00	0.00
DTE_END	T_DRG_MAPPER	DATE	0.00	0.00
DTE_END	T_DRG_MAPPER	NUMBER	8.00	0.00
DTE_END	T_DRG_NEONATAL	NUMBER	8.00	0.00
DTE_END	T_DRG_RATE	DATE	0.00	0.00
DTE_END	T_DRG_RATE	NUMBER	8.00	0.00
DTE_END	T_DRUG_AAC_PRICE	DATE	0.00	0.00
DTE_END	T_DRUG_AAC_PRICE	NUMBER	8.00	0.00
DTE_END	T_DRUG_ACT_COV	DATE	0.00	0.00
DTE_END	T_DRUG_AWP	DATE	0.00	0.00
DTE_END	T_DRUG_AWP	NUMBER	8.00	0.00
DTE_END	T_DRUG_DISEASE	DATE	0.00	0.00
DTE_END	T_DRUG_EXCEPTION_AL	NUMBER	8.00	0.00
DTE_END	T_DRUG_GER	DATE	0.00	0.00
DTE_END	T_DRUG_GER	NUMBER	8.00	0.00
DTE_END	T_DRUG_GROUP	DATE	0.00	0.00
DTE_END	T_DRUG_GROUP	NUMBER	8.00	0.00
DTE_END	T_DRUG_HCPCS	DATE	0.00	0.00
DTE_END	T_DRUG_HCPCS	NUMBER	8.00	0.00
DTE_END	T_DRUG_INVERSE	DATE	0.00	0.00
DTE_END	T_DRUG_INVERSE	NUMBER	8.00	0.00
DTE_END	T_DRUG_LIMITS	DATE	0.00	0.00
DTE_END	T_DRUG_LIMITS	NUMBER	8.00	0.00

DTE_END	T_DRUG_MAC	DATE	0.00	0.00
DTE_END	T_DRUG_MAC	NUMBER	8.00	0.00
DTE_END	T_DRUG_MAC_PCT	DATE	0.00	0.00
DTE_END	T_DRUG_MAC_PCT	NUMBER	8.00	0.00
DTE_END	T_DRUG_OVER_UTIL	DATE	0.00	0.00
DTE_END	T_DRUG_OVER_UTIL	NUMBER	8.00	0.00
DTE_END	T_DRUG_PED	DATE	0.00	0.00
DTE_END	T_DRUG_PED	NUMBER	8.00	0.00
DTE_END	T_DRUG_PREG	DATE	0.00	0.00
DTE_END	T_DRUG_PREG	NUMBER	8.00	0.00
DTE_END	T_DRUG_PRICE	DATE	0.00	0.00
DTE_END	T_DRUG_REBATE_TEMP	NUMBER	8.00	0.00
DTE_END	T_DRUG_SCREEN	DATE	0.00	0.00
DTE_END	T_DRUG_SCREEN	NUMBER	8.00	0.00
DTE_END	T_DRUG_S_MAC	DATE	0.00	0.00
DTE_END	T_DRUG_S_MAC	NUMBER	8.00	0.00
DTE_END	T_DRUG_THER_DUPE	DATE	0.00	0.00
DTE_END	T_DRUG_THER_DUPE	NUMBER	8.00	0.00
DTE_END	T_DRUG_UNDER_UTIL	DATE	0.00	0.00
DTE_END	T_DRUG_UNDER_UTIL	NUMBER	8.00	0.00
DTE_END	T_DR_INV_TYPE_XREF	DATE	0.00	0.00
DTE_END	T_DR_INV_TYPE_XREF	NUMBER	8.00	0.00
DTE_END	T_DR_JCODE_XWALK	DATE	0.00	0.00
DTE_END	T_DR_JCODE_XWALK	NUMBER	8.00	0.00
DTE_END	T_DR_STATUS	DATE	0.00	0.00
DTE_END	T_DR_STATUS	NUMBER	8.00	0.00
DTE_END	T_DR_STATUS_SUPPLE	NUMBER	8.00	0.00
DTE_END	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_END	T_DS_HM_PROV_FY_XREF	DATE	0.00	0.00
DTE_END	T_DS_RECIP_MFP	DATE	0.00	0.00
DTE_END	T_EAC	DATE	0.00	0.00
DTE_END	T_EAC	NUMBER	8.00	0.00

DTE_END	T_EDIT_PARMS	NUMBER	8.00	0.00
DTE_END	T_EDI_COVERED_PROV_XREF	NUMBER	8.00	0.00
DTE_END	T_EDI_MC_PROV_TP_XREF	NUMBER	8.00	0.00
DTE_END	T_EDI_TP_834_RQST	NUMBER	8.00	0.00
DTE_END	T_EDUCATION_CST	DATE	0.00	0.00
DTE_END	T_EDUCATION_CST	NUMBER	8.00	0.00
DTE_END	T_ENC_ERR_THRESHLD	NUMBER	8.00	0.00
DTE_END	T_EOB_ADJRSN_XREF	DATE	0.00	0.00
DTE_END	T_EOB_REMRKS_XREF	DATE	0.00	0.00
DTE_END	T_ERROR_GROUP	DATE	0.00	0.00
DTE_END	T_ERROR_GROUP	NUMBER	8.00	0.00
DTE_END	T_ERX_ALT_THERAPY	NUMBER	8.00	0.00
DTE_END	T_ERX_RESOURCE_LINK	NUMBER	8.00	0.00
DTE_END	T_ERX_TEXT	NUMBER	8.00	0.00
DTE_END	T_EVS_ELIG	DATE	0.00	0.00
DTE_END	T_EVS_ELIG	NUMBER	8.00	0.00
DTE_END	T_EVS_SVC_COVERAGE	NUMBER	8.00	0.00
DTE_END	T_FEE_SCHEDULE	NUMBER	8.00	0.00
DTE_END	T_FICA_RATE	DATE	0.00	0.00
DTE_END	T_FICA_RATE	NUMBER	8.00	0.00
DTE_END	T_FINANCIAL_PAYER	NUMBER	8.00	0.00
DTE_END	T_FIN_BUDG_GRP	NUMBER	8.00	0.00
DTE_END	T_FIN_CYCLE_BNK_XREF	NUMBER	8.00	0.00
DTE_END	T_FIN_EFT_ACCT	NUMBER	8.00	0.00
DTE_END	T_FIN_MAX_RECOUP	NUMBER	8.00	0.00
DTE_END	T_FIN_PAYER_COB	NUMBER	0.00	0.00
DTE_END	T_FIN_PRUDENT_PAY	NUMBER	8.00	0.00
DTE_END	T_FIN_PYMT_PULL	NUMBER	8.00	0.00
DTE_END	T_FIN_SCHED_HOLD	NUMBER	8.00	0.00
DTE_END	T_FIN_SCHED_OVERRIDE	NUMBER	8.00	0.00
DTE_END	T_FMAP_PCT	DATE	0.00	0.00
DTE_END	T_FMAP_PCT	NUMBER	8.00	0.00
DTE_END	T_FUND_PAYER	NUMBER	8.00	0.00
DTE_END	T_GCN_SEQNO_GROUP	DATE	0.00	0.00

DTE_END	T_GCN_SEQNO_GROUP	NUMBER	8.00	0.00
DTE_END	T_GENERIC_DRUG	DATE	0.00	0.00
DTE_END	T_GENERIC_DRUG	NUMBER	8.00	0.00
DTE_END	T_GEN_RATES	NUMBER	8.00	0.00
DTE_END	T_GERI_DOSE	NUMBER	8.00	0.00
DTE_END	T_GFC_INGREDIENT	DATE	0.00	0.00
DTE_END	T_GFC_INGREDIENT	NUMBER	8.00	0.00
DTE_END	T_GPCI	DATE	0.00	0.00
DTE_END	T_GPCI	NUMBER	8.00	0.00
DTE_END	T_HIC_GROUP	NUMBER	8.00	0.00
DTE_END	T_HIGH_DOSE	DATE	0.00	0.00
DTE_END	T_HIGH_DOSE	NUMBER	8.00	0.00
DTE_END	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_END	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_END	T_HOSPICE_RATE	DATE	0.00	0.00
DTE_END	T_HOSPICE_RATE	NUMBER	8.00	0.00
DTE_END	T_HOSP_ANC_AUTH	NUMBER	8.00	0.00
DTE_END	T_INGREDIENT	DATE	0.00	0.00
DTE_END	T_INGREDIENT	NUMBER	8.00	0.00
DTE_END	T_INGRED_DUPE	DATE	0.00	0.00
DTE_END	T_INGRED_DUPE	NUMBER	8.00	0.00
DTE_END	T_INP_LOC_RATE	DATE	0.00	0.00
DTE_END	T_INP_LOC_RATE	NUMBER	8.00	0.00
DTE_END	T_IRS_W9_INFO	DATE	0.00	0.00
DTE_END	T_IRS_W9_INFO	NUMBER	8.00	0.00
DTE_END	T_LAB_FEE	DATE	0.00	0.00
DTE_END	T_LAB_FEE	NUMBER	8.00	0.00
DTE_END	T_LIMIT_PARM	NUMBER	8.00	0.00
DTE_END	T_LOW_DOSE	DATE	0.00	0.00
DTE_END	T_LOW_DOSE	NUMBER	8.00	0.00
DTE_END	T_LS_DRUG_AWP_PRICING	DATE	0.00	0.00
DTE_END	T_LS_DRUG_MAC_PRICING	DATE	0.00	0.00
DTE_END	T_LTC_LEAVE_RATE	NUMBER	8.00	0.00
DTE_END	T_MARG_COST	DATE	0.00	0.00
DTE_END	T_MARG_COST	NUMBER	8.00	0.00
DTE_END	T_MAX_FEE	DATE	0.00	0.00
DTE_END	T_MAX_FEE	NUMBER	8.00	0.00
DTE_END	T_MB_PARMS	DATE	0.00	0.00
DTE_END	T_MCARE_DEDUCTIBLE	NUMBER	8.00	0.00

DTE_END	T_MC_AID_GRP	DATE	0.00	0.00
DTE_END	T_MC_AID_GRP	NUMBER	8.00	0.00
DTE_END	T_MC_AID_GRP_XREF	DATE	0.00	0.00
DTE_END	T_MC_AID_GRP_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_AREA_RGN_XREF	DATE	0.00	0.00
DTE_END	T_MC_AREA_RGN_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_AREA_RGN_XREF_WI	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_AMTS	DATE	0.00	0.00
DTE_END	T_MC_CAP_AMTS	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_AMTS_PMP	DATE	0.00	0.00
DTE_END	T_MC_CAP_AMTS_PMP	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_AMTS_RANGE	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_CMF_RATES	DATE	0.00	0.00
DTE_END	T_MC_CAP_CMF_RATES	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_DEMOGRAPH	DATE	0.00	0.00
DTE_END	T_MC_CAP_DEMOGRAPH	NUMBER	8.00	0.00
DTE_END	T_MC_CAP_DEMOGRAPH_KY	NUMBER	8.00	0.00
DTE_END	T_MC_CDE_AID_ENROLL	NUMBER	8.00	0.00
DTE_END	T_MC_CENSUS	NUMBER	8.00	0.00
DTE_END	T_MC_CENSUS_LOC	NUMBER	8.00	0.00
DTE_END	T_MC_DIAG_RATE	DATE	0.00	0.00
DTE_END	T_MC_DIAG_RATE	NUMBER	8.00	0.00
DTE_END	T_MC_FTE	DATE	0.00	0.00
DTE_END	T_MC_FTE	NUMBER	8.00	0.00
DTE_END	T_MC_PGM_LIV_XREF	DATE	0.00	0.00
DTE_END	T_MC_PGM_LIV_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_PGM_RGN_XREF	DATE	0.00	0.00
DTE_END	T_MC_PGM_RGN_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_PGM_STATUS_GRP	NUMBER	8.00	0.00
DTE_END	T_MC_PGM_STATUS_GRP_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_PLAN_COUNTY	DATE	0.00	0.00
DTE_END	T_MC_PLAN_COUNTY	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_EDB_XREF	DATE	0.00	0.00
DTE_END	T_MC_PMP_EDB_XREF	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_ENRL_RGN	DATE	0.00	0.00

DTE_END	T_MC_PMP_ENRL_RGN	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_ENRL_RGN_AL	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_GRP	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_PANEL_RESTRICT	DATE	0.00	0.00
DTE_END	T_MC_PMP_PANEL_RESTRICT	NUMBER	8.00	0.00
DTE_END	T_MC_PMP_SC	DATE	0.00	0.00
DTE_END	T_MC_PMP_SC	NUMBER	8.00	0.00
DTE_END	T_MC_RATE_CELL	DATE	0.00	0.00
DTE_END	T_MC_RATE_CELL	NUMBER	8.00	0.00
DTE_END	T_MC_RE_PMP_LKOUT	NUMBER	8.00	0.00
DTE_END	T_MC_RE_SPEC_COND	DATE	0.00	0.00
DTE_END	T_MC_RE_SPEC_COND	NUMBER	8.00	0.00
DTE_END	T_MC_SPEC_COND_EXCL	NUMBER	8.00	0.00
DTE_END	T_MODIFIER	DATE	0.00	0.00
DTE_END	T_MODIFIER	NUMBER	8.00	0.00
DTE_END	T_MODIFIER_RSTN	DATE	0.00	0.00
DTE_END	T_MODIFIER_RSTN	NUMBER	8.00	0.00
DTE_END	T_MOD_GROUP	NUMBER	8.00	0.00
DTE_END	T_MR_ELIG	DATE	0.00	0.00
DTE_END	T_MR_PR_ENROL	DATE	0.00	0.00
DTE_END	T_MR_WVR_PROC	NUMBER	8.00	0.00
DTE_END	T_MR_WVR_SVC	NUMBER	8.00	0.00
DTE_END	T_MULT_SURG_PCT	DATE	0.00	0.00
DTE_END	T_MULT_SURG_PCT	NUMBER	8.00	0.00
DTE_END	T_NDDF_PRICE	DATE	0.00	0.00
DTE_END	T_NDDF_PRICE	NUMBER	8.00	0.00
DTE_END	T_NONPROV_TAX_ID	DATE	0.00	0.00
DTE_END	T_NONPROV_TAX_ID	NUMBER	8.00	0.00
DTE_END	T_OUTLIER_THRESHLD	DATE	0.00	0.00
DTE_END	T_OUTLIER_THRESHLD	NUMBER	8.00	0.00
DTE_END	T_OVERHEAD_FEE	DATE	0.00	0.00
DTE_END	T_OVERHEAD_FEE	NUMBER	8.00	0.00
DTE_END	T_PATIENT_STAT	NUMBER	8.00	0.00

DTE_END	T_PAYABLE_BENEFIT	NUMBER	8.00	0.00
DTE_END	T_PAYER_HIERARCHY	NUMBER	8.00	0.00
DTE_END	T_PA_ASSIGN_CODE	DATE	0.00	0.00
DTE_END	T_PA_ASSIGN_CODE	NUMBER	8.00	0.00
DTE_END	T_PDL_MASTER	DATE	0.00	0.00
DTE_END	T_PDL_MASTER_AL	NUMBER	8.00	0.00
DTE_END	T_PDUR_ADD_TOX	NUMBER	8.00	0.00
DTE_END	T_PDUR_ADD_TOX_FAC	NUMBER	8.00	0.00
DTE_END	T_PDUR_PREG_DIAG	NUMBER	8.00	0.00
DTE_END	T_PEDI_DOSE	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_CAPT	DATE	0.00	0.00
DTE_END	T_PEER_GRP_CAPT	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_DRGR	DATE	0.00	0.00
DTE_END	T_PEER_GRP_DRGR	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_DRGR_OLD	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_EDUC	DATE	0.00	0.00
DTE_END	T_PEER_GRP_EDUC	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_FACT	DATE	0.00	0.00
DTE_END	T_PEER_GRP_FACT	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_INP_LOC	DATE	0.00	0.00
DTE_END	T_PEER_GRP_INP_LOC	NUMBER	8.00	0.00
DTE_END	T_PEER_GRP_RTIO	DATE	0.00	0.00
DTE_END	T_PEER_GRP_RTIO	NUMBER	8.00	0.00
DTE_END	T_PERF_ANALYST	NUMBER	8.00	0.00
DTE_END	T_PERF_CRIT	NUMBER	8.00	0.00
DTE_END	T_PGM_CT_XREF	DATE	0.00	0.00
DTE_END	T_PGM_CT_XREF	NUMBER	8.00	0.00
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DTE_END	T_PHS_DATES	DATE	0.00	0.00
DTE_END	T_PHS_DATES	NUMBER	8.00	0.00
DTE_END	T_PLOG_ESTIMATE	NUMBER	8.00	0.00
DTE_END	T_PMP_AUTOASSGN	DATE	0.00	0.00
DTE_END	T_PMP_AUTOASSGN	NUMBER	8.00	0.00
DTE_END	T_PMP_PANEL_SIZE	DATE	0.00	0.00
DTE_END	T_PMP_PANEL_SIZE	NUMBER	8.00	0.00
DTE_END	T_PMP_SVC_LOC	NUMBER	8.00	0.00
DTE_END	T_PMP_SVC_LOC	NUMBER	8.00	0.00
DTE_END	T_PMP_SVC_LOC_KY	NUMBER	8.00	0.00
DTE_END	T_PMP_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_END	T_PREVAILING	DATE	0.00	0.00
DTE_END	T_PREVAILING	NUMBER	8.00	0.00
DTE_END	T_PREVAILING_CONV	DATE	0.00	0.00
DTE_END	T_PREVAILING_CONV	NUMBER	8.00	0.00
DTE_END	T_PROCESS_MOD	DATE	0.00	0.00
DTE_END	T_PROCESS_MOD	NUMBER	8.00	0.00
DTE_END	T_PROC_ASC	DATE	0.00	0.00
DTE_END	T_PROC_ASC	NUMBER	8.00	0.00
DTE_END	T_PROC_CONV_FACTOR	DATE	0.00	0.00
DTE_END	T_PROC_CONV_FACTOR	NUMBER	8.00	0.00
DTE_END	T_PROC_DIAG_LIM	DATE	0.00	0.00
DTE_END	T_PROC_DIAG_LIM	NUMBER	8.00	0.00
DTE_END	T_PROC_GROUP	DATE	0.00	0.00
DTE_END	T_PROC_GROUP	NUMBER	8.00	0.00
DTE_END	T_PROC_GSN_XREF	DATE	0.00	0.00

DTE_END	T_PROC_GSN_XREF	NUMBER	8.00	0.00
DTE_END	T_PROC_ICD9_DIA	DATE	0.00	0.00
DTE_END	T_PROC_ICD9_DIA	NUMBER	8.00	0.00
DTE_END	T_PROC_ICD9_GROUP	DATE	0.00	0.00
DTE_END	T_PROC_ICD9_GROUP	NUMBER	8.00	0.00
DTE_END	T_PROC_ICD9_LIM	DATE	0.00	0.00
DTE_END	T_PROC_ICD9_LIM	NUMBER	8.00	0.00
DTE_END	T_PROC_LIMITS	DATE	0.00	0.00
DTE_END	T_PROC_LIMITS	NUMBER	8.00	0.00
DTE_END	T_PROC_MCO_LIM	DATE	0.00	0.00
DTE_END	T_PROC_MCO_LIM	NUMBER	8.00	0.00
DTE_END	T_PROC_MODIFIER	DATE	0.00	0.00
DTE_END	T_PROC_MODIFIER	NUMBER	8.00	0.00
DTE_END	T_PROC_SPEC_LIM	DATE	0.00	0.00
DTE_END	T_PROC_SPEC_LIM	NUMBER	8.00	0.00
DTE_END	T_PROC_TOOTH	DATE	0.00	0.00
DTE_END	T_PROC_TOOTH	NUMBER	8.00	0.00
DTE_END	T_PROC_TOOTH_QUAD	DATE	0.00	0.00
DTE_END	T_PROC_TOOTH_QUAD	NUMBER	8.00	0.00
DTE_END	T_PR_ACCT_REC_MAX	NUMBER	8.00	0.00
DTE_END	T_PR_ANNUAL_VISIT_CRIT	DATE	0.00	0.00
DTE_END	T_PR_ANNUAL_VISIT_CRIT	NUMBER	8.00	0.00
DTE_END	T_PR_APPLN_STATUS_RSN	NUMBER	8.00	0.00
DTE_END	T_PR_BEDS_KY	NUMBER	8.00	0.00
DTE_END	T_PR_BILLER	NUMBER	8.00	0.00
DTE_END	T_PR_BOARD	DATE	0.00	0.00
DTE_END	T_PR_BOARD	NUMBER	8.00	0.00
DTE_END	T_PR_BOARD_MEM	NUMBER	8.00	0.00
DTE_END	T_PR_CAPT_CST	NUMBER	8.00	0.00
DTE_END	T_PR_CHOW_GRP_MBR	NUMBER	8.00	0.00

DTE_END	T_PR_CHOW_XREF	DATE	0.00	0.00
DTE_END	T_PR_CHOW_XREF	NUMBER	8.00	0.00
DTE_END	T_PR_CLIA_STAT	NUMBER	8.00	0.00
DTE_END	T_PR_COVERED_PGM	DATE	0.00	0.00
DTE_END	T_PR_COVERED_PGM	NUMBER	8.00	0.00
DTE_END	T_PR_CST_CHRG	NUMBER	8.00	0.00
DTE_END	T_PR_DEA	NUMBER	8.00	0.00
DTE_END	T_PR_DISP_FEE	NUMBER	8.00	0.00
DTE_END	T_PR_DRG_RATE	DATE	0.00	0.00
DTE_END	T_PR_DRG_RATE	NUMBER	8.00	0.00
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DTE_END	T_PR_EDIT_EXEMPT	NUMBER	8.00	0.00
DTE_END	T_PR_EFT_ACCT	NUMBER	8.00	0.00
DTE_END	T_PR_ENRL_SPECIALTY	NUMBER	8.00	0.00
DTE_END	T_PR_ENRL_TAX_ID	NUMBER	8.00	0.00
DTE_END	T_PR_ENROLL_PGM	DATE	0.00	0.00
DTE_END	T_PR_ENROLL_PGM	NUMBER	8.00	0.00
DTE_END	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_END	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_END	T_PR_FACILITY	NUMBER	8.00	0.00
DTE_END	T_PR_GRP_MBR	NUMBER	8.00	0.00
DTE_END	T_PR_GRP_MBR	NUMBER	8.00	0.00
DTE_END	T_PR_HB_LIC	DATE	0.00	0.00
DTE_END	T_PR_HB_LIC	NUMBER	8.00	0.00
DTE_END	T_PR_HB_LIC_KY	NUMBER	8.00	0.00
DTE_END	T_PR_INST_RATE_WI	NUMBER	8.00	0.00
DTE_END	T_PR_LICENSE_KY	NUMBER	8.00	0.00
DTE_END	T_PR_LOC_RATE	NUMBER	8.00	0.00
DTE_END	T_PR_LOC_RATE_REQ	NUMBER	8.00	0.00
DTE_END	T_PR_LOC_RATE_WI	NUMBER	8.00	0.00
DTE_END	T_PR_MARG_CST	NUMBER	8.00	0.00
DTE_END	T_PR_MCARE_BILL	NUMBER	8.00	0.00
DTE_END	T_PR_MDED_CST	NUMBER	8.00	0.00
DTE_END	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_END	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_END	T_PR_OUT_OF_STATE	NUMBER	8.00	0.00

DTE_END	T_PR_OUT_RATE_AL	NUMBER	8.00	0.00
DTE_END	T_PR_OWNER	NUMBER	8.00	0.00
DTE_END	T_PR_PAY_PULL	NUMBER	8.00	0.00
DTE_END	T_PR_PCP	DATE	0.00	0.00
DTE_END	T_PR_PCP	NUMBER	8.00	0.00
DTE_END	T_PR_PEER_GROUP	NUMBER	8.00	0.00
DTE_END	T_PR_PEER_LEVEL	NUMBER	8.00	0.00
DTE_END	T_PR_PGM_CT_XREF	DATE	0.00	0.00
DTE_END	T_PR_PGM_CT_XREF	NUMBER	8.00	0.00
DTE_END	T_PR_PHONE_TRACK	NUMBER	8.00	0.00
DTE_END	T_PR_PHP_ELIG	NUMBER	8.00	0.00
DTE_END	T_PR_PHYS_ASST	NUMBER	8.00	0.00
DTE_END	T_PR_PHYS_SUPV	DATE	0.00	0.00
DTE_END	T_PR_PHYS_SUPV	NUMBER	8.00	0.00
DTE_END	T_PR_PSYCH_FACI	NUMBER	8.00	0.00
DTE_END	T_PR_RATE_KY	NUMBER	8.00	0.00
DTE_END	T_PR_RECP_LOC_X	DATE	0.00	0.00
DTE_END	T_PR_RECP_LOC_X	NUMBER	8.00	0.00
DTE_END	T_PR_REVIEW	DATE	0.00	0.00
DTE_END	T_PR_REVIEW	NUMBER	8.00	0.00
DTE_END	T_PR_RISK_GRP_XREF	NUMBER	8.00	0.00
DTE_END	T_PR_RST_SVC	NUMBER	8.00	0.00
DTE_END	T_PR_SPEC	NUMBER	8.00	0.00
DTE_END	T_PR_STATE_SHARE	NUMBER	8.00	0.00
DTE_END	T_PR_SURS_SPEC	NUMBER	8.00	0.00
DTE_END	T_PR_SVC_CERT	NUMBER	8.00	0.00
DTE_END	T_PR_SVC_CERT_WI	NUMBER	8.00	0.00
DTE_END	T_PR_SVC_LANG	NUMBER	8.00	0.00
DTE_END	T_PR_TAXONOMY	DATE	0.00	0.00
DTE_END	T_PR_TAXONOMY	NUMBER	8.00	0.00
DTE_END	T_PR_TAX_ID	NUMBER	8.00	0.00
DTE_END	T_PR_UB_LOC_RATE	NUMBER	8.00	0.00
DTE_END	T_PUB_HLTH_PGM	DATE	0.00	0.00
DTE_END	T_PUB_HLTH_PGM	NUMBER	8.00	0.00

DTE_END	T_RBRVS	DATE	0.00	0.00
DTE_END	T_RBRVS	NUMBER	8.00	0.00
DTE_END	T_RBRVS_PR_SPEC	DATE	0.00	0.00
DTE_END	T_RBRVS_PR_SPEC	NUMBER	8.00	0.00
DTE_END	T_REBATE	NUMBER	8.00	0.00
DTE_END	T_RECIP_REVIEW	DATE	0.00	0.00
DTE_END	T_RECIP_REVIEW	NUMBER	8.00	0.00
DTE_END	T_REF_CCI	DATE	0.00	0.00
DTE_END	T_REF_CCI	NUMBER	8.00	0.00
DTE_END	T_REF_CCI_MUE	DATE	0.00	0.00
DTE_END	T_REF_CCI_MUE	NUMBER	8.00	0.00
DTE_END	T_REF_CCI_MUE_OVERRIDE	DATE	0.00	0.00
DTE_END	T_REF_CCI_MUE_OVERRIDE	NUMBER	8.00	0.00
DTE_END	T_REF_CCI_OVERRIDE	DATE	0.00	0.00
DTE_END	T_REF_CCI_OVERRIDE	NUMBER	8.00	0.00
DTE_END	T_REF_CDE_AID_GROUP	NUMBER	8.00	0.00
DTE_END	T_REF_CDE_VALUE_GROUP	DATE	0.00	0.00
DTE_END	T_REF_CDE_VALUE_GROUP	NUMBER	8.00	0.00
DTE_END	T_REF_CLIA_LC_PROC	NUMBER	8.00	0.00
DTE_END	T_REF_DISTRICT_PLAN	NUMBER	8.00	0.00
DTE_END	T_REF_ID_PROV_GROUP	NUMBER	8.00	0.00
DTE_END	T_REF_UCC	NUMBER	8.00	0.00
DTE_END	T_REIMB_AGREEMENT	NUMBER	8.00	0.00
DTE_END	T_REIMB_RATE	NUMBER	8.00	0.00
DTE_END	T_REVENUE_CODE	DATE	0.00	0.00
DTE_END	T_REVENUE_CODE	NUMBER	8.00	0.00
DTE_END	T_REVENUE_FLAT_FEE	DATE	0.00	0.00
DTE_END	T_REVENUE_FLAT_FEE	NUMBER	8.00	0.00
DTE_END	T_REV_GROUP	DATE	0.00	0.00
DTE_END	T_REV_GROUP	NUMBER	8.00	0.00

DTE_END	T_REV_HOSPICE_XWALK	NUMBER	8.00	0.00
DTE_END	T_REV_PROC_XREF	DATE	0.00	0.00
DTE_END	T_REV_PROC_XREF	NUMBER	8.00	0.00
DTE_END	T_REV_SPEC_RSTN	DATE	0.00	0.00
DTE_END	T_REV_SPEC_RSTN	NUMBER	8.00	0.00
DTE_END	T_RE_AID_ELIG	DATE	0.00	0.00
DTE_END	T_RE_AID_ELIG	NUMBER	8.00	0.00
DTE_END	T_RE_AID_ELIG_DN	DATE	0.00	0.00
DTE_END	T_RE_ASSIGN_PLAN	DATE	0.00	0.00
DTE_END	T_RE_ASSIGN_PLAN	NUMBER	8.00	0.00
DTE_END	T_RE_ASSIGN_PLAN_LI	DATE	0.00	0.00
DTE_END	T_RE_ASSIGN_PLAN_RLOC	DATE	0.00	0.00
DTE_END	T_RE_CCHIC_TRACK	NUMBER	8.00	0.00
DTE_END	T_RE_CLM_DELINK	DATE	0.00	0.00
DTE_END	T_RE_CMS_MMA_ENROLL	DATE	0.00	0.00
DTE_END	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
DTE_END	T_RE_CUST_STATUS	DATE	0.00	0.00
DTE_END	T_RE_CUST_STATUS	NUMBER	8.00	0.00
DTE_END	T_RE_EDB_GHO	DATE	0.00	0.00
DTE_END	T_RE_EDB_GHO	NUMBER	8.00	0.00
DTE_END	T_RE_EDB_HOSPICE	DATE	0.00	0.00
DTE_END	T_RE_EDB_HOSPICE	NUMBER	8.00	0.00
DTE_END	T_RE_ELIG	DATE	0.00	0.00
DTE_END	T_RE_ELIG	NUMBER	8.00	0.00
DTE_END	T_RE_ELIG_DN	DATE	0.00	0.00
DTE_END	T_RE_HOH	DATE	0.00	0.00
DTE_END	T_RE_HOH	NUMBER	8.00	0.00
DTE_END	T_RE_INCOME	NUMBER	8.00	0.00
DTE_END	T_RE_LOC	DATE	0.00	0.00
DTE_END	T_RE_LOCKIN_INFO	DATE	0.00	0.00
DTE_END	T_RE_LOCKIN_PERIOD	DATE	0.00	0.00

DTE_END	T_RE_LTC_REQUEST	DATE	0.00	0.00
DTE_END	T_RE_MEDICARE_A	DATE	0.00	0.00
DTE_END	T_RE_MEDICARE_A	NUMBER	8.00	0.00
DTE_END	T_RE_MEDICARE_B	DATE	0.00	0.00
DTE_END	T_RE_MEDICARE_B	NUMBER	8.00	0.00
DTE_END	T_RE_MEDICARE_D	DATE	0.00	0.00
DTE_END	T_RE_MEDICARE_D	NUMBER	8.00	0.00
DTE_END	T_RE_OLD_PCN	DATE	0.00	0.00
DTE_END	T_RE_OLD_PCN	NUMBER	8.00	0.00
DTE_END	T_RE_PARTD_PDP_ASSIGN	DATE	0.00	0.00
DTE_END	T_RE_PARTD_PDP_ASSIGN	NUMBER	8.00	0.00
DTE_END	T_RE_PARTD_PDP_PLAN	DATE	0.00	0.00
DTE_END	T_RE_PARTD_PDP_PLAN	NUMBER	8.00	0.00
DTE_END	T_RE_PAT_LIAB	DATE	0.00	0.00
DTE_END	T_RE_PAT_LIAB	NUMBER	8.00	0.00
DTE_END	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_END	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_END	T_RE_RETRO_ELIG	DATE	0.00	0.00
DTE_END	T_RE_SPEND_LIAB	DATE	0.00	0.00
DTE_END	T_RE_SPEND_LIAB	NUMBER	8.00	0.00
DTE_END	T_SITE_OF_DIFF	DATE	0.00	0.00
DTE_END	T_SITE_OF_DIFF	NUMBER	8.00	0.00
DTE_END	T_SPEC_MOD	DATE	0.00	0.00
DTE_END	T_SPEC_MOD	NUMBER	8.00	0.00
DTE_END	T_STATE_ADDR	NUMBER	8.00	0.00
DTE_END	T_STATE_DESI	DATE	0.00	0.00
DTE_END	T_STATE_DESI	NUMBER	8.00	0.00
DTE_END	T_STOP_LOSS_PARMS	DATE	0.00	0.00
DTE_END	T_STOP_LOSS_PARMS	NUMBER	8.00	0.00
DTE_END	T_SW_RTI_LOG	DATE	0.00	0.00
DTE_END	T_SYSTEM_PARMS	NUMBER	8.00	0.00
DTE_END	T_TAXONOMY_GROUP	NUMBER	8.00	0.00
DTE_END	T_THERAPEUTIC_GROUP	NUMBER	8.00	0.00

DTE_END	T_THERA_DURATION	DATE	0.00	0.00
DTE_END	T_THERA_DURATION	NUMBER	8.00	0.00
DTE_END	T_TOB_GROUP	DATE	0.00	0.00
DTE_END	T_TOB_GROUP	NUMBER	8.00	0.00
DTE_END	T_TPL_CARRIER	DATE	0.00	0.00
DTE_END	T_TPL_CARRIER	NUMBER	8.00	0.00
DTE_END	T_TPL_CARRIER_AL	NUMBER	8.00	0.00
DTE_END	T_TPL_CAR_SUB_XREF	NUMBER	8.00	0.00
DTE_END	T_TPL_CONT_FEE	DATE	0.00	0.00
DTE_END	T_TPL_CONT_FEE	NUMBER	8.00	0.00
DTE_END	T_TPL_COV_PLAN_XREF	NUMBER	8.00	0.00
DTE_END	T_TPL_EXEMPT	NUMBER	8.00	0.00
DTE_END	T_TPL_RESTRICTION	NUMBER	8.00	0.00
DTE_END	T_TPL_RES_DEL	NUMBER	8.00	0.00
DTE_END	T_TPL_TAX_ID	NUMBER	8.00	0.00
DTE_END	T_TP_SPC_MOD_EXCL	NUMBER	8.00	0.00
DTE_END	T_TYPE_SPEC_GROUP	NUMBER	8.00	0.00
DTE_END	T_VFC_ADMIN_FEE	NUMBER	8.00	0.00
DTE_END	T_WEB_PROV_ENR	DATE	0.00	0.00
DTE_END	T_WEB_PROV_SPEC	DATE	0.00	0.00
DTE_END	T_XOVER_RATE	NUMBER	8.00	0.00
DTE_END_ACC	T_PR_BOND	DATE	0.00	0.00
DTE_END_ACC	T_PR_BOND	NUMBER	8.00	0.00
DTE_END_ACC	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_END_APP_REF_DU	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_END_CONDITION	T_MPHX_DSE_PROF	NUMBER	8.00	0.00
DTE_END_DISEASE	T_MPHX_DSE_PROF	NUMBER	8.00	0.00
DTE_END_E1	T_MB_PARMS	DATE	0.00	0.00
DTE_END_E2	T_MB_PARMS	DATE	0.00	0.00
DTE_END_E3	T_MB_PARMS	DATE	0.00	0.00
DTE_END_ENROLL	T_TPL_EMPLOYER	DATE	0.00	0.00
DTE_END_ENROLL	T_TPL_EMPLOYER	NUMBER	8.00	0.00
DTE_END_LIC	T_PR_DEA_LIC	NUMBER	8.00	0.00
DTE_END_LIC	T_PR_ENRL_IDENTIFIER	NUMBER	8.00	0.00
DTE_END_MCAID	T_PR_BOND	DATE	0.00	0.00

DTE_END_MCAID	T_PR_BOND	NUMBER	8.00	0.00
DTE_END_MCAID	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_END_MCARE	T_PR_BOND	DATE	0.00	0.00
DTE_END_MCARE	T_PR_BOND	NUMBER	8.00	0.00
DTE_END_MCARE	T_PR_ENRL_DME	NUMBER	8.00	0.00
DTE_END_OFFLINE_CLM	T_CASUALTY_CASE_OFFLINE	NUMBER	8.00	0.00
DTE_END_PAPER_RA	T_FIN_PROCESS_PROV_ID	NUMBER	8.00	0.00
DTE_END_PAPER_RA	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_END_PAPER_RA	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_END_PAPER_RA	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_END_PDF_RA	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_END_PDF_RA	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_END_PDF_RA	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_END_PLAN	T_EMP_CARR_XREF	DATE	0.00	0.00
DTE_END_PLAN	T_EMP_CARR_XREF	NUMBER	8.00	0.00
DTE_END_REQ_RECON1	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_END_RESP_MAC	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_END_RESP_RECN1	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_END_RESP_RECN2	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_END_Y1	T_MB_PARMS	DATE	0.00	0.00
DTE_END_Y2	T_MB_PARMS	DATE	0.00	0.00
DTE_END_Y3	T_MB_PARMS	DATE	0.00	0.00
DTE_END_Y4	T_MB_PARMS	DATE	0.00	0.00
DTE_ENROLL	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_ENROLL	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_ENROLL_EFF	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	8.00	0.00
DTE_ENROLL_END	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	8.00	0.00
DTE_ENTERED	T_CSR	NUMBER	8.00	0.00
DTE_ENTERED	T_DR_DISPUTE_DTL	DATE	0.00	0.00
DTE_ENTERED	T_DR_DISPUTE_DTL	NUMBER	8.00	0.00
DTE_ENTERED	T_DR_RECOUP_LTR_DATES	NUMBER	8.00	0.00

DTE_ENTERED	T_DR_RECOUP_LTR_ICN	NUMBER	8.00	0.00
DTE_ENTERED	T_DS_LVX_USER_REQ	DATE	0.00	0.00
DTE_ENTERED_INST	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_ENTITL_CHG	T_RE_EDB	DATE	0.00	0.00
DTE_ENTRY	T_CT_REFERRALS	DATE	0.00	0.00
DTE_ENTRY	T_PLOG_HEADER	NUMBER	8.00	0.00
DTE_ENTRY	T_PROJ_TRK_DTL	NUMBER	8.00	0.00
DTE_EOMB_LETTER	T_CT_EOMB	DATE	0.00	0.00
DTE_EOMB_REF_RECVD	T_CT_EOMB	DATE	0.00	0.00
DTE_EPSDT_APPL	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_ERA_REQUEST	T_WEB_RECEIVER	NUMBER	8.00	0.00
DTE_ERA_REQUEST	T_WEB_RECEIVER_BACKUP	NUMBER	8.00	0.00
DTE_ERA_REQUEST_AFT	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_ERA_REQUEST_BEF	T_PR_WEB_CHG_BACKUP	NUMBER	8.00	0.00
DTE_ERROR	T_CA_ERROR	DATE	0.00	0.00
DTE_ERROR_1	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERROR_2	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERROR_3	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERROR_4	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERROR_5	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERROR_6	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_ERR_GRP_EFF	T_ERR_RESO_GRP_XREF	NUMBER	8.00	0.00
DTE_ERR_GRP_END	T_ERR_RESO_GRP_XREF	NUMBER	8.00	0.00
DTE_ERR_RESO_STATUS	T_ERR_RESO_STATUS	DATE	0.00	0.00
DTE_ESC_ADD	T_PA_ESC	DATE	0.00	0.00
DTE_ESC_ADD	T_PA_ESC	NUMBER	8.00	0.00
DTE_ESRD_CVRG_END	T_RE_EDB	DATE	0.00	0.00
DTE_ESRD_CVRG_START	T_RE_EDB	DATE	0.00	0.00
DTE_ESRD_DLYS_END	T_RE_EDB	DATE	0.00	0.00
DTE_ESRD_DLYS_START	T_RE_EDB	DATE	0.00	0.00
DTE_ESRD_TRNS_END	T_RE_EDB	DATE	0.00	0.00
DTE_ESRD_TRNS_START	T_RE_EDB	DATE	0.00	0.00
DTE_EST_MOD	T_CSR	NUMBER	8.00	0.00
DTE_EST_PROD	T_CSR	NUMBER	8.00	0.00
DTE_ETHNICITY_DECLARE_EFF	T_TMSIS_ELG015_ETHNICITY	NUMBER	8.00	0.00
DTE_ETHNICITY_DECLARE_END	T_TMSIS_ELG015_ETHNICITY	NUMBER	8.00	0.00
DTE_EVENT	T_LG_HISTORY	NUMBER	14.00	0.00
DTE_EXCEPTION	T_TRACK_EXCEPTION_HANDLE	DATE	0.00	0.00

DTE_EXTRACT	T_PBM_PHARM_EXTRACT	NUMBER	8.00	0.00
DTE_FAX_EMAIL_EFFECTIVE	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_FAX_EMAIL_END	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_FCBC_VERIFICATION	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_FCBC_VERIFICATION	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_FCBC_VISIT	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_FCBC_VISIT	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_FDA_APPR	T_DR_CMS_TAPE	DATE	0.00	0.00
DTE_FDA_APPR	T_DR_CMS_TAPE	NUMBER	8.00	0.00
DTE_FDB_HCFA_APPC	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_FDB_HCFA_APPC	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_FDB_HCFA_MRKC	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_FDB_HCFA_MRKC	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_FDB_LAST_UPDATED	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_FDB_LAST_UPDATED	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_FDB_TERM_HCFA	T_DRUG_CMSFDB_INFO	DATE	0.00	0.00
DTE_FDB_TERM_HCFA	T_DRUG_CMSFDB_INFO	NUMBER	8.00	0.00
DTE_FED_RPT	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_FED_RPT	T_AR_SUPP_DTL	NUMBER	8.00	0.00
DTE_FFY	T_CA_TIME_KEY	NUMBER	4.00	0.00
DTE_FILE_CREATED	T_TMSIS_EXT_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_CLM_PGM_XREF	NUMBER	8.00	0.00
DTE_FINAL	T_DENY_DNTL_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_DENY_PHRM_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_DENY_PHYS_HDR	NUMBER	8.00	0.00

DTE_FINAL	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_DR_RECOUP_LTR_ICN	NUMBER	8.00	0.00
DTE_FINAL	T_PD_DNTL_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_PD_PHARM_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_FINAL	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_FINALIZED	T_PDUR_FINAL_CLM	NUMBER	8.00	0.00
DTE_FINALIZED	T_PR_APPLN	DATE	0.00	0.00
DTE_FINALIZED	T_PR_APPLN	NUMBER	8.00	0.00
DTE_FINALIZED	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_FINAL_APR	T_PS_ICF_MR	NUMBER	8.00	0.00
DTE_FINAL_DTRMN	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_FINAL_DTRMN	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_ADJ_MASS_CLAIM	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_DENY_DNTL_HDR	NUMBER	8.00	0.00

DTE_FINAL_LAST_PAYER	T_DENY_PHRM_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_HIST_DIRECTORY	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_PD_DNTL_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_PD_PHARM_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_FINAL_LAST_PAYER	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_FINISH	T_DS_LVX_MSG_LOG	DATE	0.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY	DATE	0.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY	DATE	0.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY	NUMBER	8.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY_AL	NUMBER	8.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY_WI	NUMBER	8.00	0.00
DTE_FIN_PAID	T_CAP_SUMMARY_tmp	NUMBER	8.00	0.00

DTE_FIRST_ANCHOR	T_ETG_SUMMARY	DATE	0.00	0.00
DTE_FIRST_ANCHOR	T_ETG_SUMMARY_ENCNTR	DATE	0.00	0.00
DTE_FIRST_ANCHOR	T_ETG_SUMMARY_FFS	DATE	0.00	0.00
DTE_FIRST_ANCHOR	T_ETG_SUMMARY_RCO_PAID	DATE	0.00	0.00
DTE_FIRST_PRENATAL_VISIT	T_CA_PHYS	DATE	0.00	0.00
DTE_FIRST_REBILL	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_FIRST_REBILL	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_ADJ_MASS_CLAIM	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CA_FIN	DATE	0.00	0.00
DTE_FIRST_SVC	T_CA_HDR_DTL	DATE	0.00	0.00
DTE_FIRST_SVC	T_CA_KICK_PYMT	DATE	0.00	0.00
DTE_FIRST_SVC	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_FIRST_SVC	T_CC_HIST_ADJUST	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CLM_KICK_PYMT	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CLM_MAT_CARE_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CLM_MAT_CARE_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CLM_PATLIAB_X	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CLM_SAMPLE	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CPAS_EXTRACT	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_CPAS_SPLIT	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_DNTL_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_DNTL_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_PHYS_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_UB92_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_DS_DNTL_ICN	DATE	0.00	0.00
DTE_FIRST_SVC	T_DS_HM_DETAIL	DATE	0.00	0.00
DTE_FIRST_SVC	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_FIRST_SVC	T_HIST_DIRECTORY	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_MB_DEN_ICN	DATE	0.00	0.00
DTE_FIRST_SVC	T_MB_NUM_ICN	DATE	0.00	0.00

DTE_FIRST_SVC	T_MEDPOL_UB92	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_MPHX_DENTAL_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_MPHX_PHYS_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_DNTL_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_DNTL_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_PHYS_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_UB92_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PR_CONTRACT_RATE_KY	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_PUB_HLTH_AID	DATE	0.00	0.00
DTE_FIRST_SVC	T_PUB_HLTH_AID	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_RETRO_SUMM_RECS	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_RE_EPS_ABNORMAL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_RE_EPS_HIST_EXT	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_RE_PTOT_OVERBILL	DATE	0.00	0.00
DTE_FIRST_SVC	T_SUSP_DENTAL_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_SUSP_DENTAL_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_SUSP_PHYS_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_SUSP_UB92_DTL	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_SUSP_UB92_HDR	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_FIRST_SVC	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_TPL_AR_HEALTH_XXX	NUMBER	8.00	0.00
DTE_FIRST_SVC	T_WEB_CLAIM_HDR	DATE	0.00	0.00
DTE_FIRST_SVC_DTL	T_MEDPOL_UB92	NUMBER	8.00	0.00
DTE_FIRST_SVC_MONTH	T_CA_IND_AGGR	NUMBER	6.00	0.00
DTE_FISCAL_YEAR	T_CLM_COMP_DAYS	NUMBER	8.00	0.00
DTE_FOLLOW_UP	T_AR_COLLECTION	DATE	0.00	0.00
DTE_FOLLOW_UP	T_AR_COLLECTION	NUMBER	8.00	0.00
DTE_FOLLOW_UP	T_SUSPECT_RES	NUMBER	8.00	0.00
DTE_FROM	T_PROFILE_INFO_SOLUTIONS	DATE	0.00	0.00
DTE_FROM	T_STOP_LOSS_PARMS	DATE	0.00	0.00

DTE_FROM	T_STOP_LOSS_PARMS	NUMBER	8.00	0.00
DTE_FROM	T_TPL_RQST_RPT_SRCH	NUMBER	8.00	0.00
DTE_FROM_DOS	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_FROM_DOS	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_FROM_DOS	T_EXPENDITURE_SUPP_DTL	NUMBER	8.00	0.00
DTE_FROM_HOSP	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_FROM_HOSP	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_FROM_HOSP	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_FUND_TRANSFER	T_DAILY_FUND_TXN	DATE	0.00	0.00
DTE_FUND_TRANSFER	T_DAILY_FUND_TXN	NUMBER	8.00	0.00
DTE_GEN	T_RE_CCHIC_TRACK	NUMBER	8.00	0.00
DTE_GENERATE	T_CLM_FACSIMILE_EXTRACT	NUMBER	8.00	0.00
DTE_GENERATE	T_EDI_TP_834_RQST	NUMBER	8.00	0.00
DTE_GENERATE	T_LG_LETTER_REQUEST	NUMBER	8.00	0.00
DTE_GENERATE	T_LTR_RQST_TEMPLAT	DATE	0.00	0.00
DTE_GENERIC	T_AR_DISP	DATE	0.00	0.00
DTE_GENERIC	T_AR_DISP	NUMBER	8.00	0.00
DTE_GENERIC	T_CASH_RCPT_TOTALS	DATE	0.00	0.00
DTE_GENERIC	T_CASH_RCPT_TOTALS	NUMBER	8.00	0.00
DTE_GENERIC	T_CA_EPSDT_ABNORMAL	DATE	0.00	0.00
DTE_GENERIC	T_CLAIM_ERROR	NUMBER	8.00	0.00
DTE_GENERIC	T_ERROR_EXTRACT	DATE	0.00	0.00
DTE_GENERIC	T_ERROR_EXTRACT	NUMBER	8.00	0.00
DTE_GENERIC	T_FIN_PROCESS_AR_DISP	NUMBER	8.00	0.00
DTE_GENERIC	T_PRODUR_WARN	DATE	0.00	0.00
DTE_GENERIC	T_PRODUR_WARN	NUMBER	8.00	0.00
DTE_GENERIC	T_RE_EPSDT_LETTER	NUMBER	8.00	0.00
DTE_GENERIC	T_RE_EPS_ABNORMAL	NUMBER	8.00	0.00
DTE_GS	T_TXN_BILLING	DATE	0.00	0.00
DTE_HARDSHIP	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_HARDSHIP	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_HCBS_CHRON_NHH_EFF	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	8.00	0.00
DTE_HCBS_CHRON_NHH_END	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	8.00	0.00
DTE_HCFA_ADD	T_PROC	DATE	0.00	0.00
DTE_HCFA_ADD	T_PROC	NUMBER	8.00	0.00

DTE_HCFA_APPC	T_DRUG	NUMBER	8.00	0.00
DTE_HCFA_APPC	T_DRUG_DN	DATE	0.00	0.00
DTE_HCFA_DIB_END	T_RE_EDB	DATE	0.00	0.00
DTE_HCFA_MRKC	T_DRUG	NUMBER	8.00	0.00
DTE_HCFA_MRKC	T_DRUG_DN	DATE	0.00	0.00
DTE_HCFA_TERM	T_PROC	DATE	0.00	0.00
DTE_HCFA_TERM	T_PROC	NUMBER	8.00	0.00
DTE_HFCA_DIB_START	T_RE_EDB	DATE	0.00	0.00
DTE_HH_2NDARY_DIAG1	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_2NDARY_DIAG2	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_2NDARY_DIAG3	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_2NDARY_DIAG4	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_ADMISSION	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_CHRON_COND_EFF	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	8.00	0.00
DTE_HH_CHRON_COND_END	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	8.00	0.00

DTE_HH_DISCHARGE	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_ENTITY_EFF	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	8.00	0.00
DTE_HH_ENTITY_EFF	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	8.00	0.00
DTE_HH_LAST_VISIT	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_PERIOD_END	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_PERIOD_START	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_PHYS_CONTACT	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_PHYS_ORDER	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_PRINCIP_DIAG	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_SERVICE_FROM	T_CLM_CR6	DATE	0.00	0.00
DTE_HH_SPA_PART_EFF	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	8.00	0.00
DTE_HH_SPA_PART_END	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	8.00	0.00
DTE_HH_SPA_PROV_EFF	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	8.00	0.00
DTE_HH_SPA_PROV_END	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	8.00	0.00
DTE_HH_SURGERY	T_CLM_CR6	DATE	0.00	0.00
DTE_HIST	T_MC_PMP_SC	DATE	0.00	0.00
DTE_HIST	T_MC_PMP_SC	NUMBER	8.00	0.00
DTE_HIST_FROM	T_HIST_PART	NUMBER	8.00	0.00
DTE_HIST_FROM	T_HS_DIR_PART	NUMBER	8.00	0.00
DTE_HIST_TO	T_HIST_PART	NUMBER	8.00	0.00
DTE_HIST_TO	T_HS_DIR_PART	NUMBER	8.00	0.00
DTE_HI_ENTITLE	T_RE_BNDX_BUYIN	NUMBER	6.00	0.00
DTE_HI_ENTL_DD	T_RE_BNDX_BUYIN	NUMBER	8.00	0.00
DTE_HI_TERM	T_RE_BNDX_BUYIN	NUMBER	6.00	0.00
DTE_HI_TERM_DD	T_RE_BNDX_BUYIN	NUMBER	8.00	0.00
DTE_HOLD_OCCUR	T_PAY_HOLD_TXN_XREF	NUMBER	8.00	0.00
DTE_HOLIDAY	T_HOLIDAY_DATES	NUMBER	8.00	0.00
DTE_ICD_9_CM_PROC	T_CA_ICD9_PROC	DATE	0.00	0.00
DTE_ICD_9_CM_PROC	T_UB92_HDR_ICD9CM	NUMBER	8.00	0.00
DTE_ICD_9_CM_PROC_1	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_ICD_9_CM_PROC_2	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_ICD_9_CM_PROC_3	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_ICD_9_CM_PROC_4	T_CA_ICD9_PROC_DN	DATE	0.00	0.00

DTE_ICD_9_CM_PROC_5	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_ICD_9_CM_PROC_6	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_ICD_MAPPING	T_DRG_GROUPER	DATE	0.00	0.00
DTE_ICD_MAPPING	T_DRG_GROUPER	NUMBER	8.00	0.00
DTE_ID_CRD_RQST	T_RE_ID_CRD_RQST	NUMBER	8.00	0.00
DTE_IEVES_SENT	T_DS_RECIP_SOBRA_FAMILY	DATE	0.00	0.00
DTE_IMMIG_STAT_BAN_END	T_TMSIS_ELG003_VAR_DEMO	NUMBER	8.00	0.00
DTE_INACTIVE	T_BNFT_ADJ_FACTOR	NUMBER	8.00	0.00
DTE_INACTIVE	T_BNFT_PLAN_COB	NUMBER	8.00	0.00
DTE_INACTIVE	T_CLM_MULT_SURG	NUMBER	8.00	0.00
DTE_INACTIVE	T_COUNTY_RATE	DATE	0.00	0.00
DTE_INACTIVE	T_COVERED_BENEFIT	DATE	0.00	0.00
DTE_INACTIVE	T_COVERED_BENEFIT	DATE	0.00	0.00
DTE_INACTIVE	T_DRG_DIAG_XWALK	DATE	0.00	0.00
DTE_INACTIVE	T_DRG_ICD9_XWALK	DATE	0.00	0.00
DTE_INACTIVE	T_DRG_RATE	DATE	0.00	0.00
DTE_INACTIVE	T_FINANCIAL_PAYER	DATE	0.00	0.00
DTE_INACTIVE	T_FIN_PAYER_COB	NUMBER	8.00	0.00
DTE_INACTIVE	T_FUND_PAYER	DATE	0.00	0.00
DTE_INACTIVE	T_MAX_FEE	DATE	0.00	0.00
DTE_INACTIVE	T_PAYABLE_BENEFIT	DATE	0.00	0.00

DTE_INACTIVE	T_PAYER_HIERARCHY	NUMBER	8.00	0.00
DTE_INACTIVE	T_PEER_GRP_DRGR_OLD	DATE	0.00	0.00
DTE_INACTIVE	T_PGM_HIERARCHY	DATE	0.00	0.00
DTE_INACTIVE	T_PGM_HIERARCHY	NUMBER	8.00	0.00
DTE_INACTIVE	T_PR_COVERED_PGM	DATE	0.00	0.00
DTE_INACTIVE	T_PR_DRG_RATE	DATE	0.00	0.00
DTE_INACTIVE	T_PR_ENROLL_PGM	DATE	0.00	0.00
DTE_INACTIVE	T_PR_INST_RATE_WI	DATE	0.00	0.00
DTE_INACTIVE	T_PR_LOC_RATE_WI	DATE	0.00	0.00
DTE_INACTIVE	T_PR_OUT_RATE_AL	NUMBER	8.00	0.00
DTE_INACTIVE	T_PR_PHP_ELIG	DATE	0.00	0.00
DTE_INACTIVE	T_PR_RATE_KY	DATE	0.00	0.00
DTE_INACTIVE	T_PUB_HLTH_PGM	DATE	0.00	0.00
DTE_INACTIVE	T_REF_UCC	NUMBER	8.00	0.00
DTE_INACTIVE	T_REIMB_AGREEMENT	DATE	0.00	0.00
DTE_INACTIVE	T_REV_HOSPICE_XWALK	DATE	0.00	0.00
DTE_INACTIVE	T_TPL_COV_PLAN_XREF	DATE	0.00	0.00
DTE_INACTIVE	T_TPL_EMPLOYER	DATE	0.00	0.00
DTE_INACTIVE	T_TPL_EMPLOYER	NUMBER	8.00	0.00
DTE_INBOUND	T_TRANSACTION	TIMESTAMP	0.00	0.00
DTE_INBOUND	T_TRANSACTION	TIMESTAMP	6.00	0.00
DTE_INCOME_CHG	T_RE_INCOME_LOSS	NUMBER	8.00	0.00
DTE_INCOME_CHG	T_RE_INCOME_NEW	NUMBER	8.00	0.00
DTE_INITIATED	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_INS_CATEGORIES_EFF	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	8.00	0.00
DTE_INS_CATEGORIES_END	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	8.00	0.00

DTE_INS_COV_EFF	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	8.00	0.00
DTE_INS_COV_END	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	8.00	0.00
DTE_INS_EFFECTIVE	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_INTERIM_ACTION	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_INT_LETTER	T_AR_COLLECTION	DATE	0.00	0.00
DTE_INT_LETTER	T_AR_COLLECTION	NUMBER	8.00	0.00
DTE_INT_RECOUP_LTR	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_INV_CREATED	T_DR_4002_RCPTS	DATE	0.00	0.00
DTE_INV_CREATED	T_DR_4002_RCPTS	NUMBER	8.00	0.00
DTE_IN_HOUSE	T_CALL_TRACK	NUMBER	8.00	0.00
DTE_ISA	T_TXN_BILLING	DATE	0.00	0.00
DTE_ISSUE	T_CHECK	DATE	0.00	0.00
DTE_ISSUE	T_CHECK	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_835_TRACK	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_EARNINGS_HIST	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_EARNINGS_YTD	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_EFT_RELEASE	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_PAYMENT	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_PAY_RELEASE	NUMBER	8.00	0.00
DTE_ISSUE	T_FIN_PROCESS_PYMT	NUMBER	8.00	0.00
DTE_ISSUE	T_PAYMENT_EXTRACT	DATE	0.00	0.00
DTE_ISSUE	T_PAYMENT_EXTRACT	NUMBER	8.00	0.00
DTE_ISSUE	T_PR_PROV_YTD_AMT	DATE	0.00	0.00
DTE_ISSUE	T_PR_PROV_YTD_AMT	NUMBER	8.00	0.00
DTE_ISSUE	T_PR_YTD_AMT_HIST	DATE	0.00	0.00
DTE_ISSUE	T_PR_YTD_AMT_HIST	NUMBER	8.00	0.00
DTE_ISSUE	T_RE_ID_CARD	DATE	0.00	0.00
DTE_ISSUE	T_RE_ID_CARD	NUMBER	8.00	0.00
DTE_ISSUE	T_RE_ID_CRD_ISS	DATE	0.00	0.00
DTE_ISSUE	T_RE_ID_CRD_ISS	NUMBER	8.00	0.00
DTE_ISSUE	T_RE_NET_VOUCHER	DATE	0.00	0.00
DTE_ISSUE	T_RE_RETRO_ELIG	DATE	0.00	0.00
DTE_ISSUE_CHK	T_FIN_CYCLE_HIST	NUMBER	8.00	0.00
DTE_ISSUE_EFT	T_FIN_CYCLE_HIST	NUMBER	8.00	0.00
DTE_JULIAN_BATCH	T_CLAIM_EXTRACT	CHAR	5.00	0.00

DTE_KEYED	T_CLM_PHRM_	NUMBER	8.00	0.00
DTE_KEYED	T_CLM_PHRM_PAPER_IMG	NUMBER	8.00	0.00
DTE_LAST_834	T_RE_RCO_834	NUMBER	8.00	0.00
DTE_LAST_ANCHOR	T_ETG_SUMMARY	DATE	0.00	0.00
DTE_LAST_ANCHOR	T_ETG_SUMMARY_ENCNTR	DATE	0.00	0.00
DTE_LAST_ANCHOR	T_ETG_SUMMARY_FFS	DATE	0.00	0.00
DTE_LAST_ANCHOR	T_ETG_SUMMARY_RCO_PAID	DATE	0.00	0.00
DTE_LAST_CHANGE	T_CAS_CASE_ACT	DATE	0.00	0.00
DTE_LAST_CHANGE	T_CAS_CASE_ACT	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_CLM_PHRM_	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_CLM_PHRM_PAPER_IMG	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_DR_DISPUTE_DTL	DATE	0.00	0.00
DTE_LAST_CHANGE	T_DR_DISPUTE_DTL	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_DR_INVOICE	DATE	0.00	0.00
DTE_LAST_CHANGE	T_DR_INVOICE	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_FIN_EFT_ACCT	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_LS_LVL3_PRICING	DATE	0.00	0.00
DTE_LAST_CHANGE	T_PDL_MASTER	DATE	0.00	0.00
DTE_LAST_CHANGE	T_PDL_MASTER_AL	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_PR_EFT_ACCT	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_PR_LOC_RATE_REQ	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_RE_ADDRESS	DATE	0.00	0.00
DTE_LAST_CHANGE	T_RE_ADDRESS	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_RE_CONSENT_FORM_ACTIVITY	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_RE_CONSENT_FORM_MASTER	DATE	0.00	0.00
DTE_LAST_CHANGE	T_RE_CONSENT_FORM_MASTER	NUMBER	8.00	0.00

DTE_LAST_CHANGE	T_RE_LOC	DATE	0.00	0.00
DTE_LAST_CHANGE	T_RE_NAME_XREF	DATE	0.00	0.00
DTE_LAST_CHANGE	T_RE_NAME_XREF	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_RE_PREV_CTY	DATE	0.00	0.00
DTE_LAST_CHANGE	T_RE_PREV_CTY	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_RE_PREV_SSN	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_LAST_CHANGE	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_TPL_AR_HEALTH_XXX	NUMBER	8.00	0.00
DTE_LAST_CHANGE	T_TPL_RESOURCE	DATE	0.00	0.00
DTE_LAST_CHANGE	T_TPL_RESOURCE	NUMBER	8.00	0.00
DTE_LAST_COMP	T_CLM_COMP_DAYS	NUMBER	8.00	0.00
DTE_LAST_CYCLE	T_ERX_CDE_LIST_ID	NUMBER	8.00	0.00
DTE_LAST_DENTAL	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_LAST_DENTAL	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_LAST_HEARING	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_LAST_HEARING	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_LAST_LOGON	T_WEB_USER	NUMBER	8.00	0.00
DTE_LAST_MEDICAL	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_LAST_MEDICAL	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_LAST_MENSTRUAL_CYCLE	T_CA_PHYS	DATE	0.00	0.00
DTE_LAST_PAY	T_RE_INCOME_LOSS	NUMBER	8.00	0.00
DTE_LAST_PAYMENT	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_LAST_PAYMENT	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_LAST_STATUS	T_PR_APPLN	DATE	0.00	0.00
DTE_LAST_STATUS	T_PR_APPLN	NUMBER	8.00	0.00
DTE_LAST_STATUS	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_LAST_SVC	T_ADJ_MASS_CLAIM	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CA_FIN	DATE	0.00	0.00
DTE_LAST_SVC	T_CA_HDR_DTL	DATE	0.00	0.00
DTE_LAST_SVC	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_LAST_SVC	T_CLM_MAT_CARE_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CLM_MAT_CARE_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CLM_PATLIAB_X	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CLM_SAMPLE	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CPAS_EXTRACT	NUMBER	8.00	0.00
DTE_LAST_SVC	T_CPAS_SPLIT	NUMBER	8.00	0.00

DTE_LAST_SVC	T_DENY_DNTL_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_DENY_PHYS_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_DENY_UB92_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_DENY_UB92_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_DS_HM_DETAIL	DATE	0.00	0.00
DTE_LAST_SVC	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_LAST_SVC	T_MEDPOL_UB92	NUMBER	8.00	0.00
DTE_LAST_SVC	T_MPHX_PHYS_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PD_DNTL_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PD_PHYS_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PD_UB92_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PD_UB92_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PR_CONTRACT_RATE_KY	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_LAST_SVC	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_LAST_SVC	T_PUB_HLTH_AID	DATE	0.00	0.00
DTE_LAST_SVC	T_PUB_HLTH_AID	NUMBER	8.00	0.00
DTE_LAST_SVC	T_RETRO_SUMM_RECS	NUMBER	8.00	0.00
DTE_LAST_SVC	T_SUSP_DENTAL_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_SUSP_PHYS_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_SUSP_UB92_DTL	NUMBER	8.00	0.00
DTE_LAST_SVC	T_SUSP_UB92_HDR	NUMBER	8.00	0.00
DTE_LAST_SVC	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_LAST_SVC	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_LAST_SVC	T_TPL_AR_HEALTH_XXX	NUMBER	8.00	0.00
DTE_LAST_SVC	T_WEB_CLAIM_HDR	DATE	0.00	0.00
DTE_LAST_SVC_DTL	T_MEDPOL_UB92	NUMBER	8.00	0.00
DTE_LAST_TPL_ACTION	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_LAST_TRNSFR	T_DS_RECIP_CORE	DATE	0.00	0.00

DTE_LAST_UNSUCC_ATTEMPT	T_WEB_USER	NUMBER	8.00	0.00
DTE_LAST_UPD	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_LAST_UPD	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_CLAIM_BDL_LABPANEL	DATE	0.00	0.00
DTE_LAST_UPDATE	T_CLAIM_BDL_NCCD	DATE	0.00	0.00
DTE_LAST_UPDATE	T_CLAIM_BDL_OVERRIDE	DATE	0.00	0.00
DTE_LAST_UPDATE	T_DR_RATE	DATE	0.00	0.00
DTE_LAST_UPDATE	T_DR_RATE	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_DR_RATE_UROA	DATE	0.00	0.00
DTE_LAST_UPDATE	T_DR_RATE_UROA	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_MC_PMP_NT_CENSUS	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_ASSIGN_PLAN	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_ASSIGN_PLAN	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_ASSIGN_PLAN_LI	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_ASSIGN_PLAN_RLOC	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_BASE	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_BASE_DN	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_EDB	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_HOSPICE_HDR	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_LTC_RCO_AVAILABLE	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_LTC_RCO_AVAILABLE	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_MEDICARE_A	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_MEDICARE_A	NUMBER	8.00	0.00
DTE_LAST_UPDATE	T_RE_MEDICARE_B	DATE	0.00	0.00
DTE_LAST_UPDATE	T_RE_MEDICARE_B	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_DOCUMENT_TRACK	DATE	0.00	0.00
DTE_LAST_UPDATED	T_FILE_TRACK	DATE	0.00	0.00
DTE_LAST_UPDATED	T_PR_ADR_CASS	DATE	0.00	0.00
DTE_LAST_UPDATED	T_REF_CCI	DATE	0.00	0.00
DTE_LAST_UPDATED	T_REF_CCI	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_REF_CCI_MUE	DATE	0.00	0.00
DTE_LAST_UPDATED	T_REF_CCI_MUE	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_REF_CCI_MUE_OVERRIDE	DATE	0.00	0.00
DTE_LAST_UPDATED	T_REF_CCI_MUE_OVERRIDE	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_REF_CCI_OVERRIDE	DATE	0.00	0.00

DTE_LAST_UPDATED	T_REF_CCI_OVERRIDE	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_ADR_CASS	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_LINK_RQST	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_MEDICARE_D	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_MEDICARE_D	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_ASSIGN	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_ASSIGN	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_CARRIER	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_CARRIER	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_PLAN	DATE	0.00	0.00
DTE_LAST_UPDATED	T_RE_PARTD_PDP_PLAN	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_RE_UNLINK_RQST	NUMBER	8.00	0.00
DTE_LAST_UPDATED	T_TP	DATE	0.00	0.00
DTE_LAST_UPDATED	T_TP_CONFIG	DATE	0.00	0.00
DTE_LAST_UPDATED_AMAES	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_LAST_UPDT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_LAST_VISION	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_LAST_VISION	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_LAST_VISIT	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_LAST_VISIT	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_LETTER_DATE	T_PS_LTR_REQUEST	NUMBER	8.00	0.00
DTE_LETTER_SENT	T_AR_COLLECTION	DATE	0.00	0.00
DTE_LETTER_SENT	T_AR_COLLECTION	NUMBER	8.00	0.00
DTE_LETTER_SENT	T_CAS_HIST_LETTERS	NUMBER	8.00	0.00
DTE_LETTER_SENT	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_LETTER_SENT	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_LETTER_SENT	T_RE_EPSDT_REC_NOT	DATE	0.00	0.00
DTE_LETTER_SENT	T_RE_EPSDT_REC_NOT	NUMBER	8.00	0.00
DTE_LETTER_SENT	T_TPL_CHECK_HOLD	NUMBER	8.00	0.00
DTE_LETTER_SENT_2ND	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_LETTER_SENT_2ND	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_LEVEL_I_RCVD	T_PS_LVL_I_TRACK	NUMBER	8.00	0.00
DTE_LIC_CERT	T_PR_APPLN	DATE	0.00	0.00

DTE_LIC_CERT	T_PR_APPLN	NUMBER	8.00	0.00
DTE_LIC_CERT	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_LIC_CERT_END	T_PR_APPLN	DATE	0.00	0.00
DTE_LIC_CERT_END	T_PR_APPLN	NUMBER	8.00	0.00
DTE_LIC_CERT_END	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_LIEN_ORG	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_LIEN_ORG	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_LIEN_ORG	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_LIEN_RELEASED	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_LIEN_RELEASED	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_LIEN_RELEASED	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_LIFELINE_PERMISSION	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_LI_EFF	T_RE_BASE_DN	DATE	0.00	0.00
DTE_LI_END	T_RE_BASE_DN	DATE	0.00	0.00
DTE_LOADED	T_CLM_PHRM_	NUMBER	8.00	0.00
DTE_LOADED	T_CLM_PHRM_PAPER_IMG	NUMBER	8.00	0.00
DTE_LOCKIN_EFF	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	8.00	0.00
DTE_LOCKIN_END	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	8.00	0.00
DTE_LOCKIN_FROM	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_LOCKIN_FROM	T_CT_LOCKIN	DATE	0.00	0.00
DTE_LOCKIN_THRU	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_LOCKIN_THRU	T_CT_LOCKIN	DATE	0.00	0.00
DTE_LOCK_IN	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_LOGON	T_AUDIT_LOGON	DATE	0.00	0.00
DTE_LOG_CREATED	T_SW_MASKING_DATA	VARCHAR2	25.00	0.00
DTE_LOG_CREATED	T_SW_PERFORMANCE_DATA	VARCHAR2	30.00	0.00
DTE_LST_CHANGE	T_PLOG_COMMENTS	NUMBER	8.00	0.00
DTE_LST_CHANGE	T_PLOG_VERSION	NUMBER	8.00	0.00
DTE_LST_CHG_AWP	T_DRUG	DATE	0.00	0.00
DTE_LST_CHG_AWP	T_DRUG	NUMBER	8.00	0.00

DTE_LST_CHG_AWP	T_DRUG_DN	DATE	0.00	0.00
DTE_LTC_BEGIN	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_LTC_CERT	T_PR_LOC_RATE	NUMBER	8.00	0.00
DTE_LTC_CERT	T_PR_LOC_RATE_WI	NUMBER	8.00	0.00
DTE_LTC_END	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_LTC_PARTB_EFFECTIVE	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_LTC_PARTB_END	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_LTSS_ELIG_EFF	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	8.00	0.00
DTE_LTSS_ELIG_END	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	8.00	0.00
DTE_LUMP_SUM	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_MAC_APPEAL_REQ	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_MAC_APPEAL_RSP	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_MAILED	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_MARITAL_STATUS	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_MARKET_ENTER	T_DR_CMS_TAPE	DATE	0.00	0.00
DTE_MARKET_ENTER	T_DR_CMS_TAPE	NUMBER	8.00	0.00
DTE_MATCHED	T_RE_NET_VOUCHER	DATE	0.00	0.00
DTE_MATER_WVR_BEGIN	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_MATER_WVR_END	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_MAX_PDF	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_MAX_PDF	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_MAX_PDF	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_MCARE_BEGIN	T_RE_ASSIGN_PLAN	DATE	0.00	0.00
DTE_MCARE_BEGIN	T_RE_ASSIGN_PLAN	NUMBER	8.00	0.00
DTE_MCARE_BEGIN	T_RE_ASSIGN_PLAN_RLOC	DATE	0.00	0.00
DTE_MCARE_PAID	T_CA_XOVER	DATE	0.00	0.00
DTE_MCARE_PAID	T_FINAL_PHYS_XOVER	NUMBER	8.00	0.00
DTE_MCARE_PAID	T_FINAL_UB92_XOVER	NUMBER	8.00	0.00
DTE_MCARE_PAID	T_SUSP_PHYS_XOVER	NUMBER	8.00	0.00
DTE_MCARE_PAID	T_SUSP_UB92_XOVER	NUMBER	8.00	0.00

DTE_MCO_ADJUD	T_CA_MCO_XREF	DATE	0.00	0.00
DTE_MC_CONTRACT_EFF	T_TMSIS_MCR002_MAIN	NUMBER	8.00	0.00
DTE_MC_CONTRACT_END	T_TMSIS_MCR002_MAIN	NUMBER	8.00	0.00
DTE_MC_LOC_INFO_EFF	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	8.00	0.00
DTE_MC_LOC_INFO_END	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	8.00	0.00
DTE_MC_MAIN_REC_EFF	T_TMSIS_MCR002_MAIN	NUMBER	8.00	0.00
DTE_MC_MAIN_REC_END	T_TMSIS_MCR002_MAIN	NUMBER	8.00	0.00
DTE_MC_OPER_AUTH_EFF	T_TMSIS_MCR005_OPER_AUTH	NUMBER	8.00	0.00
DTE_MC_OPER_AUTH_END	T_TMSIS_MCR005_OPER_AUTH	NUMBER	8.00	0.00
DTE_MC_PLAN_ENROLL_EFF	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	8.00	0.00
DTE_MC_PLAN_ENROLL_END	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	8.00	0.00
DTE_MC_PLAN_POP_EFF	T_TMSIS_MCR006_POP_ENRLD	NUMBER	8.00	0.00
DTE_MC_PLAN_POP_END	T_TMSIS_MCR006_POP_ENRLD	NUMBER	8.00	0.00
DTE_MC_SVC_AREA_EFF	T_TMSIS_MCR004_SVC_AREA	NUMBER	8.00	0.00
DTE_MC_SVC_AREA_END	T_TMSIS_MCR004_SVC_AREA	NUMBER	8.00	0.00
DTE_MEDICAID_PAID	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_MEDICAID_PAID	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_MEDICAID_PAID	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_MEDICAID_PAID	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_MEDICAL_SVCS	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_MEDICARE	T_BUYB_BILL	DATE	0.00	0.00
DTE_MEDICARE	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_MEDICARE	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_MEDICARE	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_MED_SUPPORT_ORDER	T_TPL_AC_PARENT_MED_XREF	DATE	0.00	0.00
DTE_MED_SUPPORT_ORDER	T_TPL_AC_PARENT_MED_XREF	NUMBER	8.00	0.00

DTE_MFP_ENROLL_EFF	T_TMSIS_ELG010_MFP_INFO	NUMBER	8.00	0.00
DTE_MFP_ENROLL_END	T_TMSIS_ELG010_MFP_INFO	NUMBER	8.00	0.00
DTE_MI_REFERRAL	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_MI_VERBAL_RCVD	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_MI_VERBAL_RCVD	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_MO	T_CA_TIME_KEY	NUMBER	6.00	0.00
DTE_MONTH_ELIG	T_DS_RECIP_AGGR_CNT	NUMBER	6.00	0.00
DTE_MONTH_LOG_CREATED	T_SW_PERFORMANCE_DATA	NUMBER	2.00	0.00
DTE_MONTH_PAID	T_DS_CLM_CNT_PAID_DTE	NUMBER	6.00	0.00
DTE_MONTH_SVC	T_DS_CLM_CNT_SVC_DTE	NUMBER	6.00	0.00
DTE_MOVE	T_PR_ADR_CASS	NUMBER	6.00	0.00
DTE_MOVE	T_RE_ADR_CASS	NUMBER	6.00	0.00
DTE_MR_REFERRAL	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_MR_VERBAL_RCVD	T_PS_DETERMINATION	NUMBER	8.00	0.00
DTE_MR_VERBAL_RCVD	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_MSP_STATUS	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_MW_ACTION	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_MW_APPROVAL	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_NATL_HC_ENTITY_EFF	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	8.00	0.00
DTE_NATL_HC_ENTITY_END	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	8.00	0.00
DTE_NDDF_ADD	T_DRUG	DATE	0.00	0.00
DTE_NDDF_ADD	T_DRUG	NUMBER	8.00	0.00
DTE_NDDF_ADD	T_DRUG_DN	DATE	0.00	0.00
DTE_NDDF_UPDT	T_DRUG	DATE	0.00	0.00
DTE_NDDF_UPDT	T_DRUG	NUMBER	8.00	0.00

DTE_NDDF_UPDT	T_DRUG_DN	DATE	0.00	0.00
DTE_NEXT_BUSINESS	T_HOLIDAY_DATES	NUMBER	8.00	0.00
DTE_NEXT_DENTAL	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_NEXT_DENTAL	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_NEXT_HEARING	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_NEXT_HEARING	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_NEXT_MEDICAL	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_NEXT_MEDICAL	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_NEXT_VISION	T_RE_EPS_CURR_SCRN	DATE	0.00	0.00
DTE_NEXT_VISION	T_RE_EPS_CURR_SCRN	NUMBER	8.00	0.00
DTE_NOTE	T_CALL_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_DIAG_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_DRG_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_DRUG_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_ERR_DISP_NOTES	DATE	0.00	0.00
DTE_NOTE	T_ERR_DISP_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_MC_NPI_NOTES	DATE	0.00	0.00
DTE_NOTE	T_MC_NPI_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_MC_PMP_NOTES	DATE	0.00	0.00
DTE_NOTE	T_MC_PMP_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_MC_RE_NOTES	DATE	0.00	0.00
DTE_NOTE	T_MC_RE_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_MODIFIER_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_PROC_ICD9_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_PROC_NOTES	NUMBER	8.00	0.00
DTE_NOTE	T_REVENUE_NOTES	NUMBER	8.00	0.00
DTE_NOTICE_ADDL	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_NOTICE_ADDL	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_NOTICE_INIT	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_NOTICE_INIT	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00

DTE_NOTIFICATION	T_TRACK_NOTIFICATION	DATE	0.00	0.00
DTE_NPI_DEACTIVATION	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_NPI_DEACTIVATION	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_NPI_REACTIVATION	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_NPI_REACTIVATION	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_OBSOLETE	T_ERX_NCPDP_QQ	NUMBER	8.00	0.00
DTE_OBSOLETE	T_LS_DRUG_MASTER	DATE	0.00	0.00
DTE_OBSOLETE	T_MB_HEDIS_DRUG	DATE	0.00	0.00
DTE_OCCURRENCE	T_CA_OCCUR	DATE	0.00	0.00
DTE_OCCURRENCE	T_UB92_HDR_OCC	NUMBER	8.00	0.00
DTE_OCCUR_1	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_2	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_3	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_4	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_5	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_6	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_7	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCCUR_8	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_OCC_CODE_EFF	T_TMSIS_CIP_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_CODE_EFF	T_TMSIS_CLT_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_CODE_EFF	T_TMSIS_COT_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_CODE_END	T_TMSIS_CIP_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_CODE_END	T_TMSIS_CLT_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_CODE_END	T_TMSIS_COT_OCC_CDE	NUMBER	8.00	0.00
DTE_OCC_TO	T_UB92_HDR_OCC	NUMBER	8.00	0.00
DTE_OFFLINE_CLM_END	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_OFFLINE_CLM_END	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_OFFLINE_CLM_END	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_OFFLINE_CLM_ST	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_OFFLINE_CLM_ST	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_OFFLINE_CLM_ST	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00

DTE_OF_ACC_INJ	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_OF_ACC_INJ	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_OF_ACC_INJ	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_OF_ADMISSION	T_PS_LVL_I_TRACK	NUMBER	8.00	0.00
DTE_OF_SERVICE	T_CA_BENEFIT_LIMITS	DATE	0.00	0.00
DTE_OF_SERVICE	T_CLM_BENEFIT_LIMITS	NUMBER	8.00	0.00
DTE_OPENED	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_ORIG_CASE_BILLED	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_ORIG_CASE_BILLED	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_OTHER_PAYER	T_PHRM_COB_XREF	NUMBER	8.00	0.00
DTE_OTHER_SUB_DOB	T_DNTL_OTH_PYR_HDR	DATE	0.00	0.00
DTE_OTHER_SUB_DOB	T_INST_OTH_PYR_HDR	DATE	0.00	0.00
DTE_OTHER_SUB_DOB	T_PROF_OTH_PYR_HDR	DATE	0.00	0.00
DTE_OTH_TPL_EFF	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	8.00	0.00
DTE_OTH_TPL_END	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	8.00	0.00
DTE_OUTBOUND	T_TRANSACTION	TIMESTAMP	0.00	0.00
DTE_OUTBOUND	T_TRANSACTION	TIMESTAMP	6.00	0.00
DTE_PAID	T_CASUALTY_CASE_OFFLINE	NUMBER	8.00	0.00
DTE_PAID	T_CA_CURRENT_DATES	DATE	0.00	0.00
DTE_PAID	T_CA_FIN	DATE	0.00	0.00
DTE_PAID	T_CLAIM_INTEREST	DATE	0.00	0.00
DTE_PAID	T_CLAIM_INTEREST	NUMBER	8.00	0.00
DTE_PAID	T_DS_DNTL_ICN	DATE	0.00	0.00
DTE_PAID	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_PAID	T_LS_PHARMACY_CLAIMS	DATE	0.00	0.00
DTE_PAID	T_LS_PHARMACY_OTHER	CHAR	10.00	0.00
DTE_PAID	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_PAID	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00

DTE_PAID	T_SCOS_CLAIMS_BY_DATE	DATE	0.00	0.00
DTE_PAID	T_SCOS_FIN_DATA_BY_DATE	DATE	0.00	0.00
DTE_PAID	T_TPL_THRESHOLD_SUMM	NUMBER	8.00	0.00
DTE_PAID	T_WEB_CLAIM_HDR	DATE	0.00	0.00
DTE_PAID	T_WEB_PAY_SUM	DATE	0.00	0.00
DTE_PAID_BEGIN	T_CLM_HIST_BALANCE	NUMBER	8.00	0.00
DTE_PAID_END	T_CLM_HIST_BALANCE	NUMBER	8.00	0.00
DTE_PAID_MAT_CARE	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_PAID_MAT_CARE	T_CLM_MAT_CARE_HDR	NUMBER	8.00	0.00
DTE_PAID_MONTH	T_SCOS_CLAIMS_BY_MONTH	NUMBER	6.00	0.00
DTE_PAID_MONTH	T_SCOS_FIN_DATA_BY_MONTH	NUMBER	6.00	0.00
DTE_PAID_NUM	T_CA_CURRENT_DATES	NUMBER	9.00	0.00
DTE_PAID_QTR	T_SCOS_CLAIMS_BY_QTR	NUMBER	6.00	0.00
DTE_PAID_QTR	T_SCOS_FIN_DATA_BY_QTR	NUMBER	6.00	0.00
DTE_PAID_YYYY	T_LS_SUMMARY_NDC	CHAR	4.00	0.00
DTE_PARM_1	T_FIN_RPT_PARMS	NUMBER	8.00	0.00
DTE_PARM_2	T_FIN_RPT_PARMS	NUMBER	8.00	0.00
DTE_PARM_2	T_SYSTEM_PARMS	NUMBER	8.00	0.00
DTE_PART_A_BYN_ACCRETION	T_RE_PART_A_ACCRETION	DATE	0.00	0.00
DTE_PART_A_BYN_DELETION	T_RE_PART_A_ACCRETION	DATE	0.00	0.00
DTE_PART_B_BYN_ACCRETION	T_RE_PART_B_ACCRETION	DATE	0.00	0.00
DTE_PART_B_BYN_DELETION	T_RE_PART_B_ACCRETION	DATE	0.00	0.00
DTE_PATIENT_DEATH	T_CLM_SBR	DATE	0.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_ADJ	NUMBER	8.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_ADJ_DN	DATE	0.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_ADJ_WI	NUMBER	8.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_HIST	NUMBER	8.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_HIST_DN	DATE	0.00	0.00
DTE_PAYMENT_BEGIN	T_CAPITATION_HIST_WI	NUMBER	8.00	0.00
DTE_PAYMENT_END	T_CAPITATION_ADJ	NUMBER	8.00	0.00
DTE_PAYMENT_END	T_CAPITATION_ADJ_DN	DATE	0.00	0.00
DTE_PAYMENT_END	T_CAPITATION_ADJ_WI	NUMBER	8.00	0.00
DTE_PAYMENT_END	T_CAPITATION_HIST	NUMBER	8.00	0.00
DTE_PAYMENT_END	T_CAPITATION_HIST_DN	DATE	0.00	0.00
DTE_PAYMENT_END	T_CAPITATION_HIST_WI	NUMBER	8.00	0.00

DTE_PAYMENT_ISSUE	T_AR_DISP	DATE	0.00	0.00
DTE_PAYMENT_ISSUE	T_AR_DISP	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_CAPITATION_HIST	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_CAPITATION_HIST_DN	DATE	0.00	0.00
DTE_PAYMENT_ISSUE	T_CAPITATION_HIST_WI	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_PAYMENT_ISSUE	T_FIN_PROCESS_AR_DISP	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_FIN_PROCESS_LIEN_DISP	NUMBER	8.00	0.00
DTE_PAYMENT_ISSUE	T_LIEN_DISP	DATE	0.00	0.00
DTE_PAYMENT_ISSUE	T_LIEN_DISP	NUMBER	8.00	0.00
DTE_PAYMENT_SLIP	T_CHECK_SLIP_DATE	DATE	0.00	0.00
DTE_PAYMENT_SLIP	T_CHECK_SLIP_DATE	NUMBER	8.00	0.00
DTE_PAY_CYCLE	T_CLM_BATCH_PROCESS	DATE	0.00	0.00
DTE_PAY_CYCLE	T_CLM_BATCH_PROCESS_ENC	DATE	0.00	0.00
DTE_PAY_CYCLE	T_ENC_BATCH_PROCESS	DATE	0.00	0.00
DTE_PAY_END	T_HIPP_EXPEND_XREF	NUMBER	8.00	0.00

DTE_PAY_START	T_HIPP_EXPEND_XREF	NUMBER	8.00	0.00
DTE_PA_ADM_MLD	T_PA_ADMIN_REV	DATE	0.00	0.00
DTE_PA_ADM_MLD	T_PA_ADMIN_REV	NUMBER	8.00	0.00
DTE_PA_ADM_REC	T_PA_ADMIN_REV	DATE	0.00	0.00
DTE_PA_ADM_REC	T_PA_ADMIN_REV	NUMBER	8.00	0.00
DTE_PA_APPEAL	T_PA_APPEAL	DATE	0.00	0.00
DTE_PA_APPEAL	T_PA_APPEAL	NUMBER	8.00	0.00
DTE_PA_APP_DISMIS	T_PA_APPEAL	DATE	0.00	0.00
DTE_PA_APP_DISMIS	T_PA_APPEAL	NUMBER	8.00	0.00
DTE_PA_APP_MAIL	T_PA_APPEAL	DATE	0.00	0.00
DTE_PA_APP_MAIL	T_PA_APPEAL	NUMBER	8.00	0.00
DTE_PA_APP_RECV	T_PA_APPEAL	DATE	0.00	0.00
DTE_PA_APP_RECV	T_PA_APPEAL	NUMBER	8.00	0.00
DTE_PA_AUTH_EFF	T_PA_LINE_ITEM	DATE	0.00	0.00
DTE_PA_AUTH_EFF	T_PA_LINE_ITEM	NUMBER	8.00	0.00
DTE_PA_AUTH_END	T_PA_LINE_ITEM	DATE	0.00	0.00
DTE_PA_AUTH_END	T_PA_LINE_ITEM	NUMBER	8.00	0.00
DTE_PA_AUTO_APPRVD	T_PA_LINE_ITEM	DATE	0.00	0.00
DTE_PA_AUTO_APPRVD	T_PA_LINE_ITEM	NUMBER	8.00	0.00
DTE_PA_KEYED	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_PA_REQ_EFF	T_PA_LINE_ITEM	DATE	0.00	0.00
DTE_PA_REQ_EFF	T_PA_LINE_ITEM	NUMBER	8.00	0.00
DTE_PA_REQ_END	T_PA_LINE_ITEM	DATE	0.00	0.00
DTE_PA_REQ_END	T_PA_LINE_ITEM	NUMBER	8.00	0.00
DTE_PBEN_EFFECTIVE	T_RE_EDB	DATE	0.00	0.00
DTE_PBEN_END	T_RE_EDB	DATE	0.00	0.00
DTE_PBEN_START	T_RE_EDB	DATE	0.00	0.00
DTE_PCCM_EXEMPT	T_DS_RECIP_CORE	DATE	0.00	0.00

DTE_PC_HST1	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_PC_HST2	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_PERIOD	T_DR_CMS_UROA	CHAR	7.00	0.00
DTE_PERIOD_EFF	T_FIN_PERIOD	NUMBER	8.00	0.00
DTE_PERIOD_END	T_FIN_PERIOD	NUMBER	8.00	0.00
DTE_PHP_ELIG	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_PLAST_CARD	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_POSSIBLE_FROM	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_POSSIBLE_FROM	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_POSSIBLE_TO	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_POSSIBLE_TO	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_POSTED	T_CASH_RCPT_DISP	DATE	0.00	0.00
DTE_POSTED	T_CASH_RCPT_DISP	NUMBER	8.00	0.00
DTE_POSTED	T_DR_INTEREST	DATE	0.00	0.00
DTE_POSTED	T_DR_INTEREST	NUMBER	8.00	0.00
DTE_POSTED	T_DR_PAYMENT_HDR	DATE	0.00	0.00
DTE_POSTED	T_DR_PAYMENT_HDR	NUMBER	8.00	0.00
DTE_POSTED	T_DR_PAYMENT_XREF	DATE	0.00	0.00
DTE_POSTED	T_DR_PAYMENT_XREF	NUMBER	8.00	0.00
DTE_POSTED	T_FIN_BUDG_DISP	NUMBER	8.00	0.00
DTE_POSTED	T_FIN_PROCESS_BUDG_DISP	NUMBER	8.00	0.00
DTE_POSTED	T_FIN_PROCESS_CASH_DISP	NUMBER	8.00	0.00
DTE_POSTED	T_RE_AR_TRANSACTION	DATE	0.00	0.00
DTE_POSTMARK	T_DR_PAYMENT_HDR	DATE	0.00	0.00
DTE_POSTMARK	T_DR_PAYMENT_HDR	NUMBER	8.00	0.00
DTE_PRCSG	T_RE_EDB_HOSPICE	DATE	0.00	0.00
DTE_PRCSG	T_RE_EDB_HOSPICE	NUMBER	8.00	0.00
DTE_PREGNANCY_DUE	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_PREPARED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_PREPARED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_PRESCRIBE	T_CA_DRUG	DATE	0.00	0.00
DTE_PRESCRIBE	T_DENY_PHRM_HDR	NUMBER	8.00	0.00
DTE_PRESCRIBE	T_PD_PHARM_HDR	NUMBER	8.00	0.00
DTE_PRESCRIBE	T_SUSP_PHRM_HDR	NUMBER	8.00	0.00
DTE_PRESCRIBED	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_PRESCRIPTION_FILL	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00

DTE_PREV_RUN_END	T_FIN_CHECKWRITE	DATE	0.00	0.00
DTE_PREV_RUN_END	T_FIN_CHECKWRITE	NUMBER	8.00	0.00
DTE_PRE_APPROVAL	T_PS_ICF_MR	NUMBER	8.00	0.00
DTE_PRE_CALL_RCVD	T_PS_ICF_MR	NUMBER	8.00	0.00
DTE_PRIM_DEMO_EFF	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	8.00	0.00
DTE_PRIM_DEMO_END	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	8.00	0.00
DTE_PRIOR_APP	T_DS_RECIP_DO_APPL_HIST	DATE	0.00	0.00
DTE_PROCESSED	T_835_CK_EFT_TRCNO	DATE	0.00	0.00
DTE_PROCESSED	T_BATCH	DATE	0.00	0.00
DTE_PROCESSED	T_CASH_RCPT_DISP	DATE	0.00	0.00
DTE_PROCESSED	T_CASH_RCPT_DISP	NUMBER	8.00	0.00
DTE_PROCESSED	T_CHECK_VOID	DATE	0.00	0.00
DTE_PROCESSED	T_CHECK_VOID	NUMBER	9.00	0.00
DTE_PROCESSED	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_PROCESSED	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_PROCESSED	T_EXPENDITURE_DN	DATE	0.00	0.00
DTE_PROCESSED	T_FEE_SCHEDULE	NUMBER	8.00	0.00
DTE_PROCESSED	T_FIN_AR_RQST_REPORT	NUMBER	8.00	0.00
DTE_PROCESSED	T_FIN_PROCESS_CASH_DISP	NUMBER	8.00	0.00
DTE_PROCESSED	T_MR_TMSIS_CMS_ERROR_FILES	NUMBER	8.00	0.00
DTE_PROCESSED	T_PDUR_SUSP	NUMBER	8.00	0.00
DTE_PROCESSED	T_PDUR_SUSP	NUMBER	8.00	0.00
DTE_PROCESSED	T_PR_CHOW_GRP_MBR	NUMBER	8.00	0.00
DTE_PROCESSED	T_RECIP_LINK_XREF	DATE	0.00	0.00
DTE_PROCESSED	T_RECIP_LINK_XREF	NUMBER	8.00	0.00
DTE_PROCESSED	T_RE_1095	NUMBER	8.00	0.00
DTE_PROCESSED	T_RE_ADPH_1095	NUMBER	8.00	0.00

DTE_PROCESSED	T_TMSIS_CMS_ERROR_FILES	NUMBER	8.00	0.00
DTE_PROCESSED_CLM	T_CLM_BATCH_PROCESS	DATE	0.00	0.00
DTE_PROCESSED_ENC	T_CLM_BATCH_PROCESS_ENC	DATE	0.00	0.00
DTE_PROCESSED_ENC	T_ENC_BATCH_PROCESS	DATE	0.00	0.00
DTE_PROCESSED_TPL	T_RE_MINI_LINK_XREF	NUMBER	8.00	0.00
DTE_PROCESS_QTR	T_DR_4002_RCPTS	NUMBER	5.00	0.00
DTE_PROCESS_QTR	T_DR_RATE	NUMBER	5.00	0.00
DTE_PROCESS_QTR	T_DR_RATE_UROA	NUMBER	5.00	0.00
DTE_PROC_CODE	T_TMSIS_CIP_HDR_PROC	NUMBER	8.00	0.00
DTE_PROC_CODE	T_TMSIS_COT003_CLM_DTL	NUMBER	8.00	0.00
DTE_PROC_ORIG	T_PDUR_FINAL_CLM	NUMBER	8.00	0.00
DTE_PRODUCTION	T_835_CK_EFT_TRCNO	DATE	0.00	0.00
DTE_PROV_AFFIL_GRP_EFF	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	8.00	0.00
DTE_PROV_AFFIL_GRP_END	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	8.00	0.00
DTE_PROV_AFFIL_PGM_EFF	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	8.00	0.00
DTE_PROV_AFFIL_PGM_END	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	8.00	0.00
DTE_PROV_ATTRIBS_EFF	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	8.00	0.00
DTE_PROV_ATTRIBS_END	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	8.00	0.00
DTE_PROV_ENUMERATION	T_PR_NAM_NPPES	DATE	0.00	0.00
DTE_PROV_ENUMERATION	T_PR_NAM_NPPES	NUMBER	8.00	0.00
DTE_PROV_ID_EFF	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	8.00	0.00
DTE_PROV_ID_END	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	8.00	0.00
DTE_PROV_LICENSE_EFF	T_TMSIS_PRV004_LICENSE_INF	NUMBER	8.00	0.00
DTE_PROV_LICENSE_END	T_TMSIS_PRV004_LICENSE_INF	NUMBER	8.00	0.00
DTE_PROV_LOC_EFF	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	8.00	0.00
DTE_PROV_LOC_END	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	8.00	0.00
DTE_PROV_MBR_ADD	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_PROV_MBR_ADD	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00

DTE_PROV_MDCD_EFF	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	8.00	0.00
DTE_PROV_MDCD_END	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	8.00	0.00
DTE_PROV_TAXNMY_CLASS_EFF	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	8.00	0.00
DTE_PROV_TAXNMY_CLASS_END	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	8.00	0.00
DTE_PR_ID_EFF	T_PR_IDENTIFIER	NUMBER	8.00	0.00
DTE_PR_ID_END	T_PR_IDENTIFIER	NUMBER	8.00	0.00
DTE_PS2_TXN	T_RE_PS2_DUPE	NUMBER	8.00	0.00
DTE_PTA_END	T_RE_EDB	DATE	0.00	0.00
DTE_PTA_START	T_RE_EDB	DATE	0.00	0.00
DTE_PTB_END	T_RE_EDB	DATE	0.00	0.00
DTE_PTB_START	T_RE_EDB	DATE	0.00	0.00
DTE_PTN	T_CA_ADJ_XREF	DATE	0.00	0.00
DTE_PTN	T_CA_ANALYSIS	DATE	0.00	0.00
DTE_PTN	T_CA_ATTACH	DATE	0.00	0.00
DTE_PTN	T_CA_ATTACH_DN	DATE	0.00	0.00
DTE_PTN	T_CA_BENEFIT_LIMITS	DATE	0.00	0.00
DTE_PTN	T_CA_COND	DATE	0.00	0.00
DTE_PTN	T_CA_COND_DN	DATE	0.00	0.00
DTE_PTN	T_CA_DENTAL	DATE	0.00	0.00
DTE_PTN	T_CA_DIAG	DATE	0.00	0.00
DTE_PTN	T_CA_DIAG_DN	DATE	0.00	0.00
DTE_PTN	T_CA_DIAG_MAT_CARE	DATE	0.00	0.00
DTE_PTN	T_CA_DRUG	DATE	0.00	0.00
DTE_PTN	T_CA_EPSDT_ABNORMAL	DATE	0.00	0.00
DTE_PTN	T_CA_ERROR	DATE	0.00	0.00
DTE_PTN	T_CA_ERROR_DN	DATE	0.00	0.00
DTE_PTN	T_CA_FIN	DATE	0.00	0.00
DTE_PTN	T_CA_HDR_DTL	DATE	0.00	0.00
DTE_PTN	T_CA_HDR_DTL_DN	DATE	0.00	0.00
DTE_PTN	T_CA_ICD9_PROC	DATE	0.00	0.00
DTE_PTN	T_CA_ICD9_PROC_DN	DATE	0.00	0.00
DTE_PTN	T_CA_IND_AGGR	DATE	0.00	0.00
DTE_PTN	T_CA_LTC	DATE	0.00	0.00
DTE_PTN	T_CA_MATERNITY_CARE	DATE	0.00	0.00
DTE_PTN	T_CA_MCO_XREF	DATE	0.00	0.00
DTE_PTN	T_CA_OCCUR	DATE	0.00	0.00
DTE_PTN	T_CA_OCCUR_DN	DATE	0.00	0.00
DTE_PTN	T_CA_PHYS	DATE	0.00	0.00
DTE_PTN	T_CA_RCO	DATE	0.00	0.00

DTE_PTN	T_CA_RECIP_HIST	DATE	0.00	0.00
DTE_PTN	T_CA_TCN	DATE	0.00	0.00
DTE_PTN	T_CA_TPL_SUMMARY	DATE	0.00	0.00
DTE_PTN	T_CA_UB92	DATE	0.00	0.00
DTE_PTN	T_CA_VALUE	DATE	0.00	0.00
DTE_PTN	T_CA_VALUE_DN	DATE	0.00	0.00
DTE_PTN	T_CA_XOVER	DATE	0.00	0.00
DTE_PTN	T_DS_HM_DETAIL	DATE	0.00	0.00
DTE_PTN	T_DS_HM_HEADER	DATE	0.00	0.00
DTE_PTN	T_MR_COPAY_DTL	DATE	0.00	0.00
DTE_PTN	T_MR_ERROR_COUNTS	DATE	0.00	0.00
DTE_PURGE	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_PURGE	T_DOWNLOAD	DATE	0.00	0.00
DTE_P_ALERT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_QTR	T_CA_TIME_KEY	NUMBER	6.00	0.00
DTE_QTR	T_DR_CMS_TAPE	NUMBER	5.00	0.00
DTE_QTR	T_PF_INPAT_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_INPAT_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_NHOME_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_NHOME_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_OUTPAT_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_OUTPAT_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PHARM_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PHARM_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PROF_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PROF_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PRREF_RE_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_PRREF_RP_TOT_Q	NUMBER	5.00	0.00
DTE_QTR	T_PF_RE_CMPR_Q	NUMBER	5.00	0.00
DTE_QTR_PAID	T_CA_DRUG_REBATE	NUMBER	6.00	0.00
DTE_QTR_REBATE	T_CA_DRUG_REBATE	NUMBER	6.00	0.00
DTE_QUARTER	T_DR_4002_RCPTS	NUMBER	5.00	0.00
DTE_QUARTER	T_DR_CLMS_XREF	NUMBER	5.00	0.00
DTE_QUARTER	T_DR_DISPUTE_RESO	NUMBER	9.00	0.00
DTE_QUARTER	T_DR_DRUGS_INV	NUMBER	9.00	0.00

DTE_QUARTER	T_DR_INVOICE	NUMBER	5.00	0.00
DTE_QUARTER	T_DR_LATE_NOTICE	NUMBER	9.00	0.00
DTE_QUARTER	T_DR_MAIL_DATE	NUMBER	9.00	0.00
DTE_QUARTER	T_DR_RATE	NUMBER	5.00	0.00
DTE_QUARTER	T_DR_RATE_UROA	NUMBER	5.00	0.00
DTE_QUARTER	T_DR_TMP_SUPP_RATES	CHAR	5.00	0.00
DTE_QUARTER	T_NDC_LOOKUP_STATS	NUMBER	5.00	0.00
DTE_QUARTER	T_PHS_CLAIM	NUMBER	9.00	0.00
DTE_QUARTER	T_PHS_CLAIM	NUMBER	9.00	0.00
DTE_QUARTER_REPORTED	T_DR_TMP_SUPP_RATES	CHAR	5.00	0.00
DTE_QUESTIONNRE	T_SUSPECT_RES	NUMBER	8.00	0.00
DTE_RACE_DECLARE_EFF	T_TMSIS_ELG016_RACE_INFO	NUMBER	8.00	0.00
DTE_RACE_DECLARE_END	T_TMSIS_ELG016_RACE_INFO	NUMBER	8.00	0.00
DTE_RCO_AVAIL	T_RE_LTC_RCO_AVAILABLE	DATE	0.00	0.00
DTE_RCO_AVAIL	T_RE_LTC_RCO_AVAILABLE	NUMBER	8.00	0.00
DTE_RCVD	T_DS_RECIP_SOBRA_APPL	DATE	0.00	0.00
DTE_RECEIPT	T_CASH_RECEIPT	DATE	0.00	0.00
DTE_RECEIPT	T_CASH_RECEIPT	NUMBER	8.00	0.00
DTE_RECEIVED	T_CT_REFERRALS	DATE	0.00	0.00
DTE_RECEIVED	T_DR_DISPUTE	DATE	0.00	0.00
DTE_RECEIVED	T_DR_DISPUTE	NUMBER	8.00	0.00
DTE_RECEIVED	T_DR_PPA_INV_DTL	DATE	0.00	0.00
DTE_RECEIVED	T_DR_PPA_INV_DTL	NUMBER	8.00	0.00
DTE_RECEIVED	T_PA_DDSD_UPD_DTL	CHAR	8.00	0.00
DTE_RECEIVED	T_PA_DDSD_UPD_HDR	CHAR	8.00	0.00
DTE_RECEIVED	T_PA_HCBW_UPD_DTL	CHAR	8.00	0.00
DTE_RECEIVED	T_PA_HCBW_UPD_HDR	CHAR	8.00	0.00
DTE_RECEIVED	T_PA_LTCA_UPD_DTL	CHAR	8.00	0.00

DTE_RECEIVED	T_PA_LTCA_UPD_HDR	CHAR	8.00	0.00
DTE_RECEIVED	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_RECEIVED	T_PA_PC_UPD_HDR	CHAR	8.00	0.00
DTE_RECEIVED	T_PR_APPLN	DATE	0.00	0.00
DTE_RECEIVED	T_PR_APPLN	NUMBER	8.00	0.00
DTE_RECEIVED	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_RECEIVED	T_RE_AR_TRANSACTION	DATE	0.00	0.00
DTE_RECEIVED	T_RE_AR_TRANSACTION	NUMBER	8.00	0.00
DTE_RECEIVED_FROM	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_RECEIVED_FROM	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_RECEIVED_THRU	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_RECEIVED_THRU	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_RECIP_MOD_MMIS	T_CA_RECIP_HIST	DATE	0.00	0.00
DTE_RECIP_REVIEW	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RECIP_REVIEW	T_CT_LOCKIN	DATE	0.00	0.00
DTE_RECON1_REQ	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RECON1_RESP	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RECON2_REQ	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RECON2_RESP	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RECOUP	T_CT_CASE_RECOUP	DATE	0.00	0.00
DTE_RECOUPED	T_CT_AR_TRACKING	DATE	0.00	0.00
DTE_RECOUPED	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REC_ADDED	T_RE_EDB_GHO	DATE	0.00	0.00
DTE_REC_ADDED	T_RE_EDB_GHO	NUMBER	8.00	0.00
DTE_REC_UPDATED	T_RE_EDB_GHO	DATE	0.00	0.00
DTE_REC_UPDATED	T_RE_EDB_GHO	NUMBER	8.00	0.00
DTE_REDETERMINATION	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_REDET_ACTUAL	T_RE_REDETERM_DTE	DATE	0.00	0.00
DTE_REDET_ACTUAL	T_RE_REDETERM_DTE	NUMBER	8.00	0.00
DTE_REDET_PLAN	T_RE_REDETERM_DTE	DATE	0.00	0.00
DTE_REDET_PLAN	T_RE_REDETERM_DTE	NUMBER	8.00	0.00

DTE_REENROLL_COMPLETE	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_REENROLL_COMPLETE	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_REFERRAL1	T_CT_REFERRALS	DATE	0.00	0.00
DTE_REFERRAL2	T_CT_REFERRALS	DATE	0.00	0.00
DTE_REFER_USER_DLC	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_REFER_USER_DLC	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_REFUND_DUE1	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REFUND_DUE2	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REFUND_DUE3	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REFUND_REC	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REF_EMAIL_SENT	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_REF_SUP	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REGISTERED	T_RE_AR_OVERPAYMENT	DATE	0.00	0.00
DTE_REGISTERED	T_RE_AR_OVERPAYMENT	NUMBER	8.00	0.00
DTE_REINSTATEMENT	T_PR_SANCTION_AL	NUMBER	8.00	0.00
DTE_REINSTATEMENT	T_PR_SANCTION_WI	NUMBER	8.00	0.00
DTE_RELEASE	T_FIN_EFT_RELEASE	NUMBER	8.00	0.00
DTE_RELEASE	T_FIN_PAY_RELEASE	NUMBER	8.00	0.00
DTE_RELEASE_835	T_FIN_835_TRACK	NUMBER	8.00	0.00
DTE_RELEASE_EFT	T_FIN_835_TRACK	NUMBER	8.00	0.00
DTE_REPLY	T_BUYA_BILL	DATE	0.00	0.00
DTE_REPLY	T_BUYA_BILL	NUMBER	8.00	0.00
DTE_REPLY	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_REPLY	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_REPLY	T_BUYB_BILL	DATE	0.00	0.00
DTE_REPLY	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_REPLY	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_REPLY	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_REPLY	T_LOCATION_NOTE	NUMBER	8.00	0.00
DTE_REPORTED	T_CHECK_STATUS_HIST	NUMBER	8.00	0.00
DTE_REPORTED	T_CLM_ARRA_STATS	NUMBER	8.00	0.00
DTE_REQUEST	T_ADJ_MASS_RQST	NUMBER	8.00	0.00
DTE_REQUEST	T_BATCH_LETTERS	NUMBER	8.00	0.00
DTE_REQUEST	T_CHK_REISSUE_XREF	DATE	0.00	0.00
DTE_REQUEST	T_CHK_REISSUE_XREF	NUMBER	8.00	0.00
DTE_REQUEST	T_CLM_RECIP_RQST	NUMBER	8.00	0.00

DTE_REQUEST	T_LETTER_REQUEST	DATE	0.00	0.00
DTE_REQUEST	T_LG_LETTER_REQUEST	NUMBER	8.00	0.00
DTE_REQUEST	T_PROJ_TRACK	NUMBER	8.00	0.00
DTE_REQUEST	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_REQUEST	T_RE_CLM_DELINK	DATE	0.00	0.00
DTE_REQUEST	T_RE_CLM_DELINK	NUMBER	8.00	0.00
DTE_REQUEST_RCVD	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_REQUEST_RCVD	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_RESIDENCE_CHG	T_RE_EDB	DATE	0.00	0.00
DTE_RESO_DUE	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_RESPONSE	T_DR_RECOUP_LTR_DATES	NUMBER	8.00	0.00
DTE_RESPONSE1	T_CT_REFERRALS	DATE	0.00	0.00
DTE_RESPONSE2	T_CT_REFERRALS	DATE	0.00	0.00
DTE_RESP_LTR_RECVD	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RESP_RCVD	T_PR_ENROLL_INFO	DATE	0.00	0.00
DTE_RESP_RCVD	T_PR_ENROLL_INFO	NUMBER	8.00	0.00
DTE_RESP_RECVD_CEO	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RESP_RECVD_MAC	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RESP_RECVD_RC1	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RESP_RECVD_RC2	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RESUB	T_CLM_RESUB_XREF	NUMBER	8.00	0.00
DTE_RETURN	T_PBM_PHARM_EXTRACT	NUMBER	8.00	0.00
DTE_RETURN	T_RE_HOSPICE_DTL	NUMBER	8.00	0.00
DTE_RETURNED	T_TPL_LTR_RESP_XREF	NUMBER	9.00	0.00
DTE_REVIEW	T_HIPP_RESOURCE	DATE	0.00	0.00
DTE_REVIEW	T_HIPP_RESOURCE	NUMBER	8.00	0.00
DTE_REVIEW	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_REVIEW	T_RE_LOCKIN_PERIOD	DATE	0.00	0.00
DTE_REVIEW_PER_BEGIN	T_ACCT_REC	NUMBER	8.00	0.00
DTE_REVIEW_PER_BEGIN	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_REVIEW_PER_BEGIN	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_REVIEW_PER_END	T_ACCT_REC	NUMBER	8.00	0.00

DTE_REVIEW_PER_END	T_ACCT_REC_DN	DATE	0.00	0.00
DTE_REVIEW_PER_END	T_FIN_PROCESS_AR	NUMBER	8.00	0.00
DTE_REVIEW_PREV	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_REVIEW_PREV	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_REVIEW_PREV	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_REVOKE	T_RE_HOSPICE_DTL	NUMBER	8.00	0.00
DTE_REVW	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_REV_CLOSED	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_REV_CLOSED	T_CASUALTY_CASE	NUMBER	8.00	0.00
DTE_REV_CLOSED	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_REV_FROM	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_REV_THRU	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_RE_MAILED	T_TPL_CHECK_HOLD	NUMBER	8.00	0.00
DTE_RLOC_EFF	T_RE_BASE_DN	DATE	0.00	0.00
DTE_RLOC_END	T_RE_BASE_DN	DATE	0.00	0.00
DTE_RPT_FROM_DTE	T_MR_RPT_PRD	NUMBER	9.00	0.00
DTE_RPT_MTH	T_MR_RPT_PRD	NUMBER	4.00	0.00
DTE_RPT_PRD	T_MR_BUYIN_PREM	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_ERROR	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_ERROR_DTL	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_ERROR_KY	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_LTC	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_LTC_REV	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_OP_PERFORM	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_OP_PERFORM_DTL	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_POS	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_POS_RE	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_DENIED	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_PERFORM	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_PERFORM_DTL	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_PERFORM_KY	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_RE	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_PROV_SUSP	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RE	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RECIP	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RECIP_KY	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RECIP_RANK	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RE_CNTY	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RE_KY	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_RPT_PRD	DATE	0.00	0.00
DTE_RPT_PRD	T_MR_XOVER	DATE	0.00	0.00

DTE_RPT_PRD_END	T_MR_WVR_CLM	DATE	0.00	0.00
DTE_RPT_PRD_END	T_MR_WVR_ELG	DATE	0.00	0.00
DTE_RPT_TO_DTE	T_MR_RPT_PRD	NUMBER	9.00	0.00
DTE_RPT_YR	T_MR_RPT_PRD	NUMBER	4.00	0.00
DTE_RQST	T_FIN_AR_RQST_REPORT	NUMBER	8.00	0.00
DTE_RS_ENTERED_USA	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_RTP	T_PR_APPLN	DATE	0.00	0.00
DTE_RTP	T_PR_APPLN	NUMBER	8.00	0.00
DTE_RTP	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_RTP_REC	T_PR_APPLN	DATE	0.00	0.00
DTE_RTP_REC	T_PR_APPLN	NUMBER	8.00	0.00
DTE_RTP_REC	T_PR_APPLN_WI	NUMBER	8.00	0.00
DTE_RULE_ENDED	T_RU_RULE_HISTORY	DATE	0.00	0.00
DTE_RUN	T_AUTO_PA_SUMMARY	NUMBER	8.00	0.00
DTE_RUN	T_CLM_HIST_BALANCE	NUMBER	8.00	0.00
DTE_RUN	T_FIN_CYCLE_HIST	NUMBER	8.00	0.00
DTE_RUN	T_PR_INTERFACE_STATS	NUMBER	8.00	0.00
DTE_RUN	T_TPL_INS_DISC_STATS	NUMBER	8.00	0.00
DTE_RUN_ACTIVE	T_EOB_CARC_RARC_XREF	DATE	0.00	0.00
DTE_RUN_ACTIVE	T_EOB_CARC_RARC_XREF	NUMBER	8.00	0.00
DTE_RUN_INACTIVE	T_EOB_CARC_RARC_XREF	DATE	0.00	0.00
DTE_RUN_INACTIVE	T_EOB_CARC_RARC_XREF	NUMBER	8.00	0.00
DTE_RUN_QTR	T_DS_DNTL_ICN	CHAR	5.00	0.00
DTE_RUN_QTR	T_DS_DNTL_PR_ENROLL	CHAR	5.00	0.00
DTE_RUN_QTR	T_DS_DNTL_PR_GRP_SUM	CHAR	5.00	0.00
DTE_RUN_QTR	T_DS_DNTL_PR_RE_SUM	CHAR	5.00	0.00
DTE_RUN_QTR	T_DS_DNTL_PR_SUM	CHAR	5.00	0.00
DTE_RUN_QTR	T_DS_DNTL_RECIP	CHAR	5.00	0.00
DTE_RUN_SCHED	T_FIN_CHECKWRITE	DATE	0.00	0.00
DTE_RUN_SCHED	T_FIN_CHECKWRITE	NUMBER	8.00	0.00

DTE_RVW_MI_REFER	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_RVW_MR_REFER	T_PS_RESIDENT_RVW	NUMBER	8.00	0.00
DTE_SANCTION	T_PR_SANCTION_AL	NUMBER	8.00	0.00
DTE_SANCTION	T_PR_SANCTION_WI	NUMBER	8.00	0.00
DTE_SANC_PROV_DOB	T_PR_SANCTION_AL	NUMBER	8.00	0.00
DTE_SANC_PROV_DOB	T_PR_SANCTION_WI	NUMBER	8.00	0.00
DTE_SCANNED	T_CLM_PHRM_	NUMBER	8.00	0.00
DTE_SCANNED	T_CLM_PHRM_PAPER_IMG	NUMBER	8.00	0.00
DTE_SCRIPTS_ORIG	T_RE_ASSIGNMENT	NUMBER	8.00	0.00
DTE_SDH_INSPECT	T_PR_LOC_RATE	NUMBER	8.00	0.00
DTE_SDH_INSPECT	T_PR_LOC_RATE_WI	NUMBER	8.00	0.00
DTE_SECOND_REBILL	T_TPL_AR_HEALTH	DATE	0.00	0.00
DTE_SECOND_REBILL	T_TPL_AR_HEALTH	NUMBER	8.00	0.00
DTE_SEG_ADDED	T_DRUG_AWP	DATE	0.00	0.00
DTE_SEG_ADDED	T_DRUG_AWP	NUMBER	8.00	0.00
DTE_SEG_ADDED	T_DRUG_MAC	DATE	0.00	0.00
DTE_SEG_ADDED	T_DRUG_MAC	NUMBER	8.00	0.00
DTE_SEG_ADDED	T_NDDF_PRICE	DATE	0.00	0.00
DTE_SEG_ADDED	T_NDDF_PRICE	NUMBER	8.00	0.00
DTE_SENT	T_DR_DISPUTE	DATE	0.00	0.00
DTE_SENT	T_DR_DISPUTE	NUMBER	8.00	0.00
DTE_SENT	T_DR_LATE_NOTICE	DATE	0.00	0.00
DTE_SENT	T_DR_LATE_NOTICE	NUMBER	8.00	0.00
DTE_SENT	T_DR_MAIL_DATE	DATE	0.00	0.00
DTE_SENT	T_DR_MAIL_DATE	NUMBER	8.00	0.00
DTE_SENT	T_DR_RECOUP_LTR_DATES	NUMBER	8.00	0.00
DTE_SENT	T_LG_LETTER_REQUEST	NUMBER	14.00	0.00
DTE_SENT	T_LOCATION_NOTE	NUMBER	8.00	0.00
DTE_SENT	T_LTR_RQST_TRK	DATE	0.00	0.00
DTE_SENT	T_PA_EXT_TEXT	NUMBER	8.00	0.00

DTE_SENT	T_PA_IAC_XREF	DATE	0.00	0.00
DTE_SENT	T_PA_IAC_XREF	NUMBER	8.00	0.00
DTE_SENT	T_PA_INT_TEXT	NUMBER	8.00	0.00
DTE_SENT	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_SENT	T_RE_CMS_MMA_ENROLL	DATE	0.00	0.00
DTE_SENT	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
DTE_SENT	T_RE_ID_LETTER	NUMBER	8.00	0.00
DTE_SENT	T_TPL_LTR_RESP_XREF	NUMBER	9.00	0.00
DTE_SENT_CR_ADJ	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SERVICE	T_ADJMS_DATES	NUMBER	8.00	0.00
DTE_SERVICE	T_AR_CLM_DTL	DATE	0.00	0.00
DTE_SERVICE	T_CPAS_DATE_SERV	NUMBER	8.00	0.00
DTE_SERVICE	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_SERVICE	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_SERVICE	T_SUR_RQST_DATES	NUMBER	8.00	0.00
DTE_SERVICE_ADJUD	T_CLM_OTH_PYR_DTL	DATE	0.00	0.00
DTE_SERVICE_BEGIN	T_TMSIS_CIP003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_BEGIN	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_SERVICE_BEGIN	T_TMSIS_CLT003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_BEGIN	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_SERVICE_BEGIN	T_TMSIS_COT003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_END	T_TMSIS_CIP003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_END	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_SERVICE_END	T_TMSIS_CLT003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_END	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_SERVICE_END	T_TMSIS_COT003_CLM_DTL	NUMBER	8.00	0.00
DTE_SERVICE_TO	T_ADJMS_DATES	NUMBER	8.00	0.00
DTE_SERVICE_TO	T_CPAS_DATE_SERV	NUMBER	8.00	0.00

DTE_SERVICE_TO	T_PAYMENT_HOLD	DATE	0.00	0.00
DTE_SERVICE_TO	T_PAYMENT_HOLD	NUMBER	8.00	0.00
DTE_SERVICE_TO	T_SUR_RQST_DATES	NUMBER	8.00	0.00
DTE_SETTLEMENT	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_SETTLEMENT	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_SETTLEMENT	T_CASUALTY_REC	DATE	0.00	0.00
DTE_SETTLEMENT	T_CASUALTY_REC	NUMBER	8.00	0.00
DTE_SETTLEMENT	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SFY	T_CA_TIME_KEY	NUMBER	4.00	0.00
DTE_SFY_END	T_TPL_COST_AVOID_SUMM	NUMBER	8.00	0.00
DTE_SHORT_FROM	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_SHORT_TO	T_PS_REFERRAL	NUMBER	8.00	0.00
DTE_SIGN	T_RE_CONSENT_FORM_ACTIVITY	NUMBER	8.00	0.00
DTE_SIGN	T_RE_CONSENT_FORM_MASTER	DATE	0.00	0.00
DTE_SIGN	T_RE_CONSENT_FORM_MASTER	NUMBER	8.00	0.00
DTE_SMI_ENTITLE	T_RE_BNDX_BUYIN	NUMBER	6.00	0.00
DTE_SMI_ENTL_DD	T_RE_BNDX_BUYIN	NUMBER	8.00	0.00
DTE_SMI_TERM	T_RE_BNDX_BUYIN	NUMBER	6.00	0.00
DTE_SMI_TERM_DD	T_RE_BNDX_BUYIN	NUMBER	8.00	0.00
DTE_SOBRA_APPL_ACCEPTED	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_SOBRA_APPL_STATUS	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_SOBRA_REVIEW	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_SOBRA_RVW	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_SSI_BEGIN	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_SSI_RCVD	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_SSI_RVW	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_START	T_DRUG_EXCEPTION_AL	NUMBER	8.00	0.00
DTE_START	T_DS_LVX_MSG_LOG	DATE	0.00	0.00
DTE_START	T_MB_PARMS	DATE	0.00	0.00
DTE_START	T_PLOG_ESTIMATE	NUMBER	8.00	0.00

DTE_START	T_RE_EDB_GHO	DATE	0.00	0.00
DTE_START	T_RE_EDB_GHO	NUMBER	8.00	0.00
DTE_START	T_RE_EDB_HOSPICE	DATE	0.00	0.00
DTE_START	T_RE_EDB_HOSPICE	NUMBER	8.00	0.00
DTE_START	T_SW_RTI_LOG	DATE	0.00	0.00
DTE_START_CONDITION	T_MPHX_DSE_PROF	NUMBER	8.00	0.00
DTE_START_DISEASE	T_MPHX_DSE_PROF	NUMBER	8.00	0.00
DTE_START_E1	T_MB_PARMS	DATE	0.00	0.00
DTE_START_E2	T_MB_PARMS	DATE	0.00	0.00
DTE_START_E3	T_MB_PARMS	DATE	0.00	0.00
DTE_START_ENROLL	T_TPL_EMPLOYER	DATE	0.00	0.00
DTE_START_ENROLL	T_TPL_EMPLOYER	NUMBER	8.00	0.00
DTE_START_OFFLINE_CLM	T_CASUALTY_CASE_OFFLINE	NUMBER	8.00	0.00
DTE_START_PLAN	T_EMP_CARR_XREF	DATE	0.00	0.00
DTE_START_PLAN	T_EMP_CARR_XREF	NUMBER	8.00	0.00
DTE_START_XFER	T_MC_PMP_ENRL_RGN	DATE	0.00	0.00
DTE_START_XFER	T_MC_PMP_ENRL_RGN	NUMBER	8.00	0.00
DTE_START_XFER	T_MC_PMP_ENRL_RGN_AL	NUMBER	8.00	0.00
DTE_START_Y1	T_MB_PARMS	DATE	0.00	0.00
DTE_START_Y2	T_MB_PARMS	DATE	0.00	0.00
DTE_START_Y3	T_MB_PARMS	DATE	0.00	0.00
DTE_START_Y4	T_MB_PARMS	DATE	0.00	0.00
DTE_STATE_PLAN_OPTION_EFF	T_TMSIS_ELG011_STATE_PLAN	NUMBER	8.00	0.00
DTE_STATE_PLAN_OPTION_END	T_TMSIS_ELG011_STATE_PLAN	NUMBER	8.00	0.00
DTE_STATUS	T_CAPITATION_ADJ	NUMBER	8.00	0.00
DTE_STATUS	T_CAPITATION_ADJ_DN	DATE	0.00	0.00
DTE_STATUS	T_CAPITATION_ADJ_WI	NUMBER	8.00	0.00
DTE_STATUS	T_CAP_MASS_ADJ_RST	DATE	0.00	0.00
DTE_STATUS	T_CAP_MASS_ADJ_RST	NUMBER	8.00	0.00
DTE_STATUS	T_CAP_MASS_ADJ_RST_tmp	NUMBER	8.00	0.00
DTE_STATUS	T_CHECK_STATUS_HIST	NUMBER	8.00	0.00
DTE_STATUS	T_CHK_STALE_DATE	NUMBER	8.00	0.00
DTE_STATUS	T_PROJ_STATUS	NUMBER	8.00	0.00
DTE_STATUS	T_PR_APPLN_STATUS	NUMBER	8.00	0.00

DTE_STATUS	T_PR_ENRL	NUMBER	8.00	0.00
DTE_STATUS_CHG	T_DS_RECIP_SOBRA_FAMILY	DATE	0.00	0.00
DTE_STATUS_CHG	T_RE_CARE_MNGR	DATE	0.00	0.00
DTE_STATUS_CHG	T_RE_CARE_MNGR	NUMBER	8.00	0.00
DTE_STATUS_CHG	T_RE_MARITAL	NUMBER	8.00	0.00
DTE_STATUS_CHG_EXT	T_CHECK_STATUS_HIST	NUMBER	8.00	0.00
DTE_STATUS_EFF	T_RE_MC_RECIP_WI	NUMBER	8.00	0.00
DTE_STATUS_EFFECTIVE_DATE	T_TP	DATE	0.00	0.00
DTE_STAT_UPDATED	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_STAT_UPDT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_STOP	T_BUYA_BILL	DATE	0.00	0.00
DTE_STOP	T_BUYA_BILL	NUMBER	8.00	0.00
DTE_STOP	T_BUYA_EXCEPT	DATE	0.00	0.00
DTE_STOP	T_BUYA_EXCEPT	NUMBER	8.00	0.00
DTE_STOP	T_BUYA_MISMATCH	DATE	0.00	0.00
DTE_STOP	T_BUYA_MISMATCH	NUMBER	8.00	0.00
DTE_STOP	T_BUYB_BILL	DATE	0.00	0.00
DTE_STOP	T_BUYB_BILL	NUMBER	8.00	0.00
DTE_STOP	T_BUYB_EXCEPT	DATE	0.00	0.00
DTE_STOP	T_BUYB_EXCEPT	NUMBER	8.00	0.00
DTE_STOP	T_BUYB_MISMATCH	DATE	0.00	0.00
DTE_STOP	T_BUYB_MISMATCH	NUMBER	8.00	0.00
DTE_SUBMISSION	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_SUBMISSION	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_SUBMISSION	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_SUBMISSION_YM	T_MR_TMSIS_CMS_ERROR_FILES	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP002_CLM_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP003_CLM_DTL	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP_DIAG	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP_HDR_PROC	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP_OCC_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CIP_REM_CDE	NUMBER	6.00	0.00

DTE_SUBMISSION_YM	T_TMSIS_CLT001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CLT002_CLM_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CLT003_CLM_DTL	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CLT_DIAG	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CLT_OCC_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CLT_REM_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CMS_ERROR_FILES	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT002_CLM_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT003_CLM_DTL	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT_DIAG	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT_OCC_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_COT_REM_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CRX001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CRX002_CLM_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CRX003_CLM_DTL	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_CRX_REM_CDE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_EDIT_FAILURES	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_EDIT_STATS	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG003_VAR_DEMO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG004_CONTACT_INF	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	6.00	0.00

DTE_SUBMISSION_YM	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG010_MFP_INFO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG011_STATE_PLAN	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG012_WAIVER_PART	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG015_ETHNICITY	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG016_RACE_INFO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG017_DISAB_INFO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG018_1115A_DEMO	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_EXT_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR002_MAIN	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR004_SVC_AREA	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR005_OPER_AUTH	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR006_POP_ENRLD	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV001_FILE_HDR	NUMBER	6.00	0.00

DTE_SUBMISSION_YM	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV004_LICENSE_INF	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_PRV010_BED_TYPE	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_RUN_STATS	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL001_FILE_HDR	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	6.00	0.00
DTE_SUBMISSION_YM	T_TMSIS_TPL006_CONTACT_INF	NUMBER	6.00	0.00
DTE_SUBMITTED	T_RE_LTC_REQUEST	DATE	0.00	0.00
DTE_SUBSCRIBER_DOB	T_DENTAL_HDR_KEYS	DATE	0.00	0.00
DTE_SUBSCRIBER_DOB	T_PHYS_HDR_KEY	DATE	0.00	0.00
DTE_SUBSCRIBER_DOB	T_UB92_HDR_EXT_KEY	DATE	0.00	0.00
DTE_SUBSIDY	T_RE_CMS_MMA_ENROLL	DATE	0.00	0.00
DTE_SUBSIDY	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
DTE_SUPPRESS_CHECK	T_PR_SVC_LOC	NUMBER	8.00	0.00
DTE_SUPPRESS_CHECK	T_PR_SVC_LOC_AL	NUMBER	8.00	0.00
DTE_SUPPRESS_CHECK	T_PR_SVC_LOC_WI	NUMBER	8.00	0.00
DTE_SUPV_APP_CEO	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SUPV_APP_LTR	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SUPV_APP_MAC	T_CT_CASE_TRACK	DATE	0.00	0.00

DTE_SUPV_APP_RECN1	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SUPV_APP_RECN2	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_SURGERY	T_RE_CONSENT_FORM_ACTIVITY	NUMBER	8.00	0.00
DTE_SURGERY	T_RE_CONSENT_FORM_MASTER	DATE	0.00	0.00
DTE_SURGERY	T_RE_CONSENT_FORM_MASTER	NUMBER	8.00	0.00
DTE_SUSPECT	T_TPL_RESOURCE	DATE	0.00	0.00
DTE_SUSPECT	T_TPL_RESOURCE	NUMBER	8.00	0.00
DTE_SVC	T_LS_PHARMACY_CLAIMS	DATE	0.00	0.00
DTE_SYSTEM	T_PS_LOG_TRACK	NUMBER	8.00	0.00
DTE_SYSTEM_LOG	T_RE_HIST_ERR	DATE	0.00	0.00
DTE_SYSTEM_LOG	T_RE_HIST_LOG	DATE	0.00	0.00
DTE_SYSTEM_LOG	T_RE_PS2_ERR	DATE	0.00	0.00
DTE_SYSTEM_LOG	T_RE_PS2_LOG	DATE	0.00	0.00
DTE_TAPE_PROCESSED	T_LS_MANFAC_INFO	DATE	0.00	0.00
DTE_TERM	T_RE_LOC_DATES	DATE	0.00	0.00
DTE_TERMED	T_MC_PMP_SC	DATE	0.00	0.00
DTE_TERMED	T_MC_PMP_SC	NUMBER	8.00	0.00
DTE_TERMED	T_RE_PMP_ASSIGN	NUMBER	8.00	0.00
DTE_TERMED	T_RE_PMP_ASSIGN_WI	NUMBER	8.00	0.00
DTE_TERM_CMS	T_DR_CMS_TAPE	DATE	0.00	0.00
DTE_TERM_CMS	T_DR_CMS_TAPE	NUMBER	8.00	0.00
DTE_TERM_HCFA	T_DRUG	DATE	0.00	0.00
DTE_TERM_HCFA	T_DRUG	NUMBER	8.00	0.00
DTE_TERM_HCFA	T_DRUG_DN	DATE	0.00	0.00
DTE_TERM_SUSP	T_CT_CONT_TERM	DATE	0.00	0.00

DTE_TERM_SUSP_LTR	T_CT_CONT_TERM	DATE	0.00	0.00
DTE_THIRD_PARTY_COINS	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COINS	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COINS	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COINS	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COPAY	T_TMSIS_CIP002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COPAY	T_TMSIS_CLT002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COPAY	T_TMSIS_COT002_CLM_HDR	NUMBER	8.00	0.00
DTE_THIRD_PARTY_COPAY	T_TMSIS_CRX002_CLM_HDR	NUMBER	8.00	0.00
DTE_TICKLER	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_TICKLER	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_TIME_PERIOD	T_CLM_DTP	DATE	0.00	0.00
DTE_TIME_PRD_END	T_TMSIS_EXT_HDR	NUMBER	8.00	0.00
DTE_TIME_PRD_STRT	T_TMSIS_EXT_HDR	NUMBER	8.00	0.00
DTE_TO	T_PROFILE_INFO_SOLUTIONS	DATE	0.00	0.00
DTE_TO	T_STOP_LOSS_PARMS	DATE	0.00	0.00
DTE_TO	T_STOP_LOSS_PARMS	NUMBER	8.00	0.00
DTE_TO	T_TPL_RQST_RPT_SRCH	NUMBER	8.00	0.00
DTE_TODAY_JULIAN	T_CLM_BATCH_RNG	CHAR	5.00	0.00
DTE_TOT_REVISED_CASE	T_CASUALTY_CASE	DATE	0.00	0.00
DTE_TOT_REVISED_CASE	T_CASUALTY_CASE_AL	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYA_BILL_INFO	DATE	0.00	0.00
DTE_TO_CMS	T_BUYA_BILL_INFO	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYA_EXCEPT	DATE	0.00	0.00
DTE_TO_CMS	T_BUYA_EXCEPT	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYA_PREM	DATE	0.00	0.00
DTE_TO_CMS	T_BUYA_PREM	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYB_BILL_INFO	DATE	0.00	0.00
DTE_TO_CMS	T_BUYB_BILL_INFO	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYB_EXCEPT	DATE	0.00	0.00
DTE_TO_CMS	T_BUYB_EXCEPT	NUMBER	8.00	0.00
DTE_TO_CMS	T_BUYB_PREM	DATE	0.00	0.00
DTE_TO_CMS	T_BUYB_PREM	NUMBER	8.00	0.00
DTE_TO_DATE	T_HIST_DIRECTORY	NUMBER	8.00	0.00
DTE_TO_DOS	T_EXPENDITURE	NUMBER	8.00	0.00
DTE_TO_DOS	T_EXPENDITURE_DN	DATE	0.00	0.00

DTE_TO_DOS	T_EXPENDITURE_SUPP_DTL	NUMBER	8.00	0.00
DTE_TO_HOSP	T_DENY_PHYS_HDR	NUMBER	8.00	0.00
DTE_TO_HOSP	T_PD_PHYS_HDR	NUMBER	8.00	0.00
DTE_TO_HOSP	T_SUSP_PHYS_HDR	NUMBER	8.00	0.00
DTE_TPL_CONTACT_INFO_EFF	T_TMSIS_TPL006_CONTACT_INF	NUMBER	8.00	0.00
DTE_TPL_CONTACT_INFO_END	T_TMSIS_TPL006_CONTACT_INF	NUMBER	8.00	0.00
DTE_TP_PTA_ACTRN_BM	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTA_DELET_BM	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTA_END	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTA_START	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTB_ACTRN_BM	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTB_DELET_BM	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTB_END	T_RE_EDB	DATE	0.00	0.00
DTE_TP_PTB_START	T_RE_EDB	DATE	0.00	0.00
DTE_TRAINING	T_CT_PROD_TRAIN	DATE	0.00	0.00
DTE_TRANSFER	T_CALL_QUESTION	NUMBER	8.00	0.00
DTE_TRANSFER_START	T_RE_MC_RECIP	DATE	0.00	0.00
DTE_TRANSFER_START	T_RE_MC_RECIP	NUMBER	8.00	0.00
DTE_TRANSFER_START	T_RE_MC_RECIP_WI	NUMBER	8.00	0.00
DTE_TXN	T_TXN_BILLING	DATE	0.00	0.00
DTE_TXN_CREATION	T_EDI_INTERCHANGE	DATE	0.00	0.00
DTE_T_ALERT	T_DS_RECIP_CORE	DATE	0.00	0.00
DTE_UPDATE	T_CLM_BATCH_PROCESS	DATE	0.00	0.00
DTE_UPDATE	T_CLM_BATCH_PROCESS_ENC	DATE	0.00	0.00
DTE_UPDATE	T_ENC_BATCH_PROCESS	DATE	0.00	0.00
DTE_UPDATE	T_RE_ASSIGN_REASON	DATE	0.00	0.00
DTE_UPDATE	T_RE_ASSIGN_REASON	NUMBER	8.00	0.00
DTE_UPDATED	T_CA_KICK_PYMT	DATE	0.00	0.00
DTE_UPDATED	T_CLM_KICK_PYMT	NUMBER	8.00	0.00
DTE_UPDATED	T_RE_IDENTIFIER	NUMBER	8.00	0.00
DTE_UPDATE_REC	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_UPDATE_REV	T_PA_PAUTH	NUMBER	8.00	0.00
DTE_UPLOADED	T_RE_1095_ACK	NUMBER	8.00	0.00

DTE_UPLOADED	T_RE_ADPH_1095_ACK	NUMBER	8.00	0.00
DTE_UPLOADED	T_UPLOAD	DATE	0.00	0.00
DTE_US_ENTRY	T_RE_ALIEN	DATE	0.00	0.00
DTE_US_ENTRY	T_RE_ALIEN	NUMBER	8.00	0.00
DTE_VAR_DEMO_EFF	T_TMSIS_ELG003_VAR_DEMO	NUMBER	8.00	0.00
DTE_VAR_DEMO_END	T_TMSIS_ELG003_VAR_DEMO	NUMBER	8.00	0.00
DTE_VERIFICATION	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_VERIFICATION	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_VERIFIED	T_PR_PCP	DATE	0.00	0.00
DTE_VERIFIED	T_PR_PCP	NUMBER	8.00	0.00
DTE_VERIFIED	T_PR_VERIFY	NUMBER	8.00	0.00
DTE_VERIFIED_DEATH	T_RE_BASE_STATE	DATE	0.00	0.00
DTE_VISIT	T_PR_ENROLL_SCRN	DATE	0.00	0.00
DTE_VISIT	T_PR_ENROLL_SCRN	NUMBER	8.00	0.00
DTE_VOID	T_CHECK_VOID	DATE	0.00	0.00
DTE_VOID	T_CHECK_VOID	NUMBER	8.00	0.00
DTE_WAIVER_ENROLL_EFF	T_TMSIS_ELG012_WAIVER_PART	NUMBER	8.00	0.00
DTE_WAIVER_ENROLL_END	T_TMSIS_ELG012_WAIVER_PART	NUMBER	8.00	0.00
DTE_WARNING_LTR	T_CT_CASE_TRACK	DATE	0.00	0.00
DTE_WARNING_LTR	T_CT_LOCKIN	DATE	0.00	0.00
DTE_WEEK	T_CA_TIME_KEY	NUMBER	6.00	0.00
DTE_WEEK_LOG_CREATED	T_SW_PERFORMANCE_DATA	VARCHAR2	23.00	0.00
DTE_WORKER_ACTION	T_DS_RECIP_DO_APPL	DATE	0.00	0.00
DTE_WRITEOFF	T_DR_INV_WRITEOFF	DATE	0.00	0.00
DTE_WRITEOFF	T_DR_INV_WRITEOFF	NUMBER	8.00	0.00
DTE_XFER_BEGIN	T_MC_PMP_MASS_XFER	DATE	0.00	0.00
DTE_XFER_BEGIN	T_MC_PMP_MASS_XFER	NUMBER	8.00	0.00
DTE_YEAR	T_PR_DISPRO_EXPEND	NUMBER	4.00	0.00
DTE_YEAR	T_PR_DISPRO_PAY	NUMBER	4.00	0.00
DTE_YEAR_ADJ	T_1099_ADJUST	NUMBER	4.00	0.00
DTE_YEAR_MTH	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
DTE_YEAR_MTH	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
DTE_YR_END	T_MCARE_DEDUCTIBLE	NUMBER	8.00	0.00
DTE_YR_START	T_MCARE_DEDUCTIBLE	NUMBER	8.00	0.00
DT_CLOSED	T_RISKS	DATE	0.00	0.00

DT_CREATED	T_RISKS	DATE	0.00	0.00
DT_DUE	T_RISK_PLANS	DATE	0.00	0.00
DT_LAST_ASSESSED	T_RISKS	DATE	0.00	0.00
DT_LAST_MOD	T_RISKS	DATE	0.00	0.00
DT_REALIZED	T_RISKS	DATE	0.00	0.00
ECS_COUNT	T_CLAIM_EXTRACT	NUMBER	9.00	0.00
ECS_COUNT	T_CLM_SAMPLE	NUMBER	9.00	0.00
EDIF_ELEDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
EDIF_RELCH	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
EDIF_REPEA	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
EDIF_SEGDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
EDIF_SUBDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
EDI_OUT	T_AGREEMENTS	VARCHAR2	1.00	0.00
EDI_OUT	T_TRADSTAT	VARCHAR2	1.00	0.00
EFF_DATE	T_LS_MANFAC_INFO	DATE	0.00	0.00
EFF_DATE	T_PA_PC_UPD_HDR	CHAR	8.00	0.00
EFT_ISS_DAY	T_FIN_CYCLE	CHAR	1.00	0.00
EFT_ISS_NUM_DAYS	T_FIN_CYCLE	NUMBER	4.00	0.00
EIN	T_TPL_CARRIER	CHAR	9.00	0.00
EIN	T_TPL_CARRIER_AL	CHAR	9.00	0.00
EIN	T_TPL_EMPLOYER	CHAR	9.00	0.00
ELEMENT	T_TRLOG	VARCHAR2	2.00	0.00
ELE_DELIMT	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
ELIG_MONTH	T_ELIGCNT	NUMBER	8.00	0.00
EMAIL_ADDR	T_RTE_RPT_CTL	VARCHAR	40.00	0.00
EMAIL_ADDRESS	T_WEB_USER	VARCHAR2	50.00	0.00
EMPLOYEE_NBR	T_DS_RECIP_SOBRA_EMP	CHAR	2.00	0.00
END_DATE	T_PA_PC_UPD_HDR	CHAR	6.00	0.00
END_DATE	T_PF_PARMS	DATE	0.00	0.00
END_DATE	T_PROFILE_NHRECIPS	DATE	0.00	0.00
END_DATE	T_PROFILE_PARMS	DATE	0.00	0.00
END_DATE	T_WEB_PA_DTL	DATE	0.00	0.00
END_DATE1	T_PF_PARMS	DATE	0.00	0.00
END_DATE2	T_PF_PARMS	DATE	0.00	0.00

END_DOS	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
END_DOS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	8.00	0.00
END_DOS	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
END_QTR	T_DR_UNIT_CONV	NUMBER	5.00	0.00
END_TIME	T_FIN_CYCLE_HIST	DATE	0.00	0.00
ENV	T_RTE_RPT_CTL	CHAR	3.00	0.00
EPISODE_DESC	T_ETG_EPISODE_DESC	VARCHAR2	225.00	0.00
EPISODE_DURATION	T_ETG_EPISODE_DESC	VARCHAR2	20.00	0.00
EPISODE_FINISH	T_ETG_EPISODE_DESC	VARCHAR2	20.00	0.00
EPISODE_NUM	T_ETG_DTL	VARCHAR2	10.00	0.00
EPISODE_NUM	T_ETG_DTL_ENCNTR	VARCHAR2	10.00	0.00

EPISODE_NUM	T_ETG_DTL_FFS	VARCHAR2	10.00	0.00
EPISODE_NUM	T_ETG_DTL_RCO_PAID	VARCHAR2	10.00	0.00
EPISODE_NUMBER	T_ETG_SUMMARY	VARCHAR2	10.00	0.00
EPISODE_NUMBER	T_ETG_SUMMARY_ENCNTR	VARCHAR2	10.00	0.00
EPISODE_NUMBER	T_ETG_SUMMARY_FFS	VARCHAR2	10.00	0.00
EPISODE_NUMBER	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	10.00	0.00
EPISODE_START	T_ETG_EPISODE_DESC	VARCHAR2	20.00	0.00

EPISODE_TYPE	T_ETG_COMPARISON_TOTS	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_COMP_TOTS_ENCNTR	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_COMP_TOTS_FFS	VARCHAR2	2.00	0.00

EPISODE_TYPE	T_ETG_COMP_TOTS_RCO_PAID	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00

EPISODE_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_EPISODE_DESC	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_PROV_TOTS	VARCHAR2	2.00	0.00

EPISODE_TYPE	T_ETG_PROV_TOTS_ENCNTR	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_PROV_TOTS_FFS	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_PROV_TOTS_RCO_PAID	VARCHAR2	2.00	0.00

EPISODE_TYPE	T_ETG_RECIP_TOTS	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_RECIP_TOTS_FFS	VARCHAR2	2.00	0.00

EPISODE_TYPE	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_SUMMARY	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	1.00	0.00

EPISODE_TYPE	T_ETG_SUMMARY_FFS	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	1.00	0.00
EPISODE_TYPE	T_ETG_SUMMARY_TOTS	VARCHAR2	2.00	0.00

EPISODE_TYPE	T_ETG_SUMM_TOTS_ENCNTR	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_SUMM_TOTS_FFS	VARCHAR2	2.00	0.00
EPISODE_TYPE	T_ETG_SUMM_TOTS_RCO_PAID	VARCHAR2	2.00	0.00
EP_EXCP	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00

EP_EXCP	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
EP_EXCP	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
EP_EXCP	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
ERRORS	T_TRLOG	NUMBER	19.00	0.00
ERROR_CODE	T_WEB_CLM_ERROR_CD	CHAR	3.00	0.00
ETGFILL1	T_ETG_SUMMARY	VARCHAR2	21.00	0.00
ETGFILL1	T_ETG_SUMMARY_ENCNTR	VARCHAR2	21.00	0.00
ETGFILL1	T_ETG_SUMMARY_FFS	VARCHAR2	21.00	0.00
ETGFILL1	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	21.00	0.00
ETGFILL2	T_ETG_SUMMARY	VARCHAR2	9.00	0.00
ETGFILL2	T_ETG_SUMMARY_ENCNTR	VARCHAR2	9.00	0.00
ETGFILL2	T_ETG_SUMMARY_FFS	VARCHAR2	9.00	0.00
ETGFILL2	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	9.00	0.00
ETG_DESC	T_ETG_DESC	VARCHAR2	225.00	0.00
ETG_FILL	T_ETG_DTL	VARCHAR2	10.00	0.00
ETG_FILL	T_ETG_DTL_ENCNTR	VARCHAR2	10.00	0.00
ETG_FILL	T_ETG_DTL_FFS	VARCHAR2	10.00	0.00
ETG_FILL	T_ETG_DTL_RCO_PAID	VARCHAR2	10.00	0.00
ETG_FILL2	T_ETG_DTL	VARCHAR2	15.00	0.00
ETG_FILL2	T_ETG_DTL_ENCNTR	VARCHAR2	15.00	0.00
ETG_FILL2	T_ETG_DTL_FFS	VARCHAR2	15.00	0.00
ETG_FILL2	T_ETG_DTL_RCO_PAID	VARCHAR2	15.00	0.00

ETG_NUMBER	T_ETG_COMPARISON_TOTS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_COMP_TOTS_ENCNTR	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_COMP_TOTS_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_COMP_TOTS_RCO_PAID	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_DESC	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_DTL	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_DTL_ENCNTR	VARCHAR2	6.00	0.00

ETG_NUMBER	T_ETG_DTL_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_DTL_RCO_PAID	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_PROV_TOTS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_PROV_TOTS_ENCNTR	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_PROV_TOTS_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_PROV_TOTS_RCO_PAID	VARCHAR2	6.00	0.00

ETG_NUMBER	T_ETG_RECIP_TOTS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_RECIP_TOTS_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMMARY	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMMARY_ENCNTR	VARCHAR2	6.00	0.00

ETG_NUMBER	T_ETG_SUMMARY_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMMARY_TOTS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMM_TOTS_ENCNTR	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMM_TOTS_FFS	VARCHAR2	6.00	0.00
ETG_NUMBER	T_ETG_SUMM_TOTS_RCO_PAID	VARCHAR2	6.00	0.00
ETG_RESERVED	T_ETG_SUMMARY	VARCHAR2	4.00	0.00
ETG_RESERVED	T_ETG_SUMMARY_ENCNTR	VARCHAR2	4.00	0.00
ETG_RESERVED	T_ETG_SUMMARY_FFS	VARCHAR2	4.00	0.00

ETG_RESERVED	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	4.00	0.00
ETG_SUBCLASS	T_ETG_COMPARISON_TOTS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_COMP_TOTS_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_COMP_TOTS_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_COMP_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_DESC	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_DTL	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_DTL_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_DTL_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_DTL_RCO_PAID	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_PROV_TOTS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_PROV_TOTS_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_PROV_TOTS_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_PROV_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_RECIP_TOTS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_RECIP_TOTS_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMMARY	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMMARY_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMMARY_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMMARY_TOTS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMM_TOTS_ENCNTR	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMM_TOTS_FFS	VARCHAR2	3.00	0.00
ETG_SUBCLASS	T_ETG_SUMM_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
ETHNICITY	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
EXP	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
EXPORT_FLG	T_TRADING_PARTNER	VARCHAR2	1.00	0.00
EXP_AMT	T_PF_INPAT_RE_TOT_Q	NUMBER	10.00	2.00
EXP_AMT	T_PF_NHOME_RE_TOT_Q	NUMBER	10.00	2.00

EXP_AMT	T_PF_OUTPAT_RE_TOT_Q	NUMBER	10.00	2.00
EXP_AMT	T_PF_PHARM_RE_TOT_Q	NUMBER	10.00	2.00
EXP_AMT	T_PF_PROF_RE_TOT_Q	NUMBER	10.00	2.00
EXP_AMT	T_PF_PRREF_RE_TOT_Q	NUMBER	10.00	2.00
EXP_AMT	T_PF_RECIP_CMPR	NUMBER	14.00	2.00
EXP_AMT	T_PF_RE_CMPR_Q	NUMBER	14.00	2.00
EXP_AMT	T_PROFILE_INPAT_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_INPAT_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_OUTPAT_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PHARMREF_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PHARM_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PHARM_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PROFREF_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PROFREF_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PROF_AMTS	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_PROF_PROV_TOT	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_SELECTED_CASES	NUMBER	10.00	2.00
EXP_AMT	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
EXP_HI_VALUE	T_PF_EXP_INPAT_VAL_Q	NUMBER	4.00	0.00
EXP_HI_VALUE	T_PF_EXP_NHOME_VAL_Q	NUMBER	4.00	0.00
EXP_HI_VALUE	T_PF_EXP_OUTPAT_VAL_Q	NUMBER	4.00	0.00

EXP_HI_VALUE	T_PF_EXP_PHARM_VAL_Q	NUMBER	4.00	0.00
EXP_HI_VALUE	T_PF_EXP_PROF_VAL_Q	NUMBER	4.00	0.00
EXP_HI_VALUE	T_PF_EXP_RECIP_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_INPAT_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_NHOME_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_OUTPAT_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_PHARM_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_PROF_VAL_Q	NUMBER	4.00	0.00
EXP_LOW_VALUE	T_PF_EXP_RECIP_VAL_Q	NUMBER	4.00	0.00
EXP_RANK	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
EXTERNAL_PROV_ID	T_PR_ID_XREF	CHAR	20.00	0.00
EXTRA_TEXT	T_DOWNLOAD	VARCHAR2	256.00	0.00
FACILITY_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
FACILITY_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
FACILITY_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
FACILITY_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
FACILITY_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00

FACILITY_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
FACILITY_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
FACILITY_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
FACILITY_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
FACILITY_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
FACILITY_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
FAULT	T_TRANSACTION	XMLTYPE	2,000.00	0.00
FDB_SEVERITY	T_ALERT_DISP	CHAR	1.00	0.00
FEIN	T_WEB_PROV	CHAR	9.00	0.00
FFYQ	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	5.00	0.00
FFYQ	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
FFYQ	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	5.00	0.00
FFYQ	T_MR_MSIS_ELIGIBLE	CHAR	5.00	0.00
FIELDVAL	T_TRLOG	VARCHAR2	30.00	0.00
FIELD_NAME	T_SYSTEM_KEYS	CHAR	30.00	0.00
FIELD_NAME	T_TRLOG	VARCHAR2	15.00	0.00
FILENAME	T_BATCH	VARCHAR2	255.00	0.00

FILENAME	T_DOWNLOAD	VARCHAR2	256.00	0.00
FILENAME	T_FIN_835_TRACK	VARCHAR2	50.00	0.00
FILENAME	T_TRLOG	VARCHAR2	160.00	0.00
FILEOFFSET	T_TRLOG	NUMBER	19.00	0.00
FILE_SIZE	T_UPLOAD	NUMBER	9.00	0.00
FILLER	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	52.00	0.00
FILLER	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	48.00	0.00
FILLER	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	38.00	0.00
FILLER_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
FILLER_2	T_MR_MSIS_ELIGIBLE	CHAR	9.00	0.00
FIRST_DATE_SERVICE	T_ETG_SUMMARY	DATE	0.00	0.00
FIRST_DATE_SERVICE	T_ETG_SUMMARY_ENCNTR	DATE	0.00	0.00
FIRST_DATE_SERVICE	T_ETG_SUMMARY_FFS	DATE	0.00	0.00
FIRST_DATE_SERVICE	T_ETG_SUMMARY_RCO_PAID	DATE	0.00	0.00
FIRST_DAY_MONTH	T_CA_CURRENT_DATES	DATE	0.00	0.00
FIRST_DAY_QTR	T_CA_CURRENT_DATES	DATE	0.00	0.00
FLOW_LEVEL	T_TRLOG	VARCHAR2	5.00	0.00
FOOD_STAMP_CASE_NO	T_DS_RECIP_SOBRA_APPL	CHAR	12.00	0.00
FROM_AGE	T_LS_DRUG_MASTER	CHAR	3.00	0.00
FUND_CODE	T_PA_DDSD_UPD_HDR	CHAR	1.00	0.00
FUND_CODE	T_PA_LTCA_UPD_HDR	CHAR	3.00	0.00
GROUP_NO	T_PA_DDSD_UPD_DTL	CHAR	3.00	0.00
GROUP_NO	T_PA_HCBW_UPD_DTL	CHAR	3.00	0.00
GROUP_NO	T_PA_LTCA_UPD_DTL	CHAR	3.00	0.00
GROUP_NO	T_TRLOG	VARCHAR2	35.00	0.00
GROUP_NUMBER	T_DS_RECIP_SOBRA_APPL	VARCHAR2	15.00	0.00
GRP	T_PROFILE_INPAT_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_INPAT_GRP_DESC	NUMBER	4.00	0.00
GRP	T_PROFILE_INPAT_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_INPAT_ICN_XREF	NUMBER	4.00	0.00

GRP	T_PROFILE_INPAT_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_INPAT_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_MEASURES	NUMBER	4.00	0.00
GRP	T_PROFILE_OUTPAT_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_OUTPAT_GRP_DESC	NUMBER	4.00	0.00
GRP	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_OUTPAT_ICN_XREF	NUMBER	4.00	0.00
GRP	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_OUTPAT_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PEER_PROV_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARMREF_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_PHARMREF_ICN_XREF	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARMREF_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_GRP_DESC	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_PHARM_ICN_XREF	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_MEASURES	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PHARM_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PROFREF_AMTS	NUMBER	4.00	0.00
GRP	T_PROFILE_PROFREF_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_PROFREF_ICN_XREF	NUMBER	4.00	0.00
GRP	T_PROFILE_PROFREF_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PROFREF_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PROF_AMTS	NUMBER	4.00	0.00

GRP	T_PROFILE_PROF_GRP_DESC	NUMBER	4.00	0.00
GRP	T_PROFILE_PROF_GRP_TOT	NUMBER	3.00	0.00
GRP	T_PROFILE_PROF_ICN_XREF	NUMBER	4.00	0.00
GRP	T_PROFILE_PROF_PROV_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PROF_PT_TOT	NUMBER	4.00	0.00
GRP	T_PROFILE_PROV_AVERAGES	NUMBER	4.00	0.00
GRP	T_PROFILE_PROV_NON_REFER	NUMBER	4.00	0.00
GRP	T_PROFILE_RECIP	NUMBER	4.00	0.00
GRP	T_PROFILE_SELECTED_CASES	NUMBER	4.00	0.00
GRP	T_PROFILE_TOT_CMPR	NUMBER	4.00	0.00
GRP_CLASS	T_PROFILE_INPAT_GRP_DESC	CHAR	2.00	0.00
GRP_CLASS	T_PROFILE_OUTPAT_GRP_DESC	CHAR	2.00	0.00
GRP_CLASS	T_PROFILE_PHARM_GRP_DESC	CHAR	2.00	0.00
GRP_CLASS	T_PROFILE_PROF_GRP_DESC	CHAR	2.00	0.00
GRP_DESC	T_PROFILE_INPAT_GRP_DESC	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_MEASURES	VARCHAR2	50.00	0.00
GRP_DESC	T_PROFILE_OUTPAT_GRP_DESC	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_PEER_PROV_AMTS	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_PHARM_GRP_DESC	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_PHARM_MEASURES	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_PROF_GRP_DESC	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_PROV_NON_REFER	VARCHAR2	100.00	0.00
GRP_DESC	T_PROFILE_SELECTED_CASES	VARCHAR2	100.00	0.00
GRP_PAY_RATE	T_CA_UB92	NUMBER	9.00	2.00
GRP_VERSION	T_ETG_DTL	VARCHAR2	1.00	0.00
GRP_VERSION	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
GRP_VERSION	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00

GRP_VERSION	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
GSID	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
GS_NO	T_AGREEMENTS	VARCHAR2	14.00	0.00
GS_NO	T_TRADSTAT	VARCHAR2	14.00	0.00
HAS_READ	T_WEB_MESSAGE_USER	CHAR	1.00	0.00
HCPC_CODE	T_PA_DDSD_UPD_DTL	CHAR	11.00	0.00
HCPC_CODE	T_PA_HCBW_UPD_DTL	CHAR	14.00	0.00
HEDIS_TYPE	T_MB_HEDIS_DRUG	CHAR	4.00	0.00
HIC4	T_HIC4	CHAR	4.00	0.00
HIC4_DSC	T_HIC4	CHAR	50.00	0.00
HIC4_ROOT	T_HIC4	NUMBER	9.00	0.00
HIC4_SEQNO	T_HIC4	NUMBER	9.00	0.00
HIC_NUM	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
HIGH	T_RISK_RANKING	NUMBER	4.00	1.00
HIGH_VARIANCE	T_LS_LVL3_PRICING	NUMBER	7.00	2.00
HIST_IND	T_CC_CR_SAVE	CHAR	1.00	0.00
HIST_IND_REF	T_CC_CR_SAVE	CHAR	1.00	0.00
HL7_ELEDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HL7_RELCH	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HL7_REPEAT	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HL7_SEGDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HL7_SUBDL	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HL7_SUBSUB	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
HOURS	T_AGREEMENTS	VARCHAR2	2.00	0.00
HOURS	T_TRADSTAT	VARCHAR2	2.00	0.00
ICD9_PROC	T_WEB_PA_DTL	CHAR	5.00	0.00
ICD9_THRU_PROC	T_WEB_PA_DTL	CHAR	5.00	0.00
ICF_DAYS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
ICN_ADJ	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	21.00	0.00
ICN_ADJ	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	21.00	0.00
ICN_ADJ	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	21.00	0.00
ICN_ORIG	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	21.00	0.00
ICN_ORIG	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	21.00	0.00

ICN_ORIG	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	21.00	0.00
IDCODE	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
IDENTIFIED_BY	T_RISKS	VARCHAR2	50.00	0.00
IDENTIFIED_BY_EMAIL	T_RISKS	VARCHAR2	100.00	0.00
IDQUAL	T_TRADING_PARTNER	VARCHAR2	4.00	0.00
ID_1000B_PAYEE	T_TPL_835_5010	VARCHAR2	80.00	0.00
ID_2010AC_NM109	T_CLM_DNTL_HDR	VARCHAR2	80.00	0.00
ID_2010AC_NM109	T_CLM_PHYS_HDR	VARCHAR2	80.00	0.00
ID_2010AC_NM109	T_CLM_UB92_HDR	VARCHAR2	80.00	0.00
ID_2010AC_REF02	T_CLM_UB92_HDR	VARCHAR2	50.00	0.00
ID_2010AC_REF02_2ND	T_CLM_DNTL_HDR	VARCHAR2	50.00	0.00
ID_2010AC_REF02_2ND	T_CLM_PHYS_HDR	VARCHAR2	50.00	0.00
ID_2010AC_REF02_TAX	T_CLM_DNTL_HDR	VARCHAR2	50.00	0.00
ID_2010AC_REF02_TAX	T_CLM_PHYS_HDR	VARCHAR2	50.00	0.00
ID_2010AC_REF02_TAX	T_CLM_UB92_HDR	VARCHAR2	50.00	0.00
ID_2100_OTH_SUB_CORR	T_TPL_2100_CLM_PYMT	VARCHAR2	80.00	0.00
ID_2110_SVC_POLICY	T_TPL_2110_SVC_PYMT	VARCHAR2	50.00	0.00
ID_2300_CN104	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
ID_2300_CN106	T_CLM_DNTL_2300	VARCHAR2	30.00	0.00
ID_2300_HCP04	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
ID_2300_REF02_CARE_PLAN	T_CLM_PHYS_2300	VARCHAR2	50.00	0.00
ID_2310E_NM109	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
ID_2310E_REF02_1	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
ID_2310E_REF02_2	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00

ID_2310E_REF02_3	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
ID_2310E_REF02_4	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
ID_2330B_REF02	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330B_REF02	T_CLM_PHYS_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_1	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_1	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_2	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_2	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_3	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_3	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330E_REF02_4	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330F_REF02_1	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330F_REF02_2	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02	T_CLM_PHYS_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_1	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_1	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_2	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_2	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_3	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_3	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330G_REF02_4	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330H_REF02_1	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330H_REF02_2	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00

ID_2330H_REF02_3	T_CLM_DNTL_2320	VARCHAR2	50.00	0.00
ID_2330I_REF02_1	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2330I_REF02_2	T_CLM_UB92_2320	VARCHAR2	50.00	0.00
ID_2400_CN106	T_CLM_DNTL_2400	VARCHAR2	30.00	0.00
ID_2400_HCP04	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2400_HCP10	T_CLM_DNTL_2400	VARCHAR2	48.00	0.00
ID_2400_REF04_2_SVC_PRE_1	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2400_REF04_2_SVC_PRE_2	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2400_REF04_2_SVC_PRE_3	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2400_REF04_2_SVC_PRE_4	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2400_REF04_2_SVC_PRE_5	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
ID_2420B_NM109	T_CLM_UB92_2400	VARCHAR2	80.00	0.00
ID_2420C_NM109	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
ID_2420C_NM109	T_CLM_UB92_2400	VARCHAR2	80.00	0.00
ID_2420D_NM109	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
ID_2420D_NM109	T_CLM_UB92_2400	VARCHAR2	80.00	0.00
ID_ACCT_TEAM	T_ACCOUNT_TEAM	CHAR	8.00	0.00
ID_ADMIN_PREV	T_PA_HDR	VARCHAR2	50.00	0.00
ID_ADMIT_PROV	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
ID_ADMIT_PROV	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
ID_ADMIT_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_ADMIT_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_ADPH_RECIP	T_RE_ADPH_1095	CHAR	20.00	0.00

ID_ADPH_RECIP	T_RE_ADPH_1095_TRACK	CHAR	20.00	0.00
ID_AFFILIATED_PROGRAM	T_TMSIS_PRV009_AFFIL_PGMS	VARCHAR2	50.00	0.00
ID_AID_GROUP	T_AVE_EXP_AC_XREF	CHAR	4.00	0.00
ID_AID_GROUP	T_AVE_EXP_AVGE	CHAR	4.00	0.00
ID_ANALYST	T_CT_ANALYST	CHAR	6.00	0.00
ID_ANALYST	T_CT_CASE_TRACK	CHAR	6.00	0.00
ID_ANALYST	T_CT_SELECT_LST	CHAR	6.00	0.00
ID_ANS_LOGIN	T_PR_ATT_CMS	CHAR	10.00	0.00
ID_AUDIT_CREATE	T_APPLICATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_CONTROL	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_PC_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_PROFILE	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_PW_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_UC_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_UP_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_UW_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_CREATE	T_WINDOW	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_APPLICATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_CONTROL	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_PC_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_PROFILE	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_PW_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_UC_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_UP_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_UW_AUTHORIZATION	CHAR	8.00	0.00
ID_AUDIT_UPDATE	T_WINDOW	CHAR	8.00	0.00
ID_BANK	T_DS_RECIP_DO_BANK	CHAR	5.00	0.00
ID_BATCH	T_FILE_TRACK_EXCEPTION	VARCHAR2	50.00	0.00
ID_BATCH	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	50.00	0.00
ID_BATCH	T_TRACK_NOTIFICATION	VARCHAR2	50.00	0.00
ID_BILL_PROV	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
ID_BILL_PROV	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
ID_BILL_PROV	T_TMSIS_COT002_CLM_HDR	VARCHAR2	30.00	0.00
ID_BILL_PROV	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
ID_BILL_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_BILL_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_BILL_PROV_NPI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00

ID_BILL_PROV_NPI	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	10.00	0.00
ID_CALL	T_PR_ATT_CMS	NUMBER	10.00	0.00
ID_CALLING_PARTY	T_PR_ATT_CMS	CHAR	13.00	0.00
ID_CASE_PIER	T_TPL_HMS_HIPP_XREF	CHAR	8.00	0.00
ID_CASE_WORKER	T_RE_CASE	CHAR	6.00	0.00
ID_CASE_WORKER	T_RE_HIST_ERR	CHAR	6.00	0.00
ID_CASE_WORKER	T_RE_ID_CRD_ISS	CHAR	6.00	0.00
ID_CASE_WORKER	T_RE_PS2_ERR	CHAR	6.00	0.00
ID_CHPID	T_TMSIS_MCR009_CHPID_SHPID	VARCHAR2	10.00	0.00
ID_CHRONIC	T_ETG_SUMMARY	VARCHAR2	3.00	0.00
ID_CHRONIC	T_ETG_SUMMARY_ENCNTR	VARCHAR2	3.00	0.00
ID_CHRONIC	T_ETG_SUMMARY_FFS	VARCHAR2	3.00	0.00
ID_CHRONIC	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	3.00	0.00
ID_CLERK	T_ADJ_DENT_XREF	CHAR	8.00	0.00
ID_CLERK	T_ADJ_MASS_RQST	CHAR	8.00	0.00
ID_CLERK	T_ADJ_PHRM_XREF	CHAR	8.00	0.00
ID_CLERK	T_ADJ_PHYS_XREF	CHAR	8.00	0.00
ID_CLERK	T_ADJ_UB92_XREF	CHAR	8.00	0.00
ID_CLERK	T_ADJ_VOID_RQST	CHAR	8.00	0.00
ID_CLERK	T_ANALYST	CHAR	8.00	0.00

ID_CLERK	T_ANALYST_SKILL	CHAR	8.00	0.00
ID_CLERK	T_AUDIT_LOGON	CHAR	8.00	0.00
ID_CLERK	T_CALL_CLERK_UNIT	CHAR	8.00	0.00
ID_CLERK	T_CALL_NOTES	CHAR	8.00	0.00
ID_CLERK	T_CALL_QUESTION	CHAR	8.00	0.00
ID_CLERK	T_CALL_TRACK	CHAR	8.00	0.00
ID_CLERK	T_CASUALTY_CASE	CHAR	8.00	0.00
ID_CLERK	T_CASUALTY_CASE_AL	CHAR	8.00	0.00
ID_CLERK	T_CA_KICK_PYMT	CHAR	8.00	0.00
ID_CLERK	T_CLAIM_ERROR	CHAR	8.00	0.00
ID_CLERK	T_CLERK_PROFILE	CHAR	8.00	0.00
ID_CLERK	T_CLM_IMAGE_BALANCE	CHAR	8.00	0.00
ID_CLERK	T_CLM_KICK_PYMT	CHAR	8.00	0.00
ID_CLERK	T_CLM_RESUB_XREF	CHAR	8.00	0.00
ID_CLERK	T_CPAS_STRATA	CHAR	8.00	0.00
ID_CLERK	T_CSR_ANALYST	CHAR	8.00	0.00
ID_CLERK	T_DCOR_QLTY_CTL	CHAR	8.00	0.00
ID_CLERK	T_DCOR_SCHEDULE	CHAR	8.00	0.00
ID_CLERK	T_DENY_DNTL_HDR	CHAR	8.00	0.00
ID_CLERK	T_DENY_PHRM_HDR	CHAR	8.00	0.00
ID_CLERK	T_DENY_PHYS_HDR	CHAR	8.00	0.00
ID_CLERK	T_DENY_UB92_HDR	CHAR	8.00	0.00
ID_CLERK	T_DIAG_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_DRG_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_DRUG_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_DR_STATUS	CHAR	8.00	0.00
ID_CLERK	T_ERR_DISP_NOTES	CHAR	8.00	0.00
ID_CLERK	T_ERR_DISP_NOTES	VARCHAR2	20.00	0.00
ID_CLERK	T_EXPENDITURE	CHAR	8.00	0.00
ID_CLERK	T_EXPENDITURE_DN	CHAR	8.00	0.00
ID_CLERK	T_LAST_PASSWORD	CHAR	8.00	0.00
ID_CLERK	T_LETTER_REQUEST	CHAR	8.00	0.00
ID_CLERK	T_LG_HISTORY	CHAR	8.00	0.00
ID_CLERK	T_LG_LETTER_REQUEST	CHAR	8.00	0.00
ID_CLERK	T_LOCATION_NOTE	CHAR	8.00	0.00
ID_CLERK	T_MC_NPI_NOTES	CHAR	8.00	0.00
ID_CLERK	T_MC_PMP_NOTES	CHAR	8.00	0.00

ID_CLERK	T_MC_RE_NOTES	CHAR	8.00	0.00
ID_CLERK	T_MODIFIER_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_PA_INT_TEXT	CHAR	8.00	0.00
ID_CLERK	T_PA_PAUTH	CHAR	8.00	0.00
ID_CLERK	T_PA_RULE_DECISION	CHAR	8.00	0.00
ID_CLERK	T_PD_DNTL_HDR	CHAR	8.00	0.00
ID_CLERK	T_PD_PHARM_HDR	CHAR	8.00	0.00
ID_CLERK	T_PD_PHYS_HDR	CHAR	8.00	0.00
ID_CLERK	T_PD_UB92_HDR	CHAR	8.00	0.00
ID_CLERK	T_PERF_ANALYST	CHAR	8.00	0.00
ID_CLERK	T_PERF_SUMM	CHAR	8.00	0.00
ID_CLERK	T_PROC_ICD9_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_PROC_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_PROJ_STATUS	CHAR	8.00	0.00
ID_CLERK	T_PROJ_TRK_DTL	CHARACTER	8.00	0.00
ID_CLERK	T_PR_APPLN	CHAR	8.00	0.00
ID_CLERK	T_PR_APPLN_WI	CHAR	8.00	0.00
ID_CLERK	T_PR_LABEL_CRIT	CHAR	8.00	0.00
ID_CLERK	T_PR_LOC_RATE_REQ	CHAR	8.00	0.00
ID_CLERK	T_PR_PCP	VARCHAR2	8.00	0.00
ID_CLERK	T_PR_PHONE_TRACK	CHAR	8.00	0.00
ID_CLERK	T_REVENUE_NOTES	VARCHAR2	8.00	0.00
ID_CLERK	T_RE_CLM_DELINK	CHAR	8.00	0.00
ID_CLERK	T_RU_RULE_HISTORY	CHAR	8.00	0.00
ID_CLERK	T_SUR_RQST_EOMB	CHAR	8.00	0.00
ID_CLERK	T_SUSP_ADJ_XREF	CHAR	8.00	0.00
ID_CLERK	T_SUSP_DENTAL_HDR	CHAR	8.00	0.00
ID_CLERK	T_SUSP_PHRM_HDR	CHAR	8.00	0.00
ID_CLERK	T_SUSP_PHYS_HDR	CHAR	8.00	0.00
ID_CLERK	T_SUSP_UB92_HDR	CHAR	8.00	0.00
ID_CLERK	T_TPL_CLERK	CHAR	8.00	0.00
ID_CLERK	T_UC_AUTHORIZATION	CHAR	8.00	0.00

ID_CLERK	T_UP_AUTHORIZATION	CHAR	8.00	0.00
ID_CLERK	T_UW_AUTHORIZATION	CHAR	8.00	0.00
ID_CLERK	T_WEB_USER	CHAR	8.00	0.00
ID_CLERK	T_WINDOW	CHAR	8.00	0.00
ID_CLERK_APPROVED	T_EXPENDITURE	CHAR	8.00	0.00
ID_CLERK_APPROVED	T_EXPENDITURE_DN	CHAR	8.00	0.00
ID_CLERK_ASSGND	T_PROJ_TRACK	CHAR	8.00	0.00
ID_CLERK_DESTIN	T_CALL_OTIFICATION	CHAR	8.00	0.00
ID_CLERK_ENTRY	T_PA_PAUTH	CHAR	8.00	0.00
ID_CLERK_ORIGIN	T_CALL_OTIFICATION	CHAR	8.00	0.00
ID_CLERK_RECVD	T_PROJ_TRACK	CHAR	8.00	0.00
ID_CLERK_RESO	T_CALL_QUESTION	CHAR	8.00	0.00
ID_CLERK_REV	T_PA_PAUTH	CHAR	8.00	0.00
ID_CLERK_TRANSFER	T_CALL_QUESTION	CHAR	8.00	0.00
ID_CMS_ERROR	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	32.00	0.00
ID_CONTRACT	T_RE_PARTD_PDP_CARRIER	CHAR	5.00	0.00
ID_CORRELATION	T_EDIC_CORRELATION	NUMBER	9.00	0.00
ID_CORRELATION	T_EDIC_CORRELATION_ARC	NUMBER	9.00	0.00
ID_CREATE	T_CLM_BATCH_PROCESS	CHAR	8.00	0.00
ID_CREATE	T_CLM_BATCH_PROCESS_ENC	CHAR	8.00	0.00
ID_CREATE	T_ENC_BATCH_PROCESS	CHAR	8.00	0.00
ID_CREATING_ENTITY	T_TMSIS_CIP001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_CLT001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_COT001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_CRX001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_EDIT_FAILURES	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_EDIT_STATS	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_ELG001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_EXT_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_MCR001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_PRV001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CREATING_ENTITY	T_TMSIS_RUN_STATS	VARCHAR2	3.00	0.00

ID_CREATING_ENTITY	T_TMSIS_TPL001_FILE_HDR	VARCHAR2	3.00	0.00
ID_CRITERIA	T_CM_CG_CRIT	NUMBER	4.00	0.00
ID_CRITERIA	T_CM_CT_CRIT	NUMBER	4.00	0.00
ID_CRITERIA	T_CM_PG_CRIT	NUMBER	4.00	0.00
ID_CRITERIA	T_MM_CRIT	NUMBER	4.00	0.00
ID_DIALED_NUM	T_PR_ATT_CMS	CHAR	25.00	0.00
ID_DISPVDN	T_PR_ATT_CMS	CHAR	6.00	0.00
ID_DISP_PROV	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
ID_DISP_PROV_NPI	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	10.00	0.00
ID_DO_WORKER	T_RE_BASE_STATE	CHAR	2.00	0.00
ID_DTL_REF02	T_CLM_DNTL_DTL_REF	VARCHAR2	50.00	0.00
ID_DTL_REF02	T_CLM_PHYS_DTL_REF	VARCHAR2	50.00	0.00
ID_DTL_REF02	T_CLM_UB92_DTL_REF	VARCHAR2	50.00	0.00
ID_DTL_REF04_2	T_CLM_DNTL_DTL_REF	VARCHAR2	50.00	0.00
ID_DTL_REF04_2	T_CLM_PHYS_DTL_REF	VARCHAR2	50.00	0.00
ID_DTL_REF04_2	T_CLM_UB92_DTL_REF	VARCHAR2	50.00	0.00
ID_ELECTRONIC_BILLING	T_TPL_CARRIER	NUMBER	9.00	0.00
ID_ELECTRONIC_BILLING	T_TPL_CARRIER	NUMBER	9.00	0.00
ID_ELECTRONIC_BILLING	T_TPL_CARRIER_AL	NUMBER	9.00	0.00
ID_EMPLOYEE	T_MPHX_MISC	VARCHAR2	11.00	0.00
ID_EMPLOYER	T_DS_RECIP_SOBRA_EMP	CHAR	9.00	0.00
ID_EQLOC	T_PR_ATT_CMS	CHAR	10.00	0.00
ID_FACILITY	T_FACILITY	CHAR	10.00	0.00
ID_FIRST_VDN	T_PR_ATT_CMS	CHAR	6.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_BATCH_MSGBOX	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_BATCH_MSGBOX_ARC	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_PAYLOADTYPES	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_REQUESTS	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_REQUESTS_ARC	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_RESPONSES	NUMBER	4.00	0.00
ID_FK_PAYLOADTYPE	T_EDIC_RESPONSES_ARC	NUMBER	4.00	0.00
ID_GROUP	T_GROUP	CHAR	20.00	0.00
ID_GROUP	T_LG_LETTER_GROUP	CHAR	20.00	0.00
ID_HH_PROV	T_TMSIS_ELG007_HH_SPA_PROV	VARCHAR2	30.00	0.00
ID_HH_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_HH_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_HH_PROV_NPI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_HH_PROV_NPI	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	10.00	0.00
ID_HIC2_ROOT	T_HIC3	NUMBER	6.00	0.00
ID_HIC2_SEQNO	T_HIC3	NUMBER	6.00	0.00

ID_HIC3_ROOT	T_HIC3	NUMBER	6.00	0.00
ID_HIC3_SEQNO	T_HIC3	NUMBER	6.00	0.00
ID_HIC4_ROOT	T_HIC4	NUMBER	6.00	0.00
ID_HIC4_SEQNO	T_HIC4	NUMBER	6.00	0.00
ID_IMAGE	T_CLM_IMAGE_BALANCE	NUMBER	13.00	0.00
ID_IMMUNIZATION	T_RE_EPSDT_IMMUN	NUMBER	9.00	0.00
ID_IMMUNIZATION	T_RE_EPSDT_PR_IM_X	NUMBER	9.00	0.00
ID_INS_CARRIER	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	12.00	0.00
ID_INS_CARRIER	T_TMSIS_TPL004_HLTH_INS_CT	VARCHAR2	12.00	0.00
ID_INS_CARRIER	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	12.00	0.00
ID_INS_PLAN	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	20.00	0.00
ID_INS_PLAN	T_TMSIS_TPL004_HLTH_INS_CT	VARCHAR2	20.00	0.00
ID_ISA_IDENTIFIER	T_TP	VARCHAR2	15.00	0.00
ID_ISA_IDENTIFIER_QUALIFIER	T_TP	VARCHAR2	2.00	0.00
ID_LAST_CHANGE_CLERK	T_RE_CONSENT_FORM_ACTIVITY	CHAR	4.00	0.00
ID_LAST_CHANGE_CLERK	T_RE_CONSENT_FORM_MASTER	CHAR	4.00	0.00
ID_LAST_CWC	T_PR_ATT_CMS	CHAR	17.00	0.00
ID_LAST_OBSERVER	T_PR_ATT_CMS	CHAR	10.00	0.00
ID_LEGACY_SUBMITTER	T_EDI_TP_XREF	VARCHAR2	35.00	0.00
ID_LETTER	T_LETTER	CHAR	20.00	0.00
ID_LETTER	T_LG_LETTER_TEMPLATE	CHAR	20.00	0.00
ID_LOCKIN_PROV	T_TMSIS_ELG009_LOCKIN_INFO	VARCHAR2	30.00	0.00

ID_LOG_NUMBER	T_PS_CASE	CHAR	12.00	0.00
ID_LOG_USER	T_SW_MASKING_DATA	VARCHAR2	20.00	0.00
ID_LOG_USER	T_SW_PERFORMANCE_DATA	VARCHAR2	20.00	0.00
ID_LTC_PROVIDER	T_DS_RECIP_CORE	CHAR	10.00	0.00
ID_LTSS_PROV	T_TMSIS_ELG013_LTSS_PARTIC	VARCHAR2	30.00	0.00
ID_MC_LOCATION	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	15.00	0.00
ID_MC_PLAN	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	12.00	0.00
ID_MEDICAID	T_BUYA_BILL_INFO	CHAR	12.00	0.00
ID_MEDICAID	T_BUYA_EXCEPT	CHAR	12.00	0.00
ID_MEDICAID	T_BUYA_MISMATCH	CHAR	12.00	0.00
ID_MEDICAID	T_BUYA_PREM	CHAR	12.00	0.00
ID_MEDICAID	T_BUYB_BILL_INFO	CHAR	12.00	0.00
ID_MEDICAID	T_BUYB_EXCEPT	CHAR	12.00	0.00
ID_MEDICAID	T_BUYB_MISMATCH	CHAR	12.00	0.00
ID_MEDICAID	T_BUYB_PREM	CHAR	12.00	0.00
ID_MEDICAID	T_CALL_TRACK	CHAR	12.00	0.00
ID_MEDICAID	T_CA_FIN	CHAR	12.00	0.00
ID_MEDICAID	T_CA_MATERNITY_CARE	CHAR	12.00	0.00
ID_MEDICAID	T_CC_HIST_ADJUST	CHAR	12.00	0.00
ID_MEDICAID	T_CLM_MAT_CARE_HDR	CHAR	12.00	0.00
ID_MEDICAID	T_DENTAL_HDR_KEYS	CHAR	12.00	0.00
ID_MEDICAID	T_DS_DNTL_ICN	CHAR	12.00	0.00
ID_MEDICAID	T_DS_DNTL_PR_RE_SUM	CHAR	12.00	0.00
ID_MEDICAID	T_DS_DNTL_RECIP	CHAR	12.00	0.00
ID_MEDICAID	T_DS_HM_HEADER	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_CORE	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_APPL	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_APPL_HIST	CHAR	12.00	0.00

ID_MEDICAID	T_DS_RECIP_DO_APPL_SPONS	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_BANK	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_CLSD_ACCT	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_FAMILY	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_HLTH_INS	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_INCOME	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_PREV_PROP	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_REAL_EST	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_RESOURCE	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_DO_VEHICLE	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_SOBRA_APPL	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_SOBRA_EMP	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_SOBRA_FAMILY	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	12.00	0.00
ID_MEDICAID	T_DS_RECIP_SOBRA_FAM_HIST	CHAR	12.00	0.00
ID_MEDICAID	T_ELIGCNT	CHAR	12.00	0.00
ID_MEDICAID	T_MB_DEN_ICN	CHAR	12.00	0.00
ID_MEDICAID	T_MB_DEN_RECIP	CHAR	12.00	0.00
ID_MEDICAID	T_MB_NUM_ICN	CHAR	12.00	0.00
ID_MEDICAID	T_MB_NUM_RECIP	CHAR	12.00	0.00
ID_MEDICAID	T_MC_POSTCARD_RERUN	CHAR	12.00	0.00
ID_MEDICAID	T_MC_RE_PMP_SEL	CHAR	12.00	0.00
ID_MEDICAID	T_MR_BUYIN_PREM	CHAR	12.00	0.00
ID_MEDICAID	T_MR_ELIG	CHAR	12.00	0.00
ID_MEDICAID	T_MR_LTC_REV	CHAR	12.00	0.00
ID_MEDICAID	T_MR_POS_RE	CHAR	12.00	0.00
ID_MEDICAID	T_MR_PROV_RE	CHAR	12.00	0.00
ID_MEDICAID	T_MR_RE	CHAR	12.00	0.00
ID_MEDICAID	T_MR_RECIP_RANK	CHAR	12.00	0.00
ID_MEDICAID	T_MR_RE_KY	CHAR	12.00	0.00
ID_MEDICAID	T_PA_RECIP_ADH	CHAR	12.00	0.00
ID_MEDICAID	T_PDUR_SUSP	CHAR	12.00	0.00
ID_MEDICAID	T_PF_RE_DECEASED	CHAR	12.00	0.00
ID_MEDICAID	T_PF_RE_SUPPRESS	CHAR	12.00	0.00
ID_MEDICAID	T_PHRM_HDR_KEYS	CHAR	12.00	0.00
ID_MEDICAID	T_PHYS_HDR_KEY	CHAR	12.00	0.00

ID_MEDICAID	T_PS_CASE	CHAR	12.00	0.00
ID_MEDICAID	T_RELATED_CASES	CHAR	12.00	0.00
ID_MEDICAID	T_RETRO_SUMM_RECS	CHAR	12.00	0.00
ID_MEDICAID	T_RE_BASE	CHAR	12.00	0.00
ID_MEDICAID	T_RE_BASE_DN	CHAR	12.00	0.00
ID_MEDICAID	T_RE_BNDX_BUYIN	CHAR	12.00	0.00
ID_MEDICAID	T_RE_CONSENT_FORM_MASTER	CHAR	12.00	0.00
ID_MEDICAID	T_RE_EBS_CARD_RQST	CHAR	12.00	0.00
ID_MEDICAID	T_RE_EDB	CHAR	25.00	0.00
ID_MEDICAID	T_RE_HIST_ERR	CHAR	12.00	0.00
ID_MEDICAID	T_RE_HIST_LOG	CHAR	12.00	0.00
ID_MEDICAID	T_RE_ID_CRD_ISS	CHAR	12.00	0.00
ID_MEDICAID	T_RE_LTC_REQUEST	CHAR	12.00	0.00
ID_MEDICAID	T_RE_PS2_ERR	CHAR	12.00	0.00
ID_MEDICAID	T_RE_PS2_LOG	CHAR	12.00	0.00
ID_MEDICAID	T_RE_PTOT_OVERBILL	CHAR	12.00	0.00
ID_MEDICAID	T_UB92_HDR_EXT_KEY	CHAR	12.00	0.00
ID_MEDICAID_CURR	T_RE_ORIG_ID_XREF	CHAR	12.00	0.00
ID_MEDICAID_HOH	T_RE_HOH	CHAR	12.00	0.00
ID_MEDICAID_NEW	T_CA_RECIP_HIST	CHAR	12.00	0.00
ID_MEDICAID_NEW	T_CLM_RECIP_HIST	CHAR	12.00	0.00
ID_MEDICAID_OLD	T_CA_RECIP_HIST	CHAR	12.00	0.00
ID_MEDICAID_OLD	T_CLM_RECIP_HIST	CHAR	12.00	0.00
ID_MEDICAID_ORIG	T_RE_ORIG_ID_XREF	CHAR	12.00	0.00
ID_MEDICAID_PS2	T_RE_PS2_DUPE	CHAR	12.00	0.00
ID_MEDICARE	T_BUYA_BILL	CHAR	12.00	0.00
ID_MEDICARE	T_BUYA_DEMO_CHANGE	CHAR	12.00	0.00
ID_MEDICARE	T_BUYA_EXCEPT	CHAR	12.00	0.00
ID_MEDICARE	T_BUYA_MISMATCH	CHAR	12.00	0.00
ID_MEDICARE	T_BUYA_PREM	CHAR	12.00	0.00
ID_MEDICARE	T_BUYB_BILL	CHAR	12.00	0.00
ID_MEDICARE	T_BUYB_DEMO_CHANGE	CHAR	12.00	0.00
ID_MEDICARE	T_BUYB_EXCEPT	CHAR	12.00	0.00
ID_MEDICARE	T_BUYB_MISMATCH	CHAR	12.00	0.00
ID_MEDICARE	T_BUYB_PREM	CHAR	12.00	0.00
ID_MEDICARE	T_CLM_SYS_FIELDS_HDR	CHAR	12.00	0.00
ID_MEDICARE	T_RE_CMS_MMA_ENROLL	CHAR	15.00	0.00
ID_MEDICARE	T_RE_HIB	CHAR	12.00	0.00

ID_MEDICARE_BENE	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	12.00	0.00
ID_MEDICARE_BENEFICIARY	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_BENEFICIARY	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_BENEFICIARY	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_BENEFICIARY	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_HIC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_HIC	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_HIC	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_HIC	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
ID_MEDICARE_HIC	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	12.00	0.00
ID_MEDICARE_NEW	T_BUYA_BILL	CHAR	12.00	0.00
ID_MEDICARE_NEW	T_BUYA_MISMATCH	CHAR	12.00	0.00
ID_MEDICARE_NEW	T_BUYB_BILL	CHAR	12.00	0.00
ID_MEDICARE_NEW	T_BUYB_MISMATCH	CHAR	12.00	0.00
ID_MEDIGAP	T_CLM_PHRM_HDR	VARCHAR2	20.00	0.00
ID_MED_PLUS_CHK	T_RE_CONSENT_FORM_ACTIVITY	CHAR	13.00	0.00
ID_MED_PLUS_CHK	T_RE_FEITH_IDCHK	CHAR	13.00	0.00
ID_MED_RECIP_PREV	T_RE_OLD_PCN	CHAR	12.00	0.00
ID_MEMBER	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	20.00	0.00
ID_MSGBOX	T_EDIC_BATCH_MSGBOX	NUMBER	10.00	0.00
ID_MSGBOX	T_EDIC_BATCH_MSGBOX_ARC	NUMBER	10.00	0.00
ID_MSGBOX	T_EDIC_MSG_RECEIVE	NUMBER	10.00	0.00
ID_MSGBOX	T_EDIC_MSG_RECEIVE_ARC	NUMBER	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	10.00	0.00

ID_NATL_HC_ENTITY	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_MCR008_NATL_HC_ENT	VARCHAR2	10.00	0.00
ID_NATL_HC_ENTITY	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	10.00	0.00
ID_NON_SSN	T_RE_BASE_STATE	CHAR	12.00	0.00
ID_NPI	T_CA_PR_HB_LIC	CHAR	15.00	0.00
ID_NPI	T_PR_HB_LIC	CHAR	15.00	0.00
ID_NPI	T_PR_HB_LIC_KY	CHAR	10.00	0.00
ID_NUM_PLAN	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
ID_NUM_PLAN	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_NUM_PLAN	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_NUM_PLAN	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR002_MAIN	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR004_SVC_AREA	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR005_OPER_AUTH	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR006_POP_ENRLD	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR007_ACCRED_ORG	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR008_NATL_HC_ENT	VARCHAR2	12.00	0.00
ID_NUM_STATE_PLAN	T_TMSIS_MCR009_CHPID_SHPID	VARCHAR2	12.00	0.00
ID_NUM_TMSIS	T_MR_TMSIS_ALLKIDS	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_COT002_CLM_HDR	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_COT003_CLM_DTL	VARCHAR2	20.00	0.00

ID_NUM_TMSIS	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG006_HH_SPA_PART	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG007_HH_SPA_PROV	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG008_HH_CHR_CON	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG009_LOCKIN_INFO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG011_STATE_PLAN	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG012_WAIVER_PART	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG013_LTSS_PARTIC	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG015_ETHNICITY	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG016_RACE_INFO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG017_DISAB_INFO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG018_1115A_DEMO	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG020_HCBS_CH_NHH	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_ELG021_ENROL_SPAN	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	20.00	0.00
ID_NUM_TMSIS	T_TMSIS_TPL005_OTH_TPL_COV	VARCHAR2	20.00	0.00
ID_OPER_PROV_NPI	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	10.00	0.00

ID_ORGN_RECV	T_DOCUMENT_TRACK	VARCHAR2	15.00	0.00
ID_ORGN_RECV_QUALIFY	T_DOCUMENT_TRACK	VARCHAR2	2.00	0.00
ID_ORGN_SND	T_DOCUMENT_TRACK	VARCHAR2	15.00	0.00
ID_ORGN_SND_QUALIFY	T_DOCUMENT_TRACK	VARCHAR2	2.00	0.00
ID_ORIG_LOGIN	T_PR_ATT_CMS	CHAR	10.00	0.00
ID_OTHER	T_PR_ENRL_EFT_ERA_MAINT	CHAR	15.00	0.00
ID_OTHER	T_PR_ENRL_IDENTIFIER	CHAR	15.00	0.00
ID_OTH_PYR_PARTY	T_CA_TPL_SUMMARY	VARCHAR2	80.00	0.00
ID_OTH_PYR_PARTY	T_CLM_OTH_PYR_DTL	VARCHAR2	80.00	0.00
ID_OTH_PYR_PARTY	T_CLM_TPL_SUMMARY	VARCHAR2	80.00	0.00
ID_PARCEL	T_DS_RECIP_DO_REAL_EST	VARCHAR2	22.00	0.00
ID_PARENT	T_CM_CG_CRIT	NUMBER	4.00	0.00
ID_PARENT	T_CM_CT_CRIT	NUMBER	4.00	0.00
ID_PARENT	T_CM_PG_CRIT	NUMBER	4.00	0.00
ID_PARENT	T_MM_CRIT	NUMBER	4.00	0.00
ID_PAYEE	T_DS_PAYEE_NAM_ADR	CHAR	15.00	0.00
ID_PAYER	T_835_CK_EFT_TRCNO	VARCHAR2	80.00	0.00
ID_PAYLOAD	T_EDIC_BATCH_MSGBOX	VARCHAR2	36.00	0.00
ID_PAYLOAD	T_EDIC_BATCH_MSGBOX_ARC	VARCHAR2	36.00	0.00
ID_PAYLOAD	T_EDIC_REQUESTS	VARCHAR2	36.00	0.00
ID_PAYLOAD	T_EDIC_REQUESTS_ARC	VARCHAR2	36.00	0.00
ID_PEOPLE	T_LG_LETTER_REQUEST	CHAR	256.00	0.00
ID_PEOPLE	T_LTR_RQST_TEMPLAT	CHAR	256.00	0.00
ID_PERF_PROV	T_DENTAL_HDR_KEYS	CHAR	15.00	0.00
ID_PERF_PROV	T_PHYS_DEXT_KEY	CHAR	15.00	0.00
ID_PERF_PROV	T_PHYS_HDR_KEY	CHAR	15.00	0.00
ID_PERIOD	T_RE_EPSDT_PERIODS	NUMBER	9.00	0.00
ID_PERIOD	T_RE_EPSDT_PR_IM_X	NUMBER	9.00	0.00
ID_PERIOD	T_RE_EPSDT_PR_SC_X	NUMBER	9.00	0.00
ID_PLAN	T_RE_PARTD_PDP_PLAN	CHAR	3.00	0.00
ID_POP	T_PR_LOC_RATE_WI	NUMBER	4.00	0.00

ID_PRESCR_PROV	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
ID_PRESCR_PROV_NPI	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	10.00	0.00
ID_PROCESS	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	10.00	0.00
ID_PROV	T_WEB_CLAIM_HDR	CHAR	11.00	0.00
ID_PROV	T_WEB_PAY_SUM	CHAR	11.00	0.00
ID_PROV	T_WEB_PA_HDR	CHAR	11.00	0.00
ID_PROV	T_WEB_PROV	CHAR	11.00	0.00
ID_PROVIDER	T_ADJMS_PROV	CHARACTER	15.00	0.00
ID_PROVIDER	T_ADJ_REV_RQST	CHARACTER	15.00	0.00
ID_PROVIDER	T_CALL_TRACK	CHARACTER	15.00	0.00
ID_PROVIDER	T_CC_HIST_ADJUST	CHAR	15.00	0.00
ID_PROVIDER	T_CLAIM_EXTRACT	CHAR	15.00	0.00
ID_PROVIDER	T_CLM_FCA	CHAR	15.00	0.00
ID_PROVIDER	T_CT_CONT_TERM	CHAR	10.00	0.00
ID_PROVIDER	T_DENTAL_HDR_KEYS	CHAR	15.00	0.00
ID_PROVIDER	T_EDI_TP_XREF	VARCHAR2	15.00	0.00
ID_PROVIDER	T_PDUR_SUSP	CHAR	9.00	0.00
ID_PROVIDER	T_PHRM_HDR_KEYS	CHAR	15.00	0.00
ID_PROVIDER	T_PHRM_HDR_KEYS	CHAR	15.00	0.00
ID_PROVIDER	T_PHYS_HDR_KEY	CHAR	15.00	0.00
ID_PROVIDER	T_PR_CHOW_GRP_MBR	CHAR	15.00	0.00
ID_PROVIDER	T_PR_IDENTIFIER	CHAR	15.00	0.00
ID_PROVIDER	T_PR_PROV	CHAR	9.00	0.00
ID_PROVIDER	T_REF_ID_PROV_GROUP	CHAR	15.00	0.00
ID_PROVIDER	T_RETRO_SUMM_RECS	CHAR	15.00	0.00
ID_PROVIDER	T_RE_LTC_REQUEST	CHAR	15.00	0.00
ID_PROVIDER	T_TP	CHAR	15.00	0.00
ID_PROVIDER	T_UB92_HDR_EXT_KEY	CHAR	15.00	0.00
ID_PROVIDER_FROM	T_PR_LABEL_CRIT	CHAR	15.00	0.00
ID_PROVIDER_MCAID	T_DS_HM_HEADER	CHAR	15.00	0.00
ID_PROVIDER_MCAID	T_PF_PR_SUPPRESS	CHAR	15.00	0.00
ID_PROVIDER_NPI	T_DS_DNTL_ICN	CHAR	15.00	0.00
ID_PROVIDER_NPI	T_DS_DNTL_PR_ENROLL	CHAR	15.00	0.00
ID_PROVIDER_NPI	T_DS_DNTL_PR_GRP_SUM	CHAR	15.00	0.00

ID_PROVIDER_NPI	T_DS_DNTL_PR_RE_SUM	CHAR	15.00	0.00
ID_PROVIDER_NPI	T_DS_DNTL_PR_SUM	CHAR	15.00	0.00
ID_PROVIDER_NPI	T_DS_HM_HEADER	CHAR	15.00	0.00
ID_PROVIDER_TO	T_PR_LABEL_CRIT	CHAR	15.00	0.00
ID_PROV_ATTEND	T_CA_HDR_DTL	CHAR	15.00	0.00
ID_PROV_ATTEND	T_DENY_UB92_HDR	CHAR	15.00	0.00
ID_PROV_ATTEND	T_PD_UB92_HDR	CHAR	11.00	0.00
ID_PROV_ATTEND	T_PD_UB92_HDR	CHAR	15.00	0.00
ID_PROV_ATTEND	T_SUSP_UB92_HDR	CHAR	15.00	0.00
ID_PROV_ATTEND	T_UB92_DTL_EXT_KEY	CHAR	15.00	0.00
ID_PROV_BASE	T_MR_PR_ENROL	CHAR	15.00	0.00
ID_PROV_BILL_NPI	T_CA_MATERNITY_CARE	CHAR	15.00	0.00
ID_PROV_BILL_NPI	T_CLM_MAT_CARE_HDR	CHAR	15.00	0.00
ID_PROV_DEFAULT	T_FIN_PROCESS_PROV_ID	CHAR	15.00	0.00
ID_PROV_IDENTIFIER	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	12.00	0.00
ID_PROV_LOC	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_COT002_CLM_HDR	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	5.00	0.00
ID_PROV_LOC	T_TMSIS_PRV010_BED_TYPE	VARCHAR2	5.00	0.00
ID_PROV_MATC_NPI	T_CA_MATERNITY_CARE	CHAR	15.00	0.00

ID_PROV_MATC_NPI	T_CLM_MAT_CARE_HDR	CHAR	15.00	0.00
ID_PROV_MCD	T_FIN_PROCESS_PROV_ID	CHAR	15.00	0.00
ID_PROV_MCD	T_PR_ENRL_GROUP	CHAR	15.00	0.00
ID_PROV_NPI	T_FIN_PROCESS_PROV_ID	CHAR	15.00	0.00
ID_PROV_NPI	T_PR_APPLN_STATUS	CHAR	15.00	0.00
ID_PROV_NPI	T_PR_ENRL_EFT_ERA_MAINT	CHAR	15.00	0.00
ID_PROV_NPI	T_PR_ENRL_GROUP	CHAR	15.00	0.00
ID_PROV_NPI	T_PR_ENRL_IDENTIFIER	CHAR	15.00	0.00
ID_PROV_NPI	T_PR_NAM_NPPES	NUMBER	10.00	0.00
ID_PROV_NPI_ACCT_LINKAGE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	15.00	0.00
ID_PROV_NPI_AGGREGATION	T_PR_ENRL_EFT_ERA_MAINT	CHAR	15.00	0.00
ID_PROV_NPI_CHOW	T_PR_SVC_LOC_AL	CHAR	15.00	0.00
ID_PROV_NPI_EVE	T_PR_CHOW_XREF	CHAR	15.00	0.00
ID_PROV_NPI_NEW	T_PR_CHOW_XREF	CHAR	15.00	0.00
ID_PROV_NPI_ORIG	T_PR_CHOW_XREF	CHAR	15.00	0.00
ID_PROV_ORDER	T_PHYS_DEXT_KEY	CHAR	15.00	0.00
ID_PROV_OTHER	T_DENY_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER	T_FIN_PROCESS_PROV_ID	CHAR	15.00	0.00
ID_PROV_OTHER	T_PD_UB92_HDR	CHAR	11.00	0.00
ID_PROV_OTHER	T_PD_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER	T_SUSP_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER	T_UB92_DTL_EXT_KEY	CHAR	15.00	0.00
ID_PROV_OTHER_2	T_DENY_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER_2	T_PD_UB92_HDR	CHAR	11.00	0.00
ID_PROV_OTHER_2	T_PD_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER_2	T_SUSP_UB92_HDR	CHAR	15.00	0.00
ID_PROV_OTHER_2	T_UB92_DTL_EXT_KEY	CHAR	15.00	0.00
ID_PROV_PERF	T_DENTAL_DTL_KEYS	CHAR	15.00	0.00
ID_PROV_PERF_NPI	T_CA_MATERNITY_CARE	CHAR	15.00	0.00
ID_PROV_PERF_NPI	T_CLM_MAT_CARE_DTL	CHAR	15.00	0.00
ID_PROV_PHRM_NPI	T_PR_ENRL_PROV	CHAR	15.00	0.00
ID_PROV_PHYS_NPI	T_PR_ENRL_PROV	CHAR	15.00	0.00

ID_PROV_PHYS_NPI	T_PR_PHYS_SUPV	CHAR	15.00	0.00
ID_PROV_PMP	T_CLM_SYS_FIELDS_HDR	CHAR	15.00	0.00
ID_PROV_PRESCRB	T_DENY_PHRM_HDR	CHAR	15.00	0.00
ID_PROV_PRESCRB	T_MPHX_PHRM_DTL_AL	CHAR	15.00	0.00
ID_PROV_PRESCRB	T_PD_PHARM_HDR	CHAR	10.00	0.00
ID_PROV_PRESCRB	T_PD_PHARM_HDR	CHAR	15.00	0.00
ID_PROV_PRESCRB	T_SUSP_PHRM_HDR	CHAR	15.00	0.00
ID_PROV_PRESCRB_NPI	T_DENY_PHRM_HDR	CHAR	10.00	0.00
ID_PROV_PRESCRB_NPI	T_PD_PHARM_HDR	CHAR	10.00	0.00
ID_PROV_PRESCRB_NPI	T_SUSP_PHRM_HDR	CHAR	10.00	0.00
ID_PROV_PRIMARY	T_FIN_PROCESS_PROV_ID	CHAR	15.00	0.00
ID_PROV_RCO	T_CA_RCO	VARCHAR2	80.00	0.00
ID_PROV_RCO	T_CLM_RCO	VARCHAR2	80.00	0.00
ID_PROV_RECIP	T_CT_CASE_TRACK	VARCHAR2	12.00	0.00
ID_PROV_RECIP	T_CT_SELECT_LST	CHAR	12.00	0.00
ID_PROV_REFER	T_PHYS_HDR_KEY	CHAR	15.00	0.00
ID_PROV_REFERRING	T_DENTAL_HDR_KEYS	CHAR	15.00	0.00
ID_PROV_REFERRING	T_PHYS_DEXT_KEY	CHAR	15.00	0.00
ID_PROV_REFERRING_2	T_DENTAL_HDR_KEYS	CHAR	15.00	0.00
ID_PROV_REFERRING_2	T_PHYS_DEXT_KEY	CHAR	15.00	0.00
ID_PROV_REFERRING_2	T_PHYS_HDR_KEY	CHAR	15.00	0.00
ID_PROV_RENDER	T_EXPENDITURE	CHAR	9.00	0.00
ID_PROV_RENDER	T_EXPENDITURE_DN	CHAR	9.00	0.00
ID_PROV_RENDERING	T_PHRM_HDR_KEYS	CHAR	15.00	0.00
ID_PR_FACILITY	T_UB92_HDR_EXT_KEY	CHAR	15.00	0.00
ID_QUERY	T_QUERY	CHAR	20.00	0.00

ID_RECEIPT	T_RE_1095_ACK	VARCHAR2	30.00	0.00
ID_RECEIPT	T_RE_ADPH_1095_ACK	VARCHAR2	30.00	0.00
ID_RECEIVE	T_EDIC_MSG_RECEIVE	NUMBER	10.00	0.00
ID_RECEIVE	T_EDIC_MSG_RECEIVE_ARC	NUMBER	10.00	0.00
ID_RECIP	T_CT_EOMB	VARCHAR2	12.00	0.00
ID_RECIP	T_WEB_CLAIM_HDR	CHAR	12.00	0.00
ID_RECIP	T_WEB_PA_HDR	CHAR	12.00	0.00
ID_RECIP_BASE	T_RE_NET_VOUCHER	CHAR	12.00	0.00
ID_RECIP_CURR	T_RE_NET_VOUCHER	CHAR	12.00	0.00
ID_RECV	T_DOCUMENT_TRACK	VARCHAR2	15.00	0.00
ID_RECV_QUALIFY	T_DOCUMENT_TRACK	VARCHAR2	2.00	0.00
ID_REFER_PROV	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
ID_REFER_PROV	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
ID_REFER_PROV	T_TMSIS_COT002_CLM_HDR	VARCHAR2	30.00	0.00
ID_REFER_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_REFER_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_REFER_PROV_NPI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_REF_1	T_PA_HDR_PE_UMO	VARCHAR2	50.00	0.00
ID_REF_2	T_PA_HDR_PE_UMO	VARCHAR2	50.00	0.00
ID_REF_3	T_PA_HDR_PE_UMO	VARCHAR2	50.00	0.00
ID_REF_4	T_PA_HDR_PE_UMO	VARCHAR2	50.00	0.00
ID_REPORT	T_TPL_RQST_REPORT	CHAR	20.00	0.00
ID_REQUEST	T_EDIC_CORRELATION	NUMBER	9.00	0.00
ID_REQUEST	T_EDIC_CORRELATION_ARC	NUMBER	9.00	0.00
ID_REQUEST	T_EDIC_REQUESTS	NUMBER	10.00	0.00
ID_REQUEST	T_EDIC_REQUESTS_ARC	NUMBER	10.00	0.00
ID_REQUEST	T_EDIC_RESPONSES	NUMBER	10.00	0.00
ID_REQUEST	T_EDIC_RESPONSES_ARC	NUMBER	10.00	0.00
ID_RESPONSE	T_EDIC_RESPONSES	NUMBER	10.00	0.00
ID_RESPONSE	T_EDIC_RESPONSES_ARC	NUMBER	10.00	0.00
ID_REVIEWER	T_DR_DISPUTE	CHAR	8.00	0.00

ID_REVIEWER	T_LOCATION_NOTE	CHAR	8.00	0.00
ID_REVIEWER	T_RE_LOC	CHAR	3.00	0.00
ID_SANC_PROV_TAX	T_PR_SANCTION_AL	CHAR	9.00	0.00
ID_SANC_PROV_TAX	T_PR_SANCTION_WI	CHAR	9.00	0.00
ID_SANC_PROV_UPIN	T_PR_SANCTION_AL	CHAR	6.00	0.00
ID_SANC_PROV_UPIN	T_PR_SANCTION_WI	CHAR	6.00	0.00
ID_SCHOOL	T_MPHX_MISC	VARCHAR2	11.00	0.00
ID_SCREEN	T_RE_EPSDT_PROC_XR	NUMBER	9.00	0.00
ID_SCREEN	T_RE_EPSDT_PR_SC_X	NUMBER	9.00	0.00
ID_SCREEN	T_RE_EPSDT_SCREEN	NUMBER	9.00	0.00
ID_SCRIPT_QQ	T_ERX_GCDF_NCPDP_QQ_XREF	CHAR	8.00	0.00
ID_SCRIPT_QQ	T_ERX_NCPDP_QQ	CHAR	8.00	0.00
ID_SE	T_SETEAM_MEMBER	CHAR	8.00	0.00
ID_SENDER	T_835_CK_EFT_TRCNO	VARCHAR2	15.00	0.00
ID_SENDER	T_EDIC_BATCH_MSGBOX	VARCHAR2	35.00	0.00
ID_SENDER	T_EDIC_BATCH_MSGBOX_ARC	VARCHAR2	35.00	0.00
ID_SENDER	T_EDIC_REQUESTS	VARCHAR2	35.00	0.00
ID_SENDER	T_EDIC_REQUESTS_ARC	VARCHAR2	35.00	0.00
ID_SENDER_ST	T_835_CONSTANTS	CHAR	10.00	0.00
ID_SENDER_ST	T_FIN_CYCLE	CHAR	30.00	0.00
ID_SHPID	T_TMSIS_MCR009_CHPID_SHPID	VARCHAR2	10.00	0.00
ID_SND	T_DOCUMENT_TRACK	VARCHAR2	15.00	0.00
ID_SND_QUALIFY	T_DOCUMENT_TRACK	VARCHAR2	2.00	0.00
ID_SOBRA_WORKER	T_RE_BASE_STATE	CHAR	2.00	0.00
ID_SOURCE	T_RE_ID_CARD	CHAR	8.00	0.00
ID_SOURCE	T_RE_ID_CRD_ISS	CHAR	8.00	0.00
ID_SRC	T_RE_EBS_CARD_RQST	CHAR	8.00	0.00
ID_SSAN	T_PS_CASE	NUMBER	9.00	0.00
ID_SUBMIT	T_RE_LTC_REQUEST	CHAR	9.00	0.00
ID_SUBMITTER	T_CLM_BENEFIT_LIMITS	CHAR	16.00	0.00
ID_SUBMITTER	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	12.00	0.00

ID_SUBMITTER	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_COT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_COT003_CLM_DTL	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	12.00	0.00
ID_SUBMITTER	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	12.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV006_TAXON_CLASS	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV007_MDCD_ENROLL	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV008_AFFIL_GRP	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV009_AFFIL_PGMS	VARCHAR2	30.00	0.00
ID_SUBMITTING_STATE_PROV	T_TMSIS_PRV010_BED_TYPE	VARCHAR2	30.00	0.00
ID_SUBMIT_STATE_AFFIL_ENTITY	T_TMSIS_PRV008_AFFIL_GRP	VARCHAR2	12.00	0.00
ID_SUPERVISOR	T_CT_CASE_TRACK	CHAR	6.00	0.00
ID_SVC_PROV	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	30.00	0.00
ID_SVC_PROV	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	30.00	0.00
ID_SVC_PROV	T_TMSIS_COT003_CLM_DTL	VARCHAR2	30.00	0.00
ID_SVC_PROV_NPI	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	10.00	0.00
ID_SVC_PROV_NPI	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	10.00	0.00
ID_SVC_PROV_NPI	T_TMSIS_COT003_CLM_DTL	VARCHAR2	10.00	0.00
ID_TAB	T_SW_PERFORMANCE_DATA	NUMBER	3.00	0.00
ID_TEAM	T_EDS_TEAM	CHAR	8.00	0.00
ID_TEAM	T_PLOG_ESTIMATE	CHAR	8.00	0.00
ID_TEAM	T_SETEAM_MEMBER	CHAR	8.00	0.00

ID_TMSIS_RECORD	T_MR_TMSIS_CMS_ERROR_RECS	CHAR	8.00	0.00
ID_TMSIS_RECORD	T_MR_TMSIS_ELEMENTS_XREF	CHAR	8.00	0.00
ID_TMSIS_RECORD	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	8.00	0.00
ID_TMSIS_RECORD	T_TMSIS_DATA_ELEMENTS	VARCHAR2	8.00	0.00
ID_TMSIS_RECORD	T_TMSIS_RUN_STATS	VARCHAR2	8.00	0.00
ID_TOKEN	T_PR_ENRL	VARCHAR2	30.00	0.00
ID_TRADING_PARTNER	T_CALL_TRACK	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_CDE_TP_GROUP	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_EDI_COVERED_PROV_XREF	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_EDI_MC_PROV_TP_XREF	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_EDI_TP_834_RQST	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_EDI_TP_XREF	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_PR_ENRL_EFT_ERA	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_TPL_835_NCPDP_XREF	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_TP_GROUP_XREF	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_WEB_RECEIVER	VARCHAR2	35.00	0.00
ID_TRADING_PARTNER	T_WEB_RECEIVER_BACKUP	VARCHAR2	35.00	0.00
ID_TRANSACTION	T_FILE_TRACK	VARCHAR2	50.00	0.00
ID_TRANSACTIONTYPE	T_EDIC_REQUESTS	NUMBER	4.00	0.00
ID_TRANSACTIONTYPE	T_EDIC_REQUESTS_ARC	NUMBER	4.00	0.00
ID_TRANSACTIONTYPE	T_EDIC_TRANSACTION_TYPES	NUMBER	4.00	0.00
ID_UNDER_DIR_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_UNDER_DIR_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00
ID_UNDER_DIR_PROV_NPI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_UNDER_SUP_PROV_NPI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	10.00	0.00
ID_UNDER_SUP_PROV_NPI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	12.00	0.00

ID_UNDER_SUP_PROV_NPI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	10.00	0.00
ID_UPDATE	T_CLM_BATCH_PROCESS	CHAR	8.00	0.00
ID_UPDATE	T_CLM_BATCH_PROCESS_ENC	CHAR	8.00	0.00
ID_UPDATE	T_ENC_BATCH_PROCESS	CHAR	8.00	0.00
ID_USER	T_AR_COMMENTS	CHAR	8.00	0.00
ID_USER	T_CASH_COMMENT	CHAR	8.00	0.00
ID_USER	T_CHECK_COMMENT	CHAR	8.00	0.00
ID_USER	T_EXPEND_COMMENT	CHAR	8.00	0.00
ID_USER	T_LIEN_COMMENT	CHAR	8.00	0.00
ID_USER	T_RE_COMMENT	CHAR	8.00	0.00
ID_UUID	T_RE_1095_ACK	VARCHAR2	51.00	0.00
ID_UUID	T_RE_ADPH_1095_ACK	VARCHAR2	51.00	0.00
ID_WAIVER	T_MR_TMSIS_BEN_PLAN	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_COT002_CLM_HDR	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_ELG012_WAIVER_PART	VARCHAR2	20.00	0.00
ID_WAIVER	T_TMSIS_MCR005_OPER_AUTH	VARCHAR2	20.00	0.00
ID_WVR	T_MR_WVR_CLM	CHAR	3.00	0.00
ID_WVR	T_MR_WVR_ELG	CHAR	3.00	0.00
ID_WVR	T_MR_WVR_SVC	CHAR	3.00	0.00
ID_XREF_SRC	T_ERX_NCPDP_QQ	VARCHAR2	50.00	0.00
INCOME_SRC	T_DS_RECIP_DO_FAMILY	VARCHAR2	10.00	0.00
IND	T_CASH_BATCH_NUM	CHAR	1.00	0.00

IND	T_CASH_DISP_REASON	CHAR	1.00	0.00
IND	T_CASH_RCPT_DISP	CHAR	1.00	0.00
IND	T_DRUG_CLASS	CHAR	1.00	0.00
IND	T_DRUG_REBATE_TEMP	CHAR	1.00	0.00
IND	T_DR_ADJ_IND	CHAR	1.00	0.00
IND	T_DR_INCR_ADJ	CHAR	1.00	0.00
IND	T_DR_PPA_INV_DTL	CHAR	1.00	0.00
IND	T_DUPE_AUDIT	CHAR	1.00	0.00
IND	T_FIN_PROCESS_CASH_DISP	CHAR	1.00	0.00
IND	T_MEDPOL_UB92	CHAR	1.00	0.00
IND	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
IND	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
IND	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
IND	T_PRICING_IND	CHAR	1.00	0.00
IND	T_RE_EPSDT_IMMUN	CHAR	1.00	0.00
IND	T_RE_EPSDT_PERIODS	CHAR	1.00	0.00
IND	T_RE_EPSDT_PROC_XR	CHAR	1.00	0.00
IND	T_RE_EPSDT_PR_IM_X	CHAR	1.00	0.00
IND	T_RE_EPSDT_PR_SC_X	CHAR	1.00	0.00

IND	T_RE_EPSDT_SCREEN	CHAR	1.00	0.00
IND	T_RTS_INFO	CHAR	1.00	0.00
IND	T_RTS_REASON	CHAR	1.00	0.00
IND	T_SYSTEM_PARMS	CHAR	1.00	0.00
IND	T_TPL_CARR_EXCEPT	CHAR	1.00	0.00
IND_1099	T_FIN_PAYEE	CHAR	1.00	0.00
IND_1115A_DEMO	T_MR_TMSIS_BEN_PLAN	CHAR	1.00	0.00
IND_1115A_DEMO	T_TMSIS_CIP002_CLM_HDR	NUMBER	1.00	0.00
IND_1115A_DEMO	T_TMSIS_CLT002_CLM_HDR	NUMBER	1.00	0.00
IND_1115A_DEMO	T_TMSIS_COT002_CLM_HDR	NUMBER	1.00	0.00
IND_1115A_DEMO	T_TMSIS_CRX002_CLM_HDR	NUMBER	1.00	0.00
IND_1115A_DEMO	T_TMSIS_ELG018_1115A_DEMO	VARCHAR2	1.00	0.00
IND_2300_CRC02	T_CLM_UB92_2300	CHAR	1.00	0.00
IND_277_STATUS	T_CLM_BATCH_PROCESS_ENC	CHAR	1.00	0.00
IND_ABORTION	T_CA_HDR_DTL	CHAR	1.00	0.00
IND_ABORTION	T_CA_IND_KEY	CHAR	1.00	0.00
IND_ABOVE_BELOW	T_CLM_AMT_VARIANCE	CHAR	1.00	0.00
IND_ACADEMIC	T_PMP_SVC_LOC_AL	CHAR	1.00	0.00
IND_ACADEMIC	T_PMP_SVC_LOC_STATE	CHAR	1.00	0.00
IND_ACCIDENT	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_ACCIDENT	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_ACCIDENT	T_PA_PAUTH	CHAR	1.00	0.00
IND_ACCIDENT	T_PD_DNTL_HDR	CHAR	1.00	0.00

IND_ACCIDENT	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_ACCIDENT	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_ACCIDENT	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_ACCPTG_NEW_PATS	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	1.00	0.00
IND_ACCT_TYPE	T_FIN_EFT_ACCT	CHAR	1.00	0.00
IND_ACCT_TYPE	T_PR_EFT_ACCT	CHAR	1.00	0.00
IND_ACCT_TYPE	T_PR_ENRL_EFT_ACCT	CHAR	1.00	0.00
IND_ACCT_TYPE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	1.00	0.00
IND_ACCT_TYPE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
IND_ACCT_TYPE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	1.00	0.00
IND_ACC_SETTLE	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_ACTION	T_ERM_DEP	CHAR	1.00	0.00
IND_ACTION	T_ERM_ENT	CHAR	1.00	0.00
IND_ACTION_REQ	T_CT_EOMB	CHAR	1.00	0.00
IND_ACTIVATE	T_CDE_DRUG_ACT	CHAR	1.00	0.00
IND_ACTIVATE	T_DRUG_ACT_COV	CHAR	1.00	0.00
IND_ACTIVE	T_ALLERGY	CHAR	1.00	0.00
IND_ACTIVE	T_ALLERGY_DIAG	CHAR	1.00	0.00
IND_ACTIVE	T_BATCH_ERR_MSG	CHAR	1.00	0.00
IND_ACTIVE	T_CDE_BUY_ELIG	CHAR	1.00	0.00
IND_ACTIVE	T_CONTRA_DISEASE	CHAR	1.00	0.00
IND_ACTIVE	T_CT_ANALYST	CHAR	1.00	0.00
IND_ACTIVE	T_DIAG_DSE_XREF	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_DISEASE	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_GER	CHAR	1.00	0.00

IND_ACTIVE	T_DRUG_GER	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_GER_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_INVERSE	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_OVER_UTIL	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_PED	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_PED	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_PED_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_PREG	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_PREG_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_THER_DUPE	CHAR	1.00	0.00
IND_ACTIVE	T_DRUG_UNDER_UTIL	CHAR	1.00	0.00
IND_ACTIVE	T_DR_STATUS_SUPPLE	CHAR	1.00	0.00
IND_ACTIVE	T_EVS_INQUIRY	CHAR	1.00	0.00
IND_ACTIVE	T_FIN_FUND_CODE	CHAR	1.00	0.00
IND_ACTIVE	T_GERI_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_HIGH_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_HIGH_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_HIGH_DOSE_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_INGRED_DUPE	CHAR	1.00	0.00
IND_ACTIVE	T_INVRS_UPDT_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_LG_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_ACTIVE	T_LOW_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_LOW_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_LOW_DOSE_LOG	CHAR	1.00	0.00

IND_ACTIVE	T_LS_MANFAC_INFO	CHAR	1.00	0.00
IND_ACTIVE	T_MCARE_DEDUCTIBLE	CHAR	1.00	0.00
IND_ACTIVE	T_MR_AGE_GROUP	CHAR	1.00	0.00
IND_ACTIVE	T_MR_COPAY_TYPE	CHAR	1.00	0.00
IND_ACTIVE	T_MR_THRUPUT_GRP	CHAR	1.00	0.00
IND_ACTIVE	T_OVER_UTIL_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_PDL_SCRN_CRIT	CHAR	1.00	0.00
IND_ACTIVE	T_PDUR_ADD_TOX	CHAR	1.00	0.00
IND_ACTIVE	T_PDUR_PREG_DIAG	CHAR	1.00	0.00
IND_ACTIVE	T_PEDI_DOSE	CHAR	1.00	0.00
IND_ACTIVE	T_PR_RISK_GRP_XREF	CHAR	1.00	0.00
IND_ACTIVE	T_RE_AR_WORKER	CHAR	1.00	0.00
IND_ACTIVE	T_RE_BASE	CHAR	1.00	0.00
IND_ACTIVE	T_RE_BASE	CHAR	1.00	0.00
IND_ACTIVE	T_RE_BASE_DN	CHAR	1.00	0.00
IND_ACTIVE	T_THERA_DUP_LOG	CHAR	1.00	0.00
IND_ACTIVE	T_THERA_DURATION	CHAR	1.00	0.00
IND_ACTIVE	T_THERA_DURATION	CHAR	1.00	0.00
IND_ACTIVE	T_UNDER_UTIL_LOG	CHAR	1.00	0.00
IND_ACUTE_CHRONIC	T_DISEASE_DSC	CHAR	1.00	0.00
IND_ADDR_TYPE	T_PA_NONMED_PROV	CHAR	1.00	0.00

IND_ADDR_TYPE	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_ADDR_TYPE	T_PR_ENRL_LOC	CHAR	1.00	0.00
IND_ADDR_TYPE	T_PR_LOC_NM_ADR	CHAR	1.00	0.00
IND_ADDR_TYPE	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_ADDR_TYPE	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_ADDR_VALID	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_ADDR_VALID	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_ADJ	T_CA_DRUG_REBATE	CHAR	1.00	0.00
IND_ADJ	T_DR_CLMS_INV_XREF	CHAR	1.00	0.00
IND_ADJ	T_DR_CLMS_XREF	CHAR	1.00	0.00
IND_ADJUST	T_CLM_BENEFIT_LIMITS	CHAR	1.00	0.00
IND_ADJUST	T_SUSP_DENTAL_DTL	CHAR	1.00	0.00
IND_ADJUST	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_ADJUSTMENT	T_CT_AR_TRACKING	CHAR	1.00	0.00
IND_ADJUSTMENT	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_ADJUSTMENT	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_ADJUSTMENT	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_ADJUSTMENT	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_ADR_BORDER_STATE	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	1.00	0.00
IND_ADVANTAGE	T_PS_CASE	CHAR	1.00	0.00
IND_AGENCY_OVERRIDE	T_TPL_HMS_HIPP_XREF	CHAR	1.00	0.00

IND_AGENCY_REVIEW	T_PR_ENRL	CHAR	1.00	0.00
IND_ALGI	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_ALGI	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
IND_ALLOW_EFT	T_FIN_CYCLE	CHAR	1.00	0.00
IND_ALLOW_EXCEED	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00
IND_ALL_RA	T_CHECK_BANNER	CHAR	1.00	0.00
IND_ALL_YEAR	T_RE_1095	CHAR	1.00	0.00
IND_ALL_YEAR	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_ALT_ADDR	T_RE_BASE	CHAR	1.00	0.00
IND_ALT_ADDR	T_RE_BASE_DN	CHAR	1.00	0.00
IND_ALT_ALGI	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_ALT_PA	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_ALT_PDL	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_ALT_PHONE	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_ALW_CCF	T_ERROR_DISP	CHAR	1.00	0.00
IND_ALW_DENY	T_ERROR_DISP	CHAR	1.00	0.00
IND_ALW_OVERIDE	T_ERROR_DISP	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_DENY_PHRM_DTL	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_DRUG_DN	CHAR	1.00	0.00

IND_AL_GEN_PROD	T_DRUG_STATE_AL	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_PDL_MASTER	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_PDL_MASTER_AL	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_PD_PHARM_DTL	CHAR	1.00	0.00
IND_AL_GEN_PROD	T_SUSP_PHRM_DTL	CHAR	1.00	0.00
IND_ANALYST_ANSWER	T_PA_RULE_QUESTION	CHAR	1.00	0.00
IND_ANALYST_DECISION	T_PA_RULE_DECISION	CHAR	1.00	0.00
IND_ANDA	T_NDC_NDA_ANDA	CHAR	1.00	0.00
IND_ANOTHER_PLAN	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_ANOTHER_PLAN	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_ANOTHER_PLAN	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_ANSWER	T_PR_ENRL_DISCLOSURE_ANS	CHAR	1.00	0.00
IND_APPEAL_STATUS	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
IND_APPL_APPROVAL	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_APPROVAL	T_RE_CONSENT_FORM_ACTIVITY	CHAR	1.00	0.00
IND_APPROVAL	T_RE_CONSENT_FORM_MASTER	CHAR	1.00	0.00
IND_APR	T_RE_1095	CHAR	1.00	0.00
IND_APR	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_AP_MED_SUPP	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	1.00	0.00

IND_AR	T_EXPENDITURE_RSN	CHAR	1.00	0.00
IND_AR	T_FIN_PAYEE	CHAR	1.00	0.00
IND_ARCHIVE	T_LG_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_ASSIST	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_ATTACHMENT	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_ATTACHMENT	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_ATTACHMENT	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_ATTACHMENT	T_PROC_ICD9_LIM	CHAR	1.00	0.00
IND_ATTACHMENT	T_PROC_LIMITS	CHAR	1.00	0.00
IND_ATTACHMENT	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_ATTACH_RECEIVED	T_ATTACHMENT_XREF	CHAR	1.00	0.00
IND_AUDIO	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_AUDIT	T_PR_PCP	CHAR	1.00	0.00
IND_AUDIT	T_RE_NET_VOUCHER	CHAR	1.00	0.00
IND_AUG	T_RE_1095	CHAR	1.00	0.00
IND_AUG	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_AUTH_REP	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_AUTOASSIGN	T_MC_PMP_ENRL_RGN	CHAR	1.00	0.00
IND_AUTOASSIGN	T_MC_PMP_ENRL_RGN_AL	CHAR	1.00	0.00
IND_AUTOMATED	T_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_AUTOMATED	T_LG_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_AUTO_ADJ	T_MC_RATE_CELL	CHAR	1.00	0.00
IND_AUTO_ASSIGN	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00

IND_AUTO_PA	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_BAD_STATUS	T_CLM_BATCH_PROCESS	CHAR	1.00	0.00
IND_BAD_STATUS	T_CLM_BATCH_PROCESS_ENC	CHAR	1.00	0.00
IND_BAD_STATUS	T_ENC_BATCH_PROCESS	CHAR	1.00	0.00
IND_BASE_ENTITY	T_FIN_PAYEE	CHAR	1.00	0.00
IND_BENEFITS_ASSIGNMENT	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00
IND_BENEFITS_ASSIGNMENT	T_INST_OTH_PYR_HDR	CHAR	1.00	0.00
IND_BENEFITS_ASSIGNMENT	T_PHYS_HDR_KEY	CHAR	1.00	0.00
IND_BENEFITS_ASSIGNMENT	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
IND_BENEFIT_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_BEN_ASSIGNMENT	T_DNTL_OTH_PYR_HDR	CHAR	1.00	0.00
IND_BEN_ASSIGNMENT	T_PROF_OTH_PYR_HDR	CHAR	1.00	0.00
IND_BILLER	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_BILLER	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_BIRTH_MONTH	T_ELIGCNT	CHAR	1.00	0.00

IND_BNFT_EXCLUDE	T_COV_BNFT_BNFT	CHAR	1.00	0.00
IND_BNFT_EXCLUDE	T_PAY_BNFT_BNFT	CHAR	1.00	0.00
IND_BNFT_EXCLUDE	T_REIMB_BNFT_BNFT	CHAR	1.00	0.00
IND_BORDER_STATE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_BORDER_STATE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_BORDER_STATE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_BORDER_STATE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_BP_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_BP_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_BP_IN_EXCLUD	T_MR_MSIS_AID	CHAR	1.00	0.00
IND_BP_IN_EXCLUD	T_STATE_COS	CHAR	1.00	0.00
IND_BRAND_GENERIC	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	1.00	0.00
IND_BRAND_MED_NEC	T_CA_DRUG	CHAR	1.00	0.00
IND_BRAND_MED_NEC	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_BRAND_MED_NEC	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_BRAND_MED_NEC	T_RETRO_SUMM_RECS	CHAR	1.00	0.00

IND_BRAND_MED_NEC	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_BRF_STATUS	T_CLM_BATCH_PROCESS	CHAR	1.00	0.00
IND_BRF_STATUS	T_CLM_BATCH_PROCESS_ENC	CHAR	1.00	0.00
IND_BUDGET	T_FINANCIAL_PAYER	CHAR	1.00	0.00
IND_BUDGET	T_FUND_PAYER	CHAR	1.00	0.00
IND_BURY_ASIDE	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_BURY_PREPAID	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_BURY_TRUST	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_BUYINA	T_PUB_HLTH_AID	CHAR	1.00	0.00
IND_CALC_GENERIC	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_CALC_GENERIC	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
IND_CALC_INTEREST	T_AR_DISP_REAS	CHAR	1.00	0.00
IND_CALC_PRICE	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_CANCEL	T_LS_DRUG_AWP_PRICING	CHAR	1.00	0.00
IND_CANCEL	T_LS_DRUG_MAC_PRICING	CHAR	1.00	0.00
IND_CANCEL	T_LS_LVL1_PRICING	CHAR	1.00	0.00
IND_CANCEL	T_LS_LVL3_PRICING	CHAR	1.00	0.00
IND_CANCEL	T_PDL_MASTER	CHAR	1.00	0.00
IND_CANCEL	T_PDL_MASTER_AL	CHAR	1.00	0.00
IND_CAP	T_FIN_BUDGET	CHAR	1.00	0.00
IND_CAPTURE	T_LG_LETTER_REQUEST	CHAR	1.00	0.00
IND_CAPTURE	T_LG_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_CAP_ADJ	T_CAP_REASON	CHAR	1.00	0.00
IND_CAP_OVERRIDE	T_MC_SPEC_COND	CHAR	1.00	0.00

IND_CARRIER	T_RE_CDE_PDP_TYPE	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_CA_CLAIM_KEY	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_CARRIER_DENIED	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_CASE_STATUS	T_RE_CARE_MNGR	CHAR	1.00	0.00
IND_CASH	T_FIN_PAYEE	CHAR	1.00	0.00
IND_CAST_CROWN	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_CC_PHTAR	T_CC_INDICATORS	CHAR	1.00	0.00
IND_CC_PHTAR	T_ERROR_DISP	CHAR	1.00	0.00
IND_CC_PRE_EMPTIVE	T_ERROR_DISP	CHAR	1.00	0.00
IND_CC_SAVINGS	T_CC_INDICATORS	CHAR	1.00	0.00
IND_CC_SAVINGS	T_ERROR_DISP	CHAR	1.00	0.00
IND_CDE_AID	T_STATE_COS	CHAR	1.00	0.00
IND_CDE_AID_REQ	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
IND_CERTIFIED_ASSIST	T_RE_IDENTIFIER	CHAR	1.00	0.00
IND_CG	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_CHECK	T_FIN_PAYEE	CHAR	1.00	0.00
IND_CHILD_SUPP_PAT_EST	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_CHIP	T_MR_TMSIS_CMS_ERROR_RECS	CHAR	1.00	0.00

IND_CHIP	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_CITIZENSHIP	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
IND_CLAIM	T_CASH_DISP_REASON	CHAR	1.00	0.00
IND_CLAIM	T_CA_CLAIM_KEY	CHAR	1.00	0.00
IND_CLAIM_CHECK	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_CLAIM_CHECK	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_CLAIM_CHECK	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_CLAIM_DENIED	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CLAIM_DENIED	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CLAIM_DENIED	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CLAIM_DENIED	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CLAIM_ONLY	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_CLAIM_TYPE	T_RE_EPS_HIST_EXT	CHAR	1.00	0.00
IND_CLDENDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLIA	T_PROC_LIMITS	CHAR	1.00	0.00
IND_CLLIDDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLLIRDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLM_BNFT_ROLE	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_CLM_BNFT_ROLE	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_CLM_INQUIRY	T_CLM_STATUS	CHAR	1.00	0.00
IND_CLOSED	T_CT_AR_TRACKING	CHAR	1.00	0.00
IND_CLOVLCLD	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLPROFLG	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLREJDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLRPRDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00
IND_CLSUSDSP	T_UB92_HDR_OUTPAT	CHAR	1.00	0.00

IND_CMHC	T_CT_CASE_TRACK	CHAR	1.00	0.00
IND_CMS	T_DR_INVOICE_TYPE	CHAR	1.00	0.00
IND_CMS64_REPORT	T_DR_INVOICE_TYPE	CHAR	1.00	0.00
IND_CMS_ACCEPTED	T_RE_MEDICARE_D	CHAR	1.00	0.00
IND_CMS_CLOTTING_FACTOR	T_DRUG_CMSFDB_INFO	CHAR	1.00	0.00
IND_CMS_CORRECTION	T_DR_CMS_TAPE	CHAR	1.00	0.00
IND_CMS_CORRECTION	T_DR_CMS_UROA	CHAR	1.00	0.00
IND_CMS_DRUG_TYPE	T_DRUG_CMSFDB_INFO	CHAR	1.00	0.00
IND_CMS_DRUG_TYPE	T_DR_CMS_TAPE	CHAR	1.00	0.00
IND_CMS_HCFA_UNIT	T_DRUG_CMSFDB_INFO	CHAR	3.00	0.00
IND_CMS_PARTD_FACILITY	T_CLM_PHRM_HDR	CHAR	1.00	0.00
IND_CMS_PEDIATRIC	T_DRUG_CMSFDB_INFO	CHAR	1.00	0.00
IND_CNTRL_SUBST	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_CNT_CHANGE	T_RE_PMP_REASON	CHAR	1.00	0.00
IND_COBA	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_CODE	T_TYPE_SPEC_EXCL	CHAR	1.00	0.00
IND_CODE_TYPE	T_PS_CDE_MI_DTRM	CHAR	1.00	0.00
IND_COMPOUND_DRUG	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CONCEPTN_TO_BIRTH	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
IND_CONDITION	T_CLM_CRC	CHAR	1.00	0.00
IND_CONDITION	T_MPHX_DSE_PROF	CHAR	1.00	0.00

IND_CONDITION_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_CONDITION_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_CONFERENCE	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_CONFIDENTIAL	T_PROC_LIMITS	CHAR	1.00	0.00
IND_CONFLICT	T_AUDIT_CL_TYPE_X	CHAR	1.00	0.00
IND_CONFLICTING_MME_FACTOR	T_MME_OPIOID_RTD_ING_MME	CHAR	1.00	0.00
IND_CONTRACT_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_CONV	T_DRUG_AWP	CHAR	1.00	0.00
IND_CONV	T_EAC	CHAR	1.00	0.00
IND_COPAY	T_CA_DRUG	CHAR	1.00	0.00
IND_COPAY	T_CLM_SYS_FIELDS_DTL	CHAR	1.00	0.00
IND_COPAY	T_LS_PHARMACY_OTHER	CHAR	1.00	0.00
IND_COPAY	T_PR_TYPE_CDE	CHAR	1.00	0.00
IND_COPAY	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_COPAY_WAIVER	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_COPAY_WAIVER	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_COPAY_WAIVER	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_COPAY_WAIVER	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CORRECTIONS	T_CLM_STATUS	CHAR	1.00	0.00
IND_CORR_FLAG	T_DR_INVOICE_DTL	CHAR	1.00	0.00

IND_CORR_FLAG	T_DR_RATE	CHAR	1.00	0.00
IND_CORR_FLAG	T_DR_RATE_UROA	CHAR	1.00	0.00
IND_COST_AVOID	T_TPL_RESOURCE	CHAR	1.00	0.00
IND_COST_CONT	T_ERROR_DISP	CHAR	1.00	0.00
IND_COUGH_AND_COLD_PREP	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
IND_COVERAGE	T_DRUG_DN	CHAR	1.00	0.00
IND_COVERED	T_PROC_ICD9_LIM	CHAR	1.00	0.00
IND_COV_PTPS_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_CREDIT	T_BUYA_BILL	CHAR	1.00	0.00
IND_CREDIT	T_BUYA_MISMATCH	CHAR	1.00	0.00
IND_CREDIT	T_BUYB_BILL	CHAR	1.00	0.00
IND_CREDIT	T_BUYB_MISMATCH	CHAR	1.00	0.00
IND_CREDIT_BALANCE	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_CRITERIA	T_AUTO_PA	CHAR	1.00	0.00
IND_CRITERIA	T_AUTO_PA_STEP_THPY_1	CHAR	1.00	0.00
IND_CRITERIA	T_AUTO_PA_STEP_THPY_2	CHAR	1.00	0.00
IND_CRITICAL	T_ERROR_DISP	CHAR	1.00	0.00
IND_CROSSOVER	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CROSSOVER	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CROSSOVER	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CROSSOVER	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_CT_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_CT_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00

IND_CT_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_CT_EDITING	T_PR_ENROLL_PGM	CHAR	1.00	0.00
IND_CT_EDITING	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_CURRENT	T_RE_AID_ELIG_DN	CHAR	1.00	0.00
IND_CURRENT	T_RE_ELIG_DN	CHAR	1.00	0.00
IND_CURRENT_SEG	T_LS_DRUG_AWP_PRICING	CHAR	1.00	0.00
IND_CURRENT_SEG	T_LS_DRUG_MAC_PRICING	CHAR	1.00	0.00
IND_CURRENT_SEGMENT	T_LS_LVL3_PRICING	CHAR	1.00	0.00
IND_DAW	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_DAY_CARE_EXCL	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_DCOR_RELEASE	T_DCOR_QLTY_CTL	CHAR	1.00	0.00
IND_DEBIT	T_TPL_AR_CAS_DISPS	CHAR	1.00	0.00
IND_DEBIT	T_TPL_AR_DISPS	CHAR	1.00	0.00
IND_DEBIT	T_TPL_AR_DISPS_AL	CHAR	1.00	0.00
IND_DEC	T_RE_1095	CHAR	1.00	0.00
IND_DEC	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_DEDUCTIBLE	T_DS_RECIP_DO_HLTH_INS	CHAR	1.00	0.00

IND_DEFAULT	T_FIN_CYCLE	CHAR	1.00	0.00
IND_DEFAULT_AA	T_MC_PMP_PANEL_RESTRICT	CHAR	1.00	0.00
IND_DEPENDENT	T_TPL_271_COVERAGE	CHAR	1.00	0.00
IND_DEPOSIT	T_CASH_BATCH_NUM	CHAR	1.00	0.00
IND_DET_EMAIL_SENT	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_DFLT_NPI_LOC	T_PR_IDENTIFIER	CHAR	1.00	0.00
IND_DHR_CHECK	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_DIAG	T_ERX_FORMULARY	CHAR	1.00	0.00
IND_DIAG_IN_EX	T_AUTO_PA_COMOR_DIAG	CHAR	1.00	0.00
IND_DIAG_IN_EX	T_AUTO_PA_PRIM_DIAG	CHAR	1.00	0.00
IND_DIAG_IN_EX	T_AUTO_PA_SECD_DIAG	CHAR	1.00	0.00
IND_DIAG_IN_EXCLUD	T_CDE_AID	CHAR	1.00	0.00
IND_DIAG_IN_EXCLUD	T_PLACE_OF_SERVICE	CHAR	1.00	0.00
IND_DIAG_IN_EXCLUD	T_STATE_COS	CHAR	1.00	0.00
IND_DIAG_REQ	T_PROC_LIMITS	CHAR	1.00	0.00
IND_DIAG_TYPE	T_AUDIT_CRIT	CHAR	1.00	0.00
IND_DIAG_TYPE	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
IND_DIR_AGT_QUE	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_DISABLED	T_PUB_HLTH_AID	CHAR	1.00	0.00
IND_DISBURSE	T_FIN_BUDGET	CHAR	1.00	0.00
IND_DISENROLL	T_POLICY_TYPE	CHAR	1.00	0.00
IND_DISENROLL	T_PR_ENROLL_INFO	CHAR	1.00	0.00

IND_DISP_FEE	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_DOB_VERIFIED	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_DO_NOT_TRNSFR	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_DO_NOT_UPDT	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_DO_NOT_XFER	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_DPV_CMRA	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_DPV_CMRA	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_DPV_CONFIRM	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_DPV_CONFIRM	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_DPV_FALSE_POS	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_DPV_FALSE_POS	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_DPV_NOSTAT	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_DPV_NOSTAT	T_RE_ADR_CASS	CHAR	1.00	0.00

IND_DPV_VACANT	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_DPV_VACANT	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_DRG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	4.00	0.00
IND_DRIVER	T_ERM_ENT	CHAR	1.00	0.00
IND_DRUG	T_TPL_RESTRICTION	CHAR	1.00	0.00
IND_DRUG_ALT	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_DRUG_CLASS	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_DRUG_CLASS	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
IND_DRUG_CNS	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_DRUG_CODE	T_STATE_COS	CHAR	1.00	0.00
IND_DRUG_GENERIC	T_AUDIT_GPI_XREF	CHAR	2.00	0.00
IND_DRUG_GENERIC	T_CA_DRUG	CHAR	1.00	0.00
IND_DRUG_GENERIC	T_CA_DRUG_GENERIC	CHAR	1.00	0.00
IND_DRUG_GENERIC	T_CLM_FCA	CHAR	1.00	0.00
IND_DRUG_GENERIC	T_DRUG	CHAR	1.00	0.00
IND_DRUG_GENERIC	T_DRUG_DN	CHAR	1.00	0.00
IND_DRUG_INNOV	T_DRUG	CHAR	1.00	0.00
IND_DRUG_INNOV	T_DRUG_DN	CHAR	1.00	0.00
IND_DRUG_IN_EX	T_AUTO_PA_STEP_THPY_1	CHAR	1.00	0.00

IND_DRUG_IN_EX	T_AUTO_PA_STEP_THPY_2	CHAR	1.00	0.00
IND_DRUG_MAINT	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_DRUG_REQ	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
IND_DRUG_SOURCE	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_DRUG_STD_PACK	T_DRUG	CHAR	1.00	0.00
IND_DRUG_STD_PACK	T_DRUG_DN	CHAR	1.00	0.00
IND_DRUG_TYPE	T_DISP_FEE	CHAR	1.00	0.00
IND_DRUG_TYPE	T_PR_DISP_FEE	CHAR	1.00	0.00
IND_DTRMN_RCVD	T_PS_DETERMINATION	CHAR	1.00	0.00
IND_DTRMN_RCVD	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_DUAL	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_DUAL_AID	T_PUB_HLTH_AID	CHAR	1.00	0.00
IND_DUAL_ELIGIBLES	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_DUPE	T_TPL_AR_HEALTH	CHAR	1.00	0.00
IND_DUPE	T_TPL_AR_HEALTH_XXX	CHAR	1.00	0.00
IND_DUPLEX	T_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_EARNINGS	T_FIN_PAYEE	CHAR	1.00	0.00
IND_EDIT_DISP	T_CLM_STATUS	CHAR	1.00	0.00

IND_EFT	T_FIN_PAYEE	CHAR	1.00	0.00
IND_EFT_TYPE	T_PR_ENRL_EFT_ACCT	CHAR	1.00	0.00
IND_EFT_TYPE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	1.00	0.00
IND_ELECT_CLM	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_ELECT_CLM	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_ELEC_BILLER	T_PR_SVC_LOC_STATE_KY	CHAR	1.00	0.00
IND_ELIG_STA	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
IND_EMAIL_SENT	T_PS_DETERMINATION	CHAR	1.00	0.00
IND_EMAIL_SENT	T_PS_REFERRAL	CHAR	1.00	0.00
IND_EMERG	T_PA_PAUTH	CHAR	1.00	0.00
IND_EMERGENCY	T_CDE_AID	CHAR	1.00	0.00
IND_EMERGENCY	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_DENY_PHYS_DTL	CHAR	1.00	0.00

IND_EMERGENCY	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_EMERGENCY	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
IND_EMERGENCY	T_PA_1261A_PSY	CHAR	1.00	0.00
IND_EMERGENCY	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_EMERGENCY	T_PHYSICIAN_COS	CHAR	1.00	0.00
IND_EMERGENCY	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_EMERGENCY	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_EMPTY_BED	T_RE_LOC	CHAR	1.00	0.00
IND_ENABLED	T_LG_CDE_HISTORY	CHAR	1.00	0.00
IND_ENCOUNTER	T_CDE_SUPPORTED_DOC	CHAR	1.00	0.00
IND_ENCOUNTER	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_MEDPOL_UB92	CHAR	1.00	0.00
IND_ENCOUNTER	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
IND_ENCOUNTER	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
IND_ENCOUNTER	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
IND_ENCOUNTER	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_SUSP_PHRM_HDR	CHAR	1.00	0.00

IND_ENCOUNTER	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_ENCOUNTER	T_TPL_COST_AVOID_SUMM	CHAR	1.00	0.00
IND_ENCOUNTER_CURR	T_AUDIT_ENC_XREF	CHAR	1.00	0.00
IND_ENCOUNTER_HIST	T_AUDIT_ENC_XREF	CHAR	1.00	0.00
IND_EPSDT	T_CA_HDR_DTL	CHAR	1.00	0.00
IND_EPSDT	T_CA_IND_KEY	CHAR	1.00	0.00
IND_EPSDT	T_PA_DTL	CHAR	1.00	0.00
IND_EPSDT_IN_EX	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
IND_EPSDT_REF	T_DENY_PHYS_DTL	CHAR	2.00	0.00
IND_EPSDT_REF	T_MPHX_PHYS_DTL	CHAR	2.00	0.00
IND_EPSDT_REF	T_PD_PHYS_DTL	CHAR	2.00	0.00
IND_EPSDT_REF	T_SUSP_PHYS_DTL	CHAR	2.00	0.00

IND_EPSDT_SCREEN	T_CA_IND_KEY	CHAR	1.00	0.00
IND_ERROR	T_BUYA_BILL	CHAR	1.00	0.00
IND_ERROR	T_BUYB_BILL	CHAR	1.00	0.00
IND_ERROR	T_PR_INTERFACE_STATS	CHAR	1.00	0.00
IND_ERROR	T_RE_HIST_LOG	CHAR	1.00	0.00
IND_ERROR	T_RE_PS2_LOG	CHAR	1.00	0.00
IND_ETHNIC_CHICANO	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_CUBAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_MEXICAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_MEX_AMER	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_NONE_SEL	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_OTHER	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_ETHNIC_PUERTO_RICO	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_EWS	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_EWS	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_EXAM	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_EXCL	T_TP_SPC_MOD_EXCL	CHAR	1.00	0.00
IND_EXCLUDE	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
IND_EXCLUDE	T_DS_RECIP_DO_VEHICLE	CHAR	1.00	0.00
IND_EXCLUDE	T_HIPP_RECIP	CHAR	1.00	0.00
IND_EXEMPT_DEACTIV	T_PR_SVC_LOC_STATE_KY	CHAR	1.00	0.00
IND_EXHAUST	T_COVERAGE_XREF	CHAR	1.00	0.00
IND_EXHAUST	T_COVERAGE_XREF	CHAR	1.00	0.00
IND_EXPECT_INBOUND_997	T_TP_CONFIG	CHAR	1.00	0.00

IND_EXPEND	T_FIN_PAYEE	CHAR	1.00	0.00
IND_EXPENSE	T_RE_EXPENSE	CHAR	1.00	0.00
IND_EXPLICIT	T_EVS_CDE_SVC_TYPE	CHAR	1.00	0.00
IND_EXTERNAL	T_LOCATION	CHAR	1.00	0.00
IND_FAMILY_PLANNING	T_CLM_FCA	CHAR	1.00	0.00
IND_FAM_PLAN	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_FAM_PLAN	T_PROC_LIMITS	CHAR	1.00	0.00
IND_FCBC_CRITERIA_MET	T_PR_ENROLL_SCRN	CHAR	1.00	0.00
IND_FDB_HCFA_UNIT	T_DRUG_CMSFDB_INFO	CHAR	3.00	0.00
IND_FDOS_ADMIT	T_CONFLICT_PARM	CHAR	1.00	0.00
IND_FEB	T_RE_1095	CHAR	1.00	0.00
IND_FEB	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_FEE	T_PR_ENROLL_SCRN	CHAR	1.00	0.00
IND_FFS	T_MR_ERROR	CHAR	1.00	0.00
IND_FFS	T_MR_ERROR_DTL	CHAR	1.00	0.00
IND_FFS	T_MR_ERROR_KY	CHAR	1.00	0.00
IND_FFS	T_MR_LTC	CHAR	1.00	0.00
IND_FFS	T_MR_LTC_REV	CHAR	1.00	0.00
IND_FFS	T_MR_OP_PERFORM	CHAR	1.00	0.00
IND_FFS	T_MR_OP_PERFORM_DTL	CHAR	1.00	0.00

IND_FFS	T_MR_POS	CHAR	1.00	0.00
IND_FFS	T_MR_POS_RE	CHAR	1.00	0.00
IND_FFS	T_MR_PROV	CHAR	1.00	0.00
IND_FFS	T_MR_PROV_DENIED	CHAR	1.00	0.00
IND_FFS	T_MR_PROV_PERFORM	CHAR	1.00	0.00
IND_FFS	T_MR_PROV_PERFORM_DTL	CHAR	1.00	0.00
IND_FFS	T_MR_PROV_PERFORM_KY	CHAR	1.00	0.00
IND_FFS	T_MR_PROV_RE	CHAR	1.00	0.00
IND_FFS	T_MR_RE	CHAR	1.00	0.00
IND_FFS	T_MR_RECIP	CHAR	1.00	0.00
IND_FFS	T_MR_RECIP_KY	CHAR	1.00	0.00
IND_FFS	T_MR_RECIP_RANK	CHAR	1.00	0.00
IND_FFS	T_MR_RE_CNTY	CHAR	1.00	0.00
IND_FFS	T_MR_RE_KY	CHAR	1.00	0.00
IND_FFS	T_MR_XOVER	CHAR	1.00	0.00
IND_FICA	T_FIN_PROCESS_PROV_ID	CHAR	1.00	0.00
IND_FICA	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_FICA	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_FICA	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
IND_FILE_OTHER1	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FILE_OTHER2	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FILE_PSYCHIATR	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FILE_PSYCHOLOG	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FILE_QUEST	T_PS_ICF_MR	CHAR	1.00	0.00

IND_FILE_SOC_HIST	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FILE_STATUS	T_TMSIS_EXT_HDR	VARCHAR2	1.00	0.00
IND_FILE_WORKSHEET	T_PS_ICF_MR	CHAR	1.00	0.00
IND_FINAL_NF	T_PS_DETERMINATION	CHAR	1.00	0.00
IND_FINAL_NF	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_FIXED_PAYMENT	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FIXED_PAYMENT	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FIXED_PAYMENT	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FIXED_PAYMENT	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FLUORIDE_TREAT	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_FMLY_PRAC	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_FMLY_PRAC	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_FMLY_PRAC	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_FMLY_PRAC	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00
IND_FMLY_PRAC	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_FOOD_STAMPS	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_FORCED_CLAIM	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FORCED_CLAIM	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FORCED_CLAIM	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FORCED_CLAIM	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_FORCE_MANUAL_PRICE	T_ERROR_DISP	CHAR	1.00	0.00
IND_FORM_147	T_IRS_W9_INFO	CHAR	1.00	0.00
IND_FP	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_FP_SYS	T_CA_DRUG	CHAR	1.00	0.00

IND_FP_SYS	T_CLM_SYS_FIELDS_DTL	CHAR	1.00	0.00
IND_FQHC_ENC	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
IND_FQHC_PROV	T_DS_DNTL_PR_ENROLL	CHAR	1.00	0.00
IND_FREQUENCY	T_MC_CENSUS	CHAR	1.00	0.00
IND_FREQUENCY	T_MC_CENSUS_LOC	CHAR	1.00	0.00
IND_FROM_THRU_OK	T_PROC_LIMITS	CHAR	1.00	0.00
IND_FULL_FILE_RQST	T_EDI_TP_834_RQST	CHAR	1.00	0.00
IND_FUND_CODE	T_STATE_COS	CHAR	1.00	0.00
IND_FUND_REQ	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
IND_GCNSEQ_GI	T_GENERIC_DRUG	CHAR	1.00	0.00
IND_GENDER	T_GENERIC_DRUG	CHAR	1.00	0.00
IND_GENERATE_MODE	T_LG_LETTER_REQUEST	CHAR	1.00	0.00
IND_GENERATE_MODE	T_LTR_RQST_TEMPLAT	CHAR	1.00	0.00
IND_GENERIC	T_EVS_CDE_SVC_TYPE	CHAR	1.00	0.00
IND_GENERIC	T_LS_DRUG_MASTER	CHAR	1.00	0.00
IND_GENERIC_PROD	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_GENERIC_PROD	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
IND_GENERIC_PRODUCT	T_LS_DRUG_MASTER	CHAR	1.00	0.00
IND_GENERIC_PROD_AL	T_LS_DRUG_MASTER	CHAR	1.00	0.00

IND_GI	T_LS_PHARMACY_CLAIMS	CHAR	1.00	0.00
IND_GI	T_LS_SUMMARY_NDC	CHAR	1.00	0.00
IND_GIS_QUALITY	T_PR_ADR	NUMBER	4.00	0.00
IND_GIS_QUALITY	T_PR_ADR_AL	NUMBER	4.00	0.00
IND_GIS_QUALITY	T_PR_ADR_WI	NUMBER	4.00	0.00
IND_GL	T_CASH_DISP_REASON	CHAR	1.00	0.00
IND_GNI	T_DRUG	CHAR	1.00	0.00
IND_GNI	T_DRUG_DN	CHAR	1.00	0.00
IND_GOOD_CAUSE	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_GROUP	T_PR_TYPE_CDE	CHAR	1.00	0.00
IND_GRP_INDIV	T_PR_LABEL_CRIT	CHAR	1.00	0.00
IND_HAS_OPIOID_DAILY_DOSE	T_MME_OPIOID_CF_MME_FACTOR	CHAR	1.00	0.00
IND_HAS_OPIOID_DAILY_DOSE	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
IND_HAS_OPIOID_DAILY_DOSE	T_MME_OPIOID_RTD_ING_MME	CHAR	1.00	0.00
IND_HCAC	T_CA_UB92	CHAR	1.00	0.00
IND_HCAC	T_UB92_HDR_INP	CHAR	1.00	0.00
IND_HCFA_UNIT	T_DRUG	CHAR	3.00	0.00

IND_HCFA_UNIT	T_DRUG_DN	CHAR	3.00	0.00
IND_HEALTHCARE	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_HEALTHCARE	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_HEALTHCARE	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
IND_HEALTHCARE	T_PR_TYPE_SPEC	CHAR	1.00	0.00
IND_HEIR	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
IND_HH_MEDICARE_COV	T_CLM_CR6	CHAR	1.00	0.00
IND_HH_SNF	T_CLM_CR6	CHAR	1.00	0.00
IND_HIPAA	T_TRANSACTION_TYPE	CHAR	1.00	0.00
IND_HIPP	T_TPL_EMPLOYER	CHAR	1.00	0.00
IND_HIPP	T_TPL_HMS_HIPP_XREF	CHAR	1.00	0.00
IND_HIPP_PURCHASE	T_HIPP_RESOURCE	CHAR	1.00	0.00
IND_HISPANIC	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_HIST	T_ADJ_MASS_RQST	CHAR	1.00	0.00
IND_HIST	T_CA_MATERNITY_CARE	CHAR	1.00	0.00
IND_HIST	T_CLM_MAT_CARE_HDR	CHAR	1.00	0.00
IND_HIST	T_DR_RATE	CHAR	1.00	0.00
IND_HIST	T_DR_RATE_UROA	CHAR	1.00	0.00
IND_HISTORY_MI	T_PS_DETERMINATION	CHAR	1.00	0.00
IND_HIST_CURR	T_CC_HIST_ADJUST	CHAR	1.00	0.00
IND_HIST_CURR	T_FIN_EFT_RELEASE	CHAR	1.00	0.00
IND_HIST_MI	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_HLTH_CARE_ACQ_COND	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HLTH_CARE_ACQ_COND	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HLTH_CARE_ACQ_COND	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HLTH_HOME_PROV	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00

IND_HLTH_HOME_PROV	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HLTH_HOME_PROV	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HLTH_HOME_PROV	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_HOH	T_RE_HOH	CHAR	1.00	0.00
IND_HOLD	T_SYS_REPORT_ROUTE	CHAR	1.00	0.00
IND_HOLD_ABANDON	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_HOSPICE_NH	T_RE_ASSIGN_PLAN	CHAR	1.00	0.00
IND_HOSPICE_NH	T_RE_ASSIGN_PLAN_LI	CHAR	1.00	0.00
IND_HOSPICE_NH	T_RE_ASSIGN_PLAN_RLOC	CHAR	1.00	0.00
IND_HOSPICE_NH_RLOC	T_RE_BASE_DN	CHAR	1.00	0.00
IND_HYST	T_CA_HDR_DTL	CHAR	1.00	0.00
IND_HYST	T_CA_IND_KEY	CHAR	1.00	0.00
IND_INACTIVE	T_HIC4	CHAR	1.00	0.00
IND_INCL_DEDUCT	T_MC_RATE_CELL	CHAR	1.00	0.00
IND_INCL_IN_BUDGET	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_INDIAN_MGDCARE	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_INDIAN_MGDCARE	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_INDIAN_MGDCARE	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
IND_INJECTABLE_OPIOID	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
IND_INST_STATUS	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00

IND_INSURED	T_PA_HDR	CHAR	1.00	0.00
IND_INS_DISCLOSURE	T_TPL_CARRIER	CHAR	1.00	0.00
IND_INS_DISCLOSURE	T_TPL_CARRIER_AL	CHAR	1.00	0.00
IND_INS_TERM_ID	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_INTEREST	T_LOCATION	CHAR	1.00	0.00
IND_INTEREST_CALC	T_DR_INVOICE_TYPE	CHAR	1.00	0.00
IND_INT_ADDRESS	T_COUNTRY	CHAR	1.00	0.00
IND_INT_PHONE	T_COUNTRY	CHAR	1.00	0.00
IND_IN_EX	T_AUDIT_NDC	CHAR	1.00	0.00
IND_IN_EXCLUDE	T_PROC_ICD9_DIA	CHAR	1.00	0.00
IND_IN_EXCLUDE	T_PR_RST_SVC	CHAR	1.00	0.00
IND_IN_EX_CLAIM	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_CLM_MED	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_FUND	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PAYEE	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PAYER	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PAY_TYPE	T_PAYMENT_HOLD	CHAR	1.00	0.00

IND_IN_EX_PROGRAM	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PROVIDER	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PROV_SPEC	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_PR_TYPE	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IN_EX_SCOS	T_PAYMENT_HOLD	CHAR	1.00	0.00
IND_IPI	T_DRUG_STATE_AL	CHAR	1.00	0.00
IND_IRS_B	T_LIEN_RSN_CODE	CHAR	1.00	0.00
IND_JAN	T_RE_1095	CHAR	1.00	0.00
IND_JAN	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_JUL	T_RE_1095	CHAR	1.00	0.00
IND_JUL	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_JUN	T_RE_1095	CHAR	1.00	0.00
IND_JUN	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_LABELER_UPDATE	T_DR_INVOICE_TYPE	CHAR	1.00	0.00

IND_LACS	T_PR_ADR_CASS	CHAR	1.00	0.00
IND_LACS	T_RE_ADR_CASS	CHAR	1.00	0.00
IND_LANDSCAPE	T_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_LAST_ACTION	T_LS_DRUG_AWP_PRICING	CHAR	1.00	0.00
IND_LAST_ACTION	T_LS_DRUG_MAC_PRICING	CHAR	1.00	0.00
IND_LATEST_CLM	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_LATEST_CLM	T_DS_HM_HEADER	CHAR	1.00	0.00
IND_LBLRIND	T_DRUG_MANUF	CHAR	1.00	0.00
IND_LEGAL_AUTH	T_DS_RECIP_DO_APPL_SPONS	CHAR	1.00	0.00
IND_LEGAL_GUARDIAN	T_PS_CASE_ADDRESS	CHAR	1.00	0.00
IND_LETTER	T_PA_PAUTH	CHAR	1.00	0.00
IND_LETTER	T_RE_EPSDT_LETTER	CHAR	1.00	0.00
IND_LETTER	T_RE_EPSDT_LETTER	CHAR	1.00	0.00
IND_LETTER	T_RE_EPSDT_NOTICE	CHAR	1.00	0.00
IND_LETTERHEAD	T_LETTER_TEMPLATE	CHAR	1.00	0.00
IND_LETTERS	T_MC_PMP_ENRL_RGN	CHAR	1.00	0.00
IND_LETTERS	T_MC_PMP_ENRL_RGN_AL	CHAR	1.00	0.00
IND_LETTERS	T_MC_PMP_MASS_XFER	CHAR	1.00	0.00
IND_LEVEL	T_ERX_RESOURCE_LINK	CHAR	1.00	0.00
IND_LEVEL_II_NEED	T_PS_CASE	CHAR	1.00	0.00
IND_LICENSE_REQD	T_PR_TYPE_CDE	CHAR	1.00	0.00

IND_LIEN	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
IND_LIEN	T_FIN_PAYEE	CHAR	1.00	0.00
IND_LIFELINE_PERMISSION	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_LIFETIME	T_PROC_LIMITS	CHAR	1.00	0.00
IND_LIFETIME_CARE	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_LIFE_ESTATE	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
IND_LINE_ADJUST	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	1.00	0.00
IND_LINE_ADJUST	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	1.00	0.00
IND_LINE_ADJUST	T_TMSIS_COT003_CLM_DTL	VARCHAR2	1.00	0.00
IND_LINE_ADJUST	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	1.00	0.00
IND_LINK	T_AUTO_PA_AGE	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_COMOR_DIAG	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_GRNDFTR	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_PRIM_DIAG	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_SECD_DIAG	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_STEP_THPY_1	CHAR	1.00	0.00
IND_LINK	T_AUTO_PA_STEP_THPY_2	CHAR	1.00	0.00
IND_LINKED	T_BUYA_MISMATCH	CHAR	1.00	0.00
IND_LINKED	T_BUYB_MISMATCH	CHAR	1.00	0.00
IND_LIVE_W_PARENTS	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_LNDISCFN	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LNLIAFLG	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00

IND_LNLIRFLG	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LNPAYADJ	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LNPAYMTH	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LNPKGFLG	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LNPPYIND	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00

IND_LNPSEIND	T_UB92_DTL_OUTPAT_GROUP	CHAR	1.00	0.00
IND_LOCKED	T_CT_PROV_CRIT	CHAR	1.00	0.00
IND_LOCKED	T_CT_RE_CRIT	CHAR	1.00	0.00
IND_LONG_ACTING_OPIOID	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
IND_LTC	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_LTC_PARTB	T_DS_RECIP_DO_HLTH_INS	CHAR	1.00	0.00
IND_LTR_AUTH	T_TPL_CLERK	CHAR	1.00	0.00
IND_LTR_GEN	T_AUTO_PA	CHAR	1.00	0.00
IND_LVL_CARE	T_PR_TYPE_CDE	CHAR	1.00	0.00
IND_MAC	T_LS_DRUG_MAC_PRICING	CHAR	1.00	0.00
IND_MAILABILITY	T_REF_CDE_DPV_GROUP	CHAR	1.00	0.00
IND_MAINT	T_DRUG	CHAR	1.00	0.00

IND_MAINT	T_DRUG_DN	CHAR	1.00	0.00
IND_MAJOR_PGM	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_MALICIOUS	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_MANAGED_CARE	T_MR_ELIG_SAK	CHAR	1.00	0.00
IND_MANAGED_CARE	T_MR_PR_ENROL_SAK	CHAR	1.00	0.00
IND_MANAGE_CARE	T_PA_PAUTH	CHAR	1.00	0.00
IND_MANAGE_CARE	T_PR_LABEL_CRIT	CHAR	1.00	0.00
IND_MANAGE_CARE	T_PUB_HLTH_AID	CHAR	1.00	0.00
IND_MANUAL	T_EXPENDITURE_RSN	CHAR	1.00	0.00
IND_MAN_ONLY	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
IND_MAN_ONLY	T_STATE_COS	CHAR	1.00	0.00
IND_MAR	T_RE_1095	CHAR	1.00	0.00
IND_MAR	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_MASS_RATE_UPD	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_MASS_RATE_UPD	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_MASS_RATE_UPD	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
IND_MATCH	T_CLM_FACSIMILE_EXTRACT	CHAR	1.00	0.00
IND_MATCH	T_CLM_PROCESSED_EXTRACT	CHAR	1.00	0.00
IND_MAT_CARE_EXEMPT	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
IND_MAY	T_RE_1095	CHAR	1.00	0.00

IND_MAY	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_MC	T_CLM_PGM_XREF	CHAR	1.00	0.00
IND_MCAID_BOND_EXEMPT	T_PR_BOND	CHAR	1.00	0.00
IND_MCARE_ACC_EXEMPT	T_PR_BOND	CHAR	1.00	0.00
IND_MCARE_BOND_EXEMPT	T_PR_BOND	CHAR	1.00	0.00
IND_MCARE_CLM_CNTRL	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_MCARE_COVERED	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_MC_EXCL	T_PGM_EXCLUSION	CHAR	1.00	0.00
IND_MDCR_COMB_DED	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_MDCR_COMB_DED	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_MDCR_COMB_DED	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_MDCR_COMB_DED	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_MEDIA_TYPE	T_LTR_RQST_TRK	CHAR	1.00	0.00
IND_MEDICAL_SVCS	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_ADJ	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_ADJ_DN	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_ADJ_WI	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_HIST	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_HIST_DN	CHAR	1.00	0.00
IND_MEDICARE	T_CAPITATION_HIST_WI	CHAR	1.00	0.00

IND_MEDICARE	T_MC_CAP_DEMOGRAPH_KY	CHAR	1.00	0.00
IND_MEDICARE_A	T_RE_BASE_DN	CHAR	1.00	0.00
IND_MEDICARE_B	T_RE_BASE_DN	CHAR	1.00	0.00
IND_MED_INCURRED	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_MED_REVIEW	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_MED_REVIEW	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_MEETS	T_PR_PCP	CHAR	1.00	0.00
IND_MESSAGE	T_FILE_TRACK	CHAR	1.00	0.00
IND_MGD_CARE	T_PR_COVERED_PGM	CHAR	1.00	0.00
IND_MGD_PLAN	T_DS_CLM_CNT_PAID_DTE	CHAR	1.00	0.00
IND_MGD_PLAN	T_DS_CLM_CNT_SVC_DTE	CHAR	1.00	0.00
IND_MGD_REF	T_CA_IND_KEY	CHAR	1.00	0.00
IND_MGD_REF	T_CLM_SYS_FIELDS_DTL	CHAR	1.00	0.00
IND_MGD_REF	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
IND_MI_OBSOLETE	T_PS_CDE_MI_DTRM	CHAR	1.00	0.00
IND_MLIF	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_MME_FACTOR_AVAILABLE	T_MME_OPIOID_MED_MASTER	CHAR	1.00	0.00
IND_MN	T_ERX_FORMULARY	CHAR	1.00	0.00
IND_MNGD_HLTH	T_CA_IND_KEY	CHAR	1.00	0.00

IND_MNY_GRANT	T_RE_BASE	CHAR	1.00	0.00
IND_MOBILE_HOME	T_DS_RECIP_DO_REAL_EST	CHAR	1.00	0.00
IND_MOD_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_MOD_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_MOD_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_MORE_BUYIN	T_BUYA_BILL	CHAR	1.00	0.00
IND_MORE_BUYIN	T_BUYB_BILL	CHAR	1.00	0.00
IND_MOVE_IN_OUT	T_RE_MOVE_IN_OUT	CHAR	1.00	0.00
IND_MR_OBSOLETE	T_PS_CDE_MR_DTRM	CHAR	1.00	0.00
IND_MULTIVALUE	T_RU_RELATION	CHAR	1.00	0.00
IND_MULTI_SURFACE	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_NAME_TYPE	T_FIN_PROCESS_PROV_ID	CHAR	1.00	0.00
IND_NAME_TYPE	T_PR_APPLN	CHAR	1.00	0.00
IND_NAME_TYPE	T_PR_APPLN_WI	CHAR	1.00	0.00

IND_NAME_TYPE	T_PR_BOARD	CHAR	1.00	0.00
IND_NAME_TYPE	T_PR_NAM	CHAR	1.00	0.00
IND_NAME_TYPE	T_PR_SANCTION_AL	CHAR	1.00	0.00
IND_NAME_TYPE	T_PR_SANCTION_WI	CHAR	1.00	0.00
IND_NDA	T_NDC_NDA_ANDA	CHAR	1.00	0.00
IND_NDC_LOCK	T_PA_LINE_ITEM	CHAR	1.00	0.00
IND_NDC_REQUIRED	T_CLM_NDC_DTL	CHAR	1.00	0.00
IND_NEW_REFILL	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	2.00	0.00
IND_NF_OBSOLETE	T_PS_CDE_NF_DISP	CHAR	1.00	0.00
IND_NOV	T_RE_1095	CHAR	1.00	0.00
IND_NOV	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_NO_INCOME	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_NO_SUR_CSE_OPN	T_CT_REFERRALS	CHAR	1.00	0.00
IND_NPI_TRIGGER	T_DISP_SHARE	CHAR	1.00	0.00
IND_NPI_TRIGGER	T_RE_SPEND_PROV	CHAR	1.00	0.00
IND_NPI_VERIFY	T_PR_IDENTIFIER	CHAR	1.00	0.00
IND_NURSE_HOME	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_NURSE_HOME	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_NURSE_HOME	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_OBSERVG_CALL	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_OBSTETRICS	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_OBSTETRICS	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_OBSTETRICS	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_OBSTETRICS	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00

IND_OBSTETRICS	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_OCCURRENCE_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_OCCURRENCE_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_OCT	T_RE_1095	CHAR	1.00	0.00
IND_OCT	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_OFST_EPSDT_SCRNR	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_OL	T_CASH_DISP_REASON	CHAR	1.00	0.00
IND_ONE_SURFACE	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_ON_REVIEW	T_DRG_RATE	CHAR	1.00	0.00
IND_ON_REVIEW	T_PR_PROV	CHAR	1.00	0.00
IND_OOS	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_OOS	T_PR_SVC_LOC_STATE_KY	CHAR	1.00	0.00
IND_OPER_ROOM	T_PROC_ICD9_LIM	CHAR	1.00	0.00
IND_ORDER	T_PROFILE_PHARM_TOP_DRUGS	CHAR	1.00	0.00
IND_OTHER_INSURANCE	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_OTHER_INSURANCE	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_OTHER_INSURANCE	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_OTHER_INSURANCE	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_OTH_PAY_RECOUP	T_FINANCIAL_PAYER	CHAR	1.00	0.00
IND_OTH_PAY_RECOUP	T_FUND_PAYER	CHAR	1.00	0.00
IND_OTH_PHAR	T_PRODUR_WARN	CHAR	1.00	0.00

IND_OTH_PRESCRB	T_PRODUR_WARN	CHAR	1.00	0.00
IND_OVERRIDE	T_ALERT_DISP	CHAR	1.00	0.00
IND_OVERRIDE	T_ALLERGY	CHAR	1.00	0.00
IND_OVERRIDE	T_CONTRA_DISEASE	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_DISEASE	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_GER	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_GER	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_GER_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_INVERSE	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_LIMITS	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_OVER_UTIL	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_PED	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_PED	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_PED_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_PREG	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_PREG_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_SCREEN	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_SCREEN	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_THER_DUPE	CHAR	1.00	0.00
IND_OVERRIDE	T_DRUG_UNDER_UTIL	CHAR	1.00	0.00
IND_OVERRIDE	T_GERI_DOSE	CHAR	1.00	0.00

IND_OVERRIDE	T_HIGH_DOSE	CHAR	1.00	0.00
IND_OVERRIDE	T_HIGH_DOSE	CHAR	1.00	0.00
IND_OVERRIDE	T_HIGH_DOSE_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_INGRED_DUPE	CHAR	1.00	0.00
IND_OVERRIDE	T_INVRS_UPDT_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_LOW_DOSE	CHAR	1.00	0.00
IND_OVERRIDE	T_LOW_DOSE	CHAR	1.00	0.00
IND_OVERRIDE	T_LOW_DOSE_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_OVER_UTIL_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_PEDI_DOSE	CHAR	1.00	0.00
IND_OVERRIDE	T_REF_CDE_DPV_GROUP	CHAR	1.00	0.00
IND_OVERRIDE	T_RE_CONSENT_FORM_ACTIVITY	CHAR	1.00	0.00
IND_OVERRIDE	T_RE_CONSENT_FORM_MASTER	CHAR	1.00	0.00
IND_OVERRIDE	T_THERA_DUP_LOG	CHAR	1.00	0.00
IND_OVERRIDE	T_THERA_DURATION	CHAR	1.00	0.00
IND_OVERRIDE	T_THERA_DURATION	CHAR	1.00	0.00
IND_OVERRIDE	T_UNDER_UTIL_LOG	CHAR	1.00	0.00
IND_OWNER_INTEREST	T_PR_PROV	CHAR	1.00	0.00
IND_OWN_HOME	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_PA	T_AUDIT_CRIT	CHAR	1.00	0.00
IND_PA	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
IND_PA	T_COVERED_BENEFIT	CHAR	1.00	0.00
IND_PA	T_DRUG_ACT_COV	CHAR	1.00	0.00

IND_PA	T_DRUG_DN	CHAR	1.00	0.00
IND_PA	T_ERX_FORMULARY	CHAR	1.00	0.00
IND_PA	T_MEDPOL_UB92	CHAR	1.00	0.00
IND_PA	T_MPHX_DENTAL_DTL	CHAR	1.00	0.00
IND_PA	T_MPHX_PHRM_DTL_AL	CHAR	1.00	0.00
IND_PA	T_MPHX_PHYS_DTL	CHAR	1.00	0.00
IND_PA	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_PAID_DENIED	T_RE_EPS_HIST_EXT	CHAR	1.00	0.00
IND_PALLIATIVE_TREAT	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_PANEL_HOLD	T_MC_PMP_ENRL_RGN	CHAR	1.00	0.00
IND_PANEL_HOLD	T_MC_PMP_ENRL_RGN_AL	CHAR	1.00	0.00
IND_PANEL_HOLD	T_MC_PMP_PANEL_RESTRICT	CHAR	1.00	0.00
IND_PANEL_HOLD_OVRD	T_MC_RE_PMP_SEL	CHAR	1.00	0.00
IND_PAPER_ALLOW	T_PR_SVC_LOC_STATE_KY	CHAR	1.00	0.00
IND_PAPER_EOB	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
IND_PARTD_AE_DECL	T_RE_PARTD_PDP_ASSIGN	CHAR	1.00	0.00
IND_PARTD_EXCL	T_CA_DRUG	CHAR	1.00	0.00
IND_PARTD_EXCL	T_DENY_PHRM_DTL	CHAR	1.00	0.00
IND_PARTD_EXCL	T_PD_PHARM_DTL	CHAR	1.00	0.00
IND_PARTD_EXCL	T_SUSP_PHRM_DTL	CHAR	1.00	0.00

IND_PAS_OBSOLETE	T_PS_CDE_PASRR	CHAR	1.00	0.00
IND_PATIENT_ASSIGNMENT	T_CLM_PHRM_HDR	CHAR	1.00	0.00
IND_PAT_EST	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_PAYEE	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_PAYEE	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_PAYMENT_LEVEL	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_PAYMENT_LEVEL	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_PAYMENT_LEVEL	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_PAYMENT_LEVEL	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
IND_PAY_BNFT_BNFT	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_PAY_DAY_CARE	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_PA_FORCE	T_CA_BENEFIT_LIMITS	CHAR	1.00	0.00
IND_PA_FORCE	T_CLM_BENEFIT_LIMITS	CHAR	1.00	0.00
IND_PA_REQ	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
IND_PBSH_EPSDT_SCRNR	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_PCP	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_PCP_TYPE	T_PR_PCP	CHAR	1.00	0.00
IND_PC_ADDR_CHG	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_PC_TC	T_RBRVS	CHAR	1.00	0.00
IND_PC_TC	T_RBRVS_UPDATE	CHAR	1.00	0.00
IND_PDL	T_ERX_FORMULARY	CHAR	1.00	0.00

IND_PDL	T_PDL_MASTER	CHAR	1.00	0.00
IND_PDL	T_PDL_MASTER_AL	CHAR	1.00	0.00
IND_PDL_ASSIGN	T_DRUG_STATE_AL	CHAR	1.00	0.00
IND_PEER_GROUP	T_PR_TYPE_CDE	CHAR	1.00	0.00
IND_PERSIST	T_PR_INACTV_EXMPT_AL	CHAR	1.00	0.00
IND_PES	T_CA_IND_KEY	CHAR	1.00	0.00
IND_PLA	T_HIPAA_MC_ASSIGN	CHAR	1.00	0.00
IND_PLAN	T_RE_CDE_PDP_TYPE	CHAR	1.00	0.00
IND_PLAST_CARD_WARN	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_PMP	T_PA_PAUTH	CHAR	1.00	0.00
IND_POLICY_ADJUSTER	T_CA_UB92	CHAR	1.00	0.00
IND_POLICY_ADJUSTER	T_PR_DRG_RATE	CHAR	1.00	0.00
IND_POLICY_ADJUSTER	T_UB92_HDR_INP	CHAR	1.00	0.00
IND_POLICY_ADJUSTOR	T_PEER_GRP_DRGR	CHAR	1.00	0.00
IND_POLICY_RECOM	T_CT_CASE_TRACK	CHAR	1.00	0.00
IND_POS	T_LIMIT_PARM	CHAR	1.00	0.00
IND_POS	T_LIMIT_PARM	CHAR	1.00	0.00
IND_POS_EDITING	T_COVERED_BENEFIT	CHAR	1.00	0.00

IND_POS_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_POS_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_PREF_DRUG	T_DENY_PHRM_DTL	CHAR	1.00	0.00
IND_PREF_DRUG	T_PD_PHARM_DTL	CHAR	1.00	0.00
IND_PREF_DRUG	T_SUSP_PHRM_DTL	CHAR	1.00	0.00
IND_PREGNANCY	T_CLM_SBR	CHAR	1.00	0.00
IND_PREGNANCY	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_PREGNANCY	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_PREGNANCY	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_PREGNANCY	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_PREGNANCY	T_PDUR_PREG_DIAG	CHAR	1.00	0.00
IND_PREGNANCY	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_PREGNANCY	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_PREGNANCY	T_PROC_LIMITS	CHAR	1.00	0.00
IND_PREGNANCY	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_PREGNANCY	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_PREGNANCY	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
IND_PREGNANCY_VERIFIED	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_PRFRM_IMMUN	T_RE_EPSDT_PR_IM_X	CHAR	1.00	0.00
IND_PRFRM_SCRN	T_RE_EPSDT_PR_SC_X	CHAR	1.00	0.00
IND_PRICE_CLAIM_TYPE	T_REIMB_AGREEMENT	CHAR	1.00	0.00

IND_PRICING	T_CA_DRUG	CHAR	6.00	0.00
IND_PRICING	T_CA_HDR_DTL	CHAR	6.00	0.00
IND_PRICING	T_CLM_PGM_XREF	CHAR	6.00	0.00
IND_PRICING	T_FEE_SCHEDULE	CHAR	6.00	0.00
IND_PRICING	T_MR_TMSIS_PRICING	CHAR	6.00	0.00
IND_PRICING	T_PD_PHARM_DTL	CHAR	6.00	0.00
IND_PRICING	T_PRICING_IND	CHAR	6.00	0.00
IND_PRICING	T_REIMB_AGREEMENT	CHAR	6.00	0.00
IND_PRIMARY	T_CLM_PGM_XREF	CHAR	1.00	0.00
IND_PRIMARY	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_PRIMARY	T_HIPP_RECIP	CHAR	1.00	0.00
IND_PRIMARY	T_PR_ENRL_LOC	CHAR	1.00	0.00
IND_PRIMARY	T_PR_ENRL_SPECIALTY	CHAR	1.00	0.00
IND_PRIMARY	T_PR_TAXONOMY	CHAR	1.00	0.00
IND_PRIMARY	T_RE_PMP_ASSIGN	CHAR	1.00	0.00
IND_PRIMARY	T_RE_PMP_ASSIGN_WI	CHAR	1.00	0.00
IND_PRIMARY_FIELD	T_TMSIS_CMS_ERROR_RECS	CHAR	1.00	0.00

IND_PRIMARY_ID	T_CLM_ENT_NM_ADR	CHAR	1.00	0.00
IND_PRIMARY_ID	T_CLM_PYR_ENTNMADR	CHAR	1.00	0.00
IND_PRIMARY_LOC	T_PMP_SVC_LOC_AL	CHAR	1.00	0.00
IND_PRIMARY_LOC	T_PMP_SVC_LOC_STATE	CHAR	1.00	0.00
IND_PRIME_PYMT	T_MC_RATE_CELL	CHAR	1.00	0.00
IND_PRIM_ELIG_GRP	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
IND_PRINT_DETAIL	T_CLM_SAMPLE	CHAR	1.00	0.00
IND_PRINT_REPORT	T_TMSIS_CMS_ERROR_FILES	CHAR	1.00	0.00
IND_PRIORITY	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
IND_PRIOR_ADC	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_PRIVATE	T_MC_RATE_CELL	CHAR	1.00	0.00
IND_PRNT_SUPP_ALIMONY	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_PROCESSED	T_EXPENDITURE	CHAR	1.00	0.00
IND_PROCESSED	T_EXPENDITURE	CHAR	1.00	0.00
IND_PROCESSED	T_EXPENDITURE_DN	CHAR	1.00	0.00
IND_PROCESSED	T_FIN_AR_RQST_REPORT	CHAR	1.00	0.00
IND_PROCESSED	T_FIN_PAY_RELEASE	CHAR	1.00	0.00
IND_PROCESSED	T_TPL_RQST_REPORT	CHAR	1.00	0.00
IND_PROC_IN_EXCLUD	T_PHYSICIAN_COS	CHAR	1.00	0.00
IND_PROC_IN_EXCLUD	T_PLACE_OF_SERVICE	CHAR	1.00	0.00
IND_PROC_IN_EXCLUD	T_PR_SPEC_CDE	CHAR	1.00	0.00

IND_PROC_IN_EXCLUD	T_REVENUE_CODE	CHAR	1.00	0.00
IND_PROC_IN_EXCLUD	T_STATE_COS	CHAR	1.00	0.00
IND_PROC_IN_EXCLUD	T_TYPE_OF_BILL	CHAR	1.00	0.00
IND_PROPHY	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_PRORATE	T_MC_RATE_CELL	CHAR	1.00	0.00
IND_PROT_RSRC	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_PROV	T_STATE_COS	CHAR	1.00	0.00
IND_PROV_ASSIGNMENT	T_CLM_PHRM_HDR	CHAR	1.00	0.00
IND_PROV_DESEL	T_CT_PROV_CRIT	CHAR	1.00	0.00
IND_PROV_RECIP	T_CM_PEER_GROUP	CHAR	1.00	0.00
IND_PROV_RECIP	T_CM_PG_FILTER	CHAR	1.00	0.00
IND_PROV_RECIP	T_CT_REFERRALS	CHAR	1.00	0.00
IND_PROV_RECIP	T_CT_SELECT_LST	CHAR	1.00	0.00
IND_PROV_REQ	T_COS_ASSIGN_CRIT	CHAR	1.00	0.00
IND_PROV_SIGN	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_SUSP_PHRM_HDR	CHAR	1.00	0.00

IND_PROV_SIGN	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_PROV_SIGN	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PROV_TYPE_ALL	T_CT_ANALYST	CHAR	1.00	0.00
IND_PR_ID_AUTO	T_PR_ID_TYPE	CHAR	1.00	0.00
IND_PR_ID_UNIQUE	T_PR_ID_TYPE	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_ATTEND	T_DENY_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_ATTEND	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_ATTEND	T_PD_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_ATTEND	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_ATTEND	T_SUSP_UB92_DTL	CHAR	18.00	0.00
IND_PR_OVERRIDE_ATTEND	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_FACILITY	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_FACILITY	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_FACILITY	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_ORDER	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_ORDER	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_ORDER	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_DENY_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_PD_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_SUSP_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_1	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_2	T_DENY_UB92_DTL	CHAR	1.00	0.00

IND_PR_OVERRIDE_OTHER_2	T_DENY_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_2	T_PD_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_2	T_PD_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_2	T_SUSP_UB92_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_OTHER_2	T_SUSP_UB92_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_DENY_DNTL_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_PD_DNTL_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_SUSP_DENTAL_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PERF	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PRESCRB	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PRESCRB	T_PD_PHARM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_PRESCRB	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_1	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_DENY_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_DENY_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_PD_DNTL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_PD_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_SUSP_DENTAL_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REF_2	T_SUSP_PHYS_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REND	T_DENY_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REND	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REND	T_PD_PHARM_HDR	CHAR	1.00	0.00

IND_PR_OVERRIDE_REND	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_PR_OVERRIDE_REND	T_SUSP_PHRM_HDR	CHAR	1.00	0.00
IND_PR_OVERRIDE_REND	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_PR_PTPS_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_PUBLISH	T_REF_CCI_MUE	CHAR	1.00	0.00
IND_PUBLISH	T_REF_CCI_MUE_OVERRIDE	CHAR	1.00	0.00
IND_PUB_PRIVATE	T_STATE_COS	CHAR	1.00	0.00
IND_PULP_CAP	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_PURCHASE	T_HIPP_RSN_CODES	CHAR	1.00	0.00
IND_QIT	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_RACE_ASIAN_INDIAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_BLACK	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_CHINESE	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_FILIPINO	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_GUAM	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_JAPANESE	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_KOREAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_NATIVE_AMER	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_NATIVE_HAWAII	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_NONE_SEL	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_OTHER	T_RE_BASE_STATE	CHAR	1.00	0.00

IND_RACE_OTH_ASIAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_OTH_PAC_ISL	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_SAMOAN	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_VIETNAMESE	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RACE_WHITE	T_RE_BASE_STATE	CHAR	1.00	0.00
IND_RADIOGRAPH	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_RANK	T_MR_MSIS_AID	NUMBER	4.00	0.00
IND_RA_PRINT	T_CLM_EOB_XREF	CHAR	1.00	0.00
IND_RA_PRINT	T_ERR_DISP_LINE	CHAR	1.00	0.00
IND_RCO_REQD_SERV	T_PA_ASSIGN_CODE	CHAR	1.00	0.00
IND_REASON_MC	T_RE_MC_REASON	CHAR	1.00	0.00
IND_REASSIGN_6_MO	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_REASSIGN_90	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_REBATE	T_ERX_FORMULARY	CHAR	1.00	0.00
IND_REBATE_ELIG	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	1.00	0.00
IND_REBILL	T_TPL_AR_HEALTH	CHAR	1.00	0.00
IND_RECEIVE_SSI	T_RE_MOVE_IN_OUT	CHAR	1.00	0.00
IND_RECIP_CASE	T_CT_ANALYST	CHAR	1.00	0.00
IND_RECIP_CHOICE	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_RECIP_DESEL	T_CT_RE_CRIT	CHAR	1.00	0.00
IND_RECIP_ONLY	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_RECORD_KEY	T_MR_TMSIS_ELEMENTS_XREF	CHAR	1.00	0.00
IND_RECOUP_OTH_PAY	T_FINANCIAL_PAYER	CHAR	1.00	0.00

IND_RECOUP_OTH_PAY	T_FUND_PAYER	CHAR	1.00	0.00
IND_REC_REJD	T_RE_CMS_MMA_RESPONSE	CHAR	1.00	0.00
IND_REDUCED	T_BUYA_BILL	CHAR	1.00	0.00
IND_REDUCED	T_BUYA_MISMATCH	CHAR	1.00	0.00
IND_REF_EMAIL_SENT	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_REF_FAM_PLAN	T_CA_HDR_DTL	CHAR	1.00	0.00
IND_REIMB_BNFT_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_BP_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_CONDITION_EDIT	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_CONTRACT_EDIT	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_MOD_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_PAYER_EDIT	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_PR_LOCATION	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_PTPS_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_REG_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REIMB_RE_LOCATION	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_REISSUE	T_CHK_REISSUE_XREF	CHAR	1.00	0.00
IND_REJECTED	T_RE_LTC_REQUEST	CHAR	1.00	0.00
IND_RELEASE_OF_INFO	T_DNTL_OTH_PYR_HDR	CHAR	1.00	0.00
IND_RELEASE_OF_INFO	T_PROF_OTH_PYR_HDR	CHAR	1.00	0.00
IND_REL_CASE	T_CASUALTY_CASE	CHAR	1.00	0.00

IND_REL_CASE	T_CASUALTY_CASE_AL	CHAR	1.00	0.00
IND_REN_UTIL_PD	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_REPACK	T_DRUG_STATE_AL	CHAR	1.00	0.00
IND_REPORT	T_PR_LABEL_CRIT	CHAR	1.00	0.00
IND_REPORT_TYPE	T_1099_DETAIL	CHAR	1.00	0.00
IND_REQUEST_RCVD	T_PS_REFERRAL	CHAR	1.00	0.00
IND_REQUEST_RCVD	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_REQUIRED	T_RU_DECISION_VAR	CHAR	1.00	0.00
IND_RESOURCES	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_RESTRICT	T_PHARMACY_COS	CHAR	1.00	0.00
IND_RESTRICT	T_PHYSICIAN_COS	CHAR	1.00	0.00
IND_RESTRICT	T_RE_LOCKIN_PERIOD	CHAR	1.00	0.00
IND_RESTRICT	T_RE_LOCK_DIAG_RNG	CHAR	1.00	0.00
IND_RESTRICT	T_RE_LOCK_DRUG	CHAR	1.00	0.00
IND_RESTRICT	T_RE_LOCK_PROC_RNG	CHAR	1.00	0.00
IND_RESTRICT	T_STATE_COS	CHAR	1.00	0.00
IND_RESTRICT	T_UB92_COS	CHAR	1.00	0.00
IND_RESTRICT_LI	T_RE_BASE_DN	CHAR	1.00	0.00
IND_RETRO	T_RE_MEDICARE_A	CHAR	1.00	0.00

IND_RETRO	T_RE_MEDICARE_B	CHAR	1.00	0.00
IND_RETRO_ELIG	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
IND_REVIEW	T_PR_REVIEW	CHAR	1.00	0.00
IND_RE_ANSWER	T_PA_RULE_QUESTION	CHAR	1.00	0.00
IND_RE_DECISION	T_PA_RULE_DECISION	CHAR	1.00	0.00
IND_RE_SENT	T_RE_1095_REJECT	CHAR	1.00	0.00
IND_RE_SENT	T_RE_ADPH_1095_REJECT	CHAR	1.00	0.00
IND_RISK_LEVEL_ADJ	T_PR_ENROLL_SCRN	CHAR	1.00	0.00
IND_ROOT_CANAL	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_RPT	T_CLAIM_ERROR	CHAR	1.00	0.00
IND_RTS	T_CASH_BATCH_NUM	CHAR	1.00	0.00
IND_RVW_RCVD	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_RVW_RCVD	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_RX_FOR_J_CODE	T_AUDIT_CRIT	CHAR	1.00	0.00
IND_RX_FOR_J_CODE	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
IND_SCHEDULE	T_DS_LVX_USER_REQ	CHAR	1.00	0.00
IND_SCHEDULE	T_FIN_TXN_TYPE	CHAR	1.00	0.00
IND_SD_PRE_EMPTIVE	T_ERROR_DISP	CHAR	1.00	0.00
IND_SD_PRE_EMPTIVE	T_ERROR_DISP	CHARACTER	1.00	0.00
IND_SEALANT	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_SEC_DESTRUCT	T_CT_EOMB	CHAR	1.00	0.00
IND_SED_FILLING	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_SELECT	T_CT_CASE_RECOUP	CHAR	1.00	0.00
IND_SELECTED	T_CT_SELECT_LST	CHAR	1.00	0.00
IND_SELECTED	T_HIPP_PENDING	CHAR	1.00	0.00

IND_SEND_TO_DMH	T_PS_ICF_MR	CHAR	1.00	0.00
IND_SENT_ADDL	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
IND_SENT_INIT	T_RE_AR_OVERPAYMENT	CHAR	1.00	0.00
IND_SENT_OUTBOUND_997	T_TP_CONFIG	CHAR	1.00	0.00
IND_SEP	T_RE_1095	CHAR	1.00	0.00
IND_SEP	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_SERV_PROV_REQ	T_PA_ASSIGN_CODE	CHAR	1.00	0.00
IND_SEV_ERROR_STATUS	T_ETG_SUMMARY	CHAR	1.00	0.00
IND_SEV_ERROR_STATUS	T_ETG_SUMMARY_ENCNTR	CHAR	1.00	0.00
IND_SEV_ERROR_STATUS	T_ETG_SUMMARY_FFS	CHAR	1.00	0.00
IND_SEV_ERROR_STATUS	T_ETG_SUMMARY_RCO_PAID	CHAR	1.00	0.00
IND_SHIPPED	T_BUYA_PREM	CHAR	1.00	0.00
IND_SHIPPED	T_BUYB_PREM	CHAR	1.00	0.00
IND_SHORT_TERM	T_CLM_PATLIAB_X	CHAR	1.00	0.00
IND_SHORT_TERM	T_RE_ASSIGN_PLAN	CHAR	1.00	0.00
IND_SHORT_TERM	T_RE_ASSIGN_PLAN_RLOC	CHAR	1.00	0.00
IND_SIMPLE_EXTRACT	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_SOLD_PROP	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_SOS_DIFF	T_RBRVS	CHAR	1.00	0.00
IND_SOS_DIFF	T_RBRVS_UPDATE	CHAR	1.00	0.00
IND_SOURCE	T_BUYA_PREM	CHAR	1.00	0.00
IND_SOURCE	T_BUYB_PREM	CHAR	1.00	0.00
IND_SOURCE	T_CDE_HIB_SOURCE	CHAR	1.00	0.00

IND_SOURCE	T_RE_HIB	CHAR	1.00	0.00
IND_SOURCE	T_TPL_AR_HEALTH	CHAR	1.00	0.00
IND_SOURCE	T_TPL_AR_HEALTH_XXX	CHAR	1.00	0.00
IND_SOURCE_ALGI	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_SOURCE_PA	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_SOURCE_PDL	T_ERX_ALT_THERAPY	CHAR	1.00	0.00
IND_SPECIAL_CONSID	T_PA_PAUTH	CHAR	1.00	0.00
IND_SPEC_COND	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_SPEC_COND	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_SPEC_COND	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_SPEC_COND	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00
IND_SPEC_COND	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_SPEC_HLTH	T_RE_BASE	CHAR	1.00	0.00
IND_SPEC_HLTH	T_RE_BASE_DN	CHAR	1.00	0.00
IND_SPEC_IN_EXCLUD	T_CDE_AID	CHAR	1.00	0.00
IND_SPEC_IN_EXCLUD	T_REVENUE_CODE	CHAR	1.00	0.00
IND_SPLIT_CLAIM	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
IND_SPLIT_CLAIM	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
IND_SPONSOR_USED	T_RE_AR_BASE	CHAR	1.00	0.00
IND_SPOUSAL_IMPOV	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_SS	T_PS_DETERMINATION	CHAR	1.00	0.00
IND_SS	T_PS_RESIDENT_RVW	CHAR	1.00	0.00
IND_SSDI	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
IND_SSI	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	1.00	0.00
IND_SSI_RCVD	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_SSN	T_TMSIS_EXT_HDR	VARCHAR2	1.00	0.00

IND_SSN_VERIFIED	T_DS_RECIP_SOBRA_FAMILY	CHAR	1.00	0.00
IND_SS_CLM_TYPE	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_STAND_ALONE	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_STATE_SHARE	T_STATE_COS	CHAR	1.00	0.00
IND_STATE_SUPPLY_VALUE	T_TMSIS_VALID_VALUES_XREF	VARCHAR2	1.00	0.00
IND_STATE_TXFR	T_FIN_FUND_CODE	CHAR	1.00	0.00
IND_STATUS	T_ACCT_REC	CHAR	1.00	0.00
IND_STATUS	T_ACCT_REC_DN	CHAR	1.00	0.00
IND_STATUS	T_DESI	CHAR	1.00	0.00
IND_STATUS	T_DRUG_AAC_PRICE	CHAR	1.00	0.00
IND_STATUS	T_DRUG_AWP	CHAR	1.00	0.00
IND_STATUS	T_DRUG_MAC	CHAR	1.00	0.00
IND_STATUS	T_DRUG_PRICE	CHAR	1.00	0.00
IND_STATUS	T_DRUG_S_MAC	CHAR	1.00	0.00
IND_STATUS	T_FIN_AR_RQST_REPORT	CHAR	1.00	0.00
IND_STATUS	T_FIN_PROCESS_AR_DISP	CHAR	1.00	0.00
IND_STATUS	T_HIC4	CHAR	1.00	0.00

IND_STATUS	T_NDDF_PRICE	CHAR	1.00	0.00
IND_STATUS	T_PR_CHOW_GRP_MBR	CHAR	1.00	0.00
IND_STATUS	T_PR_LABEL_CRIT	CHAR	1.00	0.00
IND_STATUS	T_RE_1095_ACK	CHAR	1.00	0.00
IND_STATUS	T_RE_ADPH_1095_ACK	CHAR	1.00	0.00
IND_STAYING_AL	T_DS_RECIP_DO_APPL	CHAR	1.00	0.00
IND_STEEL_CROWN	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_STEP_PRNT	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_STERILIZATION	T_CA_HDR_DTL	CHAR	1.00	0.00
IND_STERILIZATION	T_CA_IND_KEY	CHAR	1.00	0.00
IND_STERILIZATION	T_DS_RECIP_CORE	CHAR	1.00	0.00
IND_SUBSIDY	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
IND_SUBSIDY_CANCEL	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
IND_SUBSIDY_CHG	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
IND_SUB_CLASS	T_DIAG_LIMIT	CHAR	1.00	0.00
IND_SUPERVISOR	T_CT_ANALYST	CHAR	1.00	0.00
IND_SUPPLEMENTAL	T_LG_LETTER_REQUEST_IDX	CHAR	1.00	0.00
IND_SUPPRESS_RA	T_FIN_PROCESS_PROV_ID	CHAR	1.00	0.00
IND_SUPPRESS_RA	T_PR_SVC_LOC	CHAR	1.00	0.00
IND_SUPPRESS_RA	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_SUPPRESS_RA	T_PR_SVC_LOC_WI	CHAR	1.00	0.00
IND_SURCHARGE	T_BUYA_BILL	CHAR	1.00	0.00
IND_SURCHARGE	T_BUYA_MISMATCH	CHAR	1.00	0.00

IND_SURG_EXTRACT	T_DS_DNTL_ICN	CHAR	1.00	0.00
IND_SUSPECT	T_RE_BASE	CHAR	1.00	0.00
IND_SUSPEND	T_ADJ_MASS_CLAIM	CHAR	1.00	0.00
IND_SUSPEND	T_ADJ_MASS_RQST	CHAR	1.00	0.00
IND_SVC_LMT_AUD	T_AUDIT_CRIT	CHAR	1.00	0.00
IND_SVC_LMT_AUD	T_AUDIT_CRIT_AL	CHAR	1.00	0.00
IND_SYSTEMIC	T_DRUG	CHAR	1.00	0.00
IND_SYSTEMIC	T_DRUG_DN	CHAR	1.00	0.00
IND_SYS_GENERATE	T_DENY_DNTL_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_DENY_PHYS_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_DENY_UB92_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_HIPP_RESOURCE	CHAR	1.00	0.00
IND_SYS_GENERATE	T_PD_DNTL_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_PD_PHYS_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_PD_UB92_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_SUSP_DENTAL_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_SUSP_PHYS_DTL	CHAR	1.00	0.00
IND_SYS_GENERATE	T_SUSP_UB92_DTL	CHAR	1.00	0.00
IND_TAX_ID_EXEMPT	T_IRS_W9_INFO	CHAR	1.00	0.00
IND_TAX_ID_EXEMPT	T_NONPROV_TAX_ID	CHAR	1.00	0.00
IND_TAX_ID_EXEMPT	T_PR_TAX_ID	CHAR	1.00	0.00

IND_TAX_ID_EXEMPT	T_TPL_TAX_ID	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_IRS_B_NOTICE_AL	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_IRS_B_NOTICE_WI	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_IRS_W9_INFO	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_NONPROV_TAX_ID	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_PR_APPLN	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_PR_APPLN_WI	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_PR_ENRL_TAX_ID	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_PR_TAX_ID	CHAR	1.00	0.00
IND_TAX_ID_TYPE	T_TPL_TAX_ID	CHAR	1.00	0.00
IND_TEACHING	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	1.00	0.00
IND_TEACH_FACILITY	T_PR_SVC_LOC_AL	CHAR	1.00	0.00
IND_TMSIS_EDIT	T_TMSIS_DATA_ELEMENTS	VARCHAR2	1.00	0.00
IND_TMSIS_EDIT_ENABLED	T_TMSIS_EDIT_CTL	VARCHAR2	1.00	0.00
IND_TMSIS_EDIT_ENABLED	T_TMSIS_EDIT_RULES	CHAR	1.00	0.00
IND_TOB_EDITING	T_PAYABLE_BENEFIT	CHAR	1.00	0.00
IND_TOB_EDITING	T_REIMB_AGREEMENT	CHAR	1.00	0.00
IND_TOTAL	T_CM_MEASURE	CHAR	1.00	0.00
IND_TPL_ACTION	T_PUB_HLTH_PGM	CHAR	1.00	0.00
IND_TPL_HLTH_INS_COV	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	1.00	0.00
IND_TPL_OTH_COV	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	1.00	0.00
IND_TRACTION_DEVICE	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00
IND_TRANSFER	T_RE_MC_REASON	CHAR	1.00	0.00
IND_TRANSFERRED	T_PR_ATT_CMS	CHAR	1.00	0.00
IND_TXN_ACK	T_TRANSACTION	CHAR	1.00	0.00
IND_TXN_AGENCY	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_DB_SEARCH	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_DB_UPDATE	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00

IND_TXN_EXCLUDED	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_NEWPAGE	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_PORTAL	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_REC_RETRIEVAL	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_REC_SEARCH	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TXN_REPORT	T_SW_PERFORMANCE_DATA	CHAR	1.00	0.00
IND_TYPE	T_AUTO_PA	CHAR	1.00	0.00
IND_TYPE	T_CASH_DISP_REASON	CHAR	1.00	0.00
IND_TYPE	T_CLAIM_INTEREST	CHAR	1.00	0.00
IND_TYPE	T_CSR_ANALYST	CHAR	1.00	0.00
IND_TYPE	T_DRUG_PRICE	CHAR	1.00	0.00
IND_TYPE	T_SKILL	CHAR	1.00	0.00
IND_TYPE_1095	T_RE_1095	CHAR	1.00	0.00
IND_TYPE_1095	T_RE_1095_TRACK	CHAR	1.00	0.00
IND_TYPE_1095	T_RE_ADPH_1095	CHAR	1.00	0.00
IND_TYPE_1095	T_RE_ADPH_1095_TRACK	CHAR	1.00	0.00
IND_TYPE_CLMS	T_EDIT_RECYCLE	CHAR	1.00	0.00
IND_TYPE_REJECT	T_RE_1095_REJECT	CHAR	1.00	0.00
IND_TYPE_REJECT	T_RE_ADPH_1095_REJECT	CHAR	1.00	0.00
IND_UNDER_AGE	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_UNIT_DOSE	T_DRUG	CHAR	1.00	0.00

IND_UNIT_DOSE	T_DRUG_DN	CHAR	1.00	0.00
IND_UNIT_DOSE	T_LS_DRUG_MASTER	CHAR	1.00	0.00
IND_UNIT_OF_USE	T_DRUG	CHAR	1.00	0.00
IND_UNIT_OF_USE	T_DRUG	CHAR	1.00	0.00
IND_UNIT_OF_USE	T_DRUG_DN	CHAR	1.00	0.00
IND_UPDATE	T_DRUG_AAC_PRICE	CHAR	1.00	0.00
IND_UPDATE	T_DRUG_HCPCS	CHAR	1.00	0.00
IND_UPDATE	T_DRUG_INDICATOR	CHAR	1.00	0.00
IND_UPDATE	T_RE_EPS_CURR_SCRN	CHAR	1.00	0.00
IND_USER_ASSIGN	T_CASH_BATCH_NUM	CHAR	1.00	0.00
IND_USE_4_PEER_GRP_SUM	T_DS_DNTL_PR_ENROLL	CHAR	1.00	0.00
IND_USE_4_PEER_GRP_SUM	T_DS_DNTL_RECIP	CHAR	1.00	0.00
IND_UTILIZATION	T_DR_CLMS_INV_XREF	CHAR	1.00	0.00
IND_UTILIZATION_1	T_CA_DRUG_REBATE	CHAR	1.00	0.00

IND_UTILIZATION_2	T_CA_DRUG_REBATE	CHAR	1.00	0.00
IND_UTILIZATION_3	T_CA_DRUG_REBATE	CHAR	1.00	0.00
IND_UTILIZATION_4	T_CA_DRUG_REBATE	CHAR	1.00	0.00
IND_VALID_FOR_ACHN	T_RE_PMP_REASON	CHAR	1.00	0.00
IND_VAN	T_TP	CHAR	1.00	0.00
IND_VERIFY	T_PR_PCP	CHAR	1.00	0.00
IND_VETERAN	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
IND_W9_FORM	T_IRS_W9_INFO	CHAR	1.00	0.00
IND_WAIVER	T_PHYSICIAN_COS	CHAR	1.00	0.00
IND_WARN_LTR	T_CT_CASE_TRACK	CHAR	1.00	0.00
IND_WIC	T_DS_RECIP_SOBRA_APPL	CHAR	1.00	0.00
IND_WILL	T_TPL_CASE_INFO	CHAR	1.00	0.00
IND_WITHHOLD	T_FIN_FUND_CDE_RATE	CHAR	1.00	0.00
IND_WOMEN_ONLY	T_MC_PMP_GRP_MBR	CHAR	1.00	0.00
IND_WOMEN_ONLY	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_WOMEN_ONLY	T_PMP_SVC_LOC	CHAR	1.00	0.00
IND_WOMEN_ONLY	T_PMP_SVC_LOC_KY	CHAR	1.00	0.00
IND_WOMEN_ONLY	T_PMP_SVC_LOC_WI	CHAR	1.00	0.00
IND_WRAP_PAYMENT	T_CA_IND_KEY	CHAR	1.00	0.00
IND_XRAY_AVAILABLE	T_CLM_CR2	CHAR	1.00	0.00
INPAT_DAYS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
INTERCHANG	T_TRLOG	VARCHAR2	35.00	0.00
INTERNET_IND	T_WEB_ROLE	CHAR	1.00	0.00
INT_PRIORITY	T_PLOG_HEADER	NUMBER	9.00	0.00
INT_PRIORITY	T_PLOG_VERSION	NUMBER	9.00	0.00
INT_PROV_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00

INT_PROV_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
INT_PROV_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
INT_PROV_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
INT_SVC_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00
INT_SVC_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
INT_SVC_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
INT_SVC_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
INVOICE_ADDR_1	T_LS_MANFAC_INFO	CHAR	39.00	0.00
INVOICE_ADDR_2	T_LS_MANFAC_INFO	CHAR	39.00	0.00
INVOICE_ADDR_3	T_LS_MANFAC_INFO	CHAR	39.00	0.00
INVOICE_CITY	T_LS_MANFAC_INFO	CHAR	27.00	0.00
INVOICE_CONTACT	T_LS_MANFAC_INFO	CHAR	39.00	0.00
INVOICE_CORP	T_LS_MANFAC_INFO	CHAR	39.00	0.00
INVOICE_PHONE	T_LS_MANFAC_INFO	CHAR	14.00	0.00
INVOICE_ST	T_LS_MANFAC_INFO	CHAR	2.00	0.00
INVOICE_ZIP_4	T_LS_MANFAC_INFO	CHAR	4.00	0.00
INVOICE_ZIP_5	T_LS_MANFAC_INFO	CHAR	5.00	0.00
ISA_IN_NO	T_TRADING_PARTNER	VARCHAR2	14.00	0.00
ISA_OUT_NO	T_TRADING_PARTNER	VARCHAR2	14.00	0.00
ISA_TYPE	T_AGREEMENTS	VARCHAR2	5.00	0.00
ISA_TYPE	T_TRADSTAT	VARCHAR2	5.00	0.00
ISA_TYPE	T_TRLOG	VARCHAR2	5.00	0.00
KEY_REASON	T_EDI_RETURN_REASON	NUMBER	3.00	0.00
LABELER_NAME	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LABELER_NAME_MI	T_LS_SUMMARY_NDC	CHAR	39.00	0.00
LAST_CHANGE_DTE	T_LS_LVL1_PRICING	DATE	0.00	0.00

LAST_CHG	T_PA_HCBW_UPD_HDR	CHAR	6.00	0.00
LAST_CHG_DATE	T_PA_DDSD_UPD_HDR	CHAR	6.00	0.00
LAST_DATE_SERVICE	T_ETG_SUMMARY	DATE	0.00	0.00
LAST_DATE_SERVICE	T_ETG_SUMMARY_ENCNTR	DATE	0.00	0.00
LAST_DATE_SERVICE	T_ETG_SUMMARY_FFS	DATE	0.00	0.00
LAST_DATE_SERVICE	T_ETG_SUMMARY_RCO_PAID	DATE	0.00	0.00
LAST_DAY_MONTH	T_CA_CURRENT_DATES	DATE	0.00	0.00
LAST_DAY_QTR	T_CA_CURRENT_DATES	DATE	0.00	0.00
LAST_LOGIN_DATE	T_SEC_USER	DATE	0.00	0.00
LAST_PASSWORD_UPDATE	T_SEC_USER	DATE	0.00	0.00
LAST_UPDATE_DATE	T_SEC_USER	DATE	0.00	0.00
LAST_UPD_DTE	T_PA_LTCA_UPD_HDR	CHAR	8.00	0.00
LEAVE_DAYS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
LEGAL_ADDR_1	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LEGAL_ADDR_2	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LEGAL_ADDR_3	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LEGAL_CITY	T_LS_MANFAC_INFO	CHAR	27.00	0.00
LEGAL_CONTACT_NAME	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LEGAL_CORP_NAME	T_LS_MANFAC_INFO	CHAR	39.00	0.00
LEGAL_PHONE	T_LS_MANFAC_INFO	CHAR	14.00	0.00
LEGAL_ST	T_LS_MANFAC_INFO	CHAR	2.00	0.00
LEGAL_ZIP_4	T_LS_MANFAC_INFO	CHAR	4.00	0.00
LEGAL_ZIP_5	T_LS_MANFAC_INFO	CHAR	5.00	0.00
LEVEL_CARE	T_PA_PC_UPD_HDR	CHAR	2.00	0.00
LEVEL_OF_SERVICE	T_CA_DRUG	NUMBER	2.00	0.00
LIC_SOURCE	T_PR_HB_LIC_KY	CHAR	1.00	0.00
LINEDESC	T_PROFILE_INPAT_MIX	VARCHAR2	1,000.00	0.00
LINEDESC	T_PROFILE_OUTPAT_MIX	VARCHAR2	1,000.00	0.00
LINEDESC	T_PROFILE_PHARM_MIX	VARCHAR2	1,000.00	0.00
LINEDESC	T_PROFILE_PROF_MIX	VARCHAR2	1,000.00	0.00
LINENO	T_PROFILE_INPAT_MIX	NUMBER	6.00	0.00
LINENO	T_PROFILE_OUTPAT_MIX	NUMBER	6.00	0.00
LINENO	T_PROFILE_PHARM_MIX	NUMBER	6.00	0.00
LINENO	T_PROFILE_PROF_MIX	NUMBER	6.00	0.00
LIQUIDATION_FLAG	T_PA_HCBW_UPD_DTL	CHAR	1.00	0.00

LOGIN_ATTEMPT	T_SEC_USER	NUMBER	1.00	0.00
LONG_DESC	T_MB_DESC	VARCHAR2	250.00	0.00
LOW	T_RISK_RANKING	NUMBER	4.00	1.00
LOW_VARIANCE	T_LS_LVL3_PRICING	NUMBER	7.00	2.00
M1_BOE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_CHIP	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_DAYS	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_DUAL_ELIG_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_ELIG_GRP	T_MR_MSIS_ELIGIBLE	CHAR	6.00	0.00
M1_FILLER	T_MR_MSIS_ELIGIBLE	CHAR	8.00	0.00
M1_HLTH_INS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_INCOME_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_MAS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_PLAN_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M1_PLAN_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M1_PLAN_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M1_PLAN_ID_4	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M1_PLAN_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_PLAN_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_PLAN_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00

M1_PLAN_TYPE_4	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_RESTR_BENE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_TANF	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_WAIVER_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_WAIVER_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_WAIVER_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M1_WAIVER_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_WAIVER_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M1_WAIVER_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_BOE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_CHIP	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_DAYS	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_DUAL_ELIG_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_ELIG_GRP	T_MR_MSIS_ELIGIBLE	CHAR	6.00	0.00
M2_FILLER	T_MR_MSIS_ELIGIBLE	CHAR	8.00	0.00

M2_HLTH_INS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_INCOME_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_MAS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_PLAN_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M2_PLAN_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M2_PLAN_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M2_PLAN_ID_4	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M2_PLAN_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_PLAN_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_PLAN_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_PLAN_TYPE_4	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_RESTR_BENE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_TANF	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_WAIVER_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00

M2_WAIVER_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_WAIVER_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M2_WAIVER_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_WAIVER_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M2_WAIVER_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_BOE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_CHIP	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_DAYS	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_DUAL_ELIG_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_ELIG_GRP	T_MR_MSIS_ELIGIBLE	CHAR	6.00	0.00
M3_FILLER	T_MR_MSIS_ELIGIBLE	CHAR	8.00	0.00
M3_HLTH_INS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_INCOME_CDE	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_MAS	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00

M3_PLAN_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M3_PLAN_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M3_PLAN_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M3_PLAN_ID_4	T_MR_MSIS_ELIGIBLE	CHAR	12.00	0.00
M3_PLAN_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_PLAN_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_PLAN_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_PLAN_TYPE_4	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_RESTR_BENE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_TANF	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_WAIVER_ID_1	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_WAIVER_ID_2	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_WAIVER_ID_3	T_MR_MSIS_ELIGIBLE	CHAR	2.00	0.00
M3_WAIVER_TYPE_1	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00

M3_WAIVER_TYPE_2	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
M3_WAIVER_TYPE_3	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
MAILBOX	T_TRADING_PARTNER	VARCHAR2	100.00	0.00
MAP_EXT	T_AGREEMENTS	VARCHAR2	8.00	0.00
MAP_FILENAME	T_AGREEMENTS	VARCHAR2	30.00	0.00
MAP_FILENAME	T_TRADSTAT	VARCHAR2	30.00	0.00
MAP_TRAN	T_AGREEMENTS	VARCHAR2	6.00	0.00
MAP_TRAN	T_TRADSTAT	VARCHAR2	6.00	0.00
MAP_TRAN	T_TRANSACTION_TYPE	VARCHAR2	6.00	0.00
MAX_AGE	T_MC_CAP_DEMOGRAPH	NUMBER	3.00	0.00
MAX_AGE	T_MC_CAP_DEMOGRAPH_KY	NUMBER	3.00	0.00
MAX_AGE	T_THERA_DURATION	NUMBER	9.00	0.00
MAX_AGE	T_THERA_DURATION	NUMBER	9.00	0.00
MAX_ALLWD	T_LS_LVL3_PRICING	NUMBER	7.00	2.00
MAX_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MAX_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MAX_STATE_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MAX_STATE_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MBOX_NAME	T_AGREEMENTS	VARCHAR2	35.00	0.00
MBOX_NAME	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
MBOX_NAME	T_TRADSTAT	VARCHAR2	35.00	0.00
MBR_NUMBER	T_DS_RECIP_SOBRA_FAMILY	CHAR	2.00	0.00
MCAID_MAX_ALLWD	T_LS_LVL3_PRICING	NUMBER	7.00	2.00
MCARE_CLM_ALPHA	T_DS_RECIP_CORE	CHAR	3.00	0.00
MCARE_CLM_NO	T_DS_RECIP_CORE	CHAR	9.00	0.00
MCARE_CLM_NO	T_DS_RECIP_DO_APPL	CHAR	13.00	0.00
MC_PLAN_NO	T_DS_RECIP_SOBRA_APPL	CHAR	9.00	0.00
MEASURE_BASE_NAME	T_MM_MEASURE_BASE	VARCHAR2	200.00	0.00
MEAS_CODE	T_MB_CALC	NUMBER	4.00	0.00
MEAS_CODE	T_MB_DEN_ICN	NUMBER	4.00	0.00
MEAS_CODE	T_MB_DEN_RECIP	NUMBER	4.00	0.00
MEAS_CODE	T_MB_DESC	NUMBER	4.00	0.00
MEAS_CODE	T_MB_NUM_ICN	NUMBER	4.00	0.00
MEAS_CODE	T_MB_NUM_RECIP	NUMBER	4.00	0.00
MEAS_DESC	T_MB_DESC	VARCHAR2	250.00	0.00
MEAS_DOMAIN	T_MB_DESC	VARCHAR2	250.00	0.00

MEAS_SOURCE	T_MB_DESC	VARCHAR2	250.00	0.00
MEDIA	T_BATCH	VARCHAR2	50.00	0.00
MEDICAL_RECORD_NUMBER	T_WEB_CLAIM_HDR	CHAR	17.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
MEDICAL_SVCS_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00

MEDICARE_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
MEDICARE_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
MEDI_COIN	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	5.00	0.00
MEDI_COIN	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
MEDI_COIN	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	5.00	0.00

MEDI_DED	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	5.00	0.00
MEDI_DED	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
MEDI_DED	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	5.00	0.00
MEMBER_MONTHS	T_PROFILE_ASM_MM_PEER	NUMBER	8.00	0.00
MEMBER_MONTHS	T_PROFILE_ASM_MM_PROV	NUMBER	8.00	0.00
MEMBER_MONTHS	T_PROFILE_MM_RECIP	NUMBER	8.00	0.00
MEMBER_MONTHS	T_PROFILE_PMPM_PROV	NUMBER	6.00	0.00
MEMBER_MONTHS	T_PROF_MM_PEER	NUMBER	8.00	0.00
MEMBER_MONTHS	T_PROF_MM_PROV	NUMBER	8.00	0.00
MID_TIME	T_RE_HIST_ERR	CHAR	10.00	0.00
MID_TIME	T_RE_PS2_ERR	CHAR	10.00	0.00
MINUTES	T_AGREEMENTS	VARCHAR2	2.00	0.00
MINUTES	T_TRADSTAT	VARCHAR2	2.00	0.00
MIN_AGE	T_MC_CAP_DEMOGRAPH	NUMBER	3.00	0.00
MIN_AGE	T_MC_CAP_DEMOGRAPH_KY	NUMBER	3.00	0.00
MIN_AGE	T_THERA_DURATION	NUMBER	9.00	0.00
MIN_AGE	T_THERA_DURATION	NUMBER	9.00	0.00
MIN_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MIN_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MIN_PERF_STD	T_MB_DESC	NUMBER	15.00	4.00
MIN_PERF_TARGET	T_MM_MEASURE_BASE	NUMBER	5.00	4.00
MIN_STATE_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MIN_STATE_DAYS	T_THERA_DURATION	NUMBER	9.00	0.00
MISC_CDE_DTE	T_BUYA_BILL	CHAR	8.00	0.00
MISC_CDE_DTE	T_BUYA_MISMATCH	CHAR	8.00	0.00

MISC_CDE_DTE	T_BUYB_BILL	CHAR	8.00	0.00
MISC_CDE_DTE	T_BUYB_MISMATCH	CHAR	8.00	0.00
MITIGATION_PLAN_REQ	T_RISK_RANKING	CHAR	1.00	0.00
MOD1	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
MOD2	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
MOD3	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
MOD4	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
MORB	T_PF_INPAT_RE_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_INPAT_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_NHOME_RE_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_NHOME_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_OUTPAT_RE_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_OUTPAT_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_PHARM_RE_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_PHARM_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_PROF_RE_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_PROF_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_PRREF_RE_TOT_Q	CHAR	1.00	0.00

MORB	T_PF_PRREF_RP_TOT_Q	CHAR	1.00	0.00
MORB	T_PF_RECIP_ACG	CHAR	1.00	0.00
MORB	T_PF_RECIP_CMPR	CHAR	1.00	0.00
MORB	T_PF_RE_CMPR_Q	CHAR	1.00	0.00
MORB	T_PROFILE_ASM_MM_PEER	CHAR	1.00	0.00
MORB	T_PROFILE_ASM_MM_PROV	CHAR	1.00	0.00
MORB	T_PROFILE_INPAT_AMTS	CHAR	1.00	0.00
MORB	T_PROFILE_INPAT_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_INPAT_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_INPAT_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_INPAT_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_MM_RECIP	CHAR	1.00	0.00
MORB	T_PROFILE_OUTPAT_AMTS	CHAR	1.00	0.00
MORB	T_PROFILE_OUTPAT_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_OUTPAT_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_OUTPAT_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_OUTPAT_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARMREF_AMTS	CHAR	1.00	0.00
MORB	T_PROFILE_PHARMREF_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_PHARMREF_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARMREF_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARMREF_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARM_AMTS	CHAR	1.00	0.00
MORB	T_PROFILE_PHARM_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_PHARM_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARM_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PHARM_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROFREF_AMTS	CHAR	1.00	0.00

MORB	T_PROFILE_PROFREF_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_PROFREF_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROFREF_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROFREF_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROF_AMTS	CHAR	1.00	0.00
MORB	T_PROFILE_PROF_GLOBALS	CHAR	1.00	0.00
MORB	T_PROFILE_PROF_GRP_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROF_PROV_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_PROF_PT_TOT	CHAR	1.00	0.00
MORB	T_PROFILE_RECIP	CHAR	1.00	0.00
MORB	T_PROFILE_RECIP_ACG	CHAR	1.00	0.00
MORB	T_PROFILE_RPT_GRAPHS	CHAR	1.00	0.00
MORB	T_PROFILE_TOT_CMPR	CHAR	1.00	0.00
MORBIDITY_INDEX	T_PROFILE_MORBIDITY_INDEX	NUMBER	6.00	4.00
MPC	T_ETG_DESC	VARCHAR2	2.00	0.00
MPC	T_ETG_MPC_DESC	VARCHAR2	2.00	0.00
MPC_DESC	T_ETG_MPC_DESC	VARCHAR2	100.00	0.00
MSG_IMPID	T_AGREEMENTS	VARCHAR2	14.00	0.00
MSG_IMPID	T_TRADSTAT	VARCHAR2	14.00	0.00
MSG_IMPREL	T_AGREEMENTS	VARCHAR2	3.00	0.00

MSG_IMPREL	T_TRADSTAT	VARCHAR2	3.00	0.00
MSG_IMPVER	T_AGREEMENTS	VARCHAR2	3.00	0.00
MSG_IMPVER	T_TRADSTAT	VARCHAR2	3.00	0.00
MSG_NO	T_TRLOG	VARCHAR2	5.00	0.00
MSG_SUBID	T_AGREEMENTS	VARCHAR2	14.00	0.00
MSG_SUBID	T_TRADSTAT	VARCHAR2	14.00	0.00
MSG_SUBREL	T_AGREEMENTS	VARCHAR2	3.00	0.00
MSG_SUBREL	T_TRADSTAT	VARCHAR2	3.00	0.00
MSG_SUBVER	T_AGREEMENTS	VARCHAR2	3.00	0.00
MSG_SUBVER	T_TRADSTAT	VARCHAR2	3.00	0.00
MSG_TEXT	T_TRLOG	VARCHAR2	100.00	0.00
MSG_TYPE	T_AGREEMENTS	VARCHAR2	6.00	0.00
MSG_TYPE	T_TRADSTAT	VARCHAR2	6.00	0.00
MSG_TYPE	T_TRLOG	VARCHAR2	6.00	0.00
MSIS_ID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	20.00	0.00
MSIS_ID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	20.00	0.00
MSIS_ID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	20.00	0.00
MSIS_ID	T_MR_MSIS_ELIGIBLE	CHAR	20.00	0.00
MTH_BENEFIT	T_RE_CMS_MMA_ENROLL	NUMBER	6.00	0.00
MULT_SURG_PERCENT	T_CLM_MULT_SURG	NUMBER	3.00	2.00
NAM	T_RISK_CATEGORY	VARCHAR2	64.00	0.00
NAM	T_RISK_IMPACT	VARCHAR2	64.00	0.00
NAM	T_RISK_PLAN_STATUS	VARCHAR2	64.00	0.00
NAM	T_RISK_PROBABILITY	VARCHAR2	64.00	0.00
NAM	T_RISK_STATUS	VARCHAR2	64.00	0.00
NAM	T_STATE_ADDR	VARCHAR2	50.00	0.00
NAME	T_CASH_RECEIPT	CHAR	50.00	0.00
NAME	T_CA_PR_HB_LIC	CHAR	50.00	0.00
NAME	T_DRUG_LBLR	CHAR	39.00	0.00
NAME	T_DR_DISPUTE_RESO	CHAR	39.00	0.00
NAME	T_FIN_NONPROV	CHAR	39.00	0.00
NAME	T_IRS_W9_INFO	CHAR	40.00	0.00
NAME	T_LS_MANFAC_GROUPING	CHAR	30.00	0.00
NAME	T_MB_DEN_RECIP	VARCHAR2	50.00	0.00
NAME	T_MB_NUM_RECIP	VARCHAR2	50.00	0.00
NAME	T_PA_NONMED_PROV	CHAR	39.00	0.00
NAME	T_PHS_PROVIDER	CHAR	50.00	0.00

NAME	T_PR_APPLN	CHAR	50.00	0.00
NAME	T_PR_APPLN_WI	CHAR	50.00	0.00
NAME	T_PR_HB_LIC	CHAR	50.00	0.00
NAME	T_PR_HB_LIC_KY	CHAR	50.00	0.00
NAME	T_PR_NAM	CHAR	50.00	0.00
NAME	T_SECURITY_LEVEL	VARCHAR2	30.00	0.00
NAME	T_SUSPECT_RES	CHAR	50.00	0.00
NAME	T_TPL_CNTY_PROS	CHAR	39.00	0.00
NAME	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
NAME	T_WEB_ROLE	CHAR	20.00	0.00
NAME_ABSNT_PRNT	T_DS_RECIP_SOBRA_FAM_ABSNT	VARCHAR2	22.00	0.00
NAME_GROUP	T_LS_SUMMARY_NDC	CHAR	30.00	0.00
NAME_USER	T_ANALYST	VARCHAR2	32.00	0.00
NAM_1000A_TECH_CONTACT	T_TPL_1000_PYR_TECH	VARCHAR2	60.00	0.00
NAM_1000B_PAYEE	T_TPL_835_5010	VARCHAR2	60.00	0.00
NAM_2010AA_PER02	T_CLM_DNTL_HDR	VARCHAR2	60.00	0.00
NAM_2010BA_PER02	T_CLM_PHYS_HDR	VARCHAR2	60.00	0.00
NAM_2310C_PER02	T_CLM_PHYS_2300	VARCHAR2	60.00	0.00
NAM_ACCT	T_DS_RECIP_DO_BANK	VARCHAR2	21.00	0.00
NAM_ACCT2	T_DS_RECIP_DO_BANK	VARCHAR2	21.00	0.00
NAM_ACCT3	T_DS_RECIP_DO_BANK	VARCHAR2	21.00	0.00
NAM_ACCT4	T_DS_RECIP_DO_BANK	VARCHAR2	21.00	0.00
NAM_AGENT	T_PR_ENRL_EFT_ACCT	VARCHAR2	50.00	0.00
NAM_AGENT	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_AGENT	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_AGENT	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_AGENT	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT	T_PR_ENRL_EFT_ACCT	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00

NAM_AGENT_CONTACT	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_AGENT_CONTACT_TITLE	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	15.00	0.00
NAM_AGENT_CONTACT_TITLE	T_WEB_RECEIVER	CHAR	15.00	0.00
NAM_AGENT_CONTACT_TITLE	T_WEB_RECEIVER_BACKUP	CHAR	15.00	0.00
NAM_AGENT_CONTACT_TITLE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	15.00	0.00
NAM_AGENT_CONTACT_TITLE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	15.00	0.00
NAM_AKA	T_RE_AR_BASE	VARCHAR2	100.00	0.00
NAM_ALT_THERAPY	T_ERX_ALT_THERAPY	VARCHAR2	35.00	0.00
NAM_ANALYST	T_CT_ANALYST	VARCHAR2	25.00	0.00
NAM_ANALYST	T_CT_CASE_RECOUP	VARCHAR2	25.00	0.00
NAM_ANALYST	T_CT_PROD_TRACK	VARCHAR2	25.00	0.00
NAM_APPLICATION	T_APPLICATION	CHAR	40.00	0.00
NAM_APPLICATION	T_CONTROL	CHAR	40.00	0.00
NAM_APPLICATION	T_PC_AUTHORIZATION	CHAR	40.00	0.00
NAM_APPLICATION	T_PROFILE	CHAR	40.00	0.00
NAM_APPLICATION	T_PW_AUTHORIZATION	CHAR	40.00	0.00
NAM_APPLICATION	T_UC_AUTHORIZATION	CHAR	40.00	0.00
NAM_APPLICATION	T_UP_AUTHORIZATION	CHAR	40.00	0.00
NAM_APPLICATION	T_UW_AUTHORIZATION	CHAR	40.00	0.00
NAM_APPLICATION	T_WINDOW	CHAR	40.00	0.00
NAM_ASSEMBLY	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	100.00	0.00
NAM_ATTN	T_DS_RECIP_DO_BANK	VARCHAR2	22.00	0.00
NAM_ATTRIBUTE	T_CCF_ERROR_DATA	CHAR	15.00	0.00
NAM_ATTRIBUTE	T_HIERARCHY_ATTRIBUTE	VARCHAR2	35.00	0.00
NAM_BANK	T_DS_RECIP_DO_BANK	VARCHAR2	22.00	0.00
NAM_BILLING_TEAM	T_PS_REFERRAL	VARCHAR2	24.00	0.00
NAM_BNFT_GETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_BUS	T_TPL_CARRIER	CHAR	45.00	0.00
NAM_BUS	T_TPL_CARRIER_AL	CHAR	45.00	0.00

NAM_BUS	T_TPL_CONTRACTOR	CHAR	45.00	0.00
NAM_BUS	T_TPL_EMPLOYER	CHAR	39.00	0.00
NAM_BUS	T_TPL_SUB	CHAR	39.00	0.00
NAM_BUSINESS	T_OWNER	CHAR	50.00	0.00
NAM_BUSINESS	T_OWNER_WI	CHAR	50.00	0.00
NAM_BUSINESS	T_PR_ENRL_PROV	VARCHAR2	50.00	0.00
NAM_BUSINESS	T_RE_PARTD_PDP_CARRIER	CHAR	50.00	0.00
NAM_CALC_GETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_CASE	T_CASUALTY_CASE	CHAR	60.00	0.00
NAM_CASE	T_CASUALTY_CASE_AL	CHAR	60.00	0.00
NAM_CDE_GETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_CLASS	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	100.00	0.00
NAM_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CLEARINGHOUSE_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CLS_SETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_CMS_DRUG_FDA	T_DRUG_CMSFDB_INFO	CHAR	10.00	0.00
NAM_CMS_ERROR_FILE	T_MR_TMSIS_CMS_ERROR_FILES	VARCHAR2	50.00	0.00
NAM_CMS_ERROR_FILE	T_TMSIS_CMS_ERROR_FILES	VARCHAR2	50.00	0.00
NAM_CODE	T_CODE_RESOLUTION	CHAR	18.00	0.00
NAM_COLUMN	T_REF_CDE_VALUE_GROUP	VARCHAR2	30.00	0.00
NAM_COLUMN_CDE	T_RU_DOMAIN	VARCHAR2	40.00	0.00
NAM_COLUMN_DSC	T_RU_DOMAIN	VARCHAR2	40.00	0.00
NAM_COMPANY	T_DS_RECIP_DO_HLTH_INS	VARCHAR2	22.00	0.00

NAM_COMPANY	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_COMPANY	T_INS_AGENT	CHAR	40.00	0.00
NAM_CONTACT	T_835_CONTACTS	CHAR	60.00	0.00
NAM_CONTACT	T_ATTORNEY_XREF	CHAR	40.00	0.00
NAM_CONTACT	T_ATTORNEY_XREF_WI	CHAR	40.00	0.00
NAM_CONTACT	T_DR_LBLR_CONTACT	VARCHAR2	39.00	0.00
NAM_CONTACT	T_FIN_CYCLE_TAX_INFO	CHAR	40.00	0.00
NAM_CONTACT	T_HIPP_RESOURCE	CHAR	40.00	0.00
NAM_CONTACT	T_OWNER_WI	VARCHAR2	50.00	0.00
NAM_CONTACT	T_PMP_SVC_LOC_AL	CHAR	25.00	0.00
NAM_CONTACT	T_PMP_SVC_LOC_STATE	CHAR	25.00	0.00
NAM_CONTACT	T_PR_ADR_WI	VARCHAR2	50.00	0.00
NAM_CONTACT	T_PR_APPLN	CHAR	40.00	0.00
NAM_CONTACT	T_PR_APPLN_WI	CHAR	40.00	0.00
NAM_CONTACT	T_PR_ENRL	VARCHAR2	50.00	0.00
NAM_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_CONTACT	T_PR_SVC_LOC_AL	VARCHAR2	50.00	0.00
NAM_CONTACT	T_RELATED_CASES	CHAR	40.00	0.00
NAM_CONTACT	T_RE_PARTD_PDP_CARRIER	CHAR	30.00	0.00
NAM_CONTACT	T_STATE_ADDR	VARCHAR2	40.00	0.00
NAM_CONTACT	T_TP	VARCHAR2	60.00	0.00
NAM_CONTACT	T_TPL_CARRIER	CHAR	40.00	0.00
NAM_CONTACT	T_TPL_CARRIER_AL	CHAR	40.00	0.00
NAM_CONTACT	T_TPL_CAR_SUB_XREF	CHAR	40.00	0.00
NAM_CONTACT	T_TPL_CONTRACTOR	CHAR	40.00	0.00
NAM_CONTACT	T_TPL_EMPLOYER	CHAR	40.00	0.00
NAM_CONTACT_AFT	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
NAM_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CONTACT_BEF	T_PR_WEB_CHG	VARCHAR2	50.00	0.00
NAM_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CONTACT_CH_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CONTACT_CH_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_CONTACT_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_CONTACT_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00

NAM_CONTACT_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_CONTACT_CLEARINGHOUSE	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_CONTACT_CLEARINGHOUSE	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_CONTACT_FIRST	T_CALL_TRACK	CHAR	20.00	0.00
NAM_CONTACT_LAST	T_CALL_TRACK	CHAR	30.00	0.00
NAM_CONTACT_PERSON	T_PS_BILLING_CTR	VARCHAR2	24.00	0.00
NAM_CONTACT_PERSON	T_PS_CASE	VARCHAR2	24.00	0.00
NAM_CONTACT_PERSON	T_PS_CASE_ADDRESS	VARCHAR2	24.00	0.00
NAM_CONTACT_PERSON	T_PS_NF_FACILITY	VARCHAR2	24.00	0.00
NAM_CONTACT_PERSON	T_PS_NONCERT_FAC	VARCHAR2	24.00	0.00
NAM_CONTACT_TITLE	T_PR_ENRL	VARCHAR2	40.00	0.00
NAM_CONTACT_TITLE	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	40.00	0.00
NAM_CONTROL	T_CONTROL	CHAR	41.00	0.00
NAM_CONTROL	T_PC_AUTHORIZATION	CHAR	41.00	0.00
NAM_CONTROL	T_UC_AUTHORIZATION	CHAR	41.00	0.00
NAM_CONTROL_TYPE	T_CONTROL	CHAR	24.00	0.00
NAM_CORP	T_DR_LBLR_CONTACT	VARCHAR2	39.00	0.00
NAM_CORP_CONTACT	T_TPL_CORR_ADDR	CHAR	40.00	0.00
NAM_CP2100	T_IRS_B_NOTICE_AL	VARCHAR2	40.00	0.00
NAM_CTL_FILE	T_SYS_REPORT_CTL	VARCHAR2	30.00	0.00
NAM_CURR_GETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_DEGREE	T_PR_DEA_LIC	CHAR	3.00	0.00
NAM_DESC	T_CODE_RESOLUTION	CHAR	18.00	0.00
NAM_DEST	T_SYS_DEST	VARCHAR2	60.00	0.00
NAM_DOC_LETTER	T_RTS_REASON	CHAR	12.00	0.00
NAM_DOMAIN	T_ANALYST	VARCHAR2	67.00	0.00
NAM_DOMAIN_PLURAL	T_RU_DOMAIN	VARCHAR2	40.00	0.00
NAM_DRUG_BRAND	T_LS_DRUG_MASTER	CHAR	30.00	0.00
NAM_DRUG_BRAND	T_LS_SUMMARY_NDC	CHAR	30.00	0.00
NAM_DRUG_BRAND	T_PROFILE_PHARM_TOP_DRUGS	VARCHAR2	30.00	0.00
NAM_DRUG_FDA	T_DR_CMS_TAPE	CHAR	10.00	0.00
NAM_DRUG_FDA	T_DR_DISPUTE_RESO	CHAR	10.00	0.00

NAM_DRUG_FDA	T_DR_INVOICE_DTL	CHAR	10.00	0.00
NAM_DRUG_GENERIC	T_DRUG_GER_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_DRUG_PED_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_DRUG_PREG_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_GENERIC_DRUG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_GENERIC_DRUG	VARCHAR2	100.00	0.00
NAM_DRUG_GENERIC	T_HIGH_DOSE_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_LOW_DOSE_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_OVER_UTIL_LOG	CHAR	63.00	0.00
NAM_DRUG_GENERIC	T_UNDER_UTIL_LOG	CHAR	63.00	0.00
NAM_DRUG_LABEL	T_LS_DRUG_MASTER	CHAR	30.00	0.00
NAM_DRUG_MANUF	T_DRUG_MANUF	CHAR	15.00	0.00
NAM_EDS_TEAM	T_EDS_TEAM	CHAR	35.00	0.00
NAM_ELIGIBLE_FIRST	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_FIRST	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_FIRST	T_TMSIS_COT002_CLM_HDR	VARCHAR2	30.00	0.00

NAM_ELIGIBLE_FIRST	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_FIRST	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_LAST	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_LAST	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_LAST	T_TMSIS_COT002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_LAST	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_LAST	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	30.00	0.00
NAM_ELIGIBLE_MI	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	1.00	0.00
NAM_ELIGIBLE_MI	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	1.00	0.00
NAM_ELIGIBLE_MI	T_TMSIS_COT002_CLM_HDR	VARCHAR2	1.00	0.00
NAM_ELIGIBLE_MI	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	1.00	0.00
NAM_ELIGIBLE_MI	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	1.00	0.00
NAM_EMPLOYER	T_DS_RECIP_SOBRA_EMP	VARCHAR2	22.00	0.00
NAM_EMPLOYER	T_RE_INCOME_LOSS	CHAR	22.00	0.00
NAM_EMPLOYER	T_RE_INCOME_NEW	CHAR	22.00	0.00
NAM_ERM	T_ERM_ENT	CHAR	15.00	0.00
NAM_ERM	T_ERM_HDR	CHAR	15.00	0.00
NAM_ERM_AFF	T_ERM_DEP	CHAR	15.00	0.00
NAM_ERM_AFF_PGM	T_ERM_DEP	CHAR	15.00	0.00
NAM_ERM_CUR	T_ERM_DEP	CHAR	15.00	0.00
NAM_ERM_CUR_PGM	T_ERM_DEP	CHAR	15.00	0.00
NAM_EVENT	T_PLOG_EVENTS	CHAR	45.00	0.00
NAM_EVENT_SET	T_EVENT_SETS	CHAR	45.00	0.00
NAM_FACILITY	T_DS_RECIP_DO_APPL	VARCHAR2	40.00	0.00
NAM_FACILITY	T_FACILITY	CHAR	50.00	0.00
NAM_FACILITY	T_PR_FACILITY	CHAR	50.00	0.00
NAM_FAMILY_MBR	T_DS_RECIP_SOBRA_FAMILY	VARCHAR2	22.00	0.00
NAM_FIELD	T_RE_HIST_ERR	CHAR	15.00	0.00
NAM_FIELD	T_RE_PS2_ERR	CHAR	15.00	0.00
NAM_FIELD	T_SW_MASKING_DATA	VARCHAR2	25.00	0.00
NAM_FILE	T_FILE_TRACK	VARCHAR2	255.00	0.00

NAM_FILE	T_PR_ENRL_UPLOAD	VARCHAR2	30.00	0.00
NAM_FILE	T_RE_1095_ACK	VARCHAR2	50.00	0.00
NAM_FILE	T_RE_ADPH_1095_ACK	VARCHAR2	50.00	0.00
NAM_FILE	T_TMSIS_CIP001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_CLT001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_COT001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_CRX001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_EDIT_FAILURES	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_ELG001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_MCR001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_PRV001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_TMSIS_TPL001_FILE_HDR	VARCHAR2	8.00	0.00
NAM_FILE	T_WEB_FEITH_DOWNLOAD	VARCHAR2	256.00	0.00
NAM_FILECABINET	T_WEB_FEITH_DOWNLOAD	VARCHAR2	30.00	0.00
NAM_FILENAME	T_DS_LVX_USER_REQ	VARCHAR2	256.00	0.00
NAM_FILEPATH	T_FILE_TRACK	VARCHAR2	255.00	0.00
NAM_FILE_ZIP	T_PR_ENRL_UPLOAD	VARCHAR2	30.00	0.00
NAM_FIRM	T_ATTORNEY_FIRM	VARCHAR2	50.00	0.00
NAM_FIRM	T_PR_ADR_CASS	VARCHAR2	50.00	0.00
NAM_FIRST	T_ANALYST	CHAR	13.00	0.00
NAM_FIRST	T_ANALYST	VARCHAR2	50.00	0.00
NAM_FIRST	T_ATTORNEY	CHAR	13.00	0.00
NAM_FIRST	T_BOARD_PART	CHAR	50.00	0.00
NAM_FIRST	T_BUYA_BILL_INFO	CHAR	15.00	0.00
NAM_FIRST	T_BUYA_DEMO_CHANGE	CHAR	15.00	0.00
NAM_FIRST	T_BUYA_EXCEPT	CHAR	15.00	0.00
NAM_FIRST	T_BUYA_MISMATCH	CHAR	15.00	0.00
NAM_FIRST	T_BUYB_BILL_INFO	CHAR	15.00	0.00
NAM_FIRST	T_BUYB_DEMO_CHANGE	CHAR	15.00	0.00
NAM_FIRST	T_BUYB_EXCEPT	CHAR	15.00	0.00
NAM_FIRST	T_BUYB_MISMATCH	CHAR	15.00	0.00
NAM_FIRST	T_CALL_OTHER_INFO	VARCHAR2	13.00	0.00
NAM_FIRST	T_CA_TPL_SUMMARY	VARCHAR2	35.00	0.00
NAM_FIRST	T_CLERK_PROFILE	VARCHAR2	13.00	0.00
NAM_FIRST	T_CLM_NAME_NM1	VARCHAR2	35.00	0.00
NAM_FIRST	T_CLM_SYS_FIELDS_HDR	CHAR	15.00	0.00
NAM_FIRST	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00

NAM_FIRST	T_INS_AGENT	CHAR	13.00	0.00
NAM_FIRST	T_OWNER	CHAR	50.00	0.00
NAM_FIRST	T_OWNER_WI	CHAR	50.00	0.00
NAM_FIRST	T_POLICY_HOLDER	CHAR	13.00	0.00
NAM_FIRST	T_PR_ENRL_BOARD	CHAR	15.00	0.00
NAM_FIRST	T_PR_ENRL_EFT_ERA_MAINT	CHAR	15.00	0.00
NAM_FIRST	T_PR_ENRL_PROV	CHAR	15.00	0.00
NAM_FIRST	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
NAM_FIRST	T_RE_AR_WORKER	VARCHAR2	15.00	0.00
NAM_FIRST	T_RE_BASE	CHAR	15.00	0.00
NAM_FIRST	T_RE_BASE_DN	CHAR	15.00	0.00
NAM_FIRST	T_RE_CASE	CHAR	15.00	0.00
NAM_FIRST	T_RE_CHILD_EXPECT	CHAR	15.00	0.00
NAM_FIRST	T_RE_CHILD_HAD	CHAR	15.00	0.00
NAM_FIRST	T_RE_CMS_MMA_ENROLL	CHAR	15.00	0.00
NAM_FIRST	T_RE_DEMOGRAPHIC	CHAR	15.00	0.00
NAM_FIRST	T_RE_EDB	CHAR	15.00	0.00
NAM_FIRST	T_RE_EPSDT_LETTER	CHAR	13.00	0.00
NAM_FIRST	T_RE_HIST_ERR	CHAR	15.00	0.00
NAM_FIRST	T_RE_ID_CRD_ISS	CHAR	13.00	0.00
NAM_FIRST	T_RE_ID_CRD_ISS	CHAR	15.00	0.00
NAM_FIRST	T_RE_INCOME_LOSS	CHAR	15.00	0.00
NAM_FIRST	T_RE_INCOME_NEW	CHAR	15.00	0.00
NAM_FIRST	T_RE_LTC_REQUEST	CHAR	20.00	0.00
NAM_FIRST	T_RE_MARITAL	CHAR	15.00	0.00
NAM_FIRST	T_RE_MOVE_IN_OUT	CHAR	15.00	0.00
NAM_FIRST	T_RE_MULTI_ADDRESS	CHAR	15.00	0.00
NAM_FIRST	T_RE_NAME_XREF	CHAR	15.00	0.00
NAM_FIRST	T_RE_PS2_DUPE	CHAR	15.00	0.00
NAM_FIRST	T_RE_PS2_ERR	CHAR	15.00	0.00
NAM_FIRST	T_TORTFEASOR	CHAR	13.00	0.00
NAM_FIRST	T_TORTFEASOR_AL	CHAR	13.00	0.00
NAM_FIRST	T_TPL_AC_PARENT	CHAR	13.00	0.00
NAM_FIRST	T_TPL_CASE_INFO	CHAR	15.00	0.00
NAM_FIRST	T_TPL_SUSP_XREF	CHAR	13.00	0.00
NAM_FIRST_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	VARCHAR2	35.00	0.00
NAM_FIRST_2310E_NM104	T_CLM_DNTL_2300	VARCHAR2	35.00	0.00

NAM_FIRST_2420B_NM104	T_CLM_UB92_2400	VARCHAR2	35.00	0.00
NAM_FIRST_2420C_NM104	T_CLM_DNTL_2400	VARCHAR2	35.00	0.00
NAM_FIRST_2420C_NM104	T_CLM_UB92_2400	VARCHAR2	35.00	0.00
NAM_FIRST_2420D_NM104	T_CLM_UB92_2400	VARCHAR2	35.00	0.00
NAM_FIRST_ACCT	T_ACCOUNT_TEAM	CHAR	35.00	0.00
NAM_FIRST_ADMIN	T_PR_FACILITY	CHAR	50.00	0.00
NAM_FIRST_ASSGND	T_PROJ_TRACK	CHAR	13.00	0.00
NAM_FIRST_BNDX	T_RE_BNDX_BUYIN	CHAR	7.00	0.00
NAM_FIRST_CO_ADMIN	T_PR_FACILITY	CHAR	50.00	0.00
NAM_FIRST_EDB	T_BUYA_DEMO_CHANGE	CHAR	15.00	0.00
NAM_FIRST_EDB	T_BUYB_DEMO_CHANGE	CHAR	15.00	0.00
NAM_FIRST_INCARE	T_RE_EXPENSE	CHAR	15.00	0.00
NAM_FIRST_NAME	T_PS_CASE_ADDRESS	VARCHAR2	7.00	0.00
NAM_FIRST_PAYEE	T_RE_EXPENSE	CHAR	15.00	0.00
NAM_FIRST_PS2	T_RE_PS2_DUPE	CHAR	15.00	0.00
NAM_FIRST_RECVD	T_PROJ_TRACK	CHAR	13.00	0.00
NAM_FIRST_RQSTR	T_PROJ_TRACK	CHAR	13.00	0.00
NAM_FIRST_SE	T_SETEAM_MEMBER	CHAR	35.00	0.00
NAM_FIRST_SPONSOR	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	15.00	0.00
NAM_FIRST_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00
NAM_FIRST_TESTER	T_PLOG_HEADER	CHAR	35.00	0.00
NAM_FIRST_TESTER	T_PLOG_TESTER	CHAR	35.00	0.00
NAM_FIRST_VT	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00
NAM_FOR_PAY_DAY_CARE	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_FULL	T_RE_ADR_CASS	VARCHAR2	50.00	0.00
NAM_FULL	T_RE_CARE_MNGR	CHAR	50.00	0.00
NAM_FUNCTION	T_RU_VARIABLE	VARCHAR2	50.00	0.00

NAM_GENERIC	T_HICL_SEQ_NO	VARCHAR2	30.00	0.00
NAM_GENERIC_LONG	T_HICL_SEQ_NO	VARCHAR2	60.00	0.00
NAM_GROUP	T_BNFT_GROUP_STD	VARCHAR2	100.00	0.00
NAM_GROUP	T_PR_ENRL_GROUP	VARCHAR2	50.00	0.00
NAM_HH_ENTITY	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	50.00	0.00
NAM_HH_ENTITY	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	50.00	0.00
NAM_HH_ENTITY	T_TMSIS_COT002_CLM_HDR	VARCHAR2	50.00	0.00
NAM_HH_ENTITY	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	50.00	0.00
NAM_HH_ENTITY	T_TMSIS_ELG006_HH_SPA_PART	VARCHAR2	100.00	0.00
NAM_HH_ENTITY	T_TMSIS_ELG007_HH_SPA_PROV	VARCHAR2	100.00	0.00
NAM_HH_SPA	T_TMSIS_ELG006_HH_SPA_PART	VARCHAR2	100.00	0.00
NAM_HH_SPA	T_TMSIS_ELG007_HH_SPA_PROV	VARCHAR2	100.00	0.00
NAM_INGREDIENT	T_INGREDIENT	VARCHAR2	50.00	0.00
NAM_INSURED_GROUP	T_CLM_SBR	VARCHAR2	60.00	0.00
NAM_INS_CARRIER	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	30.00	0.00
NAM_INV_CORP	T_FIN_INSTITUTION	CHAR	39.00	0.00
NAM_INV_CORP	T_PR_ENRL_EFT_ACCT	CHAR	39.00	0.00
NAM_INV_CORP	T_PR_ENRL_EFT_ERA_MAINT	CHAR	39.00	0.00
NAM_INV_CORP	T_PR_FIN_INST	CHAR	39.00	0.00
NAM_LABELER	T_DR_TMP_SUPP_RATES	CHAR	30.00	0.00
NAM_LAST	T_ANALYST	CHAR	15.00	0.00
NAM_LAST	T_ANALYST	VARCHAR2	50.00	0.00
NAM_LAST	T_ATTORNEY	CHAR	15.00	0.00
NAM_LAST	T_BOARD_PART	CHAR	50.00	0.00
NAM_LAST	T_BUYA_BILL_INFO	CHAR	24.00	0.00
NAM_LAST	T_BUYA_DEMO_CHANGE	CHAR	24.00	0.00
NAM_LAST	T_BUYA_EXCEPT	CHAR	24.00	0.00
NAM_LAST	T_BUYA_MISMATCH	CHAR	24.00	0.00
NAM_LAST	T_BUYB_BILL_INFO	CHAR	24.00	0.00
NAM_LAST	T_BUYB_DEMO_CHANGE	CHAR	24.00	0.00
NAM_LAST	T_BUYB_EXCEPT	CHAR	24.00	0.00

NAM_LAST	T_BUYB_MISMATCH	CHAR	24.00	0.00
NAM_LAST	T_CALL_OTHER_INFO	VARCHAR2	15.00	0.00
NAM_LAST	T_CA_TPL_SUMMARY	VARCHAR2	60.00	0.00
NAM_LAST	T_CLERK_PROFILE	VARCHAR2	15.00	0.00
NAM_LAST	T_CLM_NAME_NM1	VARCHAR2	60.00	0.00
NAM_LAST	T_CLM_SYS_FIELDS_HDR	CHAR	20.00	0.00
NAM_LAST	T_DS_RECIP_DO_APPL	VARCHAR2	30.00	0.00
NAM_LAST	T_INS_AGENT	CHAR	15.00	0.00
NAM_LAST	T_OWNER	CHAR	50.00	0.00
NAM_LAST	T_OWNER_WI	CHAR	50.00	0.00
NAM_LAST	T_PA_HDR_PE_TRNSP	VARCHAR2	60.00	0.00
NAM_LAST	T_PA_HDR_PE_UMO	VARCHAR2	60.00	0.00
NAM_LAST	T_POLICY_HOLDER	CHAR	15.00	0.00
NAM_LAST	T_PR_ENRL_BOARD	CHAR	20.00	0.00
NAM_LAST	T_PR_ENRL_EFT_ERA_MAINT	CHAR	20.00	0.00
NAM_LAST	T_PR_ENRL_PROV	CHAR	20.00	0.00
NAM_LAST	T_PR_NAM_NPPES	VARCHAR2	35.00	0.00
NAM_LAST	T_RE_AR_WORKER	VARCHAR2	20.00	0.00
NAM_LAST	T_RE_BASE	CHAR	20.00	0.00
NAM_LAST	T_RE_BASE_DN	CHAR	20.00	0.00
NAM_LAST	T_RE_CASE	CHAR	20.00	0.00
NAM_LAST	T_RE_CHILD_EXPECT	CHAR	30.00	0.00
NAM_LAST	T_RE_CHILD_HAD	CHAR	30.00	0.00
NAM_LAST	T_RE_CMS_MMA_ENROLL	CHAR	20.00	0.00
NAM_LAST	T_RE_DEMOGRAPHIC	CHAR	30.00	0.00
NAM_LAST	T_RE_EDB	CHAR	24.00	0.00
NAM_LAST	T_RE_EPSDT_LETTER	CHAR	15.00	0.00
NAM_LAST	T_RE_HIST_ERR	CHAR	20.00	0.00
NAM_LAST	T_RE_ID_CRD_ISS	CHAR	15.00	0.00
NAM_LAST	T_RE_ID_CRD_ISS	CHAR	20.00	0.00
NAM_LAST	T_RE_INCOME_LOSS	CHAR	30.00	0.00
NAM_LAST	T_RE_INCOME_NEW	CHAR	30.00	0.00
NAM_LAST	T_RE_LTC_REQUEST	CHAR	30.00	0.00
NAM_LAST	T_RE_MARITAL	CHAR	30.00	0.00
NAM_LAST	T_RE_MOVE_IN_OUT	CHAR	30.00	0.00
NAM_LAST	T_RE_MULTI_ADDRESS	CHAR	20.00	0.00

NAM_LAST	T_RE_NAME_XREF	CHAR	20.00	0.00
NAM_LAST	T_RE_PS2_DUPE	CHAR	20.00	0.00
NAM_LAST	T_RE_PS2_ERR	CHAR	20.00	0.00
NAM_LAST	T_TORTFEASOR	CHAR	15.00	0.00
NAM_LAST	T_TORTFEASOR_AL	CHAR	15.00	0.00
NAM_LAST	T_TPL_AC_PARENT	CHAR	15.00	0.00
NAM_LAST	T_TPL_CASE_INFO	CHAR	20.00	0.00
NAM_LAST	T_TPL_SUSP_XREF	CHAR	15.00	0.00
NAM_LAST_2010AC_NM103	T_CLM_DNTL_HDR	VARCHAR2	60.00	0.00
NAM_LAST_2010AC_NM103	T_CLM_PHYS_HDR	VARCHAR2	60.00	0.00
NAM_LAST_2010AC_NM103	T_CLM_UB92_HDR	VARCHAR2	60.00	0.00
NAM_LAST_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	VARCHAR2	60.00	0.00
NAM_LAST_2310E_NM103	T_CLM_DNTL_2300	VARCHAR2	60.00	0.00
NAM_LAST_2310F_NM103	T_CLM_PHYS_2300	VARCHAR2	60.00	0.00
NAM_LAST_2420B_NM103	T_CLM_UB92_2400	VARCHAR2	60.00	0.00
NAM_LAST_2420C_NM103	T_CLM_DNTL_2400	VARCHAR2	60.00	0.00
NAM_LAST_2420C_NM103	T_CLM_UB92_2400	VARCHAR2	60.00	0.00
NAM_LAST_2420D_NM103	T_CLM_DNTL_2400	VARCHAR2	60.00	0.00
NAM_LAST_2420D_NM103	T_CLM_UB92_2400	VARCHAR2	60.00	0.00
NAM_LAST_2420H_NM103	T_CLM_PHYS_2400	VARCHAR2	60.00	0.00
NAM_LAST_ADMIN	T_PR_FACILITY	CHAR	50.00	0.00
NAM_LAST_ASSGND	T_PROJ_TRACK	CHAR	15.00	0.00
NAM_LAST_BNDX	T_RE_BNDX_BUYIN	CHAR	12.00	0.00
NAM_LAST_CO_ADMIN	T_PR_FACILITY	CHAR	50.00	0.00
NAM_LAST_EDB	T_BUYA_DEMO_CHANGE	CHAR	24.00	0.00
NAM_LAST_EDB	T_BUYB_DEMO_CHANGE	CHAR	24.00	0.00
NAM_LAST_INCARE	T_RE_EXPENSE	CHAR	30.00	0.00
NAM_LAST_NAME	T_PS_CASE_ADDRESS	VARCHAR2	12.00	0.00

NAM_LAST_NORM	T_RE_BASE	VARCHAR2	20.00	0.00
NAM_LAST_PAYEE	T_RE_EXPENSE	CHAR	30.00	0.00
NAM_LAST_PS2	T_RE_PS2_DUPE	CHAR	20.00	0.00
NAM_LAST_RECVD	T_PROJ_TRACK	CHAR	15.00	0.00
NAM_LAST_RQSTR	T_PROJ_TRACK	CHAR	15.00	0.00
NAM_LAST_SPONSOR	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	30.00	0.00
NAM_LAST_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	20.00	0.00
NAM_LAST_VT	T_DS_RECIP_DO_APPL	VARCHAR2	30.00	0.00
NAM_LIBRARY	T_RU_VARIABLE	VARCHAR2	50.00	0.00
NAM_LIST	T_ERX_CDE_LIST_ID	VARCHAR2	35.00	0.00
NAM_LISTED_OWNER	T_DS_RECIP_DO_PREV_PROP	VARCHAR2	57.00	0.00
NAM_LOCATION	T_PR_ENRL_LOC	VARCHAR2	30.00	0.00
NAM_LOG_FILE	T_SW_RTI_LOG	CHAR	50.00	0.00
NAM_MACHINE	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	100.00	0.00
NAM_MANUFACTURER	T_DR_TMP_SUPP_RATES	CHAR	16.00	0.00
NAM_MC_PLAN	T_TMSIS_MCR002_MAIN	VARCHAR2	55.00	0.00
NAM_MC_SVC_AREA	T_TMSIS_MCR004_SVC_AREA	VARCHAR2	30.00	0.00
NAM_MEMBER	T_CT_EDIT_MEMBERS	VARCHAR2	50.00	0.00
NAM_MEMBER	T_DS_RECIP_DO_FAMILY	VARCHAR2	35.00	0.00
NAM_MEMBER_FIRST	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	30.00	0.00
NAM_MEMBER_LAST	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	30.00	0.00
NAM_MEMBER_MI	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	1.00	0.00
NAM_METHOD	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	500.00	0.00
NAM_MFG	T_LS_DRUG_MASTER	CHAR	15.00	0.00
NAM_MFG	T_LS_SUMMARY_NDC	CHAR	15.00	0.00
NAM_MI	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00
NAM_MI	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
NAM_MI	T_RE_EDB	CHAR	1.00	0.00
NAM_MIDDLE	T_CA_TPL_SUMMARY	VARCHAR2	25.00	0.00
NAM_MIDDLE	T_CLM_NAME_NM1	VARCHAR2	25.00	0.00

NAM_MIDDLE	T_RE_CHILD_EXPECT	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_CHILD_HAD	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_DEMOGRAPHIC	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_INCOME_LOSS	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_INCOME_NEW	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_MARITAL	CHAR	15.00	0.00
NAM_MIDDLE	T_RE_MOVE_IN_OUT	CHAR	15.00	0.00
NAM_MIDDLE_INCARE	T_RE_EXPENSE	CHAR	15.00	0.00
NAM_MIDDLE_INIT	T_PS_CASE_ADDRESS	CHAR	1.00	0.00
NAM_MIDDLE_INT	T_BOARD_PART	CHAR	1.00	0.00
NAM_MIDDLE_INT	T_OWNER	CHAR	1.00	0.00
NAM_MIDDLE_INT	T_OWNER_WI	CHAR	1.00	0.00
NAM_MIDDLE_PAYEE	T_RE_EXPENSE	CHAR	15.00	0.00
NAM_MID_BNDX	T_RE_BNDX_BUYIN	CHAR	1.00	0.00
NAM_MID_INIT	T_ANALYST	CHAR	1.00	0.00
NAM_MID_INIT	T_ANALYST	VARCHAR2	4.00	0.00
NAM_MID_INIT	T_ATTORNEY	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYA_BILL_INFO	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYA_DEMO_CHANGE	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYA_EXCEPT	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYA_MISMATCH	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYB_BILL_INFO	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYB_DEMO_CHANGE	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYB_EXCEPT	CHAR	1.00	0.00
NAM_MID_INIT	T_BUYB_MISMATCH	CHAR	1.00	0.00
NAM_MID_INIT	T_CLM_SYS_FIELDS_HDR	CHAR	1.00	0.00
NAM_MID_INIT	T_INS_AGENT	CHAR	1.00	0.00
NAM_MID_INIT	T_POLICY_HOLDER	CHAR	1.00	0.00
NAM_MID_INIT	T_PR_ENRL_PROV	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_AR_WORKER	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_BASE	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_BASE_DN	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_CASE	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_CMS_MMA_ENROLL	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_EPSDT_LETTER	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_HIST_ERR	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_ID_CRD_ISS	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_MULTI_ADDRESS	CHAR	1.00	0.00
NAM_MID_INIT	T_RE_NAME_XREF	CHAR	1.00	0.00

NAM_MID_INIT	T_RE_PS2_ERR	CHAR	1.00	0.00
NAM_MID_INIT	T_TORTFEASOR	CHAR	1.00	0.00
NAM_MID_INIT	T_TORTFEASOR_AL	CHAR	1.00	0.00
NAM_MID_INIT	T_TPL_AC_PARENT	CHAR	1.00	0.00
NAM_MID_INIT	T_TPL_CASE_INFO	CHAR	1.00	0.00
NAM_MID_INIT	T_TPL_SUSP_XREF	CHAR	1.00	0.00
NAM_MID_INIT_EDB	T_BUYA_DEMO_CHANGE	CHAR	1.00	0.00
NAM_MID_INIT_EDB	T_BUYB_DEMO_CHANGE	CHAR	1.00	0.00
NAM_MID_LVL_ASSOC	T_PMP_SVC_LOC_AL	CHAR	16.00	0.00
NAM_MID_LVL_ASSOC	T_PMP_SVC_LOC_STATE	CHAR	16.00	0.00
NAM_MI_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	VARCHAR2	25.00	0.00
NAM_MI_2310E_NM105	T_CLM_DNTL_2300	VARCHAR2	25.00	0.00
NAM_MI_2420B_NM105	T_CLM_UB92_2400	VARCHAR2	25.00	0.00
NAM_MI_2420C_NM105	T_CLM_DNTL_2400	VARCHAR2	25.00	0.00
NAM_MI_2420C_NM105	T_CLM_UB92_2400	VARCHAR2	25.00	0.00
NAM_MI_2420D_NM105	T_CLM_UB92_2400	VARCHAR2	25.00	0.00
NAM_MI_ADMIN	T_PR_FACILITY	CHAR	1.00	0.00
NAM_MI_CO_ADMIN	T_PR_FACILITY	CHAR	1.00	0.00
NAM_MI_ORDERED_TO	T_PS_REFERRAL	VARCHAR2	8.00	0.00
NAM_MI_SPONSOR	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	15.00	0.00
NAM_MI_SPOUSE	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00
NAM_MI_VERBAL_FROM	T_PS_DETERMINATION	VARCHAR2	24.00	0.00
NAM_MI_VT	T_DS_RECIP_DO_APPL	VARCHAR2	15.00	0.00
NAM_MODULE	T_PLOG_HEADER	CHAR	45.00	0.00
NAM_MODULE	T_PLOG_MODULES	CHAR	45.00	0.00
NAM_MR_ORDERED_TO	T_PS_REFERRAL	VARCHAR2	8.00	0.00
NAM_MR_VERBAL_FROM	T_PS_DETERMINATION	VARCHAR2	24.00	0.00
NAM_NAME	T_PS_BILLING_CTR	VARCHAR2	60.00	0.00
NAM_NAME	T_PS_CASE_ADDRESS	VARCHAR2	24.00	0.00
NAM_NAME	T_PS_NONCERT_FAC	VARCHAR2	24.00	0.00

NAM_NAM_SETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_NATL_HC_ENTITY	T_TMSIS_MCR008_NATL_HC_ENT	VARCHAR2	50.00	0.00
NAM_NATL_HC_ENTITY	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	50.00	0.00
NAM_OPERATOR	T_PR_FACILITY	CHAR	50.00	0.00
NAM_ORGN_SERVER	T_FILE_TRACK	VARCHAR2	50.00	0.00
NAM_ORG_SPONSOR	T_DS_RECIP_DO_APPL_SPONS	VARCHAR2	40.00	0.00
NAM_OWNER	T_PR_BOARD	VARCHAR2	50.00	0.00
NAM_OWNER_PARCEL	T_DS_RECIP_DO_REAL_EST	VARCHAR2	57.00	0.00
NAM_PANEL	T_SW_MASKING_DATA	VARCHAR2	50.00	0.00
NAM_PARM	T_TMSIS_PARMS	VARCHAR2	30.00	0.00
NAM_PAYEE	T_DS_PAYEE_NAM_ADR	VARCHAR2	100.00	0.00
NAM_PAYER	T_835_CK_EFT_TRCNO	VARCHAR2	60.00	0.00
NAM_PAYER_ST	T_835_CONSTANTS	CHAR	60.00	0.00
NAM_PAYER_ST	T_FIN_CYCLE	CHAR	50.00	0.00
NAM_PAY_TO_PROV	T_FIN_PROCESS_PROV_ID	VARCHAR2	50.00	0.00
NAM_PERSON_ASSIST	T_RE_IDENTIFIER	CHAR	60.00	0.00
NAM_PERSON_UPDATE	T_RE_IDENTIFIER	CHAR	60.00	0.00
NAM_PLAN	T_RE_PARTD_PDP_PLAN	VARCHAR2	50.00	0.00
NAM_POLHLD_ICES	T_TPL_RES_DEL	CHAR	31.00	0.00
NAM_POLICY_HOLDER	T_DS_RECIP_DO_HLTH_INS	VARCHAR2	22.00	0.00
NAM_POLICY_HOLDER	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_POLICY_OWNER_FIRST	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	30.00	0.00
NAM_POLICY_OWNER_LAST	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	30.00	0.00
NAM_PREAPR_CONTACT	T_PS_ICF_MR	CHAR	24.00	0.00
NAM_PREFIX	T_PR_ENRL_PROV	CHAR	4.00	0.00
NAM_PREFIX	T_PR_NAM_NPPES	VARCHAR2	5.00	0.00
NAM_PREFIX_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	VARCHAR2	10.00	0.00
NAM_PRESCRB_FIRST	T_CLM_PHRM_HDR	VARCHAR2	12.00	0.00
NAM_PROBATE_COUNTY	T_TPL_COUNTY_PROBATE	VARCHAR	25.00	0.00
NAM_PROBATE_DIV	T_TPL_COUNTY_PROBATE	VARCHAR	50.00	0.00
NAM_PROCESS	T_AR_LETTERS	VARCHAR	20.00	0.00
NAM_PROCESS	T_TMSIS_PARMS	VARCHAR2	20.00	0.00
NAM_PROFILE	T_PC_AUTHORIZATION	CHAR	32.00	0.00
NAM_PROFILE	T_PROFILE	CHAR	32.00	0.00

NAM_PROFILE	T_PW_AUTHORIZATION	CHAR	32.00	0.00
NAM_PROFILE	T_UP_AUTHORIZATION	CHAR	32.00	0.00
NAM_PROGRAM	T_BATCH_RESTART	CHAR	8.00	0.00
NAM_PROGRAM	T_ERM_ENT	CHAR	15.00	0.00
NAM_PROGRAM	T_STATE_ADDR	CHAR	8.00	0.00
NAM_PROGRAM	T_SYSTEM_PARMS	CHAR	8.00	0.00
NAM_PROVIDER	T_CT_CONT_TERM	VARCHAR2	50.00	0.00
NAM_PROVIDER	T_DS_HM_HEADER	CHAR	50.00	0.00
NAM_PROVIDER	T_PR_APPLN_STATUS	VARCHAR2	50.00	0.00
NAM_PROVIDER	T_PR_DEA_LIC	VARCHAR2	40.00	0.00
NAM_PROVIDER	T_RE_NET_VOUCHER	CHAR	30.00	0.00
NAM_PROV_DBA	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	100.00	0.00
NAM_PROV_FIRST	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	30.00	0.00
NAM_PROV_LAST	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	30.00	0.00
NAM_PROV_LEGAL	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	100.00	0.00
NAM_PROV_MI	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	1.00	0.00
NAM_PROV_ORG	T_PR_NAM_NPPES	VARCHAR2	70.00	0.00
NAM_PROV_ORG	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	60.00	0.00
NAM_PROV_PHRM	T_PR_ENRL_PROV	VARCHAR2	50.00	0.00
NAM_PROV_PHYS	T_PR_ENRL_PROV	VARCHAR2	50.00	0.00
NAM_PROV_PHYS	T_PR_PHYS_SUPV	VARCHAR2	50.00	0.00
NAM_PROV_RECIP	T_CT_SELECT_LST	VARCHAR2	50.00	0.00
NAM_PROV_RECIP_F	T_CT_CASE_TRACK	VARCHAR2	13.00	0.00
NAM_PROV_RECIP_F	T_CT_REFERRALS	VARCHAR2	10.00	0.00
NAM_PROV_RECIP_L	T_CT_CASE_TRACK	VARCHAR2	39.00	0.00
NAM_PROV_RECIP_L	T_CT_REFERRALS	VARCHAR2	39.00	0.00
NAM_PROV_RECIP_MI	T_CT_CASE_TRACK	CHAR	1.00	0.00
NAM_PROV_TAX	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	100.00	0.00
NAM_PROV_TWO	T_DENTAL_HDR_KEYS	CHAR	2.00	0.00
NAM_PROV_TWO	T_PHYS_HDR_KEY	CHAR	2.00	0.00
NAM_PROV_TWO	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
NAM_RECIP	T_DS_DNTL_RECIP	VARCHAR2	50.00	0.00

NAM_RECIP	T_RE_1095	VARCHAR2	50.00	0.00
NAM_RECIP	T_RE_ADPH_1095	VARCHAR2	63.00	0.00
NAM_RECIPIENT	T_CT_EOMB	VARCHAR2	50.00	0.00
NAM_REFERRED	T_PR_APPLN_WI	VARCHAR2	50.00	0.00
NAM_REMITTER	T_CASH_RECEIPT	CHAR	50.00	0.00
NAM_REPORT	T_PLOG_HEADER	CHAR	45.00	0.00
NAM_REPORT	T_PLOG_REPORTS	CHAR	45.00	0.00
NAM_REQUESTOR	T_FIN_PYMT_PULL	CHAR	50.00	0.00
NAM_REQUESTOR	T_PR_PAY_PULL	CHAR	50.00	0.00
NAM_RLINK	T_ERX_RESOURCE_LINK	VARCHAR2	35.00	0.00
NAM_RLINK_TYPE	T_ERX_CDE_RLINK	VARCHAR2	25.00	0.00
NAM_RPT	T_SYS_REPORT	VARCHAR2	50.00	0.00
NAM_RPT_FILE	T_SYS_REPORT	VARCHAR2	30.00	0.00
NAM_RPT_OUTPUT	T_SYS_REPORT_ROUTE	VARCHAR2	30.00	0.00
NAM_RPT_RECIP	T_SYS_REPORT_RECIP	VARCHAR2	50.00	0.00
NAM_RULE_GETTER	T_HIERARCHY_ATTRIBUTE	VARCHAR2	15.00	0.00
NAM_SANC_PROV	T_PR_SANCTION_AL	VARCHAR	50.00	0.00
NAM_SANC_PROV	T_PR_SANCTION_WI	VARCHAR	50.00	0.00
NAM_SCHEMA	T_HIST_PART	CHAR	5.00	0.00
NAM_SCHEMA	T_HS_DIR_PART	CHAR	5.00	0.00
NAM_SERVER	T_SW_PERFORMANCE_DATA	VARCHAR2	12.00	0.00
NAM_SIGNATURE	T_FIN_EFT_ACCT	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_PR_ENRL	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_PR_SVC_LOC	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_PR_SVC_LOC_AL	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_PR_SVC_LOC_WI	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_SIGNATURE	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_SIGNATURE_EFT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_SIGNATURE_EFT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_SIGNATURE_ERA_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_SIGNATURE_ERA_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00

NAM_SITE	T_PMP_SVC_LOC_KY	CHAR	50.00	0.00
NAM_SPONSOR_SUFFIX	T_DS_RECIP_DO_APPL_SPONS	CHAR	4.00	0.00
NAM_SUBSYSTEM	T_SW_PERFORMANCE_DATA	VARCHAR2	50.00	0.00
NAM_SUFFIX	T_CLM_NAME_NM1	VARCHAR2	10.00	0.00
NAM_SUFFIX	T_DS_RECIP_DO_APPL	CHAR	4.00	0.00
NAM_SUFFIX	T_PR_ENRL_PROV	CHAR	4.00	0.00
NAM_SUFFIX	T_PR_NAM_NPPES	VARCHAR2	5.00	0.00
NAM_SUFFIX	T_RE_BASE_STATE	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_CHILD_EXPECT	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_CHILD_HAD	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_DEMOGRAPHIC	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_INCOME_LOSS	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_INCOME_NEW	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_MARITAL	CHAR	4.00	0.00
NAM_SUFFIX	T_RE_MOVE_IN_OUT	CHAR	4.00	0.00
NAM_SUFFIX_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	VARCHAR2	10.00	0.00
NAM_SUFFIX_2310E_NM107	T_CLM_DNTL_2300	VARCHAR2	10.00	0.00
NAM_SUFFIX_2420B_NM107	T_CLM_UB92_2400	VARCHAR2	10.00	0.00
NAM_SUFFIX_2420C_NM107	T_CLM_DNTL_2400	VARCHAR2	10.00	0.00
NAM_SUFFIX_2420C_NM107	T_CLM_UB92_2400	VARCHAR2	10.00	0.00
NAM_SUFFIX_2420D_NM107	T_CLM_UB92_2400	VARCHAR2	10.00	0.00
NAM_SUFFIX_INCARE	T_RE_EXPENSE	CHAR	4.00	0.00
NAM_SUFFIX_PAYEE	T_RE_EXPENSE	CHAR	4.00	0.00
NAM_SUFFIX_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	4.00	0.00
NAM_SUFFIX_VT	T_DS_RECIP_DO_APPL	CHAR	4.00	0.00
NAM_TABLE	T_CODE_RESOLUTION	VARCHAR2	32.00	0.00
NAM_TABLE	T_GROUP_TYPE	VARCHAR2	40.00	0.00
NAM_TABLE	T_HIERARCHY_ATTRIBUTE	VARCHAR2	35.00	0.00
NAM_TABLE	T_REF_CDE_VALUE_GROUP	VARCHAR2	30.00	0.00
NAM_TABLE	T_RU_DOMAIN	VARCHAR2	40.00	0.00
NAM_TABLES_USED	T_DS_LVX_MSG_LOG	VARCHAR2	4,000.00	0.00
NAM_TABLE_NAME	T_PR_SUMM_TBL_LIST	CHAR	50.00	0.00
NAM_TAB_PATH	T_SW_PERFORMANCE_DATA	VARCHAR2	255.00	0.00
NAM_TAX	T_PR_ENRL_TAX_ID	VARCHAR2	30.00	0.00

NAM_TAX_NM1	T_FIN_CYCLE_TAX_INFO	CHAR	40.00	0.00
NAM_TAX_NM2	T_FIN_CYCLE_TAX_INFO	CHAR	40.00	0.00
NAM_TBL_ACTUAL	T_AUDIT_TBL_EXCPT	CHAR	20.00	0.00
NAM_TBL_AUDIT	T_AUDIT_TBL_EXCPT	CHAR	20.00	0.00
NAM_TECH_CONTACT	T_835_CONTACTS	VARCHAR2	60.00	0.00
NAM_TECH_CONTACT	T_TPL_CORR_ADDR	CHAR	40.00	0.00
NAM_TEXT	T_ERX_TEXT	VARCHAR2	35.00	0.00
NAM_THREAD	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	100.00	0.00
NAM_TITLE	T_FIN_EFT_ACCT	VARCHAR2	40.00	0.00
NAM_TITLE	T_PR_ENRL	VARCHAR2	40.00	0.00
NAM_TITLE	T_PR_NAM	CHAR	15.00	0.00
NAM_TITLE	T_PR_SVC_LOC	VARCHAR2	40.00	0.00
NAM_TITLE	T_PR_SVC_LOC_AL	VARCHAR2	40.00	0.00
NAM_TITLE	T_PR_SVC_LOC_WI	VARCHAR2	40.00	0.00
NAM_TITLE	T_RE_BASE	CHAR	5.00	0.00
NAM_TITLE	T_RE_BASE_DN	CHAR	5.00	0.00
NAM_TITLE	T_RE_MULTI_ADDRESS	CHAR	5.00	0.00
NAM_TITLE	T_WEB_RECEIVER	VARCHAR2	40.00	0.00
NAM_TITLE	T_WEB_RECEIVER_BACKUP	VARCHAR2	40.00	0.00
NAM_TITLE2	T_PR_SVC_LOC	VARCHAR2	40.00	0.00
NAM_TITLE_DEGREE	T_PR_ENRL_PROV	CHAR	15.00	0.00
NAM_TITLE_EFT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	40.00	0.00
NAM_TITLE_EFT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	40.00	0.00
NAM_TITLE_ERA_AFT	T_PR_WEB_CHG_BACKUP	CHAR	15.00	0.00
NAM_TITLE_ERA_BEF	T_PR_WEB_CHG_BACKUP	CHAR	15.00	0.00
NAM_TMSIS_DATA_ELEMENT	T_TMSIS_DATA_ELEMENTS	VARCHAR2	125.00	0.00
NAM_TMSIS_EDIT_GROUP	T_TMSIS_VALID_VALUES	VARCHAR2	200.00	0.00
NAM_TMSIS_LOGICAL_TABLE	T_TMSIS_DATA_ELEMENTS	VARCHAR2	30.00	0.00
NAM_TMSIS_PHYS_TABLE	T_TMSIS_DATA_ELEMENTS	VARCHAR2	30.00	0.00
NAM_TMSIS_TABLE_COL	T_TMSIS_DATA_ELEMENTS	VARCHAR2	30.00	0.00
NAM_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES_TYPE	VARCHAR2	125.00	0.00
NAM_TP	T_TP	VARCHAR2	50.00	0.00
NAM_TRANSACT	T_TRANSACTIONS	CHAR	45.00	0.00
NAM_URL	T_ERX_RESOURCE_LINK	VARCHAR2	255.00	0.00
NAM_URL	T_SW_MASKING_DATA	VARCHAR2	1,000.00	0.00
NAM_URL	T_SW_PERFORMANCE_DATA	VARCHAR2	1,000.00	0.00

NAM_USER	T_DS_LVX_MSG_LOG	CHAR	8.00	0.00
NAM_USER	T_DS_LVX_USER_REQ	CHAR	8.00	0.00
NAM_USER	T_WEB_FEITH_DOWNLOAD	VARCHAR2	20.00	0.00
NAM_USER_VALUE	T_CODE_RESOLUTION	CHAR	18.00	0.00
NAM_VALUE	T_SW_MASKING_DATA	VARCHAR2	25.00	0.00
NAM_VENDOR	T_MC_PMP_EDB_VENDOR	CHAR	4.00	0.00
NAM_VENDOR	T_MC_PMP_EDB_XREF	CHAR	4.00	0.00
NAM_VENDOR	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_VENDOR	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_VENDOR	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_VENDOR	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT	T_WEB_RECEIVER	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT	T_WEB_RECEIVER_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_VENDOR_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	VARCHAR2	50.00	0.00
NAM_WHOSE_PHONE	T_DS_RECIP_DO_APPL	VARCHAR2	22.00	0.00
NAM_WHOSE_PHONE	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_WHO_MEDICAL_SVCS	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_WHO_PAY_DAY_CARE	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_WHO_PREGNANT	T_DS_RECIP_SOBRA_APPL	VARCHAR2	22.00	0.00
NAM_WINDOW	T_CONTROL	CHAR	42.00	0.00
NAM_WINDOW	T_PC_AUTHORIZATION	CHAR	42.00	0.00
NAM_WINDOW	T_PLOG_HEADER	CHAR	42.00	0.00
NAM_WINDOW	T_PLOG_WINDOWS	CHAR	42.00	0.00
NAM_WINDOW	T_PW_AUTHORIZATION	CHAR	42.00	0.00
NAM_WINDOW	T_UC_AUTHORIZATION	CHAR	42.00	0.00
NAM_WINDOW	T_UW_AUTHORIZATION	CHAR	42.00	0.00
NAM_WINDOW	T_WINDOW	CHAR	42.00	0.00
NAT_PROV_ID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	12.00	0.00
NAT_PROV_ID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	12.00	0.00
NAT_PROV_ID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	12.00	0.00

NBR_IN_ALLOC	T_DS_RECIP_DO_APPL	CHAR	2.00	0.00
NDC	T_WEB_CLAIM_DTL	CHAR	11.00	0.00
NDC	T_WEB_PA_DTL	CHAR	11.00	0.00
NO_MONTHS	T_TPL_THRESHOLD	NUMBER	2.00	0.00
NPI	T_PR_APPLN	CHAR	10.00	0.00
NPI	T_PR_APPLN_WI	CHAR	10.00	0.00
NUMBER_OF_UNITS	T_PA_DDSD_UPD_DTL	CHAR	6.00	0.00
NUMBER_OF_UNITS	T_PA_HCBW_UPD_DTL	CHAR	6.00	0.00
NUMBER_OF_UNITS	T_PA_LTCA_UPD_DTL	CHAR	5.00	0.00
NUM_2400_PWK06	T_CLM_PHYS_2400_PWK	VARCHAR2	80.00	0.00
NUM_2400_REF02_ADJ_CTL	T_CLM_UB92_2400	VARCHAR2	50.00	0.00
NUM_2400_REF02_REPRIC_CTL	T_CLM_UB92_2400	VARCHAR2	50.00	0.00
NUM_2400_REF04_2_REFER_1	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
NUM_2400_REF04_2_REFER_2	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
NUM_2400_REF04_2_REFER_3	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
NUM_2400_REF04_2_REFER_4	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
NUM_2400_REF04_2_REFER_5	T_CLM_DNTL_2400	VARCHAR2	50.00	0.00
NUM_ABA	T_FIN_EFT_ACCT	CHAR	9.00	0.00
NUM_ABA	T_FIN_INSTITUTION	CHAR	9.00	0.00
NUM_ABA	T_PR_EFT_ACCT	CHAR	9.00	0.00
NUM_ABA	T_PR_ENRL_EFT_ACCT	CHAR	9.00	0.00
NUM_ABA	T_PR_ENRL_EFT_ERA_MAINT	CHAR	9.00	0.00
NUM_ABA	T_PR_FIN_INST	CHAR	9.00	0.00
NUM_ABA_AFT	T_PR_WEB_CHG_BACKUP	CHAR	9.00	0.00
NUM_ABA_BEF	T_PR_WEB_CHG_BACKUP	CHAR	9.00	0.00
NUM_ABA_EFT	T_FIN_BANK_ACCT	CHAR	17.00	0.00

NUM_ABA_MICR	T_FIN_BANK_ACCT	CHAR	9.00	0.00
NUM_ABA_ST	T_835_CONSTANTS	CHAR	12.00	0.00
NUM_ACCT_EFT	T_FIN_BANK_ACCT	CHAR	17.00	0.00
NUM_ACCT_MICR	T_FIN_BANK_ACCT	CHAR	18.00	0.00
NUM_ACCT_ST	T_835_CONSTANTS	CHAR	35.00	0.00
NUM_ACD	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_ACTUAL	T_MC_PGM_AUTOASSIGN	NUMBER	9.00	0.00
NUM_ACT_PANEL	T_PMP_SVC_LOC	NUMBER	9.00	0.00
NUM_ACT_PANEL	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_ACT_PANEL	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
NUM_ADD	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_ADD_PHONE	T_RE_BASE	CHAR	10.00	0.00
NUM_ADJUSTMENT_ICN	T_CT_AR_TRACKING	CHAR	13.00	0.00
NUM_ADJ_ADULT	T_DRG_RATE	NUMBER	7.00	4.00
NUM_ADJ_ICN	T_DS_HM_HEADER	CHAR	13.00	0.00
NUM_ADJ_PED	T_DRG_RATE	NUMBER	7.00	4.00
NUM_ADMIT_HOUR	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
NUM_ADMIT_HOUR	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
NUM_AGCCS	T_ALLERGY	NUMBER	6.00	0.00
NUM_AGCCS	T_ALLERGY_AGCCS	NUMBER	6.00	0.00
NUM_AGCSP	T_ALLERGY	NUMBER	7.00	0.00
NUM_AGCSP	T_ALLERGY_AGCSP	NUMBER	7.00	0.00
NUM_AGCSP	T_ALLERGY_DIAG	NUMBER	7.00	0.00
NUM_AGCSP	T_MPHX_DSE_PROF	NUMBER	7.00	0.00
NUM_AGE	T_CLM_SYS_FIELDS_DTL	NUMBER	3.00	0.00
NUM_AGENCY	T_EFT_TRACE_XREF	NUMBER	7.00	0.00
NUM_AGENCY_CLIENT_ID	T_BUYA_DEMO_CHANGE	CHAR	20.00	0.00
NUM_AGENCY_CLIENT_ID	T_BUYB_DEMO_CHANGE	CHAR	20.00	0.00
NUM_AGE_FROM	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_AGE_FROM	T_DRUG_ACT_COV	NUMBER	3.00	0.00
NUM_AGE_FROM	T_PAYABLE_BENEFIT	NUMBER	3.00	0.00
NUM_AGE_FROM	T_PDL_MASTER	NUMBER	4.00	0.00

NUM_AGE_FROM	T_PDL_MASTER_AL	NUMBER	4.00	0.00
NUM_AGE_FROM	T_PR_RST_SVC_STATE_KY	NUMBER	4.00	0.00
NUM_AGE_INCARE	T_RE_EXPENSE	NUMBER	3.00	0.00
NUM_AGE_MAX	T_AUTO_PA_AGE	NUMBER	3.00	0.00
NUM_AGE_MAX	T_MC_PMP_MASS_XFER	NUMBER	3.00	0.00
NUM_AGE_MIN	T_AUTO_PA_AGE	NUMBER	3.00	0.00
NUM_AGE_MIN	T_MC_PMP_MASS_XFER	NUMBER	3.00	0.00
NUM_AGE_THD	T_CA_UB92	NUMBER	4.00	0.00
NUM_AGE_THD	T_UB92_HDR_INP	NUMBER	4.00	0.00
NUM_AGE_TO	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_AGE_TO	T_DRUG_ACT_COV	NUMBER	3.00	0.00
NUM_AGE_TO	T_PAYABLE_BENEFIT	NUMBER	3.00	0.00
NUM_AGE_TO	T_PDL_MASTER	NUMBER	4.00	0.00
NUM_AGE_TO	T_PDL_MASTER_AL	NUMBER	4.00	0.00
NUM_AGE_TO	T_PR_RST_SVC_STATE_KY	NUMBER	4.00	0.00
NUM_ALERT_IDX	T_PDUR_RLHX	NUMBER	4.00	0.00
NUM_AMENDED_LIEN_AMT	T_CASUALTY_CASE	NUMBER	9.00	2.00
NUM_AMENDED_LIEN_AMT	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
NUM_APPL	T_NDC_APPL	VARCHAR2	25.00	0.00
NUM_AP_SSN	T_DS_RECIP_SOBRA_FAM_ABSNT	CHAR	9.00	0.00
NUM_ARCHIVE_THRESHOLD	T_LG_CDE_HISTORY	NUMBER	4.00	0.00
NUM_AREA_RANK	T_MC_AREA_TYPE	NUMBER	4.00	0.00
NUM_ARNP	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_AR_NUMBER	T_CT_AR_TRACKING	CHAR	13.00	0.00
NUM_ASSIGNED	T_CLM_OTH_PYR_DTL	NUMBER	6.00	0.00
NUM_ASSOC_PRSCRIP	T_PHRM_HDR_OPT	CHAR	7.00	0.00

NUM_AVG_LENGTH_STAY	T_CA_UB92	NUMBER	5.00	2.00
NUM_AVG_LENGTH_STAY	T_UB92_HDR_INP	NUMBER	5.00	2.00
NUM_BANK_ACCT	T_DS_RECIP_DO_BANK	VARCHAR2	20.00	0.00
NUM_BANK_ACCT	T_DS_RECIP_DO_CLSD_ACCT	VARCHAR2	20.00	0.00
NUM_BANK_ACCT2	T_DS_RECIP_DO_BANK	VARCHAR2	20.00	0.00
NUM_BANK_ACCT3	T_DS_RECIP_DO_BANK	VARCHAR2	20.00	0.00
NUM_BANK_ACCT4	T_DS_RECIP_DO_BANK	VARCHAR2	20.00	0.00
NUM_BANK_PAYEE	T_FIN_NO_ISSUE	CHAR	15.00	0.00
NUM_BASE_RATE	T_CA_UB92	NUMBER	9.00	2.00
NUM_BASE_RATE	T_PEER_GRP_DRGR	NUMBER	10.00	2.00
NUM_BASE_RATE	T_PEER_GRP_DRGR_OLD	NUMBER	10.00	3.00
NUM_BASE_RATE	T_PR_DRG_RATE	NUMBER	10.00	2.00
NUM_BASE_RATE	T_PR_DRG_RATE	NUMBER	10.00	3.00
NUM_BASE_RATE	T_UB92_HDR_INP	NUMBER	9.00	2.00
NUM_BATCH	T_CASH_BATCH_NUM	NUMBER	4.00	0.00
NUM_BATCH	T_CASH_RECEIPT	NUMBER	4.00	0.00
NUM_BATCH_BEGIN	T_CLM_BATCH_RNG	NUMBER	9.00	0.00
NUM_BATCH_END	T_CLM_BATCH_RNG	NUMBER	9.00	0.00
NUM_BATCH_FROM	T_DCOR_SCHEDULE	NUMBER	3.00	0.00
NUM_BATCH_NEXT	T_CLM_BATCH_RNG	NUMBER	9.00	0.00
NUM_BATCH_SEQ	T_TRACK_EXCEPTION_HANDLE	NUMBER	11.00	0.00

NUM_BATCH_TO	T_DCOR_SCHEDULE	NUMBER	3.00	0.00
NUM_BC_CHK_DIG	T_PR_ADR_CASS	CHAR	1.00	0.00
NUM_BC_CHK_DIG	T_RE_ADR_CASS	CHAR	1.00	0.00
NUM_BIN	T_TPL_PHRM_XREF	VARCHAR2	15.00	0.00
NUM_BIRTH_WEIGHT_GRAMS	T_TMSIS_CIP002_CLM_HDR	NUMBER	9.00	3.00
NUM_BMI	T_TMSIS_CIP002_CLM_HDR	NUMBER	6.00	1.00
NUM_BMI	T_TMSIS_CLT002_CLM_HDR	NUMBER	6.00	1.00
NUM_BMI	T_TMSIS_COT002_CLM_HDR	NUMBER	6.00	1.00
NUM_BOND_MCAID	T_PR_BOND	VARCHAR2	15.00	0.00
NUM_BOND_MCAID	T_PR_ENRL_DME	VARCHAR2	15.00	0.00
NUM_BOND_MCARE	T_PR_BOND	VARCHAR2	15.00	0.00
NUM_BOND_MCARE	T_PR_ENRL_DME	VARCHAR2	15.00	0.00
NUM_BOTH_BEDS	T_PR_BEDS_KY	NUMBER	6.00	0.00
NUM_CALLER_EXT	T_CALL_TRACK	CHAR	5.00	0.00
NUM_CALLER_TEL	T_CALL_TRACK	CHAR	10.00	0.00
NUM_CALL_LENGTH	T_CALL_TRACK	NUMBER	11.00	2.00
NUM_CAP_COUNT	T_CAP_MASS_ADJ_RST	NUMBER	9.00	0.00
NUM_CAP_COUNT	T_CAP_MASS_ADJ_RST_tmp	NUMBER	9.00	0.00
NUM_CAP_DAYS	T_CAPITATION_HIST	NUMBER	2.00	0.00
NUM_CAP_DAYS	T_CAPITATION_HIST_DN	NUMBER	2.00	0.00
NUM_CAP_DAYS	T_CAPITATION_HIST_WI	NUMBER	2.00	0.00
NUM_CASE	T_CALL_TRACK	CHAR	12.00	0.00
NUM_CASE	T_CT_PROV_CRIT	NUMBER	9.00	0.00
NUM_CASE	T_CT_RE_CRIT	NUMBER	9.00	0.00
NUM_CASE	T_RE_1095	CHAR	12.00	0.00
NUM_CASE	T_RE_BASE_DN	CHAR	12.00	0.00
NUM_CASE	T_RE_CASE	CHAR	10.00	0.00
NUM_CASE	T_RE_CASE	CHAR	12.00	0.00
NUM_CASE	T_RE_HIST_ERR	CHAR	12.00	0.00
NUM_CASE	T_RE_PS2_ERR	CHAR	12.00	0.00
NUM_CASE_LIEN	T_CASUALTY_CASE	CHAR	7.00	0.00
NUM_CASE_LIEN	T_CASUALTY_CASE_AL	CHAR	7.00	0.00
NUM_CASE_NEW	T_CA_RECIP_HIST	CHAR	12.00	0.00
NUM_CASE_OLD	T_CA_RECIP_HIST	CHAR	12.00	0.00

NUM_CAS_CASE	T_CASUALTY_CASE	NUMBER	9.00	0.00
NUM_CAS_CASE	T_CASUALTY_CASE_AL	NUMBER	9.00	0.00
NUM_CAS_CASE	T_RELATED_CASES	NUMBER	9.00	0.00
NUM_CAS_CASE_EXT	T_TPL_CASE_XREF	NUMBER	9.00	0.00
NUM_CAS_ENT_ID	T_ATTORNEY	CHAR	8.00	0.00
NUM_CAS_ENT_ID	T_INS_AGENT	CHAR	8.00	0.00
NUM_CAS_ENT_ID	T_TORTFEASOR	CHAR	8.00	0.00
NUM_CAS_ENT_ID	T_TORTFEASOR_AL	CHAR	8.00	0.00
NUM_CAS_SEQ	T_CLM_CAS	NUMBER	4.00	0.00
NUM_CAUSE	T_TRTFEASR_XREF	CHAR	15.00	0.00
NUM_CC_PCT	T_CC_INDICATORS	NUMBER	3.00	0.00
NUM_CC_RANK	T_CC_INDICATORS	NUMBER	3.00	0.00
NUM_CELL_PHONE	T_DS_RECIP_DO_APPL_SPONS	CHAR	10.00	0.00
NUM_CERTIFICATION	T_PR_SVC_CERT_WI	VARCHAR2	15.00	0.00
NUM_CHANGE	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_CHECK	T_BANK_PD_NOISSUE	CHAR	9.00	0.00
NUM_CHECK	T_CASH_RECEIPT	CHAR	9.00	0.00
NUM_CHECK	T_CASH_RECEIPT	CHAR	30.00	0.00
NUM_CHECK	T_CA_FIN	CHAR	9.00	0.00
NUM_CHECK	T_CHECK	CHAR	9.00	0.00
NUM_CHECK	T_EFT_TRACE_XREF	CHAR	9.00	0.00
NUM_CHECK	T_FIN_835_TRACK	CHAR	9.00	0.00
NUM_CHECK	T_FIN_PROCESS_PYMT	CHAR	9.00	0.00
NUM_CHECK	T_RE_AR_TRANSACTION	VARCHAR2	30.00	0.00
NUM_CHECK	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	15.00	0.00
NUM_CHECK	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	15.00	0.00
NUM_CHECK	T_TMSIS_COT002_CLM_HDR	VARCHAR2	15.00	0.00
NUM_CHECK	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	15.00	0.00

NUM_CHECK_EXTERNAL	T_FIN_PAYMENT	CHAR	9.00	0.00
NUM_CHECK_NO_ISSUE	T_FIN_NO_ISSUE	CHAR	9.00	0.00
NUM_CHECK_ORIG	T_FIN_PAYMENT	CHAR	9.00	0.00
NUM_CHILD	T_RE_CHILD_EXPECT	NUMBER	2.00	0.00
NUM_CLAIMS	T_CLM_ARRA_STATS	NUMBER	9.00	0.00
NUM_CLAIMS	T_WEB_PAY_SUM	NUMBER	7.00	0.00
NUM_CLAIMS_COMPLIANT	T_CLM_ARRA_STATS	NUMBER	9.00	0.00
NUM_CLAIMS_SUSPENSE	T_CLM_ARRA_STATS	NUMBER	9.00	0.00
NUM_CLCCR	T_UB92_HDR_OUTPAT	NUMBER	9.00	5.00
NUM_CLIA	T_CLIA_CERT	CHAR	10.00	0.00
NUM_CLIA	T_CLIA_LAB	CHAR	10.00	0.00
NUM_CLIA	T_PR_CLIA_STAT	CHAR	10.00	0.00
NUM_CLIA	T_PR_ENRL_CLIA	CHAR	10.00	0.00
NUM_CLINICAL_ROUTE	T_GENERIC_DRUG	NUMBER	6.00	0.00
NUM_CLM	T_DS_RECIP_DO_INCOME	CHAR	12.00	0.00
NUM_CLMS_REV	T_CT_CASE_TRACK	NUMBER	8.00	0.00
NUM_CLM_CONTROL	T_AR_CLM_HDR	VARCHAR2	30.00	0.00
NUM_CLPGMVER	T_UB92_HDR_OUTPAT	VARCHAR2	8.00	0.00
NUM_CLPRCVER	T_UB92_HDR_OUTPAT	VARCHAR2	7.00	0.00
NUM_CLQVERS	T_UB92_HDR_OUTPAT	CHAR	10.00	0.00
NUM_CLWIN	T_UB92_HDR_OUTPAT	NUMBER	9.00	4.00
NUM_CMS_EVENT1	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT2	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT3	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT4	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT5	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT6	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT7	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT8	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_EVENT9	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_CMS_HCFA_PS	T_DRUG_CMSFDB_INFO	NUMBER	11.00	3.00

NUM_CMS_PKG_SIZE	T_DR_CMS_TAPE	NUMBER	10.00	0.00
NUM_CNT	T_MB_CALC	NUMBER	10.00	0.00
NUM_CNTL_PROJ	T_PROJ_DESC	CHAR	11.00	0.00
NUM_CNTL_PROJ	T_PROJ_STATUS	CHAR	11.00	0.00
NUM_CNTL_PROJ	T_PROJ_TRACK	CHAR	11.00	0.00
NUM_CNTL_PROJ	T_PROJ_TRK_DTL	CHAR	11.00	0.00
NUM_CNT_AREA	T_PS_BILLING_CTR	CHAR	3.00	0.00
NUM_CNT_EXT	T_PS_BILLING_CTR	CHAR	5.00	0.00
NUM_CNT_NUMBER	T_PS_BILLING_CTR	CHAR	4.00	0.00
NUM_CNT_PRE	T_PS_BILLING_CTR	CHAR	3.00	0.00
NUM_CNT_TOT	T_CLAIM_EXTRACT	NUMBER	9.00	0.00
NUM_CONTACT_AREA	T_PS_CASE	CHAR	3.00	0.00
NUM_CONTACT_EXT	T_PS_CASE	CHAR	5.00	0.00
NUM_CONTACT_FAX	T_PR_ENRL	CHAR	10.00	0.00
NUM_CONTACT_FAX	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_CONTACT_FAX	T_PR_SVC_LOC_AL	CHAR	10.00	0.00
NUM_CONTACT_FAX_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_CONTACT_FAX_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_CONTACT_FAX_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_CONTACT_FAX_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_CONTACT_NUMBER	T_PS_CASE	CHAR	4.00	0.00
NUM_CONTACT_PHONE	T_PR_ENRL	CHAR	10.00	0.00
NUM_CONTACT_PHONE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_CONTACT_PHONE	T_PR_SVC_LOC_AL	CHAR	10.00	0.00
NUM_CONTACT_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_CONTACT_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_CONTACT_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00

NUM_CONTACT_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_CONTACT_PHONE_EXT	T_PR_ENRL	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT	T_PR_SVC_LOC_AL	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_CONTACT_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_CONTACT_PRE	T_PS_CASE	CHAR	3.00	0.00
NUM_CONTRACT	T_MC_PMP_EDB_VENDOR	CHAR	5.00	0.00
NUM_CONTRACT	T_MC_PMP_EDB_XREF	CHAR	5.00	0.00
NUM_CONTRACT	T_RE_EDB_GHO	CHAR	5.00	0.00
NUM_CONTRACT	T_RE_MEDICARE_D	CHAR	5.00	0.00
NUM_CONTRACT_MAX	T_MC_NPI	NUMBER	9.00	0.00
NUM_CONTRACT_PERCENT	T_CLM_CN1	NUMBER	6.00	2.00
NUM_CONTROL	T_CLM_ADJ_XREF	CHAR	12.00	0.00
NUM_CONTROL	T_PAYMENT_HOLD	NUMBER	9.00	0.00
NUM_CONTROL	T_PLOG_PARAMETER	NUMBER	9.00	0.00
NUM_CONTROL	T_RE_LTC_REQUEST	CHAR	10.00	0.00
NUM_CONTROL_AR	T_ACCT_REC	CHAR	13.00	0.00
NUM_CONTROL_AR	T_ACCT_REC_DN	CHAR	13.00	0.00
NUM_CONTROL_AR	T_AR_COLLECTION	CHAR	13.00	0.00
NUM_CONTROL_AR	T_FIN_PROCESS_AR	CHAR	13.00	0.00
NUM_CONTROL_AR	T_TPL_AR_HEALTH	CHAR	13.00	0.00

NUM_CONTROL_AR	T_TPL_AR_HEALTH_XXX	CHAR	13.00	0.00
NUM_CONTROL_AR_CONVERTED	T_TPL_LEGACY_AR_XREF	CHAR	13.00	0.00
NUM_CONTROL_AR_LEGACY	T_TPL_LEGACY_AR_XREF	CHAR	13.00	0.00
NUM_CONTROL_DOCUMENT	T_CALL_OTIFICATION	CHAR	20.00	0.00
NUM_CONT_CATG_MNTH	T_ELIGCNT	NUMBER	8.00	0.00
NUM_CONT_DAYS_ELIG	T_ELIGCNT	NUMBER	8.00	0.00
NUM_CONT_MTH_ELIG	T_ELIGCNT	NUMBER	8.00	0.00
NUM_CONT_PHONE	T_HIPP_RESOURCE	CHAR	15.00	0.00
NUM_CONV_FACTOR	T_PREVAILING_CONV	NUMBER	8.00	3.00
NUM_COPIES	T_SYS_REPORT_DIST	NUMBER	9.00	0.00
NUM_COR	T_EXPENDITURE	CHAR	6.00	0.00
NUM_COR	T_EXPENDITURE	CHAR	6.00	0.00
NUM_COR	T_EXPENDITURE_DN	CHAR	6.00	0.00
NUM_COR	T_FIN_NUM_COR	VARCHAR2	13.00	0.00
NUM_CORP_ID	T_DRUG_MANUF	NUMBER	5.00	0.00
NUM_COST_FACTOR	T_MARG_COST	NUMBER	4.00	2.00
NUM_COST_FACTOR	T_PEER_GRP_FACT	NUMBER	4.00	2.00
NUM_COST_FACTOR	T_PR_MARG_CST	NUMBER	4.00	2.00
NUM_COST_OUTLIER	T_PEER_GRP_DRGR_OLD	NUMBER	11.00	2.00
NUM_COST_TO_CHRG_RATIO	T_CA_UB92	NUMBER	6.00	5.00
NUM_COST_TO_CHRG_RATIO	T_UB92_HDR_INP	NUMBER	6.00	5.00
NUM_COUNT	T_ADJ_MASS_RQST	NUMBER	9.00	0.00
NUM_COUNT	T_CLAIM_EXTRACT	NUMBER	9.00	0.00
NUM_COUNT_ADJ	T_ADJ_MASS_RQST	NUMBER	9.00	0.00
NUM_COUNT_DEL	T_ADJ_MASS_RQST	NUMBER	9.00	0.00
NUM_COUNT_MAIL	T_CASH_RCPT_TOTALS	NUMBER	9.00	0.00
NUM_COUNT_MISC	T_CASH_RCPT_TOTALS	NUMBER	9.00	0.00
NUM_COUNT_PROV	T_CASH_RCPT_TOTALS	NUMBER	9.00	0.00

NUM_COUNT_SURS	T_CASH_RCPT_TOTALS	NUMBER	9.00	0.00
NUM_COUNT_TPL	T_CASH_RCPT_TOTALS	NUMBER	9.00	0.00
NUM_COURT_CASE	T_ATTORNEY_XREF_WI	CHAR	50.00	0.00
NUM_COURT_CASE	T_CASUALTY_CASE	CHAR	12.00	0.00
NUM_COURT_CASE	T_CASUALTY_CASE_AL	CHAR	12.00	0.00
NUM_COURT_ORDER	T_TPL_AC_PARENT_MED_XREF	VARCHAR2	16.00	0.00
NUM_COV_CND_CLUSTER	T_COV_CND_AXIS_RANGE	NUMBER	4.00	0.00
NUM_COV_CND_RANGE_MAX	T_COV_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_COV_CND_RANGE_MIN	T_COV_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_COV_MOD_CLUSTER	T_COV_MOD_AXIS_RANGE	NUMBER	4.00	0.00
NUM_COV_MOD_RANGE_MAX	T_COV_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_COV_MOD_RANGE_MIN	T_COV_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_COV_OCC_CLUSTER	T_OCC_MOD_AXIS_RANGE	NUMBER	4.00	0.00
NUM_COV_OCC_RANGE_MAX	T_OCC_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_COV_OCC_RANGE_MIN	T_OCC_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_CPAS_ADJ_SMPLE	T_CPAS_STRATA	NUMBER	4.00	0.00
NUM_CPAS_PRCNT	T_CPAS_STRATA	NUMBER	5.00	3.00
NUM_CPAS_SAMPLE	T_CPAS_STRATA	NUMBER	4.00	0.00
NUM_CSR	T_CSR	CHAR	8.00	0.00
NUM_CSR	T_CSR_ANALYST	CHAR	8.00	0.00
NUM_CSR	T_CSR_RELATED	CHAR	8.00	0.00
NUM_CSR	T_CSR_SLC_TASK	CHAR	8.00	0.00

NUM_CSR	T_CSR_TEXT	CHAR	8.00	0.00
NUM_CSR_RELATED	T_CSR_RELATED	CHAR	8.00	0.00
NUM_CST_CHRG_RATE	T_PEER_GRP_DRGR	NUMBER	5.00	4.00
NUM_CST_CHRG_RATE	T_PEER_GRP_DRGR_OLD	NUMBER	6.00	5.00
NUM_CTL	T_FIN_CYCLE_TAX_INFO	CHAR	5.00	0.00
NUM_CURRENT_PANEL	T_MC_PMP_PANEL_RESTRICT	NUMBER	9.00	0.00
NUM_DAYS	T_CLAIM_INTEREST	NUMBER	9.00	0.00
NUM_DAYS	T_CLM_ARRA_STATS	NUMBER	4.00	0.00
NUM_DAYS	T_EDIT_RECYCLE	NUMBER	4.00	0.00
NUM_DAYS	T_FIN_PRUDENT_PAY	NUMBER	4.00	0.00
NUM_DAYS	T_PAYMENT_HOLD	NUMBER	4.00	0.00
NUM_DAYS_AGE	T_RE_EPSDT_PERIODS	NUMBER	4.00	0.00
NUM_DAYS_AGED	T_FIN_AR_RQST_REPORT	CHAR	3.00	0.00
NUM_DAYS_COVD	T_CA_UB92	NUMBER	4.00	0.00
NUM_DAYS_COVD	T_DENY_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_COVD	T_MEDPOL_UB92	NUMBER	4.00	0.00
NUM_DAYS_COVD	T_PD_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_COVD	T_SUSP_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_COVD_ORIG	T_CA_UB92	NUMBER	6.00	2.00
NUM_DAYS_DSE_DUR	T_DIAG_DSE_XREF	NUMBER	8.00	0.00
NUM_DAYS_DSE_DUR	T_DISEASE_INFERRED	NUMBER	9.00	0.00
NUM_DAYS_ELIG	T_ETG_SUMMARY	VARCHAR2	3.00	0.00
NUM_DAYS_ELIG	T_ETG_SUMMARY_ENCNTR	VARCHAR2	3.00	0.00
NUM_DAYS_ELIG	T_ETG_SUMMARY_FFS	VARCHAR2	3.00	0.00

NUM_DAYS_ELIG	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	3.00	0.00
NUM_DAYS_HIST_LOOKBACK	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
NUM_DAYS_HIST_LOOKBACK	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
NUM_DAYS_NCOVD	T_CA_UB92	NUMBER	4.00	0.00
NUM_DAYS_NCOVD	T_DENY_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_NCOVD	T_PD_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_NCOVD	T_SUSP_UB92_HDR	NUMBER	4.00	0.00
NUM_DAYS_OUT	T_RE_HOSPICE_DTL	NUMBER	3.00	0.00
NUM_DAYS_PA_LOOKBACK	T_AUTO_PA_GRNDFTR	NUMBER	9.00	0.00
NUM_DAYS_SUPPLY	T_TMSIS_CRX003_CLM_DTL	NUMBER	5.00	0.00
NUM_DAY_OUTLIER_HIGH	T_DRG_RATE	NUMBER	3.00	0.00
NUM_DAY_OUTLIER_LOW	T_DRG_RATE	NUMBER	3.00	0.00
NUM_DAY_OUTLIER_THD	T_CA_UB92	NUMBER	4.00	0.00
NUM_DAY_OUTLIER_THD	T_UB92_HDR_INP	NUMBER	4.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_AGE	NUMBER	3.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_GRNDFTR	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_CA_DRUG	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_PDUR_SUSP	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_PDUR_SUSP	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_PD_PHARM_HDR	NUMBER	9.00	0.00

NUM_DAY_SUPPLY	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
NUM_DAY_SUPPLY	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
NUM_DCOR_PCT	T_DCOR_QLTY_CTL	NUMBER	4.00	2.00
NUM_DEA	T_PR_DEA	CHAR	9.00	0.00
NUM_DEA	T_PR_DEA_LIC	CHAR	9.00	0.00
NUM_DEA	T_PR_ENRL_IDENTIFIER	CHAR	9.00	0.00
NUM_DEA	T_PR_HB_LIC	CHAR	9.00	0.00
NUM_DELETE	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_DELETED_AMT	T_CASUALTY_CASE	NUMBER	9.00	2.00
NUM_DELETED_AMT	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
NUM_DEP_IDX	T_ERM_ENT	NUMBER	4.00	0.00
NUM_DIAG_SEQ	T_CA_DIAG	NUMBER	4.00	0.00
NUM_DISCHARGE_HOUR	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	2.00	0.00
NUM_DISCHARGE_HOUR	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	2.00	0.00
NUM_DISPOSITION	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_DISP_FEE_PCT	T_DRUG_LIMITS	NUMBER	5.00	4.00
NUM_DISP_PRIOR	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_DISP_SPLIT	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_DISP_VECTOR	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_DISTANCE	T_PMP_SVC_LOC_AL	NUMBER	4.00	0.00
NUM_DISTANCE	T_PMP_SVC_LOC_STATE	NUMBER	4.00	0.00
NUM_DO	T_RE_BASE_STATE	CHAR	2.00	0.00
NUM_DRG_REL_WEIGHT	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	8.00	0.00
NUM_DRUG_COUNT	T_AUDIT_ST_LEVEL	NUMBER	4.00	0.00
NUM_DRUG_GCN_SEQ	T_CA_DRUG	NUMBER	9.00	0.00

NUM_DRUG_GCN_SEQ	T_DRUG_DRUG_CRIT_DN	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_DRUG_GER_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_DRUG_PED_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_DRUG_PREG_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_GCN	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_GENERIC_DRUG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_HIGH_DOSE_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_LOW_DOSE_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ	T_OVER_UTIL_LOG	NUMBER	9.00	0.00

NUM_DRUG_GCN_SEQ	T_UNDER_UTIL_LOG	NUMBER	9.00	0.00
NUM_DRUG_GCN_SEQ2	T_DRUG_DRUG_CRIT_DN	NUMBER	9.00	0.00
NUM_DRUG_HICL_SEQ	T_AUDIT_ST_MEM	NUMBER	9.00	0.00
NUM_DRUG_HICL_SEQ	T_GENERIC_DRUG	NUMBER	6.00	0.00
NUM_DRUG_HICL_SEQ	T_HICL_CLASS_XREF	NUMBER	9.00	0.00
NUM_DRUG_HICL_SEQ	T_HICL_SEQ	NUMBER	9.00	0.00
NUM_DRUG_HICL_SEQ	T_HICL_SEQ_NO	NUMBER	6.00	0.00
NUM_DRUG_HICL_SEQ	T_PDUR_SUSP	NUMBER	9.00	0.00
NUM_DRUG_HICL_SEQ	T_PRODUR_WARN	NUMBER	9.00	0.00
NUM_DTL	T_AR_CLM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_ATTACHMENT_XREF	NUMBER	4.00	0.00
NUM_DTL	T_CA_ATTACH	NUMBER	4.00	0.00
NUM_DTL	T_CA_ATTACH_DN	NUMBER	4.00	0.00
NUM_DTL	T_CA_BENEFIT_LIMITS	NUMBER	4.00	0.00
NUM_DTL	T_CA_DENTAL	NUMBER	4.00	0.00
NUM_DTL	T_CA_DIAG_MAT_CARE	NUMBER	4.00	0.00
NUM_DTL	T_CA_DRUG	NUMBER	4.00	0.00
NUM_DTL	T_CA_DRUG_REBATE	NUMBER	4.00	0.00
NUM_DTL	T_CA_EPSDT_ABNORMAL	NUMBER	4.00	0.00

NUM_DTL	T_CA_ERROR	NUMBER	4.00	0.00
NUM_DTL	T_CA_ERROR_DN	NUMBER	4.00	0.00
NUM_DTL	T_CA_HDR_DTL	NUMBER	4.00	0.00
NUM_DTL	T_CA_KICK_PYMT	NUMBER	4.00	0.00
NUM_DTL	T_CA_LTC	NUMBER	4.00	0.00
NUM_DTL	T_CA_MATERNITY_CARE	NUMBER	4.00	0.00
NUM_DTL	T_CA_PHYS	NUMBER	4.00	0.00
NUM_DTL	T_CA_RCO	NUMBER	4.00	0.00
NUM_DTL	T_CA_TPL_SUMMARY	NUMBER	4.00	0.00
NUM_DTL	T_CA_XOVER	NUMBER	4.00	0.00
NUM_DTL	T_CC_CR_SAVE	NUMBER	4.00	0.00
NUM_DTL	T_CC_HIST_ADJUST	NUMBER	4.00	0.00
NUM_DTL	T_CHCK_CLM_XREF	NUMBER	4.00	0.00
NUM_DTL	T_CLAIM_ERROR	NUMBER	4.00	0.00
NUM_DTL	T_CLM_ADJ_NCCI	NUMBER	4.00	0.00
NUM_DTL	T_CLM_AMT	NUMBER	4.00	0.00
NUM_DTL	T_CLM_BENEFIT_LIMITS	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CAS	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CN1	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CR1	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CR2	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CR3	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CR5	NUMBER	4.00	0.00
NUM_DTL	T_CLM_CRC	NUMBER	4.00	0.00
NUM_DTL	T_CLM_DNTL_2400	NUMBER	4.00	0.00
NUM_DTL	T_CLM_DNTL_2430_AMT	NUMBER	4.00	0.00
NUM_DTL	T_CLM_DNTL_DTL_REF	NUMBER	4.00	0.00
NUM_DTL	T_CLM_DTL_TTH_SFC	NUMBER	4.00	0.00
NUM_DTL	T_CLM_DTP	NUMBER	4.00	0.00
NUM_DTL	T_CLM_ENTITY	NUMBER	4.00	0.00
NUM_DTL	T_CLM_ENT_NM_ADR	NUMBER	4.00	0.00
NUM_DTL	T_CLM_EOB_XREF	NUMBER	4.00	0.00
NUM_DTL	T_CLM_HSD	NUMBER	4.00	0.00
NUM_DTL	T_CLM_K3	NUMBER	4.00	0.00
NUM_DTL	T_CLM_KICK_PYMT	NUMBER	4.00	0.00
NUM_DTL	T_CLM_MAT_CARE_DTL	NUMBER	4.00	0.00
NUM_DTL	T_CLM_MEA	NUMBER	4.00	0.00
NUM_DTL	T_CLM_MISC	NUMBER	4.00	0.00
NUM_DTL	T_CLM_MODIFIER	NUMBER	4.00	0.00
NUM_DTL	T_CLM_NDC_DTL	NUMBER	4.00	0.00

NUM_DTL	T_CLM_NTE	NUMBER	4.00	0.00
NUM_DTL	T_CLM_OTH_PYR_DTL	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PATLIAB_X	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PAYER_ENTITY	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PGM_XREF	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PHRM_CMPD_MOD	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PHYS_2400	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PHYS_2400_PWK	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PHYS_2430	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PHYS_DTL_REF	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PWK	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PYR_ENTNMADR	NUMBER	4.00	0.00
NUM_DTL	T_CLM_PYR_MOD	NUMBER	4.00	0.00
NUM_DTL	T_CLM_QTY	NUMBER	4.00	0.00
NUM_DTL	T_CLM_RCO	NUMBER	4.00	0.00
NUM_DTL	T_CLM_REF	NUMBER	4.00	0.00
NUM_DTL	T_CLM_RU_MATCHED	NUMBER	4.00	0.00
NUM_DTL	T_CLM_SYS_FIELDS_DTL	NUMBER	4.00	0.00
NUM_DTL	T_CLM_TPL_RESOURCE	NUMBER	4.00	0.00
NUM_DTL	T_CLM_TPL_SUMMARY	NUMBER	4.00	0.00
NUM_DTL	T_CLM_UB92_2400	NUMBER	4.00	0.00
NUM_DTL	T_CLM_UB92_2430	NUMBER	4.00	0.00
NUM_DTL	T_CLM_UB92_DTL_REF	NUMBER	4.00	0.00
NUM_DTL	T_COS_DTL_XREF	NUMBER	4.00	0.00
NUM_DTL	T_DENTAL_DTL_KEYS	NUMBER	4.00	0.00
NUM_DTL	T_DENY_DNTL_DTL	NUMBER	4.00	0.00
NUM_DTL	T_DENY_PHRM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_DENY_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL	T_DENY_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL	T_DR_CLMS_INV_XREF	NUMBER	4.00	0.00
NUM_DTL	T_DR_CLMS_XREF	NUMBER	4.00	0.00
NUM_DTL	T_DR_RECOUP_LTR_ICN	NUMBER	4.00	0.00
NUM_DTL	T_DS_DNTL_ICN	NUMBER	4.00	0.00
NUM_DTL	T_DS_HM_DETAIL	NUMBER	4.00	0.00
NUM_DTL	T_DS_HM_HEADER	NUMBER	4.00	0.00
NUM_DTL	T_ETG_DTL	NUMBER	4.00	0.00
NUM_DTL	T_ETG_DTL_ENCNTR	NUMBER	4.00	0.00
NUM_DTL	T_ETG_DTL_FFS	NUMBER	4.00	0.00
NUM_DTL	T_ETG_DTL_RCO_PAID	NUMBER	4.00	0.00
NUM_DTL	T_FINAL_PHYS_XOVER	NUMBER	4.00	0.00

NUM_DTL	T_FIN_BUDG_DISP	NUMBER	4.00	0.00
NUM_DTL	T_FIN_PROCESS_BUDG_DISP	NUMBER	4.00	0.00
NUM_DTL	T_FIN_PROCESS_PYMT_XREF	NUMBER	4.00	0.00
NUM_DTL	T_MB_DEN_ICN	NUMBER	4.00	0.00
NUM_DTL	T_MB_NUM_ICN	NUMBER	4.00	0.00
NUM_DTL	T_MC_CAP_CLM_XREF	NUMBER	4.00	0.00
NUM_DTL	T_MEDPOL_UB92	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_DENTAL_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_MISC	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_PHRM_DTL_AL	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_PH_DIAG	NUMBER	4.00	0.00
NUM_DTL	T_MPHX_XOVER	NUMBER	4.00	0.00
NUM_DTL	T_MR_CMS64	NUMBER	4.00	0.00
NUM_DTL	T_MR_COPAY_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MR_ERROR_COUNTS	NUMBER	4.00	0.00
NUM_DTL	T_MR_ERROR_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MR_OP_PERFORM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MR_PROV_PERFORM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_MR_WVR_CLM	NUMBER	4.00	0.00
NUM_DTL	T_NCPDP_P4_LOG	NUMBER	4.00	0.00
NUM_DTL	T_PAYER_ADJUSTMENT	NUMBER	4.00	0.00
NUM_DTL	T_PAYER_REF	NUMBER	4.00	0.00
NUM_DTL	T_PAYER_REMARK	NUMBER	4.00	0.00
NUM_DTL	T_PA_ITEM_DTL_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PD_DNTL_DTL	NUMBER	4.00	0.00
NUM_DTL	T_PD_PHARM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_PD_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL	T_PD_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL	T_PHRM_DTL_KEYS	NUMBER	4.00	0.00
NUM_DTL	T_PHYS_DEXT_KEY	NUMBER	4.00	0.00
NUM_DTL	T_PROFILE_INPAT_ICN_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PROFILE_OUTPAT_ICN_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PROFILE_PHARMREF_ICN_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PROFILE_PHARM_ICN_XREF	NUMBER	4.00	0.00

NUM_DTL	T_PROFILE_PROFREF_ICN_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PROFILE_PROF_ICN_XREF	NUMBER	4.00	0.00
NUM_DTL	T_PROJ_TRK_DTL	NUMBER	4.00	0.00
NUM_DTL	T_RETRO_SUMM_RECS	NUMBER	4.00	0.00
NUM_DTL	T_RE_EPS_ABNORMAL	NUMBER	4.00	0.00
NUM_DTL	T_RE_EPS_HIST_EXT	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_DENTAL_DTL	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_PHRM_DTL	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_PHYS_XOVER	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_RLHX	NUMBER	4.00	0.00
NUM_DTL	T_SUSP_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL	T_TPL_2110_SVC_PYMT	NUMBER	4.00	0.00
NUM_DTL	T_UB92_DTL_EXT_KEY	NUMBER	4.00	0.00
NUM_DTL	T_UB92_DTL_OUTPAT_EDIT	NUMBER	2.00	0.00
NUM_DTL	T_UB92_DTL_OUTPAT_GROUP	NUMBER	2.00	0.00
NUM_DTL	T_UB92_DTL_OUTPAT_PRICE	NUMBER	2.00	0.00
NUM_DTL	T_WEB_CLAIM_DTL	NUMBER	4.00	0.00
NUM_DTL_ADJ	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	3.00	0.00
NUM_DTL_DSS	T_DS_DNTL_ICN	NUMBER	4.00	0.00
NUM_DTL_HX	T_PDUR_RLHX	NUMBER	4.00	0.00
NUM_DTL_NPI	T_DS_DNTL_ICN	NUMBER	4.00	0.00
NUM_DTL_ORIG	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	3.00	0.00
NUM_DTL_REF	T_CC_CR_SAVE	NUMBER	4.00	0.00
NUM_DTL_REF	T_DENY_DNTL_DTL	NUMBER	4.00	0.00

NUM_DTL_REF	T_DENY_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_DENY_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_PD_DNTL_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_PD_PHYS_DTL	NUMBER	4.00	0.00

NUM_DTL_REF	T_PD_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_SUSP_DENTAL_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_SUSP_PHYS_DTL	NUMBER	4.00	0.00
NUM_DTL_REF	T_SUSP_UB92_DTL	NUMBER	4.00	0.00
NUM_DTL_RELATED	T_CLM_ADJ_NCCI	NUMBER	4.00	0.00
NUM_DTL_RELATED	T_SUSP_RLHX	NUMBER	4.00	0.00
NUM_DTL_SVD	T_CLM_CAS	NUMBER	4.00	0.00
NUM_DTL_SVD	T_CLM_OTH_PYR_DTL	NUMBER	4.00	0.00

NUM_DTL_SVD	T_CLM_PYR_MOD	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_CLM_MAT_CARE_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_DENY_DNTL_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_DENY_PHRM_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_DENY_PHYS_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_DENY_UB92_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_PD_DNTL_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_PD_PHARM_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_PD_PHYS_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_PD_UB92_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_SUSP_DENTAL_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_SUSP_PHRM_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_SUSP_PHYS_HDR	NUMBER	4.00	0.00
NUM_DTL_TOTAL	T_SUSP_UB92_HDR	NUMBER	4.00	0.00
NUM_DURATION	T_CALL_QUESTION	NUMBER	8.00	2.00
NUM_DURATION	T_PR_ATT_CMS	NUMBER	10.00	0.00
NUM_EFT_ACCT	T_FIN_EFT_ACCT	CHAR	17.00	0.00
NUM_EFT_ACCT	T_PR_EFT_ACCT	CHAR	17.00	0.00
NUM_EFT_ACCT	T_PR_ENRL_EFT_ACCT	CHAR	17.00	0.00
NUM_EFT_ACCT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	17.00	0.00
NUM_EFT_ACCT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	17.00	0.00
NUM_EFT_ACCT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	17.00	0.00
NUM_EIN	T_RE_PARTD_PDP_CARRIER	CHAR	9.00	0.00
NUM_ELIGIBLE_PHONE	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	10.00	0.00
NUM_ERM_ADR	T_ERM_DEP	NUMBER	9.00	0.00
NUM_ERM_AFF	T_ERM_DEP	RAW	64.00	0.00
NUM_ERM_CUR	T_ERM_DEP	RAW	64.00	0.00
NUM_ERM_HIER	T_ERM_ENT	RAW	64.00	0.00
NUM_ERM_HIER	T_ERM_HDR	RAW	64.00	0.00
NUM_ERM_IDX	T_ERM_DEP	NUMBER	4.00	0.00
NUM_EVD_SOURCE_ID	T_MME_VOCAB_TYPE_DEF	NUMBER	4.00	0.00

NUM_EVD_VOCAB_TYPE_ID	T_MME_VOCAB_TYPE_DEF	NUMBER	4.00	0.00
NUM_EVENT_EXT	T_LG_HISTORY_EXT	NUMBER	9.00	0.00
NUM_EVS_VER	T_EVS_ELIG	VARCHAR2	10.00	0.00
NUM_EVS_VER	T_EVS_INQUIRY	VARCHAR2	10.00	0.00
NUM_EXT_CORP	T_TPL_CORR_ADDR	CHAR	6.00	0.00
NUM_EXT_TECH	T_TPL_CORR_ADDR	CHAR	6.00	0.00
NUM_FACILITY	T_PS_NONCERT_FAC	CHAR	11.00	0.00
NUM_FACILITY_DAYS	T_CA_LTC	NUMBER	4.00	0.00
NUM_FAC_CNT_AREA	T_PS_NF_FACILITY	CHAR	3.00	0.00
NUM_FAC_CNT_EXT	T_PS_NF_FACILITY	CHAR	5.00	0.00
NUM_FAC_CNT_NUMBER	T_PS_NF_FACILITY	CHAR	4.00	0.00
NUM_FAC_CNT_PRE	T_PS_NF_FACILITY	CHAR	3.00	0.00
NUM_FAMILY_SZ	T_DS_RECIP_CORE	NUMBER	3.00	0.00
NUM_FAX	T_ATTORNEY	CHAR	15.00	0.00
NUM_FAX	T_ATTORNEY_FIRM	VARCHAR2	15.00	0.00
NUM_FAX	T_CT_EDIT_MEMBERS	NUMBER	10.00	0.00
NUM_FAX	T_DR_LBLR_CONTACT	CHAR	10.00	0.00
NUM_FAX	T_HIPP_RESOURCE	CHAR	15.00	0.00
NUM_FAX	T_INS_AGENT	CHAR	15.00	0.00
NUM_FAX	T_POLICY_HOLDER	CHAR	15.00	0.00
NUM_FAX	T_RE_MULTI_ADDRESS	CHAR	10.00	0.00
NUM_FAX	T_STATE_ADDR	CHAR	15.00	0.00
NUM_FAX	T_TORTFEASOR	CHAR	15.00	0.00
NUM_FAX	T_TORTFEASOR_AL	CHAR	15.00	0.00
NUM_FAX	T_TP	VARCHAR2	15.00	0.00
NUM_FAX	T_TPL_AC_PARENT	CHAR	15.00	0.00
NUM_FAX	T_TPL_CARRIER	CHAR	15.00	0.00

NUM_FAX	T_TPL_CARRIER_AL	CHAR	15.00	0.00
NUM_FAX	T_TPL_CONTRACTOR	CHAR	10.00	0.00
NUM_FAX	T_TPL_CORR_ADDR	CHAR	15.00	0.00
NUM_FAX	T_TPL_EMPLOYER	CHAR	15.00	0.00
NUM_FAX	T_TPL_LIEN	CHAR	15.00	0.00
NUM_FAX_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	10.00	0.00
NUM_FAX_AGENT_CONTACT	T_WEB_RECEIVER	CHAR	10.00	0.00
NUM_FAX_AGENT_CONTACT	T_WEB_RECEIVER_BACKUP	CHAR	10.00	0.00
NUM_FAX_AGENT_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_FAX_AGENT_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_FAX_PHONE	T_DS_RECIP_DO_APPL_SPONS	CHAR	10.00	0.00
NUM_FAX_VT	T_DS_RECIP_DO_APPL	CHAR	10.00	0.00
NUM_FDB_HCFA_PS	T_DRUG_CMSFDB_INFO	NUMBER	11.00	3.00
NUM_FED_ACCT	T_FIN_FED_ACCT_AL	CHAR	6.00	0.00
NUM_FIELD_POSITION	T_MR_TMSIS_CMS_ERROR_RECS	NUMBER	5.00	0.00
NUM_FIELD_POSITION	T_MR_TMSIS_ELEMENTS_XREF	NUMBER	5.00	0.00
NUM_FILESIZE	T_DS_LVX_MSG_LOG	NUMBER	15.00	3.00
NUM_FILESIZE	T_FILE_TRACK	NUMBER	11.00	0.00
NUM_FIRST_VECTOR	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_FISCAL_YR_END_MO	T_PR_SVC_LOC_AL	CHAR	2.00	0.00
NUM_FORMULATION	T_DRUG_EXCEPTION_AL	NUMBER	6.00	0.00
NUM_FORMULATION	T_GENERIC_DRUG	NUMBER	6.00	0.00

NUM_FORMULATION	T_PA_LINE_ITEM	NUMBER	6.00	0.00
NUM_FORMULATION	T_PDL_MASTER	NUMBER	6.00	0.00
NUM_FORMULATION	T_PDL_MASTER_AL	NUMBER	6.00	0.00
NUM_FORMULATION	T_PDL_SCRN_CRIT	CHAR	6.00	0.00
NUM_FORMULATION	T_THERA_AHFS	NUMBER	6.00	0.00
NUM_FORMULATION_FROM	T_GCN_SEQNO_GROUP	NUMBER	6.00	0.00
NUM_FORMULATION_FROM	T_GCN_SEQNO_GROUP	NUMBER	9.00	0.00
NUM_FORMULATION_TO	T_GCN_SEQNO_GROUP	NUMBER	6.00	0.00
NUM_FORMULATION_TO	T_GCN_SEQNO_GROUP	NUMBER	9.00	0.00
NUM_FUTURE_PANEL	T_MC_PMP_PANEL_RESTRICT	NUMBER	9.00	0.00
NUM_FUTURE_PANEL	T_PMP_SVC_LOC	NUMBER	9.00	0.00
NUM_FUTURE_PANEL	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_FUTURE_PANEL	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
NUM_FYE_MONTH	T_PR_SVC_LOC_STATE_KY	CHAR	2.00	0.00
NUM_GAP_DAYS	T_AUDIT_ST_LEVEL	NUMBER	4.00	0.00

NUM_GCN	T_CA_DRUG	NUMBER	5.00	0.00
NUM_GCN	T_DRUG_DRUG_CRIT_DN	NUMBER	5.00	0.00
NUM_GCN	T_GCN	NUMBER	5.00	0.00
NUM_GCN	T_GENERIC_DRUG	NUMBER	5.00	0.00
NUM_GCN2	T_DRUG_DRUG_CRIT_DN	NUMBER	5.00	0.00
NUM_GCN_FROM	T_AUDIT_GCN_XREF	NUMBER	5.00	0.00
NUM_GCN_FROM	T_AUDIT_GEN_SEQ_X	NUMBER	9.00	0.00
NUM_GCN_SEQ	T_LS_DRUG_MASTER	CHAR	6.00	0.00
NUM_GCN_TO	T_AUDIT_GCN_XREF	NUMBER	5.00	0.00
NUM_GCN_TO	T_AUDIT_GEN_SEQ_X	NUMBER	9.00	0.00
NUM_GENERIC	T_LS_DRUG_MASTER	CHAR	5.00	0.00
NUM_GIS_QUALITY	T_GIS_CODES	NUMBER	4.00	0.00

NUM_GLOBAL_SURG	T_RBRVS	CHAR	3.00	0.00
NUM_GLOBAL_SURG	T_RBRVS_UPDATE	CHAR	3.00	0.00
NUM_GLOBAL_SURG	T_UMBRELLA_PARM	CHAR	3.00	0.00
NUM_GM_AF	T_INGREDIENT	NUMBER	6.00	0.00
NUM_GM_ID	T_INGREDIENT	NUMBER	6.00	0.00
NUM_GPCI_M	T_GPCI	NUMBER	5.00	3.00
NUM_GPCI_PE	T_GPCI	NUMBER	5.00	3.00
NUM_GPCI_W	T_GPCI	NUMBER	5.00	3.00
NUM_GROUP	T_EMP_CARR_XREF	CHAR	30.00	0.00
NUM_GROUP	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	16.00	0.00
NUM_GROUP	T_TPL_GROUP_COV_ASSIGN	CHAR	30.00	0.00
NUM_GROUP	T_TPL_RESOURCE	CHAR	16.00	0.00
NUM_GROUP	T_TPL_RESOURCE	CHAR	30.00	0.00
NUM_GROUP	T_TPL_RES_DEL	CHAR	16.00	0.00
NUM_GROUP_CNTRL	T_DOCUMENT_TRACK	VARCHAR2	9.00	0.00
NUM_GS_CONTROL	T_835_CK_EFT_TRCNO	NUMBER	9.00	0.00
NUM_GS_CONTROL	T_EDI_INTERCHANGE	NUMBER	9.00	0.00
NUM_HCFA_PS	T_DRUG	NUMBER	11.00	3.00
NUM_HCFA_PS	T_DRUG_DN	NUMBER	11.00	3.00
NUM_HELD	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_HFY	T_DS_HM_PROV_FY_XREF	NUMBER	4.00	0.00
NUM_HIC	T_RE_EDB	CHAR	11.00	0.00
NUM_HIC	T_RE_EDB_HIC	CHAR	11.00	0.00
NUM_HIC3_SEQN	T_GENERIC_DRUG	NUMBER	6.00	0.00

NUM_HICL_FROM	T_AUDIT_HICL_XREF	NUMBER	9.00	0.00
NUM_HICL_SEQ	T_LS_DRUG_MASTER	CHAR	6.00	0.00
NUM_HICL_TO	T_AUDIT_HICL_XREF	NUMBER	9.00	0.00
NUM_HIC_REL	T_GFC_INGREDIENT	NUMBER	1.00	0.00
NUM_HIERARCHY	T_ACCT_REC	NUMBER	4.00	0.00
NUM_HIERARCHY	T_ACCT_REC_DN	NUMBER	4.00	0.00
NUM_HIERARCHY	T_FIN_BUDG_ALT	NUMBER	9.00	0.00
NUM_HIERARCHY	T_FIN_PROCESS_AR	NUMBER	4.00	0.00
NUM_HIERARCHY	T_FIN_SCHEDULE	CHAR	4.00	0.00
NUM_HIERARCHY_PYR	T_CA_TPL_SUMMARY	NUMBER	4.00	0.00
NUM_HIERARCHY_PYR	T_CLM_TPL_SUMMARY	NUMBER	4.00	0.00
NUM_HIER_ID_ASGN	T_PUB_HLTH_PGM	NUMBER	9.00	0.00
NUM_HIER_ID_BNFT	T_PUB_HLTH_PGM	NUMBER	9.00	0.00
NUM_HIER_ID_PAYER	T_FINANCIAL_PAYER	NUMBER	9.00	0.00
NUM_HIER_ID_PAYER	T_FUND_PAYER	NUMBER	9.00	0.00
NUM_HIGH_TOT_OPIOID_DAY_DOSE	T_MME_MME_RANGE_FACTOR	NUMBER	34.00	17.00
NUM_HIST_LOG_RETAIN	T_RE_CDE_SOURCE	NUMBER	9.00	0.00
NUM_HOME_PHONE	T_DS_RECIP_DO_APPL	CHAR	10.00	0.00

NUM_HOME_PHONE	T_DS_RECIP_DO_APPL_SPONS	CHAR	10.00	0.00
NUM_HOSPICE_PERIOD	T_RE_HOSPICE_HDR	NUMBER	2.00	0.00
NUM_HOSPITAL_DAYS	T_CA_LTC	NUMBER	4.00	0.00
NUM_HOURS	T_CT_PROD_TRACK	NUMBER	6.00	2.00
NUM_HOURS	T_CT_PROD_TRAIN	NUMBER	6.00	2.00
NUM_HOUSEHOLD_SIZE	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	2.00	0.00
NUM_HRS_EST	T_PROJ_TRACK	NUMBER	4.00	0.00
NUM_HRS_EXP	T_PROJ_TRACK	NUMBER	4.00	0.00
NUM_HRS_EXP	T_PROJ_TRK_DTL	NUMBER	6.00	2.00
NUM_HRS_WEEK	T_MC_FTE	NUMBER	9.00	0.00
NUM_HRS_WRK_WK	T_RE_INCOME_NEW	NUMBER	3.00	0.00
NUM_ICD9CM_TYPE	T_DRG_MAPPER	NUMBER	4.00	0.00
NUM_ICF_IID_DAYS	T_TMSIS_CLT002_CLM_HDR	NUMBER	5.00	0.00
NUM_ICN	T_ADJ_MASS_CLAIM	CHAR	13.00	0.00
NUM_ICN	T_CALL_QUESTION	CHAR	13.00	0.00
NUM_ICN	T_CA_MATERNITY_CARE	CHAR	13.00	0.00
NUM_ICN	T_CA_RECIP_HIST	CHAR	13.00	0.00
NUM_ICN	T_CC_HIST_ADJUST	CHAR	13.00	0.00
NUM_ICN	T_CLAIM_LOCAT	CHAR	13.00	0.00
NUM_ICN	T_CLM_MAT_CARE_HDR	CHAR	13.00	0.00
NUM_ICN	T_CLM_PHRM_	CHAR	13.00	0.00
NUM_ICN	T_CLM_PHRM_PAPER_IMG	CHAR	13.00	0.00
NUM_ICN	T_CLM_RECIP_HIST	CHAR	13.00	0.00
NUM_ICN	T_CPAS_EXTRACT	CHAR	13.00	0.00
NUM_ICN	T_CPAS_HCFA_INFO	CHAR	13.00	0.00
NUM_ICN	T_CPAS_SPLIT	CHAR	13.00	0.00
NUM_ICN	T_CT_AR_TRACKING	CHAR	13.00	0.00

NUM_ICN	T_DENY_DNTL_HDR	CHAR	13.00	0.00
NUM_ICN	T_DENY_PHRM_HDR	CHAR	13.00	0.00
NUM_ICN	T_DENY_PHYS_HDR	CHAR	13.00	0.00
NUM_ICN	T_DENY_UB92_HDR	CHAR	13.00	0.00
NUM_ICN	T_DR_RECOUP_LTR_ICN	NUMBER	13.00	0.00
NUM_ICN	T_DS_DNTL_ICN	CHAR	13.00	0.00
NUM_ICN	T_DS_HM_HEADER	CHAR	13.00	0.00
NUM_ICN	T_FIN_PROCESS_AR	CHAR	13.00	0.00
NUM_ICN	T_LS_PHARMACY_CLAIMS	CHAR	13.00	0.00
NUM_ICN	T_LS_PHARMACY_OTHER	CHAR	13.00	0.00
NUM_ICN	T_MR_CMS64	CHAR	13.00	0.00
NUM_ICN	T_MR_WVR_CLM	CHAR	13.00	0.00
NUM_ICN	T_PBM_PHARM_EXTRACT	CHAR	13.00	0.00
NUM_ICN	T_PD_DNTL_HDR	CHAR	13.00	0.00
NUM_ICN	T_PD_PHARM_HDR	CHAR	13.00	0.00
NUM_ICN	T_PD_PHYS_HDR	CHAR	13.00	0.00
NUM_ICN	T_PD_UB92_HDR	CHAR	13.00	0.00
NUM_ICN	T_RETRO_SUMM_RECS	CHAR	13.00	0.00
NUM_ICN	T_SAK_ICN_DAILY	CHAR	13.00	0.00

NUM_ICN	T_SUSP_DENTAL_HDR	CHAR	13.00	0.00
NUM_ICN	T_SUSP_PHRM_HDR	CHAR	13.00	0.00
NUM_ICN	T_SUSP_PHYS_HDR	CHAR	13.00	0.00
NUM_ICN	T_SUSP_UB92_HDR	CHAR	13.00	0.00
NUM_ICN	T_TPL_LEGACY_AR_XREF	CHAR	13.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_COT002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_COT003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ADJUST	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_CCF	T_CLM_HDR_CCF	CHAR	13.00	0.00
NUM_ICN_CONSENT_FORM	T_RE_CONSENT_FORM_ACTIVITY	CHAR	20.00	0.00
NUM_ICN_CONSENT_FORM	T_RE_CONSENT_FORM_MASTER	CHAR	20.00	0.00
NUM_ICN_FL	T_CLM_FACSIMILE_EXTRACT	NUMBER	13.00	0.00
NUM_ICN_FL	T_CLM_PROCESSED_EXTRACT	NUMBER	13.00	0.00
NUM_ICN_FL	T_HIST_DIRECTORY	NUMBER	13.00	0.00
NUM_ICN_MOM	T_AR_CLAIM_XREF	CHAR	13.00	0.00

NUM_ICN_MOM	T_FIN_PROCESS_AR_XREF	CHAR	13.00	0.00
NUM_ICN_ORIG	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_COT002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_COT003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	50.00	0.00
NUM_ICN_ORIG	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	50.00	0.00
NUM_ICN_OTHER_PAYER	T_PHRM_COB_XREF	VARCHAR2	30.00	0.00
NUM_ICN_SENDER	T_TPL_835_NCPDP_XREF	VARCHAR2	20.00	0.00
NUM_ICN_XREF	T_CLM_MAT_CARE_HDR	CHAR	17.00	0.00
NUM_ID_CARD	T_RE_ID_CARD	NUMBER	4.00	0.00
NUM_INBOUND_PORT_INSTANCE	T_FILE_SOLICITED_TRACK	NUMBER	11.00	0.00
NUM_INDV_GROUP	T_CLM_MISC	NUMBER	2.00	0.00
NUM_INDV_GROUP	T_MPHX_MISC	NUMBER	3.00	0.00
NUM_INGRED_FROM	T_DISP_FEE	NUMBER	4.00	0.00
NUM_INGRED_FROM	T_PR_DISP_FEE	NUMBER	4.00	0.00
NUM_INGRED_LIST	T_AUDIT_ST_MEM	NUMBER	6.00	0.00
NUM_INGRED_LIST	T_GENERIC_DRUG	NUMBER	6.00	0.00
NUM_INGRED_LIST	T_HICL_SEQ_NO	NUMBER	6.00	0.00

NUM_INGRED_LIST	T_PDUR_FINAL_CLM	NUMBER	6.00	0.00
NUM_INGRED_LIST	T_PDUR_FINAL_WARN	NUMBER	6.00	0.00
NUM_INGRED_LIST	T_PDUR_SUSP	NUMBER	6.00	0.00
NUM_INGRED_LIST	T_PRODUR_WARN	NUMBER	6.00	0.00
NUM_INGRED_LIST_O	T_PDUR_FINAL_WARN	NUMBER	6.00	0.00
NUM_INGRED_TO	T_DISP_FEE	NUMBER	4.00	0.00
NUM_INGRED_TO	T_PR_DISP_FEE	NUMBER	4.00	0.00
NUM_INS_CARRIER_PHONE	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	10.00	0.00
NUM_INS_CLAIM	T_CASUALTY_CASE	CHAR	16.00	0.00
NUM_INS_CLAIM	T_CASUALTY_CASE_AL	CHAR	16.00	0.00
NUM_ISA_CNTRL	T_DOCUMENT_TRACK	VARCHAR2	9.00	0.00
NUM_ISA_CONTROL	T_835_CK_EFT_TRCNO	NUMBER	9.00	0.00
NUM_ISA_CONTROL	T_EDI_INTERCHANGE	NUMBER	9.00	0.00
NUM_LATITUDE	T_PR_ADR	NUMBER	11.00	6.00
NUM_LATITUDE	T_PR_ADR_AL	NUMBER	11.00	6.00
NUM_LATITUDE	T_PR_ADR_WI	NUMBER	11.00	6.00
NUM_LATITUDE	T_RE_ADDRESS	NUMBER	11.00	6.00
NUM_LATITUDE	T_RE_BASE	NUMBER	11.00	6.00
NUM_LATITUDE	T_RE_BASE_DN	NUMBER	11.00	6.00
NUM_LATITUDE	T_RE_LOOKUP_PO_BOX	NUMBER	11.00	6.00
NUM_LEAVE_DAYS	T_CA_LTC	NUMBER	4.00	0.00
NUM_LEAVE_DAYS	T_TMSIS_CLT002_CLM_HDR	NUMBER	5.00	0.00
NUM_LENGTH_OF_STAY	T_CA_UB92	NUMBER	4.00	0.00
NUM_LENGTH_OF_STAY	T_UB92_HDR_INP	NUMBER	4.00	0.00
NUM_LETTER	T_BATCH_LETTERS	NUMBER	9.00	0.00
NUM_LEVEL	T_HIERARCHY_ATTRIBUTE	NUMBER	1.00	0.00
NUM_LEVEL1	T_CONTROL	NUMBER	9.00	0.00
NUM_LEVEL2	T_CONTROL	NUMBER	9.00	0.00
NUM_LEVEL3	T_CONTROL	NUMBER	9.00	0.00
NUM_LICENSE_ACCRED	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	20.00	0.00
NUM_LINE	T_PROJ_DESC	CHAR	2.00	0.00
NUM_LINES_SUBMITTED	T_DENTAL_HDR_KEYS	NUMBER	4.00	0.00

NUM_LINES_SUBMITTED	T_PHYS_HDR_KEY	NUMBER	4.00	0.00
NUM_LINE_ADJ	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ADJ	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ADJ	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ADJ	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_NUMBER	T_PA_EXT_TEXT	NUMBER	4.00	0.00
NUM_LINE_NUMBER	T_PA_INT_TEXT	NUMBER	4.00	0.00
NUM_LINE_ORIG	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ORIG	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ORIG	T_TMSIS_COT003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LINE_ORIG	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	3.00	0.00
NUM_LISTING_SEQ	T_NDC_NDA_ANDA	NUMBER	7.00	0.00
NUM_LNAPCWT	T_UB92_DTL_OUTPAT_PRICE	NUMBER	8.00	5.00
NUM_LNSEUNIT	T_UB92_DTL_OUTPAT_GROUP	NUMBER	7.00	0.00
NUM_LOCKBOX_TXN_ABA	T_FIN_LOCKBOX_XREF	CHAR	9.00	0.00
NUM_LOCKBOX_TXN_ACCT	T_FIN_LOCKBOX_XREF	CHAR	17.00	0.00
NUM_LOCKBOX_TXN_ID	T_FIN_LOCKBOX_XREF	CHAR	17.00	0.00
NUM_LOG_SEQUENCE	T_PS_LOG_TRACK	NUMBER	3.00	0.00
NUM_LONGITUDE	T_PR_ADR	NUMBER	11.00	6.00
NUM_LONGITUDE	T_PR_ADR_AL	NUMBER	11.00	6.00
NUM_LONGITUDE	T_PR_ADR_WI	NUMBER	11.00	6.00
NUM_LONGITUDE	T_RE_ADDRESS	NUMBER	11.00	6.00
NUM_LONGITUDE	T_RE_BASE	NUMBER	11.00	6.00

NUM_LONGITUDE	T_RE_BASE_DN	NUMBER	11.00	6.00
NUM_LONGITUDE	T_RE_LOOKUP_PO_BOX	NUMBER	11.00	6.00
NUM_LOW_TOT_OPIOID_DAY_DOSE	T_MME_MME_RANGE_FACTOR	NUMBER	34.00	17.00
NUM_MAIL_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_MAIL_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_MAIL_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_MAIL_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_MAIL_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_MAIL_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_MAIL_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_MAIL_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_MAIL_PHONE_FAX_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_MAIL_PHONE_FAX_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_MAIL_PHONE_FAX_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_MAIL_PHONE_FAX_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_MAIL_SCORE	T_PR_ADR_CASS	CHAR	1.00	0.00
NUM_MAIL_SCORE	T_RE_ADR_CASS	CHAR	1.00	0.00
NUM_MASS_RQST	T_ADJMS_AGE_SEX	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_AID_CAT	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_CT	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_DATES	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_DIAG	NUMBER	10.00	0.00

NUM_MASS_RQST	T_ADJMS_DRG	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_DRUG	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_ERROR	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_LOC	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_MEDAST	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_MODIF	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_PROV	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_PROVTYP	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_PRSPEC	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_PRSVC	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_RECIP	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_REGION	NUMBER	10.00	0.00

NUM_MASS_RQST	T_ADJMS_REVENUE	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJMS_SERV	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJ_MASS_CLAIM	NUMBER	10.00	0.00
NUM_MASS_RQST	T_ADJ_MASS_RQST	NUMBER	10.00	0.00
NUM_MASTER_LOG	T_CT_AR_TRACKING	NUMBER	8.00	0.00
NUM_MATCH	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_MAX	T_MC_PGM_PANEL_SZ	NUMBER	9.00	0.00
NUM_MAX_AGE	T_AGE_RESTRICT	NUMBER	4.00	0.00
NUM_MAX_AGE	T_CDE_PEDI_WEIGHTS	NUMBER	4.00	0.00
NUM_MAX_AGE	T_PEDI_DOSE	NUMBER	4.00	0.00
NUM_MAX_AXIS	T_RU_TUPLE_SET	NUMBER	9.00	0.00
NUM_MAX_LOS	T_DRG_CROSSWALK	NUMBER	4.00	0.00
NUM_MAX_PANEL	T_MC_PMP_PANEL_RESTRICT	NUMBER	9.00	0.00
NUM_MAX_RECIPS	T_PMP_PANEL_SIZE	NUMBER	9.00	0.00
NUM_MAX_WORK_CASE	T_CT_ANALYST	NUMBER	3.00	0.00
NUM_MCAID_BEDS	T_PR_LOC_RATE	NUMBER	9.00	0.00
NUM_MCAID_BEDS	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
NUM_MCARE_BEDS	T_PR_LOC_RATE	NUMBER	9.00	0.00
NUM_MCARE_BEDS	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
NUM_MC_ACTUAL	T_PMP_AUTOASSGN	NUMBER	9.00	0.00
NUM_MC_PLAN_FAX	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	10.00	0.00
NUM_MC_PLAN_PHONE	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	10.00	0.00

NUM_MC_PLAN_POP	T_TMSIS_MCR006_POP_ENRLD	NUMBER	2.00	0.00
NUM_MDCD_COV_IP_DAYS	T_TMSIS_CIP002_CLM_HDR	NUMBER	7.00	0.00
NUM_MDCD_COV_IP_DAYS	T_TMSIS_CLT002_CLM_HDR	NUMBER	5.00	0.00
NUM_MEAN_LOS	T_DRG_RATE	NUMBER	6.00	2.00
NUM_MEASUREMENT	T_CLM_MEA	NUMBER	9.00	2.00
NUM_MEDICAID_BEDS	T_PR_BEDS_KY	NUMBER	6.00	0.00
NUM_MEDICARE	T_PR_ENRL_IDENTIFIER	CHAR	10.00	0.00
NUM_MEDICARE	T_PR_MCARE_BILL	CHAR	10.00	0.00
NUM_MEDICARE_BEDS	T_PR_BEDS_KY	NUMBER	6.00	0.00
NUM_MED_REC_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	12.00	0.00
NUM_MEMBER_AGE	T_DS_RECIP_DO_FAMILY	NUMBER	3.00	0.00
NUM_MIDWIFE	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_MIN	T_MC_PGM_PANEL_SZ	NUMBER	9.00	0.00
NUM_MIN_AGE	T_AGE_RESTRICT	NUMBER	4.00	0.00
NUM_MIN_AGE	T_CDE_PEDI_WEIGHTS	NUMBER	4.00	0.00
NUM_MIN_AGE	T_PEDI_DOSE	NUMBER	4.00	0.00
NUM_MIN_AXIS	T_RU_TUPLE_SET	NUMBER	9.00	0.00
NUM_MIN_LOS	T_DRG_CROSSWALK	NUMBER	4.00	0.00
NUM_MIN_PANEL	T_MC_PMP_PANEL_RESTRICT	NUMBER	9.00	0.00
NUM_MISMATCH	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_MME_DAILY_DOSE_CONV_FACT	T_MME_MME_RANGE_FACTOR	NUMBER	34.00	17.00
NUM_MME_FACTOR	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	34.00	17.00
NUM_MME_FACTOR	T_MME_OPIOID_RTD_ING_MME	NUMBER	34.00	17.00
NUM_MOA_REIMB_PCNT	T_CLM_MOA	NUMBER	10.00	2.00
NUM_MONTH	T_MC_ANNUAL_POSTCARD_CRIT	CHAR	2.00	0.00
NUM_MONTH	T_PR_ANNUAL_VISIT_CRIT	CHAR	2.00	0.00

NUM_MR_AGE_FROM	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_MR_AGE_TO	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_MSG	T_ERM_ENT	RAW	8.00	0.00
NUM_MSTR_LOG	T_CT_CASE_RECOUP	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_CASE_TRACK	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_CONT_TERM	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_EOMB	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_LOCKIN	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_PROD_TRACK	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_REFERRALS	NUMBER	8.00	0.00
NUM_MSTR_LOG	T_CT_SELECT_LST	NUMBER	8.00	0.00
NUM_NATL_PLAN_ST	T_835_CONSTANTS	CHAR	80.00	0.00
NUM_NATL_PLAN_ST	T_FIN_CYCLE	CHAR	30.00	0.00
NUM_NC_CNT_AREA	T_PS_NONCERT_FAC	CHAR	3.00	0.00
NUM_NC_CNT_EXT	T_PS_NONCERT_FAC	CHAR	5.00	0.00
NUM_NC_CNT_NUMBER	T_PS_NONCERT_FAC	CHAR	4.00	0.00
NUM_NC_CNT_PRE	T_PS_NONCERT_FAC	CHAR	3.00	0.00
NUM_NON_COV_DAYS	T_TMSIS_CIP002_CLM_HDR	NUMBER	5.00	0.00
NUM_NON_COV_DAYS	T_TMSIS_CLT002_CLM_HDR	NUMBER	5.00	0.00
NUM_NOTE	T_PA_RULE_NOTE	NUMBER	9.00	0.00
NUM_NOTIFICATION_ID	T_CALL_OTIFICATION	NUMBER	9.00	0.00
NUM_NURSING_FAC_DAYS	T_TMSIS_CLT002_CLM_HDR	NUMBER	5.00	0.00
NUM_OFFLINE_CLM	T_CASUALTY_CASE_OFFLINE	CHAR	17.00	0.00
NUM_OPIOID_STRENGTH	T_MME_OPIOID_CF_MME_FAC TOR	NUMBER	34.00	17.00
NUM_ORDER	T_RU_ARRAY	NUMBER	4.00	0.00
NUM_ORDER	T_RU_RELATION_XREF	NUMBER	4.00	0.00
NUM_ORGN_GROUP_CNTRL	T_DOCUMENT_TRACK	VARCHAR2	9.00	0.00
NUM_ORGN_ISA_CNTRL	T_DOCUMENT_TRACK	VARCHAR2	9.00	0.00

NUM_OTHER_PHONE	T_DS_RECIP_DO_APPL	CHAR	10.00	0.00
NUM_OTH_PHONE	T_DS_RECIP_SOBRA_APPL	CHAR	10.00	0.00
NUM_OTLR_THRHLD	T_OUTLIER_THRESHLD	NUMBER	7.00	2.00
NUM_OUTLIER_DAYS	T_TMSIS_CIP002_CLM_HDR	NUMBER	5.00	0.00
NUM_PA	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	18.00	0.00
NUM_PA	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	18.00	0.00
NUM_PA	T_TMSIS_COT003_CLM_DTL	VARCHAR2	18.00	0.00
NUM_PA	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	18.00	0.00
NUM_PA	T_WEB_PA_HDR	CHAR	10.00	0.00
NUM_PACKAGE_SIZE	T_LS_DRUG_MASTER	NUMBER	11.00	3.00
NUM_PACKAGE_SIZE	T_LS_SUMMARY_NDC	NUMBER	11.00	3.00
NUM_PAGES	T_FIN_REMIT	NUMBER	6.00	0.00
NUM_PARTICIPANT	T_EFT_TRACE_XREF	CHAR	15.00	0.00
NUM_PARTITION	T_HIST_PART	NUMBER	4.00	0.00
NUM_PARTITION	T_HS_DIR_PART	NUMBER	4.00	0.00
NUM_PATIENT_CONTROL	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	20.00	0.00
NUM_PATIENT_CONTROL	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	20.00	0.00
NUM_PATIENT_CONTROL	T_TMSIS_COT002_CLM_HDR	VARCHAR2	20.00	0.00
NUM_PATIENT_CONTROL	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	20.00	0.00
NUM_PATIENT_WEIGHT	T_CLM_CR1	NUMBER	4.00	0.00
NUM_PAT_ACCT	T_CA_MATERNITY_CARE	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_CLM_MAT_CARE_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_DENY_DNTL_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_DENY_PHYS_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_DENY_UB92_HDR	VARCHAR2	38.00	0.00

NUM_PAT_ACCT	T_DS_HM_HEADER	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_MPHX_MISC	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_PD_DNTL_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_PD_PHYS_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_PD_UB92_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_SUSP_DENTAL_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_SUSP_PHYS_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT	T_SUSP_UB92_HDR	VARCHAR2	38.00	0.00
NUM_PAT_ACCT_SUB	T_DENTAL_HDR_KEYS	VARCHAR2	38.00	0.00
NUM_PAT_ACCT_SUB	T_PHYS_HDR_KEY	VARCHAR2	38.00	0.00
NUM_PAT_ACCT_SUB	T_UB92_HDR_EXT_KEY	VARCHAR2	38.00	0.00
NUM_PAY_CND_CLUSTER	T_PAY_CND_AXIS_RANGE	NUMBER	4.00	0.00
NUM_PAY_CND_RANGE_MAX	T_PAY_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_PAY_CND_RANGE_MIN	T_PAY_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_PAY_MOD_CLUSTER	T_PAY_MOD_AXIS_RANGE	NUMBER	4.00	0.00
NUM_PAY_MOD_RANGE_MAX	T_PAY_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_PAY_MOD_RANGE_MIN	T_PAY_MOD_AXIS_RANGE	NUMBER	2.00	0.00

NUM_PAY_OCC_CLUSTER	T_PAY_OCC_AXIS_RANGE	NUMBER	4.00	0.00
NUM_PAY_OCC_RANGE_MAX	T_PAY_OCC_AXIS_RANGE	NUMBER	2.00	0.00
NUM_PAY_OCC_RANGE_MIN	T_PAY_OCC_AXIS_RANGE	NUMBER	2.00	0.00
NUM_PAY_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_PAY_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PAY_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_PAY_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PAY_PHONE_FAX_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_PHONE_FAX_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_PHONE_FAX_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_PHONE_FAX_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_TF_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_TF_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_TF_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_PAY_TF_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PAY_TF_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_PAY_TF_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PAY_TF_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_PAY_TF_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00

NUM_PAY_TOLL_FREE_EXT	T_PR_SVC_LOC_AL	VARCHAR2	4.00	0.00
NUM_PAY_TOLL_FREE_PHONE	T_PR_SVC_LOC_AL	VARCHAR2	10.00	0.00
NUM_PA_AGE_FROM	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_PA_AGE_FROM	T_DRUG_ACT_COV	NUMBER	3.00	0.00
NUM_PA_AGE_TO	T_COVERED_BENEFIT	NUMBER	3.00	0.00
NUM_PA_AGE_TO	T_DRUG_ACT_COV	NUMBER	3.00	0.00
NUM_PA_LINE_ITEM	T_PA_DTL	CHAR	2.00	0.00
NUM_PA_LINE_ITEM	T_PA_IAC_XREF	CHAR	2.00	0.00
NUM_PA_LINE_ITEM	T_PA_ITEM_DTL_XREF	CHAR	2.00	0.00
NUM_PA_LINE_ITEM	T_PA_LINE_ITEM	CHAR	2.00	0.00
NUM_PA_LINE_ITEM	T_PA_RULE_DECISION	CHAR	2.00	0.00
NUM_PBEN	T_RE_EDB	CHAR	3.00	0.00
NUM_PCN	T_TPL_PHRM_XREF	VARCHAR2	15.00	0.00
NUM_PCN_CHK_DIG	T_CLM_MAT_CARE_HDR	CHAR	1.00	0.00
NUM_PCN_CHK_DIG	T_DENTAL_HDR_KEYS	CHAR	1.00	0.00
NUM_PCN_CHK_DIG	T_PHRM_HDR_KEYS	CHAR	1.00	0.00
NUM_PCN_CHK_DIG	T_PHYS_HDR_KEY	CHAR	1.00	0.00
NUM_PCN_CHK_DIG	T_RE_BASE_STATE	NUMBER	1.00	0.00
NUM_PCN_CHK_DIG	T_RE_CONSENT_FORM_MASTER	CHAR	1.00	0.00
NUM_PCN_CHK_DIG	T_UB92_HDR_EXT_KEY	CHAR	1.00	0.00
NUM_PERCENT_ADJ	T_PR_LOC_RATE_REQ	NUMBER	4.00	3.00
NUM_PERCENT_OWNER	T_PR_OWNER	NUMBER	3.00	2.00
NUM_PERIOD	T_PR_DISPRO_EXPEND	NUMBER	4.00	0.00
NUM_PERIODS	T_CLM_HSD	NUMBER	3.00	0.00

NUM_PGM_1_32	T_PAYER_HIERARCHY	NUMBER	10.00	0.00
NUM_PGM_1_32	T_PGM_HIERARCHY	NUMBER	10.00	0.00
NUM_PGM_33_64	T_PAYER_HIERARCHY	NUMBER	10.00	0.00
NUM_PGM_33_64	T_PGM_HIERARCHY	NUMBER	10.00	0.00
NUM_PGM_65_96	T_PAYER_HIERARCHY	NUMBER	10.00	0.00
NUM_PGM_65_96	T_PGM_HIERARCHY	NUMBER	10.00	0.00
NUM_PHONE	T_ANALYST	CHAR	10.00	0.00
NUM_PHONE	T_ANALYST	VARCHAR2	10.00	0.00
NUM_PHONE	T_ATTORNEY	CHAR	15.00	0.00
NUM_PHONE	T_ATTORNEY_FIRM	VARCHAR2	15.00	0.00
NUM_PHONE	T_CLERK_PROFILE	CHAR	10.00	0.00
NUM_PHONE	T_CT_EDIT_MEMBERS	NUMBER	10.00	0.00
NUM_PHONE	T_CT_EOMB	CHAR	10.00	0.00
NUM_PHONE	T_CT_REFERRALS	CHAR	10.00	0.00
NUM_PHONE	T_DR_LBLR_CONTACT	CHAR	10.00	0.00
NUM_PHONE	T_DS_RECIP_SOBRA_APPL	CHAR	10.00	0.00
NUM_PHONE	T_FIN_INSTITUTION	CHAR	10.00	0.00
NUM_PHONE	T_FIN_NONPROV	CHAR	10.00	0.00
NUM_PHONE	T_INS_AGENT	CHAR	15.00	0.00
NUM_PHONE	T_IRS_W9_INFO	CHAR	10.00	0.00

NUM_PHONE	T_OWNER_WI	CHAR	10.00	0.00
NUM_PHONE	T_PA_NONMED_PROV	CHAR	10.00	0.00
NUM_PHONE	T_POLICY_HOLDER	CHAR	15.00	0.00
NUM_PHONE	T_PR_ADR	CHAR	10.00	0.00
NUM_PHONE	T_PR_ADR_AL	CHAR	10.00	0.00
NUM_PHONE	T_PR_ADR_WI	CHAR	10.00	0.00
NUM_PHONE	T_PR_APPLN	CHAR	10.00	0.00
NUM_PHONE	T_PR_APPLN_WI	CHAR	10.00	0.00
NUM_PHONE	T_PR_ENRL_EFT_ACCT	CHAR	10.00	0.00
NUM_PHONE	T_PR_ENRL_LOC_PHONE	CHAR	10.00	0.00
NUM_PHONE	T_PR_FIN_INST	CHAR	10.00	0.00
NUM_PHONE	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
NUM_PHONE	T_RE_AR_WORKER	CHAR	10.00	0.00
NUM_PHONE	T_RE_BASE	CHAR	10.00	0.00
NUM_PHONE	T_RE_MARITAL	CHAR	10.00	0.00
NUM_PHONE	T_RE_MULTI_ADDRESS	CHAR	10.00	0.00
NUM_PHONE	T_RE_PARTD_PDP_CARRIER	CHAR	10.00	0.00
NUM_PHONE	T_RE_PHONE	CHAR	10.00	0.00
NUM_PHONE	T_RE_SPONSOR	CHAR	10.00	0.00
NUM_PHONE	T_STATE_ADDR	CHAR	15.00	0.00
NUM_PHONE	T_TORTFEASOR	CHAR	15.00	0.00
NUM_PHONE	T_TORTFEASOR_AL	CHAR	15.00	0.00
NUM_PHONE	T_TP	VARCHAR2	15.00	0.00
NUM_PHONE	T_TPL_AC_PARENT	CHAR	15.00	0.00
NUM_PHONE	T_TPL_CARRIER	CHAR	15.00	0.00
NUM_PHONE	T_TPL_CARRIER_AL	CHAR	15.00	0.00
NUM_PHONE	T_TPL_CAR_SUB_XREF	CHAR	10.00	0.00
NUM_PHONE	T_TPL_CASE_INFO	CHAR	15.00	0.00
NUM_PHONE	T_TPL_CNTY_PROS	CHAR	10.00	0.00
NUM_PHONE	T_TPL_CONTRACTOR	CHAR	10.00	0.00
NUM_PHONE	T_TPL_EMPLOYER	CHAR	15.00	0.00
NUM_PHONE	T_TPL_LIEN	CHAR	15.00	0.00
NUM_PHONE1	T_835_CONTACTS	CHAR	80.00	0.00
NUM_PHONE2	T_835_CONTACTS	CHAR	80.00	0.00
NUM_PHONE_AGENT_CONTACT	T_PR_ENRL_EFT_ACCT	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT	T_PR_ENRL_EFT_ERA	CHAR	10.00	0.00

NUM_PHONE_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT	T_WEB_RECEIVER	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT	T_WEB_RECEIVER_BACKUP	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_AGENT_CONTACT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_AREA	T_PS_CNT_PHONE	CHAR	3.00	0.00
NUM_PHONE_AREA	T_PS_PHONE_NUMBER	CHAR	3.00	0.00
NUM_PHONE_ASSGND	T_PROJ_TRACK	CHAR	10.00	0.00
NUM_PHONE_ASSIST	T_RE_IDENTIFIER	CHAR	10.00	0.00
NUM_PHONE_CELL	T_RE_DEMOGRAPHIC	CHAR	10.00	0.00
NUM_PHONE_CH_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_CH_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA	CHAR	10.00	0.00
NUM_PHONE_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	10.00	0.00
NUM_PHONE_CLEARINGHOUSE	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_PHONE_CLEARINGHOUSE	T_WEB_RECEIVER	CHAR	10.00	0.00
NUM_PHONE_CLEARINGHOUSE	T_WEB_RECEIVER_BACKUP	CHAR	10.00	0.00
NUM_PHONE_CORP	T_TPL_CORR_ADDR	CHAR	10.00	0.00
NUM_PHONE_CUST	T_PR_ADR_WI	CHAR	10.00	0.00
NUM_PHONE_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_PHONE_EFT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_EFT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_EXT	T_ANALYST	VARCHAR2	4.00	0.00
NUM_PHONE_EXT	T_CLERK_PROFILE	CHAR	5.00	0.00
NUM_PHONE_EXT	T_DR_LBLR_CONTACT	CHAR	5.00	0.00
NUM_PHONE_EXT	T_FIN_CYCLE_TAX_INFO	CHAR	5.00	0.00
NUM_PHONE_EXT	T_OWNER_WI	CHAR	6.00	0.00
NUM_PHONE_EXT	T_PR_ENRL_LOC_PHONE	CHAR	4.00	0.00
NUM_PHONE_EXT	T_PS_CNT_PHONE	CHAR	5.00	0.00
NUM_PHONE_EXT	T_PS_PHONE_NUMBER	CHAR	5.00	0.00
NUM_PHONE_EXT	T_RE_PARTD_PDP_CARRIER	CHAR	6.00	0.00

NUM_PHONE_EXT	T_TP	VARCHAR2	10.00	0.00
NUM_PHONE_EXT	T_TPL_AC_PARENT	CHAR	6.00	0.00
NUM_PHONE_EXT	T_TPL_CONTRACTOR	CHAR	4.00	0.00
NUM_PHONE_EXT_AGENT_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_AGENT_CONTACT	T_WEB_RECEIVER	CHAR	4.00	0.00
NUM_PHONE_EXT_AGENT_CONTACT	T_WEB_RECEIVER_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_AGENT_CONT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_AGENT_CONT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_EFT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	4.00	0.00
NUM_PHONE_EXT_EFT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_EFT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_PHONE_EXT_INT	T_PR_ADR	CHAR	5.00	0.00
NUM_PHONE_EXT_INT	T_PR_ADR_AL	CHAR	5.00	0.00
NUM_PHONE_EXT_INT	T_PR_ADR_WI	CHAR	5.00	0.00
NUM_PHONE_FAX	T_PR_ADR	CHAR	10.00	0.00
NUM_PHONE_FAX	T_PR_ADR_AL	CHAR	10.00	0.00
NUM_PHONE_FAX	T_PR_ADR_WI	CHAR	10.00	0.00
NUM_PHONE_FAX	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
NUM_PHONE_FAX_INT	T_PR_ADR	VARCHAR2	15.00	0.00
NUM_PHONE_FAX_INT	T_PR_ADR_AL	VARCHAR2	15.00	0.00
NUM_PHONE_FAX_INT	T_PR_ADR_WI	VARCHAR2	15.00	0.00
NUM_PHONE_FROM	T_CALL_QUESTION	CHAR	10.00	0.00
NUM_PHONE_HOME	T_RE_DEMOGRAPHIC	CHAR	10.00	0.00
NUM_PHONE_INT	T_PR_ADR	VARCHAR2	15.00	0.00
NUM_PHONE_INT	T_PR_ADR_AL	VARCHAR2	15.00	0.00
NUM_PHONE_INT	T_PR_ADR_WI	VARCHAR2	15.00	0.00
NUM_PHONE_MAIN	T_FIN_CYCLE_TAX_INFO	CHAR	10.00	0.00
NUM_PHONE_NUMBER	T_PS_CNT_PHONE	CHAR	4.00	0.00
NUM_PHONE_NUMBER	T_PS_PHONE_NUMBER	CHAR	4.00	0.00
NUM_PHONE_OTH	T_RE_DEMOGRAPHIC	CHAR	10.00	0.00
NUM_PHONE_PRE	T_PS_CNT_PHONE	CHAR	3.00	0.00
NUM_PHONE_PRE	T_PS_PHONE_NUMBER	CHAR	3.00	0.00
NUM_PHONE_RECVD	T_PROJ_TRACK	CHAR	10.00	0.00
NUM_PHONE_RQSTR	T_PROJ_TRACK	CHAR	10.00	0.00
NUM_PHONE_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	10.00	0.00
NUM_PHONE_TECH	T_TPL_CORR_ADDR	CHAR	10.00	0.00
NUM_PHONE_TO	T_CALL_QUESTION	CHAR	10.00	0.00

NUM_PHONE_UPDATE	T_RE_IDENTIFIER	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_BACKUP	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONTACT	T_PR_ENRL_EFT_ERA_MAINT	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONTACT	T_WEB_RECEIVER	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONTACT	T_WEB_RECEIVER_BACKUP	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_VENDOR_CONT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_PHONE_WORK	T_RE_DEMOGRAPHIC	CHAR	10.00	0.00
NUM_PHO_24_HOUR	T_MC_PMP_GRP_MBR	CHAR	10.00	0.00
NUM_PHO_24_HOUR	T_PMP_SVC_LOC	CHAR	10.00	0.00
NUM_PHO_24_HOUR	T_PMP_SVC_LOC	CHAR	10.00	0.00
NUM_PHO_24_HOUR	T_PMP_SVC_LOC_KY	CHAR	10.00	0.00
NUM_PHO_24_HOUR	T_PMP_SVC_LOC_WI	CHAR	10.00	0.00
NUM_PHO_CONTACT	T_PMP_SVC_LOC_AL	CHAR	10.00	0.00
NUM_PHO_CONTACT	T_PMP_SVC_LOC_STATE	CHAR	10.00	0.00
NUM_PHO_EXT	T_ATTORNEY	CHAR	6.00	0.00
NUM_PHO_EXT	T_FIN_INSTITUTION	CHAR	4.00	0.00
NUM_PHO_EXT	T_FIN_NONPROV	CHAR	4.00	0.00
NUM_PHO_EXT	T_HIPP_RESOURCE	CHAR	6.00	0.00
NUM_PHO_EXT	T_INS_AGENT	CHAR	6.00	0.00
NUM_PHO_EXT	T_IRS_W9_INFO	CHAR	4.00	0.00
NUM_PHO_EXT	T_MC_PMP_GRP_MBR	CHAR	4.00	0.00
NUM_PHO_EXT	T_PA_NONMED_PROV	CHAR	4.00	0.00
NUM_PHO_EXT	T_PMP_SVC_LOC	CHAR	4.00	0.00
NUM_PHO_EXT	T_PMP_SVC_LOC	CHAR	4.00	0.00
NUM_PHO_EXT	T_PMP_SVC_LOC_KY	CHAR	4.00	0.00
NUM_PHO_EXT	T_PMP_SVC_LOC_WI	CHAR	4.00	0.00
NUM_PHO_EXT	T_POLICY_HOLDER	CHAR	6.00	0.00
NUM_PHO_EXT	T_PR_ADR	CHAR	4.00	0.00

NUM_PHO_EXT	T_PR_ADR_AL	CHAR	4.00	0.00
NUM_PHO_EXT	T_PR_ADR_WI	CHAR	4.00	0.00
NUM_PHO_EXT	T_PR_APPLN	CHAR	4.00	0.00
NUM_PHO_EXT	T_PR_APPLN_WI	CHAR	4.00	0.00
NUM_PHO_EXT	T_PR_ENRL_EFT_ACCT	CHAR	4.00	0.00
NUM_PHO_EXT	T_PR_FIN_INST	CHAR	4.00	0.00
NUM_PHO_EXT	T_TORTFEASOR	CHAR	6.00	0.00
NUM_PHO_EXT	T_TORTFEASOR_AL	CHAR	6.00	0.00
NUM_PHO_EXT	T_TPL_CARRIER	CHAR	6.00	0.00
NUM_PHO_EXT	T_TPL_CARRIER_AL	CHAR	6.00	0.00
NUM_PHO_EXT	T_TPL_CAR_SUB_XREF	CHAR	4.00	0.00
NUM_PHO_EXT	T_TPL_CNTY_PROS	CHAR	4.00	0.00
NUM_PHO_EXT	T_TPL_EMPLOYER	CHAR	6.00	0.00
NUM_PHO_EXT	T_TPL_LIEN	CHAR	6.00	0.00
NUM_PHYS	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_PHYS_ASST	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
NUM_PIN	T_TPL_CARRIER	CHAR	10.00	0.00
NUM_PIN	T_TPL_CARRIER	VARCHAR2	22.00	0.00
NUM_PIN	T_TPL_CARRIER_AL	VARCHAR2	22.00	0.00
NUM_PLAN	T_RE_MEDICARE_D	CHAR	3.00	0.00
NUM_PLOG	T_PLOG_COMMENTS	CHAR	8.00	0.00
NUM_PLOG	T_PLOG_ESTIMATE	CHAR	8.00	0.00
NUM_PLOG	T_PLOG_HEADER	CHAR	8.00	0.00
NUM_PLOG	T_PLOG_VERSION	CHAR	8.00	0.00
NUM_PLOG	T_TEST_ITEMS	CHAR	8.00	0.00
NUM_POLICY	T_DS_RECIP_DO_HLTH_INS	VARCHAR2	15.00	0.00
NUM_POLICY_ACCT	T_TPL_CASE_INFO	CHAR	30.00	0.00
NUM_PORT	T_PORT	NUMBER	9.00	0.00
NUM_POSITION	T_LG_LETTER_REQUEST_IDX	NUMBER	2.00	0.00
NUM_POSITION	T_LG_LETTER_TEMPL_IDX	NUMBER	2.00	0.00
NUM_POV_PERCENT	T_RE_CMS_MMA_ENROLL	NUMBER	8.00	0.00
NUM_PRESCRIP	T_DR_CLMS_XREF	CHAR	12.00	0.00
NUM_PREV_SSN	T_DS_RECIP_CORE	CHAR	9.00	0.00
NUM_PRE_AREA	T_PS_ICF_MR	CHAR	3.00	0.00
NUM_PRE_EXT	T_PS_ICF_MR	CHAR	5.00	0.00
NUM_PRE_NUMBER	T_PS_ICF_MR	CHAR	4.00	0.00
NUM_PRE_PRE	T_PS_ICF_MR	CHAR	3.00	0.00

NUM_PRIORITY	T_MC_PMP_FOCUS	NUMBER	9.00	0.00
NUM_PRIORITY_CSR	T_CSR	CHAR	2.00	0.00
NUM_PRIOR_AUTH	T_DENY_PHRM_HDR	CHAR	10.00	0.00
NUM_PRIOR_AUTH	T_PD_PHARM_HDR	CHAR	10.00	0.00
NUM_PRIOR_AUTH	T_RE_NET_VOUCHER	CHAR	10.00	0.00
NUM_PRIOR_AUTH	T_SUSP_PHRM_HDR	CHAR	10.00	0.00
NUM_PROCESS	T_DR_PROCESS	NUMBER	4.00	0.00
NUM_PROCESS	T_DR_PROCESS_INV_XREF	NUMBER	4.00	0.00
NUM_PROJECTED_VISITS	T_CLM_HH_CARE_PLAN	NUMBER	9.00	0.00
NUM_PROV_LIC	T_CA_PR_HB_LIC	CHAR	10.00	0.00
NUM_PROV_LIC	T_PA_NONMED_PROV	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_APPLN	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_APPLN_WI	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_DEA_LIC	CHAR	15.00	0.00
NUM_PROV_LIC	T_PR_ENRL_IDENTIFIER	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_HB_LIC	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_HB_LIC_KY	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_PRESCRIBER	CHAR	10.00	0.00
NUM_PROV_LIC	T_PR_TYPE	CHAR	10.00	0.00
NUM_PROV_LIC	T_RE_ASSIGN_PLAN	CHAR	10.00	0.00
NUM_PROV_LIC	T_RE_ASSIGN_PLAN_LI	CHAR	10.00	0.00
NUM_PROV_LIC	T_RE_ASSIGN_PLAN_RLOC	CHAR	10.00	0.00
NUM_PROV_LIC_CS	T_PR_DEA_LIC	CHAR	15.00	0.00
NUM_PROV_LOC_FAX	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	10.00	0.00
NUM_PROV_LOC_PHONE	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	10.00	0.00
NUM_PROV_SSN	T_PR_APPLN	CHAR	9.00	0.00
NUM_PROV_SSN	T_PR_ENRL_IDENTIFIER	CHAR	9.00	0.00
NUM_PROV_SSN	T_PR_PROV	CHAR	9.00	0.00
NUM_PRSCRIP	T_ADJ_REV_RQST	CHAR	7.00	0.00
NUM_PRSCRIP	T_CA_DRUG	CHAR	12.00	0.00
NUM_PRSCRIP	T_DENY_PHRM_HDR	CHAR	12.00	0.00

NUM_PRSCRIP	T_DR_RECOUP_LTR_ICN	CHAR	12.00	0.00
NUM_PRSCRIP	T_MPHX_PHRM_DTL_AL	CHAR	12.00	0.00
NUM_PRSCRIP	T_PDUR_SUSP	CHAR	7.00	0.00
NUM_PRSCRIP	T_PDUR_SUSP	CHAR	12.00	0.00
NUM_PRSCRIP	T_PD_PHARM_HDR	CHAR	7.00	0.00
NUM_PRSCRIP	T_PD_PHARM_HDR	CHAR	12.00	0.00
NUM_PRSCRIP	T_RETRO_SUMM_RECS	CHAR	12.00	0.00
NUM_PRSCRIP	T_SUSP_PHRM_HDR	CHAR	12.00	0.00
NUM_PRSCRIP_SUB	T_PHRM_HDR_KEYS	CHAR	7.00	0.00
NUM_PRSCRIP_SUB	T_PHRM_HDR_KEYS	CHAR	12.00	0.00
NUM_PSEUDO	T_DS_RECIP_CORE	CHAR	6.00	0.00
NUM_QUANTITY	T_CLM_QTY	NUMBER	6.00	2.00
NUM_RA	T_CA_FIN	NUMBER	9.00	0.00
NUM_RA	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	30.00	0.00
NUM_RA	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	30.00	0.00
NUM_RA	T_TMSIS_COT002_CLM_HDR	VARCHAR2	30.00	0.00
NUM_RA	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	30.00	0.00
NUM_RANDOM_START	T_CLM_SAMPLE	NUMBER	9.00	0.00
NUM_RANDOM_START	T_CPAS_STRATA	NUMBER	9.00	0.00
NUM_RANGE_BEGIN	T_PMT_NUM_RNG	NUMBER	9.00	0.00
NUM_RANGE_CURR	T_PMT_NUM_RNG	NUMBER	9.00	0.00
NUM_RANGE_END	T_PMT_NUM_RNG	NUMBER	9.00	0.00
NUM_RANGE_HI	T_CM_CASE_GROUP	NUMBER	9.00	0.00
NUM_RANGE_HI	T_CM_CG_PEERGRP	NUMBER	9.00	0.00
NUM_RANGE_LO	T_CM_CASE_GROUP	NUMBER	9.00	0.00
NUM_RANGE_LO	T_CM_CG_PEERGRP	NUMBER	9.00	0.00
NUM_RANK	T_MC_PMP_RESTRICT_TYPE	NUMBER	4.00	0.00
NUM_RANK	T_PLOG_HEADER	NUMBER	9.00	0.00
NUM_RANK_LOWER	T_MULT_SURG_PCT	NUMBER	4.00	0.00

NUM_RANK_UPPER	T_MULT_SURG_PCT	NUMBER	4.00	0.00
NUM_RATE_ID	T_ACCOMM_FEE	NUMBER	4.00	0.00
NUM_RATE_ID	T_HOSP_ANC_AUTH	NUMBER	4.00	0.00
NUM_RATE_ID	T_REVENUE_CODE	NUMBER	4.00	0.00
NUM_RATIO	T_CST_CHG_RATIO	NUMBER	6.00	4.00
NUM_RATIO	T_PEER_GRP_RTIO	NUMBER	6.00	4.00
NUM_RATIO	T_PR_CST_CHRG	NUMBER	6.00	4.00
NUM_RA_CURR	T_FIN_CYCLE	NUMBER	9.00	0.00
NUM_REBILL_FREQ	T_TPL_CARRIER	CHAR	3.00	0.00
NUM_REBILL_FREQ	T_TPL_CARRIER_AL	CHAR	3.00	0.00
NUM_REC	T_RE_1095_REJECT	NUMBER	9.00	0.00
NUM_REC	T_RE_1095_TRACK	NUMBER	9.00	0.00
NUM_REC	T_RE_ADPH_1095_REJECT	NUMBER	9.00	0.00
NUM_REC	T_RE_ADPH_1095_TRACK	NUMBER	9.00	0.00
NUM_RECIPIENT_SETTLEMENT_AMT	T_CASUALTY_CASE	NUMBER	9.00	2.00
NUM_RECIPIENT_SETTLEMENT_AMT	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
NUM_RECIP_AGE	T_EXPENDITURE	NUMBER	4.00	0.00
NUM_RECIP_AGE	T_RE_BASE_DN	NUMBER	4.00	0.00
NUM_RECIP_AGE_DNTL	T_DS_DNTL_RECIP	NUMBER	4.00	0.00
NUM_RECIP_AGE_NEW	T_CA_RECIP_HIST	NUMBER	4.00	0.00
NUM_RECIP_AGE_OLD	T_CA_RECIP_HIST	NUMBER	4.00	0.00
NUM_RECORD	T_DIAG_DSE_XRF_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_DRUG_GER_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_DRUG_PED_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_DRUG_PREG_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_HIGH_DOSE_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_INVRS_UPDT_LOG	NUMBER	9.00	0.00

NUM_RECORD	T_LOW_DOSE_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_MR_TMSIS_CMS_ERROR_RECS	NUMBER	11.00	0.00
NUM_RECORD	T_OVER_UTIL_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_PDUR_UPD_ERROR	NUMBER	9.00	0.00
NUM_RECORD	T_THERA_DUP_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_TMSIS_CIP002_CLM_HDR	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CIP003_CLM_DTL	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CLT002_CLM_HDR	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CLT003_CLM_DTL	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CMS_ERROR_RECS	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_COT002_CLM_HDR	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_COT003_CLM_DTL	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CRX002_CLM_HDR	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_CRX003_CLM_DTL	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG003_VAR_DEMO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG004_CONTACT_INF	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG010_MFP_INFO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG011_STATE_PLAN	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG012_WAIVER_PART	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	11.00	0.00

NUM_RECORD	T_TMSIS_ELG015_ETHNICITY	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG016_RACE_INFO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG017_DISAB_INFO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG018_1115A_DEMO	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR002_MAIN	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR004_SVC_AREA	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR005_OPER_AUTH	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR006_POP_ENRLD	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV004_LICENSE_INF	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_PRV010_BED_TYPE	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	11.00	0.00

NUM_RECORD	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	11.00	0.00
NUM_RECORD	T_TMSIS_TPL006_CONTACT_INF	NUMBER	11.00	0.00
NUM_RECORD	T_UNDER_UTIL_LOG	NUMBER	9.00	0.00
NUM_RECORD	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	11.00	0.00
NUM_RECORD_FAILED	T_TMSIS_EDIT_FAILURES	NUMBER	11.00	0.00
NUM_RECORD_FAILED_3	T_TMSIS_EDIT_FAILURES	NUMBER	11.00	0.00
NUM_RECORD_FAILED_DEP	T_TMSIS_EDIT_FAILURES	NUMBER	11.00	0.00
NUM_RECYCLE_DAY	T_EDIT_RECYCLE	NUMBER	1.00	0.00
NUM_REC_TOTAL	T_RE_1095_ACK	NUMBER	9.00	0.00
NUM_REC_TOTAL	T_RE_ADPH_1095_ACK	NUMBER	9.00	0.00
NUM_REFERENCE	T_FIN_PROCESS_LIEN_DISP	CHAR	20.00	0.00
NUM_REFERENCE	T_LIEN	CHAR	20.00	0.00
NUM_REFERENCE	T_LIEN_DISP	CHAR	20.00	0.00
NUM_REGION	T_CLM_BATCH_RNG	CHAR	2.00	0.00
NUM_REGION	T_EDIT_RECYCLE	CHAR	2.00	0.00
NUM_REGION	T_FIN_REGION_RULES	CHAR	2.00	0.00
NUM_REGION	T_PAY_HOLD_CLM_MED	CHAR	2.00	0.00
NUM_REGION	T_REGION	CHAR	2.00	0.00
NUM_REGION	T_REGION_DISP	CHAR	2.00	0.00
NUM_REGION	T_REIMB_REGION	CHAR	2.00	0.00

NUM_REGION_RANK	T_MC_REGION	NUMBER	4.00	0.00
NUM_REGION_RANK	T_MC_REGION_WI	NUMBER	4.00	0.00
NUM_REIMB_AGE_FROM	T_REIMB_AGREEMENT	NUMBER	3.00	0.00
NUM_REIMB_AGE_TO	T_REIMB_AGREEMENT	NUMBER	3.00	0.00
NUM_REIMB_CND_CLUSTER	T_REIMB_CND_AXIS_RANGE	NUMBER	4.00	0.00
NUM_REIMB_CND_RANGE_MAX	T_REIMB_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_REIMB_CND_RANGE_MIN	T_REIMB_CND_AXIS_RANGE	NUMBER	2.00	0.00
NUM_REIMB_MOD_CLUSTER	T_REIMB_MOD_AXIS_RANGE	NUMBER	4.00	0.00
NUM_REIMB_MOD_RANGE_MAX	T_REIMB_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_REIMB_MOD_RANGE_MIN	T_REIMB_MOD_AXIS_RANGE	NUMBER	2.00	0.00
NUM_RELATIVE_WEIGHT	T_CA_UB92	NUMBER	7.00	4.00
NUM_RELATIVE_WEIGHT	T_UB92_HDR_INP	NUMBER	7.00	4.00

NUM_RELATIVE_WEIGHT_HIGH	T_CA_UB92	NUMBER	7.00	4.00
NUM_RELATIVE_WEIGHT_HIGH	T_UB92_HDR_INP	NUMBER	7.00	4.00
NUM_REL_VALUE	T_FEE_SCHEDULE	NUMBER	4.00	1.00
NUM_REL_VALUE	T_MAX_FEE	NUMBER	4.00	1.00
NUM_REQUEST	T_RE_CLM_DELINK	NUMBER	9.00	0.00
NUM_REQUEST_SIZE	T_SW_PERFORMANCE_DATA	NUMBER	20.00	0.00
NUM_RVU_M	T_RBRVS	NUMBER	9.00	2.00
NUM_RVU_M	T_RBRVS_UPDATE	NUMBER	9.00	2.00
NUM_RVU_PE	T_RBRVS	NUMBER	9.00	2.00
NUM_RVU_PE	T_RBRVS_UPDATE	NUMBER	9.00	2.00
NUM_RVU_W	T_RBRVS	NUMBER	9.00	2.00
NUM_RVU_W	T_RBRVS_UPDATE	NUMBER	9.00	2.00
NUM_SAMPLE_SELECTION	T_CLM_HSD	NUMBER	6.00	0.00
NUM_SAMPLE_SIZE	T_CPAS_CLM_STATUS	NUMBER	4.00	0.00
NUM_SAMPLE_SIZE	T_CT_CASE_TRACK	NUMBER	8.00	0.00
NUM_SEGMENT	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_SELCPAS	T_CPAS_EXTRACT	NUMBER	9.00	0.00
NUM_SELCPAS	T_CPAS_SPLIT	NUMBER	9.00	0.00
NUM_SEL_INTERVAL	T_CLM_SAMPLE	NUMBER	9.00	0.00
NUM_SEL_INTERVAL	T_CPAS_STRATA	NUMBER	9.00	0.00
NUM_SEQ	T_AR_COMMENTS	NUMBER	4.00	0.00
NUM_SEQ	T_AR_DISP_COMM	NUMBER	4.00	0.00
NUM_SEQ	T_CASH_COMMENT	NUMBER	4.00	0.00
NUM_SEQ	T_CA_ICD9_PROC	NUMBER	4.00	0.00
NUM_SEQ	T_CA_OCCUR	NUMBER	4.00	0.00
NUM_SEQ	T_CA_VALUE	NUMBER	4.00	0.00

NUM_SEQ	T_CCF_ERROR_DATA	NUMBER	4.00	0.00
NUM_SEQ	T_CLM_BATCH_RNG	NUMBER	4.00	0.00
NUM_SEQ	T_CLM_DTL_TTH_SFC	NUMBER	4.00	0.00
NUM_SEQ	T_CLM_RU_MATCHED	NUMBER	4.00	0.00
NUM_SEQ	T_CSR_TEXT	NUMBER	9.00	0.00
NUM_SEQ	T_DIAG_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_DRG_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_DRUG_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_ERM_ENT	NUMBER	4.00	0.00
NUM_SEQ	T_ERR_DISP_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_EXPEND_COMMENT	NUMBER	4.00	0.00
NUM_SEQ	T_EXPEND_TXN_XREF	NUMBER	9.00	0.00
NUM_SEQ	T_LIEN_COMMENT	NUMBER	4.00	0.00
NUM_SEQ	T_MC_NPI_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_MC_PMP_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_MC_RE_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_MODIFIER_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_PA_HDR_PE_TRNSP	NUMBER	4.00	0.00
NUM_SEQ	T_PA_HDR_PE_UMO	NUMBER	4.00	0.00
NUM_SEQ	T_PERF_ANALYST	NUMBER	4.00	0.00
NUM_SEQ	T_PROC_ICD9_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_PROC_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_REVENUE_NOTES	NUMBER	9.00	0.00
NUM_SEQ	T_RE_EDB	CHAR	13.00	0.00
NUM_SEQ	T_RTS_COMMENT	NUMBER	4.00	0.00
NUM_SEQ	T_TP	NUMBER	11.00	0.00
NUM_SEQ	T_UB92_HDR_ICD9CM	NUMBER	4.00	0.00
NUM_SEQ	T_UB92_HDR_OCC	NUMBER	4.00	0.00
NUM_SEQ	T_UB92_HDR_PAYER	NUMBER	4.00	0.00
NUM_SEQ	T_UB92_HDR_VALUE	NUMBER	4.00	0.00
NUM_SEQ	T_UB92_TREATMENT	NUMBER	4.00	0.00
NUM_SEQCPAS	T_CPAS_EXTRACT	NUMBER	9.00	0.00

NUM_SEQCPAS	T_CPAS_HCFA_INFO	NUMBER	9.00	0.00
NUM_SEQCPAS	T_CPAS_SPLIT	NUMBER	9.00	0.00
NUM_SEQUENCE	T_BNFT_ADJ_FACTOR_XREF	NUMBER	9.00	0.00
NUM_SEQUENCE	T_EFT_TRACE_XREF	NUMBER	3.00	0.00
NUM_SEQUENCE	T_PA_ATTACH_INFO	NUMBER	4.00	0.00
NUM_SEQUENCE	T_STOP_LOSS_PARMS	NUMBER	9.00	0.00
NUM_SEQUENCE_THREAD	T_CLM_EOB_XREF	NUMBER	4.00	0.00
NUM_SEQUENCE_THREAD	T_HIERARCHY_NODE	NUMBER	4.00	0.00
NUM_SEQUENCE_THREAD	T_PAYER_NODE	NUMBER	4.00	0.00
NUM_SEQ_2100	T_TPL_2100_CLM_PYMT	NUMBER	9.00	0.00
NUM_SEQ_2110	T_TPL_2110_SVC_PYMT	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_2300	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_2300_DN2	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_2320	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_2400	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_2430_AMT	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_DNTL_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_PHYS_2300	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_PHYS_2320	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_PHYS_2400	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_PHYS_2400_PWK	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_PHYS_2430	NUMBER	4.00	0.00

NUM_SEQ_2300	T_CLM_PHYS_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_UB92_2300	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_UB92_2320	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_UB92_2400	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_UB92_2430	NUMBER	4.00	0.00
NUM_SEQ_2300	T_CLM_UB92_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_2300_DN2	T_CLM_DNTL_2300_DN2	NUMBER	4.00	0.00
NUM_SEQ_2320	T_CLM_DNTL_2320	NUMBER	4.00	0.00
NUM_SEQ_2320	T_CLM_PHYS_2320	NUMBER	4.00	0.00
NUM_SEQ_2320	T_CLM_UB92_2320	NUMBER	4.00	0.00
NUM_SEQ_2400_PWK	T_CLM_PHYS_2400_PWK	NUMBER	4.00	0.00
NUM_SEQ_2430	T_CLM_PHYS_2430	NUMBER	4.00	0.00
NUM_SEQ_2430	T_CLM_UB92_2430	NUMBER	4.00	0.00
NUM_SEQ_2430_AMT	T_CLM_DNTL_2430_AMT	NUMBER	4.00	0.00
NUM_SEQ_AR_LTR	T_AR_LETTERS	NUMBER	4.00	0.00
NUM_SEQ_BATCH	T_ADJ_VOID_RQST	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_CASH_COMMENT	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_CASH_RCPT_XREF	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_COVERAGE_XREF	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_EXPENDITURE	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_FIN_PROCESS_CASH_DISP	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_HIPP_PENDING	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_TPL_AR_DISPS	NUMBER	9.00	0.00
NUM_SEQ_BATCH	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00

NUM_SEQ_CIP003	T_TMSIS_CIP003_CLM_DTL	NUMBER	3.00	0.00
NUM_SEQ_CIP_DIAG	T_TMSIS_CIP_DIAG	NUMBER	2.00	0.00
NUM_SEQ_CIP_OCC	T_TMSIS_CIP_OCC_CDE	NUMBER	2.00	0.00
NUM_SEQ_CIP_PROC	T_TMSIS_CIP_HDR_PROC	NUMBER	1.00	0.00
NUM_SEQ_CIP_REM	T_TMSIS_CIP_REM_CDE	NUMBER	1.00	0.00
NUM_SEQ_CLT003	T_TMSIS_CLT003_CLM_DTL	NUMBER	3.00	0.00
NUM_SEQ_CLT_DIAG	T_TMSIS_CLT_DIAG	NUMBER	2.00	0.00
NUM_SEQ_CLT_OCC	T_TMSIS_CLT_OCC_CDE	NUMBER	2.00	0.00
NUM_SEQ_CLT_REM	T_TMSIS_CLT_REM_CDE	NUMBER	1.00	0.00
NUM_SEQ_COT003	T_TMSIS_COT003_CLM_DTL	NUMBER	3.00	0.00
NUM_SEQ_COT_DIAG	T_TMSIS_COT_DIAG	NUMBER	2.00	0.00
NUM_SEQ_COT_OCC	T_TMSIS_COT_OCC_CDE	NUMBER	2.00	0.00
NUM_SEQ_COT_REM	T_TMSIS_COT_REM_CDE	NUMBER	1.00	0.00
NUM_SEQ_CRX003	T_TMSIS_CRX003_CLM_DTL	NUMBER	3.00	0.00
NUM_SEQ_CRX_REM	T_TMSIS_CRX_REM_CDE	NUMBER	1.00	0.00
NUM_SEQ_DTL_REF	T_CLM_DNTL_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_DTL_REF	T_CLM_PHYS_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_DTL_REF	T_CLM_UB92_DTL_REF	NUMBER	4.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG003_VAR_DEMO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG004_CONTACT_INF	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG010_MFP_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG011_STATE_PLAN	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG012_WAIVER_PART	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG015_ETHNICITY	NUMBER	3.00	0.00

NUM_SEQ_ELG002	T_TMSIS_ELG016_RACE_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG017_DISAB_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG018_1115A_DEMO	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	3.00	0.00
NUM_SEQ_ELG002	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	3.00	0.00
NUM_SEQ_ELG003	T_TMSIS_ELG003_VAR_DEMO	NUMBER	3.00	0.00
NUM_SEQ_ELG004	T_TMSIS_ELG004_CONTACT_INF	NUMBER	3.00	0.00
NUM_SEQ_ELG005	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	3.00	0.00
NUM_SEQ_ELG006	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	3.00	0.00
NUM_SEQ_ELG006	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	3.00	0.00
NUM_SEQ_ELG007	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	3.00	0.00
NUM_SEQ_ELG008	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	3.00	0.00
NUM_SEQ_ELG009	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG010	T_TMSIS_ELG010_MFP_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG011	T_TMSIS_ELG011_STATE_PLAN	NUMBER	3.00	0.00
NUM_SEQ_ELG012	T_TMSIS_ELG012_WAIVER_PART	NUMBER	3.00	0.00
NUM_SEQ_ELG013	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	3.00	0.00
NUM_SEQ_ELG014	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	3.00	0.00
NUM_SEQ_ELG015	T_TMSIS_ELG015_ETHNICITY	NUMBER	3.00	0.00
NUM_SEQ_ELG016	T_TMSIS_ELG016_RACE_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG017	T_TMSIS_ELG017_DISAB_INFO	NUMBER	3.00	0.00
NUM_SEQ_ELG018	T_TMSIS_ELG018_1115A_DEMO	NUMBER	3.00	0.00
NUM_SEQ_ELG020	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	3.00	0.00
NUM_SEQ_ELG021	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	3.00	0.00
NUM_SEQ_HELD	T_PAY_HOLD_TXN_XREF	NUMBER	9.00	0.00

NUM_SEQ_MCR002	T_TMSIS_MCR002_MAIN	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR004_SVC_AREA	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR005_OPER_AUTH	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR006_POP_ENRLD	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	3.00	0.00
NUM_SEQ_MCR002	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	3.00	0.00
NUM_SEQ_MCR003	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	3.00	0.00
NUM_SEQ_MCR004	T_TMSIS_MCR004_SVC_AREA	NUMBER	3.00	0.00
NUM_SEQ_MCR005	T_TMSIS_MCR005_OPER_AUTH	NUMBER	3.00	0.00
NUM_SEQ_MCR006	T_TMSIS_MCR006_POP_ENRLD	NUMBER	3.00	0.00
NUM_SEQ_MCR007	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	3.00	0.00
NUM_SEQ_MCR008	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	3.00	0.00
NUM_SEQ_MCR009	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV004_LICENSE_INF	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	3.00	0.00
NUM_SEQ_PRV002	T_TMSIS_PRV010_BED_TYPE	NUMBER	3.00	0.00
NUM_SEQ_PRV003	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	3.00	0.00
NUM_SEQ_PRV003	T_TMSIS_PRV004_LICENSE_INF	NUMBER	3.00	0.00

NUM_SEQ_PRV003	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	3.00	0.00
NUM_SEQ_PRV003	T_TMSIS_PRV010_BED_TYPE	NUMBER	3.00	0.00
NUM_SEQ_PRV004	T_TMSIS_PRV004_LICENSE_INF	NUMBER	3.00	0.00
NUM_SEQ_PRV005	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	3.00	0.00
NUM_SEQ_PRV006	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	3.00	0.00
NUM_SEQ_PRV007	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	3.00	0.00
NUM_SEQ_PRV008	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	3.00	0.00
NUM_SEQ_PRV009	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	3.00	0.00
NUM_SEQ_PRV010	T_TMSIS_PRV010_BED_TYPE	NUMBER	3.00	0.00
NUM_SEQ_SUBMISSION	T_MR_TMSIS_CMS_ERROR_FILES	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_CIP001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_CLT001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_CMS_ERROR_FILES	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_COT001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_CRX001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_EDIT_FAILURES	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_EDIT_STATS	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_ELG001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_EXT_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_MCR001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_PRV001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_RUN_STATS	NUMBER	4.00	0.00
NUM_SEQ_SUBMISSION	T_TMSIS_TPL001_FILE_HDR	NUMBER	4.00	0.00
NUM_SEQ_TPL002	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	3.00	0.00
NUM_SEQ_TPL002	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	3.00	0.00

NUM_SEQ_TPL002	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	3.00	0.00
NUM_SEQ_TPL003	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	3.00	0.00
NUM_SEQ_TPL004	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	6.00	0.00
NUM_SEQ_TPL005	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	3.00	0.00
NUM_SEQ_TPL006	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	3.00	0.00
NUM_SEQ_TPL006	T_TMSIS_TPL006_CONTACT_INF	NUMBER	3.00	0.00
NUM_SERVICE_ADJUSTER	T_CA_UB92	NUMBER	6.00	3.00
NUM_SERVICE_ADJUSTER	T_UB92_HDR_INP	NUMBER	6.00	3.00
NUM_SEV_SCORE	T_ETG_SUMMARY	VARCHAR2	10.00	0.00
NUM_SEV_SCORE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	10.00	0.00
NUM_SEV_SCORE	T_ETG_SUMMARY_FFS	VARCHAR2	10.00	0.00
NUM_SEV_SCORE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	10.00	0.00
NUM_SHORT_DAYS	T_PS_REFERRAL	NUMBER	3.00	0.00
NUM_SITE	T_PMP_SVC_LOC_KY	CHAR	4.00	0.00
NUM_SKEY_DOSE	T_CDE_DOSAGE_FORM	NUMBER	3.00	0.00
NUM_SORT	T_CM_CT_FILTER	NUMBER	4.00	0.00
NUM_SORT	T_CM_DAY	NUMBER	2.00	0.00
NUM_SORT	T_CM_FREQUENCY	NUMBER	2.00	0.00
NUM_SORT	T_CM_MEASURE	NUMBER	4.00	0.00
NUM_SORT	T_CM_PAID_LEVEL	NUMBER	2.00	0.00
NUM_SORT	T_CM_PG_FILTER	NUMBER	4.00	0.00
NUM_SORT	T_CM_RPT_CAT	NUMBER	2.00	0.00
NUM_SORT	T_CM_SEX	NUMBER	2.00	0.00
NUM_SORT	T_CM_STATUS	NUMBER	2.00	0.00
NUM_SORT	T_MM_CALC_TYPE	NUMBER	2.00	0.00

NUM_SORT	T_MM_CNT_CRIT	NUMBER	2.00	0.00
NUM_SORT	T_MM_DATA_SRCE	NUMBER	2.00	0.00
NUM_SORT	T_MM_DATE_RANGE	NUMBER	2.00	0.00
NUM_SORT	T_MM_DOMAIN	NUMBER	2.00	0.00
NUM_SORT	T_MM_FILTER	NUMBER	4.00	0.00
NUM_SORT	T_MM_FREQUENCY	NUMBER	2.00	0.00
NUM_SORT	T_MM_GROUP	NUMBER	2.00	0.00
NUM_SORT	T_MM_JOIN_TYPE	NUMBER	2.00	0.00
NUM_SORT	T_MM_MEASURE_SRCE	NUMBER	2.00	0.00
NUM_SORT	T_MM_PART	NUMBER	2.00	0.00
NUM_SORT	T_MM_PART_IND	NUMBER	2.00	0.00
NUM_SORT	T_MM_PART_SEQ	NUMBER	2.00	0.00
NUM_SORT	T_MM_QUALIFIER_SEQ	NUMBER	2.00	0.00
NUM_SORT	T_MM_QUALIFIER_TYPE	NUMBER	2.00	0.00
NUM_SORT	T_MM_SEQ_TYPE	NUMBER	2.00	0.00
NUM_SORT	T_PR_SUMM_TBL_LIST	NUMBER	4.00	0.00
NUM_SPLIT1	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_SPLIT2	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_SPLIT3	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_SSI_PHONE	T_DS_RECIP_CORE	CHAR	10.00	0.00
NUM_SSN	T_BUYA_BILL_INFO	CHAR	9.00	0.00
NUM_SSN	T_BUYA_DEMO_CHANGE	CHAR	9.00	0.00
NUM_SSN	T_BUYA_EXCEPT	CHAR	9.00	0.00
NUM_SSN	T_BUYA_MISMATCH	CHAR	9.00	0.00
NUM_SSN	T_BUYB_BILL_INFO	CHAR	9.00	0.00
NUM_SSN	T_BUYB_DEMO_CHANGE	CHAR	9.00	0.00
NUM_SSN	T_BUYB_EXCEPT	CHAR	9.00	0.00
NUM_SSN	T_BUYB_MISMATCH	CHAR	9.00	0.00
NUM_SSN	T_CA_PR_HB_LIC	CHAR	9.00	0.00
NUM_SSN	T_DS_RECIP_SOBRA_FAMILY	CHAR	9.00	0.00
NUM_SSN	T_DS_RECIP_SOBRA_FAM_AB SNT	CHAR	9.00	0.00
NUM_SSN	T_DS_RECIP_SOBRA_FAM_HIS T	CHAR	9.00	0.00
NUM_SSN	T_MC_CENSUS	CHAR	9.00	0.00
NUM_SSN	T_POLICY_HOLDER	CHAR	9.00	0.00
NUM_SSN	T_PR_BOARD	CHAR	9.00	0.00
NUM_SSN	T_PR_DEA_LIC	CHAR	9.00	0.00
NUM_SSN	T_PR_ENRL_BOARD	CHAR	9.00	0.00
NUM_SSN	T_PR_HB_LIC	CHAR	9.00	0.00
NUM_SSN	T_PR_HB_LIC_KY	CHAR	9.00	0.00
NUM_SSN	T_RE_1095	CHAR	9.00	0.00

NUM_SSN	T_RE_ADPH_1095	CHAR	9.00	0.00
NUM_SSN	T_RE_BASE	CHAR	9.00	0.00
NUM_SSN	T_RE_BASE_DN	CHAR	9.00	0.00
NUM_SSN	T_RE_CHILD_HAD	CHAR	9.00	0.00
NUM_SSN	T_RE_CMS_MMA_ENROLL	CHAR	9.00	0.00
NUM_SSN	T_RE_EDB	CHAR	9.00	0.00
NUM_SSN	T_RE_EDB_SSN	CHAR	9.00	0.00
NUM_SSN	T_RE_HIST_ERR	CHAR	9.00	0.00
NUM_SSN	T_RE_LTC_REQUEST	CHAR	9.00	0.00
NUM_SSN	T_RE_MARITAL	CHAR	9.00	0.00
NUM_SSN	T_RE_MOVE_IN_OUT	CHAR	9.00	0.00
NUM_SSN	T_RE_PREV_SSN	CHAR	9.00	0.00
NUM_SSN	T_RE_PS2_DUPE	NUMBER	9.00	0.00
NUM_SSN	T_RE_PS2_ERR	CHAR	9.00	0.00
NUM_SSN	T_TMSIS_ELG003_VAR_DEMO	NUMBER	9.00	0.00
NUM_SSN	T_TPL_AC_PARENT	CHAR	9.00	0.00
NUM_SSN	T_TPL_RES_DEL	CHAR	9.00	0.00
NUM_SSN	T_TPL_SUSP_XREF	CHAR	9.00	0.00
NUM_SSN_APPL	T_DS_RECIP_DO_APPL	CHAR	9.00	0.00
NUM_SSN_CLM	T_DS_RECIP_DO_APPL	CHAR	12.00	0.00
NUM_SSN_EDB	T_BUYA_DEMO_CHANGE	CHAR	9.00	0.00
NUM_SSN_EDB	T_BUYB_DEMO_CHANGE	CHAR	9.00	0.00
NUM_SSN_PS2	T_RE_PS2_DUPE	NUMBER	9.00	0.00
NUM_SSN_SPOUSE	T_DS_RECIP_DO_APPL	CHAR	9.00	0.00
NUM_SSN_VER_FLAG	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	1.00	0.00
NUM_STEP_DAYS	T_AUDIT_ST_LEVEL	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_AID_CAT	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_AMT_PAID	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_CLAIM_TYPE	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_CLM_STATUS	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_DATE_SERV	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_EXTRACT	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_HCFA_INFO	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_PROV_SPEC	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_PROV_TYPE	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_SPLIT	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_STRATA	NUMBER	4.00	0.00
NUM_STRATA	T_CPAS_STRAT_STAT	NUMBER	4.00	0.00
NUM_ST_CONTROL	T_835_CK_EFT_TRCNO	NUMBER	9.00	0.00

NUM_ST_CONTROL	T_EDI_INTERCHANGE	NUMBER	9.00	0.00
NUM_SUBSIDY_LVL	T_RE_CMS_MMA_ENROLL	CHAR	3.00	0.00
NUM_SUR_RQST	T_SUR_RQST_EOMB	NUMBER	9.00	0.00
NUM_SVC_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_SVC_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_SVC_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_SVC_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_SVC_PHONE_FAX_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_PHONE_FAX_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_PHONE_FAX_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_PHONE_FAX_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_TF_PHONE_AFT	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_TF_PHONE_AFT	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_TF_PHONE_BEF	T_PR_WEB_CHG	CHAR	10.00	0.00
NUM_SVC_TF_PHONE_BEF	T_PR_WEB_CHG_BACKUP	CHAR	10.00	0.00
NUM_SVC_TF_PHONE_EXT_AFT	T_PR_WEB_CHG	CHAR	4.00	0.00

NUM_SVC_TF_PHONE_EXT_AFT	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_SVC_TF_PHONE_EXT_BEF	T_PR_WEB_CHG	CHAR	4.00	0.00
NUM_SVC_TF_PHONE_EXT_BEF	T_PR_WEB_CHG_BACKUP	CHAR	4.00	0.00
NUM_SVC_TOLL_FREE_EXT	T_PR_SVC_LOC_AL	VARCHAR2	4.00	0.00
NUM_SVC_TOLL_FREE_PHONE	T_PR_SVC_LOC_AL	VARCHAR2	10.00	0.00
NUM_TAX_ID	T_1099_ADJUST	CHAR	9.00	0.00
NUM_TAX_ID	T_1099_DETAIL	CHAR	9.00	0.00
NUM_TAX_ID	T_BOARD_PART	CHAR	9.00	0.00
NUM_TAX_ID	T_IRS_B_NOTICE_AL	CHAR	9.00	0.00
NUM_TAX_ID	T_IRS_B_NOTICE_WI	CHAR	9.00	0.00
NUM_TAX_ID	T_IRS_W9_INFO	CHAR	9.00	0.00
NUM_TAX_ID	T_NONPROV_TAX_ID	CHAR	9.00	0.00
NUM_TAX_ID	T_OWNER	CHAR	9.00	0.00
NUM_TAX_ID	T_OWNER_WI	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_APPLN	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_APPLN_WI	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_BOARD	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_DEA_LIC	CHAR	13.00	0.00
NUM_TAX_ID	T_PR_ENRL_EFT_ERA_MAINT	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_ENRL_TAX_ID	CHAR	9.00	0.00
NUM_TAX_ID	T_PR_TAX_ID	CHAR	9.00	0.00
NUM_TAX_ID	T_TPL_TAX_ID	CHAR	9.00	0.00
NUM_TAX_ID_ST	T_835_CONSTANTS	CHAR	10.00	0.00
NUM_TAX_ID_ST	T_FIN_CYCLE	CHAR	12.00	0.00
NUM_TAX_YEAR	T_IRS_B_NOTICE_AL	CHAR	4.00	0.00
NUM_TAX_YEAR	T_IRS_B_NOTICE_WI	CHAR	4.00	0.00
NUM_TCN	T_CA_MATERNITY_CARE	CHAR	17.00	0.00
NUM_TCN	T_CA_TCN	NUMBER	17.00	0.00
NUM_TCN	T_CLM_MAT_CARE_HDR	CHAR	17.00	0.00
NUM_TCN	T_TCN_XREF	NUMBER	17.00	0.00

NUM_TCN_MCO	T_CA_MCO_XREF	CHAR	20.00	0.00
NUM_TERMS_DISC_PCNT	T_CLM_CN1	NUMBER	6.00	2.00
NUM_THERA_CLS_GEN	T_GENERIC_DRUG	NUMBER	2.00	0.00
NUM_THERA_CLS_STD	T_GENERIC_DRUG	NUMBER	2.00	0.00
NUM_TIN	T_FIN_CYCLE_TAX_INFO	CHAR	9.00	0.00
NUM_TMSIS_CASE	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	12.00	0.00
NUM_TMSIS_EDIT	T_MR_TMSIS_CMS_ERROR_RECS	NUMBER	5.00	0.00
NUM_TMSIS_EDIT	T_TMSIS_EDIT_CTL	NUMBER	5.00	0.00
NUM_TMSIS_EDIT_RULE	T_TMSIS_EDIT_CTL	NUMBER	4.00	0.00
NUM_TMSIS_EDIT_TIER	T_TMSIS_EDIT_CTL	NUMBER	4.00	0.00
NUM_TMSIS_LENGTH	T_TMSIS_DATA_ELEMENTS	NUMBER	4.00	0.00
NUM_TMSIS_RULE	T_TMSIS_CMS_ERROR_RECS	NUMBER	5.00	0.00
NUM_TOOTH	T_TMSIS_COT003_CLM_DTL	VARCHAR2	2.00	0.00
NUM_TOP_VOL_RANK	T_DRUG	NUMBER	4.00	0.00
NUM_TOP_VOL_RANK	T_DRUG_DN	NUMBER	4.00	0.00
NUM_TOTAL_BEDS	T_PR_LOC_RATE	NUMBER	9.00	0.00
NUM_TOTAL_BEDS	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
NUM_TOTAL_EDITS	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_TOTAL_HIGH_DAILY_MME	T_MME_DAILY_MME_ALERTING	NUMBER	34.00	17.00

NUM_TOTAL_LOW_DAILY_MME	T_MME_DAILY_MME_ALERTING	NUMBER	34.00	17.00
NUM_TOTAL_RECS	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
NUM_TOT_CLMS	T_CT_CASE_TRACK	NUMBER	8.00	0.00
NUM_TOT_DAYS_COVD	T_CA_IND_AGGR	NUMBER	9.00	0.00
NUM_TOT_DAYS_COVD_ORIG	T_CA_IND_AGGR	NUMBER	9.00	0.00
NUM_TOT_DAYS_INIT_RCALL	T_DS_DNTL_PR_RE_SUM	NUMBER	9.00	0.00
NUM_TOT_DAYS_INIT_RCALL	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
NUM_TOT_DAYS_NCOVD	T_CA_IND_AGGR	NUMBER	9.00	0.00
NUM_TOT_RECIPS	T_CT_CASE_TRACK	NUMBER	8.00	0.00
NUM_TOT_RECIP_AGE_DNTL	T_DS_DNTL_PR_SUM	NUMBER	9.00	0.00
NUM_TOT_REVISED_CASE_AMT	T_CASUALTY_CASE	NUMBER	9.00	2.00
NUM_TOT_REVISED_CASE_AMT	T_CASUALTY_CASE_AL	NUMBER	9.00	2.00
NUM_TPL_POLICY	T_CASUALTY_CASE	VARCHAR2	30.00	0.00
NUM_TPL_POLICY	T_CASUALTY_CASE_AL	VARCHAR2	30.00	0.00
NUM_TPL_POLICY	T_TPL_AR_HEALTH	CHAR	30.00	0.00
NUM_TPL_POLICY	T_TPL_RESOURCE	CHAR	16.00	0.00
NUM_TPL_POLICY	T_TPL_RESOURCE	CHAR	30.00	0.00
NUM_TPL_POLICY	T_TPL_RES_DEL	CHAR	16.00	0.00
NUM_TRACE	T_EFT_TRACE_XREF	NUMBER	7.00	0.00
NUM_TRACKING	T_PR_APPLN_STATUS	CHAR	10.00	0.00
NUM_TRACKING	T_PR_ENRL	CHAR	10.00	0.00
NUM_TRANSACTION_CNTRL	T_DOCUMENT_TRANSACTIONS	VARCHAR2	9.00	0.00
NUM_TRIM_POINT	T_OUTLIER_THRESHLD	NUMBER	9.00	0.00
NUM_TRUNK_GRP	T_PR_ATT_CMS	NUMBER	4.00	0.00
NUM_UNDUP_RECIP_THERAPY	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
NUM_UNITS	T_AUTO_PA_SUMMARY	NUMBER	12.00	3.00
NUM_UNITS	T_LS_LVL3_PRICING	NUMBER	11.00	3.00
NUM_UNITS	T_PERF_CRIT	NUMBER	8.00	0.00
NUM_UNITS_DENIED	T_AUTO_PA_SUMMARY	NUMBER	12.00	3.00

NUM_UNIT_AFTER	T_CONFLICT_PARM	NUMBER	4.00	0.00
NUM_UNIT_AFTER	T_CONTRA_PARM	NUMBER	4.00	0.00
NUM_UNIT_AFTER	T_READMIT_PARM	NUMBER	4.00	0.00
NUM_UNIT_AFTER	T_UMBRELLA_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_CONFLICT_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_CONTRA_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_LIMIT_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_LIMIT_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_READMIT_PARM	NUMBER	4.00	0.00
NUM_UNIT_BEFORE	T_UMBRELLA_PARM	NUMBER	4.00	0.00
NUM_UNIT_FRCT	T_AUDIT_PROC	NUMBER	5.00	2.00
NUM_UNIT_FRCT	T_AUDIT_PROC_MIRROR	NUMBER	5.00	2.00
NUM_UNIT_FRCT	T_AUDT_PROC_XRF	NUMBER	5.00	2.00
NUM_UNIV_SIZE	T_CPAS_STRATA	NUMBER	9.00	0.00
NUM_UPIN	T_PR_PROV	CHAR	6.00	0.00
NUM_VERSION	T_LETTER	NUMBER	9.00	0.00
NUM_VERSION	T_LG_LETTER_TEMPLATE	NUMBER	9.00	0.00
NUM_VERSION_DRG	T_UB92_HDR_INP	VARCHAR2	20.00	0.00
NUM_VERSION_DRG	T_UB92_HDR_INP_OLD	VARCHAR2	20.00	0.00
NUM_VERSION_LETTER	T_LTR_RQST_TRK	NUMBER	9.00	0.00
NUM_VERSION_QUERY	T_LTR_RQST_TRK	NUMBER	9.00	0.00
NUM_VERSION_QUERY	T_QUERY	NUMBER	9.00	0.00
NUM_VISITS	T_CLM_HH_CARE_PLAN	NUMBER	9.00	0.00
NUM_VISIT_RANK	T_DS_DNTL_ICN	NUMBER	4.00	0.00
NUM_VOUCHER	T_RE_NET_VOUCHER	CHAR	8.00	0.00
NUM_VT_CLM	T_DS_RECIP_DO_APPL	CHAR	12.00	0.00
NUM_WEIGHT	T_CLM_SBR	NUMBER	10.00	0.00
NUM_WEIGHT	T_CT_SELECT_LST	NUMBER	7.00	0.00

NUM_WEIGHT	T_DRG_RATE	NUMBER	7.00	4.00
NUM_WEIGHT	T_PDUR_ADD_TOX_FAC	NUMBER	3.00	0.00
NUM_WEIGHT_MAX	T_BIRTH_WEIGHT	NUMBER	4.00	0.00
NUM_WEIGHT_MIN	T_BIRTH_WEIGHT	NUMBER	4.00	0.00
NUM_WGHT_25TH_PCTL_F	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_25TH_PCTL_M	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_50TH_PCTL_F	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_50TH_PCTL_M	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_5TH_PCTL_F	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_5TH_PCTL_M	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_75TH_PCTL_F	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_75TH_PCTL_M	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_95TH_PCTL_F	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WGHT_95TH_PCTL_M	T_CDE_PEDI_WEIGHTS	NUMBER	5.00	2.00
NUM_WORK_PHONE	T_DS_RECIP_DO_APPL_SPONS	CHAR	10.00	0.00
NUM_XFER_MAX	T_MC_PMP_MASS_XFER	NUMBER	9.00	0.00
NURSE_DAYS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	5.00	0.00
OCCURS_COUNT	T_PA_HCBW_UPD_HDR	CHAR	2.00	0.00
OCCURS_NO	T_PA_DDSD_UPD_HDR	CHAR	2.00	0.00
OCCURS_NO	T_PA_LTCA_UPD_HDR	CHAR	2.00	0.00
ORDER_PROV_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
ORIGIN_DESC	T_ORIGIN_CODE	CHAR	40.00	0.00

ORIG_CLM_CNT	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
ORIG_CLM_TOT	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
ORIG_CORR_ID	T_CORRESPOND_XREF	NUMBER	9.00	0.00
ORIG_QTR_PD	T_DR_CLMS_XREF	NUMBER	5.00	0.00
OUTLIER_STATUS	T_ETG_SUMMARY	VARCHAR2	1.00	0.00
OUTLIER_STATUS	T_ETG_SUMMARY_ENCNTR	VARCHAR2	1.00	0.00
OUTLIER_STATUS	T_ETG_SUMMARY_FFS	VARCHAR2	1.00	0.00
OUTLIER_STATUS	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	1.00	0.00
OUT_MEDIA	T_RTE_RPT_CTL	CHAR	4.00	0.00
OWNER	T_AUDIT_PURGE	CHAR	8.00	0.00
PAID_DTE_CY	T_CA_CURRENT_DATES	NUMBER	4.00	0.00
PAID_DTE_FFY	T_CA_CURRENT_DATES	NUMBER	4.00	0.00

PAID_DTE_MONTH	T_CA_CURRENT_DATES	NUMBER	6.00	0.00
PAID_DTE_QTR	T_CA_CURRENT_DATES	NUMBER	6.00	0.00
PAID_DTE_SFY	T_CA_CURRENT_DATES	NUMBER	4.00	0.00
PAID_DTE_WEEK	T_CA_CURRENT_DATES	NUMBER	6.00	0.00
PAID_TIME_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
PAID_TIME_KEY	T_CA_FIN	NUMBER	9.00	0.00
PARENT_LBLR	T_DRUG_LBLR	CHAR	5.00	0.00
PASSWORD	T_LAST_PASSWORD	VARCHAR2	30.00	0.00
PASSWORD	T_SEC_USER	VARCHAR2	64.00	0.00
PASSWORD	T_WEB_USER	VARCHAR2	20.00	0.00
PASSWORD_CHANGE_DATE	T_SEC_PASSWORD_HISTORY	DATE	0.00	0.00
PASSWORD_HISTORY	T_SEC_PASSWORD_HISTORY	VARCHAR2	64.00	0.00
PASSWORD_HISTORY_COUNT	T_SEC_PASSWORD_HISTORY	NUMBER	1.00	0.00
PATIENT_AGE	T_ETG_PROV_TOTS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_PROV_TOTS_ENCNTR	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_PROV_TOTS_FFS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_PROV_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_RECIP_TOTS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_RECIP_TOTS_FFS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMMARY	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMMARY_FFS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMMARY_TOTS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMM_TOTS_ENCNTR	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMM_TOTS_FFS	VARCHAR2	3.00	0.00
PATIENT_AGE	T_ETG_SUMM_TOTS_RCO_PAID	VARCHAR2	3.00	0.00
PATIENT_GENDER	T_ETG_PROV_TOTS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_PROV_TOTS_ENCNTR	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_PROV_TOTS_FFS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_PROV_TOTS_RCO_PAID	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_RECIP_TOTS	VARCHAR2	1.00	0.00

PATIENT_GENDER	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_RECIP_TOTS_FFS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMMARY	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMMARY_ENCNTR	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMMARY_FFS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMMARY_TOTS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMM_TOTS_ENCNTR	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMM_TOTS_FFS	VARCHAR2	1.00	0.00
PATIENT_GENDER	T_ETG_SUMM_TOTS_RCO_PAID	VARCHAR2	1.00	0.00
PATIENT_LOCATION	T_CA_DRUG	NUMBER	2.00	0.00
PAT_LIAB	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	6.00	0.00
PAT_STAT	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PAT_STAT	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	2.00	0.00
PAYLOADTYPE	T_EDIC_PAYLOADTYPES	VARCHAR2	360.00	0.00
PAYMENT_METHOD	T_PA_DDSD_UPD_DTL	CHAR	1.00	0.00
PAYMENT_METHOD	T_PA_LTCA_UPD_DTL	CHAR	1.00	0.00
PAY_METHOD	T_PA_HCBW_UPD_DTL	CHAR	1.00	0.00
PA_EDS_ATND_APPEAL	T_PA_APPEAL	CHAR	1.00	0.00
PA_NUMBER	T_PA_HCBW_UPD_DTL	CHAR	10.00	0.00
PA_NUMBER	T_PA_HCBW_UPD_HDR	CHAR	10.00	0.00
PA_NUMBER	T_PA_LTCA_UPD_DTL	CHAR	10.00	0.00
PA_NUMBER	T_PA_LTCA_UPD_HDR	CHAR	10.00	0.00
PA_NUMBER	T_PA_PC_UPD_HDR	CHAR	10.00	0.00
PCP_PROV_ID	T_PROFILE_ASM_MM_PROV	CHAR	15.00	0.00
PCP_PROV_ID	T_PROFILE_PMPM_PROV	CHAR	15.00	0.00
PCP_PROV_ID	T_PROF_MM_PROV	CHAR	15.00	0.00

PCT	T_DRUG_MAC_PCT	NUMBER	3.00	2.00
PCT	T_EAC	NUMBER	4.00	3.00
PCT	T_FMAP_PCT	NUMBER	6.00	5.00
PCT	T_LIEN	NUMBER	6.00	4.00
PCT	T_MULT_SURG_PCT	NUMBER	3.00	2.00
PCT	T_RBRVS_PR_SPEC	NUMBER	3.00	2.00
PCT	T_SITE_OF_DIFF	NUMBER	3.00	2.00
PCTDIFF	T_PF_RECIP_CMPR	NUMBER	10.00	2.00
PCTDIFF	T_PF_RE_CMPR_Q	NUMBER	10.00	2.00
PCTDIFF	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
PCT_2300_CN103	T_CLM_DNTL_2300	NUMBER	6.00	2.00
PCT_2300_CN105	T_CLM_DNTL_2300	NUMBER	6.00	2.00
PCT_2320_MOA01	T_CLM_DNTL_2320	NUMBER	10.00	2.00
PCT_2400_CN103	T_CLM_DNTL_2400	NUMBER	6.00	2.00
PCT_2400_CN105	T_CLM_DNTL_2400	NUMBER	6.00	2.00
PCT_ACCEPTED	T_CLM_BATCH_PROCESS_ENC	NUMBER	3.00	0.00
PCT_BOTTOM	T_CT_PROV_CRIT	NUMBER	3.00	0.00
PCT_BOTTOM	T_CT_RE_CRIT	NUMBER	3.00	0.00
PCT_BUSINESS	T_TMSIS_MCR002_MAIN	NUMBER	3.00	0.00
PCT_CAPT_MED_ED	T_PEER_GRP_DRGR_OLD	NUMBER	7.00	4.00
PCT_COINS_RATE	T_XOVER_RATE	NUMBER	5.00	2.00
PCT_CONFIDENCE	T_PR_ADR_CASS	NUMBER	6.00	2.00
PCT_CONFIDENCE	T_RE_ADR_CASS	NUMBER	6.00	2.00

PCT_CONTRACT_RATE	T_PR_CONTRACT_RATE_KY	NUMBER	6.00	3.00
PCT_CONT_FEE	T_TPL_CONT_FEE	NUMBER	9.00	0.00
PCT_COST_OUTLIER	T_PEER_GRP_DRGR_OLD	NUMBER	5.00	4.00
PCT_CO_PAY	T_TPL_COIN_DED	NUMBER	4.00	0.00
PCT_DAYS_SUPPLY	T_DRUG_SCREEN	NUMBER	4.00	3.00
PCT_DAYS_SUPPLY	T_DRUG_SCREEN	NUMBER	4.00	3.00
PCT_DED_RATE	T_XOVER_RATE	NUMBER	5.00	2.00
PCT_DISP_SHARE	T_DISP_SHARE	NUMBER	5.00	4.00
PCT_DISP_SHR	T_PEER_GRP_DRGR_OLD	NUMBER	5.00	5.00
PCT_ESC	T_CC_CR_SAVE	NUMBER	3.00	0.00
PCT_FEE	T_CAS_REATT_INF	NUMBER	4.00	0.00
PCT_FICA_RATE	T_FICA_RATE	NUMBER	5.00	4.00
PCT_FICA_RATE	T_FICA_RATE	NUMBER	6.00	4.00
PCT_INTRAOP	T_RBRVS	NUMBER	6.00	5.00
PCT_INTRAOP	T_RBRVS_UPDATE	NUMBER	6.00	5.00
PCT_LEAVE_RATE	T_LTC_LEAVE_RATE	NUMBER	5.00	2.00
PCT_MC_TARGET	T_PMP_AUTOASSGN	NUMBER	5.00	4.00
PCT_MED_ED	T_PEER_GRP_DRGR_OLD	NUMBER	7.00	4.00
PCT_MIDDLE	T_CT_PROV_CRIT	NUMBER	3.00	0.00
PCT_MIDDLE	T_CT_RE_CRIT	NUMBER	3.00	0.00
PCT_MODIFIER	T_PROCESS_MOD	NUMBER	4.00	3.00
PCT_OUTLIER_ADJ	T_DRG_RATE	NUMBER	5.00	4.00
PCT_PAID	T_LS_LVL3_PRICING	NUMBER	2.00	0.00
PCT_PAID	T_PEER_GRP_DRGR_OLD	NUMBER	5.00	4.00
PCT_PCP	T_PR_PCP	NUMBER	3.00	0.00
PCT_POSTOP	T_RBRVS	NUMBER	6.00	5.00
PCT_POSTOP	T_RBRVS_UPDATE	NUMBER	6.00	5.00
PCT_PREOP	T_RBRVS	NUMBER	6.00	5.00

PCT_PREOP	T_RBRVS_UPDATE	NUMBER	6.00	5.00
PCT_RATE	T_PR_RATE_KY	NUMBER	7.00	3.00
PCT_RATE_ADJ	T_BNFT_ADJ_FACTOR	NUMBER	5.00	3.00
PCT_RATE_INTEREST	T_AR_INTEREST_RATE	NUMBER	5.00	2.00
PCT_RATE_INTEREST	T_CLM_INT_RATE	NUMBER	5.00	2.00
PCT_RECIPS	T_SUR_RQST_EOMB	NUMBER	5.00	2.00
PCT_RECOUP	T_ACCT_REC	NUMBER	4.00	2.00
PCT_RECOUP	T_ACCT_REC_DN	NUMBER	4.00	2.00
PCT_RECOUP	T_FIN_PROCESS_AR	NUMBER	4.00	2.00
PCT_REIMB_RATE	T_REIMB_RATE	NUMBER	5.00	2.00
PCT_TARGET	T_MC_PGM_AUTOASSIGN	NUMBER	5.00	4.00
PCT_TBILL	T_DR_TBILL_RATE	NUMBER	6.00	4.00
PCT_THRESHOLD	T_ENC_ERR_THRESHLD	NUMBER	5.00	2.00
PCT_TOP	T_CT_PROV_CRIT	NUMBER	3.00	0.00
PCT_TOP	T_CT_RE_CRIT	NUMBER	3.00	0.00
PCT_TOTAL_REBATE	T_DR_TMP_SUPP_RATES	NUMBER	12.00	6.00
PCT_VALUE	T_FIN_FUND_CDE_RATE	NUMBER	4.00	2.00
PEER_AVG_AGE	T_PROFILE_AVG_AGE	NUMBER	4.00	0.00
PEER_PROV_AMT	T_PROFILE_PEER_PROV_AMTS	NUMBER	10.00	2.00
PEER_PROV_CLM_CNT	T_PROFILE_PEER_PROV_AMTS	NUMBER	8.00	0.00
PEER_PROV_CLM_CNT	T_PROFILE_PROV_NON_REFER	NUMBER	8.00	0.00
PEER_PROV_UNITS	T_PROFILE_PEER_PROV_AMTS	NUMBER	10.00	2.00
PEER_RE_CNT	T_PROFILE_PEER_PROV_AMTS	NUMBER	8.00	0.00
PEER_RE_CNT	T_PROFILE_RPT_GRAPHS	NUMBER	5.00	0.00
PEER_RE_CNT	T_PROFILE_SELECTED_CASES	NUMBER	8.00	0.00
PEER_RX_AMT	T_PROFILE_PHARM_MEASURES	NUMBER	13.00	2.00
PEER_RX_CNT	T_PROFILE_PHARM_MEASURES	NUMBER	8.00	0.00
PERCENT_VARIANCE	T_CLM_AMT_VARIANCE	NUMBER	7.00	2.00

PERF_PROV_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
PERF_PROV_KEY	T_DS_DNTL_ICN	NUMBER	9.00	0.00
PHONE_NUMBER	T_WEB_USER	VARCHAR2	20.00	0.00
PHONE_SE	T_ACCOUNT_TEAM	CHAR	15.00	0.00
PHONE_SE	T_SETEAM_MEMBER	CHAR	15.00	0.00
PHONE_TESTER	T_PLOG_TESTER	CHAR	15.00	0.00
PLAN_CDE	T_LS_LVL1_PRICING	CHAR	3.00	0.00
PLAN_ID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	12.00	0.00
PLAN_ID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	12.00	0.00
PLAN_ID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	12.00	0.00
POLICY_NUMBER	T_DS_RECIP_SOBRA_APPL	VARCHAR2	15.00	0.00
POLICY_TYPE_DSC	T_POLICY_TYPE	CHAR	30.00	0.00
POS	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	2.00	0.00
POS_LTR	T_TRADING_PARTNER	VARCHAR2	1.00	0.00
PRESCR_PROV_ID	T_LS_PHARMACY_CLAIMS	CHAR	9.00	0.00
PREVIOUS_NDC	T_LS_DRUG_MASTER	CHAR	11.00	0.00
PRINT_CTL_FILE	T_RTE_RPT_CTL	VARCHAR	30.00	0.00
PRINT_VAR	T_RTE_RPT_CTL	CHAR	10.00	0.00
PRIOR_AUTH_NUM	T_PA_PAUTH	CHAR	10.00	0.00
PRI_PR_ID_DSP	T_PR_ID_TYPE	NUMBER	2.00	0.00
PRI_PR_ID_PRT	T_PR_ID_TYPE	NUMBER	2.00	0.00
PROCEDURE_CODE	T_ETG_SUMMARY	VARCHAR2	5.00	0.00
PROCEDURE_CODE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	5.00	0.00
PROCEDURE_CODE	T_ETG_SUMMARY_FFS	VARCHAR2	5.00	0.00
PROCEDURE_CODE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	5.00	0.00
PROCESSING_MODE	T_EDIC_REQUESTS	VARCHAR2	50.00	0.00
PROCESSING_MODE	T_EDIC_REQUESTS_ARC	VARCHAR2	50.00	0.00
PROCESS_ID	T_TRANSACTION	NUMBER	9.00	0.00
PROCESS_IND	T_FIN_PROCESS_AR	CHAR	1.00	0.00
PROCESS_IND	T_FIN_PROCESS_AR_DISP	CHAR	1.00	0.00
PROCESS_IND	T_FIN_PROCESS_AR_XREF	VARCHAR2	18.00	0.00

PROCESS_IND	T_FIN_PROCESS_DNTL	CHAR	1.00	0.00
PROCESS_IND	T_FIN_PROCESS_PHRM	CHAR	1.00	0.00
PROCESS_IND	T_FIN_PROCESS_PHYS	CHAR	1.00	0.00
PROCESS_IND	T_FIN_PROCESS_UB92	CHAR	1.00	0.00
PROC_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_CDE	T_LS_LVL1_PRICING	CHAR	5.00	0.00
PROC_CODE	T_WEB_CLAIM_DTL	CHAR	5.00	0.00
PROC_CODE	T_WEB_PA_DTL	CHAR	5.00	0.00
PROC_DATE_PRIN	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
PROC_FLAG_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_FLAG_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_FLAG_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_FLAG_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_FLAG_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_FLAG_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_MOD_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_MOD_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00

PROC_MOD_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_MOD_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_MOD_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_MOD_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
PROC_NUMB	T_TRADING_PARTNER	VARCHAR2	10.00	0.00
PROC_PRIOR	T_AGREEMENTS	VARCHAR2	1.00	0.00
PROC_PRIOR	T_TRADSTAT	VARCHAR2	1.00	0.00
PROC_PRIOR	T_TRLOG	VARCHAR2	1.00	0.00
PRODUCT_NAME	T_MB_HEDIS_DRUG	VARCHAR2	100.00	0.00
PROG_TYPE	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
PROG_TYPE	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
PROG_TYPE	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	1.00	0.00
PROVIDER	T_PA_LTCA_UPD_HDR	CHAR	15.00	0.00
PROVIDER_ID	T_PR_STUDY_GRP1	CHAR	15.00	0.00
PROVIDER_ID	T_PR_STUDY_GRP2	CHAR	15.00	0.00
PROVIDER_ID	T_PR_STUDY_GRP3	CHAR	15.00	0.00
PROVIDER_ID	T_PR_STUDY_GRP4	CHAR	15.00	0.00
PROVIDER_ID	T_PR_STUDY_GRP5	CHAR	15.00	0.00
PROVIDER_LOCATION	T_PA_LTCA_UPD_HDR	CHAR	1.00	0.00
PROVIDER_NUMBER	T_PA_DDSD_UPD_HDR	CHAR	15.00	0.00
PROVIDER_NUMBER	T_PA_HCBW_UPD_HDR	CHAR	15.00	0.00
PROVIDER_PREFIX	T_PA_DDSD_UPD_HDR	CHAR	1.00	0.00
PROVIDER_PREFIX	T_PA_HCBW_UPD_HDR	CHAR	1.00	0.00
PROV_ADDR_1	T_WEB_PROV_ADDR	CHAR	26.00	0.00
PROV_ADDR_2	T_WEB_PROV_ADDR	CHAR	26.00	0.00
PROV_ADDR_CITY	T_WEB_PROV_ADDR	CHAR	16.00	0.00
PROV_AVG_AGE	T_PROFILE_AVG_AGE	NUMBER	4.00	0.00
PROV_BILLING	T_CPAS_EXTRACT	NUMBER	9.00	0.00
PROV_BILLING	T_CPAS_SPLIT	NUMBER	9.00	0.00
PROV_BILLING	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_DENY_UB92_HDR	NUMBER	9.00	0.00

PROV_BILLING	T_MEDPOL_UB92	NUMBER	9.00	0.00
PROV_BILLING	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
PROV_BILLING	T_MPHX_INPT_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_MPHX_INPT_HDR2	NUMBER	9.00	0.00
PROV_BILLING	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
PROV_BILLING	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
PROV_BILLING	T_PD_DNTL_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_PD_PHARM_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_PD_PHYS_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_PD_UB92_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_PR_PROV_YTD_AMT	NUMBER	9.00	0.00
PROV_BILLING	T_PR_YTD_AMT_HIST	NUMBER	9.00	0.00
PROV_BILLING	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
PROV_BILLING	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
PROV_BILLING	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
PROV_CNT	T_PF_INPAT_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_INPAT_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_NHOME_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_NHOME_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_OUTPAT_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_OUTPAT_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PHARM_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PHARM_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PROF_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PROF_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PRREF_RE_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_PRREF_RP_TOT_Q	NUMBER	8.00	0.00
PROV_CNT	T_PF_RECIP_CMPR	NUMBER	8.00	0.00
PROV_CNT	T_PF_RE_CMPR_Q	NUMBER	8.00	0.00

PROV_FULL_NAME	T_PROFILE_PROV_ADDR	VARCHAR2	30.00	0.00
PROV_ID	T_LS_PHARMACY_CLAIMS	CHAR	9.00	0.00
PROV_ID	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	12.00	0.00
PROV_ID	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	12.00	0.00
PROV_ID	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	12.00	0.00
PROV_ID	T_PROFILE_AVG_AGE	CHAR	15.00	0.00
PROV_ID	T_PROFILE_DISTINCT_PROVS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_INFO_SOLUTIONS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_INPAT_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_INPAT_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_INPAT_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_MEASURES	CHAR	15.00	0.00
PROV_ID	T_PROFILE_MM_RECIP	CHAR	15.00	0.00
PROV_ID	T_PROFILE_MORBIDITY_INDEX	CHAR	15.00	0.00
PROV_ID	T_PROFILE_NHRECIPS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_OUTPAT_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_OUTPAT_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_OUTPAT_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PEER_PROV_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARMREF_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARMREF_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARMREF_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARM_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARM_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARM_MEASURES	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARM_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PHARM_TOP_DRUGS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROFREF_AMTS	CHAR	15.00	0.00

PROV_ID	T_PROFILE_PROFREF_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROFREF_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROF_AMTS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROF_ICN_XREF	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROF_PROV_TOT	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROV_AVERAGES	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROV_NON_REFER	CHAR	15.00	0.00
PROV_ID	T_PROFILE_PROV_SPEC	CHAR	15.00	0.00
PROV_ID	T_PROFILE_RANKINGS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_RPT_GRAPHS	CHAR	15.00	0.00
PROV_ID	T_PROFILE_SELECTED_CASES	CHAR	15.00	0.00
PROV_ID	T_PROFILE_TOT_CMPR	CHAR	15.00	0.00
PROV_ID_SVC	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	12.00	0.00
PROV_KEY	T_DS_HM_PROV_FY_XREF	NUMBER	9.00	0.00
PROV_NAME	T_WEB_PROV	CHAR	26.00	0.00
PROV_NUM	T_LS_LVL1_PRICING	CHAR	9.00	0.00
PROV_RE_CNT	T_PROFILE_RPT_GRAPHS	NUMBER	5.00	0.00
PROV_SPEC	T_PROFILE_ASM_MM_PEER	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_ASM_MM_PROV	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_AVG_AGE	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_DISTINCT_PROVS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_INFO_SOLUTIONS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_INPAT_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_INPAT_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_INPAT_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_MEASURES	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_MM_RECIP	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_MORBIDITY_INDEX	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_OUTPAT_AMTS	CHAR	3.00	0.00

PROV_SPEC	T_PROFILE_OUTPAT_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_OUTPAT_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PEER_PROV_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARMREF_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARMREF_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARMREF_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARM_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARM_MEASURES	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARM_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARM_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PHARM_TOP_DRUGS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PMPM_PROV	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROFREF_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROFREF_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROFREF_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROF_AMTS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROF_PROV_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROF_PT_TOT	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROV_AVERAGES	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROV_NON_REFER	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_PROV_SPEC	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_RANKINGS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_RPT_GRAPHS	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_SELECTED_CASES	CHAR	3.00	0.00
PROV_SPEC	T_PROFILE_TOT_CMPR	CHAR	3.00	0.00

PROV_SPEC	T_PROF_MM_PEER	CHAR	3.00	0.00
PROV_SPEC	T_PROF_MM_PROV	CHAR	3.00	0.00
PROV_STATE	T_WEB_PROV_ADDR	CHAR	2.00	0.00
PROV_TAXONOMY	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	12.00	0.00
PROV_TAXONOMY	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	12.00	0.00
PROV_TAXONOMY	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	12.00	0.00
PROV_TYPE	T_PROFILE_ASM_MM_PEER	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_ASM_MM_PROV	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_AVG_AGE	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_DISTINCT_PROVS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_INFO_SOLUTIONS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_INPAT_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_INPAT_PROV_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_INPAT_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_MEASURES	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_MM_RECIP	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_MORBIDITY_INDEX	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_OUTPAT_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_OUTPAT_PROV_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_OUTPAT_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PEER_PROV_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARMREF_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARMREF_PROV_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARMREF_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARM_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARM_MEASURES	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARM_PROV_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PHARM_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PMPM_PROV	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROFREF_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROFREF_PROV_TOT	CHAR	3.00	0.00

PROV_TYPE	T_PROFILE_PROFREF_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROF_AMTS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROF_PROV_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROF_PT_TOT	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROV_AVERAGES	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_PROV_NON_REFE R	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_RANKINGS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_RPT_GRAPHS	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_SELECTED_CASES	CHAR	3.00	0.00
PROV_TYPE	T_PROFILE_TOT_CMPR	CHAR	3.00	0.00
PROV_TYPE	T_PROF_MM_PEER	CHAR	3.00	0.00
PROV_TYPE	T_PROF_MM_PROV	CHAR	3.00	0.00
PROV_UNIQUE_ADDR	T_PROFILE_PROV_ADDR	VARCHAR2	200.00	0.00
PROV_UNIQUE_ID	T_PROFILE_PROV_ADDR	CHAR	15.00	0.00
PROV_ZIP	T_WEB_PROV_ADDR	CHAR	9.00	0.00
PRT_NUM_CPY	T_RTE_RPT_CTL	CHAR	2.00	0.00
QLF_1000A_TECH_CONTACT1	T_TPL_1000_PYR_TECH	CHAR	2.00	0.00
QLF_1000A_TECH_CONTACT2	T_TPL_1000_PYR_TECH	CHAR	2.00	0.00
QLF_1000A_TECH_CONTACT3	T_TPL_1000_PYR_TECH	CHAR	2.00	0.00
QLF_1000A_WEB_CONTACT	T_TPL_835_5010	CHAR	2.00	0.00
QLF_1000B_PAYEE	T_TPL_835_5010	CHAR	2.00	0.00
QLF_2010AA_PER03	T_CLM_DNTL_HDR	CHAR	2.00	0.00
QLF_2010AA_PER05	T_CLM_DNTL_HDR	CHAR	2.00	0.00
QLF_2010AA_PER07	T_CLM_DNTL_HDR	CHAR	2.00	0.00
QLF_2010AC_NM102	T_CLM_DNTL_HDR	CHAR	1.00	0.00
QLF_2010AC_NM102	T_CLM_PHYS_HDR	CHAR	1.00	0.00
QLF_2010AC_NM102	T_CLM_UB92_HDR	CHAR	1.00	0.00
QLF_2010AC_NM108	T_CLM_DNTL_HDR	CHAR	2.00	0.00
QLF_2010AC_NM108	T_CLM_PHYS_HDR	CHAR	2.00	0.00
QLF_2010AC_NM108	T_CLM_UB92_HDR	CHAR	2.00	0.00
QLF_2010AC_REF01	T_CLM_UB92_HDR	CHAR	3.00	0.00

QLF_2010AC_REF01_2ND	T_CLM_DNTL_HDR	CHAR	3.00	0.00
QLF_2010AC_REF01_2ND	T_CLM_PHYS_HDR	CHAR	3.00	0.00
QLF_2010AC_REF01_TAX	T_CLM_DNTL_HDR	CHAR	3.00	0.00
QLF_2010AC_REF01_TAX	T_CLM_PHYS_HDR	CHAR	3.00	0.00
QLF_2010AC_REF01_TAX	T_CLM_UB92_HDR	CHAR	3.00	0.00
QLF_2010BA_PER03	T_CLM_PHYS_HDR	CHAR	2.00	0.00
QLF_2010BA_PER05	T_CLM_PHYS_HDR	CHAR	2.00	0.00
QLF_2100_CLM_RCVD	T_TPL_2100_CLM_PYMT	CHAR	3.00	0.00
QLF_2100_COVRG_EXPIRED	T_TPL_2100_CLM_PYMT	CHAR	3.00	0.00
QLF_2100_OTH_SUB	T_TPL_2100_CLM_PYMT	CHAR	1.00	0.00
QLF_2100_OTH_SUB_CORR	T_TPL_2100_CLM_PYMT	CHAR	2.00	0.00
QLF_2110_SVC_POLICY	T_TPL_2110_SVC_PYMT	CHAR	3.00	0.00
QLF_2300_CLM05_2	T_CLM_DNTL_2300	CHAR	2.00	0.00
QLF_2300_CLM05_2	T_CLM_PHYS_2300	CHAR	2.00	0.00
QLF_2300_CRC01	T_CLM_UB92_2300	CHAR	2.00	0.00
QLF_2300_DTP01	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_DTP01	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_DTP01	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_DTP01_RECV	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_DTP02	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_DTP02	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_DTP02	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_DTP02_RECV	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI01_1	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_HI01_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00

QLF_2300_HI01_1_PROC	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI02_1	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_HI02_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI02_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI02_1_PAT_RSN	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI02_1_PROC	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI03_1	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_HI03_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI03_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI03_1_PAT_RSN	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI04_1	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_HI04_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI04_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI05_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI05_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI06_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI06_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI07_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI07_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI08_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI08_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI09_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI09_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI10_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI10_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI11_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00

QLF_2300_HI11_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_HI12_1_COND	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_HI12_1_EXT_CAUSE	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_REF01	T_CLM_UB92_2300	CHAR	3.00	0.00
QLF_2300_REF01_CARE_PLAN	T_CLM_PHYS_2300	CHAR	3.00	0.00
QLF_2300_REF01_CLM_ADJ	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2300_REF01_REPRIC_CLM	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2310C_PER03	T_CLM_PHYS_2300	CHAR	2.00	0.00
QLF_2310C_PER05	T_CLM_PHYS_2300	CHAR	2.00	0.00
QLF_2310E_NM102	T_CLM_DNTL_2300	CHAR	1.00	0.00
QLF_2310E_NM102	T_CLM_PHYS_2300	CHAR	1.00	0.00
QLF_2310E_NM108	T_CLM_DNTL_2300	CHAR	2.00	0.00
QLF_2310E_REF01_1	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2310E_REF01_2	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2310E_REF01_3	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2310E_REF01_4	T_CLM_DNTL_2300	CHAR	3.00	0.00
QLF_2310F_NM102	T_CLM_PHYS_2300	CHAR	1.00	0.00
QLF_2320_AMT01_COB	T_CLM_PHYS_2320	CHAR	3.00	0.00
QLF_2320_AMT01_COB_NON_COV	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2320_AMT01_PAT_LIAB	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2320_AMT01_PAT_LIAB	T_CLM_PHYS_2320	CHAR	3.00	0.00
QLF_2320_AMT01_PAT_LIAB	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330B_REF01	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330B_REF01	T_CLM_PHYS_2320	CHAR	3.00	0.00
QLF_2330B_REF01_CLM_ADJ	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330E_NM102	T_CLM_DNTL_2320	CHAR	1.00	0.00
QLF_2330E_NM102	T_CLM_UB92_2320	CHAR	1.00	0.00

QLF_2330E_REF01_1	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330E_REF01_1	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330E_REF01_2	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330E_REF01_2	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330E_REF01_3	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330E_REF01_3	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330E_REF01_4	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330F_NM102	T_CLM_DNTL_2320	CHAR	1.00	0.00
QLF_2330F_REF01_1	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330F_REF01_2	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330G_NM102	T_CLM_DNTL_2320	CHAR	1.00	0.00
QLF_2330G_NM102	T_CLM_PHYS_2320	CHAR	1.00	0.00
QLF_2330G_NM102	T_CLM_UB92_2320	CHAR	1.00	0.00
QLF_2330G_REF01	T_CLM_PHYS_2320	CHAR	3.00	0.00
QLF_2330G_REF01_1	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330G_REF01_1	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330G_REF01_2	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330G_REF01_2	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330G_REF01_3	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330G_REF01_3	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330G_REF01_4	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2330H_NM102	T_CLM_DNTL_2320	CHAR	1.00	0.00
QLF_2330H_REF01_1	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330H_REF01_2	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330H_REF01_3	T_CLM_DNTL_2320	CHAR	3.00	0.00
QLF_2330I_NM102	T_CLM_UB92_2320	CHAR	1.00	0.00
QLF_2330I_REF01_1	T_CLM_UB92_2320	CHAR	3.00	0.00

QLF_2330I_REF01_2	T_CLM_UB92_2320	CHAR	3.00	0.00
QLF_2400_DTP01	T_CLM_PHYS_2400	CHAR	3.00	0.00
QLF_2400_DTP01_START	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_DTP01_STOP	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_DTP02	T_CLM_PHYS_2400	CHAR	3.00	0.00
QLF_2400_DTP02_START	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_DTP02_STOP	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_HCP09	T_CLM_DNTL_2400	CHAR	2.00	0.00
QLF_2400_NTE01	T_CLM_PHYS_2400	CHAR	3.00	0.00
QLF_2400_NTE01	T_CLM_UB92_2400	CHAR	3.00	0.00
QLF_2400_PATIENT01	T_CLM_PHYS_2400	CHAR	2.00	0.00
QLF_2400_PWK05	T_CLM_PHYS_2400_PWK	CHAR	2.00	0.00
QLF_2400_REF01_ADJ_CTL	T_CLM_UB92_2400	CHAR	3.00	0.00
QLF_2400_REF01_REPRIC_CTL	T_CLM_UB92_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_CLM_ADJ	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_PAUTH_1	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_PAUTH_2	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_PAUTH_3	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_PAUTH_4	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_PAUTH_5	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REFER_1	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REFER_2	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REFER_3	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REFER_4	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REFER_5	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_REPRIC_CLM	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_SVC_PRE_1	T_CLM_DNTL_2400	CHAR	3.00	0.00

QLF_2400_REF04_1_SVC_PRE_2	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_SVC_PRE_3	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_SVC_PRE_4	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_REF04_1_SVC_PRE_5	T_CLM_DNTL_2400	CHAR	3.00	0.00
QLF_2400_UNIT01	T_CLM_PHYS_2400	CHAR	2.00	0.00
QLF_2420B_NM102	T_CLM_UB92_2400	CHAR	1.00	0.00
QLF_2420B_NM108	T_CLM_UB92_2400	CHAR	2.00	0.00
QLF_2420C_NM102	T_CLM_DNTL_2400	CHAR	1.00	0.00
QLF_2420C_NM102	T_CLM_UB92_2400	CHAR	1.00	0.00
QLF_2420C_NM108	T_CLM_DNTL_2400	CHAR	2.00	0.00
QLF_2420C_NM108	T_CLM_UB92_2400	CHAR	2.00	0.00
QLF_2420D_NM102	T_CLM_DNTL_2400	CHAR	1.00	0.00
QLF_2420D_NM102	T_CLM_UB92_2400	CHAR	1.00	0.00
QLF_2420D_NM108	T_CLM_DNTL_2400	CHAR	2.00	0.00
QLF_2420D_NM108	T_CLM_UB92_2400	CHAR	2.00	0.00
QLF_2420G_NM102	T_CLM_PHYS_2400	CHAR	1.00	0.00
QLF_2420H_NM102	T_CLM_PHYS_2400	CHAR	1.00	0.00
QLF_2430_AMT01	T_CLM_DNTL_2430_AMT	CHAR	3.00	0.00
QLF_2430_AMT01	T_CLM_UB92_2430	CHAR	3.00	0.00
QLF_2430_AMT01_PAT_LIAB	T_CLM_PHYS_2430	CHAR	3.00	0.00
QLF_837_LOOP	T_CDE_CLM_REF	CHAR	6.00	0.00
QLF_837_TXN	T_CDE_CLM_REF	CHAR	1.00	0.00
QLF_ADJUDICATION_DATE	T_INST_OTH_PYR_HDR	CHAR	3.00	0.00

QLF_ADJUDICATION_DTE_FMT	T_INST_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_ADMIT_DT_HOUR	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
QLF_ADMIT_DT_TM_FMT	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
QLF_AMOUNT	T_CLM_AMT	CHAR	3.00	0.00
QLF_APPROVED_AMOUNT	T_PHYS_DEXT_KEY	CHAR	3.00	0.00
QLF_ATTACHMENT	T_CLM_PWK	CHAR	2.00	0.00
QLF_CLAIM_ADJUD_DT	T_DNTL_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_CLAIM_ADJUD_DT	T_PROF_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_CLM_ADJUD_DT_FMT	T_DNTL_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_CLM_ADJUD_DT_FMT	T_PROF_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_CODE_LIST	T_CA_DIAG	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_CA_ICD9_PROC	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_CLM_DIAG_XREF	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_PHYS_COND	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_HDR_COND_X	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_HDR_DIAG_X	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_HDR_ICD9CM	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_HDR_OCC	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_HDR_VALUE	VARCHAR2	3.00	0.00
QLF_CODE_LIST	T_UB92_TREATMENT	VARCHAR2	3.00	0.00
QLF_DATE_SERVICE	T_AR_CLM_DTL	VARCHAR2	3.00	0.00
QLF_DATE_TIME	T_CLM_DTP	CHAR	3.00	0.00
QLF_DISCHARGE_TIME	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
QLF_DISCHARGE_TIME_FMT	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00

QLF_DTE	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_DTE_PATIENT_DEATH	T_CLM_SBR	VARCHAR2	3.00	0.00
QLF_DTE_TIME_PRD_FMT	T_CLM_DTP	CHAR	3.00	0.00
QLF_DTL_REF01	T_CLM_DNTL_DTL_REF	CHAR	3.00	0.00
QLF_DTL_REF01	T_CLM_PHYS_DTL_REF	CHAR	3.00	0.00
QLF_DTL_REF01	T_CLM_UB92_DTL_REF	CHAR	3.00	0.00
QLF_DTL_REF04_1	T_CLM_DNTL_DTL_REF	CHAR	3.00	0.00
QLF_DTL_REF04_1	T_CLM_PHYS_DTL_REF	CHAR	3.00	0.00
QLF_DTL_REF04_1	T_CLM_UB92_DTL_REF	CHAR	3.00	0.00
QLF_DT_PERIOD_FORMAT	T_UB92_HDR_ICD9CM	VARCHAR2	3.00	0.00
QLF_DT_PERIOD_FORMAT	T_UB92_HDR_OCC	VARCHAR2	3.00	0.00
QLF_ENTITY_ID	T_PA_HDR_PE_TRNSP	CHAR	1.00	0.00
QLF_ENTITY_ID	T_PA_HDR_PE_UMO	CHAR	1.00	0.00
QLF_ENTITY_TYPE	T_CLM_ENTITY	CHAR	3.00	0.00
QLF_ENTITY_TYPE	T_CLM_ENT_NM_ADR	CHAR	3.00	0.00
QLF_ENTITY_TYPE	T_CLM_PAYER_ENTITY	CHAR	3.00	0.00
QLF_ENTITY_TYPE	T_CLM_PYR_ENTNMADR	CHAR	3.00	0.00

QLF_ENTITY_TYPE	T_CLM_REF	CHAR	3.00	0.00
QLF_FACILITY	T_UB92_HDR_EXT_KEY	CHAR	2.00	0.00
QLF_FORMAT_DTE	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_HH_LAST_ADMIT	T_CLM_CR6	CHAR	3.00	0.00
QLF_HH_PERIOD_FMT	T_CLM_CR6	CHAR	3.00	0.00
QLF_HH_SURGICAL_PROC	T_CLM_CR6	CHAR	2.00	0.00
QLF_ID_PATIENT	T_AR_CLM_HDR	VARCHAR2	3.00	0.00
QLF_ID_PROVIDER	T_AR_CLM_HDR	VARCHAR2	3.00	0.00
QLF_ID_TAXONOMY	T_CLM_ENTITY	CHAR	3.00	0.00
QLF_ID_TYPE	T_835_CK_EFT_TRCNO	CHAR	2.00	0.00
QLF_ID_TYPE	T_PARTY_IDENTIFIER	CHAR	2.00	0.00
QLF_MEASUREMENT	T_CLM_MEA	CHAR	3.00	0.00
QLF_MISC_TYPE	T_CLM_MISC	VARCHAR2	5.00	0.00
QLF_OP_BENEFIT_STAGE_AMT	T_CLM_PHRM_COB_BENEFIT	CHAR	2.00	0.00
QLF_OP_PAT_RESP_AMT	T_CLM_PHRM_COB_PAT_RESP	CHAR	2.00	0.00
QLF_OTHR_SUB_DOB_FMT	T_DNTL_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_OTHR_SUB_DOB_FMT	T_INST_OTH_PYR_HDR	CHAR	3.00	0.00

QLF_OTHR_SUB_DOB_FMT	T_PROF_OTH_PYR_HDR	CHAR	3.00	0.00
QLF_PRESCRIPT_ID	T_CLM_NDC_DTL	CHAR	3.00	0.00
QLF_PROCEDURE_CODE	T_CLM_OTH_PYR_DTL	CHAR	2.00	0.00
QLF_PROCEDURE_CODE	T_DENTAL_DTL_KEYS	CHAR	2.00	0.00
QLF_PROCEDURE_ID	T_UB92_DTL_EXT_KEY	CHAR	2.00	0.00
QLF_PROCEDURE_QLF	T_PHYS_DEXT_KEY	CHAR	2.00	0.00
QLF_PROD_SERV_ID	T_CLM_NDC_DTL	CHAR	2.00	0.00
QLF_PROV_ID_TYPE	T_PR_ID_TYPE	CHAR	2.00	0.00
QLF_QUANTITY	T_CLM_HSD	CHAR	2.00	0.00
QLF_QUANTITY	T_CLM_QTY	CHAR	2.00	0.00
QLF_REFERENCE_DESC	T_CDE_CLM_REF	VARCHAR2	80.00	0.00
QLF_REFERENCE_ID	T_CDE_CLM_REF	CHAR	3.00	0.00
QLF_REFERENCE_ID	T_CLM_REF	CHAR	3.00	0.00
QLF_REFERENCE_ID	T_PAYER_REF	VARCHAR2	3.00	0.00
QLF_REF_ID	T_PA_HDR	CHAR	3.00	0.00
QLF_REF_ID_1	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_REF_ID_2	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_REF_ID_3	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_REF_ID_4	T_PA_HDR_PE_UMO	CHAR	3.00	0.00
QLF_REMARK	T_PAYER_REMARK	CHAR	3.00	0.00
QLF_STATEMENT_DATES	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00

QLF_STATEMENT_DT_FMT	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
QLF_SUB_DOB_FMT	T_DENTAL_HDR_KEYS	VARCHAR2	3.00	0.00
QLF_SUB_DOB_FMT	T_PHYS_HDR_KEY	CHAR	3.00	0.00
QLF_SUB_DOB_FMT	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
QLF_SVC_ADJUD_DTE	T_CLM_OTH_PYR_DTL	VARCHAR2	3.00	0.00
QLF_SVC_ADJUD_DTE_FMT	T_CLM_OTH_PYR_DTL	CHAR	3.00	0.00
QLF_SVC_DATE	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
QLF_SVC_DATE	T_DENTAL_HDR_KEYS	VARCHAR2	3.00	0.00
QLF_SVC_DATE_FMT	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
QLF_SVC_DATE_FMT	T_DENTAL_HDR_KEYS	VARCHAR2	3.00	0.00
QLF_SVC_LINE_DTE	T_PHYS_DEXT_KEY	CHAR	3.00	0.00
QLF_SVC_LINE_DTE	T_UB92_DTL_EXT_KEY	CHAR	3.00	0.00
QLF_SVC_LINE_DTE_FMT	T_PHYS_DEXT_KEY	CHAR	3.00	0.00
QLF_SVC_LINE_DTE_FMT	T_UB92_DTL_EXT_KEY	CHAR	3.00	0.00
QLF_TIME_PERIOD	T_CLM_HSD	CHAR	2.00	0.00
QLF_TOOTH_CODE_LIST	T_DENTAL_DTL_KEYS	VARCHAR2	3.00	0.00
QLF_TYPE_ORG	T_CLM_ENTITY	CHAR	2.00	0.00
QLF_TYPE_ORG	T_CLM_PAYER_ENTITY	CHAR	2.00	0.00
QTY	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	5.00	0.00
QTY	T_PROCESS_MOD	NUMBER	4.00	0.00
QTY_2400_HCP12	T_CLM_DNTL_2400	NUMBER	15.00	3.00
QTY_2400_UNIT02	T_CLM_PHYS_2400	NUMBER	15.00	3.00
QTY_ADJUSTED	T_CLM_EOB_XREF	NUMBER	15.00	3.00
QTY_ADJUSTMENT	T_CLM_CAS	NUMBER	15.00	3.00
QTY_ADJUSTMENT	T_PAYER_ADJUSTMENT	NUMBER	8.00	2.00
QTY_ADULT_SIZE	T_RE_CASE	CHAR	2.00	0.00
QTY_AGE	T_MEDPOL_UB92	NUMBER	4.00	0.00
QTY_AGE	T_MPHX_DENTAL_DTL	NUMBER	4.00	0.00
QTY_AGE	T_MPHX_INPT_HDR	NUMBER	4.00	0.00

QTY_AGE	T_MPHX_INPT_HDR2	NUMBER	4.00	0.00
QTY_AGE	T_MPHX_PHYS_DTL	NUMBER	4.00	0.00
QTY_AGE_BEGIN	T_COS_ASSIGN_CRIT	NUMBER	4.00	0.00
QTY_AGE_END	T_COS_ASSIGN_CRIT	NUMBER	4.00	0.00
QTY_AGE_FROM	T_PR_STATE_SHARE	NUMBER	3.00	0.00
QTY_AGE_MAX	T_AUDIT_AGEREST	NUMBER	4.00	0.00
QTY_AGE_MAX	T_DIAG_LIMIT	NUMBER	4.00	0.00
QTY_AGE_MAX	T_DRUG_LIMITS	NUMBER	4.00	0.00
QTY_AGE_MAX	T_ERX_FORMULARY	NUMBER	4.00	0.00
QTY_AGE_MAX	T_PROC_ICD9_LIM	NUMBER	4.00	0.00
QTY_AGE_MAX	T_PROC_LIMITS	NUMBER	4.00	0.00
QTY_AGE_MIN	T_AUDIT_AGEREST	NUMBER	4.00	0.00
QTY_AGE_MIN	T_DIAG_LIMIT	NUMBER	4.00	0.00
QTY_AGE_MIN	T_DRUG_LIMITS	NUMBER	4.00	0.00
QTY_AGE_MIN	T_ERX_FORMULARY	NUMBER	4.00	0.00
QTY_AGE_MIN	T_PROC_ICD9_LIM	NUMBER	4.00	0.00
QTY_AGE_MIN	T_PROC_LIMITS	NUMBER	4.00	0.00
QTY_AGE_TO	T_PR_STATE_SHARE	NUMBER	3.00	0.00
QTY_ALLOWED	T_CLM_PGM_XREF	NUMBER	15.00	3.00
QTY_ALLOWED	T_DENY_DNTL_DTL	NUMBER	7.00	2.00
QTY_ALLOWED	T_DENY_PHYS_DTL	NUMBER	15.00	3.00
QTY_ALLOWED	T_MPHX_DENTAL_DTL	NUMBER	6.00	2.00
QTY_ALLOWED	T_MPHX_PHYS_DTL	NUMBER	15.00	3.00
QTY_ALLOWED	T_PD_DNTL_DTL	NUMBER	7.00	2.00
QTY_ALLOWED	T_PD_PHYS_DTL	NUMBER	15.00	3.00
QTY_ALLOWED	T_SUSP_DENTAL_DTL	NUMBER	7.00	2.00
QTY_ALLOWED	T_SUSP_PHYS_DTL	NUMBER	15.00	3.00
QTY_ARTERIAL_BLOOD_GAS	T_CLM_CR5	NUMBER	10.00	0.00
QTY_BAL_UNITS	T_DR_DISPUTE_DTL	NUMBER	13.00	3.00
QTY_BILLED	T_CA_MATERNITY_CARE	NUMBER	15.00	3.00
QTY_BILLED	T_CC_HIST_ADJUST	NUMBER	8.00	2.00

QTY_BILLED	T_CLAIM_BDL_LABPANEL	NUMBER	6.00	2.00
QTY_BILLED	T_CLM_MAT_CARE_DTL	NUMBER	15.00	3.00
QTY_BILLED	T_DENY_DNTL_DTL	NUMBER	7.00	2.00
QTY_BILLED	T_DENY_PHYS_DTL	NUMBER	15.00	3.00
QTY_BILLED	T_MPHX_PHYS_DTL	NUMBER	15.00	3.00
QTY_BILLED	T_PD_DNTL_DTL	NUMBER	7.00	2.00
QTY_BILLED	T_PD_PHYS_DTL	NUMBER	15.00	3.00
QTY_BILLED	T_SUSP_DENTAL_DTL	NUMBER	7.00	2.00
QTY_BILLED	T_SUSP_PHYS_DTL	NUMBER	15.00	3.00
QTY_BILLED_ORIG	T_DENTAL_DTL_KEYS	NUMBER	7.00	2.00
QTY_BILLED_ORIG	T_PHYS_DEXT_KEY	NUMBER	15.00	3.00
QTY_BILLED_SUB	T_DENTAL_DTL_KEYS	NUMBER	7.00	2.00
QTY_BILLED_SUB	T_PHYS_DEXT_KEY	NUMBER	15.00	3.00
QTY_BILLED_SUB	T_UB92_DTL_EXT_KEY	NUMBER	9.00	2.00
QTY_CHILD_SIZE	T_RE_CASE	CHAR	2.00	0.00
QTY_CLAIM_ACTUAL	T_TMSIS_COT003_CLM_DTL	NUMBER	9.00	3.00
QTY_CLAIM_ACTUAL	T_TMSIS_CRX003_CLM_DTL	NUMBER	9.00	3.00
QTY_CLAIM_ALLOWED	T_TMSIS_COT003_CLM_DTL	NUMBER	9.00	3.00
QTY_CLAIM_ALLOWED	T_TMSIS_CRX003_CLM_DTL	NUMBER	9.00	3.00
QTY_COMMIT_FREQ	T_BATCH_RESTART	NUMBER	9.00	0.00
QTY_DAYS_FOL_UP	T_AR_INTEREST_RATE	NUMBER	4.00	0.00
QTY_DAYS_HISTORY	T_DRUG_SCREEN	NUMBER	9.00	0.00
QTY_DAYS_HISTORY	T_DRUG_SCREEN	NUMBER	9.00	0.00
QTY_DAYS_INTEND	T_PHRM_HDR_OPT	NUMBER	3.00	0.00

QTY_DAYS_SPLY_MAX	T_DRUG_LIMITS	NUMBER	4.00	0.00
QTY_DAYS_SPLY_MIN	T_DRUG_LIMITS	NUMBER	4.00	0.00
QTY_DCOR_MAX	T_DCOR_QLTY_CTL	NUMBER	9.00	0.00
QTY_DISPENSE	T_CA_DRUG	NUMBER	10.00	3.00
QTY_DISPENSE	T_DENY_PHRM_DTL	NUMBER	10.00	3.00
QTY_DISPENSE	T_DENY_PHRM_HDR	NUMBER	10.00	3.00
QTY_DISPENSE	T_MPHX_PHRM_DTL_AL	NUMBER	10.00	3.00
QTY_DISPENSE	T_PDUR_FINAL_CLM	NUMBER	10.00	3.00
QTY_DISPENSE	T_PDUR_SUSP	NUMBER	10.00	3.00
QTY_DISPENSE	T_PDUR_SUSP	NUMBER	10.00	3.00
QTY_DISPENSE	T_PD_PHARM_DTL	NUMBER	10.00	3.00
QTY_DISPENSE	T_PD_PHARM_HDR	NUMBER	10.00	3.00
QTY_DISPENSE	T_PRODUR_WARN	NUMBER	9.00	3.00
QTY_DISPENSE	T_PRODUR_WARN	NUMBER	10.00	3.00
QTY_DISPENSE	T_SUSP_PHRM_DTL	NUMBER	10.00	3.00
QTY_DISPENSE	T_SUSP_PHRM_HDR	NUMBER	10.00	3.00
QTY_DISPENSE_SUB	T_PHRM_DTL_KEYS	NUMBER	10.00	3.00
QTY_DISP_INTEND	T_PHRM_HDR_OPT	NUMBER	10.00	3.00
QTY_DME_DURATION	T_CLM_CR3	NUMBER	6.00	0.00
QTY_DOSE_RATIO	T_AUTO_PA_AGE	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_GRNDFTR	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	3.00
QTY_DOSE_RATIO	T_AUTO_PA_TXNMY	NUMBER	9.00	3.00
QTY_DRUG	T_LS_PHARMACY_CLAIMS	NUMBER	11.00	3.00
QTY_DRUG	T_LS_SUMMARY_NDC	NUMBER	11.00	3.00
QTY_DRUG_CASE_SZ	T_DRUG	NUMBER	9.00	0.00
QTY_DRUG_CASE_SZ	T_DRUG_DN	NUMBER	9.00	0.00
QTY_DRUG_PACK_SZ	T_DRUG	NUMBER	11.00	3.00

QTY_DRUG_PACK_SZ	T_DRUG_DN	NUMBER	11.00	3.00
QTY_DRUG_STRGTH	T_CDE_STRENGTH	NUMBER	11.00	3.00
QTY_DRUG_STRGTH	T_DRUG	NUMBER	11.00	3.00
QTY_DRUG_STRGTH_V	T_CDE_STRENGTH	NUMBER	7.00	3.00
QTY_DRUG_STRGTH_V	T_DRUG	NUMBER	7.00	3.00
QTY_DTL_METRIC_DECIMAL	T_TMSIS_CRX003_CLM_DTL	NUMBER	10.00	3.00
QTY_ERM_COUNT	T_ERM_HDR	NUMBER	4.00	0.00
QTY_ERM_DEPENDS	T_ERM_HDR	NUMBER	4.00	0.00
QTY_ERM_DEPTH	T_ERM_HDR	NUMBER	4.00	0.00
QTY_FFS_UNITS	T_DR_4002_RCPTS	NUMBER	13.00	3.00
QTY_FOLLOWUP	T_PROC_LIMITS	NUMBER	4.00	0.00
QTY_INCR_PRESCRIP	T_DR_INCR_ADJ	NUMBER	6.00	0.00
QTY_INCR_UNT_RMB	T_DR_INCR_ADJ	NUMBER	13.00	3.00
QTY_ITERATION	T_ERM_ENT	NUMBER	9.00	0.00
QTY_LIMIT_DOLL	T_LIMIT_PARM	NUMBER	9.00	2.00
QTY_LIMIT_DOLL	T_LIMIT_PARM	NUMBER	9.00	2.00
QTY_LIMIT_UNITS	T_LIMIT_PARM	NUMBER	9.00	2.00
QTY_LIMIT_UNITS	T_LIMIT_PARM	NUMBER	9.00	2.00
QTY_MAXIMUM_AGE	T_DRUG_GER	NUMBER	5.00	0.00
QTY_MAXIMUM_AGE	T_DRUG_PED	NUMBER	9.00	0.00
QTY_MAXIMUM_AGE	T_DRUG_PED_LOG	NUMBER	9.00	0.00

QTY_MAX_DAYS	T_ERX_FORMULARY	NUMBER	4.00	0.00
QTY_MAX_DOSE	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_MAX_DOSE	T_HIGH_DOSE	NUMBER	9.00	3.00
QTY_MAX_DOSE	T_HIGH_DOSE	NUMBER	12.00	6.00
QTY_MAX_DOSE	T_HIGH_DOSE_LOG	NUMBER	9.00	3.00
QTY_MAX_DOSE	T_PEDI_DOSE	NUMBER	12.00	6.00
QTY_MAX_DOSE_UNITS	T_GERI_DOSE	CHAR	3.00	0.00
QTY_MAX_FILLS	T_ERX_FORMULARY	NUMBER	4.00	0.00
QTY_MAX_UNIT	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_MAX_UNIT	T_HIGH_DOSE	NUMBER	7.00	3.00
QTY_MAX_UNIT	T_HIGH_DOSE	NUMBER	12.00	6.00
QTY_MAX_UNIT	T_HIGH_DOSE_LOG	NUMBER	7.00	3.00
QTY_MAX_UNIT	T_PEDI_DOSE	NUMBER	12.00	6.00
QTY_MAX_UNITS	T_ERX_FORMULARY	NUMBER	10.00	3.00
QTY_MAX_UNIT_FORM	T_GERI_DOSE	CHAR	2.00	0.00
QTY_MED_NECESSITY_LNTH	T_PHYS_DEXT_KEY	NUMBER	6.00	2.00
QTY_MINIMUM_AGE	T_DRUG_GER	NUMBER	5.00	0.00

QTY_MINIMUM_AGE	T_DRUG_PED	NUMBER	9.00	0.00
QTY_MINIMUM_AGE	T_DRUG_PED_LOG	NUMBER	9.00	0.00
QTY_MIN_DOSE	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_MIN_DOSE	T_LOW_DOSE	NUMBER	9.00	3.00
QTY_MIN_DOSE	T_LOW_DOSE	NUMBER	12.00	6.00
QTY_MIN_DOSE	T_LOW_DOSE_LOG	NUMBER	9.00	3.00
QTY_MIN_DOSE	T_PEDI_DOSE	NUMBER	12.00	6.00
QTY_MIN_DOSE_UNITS	T_GERI_DOSE	CHAR	3.00	0.00
QTY_MIN_UNIT	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_MIN_UNIT	T_LOW_DOSE	NUMBER	7.00	3.00
QTY_MIN_UNIT	T_LOW_DOSE	NUMBER	12.00	6.00
QTY_MIN_UNIT	T_LOW_DOSE_LOG	NUMBER	7.00	3.00
QTY_MIN_UNIT	T_PEDI_DOSE	NUMBER	12.00	6.00
QTY_MIN_UNIT_FORM	T_GERI_DOSE	CHAR	2.00	0.00
QTY_MME	T_CA_DRUG	NUMBER	9.00	4.00
QTY_MME	T_DENY_PHRM_DTL	NUMBER	9.00	4.00
QTY_MME	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	4.00

QTY_MME	T_PD_PHARM_DTL	NUMBER	9.00	4.00
QTY_MME	T_SUSP_PHRM_DTL	NUMBER	9.00	4.00
QTY_NDC	T_TMSIS_CIP003_CLM_DTL	NUMBER	9.00	3.00
QTY_NDC	T_TMSIS_CLT003_CLM_DTL	NUMBER	9.00	3.00
QTY_NDC	T_TMSIS_COT003_CLM_DTL	NUMBER	9.00	3.00
QTY_NEW_UNITS	T_DR_DISPUTE_RESO	NUMBER	13.00	3.00
QTY_ORTHO_MTHS_EST	T_DENTAL_HDR_KEYS	NUMBER	6.00	0.00
QTY_ORTHO_MTHS_LEFT	T_DENTAL_HDR_KEYS	NUMBER	6.00	0.00
QTY_OXYGEN_SATURATION	T_CLM_CR5	NUMBER	10.00	0.00
QTY_OXY_TRTMNT_PRD	T_CLM_CR5	NUMBER	6.00	0.00
QTY_PAID	T_AR_CLM_DTL	NUMBER	6.00	2.00
QTY_PAID	T_AR_CLM_DTL	NUMBER	10.00	3.00
QTY_PAID	T_MEDPOL_UB92	NUMBER	9.00	0.00
QTY_PAID	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
QTY_PAID	T_MPHX_PHYS_DTL	NUMBER	15.00	3.00
QTY_PRESCRIP	T_DR_DISPUTE_DTL	NUMBER	6.00	0.00
QTY_PRESCRIP	T_DR_INVOICE_DTL	NUMBER	6.00	0.00
QTY_PRESCRIP	T_DR_PPA_INV_DTL	NUMBER	6.00	0.00
QTY_REFILL	T_CA_DRUG	CHAR	2.00	0.00
QTY_REFILL	T_DENY_PHRM_HDR	CHAR	2.00	0.00
QTY_REFILL	T_DRUG_LIMITS	CHAR	2.00	0.00
QTY_REFILL	T_MPHX_PHRM_DTL_AL	NUMBER	2.00	0.00

QTY_REFILL	T_PDUR_SUSP	CHAR	2.00	0.00
QTY_REFILL	T_PDUR_SUSP	CHAR	2.00	0.00
QTY_REFILL	T_PD_PHARM_HDR	CHAR	2.00	0.00
QTY_REFILL	T_RETRO_SUMM_RECS	CHAR	2.00	0.00
QTY_REFILL	T_SUSP_PHRM_HDR	CHAR	2.00	0.00
QTY_RTN_FRM_PRV	T_PR_APPLN	NUMBER	4.00	0.00
QTY_RTN_FRM_PRV	T_PR_APPLN_WI	NUMBER	4.00	0.00
QTY_RTN_TO_PROV	T_PR_APPLN	NUMBER	4.00	0.00
QTY_RTN_TO_PROV	T_PR_APPLN_WI	NUMBER	4.00	0.00
QTY_SERVICE	T_CLM_OTH_PYR_DTL	NUMBER	15.00	2.00
QTY_SERVICE_ACTUAL	T_TMSIS_CIP003_CLM_DTL	NUMBER	9.00	3.00
QTY_SERVICE_ACTUAL	T_TMSIS_CLT003_CLM_DTL	NUMBER	9.00	3.00
QTY_SERVICE_ALLOWED	T_TMSIS_CIP003_CLM_DTL	NUMBER	9.00	3.00
QTY_SERVICE_ALLOWED	T_TMSIS_CLT003_CLM_DTL	NUMBER	9.00	3.00
QTY_SHELF_PACK	T_DRUG	NUMBER	9.00	0.00
QTY_SHELF_PACK	T_DRUG_DN	NUMBER	9.00	0.00
QTY_SHIPPER	T_DRUG	NUMBER	9.00	0.00
QTY_SHIPPER	T_DRUG_DN	NUMBER	9.00	0.00
QTY_STATE_MAX_UNIT	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_STATE_MAX_UNIT	T_HIGH_DOSE	NUMBER	7.00	3.00
QTY_STATE_MAX_UNIT	T_HIGH_DOSE	NUMBER	12.00	6.00
QTY_STATE_MAX_UNIT	T_HIGH_DOSE_LOG	NUMBER	7.00	3.00
QTY_STATE_MAX_UNIT	T_PEDI_DOSE	NUMBER	12.00	6.00

QTY_STATE_MIN_UNIT	T_GERI_DOSE	NUMBER	12.00	6.00
QTY_STATE_MIN_UNIT	T_LOW_DOSE	NUMBER	7.00	3.00
QTY_STATE_MIN_UNIT	T_LOW_DOSE	NUMBER	12.00	6.00
QTY_STATE_MIN_UNIT	T_LOW_DOSE_LOG	NUMBER	7.00	3.00
QTY_STATE_MIN_UNIT	T_PEDI_DOSE	NUMBER	12.00	6.00
QTY_SUPPLY_MAX	T_DRUG_LIMITS	NUMBER	10.00	3.00
QTY_SUPPLY_MAX	T_GCN_SEQNO_MIN_MAX	NUMBER	10.00	3.00
QTY_SUPPLY_MIN	T_DRUG_LIMITS	NUMBER	10.00	3.00
QTY_SUPPLY_MIN	T_GCN_SEQNO_MIN_MAX	NUMBER	10.00	3.00
QTY_TOTAL_UNITS_PD	T_DR_DISPUTE_DTL	NUMBER	13.00	3.00
QTY_TOTAL_UNITS_PD	T_DR_DISPUTE_RESO	NUMBER	13.00	3.00
QTY_TOTAL_UNITS_PD	T_DR_PAYMENT_XREF	NUMBER	13.00	3.00
QTY_TOT_CLM	T_PROFILE_PROV_AVERAGES	NUMBER	8.00	0.00
QTY_TOT_CLM_PEER	T_PROFILE_PROV_AVERAGES	NUMBER	8.00	0.00
QTY_TOT_UNITS_ALWD	T_CA_IND_AGGR	NUMBER	15.00	3.00
QTY_TOT_UNITS_BILLED	T_CA_IND_AGGR	NUMBER	15.00	3.00
QTY_TRANS_DISTANCE	T_CLM_CR1	NUMBER	5.00	0.00
QTY_TTL_UNT_RMB	T_DR_DISPUTE_DTL	NUMBER	13.00	3.00
QTY_TTL_UNT_RMB	T_DR_DISPUTE_RESO	NUMBER	13.00	3.00
QTY_TTL_UNT_RMB	T_DR_INVOICE_DTL	NUMBER	13.00	3.00
QTY_TTL_UNT_RMB	T_DR_PPA_INV_DTL	NUMBER	13.00	3.00
QTY_TXN_COUNT	T_BATCH_RESTART	NUMBER	9.00	0.00
QTY_UNITS_ADJUST	T_DR_DISPUTE_DTL	NUMBER	13.00	3.00
QTY_UNITS_ALWD	T_CA_HDR_DTL	NUMBER	15.00	3.00
QTY_UNITS_ALWD	T_MEDPOL_UB92	NUMBER	9.00	0.00
QTY_UNITS_ALWD	T_PD_UB92_DTL	NUMBER	9.00	0.00
QTY_UNITS_ALWD_1	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_10	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00

QTY_UNITS_ALWD_11	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_12	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_13	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_14	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_15	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_16	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_17	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_18	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_19	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_2	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_20	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_21	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_22	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_23	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_3	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_4	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_5	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_6	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_7	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_8	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_ALWD_9	T_CA_HDR_DTL_DN	NUMBER	15.00	3.00
QTY_UNITS_BILLED	T_CA_HDR_DTL	NUMBER	15.00	3.00
QTY_UNITS_BILLED	T_DENY_UB92_DTL	NUMBER	9.00	2.00
QTY_UNITS_BILLED	T_DR_CLMS_XREF	NUMBER	13.00	3.00
QTY_UNITS_BILLED	T_PD_UB92_DTL	NUMBER	9.00	2.00
QTY_UNITS_BILLED	T_SUSP_UB92_DTL	NUMBER	9.00	2.00
QTY_UNITS_MAX	T_COVERED_BENEFIT	NUMBER	9.00	0.00

QTY_UNITS_MAX	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00
QTY_UNITS_MAX	T_PROC_GLOBAL_LAB	NUMBER	9.00	0.00
QTY_UNITS_MAX	T_PROC_LIMITS	NUMBER	9.00	0.00
QTY_UNITS_MAX	T_REF_CCI_MUE	NUMBER	5.00	0.00
QTY_UNITS_MAX	T_REF_CCI_MUE_OVERRIDE	NUMBER	5.00	0.00
QTY_UNITS_MAX	T_REV_HOSPICE_XWALK	NUMBER	9.00	0.00
QTY_UNITS_MIN	T_COVERED_BENEFIT	NUMBER	9.00	0.00
QTY_UNITS_MIN	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00
QTY_UNITS_MIN	T_PROC_GLOBAL_LAB	NUMBER	9.00	0.00
QTY_UNITS_MIN	T_PROC_LIMITS	NUMBER	9.00	0.00
QTY_UNITS_MIN	T_REV_HOSPICE_XWALK	NUMBER	9.00	0.00
QTY_UNITS_REBATE	T_CA_DRUG_REBATE	NUMBER	13.00	3.00
QTY_UNITS_REBATE	T_DR_CLMS_XREF	NUMBER	13.00	3.00
QTY_UNITS_SVC_CALC	T_CLM_NDC_DTL	NUMBER	15.00	3.00
QTY_UNITS_SVC_SUB	T_CLM_NDC_DTL	NUMBER	15.00	3.00
QTY_UNITS__DUE	T_DR_DISPUTE_RESO	NUMBER	13.00	3.00
QTY_UNT_SVC_ATH	T_PA_LINE_ITEM	NUMBER	9.00	0.00
QTY_UNT_SVC_ATH	T_PA_LINE_ITEM	NUMBER	15.00	3.00
QTY_UNT_SVC_REQ	T_PA_LINE_ITEM	NUMBER	9.00	0.00
QTY_UNT_SVC_REQ	T_PA_LINE_ITEM	NUMBER	15.00	3.00
QTY_UNT_SVC_USD	T_PA_ITEM_DTL_XREF	NUMBER	15.00	3.00
QTY_VISITS	T_CLM_HSD	NUMBER	15.00	0.00
QUAL_PART_IND	T_MM_QUALIFIER	CHAR	1.00	0.00
QUEST_SENT_DESC	T_QUES_REC_CODE	CHAR	20.00	0.00
RACE	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
RACE_CDE_1	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00

RACE_CDE_2	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
RACE_CDE_3	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
RACE_CDE_4	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
RACE_CDE_5	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
RANK_ESC	T_CC_CR_SAVE	NUMBER	2.00	0.00
RATE_PRICE	T_CA_DRUG	CHAR	4.00	0.00
RATE_PRICE	T_PD_PHARM_DTL	CHAR	4.00	0.00
RATIO_CONV_FROM	T_DR_UNIT_CONV	NUMBER	8.00	4.00
RATIO_CONV_TO	T_DR_UNIT_CONV	NUMBER	8.00	4.00
RCOUNT	T_TRLOG	NUMBER	5.00	0.00
RCVR_ROUTE	T_AGREEMENTS	VARCHAR2	35.00	0.00
RCVR_ROUTE	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
RCVR_ROUTE	T_TRADSTAT	VARCHAR2	35.00	0.00
RCVR_ROUTE	T_TRLOG	VARCHAR2	35.00	0.00
RCVR_SUBID	T_AGREEMENTS	VARCHAR2	35.00	0.00
RCVR_SUBID	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
RCVR_SUBID	T_TRADSTAT	VARCHAR2	35.00	0.00
RCVR_SUBID	T_TRLOG	VARCHAR2	35.00	0.00
RCV_GSID	T_AGREEMENTS	VARCHAR2	35.00	0.00
RCV_GSID	T_TRADSTAT	VARCHAR2	35.00	0.00
RCV_IDCODE	T_AGREEMENTS	VARCHAR2	35.00	0.00
RCV_IDCODE	T_TRADSTAT	VARCHAR2	35.00	0.00
RCV_IDQUAL	T_AGREEMENTS	VARCHAR2	4.00	0.00
RCV_IDQUAL	T_TRADSTAT	VARCHAR2	4.00	0.00
RE	T_PROFILE_RANKINGS	NUMBER	8.00	0.00

REASON_IND	T_FIN_BUDG_DISP	CHAR	1.00	0.00
REASON_IND	T_FIN_PROCESS_BUDG_DISP	CHAR	1.00	0.00
RECIPIENT_ID	T_RE_STUDY_GRP1	CHAR	12.00	0.00
RECIPIENT_ID	T_RE_STUDY_GRP2	CHAR	12.00	0.00
RECIPIENT_ID	T_RE_STUDY_GRP3	CHAR	12.00	0.00
RECIPIENT_ID	T_RE_STUDY_GRP4	CHAR	12.00	0.00
RECIPIENT_ID	T_RE_STUDY_GRP5	CHAR	12.00	0.00
RECIPIENT_NUMBER	T_PA_LTCA_UPD_HDR	CHAR	12.00	0.00
RECIPNUM	T_PA_DDSD_UPD_HDR	CHAR	13.00	0.00
RECIPNUM	T_PA_HCBW_UPD_HDR	CHAR	13.00	0.00
RECIPNUM	T_PA_PC_UPD_HDR	CHAR	12.00	0.00
RECIP_AGE	T_ELIGCNT	CHAR	3.00	0.00
RECIP_BASE_ID	T_ETG_DTL	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_DTL_ENCNTR	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_DTL_FFS	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_DTL_RCO_PAID	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_RECIP_TOTS	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_RECIP_TOTS_ENCNTR	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_RECIP_TOTS_FFS	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_RECIP_TOTS_RCO_PAID	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_SUMMARY	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_SUMMARY_FFS	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	12.00	0.00
RECIP_BASE_ID	T_PF_RECIP_ACG	CHAR	12.00	0.00
RECIP_BASE_ID	T_PROFILE_MM_RECIP	CHAR	12.00	0.00
RECIP_BASE_ID	T_PROFILE_NHRECIPS	CHAR	12.00	0.00
RECIP_BASE_ID	T_PROFILE_RECIP_ACG	CHAR	12.00	0.00
RECIP_BASE_ID	T_PROFILE_RECP_OUTLIER	CHAR	12.00	0.00
RECIP_ID	T_PF_INPAT_RE_TOT_Q	CHAR	12.00	0.00
RECIP_ID	T_PF_NHOME_RE_TOT_Q	CHAR	12.00	0.00
RECIP_ID	T_PF_OUTPAT_RE_TOT_Q	CHAR	12.00	0.00
RECIP_ID	T_PF_PHARM_RE_TOT_Q	CHAR	12.00	0.00
RECIP_ID	T_PF_PROF_RE_TOT_Q	CHAR	12.00	0.00
RECIP_ID	T_PF_PRREF_RE_TOT_Q	CHAR	12.00	0.00

RECIP_ID	T_PF_RECIP_CMPR	CHAR	12.00	0.00
RECIP_ID	T_PF_RE_CMPR_Q	CHAR	12.00	0.00
RECIP_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
RECIP_KEY	T_CA_FIN	NUMBER	9.00	0.00
RECIP_KEY	T_CA_RECIP_KEY	NUMBER	9.00	0.00
RECIP_KEY	T_DS_HM_HEADER	NUMBER	9.00	0.00
RECIP_KEY_NEW	T_CA_RECIP_HIST	NUMBER	9.00	0.00
RECIP_KEY_OLD	T_CA_RECIP_HIST	NUMBER	9.00	0.00
RECIP_NAME	T_WEB_PA_HDR	CHAR	20.00	0.00
RECORD_ID	T_DR_CMS_TAPE	CHAR	4.00	0.00
RECORD_ID	T_DR_CMS_UROA	CHAR	4.00	0.00
RECORD_NAM	T_TRLOG	VARCHAR2	10.00	0.00
RECORD_NO	T_TRLOG	VARCHAR2	6.00	0.00
RECORD_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00
RECORD_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
RECORD_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
RECORD_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
RECV_CODE	T_TRLOG	VARCHAR2	35.00	0.00
RECV_QUAL	T_TRLOG	VARCHAR2	4.00	0.00
REC_RPT_QTR	T_MR_CMS64	NUMBER	6.00	0.00
REFER_PROV_KEY	T_CA_ANALYSIS	NUMBER	9.00	0.00
REFILL_LIMIT	T_LS_DRUG_MASTER	CHAR	2.00	0.00

RELATION_DESC	T_RELATION_CODE	CHAR	20.00	0.00
RELEASE_CH	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
REL_RQST	T_PROJ_TRACK	CHAR	11.00	0.00
REPLACE_NDC	T_LS_DRUG_MASTER	CHAR	11.00	0.00
REPORT_REQUEST	T_CASUALTY_CASE	CHAR	1.00	0.00
REPORT_REQUEST	T_CASUALTY_CASE_AL	CHAR	1.00	0.00
REQUEST	T_TRANSACTION	XMLTYPE	2,000.00	0.00
REQ_TABLE_NAME	T_PR_LOC_REQ_TABLE	CHAR	30.00	0.00
REQ_TABLE_ORDER	T_PR_LOC_REQ_TABLE	NUMBER	4.00	0.00
RESPONSE	T_TRANSACTION	XMLTYPE	2,000.00	0.00
RET_PERIOD	T_AUDIT_PURGE	NUMBER	9.00	0.00
REV_CODE	T_WEB_CLAIM_DTL	CHAR	3.00	0.00
RE_BASE_ID	T_PROFILE_INPAT_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_OUTPAT_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_PHARMREF_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_PHARM_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_PROFREF_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_PROF_ICN_XREF	CHAR	12.00	0.00
RE_BASE_ID	T_PROFILE_RECIP	CHAR	12.00	0.00
RE_CNT	T_PROFILE_INPAT_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_INPAT_GLOBALS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_INPAT_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_INPAT_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_INPAT_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_OUTPAT_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_OUTPAT_GLOBALS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_OUTPAT_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PEER_PROV_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARMREF_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARMREF_GLOBALS	NUMBER	8.00	0.00

RE_CNT	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARMREF_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_GLOBALS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PMPM_PROV	NUMBER	5.00	0.00
RE_CNT	T_PROFILE_PROFREF_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROFREF_GLOBALS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROFREF_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROFREF_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROFREF_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROF_AMTS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROF_GLOBALS	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROF_GRP_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROF_PROV_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_PROF_PT_TOT	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_SELECTED_CASES	NUMBER	8.00	0.00
RE_CNT	T_PROFILE_TOT_CMPR	NUMBER	8.00	0.00
RE_CNT	T_PROF_MM_PEER	NUMBER	8.00	0.00
RE_CNT_CLM	T_PROFILE_PROV_AVERAGES	NUMBER	8.00	0.00
RE_CNT_CLM_PEER	T_PROFILE_PROV_AVERAGES	NUMBER	8.00	0.00
RE_CNT_PEER	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	8.00	0.00
RE_EXCP	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00

RE_EXCP	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
RE_EXCP	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
RE_EXCP	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
RE_RANK	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
RISK	T_RISKS	VARCHAR2	4,000.00	0.00
RISK_ACTION	T_RISK_ACTIONS	CLOB	0.00	0.00
RISK_ACTION_TIMESTAMP	T_RISK_ACTIONS	DATE	0.00	0.00
RISK_ACTION_USERID	T_RISK_ACTIONS	VARCHAR2	200.00	0.00
RISK_PLAN_TYPE_DSC	T_RISK_PLAN_TYPE	VARCHAR2	200.00	0.00
ROLE_NAME	T_SEC_ROLE	VARCHAR2	64.00	0.00
ROUTE	T_MB_HEDIS_DRUG	VARCHAR2	100.00	0.00
ROUTE_DSC	T_LS_DRUG_MASTER	CHAR	10.00	0.00
RPT_CAT_CDE	T_PF_RECIP_CMPR	NUMBER	4.00	0.00
RPT_CAT_CDE	T_PF_RE_CMPR_Q	NUMBER	4.00	0.00

RPT_CAT_CDE	T_PF_RPT_CAT_DSC	NUMBER	4.00	0.00
RPT_CAT_DSC	T_PF_RPT_CAT_DSC	VARCHAR2	100.00	0.00
RPT_EXT_ROW	T_MR_WVR_CLM	NUMBER	2.00	0.00
RPT_FILE_NAME	T_RTE_RPT_CTL	VARCHAR	30.00	0.00
RPT_NAME	T_FIN_REPORT	CHAR	18.00	0.00
RPT_NO	T_TRLOG	VARCHAR2	2.00	0.00
RPT_QTR_END	T_MR_CMS64	DATE	0.00	0.00
RPT_SECT	T_MR_WVR_CLM	CHAR	5.00	0.00
RUN_DATE	T_TRLOG	DATE	0.00	0.00
RUN_ID	T_TRLOG	NUMBER	19.00	0.00
RX	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	8.00	0.00
RX_AMT	T_PROFILE_PHARM_MEASURES	NUMBER	10.00	2.00
RX_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00

RX_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
RX_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
RX_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
RX_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
RX_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
RX_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_CNT	T_PROFILE_PHARM_MEASURES	NUMBER	8.00	0.00
RX_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
RX_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
RX_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
RX_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
RX_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
RX_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
RX_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
RX_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
RX_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
RX_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
RX_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00

RX_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
RX_PEER	T_PROFILE_PHARM_TOP_DRUGS	NUMBER	10.00	0.00
SAK	T_CASH_RCPT_XREF	NUMBER	9.00	0.00
SAK	T_CHCK_CLM_XREF	NUMBER	9.00	0.00
SAK	T_CHRONO_NOTES	NUMBER	9.00	0.00
SAK	T_CLM_RU_MATCHED	NUMBER	9.00	0.00
SAK	T_DR_CLM_SAK	NUMBER	9.00	0.00
SAK	T_EVENT_TRACK	NUMBER	9.00	0.00
SAK	T_FIN_PROCESS_PYMT_XREF	NUMBER	9.00	0.00
SAK	T_NULL_SAK	NUMBER	9.00	0.00
SAK	T_PR_PHONE_TRACK	NUMBER	9.00	0.00
SAK	T_RTS_COMMENT	NUMBER	9.00	0.00
SAK	T_RTS_INFO	NUMBER	9.00	0.00
SAK	T_SYSTEM_KEYS	NUMBER	9.00	0.00
SAK	T_TPL_LAST_REPTD	NUMBER	9.00	0.00
SAK_835_TRACE	T_835_CK_EFT_TRCNO	NUMBER	9.00	0.00
SAK_835_TRACE	T_AR_CLM_DTL	NUMBER	9.00	0.00
SAK_835_TRACE	T_AR_CLM_HDR	NUMBER	9.00	0.00
SAK_835_TRACE	T_PAYER_ADJUSTMENT	NUMBER	9.00	0.00
SAK_835_TRACE	T_PAYER_REF	NUMBER	9.00	0.00
SAK_835_TRACE	T_PAYER_REMARK	NUMBER	9.00	0.00
SAK_835_TRACE	T_TPL_1000_PYR_TECH	NUMBER	9.00	0.00
SAK_835_TRACE	T_TPL_2100_CLM_PYMT	NUMBER	9.00	0.00
SAK_835_TRACE	T_TPL_2110_SVC_PYMT	NUMBER	9.00	0.00
SAK_835_TRACE	T_TPL_835_5010	NUMBER	9.00	0.00
SAK_ACCT_REC	T_ACCT_REC	NUMBER	9.00	0.00
SAK_ACCT_REC	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_CLAIM_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_CLM_DTL	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_CLM_HDR	NUMBER	9.00	0.00

SAK_ACCT_REC	T_AR_COLLECTION	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_COMMENTS	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_DISP	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_LETTERS	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_SUPP_DTL	NUMBER	9.00	0.00
SAK_ACCT_REC	T_AR_TXN_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_ACCT_REC	T_FIN_PROCESS_AR	NUMBER	9.00	0.00
SAK_ACCT_REC	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_ACCT_REC	T_FIN_PROCESS_AR_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_PAYER_ADJUSTMENT	NUMBER	9.00	0.00
SAK_ACCT_REC	T_PAYER_REF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_PAYER_REMARK	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_2100_CLM_PYMT	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_2110_SVC_PYMT	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_835_NCPDP_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_CLM_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_DISPS	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_CDE_PCN_AR	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_LEGACY_AR_XREF	NUMBER	9.00	0.00
SAK_ACCT_REC	T_TPL_PREBILL	NUMBER	9.00	0.00
SAK_ACTION	T_RU_ACTION	NUMBER	9.00	0.00
SAK_ACTION	T_RU_RULE_ACTION	NUMBER	9.00	0.00
SAK_ACTION_FAILS	T_RU_DECISION	NUMBER	9.00	0.00
SAK_ACTION_NOMATCH	T_RU_DECISION_VAR	NUMBER	9.00	0.00
SAK_ACTION_PASS	T_RU_DECISION	NUMBER	9.00	0.00
SAK_AC_PARENT	T_TPL_AC_PARENT	NUMBER	0.00	0.00

SAK_AC_PARENT	T_TPL_AC_PARENT	NUMBER	9.00	0.00
SAK_AC_PARENT	T_TPL_AC_PARENT_EMP_XREF	NUMBER	9.00	0.00
SAK_AC_PARENT	T_TPL_AC_PARENT_MED_XREF	NUMBER	9.00	0.00
SAK_AC_PARENT	T_TPL_AC_PARENT_RECIP_XREF	NUMBER	9.00	0.00
SAK_ADDRESS	T_IRS_W9_INFO	NUMBER	9.00	0.00
SAK_ADDRESS	T_PR_ADR_AL	NUMBER	9.00	0.00
SAK_ADDRESS	T_PR_ADR_CASS	NUMBER	9.00	0.00
SAK_ADDRESS	T_PR_HB_LIC	NUMBER	9.00	0.00
SAK_ADDRESS	T_RTS_INFO	NUMBER	9.00	0.00
SAK_ADD_PHONE	T_RE_BASE	NUMBER	9.00	0.00
SAK_ADD_TOX	T_PDUR_ADD_TOX	NUMBER	9.00	0.00
SAK_ADJ_RSN	T_CDE_CARC_RARC	NUMBER	9.00	0.00
SAK_ADJ_RSN	T_CDE_HIPAA_ADJRSN	NUMBER	9.00	0.00
SAK_ADJ_RSN	T_EOB_ADJRSN_XREF	NUMBER	9.00	0.00
SAK_ADJ_RSN	T_HIPAA_ADJRSN_XRF	NUMBER	9.00	0.00
SAK_ADPH_UUID	T_RE_ADPH_1095_ACK	NUMBER	9.00	0.00
SAK_ADPH_UUID	T_RE_ADPH_1095_REJECT	NUMBER	9.00	0.00
SAK_ADPH_UUID	T_RE_ADPH_1095_TRACK	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_CA_RECIP_KEY	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_AGE_GROUP	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_ELIG_SAK	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_POS	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_POS_RE	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_RE	NUMBER	9.00	0.00
SAK_AGE_GROUP	T_MR_RE_CNTY	NUMBER	9.00	0.00

SAK_AGE_GROUP	T_MR_RE_KY	NUMBER	9.00	0.00
SAK_AHFS_TYPE	T_AHFS_GROUP	NUMBER	9.00	0.00
SAK_AHFS_TYPE	T_AHFS_TYPE	NUMBER	9.00	0.00
SAK_AHFS_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_AHFS_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_AID_ELIG	T_RE_AID_ELIG	NUMBER	9.00	0.00
SAK_AID_ELIG	T_RE_AID_ELIG_DN	NUMBER	9.00	0.00
SAK_AID_GROUP	T_CA_AID_GROUP	NUMBER	9.00	0.00
SAK_AID_GROUP_NEW	T_CA_RECIP_HIST	NUMBER	9.00	0.00
SAK_AID_GROUP_OLD	T_CA_RECIP_HIST	NUMBER	9.00	0.00
SAK_AID_TYPE	T_REF_CDE_AID_GROUP	NUMBER	9.00	0.00
SAK_AID_TYPE	T_REF_CDE_AID_TYPE	NUMBER	9.00	0.00
SAK_ALLERGY	T_ALLERGY	NUMBER	9.00	0.00
SAK_ALLOWED_TRANSPORT	T_TP_ALLOWED_TRANSPORT	NUMBER	9.00	0.00
SAK_ALT_THERAPY	T_ERX_ALT_THERAPY	NUMBER	9.00	0.00
SAK_ALT_THERAPY	T_ERX_FORM_ALT_THERAPY	NUMBER	9.00	0.00
SAK_AR_INT_RATE	T_AR_COLLECTION	NUMBER	9.00	0.00
SAK_AR_INT_RATE	T_AR_INTEREST_RATE	NUMBER	9.00	0.00
SAK_ASNGMT_BENE	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_ASNGMT_BENE	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_ASNGMT_BENE	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_ASNGMT_BENE	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_ASNGMT_BENE	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_ASSIGN_PLAN	T_RE_ASSIGN_PLAN	NUMBER	9.00	0.00
SAK_ASSIGN_PLAN	T_RE_ASSIGN_PLAN_RLOC	NUMBER	9.00	0.00
SAK_ASSIGN_PLAN	T_RE_ASSIGN_REASON	NUMBER	9.00	0.00
SAK_ASSIGN_PLAN	T_RE_LTC_REQUEST	NUMBER	9.00	0.00
SAK_ATN	T_CALL_TRACK	NUMBER	9.00	0.00
SAK_ATN	T_PR_APPLN	NUMBER	9.00	0.00
SAK_ATN	T_PR_APPLN_COMMENT	NUMBER	9.00	0.00
SAK_ATN	T_PR_APPLN_RTP	NUMBER	9.00	0.00

SAK_ATN	T_PR_APPLN_STATUS_RSN	NUMBER	9.00	0.00
SAK_ATN	T_PR_APPLN_WI	NUMBER	9.00	0.00
SAK_ATTORNEY	T_ATTORNEY	NUMBER	9.00	0.00
SAK_ATTORNEY	T_ATTORNEY_FIRM_XREF	NUMBER	9.00	0.00
SAK_ATTORNEY	T_ATTORNEY_XREF	NUMBER	9.00	0.00
SAK_ATTORNEY	T_ATTORNEY_XREF_WI	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_AGE	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_GRNDFTR	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
SAK_AUTO_PA	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
SAK_BANK_ACCT	T_FIN_BANK_ACCT	NUMBER	9.00	0.00
SAK_BANK_ACCT	T_FIN_CYCLE_BNK_XREF	NUMBER	9.00	0.00
SAK_BANK_ACCT	T_FIN_PAYMENT	NUMBER	9.00	0.00
SAK_BASE_ING_DESC	T_MME_OPIOID_BASE_ING_DESC	NUMBER	9.00	0.00
SAK_BASE_PROC	T_BASE_ENDO_PROC	NUMBER	9.00	0.00
SAK_BATCH	T_BATCH_ERR_SUM	NUMBER	9.00	0.00
SAK_BATCH	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
SAK_BATCH	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
SAK_BATCH	T_CLM_BATCH_XREF	NUMBER	9.00	0.00
SAK_BATCH	T_ENC_BATCH_PROCESS	NUMBER	9.00	0.00
SAK_BDL_NCCD	T_CLAIM_BDL_OVERRIDE	NUMBER	9.00	0.00
SAK_BENEFIT	T_CLM_RU_MATCHED	NUMBER	9.00	0.00
SAK_BENEFIT	T_COVERED_BENEFIT	NUMBER	9.00	0.00
SAK_BENEFIT	T_COV_BNFT_BNFT	NUMBER	9.00	0.00
SAK_BENEFIT	T_GROUP_STD_BNFT	NUMBER	9.00	0.00
SAK_BENEFIT	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00

SAK_BENEFIT	T_PAY_BNFT_BNFT	NUMBER	9.00	0.00
SAK_BENEFIT	T_REIMB_AGREEMENT	NUMBER	9.00	0.00
SAK_BENEFIT	T_REIMB_BNFT_BNFT	NUMBER	9.00	0.00
SAK_BENEFIT_ADJ_FACTOR	T_BNFT_ADJ_FACTOR	NUMBER	9.00	0.00
SAK_BENEFIT_ADJ_FACTOR	T_BNFT_ADJ_FACTOR_XREF	NUMBER	9.00	0.00
SAK_BENEFIT_ADJ_FACTOR_TYPE	T_BNFT_ADJ_FACTOR	NUMBER	9.00	0.00
SAK_BENEFIT_ADJ_FACTOR_TYPE	T_BNFT_ADJ_FACTOR_TYPE	NUMBER	9.00	0.00
SAK_BENEFIT_LIMIT	T_CA_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_BENEFIT_LIMIT	T_CLM_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_BENEFIT_PLAN_GROUP	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_BENEFIT_PLAN_TYPE	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_ERX_ALT_THERAPY	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_BENEFIT_PLAN_TYPE	T_RE_ASSIGN_RSN_CODE	NUMBER	9.00	0.00
SAK_BNFT_COB_GRP	T_BNFT_PLAN_COB	NUMBER	9.00	0.00
SAK_BNFT_GROUP	T_BNFT_GROUP_STD	NUMBER	9.00	0.00
SAK_BNFT_GROUP	T_GROUP_STD_BNFT	NUMBER	9.00	0.00
SAK_BOARD_PART	T_BOARD_PART	NUMBER	9.00	0.00
SAK_BOARD_PART	T_PR_BOARD_MEM	NUMBER	9.00	0.00
SAK_BUDGET	T_ACCT_REC	NUMBER	9.00	0.00
SAK_BUDGET	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_BUDGET	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_BUDGET	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_BUDGET	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_BUDG_PERIOD	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_BUDGET	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00

SAK_BUDGET	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_BUDGET	T_TPL_AR_CAS_DISPS_ADJ	NUMBER	9.00	0.00
SAK_BUDGET	T_TPL_AR_DISPS	NUMBER	9.00	0.00
SAK_BUDGET	T_TPL_AR_DISPS_ADJ_AL	NUMBER	9.00	0.00
SAK_BUDGET	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00
SAK_BUDGET_ALT	T_FIN_BUDG_ALT	NUMBER	9.00	0.00
SAK_BUDGET_ASGN	T_FIN_BUDG_ALT	NUMBER	9.00	0.00
SAK_BUDGET_CHILD	T_FIN_BUDG_GRP	NUMBER	9.00	0.00
SAK_BUDGET_DEP	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_BUDGET_DISB	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_BUDGET_DISP	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_BUDGET_DISP	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00
SAK_BUDGET_PARENT	T_FIN_BUDG_GRP	NUMBER	9.00	0.00
SAK_BUDGET_RCP	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_BUDGET_RET	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_BUYA_ERROR	T_BUYA_ERROR	NUMBER	9.00	0.00
SAK_BUYA_EXCEPT	T_BUYA_EXCEPT	NUMBER	9.00	0.00
SAK_BUYA_EXCEPT	T_BUYA_MISMATCH	NUMBER	9.00	0.00
SAK_BUYA_MISMATCH	T_BUYA_EXCEPT	NUMBER	9.00	0.00
SAK_BUYA_MISMATCH	T_BUYA_MISMATCH	NUMBER	9.00	0.00
SAK_BUYB_ERROR	T_BUYB_ERROR	NUMBER	9.00	0.00
SAK_BUYB_EXCEPT	T_BUYB_EXCEPT	NUMBER	9.00	0.00
SAK_BUYB_EXCEPT	T_BUYB_MISMATCH	NUMBER	9.00	0.00
SAK_BUYB_MISMATCH	T_BUYB_EXCEPT	NUMBER	9.00	0.00
SAK_BUYB_MISMATCH	T_BUYB_MISMATCH	NUMBER	9.00	0.00

SAK_BUYIN	T_BUYA_BILL	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYA_BILL_INFO	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYA_PERD	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYA_PREM	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYB_BILL	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYB_BILL_INFO	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYB_PERD	NUMBER	4.00	0.00
SAK_BUYIN	T_BUYB_PREM	NUMBER	4.00	0.00
SAK_BUYIN	T_TPL_CAS_BI_XREF	NUMBER	4.00	0.00
SAK_BUY_DEMO_A	T_BUYA_DEMO_CHANGE	NUMBER	9.00	0.00
SAK_BUY_DEMO_B	T_BUYB_DEMO_CHANGE	NUMBER	9.00	0.00
SAK_CALL	T_CALL_NOTES	NUMBER	9.00	0.00
SAK_CALL	T_CALL_OTHER_INFO	NUMBER	9.00	0.00
SAK_CALL	T_CALL_QUESTION	NUMBER	9.00	0.00
SAK_CALL	T_CALL_TRACK	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_ADJ_STATE	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAPITATION_HIST_STATE	NUMBER	9.00	0.00

SAK_CAPITATION	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_CAPITATION	T_CAP_HIST_XREF	NUMBER	9.00	0.00
SAK_CAPITATION	T_CA_KICK_PYMT	NUMBER	9.00	0.00
SAK_CAPITATION	T_CLM_KICK_PYMT	NUMBER	9.00	0.00
SAK_CAPITATION	T_MC_CAP_CLM_XREF	NUMBER	9.00	0.00
SAK_CAPITATION	T_TPL_CAS_MC_XREF	NUMBER	9.00	0.00
SAK_CAPITATION_ADJ	T_CAP_ADJ_HIST_XREF	NUMBER	9.00	0.00
SAK_CAPITATION_ADJ	T_CAP_ADJ_XREF	NUMBER	9.00	0.00
SAK_CAPITATION_HIST	T_CAP_ADJ_HIST_XREF	NUMBER	9.00	0.00
SAK_CAPITATION_HIST	T_CAP_ADJ_XREF	NUMBER	9.00	0.00
SAK_CAPITATION_RATE	T_HIPP_CAPITATION_RATE	NUMBER	9.00	0.00
SAK_CAP_DEMOGRAPH	T_MC_CAP_DEMOGRAPH	NUMBER	9.00	0.00
SAK_CAP_DEMOGRAPH	T_MC_CAP_DEMOGRAPH_KY	NUMBER	9.00	0.00
SAK_CAP_SUMMARY	T_CAP_HIST_XREF	NUMBER	9.00	0.00
SAK_CAP_SUMMARY	T_CAP_SUMMARY	NUMBER	9.00	0.00
SAK_CAP_SUMMARY	T_CAP_SUMMARY_AL	NUMBER	9.00	0.00
SAK_CAP_SUMMARY	T_CAP_SUMMARY_WI	NUMBER	9.00	0.00
SAK_CAP_SUMMARY	T_CAP_SUMMARY_tmp	NUMBER	9.00	0.00
SAK_CARC_RARC	T_CA_ERROR	NUMBER	9.00	0.00
SAK_CARC_RARC	T_CDE_CARC_RARC	NUMBER	9.00	0.00
SAK_CARC_RARC	T_CLM_EOB_XREF	NUMBER	9.00	0.00
SAK_CARC_RARC	T_EOB_CARC_RARC_XREF	NUMBER	9.00	0.00
SAK_CARC_RARC_1	T_CA_ERROR_DN	NUMBER	9.00	0.00

SAK_CARC_RARC_2	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CARC_RARC_3	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CARC_RARC_4	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CARC_RARC_5	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CARC_RARC_6	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CARRIER	T_CARRIER_COV_XREF	NUMBER	9.00	0.00
SAK_CARRIER	T_CASUALTY_CASE	NUMBER	9.00	0.00
SAK_CARRIER	T_CASUALTY_CASE_AL	NUMBER	9.00	0.00
SAK_CARRIER	T_EMP_CARR_XREF	NUMBER	9.00	0.00
SAK_CARRIER	T_HIPP_PENDING	NUMBER	9.00	0.00
SAK_CARRIER	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_CARRIER	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
SAK_CARRIER	T_RE_MEDICARE_A	NUMBER	9.00	0.00
SAK_CARRIER	T_RE_MEDICARE_B	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_271_DEPENDENT	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_271_SUBSCRIBER	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00

SAK_CARRIER	T_TPL_CARRIER	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_CARRIER_AL	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_CARR_EXCEPT	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_CAR_SUB_XREF	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_CHECK_HOLD	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_CORR_ADDR	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_COV_PLAN_XREF	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_INS_DISC_STATS	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_PREBILL	NUMBER	9.00	0.00
SAK_CARRIER	T_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_CASE	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
SAK_CASE	T_HIPP_RECIP	NUMBER	9.00	0.00
SAK_CASE	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_CASE	T_RE_BASE	NUMBER	9.00	0.00
SAK_CASE	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_CASE	T_RE_CASE	NUMBER	9.00	0.00
SAK_CASE	T_RE_CASE_XREF	NUMBER	9.00	0.00
SAK_CASE	T_RE_SPEND_LIAB	NUMBER	9.00	0.00
SAK_CASE_GROUP	T_CM_CASE_GROUP	NUMBER	4.00	0.00
SAK_CASE_GROUP	T_CM_CG_CRIT	NUMBER	4.00	0.00
SAK_CASE_GROUP	T_CM_CG_PEERGRP	NUMBER	4.00	0.00
SAK_CASE_GROUP	T_CM_CG_TYPE	NUMBER	4.00	0.00
SAK_CASE_INFO	T_TPL_CASE_INFO	NUMBER	9.00	0.00
SAK_CASE_INFO	T_TPL_CASE_INFO_XREF	NUMBER	9.00	0.00
SAK_CASE_TYPE	T_CM_CASE_TYPE	NUMBER	4.00	0.00
SAK_CASE_TYPE	T_CM_CG_CRIT	NUMBER	4.00	0.00

SAK_CASE_TYPE	T_CM_CG_TYPE	NUMBER	4.00	0.00
SAK_CASE_TYPE	T_CM_CT_CRIT	NUMBER	4.00	0.00
SAK_CASE_XREF	T_RE_CASE_XREF	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_835_CK_EFT_TRCNO	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_ADJ_VOID_RQST	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_CASH_COMMENT	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_CASH_RCPT_XREF	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_CASH_RECEIPT	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_DR_PAYMENT_HDR	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_FIN_LOCKBOX_XREF	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_FIN_PROCESS_CASH_DISP	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_TPL_AR_DISPS	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00
SAK_CASH_RECEIPT	T_TPL_CHECK_HOLD	NUMBER	9.00	0.00
SAK_CASUALTY	T_ATTORNEY_XREF	NUMBER	9.00	0.00
SAK_CASUALTY	T_ATTORNEY_XREF_WI	NUMBER	9.00	0.00
SAK_CASUALTY	T_BATCH_LETTERS	NUMBER	9.00	0.00
SAK_CASUALTY	T_CASUALTY_CASE	NUMBER	9.00	0.00
SAK_CASUALTY	T_CASUALTY_CASE_AL	NUMBER	9.00	0.00
SAK_CASUALTY	T_CASUALTY_CASE_OFFLINE	NUMBER	9.00	0.00
SAK_CASUALTY	T_CASUALTY_REC	NUMBER	9.00	0.00
SAK_CASUALTY	T_CAS_CASE_ACT	NUMBER	9.00	0.00
SAK_CASUALTY	T_CAS_CLAIM_SUMM	NUMBER	9.00	0.00
SAK_CASUALTY	T_CAS_HIST_LETTERS	NUMBER	9.00	0.00
SAK_CASUALTY	T_CAS_REATT_INF	NUMBER	9.00	0.00
SAK_CASUALTY	T_INS_AGENT_XREF	NUMBER	9.00	0.00
SAK_CASUALTY	T_RELATED_CASES	NUMBER	9.00	0.00
SAK_CASUALTY	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_CASUALTY	T_TPL_CASE_INFO_XREF	NUMBER	9.00	0.00

SAK_CASUALTY	T_TPL_CASE_XREF	NUMBER	9.00	0.00
SAK_CASUALTY	T_TPL_CAS_BI_XREF	NUMBER	9.00	0.00
SAK_CASUALTY	T_TPL_CAS_MC_XREF	NUMBER	9.00	0.00
SAK_CASUALTY	T_TPL_LIEN	NUMBER	9.00	0.00
SAK_CASUALTY	T_TRTFEASR_XREF	NUMBER	9.00	0.00
SAK_CAS_REL_CASE	T_RELATED_CASES	NUMBER	9.00	0.00
SAK_CAS_SET	T_CASUALTY_REC	NUMBER	9.00	0.00
SAK_CAS_SET	T_CAS_REATT_INF	NUMBER	9.00	0.00
SAK_CAS_SET	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_CCI	T_REF_CCI	NUMBER	9.00	0.00
SAK_CCI	T_REF_CCI_OVERRIDE	NUMBER	9.00	0.00
SAK_CCI_MUE	T_REF_CCI_MUE	NUMBER	9.00	0.00
SAK_CCI_MUE	T_REF_CCI_MUE_OVERRIDE	NUMBER	9.00	0.00
SAK_CCI_MUE_OVERRIDE	T_REF_CCI_MUE_OVERRIDE	NUMBER	9.00	0.00
SAK_CCI_OVERRIDE	T_REF_CCI_OVERRIDE	NUMBER	9.00	0.00
SAK_CDE_ACTION	T_BATCH_ERR_ACT	NUMBER	9.00	0.00
SAK_CDE_ACTION	T_BATCH_ERR_MSG	NUMBER	9.00	0.00
SAK_CDE_AID	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_CDE_AID	T_ADJMS_AID_CAT	NUMBER	9.00	0.00
SAK_CDE_AID	T_AR_SUPP_DTL	NUMBER	9.00	0.00
SAK_CDE_AID	T_AVERAGE_EXPEND	NUMBER	9.00	0.00
SAK_CDE_AID	T_AVE_EXP_AC_XREF	NUMBER	9.00	0.00
SAK_CDE_AID	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_CDE_AID	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_CDE_AID	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_CDE_AID	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_CDE_AID	T_CDE_AID	NUMBER	9.00	0.00
SAK_CDE_AID	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_CDE_AID	T_COS_AID_CAT	NUMBER	9.00	0.00
SAK_CDE_AID	T_CPAS_AID_CAT	NUMBER	9.00	0.00
SAK_CDE_AID	T_CPAS_EXTRACT	NUMBER	9.00	0.00
SAK_CDE_AID	T_CPAS_SPLIT	NUMBER	9.00	0.00

SAK_CDE_AID	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_CDE_AID	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_CDE_AID	T_EXPENDITURE_SUPP_DTL	NUMBER	9.00	0.00
SAK_CDE_AID	T_MC_AID_GRP_XREF	NUMBER	9.00	0.00
SAK_CDE_AID	T_MC_CDE_AID_ENROLL	NUMBER	9.00	0.00
SAK_CDE_AID	T_MR_MSIS_AID	NUMBER	9.00	0.00
SAK_CDE_AID	T_PUB_HLTH_AID	NUMBER	9.00	0.00
SAK_CDE_AID	T_RE_AID_ELIG	NUMBER	9.00	0.00
SAK_CDE_AID	T_RE_RETRO_ELIG	NUMBER	9.00	0.00
SAK_CDE_AID_FROM	T_REF_CDE_AID_GROUP	NUMBER	9.00	0.00
SAK_CDE_AID_TO	T_REF_CDE_AID_GROUP	NUMBER	9.00	0.00
SAK_CDE_PHONE	T_CDE_PHONE	NUMBER	9.00	0.00
SAK_CDE_PHONE	T_RE_BASE	NUMBER	9.00	0.00
SAK_CDE_PHONE	T_RE_MULTI_ADDRESS	NUMBER	9.00	0.00
SAK_CDE_PHONE	T_RE_PHONE	NUMBER	9.00	0.00
SAK_CDE_RSN	T_IFFSA_AID_RSN	NUMBER	9.00	0.00
SAK_CHECK	T_CHECK_COMMENT	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHECK_BANNER	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_CLM_TYPE	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_FIN_CYCLE	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_PAYEE	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_PGM	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_PROV	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_PROV_TYP	NUMBER	9.00	0.00
SAK_CHECK_BANNER	T_CHK_BAN_PR_SPEC	NUMBER	9.00	0.00
SAK_CHILD_EXPECT	T_RE_CHILD_EXPECT	NUMBER	9.00	0.00
SAK_CHILD_HAD	T_RE_CHILD_HAD	NUMBER	9.00	0.00
SAK_CHILD_PGM	T_PGM_DEPENDENCY	NUMBER	9.00	0.00
SAK_CHK_REISSUE	T_CHK_REISSUE_XREF	NUMBER	9.00	0.00
SAK_CHRONO_NOTE	T_CHRONO_NOTES	NUMBER	9.00	0.00
SAK_CITIZEN_DSC	T_RE_BASE	NUMBER	9.00	0.00
SAK_CITIZEN_DSC	T_RE_BASE	NUMBER	9.00	0.00
SAK_CITIZEN_DSC	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_CITIZEN_DSC	T_RE_CITIZEN_DSC	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_DENT_XREF	NUMBER	9.00	0.00

SAK_CLAIM	T_ADJ_MASS_CLAIM	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_PHRM_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_PHYS_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_REV_RQST	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_UB92_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_ADJ_VOID_RQST	NUMBER	9.00	0.00
SAK_CLAIM	T_ATTACHMENT_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CAS_CLAIM_SUMM	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ATTACH	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ATTACH_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_COND	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_COND_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DENTAL	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DENT_VOID	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DIAG	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DIAG_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DIAG_MAT_CARE	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DRUG	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DRUG_REBATE	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_DRUG_VOID	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_EPSDT_ABNORMAL	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ERROR	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_HDR_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_HDR_DTL_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ICD9_PROC	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_ICD9_PROC_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_KICK_PYMT	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_LTC	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_MCO_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_OCCUR	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_OCCUR_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_PHYS	NUMBER	9.00	0.00

SAK_CLAIM	T_CA_PHYS_VOID	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_RCO	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_RECIP_HIST	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_TCN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_TPL_SUMMARY	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_UB92	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_UB92_VOID	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_VALUE	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_VALUE_DN	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_VOID_ALL	NUMBER	9.00	0.00
SAK_CLAIM	T_CA_XOVER	NUMBER	9.00	0.00
SAK_CLAIM	T_CC_CR_SAVE	NUMBER	9.00	0.00
SAK_CLAIM	T_CLAIM_ERROR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLAIM_INTEREST	NUMBER	9.00	0.00
SAK_CLAIM	T_CLAIM_LOCAT	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_ADJ_NCCI	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_AMT	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_BATCH_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CAS	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CN1	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CR1	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CR2	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CR3	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CR5	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CR6	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_CRC	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DIAG_XREF	NUMBER	9.00	0.00

SAK_CLAIM	T_CLM_DN2	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_2300	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_2300_DN2	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_2320	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_2400	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_2430_AMT	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_DTL_REF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DNTL_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DTL_TTH_SFC	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_DTP	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_ENTITY	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_ENT_NM_ADR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_EOB_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_HDR_CCF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_HDR_DELIVERY	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_HH_CARE_PLAN	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_HSD	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_K3	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_KICK_PYMT	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_LINK_UNLINK_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MAT_CARE_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MEA	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MIA	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MISC	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_MOA	NUMBER	9.00	0.00

SAK_CLAIM	T_CLM_MODIFIER	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_NCPDP_MSG	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_NDC_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_NTE	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_OTH_PYR_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PAYER_ENTITY	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHRM_CMPD_MOD	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHRM_COB_BENEFIT	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHRM_COB_PAT_RESP	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHRM_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_2300	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_2320	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_2400	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_2400_PWK	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_2430	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_DTL_REF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PHYS_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PROCESSED_EXTRAC T	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PWK	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PYR_ENTNMADR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_PYR_MOD	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_QTY	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_RCO	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_RECIP_HIST	NUMBER	9.00	0.00

SAK_CLAIM	T_CLM_REF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_RESUB_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_RU_MATCHED	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_SBR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_SUM_ERR_X	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_SYS_FIELDS_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_SYS_FIELDS_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_TPL_SUMMARY	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_2300	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_2320	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_2400	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_2430	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_DTL_REF	NUMBER	9.00	0.00
SAK_CLAIM	T_CLM_UB92_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_DENTAL_DTL_KEYS	NUMBER	9.00	0.00
SAK_CLAIM	T_DENTAL_HDR_KEYS	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_DNTL_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_PHRM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_DENY_UB92_HDR	NUMBER	9.00	0.00

SAK_CLAIM	T_DNTL_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_DR_CLMS_INV_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_DR_CLMS_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_DS_DNTL_ICN	NUMBER	9.00	0.00
SAK_CLAIM	T_DS_HM_DETAIL	NUMBER	9.00	0.00
SAK_CLAIM	T_DS_HM_HEADER	NUMBER	9.00	0.00
SAK_CLAIM	T_ETG_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_ETG_DTL_ENCNTR	NUMBER	9.00	0.00
SAK_CLAIM	T_ETG_DTL_FFS	NUMBER	9.00	0.00
SAK_CLAIM	T_ETG_DTL_RCO_PAID	NUMBER	9.00	0.00
SAK_CLAIM	T_FINAL_PHYS_XOVER	NUMBER	9.00	0.00
SAK_CLAIM	T_FINAL_UB92_XOVER	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_MAN_REJECT	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_PROCESS_DNTL	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_PROCESS_EOMB	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_PROCESS_PHRM	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_PROCESS_PHYS	NUMBER	9.00	0.00
SAK_CLAIM	T_FIN_PROCESS_UB92	NUMBER	9.00	0.00
SAK_CLAIM	T_HIST_DIRECTORY	NUMBER	9.00	0.00
SAK_CLAIM	T_INST_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_LOCATION_NOTE	NUMBER	9.00	0.00
SAK_CLAIM	T_MB_DEN_ICN	NUMBER	9.00	0.00
SAK_CLAIM	T_MB_NUM_ICN	NUMBER	9.00	0.00
SAK_CLAIM	T_MC_CAP_CLM_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_CLAIM	T_MEDPOL_UB92_DIAG	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_DSE_PROF	NUMBER	9.00	0.00

SAK_CLAIM	T_MPHX_INPT_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_INPT_HDR2	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_MISC	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_PH_DIAG	NUMBER	9.00	0.00
SAK_CLAIM	T_MPHX_XOVER	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_COPAY_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_ERROR_COUNTS	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_ERROR_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_OP_PERFORM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_PROV_PERFORM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_MR_WVR_CLM	NUMBER	9.00	0.00
SAK_CLAIM	T_NCPDP_P4_LOG	NUMBER	9.00	0.00
SAK_CLAIM	T_PA_ITEM_DTL_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_PBM_PHARM_EXTRACT	NUMBER	9.00	0.00
SAK_CLAIM	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_CLAIM	T_PDUR_RLHX	NUMBER	9.00	0.00
SAK_CLAIM	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_DNTL_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_PHARM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_PHRM_COB	NUMBER	9.00	0.00

SAK_CLAIM	T_PHRM_COB_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_PHRM_DTL_KEYS	NUMBER	9.00	0.00
SAK_CLAIM	T_PHRM_HDR_KEYS	NUMBER	9.00	0.00
SAK_CLAIM	T_PHRM_HDR_OPT	NUMBER	9.00	0.00
SAK_CLAIM	T_PHYS_COND	NUMBER	9.00	0.00
SAK_CLAIM	T_PHYS_DEXT_KEY	NUMBER	9.00	0.00
SAK_CLAIM	T_PHYS_HDR_KEY	NUMBER	9.00	0.00
SAK_CLAIM	T_PRODUR_WARN	NUMBER	9.00	0.00
SAK_CLAIM	T_PROF_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
SAK_CLAIM	T_RE_CLM_DELINK	NUMBER	9.00	0.00
SAK_CLAIM	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_CLAIM	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_CLAIM	T_SAK_ICN_DAILY	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_DENTAL_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_PHRM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_PHYS_XOVER	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_RLHX	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_SUSP_UB92_XOVER	NUMBER	9.00	0.00

SAK_CLAIM	T_TCN_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_TMSIS_CIP002_CLM_HDR	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CIP003_CLM_DTL	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CIP_DIAG	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CIP_HDR_PROC	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CIP_OCC_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CIP_REM_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CLT002_CLM_HDR	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CLT003_CLM_DTL	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CLT_DIAG	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CLT_OCC_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CLT_REM_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_COT002_CLM_HDR	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_COT003_CLM_DTL	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_COT_DIAG	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_COT_OCC_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_COT_REM_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CRX002_CLM_HDR	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CRX003_CLM_DTL	NUMBER	10.00	0.00
SAK_CLAIM	T_TMSIS_CRX_REM_CDE	NUMBER	10.00	0.00
SAK_CLAIM	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_CLAIM	T_TPL_AR_CLM_XREF	NUMBER	9.00	0.00
SAK_CLAIM	T_TPL_PREBILL	NUMBER	9.00	0.00
SAK_CLAIM	T_TPL_THRESHOLD_SUMM	NUMBER	9.00	0.00
SAK_CLAIM	T_TRANSACTION	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_DTL_EXT_KEY	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_DTL_OUTPAT_EDIT	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_DTL_OUTPAT_GROUP	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_DTL_OUTPAT_PRICE	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_COND_X	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_DIAG_X	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_EXT_KEY	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_ICD9CM	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_INP	NUMBER	9.00	0.00

SAK_CLAIM	T_UB92_HDR_INP_OLD	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_OCC	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_OUTPAT	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_OUTPAT_EDIT	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_PAYER	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_HDR_VALUE	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_NH_HDR	NUMBER	9.00	0.00
SAK_CLAIM	T_UB92_TREATMENT	NUMBER	9.00	0.00
SAK_CLAIM	T_WEB_CLAIM_DTL	NUMBER	9.00	0.00
SAK_CLAIM	T_WEB_CLAIM_HDR	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_ADJ_DENT_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_ADJ_PHRM_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_ADJ_PHYS_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_ADJ_UB92_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_AR_CLAIM_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_CA_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_CLM_LINK_UNLINK_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_FIN_PROCESS_AR_XREF	NUMBER	9.00	0.00
SAK_CLAIM_ADJ	T_SUSP_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM_BDL	T_CLAIM_BDL_NCCD	NUMBER	9.00	0.00
SAK_CLAIM_BDL	T_CLAIM_BDL_OVERRIDE	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_ADJ_DENT_XREF	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_ADJ_PHRM_XREF	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_ADJ_PHYS_XREF	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_ADJ_UB92_XREF	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_CA_ADJ_XREF	NUMBER	9.00	0.00
SAK_CLAIM_EVE	T_SUSP_ADJ_XREF	NUMBER	9.00	0.00

SAK_CLAIM_ORIGINAL	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
SAK_CLAIM_REF	T_CC_CR_SAVE	NUMBER	9.00	0.00
SAK_CLAIM_RELATED	T_CC_CR_SAVE	NUMBER	9.00	0.00
SAK_CLAIM_RELATED	T_CC_HIST_ADJUST	NUMBER	9.00	0.00
SAK_CLAIM_RELATED	T_CLM_ADJ_NCCI	NUMBER	9.00	0.00
SAK_CLAIM_RESPONSE	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
SAK_CLAIM_RESPONSE	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_CLAIM_RESPONSE	T_PDUR_RLHX	NUMBER	9.00	0.00
SAK_CLAIM_RESUB	T_CLM_RESUB_XREF	NUMBER	9.00	0.00
SAK_CLASS_HIERARCHY	T_BNFT_GROUP_STD	NUMBER	9.00	0.00
SAK_CLASS_HIERARCHY	T_CLASSIFICATION_BNFT	NUMBER	9.00	0.00
SAK_CLASS_HIERARCHY	T_CLASS_OBJECT_GROUP_X	NUMBER	9.00	0.00
SAK_CLASS_HIERARCHY	T_GROUP_STD_BNFT	NUMBER	9.00	0.00
SAK_CLASS_HIERARCHY	T_HIERARCHY_ATTRIBUTE	NUMBER	9.00	0.00
SAK_CLASS_OBJECT_GROUP	T_CLASS_OBJECT_GROUP	NUMBER	9.00	0.00
SAK_CLASS_OBJECT_GROUP	T_CLASS_OBJECT_GROUP_X	NUMBER	9.00	0.00
SAK_CLM	T_CPAS_EXTRACT	NUMBER	9.00	0.00
SAK_CLM	T_CPAS_SPLIT	NUMBER	9.00	0.00
SAK_CLM_ADDR	T_CLM_ADR_N3_N4	NUMBER	9.00	0.00
SAK_CLM_ADDR	T_CLM_ENT_NM_ADR	NUMBER	9.00	0.00
SAK_CLM_ADDR	T_CLM_PYR_ENTNMADR	NUMBER	9.00	0.00
SAK_CLM_CNT_PAID_DTE	T_DS_CLM_CNT_PAID_DTE	NUMBER	9.00	0.00
SAK_CLM_CNT_SVC_DTE	T_DS_CLM_CNT_SVC_DTE	NUMBER	9.00	0.00
SAK_CLM_DELINK	T_RE_CLM_DELINK	NUMBER	9.00	0.00
SAK_CLM_FCA	T_CLM_FCA	NUMBER	9.00	0.00
SAK_CLM_NAME	T_CLM_ENT_NM_ADR	NUMBER	9.00	0.00
SAK_CLM_NAME	T_CLM_NAME_NM1	NUMBER	9.00	0.00
SAK_CLM_NAME	T_CLM_PYR_ENTNMADR	NUMBER	9.00	0.00
SAK_CLOSE_MCD	T_RE_CLOSE_MCD	NUMBER	9.00	0.00
SAK_CNCRNT_MED_ALERTING	T_MME_OPIOID_CONCR_ALERT	NUMBER	9.00	0.00
SAK_CNTY_OFF	T_COUNTY_OFFICE	NUMBER	9.00	0.00

SAK_CNTY_OFF_SRV	T_RE_BASE	NUMBER	9.00	0.00
SAK_CNTY_OFF_SRV	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_CNTY_OFF_SRV	T_RE_ID_CRD_ISS	NUMBER	9.00	0.00
SAK_COIN_DE_PRM	T_COVERAGE_XREF	NUMBER	9.00	0.00
SAK_COIN_DE_PRM	T_TPL_COIN_DED	NUMBER	9.00	0.00
SAK_COMPARISON	T_RU_COMPARISON	NUMBER	9.00	0.00
SAK_COMPARISON	T_RU_CONDITION	NUMBER	9.00	0.00
SAK_CONDITION	T_RU_CONDITION	NUMBER	9.00	0.00
SAK_CONDITION	T_RU_RULE	NUMBER	9.00	0.00
SAK_CONDITION_LEFT	T_RU_CONDITION	NUMBER	9.00	0.00
SAK_CONDITION_RIGHT	T_RU_CONDITION	NUMBER	9.00	0.00
SAK_CONTRA	T_CONTRA_DISEASE	NUMBER	9.00	0.00
SAK_CONTRACTOR	T_TPL_CONTRACTOR	NUMBER	9.00	0.00
SAK_CONTRACTOR	T_TPL_CONT_FEE	NUMBER	9.00	0.00
SAK_CONT_FEE	T_TPL_CONT_FEE	NUMBER	9.00	0.00
SAK_CONT_TERM_SUSP	T_CT_CONT_TERM	NUMBER	9.00	0.00
SAK_COPAY_TYPE	T_MR_COPAY_CRIT	NUMBER	9.00	0.00
SAK_COPAY_TYPE	T_MR_COPAY_DTL	NUMBER	9.00	0.00
SAK_COPAY_TYPE	T_MR_COPAY_TYPE	NUMBER	9.00	0.00
SAK_COPAY_TYPE	T_MR_RECIP	NUMBER	9.00	0.00
SAK_COPAY_TYPE	T_MR_RECIP_KY	NUMBER	9.00	0.00
SAK_COUNTY_RATE	T_COUNTY_RATE	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_CLM_COVERED_ROLE	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COVERED_BENEFIT	NUMBER	9.00	0.00

SAK_COVERED_BNFT	T_COV_BNFT_BNFT	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_BNFT_BP	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_BNFT_MOD	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_BNFT_POS	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_BNFT_TYPE_SPEC	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_CT_XREF	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_COV_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_OCC_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_COVERED_BNFT	T_PAYER_PLAN_BENEFIT	NUMBER	9.00	0.00
SAK_COV_BNFT_NULL	T_COVERED_BENEFIT	NUMBER	9.00	0.00
SAK_COV_CND_AXIS_RANGE	T_COV_BNFT_CONDITION	NUMBER	9.00	0.00
SAK_COV_CND_AXIS_RANGE	T_COV_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_COV_MOD_AXIS_RANGE	T_COV_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_COV_OCC_AXIS_RANGE	T_COV_BNFT_OCCURR	NUMBER	9.00	0.00
SAK_COV_OCC_AXIS_RANGE	T_OCC_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_CRIT	T_CT_SELECT_LST	NUMBER	9.00	0.00

SAK_CRITERIA	T_AUTO_PA	NUMBER	9.00	0.00
SAK_CRITERIA_1	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
SAK_CRITERIA_1	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
SAK_CRITERIA_2	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
SAK_CRITERIA_2	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
SAK_CRITERIA_3	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00

SAK_CRITERIA_3	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
SAK_CRIT_TXN	T_FIN_SCHED_CRIT_STATUS	NUMBER	9.00	0.00
SAK_CRIT_TXN	T_FIN_SCHED_CRIT_TXN	NUMBER	9.00	0.00
SAK_CSE_CAT	T_CM_CASE_GROUP	NUMBER	4.00	0.00
SAK_CSE_CAT	T_CM_CASE_TYPE	NUMBER	4.00	0.00
SAK_CSE_CAT	T_CM_CSE_CAT	NUMBER	4.00	0.00
SAK_CTL	T_SYS_REPORT_CTL	NUMBER	9.00	0.00
SAK_CTL	T_SYS_REPORT_ROUTE	NUMBER	9.00	0.00
SAK_CURR_PGM_PROC	T_OBJECT_METH	NUMBER	9.00	0.00
SAK_CUST_STATUS	T_RE_CUST_STATUS	NUMBER	9.00	0.00
SAK_DATA_SOURCE	T_MM_DATA_SRCE	CHAR	1.00	0.00
SAK_DATA_SOURCE	T_MM_QUALIFIER	CHAR	1.00	0.00
SAK_DEATH_RPT	T_RE_DEATH_RPT	NUMBER	9.00	0.00
SAK_DEFAULT_PROVIDER	T_WEB_USER	NUMBER	9.00	0.00
SAK_DEMOGRAPHIC	T_RE_DEMOGRAPHIC	NUMBER	9.00	0.00
SAK_DEST	T_SYS_DEST	NUMBER	9.00	0.00
SAK_DEST	T_SYS_REPORT_ROUTE	NUMBER	9.00	0.00
SAK_DIAG	T_ADJMS_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_ALLERGY_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_BIRTH_WEIGHT	NUMBER	9.00	0.00
SAK_DIAG	T_CAS_AT_EXCLUSIONS	NUMBER	9.00	0.00
SAK_DIAG	T_CLM_DIAG_XREF	NUMBER	9.00	0.00
SAK_DIAG	T_DIAGNOSIS	NUMBER	9.00	0.00
SAK_DIAG	T_DIAG_COMPAT_GRP	NUMBER	9.00	0.00
SAK_DIAG	T_DIAG_LIMIT	NUMBER	9.00	0.00
SAK_DIAG	T_DIAG_NOTES	NUMBER	9.00	0.00
SAK_DIAG	T_DIAG_POS_LIM	NUMBER	9.00	0.00
SAK_DIAG	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_DIAG	T_DRG_DIAG_XWALK	NUMBER	9.00	0.00
SAK_DIAG	T_HIPP_RECIP	NUMBER	9.00	0.00
SAK_DIAG	T_MC_DIAG_RATE	NUMBER	9.00	0.00

SAK_DIAG	T_MEDPOL_UB92_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_MPHX_DSE_PROF	NUMBER	9.00	0.00
SAK_DIAG	T_MPHX_PH_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_DIAG	T_PDUR_PREG_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_PROC_DIAG_PA	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_MOD_XREF	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_TRNT_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_TRT_DGN_N	NUMBER	9.00	0.00
SAK_DIAG	T_RE_EPS_XREF_N	NUMBER	9.00	0.00
SAK_DIAG	T_SUR_RQST_DIAG	NUMBER	9.00	0.00
SAK_DIAG	T_UB92_HDR_DIAG_X	NUMBER	9.00	0.00
SAK_DIAG_1	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
SAK_DIAG_1	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
SAK_DIAG_1	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
SAK_DIAG_2	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
SAK_DIAG_2	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
SAK_DIAG_2	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
SAK_DIAG_2	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_DIAG_3	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
SAK_DIAG_3	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
SAK_DIAG_3	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
SAK_DIAG_3	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_DIAG_4	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_DIAG_COMPAT	T_CDE_DIAG_COMPAT	NUMBER	9.00	0.00
SAK_DIAG_COMPAT	T_DIAG_COMPAT_GRP	NUMBER	9.00	0.00
SAK_DIAG_COMPAT	T_PROC_DIAG_LIM	NUMBER	9.00	0.00
SAK_DIAG_DSE	T_DIAG_DSE_XREF	NUMBER	9.00	0.00
SAK_DIAG_FROM	T_AUDT_DIAG_XRF	NUMBER	9.00	0.00
SAK_DIAG_FROM	T_DIAG_GROUP	NUMBER	9.00	0.00
SAK_DIAG_FROM	T_PROC_ICD9_DIA	NUMBER	9.00	0.00
SAK_DIAG_FROM	T_RE_LOCK_DIAG_RNG	NUMBER	9.00	0.00
SAK_DIAG_FROM	T_TPL_RESTRICTION	NUMBER	9.00	0.00
SAK_DIAG_TO	T_AUDT_DIAG_XRF	NUMBER	9.00	0.00

SAK_DIAG_TO	T_DIAG_GROUP	NUMBER	9.00	0.00
SAK_DIAG_TO	T_PROC_ICD9_DIA	NUMBER	9.00	0.00
SAK_DIAG_TO	T_RE_LOCK_DIAG_RNG	NUMBER	9.00	0.00
SAK_DIAG_TO	T_TPL_RESTRICTION	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_AUTO_PA_COMOR_DIAG	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_AUTO_PA_PRIM_DIAG	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_AUTO_PA_SECD_DIAG	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_CLM_FCA	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_COS_ASSIGN_CRIT	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_DIAG_GROUP	NUMBER	4.00	0.00
SAK_DIAG_TYPE	T_DIAG_GROUP	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_DIAG_TYPE	NUMBER	4.00	0.00
SAK_DIAG_TYPE	T_DIAG_TYPE	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_STATE_COS	NUMBER	9.00	0.00
SAK_DIAG_TYPE	T_UB92_COS	NUMBER	4.00	0.00
SAK_DIAG_XWALK	T_DRG_DIAG_XWALK	NUMBER	9.00	0.00
SAK_DISPOSITION	T_AR_DISP	NUMBER	9.00	0.00
SAK_DISPOSITION	T_AR_DISP_COMM	NUMBER	9.00	0.00
SAK_DISPOSITION	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_DISPOSITION	T_FIN_PROCESS_LIEN_DISP	NUMBER	9.00	0.00
SAK_DISPOSITION	T_LIEN_DISP	NUMBER	9.00	0.00
SAK_DISPOSITION	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_DISPOSITION	T_TPL_AR_CAS_DISPS_ADJ	NUMBER	9.00	0.00
SAK_DISPOSITION	T_TPL_AR_DISPS	NUMBER	9.00	0.00
SAK_DISPOSITION	T_TPL_AR_DISPS_ADJ_AL	NUMBER	9.00	0.00
SAK_DISPOSITION	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00

SAK_DISPUTE	T_DR_DISPUTE	NUMBER	9.00	0.00
SAK_DISPUTE	T_DR_DISPUTE_DTL	NUMBER	9.00	0.00
SAK_DLY_MME_ALERT	T_MME_DAILY_MME_ALERTIN G	NUMBER	9.00	0.00
SAK_DOCUMENT_TRACK	T_DOCUMENT_TRACK	NUMBER	9.00	0.00
SAK_DOCUMENT_TRACK	T_DOCUMENT_TRANSACTION S	NUMBER	9.00	0.00
SAK_DOCUMENT_TRACK	T_FUNCTIONAL_ACKS	NUMBER	9.00	0.00
SAK_DOCUMENT_TRANSACTI ONS	T_DOCUMENT_TRANSACTION S	NUMBER	9.00	0.00
SAK_DOC_TYPE	T_CDE_DOC_TYPE	NUMBER	9.00	0.00
SAK_DOC_TYPE	T_SUPP_DOC_TYPE_XREF	NUMBER	9.00	0.00
SAK_DOMAIN	T_MM_DOMAIN	NUMBER	4.00	0.00
SAK_DOMAIN	T_MM_MEASURE_BASE	NUMBER	4.00	0.00
SAK_DOWNLOAD	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_DPV_TYPE	T_REF_CDE_DPV_GROUP	NUMBER	9.00	0.00
SAK_DPV_TYPE	T_REF_CDE_DPV_TYPE	NUMBER	9.00	0.00
SAK_DRG	T_ADJMS_DRG	NUMBER	9.00	0.00
SAK_DRG	T_DRG	NUMBER	9.00	0.00
SAK_DRG	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_DRG	T_DRG_INP_LOC	NUMBER	9.00	0.00
SAK_DRG	T_DRG_MDC	NUMBER	9.00	0.00
SAK_DRG	T_DRG_NOTES	NUMBER	9.00	0.00
SAK_DRG	T_DRG_RATE	NUMBER	9.00	0.00
SAK_DRG	T_PEER_GRP_DRGR_OLD	NUMBER	9.00	0.00
SAK_DRG	T_PR_DRG_RATE	NUMBER	9.00	0.00
SAK_DRG	T_UB92_HDR_INP	NUMBER	9.00	0.00
SAK_DRG	T_UB92_HDR_INP_OLD	NUMBER	9.00	0.00
SAK_DRG_CNCPT_LNK	T_MME_OPIOID_DRG_CONCEP T_L	NUMBER	9.00	0.00
SAK_DRG_CROSSWALK	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_DRG_DX_XWLK	T_DRG_DIAG_XWALK	NUMBER	9.00	0.00

SAK_DRG_ENHANCED	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_DRG_ENHANCED	T_UB92_HDR_INP_OLD	NUMBER	9.00	0.00
SAK_DRG_FROM	T_DRG_GROUP	NUMBER	9.00	0.00
SAK_DRG_HIGH	T_CA_UB92	NUMBER	9.00	0.00
SAK_DRG_HIGH	T_UB92_HDR_INP	NUMBER	9.00	0.00
SAK_DRG_PROC_XWLK	T_DRG_ICD9_XWALK	NUMBER	9.00	0.00
SAK_DRG_TO	T_DRG_GROUP	NUMBER	9.00	0.00
SAK_DRG_TYPE	T_DRG_GROUP	NUMBER	4.00	0.00
SAK_DRG_TYPE	T_DRG_TYPE	NUMBER	4.00	0.00
SAK_DRUG	T_ADJMS_DRUG	NUMBER	9.00	0.00
SAK_DRUG	T_AUDIT_NDC	NUMBER	9.00	0.00
SAK_DRUG	T_AUTO_PA_LTR	NUMBER	9.00	0.00
SAK_DRUG	T_CA_DRUG_REBATE	NUMBER	9.00	0.00
SAK_DRUG	T_CLM_NDC_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_COS_DRUG	NUMBER	9.00	0.00
SAK_DRUG	T_DENY_PHRM_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_DESI	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_AWP	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_CMSFDB_INFO	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_DN	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_HCPCS	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_INDICATOR	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_LIMITS	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_MAC	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_NOTES	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_PREV	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_PRICE	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_STATE_AL	NUMBER	9.00	0.00
SAK_DRUG	T_DRUG_S_MAC	NUMBER	9.00	0.00
SAK_DRUG	T_DR_4002_RCPTS	NUMBER	9.00	0.00
SAK_DRUG	T_DR_CLMS_XREF	NUMBER	9.00	0.00
SAK_DRUG	T_DR_DISPUTE_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_DR_DRUGS_INV	NUMBER	9.00	0.00
SAK_DRUG	T_DR_FUND_CODE_PERCENT	NUMBER	9.00	0.00
SAK_DRUG	T_DR_INCR_ADJ	NUMBER	9.00	0.00
SAK_DRUG	T_DR_INCR_PAY	NUMBER	9.00	0.00

SAK_DRUG	T_DR_INVOICE_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_DR_INV_COMMENT	NUMBER	9.00	0.00
SAK_DRUG	T_DR_INV_WRITEOFF	NUMBER	9.00	0.00
SAK_DRUG	T_DR_JCODE_XWALK	NUMBER	9.00	0.00
SAK_DRUG	T_DR_PAYMENT_XREF	NUMBER	9.00	0.00
SAK_DRUG	T_DR_PPA_INV_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_DR_RATE	NUMBER	9.00	0.00
SAK_DRUG	T_DR_RATE_UROA	NUMBER	9.00	0.00
SAK_DRUG	T_DR_STATUS_SUPPLE	NUMBER	9.00	0.00
SAK_DRUG	T_DR_UNIT_CONV	NUMBER	9.00	0.00
SAK_DRUG	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_DRUG	T_ERX_FORMULARY_RLINK	NUMBER	9.00	0.00
SAK_DRUG	T_ERX_FORM_ALT_THERAPY	NUMBER	9.00	0.00
SAK_DRUG	T_ERX_NDC_RLINK	NUMBER	9.00	0.00
SAK_DRUG	T_ERX_TEXT_CONCAT	NUMBER	9.00	0.00
SAK_DRUG	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_DRUG	T_NDC_LOOKUP_STATS	NUMBER	9.00	0.00
SAK_DRUG	T_NDDF_PRICE	NUMBER	9.00	0.00
SAK_DRUG	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_DRUG	T_PDL_MASTER	NUMBER	9.00	0.00
SAK_DRUG	T_PDL_MASTER_AL	NUMBER	9.00	0.00
SAK_DRUG	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
SAK_DRUG	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_DRUG	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG	T_PD_PHARM_DTL	NUMBER	9.00	0.00
SAK_DRUG	T_PRODUR_WARN	NUMBER	9.00	0.00
SAK_DRUG	T_REBATE	NUMBER	9.00	0.00
SAK_DRUG	T_RE_LOCK_DRUG	NUMBER	9.00	0.00
SAK_DRUG	T_STATE_DESI	NUMBER	9.00	0.00
SAK_DRUG	T_SUSP_PHRM_DTL	NUMBER	9.00	0.00
SAK_DRUG_ALT	T_ERX_FORM_ALT_THERAPY	NUMBER	9.00	0.00
SAK_DRUG_BASE_ING_MME_FACTOR	T_MME_OPIOID_RTD_ING_MME	NUMBER	9.00	0.00
SAK_DRUG_CLS	T_DRUG_THER_DUPE	NUMBER	9.00	0.00
SAK_DRUG_DISEASE	T_DRUG_DISEASE	NUMBER	9.00	0.00
SAK_DRUG_EXCEPTION	T_DRUG_EXCEPTION_AL	NUMBER	9.00	0.00
SAK_DRUG_FROM	T_DRUG_GROUP	NUMBER	9.00	0.00

SAK_DRUG_GEN	T_AUDIT_ST_MEM	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_CONTRA_DISEASE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DISEASE_INFERRED	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_AAC_PRICE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_DISEASE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_DN	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_DRUG_CRIT	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_DRUG_CRIT	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_GER	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_OVER_UTIL	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_PED	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_PREG	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_DRUG_UNDER_UTIL	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_GCN_SEQNO_MIN_MAX	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_GENERIC_DRUG	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_GERI_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_GFC_INGREDIENT	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_HIGH_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_HIGH_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_LOW_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_LOW_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_MME_OPIOID_CF_MME_FAC TOR	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_MME_OPIOID_MED_MASTER	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PDUR_ADD_TOX	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PEDI_DOSE	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PROC_GSN_XREF	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_PRODUR_WARN	NUMBER	9.00	0.00
SAK_DRUG_GEN	T_THERA_DURATION	NUMBER	9.00	0.00
SAK_DRUG_GEN_2	T_DRUG_DRUG_CRIT	NUMBER	9.00	0.00
SAK_DRUG_GEN_ORIG	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_DRUG_GER	T_DRUG_GER	NUMBER	9.00	0.00
SAK_DRUG_GER	T_DRUG_GER_LOG	NUMBER	9.00	0.00
SAK_DRUG_MANUF	T_DRUG	NUMBER	9.00	0.00
SAK_DRUG_MANUF	T_DRUG_DN	NUMBER	9.00	0.00

SAK_DRUG_MANUF	T_DRUG_MANUF	NUMBER	9.00	0.00
SAK_DRUG_MED_MASTER	T_MME_OPIOID_MED_MASTER	NUMBER	9.00	0.00
SAK_DRUG_PED	T_DRUG_PED	NUMBER	9.00	0.00
SAK_DRUG_PED	T_DRUG_PED_LOG	NUMBER	9.00	0.00
SAK_DRUG_PREG	T_DRUG_PREG	NUMBER	9.00	0.00
SAK_DRUG_PREG	T_DRUG_PREG_LOG	NUMBER	9.00	0.00
SAK_DRUG_PREV	T_DRUG_PREV	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DRUG	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DRUG_DN	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DRUG_LBLR	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DR_INVOICE	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DR_LATE_NOTICE	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DR_LBLR_CONTACT	NUMBER	9.00	0.00
SAK_DRUG_RBT_LBLR	T_DR_STATUS	NUMBER	9.00	0.00
SAK_DRUG_TC_ORIG	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_DRUG_THER_DUPE	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_GENERIC_DRUG	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_HICL_CLASS_XREF	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PDUR_FINAL_CLM	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_PRODUR_WARN	NUMBER	9.00	0.00
SAK_DRUG_THERA_CLS	T_THERAPEUTIC	NUMBER	9.00	0.00
SAK_DRUG_TO	T_DRUG_GROUP	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_AUTO_PA_STEP_THPY_1	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_AUTO_PA_STEP_THPY_2	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_DRUG_GROUP	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_DRUG_TYPE	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_DRUG_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_DSE_INFERRED	T_DISEASE_INFERRED	NUMBER	9.00	0.00
SAK_EDB	T_RE_EDB	NUMBER	9.00	0.00
SAK_EDB	T_RE_EDB_GHO	NUMBER	9.00	0.00

SAK_EDB	T_RE_EDB_HIC	NUMBER	9.00	0.00
SAK_EDB	T_RE_EDB_HOSPICE	NUMBER	9.00	0.00
SAK_EDB	T_RE_EDB_SSN	NUMBER	9.00	0.00
SAK_EDIT_PARM	T_EDIT_PARMS	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_DENTAL_HDR_KEYS	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_EDI_INTERCHANGE	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_PHRM_HDR_KEYS	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_PHYS_HDR_KEY	NUMBER	9.00	0.00
SAK_EDI_INTERCHANGE	T_UB92_HDR_EXT_KEY	NUMBER	9.00	0.00
SAK_ELIG_STOP	T_RE_ELIG	NUMBER	9.00	0.00
SAK_ELIG_STOP	T_RE_ELIG	NUMBER	9.00	0.00
SAK_ELIG_STOP	T_RE_ELIG_STOP	NUMBER	9.00	0.00
SAK_EMP	T_EMP_CARR_XREF	NUMBER	9.00	0.00
SAK_EMP	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_EMP	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
SAK_EMP	T_TPL_AC_PARENT_EMP_XREF	NUMBER	9.00	0.00
SAK_EMP	T_TPL_EMPLOYER	NUMBER	9.00	0.00
SAK_EMP	T_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_ENRL	T_PR_APPLN_STATUS	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_BOARD	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_CLIA	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_DISCLOSURE_ANS	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_DME	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_EFT_ACCT	NUMBER	9.00	0.00

SAK_ENRL	T_PR_ENRL_EFT_ERA	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_EFT_ERA_BACKUP	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_EFT_ERA_MAINT	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_GROUP	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_IDENTIFIER	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_LOC	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_LOC_PHONE	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_PROV	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_SPECIALTY	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_TAX_ID	NUMBER	9.00	0.00
SAK_ENRL	T_PR_ENRL_UPLOAD	NUMBER	9.00	0.00
SAK_ENTITY	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_ENT_RSN	T_RE_LOCKIN_PERIOD	NUMBER	9.00	0.00
SAK_ENT_RSN	T_RE_LOCK_ENT	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_DENT_XREF	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_MASS_CLAIM	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_MASS_RQST	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_PHRM_XREF	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_PHYS_XREF	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_REV_RQST	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_UB92_XREF	NUMBER	9.00	0.00
SAK_EOB	T_ADJ_VOID_RQST	NUMBER	9.00	0.00
SAK_EOB	T_CLAIM_ERROR	NUMBER	9.00	0.00

SAK_EOB	T_CLM_EOB_XREF	NUMBER	9.00	0.00
SAK_EOB	T_CLM_RESUB_XREF	NUMBER	9.00	0.00
SAK_EOB	T_EOB	NUMBER	9.00	0.00
SAK_EOB	T_EOB_ADJRSN_XREF	NUMBER	9.00	0.00
SAK_EOB	T_EOB_CARC_RARC_XREF	NUMBER	9.00	0.00
SAK_EOB	T_EOB_ERR_XREF	NUMBER	9.00	0.00
SAK_EOB	T_EOB_REMRKS_XREF	NUMBER	9.00	0.00
SAK_EOB	T_ESC_EOB_XREF	NUMBER	9.00	0.00
SAK_EOB	T_REGION_DISP	NUMBER	9.00	0.00
SAK_EOB	T_SUSP_ADJ_XREF	NUMBER	9.00	0.00
SAK_EOMB	T_CT_EOMB	NUMBER	9.00	0.00
SAK_ERROR_DISP	T_CCF_ERROR_DATA	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_CLAIM_ERROR	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_EOB_ERR_XREF	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_EOB_ERR_XREF	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_ERR_DISP_LINE	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_ERR_DISP_PT_PS_X	NUMBER	4.00	0.00

SAK_ERROR_DISP	T_REGION_DISP	NUMBER	4.00	0.00
SAK_ERROR_DISP	T_SYS_LOCATION	NUMBER	4.00	0.00
SAK_ERROR_TYPE	T_ERROR_GROUP	NUMBER	9.00	0.00
SAK_ERROR_TYPE	T_ERROR_TYPE	NUMBER	9.00	0.00
SAK_ESC	T_ADJMS_ERROR	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_AGEREST	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_AHFS	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_CL_TYPE_X	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_CRIT	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_CRIT_AL	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_ENC_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_GCN_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_GEN_SEQ_X	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_GPI_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_HICL_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_LOC_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_NDC	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_NDC_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_PAYER_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_PROC	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_PROC_MIRROR	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_PR_TYPE_X	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_REV	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_REV_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_ST	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_THER_CL_X	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_TOB_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDIT_TOOTH_NBR_X_AL	NUMBER	9.00	0.00
SAK_ESC	T_AUDT_DIAG_XRF	NUMBER	9.00	0.00
SAK_ESC	T_AUDT_PGM_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUDT_PROC_XRF	NUMBER	9.00	0.00
SAK_ESC	T_AUDT_SPC_XREF	NUMBER	9.00	0.00
SAK_ESC	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
SAK_ESC	T_BATCH_ERR_SUM	NUMBER	9.00	0.00
SAK_ESC	T_CA_ERROR	NUMBER	9.00	0.00
SAK_ESC	T_CCF_ERROR_DATA	NUMBER	9.00	0.00
SAK_ESC	T_CC_INDICATORS	NUMBER	9.00	0.00
SAK_ESC	T_CLAIM_ERROR	NUMBER	9.00	0.00
SAK_ESC	T_CLM_ADJ_NCCI	NUMBER	9.00	0.00
SAK_ESC	T_CONFLICT_PARM	NUMBER	9.00	0.00

SAK_ESC	T_CONTRA_PARM	NUMBER	9.00	0.00
SAK_ESC	T_CONTRA_PROC	NUMBER	9.00	0.00
SAK_ESC	T_CONTRA_PROC_EXPL	NUMBER	9.00	0.00
SAK_ESC	T_CONTRA_PROC_EXPL_MIRROR	NUMBER	9.00	0.00
SAK_ESC	T_DUPE_AUDIT	NUMBER	9.00	0.00
SAK_ESC	T_EDIT_PARMS	NUMBER	9.00	0.00
SAK_ESC	T_EDIT_RECYCLE	NUMBER	9.00	0.00
SAK_ESC	T_EOB_ERR_XREF	NUMBER	9.00	0.00
SAK_ESC	T_ERROR_DISP	NUMBER	9.00	0.00
SAK_ESC	T_ERROR_DISP_MMIS	NUMBER	9.00	0.00
SAK_ESC	T_ERROR_GROUP	NUMBER	9.00	0.00
SAK_ESC	T_ERR_DISP_LINE	NUMBER	9.00	0.00
SAK_ESC	T_ERR_DISP_NOTES	NUMBER	9.00	0.00
SAK_ESC	T_ERR_DISP_PT_PS_X	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_CLRFCTNS	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_CRIT	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_GRP_XREF	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_MTHD_CORR	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_NOTES	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_POLICY	NUMBER	9.00	0.00
SAK_ESC	T_ERR_RESO_STATUS	NUMBER	9.00	0.00
SAK_ESC	T_ESC_EOB_XREF	NUMBER	9.00	0.00
SAK_ESC	T_ESC_NCPDP_XREF	NUMBER	9.00	0.00
SAK_ESC	T_LIMITPARM_POS	NUMBER	9.00	0.00
SAK_ESC	T_LIMIT_PARM	NUMBER	9.00	0.00
SAK_ESC	T_PA_ESC	NUMBER	9.00	0.00
SAK_ESC	T_PR_EDIT_EXEMPT	NUMBER	9.00	0.00
SAK_ESC	T_READMIT_PARM	NUMBER	9.00	0.00
SAK_ESC	T_REGION_DISP	NUMBER	9.00	0.00
SAK_ESC	T_SUSP_RLHX	NUMBER	9.00	0.00
SAK_ESC	T_TYPE_SPEC_EXCL	NUMBER	9.00	0.00
SAK_ESC	T_UMBRELLA_PARM	NUMBER	9.00	0.00
SAK_ESC_1	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_ESC_2	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_ESC_3	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_ESC_4	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_ESC_5	T_CA_ERROR_DN	NUMBER	9.00	0.00

SAK_ESC_6	T_CA_ERROR_DN	NUMBER	9.00	0.00
SAK_EVENT	T_CDE_EVENT	NUMBER	9.00	0.00
SAK_EVENT	T_EVENT_TRACK	NUMBER	9.00	0.00
SAK_EVENT_KEY	T_CDE_EVENT_KEY	NUMBER	9.00	0.00
SAK_EVENT_KEY	T_EVENT_TRACK_KEYS	NUMBER	9.00	0.00
SAK_EVENT_TRACKING	T_EVENT_TRACK	NUMBER	11.00	0.00
SAK_EVENT_TRACKING	T_EVENT_TRACK_KEYS	NUMBER	11.00	0.00
SAK_EVENT_TRACK_KEYS	T_EVENT_TRACK_KEYS	NUMBER	9.00	0.00
SAK_EVS_ELIG	T_CLM_SYS_FIELDS_DTL	NUMBER	9.00	0.00
SAK_EVS_ELIG	T_EVS_ELIG	NUMBER	9.00	0.00
SAK_EXCLUDED_PGM	T_PGM_EXCLUSION	NUMBER	9.00	0.00
SAK_EXEMPT	T_TPL_EXEMPT	NUMBER	9.00	0.00
SAK_EXIT_RSN	T_RE_LOCKIN_PERIOD	NUMBER	9.00	0.00
SAK_EXIT_RSN	T_RE_LOCK_EXIT	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_EXPENDITURE_SUPP_DTL	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_EXPEND_COMMENT	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_EXPEND_TXN_XREF	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_HIPP_EXPEND_XREF	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_PR_DISPRO_EXPEND	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_TPL_AR_CAS_DISPS	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_TPL_AR_DISPS	NUMBER	9.00	0.00
SAK_EXPENDITURE	T_TPL_AR_DISPS_AL	NUMBER	9.00	0.00
SAK_EXPENSE	T_RE_EXPENSE	NUMBER	9.00	0.00
SAK_FACILITY	T_FACILITY	NUMBER	9.00	0.00
SAK_FACILITY	T_PR_FACILITY	NUMBER	9.00	0.00
SAK_FED_ACCT	T_FIN_FED_ACCT_AL	NUMBER	9.00	0.00
SAK_FED_ACCT	T_FIN_FUND_FED_XREF_AL	NUMBER	9.00	0.00
SAK_FICA_RATE	T_FICA_RATE	NUMBER	9.00	0.00
SAK_FILE	T_BATCH	NUMBER	9.00	0.00

SAK_FILE	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_FILE	T_DENTAL_HDR_KEYS	NUMBER	9.00	0.00
SAK_FILE	T_PHRM_HDR_KEYS	NUMBER	9.00	0.00
SAK_FILE	T_PHYS_HDR_KEY	NUMBER	9.00	0.00
SAK_FILE	T_TRANSACTION	NUMBER	9.00	0.00
SAK_FILE	T_UB92_HDR_EXT_KEY	NUMBER	9.00	0.00
SAK_FILE_CORRELATION	T_FILE_CORRELATION	NUMBER	9.00	0.00
SAK_FILE_DIRECTION	T_CDE_FILE_DIRECTION	NUMBER	9.00	0.00
SAK_FILE_DIRECTION	T_FILE_TRACK	NUMBER	9.00	0.00
SAK_FILE_DIRECTION	T_TP_CONFIG	NUMBER	9.00	0.00
SAK_FILE_LOCATION	T_CT_FILE_LOCATION	NUMBER	9.00	0.00
SAK_FILE_SOLICITED_TRACK	T_FILE_SOLICITED_TRACK	NUMBER	9.00	0.00
SAK_FILE_STATUS	T_CDE_FILE_STATUS	NUMBER	9.00	0.00
SAK_FILE_STATUS	T_FILE_TRACK	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_CLM_BATCH_PROCESS	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_CLM_BATCH_PROCESS_ENC	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_DOCUMENT_TRACK	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_EDIC_BATCH_MSGBOX	NUMBER	10.00	0.00
SAK_FILE_TRACK	T_EDIC_BATCH_MSGBOX_ARC	NUMBER	10.00	0.00
SAK_FILE_TRACK	T_EDIC_CORRELATION	NUMBER	10.00	0.00
SAK_FILE_TRACK	T_EDIC_CORRELATION_ARC	NUMBER	10.00	0.00
SAK_FILE_TRACK	T_FILE_SOLICITED_TRACK	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_FILE_TRACK	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_FILE_TRACK_EXCEPTION	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_TRACK_SUPP_DOC_XREF	NUMBER	9.00	0.00
SAK_FILE_TRACK	T_TRANSACTION	NUMBER	9.00	0.00
SAK_FILE_TRACK_EXCEPTION	T_FILE_TRACK_EXCEPTION	NUMBER	9.00	0.00
SAK_FILE_TRACK_REQUEST	T_FILE_CORRELATION	NUMBER	9.00	0.00

SAK_FILE_TRACK_RESPONSE	T_FILE_CORRELATION	NUMBER	9.00	0.00
SAK_FILTER	T_CM_CT_CRIT	NUMBER	4.00	0.00
SAK_FILTER	T_CM_CT_FILTER	NUMBER	4.00	0.00
SAK_FILTER	T_CM_PG_CRIT	NUMBER	4.00	0.00
SAK_FILTER	T_CM_PG_FILTER	NUMBER	4.00	0.00
SAK_FILTER	T_MM_CRIT	NUMBER	4.00	0.00
SAK_FILTER	T_MM_FILTER	NUMBER	4.00	0.00
SAK_FINAL_ESC	T_EDIT_RECYCLE	NUMBER	9.00	0.00
SAK_FIN_AR_RQST	T_FIN_AR_RQST_REPORT	NUMBER	9.00	0.00
SAK_FIN_COB_GRP	T_FIN_PAYER_COB	NUMBER	0.00	0.00
SAK_FIN_COS	T_CHCK_CLM_XREF	NUMBER	9.00	0.00
SAK_FIN_COS	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_FIN_COS	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_FIN_COS	T_FCOS_FUND_XREF	NUMBER	9.00	0.00
SAK_FIN_COS	T_FCOS_PR_SPEC_XRF	NUMBER	9.00	0.00
SAK_FIN_COS	T_FCOS_PR_TYPE_XRF	NUMBER	9.00	0.00
SAK_FIN_COS	T_FIN_COS	NUMBER	9.00	0.00
SAK_FIN_COS	T_FIN_PROCESS_PYMT_XREF	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_835_CONTACTS	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_CHK_BAN_FIN_CYCLE	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FINANCIAL_PAYER	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_CYCLE	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_CYCLE_BNK_XREF	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_CYCLE_TAX_INFO	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_EFT_ACCT	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_MAX_RECOUP	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_NO_ISSUE	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_PAY_RELEASE	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_PROCESS_SCHED	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_PRUDENT_PAY	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_PYMT_PULL	NUMBER	9.00	0.00

SAK_FIN_CYCLE	T_FIN_REPORT	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_RPT_PARMS	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FIN_SCHEDULE	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_FUND_PAYER	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_LIEN	NUMBER	9.00	0.00
SAK_FIN_CYCLE	T_PAYMENT_HOLD	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_AUDIT_PAYER_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CALL_QUESTION	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CLAIM_ERROR	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CLAIM_LOCAT	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CLM_EOB_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_COPAY	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_DIAG_LIMIT	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_DRUG_LIMITS	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_EOB_ERR_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_ERR_DISP_LINE	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_EVS_ELIG	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FINANCIAL_PAYER	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_FUND_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_PAYER_COB	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_PAYER_REIMB	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_PROCESS_DNTL	NUMBER	9.00	0.00

SAK_FIN_PAYER	T_FIN_PROCESS_PHRM	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_PROCESS_PHYS	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_FIN_PROCESS_UB92	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PAYER_CONTRACT_BENEFIT	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PAYER_NODE	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PAYER_PLAN_BENEFIT	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PA_ITEM_DTL_XREF	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PBM_PHARM_EXTRACT	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PGM_HIERARCHY	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PROC_DIAG_LIM	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PROC_ICD9_LIM	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PROC_LIMITS	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PR_APPLN_TYPE	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PR_DISP_FEE	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PR_ENROLL_PGM	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_PUB_HLTH_PGM	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_REGION_DISP	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_REGION_DISP	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_RE_ELIG	NUMBER	9.00	0.00

SAK_FIN_PAYER	T_RE_ELIG_DN	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_RE_PAT_LIAB	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_RE_SPEND_LIAB	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_STOP_LOSS_PARMS	NUMBER	9.00	0.00
SAK_FIN_PAYER	T_SUSP_RLHX	NUMBER	9.00	0.00
SAK_FIN_PAYER_CHILD	T_FIN_PAYER_COB	NUMBER	9.00	0.00
SAK_FIN_PAYER_FROM	T_DRUG_SCREEN	NUMBER	9.00	0.00
SAK_FIN_PAYER_TO	T_DRUG_SCREEN	NUMBER	9.00	0.00
SAK_FIN_PAY_RLSE	T_FIN_PAY_RELEASE	NUMBER	9.00	0.00
SAK_FIN_PERIOD	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_FIN_PERIOD	T_FIN_BUDG_PERIOD	NUMBER	9.00	0.00
SAK_FIN_PERIOD	T_FIN_PERIOD	NUMBER	9.00	0.00
SAK_FIN_PERIOD	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_AR_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CAP_SUMMARY	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CAP_SUMMARY_AL	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CAP_SUMMARY_WI	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CAP_SUMMARY_tmp	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CHECK	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_CHECK_VOID	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_EXPENDITURE	NUMBER	9.00	0.00

SAK_FIN_SCHED	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_CHECKWRITE	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_CYCLE_HIST	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_EARNINGS_HIST	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_EARNINGS_YTD	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_AR	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_CASH_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_DNTL	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_LIEN_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_PHRM	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_PHYS	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_PYMT	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_PROCESS_UB92	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_REMIT	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHEDULE	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHED_CRIT_PAYEE	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHED_CRIT_PAYER	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHED_CRIT_TXN	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHED_HOLD	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_FIN_SCHED_OVERRIDE	NUMBER	9.00	0.00

SAK_FIN_SCHED	T_LIEN_DISP	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_PAY_HOLD_TXN_XREF	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_PR_PROV_YTD_AMT	NUMBER	9.00	0.00
SAK_FIN_SCHED	T_PR_YTD_AMT_HIST	NUMBER	9.00	0.00
SAK_FIN_SCHEDULE	T_FIN_PROCESS_SCHED	NUMBER	9.00	0.00
SAK_FIRM	T_ATTORNEY_FIRM	NUMBER	9.00	0.00
SAK_FIRM	T_ATTORNEY_FIRM_XREF	NUMBER	9.00	0.00
SAK_FUNCTIONAL_ACK	T_FUNCTIONAL_ACKS	NUMBER	9.00	0.00
SAK_FUND_CODE	T_ACCT_REC	NUMBER	9.00	0.00
SAK_FUND_CODE	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_FUND_CODE	T_AR_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAP_SUMMARY	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAP_SUMMARY_AL	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAP_SUMMARY_WI	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CAP_SUMMARY_tmp	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CHCK_CLM_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CLM_FCA	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CLM_HIST_BALANCE	NUMBER	9.00	0.00
SAK_FUND_CODE	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_COS_FIN_FUND	NUMBER	9.00	0.00
SAK_FUND_CODE	T_DR_CLMS_XREF	NUMBER	9.00	0.00

SAK_FUND_CODE	T_DR_FUND_CODE_INTEREST	NUMBER	9.00	0.00
SAK_FUND_CODE	T_DR_FUND_CODE_PERCENT	NUMBER	9.00	0.00
SAK_FUND_CODE	T_DR_FUND_INV_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_DS_FIN_FUND_DEPT_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_FUND_CODE	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FCOS_FUND_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FCOS_PR_SPEC_XRF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FCOS_PR_TYPE_XRF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_AR_RQST_REPORT	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_FUND_CDE_RATE	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_FUND_FED_XREF_AL	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_PROCESS_AR	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_PROCESS_CASH_DISP	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FIN_PROCESS_PYMT_XREF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_FUND_CDE_GRP_XRF	NUMBER	9.00	0.00
SAK_FUND_CODE	T_MC_CAP_DEMOGRAPH	NUMBER	9.00	0.00
SAK_FUND_CODE	T_PAY_HOLD_FUND	NUMBER	9.00	0.00
SAK_FUND_CODE	T_PUB_HLTH_AID	NUMBER	9.00	0.00
SAK_FUND_CODE_INTEREST	T_DR_FUND_CODE_INTEREST	NUMBER	9.00	0.00
SAK_FUND_GROUP	T_FIN_835_TRACK	NUMBER	9.00	0.00
SAK_FUND_GROUP	T_FIN_EFT_RELEASE	NUMBER	9.00	0.00
SAK_FUND_GROUP	T_FUND_CDE_GRP	NUMBER	9.00	0.00
SAK_FUND_GROUP	T_FUND_CDE_GRP_XRF	NUMBER	9.00	0.00

SAK_FUND_PAYER	T_FIN_AR_RQST_REPORT	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_FUND_CODE	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_FUND_XREF	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_PROCESS_DNTL	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_PROCESS_PHRM	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_PROCESS_PHYS	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_PROCESS_SCHED	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_PROCESS_UB92	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FIN_SCHED_CRIT_PAYER	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_FUND_PAYER	NUMBER	9.00	0.00
SAK_FUND_PAYER	T_PAY_HOLD_PAYER	NUMBER	9.00	0.00
SAK_FUND_TXN	T_DAILY_FUND_TXN	NUMBER	9.00	0.00
SAK_GCN_SEQNO_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_GCN_SEQNO_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_GCN_SEQNO_TYPE	T_GCN_SEQNO_GROUP	NUMBER	4.00	0.00
SAK_GCN_SEQNO_TYPE	T_GCN_SEQNO_TYPE	NUMBER	4.00	0.00
SAK_GCN_SEQNO_TYPE	T_GCN_SEQNO_TYPE	NUMBER	9.00	0.00
SAK_GERI_DOSE	T_GERI_DOSE	NUMBER	9.00	0.00
SAK_GROUP	T_AUDIT_ST	NUMBER	9.00	0.00
SAK_GROUP	T_AUDIT_ST_GROUP	NUMBER	9.00	0.00
SAK_GROUP	T_AUDIT_ST_LEVEL	NUMBER	9.00	0.00
SAK_GROUP	T_AUDIT_ST_MEM	NUMBER	9.00	0.00
SAK_GROUP	T_GROUP	NUMBER	9.00	0.00
SAK_GROUP_CLASS	T_ERR_RESO_GRP_XREF	NUMBER	9.00	0.00
SAK_GROUP_CLASS	T_GROUP_TYPE	NUMBER	9.00	0.00
SAK_GROUP_COV	T_TPL_GROUP_COV_ASSIGN	NUMBER	9.00	0.00
SAK_GROUP_TYPE	T_ERR_RESO_GRP_XREF	NUMBER	9.00	0.00

SAK_GRP_DRGR	T_PEER_GRP_DRGR	NUMBER	9.00	0.00
SAK_GRP_DRGR	T_PEER_GRP_DRGR_OLD	NUMBER	9.00	0.00
SAK_HICL_XREF	T_HICL_CLASS_XREF	NUMBER	9.00	0.00
SAK_HIC_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_HIC_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_HIC_TYPE	T_HIC_GROUP	NUMBER	9.00	0.00
SAK_HIC_TYPE	T_HIC_TYPE	NUMBER	9.00	0.00
SAK_HIGH_DOSE	T_HIGH_DOSE	NUMBER	9.00	0.00
SAK_HIGH_DOSE	T_HIGH_DOSE_LOG	NUMBER	9.00	0.00
SAK_HIPAA_RELATION	T_HIPAA_REL_CODE	NUMBER	9.00	0.00
SAK_HIPAA_RELATION	T_HIPAA_REL_XREF	NUMBER	9.00	0.00
SAK_HIPAA_SVC_TYPE	T_HIPAA_COV_XREF	NUMBER	9.00	0.00
SAK_HIPAA_SVC_TYPE	T_HIPAA_PT_SVC_XRF	NUMBER	8.00	0.00
SAK_HIPAA_SVC_TYPE	T_HIPAA_SVC_TYPE	NUMBER	9.00	0.00
SAK_HIPP	T_HIPP_COVERAGE_XREF	NUMBER	9.00	0.00
SAK_HIPP	T_HIPP_EXPEND_XREF	NUMBER	9.00	0.00
SAK_HIPP	T_HIPP_PENDING	NUMBER	9.00	0.00
SAK_HIPP	T_HIPP_RECIP	NUMBER	9.00	0.00
SAK_HIPP	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_HIPP	T_TPL_HIPP_XREF	NUMBER	9.00	0.00
SAK_HOSPICE_PERIOD	T_RE_HOSPICE_DTL	NUMBER	9.00	0.00
SAK_HOSPICE_PERIOD	T_RE_HOSPICE_HDR	NUMBER	9.00	0.00
SAK_HOSPICE_XWALK	T_REV_HOSPICE_XWALK	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_INPAT_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_OUTPAT_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_OUTPAT_LAB_SVCS	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_PHARMREF_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_PHARM_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_PROFREF_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_PROF_ICN_XREF	NUMBER	9.00	0.00
SAK_ICN	T_PROFILE_PROF_LAB_SVCS	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_CHILD_EXPECT	NUMBER	9.00	0.00

SAK_IDENTIFIER	T_RE_CHILD_HAD	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_CLOSE_MCD	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_DEATH_RPT	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_DEMOGRAPHIC	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_EXPENSE	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_IDENTIFIER	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_INCOME_LOSS	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_INCOME_NEW	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_MARITAL	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_MOVE_IN_OUT	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_OTH_CHG	NUMBER	9.00	0.00
SAK_IDENTIFIER	T_RE_SPONSOR	NUMBER	9.00	0.00
SAK_ID_PROV_GRP_TYPE	T_REF_ID_PROV_GROUP	NUMBER	9.00	0.00
SAK_ID_PROV_GRP_TYPE	T_REF_ID_PROV_TYPE	NUMBER	9.00	0.00
SAK_IMAGE_BALANCE	T_CLM_IMAGE_BALANCE	NUMBER	9.00	0.00
SAK_INCOME_LOSS	T_RE_INCOME_LOSS	NUMBER	9.00	0.00
SAK_INCOME_NEW	T_RE_INCOME_NEW	NUMBER	9.00	0.00
SAK_IND_KEY	T_CA_HDR_DTL	NUMBER	9.00	0.00
SAK_IND_KEY	T_CA_IND_AGGR	NUMBER	9.00	0.00
SAK_IND_KEY	T_CA_IND_KEY	NUMBER	9.00	0.00
SAK_INGREDIENT	T_ALLERGY	NUMBER	9.00	0.00
SAK_INGREDIENT	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_INGREDIENT	T_GFC_INGREDIENT	NUMBER	9.00	0.00
SAK_INGREDIENT	T_INGREDIENT	NUMBER	9.00	0.00
SAK_INGREDIENT	T_INGRED_DUPE	NUMBER	9.00	0.00
SAK_INGREDIENT_FROM	T_HIC_GROUP	NUMBER	9.00	0.00
SAK_INGREDIENT_TO	T_HIC_GROUP	NUMBER	9.00	0.00
SAK_INGRED_DUPE	T_INGRED_DUPE	NUMBER	9.00	0.00
SAK_INS_AGENT	T_INS_AGENT	NUMBER	9.00	0.00
SAK_INS_AGENT	T_INS_AGENT_XREF	NUMBER	9.00	0.00
SAK_INTEREST	T_CLAIM_INTEREST	NUMBER	9.00	0.00
SAK_INTEREST	T_CLM_INT_RATE	NUMBER	9.00	0.00

SAK_INTEREST	T_DR_INTEREST	NUMBER	9.00	0.00
SAK_INVERSE	T_DRUG_DRUG_CRIT	NUMBER	9.00	0.00
SAK_INVERSE	T_DRUG_INVERSE	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_4002_RCPTS	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_DISPUTE	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_DISPUTE_DTL	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_FUND_CODE_PERCENT	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INCR_ADJ	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INCR_INT	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INCR_PAY	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INTEREST	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INVOICE	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INVOICE_DTL	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INV_COMMENT	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_INV_WRITEOFF	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_PAYMENT_HDR	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_PAYMENT_XREF	NUMBER	9.00	0.00
SAK_INVOICE	T_DR_PPA_INV_DTL	NUMBER	9.00	0.00
SAK_LETTER	T_AR_ONLINE_LETTER	NUMBER	9.00	0.00
SAK_LETTER	T_LETTER	NUMBER	9.00	0.00
SAK_LETTER	T_LETTER_TEMPLATE	NUMBER	9.00	0.00
SAK_LETTER	T_LG_LETTER_REQUEST	NUMBER	9.00	0.00
SAK_LETTER	T_LG_LETTER_TEMPLATE	NUMBER	9.00	0.00

SAK_LETTER	T_LG_LETTER_TEMPL_IDX	NUMBER	9.00	0.00
SAK_LETTER	T_LTR_RQST_TEMPLAT	NUMBER	9.00	0.00
SAK_LETTER	T_LTR_RQST_TRK	NUMBER	9.00	0.00
SAK_LETTER	T_PR_LETTER_XREF	NUMBER	9.00	0.00
SAK_LETTER	T_RE_EPSDT_LETTER	NUMBER	9.00	0.00
SAK_LETTER	T_TPL_CDE_LETTER	NUMBER	9.00	0.00
SAK_LETTER	T_TPL_LETTER_ENTITY	NUMBER	9.00	0.00
SAK_LETTER	T_TPL_LTR_RESP_XREF	NUMBER	9.00	0.00
SAK_LETTER_GROUP	T_LG_LETTER_GROUP	NUMBER	9.00	0.00
SAK_LETTER_GROUP	T_LG_LETTER_TEMPLATE	NUMBER	9.00	0.00
SAK_LETTER_ID	T_RE_ID_LETTER	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_AR_LETTERS	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LETTER_REQUEST	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LG_HISTORY	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LG_LETTER_REQUEST	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LG_LETTER_REQUEST_IDX	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LTR_RQST_TEMPLAT	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_LTR_RQST_TRK	NUMBER	9.00	0.00
SAK_LETTER_REQUEST	T_TPL_LTR_RESP_XREF	NUMBER	9.00	0.00
SAK_LETTER_TEMPLATE	T_LETTER_TEMPLATE	NUMBER	9.00	0.00
SAK_LETTER_TEMPLATE	T_LTR_RQST_TEMPLAT	NUMBER	9.00	0.00
SAK_LETTER_TEMPLATE	T_LTR_RQST_TRK	NUMBER	9.00	0.00
SAK_LETTER_TEXT	T_PR_APPLN_STATUS_RSN	NUMBER	9.00	0.00
SAK_LETTER_TEXT	T_PR_LETTER_TEXT	NUMBER	9.00	0.00
SAK_LETTER_TEXT	T_PR_LETTER_XREF	NUMBER	9.00	0.00
SAK_LG_HISTORY	T_LG_HISTORY	NUMBER	9.00	0.00
SAK_LG_HISTORY	T_LG_HISTORY_EXT	NUMBER	9.00	0.00
SAK_LIEN	T_FIN_PROCESS_LIEN	NUMBER	9.00	0.00
SAK_LIEN	T_FIN_PROCESS_LIEN_DISP	NUMBER	9.00	0.00
SAK_LIEN	T_LIEN	NUMBER	9.00	0.00
SAK_LIEN	T_LIEN_COMMENT	NUMBER	9.00	0.00
SAK_LIEN	T_LIEN_DISP	NUMBER	9.00	0.00
SAK_LIEN_HOLDER	T_LIEN	NUMBER	9.00	0.00
SAK_LIMITATION	T_PR_ACC_PTS_LIMIT_WI	NUMBER	9.00	0.00

SAK_LIMITATION	T_PR_ACC_PTS_WI	NUMBER	9.00	0.00
SAK_LINK	T_RECIP_LINK_XREF	NUMBER	9.00	0.00
SAK_LINK	T_RE_CLM_DELINK	NUMBER	9.00	0.00
SAK_LINK	T_RE_ID_LETTER	NUMBER	9.00	0.00
SAK_LINK	T_RE_LINK_PROC	NUMBER	9.00	0.00
SAK_LINK_PROC	T_RE_LINK_PROC	NUMBER	9.00	0.00
SAK_LIV_ARNG	T_MC_PGM_LIV_XREF	NUMBER	9.00	0.00
SAK_LIV_ARNG	T_RE_BASE	NUMBER	9.00	0.00
SAK_LIV_ARNG	T_RE_LIV_ARNG	NUMBER	9.00	0.00
SAK_LOCKIN_INFO	T_RE_LOCKIN_INFO	NUMBER	9.00	0.00
SAK_LOCKIN_INFO	T_RE_LOCK_DIAG_RNG	NUMBER	9.00	0.00
SAK_LOCKIN_INFO	T_RE_LOCK_DRUG	NUMBER	9.00	0.00
SAK_LOCKIN_INFO	T_RE_LOCK_PROC_RNG	NUMBER	9.00	0.00
SAK_LOCKIN_PERIOD	T_RE_LOCKIN_INFO	NUMBER	9.00	0.00
SAK_LOCKIN_PERIOD	T_RE_LOCKIN_PERIOD	NUMBER	9.00	0.00
SAK_LOCK_DIAG	T_RE_LOCK_DIAG_RNG	NUMBER	9.00	0.00
SAK_LOCK_DRUG	T_RE_LOCK_DRUG	NUMBER	9.00	0.00
SAK_LOCK_PROC	T_RE_LOCK_PROC_RNG	NUMBER	9.00	0.00
SAK_LOC_DATES	T_RE_LOC_DATES	NUMBER	9.00	0.00
SAK_LOG_TRACK	T_PS_LOG_TRACK	NUMBER	9.00	0.00
SAK_LOW_DOSE	T_LOW_DOSE	NUMBER	9.00	0.00
SAK_LOW_DOSE	T_LOW_DOSE_LOG	NUMBER	9.00	0.00
SAK_LTR_LEGEND	T_PS_LTR_LEGEND	NUMBER	9.00	0.00
SAK_LTR_REQUEST	T_PS_LTR_REQUEST	NUMBER	9.00	0.00
SAK_LVX_SEQ	T_DS_LVX_MSG_LOG	NUMBER	9.00	0.00
SAK_LVX_SEQ	T_DS_LVX_USER_REQ	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR002_MAIN	NUMBER	9.00	0.00

SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR004_SVC_AREA	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR005_OPER_AUTH	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR006_POP_ENRLD	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	9.00	0.00
SAK_MANAGED_CARE_PLAN	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	9.00	0.00
SAK_MAN_EXCL	T_RE_BASE	NUMBER	9.00	0.00
SAK_MARITAL	T_RE_MARITAL	NUMBER	9.00	0.00
SAK_MAR_CAP_TYPE	T_STATE_COS	NUMBER	9.00	0.00
SAK_MCO	T_PROC_MCO_LIM	NUMBER	9.00	0.00
SAK_MC_AID_GRP	T_MC_AID_GRP	NUMBER	9.00	0.00
SAK_MC_AID_GRP	T_MC_AID_GRP_XREF	NUMBER	9.00	0.00
SAK_MC_AID_GRP	T_MC_CAP_DEMOGRAPH	NUMBER	9.00	0.00
SAK_MC_AID_GRP	T_MC_CAP_DEMOGRAPH_KY	NUMBER	9.00	0.00
SAK_MC_ENTITY	T_MC_ENTITY	NUMBER	9.00	0.00
SAK_MC_ENTITY	T_MC_RE_PMP_SEL	NUMBER	9.00	0.00
SAK_MC_ENT_ADD	T_MC_PMP_SC	NUMBER	9.00	0.00
SAK_MC_ENT_ADD	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_MC_ENT_ADD	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_MC_ENT_CHANGE	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_MC_ENT_CHANGE	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_MC_ENT_HIST	T_MC_PMP_SC	NUMBER	9.00	0.00

SAK_MC_ENT_MBR	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_MC_ENT_MBR	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_MC_ENT_TERM	T_MC_PMP_SC	NUMBER	9.00	0.00
SAK_MC_ENT_TERM	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_MC_ENT_TERM	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_MC_PGM_STATUS_GRP	T_MC_CAP_DEMOGRAPH_KY	NUMBER	9.00	0.00
SAK_MC_PGM_STATUS_GRP	T_MC_PGM_STATUS_GRP	NUMBER	9.00	0.00
SAK_MC_PGM_STATUS_GRP	T_MC_PGM_STATUS_GRP_XREF	NUMBER	9.00	0.00
SAK_MDC	T_DRG_MDC	NUMBER	9.00	0.00
SAK_MDC	T_MDC	NUMBER	9.00	0.00
SAK_MDC	T_UB92_HDR_INP_OLD	NUMBER	9.00	0.00
SAK_MEASURE	T_CM_CG_CRIT	NUMBER	4.00	0.00
SAK_MEASURE	T_CM_MEASURE	NUMBER	4.00	0.00
SAK_MEASURE_BASE	T_MM_CRIT	NUMBER	4.00	0.00
SAK_MEASURE_BASE	T_MM_MEASURE_BASE	NUMBER	4.00	0.00
SAK_MEASURE_BASE	T_MM_QUALIFIER	NUMBER	4.00	0.00
SAK_MEASURE_SOURCE	T_MM_MEASURE_BASE	NUMBER	4.00	0.00
SAK_MEASURE_SOURCE	T_MM_MEASURE_SRCE	NUMBER	4.00	0.00
SAK_MED_RISK_DRUGS	T_MME_OPIOID_CONCR_RISK_DR	NUMBER	9.00	0.00
SAK_MEMBER	T_CT_EDIT_MEMBERS	NUMBER	9.00	0.00
SAK_MESSAGE	T_WEB_MESSAGE_USER	NUMBER	9.00	0.00
SAK_MINI_LINK	T_RE_MINI_LINK_XREF	NUMBER	9.00	0.00
SAK_MME_DOSE_RANGE_FACTOR	T_MME_MME_RANGE_FACTOR	NUMBER	9.00	0.00
SAK_MME_FACTOR	T_MME_OPIOID_CF_MME_FACTOR	NUMBER	9.00	0.00
SAK_MODIFIER	T_MODIFIER	NUMBER	9.00	0.00
SAK_MODIFIER	T_MODIFIER_NOTES	NUMBER	9.00	0.00

SAK_MOD_TYPE	T_MOD_GROUP	NUMBER	9.00	0.00
SAK_MOD_TYPE	T_MOD_GROUP_TYPE	NUMBER	4.00	0.00
SAK_MOD_TYPE	T_MOD_GROUP_TYPE	NUMBER	9.00	0.00
SAK_MOD_TYPE	T_TP_SPC_MOD_EXCL	NUMBER	4.00	0.00
SAK_MOVE_IN_OUT	T_RE_MOVE_IN_OUT	NUMBER	9.00	0.00
SAK_MR_ELIG	T_MR_ELIG	NUMBER	9.00	0.00
SAK_MR_ELIG	T_MR_ELIG_SAK	NUMBER	9.00	0.00
SAK_MR_PR_ENROL	T_MR_PR_ENROL	NUMBER	9.00	0.00
SAK_MR_PR_ENROL	T_MR_PR_ENROL_SAK	NUMBER	9.00	0.00
SAK_MULT_SURG	T_CLM_MULT_SURG	NUMBER	9.00	0.00
SAK_NAME	T_EVENT_TRACK	VARCHAR2	18.00	0.00
SAK_NAME	T_SYSTEM_KEYS	CHAR	18.00	0.00
SAK_NAME	T_SYSTEM_KEYS	VARCHAR2	18.00	0.00
SAK_NF_FACILITY	T_PS_NF_FACILITY	NUMBER	9.00	0.00
SAK_NONCERT_FAC	T_PS_NONCERT_FAC	NUMBER	9.00	0.00
SAK_NONPROV	T_FIN_NONPROV	NUMBER	9.00	0.00
SAK_NOTICE	T_RE_EPSDT_NOTICE	NUMBER	4.00	0.00
SAK_NOTICE	T_RE_EPSDT_REC_NOT	NUMBER	4.00	0.00
SAK_NOTIFICATION	T_CALL_OTIFICATION	NUMBER	9.00	0.00
SAK_NO_ISSUE	T_FIN_NO_ISSUE	NUMBER	9.00	0.00
SAK_NPI	T_MC_NPI	NUMBER	9.00	0.00
SAK_NPI	T_MC_NPI_NOTES	NUMBER	9.00	0.00
SAK_NPI	T_PR_IDENTIFIER	NUMBER	9.00	0.00
SAK_OFF_STAT	T_RE_CUST_STATUS	NUMBER	9.00	0.00
SAK_OFF_STAT	T_RE_OFF_STAT	NUMBER	9.00	0.00
SAK_OLD_PCN	T_RE_OLD_PCN	NUMBER	4.00	0.00
SAK_OTH_CHG	T_RE_OTH_CHG	NUMBER	9.00	0.00

SAK_OUTGOING_REF	T_CT_OUTGOING_REF	NUMBER	9.00	0.00
SAK_OVERPAYMENT	T_RE_AR_OVERPAYMENT	NUMBER	9.00	0.00
SAK_OVERPAYMENT	T_RE_AR_OVERPAYMENT_RSN	NUMBER	9.00	0.00
SAK_OVERPAYMENT	T_RE_AR_TRANSACTION	NUMBER	9.00	0.00
SAK_OVER_UTIL	T_DRUG_OVER_UTIL	NUMBER	9.00	0.00
SAK_OVER_UTIL	T_OVER_UTIL_LOG	NUMBER	9.00	0.00
SAK_OWNER	T_OWNER	NUMBER	9.00	0.00
SAK_OWNER	T_OWNER_WI	NUMBER	9.00	0.00
SAK_OWNER	T_PR_OWNER	NUMBER	9.00	0.00
SAK_PA	T_MPHX_MISC	NUMBER	9.00	0.00
SAK_PA	T_PA_1261A_PSY	NUMBER	9.00	0.00
SAK_PA	T_PA_ADMIN_REV	NUMBER	9.00	0.00
SAK_PA	T_PA_APPEAL	NUMBER	9.00	0.00
SAK_PA	T_PA_ATLANTES	NUMBER	9.00	0.00
SAK_PA	T_PA_ATTACH_INFO	NUMBER	9.00	0.00
SAK_PA	T_PA_DTL	NUMBER	9.00	0.00
SAK_PA	T_PA_ESC	NUMBER	9.00	0.00
SAK_PA	T_PA_EXT_TEXT	NUMBER	9.00	0.00
SAK_PA	T_PA_HDR	NUMBER	9.00	0.00
SAK_PA	T_PA_HDR_PE_TRNSP	NUMBER	9.00	0.00
SAK_PA	T_PA_HDR_PE_UMO	NUMBER	9.00	0.00
SAK_PA	T_PA_IAC_XREF	NUMBER	9.00	0.00
SAK_PA	T_PA_INT_TEXT	NUMBER	9.00	0.00
SAK_PA	T_PA_ITEM_DTL_XREF	NUMBER	9.00	0.00
SAK_PA	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_PA	T_PA_NONMED_PROV	NUMBER	9.00	0.00
SAK_PA	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_PA	T_PA_RULE_DECISION	NUMBER	9.00	0.00

SAK_PA	T_WEB_PA_DTL	NUMBER	9.00	0.00
SAK_PA	T_WEB_PA_HDR	NUMBER	9.00	0.00
SAK_PARENT_GROUP	T_BNFT_GROUP_STD	NUMBER	9.00	0.00
SAK_PARTICIPANT	T_RISKS	NUMBER	9.00	0.00
SAK_PARTICIPANT	T_RISK_PLANS	NUMBER	9.00	0.00
SAK_PARTY_IDENTIFIER	T_CLM_ENT_NM_ADR	NUMBER	9.00	0.00
SAK_PARTY_IDENTIFIER	T_CLM_PYR_ENTNMADR	NUMBER	9.00	0.00
SAK_PARTY_IDENTIFIER	T_PARTY_IDENTIFIER	NUMBER	9.00	0.00
SAK_PAT_LIAB	T_RE_PAT_LIAB	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_CLM_PAYABLE_ROLE	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAYER_CONTRACT_BENEFIT	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_BNFT	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_CONTRACT	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_PLAN	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_POS	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_TOB	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_BNFT_TYPE_SPEC	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_CT_XREF	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAYABLE_BNFT	T_PAY_OCC_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAYEE	T_1099_DETAIL	NUMBER	9.00	0.00
SAK_PAYEE	T_ACCT_REC	NUMBER	9.00	0.00
SAK_PAYEE	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_PAYEE	T_AR_DISP	NUMBER	9.00	0.00
SAK_PAYEE	T_CASH_RCPT_DISP	NUMBER	9.00	0.00

SAK_PAYEE	T_CASH_RECEIPT	NUMBER	9.00	0.00
SAK_PAYEE	T_CHECK	NUMBER	9.00	0.00
SAK_PAYEE	T_CHK_BAN_PAYEE	NUMBER	9.00	0.00
SAK_PAYEE	T_CLAIM_INTEREST	NUMBER	9.00	0.00
SAK_PAYEE	T_DS_PAYEE_NAM_ADR	NUMBER	9.00	0.00
SAK_PAYEE	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_PAYEE	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_AR_RQST_REPORT	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_EARNINGS_HIST	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_EARNINGS_YTD	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_EFT_ACCT	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_MAX_RECOUP	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_PROCESS_AR	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_PROCESS_AR_DISP	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_PROCESS_CASH_DISP	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_PROCESS_PYMT	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_PYMT_PULL	NUMBER	9.00	0.00
SAK_PAYEE	T_FIN_REMIT	NUMBER	9.00	0.00
SAK_PAYEE	T_LIEN	NUMBER	9.00	0.00
SAK_PAYEE	T_NONPROV_TAX_ID	NUMBER	9.00	0.00
SAK_PAYEE	T_PAY_HOLD_PROV	NUMBER	9.00	0.00

SAK_PAYEE	T_TPL_TAX_ID	NUMBER	9.00	0.00
SAK_PAYER	T_CA_RCO	NUMBER	9.00	0.00
SAK_PAYER	T_CA_TPL_SUMMARY	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_AMT	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_CAS	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_MIA	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_MOA	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_OTH_PYR_DTL	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_PAYER_ENTITY	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_PYR_ENTNMADR	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_PYR_MOD	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_RCO	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_REF	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_SBR	NUMBER	9.00	0.00
SAK_PAYER	T_CLM_TPL_SUMMARY	NUMBER	9.00	0.00
SAK_PAYER	T_DNTL_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_PAYER	T_INST_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_PAYER	T_PROF_OTH_PYR_HDR	NUMBER	9.00	0.00
SAK_PAYMENT	T_DR_INTEREST	NUMBER	9.00	0.00
SAK_PAYMENT	T_DR_PAYMENT_HDR	NUMBER	9.00	0.00
SAK_PAYMENT	T_DR_PAYMENT_XREF	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAYMENT_HOLD	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_CLM_MED	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_CLM_TYP	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_FUND	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PAYER	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PAY_TYP	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PGM_CDE	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PROV	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PROV_SPEC	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_PR_TYPE	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_SCOS	NUMBER	9.00	0.00
SAK_PAYMENT_HOLD	T_PAY_HOLD_TXN_XREF	NUMBER	9.00	0.00
SAK_PAY_BNFT_NULL	T_PAYABLE_BENEFIT	NUMBER	0.00	0.00
SAK_PAY_BNFT_NULL	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00

SAK_PAY_CND_AXIS_RANGE	T_PAY_BNFT_CONDITION	NUMBER	9.00	0.00
SAK_PAY_CND_AXIS_RANGE	T_PAY_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAY_MOD_AXIS_RANGE	T_PAY_BNFT_MOD	NUMBER	9.00	0.00
SAK_PAY_MOD_AXIS_RANGE	T_PAY_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAY_NUM_RANGE	T_FIN_CYCLE_BNK_XREF	NUMBER	9.00	0.00
SAK_PAY_NUM_RANGE	T_PMT_NUM_RNG	NUMBER	9.00	0.00
SAK_PAY_OCC_AXIS_RANGE	T_PAY_BNFT_OCCURR	NUMBER	9.00	0.00
SAK_PAY_OCC_AXIS_RANGE	T_PAY_OCC_AXIS_RANGE	NUMBER	9.00	0.00
SAK_PAY_SUM	T_WEB_PAY_SUM	NUMBER	9.00	0.00
SAK_PAY_TO_ADDRESS	T_FIN_PROCESS_PROV_ID	NUMBER	9.00	0.00
SAK_PA_PGM	T_ALERT_DISP	NUMBER	9.00	0.00
SAK_PA_PROV	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_PA_SERV_PROV	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_DDSD_UPD_DTL	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_DDSD_UPD_HDR	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_HCBW_UPD_DTL	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_HCBW_UPD_HDR	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_LTCA_UPD_DTL	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_LTCA_UPD_HDR	NUMBER	9.00	0.00
SAK_PA_TXN	T_PA_PC_UPD_HDR	NUMBER	9.00	0.00
SAK_PDL	T_PDL_MASTER	NUMBER	9.00	0.00
SAK_PDL	T_PDL_MASTER_AL	NUMBER	9.00	0.00
SAK_PDP	T_RE_PARTD_PDP_CARRIER	NUMBER	9.00	0.00
SAK_PDP	T_RE_PARTD_PDP_PLAN	NUMBER	9.00	0.00
SAK_PDP_PLAN	T_RE_PARTD_PDP_ASSIGN	NUMBER	9.00	0.00
SAK_PDP_PLAN	T_RE_PARTD_PDP_PLAN	NUMBER	9.00	0.00
SAK_PEDI_DOSE	T_PEDI_DOSE	NUMBER	9.00	0.00
SAK_PEER_GROUP	T_CM_CG_PEERGRP	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_CM_PEER_GROUP	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_CM_PG_CRIT	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_PF_EXP_INPAT_VAL_Q	NUMBER	4.00	0.00

SAK_PEER_GROUP	T_PF_EXP_NHOME_VAL_Q	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_PF_EXP_OUTPAT_VAL_Q	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_PF_EXP_PHARM_VAL_Q	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_PF_EXP_PROF_VAL_Q	NUMBER	4.00	0.00
SAK_PEER_GROUP	T_PR_PEER_GROUP	NUMBER	9.00	0.00
SAK_PGM	T_PROC_RU_COV_XREF	NUMBER	9.00	0.00
SAK_PGM_ELIG	T_EVS_ELIG	NUMBER	4.00	0.00
SAK_PGM_ELIG	T_RE_AID_ELIG	NUMBER	4.00	0.00
SAK_PGM_ELIG	T_RE_AID_ELIG_DN	NUMBER	4.00	0.00
SAK_PGM_ELIG	T_RE_ASSIGNMENT	NUMBER	4.00	0.00
SAK_PGM_ELIG	T_RE_ELIG	NUMBER	4.00	0.00
SAK_PGM_ELIG	T_RE_ELIG_DN	NUMBER	4.00	0.00
SAK_PHONE_NUMBER	T_PS_PHONE_NUMBER	NUMBER	9.00	0.00
SAK_PMP_FOCUS	T_MC_PMP_FOCUS	NUMBER	9.00	0.00
SAK_PMP_FOCUS	T_MC_PMP_GRP_MBR	NUMBER	9.00	0.00
SAK_PMP_FOCUS	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PMP_FOCUS	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PMP_FOCUS	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_MASS_ADJ_RST	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_MASS_ADJ_RST_tmp	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_SUMMARY	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_SUMMARY_AL	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_SUMMARY_WI	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_CAP_SUMMARY_tmp	NUMBER	9.00	0.00

SAK_PMP_SER_LOC	T_MC_CAP_AMTS_PMP	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_CENSUS	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_KENPAC_PCP	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_EDB_XREF	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_ENRL_RGN	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_ENRL_RGN_AL	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_GRP	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_MASS_XFER	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_NOTES	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_NT_CENSUS	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_PANEL_RESTRICT	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_MC_PMP_SC	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_AUTOASSGN	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_PANEL_SIZE	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_SVC_LOC_AL	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_SVC_LOC_STATE	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_PROC_DIAG_LIM	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_PMP_SER_LOC	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_PMP_TRANSFER	T_RE_MC_RECIP	NUMBER	9.00	0.00
SAK_PMP_TRANSFER	T_RE_MC_RECIP_WI	NUMBER	9.00	0.00

SAK_PMP_XFER	T_MC_PMP_ENRL_RGN	NUMBER	9.00	0.00
SAK_PMP_XFER	T_MC_PMP_ENRL_RGN_AL	NUMBER	9.00	0.00
SAK_PMP_XFER	T_MC_PMP_MASS_XFER	NUMBER	9.00	0.00
SAK_POLICY_OWNR	T_HIPP_RESOURCE	NUMBER	9.00	0.00
SAK_POLICY_OWNR	T_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_POL_HOLD	T_POLICY_HOLDER	NUMBER	9.00	0.00
SAK_POL_HOLD	T_POL_CHAMP_INFO	NUMBER	9.00	0.00
SAK_POL_HOLD	T_TPL_271_DEPENDENT	NUMBER	9.00	0.00
SAK_POL_HOLD	T_TPL_271_SUBSCRIBER	NUMBER	9.00	0.00
SAK_POL_HOLD	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_POL_HOLD	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00
SAK_PORT	T_PORT	NUMBER	9.00	0.00
SAK_PORT	T_TP_CONFIG	NUMBER	9.00	0.00
SAK_PREG_DIAG	T_PDUR_PREG_DIAG	NUMBER	9.00	0.00
SAK_PREV_CNTY	T_RE_PREV_CTY	NUMBER	4.00	0.00
SAK_PROBATE_COURT	T_TPL_COUNTY_PROBATE	NUMBER	9.00	0.00
SAK_PROC	T_AUDIT_PROC	NUMBER	9.00	0.00
SAK_PROC	T_AUDIT_PROC_MIRROR	NUMBER	9.00	0.00
SAK_PROCEDURE	T_ADJMS_MODIF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_ADJMS_SERV	NUMBER	9.00	0.00
SAK_PROCEDURE	T_CLM_MAT_CARE_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_COVERED_BENEFIT	NUMBER	9.00	0.00
SAK_PROCEDURE	T_DENY_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_DENY_PHYS_DTL	NUMBER	9.00	0.00

SAK_PROCEDURE	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_DRUG_HCPCS	NUMBER	9.00	0.00
SAK_PROCEDURE	T_DR_CLMS_XREF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_DR_JCODE_XWALK	NUMBER	9.00	0.00
SAK_PROCEDURE	T_LAB_FEE	NUMBER	9.00	0.00
SAK_PROCEDURE	T_MAX_FEE	NUMBER	9.00	0.00
SAK_PROCEDURE	T_MEDB_NONCOVERED	NUMBER	9.00	0.00
SAK_PROCEDURE	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROCEDURE	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PD_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PREVAILING	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_ASC	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_DIAG_LIM	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_DIAG_PA	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_GLOBAL_LAB	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_GSN_XREF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_LIMITS	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_MCO_LIM	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_MODIFIER	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_NOTES	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_RU_COV_XREF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_SPEC_LIM	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_TOOTH	NUMBER	9.00	0.00
SAK_PROCEDURE	T_PROC_TOOTH_QUAD	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RBRVS	NUMBER	9.00	0.00
SAK_PROCEDURE	T_REF_CLIA_LC_PROC	NUMBER	9.00	0.00
SAK_PROCEDURE	T_REF_UCC	NUMBER	9.00	0.00
SAK_PROCEDURE	T_REV_PROC_XREF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPSDT_PROC_XR	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_DRG_TRT_N	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_MOD_XREF	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_TRMNT_DRG	NUMBER	9.00	0.00

SAK_PROCEDURE	T_RE_EPS_TRNT_DIAG	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_TRT_DGN_N	NUMBER	9.00	0.00
SAK_PROCEDURE	T_RE_EPS_XREF_N	NUMBER	9.00	0.00
SAK_PROCEDURE	T_SUR_RQST_PROCMOD	NUMBER	9.00	0.00
SAK_PROCEDURE	T_SUSP_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_PROCEDURE_FROM	T_PROC_GROUP	NUMBER	9.00	0.00
SAK_PROCEDURE_GT	T_CLAIM_BDL_LABPANEL	NUMBER	9.00	0.00
SAK_PROCEDURE_GT	T_CLAIM_BDL_NCCD	NUMBER	9.00	0.00
SAK_PROCEDURE_GT	T_CLAIM_BDL_OVERRIDE	NUMBER	9.00	0.00
SAK_PROCEDURE_LT	T_CLAIM_BDL_LABPANEL	NUMBER	9.00	0.00
SAK_PROCEDURE_LT	T_CLAIM_BDL_NCCD	NUMBER	9.00	0.00
SAK_PROCEDURE_LT	T_CLAIM_BDL_OVERRIDE	NUMBER	9.00	0.00
SAK_PROCEDURE_THRU	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_PROCEDURE_TO	T_PROC_GROUP	NUMBER	9.00	0.00
SAK_PROC_FROM	T_AUDT_PROC_XRF	NUMBER	9.00	0.00
SAK_PROC_FROM	T_DUPE_AUDIT	NUMBER	9.00	0.00
SAK_PROC_FROM	T_PROC_CONV_FACTOR	NUMBER	9.00	0.00
SAK_PROC_FROM	T_RE_LOCK_PROC_RNG	NUMBER	9.00	0.00
SAK_PROC_ICD9	T_DRG_ICD9_XWALK	NUMBER	9.00	0.00
SAK_PROC_ICD9	T_PROC_ICD9	NUMBER	9.00	0.00
SAK_PROC_ICD9	T_PROC_ICD9_DIA	NUMBER	9.00	0.00
SAK_PROC_ICD9	T_PROC_ICD9_LIM	NUMBER	9.00	0.00
SAK_PROC_ICD9	T_PROC_ICD9_NOTES	NUMBER	9.00	0.00

SAK_PROC_ICD9	T_UB92_HDR_ICD9CM	NUMBER	9.00	0.00
SAK_PROC_ICD9_1	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_PROC_ICD9_2	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_PROC_ICD9_FROM	T_PROC_ICD9_GROUP	NUMBER	9.00	0.00
SAK_PROC_ICD9_TO	T_PROC_ICD9_GROUP	NUMBER	9.00	0.00
SAK_PROC_ICD9_XWLK	T_DRG_ICD9_XWALK	NUMBER	9.00	0.00
SAK_PROC_OLD	T_DENTAL_DTL_KEYS	NUMBER	9.00	0.00
SAK_PROC_OLD	T_PHYS_DEXT_KEY	NUMBER	9.00	0.00
SAK_PROC_TO	T_AUDT_PROC_XRF	NUMBER	9.00	0.00
SAK_PROC_TO	T_DUPE_AUDIT	NUMBER	9.00	0.00
SAK_PROC_TO	T_PROC_CONV_FACTOR	NUMBER	9.00	0.00
SAK_PROC_TO	T_RE_LOCK_PROC_RNG	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_AUDIT_PROC	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_AUDIT_PROC_MIRROR	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_AUDT_PROC_XRF	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_CLM_FCA	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_CONTRA_PROC	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_CONTRA_PROC_EXPL	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_CONTRA_PROC_EXPL_MIRROR	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_COPAY	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_COS_ASSIGN_CRIT	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_PHYSICIAN_COS	NUMBER	4.00	0.00
SAK_PROC_TYPE	T_PROC_GROUP	NUMBER	9.00	0.00

SAK_PROC_TYPE	T_PROC_TYPE	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_STATE_COS	NUMBER	9.00	0.00
SAK_PROC_TYPE	T_UB92_COS	NUMBER	4.00	0.00
SAK_PROC_TYPE	T_VFC_ADMIN_FEE	NUMBER	9.00	0.00
SAK_PROC_TYPE_CURR	T_CONTRA_PROC	NUMBER	9.00	0.00
SAK_PROC_TYPE_CURR	T_CONTRA_PROC_EXPL	NUMBER	9.00	0.00
SAK_PROC_TYPE_CURR	T_CONTRA_PROC_EXPL_MIRROR	NUMBER	9.00	0.00
SAK_PRODUCTIVITY_CD	T_CT_PROD_CD	NUMBER	3.00	0.00
SAK_PRODUCTIVITY_CD	T_CT_PROD_TRACK	NUMBER	3.00	0.00
SAK_PROD_TRACK	T_CT_PROD_TRACK	NUMBER	9.00	0.00
SAK_PROD_TRACK	T_CT_PROD_TRAIN	NUMBER	9.00	0.00
SAK_PROD_TRAIN	T_CT_PROD_TRAIN	NUMBER	9.00	0.00
SAK_PROV	T_1099_DETAIL	NUMBER	9.00	0.00
SAK_PROV	T_ACCOMM_FEE	NUMBER	9.00	0.00
SAK_PROV	T_ADJMS_PROV	NUMBER	9.00	0.00
SAK_PROV	T_ADJMS_PRSVC	NUMBER	9.00	0.00
SAK_PROV	T_ADJ_MASS_CLAIM	NUMBER	9.00	0.00
SAK_PROV	T_ADJ_RET_RQST_ERR	NUMBER	9.00	0.00
SAK_PROV	T_ADJ_REV_RQST	NUMBER	9.00	0.00
SAK_PROV	T_ATTACHMENT_XREF	NUMBER	9.00	0.00
SAK_PROV	T_CALL_TRACK	NUMBER	9.00	0.00
SAK_PROV	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_PROV	T_CHK_BAN_PROV	NUMBER	9.00	0.00
SAK_PROV	T_DCOR_SCHEDULE	NUMBER	9.00	0.00
SAK_PROV	T_DISP_SHARE	NUMBER	9.00	0.00
SAK_PROV	T_DR_RECOUP_LTR_DATES	NUMBER	9.00	0.00
SAK_PROV	T_DR_RECOUP_LTR_ICN	NUMBER	9.00	0.00

SAK_PROV	T_EDI_COVERED_PROV_XREF	NUMBER	9.00	0.00
SAK_PROV	T_EDI_MC_PROV_TP_XREF	NUMBER	9.00	0.00
SAK_PROV	T_EVS_INQUIRY	NUMBER	9.00	0.00
SAK_PROV	T_FIN_PROCESS_PROV_ID	NUMBER	9.00	0.00
SAK_PROV	T_HIST_DIRECTORY	NUMBER	9.00	0.00
SAK_PROV	T_HOSP_ANC_AUTH	NUMBER	9.00	0.00
SAK_PROV	T_MC_FTE	NUMBER	9.00	0.00
SAK_PROV	T_MC_PMP_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV	T_MC_PMP_NT_CENSUS	NUMBER	9.00	0.00
SAK_PROV	T_MC_RE_PMP_LKOUT	NUMBER	9.00	0.00
SAK_PROV	T_MC_RE_PMP_SEL	NUMBER	9.00	0.00
SAK_PROV	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_PROV	T_PHS_CLAIM	NUMBER	9.00	0.00
SAK_PROV	T_PHS_DATES	NUMBER	9.00	0.00
SAK_PROV	T_PHS_PROVIDER	NUMBER	9.00	0.00
SAK_PROV	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PROV	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_ACCT_REC_MAX	NUMBER	9.00	0.00
SAK_PROV	T_PR_ADR	NUMBER	9.00	0.00
SAK_PROV	T_PR_ADR_AL	NUMBER	9.00	0.00
SAK_PROV	T_PR_ADR_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_APPLN	NUMBER	9.00	0.00
SAK_PROV	T_PR_APPLN_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_BOARD	NUMBER	9.00	0.00
SAK_PROV	T_PR_BOARD_MEM	NUMBER	9.00	0.00
SAK_PROV	T_PR_BOND	NUMBER	9.00	0.00
SAK_PROV	T_PR_CAPT_CST	NUMBER	9.00	0.00

SAK_PROV	T_PR_CLIA_STAT	NUMBER	9.00	0.00
SAK_PROV	T_PR_COMMENT	NUMBER	9.00	0.00
SAK_PROV	T_PR_CST_CHRG	NUMBER	9.00	0.00
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SAK_PROV	T_PR_DISPRO_EXPEND	NUMBER	9.00	0.00
SAK_PROV	T_PR_DISPRO_PAY	NUMBER	9.00	0.00
SAK_PROV	T_PR_DISP_FEE	NUMBER	9.00	0.00
SAK_PROV	T_PR_DRG_RATE	NUMBER	9.00	0.00
SAK_PROV	T_PR_EDIT_EXEMPT	NUMBER	9.00	0.00
SAK_PROV	T_PR_EFT_ACCT	NUMBER	9.00	0.00
SAK_PROV	T_PR_ENRL	NUMBER	9.00	0.00
SAK_PROV	T_PR_ENROLL_INFO	NUMBER	9.00	0.00
SAK_PROV	T_PR_ENROLL_SCRN	NUMBER	9.00	0.00
SAK_PROV	T_PR_FACILITY	NUMBER	9.00	0.00
SAK_PROV	T_PR_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV	T_PR_IDENTIFIER	NUMBER	9.00	0.00
SAK_PROV	T_PR_ID_XREF	NUMBER	9.00	0.00
SAK_PROV	T_PR_IMPUTED_SPEC_XREF	NUMBER	9.00	0.00
SAK_PROV	T_PR_INACTV_EXMPT_AL	NUMBER	9.00	0.00
SAK_PROV	T_PR_LOC_NM_ADR	NUMBER	9.00	0.00
SAK_PROV	T_PR_LOC_RATE	NUMBER	9.00	0.00
SAK_PROV	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_MARG_CST	NUMBER	9.00	0.00
SAK_PROV	T_PR_MCARE_BILL	NUMBER	9.00	0.00
SAK_PROV	T_PR_MDED_CST	NUMBER	9.00	0.00
SAK_PROV	T_PR_NAM	NUMBER	9.00	0.00

SAK_PROV	T_PR_OWNER	NUMBER	9.00	0.00
SAK_PROV	T_PR_PAY_PULL	NUMBER	9.00	0.00
SAK_PROV	T_PR_PAY_PULL	NUMBER	9.00	0.00
SAK_PROV	T_PR_PCP	NUMBER	9.00	0.00
SAK_PROV	T_PR_PEER_GROUP	NUMBER	9.00	0.00
SAK_PROV	T_PR_PEER_LEVEL	NUMBER	9.00	0.00
SAK_PROV	T_PR_PHONE_TRACK	NUMBER	9.00	0.00
SAK_PROV	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_PROV	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_PROV	T_PR_PHYS_ASST	NUMBER	9.00	0.00
SAK_PROV	T_PR_PHYS_SUPV	NUMBER	9.00	0.00
SAK_PROV	T_PR_PRESCRIBER	NUMBER	9.00	0.00
SAK_PROV	T_PR_PROV	NUMBER	9.00	0.00
SAK_PROV	T_PR_PSYCH_FACI	NUMBER	9.00	0.00
SAK_PROV	T_PR_REVIEW	NUMBER	9.00	0.00
SAK_PROV	T_PR_RST_SVC	NUMBER	9.00	0.00
SAK_PROV	T_PR_RST_SVC_STATE_KY	NUMBER	9.00	0.00
SAK_PROV	T_PR_SPEC	NUMBER	9.00	0.00
SAK_PROV	T_PR_STATE_SHARE	NUMBER	9.00	0.00
SAK_PROV	T_PR_SUBSPEC	NUMBER	9.00	0.00
SAK_PROV	T_PR_SURS_SPEC	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_CERT	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_CERT_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_LANG	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_LOC	NUMBER	9.00	0.00

SAK_PROV	T_PR_SVC_LOC_AL	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_LOC_STATE_KY	NUMBER	9.00	0.00
SAK_PROV	T_PR_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PROV	T_PR_TAX_ID	NUMBER	9.00	0.00
SAK_PROV	T_PR_TYPE	NUMBER	9.00	0.00
SAK_PROV	T_PR_UB_LOC_RATE	NUMBER	9.00	0.00
SAK_PROV	T_PR_VERIFY	NUMBER	9.00	0.00
SAK_PROV	T_PR_WEB_CHG	NUMBER	9.00	0.00
SAK_PROV	T_PR_WEB_CHG_BACKUP	NUMBER	9.00	0.00
SAK_PROV	T_PS_NF_FACILITY	NUMBER	9.00	0.00
SAK_PROV	T_REF_UCC	NUMBER	9.00	0.00
SAK_PROV	T_REIMB_RATE	NUMBER	9.00	0.00
SAK_PROV	T_RE_ASSIGNMENT	NUMBER	9.00	0.00
SAK_PROV	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_PROV	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_PROV	T_RE_LOC	NUMBER	9.00	0.00
SAK_PROV	T_RE_LOCKIN_INFO	NUMBER	9.00	0.00
SAK_PROV	T_RE_LOC_DATES	NUMBER	9.00	0.00
SAK_PROV	T_RE_SPEND_PROV	NUMBER	9.00	0.00
SAK_PROV	T_RTS_INFO	NUMBER	9.00	0.00
SAK_PROV	T_SUR_RQST_PR_SVC	NUMBER	9.00	0.00
SAK_PROV	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_PROV	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00
SAK_PROV	T_WEB_FEITH_DOWNLOAD	NUMBER	9.00	0.00
SAK_PROV	T_WEB_PROV	NUMBER	9.00	0.00
SAK_PROV	T_WEB_PROV_ADDR	NUMBER	9.00	0.00
SAK_PROV	T_WEB_PROV_ENR	NUMBER	9.00	0.00
SAK_PROV	T_WEB_PROV_SPEC	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	9.00	0.00

SAK_PROVIDER	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV004_LICENSE_INF	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	9.00	0.00
SAK_PROVIDER	T_TMSIS_PRV010_BED_TYPE	NUMBER	9.00	0.00
SAK_PROV_ATT_CMS	T_PR_ATT_CMS	NUMBER	9.00	0.00
SAK_PROV_BILL	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_BILL	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_PROV_CRIT	T_CT_PROV_CRIT	NUMBER	9.00	0.00
SAK_PROV_GROUP	T_MC_PMP_GRP	NUMBER	9.00	0.00
SAK_PROV_GROUP	T_MC_PMP_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_GROUP	T_MC_PMP_NT_CENSUS	NUMBER	9.00	0.00
SAK_PROV_GROUP	T_PR_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_GROUP	T_PR_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_KEY	T_DS_DNTL_PR_ENROLL	NUMBER	9.00	0.00
SAK_PROV_LIC	T_PR_HB_LIC_KY	NUMBER	9.00	0.00
SAK_PROV_LIC	T_PR_LICENSE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_1099_DETAIL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_ACCOMM_FEE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_ADJMS_PROV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_ADJMS_PRSVC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_ADJ_MASS_CLAIM	NUMBER	9.00	0.00
SAK_PROV_LOC	T_ADJ_REV_RQST	NUMBER	9.00	0.00
SAK_PROV_LOC	T_CALL_TRACK	NUMBER	9.00	0.00
SAK_PROV_LOC	T_CASUALTY_CASE_OFFLINE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_CLM_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_PROV_LOC	T_COS_PROV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_CPAS_EXTRACT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_CPAS_SPLIT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DENY_DNTL_HDR	NUMBER	9.00	0.00

SAK_PROV_LOC	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DISP_SHARE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DRG_CROSSWALK	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DR_CLMS_XREF	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DR_RECOUP_LTR_DATES	NUMBER	9.00	0.00
SAK_PROV_LOC	T_DR_RECOUP_LTR_ICN	NUMBER	9.00	0.00
SAK_PROV_LOC	T_EDI_COVERED_PROV_XREF	NUMBER	9.00	0.00
SAK_PROV_LOC	T_EDI_MC_PROV_TP_XREF	NUMBER	9.00	0.00
SAK_PROV_LOC	T_EVS_INQUIRY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_FIN_835_TRACK	NUMBER	9.00	0.00
SAK_PROV_LOC	T_FIN_PROCESS_PROV_ID	NUMBER	9.00	0.00
SAK_PROV_LOC	T_HIST_DIRECTORY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_HOSP_ANC_AUTH	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_FTE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_KENPAC_PCP	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_PMP_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_PMP_NT_CENSUS	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_RE_PMP_LKOUT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MC_RE_PMP_SEL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MPHX_INPT_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MPHX_INPT_HDR2	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_ERROR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_ERROR_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_ERROR_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_LTC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_LTC_REV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV_DENIED	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV_PERFORM	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV_PERFORM_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV_PERFORM_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_MR_PROV_RE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PA_PAUTH	NUMBER	9.00	0.00

SAK_PROV_LOC	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PHS_CLAIM	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PHS_DATES	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PHS_PROVIDER	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ACCT_REC_MAX	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ACC_PTS_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_APPLN	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_APPLN_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_BEDS_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_BILLER	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_BOARD	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_BOARD_MEM	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_BOND	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_CLIA_STAT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_CONTRACT_RATE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_DEA	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_DISPRO_EXPEND	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_DISPRO_PAY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_DISP_FEE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_DRG_RATE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_EDIT_EXEMPT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_EFT_ACCT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ENRL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ENROLL_INFO	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ENROLL_SCRN	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_FACILITY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_IDENTIFIER	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_ID_XREF	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_INACTV_EXMPT_AL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_INST_RATE_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_LABEL_CRIT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_LICENSE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_LOC_NM_ADR	NUMBER	9.00	0.00

SAK_PROV_LOC	T_PR_LOC_RATE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_MCARE_BILL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_MDED_CST	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_OUT_OF_STATE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_OUT_RATE_AL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_OWNER	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PAY_PULL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PCP	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PEER_GROUP	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PEER_LEVEL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PHYS_ASST	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PHYS_SUPV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_PSYCH_FACI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_RATE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_REVIEW	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_RST_SVC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_RST_SVC_STATE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SPEC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_STATE_SHARE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SUBSPEC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SURS_SPEC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_CERT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_CERT_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_LANG	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_LOC_AL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_LOC_STATE_KY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_TAXONOMY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_TAX_ID	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_TYPE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_UB_LOC_RATE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_VERIFY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_WEB_CHG	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PR_WEB_CHG_BACKUP	NUMBER	9.00	0.00
SAK_PROV_LOC	T_PS_NF_FACILITY	NUMBER	9.00	0.00
SAK_PROV_LOC	T_REF_DISTRICT_PLAN	NUMBER	9.00	0.00
SAK_PROV_LOC	T_REF_UCC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_REIMB_RATE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00

SAK_PROV_LOC	T_RE_ASSIGN_PLAN	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RE_ASSIGN_PLAN_LI	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RE_ASSIGN_PLAN_RLOC	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_RE_SPEND_PROV	NUMBER	9.00	0.00
SAK_PROV_LOC	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	9.00	0.00
SAK_PROV_LOC	T_TMSIS_PRV004_LICENSE_INF	NUMBER	9.00	0.00
SAK_PROV_LOC	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	9.00	0.00
SAK_PROV_LOC	T_TMSIS_PRV010_BED_TYPE	NUMBER	9.00	0.00
SAK_PROV_LOC	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_PROV_LOC	T_WEB_FEITH_DOWNLOAD	NUMBER	9.00	0.00
SAK_PROV_LOC_2	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_PROV_LOC_ASST	T_PR_PHYS_ASST	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_CA_HDR_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ATTEND	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_BILL	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_LOC_BILL	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_BILL	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROV_LOC_BILL	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_BILL	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00

SAK_PROV_LOC_BILL	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_FA	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_FA	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_FA	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_GRP	T_MC_PMP_GRP	NUMBER	9.00	0.00
SAK_PROV_LOC_LTC	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_PROV_LOC_MATC	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_LOC_MATC	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_MC_PMP_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_MC_PMP_NT_CENSUS	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_MC_RE_PMP_SEL	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_PR_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_PROV_LOC_MBR	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_PROV_LOC_NEW	T_PR_CHOW_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC_ORDER	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ORDER	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ORDER	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_ORIG	T_PR_CHOW_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_1	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_2	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_2	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_2	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_2	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_OTHER_2	T_SUSP_UB92_DTL	NUMBER	9.00	0.00

SAK_PROV_LOC_OTHER_2	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PAYEE	T_CAP_SUMMARY	NUMBER	9.00	0.00
SAK_PROV_LOC_PAYEE	T_CAP_SUMMARY_AL	NUMBER	9.00	0.00
SAK_PROV_LOC_PAYEE	T_CAP_SUMMARY_WI	NUMBER	9.00	0.00
SAK_PROV_LOC_PAYEE	T_CAP_SUMMARY_tmp	NUMBER	9.00	0.00
SAK_PROV_LOC_PCP	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_CLM_MAT_CARE_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_DENY_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_ETG_DTL	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_DTL_ENCNTR	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_DTL_FFS	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_DTL_RCO_PAID	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_PROV_TOTS	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_PROV_TOTS_ENCNTR	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_PROV_TOTS_FFS	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_PROV_TOTS_RCO_PAI D	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_SUMMARY	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_SUMMARY_ENCNTR	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_SUMMARY_FFS	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_ETG_SUMMARY_RCO_PAID	CHAR	10.00	0.00
SAK_PROV_LOC_PERF	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_PD_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_SUSP_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PERF	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PRESCRB	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PRESCRB	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_PRESCRB	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00

SAK_PROV_LOC_RCO	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_RCO	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_1	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REF_2	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_LOC_REND	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_MATC	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_MATC	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_PROV_MBR	T_MC_RE_PMP_SEL	NUMBER	9.00	0.00
SAK_PROV_MBR	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_PROV_MBR	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_PROV_NEW	T_PR_CHOW_GRP_MBR	NUMBER	9.00	0.00

SAK_PROV_ORDER	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_ORDER	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_ORDER	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_ORIG	T_PR_CHOW_GRP_MBR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_PROV_PERF	T_CLM_MAT_CARE_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_DENY_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROV_PERF	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_PD_DNTL_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_PROV_PERF	T_SUSP_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_PERF	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_PERF	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_PGM	T_CHK_BAN_PGM	NUMBER	9.00	0.00
SAK_PROV_PGM	T_CLM_FCA	NUMBER	9.00	0.00
SAK_PROV_PGM	T_DISP_FEE	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PAYABLE_BENEFIT	NUMBER	9.00	0.00

SAK_PROV_PGM	T_PAYER_CONTRACT_BENEFIT	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PAY_BNFT_CONTRACT	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_CONTRACT_REIMB	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_CONTRACT_TYPE_SPEC	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_COVERED_PGM	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_ENROLL_PGM	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_LABEL_CRIT	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_PGM_CT_XREF	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_PROV_PGM	T_PR_PHP_ELIG	NUMBER	9.00	0.00
SAK_PROV_PGM_BILL	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_PROV_PGM_PERF	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_PROV_PRESCRB	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_PRESCRB	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_PROV_PRESCRB	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_RCO	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_RCO	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_RCO	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PROV_RCO	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_RCO	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_RCO	T_PD_UB92_HDR	NUMBER	9.00	0.00

SAK_PROV_RCO	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_RCO	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PROV_RECIP	T_CT_CASE_TRACK	NUMBER	9.00	0.00
SAK_PROV_RECIP	T_CT_CONT_TERM	NUMBER	9.00	0.00
SAK_PROV_RECIP	T_CT_REFERRALS	NUMBER	9.00	0.00
SAK_PROV_RECIP	T_CT_SELECT_LST	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_DENY_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_PD_DNTL_HDR	NUMBER	9.00	0.00

SAK_PROV_REFERRING_2	T_PD_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_SUSP_PHYS_DTL	NUMBER	9.00	0.00
SAK_PROV_REFERRING_2	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_PROV_REND	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_PROV_REND	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_PROV_RENDERING	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_PRUD_PAY	T_FIN_PRUDENT_PAY	NUMBER	9.00	0.00
SAK_PRUD_PAY	T_FIN_PRU_PAY_CLM	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_ATTEND	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_DRG_RT	T_PR_DRG_RATE	NUMBER	9.00	0.00
SAK_PR_FACILITY	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_FACILITY	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_FACILITY	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_LABEL	T_PR_LABEL_CRIT	NUMBER	9.00	0.00
SAK_PR_OTHER_1	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_OTHER_1	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_OTHER_1	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_OTHER_1	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_OTHER_1	T_SUSP_UB92_DTL	NUMBER	9.00	0.00

SAK_PR_OTHER_1	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_DENY_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_PD_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_SUSP_UB92_DTL	NUMBER	9.00	0.00
SAK_PR_OTHER_2	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_PS_ADDRESS	T_PS_CASE_ADDRESS	NUMBER	9.00	0.00
SAK_PS_ADDRESS	T_PS_PHONE_NUMBER	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_CASE	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_CASE_ADDRESS	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_CNT_PHONE	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_DETERMINATION	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_ICF_MR	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_LTR_REQUEST	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_LVL_I_TRACK	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_NF_FACILITY	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_NONCERT_FAC	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_PHONE_NUMBER	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_PUBLIC_INFO	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_REFERRAL	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_RESIDENT_RVW	NUMBER	9.00	0.00
SAK_PS_CASE	T_PS_SECURE_INFO	NUMBER	9.00	0.00
SAK_PS_CNT_PHONE	T_PS_CNT_PHONE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ADJMS_MEDAST	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_AR_SUPP_DTL	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_AUDT_PGM_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_AUTO_PA	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_AUTO_PA_SUMMARY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_BENEFIT_PLAN_GROUP	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_BNFT_PLAN_COB	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_BNFT_PLAN_REIMB	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CALL_QUESTION	NUMBER	9.00	0.00

SAK_PUB_HLTH	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CA_ERROR	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CHCK_CLM_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CLAIM_ERROR	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CLAIM_INTEREST	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CLM_EOB_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_COPAY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_COS_ASSIGN_CRIT	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_COVERED_BENEFIT	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_COV_BNFT_BP	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_DRUG_ACT_COV	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EOB_ERR_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERR_DISP_LINE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERR_DISP_PT_PS_X	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_CDE_LIST_ID	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_FORMULARY_RLINK	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_FORM_ALT_THERAPY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_NDC_RLINK	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_ERX_TEXT_CONCAT	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EVS_ELIG	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EVS_SVC_COVERAGE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_EXPENDITURE_SUPP_DTL	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_FIN_PROCESS_PYMT_XREF	NUMBER	9.00	0.00

SAK_PUB_HLTH	T_HIERARCHY_NODE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_CENSUS	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_AUTOASSIGN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_GROUP_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_LIV_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_PANEL_SZ	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_RGN_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PGM_STATUS_GRP	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_PMP_FOCUS	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_SPEC_COND	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MC_SPEC_COND_PGM_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MR_MSIS_AID	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_MR_TMSIS_BEN_PLAN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PAYER_PLAN_BENEFIT	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PAY_BNFT_PLAN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PAY_HOLD_PGM_CDE	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PGM_CT_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PGM_DEPENDENCY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PGM_EXCLUSION	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PMP_SVC_LOC	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PMP_SVC_LOC_KY	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PMP_SVC_LOC_WI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PROC_DIAG_PA	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PR_COVERED_PGM	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PUB_HLTH_AID	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_PUB_HLTH_PGM	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_REGION_DISP	NUMBER	9.00	0.00

SAK_PUB_HLTH	T_RE_ASSIGN_PLAN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_ASSIGN_PLAN_LI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_ASSIGN_PLAN_RLOC	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_ELIG	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_ELIG_DN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_MC_RECIP	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_MC_RECIP_WI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_MEDICARE_D	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_RE_RETRO_ELIG	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_STATE_COS	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_STOP_LOSS_PARMS	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_SUR_RQST_EOMB	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_SUSP_RLHX	NUMBER	9.00	0.00
SAK_PUB_HLTH	T_TPL_COV_PLAN_XREF	NUMBER	9.00	0.00
SAK_PUB_HLTH_AID	T_PUB_HLTH_AID	NUMBER	9.00	0.00
SAK_PUB_HLTH_CHILD	T_BNFT_PLAN_COB	NUMBER	9.00	0.00
SAK_QUAL	T_MM_CRIT	NUMBER	4.00	0.00
SAK_QUAL	T_MM_QUALIFIER	NUMBER	4.00	0.00
SAK_QUERY	T_LETTER_TEMPLATE	NUMBER	9.00	0.00
SAK_QUERY	T_QUERY	NUMBER	9.00	0.00
SAK_QUESTION	T_PA_RULE_QUESTION	NUMBER	9.00	0.00
SAK_QUESTION	T_PR_ENRL_DISCLOSURE_ANS	NUMBER	4.00	0.00
SAK_QUESTION	T_PR_ENRL_DISCLOSURE_QUES	NUMBER	4.00	0.00
SAK_RATE_CELL	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_RATE_CELL	T_CAP_MASS_ADJ_RST	NUMBER	9.00	0.00

SAK_RATE_CELL	T_CAP_MASS_ADJ_RST_tmp	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CAP_AMTS	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CAP_AMTS_PMP	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CAP_AMTS_RANGE	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CAP_DEMOGRAPH	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CAP_DEMOGRAPH_KY	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_CENSUS	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_DIAG_RATE	NUMBER	9.00	0.00
SAK_RATE_CELL	T_MC_RATE_CELL	NUMBER	9.00	0.00
SAK_RATE_REQ	T_PR_LOC_RATE_REQ	NUMBER	9.00	0.00
SAK_RA_CURR	T_FIN_CYCLE	NUMBER	9.00	0.00
SAK_RC	T_PA_IAC_TEXT	NUMBER	9.00	0.00
SAK_RC	T_PA_IAC_XREF	NUMBER	9.00	0.00
SAK_RCP_MINI_LINK	T_RE_MINI_LINK_XREF	NUMBER	9.00	0.00
SAK_RCP_PURGED	T_RECIP_LINK_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_ACCT_REC_DN	NUMBER	9.00	0.00
SAK_RECIP	T_ADJMS_RECIP	NUMBER	9.00	0.00
SAK_RECIP	T_ADJ_MASS_CLAIM	NUMBER	9.00	0.00
SAK_RECIP	T_AR_SUPP_DTL	NUMBER	9.00	0.00
SAK_RECIP	T_ATTACHMENT_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_AUTO_PA_LTR	NUMBER	9.00	0.00
SAK_RECIP	T_BUYA_BILL	NUMBER	9.00	0.00
SAK_RECIP	T_BUYA_BILL_INFO	NUMBER	9.00	0.00
SAK_RECIP	T_BUYA_DEMO_CHANGE	NUMBER	9.00	0.00
SAK_RECIP	T_BUYA_PERD	NUMBER	9.00	0.00
SAK_RECIP	T_BUYA_PREM	NUMBER	9.00	0.00
SAK_RECIP	T_BUYB_BILL	NUMBER	9.00	0.00
SAK_RECIP	T_BUYB_BILL_INFO	NUMBER	9.00	0.00
SAK_RECIP	T_BUYB_DEMO_CHANGE	NUMBER	9.00	0.00
SAK_RECIP	T_BUYB_PERD	NUMBER	9.00	0.00
SAK_RECIP	T_BUYB_PREM	NUMBER	9.00	0.00
SAK_RECIP	T_CALL_TRACK	NUMBER	9.00	0.00
SAK_RECIP	T_CAPITATION_ADJ	NUMBER	9.00	0.00

SAK_RECIP	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_RECIP	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_RECIP	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_RECIP	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_RECIP	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_RECIP	T_CASH_RCPT_DISP	NUMBER	9.00	0.00
SAK_RECIP	T_CASUALTY_CASE	NUMBER	9.00	0.00
SAK_RECIP	T_CASUALTY_CASE_AL	NUMBER	9.00	0.00
SAK_RECIP	T_CAS_AT_EXCLUSIONS	NUMBER	9.00	0.00
SAK_RECIP	T_CA_KICK_PYMT	NUMBER	9.00	0.00
SAK_RECIP	T_CA_MATERNITY_CARE	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_BENEFIT_LIMITS	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_COMP_DAYS	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_KICK_PYMT	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_MAT_CARE_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_PATLIAB_X	NUMBER	9.00	0.00
SAK_RECIP	T_CLM_RECIP_RQST	NUMBER	9.00	0.00
SAK_RECIP	T_CPAS_EXTRACT	NUMBER	9.00	0.00
SAK_RECIP	T_CPAS_SPLIT	NUMBER	9.00	0.00
SAK_RECIP	T_DCOR_SCHEDULE	NUMBER	9.00	0.00
SAK_RECIP	T_DENY_DNTL_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_DENY_PHRM_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_DENY_PHYS_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_DENY_UB92_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_DR_CLMS_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_DR_RECOUP_LTR_ICN	NUMBER	9.00	0.00
SAK_RECIP	T_DS_DNTL_ICN	NUMBER	9.00	0.00
SAK_RECIP	T_DS_DNTL_RECIP	NUMBER	9.00	0.00
SAK_RECIP	T_DS_HM_HEADER	NUMBER	9.00	0.00
SAK_RECIP	T_DS_RECIP_MFP	NUMBER	9.00	0.00
SAK_RECIP	T_EVS_ELIG	NUMBER	9.00	0.00
SAK_RECIP	T_EVS_INQUIRY	NUMBER	9.00	0.00
SAK_RECIP	T_EXPENDITURE	NUMBER	9.00	0.00
SAK_RECIP	T_EXPENDITURE_DN	NUMBER	9.00	0.00
SAK_RECIP	T_EXPENDITURE_SUPP_DTL	NUMBER	9.00	0.00
SAK_RECIP	T_HIPP_RECIP	NUMBER	9.00	0.00
SAK_RECIP	T_HIST_DIRECTORY	NUMBER	9.00	0.00
SAK_RECIP	T_MC_CENSUS	NUMBER	9.00	0.00
SAK_RECIP	T_MC_EXT_RECIPS	NUMBER	9.00	0.00
SAK_RECIP	T_MC_RE_NOTES	NUMBER	9.00	0.00
SAK_RECIP	T_MC_RE_PMP_LKOUT	NUMBER	9.00	0.00
SAK_RECIP	T_MC_RE_SPEC_COND	NUMBER	9.00	0.00

SAK_RECIP	T_MEDPOL_UB92	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_DENTAL_DTL	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_DSE_PROF	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_INPT_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_INPT_HDR2	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_PHRM_DTL_AL	NUMBER	9.00	0.00
SAK_RECIP	T_MPHX_PHYS_DTL	NUMBER	9.00	0.00
SAK_RECIP	T_MR_WVR_CLM	NUMBER	9.00	0.00
SAK_RECIP	T_MR_WVR_ELG	NUMBER	9.00	0.00
SAK_RECIP	T_PA_PAUTH	NUMBER	9.00	0.00
SAK_RECIP	T_PA_RECIP_ADH	NUMBER	9.00	0.00
SAK_RECIP	T_PDUR_SUSP	NUMBER	9.00	0.00
SAK_RECIP	T_PD_DNTL_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_PD_PHARM_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_PD_PHYS_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_PD_UB92_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_PR_CONTRACT_RATE_KY	NUMBER	9.00	0.00
SAK_RECIP	T_RECIP_LINK_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_RECIP_REVIEW	NUMBER	9.00	0.00
SAK_RECIP	T_RE_1095	NUMBER	9.00	0.00
SAK_RECIP	T_RE_1095_TRACK	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ADDRESS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ADR_CASS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_AID_ELIG	NUMBER	9.00	0.00
SAK_RECIP	T_RE_AID_ELIG_DN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ALIEN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_AR_BASE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ASSIGNMENT	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ASSIGN_PLAN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ASSIGN_PLAN_LI	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ASSIGN_PLAN_RLOC	NUMBER	9.00	0.00
SAK_RECIP	T_RE_BASE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_BASE_DN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_BASE_STATE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_BNDX_BUYIN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CARE_MNGR	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CASE_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CCHIC_TRACK	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CLOSE_MCD	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CMS_MMA_ENROLL	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CMS_MMA_RESPONSE	NUMBER	9.00	0.00

SAK_RECIP	T_RE_COMMENT	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CONSENT_FORM_MASTER	NUMBER	9.00	0.00
SAK_RECIP	T_RE_CUST_STATUS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_DEATH_CHG	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EDB	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ELIG	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ELIG_DN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EMAIL	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EPSDT_LETTER	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EPSDT_REC_NOT	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EPS_ABNORMAL	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EPS_CURR_SCRN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EPS_HIST_EXT	NUMBER	9.00	0.00
SAK_RECIP	T_RE_EXT_RECIPS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_HIB	NUMBER	9.00	0.00
SAK_RECIP	T_RE_HOH	NUMBER	9.00	0.00
SAK_RECIP	T_RE_HOSPICE_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_RE_IDENTIFIER	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ID_CARD	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ID_CRD_ISS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_ID_CRD_RQST	NUMBER	9.00	0.00
SAK_RECIP	T_RE_INCOME	NUMBER	9.00	0.00
SAK_RECIP	T_RE_LINK_RQST	NUMBER	9.00	0.00
SAK_RECIP	T_RE_LOC	NUMBER	9.00	0.00
SAK_RECIP	T_RE_LOCKIN_PERIOD	NUMBER	9.00	0.00
SAK_RECIP	T_RE_LOC_DATES	NUMBER	9.00	0.00
SAK_RECIP	T_RE_LTC_RCO_AVAILABLE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MC_RECIP	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MC_RECIP_WI	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MEDICARE_A	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MEDICARE_B	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MEDICARE_D	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MINI_LINK_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_RE_MULTI_ADDRESS	NUMBER	9.00	0.00
SAK_RECIP	T_RE_NAME_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_RE_OLD_PCN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_OTH_CHG	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PARTD_PDP_ASSIGN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PART_A_ACCRETION	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PART_B_ACCRETION	NUMBER	9.00	0.00

SAK_RECIP	T_RE_PAT_LIAB	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PHONE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PREV_CTY	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PREV_SSN	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PS2_DUPE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_PTOT_OVERBILL	NUMBER	9.00	0.00
SAK_RECIP	T_RE_RCO_834	NUMBER	9.00	0.00
SAK_RECIP	T_RE_REDETERM_DTE	NUMBER	9.00	0.00
SAK_RECIP	T_RE_RETRO_ELIG	NUMBER	9.00	0.00
SAK_RECIP	T_RE_UNLINK_RQST	NUMBER	9.00	0.00
SAK_RECIP	T_SUSP_DENTAL_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_SUSP_PHRM_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_SUSP_PHYS_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_SUSP_UB92_HDR	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_AC_PARENT_RECIP_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_CANCER_REGISTRY	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_CASE_INFO	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_CAS_BI_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_EXEMPT	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_LAST_REPTD	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_PREBILL	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_RES_DEL	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_SUSP_XREF	NUMBER	9.00	0.00
SAK_RECIP	T_TPL_THRESHOLD_SUMM	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG003_VAR_DEMO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG004_CONTACT_INF	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	9.00	0.00

SAK_RECIPIENT	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG010_MFP_INFO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG011_STATE_PLAN	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG012_WAIVER_PART	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG015_ETHNICITY	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG016_RACE_INFO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG017_DISAB_INFO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG018_1115A_DEMO	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	9.00	0.00
SAK_RECIPIENT	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	9.00	0.00
SAK_RECIP_AGGR_CNT	T_DS_RECIP_AGGR_CNT	NUMBER	9.00	0.00
SAK_RECIP_ALLKIDS	T_MR_TMSIS_ALLKIDS	NUMBER	9.00	0.00
SAK_RECIP_LINK	T_RE_LINK_RQST	NUMBER	9.00	0.00
SAK_RECIP_NEW	T_CA_RECIP_HIST	NUMBER	9.00	0.00
SAK_RECIP_NEW	T_CLM_RECIP_HIST	NUMBER	9.00	0.00
SAK_RECIP_NEW	T_RE_CLM_DELINK	NUMBER	9.00	0.00
SAK_RECIP_OLD	T_CA_RECIP_HIST	NUMBER	9.00	0.00
SAK_RECIP_OLD	T_CLM_RECIP_HIST	NUMBER	9.00	0.00
SAK_RECIP_OLD	T_RE_CLM_DELINK	NUMBER	9.00	0.00
SAK_RECIP_UNLINK	T_RE_UNLINK_RQST	NUMBER	9.00	0.00
SAK_RECORD	T_CA_FIN	NUMBER	9.00	0.00
SAK_RECORD	T_COS_DTL_XREF	NUMBER	9.00	0.00

SAK_RECORD	T_MR_CMS64	NUMBER	9.00	0.00
SAK_REC_ID_CARD	T_RE_ID_CARD	NUMBER	9.00	0.00
SAK_REFERRAL	T_CT_REFERRALS	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_BNFT_ADJ_FACTOR_XREF	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_BNFT_PLAN_REIMB	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_FIN_PAYER_REIMB	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_PRCNG_TYPE_SPEC	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_PRICING_CLM_TYPE	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_PR_CONTRACT_REIMB	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_AGREEMENT	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_BNFT_BNFT	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_LOCATION	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_POS	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_REGION	NUMBER	9.00	0.00
SAK_REIMB_AGRMNT	T_REIMB_TOB	NUMBER	9.00	0.00
SAK_REIMB_CND_AXIS_RANGE	T_REIMB_CND_AXIS_RANGE	NUMBER	9.00	0.00
SAK_REIMB_CND_AXIS_RANGE	T_REIMB_CONDITION	NUMBER	9.00	0.00
SAK_REIMB_MOD_AXIS_RANGE	T_REIMB_MODIFIER	NUMBER	9.00	0.00
SAK_REIMB_MOD_AXIS_RANGE	T_REIMB_MOD_AXIS_RANGE	NUMBER	9.00	0.00
SAK_REIMB_NULL	T_REIMB_AGREEMENT	NUMBER	9.00	0.00

SAK_RELATED_HX	T_PDUR_FINAL_WARN	NUMBER	9.00	0.00
SAK_RELATED_HX	T_PDUR_RLHX	NUMBER	9.00	0.00
SAK_RELATED_HX	T_PRODUR_WARN	NUMBER	9.00	0.00
SAK_RELATED_HX	T_SUSP_RLHX	NUMBER	9.00	0.00
SAK_RELATION	T_RU_RELATION	NUMBER	9.00	0.00
SAK_RELATION	T_RU_RELATION_XREF	NUMBER	9.00	0.00
SAK_RELATION	T_RU_VARIABLE	NUMBER	9.00	0.00
SAK_RELATION_CHILD	T_RU_RELATION_XREF	NUMBER	9.00	0.00
SAK_REMARK	T_CDE_CARC_RARC	NUMBER	9.00	0.00
SAK_REMARK	T_CDE_HIPAA_REMRKS	NUMBER	9.00	0.00
SAK_REMARK	T_EOB_REMRKS_XREF	NUMBER	9.00	0.00
SAK_REMIT	T_FIN_REMIT	NUMBER	9.00	0.00
SAK_REMIT	T_FIN_REMIT_TXN_XREF	NUMBER	9.00	0.00
SAK_REPRESENTS	T_ATTORNEY_XREF	NUMBER	9.00	0.00
SAK_REPRESENTS	T_ATTORNEY_XREF_WI	NUMBER	9.00	0.00
SAK_REPRESENTS	T_BATCH_LETTERS	NUMBER	9.00	0.00
SAK_REPRESENTS	T_CAS_HIST_LETTERS	NUMBER	9.00	0.00
SAK_REPRESENTS	T_INS_AGENT_XREF	NUMBER	9.00	0.00
SAK_RESO_STATUS	T_ERR_RESO_STATUS	NUMBER	9.00	0.00
SAK_RESO_STATUS	T_RESO_STATUS	NUMBER	9.00	0.00
SAK_REV	T_AUDIT_REV	NUMBER	9.00	0.00
SAK_REVENUE	T_COUNTY_RATE	NUMBER	9.00	0.00
SAK_REVENUE	T_PA_LINE_ITEM	NUMBER	9.00	0.00
SAK_REVENUE	T_PR_LOC_RATE_WI	NUMBER	9.00	0.00
SAK_REVENUE	T_REVENUE_CODE	NUMBER	9.00	0.00
SAK_REVENUE	T_REVENUE_FLAT_FEE	NUMBER	9.00	0.00
SAK_REVENUE	T_REVENUE_NOTES	NUMBER	9.00	0.00
SAK_REVENUE	T_REV_PROC_XREF	NUMBER	9.00	0.00

SAK_REVENUE	T_REV_SPEC_RSTN	NUMBER	9.00	0.00
SAK_REVENUE_FROM	T_REV_GROUP	NUMBER	9.00	0.00
SAK_REVENUE_TO	T_REV_GROUP	NUMBER	9.00	0.00
SAK_REVIEW	T_RECIP_REVIEW	NUMBER	9.00	0.00
SAK_REV_CLAIM	T_REV_HOSPICE_XWALK	NUMBER	9.00	0.00
SAK_REV_PRICE	T_REV_HOSPICE_XWALK	NUMBER	9.00	0.00
SAK_REV_REQ	T_RECIP_REVIEW	NUMBER	9.00	0.00
SAK_REV_REQ	T_RE_REV_REQ	NUMBER	9.00	0.00
SAK_REV_RSN	T_RECIP_REVIEW	NUMBER	9.00	0.00
SAK_REV_RSN	T_RE_REV_RSN	NUMBER	9.00	0.00
SAK_REV_TYPE	T_HOSPICE_RATE	NUMBER	4.00	0.00
SAK_REV_TYPE	T_HOSPICE_RATE	NUMBER	9.00	0.00
SAK_REV_TYPE	T_REV_GROUP	NUMBER	4.00	0.00
SAK_REV_TYPE	T_REV_GROUP	NUMBER	9.00	0.00
SAK_REV_TYPE	T_REV_TYPE	NUMBER	4.00	0.00
SAK_REV_TYPE	T_REV_TYPE	NUMBER	9.00	0.00
SAK_REV_TYPE	T_UB92_COS	NUMBER	4.00	0.00
SAK_RE_AR	T_RE_AR_BASE	NUMBER	9.00	0.00
SAK_RE_AR	T_RE_AR_OVERPAYMENT	NUMBER	9.00	0.00
SAK_RE_CRIT	T_CT_RE_CRIT	NUMBER	9.00	0.00
SAK_RE_DECISION	T_PA_RULE_DECISION	NUMBER	9.00	0.00
SAK_RE_DECISION	T_PA_RULE_NOTE	NUMBER	9.00	0.00
SAK_RE_DECISION	T_PA_RULE_QUESTION	NUMBER	9.00	0.00
SAK_RE_DUPE	T_RE_PS2_DUPE	NUMBER	9.00	0.00
SAK_RE_PDP_ASSIGN	T_RE_PARTD_PDP_ASSIGN	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_ADJ	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_ADJ_DN	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_ADJ_WI	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_HIST	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_HIST_DN	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_CAPITATION_HIST_WI	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_MC_CENSUS	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_MC_CENSUS_LOC	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_MC_RE_ASGN_LTRS	NUMBER	9.00	0.00
SAK_RE_PMP_ASSIGN	T_RE_PMP_ASSIGN	NUMBER	9.00	0.00

SAK_RE_PMP_ASSIGN	T_RE_PMP_ASSIGN_WI	NUMBER	9.00	0.00
SAK_RE_TXN	T_RE_HIST_ERR	NUMBER	9.00	0.00
SAK_RE_TXN	T_RE_HIST_LOG	NUMBER	9.00	0.00
SAK_RE_TXN	T_RE_PS2_ERR	NUMBER	9.00	0.00
SAK_RE_TXN	T_RE_PS2_LOG	NUMBER	9.00	0.00
SAK_RISK_ACTION	T_RISK_ACTIONS	NUMBER	9.00	0.00
SAK_RISK_CATEGORY	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_CATEGORY	T_RISK_CATEGORY	NUMBER	9.00	0.00
SAK_RISK_COLOR	T_RISK_COLORS	NUMBER	9.00	0.00
SAK_RISK_COLOR	T_RISK_RANKING	NUMBER	9.00	0.00
SAK_RISK_GRP_ID	T_MME_CONCR_RISK_GRP_ID_DS	NUMBER	9.00	0.00
SAK_RISK_ID	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_ID	T_RISK_ACTIONS	NUMBER	9.00	0.00
SAK_RISK_ID	T_RISK_PLANS	NUMBER	9.00	0.00
SAK_RISK_IMPACT	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_IMPACT	T_RISK_IMPACT	NUMBER	9.00	0.00
SAK_RISK_PLAN	T_RISK_PLANS	NUMBER	9.00	0.00
SAK_RISK_PLAN_STATUS	T_RISK_PLANS	NUMBER	9.00	0.00
SAK_RISK_PLAN_STATUS	T_RISK_PLAN_STATUS	NUMBER	9.00	0.00
SAK_RISK_PLAN_TYPE	T_RISK_PLANS	NUMBER	9.00	0.00
SAK_RISK_PLAN_TYPE	T_RISK_PLAN_TYPE	NUMBER	9.00	0.00
SAK_RISK_PROBABILITY	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_PROBABILITY	T_RISK_PROBABILITY	NUMBER	9.00	0.00
SAK_RISK_PROJECT	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_RANKING	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_RANKING	T_RISK_RANKING	NUMBER	9.00	0.00
SAK_RISK_SET_GRP_ID_LINK	T_MME_OPIOID_CONCR_RISK_LN	NUMBER	9.00	0.00
SAK_RISK_STATUS	T_RISKS	NUMBER	9.00	0.00
SAK_RISK_STATUS	T_RISK_STATUS	NUMBER	9.00	0.00
SAK_RLINK	T_ERX_FORMULARY_RLINK	NUMBER	9.00	0.00
SAK_RLINK	T_ERX_NDC_RLINK	NUMBER	9.00	0.00
SAK_RLINK	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_RPT	T_SYS_REPORT	NUMBER	9.00	0.00
SAK_RPT	T_SYS_REPORT_ROUTE	NUMBER	9.00	0.00
SAK_RPT_RECIP	T_SYS_REPORT_DIST	NUMBER	9.00	0.00
SAK_RPT_RECIP	T_SYS_REPORT_RECIP	NUMBER	9.00	0.00
SAK_RPT_ROUTE	T_SYS_REPORT_DIST	NUMBER	9.00	0.00
SAK_RPT_ROUTE	T_SYS_REPORT_ROUTE	NUMBER	9.00	0.00
SAK_RPT_RQST	T_TPL_RQST_REPORT	NUMBER	9.00	0.00
SAK_RPT_RQST	T_TPL_RQST_RPT_SRCH	NUMBER	9.00	0.00

SAK_RQST	T_ADJMS_AGE_SEX	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_AID_CAT	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_CT	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_DATES	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_DIAG	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_DRG	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_DRUG	NUMBER	4.00	0.00

SAK_RQST	T_ADJMS_ERROR	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_LOC	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_MEDAST	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_MODIF	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_PROV	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_PROVTYP	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_PRSPEC	NUMBER	4.00	0.00

SAK_RQST	T_ADJMS_PRSVC	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_RECIP	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_REGION	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_REVENUE	NUMBER	4.00	0.00
SAK_RQST	T_ADJMS_SERV	NUMBER	4.00	0.00
SAK_RQST	T_ADJ_MASS_CLAIM	NUMBER	4.00	0.00
SAK_RQST	T_ADJ_MASS_RQST	NUMBER	4.00	0.00
SAK_RULE	T_CLM_RU_MATCHED	NUMBER	9.00	0.00
SAK_RULE	T_ERX_FORMULARY	NUMBER	9.00	0.00

SAK_RULE	T_PROC_RU_COV_XREF	NUMBER	9.00	0.00
SAK_RULE	T_RU_COMPARISON	NUMBER	9.00	0.00
SAK_RULE	T_RU_CONDITION	NUMBER	9.00	0.00
SAK_RULE	T_RU_RULE	NUMBER	9.00	0.00
SAK_RULE	T_RU_RULE_ACTION	NUMBER	9.00	0.00
SAK_RULE	T_RU_RULE_HISTORY	NUMBER	9.00	0.00
SAK_RULE_EXCEPTION	T_RU_RULE	NUMBER	9.00	0.00
SAK_RULE_REPLACED	T_RU_RULE	NUMBER	9.00	0.00
SAK_SCHED_OVERRIDE	T_FIN_SCHED_OVERRIDE	NUMBER	9.00	0.00
SAK_SCREENING	T_ALLERGY	NUMBER	9.00	0.00
SAK_SCREENING	T_CONTRA_DISEASE	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_DISEASE	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_GER	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_GER	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_INVERSE	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_OVER_UTIL	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_PED	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_PED	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_PREG	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_SCREEN	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_THER_DUPE	NUMBER	9.00	0.00
SAK_SCREENING	T_DRUG_UNDER_UTIL	NUMBER	9.00	0.00
SAK_SCREENING	T_GERI_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_HIGH_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_HIGH_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_INGRED_DUPE	NUMBER	9.00	0.00
SAK_SCREENING	T_LOW_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_LOW_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_PDUR_ADD_TOX	NUMBER	9.00	0.00

SAK_SCREENING	T_PDUR_UPD_ERROR	NUMBER	9.00	0.00
SAK_SCREENING	T_PEDI_DOSE	NUMBER	9.00	0.00
SAK_SCREENING	T_THERA_DURATION	NUMBER	9.00	0.00
SAK_SCREENING	T_THERA_DURATION	NUMBER	9.00	0.00
SAK_SCRN_CRIT	T_PDL_SCRN_CRIT	NUMBER	9.00	0.00
SAK_SEL_LST	T_CT_SELECT_LST	NUMBER	9.00	0.00
SAK_SEQ	T_CASUALTY_CASE_OFFLINE	NUMBER	9.00	0.00
SAK_SEQUENCE	T_ASC_PRICING	NUMBER	9.00	0.00
SAK_SEQUENCE	T_DRUG_AAC_PRICE	NUMBER	9.00	0.00
SAK_SEQUENCE	T_DRUG_AWP	NUMBER	9.00	0.00
SAK_SEQUENCE	T_DRUG_MAC	NUMBER	9.00	0.00
SAK_SEQUENCE	T_DRUG_S_MAC	NUMBER	9.00	0.00
SAK_SEQUENCE	T_NDDF_PRICE	NUMBER	8.00	0.00
SAK_SEQUENCE	T_PROC_ASC	NUMBER	9.00	0.00
SAK_SHORT	T_ADJ_RET_RQST_ERR	NUMBER	4.00	0.00
SAK_SHORT	T_AHFS_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_ALLERGY_DIAG	NUMBER	4.00	0.00
SAK_SHORT	T_CA_RECIP_HIST	NUMBER	4.00	0.00
SAK_SHORT	T_CHECK_COMMENT	NUMBER	4.00	0.00
SAK_SHORT	T_CLIA_CERT	NUMBER	4.00	0.00
SAK_SHORT	T_CLIA_LAB	NUMBER	4.00	0.00
SAK_SHORT	T_CLM_HIST_BALANCE	NUMBER	4.00	0.00
SAK_SHORT	T_CLM_NDC_DTL	NUMBER	4.00	0.00
SAK_SHORT	T_CLM_RECIP_RQST	NUMBER	4.00	0.00
SAK_SHORT	T_CONDITION	NUMBER	4.00	0.00
SAK_SHORT	T_COV_BNFT_CONDITION	NUMBER	4.00	0.00
SAK_SHORT	T_DRG_CROSSWALK	NUMBER	4.00	0.00
SAK_SHORT	T_DRUG_HCPCS	NUMBER	4.00	0.00
SAK_SHORT	T_DR_INCR_ADJ	NUMBER	4.00	0.00
SAK_SHORT	T_DR_INCR_INT	NUMBER	4.00	0.00
SAK_SHORT	T_DR_INCR_PAY	NUMBER	4.00	0.00

SAK_SHORT	T_DR_INV_COMMENT	NUMBER	4.00	0.00
SAK_SHORT	T_DR_INV_TYPE_XREF	NUMBER	4.00	0.00
SAK_SHORT	T_DR_JCODE_XWALK	NUMBER	4.00	0.00
SAK_SHORT	T_DR_PPA_INV_DTL	NUMBER	4.00	0.00
SAK_SHORT	T_DR_RATE	NUMBER	4.00	0.00
SAK_SHORT	T_DR_RATE_UROA	NUMBER	4.00	0.00
SAK_SHORT	T_DR_STATUS	NUMBER	4.00	0.00
SAK_SHORT	T_DR_STATUS_SUPPLE	NUMBER	4.00	0.00
SAK_SHORT	T_DR_UNIT_CONV	NUMBER	3.00	0.00
SAK_SHORT	T_DS_RECIP_MFP	NUMBER	4.00	0.00
SAK_SHORT	T_EDI_TP_834_RQST	NUMBER	4.00	0.00
SAK_SHORT	T_EVS_SVC_COVERAGE	NUMBER	4.00	0.00
SAK_SHORT	T_FIN_EFT_ACCT	NUMBER	4.00	0.00
SAK_SHORT	T_FIN_MAX_RECOUP	NUMBER	4.00	0.00
SAK_SHORT	T_FIN_PYMT_PULL	NUMBER	4.00	0.00
SAK_SHORT	T_HIC_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_INP_LOC_RATE	NUMBER	4.00	0.00
SAK_SHORT	T_IRS_W9_INFO	NUMBER	4.00	0.00
SAK_SHORT	T_LIMITPARM_POS	NUMBER	4.00	0.00
SAK_SHORT	T_LIMIT_PARM	NUMBER	4.00	0.00
SAK_SHORT	T_LOCATION_NOTE	NUMBER	4.00	0.00
SAK_SHORT	T_MC_CENSUS_LOC	NUMBER	4.00	0.00
SAK_SHORT	T_MC_FTE	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_EDB_XREF	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_ENRL_RGN	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_ENRL_RGN_AL	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_GRP	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_GRP_MBR	NUMBER	4.00	0.00

SAK_SHORT	T_MC_PMP_MASS_XFER	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_NT_CENSUS	NUMBER	4.00	0.00
SAK_SHORT	T_MC_PMP_PANEL_RESTRICT	NUMBER	4.00	0.00
SAK_SHORT	T_MC_RE_PMP_SEL	NUMBER	4.00	0.00
SAK_SHORT	T_MR_WVR_SVC	NUMBER	4.00	0.00
SAK_SHORT	T_PATIENT_STAT	NUMBER	4.00	0.00
SAK_SHORT	T_PAY_BNFT_CONDITION	NUMBER	4.00	0.00
SAK_SHORT	T_PDUR_ADD_TOX_FAC	NUMBER	4.00	0.00
SAK_SHORT	T_PEER_GRP_INP_LOC	NUMBER	4.00	0.00
SAK_SHORT	T_PHS_DATES	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ACCT_REC_MAX	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ACC_PTS_WI	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ANNUAL_VISIT_CRIT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_APPLN_STATUS_RSN	NUMBER	4.00	0.00
SAK_SHORT	T_PR_BEDS_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_BILLER	NUMBER	4.00	0.00
SAK_SHORT	T_PR_BOARD	NUMBER	4.00	0.00
SAK_SHORT	T_PR_BOARD_MEM	NUMBER	4.00	0.00
SAK_SHORT	T_PR_BOND	NUMBER	4.00	0.00
SAK_SHORT	T_PR_CAPT_CST	NUMBER	4.00	0.00
SAK_SHORT	T_PR_CHOW_GRP_MBR	NUMBER	4.00	0.00
SAK_SHORT	T_PR_CLIA_STAT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_COMMENT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_CONTRACT_RATE_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_CST_CHRG	NUMBER	4.00	0.00

SAK_SHORT	T_PR_DEA	NUMBER	4.00	0.00
SAK_SHORT	T_PR_DISP_FEE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_DRG_RATE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_EFT_ACCT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENRL_BOARD	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENRL_EFT_ACCT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENRL_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENRL_SPECIALTY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENRL_UPLOAD	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENROLL_INFO	NUMBER	4.00	0.00
SAK_SHORT	T_PR_ENROLL_SCRN	NUMBER	4.00	0.00
SAK_SHORT	T_PR_FACILITY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_GRP_MBR	NUMBER	4.00	0.00
SAK_SHORT	T_PR_HB_LIC	NUMBER	4.00	0.00
SAK_SHORT	T_PR_HB_LIC_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_IDENTIFIER	NUMBER	4.00	0.00
SAK_SHORT	T_PR_INST_RATE_WI	NUMBER	4.00	0.00
SAK_SHORT	T_PR_INTERFACE_STATS	NUMBER	4.00	0.00
SAK_SHORT	T_PR_LICENSE_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_LOC_RATE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_LOC_RATE_WI	NUMBER	4.00	0.00
SAK_SHORT	T_PR_MARG_CST	NUMBER	4.00	0.00
SAK_SHORT	T_PR_MDED_CST	NUMBER	4.00	0.00
SAK_SHORT	T_PR_NAM_NPPES	NUMBER	4.00	0.00

SAK_SHORT	T_PR_OUT_OF_STATE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_OUT_RATE_AL	NUMBER	4.00	0.00
SAK_SHORT	T_PR_OWNER	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PAY_PULL	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PCP	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PEER_LEVEL	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PHP_ELIG	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PHP_ELIG	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PHYS_ASST	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PHYS_SUPV	NUMBER	4.00	0.00
SAK_SHORT	T_PR_PRESCRIBER	NUMBER	4.00	0.00
SAK_SHORT	T_PR_RATE_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_REVIEW	NUMBER	4.00	0.00
SAK_SHORT	T_PR_RST_SVC	NUMBER	4.00	0.00
SAK_SHORT	T_PR_RST_SVC_STATE_KY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SANCTION_AL	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SANCTION_WI	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SPEC	NUMBER	4.00	0.00
SAK_SHORT	T_PR_STATE_SHARE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SURS_SPEC	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SVC_CERT	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SVC_CERT_WI	NUMBER	4.00	0.00
SAK_SHORT	T_PR_SVC_LANG	NUMBER	4.00	0.00

SAK_SHORT	T_PR_TAXONOMY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_TAX_ID	NUMBER	4.00	0.00
SAK_SHORT	T_PR_TYPE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_UB_LOC_RATE	NUMBER	4.00	0.00
SAK_SHORT	T_PR_VERIFY	NUMBER	4.00	0.00
SAK_SHORT	T_PR_WEB_CHG	NUMBER	4.00	0.00
SAK_SHORT	T_PR_WEB_CHG_BACKUP	NUMBER	4.00	0.00
SAK_SHORT	T_REF_CDE_AID_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_REF_CDE_VALUE_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_REF_ID_PROV_GROUP	NUMBER	4.00	0.00
SAK_SHORT	T_REF_UCC	NUMBER	4.00	0.00
SAK_SHORT	T_RE_1095	NUMBER	4.00	0.00
SAK_SHORT	T_RE_1095_TRACK	NUMBER	4.00	0.00
SAK_SHORT	T_RE_ADPH_1095	NUMBER	4.00	0.00
SAK_SHORT	T_RE_ADPH_1095_TRACK	NUMBER	4.00	0.00
SAK_SHORT	T_RE_AR_OVERPAYMENT	NUMBER	4.00	0.00
SAK_SHORT	T_RE_AR_TRANSACTION	NUMBER	4.00	0.00
SAK_SHORT	T_RE_ASSIGN_REASON	NUMBER	4.00	0.00
SAK_SHORT	T_RE_CHILD_EXPECT	NUMBER	4.00	0.00
SAK_SHORT	T_RE_CHILD_HAD	NUMBER	4.00	0.00
SAK_SHORT	T_RE_CMS_MMA_ENROLL	NUMBER	4.00	0.00

SAK_SHORT	T_RE_CMS_MMA_RESPONSE	NUMBER	4.00	0.00
SAK_SHORT	T_RE_COMMENT	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EDB_GHO	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EDB_HIC	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EDB_HOSPICE	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EDB_SSN	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EMAIL	NUMBER	4.00	0.00
SAK_SHORT	T_RE_EXPENSE	NUMBER	4.00	0.00
SAK_SHORT	T_RE_HIST_ERR	NUMBER	4.00	0.00
SAK_SHORT	T_RE_HOH	NUMBER	4.00	0.00
SAK_SHORT	T_RE_HOSPICE_DTL	NUMBER	4.00	0.00
SAK_SHORT	T_RE_ID_CRD_RQST	NUMBER	4.00	0.00
SAK_SHORT	T_RE_INCOME_LOSS	NUMBER	4.00	0.00
SAK_SHORT	T_RE_INCOME_NEW	NUMBER	4.00	0.00
SAK_SHORT	T_RE_MEDICARE_D	NUMBER	4.00	0.00
SAK_SHORT	T_RE_MOVE_IN_OUT	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PART_A_ACCRETION	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PART_B_ACCRETION	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PHONE	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PREV_SSN	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PS2_ERR	NUMBER	4.00	0.00
SAK_SHORT	T_RE_PTOT_OVERBILL	NUMBER	4.00	0.00
SAK_SHORT	T_RE_RCO_834	NUMBER	4.00	0.00
SAK_SHORT	T_RE_RETRO_ELIG	NUMBER	4.00	0.00
SAK_SHORT	T_TPL_AC_PARENT_MED_XREF	NUMBER	4.00	0.00
SAK_SHORT	T_TPL_EXEMPT	NUMBER	4.00	0.00

SAK_SHORT	T_TPL_SUSP_XREF	NUMBER	4.00	0.00
SAK_SHORT	T_WEB_MESSAGE_USER	NUMBER	4.00	0.00
SAK_SHORT_1099_DSC	T_1099_DETAIL	NUMBER	9.00	0.00
SAK_SHORT_ADDRESS	T_PR_ADR	NUMBER	4.00	0.00
SAK_SHORT_ADDRESS	T_PR_ADR_AL	NUMBER	4.00	0.00
SAK_SHORT_ADDRESS	T_PR_ADR_WI	NUMBER	4.00	0.00
SAK_SHORT_ADDRESS	T_PR_LOC_NM_ADR	NUMBER	4.00	0.00
SAK_SHORT_ADDRESS	T_RE_ADDRESS	NUMBER	4.00	0.00
SAK_SHORT_ATN	T_PR_APPLN_COMMENT	NUMBER	4.00	0.00
SAK_SHORT_BNDX	T_RE_BNDX_BUYIN	NUMBER	4.00	0.00
SAK_SHORT_CALL	T_CALL_NOTES	NUMBER	8.00	0.00
SAK_SHORT_CALL	T_CALL_QUESTION	NUMBER	8.00	0.00
SAK_SHORT_CAP_ADJ	T_CAP_MASS_ADJ_RST	NUMBER	4.00	0.00
SAK_SHORT_CAP_ADJ	T_CAP_MASS_ADJ_RST_tmp	NUMBER	4.00	0.00
SAK_SHORT_COS	T_ACCT_REC	NUMBER	4.00	0.00
SAK_SHORT_COS	T_ACCT_REC_DN	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_AID_CAT	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_ASSIGN_CRIT	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_CLM_TYPE	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_DRUG	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_FIN_FUND	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_PROV	NUMBER	4.00	0.00
SAK_SHORT_COS	T_COS_PROV_SPEC	NUMBER	4.00	0.00
SAK_SHORT_COS	T_EXPENDITURE	NUMBER	4.00	0.00
SAK_SHORT_COS	T_EXPENDITURE_DN	NUMBER	4.00	0.00
SAK_SHORT_COS	T_FIN_PROCESS_AR	NUMBER	4.00	0.00

SAK_SHORT_COS	T_PAY_HOLD_SCOS	NUMBER	4.00	0.00
SAK_SHORT_COS	T_PHARMACY_COS	NUMBER	4.00	0.00
SAK_SHORT_COS	T_PHYSICIAN_COS	NUMBER	4.00	0.00
SAK_SHORT_COS	T_STATE_COS	NUMBER	4.00	0.00
SAK_SHORT_COS	T_UB92_COS	NUMBER	4.00	0.00
SAK_SHORT_COVERAGE	T_TPL_271_COVERAGE	NUMBER	4.00	0.00
SAK_SHORT_DEPENDENT	T_TPL_271_COVERAGE	NUMBER	4.00	0.00
SAK_SHORT_DEPENDENT	T_TPL_271_DEPENDENT	NUMBER	4.00	0.00
SAK_SHORT_HIB	T_RE_HIB	NUMBER	4.00	0.00
SAK_SHORT_ICD9_TYP	T_CLM_FCA	NUMBER	9.00	0.00
SAK_SHORT_ICD9_TYP	T_PROC_ICD9_GROUP	NUMBER	4.00	0.00
SAK_SHORT_ICD9_TYP	T_PROC_ICD9_GROUP	NUMBER	9.00	0.00
SAK_SHORT_ICD9_TYP	T_PROC_ICD9_TYPE	NUMBER	4.00	0.00
SAK_SHORT_ICD9_TYP	T_PROC_ICD9_TYPE	NUMBER	9.00	0.00
SAK_SHORT_ID	T_DR_RECOUP_LTR_DATES	NUMBER	4.00	0.00
SAK_SHORT_ID	T_DR_RECOUP_LTR_ICN	NUMBER	4.00	0.00
SAK_SHORT_LOC	T_PR_ENRL_LOC	NUMBER	4.00	0.00
SAK_SHORT_LOC	T_PR_ENRL_LOC_PHONE	NUMBER	4.00	0.00
SAK_SHORT_LOC	T_RE_LOC	NUMBER	4.00	0.00
SAK_SHORT_MEDICARE	T_RE_MEDICARE_A	NUMBER	4.00	0.00
SAK_SHORT_MEDICARE	T_RE_MEDICARE_B	NUMBER	4.00	0.00
SAK_SHORT_NAME	T_PR_LOC_NM_ADR	NUMBER	4.00	0.00
SAK_SHORT_NAME	T_PR_NAM	NUMBER	4.00	0.00
SAK_SHORT_NAME	T_RE_NAME_XREF	NUMBER	4.00	0.00
SAK_SHORT_NOTE	T_CALL_NOTES	NUMBER	9.00	0.00
SAK_SHORT_OTHER	T_CALL_OTHER_INFO	NUMBER	4.00	0.00
SAK_SHORT_REJECT	T_RE_1095_TRACK	NUMBER	4.00	0.00

SAK_SHORT_REJECT	T_RE_ADPH_1095_TRACK	NUMBER	4.00	0.00
SAK_SPEC_COND	T_MC_CAP_CMF_RATES	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_CAP_DEMOGRAPH_KY	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_CENSUS_LOC	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_PMP_SC	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_RE_SPEC_COND	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_SPEC_COND	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_SPEC_COND_CLASS_XREF	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_SPEC_COND_EXCL	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_SPEC_COND_PGM_XREF	NUMBER	9.00	0.00
SAK_SPEC_COND	T_MC_SPEC_COND_TYPE_XREF	NUMBER	9.00	0.00
SAK_SPEC_COND_EXCL	T_MC_SPEC_COND_EXCL	NUMBER	9.00	0.00
SAK_SPEND_LIAB	T_RE_SPEND_LIAB	NUMBER	9.00	0.00
SAK_SPEND_LIAB	T_RE_SPEND_PROV	NUMBER	9.00	0.00
SAK_SPONSOR	T_RE_SPONSOR	NUMBER	9.00	0.00
SAK_STD_POLICY	T_CDE_STD_POLICY	NUMBER	9.00	0.00
SAK_STD_POLICY	T_CLAIM_BDL_NCCD	NUMBER	9.00	0.00
SAK_STD_POLICY	T_REF_CCI	NUMBER	9.00	0.00
SAK_STD_POLICY	T_REF_CCI_MUE	NUMBER	9.00	0.00
SAK_STD_POLICY	T_REF_CCI_MUE_OVERRIDE	NUMBER	9.00	0.00
SAK_STD_POLICY	T_REF_CCI_OVERRIDE	NUMBER	9.00	0.00
SAK_SUB	T_TPL_CAR_SUB_XREF	NUMBER	9.00	0.00
SAK_SUB	T_TPL_CHECK_HOLD	NUMBER	9.00	0.00
SAK_SUB	T_TPL_SUB	NUMBER	9.00	0.00
SAK_SUBSCRIBER	T_TPL_271_COVERAGE	NUMBER	9.00	0.00
SAK_SUBSCRIBER	T_TPL_271_DEPENDENT	NUMBER	9.00	0.00
SAK_SUBSCRIBER	T_TPL_271_SUBSCRIBER	NUMBER	9.00	0.00

SAK_SUM_ERR	T_BATCH_ERR_SUM	NUMBER	9.00	0.00
SAK_SUM_ERR	T_CLM_SUM_ERR_X	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_CDE_SUPPORTED_DOC	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_EDI_COVERED_PROV_XREF	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_SUPP_DOC_TYPE_XREF	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_TP_CONFIG	NUMBER	9.00	0.00
SAK_SUPPORTED_DOC	T_TRACK_SUPP_DOC_XREF	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_CLM_TYP	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_DATES	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_DIAG	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_EOMB	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_PROCMOD	NUMBER	9.00	0.00
SAK_SUR_RQST	T_SUR_RQST_PR_SVC	NUMBER	9.00	0.00
SAK_SW_MASKING_DATA	T_SW_MASKING_DATA	NUMBER	9.00	0.00
SAK_TAXONOMY	T_MR_TMSIS_PROV_TAXON	NUMBER	9.00	0.00
SAK_TAXONOMY	T_PR_APPLN	NUMBER	9.00	0.00
SAK_TAXONOMY	T_PR_TAXONOMY	NUMBER	9.00	0.00
SAK_TAXONOMY	T_PR_TAXONOMY_CDE	NUMBER	9.00	0.00
SAK_TAXONOMY	T_PR_TYPE_SPEC	NUMBER	9.00	0.00
SAK_TAXONOMY_1	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
SAK_TAXONOMY_2	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
SAK_TAXONOMY_3	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
SAK_TAXONOMY_FROM	T_TAXONOMY_GROUP	NUMBER	9.00	0.00
SAK_TAXONOMY_TO	T_TAXONOMY_GROUP	NUMBER	9.00	0.00
SAK_TAXONOMY_TYPE	T_AUTO_PA_TXNMY	NUMBER	9.00	0.00
SAK_TAXONOMY_TYPE	T_TAXONOMY_GROUP	NUMBER	9.00	0.00
SAK_TAXONOMY_TYPE	T_TAXONOMY_TYPE	NUMBER	9.00	0.00
SAK_TEXT	T_ERX_FORMULARY	NUMBER	9.00	0.00
SAK_TEXT	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_TEXT_CONCAT	T_ERX_TEXT_CONCAT	NUMBER	9.00	0.00
SAK_THERA_CLASS_FROM	T_THERAPEUTIC_GROUP	NUMBER	9.00	0.00
SAK_THERA_CLASS_TO	T_THERAPEUTIC_GROUP	NUMBER	9.00	0.00
SAK_THERA_CLASS_TYPE	T_ERX_RESOURCE_LINK	NUMBER	9.00	0.00
SAK_THERA_CLASS_TYPE	T_ERX_TEXT	NUMBER	9.00	0.00
SAK_THERA_CLASS_TYPE	T_THERAPEUTIC_GROUP	NUMBER	9.00	0.00
SAK_THERA_CLASS_TYPE	T_THERAPEUTIC_TYPE	NUMBER	9.00	0.00
SAK_THERA_DUP	T_DRUG_THER_DUPE	NUMBER	9.00	0.00

SAK_THERA_DUP	T_THERA_DUP_LOG	NUMBER	9.00	0.00
SAK_THERA_DURATION	T_THERA_DURATION	NUMBER	9.00	0.00
SAK_THREAD	T_BNFT_PLAN_COB	NUMBER	9.00	0.00
SAK_THREAD	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_THREAD	T_HIERARCHY_NODE	NUMBER	9.00	0.00
SAK_THREAD	T_PGM_HIERARCHY	NUMBER	9.00	0.00
SAK_THREAD_ASSIGNMENT	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_THREAD_PAYER	T_CLM_PGM_XREF	NUMBER	9.00	0.00
SAK_THREAD_PAYER	T_PAYER_HIERARCHY	NUMBER	9.00	0.00
SAK_THREAD_PAYER	T_PAYER_NODE	NUMBER	9.00	0.00
SAK_THRUPUT_GRP	T_MR_OP_PERFORM	NUMBER	4.00	0.00
SAK_THRUPUT_GRP	T_MR_OP_PERFORM_DTL	NUMBER	4.00	0.00
SAK_THRUPUT_GRP	T_MR_PROV_PERFORM	NUMBER	4.00	0.00
SAK_THRUPUT_GRP	T_MR_PROV_PERFORM_DTL	NUMBER	4.00	0.00
SAK_THRUPUT_GRP	T_MR_PROV_PERFORM_KY	NUMBER	4.00	0.00
SAK_THRUPUT_GRP	T_MR_THRUPUT_GRP	NUMBER	4.00	0.00
SAK_TIME_KEY	T_CA_TIME_KEY	NUMBER	9.00	0.00
SAK_TIME_KEY	T_DS_HM_HEADER	NUMBER	9.00	0.00

SAK_TMSIS_DATA_ELEMENT	T_MR_TMSIS_CMS_ERROR_RECS	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_MR_TMSIS_ELEMENTS_XREF	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_CMS_ERROR_RECS	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_DATA_ELEMENTS	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_DEP_ELEM_XREF	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_EDIT_CTL	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_EDIT_FAILURES	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_EDIT_RULES_XREF	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_EDIT_STATS	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEMENT	T_TMSIS_VALID_VALUES_XREF	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEM_3	T_TMSIS_EDIT_FAILURES	NUMBER	9.00	0.00
SAK_TMSIS_DATA_ELEM_DEP	T_TMSIS_EDIT_FAILURES	NUMBER	9.00	0.00
SAK_TMSIS_DEP_ELEMENT	T_TMSIS_DEP_ELEM_XREF	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_CTL	T_TMSIS_DEP_ELEM_XREF	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_CTL	T_TMSIS_EDIT_CTL	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_CTL	T_TMSIS_EDIT_FAILURES	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_CTL	T_TMSIS_EDIT_RULES_XREF	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_CTL	T_TMSIS_EDIT_STATS	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_FAILURE	T_TMSIS_EDIT_FAILURES	NUMBER	12.00	0.00
SAK_TMSIS_EDIT_GROUP	T_TMSIS_EDIT_CTL	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_GROUP	T_TMSIS_VALID_VALUES	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_RULE	T_TMSIS_EDIT_RULES	NUMBER	9.00	0.00
SAK_TMSIS_EDIT_RULE	T_TMSIS_EDIT_RULES_XREF	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG002_PRIM_DEMO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG003_VAR_DEMO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG004_CONTACT_INF	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG005_ELIG_DETERM	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG006_HH_SPA_PART	NUMBER	9.00	0.00

SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG007_HH_SPA_PROV	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG008_HH_CHR_CON	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG009_LOCKIN_INFO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG010_MFP_INFO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG011_STATE_PLAN	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG012_WAIVER_PART	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG013_LTSS_PARTIC	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG014_MC_PARTICIP	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG015_ETHNICITY	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG016_RACE_INFO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG017_DISAB_INFO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG018_1115A_DEMO	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG020_HCBS_CH_NHH	NUMBER	9.00	0.00
SAK_TMSIS_ELIGIBLES	T_TMSIS_ELG021_ENROL_SPAN	NUMBER	9.00	0.00
SAK_TMSIS_ERROR_FILE	T_MR_TMSIS_CMS_ERROR_FILES	NUMBER	9.00	0.00
SAK_TMSIS_ERROR_FILE	T_MR_TMSIS_CMS_ERROR_RECS	NUMBER	9.00	0.00
SAK_TMSIS_ERROR_FILE	T_TMSIS_CMS_ERROR_FILES	NUMBER	9.00	0.00
SAK_TMSIS_ERROR_FILE	T_TMSIS_CMS_ERROR_RECS	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_CIP001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_CLT001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_COT001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_CRX001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_EDIT_FAILURES	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_EDIT_STATS	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_ELG001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_EXT_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_MCR001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_PRV001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_RUN_STATS	NUMBER	9.00	0.00
SAK_TMSIS_EXTRACT	T_TMSIS_TPL001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP002_CLM_HDR	NUMBER	9.00	0.00

SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP003_CLM_DTL	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP_DIAG	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP_HDR_PROC	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP_OCC_CDE	NUMBER	9.00	0.00
SAK_TMSIS_IP_CLAIMS	T_TMSIS_CIP_REM_CDE	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT002_CLM_HDR	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT003_CLM_DTL	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT_DIAG	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT_OCC_CDE	NUMBER	9.00	0.00
SAK_TMSIS_LT_CLAIMS	T_TMSIS_CLT_REM_CDE	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR002_MAIN	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR003_LOC_CONTACT	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR004_SVC_AREA	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR005_OPER_AUTH	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR006_POP_ENRLD	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR007_ACCRED_ORG	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR008_NATL_HC_ENT	NUMBER	9.00	0.00
SAK_TMSIS_MGD_CARE	T_TMSIS_MCR009_CHPID_SHPID	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT002_CLM_HDR	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT003_CLM_DTL	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT_DIAG	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT_OCC_CDE	NUMBER	9.00	0.00
SAK_TMSIS_OT_CLAIMS	T_TMSIS_COT_REM_CDE	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV002_ATTRIB_MAIN	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV003_LOC_CONTACT	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV004_LICENSE_INF	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV005_IDENTIFIERS	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV006_TAXON_CLASS	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV007_MDCD_ENROLL	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV008_AFFIL_GRP	NUMBER	9.00	0.00

SAK_TMSIS_PROVIDER	T_TMSIS_PRV009_AFFIL_PGMS	NUMBER	9.00	0.00
SAK_TMSIS_PROVIDER	T_TMSIS_PRV010_BED_TYPE	NUMBER	9.00	0.00
SAK_TMSIS_RX_CLAIMS	T_TMSIS_CRX001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_RX_CLAIMS	T_TMSIS_CRX002_CLM_HDR	NUMBER	9.00	0.00
SAK_TMSIS_RX_CLAIMS	T_TMSIS_CRX003_CLM_DTL	NUMBER	9.00	0.00
SAK_TMSIS_RX_CLAIMS	T_TMSIS_CRX_REM_CDE	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL001_FILE_HDR	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL002_ELIG_PERSON	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL003_HLTH_INS_CV	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL004_HLTH_INS_CT	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL005_OTH_TPL_COV	NUMBER	9.00	0.00
SAK_TMSIS_TPL	T_TMSIS_TPL006_CONTACT_INF	NUMBER	9.00	0.00
SAK_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES	NUMBER	9.00	0.00
SAK_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES_TYPE	NUMBER	9.00	0.00
SAK_TMSIS_VALID_VALUE	T_TMSIS_VALID_VALUES_XREF	NUMBER	9.00	0.00
SAK_TMSIS_VV_DATA_ELEMENT	T_TMSIS_DEP_ELEM_XREF	NUMBER	9.00	0.00
SAK_TMSIS_VV_DEP_ELEMENT	T_TMSIS_DEP_ELEM_XREF	NUMBER	9.00	0.00
SAK_TOB_TYPE	T_TOB_GROUP	NUMBER	4.00	0.00
SAK_TOB_TYPE	T_TOB_GROUP	NUMBER	9.00	0.00
SAK_TOB_TYPE	T_TOB_TYPE	NUMBER	9.00	0.00
SAK_TORTFEASOR	T_CASUALTY_REC	NUMBER	9.00	0.00
SAK_TORTFEASOR	T_TORTFEASOR	NUMBER	9.00	0.00
SAK_TORTFEASOR	T_TORTFEASOR_AL	NUMBER	9.00	0.00
SAK_TORTFEASOR	T_TRTFEASR_XREF	NUMBER	9.00	0.00
SAK_TP	T_TP	NUMBER	9.00	0.00
SAK_TP	T_TP_ALLOWED_TRANSPORT	NUMBER	9.00	0.00
SAK_TP	T_TP_CONFIG	NUMBER	9.00	0.00
SAK_TPL_LIEN	T_TPL_LIEN	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_CLM_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_COVERAGE_XREF	NUMBER	9.00	0.00

SAK_TPL_RESOURCE	T_RETRO_SUMM_RECS	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_SUSPECT_RES	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_271_COVERAGE	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_271_DEPENDENT	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_271_SUBSCRIBER	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_AR_HEALTH	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_AR_HEALTH_XXX	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_EXEMPT	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_HIPP_XREF	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_HMS_HIPP_XREF	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_PHRM_XREF	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_POLICY_TRIGGER	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_PREBILL	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_RESOURCE	NUMBER	9.00	0.00
SAK_TPL_RESOURCE	T_TPL_RESTRICTION	NUMBER	9.00	0.00
SAK_TPL_RESTRICT	T_TPL_RESTRICTION	NUMBER	9.00	0.00
SAK_TPL_THRESHOLD	T_TPL_THRESHOLD	NUMBER	9.00	0.00
SAK_TP_CONFIG	T_DOCUMENT_TRACK	NUMBER	9.00	0.00
SAK_TP_CONFIG	T_TP_CONFIG	NUMBER	9.00	0.00
SAK_TP_STATUS	T_CDE_TP_STATUS	NUMBER	9.00	0.00
SAK_TP_STATUS	T_TP	NUMBER	9.00	0.00
SAK_TP_TYPE	T_CDE_TP_TYPE	NUMBER	9.00	0.00
SAK_TP_TYPE	T_TP	NUMBER	9.00	0.00
SAK_TRACK_EXCEPTION_HANDLE	T_TRACK_EXCEPTION_HANDLE	NUMBER	9.00	0.00
SAK_TRACK_NOTIFICATION	T_TRACK_NOTIFICATION	NUMBER	9.00	0.00
SAK_TRANSACTION	T_TRANSACTION	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_TRANSACTION	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_TRANSACTION_TYPE	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_TRANS_MEDIA_XREF	NUMBER	9.00	0.00

SAK_TRANSACTION_TYPE	T_UPLOAD	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_WEB_RECEIVER	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_WEB_RECEIVER_BACKUP	NUMBER	9.00	0.00
SAK_TRANSACTION_TYPE	T_WEB_SENDER	NUMBER	9.00	0.00
SAK_TRANSPORT	T_CDE_TRANSPORT	NUMBER	9.00	0.00
SAK_TRANSPORT	T_FILE_TRACK	NUMBER	9.00	0.00
SAK_TRANSPORT	T_TP_ALLOWED_TRANSPORT	NUMBER	9.00	0.00
SAK_TXN	T_AR_TXN_XREF	NUMBER	9.00	0.00
SAK_TXN	T_EXPEND_TXN_XREF	NUMBER	9.00	0.00
SAK_TXN	T_FIN_BUDG_DISP	NUMBER	9.00	0.00
SAK_TXN	T_FIN_NUM_COR	NUMBER	9.00	0.00
SAK_TXN	T_FIN_PROCESS_BUDG_DISP	NUMBER	9.00	0.00
SAK_TXN	T_FIN_REMIT_TXN_XREF	NUMBER	9.00	0.00
SAK_TXN	T_PAY_HOLD_TXN_XREF	NUMBER	9.00	0.00
SAK_TXN_TYPE	T_TXN_BILLING	NUMBER	9.00	0.00
SAK_TYPE_SPEC	T_TYPE_SPEC_CODE	NUMBER	9.00	0.00
SAK_TYPE_SPEC	T_TYPE_SPEC_GROUP	NUMBER	9.00	0.00
SAK_UNDER_UTIL	T_DRUG_UNDER_UTIL	NUMBER	9.00	0.00
SAK_UNDER_UTIL	T_UNDER_UTIL_LOG	NUMBER	9.00	0.00
SAK_UPLOAD	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_UPLOAD	T_UPLOAD	NUMBER	9.00	0.00
SAK_UUID	T_RE_1095_ACK	NUMBER	9.00	0.00
SAK_UUID	T_RE_1095_REJECT	NUMBER	9.00	0.00
SAK_UUID	T_RE_1095_TRACK	NUMBER	9.00	0.00
SAK_VALUE	T_RU_ARRAY	NUMBER	8.00	0.00
SAK_VALUE	T_RU_DISCRETE_SET	NUMBER	9.00	0.00
SAK_VALUE	T_RU_TUPLE_SET	NUMBER	9.00	0.00
SAK_VALUE_CHILD	T_RU_ARRAY	NUMBER	9.00	0.00
SAK_VALUE_DISCRETE	T_RU_COMPARISON	NUMBER	9.00	0.00
SAK_VALUE_DISCRETE	T_RU_TUPLE_SET	NUMBER	9.00	0.00
SAK_VALUE_TYPE	T_REF_CDE_VALUE_GROUP	NUMBER	9.00	0.00

SAK_VALUE_TYPE	T_REF_CDE_VALUE_TYPE	NUMBER	9.00	0.00
SAK_VFC_ADMIN_FEE	T_VFC_ADMIN_FEE	NUMBER	9.00	0.00
SAK_VOCAB	T_MME_VOCAB_TYPE_DEF	NUMBER	9.00	0.00
SAK_WEB_PAGE	T_WEB_PAGE	NUMBER	9.00	0.00
SAK_WEB_PAGE	T_WEB_SUPPORT	NUMBER	9.00	0.00
SAK_WEB_PARNT	T_WEB_USER_ROLE	NUMBER	9.00	0.00
SAK_WEB_ROLE	T_WEB_ROLE	NUMBER	9.00	0.00
SAK_WEB_ROLE	T_WEB_USER_ROLE	NUMBER	9.00	0.00
SAK_WEB_SUPPORT	T_WEB_SUPPORT	NUMBER	9.00	0.00
SAK_WEB_USER	T_DOWNLOAD	NUMBER	9.00	0.00
SAK_WEB_USER	T_EDIC_MSG_RECEIVE	NUMBER	9.00	0.00
SAK_WEB_USER	T_EDIC_MSG_RECEIVE_ARC	NUMBER	9.00	0.00
SAK_WEB_USER	T_EDIC_REQUESTS	NUMBER	9.00	0.00
SAK_WEB_USER	T_EDIC_REQUESTS_ARC	NUMBER	9.00	0.00
SAK_WEB_USER	T_FILE_TRACK	NUMBER	9.00	0.00
SAK_WEB_USER	T_PS_CASE	NUMBER	9.00	0.00
SAK_WEB_USER	T_PS_DETERMINATION	NUMBER	9.00	0.00
SAK_WEB_USER	T_PS_REFERRAL	NUMBER	9.00	0.00
SAK_WEB_USER	T_PS_RESIDENT_RVW	NUMBER	9.00	0.00
SAK_WEB_USER	T_TP	NUMBER	9.00	0.00
SAK_WEB_USER	T_TRANSACTION	NUMBER	9.00	0.00
SAK_WEB_USER	T_UPLOAD	NUMBER	9.00	0.00
SAK_WEB_USER	T_WEB_FEITH_DOWNLOAD	NUMBER	9.00	0.00
SAK_WEB_USER	T_WEB_MESSAGE_USER	NUMBER	9.00	0.00
SAK_WEB_USER	T_WEB_USER	NUMBER	9.00	0.00
SAK_WEB_USER	T_WEB_USER_ROLE	NUMBER	9.00	0.00
SAK_WEB_USER_CHILD	T_WEB_RECEIVER	NUMBER	9.00	0.00
SAK_WEB_USER_CHILD	T_WEB_RECEIVER_BACKUP	NUMBER	9.00	0.00
SAK_WEB_USER_CHILD	T_WEB_SENDER	NUMBER	9.00	0.00
SAK_WEB_USER_PARNT	T_WEB_RECEIVER	NUMBER	9.00	0.00
SAK_WEB_USER_PARNT	T_WEB_RECEIVER_BACKUP	NUMBER	9.00	0.00
SAK_WEB_USER_PARNT	T_WEB_SENDER	NUMBER	9.00	0.00
SAK_WORKER	T_RE_AR_OVERPAYMENT	NUMBER	4.00	0.00
SAK_WORKER	T_RE_AR_WORKER	NUMBER	4.00	0.00
SAK_WVR_SVC	T_MR_WVR_PROC	NUMBER	9.00	0.00
SAK_WVR_SVC	T_MR_WVR_SVC	NUMBER	9.00	0.00
SCEN_ID	T_AGREEMENTS	VARCHAR2	14.00	0.00
SCEN_ID	T_TRADSTAT	VARCHAR2	14.00	0.00
SCEN_REL	T_AGREEMENTS	VARCHAR2	3.00	0.00
SCEN_REL	T_TRADSTAT	VARCHAR2	3.00	0.00
SCEN_VER	T_AGREEMENTS	VARCHAR2	3.00	0.00
SCEN_VER	T_TRADSTAT	VARCHAR2	3.00	0.00

SCHED_CODE	T_COIN_DE_SCH	CHAR	1.00	0.00
SCHED_CODE	T_HIPP_RESOURCE	CHAR	1.00	0.00
SCHED_CODE	T_TPL_SCHED	CHAR	1.00	0.00
SCHED_DESC	T_COIN_DE_SCH	CHAR	20.00	0.00
SCHED_DESC	T_FIN_SCHEDULE	VARCHAR	80.00	0.00
SCHED_TITLE	T_FIN_SCHEDULE	CHAR	30.00	0.00
SCHEMA_NAME	T_SYSTEM_KEYS	VARCHAR2	50.00	0.00
SECONDS	T_AGREEMENTS	VARCHAR2	2.00	0.00
SECONDS	T_TRADSTAT	VARCHAR2	2.00	0.00
SECRET_QUESTION1	T_WEB_USER	VARCHAR2	50.00	0.00
SECRET_QUESTION2	T_WEB_USER	VARCHAR2	50.00	0.00
SECTION	T_PA_PC_UPD_HDR	CHAR	2.00	0.00
SECURITY_LEVEL	T_SECURITY_LEVEL	NUMBER	9.00	0.00
SECURITY_LEVEL	T_WEB_USER	NUMBER	9.00	0.00
SECURITY_QUESTION1	T_SEC_USER	CHAR	60.00	0.00
SECURITY_QUESTION2	T_SEC_USER	CHAR	60.00	0.00
SECURITY_RESPONSE1	T_SEC_USER	CHAR	20.00	0.00
SECURITY_RESPONSE2	T_SEC_USER	CHAR	20.00	0.00
SECU_CODE	T_TRADING_PARTNER	VARCHAR2	10.00	0.00
SECU_QUAL	T_TRADING_PARTNER	VARCHAR2	2.00	0.00
SEGMENT	T_TRLOG	VARCHAR2	3.00	0.00
SEG_COUNT	T_TRLOG	NUMBER	10.00	0.00
SEG_DELIMT	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
SEG_START	T_PR_ATT_CMS	NUMBER	10.00	0.00
SEG_STOP	T_PR_ATT_CMS	NUMBER	10.00	0.00
SENDER	T_BATCH	VARCHAR2	50.00	0.00
SEND_CODE	T_TRLOG	VARCHAR2	35.00	0.00
SEND_QUAL	T_TRLOG	VARCHAR2	4.00	0.00
SEQ	T_ADJ_MASS_CLAIM	NUMBER	4.00	0.00
SEQ	T_CLM_BATCH_XREF	NUMBER	9.00	0.00
SEQ	T_CLM_MODIFIER	NUMBER	4.00	0.00
SEQ	T_CLM_NCPDP_MSG	NUMBER	4.00	0.00
SEQ	T_CLM_PYR_MOD	NUMBER	4.00	0.00
SEQ	T_PA_PC_UPD_HDR	CHAR	3.00	0.00

SEQUENCE_NUMBER	T_WEB_PA_DTL	NUMBER	4.00	0.00
SEQUENCE_NUMBER	T_WEB_PROV_ADDR	NUMBER	4.00	0.00
SEQUENCE_NUMBER	T_WEB_PROV_ENR	NUMBER	4.00	0.00
SEQUENCE_NUMBER	T_WEB_PROV_SPEC	NUMBER	4.00	0.00
SEQ_CLM_FCA	T_CLM_FCA	NUMBER	9.00	0.00
SEQ_FROM	T_CLM_MULT_SURG	NUMBER	3.00	0.00
SEQ_NUM	T_FIN_SCHED_HOLD	NUMBER	4.00	0.00
SEQ_NUM	T_UB92_DTL_OUTPAT_EDIT	NUMBER	2.00	0.00
SEQ_NUM	T_UB92_HDR_OUTPAT_EDIT	NUMBER	2.00	0.00
SEQ_NUM_IMMUN	T_CLM_MISC	NUMBER	2.00	0.00
SEQ_NUM_IMMUN_2	T_CLM_MISC	NUMBER	2.00	0.00
SEQ_NUM_IMMUN_3	T_CLM_MISC	NUMBER	2.00	0.00
SEQ_PROV_PGM	T_PR_ENROLL_PGM	NUMBER	9.00	0.00
SEQ_SORT	T_PRODUR_WARN	NUMBER	4.00	0.00
SEQ_TO	T_CLM_MULT_SURG	NUMBER	3.00	0.00
SEQ_WVR_SVC	T_MR_WVR_SVC	NUMBER	4.00	0.00
SERVICE_CODE	T_PA_LTCA_UPD_DTL	CHAR	11.00	0.00
SERVICE_DESCRIPTION	T_SEC_SERVICE	VARCHAR2	80.00	0.00
SERVICE_DTE	T_PA_HCBW_UPD_DTL	CHAR	6.00	0.00
SERVICE_ID	T_SEC_SERVICE	NUMBER	2.00	0.00
SERVICE_ID	T_SEC_SUPPORT	NUMBER	2.00	0.00
SERVICE_ID	T_SEC_USERID_XREF	NUMBER	2.00	0.00
SERVICE_ID	T_SEC_USER_AUTHORITY	NUMBER	2.00	0.00
SERVICE_LOGIN_ATTEMPT	T_SEC_USER_AUTHORITY	NUMBER	1.00	0.00
SERVICE_NAME	T_SEC_SERVICE	CHAR	25.00	0.00
SERVICE_TYPE	T_PA_LTCA_UPD_DTL	CHAR	1.00	0.00
SERVICE_USER_ID	T_SEC_USERID_XREF	CHAR	15.00	0.00
SERV_CODE	T_AGREEMENTS	VARCHAR2	6.00	0.00
SERV_CODE	T_TRADSTAT	VARCHAR2	6.00	0.00
SERV_ID	T_TRADING_PARTNER	VARCHAR2	15.00	0.00
SERV_QUAL	T_TRADING_PARTNER	VARCHAR2	2.00	0.00
SEV_CODE	T_TRLOG	VARCHAR2	2.00	0.00
SEX	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
SEX	T_PROFILE_ASM_MM_PEER	CHAR	1.00	0.00
SEX	T_PROFILE_ASM_MM_PROV	CHAR	1.00	0.00
SEX	T_PROFILE_INPAT_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_INPAT_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_INPAT_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_INPAT_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_INPAT_PT_TOT	CHAR	1.00	0.00

SEX	T_PROFILE_OUTPAT_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_OUTPAT_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_OUTPAT_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_OUTPAT_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_OUTPAT_PT_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARMREF_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_PHARMREF_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_PHARMREF_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARMREF_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARMREF_PT_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARM_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_PHARM_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_PHARM_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARM_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PHARM_PT_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROFREF_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_PROFREF_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_PROFREF_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROFREF_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROFREF_PT_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROF_AMTS	CHAR	1.00	0.00
SEX	T_PROFILE_PROF_GLOBALS	CHAR	1.00	0.00
SEX	T_PROFILE_PROF_GRP_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROF_PROV_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_PROF_PT_TOT	CHAR	1.00	0.00
SEX	T_PROFILE_RECIP	CHAR	1.00	0.00
SEX	T_PROFILE_RECIP_ACG	CHAR	1.00	0.00
SEX	T_PROFILE_RPT_GRAPHS	CHAR	1.00	0.00
SEX	T_PROFILE_TOT_CMPR	CHAR	1.00	0.00
SEX_IND	T_LS_DRUG_MASTER	CHAR	1.00	0.00
SFY	T_PF_PARMS	CHAR	4.00	0.00

SFY	T_PF_RECIP_ACG	CHAR	4.00	0.00
SFY	T_PROFILE_PARMS	CHAR	4.00	0.00
SFY	T_PROFILE_RECIP_ACG	CHAR	4.00	0.00
SHIPIDEN	T_TRADING_PARTNER	VARCHAR2	15.00	0.00
SHIPQUAL	T_TRADING_PARTNER	VARCHAR2	2.00	0.00
SHORT_DESC	T_RISKS	VARCHAR2	240.00	0.00
SNDR_ROUTE	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
SNDR_ROUTE	T_TRLOG	VARCHAR2	35.00	0.00
SNDR_SUBID	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
SNDR_SUBID	T_TRLOG	VARCHAR2	35.00	0.00
SND_CTRL_NUM	T_TXN_BILLING	CHAR	9.00	0.00
SND_GSID	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
SND_IDCODE	T_TRADING_PARTNER	VARCHAR2	35.00	0.00
SND_IDQUAL	T_TRADING_PARTNER	VARCHAR2	4.00	0.00
SND_VER_NUM	T_TXN_BILLING	CHAR	12.00	0.00
SOFT_ID	T_TRADING_PARTNER	VARCHAR2	10.00	0.00
SPECIALTY	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	4.00	0.00
SRT_PR_ID_SEARCH	T_PR_ID_TYPE	NUMBER	1.00	0.00
SSN	T_MR_MSIS_ELIGIBLE	CHAR	9.00	0.00
SS_CLAIM_NO	T_RE_BNDX_BUYIN	CHAR	11.00	0.00
SS_CLM_ALPHA	T_DS_RECIP_CORE	CHAR	3.00	0.00
SS_CLM_NO	T_DS_RECIP_CORE	CHAR	9.00	0.00
ST03	T_AGREEMENTS	VARCHAR2	35.00	0.00
ST03	T_TRADSTAT	VARCHAR2	35.00	0.00
ST03	T_TRLOG	VARCHAR2	35.00	0.00
STARTING_DX	T_ETG_SUMMARY	VARCHAR2	7.00	0.00
STARTING_DX	T_ETG_SUMMARY_ENCNTR	VARCHAR2	7.00	0.00
STARTING_DX	T_ETG_SUMMARY_FFS	VARCHAR2	7.00	0.00
STARTING_DX	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	7.00	0.00
START_DATE	T_PF_PARMS	DATE	0.00	0.00
START_DATE	T_PROFILE_PARMS	DATE	0.00	0.00
START_DATE1	T_PF_PARMS	DATE	0.00	0.00
START_DATE2	T_PF_PARMS	DATE	0.00	0.00
START_TIME	T_FIN_CYCLE_HIST	DATE	0.00	0.00
STAT	T_AGREEMENTS	VARCHAR2	1.00	0.00
STAT	T_TRADSTAT	VARCHAR2	1.00	0.00
STAT	T_TRLOG	VARCHAR2	1.00	0.00
STATE	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	5.00	0.00
STATE	T_TRADING_PARTNER	VARCHAR2	15.00	0.00
STATE_RETURN_ST	T_835_CONSTANTS	CHAR	2.00	0.00

STATE_RETURN_ST	T_FIN_CYCLE	CHAR	2.00	0.00
STATE_SEVERITY	T_ALERT_DISP	NUMBER	2.00	0.00
STATUS	T_PA_LTCA_UPD_DTL	CHAR	1.00	0.00
STATUS	T_PA_PC_UPD_HDR	CHAR	1.00	0.00
STATUS_CODE	T_SEC_STATUS	CHAR	1.00	0.00
STATUS_DESCRIPTION	T_SEC_STATUS	VARCHAR2	64.00	0.00
STATUS_RQST	T_DR_RECOUP_LTR_DATES	CHAR	1.00	0.00
STD_TYPE	T_AGREEMENTS	VARCHAR2	2.00	0.00
STD_TYPE	T_TRADSTAT	VARCHAR2	2.00	0.00
STEP	T_RISK_PLANS	NUMBER	4.00	0.00
ST_CTRL_NUM	T_TXN_BILLING	CHAR	9.00	0.00
ST_LEVEL1_ID	T_TXN_BILLING	CHAR	15.00	0.00
ST_LEVEL1_ID	T_TXN_BILLING_DESC	CHAR	15.00	0.00
ST_LEVEL1_NAME	T_TXN_BILLING	CHAR	35.00	0.00
ST_LEVEL1_NAME	T_TXN_BILLING_DESC	CHAR	35.00	0.00
ST_LEVEL2_ID	T_TXN_BILLING	CHAR	15.00	0.00
ST_LEVEL2_ID	T_TXN_BILLING_DESC	CHAR	15.00	0.00
ST_LEVEL2_ID2	T_TXN_BILLING	CHAR	15.00	0.00
ST_LEVEL2_ID2	T_TXN_BILLING_DESC	CHAR	15.00	0.00
ST_LEVEL2_NAME	T_TXN_BILLING	CHAR	35.00	0.00
ST_LEVEL2_NAME	T_TXN_BILLING_DESC	CHAR	35.00	0.00
SUBELEM	T_TRLOG	VARCHAR2	2.00	0.00
SUB_DELIMT	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
SURGERY_CHARGE	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00

SURGERY_CHARGE	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
SURGERY_CHARGE	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
SURGERY_CHARGE	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
SURGERY_CHARGE	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
SURGERY_CHARGE	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_CHARGE	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_PROV_TOTS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_PROV_TOTS_ENCNTR	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_PROV_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_PROV_TOTS_RCO_PAID	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_RECIP_TOTS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_RECIP_TOTS_ENCNTR	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_RECIP_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_RECIP_TOTS_RCO_PAID	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_SUMMARY	VARCHAR2	11.00	0.00
SURGERY_PAID	T_ETG_SUMMARY_ENCNTR	VARCHAR2	11.00	0.00
SURGERY_PAID	T_ETG_SUMMARY_FFS	VARCHAR2	11.00	0.00
SURGERY_PAID	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	11.00	0.00
SURGERY_PAID	T_ETG_SUMMARY_TOTS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_SUMM_TOTS_ENCNTR	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_SUMM_TOTS_FFS	NUMBER	9.00	0.00
SURGERY_PAID	T_ETG_SUMM_TOTS_RCO_PAID	NUMBER	9.00	0.00
SUSPECT_DESC	T_SUSPECT_CODE	CHAR	20.00	0.00
SVC_CDE	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	8.00	0.00
SVC_CDE_FLAG	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	2.00	0.00
SVC_CDE_MOD	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	2.00	0.00
SVC_TYP	T_PROFILE_TOT_CMPR	VARCHAR2	50.00	0.00
SVC_TYPE	T_PROFILE_RECIP	CHAR	1.00	0.00
TABLE_NAME	T_AUDIT_PURGE	CHAR	30.00	0.00

TABLE_NAME	T_SYSTEM_KEYS	CHAR	30.00	0.00
TALK_TIME	T_PR_ATT_CMS	NUMBER	10.00	0.00
TARGET	T_MM_MEASURE_BASE	NUMBER	5.00	4.00
TARGET_UNITS	T_PERF_SUMM	NUMBER	8.00	0.00
TARGET_VAL	T_MB_DESC	NUMBER	15.00	4.00
TAX_YEAR	T_RE_1095	NUMBER	4.00	0.00
TAX_YEAR	T_RE_1095_TRACK	NUMBER	4.00	0.00
TAX_YEAR	T_RE_ADPH_1095	NUMBER	4.00	0.00
TAX_YEAR	T_RE_ADPH_1095_TRACK	NUMBER	4.00	0.00
TBCODE	T_AGREEMENTS	VARCHAR2	60.00	0.00
TBCODE	T_TRADSTAT	VARCHAR2	60.00	0.00
TCN	T_WEB_CLAIM_HDR	CHAR	17.00	0.00
TCN_RCO	T_CA_RCO	VARCHAR2	40.00	0.00
TCN_RCO	T_CLM_RCO	VARCHAR2	40.00	0.00
TECH_ADDR_1	T_LS_MANFAC_INFO	CHAR	39.00	0.00
TECH_ADDR_2	T_LS_MANFAC_INFO	CHAR	39.00	0.00
TECH_ADDR_3	T_LS_MANFAC_INFO	CHAR	39.00	0.00
TECH_CITY	T_LS_MANFAC_INFO	CHAR	27.00	0.00
TECH_CORP	T_LS_MANFAC_INFO	CHAR	39.00	0.00
TECH_NAME	T_LS_MANFAC_INFO	CHAR	39.00	0.00
TECH_PHONE	T_LS_MANFAC_INFO	CHAR	14.00	0.00
TECH_ST	T_LS_MANFAC_INFO	CHAR	2.00	0.00
TECH_SUPPORT_USER	T_WEB_PAGE	NUMBER	9.00	0.00
TECH_ZIP_4	T_LS_MANFAC_INFO	CHAR	4.00	0.00
TECH_ZIP_5	T_LS_MANFAC_INFO	CHAR	5.00	0.00
TELEPHONE1	T_TRADING_PARTNER	VARCHAR2	22.00	0.00
TELEPHONE2	T_TRADING_PARTNER	VARCHAR2	22.00	0.00
TERM_DATE	T_LS_MANFAC_INFO	DATE	0.00	0.00
THREAD_ID	T_TRANSACTION	NUMBER	9.00	0.00
THRESHOLD_1	T_MM_QUALIFIER	NUMBER	10.00	0.00
THRESHOLD_2	T_MM_QUALIFIER	NUMBER	10.00	0.00
THRU_MODIFIER_1	T_WEB_PA_DTL	CHAR	2.00	0.00
THRU_MODIFIER_2	T_WEB_PA_DTL	CHAR	2.00	0.00
THRU_PROC_CODE	T_WEB_PA_DTL	CHAR	5.00	0.00
TIME_DISCHARGE	T_CA_UB92	NUMBER	4.00	0.00
TIME_DISCHARGE	T_UB92_HDR_EXT_KEY	NUMBER	4.00	0.00
TIME_FINALIZED	T_PDUR_FINAL_CLM	NUMBER	8.00	0.00
TIME_SYSTEM	T_ADJ_REV_RQST	NUMBER	8.00	0.00
TIME_SYSTEM	T_CLAIM_LOCAT	NUMBER	8.00	0.00
TIME_SYSTEM	T_PDUR_FINAL_CLM	NUMBER	8.00	0.00

TIME_SYSTEM	T_PDUR_SUSP	NUMBER	8.00	0.00
TIME_SYSTEM	T_PDUR_SUSP	NUMBER	8.00	0.00
TIME_SYSTEM	T_SYSTEM_PARMS	NUMBER	8.00	0.00
TIME_TXN_CREATION	T_EDI_INTERCHANGE	VARCHAR2	8.00	0.00
TME_ACTIVATION	T_EXPENDITURE	NUMBER	8.00	0.00
TME_ACTIVATION	T_EXPENDITURE_DN	NUMBER	8.00	0.00
TME_ASSIGNED	T_SYSTEM_PARMS	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_APPLICATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_CONTROL	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_PROFILE	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_CREATE	T_WINDOW	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_APPLICATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_CONTROL	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_PROFILE	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00
TME_AUDIT_UPDATE	T_WINDOW	NUMBER	8.00	0.00
TME_CALL_END	T_CALL_TRACK	NUMBER	8.00	0.00
TME_CALL_RECEIVED	T_CALL_TRACK	NUMBER	8.00	0.00
TME_CC_PROCESSED	T_CC_HIST_ADJUST	NUMBER	8.00	0.00
TME_CLM_RECIP_CHANGED	T_CLM_RECIP_HIST	NUMBER	8.00	0.00
TME_CLOSED	T_CALL_QUESTION	NUMBER	8.00	0.00
TME_CREATED	T_CALL_OTIFICATION	NUMBER	8.00	0.00
TME_CREATED	T_RE_EBS_CARD_RQST	CHAR	4.00	0.00
TME_EFFECTIVE	T_PC_AUTHORIZATION	NUMBER	8.00	0.00
TME_EFFECTIVE	T_PW_AUTHORIZATION	NUMBER	8.00	0.00
TME_EFFECTIVE	T_UC_AUTHORIZATION	NUMBER	8.00	0.00
TME_EFFECTIVE	T_UP_AUTHORIZATION	NUMBER	8.00	0.00
TME_EFFECTIVE	T_UW_AUTHORIZATION	NUMBER	8.00	0.00

TME_EFFECTIVE	T_WINDOW	NUMBER	8.00	0.00
TME_EMAIL_CHANGED	T_RE_EMAIL	NUMBER	8.00	0.00
TME_END	T_PLOG_ESTIMATE	NUMBER	8.00	0.00
TME_ENTRY	T_PLOG_HEADER	NUMBER	8.00	0.00
TME_ID_CRD_RQST	T_RE_ID_CRD_RQST	NUMBER	8.00	0.00
TME_LST_CHANGE	T_PLOG_COMMENTS	NUMBER	8.00	0.00
TME_LST_CHANGE	T_PLOG_VERSION	NUMBER	8.00	0.00
TME_MS	T_SW_PERFORMANCE_DATA	NUMBER	8.00	0.00
TME_NOTE	T_CALL_NOTES	NUMBER	8.00	0.00
TME_NOTE	T_DIAG_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_DRG_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_DRUG_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_ERR_DISP_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_MC_NPI_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_MC_PMP_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_MC_RE_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_MODIFIER_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_PROC_ICD9_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_PROC_NOTES	NUMBER	6.00	0.00
TME_NOTE	T_REVENUE_NOTES	NUMBER	6.00	0.00
TME_OPENED	T_CALL_QUESTION	NUMBER	8.00	0.00
TME_RECEIVED	T_PA_DDSD_UPD_DTL	CHAR	8.00	0.00
TME_RECEIVED	T_PA_DDSD_UPD_HDR	CHAR	8.00	0.00
TME_RECEIVED	T_PA_HCBW_UPD_DTL	CHAR	8.00	0.00
TME_RECEIVED	T_PA_HCBW_UPD_HDR	CHAR	8.00	0.00
TME_RECEIVED	T_PA_LTCA_UPD_DTL	CHAR	8.00	0.00
TME_RECEIVED	T_PA_LTCA_UPD_HDR	CHAR	8.00	0.00
TME_RECEIVED	T_PA_PAUTH	NUMBER	8.00	0.00
TME_RECEIVED	T_PA_PC_UPD_HDR	CHAR	8.00	0.00
TME_RELEASE	T_FIN_PAY_RELEASE	NUMBER	8.00	0.00
TME_REPLY	T_LOCATION_NOTE	NUMBER	8.00	0.00
TME_RESO_DUE	T_CALL_QUESTION	NUMBER	8.00	0.00
TME_SENT	T_LOCATION_NOTE	NUMBER	8.00	0.00
TME_STAMP	T_CLAIM_ERROR	NUMBER	8.00	0.00
TME_STAMP	T_DR_INV_COMMENT	NUMBER	8.00	0.00
TME_STAMP	T_EVS_INQUIRY	NUMBER	8.00	0.00
TME_STAMP	T_RECIP_LINK_XREF	NUMBER	8.00	0.00
TME_START	T_PLOG_ESTIMATE	NUMBER	8.00	0.00

TME_STATUS_CHG	T_RE_CARE_MNGR	NUMBER	8.00	0.00
TME_TRANSFER	T_CALL_QUESTION	NUMBER	8.00	0.00
TME_UPDATED	T_RE_IDENTIFIER	NUMBER	8.00	0.00
TOB_FROM	T_XOVER_RATE	CHAR	3.00	0.00
TOB_SUB	T_UB92_HDR_EXT_KEY	CHAR	3.00	0.00
TOB_TO	T_XOVER_RATE	CHAR	3.00	0.00
TOOTH	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
TOOTH_QUADRANT	T_PA_LTCA_UPD_DTL	CHAR	2.00	0.00
TOS	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	2.00	0.00
TOS	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	2.00	0.00
TOS	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	2.00	0.00
TOTAL_AMT_PAID	T_1099_DETAIL	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_BANK_PD_NOISSUE	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CAP_SUMMARY	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CAP_SUMMARY	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CAP_SUMMARY_AL	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CAP_SUMMARY_WI	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CAP_SUMMARY_tmp	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CHECK	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_CHK_ENCODE_ERROR	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_FIN_PROCESS_PYMT	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_PR_PROV_YTD_AMT	NUMBER	11.00	2.00
TOTAL_AMT_PAID	T_PR_YTD_AMT_HIST	NUMBER	11.00	2.00
TOTAL_NUMBER_OF_CLUSTERS	T_ETG_SUMMARY	VARCHAR2	4.00	0.00
TOTAL_NUMBER_OF_CLUSTERS	T_ETG_SUMMARY_ENCNTR	VARCHAR2	4.00	0.00
TOTAL_NUMBER_OF_CLUSTERS	T_ETG_SUMMARY_FFS	VARCHAR2	4.00	0.00
TOTAL_NUMBER_OF_CLUSTERS	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	4.00	0.00
TOTAL_NUM_PHANTOM_CLUSTERS	T_ETG_SUMMARY	VARCHAR2	4.00	0.00
TOTAL_NUM_PHANTOM_CLUSTERS	T_ETG_SUMMARY_ENCNTR	VARCHAR2	4.00	0.00

TOTAL_NUM_PHANTOM_CLUSTERS	T_ETG_SUMMARY_FFS	VARCHAR2	4.00	0.00
TOTAL_NUM_PHANTOM_CLUSTERS	T_ETG_SUMMARY_RCO_PAID	VARCHAR2	4.00	0.00
TOT_AMT_ALLOWED	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
TOT_AMT_ALLOWED	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
TOT_AMT_ALLOWED	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
TOT_AMT_ALLOWED	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
TOT_AMT_ALWD	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_BILLED	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_CO_PAY	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_ENCOUNTER	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_MCARE_PAID	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_PAID	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_PAID	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
TOT_AMT_PAID	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
TOT_AMT_PAID	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
TOT_AMT_PAID	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
TOT_AMT_PAT_PAID	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_REIMB	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_ST_SHARE	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_AMT_TPL	T_CA_ANALYSIS	NUMBER	11.00	2.00
TOT_CLAIMS_TPL	T_CA_ANALYSIS	NUMBER	9.00	0.00
TOT_DAYS_COVRD	T_CA_ANALYSIS	NUMBER	9.00	0.00
TOT_DAYS_NCOVRD	T_CA_ANALYSIS	NUMBER	9.00	0.00
TOT_EPISODES	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
TOT_EPISODES	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
TOT_EPISODES	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
TOT_EPISODES	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
TOT_QTY_ALWD	T_CA_ANALYSIS	NUMBER	15.00	3.00
TOT_QTY_BILLED	T_CA_ANALYSIS	NUMBER	15.00	3.00
TOT_RECIPIENTS	T_ETG_COMPARISON_TOTS	NUMBER	9.00	0.00
TOT_RECIPIENTS	T_ETG_COMP_TOTS_ENCNTR	NUMBER	9.00	0.00
TOT_RECIPIENTS	T_ETG_COMP_TOTS_FFS	NUMBER	9.00	0.00
TOT_RECIPIENTS	T_ETG_COMP_TOTS_RCO_PAID	NUMBER	9.00	0.00
TO_AGE	T_LS_DRUG_MASTER	CHAR	3.00	0.00
TPKEY	T_TRADING_PARTNER	NUMBER	10.00	0.00
TPL_AMT	T_DENY_DNTL_HDR	NUMBER	9.00	2.00
TPL_AMT	T_DENY_PHRM_HDR	NUMBER	9.00	2.00

TPL_AMT	T_DENY_PHYS_HDR	NUMBER	9.00	2.00
TPL_AMT	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	6.00	0.00
TPL_AMT	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	6.00	0.00
TPL_AMT	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	6.00	0.00
TPL_AMT	T_PD_DNTL_HDR	NUMBER	8.00	2.00
TPL_AMT	T_PD_DNTL_HDR	NUMBER	9.00	2.00
TPL_AMT	T_PD_PHARM_HDR	NUMBER	8.00	2.00
TPL_AMT	T_PD_PHARM_HDR	NUMBER	9.00	2.00
TPL_AMT	T_PD_PHYS_HDR	NUMBER	8.00	2.00
TPL_AMT	T_PD_PHYS_HDR	NUMBER	9.00	2.00
TPL_AMT	T_SUSP_DENTAL_HDR	NUMBER	9.00	2.00
TPL_AMT	T_SUSP_PHRM_HDR	NUMBER	9.00	2.00
TPL_AMT	T_SUSP_PHYS_HDR	NUMBER	9.00	2.00
TPTNER_ID	T_TRLOG	VARCHAR2	35.00	0.00
TRADKEY	T_TRADSTAT	NUMBER	10.00	0.00
TRANSACTIONTYPE	T_EDIC_TRANSACTION_TYPES	VARCHAR2	360.00	0.00
TRANS_CNT	T_TRLOG	NUMBER	10.00	0.00
TRANS_CODE	T_TRLOG	VARCHAR2	2.00	0.00
TRANS_NAME	T_TRLOG	VARCHAR2	6.00	0.00
TRANS_NO	T_TRLOG	VARCHAR2	35.00	0.00
TROUBLED_USER	T_WEB_SUPPORT	NUMBER	9.00	0.00
TR_ACK_TYP	T_TRLOG	VARCHAR2	1.00	0.00
TXN_ACCEPTED	T_BATCH	NUMBER	9.00	0.00
TXN_REJECTED	T_BATCH	NUMBER	9.00	0.00
TXN_TYPE	T_EVS_INQUIRY	CHAR	4.00	0.00
TXT_1000A_TECH_CONTACT1	T_TPL_1000_PYR_TECH	VARCHAR2	256.00	0.00
TXT_1000A_TECH_CONTACT2	T_TPL_1000_PYR_TECH	VARCHAR2	256.00	0.00
TXT_1000A_TECH_CONTACT3	T_TPL_1000_PYR_TECH	VARCHAR2	256.00	0.00
TXT_1000A_WEB_CONTACT	T_TPL_835_5010	VARCHAR2	256.00	0.00
TXT_2010AA_PER04	T_CLM_DNTL_HDR	VARCHAR2	256.00	0.00
TXT_2010AA_PER06	T_CLM_DNTL_HDR	VARCHAR2	256.00	0.00
TXT_2010AA_PER08	T_CLM_DNTL_HDR	VARCHAR2	256.00	0.00
TXT_2010BA_PER04	T_CLM_PHYS_HDR	VARCHAR2	256.00	0.00

TXT_2010BA_PER06	T_CLM_PHYS_HDR	VARCHAR2	256.00	0.00
TXT_2100C_HI01_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI01_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI02_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI02_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI03_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI03_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI04_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI04_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI05_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI05_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI06_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI06_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI07_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI07_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_HI08_01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_HI08_02	T_TPL_271_SUBSCRIBER	VARCHAR2	30.00	0.00
TXT_2100C_MPI01	T_TPL_271_SUBSCRIBER	CHAR	1.00	0.00
TXT_2100C_MPI02	T_TPL_271_SUBSCRIBER	CHAR	2.00	0.00
TXT_2100C_MPI03	T_TPL_271_SUBSCRIBER	CHAR	1.00	0.00
TXT_2100C_MPI04	T_TPL_271_SUBSCRIBER	VARCHAR2	80.00	0.00
TXT_2100C_MPI05	T_TPL_271_SUBSCRIBER	CHAR	2.00	0.00
TXT_2100C_MPI06	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_MPI07	T_TPL_271_SUBSCRIBER	VARCHAR2	35.00	0.00
TXT_2100C_N407	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_PRV01	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_PRV02	T_TPL_271_SUBSCRIBER	CHAR	3.00	0.00
TXT_2100C_PRV03	T_TPL_271_SUBSCRIBER	VARCHAR2	50.00	0.00
TXT_2100D_HI01_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI01_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI02_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI02_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00

TXT_2100D_HI03_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI03_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI04_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI04_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI05_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI05_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI06_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI06_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI07_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI07_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_HI08_01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_HI08_02	T_TPL_271_DEPENDENT	VARCHAR2	30.00	0.00
TXT_2100D_MPI01	T_TPL_271_DEPENDENT	CHAR	1.00	0.00
TXT_2100D_MPI02	T_TPL_271_DEPENDENT	CHAR	2.00	0.00
TXT_2100D_MPI03	T_TPL_271_DEPENDENT	CHAR	1.00	0.00
TXT_2100D_MPI04	T_TPL_271_DEPENDENT	VARCHAR2	80.00	0.00
TXT_2100D_MPI05	T_TPL_271_DEPENDENT	CHAR	2.00	0.00
TXT_2100D_MPI06	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_MPI07	T_TPL_271_DEPENDENT	VARCHAR2	35.00	0.00
TXT_2100D_N407	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_PRV01	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_PRV02	T_TPL_271_DEPENDENT	CHAR	3.00	0.00
TXT_2100D_PRV03	T_TPL_271_DEPENDENT	VARCHAR2	50.00	0.00
TXT_2110_EB13_8	T_TPL_271_COVERAGE	VARCHAR2	48.00	0.00
TXT_2110_EB14_1	T_TPL_271_COVERAGE	CHAR	2.00	0.00
TXT_2110_EB14_2	T_TPL_271_COVERAGE	CHAR	2.00	0.00
TXT_2110_EB14_3	T_TPL_271_COVERAGE	CHAR	2.00	0.00
TXT_2110_EB14_4	T_TPL_271_COVERAGE	CHAR	2.00	0.00
TXT_2300_DN104	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_DTP03_DTE	T_CLM_DNTL_2300	VARCHAR2	35.00	0.00
TXT_2300_DTP03_DTE	T_CLM_PHYS_2300	VARCHAR2	35.00	0.00
TXT_2300_DTP03_DTE	T_CLM_UB92_2300	VARCHAR2	35.00	0.00

TXT_2300_DTP03_RECV_DTE	T_CLM_PHYS_2300	VARCHAR2	35.00	0.00
TXT_2300_HCP06	T_CLM_DNTL_2300	VARCHAR2	50.00	0.00
TXT_2300_K301_1	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_10	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_2	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_3	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_4	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_5	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_6	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_7	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_8	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2300_K301_9	T_CLM_DNTL_2300	VARCHAR2	80.00	0.00
TXT_2310C_PER04	T_CLM_PHYS_2300	VARCHAR2	256.00	0.00
TXT_2310C_PER06	T_CLM_PHYS_2300	VARCHAR2	256.00	0.00
TXT_2400_DTP03_DTE	T_CLM_PHYS_2400	VARCHAR2	35.00	0.00

TXT_2400_DTP03_START_DTE	T_CLM_DNTL_2400	VARCHAR2	35.00	0.00
TXT_2400_DTP03_STOP_DTE	T_CLM_DNTL_2400	VARCHAR2	35.00	0.00
TXT_2400_K301_1	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_10	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_2	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_3	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_4	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_5	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_6	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_7	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_8	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_K301_9	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_2400_NTE02	T_CLM_PHYS_2400	VARCHAR2	80.00	0.00
TXT_2400_NTE02	T_CLM_UB92_2400	VARCHAR2	80.00	0.00
TXT_2400_SV202_7	T_CLM_UB92_2400	VARCHAR2	80.00	0.00
TXT_2400_SV301_7	T_CLM_DNTL_2400	VARCHAR2	80.00	0.00
TXT_ALERT_EXCEPTION_TEXT	T_MME_DAILY_MME_ALERTIN G	VARCHAR2	500.00	0.00
TXT_ALERT_EXCEPTION_TEXT	T_MME_OPIOID_CONCR_ALER T	VARCHAR2	2,000.00	0.00
TXT_ALERT_LONG_MSG	T_MME_DAILY_MME_ALERTIN G	VARCHAR2	2,000.00	0.00
TXT_ALERT_TEXT	T_MME_DAILY_MME_ALERTIN G	VARCHAR2	500.00	0.00
TXT_ALERT_TEXT	T_MME_OPIOID_CONCR_ALER T	VARCHAR2	2,000.00	0.00
TXT_ANALYST_COMM	T_CT_CASE_TRACK	VARCHAR2	4,000.00	0.00
TXT_ANALYST_COMM	T_CT_EOMB	VARCHAR2	4,000.00	0.00
TXT_ANONYMOUS	T_CT_REFERRALS	VARCHAR2	50.00	0.00
TXT_ANSWER	T_PR_ENRL_DISCLOSURE_AN S	VARCHAR2	500.00	0.00
TXT_BILLING_TEAM	T_PS_RESIDENT_RVW	VARCHAR2	24.00	0.00
TXT_CALL	T_PS_LTR_LEGEND	VARCHAR2	80.00	0.00
TXT_CHECKLIST	T_DS_RECIP_DO_APPL	CHAR	10.00	0.00
TXT_CITATION_TEXT	T_MME_DAILY_MME_ALERTIN G	VARCHAR2	255.00	0.00
TXT_CITATION_TEXT	T_MME_OPIOID_CONCR_ALER T	VARCHAR2	255.00	0.00
TXT_CLCBSA	T_UB92_HDR_OUTPAT	VARCHAR2	5.00	0.00

TXT_CMS_FDAAPP_OTCMONO	T_DRUG_CMSFDB_INFO	CHAR	7.00	0.00
TXT_CNCRNT_RISK_GRP_ID_DESC	T_MME_CONCR_RISK_GRP_ID_DS	VARCHAR2	255.00	0.00
TXT_COL_CODE	T_CM_CT_FILTER	VARCHAR2	22.00	0.00
TXT_COL_CODE	T_CM_PG_FILTER	VARCHAR2	22.00	0.00
TXT_COL_CODE	T_MM_FILTER	VARCHAR2	22.00	0.00
TXT_COL_DESC	T_CM_CT_FILTER	VARCHAR2	20.00	0.00
TXT_COL_DESC	T_CM_PG_FILTER	VARCHAR2	20.00	0.00
TXT_COL_DESC	T_MM_FILTER	VARCHAR2	20.00	0.00
TXT_COMMENT	T_CM_CASE_GROUP	VARCHAR2	250.00	0.00
TXT_COMMENTS	T_CT_CASE_TRACK	VARCHAR2	4,000.00	0.00
TXT_COMMENTS	T_CT_REFERRALS	VARCHAR2	4,000.00	0.00
TXT_COMMENTS	T_DR_INCR_ADJ	CHAR	20.00	0.00
TXT_COMMENTS	T_PS_ICF_MR	VARCHAR2	400.00	0.00
TXT_COMMENTS	T_PS_LVL_I_TRACK	VARCHAR2	400.00	0.00
TXT_COMPONENT_SEPARATOR	T_TP	VARCHAR2	10.00	0.00
TXT_CONTROL_PLAN	T_TPL_CDE_POLICY_PREFIX	VARCHAR2	50.00	0.00
TXT_COUNTY_OFFICE	T_PS_CASE	CHAR	1.00	0.00
TXT_DATA	T_PR_ENRL_UPLOAD	VARCHAR2	30.00	0.00
TXT_DATA_HASH	T_PR_ENRL_UPLOAD	VARCHAR2	30.00	0.00
TXT_DENIAL_DTE	T_PA_HDR_PE_UMO	VARCHAR2	35.00	0.00
TXT_ENCRYPTION_USERID	T_TP	VARCHAR2	100.00	0.00
TXT_ENTER_BY	T_CT_REFERRALS	VARCHAR2	25.00	0.00
TXT_ERROR_VALUE	T_MR_TMSIS_CMS_ERROR_RECS	VARCHAR2	500.00	0.00
TXT_ERROR_VALUE	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	500.00	0.00
TXT_EVD_VOCAB_TYPE_DESC	T_MME_VOCAB_TYPE_DEF	VARCHAR2	50.00	0.00
TXT_EVENT_EXT_SOURCE	T_LG_HISTORY_EXT	VARCHAR2	50.00	0.00
TXT_EVENT_KEY_VALUE	T_EVENT_TRACK_KEYS	VARCHAR2	255.00	0.00
TXT_EXCEPTION_TYPE	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	100.00	0.00
TXT_EXEMPT_NOTES	T_TPL_EXEMPT	CHAR	100.00	0.00

TXT_EXPLANATION	T_PS_REFERRAL	VARCHAR2	400.00	0.00
TXT_FILE_LOCATION	T_CT_CASE_TRACK	VARCHAR2	50.00	0.00
TXT_FILTER	T_CM_CT_FILTER	VARCHAR2	20.00	0.00
TXT_FILTER	T_CM_PG_FILTER	VARCHAR2	20.00	0.00
TXT_FILTER	T_MM_FILTER	VARCHAR2	20.00	0.00
TXT_GROUP_OP	T_CM_CT_CRIT	VARCHAR2	3.00	0.00
TXT_GROUP_OP	T_CM_PG_CRIT	VARCHAR2	3.00	0.00
TXT_GROUP_OP	T_MM_CRIT	VARCHAR2	3.00	0.00
TXT_HH_CHRON_COND_OTH	T_TMSIS_ELG008_HH_CHR_CON	VARCHAR2	50.00	0.00
TXT_LICENSE_ISSUING_ENTITY	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	60.00	0.00
TXT_LIVING_ARRANGEMENT	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	100.00	0.00
TXT_LOCATION	T_CT_PROD_TRAIN	VARCHAR2	255.00	0.00
TXT_LOCATION	T_RE_AR_BASE	VARCHAR2	15.00	0.00
TXT_LOCEU_MI_CMT	T_PS_REFERRAL	VARCHAR2	400.00	0.00
TXT_LOCEU_MI_CMT	T_PS_RESIDENT_RVW	VARCHAR2	400.00	0.00
TXT_LOCEU_MR_CMT	T_PS_REFERRAL	VARCHAR2	400.00	0.00
TXT_LOCEU_MR_CMT	T_PS_RESIDENT_RVW	VARCHAR2	400.00	0.00
TXT_LOCKIN_COMM	T_CT_CASE_TRACK	VARCHAR2	4,000.00	0.00
TXT_LOGIC_OP	T_CM_CT_CRIT	VARCHAR2	7.00	0.00
TXT_LOGIC_OP	T_CM_PG_CRIT	VARCHAR2	7.00	0.00
TXT_LOGIC_OP	T_MM_CRIT	VARCHAR2	7.00	0.00
TXT_MARITAL_STAT_EXPL	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	50.00	0.00
TXT_MASK	T_CM_CT_FILTER	VARCHAR2	15.00	0.00
TXT_MASK	T_CM_PG_FILTER	VARCHAR2	15.00	0.00
TXT_MASK	T_MM_FILTER	VARCHAR2	15.00	0.00
TXT_MASK_RE	T_CM_CT_FILTER	VARCHAR2	30.00	0.00
TXT_MASK_RE	T_CM_PG_FILTER	VARCHAR2	30.00	0.00
TXT_MASK_RE	T_MM_FILTER	VARCHAR2	30.00	0.00
TXT_MC_PLAN_EMAIL	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	60.00	0.00
TXT_MEASURE	T_CM_MEASURE	VARCHAR2	15.00	0.00

TXT_MEDIA_DEST	T_LG_LETTER_REQUEST	VARCHAR2	100.00	0.00
TXT_MESSAGE	T_EVS_SVC_COVERAGE	VARCHAR2	256.00	0.00
TXT_MESSAGE	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	1,000.00	0.00
TXT_MI_COMMENT	T_PS_DETERMINATION	VARCHAR2	400.00	0.00
TXT_MR_COMMENT	T_PS_DETERMINATION	VARCHAR2	400.00	0.00
TXT_MSG_DATA	T_NCPDP_P4_LOG	VARCHAR2	1,000.00	0.00
TXT_NOTES	T_TP	CLOB	0.00	0.00
TXT_NOTIFICATION_SUBJECT	T_TRACK_NOTIFICATION	VARCHAR2	255.00	0.00
TXT_NUM_CTRL	T_PA_ATTACH_INFO	VARCHAR	80.00	0.00
TXT_OAC_REF_NUM	T_CT_REFERRALS	VARCHAR2	50.00	0.00
TXT_OPIOIDTH_UOM	T_MME_MME_RANGE_FACTOR	VARCHAR2	255.00	0.00
TXT_OPIOID_BASE_ING_ID_DESC	T_MME_OPIOID_BASE_ING_DESC	VARCHAR2	50.00	0.00
TXT_OTHER_COMMENTS	T_PS_ICF_MR	VARCHAR2	400.00	0.00
TXT_OTHER_IDS	T_CT_REFERRALS	VARCHAR2	254.00	0.00
TXT_OUTBOUND_FILEMASK	T_TP_CONFIG	VARCHAR2	255.00	0.00
TXT_OUTGOING_REF1	T_CT_REFERRALS	VARCHAR2	50.00	0.00
TXT_OUTGOING_REF2	T_CT_REFERRALS	VARCHAR2	50.00	0.00
TXT_OWNER	T_CM_CT_FILTER	VARCHAR2	10.00	0.00
TXT_OWNER	T_CM_PG_FILTER	VARCHAR2	10.00	0.00
TXT_OWNER	T_MM_FILTER	VARCHAR2	10.00	0.00
TXT_PARM	T_BUY_PARMS	CHAR	10.00	0.00
TXT_PARM	T_TMSIS_PARMS	VARCHAR2	50.00	0.00
TXT_PARM	T_TPL_RQST_REPORT	CHAR	100.00	0.00
TXT_PAYMNT_DURING	T_CT_EOMB	VARCHAR2	5.00	0.00
TXT_PRODUCTIVITY_DESC	T_CT_PROD_CD	VARCHAR2	50.00	0.00
TXT_PROV_CRED	T_PR_NAM_NPPES	VARCHAR2	20.00	0.00
TXT_PROV_ID_ISSUING_ENTITY	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	18.00	0.00
TXT_PROV_INT	T_CT_CASE_TRACK	VARCHAR2	10.00	0.00
TXT_PROV_LOC	T_CT_PROV_CRIT	VARCHAR2	255.00	0.00
TXT_PROV_LOC_EMAIL	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	60.00	0.00
TXT_PROV_SPC	T_CT_PROV_CRIT	VARCHAR2	255.00	0.00
TXT_PROV_TYP	T_CT_PROV_CRIT	VARCHAR2	255.00	0.00

TXT_PUBLIC_INFO	T_PS_PUBLIC_INFO	VARCHAR2	2,000.00	0.00
TXT_QUESTION	T_PR_ENRL_DISCLOSURE_QUES	VARCHAR2	1,500.00	0.00
TXT_RANGE_HI	T_CM_CT_CRIT	VARCHAR2	4,000.00	0.00
TXT_RANGE_HI	T_CM_PG_CRIT	VARCHAR2	4,000.00	0.00
TXT_RANGE_HI	T_MM_CRIT	VARCHAR2	4,000.00	0.00
TXT_RANGE_LO	T_CM_CT_CRIT	VARCHAR2	4,000.00	0.00
TXT_RANGE_LO	T_CM_PG_CRIT	VARCHAR2	4,000.00	0.00
TXT_RANGE_LO	T_MM_CRIT	VARCHAR2	4,000.00	0.00
TXT_REASON	T_EDI_RETURN_REASON	VARCHAR2	500.00	0.00
TXT_RECIP_COMM	T_CT_EOMB	VARCHAR2	4,000.00	0.00
TXT_RECORD_KEY	T_MR_TMSIS_CMS_ERROR_RECS	VARCHAR2	50.00	0.00
TXT_RECORD_KEY	T_TMSIS_CMS_ERROR_RECS	VARCHAR2	50.00	0.00
TXT_REF_TYPE	T_CT_REFERRALS	VARCHAR2	50.00	0.00
TXT_RELATION	T_PS_CASE_ADDRESS	VARCHAR2	15.00	0.00
TXT_REV_BY	T_CT_REFERRALS	VARCHAR2	25.00	0.00
TXT_SCHED	T_TPL_SCHED	CHAR	20.00	0.00
TXT_SECURE_INFO	T_PS_SECURE_INFO	VARCHAR2	2,000.00	0.00
TXT_SEGMENT_TERMINATOR	T_TP	VARCHAR2	10.00	0.00
TXT_SERVICE_AREA	T_PS_REFERRAL	CHAR	2.00	0.00
TXT_SOURCE	T_CT_CASE_TRACK	VARCHAR2	100.00	0.00
TXT_SOURCE	T_CT_REFERRALS	VARCHAR2	100.00	0.00
TXT_SQL_STMNT	T_DS_LVX_USER_REQ	CLOB	0.00	0.00
TXT_STACK_TRACE	T_TRACK_EXCEPTION_HANDLE	VARCHAR2	2,000.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CIP001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CIP002_CLM_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CIP003_CLM_DTL	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CLT001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CLT002_CLM_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CLT003_CLM_DTL	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_COT001_FILE_HDR	VARCHAR2	500.00	0.00

TXT_STATE_NOTATION	T_TMSIS_COT002_CLM_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_COT003_CLM_DTL	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CRX001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CRX002_CLM_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_CRX003_CLM_DTL	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG002_PRIM_DEMO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG003_VAR_DEMO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG004_CONTACT_INF	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG005_ELIG_DETERM	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG006_HH_SPA_PART	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG007_HH_SPA_PROV	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG008_HH_CHR_CON	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG009_LOCKIN_INFO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG010_MFP_INFO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG011_STATE_PLAN	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG012_WAIVER_PART	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG013_LTSS_PARTIC	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG014_MC_PARTICIP	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG015_ETHNICITY	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG016_RACE_INFO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG017_DISAB_INFO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG018_1115A_DEMO	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG020_HCBS_CH_NHH	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_ELG021_ENROL_SPAN	VARCHAR2	500.00	0.00

TXT_STATE_NOTATION	T_TMSIS_MCR001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR002_MAIN	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR003_LOC_CONTACT	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR004_SVC_AREA	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR005_OPER_AUTH	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR006_POP_ENRLD	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR007_ACCRED_ORG	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR008_NATL_HC_ENT	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_MCR009_CHPID_SHPID	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV002_ATTRIB_MAIN	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV003_LOC_CONTACT	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV004_LICENSE_INF	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV005_IDENTIFIERS	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV006_TAXON_CLASS	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV007_MDCD_ENROLL	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV008_AFFIL_GRP	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV009_AFFIL_PGMS	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_PRV010_BED_TYPE	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL001_FILE_HDR	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL002_ELIG_PERSON	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL003_HLTH_INS_CV	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL004_HLTH_INS_CT	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL005_OTH_TPL_COV	VARCHAR2	500.00	0.00
TXT_STATE_NOTATION	T_TMSIS_TPL006_CONTACT_INF	VARCHAR2	500.00	0.00

TXT_STATUS1	T_CT_REFERRALS	VARCHAR2	254.00	0.00
TXT_STATUS2	T_CT_REFERRALS	VARCHAR2	250.00	0.00
TXT_TABLE	T_CM_CT_FILTER	VARCHAR2	26.00	0.00
TXT_TABLE	T_CM_PG_FILTER	VARCHAR2	26.00	0.00
TXT_TABLE	T_MM_FILTER	VARCHAR2	26.00	0.00
TXT_TAX_EMAIL	T_FIN_CYCLE_TAX_INFO	CHAR	35.00	0.00
TXT_TECH_CONTACT1	T_835_CONTACTS	VARCHAR2	256.00	0.00
TXT_TECH_CONTACT2	T_835_CONTACTS	VARCHAR2	256.00	0.00
TXT_TECH_CONTACT3	T_835_CONTACTS	VARCHAR2	256.00	0.00
TXT_TXN_HDR_ST03	T_CLM_DNTL_HDR	VARCHAR2	35.00	0.00
TXT_TXN_HDR_ST03	T_CLM_PHYS_HDR	VARCHAR2	35.00	0.00
TXT_TXN_HDR_ST03	T_CLM_UB92_HDR	VARCHAR2	35.00	0.00
TXT_USER_DEFINED	T_PS_CASE	CHAR	3.00	0.00
TXT_VALUE	T_BUY_PARMS	CHAR	40.00	0.00
TYP	T_TRLOG	VARCHAR2	1.00	0.00
TYPE_CLM	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	1.00	0.00
TYPE_CLM	T_MR_MSIS_CLAIMLT_ICD10Ver	CHAR	1.00	0.00
TYPE_CLM	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	1.00	0.00
TYPE_RECORD	T_MR_MSIS_ELIGIBLE	CHAR	1.00	0.00
TYP_MEMBER	T_CT_EDIT_MEMBERS	VARCHAR2	10.00	0.00
TYP_OWNER	T_TRADING_PARTNER	VARCHAR2	1.00	0.00
T_P_IND	T_TRLOG	VARCHAR2	1.00	0.00
UB92_REV_CDE	T_MR_MSIS_CLAIMOT_ICDVer	CHAR	4.00	0.00
UB_REV_CDE_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_10	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_11	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_12	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00

UB_REV_CDE_13	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_14	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_15	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_16	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_17	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_18	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_19	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_20	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_21	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_22	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_23	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_7	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_8	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CDE_9	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	4.00	0.00
UB_REV_CHG_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_10	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_11	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_12	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_13	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_14	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00

UB_REV_CHG_15	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_16	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_17	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_18	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_19	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_20	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_21	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_22	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_23	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_7	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_8	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_CHG_9	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	8.00	0.00
UB_REV_UNIT_1	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_10	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_11	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00

UB_REV_UNIT_12	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_13	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_14	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_15	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_16	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_17	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_18	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_19	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_2	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_20	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00

UB_REV_UNIT_21	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_22	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_23	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_3	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_4	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_5	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_6	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_7	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_8	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UB_REV_UNIT_9	T_MR_MSIS_CLAIMIP_ICD10Ver	CHAR	7.00	0.00
UNIT	T_PROFILE_RANKINGS	NUMBER	8.00	0.00

UNITS	T_PA_PC_UPD_HDR	CHAR	11.00	0.00
UNITS	T_PF_INPAT_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_INPAT_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_NHOME_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_NHOME_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_OUTPAT_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_OUTPAT_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PHARM_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PHARM_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PROF_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PROF_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PRREF_RE_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_PRREF_RP_TOT_Q	NUMBER	14.00	2.00
UNITS	T_PF_RECIP_CMPR	NUMBER	14.00	2.00
UNITS	T_PF_RE_CMPR_Q	NUMBER	14.00	2.00
UNITS	T_PROFILE_INPAT_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_INPAT_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_INPAT_GRP_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_INPAT_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_INPAT_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_OUTPAT_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_OUTPAT_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_OUTPAT_GRP_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_OUTPAT_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_OUTPAT_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PEER_PROV_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARMREF_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARMREF_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARMREF_GRP_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARMREF_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARMREF_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARM_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARM_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARM_GRP_TOT	NUMBER	10.00	2.00

UNITS	T_PROFILE_PHARM_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PHARM_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROFREF_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROFREF_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROFREF_GRP_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROFREF_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROFREF_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROF_AMTS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROF_GLOBALS	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROF_GRP_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROF_PROV_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_PROF_PT_TOT	NUMBER	10.00	2.00
UNITS	T_PROFILE_RECIP	NUMBER	10.00	2.00
UNITS	T_PROFILE_SELECTED_CASES	NUMBER	10.00	2.00
UNITS	T_PROFILE_TOT_CMPR	NUMBER	10.00	2.00
UNITS_AUTH	T_WEB_PA_DTL	NUMBER	5.00	0.00
UNITS_MAX	T_LS_DRUG_MASTER	NUMBER	13.00	4.00
UNITS_MIN	T_LS_DRUG_MASTER	NUMBER	13.00	4.00
UNITS_USED	T_WEB_PA_DTL	NUMBER	5.00	0.00
UNIT_CHG_1	T_PA_PC_UPD_HDR	CHARACTER	11.00	0.00
UNIT_CONV_FROM	T_DR_UNIT_CONV	CHAR	2.00	0.00
UNIT_CONV_TO	T_DR_UNIT_CONV	CHAR	2.00	0.00
UNIT_COST	T_PA_DDSD_UPD_DTL	CHAR	7.00	0.00
UNIT_COST	T_PA_HCBW_UPD_DTL	CHAR	7.00	0.00
UNIT_COST	T_PA_LTCA_UPD_DTL	CHAR	7.00	0.00
UNIT_PER_WK	T_PERF_CRIT	NUMBER	6.00	2.00
UNIT_RANK	T_PROFILE_RANKINGS	NUMBER	8.00	0.00
UNIT_TYPE	T_PA_PC_UPD_HDR	CHAR	1.00	0.00
UOM	T_PERF_CRIT	CHAR	1.00	0.00
UOM	T_PERF_SUMM	CHAR	1.00	0.00
USERNAME	T_EDIC_MSG_RECEIVE	VARCHAR2	20.00	0.00
USERNAME	T_EDIC_MSG_RECEIVE_ARC	VARCHAR2	20.00	0.00
USERNAME	T_EDIC_REQUESTS	VARCHAR2	20.00	0.00
USERNAME	T_EDIC_REQUESTS_ARC	VARCHAR2	20.00	0.00
USERNAME	T_WEB_USER	VARCHAR2	20.00	0.00

USER_EPISODE_TYPE	T_ETG_DTL	VARCHAR2	1.00	0.00
USER_EPISODE_TYPE	T_ETG_DTL_ENCNTR	VARCHAR2	1.00	0.00
USER_EPISODE_TYPE	T_ETG_DTL_FFS	VARCHAR2	1.00	0.00
USER_EPISODE_TYPE	T_ETG_DTL_RCO_PAID	VARCHAR2	1.00	0.00
USER_FILENAME	T_UPLOAD	VARCHAR2	256.00	0.00
USER_ID	T_SEC_PASSWORD_HISTORY	CHAR	15.00	0.00
USER_ID	T_SEC_USER	CHAR	15.00	0.00
USER_ID	T_SEC_USERID_XREF	CHAR	15.00	0.00
USER_IDENT	T_TRLOG	VARCHAR2	35.00	0.00
USER_ID_ADD_DATE	T_SEC_USER	DATE	0.00	0.00
USER_ID_LAST_UPDATE	T_SEC_USER	CHAR	15.00	0.00
USER_ID_LAST_UPDTE	T_SEC_USER_AUTHORITY	CHAR	15.00	0.00
USER_ROLE_ID	T_SEC_ROLE	CHAR	1.00	0.00
USER_STATUS	T_SEC_USER	CHAR	1.00	0.00
VAL	T_RISK_IMPACT	NUMBER	4.00	0.00
VAL	T_RISK_PROBABILITY	NUMBER	2.00	1.00
VENDOR	T_PA_PC_UPD_HDR	CHAR	10.00	0.00
VERS	T_AGREEMENTS	VARCHAR2	12.00	0.00
VERS	T_TRADSTAT	VARCHAR2	12.00	0.00
VERSION	T_TRLOG	VARCHAR2	12.00	0.00
WARRANT_NUMBER	T_WEB_CLAIM_HDR	CHAR	10.00	0.00
WARRANT_NUMBER	T_WEB_PAY_SUM	CHAR	10.00	0.00
WEIGHT_ACG	T_PROFILE_ACG_WEIGHTS	NUMBER	5.00	3.00

X12_REPEAT	T_TRADING_PARTNER	VARCHAR2	3.00	0.00
XREF_CORR_ID	T_CORRESPOND_XREF	NUMBER	9.00	0.00
XREF_RECIP_ID	T_WEB_RECIP_XREF	CHAR	12.00	0.00
ZIP	T_TRADING_PARTNER	VARCHAR2	9.00	0.00
ZIP_CDE	T_MR_MSIS_ELIGIBLE	CHAR	5.00	0.00
ZIP_CODE_4	T_FIN_PROCESS_AR	CHAR	4.00	0.00
ZIP_CODE_4	T_FIN_PROCESS_CASH_DISP	CHAR	4.00	0.00
ZIP_CODE_5	T_FIN_PROCESS_AR	CHAR	5.00	0.00
ZIP_CODE_5	T_FIN_PROCESS_CASH_DISP	CHAR	5.00	0.00
ZIP_RETURN_ST	T_835_CONSTANTS	CHAR	15.00	0.00
ZIP_RETURN_ST	T_FIN_CYCLE	CHAR	9.00	0.00

DESCRIPTION
This column contains the number of days a particular reason code should wait before recipients having it are Autoassigned.
Adjusted Clinical Group assigned through ACG grouper software.
ACG Code that John Hopkins assigns.
This is the ACG level that is given to the recipient by the John Hopkin's ACG software. It defines the sick level of the Patient first recipient.
Flag that specifies whether a interchange-level CONTRL segment is generated in response to inbound EDIFACT message. (1=yes; space=no)
Flag that specifies whether a message-level CONTRL segment is generated in response to inbound EDIFACT message. (1=yes; space=no)
Flag that specifies whether X12 interchange TA1 acknowledgement is expected on outbound EDI maps. (1=yes; space=no) ISA14
Flag that specifies whether X12 interchange 997 acknowledgement is expected on outbound EDI maps. (1=yes; space=no) ISA14
This is the action to be done with the update transaction..
This indicates if the transaction is an update or add transaction.
This describes the type of transaction.
This is the prior authorization status received on the transaction.
This is the allowed amount of the claim for the Provider.
The actual relationship of Target units to actual units. This is a calculated data value.
The actual units for the reporting period
The amount of money the facility collected from the Medicaid program.
The amount of money the facility collected from the Medicaid program.
This is the actual amount per recipient.
The time spent in ACW.
The mailing address city of the absent parent

The mailing address state of the absent parent
The first line of the street address for the absent parent
The second line of the street address for the absent parent
The mailing address zip code of the absent parent
The street address of the employer
The mailing address city of the employer
The mailing address state of the employer
The mailing address zip code of the employer
The city of an alternative address for the applicant
The state portion of an alternative address for the applicant
The first line of an alternative street address for the applicant
The second line of an alternative street address for the applicant
The zip code portion of an alternative address for the applicant
This is the date the segment was added.
Code indicating type of adjustment record claim/encounter represents.
Code indicating type of adjustment record claim/encounter represents.
Code indicating type of adjustment record claim/encounter represents.
The date on which the recipient was admitted to a hospital or long term care facility.
The date on which the recipient was admitted to a hospital or long term care facility.
This is the first line of the State's return address.
This is the first address line of the State's return address that will be displayed on the 835.
This is the second line of the State's return address.
This is the second address line of the State's return address that will be displayed on the 835.
This is the ADPH mailing address city for the Recipient
This is the ADPH mailing address first line for the Recipient
This is the ADPH secondary mailing address line for the Recipient
Name of the city for the address.
Name of the city for the address.
Name of the city for the address.
Agent's City after change.
Agent's City before change.
State code corresponding to the address.
State code corresponding to the address.

State code corresponding to the address.
Agent's State after change.
Agent's State before change.
Address line 1.
Address line 1.
Address line 1.
Agent's Address line 1 after changes
Agent's Address line 1 before changes
Address line 2.
Address line 2.
Address line 2.
Agent's Address line 2 after changes
Agent's Address line 2 before changes
Address zip code. This is the first 5 digits of the zip code.
Address zip code. This is the first 5 digits of the zip code.
Address zip code. This is the first 5 digits of the zip code.
Address zip code + 4. This is the last 4 digits of a zip code.
Address zip code + 4. This is the last 4 digits of a zip code.
Address zip code + 4. This is the last 4 digits of a zip code.
Agent's Zip +4 code after change.
Agent's Zip +4 code before change.
Agent's Zip code after change.
Agent's Zip code before change.
Care of address.
This is the attorney's city that the correspondence and liens are sent to.
The city of the attorney firm.
This field will hold board participant city address information.
This is the city name.
The address city associated with the Provider License Number.
The city associated with the address for the recipient/provider.
The name of the city to use in correspondence with county.
This is the county office Mailing Address City.
Member's city.
Client's city.
Provider/Client city.
The city of the contact
This is the city of the facility.
The city of the non-provider.
The city where the carrier's contact person is located.

The city of the insurance agent where correspondence, cover letters, and liens are sent to.
Recipient Mailing Address City.
Recipient Mailing Address City.
This is the city of the owner.
This is the city of the owner.
Subscriber City Name found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N4, element N401.
Patient Event Transport Location City Name found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N4, element N401.
This is the city name.
This is the city field in an address.
This is the city field in an address.
Provider city.
This is the city for a provider where the license is valid.
Address city as it appears on the license.
This is city from criteria.
City name of the provider's service location address
The billing center's mailing address city.
The city of the addressee's mailing address. PASRR PRE-ADMISSION SCREEN: City; RESIDENT REVIEW SCREEN: City;
The city for the " non Medicaid certified" facility's mailing address that is associated with the case.
This is the city name from the T_RE_ADR_CASS table for the Recipient
Indicates the city in which a Medicaid recipient resides.
This is the city name.
The city where the recipient resides.
The city where the beneficiary resides.
The city where the child resides.
The city where the recipient resides.
The city where the recipient resides.
This is the city field in an address.
This is the city field in a recipient's address.
The city for the employer.
The city where the spouse resides.
This is the city information of the address for the contact.
The city where the sponsor resides.
Mailing address city.
This is the city of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
The city of the tortfeasor where the correspondence, cover letters, and liens are sent to.

The city of the tortfeasor where the correspondence, cover letters, and liens are sent to.
City of the trading partner.
This is the absent parent's city where the correspondence is sent to. Could be an out of country city if country code is not US.
The city of the executor/trustee.
This is the city for the subcontractor.
The city of the mailing address of the County Probate court.
The city of the property on which the lien is held.
Pay-to Plan City Name.
Free-form text for city name of Pay-to Plan City, State, Zip Code.
Pay-to Plan City Name.
Laboratory or Facility City Name.
Free-form text for city name of Ambulance Pick Up Location City, State, Zip Code.
Free-form text for city name of Ambulance Drop Off Location City, State, Zip Code.
Other Payer City Name.
Free-form text for city name of other payer city/state/zip code.
Service Facility City Name.
Free-form text for city name of ambulance pick up location city, state, zip code.
Free-form text for city name of ambulance drop off location city, state, zip code.
City of the mailing address for the applicant.
City of the mailing address for the sponsor.
The city of the recipient's physical address.
The city of the recipient's physical address.
The city of the applicant's residence.
The city of the spouse's mailing address
This is the city for correspondence with a carrier.
This is the state for correspondence with a carrier.
This is the street address for correspondence with a TPL carrier.
This is the second street address for correspondence with a TPL carrier.
This is the first five digits of the zip code for correspondence with a carrier.
This is the last four digits of the zip code for correspondence with a carrier.
The contact email address of the applicant as provided on the enrollment application.
The contact email address of the applicant as provided on the enrollment application.

Contact Email Address of Provider Service Location.
E-mail of the contact person, after the change.
E-mail of the contact person, after the change.
E-mail of the contact person, before the change.
E-mail of the contact person, before the change.
The location of the contact person. (PASRR PRE-ADMISSION SCREEN, Case Information, Contact Location) ; (RESIDENT REVIEW SCREEN, Case Information, Contact Location), (ICF/MR SCREEN, Case Information, Contact Location);
The country associated with the address for the recipient/provider.
The county where the applicant resides.
The two digit code indicating the county in which the previously owned property is located (if in Alabama)
The two digit code indicating the county in which the property is located (if in Alabama)
County of the applicant's residence address.
The county where the applicant's spouse resides
The name of the destination city to which a patient is transported.
The street address of the destination point to which a patient is transported from or to.
The street address of the destination point to which a patient is transported from or to.
The ANSI state numeric code denoting the destination location in which a patient is transported.
The zip code of the destination city to which a patient is transported.
The city for the type of address indicated.
The street address for the type of address indicated.
The street address for the type of address indicated.
The street address for the type of address indicated.
The ANSI state numeric where the individual eligible to receive healthcare services resides.
The zip code for the type of address indicated.
This is the Email address of the clerk.
This is the email address for the attorney.
Member's e-mail address.
The email address of the contact
Requestor Email Address.
Applicant e-mail address

Sponsor e-mail address
This is the email address of the insurance agent
Email address of the provider.
Email address of the provider.
Email address of the provider.
The email address of this location.
Email address of the recipient.
Contact person email address.
This is the e-mail address for the subcontractor contact.
This is the email address of the employer.
An electronic mail address at which the plan might contact the provider.
An electronic mail address at which the health plan might contact the provider.
An electronic mail address at which the health plan might contact the provider.
An electronic mail address at which the health plan might contact the provider.
An electronic mail address at which the health plan might contact the provider.
An electronic mail address at which the health plan might contact the provider.
Agent contact's email after change.
Agent contact's email before change.
Clearinghouse contact's email after change.
Clearinghouse contact's email before change.
An electronic mail address at which the health plan might contact the provider's clearinghouse.
An electronic mail address at which the health plan might contact the provider's clearinghouse.
An electronic mail address at which the health plan might contact the provider's clearinghouse.
An electronic mail address at which the health plan might contact the provider's clearinghouse.
An electronic mail address at which the health plan might contact the provider's clearinghouse.
The e-mail address of the applicant's spouse
E-mail address of SSA office
An electronic mail address at which the health plan might contact the provider's vendor.
An electronic mail address at which the health plan might contact the provider's vendor.
An electronic mail address at which the health plan might contact the provider's vendor.
An electronic mail address at which the health plan might contact the provider's vendor.

An electronic mail address at which the health plan might contact the provider's vendor.
Vendor contact's email after change.
Vendor contact's email before change.
E-mail address of VA office associated with veteran
FIPS code for state used by T-MSIS
The city of the Third Party Liability (TPL) Insurance carrier.
The street address for the location for the Third Party Liability (TPL) Insurance carrier.
The street address for the location for the Third Party Liability (TPL) Insurance carrier.
The street address for the location for the Third Party Liability (TPL) Insurance carrier.
The ANSI state numeric code of the Third Party Liability (TPL) Insurance carrier.
The Zip Code of the Third Party Liability (TPL) Insurance carrier.
IP address of the request.
This is the city field in an address.
This is the city where the provider would receive the W9 form.
This represents the mailing address City for the non-Medicaid provider requesting PA.
This is the city of the policyholder. It is used to send correspondence to the policyholder.
Mailing address city. This is the city where a provider would receive business mail.
Mailing address city. This is the city where a provider would receive business mail.
Mailing address city. This is the city where a provider would receive business mail.
Name of city for the bank.
Name of the city for the address.
Name of the city for the address.
This is the city field in an address.
The city name of the PDP's mailing address
This is the city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the city for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the city of an employer.
This is the city of a TPL Subcontractor.
City of the provider's mail to address, after the change.
City of the provider's mail to address, after the change.

City of the provider's mail to address, before the change.
City of the provider's mail to address, before the change.
Name of the city for the EFT address.
Mailing address zip code
E-mail of the provider's mail to address, after the change.
E-mail of the provider's mail to address, after the change.
E-mail of the provider's mail to address, before the change.
E-mail of the provider's mail to address, before the change.
The international address line. This will contain the international equivalent of City, State, and Zip.
The international address line. This will contain the international equivalent of City, State, and Zip.
The international address line. This will contain the international equivalent of City, State, and Zip.
This is the abbreviated 2 character state code.
This is the state where the provider would receive the W9 form.
This represents the mailing address State for the non-Medicaid provider requesting PA.
This is the state of the policyholder. It is used to send correspondence to the policyholder.
Mailing address state. This is the state where a provider would receive business mail.
Mailing address state. This is the state where a provider would receive business mail.
Mailing address state. This is the state where a provider would receive business mail.
State code corresponding to the address.
State code corresponding to the address.
State code corresponding to the address.
This is the abbreviated 2 character state code.
The state name of the PDP's mailing address
This is the state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the state for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the state of an employer.
This is the state of a TPL Subcontractor
State of the provider's mail to address, after the change.
State of the provider's mail to address, after the change.
State of the provider's mail to address, before the change.
State of the provider's mail to address, before the change.
State code corresponding to the EFT address.
Street address 1. This is the street address where the provider would receive the W9 form.

This represents Line 1 of the mailing address for the non-Medicaid provider requesting PA.
This is the street address of the policyholder. It is used to send correspondence to the policyholder.
Mailing address street 1. This is the street address for a provider.
Mailing address street 1. This is the street address for a provider.
Mailing address street 1. This is the street address for a provider.
Address line 1.
Address line 1.
This is the first street line in an address.
The first line of the PDP's mailing address.
This is the street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the street address of an employer.
This is the street address of the TPL Subcontractor.
Provider's mail to address, after the change.
Provider's mail to address, after the change.
Provider's mail to address, before the change.
Provider's mail to address, before the change.
EFT Address line 1.
Street address 2. This is the street address where the provider would receive the W9 form.
This represents Line 2 of the mailing address for the non-Medicaid provider requesting PA.
This is the second street address of the policyholder. It is used to send correspondence to the policyholder.
Mailing address street 2. This is the mailing address for a provider.
Mailing address street 2. This is the mailing address for a provider.
Mailing address street 2. This is the mailing address for a provider.
Address line 2.
Address line 2.
This is the second street line in an address.
The second line of the PDP's mailing address.
This is the second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the second street address for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the second street address of an employer.

This is the second line of the street address of a TPL Subcontractor.
Provider's mail to address, line 2, after the change.
Provider's mail to address, line 2, after the change.
Provider's mail to address, line 2, before the change.
Provider's mail to address, line 2, before the change.
EFT Address line 2.
This is the first street line in an address
Address line 1.
This is the second street line in an address.
Address line 2.
The five digit zip code prefix in an address
This is the zip code where the provider would receive the W9 form.
This represents the mailing address Zip Code of the non-Medicaid provider requesting PA.
This is the first 5 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.
Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.
Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.
Mailing address zip code. This is the first 5 digits of the zip code for a business mailing zip code.
Postal code for the address (Zip).
Postal code for the address (Zip).
Postal code for the address (ZIP+4).
The five digit zip code prefix in an address.
The five character zip code of the PDP mailing address
This is the first 5 digits of the zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the first 5 digits of the zip code for the claim submission address of a carrier. It is used for mailing TPL claim facsimiles.
This is the first 5 digits of the zip code of an employer.
This is the first 5 digits of the zip code of a TPL SubContractor.
The four digit zip code suffix in an address
This is the zip code extension where the provider would receive the W9 form.
This represents the mailing address 4 digit Zip Code for the non-Medicaid provider requesting the PA.
This is the last 4 digits of the zip code of the policyholder. It is used to send correspondence to the policyholder.
Mailing address zip code + 4. This is the last 4 digits of a zip code.
Mailing address zip code + 4. This is the last 4 digits of a zip code.

Mailing address zip code + 4. This is the last 4 digits of a zip code.
Postal code for the address (+4).
Postal code for the address (+4).
The four digit zip code suffix in an address.
The zip plus four of the PDP's mailing address
This is the last 4 digits of the zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.
This is the last 4 digits of the zip code of a claim submission address for a carrier. It is used for mailing TPL claim facsimiles.
This is the last 4 digits of the zip code of an employer.
This is the last 4 digits of the zip code of a TPL SubContractor.
Zip code +4 of the provider's mail to address, after the change.
Zip code +4 of the provider's mail to address, after the change.
Zip code +4 of the provider's mail to address, before the change.
Zip code +4 of the provider's mail to address, before the change.
Postal code for the EFT address (+4).
Zip of the provider's mail to address, after the change.
Zip of the provider's mail to address, after the change.
Zip of the provider's mail to address, before the change.
Zip of the provider's mail to address, before the change.
Postal code for the EFT address (Zip).
The city of the managed care entity's address as listed on the contract with the state.
The managed care entity's address listed on the contract with the state.
The managed care entity's address listed on the contract with the state.
The managed care entity's address listed on the contract with the state.
The ANSI state numeric code of the of the managed care entity's address as listed on the contract.
The zip code of the managed care entity.
Email notification which sents the exception.
Email address notification was sent to.
The name of the origination city from which a patient is transported.
The street address of the origination point from which a patient is transported.
The street address of the origination point from which a patient is transported.
The ANSI 2 numeric code of the origination state in which a patient is transported.

The zip code of the origination city from which a patient is transported.
NCPDP field 350-HN, The E-Mail address of the patient (member).
The address city associated with the payee.
The address state associated with the payee.
The first line of the street address associated with the payee.
The second line of the street address associated with the payee.
The address zip code associated with the payee.
The address zip code extension associated with the payee.
City of provider's pay to address, after the change.
City of provider's pay to address, after the change.
City of provider's pay to address, before the change.
City of provider's pay to address, before the change.
E-mail address of the provider's pay to address, after the change.
E-mail address of the provider's pay to address, after the change.
E-mail address of the provider's pay to address, before the change.
E-mail address of the provider's pay to address, before the change.
State of the provider's pay to address, after the change.
State of the provider's pay to address, after the change.
State of the provider's pay to address, before the change.
State of the provider's pay to address, before the change.
Provider's pay to address, after the change.
Provider's pay to address, after the change.
Provider's pay to address, before the change.
Provider's pay to address, before the change.
Provider's pay to address, line 2, after the change.
Provider's pay to address, line 2, after the change.
Provider's pay to address, line 2, before the change.
Provider's pay to address, line 2, before the change.
Zip code + 4 of the provider's pay to address, after the change.
Zip code + 4 of the provider's pay to address, after the change.
Zip code + 4 of the provider's pay to address, before the change.
Zip code + 4 of the provider's pay to address, before the change.
Zip of the provider's pay to address, after the change.
Zip of the provider's pay to address, after the change.
Zip of the provider's pay to address, before the change.
Zip of the provider's pay to address, before the change.
NCPDP 366-2M, Prescriber city name.

NCPDP field 367-2N, Standard state/province code as defined by government agency. For code values, consult the External Code List located at I:\2010 Enhancement Implementation Project (EIP)\5010 Project\NCPDP.
NCPDP 365-2K, Prescriber street address information.
NCPDP field 368-2P, Code defining international postal code.
The city name for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
The ANSI county code for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
The street address for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
The street address for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
The street address for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
The ANSI state numeric code for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO
The Zip Code for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO record.
Sanctioned Provider's city
Sanctioned Provider's city
Sanctioned Provider's state
Sanctioned Provider's state
Sanctioned Provider's address
Sanctioned Provider's address
Sanctioned Provider's zip
Sanctioned Provider's zip
Provider/Client city.
This is the city for the physical location of the site.
This is the state for the physical location of the site.
This is the street address for the physical location of the site.
This is the second street address for the physical location of the site.
This is the first 5 digits of the zip code for the physical location of the site.
This is the last 4 digits of the zip code for the physical location of the site.
The state of the attorney correspondence and liens are sent to.
The state abbreviation of the attorney firm.
This field will hold board participant state address information.
The address state associated with the Provider License Number.
The city associated with the address for the recipient/provider.
This is the state code for the county office address.
This is the county office Mailing Address State.

Member's state.
Client's state.
Provider/Client state.
The state of the contact
This is the state of the facility.
The state of the non-provider.
The state where the carrier's contact person is located.
The state of the insurance agent where correspondence, cover letters, and liens are sent to.
Recipient Mailing Address State.
Recipient Mailing Address State.
This is the state code of the owner.
This is the state code of the owner.
Subscriber State found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N4, element N402.
Patient Event Transport Location State Code found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N4, element N402.
This is the 2-character state code.
This is the abbreviated 2 character state code.
This is the abbreviated 2 character state code.
Provider state.
This is the state for a provider where the license is valid.
Address city as it appears on the license
State code of the provider's service location address
This is the state from T_RE_ADR_CASS table for the Recipient
A code indicating the state in which a Medicaid recipient resides.
This is the ADPH mailing address state for the Recipient
This is the 2-character state code.
The state where the recipient resides.
The state where the beneficiary resides.
The state where the child resides.
The state where the recipient resides.
The state where the recipient resides.
This is the abbreviated 2 character state code.
The recipient's state of residence.
The state for the employer.
The state where the spouse resides.
The two byte state abbreviation for the address.
The state where the sponsor resides.
Mailing address state.
This is the state of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.

The state where the tortfeasor's correspondence, cover letters, and liens are sent to.
The state where the tortfeasor's correspondence, cover letters, and liens are sent to.
State of the trading partner.
This is the state abbreviation for the state in which the absent parent resides.
The state of the executor/trustee.
This is the state for the subcontractor.
The state of the mailing address of the County Probate court.
The state of the property on which the lien is held.
Pay-to Plan State or Province Code as defined by appropriate government agency.
Code (Standard State/Province) as defined by appropriate government agency of Pay-to Plan City, State, Zip Code, required when address is in the United States of America.
Pay-to Plan State Code.
Laboratory or Facility State or Province Code defined by appropriate government agency.
Code (Standard State/Province) as defined by appropriate government agency of Ambulance Pick Up Location City, State, Zip Code, required when address is in the United States of America.
Code (Standard State/Province) as defined by appropriate government agency of Ambulance Drop Off Location City, State, Zip Code, required when address is in the United States of America.
Other Payer State Code.
Code (Standard State/Province) as defined by appropriate government agency of other payer city/state/zip code, required when the address is in the United States of America.
Service Facility State or Province Code.
Code (Standard State/Province) as defined by appropriate government agency of ambulance pick up location city, state, zip code, required when the address is in the United States of America.
Code (Standard State/Province) as defined by appropriate government agency of ambulance drop off location city, state, zip code, required when the address is in the United States of America.
The state the license is issued for.
The two digit code indicating the State in which the previously owned property is located
State associated with the mailing address for the applicant.
State associated with the mailing address for the sponsor.
The two digit code indicating the State in which the property is located

The state of the recipient's physical address.
The state of the recipient's physical address.
State associated with the applicant's residence address.
The state portion of the spouse's mailing address
Member's street address.
Client's street address.
Provider/Client street.
This field will hold board participant street address.
The first address line of this contact
This is the first street address of the facility.
This is the first street address of the owner.
This is the first street address of the owner.
Address line 1 of the provider's service location address
The first line of the applicant's mailing address.
The first line of the street address of the sponsor.
The first line of the applicant's residence address.
The first line of the spouse's mailing address
This field will hold board participant street address information.
The second address line of this contact
This is the second street address of the facility.
This is the second street address of the owner.
This is the second street address of the owner.
Address line 2 of the provider's service location address
The second line of the applicant's mailing address.
The second line of the street address of the sponsor.
The second line of the applicant's residence address.
The second line of the spouse's mailing address
The third address line of this contact
The third line of the street address of the sponsor. Present only for the third sponsor if one exists.
The first address line of the attorney used for correspondence and liens.
The first line of the address for the attorney firm.
The first line of the street address associated with the Provider License Number.
The first address line of the recipient/provider.
The first line of the address to use in correspondence with county.
This is the county office mailing Address 1.
The first line of the address of the non-provider.
The street address where the carrier's contact person is located.
The first street address of the insurance agent where the correspondence, cover letters, and liens are sent to.

Recipient Mailing Address Street 1.
Recipient Mailing Address Street 1.
First line of the Subscriber mailing address found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N3, element N301.
First line of the Transport Location address found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N3, element N301.
This is the Primary address.
This is the first street line in an address.
This is the first street line in an address.
Provider address 1.
Address street 1. This is the street address for a provider where the license is valid.
Address street 1 as it appears on the license.
The first line of the billing center's mailing address.
The address line 1 of the addressee's mailing address. PASRR PRE-ADMISSION SCREEN: Street 1; RESIDENT REVIEW SCREEN: Street 1;
The first line of the mailing address for the " non Medicaid certified" facility that is associated with the case.
This is the primary address from the T_RE_ADR_CASS table for the Recipient
The first address possible to identify the place of residence.
This is the Primary address.
The first line of the recipient's street address.
The first line of the beneficiary's street address.
The first line of the recipient's street address.
The first line of the recipient's street address.
List of street addresses
This is the first street line in an address.
This is the first street line in a recipient's address.
The first line of the employer's street address.
The first line of the spouse's street address.
This is the first line of the street address for the contact information.
The first line of the sponsor's street address.
The first address line of the address
This is the street address of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
The first street address of the tortfeasor's where the correspondence, cover letters, and liens are sent to.
The first street address of the tortfeasor's where the correspondence, cover letters, and liens are sent to.
Address line 1 of the trading partner.

The first address line of the absent parent used for correspondence. Could be an international address if country code is not US.
The first street address of the executor/trustee.
This is the street address for the subcontractor.
The first street address of the County Probate court.
The first line of the street address of the property on which the lien is held.
The first line of the recipient's physical address.
The first line of the recipient's physical address.
The second address line of the attorney used for correspondence and liens.
The second line of the address for the attorney firm.
The second line of the street address associated with the Provider License Number.
The second address line of the recipient/provider.
The second line of the address to use in correspondence with county.
This is the county office mailing Address 2.
The second line of the address of the non-provider.
The second street address where the carrier's contact person is located.
The second street address of the insurance agent where the correspondence, cover letters and liens are sent to.
Recipient Mailing Address Street 2.
Recipient Mailing Address Street 2.
Second line of the Subscriber mailing address found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N3, element N302.
Second line of the Transport Location address found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N3, element N302.
This is the Secondary address.
This is the second street line in an address.
This is the second street line in an address.
Provider address 2.
Address street 2. This is the street address for a provider where the license is valid.
Address street line 2 as it appears on the license.
The second line of the billing center's mailing address.
The address line 2 of the addressee's mailing address. PASRR PRE-ADMISSION SCREEN: Street 2; RESIDENT REVIEW SCREEN: Street 2;
The second line of the mailing address for the " non Medicaid certified" facility that is associated with the case.
This is the secondary address from the T_RE_ADR_CASS table for the Recipient

Additional address information about the place of residence.
This is the Secondary address.
The second line of a recipient's street address.
The second line of a beneficiary's street address.
The second line of the recipient's street address.
The second line of the recipient's street address.
Street Address 2
This is the second street line in an address.
The recipient's second line of the address.
The second line of the employer's street address.
The second line of the spouse's street address.
This is the second line of the street address for the contact information.
The second line of the sponsor's street address.
The second address line of the address
This is the second street address of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
The second street address of the tortfeasor's where the correspondence, cover letters, and liens are sent to.
The second street address of the tortfeasor's where the correspondence, cover letters, and liens are sent to.
Address line 2 of the trading partner.
The second address line of the absent parent used for correspondence. Could be an international address if country code is not US.
The second street address of the executor/trustee.
This is the second street address for the subcontractor.
The second street address of the County Probate court.
The second line of the street address of the property on which the lien is held.
The second line of the recipient's physical address.
The second line of the recipient's physical address.
Provider address 3.
Additional address information about the place of residence.
The third line of a recipient's street address.
The third line of a beneficiary's street address.
Street Address 3
This is the third line of the street address for the contact information.
The third line of the recipient's physical address.
The third line of the recipient's physical address.
Street Address 4
Street Address 5
Street Address 6

Street address of property
Street address of property
Pay-to Plan Address Line 1.
Address information of first address Line for Pay-to Plan Address.
Pay-to Plan Address Line 1.
Laboratory or Facility Address Line 1.
Address information of Ambulance Pick Up Location Address line 1.
Address information of Ambulance Drop Off Location Address line 1.
Other Payer Address Line 1.
Address information of other payer address line 1.
Service Facility Address Line 1 Information.
Address information of ambulance pick up location address line 1.
Address information of ambulance drop off location address line 1.
Pay-to Plan Address Line 2. Required when there is a second address line.
Address information of second address line for Pay-to Plan Address, used only when there is second address line.
Pay-to Plan Address Line 2.
Laboratory or Facility Address Line 2.
Address information.of Ambulance Pick Up Location Address line 2, used only when there is second address line.
Address information of Ambulance Drop Off Location Address line 2, used only when there is second address line.
Other Payer Address Line 2.
Address information of other payer address line 2, required only when there is a second address line.
Service Facility Address Line 2 Information.
Address information of ambulance pick up location address line 2, required when there is a second address line.
Address information of ambulance drop off location address line 2, required when there is a second address line.
E-mail address associated to the provider's physical service location, after the change.
E-mail address associated to the provider's physical service location, after the change.
E-mail address associated to the provider's physical service location, before the change.
E-mail address associated to the provider's physical service location, before the change.
This is the company, payer, vendor or other address that will appear on the tax form.
This is the company, payer, vendor or other city that will appear on the tax form.

This is the company, payer, vendor or other state that will appear on the tax form.
This is the company, payer, vendor or other zip that will appear on the tax form.
This is the company, payer, vendor or other zip+4 that will appear on the tax form.
This field will hold board participant zip code address information.
Member's zip code.
Client's zip code.
Provider/Client zip code.
The zip code for the contact
This is the zip code of the facility.
This is the zip code of the owner.
This is the zip code of the owner.
Provider zip code.
Zip of the trading partner.
This is the first five digits of the absent parent's zip code used for correspondence. Could also be an out of country zip code if country code is not US.
This is the zip code for the subcontractor.
The first five characters of the zip code of the County Probate court.
Pay-to Plan Postal Zone or ZIP Code. Code defining international postal zone code excluding punctuation and blanks.
Code defining international postal zone code excluding punctuation and blanks (zip codes for United States) of Pay-to Plan City, State, Zip Code, required when address is in the United States of America.
Pay-to Plan Postal Zone or ZIP Code.
Laboratory or Facility Postal Zone or zip code excluding punctuation and blanks (zip code for United States).
Code defining international postal zone code excluding punctuation and blanks of Ambulance Pick Up Location City, State, Zip Code, required when the address is in the United States of America.
Code defining international postal zone code excluding punctuation and blanks of Ambulance Drop Off Location City, State, Zip Code, required when address is in the United States of America.
Other Payer Postal Zone or ZIP Code.
Code defining international postal zone code excluding punctuation and blanks of other payer city/state/zip code, required when the address is in the United States of America.
Service Facility Postal Code.

Code defining international postal zone code excluding punctuation and blanks of ambulance pick up location city, state, zip code, required when the address is in the United States of America.
Code defining international postal zone code excluding punctuation and blanks of ambulance drop off location city, state, zip code, required when the address is in the United States of America.
This field will hold board participant zip code + 4 address information.
The address zip code extension associated with the Provider License Number.
The zip code plus 4 of the contact
This is the zip + 4 code of the facility.
This is the zip code 4 extension for the owner.
This is the zip code 4 extension for the owner.
Provider 4-digit zip code extension.
This is the zip code extension for a provider where the license is valid.
Address zip code 4 digit extension as it appears on the license
This is the postal zip code extension of the address for the contact information.
This is the last four digits of the zip code for correspondence of an absent parent if within the US.
The last four characters of the zip code of the executor/trustee.
This is the four digit zip code extension for the subcontractor.
The last four bytes of the zip code of the County Probate court.
Address zip code as it appears on the license.
The zip code of the attorney used for correspondence and letters.
The zip code of the attorney firm.
Zip code received from CMS
The five character zip code for the beneficiary, according to CMS.
The five character zip code for the beneficiary, according to CMS.
The address zip code associated with the Provider License Number.
The zip code associated with the address for the recipient/provider.
The five byte zip code to use in correspondence with county.
This the county office Mailing Address Zip.
The zip code of the non-provider.
The first five digits of the carrier's contact person's zip code.
The insurance agent's zip code where the correspondence, cover letters and liens are sent to.
Recipient Mailing Address Zip Code

Recipient Mailing Address Zip Code.
The five character USPS zip code
Subscriber Postal Zone or ZIP Code found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N4, element N403.
Patient Event Transport Location Postal Zone or Zip Code found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N4, element N403.
This is the first 5 digits of the zip code.
The five digit zip code prefix in an address.
The five digit zip code prefix in an address.
This is the zip code for a provider where the license is valid.
Zip code of the provider's service location address
The zip code of the billing center's mailing address.
The zip code of the addressee's mailing address.
The zip code of the mailing address for the " non Medicaid certified" facility that is associated with the case.
This is the first five digits of the zip code from T_RE_ADR_CASS table for the Recipient
Zip code of a Medicaid recipient's primary residence.
This is the nine digit ADPH mailing address zip code for the Recipient
This is the first 5 digits of the zip code.
The five character zip code for the recipient.
The five character zip code for the beneficiary.
The five character zip code for the child.
The five character zip code for the recipient.
The five character zip code for the recipient.
The five digit zip code prefix in an address.
The five digit zip code prefix in a recipient's address.
The five character zip code for the employer.
The five character zip code of the spouse.
This is the postal zip code of the address for the contact information.
The five character zip code for the sponsor.
Field used to store the five digit address zip code.
This is the first 5 digits of the zip code of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
The tortfeasor's zip code where the correspondence, cover letters, and liens are sent.
The tortfeasor's zip code where the correspondence, cover letters, and liens are sent.
The zip code of the executor/trustee.

The five character zip code of the property on which the lien is held.
The last four characters of the zip code of the attorney used for correspondence.
The zip code extension of the attorney firm.
The 4 digit zip code that follows the 5 digit zip code.
This is the county office Mailing Address Zip-4.
The zip code "plus four" of the non-provider.
The last four digits of the carrier's contact person's zip code.
The insurance agent's last four zip code numbers where the correspondence, cover letters, and liens are sent.
Recipient Mailing Address Zip Code 4.
Recipient Mailing Address Zip Code 4.
This is the last 4 digits of a zip code.
The four digit zip code suffix in an address.
The four digit zip code suffix in an address.
The zip router of the billing center's mailing address.
The zip router of the addressee's mailing address.
The zip router of the mailing address for the "non Medicaid certified" facility that is associated to the case.
This is the last four digits of the zip code from T_RE_ADR_CASS table for the Recipient
Suffix for recipient zip code.
This is the last 4 digits of a zip code.
The zip plus four of the recipient.
The zip plus four of the beneficiary.
The zip plus four of the recipient.
The zip plus four of the recipient.
The four digit zip code suffix in an address.
The zip plus four of the employer.
The zip plus four of the spouse.
The zip plus four of the sponsor.
Field used to store the address zip code plus four.
This is the last 4 digits of the zip code of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
The last four numbers of the torfeasor's zip code where the correspondence, cover letters, and liens are sent to.
The last four numbers of the torfeasor's zip code where the correspondence, cover letters, and liens are sent to.
The zip plus 4 code of the property on which the lien is held.
The zip plus four of the recipient's physical address.
The zip plus four of the recipient's physical address.
From range for the provider address zip code used to limit the report.

The five character zip code of the recipient's physical address.
The five character zip code of the recipient's physical address.
To range for the provider address zip code used to limit the report.
Member's zip code extension.
Client's zip code extension.
Provider/Client zip code extension.
Mailing address zip code for the applicant.
Mailing address zip code for the sponsor.
Zip code for the applicant's residence.
The zip code of the spouse's mailing address
The age of the recipient at the end of the reporting period.
The recipients age at the end of the reporting period.
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
This is the age of the recipient.
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This is the age of the recipient.
This is the age of the recipient.
The beginning age range.
The starting age for the grouping.
The starting age of an age grouping.
The beginning recipient age restiction for a MSIS MAS/BOE entry.
The beginning recipient age restiction for a COS.
The beginning age restriction for this category of service.
The ending age range.
Then ending age for the grouping.
The ending age of an age grouping.
The ending recipient age restiction for a MSIS MAS/BOE entry.
The ending recipient age restriction for a COS. Setting the ending age restriction to 999 indicates that the age restriction is not needed for MAR COS assignment. To setup an age restriction the ending age should be set less than 999 (i.e. Begin = 0 and End = 20; or Begin = 21 and End = 199).
The ending age restriction for this category of service.
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+

Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
Age Group Of the recipient. Ages in this report are separated into 6 age groups. They are 00-05, 06-17, 18-20, 21-34, 35-64, & 65+
The high age range of the recipient.
The low age range of the recipient.
This field is the maximum recipient age that applies to the benefit plan - service type combination.
It specifies the maximum age that a beneficiary must be in order to be assigned to the PMP.
This field is the minimum recipient age that applies to the benefit plan - service type combination.
It specifies the minimum age that a beneficiary must be in order to be assigned to the PMP.
Recipient's alien id number, if they have one.

The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
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The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
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The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported paid amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).

The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
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The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The sum of the reported charge amounts across all components of the episode (management,surgery, facility, ancillary and pharmaceutical charges).
The amount of the disposition that was applied to the accounts receivable.
Rate to be paid for an Ambulatory Surgical Center procedure. The rate is based on the ASC group.
This is the adjustment component of the DRG rate for new construction or equipment. Used for the statewide calculation.

Costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. Used for the statewide calculation.
This is the amount of money requested by a provider for payment. This can appear on the header or detail of a claim.
The amount of the disposition that was applied to the accounts receivable.
The hospice level of care rate.
The per diem rate to be paid for the related level of care.
The maximum fee amount that may be paid for a procedure.
This field contains the Overhead amount that is added to the allowed amount when pricing new Home Health.
This is the adjustment component of the DRG rate for new construction or equipment. Used for the peer group specific calculation.
Costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. Used for the peer group specific calculation.
The per diem rate to be paid for the related level of care.
The prevailing charge for a procedure based on the customary charges made by a group of medical providers who share the same geographic locality and medical specialty.
Dollar amount used to change the allowed amount for a procedure.
This is the allowed amount of the claim.
This is the allowed amount of the claim.
This is the allowed amount of the claim.
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This is the allowed amount of the claim.
This is the allowed amount of the claim.
This is the allowed amount for this prescription of the PMP.
This is the allowed amount of the claim.
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This is the allowed amount of the claim.
This is the allowed amount of the claim.
This is the allowed amount of the claim.
This is the allowed amount of the claim.
This is the adjustment component of the DRG rate for new construction or equipment. Used for the provider specific calculation.
Costs incurred by a teaching hospital for training physicians, nurses, and other health care professionals. Used for the provider specific calculation.
The amount charged for this level of care.
This field is the flat fee amount. It is used in new outpatient pricing.
The amount that the disposition is to increase or decrease the expected receipt from the TPL A/R.
Amount for which the disposition is to apply to the associated A/R.
Amount for which the disposition is to apply to the associated A/R.
The amount that is expected to be received due to the A/R.
The amount that is expected to be received due to the A/R.

This amount reflects the total of accumulated paid claims for the Accident/Trauma report for this recipient, or this amount reflects the TPL paid amount on the claim for the Potential TPL for Follow-Up report.
Flat fee rate at which vaccine administration for recipients ages 18 years and younger are reimbursed.
Contract Amount. Required when the provider is required by contract to supply this information on the claim.
Repriced Allowed Amount.
Repriced Saving Amount. Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only.
Repricing Per Diem or Flat Rate Amount, rate expressed in the standard monetary denomination for the currency specified.
Monetary amount (non-covered) of COB total non covered amount.
Non-Covered Charge Amount.
Remaining Patient Liability Amount.
Monetary amount (remaining patient liability) of Remaining Patient Liability.
Remaining Patient Liability Amount.
MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
Monetary amount required when returned in the remittance advice.
Contract Amount.
Repriced allowed Amount.
Repriced saving Amount.
Repricing Per Diem or Flat Rate Amount.
Remaining Patient Liability Amount.
Remaining Patient Liability amount.
Monetary amount of remaining patient liability.
The lab fee reimbursement rate base on 60% of the lab fee schedule.
The lab fee reimbursement rate base on 62% of the lab fee schedule.
This is the Maximum Allowable Cost for a GSN level drug as determined by the State.
The accommodation amount is used in the old pricing logic.
The balance in the second account at the same bank where district office claimant has funds
The balance in the third account at the same bank where district office claimant has funds
The balance in the fourth account at the same bank where district office claimant has funds

The balance in the account where district office claimant has funds
The dollar amount of the 2% sequestration as required by the ACC.
The dollar amount of the 2% sequestration as required by the ACC.
The dollar amount of the 2% sequestration as required by the ACC.
The dollar amount of the 2% sequestration as required by the ACC.
The dollar amount of the 2% sequestration as required by the ACC.
This is the amount removed from the case since it is not actually part of the case.
This is the amount removed from the case since it is not actually part of the case.
The dollar amount adjusted on the detail.
Adjustment Amount. Monetary Amount of the Adjustment.
Adjustment Amount - Monetary Amount of the Adjustment.
The estimated amount to be added to every calculation to represent the administrative expense.
Amount withheld from an individual provider's payment due to accounts receivable established by an advance payment to the provider.
Amount withheld from an individual provider's payment due to accounts receivable established by an advance payment to the provider.
This is the allowed amount of the claim.
The maximum amount determined by the payer as being `allowable` under the provisions of the contract
The maximum amount determined by the payer as being `allowable` under the provisions of the contract
The maximum amount determined by the payer as being `allowable` under the provisions of the contract
The maximum amount determined by the payer as being `allowable` under the provisions of the contract
The Medicaid allowed amount: Rules: When the claim has not Medicare coverage this amount is reported as the Medicaid Allowed Amount. When the claim has Medicare coverage, this amount is reported as the Medicare Allowed Amount. When the claim is Paid, this amount is > 0 When the claim is denied, this amount is set to zeros. When the claim has Medicare coverage, this amount is the Medicare Allowed Amount. When the claim is a Crossover claim (CDE_CLM_TYPE=X), this field is set to zeros.
This is the allowed amount of the claim.
Sum of dollar amount allowed by Medicaid for a particular service.

Sum of dollar amount allowed by Medicaid for a particular service.
Sum of dollar amount allowed by Medicaid for a particular service.
Sum of dollar amount allowed by Medicaid for a particular service.
Sum of dollar amount allowed by Medicaid for a particular service.
Sum of dollar amount allowed by Medicaid for a particular service.
Amount approved for payment for services rendered.
Amount MA approved for the service.
Amount approved to pay for services provided to a recipient.
Amount approved to pay for services provided to a beneficiary under a financial payer/benefit plan.
The maximum amount allowed for reimbursement to the pharmacy.
Aggregated allowed amount for all claims for a invoice detail.
The amount approved to pay for services provided to a recipient.
Amount approved to pay for services provided to a recipient.
Amount approved to pay for services provided to a recipient.
Amount allowed by the specific program.
Amount allowed by the specific program (Medicaid, 590, etc.) for the procedure.
Amount allowed for services rendered.
Amount allowed by the specific program.
The accumulation of the allowed amounts for paid long term care claims during the reporting period.
The accumulation of the allowed amounts for the paid claims for a recipient group during the reporting period.
The accumulation of the allowed amounts for the paid claims during the reporting period.
The accumulation of the allowed amounts for the paid claims for the reporting period.
The accumulation of the allowed amounts for the paid claims for the reporting period.
The accumulation of the allowed amounts for the paid claims for the reporting period.
The accumulation of the allowed amounts for the paid Medicare crossover claims paid during the reporting period.
Amount approved to pay for services provided to a recipient.
Amount allowed for services rendered.
Amount approved to pay for services provided to a recipient.
Amount allowed by the specific program.
The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.

The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
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The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The allowed amount of money the Medicaid program can pay on this particular grouping of claims for this specific recipient.
The allowed amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
Amount approved to pay for services provided to a recipient.
Amount approved to pay for services provided to a recipient.
Amount approved to pay for services provided to a recipient.
Amount of money that is approved to be paid to a provider for a service.
The usual and customary charge for the respective code (1 of 23).
The usual and customary charge for the respective code (10 of 23).
The usual and customary charge for the respective code (11 of 23).
The usual and customary charge for the respective code (12 of 23).
The usual and customary charge for the respective code (13 of 23).
The usual and customary charge for the respective code (14 of 23).
The usual and customary charge for the respective code (15 of 23).
The usual and customary charge for the respective code (16 of 23).
The usual and customary charge for the respective code (17 of 23).

The usual and customary charge for the respective code (18 of 23).
The usual and customary charge for the respective code (19 of 23).
The usual and customary charge for the respective code (2 of 23).
The usual and customary charge for the respective code (20 of 23).
The usual and customary charge for the respective code (21 of 23).
The usual and customary charge for the respective code (22 of 23).
The usual and customary charge for the respective code (23 of 23).
The usual and customary charge for the respective code (3 of 23).
The usual and customary charge for the respective code (4 of 23).
The usual and customary charge for the respective code (5 of 23).
The usual and customary charge for the respective code (6 of 23).
The usual and customary charge for the respective code (7 of 23).
The usual and customary charge for the respective code (8 of 23).
The usual and customary charge for the respective code (9 of 23).
The dollar amount allowed by Medicare for the services provided.
The dollar amount ALLOWED by Medicare for the services provided. For 5010 837 claims this amount is calculated by EDI. Paper and Web claims will continue to submit the amount.
The dollar amount ALLOWED by Medicare for the services provided. For 5010 837 claims this amount is calculated by EDI. Paper and Web claims will continue to submit the amount.
The dollar amount ALLOWED by Medicare for the services provided. For 5010 837 claims this amount is calculated by EDI. Paper and Web claims will continue to submit the amount.
The dollar amount ALLOWED by Medicare for the services provided. For 5010 837 claims this amount is calculated by EDI. Paper and Web claims will continue to submit the amount.
The previous amount that would have been paid for services provided to a recipient. Used specifically for ClaimCheck processing and Savings Report.
The amount that would have been paid for services provided to a recipient.
Payer allowed amount.
Payer allowed amount.

Annual amount paid each year by the enrollee in the plan before a health plan benefit begins.
This is the amount of interest that has been posted to the original AR.
The appraisal amount of the property
Data dictionary says not used.
Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. 2. The allowed amount equals the amount for the service line that was approved by the payer sending this 837 to another payer.
The dollar amount owed to the attorney for working the case.
The dollar amount the attorney kept prior to turning in the settlement.
Dollar amount authorized
The equity or value of the recipient's vehicle.
Average cost per eligible = amt_pd/cnt_eligibles
Average cost per recipient = amt_pd/undup_recip_therapy
Average unit price actual = amount paid/units
Average unit price calculated = accumulated prices/units
This is the drug's Blue Book average wholesale unit price and represents the most common wholesaler price to the retailer or hospital. This price is based on actual surveys of drug wholesalers.
This is the AWP price for the drug code.
This is the amount that the backup withholding is being adjusted by.
This is the amount of backup withhholding on this record.
This is the amount of money the is being withheld for IRS Backup Withholding.
This is the amount of money the is being withheld for IRS Backup Withholding.
The balance amount of a dispute
The dollar amount balance that is outstanding for a specific drug rebate invoice
Base payment amount for an inpatient claim prior to any payment adjustments such as outliers or medical education costs.
The amount of money the beneficiary paid towards coinsurance.
The amount of money the beneficiary paid towards coinsurance.
The amount of money the beneficiary paid towards coinsurance.
The amount of money the beneficiary paid towards coinsurance.

The amount of money the beneficiary paid towards a copayment.
The amount of money the beneficiary paid towards a copayment.
The amount of money the beneficiary paid towards a copayment.
The amount of money the beneficiary paid towards a copayment.
The amount of money the beneficiary paid towards an annual deductible.
The amount of money the beneficiary paid towards an annual deductible.
The amount of money the beneficiary paid towards an annual deductible.
The amount of money the beneficiary paid towards an annual deductible.
Amount provider billed for the service.
Amount requested by provider for services rendered.
The total amount billed for the batch.
The total amount billed for the batch
Amount requested by provider for services rendered.
Amount requested by provider for services rendered.
Amount of money requested for payment by a provider for services rendered to a recipient.
Amount requested by the provider for services rendered.
Amount billed by the provider for dispensing a specific drug.
Amount billed by provider for services rendered.
Amount of money requested for payment by a provider for services rendered to a recipient.
Amount requested by provider for services rendered.
The amount requested for payment by a provider for services rendered to a recipient.
Amount of money requested for payment by a provider for services rendered to a recipient.
Amount of money requested for payment by a provider for services rendered to a recipient.
The total amount billed for the batch.
Amount requested by provider for services rendered.
This is the billed amount of the claim.
The accumulation of the billed amounts for the paid claims during the reporting period.
Amount of money requested for payment by a provider for services rendered to a recipient.
The amount billed to Medicaid for the rendered long term care service.
The accumulation of the billed amounts for the denied claims during the reporting period.

The accumulation of the billed amounts for the suspended claims for the reporting period.
The accumulation of the billed amounts for the paid claims during the reporting period.
The accumulation of the billed amounts for the paid claims during the reporting period.
The accumulation of the billed amounts for the paid claims during the reporting period.
Amount of money requested by a provider for payment for services rendered to a recipient.
Amount requested by provider for services rendered.
Amount requested by provider for services rendered.
Amount request by provider for payment for services rendered to a recipient.
Amount billed by provider for services rendered.
Amount billed by provider for services rendered.
Amount of money requested for payment by a provider for services rendered to a recipient.
Amount requested by provider for services rendered.
Amount requested by provider for services rendered.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
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The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program billed on this particular grouping of claims for this specific beneficiary.
This dollar amount identifies the billed amount of a claim.

Amount of money requested for payment by a provider for services rendered to a recipient.
Amount requested by provider for services rendered.
Amount requested by a provider for payment for services rendered to a recipient.
Amount billed by provider for services rendered.
Amount of money requested for payment by a provider for services rendered to a recipient.
Amount billed by provider for services rendered.
The amount charged at the claim detail level as submitted by the provider.
The amount charged at the claim detail level as submitted by the provider.
Amount requested by provider for services rendered.
This is the amount billed by the provider for services rendered.
The accumulation of the billed amounts for the denied claims during the reporting period.
The accumulation of the billed amounts for the denied claims during the reporting period.
The accumulation of the billed amounts for the denied claims during the reporting period.
The accumulation of the billed amounts for the denied claims during the reporting period.
The previous amount of money requested for payment by a provider for services rendered to a recipient. Used specifically for ClaimCheck processing and Savings Report.
Original billed amount on the claim detail. Will be NULL if the original billed amount was not changed. If the original billed amount was changed, this column will retain the value of the original billed amount before it was changed.
The accumulation of the billed amounts for the paid claims during the reporting period.
The accumulation of the billed amounts for the paid claims during the reporting period.
The amount of money requested for payment by a provider for services rendered to a recipient.
Amount of money that was requested for payment by a provider for services that were rendered to a recipient. This amount represents the units billed multiplied by the rate billed.
Amount of money requested for payment by the provider for services performed.
Amount of money requested by a provider for payment on a UB92 claim form.
Amount of money requested for payment by the provider for services performed.
Amount of money that was requested for payment by a provider for services that were rendered to a recipient. This amount represents the units billed multiplied by the rate billed.

Amount of money requested for payment by the provider for services performed.
The maximum amount that can be spent from this budget. An amount of zero indicates there is no cap on spending.
This is the capital amount utilized to calculate the DRG base rate specific for a provider.
The amount of the capitated payment bill submitted by the managed care entity to the state.
The capitation rate for the region or county
Amount of the capitation payment.
Amount of the capitation payment.
Maximum capitation payment amount for this capitation category.
Minimum capitation payment amount for this capitation category.
The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment.
The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment.
The amount of money that was paid or recouped to an external entity. The amount could be negative if it was a recoupment.
The amount of money (check or EFT) we will pay to an external entity for capitation.
The amount of money (check or EFT) we will pay to an external entity for capitation.
The amount of money (check or EFT) we will pay to an external entity for capitation.
The amount to increase or decrease the payment.
The amount to increase or decrease the payment.
Amount of capitation payment
Amount of capitation payment
The total dollar amount of the case settlement.
Total dollar amount expended by Medicaid pertaining to this casualty case.
Total dollar amount expended by Medicaid pertaining to this casualty case.
The amount paid to an individual provider outside of the weekly financial cycle.
The amount paid to an individual provider outside of the weekly financial cycle.
The amount paid to an individual provider outside of the weekly financial cycle.
The amount an individual provider's 1099 is credited for due to a check that has never been cashed.
The amount an individual provider's 1099 is credited for due to a check that has never been cashed.
The amount an individual provider's 1099 is credited for due to a check that has never been cashed.
The amount of the payment.

This is the total amount presented to the Federal Reserve bank.
The total charge for this claim as submitted by the provider.
The total charge for this claim as submitted by the provider.
The total charge for this claim as submitted by the provider.
Amount of interest accumulated on a given provider's claims in the current year.
The amount of interest on claims accumulated by the provider and service location this year.
The amount withheld from an individual providers payments for the overpayment of previously submitted claims.
The amount withheld from an individual providers payments for the overpayment of previously submitted claims.
TOTAL CLAIM DEDUCTIBLE AMOUNT
Total Claim Charge Amount
This is the Claim Price.
Amount returned from an individual provider for claims that had previously been overpaid.
Amount returned from an individual provider for claims that had previously been overpaid.
Amount returned from an individual provider for claims that had previously been overpaid.
TOTAL OUTLIER PAYMENT
TOTAL CLAIM CHARGE
TOTAL CLAIM COINSURANCE
TOTAL CLAIM PAYMENT RECEIVED FROM BOTH THE APC AND THE PATIENT
TOTAL CLAIM REIMBURSEMENT - SUM OF ALL LINE ITEM REIMBURSEMENT FIELDS
The amount due from MA for the resident's Medicare coinsurance days.
Payer coinsurance amount.
The amount of Medicare Co-Insurance paid by the recipient for this claim.
Payer coinsurance amount.
Dollar amount which represents the recipient's coinsurance payment.
Dollar amount which represents the recipient's coinsurance payment.
A standard amount that Medicaid will pay for each claim.
Dollar amount which represents the recipient's coinsurance payment.
The accumulation of the deductible amounts from the Medicare crossover claims paid during the reporting period.
Dollar amount which represents the recipient's coinsurance payment.

Dollar amount which represents the recipient's coinsurance payment.
This is the total amount awarded to Medicaid.
This is the total amount awarded to Medicaid.
Contract Amount. Monetary Contract Amount.
This is the amount of the contingency fee.
Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations.
Conversion factor.
Conversion factor.
Multiplier which transforms relative values into payment amounts during RBRVS pricing calculations.
Payer copay amount.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
Payer copay amount.
This is the amount of copay that will be subtracted from the allowed amount.
Copay amount that the recipient must pay.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
This is the copay amount of the claim.
Copay amount.
The accumulation of the copayment amounts for paid claims during the reporting period.
The accumulation of the copayment amounts for paid claims during the reporting period.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
The copayment amount paid by an enrollee for the service.
The copayment amount paid by an enrollee for the service.
This field is the maximum amount covered for particular benefit plans service type. The amount for each service type can have different max copay amounts. This represents a dollar figure and could include decimal if appropriate. This will be used for the EB07 amount.
This field is the minimum amount covered for particular benefit plans service type. The amount for each service type can have different min copay amounts. This represents a dollar figure and could include decimal if appropriate. This will be used for the EB07 amount.
RCO claim copay amount
RCO claim copay amount

Costs associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, and property insurance.
The amount of recipient cost share that is deducted from the capitation payment.
The amount of recipient cost share that is deducted from the captation payment.
This is the DRG provider loss cost outlier threshold
This is the DRG provider loss cost outlier threshold
The gross amount or value of the resource
The copay amount paid by the payer for the claim detail.
Amount paid by recipient for services rendered.
Amount paid by recipient for service rendered.
The amount recipients age 18 and older are responsible to pay the provider for the service
The amount recipients age 18 and older are responsible to pay the provider for the service
The accumulation of copayment amounts for paid long term care claims during the reporting period.
Amount paid by recipient for services rendered.
Amount paid by the recipient for drugs dispensed.
Amount paid by recipient for services rendered.
Amount paid by recipient for services rendered.
Amount paid by recipient for services rendered.
Amount paid by recipient for services rendered.
Amount paid by recipient for services rendered.
This is the coinsurance amount that a recipient is responsible for on a specific coverage type of a policy.
Current amount requested.
The amount a policy will pay per day for a covered service.
The amount a policy will pay per day for a covered service.
The amount at which day care services should be capped
Amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the State.
Day outlier per diem amount.
Day outlier per diem amount.

Payer deductible amount.
Amount of Medicare deductible the recipient must meet before Medicare will pay.
Payer deductible amount.
The amount the recipient must pay before Medicare will begin to pay this claim.
The amount the recipient must pay before Medicare will begin to pay this claim.
The amount that Medicaid must meet before the insurance carrier will pay for services rendered.
The amount the recipient must pay before Medicare will begin to pay this claim.
The accumulation of the deductible amounts from the Medicare crossover claims paid during the reporting period.
The amount the recipient must pay before Medicare will begin to pay this claim.
The amount the recipient must pay before Medicare will begin to pay this claim.
The amount Medicare has determined that a recipient must pay for blood procedures performed.
The amount Medicare has determined that a recipient must pay for blood procedures performed.
The amount Medicare has determined that a recipient must pay for blood procedures performed.
This is the family deductible amount a recipient is responsible for on a specific coverage type of a policy.
This is the individual deductible amount a recipient is responsible for on a specific coverage type of a policy.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS 03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.
Total amount that other insurance paid prior to submission to Medicaid for the service.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS 03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.

This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts inCAS03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.
This is the total amount paid by other payers for this detail.
Total amount that other insurance paid prior to submission to Medicaid for the service.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS 03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount. This is only available for electronic claims.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts inCAS03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS 03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.
Total amount that other insurance paid prior to submission to Medicaid for the service.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS 03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount.
This is the total amount paid by this payer for this detail. This is a derived field computed from the CAS segments on the 837 as follows. The total Provider Adjustment Amt (DA3-25.0) for a detail equals the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18. Subtracting this amount form detail billed amounts yields the detail TPL amount. .
This is the amount of the disposition for the budget. These values should not be negative.
This is the amount of the disposition for the budget. These values should not be negative.
The charge to cover the cost of dispensing the prescription.
Amount of claim being reversed.
The amount being applied from a check for a single transaction (void).

The amount being applied from a check for a single transaction (adjustment, overpayment return, accounts receivable payment, etc.).
The amount being applied from a check for a single transaction (adjustment, overpayment return, accounts receivable payment, etc.).
This is the amount of disposition that has occurred on the AR.
The amount being applied from a check for a single transaction (adjustment, overpayment return, accounts receivable payment, etc.).
Amount of the disposition against the original lien.
Amount of the disposition against the original lien.
This is the amount of disposition that has occurred on the mother AR
This is the annual amount that should be paid to the provider/hospital for disproportionate share.
Dollar amount applied from a given CCN applied to a drug rebate invoice.
The interest dollar amount applied to a drug rebate invoice.
Dollar amount applied from a given CCN applied to a drug rebate invoice.
Dollar amount applied from a given CCN applied to a drug rebate invoice.
This field holds the result of the disproportionate share multiplied by the total allowed.
This field holds the result of the disproportionate share amount multiplied by the total allowed amount.
This field holds the disproportionate share amount multiplied by the total allowed amount.
This is the disproportionate share amount that is calculated during the claims pricing process and paid on the claim.
For CMHC's, amount owed to DMH if client was an adult.
This is the fixed amount that the rate will be changed by.
The additional claim payment that is associated with either a cost outlier or length of stay outlier
This is the difference between the hospital cost and full stay DRG payment minus the outlier threshold amount
This is the difference between the hospital cost and full stay DRG payment minus the outlier threshold amount
This is the total amount deposited due to Drug Rebate cash receipts.
Price per unit of product. The EDI specification allows for large numbers.
The rate per unit paid by a drug rebate labeler for an invoiced NDC.
Line Item Charge Amount
Line Item Provider Payment Amount - This is the amount the Payer would have payed the provider for this service.
Amount paid by a third party.

The amount received by the provider from private insurers.
The amount estimated by the hospital to be due from the indicated payer.
Amount due or refunded
Amount due or refunded from CMS
This is the total amount presented to the Federal Reserve bank.
The health insurance premium amount for an employee plus dependent coverage.
This contains the amount for encounter services on the claim detail indicated by the detail number on the table.
Amount for encounter services on the claim detail indicated by the detail number on the table.
This contains the amount for encounter services on the claim detail indicated by the detail number on the table.
This contains the amount for encounter services on the claim detail indicated by the detail number on the table.
This contains the amount for encounter services on the claim detail indicated by the detail number on the table.
This contains the amount for encounter services on the claim detail indicated by the detail number on the table.
The amount of equity the owner has in the property
This is the Amount of the Medicare eRX reduction.
The dollar amount of the eRX reduction.
The dollar amount of the eRX reduction.
The Estimated overpayment Amount.
This is the estimated provider cost
This is the estimated provider cost
The excluded amount of this non-liquid resource
The average amount of expenditures for claims that fall into the age, sex, and aid category.
The dollar amount of the expenditure.
The dollar amount of the expenditure.
The average claim amount for the recipient's age, sex, and aid category.
The total dollar amount expended while settling the case.
The amount of expenses paid for the person in care.
The amount paid for non-claim payments to an individual provider during the current year.
The amount paid for non-claim payments to an individual provider during the current year.
The number of facility days plus leave days multiplied by the per diem. This allowance applicable to facility and leave days.
The health insurance premium amount for family coverage.

Family allocation amount
Enrollment Fee paid by provider.
This is the amount of FICA paid for this detail payment record.
This is that amount of FICA that will be removed from the reimbursement amount to calculate the paid amount.
This is that amount of FICA that will be removed from the reimbursement amount to calculate the paid amount.
The amount of FICA accumulated by the provider and service location for this payment.
The amount of FICA accumulated by the provider and service location for this payment.
This is amount that the FICA was adjusted.
This is the final DRG payment plus the supplemental payment.
This is the final DRG payment plus the supplemental payment.
This is the amount that we should start flagging the budget as low on funds. This can be used on reports as well as on windows.
This is the full stay DRG base payment amount. It does not include outlier
This is the full stay DRG base payment amount. It does not include outlier
This is the full stay DRG payment. It includes the outlier payment. It is not reduced by non-covered days
This is the full stay DRG payment. It includes the outlier payment. It is not reduced by non-covered days
The gross amount of district office claimant's income before deductions
The value submitted by the provider in the gross amount due field (NCPDP field 430-DU).
The value submitted by the provider in the gross amount due field (NCPDP field 430-DU).
The value submitted by the provider in the gross amount due field (NCPDP field 430-DU).
Total price claimed from all sources. Used for copay only billing.
The value submitted by the provider in the gross amount due field (NCPDP field 430-DU).
Gross earned income
The gross pay amount.
Gross unearned income amount
This is the total amount deposited due to SUR cash receipts.
This is the amount that was held in the batch cycle on the transaction.
Recipient's Part A premium amount from the Bendex tape.
This is the total amount deposited due to TPL cash receipts.
Estimated home value

The number of hospital days multiplied by 1/3rd the per diem. This allowance applicable to hospital reserve bed days.
This is the incentive amount submitted by the provider on a NCPDP pharmacy claim billing transaction. The amount submitted in NCPDP field 438-E3 is stored in this field.
This is the most current income amount information for the recipient.
This is the case income amount.
This is the recipient's income for a specified period of time.
The amount of income of the move in/out person.
Incremental change in dollars reimbursed to providers for an NDC for a given quarter/year
The incremental rebate amount per unit.
Incremental change in rebate amount billed for an NDC for a given quarter/year
This is the insurance amount of the claim.
The total amount of interest paid on the claim.
This is the amount of interest on the AR.
The dollar amount balance of applied interest for an outstanding drug rebate invoice not paid
The incremental amount of interest that has been billed for this invoice
The amount of interest that has been billed for this invoice
The incremental amount of interest that is due for this invoice
The incremental amount of interest that has been paid for this invoice
The incremental amount of interest that has been written off for this invoice
The amount of interest billed that has been written-off for this invoice
The amount of recoupment that is currently in process for the cycle on the daughter claim.
The amount of recoupment that is currently in process for the cycle on the mom claim.
The maximum yearly Medicare approved Inpatient Coinsurance Cap Rate.
The amount Medicare has determined that a recipient must pay for late filing. Displayed for 5010 claims only.
The amount Medicare has determined that a recipient must pay for late filing. Displayed for 5010 claims only.
The amount Medicare has determined that a recipient must pay for late filing. Displayed for 5010 claims only.
The amount Medicare has determined that a recipient must pay for late filing. Displayed for 5010 claims only.
The amount Medicare has determined that a recipient must pay for late filing. Displayed for 5010 claims only.
The lien amount on the case.
The lien amount on the case.

Amount of the flat payment per claim cycle taken from a provider to pay the lien holder.
The maximum yearly Medicare approved Lifetime Reserve Rate Cap Rate.
ADJUSTED COINSURANCE
OUTLIER AMOUNT ASSOCIATED WITH THE APC PAYMENT
LINE ITEM PAYMENT
REDUCED COINSURANCE
LINE ITEM REIMBURSEMENT
TOTAL LINE ITEM DEDUCTION
A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.
A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.
A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.
A daily room rate or percentage of charge value depending on the pricing indicator that may be additional.
The accumulation of the Other Insurance Paid amounts for paid long term care claims during the reporting period.
LTC policy Part B exclusion amount
The total amount paid by the patient for services.
This is the BIG MAC and/or MAC unit price. The MAC is the unit price for a drug under Federal MAC regulation. The BIG MAC unit price is the Federal Participation Plan Upper Limits for a drug and is published by HCFA in the State Medicaid Manual.
For the OTC MAC table (t_drug_otc_mac):This is a calcd value (ie 150%) using a base rate. For State MAC table (t_drug_s_mac):This value is used for pricing which is determined as 150% of the base MAC rate like that on the t_drug_mac table.
This is the Maximum Allowable Cost for a drug as determined by the State.
This is the AWP price for the drug code.
This is the DRG outlier marginal cost percent
This is the DRG outlier marginal cost percent
This field represents the maximum allowed amount for a copay segment. It is used in transportation pricing.
This is the maximum amount that can be recovered for a specific payee in one cycle.
This is the maximum amount that can be recovered for a specific provider service location in one cycle.
The maximum amount of the account receivable that can be recouped in a payment cycle.
The maximum amount of the account receivable that can be recouped in a payment cycle.
The maximum amount of the account receivable that can be recouped in a payment cycle.

The amount received by the provider for the claim from Medicare.
An approximation amount that a MCP would have reimbursed a provider for this claim.
An approximation amount that a MCP would have reimbursed a provider for this claim.
An approximation amount that a MCP would have reimbursed a provider for this claim.
An approximation amount that a MCP would have reimbursed a provider for this claim.
The amount of TOT-MEDICAID-PAID-AMT attributable to a Disproportionate Share Hospital payment.
The amount paid by Medicaid/CHIP on this claim toward the beneficiarys Medicare coinsurance.
The amount paid by Medicaid/CHIP on this claim toward the beneficiarys Medicare deductible.
The amount paid by Medicaid on this claim or adjustment at the claim detail level.
The amount paid by Medicaid on this claim or adjustment at the claim detail level.
The amount paid by Medicaid on this claim or adjustment at the claim detail level.
The amount paid by Medicaid on this claim or adjustment at the claim detail level.
The amount paid by Medicare on this claim or adjustment.
The amount paid by Medicare on this claim or adjustment.
The amount paid by Medicare on this claim or adjustment.
The amount paid by Medicare on this claim or adjustment.
This is the educational amount utilized to calculate the DRG base rate specific for a provider.
Medicare Inpatient Adjudication - Claim Disproportionate Share Amount. This is the disproportionate share amount.
Medicare Inpatient Adjudication - Claim DRG Amount.
Medicare Inpatient Adjudication - Claim Indirect Teaching Amount.
Claim PPS Capital Amount - This is the total Prospective Payment System (PPS) capital amount
Medicare Inpatient Adjudication - Claim PPS Capital Outlier Amount.
Medicare Inpatient Adjudication - Claim Medicare Secondary Payor (MSP) Pass-through Amount. This amount to indicate the Medicare Secondary Payer (MSP) pass-through amount.
Medicare Inpatient Adjudication - Nonpayable Professional Component Amount.
Medicare Inpatient Adjudication - Old Capital Amount.
Medicare Inpatient Adjudication - This is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.

Medicare Inpatient Adjudication - This is the Prospective Payment System (PPS) capital, federal-specific portion, Diagnosis Related Group (DRG) amount.
Medicare Inpatient Adjudication - This is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
Medicare Inpatient Adjudication - PPS-Operating Federal Specific DRG Amount.
Medicare Inpatient Adjudication - PPS-Operating Hospital Specific DRG Amount
Medicare Inpatient Adjudication - This is the Prospective Payment System (PPS) capital indirect medical education claim amount.
Medicare Inpatient Adjudication - PPS-Capital Exception Amount.
This field is the minimum allowed amount. It is compared against the pricing allowed amount. If the pricing allowed amount is greater than the minimum and less than the maximum, then the copay amount is used.
Medicare Outpatient Adjudication - Claim End Stage Renal Disease (ESRD) Payment Amount.
Medicare Outpatient Adjudication - This is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
Medicare Outpatient Adjudication - Nonpayable Professional Component Amount
Payer Estimated Amount Due.
X12 - 837P, I, D - Loop 2300 - AMT02
X12 - 837P, I, D - Loop 2320 - AMT02
X12 - 837P, I, D - Loop 2400 - AMT02
This is the Maximum or Minimum allowed amount (depending on the IND_ABOVE_BELOW) that is to be compared against the non-PH Claims Paid Amount.
This is the Maximum or Minimum allowed amount (depending on the CDE_ABOVE_BELOW) that is to be compared against the PH Claims Adjudicated Paid Amount for the specific identifying codes.
The gross monthly income amount for the family member
Amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.
This is the amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.
The amount that the provider receives for dispensing a prescription drug. This amount may vary by provider specialty.
Fee paid for dispensing the drug.
This is the amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.
This is the dispensing fee for the provider.

This is the amount that the provider receives for dispensing a prescription drug. This amount varies by provider type.
This is the total adjustment negative amount.
The net amount of district office claimant's income after deductions
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc).
Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL, etc).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Amount remaining on a claim after payment has been made by all other sources (co-pay, TPL).
Amount remaining on a claim after payment has been made by all other sources (TPL).
Net Voucher Amount.
The amount withheld from an individual provider's payment for accounts receivable that were established for a reason other than an overpayment of a previous claim.
The amount withheld from an individual provider's payment for accounts receivable that were established for a reason other than an overpayment of a previous claim.
Amount returned from an individual provider for a reason other than overpayment of claims.
Amount returned from an individual provider for a reason other than overpayment of claims.
Amount returned from an individual provider for a reason other than overpayment of claims.
This is the non-covered day adjusted DRG payment amount. Does not include outlier
This is the non-covered day adjusted DRG payment amount. Does not include outlier
This is the non-covered day adjustment factor
This is the non-covered day adjustment factor
This is the non-covered day adjusted outlier
This is the non-covered day adjusted outlier

This is the per diem DRG payment amount. This includes outlier Only calculated if number of Medicaid covered days is less than full length of stay
This is the per diem DRG payment amount. This includes outlier Only calculated if number of Medicaid covered days is less than full length of stay
Service Line Non-Covered Charge Amount, Line Item Denied Charge or Non-Covered Charge Amount.
Service Line Non-Covered Charge Amount, Line Item Denied Charge or Non-Covered Charge Amount.
The charges for institutional long-term care which are not reimbursable by the primary payer.
The charges for institutional long-term care which are not reimbursable by the primary payer.
The amount on the bank clears record.
NDC Price Table Rate.
Amount for the Offline Claim.
This is the operation cost amount.
The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).
Amount of any payment known by the pharmacy from other sources.
Dollar amount which represents the recipient's copayment. Displayed for 5010 claims only.
The patient's cost share from a previous payer.
The patient's cost share from a previous payer.
The patient's cost share from a previous payer.
The patient's cost share from a previous payer.
Original amount assessed by the lien holder against the provider.
The amount owed to Medicaid for claims overpaid in the current financial year.
The amount owed to Medicaid for claims overpaid in the prior financial year.
The amount owed to Medicaid for claims overpaid in the second prior financial year.
Amount of family member other income
Amount representing the additional incurred costs for a dispensed prescription or service. Used for Copay only billing. This amount is included in the 'Gross Amount Due'.
The amount paid by insurance other than Medicare or Medicaid on this claim.
The amount paid by insurance other than Medicare or Medicaid on this claim.
The amount paid by insurance other than Medicare or Medicaid on this claim.

The amount paid by insurance other than Medicare or Medicaid on this claim.
This is the full stay DRG outlier amount. (AMT_DRG_OUT_COST * AMT_MARG_COST_PCT)
This is the full stay DRG outlier amount. (AMT_DRG_OUT_COST * AMT_MARG_COST_PCT)
Amt overhead is used for new home health pricing. Not used currently.
Unused.
Amt overhead is used by new home health pricing.
The amount of money (check or EFT) we will pay to an external entity for a paid claim.
The amount of the check received.
The amount of the check received.
The amount of money (check or EFT) paid to the provider for services rendered.
Amount that will be applied toward the check amount.
Amount sent to a provider for payment for services rendered to a recipient.
The amount that a specific transaction paid for the payment specified.
The total amount paid for the batch.
The total amount paid for the batch
The paid amount on the claim. NOTE: This amount is only reliable on this table for header paid claims. For more accurate paid amount information for claims processed, please reference table T_CLM_PGM_XREF.
Paid amount of non-adjusted lines
Amount sent to a provider for payment for services rendered to a recipient.
Amount sent to a provider for payment for services rendered to a recipient.
This is the amount that will be applied toward the check amount.
Amount sent to a provider for payment for services rendered to a recipient.
The amount that will be applied toward the check amount.
Amount that will be applied toward the check amount.
Amount that will be applied toward the check amount.
The total amount paid for the batch.
The amount that the payee is paid.
The amount that the payee is paid.
The amount that the payee is paid.
Amount paid to the provider on this 835.

This is the total amount of the financial cycle's checkwrite.
This is the amount that the transaction contributed to the payment.
This is the paid amount of the claim.
This is the total amount paid for the drug.
Amount paid for services rendered.
Amount paid for services rendered.
The amount of money we will pay to the submitter of the claim.
The amount of money we will pay to the submitter of the claim.
Amount paid for services rendered.
The accumulation of the paid amounts for the paid claims for the reporting period.
The accumulation of the paid amounts for paid long term care claims during the reporting period.
The amount paid by Medicaid on this claim or adjustment.
The amount paid by Medicaid on this claim or adjustment.
The amount paid by Medicaid on this claim or adjustment.
The accumulation of the paid amounts for the paid claims during the reporting period.
The accumulation of the paid amounts for the paid claims during the reporting period.
Amount that will be applied toward the check amount.
The accumulation of the paid amounts for the paid claims for the reporting period.
The accumulation of the paid amounts for the paid claims for the reporting period.
The accumulation of the paid amounts for the paid claims during the reporting period.
The accumulation of the paid amounts for the paid claims for the reporting period.
Payment amount reported on the CMS 372 for this record.
The accumulation of the paid amounts for the Medicare crossover paid claims paid during the reporting period.
Amount paid for services rendered.
Amount sent to a provider for payment of services rendered to a recipient.
Amount paid for services rendered.
Amount sent to a provider for payment for services rendered to a recipient.
Amount paid for services rendered.
The amount of money (check or EFT) we will pay to the submitter of the claim.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.

The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific recipient.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific beneficiary.
The actual amount of money the Medicaid program paid on this particular grouping of claims for this specific beneficiary.
This identifies the amount of a claim that medicaid paid.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Computed amount of payment due to a provider for a claim or an adjustment transaction.
Amount sent to a provider for payment of services rendered to a recipient.
The amount Medicaid paid.
This is the claim payment amount.
This is the claim payment amount.
Amount paid for 2009.
Amount paid for 2009.
Contains the dollar amount paid for adjustment claims contained in this entity
The total amount paid to an individual provider for administrative fees during the current year.
The total amount paid to an individual provider for administrative fees during the current year.

The amount paid for capitation to an individual provider during the current year.
The amount paid for capitation to an individual provider during the current year.
The amount of money (check or EFT) that will be paid to an external entity.
The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.
The dollar amount paid by Medicare for the services provided.The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.
The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.
The accumulation of the paid amounts from the Medicare Part A crossover claims paid during the reporting period.
The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.
The dollar amount paid by Medicare plus the 2% sequestration amount for the services provided.
The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.
The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.
The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.
The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.
The dollar amount paid by Medicare for the services provided. This amount reflects the subtraction of the 2% sequestration amount.
RCO claim paid amount
RCO claim paid amount
Maximum amount of money (check or EFT) that will be paid to an external entity.
Total Actual Payer Payment Amount
The amount paid for adjustments to an individual provider during the current year.
The amount paid for adjustments to an individual provider during the current year.
Payer paid amount.
Payer paid amount.
Patient Responsibility Amount
The patient financial liability amount that must be paid by the recipient before Medicaid will make payment on the claim.
Amount of money that a recipient is responsible for paying for services rendered.

Amount of money that a recipient is responsible for paying for services rendered.
Amount of money that a recipient is responsible for paying for services rendered.
Amount of money that recipient is responsible for paying for services rendered.
Amount of money that recipient is responsible for paying for services rendered.
Amount that the recipient is responsible to pay for drugs dispensed.
Amount that the recipient is responsible to pay for drugs dispensed.
Amount recipient is responsible to pay for services rendered.
Amount recipient is responsible to pay for services rendered.
The patient financial liability amount that must be paid by the recipient before Medicaid will make payment on the claim. This is a monthly amount.
Amount of money that a recipient is responsible for paying for services rendered.
Amount recipient is responsible to pay for drug dispensed.
Amount recipient is responsible to pay for services rendered.
Patient Liability Amount.
The accumulation of patient liabillity amounts for paid long term care claims during the reporting period.
Claim Payment Amount
The amount of the EFT paid to the provider.
The amount paid for day care services
The amount the recipient has agreed to pay each month.
This is the amount of money that can be paid out before the hold begins.
The hourly pay rate.
This is the dollar amount authorized for the Prior Authorization line-item service.
This is the dollar amount requested for the Prior Authorization line-item service.
This indicates the dollar amount that has been used to date for a prior authorization line item for a particular claim detail.
The total paid amount on claims for this year/month, set of criteria, benefit plan, and error number
This is the amount of patient liability that was used on the claim.
This is the amount of patient liability that was used on the claim.
Amount of money that a recipient is responsible for paying for services that were rendered.
Amount of money a recipient is responsible for paying for services that were rendered.
Amount of money a recipient is responsible for paying for services that were rendered.

This is the allowed amount for this prescription of the PMP peer group.
This is the cost associated to the peer level.
Percent that applies to the allowed amount.
The percentage of units the specific fund code has invoiced for an NDC.
This is the average allowed amount for this prescription of the PMP.
This is the average allowed amount for this prescription of the PMP peer group.
Total amount paid per ETG episode.
Total amount paid per ETG episode.
Total amount paid per ETG episode.
Total amount paid per ETG episode.
Total amount paid per recipient.
Total amount paid per recipient.
Total amount paid per recipient.
Total amount paid per recipient.
The average allowed amount per recipient for the grouping.
The policy premium amount
This is the total adjustment positive amount.
Premium amount on the transaction. On an accretion acknowledgment record, this field reflects a debit for the amount the State owes. On a deletion acknowledgment record, this field reflects a credit for the amount due to the State.
Premium amount on the transaction. On an accretion acknowledgment record, this field reflects a debit for the amount the State owes. On a deletion acknowledgment record, this field reflects a credit for the amount due to the State.
The yearly amount that will be paid to the insurance carrier.
The premium amount paid to Medicare for the reporting period.
Total amount of Part A premium paid for the buy-in coverage period.
Total amount of Part B premium paid for the buy-in period.
The individual payment amount due to the insurance carrier.
Premium rate per period
Monthly premium from CMS
Premium rate per period
Monthly premium from CMS
This is the Pre-transfer DRG base payment amount
This is the Pre-transfer DRG base payment amount
This is the lower of the Federal MAC, State MAC, EAC, Depart of Justice, and the WHN prices.

Rate to be paid for an Ambulatory Surgical Center procedure. The rate is based on the ASC pricing group.
The price per unit supplied by the manufacturer.
The amount that the hospital has received toward payment of a UB92 bill prior to the billing on the claim.
The amount of parental support alimony the applicant receives
This identifies the amount the provider has billed Medicaid.
The maximum amount to be paid to the provider for each day of care.
The maximum amount to be paid to the provider for each day of care.
This is the total amount of deposits made into the EDS bank account due to provider cash refunds.
Amount Medicare has determined the recipient must pay for psychiatric services received.
Amount Medicare has determined the recipient must pay for psychiatric services received.
The amount Medicare has determined that a recipient must pay for psychiatric services received. Displayed for 5010 claims only.
The amount Medicare has determined that a recipient must pay for psychiatric services received.
The amount Medicare has determined that a recipient must pay for psychiatric services received. Displayed for 5010 claims only.
The purchase amount of the HIPP policy.
Loop 2400 SV505
This is the provider's total allowed amount ranking within their peer group.
The per unit rate for this revenue code/county code combination.
Individual component rate.
The per unit, per diem, or flat rate amount for this provider.
The amount that will be used to adjust an allowed amount already calculated using the pricing methodology that applies to the claim/detail.
A daily room rate or percentage of charge value depending on the pricing indicator.
A daily room rate or percentage of charge value depending on the pricing indicator.
A daily room rate or percentage of charge value depending on the pricing indicator.
A daily room rate or percentage of charge value depending on the pricing indicator.
The percentage rate amount for this provider.
A daily room rate or percentage of charge value depending on the pricing indicator.
A daily room rate or percentage of charge value depending on the pricing indicator.

The percentage amount for this provider service location.
Rate as of 6/1/2009.
Rate as of 6/1/2009.
The per diem rate amount for this provider.
Rate amount used to price the claim.
Rate amount used to price the claim.
The incremental rebate amount paid.
The rebate amount per unit supplied for the calculation of the drug rebate amount for each NDC in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then includes it on the rate tape.
The rebate amount per unit supplied by CMS on a quarterly basis for the calculation of the drug rebate amount for each NDC in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.
The rebate amount per unit supplied by CMS on a quarterly basis for the calculation of the drug rebate amount for each NDC in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.
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The rebate amount per unit supplied by CMS on a quarterly basis for the calculation of the drug rebate amount for each NDC in the program. The rebate amount per unit is determined by the manufacturer and forwarded to CMS, who then forwards it to the State Medicaid Agencies.
The rebate amount per unit from CMS.
The unit rebate offset amount. 100% of this amount is returned to CMS.
The rebate offset amount per unit supplied by CMS on a quarterly basis. 100% of this amount is returned to the Feds, via 64.9r reporting.
The supplemental rebate per unit amount.
Total amount recouped for the ICN.
Total amount that has been recouped for the case.
Reduced premium rate from CMS

Reduced premium rate from CMS
Reduced premium rate.
Recoupment refund amount.
The amount expected to be received from the insurance carrier as a result of over-payment.
Refund amount received from provider.
Refund amount requested in initial letter.
Refund amount requested following CEO decision.
Refund amount requested in MAC appeal response letter.
First refund amount requested in reconsideration response.
Second refund amount requested in reconsideration response letter.
The amount reimbursed as reported on the CMS 64 report.
The accumulation of the paid amounts for the paid claims for the reporting period.
The accumulation of the reimbursement amounts for paid long term care claims during the reporting period.
The accumulation of the paid amounts for the paid claims for a recipient during the reporting period.
The accumulation of the reimbursement amounts for the paid claims during the reporting period.
The accumulation of the reimbursement amounts for the paid claims for the reporting period.
The accumulation of the reimbursement amounts for the paid claims for the reporting period.
The accumulation of the reimbursement amounts for the paid claims during the reporting period.
The accumulation of the reimbursement amounts for the paid claims for the reporting period.
The accumulation of the reimbursement amounts for the paid claims for the reporting period.
Payment amount received by the Billing Provider.
Amount sent to a provider for payment for services rendered to a recipient.
Percentage that is used to modify the allowed amount. This percentage could cause more or less money to be paid to the provider.
Total dollar reimbursed to providers for a specific claim.
This is the amount that is keyed in by the online clerk. It there are any deductions to take (ie. State Share or FICA) they will be computed off of this amount.
This is the amount that is keyed in by the online clerk. It there are any deductions to take (ie. State Share or FICA) they will be computed off of this amount.
This is the amount that is keyed in by the online clerk. It there are any deductions to take (ie. State Share or FICA) they will be computed off of this amount.
Percentage that is used to modify the allowed amount.

Percentage that is used to modify the allowed amount. This percentage could cause more or less money to be paid to the provider.
Loop 2400 SV504
This is the total amount returned to due to non-sufficient funds (NFS).
The total charge for the related UB-04 Revenue Code.
The total charge for the related UB-04 Revenue Code (REVENUE-CODE)
The calculated amount of savings for denied claims and paid claims. If the AMT_TPL_PAID is zeros, the AMT_SAVINGS is calculated by AMT_BILLED times 0.43. If the AMT_TPL_PAID is not zeros then the AMT_SAVINGS is set to the AMT_ALLOWED on the claim.
Family member self-employed amount
Amount of family member self-employment income excluded
Service line paid amount.
This is the amount the case was settled for
This is the amount the case was settled for.
This is the amount the case was settled for.
The original amount of the accounts receivable to be collected from a provider.
The original amount of the accounts receivable to be collected from a provider.
The original amount of the accounts receivable to be collected from a provider.
Recipient's Part B premium amount from the Bendex tape.
The maximum yearly Medicare approved Skilled Nursing Facility Cap Rate.
The total amount of spenddown the case is responsible for during the specified time period.
Spousal impoverishment amount. NOTE: 8888.88=not eligible for spousal allocation. 9999.99=refused
Amount received from SSA
SSI payment amount
The amount that a specific transaction paid for state share.
This is the amount of state share for this payment. The state share amount plus the AMT_PAID = reimbursement amount.
Amount of state share for this payment.
This is that amount of State Share that will be removed from the reimbursement amount to calculate the paid amount.
This is that amount of State Share that will be removed from the reimbursement amount to calculate the paid amount.
This is that amount of State Share that will be removed from the reimbursement amount to calculate the paid amount.

This is the amount of the state share for the transaction.
The amount of State Share accumulated by the provider and service location for this payment.
The amount of State Share accumulated by the provider and service location for this payment.
This is the supplemental payment amount.
Amount % of what we would pay for an out of stat provider.
This is the supplemental payment amount.
This is the supplemental payment percentage
This is the supplemental payment percentage
Supplemental payment amount from DHR to DHR cases with aid category = 1, 2 or 4
On service tracking claims the lump sum amount paid to the provider.
On service tracking claims the lump sum amount paid to the provider.
On service tracking claims the lump sum amount paid to the provider.
On service tracking claims the lump sum amount paid to the provider.
The amount paid by a third party on behalf of the beneficiary towards coinsurance on the claim.
The amount paid by a third party on behalf of the beneficiary towards coinsurance on the claim.
The amount paid by a third party on behalf of the beneficiary towards coinsurance on the claim.
The amount paid by a third party on behalf of the beneficiary towards coinsurance on the claim.
The amount the third party paid the copayment amount.
The amount the third party paid the copayment amount.
The amount the third party paid the copayment amount.
The amount the third party paid toward the copayment amount.
The dollar threshold used for reporting on the Invoice Threshold Report - RBT-2006-Q.
Dollar amount of threshold.
The dollar amount that begins the pricing rule.
The dollar amount of the threshold that ends the pricing rule.
The amount of money (check or EFT) that will be paid to an external entity.
The claim header level maximum amount determined by the payer as being `allowable`.
The claim header level maximum amount determined by the payer as being `allowable`.
The claim header level maximum amount determined by the payer as being `allowable`.

The claim header level maximum amount determined by the payer as being `allowable`.
Total allowed amount.
The amount allowed for all dental claims summarized by the various dimensions on the row.
Total billed amount.
The amount billed for all dental claims summarized by the various dimensions on the row.
The total amount charged for this claim at the claim header level as submitted by the provider.
The total amount charged for this claim at the claim header level as submitted by the provider.
The total amount charged for this claim at the claim header level as submitted by the provider.
The total amount charged for this claim at the claim header level as submitted by the provider.
This is the total amount paid or recouped on a rate change or correction adjustment once it has been processed.
This is the total amount paid or recouped on a rate change or correction adjustment once it has been processed.
The amount paid for cast crown dental services summarized by the various dimensions on the row.
The average allowed amount for the Patient First Provider(PMP).
The average allowed amount for the Patient First Provider's peer group.
The total amount paid by Medicaid/CHIP enrollee in addition to the amount paid by Medicaid/CHIP.
The total amount paid by Medicaid/CHIP enrollee in addition to the amount paid by Medicaid/CHIP.
The total amount paid by Medicaid/CHIP enrollee in addition to the amount paid by Medicaid/CHIP.
The total amount paid by Medicaid/CHIP enrollee in addition to the amount paid by Medicaid/CHIP.
Total recipient copay amount.
This is the amount that the earnings is being adjusted by. This amount can be using to increase or decrease earnings.
Total encounter amount.
The amount paid for exam dental services summarized by the various dimensions on the row.
The amount paid for fluoride treatment dental services summarized by the various dimensions on the row.
Total Medicare paid amount.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare coinsurance.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare coinsurance.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare coinsurance.

The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare coinsurance.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare deductible.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare deductible.
The amount paid by Medicaid/CHIP on this claim toward the beneficiary's Medicare deductible.
The total amount paid by Medicaid on this claim or adjustment.
The total amount paid by Medicaid on this claim or adjustment.
The total amount paid by Medicaid on this claim or adjustment.
The total amount paid by Medicaid on this claim or adjustment.
The amount paid for multi surface restoration dental services summarized by the various dimensions on the row.
The amount paid for one surface restoration dental services summarized by the various dimensions on the row.
The amount paid by insurance other than Medicare or Medicaid on this claim.
The amount paid by insurance other than Medicare or Medicaid on this claim.
The amount paid by insurance other than Medicare or Medicaid on this claim.
The amount paid by insurance other than Medicare or Medicaid on this claim.
Total Amount of summing the Other Insurance Paid Amount, Copay Amount and the Medicare Paid Amounts for the claim.
Total amount paid.
Total paid.
The sum of amount paid for services rendered to recipients summarized by various dimensions on the row during the reporting month.
The sum of amount paid for services rendered to recipients summarized by various dimensions on the row during the reporting month.
The amount paid for all dental claims summarized by the various dimensions on the row.
The amount paid for dental services summarized by Provider NPI / Recipient ID / Service Date Quarter.
The amount paid for all dental claims summarized by the various dimensions on the row.
The amount paid for initial services summarized by Provider NPI / Recipient ID / Service Date Quarter.
The amount paid for initial services summarized by the various dimensions on the row.
The amount paid for all recall services summarized by Provider NPI / Recipient ID / Service Date Quarter.
The amount paid for recall services summarized by the various dimensions on the row.

The amount paid for palliative treatment dental services summarized by the various dimensions on the row.
Total amount of patient paid amounts.
Total receipts posted during the reporting quarter period.
Total paid in sample.
The amount paid for prophy dental services summarized by the various dimensions on the row.
The amount paid for pulp cap dental services summarized by the various dimensions on the row.
The amount paid for radiograph dental services summarized by the various dimensions on the row.
Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for an NDC for a given quarter/year
Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for an NDC for a given quarter/year
Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for an NDC for a given quarter/year.
Result of multiplying the "rebate amount per unit" by the "total units reimbursed" for an NDC for a given quarter/year
Total rebate amount paid by the drug labeler for an NDC for a given quarter/year
Total rebate amount paid by the drug labeler for an NDC for a given quarter/year.
Total amount reimbursed for the claim. This is the amount from the claim header.
Total amount reimbursed to the provider.
Amount reimbursed to provider for drugs dispensed.
Amount reimbursed to provider.
Total paid amount reflected on a check to a provider.
Total amount reviewed.
The amount paid for root canal dental services summarized by the various dimensions on the row.
The amount paid for sealant dental services summarized by the various dimensions on the row.
The amount paid for sedative filling dental services summarized by the various dimensions on the row.
The amount paid for simple extract dental services summarized by the various dimensions on the row.
Total amount of state share.
The amount paid for steel crown dental services summarized by the various dimensions on the row.
The amount paid for surgical extract dental services summarized by the various dimensions on the row.
Total amount of other insurance paid.
This is the total amount denoted at the claim header level paid by the third party.
This is the total amount denoted at the claim header level paid by the third party.

This is the total amount denoted at the claim header level paid by the third party.
This is the total amount denoted at the claim header level paid by the third party.
The total amount of all transactions for each overpayment.
TPL Amount.
The amount received by the provider from private insurers.
The accumulation of claim TPL amounts reported by billing providers during the reporting period.
This is the total amount denoted at the claim detail level paid by the third party.
This is the total amount denoted at the claim detail level paid by the third party.
This is the total amount denoted at the claim detail level paid by the third party.
This is the total amount denoted at the claim header level paid by the third party.
This is the TPL amount for header only services.
The amount a third party paid.
The amount of the transaction.
Total dollars reimbursed to providers for an NDC for a given quarter/year
Total dollars reimbursed to providers for an NDC for a given quarter/year.
Total dollars reimbursed to providers for an NDC for a given quarter/year
The dollar amount that was written off for a specific invoice detail
The amount paid to an individual provider during the current year
The amount paid to an individual provider during the current year.
The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).
The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).
The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).
The value submitted by the provider in the usual and customary field (NCPDP field 426-DQ).
The Usual and Customary Charge associated with this procedure code.
Amount of family member unearned income
The rebate amount per unit supplied by HCFA on a quarterly basis for the calculation of the drug rebate amount for each NDC.
The guaranteed net unit price offered by the manufacturer.

The rate per unit of associate revenue for hospital accommodation. Found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV206).
Unit Rate. AKA Service Line Rate, Service Line Rate Amount. The rate per unit of associate revenue for hospital accommodation.
Current URA as of the report run date. (URA = National Agreement URA + UROA). This is the URA received from CMS on the quarterly Rate file.
Current units multiplied by the National Agreement URA (AMT_URA).
The amout allocated to the National Agreement in the current report period. Includes payments and credits.
Summation of all prior report runs National Agreement paids.
Ratio of National Agreement portion to the total URA.
Current UROA as of the report run date. This is the rate received from CMS on the quarterly Offset Rate file.
Current units multiplied by the UROA (AMT_UROA).
The amout allocated to the ACA in the current report period. Includes payments and credits.
Summation of all prior report runs ACA paids.
Ratio of ACA portion to the total URA.
Dollar amount used
Dollar amount of the corresponding value code.
Dollar amount of the corresponding value code.
Dollar amount of the corresponding value code (1 of 12).
Dollar amount of the corresponding value code (10 of 12).
Dollar amount of the corresponding value code (11 of 12).
Dollar amount of the corresponding value code (12 of 12).
Dollar amount of the corresponding value code (2 of 12).
Dollar amount of the corresponding value code (3 of 12).
Dollar amount of the corresponding value code (4 of 12).
Dollar amount of the corresponding value code (5 of 12).
Dollar amount of the corresponding value code (6 of 12).
Dollar amount of the corresponding value code (7 of 12).
Dollar amount of the corresponding value code (8 of 12).
Dollar amount of the corresponding value code (9 of 12).
Family member wage amount
Warrant amount
This is the transfer payment amount. Only calculated if patient discharge status is a DRG transfer policy status code)
This is the transfer payment amount. Only calculated if patient discharge status is a DRG transfer policy status code)

The sum of the ancillary inpatient record charge amounts in the episode.
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The sum of the ancillary outpatient record paid amount in the episode.
For self-authentication. Answer to the first question.
For self-authentication. Answer to the 2nd question.
The amount of time spent on hold while answering a phone call.
Name of application messages contained in the EDIFACT UNB envelope.
Outbound - Application Password.
Qualifier that specifies the type of code used to identify the group level override receiver on outbound maps. The value in this field is overridden by value in agreement table.

Three character area code for those countries that can be dialed without using the country dialing prefix.
This is the area number on the requested prior authorization transaction.
This is the area number for the county office of the recipient.
Assigning Authority of Other Identifier - Medicaid is the default value for the enrollment portal page.
Assigning Authority of Other Identifier - Medicaid is the default value for the enrollment portal page.
This contains the prior authorization assignment code which classifies the requested service.
Outbound - Association Assigned Code.
The percentage amount that would be paid to attorney for representing the case on a casualty case.
The percentage amount that would be paid to attorney for representing the case on a casualty case.
This is the authorized effective date for the services.
This is the authorized effective date for the requested service.
The effective date for the requested authorized service.
This is the authorized ending date for the services.
This is the authorized end date for the requested service.
The ending effective date for the requested authorized service.
This is the prior authorization number assigned to this service request.
This is the authorization number assigned on the originating system.
The make or manufacturer of the recipient's vehicle.
The model of the recipient's vehicle.
The model year of the recipient's vehicle
This is the average Peer group claim count or recipient count depending on what type of grouping.
This is the average PMP claim count or recipient count depending on what type of grouping.
The AVR PIN, which is used to authenticate users during a phone session.
DATE AVR PASSWORD LAST UPDATED
The number of claims not processed due to internal errors in the batch.
The address of the bank at which the district office claimant has an account.
The city of the bank at which the district office claimant has an account.
The two digit code indicating the state in which the bank branch is located

The zip code of the bank where the district office claimant's bank account is located
The resolution code description for a drug rebate dispute
This is the authorized effective date for the services.
This is the effective date of the Nursing Home recipient.
Authorizion begin date
The first quarter in which this conversion should take place
For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim began. For capitation premium payments, the date on which the period of coverage related to this payment began.
For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim began. For capitation premium payments, the date on which the period of coverage related to this payment began.
For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim began. For capitation premium payments, the date on which the period of coverage related to this payment began.
The recipients beneficary category at the end of the reporting period.
The recipients' beneficiary category at the end of the reporting period.
Billing File Name
Number of atomic transactions to be billed
Values: Y - Yes, bill the transactions; N - No, don?t bill the transactions. This indicator will be used to signal that the transaction count should not be billed (due to some system problem or other error encountered)
System assigned key for the provider dimension. This is a unique number assigned to the billing provider service location SAK.
System assigned key for the provider dimension table based on billing provider.
The system assigned key for the billing provider on the claim.
System assigned key for the provider dimension. This is a unique number assigned to the billing provider service location SAK.

Drug brand name.
Contains the final value for the measure.
Paid Amount Per Provider
Paid Amount Per Provider
Paid Amount Per Provider
Paid Amount Per Provider
Paid Amount Per Provider
Paid Amount Per Recipient
The average allowed amount per recipient for the grouping.
This is the average allowed amount per recipient.
The average allowed amount per recipient for the grouping.
The average allowed amount per recipient for the grouping.
The average allowed amount per recipient for the grouping.
This is the calculated ingredient cost of the drug.
This is the total calculated ingredient cost for the drug.
Indicates capitation or Fee For Service. 'Y' = Capitatied ' ' = FFS.
Indicates if the associated recipients claimks were capitated of FFS. 'Y' - Capitated, ' ' = FFS
The state-assigned number which uniquely identifies the Medicaid case to which the enrollee belongs on the last day of the current Federal Fiscal Year Quarter.
Case Type Code or Claim Grouping.
Case Type Code or Claim Grouping.
Case Type Code or Claim Grouping
Case Type Code or Claim Grouping.
Case Type Code or Claim Grouping.
Case Type Code or Claim Grouping.
A user defined group based on the case mix file. The claim grouping should be specific to the area of service
A user defined group based on the case mix file. The claim grouping should be specific to the area of service
A user defined group based on the case mix file. The claim grouping should be specific to the area of service
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A user defined group based on the case mix file. The claim grouping should be specific to the area of service
A user defined group based on the case mix file. The claim grouping should be specific to the area of service
Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
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Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code Description, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code Description, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
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Case Type Group Code Description, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Case Type Group Code Description, a higher classification for the Case Type Code that corresponds to a SUR Report Line Item.
Cash Control Number used to assign cash to the adjustment.
Cash Control Number used to assign cash to the adjustment.
This number is entered into the system for matching the internal record with its paper copy.

reference purposes for UNISYS conversion
The maximum yearly cash deductible for the specified claim type.
Drug Categorization.
A Category of Messages.
Code that indicates whether date range represents 'S'ervice, 'P'ayment or 'R'eceipt.
Code used to indicate whether error should be checked for at 'H' - header, 'D' - detail, 'B' - both header and detail.
Defines the system assigned key as claim adjustment ('claim type'), Account receivable ('R'), or system payout ('S').
Code which is used to control dependencies.
Code that identifies the type of txn (Claim Type or Financial Txn) that required a payment. This code may be any of the claim types (D,M,B,H,I,L,O,P,Q,A,C) OR financial txns R (Acct Recs), S (expenditures), V (capitation), X (Lien recovery), F (FICA reduction).
Code identifying the type of copay. The copay type is used along with the claim type to identify the copay amount to pay on a claim.
Identifies the classification of the drug. Classifications are Vaccine (V), Insulin (I), Supply (S), Nutritional (N), Class 1A (1), Anorexic (A), Family Planning (F), Smoking Cessation (C), Fertility Enhancements (E) and Minoxidil (M).
Identifies the classification of the drug. Classifications are Vaccine (V), Insulin (I), Supply (S), Nutritional (N), Class 1A (1), Anorexic (A), Family Planning (F), Smoking Cessation (C), Fertility Enhancements (E) and Minoxidil (M).
Indication of what type of processing should be performed. This is used for processing of adjustments based on the EOB assigned as the adjustment reason.
One character code used to identify the type of processing that should occur when an EOB is assigned. For example, A-full refund, U-underpayment, E-enter mass adjustment
Code that identifies the type of txn (CLAIM TYPE or Financial Txn) that required a payment. This code may be any of the claim types (D,M,B,H,I,L,O,P,Q,A,C) OR financial txns (R (Acct Recs), S (expenditures), V(capitation), X (Lien recovery), F (FICA reduction)
Used to determine the pricing methodology for the lab test procedure (this is the procedure exemption code). Values are "B" (blood product), "E" (exempt from fee schedule), "M" (multichannel procedure) and "R" (related lab test).
This code indicates whether the limitation audit limits procedure codes ( ) or revenue codes (R).
This code indicates whether the limitation audit limits procedure codes ( ) or revenue codes (R).
Code used to identify type of modifier.

Code used to identify type of modifier.
This code indicates the type of outcome: 1 = prescription filled; 2 = prescription not filled.
Specifies the type of sort to be used for the label or list.
This is the rebate status of the drug and is used in determining if the drug should be included/excluded in the drug rebate program. Different values are used to signify different classes of drugs, like "smoking cessation" and "supplies".
This is an emergency code. Valid values are 'E' or space.
Indicates whether the system assigned key is cash receipts (check related 'C') or an adjustment request (non-check related 'A' or 'P'). 'A' indicates that provider mailing address will be used, 'P' indicates that address keyed on RTS will be used.
Indicates whether the system assigned key is cash receipts (check related 'C') or an adjustment request (non-check related 'A' or 'P'). 'A' indicates that provider mailing address will be used, 'P' indicates that address keyed on RTS will be used.
The CDE attribute is used to determine the type of editing to perform. A value of 'R' (Required) indicates the modifier is required to be billed on the claim for providers that have the defined specialty. A value of 'N' (Not allowed), indicates the modifier is not allowed to be billed on claims for the defined provider specialty.
Code that indicates whether date range represents 'S'ervice or 'P'ayment.
This field is used to describe the type of absent parent. Recommended values are as follows: 'A' = ABSENT PARENT; 'C' = CUSTODIAL PARENT
Code indicating the payer. A value of 'C' indicates that Medicaid is the payer, 'A' indicates that Medicare is the payer and 'B' indicates that another insurance company was the payer.
This field stores the code identifying the major duty or responsibility of the person or group named.
This field stores the code identifying the major duty or responsibility of the person or group named.
This field stores the Entity Identifier Code which is used for identifying an organizational entity, a physical location, property or an individual.
This is the reason code for the 1099 adjustments.
This is the reason code for the 1099 adjustments.
Code identifying the type of insurance policy within a specific insurance program.
Billing Provider Contact Information. Contact function code identifying the major duty or responsibility of the person or group named.
Pay-to Plan Name. Code identifying an organizational entity, a physical location, property or an individual.
Code identifying an organizational entity, a physical location, property or an individual for Pay-to Plan Name.

Pay-to Plan Code identifying an organizational entity, a physical location, property or an individual.
Code identifying the major duty or responsibility of the person or group named of Property & Casualty Subscriber Contact Information.
This field stores the Code identifying an organizational entity, a physical location, property or an individual.
Code identifying a contract type.
EPSDT Referral Condition Code.
EPSDT Referral Condition Code.
EPSDT Referral Condition Code.
Code identifying which tooth is missing or to be extracted in the future.
Healthcare code specifying pricing methodology at which the claim or line item has been priced or repriced.
Reject reason code assigned by issuer to identify reason for rejection.
Code specifying policy compliance.
Code specifying the exception reason for consideration of out-of-network health care services.
Principal Diagnosis code indicating a code from a specific industry code list.
Code indicating a code from a specific industry code list of Condition Information.
Code indicating a code from a specific industry code list of Anesthesia Related Procedure.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Diagnosis code indicating a code from a specific industry code list.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
Patient Reason for visit diagnosis code.
Code indicating a code from a specific industry code list of Anesthesia Related Procedure.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Diagnosis Code indicating a code from a specific industry code list
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
Patient Reason for visit diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Diagnosis Code indicating a code from a specific industry code list.

Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.
External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Code indicating a code from a specific industry code list of Condition Information.

External Cause of Injury diagnosis code.
External Cause of Injury Present on Admission Indicator indicating if a condition was present at the time of admission.
Auto Accident State or Province code.
Adjusted Repriced Claim Reference Number, reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Repriced Claim Reference code reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Code identifying the major duty or responsibility of the person or group named of Service Facility Contact Information.
Supervising provider code for an organizational entity, a physical location, property or an individual.
Code identifying an organizational entity, a physical location, property or an individual of Ambulance Pick Up Location.
Code identifying an organizational entity, a physical location, property or an individual of Ambulance Drop Off Location.
Claim Payment Remark Code 1 - Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Claim Payment Remark Code 2 - Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Claim Payment Remark Code 3 - Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Claim Payment Remark Code 4 - Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Claim Payment Remark Code 5 - Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Code identifying the type of insurance policy within a specific insurance program.
Other Payer Claim Adjustment code.
Other Payer supervising provider. Entity Identifier Code identifying an organizational entity, a physical location, property or an Individual.
Other Payer Other Operating Physician entity identifier code.
Other Payer Billing Provider. Entity Identifier Code identifying an organizational entity, a physical location, property or an Individual.
Other Payer Service Facility Location. Code identifying an organizational entity, a physical location, property or an individual.
Code identifying an organizational entity, a physical location, property of other payer billing provider.

Other Payer Rendering Provider code identifying an organizational entity, a physical location, property or an individual.
Other Payer Assistant Surgeon. Code identifying an organizational entity, a physical location, property or an individual.
Other Payer Billing Provider entity identifier code.
Contract Type Code.
Contract code, reference identification.
Pricing Methodology.
Unit or Basis for Measurement Code.
Reject Reason code assigned by issuer to identify reason for rejection.
Policy Compliance Code specifying policy compliance.
Exception Code specifying the exception reason for consideration of out-of-network health care services.
Attachment Report Type Code.
Attachment transmission code.
Adjusted Repriced claim Reference Identification.
Prior Authorization Reference Identification code.
Prior Authorization Reference Identification code.
Prior Authorization Reference Identification code.
Prior Authorization Reference Identification code.
Prior Authorization Reference Identification code.
Repriced Claim reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Identifies the primary diagnosis code for this service line.
Identifies the second diagnosis code for this service line.
Identifies the third diagnosis code for this service line.
Identifies the fourth diagnosis code for this service line.
Other Operating Physician code identifying an organizational entity, a physical location, property or an individual.
Supervising Provider entity Identifier Code identifying an organizational entity, a physical location, property or an Individual.
Rendering Provider Name Code identifying an organizational entity, a physical location, property or an individual.
Service Facility code identifying an organizational entity, a physical location, property or an Individual.

Referring Provider Code identifying an organizational entity, a physical location, property or an individual. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
Code identifying an organizational entity , a physical location, property of ambulance pick up location.
Code identifying an organizational entity, a physical location, property or an individual of ambulance drop off location.
Indicates the type of secondary provider number. 82 - Rendering; DD - Assistant Surgeon; DQ - Supervising; 77 - Service Facility Location.
Code identifying an organizational entity, a physical location, property of ambulance pick up location.
Rendering Provider Name Code identifying an organizational entity, a physical location, property or an individual.
Determine if the units should be halved if first claim is after July 1
Determine if the units should be halved if first claim is after July 1.
The GSN Drug Code Price Type. GEN - Generic Price Type, BRN - Brand Price Type.
Obsolete.
Indicator to specify if the value in the AMT_MONETARY field is the minimum low value or the maximum high value of the PH Claim Adjudicated Paid Amount. Valid Values are 'A' - Above value or maximum amount or 'B' - Below value or minimum amount.
Accident Country.
CLM - Accident Country.
Auto Accident Country Code. Code identifying the country where the accident occurred if outside the US. Component of Claim Information.
Auto Accident State or Province Code. For Auto Accident Related Causes, the Standard State or Province Code as defined by the appropriate government agency. Component of Claim Information.
Accident State.
CLM - Accident State.
Unisys's accounting code which indicates the type of transaction such as a payment, credit, adjustment, etc.
Identify the accreditation awarded to the managed care entity.
Code indicating the type of second account at the same bank. These values are maintained by the AMAES system and include: B = Burial N = Additional Name on the Account C = Checking Q = QIT D = CD S = Savings I = Investment T = Trust X = Closed O = Other

Code indicating the type of third account at the same bank. These values are maintained by the AMAES system and include: B = Burial N = Additional Name on the Account C = Checking Q = QIT D = CD S = Savings I = Investment T = Trust X = Closed O = Other
Code indicating the type of fourth account at the same bank. These values are maintained by the AMAES system and include: B = Burial N = Additional Name on the Account C = Checking Q = QIT D = CD S = Savings I = Investment T = Trust X = Closed O = Other
Code indicating the type of account. These values are maintained by the AMAES system and include: B = Burial N = Additional Name on the Account C = Checking Q = QIT D = CD S = Savings I = Investment T = Trust X = Closed O = Other
This one byte indicator identifies the type of the bank account that a provider is using for Electronic Funds Transfers. The valid values are 'C'hecking, 'S'avings.
A code that indicates how the account is used. U= disbursement, D= deposit, B=both.
Code indicating whether the provider is accepting new patients. Valid values are Y - Yes, N - No, and L-Limited.
A code that indicates a type of accident that qualifies a recipient for services.
Adjusted Clinical Grouper Code.
This is the ACQ code of the drug. (Values are 1 - ACQ found; 2 - ACQ not found)
This is the ACQ of the claim. (1 - ACQ found; 2 - ACQ not found)
This is the ACQ code for the drug. (Values are 1 = ACQ and 0 = No ACQ)
A list of actions for an element.
Indicates the action to be taken when an error fails on the PS/2 transaction.
This field indicates the action to be taken to ensure that all claims have a facsimile and all facsimiles have a claim. Valid values are: A - Add facsimile; D - Delete facsimile.
A code representing actions taken related to family members documented on SOBRA applications. These codes are maintained and assigned by the ADPH E&E system. Valid values include: 01 = Your VA contract covered your medical expenses 02 = You are not in a medical institution 4A = Failure to return a signed Appointment of representative form
The action that claims engine need to take on this adjustment: A or blank - reprocess the whole claim; P - reprocess specific details; H - update history only do not edit, audit, or re-price.
A code that indicates the action reason
An additional code to indicate the action reason

A code representing the last action taken for this recipient. Valid values are: I - INITIAL APPLICATION R - RE-APPLICATION A - ANNUAL REVIEW C - CHANGE L - LATE REVIEW
An indicator used to order the screenings by importance. A is the most important screening and Z is used to make a screening inactive.
Indicates the status of the criteria record where Y=Active, N=Inactive.
This is a one-character field and indicates the address type. Possible valid values are: 1 - Recipient Batch, 2 - Provider Mail To Batch, 3 - Provider Pay To Batch, 4 - Provider Service Location Batch, 5 - Recipient Portal, 6 - Provider Mail To UI/All Portals, 7 - Provider Pay To UI/All Portals, and 8 - Provider Service Location UI/All Portals.
Indicates either M - Mailing Address or R - Residence Address.
A one character code that identifies the type of address.
This is the type of address that is being kept.
This is the type of address that is being kept.
The Drug Drug inverse code.
The Drug Drug inverse code.
The adverse drug reaction code.
The Drug/Drug inverse code
This code identifies the adjustment type
A reason that an adjustment was made to the amount originally billed
A reason that an adjustment was made to the amount originally billed
A reason that an adjustment was made to the amount originally billed
Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
Claim adjustment reason codes communicate why a claim was paid differently than it was billed.
The action that claims engine need to take on this adjustment: A or blank - reprocess the whole claim; P - reprocess specific details; H - update history only do not edit, audit, ore re-price.
HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.

Code used to indicate the source of the update. Values converted from legacy are "U" for SUR and "H" for HWT. "C" indicates a converted claim that may not be adjusted. "F" indicates an online FULL REFUND transaction. Current batch update program uses "U" whether the input file is from the Agency or a 3rd party.
A code to indicate whether the record is a new day claim (N), adjustment (A=daughter claim) or a void (V).
A code indicating if the claim is a new day claim (N) or an adjustment (A).
The ICD-9/10-CM Diagnosis Code provided at the time of admission by the physician.
The ICD-9/10-CM Diagnosis Code provided at the time of admission by the physician.
A flag that identifies the coding system used for the ADMITTING-DIAGNOSIS-CODE.
A flag that identifies the coding system used for the ADMITTING-DIAGNOSIS- CODE.
The hour the recipient was admitted to the hospital. Hour 01 is 1:00 am; hour 24 is midnight.
The hour and minute during which the patient was admitted for inpatient or outpatient care.
The hour during which the patient was admitted for inpatient or outpatient care in HHMM format.
The hour during which the patient was admitted for inpatient or outpatient care.
The hour the patient was admitted to the facility; 0-24.
The hour during which the patient was admitted for inpatient or outpatient care.
This code describes the area of specialty for the admitting provider.
This code describes the area of specialty for the admitting provider.
The taxonomy code for the admitting provider.
The taxonomy code for the admitting provider.
A code describing the type of admitting provider.
A code describing the type of admitting provider.
Code identifiying the source of admission in block 20 on the UB92 claim record for inpatient and LTC claims.
A code to indicate the type of residence of the recipient required before payment can be authorized.
The admission source code is used to indicate if the recipient is coming from a LTC facility. A code of 5 indicates admission from a LTC facility.
The source of admission code that is found in block 20 of the UB92 claim form for inpatient and LTC claims.
Code identifiying the source of admission in block 20 on the UB92 claim record for inpatient and LTC claims.
The source of admission code that is found in block 20 of the UB92 claim form for inpatient and LTC claims.

The source of admission code that is found in block 20 of the UB92 claim form for inpatient and LTC claims.
Code which indicates the priority of the admission of a recipient for inpatient services.
Code which indicates the priority of the admission of a recipient for inpatient services.
Code which indicates the priority of the admission for inpatient or outpatient care.
Code which indicates the priority of the admission for inpatient or outpatient care.
The admit reason type code values.
Code which indicates the priority of the admission for inpatient or outpatient care.
Types of admission for Inpatient hospital stays and a code indicating the priority of this admission
The code for the address type value. It identifies to whom the address pertains (CLI=client; GRD= guardian; SIG=significant other; PHY = physician; DSH = discharging hospital; IP1 = interested party # 1; IP2 = interested party #2). PASRR PRE-ADMISSION SCREEN: Type; RESIDENT REVIEW SCREEN: Type;
The code for the address type value. It identifies to whom the address pertains (CLI=client; GRD= guardian; SIG=significant other; PHY = physician; DSH = discharging hospital; IP1 = interested party # 1; IP2 = interested party #2).
The type of address and contact information for the eligible submitted in the record segment.
Identifies if eligible recipient is Adult (A) or Child (C). This is based upon the CMS definition of adult/child, not the adult/child indicator and is calculated using recipients age when counts are gathered.
Indicate whether an Adult or Child. Cannot be calculated from date of birth. A = ADULT, C = CHILD, Blank = NA.
The code value for the ADvantage disposition which describes the action taken as a result of an assessment
The code value for the ADvantage disposition which describes the action taken as a result of an assessment (PASRR PRE-ADMISSION SCREEN, Determinations, ADvantage Disposition)
The action pertaining to the ADvantage program that is taken for a client as a result of an assessment.
The code value for the ADvantage disposition which describes the action taken as a result of an assessment. (Resident Review Screen, Resident Reviews, ADvantage Disposition)
A code to identify the category of program that the provider is affiliated.
Agency code received from CMS
Agency code received from CMS
Agency code as provided by CMS.
Agency code transmitted to CMS.
Agency code received from CMS

Agency code received from CMS
Agency code as provided by CMS.
Agency code transmitted to CMS.
This is the State Agency Code.
This is the State Agency Code resposible for the "share" portion of the claim payment.
Indicates the certified agency. H = All human resource recipients, D = D.O., M = Medicaid SOBRA, S = SSI, Y = Foster Care-ADC.
Indicates the previous certifying agency. H = All human resource recipients, D = D.O., M = Medicaid SOBRA, S = SSI, Y = Foster Care-ADC.
Country code for Agent address.
Country code for Agent address.
Country code for Agent address.
Agent's country code after.
Agent's country code before.
The recipient's age group based on the From Date of Service month on the claim. Valid values are 0 for age < 0, 1 for ages 0-5 years, 2 for ages 6-20 years, 3 for ages 21-64 years and 4 for ages 65 & over
The recipient's age group based on the From Date of Service month on the claim. Valid values are 0 for age < 0, 1 for ages 0-5 years, 2 for ages 6-20 years, 3 for ages 21-64 years and 4 for ages 65 & over
The recipient's age group based on their eligibility month. Valid values are 0 for age < 0, 1 for ages 0-5 years, 2 for ages 6-20 years, 3 for ages 21-64 years and 4 for ages 65 & over
A code used to classify the age groupings.
Indication of whether a recipient's age is included, excluded, or not in the audit criteria.
Indication of whether a recipient's age is included, excluded, or not in the audit criteria.
Identifies the age restrictions that this PMP has selected for this service location. AA - No age restrictions BB - Age 0 - 12 years CC - Age 13 - 20 years DD - Age 21 and Over EE - Age 0 - 20 years FF - Age 13 and Over
Identifies the age restrictions that this PMP has selected for this service location. AA - No age restrictions BB - Age 0 - 12 years CC - Age 13 - 20 years DD - Age 21 and Over EE - Age 0 - 20 years FF - Age 13 and Over
Obsolete.
Identifies the age restrictions that this PMP has selected for this service location. AA - No age restrictions BB - Age 0 - 12 years CC - Age 13 - 20 years DD - Age 21 and Over EE - Age 0 - 20 years FF - Age 13 and Over

Identifies the age restrictions that this PMP has selected for this service location. AA - No age restrictions BB - Age 0 - 12 years CC - Age 13 - 20 years DD - Age 21 and Over EE - Age 0 - 20 years FF - Age 13 and Over
The valid values are FS, FB, EN, EB.
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation Code of the claim
Aggregation code of the claim.
Aggregation Code of the claim
Audit criteria for AHFS. Valid values: NA (space), INCLUDE (I), or EXCLUDE (E).
The GCN_SEQNO / AHFS Code Relation uses a concatenated key of GCN_SEQNO + AHFS to resolve the many-to-many relationship between GCNSEQNOTBL and AHFS Codes in AHFSDESCTBL. Each instance of this table provides the relative priority of assignment of a specific AHFS Code to its associated GCN_SEQNO (data element AHFS_REL). Each GCN_SEQNO value in GCNSEQNOTBL has at least one corresponding record in AHFSTBL.
Aid Category Code
Population Code.
Identifies the type of aid for which a recipient is eligible.
Identifies the type of aid for which a recipient is eligible.
Identifies the type of aid for which a recipient is eligible.
Aid category code
Identifies the type of aid for which a recipient is eligible. This value is present in the CDE_AID_CATEGORY in table T_CDE_AID.
The code indicating recipient's aid category type. List of valid aid category codes and their description can be found in table T_CDE_AID.
The code indicating recipient's aid category type. List of valid aid category codes and their description can be found in table T_CDE_AID.
Identifies the type of aid for which recipients are eligible. List of valid aid category codes and their description can be found in table T_CDE_AID.

This is the recipient aid category or population code.
The recipients' eligibility category at the end of the reporting period.
The recipients Eligibility Category at the end of the reporting period.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
A character code used to represent the aid category of the recipient.
A character code used to represent the aid category of the recipient.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
Code identifying the type of aid for which a recipient is eligible.
A code to uniquely identify a valid population code.
Code identifying the type of aid for which a recipient is eligible.
System assigned key to uniquely identify a valid population code.
This is the Population code.
Category of aid. Values include: 1 = AGED (D.O.,SSI,DHR) 2 = BLIND (D.O.,SSI,DHR) 3 = ADC (DHR OR SOBRA) 4 = DISABLED (D.O.,SSI, OR DHR) 5 = SOBRA(OR PRESUMPTIVE ELIGIBILITY-OLD) 6 = REFUGEE (DHR) 7 = FOSTER CARE-ADC(DHR) 8 = FOSTER CARE-STATE (DHR) 9 = FOSTER CARE-STATE (NEWBORN CHILD OF SSI MOTHER) (D.O.) Q = QUALIFIED MEDICARE BENEFICIARY L = SLIMB
A code used to describe the aid category grouping used by IFSSA.
A code representing the reason a SOBRA alert action is required. Valid values include: A = Application for a social security number. C = Alert for unemployment compensation set as reported E = Alert for earned income scheduled as anticipated G = General worker alert as applicable I = Alert for increase in social security set as expected N = Alert for various deprivation reasons set at 11 months past EDC date of unborn U = Alert for unearned income scheduled as anticipated V = Alert for veteran's administration benefits as expected W = Alert when returned to work as reported if changing from SOBRA certification. Do not change this field.
These T-MSIS codes indicate how each allowed charge was determined.
These codes indicate how each allowed charge was determined.

This is the SAK or code associated with the alternate drug or NDC and will be one of the following based on the IND_DRUG_ALT value: H=sak_drug_thera_cls, I=sak_ingredient, G=sak_drug_gen, N=sak_drug, A=cde_thera_cls_ahfs.
ID associated with an ePrescribing Alternate Therapy List; value from CDE_LIST_ID in T_ERX_CDE_LIST_ID record where SAK_PUB_HLTH matches T_PGM_HIERARCHY record and CDE_LIST_ID = ALT.
This indicator is necessary to identify if the benefit adjustment factor will be applied before or after the allowed amount was finalized. Some Benefit adjustment factors can be applied before a comparison between the billed amount and the allowed amount is done. Values "B" Before the calculated allowed amount is compared to the billed amount. Value "A" after the calculated amount is finalized
The unique two character code for the description of the Alabama Schedule.
The unique two character code for the description of the Alabama Schedule.
The unique two character code for the description of the Alabama Schedule.
The unique two character code for the description of the Alabama Schedule.
The unique two character code for the description of the Alabama Schedule.
The unique two character code for the description of the Alabama Schedule.
For informational purposes only: Indicates a recipient's Medicare eligibility status and the State's payment of the Medicare premium. Valid Values: Blank = No Medicare eligibility or payment of premium indicated on recipient's record; 0 = Current Medicare status unknown, State no longer pays Medicare premium; 1 = QDWI: eligible for Part A only, State pays Part A premium; 2 = Eligible for Parts A & B, State pays Part B premium; 3 = Eligible for Part B only, State pays Part B premium; 4 = Eligible for Part A only, States pays Part A premium; 5 = No longer has Medicare eligibility, State no longer pays Medicare premium; 6 = Eligible for Parts A & B, State pays both Part A and B premiums. For actual Medicare Part A/B coverage, please use T_RE_MEDICARE_A and T_RE_MEDICARE_B.
CR1 - Code indicating the type of ambulance transport
CR1 - Code indicating the reason for the ambulance transport
This is the 2-digit code that specifies if a move occurred between 19-48 months before today.
This is the 2-digit code that specifies if a move occurred between 19-48 months before today.
The numeric county code where the applicant resides
The numeric representation of the district office or central office

Offset indicator. Values are C, P, MI, MN, or blank.
A one or two digit code identifying the Medicaid program for which the claimant is applying or is eligible through the district office
District office worker code
Physical type of application submitted. Sample values include: LIS = Low Income Subsidy L21 = Low Income Subsidy application received on Active DO case L99 = Low Income Subsidy application received on a DO case that is under URC sanction PAP = paper application WEB = received via web (future use)
Method or place the application was received. Valid values are: A = ALLKIDS REFERAL B = PLAN FIRST C = ALLKIDS CENTRAL OFFICE D = DROPPED OFF - NO CONTACT F = FEDERALLY QUALIFIED HEALTH CENTER H = HOSPITAL M = MAIL IN/CENTRAL OFC O = OTHER LOCATION P = PUBLIC HEALTH Q = QUALIFED PROVIDER APPLICATION ASSISTER R = HUMAN RESOURCES S = MAILED DIRECTLY TO SITE BY RECIP. OR REP. T = TRANSUNION APPLICATION V = AVAA W = WEB X = MYALABAMA Y = APHCA
Code that represents the status of the recipient application. Valid values are: BLK=N/A A=AWARD D=DENIED P=PENDING T=TERMINATED
Current status of the SOBRA Medicaid application. Valid values: BLANK = ACTIVE 1 = DENIED 2 = PENDING 3 = DEATH DELETE 4 = REGULAR DELETE 5 = SUSPENDED
The FDA Drug Application Type Code is a four-character numeric column that identifies the FDA drug application type of an NDC. Valid values: 1 - New Drug Application (NDA) - The drug product was approved under an NDA. 2 - Abbreviated New Drug Application (ANDA) - The drug product was approved under an ANDA. 3 - Other - Other-the drug product was listed under the FDA's 'Other' category. The FDA assigns this type to a drug product when A) an approved application number was not provided with the listing submission, B) it does not need one, or C) the drug product is unapproved by the FDA. 4 - Not Defined - The drug product was approved and assigned an application number by the FDA that doesn't fit the FDA's numbering schema for the assignment of a particular status.

The FDA Drug Application Type Code is a four-character numeric column that identifies the FDA drug application type of an NDC. Valid values: 1 - New Drug Application (NDA) - The drug product was approved under an NDA. 2 - Abbreviated New Drug Application (ANDA) - The drug product was approved under an ANDA. 3 - Other - Other-the drug product was listed under the FDA's 'Other' category. The FDA assigns this type to a drug product when A) an approved application number was not provided with the listing submission, B) it does not need one, or C) the drug product is unapproved by the FDA. 4 - Not Defined - The drug product was approved and assigned an application number by the FDA that doesn't fit the FDA's numbering schema for the assignment of a particular status.
This code indicates the type of enrollment for which a provider is applying.
A system generated number that uniquely identifies an application type
A system generated number that uniquely identifies an application type
The code used to identify the status of the approval of the check reissue. 'Y' is used to indicate that the approval has processed, 'N' is used to indicate that the approval has been rejected, and 'O' is used to indicate the approval is open.
A code representing the good cause status. Valid values are: Y - GOOD CAUSE CLAIM (GOOD CAUSE CLAIM) APPROVED N - GOOD CAUSE N/A A - GOOD CAUSE DUE TO ADOPTION PROCEDURES C - GOOD CAUSE DUE TO ANTICIPATED HARM TO CHILD D - GOOD CAUSE CLAIM DENIED H - GOOD CAUSE DUE TO ANTICIPATED HARM TO PARENT P - GOOD CAUSE CLAIM PENDING R - GOOD CAUSE DUE TO RAPE OR INCEST W - GOOD CAUSE CLAIM SUBMITTED & WITHDRAWN
The race of the absent parent
The sex of the absent parent
Code which indicates the internal area on which a particular field resides. This is used during the production of Claim Correction Forms in order to identify which tables should be accessed to retrieve the appropriate data.
This field is the code (zip, county, district or state) that is part of the specified region. If the CDE_AREA_TYPE field's value is 'Z', then this field will contain a zip code. If the type is 'C', then this field will contain a county code. If the type is 'D', then this field will contain a district code. If the type is 'S', then this field will contain a state code..
This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as certifying county/zip code , zip codes, counties, or the entire state.
2 byte code for the work areas on the account

This code represents the type of gepgraphical area. Examples include zip code (Z), county code (C) and state code (S).
This code represents the type of gepgraphical area. Examples include zip code (Z), county code (C) and state code (S).
This code represents the type of gepgraphical area. Examples include zip code (Z), county code (C) and state code (S).
Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.
This number indicates the ambulatory surgical center group.
Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.
This number indicates the ambulatory surgical center group.
Ambulatory Surgical Center (ASC) payment group codes classify procedures into different payment groups that are based on surgical procedure complexity. Rates by ASC payment group are established by CMS.
Indicates the reason the beneficiary was assigned to a hospice or SCRIPTS provider. SCRIPTS does not presently have assignment reasons.
Indicates the reason the beneficiary's assignment to a hospice or SCRIPTS provider ended. SCRIPTS does not presently have assignment reasons.
Indicates assistant at surgery service restriction.
Indicates assistant at surgery service restriction.
A code to indicate the type of form the provider included with the invoice.
A code to indicate the type of form the provider included with the invoice.
Code used to identify the type of claims attachment.
The control number associated with an attachment that is being sent by the provider for an electronically submitted claim.
Code identifying a party or other code.
Report Type Code that identifies the title or contents of a document, report or supporting item (1 of 4).
Report Type Code that identifies the title or contents of a document, report or supporting item (2 of 4).
Report Type Code that identifies the title or contents of a document, report or supporting item (3 of 4).
Report Type Code that identifies the title or contents of a document, report or supporting item (4 of 4).
This indicates whether the audit is a one-way or two-way audit
This indicates whether the audit is a one-way or two-way audit.

Indicates whether the audit checks a surgery on the current claim against a pre- or post- op visit in history or checks a pre- or post- op visit on the current claim against a surgery code in history.
The authorization code indicates if a provider is authorized for a revenue code for a date of service.
ISA02 value in X12 document.
ISA01 value in X12 document.
Store field 423-DN (Basis of Cost Determination). Values include "00" - Default, "01" - AWP, "02" - Direct, "03" - Direct, "04" - EAC , "05" - Acquisition, "06" - MAC, "07" - Usual & Customary, "08" - 340B/Disproportionate Share Pricing, "09" - Other, "10" - ASP, "11" - AMP, "12" - WAC.
Store field 423-DN (Basis of Cost Determination). Values include "00" - Default, "01" - AWP, "02" - Direct, "03" - Direct, "04" - EAC , "05" - Acquisition, "06" - MAC, "07" - Usual & Customary, "08" - 340B/Disproportionate Share Pricing, "09" - Other, "10" - ASP, "11" - AMP, "12" - WAC.
Store field 423-DN (Basis of Cost Determination). Values include "00" - Default, "01" - AWP, "02" - Direct, "03" - Direct, "04" - EAC , "05" - Acquisition, "06" - MAC, "07" - Usual & Customary, "08" - 340B/Disproportionate Share Pricing, "09" - Other, "10" - ASP, "11" - AMP, "12" - WAC.
The status of the batch. Values can be "C" (created), or "F" (finalized).
The status of the batch. Accepted Values:P-processing ,R-rejected threshold error, C-complete processing, W-write response without thresh. errors, F-write response with thresh. errors, A-activation for fin. pickup, X-claims deleted for rejection
The status of the batch.
Code depicting the type of bed.
Code depicting the type of bed.
A code to classify beds available at a facility.
Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.
Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.
Indicates whether the time limit specified should be checked for services before, after, or before and after the current claim.
Indicates whether the time limit specified should be checked for services before history, after history, or both.
Indicates if a Bendex record has been requested on the recipient. Values Q=Requested, S=Request Sent
The category key for the benefit limit.
The benefit category that defines the contact for the recipient.
The benefit category that defines the contact for the recipient.
The category key for the benefit limit.

Corresponding Benefit category to cde_benefit_category, so that suspended counts can be separated.
The key defines how a unique contact is determined; by recipient, provider and recipient, pharmacy or dental.
This defines a contact by recipient, recipient and provider, pharmacy or dental.
This identifies the role of the particular benefit (procedure, diagnosid,...) on the claim.
Values include PRIM (primary diagnosis), ADMT (admitting diagnosis), PRIN (principal procedure), ADTL (all at detail), AHDR (all at header) and so on.
This identifies the role of the particular benefit (procedure, diagnosid,...) on the claim.
Values include PRIM (primary diagnosis), ADMT (admitting diagnosis), PRIN (principal procedure), ADTL (all at detail), AHDR (all at header) and so on.
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Values include PRIM (primary diagnosis), ADMT (admitting diagnosis), PRIN (principal procedure), ADTL (all at detail), AHDR (all at header) and so on.
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This identifies the role of the particular benefit (procedure, diagnosid,...) on the claim.
Values include PRIM (primary diagnosis), ADMT (admitting diagnosis), PRIN (principal procedure), ADTL (all at detail), AHDR (all at header) and so on.
This identifies the role of the particular benefit (procedure, diagnosid,...) on the claim.
Values include PRIM (primary diagnosis), ADMT (admitting diagnosis), PRIN (principal procedure), ADTL (all at detail), AHDR (all at header) and so on.
The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).
The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).
Other allowed values may identify GROUPS of benefits such as Procedure groups etc...

The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).
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Other allowed values may identify GROUPS of benefits such as Procedure groups etc...
The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).
The T-MSIS benefit category corresponding to the service reported on the claim or encounter record. Note: The code definitions in the valid value list originate from the Medicaid and CHIP Program Data System's (MACPro's) benefit type list. See Appendix H: Benefit Types for descriptions of the categories.
The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs). Other allowed values may identify GROUPS of benefits such as Procedure groups etc...
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Other allowed values may identify GROUPS of benefits such as Procedure groups etc...
The benefit type code is used to identify the coding scheme for a service. Valid schemes include procedure (HCPCS & CPT-4), ICD-9-CM procedures, ICD-9-CM diagnosis, Revenue Code and Drug codes (NDCs).
Other allowed values may identify GROUPS of benefits such as Procedure groups etc....
The benefit category corresponding to the service reported on the claim or encounter record.
The benefit category corresponding to the service reported on the claim or encounter record.

The benefit category corresponding to the service reported on the claim or encounter record.
The benefit category corresponding to the service reported on the claim or encounter record.
Indicates if the provider is Y - Biller, N - Performer, or B - Biller and Performer.
This is the code to indicate what type of state share the provider is. Valid Values: B - Bill back D - Deductible
The unique code that is assigned to identify a billing center.
The unique code that is assigned to identify a billing center.
The unique code that is assigned to identify a billing center.
Billing provider name identification code.
Loop: 2010AA BILLING PROVIDER NAME. NM109 Identification Code. INDUSTRY: Billing Provider Identifier. ALIAS: Billing Provider Primary ID.
Billing Provider Primary ID.
MMIS Billing Record ID
MMIS Billing Record ID
T-MSIS Unit of billing that is used for billing services by the facility.
Unit of billing that is used for billing services by the facility.
Unit of billing that is used for billing services by the facility.
Loop 2400 SV506
Code designating the Provider's preference to how they receive the Provider Billing Manual. Valid values "P"aper or "C"D.
This code is used to identify on which billing media an employer or carrier wishes to receive TPL claim facsimiles.
This code is used to identify on which billing media an employer or carrier wishes to receive TPL claim facsimiles.
This code identifies the billing media on which this carrier wishes to receive TPL claim facsimiles.
This code identifies the billing media on which this carrier wishes to receive TPL claim facsimiles.
Code indentifying the type of provider. CODE DEFINITION: BI - Billing; PT - Pay-To (valid only for 4010 txns).
Code indentifying the type of provider. CODE DEFINITION: BI - Billing; PT - Pay-To (valid only for 4010 txns).
Code indentifying the type of provider. CODE DEFINITION: BI - Billing; PT - Pay-To (valid only for 4010 txns).
This code describes the area of specialty for the billing provider.
This code describes the area of specialty for the billing provider.
This code describes the area of specialty for the billing provider.
This code describes the area of specialty for the billing provider.
The taxonomy code for the provider billing for the service.
For CLAIMIP and CLAIMLT files the taxonomy code for the institution billing for the beneficiary.
For CLAIMIP and CLAIMLT files the taxonomy code for the institution billing for the beneficiary.

The taxonomy code for the provider/ institution billing for the service.
A code describing the type of entity billing for the service.
A code describing the type of entity billing for the service.
A code describing the type of entity billing for the service.
This code describes how the CSR should be billed. ie. Modification, Maintenance, Phase II, Prod Support...
This identifies the entity that needs to receive the bill.
This code describes who TPL claim facsimiles are billed to: the employer of the policyholder or the carrier.
This code identifies the type of TPL billing.
This code identifies the type of TPL billing.
Identifies an ICD procedure as a biopsy. (O) - Open, (C) - Closed or blank - not applicable.
This is the last digit from the diagnosis code that represents the birth weight.
This is the last digit from the diagnosis code that represents the birth weight.
Identifies the ICD procedure as a bilateral procedure.
Indicates bilateral surgery service payment adjustment rule to use for pricing.
Indicates bilateral surgery service payment adjustment rule to use for pricing.
The code identifying the class of services/products to which the adjustment factor applies.
This is a basis of eligibility code.
This is a basis of eligibility code.
An indicator used to specify if the benefit plan defined by SAK_PUB_HLTH should be included ('I') or excluded ('E').
A code representing if the recipient was in Baldwin or Mobile county. Values: Blank = not known to be in Baldwin or Mobile county AO = Known to be in Baldwin or Mobile county on or after 4/20/2010
This is the policyholder's branch of service according to CHAMPUS.
Breast / cervical cancer code. Valid values include: A = Awarded D = Denied T = Terminated
An optional business code value used to identify the budget. This code may be used for reporting or identifying this budget on feeds to external systems.
Type of budget used for the disposition (valid values are B - primary budget, A - alternate budget, P - parent budget).
Type of budget used for the disposition (valid values are B - primary budget, A - alternate budget, P - parent budget).
Code designating which media a Service Location prefers to receive their bulletins through. Valid values "E"mail, "F"ax, "P"aper or "N"one.
Business activity code.
Business activity code.

Business activity subcode.
The code that uniquely identifies a business process
The code for the business process that the individual performs.
The role that the criteria is for i.e. resolution clerk level 1
The role for which the individual is being measured
A code to indicate the Business Scenario for the combination.
The code that uniquely identifies a specific business unit
The code for the Business Unit that the assigned individual works for.
The business unit that the criteria is assigned to.
The unit the individual is assigned to
Indicates if the recipient has Medicare part A or part B or both. The values can be 'A' for Part A, 'B' for Part B, 'Y' for Part AB or 'N' for None.
A three position alphanumeric code assigned to the last entity (State) which had jurisdiction over the (beneficiary's) account.
A three position alphanumeric code assigned to the last entity (State) which had jurisdiction over the (beneficiary's) account.
Buy-in eligibility code designed to provide State agencies with a method of identifying the specific catagory of assistance for each individual enrolled.
Buy-in eligibility code designed to provide State agencies with a method of identifying the specific catagory of assistance for each individual enrolled.
Buy-in eligibility code designed to provide State agencies with a method of identifying the specific catagory of assistance for each individual enrolled.
Buy-in eligibility code designed to provide State agencies with a method of identifying the specific catagory of assistance for each individual enrolled.
Buy-in eligibility code designed to provide State agencies with a method of identifying the specific catagory of assistance for each individual enrolled.
A one position alphabetic code of "D" which indicates that the beneficiary is a resident of a Title XIX Institution. Could be spaces. A Title XIX Institution Includes eligible persons who live in a public or private medical institution throughout a month and Medicaid is paying more than 50% of the cost of their care; and eligible children under age 18, who live in a public or private medical treatment facility throughout a month and Medicaid, or a combination of Medicaid and private insurance is paying more than 50 percent of the cost of care.
A one position alphabetic code of "D" which indicates that the beneficiary is a resident of a Title XIX institution. Could be spaces.
Last two positions of a four position numeric code, the buy-in transaction code modifier provides the rationale for the action. Could be spaces.

Last two positions of a four position numeric code, the buy-in transaction code modifier provides the rationale for the action. Could be spaces.
Last two positions of a four position numeric code, the buy-in transaction code modifier provides the rationale for the action. Could be spaces.
Last two positions of a four position numeric code, the buy-in transaction code modifier provides the rationale for the action. Could be spaces.
Last two positions of a four position numeric code, the buy-in transaction code modifier provides the rationale for the action. Could be spaces.
One-position alphabetic code that describes the beneficiary's Social Security Income (SSI) status.
One-position alphabetic code that describes the beneficiary's Social Security Income (SSI) status.
One position alphabetic sub-code, the buy-in sub-code further enchances the rationale for the action. Could be spaces.
One position alphabetic sub-code, the buy-in sub-code further enchances the rationale for the action. Could be spaces.
One position alphabetic sub-code, the buy-in sub-code further enchances the rationale for the action. Could be spaces.
One position alphabetic sub-code, the buy-in sub-code further enchances the rationale for the action. Could be spaces.
One position alphabetic sub-code, the buy-in sub-code further enchances the rationale for the action. Could be spaces.
First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction.
First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction. When a response appears on the billing tape, this code becomes the buy-in transaction code modifier.
First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction.
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First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction.

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First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction.
First two positions of a four position numeric code, the buy-in transaction code identifies the type of record conveyed by the transaction. When a response appears on the billing tape, this code becomes the buy-in transaction code modifier.
The measure's calculation type (Percentage, per 1000.....)
Indicates the type of final calculation that need to be applied to the individual measure(Percentage, per 1000, per 10,0000...)
Indicates the final calculation for the measure.
Indicates the final calculation for the measure.
The unique code of the caller type.
The unique code of the caller type.
The unique code of the call category.
The unique code of the call category.
The code for the call completion.
The unique code for the call completion.
The code for the method of the call.
The unique code for the method of the call.
The unique code for the priority of the call.
The unique code for the priority of the call.
The unique code for the status of the call.
The code for the status of the call.
The unique code for the status of the call.
The unique code for the call type.
The unique code for the call type.
The code which identifies the unit the clerk works in.
The code which identifies the unit the clerk works in.
The unique code for the unit.
The unique code for a canned response.
The unique code for a canned response.
A capitation category needed for a MAR COS assignment. Spaces are used to indicate no capitation category restriction.
This is the code of the reason the capitation is being done.
This is the code of the reason the capitation is being done.
This is the code of the reason the capitation is being done.
This is the code of the reason the capitation is being done.
This is the code of the reason the capitation is being done.
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This is the code of the reason the capitation is being done.

This is the code of the reason the capitation is being done.
Values: P= paid, R=recoup, F= pending force payment, S= pending force recoupment, C= cancelled force payment or recoupment, E= forced payment or recoupment that encountered an error in batch processing
Values: P= paid, R=recoup, F= pending force payment, S= pending force recoupment, C= cancelled force payment or recoupment, E= forced payment or recoupment that encountered an error in batch processing
This code identifies a carrier with which the recipient has other coverage.
An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.
An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.
An unique identifier used to determine the type of carrier as well as to identify correspondence sent from the carrier.
This is a unique, user-defined carrier ID which is used on all screens and reports to identify the carrier.
Carrier code. Used to identify a carrier in the TPL processes. Must be numeric and present when a carrier is added.
This is the 4-character Carrier Route code.
This is the 4-character Carrier Route code.
This is the code for the carrier status.
This is the code for the carrier status.
This is the code for the carrier status.
This is the code for the carrier type.
This is the code for the carrier type.
This is the code for the carrier type.
Code that identifies the user that is responsible for the carrier.
Code that identifies the user that is responsible for the carrier.
Case Status Code.
Status of case.
This indicates the type of the casualty case.
This indicates the type of the casualty case.
This indicates the type of the casualty case.
This indicates the type of the casualty case.
This code maps to the case type. 'P' = PASRR; 'T' = Level I tracking; 'R' = Resident review; 'I' = ICF/MR.
This code maps to the case type. 'P' = PASRR; 'T' = Level I tracking; 'R' = Resident review; 'I' = ICF/MR.
This indicates the type of the casualty case.
This indicates the type of the casualty case.
This is the unique code value of the cash status.
This is the unique code value of the cash status.
This field identifies the party who sent the intake notification originally.

This field identifies the party who sent the intake notification originally.
This field identifies the party who sent the intake notification originally.
Specifies the situation or category to which the code applies.
Indicates whether the modifier is a HCPCS or Ambulance Modifier. Valid values are A (Ambulance) and H (HCPCS).
The cause of the overpayment. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3010 in the column SAK_VALUE_TYPE.
Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.
Oral Cavity Designation Code. Code Identifying the area of the oral cavity in which service is rendered. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV304-1).
Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.
Oral Cavity Designation Code. Code Identifying the area of the oral cavity in which service is rendered. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV304-2).
Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.
Oral Cavity Designation Code. Code Identifying the area of the oral cavity in which service is rendered. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV304-3).
Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.
Oral Cavity Designation Code. Code Identifying the area of the oral cavity in which service is rendered. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV304-4).
Oral Cavity Designation Code. Code identifying the area of the oral cavity in which service was rendered.
Oral Cavity Designation Code. Code Identifying the area of the oral cavity in which service is rendered. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV304-5).
Certification code that belongs to the primary medical provider (PMP).
This field represents the certification code for Managed Care recipients.
Certification code that belongs to the primary medical provider (PMP).
This field represents the certification code for Managed Care recipients.

Certification code that belongs to the primary medical provider (PMP).
This field represents the certification code for Managed Care recipients.
Indicates the certifying agency. Valid values are: H = All human resource recipients, D = D.O., M = Medicaid SOBRA, S = SSI, Y = Foster Care-ADC.
Indicates the certifying agency. H = All human resource recipients, D = D.O., M = Medicaid SOBRA, S = SSI, Y = Foster Care-ADC.
Indicates that the individual is an American Indian or Alaskan Native whose race status is certified
CLIA Certificate number. The latest certificate issued is always = 1.
The certifying agency. Valid values are: H = All human resource recipients D = D.O. M = Medicaid SOBRA S = SSI Y = Foster Care-ADC
This is the CLIA type 3 certification code . 1 = Regular 2 = Waiver 3 = Accreditation 4 = Provider-performed Microscopy Procedure (PPMP 5 = Partial Accredited 9 = Registration
This is the code value for the specific provider certifications.
This is the code value for the specific provider certifications.
This is the code value for the specific provider certifications.
Check or EFT Trace Number
Child support non-cooperation code
A code for T-MSIS indicating the individual's inclusion in a STATE Only CHIP Program.
A code indicating the individuals inclusion in a STATE Only CHIP Program.
This code identifies the type of chrono note.
This code identifies the type of chrono note.
A code presenting the nature of the family member's citizenship. These values are maintained by the E&E system. Valid values include: A = Asylee B = Battered Immigrant C = Citizen (before 7/1/2006) F = Parolee R = Refugee
Code used to identify a specific citizenship value.
System assigned key to uniquely identify a citizen status code and associated description.
Citizen Status Code
Indicates the individual is enrolled in Medicaid pending citizenship verification.
Claim Filing Indicator Code.
This code identifies the claim form type on which a carrier wishes to receive TPL claim facsimiles.
This identifies the type of claim form for this particular claim.
Allowed values are :
"INST" - Institutional claim.
"PROF" - Professional claim.

"DNTL" - Dental claim.
"PHRM" - Pharmacy claim.
This code identifies the claim form on which this carrier wishes to receive TPL claim facsimiles.
This code identifies the claim form on which this carrier wishes to receive TPL claim facsimiles.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type INDUSTRY: Claim Submission Reason Code.
CLM - Claims Frequency Code. Code specifying the reason for claim submission.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type INDUSTRY: Claim Submission Reason Code.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
CLM - Claims Frequency Code. Code specifying the reason for claim submission. Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
Status of the claim: L=loaded, K=keyed, A=adjudicated, I=in keying process.
Status of the claim: L=loaded, K=keyed, A=adjudicated, I=in keying process.
Unisys' claim status code
Claims Submission Reason Code. Code identifying reason for claim submission.
Up to six Claim Types that the criteria applies to.

Unisys's form indicator, which is the claim type
0 - APC RETURN BUFFER FILLED IN WITH DEFAULT VALUES; NO SERVICES PAID UNDER OPPS, 1 - APC RETURN BUFFER FILLED IN; ONE OR MORE SERVICES PAID UNDER OPPS
Submission Clarification Code.
Submission Clarification Code
Submission Clarification Code.
Added to allow up to 3 submission clarification codes (field 420-DK) to be captured and stored. Values include "1" - No override, "8" - Process Compound for Approved Ingredients, "99" - Other.
Added to allow up to 3 submission clarification codes (field 420-DK) to be captured and stored. Values include "1" - No override, "8" - Process Compound for Approved Ingredients, "99" - Other.
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Added to allow up to 3 submission clarification codes (field 420-DK) to be captured and stored. Values include "1" - No override, "8" - Process Compound for Approved Ingredients, "99" - Other.
The class code defined by STO. Being stored as informational.
Describes the operative or non operative class of a procedure. 1 = Class 1, surgery, 2 = Class 2, significant procedure, 3 = Class 3, significant procedure, 4 = Class 4, other.
A short hand code to identify the hierarchy.
SHORT DESCRIPTION FOR THE GROUP.
This field corresponds to Field 6 on the NCCI data, containing the CLE ID (Correspondence Language Example Identification Number). Please refer to the NCCI documentation for a more detailed description of this field.
This field corresponds to Field 6 on the NCCI MUE data, containing the CLE ID (Correspondence Language Example Identification Number). Please refer to the NCCI documentation for a more detailed description of this field.
This field corresponds to Field 6 on the NCCI MUE data, containing the CLE ID (Correspondence Language Example Identification Number). Please refer to the NCCI documentation for a more detailed description of this field.

This field corresponds to Field 6 on the NCCI data, containing the CLE ID (Correspondence Language Example Identification Number). Please refer to the NCCI documentation for a more detailed description of this field.
ID of the person that clicked on the ICN to enter it through the Web.
ID of the person that clicked on the ICN to enter it through the Web.
METROPOLITAN STATISTICAL AREA ASSOCIATED WITH APC PRICING
Claim Adjustment Group Code. Code identifying the general category of payment adjustment.
Claim Adjustment Group Code - Code identifying the general category of payment adjustment.
Claim Adjustment Reason Code. Code identifying the detailed reason the adjustment was made.
Claim Adjustment Reason Code - Code identifying the detailed reason the adjustment was made.
HIPAA Claim Category Status Code.
HIPAA Claim Category Status Code.
Claim Filing Indicator Code
Claim form
Claim form for current claim
Claim form for history claim.
The status of a specific detail claim line rather than the entire claim.
The status of a specific detail claim line rather than the entire claim.
The status of a specific detail claim line rather than the entire claim.
The status of a specific detail claim line rather than the entire claim.
Type of location in which a claim can be placed during processing in the MMIS system.
A code identifying the pending location of the claim.
Code set to convey non-financial information to understand the adjudication of a claim
Code set to convey non-financial information to understand the adjudication of a claim
Code set to convey non-financial information to understand the adjudication of a claim
Code set to convey non-financial information to understand the adjudication of a claim
The claim source indicator is a code used to identify how the claim entered the system.
The value for the claim region to assign to a user for data correction.
Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.

Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.
Code indicating the media on which a claim entered the MMIS.
Indicates the status of a claim in the MMIS system. The valid values are: D-Denied, P-Paid, R-Resubmitted, S-Suspended, and Q-Quality Review by Supervisor is pending.
Claim Status Code
Indicates the status of a claim. The list of valid values in F&A is "P" - paid, "D" - denied, "V" - voided.
Indicates the status of a claim in the system.
Indicates the status of a claim in the system.
Indicates the status of a claim in the system.
Claim status code
MMIS Claim Status Code.
MMIS Claim Status Code.
Indicates the status of a claim in the MMIS system. The valid values are: C-CCF, D-Denied, P-Paid, R-Resubmitted, S-Suspended, and Q-Quality Review by Supervisor is pending.
Indicates the status of the detail in the MMIS system. This can be paid, suspended, or denied.
Indicates the status of a claim in the system.
Indicates the status of the detail in the MMIS system.
Indicates the status of a claim.
Indicates the status of the detail in the MMIS system. This can be paid, suspended, or denied.
Indicates the status of a claim in the system.
Code which indicates the status of the claim detail in the MMIS system. This status can be paid, suspended or denied.
Code which indicates the header status of the claim in the system.
This is the status of the claim (P - Paid, D - Denied)
This is the status of the claim (P - Paid, D - Denied)
This is the status of the claim (P - Paid, D - Denied)
This is the status of the claim (P - Paid, D - Denied)
The status of the claim.
Indicates the status of the detail record. This can be P - paid or D - denied.
Indicates the status of the detail record. This can be P - paid or D - denied.
The status of the claim (P - paid, D - denied)
Indicates the status of the detail in the MMIS system. This can be paid or denied.
Indicates the status of a claim in the system.
Indicates the status of the detail in the MMIS system.

Indicates the status of a claim.
Indicates the status of the detail in the MMIS system.
Indicates the status of a claim in the system. Codes: "P" - paid, "D" - denied, "S" - Suspended, and "R" - Resubmitted.
Indicates the status of a transaction record in the MMIS system.
Code which indicates the header status of the claim in the system.
Disposition status of the claim; for example, paid, denied, suspended.
Indicates the status of the detail in the MMIS system. This can be paid, suspended, or denied.
Indicates the status of a suspended claim. The valid values are: S-Suspended, R-Resubmitted, and Q-Quality Review by Supervisor is pending.
Indicates the status of the detail in the MMIS system.
Indicates the status of a suspended claim. The valid values are: S-Suspended, R-Resubmitted, and Q-Quality Review by Supervisor is pending.
Indicates the status of the detail in the MMIS system. This can be paid, suspended, or denied.
Indicates the status of a suspended claim. The valid values are: S-Suspended, R-Resubmitted, and Q-Quality Review by Supervisor is pending.
Code which indicates the status of the claim detail in the MMIS system. This status can be paid, suspended, or denied.
Indicates the status of a suspended claim. The valid values are: S-Suspended, R-Resubmitted, and Q-Quality Review by Supervisor is pending.
The health care claim status codes convey the status of an entire claim.
The health care claim status codes convey the status of an entire claim.
The health care claim status codes convey the status of an entire claim.
The health care claim status codes convey the status of an entire claim.
The general category of the claim status which is then further detailed in the element CLAIM-STATUS.
The general category of the claim status which is then further detailed in the element CLAIM-STATUS.
The general category of the claim status which is then further detailed in the element CLAIM-STATUS.
The general category of the claim status which is then further detailed in the element CLAIM-STATUS.
Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.

Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.
Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.
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Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.
Code which further defines the status of a claim in the MMIS system. This is used to identify whether the claim processed to pay during the first cycle in which it was submitted or whether it took several cycles before the errors were corrected.
Value for the type of claim that can be processed in the MMIS system.
Code that specifies the type of claim record that should be included in the selection. Valid claim type values to be used in claim selection.
Value used to describe the type of Medicaid claim being processed.

Code that specifies the type of claim record. Such as A - UB92 Crossover Part A, B- HCFA 1500 Crossover Part B, I - UB92 Inpatient, M - HCFA 1500 Medical/Professional.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Code that specifies the type of claim record.
Code indicating the type of claim record.
A code to indicate the type of medical assistance invoice used by the provider to bill omap for the rendered service.
Code that specifies the type of claim record.
Indicator that identifies the type of medicaid claim; medical, pharmacy, nursing home, and others.
A code to represent the type of claim we are processing. (i.e. Physician, Inpatient, Outpatient, Pharmacy, etc.). This is used to determine which message to display.
Code that specifies the type of claim record on which the error occurred.
Code that specifies the type of claim record which resides in the specified location.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Code that specifies the type of claim record.
This field indicates the claim type. See T_CLAIM_TYPE for possible values.
Value for the type of claim that can be processed in the MMIS system.
Claim type code
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
A value used to describe the type of Medicaid claim being processed.
This code identifies the Medicaid claim type.
This code identifies the type of claim.
Value for the type of claim that can be processed in the MMIS system.
This code identifies the type of Medicaid claim.
This identifies the type of Medicaid claim.
This identifies the type of Medicaid claim.
This code identifies the type of Medicaid claim.

This code identifies the type of Medicaid claim.
This code identifies the type of Medicaid claim.
Code that identifies a type of claim that will process in the MMIS system. For example, 'M' = HCFA 1500, 'P' = Pharmacy
One of the 4 major claim types in which data correction scheduling is controlled.
The From batch range to be used in scheduling claims for data correction.
Code that specifies the type of claim record. The code for Dental claims is 'D'.
Code that specifies the type of claim record. The code for pharmacy claims is "P".
Code that specifies the type of claim record. The code for Physician claims is 'M' or Crossover Part B 'B'.
Code that specifies the type of claim record. The valid codes for UB92 claims are I - Inpatient, O - Outpatient, L - Nursing Home, H - Home Health, A - Part A Crossover and C - Part C Crossover.
The code indicating the type of claim.
The code indicating the type of claim.
A code to indicate the type of medical assistance invoice used by the provider to bill for the rendered service. The list of codes and their descriptions are in T_CLAIM_TYPE. The current allowable codes and description are: A Inpatient Xover Claims C Outpatient Xover Claims I Inpatient Claims O Outpatient Claims
Type of claim that will be checked for duplication.
Code for the claim type to filter the claims recycle by. Possible values are 0, A, B, C, D, I, L, M, O, P, Q. A claim type of 0 will not filter by claim type.
This is the value used to describe the type of Medicaid claim being processed.
Type of claim assigned to specified error criteria used for disposition of the claim.
Value for the type of claim that can be processed in the MMIS system.
The type of claim.
Code that specifies the type of claim record which resides in the specified location.
Code that specifies the type of claim record. The valid codes for UB92 claims are I - Inpatient, O - Outpatient, L - Nursing Home, A - Crossover Part A, C - Crossover Part C, and H - Home Health.
Code that specifies the type of claim record. The valid codes for UB92 claims are A - Crossover Part A, C - Crossover Part C, H - Home Health, I - Inpatient, L - Nursing Home (Long Term Care), and O - Outpatient.

Code that specifies the type of claim record. The valid codes for UB92 claims are A - Crossover Part A, C - Crossover Part C, H - Home Health, I - Inpatient, L - Nursing Home (Long Term Care), and O - Outpatient.
Code that specifies the type of claim record. The code for Physician claims is 'M' or Crossover Part B 'B'.
A value used to describe the type of Medicaid record being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Code describing the type of Medicaid claim being processed.
Value used to describe the type of Medicaid claim being processed.
Value for the type of claim that can be processed in the MMIS system.
Claim type selected for payment hold.
Code that specifies the type of claim record. The code for Dental claims is 'D'.
Code that specifies the type of claim record. The code for pharmacy claims is "P", and compound is "Q".
Code that specifies the type of claim record. Physician claims are type M=medical or B=crossover Part B.
Code that specifies the type of claim record. The valid codes for UB92 claims are I - Inpatient, O - Outpatient, L - Nursing Home, A - Crossover Part A, C - Crossover Part C, and H - Home Health.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Claim type can be submitted by the provider type.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value used to describe the type of Medicaid claim being processed.
The claim type identities the claim type. It is one of the keys to the reimbursement rate entity. In the old system there were rates on the provider file for inpatient and outpatient.

Identifies the type of claim that will be adjusted; inpatient, nursing home.
Claim type that the restriction is for. ZZ means all claim types.
Code that specifies the type of claim record that should be included in the selection. Valid claim type values to be used in claim selection.
Code that specifies the type of claim record. The code for Dental claims is 'D'.
Code that specifies the type of claim record. At this time, the code for pharmacy claims is "P", and for compound drug is "Q".
Code that specifies the type of claim record. The code for physician claims are M=medical or B=crossover part B.
Code that specifies the type of claim record. The valid codes for UB92 are I=Inpatient, O=Outpatient, L=Nursing Home, H=Home Health, A=Crossover Part A, C=Crossover Part C.
Claim type used to derive a specific location for dispositioning.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Value for the type of claim that can be processed in the MMIS system.
Include/Exclude indicator for claim type
Include/Exclude indicator for claim type.
Indicates the HIPAA transaction version a claim was submitted in. Valid values for all claim types except pharmacy (P and Q): 4010 (old version) or 5010 (current version); Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 4010.
Indicates the HIPAA transaction version a claim was submitted in. Valid values for all claim types except pharmacy (P and Q): 4010 (old version) or 5010 (current version); Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 4010.
Indicates the HIPAA transaction version a claim was submitted in. Valid values for all claim types except pharmacy (P and Q): 4010 (old version) or 5010 (current version); Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 4010.

Indicates the HIPAA transaction version a claim was submitted in. Valid values for Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 51B1.
Indicates the HIPAA transaction version a claim was submitted in. Valid values for all claim types except pharmacy (P and Q): 4010 (old version) or 5010 (current version); Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 4010.
Indicates the HIPAA transaction version a claim was submitted in. Valid values for all claim types except pharmacy (P and Q): 4010 (old version) or 5010 (current version); Pharmacy claims (all regions except 59): 51B1 (old version) or D0B1 (new version); Pharmacy claims (region 59): 51B2 (old version) or D0B2 (new version); and blank: 4010.
A one byte code indicating the reason for closing of Medicaid or withdrawal of application. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 110.
METHOD BY WHICH IRP PROCESSED THE CLAIM 01-CLAIM WAS GROUPED AS A CMS IN-PATIENT CLAIM (NO PRICING) 02-CLAIM WAS PRICED AS A CMS IN-PATIENT CLAIM (NO GROUPING) 03-CLAIM WAS GROUPED AND PRICED AS A CMS IN-PATIENT CLAIM 05-CLAIM WAS GROUPED AS A CMS OUT-PATIENT CLAIM (NO PRICING) 06-CLAIM WAS GROUPED AND PRICED AS A CMS OUT-PATIENT CLAIM
PRICER RETURN CODE
NCPDP field 451-EG. The total compound metric decimal quantity expressed as Each, Gram, or Milliliter. When used in combination with Compound Dosage Form Description Code field 45Ø-EF, a complete description of the compound prescription dispensed is provided. Values include "1" - Each, "2" - Grams, "3" - Milliliters.
NCPDP field 450-EF. The data in this field is reported one time. When used in combination with Compound Dispensing Unit Form Indicator field 451-EG, a complete description of the compound prescription dispensed is provided. Values include "01" - Capsule, "02" - Ointment, "03" - Cream, "04" - Suppository, "05" - Powder, "06" - Emulsion, "07" - Liquid, "10" - Tablet, "11" - Solution, "12 - Suspension, "13" - Lotion, "14" - Shampoo, "15" - Elixir, "16 - Syrup, "17" - Lozenge, "18" - Enema.

NCPDP field 450-EF. The data in this field is reported one time. When used in combination with Compound Dispensing Unit Form Indicator field 451-EG, a complete description of the compound prescription dispensed is provided. Values include "01" - Capsule, "02" - Ointment, "03" - Cream, "04" - Suppository, "05" - Powder, "06" - Emulsion, "07" - Liquid, "10" - Tablet, "11" - Solution, "12 - Suspension, "13" - Lotion, "14" - Shampoo, "15" - Elixir, "16 - Syrup, "17" - Lozenge, "18" - Enema.
NCPDP Field 363-2H, Identifies special circumstances related to the dispensing of the product as identified in the Compound Product ID (498-TE). For more info, consult the NCPDP D.0 data dictionary at I:\2010 Enhancement Implementation Project (EIP)\5010 Project\NCPDP.
NCPDP Code for the route of administration of the complete compound mixture.
NCPDP field 996-G1, Clarifies the type of compound. Values are Blank - Not specified, 01 - Anti-infective, 02 - Ionotropic, 03 - Chemotherapy, 04 - Pain Management, 05 - Total Parenteral Nutrition/ Peripheral Parenteral Nutrition, 06 - Hydration, 07 - Ophthalmic, 99 - Other.
This code indicates if the claim was matched with Title XIX or Title XXI.
This code indicates if the claim was matched with Title XIX or Title XXI.
This code indicates if the claim was matched with Title XIX or Title XXI.
This code indicates if the claim was matched with Title XIX or Title XXI.
Identifies whether or not a product meets the statutory definition of a covered outpatient drug. Valid Values: 01 = Abbreviated New Drug Application (ANDA) 02 = Biological License Application (BLA) 03 = New Drug Application (NDA) 04 = NDA Authorized Generic 05 = DESI 5* - LTE/IRS drug for all indications 06 = DESI 6* - LTE/IRS drug withdrawn from market 07 = Prescription Pre-Natal Vitamin or Fluoride 08 = Prescription Dietary Supplement/Vitamin/Mineral (Other than Prescription Pre-Natal Vitamin or Fluoride) 09 = OTC Monograph Tentative 10 = OTC Monograph Final 11 = Unapproved Drug - Drug Shortage 12 = Unapproved Drug - Per 1927(k)(2)(A)(ii) 13 = Unapproved Drug - Per 1927(k)(2)(A)(iii) *NDCs with a COD Status of DESI 5/6 are not eligible for coverage or rebates under the Medicaid Drug Rebate Program.
Identifies single source, multi-source, or innovator status as supplied by CMS. Valid values are: SPACE - Unspecified, S - Single Source, I - Innovator Multi-source, N - Non-Innovator Multi-source.
Code indicating the CMS file type. Values are ELG, TPL, MCR, PRV, COT, CRX, CLT, and CIP.
Code indicating the CMS file type. Values are ELG, TPL, MCR, PRV, COT, CRX, CLT, and CIP.

This system assigned code indicates the NCCI source file for the data. The code for this column can be found on t_ref_cde_value_group.cde_value.
This system assigned code indicates the NCCI source file for the data. The code for this column can be found on t_ref_cde_value_group.cde_value.
This system assigned code indicates the NCCI MUE source file for the data. The code for this column can be found on t_ref_cde_value_group.cde_value.
This system assigned code indicates the NCCI MUE source file for the data. The code for this column can be found on t_ref_cde_value_group.cde_value.
Indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent as supplied by CMS. This 2 digit code begins with either an "A" (therapeutically equivalent to other products), a "B" (NOT therapeutically equivalent to any other product), or contains "NR" (not rated) rating.
The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code
CMS Type of Service Code
The carrier assigned CMS type of service which describes the particular kind(s) of service represented by the procedure code
The Unit Type Indicator indicates the unit of measure as supplied on the CMS's quarterly tape.
Concurrent Risk Group Identifier
Concurrent Risk Group Identifier
Concurrent Risk Group Identifier
Concurrent Risk Set Identifier
Concurrent Risk Set Identifier
Concurrent Risk Set Identifier Description
From range for the provider county used to limit the report.
To range for the provider county used to limit the report.
Indicates what to count.
Indicates what to count.
Used to identify data type of the NAM CODE.
The collection authorization. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3001 in the column SAK_VALUE_TYPE.
Media used to collect rebate payments
Media used to collect rebate payments

The collection status of the overpayment case. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3003 in the column SAK_VALUE_TYPE.
This is a combination of procedure code and modifiers used to speed up queries. (Values are 000202200022000000 - All procs; 000302000000001020 - Non specified procedures)
This is a combination of procedure code and modifiers used to speed up queries. (Values are 000202200022000000 - All procs; 000302000000001020 - Non specified procedures)
Possible values are "EQ", "NE", "GT", "LT", "GE", "LE", "BW", and "IN". Others may be added as needed.
Possible values are "EQ", "NE", "GT", "LT", "GE", "LE", "BW", and "IN". Others may be added as needed.
The physical form of a dose of medication such as a capsule or injection.
Value 'Y' causes last compensable day to be re-calculated.
value 'Y' causes last compensable day to be re-calculated
Code used to identify conditions relating to an institutional claim that may affect payer processing.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to a Professional claim that may affect payer processing.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Identifies if the provider is FS or has a DPU facility or identifies if the provider is paid by Per Diem.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code(s) indicating a condition. The 837 Professional HIPAA Implementation Guide provides the valid values.
Value returned by current process to help determine which dependencies to process.
Code used to identify conditions relating to an institutional claim that may affect payer processing (1 of 8).
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to an institutional claim that may affect payer processing (2 of 8).
Code used to identify conditions relating to a UB92 claim that may affect payer processing.

Code used to identify conditions relating to an institutional claim that may affect payer processing (3 of 8).
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to an institutional claim that may affect payer processing (4 of 8).
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to an institutional claim that may affect payer processing (5 of 8).
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Code used to identify conditions relating to an institutional claim that may affect payer processing (6 of 8).
Code used to identify conditions relating to an institutional claim that may affect payer processing (7 of 8).
Code used to identify conditions relating to an institutional claim that may affect payer processing (8 of 8).
Sequence number where the condition code was entered on the claim.
Sequence number where the condition code was entered on the claim.
Sequence number where the condition code was entered on the claim.
Confirmation Code
Provider's contact preference - Electronic, Paper, or Fax.
The type of contact for the Labeler (e.g. Invoice, Legal, Techncal).
The type of contact for the Labeler (e.g. Invoice, Legal, Techncal).
External Context code used to identify the type of Case. Values are CTSCASAL for Casualty Cases and CTSESTAL for Estate Cases.
Contract reference ID. Required if the provider is required by contract to supply this information on the claim.
Contract Type Code. Code identifying a contract type
Contract Version Identifier. Revision level of a particular contract.
This field is used to distinguish units of measure that are used to either convert to or convert from.
Code identifying the coordination of benefits between different insurance carriers.
Code indicating whether or not co-payment requirements were met on a line by line basis. Required if patient was exempt from co-pay.
Code identifying the type of copay. The copay type is used along with the claim type to identify the copay amount to pay on a claim.

ID associated with an ePrescribing Copay List; value from CDE_LIST_ID in T_ERX_CDE_LIST_ID record where SAK_PUB_HLTH matches T_PGM_HIERARCHY record and CDE_LIST_ID = COP.
A code signifying if the MCOs service area falls into one or more metro or micro statistical areas.
Category of Service.
Indicates the reporting category for Medicare and TPL related claims. M = Regular claim denied for Medicare coverage. T = Regular claim denied for Other Insurance. X = Crossover claims paid. O = Other adjudicated claims paid.
Code for the CMS 21 line item assigned to this record.
Code for the CMS 21 line item assigned to this record.
Code for the CMS 64.21 line item assigned to this record.
Code for the CMS 64.21 line item assigned to this record.
The CMS 64.21 COS code.
Code for the CMS 64.9 line item assigned to this record.
Code for the CMS 64.9 line item assigned to this record.
The CMS 64.9 COS code.
Category of service type code classifies the individual category of service into higher level classifications. Ex. Inpatient, outpatient...
Category of service type code classifies the individual category of service into higher level classifications. Ex. Inpatient, outpatient...
Category of service type code classifies the individual category of service into higher level classifications. Ex. Inpatient, outpatient.
The HCFA 64.9 Category of Service code.
The HCFA 64.9 Category of Service code.
The HCFA 64.9 Category of Service code.
Code for the MSIS type of service assigned to this record.
Code for the MSIS type of service assigned to this record.
Code for the MSIS type of service assigned to this record.
A COS type code used to classify the individual COS codes into higher level classifications for MSIS reporting.
The state COS code that defines the grouping of services desired on State MAR reports (i.e. Inpatient, Outpatient, Psychiatric, etc.).
COS ST code
Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
MAR State Category of Service Code.

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Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
The state COS code that defines the grouping of services desired on State MAR reports (i.e. Inpatient, Outpatient, Psychiatric, etc.).
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Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
The State category of service code that defines the groupings of services desired on State MAR reports. Ex. Inpatient, outpatient...
The State category of service code that defines the groupings of services desired on State MAR reports. Ex. Inpatient, outpatient...
Category of service group.
Category of service group.
Category of service group.
Category of service group.
Category of service group.
Category of service group.
The state COS code that defines the grouping of services desired on State MAR reports (i.e. Inpatient, Outpatient, Psychiatric, etc.).
The State category of service code that defines the groupings of services desired on State MAR reports. Ex. Inpatient, outpatient.
A sub COS used to provide a more detailed service classification in MAR state reporting.

Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
MAR State Sub Category of Service Code.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
MAR State Sub Category of Service Code.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
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Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
A sub COS used to provide a more detailed service classification in MAR state reporting.
A sub COS used to provide a more detailed service classification in MAR state reporting.
Code for a sub-category of service (COS) that provides a more detailed State Category of Service classification in MAR state reporting.
Category of service subgroup.
Category of service subgroup.
Category of service subgroup.

Category of service subgroup.
Category of service subgroup.
Category of service subgroup.
A sub COS used to provide a more detailed service classification in MAR state reporting.
COS SUB1 code
A sub category of service used to provide a more detail service classification in MAR reporting.
A sub category of service used to provide a more detail service classification in MAR reporting.
A sub category of service used to provide a more detail service classification in MAR reporting.
COS SUB2 code
A sub, sub category of service used to provide a more detail service classification in MAR reporting.
A sub, sub category of service used to provide a more detail service classification in MAR reporting.
A sub, sub category of service used to provide a more detail service classification in MAR reporting.
Code identifying the type of COS value in the CDE_COS_VALUE column. Values include the following but States may add new ones: SCOS - State Category of Service MSIS - MSIS Type of Service C649 - CMS 64.9 Line Number C6421 - CMS 64.21 Line Number C21 - CMS 21 Line Number
Code for the Category of Service value.
This is the country code for the attorney.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Subscriber Country Code found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N4, element N404.
Patient Event Transport Location Country Code found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N4, element N404.
This is the country code for the policyholder.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Country the provider's service location address is in.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Country of the trading partner.
Two character ISO country abbreviation.
This is the country code of the carrier contact.
Two character ISO country abbreviation.

Two character ISO country abbreviation.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Two character ISO country abbreviation.
Pay to plan country code. Use the alpha-2 country codes from Part 1 of ISO 3166.
Code identifying the country of Pay-to Plan City, State, Zip Code, required when address is outside the United States of America.
Pay-to Plan Country Code.
Laboratory or Facility Code identifying the country. Use the alpha-2 country codes from Part 1 of ISO 3166.
Code identifying the country of Ambulance Pick Up Location City, State, Zip Code, required when address is outside the United States of America.
Code identifying the country of Ambulance Drop Off Location City, State, Zip Code, required when address is outside the United States of America.
Other Payer Country Code.
Code identifying the country of other payer city/state/zip code, required when the address is outside the United States of America.
Service Facility Country Code.
Code identifying the country of ambulance pick up location city, state, zip code, required when the address is outside the United States of America.
Code indentifying the country of ambulance drop off location city, state, zip code, required when the address is outside the United States of America.
Three character ISO country currency abbreviation.
Patient Event Transport Location Country Subdivision Code found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment N4, element N407.
Dependent Country Subdivision Code found in the HIPAA 278 Request and Response Guide in loop 2010EA, segment N4, element N407.
Code identifying the country subdivision for the requesting provider found in the HIPAA 278 Request and Response Guide in loop 2010B, segment N4, element N407.
Code identifying the country subdivision for the Subscriber found in the HIPAA 278 Request and Response Guide in loop 2010C, segment N4, element N407.
The county code used to identify a geographical/political area in the state.
County code received from CMS
County code received from CMS
County code received from CMS

County code received from CMS
The 2 digit county number used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The county code associated with the Provider License Number.
The County Code used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The 2 digit county number used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state in which a member resides.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
The code indicating recipient's county.
The code indicating recipient's county.
Indicates the county code in which the eligible recipient resided during the Eligibility months.
The county code used to identify a county in the state.
A unique code that identifies the county to which a payment is made.
A unique code that identifies the county to which a payment is made.
A unique code that identifies the county to which a payment is made.
The county code used to identify a geographical/political area in the state.
The 2 digit county number used to identify a geographical and/or political area in the state. CHAR
The county code used to identify a geographical/political area in the state.
The county number used to identify a geographical/political area in the state.
Code representing county description/name.
This is the eligible recipient's county of residence.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
A character code used to indicate a county in the state.

This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the provider's service location.
This is the county of the billing provider's service location.
This is the county of the billing provider's service location.
This is the county of the enrolled provider's service location.
This is the recipient's county of residence.
This is the recipient's county of residence.
This is the recipient's county of residence.
This is the recipient's county of residence.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state of MMIS in which the provider practices.
Numeric (geographical/political) representation of the county in the state of MMIS in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
The county code used to identify a geographical/political area in the state.
County code corresponding to the address.
This is the county for a provider where the license is valid.
Code indicating the county the license is valid for.
Member county to which the restriction applies.
Numeric representation of county in the state.
Numeric representation of county in the state.
Numeric representation of county in the state.
The 2 digit county number used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
The 2 digit county number used to identify a geographical/political area in the state.

The county code used to identify a geographical/political area in the state.
The 2 digit county code used to identify a county in the state.
The county code used to identify a geographical/political area in the state.
The recipient's county code of residence.
The recipient's county code of residence.
The county number used to identify a geographical/political area in the state.
The 2 digit county number used to identify a geographical/political area in the state.
The county code used to identify a geographical/political area in the state.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
Numeric (geographical/political) representation of the county in the state in which the provider practices.
The county code used to identify a geographical/political area in the state.
The recipient's county code as of the last day of the quarter.
The USPS county number used to identify a geographical/political area in the state.
The USPS county number used to identify a geographical/political area in the state.
The USPS county FIPS number used to identify a geographical/political area in the state. Look at T_COUNTY table for the possible valid values.
The USPS county FIPS number used to identify a geographical/political area in the state. Look at T_COUNTY table for the possible valid values.
The county number for the county reviewing the SOBRA family member.
The county of service on the PS/2 transaction
Recipient's county of service on the PS/2 transaction.
The county of service on the PS/2 transaction
Recipient's county of service on the PS/2 transaction.
The county of service on the PS/2 transaction
This is the county associated with a ward. This field will always contain spaces in the OK MMIS.
This code identifies the court ordered coverage that must be provided by an absent parent.
This code identifies the type of court-ordered insurance that must be provided by an absent parent.

This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
The TPL coverage code.
This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
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This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
Identifies the TPL policy's claim type coverage.
This code identifies the type of coverage that a TPL policy provides.

This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
This code identifies the type of coverage that a TPL policy provides.
Indicates coverage for a TPL Service Class.
This code identifies the type of coverage that a TPL policy provides.
T-MSIS code indicating the level of coverage being provided under this policy for the insured by the TPL carrier.
Code indicating the level of coverage being provided under this policy for the insured by the TPL carrier.
Code indicating the level of coverage being provided by the TPL carrier.
This is the new coverage the policy will be assigned based off of the policy group number.
This is an Exclude/Include code denoting that the list of associated condition codes is excluded or included, respectively.
The 10 occurrences of the TPL coverage codes from ICES
ID associated with an ePrescribing Coverage List; value from CDE_LIST_ID in T_ERX_CDE_LIST_ID record where SAK_PUB_HLTH matches T_PGM_HIERARCHY record and CDE_LIST_ID = COV.
This is an Exclude/Include code denoting that the list of associated modifiers is excluded or included, respectively.
This is an Exclude/Include code denoting that the list of associated occurrence codes is excluded or included, respectively.
This is the coinsurance schedule for a specific coverage type of a policy.
Indicates services for which two surgeons, each in a different specialty, may be paid.
Indicates services for which two surgeons, each in a different specialty, may be paid.
CRC 32 code unique for every file. This is used for duplicate check.
Identifies a valid status code for CSHCS recipient eligibility.
Interchange Control Number
The family member citizenship source code. This will have a value of 0-9 is citizenship code is 'D'. It is blank if the citizenship code is not 'D'. Code values are maintained by the E&E system.

Indicates verified citizenship data from SVES. Sample values: A = Documented as a citizen at SSA B = Citizenship not documented at SSA C = Documented citizen at SSA - person is deceased D = Citizenship not documented at SSA. Person is deceased
Code for the first procedure in a range of procedures used to define audit criteria.
Further specifies what type of procedure codes should be included in an audit.
Modifier that further defines the type of procedure code to be included in the audit.
Modifier that further defines the type of procedure code to be included in the audit.
Code for the procedure used to define the audit criteria.
Code for the procedure used to define the audit criteria.
Code for the last procedure in a range of procedures used to define audit criteria.
Indicates the type of code (revenue or procedure) used in the audit.
Indicates the type of code (revenue or procedure code) used in the audit.
Indicates the type of code (revenue or procedure code) used in the audit.
This is the coverage level codes. Valid values include: I - Individual E - Employee Only F - Employee + Family C - Employee + Children (default) S - Employee + Spouse O - Other 1 - Employee + 1.
This is the coverage level codes. Valid values include: I - Individual E - Employee Only F - Employee + Family C - Employee + Children (default) S - Employee + Spouse O - Other 1 - Employee + 1
This is the coverage level codes. Valid values include: I - Individual E - Employee Only F - Employee + Family C - Employee + Children (default) S - Employee + Spouse O - Other 1 - Employee + 1.
This field indicates whether data for an element is Always, Sometimes or Never collected by the state.
Data Type Code
Identifies the field data type.
Indicates the date range used.
Indicates the date range used.
A date type: program enrollment date or date of service
Day Code
M = Monday, T = Tuesday, W = Wednesday, H = Thursday, F= Friday. A value of 'D' in cde_occur would result in any value in this field being ignored.

M = Monday, T = Tuesday, W = Wednesday, H = Thursday, F= Friday. A value of 'D' in cde_occur would result in any value in this field being ignored.
Determine if the number of days must be consecutive
Determine if the number of days must be consecutive.
Drug Category Code - Indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.
Drug Category Code - Indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.
Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5.
The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This code is subject to change by Federal regulation.
The Drug Enforcement Administration (DEA) code denotes the degree of potential abuse and Federal control of a drug. This code is subject to change by Federal regulation.
The Drug Enforcement Administration Code denotes the degree of potential abuse and Federal control of a drug. It is subject to change by Federal regulation. The current code list is: 0, 1, 2, 3, 4, 5 with 0 being the highest risk for abuse.
This is the DEA code for this drug code. (1 - DEA; 2 - Non DEA)
A short identifier for the decision. Examples, BP (Recipient Benefit Plan - Procedure), BD (Recipient Benefit Plan - Diagnosis).
Primary-Key. A short identifier for the decision. It must be unique within a transaction.
Examples, BP (Recipient Benefit Plan - Procedure), BD (Recipient Benefit Plan - Diagnosis).
Primary-Key. A short identifier for the decision. It must be unique within a transaction.
Examples, BP (Recipient Benefit Plan - Procedure), BD (Recipient Benefit Plan - Diagnosis).
Primary-Key. A short identifier for the decision. It must be unique within a transaction.
Examples, BP (Recipient Benefit Plan - Procedure), BD (Recipient Benefit Plan - Diagnosis).
This is the deductible schedule for a specific coverage type of a policy.
The default action for the process.
Delay Reason Code. Code indicating the reason why a request was delayed.

NCPDP field 357-NV, Code to specify the reason that submission of the transactions has been delayed. For code values, refer to the External Code List document located at I:\2010 Enhancement Implementation Project (EIP)\5010 Project\NCPDP.
CLM - Delay Reason Code. Code indicating the reason why a request was delayed.
Delay Reason Code. Code indicating the reason why a request (e.g. for information) was delayed. Component of Claim Information.
Indicates if this budget can be updated with deposited funds from external entities. Valid values would include: N = Do not allow funds to be deposited into this budget, Y = Allow funds to be deposited for reporting only, but do not add them to the amount to be spent, S = Allow funds to be deposited and allow the deposited funds to be spent.
Identifies the type of deprivation reason for which recipient is eligible. (only AFDC and SOBRA)
Identifies the type of deprivation reason for which recipient is eligible. (only AFDC and SOBRA)
Identifies the type of deprivation reason for which recipient is eligible. (only AFDC and SOBRA)
Deprivation reason code; used for AFDC and SOBRA recipients only
Values 0 - 1 are used with the DESI and DESI2 indicators and indicate this drugs is DESI (1) or DESI at one point in time, but no longer (0). Values 0, 2-6 are used with the HCFA DESI and indicate this drug's status as less than effective.
Values 0 - 1 are used with the DESI and DESI2 indicators and indicate this drugs is DESI (1) or DESI at one point in time, but no longer (0). Values 0, 2-6 are used with the HCFA DESI and indicate this drug's status as less than effective.
Code used to indicate the DESI type. 1 = DESI Drug Indicator DESI on the NDDF. 2 = DESI 2 Drug Indicator on the NDDF. H = HCFA DESI code on the NDDF.
The diagnosis code that was keyed on the claim.
The diagnosis code that was keyed on the claim.
A code for the condition requiring medical attention.
ICD9 Diagnosis code.
The actual high cost diagnosis code.
ICD-9/10-CM code found on the claim.
ICD-9/10-CM code found on the claim.
ICD-9/10-CM code found on the claim.
The diagnosis code that was keyed on the claim.
First diagnosis (other than principal) that influenced DRG assignment. This field will be blank if a diagnosis (other than principal) did not influence DRG assignment.
Second diagnosis (other than principal) that influenced DRG assignment. This field will be blank if a second diagnosis (other than principal) did not influence DRG assignment.

The CDE_DIAGS_DSPLY column contains all diagnosis codes for the claim from T_CA_DIAG concatenated together in the following format: S1 - DDDDDD1; S2 - DDDDDD2; Diagnosis codes without a numerical sequence (admitting, emergency, etc.) will be added to the end of the string. S1 - Sequence 01 DDDDDD1 - Diagnosis 1 S2 - Sequence 02 DDDDDD2 - Diagnosis
The CDE_DIAG_1 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 1. Typically this will be the primary diagnosis code in the MMIS with a CDE_DIAG_SEQ of 01.
The CDE_DIAG_1 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 1. Typically this will be the primary diagnosis code in the MMIS with a CDE_DIAG_SEQ of 01.
The CDE_DIAG_10 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 10. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 10.
The CDE_DIAG_10 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 10. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 10.
The CDE_DIAG_11 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 11. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 11.
The CDE_DIAG_11 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 11. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 11.
The CDE_DIAG_12 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 12. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 12.
The CDE_DIAG_12 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 12. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 12.
The CDE_DIAG_2 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 2. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 02.
The CDE_DIAG_2 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 2. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 02.
The CDE_DIAG_3 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 3. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 03.

The CDE_DIAG_3 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 3. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 03.
The CDE_DIAG_4 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 4. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 04.
The CDE_DIAG_4 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 4. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 04.
The CDE_DIAG_5 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 5. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 05.
The CDE_DIAG_5 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 5. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 05.
The CDE_DIAG_6 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 6. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 06.
The CDE_DIAG_6 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 6. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 06.
The CDE_DIAG_7 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 7. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 07.
The CDE_DIAG_7 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 7. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 07.
The CDE_DIAG_8 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 8. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 08.
The CDE_DIAG_8 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 8. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 08.
The CDE_DIAG_9 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 9. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 09.

The CDE_DIAG_9 column will be populated with the diagnosis code on T_CA_DIAG with a NUM_DIAG_SEQ of 9. Typically this will be the diagnosis code in the MMIS with a CDE_DIAG_SEQ of 09.
Diagnosis that satisfied the complication/cormorbidity (CC) criteria and influenced DRG assignment. This filed will be blank if there is no CC, major CC or non-traumatic major CC.
Code that indicates whether and what type of editing is to be performed in claims processing on the procedure/diagnosis compatibility groupings. An 'N' indiates not editing is to be performed. An 'I' (Include) indicates only diagnosis codes on the diagnosis compatibility groups listed are acceptable. An 'E' (Exclude) indicates the diagnosis codes in the listed diagnosis compatibility groups cannot be billed with the procedure. Valid Diagnosis Compatibility groups for editing are listed on the T_PROC_DIAG_LIM entity.
Code for Diagnosis Compatibility code.
ICD-9-CM Diagnosis code which identifies a disease.
ICD-9-CM Diagnosis code which identifies a disease.
ICD-9-CM Diagnosis code which identifies a disease.
A flag that identifies the coding system used for the ADMITTING-DIAGNOSIS-CODE.
A flag that identifies the coding system used for the ADMITTING-DIAGNOSIS-CODE.
A flag that identifies the coding system used for the ADMITTING-DIAGNOSIS-CODE.
Code used to indicate the first diagnosis in a range used for audit criteria.
Code used to indicate the first diagnosis in a range used for audit criteria.
System assigned key for the diagnosis.
This is the beginning range of codes for a condition requiring medical attention
The code identifying the diagnosis that is the lower limit of a range of diagnosis codes which will be used to restrict an ICD Procedure to a diagnosis.
Claim search beginning diagnosis code
Indication of whether diagnosis code(s) is included, excluded, or not in the audit criteria.
Indication of whether diagnosis code(s) is included, excluded, or not in the audit criteria.
An indicator used to specify if the diagnosis codes defined by SAK_DIAG_TYPE should be included ('I') or excluded ('E').

The Present On Admission code received on institutional claims. Valid values are: Y - Diagnosis was present at time of inpatient admission; N - Diagnosis was not present at time of inpatient admission; U - Documentation insufficient to determine if condition was present at the time of inpatient admission; W - Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission; 1 - Exempt from POA reporting; blank - Exempt from POA reporting; # - Non Applicable.
The Present On Admission field indicates if a recipient's condition existed at the time of admission. It applies only to Inpatient hospital claims and is required for a specific set of diagnosis codes in order to be paid. Valid values are: Y - condition was present at time of admission (POA); W - clinically undetermined if POA; N - not POA; U - insufficient documentation to determine if POA; 1 or space - exempt from POA reporting.
The CDE_DIAG_POA_1 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 1. Typically this will be the primary diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 01.
The CDE_DIAG_POA_10 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 10. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 10.
The CDE_DIAG_POA_11 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 11. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 11.
The CDE_DIAG_POA_12 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 12. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 12.
The CDE_DIAG_POA_2 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 2. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 02.
The CDE_DIAG_POA_3 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 3. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 03.
The CDE_DIAG_POA_4 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 4. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 04.
The CDE_DIAG_POA_5 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 5. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 05.

The CDE_DIAG_POA_6 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 6. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 06.
The CDE_DIAG_POA_7 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 7. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 07.
The CDE_DIAG_POA_8 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 8. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 08.
The CDE_DIAG_POA_9 column will be populated with the diagnosis POA code on T_CA_DIAG with a NUM_DIAG_SEQ of 9. Typically this will be the diagnosis POA code in the MMIS with a CDE_DIAG_SEQ of 09.
A code to identify conditions that are present at the time the order for inpatient admission occurs.
A code to identify conditions that are present at the time the order for inpatient admission occurs.
A code to identify conditions that are present at the time the order for inpatient admission occurs.
A code for the condition requiring medical attention.
A Diagnosis pointer that identifies the primary diagnosis code for this service line. Found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV107-1).
A Diagnosis pointer that identifies the second diagnosis code for this service line. Found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV107-2).
A Diagnosis pointer that identifies the third diagnosis code for this service line. Found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV107-3).
A Diagnosis pointer that identifies the fourth diagnosis code for this service line. Found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV107-4).
A code for the condition requiring medical attention.
Indicates whether diagnosis is primary, second, third, or fourth in the header. Values are 1,2,3 or 4.
Indicates whether a diagnosis is primary, second, third, fourth, etc in the header. Values are 1-4 for paper claims. Values are 1 - 12 for electronic claims.
The sequence number of the diagnosis on the claim that identifies whether the diagnosis is the admitting, primary, 'E' code, etc.

Indicates if the diagnosis is, primary, secondary, third, or fourth, etc... on professional claims. Electronic claims can submit up to 12 diagnosis codes. Paper claims can submit up to 4.
Indicates whether diagnosis is primary, secondary, third, fourth, fifth, sixth, seventh, eighth, ninth, admitting, or emergency in the header. Values are 1 - 9, A, or E. The admitting diagnosis is sequence A and the emergency diagnosis is sequence E.
A clean version of the CDE_DIAG_SEQ that is received from the MMIS. Valid values for this column are: 01 - 25, 99, A and E. All other values received from the MMIS in CDE_DIAG_SEQ are defaulted to ##.
Code used to indicate the last diagnosis in a range used for audit criteria.
Code used to indicate the last diagnosis in a range used for audit criteria.
System assigned key for the diagnosis.
This is the ending range of codes for the condition requiring medical attention.
The code identifying the diagnosis that is the upper limit of a range of diagnosis codes which will be used to restrict an ICD Procedure to a diagnosis.
Claim search ending diagnosis code
Indicates which diagnosis (or diagnoses) applies for the services billed on this detail. Valid values are 1-12 for electronic claims and 1-4 for paper claims. Each detail can be associated to a minimum of 1 and a maximum of 4 header diagnosis codes for non-transportation claims only.
Indicates which diagnosis (or diagnoses) applies for the services billed on this detail. Valid values are 1-12 for electronic claims and 1-4 for paper claims. Each detail can be associated to a minimum of 1 and a maximum of 4 header diagnosis codes for non-transportation claims only.
Not currently used for dental claims.
Indicates which diagnosis (or diagnoses) applies for the services billed on this detail. Valid values are 1-12 for electronic claims and 1-4 for paper claims. Each detail can be associated to a minimum of 1 and a maximum of 4 header diagnosis codes for non-transportation claims only.
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Not currently used for dental claims.
Indicates which diagnosis (or diagnoses) applies for the services billed on this detail. Valid values are 1-12 for electronic claims and 1-4 for paper claims. Each detail can be associated to a minimum of 1 and a maximum of 4 header diagnosis codes for non-transportation claims only.
Not currently used for dental claims.
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Not currently used for dental claims.
Indicates which diagnosis (or diagnoses) applies for the services billed on this detail. Valid values are 1-12 for electronic claims and 1-4 for paper claims. Each detail can be associated to a minimum of 1 and a maximum of 4 header diagnosis codes for non-transportation claims only.
A code for T-MSIS to identify disability status in accordance with requirements of Section 4302 of the Affordable Care Act.
Identifies the disability status in accordance with requirements of ACA Section 4302.
Identifies disaster survivors who are temporarily receiving coverage.
Identifies disaster survivors who are temporarily receiving coverage.

Disaster survivor code. Values: FA = Tornado Disaster April 15 2011 and April 27 2011 - Alabama FG = Tornado Disaster April 15 2011 and April 27 2011 - Georgia FM = Tornado Disaster April 15 2011 and April 27 2011 - Mississippi FN = Tornado Disaster April 15 2011 and April 27 2011- Recipient New to Medicaid FT = Tornado Disaster April 15 2011 and April 27 2011 - Tennessee FC = Foster Care IN = Institutionalized MC = Specialized Medical Care RL - Rita Disaster Survivor Louisiana MV = Moved out of state OT = Other reason RT - Rita Disaster Survivor Texas YA - Katrina Disaster Survivor Alabama YL - Katrina Disaster Survivor Louisiana YM - Katrina Disaster Survivor Mississippi
Indicates when discharges from LTC Program is considered Long Term or Short Term. For RCO implementation, the following codes have been agreed upon: D - Death H - Discharge Home T - Terminated from Program C - Calculated end date based upon admission/Provider type criteria R - Recipient is Transferring/Reassigned to another Facility or Program G - Recipient participating in Gateway to Community Living S - Short Term Hospital Stay M - Medicare Days P - Spend Down V - Revoked
Indicates when discharges from LTC Program is considered Long Term or Short Term. For RCO implementation, the following codes have been agreed upon: D - Death H - Discharge Home T - Terminated from Program C - Calculated end date based upon admission/Provider type criteria R - Recipient is Transferring/Reassigned to another Facility or Program G - Recipient participating in Gateway to Community Living S - Short Term Hospital Stay M - Medicare Days P - Spend Down V - Revoked
Code indicating the explanation for discharge (admit type 7). Valid values are: H - Recipient Discharged Home, D - Recipient Died, or T - Recipient Was Terminated From The Program.
Discipline Type Code. Code indicating disciplines ordered by a physician
Discipline Type Code. Code indicating disciplines ordered by a physician
Indicates how the overpayment was discovered. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3004 in the column SAK_VALUE_TYPE.
Disease code.
Disease Code.
Disease code (this will hold either the FDB disease code or the Micromedex disease code).
Disease code (this will hold either the FDB disease code or the Micromedex disease code).
Disease code (this will hold either the FDB disease code or the Micromedex disease code).
Disease code (this will hold either the FDB disease code or the Micromedex disease code).

Disease code related to this criteria record.
FDB proprietary disease code
The First DataBank disease code (FDBDX in FDB manual) identifies specific disease states and side effects.
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The First DataBank disease code (FDBDX in FDB manual) identifies specific disease states and side effects.
FDB proprietary disease code.
The disposition status for the alert. P = PA Override D = Deny (non-overrideable) I = Informational O = Provider Override N = Not Active
Code indicating how an alert dispositioned. The values are: P = PA Override, D = Deny (non-overrideable), I = Informational, O = Provider Override, N = Not Active
The disposition status for the alert. P = PA Override D = Deny (non-overrideable) I = Informational O = Provider Override N = Not Active
Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.
Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.
Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.
Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.
Indicates a reason code for the dispute
One byte reason code used to describe the reason a dispute was initiated by the drug labeler
Indicates a reason code for the dispute
Indicates a reason code for the dispute
Indicates the reason for the dispute
Indicates the reason for the dispute
Indicates the reason for the dispute
The Provider Taxonomy of the provider responsible for dispensing the prescription drug.
Contains the reason code for the status of an A/R

Code used to identify the reason for the disposition against the lien.
The disposition reason code identifies the reason for the disposition against a lien.
Code indicating disposition status.
Code that represents the action that is taken on a claim at the time of disposition. Pay = P, deny = D, suspend = S, force override = F, reject = J, or batch suspend = B.
Code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
Code that represents the action (pay(P), deny(D), suspend(S), force override(F), reject(J), batch suspend(B), or recycle limit of the original error has expired(O)) that is taken on a claim at disposition time.
Code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
Code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
Indicates if a line item criteria is active or inactive.
A code that represents the action (pay, deny, suspend) which should be taken on on a claim at disposition time.
A code that represents the action (pay, deny, suspend) which should be taken on a claim at disposition time.
A code that represents the action (pay, deny, suspend) which should be taken on on a claim at disposition time.
Code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
Code that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
Code that represents the action that is taken on a claim at the time of disposition (1 of 6). Pay = P, deny = D, suspend = S, force override = F, reject = J, or batch suspend = B.
Code that represents the action that is taken on a claim at the time of disposition (2 of 6).
Code that represents the action that is taken on a claim at the time of disposition (3 of 6).
Code that represents the action that is taken on a claim at the time of disposition (4 of 6).
Code that represents the action that is taken on a claim at the time of disposition (5 of 6).
Code that represents the action that is taken on a claim at the time of disposition (6 of 6).
Indicates the plan district that the claim is assigned to. This value is taken from the CDE_DISTRICT_PLAN from the T_REF_DISTRICT_PLAN table.

The Managed Care plan code assigned to the claim. For example: ZZZ = Medicaid
The district code used to identify a geographical/political area in the state.
CR3 - Code indicating the type of certification. Valid values are: I - Initial, R - Renewal, S - Revised
CR3 - Code specifying the units in which a value is expressed. SEMANTIC: CR302 and CR303 specify the time period covered by this certification. CODE DEFINITION MO Months
A code assigned to a grouping of dental procedure codes used for the Dental Profiler Participation Analysis reports.
A code assigned to a grouping of dental procedure codes.
A code assigned to a grouping of dental procedure codes used for the Dental Profiler Participation Analysis reports.
A code indicating the peer group of the Provider NPI. The value is based on the provider's type code and the number of recipients served by the provider. A code of ## indicates a peer group for the provider could not be determined.
A code indicating the peer group of the Provider NPI. The value is based on the provider's type code and the number of recipients served by the provider. A code of ## indicates the data was summarized without regard to provider peer group.
The value is based on the provider's type code and the number of recipients served by the provider.
A code indicating the peer group of the Provider NPI. The value is based on the provider's type code and the number of recipients served by the provider. A code of ## indicates the data was summarized without regard to provider peer group.
Abbreviated codes representing different indicators.
Source of verified date of death. O = Override of DOD from Vital Statistics V = Vital Statistics
The short identifier of the domain, used as a primary key. Examples, INT (integer), DATE, BOOL (boolean), POS (place of service).
This is an optional column. It is equal to " " if the relation has at least two attributes. Otherwise this "Relation" has only one attribute in which case it represents a domain to which it points.
An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.
An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.
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An abbreviated two-byte code (GCDF on NDDF update) is available for applications. Users may request the code in addition to or instead of the description.

The AMAES aid category carried over from the recipient "core" record. Sample values: 1=AGED 2=BLIND 3=TANF 4=DISABLED 5=SOBRA 6=REFUGEE 7=FOSTER CARE(DHR) 8=FOSTER CARE(ST) 9=CHILD OF SSI MOTHERS L=SLMB Q=QMB
Status of DO Elderly and Disabled application. Valid values are: blank = Awarded, 1 = Denied, 2 = Pending, 3 = Termination.
District Office program code used to identify certain kinds of recipients.
Status of DO Medicare Savings Program application. Valid values are: blank = Awarded, 1 = Denied, 2 = Pending, 3 = Termination.
District Office program code used to identify certain kinds of recipients.
This column will have the values that correspond to the sak_dpv_type. All the DPV footnote codes, DPV Vacant, and DPV Nostat codes will be stored in this column.
There can be up to 3 sets of footnotes that are important to DPV processing.
There can be up to 3 sets of footnotes that are important to DPV processing.
Pricing DRG CODE
This is a three byte code field used to identify a DRG grouping. The DRG code and description are obtained from HCIA.
This code represents the original DRG code that will be replaced in a claim through the Neonatal logic.
System assigned key for a unique DRG.
Code representing the Diagnosis Related Group (DRG) for the inpatient services being rendered.
Pricing DRG CODE
Base Rate Category: 0=All Other; 1=Childrens of AL; 2=Major Teaching; 3=USA Womens and Childrens
Higher weight DRG code assigned to the claim
Higher weight DRG code assigned to the claim
This code represents the 800 series Neonatal DRG codes that replace the original DRG code.
This is the drug category for this drug code. (Values are 0 - Drug Category; 1 - No Drug Category specified)
The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.
The Drug Category Code indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans. Sample values are: 0 Unspecified, A Anti-Anxiety Agents, B Fertility Agents, C Contraceptives, D Diagnostics, E Fluoride Preparations, F Antiobesity Drugs/Amphetamines, G Antacids, H Hematinics.
The CMS Drug Category identifies single source, multi-source, or innovator status.

The Drug Category Code (DCC) indicates that a drug product belongs to a category that is commonly treated as an exception in third party plans.
A drug class needed for MAR COS assignment. The valid codes are: O - Over the Counter F - Federal Legend Spaces are used to indicate no drug class restriction.
Identifies a classification of drugs; for example, barbiturate or amphetamine.
Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Prescription required per the product labeling.
Identifies a classification of drugs; for example, barbiturate or amphetamine.
Identifies a classification of drugs; for example, barbiturate or amphetamine.
This is the drug class for this drug code. (Values are 0 = drug class; 1 = non drug class)
Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Federal Legend (Prescription required) per the product labeling.
Classifies a drug by its availability to the consumer according to federal specifications. Values may change even after the NDC has become obsolete. Valid Values are: O = Over-the-Counter. A prescription is not required per the product labeling. F = Federal Legend (Prescription required) per the product labeling.
Identifies a classification of drugs; for example, barbiturate or amphetamine.
A drug class needed for MAR COS assignment. The valid codes are: O - Over the Counter; F - Federal Legend; A - All Types. Spaces are used to indicate no drug class restriction.
Recipient's drug coverage indicator under Medicaid. Values are 0 for No coverage, 1 for Medicaid drug coverage and 9 for Unknown.
This code represents the drug exception category code. The valid values can be found in T_REF_CDE_VALUE_GROUP for sak_value_type = 5.
The basic drug measurement unit (each - EA, milliliter - ML, or grams) for performing price calculations.
The Drug Form Code indicates the basic drug measurement unit for performing price calculations. The current codes are: EA - (tables,kits,etc.) ML - (liquids) GM - (solids).
The Drug Form Code indicates the basic drug measurement unit for performing price calculations. The current codes are: EA - (tables,kits,etc.) ML - (liquids) GM - (solids).

This is the drug form for this drug code. (Values are 1 - Formulated Drug; 0 - Non Formulated Drug)
The basic drug measurement unit (each, milliliter, or grams) for performing price calculations.
The basic drug measurement unit (each, milliliter, or grams) for performing price calculations.
A code indicating if a drug is single-sourced or has multiple sources. 1 = Multiple Sources, 2 = Single Source.
The Drug Source Code differentiates single source from multiple source drugs. The current codes are: 1 - Multiple sources & 2 - Single source. Note that this field does not distinguish between the "innovator" products and its substitutes.
The Drug Source Code differentiates single source from multiple source drugs. The current codes are: 1 - Multiple sources & 2 - Single source. Note that this field does not distinguish between the "innovator" products and its substitutes.
This field is used to identify the status of a drug. A drug will be marked as either Active (A) or Inactive (I). This information is used to allow the user to review additions and updates to a drug before they are activated for use by the MMIS.
This field is used to identify the status of a drug. A drug will be marked as either Active (A) or Inactive (I). This information is used to allow the user to review additions and updates to a drug before they are activated for use by the MMIS.
This will indicate if the drug is State-unique (S), First Data Bank (F) supplied (is added and updated by them), MediSpan unique (M) from the old system or was added by the National Pro-DUR system (N).
This will indicate if the drug is State-unique (S), First Data Bank (F) supplied (is added and updated by them), MediSpan unique (M) from the old system or was added by the National Pro-DUR system (N).
A code indicating the conflict intervention and outcome of a prescription presented for fulfillmnt.
This is used for Prior Period Adjustments (PPA). A "0" means not a PPA, it is current. A "2" is the original rebate record and a "3" is the corrected rebate record for the original.
This indicates the type of unit the drug is measured in.
The day code.
Indicates whether the claim search was based on dates of service (S) or paid dates (P)
Code that indicates if the claim is approved or rejected.
Code to indicate payment status of the detail.
A code indicating if the service line was approved or rejected for payment. Valid values are paid (P) and denied (D).
Code that indicates if the claim is approved or rejected. The current status and the values are: D- Denied P-Paid V-Void
Code that indicates if the claim is approved or rejected. The current status and the values are: D-Denied P- Paid V-Voidl

A code for T-MSIS to indicate coverage for individuals entitled to Medicare (Part A and/or B benefits) and eligible for some category of Medicaid benefits.
Indicates coverage for individuals entitled to Medicare and eligible for some Medicaid benefits.
Indicates the recipient's dual status code.
Indicates the recipient's dual status code.
The conflict code alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria ER = Early Refill; TD = Therapeutic duplication; DD = Drug Interaction; EQ = Excessive Quantity.
The intervention codes: M0- Presrciber consulted; P0-Patient consulted; R0-Pharmacist consulted other source.
Record of whether a drug utilization and review intervention code was given in response to a DUR alert. The intervention code indicates whom the pharmacist consulted with (nobody, physician, recipient) to decide whether to fill the prescription.
Drug utilization review intervention code
Record of whether a drug utilization and review intervention code was given in response to a ProDUR alert. The intervention code indicates whom the pharmacist consulted with (nobody, physician, recipient) to decide whether to fill the prescription.
This field should not be used for a suspended claim since the corresponding data can only be received on a POS claim, and POS claims cannot suspend.
The outcome codes: 1A - Filled As Is, False Positive; 1B - Filled Prescription As Is; 1C - Filled, with Different Dose; 1D - Filled, with Different; Directions; 1E - Filled, with Different Dose; 1F - Filled, with Different Quantity; 2A - Prescription Not Filled; 2B - Not Filled, Directions Clarified.
The response of the pharmacist to the DUR conflict code. This code indicates whether the prescription was filled as is, not filled, or changed.
Drug utilization review outcome code
Code used to identify why the pharmacist filled the prescription after he received ProDUR warnings.
The outcome code returned from the provider in response to a Prospective Drug Utilization Review alert. This code indicates whether the prescription was filled as is, changed, or not filled.
This field should not be used for a suspended claim since the corresponding data can only be received on a POS claim, and POS claims cannot suspend.
District Office track code used to identify certain kinds of recipients.
District Office track code used to identify certain kinds of recipients.

District Office track code used to identify certain kinds of recipients.
The code of the earnings record.
The code of the earnings record.
The code of the earnings record.
This is the code of the earnings category. Values are IN = Increase to Earnings; DE = Decrease to Earnings; NA = No Effect on Earnings.
This is the code of the earnings category. Values are IN = Increase to Earnings; DE = Decrease to Earnings; NA = No Effect on Earnings.
The insurance disclosure edit code
APC EDIT CODE
APC EDIT CODE
The element name of an element in a schema.
This contains the data element dictionary number within the HIPAA transaction guide.
The eligibility group applicable to the individual based on the eligibility determination process.
ANSI county numeric code indicating the county for the type of address indicated.
The reason for a change in an individual`s eligibility status.
The T-MSIS eligibility group applicable to the individual based on the eligibility determination process. The valid value list of eligibility groups aligns with those being used in the Medicaid and CHIP Program Data System (MACPro).
This field is related to the Episode Type column in that it deals with episode completeness. An episode may be incomplete due to the service dates in the episode and/or the patient's eligibility dates being too close to the ends of the claims data range (i.e. within the ETG's clean period). This field discriminates between the two sets of dates, and can have the following alphanumeric values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
This field is related to the Episode Type column in that it deals with episode completeness. An episode may be incomplete due to the service dates in the episode and/or the patient's eligibility dates being too close to the ends of the claims data range (i.e. within the ETG's clean period). This field discriminates between the two sets of dates, and can have the following alphanumeric values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.

This field is related to the Episode Type column in that it deals with episode completeness. An episode may be incomplete due to the service dates in the episode and/or the patient's eligibility dates being too close to the ends of the claims data range (i.e. within the ETG's clean period). This field discriminates between the two sets of dates, and can have the following alphanumeric values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
This field is related to the Episode Type column in that it deals with episode completeness. An episode may be incomplete due to the service dates in the episode and/or the patient's eligibility dates being too close to the ends of the claims data range (i.e. within the ETG's clean period). This field discriminates between the two sets of dates, and can have the following alphanumeric values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
Eligibility status code. Valid values are: A=ACTIVE 1=DENIED 2=PEND 3=DTH DEL 4=REG DEL 5=SUSPEND 0=PAYEE ONLY(FROM AMAES)
This is the 5-character Enhanced Line of Travel.
This is the 5-character Enhanced Line of Travel.
A code to indicate whether the claim was for a service provided in an emergency situation.
Emergency Code.
This field is the unique, user-defined employer ID which is used on all screens and reports to identify the employer.
Employment Status Code used to qualify the patient's relationship to the military. Found in the HIPAA 278 Request and Response Guide in loop 2010C, segment INS, element INS08.
Employment status
Include/Exclude indicator for current and history encounter indicator. Valid values are I, E, and space.
FFS detail status for encounter claims. Values: 'P' - Paid, 'D' - Denied, ' ' - Not an encounter.
Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.
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FFS detail status for encounter claims. Values: 'P' Paid, 'D' Denied, ' ' Not an encounter.
Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.
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Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.
FFS detail status for encounter claims. Values: 'P' Paid, 'D' Denied, ' ' Not an encounter. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.
FFS detail status for encounter claims. Values: 'P' Paid, 'D' Denied, ' ' Not an encounter. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
Code which indicates the status of the encounter in the system as a result of interChange editing. The values will be T - Threshold, I - Informational or P - paid.
The recipients enrolled rate code at the time of the end date of measurebase calculations
The recipients enrolled rate code at the end of the period.
The general type of provider that has applied for enrollment. The valid values are: 1 - Facility, 2 - Group, 3 - Individual, 4 - Individual within Group, 5 - OPR, 6 = EFT, 7 = ERA
Frequency that re-enrollment is required. Valid values are: 1 = Every year, 5 = Every 5 years, S = State Agency which enrolls every 5 years, V = Yearly Visit Required, F = Provider who require a visit every five years, X = Exclude from re-enrollment.
Identifies the reason that this enrollment was initiated.
Identifies the reason that this enrollment was initiated.

Identifies the reason that this enrollment was initiated.
Identifies the current status of this disenrollment (E - Enrolled, P - Mass Disenrollment Approval Pending, A - Mass Disenrollment Approved, D - Disenrolled)
Identifies the current status of this disenrollment (E - Enrolled, P - Mass Disenrollment Approval Pending, A - Mass Disenrollment Approved, D - Disenrolled)
Identifies the current status of this disenrollment (E - Enrolled, P - Mass Disenrollment Approval Pending, A - Mass Disenrollment Approved, D - Disenrolled).
This is the letter assigned to the enrollment status description to uniquely identify it.
This is the letter assigned to the enrollment status description to uniquely identify it. Examples of valid values are: R=Retired, D=Deceased, M=Return Mail, I=Term by IFSSA, H=Term by HCFA, B=Term by HPB, and A=Active.
Unisys' provider enrollment status code
Unisys' provider enrollment status code
Indicates what enrollment activity prompted the creation of this application tracking record, such as initial enrollment or recertification. Values are I - Initial Enrollment, E - Re-enrollment, R - Recertification, and C - Change of Ownership.
The enrollment type for the Part D Medicare.
The enrollment type for the Part D Medicare.
Type of enrollment that the eligible person has been enrolled into as either Medicaid or CHIP.
Code identify whether the entity to whom the premium payment is being mailed is a recipient, policyholder, carrier, or employer.
This is the entity for the TPL Letter being produced.
This is the entity for the TPL Letter being produced.
This is HMS' Account Receivable code.
Entity Identifier Code - Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment NM, element NM101. Valid Values - 'L5'.
Entity Identifier Code - Code identifying an organizational entity, a physical location, property or an individual. Found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment NM, element NM101. Valid Values - '00', 'CA', 'GG'.
The code for the type of entity. This is usually provider, beneficiary or other. (P,B,O)
This field contains the code for the environment. T-Test, P-Prod, etc.
The EOB to report to the provider for the alert. No EOB indicates the alert will not be sent to the provider
A code which represents a policy for Medicaid claim adjudication.

A code which represents a policy for Medicaid claim adjudication.
This is the number assigned to an explanation of benefits description to uniquely identify it.
A code which represents a policy for Medicaid claim adjudication.
A code which represents a policy for Medicaid claim adjudication.
A code which represents a policy for Medicaid claim adjudication.
A code which represents a policy for Medicaid claim adjudication.
A code which represents a policy for Medicaid claim adjudication.
A code which represents a policy for Medicaid claim adjudication.
A code from the CMS 1500 and ADA 200 claim forms indicating EPSDT or Family Planning services. This column only applies to medical/professional and dental claims.
DO NOT USE - not applicable to Dental claims.
Family Planning indicator. Mapped from field SV112 of the 837P transaction. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement. Paper claim: source field is 24H. In Alabama a "2" in this field indicates family planning and is mapped into the system as a "Y".
A code from the ADA 200 claim form indicating EPSDT.
Family Planning indicator. Mapped from field SV112 of the 837P transaction. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement. Paper claim: source field is 24H. In Alabama a "2" in this field indicates family planning and is mapped into the system as a "Y".
DO NOT USE - not applicable to Dental claims.
Family Planning indicator. Mapped from field SV112 of the 837P transaction. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement. Paper claim: source field is 24H. In Alabama a "2" in this field indicates family planning and is mapped into the system as a "Y".
This information comes from the CMS 1500 claim form. Defines EPSDT referal/treatment information. The valid values are as follows: YD - EPSDT, dental referral YV - EPSDT, vision referral YH - EPSDT, hearing referral YO - EPSDT, other referral AT - EPSDT, abnormal not treated AN - EPSDT, abnormal treated AR - EPSDT, abnormal. This column only applies to medical/professional claims.
The transaction type code identifies the type of driver we are executing for claims processing (POS, Pharmacy, Physician, etc). Each electronic driver type will have batch ranges assigned based on its transaction type.

Code that identifies the type of driver that will execute for claim processing (POS, Pharmacy, Physician, etc).
Identifies possible input (transaction) into the MMIS system.
Identifies requests (transactions) that input into the system. For example, POS pharmacy claim or eligibility verification request.
Identifies possible input (transaction) into the MMIS system.
The error number for a batch edit error
This is the error code that is used to describe a specific financial transaction for reporting.
This is the error code that is used to describe a specific financial transaction for reporting.
The error number for a batch edit error
Indicates IDcard request error code. This value on the input file should always be spaces.
The error number for a batch edit error
The error number for a batch edit error
The code assigned to a particular ICES error.
NCPDP reject code. This is the Unique code number/value assigned to a specific reject message per National council for prescription drug pricing and is a Foreign Key inherited from the T_NCPDP_RESPONSE table (see Relationship document). It is also a field (not a key) on the T_ESC_NCPDP_XREF table.
Contains one of the valid NCPDP values
Unique code number/value assigned to a specific reject message per National council for prescription drug pricing
Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.
Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.
Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.
Identifies the audit as limitation, bundling, unbundling, contraindicated, or umbrella.
A code that corresponds to a particular edit/audit.
The CC edit code that was posted.
Code used to indicate an error was discovered on a claim during processing in the MMIS system. This can be either an edit or an audit.
A code that corresponds to a particular edit/audit.
This is a number that corresponds to a particular edit/audit.
A code that corresponds to a particular edit/audit.
A code that corresponds to a particular edit/audit.
A code that corresponds to a particular edit/audit.
Code used to indicate an error was discovered during ClaimCheck processing.
Code used to indicate an error was discovered during ClaimCheck processing.

Code used to indicate an error was discovered during ClaimCheck processing.
Code used to indicate an error was discovered during ClaimCheck processing.
Code used to indicate an error was discovered during ClaimCheck processing.
End stage renal disease coverage end code
Recipient's ethnicity code.
The ethnicity of the recipient. Value of 01 means Hispanic. Value of 00 means not Hispanic.
The ethnicity of the beneficiary.
A code indicating that the individuals ethnicity is Hispanic Latino/a or Spanish.
Codes representing the type of event.
Event Type Code that will be the value inserted into t_lg_history when a history event is recorded.
Event Type Code that will be the value inserted into t_lg_history when a history event is recorded.
An event set contains multiple events, and this identifies the event component
The event to which the event set belongs, that contains the report specified in the table
Code representing the different Event keys.
Indicator of which event set during implementation this represented.
Unique identifier for a particular event of MMIS
The event set to which this report belongs, or was documented.
Unisys' exception status which is akin to the claim resolultion status
The reason property is excluded as a resource. These are maintained by the Medicaid AMAES system. Valid values are A, B and D.
Statutory aid category under Medicaid (SSI only). Valid values include AI, BI, DI, BC, DC, AS, BS, DS, EP, HR EP = Essential Person HR= Restricted to Humana for inpatient services 1st character: A, B, D = Aged, Blind, Disabled 2nd character: I, C, S = Individual, Child, Spouse Example: AI = Aged Individual
The analyst's level of experience.
Express lane eligibility code

Family member express lane eligibility code. This is a combination of a one-byte verification source value and a one-byte "when action taken" value. These values are maintained by Medicaid outside the MMIS. Sample values are: Verification source: A = ADMINISTRATIVE RENEWALS S = SNAP T = TANF B = BOTH SNAP & TANF Action taken: I = AT INITIAL APPLICATION OR RE-APPLICATION R = AT RENEWAL (OR REVIEW)
A code representing when express lane eligibility action was taken. Values: I = At initial application or re-application R = At renewal (or review)
A code representing express lane eligibility. Values: A = ADMINISTRATIVE RENEWALS S = SNAP T = TANF B = BOTH SNAP & TANF
Facility code for facility on D.O. application
This field will always contain spaces.
Identifies whether the SUBMITTING-STATE-PROV-ID is assigned to an individual, group or a facility.
Endoscopic services performed through the same orifice are grouped into families of endoscopic surgeries.
Code associated to State/Federal Agency who conducted the FCBC visit. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value_type = 221
Identifies single source, multi-source, or innovator status as supplied by FDB. Valid values are: SPACE - Unspecified, S - Single Source, I - Innovator Multi-source, N - Non-Innovator Multi-source.
FDB Drug Identifier
FDB Drug Identifier
FDB Drug Identifier Type. 3 MEDID;6 GCN_SEQNO;100 NDC;101 FDB_PRODUCT_ID
FDB Drug Identifier Type
A code used with a Federal Aid Category Description. This is not a Federal assigned code.
Code associated to the State/Federal to whom the fee was paid. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 218.
Codes representing the different file directions. Valid values are: - Inbound - Outbound - Solicited_Request - Solicited_Response
A data element to denote whether the file is in fixed length line format or pipe-delimited format
This column controls if the PMP receives electronic file or paper reports.
This column controls if the PMP receives electronic file, paper reports, or both.
This column controls if the PMP receives electronic file or paper reports.

This column controls if the PMP receives electronic file or paper reports.
Code representing different file statuses.
Initials of final level of care evaluator. (ICF/MR SCREEN, ICF MR Approval, Final LOC Evaluator)
Indicates whether the final decision is NF.
The activity code that is used in Medicaid financial reporting to correctly categorize funds.
The activity code that is used in Medicaid financial reporting to correctly categorize funds.
The activity code that is used in Medicaid financial reporting to correctly categorize funds.
This the code for the Financial Category of Service.
An optional business code value used to identify the financial cycle. This code may be used for reporting or identifying the financial cycle on feeds to external systems.
The department code that is used in Medicaid financial reporting to correctly categorize funds.
The department code that is used in Medicaid financial reporting to correctly categorize funds.
The department code that is used in Medicaid financial reporting to correctly categorize funds.
The department code that is used in Medicaid financial reporting to correctly categorize funds.
The department code that is used in Medicaid financial reporting to correctly categorize funds.
An optional business code value used to identify the payer. This code may be used for reporting or identifying payers on feeds to external systems.
The federal assigned code for the county.
The recipient fluoridation code assigned to the summarized data. The data is summarized by 3 recipient fluoridation codes: F - indicating the data was summarized for recipients residing in counties with fluoridated drinking water; NF - indicating the data was summarized for recipients residing in counties without fluoridated drinking water; ## - indicating the data was summarized without regard to recipient fluoridation code.
The recipient fluoridation code assigned to the summarized data. The data is summarized by 3 recipient fluoridation codes: F - indicating the data was summarized for recipients residing in counties with fluoridated drinking water; NF - indicating the data was summarized for recipients residing in counties without fluoridated drinking water; ## - indicating the data was summarized without regard to recipient fluoridation code.
A code value indicating if the recipient was residing in a county with fluoridated drinking water as of the last day of the quarter. There are two values: F - The recipient was residing in a county with fluoridated drinking water; NF - The recipient was not residing in a county with fluoridated drinking water.

This indentifies the type of footnote. The valid values are 'P' (Periodicity) or 'V' (Vaccine).
This is the cooresponding footnote defined on the Periodicity and Vaccine Schedules.
The key value used to define the Peridicity and Vaccine Schedule. Valid values are 'P', 'S', '-', 'O', 'R', '<', '>'.
Claim form (PHRM, DNTL, PHYS, UB92) or env (to get env variable).
Code that identifies with which form the return reason is associated. Used by the letter panel logic to display only the appropriate return reasons for the user to select from, based on the form being returned. Valid values are: 'D' - Trading Partner 835 Designation, 'M' - Managed Care Trading Partner Profile, and 'P' - Trading Partner Profile.
This uniquely identifies the tax form type such as W2 or 1099.
This uniquely identifies the tax form type such as W2 or 1099.
This uniquely identifies the tax form type such as W2 or 1099.
This field identifies that this form is a Consent Form. Valid values are "H", "S", or "A". "H" - indicates the recipient has consented to hysterectomy related procedures, "S" - indicates the recipient has consented to sterilization related procedures, and "A" - indicates the provider has noted that the abortion is required because the mother's life is endangered.
This field identifies that this form is a Consent Form. Valid values are "H", "S", or "A". "H" - indicates the recipient has consented to hysterectomy related procedures, "S" - indicates the recipient has consented to sterilization related procedures, and "A" - indicates the provider has noted that the abortion is required because the mother's life is endangered.
Indicates the Federal Poverty Level. Values are '1' for <=100% of FPL, '2' FOR >100 of FPL and '9' for Unknown.
FF=First, SS=Second, TT=Third,LL=Last,SL=Second to Last A value of 'D' or 'W' in cde_occur would result in any value in this field being ignored.
FF=First, SS=Second, TT=Third,LL=Last,SL=Second to Last A value of 'D' or 'W' in cde_occur would result in any value in this field being ignored.
Frequency Code
Frequency Code
Frequency Code
Frequency Code
This defines the frequency of the batch process that is utilizing the program group. Valid values are 'D'aily, 'W'eekly, 'M'onthly, 'Q'uarterly, and 'A'nnual.
Indicates the frequency the measure base can be used in reporting.
Indicates the frequency the measure base can be used in reporting.
FDB provide Frequency Code. This number is used to cross reference the factor table to determine the weight.

This is the value of the frequency used for calculating where the AT Alert needs to be sent. Valid values for this field are 0 = Incidence More Frequent 1 = Incidence Less Frequent 2 = Incidence Rare or Very Rare
The is the frequency by which the deduction recoupment occurs.
ID associated with an ePrescribing Formulary List; value from CDE_LIST_ID in T_ERX_CDE_LIST_ID record where SAK_PUB_HLTH matches T_PGM_HIERARCHY record and CDE_LIST_ID = FRM.
GS01 value of the EDI document.
GS01 value in the EDI file that represents the functional identifier code.
Codes representing the different AK5-01 values of 997. Valid values are: - A - E - M - R - W - X
This represents the codes from T_CDE_FUNCTIONAL_STATUS codes.
A T-MSIS code to indicate the source of non-federal share funds.
This code indicates if the claim was matched with Title XIX Title XXI local or other funding.
This code indicates if the claim was matched with Title XIX Title XXI local or other funding.
This code indicates if the claim was matched with Title XIX Title XXI local or other funding.
This code indicates if the claim was matched with Title XIX Title XXI local or other funding.
PCA Code.
This is the fund code that is used in financial reporting to correctly categorize funds (money).
Funding Code.
This is the fund code that is used in financial reporting to correctly categorize funds (money). List of valid fund codes are in t_fin_fund_code table.
This is the fund code that is used in financial reporting to correctly categorize funds (money). List of valid fund codes are in t_fin_fund_code table.
This is the fund code that is used in financial reporting to correctly categorize funds (money).
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Code used in financial reporting to correctly categorize funds (money).
Code used in financial reporting to correctly categorize funds (money).
This is the fund code that is used in financial reporting to correctly categorize funds (money).
Code used in financial reporting to correctly categorize funds (money).
An optional business code value used to identify the payer. This code may be used for reporting or identifying payers on feeds to external systems.
Code for the fund source used in federal reporting. Values include the following but States may add new values as needed: M - Medicaid B - BCCTS F - Family Planning I - Indian Health Services E - EPSDT
Value used in MSIS processing. Values are: E - EPSDT; F - Family Planning; M - Medicaid.
Code identifying the funding source for this record that is used in federal reporting like MSIS and CMS 64.

Indicates the Funding Source of the series of claims/encounters contained in this measure.
The claim/encounter funding source.
This code indicates the state account from which the payment was made.
This code indicates the state account from which the payment was made.
This code indicates the state account from which the payment was made.
This code indicates the state account from which the payment was made.
This field corresponds to Field 7 on the NCCI database, containing the GB Modified Indicator. The valid values are: 0, 1, 9. Please refer to the NCCD documentation for a more detailed description of this field.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds the FDB GCN Sequence Number
Clinical Formulation ID
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds the FDB GCN Sequence Number
Route of Administration Code, location a drug is administered. Valid values 1-ORAL, 2-INJECTION, 3-RECTAL, 4-MUCOUS MEMBRANE, 5-TOPICAL.
Route of Administration Code, location a drug is administered. Valid values 1-ORAL, 2-INJECTION, 3-RECTAL, 4-MUCOUS MEMBRANE, 5-TOPICAL.
Route of Administration Code, location a drug is administered. Valid values 1-ORAL, 2-INJECTION, 3-RECTAL, 4-MUCOUS MEMBRANE, 5-TOPICAL.
Sex code for which this criteria applies.
Sex code for which this criteria applies.
A code value indicating the gender of the recipient.
Gender the recipient must be to receive this drug. Valid values are: 1=Male, 2=Female, Space=Both.
Sex code for which this criteria applies. N=both, M=male, F=female.
Sex code for which this criteria applies. N=both, M=male, F=female.
Sex code for which this criteria applies. N=both, M=male, F=female.
Sex code for which this criteria applies. N=both, M=male, F=female
Sex of the recipient
Gender of the recipient
Gender of the recipient
Gender of the recipient

Sex of the recipient
Sex of the recipient
Gender of the recipient
Gender of the recipient
Sex of the beneficiary
Sex of the beneficiary
Gender of the recipient
Gender of the recipient
Sex of the beneficiary
Sex of the beneficiary
Sex of the beneficiary
Code describing the gender of an individual. Valid Values: F - Female M Male
This identifies the gender of the provider. Current Valid Values: M = Male F = Female O = Organization N = N/A
Limitation to gender of member.
Sex code for which this criteria applies. N=both, M=male, F=female
It will specify the gender(s) that the PMP will allow to be assigned to them. The valid values are: 'F' for females only, 'M' for males only, and 'B' for both sexes.
Include/Exclude indicator for generic code
Include/Exclude indicator for generic code.
Include/Exclude indicator for generic code sequence
Include/Exclude indicator for generic code sequence.
Code indicating the quality of the address match when assigning latitude and longitude.
This is the code that stores the precision of the address match for the latitude and longitude lookup.
This is the code that stores the precision of the address match for the latitude and longitude lookup.
This is the code that stores the precision of the address match for the latitude and longitude lookup.
Include/Exclude indicator for generic pricing indicator
Include/Exclude indicator for generic pricing indicator.
The Group identitfies whether Call Unit belongs to [R]ecipient, [P]rovider, [G]rievance, [A]ppeal or [O]ther. Valid values are R,P,G,A,O.
The Group identitfies whether Call Unit belongs to [R]ecipient, [P]rovider, [G]rievance, [A]ppeal or [O]ther. Valid values are R,P,G,A,O.
The Group identitfies whether Call Unit belongs to [R]ecipient, [P]rovider, [G]rievance, [A]ppeal or [O]ther. Valid values are R,P,G,A,O.
Code identifying the general category of the payment adjustment.
This is the pharmacy litigation labeler family number. (Values are 0001 - Family 1; 0002 - Family 2; 0003 - Family 3)

This is the pharmacy litigation code for the manufacturer family. (Values are 001 = Legal Family 1; 002 = Legal Family 2; 003 = Legal Family 3)
Code that indicates the group.
Code that indicates the group.
Code used to group claims or recipients
Code used to group claims or recipients.
Code identifying the general category of the payment adjustment (CAGC = Claim Adjustment Group Code).
Dual grouping code that is associated to the claim based on reference table and internal claim star logic.
Eligibility grouping code that is associated to the claim based on reference table.
PHP grouping code that is associated to the claim based on reference table.
A 1-character binary field which contains a value identifying the requested Grouper type. 1 = HCFA, 2 = NY, 4 = CHAMPUS, 8 = NJ, 16 = PA
Version number of the Grouper to be used for DRG assignment. Through version 9, enter the corresponding 1-digit version number. After version 9, use the following coding scheme: A = version 10; B = version 11, and so on.
Indicates the Geographic Service Area of the Health Plan.
The Health Plans' Geographic Service Area at the end of the reporting period.
Clinical Formulation Dosage Unit. For example, tablet, mL, powder, capsule, lozenge.
GS02 value in X12 document.
Identify whether the providers service location has handicap access. Valid values: Y = Yes N = No
Identify whether the providers service location has handicap access. Valid values: Y = Yes N = No
Identify whether the providers service location has handicap access. Valid values: Y = Yes N = No
Transaction Handling Code.
HCAC category returned by the DRG grouper
HCAC category returned by the DRG grouper
The chronic condition for which the eligible person is receiving care.
Indicates the service represents a long-term care based service/support for a chronic condition.
Indicates the service represents a long-term care based service/support for a chronic condition.
A code that classifies home and community based services listed on the claim into the HCBS taxonomy.
A code that classifies home and community based services listed on the claim into the HCBS taxonomy
HFCA (CMS) justification

Code indicating the unit of measure used by CMS. This unit of measure should match the unit of measure being billed by the provider and the unit of measure being used in drug pricing.
Code indicating the unit of measure used by CMS. This unit of measure should match the unit of measure being billed by the provider and the unit of measure being used in drug pricing.
Code indicating the unit of measure used by CMS. This unit of measure should match the unit of measure being billed by the provider and the unit of measure being used in drug pricing.
This data element captures data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44.
This data element captures data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44.
This data element captures data from the HIPAA 837I claim loop 2400 SV206 or UB-04 FL 44.
The HIPAA Health Care Claim Status Codes. Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.
The HIPAA Health Care Claim Status Codes. Claim status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.
The HIPAA Health Care Claim Status Entity Identifier Code.
The HIPAA Health Care Claim Status Entity Identifier Code.
The HIPAA Health Care Claim Status Entity Identifier Code.
Indicates whether edit or audit should be set on the header - 'H', or detail - 'D' of a claim.
Prognosis Code inidcating indicating physician's prognosis for the patient. Component of Home Health Care information.
Certification Type Code. Code indicating the type of certification.
The chronic condition used to determine the individual`s eligibility for the health home provision.
Patient Location Code. AKA Patient Discharge Facility Type Code. Code identifying the location where patient is receiving medical treatment.
Surgical Procedure Code. Code value for describing the surgical procedure.
Hierarchal ingredient code as supplied by FDB. First 3 positions are the HIC3. (Also referred to as GC3; Also referred to as Therapeutic Class, specific).
Pharmacological Class identifier for an active ingredient.
Therapeutic Class identifier for an active ingredient. Also referred as GC3 and Therapeutic Class, Specific.
HIC3 Group ID.
Hierarchical Base Ingredient Code (also referred to as HIC4).
The HIC4, or Hierarchical Base Ingredient Code.
Include/Exclude indicator for HICL
Include/Exclude indicator for HICL.

Indicator for the recipient's Medicare id. Health Insurance claim number of Railroad retirement board claim number. Valid values are H or R.
Code to denote which format the insurance carrier will accept the 837TPL D, P and I transactions in. The valid values will be '4010' for the HIPAA 4010 transactions and '5010' for the HIPAA 5010 transactions.
Code to denote which format the insurance carrier will accept the 837TPL D, P and I transactions in. The valid values for carriers accepting the 837 TPL transactions will be '4010' for the HIPAA 4010 version and '5010' for the HIPAA 5010 version. All other carriers will have a value of spaces.
The code that identifies why a policy was or was not purchased.
The code that identifies why a policy was or was not purchased.
This code identifies which HIPP cost effectiveness process to use.
Values: spaces = not a history record, A = claim recouped
Values: spaces = not a history record, A = claim recouped
Code for the first procedure in a range of procedures used to define audit criteria.
Code for the first procedure in a range of procedures used to define audit criteria.
Code for the first procedure in a range of procedures used to define audit criteria.
Further specifies what type of procedure codes audited against.
Modifier that further defines the type of procedure code to be included in the audit.
Modifier that further defines the type of procedure code to be included in the audit.
Code for the last procedure in a range of procedures used to define audit criteria.
Code for the last procedure in a range of procedures used to define audit criteria.
Code for the last procedure in a range of procedures used to define audit criteria.
Indicates the type of code (revenue or procedure) used in the audit.
Indicates the type of code (revenue or procedure code) used in the audit.
Indicates the type of code (revenue or procedure code) used in the audit.
This code identifies whether a TPL carrier is an HMO or PPO.
This code identifies whether a TPL carrier is an HMO or PPO.
This code identifies whether this carrier is an HMO or PPO.
This code identifies whether this carrier is an HMO or PPO.

Indicates whether additional notices should be generated. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3006 in the column SAK_VALUE_TYPE.
Indicates whether an initial notice should be created. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3005 in the column SAK_VALUE_TYPE.
This is the code that uniquely identifies a reason code used to document Prior Authorization decisions.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or surgical procedure code set is being referenced. The valid values will be '9' for ICD-9, '0' for ICD-10, or blank if corresponding code is not present.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD Procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.

Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_1. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_1 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_1. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_1 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_1. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_1 is 7 '#'s.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 or '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_10. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_10 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_10. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_10 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_11. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_11 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_11. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_11 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_12. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_12 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_12. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_12 is 7 '#'s.

Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_2. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_2 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_2. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_2 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_2. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_2 is 7 '#'s.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis or procedure code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 or '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_3. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_3 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_3. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_3 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_3. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_3 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 or '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_4. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_4 is 7 '#'s.

Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_4. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_4 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_4. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_4 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 or '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_5. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_5 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_5. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_5 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_5. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_5 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 or '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_6. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_6 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_6. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_6 is 7 '#'s.
Code to denote which version of the ICD surgical procedure code set is being referenced by CDE_PROC_ICD9_6. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_PROC_ICD9_6 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_7. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_7 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_7. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_7 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.

Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_8. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_8 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_8. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_8 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_9. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_9 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced by CDE_DIAG_9. The valid values will be '9' for ICD-9 and '0' for ICD-10, and '#' if CDE_DIAG_9 is 7 '#'s.
Code to denote which version of the ICD diagnosis code set is being referenced. The valid values will be '9' for ICD-9 and '0' for ICD-10.
This code maps to the ICF/MR final approval values.
This code maps to the ICF/MR final approval status codes. (ICF/MR SCREEN, ICF MR Approval, ICF/MR Final Approval Status)
This code maps to the ICF/MR pre-approval values.
This code maps to the ICF/MR pre-approval values. (ICF/MR SCREEN, ICF MR Approval, ICF/MR Pre-approval Status)
The transaction control number for the claim.
This control number is assigned by West Lake, Ohio for each county office to determine which return address to print on the envelope for the recipient id card. Not used by OK MMIS.
Identification code for the document.
The id of the user that added the comment.
Patient ID code
Provider ID code
Family member IEVES sent code; S = SENT TO DHR R = RESPONSE RECEIVED
This field identifies the type of image that the image identifier represents. Initially, this will only contain "ICN" but may contain other values in the future.
The unique code used to categorize a recipient, primarily in terms of their family arrangement/status.
The unique code used to categorize a recipient, primarily in terms of their family arrangement/status.
The immigration status of the individual.
Indicates the individual is enrolled in Medicaid pending immigration verification.
This field identifies the type of immunization provided in order to track additional detail not currently contained in CPT codes.
Identifies the type of immunization provided.

Identifies the type of immunization provided.
Identifies the type of immunization provided.
Identifies the type of immunization provided.
Specialty codes that are designated as possible imputed specialty codes
A code indicating the family income level.
Indicates who the income is from. Valid values are A= Applicant, S = Spouse, O = Other, and blank.
Income level used to determine the subsidy. Values are 1 for Individual, 2 for Couple and 9 for n/a.
The type of income for the recipient submitted on the application. This is maintained by the Medicaid AMAES system, but valid values include: A = SSA, B = VA, C = RR, D= FCS Pension, E= Other, F= SSA - VA, G = SSA - RR, H = SSA - FCS, I = SSA - Other, J = VA - RR, K = VA - FCS, L = VA - Other, M = RR - FCS, N = RR - Other, O = FCS - Other, P = SSA - VA - RR, Q = SSA - VA - FCS, R = SSA - VA - Other, S = SSA - RR - FCS, T = SSA - RR - Other, U = SSA - FCS - Other, V = VA - RR - FCS, W = VA - RR - Other, X = VA - FCS - Other, Y = RR - FCS - Other, Z = Black Lung, 1 = BL - SSA, 2 = BL - Other, 3 = BL - SSA - Other, 4 = Rent - SSA, 5 = RT - VA, 6 = RT - RRR, 7 = RT - SSA - VA, 8 = RT - SSA - RRR, 9 = RT - SSA - Other
Indicates the recipient's income type. Valid values: E-Employer; O-Other.
Indicates the recipient's income type. Valid values: E-Employer; O-Other.
Code identifying whether the Aid Category associated with this entry is included (I) or excluded (E).
Code identifying whether the Claim Types associated with this entry are included (I) or excluded (E).
Code identifying whether the Recipient County associated with this entry is included (I) or excluded (E).
Code identifying whether the Diagnosis associated with this entry is included (I) or excluded (E).
Code identifying whether the Drug Code associated with this entry is included (I) or excluded (E).
Code identifying whether the ICD9 Procedure associated with this entry is included (I) or excluded (E).
This is an Include/Exclude indicator used to determine if a claim is to be included or excluded from the billing process. Y=Exclude N=Include
Code identifying whether the Procedure Code associated with this entry is included (I) or excluded (E).
Code identifying whether the Procedure Modifier associated with this entry is included (I) or excluded (E).
Code identifying whether the Provider ID associated with this entry is included (I) or excluded (E).

Code identifying whether the Provider Program associated with this entry is included (I) or excluded (E).
Code identifying whether the Provider Specialty associated with this entry is included (I) or excluded (E).
Code identifying whether the Provider Type associated with this entry is included (I) or excluded (E).
This identifies the type of Indian provider.
This identifies the type of Indian provider.
This identifies the type of Indian provider.
GS08 value of the EDI document.
GS08 value in the EDI file that represents the industry version code.
This field indicates if there was an 835 transaction created for this RA.
Code identifying the relationship between two individuals or entities
Individual Relationship Code indicating the relationship between two individuals or entities. Found in the HIPAA 278 Request and Response Guide in loop 2010C, segment INS, element INS02.
This identifies the type of the indicator for the drug. Valid values include: USM - State MAC update indicator, UFM - Federal MAC update indicator.
Code indicating unit of measure based on the First Data Bank Tape
Status of the ingredient. 0=LIVE, 1=REPLACED, 2=RETIRED. ONLY SUPPLIED BY FDB.
Initial award code; Valid values include: Blank = No longer considered initial award A = first time award of Medicaid eligibility or reactivation after 6 months off Medicaid
Code identifying whether this record is for the Initial (I) or Lag (L) reporting period.
Code identifying whether this record is for the Initial (I) or Lag (L) reporting period.
This tells who is gave us the information for the latest change to this resource.
This tells who is gave us the information for the latest change to this resource.
Input code
This field contains the input and output code values used in back end reporting.
"I" for input, "O" for output. Input variables can be used in a rule's condition. Output variables can be used in rule's action.
I = Input O = Output B = Both
First inquiry code for the provider phone calls.
Valid codes for type of provider phone calls.
Second inquiry code for the provider phone calls.
Third inquiry code for the provider phone calls.
Type of institutional rate. O - Outpatient or I- Inpatient

Code identifying the type of insurance policy within a specific insurance program.
Reference Identification. Insured Group or Policy Number.
The National Association of Insurance Commissioners (NAIC) code of the TPL Insurance carrier.
Code identifying a group of insurance products. Codes maintained in this table are found in the 834 HIPAA Implementation Guide.
Code identifying a group of insurance products. Codes maintained in this table are found in the 834 HIPAA Implementation Guide.
Code to classify the entity providing TPL coverage.
Code to classify the type of insurance plan providing TPL coverage.
This is a hard coded value to signify the records processed against Excluded parties list system (EPLS). Possible values are: 271 - Corresponds to batch processing against the EPLS.
Interim action indicated by worker
Invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have it's own invoice type.
Invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have it's own invoice type.
Invoice Type
Invoice Type
Invoice Type
Invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have it's own invoice type.
Invoice Type
Invoice Type.
Invoice Type
Invoice Type
Invoice Type.
Invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have it's own invoice type.
Invoice Type
Invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have it's own invoice type.
Invoice Type
First invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have its own invoice type.

Second invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have its own invoice type.
Third invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have its own invoice type.
Fourth invoice Type. Each Rebate Program (e.g. Federal, Federal Supplemental, State Program, State Supplemental) will have its own invoice type.
Supplemental Invoice Type.
Interchange Control Header Reserved Use
Code to identify the reason an ID card was issued to the Medicaid recipient.
Indicates IDcard request reason.
Code to identify the reason an ID card was issued to the Medicaid recipient.
Code to identify the reason an ID card was issued to the Medicaid recipient.
Code to identify the reason an ID card was issued to the Medicaid recipient.
Indicates how qualifiers should be joined.
Indicates how qualifiers should be joined.
Kick payment eligibility indicator. Values: spaces = no kick payment, L = Low risk, H = high risk. (this field only applicable to Professional Claims (M))
This code is used to uniquely identify the labeler of a drug. This code is assigned by CMS and is used as the first 5 characters of the labeler's NDCs.
This code is used to uniquely identify the labeler of a drug. This code is assigned by HCFA and is used as the first 5 characters of the labeler's NDCs.
This code is used to identify the labeler of a drug. This code is assigned by CMS and is used as the first 5 characters of the labeler's NDC's.
This is the labeler code that represents this labeler of this drug code. (Values are 0001 - Labeler 1; 0002 - Labeler 2; 0003 - Labeler 3)
This is the labeler code. (0001 - Labeler 1; 0002 - Labeler 2; 0003 - Labeler 3)
This is the labeler code that represents this labeler of this drug code. (Values are 0001 - Labeler 1; 0002 - Labeler 2; 0003 - Labeler 3)
This is the labeler code of the claim. (0001 - Labeler 1; 0002 - Labeler 2; 0003 - Labeler 3)
This is the labeler code that represents this labeler of this drug code. (Values are 0001 - Labeler 1; 0002 - Labeler 2; 0003 - Labeler 3)
This field is a FDB code used to uniquely identify the distributor. This field is independent of the NDC and facilitates the grouping of the NDC's by unique distributor.

This is the CLIA type 5 lab code.
CLIA Lab Certification Code
This is the CLIA type of laboratory. 1 = Independent 2 = Physician-owned
This is a 2-character field that describes the output of the LACS output address.
This is a 2-character field that describes the output of the LACS output address.
This is the unique two character code for each language that the system tracks.
Language code. Valid values: 1 = ENGLISH 2 = SPANISH 3 = OTHER Blank = N/A OR UNKNOWN
A code representing the language of the applicant
This is the unique two character code for each language that the system tracks.
Language type code.
Language type code.
This is the unique two character code for each language that the system tracks.
This is the recipient's primary spoken language.
This is the language that the recipient uses for writen correspondence.
This is the language that the recipient uses for writen correspondence.
This is the HIPAA code for a specific language.
This is the HIPAA code for a specific language.
This is the MMIS code for a specific language. It relates to the cde_lang_primary column on T_RE_BASE.
Indicates the last action relating to TPL done by the worker. A=Add, C=Change, D=Delete
The type or format of the letter generated by the letter request.
Contains code for letterhead.
Contains code for letterhead.
The code inputted by the user to get the text for the letter.
The specific letter actually generated. It may not be the same as the one selected by the legend table.
Step therapy level assigned by the user. The drugs in a STG are classified into levels. The most preferred level in an STG is called "step therapy level A (Stl-A), the next most preferred level is "step level B (STL-B). STL's other than STL-A are called "non-preferred" STL's
Step therapy level assigned by the user. The drugs in a STG are classified into levels. The most preferred level in an STG is called "step therapy level A (Stl-A), the next most preferred level is "step level B (STL-B). STL's other than STL-A are called "non-preferred" STL's
The code assigned to the recipient's level of care.
Identifies the level of care for a recipient.

A two digit code indicating the type and amount of care provided for a recipient in an institution.
A two digit code indicating the type and amount of care provided for a recipient in an institution.
Specifies error handling based on the type of nursing care being provided on the claim.
Code identifying the recipient level of care.
Code identifying the recipient level of care.
Unique value identifying the level of care code
Provider's level of care code.
Identifies the level of care for a beneficiary.
Code indicating the type of service the provider rendered.
Identifies the kind of license or accreditation number captured in LICENSE-OR-ACCREDITATION-NUMBER.
Code identifying the classification of provider license.
Code identifying the classification of provider license.
The state the provider is licensed or certified in.
The state the provider is licensed or certified in.
A type code value which identifies the licensing entity. The valid values are: P - Prescriber; H - Health Board; O - Other.
The license type, typically a licensing agency or board.
The license type, typically a licensing agency or board.
This identifies the licensure. The current valid values are: P = Prescriber, H = Health Board.
Code identifying the licensure board.
This identifies the licensure. The current valid values are: P = Prescriber, H = Health Board.
This identifies the licensure. The current valid values are: P = Prescriber, H = Health Board.
Value 'P' show PA was used to process this claim.
Code indicating type of limitation. Valid values are A-Age, E-Emergency, G-Geographic, P-Population, S-Service.
Communicate why a service line was paid differently than it was billed.
Communicate why a service line was paid differently than it was billed.
Communicate why a service line was paid differently than it was billed.
Communicate why a service line was paid differently than it was billed.
List ID. A unique ID will be assigned for each applicable Benefit Plan.
List ID type as defined in the SureScripts prn guide.
List ID type. FRM=Formulary, ALT=Alternate Therapy, COV=Coverage, COP=Copay.
A code indicating if the individual lives with family or is not a participant in the MFP program. 1 Yes, 2 - No

Claimant's current living arrangement. Valid values include: BLK = N/A A = OWN HOUSEHOLD B = ANOTHER'S HOUSEHOLD C = PARENT'S HOUSEHOLD D = INST TITLE XIX E = HOSPITAL F = INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED
Code indicating the recipient's living arrangement, i.e. state hospital, independent living, etc.
Living Arrangement Code.
Living Arrangement Code.
A code representing the applicant's living situation. Values are: BLANK=N/A A=OWN HOUSEHOLD B=ANOTHER'S HOUSEHOLD C=PARENT'S HOUSEHOLD D=INST TITLE XIX E=HOSPITAL F=ICF FOR MENTALLY RETARDED
HCPCS PROCEDURE CODE TRANSFERRED FROM INPUT
APC ASSIGNED TO HCPCS CODE
LINE ITEM RETURN CODE
APC USED TO DETERMINE PAYMENT - IF NO APC IS ASSIGNED, A VALUE OF 00000 IS ASSIGNED - FOR PARTIAL HOSPITALIZATION CLAIMS, THE PAYMENT APC MAY DIFFER FROM THE APC ASSIGNED TO THE HCPCS CODE
METHOD TO IDENTIFY TYPE OF PRICING WAS USED TO PRICE THE LINE ITEM AP-AMBULATORY PAYMENT CLASSIFICATION (APC) CL-CLINICAL LABORATORY FEE SCHEDULE DM - DURABLE MEDICAL EQUIPMENT PH -PHYSICIAN'S FEE SCHEDULE AM -AMBULANCE FEE SCHEDULE 00 - NOT APPLICABLE
The level of care code associated with a provider's claim.
The recipient level of care that is included or excluded from an audit.
A code that identifies the provider level of care, such as skilled, intermediate, developmentally disabled
A unique code identifying a specific provider level of care
A unique code identifying recipient level of care
Code identifying the recipient level of care where this record was reported.
Code identifying the recipient level of care where this record was reported.
A unique code identifying a specific provider level of care
A code that identifies the provider level of care, such as skilled, intermediate, developmentally disabled.
A code that identifies the provider level of care, such as skilled, intermediate, developmentally disabled.
Recipient's level of care code.
The system code for the level of care.
Identifies the level of care for a recipient.
Identifies the level of care for a recipient.

This is the recipient's level of care code.
This attribute indicates the locality code for a county. Valid values include 01 - Metropolitan, 02 - Urban, 03 - Rural.
This field indicates the locality code for a provider to indicate if the provider practices in an urban, metropolitan, rural, or out-of-state location.
Locality code used to indicate geographical area of practice for a provider. Valid values include 01 - Metropolitan, 02 - Urban, 03 - Rural, 07 - Out-of-state, and 99 - Statewide.
Locality code indicating the geographic location of a provider.
Locality code indicating the geographic location of a provider.
The person who provides the level of care support for this client. (PASRR PRE-ADMISSION SCREEN, Case Information, Local Support); (RESIDENT REVIEW SCREEN, Case Information, Local Support);
Type of location in which a claim can be placed during processing in the MMIS system.
The numeric designation of the district office or central office
Type of location in which a claim can be placed during processing in the MMIS system.
District Office Program code.
District Office Program code.
District Office program code used to identify certain kinds of recipients.
This indicates that the location refers to a recipient or provider. Allowed values are "PROV" and "RECP".
Lock-in code. Valid values: N or blank = Not locked in Y = Locked in, restrictions apply P = Previously locked
Describes the provider type classification for the provider/beneficiary lock-in.
Indicates the reason the recipient was entered into the lockin program
Indicates the reason the recipient exited from the lockin program
This the field that indicate who requested the lockout, the Provider/PMP (P) or the recipient (R).
The initials of the level of care evaluator. (ICF/MR SCREEN, ICF MR Approval, LOC Analyst)
The numeric county code for the county of origin
The numeric designation of the district office or central office. Sample values: 71 - 98 = DISTRICT OFFICES 89 = CENTRAL OFFICE
The level of care evaluator. (PASRR PRE-ADMISSION SCREEN, Case information, LOC Evaluator) ; (RESIDENT REVIEW SCREEN, Case Information, LOC Evaluator);
This is the low value for the range of claim locations to assign to a user for data correction.

The location that the note was sent from.
Indicates if a recipient level of care is included, excluded, or not applicable for a specified audit.
A one or two digit code identifying the Medicaid program for which the claimant is applying or is eligible through the district office
The numeric designation of the worker at either the district office or central office
The level of care required to meet an individual's needs and to determine LTSS program eligibility.
Indicates provider's location status. Values are O - Out of State, I - In State, E - In State Emergency, and D - In State Emergency Dental.
The level of care required to meet an individual`s needs and used to determine program eligibility.
The reason a recipient is no longer authorized to receive the corresponding level of care. (Not Used in OK MMIS)
Code used in the first position of the level of care stop reason.
Code for the second and third position of the level of care stop reason code.
This is the high value for the range of claim locations to assign to a user for data correction.
The location that the note was sent to.
Define the relationship between the left and right conditions.
Allowed values are "AND", "OR", "NOT", and " ".
The value " " indicates that SAK_COMPARISON > 0.
The field represents the status of the logon. Valid values are 'Y' for successful logon and 'N' for unsuccessful logon.
Indicates the status of the job (In Progress, Abend, Complete).
Values D or H. D means the pricing DRG is the discharge DRG. H means the pricing DRG is the HCAC DRG.
Values D or H. D means the pricing DRG is the discharge DRG. H means the pricing DRG is the HCAC DRG.
LTC type. Values: A = (ACT) - Alabama Community Transition model waiver B = elderly and disabled waiver (ADSS) or elderly and disabled waiver (ADPH) H = State of Alabama Independent Living waiver (SAIL) I = Post extended care (PEC) intermediate care for the mentally retarded (ICFMR) - skilled nursing facility P = Program of All-inclusive Care for the Elderly (PACE) R = Mentally Retarded waiver (MR) T = Technology Assistance waiver (TA) X = HIV (530)/waiver Y = Hospice Z = Living at Home Waiver (LAHW)
The code for the category value of the letter type.
The code for the category value of the letter type.
This represents the type of letter to be printed.
This field holds the type of letter that was sent to track which letters are sent.
The identifier of all of the letter types that can be printed.

The code for the letter type value. It identifies the type of letter requested for a case.
Indicates the type of ID card letter. A 'CH' means that the letter is for a recipient whose Medicaid ID has changed (unlinked). An 'LI' means that the letter is for a recipient that has been linked.
The level of care provided to the individual by the long term care facility.
The level of care provided to the individual by the long term care facility.
Level of Care Code that specifies the level of care provided by a nursing home facility. Found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV210).
Code specifying the level of care provided by a nursing home facility found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV120).
Indicates which address should be used for correspondence. Valid values are 'L' (legal), 'T' (technical), and 'I' (invoice). The technical address ('T') is the default mailing address.
Code indicating the address to which the labeler's invoice is being mailed
A code for T-MSIS indicating the individual's maintenance assistance status. See T-MSIS data dictionary Appendix C for a description of coding categories. Note: This data element will be phased out in lieu of ELIGIBILITY-GROUP.
A code indicating the individuals maintenance assistance status.
This is the mandatory voluntary code. This code only applies to regions where the CDE_REGION_TYPE is equal to "E" (enrollment). Valid values for enrollment regions are "M" to indicate a mandatory enrollment, "R" to indicate a rural enrollment region and "V" to indicate a voluntary enrollment region. If the CDE_REGION_TYPE is equal to "C" (capitation) the CDE_MAND_VOL will contain space.
Values: spaces = not a manual cap, F=Force payment, R= manual recoup, H = manual recoup retain history
Values: spaces = not a manual cap, F=Force payment, R= manual recoup, H = manual recoup retain history
Mapped code
Mapper type code
Map version code
The marital status code.
The code used to map to the client's marital status. (PASRR PRE-ADMISSION SCREEN, Case Information, Marital Status) ; (RESIDENT REVIEW SCREEN, Case Information, Marital Status); (ICF/MR SCREEN, Case Information, Marital Status)
The code used to map to the client's marital status.
Indicates the marital status of a recipient. This field will always contain an X in the OK MMIS.

Indicates the marital status of a beneficiary. This field will always contain an X in the KS MMIS.
Indicates the marital status of a recipient. Valid values are: M - Married; D - Divorced; N - Single; S - Separated; W - Widowed.
A code that represents marital status. Sample values include: D=DIVORCED M=MARRIED I=INELIG SPOUSE N=SINGLE (NEVER MARRIED) S=SEPARATED W=WIDOWED BLANK=NOT APPLICABLE
A code representing the claimant's marital status. Valid values are: D = DIVORCED M = MARRIED N = SINGLE S = SEPARATED W = WIDOWED
A code to classify eligible individuals marital/domestic-relationship status.
This is a maintenance assistance status code.
This is a maintenance assistance status code.
Maternity Waiver Exemption information. If the value is non-blank, the recipient is exempt from the Maternity Waiver Program. 3= Exempt from Maternity Waiver for the MW Exemption dates. The Provider may bill for Fee for Service. 4= No Exemption from Maternity Waiver. The provider may bill for Fee for Service.
Mathematical Operation Code
Status of coverage for TPL service class.
This field defines the unit which must be used in conjunction with the Maximum Dose Quantity field. These units are usually expressed as metric strength units.
This field defines the units which must be used in conjunction with the Maximum Dose Quantity field. These units are usually expressed as metric strength units.
This field defines the units which must be used in conjunction with the Maximum Dose Quantity field. These units are usually expressed as metric strength units. The units currently in use are GM=Gram, MG=Milligram, MCG=Microgram, MEQ=Milliequivalent
This field defines the unit of use form which must be used in conjunction with the Maximum Units Quantity field.
This field defines the unit of use form which must be used in conjunction with the Maximum Units Quantity field.
This field defines the unit of use form which must be used in conjunction with the Maximum Unit Quantity field.
Family member status. Valid values include: BLANK = ACTIVE 1 = DENIED 2 = PENDING 3 = DEATH DELETE 4 = REGULAR DELETE 5 = SUSPENDED 6 = INCLUDED IN BUDGET NOT MEDICAID ELIGIBLE 7 = NOT INCLUDED IN BUDGET NOT MEDICAID ELIGIBLE 9 = ACTIVE ON ALLKIDS
The Medicare Claim Number Type Code. Values include: R = Railroad Number Z = Pseudo Number Blank = Other
Medicare type. Valid values are: M - Medicare and D - DMERC.
Medicare type, valid values are M (Medicare) and D (DMERC).
A code denoting Medicare coverage status

Medicare Coverage Code
A code denoting Medicare coverage status
A code to distinguish various addresses that a managed care entity may have.
Code of the group.
Code identifier for the entity
Code value of the Managed Care program status code group.
The ANSI County numeric code for the county or county equivalent.
The type of managed care plan that corresponds to the MANAGED-CARE-PLAN-ID on the T-MSIS plan type segment.
The type of managed care plan that corresponds to the MANAGED-CARE-PLAN-ID.
The type of managed care plan that corresponds to the MANAGED-CARE-PLAN-ID.
A code denoting the profit status of managed care entity.
The state program through which a managed care plan is approved to operate.
This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.
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This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.
This is the code that identifies a region (or Managed Care coverage area) of the state. A region is made up of different geographical areas such as zip codes, counties, or the entire state.
The area under which the managed care entity is under contract to provide services.
The service class indicates the type of services provided.

The service class indicates the type of services provided.
The service class indicates the type of services provided.
The service class indicates the type of services provided.
Major Diagnostic Category for the pricing DRG code
This is a two byte code field used to identify a MDC. The MDC code and description are supplied by HCIA.
Major Diagnostic Category for the pricing DRG code
A code representing the providers Medicaid and/or CHIP enrollment status.
The state plan with which a provider has an affiliation.
Code identifying the broad category to which a measurement applies. Valid values are: OG - Original Starting Dosage and TR - Test Results.
Unit or Basis for Measurement Code found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV204).
Code specifying the service units found in the HIPAA 278 Request and Response Guide in the SV1Professional Service segment; element (SV103).
Code.
This field contains the media of the report. P-printer, E-email, etc.
Code.
Code.
Code.
Media used to send Drug Labeler Invoice Information. Valid values are blank for paper and "D" for 3 1/4" diskettes. Note: All invoices are always produced on paper as well as the alternate format if requested.
Code indicating the media type in which the labeler is receiving their invoice
Code for type of media output allowed (Paper, Email, Fax, or Other).
Code for type of media output allowed (Paper, Email, Fax, or Other).
This represents the media type used by the provider or IFSSA when communicating with the Prior Authorization unit. The types of media are telephone, fax and mail.
This represents the media type in which Prior Authorization communications are received by EDS. The valid types are mail, telephone and fax.
A code for T-MSIS indicating the individual's most recent Medicaid eligibility for the month (not including CHIP). Note: This data element will be phased out in lieu of ELIGIBILITY-GROUP.
Indicates the individuals most recent Medicaid eligibility for the month (not including CHIP)
NCPDP field 360-2B, Two character State Postal Code indicating the state where Medicaid coverage exists.

This code represents if the recipient is enrolled in Medicare Part A or Medicare Part B or Both. The valid codes are (A=Medicare Part A ; B=Medicare Part B; Y = Medicare Part A and B; N=Not Enrolled in Medicare).
This code represents if the recipient is enrolled in Medicare Part A or Medicare Part B or Both. The valid codes are (A=Medicare Part A ; B=Medicare Part B; Y = Medicare Part A and B; N=Not Enrolled in Medicare).
This code represents if the recipient is enrolled in Medicare Part A or Medicare Part B or Both. The valid codes are (A=Medicare Part A ; B=Medicare Part B; Y = Medicare Part A and B; N=Not Enrolled in Medicare).
This code represents if the recipient is enrolled in Medicare Part A or Medicare Part B or Both. The valid codes are (A=Medicare Part A ; B=Medicare Part B; Y = Medicare Part A and B; N=Not Enrolled in Medicare).
A code that represents SSA Medicare eligibility status. Valid values include: Blank = Medicaid only 0 = Previous buyin state no longer paying Medicare premiums 1 = Potentially eligible for Medicare - Medicaid sets this 2 = Eligible for SSA Medicare parts A & B; part A is free, state pays part B 3 = Eligible for SSA Medicare (state only pays part B) 4 = Eligible for SSA Medicare; part A is free, no part B 5 = Verified as not eligible for Medicare 6 = Eligible for SSA Medicare parts A & B (both paid by state)
For dual eligible (DET) record, this field indicates the presence of Medicare Part A and/or Part B entitlement during the benefit month, For LIS record, it indicates the A/B entitlement during first month of subsidy period as given in Part D approved or disapproved date. Valid values are Y or N.
For dual eligible (DET) record, this field indicates the presence of Medicare Part D enrollment during the benefit month, for LIS record this indicates the enrollment during first month of subsidy period as given in Part D approved/disapproved date. Valid values are Y or N.
Type of Medicare ID Values are H: HICN = SSN based old IDs M: MBI = new Medicare Beneficiary ID
A code indicating if the recipient is enrolled in Medicare Part A, Part B, both or neither.
This code indicates the type of Medicare Reimbursement.
This code indicates the type of Medicare Reimbursement.
This code indicates the type of Medicare Reimbursement.
This code indicates the type of Medicare Reimbursement.
CLM07 Loop 2300 Provider Accept Assignment Code. Code indicating whether the provider accepts assignment. INDUSTRY: Medicare Assignment Code. Valid values: A - Assigned; B - Assignment Accepted on Clinical Lab Services Only; C - Not Assigned; P - Patient Refuses to Assign Benefits (valid only for 4010).

CLM07 Loop 2300 Provider Accept Assignment Code. Code indicating whether the provider accepts assignment. INDUSTRY: Medicare Assignment Code. Valid values: A - Assigned; B - Assignment Accepted on Clinical Lab Services Only; C - Not Assigned; P - Patient Refuses to Assign Benefits (valid only for 4010).
CLM07 Loop 2300 Provider Accept Assignment Code. Code indicating whether the provider accepts assignment. INDUSTRY: Medicare Assignment Code. Valid values: A - Assigned; B - Assignment Accepted on Clinical Lab Services Only; C - Not Assigned; P - Patient Refuses to Assign Benefits (valid only for 4010).
This field (Medical Record Number) allows the provider to input data to identify the individual patient to whom services where provided. This number is not required for processing (information only).
This field (Medical Record Number) allows the provider to input data to identify the individual patient to whom services where provided. This number is not required for processing (information only).
The code representing the Medical Record Number.
The code for the Medical Record Number.
This field (Medical Record Number) allows the provider to input data to identify the individual patient to whom services where provided. This number is not required for processing (information only).
Medical Record Number
Medical Record Number.
Medical Record Number
Medical Record Number.
Code representing the Medical Record Number.
Code representing the Medical Record Number.
Medical Support Code.
Medical Support Code.
A choice of encounter or fee for service.
A code indicating if the individual lives with family or is not a participant in the MFP program.
Describes reason why individuals participation in the Money Follows the Person Demonstration ended.
A code describing type of qualified institution at the time of transition.
A code indicating the type of qualified residence.
Describes the reason why individual was re-institutionalized after participation in MFP Demo

Identifies the managed care program of the recipient. List of valid managed care plans and their description can be found in table T_PUB_HLTH_PGM.
Medicare Inpatient Adjudication - Remark Code This reference identification is the Health Care Financing Administration claim payment remark code.
Medicare Inpatient Adjudication - Remark Code.
Medicare Inpatient Adjudication - Remark Code.
Medicare Inpatient Adjudication - Remark Code.
Medicare Inpatient Adjudication - Remark Code.
The absent parent?s branch of service code.
This is the Military status of the absent parent. Recommended values are 'A' - Active, 'D' - 100% DAV, 'E' - MEPCOM Enlistee, 'N' - National Guard, 'R' - Retired, 'V' - Reserve, 'X' - Other, 'Z' - Unknown, Space - Not Military
A file ending that denotes the file's content. Often called its "MIME" type. Some examples would be ".Z", ".txt", ".doc", and ".xls". The first character in this filed should always be a period.
A file ending that denotes the file's content. Often called its "MIME" type. Some examples would be ".Z", ".txt", ".doc", and ".xls". The first character in this filed should always be a period.
This field provides the quantitative value for the minimum pediatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field defines the units which must be used in conjunction with the Minimum Dose Quantity field. These units are usually expressed as metric strength units.
This field defines the units which must be used in conjunction with the Minimum Dose Quantity field. These units are usually expressed as metric strength units.
This field defines the unit of use form which must be used in conjunction with the Minimum Unit Quantity field.
This field defines the unit of use form which must be used in conjunction with the Minimum Unit Quantity field.
This field defines the unit of use form which must be used in conjunction with the Minimum Unit Quantity field.
A code used in claims processing, such as Employee Identification, School Identification or Pickup time (HHMM). The information on this attribute is determined on the qualifier QLF_MISC_TYPE.
Mismatch Reason Code. Values are the following: 1 - TIN Missing 2 - TIN Not Issued 3 - TIN is Incorrect
Mismatch Reason Code Values are the following: 1 - TIN Missing 2 - TIN Not Issued 3 - TIN is Incorrect
This code maps to the MI determination code that the LOCEU received verbally.
This code maps to the MI determination code that the LOCEU received verbally. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Verbal Dtrm)

This code maps to the MI determination code that the LOCEU received verbally. Resident Review Screen, Resident Reviews, MI Verbal Determination)
The analyst at the LOCEU who received and processed the call for the level II MI. (PASRR PRE-ADMISSION SCREEN, Determinations, MI Verbal Received By)
MME Alert Identifier
Medicare Outpatient Adjudication - Remark Code.
Medicare Outpatient Adjudication - Remark Code.
Medicare Outpatient Adjudication - Remark Code
Medicare Outpatient Adjudication - Remark Code
Medicare Outpatient Adjudication - Remark Code
Procedure modifier
Procedure modifier.
This is the first modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the first modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the second modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the second modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the third modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the second modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the forth modifier. (00 - Service with no replacement; Space - No modifier specified)
This is the forth modifier. (00 - Service with no replacement; Space - No modifier specified)
Code used to further define a procedure provided.
Code used to further define a procedure provided.
The first of four possible codes that may be used to supplement the procedure code.
Procedure code modifier 1
Two byte character that represents the second of the modifier code(s) that will be used in selection.
The second of four possible codes that may be used to supplement the procedure code.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Pricing modifier used to identify the appropriate UCC rate for a procedure modifier combination.
This is the second modifier code which supplies additional information on the procedure code.

This is the second modifier code which supplies additional information on the procedure code.
Code used to further define a procedure provided.
Procedure code modifier 2
Two byte character that represents the third of the modifier code(s) that will be used in selection.
The third of four possible codes that may be used to supplement the procedure code.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
The modifier code used to further describe a procedure.
This is the third modifier code which supplies additional information on the procedure code.
This is the third modifier code which supplies additional information on the procedure code.
Code used to further define a procedure provided.
Two byte character that represents the fourth of the modifier code(s) that will be used in selection.
The fourth possible code that may be used to supplement the procedure code.
Code used to further define a procedure provided. The fourth modifier field on the claim detail.
Code used to further define a procedure provided.
This contains the fourth modifier field on the claim detail.
The modifier code used to further describe a procedure.
Code used to further define a procedure provided. The fourth modifier field on the claim detail.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Code used to further define a procedure provided.
Indicates the type of editing necessary for the procedure/modifier combination. Valid values are 'A' (Allowed), 'N' (Not Allowed), or 'R' (Required). An 'A' indicates the modifier is allowed to be billed with the procedure. An 'N' indicates the modifier can not be billed with the procedure. An 'R' indicates the modifier is required to bill the procedure. If more than 1 'required' modifiers exist for a procedure, the claim only needs 1 of the required modifiers be billed.
The lower range of modifier restrictions. Modifiers in the From/To range can not be billed on the same claim detail as the value in CDE_PROC_MOD

The modifier code used to further describe a procedure.
This field corresponds to Field 5 on the NCCI data, containing the Modified Indicator. The valid values are: 0, 1, 9. Please refer to the NCCD documentation for a more detailed description of this field.
This field corresponds to Field 5 on the NCCI data, containing the Modified Indicator. The valid values are: 0, 1, 9. Please refer to the NCCD documentation for a more detailed description of this field.
The upper range of modifier restrictions. Modifiers in the From/To range can not be billed on the same claim detail as the value in CDE_PROC_MOD
The modifier code used to further describe a procedure.
This is a one-character code that defines the move type for NCOA record. Possible valid values for NCOA record are: I - Individual match; F - Family match; B - Business match. For a CASS record, this column will have a value for name type. P - Personal name; B - Business name.
This is a one-character code that defines the move type for NCOA record. Possible valid values for NCOA record are: I - Individual match; F - Family match; B - Business match. For a CASS record, this column will have a value for name type. P - Personal name; B - Business name.
This code maps to the MR determination code that the LOCEU received verbally.
This code maps to the MR determination code that the LOCEU received verbally. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Verbal Dtrm)
This code maps to the MR determination code that the LOCEU received verbally. (Resident Review Screen, Resident Reviews, MR Verbal Determination)
The analyst at the LOCEU who received and processed the call for the level II MR. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Verbal Received By)
A code which classifies an associated messaged number.
An indicator describing the logged message. Value of "I" will indicate an incoming transaction (P4 response) and a value of "O" will indicate an outgoing transaction (P4 request).
A code representing the MSP status. Valid values are: Q = QMB L = SLIMB, L, Q1, Q2, OR W
MSP location county code
MSP location D.O. code
MSP location program code
MSP location district office worker code
QMB/SLIMB application status. Valid values include: BLK=N/A A=AWARD D=DENIED P=PENDING T=TERMINATED
Indicates multiple surgery service payment adjustment rules to use for pricing.
Indicates multiple surgery service payment adjustment rules to use for pricing.

Maternity waiver action code. Valid values include: BLK = N/A D = Denied R = Rescinded O = Other
Unisys' provider name type
Distinguishes the type of entity identifiers from one another.
Distinguishes the type of entity identifiers from one another.
Distinguishes the type of entity identifiers from one another.
This is the NCOA action code that defines the type of NCOA match. Possible valid values are: I - Individual Move; M - Family Move; O - Business Move.
This is the NCOA action code that defines the type of NCOA match. Possible valid values are: I - Individual Move; M - Family Move; O - Business Move.
This is the 2-byte NCOA return code.
This is the 2-byte NCOA return code.
The code assigned by NCPDP for the conflict.
Reason for Service Code.
The code assigned by NCPDP for the conflict.
The code assigned by NCPDP for the conflict.
The code assigned by NCPDP for the conflict.
NCPDP conflict code
NCPDP conflict code
The code assigned by NCPDP for the conflict. Refer to the NCPDP Conflict table for codes and their descriptions.
Reason for Service Code
The code assigned by NCPDP for the DUR conflict.
Reason for Service Code.
National Drug Code prescribed/dispensed to a recipient.
The national drug code for the drug dispensed.
The national drug code for the drug dispensed.
National Drug Code for a unique Drug. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and service/prior authorization.
National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and prior authorization.
National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and prior authorization.

National Drug Code is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and a 2 byte numeric package code. Used to uniquely identify a drug, it's labeler & package size of a product for pricing and service/prior authorization. ZZZZZZZZZZZ to include all codes.
The National Drug Code used to identify each drug.
The National Drug Code used to identify each drug. All of the possible values for CDE_NDC can be found on the T_DRUG table.
The National Drug Code is comprised of a 5 byte numeric product labeler code, a 4 byte numeric product code, and a 2 byte numeric package size code. It is used to uniquely identify a drug.
The National Drug Code used to identify each drug
This is the National Drug Code. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
This is the National Drug Code. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
This is the National Drug Code. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
This the Nation Drug Code. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
This is the national drug code of the drug. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
This is the National Drug Code. Values are 00012220000 - Drug 1; 00002000102 - Drug 2.
National Drug Code.
Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.
Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size. The NDC is represented in an 11-digit 5-4-2 format: A 5 digit labeler code, a 4 digit product code and a 2 digit package code.
National Drug Code prescribed/dispensed to a recipient.
The National Drug Code for the drug device or medical supply covered by this claim.
The National Drug Code for the drug device or medical supply covered by this claim.
The National Drug Code for the drug device or medical supply covered by this claim.
The National Drug Code for the drug device or medical supply covered by this claim.

The NDC Format Indicator (NDCFI) is used to identify the original 10-character format of the NDC and the type of code, such as NDC, UPC, and HRI. See the "National Drug Code Configuration Editorial Policies" and "National Drug Code Format Indicator Editorial Policies" in the NDDF documentation for further discussion.
The NDC Format Indicator (NDCFI) is used to identify the original 10-character format of the NDC and the type of code, such as NDC, UPC, and HRI. See the "National Drug Code Configuration Editorial Policies" and "National Drug Code Format Indicator Editorial Policies" in the NDDF documentation for further discussion.
The first NDC in a range of codes
The beginning range of the National Drug code which is comprised of a 5 byte numeric labeler code, 4 byte numeric product code and 2 byte numeric package code
This is the NDC. The EDI specification allows for a larger data element to be captured.
Include/Exclude indicator for NDC
Include/Exclude indicator for NDC.
This field contains either the jcode or the ndc for the icn detail, depending on it's claim type.
Indicates whether drug code is prescription only - R, or Non-Legend - spaces.
Indicates whether drug code is prescription only or non-legend.
Indicates whether drug code is prescription only or Non-legend.
submitted NDC for HIPAA 835
The last NDC in a range of codes.
The ending range of the National Drug Code.
The unit of measure for each corresponding quantity value.
The unit of measure for each corresponding quantity value.
The unit of measure for each corresponding quantity value.
Part A no entitlement code
Part B no entitlement code
The code value to map to the nursing facility disposition. The action taken by the nursing facility as a result of an assessment.
The code value to map to the nursing facility disposition. The action taken by the nursing facility as a result of an assessment. (PASRR PRE-ADMISSION SCREEN, Determinations, NF Disposition)
The action pertaining to the nursing facility that is taken for a client as a result of an assessment.

The code value to map to the nursing facility disposition. The action taken by the nursing facility as a result of an assessment. (Resident Review Screen, Resident Reviews, NF Disposition)
Nursing Home Residential Status Code. Code specifying the status of a nursing home resident at the time of service. Found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV209).
Identifies an ICD procedure as a nonspecific procedure. Nonspecific procedures are used by providers when more precise information is not obtainable.
Code identifying the functional area or purpose for which the note applies
The unique code for the note type.
The unique code for the note type.
1st or 2nd Notice Indicator. Values are the following: 1 - 1st Notice 2 - 2nd Notice blank - default
1st or 2nd Notice Indicator Values are the following: 1 - 1st Notice 2 - 2nd Notice blank - default
These codes identify the type of notification to a supervisor or a higher level resolution clerk. Example, e-mail, system-alert, fax, phone.. etc
Notification Preferences eg: Email, System Tray, Fax, Web Svc..etc
Status code to indicate in the error has been resolved. 'A' for an active error that is not resolved. 'I' for inactive for an inactive error that has been resolved.
NPI code of the healthcare providers.
The National Drug Code (NDC) Price Type.
The National Drug Code (NDC) Price Type.
Identifies the equivalency ratings assigned to an approved prescription product according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).
Orange Book Code (3-Byte version) identifies the equivalency ratings assigned to approved prescription products according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).
Orange Book Code (3-Byte version) identifies the equivalency ratings assigned to approved prescription products according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).
D=Daily, W= Weekly, M=Monthly,
D=Daily, W= Weekly, M=Monthly,
The code defining a significant event relating to the bill that may affect the claims processing.
Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.
Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.

Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.
Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.
A code to describe specific event(s) relating to this billing period covered by the claim.
A code to describe specific event(s) relating to this billing period covered by the claim.
A code to describe specific event(s) relating to this billing period covered by the claim.
Code which defines a significant event relating to a particular UB92 claim that may affect payer processing.
Code which defines a significant event relating to an institutional claim that may affect payer processing (1 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (2 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (3 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (4 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (5 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (6 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (7 of 8).
Code which defines a significant event relating to an institutional claim that may affect payer processing (8 of 8).
Identifies the county office within county.
County office that the recipient lives near.
County office that the beneficiary lives near.
The county office within the recipient's county of residence.
County office number within county
The county office of service on the PS/2 transaction.
Recipient's county office of service on the PS/2 transaction.
The county office of service on the PS/2 transaction.
Recipient's county office of service on the PS/2 transaction.
The county office of service on the PS/2 transaction
Official status code
Indicates if the provider is O - Out of State, Y - Out of State Youth, E - In-state Emergency or I - In-state.
The type of operating authority through which the managed care entity receives its contract authority.
Type of operating authority through which the managed care entity receives its contract authority.
The Provider Taxonomy of the provider who performed an operation on the patient.

Indicates the claim is an Opioid claim. Values: N - Naive Opioid Claim. O - Opioid Claim. R - Refill of a naive claim exempted from script limit X - Claims with oncologist as prescribing provider are exempted from MME limit.. Blank - Not an Opioid claim.
Indicates the claim is an Opioid claim. Values: N - Naive Opioid Claim. O - Opioid Claim. R - Refill of a naive claim exempted from script limit. X - Claims with oncologist as prescribing provider are exempted from MME limit. Blank - Not an Opioid claim.
Indicates the claim is an Opioid claim. Values: N - Naive Opioid Claim. O - Opioid Claim. R - Refill of a naive claim exempted from script limit. X - Claims with oncologist as prescribing provider are exempted from MME limit. Blank - Not an Opioid claim.
Indicates the claim is an Opioid claim. Values: N - Naive Opioid Claim. O - Opioid Claim. R - Refill of a naive claim exempted from script limit. X - Claims with oncologist as prescribing provider are exempted from MME limit. Blank - Not an Opioid claim.
Indicates the claim is an Opioid claim. Values: N - Naive Opioid Claim. O - Opioid Claim. R - Refill of a naive claim exempted from script limit. X - Claims with oncologist as prescribing provider are exempted from MME limit. Blank - Not an Opioid claim.
Opioid Base Ingredient Identifier that represents the base ingredient code of a given active ingredient
Opioid Base Ingredient Identifier
Opioid Base Ingredient Identifier that represents the base ingredient code of a given active ingredient
Opioid Base Ingredient Identifier
Opioid Strength Unit of Measure (UCUM). For example, mg, %, ug.
Opioid Strength Unit of Measure
Code identifying the type of the Other Payer ID.
Code identifying the type of the Other Payer ID.
A code to indicate the type of pharmacy.
Proprietary nature of a provider's practice. Values: "1" = individual, "2" = partnership, "3" = corporation, etc.
This code identifies the proprietary nature of a provider's practice. (1-Individual, 2-Partnership, 3-Corporation, etc.)
This code identifies the proprietary nature of a provider's practice. (1-Individual, 2-Partnership, 3-Corporation, etc.)
This code identifies the proprietary nature of a provider's practice. (1-Individual, 2-Partnership, 3-Corporation, etc.)
This code identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.

This code identifies the source of TPL coverage information or the source of changes to existing TPL coverage information.
This is who told us about the coverage the very first time.
This is who told us about the coverage the very first time.
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.
Code indicating whether or not the patient has other insurance coverage.
Code indicating whether or not the patient has other insurance coverage.
A code representing the frequency at which the family member receives income from an unearned source. Valid values are: W = WEEKLY B = BIWEEKLY S = SEMI MONTHLY M = MONTHLY Q = QUARTERLY H = SEMI ANNUALLY A = ANNUALLY
A code representing the source of the family member other income. Example values are: 1 = Social Security (include Medicare premiums) 2 = SSI (Gold check) 3 = Public Assistance (Welfare) 4 = Railroad Retirement QT = Qualified Income Trust
Other Subscriber Gender
Other Insured Gender Code. Valid values are F - - Female, M - Male, U - Unknown
Other Subscriber Gender
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates that claim has other third party resource collection activities in progress.
Indicates how to handle the possible types of failure of an edit or audit (full failure or cutback).
This code indicates the Type of Outlier Code or DRG Source.
Type of outlier. D = Day. C = Cost.
Type of outlier. D = Day. C = Cost.

An indicator identifying who was billed for the A/R.
An indicator identifying who was billed for the A/R.
A T-MSIS code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list.
Denotes the ownership interest and/or managing control information.
Indicates the type of ownership provider has. The valid values are stored in the T_REF_CDE_VALUE_GROUP where SAK_VALUE_TYPE=201.
Code indicating the type of certification. Valid values are I - Initial, R - Renewal, S - Revised
Code indicating the conditions under which a patient was tested. Valid values are E - Exercising, R - At rest on room air, S - Sleeping
CODE DEFINITION - Dependent edema suggesting congestive heart failure. Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%.
CODE DEFINITION - "P" Pulmonale on Electrocardiogram (EKG) Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%.
CODE DEFINITION 3 Erythrocythemia with a hematocrit greater than 56 percent Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%.
The paid day. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 109.
The frequency expenses are paid. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 108.
The paid frequency. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 108.
The unique payment level code for the DSSProfiler payment level. Valid values are H for header and D for detail.
Identifies who has put the Panel on hold (ind_panel_hold = Y). Valid values: A - Agency, P - Provider, H - HP and N - No hold on panel.
The parent name of a element in a schema.
The parameter type.
The parameter type.
Part Code Identifier.
Part Code Identifier.
Identifies the source of the update. 'W' for window, 'B' for batch and 'M' for MMA response file.
History database partition ID.
The database partition the claim is located on

Identifies to system where to look for history claims; AIM is segmented into partitions of history so that no single partition is too large.
Unique identifier for the entity type specified by the qualifier. INDUSTRY: Other Payer Primary Identifier ALIAS: Other Payer Primary Identification Number SYNTAX: P0809 NSF Reference: DA0-07.0 This number must be identical to SVD01 (Loop ID-2430) for COB.
Contains the accretion code of Part A Buyin. This field is being stored and passed to DSS for the customer's querying needs. There is not a valid value list for the accretion or deletion codes. These are used by the customer and simply passed to DSS for the customer to be able to run queries.
Contains the deletion code of Part A Buyin. This field is being stored and passed to DSS for the customer's querying needs. There is not a valid value list for the accretion or deletion codes. These are used by the customer and simply passed to DSS for the customer to be able to run queries.
Contains accretion code of Part B Buyin. This field is being stored and passed to DSS for the customer's querying needs. There is not a valid value list for the accretion or deletion codes. These are used by the customer and simply passed to DSS for the customer to be able to run queries.
Contains the deletion code of Part B Buyin. This field is being stored and passed to DSS for the customer's querying needs. There is not a valid value list for the accretion or deletion codes. These are used by the customer and simply passed to DSS for the customer to be able to run queries.
Describes why individuals participation in the Money Follows the Person Demonstration ended. 01Completed 365 days of Participation,02 Suspended Eligibility, 03 Reinstitutionalized, 04 Died, 05 Moved, 06 No Longer Needed, 07 Other
Part Indicator Code.
Code indicating the part sequence.
Code indicating the part sequence.
This code maps to the PASRR which is the call made by MR/MI authorities on mental illness/mental retardation.
This code maps to the PASRR which is the call made by MR/MI authorities on mental illness/mental retardation. (PASRR PRE-ADMISSION SCREEN, Determinations, PASRR Code)
The call made by MR/MI authorities on mental illness / mental retardation.
This code maps to the PASRR which is the call made by MR/MI authorities on mental illness/mental retardation. Resident Review Screen, Resident Reviews, PASRR Code)
Code identifying the location of the patient when receiving pharmacy services.

NCPDP field 384-4X, Code identifying the patient's place of residence. Values are 0 - Not Specified, 1- Home, 2 - Skilled Nursing Facility, 3 - Nursing Facility, 4 - Assisted Living Facility, 5 - Custodial Care Facility, 6 - Group Home, 7 - Inpatient Psychiatric Facility, 8 - Psychiatric Facility, 9 - Intermediate Care Facility/Mentally Retarded, 10 - Residential Substance Abuse, 11 - Hospice, 12 - Psychiatric Residential Treatment Facility, 13 - Comprehensive Inpatient Rehab Facility, 14 - Homeless Shelter, 15 - Correctional Institution.
CLM - Patient Signature Code.
The patient status code indicates the reason for discharge or that there was no discharge from a hospital or long term care facility at the end of the billing period.
The patient status code indicates the reason for discharge or that there was no discharge from a hospital or long term care facility at the end of the billing period.
Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Patient Status Code.
Indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Identifies status of patient, whether discharged, still a patient, transferred, for example.
Code which indicates the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Indicates the Patients status as of the ENDING-DATE-OF-SERVICE.
A code indicating the patients status as of the ENDING-DATE-OF-SERVICE.
Nature of Condition Code. Code indicating the nature of the patient's condition.
OI - Code identifying how the patient or subscriber authorization signatures were obtained and retained by the provider
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.

A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.
Unique char value for payee types defined within financial.
A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.
Unique char value for payee types defined within financial.
Unique char value for payees. P = provider R = recipient O = Other C = carrier L = lien holder Y = county
A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
This is the code that identifies what type of person or organization is being used. The following are the valid values : C - TPL Carrier, O - Other, R - Recipient, Y - County, P - Provider.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
Unique char value for payee types defined within financial.
A type code value which categories the payees. The valid values are: P - Provider; R - Recipient; L - Lien Holder; C - TPL Carrier; H - HIPP Resource; L - Drug Labeler; O - Other.
This is the code that identifies what type of person or organization is being used. The following are the valid values : C - TPL Carrier, O - Other, R - Recipient, Y - County
Unique char value for payee types defined within financial.
Type of TPL Entity being reported. Currently SubContractor or Carrier are the valid types
Indicates if a FINANCIAL PAYER from a recipient is included, excluded, or not applicable for a specified audit.
Indicates if a FINANCIAL PAYER from a recipient is included, excluded, or not applicable for a specified audit.
Code identifying the insurance carrier's level of responsibility for payment of a claim
Code indicating the reason the drug rebate invoice is paid
The reason that the NDC was paid.

Method of payment code: NON (non payment), CHK (Check), EFT (Electronic Funds)
This field stores the code of the cash receipt payment type.
This field stores the code of the cash receipt payment type.
This code is used to determine if the payment will be made by interChange or by an external system to interChange. (I = Internal, E = External)
This is an Exclude/Include code denoting that the list of associated condition codes is excluded or included, respectively.
The frequency at which the day care amount is paid. Values are: W = WEEKLY B = BI-WEEKLY M = MONTHLY
A code representing the frequency at which the premium is paid. Valid values are: W=WEEKLY M=MONTHLY Q=QUARTERLY A=ANNUAL BLANK
This is an Exclude/Include code denoting that the list of associated modifiers is excluded or included, respectively.
This is an Exclude/Include code denoting that the list of associated occurrence codes is excluded or included, respectively.
This specifies if the reason is for payments or recoupments.
Code field to store an 'E' for EFT, 'T' for State Transfer, or 'C' for check. Used to designate the payment type.
Code field to store an 'E' for EFT, 'T' for State Transfer, or 'C' for check. Used to designate the payment type.
This is the code of the payment type (ie. EFT, check, transfer) .
This represents the Prior Authorization assignment code used to batch PA requests.
This represents the Prior Authorization assignment code used to batch PA requests.
GROUP OF PA ASSIGN CODES.
This is the Prior Authorization Psychiatric diagnosis code, as defined by the account. This field is not an ICD9 diagnosis, but an indicator.
This is the Prior Authorization psychiatric diagnosis code, used to identify the PA.
This represents the decision status of a Prior Authorization line-item.
This represents the status of a Prior Authorization line-item. Status is used interchangeably with 'decision'.
Unisys' prior authorization status code
Unisys' prior authorization status code
Unisys' prior authorization status code
NCPDP field 461-EU, Prior Authorization Type Code. A code indicating the data type of the response to the Prior Authorization question code. Values include "0" - Not Specified, "1" - Prior Authorization, "4" - Exemption from Copay and/or Coinsurance, "8" - Payer Defined Exemption, "9" - Emergency Preparedness.

NCPDP field 461-EU, Prior Authorization Type Code. A code indicating the data type of the response to the Prior Authorization question code. Values include "0" - Not Specified, "1" - Prior Authorization, "4" - Exemption from Copay and/or Coinsurance, "8" - Payer Defined Exemption, "9" - Emergency Preparedness.
NCPDP field 461-EU, Prior Authorization Type Code. A code indicating the data type of the response to the Prior Authorization question code. Values include "0" - Not Specified, "1" - Prior Authorization, "4" - Exemption from Copay and/or Coinsurance, "8" - Payer Defined Exemption, "9" - Emergency Preparedness.
Unisys' prior authorization type
Unisys' prior authorization type
Personal benefits coverage type
PCCM exempt code that shows the person is not eligible for the Patient First Plan for the reason code indicated. Values include: CA = Cancer EC = Extenuating Circumstances FC = Foster Care IN = Institutionalized MC = Specialized Medical Care OT = Other Reason PI = Personal Income SC = Stem Cell TP = Transplant
Plastic card address change code; same values as plastic card reason code
Most current plastic card history code; same values as plastic card code.
Next most current plastic card history code; same values as plastic card code.
Most current plastic card returned history code; same values as plastic card returned code.
Next most current plastic card returned history code; same values as plastic card returned code.
Most current plastic card reason history code; same values as plastic card reason code.
Next most current plastic card reason history code; same values as plastic card reason code.
This code identifies the type of PDP plan such as HMO, PPO.
This code identifies the type of PDP plan such as HMO, PPO.
This code identifies the type of PDP plan such as HMO, PPO.
The Package Description Mnemonic is the abbreviated description of the package.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.

This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
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This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This is a one byte key field used to identify a peer group for DRG pricing. The peer group code and description are determined by the State.
This field indicates the peer group for a provider's service location.
This field indicates the peer group for a provider's service location.
This field indicates the peer group for a provider's service location.
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Recipient Peer Group
Provider Specialty
Provider Specialty
Indication of whether performing provider specialty is included, excluded, or not in the audit criteria. The valid values are "I" - Include, "E" - Exclude, and space - "NONE".
Include/Exclude indicator for performing provider type. The valid values are "I" - Include, "E" - Exclude. and space - "NONE".
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
A unique value that identifies the financial period type in the system.

A unique value that identifies the financial period type in the system.
MME Strength Per Dosage Unit provides a total MME per dosage form. If the Clinical Formulation contains an ingredient with two different salts then results in this field is a sum of both.
This is a code that represents the program grouping.
This is a code that represents the program grouping.
Code identifies the type medical assistance program that should be included in the selection.
Code indicating who is eligible and what types of services are provided.
The code indicating recipient's benefit plan. List of valid recipient benefit plans and their description can be found in table T_PUB_HLTH_PGM.
The code indicating recipient's benefit plan. List of valid recipient benefit plans and their description can be found in table T_PUB_HLTH_PGM.
Identifies the benefit plan of eligible recipients. List of valid recipient benefit plans and their description can be found in table T_PUB_HLTH_PGM.
Identifies the medical assistance program that is supported in the system. Valid values are from T_PUB_HLTH_PGM.
The health plan id of the associated claims that were part of this measure.
The identifier for the health plan.
The Health Plan identifier.
The unique identifier for a health plan.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
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Code identifying the medical assistance program.

Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Code identifying the medical assistance program.
Identifies the medical assistance program that is supported in the system.
Identifies the medical assistance program that is supported in the system.
This is the current lock-in assignment plan for the recipient.
Program Status Code
Program Status Code
Program Status Code
The Program Status Code that is assigned to the recipient.
The program status code adds more information to the eligibility defined by the program code (stored as cde_aid_category in interChange).
The program status code adds more information to the eligibility defined by the program code (stored as cde_aid_category in interChange).
Program Status Code
Code indicating who the phone belongs to or what type of phone it is.
Type of phone number. The valid values are: OF - Office, CE - Cell, FA - Fax, HO - Home, TO - Toll-Free.
This code maps to the telephone types.
This code maps to the telephone types.
This code maps to the telephone types.
NCPDP field 147-U7, The type of service being performed by a pharmacy. Values are 1 - Community/Retail Pharmacy, 2 - Compounding Pharmacy, 3 - Home Infusion Therapy Provider, 4 - Institutional Pharmacy, 5 - Long Term Care Pharmacy, 6 - Mail Order Pharmacy, 7 - Managed Care Organization Pharmacy, 8 - Specialty Care Pharmacy, 99 - Other.
Value used to identify the classification of the Public Health Service (PHS) or Indian Health Service (IHS) provider
Value used to identify the classification of the Public Health Service (PHS) or Indian Health Service (IHS) provider
The hour during which the patient was picked up for transportation-based physician claims. HHMM format.
The Package Description Code indicates the drug product's packaging, stored by the healthcare provider.

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.
Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.
The place of service code representing the location where the dental treatment was rendered.
The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.
NCPDP field 307-C7, Code identifying the place where a drug or service is dispensed or administered. For code values, refer to the External Code List document located at I:\2010 Enhancement Implementation Project (EIP)\5010 Project\NCPDP.
The place of service code representing the location where the dental treatment was rendered.
The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.
A code indicating where the service was performed. CMS 1500 values are used for this data element.
The Managed Care plan code assigned to the claim. For example: ZZZ = Medicaid
This is the plan code. (C00 - Plan 1; ZZZ - Regular visits)
Plan Code Valid Values: P = PCNA R = RCO
Plan District Code Valid Values: Blank, A, B, C, D, E
Internal system code referencing the type of insurance plan
Indicates what the district information row represents. MC = Maternity Care, MCINP = Maternity Care Inpatient, PHP = PHP, EV = Evacuee. MCINP are Maternity Care entries for INPATIENT claim type. MC and MCINP rows must be kept in sync if MCINP not ended.
Internal system code referencing the type of insurance plan
Plastic card code; Values: R - REQUEST CARD(OLD) S - SENT CARD I - ISSUE REPLACEMENT C - SENT REPLACEMENT F - FORCE NEW CARD X - SENT FORCED CARD Blank = N/A
Plastic card return code. Valid values: Blank = n/a E = returned card resent K = card returned due to address problem N = card returned- recipient deceased S = card returned- name change requested T = card returned- sent to wrong person U = card returned- no longer Medicaid eligible V = card returned- sent replacement card X = original card in RIU Z = returned card destroyed by RIU

The reason for issuing or re-issuing a plastic card. Valid values include: Blank=N/A; A=never rec'd card; B=Lost card; C=Card was stolen; D=Damaged or Destroyed; F=Change in name; G=Change in sex; H=Change in race; I=Change to DOB; J=Change in Med#; 1=New card; 2=Awarded Eligibility; 3=Elig re-awarded; 4=New Medicaid #; 5=Left Nursing home
Unique code that identifies the focus.
A T-MSIS code to indicate the type of policy owner.
This code identifies the relationship of the policy holder to the Medicaid/CHIP beneficiary.
The policy owner's social security number.
This code identifies whether the policy owner is a Recipient or a Policyholder.
Stores the TPL policy prefix.
This code identifies the type of insurance policy that the recipient is covered under.
This code identifies whether the recipient's resource is private pay insurance or state paid insurance.
Unique key. Valid values are: - T - M - P
Code from T_CDE_PORT.
A code to indicate where the service was provided.
Location where service was rendered.
Place of medical assistance service code.
Code which indicates the location where service was rendered.
Location where service was rendered.
The Place of Service for which the diagnosis code is valid or invalid. There is an indicator that will indicate whether the POS is valid or not.
Code representing the place of service which should be included or excluded from limitations.
Code which indicates the location where service was rendered.
Location where service was rendered.
Code indicating where a service was rendered.
Code indicating where a service was rendered.
Place of medical assistance service code.
Code that indicates where the dental services were rendered.
Location where service was rendered.
Place of medical assistance service code.
Place of medical assistance service code.
Place of medical assistance service code.
Place of medical assistance service code.

Setting where service was rendered (i.e. Office, Home, Inpatient Hospital, Outpatient Hospital, etc.). Valid values are maintained on the Place of Service Entity.
Code that indicates where the medical services were rendered.
Location where service was rendered.
This is the board position code.
This is the board position code.
Indicates the two-digit delivery point portion of the delivery point barcode.
Indicates the two-digit delivery point portion of the delivery point barcode.
Include/Exclude indicator for place of service
Include/Exclude indicator for place of service.
Submitted place of service for HIPAA 835.
Submitted place of service for HIPAA 835.
Indicates preferred method of billing. The valid values are: N - None, C - CD and P - Paper.
Indicates the preferred method to deliver bulletins. The valid values are: N - None, E - Email, F - Fax, P - Paper.
Indicates the preferred method of contact. The valid values are: 0 - Email, 1 - Mail, 2 - Phone and 3 - Not Specified.
Preference level for this Drug's alternate therapy, applicable when an NDC has more than 1 alternate NDC. Valid values are 1-99 where higher numbers indicates more preferred.
Preference level for this Drug's alternate therapy, applicable when an NDC has more than 1 alternate NDC. Valid values are 1-99 where higher numbers indicates more preferred.
A code indicating the Medicare program associated with the premium amount. Valid values are A (Medicare Part A) and B (Medicare Part B).
Part A premium payer
Part B premium payer
Indicates the type of prescriber that was submitted on the claim. Valid values are "01" - NPI, or "08" - State License.
Indicates the type of prescriber that was submitted on the claim. Valid values are "01" - NPI, or "08" - State License.
Indicates the type of prescriber that was submitted on the claim. Valid values are "01" - NPI, or "08" - State License.
The unique identification number assigned by the pharmacy or supplier to the prescription
Prescription code identifier of this NDC.
This code indicates the area of specialty for the PRESCRIBING PROVIDER.
The taxonomy code for the medical provider writing the prescription
A code describing the type of entity prescribing the drug device or supply

Recipient's status prior to current status. This will be blank on new records. Valid values are: BLK = ACTIVE 0 = SOBRA PAYEE ONLY-NOT MEDICAID; HAS SOBRA APPL. PAYEE DATA 1 = DENIED D.O. OR SOBRA APPLICATION 2 = PENDING SOBRA OR D.O APPLICATION; OR SSI FUTURE ELIGIBILITY (SEE SSI-BEGIN-DATE) 3 = DEATH DELETION 4 = REGULAR DELETION 5 = SUSPENDED
This is the pricing action code. (1 - Pricing at Cost; 2 - Pricing with Sale cost)
The is the type of ID that is being used in the Primary ID field. This is typically (DFT) Default, (NPI), (MCD) Medicaid.
A code indicating the language the individual speaks other than English at home
A code indicating the level of spoken English proficiency by the individual
Indicates if details that fail this edit/audit should produce a paper worksheet or appear on the edit list report.
This field corresponds to Field 5 on the NCCI database, containing the Prior Rebundled Code Indicator. An '*' designates rebundled prior to 1996 edits. A blank space shows the code was rebundled 1/1/1996 or later.
Priority of Request Designated By User. (1=High, 2=Medium, 3=Low)
Priority code used by HP to determine when to add/change eligibility segments.
Depicts the priority level assigned to the research request or project on an account level. (High, Medium, Low)
Priority code is used by the Medicaid Agency to indicate the hierarchy between aid categories so that eligibility can be properly updated.
Priority code is used by the Medicaid Agency to indicate the hierarchy between aid categories so that eligibility can be properly updated.
Priority code is used by the Medicaid Agency to indicate the hierarchy between aid categories so that eligibility can be properly updated.
First denial/termination/liability code for the application. These codes are maintained by the AMAES system. Example values are: 01 - VA contract covers medical expenses 4F - Failure to provide verification of burial / life insurance 40 - You are no longer paying an insurance premium
Second denial/termination/liability code for the application. These codes are maintained by the AMAES system.
Prior district office code
Prior program code
Prior reviewer code
Prior application status. Valid values are: A=AWARD P=PEND D=DENIED T=TERMINATION BLANK
Private managed care code. Values are: SPACE = N/A H = HOSPITAL

A code representing the frequency at which the applicant receives parental support alimony. Valid values are: W = WEEKLY B = BI-WEEKLY S = SEMI-MONTHLY M = MONTHLY Q = QUARTERLY H = SEMI-ANNUALLY A = ANNUALLY
Five byte code that specifies a service rendered to a recipient.
A code from the MA fee schedule to indicate the service performed.
The HCPCS procedure code billed for the service performed.
Six byte code that specifies a service rendered to a recipient.
Procedure Code
The HCPCS procedure code billed for the service performed.
Code that identifies the service performed for a recipient.
The HCPCS procedure code billed for the dental service performed.
Procedure Code
This is the procedure code. (Values are 00200 - Operation 3 - dissect; 00300 - Bone removal)
Code which indicates a specific surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.
Code used to identify a medical, dental, or DME procedure.
Procedure code for this waiver service.
The Procedure Code found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-2).
Five byte code that specifies a service rendered to a recipient.
Code used to identify a medical, dental, or DME procedure.
Code used to identify a medical, dental, or DME procedure.
The procedure code is a five character code that identifies the service performed.
This column corresponds to Field 1of the NCCI MUE data. This procedure code contains the procedure code to which the MUE should be applied. The codes for this column come from the table t_proc.cde_proc.
This column corresponds to Field 1of the NCCI MUE data. This procedure code contains the procedure code to which the MUE should be applied. The codes for this column come from the table t_proc.cde_proc.
Code based on ICD-9/CM, CPT, HCPCS or ICD-10-PCS identifying procedures performed on this claim.
A ICD-9/CM CPT HCPCS or ICD-10-PCS that identify the principal procedure performed on this claim.
Code which indicates the service that was performed.
First operating room procedure that influenced DRG assignment. This field will be blank if no operating room procedure influenced DRG assignment.

Second operating room procedure that influenced DRG assignment. This field will be blank if no operating room procedure influenced DRG assignment.
Procedure Code identifying the service provided.
This column hold the code, which indicates the reason for provider contract closure/reopen. EG --> Contract closed due to group provider contract closure. RM --> Contract was reopened manually. Blank --> Contract closed by normal deactivation process.
Indicates if the request has been processed yet or not. Valid values are 'U' for unprocessed and 'P' for processed.
The level where the process should execute. Values are 'C' for Claim and 'I' for Invoice Type and 'R' for Rates.
The level where the process should execute. Values are 'C' for Claim and 'I' for Invoice Type and 'R' for Rates.
This indicator tells financial how to process the claim within financial. "H" = History Only, "R" = Report Only, "A" = Standard adjustment processing, "C" = Cash adjustment
This field is used to indicate what type of process the expenditure should go through. This was formerly ind_manual.
M = manual process, where a physical check was cut outside of MMIS and a system entry must be made without generating a payment.
D = Immediate process, this would be the same as a daily check cycle. It means that the expenditure must get processed as soon as possible.
R = Regular process. This would indicate that the expenditure is to go through the normal financial cycle(s).
This field is used to indicate what type of process the expenditure should go through. This was formerly ind_manual.
M = manual process, where a physical check was cut outside of MMIS and a system entry must be made without generating a payment.
D = Immediate process, this would be the same as a daily check cycle. It means that the expenditure must get processed as soon as possible.
R = Regular process. This would indicate that the expenditure is to go through the normal financial cycle(s).
Indicates whether code is system assigned (S) or manual assigned (M), or both (B).
A code indicating the service performed (1 of 23).
A code indicating the service performed (10 of 23).
A code indicating the service performed (11 of 23).
A code indicating the service performed (12 of 23).
A code indicating the service performed (13 of 23).
A code indicating the service performed (14 of 23).
A code indicating the service performed (15 of 23).
A code indicating the service performed (16 of 23).
A code indicating the service performed (17 of 23).

A code indicating the service performed (18 of 23).
A code indicating the service performed (19 of 23).
A code indicating the service performed (2 of 23).
A code indicating the service performed (20 of 23).
A code indicating the service performed (21 of 23).
A code indicating the service performed (22 of 23).
A code indicating the service performed (23 of 23).
A code indicating the service performed (3 of 23).
A code indicating the service performed (4 of 23).
A code indicating the service performed (5 of 23).
A code indicating the service performed (6 of 23).
A code indicating the service performed (7 of 23).
A code indicating the service performed (8 of 23).
A code indicating the service performed (9 of 23).
This column corresponds to Field 1 on the NCCI data. This procedure code represents the "MORE IMPORTANT" service that should be paid when the code pair is billed together. The codes for this column come from the table t_proc.cde_proc.
This column corresponds to Field 1 on the NCCI data. This procedure code represents the "MORE IMPORTANT" service that should be paid when the code pair is billed together. The codes for this column come from the table t_proc.cde_proc.
This column corresponds to Field 2 on the NCCI data. This procedure code represents the "LESS IMPORTANT" service that should be denied when the code pair is billed together. The codes for this column come from the table t_proc.cde_proc.
This column corresponds to Field 2 on the NCCI data. This procedure code represents the "LESS IMPORTANT" service that should be denied when the code pair is billed together. The codes for this column come from the table t_proc.cde_proc.
Classification of group responsible for the adjudication of claims.
Processing department code used to derive a specific location for dispositioning.
A flag that identifies the coding system used for the PROCDURE-CODE.
A flag that identifies the coding system used for the PROCDURE-CODE.
Code for the first procedure in a range of procedures used to define audit criteria.
The beginning range of a code used to identify a medical, dental, or DME procedure.
The start of a HCPCS dental procedure code range used to assign a grouping code.
Code that identifies the first procedure code used in duplicate checking in the MMIS system.
Claim search beginning procedure code
Code which represents the surgical procedure code.

Code which indicates a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.
Code which represents the surgical procedure code.
First (primary) surgical procedure code.
Second surgery code.
Third surgery code.
Fourth surgery code.
Fifth surgery code.
Sixth surgery code.
An indicator used to specify if the procedures defined by SAK_PROC_TYPE should be included ('I') or excluded ('E').
Two byte character that represents the first modifier code(s) that will be used in selection.
Further specifies what type of procedure codes should be included in an audit. This code applies to both the beginning and ending procedures in the range.
The Modifier Code used to further describe a procedure.
The modifier code used to further describe a procedure.
Code used to further define a procedure provided.
Pricing modifier used to identify the appropriate max fee for a procedure modifier combination.
Procedure Code
The modifier code used to further describe a procedure.
Code used to further define a procedure provided.
The modifier code used to further describe a procedure.
The first Procedure Code Modifier found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-3).
This is the procedure code modifier of the Prior Authorization.
Code used to further define a procedure provided.
Pricing modifier used to further identify the appropriate prevailing charge for a procedure/locality/specialty combination.
Pricing modifier used to further identify the appropriate prevailing charge conversion factor for a locality/specialty/modifier combination.
The modifier code used to further describe a procedure.
Procedure modifier to further refine the entry.
The modifier code used to further describe a procedure.
This is the first modifier code which supplies additional information about the procedure code.
Indicates the technical or professional component of a procedure. A blank will identify a global service. A modifier of 26 will identify professional component and a TC will identify technical component.

Indicates the technical or professional component of a procedure. A blank will identify a global service. A modifier of 26 will identify professional component and a TC will identify technical component.
Modifier for the procedure code
Further clarifies a procedure.
The modifier code used to further describe a procedure.
This is the modifier which identifies what type of abnormality is present.
The modifier code used to further describe a procedure.
This is the first modifier code which supplies additional information on the procedure code
This is the first modifier code which supplies additional information on the procedure code
This is the first modifier code which supplies additional information on the procedure code
The modifier code used to further describe a procedure.
This is the first modifier code which supplies additional information on the procedure code.
Code used to further define a procedure provided.
The procedure code modifier used with the (Principal) Procedure Code 1.
The procedure code modifier used with the (Principal) Procedure Code 1.
The first HCPCS procedure code modifier billed for the service performed.
Code used to further define a procedure provided.
The first HCPCS procedure code modifier billed for the service performed.
Original procedure modifier 1. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.
submitted Procedure Modifier1 for HIPAA 835
Submitted Procedure Modifier1 for HIPAA 835.
submitted Procedure Modifier1 for HIPAA 835
The second HCPCS procedure code modifier billed for the service performed.
Code used to further define a procedure provided.
The second HCPCS procedure code modifier billed for the service performed.
Pricing modifier used to identify the appropriate max fee for a procedure modifier combination.
This is the second procedure code modifier of the Prior Authorization.
The modifier for the corresponding procedure code.

Original procedure modifier 2. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.
submitted Procedure Modifier2 for HIPAA 835
Submitted Procedure Modifier2 for HIPAA 835.
submitted Procedure Modifier2 for HIPAA 835
The third HCPCS procedure code modifier billed for the service performed.
Code used to further define a procedure provided.
The third HCPCS procedure code modifier billed for the service performed.
The modifier code used to further describe a procedure.
This is the third procedure code modifier of the Prior Authorization.
The modifier for the corresponding procedure code.
Original procedure modifier 3. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.
submitted Procedure Modifier3 for HIPAA 835
Submitted Procedure Modifier3 for HIPAA 835.
submitted Procedure Modifier3 for HIPAA 835
The fourth HCPCS procedure code modifier billed for the service performed.
Code used to further define a procedure provided.
The fourth HCPCS procedure code modifier billed for the service performed.
The modifier code used to further describe a procedure.
This is the fourth procedure code modifier of the Prior Authorization.
The modifier for the corresponding procedure code.
Original procedure modifier 4. Will be NULL if the original modifier was not changed. If the original modifier was changed, this column will retain the value of the original modifier before it was changed.
submitted Procedure Modifier4 for HIPAA 835
Submitted Procedure Modifier4 for HIPAA 835.
submitted Procedure Modifier4 for HIPAA 835
First modifier for this waiver service.
Second modifier for this waiver service.
The second Procedure Code Modifier found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-4).
Third modifier for this waiver service.
The third Procedure Code Modifier found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-5).

The fourth Procedure Code Modifier found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-6).
Include/Exclude indicator for procedure modifier
Include/Exclude indicator for procedure modifier.
The procedure that ClaimCheck was the original submitted procedure.
The procedure that ClaimCheck indicates should replace the submitted procedure.
The service that ClaimCheck indicates should replace the submitted service.
This is a 2-character field that describes the result of the output quality.
This is a 2-character field that describes the result of the output quality.
submitted Procedure Code for HIPAA 835
Submitted Procedure Code for HIPAA 835.
submitted Procedure Code for HIPAA 835
Code for the last procedure in a range of procedures used to define audit criteria.
The ending range of a code used to identify a medical, dental, or DME procedure.
The end of a HCPCS dental procedure code range used to assign a grouping code.
Code that identifies the last procedure code used in duplicate checking in the MMIS system.
Indicates the ending value range of the procedure code. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV301-8).
Claim search ending procedure code
International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors). MJ Minutes UN Unit Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.
The program associated with the recipient. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3007 in the column SAK_VALUE_TYPE.
Code indicating special Medicaid program under which the service was provided.
Code indicating special Medicaid program under which the service was provided.
Code indicating special Medicaid program under which the service was provided.
Code indicating special Medicaid program under which the service was provided.
Indicates if a program from a recipient is included, excluded, or not applicable for a specified audit.

Indicates if a program from a recipient is included, excluded, or not applicable for a specified audit.
Recipient's projected status as provided by the Alabama Medicaid Agency.
Recipient's projected status as provided by the Alabama Medicaid Agency.
Prosthesis, crown or inlay code. Code specifying the placement status for the dental work
Prosthesis, Crown or Inlay Code. Code specifying the placement status for the dental work. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV305).
A code to identify the kind of provider identifier captured in the PROV-IDENTIFER.
The type of practice for a provider.
This is an identifier for the attending provider on an institutional claim. This may be a license ID or some other agreed upon provider identifier.
The code values from the categorization schema identified in the PROV-CLASSIFICATION-TYPE element.
A code to identify the schema used to categorize providers.
Process by which a provider was enrolled in Medicaid.
The type of facility for the servicing provider using the HIPAA provider taxonomy codes.
The type of facility for the servicing provider using the HIPAA provider taxonomy codes.
Code identifying the type of Provider ID - 'MCD', 'NPI' or 'BSE'.
Type of Provider ID.
Type of Provider ID.
Type of Provider ID
The type of address that is stored in the this address segment.
Identifies the medical assistance programs that a provider can enroll in.
A T-MSIS code denoting the profit status of the provider.
A code denoting the profit status of the provider.
The individuals biological sex.
Code which indicates the scope of practice or operations of the provider that will be used in selection.
A code representing the specialized area of practice for a provider.
Provider specialty code that should be included or excluded for audit criteria.
A code representing the specialized area of practice for a provider.

This is the provider specialty that will get the banner message.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
Provider specialty code
A code representing the specialized area of practice for a provider.
A value used to indicate the scope of practice for the provider type.
A code representing the specialized area of practice for a provider.
This code identifies the type of specialty a provider performs.
A designation indicating the scope of practice or operations of the provider type.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the billing provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
This is the provider's specialty.
A value used to indicate the scope of practice for the provider type.
A value used to indicate the scope of practice for the provider type.
A value used to indicate the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
A value used to indicate the scope of practice for the provider type.

Code describing the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
A value used to indicate the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
A value used to indicate the scope of practice for the provider type.
Code describing the scope of practice for the provider type.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
The provider specialty selected for payment hold.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the billing provider.
Code which indicates the scope of practice or operations of the billing provider.
A code representing the specialized area of practice for a provider.
Code indicating a provider's medical specialty.
Code indicating a provider's medical specialty.
A code representing the specialized area of practice for a provider.
This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
The Health Care Specialty.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.

A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A designation indicating the scope of practice or operations of the provider type.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
The provider specialty identifies the type of practice performed, for example, pediatrics, obstetrics, ear nose and throat.
Provider specialty code that the restriction is for. ZZ means all provider specialties.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the rendering provider.
Code which indicates the scope of practice or operations of the billing provider.
This code indicates that services, rendered by providers under these specialties, are not covered under the resource.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
Unisys' provider specialty code
Unisys' provider specialty code
Two byte integer value for the specialty of the billing provider. Highest value possible 256 in HEX format.
Specialty code of the rendering provider.
Two byte integer value for the specialty of the billing provider.
Two byte integer value for the specialty of the billing provider.
Two byte integer value for the specialty of the rendering provider. Highest value possible 256 in HEX format.
Two byte integer value for the specialty of the billing provider. Highest value possible 256 in HEX format.

Indicates whether and what type of provider specialty editing is to be performed for the procedure during claims processing. An 'N' indicates not editing is to be performed. An 'I' (Include) indicates only the provider specialty listed are acceptable. An 'E' (Exclude) indicates the listed provider specialties cannot bill the procedure. Provider Specialties for editing are listed on the T_PROV_SPEC_LIM entity.
Two byte integer value for the specialty of the performing provider. Highest value possible 256 in HEX format.
A code representing the specialized area of practice for a provider.
A code representing the specialized area of practice for a provider.
This field contains the provider specialty which is the main focus of the provider's practice. Each provider type must have a primary specialty and the primary specialty must be one of the provider's existing specialties.
Provider's status.
A designation indicating the scope of practice or operations of the provider within a provider specialty.
A designation indicating the scope of practice or operations of the provider within a provider specialty.
A designation indicating the scope of practice or operations of the provider within a provider specialty.
A designation indicating the scope of practice or operations of the provider within a provider specialty.
This field is the provider super specialty, which means the are more than one specialty within this group that make up one super specialty.
Referring Provider Taxonomy. The providers specialty.
Type that a provider is licensed for.
Type that a provider is licensed for or 'ZZ' to indicate all provider types should be used in selection.
Type that a provider is licensed for.
Provider type
Type that a provider is licensed for.
Provider type used as selection criteria for the associated check banner.
Type that a provider is licensed for.
The Provider Type Code that a provider is licensed for.
Provider type code
A value used to describe the services a provider is licensed to perform.
Type that a provider is licensed for.
This code identifies the type of provider.
This is the provider type that a provider is licensed for.
The provider type the analyst is allowed to work on.

Provider type.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Type that a provider is licensed for.
Type that a provider is licensed for.
Type that a provider is licensed for.
This is the provider type.
This is the provider type.
This is the provider type.
Identifies the type of provider.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Code describing the services a provider is licensed to perform.
Type that a provider is licensed for.
Type that a provider is licensed for.
The provider type selected for payment hold.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.

Type that a provider is licensed for.
The provider type which is set to constant "ALL".
Provider type which can submit the claim type on the record.
Type that a provider is licensed for.
Type that a provider is licensed for.
Type that a provider is licensed for.
Indicates the type of health care services rendered by this Provider.
Type that a provider is licensed for.
Type that a provider is licensed for.
Type that a provider is licensed for.
This is the provider type that a provider is licensed for.
Type that a provider is licensed for.
Type that a provider is licensed for.
This is the provider type that a provider is licensed for.
Provider type that the restriction is for. ZZ means all provider types.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
Code which indicates the provider type for which a provider is licensed.
This code indicates services, rendered by these provider types, are not covered under the resource.
Type that a provider is licensed for.
Type that a provider is licensed for.
Type that a provider is licensed for.
Unisys's provider type
Unisys's provider type
Type that a provider is licensed for.
Code which indicates the billing provider type for which a provider is licensed.
Code which indicates the performing provider type for which a provider is licensed.
Type that a provider is licensed for.
Store field 419-DJ (Prescription Origin Code). Values include "0" - Not Known, "1" - Written, "2" - Telephone, "3" - Electronic, "4" - Facsimile.
Store field 419-DJ (Prescription Origin Code). Values include "0" - Not Known, "1" - Written, "2" - Telephone, "3" - Electronic, "4" - Facsimile.
Store field 419-DJ (Prescription Origin Code). Values include "0" - Not Known, "1" - Written, "2" - Telephone, "3" - Electronic, "4" - Facsimile.

CLM - Provider Agreement Code. Code indicating the type of agreement under which the provider is submitting this claim.
From range for the provider specialty used to limit the report.
Reason code for end dating the t_pr_identifier segment.
Reason code for end dating the t_pr_identifier segment.
This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.
This is used to designate the role of the provider in the claim against which this criteria should apply. Valid codes are "B" for billing; "P" for performing; "R" for referring. For example, if the code is "B" then the Provider Type/Specialty of the Billing Provider will be used to match against the restriction in this table.
This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.
This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.
This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.
This code represents the provider role on the claim. For example, a value of BILL REPRESENTS THE BILLING PROVIDER ON THE CLAIM.
This is the code used to identify the Provider Specialty. A value of "000" will be used to designate any specialty.
To range for the provider specialty used to limit the report.
This is the code used to identify the Provider Type. A value of "00" will designate any type.
Include/Exclude indicator for provider type
Include/Exclude indicator for provider type.
Part A reason code
Part A status code
Part B reason code
Part B status code
This code will state whether the type/specialty combination will be excluded (E) or included(I) in the restriction.
Indicates if a provider is a private or public organization/practice. Valid values are: "B" = public and "V" = private.
This indicator will identify whether a provider is a private or public organization/practice. Valid values are: B - Public, V - Private
Indicates if the Billing Provider of this claim is a private or public organization / practice. Valid values are: "B" = public and "V" = private.
This indicates whether the provider is public (B) or private (V).

This indicator will identify whether a provider is a private or public organization/practice. Valid values are: B: Public V: Private
This indicator will identify whether a provider is a private or public organization/practice. Valid values are: B: Public V: Private
This indicator will identify whether a provider is a private or public organization/practice. Valid values are: B: Public V: Private
This is the reason that a payment can be pulled for manual review.
This is the reason that a payment can be pulled for manual review.
This is the reason that a payment can be pulled for manual review.
This is the payment method to be used when paying the authorized service.
Indicates whether post partum is estimated, actual or computer generated. M=automatic flip to Plan First services, P=post partum estimated by EDC date, R=actual date of birth reported by claimant
Indication of whether matching should be done on quadrant between the current and history claim. Values are (C)omplete, (I)nclusive, (P)artial and (E)xclusive
Indication of whether matching should be done on quadrant between the current and history claim. Values are (C)omplete, (I)nclusive, (P)artial, and (E)xclusive.
The quadrant of the mouth that the procedure on the claim is related to.
The first quadrant of the mouth that the procedure on the claim is related to. This could also indicate other mouth areas such as mandibular or maxillary.
The quadrant of the mouth that the procedure on the claim is related to.
The quadrant of the mouth that the procedure on the claim is related to.
The second quadrant of the mouth that the procedure on the claim is related to. This could also indicate other mouth areas such as mandibular or maxillary.
The third quadrant of the mouth that the procedure on the claim is related to. This could also indicate other mouth areas such as mandibular or maxillary.
The fourth quadrant of the mouth that the procedure on the claim is related to. This could also indicate other mouth areas such as mandibular or maxillary.
The fifth quadrant of the mouth that the procedure on the claim is related to. This could also indicate other mouth areas such as mandibular or maxillary.
Qualified trust indicator. Values are 01 - 27, DI, QT, NI, NC, or blank

A code describing type of qualified institution at the time of transition. 01 Nursing facility, 02 ICF/MR, 03 IMD, 04 - Other
Code indicating the type of qualified residence.01 Home owned by participant, 02 Home owned by family member, 03 Apartment leased by participant, not assisted living, 04 Apartment leased by participant, assisted living, 05 Group home of less than 5 people
Indicates the sequence of the qualifier.
Indicates the sequence of the qualifier.
Indicates if the qualifier has a single or multiple parts.
Qualifier code identifying numerator or denominator.
Qualifier code identifying numerator or denominator.
This code identifies to whom a TPL questionnaire is sent.
This tells us who we have sent the questionnaire to when we have marked the resource as suspect.
Code describing the race of an individual. Each position of this field can contain a different race code.
Code that will map to a specific race.
Code that will map to a specific race or combination of races. The values are: BLACK '2', ASIAN '4', HISPANIC '5', INDIAN '3', OTHER '6', UNKNOWN '9'.
Code that will map to a specific race.
Code that will map to a specific race.
A code value indicating the race of the recipient.
Code that will map to a specific race.
The race of the applicant
The race of the family member
The ethnicity of the recipient.
The recipients' race code at the end of the reporting period.
Indicates the recipients race code at the end of the reporting period.
This is the race code of the recipient.
This is the race code of the recipient.
This is the race code of the recipient.
This is the race code of the recipient.
The code that maps to a specific race. (PASRR PRE-ADMISSION SCREEN, Case Information, Race) ; (RESIDENT REVIEW SCREEN, Case Information, Race); (ICF/MR SCREEN, Case Information, Race);
The code that maps to a specific race.
Code that will map to a specific race or combination of races.
The beneficiary's first race code.
Code that will map to a specific race.
A code indicating the individuals race
This is the HIPAA code for a specific race.

This is the HIPAA code for a specific race.
This is the MMIS code for a specific race. This relates to the CDE_RACE column in T_RE_BASE.
Documents the race of the recipient when they identify as Other Asian, Other Pacific Islander, Other
Indicates whether the recipient is a railroad retiree. R = Railroad, Blank = NA.
This field contains the high value in a range of drug, revenue, or procedure codes for which a restriction exists for a provider.
This field contains the low value in a range of generic drug, revenue, or procedure codes for which a restriction exists for a provider.
The type of range to assigned. Examples include check ('C')or EFT ('E').
The type of range to be assigned. Examples include check ('C')or EFT ('E').
Each managed care rate cell has a code.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
This the unique code value that represents a code rate type. Code rate types are state, federal, local agencies.
This the unique code value that represents a code rate type. Code rate types are state, federal, local agencies.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.

Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
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Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
Code used to identify the rate type to use in determining provider reimbursement.
The overpayment reason. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3008 in the column SAK_VALUE_TYPE.
This is the reason code for the assignment plan.
This is the reason code for the assignment plan.
The reason code used to assist in recipient auto-assignment. AA - No valid PMP choices; BB - Pend for manual assign; CC - BA Assistance required; EE - Redetermination date > 30 days; FF - Recipient has Medicare
This is the recipient's status in the enrollment process. This status will indicate if the recipient has been sent an enrollment packet, is ready to be enrolled etc.
This code identifies the reason the restriction was placed on the resource.
This code identifies the type of coverage that a TPL policy provides.
REASON CODE: 1 DENIED, 2 RETURNED TO PROVIDER, 3 SUSPEND, 4 LINE ITEM REJECTED , 5 LINE ITEM DENIED

REASON CODE: 1 DENIED, 2 RETURNED TO PROVIDER, 3 SUSPEND, 4 LINE ITEM REJECTED , 5 LINE ITEM DENIED
A four digit code assigned to describe the reason for setting up the accounts receivable.
A four digit code assigned to describe the reason for setting up the accounts receivable.
The unique fourd digit code to define the AR disposition reasons.
Unique code assigned to the reason.
Unique code assigned for the reason. This code is used as the accounts receivable EOB on the RA.
Code used to track the reason a transaction is done.
Code used to track the reason a transaction is done.
Code indicates why a rebate invoice detail was written off
A reason code which describes why a drug rebate detail was written off
Indicates the reason for which an expenditure is added to the system.
Indicates the reason an expenditure is added to the system.
Indicates the reason an expenditure is added to the system.
Indicates the reason for which an expenditure is added to the system.
A four digit code assigned to describe the reason for setting up the accounts receivable.
A four digit code assigned to describe the reason for setting up the accounts receivable.
The unique four digit code to define the AR disposition reason.
Code used to track the reason a transaction is done.
A four digit code, user defined, that represents the reason for the payment hold and who initiated the request for the hold.
Four digit code used as the payment hold reason code.
Indicates the reason the request (check or non-check related) is being returned to the sender. This code will help determine which letter format to produce.
A code which represents the reason why correspondence received by the account is being returned to the sender.
This is the reason the recipient was locked into an assignment plan.
The disposition reason code identifies the reason for the disposition against a lien.
Code used to uniquely identify the reason for the original lien against a provider on the MMIS system.
Code used to uniquely identify the reason for the original lien against a provider on the MMIS system.
The reason code for potential managed care recipients used to auto-assign or keep recipients from auto-assignment.
The reason code that associates the reason table entry with the check reissue check xref entry.

The reason code that associates the reason table entry with the check reissue check xref entry.
The reason code that associates the reason table entry with the check reissue check xref entry.
This is the reason for the recipient was assigned the level of care.
The reason the recipient is authorized to receive the corresponding level of care. (Not Used in OK MMIS)
A two byte code used to identify a reason.
The reason that the A/R disposition was added.
The reason that the A/R disposition was added.
A code identifying the reason for creating a TPL A/R disposition.
A code identifying the reason for creating a TPL A/R disposition.
A code identifying the reason for creating a TPL A/R disposition.
Code identifying the current status of the A/R.
Code identifying the current status of the A/R.
Code identifying the current status of the A/R.
The reason that the A/R disposition was added.
The reason that the A/R disposition was added.
The reason that the A/R disposition was added.
Code used to identify what the reason code can be used for. A = Manual Adjustment, I = Interest, C = Cash Receipts, D = Claim Activity.
Code used to identify what the reason code can be used for. An example of this is that some reason codes will only be allowed for manual accounts receivables.
Indicator used to determine whether the user has the ability to select a disposition code for a record.
Used on the reason code to indicate the type of transaction that produced the expenditure/non-claim payout. This field determines if any additional processing must occur. Valid values are A - Account Receivable, E - Expenditure, and C - Cash Receipt.
This is the type of AR used in batch.
Indicator used to determine the type of deduction. Possible values: 'L' - Lien, 'W' - Withhold, 'S' - Sanction, (Note backup withholding is considered a lien since payment needs to be made to a third party)
Code used to identity the payment hold type. H = Payment Hold, P = Prudent Pay.
The recipient age group assigned to the summarized data. The data is summarized by 3 age groups: 12U - indicating the data was summarized for recipients 12 and Under; 13O - indicating the data was summarized for recipients 13 and Over; ### - indicating the data was summarized without regard to the recipient age group.

The recipient age group assigned to the summarized data. The data is summarized by 3 age groups: 12U - indicating the data was summarized for recipients 12 and Under; 13O - indicating the data was summarized for recipients 13 and Over; ### - indicating the data was summarized without regard to the recipient age group.
The recipient age group assigned to the demographic segment as of the last day of the quarter. There are two recipient age grouping: 12U - 12 and Under; 13O - 13 and Over.
The county number used to identify a geographical/political area in the state.
The recipients county at the end of the reporting period.
The recipients' county of residence at the end of the reporting period.
Indicates if the resource belongs to the applicant, spouse, or other individual. Valid values are: A=APPLICANT S=SPOUSE O = OTHER
Code that uniquely identifies each record within the Unisys system.
This code maps to the record type code. The record type identifies the type of review that the client is receiving.
This code maps to the record type code. The record type identifies the type of review that the client is receiving. (PASRR PRE-ADMISSION SCREEN, Determinations, Record Type)
This code maps to the record type code. The record type identifies the type of review that the client is receiving. Resident Review Screen, Resident Reviews, Record Type)
Indicates if this budget can be updated with money recouped from an outstanding accounts receivable. Valid values would include: N = Do not allow recoupments to be deposited into this budget, Y = Allow recoupments to be deposited for reporting only, but do not add them to the amount to be spent, S = Allow recoupments to be deposited and allow the deposited funds to be spent.
This field indicates the frequency by which the AR recoupment occurs. ("A" = Anytime, "M" = Monthly, "W" = Weekly, "Q" = Quarterly).
This field indicates the frequency by which the AR recoupment occurs. ("M" = Monthly, "W" = Weekly, "Q" = Quarterly)
This field indicates the frequency by which the AR recoupment occurs. ("M" = Monthly, "W" = Weekly, "Q" = Quarterly)
Indicates the type of recoupment that will be processed on the AR. ("A" = Automatic system recoupment, "M" = Manual recoupment, "R" = Repayment).
Indicates the type of recoupment that will be processed on the AR. ("A" = Automatic\system recoupment, "M" = Manual recoupment, "R" = Repayment).
Indicates the type of recoupment that will be processed on the AR. ("A" = Automatic system recoupment, "M" = Manual recoupment, "R" = Repayment).

Indicates whether the recycle is a one-time request or an on-going request.
This is the numeric code indicating the reason for the reject. The actual description for the error code can be found in T_BATCH_ERR_MSG by using the field CDE_ERROR.
Identifies the record source. Valid value is 52.
This uniquely identifies the tax record type and can correspond to a specific record type on a IRS tax file.
This uniquely identifies the tax record type and can correspond to a specific record type on a IRS tax file.
The code for a particular type of claim or financial transaction that will be selected for the schedule. For example, D = Claim Dental transactions and E = Financial Expenditure transactions. Z = the default for selecting all claim types for the claim category.
A single-character code that describes the type of a mailbox or delivery.
A single-character code that describes the type of a mailbox or delivery.
Identifies the type of the record that was sent. Valid values are 'D' for Detail (DET) and 'S' for Low income subsidy record (LIS).
Redetermination code used for D.O. only to determine recipient's eligibility. Values: XC = EXPARTE CHILD XA = EXPARTE ADULT Blank = N/A
Specifies criterion for bypassing an audit based on the presence of a referring provider on the claim being audited. Values are 'A' (any), 'P' (PCCM) and space (not considered).
Specifies criterion for bypassing an audit based on the presence of a referring provider on the claim being audited. Values are 'A' (any), 'P' (PCCM), and space (not considered).
The unit to which the case has been referred prior to initiating collection. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3009 in the column SAK_VALUE_TYPE.
Designates whether the referral is MI, MR, or both.
Designates whether the referral is MI, MR, or both. (PASRR PRE-ADMISSION SCREEN, Referral, Referred Code) ;
Designates whether the referral is MI, MR, or both.
This code indicates the area of specialty of the referring provider.
This code indicates the area of specialty of the referring provider.
This code indicates the area of specialty of the referring provider.
For CLAIMIP and CLAIMLT files the taxonomy code for the referring provider.
For CLAIMIP and CLAIMLT files the taxonomy code for the referring provider.
For CLAIMOT files the taxonomy code for the provider who referred the beneficiary for treatment.

A code describing the type of provider (i.e. doctor) who referred the patient.
A code describing the type of provider (i.e. doctor) who referred the patient.
A code describing the type of provider (i.e. doctor) who referred the patient.
This code maps to the answers to the first question on the PASRR referral screen. (PASRR PRE-ADMISSION SCREEN, Referral, "Does the patient/legal guardian give permission for the family or significant other to participate in the Level II evaluation?")
This code maps to the answers to the second question on the PASRR referral screen. (PASRR PRE-ADMISSION SCREEN, Referral, "Does the patient require a special means of communication such as a language other than English, signing or an interpreter, or some other communication device?")
Reference information as defined for a particular transaction set or as specified by the reference identification qualifier.
Reference identification code
Reference identification code.
Code which identifies the claim type and media of the claim.
Code which indicates the media on which a claim was submitted.
A user defined code that identifies a geographical region.
A user defined code that identifies a geographical region.
A user defined code that identifies a geographical region.
A user defined code that identifies a geographical region.
A user defined code that identifies a geographical region.
A user defined code that identifies a geographical region.
This field defines the type of the region. The initial design for the Core iC system calls for types of Enrollment ('E') and Capitation ('C'). The Enrollment region type says that for the specified program, the region is utilized in determining which recipients reside in the specified region and therefore may be eligibile for the program. The Capitation region type is utilized in determining the geographic area that capitation rates apply to.
This field defines the type of the region. The initial design for the Core iC system calls for types of Enrollment ('E') and Capitation ('C'). The Enrollment region type says that for the specified program, the region is utilized in determining which recipients reside in the specified region and therefore may be eligibile for the program. The Capitation region type is utilized in determining the geographic area that capitation rates apply to.
A code indicating the how the managed care entity is reimbursed.
This is an Exclude/Include code denoting that the list of associated condition codes is excluded or included, respectively.
This is an Exclude/Include code denoting that the list of associated modifiers is excluded or included, respectively.

Describes why individual was re-inst after MFP part; 01 Acute care hosp followed by rehab, 02 Det. in cognitive func, 03 Det. in health, 04 Det. in mental health, 05 Loss of house, 06 Loss of care giver, 07 Request of participant, 08 Lack of comm. srvc
Indicates the reason the EVS transaction was rejected.
The reason for rejection.
Accident Related Cause.
CLM - Accident Related Cause.
CLM - Accident Related Cause.
Accident Related Cause.
CLM - Accident Related Cause.
CLM - Accident Related Cause.
Accident Related Cause.
CLM - Accident Related Cause.
CLM - Accident Related Cause.
This code identifies the relationship of the recipient to the policyholder.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
The relationship of the move in/out person to the identifier. Valid values are: C - Child, W - Wife, H - Husband, P - Parent, S - Sibling, E - Cousin, O - Other, N - Niece/Nephew, I - Grandchild, F - Foster Child.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
This code identifies the relationship of the policyholder to the recipient covered by a TPL policy.
Relationship of the Caller to the Recipient
This is the code value of the relationships that a provider and owner can have.
This is the code value of the relationships that a provider and owner can have.
Release of Information Code.
CLM - Release of Information Code.
Release of Information Code. Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data to other organizations.

Release of Information Code. Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. Component of Claim Information.
A code representing the relationship of the sponsor to the applicant. These codes are maintained by the Medicaid AMAES system. Valid values include: C=CHILD H=HUSBAND M=MYSELF I=INTERESTED PARTY O=OTHER P=PARENT S=SIBLING W=WIFE
A code presenting the relationship of the family member to the applicant. This is defined as three bytes but currently holds only one-byte values. Valid values include: C=CHILD H=HUSBAND M=MYSELF O=OTHER W=WIFE I=INTERESTED PARTY P=PARENT S=SIBLING BLANK
A code presenting the relationship of the family member to the applicant. Valid values include: C=CHILD H=HUSBAND M=MYSELF O=OTHER W=WIFE I=INTERESTED PARTY P=PARENT S=SIBLING BLANK
HIPAA remarks code
HIPAA remark code sent with the 835 (RARC).
Repayee switch
This field indicates the type of repayment options. ("F" = Fixed, "X" = Flexible).
This field indicates the type of repayment options. ("F" = Fixed, "X" = Flexible)
This field indicates the type of repayment options. ("F" = Fixed, "X" = Flexible)
The code that identifies the type of DRG code that needs to be replaced. Valid codes are: 1. N - Neonatal DRG codes 2. T - Transplant DRG codes 3. P - Provider specific crosswalks
This field is used to report the information as a individual line item on the report or as a summary group. The valid values are "I" for individual listing and "O" for other/summary.
This is the report frequency code. D = Daily W = Weekly M = Monthly Q = Quarterly A = Annual
This is the report frequency code. D = Daily W = Weekly M = Monthly Q = Quarterly A = Annual
Type of reports associated with this schedule. Weekly ('W'), Daily ('D'), Monthy ('M')
A code that is used to identify who the attorney represents in the casualty case.
A code that is used to identify who the attorney represents in the casualty case.
This identifies the entity who receives the letter.
An indicator that identifies who is represented by the person that the letter was sent to.
Identifies who the insurance agent represents.
This code represents the media in which the application request was received.

This code represents the media in which the application request was received.
Code for table to be mass rate updated.
Code for table to be mass rate updated.
Indicates a resolution code for the dispute
Code indicates a drug rebate dispute resolution
Code indicates a drug rebate dispute resolution
Indicates a resolution code for the dispute
Code indicates a drug rebate dispute resolution
Indicates a resolution code for the dispute
Code indicates a drug rebate dispute resolution
Indicates the resource level. Values are 1=Over limit, 2=Under limit and 9=n/a.
The type of canned response.
A code for T-MSIS that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled to.
A flag that indicates the scope of Medicaid or CHIP benefits to which an individual is entitled to.
An indicator used to specify the type of restriction(s): ('00') State program category assigned differently than all other categories; ('01') Provider Type/Specialty, Claim Type and Other Criteria; ('02') Provider Type/Specialty and Claim Type; ('03') Provider Type/Specialty and Other Criteria; ('04') Provider Type and Other Criteria; ('05') Provider Type/Specialty only; ('06') Provider Type only; ('07') Other Criteria only; ('08') Claim Type only.
This column defines if the restriction is of 2 different types. The first type is an Exclusion (E) -any recipient that meets the restriction is excluded from being assigned to the PMP. The second type is Inclusion (I) - a recipient that meets the restriction may be assigned, but only if the PMP is under the max panel size for that restriction.
This column defines if the restriction is of 2 different types. The first type is an Exclusion (E)-any RCBM (recipient/client/beneficiary/member) that meets the restriction is excluded from being assigned to the PMP. The second type is Inclusion (I) - an RBMC that meets the restriction may be assigned, but only if the PMP is under the max panel size for that restriction.
Unique identifier for the resource casualty associated with the origin of this TPL
The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other

The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other
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The method in which the provider will receive the ERA from the health plan. Valid values are: 1-Web Download from Health Plan-Software Vendor 2-Web Download from Health Plan-Clearinghouse 3-Web Download from Health Plan-Direct Access/Download 4-State Agency Main Office Connect Direct 5-State Agency Provider Disbursement from Main Office 6-Other
Code retrieval before change.
Code retrieval before change.
Identifies if the letter was responded to.
Used to identify data type of the NAM USER VALUE.
Indicates if this budget can be updated with returned (or stopped) system payments. Valid values would include: N = Do not allow returned payments to be deposited into this budget, Y = Allow returned payments to be deposited for reporting only, but do not add them to the amount to be spent, S = Allow returned payments to be deposited and allow the deposited funds to be spent.
This identifies the first accommodation or ancillary service in the range that is included in the audit.
This identifies the beginning range of a specific accommodation or ancillary service. Revenue codes are determined by HFCA.
This identifies the last accommodation or ancillary service in the range that is included in the audit.
This code identifies the ending range of a specific accommodation or ancillary service. Revenue codes are determined by HFCA
Code which identifies a specific accommodation or ancillary service. '999' will indicate that all revenue codes should be included.

Identifies a specific accommodation or ancillary service.
This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
Identifies a specific accommodation or ancillary service.
System assigned key used to uniquely identify a revenue code.
Code representing the service rendered to a long term care recipient.
System assigned key used to uniquely identify a revenue code.
This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
This identifies a specific accommodation or ancillary service. Revenue codes are determined by HCFA.
System assigned key used to uniquely identify a revenue code.
A code which identifies a specific accommodation ancillary service or billing calculation.
A code which identifies a specific accommodation ancillary service or billing calculation.
A code which identifies a specific accommodation ancillary service or billing calculation.
A code indicating the ancillary services provided to the recipient during the billing period (1 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (10 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (11 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (12 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (13 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (14 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (15 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (16 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (17 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (18 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (19 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (2 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (20 of 23).

A code indicating the ancillary services provided to the recipient during the billing period (21 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (22 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (23 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (3 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (4 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (5 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (6 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (7 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (8 of 23).
A code indicating the ancillary services provided to the recipient during the billing period (9 of 23).
Code indicating if a provider's EFT has ended due to investigation.
Code depicting the reason a provider has been placed on review.
Code depicting the reason a provider has been placed on review.
Code depicting the type of review or agency conducting the review.
Code depicting the type of review or agency conducting the review.
Code depicting the type of review or agency conducting the review.
Revocation reason. Code values are hardcoded into the UI. Valid values are, V - Voluntary I - Involuntary R - Release Plan C - Calculated by period end
Include/Exclude indicator for revenue code
Include/Exclude indicator for revenue code.
Code indicating the requestor that decided the recipient should be put on review
Code indicating the reason the recipient was put on review.
submitted Revenue Code for HIPAA 835
Record ID code received from CMS
Record ID code received from CM
Record ID code from CMS.
Record ID received from CMS
Record ID code that generated this premium entry.
Record ID code received from CMS
Record ID code received from CM
Record ID code from CMS.

Record ID received from CMS
Record ID code that generated this premium entry.
Risk level involved with the provider. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 219.
Code value to be selected if the provider type/specialty for a provider met the condition. Valid values are: LT - Limited MO - Moderate HI High Risk
Code value to be selected if the provider type/specialty for a providers did not meet the condition. Valid values are: LT - Limited MO - Moderate HI High Risk
Type of Resource Link which may be associated with covered Drugs.
Type of Resource Link which may be associated with covered Drugs.
This is the release status code for the record. There are two statuses: Pending (P), Released (R)
This field will indicate the role of provider type. Allowed values are space, P (Performing), B (Billing) and A (All).
This field will indicate the role of provider specialty. Allowed values are space, P (Performing), B (Billing) and A (All).
Routed Generic Identifier
On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the two-byte code (GCRT2).
The Route indicates the normal site or method by which a drug is administered. On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the one-byte code (GCRT).
Store field 995-E2 (Route of Administration). Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/.
The Route indicates the normal site or method by which a drug is administered. On the NDDF alternate forms of the route description are available in two codes: A one-byte route code (GCRT) is available for applications where the description is transparent to the user. A two-byte route code (GCRT2) is available as an abbreviation. This is the one-byte code (GCRT).
This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.

Store field 995-E2 (Route of Administration). Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/.
Store field 995-E2 (Route of Administration). Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/
Route of Administration related to this criteria record. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.
This field contains a meaningful abbreviation of the normal method by which a drug is administered. Some abbreviations include: IV = Intravenous (only), DT = Dental and NS = Nasal. GCRT on NDDF.
There are 4 types of provider NPI summaries on this table: Detail (DT) - summaries generated each quarter at the provider NPI level; Provider (PV) - summaries generated at the TQ/LQ and TY/LY level for each provider NPI designed specifically for the Dental Profiler reports; Peer Group (PG) - summaries generated at the TQ/LQ and TY/LY level for each provider peer group designed specifically for the Dental Profiler reports; and All Provider (AL) - summaries generated at the TQ/LQ and TY/LY level for the entire dental program designed specifically for the Dental Profiler reports.
There are 4 types of provider NPI summaries on this table: Detail (DT) - summaries generated each quarter at the provider NPI level; Provider (PV) - summaries generated at the TQ/LQ and TY/LY level for each provider NPI designed specifically for the Dental Profiler reports; Peer Group (PG) - summaries generated at the TQ/LQ and TY/LY level for each provider peer group designed specifically for the Dental Profiler reports; and All Provider (AL) - summaries generated at the TQ/LQ and TY/LY level for the entire dental program designed specifically for the Dental Profiler reports.
Report Category Code
Report Category Code
Report Category Code
Indicates the report priority for the error. Valid values are 1-5. A priority of 1 has the highest and is fatal. Priorities of 2-4 are non-fatal.
This column indicates the report priority for the error. Errors with highest priority will be printed first on the report. Values 1-5, 1 being the highest priority.
This column indicates the report priority for the error. Errors with highest priority will be printed first on the report. Values 1-5, 1 being the highest priority.

A code indicating if the claim is used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The claim is used for "This Fiscal Year to Date" reporting; LY - The claim is used for "Last Fiscal Year to Date" reporting; ## - The claim is not used for fiscal year reporting.
A code indicating if the enrollment segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The segment will be used for "This Fiscal Year to Date" reporting; LY - The segment will be used for "Last Fiscal Year to Date" reporting; ## - The segment will not be used for fiscal year reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The data segment is used for "This Fiscal Year to Date" reporting; LY - The data segment is used for "Last Fiscal Year to Date" reporting; ## - The data segment is not used for fiscal year reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The data segment is used for "This Fiscal Year to Date" reporting; LY - The data segment is used for "Last Fiscal Year to Date" reporting; ## - The data segment is not used for fiscal year reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The data segment will be used for "This Fiscal Year to Date" reporting; LY - The data segment will be used for "Last Fiscal Year to Date" reporting; ## - The data segment will not be used for fiscal year reporting.
A code indicating if the recipient segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TY - The segment will be used for "This Fiscal Year to Date" reporting; LY - The segment will be used for "Last Fiscal Year to Date" reporting; ## - The segment will not be used for fiscal year reporting.
A code indicating if the Dental Profiler data segment will be used for the Dental Profiler Participation Analysis reports. The code has 5 valid values: TQ - The data segment is used for "This Quarter" reporting; LQ - The data segment is used for "Same Quarter Last Year" reporting; TY - The data segment is used for "This Fiscal Year to Date" reporting; LY - Then data segment is used for "Last Fiscal Year to Date" reporting; ## - The data segment is not used for the Dental Profiler Participation Analysis reports.
A code indicating if the claim is used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The claim is used for "This Quarter" reporting; LQ - The claim is used for "Same Quarter Last Year" reporting; ## - The claim is not used for quarterly reporting.

A code indicating if the enrollment segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The segment will be used for "This Quarter" reporting; LQ - The segment will be used for "Same Quarter Last Year" reporting; ## - The segment will not be used for quarterly reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The data segment is used for "This Quarter" reporting; LQ - The data segment is used for "Same Quarter Last Year" reporting; ## - The data segment is not used for quarterly reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The data segment is used for "This Quarter" reporting; LQ - The data segment is used for "Same Quarter Last Year" reporting; ## - The data segment is not used for quarterly reporting.
A code indicating if the summarized data segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The data segment will be used for "This Quarter" reporting; LQ - The data segment will be used for "Same Quarter Last Year" reporting; ## - The data segment will not be used for quarterly reporting.
A code indicating if the recipient segment will be used for the Dental Profiler Participation Analysis reports. The code has 3 valid values: TQ - The segment will be used for "This Quarter" reporting; LQ - The segment will be used for "Same Quarter Last Year" reporting; ## - The segment will not be used for quarterly reporting.
Code defining timing, transmission method or format by which reports are to be sent. Valid Values are: AA - Available on Request at Provider Site; EM - EM - Mail; FX - By Fax; BM - By Mail; EL - Electronically Only.
Report Type Code. Code identifying the title or contents of a document, report or supporting item.
This is the generic transaction type to be reported. A report is associated with a particular transaction type. R = Account Recievables M = Capitation P = Payment H = Cash Reciepts E = Expenditures V = Voids U = Reissues C = Claims G = Generic (this applies to reports that need to always run within a given cycle)
This is the generic transaction type to be reported. A report is associated with a particular transaction type. R = Account Recievables M = Capitation P = Payment H = Cash Reciepts E = Expenditures V = Voids U = Reissues C = Claims G = Generic (this applies to reports that need to always run within a given cycle)
Code used to identify the requester

Indicates the type of person requesting the research or the project. Value values are P, R, S, L, E, O (provider, recipient, state, legislation, EDS, other).
The reason the recipient is about to be deleted from the list of potentials for Managed Care.
The reason the recipient is about to be deleted from the list of potentials for Managed Care.
This is the HIPAA expenditure reason code to put on the 835 transaction.
This is the managed care eligibility reason codes for HIPAA.
This is the managed care eligibility reason codes for HIPAA.
This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.
The reason code used to determine if a recipient was identified as a potential managed care recipient through redetermination or as an add. A=add, R=redetermine,D=disenrollment, M=identify MCPD eligibles.
The reason code used to determine if a recipient was identified as a potential managed care recipient. Possibilities include 'I' for the Managed Care recipient identification process, or 'P' for the PS/2 eligibility process.
This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.
This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.
This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.
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This indicates the reason a recipient was assigned to a specific PMP; for example, newly eligible or an approved change. This also includes the reasons a recipients relationship with a PMP was terminated; for example, death or an approved change.
This indicates if a reason code may be used as only a start reason, as only a stop reason, or both a start and stop reason. Start Reason ONLY = 'S', Stop/Terminate Reason = 'T', both = 'B', or ' ' (space) if the reason is no longer used.
Code that indicates if submission was for following reasons: N=New C=Change X=Cancel

Code that indicates if submission was for following reasons: N=New C=Change X=Cancel
Code that indicates if submission was for following reasons: N=New C=Change X=Cancel
Code that indicates if submission was for following reasons: N=New C=Change X=Cancel
Code that indicates if submission was for following reasons: N=New C=Change X=Cancel
EFT submission reason after change.
EFT submission reason before change.
ERA submission reason after change.
ERA submission reason before change.
Indicates the type of resource. This is maintained by the Medicaid AMAES system and valid values include: PA - PATIENT ACCOUNT CN - CASH NOT IN BANK TR - TRUSTS SB - SAVINGS BONDS LE - LEASES FV - INS FACE VALUE SV - INS CASH SURR VALUE BF - BURIAL FUNDS OT - OTHER ME - MACHINERY/EQUIPMENT
This field indicates the type of restriction that is being enforced for the NDC, revenue code or procedure code.
Citizen / alien status
The number for the clerk reviewing this family member.
Indication of whether same or different modifier(s) are to be used in the audit criteria. The valid values are "S" - Same, "D" - Different, and space - "BOTH".
Indication of whether the same or different performing provider number is to be used in the audit criteria. The valid values are "S" - Same, "D" - Different, and space - "BOTH".
Indication of whether same or different billing provider location is to be used in the audit criteria. The valid values are "S" - Same, "D" - Different, and space - "BOTH".
Indication of whether same or different performing provider location is to be used in the audit criteria. The valid values are "S" - Same, "D" - Different, and space - "BOTH".
Indication of whether same or different performing provider specialty is to be used in the audit criteria. The valid values are "S" - Same, "D" - Different, and space - "BOTH" (default).
Indication of whether the specified audit should audit against details of the current claim only, details on claims in history only, or either current or history details.
Indication of whether the specified audit should audit against details of the current claim only, details on claims in history only, or either current or history details.

Indication of whether the same or different diagnosis code is to be used in the audit criteria.
Indication of whether the same or different DOS (date of service) is to be used in the audit criteria.
Indication of whether the same or different DOS (date of service) is to be used in the audit criteria.
This code defines the Payer "scope" of the audit.
A value of "S" indicates only services with the same payer as the current service are considered in the audit.
A value of "D" indicates only services from different payers from the current service are considered in the audit.
A value of "A" means all services are considered in the audit regardless of payer.
This code defines the Payer "scope" of the audit.
A value of "S" indicates only services with the same payer as the current service are considered in the audit.
A value of "D" indicates only services from different payers from the current service are considered in the audit.
A value of "A" means all services are considered in the audit regardless of payer.
Indicator to allow for auditing based on Place Of Service (POS). The valid values are "S" - Same, "D" - Different, and space - "BOTH".
Indication of whether the same or different provider number is to be used in the audit criteria.
Indication of whether the same or different provider number is to be used in the audit criteria.
Indication of whether the same or different procedure code is to be used in the audit criteria.
Indication of whether the same or different procedure code is to be used in the audit criteria.
Code for source of sanction "S"tate or "F"ederal
Code for source of sanction "S"tate or "F"ederal
One Character field that corresponds to which source the records corresponds to. Possible values are '1' - Provider SSN , '2' - Provider TaxId , '3' - Board SSN, '4' - Board TaxId.
Sanction type code.
Sanction type code.
The numeric county code for the county of origin
SOBRA deprivation code
For SOBRA cases, the worker's county number. 01-67 = COUNTY 69 = D.Y.S 88 = SOBRA CENTRAL OFFICE 89 = SOBRA CENTRAL OFFICE
The numeric designation of the worker
This is the schedule 1 for the drug code. Values are spaces - non scheduled; 1 - scheduled.
This is the schedule 2 for the drug code. Values are spaces - non scheduled; 1 - scheduled.
Funding or old Category of Service code used for grouping.

Main grouping code for the SCOS datamart process.
Main grouping code for the SCOS datamart process.
Subgrouping code for the SCOS datamart process.
Subgrouping code for the SCOS datamart process.
The internal code for the ProDUR screening.
The internal code for the ProDUR screening.
NCPDP SCRIPT Quantity Qualifier Code
Indicating whether a given window is secured or not
Indicating whether a control in a window is secured or not
ISA04 value in X12 document.
ISA03 value in X12 document.
A data element to identify how the beneficiary self-directed the service.
A data element to identify how the beneficiary self-directed the service.
A data element to identify how the beneficiary self-directed the service.
A data element to identify how the beneficiary self-directed the service.
A code representing the frequency at which the family member receives an income from self-employment. Valid values are: W = WEEKLY B = BIWEEKLY S = SEMI MONTHLY M = MONTHLY Q = QUARTERLY H = SEMI ANNUALLY A = ANNUALLY
ISA06 - Interchange Sender ID. Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. This is the identifier for the trading partner on the Trading Partner DB.
Application Sender's Code orApplication Receiver's Code (depending on CDE_BILLING_REC_ID)
Interchange Sender ID orInterchange Receiver ID (depending on CDE_BILLING_REC_ID)
The Seniority identifies seniority level of Clerk within the Department.
Indicates the sequence type.
Indicates the sequence type.
The service area of the state for PASRR evaluation. Resident Review Screen, Resident Reviews, Service Area)
Suffix added to the provider number to identify the various locations that a provider does business.
Service location of the provider which the disposition is associated with.
This is the provider service location. If this field is blank then the banner will be for all the service locations of this provider.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.

The service location code for a provider payee. This field is only valid in the CDE_PAYEE_TYPE is 'P' for provider.
Suffix added to the provider number to identify the various locations that a provider does business.
The service location code of the billing provider who submitted the claim.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Unique code suffixed to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
A code that indicates the location the provider is performing the services from.
A code that indicates the location the provider is performing the services from.
Suffix added to the provider number to identify the various locations that a provider does business.
Provider's service location.
Identifies the various locations that a provider does business.
Provider's service location.
Identifies the provider's service location.
Suffix added to the provider number to identify the various locations that a provider does business.
The service location of the provider that the recipient will be seeing for their actual care.
Type of Service Provider validation. Possible Values: S - Service Location N - NPI B - Base Provider A - All Service Providers
This field contains the HIPAA service type code which describes the type of coverage a recipient has with a policy.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
FDB severity level where 1=Most Severe, 2=Less Severe, and 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1,2, or 3.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values are 1,2, or 3.

The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values are 1, 2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1, 2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1,2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values are 1,2, or 3.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1,2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1, 2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1,2, or 3.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1, 2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid values include 1, 2, or 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
FDB provided Severity Code. This number is used to cross reference the factor table to determine the weight.
This is the value of the severity used for calculating where the AT Alert needs to be sent.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the Pro-DUR warning that the current claim failed.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.

Severity level where 1=Most Severe, 2=Less Severe, 3=Least Severe.
The code assigned to criteria to indicate the level of severity associated with the criteria. The valid codes are 1, 2, and 3.
Indicates the priority of the claim location.
New field produced by version 7.0 of ETG. This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4 or blank.
New field produced by version 7.0 of ETG. This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4 or blank.
New field produced by version 7.0 of ETG. This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4 or blank.
New field produced by version 7.0 of ETG. This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4 or blank.
New field produced by version 7.0 of ETG: This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4. If the Severity Score is blank, the Severity Level is also blank.
New field produced by version 7.0 of ETG: This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4. If the Severity Score is blank, the Severity Level is also blank.
New field produced by version 7.0 of ETG: This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4. If the Severity Score is blank, the Severity Level is also blank.
New field produced by version 7.0 of ETG: This field identifies the severity level of the episode. Valid values are 1, 2, 3, 4. If the Severity Score is blank, the Severity Level is also blank.
The sex of the recipient. Valid values are 'B' - Both, 'F' - Female, 'M' - Male.
Identifies the gender.
Identifies the sex of a person.
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
Sex code
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
Sex code
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
A numeric code indicating the sex of the beneficiary, according to CMS (male "1", female "2", or unknown "3").
Code describing the gender of an individual.
Code describing the gender of an individual.

Indicates the sex of the recipient. 'M' for Male, 'F' for Female or 'U' for unknown.
Sex Code
The recipient gender that a benefit may be valid for. Valid values are M, F, or blank.
Claims processing no longer uses this field and uses Benefit Plan rules instead. Code that identifies the sex for which the diagnosis is limited. If a diagnosis is valid for both sexes, the value in this field will be 'B'.
Identifies the sex of a person that this drug is limited to.
Code describing the gender of an individual.
Code describing the gender of an individual.
Code describing the gender of an individual.
The sex of the applicant
The sex of the family member
Indicates the sex of the recipient.
The recipient gender code at the end of the reporting period.
Indicates the recipients gender.
The gender of the recipients that this demographic record describes. Valid values are 'M' or 'F'. 'B' (for both) is NOT allowed.
The gender of the recipients that this demographic record describes. Valid values are 'M' or 'F'. 'B' (for both) is NOT allowed.
This is the sex of the recipient.
This is the gender code for the recipient.
This is the gender of the recipient.
This is the gender code of the recipient.
This is the gender of the recipient.
The recipient gender that a benefit may be valid for. Valid values are M, F, or blank.
The recipient gender that a procedure may be valid for. Valid values are M, F, or blank.
The recipient gender that a procedure may be valid for. Valid values are M, F, or blank.
Code describing the gender.
The code that maps the client's sex code. (PASRR PRE-ADMISSION SCREEN, Case Information, Gender) ; (RESIDENT REVIEW SCREEN, Case Information, Gender); (ICF/MR SCREEN, Case Information, Gender0
The code that maps the client's sex code.
Indicates the sex of the recipient.
Indicates the sex of the beneficiary.
Recipient's sex code on the Bendex tape.
Code describing the gender of an individual.
Indicates the sex of recipient
Indicates the gender of the recipient.

Sex code
The recipient's sex code on the PS/2 transaction.
The sex code of the recipient that needs an ID card.
The recipient's sex code on the PS/2 transaction.
The individuals biological sex.
This is the code describing the gender of an individual.
Sex on EDB records
Sex on EDB records
Indicates which sex (male, female, both) should be included in the audit criteria.
Indicates which sex (male, female, both) should be included in the audit criteria.
This code is used to determine which TPL retroactive billing run is used.
This code is used to determine which TPL retroactive billing run is used.
Ship/Delivery or Calendar Pattern Code. Code that specifies the routine shipments, deliveries, or calendar pattern.
Ship/Delivery Pattern Time Code. Code that specifies the time for routine shipments or deliveries.
The code that maps to a value of the type of short stay that was granted.
The code that maps to a value of the type of short stay that was granted. (PASRR PRE-ADMISSION SCREEN, Referral, Short Stays Granted)
KenPAC site status (1=Active, 2=Unknown, 3=Not Active).
Independent code that is part of the FDB Smart Key. This code is the dosage form number (3 bytes).
Independent code that is the first two characters of the FDB Smart Key. This code is a high level therapeutic class code (2 bytes).
Independent code that is part of the FDB Smart Key. This code is the modified hierarchical ingredient code list sequence number (5 bytes).
Independent code that is part of the FDB Smart Key. This code is the package size number (4 bytes).
The sixth component of the Smart Key is the Smart Key - Route Code (SKEY-RT), a two-digit number. An SKEY-RT code value is interpreted the same across all like NDCs.
Independent code that is part of the FDB Smart Key. This code is the route of administration code (2 bytes).
Independent code that is part of the FDB Smart Key. This code is a specific therapeutic class code (4 bytes).
Independent code that is part of the FDB Smart Key. This code is the strength number (4 bytes).
Indicates the area of skill an individual posses. This includes both business and technical skills. PB - powerbuilder, LBM - LMBS, VB - Visual Basic, PRV - provider or CLM - claims

Represents available skill levels. ie - E - Expert, I - Intermediate, N - Novice, B - Beginner ...
This field has a unique value that consists of seven independent codes: high level therapeutic class code (2 bytes), specific therapeutic class code (4 bytes), modified hierarchcial ingredient code list sequence number (5 bytes), strength code (4 bytes),
This has a unique value that consists of 7 independent codes. It accommodates both general and specific classification of drugs, with ingredients, strengths, dosage form and package size identification.
This field has a unique value that consists of seven independent codes: high level therapeutic class code (2 bytes), specific therapeutic class code (4 bytes), modified hierarchical ingredient code list sequence number (5 bytes), strength code (4 bytes),
This field has a unique value that consists of seven independent codes: high level therapeutic class code (2 bytes), specific therapeutic class code (4 bytes), modified hierarchcial ingredient code list sequence number (5 bytes), strength code (4 bytes),
Code to indicate the standard metropolitan statistical area. Values include: 1=CITY OF 400,000+ 2=OTHER SMSA 3=NOT SMSA 0=N/A
Status of SOBRA Application. Valid values are: blank = Awarded, 1 = Denied, 2 = Pending, 3 = Death Delete, 4 = Delete, 5 = Suspended.
The county number used to identify a geographical/political area in the state.
Indicates sort order of the report. ("A" = Ascending , "D" = Descending).
Identify the Oracle Soundex phonetic value.
Identifies the Oracle Soundex phonetic value.
Identifies the Oracle Soundex phonetic value.
A code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
Source for row data C - Claims Month-End A - Financial Amount Paid L - Financial Line Items
Source of case selection.
Source of case selection.
Source of provider/client selection.

Source Code.
Indicates the source used to update the DESI. CQ = CMS, FW = FDB, MX = MDX.
This is the SAK or code associated with the source drug or NDC and will be one of the following based on the IND_DRUG_SOURCE value: H=sak_drug_thera_cls, I=sak_ingredient, G=sak_drug_gen, N=sak_drug, A=cde_thera_cls_ahfs.
A code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
A code indicating the source for the data on this row. Valid values are: CO - Claim original; IN - Increasing adjustment record; DE - Decreasing adjustment record; CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
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Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
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Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
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Code indicating the source for the data on this row. Valid values are: CO - Claim original; CV - Claim void (the negative reversal); CA - Claim adjustment (the daughter); EO - Encounter original claim; EV - Encounter void claim (the negative reversal); EA - Encounter adjustment claim (the daughter); CP - Capitation transaction; EX - Expenditure transaction; AR - A/R transaction.
This is the source of the recipient updates and information.
This is the source of the recipient updates and information.
This is the source of the recipient updates and information.
This is the source of the recipient updates and information.
Identifies the source of the general recipient information.
This is the source of the recipient updates and information.
This is the source of the recipient updates and information.
Identifies what type of source caused the id card to be created. Valid values are 'W' for window, 'P' for PS/2, and 'E' for EBS.
Identifies what type of source caused the id card to be created. Valid values are 'W' for window, 'P' for PS/2, and 'E' for EBS.
This is the source of the income for the recipient.
This is the source of the recipient updates and information.
This is the source of the recipient updates and information.
This is the source of the address/contact information.

This is the source of the recipient address information.
Identifies the source of the recipient income information.
This is the source of the recipient lockin assignment plan information.
The field denotes the claims payment system from which the claim was extracted
The field denotes the claims payment system from which the claim was extracted.
The field denotes the claim payment system from which the claim was adjudicated.
The field denotes the claim payment system from which the claim was adjudicated.
Identifies the source of the recipient level of care information.
This code maps to special codes which indicate unique conditions that pertain to the case. For example: 'SMI' = serious mental illness; 'DD ' = developmental disability; 'M ' = must move from NF; 'MD ' = must from NF by date
This code maps to special codes which indicate unique conditions that pertain to the case. For example: 'SMI' = serious mental illness; 'DD ' = developmental disability; 'M ' = must move from NF; 'MD ' = must from NF by date (PASRR PRE-ADMISSION SCREEN, Determinations, Special Code)
Indicates unique conditions that pertain to the case. For example: 'SMI' = serious mental illness; 'DD ' = developmental disability; 'M ' = must move from NF; 'MD ' = must from NF by date.
This code maps to special codes which indicate unique conditions that pertain to the case. For example: 'SMI' = serious mental illness; 'DD ' = developmental disability; 'M ' = must move from NF; 'MD ' = must from NF by date (Resident Review Screen, Resident Reviews, Special Code)
Specialty Code that is identified as the imputed specialty code
Special Program Code. Code indicating the special program under which the services rendered were performed.
CLM - Special Program Code. Code indicating the special program under which the services rendered were performed.
Special Program Code. Code indicating the Special Program under which the services rendered to the patient were performed. Component of Claim Information.
Specialty/Aid category.
Code representing the special condition.
The special condition class code represents the class of the special condition code.
The special condition class code represents the class of the special condition code.
The special condition class code represents the class of the special condition code.
This code represents the special condition type.

This code represents the special condition type.
Indication of whether provider specialty is included, excluded, or not in the audit criteria.
Indication of whether provider specialty is included, excluded, or not in the audit criteria.
This is a code that is assigned to each specialty. This code is based on the Priority of the specialty. No two specialties can have the same code.
Type of sponsor. Valid values are: P=PRIMARY A=ATTORNEY O=OFFSET
Will always contain 00 in OK system.
Indicates whether the client requires specialized services.
Indicates the individual`s SSI State Supplemental Status.
Indicates the individual`s SSI Status.
SSN verified code. Sample values: A = SSN is verified. There is no indication of death, and the allegation of citizenship is consistent with SSA data - returned for citizenship request only 3 = Surname matched, but DOB did not match recipient. the DOB on the recipient will be displayed in the verified SSN data field
The two byte state abbreviation.
The two byte state abbreviation.
The two byte state abbreviation.
The two byte state abbreviation.
The two byte state abbreviation.
The two byte state abbreviation.
This code represents the state agency indicator. The valid values can be found in T_REF_CDE_VALUE_GROUP for sak_value_type = 215.
The state that issued the provider license.
This field specifies the State Plan Options in which the individual is enrolled. Use on occurrence for each State Plan Option enrollment.
The State Plan Options in which the individual is enrolled.

Column states can use to identify their record type on this table, such as "BC", "CH", "7Q", "5D", etc.
Code for the geographic state region calculated from the eligible recipient's county of residence.
Code for the geographic state region calculated from the billing provider's service location county.
Code for the geographic state region calculated from the billing provider's service location county.
Code for the geographic state region calculated from the billing provider's service location county.
Code for the geographic state region calculated from the billing provider's service location county.
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Code for the geographic state region calculated from the billing provider's service location county.
This is the state region calculated from the provider's service location county.
Code for the geographic state region calculated from the billing provider's service location county.
Code for the geographic state region calculated from the billing provider's service location county.
Code for the geographic state region calculated from the enrolled provider's service location county.
Code for the geographic state region calculated from the recipient's county of residence.
Code for the geographic state region calculated from the recipient's county of residence.
Code for the geographic state region calculated from the recipient's county of residence.
Code for the geographic state region calculated from the recipient's county of residence.
Composite of mapping factors used to create the Maintenance Assistance and Basis of Eligibility.

Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle an item is in. 1= new ;2 = change ;3 = re add ;4 = delete
This field indicates what stage in the life cycle an item is in. 1= new ;2 = change ;3 = re add ;4 = delete
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle the criteria is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete.
This field indicates what stage in the life cycle the inverse code is in. 1= new; 2 = change; 3 = re-add; 4 = delete
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete;
This field indicates what stage in the life cycle the criteria is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle an item is in. 1= new ;2 = change ;3 = re add ;4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
The code that indicates the stage of the life cycle that the criteria is in. 1 = new; 2=change; 3=re add; 4=delete.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle the criteria is in. 1 = new; 2 = change; 3 = re-add; 4 = delete.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.

This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle the criteria is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle the criteria is in. 1= new; 2 = change; 3 = re-add; 4 = delete.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.

This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1=New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Change Indicator where 1= New Add, 2=Historical Change, 3=Active Change, 4=Deleted.
This field indicates what stage in the life cycle an item is in. 1= new; 2 = change; 3 = re add; 4 = delete. If a record is changed, its state is set to 2 and a new, updated record is added with a state of 3.
Code indicating whether check has been processed.
This will indicate if the clerk is active or inactive.
To check whether the application is active or not
The status of the accounts receivable collection process. The following are the valid statuses: O-Open, C-Closed, S-Sent to IFSSA for review, H-Collections hold mode, I-Collections interest on hold.
Indicates if criteria is 'A'ctive or 'I'nactive
This code indicates the status of the adjustment. Valid values are: A = Approved, D=Denied, H = Hold, S = In Suspension.
This code indicates the status of the adjustment if it has been processed or if it still pending. P = Pending Adjustment and H = Hold Adjustment
This code indicates the status of the adjustment if it has been processed or if it still pending. P = Pending Adjustment and H = Hold Adjustment
This is to indicate the status of the request. (A) Active, (D) Denied, (H) Hold, (P) Processed.
This is to indicate the status of the request. (A) Active, (H) Hold, (P) Processed.
This field identifies the status of the payment. A = Active and V = Void
This field identifies the status of the payment. A = Active and V = Void.
This field identifies the status of the payment. A = Active and V = Void

This field identifies the status of the payment. A = Active and V = Void
This field identifies the status of the payment. A = Active and V = Void
Status Code
Status Code
Status Code
Flag indicating whether the control is active or not
The Status of the Drug Exception. If the Status is 'I' (INACTIVE) the Drug does not require low / high value editing. If the Status is 'A' (ACTIVE) the Drug DOES require low / high value editing.
The status of the drug rebate invoice dispute.
The dispute status code for tracking the progression of a dispute over time
One byte status code used to describe the status of a drug rebate dispute
The field used to identify the status of an invoice detail. Values are "0" (Original Invoice), and "1" (Adjusted).
Completion Status Code. (C=Completed, E=Error)
This field shows the CDE status and identifies if the service is Active, Inactive depending on the date range on the record. Character code 'Y' means active and 'N' means inactive.
Code to designate the current status of the 835.
The status of the payment. This could be issued, voided, stopped or cleared.
This field contains the RA status.
This field is status of the transaction criteria. For claims it would be an applicable claim status. For Expenditures it can be Manual, Immediate, Regular.
The flag indicating whether the control is active or not
This is the policyholder's status with CHAMPUS.
The status code
The status of the application in regard to the health insurance carrier's enrollment process. The valid values are stored in the T_REF_CDE_VALUE_GROUP table where SAK_VALUE_TYPE = 120.
The status of the application in regard to the health insurance carrier's enrollment process. The valid values are stored in the T_REF_CDE_VALUE_GROUP where SAK_VALUE_TYPE=200.
This is the status of the mass adjustment. The valid values are A = Active, C = Close/Complete, H = Hold, V= Cancelled/Void.
One character field that corresponds to whether a match was found/ not found or an Error was returned. Possible values are P - Pass F - Fail M - Multiple matches found E - Error found
Indicates whether the authorization is active or not
Tells current status of link/unlink txn. Values are: 'L' - Link of recip/clms completed. 'C' - Claims still to be Linked. 'P' - Unlink of recip/clms completed. 'U' - Claims still to be Unlinked.

The status of the overpayment case. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3012 in the column SAK_VALUE_TYPE.
This will be a space for active records and an 'H' for history and inactive records.
This will be a space for active records and an 'H' for history and inactive records.
This will be a space for active records and an 'H' for history and inactive records.
Status from finder file
This will be 'A' for currently active records, 'P' for previous active records and an 'H' for history and inactive records.
The status code of the link.
The status code of the unlink.
Code identifying if the A/R has been billed or rebilled.
This is the billing status code.
This is the billing status code.
This is the billing status code.
The status code
Status Code
Code Status.
Code Status.
The status code of the claim selected for mass adjustment. Valid values are: "R" - Released, "S" - Suspended, "D" Deleted, "E" Error, and "P" - Processed.
Indicates whether adjustment request is 'S' - submitted, 'I' - Claims Identified, 'P' - Processing, or 'F' - Finalized
Status code to indicate in the error has been resolved. 'A' for an active error that is not resolved. 'I' for inactive for an inactive error that has been resolved.
A one byte code indicating whether an abnormality has an open or closed status.
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application.
This is the status code used on the T_CHECK and T_PAYMENT_TMP tables. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank and 'S' indicates Stopped. Please see the code table for the full list of values.

This is the status code used on the T_CHECK and T_PAYMENT_TMP tables. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute. Please see the table for the full list of values.
This is the status code used on the T_CHECK and T_PAYMENT_TMP tables. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Staledate. Please see the table for the full list of values.
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application.
Indicates whether an EOB was added to the claim manually in data corrections or adjustments ('U') or systematically in the claims process ('S').
Indicates whether the cross-reference record is active or not. It will become inactive only after an adjustment to the claim is released. Only active rows are used in accumulating used patient liability. 'I' is for Inactive records, 'A' is for Active records.
Indicates whether the cross-reference record is active or not. It will become inactive only after an adjustment to the claim is released. Only active rows are used in accumulating used patient liability. 'I' is for Inactive records, 'A' is for Active records.
This field is used to identify whether the drug has been replaced or reused. The valid values are 'R' for replace and 'U' for reuse.
This field is used to identify whether the drug has been replaced or reused. The valid values are 'R' for replace and 'U' for reuse.
The current status of the drug rebate invoice
Status code for program eligibility segment. Blank means the segment is active, G means the segment is guaranteed eligibility, and H means it is historied and can no longer be used to process claims.
This is the status code used on the T_CHECK and T_PAYMENT_TMP tables. Examples are: An 'I' would indicate the check has been issued, a 'V' indicates a VOID, an 'R' indicates the check was reissued, a 'C' indicates a check has CLEARED the bank, an 'S' indicates Stopped and an 'X' for Cancelled by Statute. Please see the table for the full list of values.
Code that uniquely identifies the status of the lien against a provider on the MMIS system.
Code that uniquely identifies the status of the lien against a provider on the MMIS system.

Specifies if the assignment is valid (space) or if the assignment has been historied ('H').
Status of PMP Special Condition Code. Valid values are Space for Active records and 'H' for Historic.
Indicates whether the cross-reference record is active or not. It will become inactive only after an adjustment to the claim is released. Only active rows are used in accumulating PA used amounts and units.
1 byte code used by the Research/Project Tracking System to identify the request progress.
Code to depict generic status of research request or project. Valid values are N, I, C, X, R (New, In-Work, Closed, Cancelled, Re-Opened).
This is a description of possible statuses.
Code value for the application tracking record status.
Code value for the application tracking record status.
Code value for the application tracking record status.
Status code which indicates the status of the license. 'A' is for an active status.
The status of the license row, Active or Inactive (A or I).
Code value for the application tracking record status.
Status indicating whether the phone tracking request is complete or incomplete.
Code that represents the status of the restricted service.
Status Code
Identifies whether or not the eligibility aid segment is active. A blank means that the segment is active. An 'H' means that the segment is history and no longer active. A 'G' means that the segment is Guaranteed Eligibility.
Identifies whether or not the eligibility aid segment is active. A blank means that the segment is active. An 'H' means that the segment is history and no longer active.
Identifies whether or not the eligibility aid segment is active. A blank means that the segment is active. An 'H' means that the segment is history and no longer active.
The status code for the program eligibility segment. A blank means the segment is active, a 'G' means it is Guaranteed Eligibility, and an 'H' means that the segment is history and no longer valid.
The status code for the program eligibility segment. A blank means the segment is active, and an 'H' means that the segment is history and no longer valid.
A one byte code indicating whether an abnormality has an open or closed status.
Status of HOH association. Valid values are Space for Active records and 'H' for Historic.
The status code for the PDP assignment segment. A blank means the segment is active, and an 'H' means that the segment is history and no longer valid.

Specifies if the assignment is valid (space) or if the assignment has been historied ('H').
Specifies if the assignment is valid (space) or if the assignment has been historied ('H').
Identifies whether or not the eligibility aid segment is active. A blank means that the segment is active. An 'H' means that the segment is history and no longer active.
Indicates whether SUR request is 'S' - submitted or 'V' - Verified.
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application.
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application (2 of 6)
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application (3 of 6)
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application (4 of 6)
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application (5 of 6)
Code that indicates whether the Error Status Code was added to the claim during Claims processing or through Data Corrections or Adjustments. The values are 'S' for errors encountered in processing, and 'U' for user added from the windows application (6 of 6)
The current status of the payment header.
Code that indicates the status of the drug rebate invoice payments
The current status of the payment detail.
The status of a transaction type selected for a schedule. Values for claim transaction types are: P = Paid, D = Denied, S = Suspended. Values for financial transaction type expenditure are: M = Manual, D = Immediate Processing, R = Regular Processing.

The status of a transaction type selected for a schedule. Values for claim transaction types are: P = Paid, D = Denied, S = Suspended. Values for financial transaction type expenditure are: M = Manual, D = Immediate Processing, R = Regular Processing.
The status of a transaction type selected for a schedule. Values for claim transaction types are: P = Paid, D = Denied, S = Suspended. Values for financial transaction type expenditure are: M = Manual, D = Immediate Processing, R = Regular Processing.
This field is used to identify the current status of the case.
This field is used to identify the current status of the case.
This represents the current status of the casualty case.
Current status of check hold letters. O=Open(initial mailing), R=Reopen(2nd mailing), C=Completed
Code indicating the status of a provider's electronic funds transfer (EFT) account. The valid values are the following: Pending (0),Pre-notification (1), Active (2), Canceled (3), Interrupt (4), Failed (5), Expired (6)
Code indicating the status of a provider's electronic funds transfer (EFT) account. The valid values are the following: Pending (0),Pre-notification (1), Active (2), Canceled (3), Interrupt (4), Failed (5), Expired (6)
Code indicating the status of a provider's electronic funds transfer (EFT) account. The valid values are the following: Pre-notification (1), Active (2), Canceled (3), Interrupt (4).
Code indicating the status of the ICN. C = Compound Recoup, T = TPL Recoup, U = Units Recoup, W = Wrong NDC Recoup, N = No Action
Level of Information received. N=No information was received, P=All the information received is partial information, S=Some complete information is received, A=All information has been received.
This code indicates the type of decision status (e.g. approved or denied).
Code used to indicate whether the error on the claim is a current error ('C'), one that failed in the current cycle, or an historical error ('H'), one that previously failed.
Code used to indicate whether the error on the claim is a current error ('C') - one that failed in the current cycle, or an historical error ('H') - one that previously failed.
Code used to indicate whether the EOB on the claim is a current EOB ('C'), one that failed in the current cycle, or a historical EOB ('H'), one that previously failed.
Code used to indicate if a rule on the claim is a current rule ('C') - a rule that was used in the the most recent processing of the claim, or an historical rule ('H') - a rule that was previously used when the claim previously processed..

System assigned key to uniquely identify an eligibility stop reason code and it's description.
Alphabetic code for the termination of an eligibility period for a Medicaid recipient.
Special indicator for special criteria (such aid and/or diag)
Strata type code
This field contains the current status of the casualty case to track and report casualty case actions.
This field contains the previous status of the case. It is used to track and report status changes.
Transaction Set Identifier Code: 270 (Eligibility, Coverage or Benefit Inquiry), 271 (Eligibility, Coverage or Benefit Information), 276 (Health Care Claim Status Request)277 (Health Care Claim Status Notification)278 (Health Care Services Review Information)820 (Payment Order/Remittance Advice)834 (Benefit Enrollment and Maintenance)835 (Health Care Claim Payment/Advice)837 (Health Care Claim)
The code of the status of the Level I tracking screening value.
The code of the status of the Level I tracking screening value.
txn is the transaction type (837P, 837I, 837D, 270, 276, NCPDP, etc. -- claims would only be the 837x and NCPDP types).
The ANSI numeric state code for the U.S. state that has submitted the data.
Internal edit number for a CMS required edit
Total number of records of a given type that were written to the TMSIS data file
Edit number assigned by CMS to a particular edit
The type (original, resubmission, update) of transactions included on the TMSIS file.
2000BA - Subscriber Gender.
Billing Provider code identifying the country subdivision, required when the address is not in the United States Of America. Use the country subdivision codes from Part 2 of ISO 3166.
Code identifying the country subdivision for Billing Provider, used only when outside of US.
Billing Provider country subdivision code.
Pay-to country subdivision code. Use the country subdivision codes from Part 2 of ISO 3166.
Code identifying the country subdivision for Pay-to Address, used only when outside of US.
Pay-to Provider country subdivision code.
Pay-to plan country subdivision code. Use the alpha-2 country codes from Part 2 of ISO 3166.
Code identifying the country subdivision of Pay-to Plan City, State, Zip Code, required only when the address is not in the United States of America.
Pay-to Plan Country Subdivision Code.

Subscriber country subdivision code. Use the country subdivision codes from Part 2 of ISO 3166.
Code identifying the country subdivision of Subscriber City, State, Zip Code, required only when the address is not in the United States of America.
Subscriber Country Subdivision Code.
Laboratory or Facility Code identifying the country subdivision. Use the country subdivision codes from Part 2 of ISO 3166.
Code identifying the country subdivision of Service Facility Location City, State, Zip Code.
Code identifying the country subdivision of Ambulance Pick Up Location City, State, Zip Code, required only when the address is not in the United States of America.
Code identifying the country subdivision of Ambulance Drop Off Location City, State, Zip Code, required when address is outside the United States of America.
Other Subscriber country subdivision. Use the country subdivision codes from Part 2 of ISO 3166.
Code identifying the country subdivision of other subscriber city/state/zip code.
Other Subscriber Country Subdivision Code.
Other Payer Country Subdivision Code.
Code identifying the country subdivision of other payer city/state/zip code, required when the address is not in the United States of America.
Other Payer Country Subdivision Code.
Code identifying the country subdivision of US of service facility location city/state/zip, required when the address is not in the United States of America.
Service Facility Country Subdivision Code.
Code identifying the country subdivision of US of ordering provider city/state/zip code, required when the address is outside the United States of America.
Code identifying the country subdivision of ambulance pick up location city, state, zip code, required when the address is not in the United States of America.
Code identifying the country subdivision of ambulance drop off location city, state, zip code, required when the address is not in the United States of America.
Subscriber Gender. Code indicating the sex of the individual: F, M or U.
2000BA - Subscriber Gender.
Submitter ID number from the transaction header.
This is a 2-character field that describes the output of the Suite/Link output address.
This is a 2-character field that describes the output of the Suite/Link output address.
Code which indicates the tooth surface of a particular tooth.
Code which indicates the tooth surface of a particular tooth.

Code which indicates the tooth surface of a particular tooth.
Code which indicates the tooth surface of a particular tooth.
Code which indicates the tooth surface of a particular tooth.
This field identifies the TPL suspect code which identifies whether a TPL resource is suspect and, if so, how it was determined to be suspect.
This code identifies whether a TPL resource is active or suspect and, if suspect, who marked it as suspect (the system or the user).
The category of service. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3002 in the column SAK_VALUE_TYPE.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
Suffix added to the provider number to identify the various locations that a provider does business.
This code indicates the area of specialty for the servicing provider.
This code indicates the area of specialty for the servicing provider.
This code indicates the area of specialty for the servicing provider.
The taxonomy code for the institution billing/caring for the beneficiary.
The taxonomy code for the institution billing/caring for the beneficiary.
The taxonomy code for the provider who treated the recipient.
A code describing the type of provider (i.e. doctor or facility) responsible for treating a patient.
A code describing the type of provider (i.e. doctor or facility) responsible for treating a patient.
A code describing the type of provider (i.e. doctor or facility) who treated the patient.
Indicates the type of service that is tracking the claim.
This code indicates the type of service that is tracking the claim.
This code indicates the type of service that is tracking the claim.

This code indicates the type of service that is tracking the claim.
The service type code defined by the X12 implementation guide.
The service type code defined by the X12 implementation guide.
This field represents the type of procedure code being used on a Prior Authorization request. For example, it may be a revenue code (length of 3), HCPC code (length of 5) or an NDC (length of 11).
Route of Admin. Systemic Indicator.
Indication of whether the same or different primary diagnosis is to be used in the audit criteria.
Indication of whether the same or different primary diagnosis is to be used in the audit criteria.
Indication of whether the same or different tooth identification number is to be used in the audit criteria.
Indication of whether the same or different tooth identification number is to be used in the audit criteria.
Indication of whether the same or different tooth surface number is to be used in the audit criteria.
Indication of whether the same or different tooth surface number is to be used in the audit criteria.
Indicates if the individual received Temporary Assistance for Needy Families (TANF) benefits.
This is the "target" who was sent an 834 for the recipient. Values will include 'EB' for Enrollment Broker and RCO cde_pgm_health values from T_PUB_HLTH_PGM indicating the specific RCO and Region
This is the 10 character taxonomy code.
The Health Care Provider Taxonomy code that corresponds to the specialty for the Provider's type. The valid values are present in the CDE_TAXONOMY in table T_PR_TAXONOMY_CDE.
This is the 10 character taxonomy code.
The Health Care Provider additional taxonomy code that corresponds to the specialty for the Provider's type. The valid values are present in the CDE_TAXONOMY in table T_PR_TAXONOMY_CDE.
Code for Tax ID Type "F"ederal, "S"tate
Code for Tax ID Type "F"ederal, "S"tate
Identifies services for which team surgeons may be paid.
Identifies services for which team surgeons may be paid.
First form of contact. Valid values are: EM = Email TE = Telephone UR = URL
Second form of contact. Valid values are: EM = Email EX = Extension FX = Facsimile TE = Telephone UR = URL
Third form of contact. Valid values are: EM = Email EX = Extension FX = Facsimile UR = URL

An environment variable defintion or element description.
Element description used to process an action.
Element description used to process an action.
Element description used to process an action.
Element description used to process an action.
Element description used to process an action.
This is the AHFS class for this drug code. (Values are 000322 - Thera AHFS code specified; 000323 - Thera AHFS code not specified)
This is the AHFS code for the drug. (Values are 1 = Thera AHFS; 0 = No Thera AHFS)
This is the THERA class for this drug code. (Values are 0000001 = thera drug class; 0000002 = non thera drug class)
Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.
Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.
Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system
Identifies the pharmacological therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.
Identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system.
The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.
The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.

The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.
The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.
The Therapeutic Class Code, AHFS identifies the pharmacologic therapeutic category of the drug product according to the American Hospital Formulary Service (AHFS) classification system. For FDB implementations, it is an 8-character field as supplied by ASHP (American Society of Health-System Pharmacists). For MDX implementations, it is a 10-digit code; the first 6 digits represent the AHFS Drug Information Classification System as supplied by ASHP, and the last four digits are a suffix added by Micromedex to differentiate the product's ingredient formulation.
The first 6 bytes of the CDE_THERA_CLS_AHFS on the drug table used to specify types of brand drugs.
First 6 digits of the CDE_THERA_CLS_AHFS or ZZZZZZ if all CDE_THERA_CLS_AHFS codes should be included. Data type change to CHAR to support ZZZZZZ entries.
Identifies the pharmacologic therapeutic category of the drug product according to the AHFS classification system for the first drug in an inclusive alphabetic range of AHFS codes.
Identifies the pharmacologic therapeutic category of the drug product according to the AHFS classification system for the last drug in an inclusive alphabetic range of AHFS codes. If only 1 AHFS code is required, this should be the same as the CDE_THERA_CLS_AHFS_FROM.
Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.
Provided from CMS's quarterly tape and is a 2 character code, as indicated by the U.S. Food and Drug's Administration's (FDA) rating of the therapeutic equivalence of a product within other pharmaceutically equivalent drug products, as published.

The HCFA FDA Therapeutic Equivalency Code (HCFA_FDA) indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent. The HCFA_FDA is provided on the Health Care Financing Administration's quarterly tape.
The generic therapeutic class has 40 groupings for drug class. This is assigned by First Data Bank.
The Generic Therapeutic Class code classifies drugs according to the most general therapeutic groupings.
The Therapeutic Class Code, Generic (GTC) classifies drug with the second most broad therapeutic grouping. Users that need more definitive therapeutic classing should consider Therapeutic Class, Specific (GC3) or the Therapeutic Class, AHFS (AHFS). In FDB implementations this field holds TC, Generic. In Micromedex implementations, this field holds the Therapeutic Class - Level 2 (UltiMedex Code positions 4-6).
Therapeutic Class Code, Specific (GC3, Alias, HIC3). The most specific therapeutic class code offered by First DataBank, intended for users who need a very definitive therapeutic classification system.
For FDB implementations: Therapeutic Class Code, Specific. For MDX implementations: Therapeutic Class Code, UMC lowest detail TC available in TC1 thru TC5. ZZZ to include all codes.
This field holds the Therapeutic Class Code, Specific. (Also known as HIC3).
This field holds the Therapeutic Class Code, Specific. (Also known as HIC3).
This field holds the Therapeutic Class Code, Specific. 'ZZZ' Indicates all the classes are screened in the corresponding CDE_THERA_CLS_AHFS. Value other that 'ZZZ' indicates only that class will be screened.
For FDB implementations: Therapeutic Class Code, Specific. For MDX implementations: Therapeutic Class Code, UMC lowest detail TC available in TC1 thru TC5.
This therapeutic class coding scheme is the most specific offered by FDB and is intended for users who need a very definitive therapeutic classification system.
The standard therapeutic class has 100 groupings for drug class. This is assigned by First Data Bank.
The Standard Therapeutic Class code classifies drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system.

The Therapeutic Class Code, Standard (TC) can be used to classify drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system. Comprehensive therapeutic classification is provided by Therapeutic Class, Specific (GC3), Therapeutic Class, AHFS (AHFS), or Therapeutic Class, Generic (GTC).
Therapeutic Class From
Therapeutic Class To
The Therapeutic Equivalency Code indicates that although the drugs may have a different therapeutic classification, the FDA considers them therapeutically equivalent.
Code representing the type of threshold
Code identifying the type of throughput days grouping represented in the Paid Claims Days Count (CNT_PC_DAYS) field.
Code identifying the type of throughput days grouping represented in the Paid Claims Days Count (CNT_PC_DAYS) field.
Code identifying the type of throughput days grouping represented in the Paid Claims Days Count (CNT_PC_DAYS) field.
Code identifying the type of throughput days grouping represented in the Paid Claims Days Count (CNT_PC_DAYS) field.
Code identifying the type of throughput days grouping represented in the Paid Claims Days Count (CNT_PC_DAYS) field.
Code identifying the type of throughput days grouping.
Include/Exclude indicator for therapeutic class
Include/Exclude indicator for therapeutic class.
SureScripts tier ID. Valid values are 1 to 9, from lowest copay to higher copay amounts.
Indicates if the spenddown time period is monthly or a date span. The valid values are 'M' for monthly and 'S' for date span.
Indicates the unit of time measurement to be used in auditing.
Indicates the unit of time measurement to be used in auditing.
Indicates whether days, months, or years should be used as the unit of measure for the audit.
Indicates whether days, months, or years should be used as the unit of measure for the audit.
Indicates whether days, months, or years should be used as a unit of measure for an audit.
Indicates whether days, months, or years should be used as a unit of measure for an audit.
Indicates whether days, months, or years should be used as the unit of measure for the audit.
Indicates whether days, months, or years should be used as the unit of measure for the audit.
Professional title

CMS name for the data contained in the column
CMS name for the data contained in the column
CDE_TMSIS_DATA_ELEMENT
CMS name for the data contained in the column
A data element to capture the version of the T-MSIS data dictionary that was used to build the file.
A data element to identify the version of the T-MSIS data mapping document used to build the file.
CMS RULE-ID, such as "RULE-1234"
CMS TIER, such as "1.1"
CMS ERROR CATEGORY, such as "E3001"
CMS ERROR CATEGORY, such as "E3001"
This T-MSIS code describes the area of specialty for the provider.
A T-MSIS code describing the type of entity associated with the service.
A T-MSIS data element corresponding with UB-04 form locator FL4 that classifies the claim as to the type of facility (2nd digit), type of care (3rd digit) and the billing record's sequence in the episode of care (4th digit). (Note that the 1st digit is always zero.)
Name of the table that contains the column whose valid value is reflected
Code indicating whether the primary data element valid values list includes or excludes the value
Code indicating whether the dependent data element valid values list includes or excludes the value
Include/Exclude indicator for type of bill
Include/Exclude indicator for type of bill.
This is the first tooth number of the authorized service.
Tooth 1 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 1 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 1 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 1 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).

Tooth 1 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 2nd tooth number of the authorized service.
Tooth 2Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 2 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 2 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 2 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 2 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 3rd tooth number of the authirized service.
Tooth 3 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 3 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 3 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 3 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 3 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 4th tooth number of the authirized service.

Tooth 4 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 4 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 4 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 4 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 4 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 5TH tooth number of the authirized service.
Tooth 5 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 5 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 5 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 5 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 5 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 6th tooth number of the authirized service.
Tooth 6 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).

Tooth 6 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 6 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 6 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 6 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 7th tooth number of the authirized service.
Tooth 7 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 7 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).
Tooth 7 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 7 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 7 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
Code representing the 8th tooth number of the authirized service.
Tooth 8 Surface Code 1. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-1).
Tooth 8 Surface Code 2. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-2).

Tooth 8 Surface Code 3. Code identifying the area of the tooth that was treated. Found in the HIPA A 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-3).
Tooth 8 Surface Code 4. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-4).
Tooth 8 Surface Code 5. Code identifying the area of the tooth that was treated. Found in the HIPAA 278 Request and Response Guide in the SV3 Tooth Information segment; element (TOO03-5).
A code to identify the tooth numbering system is being used.
The code associated to a particular tooth.
A code to indicate the tooth on which the service was performed.
Code which indicates the tooth on which a particular service was performed.
Code which indicates the tooth on which a particular service was performed.
Code which indicates the tooth on which a particular service was performed.
The code of the particular tooth that the procedure is restricted to.
Code which indicates the tooth on which a particular service was performed.
The code associated to a particular tooth.
Include/Exclude indicator for tooth number. The valid values for this field are "I" - Include, "E" - Exclude, and space - "NONE".
Reference Identification. Code identifying the tooth number
This is the tooth quadrant of the authorized service.
Code identifying the tooth quadrant.
The area of the oral cavity is designated by a two-digit code.
Code identifying the tooth quadrant.
Tooth Status Code. Code specifying the status of the tooth. Valid values are: E-To Be Extracted, I-Impacted, or M-Missing.
Code that indicates the tooth surface of a particular tooth.
A code to identify the tooths surface on which the service was performed.
The code used to identify a surface of a tooth.
A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.

A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
A code for the tooth surface on which the service was performed. There are 6 possible surface code for a service.
Indicates if a drug is included in the list of the most frequently dispensed 200 drug products. Different package sizes and dose forms of the same drug will have the same number. The order is changed annually, based on pharmaceutical market surveys.
This is the type of service code. (1 - Medical service; 2 - Non medical service)
This is the type of service code. (1 - Medical service; 2 - Non medical service)
A code to categorize the services provided to a Medicaid or CHIP enrollee.
This indicator identifies the action taken for TPL editing based on the OI Plan. Values can be 1 - Suspend , 2 - Medicare, 3 - Private TPL deny, 4 - Pay and report.
Distinguishes various addresses that a TPL entity may have.
System derived TPL input code. This code will be derived from the CDE_INPUT_OUTPUT from the table T_CDE_TPL_IN_OUT.
System derived TPL output code. This code will be derived from the CDE_INPUT_OUTPUT from the table T_CDE_TPL_IN_OUT.
TPL Service Class used to determine TPL coverage.
TPL Service Class used to determine TPL coverage.
A functional area of the TPL sub-business function
A functional area of the TPL sub-business function
Code used for grouping trading partners.
Trading Partner group code.
Trading Partner Identification Code.
Trading Partner Identification Code.
Third party Part A accretion transaction code
Third party Part A Buy-In eligibility code
Third party Part A deletion transaction code
Third party Part A payer code
Third party Part B accretion transaction code
Third party Part B Buy-In eligibility code
Third party Part B deletion transaction code
Third party Part B payer code
Unique code representing the different statuses of trading partners.
Abbreviated code representing different Trading Partner types.
Unique code that identifies the current tracking status of the AR.
Unique code that identifies the current tracking status of the AR.

This is the code defining timing, transmission method or format by which attachments are to be sent. Codes are from PWK02, Data Element 756 of the HIPAA 278 implementation guide, and are stored on T_CDE_HIPAA where CDE_ELEMENT=756
A transaction code assigned to this report
ST01 value of the EDI document.
This is the unique identifier for this table. Example, CLMS (Claim Submission).
ST01 value in the EDI file that represents the transaction set identifier code.
This is the unique identifier for this table. Example, CLMS (Claim Submission).
This is the unique identifier for this table. Example, CLMS (Claim Submission).
This is the unique identifier for this table. Example, CLMS (Claim Submission).
The category of the transaction. Indicates whether it is a payment or an adjustment. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3011 in the column SAK_VALUE_TYPE.
The type of transaction. Valid values for this column are found on the table T_REF_CDE_VALUE_GROUP in the column CDE_VALUE on records with 3000 in the column SAK_VALUE_TYPE.
Abreviated codes representing different transport types: - FTP - FTPS
Code used to identify conditions relating to a UB92 claim that may affect payer processing.
Triple Threat Indicator. 0 No triple threat present.; 1 Triple threat is present
The code of the financial transaction
Describes the set of transactions. Values: A - Claim, B - Reversal, C - PA Inq., D - PA Rqst., E - Claim Inq., F - Elig Inq, G - Unknown.
Unknown.
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code of the financial transaction

This is the type code of the txn. It is only required when the sak_txn > 0. C = claim, E = Expenditure, M=Capitation. A = Acct Rec, H=Cash Reciept, V=Void, Default value = X.
The code of the financial transaction.
This is the type code of the txn. It is only required when the sak_txn > 0. C = claim, E = Expenditure, M=Capitation. A = Acct Rec, H=Cash Reciept, V=Void, Default value = X.
The category of transactions and payers selected for a financial schedule. The categories are: C = Claim, F = Financial, P = Payer.
The code of the financial transaction.
The code of the financial transaction
The code of the financial transaction
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
The code of the financial transaction
The code used to identify whether the update transaction is an Add, Change, or Delete
The code used to identify whether the update transaction is an Add, Change, or Delete
Unknown.
Secondary code used for the txn, these are old codes used for the transaction in various parts of the system.
The sort key value for the transaction.
Identifies the type of record for the SAK_RECORD column. Values include the following but new State values may be added: C - Claim R - Acct Receivables S - Expenditures V - Capitation
Code describing the type of record (claim, capitation, financial transaction).
This indicates how the EFT account will be used. The valid values are "W" - Withdrawals or "D" Deposits.
The code for a particular type of claim or financial transaction that will be selected for the schedule. For example, D = Claim Dental transactions and E = Financial Expenditure transactions. Z = the default for selecting all claim types for the claim category.
This field describes the type of transaction record. C for claim, F for financial.
This is the indicator for the external transaction code.
This is the indicator for the external transaction code.

This field identifies the code value as an input(I) or output(O) code.
The type of payment. This could be check, EFT, wire transfer, or state transfer.
This identifies whether the capitation payment was an EPSDT (E), Family Planning (F), or Delivery (D).
Type of Postcard to create. valid values are: 'A' = Annual, 'M' = Monthly Reminder, and 'R' = Recent Recertification.
Code type. Valid values are 'W' for the Welcome Letter or 'R' for the Recent Recert Postcard.
Indicates which payment adjustment rules for multiple surgery procedures apply to a service. 1 = Standard payment adjustment (General Surgery), 2 = Rules for Dermatology services apply, and 3 = Rules for Endoscopic services apply.
This is the code indicating the title or contents of a document, report or supporting item. Codes are from PWK01, Data Element 755 of the HIPAA 278 implementation guide, and are stored on T_CDE_HIPAA where CDE_ELEMENT=755.
Indicates the type of output being sent from the MMIS to an outside entity. The following codes are being used and represent each output as follows: C = Cert. of Creditable Health Ins. Coverage Letter M = Metabolic Screening Extract
Indicate which program to apply patient obligation to. N = Nursing Home; P = Personal Care.
Indicates Pharmacy vs. Non-Pharmacy claims. Valid values are: P = Pharmacy claims. T = NON-Pharmacy claims.
Identifies the type of 834 that was last sent for this recipient to this "target". Will be 'R' for Regular or 'T' for Termination
Type of assistance. Applicable for DHR and SOBRA only. Valid values include: FM = Financial aid (Money) Blank = Medicaid M = No money - Medicaid only
This identifies the beginning type of bill that is set up for the coverage code.
This identifies the ending type of bill that is set up for the coverage code.
The beginning range of the provider types that have been requested for label generation
Sources of income and combinations of sources income (only for D.O.). Sample values: A = SSA B = VA C = RR D = FCS Pension
Type of Medicare A, B, C, D.
These codes identify the manner of notification to a supervisor or a highr level resolution clerk. Example, e-mail.
Code which indicates a specific type of facility.
Code which indicates the specific type of facility that is billing for services on a UB92 claim form.
Indicates the specific type of facility that is billing for services on a UB92 claim form.
Indicates the specific type of facility that is billing for services on a UB92 claim form.

Code which indicates a specific type of facility.
Code which indicates a specific type of facility.
The location at which a service was rendered, such as office, home, emergency room, etc. This applies only to electronic claims. Paper claims do not carry place of service at header.
Code which indicates a specific type of facility.
Code which indicates a specific type of facility.
Indicates the specific type of facility that is billing for services on a UB92 claim form.
Code which indicates the specific type of facility that is billing for services on a UB92 claim form.
The type of facility, type of care, and the billing record`s sequence in the episode of care.
The type of facility, type of care, and the billing record`s sequence in the episode of care.
The type of facility, type of care, and the billing record`s sequence in the episode of care.
Code which indicates a specific type of facility.
Type of bill from the UB92 claim form.
Code which indicates a specific type of facility.
A code indicating what kind of payment is covered in this claim
A code indicating what kind of payment is covered in this claim.
A code indicating what kind of payment is covered in this claim.
A code indicating what kind of payment is covered in this claim.
This code denotes the type of hospital on the claim (servicing provider).
This code denotes the type of hospital on the claim
This code maps the type of screening values.
This code maps the type of screening values. (LEVEL I TRACKING SCREEN, Case Information, Type Of Screening)
A code to categorize the services provided to a Medicaid or CHIP enrollee.
A code to categorize the services provided to a Medicaid or CHIP enrollee.
A code to categorize the services provided to a Medicaid or CHIP enrollee.
A code to categorize the services provided to a Medicaid or CHIP enrollee.
The interChange user type who originates the notification.
Identifies the other types of liabilities an individual may have not defined as a health insurance.
This is the type of plan. There are two types of Plans. For Benefit Plans, the value in this column is 'BNFT'. For Assignment Plans, the value in this column is 'ASGN'.
Identifies if the associated provider type and provider specialty is included or excluded from the group.
This is the provider type that a provider is licensed for.

For SOBRA only, the transitional Medicaid code. Values include: A = 1ST REPORTING PERIOD B = 2ND REPORTING PERIOD C = 3RD REPORTING PERIOD D = 4TH REPORTING PERIOD F = INITIAL AWARD 12 MTH G = INITIAL AWARD 11 MTH S = INITIAL AWARD DUE TO CHILD SUPPORT 4 MTHS X = IN CHILD SUPPORT REPORTING PERIOD
Usage Indicator: P (Production Data), T (Test Data)
Taxonomy of the provider who directed the care of a patient.
Taxonomy of the provider who directed the care of a patient.
Taxonomy of the provider who directed the care of a patient.
The Provider Taxonomy of the provider who supervised another provider
The Provider Taxonomy of the provider who supervised another provider.
The Provider Taxonomy of the provider who supervised another provider.
A code representing the frequency at which the family member receives income from an unearned source. Valid values are: W = WEEKLY B = BIWEEKLY S = SEMI MONTHLY M = MONTHLY Q = QUARTERLY H = SEMI ANNUALLY A = ANNUALLY
A code representing the source of the family member unearned income. Example values are: 1 = Social Security (include Medicare premiums) 2 = SSI (Gold check) 3 = Public Assistance (Welfare) 4 = Railroad Retirement QT = Qualified Income Trust
Code used to identify a specific unearned source value.
This field defines the unit which must be used in conjunction with the Minimum Dose Quantity field. (PRIMARY KEY). This field provides a description of the codes found in the t_pedi_dose table dose_units and unit-form fields.
This field designates the unit of measure used in conversion
Identifies the unit/department that created the financial transaction.
Identifies the unit\department that created the financial transaction.
Identifies the unit\department that created the financial transaction.
Identifies the unit\department that created the financial transaction.
Identifies the unit\department that created the financial transaction.
Identifies the unit\department that created the financial transaction.
Identifies the unit\department that created the financial transaction.

Identifies the unit\department that created the financial transaction.
The code for the unit which transferred a question.
Code specifying units in which a value is expressed or a measure taken. Examples: F2 - International Units, GR - Grams, ML - Milliliter.
Unit or Basis for Measurement Code. Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. E.G. Frequency Period could be Days or Months, etc.
Unit or Basis for Measurement Code. Code specifying the units in which a value is being expressed or manner in which a measurement has been taken. This is only used in institutional 837.
A code to indicate the basis by which the quantity of the drug or supply is expressed.
The code for the receiving unit of a transferred question.
The Unit Type Indicator indicates the unit of measure as supplied on the CMS's quarterly tape.
Indicates whether units, dollars, or both should be used as the unit of measure for audit.
Indicates whether units, dollars, or both should be used as the unit of measure for audit.
Code that identifies what one unit represents for the procedure code.
Code that identifies what one unit represents for the procedure code.
This indicates whether only the last unit on the detail should be priced using a different revenue code, or if all units within the range of units on the record should be priced using a different revenue code. Valid values are "L" for last unit only and "A" for all units in range.
Code that identifies what one unit represents for the procedure code.
Unit or Basis for Measurement Code. Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.
CR1 - Code specifying the units in which a value is expressed
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.
Indicates source of drug update data. F = FDB or M = Micromedex.
Indicates source of drug update data. F = FDB or M = Micromedex.
Indicates if drug record should by updated by Drug Update process. 'Y' = Yes (Update), 'N' = No (Bypass).
This will indicate if the drug data has been overridden by the State (S) or is the data is First DataBank (F) supplied. If the indicator is set to "S", the update process will not overlay the data entered by State personnel.

Indicates whether or not a county is Rural (R) or Urban (U). This is used for payment of capitation under the Managed Care RBMC program.
ISA16 value of an X12 document. Valid values are T and P.
This field considers episode completeness using any custom clean periods that were users defined instead of the default clean periods. Valid values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
This field considers episode completeness using any custom clean periods that were users defined instead of the default clean periods. Valid values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
This field considers episode completeness using any custom clean periods that were users defined instead of the default clean periods. Valid values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
This field considers episode completeness using any custom clean periods that were users defined instead of the default clean periods. Valid values: Space/Blank = Episode is complete; 0 = Incomplete due to service dates; 1 = Incomplete due to eligibility dates.
The values for this field are the same as the Episode Type field, but are calculated using any custom clean period defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field (not currently used). Values 0, 1, 2, 3, 4, 5, 6, 7, or blank.
The values for this field are the same as the Episode Type field, but are calculated using any custom clean period defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field (not currently used). Values 0, 1, 2, 3, 4, 5, 6, 7, or blank.
The values for this field are the same as the Episode Type field, but are calculated using any custom clean period defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field (not currently used). Values 0, 1, 2, 3, 4, 5, 6, 7, or blank.
The values for this field are the same as the Episode Type field, but are calculated using any custom clean period defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field (not currently used). Values 0, 1, 2, 3, 4, 5, 6, 7, or blank.
The custom outlier value for the episode, based on user-defined custom outliers (not currently used).

The custom outlier value for the episode, based on user-defined custom outliers (not currently used).
The custom outlier value for the episode, based on user-defined custom outliers (not currently used).
The custom outlier value for the episode, based on user-defined custom outliers (not currently used).
Codes designating the nature of VA income, if applicable. Valid values are: C = VA Compensation P = VA Pension I = VA insurance income as beneficiary of policy
Code used to relate values to identified data elements necessary to process an institutional claim. This identifier will be 'BE'.
This is the value for the code specified by the data element dictionary number.
The value code to be defined by this group entry.
If IND_VALUE_TYPE is "A", then this column is a FK to T_RU_ARRAY.
Otherwise it's an arbitrary string value.
This is string of characters. Sometimes it will represent a SAK of a data base row such as the SAK of a procedured code.
Code used to relate values to identified data elements necessary to process a UB92 claim.
Code used to relate values to identified data elements necessary to process a UB92 claim.
Code used to relate values to identified data elements necessary to process an institutional claim (1 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (10 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (11 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (12 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (2 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (3 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (4 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (5 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (6 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (7 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (8 of 12).
Code used to relate values to identified data elements necessary to process an institutional claim (9 of 12).
If SAK_VALUE_CHILD is -1 this is the value of the array entry. Otherwise it is " ".

If IND_VALUE_TYPE is "D", then this column is a FK to T_RU_DISCRETE_SET. If the IND is "T", then this column is a FK to T_RU_TUPLE_SET. Otherwise it's an arbitrary string value that's interpreted differently for each domain. A RangedValue (for the "BW" operation) will have two domain values separated by " - ".
This value is either "S" for Single Value, or "A" for ARRAY.
If IND_VALUE_TYPE is "D", then this column is a FK to T_RU_DISCRETE_SET. If the IND is "T", then this column is a FK to T_RU_TUPLE_SET. Otherwise it's an arbitrary string value that's interpreted differently for each domain. A RangedValue (for the "BW" operation) will have two domain values separated by " - ".
Van ID number. For VAN media type this could be the same or different than the submitter id. For WEB and NCP media types Van ID and Sub ID will be the same.
Points to the Transaction variable that is the direct object of the Action.
Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.
Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.
Primary key for this table. The short identifier for the variable. It must be unique for the transaction that owns it.
Interchange Control Version Number
Code associated to the State/Federal Agency who conducted the visit. The valid values are stored in the T_REF_CDE_VALUE_GROUP where sak_value = 217.
A code indicating the relationship between the veteran and the applicant. Values are: C=CHILD H=HUSBAND M=MYSELF I=INTERESTED PARTY O=OTHER P=PARENT S=SIBLING W=WIFE
A code representing the frequency at which the family member receives a wage. Valid values are: W = WEEKLY B = BIWEEKLY S = SEMI MONTHLY M = MONTHLY Q = QUARTERLY H = SEMI ANNUALLY A = ANNUALLY
Code for specifying T-MSIS waiver type under which the eligible individual is covered during the month and receiving services/under which claim is submitted.
Codes for specifying waiver types under which the eligible individual is covered during the month.
Code for specifying waiver type under which the eligible individual is covered.
Code for specifying waiver type under which the eligible individual is covered.
Code for specifying waiver type under which the eligible individual is covered.
Code for specifying waiver type under which the eligible individual is covered.

This is a code that represents the type of ward. This field will always contain an N in the OK MMIS.
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Required if CR102 is present.
Unit of measure for weight.
Final action indicated by worker
The type of work performed. i.e. research, telephone time,etc.
This code identifies the work area to which an analyst is assigned
This is the version transaction identifier code. 5010 values are: 005010X224(dental), 005010X222A1(professional), 005010X223A2(institutional); 4010 values are: 0 - all existing claims initialized to zero, 004010X097A1 (dental), 004010X098A1 (professional), 004010X096A1 (institutional).
Transfer Reason code.
Transfer Reason code.
Transfer/Release status code.
Transfer/Release status code.
A T-MSIS code indicating the category of service for the paid claim. The category of service is the line item from the CMS-64 form that states use to report their expenditures and request federal financial participation
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
A code indicating the category of service for the paid claim.
This is the first 5 digits of the zip code.
Reason entitlement changed
System assigned key that uniquely identifies a check issued from the MMIS system.
The unique system assigned key that identifies a remittance advice/letter in the system. The actual check is on t_check.
The unique system assigned key that identifies a check in the system.

The unique system assigned key that identifies a remittance advice\letter in the system. The actual check is on t_fin_payment.
The unique system assigned key that identifies a check in the system.
The unique system assigned key that identifies a payment that originaites from the MMIS.
The unique system assigned key that identifies a check in the system.
The unique system assigned key that identifies a check in the system.
The unique system assigned key that identifies a check in the system.
The unique system assigned key that identifies a remittance advice\letter in the system. The actual check is on t_fin_payment.
The unique system assigned key that identifies a payment that originaites from the MMIS.
The unique system assigned key that identifies a payment that originaites from the MMIS.
This is the unique key for a payment.
The unique system assigned key that identifies a remittance advice\letter in the system. The actual check is on t_fin_payment.
The unique system assigned key that identifies a payment that originaites from the MMIS.
A flag to indicate that the receiver has acknowledged is selection as an alternate receiver of the specified transaction type for the specified ID.
A flag to indicate that the receiver has acknowledged is selection as an alternate receiver of the specified transaction type for the specified ID.
This is the specified day a check can be issued in relation to the process date or financial run date. (optional). To not specify a date parameter the default issue date will be the date of cycle. M = Monday, T = Tuesday, W = Wednesday, H = Thursday, F= Friday.
This is the number of days an CHECK can be issued from the process date or financial run date. (optional). To not specify a CHECK date parameter will result in the the default issue date which is the date of cycle.
This is the city of the State's return address.
This is the city of the State's return address that will be displayed on the 835.
System assigned key for the claim dimension table.
System assigned key for the claim dimension table.
System assigned key for the claim dimension table.
System assigned key for the claim dimension table.
The claim type for a given ETG claim.

The claim type for a given ETG claim.
The claim type for a given ETG claim.
The claim type for a given ETG claim.
Outbound - Code List Directory Version Number.
This is the claim count for this grouping.
Billed claims
The accumulated total number of claims extracted out of the quarterly invoice for the PHS provider/entity number
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the beneficiary.
The number of claims the provider filed in the particular claim group for the beneficiary.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the recipient.
The number of claims the provider filed in the particular claim group for the beneficiary.
The number of claims the provider filed in the particular claim group for the beneficiary.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.

This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this provider.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
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This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
The total claim count for the non referral Patient first provider.
This is the claim count for this grouping.
This is the claim count for this grouping.
This is the claim count for this grouping.
Date the drug was dispensed or if other claim type, date claim was processed.
This is the first two characters of the recipient's last name. It is what is keyed on the claim.
Recipient's last name on the claim

Recipient's last name on the claim.
This is the first three characters of the recipient's last name. It is what is keyed on the claim.
This is the first three characters of the recipient's last name. It is what is keyed on the claim.
This is the provider's total claim count ranking within their peer group.
This is the first three characters of the recipient's name. It is what is keyed on the claim.
Recipient's first name on the claim
Recipient's first name on the claim.
This is the first initial of the recipient's name. It is what is keyed on the claim.
This is the first initial of the recipient's name. It is what is keyed on the claim.
This is the recipient count for this grouping that have claims paid during this Profiler cycle.
This is the claim count for this grouping.
The total charge of the claim.
Cluster number represents the building block of a treatment episode. Each episode consists of one or more clusters. A cluster is composed of a single anchor record, and can include an unlimited number of records of other types.
Cluster number represents the building block of a treatment episode. Each episode consists of one or more clusters. A cluster is composed of a single anchor record, and can include an unlimited number of records of other types.
Cluster number represents the building block of a treatment episode. Each episode consists of one or more clusters. A cluster is composed of a single anchor record, and can include an unlimited number of records of other types.
Cluster number represents the building block of a treatment episode. Each episode consists of one or more clusters. A cluster is composed of a single anchor record, and can include an unlimited number of records of other types.
The CMS 64 line number assigned to the record.
The report line on the CMS 64 where the record was reported. This may be different than the CMS 64 COS if reported in another "override" category as defined by the State.
A number indicating the CMS 64 report where the record was reported.
The count of the number of updates to the group of claim types for the associated check banner. This count is used internally for audit purposes.
The count of the number of updates to the group of provider types for the associated check banner. This count is used internally for audit purposes.

The count of the number of times the payment hold claim types have been updated for a specific claim payment hold. This count is used in internal audit processing.
The count of the number of times the payment hold programs have been updated. This is used in internal audit processing.
This count is the number of times the payment hold providers are updated. This is used for internal audit processing.
This count is the number of times the payment hold provider types have been updated. This count is used in internal audit processing.
Numeric value of quantity of ambulance patient count.
Outbound - Controlling Agency, Coded.
Outbound - Controlling Agency, Coded.
Outbound - Controlling Agency, Coded.
Outbound - Controlling Agency, Coded.
This is the number of times the system attempted to locate the cash receipt for this payment
The number of claims not processed due to internal errors in the batch.
The number of claims not processed due to internal errors in the batch.
A count of the number of beds available at the facility.
Case Type Count
Count of claims per grouping of report
The total count of claims summarized by various dimensions on the row during the reporting month. Add 1 for Paid records and Subtract 1 for Voided records.
The total count of claims summarized by various dimensions on the row during the reporting month. Add 1 for Paid records and Subtract 1 for Voided records.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.
This is the count of ETG claims.

This is the count of ETG claims.
This is the count of ETG claims.
The number of claims for a provider that have failed a given edit or audit during the reporting period.
The number of claims for a provider that have failed a given edit or audit during the reporting period.
The number of claims for a provider that have failed a given edit or audit during the reporting period.
The total number of claims denied during the reporting period.
The total number of claims paid during the reporting period.
The total number of Medicare crossover claims paid for the reporting period.
The number of detail lines on this claim that required some form of correction.
The number of paid claims that required some form of correction during the reporting period.
The number of denied claims during the reporting period that received some form of correction.
Total number of denied claims.
The number of details on this claim with edits applied.
The count of paid claims that contained errors during the reporting period.
The count of denied claims that contained errors during the reporting period.
The number of detail lines on this claim that were paid after overriding a claim edit.
The number of claims paid after overriding a claim edit during the reporting period.
The number of claims denied after overriding a claim edit during the reporting period.
Total number of paid claims.
Counts the claim as a paid claim.
The count of services paid on the claim.
The number of paid claims during the reporting period.
The number of paid claims during the reporting period.
The number of paid claims for the reporting period.
The number of paid claims for the reporting period.
The number of paid claims for the reporting period.
The number of claims paid to an individual provider in the current year.
The number of claims paid to an individual provider in the current year.
The total number of paid claims which had Third Party Liability for a provider during the reporting period.
The total number of lines on the claim
The total number of lines on the claim.
The total number of lines on the claim.

The total number of lines on the claim.
Summarized paid claims count.
Summarized paid claims count.
Summarized paid claims count.
Summarized paid claims count.
Summarized paid claims count.
Summarized paid claims count.
The number State Fiscal year to date claim count.
The total number claims denied during the reporting period.
The total number of claims denied during the reporting period.
The total number of claims denied during the reporting period.
The total number claims denied during the reporting period.
The number of claims denied for an individual provider during the current year.
The number of claims denied for an individual provider during the current year.
The number of claims with a date of receipt (DOR) to date of adjudication (DOA) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of adjudication (DOA) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of receipt (DOR) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of adjudication (DOA) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of adjudication (DOA) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.

The number of claims with a date of service (DOS) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of payment (DOP) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of receipt (DOR) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of receipt (DOR) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of receipt (DOR) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of receipt (DOR) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of claims with a date of service (DOS) to date of receipt (DOR) day range for the value in the Paid Claim Days Count (CNT_PC_DAYS) field.
The number of adjustments processed for an individual provider during the current year.
The number of adjustments processed for an individual provider during the current year.
This will vary depending on the value received in the Compound Ingredient Modifier Code Count (362-2G). This will be a sequential number to identify the occurrence of the Compound Ingredient Modifier Code submitted.
Criteria Count
Criteria Count
Criteria Count
The accumulation of the number of covered days for paid long term care claims during the reporting period.
Count of non-adjusted denied lines
Count of adjusted paid lines
Count of claims denied within a reporting group for sak_esc
Count of number of unique GCN's that have to be found in history. Typically set at one, but sometimes is more.
Secondary drug therapy GCN count
The number of unique eligibles within a report grouping of year/month, set of criteria, benefit plan, and error number
Indicates the aggregate number of eligible recipients for a given month when counts are gathered.

Total number of submitted physician details that met PCP evaluation and management criteria for a provider of specific service location.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
This is the count of ETG episodes.
Number of claims setting an error.
Number Of Files Created.
The number of times the provider logged into the BCBS InfoSolutions Website.
The count of informational errors on the batch.
The count of informational errors on the batch
The count of informational errors on the batch.
Count of successful lookup made for a drug in a quarter.
This is the sum of the days of long term care coverage for this recipient within the level of care, initial/lag period, reporting period and waiver.
The accumulation of the number of covered days for paid long term care claims during the reporting period.
Medicare Inpatient Adjudication - Cost Report Day Count
Medicare Inpatient Adjudication - Covered Days or Visits Count.
Medicare Inpatient Adjudication - Lifetime Pschiatric Days Count
Medicare Inpatient Adjudication - Lifetime Reserve Days Count.This quantity indicates the lifetime reserve days.
This field is not used.
Distinct count of claims based on the individual ICN.
Distinct count of claims based on the individual ICN.
Distinct count of claims based on the individual ICN.
Distinct count of claims based on the individual ICN.

Distinct count of claims based on the individual ICN.
Distinct count of claims based on the individual ICN.
Occurrence count of Other Payer information for a particular coverage type and date.
This will capture NCPDP field #392-MU, Count of 'Benefit Stage Amount' (394-MW) occurrences. This will be a sequential number based on submitted values.
This will capture NCPDP field 353-NR, which is the Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences. This will be a sequential number based on values submitted.
The number of newday claims in the batch that have been processed.
The number of newday claims in the batch that have been processed
This is the other payer sequence count.
This is the other payer sequence count.
This is the other payer sequence count.
This is the other payer sequence count.
Count of non-adjusted paid lines
Count of adjusted paid lines
Represents the number of days for the Throughput Type Code (CDE_THRUPUT_TYPE). This field is used with the applicable claim count fields in this table to display the number of claims for the desired day range.
Represents the number of days for the Throughput Type Code (CDE_THRUPUT_TYPE). This field is used with the applicable claim count fields in this table to display the number of claims for the desired day range.
Represents the number of days for the Throughput Type Code (CDE_THRUPUT_TYPE). This field is used with the applicable claim count fields in this table to display the number of claims for the desired day range.
Represents the number of days for the Throughput Type Code (CDE_THRUPUT_TYPE). This field is used with the applicable claim count fields in this table to display the number of claims for the desired day range.
Represents the number of days for the Throughput Type Code (CDE_THRUPUT_TYPE). This field is used with the applicable claim count fields in this table to display the number of claims for the desired day range.
Most current plastic card history count
Next most current plastic card history count
The number of occurrences a provider has had a PDF version of their RA created.
The number of occurrences a provider has had a PDF version of their RA created.

The number of occurrences a provider has had a PDF version of their RA created.
Peer Group Count
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
A distinct count of the provider number of the individual that performed the service for the recipient (performing provider).
Number of cards issued
This is the count of ETG providers.
This is the count of ETG providers.
This is the count of ETG providers.
This is the count of ETG providers.
This is the count of ETG providers.
This is the count of ETG providers.
This is the count of ETG providers.
Distinct count of providers based on the billing provider ID.
Distinct count of providers based on the billing provider ID.
Distinct count of providers based on the billing provider ID.
Distinct count of providers based on the billing provider ID.
Distinct count of providers based on the billing provider ID.
Distinct count of providers based on the billing provider ID.
The count of the number of times the payment hold programs have been updated. This is used in internal audit processing.
This is the count of ETG recipients.
This is the count of ETG recipients.
This is the count of ETG recipients.
This is the count of ETG recipients.
This is the count of ETG recipients.
This is the count of ETG recipients.
This is the count of ETG recipients.

This is the count of ETG recipients.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
A distinct count based on the individual recipient ID number on a claim based on the Recipient Base ID.
This corresponds to the number of records inserted.
This corresponds to the number of records processed.
The number of claims rejected due to internal errors in the batch.
A count of the number of criteria used to define a COS. This is used to rank COS rows with the same restriction category. The higher the restriction count within a restriction category the more priority given to the COS.
A count of the number of criteria used to define a COS. This is used to rank COS rows with the same restriction category. The higher the restriction count within a restriction category the more priority given to the COS.
Number of Rows Processed.
The count of the number of times the payment hold programs have been updated. This is used in internal audit processing.
Number of claims in suspense at the end of the report month
The count of threshold errors on the batch.
The count of threshold errors on the batch
The count of threshold errors on the batch.
Percentage of total records that failed a given edit
The type of file being submitted (claims, provider, etc)
The count of paid cast crown dental services summarized by the various dimensions on the row.
Total number of denied claims.
Total number of paid claims.
The total number of details with TPL indicated.
The total count of newday claims in the batch.
The total count of newday claims in the batch
The count of distinct paid ICNs summarized by Provider NPI / Recipient ID / Service Date Quarter.
The count of distinct paid ICNs summarized by the various dimensions on the row.

Total number of physician details submitted by a provider of specific service location.
The count of paid exam dental services summarized by the various dimensions on the row.
The count of paid fluoride treatment dental services summarized by the various dimensions on the row.
The count of paid multi surface restoration dental services summarized by the various dimensions on the row.
The count of paid one surface restoration dental services summarized by the various dimensions on the row.
The count of paid palliative treatment dental services summarized by the various dimensions on the row.
The count of paid prophy dental services summarized by the various dimensions on the row.
The count of paid pulp cap dental services summarized by the various dimensions on the row.
The count of paid radiograph dental services summarized by the various dimensions on the row.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
A count of all records in the file except for the file header record.
The count of paid root canal dental services summarized by the various dimensions on the row.
The count of paid sealant dental services summarized by the various dimensions on the row.
The count of paid sedative filling dental services summarized by the various dimension on the row.
The count of paid simple extract dental services summarized by the various dimensions on the row.
The count of paid steel crown dental services summarized by the various dimensions on the row.
The count of paid surgical extract dental services summarized by the various dimensions on the row.
The count of services provided for the Provider NPI / Recipient ID combination at the initial visit.
The count of services provided during initial visits summarized by the various dimensions on the row.

The count of paid dental services summarized by the various dimensions on the row.
The count of paid dental services summarized by Provider NPI / Recipient ID / Service Date Quarter.
The count of paid dental services summarized by the various dimensions on the row.
The count of services provided for the Provider NPI / Recipient ID combination at all recall visits.
The count of services provided during recall visits summarized by the various dimensions on the row.
An unduplicated count of provider NPIs summarized by the various dimensions on the row.
An unduplicated count of provider NPIs summarized by the various dimensions on the row.
An unduplicated count of recipient IDs summarized by the various dimensions on the row.
An unduplicated count of recipient IDs summarized by the various dimensions on the row.
The count of visits (unique occurrences of Provider NPI / Recipient ID / service date) summarized by Provider NPI / Recipient ID / Service Date Quarter.
The count of visits summarized by the various dimensions on the row.
A visit is a unique occurrence of a Provider NPI / Recipient ID / service date. When a Provider NPI / Recipient ID combination occurs on more than one service date within a service quarter, the first occurrence is referred to as the initial visit. If the Provider NPI / Recipient ID combination only occurs once within the service quarter the count is set to 0. If the Provider NPI / Recipient ID combination occurs more than once within the service quarter the count is set to 1.
The count of initial visits summarized by the various dimensions on the row.
The count of visits where at least one radiograph service was provided summarized by Provider NPI / Recipient ID / Service Date Quarter.
The count of visits where at least one radiograph service was provided summarized by the various dimensions on the row.
When a Provider NPI / Recipient ID combination occurs on more than one service date within a service quarter, all occurrences after the first occurrence are referred to as recall visits. If the Provider NPI / Recipient ID combination only occurs once within the service quarter the count is set to 0. If the Provider NPI / Recipient ID combination occurs more than once within the service quarter the count is set to the total number of visits for the Provider NPI / Recipient ID combination minus 1.
The count of recall visits summarized by the various dimensions on the row.
The number of claims paid to an individual provider in the current year.

The number of claims paid to an individual provider in the current year.
Counter. (Count of Subscribers, Organization Summary Remittances, Member Details, Payees or Claims depending on CDE_BILLING_REC_ID)
Counter.(Count of Subscriber Eligibility or Benefit Inquiries, Subscriber Eligibility or Benefit Information, Claim Submitter Trace Numbers, Service Lines, Organization Summary Remittance Details, Member Details orClaim Payment Information depending on CDE_BILLING_REC_ID)
Count of unique recipients within a reporting group that have a claim denied for sak_esc
The unduplicated count of recipient IDs summarized by the various dimensions on the row during the reporting month.
The unduplicated count of recipient IDs summarized by the various dimensions on the row during the reporting month.
The accumulation of the units of service for the paid claims for a recipient during the reporting period.
The accumulation of the units of service for the paid claims for the reporting period.
The accumulation of the units of service for the paid claims for the reporting period.
The accumulation of the units of service for the paid claims for the reporting period.
This is the sum of the covered waiver days for this recipient within the level of care, initial/lag period, reporting period and waiver.
This is the case mix code.
This is the case mix code.
This is the case mix code.
This is the case mix code.
The 8 character name from the report banner line.
Any options to be passed to the COLD solution software.
The comment related to a specific provider application
Outbound - Interchange Agreement Identifier.
Company
If the claim record's first date of service falls within a period of confinement, this field will have the confinement number. If the record falls outside of any confinement periods, it will be blank.
If the claim record's first date of service falls within a period of confinement, this field will have the confinement number. If the record falls outside of any confinement periods, it will be blank.
If the claim record's first date of service falls within a period of confinement, this field will have the confinement number. If the record falls outside of any confinement periods, it will be blank.

If the claim record's first date of service falls within a period of confinement, this field will have the confinement number. If the record falls outside of any confinement periods, it will be blank.
The amount of time spent consulting for a call.
Email Address of First Contact for Service
First name of First Contact for Service
Last name of First Contact for Service
Email Address of Second Contact for Service
First name of Second Contact for Service
Last name of Second Contact for Service
Phone Number of Second Contact for Service
Email
First Name
Last Name
Contact name of the web user.
Phone Number
Indicates if the GCN Sequence Number has a contra-indicated disease at the time this row was added or last updated via the monthly load job.
The CCN on which payment was made
Control number from cash system.

The field used to hold the number of NDCs in dispute.
FIPS code indicating eligible's county of residence.
Current court order and number if one exists
The number of inpatient days covered by Medicaid on this claim. For states that combine delivery/birth services on a single claim, include covered days for both the mother and the neonate in this field.
This is the CRVS units.
This is the cost to charge DRG rate for the provider.
This is the cost to charge DRG rate for the provider.
The call tracking number.
This is the customary amount agreed upon.
This is the effective date.
This is the end date.
Date on which Userid Record was added
Eligible's Date of Birth.
Eligible's Date of Death.
This contains the first letter of the day of the week or 'H' for Holidays.
Standard interger date i.e. 19941230
The true JULIAN date, days since 12/31 4713 b.c.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents THE CHECK ISSUE date on which the first financial cycle run for Payers that finalize the claim.
Paid date
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents financial cycle run date date that corresponds with the first financial cycle run for Payers that finalize the claim in that cycle.

The date on which the payment status of the claim was finally adjudicated by the State.
The date on which the payment status of the claim was finally adjudicated by the State.
The date on which the payment status of the claim was finally adjudicated by the State.
This date identifies the date on which a claim was paid.
The cycle date the check or EFT was created.
The cycle date the check or EFT was created.
This is the first date used for parm processing.
The system date on which the invoices for the quarter were produced. This attribute is system assigned in the invoice process.
The system date on which the invoices for the quarter were produced. This attribute is system assigned in the invoice process.
The date that the inquiry was performed
The date that the inquiry was performed.
Indicates the system date that the PS/2 record was received and processed.
Indicates the system date that the PS/2 record was received and processed.
This contains the date in year to date, day of year format I.E. YYDDD 94310.
"Days" portion of the time period within which the trading partner expectes to receive the interchange acknowledgement.
Begin Throughput Days
Ending Throughput Days
Day of week claim was adjudicated or rejected in (DD).
Delete code. No longer used.
The final answer for the denominator portion of the measure.
Description of role.
Description of Security Level.
Description.
A short explanation of which department the batch range is for and the type of return.
Description of calculation type used for drop-down list.
Narrative description of the code.
This is the description of the chrono code.
Description of count criteria used for drop-down list.
Description of the source of the data used by the drop-down list.
Description of domain used for drop-down list.
Description of date range used for drop-down list.

Description of the invoice type - used in report headings.
Description of join type used for drop-down list.
Description of measurement source used for drop-down list.
This is the description of the cde_rate_type.
The reason the schedule was placed on hold.
Reason for the override.
The sub module name of the program that will be called to format the sort key.
Trading Partner grouping code description.
The DESI Indicator from CMS. Valid values are: 0 = NDC not on CMS tape (no information submitted by manufacturer) 2 = Safe and Effective or non-DESI 3 = DESI/IRS Drugs Under Review (no Notice of Opportunity for a Hearing [NOOH] issued) 4 = Less than effective DESI/IRS Drugs for Some Indications 5 = Less than effective DESI/IRS Drugs for All Indications 6 = Less than effective DESI/IRS Drugs Removed from the Market
Full path directory name used to override the trading partner mailbox directory if EDI Out is checked and only for this agreement.
Identifies the method used to submit the transaction such as PC, Internet, VS, or a switch vendor terminal id.
Primary diagnosis code of the ETG episode.
Primary diagnosis code of the ETG episode.
Primary diagnosis code of the ETG episode.
Primary diagnosis code of the ETG episode.
The ICD Diagnosis Code for the principal diagnosis for this claim. Principal diagnosis is the condition established after study to be chiefly responsible for the admission.
The ICD Diagnosis Code for the first diagnosis for this claim.
The ICD Diagnosis Code for the first diagnosis for this claim.
The ICD Diagnosis Code for the second diagnosis for this claim.
The ICD Diagnosis Code for the second diagnosis for this claim.
The ICD Diagnosis Code for the second diagnosis for this claim.
The ICD Diagnosis Code for the third diagnosis for this claim.
The ICD Diagnosis Code for the third diagnosis for this claim.
The ICD Diagnosis Code for the fourth diagnosis for this claim.
The ICD Diagnosis Code for the fourth diagnosis for this claim.

The ICD Diagnosis Code for the fifth diagnosis for this claim.
The ICD Diagnosis Code for the fifth diagnosis for this claim.
The ICD Diagnosis Code for the sixth diagnosis for this claim.
The ICD Diagnosis Code for the seventh diagnosis for this claim.
The ICD Diagnosis Code for the eighth diagnosis for this claim.
The ICD Diagnosis Code for the ninth diagnosis for this claim.
Five character out of country dialing prefix for the country.
Direction/purpose of map. IN/OUT/PRT/CMP
This is the type of dispostion on the budget. Either a deposit or a withdrawal.
This is the type of dispostion on the budget. Either a deposit or a withdrawal.
This is the dispensing fee of the drug.
This the total dispensing fee of the drug
The amount of time spent for the disposition of a call.
The actual document name that holds the skeleton letter.
This is the difference in the actual amount and the expected amount.
This is the difference in the actual amount and the expected amount.
This is the dollar difference of the Patient First provider and the peer group.
System assigned key for the incurred time dimension table.
System assigned key for the incurred time dimension table.
Code representing the Diagnosis Related Group that is applicable for the inpatient services being rendered.
An indicator identifying the grouping algorithm used to assign DIAGNOSIS-RELATED-GROUP (DRG) values.
The Drug Class Code. This is a ETG specific class derived from groups of NDCs. The grouping identifies a specific drug by manufacturer, drug, dosage, and form. Some common drugs are released by different manufacturers under different names. Because they are really the same chemically, though, they are valid for the same ETGs. Drugs which are available in different dosages or forms are also typically valid for the same ETGs.

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Text describing the Drug Enforcement Administration (DEA) code.
The description of the DESI code value, 2-6.
Text description of Drug Category Code.
The dispute reason code description for a drug rebate dispute
This is the dispute reason code description for a drug rebate dispute
The resolution code description for a drug rebate dispute
Describes a claim classification for the purpose of MAR reporting. The claim category reflects the least common denominator of the State and Federal categories.
Describes a claim classification for the purpose of MAR reporting. The claim category reflects the least common denominator of the State and Federal categories.
A description that describes a claim classification for the purpose of MAR reporting.
Text description of the HCFA FDA Therapeutic Equivalency Code.
Describes a claim classification for the purpose of MAR reporting. The claim category reflects the least common denominator of the State and Federal categories.
Accounting code description

Unisys' claims processing error description
Unisys' claim status description
Unisys' claim type description
Unisys; exception status description
Prior authorization status description
Prior authorization type description
Provider enrollment description
Provider specialty description
Provider type description
Unisys's record code description
This is the description text of the 1099 adjustment reason.
12 byte description used by the Research/Project Tracking System to identify the project status.
Text containing comment added to disposition.
Text for the description of the research request or project. Since it may take more than 150 bytes to clearly describe the request, there may be more than row in this table for a given request. The line number is used to rebuild the entire descrip.
Detailed and clear description of the status of the project or research request. This is an important place to document significant issues pertaining to the request.
The description associated with the reason code for the check reissues.
The short nomenclature for a medical condition.
The short nomenclature for a medical condition.
Description of the drug's classification code (E.G. Vaccine, Insulin, Supply, Nutritional, Class 1A, Anorexic, Family Planning, Smoking Cessation, Fertility Enhancement and Minoxidil).
A description of a Federal category of assistance.
Text description for a modifier type.
Description of the outcome code.
Text description of the pricing indicator.
Describes the ICD procedure type.
Description for the work area on the account.
This describes the coverage codes used for the retro billing execution.
This is the description for the type of abnormality.
This is the abnormality description.
Description of the return to sender reason code.

This contains the description for the type of bill type.
Describes the base reason for assistance by IFSSA.
Describes the types of aid groupings used by IFSSA.
Description for type of provider phone calls.
Description of the table entry
This will be used to hold specific values to be used as system parms.
Succinct description (name) of the AHFS Group.
Text that describes the reason code.
Free form text describing the meaning of the reason code.
Text giving description of status reason code.
Text describing the Ambulatory Surgical Center group.
Text describing the Ambulatory Surgical Center pricing group.
Describes the benefit plan type.
This is the description on the adjustment reason code.
Describes the reason of the cash receipt disposition
Describes the diagnosis type.
Describes the NDC type.
A description of the 'ind' field
A description of the 'cde_reason_four' field
A description of the 'cde_status2' field
Description of one character code.
Describes the diagnosis type.
Description of the corresponding HICL Sequence Number.
Succinct description (name) of the HIC Group.
A free-format description of the diagnosis codes.
Describes the modifier group type.
Text description associated with specific NCPDP response code value
Describes the procedure type, for example, "Collection".
The description of the Aid Code group.
The short description of the DPV error code group.
The short description of the Value Code group.
The description of the Provider ID group.
Describes the revenue type, for example, "Recovery Room".
Describes the taxonomy type.
Describes the therapeutic class type.
This is a 50 byte description.
This contains the description for the type of bill type.
A description of the reason that the A/R disposition was added.
The description of the provider type specialty group code.
The short description of the type of abnormality. Used for reporting purposes.

The short description of the type of abnormality. This column was formerly populated from T_DIAGNOSIS.DSC_25. The Abnormality panel was modified to access DSC_25 directly to minimize duplication of data and ensure an accurate description is displayed. Because of this change, this column is no longer populated by the extract.
Short description of the abnormality used for reporting purposes.
Short description of the abnormality used for reporting purposes.
Adjusted Clinical Grouper Description.
Verbal description of the action to be taken when the error fails. This is used on the error report.
The action taken due to the error found on the PS/2 transaction.
The action taken due to the error found on the PS/2 transaction.
This field contains the report recipients address.
The description that describes the address type code.
This is the description for the address usage.
The inverse code description.
The adverse drug reaction description.
The inverse code description
This is the adjustment description field.
Description of the adjustment
Description for adjusted amount category for adults
Description for adjusted amount for children
Text description of HIPAA adjustment reason code.
Text description of HIPAA adjustment reason code.
Description of the source of admission code found in block 20 on the UB92 claim record for inpatient and LTC claims.
Description for the priority of the admission of a recipient for inpatient services.
The description of the address type value.
The description for the ADvantage disposition code.
Allergy Description.
Allergy Description.
This description of the age range.
This is the description of the State Agency.
A text description of the age grouping.
A text description of the age grouping.
The description of a PMP provider's age restrictions.
Aggregation Description
Describes the type of aid for which a recipient is eligible.
Describes the type of aid for which a recipient is eligible.

Short Aid Category Description.
Description of the Alabama Schedule Code.
Description of the Alabama Schedule Code.
The reason that the analyst made a decision that is different from what was determined by the rule engine.
The reason that the analyst chose an answer that is different from what was determined by the rule engine.
The FDA Drug Application Type Code Description is a 50-character alphanumeric column that provides the text description of the FDA Drug Application Type Code.
The description of the application type
This describes the type of gepgraphical area. Examples include Zip Code, County Code and State Code.
Description associated to the type of form the provider included with the invoice.
This is the free form text description associated with the attachment or it's content. This maps to PWK07, Data Element 352 of the HIPAA 278 implementation guide.
Text description of claims attachment.
A free-form description to clarify attachment and the contents.
Description of the attribute that caused a particular edit to fail. This description will appear on the Claim Correction Form.
Description of the Auto PA Criteria
The description of the bank account that will be shown on windows and reports.
This is the contents of the banner message.
Description of the bed type code.
The description of the benefit limit category.
A description of the role. The description should make a reference to the field(s) on the claim that contain the value for the benefit in question. For example, on the 837 Inst the Admitting diagnosis is in the first HI segment.
Describes the type of benefit.
This field provides a detailed description of it's associated billing media code.
This field describes the type of billing.
The description of the Benefit Adjustment Factor
A business description of the budget that will be used for reporting and windows.
Description of business activity code.
The description of the cde_bus_process field
The description of the 'cde_bus_unit' field
Description of the buy-in eligibility code.
Description of the buy-in transaction code.
Description of the buy-in transaction code.
The description of the caller type.

The description of the call category.
The description of the call completion.
The description of the call method.
The description of the call priority.
The description of the call status.
The description of the call type.
The description of the unit.
The text for a canned response.
Describes the managed care rate cell.
This is the description of the carrier status.
This is the description of the carrier type.
Case Group Description
Case Status Code Description.
This is the description of the case type.
Case Type Description
Describes the case type code.
This is the description of the status code.
Describes the status code for CSHCS recipient eligibility.
The description of the source indicator.
Detailed description of what the code represents based on whether it's an input or output code.
Description of the reason code for an expenditure transaction.
Describes the reason code for issuing an ID card to the Medicaid recipient.
This is the description of the Entity.
This is the description for the specific provider certifications.
The description of change line 1.
The description of change line 2.
The description of change line 3.
The description of change line 4.
The description of change line 5.
The description of change line 6.
Description associated to the citizenship code.
Citizen Status Description
This field is the claim form description associated with a claim form type code.
This is a description of the contents of the group. It should specify how this group is to be used.
A description of what the hierarchy is and to use it.
Description of HIPAA Claim Category Status Codes
The description of the location of the claim code.
Description of the code that indicates if the claim is approved or rejected.
Description of Claim Status.

Description of the value assigned to a specific claim type.
Description of the code indicating the type of claim record.
Description of the code indicating the type of claim record.
A description for the claim type value.
Description which describes the TOS code value.
Description of the 'cde_collect_media' field
A comment related to an NDC or to the entire invoice.
The text of the note or comment relating to the provider.
Notations significant to the fee collection or return.
This is a description recorded at the end of batch program. Possible values: SAMVerification batch program.
The response received from processing the record
Area for comment information for each reason code for the assignment plan.
This is the specific comment about the recipient.
A brief description of the problem log, including any special comments by the user
Original transaction received from CMS.
Original transaction received from CMS.
This is the complete transaction from the the source.
This is the complete transaction from the the source.
Description of a conditions relating to a UB92 claim that may affect payer processing.
Confirmation Description
A description for the type of contact.
Description of copay type.
A description of the copayment type.
A description that describes a claim classification for the purpose of MAR reporting.
Description for the Category of Service value.
Country name
Twelve character field containing the name of a specific county.
This field contains the description associated with a specific court ordered code.
This describes the type of coverage (services) a TPL resource provides.

Provider's case selection criteria description.
Client's case selection criteria description.
Case Category Description
This is the description of the coverage level
Day Description
Describes the field which is returned by the SQL statement used to retrieve letter data.
Short description of the field name.
Long description of the field name.
A descriptive name of the decision. It should be unique for a transaction.
Example, is the provider allowed to bill the service on the claim?, is the Procedure covered under the Recipient Benefit Plan?
The text description of Group purpose. Definition of where and/or how the group type is used.
Definition of where and/ or how this benefit plan group is used.
Definition of where and/or how this diagnosis group is used.
Definition of where and/or how this NDC group is used.
Definition of where and/or how this Error type is used.
Definition of where and/or how this GCN Sequence Number group is used.
The text description of Group purpose. Definition of where and/or how the group type is used.
Definition of where and/or how this modifier group is used.
Definition of where and/or how this ICD procedure group is used.
Definition of where and/or how this procedure group is used.
The definition of the Aid Code group.

The text description of the group purpose. Definition of where and/or how the group is to be used.
The definition of the Value Code group.
The definition of the Provider ID group.
Definition of where and/or how this revenue code group is used.
Definition of where and/or how this taxonomy group is used.
Definition of where and/or how this specific therapeutic class group is used.
Definition of where and/or how this TOB groups is used.
Definition of where and/or how this type spec group is used.
Code Description.
This field contains the report recipients department.
This field contains the description of the destination.
Description of the diagnosis compatibility group.
Describes disaster survivor code.
Disease code description.
The text description of the First DataBank disease code (FDBDX in FDB manual).
The text description of the First DataBank disease code (FDBDX in FDB manual).
Description that represents the action (pay, deny, suspend,super suspend, Pay and List) that should be taken on a claim at dispositioning time.
A description of the Dental Procedure Group Code.
A description associated with the provider peer group code.
Description of code values.
A descriptive name for the domain. This may appear in the UI. Examples, Integer, Place of Service.
The Dosage Form Description (D) field describes the dosage form by which a drug is formulated. Descriptive terms include tablet, capsule, and cream. Abbreviations may be used to conform to space requirements.
Dosage Form Code Interpretation (GCDF_DESC on NDDF)
This is the Dose description for the drug code.
This is the description of the dose formula for the drug.
The short description of DPV return code.
The detailed description of DPV return code.
This is a forty byte character field used to describe a DRG grouping. The DRG code and description are obtained from HCIA.
Description of the associated state-specific DRG code.
Generic Drug Description

Describes the drug product container and includes the following: AEROSOL, AMPUL, APPLICATOR, BAG, BOTTLE, BOX, CAN, DISPENSER, DROP BTL, JAR, KIT, PACKET, SQUEEZ BTL, SYRINGE, TINE, TUBE, VIAL and WRAP. Abbreviations are used to keep within 10 characters.
The Package Description Mnemonic is the abbreviated description of the package.
Describes the drug product container and includes the following: AEROSOL, AMPUL, APPLICATOR, BAG, BOTTLE, BOX, CAN, DISPENSER, DROP BTL, JAR, KIT, PACKET, SQUEEZ BTL, SYRINGE, TINE, TUBE, VIAL and WRAP. Abbreviations are used to keep within 10 characters.
Drug Schedules.
The description of the drug source code.
The Drug Strength Units (STRUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.
Drug product strength in NDDF is usually expressed in metrics. This field, when used in conjunction with the Drug Strength Number, Drug Strength Volume Number and the Drug Strength Volume Units, will be conventional strength expression for drug product.
The Drug Strength Volume Units (VOLUN) must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Volume Number (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.
Drug product strength in NDDF is usually expressed in metrics. This field, when used in conjunction with the Drug Strength Number, Drug Strength Units and the Drug Strength Volume Number, will be the conventional strength expression for the drug product.
The description of the Prior Period Adjustment code.
This is the description of the type of unit the drug is measured in.
This the day description.
The full description for the dual status code.
The description of the conflict code.
The description of the intervention codes.
The description of the outcome code.
District Office track code description.
Description of the earnings code.
Description of the earnings category code.
The description of the insurance disclosure edit code.

Text description of the status code.
The email address of the contact for this address/contact name.
This field contains the report recipients email address.
Emergency Code Description.
This is the description of the enrollment reason code.
This is the description of the enrollment status code.
This is the enrollment status description that is added to a provider when enrolled.
The full description for the enrollment type for the Part D Medicare.
This field is the first line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
This field is the first line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
This field is the second line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
This field is the third line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
This field is the fourth line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
This field is the fifth line of the nomenclature for an Explanation of Benefits that will be printed on the remittance advice.
The short text message associated with the EOB code which will be returned on the NCPDP response.
Explanation of Medical Benefits description used on Recipient EOMB.
The sub module name of the program that will be called to format the electronic RA.
Description Of Error Encountered.
This is the short description of the error code used in standard reporting.
This is the detail description of the error code.
Contains the error text associated with the response.
Contains the error text associated with the response.
Description of an edit or an audit.
Description of an edit/audit that is performed in the MMIS system.
Description of the error type.
A description of the error taken by the update.
Description of the program that processes in the MMIS system.
Description of an edit/audit that is performed in the MMIS system.
Recipient ethnicity code description.
Description of the event.

Description of training.
User friendly description of event that occurs involving a particular letter.
Extended description of error event or stack trace.
Description for the Event Key codes.
Description or comments related to the event.
Description or comments related to the Event Key.
Gives additional description about the request.
Extra data that will be included in the letter. This is field will typically be used in a batch mode rather than online.
The value in the field in error on the PS/2 transaction.
The value in the field in error on the PS/2 transaction.
MMIS filename of ACA output batch file.
MMIS filename of ACA output batch file.
Contains the description about the filenames.
Contains the description of the filename.
Description of the File Direction Code.
Description of information in the K3 segment.
The description for the case tracking file location.
Description of the file status codes.
Filter Description
Description of the field.
The description of the Medicaid activity code that is used for financial reporting.
This the description of the Financial Category of Service.
A business description of the financial cycle that will be used for reporting and windows.
The description of the Medicaid department code that is used for financial reporting.
A business description of the payer that will be used for reporting and windows.
A short business description of the payer.
The is the actual footnote text published on the Periodiciry and Vaccine Schedule.
This a description of the use of the key indicators functions and/or meaning as used on the Periodicity and Vaccine Schedule.
This contains a brief description of the form being defined.
Frequency Description
Description of frequency used for drop-down list.

Description of codes representing the different AK5-01 values of 997. A - Accepted / ADVISED E - Accepted But Errors Were Noted M - Rejected, Message Authentication Code (MAC) / Failed R - Rejected / ADVISED W - Rejected, Assurance Failed Validity Tests X - Rejected, Content After Decryption Could Not Be Analyzed
This is the description of the financial fund code that is used for reporting.
This is the description of the financial fund code that is used for reporting.
This is the description of the a fund code group.
This is the long description for the financial fund code. This field allows for longer explanation and description of the code that is not intended for reports.
A business description of the payer that will be used for reporting and windows.
A short business description of the payer that will be used for reporting and windows.
Description for the fund source.
Description of GCN Sequence number grouping.
This is the generic description of this drug.
This is the description of the group originating from the standard code sets. For example, the source for procedure code group descriptions will be the CPT4 and HCPCS standard manuals.
A description of the group that indicates the type of letters that will contained within this group.
This field provides the description of the letter group.
Description of the code that indicates the group.
Description associated to the grouping code.
This is the description for the group class that will be displayed on the reso window. Examples: Procedure Groups, Diagnosis Groups
Description of the step therapy group.
Description of the type of group number.
Description of the Health Care Claim Status Code.
Description of Health Care Claim Status Entity Identifier Code.
Free-form HTML explaining what that page is for. This fields is seen by users of the web-site.
Description associated with the pharmacological class (HIC2).
Description associated with the Therapeutic Class (HIC3).
Description associated with the Hierarchical Base Ingredient Code (HIC4).
This contains the description for the specified data element within the HIPAA transaction.
The description of the code that identifies why a policy was or was not purchased.
This field contains the description associated with a specific HMO indicator code.

This field holds the descriptions for holidays that fall on weekdays.
This represents the descriptive text associated with a reason code.
This represents the descriptive text associated with a reason code. PA analysts may add external free-form text as a supplement to the reason code description.
The description of the ICF/MR final approval code.
The description of the ICF/MR pre-approval code.
Describes the type of immunizations that are to be performed for EPSDT eligible recipients.
These are the descriptions for the income types. Valid values are: SSA, VA, RR, FCS Pension, Other, SSA - VA, SSA - RR, SSA - FCS, SSA - Other, VA - RR, VA - FCS, VA - Other, RR - FCS, RR - Other, FCS - Other, SSA - VA - RR, SSA - VA - FCS, SSA - VA - Other, SSA - RR - FCS, SSA - RR - Other, SSA - FCS - Other, VA - RR - FCS, VA - RR - Other, VA - FCS - Other, RR - FCS - Other, Black Lung, BL - SSA, BL - Other, BL - SSA - Other, Rent - SSA, RT - VA, RT - RRR, RT - SSA - VA, RT - SSA - RRR, RT - SSA - Other
Text description of activation indicator.
Description of the insurance product. Descriptions maintained in this table are found in the 834 HIPAA Implementation Guide.
Short description for invoice type.
This is the full description for each language that the system tracks.
Language description.
This is the HIPAA description for a specific language.
Procedure Code Laymans Description
Description of the code in layman terms.
Description of the code in layman terms.
Description of the code in layman terms.
Description of the valid accident reason type codes.
Text description of pricing locality. Valid values are metropolitan, rural, urban, out-of-state, statewide.
A description of the letter and its purpose.
Contains the description of the letter
Contain the description of the letterhead
Long text description explaining why a letter is being sent to the provider. The description will be auto-populated into the text of the associated letter.
Description of the level
Description for the level of care for a recipient.
Description of License Number State Code found in the HIPAA 278 Request and Response Guide in loop 2010EA, segment REF, element REF03.
Description of the license classification code.
Description of the reason code.

Free form text used to add information to a deduction transaction.
Description of the value assigned to the lien disposition code.
Description of the limitation.
This is the type of data that was not systematically linked or unlinked and needs to be manually reviewed.
Description for code indicating the recipient's living arrangement, i.e. state hospital, independent living, etc.
Description of Living Arrangement Code.
The Label Name contains a combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.
The Label Name contains a combination of the drug name appearing on the package label, the strength description, and the dosage form description for a specified product.
The text description of the provider level of care associated with the code indicator
The text description associated with this level of care value
Describes the level of care for the recipient.
District Office program code description.
Description of the type of location in which a claim can be placed during claims processing.
Describes the reason the recipient was entered into the lockin program.
Describes the reason the recipient exited from the lockin program
Describes the meaning of the code in the first position of the level of care stop reason.
Describes the code for the second and third position of the level of care stop reason code.
Text used for additional documentation to be added to the accounts receivable.
Text used for additional documentation to be added to the accounts receivable disposition.
Free form text used to add information to a payment transaction.
The long nomenclature for a medical condition.
The long nomenclature for a medical condition.
A long description of the service type code as defined by the X12 Implementation Guide.
Free form text used to add information to an expenditure transaction.
Long text that describes the modifier.
A long medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.
A long medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.

Text used for additional documentation to be added to the return to sender letter.
Long description of the accuracy of the calculated longitude/latitude.
The description of the letter category value for a letter code type.
A description of the letter associated with a letter type.
The description of the letter code type value.
A description of the 'cde_mailing' field
The marital status description.
The description of the client's marital status code.
Description which describes the Medicare coverage code value
Description of the group.
Description of the group.
description of the entity
Description of the Managed Care program status code group.
This is a description or name of the region within the state.
This is a description or name of the region within the state.
Description of the type of services provided.
This is a forty byte character field used to describe a MDC. The MDC code and description are supplied by HCIA.
Measure Description
Description of the measure base.
A description of the 'cde_media_type' field
Description.
Description of Media Type.
This represents the description of the media type used by a provider or IFSSA when communicating with the Prior Authorization unit.
This is the description of the Medicare Indicator.
Medical Support Code Description.
Describes the edit error for batch processing
[RFC2045,RFC2046] specifies that Content Types, Content Subtypes, Character Sets, Access Types, and conversion values for MIME mail will be assigned and listed by the IANA.
This is a description of the MI determination code.
Short text that describes the modifier.
This is a description of the MR determination code.
Brief description of application
The description of the control
The description of authorization

Description of Profile Window Authorization
Description of user control authorization
The description of user profile authorization
Description
Free form description of the injury in a casualty case.
Free form description of the injury in a casualty case.
The text description of the NCPDP conflict code assigned by NCPDP.
This field is a combination of the drug name appearing on the package label, the strength description and the dosage form description. The field size is 30 characters but is edited to fit within a maximum length of 27.
Contains the name that appears on the package label provided by the manufacturer. This column is populated for all products, brand and generic.
This field is a combination of the drug name appearing on the package label, the strength description and the dosage form description. The field size is 30 characters but is edited to fit within a maximum length of 27.
The description of the nursing facility disposition code.
The description of the note.
A free-form description to clarify the related data elements and their content
The text of the note.
The text of the note.
The text of the note.
The text of the note.
The text of the note.
The Managed Care provider notes at the NPI level.
The text of the note.
The text of the note.
The text of the note.
A question to be answered by the PA analyst
The text of the note.
The text of the note.
The text of the note.
Description of the note types.
This describes the different kinds of EPSDT notices.
Free-form text to enter resolution reason for bank no issue record.
The Abbreviated Description of the National Drug Code Price Type.
The Definition of the Description of the National Drug Code Price Type.
Provides the text description for the Orange Book Code.
Member's occupation.

Date on which a significant event relating to a particular UB92 claim that may affect payer processing occurred.
Description of official status code.
Description of Other Coverage Code.
Description of recipient's source of other income.
Description of recipient's source of other income.
The description for the case tracking outgoing referrals.
The payment level description for the DSSProfiler payment level.
The sub module name of the program that will be called to format the paper RA.
Descriptino of parameter
The parameter type description.
This is the description for the parameter used in a job/process.
The short parameter type description.
Value of the parameter (format will vary depending on edit number and parm type).
Description of Part Code Identifier.
Part Indicator Code Description.
Description of the part sequence.
The description of the PASRR code.
Description. Free-form description of the patient's condition.
Description. Free-form description of the patient's condition.
Description of the status of the recipient as of the ending service date of the period covered on a UB92 claim.
Describes the payee
A description of the 'cde_payment' field
This field stores the description of the cash receipt payment type code.
This field stores the description of the cash receipt payment type code.
This is a description of the Prior Authorization assignment code used to batch the PA requests.
This is the Prior Authorization external free form text entered by the PA Analyst to be printed on the PA notice.
This is the Prior Authorization internal free-form text entered by the PA Analyst or by the 278 transaction for internal use only.
The full description for the PDP Plan code.
Peer Group Description
This is a thirty byte field used to describe a peer group for DRG pricing. The peer group code and description are determined by the State.
Indicates the month or year that a service must be performed for EPSDT screenings and immunization.
A description of the type of period as it will show on a report or window.

Text definition of program describing who is eligible and what types of services are provided.
This is a description for the program grouping.
Description of the code indicating who is eligible and what types of services are provided.
Describes the medical assistance program.
Program Status Description
Describes the phone code.
This field contains the report recipients phone number.
This describes the type of telephone number.
A description of the 'cde_phs_type' field
The Package Description is the full text description of the package.
The description of the plan code.
The description of the insurance plan.
Description of the focus.
Description describing the code valid values could be: Test Environment Model Office Environment Production Environment
Description of place where medical assistance service is performed.
Description of place where medical assistance service is performed.
This is the board position description.
Sanctioned Provider's practice type
Sanctioned Provider's practice type
Procedure Code Description
A short medical description of a specific, singular medical or dental service which is performed for the express purpose of identification or treatment of the patient's condition.
A short medical description of a specific, surgical or diagnostic procedure which is performed for the express purpose of identification or treatment of the patient's condition.
Description of the process.
The Procedure Code Description found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV301-7).
Description of group responsible for the adjudication of claims.
The Procedure Code Description found in the HIPAA 278 Request and Response Guide in the SV2 Intuitional Service segment; element (SV202-7).
Procedure Code Description found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV101-7).
The description of the ProDUR screening.
The description of the ProDUR screening.

Description of Projected Status Code.
Description of Provider ID type.
This is the short description to the provider enrollment program.
This is the long description to the provider enrollment program.
Description associated with a provider specialty code.
This is the description associated with a provider subspecialty code.
This is the description of the super specialty.
Provider type description.
Description associated with a provider type code.
Description of provider ID end date reason code.
This is a description of the psychiatric diagnosis code, used by Prior Authorization.
This is the description of the reason that a payment can be pulled for manual review.
Description of the qualifier.
Description of qualifier type used for drop-down list.
Contains the description of the data for the query generated for the request.
Description of Report Query.
Contains the description of the query required to generate the letter
A description of the query and the data that it will return.
A question to be answered by the PA analyst
Question that the user typed and needs answered by tech support.
Description of recipient's race derived from the first position of cde_race.
Race name
The description of the race code.
This is the HIPAA description for a specific race code.
A description of the range type to be assigned.
Description of rate type.
Description of the reason for withholding payment.
Short description of the reason for which a letter is sent to the provider.
This is the reason code description for the assignment plan.
This describes the type of coverage that a TPL policy provides.
The description of the managed care reason codes used to indicate when a recipient will automatically go into auto-assignment and when to be excluded.
Contains the county code description.
The description of the record type code.
This contains a brief description of the record being defined.
Description of the referred code value.

Description of the value assigned to a specific claim source.
Description of the region code.
The description of the region
The description of the region.
This field contains the description associated with a specific HIPAA relationship code.
This is the description of the relationships that a provider and owner can have.
Text Description of HIPAA remarks code.
Reason for replacement description. Found in the HIPAA 278 Request and Response Guide in the SV3 Dental Service segment; element (SV305).
The text of the reply.
Description of table to be mass rate adjusted.
This column provides a description of the restriction type.
This describes a specific accommodation or ancillary service.
Description of the review reason.
Free form text field where users may provide details about the review reason, associated document number, etc.
Description of the review type code.
This describes a specific accommodation or ancillary service.
Description of review requestor code
Description of review reason code
This field contains the report recipients room.
The Route Description (RT) indicates the normal site or method by which a drug is administered. The current range of descriptors includes oral, topical, injection, etc.
The Route Description indicates the normal site or method by which a drug is administered. The current range of descriptors includes oral, topical, injection, etc. This is the Route Code Interpretation data element (GCRT_DESC) on the NDDF update file.
Report Category Description
A description of the reporting period (i.e. Feb 2001). This description is displayed in the beginning and ending reporting period selection list boxes of the MAR windows application.
The description to identify the report the recipient is associated with.
A description of the This/Last Code used for the Dental Profiler Participation Analysis reports.
Description of the 'cde_rqstr' field
This is the managed care eligibility reason code description for HIPAA.
The description of the reason a recipient was assigned to a PMP, or the recipient's reason for dis-enrollment from a PMP.

The description of the resource if the resource type is "Other".
This is free form text description stating the reason that a provider application was returned to a provider applicant.
This is free form text description stating the reason that a provider application was returned to a provider applicant.
A string with all the rule variable information.
This field contains the description of the System Assigned Key.
Long description for the associated main grouping code.
Long description for the associated subgrouping code.
Describes the type of screenings that are to be performed for EPSDT eligible recipients.
Describes the type of screenings that are to be performed for EPSDT eligible recipients.
NCPDP SCRIPT Quantity Qualifier Description
Description of sequence type.
A free-form description to clarify the related data elements and their content.
This field contains the description for the HIPAA service type code.
Description of recipient's gender.
Text describing the gender of an individual.
Text describing the gender of an individual.
Sex Description
The description of the sex code.
A short description that can be used in a UI with limited pace or a voice response system to limit speaking time.
Short description of the accuracy of the calculated longitude/latitude.
Name of the transaction.
Name of the Transaction.
The description of the short stays code value.
A description of the CDE_SOURCE value.
Source Code Description.
A description of the transaction type value.
This is the full description of the source of recipient updates and information.
The description of the special code.
Sanctioned Provider's Specialty
Sanctioned Provider's Specialty
Description of the special condition.
This describes the special condition class.
This is the description for the special condition type.
The full name of the state.

This is the description of the check statuses that is used for display and reporting purposes.
Status Description
Description of the lien status code.
This is the description of the decision status of a Prior Authorization line-item.
Description of the application tracking record status value.
This is the description of the billing status code.
Description.
This is the description of the status code.
This field corresponds to Field 6 on the NCCI database, containing the Standard Policy Statement.
Description for the termination of an eligibility period for a Medicaid recipient.
The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.
The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.
The Drug Strength Description (STR) is a description of drug potency in units of grams, milligrams, percentage, and other terms. Strength is expressed in metric units. This field includes needle sizes, length of devices, and release rates of transdermal patches.
Indicates the strength of the drug code.
This is the strength of the drug.
CR1 -Stretcher purpose description
Description of the Level I tracking screening status value.
Description of the document type.
This is the description of the entity the system assigned key defines.
This is the report description of the audit table.
This is the description of the taxonomy code.
Contains the description of the template for the particular letter
Short Text message.
This field holds the concatenated text for up to 3 multiple messages.
This is used for free form text in the chrono notes.
Long Text message.
Provides the text description for the AHFS Therapeutic Class code.
Provides the text description for a Generic Therapeutic Class code.

Therapeutic Class description.
Provides the text description for a Standard Therapeutic Class code.
Description of the type of threshold
Description for the throughput group.
Description of the time unit.
Professional Title Description
Descriptive title for this web-page.
CMS description for the data element.
CMS Data dictionary description of the edit being performed.
CATEGORY NAME description for an ERROR CATEGORY entry
Description from CMS Validation Logic
TIER NAME description for an ERROR CATEGORY entry
A valid value for the column and table combination
This is the description of the tooth.
Description of tooth quadrant.
Description of the tooth surface.
Text description of TPL service class.
Description of the functional area of the TPL sub-business function.
Description of the status code.
Description of the Trading Partner type.
The FDA Trade Name is a 125-character alphanumeric column that contains the FDA description for an NDC.
The transaction that is in error.
This is a descriptive name for the transaction. Example, Claim submission.
Long Description.
Description of the transport types.
CR1 - Round Trip purpose description
Description for the fund source.
Description of the financial transaction.
Describes the specific type of facility.
Description of the type of screening.
Description associated to the unearned source code.
This field describes the unit code.
This field describes the cde_unit field.
The desciption of the financial unit\department.
Detailed description of what one unit represents.
A description (Add, Update, Delete, To) of the type of update being logged.

A description (Add, Update, Delete, To) of the type of update being logged.
A description (Add, Update, Delete, To) of the type of update being logged.
A description (Add, Update, Delete, To) of the type of update being logged.
A description (Add, Update, Delete, To) of the type of update being logged.
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A description (Add, Update, Delete, To) of the type of update being logged.
A description (Add, Update, Delete, To) of the type of update being logged.
URL of the web-page. Example, "/OHCA/Admin/webUserWrite.xhtml".
Describes the value of the field which is returned by the SQL statement used to retrieve letter data.
Description of the code used to relate values to identified data elements necessary to process a UB92 claim.
The description of the CDE_VALUE field.
The definition of the VALUE Code group entry.
A descriptive name of the variable. This may be used in the UI to label the variable.
A description of the cde_work_class field
A description of the waiver service that will appear on the CMS 372 report.
Contains data for the X12 ACA request or response.
Contains data for the X12 ACA request or response.
Contains data for the X12 ACA request or response..
Contains data for the X12 ACA request or response..
Contains data for the X12 ACA request or response.
Contains data for the X12 ACA request or response.
Transfer/Release reason description.
Transfer/Release status description.
The SQL query structured in a "xmlpunld" notation.
Name of an XSD file associated with this web-page.
The date on which the individuals participation in 1115A demonstration began.
The date on which the individuals participation in 1115A demonstration ended.
This is the date the 1261A Prior Authorization report was received. This is for psychiatric PAs only.

This is the date the 1261A Prior Authorization report was returned. This is for psychiatric PAs only.
This field stores the date expressed as CCYYMMDD, where CC represents the first two digits of the calendar year. This is the date that the claim was received by the payer.
This field stores the date expressed as CCYYMMDD, where CC represents the first two digits of the calendar year. This is the expiration date of the patient's coverage.
Stop date transmitted to CMS.
Stop date transmitted to CMS.
Stop date transmitted to CMS.
Stop date transmitted to CMS.
The date the signed application was received by the Medicaid representative in CCYYMMDD format
Date the accident occurred.
Date of accident found in block 14 on the HCFA-1500 claim form
Date of accident found in block 14 on the HCFA-1500 claim form
Date the accident occurred.
The date the organization achieved accreditation.
The date when organizations accreditation ends.
The date an action was taken regarding a SOBRA application family member. Format is CCYYMMDD.
The date the action was entered in CCYYMMDD format
The date that the check reissue entry is approved for payout.
The date that the check reissue entry is approved for payout.
Date on which the expenditure transaction was activated for payment.
Date on which the expenditure transaction was released into the system for payment.
Date on which the expenditure transaction was activated for payment.
The processing date this rate is active for this county.
The processing date this rate is active for this provider.
The processing date this rate is active for this provider.
The date this rate is active for this provider service location.
The processing date this rate is active for this provider.
This is the date this row becomes active. For new claims the system date is compared to this date. If the system date is less than this date, the row will not be used to process the claim.
Crosswalk segment active date. This is the date/time that the crosswalk row can be used, regardless of the dates of service on the claim.
This is the date that the row becomes active.

The date the employer started business.
The through date the assignment segment is active. When an assignment segments are added using the information received from CMS, If the same segment is not received from CMS in the subsequent MMA response file, active segment will be updated to history, the dte_active_thru will contain the date the segment was made history. This date will support the date specific assignment logic on the PDP assignment history window.
The through date the assignment segment is active. When an assignment segments are added using the information received from CMS, If the same segment is not received from CMS in the subsequent MMA response file, active segment will be updated to history, the dte_active_thru will contain the date the segment was made history. This date will support the date specific assignment logic on the PDP assignment history window.
Date of activity associated with expenditure txn.
Date of activity associated with expenditure txn.
Date the record was added to the table
This field specifies the add date for the consent form.
This field specifies the add date for the consent form.
This field specifies the add date for the consent form.
This is the date the update record was added to the table.
Date the accounts receivable was created. This date will be used in determining the age of the accounts receivable.
Date the accounts receivable was created. This date will be used in determining the age of the accounts receivable.
This is the date the AR comment was added.
This is the date the AR comment was added.
This is the date the cash receipt comment was added.
The date the case was added to the casualty case table.
The date the case was added to the casualty case table.
The date the case was added to the casualty case table.
Date record was added
System added current date to indicate when the record was added to the table.
This is the date the payment comment was added.
This is the date the payment comment was added.
This identifies the date a particular chrono note was added to the case.

This identifies the date a particular chrono note was added to the case.
System added current date to indicate when the recoupment was processed.
System added current date to indicate when the record was added to the table.
This field indicates the date the row was added to the table.
Date record was added
This field indicates the date when this record was inserted into the table as a result of successfully processing recipient link or unlink transaction.
System added current date to indicate when the record was added to the table.
Date on which the expenditure request was initiated.
Date on which the expenditure request was initiated.
Date on which the expenditure request was initiated.
This is the date the expenditure comment was added.
This is the date the expenditure comment was added.
Date the accounts receivable was created. This date will be used in determining the age of the accounts receivable.
Date that the disposition was added to the system.
This is the date the record was added to the table.
This is the date the policy was identified as a HIPP resource.
Date that the lien was added to the system.
Date that the lien was added to the system.
This is the date the lien comment was added.
Date that the disposition was added to the system.
Date that the disposition was added to the system.
This is the date the drug was added.
Date Special Condition Added.
Date Special Condition Added.
The date that the selection was added.
The current date that the row was added
The current date that the row was added
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The current date that the row was added
The current date that the row was added
The current date that the row was added
Date of original registration.
The date the label criteria was added or last updated.
Date the row was added by DXC
Date the row was added by DXC
The date that the recipient was added to the system.
The date the recipient was added to the interChange system.
This is the date and time that the comment was entered.
The date the death change was sent in by a transaction.
Date added
Date processed.
Date the recipient was identified as a potential Managed Care recipient through the PS/2 update and the data was added to the table.
Date the recipient was identified as a potential Managed Care recipient through the PS/2 update and the data was added to the table.

Date the recipient was identified as a potential Managed Care recipient through the PS/2 update and the data was added to the table.
This date identifies when the row was added to the table. The format is CCYYMMDD.
Date that the PMP assignment was created/inserted.
Date that the PMP assignment was created/inserted.
This is the date we have marked this resource as suspect.
The date that the subscriber was added to the table.
This is the date the record was added to the table.
Date added to the table.
Date added to the table.
Date on which the disposition was added to the system.
Date on which the disposition was added to the system.
Date on which the disposition was added to the system.
Date that the A/R was added to the system.
Date that the A/R was added to the system.
Date that the A/R was added to the system.
The Date the Recipient was added to the Cancer Registry.
The date on which the recipient was reported.
This is the date the resource was originally added to the system.
This is the date the resource was originally added to the system.
Date the record was added.
Effective date from CMS
Effective date from CMS
Effective date from CMS
Effective date from CMS
RCO claim adjudication date
Date adjudicated by the payer.
RCO claim adjudication date
Date adjudicated by the payer.
Date when this Payer adjudicated the claim
The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.

The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.
The date on which the payment status of the claim was finally adjudicated by the state.
Date on which adjustment request was initiated.
Date on which adjustment request was initiated.
Date on which adjustment request was initiated.
Date on which adjustment request was initiated.
Date on which adjustment request was initiated.
Date on which adjustment request was initiated.
The date system initiated adjustment transactions against the claims associated with the recoupment request.
Date on which adjustment request was initiated.
Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.
The date the recipient was admitted to the hospital
Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.
Date on which the recipient was admitted to the hospital.
Date on which the recipient was admitted to the hospital.
Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.
The date the patient was admitted to the facility.
Date that the recipient was admitted by the provider for inpatient care, outpatient services or start of care.
Date the recipient was admitted to the provider facility
The date on which the recipient was admitted to a hospital or long term care facility.
The date on which the recipient was admitted to a hospital or long term care facility.
The date the client was admitted to the nursing facility. (PASRR PRE-ADMISSION SCREEN, Referral, Date Admitted to Facility) ;
The date that enrollment agreement was signed on.
The date the agreement to repay was reached between the recipient and Medicaid.
The date the agreement to repay was reached between the recipient and Medicaid.
Date agreement was mailed.
Date agreement was received.
The date an action is required in CCYYMMDD format. SOBRA only.
Special alert date in CCYYMMDD format
The date the next annual review is due. (PASRR PRE-ADMISSION SCREEN, Determinations, Annual Due Date)

The date the annual resident review is due. Resident Review Screen, Resident Reviews, Annual Due Date)
The date of an appeal if the decision is appealed. (PASRR PRE-ADMISSION SCREEN, Determinations, Appeal date)
Indicates the application date in CCYYMMDD format
The application date in CCYYMMDD format.
The date on which the provider applied for enrollment into the States Medicaid program.
The date the completed application is received by the district office in CCYYMMDD format
Offset date in CCYYMMDD format
The date the application is received by the agency in CCYYMMDD format
The date the record is to be reviewed by the district office or another certifying agency. Format is CCYYMMDD.
The date of the last status change of the SOBRA Application in CCYYMMDD format
Appointment Date.
The date of birth of the absent parent in CCYYMMDD format
This field indicates the date that a provider became eligible to receive an automated remittance advice.
This field indicates the date that a provider became eligible to receive an automated remittance advice.
This field indicates the date that a provider became eligible to receive an automated remittance advice.
This field indicates the date that a provider became eligible to receive an automated remittance advice.
This is the date of liability of the AR when it was first established.
This is the date of liability of the AR when it was first established.
This is the date of liability of the AR when it was first established.
This allows the user to specify whether letters should be produced as a result of the transfer/disenrollment.
This is the date that the PMP service location is mass transfer/releasing it's recipients.
The date the level II assessment was completed. (PASRR PRE-ADMISSION SCREEN, Determinations, Assessment Completed Date)
The date the levl II assessment was completed. Resident Review Screen, Resident Reviews, Assessment Completion Date)
The date the assessment is received by the LOCEU. (PASRR PRE-ADMISSION SCREEN, Determinations, Assessment Received Date)
The date the level II assessment was received by the LOCEU. Resident Review Screen, Resident Reviews, Assessment Received Date)

The date this portion of the cash receipt was originally paid out.
The date this portion of the cash receipt was originally paid out.
Date case assigned to the analyst.
The date this portion of the cash receipt was originally paid out.
Date of the 'Associated Prescription/Service Reference Number'. Used for partial fill processing.
Date of creating a new record
Date of creation of new record
The date of creation OF Rc
Date of audit creation
The date of creation
Date on which it is updated
The date on which the record is created
The date on which the record is created
The date on which the record is created
Date of updation
The date of updation
The date of updation
Date of record updation
Date of updation
Date on which it is updated
The date on which the record is updated
Date on which the record is updated
Record Update date
Authorization date.
Date and time that a file was available to be downloaded by the user.
The five date Julian date in the format, yyjjj.
The first day the data elements in the PROV-BED-TYPE-INFO record are effective.
The last day the data elements in the PROV-BED-TYPE-INFO record are effective.
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
Effective date of this FDBDX/GCN combination.
The date this criteria became active. (YYYYMMDD)
Beginning date of the week for productivity tracking.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date that the criteria takes effect.
The date this criteria became active. (YYYYMMDD)

The date the inverse code took effect.
The date the inverse code took effect.
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date that the criteria takes effect.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date that the screening control takes effect.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
First day this Alternate Therapy is effective.
First day this Resource Link is effective.
First day this Text is effective.
Begin Date.
The Date that the criteria takes effect.
The date this criteria became active. (YYYYMMDD)
The date these criteria became active.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date these criteria became active.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date the criteria took effect.
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
The date this criteria became active. (YYYYMMDD)
Begin date of provider enrollment
Begin date for the provider specialty
Date Bendex file received in CCYYMMDD format
The date the beneficiary paid the coinsurance amount.
The date the beneficiary paid the coinsurance amount.
The date the beneficiary paid the coinsurance amount.
The date the beneficiary paid the coinsurance amount.
The date the beneficiary paid the copayment amount.

The date the beneficiary paid the copayment amount.
The date the beneficiary paid the copayment amount.
The date the beneficiary paid the copayment amount.
The date the beneficiary paid the deductible amount.
The date the beneficiary paid the deductible amount.
The date the beneficiary paid the deductible amount.
The date the beneficiary paid the deductible amount.
Date on which the provider or billing service prepared the claim form to be submitted.
The date on which a claim entered the system for processing.
Date on which claim entered the system for processing.
Date on which the provider or billing service prepared the claim form to be submitted.
Date on which the provider or billing service prepared the claim form to be submitted.
Date on which the provider or billing service prepared the claim form to be submitted.
Date on which the provider or billing service prepared the claim form to be submitted.
Date on which the provider or billing service prepared the claim form to be submitted.
Date on which the provider or billing service prepared the claim form to be submitted.
The date on which a claim entered the system for processing.
Date on which claim entered the system for processing.
Date on which the provider or billing service prepared the claim form to be submitted.
Date that the A/R was last billed.
Date that the A/R was last billed.
Date that the A/R was last billed.
A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.
A numeric field which designates the billing date sent on the CMS file.
A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.
A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.
A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.
A numeric field which designates the billing date sent on the CMS file.
A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.

A four position numeric field which designates the billing file on which the transaction appears. The billing date is 2 months after the current update month.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
Recipient DOB
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
Recipient DOB
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the beneficiary, according to CMS.
The date of birth for the recipient.
The birth date of the Medicaid recipient.
Date of birth of the applicant as noted on the application
The family member's date of birth as entered on the application. CCYYMMDD format.
The date of birth for the recipient.
This is the date of birth of the recipient.
This is the birth date of the policyholder.
This is the birth date of the policyholder.
The date of birth of board member.
The date of birth of board member.
The date of birth of board member.
Provider's date of birth.
The date of birth of the Provider.
Date of birth of the Recipient. This will only be filled in if the SSN was a pseudo SSN.
Date of birth of the Recipient. This will only be filled in if the SSN was a pseudo SSN.
The date of birth for the recipient.
The date of birth for the beneficiary.
Recipient's date of birth (ccyymmdd) on the Bendex tape.
The date of birth of the child.
The date of birth of the recipient.
The date of birth of the recipient.
The date of birth of the recipient.
Date of birth
The recipient's date of birth on the PS/2 transaction. CCYYMMDD format.

The Medicaid recipient's date of birth
The Medicaid recipient's date of birth
The date of birth of the spouse.
The date of birth of the move in/out person.
Date of birth of the recipient on the MMIS
The recipient's date of birth on the PS/2 transaction. CCYYMMDD format.
Absent parents date of birth
Absent parents date of birth
Child's date of birth from IV-D tape.
The client's date of birth. (PASRR PRE-ADMISSION SCREEN, case information, Birth Date) ; (RESIDENT REVIEW SCREEN, Case Information, Birth Date); (ICF/MR SCREEN, Case Information, Birth Date); (LEVEL I TRACKING SCREEN, case Information, Birth Date);
DOB on EDB records
DOB on EDB records
Individuals date of birth.
Date of birth of the individual to whom the services were provided.
Date of birth of the individual to whom the services were provided.
Date of birth of the individual to whom the services were provided.
Date of birth of the individual to whom the services were provided.
The birth date of the new recipient.
The birth date of the original recipient.
Date of birth of the provider. Applicable to individual providers only.
Date of birth on the PS/2 transaction
The date of birth of the applicant's spouse
The date the recipient was determined to be in Baldwin or Mobile county
Date the buy-in Part A billing tape processed that contained this transaction.
Date the buy-in Part A billing tape processed that contained this transaction.
Date processed by batch system
Date processed by batch system
Date processed in batch
Date processed by Buy-In receiving system
Date processed by Buy-In receiving system
Date of creation for this transaction.
Date of creation for this transaction.
Date the buy-in Part A billing tape processed that contained this transaction.

Date the buy-in Part A billing tape processed that contained this transaction.
Date of creation for this transaction.
Date of creation for this transaction.
Date the buy-in Part B billing tape processed that contained this transaction.
Date the buy-in Part B billing tape processed that contained this transaction.
Date processed by batch system
Date processed by batch system
Date processed in batch
Date processed by Buy-In receiving system
Date processed by Buy-In receiving system
Date of creation for this transaction.
Date of creation for this transaction.
Date the buy-in Part B billing tape processed that contained this transaction.
Date the buy-in Part B billing tape processed that contained this transaction.
Date of creation for this transaction.
Date of creation for this transaction.
Compliance Date.
Compliance Date
B Notice Sent Date.
Withholding Start Date.
Withholding Start Date
The date the call ended.
The date the call was received.
The date that the managed care entity submitted the capitated payment bill to the state.
This is the month that the capitation adjustment is being made for.
This is the month that the capitation adjustment is being made for
This is the month that the capitation adjustment is being made for
This is the month that the capitation payment covers.
This is the month that the capitation payment covers.
This is the month that the capitation payment covers.
This is the month that the capitation adjustment is being made.
This is the month that the capitation adjustment is being made.
This is the date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, i.e., payment in April of February admin fee, this date would have the April payment date.

This is the date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, i.e., payment in April for February capitation payment, this date would have the April payment date.
This is the date that the capitation payment was made. If the payment is being made for a retro month the date is still the current month, i.e., payment in April of February admin fee, this date would have the April payment date.
This is the date that the capitation payment was made. For a normal cycle the payment date is the first day of the month.
This is the date that the capitation payment was made. For a normal cycle the payment date is the first day of the month.
This is the date that the capitation payment was made. For a normal cycle the payment date is the first day of the month.
This is the date that the capitation payment was made. For a normal cycle the payment date is the first day of the month.
This is the date that the capitation payment was made. For a normal cycle the payment date is the first day of the month.
Date all case activity was complete.
The date that this case table entry was last changed.
Date/time that current claim was process via ClaimCheck.
Date when claim was processed in ClaimCheck.
Date of provider's request for a CEO appeal.
CEO appeal response date.
Indicates the date that the recipient was certified in the case.
Indicates the date that the recipient was certified in the case.
The date the first letter was certified as being received by the provider.
The date the first letter was certified as being received by the provider.
The date that the value for the certifying agency changed. Format is CCYYMMDD.
The date the record was updated by the certifying agency in CCYYMMDD format
Date of Change.
The date of change.
This is the date that the PMP assignment was last updated.
This is the date that the PMP assignment was last updated.
The date of sponsor's update change.
The date a returned check was issued. This is date actually printed on the check.
The date a returned check was issued. This is date actually printed on the check.
Date the check or EFT funds are issued to the payee.
Date the check or EFT funds are issued to the payee.
Date the check or EFT funds are issued to the payee.

Date the check or EFT funds are issued to the payee.
The first day that the state considers the data therein to be valid and active.
The last day the CHPID-SHPID-RELATIONSHIPS is valid and active.
The date the claim was adjudicated or rejected.
This is the date the check cleared the bank.
This is the date the check cleared the bank.
This is the date the check or EFT cleared the bank.
This is the date the check cleared the bank.
Claim Adjudication Date
Claim Adjudication Date
Date on which a claim was placed in a specific system location.
Date on which a claim was placed in a specific system location.
This field indicates the date the claim first entered the system.
Date the claim recipient was changed.
The from date of service of the claim
The to date of service of the claim.
The date the question was closed.
The date the drug rebate invoice dispute was closed/resolved.
The date the drug rebate invoice dispute was closed/resolved.
The date the overpayment case is closed.
The date the overpayment case is closed.
The date the AR is closed.
The date the AR is closed.
The date of miscarriage or death.
Date that CMS added the Modifier.
Date that CMS added the Modifier.
The date the CMS error report was received from CMS.
The date the FDA approved the drug as supplied by CMS.
The date the FDA approved the drug as supplied by CMS.
Represents the date a manufacturer releases the drug product to the marketplace as supplied by CMS.
Represents the date a manufacturer releases the drug product to the marketplace as supplied by CMS.
The date on which the record was last updated with data from CMS.
The date on which the record was last updated with data from CMS.
Date on which a terminated product is re-introduced to the market.

Date on which a terminated product is re-introduced to the market.
The date the CMS tape was received at the account.
The date the CMS tape was sent back to CMS.
Date that CMS terminated the Modifier.
Date that CMS terminated the Modifier.
The date represents the shelf life expiration date of the last batch produced as supplied by CMS.
The date represents the shelf life expiration date of the last batch produced as supplied by CMS.
The date collection is authorized to begin.
The date collection is authorized to begin.
The date on which a particular comment was added.
The date on which the comment was entered
The date on which the comment was entered
The date of the note or comment relating to the provider.
The date of the note or comment relating to the provider.
Date the research request or project is completed or cancelled.
The date of compliance.
This field indicates the date the action required was confirmed that it was successful. 22991231 is the default value which indicates that the corrective action has not been confirmed.
The date the overpayment is confirmed.
The date the overpayment is confirmed.
The beginning of the confirmed date range for claims related to the overpayment.
The beginning of the confirmed date range for claims related to the overpayment.
The end of the confirmed date range for claims related to the overpayment.
The end of the confirmed date range for claims related to the overpayment.
The date the LOCEU was notified for this case. (PASRR PRE-ADMISSION SCREEN, Case Information, Contact Date) ; (RESIDENT REVIEW SCREEN, Case Information, Contact Date); (ICF/MR SCREEN, Case Information, Contact Date);
Date of the provider's contract
This field indicates the date the action required was completed.
This is the date the cost avoidance indicator was last updated.
This is the date the cost avoidance indicator was last updated.
Contains the cost settlement date of the AR.
Contains the cost settlement date of the AR.
The ending date that the HIPP payment is covering.

The ending date that the HIPP payment is covering.
The beginning date that the HIPP payment is covering.
The date the record was created.
The date the record was created
Date/Timestamp of when ACA output batch file was loaded to table
Date/Timestamp of when ACA output batch file was loaded to table
Date the request was created.
Date the request was created.
Date the response was created.
Date the response was created.
The date the record was created.
Dte notification was created.
Date time record was created.
Date time record was created.
Date time record was created.
Date time record was created.
The date the incremental change was created
The date the incremental change was created
The date the incremental change was created
The date the incremental change was created
The date the incremental change was created
The date the incremental change was created
Identifies the date when aggregate counts are created.
Date time record was created.
Date time the record was created.
Date time record was created.
Date time record was created.
Date time when record was created.
Date time record was created.
The date the RA was generated
The date the RA was generated.
Date time record was created.
Will contain the system date when the row was written to the table.
Date that the transmission was created for the IRS.
Date that the transmission was created for the IRS.
Date that the transmission was created for the IRS.
The date the eligibility segment was created
The date the eligibility segment was created

File creation date.
Date finder file created YYMM
Date the row was created.
The date the assignment record was created.
The date the assignment record was created.
Date time record was created.
Date time record was created.
Date time record was created.
Date the record was created.
This is the date that the credit balance becomes effective. This field is required if Credit Balance is Yes.
This is the date the credit balance is no longer effective. This field is required if Credit Balance is Yes.
The last medical support referral date in CCYYMMDD format.
Calendar year claim was adjudicated or rejected in (CCYY).
The cycle date this 1099 record was last updated on.
The cycle date this 1099 record was last updated on.
This is the date of the batch cycle in which the payment/RA was generated.
The cycle date associated with the last update of the year-to-date record. This is the same as the issue date of the payment on t_check.
The cycle date associated with the last update of the year-to-date record. This is the same as the issue date of the payment on t_check.
This is the date of the batch cycle in which the payment\RA was generated.
The cycle date associated with the last update of the year-to-date record. This is the same as the issue date of the payment on t_check.
The cycle date associated with the last update of the year-to-date record. This is the same as the issue date of the payment on t_check.
The last cycle date the year-to-date information for this provider and service location were updated.
The last cycle date the year-to-date information for this provider and service location were updated.
Daily parm date taken from system parms and used for reporting.
Date the data element began to be collected. Populate with 1/1/2014 at initial startup.
Date of death as noted on the application
The date of death for the recipient.
The date of death for the beneficiary.
The recipient's date of death received on the PS/2 transaction.
Date of Death.

Date of death
Individual`s date of death.
Date of death of the provider if applicable. Applicable to individual providers only.
The date of death of the applicant's spouse
This is the date the AR is deficient based on a repayment plan.
This is the date the AR is deficient based on a repayment plan.
This is the date the AR is deficient based on a repayment plan.
Estimated date on which a pregnant woman should have her baby.
The date the payment was deposited.
The date the payment was deposited.
This is the DESI discontinue date for the drug code.
This is the DESI effective date for the drug code.
The date that the DHS or the DMH has sent an e-mail to the LOCEU informing them that a determination has been completed.
The first day the data elements on a DISABILITY-INFORMATION record are effective.
The last day the data elements on a DISABILITY-INFORMATION record are effective.
Disaster survivor begin date in CCYYMMDD format; for disaster survivor code values of FA, FG, FM and FT, the disaster survivor begin date must be in the date range of 4/2011 - 12/2012
Disaster survivor end date in CCYYMMDD format; for disaster survivor code values of FA, FG, FM, FT and FN, the disaster survivor end date must be in the date range of 4/2011 - 12/2012
This is the discontinue date for the drug code.
The date the recipient was discharged from the hospital.
This is the date that the recipient was discharged from an institution. We obtain this date from an occurrence code that has a value of '50'.
The date on which the recipient was discharged from a hospital or long term care facility.
The date on which the recipient was discharged from a hospital or long term care facility.
The date the overpayment was discovered.
The date the overpayment was discovered.
This is the date that the PMP service location is mass disenrolling.
This is the date that the PMP service location is mass disenrolling.
This is the date that the PMP service location is mass disenrolling.
Date used to update provider's contracts end date when End Reason is Prov Purge/De-activate.

Date provider is considered to no longer be enrolled or eligible for re-enrollment.
Date provider disenroll/de-activation process ran.
Date provider disenroll/de-activation process ran.
The date the service was incurred.
Date pharmacy dispensed drug to recipient.
Dispense date on the claim.
This is the dispense date of the claim.
Date pharmacy dispensed a drug to a recipient.
The date that the drug was dispensed.
The date that the drug was dispensed.
Date pharmacy dispensed drug to recipient.
Date pharmacy gave drug to recipient.
The date on which the drug was dispensed.
Property disposition date in CCYYMMDD format
This is the date the disposition entry was made.
This is the date the disposition entry was made.
The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing.
The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing, applicable by date of service of the claim.
The last date the relationship between MMIS EOB codes and the combination is valid for use in processing.
The last date the relationship between MMIS EOB codes and the combination is valid for use in processing, applicable by date of service of the claim.
The FROM date entered into the EVS system.
The FROM date entered into the EVS system.
The TO date entered into the EVS system.
The TO date entered into the EVS system.
Last date the file was downloaded by the web user.
Date/Timestamp of ACA output batch file download.
Date/Timestamp of ACA output batch file download.
This field stores the date the file was downloaded from the web portal.
The most recent date a provider downloaded their payment summary
Date the DO Application was accepted.
Date the DO Elderly and Disabled application status date was changed.
Date the Medicare Savings Program application status date was changed.

The date on which the drug product was no longer available in the market place as per the manufacturer's notification, or the best estimate of that date.
The date on which the drug product was no longer available in the market place as per the manufacturer's notification, or the best estimate of that date.
The date on which the drug product was no longer available in the market place as per the manufacturer's notification, or the best estimate of that date.
The date that the LOCEU has received or reviewed the determination information that has been sent by the DHS or the DMH. (PASRR PRE-ADMISSION SCREEN, Determinations, Date Determination Received)
The date that the LOCEU has received or reviewed the determination information that has been sent by the DHS or the DMH.
The date the determination information for this case was last changed. (PASRR PRE-ADMISSION SCREEN, Determinations, Determination User)
This is the date which the AR must be paid in full.
This is the date which the AR must be paid in full.
This is the date which the AR must be paid in full.
The date that the next payment for the policy is due.
The due date of the child.
This is the date that a provider became eligible to submit claims electronically.
This is the date that a provider became eligible to submit claims electronically.
This is the date that a provider became eligible to submit claims electronically.
Effective date for this parameter value.
The date the phone tracking request was opened.
Check Issue or EFT Effective Date
The effective date is the begin date for the accommodation fee segment.
Date the accounts receivable will take effect. This date will usually be the same as the date added, but it allows the accounts receivable recoupment process to be delayed until a future date.
Date the accounts receivable will take effect. This date will usually be the same as the date added, but it allows the accounts receivable recoupment process to be delayed until a future date.
The date from which the AHFS group becomes effective.
Effective date of the accounts receivable interest rate.
Effective date of the accounts receivable interest rate.
The date an Ambulatory Surgical Center rate becomes effective for claims processing.

The date an Ambulatory Surgical Center rate becomes effective for claims processing.
Date on which audit criteria should begin processing in the MMIS system.
Date on which audit criteria should begin processing in the MMIS system.
Date on which audit criteria should begin processing in the MMIS system.
The begin date the step therapy group will be used for auditing.
The begin date the step therapy group will be used for auditing.
Begin date of an individual drug in a STL.
Begin date of an individual drug in a STL.
Date criteria will be used to grant prior authorization
The date of service on which the Benefit Plan becomes valid for the Benefit Plan group.
The date of service on which the Benefit Plan becomes valid for the Benefit Plan group.
The date of service on which the benefit adjustment factor stops being valid.
The date the Benefit Plan COB took effect
Date the record became effective.
The effective date of the transaction.
The effective date of the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the Part A buy-in premium.
Effective date for the transaction.
Effective date for the transaction.
The effective date of the transaction.
The effective date of the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the transaction.
Effective date for the Part B buy-in premium.
Effective date for the transaction.
Effective date for the transaction.
The date the Capital Cost component took effect.
The date the Capital Cost component took effect.
The date the caller type becomes valid.
The date the call category becomes valid.
The date the call completion code becomes valid.
The date the call method becomes valid.
The date the call priority becomes valid.

The date the call status becomes valid.
The date the call type becomes valid.
The date the unit becomes valid.
The date the canned response becomes valid.
The date the combination becomes valid for use in the system.
The date the combination becomes valid for use in the system.
The date the HIPAA Adjustment Reason code becomes valid for use in the system.
The date the HIPAA Adjustment Reason code becomes valid for use in the system.
The date the remark code becomes valid for use in the system.
The date the remark code becomes valid for use in the system.
The date the note type code becomes valid.
This is the code's effective date.
This field corresponds to Field 3 on the NCCI database, containing the code's effective date.
This field is the code's effective date.
This is the effective date of the CLIA type 3 (certification) information.
This is the effective date of the CLIA type 3 (certification) information.
This is the effective date of the CLIA lab code record.
This is the effective date of the CLIA lab code record.
Effective Date of percent variance record.
The effective date of the Claim FCA record.
The date the interest rate will begin to take effect.
The effective date when a percentage for multiple surgery is in effect for claim processing.
The first day this CONDITION Code is valid.
Date Level of Care assignment to a condition code becomes valid for used in processing and determination of level of care for a claim.
Date Level of Care assignment to a condition code becomes valid for used in processing and determination of level of care for a claim.
The date a conversion factor becomes valid (effective) for claims processing.
The date a conversion factor becomes valid (effective) for claims processing.
This is the begin date for the copay segment.
This is the begin date for the copay segment.
The date of service that the county code crosswalk becomes effective.
The effective begin date of this coverage code.
The effective begin date of this coverage code.
The date a service becomes covered within a program.
The date a service becomes covered within a program.

The date the Cost to Charge Ratio component took effect.
The date the HCFA DESI status took effect.
The date the HCFA DESI status took effect.
The date that the diagnosis code is to become effective for the diagnosis compatibility in claims processing.
The date that the diagnosis code is to become effective for the diagnosis compatibility in claims processing.
The date that the diagnosis code is to become effective for the diagnosis type in claims processing.
The date that the diagnosis code is to become effective for the diagnosis type in claims processing.
The date that the limitations for the diagnosis code became effective.
The date that the limitations for the diagnosis code became effective.
The date that the POS restriction became effective.
The date that the POS restriction became effective.
The date that the dispensing fee for the provider specialty is in effect.
The date that the dispensing fee for the provider specialty is in effect.
The effective date is used to specify a date range for an entry in the disproportionate share entity.
The date that the DRG code crosswalk becomes effective.
The effective date identifies the date that the cross walk process will be performed for the diagnosis code. This will be based on the first date of service on the claim.
The date that the DRG code is to become effective for the DRG group.
The date that the DRG code is to become effective for the DRG group.
The date the version of DRG Grouper software is valid for claims processing. The claim from date of service is compared to the grouper effective and end dates to determine the correct version to use for the claim.
The date the version of DRG Grouper software is valid for claims processing. The claim from date of service is compared to the grouper effective and end dates to determine the correct version to use for the claim.
The effective date identifies the date that the cross walk process will be performed for the ICD9 procedure code. This will be based on the first date of service on the claim.
Date Level of Care assignment to a Diagnosis Related Group (DRG) becomes valid for used in processing and determination of level of care for a claim.
Date Level of Care assignment to a Diagnosis Related Group (DRG) becomes valid for used in processing and determination of level of care for a claim.
Effective date
Effective date.

This is the effective date the the replacing process will take place.
The date the DRG Rate took effect.
The date the DRG Rate took effect.
This is the date that the drug's Maximum Allowable Cost takes effect.
This is the date that the drug's Maximum Allowable Cost takes effect.
The date the Drug Activation/Program coverage information becomes active for use.
This is the date that the Average Wholesale Price and the Estimated Acquisition Cost took effect.
This is the date that the Average Wholesale Price and the Estimated Acquisition Cost took effect.
The date that the NDC is to become effective for the NDC type in claims processing.
The date that the NDC is to become effective for the NDC type in claims processing.
The date the NDC to HCPCS code association takes effect.
The date the NDC to HCPCS code association takes effect.
This is the date that the drug limitations take effect.
This is the date that the drug limitations take effect.
This is the date that the drug's Maximum Allowable Cost takes effect.
This is the date that the drug's Maximum Allowable Cost takes effect.
The date the MAC percentage becomes valid for drug pricing.
The date the MAC percentage becomes valid for drug pricing.
The date that the pricing segment became effective.
The date the drug manufacturer Drug Rebate segment is active.
This is the date that the State MAC will take effect.
This is the date that the State MAC will take effect.
The date the supplemental invoice type became effective.
The date the supplemental invoice type became effective.
The date the cross reference became effective.
The date the cross reference became effective.
The date that the drug labeler began participation in the drug rebate program. This date is obtained from the quarterly HCFA labeler contact file or from periodic HCFA releases.
The date that the drug labeler began participation in the drug rebate program. This date is obtained from the quarterly CMS labeler contact file or from periodic CMS releases.
The date on which the NDC became eligible for the Supplemental rebate progam.
Effective date of the T-Bill rate
Effective date of the T-Bill rate
Effective start date of the Fiscal Year

The date on which the individual's participation in Money Follows the Person Demonstration started.
The first date of service that the associated percentage is effective.
The first date of service that the associated percentage is effective.
Effective Start Date.
Effective Start Date.
Date Trading Partner requested to start receiving the 834 transaction.
The date the Education Cost took effect.
The date the Education Cost took effect.
The date of the EFT transaction.
The date of the EFT transaction.
The start date of the encounter batch error threshold. segment.
This is the date of service that the Explanation of Benefits code became effective.
This is the date of service that the Explanation of Benefits code became effective.
The date the relationship between MMIS EOB codes and HIPAA adjustment reason codes becomes valid for use in processing.
The date the relationship between MMIS EOB codes and HIPAA remark codes becomes valid for use in processing.
The date the Error Group took effect
The date the Error Group took effect.
Eligibility effective date
Eligibility effective date.
The beginning date for use of the information contained on this record.
This is the date that the FICA rate becomes effective.
This is the date that the FICA rate becomes effective.
The date the claim type to program restriction becomes effective for use in claims editing.
The effective date of the parent budget.
The first date this bank account and check number range is effective for this financial cycle.
Effective date for an object. Used to signify the start of a span or period.
This is the effective date when the maximum recoupment amount takes effect.
The date the financial payer COB took effect
Date the accounts receivable will take effect. This date will usually be the same as the date added, but it allows the accounts receivable recoupment process to be delayed until a future date.

This is the date that the prudent payment record is effective.
This is the date that the payment pull becomes effective.
This is the date that the schedule will begin to be put on hold.
The date the override is effective.
The first date of service to which this FMAP percentage should be applied
The first date of service to which this FMAP percentage should be applied
The date that the fund payer record becomes active.
The date that the GCN seqno grouping is to become effective for the GCN seqno type in processing.
The date that the GCN seqno grouping is to become effective for the GCN seqno type in processing.
The date the GPCI for a location becomes valid for use in claims processing.
The date the GPCI for a location becomes valid for use in claims processing.
The date from which the HIC group becomes effective.
The effective date of the HIPP policy.
The date the hospice rate took effect.
The date the hospice rate took effect.
This field is the begin date for a HOSP ANC AUTH segment.
The first date that this level of care rate is effective; compared to the actual claim processed
The first date that this level of care rate is effective; compared to the actual claim processed
The first date the W9 information for this provider becomes effective.
The first date the W9 information for this provider becomes effective.
Date lab fee schedule becomes active (effective) for claims processing.
Date lab fee schedule becomes active (effective) for claims processing.
This is the effective date of the Audit.
This is the effective date of the drug price.
This is the effective date of the drug price.
This is the effective date.
Begin date to a rate segment.
The date the Marginal Cost Factor took effect.
The date the Marginal Cost Factor took effect.
The date a max fee rate for a procedure/modifier combination becomes effective for claims processing.
The date a max fee rate for a procedure/modifier combination becomes effective for claims processing.

The first date to which the yearly deductible amount becomes effective.
The date that the group record becomes effective.
The date that the group record becomes effective.
This is the date that the aid category became associated with the aid category group.
This is the date that the aid category became associated with the aid category group.
This is the date that the area/region cross-reference becomes effective.
This is the date that the area/region cross-reference becomes effective.
This is the date that the area/region cross-reference becomes effective.
Effective date for the payment record.
Effective date for the payment record.
Effective date of the payment record.
Effective date of the payment record.
This is the date that the rate range became effective.
This is the date that the rate became effective.
This is the date that the rate became effective.
The date that the capitation demographics record becomes effective.
The date that the capitation demographics record becomes effective.
The date that the capitation demographics record becomes effective.
Effective date of the program status/program code combination.
The effective date of the PMP assignment.
The initial date that the special condition takes effect.
The date that the assignment of the diagnosis code to the rate cell becomes effective.
The date that the assignment of the diagnosis code to the rate cell becomes effective.
Effective Date of the FTE.
Effective Date of the FTE.
The date that the combination of the health program and living arrangement became valid for Managed Care.
The date that the combination of the health program and living arrangement became valid for Managed Care.
The date that the program/region combination became valid.
The date that the program/region combination became valid.
Effective date of the relationship between the program status code group and program status code.
This is the date that the program status became associated with the program status group.
Date county became effective for Plan.
Date county became effective for Plan.

Effective date of the GHO Contract.
Effective date of the GHO Contract.
Date the PMP's region enrollment became effective.
The date that the group became associated with the PMP.
This is the date that the restriction becomes effective.
This is the date that the restriction becomes effective.
Effective Date of the Special Condition.
Effective Date of the Special Condition.
This is the date that the capitation category (rate cell) became effective.
This is the date that the capitation category (rate cell) became effective.
This is the initial date that the recipient can no longer be assigned to the provider.
The initial date that the special condition takes effect.
The initial date that the special condition takes effect.
Date the special condition exclusion becomes effective.
The date that the modifier and its type are to become effective for claims processing.
The date that the modifier and its type are to become effective for claims processing.
The date that the modifier restriction is to become effective for claims processing.
Start date of the procedure/diagnosis restriction.
The date this modifier group/provider type/specialty restriction becomes effective for claims processing.
The date this modifier group/provider type/specialty restriction becomes effective for claims processing.
The date the recipient became eligible for the corresponding aid category and health program code.
The provider's start date of enrollment.
The date the waiver service is to become effective for the waiver program in MAR processing.
The date the waiver service is to become effective for the waiver program in MAR processing.
The date multiple surgery percentages become valid for use in claims processing.
The date multiple surgery percentages become valid for use in claims processing.
Effective date of the associated price.
Effective date of the associated price.
Effective date for an object. Used to signify the start of a span or period.

Effective date for an object. Used to signify the start of a span or period.
Date outlier threshold becomes valid for use in claims pricing.
Date outlier threshold becomes valid for use in claims pricing.
This field contains the beginning date for this Overhead Fee segment.
This field contains the beginning date for this Overhead Fee segment.
The first day this Patient Status Code is valid.
The date a service becomes covered within a program.
Date the hierarchy thread becomes valid for use in claims processing.
The date the payment hold criteria will take effect on claims marked as payable that are sent to financial.
The date the payment hold criteria will take effect on claims marked as payable that are sent to financial.
Effective date of the assignment code.
Effective date of the assignment code.
The date on which the authorization is done
Effective date. First date the PDL status is effective for the NDC.
Effective date. First date the PDL status is effective for the NDC.
The date the Peer Group Capital Cost component took effect.
The date the Peer Group Capital Cost component took effect.
The date the Peer Group DRG Rate took effect.
The date the Peer Group DRG Rate took effect.
The date the Peer Group DRG Rate took effect.
The date the Peer Group Medical Education Cost component took effect.
The date the Peer Group Medical Education Cost component took effect.
The date the Peer Group Marginal Cost Factor component took effect.
The date the Peer Group Marginal Cost Factor component took effect.
The first date that this level of care rate is effective; compared to the actual claim processed
The first date that this level of care rate is effective; compared to the actual claim processed
The date the Peer Group Cost to Charge Ratio component took effect.
The date the Peer Group Cost to Charge Ratio component took effect.
The effective data of the record.
The date the criteria is effective
The effective data of the record. This will be the date representing the end of the reporting week. Should be a Saturday

The date the claim type to program restriction becomes effective for use in claims editing.
The date the claim type to program restriction becomes effective for use in claims editing.
Date the program hierarchy thread becomes valid for use in claims processing.
Date the hierarchy thread becomes valid for use in claims processing.
The date that the PHS provider became eligible to participate in the Oklahoma Medicaid program
The date that the PHS/IHS provider became eligible to participate in the Medicaid program
This is the date that the Autoassignment percentages become effective for the specified PMP service location.
This is the date that the Autoassignment percentages become effective for the specified PMP service location.
This is the effective date of the current PMP panel size.
This is the effective date for PMP for this managed care program and service location. Used to signify the start of a span or period of participation in the Managed Care program.
This is the effective date for PMP for this managed care program and service location. Used to signify the start of a span or period of participation in the Managed Care program.
This is the effective date for PMP for this managed care program and service location. Used to signify the start of a span or period of participation in the Managed Care program.
This is the effective date for PMP for this managed care program and service location. Used to signify the start of a span or period of participation in the Managed Care program.
Date prevailing charge becomes active (effective) for use in claims processing.
Date prevailing charge becomes active (effective) for use in claims processing.
Date prevailing charge becomes active (effective) for use in claims processing.
Date prevailing charge becomes active (effective) for use in claims processing.
Start date of the procedure/diagnosis restriction.
Start date of the procedure/diagnosis restriction.
The date a ASC code assignment for a procedure becomes effective for claims processing.
The date a ASC payment group code assignment for a procedure becomes effective for claims processing.
The date a procedure conversion factor becomes valid for use in claims processing.
The date a procedure conversion factor becomes valid for use in claims processing.
Start date of the procedure/diagnosis restriction.
Start date of the procedure/diagnosis restriction.

The date PA diagnosis limitations become effective for claims processing.
The date PA diagnosis limitations become effective for claims processing.
The date that the procedure code is to become effective for the procedure type in claims processing.
The date that the procedure code is to become effective for the procedure type in claims processing.
The date procedure/GSN associations are effective for claims processing.
The date procedure/GSN associations are effective for claims processing.
The date a range of diagnosis restrictions becomes effective.
The date a range of diagnosis restrictions becomes effective.
The date that the ICD procedure code is become effective for the ICD procedure type in claims processing.
The date that the ICD procedure code is become effective for the ICD procedure type in claims processing.
The date procedure limitations become effective for claims processing.
The date procedure limitations become effective for claims processing.
The date procedure limitations become effective for claims processing.
The date procedure limitations become effective for claims processing.
The date a MCO procedure's coverage status becomes effective for claims processing.
The date a MCO procedure's coverage status becomes effective for claims processing.
The date that the modifier and its type are to become effective for claims processing.
The date a MCO procedure's coverage status becomes effective for claims processing.
Date a procedure/provider specialty combination becomes active (valid) for claims processing.
Date a procedure/provider specialty combination becomes active (valid) for claims processing.
The date that signifies that the procedure's tooth number restriction is in effect.
The date that signifies that the procedure's tooth number restriction is in effect.
The date that signifies that the procedure's tooth quadrant restriction is in effect.
The date that signifies that the procedure's tooth quadrant restriction is in effect.
This is the effective date when the maximum recoupment amount takes effect.
Start date of timeframe for visits to this county in this month.
Start date of timeframe for visits to this county in this month.

Effective date of the status reason.
The date the bed segment is effective.
First date the billing indicator is effective for the provider service location.
This is the date the ownership of the provider begins.
This is the date the ownership of the provider begins.
This is the effective date that the board participant became a board member for this provider.
The date the Provider Capital Cost component took effect.
Date that the provider is setup for CHOW group member association.
Date the change of ownership became effective.
Date the change of ownership became effective.
This is the effective date of the provider's CLIA number.
The date the claim type to program restriction becomes effective for use in claims editing.
The date the Provider Cost to Charge Ratio component took effect.
Effective date for an object. Used to signify the start of a span or period.
This is the date that the dispensing fee for the provider is in effect.
The date the Provider DRG Rate took effect.
The date the Provider DRG Rate took effect.
The date the Provider DRG Rate took effect.
The first date in which the exempt status becomes active for this service location.
Effective date for an object. Used to signify the start of a span or period.
The date that enrollment application was submitted to the health insurance carrier.
The start date of the assigned CLIA certification.
Effective date of the corresponding specialty.
Effective date the tax id is valid from.
The date the claim type to program restriction becomes effective for use in claims editing.
The date the claim type to program restriction becomes effective for use in claims editing.
The date the screening data took effect.
The date the screening data took effect.
This is the date that the facility becomes effective for the provider.
Date that the provider is effective with this group.
Date that the provider is effective with this group.
This is the effective date of the provider's license that Medicaid has on file.

This is the effective date of the provider's license that Medicaid has on file.
Date the license is effective
The first date of service this rate is effective for this provider.
Date the provider / license relationship becomes effective.
The first date in which the level of care rate became active.
This is the effective date that the new rate will have.
The first date in which the level of care rate became active.
The date the Provider Marginal Cost Factor component took effect.
The first date in which the medicare number became effective.
The date the Provider Education Cost took effect.
This is the effective date for provider NPPES record.
This is the effective date for provider NPPES record.
First date the out of state indicator value is effective for the provider service location.
The first date this rate is effective for this provider service location.
This is the date that the ownership of the provider begins.
This is the date that the payment pull becomes effective.
This is the date the verification of the provider begins.
This is the date the verification of the provider begins.
Effective date of the peer group.
This is the effective date of the peer level.
The date the claim type to program restriction becomes effective for use in claims editing.
The date the claim type to program restriction becomes effective for use in claims editing.
This is the effective date of the contract and status for a row.
Date that the assistant/physician relationship becomes effective.
This is the begin date for the supervising physician.
This is the begin date for the supervising physician.
This field indicates the date a provider became eligible as a FS, a DPU facility, or is paid by Per Diem.
The first date of service this rate is effective for this provider.
First date of service where a Recipient level of care maps to a Provider level of care.
First date of service where a Recipient level of care maps to a Provider level of care.
The date the review began.
The date the review began.
Date this risk record became effective.
Effective date for an object. Used to signify the start of a span or period.
The date the specialty of a provider becomes valid (effective).

This is the effective date when the provider became active as a state share provider with the agency on this record.
This is the date that the SURs specialty became effective.
This is the effective date of the provider certification information.
This is the effective date of the provider certification information.
This is the effective date of the language segment for a specific provider service location.
The date this taxonomy becomes valid for this provider (effective).
The date this taxonomy becomes valid for this provider (effective).
Effective date for an object. Used to signify the start of a span or period.
The first date this level of care is effective for this provider.
The date the claim type to program restriction becomes effective for use in claims editing.
The date on which the authorization is made
The date procedure RBRVS rates become effective for claims processing.
The date procedure RBRVS rates become effective for claims processing.
The date a provider specialty adjustment used in RBRVS pricing is effective for claims processing.
The date a provider specialty adjustment used in RBRVS pricing is effective for claims processing.
This is the date that the rebate status for the drug takes effect.
Date the recipient review is effective.
Date the recipient review is effective.
This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.
This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.
This field corresponds to Field 3 of the NCCI MUE data, containing the code's effective date.
This field corresponds to Field 3 of the NCCI MUE data, containing the code's effective date.
This field corresponds to Field 3 of the NCCI MUE data, containing the code's effective date.
This field corresponds to Field 3 of the NCCI MUE data, containing the code's effective date.
This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.
This field corresponds to Field 3 on the NCCI data, containing the code pair's effective date.
Effective date of this Aid Code group segment.
Effective date of this VALUE Code group entry.
Effective date of this VALUE Code group entry.
Effective date of the CLIA lab code

This is the begin date for the entry.
Effective date of this Provider ID group segment.
The date that the corresponding UCC became effective.
The date this row goes into effect.
The effective date is the begin date to a reimbursement rate segment.
This is the date of service that the revenue code became effective.
This is the date of service that the revenue code became effective.
The effective is the begin date for this segment.
The effective is the begin date for this segment.
The date that the revenue code is to become effective for the revenue type in claims processing.
The date that the revenue code is to become effective for the revenue type in claims processing.
The service date that this revenue code crosswalk row becomes effective.
Start date for the procedure/revenue code restriction.
Start date for the procedure/revenue code restriction.
The starting date for this combination to be effective
The starting date for this combination to be effective
The date that the recipient becomes eligible for the corresponding aid category.
The date that the recipient becomes eligible for the corresponding aid category.
The date that the beneficiary becomes eligible for the corresponding population code.
The effective date for the assignment plan.
The effective date for the assignment plan.
The effective date for the assignment plan.
The effective date for the assignment plan.
First date in the selection date range, for which ICNs are to be delinked.
The date that the recipient becomes eligible PART D subsidy coverage.
The date that the recipient becomes eligible PART D subsidy coverage.
Date recipient entered this official status
Date recipient entered this official status
The date that the recipient becomes eligible for the corresponding Medical Assistance program.
The date that the recipient becomes eligible for the corresponding Medical Assistance program.
The date that the beneficiary becomes eligible for the corresponding Medical Assistance program.
The date the new Medicare ID was added and became effective.
The date the new Medicare ID was added and became effective.

Date the designated ID_MEDICAID_HOH association was started
Date the designated ID_MEDICAID_HOH association was started
This is the effective date of the income for the recipient.
The date that the corresponding provider is authorized to bill for the level of care.
Start date of the lockin time period.
Start date of a recipient's restricted services period.
The date that the LTC will become effective for the recipient.
The effective date of the Medicare Part A coverage.
The effective date of the Medicare Part A coverage.
The effective date of the Medicare Part B coverage.
The effective date of the Medicare Part B coverage.
The date on which a recipient becomes eligible for Medicare Part D, whether or not enrolled on Medicare Part D plan.
The date on which a recipient becomes eligible for Medicare Part D, whether or not enrolled on Medicare Part D plan.
Will always contain zeroes in OK system.
Will always contain zeroes in OK system.
This is the date the beneficiaries Medicare Part D PDP plan assignment is effective.
This is the date the beneficiaries Medicare Part D PDP plan assignment is effective.
This is the date the Medicare Part D PDP plan will be effective
This is the date the Medicare Part D PDP plan will be effective
The date that the patient financial liability amount becomes effective for the recipient in a long term care facility.
The date that the patient financial liability amount becomes effective for the recipient in a long term care facility.
This is the date that the assignment became effective.
This is the date that the assignment became effective.
The date that the recipient becomes eligible for the corresponding Medical Assistance program.
The date which the case starts being liable for spenddown amount.
The date which the case starts being liable for spenddown amount.
The date a site of differential percentage becomes effective for claims processing.
The date a site of differential percentage becomes effective for claims processing.
The date the modifier to provider specialty restriction becomes valid for use in claims processing.
The date the modifier to provider specialty restriction becomes valid for use in claims processing.
The effective date for the parm to begin

The date at which the drug became DESI, signified as less than effective
The date at which the drug became DESI, signified as less than effective
The date the Plan year begins.
The effective date for the parm to begin.
The date that the taxonomy is to become effective for the taxonomy type in claims processing.
Effective Date.
The date that the therapeutic class is to become effective for the therapeutic class type in claims processing.
Beginning date for the type of bill group entity.
Beginning date for the type of bill group entity.
Employment effective date
Employment effective date
This is the carrier's beginning effective date.
This is the carriers beginning effective date.
This is the carriers beginning effective date.
Date SubContractor started with Carrier.
The effective date is the begin date for the contingency fee segment.
The effective date is the begin date for the contingency fee segment.
Effective date of the row.
The effective date of the exemption
This date is the beginning date that each restriction is effective for the policy.
This is the effective date for an insurance policy.
Effective date for TPL TAX ID entity. Used to signify the start of a span or period.
The date this modifier group/provider type/specialty restriction becomes effective for claims processing.
The date on which the provider type / specialty group becomes effective.
Effective date on which it is authorized
The effective date
Effective date
Effective date (start) of a particular administrative fee reimbursement amount.
The effective date on which the authorization is given
Begin date to a rate segment.
Effective date of Accreditation. Used to signify the start of a span or period related to the Accreditation.
Effective date of Accreditation. Used to signify the start of a span or period related to the Accreditation.

Start date from which the issued ACC number is valid.
The start date of the assigned DEA number.
EFT effective date after change.
EFT effective date before change.
Submission Date of Application
Submission Date of Application
Submission Date of Application
ERA Effective date after change.
ERA Effective date before change.
The date the check banner goes into effect.
The date the check banner goes into effect.
Indicates the report start date.
Date that determines the from effective date for garnishing a provider's payment.
Date that determines the from effective date for garnishing a provider's payment.
Date license is effective from.
Effective date of Medicaid Surety Bond. Used to signify the start of a span or period related to the Surety Bond.
Effective date of Medicaid Surety Bond. Used to signify the start of a span or period related to the Surety Bond.
Start date from which the issued Medicaid bond number is valid.
Effective date of Medicare Surety Bond. Used to signify the start of a span or period related to the Medicare Surety Bond.
Effective date of Medicare Surety Bond. Used to signify the start of a span or period related to the Medicare Surety Bond.
Start date from which the issued Medicare bond number is valid.
The start date of the assigned Medicare number.
The last date the check banner is effective.
The last date the check banner is effective.
Indicates the report end date.
Date that determines the end effective date for garnishing a provider's payment.
Date that determines the end effective date for garnishing a provider's payment.
The last date the payment hold criteria will be applied to claims in financial, also referred to as the release date.
The last date the payment hold criteria will be applied to claims in financial, also referred to as the release date.
Date claim processes in the system (date of receipt) for which the error should be set.
Date claim processes in the system (date of receipt) for which the error should be set.
Date of service for which the error should be set.
Date of service for which the error should be set.
EFT request date after change.

EFT request date before change.
Date election period begins
The first day the data elements on an ELIGIBLE-CONTACT-INFORMATION record are effective.
The last day the data elements on an ELIGIBLE-CONTACT-INFORMATION record are effective.
The start date of an individual`s reported Eligibility Status.
The date that an individual`s reported Eligibility Status ended.
The date that the beneficiary becomes eligible for the corresponding Medical Assistance program.
The date that the beneficiary is no longer eligible for the corresponding Medical Assistance program.
The recipient's most recent eligibility end date prior to the last date of service billed on the denied claim or detail. This information is reported on the provider's 835 when a claim denies for edits 2002, 2003, 2009, 2057 or 2077.
The first day the data elements in the ELIG-PRSN-MAIN-EFF-DATE record are effective.
The last day the data elements in the ELIG-PRSN-MAIN-EFF-DATE record are effective.
Date when email was added/updated.
The date that the DHS or the DMH has sent an e-mail to the LOCEU informing them that a determination has been completed. (PASRR PRE-ADMISSION SCREEN, Determinations, Date Email Sent)
The date that the LOCEU has sent an e-mail to the DMH or the DHS informing them that a referral is requested. (PASRR PRE-ADMISSION SCREEN, Referral, Date Email Sent)
The end date is the ending date of the accommodation fee segment.
The last date on which the AHFS group is effective.
The last date this criteria was active. (YYYYMMDD)
The last date this criteria was active. (YYYYMMDD)
The date an Ambulatory Surgical Center rate is no longer in effect for claims processing.
The date an Ambulatory Surgical Center rate is no longer in effect for claims processing.
Date audit criteria ceases to process in the system.
Date audit criteria ceases to process in the system.
Date audit criteria ceases to process in the system.
The date the step therapy group will no longer be used for auditing.
The date the step therapy group will no longer be used for auditing.
End date of an individual drug in a STL.
End date of an individual drug in a STL.
Date criteria will cease to be used to grant prior authorization

The date of service on which the Benefit Plan code is no longer valid for the Benefit Plan group.
The date of service on which the Benefit Plan code is no longer valid for the Benefit Plan group.
The date of service on which the benefit adjustment factor stops being valid.
The date the Benefit Plan COB is no longer in effect
Date the record is no longer valid.
End date for the Part A buy-in premium.
End date for the Part B buy-in premium.
The date the Capital Cost component is no longer in effect.
The date the Capital Cost component is no longer in effect.
The date the caller type is no longer valid.
The date the call category no loner is valid.
The date the call completion code is no longer valid.
The date the call method is no longer valid.
The date the call priority is no longer valid.
The date the call status is no longer valid.
The date the call type is no longer valid.
The date the unit is no longer valid.
The date the canned response is no longer valid.
The last date the combination is valid for use in the system
The last date the combination is valid for use in the system.
The last date the HIPAA Adjustment Reason code is valid for use in the system.
The last date the HIPAA Adjustment Reason code is valid for use in the system.
The last date the remark code is valid for use in the system.
The last date the remark code is valid for use in the system.
The date the note type code is not longer valid.
This is the code's deletion date if applicable.
This field corresponds to Field 4 on the NCCI database, containing the code's deletion date if applicable.
This is the code's deletion date if applicable.
This is the end date of the CLIA type 3 (certification) information.
This is the end date of the CLIA type 3 (certification) information.
This is the end date of the CLIA lab code record.
This is the end date of the CLIA lab code record.
End date of percent variance record.
The end date of the Claim FCA record.
The date that the interest rate is no longer in effect.
The end date when a percentage for multiple surgery is no longer in effect for claim processing.
The last day this CONDITION Code is valid.

Date level of care assignment to a condition code is no longer valid for processing.
Date level of care assignment to a condition code is no longer valid for processing.
End date of this FDBDX/GCN combination. This will be populated when cde_state_var is 2 or 4.
The last date this criteria was active. (YYYYMMDD)
The date a conversion factor is no longer valid for claims processing.
The date a conversion factor is no longer valid for claims processing.
This is the ending date for the copay segment.
This is the ending date for the copay segment.
The date of service that the county code crosswalk is no longer effective.
The effective ending date of this coverage code.
The effective ending date of this coverage code.
The last date of coverage for a service within a program.
The last date of coverage for a service within a program.
The date the Cost to Charge Ratio component is no longer in effect.
The date the HCFA DESI status is no longer in effect.
The date the HCFA DESI status is no longer in effect.
The last date that the diagnosis code is in effect for the diagnosis compatibility in claims processing.
The last date that the diagnosis code is in effect for the diagnosis compatibility in claims processing.
The last date this criteria was active. (YYYYMMDD)
The last date that the diagnosis code is in effect for the diagnosis type in claims processing.
The last date that the diagnosis code is in effect for the diagnosis type in claims processing.
The date that the limitations for the diagnosis code stopped being effective.
The date that the limitations for the diagnosis code stopped being effective.
The date that the POS restriction stopped being effective.
The date that the POS restriction stopped being effective.
The date the criteria is no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date that the dispensing fee for the provider specialty is no longer in effect.
The date that the dispensing fee for the provider specialty is no longer in effect.
The end date is used to specify a date range for an entry in the disproportionate share entity.
The date that the DRG code crosswalk is no longer effective.

The end date identifies the date that the cross walk process should be terminated. This will be based on the first date of service on the claim.
The date that the DRG code stops being effective for the DRG group.
The date that the DRG code stops being effective for the DRG group.
The date DRG Grouper is no longer effective for processing.
The date DRG Grouper is no longer effective for processing.
The end date identifies the date that the cross walk process should be terminated. This will be based on the first date of service on the claim.
Date level of care assignment to a Diagnosis Related Group (DRG) is no longer valid for processing.
Date level of care assignment to a Diagnosis Related Group (DRG) is no longer valid for processing.
End date
End date.
This date represents the end of the replacing code for this DRG code.
The date the DRG Rate is no longer in effect.
The date the DRG Rate is no longer in effect.
This is the date that the drug's Maximum Allowable Cost is no longer in effect.
This is the date that the drug's Maximum Allowable Cost is no longer in effect.
The last date the Drug Activation/Program coverage information is active for use.
This is the date that the Average Wholesale Price and the Estimated Acquisition Cost is no longer in effect.
This is the date that the Average Wholesale Price and the Estimated Acquisition Cost is no longer in effect.
The date the criteria is no longer in effect.
End Date of Drug Exception record.
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The last date that the NDC is in effect for the NDC type in claims processing.
The last date that the NDC is in effect for the NDC type in claims processing.
The date the NDC to HCPCS code association is no longer in effect.
The date the NDC to HCPCS code association is no longer in effect.
The date the inverse code was no longer in effect.
The date the inverse code was no longer in effect.
This is the date that the drug limitations no longer are in effect.
This is the date that the drug limitations no longer are in effect.

This is the date that the drug's Maximum Allowable Cost is no longer in effect.
This is the date that the drug's Maximum Allowable Cost is no longer in effect.
The date the MAC percentage is no longer valid for drug pricing.
The date the MAC percentage is no longer valid for drug pricing.
The date the criteria is no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date the criteria is no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date that the pricing segment terminated.
The date the drug manufacturer's Drug Rebate segment is inactive..
The date that the screening control is no longer in effect.
The last date this criteria was active. (YYYYMMDD)
This is the date that the State MAC will no longer be in effect.
This is the date that the State MAC will no longer be in effect.
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date the criteria is no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The date the supplemental invoice type ended.
The date the supplemental invoice type ended.
The end date the cross reference becomes ineffective.
The end date the cross reference becomes ineffective.
The date that the drug labeler's participation in the drug rebate program is terminated. This date is obtained from the quarterly HCFA labeler contact file or from periodic HCFA releases.
The date that the drug labeler's participation in the drug rebate program is terminated. This date is obtained from the quarterly CMS labeler contact file or from periodic CMS releases.
The date on which the NDC became ineligible for the Supplemental rebate program
The date the claim ended. For claims with a latest claim indicator of Y, this is set to the end of time (12/31/2299). If the status on the header is V, it is set to the Date Paid of the header. If the status on the header is P, and latest claim indicator is N, it gets the date Paid of the header. .
End date for the Fiscal Year
The date on which the individual's participation in the Money Follows the Person Demonstration ended
The last date of service, or dispense date, that this percentage is applicable.
The last date of service, or dispense date, that this percentage is applicable.

End date for this parameter value.
Effective End Date.
Effective End Date
Date Trading Partner requested to stop receiving the 834 transaction.
The date the Education Cost is no longer in effect.
The date the Education Cost is no longer in effect.
The end date of the encounter batch error threshold segment.
The last date the relationship between MMIS EOB codes and HIPAA adjustment reason codes is valid for use in processing.
The last date the relationship between MMIS EOB codes and HIPAA remark codes is valid for use in processing.
The date the Error group is no longer in effect.
The date the Error group is no longer in effect.
Last day this Alternate Therapy is effective.
Last day this Resource Link is effective.
Last day this Text is effective.
Eligibility end date
Eligibility end date.
The end date for use of the information contained on this record.
This is the date that the FICA rate ends.
This is the date that the FICA rate ends.
The last date the claim type to program restriction is effective for use in claims editing.
The end date of the parent budget.
The last date this bank account and check number range is effective for this financial cycle.
The date that this EFT segment is no longer in effect.
This is the end date when the maximum recoupment amount ends.
The date the financial payer COB is no longer in effect
This is the date that the prudent payment record is no longer effective.
This is the date that the payment pull ends.
This is the date that the schedule will no longer be on hold.
The date the override ends.
The last date of service to which this particular FMAP percentage should be applied
The last date of service to which this particular FMAP percentage should be applied
The date that the fund payer record becomes inactive.
The last date that the GCN seqno grouping is in effect for the GCN seqno type in processing.

The last date that the GCN seqno grouping is in effect for the GCN seqno type in processing.
End Date.
The date that the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The last date this criteria was active.
The last date this criteria was active. (YYYYMMDD)
The date the GPCI for a locality is no longer valid for claims processing.
The date the GPCI for a locality is no longer valid for claims processing.
The last date on which the HIC group is effective.
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The last day the HIPP policy is effective.
The date the hospice rate is no longer in effect.
The date the hospice rate is no longer in effect.
This field is the end date for a HOSP ANC AUTH segment.
The last date this criteria was active.
The last date this criteria was active. (YYYYMMDD)
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
The last date to apply this level of care rate to claims, as compared to the actual claim
The last date to apply this level of care rate to claims, as compared to the actual claim
The last date the W9 information for this provider is effective.
The last date the W9 information for this provider is effective.
Date lab fee schedule is no longer active for claims processing.
Date lab fee schedule is no longer active for claims processing.
This is the end date of the Audit.
The date the criteria was no longer in effect.
The last date this criteria was active. (YYYYMMDD)
This is the termination date of the drug price.
This is the termination date of the drug price.
End date to a rate segment.
The date the Marginal Cost Factor is no longer in effect.
The date the Marginal Cost Factor is no longer in effect.
The date a max fee rate for a procedure/modifier combination is no longer in effect for claims processing.
The date a max fee rate for a procedure/modifier combination is no longer in effect for claims processing.
Indicates the ending date for extract processing.
The last date to which the yearly deductible amount is effective.

The date that the group record ends.
The date that the group record ends.
This is the date that the aid category is no longer associated with the aid category group.
This is the date that the aid category is no longer associated with the aid category group.
This is the date that the area/region cross-reference is no longer effective.
This is the date that the area/region cross-reference is no longer effective.
This is the date that the area/region cross-reference is no longer effective.
End date of the payment record.
End date of the payment record.
End date of the payment record.
End date of the payment record.
This is the date that the rate range ended.
This is the date that the rate ended.
This is the date that the rate ended.
The date that the capitation demographics record ends.
The date that the capitation demographics record ends.
The date that the capitation demographics record ends.
End date of the program status/program code combination.
The end date of the PMP assignment.
The ending date for the special condition.
The date that the assignment of the diagnosis code to the rate cell is no longer effective.
The date that the assignment of the diagnosis code to the rate cell is no longer effective.
End Date of the FTE.
End Date of the FTE.
The date that the combination of the health program and living arrangement were no longer valid for Managed Care.
The date that the combination of the health program and living arrangement were no longer valid for Managed Care.
The date that the program/region combination is no longer valid.
The date that the program/region combination is no longer valid.
End date of the relationship between the program status code group and program status code.
This is the date that the program status is no longer associated with the program status group.
Date county ended for Plan.
Date county ended for Plan.
End date of the GHO Contract.
End date of the GHO Contract.

Date the PMP's region enrollment is no longer effective.
The date that the group is no longer associated with the PMP.
This is the date that the restriction is no longer effective.
This is the date that the restriction is no longer effective.
End Date of the Special Condition.
End Date of the Special Condition.
This is the date that the capitation category (rate cell) expired and is no longer effective.
This is the date that the capitation category (rate cell) expired and is no longer effective.
This is the end date for the recipient/provider lockout.
The ending date for the special condition.
The ending date for the special condition.
Date the special condition exclusion ends.
The date that the modifier and its type are no longer in effect for claims processing.
The date that the modifier and its type are no longer in effect for claims processing.
The date that the modifier restriction is no longer valid for claims processing.
Stop date of the procedure/diagnosis restriction.
The date this modifier group stops being effective for claims processing.
The date the recipient is no longer eligible for the corresponding aid category and health program code.
The provider's end date of enrollment.
The last date the waiver service is in effect for the waiver program in MAR processing.
The last date the waiver service is in effect for the waiver program in MAR processing.
The date multiple surgery percentages are no longer valid for use in claims processing.
The date multiple surgery percentages are no longer valid for use in claims processing.
End date of the associated price.
End date of the associated price.
The date that something is no longer in effect.
The date that something is no longer in effect.
Date outlier threshold is no longer valid for use in claims pricing.
Date outlier threshold is no longer valid for use in claims pricing.
This field contains the end date for this Overhead Fee segment.
This field contains the end date for this Overhead Fee segment.
The last day this Patient Status Code is valid.

The last date of coverage for a service within a program.
The last date the thread is valid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. To stop the use of a particular thread altogether the DTE_INACTIVE date must be used.
End date of the assignment code.
End date of the assignment code.
End Date. Last date the PDL status is effective for the NDC.
End Date. Last date the PDL status is effective for the NDC.
The last date this criteria was active. (YYYYMMDD)
The last date this criteria was active. (YYYYMMDD)
The last date this criteria was active. (YYYYMMDD)
The last date this criteria was active. (YYYYMMDD)
The date the Peer Group Capital Cost is no longer in effect.
The date the Peer Group Capital Cost is no longer in effect.
The date the Peer Group DRG Rate is no longer in effect.
The date the Peer Group DRG Rate is no longer in effect.
The date the Peer Group DRG Rate is no longer in effect.
The date the Peer Group Medical Education Cost is no longer in effect.
The date the Peer Group Medical Education Cost is no longer in effect.
The date the Peer Group Marginal Cost Factor is no longer in effect.
The date the Peer Group Marginal Cost Factor is no longer in effect.
The last date to apply this level of care rate to claims, as compared to the actual claim
The last date to apply this level of care rate to claims, as compared to the actual claim
The date the Peer Group Cost to Charge Ratio is no longer in effect.
The date the Peer Group Cost to Charge Ratio is no longer in effect.
The end date of the record
The end data of the criteria
The last date the claim type to program restriction is effective for use in claims editing.
The last date the claim type to program restriction is effective for use in claims editing.
The last date the program thread is valid for use in claims processing.
The last date the thread is valid for use in claims processing. The thread may still be used when the date of service on the claim is within the effective dates of the thread. To stop the use of a particular thread altogether the DTE_INACTIVE date must be used.

The date the PHS provider is no longer enrolled in Oklahoma Medicaid program
The date the PHS/IHS provider is no longer enrolled in Medicaid program
This is the date that the Autoassignment percentages end for the specified PMP service location.
This is the date that the Autoassignment percentages end for the specified PMP service location.
The date that the PMP panel size is no longer valid for a PMP.
The date that the PMP panel size is no longer valid for a PMP.
This is the end date for PMP for this managed care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.
This is the end date for PMP for this managed care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.
This is the end date for PMP for this managed care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.
This is the end date for PMP for this managed care program and service location. Used to signify the end of a span or period of participation in the Managed Care program.
Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.
Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.
Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.
Date a prevailing charge becomes inactive (no longer in effect) for use in claims processing.
Stop date of the procedure/diagnosis restriction.
Stop date of the procedure/diagnosis restriction.
The date a ASC code assignment for a procedure is no longer in effect for claims processing.
The date an ASC payment group code is no longer in effect for claims processing.
The date a conversion factor is no longer valid for claims processing.
The date a conversion factor is no longer valid for claims processing.
Stop date of the procedure/diagnosis restriction.
Stop date of the procedure/diagnosis restriction.
The last date that the procedure code is in effect for the procedure type in claims processing.
The last date that the procedure code is in effect for the procedure type in claims processing.
The date procedure/GSN associations become invalid (no longer active) for claims processing.

The date procedure/GSN associations become invalid (no longer active) for claims processing.
The date a range of diagnosis restrictions is no longer in effect.
The date a range of diagnosis restrictions is no longer in effect.
The last date that the ICD procedure code is in effect for the ICD procedure type in claims processing.
The last date that the ICD procedure code is in effect for the ICD procedure type in claims processing.
The date procedure limitations become invalid (no longer active) for claims processing.
The date procedure limitations become invalid (no longer active) for claims processing.
The date procedure limitations become invalid (no longer active) for claims processing.
The date procedure limitations become invalid (no longer active) for claims processing.
The date a MCO procedure's coverage status is no longer in effect for claims processing.
The date a MCO procedure's coverage status is no longer in effect for claims processing.
The date a procedure/modifier combination is no longer valid for claims processing.
The date a MCO procedure's coverage status is no longer in effect for claims processing.
Date a procedure/provider specialty combination becomes inactive (no longer valid) for claims processing.
Date a procedure/provider specialty combination becomes inactive (no longer valid) for claims processing.
The date that signifies that the procedure's tooth number restriction is no longer in effect.
The date that signifies that the procedure's tooth number restriction is no longer in effect.
The date that signifies that the procedure's tooth quadrant restriction is no longer in effect.
The date that signifies that the procedure's tooth quadrant restriction is no longer in effect.
This is the end date when the maximum recoupment amount ends.
End date of timeframe for visits to this county in this month.
End date of timeframe for visits to this county in this month.
End date of the status reason.
The date the bed segment ends.
Last date the billing indicator is effective for the provider.
This is the date the ownership of the provider ends.
This is the date the ownership of the provider ends.
This is the last date of the relationship between the board participant and board member.
The date the Provider Capital Cost is no longer in effect.
Date that the provider record is not effective with this group.

Date the change of ownership ended.
Date the change of ownership ended.
This is the end date of the provider's CLIA number.
The last date the claim type to program restriction is effective for use in claims editing.
The date the Provider Cost to Charge Ratio is no longer in effect.
The date that something is no longer in effect.
This is the date that the dispensing fee for the provider is no longer in effect.
The date the Provider DRG Rate is no longer in effect.
The date the Provider DRG Rate is no longer in effect.
The date the Provider DRG Rate is no longer in effect.
The last date in which the exempt status is active for this service location.
The date that this EFT segment is no longer in effect.
End date of the corresponding specialty.
End date the tax id is valid up to.
The last date the claim type to program restriction is effective for use in claims editing.
The last date the claim type to program restriction is effective for use in claims editing.
The date the screening data is no longer valid.
The date the screening data is no longer valid.
This is the date that the facility ends for the provider.
Date that the provider is no longer effective with this group.
Date that the provider is no longer effective with this group.
This is the date that the provider's license is no longer valid for Medicaid.
This is the date that the provider's license is no longer valid for Medicaid.
Date the license is no longer effective.
The last date of service this rate is effective for this provider.
Date the provider / license relationship ends.
The date in which the level of care rate became inactive.
This is the end date that the new rate will have.
The date in which the level of care rate became inactive.
The date the Provider Marginal Cost Factor is no longer in effect.
The last date in which the medicare number will expire.
The date the Provider Education Cost is no longer in effect.
This is the end date for the provider NPPES record.
This is the end date for the provider NPPES record.
Last date the out of state indicator value is effective for the provider.

The last date this rate is effective for this provider service location.
This is the date that the ownership of the provider ends.
This is the date that the payment pull ends.
This is the date the verification of the provider ends.
This is the date the verification of the provider ends.
The date end for the peer group.
This is the end date of the peer level.
The last date the claim type to program restriction is effective for use in claims editing.
The last date the claim type to program restriction is effective for use in claims editing.
The date the phone tracking request was marked as complete in the status field. If the request is incomplete, it will default to 2299/12/31.
This is the end date of the contract and status for a row.
Date that the assistant/physician relationship is no longer effective.
This is the end date for the supervising physician.
This is the end date for the supervising physician.
This date indicates when a provider is no longer considered a FS, a DPU facility, or is paid by Per Diem.
The last date of service this rate is effective for this provider.
End date of service where a Recipient level of care maps to a Provider level of care.
End date of service where a Recipient level of care maps to a Provider level of care.
The date the review ends.
The date the review ends.
Date this risk row was no longer effective.
The date that something is no longer in effect.
The date the specialty of a provider is no longer valid.
This is the end date when the provider became active as a state share provider with the agency on this record.
This is the date that the SURs specialty ends.
This is the end date of the provider certification information.
This is the end date of the provider certification information.
This is the end date of the language segment for a specific provider service location.
The date this taoxnomy is no longer valid for this provider.
The date this taoxnomy is no longer valid for this provider.
The date that something is no longer in effect.
The last date this level of care is effective for this provider.
The last date the claim type to program restriction is effective for use in claims editing.

The date procedure RBRVS rates become invalid (no longer active) for claims processing.
The date procedure RBRVS rates become invalid (no longer active) for claims processing.
The date a provider specialty adjustment used in RBRVS pricing is no longer valid for claims processing.
The date a provider specialty adjustment used in RBRVS pricing is no longer valid for claims processing.
This is the date that the rebate status for the drug is no longer in effect.
Date the recipient review ends.
Date the recipient review ends.
This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.
This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.
This field corresponds to Field 4 of the NCCI MUE data, containing the code's deletion date if applicable.
This field corresponds to Field 4 of the NCCI MUE data, containing the code's deletion date if applicable.
This field corresponds to Field 4 of the NCCI MUE data, containing the code's deletion date if applicable.
This field corresponds to Field 4 of the NCCI MUE data, containing the code's deletion date if applicable.
This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.
This field corresponds to Field 4 on the NCCI data, containing the code pair's deletion date if applicable.
End date of this Aid Code group segment.
End date of this VALUE Code group entry.
End date of this VALUE Code group entry.
End date of the CLIA lab code
This is the end date for the entry.
End date of this Provider ID group segment.
The date that the corresponding UCC was no longer effective.
The date this row expires.
The end date is the end date of the reimbursement rate segment.
This is the last date of service that the revenue code is effective.
This is the last date of service that the revenue code is effective.
The end date is the last date for this segment.
The end date is the last date for this segment.
The last date that the revenue code is in effect for the revenue type in claims processing.
The last date that the revenue code is in effect for the revenue type in claims processing.

The service date that this revenue code crosswalk row is no longer effective.
The last date for the procedure/revenue code restriction.
The last date for the procedure/revenue code restriction.
The last date that this revenue specialty combination is to be applied to claims processing
The last date that this revenue specialty combination is to be applied to claims processing
The date that the recipient is no longer eligible for the corresponding aid category.
The date that the recipient is no longer eligible for the corresponding aid category.
The date that the beneficiary is no longer eligible for the corresponding population code.
The end date for the assignment plan.
The end date for the assignment plan.
The end date for the assignment plan.
The end date for the assignment plan.
Recipient?s eligibility end date used for Certificate of Creditable Health Ins. Coverage Letters. This field will be populated with a zero whenever the row has a cde_type other than C.
Last date in the selection date range, for which ICNs are to be delinked.
The date that the recipient is no longer eligible for the PART D subsidy coverage.
The date that the recipient is no longer eligible for the PART D subsidy coverage.
Date recipient left this official status
Date recipient left this official status
End date as sent by CMS.
End date as sent by CMS
End date as sent by CMS
End date as sent by CMS
The date that the recipient is no longer eligible for the corresponding Medical Assistance program.
The date that the recipient is no longer eligible for the corresponding Medical Assistance program.
The date that the beneficiary is no longer eligible for the corresponding Medical Assistance program.
Date the designated ID_MEDICAID_HOH association was ended.
Date the designated ID_MEDICAID_HOH association was ended.
This is the end date of the income for the recipient.
The date that the corresponding provider is no longer authorized to bill for the recipient's level of care.
End date of the lock-in time period.
End date of a recipient's restricted services period.

The date that the LTC will end for the recipient.
The end date of the Medicare Part A coverage.
The end date of the Medicare Part A coverage.
The end date of the Medicare Part B coverage.
The end date of the Medicare Part B coverage.
The date on which recipient becomes ineligible to Part D due to Medicare A/B coverage ended.
The date on which recipient becomes ineligible to Part D due to Medicare A/B coverage ended.
Will always contain 20021231 in OK system.
Will always contain 20021231 in OK system.
This is the date the beneficiaries Medicare Part D PDP plan assignments will end.
This is the date the beneficiaries Medicare Part D PDP plan assignments will end.
This is the date the Medicare Part D PDP plan will end
This is the date the Medicare Part D PDP plan will end
The date that the patient financial liability amount is no longer effective for the recipient in a long term care facility.
The date that the patient financial liability amount is no longer effective for the recipient in a long term care facility.
This is the date that the assignment is no longer effective.
This is the date that the assignment is no longer effective.
The date that the recipient is no longer eligible for the corresponding Medical Assistance program.
The last date the case is responsible for spenddown payments.
The last date the case is responsible for spenddown payments.
The date a site of differential percentage is no longer valid for use in claims processing.
The date a site of differential percentage is no longer valid for use in claims processing.
The last date the modifier to provider specialty restriction is valid for use in claims processing.
The date the modifier to provider specialty restriction ends for use in claims processing.
The date that the parm is no longer in effect
The last date at which this DESI is effective; it is possible for a drug to be removed from DESI non payable status
The last date at which this DESI is effective; it is possible for a drug to be removed from DESI non payable status
The date the Plan year ends.
Date and time stamp the job ended.
The date that the parm is no longer in effect.
The last date that the taxonomy is in effect for the taxonomy type in claims processing.
The last date that the therapeutic class is in effect for the therapeutic class type in claims processing.

The last date this criteria was active. (YYYYMMDD)
Ending date segment for the type of bill group segment.
Ending date segment for the type of bill group segment.
This is the carrier's ending date.
This is the carriers ending effective date.
This is the carriers ending effective date.
Date contract ended between Carrier and SubContractor
The end date is the ending date of the contingency fee segment.
The end date is the ending date of the contingency fee segment.
End date of the row.
The end date of the exemption
This date is the ending date for each TPL restriction.
This is the end date for an insurance policy.
The date that the TPL TAX ID entity is no longer in effect.
The date this modifier group/provider type/specialty restriction is no longer effective for claims processing.
The date that the provider type / specialty group stops being effective.
End date of a particular administrative fee reimbursement amount.
End date of provider enrollment
End date for the provider specialty
End date to a rate segment.
End date of Accreditation. Used to signify the end of a span or period related to the Accreditation.
End date of Accreditation. Used to signify the end of a span or period related to the Accreditation.
End date up to which the issued ACC number is valid.
Refund due date (for MAC appeal amount).
End date of condition.
End date of disease
Indicates the end date of the first extra year for extract processing.
Indicates the end date of the second extra year for extract processing.
Indicates the end date of the third extra year for extract processing.
The employer's enrollement period end date.
Provider License Expiration Date.
Date license is effective up to.
End date of Medicaid Surety Bond. Used to signify the end of a span or period related to the Surety Bond.

End date of Medicaid Surety Bond. Used to signify the end of a span or period related to the Surety Bond.
End date up to which the issued Medicaid bond number is valid.
End date of Medicare Surety Bond. Used to signify the end of a span or period related to the Medicare Surety Bond.
End date of Medicare Surety Bond. Used to signify the end of a span or period related to the Medicare Surety Bond.
End date up to which the issued Medicare bond number is valid.
End date of service for the Offline Claim.
This date indicates when a provider stops receiving paper copies of the RA.
This date indicates when a provider stops receiving paper copies of the RA.
This date indicates when a provider stops receiving paper copies of the RA.
This date indicates when a provider stops receiving paper copies of the RA.
Date when the provider should no longer receive a PDF version of their paper RA.
Date when the provider should no longer receive a PDF version of their paper RA.
Date when the provider should no longer receive a PDF version of their paper RA.
First end date for provider to request reconsideration.
Last day for provider to request a CEO appeal.
First end date for provider to request a second reconsideration.
Second end date for provider to request a MAC appeal.
Indicates the end date of the most current 12 months for extract processing.
Indicates the end date of the previous for extract processing.
Indicates the end date of the third year for extract processing.
Indicates the end date of the fourth year for extract processing.
Date provider last enrolled.
Date provider last enrolled.
The first day of enrollment for the enrollment code and MSIS ID being reported.
The last day of enrollment for the enrollment code and MSIS ID being reported.
The date the labeler dispute was received and entered into the system
The date the labeler dispute was received and entered into the system
The date the recoupment request was entered in the system

The date the recoupment request was entered in the system
Date Request Added.
The date the applicant entered an institution in CCYYMMDD format
Date of entitlement change
Date referral was entered.
The date that the detail was added
Date EOMB letter was sent to client.
Date EOMB referral was received from the client.
EPSDT screening date in CCYYMMDD format
Requested ERA Start/Change/Cancel date
Requested ERA Start/Change/Cancel date
ERA Request date after change.
ERA Request date before change.
Date that the error occurred.
Date the error occurred (1 of 6).
Date the error occurred (2 of 6).
Date the error occurred (3 of 6).
Date the error occurred (4 of 6).
Date the error occurred (5 of 6).
Date the error occurred (6 of 6).
The date the group starts applying to this ESC
The last date the group applies to this ESC
This is the date the error status code was added to this prior authorization.
This is the date the error status code was added to this prior authorization.
End stage renal disease end date
End stage renal disease start date
End stage renal dialysis end date
End stage renal dialysis start date
End stage renal transplant end date
End stage renal transplant start date
The first day the data elements on an ETHNICITY-INFORMATION record are effective.
The last day the data elements on an ETHNICITY-INFORMATION record are effective.
The time a letter event occurred - stored in yyyymmddhhmiss format.
Date time of the exception.

The date the claim was extracted and sent to the PBM trading partner.
Date on which the Provider would like to start receiving bulletins via FAX or Email.
Date on which the Provider would like to stop receiving bulletins via FAX or Email.
FCBC Verification Date
FCBC Verification Date
FCBC Visit Date
FCBC Visit Date
The date the FDA approved the drug
The date the FDA approved the drug
The date CMS reports that the FDA approved the drug as supplied by FDB.
The date CMS reports that the FDA approved the drug as supplied by FDB.
The date CMS reports that a manufacturer releases the drug product to the marketplace as supplied by FDB.
The date CMS reports that a manufacturer releases the drug product to the marketplace as supplied by FDB.
The date on which the record was last updated with data from FDB.
The date on which the record was last updated with data from FDB.
The date represents the shelf life expiration date of the last batch produced as supplied by FDB.
The date represents the shelf life expiration date of the last batch produced as supplied by FDB.
Contains the date on which the outstanding AR was reported to the federal government.
Federal fiscal year claim was adjudicated or rejected in (CCYY).
The date on which the file was created.
Date that financial finalizes the claim for this Payer.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.

A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
The date that financial completes the transaction - that is the paid date of the claim
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents CHECK ISSUE date that corresponds with the first financial cycle run for Payers that finalize the claim on that cycle.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the first financial cycle runs for Payers that finalize the claim.
Finalized date
This is the date the object was finalized.
This is the date the object was finalized.
This is the date the object was finalized.
The date of determination. (ICF/MR SCREEN, ICF MR Approval, Final Date)
The last determination date. (PASRR PRE-ADMISSION SCREEN, Determinations, Final Dtrmin Date)
The date the final determination was made. Resident Review Screen, Resident Reviews, Final Determination Date)
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents THE CHECK ISSUE date on which the last financial cycle run for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.

A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents CHECK ISSUE date that corresponds with the last financial cycle run for Payers that finalize the claim in that cycle.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents last CHECK ISSUE date CORRESPONDING WITH the last financial cycle run for Payers that finalize the claim.
A claim may be adjudicated by more than one Payer depending on the beneficiary/recipient coverage. Financial may run different cycles for different Payers on different dates. This date represents date on which the last financial cycle runs for Payers that finalize the claim.
Date/Time That Request Execution Completed.
This is the date that Financial processed the summary record.
This is the date that Financial processed the summary record.
This is the date that Financial processed the summary record.
This is the date that Financial processed the summary record.
This is the date that Financial processed the summary record.

The first date of service on the first anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or low-date.
The first date of service on the first anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or low-date.
The first date of service on the first anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or low-date.
The first date of service on the first anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or low-date.
Date of first prenatal visit
The date the first bill is sent after the original bill date.
The date the first bill is sent after the original bill date.
The first date on which services are rendered for a medicaid recipient.
Date on which services were first performed for a recipient.
The date the service was incurred.
Detail first date of service
Date on which service was first provided.
Date on which services were first performed for a recipient.
Detail first date of service
Date on which service was first provided (oldest date of all details).
Date on which service was first provided (oldest date of all details).
The beginning date of service for the claim.
First date of service
Date on which services were performed for a recipient.
Date on which service was first provided on a particular claim (oldest date of all details).
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
The date on which a service was performed.
Date on which the statement period on the claim began.
The date the service for the line was performed.
Date on which services were first performed for a recipient.
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
The claim or encounters from date of service.
The from date of service for the numerator claims and encounter.

Date on which services were first performed for a recipient.
Date on which services were first performed for a recipient.
Date on which services were first performed for a recipient.
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
The first date on which services are rendered for a recipient.
Date on which the statement period on the claim began.
The first date of service this rate is effective.
This is the date of service effective date for this pgm and aid category combination.
This is the beginning date of service that the claim was submitted for.
The first date on which services are rendered for a medicaid recipient.
The first date on which services are rendered for a medicaid recipient.
Date on which services were first performed for a recipient.
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
Date on which services were first performed for a recipient.
Date on which service was first provided (oldest date of all details).
The date on which a service was performed.
Date on which the statement period on the claim began.
The first date of service on the claim that the A/R is associated to.
The first date of service on the claim that the A/R is associated to.
The first date of service on the claim that the A/R is associated to.
Claim detail first date of service.
This is the month of the date on which services were first performed for a recipient.
The state fiscal year which begins on July first and ends on June 30th of the following calendar year
The date the follow up letter was sent to the provider.
The date the follow up letter was sent to the provider.
This is the date the follow up letter was sent.
The from date range of the InfoSolutions data.
Parameter effective date.

The date the threshold amount becomes effective.
Claim search beginning date
For RA reporting only. This field is to contain the From Date of Service of the expenditure.
This field contains the from date of service of the review period.
Date on which recipient was admitted to inpatient hospital for which services are being billed.
Date on which recipient was admitted to an inpatient hospital.
Date on which recipient was admitted to inpatient hospital for which services are being billed.
This is the date the State Funds transfer.
This is the date the State Funds transfer.
The date the output was generated.
This field indicates the date the facsimile was generated.
Date 834 full file was last generated for the Trading Partner.
Contains the date the letter was generated.
The date you want the letter to be printed if the mode is batch.
Date the disposition was applied to the accounts receivable.
Date the disposition was applied to the accounts receivable.
Date the submitted checks were received by the account.
Date the submitted checks were received by the account.
The date the Abnormality was closed.
Date that the error occurred.
Generic date
Generic date
Date the disposition was applied to the accounts receivable.
The dispense date of the claim in history that the current claim failed a ProDUR warning against.
The dispense date of the claim in history that the current claim failed a ProDUR warning against.
This is the date the recipient became newly eligibile during the Recipeint update process.
The date the Abnormality was closed.
Group Date and Time
Date Hardship was approved/granted by Medicare.
Date Hardship was approved/granted by Medicare.
The last date on which the state considers the eligible person to have the chronic condition.
The date that the state considers to be the onset date for the person to have the chronic condition.
Defined by HCFA as the date the HCPCS code was added to the HCFA common procedure coding system.
Defined by HCFA as the date the HCPCS code was added to the HCFA common procedure coding system.

CMS Approval date contains the date the FDA approves a product for sale in the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS by the drug labeler.
CMS Approval date contains the date the FDA approves a product for sale in the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is supplied to CMS by the drug labeler.
HFCA (CMS) end date
CMS Market Entry Date contains the date a manufacturer releases the drug product to the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is provided to CMS by the drug labeler.
CMS Market Entry Date contains the date a manufacturer releases the drug product to the marketplace, for products introduced after 9/30/90 (the date the Rebate program started). Products introduced prior to this date will contain 19900930 in this column in lieu of the actual market entry date. This data is supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. The date is provided to CMS by the drug labeler.
Defined by HCFA as the last date for which a procedure code may be used by Medicare providers.
Defined by HCFA as the last date for which a procedure code may be used by Medicare providers.
HFCA (CMS) start date
Secondary Diagnosis Date. Date of onset or exacerbation of the first secondary diagnosis.
Secondary Diagnosis Date. Date of onset or exacerbation of the second secondary diagnosis.
Secondary Diagnosis Date. Date of onset or exacerbation of the third secondary diagnosis.
Secondary Diagnosis Date. Date of onset or exacerbation of the fourth secondary diagnosis.
Last Admission Period - Admission Date.
The first day the data elements on a HEALTH-HOME-CHRONIC-CONDITIONS record are effective.
The last day the data elements on a HEALTH-HOME-CHRONIC-CONDITIONS record are effective.

Last Admission Period - Discharge Date.
The date on which the health home entity was approved to participate in the Health Home Program.
The date on which the health home entity was approved to participate in the Health Home Program.
Last Visit Date. The Date the patient was last seen by the physician.
Home Health Certification Period - End Date.
Home Health Certification Period - Start Date.
Physician Contact Date. The date of the Home Health Agency's most recent contact with the physician.
Physician Order Date. AKA Verbal SOC Date. The date verbal orders were received from the physician for start of care.
The principal diagnosis date. Date of onset of exacerbation of the principal diagnosis.
This is the beginning date of service that home health services began.
The date on which the individuals participation in the Health Home Program started.
The date on which the individuals participation in the Health Home Program ended.
The date on which the individuals affiliation with the health home entity became effective
The date the individuals affiliation with the health home entity ended.
Surgery Date. Date Surgical Procedure performed.
Date Speical Condtion was historied off.
Date Special Condition was historied off.
The from or low date in the range of History partition.
The from or low date in the range of History partition
The to or high date in the range of History partition.
The to or high date in the range of History partition
Recipient's Part A date of Entitlement (mmccyy) from the Bendex tape.
Recipient's Part A date of Entitlement (ccyymmdd) from the Bendex tape, with the day of the month added.
Recipient's Part A date of termination (mmccyy) from the Bendex tape.
Recipient's Part A date of termination (ccyymmdd) from the Bendex tape, with the day of the month added.
This is the date that the hold occurred in the batch cycle.
This field holds the dates for holidays that fall on weekdays.
The date the surgical procedure was performed.
Date on which the surgical procedure code was performed.
Date first (primary) surgery occurred.
Date second surgery occurred.
Date third surgery occurred.
Date fourth surgery occurred.

Date fifth surgery occurred.
Date sixth surgery occurred.
ICD mapping date
ICD mapping date
Date on which request was made.
Date family member IEVES sent. CCYYMMDD format.
The date the five-year bar for an individual ends.
This is the date when this segment becomes inactive and will not be used in for claims received on and after it.
This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than or equal to this date, the row will not be used to process the claim.
This is the date the row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than this date, the row will not be used to process the claim.
The processing date this rate is inactive for this county.
Code used to identify the rate type to use in determining provider reimbursement.
This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.
Crosswalk segment inactive date. This is the date/time that the crosswalk can no longer be used, regardless of the dates of service on the claim.
Crosswalk segment inactive date. This is the date/time that the crosswalk can no longer be used, regardless of the dates of service on the claim.
Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.
This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.
This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than or equal to this date, the row will not be used to process the claim.
The date that the fund payer record was deactivated.
This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than this date, the row will not be used to process the claim.
This is the date this row becomes inactive. For new claims the ICN is compared to this date. If the ICN date is greater than this date, the row will not be used to process the claim.

This is the date when the usage of this thread was stopped. From this date onwards the thread will not be used regardless of the date of service billed on a claim.
Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.
This is the date when the usage of this thread was stopped. From this date onwards the thread will not be used regardless of the date of service billed on a claim.
This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.
Rate segment inactive date. This is the date/time that the rate can no longer be used, regardless of the dates of service on the claim.
The processing date this rate is inactive for this provider.
The processing date this rate is inactive for this provider.
The date this rate is inactive for this provider service location.
Date is defaulted to 12/31/2299 as this column is not actively used in interChange.
The processing date this rate is inactive for this provider.
This is the date this row becomes inactive. For new claims the system date is compared to this date. If the system date is greater than or equal to this date, the row will not be used to process the claim.
This is the date this row becomes inactive. For new claims the ICN is compared to this date. I the ICN date is greater than this date, the row will not be used to process the claim.
The data this row ceases to exist. On this date and thereafter this row will be ignored by the claim engine.
Crosswalk segment inactive date. This is the date/time that the crosswalk row can no longer be used, regardless of the dates of service on the claim.
The date that the row becomes inactive.
The date the emplyoer ended business.
Inbound date/time stamp - transaction begin timestamp
Inbound date/time stamp - transaction begin timestamp.
The date of change for income loss.
The date of income change.
Date analyst initiated the case.
The first day the TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES is effective.
The last day the TPL-MEDICAID-ELIGIBLE-PERSON-HEALTH-INSURANCE-COVERAGE-CATEGORIES data is effective

The first day of the time span during which the Medicaid enrollee is covered under the policy.
The last day of the time span during which the Medicaid enrollee is covered under the policy.
The date the health insurance policy listed on the SOBRA application is effective. Format is CCYYMMDD.
Date the interim action was indicated in CCYYMMDD format
The date the interest notification letter was sent to the provider.
The date the interest notification letter was sent to the provider.
Date initial recoupment letter sent/received.
Date the Invoice was created.
Date the Invoice was created.
The date the call came in.
Interchange Date and Time
The date the check was written. This will be the date of the financial cycle.
The date the payment is issued for. The date on which the payment was created is in dte_cycle.
This is the date of the check write cycle when the 835 was created
This is the issue date of the payment which the earnings are being reported.
This is the issue date of the payment which the earnings are being reported.
This is the issue date of the check to be released.
The date displayed on the check or EFT record.
This is the issue date of the financial cycle.
This is the date that the payment was issued.
The date of issue for a provider check.
The date of issue for a provider check.
This is the issue date of the payment which the earnings are being reported.
This is the issue date of the payment which the earnings are being reported.
This is the issue date of the payment which the earnings are being reported.
Date the recipient ID card was issued.
Date the recipient ID card was issued.
Issue date for the ID Card
Issue date for the ID Card
Issue Date.
The date the retro-eligibility segment was awarded to the recipient.
The payment issue date of the check.
The date of issue for EFTs.
The five byte Julian date in the format yyjjj.

Date when the paper claim was keyed into system. Updated once the claim has been keyed into the system. Shouldn't change once inserted. Format: CCYYMMDD
Date when the paper claim was keyed into system. Updated once the claim has been keyed into the system. Shouldn't change once inserted. Format: CCYYMMDD
Date that the recipient was last sent to the 834 "target"
The last date of service on the last anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or high-date.
The last date of service on the last anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or high-date.
The last date of service on the last anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or high-date.
The last date of service on the last anchor record for a chronic annual episode (blank/null for non-chronic episodes and for annual episodes without an anchor). YYYYMMDD or high-date.
The date the status was last changed, used to report and track case status changes.
The date the status was last changed, used to report and track case status changes.
Date this record was last changed. This should be updated anytime a clerk or system process updates this record. Format: CCYYMMDD
Date this record was last changed. This should be updated anytime a clerk or system process updates this record. Format: CCYYMMDD
The date the invoice dispute status last changed
The date the invoice dispute status last changed
The date the status of the drug rebate invoice was last changed. The date is in CCYY/MM/DD format.
The date the status of the drug rebate invoice was last changed. The date is in CCYY/MM/DD format.
This is the date the EFT information was last changed.
This is the date the segment was changed.
Last date the record has been modified.
Last date the record has been modified.
This is the date the EFT information was last changed.
Date the LOC request was last changed.
Date on which address was changed.
Date on which address was changed.
This field specifies the date of last change for the consent form.
This field specifies the date of last change for the consent form.
This field specifies the date of last change for the consent form.

The date that the level of care segment was last changed.
The date that the Medicaid recipient's name was changed.
The date that the recipient's name was changed.
Date on which county was changed and added.
Date on which county was changed and added.
The date that the recipient's SSN was changed.
Date that the A/R status was last updated.
Date that the A/R status was last updated.
Date that the A/R status was last updated.
Contains the date that this record was last changed to help support audit trail research
Contains the date that this record was last changed to help support audit trail research
The last day during the fiscal year for which inpatient services will be covered
Last cycle date that created a list for this recipient plan.
The recipeint's last EPSDT Dental Screening date.
The recipeint's last EPSDT Dental Screening date.
The recipient's last EPSDT Hearing Screening date.
The recipient's last EPSDT Hearing Screening date.
Date of the last successful logon to the site.
The recipient's last EPSDT Medical Screening date.
The recipient's last EPSDT Medical Screening date.
Date of the last menstrual period
The date of last pay received.
The most recent date that a check was issued for payment of the policy.
The last time the status was changed for the application.
The last time the status was changed for the application.
The last time the status was changed for the application
The last date on which services were rendered for a Medicaid recipient.
Date on which services were last performed for a recipient.
The date on which the statement period on the claim ended.
Date on which service was last provided.
Date on which service was last provided (latest date from all details).
Date on which service was last provided (latest date from all details).
The last date of service for the claim.
Last date of service

Date on which service was last provided on a particular claim (most current date of all details).
Date on which services were last performed for a recipient.
Date on which service was last provided (latest date from all details).
Service Line Date. Used to store the service line "To Date" where relevant.
Date on which the statement period on the claim ended.
Date on which services were last performed for a recipient.
Date on which services were last performed for a recipient.
Date on which services were last performed for a recipient.
Date on which services were last performed for a recipient.
Last date on which service was provided to a recipient (most recent date of all details).
Date on which services were last performed for a recipient.
Date on which service was last provided (latest date from all details).
Service Line Date. Used to store the service line "To Date" where relevant.
Date on which the statement period on the claim ended.
The last date of service this rate is effective.
Most recent DOS from paid claim, in which provider was either billing, performing, or rendering provider.
Most recent DOS from paid claim, in which provider was either billing, performing, or rendering provider.
This is the date of service end date for this pgm and aid category combination.
This is the beginning date of service that the claim was submitted for.
Date on which services were last performed for a recipient.
Date on which services were last performed for a recipient.
Date on which service was last provided (latest date from all details).
Service Line Date. Used to store the service line "To Date" where relevant.
Date on which the statement period on the claim ended.
The last date of service on the claim that the A/R is associated to.
The last date of service on the claim that the A/R is associated to.
The last date of service on the claim that the A/R is associated to.
Claim detail last date of service.
The date the worker made the change in CCYYMMDD format
The date the Medicaid number was changed to this number

Date of the last unsuccessful logon attempt to the site.
The date on which the last update occurred on CMS side.
The date on which the last update occurred on CMS side.
This date shows when this row was created or last modified.
This date shows when this row was created or last modified, due to an alteration in the NCCI database.
This date shows when this row was created or last modified.
The last date the NDC was updated with an new rate.
The date on which the update occurred.
The date on which the update occurred.
The date on which the update occurred.
Indicates the date that the record was most recently applied to the table.
This is the date that the record was last updated.
This is the date that the record was last updated.
This is the date that the record was last updated.
This is the date that the record was last updated.
The date that the recipient was last updated.
The date the recipient was last updated.
Date inserted by batch process
Date updated
Date of last update to recipients availability
Date of last update to recipients availability
Date segment was last updated.
Date segment was last updated.
Date segment was last updated.
Date segment was last updated.
Date time record was last updated.
Date time when the record was last updated.
This is the date when a last update was made to a record on this table.
This date shows when this row was created or last modified, due to an alteration in the NCCI data.
This date shows when this row was created or last modified, due to an alteration in the NCCI data.
This date shows when this row was created or last modified, due to an alteration in the NCCI data.
This date shows when this row was created or last modified, due to an alteration in the NCCI data.
This date shows when this row was created or last modified, due to an alteration in the NCCI data.
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This date shows when this row was created or last modified, due to an alteration in the NCCI data.

This date shows when this row was created or last modified, due to an alteration in the NCCI data.
This is the date when a last update was made to a record on this table.
The date on which the record was last updated.
The date on which the record was last updated.
The last date the recipient date(s) were updated.
The last date the recipient date(s) were updated.
The date that the transaction was last updated.
The date the eligibility segment was last updated.
The date the eligibility segment was last updated.
This is the date the record was last updated.
This is the date the record was last updated.
This is the date the record was last updated
This is the date the record was last updated
This is the date the record was last updated.
This is the date the record was last updated.
The date that the transaction was last updated.
Date time record was last updated.
Date time record was last updated.
Date the recipient was last received from the AMAES system. At the time of implementation, this column will be initialized to 0, so all recipients with a 0 date have not been received since implementation of the new column.
The last date any field was updated or the date the record was created in CCYYMMDD format
The recipient's last EPSDT Vison Screening date.
The recipient's last EPSDT Vison Screening date.
Date of last site visit for providers.
Date of last site visit for providers.
The date the requested letter was generated.
The date the initial collections letter was sent to the provider.
The date the initial collections letter was sent to the provider.
This field holds the date the letter was sent to track when letters are sent.
Date re-enrollment letter sent to provider.
Date re-enrollment letter sent to provider.
This is the date an EPSDT letter was sent to a recipient.
This is the date an EPSDT letter was sent to a recipient.
The date the check being held letter was first sent.
Date second re-enrollment letter sent to provider.
Date second re-enrollment letter sent to provider.
The date the client's Level I screening information was received. (LEVEL I TRACKING SCREEN, Case Information, Date Received)
The provider's license certification date.

The provider's license certification date.
The provider's license certification date.
The provider's license certification end date if applicable.
The provider's license certification end date if applicable.
The provider's license certification end date if applicable.
This field identifies the date the lien was originally filed with the county.
This field identifies the date the lien was originally filed with the county.
This field identifies the date the lien was originally filed with the county.
The date the lien was released.
The date the lien was released.
The date the lien was released.
The date lifeline permission was given to the PSC in CCYYMMDD format
This is the effective date of the lockin period.
This is the end date of the lockin period.
Date when the paper claim was loaded into this table. Updated by the process that loads records from the image file into this table. Shouldn't change once inserted. Format: CCYYMMDD
Date when the paper claim was loaded into this table. Updated by the process that loads records from the image file into this table. Shouldn't change once inserted. Format: CCYYMMDD
The date on which the lock in period begins for an individual with a healthcare service/provider
The date on which the lock in period ends for an individual with a healthcare service/provider.
Lock-in from date.
Effective date of the SUR lock-in period.
Lock-in through date.
End date of the SUR lock-in period.
The lock-in date will be used to prevent a recipient from being able to change MCOs during the Lock-In period.
The filed will store the date/time that the clerk logged onto the MMIS using the MMIS application.
This field holds a date and time in which log data created.
This field holds a date and time in which log data created.
The date the problem log was last changed by anyone
The date on which the drug's current blue book average wholesale unit or package price was changed on the NDDF master file
The date on which the drug's current blue book average wholesale unit or package price was changed on the NDDF master file

The date on which the drug's current blue book average wholesale unit or package price was changed on the NDDF master file.
This field indicates the date of LTC certification for a category of service.
This field indicates the date of LTC certification for a category of service.
Long-term care end date
Effective date of LTC Part B policy
End date of LTC Part B policy
The date on which the individuals eligibility for long term care nursing home service began.
The date on which the individuals eligibility for long term care nursing home service ended.
The claimant's last date of ineligibility due to receipt of lump sum. Format is CCYYMMDD.
Date of provider's MAC appeal request.
MAC appeal response date.
Date application was mailed to provider.
The date that the current marital status was obtained in CCYYMMDD format
The Market Entry Date represents the date a manufacturer releases the drug product to the marketplace, as supplied on the CMS's quarterly tape.
The Market Entry Date represents the date a manufacturer releases the drug product to the marketplace, as supplied on the CMS's quarterly tape.
Date Claim Matched.
Maternity Waiver Exemption Begin Date CCYYMM.
Maternity Waiver Exemption End Date CCYYMM.
Maximum date that a provider may extend their PDF version of their paper RA.
Maximum date that a provider may extend their PDF version of their paper RA.
Maximum date that a provider may extend their PDF version of their paper RA.
This date signifies that the recipient had Medicare covered days prior to this nursing facility segment.
This date signifies that the recipient had Medicare covered days prior to this nursing facility segment.
This date signifies that that the recipient had Medicare covered days prior to this nursing facility segment.
The date that Medicare paid the claim.
The date that Medicare paid the claim.
The date that Medicare paid the claim.
The date that Medicare paid the claim.
The date that Medicare paid the claim.

The start date of the managed care contract period with the state.
The expiration date of the managed care contract period with the state.
The first day the data elements in the MANAGED-CARE-LOCATION-AND-CONTACT-INFO record are effective.
The last day the data elements in the MANAGED-CARE-LOCATION-AND-CONTACT-INFO record are effective.
The first day the data elements in the MANAGED-CARE-MAIN record are effective.
The last day the data elements in the MANAGED-CARE-MAIN record are effective.
The date that the state obtains the authority to operate their managed care program.
The date that authority ends to operate the managed care program
The effective date of an individual`s enrollment in a managed care plan.
The date an individual`s enrollment in a managed care plan ends.
The effective date that the managed care plan began enrolling.
The date that the managed care plan stopped enrolling the eligibility group(s).
The first day the data elements in the MANAGED-CARE-SERVICE-AREA record are effective.
The last day the data elements in the MANAGED-CARE-SERVICE-AREA record are effective.
The date Medicaid paid on this claim or adjustment.
The date Medicaid paid on this claim or adjustment.
The date Medicaid paid on this claim or adjustment.
The date Medicaid paid on this claim or adjustment.
The date on which medical services were provided
A date which designates the month in which the beneficiary attained age 65 or became entitled to Hospital Insurance benefits (Part A).
A date which designates the month in which the beneficiary attained age 65 or became entitled to Hospital Insurance benefits (Part A).
A date which designates the month in which the beneficiary attained age 65 or became entitled to Hospital Insurance benefits (Part A).
A date which designates the month in which the beneficiary attained age 65 or became entitled to Hospital Insurance benefits (Part A).
Medical Support Order Date.
Medical Support Order Date.

The date on which the individuals participation in Money Follows the Person Demonstration started.
The date on which the individuals participation in the Money Follows the Person Demonstration ended
The date the level II evaluation for MI was ordered. (PASRR PRE-ADMISSION SCREEN, Referral, MI Referral Date)
The date the verbal call for the MI level II is received. (PASRR PRE-ADMISSION SCREEN, Determinations, MI Verbal Date Received)
The date the LOCEU verbally received the MI determination. Resident Review Screen, Resident Reviews, MI Verbal Date Received)
Calendar month the claim was adjudicated or rejected in (CCYYMM).
Identifies the month for which count of eligible recipients is gathered.
This field holds a number of the month in which log data created.
Identifies the month in which claims are paid.
Identifies the month in which services are rendered to recipients.
This is the date the move is effective. The date format is YYYYMM.
This is the date the move is effective. The date format is YYYYMM.
The date the level II evaluation for MR was ordered. (PASRR PRE-ADMISSION SCREEN, Referral, MR Referral Date)
The date the verbal call for the MR level II was received. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Verbal Date Rcvd)
The date the LOCEU verbally received the MR determination. Resident Review Screen, Resident Reviews, MR Verbal Date Received)
Date MSP status changed in CCYYMMDD format
Maternity waiver action date in CCYYMMDD format
Maternity waiver approval date in CCYYMMDD format
The first day the data elements in the NATIONAL-HEALTH-CARE-ENTITY-ID-INFO record are effective.
The first day the data elements in the NATIONAL-HEALTH-CARE-ENTITY-ID-INFO record are effective.
The date on which the drug record was added to the National Drug Data File (NDDF) master file
The date on which the drug record was added to the National Drug Data File (NDDF) master file
The date on which the drug record was added to the National Drug Data File (NDDF) master file.
Date of update (DUPDC) of NDC Record (NDCTBL) on the weekly NDDF update file.
Date of update (DUPDC) of NDC Record (NDCTBL) on the weekly NDDF update file.

Date of update (DUPDC) of NDC Record (NDCTBL) on the weekly NDDF update file.
This field holds the next business date after a holiday that falls on a weekday.
The recipient's next EPSDT Dental Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Dental Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Hearing Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Hearing Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Medical Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Medical Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Vision Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The recipient's next EPSDT Vision Screening due date. The date is calculated using the last medical screening date and the periodicity schedule.
The date of the note.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the note was entered.
The date that the latest additional notice letter was sent.
The date that the latest additional notice letter was sent.
The date that the latest initial notice letter was sent.
The date that the latest initial notice letter was sent.

Date time notification was sent.
Date of deactivation
Date of deactivation
Date of reactivation
Date of reactivation
NCPDP SCRIPT Quantity Qualifier Obsolete Date in CCYYMMDD format
This is the obsolete date for the drug code.
Obsolete Date
The date the service was incurred.
The occurrence date of a significant event relating to a particular UB92 claim that may affect payer processing.
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (1 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (2 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (3 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (4 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (5 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (6 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (7 of 8).
The occurrence date of a significant event relating to an institutional claim that may affect payer processing (8 of 8).
The start date of the corresponding occurrence code or occurrence span codes
The start date of the corresponding occurrence code or occurrence span codes
The start date of the corresponding occurrence code or occurrence span codes
The last date that the corresponding occurrence code or occurrence span code was applicable.
The last date that the corresponding occurrence code or occurrence span code was applicable.
The last date that the corresponding occurrence code or occurrence span code was applicable.
The occurrence to date of a significant event relating to a particular UB92 claim that may affect payer processing. This date is only used for span occurrence codes.
Claim Date when service ended.
Claim Date when service ended.
Claim Date when service ended.
Claim Date when service started.
Claim Date when service started.
Claim Date when service started.

This field identifies the date that the accident or injury occurred. Used to identify claims that could be used in this case.
This field identifies the date that the accident or injury occurred. Used to identify claims that could be used in this case.
This field identifies the date that the accident or injury occurred. Used to identify claims that could be used in this case.
The date the client was admitted to the nursing facility. (LEVEL I TRACKING SCREEN, Case Information, Date Of Admission)
The date of service for the claim.
The date of service for the claim.
The date the question was opened.
The date the case was originally billed.
The date the case was originally billed.
Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.
Other Subscriber Date Of Birth
Other Subscriber Date of Birth (DOB). AKA Other Insured Date of Birth (DOB).
Other Subscriber Date Of Birth
The first day the TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION is effective.
The last day the TPL-MEDICAID-ELIGIBLE-OTHER-THIRD-PARTY-COVERAGE-INFORMATION data is effective.
Outbound date/time stamp - transaction complete timestamp
Outbound date/time stamp - transaction complete timestamp.
Date when claim was paid.
The most recent paid date that financial used to place on a claim. Also known as issue or warrant date. Note this is in an Oracle date format.
The date the claim was adjudicated. Except for special processing cycles. This is not the actual date of payment; since the payment is issued by the state treasurer after a post-audit and when funds are available.
The date that the claim interest was paid to the provider.
The date that the claim interest was paid to the provider.
The date the claim was adjudicated except for special processing cycles. This is not the actual date of payment since the payment is issued by the state treasurer after a post-audit and when funds are available.
The date the claim was adjudicated except for special processing cycles. This is not the actual date of payment since the payment is issued by the state treasurer after a post-audit and when funds are available.
This is the date paid.
This is the date paid of the claim.
Year the fee was paid to the Agency.
Date Enrollment Fee was paid by provider.

Current paid date.
Current paid date.
This is the date the claim was paid.
Paid date
Checkwrite first date Format: YYYYMMDD
Checkwrite last date Format: YYYYMMDD
The date that the maternity district paid the claim.
The date that the maternity district paid the claim.
Current paid date month.
Current paid date month.
The most recent paid date that financial used to place on a claim. Also known as issue or warrant date. Note this is in an integer date format (CCYYMMDD).
Current paid date quarter.
Current paid date quater.
Indicates the Paid Date Year.
This is the begin date for the report date range. All transactions up to this date will be reported.
This is the end date for the report date range. All transactions up to this date will be reported.
This is the second date used for parm processing.
Contains the start date of Part A Buyin. This field is being stored and passed to DSS for the customer's querying needs.
Contains the end date of Part A Buyin. This field is being stored and passed to DSS for the customer's querying needs.
Contains the start date of Part B Buyin. This field is being stored and passed to DSS for the customer's querying needs.
Contains the end date of Part B Buyin. This field is being stored and passed to DSS for the customer's querying needs.
Patient's date of death
First date during the payment month that this payment covers.
First date during the payment month that this payment covers.
First date during the payment month that this payment covers.
First date during the payment month that this payment covers.
Last date during the payment month that this payment covers.
Last date during the payment month that this payment covers.
Last date during the payment month that this payment covers.
Last date during the payment month that this payment covers.

This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the disposition was created by the online (manual disposition).
This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the disposition was created by the online (manual disposition).
This is the date that Financial issued/processed the payment.
This is the date that Financial issued/processed the payment.
This is the date that Financial issued/processed the payment.
This is the financial payment issue date as it appears on the check or EFT.
This is the financial payment issue date. If the expenditure is a system expenditure, it is the date the financial cycle assigned to it. If it is a manual expenditure, it is the date the expenditure is printed and issued outside of the cycle.
This is the financial payment issue date as it appears on the check or EFT.
This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the disposition was created by the online (manual disposition).
This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the the disposition was created by the online (manual disposition).
This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the the disposition was created by the online (manual disposition).
This is the financial payment issue date if the disposition was created during a financial cycle. It is the date of the disposition if the the disposition was created by the online (manual disposition).
This is the date the OHCA indicates that the true issue date should have been. This is caused due an issue at the State Treasure's Office. If the STO changes the payment issue date to the bank this is known as a slip date.
This is the date the OHCA indicates that the true issue date should have been. This is caused due an issue at the State Treasure's Office. If the STO changes the payment issue date to the bank this is known as a slip date.
The payment cycle date of the batch.
The payment cycle date of the batch.
The payment cycle date of the batch.
The ending date of the pay period provided on the check stub that the recipient submits to the State.

The beginning date of the pay period provided on the check stub that the recipient submits to the State.
This is the date the Prior Authorization administrative review was mailed.
This is the date the Prior Authorization administrative review was mailed.
This is the date the Prior Authorization administrative review was received by EDS.
This is the date the Prior Authorization administrative review was received by EDS.
This is the date the Prior Authorization appeal was held.
This is the date the Prior Authorization appeal was held.
This is the date a Prior Authorization appeal was dismissed.
This is the date a Prior Authorization appeal was dismissed.
This is the date the Prior Authorization appeal packet was mailed.
This is the date the Prior Authorization appeal packet was mailed.
This is the date the Prior Authorization appeal was received by EDS.
This is the date the Prior Authorization appeal was received by EDS.
This is the authorized Prior Authorization start date for the line-item.
This is the authorized Prior Authorization start date for the line-item.
This is the authorized Prior Authorization stop date for the line-item.
This is the authorized Prior Authorization stop date for the line-item.
This is the date that a Prior Authorization request was automatically approved.
This is the date that a Prior Authorization request was automatically approved.
This is the date a Prior Authorization request was keyed into the MMIS system.
This is the requested Prior Authorization start date for the line-item.
This is the requested Prior Authorization start date for the line-item.
This is the requested Prior Authorization stop date for the line-item.
This is the requested Prior Authorization stop date for the line-item.
Personal benefits effective date
Personal benefits end date
Personal benefits start date
Date the person was set as not eligible for the Patient First Plan in CCYYMMDD format

Most current plastic card history date
Next most current plastic card history date
Data is in the format MMMYYYY. Valid values for the MMM portion are JFM, AMJ, JAS, OND.
The beginning date of the defined period.
The ending date of the defined period.
PHP current eligibility date in CCYYMMDD format
Date of plastic card activity in CCYYMMDD format
The beginning of the possible date range for claims related to the overpayment.
The beginning of the possible date range for claims related to the overpayment.
The end of the possible date range for claims related to the overpayment.
The end of the possible date range for claims related to the overpayment.
The date the cash receipt disposition was posted. This date will determine which week the disposition will be reported in.
The date the cash receipt disposition was posted. This date will determine which week the disposition will be reported in.
The date the interest amount was posted.
The date the interest amount was posted.
The date the payment was posted to a drug rebate invoice.
The date the payment was posted to a drug rebate invoice
The date the payment is posted.
The date the payment is posted.
This is the date that the disposition was posted (added) to the budget.
This is the date that the disposition was posted (added) to the budget.
The date the cash receipt disposition was posted. This date will determine which week the disposition will be reported in.
The date the transaction is entered.
The postmark date of the payment for a drug rebate invoice.
The postmark date of the payment for a drug rebate invoice.
PRCSG date
PRCSG date
Due date for pregnancy, if applicable. CCYYMMDD format.
The date the overpayment is prepared.
The date the overpayment is prepared.
Date the prescription was written by the physician.
Date physician prescribed a drug for a recipient.
Date physician prescribed drug for a recipient.
Date physician prescribed drug for a recipient.
The date the drug device or supply was prescribed by the physician or other practitioner.
Date the drug device or supply was dispensed by the provider.

Date the previous checkwrite cycle ran. This reflects the cycle period for this run.
Date the previous checkwrite cycle ran. This reflects the cycle period for this run.
The date pre-approval was received for this case. (ICF/MR SCREEN, ICF MR Approval, Pre-Approval Date)
The date the call was received by the LOCEU from the ICF/MR.
The first day the data elements in the PRIMARY DEMOGRAPHICS ELIGIBILITY record are effective.
The last day the data elements in the PRIMARY DEMOGRAPHICS ELIGIBILITY record are effective.
Prior application date, if applicable
The date this payment was processed.
The date that the batch of transactions completed being processed by the transaction processor.
Date the Receipt was processed.
This field contains the date on which the cash disposition was processed in batch. This is used during the extraction and balancing of the cash disposition
This field contains the date on which the account recievable was processed in batch. This is used during the extraction and balancing of the expenditure.
This field contains the date on which the account recievable was processed in batch. This is used during the extraction and balancing of the expenditure.
This field contains the date on which the expenditure was processed in batch. This is used during the extraction and balancing of the expenditure.
This field contains the date on which the expenditure was processed in batch. This is used during the extraction and balancing of the expenditure.
Indicates the date when the report was processed.
This field contains the date on which the cash disposition was processed in batch. This is used during the extraction and balancing of the cash disposition
Date that the CMS error record file was processed.
The date that the claim was processed.
The date that the claim was processed.
Date the batch process completed the member move.
This date field tells us when the transaction was initially processed. The date is in the format CCYYMMDD
This date field tells us when the transaction was initially processed. The date is in the format CCYYMMDD.
Date the 1095 was generated for the Recipient
Date the 1095 was generated for the Recipient

Date that the CMS error record file was processed.
Date the batch was processed by Medicaid.
Date the batch was processed by Medicaid.
Date the batch was processed by Medicaid.
This date identifies when the data was used by TPL to apply policies to all recipients added to the table. The format is CCYYMMDD.
RBT4002Q reporting quarter (ie. 20111 equates to the report run for the quarter ending 3/31/2011).
The date on which the update occurred.
The Invoice Qtr the data was received and processed, in YYYYQ format.
The date on which the procedure was performed
The date upon which the procedure was performed.
Original date of the procedure
Production Date
The first day the data elements in the PROV-AFFILIATED-GROUPS record are effective.
The last day the data elements in the PROV-AFFILIATED-GROUPS record are effective.
The first day the data elements in the PROV-AFFILIATED-PROGRAMS record are effective.
The last day the data elements in the PROV-AFFILIATED-PROGRAMS record are effective.
The first day the data elements in the PROV-ATTRIBUTES-MAIN record are effective.
The last day the data elements in the PROV-ATTRIBUTES-MAIN record are effective.
DTE_PROV_ENUMERATION
DTE_PROV_ENUMERATION
The first day the data elements in the PROV-IDENTIFIERS record are effective.
The last day the data elements in the PROV-IDENTIFIERS record are effective.
The first day the data elements in the PROV-LICENSING-INFO record are effective.
The last day the data elements in the PROV-LICENSING-INFO record are effective.
The first day the data elements in the PROV-LOCATION-AND-CONTACT-INFO record are effective.
The last day the data elements in the PROV-LOCATION-AND-CONTACT-INFO record are effective.
This is the date that the MCO's PCP (the group member) was associated with the recipient.
This is the date that the MCO's PCP (the group member) was associated with the recipient.

The first day the data elements on a PROV-MEDICAID record are effective.
The last day the data elements on a PROV-MEDICAID record are effective.
The first day the data elements in the PROV-TAXONOMY-CLASSIFICATION record are effective.
The last day the data elements in the PROV-TAXONOMY-CLASSIFICATION record are effective.
Effective start date.
Effective end date.
Date the PS/2 transaction was processed
Part A end date
Part A start date
Part B end date
Part B start date
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
This is the partition column for this table. It can be either First Date of Service or Paid Date.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
The date of the financial cycle the claim was paid.
Date used for database partitioning (paid date).
The date of the financial cycle the claim was paid.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
This is the partition date which is set to the paid date of the claim.
Date used for DB partitioning

Date used for database partitioning which is the checkwrite date.
Date used for database partitioning.
Date claim was processed/paid.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning.
Date used for database partitioning (paid date).
Date used for database partitioning (paid date).
Date used for database partitioning.
Date used for database partitioning.
Date the case was purged.
Date and time that a file was purged from the system.
Date post-partum services should end in CCYYMMDD format
Calendar quarter claim was adjudicated or rejected in (CCYYQQ).
The drug rebate quarter in CCYYQ where Q indicates the quarter. Valid values for the quarter are 1-4. 1 = Jan. - March, 2 = April - June, 3 = July - Sept, 4 = Oct. - Dec.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
Quarter of Profile run.
The date in ccyyq format where q indicates the quarter in which the original claim was paid
The date in ccyyq format where q indicates the quarter when the claims billed on the invoice were paid
Invoice quarter in CCYYQ format.
The date in ccyyq format where q indicates the quarter when the claims billed on the invoice were paid.
The quarter the claims on the invoice were paid. The date is in the format CCYYQ where Q indicates quarter.
The quarter NDCs were invoiced. The date is in the format CCYYQ where Q indicates the quarter.

The quarter the claims billed on the invoice were paid. The date is in the format CCYYQ where Q indicates the quarter. Valid values for the quarter are 1-4. 1 = Jan. - March, 2 = April - June, 3 = July - Sept, 4 = Oct. - Dec.
The quarter the claims billed on the invoice were paid. The date is in the format CCYYQ, where Q is the quarter.
The quarter the claims billed on the invoice were paid. The date is in the format CCYYQ, where Q indicates the quarter. Valid values for the quarter are 1-4. 1 = Jan. - March, 2 = April - June, 3 = July - Sept, 4 = Oct. - Dec.
The calendar quarter and year.
The Invoice Qtr the offset applies to, in YYYYQ format.
The rebated period in CCYYQ format. This is the quarter the rate applies to.
Quarter in which the lookup was successfully performed. Format is CCYYQ.
The calendar quarter and year of the invoice period for which PHS pharmacy claims are being counted
The calendar quarter and year of the invoice period for which PHS/IHS pharmacy claims are being counted
The reported period in CCYYQ format. This is the quarter we received the rate.
This is the date a questionnaire was sent out to resolve questions about the policy.
The first day the data elements on a RACE-INFORMATION record are effective.
The last day the data elements on a RACE-INFORMATION record are effective.
Recipients RCO Date of Availability
Recipients RCO Date of Availability
The date the signed application was received by Medicaid. Format is CCYYMMDD.
This is the date that the cash receipt was put into the system.
This is the date that the cash receipt was put into the system.
Date referral received.
The date the drug rebate invoice dispute was received/opened.
The date the drug rebate invoice dispute was received/opened.
The date the PPA was received
The date the PPA was received
This is the date stamp reflecting receipt of the update transaction by the MMIS.
This is the date stamp reflecting receipt of the update transaction by the MMIS.
This is the date stamp reflecting receipt of the update transaction by the MMIS.
This is the date stamp reflecting receipt of the update transaction by the MMIS.
This contains the date the transaction was received by the MMIS.

This is the date the transaction was received by the MMIS.
This is the date a Prior Authorization request was received by EDS.
This is the date stamp reflecting receipt of the update transaction by the MMIS.
A date that the object was received.
A date that the object was received.
A date that the object was received.
The date the payment was received or the adjustment was made.
The date the payment was received or the adjustment was made.
The date the claim is ICNed is compared to this date when selecting claims for payment hold.
The date the claim is ICNed is compared to this date when selecting claims for payment hold.
The date the claim was ICNed is compared against this date when selecting claims for payment hold.
The date the claim was ICNed is compared against this date when selecting claims for payment hold.
Date and time the claim recipient was changed within the MMIS.
Date the client is due for a SUR review.
First date of provider's reconsideration request.
First reconsideration response date.
Second date of provider's reconsideration request.
Second reconsideration response date.
Date when the recoupment can be generated.
Date when the last recoupment was done through financial for the ICN.
Date when the last recoupment was done through financial for the case.
Indicates date record added.
Indicates date record added.
Indicates date record last updated.
Indicates date record last updated.
The Redetermination Date of eligibility in CCYYMMDD format
This is the actual recipient redetermination date when the case worker reviewed the recipient's Medicaid eligibility.
This is the actual recipient redetermination date when the case worker reviewed the recipient's Medicaid eligibility.
This is the planned recipient redetermination date when the case worker plans to next review the recipient's Medicaid eligibility. Will always contain zeroes in the OK system.
This is the planned recipient redetermination date when the case worker plans to next review the recipient's Medicaid eligibility. Will always contain zeroes in the OK system.

This field specifies the completion date for the re-enrollment.
This field specifies the completion date for the re-enrollment.
Primary - Date referred to entity.
Secondary - Date referred to entity.
The date the referral information for this case was last changed. (PASRR PRE-ADMISSION SCREEN, Referral, Date Last Changed) ;
The date the resident review information for a case was last updated by the user. Resident Review Screen, Resident Reviews, Referral User DLC)
First refund due date.
Second refund due date (for reconsideration amount).
Third refund due date (for reconsideration amount).
Date refund received from the provider.
The date that the LOCEU has sent an e-mail to the DMH or the DHS informing them that a referral is requested.
Date analyst referred to supervisor.
The date possible overpayment is registered.
The date possible overpayment is registered.
Date sanction ends
Date sanction ends
This is the release date for the EFT to pay.
This is the issue date of the financial cycle.
Date 835 released to the provider. BPR16 is updated with this date.
Date EFT funds are released.
Reply date to CMS
Reply date to CMS
Date reply transmitted to CMS
Date reply transmitted to CMS
Reply date to CMS
Reply date to CMS
Date reply transmitted to CMS
Date reply transmitted to CMS
The date that a reply was sent.
This is the date that the status was reported either to the state or to CMS.
The date that is the number of days before the compliance date. This will be the ICN Julian date of claims reported.
Date on which mass adjustment request was entered or generated (retro rate and void).
This is the date that the casualty letter was printed. It will be included in the letter.
The date that the check reissue entry is made.
The date that the check reissue entry is made.
Date on which the REOMB letter was sent for a recipient.

The date the letter was requested.
Contains the date of the request for letter.
Date the research request or project was entered into the tracking system.
Date provider requested the application.
Date the delink request was submitted.
Date the delink request was submitted.
The date DMH or DHS has received or responded to the referral request.
The date that DMH or DHS has received or responded to the referral request.
Date of residence change
The date the question/issue was resolved.
The postmark date of the response from the provider to the recoupment request letter.
Primary - Date response received from entity.
Secondary - Date response received from entity.
Date green card response letter received from the provider.
Date provider re-enrollment response received.
Date provider re-enrollment response received.
Date green card CEO response letter received from the provider.
Date green card MAC response letter received from the provider.
Date green card reconciliation 1 response letter received from the provider.
Date green card reconciliation 2 response letter received from the provider.
This field indicates the date when the denied claim was resubmitted.
The date the claim was returned from the PBM trading partner
Date that the recipient returned to Hospice care within the period.
This is the date the response was returned.
The date when the policy must be reviewed.
This is the date that the prior authorization is assigned for review.
Date a recipient's restricted services are reviewed within a restriction period. Will always contain zeroes in OK system
This is the review period begin date for which this transaction applies.
This is the review period begin date for which this transaction applies.
This is the review period begin date for which this transaction applies.
This is the review period end date for which this transaction applies.

This is the review period end date for which this transaction applies.
This is the review period end date for which this transaction applies.
This is the most recent date that this case was reviewed.
This is the most recent date that this case was reviewed.
This is the most recent date that this case was reviewed.
Date that recipient revoked care.
The date the record is to be reviewed by the district office or another certifying agency in CCYYMMDD format
The last action/update date of a casualty case.
The last action/update date of a casualty case.
The last action/update date of a casualty case.
Review period from date.
Review period through date.
Date the check hold letter was resent.
This is the effective date of the recipient level of care period.
This is the end date of the recipient level of care period.
The first day of the reporting period in an Oracle DATE format.
The reporting period month in a numeric format (MM).
Date representing MAR reporting month.
Date representing MAR reporting month.
Date representing MAR reporting month.
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Date representing MAR reporting month.
Date representing MAR reporting month.

Date representing the end date of the period where this record was reported.
Date representing the end date of the period where this record was reported.
The last day of the reporting period in an Oracle DATE format.
The report period year in a numeric format (CCYY).
Indicates the date on which the user entered the request.
Date applicant entered USA if foreign born. Format is CCYYMMDD
A date that the object was returned to the provider.
A date that the object was returned to the provider.
A date that the object was returned to the provider.
A date that the RTP object was returned to OHCA.
A date that the RTP object was returned to OHCA.
A date that the RTP object was returned to OHCA.
The Date/Time the rule was changed.
Run date for report being generated, yyyymm
Date run Format: YYYYMMDD
The date that the schedule was executed.
This corresponds to the date the process was run.
The date which the insurance disclosure file was processed.
The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing, applicable by Financial run date.
The date the relationship between MMIS EOB codes and the combination becomes valid for use in processing, applicable by Financial run date.
The last date the relationship between MMIS EOB codes and the combination is valid for use in processing, applicable by Financial run date.
The last date the relationship between MMIS EOB codes and the combination is valid for use in processing, applicable by Financial run date.
The calendar quarter, formatted as YYYYQ, calculated from the first service date.
The calendar quarter, formatted as YYYYQ, for this Provider NPI enrollment segment.
The calendar quarter, formatted as YYYYQ, calculated from the claim first service date.
The calendar quarter, formatted as YYYYQ, calculated from the claim first service date.
The calendar quarter, formatted as YYYYQ, calculated from the claim first service date.
The calendar quarter, formatted as YYYYQ, for this recipient demographic reporting segment.
Date the checkwrite cycle is scheduled to run
Date the checkwrite cycle is scheduled to run

The date the level II evaluation for MI was ordered for this resident review.
The date the level II evaluation for MR was ordered for this resident review.
Date sanction begins
Date sanction begins
Sanctioned Provider's Date of Birth
Sanctioned Provider's Date of Birth
Date when the paper claim was originally scanned. This date should be the same as the julian date in the claim ICN. Shouldn't change once inserted. Format: CCYYMMDD
Date when the paper claim was originally scanned. This date should be the same as the julian date in the claim ICN. Shouldn't change once inserted. Format: CCYYMMDD
This is the SCRIPTS originated date which is the original assignment start date. This date will be zero for Hospice assignments.
This field indicates the date of State Department of Health inspection.
This field indicates the date of State Department of Health inspection.
The date the second bill is sent after the first rebill date.
The date the second bill is sent after the first rebill date.
The date the pricing segment was created.
The date the pricing segment was created.
The date the pricing segment was created.
The date the pricing segment was created.
The date the pricing segment was created.
The date the pricing segment was created.
The date the dispute resolution worksheet was mailed to the drug labeler.
The date the dispute resolution worksheet was mailed to the drug labeler.
The date the late notice letter was sent to the manufacturer
The date the late notice letter was sent to the manufacturer
The date the invoices for the quarter were mailed. This attribute should correspond to the postmark date on the invoices and is used in late payment and interest determination.
The date the invoices for the quarter were mailed. This attribute should correspond to the postmark date on the invoices and is used in late payment and interest determination.
The date the recoupment request letter was sent to the provider
Date the letter was sent.
The date that the note was sent.
The date the letter was created and printed.
This is the date a Prior Authorization notice was sent to the provider and recipient for either an original PA request or a PA update.

This is the date a Prior Authorization notice was sent to the provider and recipient for either an original PA request or a PA update.
This is the date a Prior Authorization notice was sent to the provider and recipient for either an original PA request or a PA update.
This is the date a Prior Authorization notice was sent to the provider and recipient for either an original PA request or a PA update.
This is the date a Prior Authorization notice was sent to the provider and recipient for either an original PA request or a PA update.
This is the date the record was sent to CMS.
This is the date the record was sent to CMS.
The date that the ID letter was sent. This is initially set to zeroes and is then updated to contain the date when the letter is sent.
Identifies the date the letter was sent.
Date sent to adjustments.
The first from date of service, payment, or receipt date that will be checked to select claims.
Service Date
Date of CPAS Strata Service or Payment depending on code
The beginning date of services that will be compared against the claims dates of service to determine if the claim is eligible for claim payment hold.
The beginning date of services that will be compared against the claims dates of service to determine if the claim is eligible for claim payment hold.
The beginning date of service or payment date that will be use to search for claims.
Service Adjudication Date.
The first date of service covered by the claim.
The first date of service covered by this claim.
The first date of service covered by the claim.
The first date of service covered by the claim.
The first date of service covered by this claim.
The last date of service covered by this claim.
The last date of service covered by this claim.
The last date of service covered by this claim.
The last date of service covered by this claim.
The last date of service covered by this claim.
The last from date of service, payment, or receipt date that will be checked to select claims.
Ending date of CPAS Strata Service or Payment depending on code

The ending date of service that is compared against the claims dates of service to determine if the claim is eligible for payment hold.
The ending date of service that is compared against the claims dates of service to determine if the claim is eligible for payment hold.
The end date of service or payment date that will be use to search for claims.
This is the date the settlement was established.
This is the date the settlement was established.
The date that the casualty case was settled.
The date that the casualty case was settled.
Date a settlement was reached on the case.
State Fiscal year claim was adjudicated or rejected in (CCYY).
The end date of the State Fiscal year, this date is used to detect when a new fiscal year starts to reset the table to zeros before beginning process for a new fiscal year.
The date the short term stay begins. (PASRR PRE-ADMISSION SCREEN, Referral, Beginning of Stay) ;
The date the short term stay ends. (PASRR PRE-ADMISSION SCREEN, Referral, End of Stay (Inclusive))
This field specifies the signature date for the consent form.
This field specifies the signature date for the consent form.
This field specifies the signature date for the consent form.
Recipient's Part B date of Entitlement (mmccyy) from the Bendex tape.
Recipient's Part B date of Entitlement (ccyymmdd) from the Bendex tape, with the day of the month added.
Recipient's Part B date of termination (mmccyy) from the Bendex tape.
Recipient's Part B date of termination (ccyymmdd) from the Bendex tape, with the day of the month added.
Date the SOBRA Application status was accepted.
Date the SOBRA Application status was changed.
Indicates date of annual review for SOBRA cases.
Date of annual review for SOBRA case in CCYYMMDD format
SSI only - Future date when SSI recipient will begin eligibility
This is the date the recipient last received an SSI check. (Only needed if Received SSI indicator is a Y) in CCYYMMDD format
The date the record is to be reviewed by Social Security in CCYYMMDD format
Start Date of Drug Exception record.
Date/Time That Request Execution Started.
Indicates the start date for extract processing.

Start date as sent by CMS.
Start date as sent by CMS
Start date as sent by CMS
Start date as sent by CMS
Date and time stamp the job began.
Start date of condition.
Start date of disease
Indicates the begin date of the first extra year for extract processing.
Indicates the begin date of the second extra year for extract processing.
Indicates the begin date of the third extra year for extract processing.
The employer's enrollment period start date.
Start date of service for the Offline Claim.
Date that the assignments to the transfer PMP will be effective.
Date that the assignments to the transfer PMP will be effective.
Date that the assignments to the transfer PMP will be effective.
Indicates the begin date of the most current 12 months for extract processing.
Indicates the begin date of the previous year for extract processing.
Indicates the begin date of the third year for extract processing.
Indicates the begin date of the fourth year for extract processing.
The date on which the individuals participation in the State Plan Option Type began.
The date on which the individuals participation in the State Plan Option Type ended.
Date the adjustment was added to this entity as pending or the date the status was changed to processed.
Date the adjustment was added to this entity as pending or the date the status was changed to processed.
Date the adjustment was added to this entity as pending or the date the status was changed to processed.
This is the date that the current status was done.
This is the date that the current status was done.
This is the date that the current status was done.
The date the status was updated in the system.
This is the date that the check was stale dated.
Date that the status was entered. This will be system plugged.
The date on which this status came into effect for the enrollment application.

The date on which this status came into effect for the enrollment application.
Date of family member status change in CCYYMMDD format
Contains the date in CCYYMMDD format that the case status was last updated.
Contains the date in CCYYMMDD format that the case status was last updated.
Date of marital status change.
This is the actual date the status was changed externally.
The status effective date reflects that date that the recipient's current enrollment status was set.
Status effective date.
Date status updated on eligibility system.
The date the eligibility status was updated or changed in CCYYMMDD format
Stop date from CMS
Stop date from CMS
Eligibility termination date as provided by CMS.
Eligibility termination date as provided by CMS.
End date received from CMS
End date received from CMS
Stop date from CMS
Stop date from CMS
Eligibility termination date as provided by CMS.
Eligibility termination date as provided by CMS.
End date received from CMS
End date received from CMS
Submission Date of Application
Submission Date of Application
Submission Date of Application
Year and month of data that was included in the submitted T-MSIS file.
Year and month of data that is included in the TMSIS files being submitted
Year and month of data that is included in the TMSIS files being submitted
Year and month of data that is included in the TMSIS files being submitted
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Year and month of data that was included in the submitted T-MSIS file.
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Year and month of data that is included in the TMSIS files being submitted
Year and month of data that is included in the TMSIS files being submitted
Date submitted on notification.
2000BA - Subscriber Date Of Birth.
2000BA - Subscriber Date Of Birth.
Subscriber Date of Birth (DOB). AKA Patient Date of Birth. Component of Subscriber Demographic Information.
The date that the recipient's subsidy is approved for PART D coverage.
The date that the recipient's subsidy is approved for PART D coverage.
This field indicates whether a provider is having their check suppressed or not.
This field indicates whether a provider is having their check suppressed or not.
This field indicates whether a provider is having their check suppressed or not.
Date supervisor approved CEO letter to be sent.
Date supervisor approval letter sent.
Date supervisor approved MAC letter to be sent.

Date supervisor approved first reconciliation letter to be sent.
Date supervisor approved second reconciliation letter to be sent.
This field specifies the surgery date for the consent form.
This field specifies the surgery date for the consent form.
This field specifies the surgery date for the consent form.
This is the date the suspect code was last updated.
This is the date the suspect code was last updated.
This is the dispensing date/first date of service of the claim.
The system date maintained in a CCYYMMDD format.
The date and time of the error for the recipient transaction.
The transaction date/time stamp.
The date and time of the error for the recipient transaction.
The transaction date/time stamp.
This is the date the labeler tape was processed.
Date the recipient was released from the provider facility
Date Special Condtion was terminated.
Date Special Condition was terminated.
This is the actual date that the PMP assignment was end dated. It is not necessarily the date that the PMP assignment is no longer effective (the end_date).
This is the actual date that the PMP assignment was end dated. It is not necessarily the date that the PMP assignment is no longer effective (the end_date).
The date is actually supplied to CMS from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.
The date is actually supplied to CMS from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.
This date is supplied on the HCFA quarterly tape. The date is actually supplied to HCFA from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.
This date is supplied on the CMS quarterly tape. The date is actually supplied to CMS from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.
This date is supplied on the CMS quarterly tape. The date is actually supplied to CMS from the drug manufacture/distributor. The date represents the shelf life expiration date of the last batch produced.
Date of the provider's contract was terminated or suspensed from the Provider Subsystem.

Date of the Contract Termination/Suspension Letter when the SUR's unit recommended the provider should be suspended or terminated.
The date the third party paid the coinsurance amount
The date the third party paid the coinsurance amount.
The date the third party paid the coinsurance amount.
The date the third party paid the coinsurance amount.
The date the third party paid the copayment amount
The date the third party paid the copayment amount.
The date the third party paid the copayment amount.
The date the third party paid the copayment amount.
This date triggers the generation for a follow-up on this case.
This date triggers the generation for a follow-up on this case.
Date Time Period. Expression of a date, a time, or range of dates.
Beginning date of the time period covered by this file.
Last date of the reporting period covered by the file to which this Header Record is attached.
The end date range of the InfoSolutions data.
End date of stop loss parameter.
The last day the threshold amount is effective for claims processing.
Claim search ending date
The current Julian date is the date that this batch range was last accessed. We will compare this to today's date to decide if we should start over with the beginning batch range.
This is the date the case amount was adjusted.
This is the date the case amount was adjusted.
Date response was sent to CMS
Date response was sent to CMS
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date response sent to CMS
Date response sent to CMS
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date already or to be sent to CMS.
Date on which service was provided through (latest date from all details).
For RA reporting only. This field is to contain the To Date of Service of the expenditure.

This field contains the "to" date of service of the review period.
Date on which recipient was discharged from inpatient hospital for which services are being billed.
Date on which recipient was discharged from an inpatient hospital.
Date on which recipient was discharged from inpatient hospital for which services are being billed.
The first day the data elements in the TPL-ENTITY-CONTACT-INFORMATION record are effective.
The last day the data elements in the TPL-ENTITY-CONTACT-INFORMATION record are effective.
Third party Part A accretion billing month
Third party Part A deletion billing month
Third party Part A end date
Third party Part A start date
Third party Part B accretion billing month
Third party Part B deletion billing month
Third party Part B end date
Third party Part B start date
Date of training.
The date a question was transferred.
This is only used for transfers and is the effective date that the recipient should start with the new PMP.
This is only used for transfers and is the effective date that the recipient should start with the new PMP.
This is only used for transfers and is the effective date that the recipient should start with the new PMP.
Date expressed as CCYYMMDD. BHT04 is the date the transaction was created within the business application system. Use this date to identify the date on which the submitter created the file.
For SOBRA only, the date the Transitional Medicaid report is due in CCYYMMDD format
The date the record was last updated.
The date the record was last updated
The date the record was last updated.
Date Reason was added or updated.
Date Reason was added or updated.
Date record was updated
Date record was updated
Date of update.
This is the date that EDS received a Prior Authorization update request from the provider or IFSSA.
This is the date that EDS reviewed a Prior Authorization system update request sent in by the provider or IFSSA.
Date that the file was uploaded/transmitted to the IRS.

Date that the file was uploaded/transmitted to the IRS.
Date and time the file was received by EDS.
Date the recipient entered the US, if they are an alien or a refugee.
Date the recipient entered the US, if they are an alien or a refugee.
The first day the data elements in the VARIABLE DEMOGRAPHICS - ELIGIBILITY record are effective.
The last day the data elements in the VARIABLE DEMOGRAPHICS - ELIGIBILITY record are effective.
Verification Date
Verification Date
This field indicates the date when the verification was completed.
This field indicates the date when the verification was completed.
The date the record was verified.
Indicates the verified death date for recipient.
Date the visit was conducted by State/Federal Agency.
Date the visit was conducted by State/Federal Agency.
The date the check was stamped void and destroyed.
The date the check was stamped void and destroyed.
Date an individual`s enrollment under a particular waiver began.
Date an individual`s enrollment under a particular waiver ended.
Date the Warning Letter was sent to the client.
Calendar week the claim was adjudicated or rejected in (CCYYWW).
This field holds week of the month in which log data created.
Date the final action was indicated by worker
The date the invoice detail was written off
The date the invoice detail was written off.
Date that the assignments to the transfer PMP will be effective.
Date that the assignments to the transfer PMP will be effective.
This is the year that the payments will be made for.
This is the year that the payments will be made for.
This is the tax year that is being adjusted.
This is the year and month of the date of service of the claim that used the patient liability.
This is the year and month of the date of service of the claim that used the patient liability.
This field will be set to December 31 of the effected year.
This field will be set to January 01 of the effected year.

This field is a generic counter.
Error code count
Flag that specifies if inbound EDI data is to be passed through to a mailbox, only on inbound maps. (1=yes; space=no)
This is the effective date of the labeler.
This is the effective date for the prior authorization.
This is the specified day a check can be issued in relation to the process date or financial run date. (optional). To not specify a date parameter the default issue date will be the date of cycle. M = Monday, T = Tuesday, W = Wednesday, H = Thursday, F= Friday.
This is the number of days an EFT can be issued from the process date or financial run date. (optional). To not specify a EFT date parameter will result in the the default issue date which is the date of cycle.
This is the FEIN for the Carrier.
This is the FEIN for the Carrier.
This is the FEIN for the Employer.
Month of Eligibility Record
The email address of the individual or group to be notified whern this report is ready.
An optional e-mail address.
The segment number of the employed family member documented on a SOBRA application.
This is the authorized ending date for the services.
End Date
This is the end date of the Nursing Home recipient.
This is the end date of the Profiler cycle.
Authorizion end date
End Date
End Date

For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.
For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.
For services received during a single encounter with a provider, the date the service covered by this claim was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service covered by this claim ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.
The last quarter in which this conversion should take place
The time the cycle ended.
The environment the report is produced in (mod, prod, etc.).
Description for Episode Type Code.
Describes whether or not the episode was for a 'full year' or 'incomplete'.
Describes whether or not the episode end was 'clean' or 'unknown'. A 'clean' finish is defined as a situation where the true ending date for an episode is known. An 'unknown' finish is defined as a situation where the true ending date for an episode is not known.
Unique episode number. Link to patient records through this field. The episode to which the record was grouped. All records in an episode will have the same episode number. Episode numbers are unique, and begin with the Last Episode Number given in the configuration file. This field can serve as a link between records in the claim file and records in the summary and confinement.
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Describes whether or not the episode start was 'clean' or 'unknown'. A 'clean' start is defined as a situation where the true beginning date for an episode is known. An 'unknown' start is defined as a situation where the true beginning date for an episode is not known.

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Number of Exceptions based on cost per Episode. This field is the count of providers where the absolute value of the total amount per episode subtracted from the amount paid per episode is greater than 2 * STDDEV(amount paid per episode).

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Unisys' claims processing error code
This is the ETG filler 1. This filler field is used for ETG claim file field positioning.
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The description of the ETG number.
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The ETG identifier assigned to the episode that further identifies a disease condition. Specific ETGs fall within MPCs. For example: ETG DESCRIPTION 1 AIDS 2 HIV sero-positive without AIDS 3 Major infectious disease except HIV, with comorbidity 4 Septicemia, w/o comorbidity 5 Major infectious disease except HIV and septicemia, w/o comorbidity 6 Minor infectious disease 7 Infectious disease signs & symptoms 20 Diseases of the thyroid gland, with surgery
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This is the ETG area that is reserved for future use.
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This is the ETG area that is reserved for future use.
More specific description of the ETG Number.
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More specific description of the ETG Number.
More specific description of the ETG Number.
More specific description of the ETG Number.
More specific description of the ETG Number.
A code indicating if the eligible has indicated an ethnicity of Hispanic or Latino.
This is the expected amount of the Patient First Provider compared to his peer group.
This is the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group which is based on peer group norms.
This is the amount the provider should have received based on the Adjusted Clinical Grouping (ACG) adjustment method for the particular claim group which is based on peer group norms.

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This is the expected amount of the Patient First Provider compared to his peer group.
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This is the expected amount of the Patient First Provider compared to his peer group.
This is the expected amount of the Patient First Provider compared to his peer group.
This is the expected amount of the Patient First Provider compared to his peer group.
This is the peer group's actual amount per recipient.
High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.

High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
High Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
Low Exception Value used to trigger an exception on Profiler Quarterly Exception Reports.
This is the Provider's expected ranking within their peer group.
External MMIS proprietary provider ID.
Additional information.
The sum of the facility (room & board) record charge amounts in the episode.
The sum of the facility (room & board) record charge amounts in the episode.
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The sum of the facility (room & board) record charge amounts in the episode.
The sum of the facility (room & board) record charge amounts in the episode.
The Facility charge.
The Facility charge.
The Facility charge.

The Facility charge.
The sum of the facility (room & board) record paid amounts in the episode.
The sum of the facility (room & board) record paid amounts in the episode.
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The sum of the facility (room & board) record paid amounts in the episode.
The sum of the facility (room & board) record paid amounts in the episode.
The Facility paid amount.
The Facility paid amount.
The Facility paid amount.
The Facility paid amount.
The code that FDB uses to indicate the severity level of the criteria. Valid values are 1, 2, 3 or space(not specified or not applicable).
Federal Employers Identification Number
The Federal Fiscal Year and Quarter value.
The Federal Fiscal Year and Quarter value.
The Federal Fiscal Year and Quarter value.
Indicates the Federal Fiscal Year and Quarter for the record.
The exact coulmn name of the system assigned key in the kernal table where it originates.
Filename is composed of:

media: is the media type (web, disk, tape, cdrom, ftp,TCP/IP)
sak_upload: is a 9-digit number that uniquely identifies this batch
TPID: is a 10-digit ID that identifies the submitting entity
txn is the transaction type (837P, 837I, 837D, 270, 276, NCPDP, etc. -- claims would only be the 837x and NCPDP types)
Name of the file.
Filename of the proprietary 835 file to be summarized and sent to EDI.
The number of bytes in the file.
Filler in the record layout.
Filler in the record layout.
Filler in the record layout.
Filler in the record layout.
Filler in the record layout.
The first date of service on the ETG claim.
The first date of service on the ETG claim.
The first date of service on the ETG claim.
The first date of service on the ETG claim.
First day of the month using the most current paid date from financial.
First day of the quarter using the most current paid date from financial.
Food stamp case number
This is the from age restraint for this drug.
This is the fund code for the prior authorization update transaction.
This contains the funding code for the service.
This is the line item number for the prior authorization.
This is the line item number within the prior authorization request.
This is the line item number for the service request.
The group number of the health insurance policy listed on the SOBRA application
This is the grouping/case type for the claims.
This is the grouping/case type for the claims.
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This is the grouping/case type for the claims.
This is the grouping/case type for the claims.
This is the grouping/case type for the claims.
This is the grouping/case type for the claims.
This is the group class. This field is not used in the profiler process.
This is the group class. This field is not used in the profiler process.
his is the group class. This field is not used in the profiler process.
This is the description of the grouping/case type.
This is the grouping description.
This is the grouping/case type description.
This is the group/case type description.
This is the group/case type description.
This is the group/case type description.
This is the group/case type description.
This is the group/case type description.
The payment rate for the provider's hospital group.
This is a one byte field containing a code which identifies the version of the Grouper engine which processed the record. This field is used by Symmetry for diagnostic purposes.
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This is a one byte field containing a code which identifies the version of the Grouper engine which processed the record. This field is used by Symmetry for diagnostic purposes.
Group sequence number.
Indicates user has marked the message as read
This is the procedure code authorized for service.
This is the service authorized by the request.
Type of HEDIS measurement.
Hierarchical Base Ingredient Code.
Hierarchical Base Ingredient Code Description
Hierarchical Base Ingredient Parent HIC3 Sequence Number
Hierarchical Base Ingredient Code Sequence Number
The eligible's Medicare Health Insurance Claim (HIC) Identification Number, if applicable.
This is the high variance.
History indicator for the claim detail.
History indicator for referenced claim detail or the survivor detail.
"Hours" portion of the time period within which the trading partner expectes to receive the interchange acknowledgement.
ICD9 procedure code
ICD9 through procedure code
The number of days of intermediate care for the mentally retarded should be included in this claim that were paid for, in whole or in part, by Medicaid.
ICN of the claim being reported as an adjustment claim. For original claims, this will be all 8s.
ICN of the claim being reported as an adjustment claim. For original claims, this will be all 8s.
ICN of the claim being reported as an adjustment claim. For original claims, this will be all 8s.
ICN of original claim. For original claims, this is the ICN of the claim being reported. For voided and adjusted claims, this is the ICN of the mother claim.
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ICN of original claim. For original claims, this is the ICN of the claim being reported. For voided and adjusted claims, this is the ICN of the mother claim.
This field stores the code identifying a party or other code.
Pay-to Plan Primary Code identifying a party or other code.
Code identifying a party or other code for Pay-to Plan Name.
Pay-to Plan Code identifying a party or other code.
Pay-to Plan Secondary Identifier.
Pay-to Plan Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier of Pay-to Plan Secondary Identification.
Pay-to Plan Tax Identification Number. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier of Pay-to Plan Tax Identification Number.
Pay-to Plan Tax Identification Number. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
This field stores the code identifying a party or other code.
This fields stores the Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference Identification. Reference Information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Contract version identifier, revision level of a particular format, program, technique or algorithm.
Repricing Organization Identifier, reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference information as defined for a particular Transaction Set or as specified of Care Plan Oversight.
Supervising Provider Identifier Code identifying a party or other code.
Supervising Provider Secondary Identifier reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.

Supervising Provider Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Supervising Provider Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference information as defined for a particular Transaction Set or as specified of other payer referral number.
Other Payer Supervising Provider Secondary Identifier. Reference Identification.
Other Payer other operating physician secondary identification.
Other Payer Supervising Provider Secondary Identifier. Reference Identification.
Other Payer other operating physician secondary identification.
Other Payer Supervising Provider Secondary Identifier. Reference Identification.
Other Payer other operating physician secondary identification.
Other Payer other operating physician secondary identification.
Other Payer Billing Provider Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Billing Provider Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Reference information as defined for a particular Transaction Set or as specified by the Reference of other payer billing provider secondary identification.
Other Payer Service Facility Location Secondary Identification. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Rendering Provider Secondary Identification code.
Other Payer Service Facility Location Secondary Identification. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Rendering Provider Secondary Identifier.
Other Payer Service Facility Location Secondary Identification. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Rendering Provider Secondary Identifier.
Other Payer Rendering Provider Secondary Identifier.
Other Payer Assistant Surgeon Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Assistant Surgeon Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.

Other Payer Assistant Surgeon Secondary Identifier. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Other Payer Billing Provider Secondary Identifier.
Other Payer Billing Provider Secondary Identifier.
Contract Version Identifier, revision level of a particular format, program, technique or algorithm.
Repricing organization identifier.
Product/Service ID, identifying number for a product or service.
Service Predetermination Identification code. Required when sending the Predetermination of Benefits Identification Number for the line item that has been previously predetermined and is now being submitted for payment.
Service Predetermination Identification code. Required when sending the Predetermination of Benefits Identification Number for the line item that has been previously predetermined and is now being submitted for payment.
Service Predetermination Identification code. Required when sending the Predetermination of Benefits Identification Number for the line item that has been previously predetermined and is now being submitted for payment.
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Service Predetermination Identification code. Required when sending the Predetermination of Benefits Identification Number for the line item that has been previously predetermined and is now being submitted for payment.
Other Operating Physician Identifier.
Supervising Provider Identifier.
Rendering Provider Identifier.
Laboratory or Facility Primary Identifier.
Referring Provider Identifier. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
Identifies the name of the team included in the table
Previous Administrative Reference Identification Number found in the HIPAA 278 Request and Response Guide in loop 2000E, segment REF, element REF02.
The Medicaid ID of the doctor responsible for admitting a patient.
The Medicaid ID of the doctor responsible for admitting a patient.
The National Provider ID (NPI) of the doctor responsible for admitting a patient.
The National Provider ID (NPI) of the doctor responsible for admitting a patient.
The ADPH Identifier for ALL Kids recipients.

The system assigned internal key for a unique recipient.
Identifies the Medicaid/CHIP programs waivers and demonstrations in which the provider participates
This groups aid categories into specific groups with similar characteristics.
This groups aid categories into specific groups with similar characteristics.
Analyst's ID.
Analyst's ID.
ID of analyst assigned to case.
Clerk id of newly created record
Name of clerk id who created the record
The name of the clerk which created the record
Name of Clerk id who created
Clerk id who created the record
Clerk id who created the record
Clerk id who created the record
Clerk id who created the record
This is the Clerk's id.
Clerk id who updates the table
Name of Clerk id who did the updating
Clerk id who updated the record
The name of the Clerk id who updated the record
Clerk id who updated the record
Clerk id who updated the record
Clerk id who updated the record
Clerk id who updated the record
Clerk id
Banking Institution ID number
Batch_ID from T_TRACK_EXCEPTION_HANDLE.
GUID value which ties all the exceptions and inner exceptions of the system.exception object.
Batch ID of T_TRACK_EXCEPTION_HANDLE table which links notification to the set of exceptions.
Identification number of a provider or capitation plan.
Identification number of a provider or capitation plan.
Identification number of a provider or capitation plan.
Identification number of a provider or capitation plan.
The National Provider ID (NPI) of the provider responsible for billing for the service on the claim.
The National Provider ID (NPI) of the provider responsible for billing for the service on the claim.
The National Provider ID (NPI) of the provider responsible for billing for the service on the claim.

The National Provider ID (NPI) of the provider responsible for billing for the service on the claim.
The identifying number of the telephone call.
The ID of the person placing the call.
HMS HIPP case identifier. This will be the unique identifier for a HIPP case in the PIER system.
Identifies the case worker assigned to the case.
The case worker number on the PS/2 transaction
Identifies the caseworker.
The case worker number on the PS/2 transaction
The Controlling Health Plan Identifier (CHPID).
A unique identifier per member to link episodes that were of the same underlying chronic condition. This identifier is for chronic ETG only; the value is blank for a non-chronic ETG. Values 001- 999 or blank.
A unique identifier per member to link episodes that were of the same underlying chronic condition. This identifier is for chronic ETG only; the value is blank for a non-chronic ETG. Values 001- 999 or blank.
A unique identifier per member to link episodes that were of the same underlying chronic condition. This identifier is for chronic ETG only; the value is blank for a non-chronic ETG. Values 001- 999 or blank.
A unique identifier per member to link episodes that were of the same underlying chronic condition. This identifier is for chronic ETG only; the value is blank for a non-chronic ETG. Values 001- 999 or blank.
Identification of clerk that generated adjustment request. The clerk who originates the adjustment request is responsible for the complete processing of the claim. In other words, if the adjustment suspends this clerk is responsible for working it.
Indicates a specific user of the system and can be used to identify who entered or last updated the Adjustment Request.
Identification of clerk that generated adjustment request. The clerk who originates the adjustment request is responsible for the complete processing of the claim. In other words, if the adjustment suspends this clerk is responsible for working it.
Identification of clerk that generated adjustment request. The clerk who originates the adjustment request is responsible for the complete processing of the claim. In other words, if the adjustment suspends this clerk is responsible for working it.
Identification of clerk that generated adjustment request. The clerk who originates the adjustment request is responsible for the complete processing of the claim. In other words, if the adjustment suspends, this clerk is responsible for working it.
Indicates the clerk who initiated the void check cash receipt that will cause the adjustment of all claims associated with the voided check.
Logon user id.

Logon user id.
Logon user id.
Logon user id.
Logon user id.
Logon user id.
Logon user id.
The clerk ID of the examiner assigned to the case.
The clerk ID of the examiner assigned to the case.
Clerk id
Number used to identify the user who last updated the error record.
This field indicates the user ID that performed the required action. Default value = space.
Clerk id
This field indicates the clerk ID who initiated the adjustment transaction.
The identification code of a user that is scheduled to process data corrections.
The ID of the clerk who will be assigned the claims selected by the criteria on this scheduling record.
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
User ID of person who is logged in.
User ID of person who is logged in.
User ID of person who is logged in.
Identifies the individual who is responsible for this labeler being inactive or active, CMS is a valid ID for this field since the CMS tape loads the labelers, it will be initialized with CMS.
Logon user id.
Clerk who entered the note
Logon user id.
Logon user id.
Logon user id.
The clerk that requested the letter.
User ID of person working in letter Generator when an event occurs.
Gives the MMIS generated ID of the person requesting the letter.
The id of the clerk that sent the note.
User ID of person who is logged in
User ID of person who is logged in.

User ID of person who is logged in.
User ID of person who is logged in.
Unique identifier for the person that entered the text.
This represents the clerk who enters initial Prior Authorization data upon receipt of a PA request. This person is different than the PA analyst that actually works the PA request.
The clerk that made the decision
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
The ID of the clerk who has been assigned to work this claim.
The unique identifier assigned to an individual clerk
The unique identifier of the individual
User ID of person who is logged in.
User ID of person who is logged in.
User ID of the person entering the status. This is system plugged and cannot be edited by the user.
The Unique identifier of the person creating the detail record
This is the clerk identification code of a system user who is assigned to the application.
This is the clerk identification code of a system user who is assigned to the application.
The analyst who added or last update the label criteria.
Clerk ID that added the request.
This field indicates the clerk ID who completed the verification process.
The ID of the clerk who entered the phone tracking request, automatically entered by the system.
User ID of person who is logged in.
Clerk ID who submitted request.
User who updated the rule.
Indicates a specific user of the system and can be used to identify who entered or last updated the SUR EOMB Request criteria.
Identification of clerk that generated adjustment request. The clerk who originates the adjustment request is responsible for the complete processing of the claim. In other words, if the adjustment suspends this clerk is responsible for working it.
The ID of the clerk assigned to work this claim through Data Corrections.
The ID of the clerk assigned to work this claim through Data Corrections.
The ID of the clerk assigned to work this claim through Data Corrections.
The ID of the clerk assigned to work this claim through Data Corrections.
Logon user id.
Logon user id.

Logon user id.
Logon user id.
Logon user id.
This is the Clerk id.
Logon user id.
Logon user id.
Clerk Id who receives Notification
This is the id of the clerk that entered the prior authorization.
Clerk Id who created the Notification.
The ID of the clerk that resolved the call.
This is the id of the clerk assigned to review the prior authorization.
The receiving clerk ID of a transferred question.
CMS ERROR ID from file.
Unique identification for an agreement between CMS and a Medicare Part D prescription drug coverage carrier.
Unique identifier for a ACA transaction.
Unique identifier for a ACA transaction.
The ID of the creating user or process.
The ID of the creating user or process.
The ID of the creating user or process.
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables
ID of the organization that populated the data into the TMSIS tables

ID of the organization that populated the data into the TMSIS tables
Criteria ID
Criteria ID
Criteria ID
Key for criteria.
The National Provider ID (NPI) of the provider responsible for dispensing the prescription drug.
The National Provider ID (NPI) of the provider responsible for dispensing the prescription drug.
District Office Worker.
Segment Reference Identification.
Provider Secondary Identifier.
Provider Secondary Identifier.
Other Payer Primary Identifier.
Other Payer Primary Identifier.
Other Payer Primary Identifier.
This is the electronic billing ID of the carrier contact.
This is the electronic billing identification for the carrier.
This is the electronic billing identification for the carrier.
A code used for physician group therapy services.
The tax ID of the employer
This is the unique identification number for each facility.
Unique identifier for the payload type.
Unique identifier for the payload type.
Unique identifier for the payload type.
Unique identifier for the payload type.
Unique identifier for the payload type.
Unique identifier for the payload type.
Unique identifier for the payload type.
The external identifier that this group is known by.
The Group ID
Identification number assigned by the state to the Health Home in which the individual is enrolled.
The National Provider ID (NPI) of the health home provider.
The National Provider ID (NPI) of the health home provider.
The National Provider ID (NPI) of the health home provider.
The National Provider ID (NPI) of the health home provider.
HIC1 parent sequence number.
Permanent numeric identifier of the Pharmacological Class for an active ingredient.

HIC2 parent Sequence number. (This will equal the ID_HIC2_SEQNO on T_HIC2)
Permanent numeric identifier of the Therapeutic Class for an active ingredient.
HIC3 parent sequence number. (This will equal the ID_HIC3_SEQNO on T_HIC3)
Permanent numeric identifier of the Hierarchical Base Ingredient Code.
This field contains the transaction number for the image. Initially, this will contain the ICN but may in the future contain PA or Consent Form tracking numbers.
Is the key to identifying immunizations that are to be performed for EPSDT eligible recipients.
The key that identifies the EPSDT immunizations.
The states internal identification number of the Third Party Liability (TPL) Insurance carrier.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
The states internal identification number of the Third Party Liability (TPL) Insurance carrier.
The ID number issued by the Insurance carrier providing insurance coverage to beneficiaries.
The ID number issued by the Insurance carrier providing insurance coverage to beneficiaries.
ISA06 or ISA08 value in X12 document, Id being used by trading partner as sender or receiver.
ISA05 or ISA07 value in X12 document, Qualifier being used by trading partner as sender or receiver.
This field specifies the id of the last clerk who last changed the form.
This field specifies the id of the last clerk who last changed the form.
Legacy Submitter ID.
The external identifier for this letter
Contains the IDs of various letters
Identification number of a provider furnishing locked-in healthcare services to an individual.

The ID_LOG_NUMBER is a unique identification number that the system assigns to a case when a new case is added. It consists of three components which are the subsystem type, the system date, and the sequence number . The leading position of the ID_LOG_NUMBER indicates the subsystem type (R=resident review; P= PASRR; T= Level I tracking; I = ICF/MR). The next eight positions identify the system date it was assigned in a "CCYYMMDD" format. The final three positions identify a sequential number that has a value between 001 and 999. (PASRR PRE-ADMISSION SCREEN, Case Information, Log Number); (RESIDENT REVIEW SCREEN, Case Information, Log Number); (ICF/MR SCREEN, Case Information, Log Number); LEVEL I TRACKING SCREEN: Log Number;
This field holds the user id.
This field holds the user id.
The National Provider ID of the long term care provider, if applicable
Identification number of the long term care facility furnishing healthcare services to the individual
Identifies a managed care entity s service location.
The managed care plan identification number under which the eligible individual is enrolled.
Unique identifier for the beneficiary, according to CMS.
Unique identifier for the beneficiary, according to CMS.
Unique identifier for the beneficiary, according to CMS.
Medicaid ID transmitted to CMS.
Unique identifier for the beneficiary, according to CMS.
Unique identifier for the beneficiary, according to CMS.
Unique identifier for the beneficiary, according to CMS.
Medicaid ID transmitted to CMS.
The Medicaid ID.
The unique number assigned to the recipient.
Unique identifier for the recipient.
Identification number assigned to a recipient of services.
Unique identifier for the recipient.
Identification number assigned to a recipient of services.
A unique identifier assigned to each Medicaid recipient.
The Medicaid ID of an AL recipient that received dental services within the service quarter.
A unique identifier assigned to each Medicaid recipient.
The unique number assigned to the recipient.
Unique identifier for the beneficiary.
Unique identifier for the beneficiary
Unique identifier for the beneficiary

Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the beneficiary.
Unique identifier for the beneficiary
Unique identifier for the beneficiary
Unique identifier for the recipient.
The recipients' unique identifier (primary id) at the end of the reporting period.
The recipients' unique identifier (primary id) at the end of the reporting period.
Contains the recipients primary identifier at the end of the reporting period.
Contains the recipients primary identifier at the end of the reporting period.
Medicaid ID.
The Medicaid ID of the recipient who has selected a PMP.
Unique identificiation number for the recipient.
Unique identificiation number for the eligible recipient.
Unique identificiation number for the recipient.
Unique identificiation number for the recipient.
Unique identificiation number for the recipient.
Unique identificiation number for the recipient.
Unique identificiation number for the recipient.
Unique identificiation number for the recipient.
The key to uniquely identify a recipient.
Unique identifier for the Beneficiary
Medicaid identification number
Identification number assigned to a recipient of services.

The Medicaid ID number. (PASRR PRE-ADMISSION SCREEN, Case Information, Case Number) ; (RESIDENT REVIEW SCREEN, Case Information, Case Number); (ICF/MR SCREEN, Case Information, Case Number); (LEVEL I TRACKING SCREEN, Case Information, Case Number);
The Medicaid ID of the recipient.
This number uniquely identifies a recipient.
Unique identifier for the recipient.
Unique identifier for the beneficiary.
The recipient's Medicaid ID to be put on the report.
This field identifies the recipient ID number.
Indicates the recipient that a IDcard request is for.
Medicaid ID
The recipient id on the PS/2 transaction.
Identifies recipient id on PS/2 transaction.
The identification number for a Medicaid recipient.
The recipient Medicaid number.
The recipient id on the PS/2 transaction.
Identifies recipient id on PS/2 transaction.
The unique number assigned to the recipient
Identification number assigned to a recipient of services.
Current Medicaid ID.
Unique identifier for the recipients Head of Household.
The unique number assigned to the new recipient.
Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_NEW.
The unique number assigned to the original recipient.
Identification number assigned to recipient of services. This is the number associated with the SAK_RECIP_OLD.
Original Medicaid ID.
Recipient id on the PS/2 transaction
Current Medicare ID for the beneficiary.
Recipient Medicare number
Current Medicare ID for the beneficiary, according to CMS.
Current Medicare ID for the beneficiary, according to CMS.
Current Medicare ID for the beneficiary.
Current Medicare ID for the beneficiary.
Recipient Medicare number
Current Medicare ID for the beneficiary, according to CMS.
Current Medicare ID for the beneficiary, according to CMS.
Current Medicare ID for the beneficiary.
The recipient's current or previous Medicare ID (HIB).
The recipient's current Medicare ID number. (HIC/RRB number).
The recipient's current or previous Medicare ID (HIB).

The individuals Medicare Beneficiary Identifier (MBI) Identification Number.
The individuals Medicare Beneficiary Identifier (MBI) Identification Number.
The individuals Medicare Beneficiary Identifier (MBI) Identification Number.
The individuals Medicare Beneficiary Identifier (MBI) Identification Number.
The individuals Medicare Beneficiary Identifier (MBI) Identification Number.
Health Insurance Claim (HIC) Number as it appears on the patients Medicare card.
Health Insurance Claim (HIC) Number as it appears on the patients Medicare card.
Health Insurance Claim (HIC) Number as it appears on the patients Medicare card.
Health Insurance Claim (HIC) Number as it appears on the patients Medicare card.
Health Insurance Claim (HIC) Number as it appears on the patients Medicare card.
New medicare claim number sent from CMS
New Medicare ID for the beneficiary, according to CMS. Could be spaces.
New medicare claim number sent from CMS
New Medicare ID for the beneficiary, according to CMS. Could be spaces.
NCPDP field 359-2A, Patient's ID assigned by the Medigap Insurer.
ID entered by the Provider which consists of Medicaid ID and Check Digit.
ID entered by the Provider which consists of Medicaid ID and Check Digit.
The Medicaid ID for a recipient at a particular point in time. This is a Medicaid ID that was used in the old OK system before the 2003 implementation.
Member identification number as it appears on the card issued by the TPL insurance carrier.
Unique identifier for ACA output batch file.
Unique identifier for ACA output batch file.
Unique identifier for ACA output batch file.
Unique identifier for ACA output batch file.
The national health plan identifier or other entity identifier assigned to a managed care entity.
The national health plan identifier or other entity identifier assigned to a managed care entity.
The national health plan identifier or other entity identifier assigned to a managed care entity.
The national health plan identifier or other entity identifier assigned to a managed care entity.

The national health plan identifier or other entity identifier assigned to a managed care entity.
The national health plan identifier or other entity identifier assigned to a managed care entity.
The national health plan identifier or other entity identifier assigned to a managed care entity.
ID to be used for display purposes depending on the implementation of legislation concerning the use of SSNs for Medicaid IDs in the State of Alabama.
The NPI Number associated with the Provider License Number.
The License Holder's NPI.
National Provider Identifier
Identification number of the health plan under which the non-fee-for-service encounter was provided
Identification number of the health plan under which the non-fee-for-service encounter was provided
A unique number representing the health plan under which the non-FFS encounter was provided.
A unique number representing the health plan under which the non-FFS encounter was provided.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
Contains the ID number the state issued to the managed care entity.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
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A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
The states internal identification number of the Third Party Liability (TPL) Insurance carrier.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual.
The National Provider ID (NPI) of the provider who performed the surgical procedures

Original ISA08 value from EDI document before TPM actions.
Original ISA07 value from EDI document before TPM actions.
Original ISA06 value from EDI document before TPM actions.
Original ISA05 value from EDI document before TPM actions.
Other identifier provider may enter for EFT/ERA enrollments. Usually the MCD ID.
Other identifier provider may enter for EFT/ERA enrollments. Usually the MCD ID.
The other payer party identifier.
It captures the other payer party identifier which help to identify the provider associated with the Mcare paid amounts.
The other payer party identifier.
The ID of the currently-owned property per the tax assessor's office
Parent ID
Parent ID
Parent ID
Identifies the level of the criteria.
The identifier number associated with the payee. (e.g. if the payee is a provider then the ID_PAYEE is an AL Medicaid Provider ID).
Payer Identifier
Unique identifier for the payload (usually assigned by Sender ID)
Unique identifier for the payload (usually assigned by Sender ID)
Unique identifier for the payload (usually assigned by Sender ID)
Unique identifier for the payload (usually assigned by Sender ID)
Contains the ID of the person to requested the letter.
The identifier of the person or organization you want the letter to go to.
Rendering provider identifier.
Identifies an individual who rendered a service to a recipient.
Identifies an individual who rendered a service to a recipient.
Identifies the periods that are used on the EPSDT Screening and Immunization schedules.
Identifies the periods that are used on the EPSDT Screening and Immunization schedules.
Identifies the periods that are used on the EPSDT Screening and Immunization schedules.
Unique identification for a Medicare Part D prescription drug coverage plan.
Permanent Operation Provider (POP) identification number used to track nursing home population.

Identification number assigned to the provider who prescribed the drug device or supply.
The National Provider ID (NPI) of the provider who prescribed a medication to a patient
Process ID that had an exception.
Unisys' provider ID
Unisys' provider ID
Unisys's provider ID
This is the unique number assigned to a provider for billing Medicaid services.
This is the unique number assigned to a provider for billing Medicaid services.
The ID of the provider.
Identification number assigned to a group or individual that provides medical services to recipients.
This is the unique number assigned to a provider for billing Medicaid services.
The Provider ID value.
Provider's ID.
Identification number assigned to a group or individual who provides services to a recipient.
Provider ID.
The Medicaid provider identification number of the billing provider.
Provider identification number
Provider identification number.
Identification number assigned to a group or individual that provides medical services to recipients.
Provider ID value.
Provider ID value.
The provider identification number used by the provider.
Provider ID.
Identifies the provider of services.
The provider Medicaid number.
Provider ID in the interChange system.
Identification number assigned to a group or individual who provides services to a recipient.
From value for PMP Label Request Provider ID Range.
The Medicaid ID of the provider at the service location.
This the unique identifier Provider Medicaid ID.
The NPI ID of the performing provider on the claim.
The NPI of an AL provider meeting all of the enrollment criteria to be consider an enrolled provider for the Dental Profiler.
The NPI of an AL provider that provided dental services to a recipient within the service quarter.

The NPI of an AL provider that provided dental services to a recipient within the service quarter.
The NPI of an AL provider that provided dental services to a recipient within the service quarter.
The NPI ID of the provider at the service location. Only healthcare providers are assigned NPI IDs
To value for PMP Label Request Provider ID Range.
Attending Provider ID.
The number of the licensed physician who would be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
The number of the licensed physician who would be expected to certify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
Identification number for the enrolled provider.
National Provider Identifier (NPI) associated with the billing provider.
National Provider Identifier (NPI) associated with the billing provider.
This is the default ID on file for the provider location record.
A unique identifier for the provider. The specific type is shown in the IDENTIFIER-TYPE data element
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations.
A field to differentiate a providers physical locations
National Provider Identifier (NPI) associated with the maternity district provider.

National Provider Identifier (NPI) associated with the maternity district provider.
This is the Medicaid ID for the provider location record.
Medicaid assigned provider ID for group.
This is the NPI id associated with the provider location record.
National Provider Identifier (NPI).
National Provider Identifier (NPI).
National Provider Identifier Number assigned to group.
National Provider Identifier (NPI).
Provider NPI ID value.
NPI to which EFT account is linked.
NPI to which ERAs are aggregated.
NPI ID related to change of ownership.
Original NPI ID given to the very first mother NPI ID in the ownership change chain.
NPI after change of ownership.
NPI prior to change of ownership.
Ordering provider ID.
License number of the physician who performed the principal procedure.
This is an alternative ID for the provider location record. This is to be used as needed within the batch cycle.
License number of the physician who performed the principal procedure.
License number of the physician who performed the principal procedure.
License number of the physician who performed the principal procedure.
License number of the physician who performed the procedure.
License number of the second physician who performed the principal procedure.
License number of the second physician who performed the principal procedure.
License number of the second physician who performed the principal procedure.
License number of the second physician who performed the principal procedure.
License number of the second physician who performed the procedure.
The identifier for the performing provider.
The National Provider Identifier (NPI) of the performing provider.
The National Provider Identifier (NPI) of the performing provider.
The National Provider Identifier assigned to this pharmacy.
National Provider Identification # assigned to the collaborating physician.

National Provider Identification # assigned to the collaborating physician.
Provider ID of the current recipient's PMP from the dates of service.
License number of the provider who requested drug be administered to a recipient. This does not have to be an enrolled provider.
Provider who prescribed a drug to be administered to a recipient. This does not have to be an enrolled provider.
License number of the provider who prescribed the drugs be administered to the recipient. This does not have to be an enrolled provider.
License number of the provider who prescribed the drugs be administered to the recipient. This does not have to be an enrolled provider.
License number of the provider who prescribed the drugs be administered to the recipient. This does not have to be an enrolled provider.
Holds the NPI number associated with the prescriber's state license number.
Holds the NPI number associated with the prescriber's state license number.
Holds the NPI number associated with the prescriber's state license number.
This is the ID of the provider that will be used throughout the financial cycle for use on reports internally.
RCO submitting provider NPI
RCO submitting provider NPI
Provider/Client ID.
Provider/Client ID.
Number identifying a provider or a case manager who refers recipient to another provider for services.
Number identifying a provider or a case manager who refers recipient to another provider for services.
Number identifying a provider or a case manager who refers recipient to another provider for services.
Number identifying a provider or a case manager who refers recipient to another provider for services.
Number identifying a provider or a case manager who refers recipient to another provider for services.
Number identifying a provider or a case manager who refers recipient to another provider for services.
For RA reporting only. For reporting only of possible rendering providers.
For RA reporting only. For reporting only of possible rendering providers.
Medicaid ID of the provider rendering the service.
Identification number assigned to the facility provider.
The external identifier that a user will refer to this query by.

Receipt Number provided by the IRS for successfully transmitted file.
Receipt Number provided by the IRS for successfully transmitted file.
Client's ID.
Unisys's recipient ID
Recipient Base ID.
Recipient Current ID.
ISA08 value from EDI document.
ISA07 value from EDI document.
Identification number of the provider who referred the client for service.
Identification number of the provider who referred the client for service.
Identification number of the provider who referred the client for service.
The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient
The National Provider ID (NPI) of the provider who recommended the servicing provider to the patient
The National Provider ID (NPI) of the provider who recommended the servicing provider.
Reference Identification found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF02.
Reference Identification- Other UMO Denial Reason found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-2.
Reference Identification- Other UMO Denial Reason found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-4.
Reference Identification- Other UMO Denial Reason found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-6.
This is the report requested.
Unique identifier for a request submitted to the EDI system.
Unique identifier for a request submitted to the EDI system.
Unique identifier for a request submitted to the EDI system.
Unique identifier for a request submitted to the EDI system.
Unique identifier for a request submitted to the EDI system.
Unique identifier for a request submitted to the EDI system.
Unique identifier for an EDI response.
Unique identifier for an EDI response.
Identifies the individual who entered dispute data by capturing the logon ID.

The id of the reviewer that the note was sent to.
Identifies the individual who made prior review determination for the recipient's level of care. Will always contain spaces in OK system.
SSN or FEIN
SSN or FEIN
Sanctioned Provider's UPIN
Sanctioned Provider's UPIN
A code used for physician group therapy services.
The key that identifies the EPSDT screenings.
Is the key to identifying screenings that are to be performed for EPSDT eligible recipients.
Is the key to identifying screenings that are to be performed for EPSDT eligible recipients.
NCPDP SCRIPT Quantity Qualifier Identifier
NCPDP SCRIPT Quantity Qualifier Identifier
Interchange ID Sender
Unique identifier for the trading partner.
Unique identifier for the trading partner.
Unique identifier for the trading partner.
Unique identifier for the trading partner.
This is the sender ID of the State.
This is the sender id that identifies the State program on the 835.
The Subhealth Plan Identifier (SHPID).
ISA06 value from EDI document.
ISA05 value from EDI document.
SOBRA Worker.
Identifies the clerk that asked for the replacement card or the system process that identified a card should be created.
Identifies the clerk that asked for the replacement card or the system process that identified a card should be created.
Indicates the clerk ID
The client's Social Security number. (PASRR PRE-ADMISSION SCREEN, Case Information, SSN); (RESIDENT REVIEW SCREEN, Case Information,SSN); (ICF/MR SCREEN, Case Information, SSN); (LEVEL I TRACKING SCREEN, Case Information, SSN;
The submitter ID.
Identifies the submitter of the claim.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.

Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
Identifies the provider/trading partner/clearing house to the states claim adjudication system.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The state-assigned unique identifier for the provider entity.
The unique state-assigned identification number for the group the individual is associated with.
Supervisor's ID.
A unique number to identify the provider who treated the recipient.
A unique number to identify the provider who treated the recipient.
A unique number to identify the provider who treated the recipient.
The National Provider ID (NPI) of the rendering/attending provider responsible for the beneficiary.
The National Provider ID (NPI) of the rendering/attending provider responsible for the beneficiary.
The National Provider ID (NPI) of the rendering/attending provider responsible for the beneficiary.
This field holds the tab id.
Identifier used to distinguish one team from another

Name of the column within the table.
Name of the column within the table.
T-MSIS RECORD-ID containing the element in the error
Name of the column within the table
Identification code of the record that failed an edit
A token value associated with the desired enrollment application that must be provided to re-access it.
Submitter ID for Trading Partner.[F.R to T_TRADING_PARTNER.CUSTNO]
Trading Partner ID that will be used to group 835s by the State Agency that will receive them.
Internal application identifier for the trading partner.
Internal application identifier for the trading partner.
Trading Partner ID found as CUSTNO on table TP within EDI.
InterChange Trading Partner ID.
The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.
The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.
The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor.
Trading partner ID of the entity sending the Subrogation Response and 835 TPL.
Trading Partner ID.
The provider?s submitter ID assigned by the health plan or the provider's clearinghouse or vendor.
The provider?s submitter ID assigned by the health plan or the provider's clearinghouse or vendor.
This is a GUID generated to tie two File Tracking ecords. This identifier should be same for request response tracking records.
Unique identifier for transaction type.
Unique identifier for transaction type.
Unique identifier for transaction type.
The National Provider ID (NPI) of the provider who directed the care of a patient.
The National Provider ID (NPI) of the provider who directed the care of a patient.
The National Provider ID (NPI) of the provider who directed the care of a patient.
The National Provider ID (NPI) of the provider who supervised another provider.
The National Provider ID (NPI) of the provider who supervised another provider.

The National Provider ID (NPI) of the provider who supervised another provider.
The ID of the last update user or process.
The ID of the last update user or process.
The ID of the last update user or process.
The clerk number of the user who entered the comment.
The clerk number of the user who entered the comment.
The clerk number of the user who entered the comment.
The clerk number of the user who entered the comment.
The clerk number of the user who entered the comment.
This is the user ID that entered the comment.
The Unique Identifier which must be assigned to each file transmission to the IRS.
The Unique Identifier which must be assigned to each file transmission to the IRS.
Field specifying the T-MSIS waiver or demonstration which authorized payment for a claim. These IDs must be the approved, full federal waiver ID number assigned during the state submission and CMS approval process. The categories of demonstration and waiver programs include: 1915(b)(1); 1915(b)(2); 1915(b)(3), and 1915(b)(4) managed care waivers; 1915(c) home and community based services waivers; combined 1915(b) and 1915(c) managed home and community based services waivers and 1115 demonstrations.
Specifies the waiver or demonstration which authorized payment for a claim.
Specifies the waiver or demonstration which authorized payment for a claim.
Specifies the waiver or demonstration which authorized payment for a claim.
Specifies the waiver or demonstration which authorized payment for a claim.
Specifies the waiver or demonstration which authorized payment for a claim.
Specifies the waiver or demonstration which authorized payment for a claim.
This is a unique identifier for the waiver used by internal programs to produce the CMS 372 reports. These values will vary with each State waiver.
This is a unique identifier for the waiver used by internal programs to produce the CMS 372 reports. These values will vary with each State waiver.
A code identifying the waiver program.
ID_XREF_SRC
Family member source of income
Indicates whether the check that was returned was issued from the MMIS financial system.

Indicates if we will require a provider number to be entered on the cash receipt before allowing a disposition with this reason code.
Indicates when a transaction is written to general ledger. After it has been written, no updates will be allowed to the disposition.
This indicator is used to determine if the classification is exempt from the drug rebate program. The valid values are 'N'=non-exempt, 'E'=exempt.
A one byte indicator to identify if the corresponding labeler is participating in Drug Rebate for the date rand (Y) or not participating (N).
Indicator of adjustment type
Indicator of adjustment type
Indicator of adjustment type
Indicates whether provider number should be used as part of duplicate check (Y/N).
Indicates when a transaction is written to general ledger. After it has been written, no updates will be allowed to the disposition.
Depicts whether the MEDPOL record is a claim, reversal, or adjustment.
Depicts whether the MEDPOL record is a claim, reversal, or adjustment.
Depicts whether the MEDPOL record is a claim, reversal, or adjustment.
Depicts whether the MEDPOL record is a claim, reversal, or adjustment.
Indicates if the pricing indicator value is applicable for HCPC procedures. A value of "Y" signifies the indicator is valid for HCPC procedures and "N" says it is not.
Indicates the type of periodicity schedule. Valid values are: 1 - normal schedule 2 - accelerated schedule ages 2 to 6 3 - accelerated schedule ages 7 to 18 4 - accelerated schedule ages 18 and over
Indicates the type of periodicity schedule. Valid values are: 1 - normal schedule 2 - accelerated schedule ages 2 to 6 3 - accelerated schedule ages 7 to 18 4 - accelerated schedule ages 18 and over 5 - normal notification of scheduled screenings
Indicates the type of periodicity schedule. Valid values are: 1 - normal schedule 2 - accelerated schedule ages 2 to 6 3 - accelerated schedule ages 7 to 18 4 - accelerated schedule ages 18 and over
Indicates the type of periodicity schedule. Valid values are: 1 - normal schedule 2 - accelerated schedule ages 2 to 6 3 - accelerated schedule ages 7 to 18 4 - accelerated schedule ages 18 and over
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Indicates the type of periodicity schedule. Valid values are: 1 - normal schedule 2 - accelerated schedule ages 2 to 6 3 - accelerated schedule ages 7 to 18 4 - accelerated schedule ages 18 and over
Field to indicate whether a letter has been written for the return to sender cash receipt.
Indicates if the reason code chosen requires comments to be keyed.
Identifies whether the parm entry is active or not.
Indicates whether this carrier is never billed or is billed in an exceptional manner.
Indicates whether a payee should have 1099 processing in financial. (Valid values: Y or N)
Indicates to T-MSIS that the individual participates in an 1115(A) demonstration. 1115(A) is a Center for Medicare and Medicaid Innovation (CMMI) demonstration. 0 = Not an 1115(A) participant; 1 = 1115(A) participant
Indicates that the individual participates in an 1115(A) demonstration.
Indicates that the individual participates in an 1115(A) demonstration.
Indicates that the individual participates in an 1115(A) demonstration.
Indicates that the individual participates in an 1115(A) demonstration.
Indicates that the individual participates in an 1115(A) demonstration.
EPSDT Referral Certification Condition Indicator. Code indicating a Yes or No condition or response.
Indicator which tells whether a 277-CA (batch response file) has been produced for the batch. A value of "N" will indicate that the 277-CA has not been produced for this batch, and a value of "Y" will indicate that the 277-CA has been produced.
This field indicates whether the claim is for a therapeutic abortion. Valid values are Y (Yes) and N (No).
Indicates if the procedure performed was an abortion.
Ratio indicator to specify if the percentage variance is for 'Billed to Allowed' ratio or 'Allowed to Billed' ratio. Valid values are A - Allowed to Billed rate ratio and B - Billed to Allowed rate.
Identifies if the provider is associated with a teaching facility.
Identifies if the provider is associated with a teaching facility.
Indicates whether the service performed was as a result of an accident.
Indicates whether the service performed was as a result of an accident.
Indicates if prior autorization request is the result of member involvment in an accident. Valid values are "Y" or "N".
Indicates whether the service performed was as a result of an accident.

Indicates whether the service performed was as a result of an accident.
Indicates whether the service performed was as a result of an accident.
Indicates whether the service performed was as a result of an accident.
An indicator to identify providers who are accepting new patients
This one byte indicator identifies the type of the bank account that a payee is using for Electronic Funds Transfers. The valid values are 'C'hecking, 'S'avings, 'T'ransfer (State Transfer).
This one byte indicator identifies the type of the bank account that a provider is using for Electronic Funds Transfers. The valid values are 'C'hecking, 'S'avings, 'T'ransfer (State Transfer).
The type of bank account. The valid values are: C - Checking and S - Savings.
The type of bank account. The valid values are: C - Checking and S - Savings.
Account type indicator after change.
Account type indicator before change.
Accident settlement indicator.
Indicator (Y/N) on whether a entity/process should be performed based on another entity/process.
Used to determine whether a program will process or not.
Is there further action required by the SUR's Unit? - (Y/N)
The activation indicator is used to indicate what status and program coverage the drug will have. It is also used in claims editing. This attribute is determined by FDB and is part of the FDB Drug update process.
The activation indicator is used to indicate what status and program coverage the drug will have. It is also used in claims editing. This attribute is determined by FDB and is part of the FDB Drug update process.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Indicates the status of the criteria record where Y=Active, N=Inactive.
This is a (Y/N) indicator that determines whether an error is active or not.
A (Y/N) flag indicating if the buy-in eligiblity code is used by this State's buy-in system.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Is the analyst an active member of the SURS unit? - (Y/N)
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that an item is in. Y=active N=inactive
Indicates the status of the criteria record where Y=Active, N=Inactive.

This field represents the activity state that the criteria is in. Y=active N=inactive
This field represents the activity state that an item is in. Y=active N=inactive.
This field represents the activity state that the inverse code is in. Y=active N=inactive
This field represents the activity state that an item is in. Y=active N=inactive.
This field represents the activity state that the criteria is in. Y=active N=inactive
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that an item is in. Y=active N=inactive
This field represents the activity state that an item is in. Y=active N=inactive.
This field represents the activity state that an item is in. Y=active N=inactive
This field represents the activity state that the criteria is in. Y=active N=inactive
This field represents the activity state that an item is in. Y=active N=inactive
Indicator that determines whether or not the NDC should be invoiced.
Indicates whether the EVS txn was accepted or rejected. A value of 'A' means the txn was accepted. A value of 'R' means the txn was rejected and a reject code will indicate what it rejected for.
This field determines whether or not the Fund Code is still active. Valid values are 'N' for No, and 'Y' for Yes.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that the criteria is in. Y=active N=inactive.
This field represents the activity state that an item is in. Y=active N=inactive
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that an item is in. Y=active N=inactive
Indicates this template is in use or retired. If retired it is no longer visible to users. Values are Y/N.
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that an item is in. Y = active, N = Inactive.
This field represents the activity state that an item is in. Y=active N=inactive

This represents if the labeler is active or inactive. Valid values are Y = Active; N= Inactive.
Indicates whether the record is active or not. Only active rows are used in determining the Medicare deductible.
The activity state of the age grouping. The valid values are 'Y', the age grouping is active; 'N', the age grouping is not active.
An indicator used to specify if the co-payment category is active. Valid values for this indicator are A - active; I - inactive.
The activity state of the throughput grouping. The valid values are 'Y', the grouping is active; 'N', the grouping is not active.
This field represents the activity state that an item is in. Y=active N=inactive
Indicator to identify the criteria if its active or not. Value 'Y' indicates criteria is active and 'N' indicates criteria is no longer active.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Indicates the status of the criteria record where Y=Active, N=Inactive.
Indicates the status of the risk row where value values are: Y=Active, N=Inactive.
Indicates whether or not the worker is active. Y=Yes, N=No
Indicates if the recipient Medicaid ID is active or purged because of a link. When two Medicaid IDs are linked one of them is no longer valid and will have an IND ACTIVE of 'N'. All others are active and will have a 'Y' or a 'P' (RID has changed).
Indicates if the recipient Medicaid ID is active or inactive because of a link. When two Medicaid IDs are linked one of them is no longer valid and will have an IND ACTIVE of 'N'. All others are active and will have a 'Y', which means active.
Indicates if the beneficiary Medicaid ID is active or purged because of a link. When two Medicaid IDs are linked one of them is no longer valid and will have an IND ACTIVE of 'N'. All others are active and will have a 'Y' or a 'P' (BID has changed).
This field represents the activity state that an item is in. Y=active N=inactive
Indicates the status of the criteria record where Y=Active, N=Inactive.
This field represents the activity state that an item is in. Y=active N=inactive
Indicator for an acute chronic problem
This indicates if the non-medicaid provider is the requesting provider, indicated by 'R', or the service provider, indicated by 'S'. Both an 'R' and an 'S' can be on a single PA.

A one-character code that identifies the address type. If the record is from the trigger that populated address from Address Doctor software, then this field will carry value 'C'. If the record is from the NCOA software, then the value is 'N'.
Indicates the type of location. The valid values are: S - Service, P - PayTo, M - MailTo.
A one character code that identifies the type of address.
Indicator stating which address type to pull the address, fax number, or email address from when sending the provider a bulletin. Valid values "M"ail To, "P"ay To, "S"ervice Location, and "H"ome Office
A one-character code that identifies the address type. If the record is from the trigger that populated address from Address Doctor software, then this field will carry value 'C'. If the record is from the NCOA software, then the value is 'N'.
A one-character field that corresponds to whether an address is valid or invalid. Possible valid values are: Y - Valid, N - Invalid, M - NCOA.
A one-character field that corresponds to whether an address is valid or invalid. Possible valid values are: Y - Valid, N - Invalid, M - NCOA.
Indicates whether the row is for an original claim (value of 'O') or a reversal claim (value of 'R').
Indicates whether the row is for an original claim (value of 'O') or a reversal claim (value of 'R').
Indicates whether the row is for an original claim (value of 'O') or a reversal claim (value of 'R').
Displays if a claim has been adjusted or reversed.
Indicates if this detail should be adjusted: Y - yes; N or blank - Header action determines.
Indicates if this detail should be adjusted: Y - yes; N or blank - Header action determines.
Has an adjustment been created for this ICN? - (Y/N)
Code indicating type of adjustment record.
Code indicating type of adjustment record.
Code indicating the type of adjustment record.
Code indicating the type of adjustment record.
A code indicating that the location is outside of state boundaries.
Indicates whether the client is in the ADvantage program. (PASRR PRE-ADMISSION SCREEN, Case Information, ADvantage); (RESIDENT REVIEW SCREEN, Case Information, ADvantage); (LEVEL I TRACKING SCREEN, Case Information, ADvantage);
Indicator to reflect when a state user has manually updated the ID_CASE_PIER and/or IND_HIPP fields. The values will be Y for Yes if the update has been made by the state user. Otherwise, the field will be blank.

Indicates the application needs to be sent to the Agency for review purposes. Valued values: D = Denied, Y = Yes or Blank = No.
This is the Alabama generic indicator. (Values are 0 = Generic; 1 = non generic)
This is the ALGI indicator. (Values are 0 = Generic; 1 = non generic)
An indicator to drive EFT processing. If the indicator is set to 'N', we will not check the provider to see if they are setup for EFT payments. If the indicator is set on 'Y', we will check the provider to see if they are setup for EFT payments.
This site will allow additional family members to be enrolled if the indicator is Yes. If the quota is reached, no one else may be enrolled if the indicator is No.
This is a Yes/No indicator telling whether all RA's will be getting the message or if there is criteria that must be reviewed for this message. Y = All RA's will get the message. N = use the criteria tables.
Will be 'X' if recipient had coverage for the entire tax year. If recipient did not have coverage all months, this will be space.
Will be 'X' if recipient had coverage for the entire tax year. If recipient did not have coverage all months, this will be space.
Valid values are Y and N. If the value is a Y, the Recipient has asked the Agency not to publish their address due to personal safety concerns. The recipient will not be allowed to register on the Web Portal and possibly expose their address.
Valid values are Y and N. If the value is a Y, the Recipient has asked the Agency not to publish their address due to personal safety concerns. The recipient will not be allowed to register on the Web Portal and possibly expose their address.
Indicates whether the alternate drug is generic according to State defined criteria. Valid values are: 0 - Non-drug item, 1 - Generic Product, 2 - Brand Product.
Whether the alternate requires prior authorization. Valid values are: Y = yes, N = no, SPACE = does not participate.
Whether the alternate is in the PDL. Valid values are: Y = yes, N = no, SPACE = does not participate.
Indicates if there is an alternate phone number.
Indicates (Y/N) whether a claim correction form can be generated for the specific error code. Not used in Oklahoma.
Indicates (Y/N) whether the claim should be allowed to deny upon review of the claim.
Indicates (Y/N) whether a clerk should be allowed to override an edit/audit upon review of the claim.
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product.
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product

Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item, 1 - Generic Product, 2 - Brand Product.
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item, 1 - Generic Product, 2 - Brand Product.
Indicates whether the drug is generic according to State defined criteria. 0 - Non-drug item 1 - Generic Product 2 - Brand Product.
The answer returned by the rule engine. U - Unknown or cannot answer T - True F - False
The decision returned by the rule engine. U - Unknown or cannot answer T - True F - False
The ANDA Status Indicator is a one-character numeric column that indicates an NDC that was approved under an Abbrieviated New Drug Application (ANDA). FDA application numbers outside the NDA number range, including numbers greater than 39,999 and less than 50,000, and application numbers greater than 59,999 and less than 90,000 are interpreted as Abbreviated New Drug Applications (ANDA). Valid values are: 0 - Not approved under an ANDA. 1 - Approved under an ANDA.
Indicates whether the recipient on the claim has coverage under another company's insurance plan.
Indicates whether the recipient on the claim has coverage under another company's insurance plan.
Indicates whether the recipient on the claim has coverage under another company's insurance plan.
Value selected of Yes/ No option in the answer.
Indicates the appeal result status. Values are Y, N or 9 for n/a.
Data dictionary says not used.
This fields is the approval indicator that is used within the claims engine process. Valid values are "Y" or "N".
This fields is the approval indicator that is used within the claims engine process. Valid values are "Y" or "N".
Will be 'X' if recipient had coverage for April of the tax year. Will be space if the recipient had full year or if no coverage was present for April.
Will be 'X' if recipient had coverage for April of the tax year. Will be space if the recipient had full year or if no coverage was present for April.
Indicates if the family member's absent parent applied for medical support

Used on the reason code to indicate the type of transaction that produced the expenditure/non-claim payout. This field determines if any additional processing must occur. Valid values are A - Account Receivable, E - Expenditure, and C - Cash Receipt.
Indicates whether the payee should have ARs processed in financial. (Valid values: Y or N)
Indicates that this template can be stored in a secondary location.. Values are Y/N.
Indicator which is used to identify whether a claim is submitted with or without some type of supporting documentation.
Indicates whether documentation is required for the diagnosis.
Indicator which is used to identify whether a claim is submitted with or without some type of supporting documentation.
Indicates if a special report is necessary for claims processing.
Indicates whether attachments are required for the procedure.
Indicator which is used to identify whether a claim is submitted with or without some type of supporting documentation.
Indicates if the attachment has been received.
Indicate if the provider has been selected for auditing purposes. Values: Y - Selected N - Not selected
Audit Indicator, contains Y if matching claims found.
Will be 'X' if recipient had coverage for August of the tax year. Will be space if the recipient had full year or if no coverage was present for August.
Will be 'X' if recipient had coverage for August of the tax year. Will be space if the recipient had full year or if no coverage was present for August.
Authorized representative indicator
This column specifies that the provider is not accepting new RCBMs through Default Autoassignment logic. If the value is set to 'N', then any/all values for T_MC_PMP_PANEL_RESTRICT.IND_DEFAULT_AA are IGNORED. If the value is set to 'Y', then the values in T_MC_PMP_PANEL_RESTRICT.IND_DEFAULT_AA are utilized.
Obsolete
An indicator that determines whether the letter template has been validated and whether it is ready for production use.
Yes or No indicator whether or not the batch generator will pick the template and run it
As of implementation for OK, only the EPSDT and Family Planning cap categories will have an 'N' for this field, all others will have a 'Y' value.
This controls if the MCO allows Autoassignments. Valid values are "N" and "Y"." If the value is "N" then no one will be autoassigned to this MCO, if the value is "Y" then autoassignment will occur.

Indicates if the system should generate a PA if one is not available. This functionality is available for NDC's only.
Indicator updated when bad claims have been manually resolved. Valid values are "Y" (indicates a bad status) and space (indicates a good status).
Indicator updated when bad claims have been manually resolved. Valid values are "Y" (indicates a bad status) and space (indicates a good status).
Indicator updated when bad claims have been manually resolved.
This indicates if the payee type is defined in the base system or if the payee type is defined as a non-provider within financial. (Valid values: Y or N)
CLM08 Loop 2300 Yes/No Condition or Response Code. INDUSTRY: Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider; "N" indicates benefits have not been assigned to the provider; "W" indicates not applicable (valid for 5010 transaction).
CLM08 Loop 2300 Yes/No Condition or Response Code. INDUSTRY: Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider; "N" indicates benefits have not been assigned to the provider; "W" indicates not applicable (valid for 5010 transaction).
CLM08 Loop 2300 Yes/No Condition or Response Code. INDUSTRY: Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider; "N" indicates benefits have not been assigned to the provider; "W" indicates not applicable (valid for 5010 transaction).
CLM08 Loop 2300 Yes/No Condition or Response Code. INDUSTRY: Benefits Assignment Certification Indicator. Valid values: "Y" indicates insured or authorized person authorizes benefits to be assigned to the provider; "N" indicates benefits have not been assigned to the provider; "W" indicates not applicable (valid for 5010 transaction).
Designates a Benefit restriction for this row by other benefit. Values are I (include), E (exclude), or N (no restriction).
OI - Assignment of Benefits Indicator
OI - Assignment of Benefits Indicator
Tells whether the service location can be used for billing claims. Valid value are Y = YES and N = No.
Tells whether the service location can be used for billing claims. Valid value are Y = YES and N = No.
An Indicator of ('Y' or 'N') for if the Eligibility Month is the same Month and Year as the Recipients Date of Birth.

This indicator is used to exclude a benefit (or group of benefits) from the list. A value of "Y" means the benefit has been excluded from the list. This is needed because a row may designate a group of benefits such as diagnosis. This will be interpreted as all diagnosis in that group are on the list. But maybe one or a few diagnosis should be exclude from the group. In that case the excluded diagnosis will be on the list with this indicator set to "Y".
This indicator is used to exclude a benefit (or group of benefits) from the list. A value of "Y" means the benefit has been excluded from the list. This is needed because a row may designate a group of benefits such as diagnosis. This will be interpreted as all diagnosis in that group are on the list. But maybe one or a few diagnosis should be exclude from the group. In that case the excluded diagnosis will be on the list with this indicator set to "Y".
This indicator is used to exclude a benefit (or group of benefits) from the list. A value of "Y" means the benefit has been excluded from the list.
This is needed because a row may designate a group of benefits such as diagnosis. This will be interpreted as all diagnosis in that group are on the list. But maybe one or a few diagnosis should be exclude from the group. In that case the excluded diagnosis will be on the list with this indicator set to "Y".
This code indicates whether an individual received services or equipment across state borders.
This code indicates whether an individual received services or equipment across state borders.
This code indicates whether an individual received services or equipment across state borders.
This code indicates whether an individual received services or equipment across state borders.
Designates if Benefit Plans are Included, Excluded, or not restricted for this row.
Allows to restrict the billable benefit by Benefit Plan. Values are "I" (Include), "E" (Exclude), "N" (No restriction).
An indicator used to specify if the benefit plan defined by SAK_PUB_HLTH should be included ('I') or excluded ('E').
An indicator used to specify if the benefit plan defined by SAK_PUB_HLTH should be included ('I') or excluded ('E').
Indicates whether the drug is a brand name generic single-source or multi-source drug.
Field indicates the reason, if any, that a brand name drug was dispensed.
This field indicates the reason, if any, that a brand name drug was dispensed.
This field indicates the reason, if any, that a brand name drug was dispensed.
Tells whether the doctor prescribed only the brand name, or whether generics can be substituted.

This field indicates the reason, if any, that a brand name drug was dispensed.
Indicator which tells whether a BRF (batch response file) has been produced for the batch. A value of "N" will indicate that the BRF has not been produced for this batch, and a value of "Y" will indicate that the BRF has been produced.
Indicator which tells whether a BRF (batch response file) has been produced for the batch. A value of "N" will indicate that the BRF has not been produced for this batch, and a value of "Y" will indicate that the BRF has been produced
Indicates if this payer limits the amount of claims paid based on a budget.
Indicates if this payer limits the amount of claims paid based on a budget.
Money aside burial indicator
Prepaid burial indicator
Trust burial indicator.
(Not used in AL system) Indicates whether or not the corresponding aid category is for QMB or QDWI recipients.
This is the calculated generic indicator. (Values are # = generic; 1 = non generic; 0 = generic)
Indicates the Calculated Generic Indicator. (Values are # = generic; 1 = non generic; 0 = generic)
Indicates whether dispositions with this reason code will have interest calculated or not.
This is the calculated price of the drug. (Values are # - Based on Generic; 1 - Based on non-generic)
Indicates if the segment is cancelled. (Y = Segment Cancelled; N or Space = Segment is not cancelled)
Indicates if the segment is cancelled. (Y = Cancelled; N or Space = Not cancelled)
Indicates if the segment is cancelled. (Y = Cancelled; N or space = Not cancelled)
Indicates if the segment is cancelled. (Y = Cancelled; N or space = Not cancelled)
Indicates the record has been canceled and is no longer valid for claims processing beginning on the DTE_LAST_CHANGE. 'Y' = Cancel, 'N' = Not Canceled.
Indicates the record has been canceled and is no longer valid for claims processing beginning on the DTE_LAST_CHANGE. 'Y' = Cancel 'N' = Not Canceled
This field indicates when the system should ensure that the amount spent is greater than the amount budgeted and begin holding claims because of it.
Indicator of Live Edit Capture.
Yes or No indicator whether the letter can be changed before it prints.
This value indicates whether this reason code can be used for an adjustment or not. Values are Y/N.
Obsolete.

Y/N value to identify whether this plan type is used for Carriers.
Indicates if other insurance carrier denied the claim.
Indicates if other insurance carrier denied the claim.
Indicates if other insurance carrier denied the claim
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Indicates if other insurance carrier denied the claim.
Indicates if other insurance carrier denied the claim.
Indicates if other insurance carrier denied the claim.
Indicates if the case management case is open or close. The values are 'O' and 'C'.
Indicates whether a payee should have cash receipt processing in financial. (Valid values: Y or N)
A flag indicating if the service is a cast crown dental service. Valid values are Y and N.
Indicates if an edit should appears on the potential history to adjust report.
Indicates if the error should be reported on the Potential History To Adjust Report.
Used to determine if the edit is bypassed in Claim Check processing.
Indicates if an edit should appear on the claim check savings report.
Indicates if the error should be reported on the ClaimCheck / ClaimReview Savings Report.
An indicator used to specify that a SAK aid category(s) is needed for MAR COS assignment. Valid values are 'Y', yes aid category code criteria available for this COS; and 'N', no aid category criteria available for this COS.
An indicator used to specify that a SAK aid category(s) is needed for MAR COS assignment. Valid values are 'Y', yes aid category code criteria available for this COS; and 'N', no aid category criteria available for this COS.
Indicator for Certified Application Assister. The valid values are Y- Yes; or N- No.
An "X" in this field indicates a Grandfathered Child
CHAR(1) This is a Y\N value. A value of 'Y' would indicate that the payee type can receive a check.
Indicates if paternity has been established
Indication if the erroIndication if the error belongs to a BCBS record. Y means that it is a BCBS record containing the error, and N means that it is not a BCBS record.

Indicates if the recipient is enrolled in CHIP. Y = Yes, in CHIP PRGM, N = No, not in CHIP PRGM.
Indicates if individual is identified as a U.S. Citizen.
This field if set to 'Y' means that the reason code is associated with a disposition that is claim related.
E=Encounter or F=Fee for service claim.
This field indicates whether or not the detail has been through the ClaimCheck program.
This field indicates whether or not the detail has been through the ClaimCheck program.
This field indicates whether or not the detail has been through the ClaimCheck program.
An indicator to identify a claim that the state refused pay in its entirety.
An indicator to identify a claim that the state refused pay in its entirety.
An indicator to identify a claim that the state refused pay in its entirety.
An indicator to identify a claim that the state refused pay in its entirety.
This field specifies that a provider is ONLY associated with a group (clinic) and is NOT directly associated with the MCO. In order to correctly pay claims, the provider MUST be associated with the MCO in T_PR_GRP_MBR, even though that provider does not directly contract with the MCO - only the clinic that he belongs to contracts with the MCO. These individual providers will have a value of 'Y'.
Indicates the type of claim.
CLAIM DENIAL DISPOSITION
Indicates if a procedure requires CLIA certification.
LINE ITEM DISPOSITION
LINE ITEM REJECTION
This indicates if the benefit conditions for this row are applicable to the benefit that represents a role on the claim. For example, the restriction may apply to the "primary" diagnosis on the claim only.
This indicates if the benefit conditions for this row are applicable to the benefit that represents a role on the claim. For example, the restriction may apply to the "primary" diagnosis on the claim only.
Yes/No value used to identify Claim Status codes that are valid for use in the Claims Inquiry process.
Has ICN been fully recouped.? - (Y/N)
OVERALL CLAIM DISPOSITION
CLAIM PROCESSED FLAG
CLAIM REJECTION DISPOSITION
CLAIM RETURNED TO PROVIDER DISPOSITION
CLAIM SUSPENSION DISPOSITION

Is the provider a CMHC? - (Y/N)
Indicates whether rebate data for this invoice type is sent to CMS. Values are Y or N.
Indicates whether data for the invoice type should be included on the CMS64 report. Values are Y or N.
Indicates whether CMS has enrolled or rejected this recipient into Part D.
Identifies a Single Source or Innovator Multiple Source drug as a clotting factor for which a separate furnishing payment is made. Valid values: Y = Yes N = No
The correction flag from CMS. A value of 0 indicates the rebate record for the quarter, a value of 3 indicates a PPA record for a prior quarter, and a value of 2 indicates the original rate for that prior quarter. Record types 2 and 3 occur in tandem.
The correction flag from CMS. A value of 0 indicates a current / initial record. PPA records have 8 and 9, where 8 indicates the original rate for a prior quarter. 9 indicates the new record. Record types 8 and 9 occur in tandem.
Represents the Rx or OTC status of the drug product as supplied by CMS. Valid values: 1 = Rx 2 = OTC
The Drug Type Indicator represents the Rx or OTC status of the drug product.
Indicates the unit of measure as supplied by CMS. Valid Values: AHF = refers only to injectable Anti-Hemophilic Factor units CAP = Capsule SUP = Suppository GM = Gram ML = Milliliter TAB = Tablet TDP = Transdermal patch EA = EACH (Refers to drugs not identifiable by any other unit type)
NCPDP field 997-G2, Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit. Values are Y - Yes=CMS qualified facility, N - No=Not a CMS qualified facility.
Identifies a Single Source or Innovator Multiple Source drug approved by the FDA exclusively for pediatric indications for patients in the FDA-defined pediatric age group (i.e., birth to 16 years). Valid values: Y = Yes N = No
Control substance restriction indicator for lockin recipients
Obsolete.
Indicates whether a provider's claims cross over. 'Y' if it should or 'N' if it should not.
A code to indicate the type of exclusion. An 'E' = emergency, 'F" = family planning, and '0' (zero) = general exclusion.
This indicator identifies whether a MI verbal determination code is a valid code for pre-admission determinations, resident review determinations, or for both. Values are either "R" for resident reviews, "D" for pre-admission determinations or "B" for both.
Indicator to specify if the drug is compound or not.
A flag to identify children eligible through the conception to birth option.
Code (Y or N) indicating a Yes or No condition or response.
Profile type: I=inferred disease; R=reported disease; A=allergy; P=pregnancy.

Indicates if condition editing is required for the benefit. A value of 'N' indicates no condition editing should be performed. A 'Y' indicates that condition code restrictions exist for the benefit. A value of 'Y' and no rows on the table T_CON_MOD_AXIS_RANGE means that this coverage condition for the benefit will not apply if any condition code appears on the claim.
Used to restrict rows on T_PAYABLE_BENEFIT to condition codes on the claim.
Indicates a confidential procedure. Confidential procedures will not be printed on a recipient EOMB.
Value of "Y" causes execution of conflict date overlap logic
Conflicting MME Factor Indicator. 1=True, 0=False
Designates if CONTRACTS are Included, Excluded, or not restricted for this row.
This column is used to identify AWP prices that were converted from the mainframe system. Converted AWP rates will always be multiplied by an EAC of 100% to get the EAC price for a drug.
Conversion Indicator
This is the system derived co-pay indicator whether a co-pay was applied to the detail. Y for co-pay applied, N for co-pay exempt.
This is the system derived co-pay indicator to indicate whether a co-pay was exempt for the detail or not. Valid values are: A - Exempt for American Indian with an active user letter, P - Exempt for pregnancy, I - Exempt for Institutional/LTC, S - Exempt for other reasons, C - Copay was applied.
This is the copay indicator of the claim. (Y = Copay; N = No Copay)
This field indicates whether this provider type is set up for copay or not. The valid values are 'Y' (Yes) and 'N' (No).
Yes/No indicator used to identify programs that qualify for copay calculations during claims payment determination.
An indicator signifying that the copay was waived by the provider.
An indicator signifying that the copay was waived by the provider.
An indicator signifying that the copay was waived by the provider.
An indicator signifying that the copay was waived by the provider.
Yes/No value used to identify Claim Status codes that are valid for use in the Claims Data Corrections process.
Identifies if a correction has been made to the NDC's rebate information for a given quarter. Values are "0" (Original Invoice), "1" (In Dispute), and "2" (Written Off).

Identifies if a correction has been made to the NDC's rebate information for a given quarter/year
Identifies if a correction has been made to the NDC's offset amount. 0=Initial record; 8=value of old UROA; and 9=replacement record. 8 and 9 occur in tandem.
Indicates if this is to bypass cost avoidance or not.
Indicates whether the error status code is a cost containment error.
Cough and Cold Preparation Indicator, product is considered to be a cough/cold preparation. 1-TRUE 0-FALSE
This field indicates if the drug (NDC) is covered by Medicaid or not. The valid values are Y and N.
An indicator used to denote whether an ICD procedure is a covered procedure.
Identifies the combinations of Provider type/specialties applicable to this row of conditions. Values are I - include; E - exclude; N - no restriction. A value of 00 or 000 for type or specialty represents no restriction on type or specialty, respectively.
Credit/debit indicator
Credit/debit indicator from CMS
Credit/debit indicator
Credit/debit indicator from CMS
Indicator stating if the Service Location has a credit balance. Valid values are "Y"es, "N"o.
The indicator to show if an NDC, GCN or NDC code or type was entered on the criteria screen. Valid values are N - NDC, G - GCN, and C - GC3.
The indicator to show if an NDC, GCN or NDC; code or type was entered on the criteria screen. Valid values are N - NDC, G - GCN, and C - GC3.
The indicator to show if an NDC, GCN or NDC; code or type was entered on the criteria screen. Valid values are N - NDC, G - GCN, and C - GC3.
Indicator identifying if the ESC is critical and can not be inactivated or marked as pay (forced).
An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
An indicator specifying whether the claim is a crossover claim where a portion is paid by Medicare.
Identifies the associated list of claim types as included or excluded for the covered benefit.
Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.

Identifies the associated list of claim types as included or excluded for the covered benefit.
The IND_CT_EDITING attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.
The IND_CT_EDITING attribute indicates what type of claim type to program editing is to be performed. If the indicator is set to 'N' (non), no claim type to program editing is performed. If the indicator is set to 'I' (include), only the claim types listed are billable for the specified program. If the indicator is set to 'E' (exclude), the claim types listed are not billable for the specified program.
Current indicator to display the most current eligibility with the claims without having to create a temp table. Possible values Y/N.
Current indicator to display the most current eligibility with the claims without having to create a temp table. Possible values Y/N.
Indicates if the segment is the most current segment. (Y = Current segment; N or Space = Not the current segment)
Indicates if the segment is the most current segment. (Y = Current Segment; N or space = Not the current segment)
Indicates if this is the current segment. (Y = Current segment; N or space = not cancelled)
The is the DAW of the claim. Values are 0 = DAW and 1 = Non DAW.
Indicates if day care services should be excluded
A 'Yes/No' value to indicate whether or not claims identified for supervisor review should be resubmitted in the event that the supervisor is not able to review them on that day.
Indicator identifying whether the disposition is to debit or credit the associates A/R. Debit increases the amount of the A/R, credit reduces the amount.
Indicator identifying whether the disposition is to debit or credit the associated A/R. Debit increases the amount of the A/R, and credit reduces the amount.
Indicator identifying whether the disposition is to debit or credit the associated A/R. Debit increases the amount of the A/R, and credit reduces the amount.
Will be 'X' if recipient had coverage for December of the tax year. Will be space if the recipient had full year or if no coverage was present for December.
Will be 'X' if recipient had coverage for December of the tax year. Will be space if the recipient had full year or if no coverage was present for December.
Indicates if the policy carries a deductible

This is the default record for use in the system. A "Y" indicates default. All other records will contain a null value.
This column allows the user to specify if the Inclusion/General inclusion restriction can be considered for Autoassignments through 'Default' logic. If the value is set to 'Y', then RCBMs who meet the restiction can be assigned through Default logic. If it is set to 'N', then they can not (even if they meet the restrictions).
Indicator to show if the data is for a dependent or for the recipient. Valid values are: Y - dependent N - not a dependent
Indicates whether the check that was returned should be deposited.
Indicates that the DHS or the DMH has sent an e-mail to the LOCEU informing them that a determination has been completed.
For NPI entries, indicates that this is the default service location for this NPI.
Indicates if the claimant receives a Family Assistance check. Valid values are 'Y' for Yes, 'N' for No and 'Blank' for Unknown or N/A
Indicates if the drug requires a diagnosis. Valid values are: Y=yes, N=no, blank=does not participate.
Diagnosis include/exclude indicator
Diagnosis include/exclude indicator
Diagnosis include/exclude indicator
Not currently used.
Indicates whether the associated list of diagnosis codes is valid or invalid for the place of service.
An indicator used to specify if the diagnosis codes defined by SAK_DIAG_TYPE should be included ('I') or excluded ('E').
A Yes/No indicator used in claims processing to determine if a diagnosis is required for the given procedure.
Indicates whether the diagnosis code(s) to be checked is (A)dmit, (D)ischarge, (E)mergency, (P)rimary, (S)econdary, (space)any
Indicates whether the diagnosis code(s) to be checked is (A)dmit, (D)ischarge, (E)mergency, (P)rimary, (S)econdary, (space)any.
(Not used in AL system) Indicates whether or not the aid category is for the disabled.
Indicates if this budget can be used to disburse payments.
Indicates whether the policy type should trigger disenrollment from managed care.
Indicator of whether disenrollment was through: C = Inactive prior to Conversion, D = De-activation, E = Enrolled, F = Failure to re-enroll , O = Other, P = Pending De-activation, X = Exclude from De-activation/Disenrollment.

Yes/No indicator used to identify drugs that should pay a percentage of the normally calculated dispensing fee. This indicator is used with the attribute NUM_DISP_FEE_PCT to determine the dispensing fee to pay. If the indicator is a Y (yes), the dispensing fee will be multiplied by the dispensing fee percentage to get the final dispensing fee to pay to the provider.
Indicates if the family member date of birth has been verified
Indicates this segment should not be transferred from this Medicaid number
Indicates the segment should not be updated
Valid values are space - allow transfer, and 1 do not allow transfer.
Indicates if the address is a Commercial Mail Receiving Agency (CMRA).
Indicates if the address is a Commercial Mail Receiving Agency (CMRA).
Indicates the results of Delivery Point Validation (DPV) processing.
Indicates the results of Delivery Point Validation (DPV) processing.
This is a one-character field that corresponds to false positive address detected. The False Positive table is a security feature put in by the USPS® to prevent end-users from using the DPV® system to generate address lists from the ZIP + 4® database and DPV® tables. Possible valid values are: Y - Indicator when an address error was detected; N - When address was not found on false positive table; Blank - When it was not presented to the False Positive table.
This is a one-character field that corresponds to false positive address detected. The False Positive table is a security feature put in by the USPS® to prevent end-users from using the DPV® system to generate address lists from the ZIP + 4® database and DPV® tables. Possible valid values are: Y - Indicator when an address error was detected; N - When address was not found on false positive table; Blank - When it was not presented to the False Positive table.
A one-character field that tells that this address is not included in the USPS® delivery statistics file counts. Possible valid values are: Y - means that the address on the USPS shows as NoStat; N - means that the address on the USPS does not show up on NoStat; Blank - Address not presented to NoStat table.
A one-character field that tells that this address is not included in the USPS® delivery statistics file counts. Possible valid values are: Y - means that the address on the USPS shows as NoStat; N - means that the address on the USPS does not show up on NoStat; Blank - Address not presented to NoStat table.

A one-character field that tells whether an address is vacant/not vacant. Possible valid values are: Y - means that the address on the USPS shows as Vacant; N - means that the address on the USPS shows as No Vacant; Blank - Address not presented to Vacant table.
A one-character field that tells whether an address is vacant/not vacant. Possible valid values are: Y - means that the address on the USPS shows as Vacant; N - means that the address on the USPS shows as No Vacant; Blank - Address not presented to Vacant table.
An indicator identifying the grouping algorithm used to assign Diagnosis Related Group (DRG) values
Indicates (Y/N) whether current process is driver or not.
This indicator identifies whether or not drugs are covered on the policy.
Type of classification used for the alternate drug: H=HIC3, I=HIC4, G=GSN, N=NDC, A=AHFS.
This is the drug class indicator. (Values are 0 = drug class; 1 = non drug class)
This is the drug class of the drug. (Values are 0 = drug class; 1 = non drug class)
This will indicate whether or not a drug affects the central nervous system.
An indicator used to specify that a SAK Drug(s) is needed for MAR COS assignment. Valid values are 'Y', yes SAK drug criteria available for this COS; and 'N', no SAK drug criteria available for this COS.
The Generic Price Indicator (GPI) distinguishes a product as either priced as a generic or priced as a brand.
Generic Product Indicator (GPI) distinguishes a product either as a generic drug product or a more expensive branded drug product.
Generic Drug Indicator
Indicates whether a drug product is generic product or branded product. Values - Y or N.
The Generic Product Indicator (GPI) will distinguish a product as either a generic drug product or as the more expensive branded drug products.
The Generic Product Indicator (GPI) will distinguish a product as either a generic drug product or as the more expensive branded drug products.
This field identifies the original innovator product for a particular generic code number. Values are: (0)=Default - non innovator drug; (1)=Innovator - held original patent. It is possible to have more than one product to appear to be the innovator.
This field identifies the original innovator product for a particular generic code number. Values are: (0)=Default - non innovator drug; (1)=Innovator - held original patent. It is possible to have more than one product to appear to be the innovator.
Drug include/exclude indicator

Drug include/exclude indicator
This will indicate that the drug is required for "maintaining" health and as such provisions have been made to provide the drug in quantities greater than the standard 30-day or monthly supply.
An indicator used to specify that a SAK Drug(s) is needed for MAR COS assignment. Valid values are 'Y', yes SAK drug criteria available for this COS; and 'N', no SAK drug criteria available for this COS.
Type of classification used for the source drug: H=HIC3, I=HIC4, G=GSN, N=NDC, A=AHFS.
Identifies the package size and associated price vectors to be used when pricing the "standard package size" which is defined as 100's for non-unit dose, non-prepack tablets and capsules and 473 or 480 ml for liquids. Current codes are: 0 -All & 1-Std.
Identifies the package size and associated price vectors to be used when pricing the "standard package size" which is defined as 100's for non-unit dose, non-prepack tablets and capsules and 473 or 480 ml for liquids. Current codes are: 0 -All & 1-Std.
Indicates Generic/Branded/Either for a provider.
Indicates Generic/Branded/Either for a provider.
Indicates that the LOCEU has received or reviewed the determination information that has been sent by the DHS or the DMH. (PASRR PRE-ADMISSION SCREEN, Determinations, Determination Received?)
Indicates that the LOCEU has received or reviewed the determination information that has been sent by the DHS or the DMH.
Yes/No indicator used to identify a program is a Dual program. A dual program is a program that can either stand alone or with another major/dual program.
(Not used in AL system) Indicates if the aid category may be dually enrolled. For instance, a recipient may be QMB only or QMB also, which requires the recipient to be enrolled in two aid categories.
The IND_DUAL_ELIGIBLES is a Y/N indicator to indicate if the MCO accepts recipients that have both Medicaid and Medicare coverage. * Y - The MCO accepts recipients that have Medicare coverage * N - The MCO does not accept recipients that have Medicare coverage
An indicator to denote that other A/Rs were previously created for the same claim to which this is associated.
An indicator to denote that other A/Rs were previously created for the same claim to which this is associated.
This indicates whether to double side the letter output. N = single sided, Y = double sided.
Indicates whether a payee should have earnings in financial. (Valid values: Y or N)
Yes/No value used to identify Claim Status codes that are valid for use in the Claims Dispositioning process.

Indicates whether a payee should have eft processing in financial. (Valid values: Y or N)
The type of EFT account. The valid values are: D - Deposit and W - Withdrawal.
The type of EFT account. The valid values are: D - Deposit and W - Withdrawal.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
This field is keyed in RRI to indicate if the provider is a possible electronic biller.
This field is keyed in to indicate if the provider is a possible electronic biller.
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This field is keyed in RRI to indicate if the provider is a possible electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicator that identifies paper claims where the provider has been identified as a potential electronic biller.
Indicates this provider has notified KMAA of the desire to bill electronically and has filled out the proper form with KMAA. (Y for Yes, N for No)
Indicates Recipient Medicaid eligibility for the benefit month. Valid values 'Y' or 'N' for DET records and 9 for LIS records.
Indicates that the DHS or the DMH has sent an e-mail to the LOCEU informing them that a determination has been completed. (PASRR PRE-ADMISSION SCREEN, Determinations, Email Sent)
Indicates that the LOCEU has sent an e-mail to the DMH or the DHS informing them that a referral is requested. (PASRR PRE-ADMISSION SCREEN, Referral, E-mail Sent?)
This indicator is used to identify the authorization as an emergency 72-hour supply of drugs.
Not currently used.
DO NOT USE - not applicable to Dental claims.
Indication (Y/N) of whether drugs were dispensed as a result of an emergency situation.
Indicates whether the service was provided as result of an emergency situation.

Indicates whether the diagnosis is for an emergency ASC condition. Valid values are 'Y' - yes and 'N' - no.
Indicates whether the procedure performed was the result of an emergency.
This is the Prior Authorization psychiatric emergency indicator.
Indicates whether the service was provided as a result of an emergency situation.
Indication (Y/N) of whether drugs were dispensed as a result of an emergency situation.
Indicates whether the service was provided as result of emergency situation.
Identifies an emergency claim for the category of service assignment.
DO NOT USE - not applicable to Dental claims.
Indication (Y/N) of whether services were rendered as a result of an emergency situation.
Indicates whether the service was provided as result of emergency situation.
Indicates why the long term care recipient came to Oklahoma from out of state. Will always contain a C in OK system.
Indicate whether this type of event is still being logged of if it has been updated. This will be Y/N.
Indicator if this document type represent encounter claim.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values are Y, N and space. Space indicates N.
This field indicates if the claim is an encounter. Valid values are Y, N and space. Space indicates N.
This field indicates if the claim is an encounter. Valid values are Y, N and space. Space indicates N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.

This field indicates if the claim is an encounter. Valid values Y or N.
This field indicates if the claim is an encounter. Valid values Y or N.
Indicator to denote whether the accumulated numbers include encounters or fee for service claims. Valid values are Y for encounters or N for FFS.
Value for encounter indicator for current claim. Valid values are Y and N
Value for encounter indicator for history claim. Valid values are Y and N.
Indicates whether the procedure/drug is compensable for children (under 21) with medically needy only categories of assistance if dispensed through the EPSDT program. Service is determined to be EPSDT using a procedure group maintained in the Reference system. Valid values are Y (Yes) and N (No).
Indicates whether the procedure/drug is compensable for children (under 21) with medically needy only categories of assistance if dispensed through the EPSDT program. Service is determined to be EPSDT using a procedure group maintained in the Reference system. Valid values are Y (Yes) and N (No).
The EPSDT indicator found in the HIPAA 278 Request and Response Guide in the SV1 Professional Service segment; element (SV111). Valid codes are 'Y' - Yes and 'N' - No.
This field indicates whether EPSDT referral claims are to be included or excluded from an audit criteria.
EPSDT Referral Indicator. Mapped from field SV111 of the 837P transaction. A "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement. Paper claim: source field is 24H. In Alabama a "1" or "4" in the service was provided as the result of an EPSDT referral and is mapped into the system as a "Y".
Block 24J on the HCFA 1500. Defines EPSDT referal/treatment information. The valid values are as follows: YD - EPSDT, dental referral; YV - EPSDT, vision referral; YH - EPSDT, hearing referral; YO - EPSDT, other referral; AT - EPSDT, abnormal not treated; AN - EPSDT, abnormal treated; AR - EPSDT, abnormal.
EPSDT Referral Indicator. Mapped from field SV111 of the 837P transaction. A "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement. Paper claim: source field is 24H. In Alabama a "1" or "4" in the service was provided as the result of an EPSDT referral and is mapped into the system as a "Y".
EPSDT Referral Indicator. Mapped from field SV111 of the 837P transaction. A "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement. Paper claim: source field is 24H. In Alabama a "1" or "4" in the service was provided as the result of an EPSDT referral and is mapped into the system as a "Y".

Indicator ('Y' or 'N') for claims that were for EPSDT Screenings. This means the claim record exists on the T_RE_EPS_HIST_EXT Table in the MMIS.
Indicates whether the transaction applied to the wrong beneficiary.
Indicates whether the transaction applied to the wrong beneficiary.
This corresponds to whether it was a successful or an unsuccessful run. Possible values : 0 - Successful run and was able to make a call to the interface. 1 - Unsuccessful and was not able to make a call to the interface
Indicates if the transaction had any errors when it processed. C means it was clean with no errors. N means there were non-fatal errors. F means there were fatal errors.
Indicates if the transaction had any errors when it processed. C means it was clean with no errors. N means there were non-fatal errors. F means there were fatal errors.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's ethnicity characteristics.
One-character code that represents Early Warning System code.
One-character code that represents Early Warning System code.
A flag indicating if the service is an exam dental service. Valid values are Y and N.
Indicates if the modifier group is included or excluded as a requirement for the provider type/specialty.
Indicates if the property is excluded as a resource.
Indicates if the vehicle is excluded as a resource.
A Yes/No field that indicates if the recipient is excluded from the HIPP Policy and case calculations.
Indicates a provider is to be exempted from the "No Claim Activity" deactivation process.
This indiciates if a recipient TPL has been exhausted.
This is the Exhaustion indicator used to indiciate if a recipient TPL has been exhausted.
Indicator if trading partner will send us 997 Acknowledgements for the EDI documents they send us.

This is a Y\N value. A value of 'Y' would indicate that the payee can receive expenditure payments. This primarily will be used by the expenditure window.
Indicator of Expense. Valid values are: P - Paying for day/night care, N - Not paying for day/night care.
It is used to indicate if the service type should be treated as an explicit request when received on an incoming transaction. An "N" indicates that it should not be treated as an explicit request.
Indicates whether the location is external to the Fiscal Agent (EDS). If it is an "X" then the location is external and should be treated like a CCF location in the MAR performance reports. If it is " " then the location is within the EDS control.
A value of 'Y' indicates a family planning service.
Claims processing no longer uses this field and uses Benefit Plan rules instead. The indicator for determining whether or not this diagnosis is a Family Planning diagnosis.
Indicates if a medical procedure is related to family planning.
Indicates if the FCBC criteria has been met. Valid Values are Y/N/Blank.
Indicates a product's CMS unit of measure as supplied by FDB. These units represent the standard measurements used by CMS for determining rebate quantities. Valid Values: AHF = refers only to injectable Anti-Hemophilic Factor units CAP = Capsule SUP = Suppository GM = Gram ML = Milliliter TAB = Tablet TDP = Transdermal patch EA = EACH (Refers to drugs not identifiable by any other unit type)
Indicates whether admit date should be used in evaluating the date relationship.
Will be 'X' if recipient had coverage for February of the tax year. Will be space if the recipient had full year or if no coverage was present for February.
Will be 'X' if recipient had coverage for February of the tax year. Will be space if the recipient had full year or if no coverage was present for February.
Fee exemption indicator. Y - Exempt from paying fee. N - Not Exempt from paying fee. Blank - Default (To be determined).
Indicates if record is Fee For Service (FFS) or Encounter. Value 'Y' is FFS; 'N' is Encounter.
Indicates if record is Fee For Service (FFS) or Encounter. Value 'Y' is FFS; 'N' is Encounter.
Indicates if record is Fee For Service (FFS) or Encounter. Value 'Y' is FFS; 'N' is Encounter.
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Indicates if record is Fee For Service (FFS) or Encounter. Value 'Y' is FFS; 'N' is Encounter.
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Indicates if record is Fee For Service (FFS) or Encounter. Value 'Y' is FFS; 'N' is Encounter.
Indicates whether this provider should have FICA computed on it or not. The default will be "No".
Indicates whether this service location should have FICA computed on it or not. The default will be "No".
Indicates whether this service location should have FICA computed on it or not. The default will be "No".
Indicates whether this service location should have FICA computed on it or not. The default will be "No".
This indicates whether other information is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Other 1)
This indicates whether other information is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Other 2)
This indicates whether a psychiatric is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Psychiatric)
Indicates whether a psychological worksheet is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Psychological)
This indicates whether a questionnaire is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Questionaire)

This indicates whether a social history is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Social History)
A code to indicate whether the records in the file are test or production records.
Indicates whether a worksheet is filed in the ICF/MR packet. (ICF/MR SCREEN, ICF MR Approval, File Worksheet)
Indicates whether final decision is NF. (PASRR PRE-ADMISSION SCREEN, Determinations, Final NF?)
Indicates whether the final decision is a nursing facility. Resident Review Screen, Resident Reviews, Final NF?)
This indicates that the reimbursement amount included on the claim is for a fixed payment.
This indicates that the reimbursement amount included on the claim is for a fixed payment.
This indicates that the reimbursement amount included on the claim is for a fixed payment.
This indicates that the reimbursement amount included on the claim is for a fixed payment.
A flag indicating if the service is a fluoride treatment dental service. Valid values are Y and N.
Indicates if the PCP accepts entire families.
Indicates whether a PMP accepts entire families in their practice.
Obsolete.
Indicates whether a PMP accepts entire families in their practice.
Indicates whether a PMP accepts entire families in their practice.
Indicates if the claimant receives food stamps. Valid values are 'Y' for Yes, 'N' for No and 'Blank' for Unknown or N/A
This code indicates if the claim was processed by forcing it through a manual override process.
This code indicates if the claim was processed by forcing it through a manual override process.
This code indicates if the claim was processed by forcing it through a manual override process.
This code indicates if the claim was processed by forcing it through a manual override process.
This is used to override IND_CRITICAL = "Y".
A 'Y' in this column means this ESC may be forced if the service is priced manually.
Indicator showing whether this provider requires a form 147 sent to them.
Indicates if drug claims for this applicant would be covered by the Family Planning Program
If system determines claim to be Family Planning related based on rules, the indicator will be Y, otherwise it will be N. This is not the provider-submitted family planning indicator.

If system determines claim to be Family Planning related based on rules, the indicator will be Y, otherwise it will be N. This is not the provider-submitted family planning indicator.
System derived FQHC Encounter Indicator. Values are Y or N.
A flag indicating if the provider is an FQHC provider. Valid values are Y and N.
This column designates the frequency of the roster run. Values could include M (monthly), D (daily), etc...
This column designates the frequency of the roster run. Values could include M (monthly), D (daily), etc...
Yes/No indicator used in claims process to determine if the procedure may be billed with From and Through dates of service.
Indicator to tell if the trading partner wants a full file 834 transaction. Valid values are Y - Yes and N - No.
An indicator used to specify that a SAK fun code(s) is needed for MAR COS assignment. Valid values are 'Y', yes financial fund code criteria available for this COS; and 'N', no financial fund code criteria available for this COS.
An indicator used to specify that a SAK fun code(s) is needed for MAR COS assignment. Valid values are 'Y', yes financial fund code criteria available for this COS; and 'N', no financial fund code criteria available for this COS.
The Generic Indicator (GI) differentiates single-source from multiple-source drugs. Valid values are: 1 = Multiple source 2 = Single source This is the GCNSEQ_GI on NDDF update.
The Gender-Specific Drug Indicator (GENDER) identifies drugs that are used for a specific gender. It can be used to help determine appropriateness of therapy based upon the sex of the patient (or to infer the sex of a patient). An indicator value is attached to the Generic Code Number (GCN) or the Generic Code Number Sequence Number (GCN_SEQNO) which identifies whether it is used in males or females or both.
Indicates the mode in which the letter was generated.
The mode in which to print the letter (Batch or Online).
It is used to indicate if the service type should be treated as a generic request when received on an incoming transaction. An "N" indicates that it should not be treated as a generic request.
Differentiates single source from multiple source drugs. The values for the Generic Drug Indicators are 1 = Multi and 2 = Single and (space) = Invalid.
This is the generic product code of the drug. (Values are 0 = generic; 1 = non generic)
This is the generic product indicator of the drug. (Values are 0 = generic; 1 = non generic)
Identifies drug products as branded or generic depending on their price, based on relative AWPs in relation to other drugs in the generic grouping. Values are 0 = Generic or 1 = Non generic.
This is the generic pricing indicator of this drug code. (Values are 0 - Brand; 1 - Generic)

This is the generic indicator of the drug. (Values 0 = generic; 1 = non generic)
This is the generic indicator of the drug. (Values 0 = generic; 1 = non generic)
This is the code that stores the precision of the address match for the latitude and longitude lookup.
This is the code that stores the precision of the address match for the latitude and longitude lookup.
This is the code that stores the precision of the address match for the latitude and longitude lookup.
This field if set to 'Y' means that the reason code is associated with a disposition that will be reported on the general ledger (provider earnings).
A one-character alphanumeric column that specifies whether a product is a brand named product, a generically named product, or an alternative product, using the product name as the criteria.
A one-character alphanumeric column that specifies whether a product is a brand named product, a generically named product, or an alternative product, using the product name as the criteria.
Good cause indictor. Values are: Blank = N/A Y = Good cause indicated; do not use insurance because a "good cause" exists (abuse etc.). N = No good cause indicated; use insurance because a "good cause" exemption does not exist.
When used on this table, this attribute indicates whether a provider type is only valid for a group. A value of 'Y' indicates that a member of a group may not be assigned the corresponding provider type.
Indicator which can be Group or Individual to limit the types of providers who will have labels produced for them.
Has Opioid Daily Dose Indicator, an ingredient in the product has a daily dose requirement for the MME Conv. If the product contains more than one ingredient and one of them requires a daily dose MME, this indicator is set as True. 1-True, 0 False.
Has Opioid Daily Dose Indicator, an ingredient in the product has a daily dose requirement for the MME Conv. If the product contains more than one ingredient and one of them requires a daily dose MME, this indicator is set as True. 1-True, 0 False.
Has Opioid Daily Dose Indicator. 1=True, 0=false
Values spaces = No HCAC found, 1 = HCAC found but DRG did not change, 2 = HCAC found and affected DRG assignment
Values spaces = No HCAC found, 1 = HCAC found but DRG did not change, 2 = HCAC found and affected DRG assignment
Indicates a product's unit of measure, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. These units represent the standard measurements used by CMS for determining rebate quantities.

Indicates a product's unit of measure, as supplied on the Centers for Medicare and Medicaid Services' (CMS, formerly HCFA) quarterly update. These units represent the standard measurements used by CMS for determining rebate quantities.
Indicates if item is healthcare related
Indicates if item is healthcare related
Indicates if item is healthcare related
Indicates if item is healthcare related
Indicates if the property is an inherited asset.
Medicare Coverage Indicator. Indicates whether (Yes) or not (No) the patient is covered by Medicare.
Skilled Nursing Facility Indicator. Indicates whether (Yes) or not (No) the patient is receiving care in a Skilled Nursing Facility.
Y or N. Y if this transaction type is defined by HIPAA.
This indicates whether or not the employer participates in HIPP.
HMS HIPP Indicator, 1=Member is active in HIPP, 0= Member is not active in HIPP.
Indicates whether to purchase or not to purchase the HIPP policy.
Family member Hispanic indicator
Indicate update history only do not edit, audit, ore re-price: Y - yes; N - No
Type of record. Space for new claim and 'A' for void.
Type of record. Space for new claim, and 'A' for void.
History record indicator. H = History Record C = Current Record.
History record indicator. H = History Record; C = Current Record.
Indicates whether the client has a history of mental illness. (PASRR PRE-ADMISSION SCREEN, Determinations, History of Mental Ill?)
Type of record: 'P' - Processed claim information 'A' - Affected history claim detail 'C' - Current supporting detail 'H' - History supporting detail.
This status of EFT record. Blank = Record are not released C = Current record H = History record
Indicates whether the client has a history of mental illness. Resident Review Screen, Resident Reviews, History of Mental Ill?)
This code indicates whether the claim has a Health Care Acquired Condition
Indicates whether the individual included on the claim has a Health Care Acquired Condition.
Indicates whether the individual included on the claim has a Health Care Acquired Condition.
This code indicates the claim is submitted by a prov or group enrolled in the Health Home care model

This code indicates the claim is submitted by a prov or group enrolled in the Health Home care model
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This code indicates the claim is submitted by a prov or group enrolled in the Health Home care model
Indictor to denote if current or former Head of Household. Valid values: C = Current F = Former
This is a hold indicator.
Indicates when Hospice was provided in Nursing Home. Valid values are Y/N.
Indicates when Hospice was provided in Nursing Home. Valid values are Y/N.
Indicates when Hospice was provided in Nursing Home. Valid values are Y/N.
Indicates if Hospice was provided in the Nursing Home. Valid values are Y/N.
A code to indicate whether the service was a hysterectomy. Valid values are Y (Yes) and N (No).
Indicates if the procedure performed was a hysterectomy.
Potentially inactive indicator (0 = No manual screening necessary, 1 = Could contain inactive ingredients. If implicated in a patient's profile as an allergen, prescribed NDCs that have not yet been reviewed for inactive ingredients should be manually screened for this base ingredient.)
This field indicates if the rate cell should be used when determining the total amount paid for the recipient's primary care INCLUDING Family Planning and EPSDT deductions. This is necessary for the Family Planning/EPSDT deduction process so that it includes other EPSDT/Fam Plan deductions when determining how much is remaining from the amount paid to the PMP for the recipient's primary care. As of the time of the OK implementation, all rate cells with the exception of the delivery pymts will have a value of 'Y'.
Indicates if the family member income is included in the applicant's budget
This is a Yes/No indicator to specify whether this provider is eligible to be an Indian Managed Care provider.
This is a Yes/No indicator to specify whether this provider is eligible to be an Indian Managed Care provider.
This is a Yes/No indicator to specify whether this provider is eligible to be an Indian Managed Care provider.
Injectable Opioid Indicator, product is an injectable. 1-TRUE 0-FALSE
Indicates Recipient's eligibility to the Nursing facility, Intermediate care facility/Mentally Retarded or Inpatient Psychiatric Hospital. Determined by the level of care field. Values are 'Y', 'N' or 9 for Known.

Insured Indicator found in the HIPAA 278 Request and Response Guide in loop 2010C, segment INS, element INS01. Valid indicatory is 'Y'. A 'Y' value indicates the insured is a subscriber.
This shows whether the carrier participates in the Insurance Disclosure program.
This shows whether the carrier participates in the Insurance Disclosure program.
Indicates if insurance has been terminated.
A 'Y' indicates that the code location is acceptable in a claim interest calculation. An 'N' indicates that if the claim has ever been in this location to exclude the entire claim from a claim interest calculation.
Indicates whether interest should be calculated for this invoice type. Values are Y or N.
Yes / No indicator designating whether the country requires extra fields to enter the address.
Yes / No indicator designating whether the country requires extra characters to store the phone number.
Determines inclusive query of drugs for this audit or Exclusive. (I,E)
Indicator identifying whether the specified range of diagnosis codes should be included or excluded from the procedure during claims processing.
This field indicates whether the associated drug, revenue code, or procedure range is included or excluded from the billing restrictions for a provider.
Claim type include or exclude indicator. When set to include all claims matching claim types will be eligible for payment hold. When exclude is set then claims matching claim type will not be eligible for payment hold.
Claim media include or exclude indicator. When set to include all claims matching the claim media will be eligible for payment hold. When exclude is set then claims matching claim media will not be eligible for payment hold.
Fund code include or exclude indicator. When set to include all claims matching the fund code will be eligible for payment hold. When exclude is set then claims matching fund code will not be eligible for payment hold.
The include or exclude indicator for payee. When include is set claims with matching payee ids will be eligible for payment hold. When set to exclude claims matching payees will not be eligible for payment hold.
Payer include or exclude indicator. When set to include all transactions for the payer will be eligible for payment hold. When exclude is set then transactions matching payer will not be eligible for payment hold.
Payment type include or exclude indicator. When set to include all claims matching the payment type will be eligible for payment hold. When exclude is set then claims matching payment type will not be eligible for payment hold.

The include or exclude indicator for the program code. When set to include the claims with matching program codes will be eligible for payment hold. When set to exclude all claims with matching program codes will not be eligible for payment hold.
The include or exclude indicator for billing provider. When include is set claims with matching provider numbers will be eligible for payment hold. When set to exclude claims matching providers will not be eligible for payment hold.
The include or exclude indicator for provider specialty. When set to include all claims with matching provider specialty will be eligible for this payment hold. When set to exclude all claims matching provider specialty will not be eligible for this payment hold.
The include or exclude indicator for provider types. When set to include all claims with matching provider types will be eligible for payment hold. When set to exclude all claims matching provider type will not be eligible for payment hold.
The include or exclude indicator for state category of service (SCOS). When set to include all claims with matching SCOS will be eligible for this payment hold. When set to exclude all claims matching SCOS will not be eligible for this payment hold.
Identifies products sold only to selected customers, usually at a discounted price. Institutional products are manufacturer-specified; customers must meet the manufacturer's definition of an institution (for example, nursing homes, the Veteran's Administration). 0 - Not Institutional, 1 - Institutional.
This indicated if the reason code is used for IRS Backup Withholding. The Backup Withholding will be reported on the 1099's.
Will be 'X' if recipient had coverage for January of the tax year. Will be space if the recipient had full year or if no coverage was present for January.
Will be 'X' if recipient had coverage for January of the tax year. Will be space if the recipient had full year or if no coverage was present for January.
Will be 'X' if recipient had coverage for July of the tax year. Will be space if the recipient had full year or if no coverage was present for July.
Will be 'X' if recipient had coverage for July of the tax year. Will be space if the recipient had full year or if no coverage was present for July.
Will be 'X' if recipient had coverage for June of the tax year. Will be space if the recipient had full year or if no coverage was present for June.
Will be 'X' if recipient had coverage for June of the tax year. Will be space if the recipient had full year or if no coverage was present for June.
Indicates whether labeler data for this invoice type should be updated by the Quarterly CMS tape. Values are Y or N.

This is a one-character field that gives information about Locatable Address Conversion System (LACS). Possible valid values are: Y = New address available; F = False Positive; N = New address not available.
This is a one-character field that gives information about Locatable Address Conversion System (LACS). Possible valid values are: Y = New address available; F = False Positive; N = New address not available.
This indicates whether the letter should be printed in a landscape format. N = portrait, Y = landscape
Indicates the Last action taken. (A = Record Added; U = Record Updated)
Indicates the Last action taken. (A = Add; U = Update)
A flag indicating if the claim is the latest version of the claim in an adjustment chain. Valid values are Y and N.
Code to indicate the latest claim in an adjustment chain. Valid Values are Y Yes this is the latest claim, or N No, this is NOT the latest claim.
The Labeler Indicator (LBLRIND) data element is blank for an active labeler (at least 1 active NDC) or 'I' for an inactive labeler (no NDCs or all obsolete).
Indicates if the sponsor has legal authority to sign for the applicant
Indicates whether the client's guardian is the legal guardian.
This is an indicator used to say whether a PA notice is to be mailed to the provider, whether it is batch or on-demand.
This is a generic indicator for a type of letter.
This is a generic indicator for a type of letter.
This is a one byte field indicating which type of notice was sent to the recipient. Valid values are: R - rescreening, S - pregnant woman, M - missed appointment, E - newly eligible, and N - non participating.
This indicates the type of letter head to be created when the letter is printed.
This is the letter indicator. It will be used to indicate whether letters need to be produced as a result of the mass disenrollment process. Valid values are 'Y' or 'N'.
This is the letter indicator. It will be used to indicate whether letters need to be produced as a result of the mass disenrollment process. Valid values are 'Y' or 'N'.
This allows the user to specify whether letters should be produced as a result of the transfer/disenrollment. The valid values for this column are Y/N.
Indicates Resource Link is associated with an NDC (N) or is a Summary level (S) link.
Indicates whether a Level II review is required for this client. (PASRR PRE-ADMISSION SCREEN, Case Information, Level II Needed);
Indicates whether the corresponding provider type requires a license.

Indicates whether or not Medicaid has placed a lien on the currently owned property
Indicates whether a payee should have lien processing in financial. (Valid values: Y or N)
Indicates if permission has been given to share information with the Public Service Commission. Valid values include: BLK = N/A Y = permission has been given N = permission has not been given
Indicates if a procedure can only occur once in the lifetime of a recipient.
Lifetime care indicator
Indicates of property is part of a life estate
Code indicating type of adjustment record claim/encounter represents at claim detail level.
Code indicating type of adjustment record claim/encounter represents at claim detail level.
Code indicating type of adjustment record claim/encounter represents at claim detail level.
Code indicating type of adjustment record claim/encounter represents at claim detail level.
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Linking indicator that allows for multiple criteria assessed prior to an authorization granted
Was this row manually linked?
Was this row manually linked?
Indicates if the applicant lives with their parents
DISCOUNT FORMULA NUMBER THAT IS ASSOCIATED WITH THE LINE ITEM 1 - 1.0 2 - (1.0 + D (U-1)) / U 3 - T/U 4 - (1 + D) / U 5 - D 6 - TD / U 7 - D (1 + D) / U 8 - 2.0 WHERE D = DISCOUNTING FRACTION (CURRENTLY 0.5) WHERE U = NUMBER OF UNITS WHERE T = TERMINATED PROCEDURE DISCOUNT (CURRENTLY 0.5)
LINE ITEM ACTION FLAG - USED IN THE DETERMINATION OF DISCOUNT FORMULA AND ALSO PASSED TO THE PRICER 0 - DENIAL OR REJECTION IS NOT IGNORED 1 - DENIAL OR REJECTION IS IGNORED 2 - EXTERNAL LINE ITEM DENIAL 3 - EXTERNAL LINE ITEM REJECTION 4 - EXTERNAL LINE ITEM ADJUSTMENT

LINE ITEM DENIAL OR REJECTION FLAG 0 - LINE ITEM NOT DENIED OR REJECTED 1 - LINE ITEM DENIED OR REJECTED (PROCEDURE EDIT RETURN BUFFER FOR LINE ITEM CONTAINS A 9, 13, 18-21, 28, 39, 40, 45, 47, 49, 50, 53, 64, 65, 67, 68, 69 2 - THE LINE IS NOT DENIED OR REJECTED, BUT OCCURS ON A DAY THAT HAS BEEN DENIED OR REJECTED (DISCONTINUED AS OF 04/01/2002)
PAYMENT ADJUSTMENT FLAG 0 - NO PAYMENT ADJUSTMENT 1 - ADDITIONAL PAYMENT FOR CURRENT DRUG OR BIOLOGICAL APPLIES TO APC (SERVICE INDICATOR G) 2 - ADDITIONAL PAYMENT FOR DEVICE APPLIES TO APC- (SERVICE INDICATOR H) 3 - ADDITIONAL PAYMENT FOR NEW DRUG OR NEW BIOLOGICAL APPLIES TO APC (SERVICE INDICATOR J; FOR SERVICES PRIOR TO 04/01/2002 ONLY) 4 - DEDUCTIBLE NOT APPLICABLE (SPECIFIC LIST OF HCPCS CODES)
PAYMENT METHOD FLAG 0 - OPPS PRICER DETERMINES PAYMENT FOR SERVICE 1 - BASED ON OPPS OR COVERAGE RULES, THE SERVICE IS NOT PAID 2 - SERVICE IS NOT SUBJECT TO OPPS 3 - SERVICE IS NOT SUBJECT TO OPPS AND HAS OCE LINE ITEM DENIAL OR REJECTION 4 - LINE ITEM IS DENIED OR REJECTED BY FI; OPPS IS NOT APPLIED TO LINE ITEM
PACKAGING FLAG 0 - NOT PACKAGED 1 - PACKAGED SERVICE (SERVICE INDICATOR N, OR NO HCPCS CODE AND CERTAIN REVENUE CODES) 2 - PACKAGED AS PART OF PARTIAL HOSPITALIZATION PER DIEM OR DAILY MENTAL HEALTH SERVICE PER DIEM 3 - ARTIFICIAL CHARGES FOR SURGICAL PROCEDURES (SUBMITTED CHARGES FOR SURGICAL HCPCS < $1.01) 4 - PACKAGED AS PART OF DRUG ADMINISTRATION APC PAYMENT
PAYMENT INDICATOR 1 - PAID STANDARD HOSPITAL OPPS AMOUNT (SERVICE INDICATORS K, S, T, V, X) 2 - SERVICES NOT PAID UNDER OPPS (SERVICE INDICATOR A) 3 - NOT PAID (M, W, Y, E), OR NOT PAID UNDER OPPS (SERVICE INDICATORS B, C, Z) 4 - PAID AT REASONABLE COST (SERVICE INDICATOR F, L) 5 - ADDITIONAL PAYMENT FOR DRUG OR BIOLOGICAL (SERVICE INDICATOR G) 6 - ADDITIONAL PAYMENT FOR DEVICE (SERVICE INDICATOR H) 7 - ADDITIONAL PAYMENT FOR NEW DRUG OR NEW BIOLOGICAL (SERVICE INDICATOR J; SERVICE DATES PRIOR TP 04/01/2002 ONLY) 8 - PAID PARTIAL HOSPITALIZATION PER DIEM (SERVICE INDICATOR P) 9 - NO ADDITIONAL PAYMENT; PAYMENT INCLUDED IN LINE ITEMS WITH APCS (STATUS INDICATOR N; OR NO HCPCS CODE AND CERTAIN REVENUE CODES; OR HCPCS CODES G0176 (ACTIVITY THERAPY), G0129 (OCCUPATIONAL THERAPY), OR G0177 (PARTIAL HOSPITALIZATION PROGRAM SERVICES))

SERVICE INDICATOR A - SERVICES NOT PAID UNDER OPPS B - NON-ALLOWED ITEM OR SERVICE FOR OPPS C - INPATIENT PROCEDURE E - NON-ALLOWED ITEM OR SERVICE F - CORNEAL TISSUE ACQUISITION AND ORPHAN DRUGS G - DRUG/BIOLOGICAL PASS-THROUGH (DESCRIPTION CHANGE 04/01/02) H - DEVICE PASS-THROUGH J - NEW DRUG OR NEW BIOLOGICAL PASS-THROUGH (DISCONTINUED 04/01/2002 AND REPLACED BY SERVICE INDICATOR G FOR ALL DRUGS/BIOLOGICALS) K - NON PASS-THROUGH DRUG/BIOLOGICAL, RADIOPHARMACEUTICAL AGENT, CERTAIN BRACHYTHERAPY SOURCES L - FLU/PPV VACCINES M - SERVICE NOT BILLABLE TO THE FI N - PACKAGED INCIDENTAL SERVICE P - PARTIAL HOSPITALIZATION SERVICE S - SIGNIFICANT PROCEDURE NOT SUBJECT TO MULTIPLE PROCEDURE DISCOUNTING T - SIGNIFICANT PROCEDURE SUBJECT TO MULTIPLE PROCEDURE DISCOUNTING V - MEDICAL VISIT TO CLINIC OR EMERGENCY DEPARTMENT W - INVALID HCPCS OR INVALID REVENUE CODE WITH BLANK HCPCS X - ANCILLARY SERVICE Y - NON-IMPLANTABLE DME, THERAPEUTIC SHOES Z - VALID REVENUE CODE WITH BLANK HCPCS AND NO OTHER SI ASSIGNED
Case selection locked? - (Y/N)
Case selection locked? - (Y/N)
Long Acting Opioid Indicator, product is considered to be a long acting opioid. 1-TRUE 0-FALSE
Indicates whether the drug is covered if the recipient lives a long term care facility. I = Reimbursable Only in LTC Facility. N = Reimbursable Only if NOT in LTC facilty. O = Reimbursable in Either case (default).
Indicates if the policy is an LTC Part B policy
Indicates if the clerk is allowed to request letters and have their Name appear in the signature line of the letter
Indicator to show that the Auto PA criteria will result in a PA letter being generated
Indicates whether the corresponding provider type requires a level of care segment or not.
This is the MAC indicator for the drug code. The following are valid values for the MAC Indicator: F - federal upper limit, S - State Maximum Allowable Cost (MAC), W - wholesale, B - State MAC pricing and wholesale, A - MAC price established by the state; price not calculated through MAC algorithm, (blank) - no upper limit.
Determines whether a DPV return code indicates a Valid or Invalid address. Valid addresses are considered good enough for mailing per Agency Instructions. Possible valid values are: Y - Valid address; N - Invalid address.
A one-character alphanumeric column that identifies a drug as a maintenance drug. Blank = Not a maintenance drug 1 = Maintenance drug

A one-character alphanumeric column that identifies a drug as a maintenance drug. Blank = Not a maintenance drug 1 = Maintenance drug
Yes/No indicator used to identify a program is a major program. A major program is a program that can stand alone. The program needs no other program. A major program can not be combined with any other major program.
A code indicating if the recipient is enrolled in a managed care program.
A code indicating if the provider participates in a managed care program.
This field indicates whether a recipient participates in Managed care.
Indicator that specifies what type of managed care providers are to be included in the list.
(Not used in OK system) This field indicates whether the aid category is a valid aid category for recipient particpation in the Managed Care program.
Indicates whether the expenditure requires a manual check.
An indicator used to specify that the COS is assigned manually from user input. Valid values are 'Y', yes this is a manually assigned COS; and 'N', no this is not a manually assigned COS.
An indicator used to specify that the COS is assigned manually from user input. Valid values are 'Y', yes this is a manually assigned COS; and 'N', no this is not a manually assigned COS.
Will be 'X' if recipient had coverage for March of the tax year. Will be space if the recipient had full year or if no coverage was present for March.
Will be 'X' if recipient had coverage for March of the tax year. Will be space if the recipient had full year or if no coverage was present for March.
This is a Yes/No indicator to specify whether this provider receives mass rate updates.
This is a Yes/No indicator to specify whether this provider receives mass rate updates.
This is a Yes/No indicator to specify whether this provider receives mass rate updates.
This field indicates that a match was found for this claim in the T_CLM_PROCESSED_EXTRACT table. Valid values: 'Y' - match found, 'N' - no match found - default value.
This field indicates that a match was found for this claim in the T_CLM_FACSIMILE_EXTRACT table. Valid values: 'Y' - match found, 'N' - no match found - default value.
This indicator is Y if the system determines that the recipient is exempt from maternity care, otherwise it is a N.
Will be 'X' if recipient had coverage for May of the tax year. Will be space if the recipient had full year or if no coverage was present for May.

Will be 'X' if recipient had coverage for May of the tax year. Will be space if the recipient had full year or if no coverage was present for May.
NOT USED BY ALABAMA 20070701. Manage care indicator identifies claims and other transactions as to how they affect the manage care program. Values (' ' - fee for service, 'F' - Plus fee for service, 'H' - Plus encouter, 'I' - Plus Indian fee for service, 'J' - Choice Indian fee for service, 'M' - Plus Encounter w/ stop loss, 'O' - Choice encounter w/ stop loss, 'P' - Choice encounter, 'R' - Choice fee for service, 'W' - Choice fee for service requiring recovery, 'Y' - Plus fee for service requiring capitation recovery,
Indicates provider is exempt from requiring a Medicaid Surety Bond: Y = Exempt (bond not required), N = Not Exempt (bond required), blank = N/A.
Indicates provider is exempt from requiring a Medicare Accreditation Letter: Y = Exempt (letter not required), N = Not Exempt (letter required), blank = N/A.
Indicates provider is exempt from requiring a Medicare Surety Bond: Y = Exempt (bond not required), N = Not Exempt (bond required), blank = N/A.
Medicare claim control indicator. This number restricts the update of Medicare claim number.
Yes/No indicator used to identify drugs covered by Medicare. A "N" (no) indicates the drugs is not covered by Medicare. This attribute is manually entered.
This column is used to indicate which exclusion table rows are for Managed Care exclusions specifically.
Code indicating that the amt pd by XIX/CHIP toward the XVIII deductible was combined with coins amt
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The media type that the letter was sent on. Valid values will be F-Fax, P-Paper
Yes or No to indicate if the member had Medicare insurance at the time the capitation was created.
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Indicates if Medicare coverage should be utilized as part of the demographics when determining a recipient's capitation category.
This is the Part A Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
This is the Part B Medicare indicator. Values include 'P' for Pending, 'Y' for Yes, 'N' for No.
Indicates if unpaid medical expenses have been incurred
Indicates if the service requires Medical Review.
Indicates if the service requires Medical Review.
Indicate if the provider met the audit criteria. Values: Y - Met the audit criteria N - Did not met the audit criteria
Indicator if the record represents a message. Default is file.
This is a YES/NO indicator to tell the system whether this program is a managed care program. This allows PMP service locations to specify which Managed Care program they are allowed to provide services for.
Indicates if the recipient was enrolled in a managed care plan when the claim was adjudicated. Valid values are Y and N.
Indicates if the recipient was enrolled in a managed care plan when the claim was adjudicated. Valid values are Y and N.
This indicator displays where a claim does not require a referral. The following are the valid values: N - Procedure does not require a referral D - Dummy referring provider. E - Emergency O - Edit was overridden P - Billing or Performing provider is the PMP A - Allowed provider as designated by the PMP or the group tables is the performing or billing provider R = PMP is the referring provider S = PMP designee is the referring .
The field contains the managed care referral indicator. 'N' 'PROCEDURE DOES NOT REQUIRE A REFERRAL' 'D' 'DUMMY REFERRING PROVIDER' 'E' 'EMERGENCY' 'G' 'GRACE PERIOD' 'O' 'EDIT WAS OVERRIDDEN' 'P' 'BILLING OR PERFORMING IS PMP' 'A' 'BILLING OR PERFORMING IS PMP DESIGNEE' 'R' 'REFERRING PROVIDER IS PMP' 'S' 'REFERRING PROVIDER IS PMP DESIGNEE'
This code is set to Y when the claim is a managed care referral, otherwise it is a N.
This indicator identifies those determination codes that are no longer used. A value of "Y" indicates those that are obsolete.
Indicates whether the claimant is applying for Medicaid for Low Income Families. Valid values are 'Y' for Yes, 'N' for No and 'Blank' for Unknown or N/A
MME Factor Available. For multi-ingredient products containing more than one opioid, this indicator will only be true. Valid values 1-True, 0-False.
Indicates if the drug requires a Medical Necessity PA. Valid values are: Y=yes, N=no, blank=does not participate.
Indicates if the recipient was enrolled in an hmo/hio when the claim was adjudicated.

Identifies that the recipient receives a Money Grant. The value will always be an N in the OK MMIS.
Indicates if the property is a mobile home
Indicates if modifier editing is required for the procedure code. A value 'N' indicates no modifier editing should be performed. A 'Y' indicates that modifier restrictions exist for the procedure code. A value of 'Y' and no rows on the table T_COV_MOD_AXIS_RANGE means that this coverage condition for the procedure code will not apply if any modifier appears on the claim.
Indicates if modifier editing is required for the procedure/program combination. A 'N' indicates no modifier editing should be performed. An 'E' indicates modifier editing is required and all corresponding modifier codes are excluded for a given procedure/BP. A 'I' indicates modifier editing is required and only corresponding modifier codes are valid for a given procedure/BP.
Indicates if modifier editing is required for the procedure/program combination. A 'N' indicates no modifier editing should be performed. An 'E' indicates modifier editing is required and all corresponding modifier codes are excluded for a given procedure/BP. A 'I' indicates modifier editing is required and only corresponding modifier codes are valid for a given procedure/BP.
Indicates whether there is more buy-in billing information kept on file because of a mismatch between CMS and the State MMIS.
Indicates whether there is more buy-in billing information kept on file because of a mismatch between CMS and the State MMIS.
Indicator for Moved IN or Moved OUT. Valid values are: I - Moved IN, O - Moved OUT.
This indicator identifies those determination codes that are no longer used. A value of "Y" indicates those that are obsolete.
Set to "Y" if this variable holds not just one instance of the domain for the TRANSACTION VARIABLE, but an ordered collection of domain instances. Else set to "N".
Although the relationship of this table is one to one with T_TRANSACTION_VARIABLE it must be split off from T_TRANSACTION_VARIABLE because of its complex structutre.
A flag indicating if the service is a multiple surface restoration dental service. Valid values are Y and N.
This is an indicator of whether a name is that of a person or an organization. The current valid values are: B - Business, P - Personal Name.
This is an indicator of whether a name is of a person or an organization.
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This is an indicator of whether a name is that of a person or an organization. The current valid values are: B - Business P - Personal Name
Indicator for Name type "B"usiness, "P"ersonal
Indicator for Name type "B"usiness, "P"ersonal
The NDA Status Indicator is a one-character numeric column that identifies an NDC that was approved under a New Drug Application (NDA). FDA application numbers that are below 30,000 and between 50,000 and 59,999 are interpreted as New Drug Applications (NDA). Valid values are: 0 - Not approved under an NDA. 1 - Approved under an NDA.
This is used to indicate that service is authorized at the NDC level or GCN sequence number level.
Indicate when NDC was required for claims payments. Possible valid values are 'Y' or ' '.
Indicator showing whether the prescription being filled was a new prescription or a refill.
This indicator identifies those NF disposition codes that are no longer used. A value of "Y" indicates those that are obsolete.
Will be 'X' if recipient had coverage for November of the tax year. Will be space if the recipient had full year or if no coverage was present for November.
Will be 'X' if recipient had coverage for November of the tax year. Will be space if the recipient had full year or if no coverage was present for November.
Indicates the family has no income. Valid values are 'Y' for Yes, 'N' for No and 'Blank' for Unknown
SUR's case open as a result of this referral? - (Y/N)
"Temporary Column: Trigger action indicator 'C': Updated cde_service_loc 'S': Updated sak_prov_loc"
Temporary column until the NPI solution is completed. Then this will be removed.
For NPI entries, indicates if this NPI has been validated with NPPES.
Indicates whether the drug was dispensed for a recipient who resides in a nursing home facility.
Indicates whether the drug was dispensed for a recipient who resides in a nursing home facility.
Indicates whether the recipient is in a nursing home.
Indicates if the PCP accepts women who are pregnant.
Indicates whether a PMP provides obstetric services in their practice.
Obsolete.
Indicates whether a PMP provides obstetric services in their practice.

Indicates whether a PMP provides obstetric services in their practice.
Used to restrict rows on T_COVERED_BENEFIT to occurrence code on the claim. A value of 'N' indicates no occurrence editing should be performed. A 'Y' indicates that occurrence restrictions exist for the benefit. A value of 'Y' and no rows on the table T_COV_OCC_AXIS_RANGE means that this coverage condition for the benefit will not apply if any occurrence code appears on the claim.
Used to restrict rows on T_PAYABLE_BENEFIT to occurrence code on the claim.
Will be 'X' if recipient had coverage for October of the tax year. Will be space if the recipient had full year or if no coverage was present for October.
Will be 'X' if recipient had coverage for October of the tax year. Will be space if the recipient had full year or if no coverage was present for October.
Indicates whether a Provider is an off-site EPSDT screener. Valid values are "Y"es, "N"o.
This field if set to 'Y' means that the reason code is associated with a disposition that will be posted online. A 'N' value will indicate posting in Batch
A flag indicating if the service is a one surface restoration dental service. Valid values are Y and N.
Indicator for DRG should be suspended for review Poss values are Y or space (space is the default)
This field indicates whether a provider is on review.
Indicates whether a Provider is Out-Of-State (OOS). Valid values are "Y"es, "N"o.
Out of state indicator - used for claims pricing.
Used to indicate whether a procedure requires the use of an operating room.
This is the letter that represents the sort order of the top ten drugs (P=prescriptions; A=Amount).
The field denotes whether the insured party is covered under other insurance plan
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Indicates whether this payer allows other payers to recoup funds from this payers claim payments or if this payer does not allow this.
Indicates whether this payer allows other payers to recoup funds from this payers claim payments or if this payer does not allow this.
Indicates whether the Pro-DUR warning was against a claim submitted by the same or a different pharmacy as the current claim.

Indicates whether the ProDUR warning was against a drug prescribed by the same or a different physician as the current claim.
Indicates if the alert is overrideable by the pharmacist. Currently not used.
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This field indicates if criteria can be overridden. Y= Override able N=Non-override able.
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This field indicates whether the criteria can be overridden. Y= Override able N=Non-override able. This field is not currently used.
This field indicates if criteria can be overridden. Y= Override able N=Non-override able. This field is not currently used by the system.
This field indicates whether criteria can be overridden. Y= Override able N=Non-override able. This field is currently populated but not used.
Yes/No indicator used to identify drugs that will not be edited for a 34 day supply. An indicator of Y (yes) will bypass editing.
This field indicates whether criteria can be overridden. Y= Override able N=Non-override able. This field is currently populated but not used.
This field indicates if the criteria can be overridden. Y= Override able N=Non-override able. This field is populated but not used in the current system.
Indicates if the alert is overrideable by the pharmacist. Currently not used.
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This field indicates if criteria can be overridden. Y= Override able N=Non-override able.
This data item indicates if a criteria can be overridden. Override able = Y Not Override able = N. This field is not currently used.
Indicates if the alert is overrideable by the pharmacist. Currently not used.
This field indicates if criteria can be overridden. Y= Override able N=Non-override able. This field is populated but not currently used.
This field indicates if criteria can be overridden. Y= Override able N=Non-override able. This field is populated, but it is not currently used.
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Indicates if the alert is overrideable by the pharmacist. Currently not used.
Determines whether a DPV code showing an invalid address can be overridden and the address saved. Possible valid values are: Y - override DPV code and allow address to be saved; N - do not override DPV code.
This field is the override indicator that is used within the claims engine process. Valid values are "Y" or "N".
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This field indicates if criteria can be overridden. Y= Override able N=Non-override able.
Indicates if the alert is overrideable by the pharmacist. Currently not used.
This field indicates if criteria can be overridden. Y= Override able N=Non-override able.
This indicator denotes whether a provider has an ownership interest in another provider's business.
Home owner indicator
Indicates whether prior authorization is required.
Indicates whether prior authorization is required.
Indicates if Prior Authorization (PA) is required for the procedure/program combination. A 'Y' indicates PA is required. A 'N' indicates PA is not required. If the indicator is 'Y', other PA restrictions such as age or place of service (POS) limits may apply.
Indicates if Prior Authorization (PA) is required for the activation indicator/program combination. A 'Y' indicates PA is required. A 'N' indicates PA is not required.

Indicates if Prior Authorization (PA) is required for the drug represented by the NDC. A 'Y' indicates PA is required. A 'N' indicates PA is not required.
Indicates if the drug requires PA. Valid values are: Y=yes, N=no, blank=does not participate.
Indicates that claim was approved by using a PA.
Indicates that claim was paid using a PA.
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Indicates that claim was paid using a PA.
Indicates if Prior Authorization (PA) is required for the procedure/program combination. A 'Y' indicates PA is required. A 'N' indicates PA is not required. If the indicator is 'Y', other PA restrictions such as age or place of service (POS) limits may apply.
Indicates whether or not the claim was paid or denied. Values are 'P' or 'D'.
A flag indicating if the service is a palliative treatment dental service. Valid values are Y and N.
This column specifies that the provider is not accepting new recipients. If the value is set to 'Y', then any/all values for T_MC_PMP_PANEL_RESTRICT.IND_PANEL_HOLD are IGNORED. If the value is set to 'N', then the values in T_MC_PMP_PANEL_RESTRICT.IND_PANEL_HOLD are utilized.
Obsolete
This column allows the user to halt new assignments for the Inclusion restriction.
Allow override of the PMP's panel hold. Valid values are: Y and N.
Indicates if Pharmacy provider is allowed to bill on paper media. Valid values are Y = YES (Paper media allowed) and N = No (POS only)
Explanation of Benefits (EOB) Indicator. Indicates whether (Yes) or not (No) a paper EOB is requested. Component of Claim Information.
This indicates whether or not a beneficiary had chosen not to be auto-enrolled by CMS in a Medicare Part D plan. Values: Y = YES N = NO.
This is an indicator which will be set to a value of "Y" if the NDC was a Part D excluded drug and the recipient was eligible for Medicare (Part A or Part B). It will be set to "N" otherwise.
This is an indicator which will be set to a value of "Y" if the NDC was a Part D excluded drug and the recipient was eligible for Medicare (Part A or Part B). It will be set to "N" otherwise.
This is an indicator which will be set to a value of "Y" if the NDC was a Part D excluded drug and the recipient was eligible for Medicare (Part A or Part B). It will be set to "N" otherwise.
This is an indicator which will be set to a value of "Y" if the NDC was a Part D excluded drug and the recipient was eligible for Medicare (Part A or Part B). It will be set to "N" otherwise.

This indicator identifies those PASRR codes that are no longer used. A value of "Y" indicates those that are obsolete.
NCPDP Field 391-MT, code to indicate a patient's choice on assignment of benefits. Values are Y - Patient has assigned benefits to another party, N - Patient has not assigned benefits to another party.
Family member paternity established indicator
Payee indicator; Values: Blank = Not a SOBRA payee Y = Person is SOBRA payee with SOBRA application segment T = SOBRA (transferred during AMAES 1991 conversion)
Payee indicator. 'Y' indicates this is the payee.
The field denotes whether the claim payment is made at the header level or the detail level.
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The field denotes whether the claim payment is made at the header level or the detail level.
The field denotes whether the claim payment is made at the header level or the detail level.
Used to restrict row on T_PAYABLE_BENEFIT to any other benefit.
Indicates if any member of the household receives paid day care services
Indicates if a claim's detail paid as the result of a PA or having a benefit limit audit forced. Valid values are: P - dtl paid as the result of a PA, F - dtl paid as the result of a forced benefit limit audit, Space - Default value - dtl paid through normal means.
Indicates if a claim's detail paid as the result of a PA or having a benefit limit audit forced. Valid values are: P - dtl paid as the result of a PA, F - dtl paid as the result of a forced benefit limit audit, Space - Default value - dtl paid through normal means.
If system determines that PA is required for this claim/detail to pay the indicator will be Y, otherwise it will be N.
Indicates whether a Provider is a published EPSDT screener. Valid values are "Y"es, "N"o.
Indicates if the group member actually sees recipients. This would be set to 'N' if the group member is a clinic, hospital, etc...
This is an indicator for Provider verification. The valid values are: Claims (C) and Board Certification (B).
Plastic card address change indicator
This indicates type of professional or technical component.
Identifies the extent to which professional and technical components of a service apply. Valid values and definitions may be found on the medicare fee schedule record layout.
Indicates preferred drug status. Valid values are: Y=Preferred, N=Non-preferred, blank=Does Not Participate.

PDL Indicator. Indicates the PDL status of the NDC, i.e. whether the drug or drug product is preferred (Y) or non-preferred (N).
PDL Indicator. Indicates the PDL status of the NDC, i.e. whether the drug or drug product is preferred (Y) or non-preferred (N).
Indicates the PDL Assignment status of the NDC, and how it was updated.. 'F' = FDB update process 'R' = PDL Rules 'U' = UI Panel 'M' = Manually set by SE 'P' = PDL Assingment Complete ' ' = Never PDL assigned
Indicates whether the corresponding provider type requires a peer group or not.
Indicator telling whether this exemption is permanent. Valid values are "N"o, "Y"es.
This field indicates if a claim was submitted through PES by the billing provider. Valid values are Y - Yes and N - No.
Indicator to determine if the HIPAA code is also a valid reason code for PLA segment on HIPAA 834 Transaction. Valid values are Y - Yes and N - No.
Y/N value to identify whether this plan type is used for identifying plan types for the PDP_PLAN table.
Plastic card warning. Valid values include: Blank = N/A Y = Warning letter sent to recipient
This field indicates whether a provider participates in Managed care.
This field contains the provider policy adjuster indicator. Values are 'N' or 'Y'. Y means the DRG pediatric or adult policy adjuster is applied. No means it is not applied.
Policy Adjuster is a Y or N value. Yes means the DRG policy adjustors (multipliers) apply to claims from that provider; No is the Default and means the DRG policy adjustors do not apply to claims from that provider
This field contains the provider policy adjuster indicator. Values are 'N' or 'Y'. Y means the DRG pediatric or adult policy adjuster is applied. No means it is not applied.
N = Do not apply service adjuster, Y = Apply service adjuster
Were there policy recommendations resulting from this case? - (Y/N)
Indicates (Y/N) whether place of service will be used as a limit criteria.
Indicates (Y/N) whether place of service will be used as a limit criteria.
Indicates if place of service (POS) editing is required for the procedure/program combination. A 'N' indicates no POS editing should be performed. A 'E' indicates POS editing is required and all corresponding POS codes are excluded for a given procedure/BP. A 'I' indicates POS editing is required and only corresponding POS codes are valid for a given procedure/program.

Indicates if place of service (POS) editing is required for the procedure/program combination. A 'N' indicates no POS editing should be performed. A 'E' indicates POS editing is required and all corresponding POS codes are excluded for a given procedure/BP. A 'I' indicates POS editing is required and only corresponding POS codes are valid for a given procedure/program.
Designates if Place of Services are Included, Excluded, or not restricted for this row.
This is an indicator which will tell us if the NDC was on the preferred drug list at the time the claim processed. Value of "Y" indicates the NDC was preferred, a value of "N" indicates non-preferred.
This is an indicator which will tell us if the NDC was on the preferred drug list at the time the claim processed. Value of "Y" indicates the NDC was preferred, a value of "N" indicates non-preferred.
This is an indicator which will tell us if the NDC was on the preferred drug list at the time the claim processed. Value of "Y" indicates the NDC was preferred, a value of "N" indicates non-preferred.
Indicates whether drug is related to the condition of being pregnant.
Indicates whether service is related to condition of being pregnant.
Indicates whether service is related to condition of being pregnant.
Indicates if the diagnosis is for a pregnancy.
The indicator tells whether there is a pregnant woman applying for Medicaid in the household
Indicates whether the Diagnosis code is for pregnancy (P) or termination of pregnancy (T).
Indicates whether drug is related to the condition of being pregnant.
Indicates whether service is related to condition of being pregnant.
Indicates if a medical procedure is related to a pregnancy.
Indicates whether service is related to condition of being pregnant.
Indicates whether service is related to condition of being pregnant.
A flag indicating the individual is pregnant
Indicates if pregnancy has been verified
Indicates the options for performing immunizations for EPSDT eligible recipients.
Indicates the options for performing screenings for EPSDT eligible recipients.
Defines how the rows in T_PRICING_CLAIM_TYPE should be used to restrict rows on this table.

Values are I - include; E - exclude; N - no restriction restriction by claim type.
Indicates the method used to price the service or product.
Indicator to show what pricing formula was used.
Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.
Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.
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Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.
Pricing indicator which dictates the method by which a procedure must be priced or indicates how a claim detail was priced.
Indicator which shows which benefit plan has paid, or is the most payable. Possible values are Y or N.
Indicates primary diagnosis codes cannot be billed. The valid values are Y/N.
Indicates if the recipient is the primary on the HIPP Policy.
Indicates whether this is considered the Provider's primary address. Valid values are Y - Yes and N - No.
Indicates whether this is the provider's primary specialty. The valid values are: Y - Yes and N - No.
Indicates if this is the primary taxonomy associated with this provider
Indicates if this is the primary assignment for the given program. In order to allow multiple assignments to the same program, (i.e. the recipient is assigned to an OB/GYN and assignment to a Family Practitioner at the same time) a single assignment MUST be designated as the primary assignment so that enrollment counts for a program are not exaggerated, etc... The assignment that gets marked as primary is determined by the focus of the PMP.
Indicates if this is the primary assignment for the given program. In order to allow multiple assignments to the same program, (i.e. the recipient is assigned to an OB/GYN and assignment to a Family Practitioner at the same time) a single assignment MUST be designated as the primary assignment so that enrollment counts for a program are not exaggerated, etc... The assignment that gets marked as primary is determined by the focus of the PMP.
Indicator whether row is for the primary field for the error

Entity represented by this row. This is set to Y if the SAK_PARTY_IDENTIFIER is populated from NM109 attribute of the NM1 segment The value is set to N if SAK_PARTY_IDENTIFIER is populated from the REF02 attribute of the REF segment meaning that it is a secondary identifier.
Entity represented by this row.This is set to Y if the SAK_PARTY_IDENTIFIER is populated from the NM109 attribute of the NM1 segment The value is set to N if SAK_PARTY_IDENTIFIER is populated from the REF02 attribute of the REF segment meaning that it is a secondary identifier of the the entity represented by this row.
Indicates if this service location is the PMP's primary location.
Indicates if this service location is the PMP's primary location.
As of implementation for OK, EPSDT/Family Planning deductions and supplemental delivery payments will have a value of 'N'. All other capitation categores will have a value of 'Y'.
A flag indicating the eligibility record is the primary eligibility.
Individual print detail
Indicator of whether new file reported has been printed
Indicates if priority should be given to the case. Y=Yes, N=No
Indicates whether any household member has received TANF within the last four months
This specifies if private/confidential information for recipients who are in this capitation category should be displayed on external reports. An example of a capitation category that should not have recipient's personal information displayed are the 'Family Planning' deductions. Valid values are 'Y' or 'N'.
Indicates if applicant receives parental support alimony
Indicates whether or not the expenditure payment has processed through the financial batch cycle.
Indicates whether or not the expenditure payment has processed through the financial batch cycle.
Indicates whether or not the expenditure payment has processed through the financial batch cycle.
Indicates status of the report ("N" = Not processed and "Y" = Processed).
This indicator is used by the automated process to determine when a in released status needs to be processed. N = record not processed, Y = record processed.
This is the report requested.
Indicates the procedures should be included ('I') or excluded ('E').
Indicates whether the associated list of procedure codes is valid or invalid for the place of service.
Indicates whether the associated list of procedure codes is valid or invalid for the specialty.

This field indicates whether the associated drug, revenue code, or procedure range is included or excluded from the billing restrictions for a provider.
An indicator used to specify if the procedures defined by SAK_PROC_TYPE should be included ('I') or excluded ('E').
Code which indicates whether the associated list of procedure codes is valid or invalid for the type of bill.
A flag indicating if the service is a prophy dental service. Valid values are Y and N.
This specifies if the capitation category should be pro-rated on a daily basis, or if it applies to an entire month only. Valid values are 'Y' or 'N'.
Protected resource indicator
An indicator used to specify that a SAK provider(s) is needed for MAR COS assignment. Valid values are 'Y', yes SAK provider criteria available for this COS; and 'N', no SAK provider criteria available for this COS.
NCPDP field 361-2B, Code indicating whether the provider accepts assignment. Values are Y - Assigned, N - Not Assigned.
Case selection from Deselection List? - (Y/N)
Provider Benefit Indicator
Provider Benefit Indicator
Provider/Client indicator - (R/P).
An indicator used to specify that a SAK provider(s) is needed for MAR COS assignment. Valid values are 'Y', yes SAK provider criteria available for this COS; and 'N', no SAK provider criteria available for this COS.
Indicates whether the paper claim form was signed by the provider who performed the service.
Used to indicate whether or not there was a valid provider signature on the original claim.
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Is the analyst allowed to work on all provider types? - (Y/N)
Indicates if this type of provider ID should be generated and not entered.
Indicates if this type of provider ID can only be active for one provider service location for any specific date.
Override Billing Provider calculation.
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Override Billing Provider calculation.
Override Billing Provider calculation.
Override Billing Provider calculation
Override Billing Provider calculation.
Override Attending Provider calculation.
Override Attending Provider calculation.
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Override Facility Provider calculation.
Override Facility Provider calculation.
Override Facility Provider calculation.
Override Ordering Provider calculation.
Override Ordering Provider calculation.
Override Ordering Provider calculation.
Override Other Provider 1 calculation.
Override Other Provider 1 calculation.
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Override Other Provider 2 calculation.

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Override Performing Provider calculation.
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Override Performing Provider calculation
Override Prescribing Provider calculation. Valid values are "Y" - Yes, "N" - No, or space - No (default).
Override Prescribing Provider calculation. Valid values are "Y" - Yes, "N" - No, or space - No (default).
Override Prescribing Provider calculation. Valid values are "Y" - Yes, "N" - No, or space - No (default).
Override Referring Provider 1 calculation.
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Override Referring Provider 2 calculation
Override Rendering Provider calculation.
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Override Rendering Provider calculation.

Override Rendering Provider calculation.
Override Rendering Provider calculation.
Override Rendering Provider calculation.
Identifies the combinations of Provider type/specialties applicable to this row of conditions. Values are I - include; E - exclude; N - no restriction. A value of 00 or 000 for type or specialty represents no restriction on type or specialty, respectively.
This field corresponds to Field 5 of the NCCI MUE data, containing the publication indicator. The valid values are 0 (confidential - do not share) and 1(published - ok to share). Please refer to the NCCI documentation for more information about this field.
This field corresponds to Field 5 of the NCCI MUE data, containing the publication indicator. The valid values are 0 (confidential - do not share) and 1(published - ok to share). Please refer to the NCCI documentation for more information about this field.
An indicator used to specify if the provider's public/private status is needed for MAR COS assignment. Valid values are 'P', this COS is only used if the provider is a public provider; 'V', this COS is only used if the provider is a private provider; and 'X', public/private status not checked for COS assignment.
A flag indicating if the service is a pulp cap dental service. Valid values are Y and N.
This identifies whether the policy will be purchased.
Qualifying Income Trust indicator
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.

Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
Valid values are Y-Yes, and N-No. When field has value of Y, it indicates recipient's race characteristics.
A flag indicating if the service is a radiograph dental service. Valid values are Y and N.
An indicator to specify the ranking or hierarchy of the MAS/BOE assignment.
Indicates if the error should be posted on the RA.
Indicates if the error should be posted on the RA.
Indicates if the RCO is required to perform the service for the PA assignment code/service type. Possible values are Y or N.
Used to indicate whether or not this is a reason code for recipient auto-assignment that can be changed by the clerk.
Indicates if the MCO service area will accept systematic re-assignment of clients between 90 days and 6 months of disenrollment. Valid values are "Y" and "N".
Indicates if the MCO will accept systematic reassignment of clients within 90 days of disenrollment even if the MCO has exceeded its maximum enrollment. Valid values are "Y" and "N".
Indicates if this drug is covered under Rebate. However the NDCs in a Rebate Exclusion list are excluded. Valid values are: Y=yes, N=no, blank=does not participate.
An indicator to identify claim lines with an NDC that is eligible for the drug rebate program.
Indicator to determine if AR is to pass thru the rebilled process.
Indicator whether the move in/out person is receiving SSI payments. Valid values are: Y - Yes, N - No.
Can the analyst work on client cases? - (Y/N)
Indicates if the MCO service area will allow a client to choose them. Valid values are "Y" and "N".
Case selection from Deselection List? - (Y/N)
Yes/No indicator used to identify programs that are used for recipient enrollment only. No services are covered by the program.
Indicates whether the CMS field contains key information (i.e. Member number, Provider number, Claim ICN). Valid values are Y/N.
Indicates whether this payer is allowed to recoup funds from other payers claims payments or only recoup funds from the same payers claim payments.

Indicates whether this payer is allowed to recoup funds from other payers claims payments or only recoup funds from the same payers claim payments.
Indication of whether the record is rejected or accepted. Valid values are 'Y' (Rejected) or 'N' (Accepted).
The presence of a "1" in this field means that the reduced Part A premium rate applies, otherwise it is blank.
The presence of a "1" in this field means that the reduced Part A premium rate applies, otherwise it is blank.
Indicates that the LOCEU has sent an e-mail to the DMH or the DHS informing them that a referral is requested.
The family planning indicator
This allows the benefit pricing to be varied if another benefit is found on the claim that matches one of the benefit listed on the associated table. Allowed values are "N" - meaning no restriction; "I" - included; "E" - excluded.
Designates if Benefit Plans are Included, Excluded, or not restricted for this row.
Indicates if condition codes are used to price the benefit (usually a revenue code). Allowed values are "E" or "I" to exclude or include condition codes, respectively.
Designates if CONTRACTS are Included, Excluded, or not restricted for this row.
Indicates if modifiers are used to price the benefit. Allowed values are "E" or "I" to exclude or include modifiers, respectively.
This indicates if there is a PROVIDER location restriction related to the benefit. Allowed values are "N" - meaning no restriction; "I" - included; "E" - excluded.
Identifies the combinations of Provider type/specialties applicable to this row of conditions.
Values are I - include; E - exclude; N - no restriction. A value of 00 or 000 for type or specialty represents no restriction on type or specialty, respectively.
Identifies if regions are included, excluded or not restricted from this row. Values are 'I', 'E', or 'N'.
This indicates if there is a RECIPIENT location restriction related to the benefit. Allowed values are "N" - meaning no restriction; "I" - included; "E" - excluded.
Indicates whether or not a request will be made to reissue the check or not. 'Y' to reissue the check or 'N' to not reissue the check.
Indicates whether the record was accepted or rejected. Valid values are (Y/N).
OI - Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data
OI - Code identifying whether the provider has on file a signed statement by the patient authorizing release of medical data
This indicates if there are any other cases related to this case.

This indicates if there are any other cases related to this case.
Indicates if rent or utilities are paid
Identifies a product as repackaged or not repackaged. 0 - Not repackaged 1 - Repackaged
Indicates if the criteria is for provider mailing labels or for the provider report list.
This is the type of federal reporting that this went through. If it is for1099 the value is '1'. If it is for W2 it will be a 'W'.
Indicates whether DMH or DHS has received or responded to the referral request. (PASRR PRE-ADMISSION SCREEN, Referral, Request Rcvd)
Indicates whether DMH or DHS has received or responded to the referral request. Resident Review Screen, Resident Reviews,)
Either "Y" or "N". "Y" means that all rules of this type must have that variable in their condition, which also means we can hash by that variable.
Other resources indicator
Indicates the type of restriction: ('1') Provider type/spec only, ('2') drug code only, ('3') Both Provider type/spec and drug code.
Indicates the type of restriction: ('2') Provider type/spec only, ('1') procedure code only, ('0') Both Provider type/spec and procedure code.
Indicator displaying whether a recipient is locked in or locked out of provider services.
Indicator to show whether the recipient is locked in or locked out of the associated diagnosis ranges.
Indicator to show whether the recipient is locked in or locked out of the associated drugs.
Indicator to show whether the recipient is locked in or locked out of the associated procedure ranges.
An indicator used to specify the type of restriction(s): ('0') State Programs Categories assigned differently than all other categories; ('1') Provider Type/Specialty, Claim Type and Other Criteria; ('2') Provider Type/Specialty and Claim Type; ('3') Provider Type/Specialty and Other Criteria; ('4') Provider Type and Other Criteria; ('5') Provider Type/Specialty only; ('6') Provider Type only; ('7') Other Criteria only; ('8') Claim Type only.
Indicates the type of restriction: ('0') Revenue Code only, ('1') Specific providers only, ('2') Procedure Code only, (3) Provider and Procedure Code
Indicator displaying whether a beneficiary is locked in or locked out of provider services.
Medicare Retroactive Determination Indicator. If the row is updated with dates on or before the current system date, the indicator is set to 'Y'. The only time the indicator is reset from 'Y' to 'N' is when the Medicare Billing Process has used the row.

Medicare Retroactive Determination Indicator. If the row is updated with dates on or before the current system date, the indicator is set to 'Y'. The only time the indicator is reset from 'Y' to 'N' is when the Medicare Billing Process has used the row.
This code is a 'Y' if the recipient has been granted retroactive eligibility for any portion of the claim service period, otherwise it is N.
Indicator used to identify a SUR review is in progress. Valid values: Y - Yes, N - No.
The answer returned by the rule engine. U - Unknown or cannot answer T - True F - False
The decision returned by the rule engine. U - Unknown or cannot answer T - True F - False
Indicates whether the file has been resent (Y) or needs to be resent (R)
Indicates whether the file has been resent (Y) or needs to be resent (R)
Indicator shows the risk level was adjusted manually.
A flag indicating if the service is a root canal dental service. Valid values are Y and N.
The valid values are: Space - do not select claims with this error to report; L - Report the claims at a summary level on the CLM-0024-D report; W - Report the claims on a general paper worksheet which is the CLM-0023-D report.
Indicates whether or not a check requires the return to sender information.
An "X" indicates that the review form has been received in the district office
An "X" indicates that the review form has been received in the district office
Y/N flag to check ndc/generic code match to J codes
Y/N flag to check ndc/generic code match to J codes.
LVX Scheduled Indicator. (Y=Yes, N=No, P=Processing)
Indicator that shows whether or not the transaction should be scheduled for processing from the scheduling user interface.
Used to determine if the edit prevents short term spenddown from applying
Used to determine if the edit prevents short term spenddown from applying.
A flag indicating if the service is a sealant dental service. Valid values are Y and N.
Security destruct? - (Y/N)
A flag indicating if the service is a sedative filling dental service. Valid values are Y and N.
Has the case been selected? - (Y/N)
Provider/Client selected? - (Y/N)
YES/NO field that will hold whether the calculation has been selected for possible enrollment

This indicates whether or not to send a copy of the determination to DMH. (ICF/MR SCREEN, ICF MR Approval, Send To DMH?)
Indicates whether or not an additional notice letter has been sent. Y=Yes, N=No
Indicates whether or not an initial notice letter has been sent. Y=Yes, N=No
Indicator if trading partner is expecting 997 Acknowledgement for the EDI documents they send us.
Will be 'X' if recipient had coverage for September of the tax year. Will be space if the recipient had full year or if no coverage was present for September.
Will be 'X' if recipient had coverage for September of the tax year. Will be space if the recipient had full year or if no coverage was present for September.
This indicates if a service provider is required entry for the assignment code.
A flag to indicate whether or not a severity score could be computed. Valid values are 0, 1.
A flag to indicate whether or not a severity score could be computed. Valid values are 0, 1.
A flag to indicate whether or not a severity score could be computed. Valid values are 0, 1.
A flag to indicate whether or not a severity score could be computed. Valid values are 0, 1.
Sent to CMS
Sent to CMS
Determines if spenddown is for LTC or short term. Values are: 'A', 'B' for Crossover related data; 'M','S' for Spenddown related data; 'N','P' for Patient Liability related data.
Indicates when Nursing Home stay is anticipated to be less than 90 days. If Y = short term, if N means Not short term or Not Applicable.
Indicates when Nursing Home stay is anticipated to be less than 90 days. Y=short term and N means not applicable or long term
A flag indicating if the service is a simple extract dental service. Valid values are Y and N.
Sold property indicator
Indicates services subject to payment adjustments based on site of service.
Indicates services subject to payment adjustments based on site of service.
This is the source of the transaction ('A' = automatic batch process, 'M' = manual creation or modification).
This is the source of the transaction ('A' = automatic batch process, 'M' = manual creation or modification).
The 1 byte source indicator that specifies the external entity that triggered a HIB addition or update.

The 1 byte source indicator that specifies the external entity that triggered a HIB addition or update.
Indicator identifying whether the A/R was created by the system through billing jobs, or manually by a user.
Indicator identifying whether the A/R was created by the system through billing jobs, or manually by a user.
Indicates whether the source drug is generic according to State defined criteria. Valid values are: 0 - Non-drug item, 1 - Generic Product, 2 - Brand Product.
Whether the source requires prior authorization. Valid values are: Y = yes, N = no, SPACE = does not participate.
Whether the source is in the PDL. Valid values are: Y = yes, N = no, SPACE = does not participate.
Indicates if there are special considerations concerning the prior authorization request. Valid values are "Y" or "N".
Indicates if the PCP accepts recipients who have special conditions.
Indicates whether the PMP offers special services at this location for special patient conditions.
Obsolete.
Indicates whether the PMP offers special services at this location for special patient conditions.
Indicates whether the PMP offers special services at this location for special patient conditions.
Indicates if the recipient has any special health needs.
Indicates if the beneficiary has any special health needs.
Not currently used.
This field indicates whether the associated provider specialty is included or excluded from the billing restrictions for a revenue code.
An indicator that denotes that claims in excess of a pre-determined number of claim lines.
An indicator that denotes that claims in excess of a pre-determined number of claim lines.
Indicates whether or not the sponsor's name and address is used on correspondence. Y=Yes, N=No
Spousal impoverishment indicator
Indicates whether the final decision detemines that special services are required. (PASRR PRE-ADMISSION SCREEN, Determinations, Special Services?)
Indicates whether the final decision detemines that special services are required. Resident Review Screen, Resident Reviews, Special Services)
A flag indicating if the individual is enrolled in Social Security Disability Insurance (SSDI)
A flag indicating if the individual receives Supplemental Security Income.
Indicates if the recipient has ever received SSI
Indicates whether the state uses the eligible person`s SSN instead of an MSIS ID number.

Indicates if family member SSN has been verified
SSN Claim type indicator
Yes/No indicator used to identify a program is a stand alone program. A stand alone program can only stand by itself. No other program can exist.
An indicator used to specify if the provider's state share biller status is needed for MAR COS assignment. Valid values are 'Y', yes this COS is only used if the provider is a state share biller; and 'N', this COS is only used if the provider is not a state share biller; and 'X', state share status not checked for COS assignment.
This field indicates whether valid values for the element are state supplied versus CMS provided value.
Indicates if this fund code is to suppress the physical payment in favor of an inter-State agency accounting entry transfer.
The status indicates whether the A/R is "Active" (A) or "Closed" (C). An A/R is closed when it has been fully recovered. Only a Void can reopen a closed A/R.
The status indicates whether the A/R is "Active" (A) or "Closed" (C). An A/R is closed when it has been fully recovered. Only a Void can reopen a closed A/R.
Indicates whether the DESI segment is in an active (0) or inactive (1) status. Only active segments will be used for claims processing. Inactive segments will be maintained for historical purposes.
Indicates whether the AAC pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.
Indicates whether the AWP pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.
Indicates whether the MAC pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.
Indicates whether the Drug pricing segment is in an active (0) or inactive (1) status.
Indicates whether the State MAC pricing segment is in an active (0) or inactive (1) status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.
The status indicates whether the A/R is "Active" (A) or "Closed" (C). An A/R is closed when it has been fully recovered. Only a Void can reopen a closed A/R.
The status indicates whether the AR disp is processed or voided.
Ingredient Status Code (0=Live, 1=Replaced, 2=Retired).

Indicates whether the pricing segment is in an active ('0') or inactive ('1') status. Only active segments will be used for pricing. Inactive segments will be maintained for historical purposes.
Status of the membership move. Accepted Values: R -> Ready to be processed, C -> Process completed successfully, E -> Error processing record.
Indicator that specifies what type of enrollment statuses are desired to be included in the list.
Indicates whether the transmission was accepted (A) or rejected (R).
Indicates whether the transmission was accepted (A) or rejected (R).
Indicates if applicant is staying in Alabama
A flag indicating if the service is a steel crown dental service. Valid values are Y and N.
Indicates there is a step-parent in the home. Valid values are 'Y' for Yes, 'N' for No and 'Blank' for Unknown or N/A
A code to indicate whether the service was a sterilization. This code does not include Hysterectomy. Valid values are Y (Yes) and N (No).
A code to indicate whether the service was a sterilization or a hysterectomy.
Sterilization indicator; An "S" indicates sterilized female
Indicates subsidy approval for PART D coverage. Values are 'Y','N' or 9 for n/a.
Indicates if the subsidy information record that was sent in the previous transmission is cancelled or no longer valid. Values are Y,N or 9 for n/a.
Indicates the change in the subsidy determination information sent in previous transmission. Values are Y, N or 9 for n/a.
Indicates whether the diagnosis requires further specification.
Indicates that this field will be used as a part of search index that is sent to OnBase. Y/N indicator.
Indicates whether the RA should be suppressed if the only thing there is to report on the RA is account receivables.
Indicates whether the RA should be suppressed if the only thing there is to report on the RA is account receivables.
Indicates whether the RA should be suppressed if the only thing there is to report on the RA is account receivables.
Indicates whether the RA should be suppressed if the only thing there is to report on the RA is account receivables.
The presence of a "1" in this field means that the Part A premium includes a 10% surcharge for late enrollment, otherwise it is blank.
The presence of a "1" in this field means that the Part A premium includes a 10% surcharge for late enrollment, otherwise it is blank.

A flag indicating if the service is a surgical extract dental service. Valid values are Y and N.
Indicates the recipient's file is being monitored by Program Integrity (PI) or the contractor for claim irregularity. This field will always contain an N in the OK MMIS.
Force Adjustment to suspend indicator. Values: A -suspend after CE (Claims Engine) processing, B -suspend before CE processing, space - ignore suspense and mark claim available for CE processing.
Force Adjustment to suspend indicator. Values: A -suspend after CE (Claims Engine) processing, B -suspend before CE processing, space - ignore suspense and mark claim available for CE processing.
This field indicates whether the audit is reported by EVS when the service limit enforced by the audit has been reached.
This field indicates whether the audit is reported by EVS when the service limit enforced by the audit has been reached.
This indicates if the drug is systemic, which means that it can "seep" into the body, be absorbed, and affect the entire body. Values are: "S" - Systemic, "N" - Non-systemic, "O" - Other.
This indicates if the drug is systemic, which means that it can "seep" into the body, be absorbed, and affect the entire body. Values are: "S" - Systemic, "N" - Non-systemic, "O" - Other.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.
Indicates whether the HIPP payments should be manually or systematically generated.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values are Y - yes or N - no.
Indicates whether detail was added by system during claim's processing. Valid values Y - yes or N - no.
Indicator showing whether the provider is tax exempt.
This field indicates whether the corresponding tax id field contains an EXEMPT number or not. The valid values are Y = Tax Exempt and N = Not Tax Exempt.
This field indicates whether the corresponding tax id field contains an EXEMPT number or not. The valid values are Y = Tax Exempt and N = Not Tax Exempt.

This field indicates whether the corresponding tax id field for the TPL entity contains an EXEMPT number or not. The valid values are Y = Tax Exempt and N = Not Tax Exempt.
Tax ID Type. Values are the following: F - FEIN S - SSN
Tax ID Type Values are the following: F - FEIN S - SSN
This field indicates whether the tax ID is a social security number or an FEIN.
This field indicates whether the tax ID is a social security number or an FEIN.
This is the Tax ID indicator, SSN or FEIN.
This is the Tax ID indicator, SSN or FEIN.
The type of tax identifier. The valid values are: F - FEIN and S -SSN.
This field indicates whether the tax ID is a social security number or an FEIN.
This field indicates whether the tax ID for the TPL entity is a social security number or an FEIN.
A code indicating if the providers organization is a teaching facility.
Indicates whether a Provider Service Location is a teaching facility. Valid values are "Y"es, "N"o.
CMS description of the data element
Y/N flag to indicate if an edit is enabled for execution.
Indicator of whether edit is enabled
Used to restrict rows on T_PAYABLE_BENEFIT to type of bill.
Designates if Type of Bills are Included, Excluded, or not restricted for this row.
Total Indicator
This indicator identifies the action taken for TPL editing based on the OI Plan.
A flag to indicate that the Medicaid/CHIP eligible person has some form of third party insurance.
Indicates that the Medicaid/CHIP eligible person has some other form of third party funding.
A code indicating presence of an extra traction device. A 'Y' indicates an extra oral traction device; An 'N' indicates no extra oral traction device.
This field indicates transfer disenrollments from the disenrollment process. The valid values are (Y/N).
Transaction Acknowledgement Indicator - Values: A - Transaction Acknowledged, X - Transaction not Acknowledged
This field holds the agency login.
This field indicates that this transaction is a database search
This field indicates that this transaction is a database update.

This field determines if the transaction should be excluded from the results.
This field indicates that this request is to open a new page.
This field indicates that this is a provider portal transaction.
This field indicates that this transaction is a record retrieval.
Indicates that this transaction is a record search.
This field indicates that this is a report transaction.
The indicator to show if the Drug code entered is a group code. Valid values are Y and N.
"This field if set to 'Y' means that the reason code is associated with a disposition associated with a particular type of transaction. This will be used primarily in online windows so that the CR is associated with the correct transaction. A = A/R, E = Expenditure, S = System, C = Cash "
This is the type of claim interest payment.
This field indicates what type of price was chosen for the least priced segment (F-Federal MAC, S-State MAC, E-EAC, D-DOJ,W-WHN).
Will be 'O' (the letter) for Original or 'C' for Correction.
Will be 'O' (the letter) for Original or 'C' for Correction.
Will be 'O' (the letter) for Original or 'C' for Correction.
Will be 'O' (the letter) for Original or 'C' for Correction.
Value for the type of claim that can be processed in the MMIS system.
Indicator for the type of rejection for the UUID. Valid Values will include P and R. P - File has been partially rejected. The value in NUM_REC will indicate which record in the transmission needs to be corrected and recreated. R - The entire file has rejected and must be re-created. (NUM_REC will be set to 0).
Indicator for the type of rejection for the UUID. Valid Values will include P and R. P - File has been partially rejected. The value in NUM_REC will indicate which record in the transmission needs to be corrected and recreated. R - The entire file has rejected and must be re-created. (NUM_REC will be set to 0).
Indicates if the applicant is under age
Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other.

Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other.
This is the dose in units indicator for this drug. Values Y = Dose required; N = Dose not required.
Marks a drug as packaged in unit doses. Unit dose is defined by FDB as all products labeled as Unit Dose by the mfr. This indicator does not apply to injectable products, suppositories, or powder packets. Current codes are: 1=Unit Dose & 0=All other.
The Unit of Use (UU) field denotes those packages which are supplied with appropriate labeling and (usually) child resistant closures and are appropriate to dispense as a unit. Valid values are: 1 = Unit of Use, 0 = All Other Products
The Unit of Use (UU) field denotes those packages which are supplied with appropriate labeling and (usually) child resistant closures and are appropriate to dispense as a unit. Valid values are: 1 = Unit of Use, 0 = All Other Products.
Indicates how the record was updated. N - Manual record, Y - Batch record.
This status of IND_UPDATE record. N = Manual record, Y = Batch record,
Indicates whether the system can perform an update. Y- means updatable and N - means not updatable.
This indcates the sources of the udpate(s). The valid values are: 'R' - Rescreening , 'N' - Newly eligible.
This indicates whether the user can manually assign the batch/unit number to a CCN from the online cash receipt window. Valid values (Y/N).
Characteristics of a provider can vary from quarter to quarter. To provide consistent characteristics for a provider for peer grouping summaries and reports, the characteristics for the most current quarter for each provider are marked with an indicator of Y. All other quarters are marked with an indicator of N.
Characteristics of a recipient can vary from quarter to quarter. To provide consistent characteristics for a recipient for each fiscal year for the summaries and reports, the characteristics for the most current quarter within each fiscal year marked with an indicator of Y. All other quarters are marked with an indicator of N.
Indicates whether the claim is used in drug rebate invoicing. Values are 'Y' and 'N'. When a claim is originally invoiced, it is added with a value of 'Y'. The user may change this value to 'N' during dispute processing.
Indicates whether the claim is used in drug rebate invoicing. Values are 'Y' and 'N'. When a claim is originally invoiced, it is added with a value of 'Y'. The user may change this value to 'N' during dispute processing.

Indicates whether the claim is used in drug rebate invoicing. Values are 'Y' and 'N'. When a claim is originally invoiced, it is added with a value of 'Y'. The user may change this value to 'N' during dispute processing.
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Indicates whether the claim is used in drug rebate invoicing. Values are 'Y' and 'N'. When a claim is originally invoiced, it is added with a value of 'Y'. The user may change this value to 'N' during dispute processing.
Indicates if the start and stop reason codes are valid for ACHN assignments. Valid values are Y = Yes, N=No
VAN Indicator.
Indicate if the audit was conducted and completed. Values: Y - Completed N - Not completed
A flag indicating if the individual served in the active military naval or air service.
Indicator showing whether this provider requires a W9 form sent to them.
Indicates COS is a waiver service.
Warning letter sent to client? - (Y/N)
Indicates whether any household member receives WIC
Will indicator
A yes or no indicator to indicate whether the amount is to be withheld from the amount paid. This amount would be reflected in the amount state share or amount withholding on a payment.
Indicates if the PCP only sees women.
Indicates whether the provider only accepts women as Managed Care recipients.
Obsolete.
Indicates whether the provider only accepts women as Managed Care recipients.
Indicates whether the provider only accepts women as Managed Care recipients.
Wrap Payment Indicator Y=Yes N=No
Yes/No Condition or Response Code. Indication of availability of xrays.
The number of inpatient psychiatric days covered by Medicaid on this claim.
Researching to remove.
Internal Provider Type. This field represents the translated values of your provider type values used internally by the Grouper. In addition, a record with an unknown provider type will be marked with a value of 3 in the corresponding field.

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Internal Service Type. This field represents the translated values of your service type values used internally by the Grouper. In addition, a record with an unknown service type will be marked with a value of 3 in the corresponding field.
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Internal Service Type. This field represents the translated values of your service type values used internally by the Grouper. In addition, a record with an unknown service type will be marked with a value of 3 in the corresponding field.
This is the invoice street 1 address of the labeler.
This is the invoice street 2 address of the labeler.
This is the invoice street 3 address of the labeler.
This is the invoice city of the labeler.
This is the invoice contact name of the labeler.
This is the invoice corporation name of the labeler.
This is the legal phone number of the labeler.
This is the invoice state of the labeler.
This is the last 4 digits of the invoice zip code of the labeler.
This is the first 5 digits of the invoice zip code of the labeler.
EDI standard used by this trading partner. ISA12
Number that uniquely identifies the return reason.
This is the name of the Labeler.
This is the labeler code name for the drug.
The last change date of the segment.

This is the date the prior authorization was last changed on the originating system.
This is the date the authorization was last changed on the originating system.
The last date of service on the ETG claim.
The last date of service on the ETG claim.
The last date of service on the ETG claim.
The last date of service on the ETG claim.
Last day of the month using the most current paid date from financial.
Last day of the quarter using the most current paid date from financial.
Last Date user logged in to manage password account
Last Date Password was updated
This contains the date that the transaction was created in the originating system.
The number of days, during the period covered by Medicaid, on which the patient did not reside in the long term care facility.
This is the legal street 1 address of the labeler.
This is the legal street 2 address of the labeler.
This is the legal street 3 address of the labeler.
This is the legal city of the labeler.
This is the legal contact name of the labeler.
This is the legal corporation name of the labeler.
This is the legal phone number of the labeler.
This is the legal state of the labeler.
This is the last 4 digits of the legal zip code of the labeler.
This is the first 5 digits of the legal zip code of the labeler.
The level of care from the update transaction.
Coding indicating the type of service the provider rendered. Valid values are: 0=Not Specified, 1=Patient consultation, 2=Home delivery, 3=Emergency, 4=24 hour service, 5=Patient consultation regarding generic product selection and 6=In-Home Service.
Indicates if the license was entered Manually or Electronically (M or E).
This is the ACG values for this case mix.
This is the ACG values for this case mix.
This is the ACG values for this case mix.
This is the ACG values for this case mix.
This is the unique line number for the item.
This is the unique line number for the item.
This is the unique line number for the item.
This is the unique line number for the item.
Liquidation flag from the originating system.

Number of Attempted Logins
A longer description of the measure.
This is the low variance.
A code indicating the individual's Basis of Eligibility as of the last day of the month referenced.
A code indicating the individual's inclusion in the SCHIP program for the month.
The number of days an individual was eligible for Medicaid during each month of the quarter.
Indicates coverage for individuals entitled to Medicare (Part A and/or Part B) and eligible for some category of Medicaid benefits.
The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values.
Filler in the record layout.
A flag indicating whether this enrollee had private health insurance coverage during the month. This includes both coverage purchased by the State or by a third party. Medicare is not considered private health insurance. Enrollment in a Medicaid/Medicare HMO does not constitute health insurance for this data element.
(OPTIONAL FIELD) A code indicating the family income level associated with the SCHIP program reporting requirements for the month. This code is to be reported for Medicaid eligibles below the SCHIP age limit, Medicaid expansion SCHIP enrollees and non-Medicaid SCHIP eligibles reported by the State. For States not opting to provide this data on ANY eligible records, blank-fill this field.
A code indicating an eligible's maintenance assistance status.
Fields for specifying up to four managed care plan identification numbers under which the eligible individual is covered during the month.
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Codes for specifying up to four managed care plan types under which the eligible individual is covered during the month.
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Codes for specifying up to four managed care plan types under which the eligible individual is covered during the month.
A flag that indicates the scope of Medicaid benefits to which an eligible is entitled during each month.
A flag that indicates whether the eligible received Temporary Assistance for Needy Families (TANF) benefits during the month.
Fields for specifying up to three waiver programs under which the eligible individual is covered during the month. These Ids must be assigned by the State, using alpha or numeric codes, to uniquely identify each specific waiver program(s) under which the individual is covered. The categories of waiver programs include 1915(b), 1915(c), combined (b)/(c) programs, and 1115 demonstrations. Individuals are to be associated with a specific waiver only if they are enrolled in a waiver program.
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Code for specifying the waiver type under which the eligible individual is covered during the month.
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A code indicating the individual's inclusion in the SCHIP program for the month.
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Indicates coverage for individuals entitled to Medicare (Part A and/or Part B) and eligible for some category of Medicaid benefits.
The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values.
Filler in the record layout.

A flag indicating whether this enrollee had private health insurance coverage during the month. This includes both coverage purchased by the State or by a third party. Medicare is not considered private health insurance. Enrollment in a Medicaid/Medicare HMO does not constitute health insurance for this data element.
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Indicates coverage for individuals entitled to Medicare (Part A and/or Part B) and eligible for some category of Medicaid benefits.
The composite of eligibility mapping factors used to create the corresponding Maintenance Assistance Status (MAS) and Basis of Eligibility (BOE) values.
Filler in the record layout.
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A code indicating an eligible's maintenance assistance status.

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Code for specifying the waiver type under which the eligible individual is covered during the month.

Code for specifying the waiver type under which the eligible individual is covered during the month.
Code for specifying the waiver type under which the eligible individual is covered during the month.
Unique map identifier.
Map filename.
EDI transaction(message) identifier. ST01
The Sybase tool uses a 6 character code to identify a HIPAA transaction.
Identifies the maximum age that this capitation category allows.
Identifies the maximum age that this capitation category allows.
Maximum age in days for the precaution.
This is the max allowed amount.
Maximum number of days of therapy in days for the precaution. 0 = Undetermined or use as needed or for chronic diseases.
State specified maximum number of days of therapy in days for the precaution.
Full path name of the trading partner mailbox directory. The value in this field can be overriden by the dest field in the agreement table.
A number that indicates which family member this is based on the order in which family members were listed on the application.
This is the max Medicaid allowed.
First three positions of Medicare care claim number
Remaining nine positions of Medicare claim number
Medicare Claim Number
Managed care plan number
Name/short description of the measure base.
The unique identifier of the measure.
Identifies the measure.
The unique identifier for the measure.
The unique identifier for the measure.
The internal code assigned to each individual measure.
The unique identifier for the measure.
The short description of the measure.
The measure's domain. (USE, ACCESS TO CARE...)

The source of the measure (HEDIS, AHRQ...)
media: is the media type (web, disk, tape, cdrom, ftp,TCP,RRI).
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
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The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The Medical Services Charge.
The Medical Services Charge.
The Medical Services Charge.
The Medical Services Charge.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record charge amounts in the episode.
The sum of the medical record paid amounts in the episode.
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The sum of the medical record paid amounts in the episode.
The Medical Services Paid Amount.
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The sum of the medical record paid amounts in the episode.
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The sum of the Medicare record charge amounts in the episode.
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The sum of the Medicare record charge amounts in the episode.
The sum of the Medicare record charge amounts in the episode.
The sum of the Medicare record charge amounts in the episode.
The medicare paid amount.
The medicare paid amount.
The medicare paid amount.
The medicare paid amount.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The Medicare paid amount.
The Medicare paid amount.
The Medicare paid amount.
The Medicare paid amount.
The amount paid by Medicaid, on this claim, toward the recipient's Medicare coinsurance.
The amount paid by Medicaid, on this claim, toward the recipient's Medicare coinsurance.
The amount paid by Medicaid, on this claim, toward the recipient's Medicare coinsurance.

The amount paid by Medicaid, on this claim, toward the recipient's Medicare deductible.
The amount paid by Medicaid, on this claim, toward the recipient's Medicare deductible.
The amount paid by Medicaid, on this claim, toward the recipient's Medicare deductible.
This is the number of member months that a recipient is enrolled in the Patient 1st program.
This is the number of member months that a recipient is enrolled in the Patient 1st program.
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This is the number of member months that a recipient is enrolled in the Patient 1st program.
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This is the number of member months that a recipient is enrolled in the Patient 1st program.
The machine time from the PS/2 transaction. This will aid the DHS worker in identifying which transaction for the recipient had the errors. HH:MM:SSSS format.
The machine time from the PS/2 transaction. This will aid the DHS worker in identifying which transaction for the recipient had the errors. HH:MM:SSSS format.
"Minutes" portion of the time period within which the trading partner expectes to receive the interchange acknowledgement.
Identifies the minimum age that this capitation category allows.
Identifies the minimum age that this capitation category allows.
Minimum age in days for the precaution.
Minimum number of days of therapy in days for the precaution. 1 = Undetermined or use as needed or for chronic diseases.
The measures minimum performance standard.
Minimum performance target for the measure base.
State specified minimum number of days of therapy in days for the precaution.
In most situations, this field will be blank. However, if the CDE_BUY_TXN field is "21" (and CDE_BUY_SUB is "B"), "22", "25", or "29", a date will be present (MMYY). If the CDE_BUY_TXN field is "28", an agency code will be present and the fourth position will be blank.
In most situations, this field will be blank. However, if the CDE_BUY_TXN field is "21" (and CDE_BUY_SUB is "B"), "22", "25", or "29", a date will be present (MMYY). If the CDE_BUY_TXN field is "28", an agency code will be present and the fourth position will be blank.

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This contains modifier 1 for the requested service.
This contains modifier 2 for the requested service.
This contains modifier 3 for the requested service.
This contains modifier 4 for the requested service.
Morbidity which is assigned through ACG Grouper. Shows the health status of the beneficiary. There are 6 morbidity levels, 0-5, the lower the morbidity level, the healthier the recipient.
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Morbidity which is assigned through ACG Grouper. Shows the health status of the beneficiary. There are 6 morbidity levels, 0-5, the lower the morbidity level, the healthier the recipient.
This is the morbidity level (sick level) of the recipient.
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This is the morbidity level (sick level) of the recipient.
This is the morbidity level (sick level) of the recipient.
This is the morbidity level (sick level) of the recipient. This is a grouping that is done internally using combinations of the ACG groups.
This is the morbidity level (sick level) of the recipient.
This is the morbidity level (sick level) of the recipient.
This is the derived mordity index level. It is derived using ACG weighted averages.
The Major Practice Category. This is a high level ETG specific classification for specific disease conditions. There are 22 MPCs: 1 INFECTIOUS DISEASES 2 ENDOCRINOLOGY 3 HEMATOLOGY 4 PSYCHIATRY 5 CHEMICAL DEPENDENCY 6 NEUROLOGY 7 OPHTHALMOLOGY 8 CARDIOLOGY 9 OTOLARYNGOLOGY 10 PULMONOLOGY 11 GASTROENTEROLOGY 12 HEPATOLOGY 13 NEPHROLOGY 14 UROLOGY 15 OBSTETRICS 16 GYNECOLOGY 17 DERMATOLOGY 18 ORTHOPEDICS & RHEUMATOLOGY 19 NEONATOLOGY 20 PREVENTIVE & ADMINISTRATIVE 21 LATE EFFECTS, ENVIRONMENTAL
The Major Practice Category. This is a high level ETG specific classification for specific disease conditions. There are 22 MPCs: 1 INFECTIOUS DISEASES 2 ENDOCRINOLOGY 3 HEMATOLOGY 4 PSYCHIATRY 5 CHEMICAL DEPENDENCY 6 NEUROLOGY 7 OPHTHALMOLOGY 8 CARDIOLOGY 9 OTOLARYNGOLOGY 10 PULMONOLOGY 11 GASTROENTEROLOGY 12 HEPATOLOGY 13 NEPHROLOGY 14 UROLOGY 15 OBSTETRICS 16 GYNECOLOGY 17 DERMATOLOGY 18 ORTHOPEDICS & RHEUMATOLOGY 19 NEONATOLOGY 20 PREVENTIVE & ADMINISTRATIVE 21 LATE EFFECTS, ENVIRONMENTAL
The Major Practice Category Description. This is a high level ETG specific classification for specific disease conditions.
Outbound - Message Implementation Guideline ID.
Outbound - Message Implementation Guideline Release.

Outbound - Message Implementation Guideline Version.
Outbound - Message Subset ID.
Outbound - Message Subset Release Number.
Outbound - Message Subset Version Number.
Outbound - Message Type Sub-Function Identifer.
A unique identification number used to identify a Medicaid Eligible to MSIS.
A unique identification number used to identify a Medicaid Eligible to MSIS.
A unique identification number used to identify a Medicaid Eligible to MSIS.
A unique identification number used to identify a Medicaid Eligible to MSIS.
This contains the benefit month and year (MMYYYY) for which the eligibility record has been sent
The percentage to use to price a service for multiple surgery.
The address line containing the state name.
The name of the source that has submitted a check (system issued or personal) to the account.
The organization or individual name associated with the Provider License Number.
The name of the drug labeler
Name of the drug labeler
The legal name of the non-provider.
This is the name the W9 form would be addressed to.
This is the pharmacy litigation labeler family name.
Contains the recipients complete name and id.
Contains the recipients complete name and id.
This represents the name of the non-Medicaid provider requesting Prior Authorization.
The name of the Medicaid provider/entity name as identified on the PHS dataset files. These files are sent to EDS by HCFA on the quarterly drug rebate tapes.

This is the name associated with an organization or person.
This is the name associated with an organization or person.
This is the name associated with an organization or person.
Name as it appears on the license
This is the name associated with an organization or person.
The Security Level's Name. (e.g. Admin, Provider, OHCA).
This is the name of the person or business to whom a TPL questionnaire was sent. It may be plugged by the system or keyed by the user.
Name of the role.
The name of the absent parent
This is the name of the pharmacy litigation manufacturer family.
The username of the person authenticated in a windows network.
This field stores the Payer's technical contact name.
This field stores the payee name.
Free-form Billing Provider contact name, required in the first iteration of the Billing Provider Contact Information segment.
Free-form name of Property & Casualty Subscriber Contact Information.
Free-form name of Service Facility Contact Information.
The name on the bank account
The name on a second account where district office claimant has funds
The name on a third account where district office claimant has funds
The name on a fourth account where district office claimant has funds
Name of Provider's Agent
Name of provider's authorized agent.
Name of provider's authorized agent.
Name of provider's authorized agent.
Name of provider?s authorized agent.
Name of provider?s authorized agent.
Name of provider's authorized agent after changes.
Name of providers authorized agent before changes.
Name of contact in agent office handling EFT issues.
Name of a contact in agent office for handling EFT issues.
Name of a contact in agent office for handling EFT issues.
Name of a contact in agent office for handling EFT issues.

Name of a contact in agent office for handling EFT issues.
Name of a contact in agent office for handling EFT issues.
Agent contact's name after change.
Agent contact's name before change.
Title of a contact in agent office for handling EFT issues.
Title of a contact in agent office for handling EFT issues.
Title of a contact in agent office for handling EFT issues.
Agent contact's title after change.
Agent contact's title before change.
Alternate names for a recipient.
Name of the Alternate Therapy definition.
The analyst's last name.
The analyst's last name reviewing the case.
Analyst's last name.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Used to identify different application security.
Assembly name where custom exception was created.
The name of the person or department of a bank that has been designated to receive the bank form
Name of the attribute that caused a particular edit to fail.
Name of the node level.
The name of the bank at which the district office claimant has an account
The name of the person who heads the evaluation team. (PASRR PRE-ADMISSION SCREEN, Referral, PASRR Team)
Name of routine which determines if a detail (benefit or service) exists for the parent code being classified.
This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.
This field contains the business name of an insurance carrier. This allows us to access all insurance carrier information when the carrier gives us only his business name.

This field contains the business name of a subcontractor. This allows us to access all subcontractor information when the contractor gives us only his business name.
This is the business name of an employer.
This is the business name of the TPL Subcontractor.
This is the name of the organization or business that is involved in the ownership.
This is the name of the organization or business that is involved in the ownership.
The provider's business name.
Business or organization name of the Medicare Part D prescription drug coverage carrier
Name of routine which retrieves the calculated or expected parent for the applicable node code.
This is the name of the individual holding the other insurance.
This is the name of the individual holding the other insurance.
Name of routine which retrieves the codes from the node being processed.
Class name that had an exception.
Official name of the provider's clearinghouse.
Official name of the provider's clearinghouse.
Official name of the provider's clearinghouse.
Official name of the provider?s clearinghouse.
Official name of the provider?s clearinghouse.
Clearinghouse name after change.
Clearinghouse name before change.
Name of routine which updates the code descriptions.
The name of the drug as assigned by the Food and Drug Administration as supplied by CMS.
Name of the CMS error record file.
Name of the CMS error record file
This is the key field used to retrieve a system key.
If the data in CDE_VALUE correlates with data in another table, the column is identified here.
If the value in NAM_TABLE is not " " then this is the column name of the CODE value on the source table for the domain values. Otherwise, its " ". Examples, CDE_POS, CDE_CLM_TYPE.
If the value in NAM_SOURCE_DOMAIN_TBL is not " ", then this is the column name of the DESCRIPTION value on the source table for the domain values. Otherwise, it is " ". Example, DSC_CLM_TYPE, DSC_MODIFIER.
The name of the company providing the health insurance to the applicant

The name of the health insurance company of the policy listed on the SOBRA application
The company that the insurance agent is employed by.
This is the name of the contact at MMIS that will be reported on the 835.
The name of the person that is used when contacting the attorney's office.
The name of the person that is used when contacting the attorney's office.
The name of the contact person
This is the information that will be publish on the IRS tax file. This is the person who should be contacted for any questions.
The name of the insurance carrier's person to contact concerning HIPP premium payments.
Contact person for the business owner.
Identifies the name of a contact person.
Idenfies the name of a contact person.
Provider contact name.
Contact name. This is the person you will contact if you have questions concerning an application.
Contact name. This is the person you will contact if you have questions concerning an application.
Name of the contact person.
Name of the contact person.
Name of the Primary Contact at a specific Service Location.
The name of the responsible person for this case.
This is the name of the PDP contact for any questions related to PDP and their plans
The name of the contact person or department.
Contact person name for the trading partner.
This is the name of the carrier contact when there are questions about a policy or the carrier.
This is the name of the carrier contact when there are questions about a policy or the carrier.
This is the SubContractor's contact name.
This is the name of the subcontractor contact.
This is the employer contact name.
Name of contact person, after change.
Name of contact person, after change.
Name of contact person, before change.
Name of contact person, before change.
Clearinghouse contact's name after change.
Clearinghouse contact's name before change.
Name of a contact in clearinghouse office for handling ERA issues.
Name of a contact in clearinghouse office for handling ERA issues.

Name of a contact in clearinghouse office for handling ERA issues.
Name of a contact in clearinghouse office for handling ERA issues.
Name of a contact in clearinghouse office for handling ERA issues.
The Contact's first name.
The Contact's last name.
The point of contact at the billing center.
The contact person at the facility who provided the Level I screening information. (PASRR PRE-ADMISSION SCREEN, Case Information, Contact Person) ; (RESIDENT REVIEW SCREEN, Case Information, Contact Person); (ICF/MR SCREEN, Case Information, Contact Person);
The name of the contact person.
The point of contact at the planned nursing facility that is associated with the case.
The name of the point of contact at the "non Medicaid certified" facility that is associated to the case.
Title of Contact.
Title of the contact person
The name of the window control
The name of the window control
The name of the window control
Defining the type of the control
The corporation name related to this contact
The corporate contact name for the carrier.
CP2100 Name.
This field contains the name of the control file.
Name of routine which retrieves the current parent for the applicable node code.
Provider Degree.
This is the description of the system key field.
This field contains the name of the destination.
The name of the letter document this reason code will produce during letter generation.
The name of the windows network domain.
A plural name of the domain that will be used in the UI to label a listbox of the values in the domain. Examples, Integers, Booleans, Places of Service,
Indicates the Drug Brand Name.
This is the Drug brand code name.
This the National Drug Code Brand Name.
The name of the drug as assigned by the Food and Drug Administration.
This is the name of the drug involved in the dispute

The name of the drug as assigned by the Food and Drug Administration as reported by CMS as part of the quarterly drug rebate information. This name is printed on the drug invoices.
It contains 4 fields strung together, the 30 character generic name, the 10 character route description, 10 character dosage form description and the 10 character drug strength description. These fields are each separated by a space.
The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
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The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
The first field (30 characters) is the generic drug name, the next is the route description (10), the next is the dosage form (10) and the last is the drug strength description(10). These fields are each separated by a space, for a total of 3 spaces.
Indicates the Drug Labeler Name.
This is the name of the distributor as listed on the drug label or as indicated by the NDC code. It does not necessarily identify the actual drug fabricator.
The name assigned to this unique team
The first name of the individual to whom the services were provided.
The first name of the individual to whom the services were provided.
The first name of the individual to whom the services were provided.

The first name of the individual to whom the services were provided.
The first name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
The name of the employer
The name of the last employer.
The name of employer.
Name of an internal entity.
Name of the internal entity in MMIS
Name of the entity affected by the process.
Name of the program affected by the process.
Name of the entity affecting the process.
Name of the program affecting the process.
A description of an event associated with the code value of the event above
The description associated with the code indicator for the event set; for example claims 4A may have been called crossover processing part-b.
The name of the facility on the D.O. application
This is the original name of facility.
This is the name of the facility when it was used by this provider.
Name of family member
The name of the field in error on the PS/2 transaction.
The name of the field in error on the PS/2 transaction.
This field holds the name of the field where masked button is added.
Original name of the file when it was received.

The file name.
The filename given to the unique transmission.
The filename given to the unique transmission.
The name identifying the subject area to which the records in its file relate.
The name identifying the subject area to which the records in its file relate.
The name identifying the subject area to which the records in its file relate.
The name identifying the subject area to which the records in its file relate.
Filename of the file containing the edit failure
The name identifying the subject area to which the records in its file relate.
The name identifying the subject area to which the records in its file relate.
CMS defined name for the file being submitted
The name identifying the subject area to which the records in its file relate.
This field stores the downloaded document's filename from FEITH.
This field stores the report document's file cabinet name from the FEITH database.
Filename of output file(s).
Directory path where a file was found or placed.
The file name for the zip file.
The attorney firm name.
Name corresponds to Business name if there is a Firm name, otherwise it will be Individual name.
This field represents the users first name.
This field represents the users first name.
First name of the Attorney used for correspondence and liens.
This is the first name of the board participant.
The first name of a beneficiary, according to CMS.
Recipient first name
The first name of a beneficiary, according to CMS.
The first name of a beneficiary, according to CMS.
The first name of a beneficiary, according to CMS.
Recipient first name
The first name of a beneficiary, according to CMS.
The first name of a beneficiary, according to CMS.
The first name of the recipient/provider if entity is an individual.
The first name of the recipient/provider if entity is an individual.
The first name of a recipient.
First name of applicant

The insurance agent's first name used to mail correspondence, cover letters, and liens.
This is the first name of the individual that is involved in the ownership.
This is the first name of the individual that is involved in the ownership.
This is the first name of the policyholder. It is used to send correspondence to the policyholder.
First name of the board member.
First name of the provider.
First name of the provider.
This is the first name of the providers legal name.
The first name of the worker.
The first name of a recipient.
The first name of a beneficiary.
The is the Case Head's firstname.
The first name of expecting mother.
The first name of the child.
The first name of recipient
The first name of a recipient.
First name of the recipient/member.
This is the first name of the recipient
The recipient's first name on the PS/2 transaction.
The first name of the Medicaid recipient that needs an ID card.
The first name of the Medicaid recipient that needs an ID card.
The first name of person losing income.
The first name of person with new income.
Submitted first name of recipient.
The first name of the spouse.
The first name of move in/out person.
This is the contact's first name.
The first name of a Medicaid recipient at a particular point in time.
First name of the recipient on the MMIS
The recipient's first name on the PS/2 transaction.
The first name of the tortfeasor used to address the correspondence, cover letters, and liens.
The first name of the tortfeasor used to address the correspondence, cover letters, and liens.
This is the first name of the recipient's absent or custodial parent.
First name of the executor/trustee.
Child's first name from IV-D tape.
This field stores the individual first name.
Supervising Provider First Name.

Other Operating Physician First Name.
Supervising Provider First Name.
Rendering Provider First Name.
Referring Provider First Name. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
First name of the account team member
This is the first name of the administrator of the facility when the provider was associated with the facility.
Recipient's firstname on the Bendex tape.
This is the first name of the co-administrator of the facility when the provider was associated with the facility.
First name on EDB records
First name on EDB records
The first name of the person in care.
The first name of the addressee. PASRR PRE-ADMISSION SCREEN: First Name ; RESIDENT REVIEW SCREEN: First Name; ICF/MR SCREEN: First Name; LEVEL I TRACKING SCREEN: First Name;
The first name of the payee.
First name on the PS/2 transaction
First name of person initiating the research request or project.
Name of the organization that the sponsor is associated with
The first name of the applicant's spouse
The first name of any veteran in the applicant's household
The name of the person who the day care is for
This name will follow the USPS formatted naming standard and it will be first name, middle initial, last name and followed by suffix if one exists.
The full name of the recipient's care manager.
If this variable is input-data on the transaction request, this C function should be a getter that takes no arguments and returns a value of the domain type. If the variable is output action, the function should be a setter which takes one argument of the domain type and returns nothing.

The Generic Name (GNN) field contains the drug ingredient names adopted by United States Adopted Names (USAN). The chemical name is used when the USAN name is not available. For multi-ingredient products, abbreviations may be used (such as HCTZ [Hydrochlorothiazide] and PP [Phenylpropanolamine]). Although this field is free-format, the data has been generated from a table to provide consistent spelling and sequence for sorting and reporting applications.
USAN Generic Name (Long Description).
Business name of group.
The name of the health home program approved by CMS.
Identifies the health home SPA in which an individual is enrolled.
A text field to indicate the health home program that authorized payment for service on the claim.
A text field to indicate the health home program that authorized payment for service on the claim.
A text field to indicate the health home program that authorized payment for service on the claim.
A text field to indicate the health home program that authorized payment for service on the claim.
The name of the health home program approved by CMS.
Identifies the health home SPA in which an individual is enrolled.
Ingredient Description.
Insured Group Name. AKA Plan Name.
The name of the Third Party Liability (TPL) Insurance carrier.
The financial contact's address name.
Name of bank.
Name of bank.
The financial contact's address name.
Labeler name from First Data Bank.
This field represents the users last name.
This field represents the users last name.
The last name of the attorney used for correspondence and liens.
This is the last name of the board participant.
The last name of a beneficiary, according to CMS.
Recipient last name
The last name of a beneficiary, according to CMS.
The last name of a beneficiary, according to CMS.
The last name of a beneficiary, according to CMS.
Recipient last name
The last name of a beneficiary, according to CMS.

The last name of a beneficiary, according to CMS.
The last name of the recipient/provider or the name of the organization.
The last name of the recipient/provider or the name of the organization.
The last name of a recipient.
Last name of applicant
The insurance agent's last name used to mail correspondence, cover letters, and liens.
This is the last name of the individual that is involved in the ownership.
This is the last name of the individual that is involved in the ownership.
Name Last or Organization Name found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment NM, element NM103.
Name Last or Organization Name found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment NM, element NM103.
This is the last name of the policyholder. It is used to send correspondence to the policyholder.
Last name of the board member.
Last name of the provider.
Last name of the provider.
This is the last name of the providers legal name.
The last name of the worker.
The last name of a recipient.
The last name of a beneficiary.
The is the Case Head's last name.
The last name of expecting mother.
The last name of the child.
The last name of recipient
The last name of a recipient.
Last name of the recipient/member.
This is the last name of the EPSDT recipient.
The recipient's last name on the PS/2 transaction
The last name of the Medicaid recipient that needs an ID card.
The last name of the Medicaid recipient that needs an ID card.
The last name of person losing income.
The last name of person with new income.
Submitted last name of recipient.
The last name of the spouse.
The last name of move in/out person.
This is the contact's last name.

The last name of a Medicaid recipient at a particular point in time.
Last name of the recipient on the MMIS
The recipient's last name on the PS/2 transaction
The last name of the tortfeasor used to address the correspondence, cover letters, and liens.
The last name of the tortfeasor used to address the correspondence, cover letters, and liens.
This is the last name of the recipeint's absent or custodial parent.
Last name of the executor/trustee.
Child's last name from IV-D tape.
Pay-to Plan Individual last name or Organizational Name.
Individual last name or Organizational Name for Pay-to Plan Name.
Pay-to Plan Individual or Organizational Name.
This field stores the individual last name or organizational name.
Supervising Provider Last Name.
Individual last name or organizational name of Ambulance Drop Off Location.
Other Operating Physician Last Name.
Supervising Provider Last Name.
Rendering Provider Last Name.
Laboratory or Facility Last Name.
Referring Provider Last Name. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
Individual last name or Organizational Name of Ambulance Drop Off Location.
This is the last name of the administrator of the facility when the provider was associated with the facility.
Recipient's last name on the Bendex tape.
This is the last name of the co-administrator of the facility when the provider was associated with the facility.
Last name on EDB records
Last name on EDB records
The last name of the person in care.
The last name of the addressee. PASRR PRE-ADMISSION SCREEN: Last Name ; RESIDENT REVIEW SCREEN: Last Name; ICF/MR SCREEN: Last Name; LEVEL I TRACKING SCREEN: Last Name;

This is the recipient normalized last name based on the NAM_LAST column. Steps used on last name: 1. Make all characters upper case 2. Remove all the prefixes and suffixes when preceded by a comma, space or forward slash and followed by a space or the end of the data field: JR, SR, I, II, III, IV, V, RN, MD, MR, MS, DR, MRS, PHD, REV, ESQ 3. Remove ASC X12 special characters: ! ? & ' ( ) * + , - . / : ; ? =
The last name of the payee.
Last name on the PS/2 transaction
Last name for person initiating the research request or project
Last name of the sponsor
The last name of the applicant's spouse
The last name of any veteran in the applicant's household
The library that contains the function identified in NAM_TRAN_FUNCTION.
List name. At this time, only Formulary lists will have names.
The name under which the previously owned property is listed by the tax assessor
Name of the location by which address can be identified.
File name given to the log by autosys.
Machine name that had an exception.
Manufacturer name.
The name of the managed care entity under contract with the State Medicaid Agency.
Identifies the counties cities regions zip codes and/or other areas the managed care entity serves.
Member's name.
Name of family member
The first name of the individual to whom the services were provided.
The last name of the individual to whom the services were provided.
The middle initial of the individual to whom the services were provided.
Method name where custom exception object was created.
This is the name of the manufacturer of the drug code.
The is the Manufacturer's name of the drug code.
Middle name of applicant
This is the middle initial of the providers legal name.
Middle initial of the recipient/member.
The middle name of the recipient/provider if entity is an individual.
The middle name of the recipient/provider if entity is an individual.

The middle name of expecting mother.
The middle name of the child.
The middle name of a recipient.
The middle name of person losing income.
The middle name of person with new income.
The middle name of the spouse.
The middle name of move in/out person.
The middle name of the person in care.
The middle initial of the addressee.
This is the middle initial of the board participant.
This is the middle initial of the individual that is involved in the ownership.
This is the middle initial of the individual that is involved in the ownership.
The middle name of the payee.
Recipient's middle initial on the Bendex tape.
This field represents the users middle initial.
This field represents the users middle initial.
The middle initial of the attorney used for correspondence and liens.
The middle initial of the beneficiary, according to CMS.
Recipient middle initial
The middle initial of the beneficiary, according to CMS.
The middle initial of the beneficiary, according to CMS.
The middle initial of a beneficiary, according to CMS.
Recipient middle initial
The middle initial of the beneficiary, according to CMS.
The middle initial of the beneficiary, according to CMS.
The middle initial of the recipient.
The insurance agent's middle initial used as part of the address on the correspondence, cover letters, and liens.
This is the middle initial of the policyholder. It is used to send correspondence to the policyholder.
Middle initial of the provider.
The middle initial of the worker.
The middle initial of the recipient.
The middle initial of the beneficiary.
The is the Case Head's middle initial.
The middle initial of recipient
This is the middle initial of the EPSDT recipient
The recipient's middle initial on the PS/2 transaction.
The middle initial of the Medicaid recipient that needs an ID card.
This is the contact's middle initial.
The middle initial of a Medicaid recipient at a particular point in time.

The recipient's middle initial on the PS/2 transaction.
The middle initial of the tortfeasor is used for correspondence, cover letters, and liens.
The middle initial of the tortfeasor is used for correspondence, cover letters, and liens.
This is the middle initial of the recipient's absent or custodial parent.
Middle initial of the executor/trustee.
Child's middle initial from IV-D tape.
Middle initial on EDB records
Middle initial on EDB records
Identifies the name of the 'mid-level' medical personnel contact (e.g., nurse practitioner).
Identifies the name of the 'mid-level' medical personnel contact (e.g., nurse practitioner).
This field stores the individual middle name or initial.
Supervising Provider Middle Name or Initial.
Other Operating Physician Middle Name or Initial.
Supervising Provider Middle Name or Initial.
Rendering Provider Middle Name or Initial.
Referring Provider Middle Name or Initial. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
This is the middle initial of the administrator of the facility when the provider was associated with the facility.
This is the middle initial of the co-administrator of the facility when the provider was associated with the facility.
The person at DMHSA who processed the referral order. (PASRR PRE-ADMISSION SCREEN, Referral, MI Ordered To)
Middle name of the sponsor
The middle name of the applicant's spouse
The person giving the call for the level II MI. (PASRR PRE-ADMISSION SCREEN, Determinations, MI Verbal received From)
The middle name of any veteran in the applicant's household
The person at DHS/DSD who processed the referral order. (PASRR PRE-ADMISSION SCREEN, Referral, MR Ordered To)
The person giving the call for the level II MR. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Verbal received From)
The name of the billing center.
The addressee's name.
The name of the "non Medicaid certified" nursing facility associated with the case.

Name of routine which inserts a new row into the Classification tables.
The legal name of the health care entity identified in NATIONAL-HEALTH-CARE-ENTITY-ID
The legal name of the health care entity identified in NATIONAL-HEALTH-CARE-ENTITY-ID.
This is the name of the operator of the facility.
Name of server where tacking originated from.
This is the name associated with the owner.
The name under which the property is listed by the tax assessor
This field holds name of the panel.
This is the name of the parameter used in a job/process.
The individual or business name associated with the payee.
Payer Name
This is the name that the State will be identified by on the 835 records.
This is the name by which the State will be identified on the 835.
This is the "P"ay To Name associated with the provider location record.
Name of the person assisting the update.
Name of person reporting the update.
This is the name of the PDP plan.
Name of TPL policy holder name on the ICES eligibility record.
The name of the health insurance policy holder
The owner of the health insurance policy listed on the SOBRA application
The first name of the owner of the insurance policy.
The last name of the owner of the insurance policy.
The name of the contact person at the facility.
Prefix to the name.
This is the prefix of the providers legal name. Valid values: Ms. Mr. Miss Mrs. Dr. Prof.
This field stores the prefix to individual name.
NCPDP field 364-2J, First name of the prescriber.
The name of the Probate County' court.
The division of the County Probate court.
The name of the online process or program that created the AR letter.
This is the name of process to which the parameter applies.
The name of the profile
The name of the profile

The name of the profile
The name of the profile
Name of the module set performing restart logic.
Identifies an LBMS module set or program.
Identifies a module set or program.
Identifies a module set or program.
Provider's name.
Name of the provider. This can be a personal or business name. The contents of this attribute (business or personal) can be determined by checking the provider name type.
Provider Name.
Provider Name.
Provider Name.
The name that is commonly used by the public when different than the legal name.
The first name of the provider when the provider is a person.
The last name of the provider when the provider is a person.
The name as it appears on the provider agreement between the state and the entity.
The middle initial of the provider when the provider is a person.
The Legal Business Name of the provider organization.
The name of the provider when the provider is an organization.
The business name of the pharmacy that is associated with this enrollment. Can be found in Medicaid enrollments.
Person name for the physician that provides oversight for the provider.
Person name for the physician that provides oversight for the provider.
Provider/Client name.
Provider/Client first name.
Provider/Client first name.
Provider/Client last name.
Provider/Client last name.
Provider/Client middle initial.
The name that the provider entity uses on IRS filings.
First two characters of billing provider name. This will be last name if billing provider is an individual.
First two characters of billing provider name. This will be last name if billing provider is an individual.
First two characters of billing provider last name. This will be last name if billing provider is an individual.
The recipient's name formatted as Last, First MI.

Name of the recipient (May be the same as Recipient Name). Will contain First name, Middle Initial and last name separated by a space between each value. PULL from T_RE_ADR_CASS
Name of the recipient (May be the same as Recipient Name). Will contain First name, Middle Initial and last name separated by a space between each value.
Client's name.
Name of the state personnel to whom the application has been referred for approval or review.
This is the remitter's name that will be used as a secondary name on the cash receipt.
The name of an MMIS production report
This is the name of the individual or organization that requested the payment to be pulled.
This is the name of the individual or organization that requested the payment to be pulled.
Resource Link name.
Name of Resource Link type.
This field contains the name of the report.
This field contains the name of the report file.
This field contains the name of the report output.
This field contains the name of the report recipient.
Name of routine which determines if a rule exists for codes belonging to the same parent as the code being classified.
Sanctioned Provider's Name
Sanctioned Provider's Name
This is the name of the schema to which a partition belongs. The use of a schema allows multiple physical database tables (and the columns on those tables) within the same database instance to have the same name.
This is the name of the schema to which a partition belongs. The use of a schema allows multiple physical database tables (and the columns on those tables) within the same database instance to have the same name.
This field holds the name of the UI/Web portal server.
Electronic Signature of Person Submitting Enrollment
This name represents the electronic signature for a Provider.
Electronic Signature of Person Submitting Enrollment
Electronic Signature of Person Submitting Enrollment.
Electronic Signature of Person Submitting Enrollment
Electronic Signature of Person Submitting Enrollment
Electronic Signature of Person Submitting Enrollment
EFT Signature after change.
EFT Signature before change.
ERA Signature after change.
ERA Signature before change.

Site name.
Sponsor name suffix. Example values are JR, ESQ, II, III, IV, and BLANK
This field holds name of the subsystem.
The name suffix of the recipient/provider if entity is an individual.
Sponsor name suffix. Example values are JR, ESQ, II, III, IV, and BLANK
Suffix to the name.
This is the suffix of the providers legal name. Valid Values: Jr. Sr. I II III IV V VI VII VIII IX X
Suffix for Recipient Name.
The suffix name of the expecting mother.
The suffix name of the child.
The suffix name of a recipient.
The suffix name of the person losing income.
The suffix name of person with new income.
The suffix name of the spouse.
The suffix name of move in/out person.
This field stores the suffix to individual name.
Supervising Provider Name Suffix.
Other Operating Physician Name Suffix.
Supervising Provider Name Suffix.
Rendering Provider Name Suffix.
Referring Provider Name Suffix. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
The suffix name of the person in care.
The suffix name of the payee.
Spouse name suffix. Example values are "Jr.", II, III, ESQ
Veteran name suffix. Example values are "Jr.", II, III, ESQ
The name of the Physical Database Table.
This is the name of the table that contains the groups of a Group Class. For example, if the Group Class is Procedure group then the table name is T_PROC_TYPE
Source table for the node.
If the data in CDE_VALUE correlates with data in another table, the table is identified here.
If this domain can define its list of values in a code table then this is set to the name of the code table. Otherwise, it is " ".
List of tables referenced in SQL statement.
This is the audit table name that will be used to look up the weekly information.
This field holds the tab path.
The name provider uses to file tax forms.

This is the individual, company, payer, vendor or other name that will appear on the tax form.
This is the secondary individual, company, payer, vendor or other name that will appear on the tax form.
The name of a database table that has audit trail rows on a table with a name other than 'A_' + its own table name.
The name of a database table that stores audit trail rows for a table with a name other than its own table name without the 'A_' prefix.
Contact name for 835 technical questions.
The technical contact name for the carrier.
Name describing this Text message.
Thread ID that had an exception.
Printed Title of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment
This field indicates the professional title of an individual.
Printed Title of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment.
Printed Title of Person Submitting Enrollment
The title of the recipient. (Mr., Mrs, Miss)
The title of the recipient. (Mr., Mrs., Miss.)
This is suffix of the contact's name.
Printed Title of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment
Professional degree received.
EFT Title after change
EFT Title before change
ERA Title after change
ERA Title before change
Name of the table containing the column
Description for the edit group.
This contains the common solution logical table name associated with this data element.
This contains the common solution physical table name where this data element is stored.
CMS assigned data element number
This is the logical name for a CMS field which has a list of valid values.
Name of the trading partner.
The URL for this Resource Link.
This field holds the URL.
This field holds the URL.

User Login ID.
User Login ID.
This field stores the logged in user's username.
This is the key field used to retrieve a user value for a system key.
This field holds the value of the field.
Abbreviated Vendor Name.
Abbreviated Vendor Name.
Name of vendor office for handling ERA issues.
Name of vendor office for handling ERA issues.
Name of vendor office for handling ERA issues.
Name of vendor office for handling ERA issues.
Name of vendor office for handling ERA issues.
Vendor name after change.
Vendor name before change.
Name of a contact in vendor office for handling ERA issues.
Name of a contact in vendor office for handling ERA issues.
Name of a contact in vendor office for handling ERA issues.
Name of a contact in vendor office for handling ERA issues.
Name of a contact in vendor office for handling ERA issues.
Vendor contact's name after change.
Vendor contact's name before change.
Owner of other phone number entered on D.O. application
The name of the person who owns the alternative phone number
The name of the person who received medical services
The name of the person who pays for day care
The name of the person who is pregnant, if any
Name of the window
Name of the window
Name of the window
Name of the window
Name of the window
Name of the window
NPI for billing provider.
NPI for billing provider.
NPI for performing provider.

Number in allocation
National Drug Code
Number of months claims are selected to accumulate to the threshold amount.
National Provider ID.
National Provider ID
This is the number of units authorized.
This is the number of units authorized.
This contains the number of units requested.
Attachment control number, identifying a party or other code of line supplemental information.
Adjusted Repriced Line Item Reference Number. Reference information as defined for a particular Transaction Set or as specified.
Repriced Line Item Reference Number. Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
Referral Number Reference Identification - required when this service line involved a referral number that is different than the number reported at the claim level.
Referral Number Reference Identification - required when this service line involved a referral number that is different than the number reported at the claim level.
Referral Number Reference Identification - required when this service line involved a referral number that is different than the number reported at the claim level.
Referral Number Reference Identification - required when this service line involved a referral number that is different than the number reported at the claim level.
Referral Number Reference Identification - required when this service line involved a referral number that is different than the number reported at the claim level.
A unique number assigned to individual financial institutions for identification.
A unique number assigned to individual financial institutions for identification.
A unique number assigned to individual financial institutions for identification.
The American Banking Association (ABA) number assigned to the bank to facilitate financial transaction routing.
The American Banking Association (ABA) number assigned to the bank to facilitate financial transaction routing.
A unique number assigned to individual financial institutions for identification.
ABA number after change.
ABA number before change.
The state's bank number that is sent on the EFT file to the bank.

The state's bank number that is shown in magnetic ink at the bottom of the check.
This is the State's ABA Bank number.
The state's account number that is sent on the EFT file to the bank.
The state's account number that is shown in magnetic ink at the bottom of the check.
This is the State's bank account number.
This is the actual number of Default Autoassignments that have been made to PMPs in the program.
This is the number of recipients currently assigned to the PMP service location.
This is the number of recipients currently assigned to the PMP service location.
This is the number of recipients currently assigned to the PMP service location.
The total number of adds from the insurance disclosure file to the t_tpl_resource table
This an additional phone number for contacting the recipient.
Adjustment ICN for the ICN identified by SURS as needing adjusted.
Amount we would adjust the DRG payment for adults
Internal control number of the mother claim
Amount we would adjust the DRG payment for children
The time of admission to a hospital or long term care facility.
The time of admission to a hospital or long term care facility.
Allergy Cross Sensitive Specific Condition
Allergy Cross Sensitive Specific Condition
Allergy Specific Condition
Allergy Specific Condition
Allergy Specific Condition
Allergy Code.
Recipient age as of the date of service. System calculated difference between beneficiary DOB and Detail From DOS.
The agency number defined by STO. Being stored as informational
Agency Client ID number
Agency Client ID number
The minimum age of the recipient on the date of service that the service will be covered within the program.
The minimum age of the recipient on the date of service that the service will be covered within the program.
The minimum age of the recipient on the date of service that the service will be covered within the program.
The minimum recipent age for which the PDL history segment applies.

The minimum recipent age for which the PDL history segment applies.
Member from age limitation.
The age of the person in care.
Maximum age recipient must be in order to grant prior authorization
This field indicates the oldest age of a recipient the PMP wants transferred/released. Default value is 999.
Minimum age recipient must be in order to grant prior authorization
This field indicates the youngest age of a recipient the PMP wants transferred/released. Default value is 000.
This is the age policy adjuster threshold
This is the age policy adjuster threshold
The maximum age of the recipient on the date of service that the service will be covered within the program.
The maximum age of the recipient on the date of service that the service will be covered within the program.
The maximum age of the recipient on the date of service that the service will be covered within the program.
The maximum recipent age for which the PDL history segment applies.
The maximum recipent age for which the PDL history segment applies.
Member to age limitation.
Unique interval for each DUR alert.
The amended Lien amount.
The amended lien amount.
The FDA Drug Application Number is a 25-character alphanumeric column that contains the drug application number assigned by the FDA.
The social security number of the absent parent
Times to allow a specific type of event before triggering some follow-up action.
This defines the rank that the area has when determining what region a particular area is in. For example, 'zip code' receives a higher rank than 'county code', which has a higher rank than 'state-wide'.
Number of Advanced Registered Nurse Practitioners at this site.
Account Receivable Control Number.
The service line into which this service line was bundled. Use the LX from this transaction which points to the bundled/unbundled line. Required if payer bundled/unbundled this service line. Number assigned for differentiation within a transaction set.
Related 'Prescription/Service Reference Number' to which the service is associated. Used for partial fill processing.

Average Length of stay for pricing DRG
Average Length of stay for pricing DRG
The number on the account where district office claimant has access to funds
Account number for the closed account
The number on the second account at the same bank where district office claimant has access to funds
The number on the third account at the same bank where district office claimant has access to funds
The number on the fourth account at the same bank where district office claimant has access to funds
The payee number on the bank clears record.
Provider DRG base rate. For in-state hospitals the value is copied from the provider data; out of state providers get default data
This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the peer group specific calculation.
This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the peer group specific calculation.
This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the provider specific calculation.
This is a date sensitive pricing factor expressed in dollars terms, and is one of the primary components for the DRG calculation. This base rate is used for the provider specific calculation.
Provider DRG base rate. For in-state hospitals the value is copied from the provider data; out of state providers get default data
Indicates the department the check was returned to and the type of check that was received.
Indicates the department the check was returned to and the type of check that was received.
The beginning batch number is the first batch number assigned to a claim each day for a particular transaction type.
The ending batch number is the last possible batch number that can be assigned to an ICN. If we increment past the ending batch number , the job will terminate.
The To batch range to be used in scheduling claims for data correction.
The next batch number is the batch that will be used when we fill the current batch.
Sequence number of all the exceptions.

The to batch range to be used in scheduling.
Indicates the check-digit portion of the 11-digit delivery point barcode.
Indicates the check-digit portion of the 11-digit delivery point barcode.
Pharmacy Coverage BIN Number.
The weight of a newborn at time of birth in grams (applicable to newborns only).
A key index for relating a person`s body weight to their height.
A key index for relating a person`s body weight to their height.
A key index for relating a person`s body weight to their height.
Medicaid Surety Bond Number shown on certificate.
Medicaid assigned bond number for DME supplier.
Medicare Surety Bond Number shown on certificate.
Medicare assigned bond number for DME provider.
Number of beds in the facility designated as dual, for both Medicare and Medicaid patients.
The callers extension.
The callers telephone number.
The length of the call.
The Number of Txn's created when the rate increase was processed.
The Number of Txn's created when the rate increase was processed.
This is the number of days out of the month that the capitation payment covers.
This is the number of days out of the month that the capitation payment covers.
This is the number of days out of the month that the capitation payment covers.
The case number associated with this contact. This field was added 6/18/03 to facilitate the conversion of data from Maximus.
Total number of provider cases in search criteria.
Total number of client cases in search criteria.
Number used to identify a group of recipients within the same family.
The case number assigned by KAECSES.
Number used to identify a group of recipients that are in a case created by DHS.
Number used to identify a group of recipients that are in a case created by DHS.
The case number on the PS/2 tarnsaction.
The case number on the PS/2 tarnsaction.
This field is used to identify the lien case number.
This field is used to identify the lien case number.
Contains the recipient case code assigned to the new recipient.
Contains the recipient case code assigned to the old recipient.

The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.
The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.
The unique identifier for a casualty case. Used by account to identify the casualty cases on reports.
Case number provided by external entity.
Unique identifier assigned to each attorney.
An account assigned number to an individual insurance company.
The account assigned number of the tortfeasor.
The account assigned number of the tortfeasor.
This identifies the iteration number for the CAS segment. A maximum of 99 CAS segments are allowed for a claim detail. For the claim header the maximum is 5.
The cause number that the county courthouse puts on the lien for a torfeasor and a particular case.
Percentage for claim check savings report.
Rank for claim check savings report.
Sponsor cell phone, with area code
Certification number related to the special certification or licensure represented by the certification type code.
The total number of changes to the t_tpl_resource table that were forced by the insurance disclosure file
MICR number that is preprinted on the check by the financial institution. This number is used to identify the check to all parties external to the system.
The MICR number preprinted on the check that was submitted to the state by an external source.
The MICR number or transaction number printed on the payment that was submitted to the state by an external source.
MICR number that is preprinted on the check by the financial institution. This number is used to identify the check to all parties external to the system.
The number of the EFT assigned by the MMIS and sent to STO.
The number that normally appears on the check or reported on the remittance advice. It can refer to the check or EFT or State transfer
This is the payment/check number for the payment.
The check number related to the transaction.
The check or EFT number
The check or EFT number.
The check or EFT number.
The check or EFT number that contains payment for a particular claim

The number assigned to the payment that is externally displayed to other parties. This could be the MICR number on the check or the EFT number sent to the bank. This number is significant in that it needs to populate the TRN02 attribute on the 835 file.
Check number on the bank clears record.
If the check is a reissue, this will indicate the original check number being replaced.
The number of babies in pregnancy.
The number of eligible claims with ICN date equal to DTE_REPORTED.
Number of claims processed in this warrant
The number of eligible claims compliant as of the date of compliance.
The number of eligible claims in suspended status.
COST TO CHARGE RATIO
This is the clinical lab number from OSCAR.
This is the clinical lab number from OSCAR.
This is the clinical lab number from OSCAR.
The number assigned to this certification.
Micromedex heirarchal route code used in ProDUR editing of Pharmacy claims.
The number under which the district office claimant's income is paid
Number of claims reviewed.
Payer Claim Control Number
VERSION IDENTIFICATION OF THE GROUPER USED (FOR IRP'S USAGE)
VERSION IDENTIFICATION OF THE PRICER USED (FOR IRP'S USAGE)
THE VERSION OF THE PRICER BEING CALLED
WAGE INDEX FOR THE MSA
Indicates the CMS number of units per package as supplied by CMS. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code.

The Units Per Package Size indicates the number of units per package as supplied on the CMS's quarterly tape.
The final answer for the numerator portion of the measure.
Control Number for tracking the research request or project. Format is YYYYMMDDSSS where SSS is a sequence number. This number will be generated by the system. The sequence number resets to 001 each day.
Control Number for tracking the research request or project. Format is YYYYMMDDSSS where SSS is a sequence number. This number will be generated by the system. The sequence number resets to 001 each day.
Control Number for tracking the research request or project. Format is YYYYMMDDSSS where SSS is a sequence number. This number will be generated by the system. The sequence number resets to 001 each day.
Control Number for tracking the research request or project. Format is YYYYMMDDSSS where SSS is a sequence number. This number will be generated by the system. The sequence number resets to 001 each day.
The area code of the contact person's telephone number.
The extension number of the contact person's telephone number.
The 4 character number of the contact person's telephone number.
The telephone exchange of the contact person's telephone number.
This is a generic total accumulator.
The area code of the contact person's telephone number.
The extension number of the contact person's telephone number.
The contact fax number of the applicant as provided on the enrollment application.
The contact fax number of the applicant as provided on the enrollment application.
Contact Fax Number of Provider Service Location.
Fax number of contact person, after the change.
Fax number of contact person, after the change.
Fax number of contact person, before the change.
Fax number of contact person, before the change.
The 4 character number of the contact person's telephone number.
The contact phone number of the applicant as provided on the enrollment application.
The contact phone number of the applicant as provided on the enrollment application.
Contact Phone Number of Provider Service Location.
Phone number of contact person, after the change.
Phone number of contact person, after the change.
Phone number of contact person, before the change.

Phone number of contact person, before the change.
Extension number.
Extension number.
The phone number extension used to contact the provider service location.
Extension associated to contact person's phone number, after the change.
Extension associated to contact person's phone number, after the change.
Extension associated to contact person's phone number, before the change.
Extension associated to contact person's phone number, before the change.
The telephone exchange of the contact person's telephone number.
GHO Contract Number.
GHO Contract Number.
Contract number
The maximum number of recipients an NPI is allowed to service.
Contract Percentage, expressed as a percent. AKA Allowance or Charge Percent.
Transaction number sent by HWT/ SUR.
User assigned control number made up of Julian date and three digit sequence number to make unique.
The control number or the performing provider number.
This is the external number that identifies an account receivable in the system. For manually entered account receivables this field will contain the text version of the sak_acct_rec. For claim related account receivables this field will contain the ICN of the adjusting (daughter) claim. Claim related ARs will have the same value for all those ARs related to the same claim. For all other ARs this field will contain the text version of the sak_acct_rec.
Unique number assigned to track accounts receivables. This number will be used to file any documentation related to the accounts receivable. This is often the same as sak_acct_rec.
Unique number assigned to track accounts receivables. This number will be used to file any documentation related to the accounts receivable. The format of the number is RRYYJJJBBBSSS.
Unique number assigned to track accounts receivables. This number will be used to file any documentation related to the accounts receivable. The format of the number is RRYYJJJBBBSSS.
Number that uniquely identifies the A/R to the user.

Number that uniquely identifies the A/R to the user.
Number that uniquely identifies the converted A/R to the user.
Number that uniquely identifies the legacy A/R to the user.
A tracking number for the notification document.
The number of consecutive months of eligibility for this aid category.
The number of consecutive days of eligibility for this segment.
The number of consecutive months of eligibility for this segment.
The phone number of the carrier's contact person.
Conversion factor used in claims processing.
This field contains the number of copies for the report.
Number used to reference a correspondence document to the expenditure transaction.
Number used to reference a correspondence document to the expenditure transaction.
Number used to reference a correspondence document to the expenditure transaction.
This contains the reference number used to identify scanned documents.
The CORPID represents a parent or holding company that relates to the labeler ID or a division of a company. There can be several labeler IDs to one CORPID.
This is the marginal cost of care beyond the outlier threshold. Used for the state-wide calculation.
This is the marginal cost of care beyond the outlier threshold. Used for the peer group specific calculation.
This is the marginal cost of care beyond the outlier threshold. Used for the provider specific calculation.
This is the outlier threshold. This cost is used in outlier payment determination.
Provider cost to change ratio. For in-state hospitals the value is copied from the provider data; out of state providers get default data
Provider cost to change ratio. For in-state hospitals the value is copied from the provider data; out of state providers get default data
The number of claims found for the adjustment request.
This field is a generic counter.
This field is a counter for the number of adjustments processed for an adjustment request.
This field is a counter of the adjustments deleted or errored off for an adjustment request.
The number of checks received by the mailroom on a given date.
The number of miscellaneous checks received on a given date.
The number of checks received by the provider relations department on a given date.

The number of checks received by the SURS department on a given date.
The number of checks received by the TPL department on a given date.
This is the Court Case docket number of the casualty case.
The court case number associated with this case.
The court case number associated with this case.
Court Order Number.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of condition code positions that the related set of condition codes listed in T_COV_BNFT_CONDITION may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of condition code positions that the related set of condition codes listed in T_COV_BNFT_CONDITION may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of occurrence codes is optional.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of modifier positions that the related set of modifiers listed in T_COV_BNFT_MOD may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of modifier positions that the related set of modifiers listed in T_COV_BNFT_MOD may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of modifiers is optional.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of occurrence code positions that the related set of occurrence codes listed in T_COV_BNFT_OCCURR may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of occurrence code positions that the related set of occurrence codes listed in T_COV_BNFT_OCCURR may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of occurrence codes is optional.

The Cost to charge rate for the group.
The Cost to charge rate for the group.
This is the IRS control name\number.
This is the number of recipients that are assigned to the PMP as of the current date. This applies only to the Inclusion Restriction.
The number of days used in the interest calculation.
Number of days before the compliance date for reported data. This will be 30 or 90 days.
The number of days to recycle the edit/audit before it is assigned the final edit/audit.
The number of days for prudent payment. This is the number of calendar days before a payment is sent for a claim. It is calculated from the submit date.
The number of days for (prudent) payment. This is the number of calendar days before a payment is allowed for a claim. It is calculated from the submit date (date of receipt).
This attribute will contain the number of days in the range for a period on the EPSDT periodicity schedule.
Indicates the number of days the user wants to view the report for.
Indicates the number of days covered for the statement period of the claim.
Indicates the total number of days for the statement period of the claim.
This field indicates the total number of days for the statement period of the claim.
Indicates the total number of days for the statement period of the claim.
Indicates the total number of days for the statement period of the claim.
This field is the original covered days.
Number of days suration for a Disease.
Number of days duration for a disease.
The number of days within the chronic annual episode that the member has eligibility. This identifier is for chronic ETG only; the value will be blank for non-chronic ETG. Values 001- 366 or blank.
The number of days within the chronic annual episode that the member has eligibility. This identifier is for chronic ETG only; the value will be blank for non-chronic ETG. Values 001- 366 or blank.
The number of days within the chronic annual episode that the member has eligibility. This identifier is for chronic ETG only; the value will be blank for non-chronic ETG. Values 001- 366 or blank.

The number of days within the chronic annual episode that the member has eligibility. This identifier is for chronic ETG only; the value will be blank for non-chronic ETG. Values 001- 366 or blank.
Number of days to look back for historical claims information.
Number of days to look back for historical claims information.
The number of days between the service begin-date and service end date which were not covered in any part by medical assistance or medicare.
Indicates the number of days not covered for the statement period of the claim.
Indicates the number of days not covered for the statement period of the claim.
Indicates the number of days not covered for the statement period of the claim.
This is a calculated field when both Revocation date and Return date are present. It is the number of days between them.
Number of days to look back for historical PA information.
Number of days supply dispensed.
High number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outliers logic.
Low number of days used in outlier payment determination - This attribute will not be used at this time in the code, but it is necessary to prepare for future usage when the state is ready to develop some policy that uses the day outliers logic.
Day outlier threshold.
Day outlier threshold.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
Duration for which the PA should be authorized.
The number of days the prescription should last.
Number of days a prescribed drug should last a recipient.
Number of days a prescribed drug should last a recipient.
Number of days of the supply
The number of days a prescribed drug should last a recipient from the date it is dispensed.
The number of days a prescribed drug should last a recipient from the date it is dispensed.
Number of days a prescribed drug should last a recipient.

Number of days supply of a prescription a recipient is allowed.
Number of days a prescribed drug should last a recipient.
The percentage chance that any single data correction resubmitted by the user will be intercepted and made available for quality control review by the supervisor.
Drug Enforcement Administration identification number for a provider.
Drug Enforcement Administration identification number for a provider.
The Drug Enforcement Agency (DEA) certification number.
Drug Enforcement Administration identification number for a provider.
The total number of deletes to the t_tpl_resource table that were forced by the insurance disclosure file
This is the total amount of claims removed from the case.
This is the total amount of claims removed from the case.
Points to the first entry of a program and the program it affects.
A sequence number assigned by the DSS. This column allows the diagnosis codes to be placed in a DSS specific order and allow the DSS to define a unique key to the table.
The time of discharge for inpatient claims or end time of treatment for outpatient claims.
The time of discharge for inpatient claims or end time of treatment for outpatient claims.
If the dispensing fee indicator is a Y (yes), the dispensing fee will be multiplied by the dispensing fee percentage to get the final dispensing fee to pay to the provider.
Indicates the maximum distance from the PMP's location that a PMP is willing to accept Recipient from.
Indicates the maximum distance from the PMP's location that a PMP is willing to accept Recipient from.
District Office Number.
The relative weight for the DRG on the claim.
Minimum number of distinct drugs needed to meet the requirements for the drugs in a particular step therapy level. Drugs are counted as distinct drugs if they have different HICL sequence numbers.
The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.

The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.
This field is a random number representing the generic formulation. This field is specific to generic ingredient combination, route of administration, dosage form and drug strength. It also is the same across manufacturers and/or package sizes.
This field is a random number representing the generic formulation. This field is specific to generic ingredient combination, route of administration, dosage form and drug strength. It also is the same across manufacturers and/or package sizes.
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The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.
This field is a random number representing the generic formulation. This field is specific to generic ingredient combination, route of administration, dosage form and drug strength. It also is the same across manufacturers and/or package sizes.
This field is a random number representing the generic formulation. This field is specific to generic ingredient combination, route of administration, dosage form and drug strength. It also is the same across manufacturers and/or package sizes.
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The HICL Sequence Number (HICL_SEQNO) is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.
ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.
The HICL Sequence Number is a unique and randomly assigned 6 byte numeric field which provides a link from either the NDC or the GCN Sequence Number record to the Hierarchical Ingredient Code List. It can serve as an association which reduces redundancy.
The HICL Sequence Number is a unique and randomly assigned 6 byte numeric field which provides a link from either the NDC or the GCN Sequence Number record to the Hierarchical Ingredient Code List.
The HICL Sequence Number (HICL_SEQNO) is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.
The HICL Sequence Number is a unique and randomly assigned 6 byte numeric field which provides a link from either the NDC or the GCN Sequence Number record to the Hierarchical Ingredient Code List.
The drug HICL Sequence of the drug on the claim in history which the ProDUR alert failed against.
This is the system generated detail number.
The number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
The number of the detail on a claim record.
Number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
The number of the detail on a claim record.
The detail number of a claim record.

Number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
Detail number which receives the kick payment. There will only be one kick payment detail per claim
Number of the detail on the claim.
The number of the detail on a claim record..
Number of the detail on the claim.
Detail number
The number of the detail on a claim record.
Number of the detail on the claim.
The number of the claim detail that was modified by ClaimCheck.
The number of the detail for the claim record identified by ICN.
This is the detail number of the claim if the transaction is a claim. For a claim, 0 would indicate that the claim was paid at the header and not the detail level.
The number of the detail on a claim record.
The number of the detail on the claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
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The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
Detail number which receives the kick payment. There will only be one kick payment detail per claim
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on the claim.
The number of the detail on a claim record.

The number of the detail on a claim record.
The number of the detail on a claim record.
The detail number of a claim record. If zero (0), the row contains header information.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
Detail number
The number of the detail on a claim record.
The detial number of the claim.
The number of the detail on a claim record. If zero (0), the information on the table row is for the claim header.
The number of the detail on a claim record. If zero (0), the information on the table row is for the claim header.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
Detail number for the claim record. Value of zero is used for non-claim records and header processed claims.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on the claim.
The number of the detail on a claim record.
The number of the detail on a claim record.
The detail number of the claim
The service line number of the claim.
Number of the detail on the claim.
Number of the detail on the claim.
Claim detail number on a given ETG claim.
Claim detail number on a given ETG claim.
Claim detail number on a given ETG claim.
Claim detail number on a given ETG claim.
The number of the detail on a claim record. If zero (0), the information on the table row is for the claim header.

The detail number of the claim. Default is zero
The detail number of the claim. Default is zero
This is the detail number of the claim if the transaction is a claim. For a claim, 0 would indicate that the claim was paid at the header and not the detail level.
The associated claim/encounter detail number.
The claim detail number for each claim that was associated with this measure.
The detail on the claim that caused the delivery payment to be generated.
The detail number of a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record. If zero (0), the information on the table row is for the claim header.
A unique number within the record that identifies an individual claim line.
Number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
Number of the detail on the claim.
The number of the detail on a claim record. This field will have a value of zero for header processed claims.
The number of the detail on a claim record.
This is the system generated detail number.
This is the system generated detail number.
Claim detail number associated to the remark code.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The detail number of a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
This is the detail number of the claim.
This is the detail number of the claim.
This is the detail number of the claim.
This is the detail number of the claim.

This is the detail number of the claim.
This is the detail number of the claim.
The number of this specific detail. This is a unique number
This identifies the number of details that a claim has.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record.
The number of the detail on a claim record. If zero (0), the information on the table row is for the claim header.
The number of the detail on a claim record.
The number of the detail on the claim.
The number of the detail on a claim record.
The number of the detail on the claim.
CLAIM DETAIL NUMBER
CLAIM DETAIL NUMBER
CLAIM DETAIL NUMBER
Detail number of the claim being reported as an adjustment claim. For original claims, this will be all 8s.
A sequential number, starting at 1 for each sak_claim, assigned to each row meeting the Dental Profiler claim criteria.
The number of the detail on the claim record in history that triggered the alert to set. This field will be 0 when the alert is not based on a historical claim.
A sequential number, starting at 1 for each sak_claim / performing provider NPI, assigned to each row meeting the Dental Profiler claim criteria.
Detail number of original claim. For original claims, this is the ICN of the claim being reported. For voided and adjusted claims, this is the ICN of the mother claim.
The claim detail that contains the procedure that ClaimChreck indicates is the bundled procedure.
This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number. The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.

This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number. The new bundling detail will have the system generated flag on. Unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into asingle NEW detail, then the original bundled details point to the new bundling detail using a sequence number . The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
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This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original submitted with more than one tooth number. Bundling: When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number. The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
This sequence number points to the original detail or details submitted on the claim. For dental electronic claims this will point to the original detail submitted with more than one tooth number. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number. The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
This sequence number points to the original detail or details submitted on the claim. Bundling. When two or more details are bundled into a single NEW detail, then the original bundled details point to the new bundling detail using a sequence number . The new bundling detail will have the system generated flag on unbundling. This is the reverse of bundling. In this case a detail on a claim is broken out into two or more details that replace the original detail. The new details will have the system generated flag on and will point to the original unbundled detail.
The number of the related history claim detail.
Number that identifies the header (00) or detail (01-999) of the history claim that is related to a current claim processing.
This is the sequence number of the SVD segment within a claim detail. Up to 25 SVD segments may be related to a detail.
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This is the sequence number of the SVD segment within a claim detail. Up to 25 SVD segments may be related to a detail.
Total number of details associated with claim header.
Total number of details associated with the claim header.
Total number of details associated with claim header.
Total number of details associated with the claim header.
Total number of details associated with the claim header.
Total number of details associated with the claim header.
Total number of details associated with claim header.
Total number of details associated with claim header.
Total number of details associated with the claim header.
Total number of details associated with the claim header.
Indicates the total number of details on the claim.
Total number of details associated with claim header.
Total number of details associated with the claim header.
The duration of the question.
The number of the call duration.
This is the bank account number for the payees in which the payments are electronically transferred.
This is the bank account number for the provider in which the payments are electronically transferred.
The provider's bank account number where payments will be deposited.
The provider's bank account number where payments will be deposited.
EFT account number after change.
EFT account number before change.
This is the PDPs Federal employee identification number
The telephone number of the type of address indicated.
Address of entry in entity relationship method table that dependency entry relates to. This serves as pointer from dependency entry to entity relationship method entry.
The level of processing assigned to a single entity or entity relationship that is affected by another entity or entity relationship.
The level of processing assigned to a single entity or entity relationship.
Helps to determine the processing sequence of programs and what can be reset when processing for a particular portion of an entity is complete. Occurs 32 times
Helps to determine the processing sequence of programs and what can be reset when processing for a particular portion of an entity is complete. Occurs 32 times
Indicates which entity in the entity relationship line item table the dependency is associated with.
EVD Source Identifier

EVD Vocabulary Type Identifier
Extended event error message key. For example, ORA-00980 or TNS-12541.
The unique key that identifies each inquiry made to the EVS system. The key is made up of 10 digits: a 5-digit Julian Date and a 5-digit sequence number. The format is YYJJJSSSSS.
The unique key that identifies each inquiry made to the EVS system. The key is made up of 10 digits: a 5-digit Julian Date and a 5-digit sequence number. The format is YYJJJSSSSS.
the phone number extension.
The technical contacts phone number extension.
The facility ID number for the " non Medicaid certified" facility that is associated with the case.
The number of days in the billing period the recipient was in the long term care facility (excludes ltc leave days and ltc hospital days).
The area code of the contact person's telephone number.
The extension number of the contact person's telephone number.
The 4 character number of the contact person's telephone number.
The telephone exchange of the contact person's telephone number.
Family size
This is a fax number in the format area code + prefix + suffix.
The fax number of the attorney firm.
Member's fax number.
The fax number of the contact
US or international fax number of the carrier's contact person.
The company fax number that the insurance agent is employed by.
The fax number for the policyholder in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
This is the fax number of this contact.
State Fax Number
The fax number for the tortfeasor in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
The fax number for the tortfeasor in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
Contact person facsimile number.
The fax number for the absent or custodial parent in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
The fax number for the carrier in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.

The fax number for the carrier in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
This is the fax number for the subcontractor contact.
The fax number for the corporate contact in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
The fax number of the employer.
The fax number of the property where the lien is held in the format area code + prefix + suffix if within the US. Could be an out of country fax number if country code is not US.
A number at which the provider can be sent facsimiles.
A number at which the provider can be sent facsimiles.
A number at which the provider can be sent facsimiles.
Agent contact's fax number after change.
Agent contact's fax number before change.
NUM_FAX_PHONE
Fax number of VA office associated with veteran, including area code
Indicates the CMS number of units per package as supplied by FDB. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code.
This is the unique Federal Account number to be used on the electronic Invoice extract.
Number of the position of the CMS field within a record.
Number of the position of the CMS field within a record.
Combined Size Of All Files Created.
Number of bytes in the file.
Indicates the Provider's Fiscal Year End Month.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.
The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.

This contains the gcn sequence number for the NDC.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code. Value 'ZZZZZZ' indicates that all the GSNs in the corresponding CDE_THERA_CLS_SPEC will be screened. Value other than 'ZZZZZZ' indicates only that GSN will be screened.
The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredient(s), route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.
This represents the starting range for GCN sequence number.
This field is a unique number representing the active ingredient(s), route of administration, drug strength and dosage form. This field holds either the FDB GCN Sequence Number or the Micromedex Generic Formulation Code.
This represents the ending range for GCN sequence number.
This is the number of recipients that are assigned to the PMP as of the next enrollment date for the program. This applies only to the Inclusion Restriction.
This is the number of recipients assigned to the PMP during the upcoming enrollment period.
This is the number of recipients assigned to the PMP during the upcoming enrollment period.
This is the number of recipients assigned to the PMP during the upcoming enrollment period.
Month in which the provider's fiscal year end occurs.
Maximum number of days break allowed.

The generic drug code is a 5 digit code (left justified in the 12 characters available in the field) assigned by First Data Bank (Medical Assistance contractor for drug pricing data) to group together all identical drugs. For example Acetominophen tablets/50mg drug codes will have a common Acetominophen tablets/50mg drug codes will have a common generic drug code.
The Generic Code Number (GCN) is a unique number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications, such as generic substitution.
The Generic Code Number (GCN) is a unique number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes.
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The Generic Code Number (GCN) is a unique number representing the generic formulation. The GCN is specific to generic ingredient combination, route of administration, and drug strength, across all dosage forms. The GCN is the same across manufacturers and/or package sizes. The number by itself has no significance, but is useful for online computer applications, such as generic substitution.
The beginning GCN of the GCN range for an audit. The Generic Code Number (GCN) is a unique number representing the generic formulation.
The beginning GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation.
This is the GCN Sequence number for the drug code.
The ending GCN of the GCN range for an audit. The Generic Code Number (GCN) is a unique number representing the generic formulation.
The ending GCN Sequence Number of the GCN Sequence Number range for an audit. The Generic Code Number Sequence Number (GCN_SEQNO) is a unique number representing a generic formulation.
This is the generic number.
Number indicating the quality of the address match when assigning latitude and longitude.

Provides the timeframes that apply to each surgical procedure.
Provides the timeframes that apply to each surgical procedure.
The value of the global surgical code of the procedure codes that this audit is checking.
Ingredient code as supplied by Micromedex (SALT).
Ingredient code as supplied by Micromedex (BASE).
The malpractice expense geographic adjustment factor used in computing the RBRVS fee schedule amount.
The practice expense geographic adjustment factor used in computing the RBRVS fee schedule amount.
The work geographic adjustment factor used in computing the RBRVS fee schedule amount.
The group number of the Third Party Liability (TPL) health insurance policy.
The group number of the policy.
Policy group number. If present, gives the group number of the policy.
Policy group number. If present, gives the group number of the policy.
Policy group number. If present, gives the group number of the policy.
GS06 value from EDI document.
Group Control Number
Assigned number originated and maintained by the sender. The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.
CMS Units Per Package Size indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS) quarterly update. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code.
CMS Units Per Package Size indicates the number of units per package as supplied on the Centers for Medicare and Medicaid Services' (CMS) quarterly update. This column must be used in conjunction with the CMS Unit Type Indicator to determine the appropriate number of units. Information in this column is provided by CMS and may vary from the First DataBank Package Size and Drug Form Code.
Fiscal Year for the Provider
HIC number
The previous values for the HIC numbers sent by CMS.
Hierarchical Specific Therapeutic Class Code Sequence Number (HIC3_SEQN on NDDF update).

The start value for a range of HICL sequence numbers. The HICL Sequence Number is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.
This is the HICL Sequence number for the drug code.
The end value for a range of HICL sequence numbers. The HICL Sequence Number is a six-byte numeric field which provides a link from either an NDC or a GCN Sequence Number record to the Hierarchical Ingredient Code List.
Number representing the relative order/importance of each ingredient within a multi-ingredient drug. 1 will signify primary ingredient. FDB ONLY.
This field determines the order in which an AR is recouped.
This field determines the order in which an AR is recouped.
If an assigned budget has multiple alternate budgets, this will determine the order in which they will be checked.
This field determines the order in which an AR is recouped.
A numeric value assigned to indicate the order we will check a transaction for scheduling. Once a transaction meets all criteria on a single financial schedule, it will use that assigned scheduled period. Therefore, the order in which we check the different schedules for the same transaction type is important.
The payer hierarchy sequence.
The payer hierarchy sequence.
This is another system assigned identifier that is used to identify a hiierarchy thread that contains this assignment plan. This column contains only positive values when the CDE_TYPE_PLAN is equal to 'ASGN'. Otherwise the value of this column is zero. The value is maintained as an ascending sequence of numbers starting with 1. There is a sequence for each payer. So Payer 1 may have values 1, 2, 3; and Payer 2 might have values 1,2, 3, 4.
This is another system assigned identifier that is used to identify a hiierarchy thread that contains this benefit plan within a Payer. This column contains only positive values when the CDE_TYPE_PLAN is equal to 'BNFT'. Otherwise the value of this column is zero. The value is maintained as an ascending sequence of numbers starting with 1. There is a sequence for each payer. So Payer 1 may have values 1, 2, 3; and Payer 2 might have values 1,2, 3, 4.
This is another system assigned identifier that is used to identify a hiierarchy thread that contains this Financial Payer.
This is used to identify the hierarchy of this Fund Payer. This field is currently not in use.
Total High Daily MME Range per day
Field to store the number of days to keep the history log and error records on before they are purged for a specific source code.
Applicant home phone, with area code

Sponsor home phone, with area code
The election period code
The number of days in the billing period the provider reserved a bed while the recipient was in a hospital.
Number of hours logged.
Number of training hours.
Household Size used in the eligibility determination process
Number of hours estimated to complete the research request or project.
The number of hours expended and reported on this detail.
Number of hours the provider works at the service location per week.
The hours worked per week.
ICD-9 CM type number
The number of days of intermediate care for that were paid for in whole or in part by Medicaid.
This represents the unique internal control number for a Medicaid claim. RRYYJJJBBBSSS
The ICN of the claim being questioned.
Number assigned to a claim processed in the system used for internal control purposes.
Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.
Number assigned to a claim processed in the system; used for control purposes.
Number assigned to a claim processed in the system which is used for control purposes.
Number assigned to a claim processed in the system used for internal control purposes.
Claim ICN. Format: RRYYDDDBBBSSS RR=region, YYDDD=julian date, BBB=batch, SSS=sequence number.
Claim ICN. Format: RRYYDDDBBBSSS RR=region, YYDDD=julian date, BBB=batch, SSS=sequence number.
Number assigned to a claim processed in the system.
ICN of the claim that SURS has identified as needing to be adjusted.

Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system used for internal control purposes.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
ICN for which the Drug Rebate Unit is requesting information.
A unique control number assigned to the claim.
Unique control number assigned to the invoice to indicate its date of receipt. The format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year the claim was received; JJJ is the julian date of claim receipt; BBB is the batch number; and SSS is the sequence number of the invoice within the batch.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
This is the claim's internal control number.
This is the internal control number of the claim.
The system assigned internal control number (ICN) that identifies a claim in the MMIS.
Number assigned to a claim processed in the system. This number is used for control purposes.
Claim ICN Format: RRYYDDDBBBSSS RR=region, YYDDD=julian date, BBB=batch, SSS=sequence number
Number assigned to a claim processed in the system. This is used for control purposes.
Number assigned to a claim processed in the system used for internal control purposes.
Number assigned to a claim processed in the system; used for control purposes.
Number assigned to a claim processed in the system. This number is used for control purposes.
This number uniquely identifies a claim.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.

Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system; used for control purposes. Unique number in format RRYYDDDBBBSSS: RR - region, YYDDD - julian date, BBB - batch number, SSS - sequence number.
Number assigned to a claim processed in the system; used for control purposes.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
A unique claim number assigned by the states payment system that identifies the adjustment claim.
Number assigned to a claim correction form processed in the system; used for control purposes.
This is the unique key identifier for the Consent Form. It is assigned by the Feith software and loaded into this table in the AL Interchange process and Data Model. The format is comprised of Year, Julian Date, Batch Number and Sequence
This is the unique key identifier for the Consent Form. It is assigned by the Feith software and loaded into this table in the AL Interchange process and Data Model. The format is comprised of Year, Julian Date, Batch Number and Sequence.
This field contains the Internal Control Number (ICN) assigned to the claim when it entered the system.
This field contains the Internal Control Number (ICN) assigned to the claim when it entered the system.
The unique internal control number associated with a claim.
This is the ICN of the claim that is being adjusted.

This is the field that is used to identify the claim that is having funds recouped from. This is also what the providers see on the RA to identify the AR if the AR is claim related.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
A unique number assigned by the states payment system that identifies an original claim.
NCPDP field 993-A7, Required when used for payer-to-payer coordination of benefits to track the claim without regard to the "Service provider id, Prescription Number, & Date of Service".
Claim number assigned by the external entity to the NCPDP Request record.
The original ICN of the claim that is being adjusted.
This number indicates the total number of times that a plastic ID card has been issued to a recipient.
Port instance from which request was received.
Number of individuals in a group. Used for group therapy services.
Number of individuals in a group. Used for group therapy services.
Number of ingredients from range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.
Number of ingredients from range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.
ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.
ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.
ID representing a drug's active ingredient list. For FDB implementations, this holds the HICL Sequence Number. For Micromedex, this holds the Generic Cross-Reference (GCR) code.

Drug HICL sequence number
Drug HICL sequence number
The HICL Sequence Number is a unique and randomly assigned 6 byte numeric field which provides a link from either the NDC or the GCN Sequence Number record to the Hierarchical Ingredient Code List.
The drug HICL Sequence of the drug on the claim in history which the ProDUR alert failed against.
Drug HICL number
Number of ingredients to range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.
Number of ingredients to range(1-9999) to allow for compounds to pay varying based on the number of unique ingredients in the compound.
The telephone number of the Third Party Liability (TPL) Insurance carrier.
The insurance claim number assigned by an Insurance carrier.
The insurance claim number assigned by an insurance carrier.
ISA13 value from the EDI document.
Interchange Control Number.
A control number assigned by the interchange sender. The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.
Latitude to the providers address
Latitude to the providers address.
Latitude to the providers address
Geographical Latitude of Recipient's Address
Geographical Latitude of recipient's address.
Geographical Latitude of beneficiary's address.
The number of days in the billing period the provider reserved a bed while the recipient was away on therapeutic leave.
Number of days during the period covered by Medicaid patient did not reside in the LTC facility.
The claim length of stay.
The claim length of stay.
The type of letter that is to be produced by the batch cycle.
Level of the node within the Classification hierarchy.
The license or accreditation number issued to the provider by the licensing entity.
Line number of the free form text used to describe the research request or project.
Number of line items submitted on the claim form or transaction.

Number of line items submitted on the claim form or transaction.
Transaction line number that identifies the line number on the adjustment ICN.
Transaction line number that identifies the line number on the adjustment ICN.
Transaction line number that identifies the line number on the adjustment ICN.
Transaction line number that identifies the line number on the adjustment ICN.
This is the sequence number that uniquely identifies each external text record for the prior authorization.
This is the line number of the Prior Authorization internal free-form text entered by the PA Analyst for internal use only. It is used to uniquely identify multiple internal text rows entered for the same PA request.
A unique number to identify the transaction line number being reported on the original claim.
A unique number to identify the transaction line number being reported on the original claim.
A unique number to identify the transaction line number that is being reported on the original claim
A unique number to identify the transaction line number that is being reported on the original claim
The FDA Listing Sequence Number is a 7-character numeric column that contains the unique, FDAgenerated identification number for a product. This number provides access to additional FDA descriptive elements (for example, manufacturer, ingredients, strength, and strength unit of measure) and additional FDA resources, such as RxNorm, Drugs@FDA, and Orange Book databases.
WEIGHT ASSIGNED TO THE APC
SERVICE UNITS TRANSFERRED FROM INPUT, FOR PRICER. FOR THE LINE ITEMS ASSIGNED APCS 33 OR 34, THE SERVICES UNITS ARE ALWAYS ASSIGNED A VALUE OF 1 EVEN IF THE INPUT SERVICE UNITS WERE GREATER THAN 1
This is the ABA (bank routing number) of the source bank of the lockbox transaction.
The check account number on the check used for the lockbox payment (where applicable).
System assigned key that uniquely identifies any payment submitted to the account from an outside source.
The last number used by the system to generate a case log number for a specified system date.
Longitude to the providers address.
Longitude to the providers address.
Longitude to the providers address.
Geographical Longitude of Recipient's Address
Geographical Longitude of recipient's address.

Geographical Longitude of beneficiary's address.
Total Low Daily MME Range per day
Phone number associated to the mail to address, after the change.
Phone number associated to the mail to address, after the change.
Phone number associated to the mail to address, before the change.
Phone number associated to the mail to address, before the change.
Extension of the mail to phone number, after the change.
Extension of the mail to phone number, after the change.
Extension of the mail to phone number, before the change.
Extension of the mail to phone number, before the change.
Fax number associated to the mail to address, after the change.
Fax number associated to the mail to address, after the change.
Fax number associated to the mail to address, before the change.
Fax number associated to the mail to address, before the change.
This is a one-digit field that provides an estimate of how likely successful delivery of mail to an address might be.
This is a one-digit field that provides an estimate of how likely successful delivery of mail to an address might be.
A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
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A 10 byte unique number that identifies the mass adjustment request. Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
A 10 byte unique number that identifies the mass adjustment request . Format: RRYYJJJBBB. It is user-keyed for manually entered adjustment requests, and system-assigned for system generated adjustments.
Master Log Number.
The total number of matches from the insurance disclosure file as compared to the t_tpl_resource table
The maximum panel size a PMP in the specified program is allowed to have.
The maximum age in a PMP provider's age restriction.
Maximum age in days for the precaution. (PRIMARY KEY PART 2)
Maximum age in days for the precaution. (SECOND KEY PART 3)
The MAXIMUM number of items in the variable array that this requirement must match.
Identifies the maximum number of days covered for the recipient in order for the crosswalk to apply.
This is the maximum number of recipients that the PMP is willing to see in the restricted demographics. No max panel is set for a Restriction Type of 'Exclusion'.
This field contains the maximum number of recipients allowed for a Primary Medical Provider.
Maximum number of working cases for an analyst.
The number of beds available in an institutional facility which are designated for Medicaid recipients.
The number of beds available in an institutional facility which are designated for Medicaid recipients.
The number of beds available in an institutional facility which are designated for Medicare recipients.
The number of beds available in an institutional facility which are designated for Medicare recipients.
The actual number of recipients auto-assigned to the specified PMP.
A fax number including area code as listed on the contract with the state
The telephone number including area code of the managed care entity.

The eligibility group(s) the state authorizes the managed care entity to enroll.
The number of inpatient psychiatric days covered by Medicaid on this claim.
The number of inpatient days covered by Medicaid on this claim.
This is the average length of stay associated to a particular DRG classification group.
The value of the measurement. Valid values are provided in the 837 Professional HIPAA Implementation Guide.
Number of beds in the facility designated for Medicaid patients ONLY.
The Medicare provider number assigned by the Federal government.
Medicare number assigned by the government to the provider.
Number of beds in the facility designated for Medicare patients ONLY.
The medical record number of the applicant's spouse
The age of the family member as entered on the application
Number of midwives at this site.
The minimum panel size a PMP in the specified program is allowed to have.
The minimum age in a PMP provider's age restriction.
Minimum age in days for the precaution. (PRIMARY KEY PART 1)
Minimum age in days for the precaution. (SECOND KEY PART 2)
The MINIMUM number of items in the variable array that this requirement must match.
Identifies the minimum number of days covered for the recipient in order for the crosswalk to apply.
This is the minimum number of recipients that the PMP has contracted to accept. This data is primarily for reporting purposes.
The total number of mismatches from the insurance disclosure file as compared to the t_tpl_resource tabl
MME Daily Dose Conversion Factor, based on low/high ttl daily range
Morphine Milligram Equivalent Factor provides the factor used to find the Morphine Milligram Equivalent (MME) for a dosage unit.
MME Dosage Unit Factor
Medicare Outpatient Adjudication - Reimbursement Rate Percent. Percentage expressed as a decimal.
Month of year.
Month in which providers in a county should be visited.

Minimum recipient age for Medical Review requirement. This attribute is used with the Medical Review indicator to determine if a service requires review. (Example: If the Medical Review indicator is 'Y' and the recipient age is between 0 and 21, the service requires Medical Review.)
Maximum recipient age for Medical Review requirement. This attribute is used with the Medical Review indicator to determine if a service requires review. (Example: If the Medical Review indicator is 'Y' and the recipient age is between 0 and 21, the service requires Medical Review.)
A number that identifies a condition that meets certain criteria such as a claim error or audit.
Master Log Number.
Master Log Number.
Master Log Number.
Master Log Number.
Master Log Number.
Master Log Number.
Master Log Number.
Master Log Number.
This is the State's National Plan number.
This is the national plan number of the State that will be displayed on the 835.
The area code of the contact person's telephone number.
The extension number of the contact person's telephone number.
The 4 character number of the contact person's telephone number.
The telephone exchange of the contact person's telephone number.
The number of days of institutional long-term care not covered by the payer.
The number of days of institutional long-term care not covered by the payer.
The line item number for the note
This is the contact id for the communication with the caller.
The number of days of nursing care on this claim that were paid for in whole or in part by Medicaid
This is the claim #.
Opioid Strength provides the numeric quantity of the opioid per defined drug form. For example, 20mg tablet, the Opioid Strength value is 20
This is the postion within the array of this entry which may be an array in itself.
This represents the attribute position within the relation.
Original GS06 value from EDI document before TPM actions.
Original ISA13 value from EDI document before TPM actions.

Other phone entered on application, with area code
An alternative phone number for the applicant
Dollar amount used in outlier payment determination. The outlier threshold used in outlier payment calculation will be the greater of the DRG Rate multiplied by the Outlier Trim Point or the predetermined Outlier Threshold dollar amount.
The number of days paid as outliers under Prospective Payment System and the days over the threshold
A number or other value that indicates the services provided on this claim have been authorized.
A number or other value that indicates the services provided on this claim have been authorized.
A number or other value that indicates the services provided on this claim have been authorized.
A number or other value that indicates the services provided on this claim have been authorized.
Unisys' prior authorization number
This is the package size of the drug code.
This is the package size for the drug.
This field contains the total number of pages produced for this RA.
The provider number sent to STO identifying the party being paid.
A value used in ordering multiple occurrences.
A value used in ordering multiple occurrences.
A patient`s unique number assigned by the provider which identifies the client.
A patient`s unique number assigned by the provider which identifies the client.
A patient`s unique number assigned by the provider which identifies the client.
A patient`s unique number assigned by the provider which identifies the client.
CR1 - Ambulance Patient Weight
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).

Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only). See CDE_MISC and QLF_MISC_TYPE columns in T_CLM_MISC table.
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Identification for a recipient assigned by a provider and used in their system. This number is not required for processing (information only).
Submitted patient account number for HIPAA 835.
Submitted patient account number.
Submitted Type Of Bill for HIPAA 835.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of condition code positions that the related set of condition codes listed in T_PAY_BNFT_CONDITION may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of condition code positions that the related set of condition codes listed in T_PAY_BNFT_CONDITION may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of occurrence codes is optional.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of modifier positions that the related set of modifiers listed in T_PAY_BNFT_MOD may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of modifier positions that the related set of modifiers listed in T_PAY_BNFT_MOD may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of modifiers is optional.

This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of occurrence code positions that the related set of occurrence codes listed in T_PAY_BNFT_OCCURR may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of occurrence code positions that the related set of occurrence codes listed in T_PAY_BNFT_OCCURR may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of occurrence codes is optional.
Phone number associated to the provider's pay to address, after the change.
Phone number associated to the provider's pay to address, after the change.
Phone number associated to the provider's pay to address, before the change.
Phone number associated to the provider's pay to address, before the change.
Extension of phone number associated to the provider's pay to address, after the change.
Extension of phone number associated to the provider's pay to address, after the change.
Extension of phone number associated to the provider's pay to address, before the change.
Extension of phone number associated to the provider's pay to address, before the change.
Fax number associated to the provider's pay to address, after the change.
Fax number associated to the provider's pay to address, after the change.
Fax number associated to the provider's pay to address, before the change.
Fax number associated to the provider's pay to address, before the change.
Toll Free number associated to the provider's pay to address, after the change.
Toll Free number associated to the provider's pay to address, after the change.
Toll Free number associated to the provider's pay to address, before the change.
Toll Free number associated to the provider's pay to address, before the change.
Extension associated to the Toll Free number associated to the provider's pay to address, after the change.
Extension associated to the Toll Free number associated to the provider's pay to address, after the change.
Extension associated to the Toll Free number associated to the provider's pay to address, before the change.
Extension associated to the Toll Free number associated to the provider's pay to address, before the change.

Pay To Toll Free phone number extension.
Pay To Toll Free phone number.
Minimum recipient age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the recipient age is between 0 and 21, the service requires PA.)
Minimum recipient age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the recipient age is between 0 and 21, the service requires PA.)
Maximum recipient age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the recipient age is between 0 and 21, the service requires PA.)
Maximum recipient age for PA requirement. This attribute is used with the PA indicator to determine if a service requires PA. (Example: If the PA indicator is 'Y' and the recipient age is between 0 and 21, the service requires PA.)
This represents the Prior Authorization line-item number for the PA record. Each PA record may have up to 10 line-items.
This represents the Prior Authorization line-item number for the PA record. Each PA record may have up to 10 line-items.
This represents the Prior Authorization line-item number for the PA record. Each PA record may have up to 10 line-items.
This represents the Prior Authorization line-item number for the PA record. Each PA record may have up to 10 line-items.
The sequence number for this line item
Personal benefits number
Pharmacy Coverage PCN Number.
This field identifies the recipient ID check digit to be used with the claims engine process.
ID-MEDICAID check digit used to verify recipient ID.
ID-MEDICAID check digit used to verify recipient ID.
ID-MEDICAID check digit used to verify recipient ID.
Number used to verify recipients ID.
This field identifies the recipient ID check digit to be used with the claims engine process.
ID-MEDICAID check digit used to verify recipient ID.
This is the percentage amount that the rate will be changed by.
This is the percentage of ownership of the provider that the owner has.
This is the period that the payment was made for such as the month or quarter. In Oklahoma this will be the quarter that the payment was made for.
Number of Periods. Total number of periods. For example, duration of visits and, number of units.

Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 1 AND 32 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.
Bit flags for Program SAKs 1 - 32. Used as part of the primary key and editing to determine order of processing for a program thread. If program SAK 1 - 32 exist in the thread, the appropriate bit in the flag will be set to 1 otherwise the bit will be set to 0.
Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 33 AND 64 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.
Bit flags for Program SAKs 33 - 64. Used as part of the primary key and editing to determine order of processing for a program thread. If program SAK 33 - 64 exist in the thread, the appropriate bit in the flag will be set to 1 otherwise the bit will be set to 0.
Bit flags for Financial Payer NUM_HIER_ID 1 - 32. Used as part of the primary key and editing to determine order of processing for a Financial Payer. If NUM_HIER_ID column of T_FINANCIAL_PAYER IS BETWEEN 65 AND 96 for a Payer on the thread, then corresponding bit in this column will be set to 1 otherwise the bit will be set to 0.
Bit flags for Program SAKs 65 - 96. Used as part of the primary key and editing to determine order of processing for a program thread. If program SAK 65 - 96 exist in the thread, the appropriate bit in the flag will be set to 1 otherwise the bit will be set to 0.
Phone Number where the analyst can be reached.
Phone Number where the analyst can be reached.
The phone number of the attorney.
The phone number of the attorney firm.
Member's phone number.
Client's phone number.
Provider/Client phone number.
The phone number of the contact
The primary phone number of the applicant
This is a phone number in the format area code + prefix + suffix.
The phone number of the non-provider.
The phone number where the insurance agent can be reached.
The phone number where the provider would receive the W9 form.

Telephone number for the business owner contact person.
This is the phone number of the non-medicaid provider requesting Prior Authorization.
The US or international phone number of the policyholder.
This is a phone number in the format area code + prefix + suffix.
This is a phone number in the format area code + prefix + suffix.
This is a phone number in the format area code + prefix + suffix.
This is a phone number in the format area code + prefix + suffix.
This is a phone number in the format area code + prefix + suffix.
Phone number for the bank.
Phone number for the location.
This is a phone number in the format area code + prefix + suffix.
Provider Service Location Phone Number.
The phone number of the worker.
Recipient Phone number
The phone number of the spouse.
This is the phone number of the contact.
This is the telephone number of the PDP contact
Recipient Phone Number
The phone number of the sponsor.
Phone number
The phone number where the tortfeasor can be reached.
The phone number where the tortfeasor can be reached.
Contact person telephone number.
The US or international phone number of the absent or custodial parent.
This is the telephone number of the carrier contact.
This is the telephone number of the carrier contact.
This is the TPL SubContractor contact telephone number.
Executor or Trustee phone number
This is the phone number of the subcontractor contact.
This is the employer contact telephone number.
The US or international phone number of the property on which the lien is held.
This is the phone number one on the MMIS contact.
This is the phone number two on the MMIS contact.
Phone number associated with contact person.
Phone number associated with contact person.

Phone number associated with contact person.
Phone number associated with contact person.
Phone number associated with contact person.
Phone number associated with contact person.
Agent contact's phone number after change.
Agent contact's phone number before change.
The area code for this telephone number.
The area code for this telephone number.
Phone number of the person assisting the update.
The Cell Phone of the Recipient.
Clearinghouse contact's phone number after change.
Clearinghouse contact's phone number before change.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
The corporate contacts phone number.
Telephone number to be used by provider's patients. This field will only display on the panel for the service location type address.
Phone number related to EFT Address.
EFT phone number after change.
EFT phone number before change.
Phone Number extension of user
The extension number of the contact
This is the company, payer, vendor or other phone extension that will appear on the tax form.
Telephone number extension for the business owner contact person.
Extension number for the given phone.
The extension number of this telephone number.
The extension number of this telephone number.
This is the telephone extension for PDP contact

Contact person telephone number extension.
The US or international phone extension number for the absent or custodial parent.
This is the phone extension number for the subcontractor contact.
Phone number extension associated with contact person.
Phone number extension associated with contact person.
Phone number extension associated with contact person.
Agent contact's phone number extension after change.
Agent contact's phone number extension before change.
Phone number Extension related to EFT Address.
EFT phone number extension after change.
EFT phone number extension before change.
International phone number extension.
International phone number extension.
International phone number extension.
This is fax number of the provider's office.
This is fax number of the provider's office.
This is fax number of the provider's office.
Provider Service Location Fax Number
International fax number.
International fax number.
International fax number.
Phone number of the transferring clerk.
The phone number of the recipient.
International phone number.
International phone number.
International phone number.
This is the company, payer, vendor or other phone number that will appear on the tax form.
The four character portion of this telephone number.
The four character portion of this telephone number.
This is an additional phone number for contacting the recipient.
The telephone exchange for this telephone number.
The telephone exchange for this telephone number.
Phone Number of person initiating the research request or project.
The social security number of the applicant's spouse
The technical contacts phone number.
Phone number of the receiving clerk.

Phone number of person reporting the update.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
Telephone number of contact.
Vendor contact's phone number after change.
Vendor contact's phone number before change.
The Work Phone of the Recipient.
The PCP's 24 hour phone number.
This is the 24 hour availability phone number for the provider in the format area code + prefix + suffix.
This is the 24 hour availability phone number for the provider in the format area code + prefix + suffix.
This is the 24 hour availability phone number for the provider in the format area code + prefix + suffix.
This is the 24 hour availability phone number for the provider in the format area code + prefix + suffix.
Identifies a contact phone number, which can be used to contact the provider.
Identifies a contact phone number, which can be used to contact the provider.
The US or international phone extension number for the attorney.
A phone number extension.
The phone extension of the non-provider.
The US or international phone extension number of the carrier's contact person.
The US or international phone extension number where the insurance agent can be reached.
The phone number extension where the provider would receive the W9 form.
The extension of the 24 hour phone number.
This is the phone number extension of the non-medicaid provider requesting Prior Authorization.
A phone number extension for the 24 hour phone number.
A phone number extension for the 24 hour phone number.
A phone number extension for the 24 hour phone number.
A phone number extension for the 24 hour phone number.
The US or international phone extension number for the policyholder.
A phone number extension.

A phone number extension.
A phone number extension.
A phone number extension.
A phone number extension.
Extension number for the given phone.
A phone number extension.
The US or international phone extension number for the tortfeasor.
The US or international phone extension number for the tortfeasor.
This is the telephone extension of the carrier contact.
This is the telephone extension of the carrier contact.
This is the TPL SubContractor contact telephone extension.
This is the employer contact telephone extension.
The US or international phone extension number of the property on which the lien is held.
Number of physicians at this site.
Number of Physicians Assistants at this site.
This is the pin number for the carriers electronic billing.
This is the pin number for the carrier's electronic billing.
This is the pin number for the carriers electronic billing.
The actual numeric identifier of the problem log, used for tracking
The number on the health insurance policy
Insurance policy account number.
Port number assigned to a VAN.
Parameter position as used in the SQL statement used to retrieve letter data.
Position of parameters to be used in XML queries.
Federal Poverty Level percentage for the PART D.
The prescription number for the drug dispensed.
Previous recipient SSN
The area code of the telephone number for the pre-approval contact person.
The extension number of the pre-approval contact person's telephone number.
The four character number of the pre-approval contact person's telephone number.
The telephone exchange of the pre-approval contact person's telephone number.

This is the MMIS specific priority order for the focuses to receive and the order that they should be processed. (1 = highest priority, 2 = next, etc. ...)
The prior authorization number that was sent on the claim by the submitter.
The prior authorization number that was sent on the claim by the submitter.
Prior Authorization Number.
The prior authorization number that was sent on the claim by the submitter.
A process number that uniquely identifies the process.
A process number that uniquely identifies the process.
Total visits projected during this certification period.
A license number issued to a provider by one of the various licensing entities.
This is a provider's license number.
The provider's license or certification number.
The provider's license or certification number.
Provider State License Number.
The license number assigned by the state in which this Provider practices.
A provider license number.
The Provider License Number.
A provider license number.
A provider license number.
This field will be used to capture the prescriber to from whom a recipient must get their prescription in order for their prescription to be covered by Medicaid.
This field will be used to capture the prescriber to from whom a recipient must get their prescription in order for their prescription to be covered by Medicaid.
This field will be used to capture the prescriber to from whom a recipient must get their prescription in order for their prescription to be covered by Medicaid.
Provider State CS License Number.
Fax number of the provider for the location being captured on the PROV-LOCATION-AND-CONTACT-INFO.
Primary telephone number for a particular provider location
The Social Security Number of the provider.
Provider's SSN Number.
The Social Security Number of the Provider.
Prescription number assigned by a pharmacy to a drug dispensed to a Mediciaid recipient.
The number assigned to the prescription by the provider.
Number assigned by a pharmacy to identify the drug dispensed to a recipient.

Number assigned by a pharmacy to identify the drug dispensed to a beneficiary.
Prescription number assigned by a pharmacy to a drug dispensed to a recipient.
The prescription number of the drug that was dispensed on the claim that failed a Pro-DUR warning.
The prescription number of the drug that was dispensed on the claim that failed a Pro-DUR warning.
Number assigned by a pharmacy to identify the drug dispensed to a recipient.
Number assigned by a pharmacy to identify the drug dispensed to a recipient.
The prescription number of the claim submitted by the pharmacy.
Number assigned by a pharmacy to identify the drug dispensed to a recipient.
Submitted Prescription Number for HIPAA 835
Submitted Prescription Number for HIPAA 835.
DHR case number used in matching DHR update data (formerly a part of the old Medicaid number). Will also be present if an SSI record had a DHR welfare case number at time of conversion to AMAES file (previous use of field).
Numeric Value of Quantity. For Professional and Dental 837: numeric value of units. For Institutional 837: the unit is days.
Identifies the Remittance Advice (RA) containing this claim.
Identifies the Remittance Advice (RA) containing this claim.
Identifies the Remittance Advice (RA) containing this claim.
Identifies the Remittance Advice (RA) containing this claim.
Random start number
Contains the user entered number which determines the starting point in the CPAS claim sample reporting process.
The first number to be assigned in the range.
The last number that has been assigned in the range.
The last number that can be assigned in the range.
High Range Number
High Range Number
Low Range Number
Low Range Number
This column controls the order in which the restriction types are processed. Exclusions are ranked first, Inclusions are ranked second, and General inclusions are ranked third.
Lower limit of range of multiple surgery detail rankings. Rankings are used to determine the multiple surgery percentage to apply.

Upper limit of range of multiple surgery detail rankings. Rankings are used to determine the multiple surgery percentage to apply.
The Rate ID number represents a group of revenue codes.
This field represents a group of revenue codes. Each revenue code has a NUM RATE ID that it corresponds with.
This field represents a grouping of revenue codes. Each revenue code has a rate ID number and more than one revenue code will have the same number. Revenue codes are grouped this way for use in different pricing methodologies.
The percentage of charges over a base period of time. Used for the state-wide calculation.
The percentage of charges over a base period of time. Used for the peer group specific calculation.
The percentage of charges over a base period of time. Used for the provider specific calculation.
The last RA number to be assigned for this financial cycle.
This is the carrier billing frequency, in days.
This is the carrier billing frequency, in days.
This identifies the relative position of the recipient's 1095 within the transmission to the IRS that must be corrected and resent. If the value is 0 this indicates that the entire file was rejected..
This identifies the relative position of the recipient's 1095 within the transmission to the IRS.
This identifies the relative position of the recipient's 1095 within the transmission to the IRS that must be corrected and resent. If the value is 0 this indicates that the entire file was rejected..
This identifies the relative position of the recipient's 1095 within the transmission to the IRS.
This is the amount the recipient received as part of the settlement.
This is the amount the recipient received as part of the settlement.
If the expenditure does not have a recipient ID or to override the recipient's age for reporting. If the expenditure has no Recipient ID then this field is required.
The age of the recipient on the system date rounded down to a full year.
The age of the recipient as of the last day of the quarter.
The age of the new recipient on the From Date of Service rounded down to a full year.
The age of the original recipient on the From Date of Service rounded down to a full year.
The record number of the update transaction being logged.
The record number of the update transaction being logged.
The record number of the update transaction being logged.
The record number of the update transaction being logged.
The record number of the update transaction being logged.
The record number of the update transaction being logged.

The record number of the update transaction being logged.
A sequential number assigned by the submitter to identify each row in the submission file.
The record number of the update transaction being logged.
The record number of the transaction that took the error.
The record number of the update transaction being logged.
A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
Record number containing the element in the error
A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
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A sequential number assigned by the submitter to identify each row in the submission file.
A sequential number assigned by the submitter to identify each row in the submission file.
The record number of the update transaction being logged.
Unique number of record within a submission that failed an edit
NUM_RECORD_FAILED_3
Record number of the dependent table/segment that failed the edit.
Contains the day of the week that the recycle should occur.
A count of the number of 1095s included in the unique transmission.
A count of the number of 1095s included in the unique transmission.
Document number assigned by a clerk that identifies any documentation received regarding a manually entered disposition. For a claim cycle entry, the claim number is stored in this field to relate the disposition to the claim.
A unique number assigned by the State recorded on the original documentation received that initiates a lien.
Document number assigned by a clerk that identifies any documentation received regarding a manually entered disposition. For a claim cycle entry, the claim number is stored in this field to relate the disposition to the claim.
The region number is the first two digits of the ICN. It identifies the medium of the claim.
The region number to filter the claims recycle by. A region code of 00 will not filter by region code.
Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.
This is the code of the claim media type.
Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.
Specific region for which this disposition should be assigned.
Classification of the media on which a claim is submitted into the MMIS system or the type of transaction performed on a claim that already exists in the MMIS system.

This field specifies how regions rank when they overlap. This is primarily for regions created for capitation rate overrides. For example, if a PMP has an override cap rate at the statewide region level, one at a county group region, one at a individual county level (where the county is within the county group) and an override at the zip code region (that is within the county), then the zip code region would have the highest rank, with the county having the next highest rank, etc... with the statewide region having the lowest rank. With the original Multi-Payer design, a zip code region will have a value of 1, a single county region will have a value of 2, a group of counties will have a value of 3, and the entire state will have a value of 4.
This field specifies how regions rank when they overlap. This is primarily for regions created for capitation rate overrides. For example, if a PMP has an override cap rate at the statewide region level, one at a county group region, one at a individual county level (where the county is within the county group) and an override at the zip code region (that is within the county), then the zip code region would have the highest rank, with the county having the next highest rank, etc... with the statewide region having the lowest rank. With the original Multi-Payer design, a zip code region will have a value of 1, a single county region will have a value of 2, a group of counties will have a value of 3, and the entire state will have a value of 4.
The minimum age of the recipient on the date of service used to determine the pricing method.
The maximum age of the recipient on the date of service used to determine the pricing method.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of CONDITION code positions that the related set of condition codes listed in T_REIMB_CONDITION may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of CONDITION code positions that the related set of condition codes listed in T_REIMB_CONDITION may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of condition codes is optional.
This number is the cluster of tuple sets that are "ANDed" together. Different clusters are "ORed".
This number represents the maximum number of modifier positions that the related set of modifiers listed in T_REIMB_MOD may occupy. Allowed values are 1, 2, 3, 4.
This number represents the minimum number of modifier positions that the related set of modifiers listed in T_REIMB_MOD may occupy. Allowed values are 0, 1, 2, 3, 4. The value 0 indicates that the corresponding set of modifiers is optional.
Relative weight for pricing DRG
Relative weight for pricing DRG

Relative weight for the higher DRG
Relative weight for the higher DRG
Relative value unit is a grading of the relative difficulty of all medical services and procedures and is used in determining claims payment.
Request number used to identify the delink request.
This field holds the size of the request.
The malpractice Relative Value Unit used in calculating RBRVS rates for a procedure.
The malpractice Relative Value Unit used in calculating RBRVS rates for a procedure.
Practice expense Relative Value Unit used in calculating RBRVS rates for a procedure.
Practice expense Relative Value Unit used in calculating RBRVS rates for a procedure.
Work Relative Value Unit used in calculating RBRVS rates for a procedure.
Work Relative Value Unit used in calculating RBRVS rates for a procedure.
Sample Selection Modules. To specify the sampling frequency in terms of a modulus of the Unit of Measure. For example, every 5th bag, every 1.5 minutes.
Sample size.
Interval number
Contains the user entered number which determines the claims that will be on the CPAS Sample Listing report. This number is used to extract every (nth) claim from the overall claim sample. This number enables the users to control a both random and appr
Represents the line number of the free-form text.
Represents the line number of the free-form text. The maximum number is 8 which represents a total of 2000 characters of free form text for comments.
Represents the line number of the free-form text.
Sequence numbers as they appeared on the claim.
System assigned key given to uniquely identify an occurrence code.
Sequence number which indicates the position in which the value code and amount occurred on the claim.

Sequence number of an attribute that caused a particular edit to fail. This sequence number is necessary in order to differentiate between the different claim types on which a particular field appears.
Number used to further identify an occurrence of a batch range.
Sequence number that indicates the position in which the tooth surface code occurred on the claim detail.
The order in which the rule was applied for the claim detail
Sequence number of note.
Sequence number of note.
Sequence number of note.
If a program is to be executed more than once, this indicates the sequence number of the program.
Sequence number of note.
Represents the line number of the free-form text.
The unique identifier for a cash receipt disposition.
Represents the sequence number of the comment.
Sequence number of note
Sequence number of note.
Sequence number of note.
Sequence number of note.
Identifies the occurrence - May occur 5 times.
Identifies the occurrence - May occur 3 times.
A system assigned sequence number to provide the ability to add multiple rows per individual.
Sequence number of note.
Sequence number of note.
Sequence number of note.
Sequence number in finder file
Represents the line number of the free-form text. The maximum number is 8 which represents a total of 2000 characters of free form text for comments.
Auto number to sequence the number of records of the same trading partner.
This column contains the sequence number of the surgical procedure code. The principle procedure will always be sequence 1.
Sequence number which indicates the position of the occurrence code on the claim.
Sequence number which indicates the position in which the payer information occurs on the claim.
Sequence number which indicates the position in which the value code and amount occurred on the claim.
Sequence number which indicates the position in which the ICD-9-CM Procedure code occurred on the claim.

Identifies the sequence the benefit adjustment factors should be applied.
The sequence number defined by STO. Being stored as informational.
This is the sequence number that uniquely identifies each attachment info record for the prior authorization
A number used to uniquely identify the rule
This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.
This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.
This column determines the processing order for the entities participating in the thread. For example, if the thread is of type 'PAYR', then this sequence number determines which Financial Payer will be processed first, second, and so on.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.

Sequence number generated by EDI to uniquely identify the 837P 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2300 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2300 DN2 data.
Sequence number generated by EDI to uniquely identify the 837D 2320 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2320 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2320 loop data.
Sequence number generated by EDI to uniquely identify the 837P 2400_PWK loop data.
Sequence number generated by EDI to uniquely identify the 837P 2430 loop data.
Sequence number generated by EDI to uniquely identify the 837I 2430 loop data.
Sequence number generated by EDI to uniquely identify the 837D 2430 AMT data.
Uniquely identifies the AR letter.
Number that uniquely identifies each individual cash receipt disposition which was applied to a cash receipt.
Number that uniquely identifies each individual disposition which was applied to a cash receipt.
Number that uniquely identifies each individual disposition which was applied to a cash receipt.
Number that uniquely identifies each individual disposition which was applied to a cash receipt.
This field makes this row unique per coverage code.
Batch sequence number that identifies a disposition on a cash receipt. It will be used when refunding a provider overpayment.
Number that uniquely identifies each individual disposition which was applied to a cash receipt.
Number that uniquely identifies each individual disposition that was applied to a cash receipt.
Number that uniquely identifies each individual disposition that was applied to a cash receipt
Number that uniquely identifies each individual disposition that was applied to a cash receipt.
Number that uniquely identifies each individual disposition that was applied to a cash receipt.

Sequence number for a claim detail
Sequence number for a claim diagnosis
Sequence number for a claim occurrence code
Sequence number for a claim procedure code
Sequence number for a claim remark code
Sequence number for a claim detail
Sequence number for a claim diagnosis
Sequence number for a claim occurrence code
Sequence number for a claim remark code
Sequence number for a claim detail
Sequence number for a claim diagnosis
Sequence number for a claim occurrence code
Sequence number for a claim remark code
Sequence number for a claim detail
Sequence number for a claim remark code
Sequence number generated by EDI to uniquely identify the 837D 2420 REF data.
Sequence number generated by EDI to uniquely identify the 837P DTL_REF loop data.
Sequence number generated by EDI to uniquely identify the 837I 2420 loop data.

Sequence number of recipient variable demographic rows within a client
Sequence number of recipient contact information rows within a client
Sequence number of recipient eligibility determinates rows within a client
Sequence number of recipient SPA participation rows within a client
Sequence number of recipient SPA participation rows within a client
Sequence number of recipient health home SPA provider rows within a health home chronic condition
Sequence number of recipient health home chronic condition rows within a client
Sequence number of recipient lockin rows within a client
Sequence number of recipient money follows the patient rows within a client
Sequence number of recipient State plan participation rows within a client
Sequence number of recipient waiver participation rows within a client
Sequence number of recipient LTSS participation rows within a client
Sequence number of recipient managed care participation rows within a client
Sequence number of recipient ethnicity rows within a client
Sequence number of recipient race rows within a client
Sequence number of recipient disability information rows within a client
Sequence number of recipient 1115A participation rows within a client
Sequence number of recipient chronic condition rows within a client
Sequence number for eligible enrollment rows in this table
This is the unique sequence of the payment hold transactions. This table contains all the transactions that were held for a hold in a given batch cycle.

Sequence number of location information rows within a managed care plan
Sequence number of service area information rows within a managed care plan
Sequence number of operating authority information rows within a managed care plan
Sequence number of population enrolled information rows within a managed care plan
Sequence number of accreditation rows within a managed care plan
Sequence number of national healthcare entity information rows within a managed care plan
Sequence number of CHPID SHPID relationship rows within a managed care plan

Sequence number of provider location license information rows within a provider
Sequence number of provider alternate identification number rows within a provider
Sequence number of provider taxonomy classification information rows within a provider
Sequence number of provider Medicaid enrollment information rows within a provider
Sequence number of provider affiliated group rows within a provider
Sequence number of provider affiliated program rows within a provider
Sequence number of provider bed type information rows within a provider
Sequence number for multiple sets of submissions of T-MSIS files in a given month.
Sequence number for multiple sets of submissions of TMSIS files in a given month
Sequence number for multiple sets of submissions of TMSIS files in a given month
Sequence number for multiple sets of submissions of TMSIS files in a given month
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Sequence number for multiple sets of submissions of TMSIS files in a given month
Sequence number for multiple sets of submissions of TMSIS files in a given month
Sequence number for multiple sets of submissions of TMSIS files in a given month

Sequence number of recipient insurance coverage rows within a client
Sequence number of recipient coverage category rows within a client insurance
Sequence number of recipient other coverage rows within a client
Sequence number of recipient third party liability rows within a client
Sequence number of recipient third party liability rows within a client
DRG service adjuster. This will be the pediatric value if recipient age at admission is less than the pediatric age cut-off value. Otherwise, it will be the adult service adjustor
DRG service adjuster. This will be the pediatric value if recipient age at admission is less than the pediatric age cut-off value. Otherwise, it will be the adult service adjustor
New field produced by version 7.0 of ETG: The risk score indicating the severity of the episode, or blank when the member's gender and/or age is invalid. Values 00001.0000 - 99999.9999 or blank.
New field produced by version 7.0 of ETG: The risk score indicating the severity of the episode, or blank when the member's gender and/or age is invalid. Values 00001.0000 - 99999.9999 or blank.
New field produced by version 7.0 of ETG: The risk score indicating the severity of the episode, or blank when the member's gender and/or age is invalid. Values 00001.0000 - 99999.9999 or blank.
New field produced by version 7.0 of ETG: The risk score indicating the severity of the episode, or blank when the member's gender and/or age is invalid. Values 00001.0000 - 99999.9999 or blank.
The length of time in days that short term stay is granted. (PASRR PRE-ADMISSION SCREEN, Referral, Number of Days)
KenPAC site number - 0000 for non-KenPac PMP data.
Smart Key Dosage Form Code
Sort Number
Sort Number
Sort Number
The sort order for the DSSProfiler payment level.
Sort Number
Sort Number
Sort Number
Sort Number
Sort control for drop-down list sequence.

Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort Number for the drop-down control list.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
Sort control for drop-down list sequence.
This this the sort order that the report will appear in.
SSI phone number
SSN received from CMS
Recipient SSN
SSN as provided by CMS.
SSN as received from CMS
SSN received from CMS
Recipient SSN
SSN as provided by CMS.
SSN as received from CMS
The SSN or EIN number associated with the Provider License Number.
Social security number of the family member
The social security number of the family member.
The social security number of the family member.
This is the recipient's social security number.
This is the social security number of the policyholder.
This is the SSN or FEIN for a provider or owner.
Provider Social Security Number.
SSN number of the board member.
This is the SSN or FEIN for a provider where the license is valid.
The SSN or EIN of the Provider.
SSN -- This will not be filled in if the recipient has a pseudo SSN.

SSN -- This will not be filled in if the recipient has a pseudo SSN.
The social security number for a recipient.
The social security number for a beneficiary.
The social security number of the child.
The social security number of recipient
Recipient SSN
These are the previous Social Security Number
The recipient's social security number on the PS/2 transaction
The recipient social security number.
The social security number of the spouse.
The social security number of the move in/out person.
This is the field that contains that previous SSN for the recipient.
SSN of the recipient id on the MMIS
The recipient's social security number on the PS/2 transaction
The eligible individual`s social security number.
This is the parent's social security number.
SSN of a policy holder or recipient.
Child's social security number from IV-D tape.
The social security number of the applicant
Social Security claim number
SSN on EDB records
SSN on EDB record
SSN on the PS/2 transaction
The social security number of the applicant's spouse
A code describing whether the state has verified the SSN with the Social Security Administration.
Minimum number of days a patient must have been under continuous therapy to meet the requirements for the drugs in a particular step therapy level.
Transaction Set Control Number

Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there. 524 Use the corresponding value in SE02 for this transaction set.
Identifies the portion of the PART D premium subsidized based upon the % of FPL. The following are the valid values: 100, 075, 050, 000, or 999
A 6 byte unique number that identifies the mass adjustment request. Format:JJJSSS. It is systematically assigned for SUR EOMB request. Duplication of numbers is not a factor because data will be purged after each report is printed on a weekly basis.
Phone number associated to the provider's physical service location, after the change.
Phone number associated to the provider's physical service location, after the change.
Phone number associated to the provider's physical service location, before the change.
Phone number associated to the provider's physical service location, before the change.
Extension associated to the phone of the provider's physical service location, after the change.
Extension associated to the phone of the provider's physical service location, after the change.
Extension associated to the phone of the provider's physical service location, before the change.
Extension associated to the phone of the provider's physical service location, before the change.
Provider's physical service location fax number, after the change.
Provider's physical service location fax number, after the change.
Provider's physical service location fax number, before the change.
Provider's physical service location fax number, before the change.
Toll Free number of the provider's physical service location, after the change.
Toll Free number of the provider's physical service location, after the change.
Toll Free number of the provider's physical service location, before the change.
Toll Free number of the provider's physical service location, before the change.
Extension associated to the Toll Free number of the provider's physical service location, after the change.

Extension associated to the Toll Free number of the provider's physical service location, after the change.
Extension associated to the Toll Free number of the provider's physical service location, before the change.
Extension associated to the Toll Free number of the provider's physical service location, before the change.
Service Location Toll Free phone number extension.
Service Location Toll Free phone number.
This is the tax ID that is being adjusted.
This is the tax identification number assigned to a provider by the Internal Revenue Service.
This is the tax ID of the board participant.
Tax ID.
Tax ID
This is the tax identification number assigned to a provider by the Internal Revenue Service.
This is the tax identification number assigned to a provider by the Internal Revenue Service.
Owners tax ID
Owners tax ID
This is the tax identification number assigned to a provider by the Internal Revenue Service.
This is the tax identification number assigned to a provider by the Internal Revenue Service.
This is the tax identification number assigned to a provider or owner by the Internal Revenue Service.
Provider Tax ID.
Tax Identifier, could be TAX ID or SSN.
Tax Identifier, could be TAX ID or SSN.
This is the tax identification number assigned to a provider by the Internal Revenue Service.
This is the tax identification number assigned to a TPL entity by the Internal Revenue Service. Currently Carrier and SubContractor are the valid entity types
This is the State's federal tax ID.
This is the State's tax identification number which is displayed on the 835.
Tax Year of the CP2100.
Tax Year of the CP2100
The transaction control number used to uniquely identify claims on a previous system.
Claim Reference Number of the converted claim on the current MMIS.
The transaction control number used to uniquely identify claims on a previous system.
The transaction control number used to uniquely identify claims on the previous MMIS.

Terms Discount Percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date.
The Therapeutic Class Code, Generic (GTC) is used to classify drugs according to the most common intended use. This classification provides the broadest therapeutic groupings available in NDDF. Users that need more definitive therapeutic classing should consider Therapeutic Class, Standard (TC), Therapeutic Class, Specific (GC3), or the Therapeutic Class, AHFS (AHFS).
The Therapeutic Class Code, Standard (TC) can be used to classify drugs according to the most common intended use. This therapeutic classification is intended to service those users who need a definitive but not comprehensive therapeutic classification system. Comprehensive therapeutic classification is provided by Therapeutic Class, Specific (GC3), Therapeutic Class, AHFS (AHFS), or Therapeutic Class, Generic (GTC).
The state-assigned number which uniquely identifies the Medicaid case to which the enrollee belongs.
Internal description of the edit.
Internal description of the edit
Number that uniquely identifies each business rule applied to an edit.
Edit number assigned by CMS to a particular edit
T-MSIS numeric rule ID of the error
Tooth number serviced based on the tooth numbering system identified in TOOTH-DESIGNATION-SYSTEM
Indicates the top volume products' rankings as determined by syndicated market research studies. Volume rankings are updated annually based on the total number of prescriptions dispensed (new and refills) through retail pharmacy outlets. All forms and package sizes of the product are factored into the aggregate rank; therefore, each applicable NDC carries the same rank number. For products ranked below the top 200 (FDB) or top 999 (Micromedex), this field is 0.
Indicates if a drug is included in the list of the most frequently dispensed 200 drug products. Different package sizes and dose forms of the same drug will have the same number. The order is changed annually, based on pharmaceutical market surveys.
The number of beds available in an institutional facility.
The number of beds available in an institutional facility.
The total number of edits set by the insurance disclosure process
Total High Daily MME

Total Low Daily MME
The total number of records transmitted
Total number of claims.
Total number of covered days.
The number of original days covered for the statement period of the claim.
The number of days between the initial visit and the first recall visit.
The number of days between the initial visit and the first recall visit summarized by the various dimensions on the row.
Total number of non-covered days.
Total clients.
The sum of ages of the unduplicated recipient IDs summarized by the various dimensions on the row.
This is the revised case amount as a result of adjustments to claims on the case.
This is the revised case amount as a result of adjustments to claims on the case.
The policy number associated to the case.
The policy number associated to the case.
The policy number associated with an AR.
Policy number for this TPL policy.
Policy number for this TPL policy.
Policy number for this TPL policy.
The EFT Trace number assigned by the bank and sent on the EFT record. This is the number that will display on the provider's bank statement.
The reference number assigned to the enrollment application by the health insurance carrier to uniquely identify and locate it during the enrollment process.
The reference number assigned to the enrollment application by the health insurance carrier to uniquely identify and locate it during the enrollment process.
ST02 value in the EDI document.
Factor used in outlier threshold determination. The outlier threshold used in outlier payment calculation will be the greater of the DRG Rate multiplied by the Outlier Trim Point or the predetermined Outlier Threshold dollar amount.
The number of unique recipients within a report grouping of year/month, set of criteria, benefit plan, and error number
Metric Decimal Unit Total
This is the number of units.
The number of units expected per period or UOM
Metric Decimal Unit Total on denied claims for this reporting group

Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked after a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Specifies the number of units (days, months, years) in history that should be checked before a claim's dates of service.
Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.
Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.
Conversion factor to be applied when codes being audited are measured in different increments to allow units to be counted toward limitations on an equal basis.
Number representing the defined CPAS sample size.
This is the universal provider identification number.
The version number of the letter
Contains the version information for the letter
Grouper version in use.
The version number of the letter that was created
The version number of the query that was used to generate this letter.
The version number of the query
Total visits on this bill rendered prior to the recertification to date.
A dense rank, for each performing provider NPI / recipient ID, assigned in ascending sequence by first service date.
Voucher Number.
Veteran VA Claim number
Patient's weight
Weight of provider/client.

This is a date sensitive pricing factor expressed in the 9.9999 form, and is one of the primary components for the DRG calculation. Some DRGs will not be assigned weights, so for these the Level of Care pricing method will be used.
The value used to add with other occurrences to determine whether the AT Alert needs to be sent.
The maximum birth weight specified for a diagnosis code. Unit of measurement is in grams. Used when DRG grouping is performed for recipients under 1 year of age.
The minimum birth weight specified for a diagnosis code. Unit of measurement is in grams. Used when DRG grouping is performed for recipients under 1 year of age.
The weight associated with the 25th percentile of females for this age group.
The weight associated with the 25th percentile of males for this age group.
The weight associated with the 50th percentile of females for this age group.
The weight associated with the 50th percentile of males for this age group.
The weight associated with the 5th percentile of females for this age group.
The weight associated with the 5th percentile of males for this age group.
The weight associated with the 75th percentile of females for this age group.
The weight associated with the 75th percentile of males for this age group.
The weight associated with the 95th percentile of females for this age group.
The weight associated with the 95th percentile of males for this age group.
Sponsor work phone, with area code
This number indicates how many recipients the PMP wants to transfer/release. Default value is 999999999.
The number of days of nursing care included in this claim that were paid for, in whole or in part, by Medicaid. Includes days during which nursing facility received partial payment for holding a bed during patient leave days.
This is the number of line items included on the update transaction.
This is the number of line items that are included on the update transaction.
This contains the number of line items that were sent on the transaction.
System assigned key for the provider dimension. This is a unique number assigned to the ordering provider service location SAK.
This field contains the description associated with a specific TPL origin code.

The number of newday claims in the batch that have been processed.
The total count of newday claims in the batch.
The date in ccyyq format where q indicates the quarter in which the original claim was paid.
How episode charges compare to ETG's norms. Facility and Ancillary Inpatient records are not included in the determination of outlier status. The values for this field are: 0 - Typical episode. A typical episode with total charge amounts between the low outlier and high outlier trim points. 1 - Low outlier. An episode with total charge amounts less than the low outlier trim point. 2 - High outlier. An episode with total charge amounts greater than the high outlier trim point. 3 - The Unlimited Episode Length option is turned on, so outlier status cannot be determined.
How episode charges compare to ETG's norms. Facility and Ancillary Inpatient records are not included in the determination of outlier status. The values for this field are: 0 - Typical episode. A typical episode with total charge amounts between the low outlier and high outlier trim points. 1 - Low outlier. An episode with total charge amounts less than the low outlier trim point. 2 - High outlier. An episode with total charge amounts greater than the high outlier trim point. 3 - The Unlimited Episode Length option is turned on, so outlier status cannot be determined.
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The output media type - crld, print, etc.
This is the owner of the audit table. Valid values are AIM and AIM00.
Calendar year financial completes the transaction.
Federal fiscal year financial completes the transaction.

Calendar month financial completes the transaction (CCYYMM).
Calendar quarter financial completes the transaction (CCYYQQ).
State Fiscal year financial completes the transaction.
Calendar week financial completes the transaction (CCYYWW).
System assigned key for the paid time dimension table.
System assigned key for the paid time dimension table.
The labeler code of the parent manufacturer
Password
A password choosen by the user.
Date on which Password was Changed
Previous Password
Number of Password History Record
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
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The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's age at the beginning of the episode.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.

The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
The patient's gender.
Code identifying the location of the patient when receiving pharmacy services. Valid values are: 0=Not Specified, 1=Home, 2=Inter-Care3=Nursing Home, 4=Long Term/Extended Care, 5=Rest Home6=Boarding Home, 7=Skilled Care Facility, 8=Sub-Acute Care Facility, 9=Acute Care Facility, 10=Outpatient and 11=Hospice.
The total amount paid by the patient for services where they are required to use their personal funds to cover part of their care before Medicaid funds can be utilized.
A code indicating the Patients status as of the ENDING-DATE-OF-SERVICE. Values used are from UB-92.
A code indicating the Patients status as of the ENDING-DATE-OF-SERVICE. Values used are from UB-92.
Description for X12 message (txn) type.
This is the payment method for the authorized service.
This contains the method of payment for the service authorization.
This is the payment method for the authorized service.
This is an indicator used to say whether or not EDS attended a Prior Authorization appeal.
This is the prior authorization number assigned by the originating system.
This is the prior authorization number assigned by the originating system.
This is the prior authorization number assigned to the service request.
This is the prior authorization number for the service request.
This is the prior authorization number assigned by the originating system.
This is the patient 1st provider number.
This is the patient 1st provider number.
This is the patient 1st provider number.

Percent used to adjust the MAC price sent to us by First Data Bank for Over the Counter drugs.
The actual percentage value to be applied to the estimated acquisition cost to determine reimbursement amount.
The actual FMAP percentage amount to be applied to calculate the state share amount.
Percentage amount to be taken from the provider in each claim cycle to pay the lien holder.
Multiple surgery percentage to be applied to a claim detail.
Percentage used to adjust claims payment to a provider based on the providers specialty.
Site-of-Service adjustment factor for procedures generally performed in the office setting.
The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.
The percent difference is the dollar difference divided by the expected amount multiplied by 100. The percent difference shows us the variance of dollars from the expected value to the actual value in a percentage.
This is the percentage difference of the Patient First provider and the peer group.
Contract Percentage, required when the provider is required by contract to supply this information on the claim.
Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date.
Reimbursement rate percentage expressed as a decimal.
Contract Percentage, it is the allowance or charge percentage.
Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date.
The total number of claims accepted in a batch (0-100).
Number of providers selected for the bottom percentile.
Number of clients selected for the bottom percentile.
Percent of entity total revenue from contracts with Medicare and Medicaid prior calendar year.
Medical Education percentage used to determine the capital cost rate for a DRG priced claim. Only providers who receive a medical education add-on will have a value in this field.
The percentage of coinsurance amount to pay.
This is an indication of how similar a result is to the parsed input. Possible valid values in the range of 0% to 100%. 100% - High similarity, 0% - Poor similarity.
This is an indication of how similar a result is to the parsed input. Possible valid values in the range of 0% to 100%. 100% - High similarity, 0% - Poor similarity.

The percentage amount for this claim that has been contracted by the Commonwealth with the provider of the services.
This is the contingency fee percentage amount.
Marginal Cost Percentage used to calculate price for cost outlier pricing. (Percent Cost)
This is the coinsurance percentage that a recipient is responsible for on a specific coverage type of a policy.
The percentage applied to the Days Supply of history claims to determine if the claim is still active for the Drug to Drug and Therapeutic Duplicate Screenings. This is also used to allow flexibility in the High and Low Dose screenings.
The percentage applied to the Days Supply of history claims to determine if the claim is still active for the Drug to Drug and Therapeutic Duplicate Screenings. This is also used to allow flexibility in the High and Low Dose screenings.
The percentage of deductible amount to pay.
Disproportionate share is used in old inpatient pricing. After the allowed amount is calculated, then a percent may be added to the allowed amount.
This is the disproportionate share percentage that will be utilized for pricing calculation.
The percentage of savings for that CC edit.
This is the percentage rate for FICA.
This is the percentage rate for FICA.
The Intraoperative percentage of the global surgery package.
The percentage for the intraoperative portion of the global package including postoperative work in the hospital.
The percentage of the regular per diem rate for the level of care in the nursing home that the claim is billed for
The target percentage for auto-assignment of recipients to the specified PMP.
Medical Education percentage used to determine the base rate for a DRG priced claim. Only providers who receive a medical education add-on will have a value in this field.
Number of providers selected for the middle percentile.
Number of clients selected for the middle percentile.
Percentage amount used to change the allowed amount for a procedure.
The percentage to adjust outlier days.
This is the percent paid.
Percentage used to identify if cost outlier will be applicable for DRG priced claims.
The percentage of claims meeting the criteria. Values: (0-100)
The Postoperative percentage of the global surgery package.
The percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.
The Preoperative percentage of the global surgery package.

Percentage for the preoperative portion of the global package.
The percentage amount for this provider.
The percentage that will be used to adjust an allowed amount already calculated using the pricing methodologies that applies to the claim/detail.
Accounts receivables annual interest rate.
The interest rate used in the claim interest calculations.
This synonym is used by the EOMB Reporting Request System to specify the percentage of recipients that will have letters printed per an EOMB Request.
The maximum percentage of the account receivable that can be recouped in a payment cycle.
The maximum percentage of the account receivable that can be recouped in a payment cycle.
The maximum percentage of the account recievable that can be recouped in a payment cycle.
The percentage of reimbursement that is to be subtracted from payment for inpatient hospital services.
This is the target percentage for the program.
The 90-day treasury bill auction rate used for interest calculations
The percentage of reject errors that can occur before the batch of encounter data is rejected.
Number of providers selected for the top percentile.
Number of clients selected for the top percentile.
The total percent of contract value
The factor to determine the amount of the payment that should be allocated to another agency.
Peer Group's Panel Average Age.
This is the Peer Group's allowed amount.
This is the Provider's Claim Count.
This is the non-referral Patient First Provider peer group claim count.
This is the peer group's allowed amount.
This is the peer group's recipient count.
This is the recipient count for the Patient First provider peer group.
This is the recipient count for the Patient First provider's peer group.
This is the Peer Group prescription allowed amount.
This is the Peer Group prescription claim count.
Percentage variance used in comparing if billed amount differs excessively from allowed amount.

System assigned key for the provider dimension. This is a unique number assigned to the performing provider service location SAK.
The system assigned key for the performing (rendering) provider on the claim.
A phone number they can be reached at.
Account team member's phone number
This is the plan code. (C00 - Plan 1; ZZZ - Regular visits)
A unique number which represents the health plan under which the non-fee-for-service encounter was provided.
A unique number which represents the health plan under which the non-fee-for-service encounter was provided.
A unique number which represents the health plan under which the non-fee-for-service encounter was provided.
The number on the health insurance policy listed on the SOBRA application
Identifies the descriptive name for a TPL policy type.
A code indicating where the service was performed. CMS 1500 values are used for this data element.
This is the prescribing provider ID.
This is the previous NDC of this drug.
The name of the print control file, if needed.
Any print variables needed.
This is the number assigned by the PA unit to a Prior Authorization request.
The provider ID type display priority.
The provider ID type print priority.
Primary procedure code of the ETG episode.
Primary procedure code of the ETG episode.
Primary procedure code of the ETG episode.
Primary procedure code of the ETG episode.
Mode of processing for the transaction. (values = BATCH or REALTIME ?? other values)
Mode of processing for the transaction. (values = BATCH or REALTIME ?? other values)
This indicator is used to indicate whether a transaction should be moved to the permanent AR table. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'.
This indicator is used to indicate whether a transaction should be moved to the permanent AR table. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'

This indicator is used to indicate whether a transaction should be moved to history. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'.
This indicator is used to indicate whether a transaction should be moved to history. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'.
This indicator is used to indicate whether a transaction should be moved to history. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'.
This indicator is used to indicate whether a transaction should be moved to history. A value of 'Y' would indicate the transaction can be moved. Default value is 'N'.
A code used by the State to identify the principal procedure performed during the hospital stay referenced by this claim.
Second code to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.
Third code to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.
Fourth code to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.
Fifth code to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.
Sixth code to identify a procedure performed in addition to the principal procedure during the hospital stay referenced by this claim.
This is the procedure code. (Values are 00200 - Operation 3 - dissect; 00300 - Bone removal)
Procedure code
The date on which the principal procedure was performed.
A flag that identifies the coding system used for the principal procedure code.
Flag that identifies the coding system used for the second procedure code.
Flag that identifies the coding system used for the third procedure code.
Flag that identifies the coding system used for the fourth procedure code.
Flag that identifies the coding system used for the fifth procedure code.
Flag that identifies the coding system used for the sixth procedure code.
The procedure code modifier used with the Principal Procedure Code.
The procedure code modifier used with the second procedure code.

The procedure code modifier used with the third procedure code.
The procedure code modifier used with the fourth procedure code.
The procedure code modifier used with the fifth procedure code.
The procedure code modifier used with the sixth procedure code.
Outbound - Processing Priority Code.
Drug product name.
Code indicating special Medicaid program under which the service was provided.
Code indicating special Medicaid program under which the service was provided.
Code indicating special Medicaid program under which the service was provided.
This contains the provider number for the requesting and servicing provider.
The provider identification number used by the provider.
The provider identification number used by the provider.
The provider identification number used by the provider.
The provider identification number used by the provider.
The provider identification number used by the provider.
This contains the service location for the provider.
This is the provider number on the prior authorization update transaction.
This is the provider number received on the update transaction - only bytes 1 through 9 will be used for new provider numbers.
This is the service location for the provider that has requested the services.
This is the service location for the authorized provider.
Street address 1
Street address 2
City
Provider Panel's Average Age.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.

System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider billing the claim.
System assigned key that uniquely identifies the provider billing the claim.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the billing provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
The sak of an individual provider for whom we are keeping track of activity for the current year.
The sak of an individual provider for whom we are keeping track of activity for the current year.
A system assigned key used to uniquely identify the billing provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
RecipientCount
Provider Count
Provider Count
Provider Count
Recipient Count
Provider Count
Provider Count
Provider Count
Provider Count
Provider Count
Provider Count
Recipient Count
Beneficiary Count
Provider Count

This is the Patient First Provider's full name
This is the billing provider of the claim.
A unique identification number assigned by the state to a provider or capitation plan. This should represent the entity billing for the service.
A unique identification number assigned by the state to a provider or capitation plan. This should represent the entity billing for the service.
A unique identification number assigned by the state to a provider or capitation plan. This should represent the entity billing for the service.
This is the patient 1st provider number.
This is the patient 1st provider number.
test
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This is the patient 1st provider number.
This is the patient 1st provider number.
A unique number to identify the provider who treated the recipient.
System assigned key for the provider dimension. This is a unique number assigned to the provider service location SAK
Provider name
This is the performing provider number.
This is the recipient count for the Patient First provider.
This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
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This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
This field is the provider specialty or the super specialty if the provider specialty is within a super specialty.
State
Taxonomy for billing provider.
Taxonomy for billing provider.
Taxonomy for performing provider.
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
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The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The provider type which is set to constant "ALL".
The is the Patient First Provider's Address.
This is the patient 1st provider number.
ZIP
The number of copied to be printed.
This field stores the code identifying the type of communication number.
This field stores the code identifying the type of communication number.
This field stores the code identifying the type of communication number.
This field stores the code identifying the type of communication number.
This field stores the identification code qualifier which is the code designating the system/method of code structure used for Identification Code.
Communication Number Qualifier. Code identifying the type of communication.
Communication Number Qualifier. Code identifying the type of communication.
Communication Number Qualifier. Code identifying the type of communication number.
Pay-to Plan Name Code qualifying the type of entity.
Code qualifying the type of entity for Pay-to Plan Name.
Pay-to Plan Entity Type Qualifier.
Pay-to Plan Code qualifying the system/method of code structure used for Identification.
Code designating the system/method of code structure used for Identification Code (67) Pay-to Plan Name.
Pay-to Plan Code designating the system/method of code structure used for Identification Code.
Pay-to Plan Secondary Identification code qualifying reference identifier.

Pay-to Plan Secondary Identification. Code qualifying the Reference Identification.
Code qualifying the Reference Identification of Pay-to Plan Secondary Identification.
Employer identification number. Code qualifying the Reference Identification.
Code qualifying the Reference Identification of Pay-to Plan Tax Identification Number.
Employer identification number. Code qualifying the Reference Identification.
Communication Number Qualifier identifying the type of communication number of Property & Casualty Subscriber Contact Information.
Communication Number Qualifier identifying the type of communication number of Property & Casualty Subscriber Contact Information.
This field stores the code specifying type of date or time, or both date and time.
This field stores the code specifying type of date or time, or both date and time.
This field stores the code qualifying the type of entity.
This field stores the code designating the system/method of code structure used for Identification Code.
This field stores the Reference Identification Qualifier code.
Facility Code Qualifier, code qualifying the type of facility referenced.
Code qualifier identifying the type of facility referenced of Claim Information.
EPSDT Referral code Qualifier. Specifies the situation or category to which the code applies.
Date Repricer Received date time qualifier code specifying type of date or time, or both date and time.
Code qualifier specifying type of date or time, or both date and time of Date Property & Casualty Date of First Contact.
Date Time Qualifier.
Code qualifier specifying type of date or time, or both date and time of Date Repricer Received Date.
Date Repricer Received date value qualifying the date format, time format, or date and time format.
Code qualifier indicating the date format, time format, or date and time format of Date Property & Casualty Date of First Contact.
Date Time Period Format Qualifier.
Code qualifier indicating the date format, time format, or date and time format of Date Repricer Received Date.
Healthcare diagnosis code qualifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code identifying a specific industry code list of Condition Information.

Code identifying a specific industry code list of Anesthesia Related Procedure.
Healthcare Code qualifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Patient Reason for visit diagnosis code type qualifier.
Code identifying a specific industry code list of Anesthesia Related Procedure.
Healthcare code qualifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Patient Reason for visit diagnosis code type qualifier.
Healthcare code qualifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.

External Cause of Injury diagnosis code type qualifier.
Code identifying a specific industry code list of Condition Information.
External Cause of Injury diagnosis code type qualifier.
Auto Accident State code qualifying the Reference Identification.
Code qualifying the Reference Identification of Care Plan Oversight.
Adjusted Repriced Claim code qualifying the Reference Identification.
Repriced Claim Reference code qualifying the Reference Identification.
Communication Number Qualifier identifying the type of communication number of Service Facility Contact Information.
Communication Number Qualifier identifying the type of communication number of Service Facility Contact Information.
Supervising provider code qualifying the type of entity.
Code qualifying the type of entity of Ambulance Pick Up Location.
Supervising Provider Qualifier Code designating the system/method of code structure used.
Supervising Provider Secondary Identifier. Code qualifying the Reference Identification
Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Code qualifying the type of entity of Ambulance Drop Off Location.
Code qualifier to qualify amount (non-covered) of COB total non covered amount.
Code to qualify total non-covered amount.
Code to qualify remaining patient liability amount.
Code qualifier to qualify amount (remaining patient liability) of Remaining Patient Liability.
Remaining Patient Liability Amount qualifier - value EAF.
Code qualifying the Reference Identification.
Code qualifying the Reference Identification of other payer referral number.
Other Payer Claim Adjustment code qualifying the Reference Identifier.
Other Payer supervising provider. Code qualifying the type of entity.
Other Payer Other Operating Physician code qualifying the type of entity.

Other Payer Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Other Operating Physician Secondary Identification code qualifying the Reference Identifier.
Other Payer Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Other Operating Physician Secondary Identification code qualifying the Reference Identifier.
Other Payer Supervising Provider Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Other Operating Physician Secondary Identification code qualifying the Reference Identifier.
Other Payer Other Operating Physician Secondary Identification code qualifying the Reference Identifier.
Other Payer Billing Provider. Code qualifying the type of entity.
Other Payer Billing Provider Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Billing Provider Secondary Identifier. Code qualifying the Reference identification.
Other Payer Service Facility Location. Code qualifying the type of entity.
Code qualifying the type of entity of other payer billing provider.
Other Payer Rendering Provider entity type qualifier.
Code qualifying the Reference Identification of other payer billing provider secondary identification.
Other Payer Service Facility Location Secondary Identification. Code qualifying the Reference Identification.
Other Payer Rendering Provider Secondary Identifier code qualifying the Reference Identifier.
Other Payer Service Facility Location Secondary Identification. Code qualifying the Reference Identification.
Other Payer Rendering Provider Secondary Identifier code qualifying the Reference Identifier.
Other Payer Service Facility Location Secondary Identification. Code qualifying the Reference Identification.
Other Payer Rendering Provider Secondary Identification code qualifying the Reference Identifier.
Other Payer Rendering Provider Secondary Identification code qualifying the Reference Identifier.
Other Payer Assistant Surgeon. Code qualifying the type of entity.
Other Payer Assistant Surgeon Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Assistant Surgeon Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Assistant Surgeon Secondary Identifier. Code qualifying the Reference Identification.
Other Payer Billing Provider entity type qualifier.
Other Payer Billing Provider Secondary Identification code qualifying the Reference Identifier.

Other Payer Billing Provider Secondary Identification code qualifying the Reference Identifier.
Code qualifier specifying type of date or time, or both date and time of prescription date.
Date/Time Qualifier for treatment start.
Date/Time Qualifier for treatment completion.
Code qualifier indicating the date format, time format, or date and time format of prescription date.
Date Time Period Format Qualifier for treatment start.
Date Time Period Format Qualifier for treatment completion.
Product/Service ID Qualifier.
Code identifying the functional area or purpose for which the note applies of third party organization notes.
Third Party organization notes. Code qualifying the functional area or purpose for which the note applies.
Quantity qualifier code specifying the type of quantity of ambulance patient count.
Identification Code Qualifier designating the system/method of code structure used for Identification Code of line supplemental information.
Adjusted Repriced Line Item Reference Number. Code qualifying the Reference Identification.
Repriced Line Item Reference code qualifying the Reference Identification.
Adjusted Repriced claim Reference Identification Qualifier.
Prior Authorization Code qualifying the reference identification.
Prior Authorization Code qualifying the reference identification.
Prior Authorization Code qualifying the reference identification.
Prior Authorization Code qualifying the reference identification.
Prior Authorization Code qualifying the reference identification.
Referral Number, code qualifying the Reference Identification.
Referral Number, code qualifying the Reference Identification.
Referral Number, code qualifying the Reference Identification.
Referral Number, code qualifying the Reference Identification.
Referral Number, code qualifying the Reference Identification.
Repriced Claim Code qualifying the Reference Identification.
Service Predetermination Identification code qualifying the reference identification.

Service Predetermination Identification code qualifying the reference identification.
Service Predetermination Identification code qualifying the reference identification.
Service Predetermination Identification code qualifying the reference identification.
Service Predetermination Identification code qualifying the reference identification.
Quantity qualifier code specifying the type of quantity of obstetric anesthesia additional units.
Other Operating Physician code qualifying the type of entity.
Other Operating Physician Code Qualifier designating the system/method of code structure used for Identification Code (67).
Supervising Provider entity Type Qualifier code qualifying the type of entity.
Rendering Provider Name Code qualifying the type of entity.
Supervising Provider Identification qualifier code designating the system/method of code structure used for Identification Code (67).
Rendering Provider Name Code Qualifier designating the system/method of code structure used for Identification Code (67).
Service Facility entity Type Qualifier code identifying the type of entity.
Referring Provider Code qualifying the type of entity. Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
Service Facility Identification Code Qualifier designating the system/method of code structure used for Identification Code (67).
Referring Provider Code Qualifier designating the system/method of code structure used for Identification Code (67). Later research revealed this is an existing field therefore its not going to be mapped to the capture and store tables for 5010.
Code qualifying the type of entity of ambulance pick up location.
Code qualifying the type of entity of ambulance drop off location.
Amount Qualifier.
Code to qualify amount.
Code qualifier to qualify amount of remaining patient liability.
This field represents the loop number in which the REF segment was received on a claim 837 transaction.
This field represents the claim type of the X12 transaction where the qualifier code can be received. The allowed values are "I" Institutional, "P" Professional, and "D" Dental.
Date Time Qualifier for Claim Adjudication Date. Code specifying type of date or time, or both date and time.

Date Time Period Format Qualifier for Claim Adjudication Date. Code indicating the date format, time format, or date and time format.
Date Time Qualifier for Admission Date/Hour. Code specifying type of date or time, or both date and time.
Date Time Period Format Qualifier for Admission Date/Hour. Code indicating the date format, time format, or date and time format.
Qualifier for Payer Estimated Amount Due.
X12 - 837P, I, D - Loop 2300 - AMT01
X12 - 837P, I, D - Loop 2320 - AMT01
X12 - 837P, I, D - Loop 2400 - AMT01
Qualifier for Approved Amount.
Code designating the system/method of code structure used for identification code.
Qualifier for Claim Adjudication Date DTP info
Qualifier for Claim Adjudication Date DTP info
Format Qualifier for the Claim Adjudication Date
Format Qualifier for the Claim Adjudication Date
The qualifier code list received on the 837 transaction for the diagnosis. Valid values for this column are: BF, BJ, BK, BN, DR, PR, ZZ, ABF, ABJ, ABK, ABN, APR. QLF_CODE_LIST is defaulted to #.
The qualifier code list received on the 837 transaction for the diagnosis. Valid values for this column are: BQ, BR, BBQ, BBR. All other values received from the MMIS in QLF_CODE_LIST are defaulted to #.
Identifies the type of diagnosis being submitted.
This qualifier identifies value as a condition.
This qualifier identifies value as a condition. Value is BG - condition code
This qualifier identifies the diagnosis code source. Valid values: BF - ICD-9-CM, DR - Diagnosis Related Group Number (DRG).
This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence
This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence
This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence
This qualifier identifies the type of occurrence. Values are: BI - Occurrence Span BH - Occurrence
Code specifying type of date or time, or both date and time.
Date Time Qualifier. Code specifying type of date or time, or both date and time.
Date Time Qualifier for Discharge Hour. Code specifying type of date or time, or both date and time.
Date Time Period Format Qualifier for Discharge Hour. Code indicating the date format, time format, or date and time format.

Date Time Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment DTP, element DTP01.
PAT05 Loop 2000B. Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Required if patient is known to be deceased. CODE DEFINITION D8 Date Expressed in Format CCYYMMDD
Date Time Period Format Qualifier. Code indicating the date format, time format, or date and time format.
Segment code qualifying Reference Identification.
Segment Reference Identification Qualifier.
Code qualifying the Reference Identification.
Segment Code qualifying Reference Identifier.
Segment Code qualifying Reference Identifier.
Code qualifying the Reference Identification.
This code identifies the Date-Time format of the DTE_PROC_ICD9. To be used when creating outbound 837 transaction.
This code identifies the Date-Time format of the DTE_PROC_ICD9. To be used when creating outbound 837 transaction.
Entity Type Qualifier - Code qualifying the type of entity. Found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EB, segment NM, element NM102. Valid Values - '1' and '2'.
Entity Type Qualifier - Code qualifying the type of entity. Found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment NM, element NM102. Valid Value - '2'.
The value of PR is stored here so that it can be mapped to the outbound 837 transaction. Indicates the type of entity. Example: DN - Referring Provider, P3 - Primary Care Provider, 82 - Rendering Provider, IL - Insured ,or Subscriber, PR - Payer QC - Patient. The list above is not exhaustive.
The value of PR is stored here so that it can be mapped to the outbound 837 transaction. Indicates the type of entity. Example: DN - Referring Provider, P3 - Primary Care Provider, 82 - Rendering Provider, IL - Insured ,or Subscriber, PR - Payer QC - Patient. The list above is not exhaustive.
The value of PR. It is stored here so that it can be mapped to the outbound 837 transaction. Indicates the type of entity. Example: DN - Referring Provider, P3 - Primary Care Provider, 82 - Rendering Provider, IL - Insured or Subscriber, PR - Payer QC - Patient. The list above is not exhaustive.
The value of PR. It is stored here so that it can be mapped to the outbound 837 transaction. Indicates the type of entity. Example: DN - Referring Provider, P3 - Primary Care Provider, 82 - Rendering Provider, IL - Insured or Subscriber, PR - Payer QC - Patient. The list above is not exhaustive.

The value of PR. It is stored here so that it can be mapped to the outbound 837 transaction. Indicates the type of entity. Example: DN - Referring Provider, P3 - Primary Care Provider, 82 - Rendering Provider, IL - Insured or Subscriber, PR - Payer QC - Patient. The list above is not exhaustive.
Facility Code Qualifier. Code identifying the type of facility referenced. Component of Claim Information.
Date Time Period Format Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment DTP, element DTP02.
Date Time Period Format Qualifier. Code qualifying the format for Last Admission Period.
The Date Time Period Format Qualifier is the code indicating the date format, time format, or date and time format.
Surgical Procedure Code Value Qualifier. Code identifying the type/source of the Surgical Procedure Code. E.G. HCPCS, ICD9, etc.
Patient ID qualifier
Provider ID qualifier
Qualification identification for the providers specialty.
Identification Code Qualifier.
Indicates the identification code qualifier. This is the value in NM108. This code tells the domain of the value in CDE_PAYER_ID. This code refers to a list of values used to identify the entity. Valid codes are: PI - Payer Identification XV - CMS (old HCFA) National PlanID. Required if the National PlanID is mandated for use.
Code identifying a specific product or process characteristic to which a measurement applies. Valid values are provided in the 837 Professional HIPAA Implementation Guide
This qualifier identifies the type of information under CDE_MISC. Values are: EI -Employee Identification, SI -School Identification, PT - Pick-up Time (transportation claims).
This will capture NCPDP field #393-MV. Code qualifying the 'Benefit Stage Amount' (394-MW). Values are Blank - Not Specified, 01 - Deductible, 02 - Initial Benefit, 03 - Coverage Gap, 04 - Catastrophic Coverage.
This will capture NCPDP field 351-NP, which qualifies the Payer-Patient Responsibility Amount (352-NQ)". For a list of possible values, consult the External Code List at I:\2010 Enhancement Implementation Project (EIP)\5010 Project\NCPDP.
Date Time Period Format Qualifier for Other Subscriber Date of Birth (DOB). Component of Other Subscriber Demographic Information.
Date Time Period Format Qualifier for Other Subscriber Date of Birth (DOB). Component of Other Subscriber Demographic Information.

Date Time Period Format Qualifier for Other Subscriber Date of Birth (DOB). Component of Other Subscriber Demographic Information.
Prescription Qualifier.
Qualifier for the Procedure code.
Stores sub-element SV301-1
Product/Service ID (Procedure Code) Qualifier. Code identifying the type/source of the descriptive number used in Product/Service ID (Procedure Code).
Qualifier for the Procedure code.
Code identifying the type/source of the number used in Product/Service ID. For NDC's this value is always "N4".
ASC X12 qualifier value for this provider ID type.
Quantity Qualifier. Code specifying the type of quantity. E.G. Type is Visits. Required if the order/prescription for the service contains the data.
Quantity Qualifier. Code specifying the type of quantity.
This field represents the description for the REF segments received on a claim 837 transaction.
This field represents the code qualifier received on a claim 837 REF segment.
Code qualifying the CDE_REF_ID.
Reference Identification Qualifier - Code qualifying the Reference Identification. This code explains the purpose of the CDE_REF_ID.
Reference Identification Qualifier found in the HIPAA 278 Request and Response Guide in loop 2000E, segment REF, element REF01. Valid qualifier is 'BB' - Authorization Number.
Reference Identification Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF01. Valid Value - 'ZZ'.
Reference Identification Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-1. Valid Value - 'ZZ'.
Reference Identification Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-3. Valid Value - 'ZZ'.
Reference Identification Qualifier found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment REF, element REF04-5. Valid Value - 'ZZ'.
This qualifier identifies the type of information in cde_remark. "MIA" or "MOA" are user-defined values to indicate that the cde_remark came from the MIA or MOA segments. If the cde_remark came from LQ02 in the LQ segment, then this qualifier contains the value of LQ01. Currently, possible values for LQ01 are "HE" and "RX". Refer to the X12N 835 implementation guide 2110 segment, LQ loop for more details.
Date Time Qualifier for Statement Dates. Code specifying type of date or time, or both date and time.

Date Time Period Format Qualifier for Statement Dates. Code indicating the date format, time format, or date and time format.
Stores Subscriber's Date of Birth qualifier.
Date Time Period Format Qualifier for Subscriber Date of Birth (DOB). Component of Subscriber Demographic Information.
Date Time Period Format Qualifier for Subscriber Date of Birth (DOB). Component of Subscriber Demographic Information.
Date Time Qualifier for Service Adjudication Date. Code specifiying type of date or time, or both date and time.
Date Time Period Format Qualifier for Service Adjudication Date. Code indicating the date format, time format, or date and time format.
Stores the service date qualifier.
Stores the Service Date Qualifier.
Stores the service date format qualifier.
Stores the service date format qualifier.
Date Time Qualifier for Service Line Date. Code specifying type of date or time, or both date and time.
Date Time Qualifier for Service Line Date. Code specifying type of date or time, or both date and time.
Date Time Period Format Qualifier for Service Line Date. Code indicating the date format, time format, or date and time format.
Date Time Period Format Qualifier for Service Line Date. Code indicating the date format, time format, or date and time format.
Time Period Qualifier. Code defining periods. For example, duration of visits units, frequency time period. Day and Week are examples.
Stores sub-element TOO01
Indicates whether the entity is a person or a non-person. Values are: 1 - Person 2 - Non-Person Entity
Indicates whether the entity is a person or a non-person. Values are: 1 - Person 2 - Non-Person Entity
The number of units of service received by the recipient as shown on the claim record.
Unit adjustment for units of service field on a detail.
Quantity, required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only.
Numeric value of quantity of obstetric anesthesia additional units.
The quantity adjusted on the detail.
Adjustment Quantity. Number of units of service being adjusted.
Adjustment Quantity - Number of units of service being adjusted.
Number of adults in the case.
Age of the recipient on first date of service.
Age of the recipient on the first date of service.
Age of the recipient at the time that the service was rendered.

Age of the recipient at the time that the service was rendered.
Age of recipient on first date of service.
The beginning recipient age restiction for a COS.
The ending recipient age restriction for a COS. Setting the ending age restriction to 999 indicates that the age restriction is not needed for MAR COS assignment. To setup an age restriction the ending age should be set less than 999 (i.e. Begin = 0 and End = 20; or Begin = 21 and End = 199).
This is the recipient age range start value.
Last age in a range that should be included or excluded from audit criteria.
Claims processing no longer uses this field and uses Benefit Plan rules instead. The maximum age that is valid for the diagnosis.
This is a number used to indicate the upper value in an age range. It is the maximum recipient age that is valid and is entered in number of years.
Maximum age a recipient can be to obtain the drug.
The maximum age a recipient may be to receive the procedure.
The maximum age a recipient may be to receive the procedure.
First age in a range that should be included or excluded from audit criteria.
Claims processing no longer uses this field and uses Benefit Plan rules instead. The minimum age that is valid for the diagnosis.
This is a number used to indicate the lower value in an age range. It is the minimum recipient age that is valid and is entered in number of years.
Minimum age a recipient can be to obtain the drug.
The minimum age a recipient may be to receive the procedure.
The minimum age a recipient may be to receive the procedure.
This is the recipient age range end value.
Number of units of service that will be paid under a financial payer/benefit plan.
The number of units allowed for the service.
The number of services that are allowed for the detail.
The number of units allowed for the service.
Quantity allowed for payment for services rendered to a recipient.
The number of units allowed for the service.
The number of services that are allowed for the detail.
The number of units allowed for the service.
The number of units allowed for the service.
Arterial Blood Gas Quantity
The number of units due from a labeler for a specific NDC drug rebate claim
Number of units of service that were provided.
Number of units of service that were provided.

Number of units of service required for the procedure code combination.
Number of units of service that were provided.
The number of units billed for the service. All claims will plug a '1' here. Claims converted from the MMIS may have a value greater than '1'.
Number of units of service that were provided.
Quantity billed for services rendered to a recipient.
The number of units billed for the service. All claims will plug a '1' here. Claims converted from the MMIS may have a value greater than '1'.
Number of units of service that were provided.
The number of units billed for the service. All claims will plug a '1' here. Claims converted from the MMIS may have a value greater than '1'.
Amount of services provided.
The original number of units billed for the service. All claims will plug a '1' here. Claims converted from the MMIS may have a value greater than '1'.
Original billed quantity on the claim detail. Will be NULL if the original billed quantity was not changed. If the original billed quantity was changed, this column will retain the value of the original billed quantity before it was changed.
submitted units billed for HIPAA 835
Submitted units billed for HIPAA 835.
submitted units billed for HIPAA 835
Number of children in the case.
The quantity of a drug service or product dispensed for a specific billing time span.
The maximum allowable quantity of a drug or service that may be dispensed.
The quantity of a drug service or product allowed for a specific billing time span.
The maximum allowable quantity of a drug or service that may be dispensed.
Tells process how often to commit. This value may be changed to increase or decrease the commit frequency for a particular process.
The set number of days used to determine when to send the follow up letter after the collection letter certified date.
The number of days back into history to search for conflicts. It is also used to limit screenings based on the recipient's age in days.
The number of days back into history to search for conflicts. It is also used to limit screenings based on the recipient's age in days.
Days supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in associationwith a 'P' or 'C' in 'Dispensing Status'.

The maximum number of days a prescribed drug should last a Medicaid recipient from the date it is dispensed.
The minimum number of days a prescribed drug should last a Medicaid recipient from the date it is dispensed.
The maximum number of data corrections that will be held for supervisor review for a given user.
The quantity dispensed for the drug claim.
Number of units of a drug that was dispensed to a recipient.
The number of units of a drug dispensed to a recipient.
The number of units of a drug dispensed to a recipient.
Quantity dispensed
The quantity of the drug that was dispensed.
The quantity of the drug that was dispensed.
Number of units of a drug dispensed to a recipient. The type of unit is expressed in CDE DRUG FORM.
The number of units of a drug dispensed to a recipient.
The quantity dispensed of the history claim that the current claim failed a Pro-DUR warning against.
The quantity dispensed of the history claim that the current claim failed a Pro-DUR warning against.
Number of units of a drug dispensed to a recipient. The type of unit is expressed in CDE DRUG FORM.
The quantity of the drug that was dispensed to the recipient.
submitted units billed for HIPAA 835
Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status'.
CR3 - Length of time DME equipment is needed
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
Dose ratio for which the PA should be authorized.
This is the quantity billed.
This the number of units of the drug.
This field is used as a divisor. The labeler's catalog case price is divided by the Case Size to calculate the single package price.
This field is used as a divisor. The labeler's catalog case price is divided by the Case Size to calculate the single package price.
This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc.

This field contains the metric quantity used to derive a unit price. It is the usual labeled quantity from which the pharmacist dispenses, such as 100 tablets, 1000 capsules, 20 ml vial, etc.
The Drug Strength Number (STRNUM) must be used in conjunction with the Drug Strength Unit (STRUN), the Drug Strength Volume Number (VOLNUM), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression for the drug product. The strength of a drug product is usually expressed in the metric system.
Drug product strength in NDDF is usually expressed in metrics. This field, used in conjunction with the Drug Strength Unit, Drug Strength Volume Number and the Drug Strength Volume Units, will be the conventional strength expression for drug product.
The Drug Strength Volume Number (VOLNUM) indicates the volume or weight of the drug product which contains the indicated amounts of active ingredients. This field must be used in conjunction with the Drug Strength Number (STRNUM), the Drug Strength Units (STRUN), and the Drug Strength Volume Units (VOLUN) to obtain a conventional strength expression of the drug product. The strength of a drug product is usually expressed in the metric system.
Drug product strength in NDDF is usually expressed in metrics. It indicates the volume or weight of the drug product which contains the indicated amounts of active ingredients. When used with other factors will be conventional strength expression.
Metric decimal quantity of the product with the appropriate unit of measure.
Number of programs that will process for a particular entity or relationship.
Rebated units as of the report run date. This will fluctuate from Qtr to Qtr as Units are adjusted.
This field represents the number of days before an E&M (visit) procedure can be paid, since it was included as part of the original surgery that was performed. This field is 3 bytes in length.
Incremental change in total number of prescriptions for an NDC for a given quarter/year
Incremental units dispensed for an NDC for a given quarter/year
The number of times a program is repetitively executed.
Maximum dollar amount allowed for specified services.
Maximum dollar amount allowed for specified services.
Maximum number of units allowed for specified services.
Maximum number of units allowed for specified services.
Enging age, in days, for which this criteria applies.
The maximum age for a Drug Pediatric precaution.
The maximum age for a Drug/Age precaution in days.

Maximum days that can be supplied at a given fill.
This field provides the quantitative value for the maximum geriatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.
This field provides the quantitative value for the maximum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.
This field provides the quantitative value for the maximum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.
This field provides the quantitative value for the maximum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.
This field provides the quantitative value for the maximum pediatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Maximum Dose Units field.
This field defines the units which must be used in conjunction with the Maximum Dose Quantity field. These units are usually expressed as metric strength units.
Maximum fills for the drug.
This field provides the quantitative value for the maximum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Maximum Unit Form field.
This field provides the quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Maximum Units Form field.
This field provides the quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Maximum Units Form field.
This field provides the quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Maximum Units Form field.
This field provides the quantitative value for the maximum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Maximum Unit Form field.
Maximum units that can be dispensed at a given fill.
This field defines the unit of use form which must be used in conjunction with the Maximum Unit Quantity field.
Lopp 2400 SV502
Beginning age, in days, for which this criteria applies.

The minimum age for a Drug Pediatric precaution.
The minimum age for a Drug/Age precaution in days.
This field provides the quantitative value for the minimum geriatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field provides the quantitative value for the minimum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field provides the quantitative value for the minimum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field provides the quantitative value for the minimum adult daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field provides the quantitative value for the minimum pediatric daily dosage usually expressed in metric strength units (i.e., mg, mcg, gm). This field must be used in conjunction with the Minimum Dose Units field.
This field defines the units which must be used in conjunction with the Minimum Dose Quantity field. These units are usually expressed as metric strength units.
This field provides the quantitative value for the minimum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Minimum Unit Form field.
This field provides the quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Minimum Unit Form field.
This field provides the quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Minimum Unit Form field.
This field provides the quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Minimum Unit Form field.
This field provides the quantitative value for the minimum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..). This field must be used in conjunction with the Minimum Unit Form field.
This field defines the unit of use form which must be used in conjunction with the Minimum Unit Quantity field.
Total morphine milligrams calculated for this claim detail.
Total morphine milligrams calculated for this claim detail.
Total morphine milligrams calculated for this claim detail.

Total morphine milligrams calculated for this claim detail.
Total morphine milligrams calculated for this claim detail.
The number of units of a prescription/refill that were filled.
The number of units of a prescription/refill that were filled.
The number of units of a prescription/refill that were filled.
Quantity of new units
Orthodontic Treatment Months Count. The estimated number of treatment months.
Orthodontic Treatment Months Remaining Count. The number of treatment months remaining.
Oxygen Saturation Quantity. CR511 is the oxygen saturation. Either CR510 or CR511 is required. Required on claims that report oxygen saturation quantity.
Number of months covered in this certification
Units of Service Paid Count
Units of Service Paid Count.
The quantity that was paid. This may be less than the allowed quanty. The reason for this difference is that cutbacks in the amount submitted are not always reflected in the units. For example, the allowed qty may be 3 and the unit allowed is $10.00 for a total allowed of $30.00. If there is a subsequent cut by $10.00 then the amount paid gets adjusted but the qty allowed remains the same.
QTY_PAID is set to (Paid amount * quantity billed) / Allowed amount. This is rounded to a whole number. Claims that have a tpl amount will have a paid amount that is less than the allowed amount. Therefore the field can be zero when there is a paid amount greater than zero. The field is not used in auditing.
The quantity that was paid. This may be less than the allowed quanty. The reason for this difference is that cutbacks in the amount submitted are not always reflected in the units. For example, the allowed qty may be 3 and the unit allowed is $10.00 for a total allowed of $30.00. If there is a subsequent cut by $10.00 then the amount paid gets adjusted but the qty allowed remains the same.
Total number of prescriptions for an NDC for a given quarter/year
Total number of prescriptions for an NDC for a given quarter/year.
Total number of prescriptions for an NDC for a given quarter/year
The refill number of the drug that was dispensed on the claim.
Number of times drug has been refilled.
The number of refills available for a specific prescribed drug.
This is the refill number for the prescribed drug. This is not the availbale number of refills. The first time the prescription is filled, this attribute will be 0. The second time is filled - the first refill - this attribute will be 1, and so on.

The refill number of the drug that was dispensed on the claim that failed for a Pro-DUR warning.
The refill number of the drug that was dispensed on the claim that failed for a Pro-DUR warning.
This is the refill number for the prescribed drug. This is not the availbale number of refills. The first time the prescription is filled, this attribute will be 0. The second time is filled - the first refill - this attribute will be 1, and so on.
Number of refills permitted by doctor before patient needs to return to the doctor.
Number of refill for a specific prescribed drug for the recipient.
This is an accumulator of the number of times something has been returned from a provider.
This is an accumulator of the number of times something has been returned from a provider.
This is an accumulator of the number of times something has been returned to a provider.
This is an accumulator of the number of times something has been returned to a provider.
Numeric value of quantity. If a decimal is needed to report units, include it in this element, for example, "15.6".
The actual service quantify by revenue code category.
Maximum allowable quantity by revenue code category.
The number of saleable units packed together and sold as a unit
The number of saleable units packed together and sold as a unit.
The number of saleable units (packages) in the case available from the manufacturer
The number of saleable units (packages) in the case available from the manufacturer.
This field provides the state defined quantitative value for the maximum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..).
This field provides the state defined quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the maximum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the maximum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..).

This field provides the state defined quantitative value for the minimum geriatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..).
This field provides the state defined quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the minimum adult daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc.).
This field provides the state defined quantitative value for the minimum pediatric daily dose expressed in units of use (i.e. EA for oral solids, ML for liquids, etc..).
The maximum quantity of the drug which can be dispensed. The default value is 100.
Maximum supply quantity.
The minimum quantity of the drug which can be dispensed. The default value is 1.
Minimum supply quantity.
Total units paid for an NDC for a given quarter/year by a drug labeler
The number of units paid
The quantity of the invoiced units paid.
The average allowed quantity for the Patient First Provider(PMP).
The average allowed quantity for the Patient First Provider peer group.
Total quantity allowed.
Total units billed.
CR1 - Distance traveled in transport
Total units dispensed for an NDC for a given quarter/year
Total units dispensed for an NDC for a given quarter/year
Total units dispensed for an NDC for a given quarter/year.
Total units dispensed for an NDC for a given quarter/year
Number of transactions committed for current cycle.
Total number of units adjusted on a drug rebate dispute invoice after the dispute has been resolved
Quantity allowed for payment for services rendered to a recipient.
Quantity allowed for payment for services rendered to a recipient.
Quantity allowed for payment for services rendered to a recipient.
The number of units of service included for the respective code (1 of 23).
The number of units of service included for the respective code (10 of 23).

The number of units of service included for the respective code (11 of 23).
The number of units of service included for the respective code (12 of 23).
The number of units of service included for the respective code (13 of 23).
The number of units of service included for the respective code (14 of 23).
The number of units of service included for the respective code (15 of 23).
The number of units of service included for the respective code (16 of 23).
The number of units of service included for the respective code (17 of 23).
The number of units of service included for the respective code (18 of 23).
The number of units of service included for the respective code (19 of 23).
The number of units of service included for the respective code (2 of 23).
The number of units of service included for the respective code (20 of 23).
The number of units of service included for the respective code (21 of 23).
The number of units of service included for the respective code (22 of 23).
The number of units of service included for the respective code (23 of 23).
The number of units of service included for the respective code (3 of 23).
The number of units of service included for the respective code (4 of 23).
The number of units of service included for the respective code (5 of 23).
The number of units of service included for the respective code (6 of 23).
The number of units of service included for the respective code (7 of 23).
The number of units of service included for the respective code (8 of 23).
The number of units of service included for the respective code (9 of 23).
Quantity billed by the provider for payment for services rendered to a recipient.
Number of units of service billed at the detail for a UB92 claim.
Total units dispensed for an NDC for a given quarter.
Number of units of service billed at the detail for a UB92 claim.
Number of units of service billed at the detail for a UB92 claim.
The maximum number of units that may be billed for the benefit.

The maximum number of units that may be billed for the benefit
Multi channel lab maximum number of units to accumulate for pricing purposes
The maximum number of units that may be billed for the procedure
This column corresponds to Field 2 of the NCCI MUE data. This field contains the maximum units allowed for the procedure.
This column corresponds to Field 2 of the NCCI MUE data. This field contains the maximum units allowed for the procedure.
This is the high end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is greater than this number, then it will not be valid for this row.
The minimum number of units that may be billed for the benefit.
The minimum number of units that may be billed for the benefit.
Multi channel lab minimum number of units to accumulate
The minimum number of units that may be billed for the procedure.
This is the low end of the range of the number of units billed on a claim detail. If the number of units billed on a claim detail is less than this number, then it will not be valid for this row.
The number of units rebated against. This can be different that billed units if the units have been converted.
The number of units rebated against. This can be different that billed units if the units have been converted.
NDC Unit count calculated. The units attributable to this specific product within this claim detail. This is the value calculated from the conversion factor.
NDC Unit count submitted. The units attributable to this specific product within this claim detail. This is the value actually submitted with the claim detail.
Quantity of units due
This is the number of units authorized for the Prior Authorization line-item service.
This is the number of units authorized for the Prior Authorization line-item service.
This is the number of units requested for the Prior Authorization line-item service.
This is the number of units requested for the Prior Authorization line-item service.
This indicates the number of services that has been used to date for prior authorization line item for a particular claim detail.
Number of Visits. Required if the order/prescription for the service contains the data.
Indicates if the measure base has a single or multiple parts.
This field contains the description associated with a specific questionnaire recipient code.
A code indicating the eligible's race/ethnicity.
A code indicating if the eligible has indicated a race of White. 0 = Non-White or Race Unknown and 1 = White.

A code indicating if the eligible has indicated a race of Black or African-American. 0 = Non-Black or African American or Race Unknown and 1 = Black or African American.
A code indicating if the eligible has indicated a race of American Indian or Alaska Native. 0 = Non-American Indian or Alaska Native or Race Unknown and 1 = American Indian or Alaska Native.
A code indicating if the eligible has indicated a race of Asian. 0 = Non-Asian or Race Unknown and 1 = Asian.
A code indicating if the eligible has indicated a race of Native Hawaiian or other Pacific Islander. 0 = Non-Native Hawaiian or Other Pacific Islander or Race Unknown and 1 = Native Hawaiian or Other Pacific Islander.
The rank for the CC edit.
Code used to identify the rate type use to pay the claim. Allowable values are: AWP=Average Wholesale Price, SMAC=State MAC, WAC=Wholesale Acquisition Cost, FUL=Federal Upper Limit, and DOJ=Department of Justice.
Code used to identify the rate type use to pay the claim. Allowable values are: AWP=Average Wholesale Price, SMAC=State MAC, WAC=Wholesale Acquisition Cost, FUL=Federal Upper Limit, DOJ=Department of Justice.
The numeric value to be converted from
The numeric value to be converted to
Internal code used to identify the interachange level default receiver on outbound maps.
Internal sub-code used to idnetify the interachange level default receiver on outbound maps.
Main code used to identify the group level override receiver on outbound maps. A value in this field override value in trading partner table. GS07-inbound; GS03-outbound.
Main code used to identify the interchange level override receiver on outbound maps. ISA08
Qualifier that specifies the type of main code used to identify the interachange level override receiver on outbound maps. ISA07
This is the recipient count for this grouping.

This is the reason the disposition occurred. P=Payment, R=Recovery, C=Claim Adjustment, D=Deposit,T=Transfer,A=Budget Adjustment
This is the reason the disposition occurred. P=Payment, R=Recovery, C=Claim Adjustment, D=Deposit,T=Transfer,A=Budget Adjustment
Unique identifier for the recipient.
Unique identifier for the recipient.
Unique identifier for the recipient.
Unique identifier for the recipient.
Unique identifier for the recipient.
This contains the unique identification for the recipient receiving the services.
The medicaid id for the recipient who is authorized to receive the services.
This is the medicaid id for the recipient receiving the authorized services.
This is the medicaid id for the recipient receiving the authorized services.
The recipient's age.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
The recipient's unique ID for the claim episode.
Unique identifier for the Beneficiary.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
Referring provider Id or Billing Provider ID.
Billing Provider ID.
Referring provider Id or Billing Provider ID.
Prescribing provider Id or Billing Provider ID.
Performing provider Id or Billing Provider ID.
Referring provider Id or Billing Provider ID.

For Professional Services - Performing Provider ID/Referring Provider ID, Inpatient services - Referring Provider ID, Outpatient Services - Referring Provider ID, Pharmacy Services - Prescribing Provider ID, Nursing Home Claims - Billing Provider ID
For Professional Services - Performing Provider ID/Referring Provider ID, Inpatient services - Referring Provider ID, Outpatient Services - Referring Provider ID, Pharmacy Services - Prescribing Provider ID, Nursing Home Claims - Billing Provider ID
System assigned key for the recipient dimension table.
System assigned key for the recipient dimension table.
System assigned key for the recipient dimension table.
System assigned key assigned to a recipient
System assigned key for the recipient dimension table of the original recipient.
System assigned key for the recipient dimension table of the new recipient.
Recipient name
CMS's record ID. A value of "01" in the first two bytes indicates drug rebate record.
CMS's record ID. Value of "99@@".
The record type, Management, Surgery, Facility, Ancillary and Pharmaceutical, is assigned according to the provider type, type of service, procedure code, and NDC fields on the claim record.
The record type, Management, Surgery, Facility, Ancillary and Pharmaceutical, is assigned according to the provider type, type of service, procedure code, and NDC fields on the claim record.
The record type, Management, Surgery, Facility, Ancillary and Pharmaceutical, is assigned according to the provider type, type of service, procedure code, and NDC fields on the claim record.
The record type, Management, Surgery, Facility, Ancillary and Pharmaceutical, is assigned according to the provider type, type of service, procedure code, and NDC fields on the claim record.
The year and quarter where the record reported in YYYYMM format.
System assigned key for the provider dimension. This is a unique number assigned to the referring provider service location SAK.
This is the refill limit for this drug code.

This field contains the description associated with a specific relationship code.
The number of a research request or project (YYYYMMDDSSS) that relates to the request, or a CSR number (IN
This is the replacement NDC for this drug code.
This field indicates a report has been requested.
This field indicates a report has been requested.
Table name to be mass rate adjusted.
Sort order for mass rate adjustment requests. The provider mass rate updates will need to be made in this order.
Retention period for rows on the audit tables. See entity description for details.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
The recipient ID of the Patient First recipient.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
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This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this provider.
This is the recipient count for this grouping.
This is the recipient count for this grouping.

This is the recipient count for this grouping.
This is the recipient count for this grouping.
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This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this PMP.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
This is the recipient count for this grouping.
The average recipient count for the Patient First Provider(PMP).
The average recipient count for the Patient First Provider peer group.
This is the recipient count for this PMP peer group.
Number of Exceptions based on cost per recipient. This field is the count of providers where the absolute value of the total amount per recipient subtracted from the amount paid per recipient is greater than 2 * STDDEV(amount paid per recipient).

Number of Exceptions based on cost per recipient. This field is the count of providers where the absolute value of the total amount per recipient subtracted from the amount paid per recipient is greater than 2 * STDDEV(amount paid per recipient).
Number of Exceptions based on cost per recipient. This field is the count of providers where the absolute value of the total amount per recipient subtracted from the amount paid per recipient is greater than 2 * STDDEV(amount paid per recipient).
Number of Exceptions based on cost per recipient. This field is the count of providers where the absolute value of the total amount per recipient subtracted from the amount paid per recipient is greater than 2 * STDDEV(amount paid per recipient).
This is the provider's total recipient ranking within their peer group.
Role Description
Drug Route.
This is the route description of the drug code.
The four service types are: Professional Services - Refers to the physician services received by beneficiaries residing in the nursing home. Inpatient services - Refers to instances in which inpatient services were billed for beneficiaries residing in the nursing home. Outpatient Services - Refers to instances in which outpatient services were billed for beneficiaries residing in the nursing home. Pharmacy Services - Refers to the utilization of pharmacy intervention for the individuals residing in the nursing home based on the prescribing number from drug claims.
The four service types are: Professional Services - Refers to the physician services received by beneficiaries residing in the nursing home. Inpatient services - Refers to instances in which inpatient services were billed for beneficiaries residing in the nursing home. Outpatient Services - Refers to instances in which outpatient services were billed for beneficiaries residing in the nursing home. Pharmacy Services - Refers to the utilization of pharmacy intervention for the individuals residing in the nursing home based on the prescribing number from drug claims.

A code for the four service types which are: Professional Services - Refers to the physician services received by beneficiaries residing in the nursing home. Inpatient services - Refers to instances in which inpatient services were billed for beneficiaries residing in the nursing home. Outpatient Services - Refers to instances in which outpatient services were billed for beneficiaries residing in the nursing home. Pharmacy Services - Refers to the utilization of pharmacy intervention for the individuals residing in the nursing home based on the prescribing number from drug claims.
A description for the four service types which are: Professional Services - Refers to the physician services received by beneficiaries residing in the nursing home. Inpatient services - Refers to instances in which inpatient services were billed for beneficiaries residing in the nursing home. Outpatient Services - Refers to instances in which outpatient services were billed for beneficiaries residing in the nursing home. Pharmacy Services - Refers to the utilization of pharmacy intervention for the individuals residing in the nursing home based on the prescribing number from drug claims.
Value identifying the row within the RPT_SECT of the CMS 372 where this record was reported.
The UNIX file name of the report.
Fully qualified report code. (ie: FIN-1099-X)
A date, in ORACLE date format, used to indicate the ending report period for CMS 64 data.
Value identifying the section of the CMS 372 where this record was reported.
This is the cnt of PMP prescriptions.
This is the PMP prescription allowed amount.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.

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The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
The sum of the pharmaceutical record charge amounts in the episode.
This is the PMP prescription claim count.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
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The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.
The sum of the pharmaceutical record paid amounts in the episode.

The sum of the pharmaceutical record paid amounts in the episode.
This is the cnt of Peer group prescriptions.
System assigned key that can identify a claim adjustment, account receivable, or system payout record.
System assigned key which uniquely identifies a claim in the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
System assigned key used to uniquely identify a contract or a recipient plan (benefit plan, assignment plan, level of care plan, etc.).
This field is meant to hold sak_claim values.
SAK Column from T_SYSTEM_KEYS table.
System assigned key for the financial transaction. An example of this would be a claim SAK.
The system assigned key field that contains the value of the invalid sak.
System assigned key that uniquely identifies the phone tracking record.
System assigned key that identifies either a cash receipt number (CCN) or claim adjustment (ICN).
System assigned key that identifies either a cash receipt number (CCN) or claim adjustment (ICN).
This is the system assigned internal key used to uniquely identify an entity. Its value is set to the last SAK used
System assigned key which will uniquely identify a record when the sak_recip occurs multiple times on the table.
Unique identifier for a row on this table
Unique identifier for a row on this table
Unique identifier for a row on this table
Unique identifier for a row on this table
Unique identifier for a row on this table
System assigned key to uniquely identify the payment information sent in an 835 by another payer to Medicaid. The payment information is on the T_835_CK_EFT_TRCNO table.
Unique identifier for a row on this table.
Unique identifier for a row on this table.
Unique identifier for a row on this table.
Unique identifier for a row on this table.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.

System assigned key to accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to the accounts receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
Key to uniquely identify the TPL Account Receivable.
System assigned key to identify the TPL A/R disposition.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
System assigned key to uniquely identify the converted TPL Account Receivable.
System assigned key to uniquely identify the TPL Account Receivable.
This is the primary key for this table.
This is the primary key for this table.
FK to T_RU_ACTION. It's optional. This will be greater then -1 if some action (e.g. setting an edit such as procedure not covered for benefit plan) must occur when all REQUIRED variables of a rule do not match the transaction.
This is the primary key for this table.
This is the primary key for this table.
This is the unique identifier for the absent parent.

This is the unique identifier for the absent parent.
Unique identifier for the absent parent
Unique identifier for the absent parent.
Unique identifier for the absent parent
This field is the internal ID that uniquely identifies address that is stored on Provider CASS table.
This field is the internal ID that uniquely identifies address that is stored on Provider CASS table.
This field is the internal ID that uniquely identifies address that is stored on Provider CASS table.
This field is the internal ID that uniquely identifies address that is stored on Provider CASS table.
System assigned key that uniquely identifies the address of the sender a return letter should be generated for. For cash receipts this is an optional field; provider number is stored on cash receipt. For adjustments, this is required.
This is the additional phone number type for contacting the recipient
The system assigned key for a unique side effect code.
System assigned key used internally by the system to uniquely idenitfy an HIPAA Adjustment Reason code.
System assigned key used internally by the system to uniquely identify an HIPAA Adjustement Reason code.
System assigned key used internally by the system to uniquely identify an HIPAA Adjustement Reason code.
System assigned key used internally by the system to uniquely identify an HIPAA Adjustement Reason code.
The system assigned internal key for a unique file that is transmitted to the IRS for ADPH ALLKids Recipients.
The system assigned internal key for a unique file that is transmitted to the IRS for ADPH ALLKids Recipients.
The system assigned internal key for a unique file that is transmitted to the IRS for ADPH ALLKids Recipients.
A system assigned key (SAK) used to describe a beneficiary age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.
A system assigned key (SAK) used to describe a recipient age grouping.

A system assigned key (SAK) used to describe a recipient age grouping.
The system assigned key for a grouping of American Hospital Formulary Service (AHFS) Therapeutic Classes.
System assigned key for a unique (FDB) AHFS Group type, which represents a single or collection of AHFS Therapeutic Class codes.
System assigned key for an AHFS group.
System assigned key for a AHFS group.
System assigned key used to uniquely identify an eligibility segment.
System assigned key used to uniquely identify an eligibility segment.
Aid Category Grouping System Assigned Key
A system assigned key that identifies the new recipient's Aid Category Grouping.
A system assigned key that identifies the old recipient's Aid Category Grouping.
System assigned internal key used to uniquely identify the Aid Code group.
System assigned internal key used to uniquely identify the Aid Code group.
The system assigned key to uniquely identify a row.
This system generated key identifies allowed transport types for Trading Partners.
System assigned key for an Alternate Therapy definition.
System assigned key for an Alternate Therapy definition.
System assigned key of the interest rate assigned to the accounts receivable collection.
The unique system assigned key that identifies each accounts receivable interest rate.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
This is the primary key to the assign plan table.
This is the primary key to the assign plan table.
This is the primary key to the assign plan table.
This is the primary key to the assign plan table.
Application Tracking Number.[F.R to T_PR_APPLN.SAK_ATN]
System assigned key that uniquely identifies a provider application
System assigned key that uniquely identifies a provider application
System assigned key that uniquely identifies a provider application

System assigned key that uniquely identifies a provider application
System assigned key that uniquely identifies a provider application
System assigned key that identifies an attorney.
System assigned key that identifies an attorney.
System assigned key that identifies an attorney.
System assigned key that identifies an attorney.
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
Unique system generated Auto PA number
The system assigned key that uniquely identifies a bank account within the interChange system.
The system assigned key that uniquely identifies a bank account within the interChange system.
The system assigned key that uniquely identifies a bank account within the interChange system.
System assigned key for a unique base ingredient description
System assigned key used to uniquely identify the base diagnostic endoscopic procedure for a family of endoscopy procedures.
System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD.
System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD.
System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD.
System assigned key for the batch. This sak is the same as the SAK_UPLOAD in T_UPLOAD.
This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_OVERRIDE (so that they do not overlap).
System assigned key used to uniquely identify a benefit (procedure, diagnosis, etc).
System assigned key for a unique DRG.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a revenue code.

System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a revenue code.
System assigned key for the diagnosis.
System assigned key to uniquely identify a valid benefit adjustment type.
System assigned key to uniquely identify a valid benefit adjustment type. Migrated from relationship to table T_BNFT_ADJ_FACTOR
System assigned key to uniquely identify a valid benefit adjustment type.
System assigned key to uniquely identify a valid benefit adjustment type.
System assigned key which uniquely identifies a contact for a recipient.
System assigned key which uniquely identifies a contact for a recipient.
System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.
System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.
System assigned key for a recipient plan group.
System assigned key for a recipient plan group.
System assigned key for a recipient plan group.
This is the primary key for the Benefit Plan Types.
This is a unique identifier for a row on this table.
This is the unique identifier for board participants.
This is the unique identifier for board participants.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
Associated Budget.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.

The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
The system assigned key that identifies a unique budget with interChange.
This is an optional field which identifies the budget to use to record deposits from outside entities.
This is an optional field which identifies the budget to use to pay expenses under this fund code.
The system assigned key that identifies a unique budget disposition within interChange.
The system assigned key that identifies a unique budget disposition within interChange.
The system assigned key that identifies a unique budget with interChange.
This is an optional field which identifies the budget to use to record recoupment dollars from outstanding receivables.
This is an optional field which identifies the budget to use to record returned system checks.
System assigned key
The system assigned key to identify the exception buy-in Part A transactions.
The system assigned key to identify the exception buy-in Part A transactions.
The system assigned key to identify the mismatched buy-in Part A transactions.
The system assigned key to identify the mismatched buy-in Part A transactions.
System assigned key
The system assigned key to identify the exception buy-in Part B transactions.
The system assigned key to identify the exception buy-in Part B transactions.
The system assigned key to identify the mismatched buy-in Part B transactions.
The system assigned key to identify the mismatched buy-in Part B transactions.

The system assigned key to uniquely identify all of the recipient's buy-in Part A transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recipient's buy-in Part A transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recipient's Buyin Part A coverage periods. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recipient's buy-in Part A transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recpient's buy-in Part B transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recpient's buy-in Part B transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recipient's Buyin Part B coverage periods. This column functions as a sak_short for the sak_recip.
The system assigned key to uniquely identify all of the recipient's buy-in Part A transactions. This column functions as a sak_short for the sak_recip.
The system assigned key to identify all of the recipient's Buyin Part A coverage periods.
System assigned key
System assigned key
The unique system assigned key for the contact.
The unique system assigned key for the contact.
The unique system assigned key for the contact.
The unique system assigned key for the contact.
System assigned key to uniquely identify a capitation adjustment that is pending or has been processed within the system.
System assigned key to uniquely identify a capitation adjustment that is pending or has been processed within the system.
System assigned key to uniquely identify a capitation adjustment that is pending or has been processed within the system.
System assigned key to uniquely identify a capitation adjustment that is pending or has been processed within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.

System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
This is the sak of the T_CAPITATION_ADJ row that is adjusting the T_CAPITATION_HIST row.
System assigned key to uniquely identify a capitation payment within the system.
System assigned key to uniquely identify a capitation payment within the system.
The unique system assigned key to identify a capitation rate by region and county.
The system assigned key that uniquely identifies each record.
The system assigned key that uniquely identifies each record.
This is the unique system key that identifies the capitation summary transaction.
This is the unique system key that identifies the capitation summary transaction.
This is the unique system key that identifies the capitation summary transaction.
This is the unique system key that identifies the capitation summary transaction.
This is the unique system key that identifies the capitation summary transaction.
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes.
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes.
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes.
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (1 of 6).

System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (2 of 6).
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (3 of 6).
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (4 of 6).
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (5 of 6).
System assigned key used internally by the system to uniquely identify a combination of CARC, RARC, Business Scenario, and CAGC saks/codes. (6 of 6).
The system assigned carrier key.
This is the carrier ID key assigned by the system to the carrier on this case.
This is the carrier ID key assigned by the system to the carrier on this case.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
System assigned key to identify a carrier.
The system assigned key for the carrier who is handling the Medicare policy.
The system assigned key for the carrier who is handling the Medicare policy.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This system assigned key is used to uniquely identify a carrier internal to the system.
This system assigned key is used to uniquely identify a carrier internal to the system.

This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
Unique key that identifies the carrier.
Sak of the Carrier who has subcontracted with this SubContractor
This is the system assigned key for a carrier. It is used to uniquely identify a carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This is the system assigned key for the TPL other insurance carrier. It uniquely identifies the carrier internally to the system. Each carrier also has a user-defined carrier ID which is used on all screens and reports.
This system assigned key is used to uniquely identify a TPL Carrier record internally.
The system assigned key that identifies the recipient's case number.
The system assigned key to uniquely identify a case.
The system assigned key to uniquely identify a case.
The system assigned internal key for a unique case.
The system assigned key to uniquely identify a case.
The system assigned key to uniquely identify a case.
The system assigned key to uniquely identify a case.
System Assigned Key for Case Group
System Assigned Key for Case Group
System Assigned Key for Case Group
System Assigned Key for Case Group
Unique identifier to identify the member's executor/trustee information.
Unique identifier to identify the member's executor/trustee information.
System Assigned Key for Case Type
System Assigned Key for Case Type

System Assigned Key for Case Type
System Assigned Key for Case Type
System assigned key to uniquely identify a recipient and case number.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies a check submitted to the state from an external source. In this cash it represents a check that has been returned and voided.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies a cash receipt.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any payment submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
System assigned key that uniquely identifies any check submitted to the account from an outside source.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that identifies the casualty case written about in the letter..
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
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This is the internal id that is unique to identify this case.

This is the internal ID that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that is unique to identify this case.
This is the internal id that uniquely identifies the related case.
This is an internal identifier that uniquely identifies a casualty case recovery record.
This is an internal identifier that uniquely identifies a casualty case recovery record.
This is an internal identifier that uniquely identifies a casualty case recovery record.
This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_REF_CCI_OVERRIDE (so that they do not overlap).
This system assigned key uniquely distinguishes each row on table T_REF_CCI.
This system assigned key uniquely distinguishes each row on this table.
This system assigned key uniquely distinguishes each row on table T_REF_CCI_MUE.
This system assigned key uniquely distinguishes each row on this table.
This system assigned key uniquely distinguishes each row on this table.
System assigned key to uniquely identify an action code, which tells the action to be taken when an error fails.
System assigned key to uniquely identify an action code, which tells the action to be taken when an error fails.
System assigned key that uniquely identifies the type of aid category that should be used in selection of claims for Mass Adjustments.
System assigned key to uniquely identify a valid aid category.
System assigned key that uniquely identifies the aid category of the recipient.
This is the system-assigned internal key that is 4 bytes long.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
A system assigned key (SAK) used to represent the aid category of the recipient.
This is the system-assigned internal key that is 4 bytes long.

System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
A system assigned key (SAK) used to represent a recipient aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
System assigned key to uniquely identify a valid aid category.
The system assigned key of the lowest Aid Code in the Aid Code group.
The system assigned key of the highest Aid Code in the Aid Code group.
System assigned key to uniquely identify a phone code.
System assigned key to uniquely identify a phone code.
System assigned key to uniquely identify a phone code.
System assigned key to uniquely identify a phone code.
A sak used to describe the aid category reason for eligibility.
System assigned key that uniquely identifies a payment transaction.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
Check banners system assigned key.
The system assigned internal key used to identify a row.
The system assigned internal key used to identify a row.
System assigned internal key for a medical assistance program.
The unique system assigned key that identifies a reissued check.
This is an internal identifier that uniquely identifies the chrono note.
System assigned key to uniquely identify a citizen status code and associated description.
System assigned key to uniquely identify a citizen status code and associated description.
System assigned key to uniquely identify a citizen status code and associated description.
System assigned key to uniquely identify a citizen status code and associated description.
System assigned key which uniquely identifies a claim in the system.

System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key assigned to the original claim that is being reversed.
System assigned key which uniquely identifies a claim in the system.
System assigned key for the claim's internal control number. This uniquely identifies a claim in the MMIS system.
System assigned key which uniquely identifies a claim in the system.
This is an internal identifier to uniquely identify the claim that could be associated to a casualty case.
System assigned key given to a claim (mother claim).
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key that uniquely identifies a claim.
System assigned key given to a claim.
System assigned key to uniquely identify a claim within the system.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.
System assigned key that uniquely identifies the claim record
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.

System assigned key given to a claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key for claim that was modified by ClaimCheck.
System assigned key which uniquely identifies a claim in the system.
This is the system assigned key for the claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
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System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
This field indicates the system assigned key for the original claim ICN.
System assigned key that uniquely identifies the claim record
System assigned key that uniquely identifies the claim record
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.

System assigned key which uniquely identifies a claim in the system.
The system assigned key which uniquely identifies a claim in the system.
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System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key that uniquely identifies the claim record.
System assigned key that uniquely identifies the claim record.
System assigned key that uniquely identifies the claim record.
System assigned key that uniquely identifies the claim record
System assigned key which uniquely identifies a claim in the system.
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System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.

System assigned key which uniquely identifies a claim in the system.
System assigned key that uniquely identifies a claim.
System assigned key that uniquely identifies a claim.
The system assigned key assigned to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
Unique claim system assigned key defined on a given ETG claim.
Unique claim system assigned key defined on a given ETG claim.
Unique claim system assigned key defined on a given ETG claim.
Unique claim system assigned key defined on a given ETG claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
The sak of the claim to be rejected from financial.
This is the sak of the denal claim that made it through financial.
System assigned key which uniquely identifies a claim in the system.
This is the sak of the pharmacy claim that made it through financial.
This is the sak of the physician claim that made it through financial.
This is the sak of the UB92 claim that made it through financial.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
The sak of the claim that the note is related to.
This field 'points' to the associated claims/encounter records that were part of this measure.
This 'points' to each associated claim that became part of this measure.
The system assigned key that uniquely identifies the shadow claim that caused the delivery capitation payment to be created.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.

System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key given to a claim.
System assigned key that uniquely identifies the claim record.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key for the claim
System assigned key which uniquely identifies a claim in the system
System assigned key to uniquely identify the claim within the system which failed the Pro-DUR warning.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
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System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key to uniquely identify the claim within the system which failed the Pro-DUR warning.
System assigned key which uniquely identifies a claim in the system.
System assigned key to uniquely identify a claim.
System assigned key to uniquely identify a claim to be unlinked from one recipient id to another.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key used to represent this specific claim.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.

This table contains a cross reference between claims from the old system (identified by a TCN) and their converted counterpart claims (identified by a claim SAK) on the current MMIS.
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
Unique identifier for a claim record
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
SYSTEM ASSIGNED KEY TO IDENTIFY A CLAIM
SYSTEM ASSIGNED KEY TO IDENTIFY A CLAIM
SYSTEM ASSIGNED KEY TO IDENTIFY A CLAIM
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key given to a claim.

System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
SYSTEM ASSIGNED KEY TO IDENTIFY A CLAIM
SYSTEM ASSIGNED KEY TO IDENTIFY A CLAIM
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
The sak claim relates this entity back to the paid UB92 header.
System assigned key which uniquely identifies a claim in the system.
System assigned key which uniquely identifies a claim in the system.
System assigned key that uniquely identifies the claim that was created (daughter) during the adjustment process.
System assigned key that uniquely identifies the claim that was created (daughter) during the adjustment process.
System assigned key that uniquely identifies the claim that was created (daughter) during the adjustment process.
System assigned key of the daughter claim.
System assigned key given to a claim adjustment (daughter claim).
This field indicates the system assigned key for the adjusted claim ICN that was generated as a result of processing recipient link or unlink transaction.
System assigned key of the daughter claim.
System assigned key that uniquely identifies the claim that was created (daughter) during the adjustment process.
This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_OVERRIDE (so that they do not overlap).
This system assigned key uniquely distinguishes each row on this table and is in the same domain as T_CLAIM_BDL_NCCD (so that they do not overlap).
System assigned key given to the very first mother claim in the adjustment chain.
System assigned key given to the very first mother claim in the adjustment chain.
System assigned key given to the very first mother claim in the adjustment chain.
System assigned key given to the very first mother claim in the adjustment chain.
System assigned key given to the very first mother claim in the adjustment chain.
System assigned key given to the very first mother claim in the adjustment chain.

Original claim system assigned key
The claim that contains the procedure that ClaimChreck indicates is the bundled procedure.
The claim that was being processed that caused ClaimCheck to perform the edits.
System assigned key for claim's internal control number. This one corresponds to processed claim.
System assigned key which uniquely defines the claim in history that caused an NCCI edit to be set on the claim.
Claim response system assigned key
System assigned key for the claim response
System assigned key of the response claim to the DUR failure.
This field indicates the system assigned key for the denied adjustment claim ICN that was generated as a result of processing recipient link or unlink transaction.
Unique row identifier for this table.
Unique row identifier for this table.
Unique row identifier for this table.
Unique row identifier for this table.
Unique row identifier for this table.
Unique identifier for rows on this table.
Unique identifier for rows on this table.
Unique identifier for rows on this table.
Unique identifier for rows on this table.
Unique identifier for rows on this table.
System assigned key used to uniquely identify a row on this table.
System assigned key used to uniquely identify a row on this table.
System assigned key to uniquely identify a claim to be unlinked from a specific recipient.
System assigned internal key used to uniquely identify Claim FCA records.
The sak of the name fields on the table. Uniquely identifies each row of this table.
The sak of the name fields on the table. Uniquely identifies each row of this table.
The sak of the name fields on the table. Uniquely identifies each row of this table.
The system assigned internal key used to uniquely identify a row.
System assigned key for a unique concurrent med alert
System assigned key to uniquely identify a specific county office.

System assigned key to uniquely identify a specific county office.
System assigned key to uniquely identify a specific county office.
System assigned key used to identify the recipient's county office of service.
This is the system assigned key for the coinsurance table. It is used to uniquely identify each record internally to the system.
This is the system assigned key for the coinsurance table. It is used to uniquely identify each record internally to the system.
Primary key.
Primary key.
FK to T_RU_ACTION. It's optional. This will be greater then -1 if some action (e.g. setting an edit) must occur when the required variables of a rule match a transaction, but this variable does not match the transaction.
It it's -1, there's no condition which means the rule never matches and cannot be applied. This is used when excluding a parent rule.
FK to T_RU_CONDITION.
If IND_LOGICAL_OP = " ", then this is -1.Otherwise it's > 0.
FK to T_RU_CONDITION.
If IND_LOGICAL_OP = " ", then this is -1.Otherwise it's > 0.
Unique system assigned key to each row in this table.
System assigned key that identifies the subcontractor.
System assigned key that identifies the subcontractor.
System assigned key that identifies the contingency fee record.
Contract termination/suspension system assigned key.
System assigned key for the derived recipient copayment type.
System assigned key for the derived recipient copayment type.
A system assigned key to identify the copayment type.
System assigned key for the copayment type.
System assigned key for the copayment type.
The system assigned key that uniquely identifies a row in this table.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
OBSOLETE - DO NOT USE. System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a program.

System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a program.
System Assigned Key used to identify a unique row for a benefit covered by a program.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. This will identify a row to be ignored for this benefit. For example, consider Anesthesia procedure code 00100. This code is is under the subgroup of procedures "Head". Suppose that the "Head" group has a rule1 that would then apply to all procedures in such group except for procedure 00100. The rule1 can be "nullified" by adding a row in T_COVERED_BENEFIT where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
This is the unique identifier for rows on this table.
This is the unique identifier for rows on this table.
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
Selection criteria system assigned key.

What can be in this field depends on what is in ind_type and ind_criteria. It can be a single NDC, single GCN Seq, single GC3, an NDC group, a GCN Seq group, or a GC3 group. If ind_criteria='N' and ind_type='N' Sak_drug is in this field and links to t_drug If ind_criteria='N' and ind_type='Y' Sak_drug_type is in this field and links to t_drug_type If ind_criteria='G' and ind_type='N' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='G' and ind_type='Y' Sak_gcn_seqno_type is in this field and links to t_gcn_seqno_type If ind_criteria='C' and ind_type='N' Sak_drug_thera_cls is in this field and links to t_therapeutic If ind_criteria='C' and ind_type='Y' Sak_thera_class_type is in this field and links to t_therapeutic_type
What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic
What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic
What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic
What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic
What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic

What can be in this field depends on what is in ind_criteria. It can be a single NDC, single GCN Seq, or single GC3. The relationship is many to one for each combination. If ind_criteria='N' Sak_drug is in this field and links to t_drug If ind_criteria='G' Sak_drug_gen is in this field and links to t_generic_drug If ind_criteria='C' Sak_drug_thera_cls is in this field and links to t_therapeutic
The system assigned key that identifies a unique financial schedule criteria TXN within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule criteria TXN within the interChange financial subsystem.
System Assigned Key for Case Category
System Assigned Key for Case Category
System Assigned Key for Case Category
This field contains the system assigned key.
This field contains the system assigned key.
System assigned key used to uniquely identify a program that processes in the MMIS system.
System assigned key to uniquely identify a recipient's official status code for a specified time period.
Key for the source of the data.
Key for the source of the data.
The system assigned internal key used to uniquely identify a row.
Identifies the sak_web_user value of the current users default provider.
The system assigned internal key used to uniquely identify a row.
This field contains the system assigned key.
This field contains the system assigned key.
System assigned key that describes the condition that required medical attention that should be included in the selection.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key assigned to the code that describes the condition that requires medical attention.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.

The system assigned key that uniquely identifies the diagnosis.
System assigned key for the diagnosis.
The system assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
The system assigned key for the diagnosis.
System assigned key assigned to the code that describes the condition that requires medical attention.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
This is the system assigned key for the second diagnosis on the EPSDT history extract.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
System assigned key for the diagnosis.
This is the system assigned key for the third diagnosis on the EPSDT history extract.
This is the system assigned key for the fourth diagnosis on the EPSDT history extract.
System assigned key for the diagnosis compatibility code.
System assigned key for the diagnosis compatibility code.
System assigned key for the diagnosis compatibility code.
System assigned key for a diagnosis to disease row.
System assigned key that uniquely identifies a specific diagnosis or the first in range of diagnoses that should be included or excluded from audit criteria.
System assigned key for the diagnosis.
System assigned key of the lower limit of a range of diagnosis codes.
From diagnosis code for which a recipient is restricted.
System assigned key to identify the beginning range of diagnosis codes which are excluded from coverage under the resource.
System assigned key that identifies that last diagnosis in a range.

System assigned key for the diagnosis.
System assigned key of the upper limit of a range of diagnosis codes.
To diagnosis code for which a recipient is restricted.
System assigned key to identify the ending range of diagnosis codes which are excluded from coverage under the resource.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique Diagnosis Type which represents a collection of Diagnosis Codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a single or collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
A SAK that represents the collection of diagnosis codes needed for a MAR COS assignment. Zero is used to indicate no diagnosis restriction.
System assigned key for a unique diagnosis type, that represents a collection of diagnosis codes.
System assigned key assigned to the code that describes the condition that requires medical attention. This represents the old diagnosis code that will be used by the grouper to assign a DRG code to a claim.
System assigned key of the accounts receivable disposition.
System assigned key of the accounts receivable disposition.
System assigned key of the accounts receivable disposition.
System assigned key that uniquely identifies a disposition entry associated to a lien on the MMIS system.
System assigned key that uniquely identifies a disposition entry associated to a lien on the MMIS system.
System assigned key to uniquely identify the TPL A/R disposition.
System assigned key to uniquely identify the TPL Case disposition.
System assigned key to uniquely identify the TPL A/R disposition.
System assigned key to uniquely identify the TPL A/R disposition.
System assigned key to uniquely identify the TPL A/R disposition.

System assigned key (SAK) used to uniquely identify a drug rebate invoice dispute. The SAK is used internally within the system and is not viewed by the user.
System assigned key (SAK) used to uniquely identify a drug rebate invoice dispute. The SAK is used internally within the system and is not viewed by the user.
System assigned key for a unique MME dose range factor
This is the system generated key that identifies EDI header (ISA and GS) information for the X12 files received or sent by the system.
Foreign key to T_DOCUMENT_TRACK table.
This is the system generated key that identifies EDI header (ISA and GS) information for the X12 files received or sent by the system.
This is a system generated key that identifies EDI transaction (ST-SE) information for the X12 files received or sent by the system.
Unique identifier for Doc Type Code records.
Unique identifier for Doc Type Code records.
Key for the domain of the measurement.
Key for the domain of the measurement.
The unique id for a file available to download for a web user.
System assigned key for a grouping of Delivery Point Validation (DPV) error codes.
System assigned key for a grouping of Delivery Point Validation (DPV) error codes.
System assigned key that uniquely identifies a drug code (NDC).
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for a unique Diagnosis Related Group (DRG).
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for a unique DRG.
System assigned key for Diagnosis Related Group (DRG). This uniquely identifies a DRG in the system.
System assigned key for a unique MME drug concept link
The system assigned key that uniquely identifies a row in this table.
The system assigned key that uniquely identifies a row in this table.

The system assigned key that identifies the DRG code that will be utilized during the pricing process.
System assigned key for the enhanced DRG code utilized during the DRG pricing process.
System assigned key for a unique DRG.
System assigned key for the higher weight DRG
System assigned key for the higher weight DRG
The system assigned key that uniquely identifies a row in this table.
System assigned key for a unique DRG.
This is the sak type for the drg type that can be found on t_DRG_type
System assigned key that uniquely identifies a drug code (NDC).
Drug key
Unique system generated drug number
System assigned key to uniquely identify a drug
System assigned key for a unique drug.
A system assigned key (SAK) used to represent the NDC drug code value.
System assigned key for a unique drug.
System assigned key for a unique drug
System assigned key for a unique drug
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key to uniquely identify a drug.
System assigned key (SAK) used to uniquely identify a drug rebate invoice dispute. The SAK is used internally within the system and is not viewed by the user.
System assigned key to uniquely identify a drug
System assigned key for a unique drug
System assigned key to uniquely identify a drug
System assigned key for a unique drug

System assigned key for a unique drug.
System assigned key that uniquely identifies an NDC. An invoice level comment will be assigned a 0 in this field.
System assigned key to uniquely identify a drug
System assigned key that uniquely identifies an NDC.
System assigned key to uniquely identify a drug
System assigned key to uniquely identify a drug
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key that uniquely identifies an NDC
System assigned key to uniquely identify a drug
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug. This Drug is referred to as the Source NDC.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for a unique drug
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key for a unique drug.
System assigned key for drug
System assigned key for drug
The SAK of the drug that was dispensed on the claim that failed a Pro-DUR warning.
The SAK of the drug that was dispensed on the claim that failed a Pro-DUR warning.
System assigned key for a unique drug.
The sak of the drug in history that the current claim failed a ProDUR Warning against.
System assigned key for a unique drug
System assigned key for Drug codes for which a recipient is restricted.
System assigned key for a unique drug
System assigned key for a unique drug.
System assigned key for a unique drug. Referred to as the Target NDC.
System assigned key for a unique MME drug base ingredient factor
The system assigned key for a unique drug class (this will point to a Thera Class or Ingred code).
System assigned key for a unique Drug/Disease precaution criteria.
Sak for unique key to facilitate the use of an audit table.
System assigned key for a unique drug.

The system assigned key for a unique generic drug.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a unique generic drug.
The system assigned key for a unique generic drug.
The system assigned key for a unique generic drug.
The system assigned key for a GCN Sequence number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a unique generic drug.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
System assigned key that uniquely identifies a GSN.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a unique generic drug.
The system assigned key for a GCN Sequence Number.
The system assigned key for a unique generic drug.
The system assigned key for a unique generic drug.
The system assigned key for a unique generic drug.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
This is the system assigned key of the generic drug.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
This is the system assigned key of the generic drug in history that the warning was set against.
The system assigned key for a GCN Sequence Number.
The system assigned key for a GCN Sequence Number.
Drug gen original system assigned key
The system assigned key for a Drug Geriatric precaution.
The system assigned key for a Drug Geriatric precaution.
This is the system assigned key used to uniquely identify the drug manufacturer.
This is the system assigned key used to uniquely identify the drug manufacturer.

This is the system assigned key used to uniquely identify the drug manufacturer.
System assigned key for a unique Drug Med Master
The system assigned key for a Drug Pediatric precaution.
The system assigned key for a Drug Pediatric precaution.
The system assigned key for Drug Pregnancy precautions.
The system assigned key for Drug Pregnancy precautions.
This is a system assigned key for a drug that has been replaced or reused.
System assigned key that is 4 bytes long
This is a unique key for the drug labeler table.
System assigned key that is 4 bytes long
System assigned key for a unique drug labeler code
System assigned key that uniquely identifies a Drug Labeler.
System assigned key that is 4 bytes long
This is the system assigned key for drug TC (therapeutic class) original.
The system assigned key for a unique drug therapeutic class.
The system assigned key for a drug therapeutic class. (HIC3)
The system assigned key for a unique drug therapeutic class.
The system assigned key for a unique drug therapeutic class.
The system assigned key for a unique drug therapeutic class.
System assigned key for drug therapy class
Drug therapeutic class system assigned key
This is the system-assigned key of the therapeutic class of the drug on the claim.
This is the system-assigned key of the therapeutic class of the drug on the claim.
The system-assigned key of the therapeutic class of the drug on the claim in history which the alert failed against.
The system assigned key for a unique drug therapeutic class.
System assigned key for a unique drug.
Primary drug therapy system assigned key to groups in the system
Secondary drug therapy system assigned key to groups in the system
System assigned key for a unique NDC type, that represents a collection of NDC's.
System assigned key for a unique NDC type, that represents a collection of drugs.
System assigned key for an NDC group.
System assigned key for an NDC group.
The system assigned key for a unique disease code.
This is the unique system assigned key for the record.
This is the unique system assigned key for the record.

This is the unique system assigned key for the record.
This is the unique system assigned key for the record.
This is the unique system assigned key for the record.
Sak to make primary key unique.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify a EDI record.
System assigned key to uniquely identify an eligibility stop reason code and it's description.
System assigned key to uniquely identify an eligibility stop reason code and it's description.
System assigned key to uniquely identify an eligibility stop reason code and it's description.
This is the system assigned key for the policyholder employer. It is used to uniquely identify the employer internally to the system. Each employer also has a user-defined employer ID which is used on all screens and reports.
This is the system assigned key for the policyholder employer. It is used to uniquely identify the employer internally to the system. Each employer also has a user-defined employer ID which is used on all screens and reports.
System assigned key to identify an employer.
This is the system assigned key for the policyholder employer. It is used to uniquely identify the employer internally to the system. Each employer also has a user-defined employer ID which is used on all screens and reports.
This is the system assigned key for the policyholder employer. It is used to uniquely identify the employer internally to the system. Each employer also has a user-defined employer ID which is used on all screens and reports.
This system assigned key is used to uniquely identify a TPL Employer record internally.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
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System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
System assigned key used to uniquely identify an enrollment application.
The system assigned key of the entity to whom the premium payment is being mailed.
Unique key identifying the lock entry reason codes
Unique key identifying the lock entry reason codes
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment was created.
System assigned key that uniquely identifies the reason for the adjustment.
System assigned key for the Explanation of Benefits.
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment was created.
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment was created.
System assigned key for reversal EOB.
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment was created.
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment will be created.
System assigned key that uniquely identifies the explanation of benefit code associated with a particular edit/audit for a detail.

The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).
This field indicates the EOB used for adjusting the denied claims as a denied adjustment as a result of processing recipient link or unlink transaction.
The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).
The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).
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The system assigned key for the EOB table. This key will make it possible to renumber the EOB file in the future without affecting the other tables that carry EOB (such as claim or ESC).
System assigned key that uniquely identifies the explanation of benefit code that provides the reason for which the adjustment was created.
EOMB system assigned key.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key used to define an occurrence of an error disposition for a specific edit/audit.

System assigned key used to define an occurrence of an error disposition for a specific edit/audit.
System assigned key assigned to a specific error code (edit/audit)
System Assigned Key for a Unique Error type
System Assigned Key for a Unique Error type
System assigned key that uniquely identifies an edit/audit code.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an edit number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
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System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number. This number will designate the content of the report.
System assigned key that uniquely identifies an error number.
System assigned key for an edit code that was set by the claims processing system. ESC = Error Status Code.
System assigned key for error number defined.
The system assigned key for the error code.
System assigned key that uniquely identifies an error number.
The system assigned key that uniquely defines an error code.
System assigned key that uniquely identifies an error number.

System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
Error status code system assigned key that uniquely identifies an ESC within the system.
System assigned key for error number defined.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
This is the system assigned key uniquely identifying the error status code overridden on this prior authorization.
This is the system-assigned internal key used to uniquely identify a row without using updatable attributes.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number.
System assigned key that uniquely identifies an error number (1 of 6).
System assigned key that uniquely identifies an error number (2 of 6).
System assigned key that uniquely identifies an error number (3 of 6).
System assigned key that uniquely identifies an error number (4 of 6).
System assigned key that uniquely identifies an error number (5 of 6).

System assigned key that uniquely identifies an error number (6 of 6).
Unique numeric representing different codes of the event.
Unique numeric representing different codes of the event from T_CDE_EVENT.
Unique codes for the Event Keys.
Code for the Event Key.
This is a system generated key that identifies events that have been captured by the system.
Foreign key from T_EVENT_TRACK table.
This is a system generated key that identifies a business key related to an Event and that key value.
System assigned key for EVS eligibility segment.
System assigned key for EVS eligibility segment.
System assigned internal key for a medical assistance program.
System assigned key for the T_TPL_EXEMPT table.
Unique key identifying lock exit reason codes
Unique key identifying lock exit reason codes
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
This is the system assigned key of the expenditure that made the payment.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
System assigned key that uniquely identifies an expenditure transaction.
The system assigned internal key used to identify a row.
This is the unique system assigned key for each facility.
This is the unique system assigned key for each facility.
This is the System Assigned key used to identify the Federal Account number.
This is the System Assigned key used to identify the Federal Account number.
This is the unique key for a FICA rate.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.

Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
Associates the transaction group with a file identifier that can be used to look up the recording of transaction.
This system generated key identifies correlations of solicted (request response) files created or received by the system.
Unique numeric code representing different file directions.
Unique numeric code representing different file directions.
Unique numeric code representing different file directions.
The system assigned key for the case tracking file location.
This system generated key identifies the solicited EDI messages information passing through EDI environment.
Unique codes describing the file status.
Codes from T_CDE_FILE_STATUS.
This system generated key identifies the file and message information passing thru the system.
This system generated key identifies the file and message information passing thru the system.
Foreign key to T_FILE_TRACK.
Foreign key to T_FILE_TRACK.SAK_FILE_TRACK.
Unique key used to track the file as it passes through the system.
Unique key used to track the file as it passes through the system.
Unique identifier used to track the file as it passes through the system.
Unique identifier used to track the file as it passes through the system.
Foreign key from the T_FILE_TRACK.
This system generated key identifies the file and message information passing through EDI environment.
Foreign key from T_FILE_TRACK.
This system generated key identifies the file and message information passing through EDI environment.
This system generated key identifies the file and message information passing through EDI environment.
This system generated key identifies the correlation of file tracking records to handled exceptions if the file processing failed in EDI environment.
Foreign key from the T_FILE_TRACK record of the request.

Foreign key from the T_FILE_TRACK record of the response.
System Assigned Key for Filter
System Assigned Key for Filter
System Assigned Key for Filter
Key to the filter table field used in the criteria.
Unique identifier for a filter in the DSSMeasureBase Maintenance screens.
System assigned key that uniquely identifies an error number.
Unique number to identify user request for the report.
This is a unique identifier for a row on this table.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
This is unique key for the Financial Category of Service.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
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The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within the interChange financial subsystem.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.

The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
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The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique financial cycle within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
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The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
Financial Payer.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
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The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange. This field is not used and will eventually be removed.
The system assigned key that identifies a unique payer within interChange. This field is not used and will eventually be removed.
The system assigned key that identifies a unique payment release record within interChange.
The system assigned key that identifies a unique PERIOD with interChange.
The system assigned key that identifies a unique PERIOD with interChange.
The system assigned key that identifies a unique PERIOD with interChange.
The system assigned key that identifies a unique PERIOD with interChange.
This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is -1. This may be always the default value since not all cash dispositions are processed in batch
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
Finanacial Schedule.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is 0 or -1. This may be always the default value since not all cash dispositions are processed in batch.
This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is 0 or -1. This may be always the default value since not all cash dispositions are processed in batch

This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is 0 or -1. This may be always the default value since not all cash dispositions are processed in batch.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
System assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is -1. This may be always the default value since not all cash dispositions are processed in batch
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
This field contains the sak of the schedule (cycle) under which this disposition was processed. Default value is 0 or -1. This may be always the default value since not all cash dispositions are processed in batch
The system assigned key that identifies a unique financial schedule within interChange.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within interChange.
The system assigned key that identifies a unique financial schedule within interChange.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within interChange.
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The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
The system assigned key that identifies a unique financial schedule within the interChange financial subsystem.
System assigned key that identifies the attorney firm.
System assigned key that identifies the attorney firm.
This system generated key identifies the status of all 997 acknowledgements received or sent by the system.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
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This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
A system assigned key (SAK) used to represent the financial funding code.
This is the unique system assigned key to the Financial Fund Codes.

This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
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This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
The fund code key for the transaction.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
The fund code key for the transaction.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
This is the unique system assigned key to the Financial Fund Codes.
Fund Code
This is the unique system assigned key to the Financial Fund Codes.
This is the system assigned key of the group of fund codes.
This is the system assigned key of the a group of fund codes.
This is the system assigned key of the a group of fund codes.
This is the system assigned key of the a group of fund codes.

The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
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The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key that identifies a unique payer within interChange.
The system assigned key for the daily State Fund transaction records.
System assigned key for a GCN Sequence Number group.
System assigned key for a GCN Sequence Number group.
System assigned key for a unique GCN seqno type, which represents a single or collection of GCN sequence number.
System assigned key for a unique GCN seqno type, which represents a single or collection of GCN sequence number.
System assigned key for a unique GCN seqno type, which represents a single or collection of GCN sequence number.
The system assigned key a geriatric dosing criteria. (PRIMARY KEY)
Unique Identifier of step groups
Unique Identifier of step groups
Unique Identifier of a step therapy group. A step therapys group is a group of drugs, both referred and non preferred, having a particular therapeutic effect.
Unique Identifier of a step therapy group. A step therapys group is a group of drugs, both referred and non preferred, having a particular therapeutic effect.
A unique identifier for the letter group.
System assigned key to uniquely identify the group number coverage assignment.
System assigned key for a unique Benefit Plan group that represents a single or collection of Benefit Plan codes.

System Assigned Key for the Peer Group Rate.
System Assigned Key for the Peer Group Rate.
The system assigned key of the HICL Class XREF Table
System assigned key for a HIC4 group.
System assigned key for a HIC4 group.
System assigned key for a unique (FDB) HIC Group type, which represents a single or collection of HIC.
System assigned key for a unique (FDB) HIC Group type, which represents a single or collection of HIC4.
The system assigned key for High Dose precautions.
The system assigned key for High Dose precautions.
System assigned key representing the HIPAA relationship code.
System assigned key representing the HIPAA relationship code.
System assigned key representing HIPAA service type code.
System assigned key representing the HIPAA service type code.
System assigned key representing HIPAA service type code.
System assigned key to uniquely identify a HIPP resource.
System assigned key to uniquely identify a HIPP resource.
System assigned key to uniquely identify a HIPP resource.
System assigned key to uniquely identify a HIPP resource.
System assigned key to uniquely identify a HIPP resource.
System assigned key to uniquely identify a HIPP resource.
Primary key of this table that is also employed as a foreign key to for table T_RE_HOSPICE_DTL . The value for this key will be controlled by T_SYSTEM_KEYS.
Primary key of this table that is also employed as a foreign key to for table T_RE_HOSPICE_DTL . The value for this key will be controlled by T_SYSTEM_KEYS.
The system assigned key that uniquely identifies a row in this table.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
This is the unique identifier for a claim.
The system assigned internal key of the Identifier table.

The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key used to uniquely identify a row.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
The system assigned internal key of the Identifier table.
System assigned internal key used to uniquely identify the Provider ID group.
System assigned internal key used to uniquely identify the Provider ID group.
Unique system assigned key.
The system assigned internal key used to identify a row.
The system assigned internal key used to identify a row.
This is the unique key that points the common indicators among claims.
This is the unique key that points the common indicators among claims.
This is the unique key that points the common indicators among claims.
System assigned key identifying the ingredient.
The system assigned key for a drug ingredient code. (HIC4)
System assigned key identifying the ingredient.
System assigned key identifying the ingredient.
System assigned key related to a ingredient.
System assigned key for the first HIC4 therapeutic code in an inclusive alphabetic range of HIC4 codes.
System assigned key for the first HIC4 therapeutic code in an inclusive alphabetic range of HIC4 codes. If only one HIC number is needed, this number should be the same as the HIC Range From.
The system assigned key for Ingredient Duplication precautions.
The internal identifier that is required to tie an insurance agent to a casualty case.
The internal identifier that is required to tie an insurance agent to a casualty case.
This is a unique system assigned key that will identify the interest rate.
The unique system assigned key used to identify the claim interest rate.

System assigned key which uniquely identifies a specific interest application (entry).
The system assigned key for an interaction inverse precaution.
The system assigned key for an interaction inverse precaution.
System assigned key for a unique Drug Rebate Invoice.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System Assigned Key (SAK) used to uniquely identify the Drug Rebate Invoice. The SAK is used internally and is not viewed by the user.
System assigned key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally within the system and is not viewed by the user.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System assigned key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally within the system and is not viewed by the user.
System assigned key which uniquely identifies the invoice on which the interest is being paid.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System assigned key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally within the system and is not viewed by the user.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System assigned key which uniquely identifies the drug rebate invoice to which the payment was applied.
System Assigned Key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally and is not viewed by the user.
System assigned key (SAK) used to uniquely identify a drug rebate invoice. The SAK is used internally within the system and is not viewed by the user.
This is the unique key for a letter defined on the system.
A unique identifier for the letter
A unique identifier for the letter
System Assigned Key for the letter.
System Assigned Key for the letter.

System Assigned Key for the letter.
A unique identifier for the letter
A unique identifier for the letter
system Assigned Key for the letter
This is a generic SAK that can be used for letters.
A unique identifier for the letter.
A unique identifier for the letter
Used to uniquely Identify the correct letter
System Assigned Key for the Letter group
System Assigned Key for the Letter group
System assigned key to uniquely identify an entry in the Recipient ID Card Letter entity.
Number that uniquely identifies the letter that was requested on the AR.
A unique identifier for the letter request.
System Assigned Key for the request.
System Assigned Key for the request.
System Assigned Key for the request.
A unique identifier for the letter request.
A unique identifier for the letter request.
Used to uniquely identify the correct letter request.
A unique identifier for the letter template.
A unique identifier for the letter template.
A unique identifier for the letter template.
System assigned key for the short reason code and corresponding letter text that should display on a specific letter.
System assigned key for the short reason code and corresponding letter text that should display on a specific letter.
System assigned key for the short reason code and corresponding letter text that should display on a specific letter.
Unique system assigned key for History Events.
Unique system assigned key for History Events.
System assigned key that uniquely identifies a lien against a provider on the MMIS system.
System assigned key that uniquely identifies a lien against a provider on the MMIS system.
System assigned key that uniquely identifies a lien that can process in the system.
System assigned key that uniquely identifies a lien that can process in the system.
System assigned key that uniquely identifies a lien against a provider on the MMIS system.
System assigned key that uniquely identifies the name and address of a non-provider entity on the MMIS system. For example, the addresses of Lien Holders and Counties and nonprovider entities to which we make Expenditure Payments.
System assigned key that uniquely identifies the limitation.

System assigned key that uniquely identifies the limitation.
System assigned key to uniquely identify a link/unlink transaction.
System assigned key to uniquely identify a link/unlink transaction.
System assigned key to uniquely identify a link/unlink transaction.
System assigned key to uniquely identify a link/unlink transaction.
System assigned key to uniquely identify a link/unlink process row.
System assigned key to uniquely identify a Living Arrangement Code and it's description.
System assigned key to uniquely identify a Living Arrangement Code and it's description.
System assigned key to uniquely identify a Living Arrangement Code and it's description.
Internal system assigned key used to uniquely identify provider information within a specific recipient's restriction period.
Internal system assigned key used to uniquely identify provider information within a specific recipient's restriction period.
Internal system assigned key used to uniquely identify provider information within a specific recipient's restriction period.
Internal system assigned key used to uniquely identify provider information within a specific recipient's restriction period.
Internal system assigned key used to uniquely identify a recipient's restriction period.
Internal system assigned key used to uniquely identify a recipient's restriction period.
Internal system assigned key used to uniquely identify a restricted diagnosis range associated with a recipient's restricted provider services.
Internal system assigned key used to uniquely identify a restricted drug associated with a provider's restricted recipient services.
Internal system assigned key used to uniquely identify a restricted procedure range associated with a provider's restricted recipient services.
System assigned key to uniquely identify a recipient, provider, and associated admit and termination dates
The unique system assigned key.
The system assigned key for a Low Dosage precaution.
The system assigned key for a Low Dosage precaution.
The unique system assigned key.
The unique system assigned key.
LVX Request Number.
LVX Request Number.
Unique identifier for a managed care plan

Unique identifier for a managed care plan
Unique identifier for a managed care plan
Unique identifier for a managed care plan
Unique identifier for a managed care plan
Unique identifier for a managed care plan
Unique identifier for a managed care plan
Unique identifier for a managed care plan
System assigned key to uniquely identify a managed care exclusion code.
The system assigned internal key used to uniquely identify a row.
A SAK that represents the MAR Capitation Payment Type assigned to the PMP Service Location.
System assigned key used to uniquely identify a Managed Care Organization (MCO).
The unique identifier for the group.
The unique identifier for the group.
The unique identifier for the group.
The unique identifier for the group.
This table stores all entities that affect Managed Care. Examples include system processes
Identifies the entity that inserted the PMP selection.
This table stores all entities that affect Managed Care. Examples include system processes.
Unique identifier for the Managed Care entity (interChange eligibility, enrollment broker, business staff, system processes, etc). This column identifies the entity that created the PMP assignment.
Unique identifier for the Managed Care entity (interChange eligibility, enrollment broker, business staff, system processes, etc). This column identifies the entity that created the PMP assignment.
Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that last updated the PMP assignment.
Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that last updated the PMP assignment.
This table stores all entities that affect Managed Care. Examples include system processes.

Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that added the values for the SAK_PROV_MBR and CDE_SERVICE_LOC_MBR fields.
Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that added the values for the SAK_PROV_MBR and CDE_SERVICE_LOC_MBR fields.
This table stores all entities that affect Managed Care. Examples include system processes.
Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that end dated the PMP assignment.
Unique identifier for the Managed Care entity (PS/2, Enrollment Broker, OHCA, system processes, etc). This column identifies the entity that end dated the PMP assignment.
Unique identifier of the Managed Care program status code group.
Unique identifier of the Managed Care program status code group.
Unique identifier of the Managed Care program status code group.
System assigned key for a unique MDC.
System assigned key for a unique Major Diagnostic Category code.
All possible principal diagnoses are divided into mutually exclusive areas referred to as Major Diagnostic Categories (MDC). These MDCs were formed by physician panels to insure that the DRGs would be clinically coherent.
System Assigned Key for Measure
System Assigned Key for Measure
Key for measure base.
Key for measure base.
Key for measure base.
Key for the source of the measurement.
Key for the source of the measurement.
System assigned key for a unique med risk drugs
Edit members system assigned key.
Unique ID.
System assigned key to uniquely identify a mini link transaction.
System assigned key for a unique MME dose range factor
System assigned key for a unique MME factor
System Assigned Key for the Modifier.
This is a unique identifier for a row on this table.

System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.
System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.
System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.
System assigned key for a unique modifier grouping type, that represents a collection of modifier codes.
The system assigned internal key used to identify a row.
A system assigned key (SAK) used to describe eligibility peer group information.
A system assigned key (SAK) used to describe eligibility peer group information.
A system assigned key (SAK) used to describe provider enrollment peer group information.
A system assigned key (SAK) used to describe provider enrollment peer group information.
System assigned key which uniquely identifies the row.
Name of the SAK. This should match the SAK_NAME value in T_SYSTEM_KEYS table.
The name of the system assigned key
The name of the system assigned key.
The system assigned key value that uniquely identifies the nursing facility for the case.
The system assigned unique identifier for the non Medicaid certified facility associated with the case.
System assigned key that uniquely identifies the name and address of a non-provider entity on the MMIS system. For example, the addresses of Lien Holders and Counties and nonprovider entities to which we make Expenditure Payments.
This is the system assigned key for EPSDT notices.
This is the system assigned key for EPSDT notices.
Unique identifier for a row on this table.
The unique system assigned key that identifies a bank clears record received that does not have a match on t_check.
System assigned key that uniquely identifies a provider by NPI
System assigned key that uniquely identifies a provider by NPI
System assigned key that uniquely identifies the Provider's NPI.
System assigned key to uniquely identify an official status code and the associated description.
System assigned key to uniquely identify an official status code and the associated description.
The system assigned key used along with the system assigned recipient key to uniquely identify a Medicaid recipient's Medicaid ID at a particular point in time.
The system assigned internal key used to uniquely identify a row.

The system assigned key for the case tracking outgoing referral entries.
The system assigned internal key for a unique Recipient AR overpayment record.
The system assigned internal key for a unique Recipient AR overpayment record.
The system assigned internal key for a unique Recipient AR overpayment record.
The system assigned key for an Over Utilization precaution.
The system assigned key for an Over Utilization precaution.
This is the unique identifier of the record on the owner table.
This is the unique identifier of the record on the owner table.
This is the unique identifier of the record on the owner table.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key of the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
The unique system generated key for a prior authorization.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
This is the system assigned key for the Prior Authorization record.
A unique identifier for the prior authorization

System assigned key to uniquely identify a prior authorization
System assigned key to uniquely identify a prior authorization
A unique identifier for the participant.
A unique identifier for the participant.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for patient liability.
This is the unique system assigned that identifies each row on this table.
OBSOLETE - DO NOT USE. This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned that identifies each row on this table.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. where SAK_COV_BNFT_NULL points to rule1 for the "Head" group.
This is the unique system assigned that identifies each row on this table.
System Assigned Key used to identify a unique row for a benefit covered by a PROVIDER CONTRACT
This is the unique system assigned that identifies each row on this table.
This is the unique system assigned key associated with the payee for this transaction. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
System assigned key that uniquely identifies a payee in the MMIS.
A system assigned key identifying a payee in the MMIS system.
System assigned key that uniquely identifies the payee.
This is the payee associated with this portion of the cash receipt. This field will store the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..

A system assigned key identifying a payee in the MMIS system.
A system assigned key identifying a payee in the MMIS system.
This contains the unique identifier for a payee defined in the system.
This is the provider that is being paid the interest on the claim.
A system assigned key identifying a payee in the MMIS system.
System assigned key that uniquely identifies the name and address of a provider or a non-provider entity on the MMIS system. For example, the addresses of Lien Holders and Counties and nonprovider entities to which we make Expenditure Payments.
A system assigned key identifying a payee in the MMIS system.
System assigned key that uniquely identifies a payee in the MMIS.
This unique payee system assigned key associated with this transaction. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
This unique payee system assigned key associated with this transaction. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
This unique payee system assigned key associated with this record. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc.
This unique payee system assigned key associated with this transaction. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the payee.
This is the payee associated with this portion of the cash receipt. This field will store the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
This is the system assigned key for the person/organization that is receiving the payment.
This unique payee system assigned key associated with this transaction. It contains the sak of various entities such as sak_prov_loc, sak_recip, sak_carrier, etc..
System assigned key that uniquely identifies a a payee. Such as provider, recipient, carrier, etc.
A system assigned key identifying a payee in the MMIS system.
System assigned key that uniquely identifies the name and address of a non-provider entity on the MMIS system. For example, the addresses of Lien Holders and Counties and nonprovider entities to which we make Expenditure Payments.
System assigned key that uniquely identifies a payee.

SAK of the TPL entity being reported. Current TPL entity types being reported are Sub Contractor and Carrier.
System assigned key for RCO payer
Unique identifier for a payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
System assigned key for RCO payer
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
Unique identifier for a Payer.
System Assigned key that identifies payment applications for the invoice paid.
System assigned key that uniquely identifies the payment application of an invoice.
System assigned key that uniquely identifies the payment application of an invoice.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
The unique system assigned key for the Payment Hold entity.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. This will identify a row to be ignored for this benefit.
This acts the same way as how SAK_COV_BNFT_NULL acts in T_COVERED_BENEFIT.
System Assigned Key used to identify a unique row for a benefit covered by a recipient plan. This will identify a row to be ignored for this benefit. This acts the same way as how SAK_COV_BNFT_NULL acts in T_COVERED_BENEFIT.

This is the unique identifier for rows on this table.
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
The system assigned key that uniquely identifies the payment number range in the system.
The system assigned key that uniquely identifies the payment number range in the system.
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
System assigned key to uniquely identify a payment summary
This is the key that identifies the "P"ay To address for the provider location record.
PA Program required to override a particular ProDUR alert.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This is a unique key within the date received used to link the headers with the details.
This is a unique key within the date received used to link the headers with the details.
This is a unique key within the date received used to link the headers with the details.
This is a unique key within the date received used to link the headers with the details.
This contains the system assigned key for the transaction.
This is the system assigned key for the transaction.
This is a unique key within the date received used to link the headers with the details.
System assigned key representing the PDL Master row.
System assigned key representing the PDL Master row.
The system assigned internal key for a unique recipient
The system assigned internal key for a unique recipient
The system assigned internal key for a unique PDP Plan.
The system assigned internal key for a unique PDP Plan.
The system assigned key for a pediatric dosing criteria. (PRIMARY KEY)
System Assigned Key for Peer Group
System Assigned Key for Peer Group
System Assigned Key for Peer Group
Peer Group System Assigned Key

Peer Group System Assigned Key
Peer Group System Assigned Key
Peer Group System Assigned Key
Peer Group System Assigned Key
System Assigned Key for the Peer Group.
This is the system assigned key to the provider Contract under which Providers may be certified..
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular recipient.
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular recipient.
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular beneficiary.
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular recipient.
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular recipient.
Used along with the SAK RECIP to uniquely identify an eligibility segment for a particular beneficiary.
The unique key assigned by the system to a table entry.
Unique identifer for the focus.
Unique identifer for the focus.
Unique identifer for the focus.
Unique identifer for the focus.
Unique identifer for the focus.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.

The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
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The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
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The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
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The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location.
This is the SAK_PMP_SER_LOC of the PMP that a transfer will be going to. If the record is not a transfer record, then this field should be -1.
This is the SAK_PMP_SER_LOC of the PMP that a transfer will be going to. If the record is not a transfer record, then this field should be -1.

The unique system assigned key to identify a Primary Medical Provider's service location.
The unique system assigned key to identify a Primary Medical Provider's service location for the Transfer PMP.
The unique system assigned key to identify a Primary Medical Provider's service location for the Transfer PMP.
This is the system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder Id.
This is the system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder Id.
This is the system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder Id.
This is the system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder ID.
This is the system assigned key for the TPL policyholder. This key is used to uniquely identify the policyholder internally to the system and is also used on all screens and reports as Policyholder ID.
System assigned key to identify the Policyholder to which the TPL A/R is tied.
System assigned key to identify the Policyholder to which the TPL A/R is tied.
This system generated key identifies ports available for VANs.
Foreign key from T_PORT.
System Assigned Key for the Pregnancy Diagnosis Information.
The system assigned key for the previous county table.
The unique identifier for the probate court information.
Procedure code
Procedure code.
The unique system assigned key associated with the procedure which was performed.
The unique system assigned key associated with the procedure which was performed.
System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key used to uniquely identify a procedure.
System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key for a procedure code on a detail which indicates the service that was provided.

System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key for procedure code indicating service provide on a detail.
System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key for procedure code indicating service provide on a detail.
System assigned key used to uniquely identify a procedure.
System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key for procedure code indicating service provide on a detail.
System assigned key to uniquely identify a procedure code.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key that uniquely identifies the procedure code
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
This is the system assigned key for procedure code.
System assigned key used to uniquely identify a procedure.
This is the system assigned key for the procedure code.
This is the procedure code.

This is the system-assigned internal key that is 4 bytes long.
System assigned key used to uniquely identify a procedure.
System assigned key used to uniquely identify a procedure.
This is the system-assigned internal key that is 4 bytes long.
System assigned key which uniquely identifies the procedure code indicating service provided on a detail.
System assigned key for procedure code indicating service provided on a detail.
System assigned key for a procedure code on a detail which indicates the service that was provided.
System assigned key used to uniquely identify a procedure.
This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.
This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.
This system assigned key corresponds to Field 1 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 1 procedure code.
This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.
This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.
This system assigned key corresponds to Field 2 on the NCCI database, containing a Comprehensive or Mutually Exclusive column 2 procedure code.
This is a system assigned key for a unique procedure code ending the procedure code range that is used at the line item level on a PA.
System assigned key used to uniquely identify a procedure.
System assigned key that identifies the first procedure code in a range of codes.
System assigned key that uniquely identifies the first procedure code used in duplicate checking in the MMIS system.
System assigned key used to uniquely identify a procedure.
From procedure code for which a recipient is restricted.
System assigned key used to uniquely identify an ICD-9-CM procedure.
System assigned key used to uniquely identify an ICD Procedure.
System Assigned Key used to uniquely identify an ICD procedure.
System assigned key used to uniquely identify an ICD Procedure.
System assigned key used to uniquely identify an ICD Procedure.

System assigned key which represents that surgical procedure code.
The procedure code that identifies the crosswalk. This code is only required for Neonatal DRG crosswalks.
The ICD9 procedure code that identifies the crosswalk. This is only required for Transplant DRG crosswalks.
System assigned key used to uniquely identify an ICD Procedure.
System assigned key used to uniquely identify an ICD Procedure.
System assigned key used to uniquely identify an ICD9-CM procedure. This represents the old ICD9 procedure code that will be used by the grouper to assign a DRG code to a claim
The old procedure sak used to bundle or unbundle a claim detail.
The old procedure sak used to bundle or unbundle a claim detail.
System assigned key that identifies the last procedure code in a range of codes.
System assigned key that uniquely identifies the last procedure code used in duplicate checking in the MMIS system.
System assigned key used to uniquely identify a procedure. This is the upper end of procedure range.
To procedure code for which a recipient is restricted.
This field indicates the procedure code group type used to identify the procedure code and modifier combinations that will be excluded from audit criteria.
This field indicates the procedure code group type used to identify the procedure code and modifier combinations that will be excluded from audit criteria.
This field indicates the procedure code group type used to identify the procedure code and modifier combinations that will be excluded from audit criteria.
System assigned key for a unique Procedure Type, which represents a collection of Procedure Codes.
This field indicates the procedure code group type used to identify the procedure code and modifier combinations that will be excluded from audit criteria.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
System assigned key that represents the collection of procedures needed for a MAR category of service assignment.
System assigned key for a unique procedure type, that represents a single or collection of procedures.

System assigned key for a unique procedure type, that represents a single or collection of procedures.
A SAK that represents the collection of procedure codes needed for a MAR COS assignment. Zero indicates no procedure restriction.
System assigned key that represents the collection of procedures needed for a MAR category of service assignment.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
This field indicates the procedure code group type used to identify the procedure code and modifier combinations that will be excluded from audit criteria for a contra audit on a new day (current) claim.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
System assigned key for a unique procedure type, that represents a single or collection of procedures.
Productivity code.
Productivity code.
Productivity tracking system assigned key.
Productivity tracking system assigned key.
Productivity training system assigned key.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key which uniquely identifies a provider in the system.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This is the system assigned key of the provider identified to this banner.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies a provider
System assigned key that uniquely identifies a provider

System assigned key that uniquely identifies the provider enrollment tracking.
Service Location SAK.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key to identify a provider group.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
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System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that uniquely identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.

Provider System Assigned Key.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
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System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This system assigned key (SAK) relates to the SAK_PROV of the provider selected as a group member.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
Provider System Assigned Key
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
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System assigned key that uniquely identifies the provider enrollment tracking.

System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that uniquely identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key (SAK) that identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
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System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
Uniquely identifies the provider facility.
Unique provider system assigned key.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This identifies the billing provider for the claim.
This identifies the billing provider for the claim.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key to uniquely identify a provider
System assigned key to uniquely identify a provider
System assigned key to uniquely identify a provider
System assigned key to uniquely identify a provider
Unique identifier for a provider

Unique identifier for a provider
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Unique identifier for a provider
Unique identifier for a provider
This is the SAK for the AT&T Call Management System records that are copied from the AT&T machine to one of the local SUN machines.
System assigned key that uniquely identifies the billing provider.
System assigned key that uniquely identifies the billing provider.
Provider criteria system assigned key.
This system assigned key (SAK) relates to the SAK_PROV of the provider selected as a group.
The claims analysis provider dimension system assigned key for the provider.
System assigned key used to uniquely identify the license row.
System assigned key used to uniquely identify the license row.
Service Location SAK
Service Location SAK.
Unique identifier for the provider service location
Unique identifier for the provider service location
Unique identifier for the provider service location
Unique identifier for the provider service location
Service Location SAK
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key to uniquely identify a provider.
A system assigned key (SAK) that uniquely identifies a provider in the MMIS.
'Service Location SAK
Service Location SAK
Unique identifier for the provider service location.

Unique identifier for the provider service location.
Unique identifier for the provider service location
Unique identifier for the provider service location
Service Location SAK.
Service Location SAK. This is only required for provider specific crosswalks.
System assigned key that uniquely identifies a provider service location.
System assigned key that uniquely identifies a provider service location.
System assigned key that uniquely identifies a provider service location.
Service Location SAK.
The is the primary key to get to the provider information.
Service Location SAK
This is the system assigned key for the provider location.
Unique identifier for the provider service location.
Service Location SAK.
Service Location SAK.
This uniquely identifies a provider service location. NOTE: As of 1/24/2006, this relationship is not correctly drawn in ERwin due to the fact that T_PR_SVC_LOC currently has SAK_PROV, CDE_SERVICE_LOC, and SAK_PROV_LOC as it's primary key. Once NPI is fully implemented, the primary key for the T_PR_SVC_LOC table will change and this relationship will need to be correctly drawn.
Service Location SAK
Service Location SAK
Service Location SAK.
Service Location SAK.
Unique identifier for the provider service location
Unique identifier for the provider service location
Identification number for the provider billing the claim.
Identification number for the provider billing on the claim.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
This is a system assigned key that identifies the billing provider's service location.
Identification number for the provider billing the claim.
Identification number for the provider billing the claim.
Service location SAK.

Service Location SAK.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location
Unique identifier for the provider service location.
System assigned key that uniquely identifies a provider service location.
System assigned key that uniquely identifies a provider service location.
System assigned key that uniquely identifies a provider service location.
Service Location SAK
Service Location SAK.
Service Location SAK
Service Location SAK
Service Location SAK.
Service Location SAK
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Service Location SAK
System assigned key that uniquely identifies the provider.
Service Location SAK.
Service Location SAK.
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Service Location SAK
System assigned key that uniquely identifies a provider. Indicates the district provider for Maternity Care districts. Others entries will have a - 1.
Service Location SAK
Service Location SAK.
Service Location SAK.

This is the system key that will uniquely identify a provider service location in the system.
This is the system key that will uniquely identify a provider service location in the system.
This is the system key that will uniquely identify a provider service location in the system.
Service Location SAK.
Service Location SAK.
This primary key to the provider service location information.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location
Unique identifier for the provider service location.
Unique identifier for a provider location
Unique identifier for a provider location
Unique identifier for a provider location
Unique identifier for a provider location
This identifies the billing provider for the claim at the location the service was provided.
Service Location SAK.
Service location SAK.
System assigned key that uniquely identifies the provider assistant.
System Assigned Key for Attending Provider Service Location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the attending provider's service location.
System assigned key that uniquely identifies the service location of the billing provider.
System assigned key that uniquely identifies the service location of the billing provider.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.

System assigned key that uniquely identifies the billing provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
Service Location SAK
Provider Number assigned that uniquely identifies the provider enrollment tracking for LTC providers.
System assigned key that uniquely identifies the maternity district provider service location.
System assigned key that uniquely identifies the maternity district provider service location.
Service Location SAK
Service Location SAK
Service Location SAK.
Service Location SAK
Service Location SAK.
Service Location SAK
Service Location SAK.
Service Location SAK.
Service Location SAK.
Service Location SAK.
Service Location SAK.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the operating provider's service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.
System assigned key that uniquely identifies the provider service location.

System assigned key that uniquely identifies the provider service location.
Service Location SAK
Service Location SAK
Service Location SAK
Provider Number assigned that uniquely identifies the provider enrollment tracking for PCP providers.
System assigned key for the service location of the performing provider.
System assigned key for the service location of the performing provider.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location
System Assigned Key for Performing Provider Location.
System Assigned Key for Performing Provider Location.
System Assigned Key for Performing Provider Location.
System Assigned Key for Performing Provider Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System Assigned Key for Performing Provider Service Location.
System assigned key that uniquely identifies the performing provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location
Service Location SAK.
Service Location SAK.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location
System assigned key that uniquely identifies the prescribing provider's service location.
System assigned key that uniquely identifies the prescribing provider's service location.
System assigned key that uniquely identifies the prescribing provider's service location.

Service Location SAK.
Service Location SAK.
Service Location SAK.
Service Location SAK.
Service Location SAK.
Service Location SAK.
System assigned key for the RCO submitting provider location. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
System assigned key for the RCO submitting provider location. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
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Unique identifier for the provider service location.
Unique identifier for the provider service location.
Unique identifier for the provider service location.
System assigned key that uniquely identifies the maternity district provider.
System assigned key that uniquely identifies the maternity district provider.
Obsolete.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.

System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key for the performing provider.
System assigned key for the performing provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the performing provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This is the system assigned key for the performing provider.
The system assigned key for performing provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
This is the system assigned key of the provider enrollment program.
This is the system assigned key to the provider Contract under which Providers may be certified.
This is the system assigned key to the provider Contract under which Providers may be certified.
This is the system assigned key to the provider Contract under which Providers may be certified.

This is the system assigned key to the provider Contract under which Providers may be certified..
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This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified..
Provider Program unique key
This is the system assigned key to the provider Contract under which Providers may be certified.
This is the system assigned key to the provider Contract under which Providers may be certified..
This is the system assigned key to the provider Contract under which Providers may be certified.
This is the system assigned key to the provider Contract under which Providers may be certified.
System assigned key that uniquely identifies the prescribing provider's enrollment tracking.
System assigned key that uniquely identifies the prescribing provider's enrollment tracking.
System assigned key that uniquely identifies the prescribing provider's enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.

System assigned key for the RCO submitting provider. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
System assigned key for the RCO submitting provider. (this field was added to keep all tables in sync but RCO claims are not truly applicable for Suspense)
This field contains the provider's sak_prov_loc from the provider master table or the recipient's sak_recip from the recipient's master table depending on what type of case is being added or edited.
This field contains the provider's sak_prov_loc from the provider master table or the recipient's sak_recip from the recipient's master table depending on what type of case is being added or edited.
This field contains the provider's sak_prov_loc from the provider master table or the recipient's sak_recip from the recipient's master table depending on what type of case is being added or edited.
This field contains the provider's sak_prov_loc from the provider master table or the recipient's sak_recip from the recipient's master table depending on what type of case is being added or edited.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
A system assigned key to uniquely identify the referring provider.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
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System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
The system assigned key that identifies a unique prudent pay record within the interChange financial subsystem.
The system assigned key that identifies a unique prudent pay record within the interChange financial subsystem.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System assigned key that uniquely identifies the attending provider's enrollment tracking.
System Assigned Key for the Provider Specific DRG Rate.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
Unique identifier for each run of the provider labels and reports.
System assigned key that uniquely identifies the operating provider's enrollment tracking.
System assigned key that uniquely identifies the operating provider's enrollment tracking.
System assigned key that uniquely identifies the operating provider's enrollment tracking.
System assigned key that uniquely identifies the operating provider's enrollment tracking.
System assigned key that uniquely identifies the operating provider's enrollment tracking.

System assigned key that uniquely identifies the operating provider's enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the second physician who performed the principal procedure.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
System assigned key that uniquely identifies the provider enrollment tracking.
The system assigned key value that uniquely identifies an address record case.
The system assigned key value that uniquely identifies an address record case.
The system assigned key value that uniquely identifies a case.
The system assigned key value that uniquely identifies a case.
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The system assigned key value that uniquely identifies a case.
The system assigned key value that uniquely identifies a case.
The system assigned key value that uniquely identifies a case.
The system assigned key value that uniquely identifies a case.
The unique key assigned by the system to a table entry.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.

System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
This is the health program that the recipient was under when the capitation payment was made.
System assigned internal key for a medical assistance program.
Identifies the benefit plan for which a recipient is eligible.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned key to uniquely identify each State program.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
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System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
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System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
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System assigned internal key for a medical assistance program.

System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
Obsolete.
System assigned internal key for a managed care assignment plans/programs.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
A SAK that represents the Benefit Plan needed for a MAS/BOE assignment. Negative 1 is used to indicate no benefit plan restriction.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned key to the program code entity.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned key to uniquely identify each State program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.

System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a medical assistance program.
The system assigned internal key for a unique program or benefit plan.
System assigned internal key for a medical assistance program.
System assigned internal key for a medical assistance program.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
A SAK that represents the Benefit Plan needed for a MAR COS assignment. Zero is used to indicate no benefit plan restriction.
System assigned internal key for a medical assistance program.
The system assigned internal key for a Public Health Program.
System assigned internal key for a recipient plan.
System assigned internal key for a recipient plan.
System assigned key to uniquely identify a valid health plan program and an aid category combination.
System assigned internal key for a recipient plan.
Key for the qualifier.
Key for the qualifier.
A unique identifier for the query
A unique identifier for the query
A unique identifier for the question
Question sequence number.
Question sequence number.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
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The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
The system assigned key used to uniquely identify a managed care rate cell.
This is the unique mass rate record number. This key value is system generated.
The last RA system assigned key to be assigned for this financial cycle.
This is the system assigned key that uniquely defines the reason code.
This is the system assigned key that uniquely identifies a reason code.
The system assigned internal key for a unique recipient.
System assigned key to uniquely identify the recipient that was purged as a result of a link or restored as a result of an unlink.
System assigned key that uniquely identifies a recipient that should be included in the selection.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
The recipient sak associated with this portion of the cash receipt.
This is the internal id of the recipient involved in this case.
This is the internal id of the recipient involved in this case.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
System assigned key to uniquely identify a recipient.
The system assigned internal key for a unique recipient.
The system assigned key for the recipient receiving the service.
The system assigned key for the recipient receiving the service.
System assigned key assigned to a recipient
Unique identifier for a recipient
The system assigned internal key for a unique recipient.
The system assigned key for a recipient number.
System assigned key that uniquely identifies the recipient that may be associated with the expenditure transaction.
System assigned key that uniquely identifies the recipient that may be associated with the expenditure transaction.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.

The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
System assigned key that uniquely identifies a recipient in the MMIS system.
System assigned key that uniquely identifies a recipient in the MMIS system.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
System assigned key that uniquely identifies the recipient.
System assigned key that uniquely identifies the recipient.
The system assigned internal key for a unique recipient.
The system assigned key which uniquely identifies recipient for which the drug was prescribed.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.

The system assigned internal key for a unique recipient.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
This is the recipient system assigned key. If the recipient match could not be done, the value is -1.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
System assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient for whom the plastic ID card request has been made.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient this is to be linked to. This is the recipient that will remain active after the linking is complete.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
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The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
Uniquely identifies the recipient on the MMIS that the PS/2 recipient duped against.
The system assigned internal key for a unique beneficiary.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
System assigned key to identify the Recipient to which the TPL A/R is tied.
System assigned key to identify the Recipient to which the TPL A/R is tied.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
The system assigned internal key for a unique recipient.
This system assigned key is used to uniquely identify a Recipient record internally.
This system assigned key is used to uniquely identify a recipient record internally.
The system assigned internal key for a unique recipient.
Unique identifier for a recipient
Unique identifier for a recipient
Unique identifier for a recipient
Unique identifier for a recipient
Unique identifier for a recipient
Unique identifier for a recipient

Unique identifier for a recipient
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Unique identifier for a recipient
Unique identifier for a recipient
System assigned key used to uniquely identify a row on this table.
The T-MSIS system assigned internal key for a unique AllKids beneficiary.
The system assigned internal key for a unique recipient this is to be linked from. This is the recipient that will be made inactive after the linking is complete.
System assigned key assigned to the new recipient.
The system assigned key for a unique recipient. The claim is assigned this new recipient.
New Recipient to be put on Claim.
System assigned key assigned to the original recipient.
The system assigned key for a unique recipient. This is the recipient formerly assigned to the claim.
Old Recipient on the Claim.
The system assigned internal key for a unique recipient.
System assigned key given to a claim.
System assigned key which uniquely identifies a claim in the system.

A system assigned key (SAK) that uniquely identifies the claim, expenditure, accounts receivable or capitation record.
System assigned key to uniquely identify a plastic recipient ID card that was issued.
System assigned key.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
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Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
Unique identifier for rows on this table. This is also the unique index for the audit trail table and will not change.
This is the unique identifier for rows on this table
This is the unique identifier for rows on this table
Unique identifier for each row on this table.
Unique identifier for each row on this table.
System Assigned Key used to identify a unique row for a benefit REIMBURSEMENT rule. This will identify a row to be ignored for this benefit.
For example, consider Anesthesia procedure code 00100. This code is is under the subgroup of procedures "Head". Suppose that the "Head" group has a rule1 that would then apply to all procedures in such group except for procedure 00100. The rule1 can be "nullified" by adding a row in T_REIMB_AGREEMENT where SAK_REIMB_NULL points to rule1 for the "Head" group.

For regular rules this column is not applicable. Therefore the default value is -1.
System assigned key related to history
The system assigned key of the claim in history that triggered the alert to set. This field will be 0 when the alert is not based on a historical claim.
The sak of the claim in history that the alert failed against. This will be 0 for non-history alerts.
System assigned key that uniquely identifies a claim in history that caused an error (edit/audit) to be set on a claim during processing.
The unique identifier for a row on this table.
This value groups the attributes of the relation identified by SAK_RELATION.
The unique identifier for a row on this table.
This identifies each attribute of the RELATION to which SAK_RELATION for a row on this table. this FK points to either a DOMAIN or to another RELATION with more than one attribute.
System assigned key used internally by the system to uniquely idenitfy an HIPAA remark code.
System assigned key used internally in the sysetm to uniquely identify the HIPAA remark code.
System assigned key used internally in the sysetm to uniquely identify the HIPAA remark code.
The unique id that identifies an RA.
The unique id that identifies an RA.
The system assigned key for the entity that the attorney represents in a casualty case.
The system assigned key for the entity that the attorney represents in a casualty case.
This is the internal id that represents the role of the person who is receiving the letter (e.g., the recipient's attorney).
The system assigned key that identifies who is represented by the person that the letter was sent to.
Identifies which party (tortfeasor or recipient) the insurance agent represents for this casualty case.
System assigned key to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
This identifies the system assigned key for a specific accommodation or ancillary service (revenue code) that is used at the line item level on a PA.
System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.

System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
System assigned key used to uniquely identify a revenue code.
Unique key to identify a specific row of a recipient on review.
This is the unique key that identifies a revenue code that was submitted on a claim detail.
This is the unique key that identifies a revenue code that will be used to price the number of units based on the ind_unit_type and the number of units billed on the detail.
Unique key identifying the request code
Unique key identifying the request code
Unique key identifying the reason code
Unique key identifying the reason code
The system assigned key for a unique revenue code group type.
System assigned key for a unique revenue type, that represents a single or collection of revenue codes.
System assigned key for a unique revenue type, that represents a single or collection of revenue codes.
System assigned key for a unique revenue type, that represents a single or collection of revenue codes.
System assigned key for a unique revenue type, that represents a single or collection of revenue codes.
System assigned key for a unique revenue type, that represents a single or collection of revenue codes.
System assigned key for a unique revenue type, that represents a collection of revenue codes.
The system assigned internal key for a unique Recipient AR base record.
The system assigned internal key for a unique Recipient AR base record.
Client criteria system assigned key.
A unique identifier for the rule engine decision
A unique identifier for the rule engine decision
A unique identifier for the rule engine decision
Uniquely identifies the potential duplicate recipient situation.
The unique identifier for the PDP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.
This is a unique identifier for the PMP assignment.

This is a unique identifier for the PMP assignment.
The unique value to identify the transaction.
The unique value to identify the transaction.
The unique value to identify the transaction.
The unique value to identify the transaction.
System assigned key for a unique MME risk group ID
System assigned key for a unique set group ID link
System assigned key for a Resource Link.
System assigned key for a Resource Link.
System assigned key for a Resource Link.
This field contains the system assigned key
This field contains the system assigned key
This field contains the system assigned key.
This field contains the system assigned key.
This field contains the system assigned key.
This field contains the system assigned key.
This is the sysem assigned key for the report request
This is the sysem assigned key for the report request

System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.

System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.

System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
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System assigned key that uniquely identifies the reason for the adjustment. Values: 1 -Claim Mass Adjustment, 2 -Claim Single Adjustment, 3 -Void Adjustment, 4 -Provider Mass Rate Adjustment, 5 -TPL Recoupment Adjustment, 6 -Claims Recycle, 8 -Reversal Void, 9 -History Only Suspense Copy, 10 -Create History Only, 11 -Recipient Linking, 12 -Provider Repricing.
Primary-Key for this table.
System assigned key of the rule which covers this drug.

System assigned key used to uniquely identify a rule.
Primary-Key for this table.
Primary-Key for this table.
Primary-Key for this table.
Primary-Key for this table.
This is not a unique identifier.
FK to T_RU_RULE. Optional. If it's greater than -1, then it points to a rule that is excluded from the decision making process. This is used to modify or overide a rule inherited form a group higher in the classification.
Contains the system-assigned key for the rule that is replaced. A value of -1 means this is a brand new rule that is not a replacement of any existing rule. If this column has something other then -1, then value points to a rule that was modified by an end-user. The modification became a new rule (the current row), and this column points to the old rule that is no longer active.
The system assigned key that identifies a schedule override within the interChange financial subsystem.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screenings.
The system assigned key for the ProDUR screening.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key for the ProDUR screening.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key for the current Ingredient Duplication ProDUR screening.
The system assigned key for the ProDUR screening.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key of the related Screening row on t_drug_screen.

The system assigned key for the ProDUR screening that was involved in the error.
The system assigned key of the related Screening row on t_drug_screen.
The system assigned key of the related Screening row on t_drug_screen.
Unique value to identify a particular group of screening criteria.
Selection list system assigned key.
System assigned key to uniquely identify the next sequential number for each offline claim added to the case.
Sequence number used to uniquely identify a row for an ASC pricing group/ rate type combination.
Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key.
Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key.
Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key
Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key.
Sequence number of rows used to make a unique key without using the effective date of the row as part of the primary key.
Sequence number used to uniquely identify a row for an ASC pricing group/ rate type combination.
This is the system-assigned internal key that is 2 bytes long.
System assigned sequence number used to differentiate records which are identical except for effective and end dates.
This is the system-assigned internal key. It is used to uniquely identify a row without using updateable attributes.
A sequential number used to uniquely identify the updates per claim per checkwrite.
System-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system value that makes each record unique.
This is the system value that makes each record unique.
Repeat run number
Unique identifier which tells the relative position of this NDC within the detail.
This is the system assigned key that makes this record unique.
SAK for unique key.
SAK for unique key.
SAK for unique key.
Sak to uniquely identify a procedure,drug and dte_effective combination.
System assigned key that is two bytes long
System assigned key that is two bytes long
System assigned key that is two bytes long

System assigned key that is used in conjunction with sak_invoice and sak_drug to uniquely identify a comment.
Sequence number of rows. Used to make a unique key without using the effective date of the row as part of the primary key.
Sak to uniquely identify a procedure/drug combination.
System assigned key that is two bytes long
System assigned key that combines with other fields to form the primary key of the table.
System assigned key that combines with other fields to form the primary key of the table.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This field is used to distinguish between separate conversion records for the same NDC.
Unique Identifier for identifying a row
This is the system-assigned internal key that is used to uniquely identify a row.
This is the system assigned key that makes this record unique.
This is the sequential number for the payee's EFT account.
This is the sequential number for the payee's recoupment maximum request.
This is the sequential number for the payee's payment pull request.
System assigned sequence number used to differentiate records which are identical except for effective and end dates.
System assigned key for level of care
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key. It is used to uniquely identify a row without using updateable attributes.
A sequence number for the note.
System Assigned short key to allow uniqueness
Sak short makes key unique.
This allows for a unique key for the table.
This allows for a unique key for the table.
This allows for a unique key for the table.
Unique identifier for the combination of the PMP service location, the group/group service location and the dates.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.

This allows for a unique key for the table.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This allows for a unique key for the table.
Used along with ID_MEDICAID to uniquely identify a record.
Unique key value used to allow duplicate ID_WVR and SEQ_WVR_SVC values.
SAK for unique key.
SAK for unique key.
Short Sak is used as a sequence number in the primary key.
System assigned key for level of care
System Assigned Key used to uniquely identify an occurrence
This is the column that keeps the record unique.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
2 byte sequential number used to uniquely identify a row.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system assigned key that makes this record unique.
This is the system assigned key that makes this record unique.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
System-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system value that makes each record unique.
This is the system assigned key that makes this record unique in the system.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.

This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 4 bytes long.
The system assigned internal key used to uniquely identify a row.
System assigned key used to uniquely identify a bank account.
System assigned key used to uniquely identify a group.
System assigned key used to uniquely identify a specialty.
System assigned key used to uniquely identify an upload.
This is the system-assigned internal key that is used to uniquely identify a row.
This is the system assigned key that makes this record unique.
This is the unique system assigned key for the provider facility table.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the part of the key for the T_PR_HB_LIC that makes the record unique for different date ranges.
This is the part of the key for the T_PR_HB_LIC that makes the record unique for different date ranges
Makes key unique.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system assigned key that makes this record unique.
This is the part of the key for the T_PR_HB_LIC that makes the record unique for different date ranges
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
Used along with ID_PROV_NPI to uniquely identify a record.

This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is used to uniquely identify a row without using updateable attributes.
This is the system assigned key that makes this record unique.
This is the system assigned key that makes the payment pull records unique.
This is the system assigned key that makes this record unique.
This is the column in the key to make the key unique.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system assigned key that makes this record unique.
This is the part of the key for the T_PR_HB_LIC that makes the record unique for different date ranges.
This is the system-assigned internal key that is 4 bytes long. It is used to uniquely identify a row without using updateable attributes.
2 byte sequential number used to uniquely identify a row.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
System Assigned Key
System Assigned Key
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the value that makes each record unique on this table.
This is the value on the table that makes the record unique.
This is the value that makes the certification code unique on this table.
This is the value that makes the certification code unique on this table.
This is the field that will make the language record on the provider service location unique.

This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the part of the key for the T_PR_HB_LIC that makes the record unique for different date ranges.
This field is an internal system assigned key that uniquely identifies an individual or institution's name.
This is the system assigned key that makes this record unique.
This field is the internal ID that uniquely identifies an occurrence of the provider's maintenance.
This field is the internal ID that uniquely identifies an occurrence of the provider's maintenance.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
The system assigned key to uniquely identify each 1095 submitted for a recipient for the tax year. (There can be multiples for a tax year.)
The system assigned key to uniquely identify each 1095 submitted for a recipient for the tax year. (There can be multiples for a tax year.)
The system assigned key to uniquely identify each 1095 submitted for a recipient for the tax year. (There can be multiples for a tax year.)
The system assigned key to uniquely identify each 1095 submitted for a recipient for the tax year. (There can be multiples for a tax year.)
A number that helps sequence overpayment records.
A number that helps sequence transact records.
A system assigned key (SAK) which allows multiple entries of the same CDE_REASON for the same SAK_ASSIGN_PLAN.
Used along with SAK_CHILD_EXPECT to uniquely identify a record.
Used along with SAK_CHILD_HAD to uniquely identify a record.
The system assigned key used along with the SAK RECIP to uniquely identify an eligibility segment for a particular recipient

The system assigned key used along with the SAK RECIP to uniquely identifies the enrollment response record for a particular recipient.
This is the key value on the table that makes the comment unique for a recipient.
The key value that will make the record unique.
The key value that will make the record unique.
The key value that will make the record unique.
The key value that will make the record unique.
The system assigned internal key used to uniquely identify a row.
Used along with SAK_EXPENSE to uniquely identify a record.
This field uniquely identifies the record on the error table.
This is the system-assigned internal key that is 2 bytes long.
The second primary key column. A system assigned key (SAK) which allows multiple entries of the same CDE_REVOKE_RSN for the same SAK_HOSPICE_PERIOD. This field is simply incremented when a new row is added (not controlled by t_system_keys).
The system assigned internal key used to uniquely identify a row.
Used along with SAK_INCOME_LOSS to uniquely identify a record.
Used along with SAK_INCOME_NEW to uniquely identify a record.
The system assigned key to uniquely identify the appeal information for a recipient.
Used along with SAK_MOVE_IN_OUT to uniquely identify a record.
Used along with SAK_RECIP to uniquely identify a particular row for a recipient.
Used along with SAK_RECIP to uniquely identify a particular row for a recipient.
The system assigned internal key to allow for multiple phone numbers with the same type for a recipient.
This is a number used to keep the record unique for a specific recipient.
This field uniquely identifies the record on the error table.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
Used along with SAK_RECIP to uniquely identify a row.
The system assigned internal key for a unique recipient.
This field uniquely identifies the record on the medical support table.
This system assigned key will uniquely identify a record in cases where the sak_exempt occurs multiple times on the table

This system assigned key will uniquely identify a record in cases where the sak_recip occurs multiple times on the table.
Makes key unique.
This is the system-assigned internal key that is 2 bytes long. It is used to uniquely identify a row without using updateable attributes.
This field is the internal ID that uniquely identifies an occurrence of the address attribute.
This field is the internal ID that uniquely identifies an occurrence of the address attribute.
This field is the internal ID that uniquely identifies an occurrence of the address attribute.
This field is the internal ID that uniquely identifies an occurrence of the address attribute.
System assigned key that uniquely identifies a Medicaid recipient's previous address.
The incremental counter that uniquely identifies a comment on a specific provider application, when combined with the sak_atn.
System assigned key to uniquely identify a row in the Bendex buyin table.
The unique system assign key of the question for a contact.
The unique system assigned key of the question within a contact.
This is the column to give uniqueness to the key of the table.
This is the column to give uniqueness to the key of the table.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A system assigned key (SAK) classifying a rule that qualifies a COS.

System assigned key to the state category of service.
A SAK classifying a rule that qualifies the category of services.
A SAK classifying a rule that qualifies the category of services.
A system assigned key (SAK) classifying a rule that qualifies a COS.
A SAK classifying a rule that qualifies the category of services.
Sequential number assigned to the coverage for a specific subscriber or dependent.
Sequential number assigned to a dependent associated with a specific subscriber. Or 0 if not dependent row.
Sequential number assigned to a dependent associated with a specific subscriber.
The system assigned key to uniquely identify each Medicare ID for a recipient.
System assigned key for a unique ICD9 Procedure Type, which represents a collection of ICD9 Procedure Codes.
System assigned key for a unique procedure type, that represents a collection of procedures.
System assigned key for a unique procedure type, that represents a collection of procedures.
System assigned key for a unique procedure type, that represents a collection of procedures.
System assigned key for a unique procedure type, that represents a collection of procedures.
An id to make the key unique since more than one request can be entered on the same day
An id to make the key unique since more than one request can be entered on the same day
System assigned key used to uniquely identify a location.
System assigned key used to uniquely identify a location.
Uniquely identifies a level of care segment for a particular recipient.
The system assigned key to uniquely identify each enrollment period of Medicare Part A coverage for a recipient.
The system assigned key to uniquely identify each enrollment period of Medicare Part B coverage for a recipient.
This field is an internal system assigned key that uniquely identifies an individual or institution's name.
This field is an internal system assigned key that uniquely identifies an individual or institution's name.
The system assigned key used along with the system assigned recipient key to uniquely identify a Medicaid recipient's name at a particular point in time.
The unique system assigned key of the note for a question.
Number used to identify a unique send of a specific 1095 for a recipient. If the IRS rejects an entire transmission, it may be necessary to add additional rows for the sak_recip, tax_year, sak-short combination and this field will allow us to have a unique key.

Number used to identify a unique send of a specific 1095 for a recipient. If the IRS rejects an entire transmission, it may be necessary to add additional rows for the sak_recip, tax_year, sak-short combination and this field will allow us to have a unique key.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a Special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
Unique identifier for a special condition.
System assigned internal key for the mutually exclusive special condition.
Internal system assigned key used to uniquely identify recipient spenddown liability.
Internal system assigned key used to uniquely identify recipient spenddown liability.
The system assigned internal key used to uniquely identify a row.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key distinguishes the different Standard Policy Statements, as they appear on the NCCI database.
This system assigned key is used to uniquely identify a TPL SubContractor internally to the system.
Sak of the SubContractor who is receiving the letters
This is the system assigned key for the TPL Subcontractor. It is used to uniquely identify the Subcontractor internally to the system. This is also used to uniquely define the subcontractor on TPL windows..
The system assigned internal key assigned to the subscriber.
The system assigned internal key assigned to the subscriber.
The system assigned internal key assigned to the subscriber.

System assigned key for the batch/error/claim relationship.
System assigned key for the batch/error/claim relationship.
Unique numeric for different document types.
Foreign key to T_CDE_SUPPORTED_DOC.
Unique numeric for different document types.
Unique numeric for different document types.
Foreign key from T_CDE_SUPPORTED_DOCS.
Unique numeric for different document types.
System assigned key for a unique EOMB SUR request report.
System assigned key for a unique EOMB SUR request report.
System assigned key for a unique EOMB SUR request report.
System assigned key for a unique EOMB SUR request report.
System assigned key for a unique EOMB SUR request report.
System assigned key for a unique EOMB SUR request report.
The system assigned internal key for each masking record
This is the system assigned key for the taxonomy code.
This is the system assigned key for the taxonomy code.
This is the system assigned key for the taxonomy code.
This is the system assigned key for the taxonomy code.
This is the system assigned key for the taxonomy code.
System assigned key for the taxonomy.
System assigned key for the taxonomy.
System assigned key for the taxonomy.
This is the system assigned key for the taxonomy code.
This is the system assigned key for the taxonomy code.
Taxonomy full system assigned key to groups in the system
System assigned key for a unique taxonomy type, that represents a collection of taxonomies.
System assigned key for a unique taxonomy type, that represents a collection of taxonomies.
System assigned key for an optional Text Message.
System assigned key for a Text message.
System assigned key unique to and for this table.
The system assigned key for a unique drug therapeutic class.
The system assigned key for a unique drug therapeutic class.
System assigned key for a HIC3 group.
System assigned key for a HIC3 group.
System assigned key for a unique therapeutic class type, that represents a collection of specific therapeutic class codes.
System assigned key for a unique specific therapeutic class type, that represents a collection of specific therapeutic class codes.
The system assigned key for the Therapeutic Duplication precaution.

The system assigned key for the Therapeutic Duplication precaution.
The system assigned key for therapy duration criteria.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
OBSOLETE - DO NOT USE. System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers, Benefit Plans, or Assignment Plans for beneficiarys who are enrolled in multiple entities of any of these types.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers for recipient beneficiaries who are concurrently enrolled under multiple payers.
System assigned key used to uniquely identify a hierarchy thread. The hierarchy thread is used to identify the order of processing of Financial Payers for recipient beneficiaries who are concurrently enrolled under multiple payers.
System assigned key for the range of throughput days.
System assigned key for the range of throughput days.
System assigned key for the range of throughput days.
System assigned key for the range of throughput days.
System assigned key for the range of throughput days.
System assigned key for the range of throughput days.
System assigned key for the incurred time dimension table.
System assigned key for the incurred time dimension table.

System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that identifies the T-MSIS data element involved in the error
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
This is a unique value which identifies a CMS data element.
System assigned key that uniquely identifies the third data element causing the edit failure
System assigned key that uniquely identifies the dependent data element causing the edit failure.
System assigned key that uniquely identifies a dependent CMS data element used for a particular edit.
System assigned key that uniquely identifies a CMS edit and business rule combination for the data element represented by SAK_TMSIS_DATA_ELEMENT.
System assigned key that uniquely identifies an edit.
System assigned key that uniquely identifies an edit.
System assigned key that uniquely identifies an edit.
System assigned key that uniquely identifies an edit.
Unique identifier for an edit failure entry.
Key for the edit group associated with this edit row.
Key for the edit group associated with this edit row.
System assigned key for each CMS RULE.
System assigned key for each CMS RULE.
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission

Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
Unique identifier for a single eligibles file submission
System assigned key that uniquely identifies a CMS error record file.
System assigned key that uniquely identifies a CMS error record file.
System assigned key that uniquely identifies a CMS error record file.
System assigned key that uniquely identifies a CMS error record file.
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for a set of TMSIS extract files
Unique identifier for an single IP Claims submission file
Unique identifier for an single IP Claims submission file

Unique identifier for an single IP Claims submission file
Unique identifier for an single IP Claims submission file
Unique identifier for an single IP Claims submission file
Unique identifier for an single IP Claims submission file
Unique identifier for an single IP Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for an single LT Claims submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for a single managed care submission file
Unique identifier for an single OT Claims submission file
Unique identifier for an single OT Claims submission file
Unique identifier for an single OT Claims submission file
Unique identifier for an single OT Claims submission file
Unique identifier for an single OT Claims submission file
Unique identifier for an single OT Claims submission file
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single provider file submission

Unique identifier for a single provider file submission
Unique identifier for a single provider file submission
Unique identifier for a single RX claims submission file
Unique identifier for a single RX claims submission file
Unique identifier for a single RX claims submission file
Unique identifier for a single RX claims submission file
Unique identifier for a single TPL submission file
Unique identifier for a single TPL submission file
Unique identifier for a single TPL submission file
Unique identifier for a single TPL submission file
Unique identifier for a single TPL submission file
Unique identifier for a single TPL submission file
System assigned key that uniquely identifies a TMSIS data element.
System assigned key that uniquely identifies a TMSIS data element.
This is a unique value which identifies the CMS fields with lists of valid values used in the editing process.
Key value for the primary data element to be validated.
Key value for the dependent data element to be edited.
This field is used to refer to a group of type of bill codes.
This field is used to identify the type of bill type. It contains a number from 1 to 999 that corresponds to a range of type of bill codes.
This field is used to identify the type of bill type. It contains a number from 1 to 999 that corresponds to a range of type of bill codes.
The unique internal identifier used to identify the tortfeasor.
The unique internal identifier used to identify the tortfeasor.
The unique internal identifier used to identify the tortfeasor.
The unique internal identifier used to identify the tortfeasor.
This system generated key identifies the trading partners.
Foreign key from T_TP table.
Foreign key from T_TP table.
This is the unique identifier for the TPL Lien table.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.

Unique system assigned key that is associated to a TPL resource.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This identifies the resource for which the account receivable was created.
This identifies the resource for which the account receivable was created.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
The is the system assigned key that uniquely identifies a TPL Resource.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This is the Recipient Id number for which a policy update has been performed.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
This system assigned key is used to uniquely identify a TPL resource record internally to the system.
System assigned key to identify the TPL restriction.
System assigned key that uniquely identifies the threshold type.
Foreign key from T_TP_CONFIG.
This system generated key identifies configurations of trading partner.
Unique numeric code for different trading partner statuses.
Unique numeric code for different trading partner statuses.
Numeric code for different Trading Partner types.
Foreign key from T_CDE_TP table.
This system generated key identifies exceptions handled by the system.
This system generated key identifies the notifications sent by the system.
Unique ID identifying a transaction.
Unique ID.
Unique ID.
Unique ID.
Unique ID.

Unique ID.
Unique ID.
Unique ID.
Unique ID.
Unique numeric code for different transport types.
Unique numeric code for different transport types.
Unique numeric code for different transport types.
This is the system assigned key of the transaction for which the AR is related.
This is the system assigned key of the transaction for which the Expenditure is related.
This is the unique key of the transaction. It is used for research and balancing purposes.
System assigned key to the accounts receivable.
This is the unique key of the transaction. It is used for research and balancing purposes.
This field contains the sak of the transactions that are related to the RA.
This field contains the sak of the transactions that are related to the payment hold that occurred in the batch cycle.
Transaction Type System Assigned Key.
The system assigned key for the type specialty group.
The system assigned key for the type specialty group.
The system assigned key for the Under Utilization precaution.
The system assigned key for the Under Utilization precaution.
Unique ID.
Unique ID.
The system assigned internal key for a unique file that is transmitted to the IRS.
The system assigned internal key for a unique file that is transmitted to the IRS.
The system assigned internal key for a unique file that is transmitted to the IRS.
Identifier for an array. IMPORTANT: There can be multiple rows with the same PK. Each row is another value of the array.
Primary Key. IMPORTANT: There can be multiple rows with the same PK. Each row is another value in the set.
Primary key.
If the value is -1 then CDE_VALUE contains the value for this array position.
Primary Key. IMPORTANT: There can be multiple rows with the same PK. Each row is another value in the set.
Primary Key. IMPORTANT: There can be multiple rows with the same PK. Each row is another value in the set.
System assigned internal key used to uniquely identify the VALUE Code group.

System assigned internal key used to uniquely identify the Value Code group.
System assigned key for a unique MME vocabulary definition
Unique ID.
Unique ID.
The user that granted the role to the web user.
The role given to a user.
The system assigned key for the role given to a user.
Unique ID.
The unique id for a Web User.
Unique identifier assigned to the Web User.
Unique identifier assigned to the Web User.
Unique identifier assigned to the web user.
Unique identifier assigned to the web user.
Unique ID givng the ID of the web DDE user.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
SAK of the user that is logged into the site.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The system assigned key for for a web user.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The unique id for a Web User.
The system assigned internal key for a unique Recipient AR worker record.
The system assigned internal key for a unique Recipient AR worker record.
Key value to identify distinct waiver service.
Key value to identify distinct waiver service.
Outbound - Scenario ID.
Outbound - Scenario Release Number.
Outbound - Scenario Version Number.

This code identifies the schedule for deductible, coinsurance, or premium payments for a specific coverage type of a policy.
This is the schedule code. Identifies when (monthly, quarterly, etc.) the HIPP policy must be paid.
This is the schedule code. Identifies when (monthly, quarterly, etc.) the HIPP policy must be paid.
This field contains the description associated with a schedule code.
Long description for the schedule
Short name describing the schedule
"Seconds" portion of the time period within which the trading partner expectes to receive the interchange acknowledgement.
For self-authentication. A secret question they can answer in lieu of their password.
For self-authentication. 2nd question. They must answer both questions to gain access.
The section from the update tape.
Security level is a number starting at 1 and going on up. 1 is considered the highest level and is reserved for Admins. The security level essentially describes what type of user this is.
Security level is a number starting at 1 and going on up. 1 is considered the highest level and is reserved for Admins. The security level essentially describes what type of user this is.
First Security Question
Second Security Question
First Security Response
Second Security Response
The start time of this call segment.
The stop time of this call segment.
TPID: is a 10-digit ID that identifies the submitting entity.
Sequence number which uniquely identifies each claim within an adjustment request.
Sequential number which will hold the claim's position in the batch request.
Position of the modifier within the detail.
The sequence number of the record.
Position of the modifier within the detail.
The effective date sequence number.

Sequence number to make a unique key
Sequence number to make a unique key
Sequence number to make a unique key
Sequence number to make a unique key
The sequence in which the FCA rows should be processed.
The beginning sequence to use to price a service for multiple surgery.
SEQUENCE NUMBER
SEQUENCE NUMBER
Immunization sequence on a series of vaccinations.
Immunization sequence on a series of vaccinations.
Immunization sequence on a series of vaccinations.
Sequence number for provider contracts to designate processing priority.
Indicates the order that the warnings should appear on the claim.
The ending sequence to use to price a service for multiple surgery.
An indicator that determines the order the waiver services for the specified waiver program will appear on the CMS 372 report.
This is the code for the requested service.
Description of a Service
This is the date of service authorized.
Identifies a Service
Identifies a Service
Identifies a Service
Identifies a Service
Number of Login Attempts
Name of a Service
This indicates the type of service requested.
Identifies Service User
Outbound - Service Code List Directory Version Number.
The eligible's gender.
This is the gender of the recipient.
This is the gender of the recipient.
This is the gender of the recipient.
This is the gender of the recipient.
This is the gender of the recipient.
This is the gender of the recipient.
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This is the gender of the recipient.
This is the gender of the recipient.
This is the gender of the recipient.
This is the gender indicator for the drug code if it is only for a specific gender. Values are F = female or M = male or O = other.
State Fiscal Year

State Fiscal Year
This is the fiscal year of the Profiler cycle.
This is the fiscal year for the Profiler cycle.
Group Control Number
Version/Release/Industry Identifier Code
Code which describes the area of specialty for the individual providing the service.
Indicates if this provider ID type should be displayed on the provider search window and the order in which to display it.
The eligible's social security number.
The recipient's social security claim number (HIB) from the Bendex tape.
The first three positions of the claim number
Social Security claim number
Value to be used as ST03 on outbound X12 processing.
This field is the starting DX.
This field is the starting DX.
This field is the starting DX.
This field is the starting DX.
Start Date
This is the effective date of the Profiler cycle.
Start Date
Start Date
The time the cycle started.
Transaction mode - Test, Production or Compliance. ISA15
Field will be populated with State information, but for now, the value will be populated with the verbiage 'STATE'.
This is the state code of the State's return address.

This is the state code of the State's return address that will be displayed on 835.
The State defined severity level, used to determine alert priorities. Valid values are 1-99.
This is the status for the prior authorization line item.
The status of the prior authorization.
Identifies a Status
Description of a Status
Code indicating the status of the recoupment request. I=In Work, S=Request Letter Sent, R=Responded, N=No Response, T=Notification Letter Sent, V=Verification Letter Sent, P=Ready to Process/Initiate Adjustments, A=Adjusted
The type of standard used in the map. (X=X12)
Transaction Set Control Number
Identification Code.(T_TXN_BILLING_DESC.ST_LEVEL1_ID qualifies the identification code based on CDE_BILLING_REC_ID)
Qualifies T_TXN_BILLING.ST_LEVEL1_ID based on CDE_BILLING_REC_ID
Name.(T_TXN_BILLING_DESC.ST_LEVEL1_ID qualifies the name based on CDE_BILLING_REC_ID)
Qualifies T_TXN_BILLING.ST_LEVEL1_NAME based on CDE_BILLING_REC_ID
Identification Code. (T_TXN_BILLING_DESC.ST_LEVEL2_ID qualifies the identification code based on CDE_BILLING_REC_ID)
Qualifies T_TXN_BILLING.ST_LEVEL2_ID based on CDE_BILLING_REC_ID
Identification Code.(T_TXN_BILLING_DESC.ST_LEVEL2_ID2 qualifies the identification code based on CDE_BILLING_REC_ID)
ST_LEVEL2_ID2
Name.(T_TXN_BILLING_DESC.ST_LEVEL2_ID qualifies the name based on CDE_BILLING_REC_ID)
Qualifies T_TXN_BILLING.ST_LEVEL2_NAME based on CDE_BILLING_REC_ID
The sum of the surgery record charge amounts in the episode.
The sum of the surgery record charge amounts in the episode.
The sum of the surgery record charge amounts in the episode.
The sum of the surgery record charge amounts in the episode.
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The sum of the surgery record charge amounts in the episode.
The sum of the surgery record charge amounts in the episode.
The sum of the surgery record paid amounts in the episode.
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The sum of the surgery record paid amounts in the episode.
The sum of the surgery record paid amounts in the episode.
The sum of the surgery record paid amounts in the episode.
The sum of the surgery record paid amounts in the episode.
This field contains the description associated with a specific TPL suspect code.
The code used by the State to indicate the service provided during the period covered by this claim.
A flag that identifies the coding system used for the service code.
A service code modifier for the Service Code.
This is the service type.
This is the service type code for the Patient First recipient.
Name of the audit table.

The exact table name where the system assigned key originates. This is often called the "kernal" or "entity" table.
The amount of time spent talking during the call.
Benchmark for the measure base.
The units required for the role
The measure's target value.
The Tax Year being reported for the recipient
The Tax Year being reported for the recipient
The Tax Year being reported for the recipient
The Tax Year being reported for the recipient
Refers to map name.
RCO transaction control number their ICN
RCO transaction control number their ICN
This is the technical street 1 address of the labeler.
This is the technical street 2 address of the labeler.
This is the technical street 3 address of the labeler.
This is the technical city of the labeler.
This is the technical corporation name of the labeler.
This is the technical contact name of the labeler.
This is the technical phone number of the labeler.
This is the technical state of the labeler.
The unique id for a Web User.
This is the last 4 digits of the technical zip code of the labeler.
This is the first 5 digits of the technical zip code of the labeler.
This is the termination/expiration date of the labeler.
Indicates the threshold used for extraction.
Indicates another threshold used for extraction.
Through procedure code modifier 1
Through procedure code modifier 2
Through procedure code to allow authorization of a range of codes
The hour the recipient was discharged from the hospital. Hour 01 is 1:00 am; hour 24 is midnight.
Discharge Hour (HHMM).
Finalized time
Indicates the system time that a reversal record was created.
Indicates the system time that a claim location record was created for a claim. This helps indicate the most recent location for a claim.
System time

This is the time that the claim processed.
This is the time that the claim processed.
The time the table data was entered..
Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9)and DD = hundredths (00-99). BHT05 is the time the transaction was created within the business application system. Use this time to identify the time of day that the submitter created the file.
This is the time that the expenditure was activated for release to payment.
This is the time that the expenditure was activated for release to payment.
The time the values were assigned to the table.
Time of creation of records
Time of newly created record
Time of creation of record
Time of record creation
Time of creation
Time on which it is created
The time at which the record is created
Time at which the record is created
Time at which the record is created
Time of updating
Time of audit updating
Time of updating
Time of record updating
Time on which it is updated
Updated time
Time at which the record is updated
Updated time
The time the call ended.
The time the call was received.
Time when claim was processed in ClaimCheck.
Time the claim recipient was changed.
The time the question was closed.
Time created.
File creation time.
Time of authorization
Time at which the authorization is made
Effective time on which it is authorized
The effective time
Effective time

The effective time at which the authorization is made
Time when email was added/updated.
Time stamp of the request.
The time at which this problem log was last changed by anyone
This field holds request executing time in milliseconds.
The time of the note.
The TIME that the note was entered.
The TIME that the note was entered.
The TIME that the note was entered.
The time that the note was entered.
The time that the note was entered.
The time that the note was entered.
The time that the note was entered.
The time that the note was entered.
The TIME that the note was entered.
The TIME that the note was entered.
The TIME that the note was entered.
The time the question was opened.
This is the time stamp reflecting receipt of the update transaction by the MMIS.
This is the time stamp reflecting receipt of the update transaction by the MMIS.
This is the time stamp reflecting receipt of the update transaction by the MMIS.
This is the time stamp reflecting receipt of the update transaction by the MMIS.
This contains the time the transaction was recieved by the MMIS.
This is the time that the transaction was received by the MMIS.
This is the time that the prior authorization was entered.
This is the time stamp reflecting receipt of the update transaction by the MMIS.
This is the time the checkwrite was released to print.
The time of the message response
Time of the day when question/issue was resolved.
The time that the note was sent.
Time that the error occurred.
The time that the comment was added.
The time that the inquiry was performed.
This time stamp field tells us when the transaction was initially processed. The time is in format hhmmssss.

Time (HHMMSS 24 hr) that the case status indicator was last changed.
The time a question was transferred.
Time of update.
Begin Code range which indicates a specific type of facility. Set to be blank when cde_rate_type is 'B'. Default is '000'.
Submitted Type Of Bill for HIPAA 835.
End Code range which indicates a specific type of facility. Set to be blank when cde_rate_type is 'B'. Default is '000'.
This contains the tooth number for the request.
This contains the tooth quadrant for the requested service.
A code indicating the type of service being billed.
A code indicating the type of service being billed.
A code indicating the type of service being billed.
The amount paid to an individual provider during the current year.
The amount for which the check was written.
This is the total capitation payment made to an MCO for a given month
This is the total capitation payment made to an MCO for a given month.
This is the total capitation payment made to an MCO for a given month
This is the total capitation payment made to an MCO for a given month
This is the total capitation payment made to an MCO for a given month
The amount for which the check was written.
The amount for which the check was written.
This is the amount of the payment.
The amount paid to an individual provider during the current year.
The amount paid to an individual provider during the current year.
Total number of clusters in episode (including phantoms).
Total number of clusters in episode (including phantoms).
Total number of clusters in episode (including phantoms).
Total number of clusters in episode (including phantoms).
Number of phantom clusters in episode.
Number of phantom clusters in episode.

Number of phantom clusters in episode.
Number of phantom clusters in episode.
This is the total allowed amount from the ETG summary file.
This is the total allowed amount from the ETG summary file.
This is the total allowed amount from the ETG summary file.
This is the total allowed amount from the ETG summary file.
Total allowed amount.
Total billed amount.
Total recipient copay amount.
Total encounter amount.
Total Medicare paid amount.
Total amount paid.
This is the Total Amount paid for this ETG classification.
This is the Total Amount paid for this ETG classification.
This is the Total Amount paid for this ETG classification.
This is the Total Amount paid for this ETG classification.
Total amount of patient paid amounts.
Total paid amount reflected on a check to a provider.
Total amount of state share.
Total amount of other insurance paid.
The total number of details with TPL indicated.
Total number of covered days.
Total number of non-covered days.
This is the total number of ETG episodes.
This is the total number of ETG episodes.
This is the total number of ETG episodes.
This is the total number of ETG episodes.
Total quantity allowed.
Total units billed.
This is a count of the recipients.
This is a count of the recipients.
This is a count of the recipients.
This is a count of the recipients.
This is the to age restraint for this drug code.
Amount paid by a third party for services that were provided.
Amount paid for services by a third party.

Amount paid by third party for services.
The total amount paid by all sources other than Medicaid, Medicare, and the recipient's personal funds.
The total amount paid by all sources other than Medicaid, Medicare, and the recipient's personal funds.
The total amount paid by all sources other than Medicaid, Medicare, and the recipient's personal funds.
Amount paid by third party for services.
Amount paid by third party for services.
Amount paid for drugs by a third party.
Amount paid for drugs by a third party.
Amount paid by third party for services rendered.
Amount paid by third party for services rendered.
Amount paid by third party for services.
Amount paid for services by a third party.
Amount paid by third party for services.
Description of transaction type.
The unique id for a Web User.
Number of transaction that could be translated.
Number of transactions that failed to translate or were unsuccessful.
Identifies the type of transaction that was submitted.
This field stores the complete communications number including country or area code.
This field stores the complete communications number including country or area code.
This field stores the complete communications number including country or area code.
This field stores the complete communications number including country or area code.
Billing Provider Contact Information. Complete communications number including country or area code when applicable.
Billing Provider Contact Information. Complete communications number including country or area code when applicable.
Billing Provider Contact Information. Complete communications number including country or area code when applicable.
Complete communications number including country or area code when applicable of Property & Casualty Subscriber Contact Information.

Complete communications number including country or area code when applicable of Property & Casualty Subscriber Contact Information.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code to indicate the status of information.
Code showing the general employment status of an employee/claimant.
Code specifying the government service affiliation.
Description to clarify the related data elements and their content.
Code specifying the military service rank.
Code indicating the date format, time format, or date and time format.
Indicates the date span of military service.
Code identifying the country subdivision.
Code identifying the type of provider.
Code qualifying the Reference Identification. Value PXC for provider taxonomy.
Provider identifier - taxonomy.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.

Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code identifying a specific industry code list as ICD-9-CM or ICD-10-CM diagnosis.
Code indicating a code from a specific industry code list.
Code to indicate the status of information.
Code showing the general employment status of an employee/claimant.
Code specifying the government service affiliation.
Description to clarify the related data elements and their content.
Code specifying the military service rank.
Code indicating the date format, time format, or date and time format.
Indicates the date span of military service.
Code identifying the country subdivision.
Code identifying the type of provider.
Code qualifying the Reference Identification. Value PXC for provider taxonomy.
Provider identifier - taxonomy.
The ending value in the range in which the diagnosis code occurs.
A pointer to the primary diagnosis code for the service line.
A pointer to the second diagnosis code for the service line.
A pointer to the third diagnosis code for the service line.
A pointer to the fourth diagnosis code for the service line.
Orthodontic total months of Treatment. A free-form description to clarify the related data elements and their content.
Date Repricer Received date. Expression of a date, a time, or range of dates, times or dates and times.
Expression of a date, a time, or range of dates, times or dates and times of Date Property & Casualty Date of First Contact.
Expression of a date, a time, or range of dates, times or dates and times.

Expression of a date, a time, or range of dates, times or dates and times of Date Repricer Received Date.
Repriced Approved Ambulatory Patient Group Code, reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.
At the time of publication of this implementation, K3 segments have no specific use. The K3 segment is expected to be used only when necessary to meet the unexpected data requirement of a legislative authority.
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At the time of publication of this implementation, K3 segments have no specific use. The K3 segment is expected to be used only when necessary to meet the unexpected data requirement of a legislative authority.
Complete communications number including country or area code when applicable of Service Facility Contact Information.
Complete communications number including country or area code when applicable of of Service Facility Contact Information.
Code specifying type of date or time, or both date and time of prescription date.

Date Time Period. Treatment start date.
Date Time Period. Treatment completion date.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
Fixed Format Information.
A free-form description to clarify the related data elements and their content of third party organization notes.
Third Party organization notes. A free-form description to clarify the related data elements and their content.
Institutional Service line. A free-form description to clarify the related data elements and their content.
Required when, in the judgment of the submitter, the Procedure Code does not definitively describe the service/product/supply.
Alert Exception Text
Alert Exception Text
Alert Long Message
Alert Text
Alert Text
Analyst's comments.
Analyst's comments.
Anonymous source information.
Clarification for the selected answer.
The name of the person who heads the evaluation team. Resident Review Screen, Resident Reviews, PASRR Team)
The call made by the determination authority for this type of letter.
Indicates if an active or older checklist exists. Values are blank, "Current", or "Not active"
Citation Text
Citation Text
CORE-BASED STATISTICAL AREA ASSOCIATED WITH APC PRICING

For drugs with a COD status of ANDA, BLA, NDA, or NDA Authorized Generic, this is the seven-digit application number that is assigned by the FDA for approval to market a generic drug or new drug in the United States. For drugs with a COD status of OTC Monograph Tentative or Final, this is the FDA's regulatory citation for the OTC.
Concurrent Risk Group Identifier Description
Column Code Text
Database field name of criteria field.
Column Description Text
Database field name of criteria field description.
Comment Text
Comments.
Comments.
Comments on adjustments.
ICF/MR information and pending reason. (ICF/MR SCREEN, ICF MR Approval, Comments)
Comments pertinent to the Level I tracking for this case. (LEVEL I TRACKING SCREEN, case Information, Comments)
Component separator to be used for X12 documents.
Description of the BCBS Control plan the prefix belongs to.
Identifies a specific office within a given county. (PASRR PRE-ADMISSION SCREEN, Case Information, County Office) ; (RESIDENT REVIEW SCREEN, Case Information, County Office; (ICF/MR SCREEN, Case Information, County Office);
The file data.
The SHA1 hash of the file data.
Other UMO Denial Date found in the HIPAA 278 Request and Response Guide in Patient Event Transport loop 2010EC, segment DTP, element DTP03.
Encryption id if file or message is encrypted.
Analyst entering referral.
Value of the field within the CMS error record that has failed an edit.
Value of the data element involved in the error
EVD Vocabulary Type Description
Source of error such as Oracle, Fax hardware, network error, etc.
Value related to the Event Key.
Object type of the exception.
Free form notes the user can enter

An explanation of why "yes" was answered to either of the referral questions. (PASRR PRE-ADMISSION SCREEN, Referral, "If yes to the above question, explain") ;
Physical location of file.
Filter Text
Database field name of criteria field used for drop-down lists.
Group Text
Group Text
Identifies the combination operator for the group level of the criteria (different parent levels).
Description of the other chronic condition(s) when H is in the HEALTH-HOME-CHRONIC-CONDITION.
A free text field to capture the identity of the entity issuing the license or accreditation.
Describes the type of living arrangement used for the eligibility determination process.
Location of training.
The Alabama district office location.
The free-form text comment that describes the MI Interface transaction sent to DMH. (MI Interface Screen, PASRR Initial Contact Information for DMH, "LOCEU Comments") ;
The free-form text comment that describes the MI Interface transaction sent to DMH. (MI Interface Screen, PASRR Initial Contact Information for DMH, "LOCEU Comments") ;
The free-form text comment that describes the MR Interface transaction sent to DHS/DDSD. (MR Interface Screen, PASRR Initial Contact Information for DHS/DDSD, "LOCEU Comments") ;
The free-form text comment that describes the MR Interface transaction sent to DHS/DDSD. (MR Interface Screen, PASRR Initial Contact Information for DHS/DDSD, "LOCEU Comments") ;
Comments associated with client lock-in program.
Logic Text
Logic Text
Operator of the criteria (same parent levels).
Description of the marital/domestic-relationship status when MARITAL-STATUS=14 (Other) is selected.
Mask Text
Mask for the field shown on the window.
Mask RE Text
Mask for the field for programatic use.
The email address of the managed care entity as listed on the contract with the state.
Measure Text

This is left blank for paper transactions, but is populated with an email destination or fax destination.
This field is the text message that applies to the benefit plan - service type combination.
Custom message associated to the exception.
Comments pertinent to a MI referral for the client. (PASRR PRE-ADMISSION SCREEN, Determinations, MI Comments)
Comments pertinent to a MR referral. (PASRR PRE-ADMISSION SCREEN, Determinations, MR Comments)
Will contain the actual text of the message/transaction that was sent or received.
Notes or comments.
Subject line on the email notification.
This is the attachment control number assigned to the attachment. This maps to PWK06, Data Element 67 of the HIPAA 278 implementation guide
OAC reference number.
Opioid Strength Unit of Measure (UCUM). For example, mg, %, ug.
Opioid Base Ingredient Identifier Description
Other ICF/MR comments. (ICF/MR SCREEN, ICF MR Approval, Other Comments)
Other ID's associated with a provider.
File mask of the outbound file as required by the trading partner.
Primary - Referred to entity.
Secondary - Referred to entity.
Owner Text
Database owner of table for criteria field/table.
Parameter name
This is the data value for the parameter used in a job/process.
This contains any parms that are passed to the report for processing.
Dates of payment.
Productivity description.
Text regarding provider credentials
Identities the entity that issued the provider identifier in PROV-IDENTIFER.
Professional initials.
Provider's location (county).
The email address of the provider for the location in the PROV-LOCATION-AND-CONTACT-INFO.
Provider's specialty.
Provider type.

This contains miscellaneous information and comments pertaining to a case that are not considered to be sensitive or confidential in nature and are available for viewing by any user who has access to the initial contact information.
Disclosure question to be asked during provider enrollment.
High Range Text
High Range Text
Identifies the high value of the field in the criteria.
Low Range Text
Low Range Text
Identifies the low value of the field in the criteria.
Return reason text that is printed in the letter.
Client's comments.
Value of the key field within the CMS error record (i.e. Member number, Provider number, Claim ICN).
KEY value of the element involved in the error
Referral type.
The relationship of the addressee to the client.
Analyst reviewing the referral.
This is the text description of the schedule code.
This is miscellaneous information and comments pertaining to a case that are considered to be confidential or sensitive in nature and are only available for viewing by users who have specific access rights.
Segment terminator to be used for X12 documents.
The service area of the state for PASRR evaluation. (PASRR PRE-ADMISSION SCREEN, Referral, Service Area)
Source of case (Ranking List, Exception Profile or Referral).
Source of referral.
SQL Statement To Execute.
Stact trace associated to the exception.
A free text field for the submitting state to enter whatever information it chooses.
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A free text field for the submitting state to enter whatever information it chooses.
A free text field for the submitting state to enter whatever information it chooses.
A free text field for the submitting state to enter whatever information it chooses.

Primary - Entity status.
Secondary - Entity status.
Table Text
Database table housing criteria field.
This is the information that will be publish on the IRS tax file. This is the email of the person who would be contacted for any questions.
First form of contact information.
Second form of contact information.
Third form of contact information.
Identifies the txn version.
Reference assigned to identify Implementation Convention of Transaction Set Header.
Identifies the txn version.
Provides a user defined value for reporting purposes. (PASRR PRE-ADMISSION SCREEN, Case Information, User Defined Option); (RESIDENT REVIEW SCREEN, Case Information, User Defined Option); (ICF/MR SCREEN, Case Information, User Defined Option); (LEVEL I TRACKING SCREEN, Case Information, User Defined Option);
Parameter value
A code indicating what kind of payment is covered in this claim.
A code indicating what kind of payment is covered in this claim.
A code indicating what kind of payment is covered in this claim.
A code indicating whether the eligibility information contained in this record refers to the current fiscal quarter (the quarter specified in the Header Record) or to a previous quarter. A previous quarter could pertain to either retroactive eligibility or to a record that corrects eligibility information submitted in an earlier quarter.
Type of member - (MAC or Consultant).
UB-92 revenue code reported on the UB-92 line item that is represented on this claim/encounter record.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.

Code which identifies a specific accommodation, ancillary service or billing calculation.
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Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
Code which identifies a specific accommodation, ancillary service or billing calculation.
The total charge for UB92 revenue code 1 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 10 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 11 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 12 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 13 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 14 for the billing period. Total charges include both covered and non covered charges.

The total charge for UB92 revenue code 15 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 16 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 17 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 18 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 19 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 2 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 20 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 21 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 22 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 23 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 3 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 4 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 5 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 6 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 7 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 8 for the billing period. Total charges include both covered and non covered charges.
The total charge for UB92 revenue code 9 for the billing period. Total charges include both covered and non covered charges.
Units associated UB92 Revenue Code 1 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 10 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 11 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.

Units associated UB92 Revenue Code 12 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 13 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 14 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 15 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 16 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 17 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 18 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 19 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 2 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 20 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.

Units associated UB92 Revenue Code 21 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 22 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 23 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 3 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 4 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 5 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 6 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 7 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 8 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
Units associated UB92 Revenue Code 9 defined as a quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood , or renal dialysis treatments, etc.
The number of quantity units allowed.

The number of units authorized.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the beneficiary.
Quantity billed in the particular claim group for the beneficiary.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the recipient.
Quantity billed in the particular claim group for the beneficiary.
Quantity billed in the particular claim group for the beneficiary.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
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The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
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The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
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The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
The number of quantity units allowed.
Units authorized
This is the maximum units restraint for this drug.
This is the minimum units restraint for this drug code.
Units used
The unit price authorized.
The unit type to be converted from
The unit type to be converted to
This is the cost per unit of service for the authorization.
This is the unit cost authorized.
This contains the cost per unit for the requested service.
The desired/required units per week
This is the provider's total quantity allowed ranking within their peer group.
The type of units authorized.
The Unit of Measure or period for the criteria measurement i.e. week, day or hour
The Unit of Measure or period. I.e. day.week, hour
Web User ID
Web User ID
Web User ID
Web User ID
The unique name given to this web user. They will use this to log into the system.

The values for this field are the same as for the Episode Type field, but are calculated using any custom clean period you have defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field. If the ETG for the record does not have a custom clean period defined for it, this field will not be meaningful.
The values for this field are the same as for the Episode Type field, but are calculated using any custom clean period you have defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field. If the ETG for the record does not have a custom clean period defined for it, this field will not be meaningful.
The values for this field are the same as for the Episode Type field, but are calculated using any custom clean period you have defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field. If the ETG for the record does not have a custom clean period defined for it, this field will not be meaningful.
The values for this field are the same as for the Episode Type field, but are calculated using any custom clean period you have defined for the episode's ETG. Custom clean periods are not used for grouping. They are used solely to determine the type of start and finish for this field. If the ETG for the record does not have a custom clean period defined for it, this field will not be meaningful.
Original name the user had for the file.
Identifies a User
Identifies a User
Identifies a User
Date on which Userid was added
Last Date on which Userid Record was altered
Last Date on which Userid Record was altered
Role of the User
User's Status
This is the provider number and service location for the authorized provider.
Version of EDI standard used in the map. GS08
Unisys' warrant number
John Hopkins assigned weighted value of the ACG Code.

Code indicates a drug rebate dispute resolution
Zip code of eligible's place of residence.
Provider zip code. Used to sort records for the RA.
Provider zip code. Used to sort records for the RA.
Provider zip code. Used to sort records for the RA.
Provider zip code. Used to sort records for the RA.
This is the zip code of the State's return address.
This is the zip code of the State's return address that will be displayed on the 835.

DRUG REFERENCE FILE FIELDS

Column Name	***Column Description***	***Format***	***Length***	***Picture***
NDC	National Drug Code	AN	11	X(11)
LBLRID	Labeler Identifier	AN	6	X(6)
GCN_SEQNO	Clinical Formulation ID (Stable ID)	N	6	9(6)
PS	Package Size	N	12	9(8).9(3)
DF	Drug Form Code	AN	1	X(1)
AD	Additional Descriptor	AN	20	X(20)
AHFS	Alabama Hospital Formulary System	N	8	X(8)
ALGI	Alabama Generic Indicator	AN	20	X(20)
LN	Label Name	AN	30	X(30)
BN	Brand Name	AN	30	X(30)
PNDC	Previous National Drug Code	AN	11	X(11)
REPNDC	Replacement National Drug Code	AN	11	X(11)
NDCFI	NDC Format Indicator	AN	1	X(1)
DADDNC	Date of Add—NDC	N	8	9(8)
DUPDC	Date of Update—NDC	N	8	9(8)
DESI	DESI Drug Indicator	AN	1	X(1)
DESDTEC	DESI Status Change Effective Date	N	8	9(8)
DESI2	DESI2 Drug Indicator	AN	1	X(1)
DES2DTEC	DESI2 Status Change Effective Date	N	8	9(8)
DEA	Drug Enforcement Administration Code	AN	1	X(1)
CL	Drug Class	AN	1	X(1)
HOSP	Hospital Selection Indicator	AN	1	X(1)
INNOV	Innovator Indicator	AN	1	X(1)
IPI	Institutional Product Indicator	AN	1	X(1)
MINI	Mini Selection Indicator	AN	1	X(1)
MAINT	Maintenance Drug Indicator	AN	1	X(1)
OBC	Orange Book Code	AN	2	X(2)
OBSDTEC	Obsolete Date	N	8	9(8)

DRUG REFERENCE FILE FIELDS

PPI	Patient Package Insert Indicator	AN	1	X(1)
STPK	Standard Package Indicator	AN	1	X(1)
REPACK	Repackaged Indicator	AN	1	X(1)
TOP200	Top 200 Drugs Indicator	AN	3	X(3)
UD	Unit Dose Indicator	AN	1	X(1)
CSPCSP	Case Pack	N	7	9(7)
NDL_GDGE	Needle Gauge	N	6	9(2).9(3)
NDL_LNGTH	Needle Length	N	6	9(2).9(3)
SYR_CPCTY	Syringe Capacity	N	6	9(2).9(3)
SHLF_PCK	Shelf Pack	N	7	9(7)
SHIPPER	Shipper Quantity	N	7	9(7)
HCFA_FDA	HCFA FDA Therapeutic Equivalency Code	AN	2	X(2)
HCFA_UNIT	HCFA Unit Indicator	AN	3	X(3)
HCFA_PS	HCFA Units Per Package	N	12	9(8).9(3)
HCFA_APPC	HCFA FDA Approval Date	N	8	9(8)
HCFA_MRKC	HCFA Market Entry Date	N	8	9(8)
HCFA_TRMC	HCFA Termination Date	N	8	9(8)
HCFA_TYP	HCFA Drug Type Code	AN	1	X(1)
HCFA_DESC1	HCFA DESI Effective Date	N	8	9(8)
HCFA_DESI1	HCFA DESI Code	AN	1	X(1)
UU	Unit of Use Indicator	AN	1	X(1)
PD	Package Description	AN	10	X(10)
LN25	Label Name - 25	AN	25	X(25)
LN25I	Label Name - 25/Generic Name Use Indicator	AN	1	X(1)
GPIDC	Cost Alternative Pricing Indicator Date of Change	N	8	9(8)
BBDC	Date of Last AWP change	N	8	9(8)
HOME	Home Health Selection Indicator	AN	1	X(1)
INPCKI	Inner Package Indicator	AN	1	X(1)
OUTPCKI	Outer Package Indicator	AN	1	X(1)

DRUG REFERENCE FILE FIELDS

OBC_EXP	Expanded Orange Book Code	AN	2	X(2)
PS_EQUIV	Package Size Equivalent Value	N	12	9(8).9(3)
PLBLR	Private Labeler Indicator	AN	1	X(1)
TOP50GEN	Top 50 Generics	AN	2	X(2)
OBC3	Orange Book Code; three-byte version	AN	3	X(3)
GMI	Generic Manufacturer Indicator	AN	1	X(1)
GNI	Generic Name Indicator	AN	1	X(1)
GSI	Price Spread Indicator	AN	1	X(1)
GTI	Therapeutic Equivalence Indicator	AN	1	X(1)
NDCGI1	Multi-Source/Single Source Indicator (NDC-Level)	AN	1	X(1)
HCFA_DC	HCFA Drug Category	AN	1	X(1)
LN60	Label Name - 60	AN	60	X(

Building Reports with SAP BusinessObjects Web Intelligence Rich Client

SAP BusinessObjects Enterprise LA Fix 0.9.1

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About Web Intelligence

chapter 1

How Web Intelligence performs business intelligence over the web

Web Intelligence provides business users with an easy to use interactive and flexible user interface for building and analyzing reports on corporate data over the web, on secured intranets and extranets. The Web Intelligence software is installed by your administrator on a web server on your corporate network.

To use Web Intelligence from your local computer, you log into the business intelligence portal InfoView via your Internet browser. Then, depending on your security profile, you can interact with the reports in corporate documents or edit or build your own documents using a Web Intelligence report panel or query panel.

How Web Intelligence performs business intelligence offline

Web Intelligence can be used offline as Web Intelligence Rich Client, a standalone Microsoft Windows application, equivalent to the Java Report Panel, that you can install on your computer. Web Intelligence Rich Client lets you continue to work with Web Intelligence (WID) documents when you are unable to connect to a CMS, when you want to perform calculations locally rather than on the server, and when you want to work with Web Intelligence documents without installing a CMS or application server.

Web Intelligence Rich Client can also be used when connected to a CMS.

Interacting with Web Intelligence reports

Depending on your security profile and on how Web Intelligence is deployed across your organization, you can view, analyze, or enhance and modify the data displayed on reports.

Viewing and printing Web Intelligence reports

Once logged into the business intelligence portal InfoView, you can access Web Intelligence documents and view reports. Onscreen navigation is made easy with page-to-page navigation buttons and a document map that allows you to jump from section to section or report to report.

The same document can provide the information adapted to each user due to prompts that request each user, who opens the document, to specify the data they want to return to the reports.

When you print, Web Intelligence automatically generates a copy of reports in Portable Document Format (PDF) format for optimum print quality. You can print reports directly from the Web Intelligence Java Report Panel or Web Intelligence Rich Client without exporting to PDF.

Drilling on Web Intelligence reports

Drilling on Web Intelligence reports enables you to analyze the detailed data behind the displayed results. You can turn the report you are viewing into a drillable report or drill on a duplicate of the original report to retain a version of the results before your drill analysis.

Once you have found the information you need, you can save a snapshot of the drilled report to share the results of your analysis with other Web Intelligence users, or save the document in Excel or Portable Document (PDF) format to print or email to other business contacts.

Performing on-report analysis

Viewing Web Intelligence reports in Interactive view format enables you to enhance reports and fine-tune the data reports contain, to highlight the information that most interests you on demand.

On-Report Analysis is designed for:

- users who need to build queries and then want to build reports
- report consumers who need to manipulate the reports created by others

With On-Report Analysis you can:

- view document metadata to understand the data behind reports and see how reports are structured and filtered
- filter and sort results
- add new tables and charts
- add formulas and create variables
- format and change the layout of charts and tables
- slice and dice results by adding other data to charts and tables

Note:
On-report analysis of Web Intelligence reports in Interactive view format is only available if your administrator has deployed Web Intelligence in JSP mode.

Creating and editing Web Intelligence documents

You can create or edit Web Intelligence documents using the Web Intelligence HTML Report Panel, Web Intelligence Query - HTML, Web Intelligence in Interactive mode, the Web Intelligence Java Report Panel and Web Intelligence Rich Client.

Web Intelligence Query - HTML

Designed for users requiring a pure HTML environment to build queries, Web Intelligence Query – HTML offers the ability to define the data content of documents on multiple data sources. You can use Query – HTML to create new documents from scratch or edit the queries in documents created using any of the other Web Intelligence tools.

Used together with On-Report Analysis, Query – HTML provides a complete solution for building queries and designing powerful reports in a pure HTML environment. Once you have run the queries to generate a standard report, you can leverage Web Intelligence On-Report Analysis features to format multiple reports, add formulas, and create variables.

Note:
Web Intelligence Query – HTML and On-Report Analysis in Interactive view format are only available, if your administrator has deployed Web Intelligence in JSP mode.

Web Intelligence Java Report Panel

The Java Report Panel is designed for users who need more flexibility with designing report layout and defining formulas and variables. A graphical Formula Editor enables you to build formulas rapidly using drag-and-drop.

Note:
The Web Intelligence Java Report Panel is available if your administrator has deployed Web Intelligence in ASP mode and if your administrator has deployed Web Intelligence in JSP mode.

Web Intelligence Rich Client

Web Intelligence Rich Client is a locally installed Microsoft Windows application that lets you work with Web Intelligence (WID) documents that are stored locally or in a CMS.

When working without a CMS connection you can work on your local machine with either CMS-secured or unsecured documents.

Web Intelligence Rich Client is based on the Web Intelligence Java Report Panel and provides equivalent document creation, editing, formatting, printing and saving capabilities.

There are a number of reasons for using Web Intelligence Rich Client to work with WID documents:

- You want to work with Web Intelligence documents but you are unable to connect to a CMS (while traveling, for example).
- You want to improve calculation performance: Web Intelligence Rich Client performs calculations locally, rather than on the server, and local calculations can perform better than server calculations.
- You want to work with Web Intelligence documents without installing a CMS or application server.

Web Intelligence HTML Report Panel

Designed for users who need to build basic reports, the HTML Report Panel provides query and report features in a simple wizard-like interface. Each document is based on a single data source and can contain multiple reports, displaying different subsets of information.

In addition, the HTML Report Panel is 508 compliant and can be customized for specialized deployments.

Note:
The Web Intelligence HTML Report Panel is only available if your administrator has deployed Web Intelligence in JSP mode.

Accessing Web Intelligence from InfoView

chapter 2

You access Web Intelligence reports and set global Web Intelligence options from InfoView, the corporate business intelligence portal.

To log in to InfoView

Before you can use InfoView and Web Intelligence you need the following information:

- a URL to the InfoView server
- the InfoView server name and port number
- your login and password
- your authentication, which controls the InfoView resources available to you

Contact your adminstrator for these details if you do not already know them.

Note:
By default the InfoView server name and authentification method are not displayed on the InfoView logon page. You need to supply this information only if your administrator has made these options visible.

You access Web Intelligence by using your web browser to log into InfoView, the corporate business intelligence portal. Once you are in InfoView, you can analyze and enhance Web Intelligence reports.

1. Launch your web browser.
2. Point your browser to the InfoView bookmark or URL.

   The InfoView login page appears.
3. If the **System** box is blank, type the name of the InfoView server followed by a colon (:), and then type the port number.
4. In the **Username** box, type your user name.
5. In the **Password** box, type your password.
6. In the **Authentication** box, select the authentication provided to you by your administrator.
7. Click **Log On**.

   The InfoView home page appears.

To log out of InfoView

When you finish using InfoView or Web Intelligence you need to log out, instead of simply closing your web browser.

Logging out of InfoView ensures that any preferences you modified during your InfoView session are saved. It also lets your administrator track how many users are logged into the system at any given time and thus optimize InfoView and Web Intelligence performance.

- Click **Log Out**.

  The login page appears. You are logged out of InfoView

Web Intelligence InfoView options

Web Intelligence document creation and viewing options

You can set your Web Intelligence options to determine how you create, view and interact with documents using Web Intelligence.

You create documents using a query editor to build the query to retrieve the document data. After the query returns the data to the document, you can view and interact with the data.

Document creation option	Description
Advanced	You create documents using the Java Report Panel, a Java applet than launches in your Web browser. The Java Report Panel is a combined query building, report editing and data analysis environment. If you choose **Advanced** as your document creation option, you also use the Java Report Panel for working with the data returned by the query. The **Select a default view format** option is not taken into account. The Java Report Panel provides the richest feature set of all Web Intelligence query building, report editing and data analysis environments.
Interactive	You build queries using Query - HTML, an HTML-based query editor.
Desktop	You build queries, edit reports and analyze data using Web Intelligence Rich Client, a standalone version of the Java Report Panel that runs outside your web browser.
Web Accessibility	You create reports using the HTML Report Panel, a 508-compliant query and report building environment.

You can use the following view formats to view and interact with existing Web Intelligence documents, or documents that you have just created using a query editor:

View format	Description
Web	Use Web (HTML) format when you want to open reports, answer prompts, navigate reports, and/or perform drill analysis.
Interactive	Use Interactive format when you want to apply filters, sorts, calculations, modify formatting and data displayed on tables and charts, and/or perform drill analysis. Use Interactive format if you are using Query – HTML to define queries, and you want to format reports based on those queries and add formulas and variables. Interactive format + Query HTML provides an approximate equivalent to the Java Report Panel or Web Intelligence Rich Client, in a pure HTML environment. You can also use Interactive format to view and work with reports generated from the HTML Report Panel. Unline Query - HTML, which is a pure query-building environment, the HTML Report Panel also allows you to define reports. After running your query, you can continue to work with the report either by using Interactive format, or by returning to the HTML Report Panel. Interactive view format is only available if your administrator has deployed Web Intelligence in JSP mode.

View format	Description
PDF	Use PDF mode when you want to view static reports.

To select the Web Intelligence query editor

1. Click the **Preferences** button on the InfoView toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. Select the query editor beneath **Select a default creation/editing tool**.
4. Click **OK**.

To select the Web Intelligence view format

You can select different view formats for Web Intelligence documents depending on how you want to interact with the information displayed on the reports. You select your Web Intelligence view options in InfoView. When you modify your view options, the new settings are implemented the next time you open a Web Intelligence document.

1. Click the **Preferences** button on the InfoView toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. In the **Select a view format** section, select the view format.

To select a default universe for new documents

1. Click **Preferences** on the Infoview toolbar.
2. Click**Web Intelligence Preferences** to display the Web Intelligence options.
3. Click **Browse** beneath **Select a default universe** and browse to the universe you want to select as the default.

Refresh option in Infoview

With SAP BusinessObjects XI 3.1 SP3 refresh of Web Intelligence documents created from custom data sources like text, excel files and Custom Data Provider plug-in are supported in Infoview.

Note:
The refresh option is available for Windows operating system only.

To refresh a text or excel file, set the `RefreshOnServer` registry to the following values:

`RefreshOnServer = NO or Disable` to disable refresh on Server.

`RefreshOnServer = YES or ENABLE` to enable refresh on Server, by default it is set to `YES` or `Enable`.

`RefreshOnServer = ALLOW_USE_WINDOWS_SHARE` to enable refresh on Windows server only.

The registry path is: **HKEY_LOCAL_MACHINE** > **SOFTWARE** > **Business Objects** > **Suite 12.0** > **Default** > **Web Intelligence** > **Calculator** > **PDP**.

Before refreshing a document from Infoview make sure that the following points are taken care:

1. The Custom Data Provider has to be on the BOE server, if it is clustered then each and every cluster needs to be updated with the same copy of Custom Data Provider.
2. Incase of a blocker issue and the file cannot be accessed from its original source location then the file should be placed in the default location for each server.

   The default server path is `<Installdir>Business Objects\PersonalDPFilessymantec`, you can change this path by changing the value of `Server_Path` in the registry.
3. The Server Intelligence Agent (SIA) should be managed by a user authentication valid in the network domain. Normally SIA is managed using local system account; this practice is not recommended when deploying Custom Data Provider in server.

4. For refreshing a document based on Generic WS, update the *net.properties* file present at: `<Installdir>\javasdk\jre\lib` with the following lines:

```
http.proxyHost=bluecoat-proxy
http.proxyPort=8080
http.nonProxyHosts=localhost|127.0.0.1|10.
```

   Where, `proxyHost` is the name of the proxy server (e.g. proxy.mydomain.com),

   `proxyPort` is the port number to use (default value is 80),

   `nonProxyHosts` is a '|' separated list of hostnames which should be accessed directly, ignoring the proxy server (default value is localhost & 127.0.0.1)

Note:
The `.pac` files are not supported, you have to explicitly configure the proxy server in the proxy settings for the URL.

To set Web Intelligence drill options

Drilling on reports lets you look deeper into data to discover the details behind a good or bad summary result displayed on a table, chart, or section. Before you begin a drill session, you can set your drill options in InfoView to specify how reports will change each time you drill.

1. Click **Preferences** on the Infoview toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. Select the drill options under **Drill options** and **Start drill session**.

Hide drill toolbar option

When you drill on a value displayed on a report, the Drill toolbar appears and displays the value on which you drilled. The value displayed on the toolbar filters the results displayed on the drilled report.

For example, if you drill on year 2001, the results displayed on the drilled table are Q1, Q2, Q3, and Q4 for year 2001. This means that the quarterly values you drilled to are filtered by 2001.

Note:
If the drilled report includes dimensions from multiple queries, a ToolTip appears when you rest your cursor on the value displayed on the filter. The ToolTip displays the name of the query and the dimension for the value.

The Drill toolbar allows you to select alternative values on the same level, in order to filter the results differently. For example, if you use the Drill toolbar illustrated above to select “2002,□? the results displayed on the drilled table would be Q1, Q2, Q3, and Q4 for year 2002.

You can opt to hide the Drill toolbar when you start drill mode. The Drill toolbar is only useful if you want to select filters during your drill session.

Prompt when drill requires additional data option

When you drill the results displayed on a Web Intelligence report, you may want to drill to higher- or lower-level information that isn’t included in the scope of analysis for the document. When this is the case, Web Intelligence needs to run a new query to retrieve the additional data from the data source.

Since queries on large selections of data may take a long time to be completed, you can choose to be prompted with a message every time a new query is necessary. The prompt message asks you whether you want to run the additional query or not. In addition, the prompt lets you apply filters to the extra dimensions you include in the new query. This means you can restrict the size of the query to only the data necessary for your analysis.

You need permission from your administrator to drill out of the scope of analysis during a drill session.

Synchronize drill on report blocks option

When you select the **Sychronize drill on all report blocks** option, the display of all blocks changes to correspond with your drill actions. For example, if you drill down on a block from year to quarter, and your report also contains a chart showing data by year, the chart display also changes to display data by quarter.

If you do not select the option, only the drilled block changes in response to drill actions.

Start drill session option

The **Start drill session** option controls how Web Intelligence behaves when you start drill mode.

Start drill session on existing report option

When you select **Start drill session on existing report**, the current report becomes drillable when you start drill mode. When you end drill mode, the report displays the drilled values.

Start drill session on a duplicate report option

When you select **Start drill on a duplicate report**, Web Intelligence creates a duplicate of the current report when you start drill mode, and you drill on the duplicate. This allows you to compare the results of the original report with the results you discover during your drill analysis.

Web Intelligence locale options

Locales determine how Web Intelligence displays its interface (for example, menu items and button text) and data (for example, date and number formatting).

Web Intelligence has three locales:

Locale	Description
Product Locale	The locale in which the Web Intelligence interface is displayed
Document Locale	The locale of the data currently contained in the document
Preferred Viewing Locale	The user's preferred locale for displaying document data

The InfoView settings determine how the Document Locale and Preferred Viewing Locale interact to display document data.

Related Topics

- *To permanently associate a locale with a document*

The Product Locale

The product locale is used to display the Web Intelligence interface (for example, menu items and button text).

Note:
The `GetLocale` function returns the Product Locale.

To set the Product Locale

1. Click **Preferences** on the main InfoView toolbar.
2. Click **General** to display the general options.
3. Select the product locale from the **Product locale** list.

The Document Locale

The Document Locale formats the data in a document. For example, the Document Locale determines how Web Intelligence displays dates and numbers.

If the Web Intelligence settings in InfoView give the user's Preferred Viewing Locale priority through the **Use my Preferred Viewing Locale to format the data** setting, Web Intelligence sets the Document Locale to the Preferred Viewing Locale when the user opens a document. When the user saves the document, Web Intelligence saves this Document Locale with the document.

If the Web Intelligence settings do not give the user's Preferred Viewing Locale Priority, Web Intelligence formats the data according to the Document Locale saved with the document.

When a user creates a document, Web Intelligence always assigns the user's Preferred Viewing Locale as the initial Document Locale, whether or not the Web Intelligence settings in InfoView give the Preferred Viewing Locale priority.

A user can permanently associate the current Document Locale with a document by saving the document with the **Permanent Regional Formatting** option selected. Once a document has been saved with the option selected, Web Intelligence ignores the InfoView settings and always formats the document data using the saved Document Locale. This applies to all users, not just the user who selected the **Permanent Regional Formatting** option.

Note:
The `GetContentLocale` function returns the Document Locale.

Related Topics

- *To permanently associate a locale with a document*

To set the Document Locale

1. Click **Web Intelligence Preferences** to display the Web Intelligence options.
2. Click **Use the document locale to format the data** beneath **When viewing a document**.

The Preferred Viewing locale

The Preferred Viewing Locale is a user's preferred locale for displaying document data. The Document Locale becomes the user's Preferred Viewing Locale when the InfoView settings give the Preferred Viewing Locale priority.

Note:
The `GetPreferredViewingLocale` function returns the Preferred Viewing Locale. The `GetLocalized` function also uses the Preferred Viewing Locale to display translated strings.

To set the Preferred Viewing Locale

1. Click **Preferences** on the main InfoView toolbar.
2. Click **General** to display the general options.
3. Select the preferred viewing locale from the **Preferred viewing locale** list.
4. Click **Web Intelligence Preferences** to display the Web Intelligence options.

5. If you want data to be formatted using the preferred viewing locale, click **Use my Preferred Viewing Locale to format the data** beneath **When viewing a document**.

To permanently associate a locale with a document

1. In Web Intelligence Interactive, select **Document** > **Properties** from the menu to display the" Document Properties" dialog box, then select **Permanent regional formatting**.
2. In the Web Intelligence Java Report Panel or Web Intelligence Rich Client, right-click an empty area of the report, select **Document Properties** to display the **Document Properties** pane, then select **Permament Regional Formatting** in the **Document Options** section of the pane.
3. Save the document.

   The current Document Locale is associated permanently with the document.

Getting started with Web Intelligence Rich Client

chapter 3

To install Web Intelligence Rich Client from InfoView

1. Log into InfoView.
2. Click **Preferences** at the top right of the InfoView screen.
3. Scroll down and click **Web Intelligence Preferences**.
4. Click **Desktop (Web Intelligence Rich Client required)** in the **Select a default creation/editing tool** section.
5. Click **Document List** at the top left of the InfoView screen.
6. Click **New** > **Web Intelligence Document** or select an existing document to edit.

Web Intelligence Rich Client is downloaded to your computer and launched to create the document.

Note:
If you install Web Intelligence Rich Client from InfoView, the Web Intelligence Rich Client online help system is not installed to your local computer. If you work in Connected mode, Web Intelligence Rich Client displays help pages stored on the server. If you work in Offline or Standalone mode, help pages are not available.

Related Topics

- *Web Intelligence Rich Client working modes*

To install Web Intelligence Rich Client from the Business Objects Enterprise CD

- See the Business Objects Enterprise XI 3.1 Installation Guide for full installation instructions.

Web Intelligence Rich Client working modes

You can work with Web Intelligence Rich Client in three modes: Connected, Offline, or Standalone.

Web Intelligence Rich Client Connected mode

In Connected mode, Web Intelligence Rich Client is connected to a CMS. You can work with documents on the CMS or with local secured or unsecured documents. According to your security rights in the CMS, you can do the following:

- import documents from the CMS
- import universes from the CMS
- open local documents
- create documents
- edit documents
- refresh documents
- save documents locally
- export documents to the CMS

Security in Connected mode

When you work with Web Intelligence documents in Connected mode, the security rights of your user account are applied by the CMS.

Connecting to the CMS in Connected mode

There are two ways of launching Web Intelligence Rich Client, and each connects to the CMS differently:

- When you launch from InfoView, Web Intelligence Rich Client connects to the CMS within the same InfoView session, so no login is required. Communication with the CMS goes via HTTP to an application server, which reroutes the calls to the CMS and repository. No local middleware is required.
- When you launch locally, by logging in to Web Intelligence Rich Client through the Windows Start menu or by double-clicking a Web Intelligence document, Web Intelligence Rich Client can connect to the CMS in client-server mode via the OCA/CORBA framework of the Enterprise SDK or via HTTP as above. In client-server mode the appropriate database middleware is required on your local machine. To launch via HTTP you must have previously launch the Web Intelligence Rich Client from Infoview and the system name will include '(J2EE Portal)'.

Related Topics

- *To launch Web Intelligence Rich Client in Connected mode locally*
- *To launch Web Intelligence Rich Client in Connected mode from InfoView*

Web Intelligence Rich Client Offline mode

In Offline mode, Web Intelligence Rich Client is not connected to a CMS but applies CMS security. You can work with local documents and universes that are secured by the CMS you select at login, or with unsecured local documents and universes. You can do the following:

- open local documents
- create documents (requires local universe and local connection server)
- edit documents
- refresh documents (requires local universe and local connection server)
- save documents locally

In Offline mode, you cannot import documents from or export documents to a CMS.

Security in Offline mode

When you connect to a CMS in Connected mode, your security rights in that CMS are downloaded to your computer. Each document and universe downloaded from a CMS contains within it an access control list identifying groups and users that have access rights to the document. In Offline mode, Web Intelligence Rich Client applies CMS security rights by matching the access rights for the document or universe against the locally stored security file. For example, if a document was downloaded from a CMS to your local machine, and you do not have the right to open the document in the CMS from which it was downloaded, you cannot open the document on your local machine.

Note:
Before you can work in Offline mode with documents or universes secured by a CMS, you must first have connected to that CMS at least once in Connected mode. This allows Web Intelligence Rich Client to download the CMS security information to your local machine, and to display the CMS as a choice in the System list on the login page. You can then log in in Offline

mode and work with no CMS connection because Web Intelligence Rich Client reads the CMS security information in the local file.

Technical notes

- When working in Offline mode, you must have the appropriate universes and database middleware installed on the same machine as Web Intelligence Rich Client to be able to create or refresh documents. If you do not, you can still open, edit, and save documents locally as long as you have the appropriate security rights.
- The security information for a CMS is stored in a local security information file (extension LSI) in the LocData folder under My Business Objects Documents in the My Documents folder. One computer can store LSI files for several CMSs.

Web Intelligence Rich Client Standalone mode

In Standalone mode, Web Intelligence Rich Client is not connected to a CMS and no security is enforced. You can work with local, unsecured documents and universes only. You can do the following:

- open documents
- create documents
- edit documents
- refresh documents
- save documents locally

You cannot import documents from or export documents to a CMS.

The middleware required to create and refresh local, unsecured documents with local, unsecured universes must be installed on the computer with Web Intelligence Rich Client.

To set user preferences in Web Intelligence Rich Client

1. Click **Tools** > **Options**.

   The Preferences dialog box opens.

2. Click one of the tabs:

- **General**: to set general preferences
- **Viewing**: to set document viewing preferences
- **Locale**: to set preferences for interface and formatting locales and how to use them
- **Drilling**: to set document drill preferences

3. Set preferences and click **OK**.

   The preferences are now applied. They are stored in a file in the LocData folder under the BusinessObjects Enterprise 12.0 installation folder.

Web Intelligence Rich Client general preferences

You set general preferences for Web Intelligence Rich Client by clicking **Tools** > **Options** and clicking the **General** tab of the Preferences box.

General

In the General section, you choose whether to show the welcome wizard each time Web Intelligence Rich Client is started. The welcome wizard lets you select from a list of recently used universes or browse for more data sources to create a new document.

Select default universe

In this section, you choose whether to select a default universe for new documents. The default universe is pre-selected in the Universe dialog box when you create a new document. When creating a document, you can use the default universe or select another one.

- **No default universe** means that no universe in the list is pre-selected when you open the Universe dialog box. You must select a universe from the list when creating a document.
- The other choice shows the name of the default universe, or **None** if no default universe has been selected. To choose a default universe, click **Browse**, then browse to and select a universe.

Select default folders

In this section, you choose the default folders in which to store user documents, universes, and help files. To change the default locations, click **Browse**, then browse to and select a folder.

Note:
If Web Intelligence Rich Client was downloaded and installed from InfoView, help files are not installed locally. However, they are installed on the InfoView server. Contact your company's Business Objects administrator to get the URL of the help files on the server, then enter the URL here for help to be available.

Select Microsoft Excel format

In this section you choose the format to use when you save a document in Microsoft Excel format.

- **Prioritize easy data processing in the Excel document**: the Excel document will be formatted to ensure efficient data processing.
- **Prioritize the format of reports in the Excel document**: the Excel document will be formatted to ensure optimum readability.

Web Intelligence Rich Client viewing preferences

You set general preferences for Web Intelligence Rich Client by clicking **Tools** > **Options** and clicking the **Viewing** tab of the Preferences box.

General

In this section, you set the unit of measurement for report display: pixel, inch, or centimeter.

Grid

In this section you set grid options:

- **Show grid**: When this is selected, a grid is displayed to help align page elements.
- **Snap to grid**: When this is selected, page elements align to the grid to enable accurate repositioning.
- **Grid spacing**: This defines the distance between lines on the grid.

Web Intelligence Rich Client locale preferences

You set locale preferences for Web Intelligence Rich Client by clicking **Tools** > **Options** and clicking the **Locale** tab of the Preferences box.

Locale

In this section, you set preferences for interface and formatting locales. A locale is a combination of language and geographical area.

- **Select interface locale**: Select an available locale to set the application interface language. If you change this setting, you must restart Web Intelligence Rich Client for the change to be taken into account.
- **Select formatting locale**: Select an available locale to determine locale-specific formatting (for example, date and time formats). If you change this setting, any documents that are open must be closed and reopened for the new formatting locale to be applied.

When viewing a document

In this section, you set how the formatting locale is decided:

- **Use the document locale to format the data**: When this is selected, data is formatted according to the document locale. The document locale can be saved with the document by means of the permanent regional formatting option that you can select when saving.
- **Use my formatting locale to format the data**: When this is selected, data is formatted according to your formatting locale preference. This overrides the document locale.

Web Intelligence Rich Client drill preferences

You set drill preferences for Web Intelligence Rich Client by clicking **Tools** > **Options** and clicking the **Drilling** tab of the Preferences box.

For each new drill session

In this section, you choose how to start a new drill session:

- **Start drill on duplicate report**: When you start a new drill session, a duplicate report is opened in the document and you drill on the duplicate.

When you end drill mode, both the original report and the drilled report remain in the document.

- **Start drill on existing report**: When you start a new drill session, the current report becomes drillable. When you end drill mode, the report displays the drilled values.

General drill options

- **Prompt if drill requires additional data**: You are prompted when Web Intelligence needs to retrieve additional data to complete the drill, and can decide whether to go ahead. If the amount of data is large, the retrieval can take time and you may decide not to drill. When this option is not selected, Web Intelligence retrieves the additional data without prompting you.
- **Synchronize drill on report blocks**: When this is selected, drilled values are shown in all the report blocks in the report. When it is not selected, drilled values are shown only in the report block selected for the drill.
- **Hide drill toolbar**: When this is selected, the drill toolbar that is normally displayed at the top of drilled reports is not shown. The drill toolbar displays the value on which you drilled. It is only useful if you want to select filters during your drill session.

To change your password

You can only change your password from Web Intelligence Rich Client if you are in client-server connection mode: you must have launched Web Intelligence Rich Client locally rather than from InfoView.

1. Click **Tools** > **Change Password**.
2. Type your current password in the Enter Old Password box.
3. Type your new password in the Enter New Password box.
4. Type your new password again in the Confirm New Password box.

Your password is changed to the new password.

Launching Web Intelligence Rich Client

You can launch Web Intelligence Rich Client in any of its three working modes:

- Connected
- Offline
- Standalone

You can run multiple instances of Web Intelligent Rich Client simultaneously, in any mode and connected to any available CMS.

The CMS connection status and the current Web Intelligence Rich Client working mode are shown in the status bar on the lower right of the screen.

Related Topics

- *Web Intelligence Rich Client working modes*

To launch Web Intelligence Rich Client in Connected mode from InfoView

In Connected mode, security is handled by the CMS. You work with reports in Web Intelligence Rich Client as you do with the Java Report Panel. You do not need database middleware on your local machine when you launch in Connected mode from InfoView.

1. Log into InfoView.
2. Click **Preferences** at the top right of the InfoView screen.
3. On the Preferences page, scroll down and click **Web Intelligence Preferences**.
4. In the **Select a default creation/editing tool** section, click **Desktop (Web Intelligence Rich Client required)**.
5. Click **OK**.
6. At the top left of the screen, click **Document List**.
7. Open an existing document or click **New** > **Web Intelligence Document** to create a new document.

   Web Intelligence Rich Client is launched on your computer in Connected mode. If it is not yet installed on your computer, it is installed from InfoView.

   If Web Intelligence Rich Client was already running on your computer, launching from InfoView opens a new instance of the application. The document is not opened in the application instance that was already open.

Related Topics

- *Web Intelligence Rich Client working modes*

To launch Web Intelligence Rich Client in Connected mode locally

To launch Web Intelligence Rich Client in Connected mode locally, Web Intelligence Rich Client must be installed on your computer. You must have already connected at least once to the CMS you want to work with using Web Intelligence Rich Client via InfoView.

You need to have the middleware required to connect to the CMS installed on your computer.

In Connected mode, security is handled by the CMS. You work with reports in Web Intelligence Rich Client as you do with the Java Report Panel.

When you launch Web Intelligence Rich Client in Connected mode locally, you have a client-server connection to the CMS. In this case, you can log out and log in again within the same application session by clicking **Tools** > **Login As**.

1. Start Web Intelligence Rich Client locally in either of two ways:
   - Click **Start** > **Programs** > **BusinessObjects XI 3.1** > **BusinessObjects Enterprise** > **Web Intelligence Rich Client**
   - In Windows Explorer, associate the WID file type with Web Intelligence Rich Client, and then double-click a Web Intelligence (WID) file.

   The Web Intelligence login page opens.
2. Select a CMS in the System list.

   An icon shows what kind of connection was used for the last connection with the CMS:

   - An icon of a desktop computer means Web Intelligence Rich Client last connected to this CMS in client-server mode (local launch from the client computer). The name of the CMS is the server name.
   - An icon of a globe means Web Intelligence Rich Client last connected to this CMS in HTTP mode (connection via InfoView). The name of the CMS is the full name of the connected cluster.
3. Enter a valid user name and password.

4. Select an authentication mode from the list.

   Do not choose Standalone if you want to work in Connected mode. When you choose Standalone authentication you work in Standalone mode, with no CMS connection.

5. Make sure the Use in Offline Mode option is not selected.
6. Click **Log In**.

Web Intelligence Rich Client is launched in Connected mode. If Web Intelligence Rich Client was already running on your computer, launching it again opens a new instance of the application. If you double-clicked a Web Intelligence document, the document will not be opened in the application instance that was already open.

Related Topics

- *Web Intelligence Rich Client working modes*

To launch Web Intelligence Rich Client in Offline mode

To launch Web Intelligence Rich Client in Offline mode, Web Intelligence Rich Client must be installed on your computer. You must have already connected at least once to the CMS you want to work with using Web Intelligence Rich Client via InfoView.

In Offline mode, Web Intelligence Rich Client uses the locally stored security file of the CMS you want to work with to authenticate documents. You cannot import to or export from the CMS. To create or refresh documents, you need to have a connection server installed on your computer.

1. Start Web Intelligence Rich Client in Offline mode in either of two ways:
   - Click **Start** > **Programs** > **BusinessObjects XI 3.1** > **BusinessObjects Enterprise** > **Web Intelligence Rich Client**
   - In Windows Explorer, associate the WID file type with Web Intelligence Rich Client, and then double-click a Web Intelligence (WID) file.

   The Web Intelligence login page opens.

2. Select a CMS in the System list.
3. Enter a valid user name and password.
4. Select an authentication mode from the list.

Do not choose Standalone if you want to work in Connected mode. When you choose Standalone authentication you work in Standalone mode, with no CMS connection.

5. Select the **Offline Mode** option.
6. Click **Log In**.

Web Intelligence Rich Client is launched in Offline mode. If Web Intelligence Rich Client was already running on your computer, launching it again opens a new instance of the application. If you double-clicked a Web Intelligence document, the document will not be opened in the application instance that was already open.

Related Topics

- *Web Intelligence Rich Client working modes*

To launch Web Intelligence Rich Client in Standalone mode

To launch Web Intelligence Rich Client in Standalone mode, Web Intelligence Rich Client must be installed on your computer.

Any middleware required to work with unsecured documents and universes must be installed on your computer.

In Standalone mode, you cannot work with documents or universes that have been secured by a CMS.

1. Start Web Intelligence Rich Client in Standalone mode in either of two ways:
   - Click **Start** > **Programs** > **BusinessObjects XI 3.1** > **BusinessObjects Enterprise** > **Web Intelligence Rich Client**
   - In Windows Explorer, associate the WID file type with Web Intelligence Rich Client, and then double-click a Web Intelligence (WID) file.

   The Web Intelligence login page opens.
2. Select **Standalone** in the Authentication list.

   The System, User Name, and Password boxes, as well as the Use in Offline Mode option, are grayed.
3. Click **Log In**.

Web Intelligence Rich Client is launched in Standalone mode. If Web Intelligence Rich Client was already running on your computer, launching it again opens a new instance of the application. If you double-clicked a Web Intelligence document, the document will not be opened in the application instance that was already open.

Related Topics

- *Web Intelligence Rich Client working modes*

To log into Web Intelligence Rich Client as a different user

To log into Web Intelligence Rich Client as a different user without exiting the application, you must have launched Web Intelligence Rich Client via the Windows Start menu or by double-clicking a local WID file, and then connected to the CMS in Connected mode.

1. Save any open documents.
2. Click **Tools** > **Login As**.

   If any documents have not been saved, you are asked if you want to save them.
3. When you are asked if you are sure you want to log out, click **Yes**.

   Any open documents are closed.
4. In the User Identification box, enter your login information and click **OK**.

Related Topics

- *To launch Web Intelligence Rich Client in Connected mode locally*
- *Web Intelligence Rich Client working modes*

Working with universes in Web Intelligence Rich Client

Universe security in Web Intelligence Rich Client

Universe security in Connected mode

When you work with Web Intelligence Rich Client in Connected mode, you access CMS universes remotely. The CMS applies the security rights directly, exactly as if you were working with Web Intelligence through InfoView in your browser.

In Connected mode, you cannot access local, CMS-secured universes. You must access the CMS universes remotely.

Universe security in Offline mode

To create or refresh a report in Offline mode, you must have first connected to the CMS in Connected mode. When you work in Connected mode with a CMS, a local security information (LSI) file is downloaded to your computer containing your security rights to the resources in the CMS.

When you try to create or refresh a report in Offline mode, you can use:

- locally installed universes that are not secured by the CMS
- locally installed universes which you are authorized to access, as verified by the LSI file

You cannot access universes on the CMS remotely, because in Offline mode you are working without a CMS connection.

Note that you need to have a Connection Server installed on your computer with Web Intelligence Rich Client in order to create or refresh documents in Offline mode.

Universe security in Standalone mode

In Standalone mode, you work with no security and no connection to the CMS. You can work with unsecured, locally installed universes only.

The middleware required to create and refresh local, unsecured documents with local, unsecured universes must be installed on the computer with Web Intelligence Rich Client.

Related Topics

- *Launching Web Intelligence Rich Client*
- *Web Intelligence Rich Client working modes*

To import a universe from the CMS in Web Intelligence Rich Client

You can import a universe from the CMS in Connected mode only. Import is automatic to provide a universe that is required to create or refresh a document. However, you may want to import universes first to be able to then work with them offline.

1. Click **Tools** > **Universes**.

   The list of available universes appears in the Universe dialog box. These include both local and CMS universes. Universes that have already been imported are indicated with a green check mark.

2. Select one or more universes to import.
3. Click **Import**.

The universes you selected are imported from the CMS to your computer, together with their dependencies (derived or core universes).

Related Topics

- *To launch Web Intelligence Rich Client in Connected mode locally*
- *To launch Web Intelligence Rich Client in Connected mode from InfoView*
- *Web Intelligence Rich Client working modes*

To select a universe

1. Select a universe in the **Available Universes** list.

   A description of the universe appears in the **Help on selected universe** box.

2. Click **OK**.

The query panel opens, showing the universe's data in the Data tab.

You can now use the query panel to build queries in your document.

Returning data using queries

chapter 4

Creating, editing and saving documents

You create documents using Web Intelligence Rich Client by building a query on a universe stored in the InfoView repository, a local universe, or a local non-universe data source.

After you have selected a universe or a non-universe data source you you its objects to build a query that returns data from the data source to your Web Intelligence document.

After creating a document you can work with it locally or export it to the InfoView repository.

Building and working with queries

To build a query on a universe

1. Click **File** > **New**
2. Select **Universe** in the "Data Source Selection" dialog box and click **Next.**
3. Select the universe in the "Universe" dialog box and click **OK.**
4. Select the objects you want to include in the query and drag them to the **Result Objects** pane.

   Note:
   To add all the objects in the class, drag the class to the **Result Objects** pane.

5. Repeat the previous step until the query contains all the objects you want to include.
6. Select the objects on which you want to define query filters and drag them to the **Query Filters** pane.
7. Set the scope of analysis and other query properties.
8. Click **Run Query** to run the query.

Related Topics

• *Displaying data from an added query*

How universe objects map to data

Classes and subclasses

Objects are grouped into folders called classes. Each class can also contain one or more subclasses. Subclasses contain objects that are a further subcategory of the objects in the upper level of the class.

The role of classes is to organize the objects into logical groups. When you create queries on the universe, classes help you to find the objects that represent the information that you want to use in a query.

Dimension object

A dimension object represents data that provides the basis for analysis in a report. Dimension objects typically retrieve character-type data, for example; customer names, resort names, or dates.

Dimension objects appear as follows in the Web Intelligence query panel:

Detail object

A detail obect provides descriptive data about a dimension. A detail is always attached to the dimension for which it provides additional information. For example, [Age] is a detail object that is associated with the (Customer] dimension.

Detail objects appear as follows in the Web Intelligence query panel:

Measure object

The measure object retrieves numeric data that is the result of calculations on data in the database. For example, [Revenue] is the calculation of the number of items sold multiplied by item price. Measure objects are often located in a Measures class.

Measure objects appear as follows in the Web Intelligence query panel:

There are two types of measure:

- classic measures - calculated by Web Intelligence
- smart measures - calculated by the database on which the universe is based

In certain situations, smart measures impact the way in which Web Intelligence displays calculations. For more information on smart measures, see the *Using Functions, Formulas and Calculations in SAP BusinessObjects Web Intelligence* guide.

To build a query on a text or Excel file

1. Click **File** > **New**
2. Select **Other data source** in the "Data Source Selection", select **Text and Excel files** from the list, then click **Next.**
3. Type the file name in the **Name** box or click **Browse** and select the file.

   Web Intelligence displays the options relating to the type of file you chose. These options determine how Web Intelligence interprets the data in the file and transforms it to result objects for use in the query.
4. Select the options relating to the file type and click **Next.**

   Web Intelligence populates the Result Objects pane in the Query Panel based on the options you selected.
5. Click **Run Query** to run the query.

Related Topics

- *Displaying data from an added query*

CSV data source options

You can set the following options when you choose a CSV file as a local data source. You can edit the options later by clicking **Edit Settings** in the **Query Definition** pane in the Query Panel.

Option	Description
Data Separator	The character that separates the data relating to each result object. • **Tabulation** - data is tab-separated • **Space** - data is separated by spaces • **Character** - data is separated by the character you specify
Text delimeter	The character that delimits the data relating to each result object.
First row contains column names	Web Intelligence uses the first row in the file as the names of the result objects.
Locale	The document locale
Charset	The document character set
Date format	The date format used in the document

Excel data source options

You can set the following options when you choose an Excel file as a local data source. You can edit the options later by clicking **Edit Settings** in the **Query Definition** pane in the Query Panel.

Option	Description
Sheet Name	The name of the worksheet containing the data
Field selection - All fields	Web Intelligence treats all data in the worksheet as query data
Field selection - Range Definition	Web Intelligence treats the data in the specified range as query data
Field selection - Range Name	Web Intelligence treats the data in the named range as query data
First row contains column names	Web Web Intelligence uses the first row in the range as the names of the result objects.

Displaying data from an added query

When a query is not the first query in the document, you need to specify in the New Query box how its data will be displayed.

Option	Description
Insert a table in a new report	Display the data on a new report in the document
Insert a table in the current report	Display the data on the currently selected report in a new table
Include the result objects in the document without generating a table	Include the data in the document without displaying the data on a report. (You can add the objects returned by the query to the report later.)

To interrupt a query

You can interrupt a query before Web Intelligence has returned all the data to the document.

When you interrupt a query, only partial data is returned to the document. The values displayed in the document do not accurately reflect the definition in the query.

Before returning the data to the document, Web Intelligence requests you to choose which version of the data you want retrieved

1. On the "Waiting - Refresh Data" dialog box, click **Cancel**.

   The "Interrupt Data Retrieval" dialog box appears.

2. Select one of the options on the "Interrupt Data Retrieval" dialog box.

Option	Description
Restore the results from the previous data retrieval	Web Intelligence restores the values to the document that were retrieved the last time the query was run. The values displayed will not be the most up to data information available on the database. You can run the query later to return the up to date values from the database
Purge all data from the document	Web Intelligence displays the document empty of values. The structure and formatting of the document is retained. You can run the query later to return the up to date values from the database
Return the partial results	Web Intelligence displays the new values retrieved so far in the appropriate parts of the document. The rest of the document will display the values retrieved the last time the query was run

To remove a query

1. Select a the query you want to remove by right-clicking the appropriate Query tab.
2. Click **Remove**.

To duplicate a query

If you want to build a different query on a universe already included in the document, you can duplicate the existing query on that universe and then modify it, instead of starting from scratch.

1. Select the query you want to duplicate by right-clicking the appropriate Query tab at the bottom of the report panel.
2. Select **Duplicate**

To edit a query

1. Click **Edit Query**
2. Edit the query in the Query Panel.

Multiple queries

You can include one or multiple queries in a Web Intelligence document. When you include multiple queries, those queries can be based on a single universe or on multiple universes available in InfoView.

For example, you can include product sales data and customer data in the same document. In this case, your corporate data for product line sales is available on one universe and data on customers is available on another universe. You want to present product line sales results and information on customer age groups in the same report. To do this, you create a single document that includes two queries; one query on each universe. You can then include and format results from both queries on the same report.

Defining multiple queries in a single document is necessary when the data you want to include in a document is available on multiple universes, or when you want to create several differently-focused queries on the same universe. You can define multiple queries when you build a new document or add more queries to an existing document. You can present the information from all of the queries on a single report or on multiple reports in the same document.

Multiple queries, combined queries and synchronized queries compared

Multiple queries can be related in a Web Intelligence document in different ways.

- Basic multiple queries draw unrelated data from different sources.
- “Synchronized queries” relate the data from different queries around a dimension that contains data common to both queries. These dimensions are called merged dimensions.

  You merge dimensions in the Web Intelligence reporting interface after you have created and run your multiple queries.
- “Combined queries” are a special kind of query created in the Web Intelligence query interface. Combined queries generate SQL containing the UNION, INTERSECT and MINUS operators (if the database supports them) or simulate the effect of these operators.

  Combined queries allow you to answer complex business questions that are difficult to formulate using standard queries.

  You cannot create combined queries in Query - HTML.

To refresh queries

1. If the report contains one query only, click **Refresh Data** on the main toolbar.
2. If the report contains multiple queries, click **Refresh All** to refresh all queries, or click the arrow to the right of **Refresh All** and select the query from the menu.

Note:
If a query is based on a personal data provider, Web Intelligence Rich Client searches for the data provider in the following locations:

- The folder where the local data file was stored when the data provider was created
- The same folder as the Web Intelligence document

- The default user document folder (`C:\Documents and Settings\%currentUser%\My Documents\My Business Objects Documents\userDocs`)

If the file is not found in any of these folders, Web Intelligence Rich Client displays an error.

Viewing the SQL generated by a query

When you build a query in Web Intelligence, Web Intelligence generates SQL to run against the database to return the query result. S(tructured) Q(uery) L(anguage) is the query language understood by all relational databases.

You can view and edit the SQL generated by Web Intelligence.

Note:
You cannot view the SQL of queries that call database stored procedures.

To view and edit the generated SQL

Note:
You cannot edit the query SQL when the query contains optional prompts. Edit the query to remove the optional prompts before attempting to edit the SQL.

1. Click **SQL** on the query toolbar to display the "SQL Viewer" dialog box.

   When SQL is not editable, values supplied in response to prompts appear directly in the query.

   For example, if "UK" was supplied in response to a prompt on [Country], a line similar to

   ```
   Resort_country.country In ('UK')
   ```

   appears in the query.

   If no value has yet been supplied for the prompt, the Web Intelligence syntax for prompts (described below) appears in the query.

2. Click **Use custom SQL** to make the generated SQL editable.

When you make the SQL editable, the Web Intelligence syntax for prompts appears in the query.

For example, a line similar to

```
Resort_Country.country  =  @prompt('Enter Coun
try:','A','Resort\Country',
Mono,Free,Persistent,,User:0)
```

appears in the query.

3. Click **Validate** after editing the SQL to check that your edits are valid.
4. Click **Copy** (Java Report Panel and Web Intelligence Rich Client only) to copy the SQL to the clipboard.
5. Click **Print** (Query - HTML only) to print the SQL.

Setting the scope of analysis

Scope of analysis

The scope of analysis for a query is extra data that you can retrieve from the database to give more details on the results returned by each of the objects in a query. This extra data does not appear in the initial result report, but it remains available in the data cube, so you can pull this data in to the report to allow you to access more detail at any time. This process of refining the data to lower levels of detail is called drilling down on an object.

In the universe, the scope of analysis corresponds to the hierarchical levels below the object selected for a query. For example, a scope of analysis of one level down for the object Year, would include the object Quarter, which appears immediately under Year.

You can set this level when you build a query. It allows objects lower down the hierarchy to be included in the query, without them appearing in the **Results Objects** pane. The hierarchies in a universe allow you to choose your scope of analysis, and correspondingly the level of drill available.

In the Java Report Panel and in Web Intelligence Rich Client, you can also create a custom scope of analysis by selecting specific dimensions for the **Scope of Analysis** pane.

Note:
You cannot set the scope of analysis when working in query drill mode because this drill mode causes Web Intelligence to modify the scope dynamically in response to drill actions.

Levels of scope of analysis

You can set the following levels for scope of analysis:

Level	Description
None	Only the objects that appear in the **Results Objects** pane are included in the query.
• One level down • Two levels down • Three levels down	For each object in the **Result Objects** pane, one, two, or three objects lower down the hierarchy tree are included in the query. The data from these objects is stored in the cube until you add them to the document.
Custom **Note:** This option is available in the Java Report Panel and in Web Intelligence Rich Client only.	All objects added manually to the Scope of Analysis panel are included in the query.

Including a scope of analysis in a document increases the document size significantly. This is because the data necessary for the scope you specify is saved with the document, even though it is not visible in the reports unless you start drill mode and drill down to the data to display the corresponding values.

In order to minimize the size of documents and optimize performance, we recommend that you only include a scope of analysis in documents where you are certain that users will need to drill.

We suggest the following method because it will be easier for you to set the scope of analysis seeing the hierarchy of the classes and objects.

To set the scope of analysis

1. Click the **Show/Hide Scope of Analysis** Pane button so that it appears pressed in.

   The Scope of Analysis panel appears at the bottom of the Result Objects pane. The default scope of analysis is None. Each dimension in the Result Objects pane appears in the Scope of Analysis pane.
2. Click the down arrow in the **Scope of Analysis** drop-down list box.
3. Select a level for the scope of analysis.

   The level appears in the list box and the dimensions that are hierarchically below each dimension in the Result Objects pane appear in the **Scope of Analysis** pane.
4. If you want to add selected dimensions to the scope of analysis or create a custom scope of analysis, select dimensions in the Query Manager and drag them across to the **Scope of Analysis** panel.

Query contexts

What is an ambiguous query?

An ambiguous query is a query that contains one or more objects that can potentially return two different types of information.

In a universe, certain dimensions may have values that are used for two different purposes in the database. For example, the [Country] dimension in the query below can return two types of information:

- Customers and the country in which they spent their vacation.
- Customers and the country for which they have made their reservation.

The role that Country plays in this query is ambiguous. A country can be either the country where a vacation was sold, or a country where a vacation is reserved. One is existing information (sales), and the other is future information (reservations).

To avoid ambiguities in a query, the universe designer identifies the different ways that objects can be used in the universe, and implements restrictions on how these objects can be combined. These restrictions are called contexts.

What is a context?

A context is a defined group of objects that share a common business purpose. This business purpose is usually the type of information that these related objects represent. For example, a sales context is a grouping of all the objects that can be used to create sales queries. A reservations context is a grouping of all the objects that can be used in reservation queries. Contexts are defined in a universe by the universe designer.

You can combine any object within the same context to create a query. You can also combine objects in different contexts. If you use an object that is common to both contexts, Web Intelligence will try to determine the context that best fits the other objects in the query.

If it cannot determine a context, you are prompted to choose the context that you want to apply to the query.

Choosing a context when you run a query

When you create a query or refresh a report, you may be asked to choose a context before the query can run. Contexts are set up in a universe to avoid ambiguous queries.

To choose a context when you run a query

1. Run the query containing multiple contexts.
   The "Select a Context" dialog box appears.
2. Select the context in the "Select a Context" dialog box.

Web Intelligence query properties

Allow other users to edit all queries property

When selected, other users who have the appropriate editing rights can access Query View and modify the queries in the document. When cleared, only the report creator can modify the queries. This option is selected by default. Unlike the other query properties, which only apply to the selected query, this option applies to all of the queries in the document.

Max retrieval time query property

Maximum time that a query can run before the query is stopped. This can be useful when a query is taking too long due to an excess of data, or network problems. You can set a time limit so a query can stop within a reasonable time.

Max rows retrieved query property

The **Max rows retrieved** query property determines the maximum number of rows of data that are displayed when a query is run. If you only need a certain amount of data, you can set this value to limit the number of rows of data in your document.

Max rows retrieved does not operate at the database level. If you set **Max rows retrieved** to 1000, and your query returns 5000 rows, Web Intelligence initially retrieves all 5000 rows, before discarding 4000 and retaining only the first 1000 rows.

The **Sample result set** query property also applies a restriction on the number of rows in the query, but at the database level. If you set **Max rows retrieved** to 2000 and **Sample result set** to 1000, the query retrieves a maximum of 1000 rows only.

This setting can be overridden by the limits set by your administrator in your security profile. For example, if you set the **Max rows retrieved** setting to

400 rows, but your security profile limits you to 200 rows, only 200 rows of data will be retrieved when you run the query.

Query prompt order

Prompts are listed in the list. You can use the up and down arrows to move a prompt up or down the list to change the order in which they are executed.

Retrieve duplicate rows query property

In a database, the same data may be repeated over many rows. You can choose to have these repeated rows returned in a query, or to have only unique rows returned.

Query Stripping

Query Stripping enables you to optimize the query generation automatically. With Query Stripping enabled, Web Intelligence generates a query containing only those objects that effectively contribute to a report. It improves the performance of the report by sending the stripped query to the connection server.

Each time you refresh a query, Web Intelligence strips the objects which are not contributing to the report (directly or indirectly) from the report as well as from the SQL Viewer tab. It refreshes only the query that is directly related to the report. The stripped objects get deleted from the report and appear as bold in the Data map to allow easy identification of the stripped objects. You can drag and drop these objects if you want them to appear in the report again. Once you drag and drop these objects, the column header of the report displays the object definition and data cells display **#Refresh** . Refresh the query again to allow the stripped objects data to appear in the report.

Note:

- Query Stripping is applicable only for OLAP database users.
- In a Query Stripping enabled document, if a query filter is used on a Measure object, Web Intelligence does not strip the objects.

For more information about how to work with Web Intelligence, see *Building Reports with Web Intelligence Rich Client* guide on SAP Help Portal: *http://help.sap.com*

To control Query Stripping

You can control the automatic query optimization by enabling or disabling **Query Stripping** at two levels, namely, Query and Document level property.

- Query level property: At Query level property, Query Stripping can be enabled or disabled only by Power users, who create a Web Intelligence report and defines queries and initial structures of the report. Query Stripping at query level property is disabled by default. In case of multiple queries in the same document, the query set for Query Stripping will be stripped and other queries would remain unaffected.
- Document level property: At Document level property, Query Stripping can be enabled or disabled by all the users of Web Intelligence to change the report objects for analysis. Query Stripping at document level property is disabled by default.

When you create a Web Intelligence document, by default the Query Stripping is disabled. A power user needs to enable this parameter to strip an object for a specific query. Web Intelligence fails to strip a query if the document level property is enabled and query level property is disabled or vice-versa. Query Stripping works only when Query Stripping is enabled at both Query and document level properties.

Once the Query Stripping is disabled at the document level property, Web Intelligence retains the default pattern of refreshing all the objects selected in the query panel for a specific query sent to the connection server.

1. To enable Query Stripping at the query level for a specified query, select **Enable Query Stripping** in the "Query Properties" tab while creating a Web Intelligence report.

   Note:
   Enable Query Stripping parameter is set only by the Power users who needs to edit Query or create query rights. The user of a report will not be able to set this parameter.

2. To enable Query Stripping at the document level for a specified query, select **Enable Query Stripping** in the Document Properties tab.

As a result, Query Stripping is enabled for a specified query.

Reset contexts on refresh query property

When selected, you are prompted to choose a context each time a query requiring a context is run. When unselected, Web Intelligence retains the context specified the first time you run the query.

Clear contexts query property

When this property is selected, Web Intelligence clears the contexts listed in the list when you next run the query or refresh the data.

Sample result set query property

The **Sample result set** property determines the maximum number of rows that a query returns. The property applies this restriction at the database level. If the database supports sampling, Web Intelligence adds the restriction to the SQL that Web Intelligence generates to return the data.

If you select the **Fixed** option, Web Intelligence uses fixed sampling. At each data refresh, the query returns the same rows. If you do not set the **Fixed** option, Web Intelligence uses random sampling. At each data refresh, the query returns a different set of sampled rows.

Sample result set is more efficient than the **Max rows retrieved** property, which discards rows beyond the maximum limit only after retrieving all the rows in the query.

Not all databases support fixed and random sampling. If they are not supported, the properties are disabled (in the Java Report Panel) or invisible (in Query - HTML). Sampling is not available at all in the HTML Report Panel.

Filtering data using query filters

chapter 5

Query filters defined

You limit the data returned to the document by applying filters when you define the query. Using query filters enables you to secure the data that you don't want specific user groups to see and limits the size of the documents that are stored on your network. When you run the query on the document data, the Web Intelligence returns only the values that meet the query filter definitions.

Query filters limit the data Web Intelligence returns to a document. They retrieve a sub-set of the data from the database and return the corresponding values to the document. You define filters to match business questions. For example, you can filter the [Year] dimension to view only sales revenue for Year 2003; or filter the [Annual Income] dimension to view only customers whose annual income is equal to or greater than $1.5M.

Query filters allow you to:

- retrieve only the data you need to answer a specific business question
- hide the data you don't want specific users to see when they access the document
- minimize the quantity of data returned to the document to optimize performance

Example: In Q4 2002, which stores in my sales region gained margins above $130K?

As Regional Marketing Manager for Texas, you are only interested in analyzing margins for Texas, but the sales universe includes data US-wide. In addition, you only want to view information for stores where margins reached over your 4Q 2002 quarterly target figure: $130K. To create a document with only the information you need, you apply a filter on the [State], [Year], and [Quarter] dimensions and a filter on the [Margin] measure:

AND	Year Equal to 2002
	Quarter Equal to Q4
	State Equal to Texas
	Margin Greater than or equal to 130000

To avoid displaying the filtered values Texas, 2002, and Q4 in the table columns Year, Quarter, and State, you exclude the [Year], [Quarter], and [State] objects from the Result Objects pane. When you generate the report, the report values correspond to Texas stores with 4Q 2002 margins greater than or equal to $130K:

Store name	Sales Revenue	Margin
e-Fashion Houston	307,914	133,802
e-Fashion Houston Leighton	316,232	136,055

Query filters and report filters compared

You can apply filters at two levels within a document:

- query filters – these filters are defined on the query; they limit the data retrieved from the data source and returned to the Web Intelligence document.
- report filters – these filters limit the values displayed on reports, tables, charts, sections within the document, but they don't modify the data that is retrieved from the data source; they simply hide values at the report level.

Types of query filter

You can create the following types of query filter:

- predefined filters – created by your administrator
- custom filters – you define on the query
- quick filters - a simplified form of custom filter for simple filters
- prompts – you define these dynamic filters to display a question or a list of values so you or other users can select different filter value(s) at each run query

You can mix different types of filters on a single query.

Predefined query filters

Predefined filters make the specific data you most typically need for reports permanently available in Web Intelligence. They are created by an administrator and saved with the universe. Predefined filters often contain complex expressions that require a detailed knowledge of the database structure. Including predefined filters on the universe means you don't need to create the same custom filters every time you create new Web Intelligence documents based on the same universe.

As a Web Intelligence user, you cannot view the component parts of predefined filters or edit predefined filters.

To select a predefined query filter

- Double-click the predefined filter or drag it to the **Query Filters** pane.

When you run the query, the data corresponding to the query filters you selected is returned to the report.

Quick filters

Quick filters allow you to quickly define the values you want to retrieve for a specific object without launching the Filter Editor. By default, Quick filters use the Equal to operator if you select a single value or the In list operator if you select multiple values.

For example:

- If you select the [Payment Status] dimension and the value "unpaid? you create the filter: [Payment Status] Equal to "unpaid?

- If you select the [Country] dimension and the values US, Japan, Germany, you create the filter: [Country] In list “US;Japan;Germany?

To create or remove a quick filter

1. Select the column you want to filter.
2. Click the arrow to the right of **Add Filter** on the **Reporting** toolbar and click **Add Quick Filter**.

   The **List of Values** dialog box appears. The values for the selected object are listed.
3. Select the values you want to retrieve from the database.

   For example, to filter the query for values in Q1, select the [Quarter] dimension, then select Q1 from the list of values.
4. Click **OK**

   The new filter appears on the **Query Filters** pane.
5. To remove the filter, click the arrow to the right of **Add Filter** and select **Remove Filter**.

Custom query filters

You create custom query filters to limit document data to information corresponding to:

- a specific business question
- the business information needs of a specific group of users

For example, you can create custom filters to retrieve sales results data for specific dates, products, or services, or to view customer information only for customers who are high wage earners or who live in a particular region.

To add and remove custom query filters

1. Select the object you want to filter and drag it to the **Query Filters** pane.

   The query filter appears in outline in the **Query Filters** pane.
2. Click the arrow next to the default operator (In List) and select the query operator from the list of operators.

3. Click the arrow on the right of the query filter and select the type of filter you want to apply: **Constant**, **Value(s) from List**, **Prompt**, **Object from this query**, **Result from another query, Result from another query (Any)**, **Result from another query (All)**.

Option	Description
Constant	You compare the object against a constant value to filter the query result.
Value(s) from list	You compare the object against values from a list of values to filter the query result.
Prompt	You create a filter which requires the user to supply filter values on data refresh.
Object from this query	You compare the object against the values returned by an object from in the same query.
Result from another query	You compare the object against the values returned by an object from another query (the filtering query) to filter the query result.
Result from another query (Any)	You compare the object against any of the values returned by an object from another query (the filtering query) to filter the query result.
Result from another query (All)	You compare the object against all of the values returned by an object from another query (the filtering query) to filter the query result.

4. Type/select the constant, list of values or object you want to include in the filter.
5. To remove the filter, select it and click the Delete key, or click **Remove** at the top right corner of the **Query Filters** pane. To remove all filters, click **Remove All** at the top right corner of the **Query Filters** pane.

Related Topics

- *What is a prompt?*
- *Filtering a query on values returned from another query*

Filtering a query on values returned from another query

You can filter a query on values returned from another query. For example, if you want to return results for all the countries in Query 1 that have a corresponding country in Query 2, you can filter the `[Query 1].[Country]` object on the values of the `[Query 2].[Country]` object.

The filtered query must be in a universe based on a relational (RDBMS) data source. The query that supplies the filtering values (filtering query) can be based on a relational, OLAP or local data source.

When you are building a query on a query, the filtering query does not appear in the list of queries that can be used as filtering queries until it has been run or saved.

The filtering query is not refreshed when you refresh the filtered query.

The query filter can filter against all or any of the values returned by the filtering query. The supported combinations of operator and filter mode appear in the table below. If you do not choose an operator from the table, the **Result from another query** menu item is not available.

Operator	Filter mode	Description
Equal To	Any	Keep values in the filtered query that are equal to any value returned by the filtering query.
Not Equal To	All	Keep values in the filtered query that are different from all the values returned by the filtering query.
Greater Than Greater Than or Equal To	Any	Keep values in the filtered query that are greater than/greater than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are greater than/greater than or equal to the minimum value returned by the filtering query.
Greater Than Greater Than or Equal To	All	Keep values in the filtered query that are greater than all of the values in the filtering query. In other words, keep values in the filtered query that are greater than/greater than or equal to the maximum value returned by the filtering query.
Less Than Less Than or Equal To	Any	Keep values in the filtered query that are less than/less than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are less than/less than or equal to the maximum value returned by the filtering query.

Operator	Filter mode	Description
Less Than Less Than or Equal To	All	Keep values in the filtered query that are less than/less than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are less than/less than or equal to the minimum value returned by the filtering query.
InList	Any	Keep values in the filtered query that are equal to any value in the list of values returned by the filtering query.
Not InList	Any	Keep values in the filtered query that are not equal to any of the values in the list of values returned by the filtering query.

Query filter and prompt operators

Equal To operator

Use the Equal to operator to obtain data equal to a value.

For example, to return data for the US only, create the filter "County Equal To US".

Not Equal To operator

Use the Not Equal To operator to obtain data not equal to a value.

For example, to return data for all countries except the US create the filter "County Not Equal To US".

Different From operator

Use the Different From operator to retrieve data different from a value.

For example, to retrieve data for all quarters execpt Q4, create the filter [Quarter] Different From "Q4"

Greater Than operator

Use the Greater Than operator to retrieve data greater than a value.

For example, to retrieve data for customers aged over 60, create the filter "[Customer Age] Greater than 60".

Greater Than Or Equal To operator

Use the Greater Than Or Equal To operator to retrieve data greater than or equal to a value.

For example, to retrieve data for revenue starting from $1.5M, create the filter "[Revenue] Greater than or equal to 1500000".

Less Than operator

Use the Less Than operator to retrieve data lower than a value.

For example, to retrieve data for exam grades lower than 40, create the filter "[Exam Grade] Less Than 40".

Less Than Or Equal To operator

Use the Less Than Or Equal To operator to retrieve data less than or equal to a value.

For example, to retrieve data for customers whose age is 30 or less, create the filter "[Age] Less Than Or Equal To 30".

Between operator

Use the Between operator to retrieve data between and including two values.

For example, to retrieve data for weeks starting at week 25 and finishing at 36 (including week 25 and week 36), create the filter "[Week] Between 25 and 36".

Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

Not In List operator

Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

Matches Pattern operator

Use the Matches Pattern operator to retrieve data that includes a specific string or part of a string.

For example, to retrieve customers whose date of birth is 1972, create the filter [DOB] Matches Pattern "72".

Different From Pattern operator

Use the Different From Pattern operator to return data that doesn't include a specific string.

For example, to retrieve customers whose date of birth is not 1972, create the filter [DOB] Different From Pattern '72'.

Both operator

Use the Both operator to retrieve data that corresponds to two values.

For example, to retrieve customers who have both a fixed and a mobile telephone, create the filter [Account Type] Both 'Fixed' And 'Mobile'.

Except operator

Use the Except operator to retrieve data that corresponds to one value and excludes another.

For example, to retrieve customers who have a fixed telephone and do not have a mobile telephone, create the filter [Account Type] 'Fixed' Except 'Mobile'.

The Except operator is more restrictive than `Different From` or `Not In List`. For example, a report that returns customers and that includes the filter `[Lines] Different From 'Accessories'` excludes all sales records where the item sold is part of the 'Accessories' line. If the same customer has purchased Accessories and non-Accessories items, the customer still appears in the report, but their spending total includes only non-Accessories sales.

If the filter is `[Lines] Except 'Accessories'`, only customers who have bought no accessories are included in the report.

Related Topics

- *Not In List operator*

- *Different From operator*

Combining query filters

Combining query filters

Typical business questions require you to retrieve information that matches more than one criteria. For example, if you are analyzing customer services data, you will most likely want to focus on customers for a specific time period and also for a specific region, and probably also for a specific level of customer service contract. You can retrieve data that answers several criteria like this by combining filters in the same query.

Example: Analyze sales revenue this year at stores where the floor size is over 4,000 square feet and sales revenue figures are equal to or less than $1.5M

In this example, you are an operations manager for a retail chain. You want to analyze information about the large retail stores in your chain that are making less than the sales revenue figure your company has set as the target.

To do this you add a predefined filter on the [Year] dimension to specify that you only want to retrieve values for this year. Then you create a second filter on the [Sales Floor Size] dimension to specify that you only want to retrieve data for stores where the floor size is greater than 4,000 square feet. After this, you create a third filter on the [Sales Revenue] measure to specify that you only want to retrieve data for stores where the sales revenue figures are equal to or less than $1.5M. Finally, you combine these three filters with the And operator:

AND	Last Year
	Sales Floor Size Group Greater than or equal to: 4000
	Sales Revenue Less than 1,500,000

When you run the query, only data for stores that satisfy all three criteria will be returned to the report.

To combine query filters

1. Create the filters and add them to the **Query Filters** pane.

   By default, Web Intelligence combines the filters with the AND operator.

2. Double-click the operator (Java Report Panel, Rich Client and Query - HTML) or click the arrow next to the operator checkbox and select the other operator (HTML Report Panel) to toggle between AND and OR.

Nesting query filters

Nesting query filters allows you to create more complex filter conditions than is possible when you combine filters at the same level.

When you nest filters, you set the order in which Web Intelligence evaluates them. For example, Web Intelligence can return the data given by two query filters joined in an OR relationship (where either one filter condition or the other is true) and then further restrict this data by applying another filter to it. In this case, the two filters in an OR relationship are nested, then compared with the other filter in an AND relationship.

The following example illustrates this:

Example: List all sales made in Japan either in Q4 or where the revenue was greater than 1000000

To answer this question you create the following nested query filter:

<table>
<tr><td rowspan="3">AND</td><td>Country Equal To Japan</td><td></td></tr>
<tr><td rowspan="2">OR</td><td>Quarter Equal To Q4</td></tr>
<tr><td>Revenue Greater Than 1000000</td></tr>
</table>

Web Intelligence first returns sales data where the sale was made in Q4 or the revenue was greater than 1000000, then restricts this data further by returning only those sales made in Japan.

To nest query filters

1. Drag and drop a report object onto an existing query filter.

   A query filter outline on the report object appears in a nested AND relationship with the existing query filter.

2. Define the new query filter.

Filtering data using prompts

chapter 6

What is a prompt?

A prompt is a special type of query filter. It is a dynamic filter that displays a question every time you refresh the data in a document. You answer prompts by either typing or selecting the value(s) you want to view before you refresh the data. Web Intelligence retrieves only the values you specified from the database and returns those values to the reports within the document. Prompts allow multiple users viewing a single document to specify a different sub-set of the database information and display it in the same report tables and charts. Prompts also reduce the time it takes for the data to be retrieved from the database.

A prompt contains the following elements:

- a filtered object
- an operator
- a message

For example, to prompt users to select a specific year, you define a prompt on the [Year] dimension:

```
Year Equal To ("Which year?°)
```

In this prompt, the filtered object is [Year], the operator is Equal To, and the prompt message is "Which year?".

You can define prompts on any dimension, measure, or detail object. For example, you can filter the [Year] dimension to return values for a specific year, filter the [Sales Revenue] measure to return values for a range of revenue figures, or filter the [Year/week] detail to return values for a specific week in a year.

You can create multiple prompts, related by the AND or OR operators, in the same query. You can also nest prompts. When the user runs a query, Web Intelligence displays the prompts.

Prompts appear in the SQL generated by a Web Intelligence query as either the value supplied in response to the prompt (when the SQL is read-only), or as Web Intelligence prompt syntax (when the SQL is editable). For example, a prompt on [Country] can appear in the generated SQL as

```
Resort_Country.country  =  @prompt('Enter Country:','A',
'Resort\Country', Mono,Free,Persistent,,User:0)
```

or as

```
Resort_country.country In ('UK')
```

Prompts can be optional. The user is not obliged to specfy a value for an optional prompt. If no value is specified, Web Intelligence ignores the prompt.

Merged prompts

When a document contains multiple data providers, any prompts that include (1) objects with the same data type, (2) operators of the same operator type, and that (3) use the same prompt text are merged.

When all the data providers are refreshed, a single prompt message appears for such prompts.

The List of Values displayed by the merged prompt is the list associated with the object in the prompt that has the most display property constraints.

Cascading prompts

Some objects cause Web Intelligence to display a cascading prompt when they are included in a prompt definition. The universe designer defines the lists of values of these objects hierarchically in relation to other object lists of values in the universe.

Cascading prompts help the user to focus on the object values they want to include in the prompt without the need to search all possible object values.

Example: Choosing a store

In this example the universe designer has defined the [Store Name], [City] and [State] objects in a hierarchy. If you include a prompt `[Store Name] Equal To <value>`, Web Intelligence displays these objects in a hierarchy in the Prompts dialog box. In order to select the store, the user must first select the state in which the store city is found, then the city in which the store is found, then the store itself. When the user selects the state, Web Intelligence restricts the values of City to the cities in the state; when the user selects the city, Web Intelligence restricts the stores to the stores in the city.

Hierarchical lists of values

If your universe contains hierararchical lists of values, these lists appear in tree form. You navigate down through the tree to the items you want.

Whether a list of values appears as a cascading prompt or hierarchically depends on how the list is configured in the universe. See your administrator for more information.

Query filter and prompt operators

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Not Equal To operator

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Use the Between operator to retrieve data between and including two values.

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Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

Not In List operator

Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

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Use the Matches Pattern operator to retrieve data that includes a specific string or part of a string.

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Different From Pattern operator

Use the Different From Pattern operator to return data that doesn't include a specific string.

For example, to retrieve customers whose date of birth is not 1972, create the filter [DOB] Different From Pattern '72'.

Both operator

Use the Both operator to retrieve data that corresponds to two values.

For example, to retrieve customers who have both a fixed and a mobile telephone, create the filter [Account Type] Both 'Fixed' And 'Mobile'.

Except operator

Use the Except operator to retrieve data that corresponds to one value and excludes another.

For example, to retrieve customers who have a fixed telephone and do not have a mobile telephone, create the filter [Account Type] 'Fixed' Except 'Mobile'.

The Except operator is more restrictive than `Different From` or `Not In List`. For example, a report that returns customers and that includes the filter `[Lines] Different From 'Accessories'` excludes all sales records where the item sold is part of the 'Accessories' line. If the same customer has purchased Accessories and non-Accessories items, the customer still appears in the report, but their spending total includes only non-Accessories sales.

If the filter is `[Lines] Except 'Accessories'`, only customers who have bought no accessories are included in the report.

Related Topics

- *Not In List operator*
- *Different From operator*

To create a prompt

1. From the **Data** tab, drag the object on which you want to apply a prompt and drop it onto the **Query Filters** pane.

   The query filter appears in outline in the **Query Filters** pane.
2. Click the arrow at the right of the Query Filter and select **Prompt** from the menu.
3. Type the prompt text in the text box.
4. Click the icon next to the text box and use the dialog box that appears to set the prompt properties.
   - If the prompt is for a date and you want users to see the popup calendar in order to select the date(s) then do not select **Prompt with List of Values**
   - If the document contains multiple data providers, and there is already a prompt that includes (1) objects with the same data type, (2) operators of the same operator type, and (3) that uses the same prompt text as the new prompt, Web Intelligence displays a warning to tell you that the two prompts will be merged. This means that whenever all the data providers are refreshed, a single prompt message will appear for the two prompts.
5. Select **Optional prompt** to make the prompt optional.
6. To delete a prompt, right-click it and select **Remove** from the menu.

The prompt appears at each document refresh.

Related Topics

- *Defining how prompts display*
- *Merged prompts*

To remove a prompt

- Select the prompt and then click the **Delete** key.

Defining how prompts display

By default, prompts display a box and a list of values. You answer the prompt by either typing the value(s) in the box or by selecting value(s) from the list.

You can modify how prompts display by checking one, some, or all of the following options:

If you want the prompt to display...	(useful when you...)	then...
the list of values associated with the filtered dimension, measure, or detail,	want to view all the values for the object and then select from those values	leave the option selected by default: **Prompt with List of Values**
the value(s) specified the last time the prompt was answered (users can select a different value(s)),	often reselect the same value(s) when you refresh the document, but want the ability to select a different value when necessary, such as the name of the current month	select the option: **Keep last values selected**
the value(s) you specify as the default (users can select a different value(s)),	almost always reselect the same value(s) when you refresh the document, but want the ability to select a different value when necessary, such as the number for the current year	select the option: **Set default value(s)**
a list of values from which users select a value(s),	prevent users from typing a value that might not exist on the database	select the option: **Select only from List**

To make the prompt optional, select **Optional prompt**. The user is not obliged to specify a value for the prompt. In this case, Web Intelligence ignores the prompt.

Note:
If the prompt is for a date and you want users to see the popup calendar in order to select the date(s) then do not select **Prompt with List of Values**

Combining prompts

Combining multiple prompts on a single query enables you to filter the data returned to the document so that each person viewing the reports sees only the information relevant to their business need. For example, you can combine the following three prompts on a Customer Accounts document:

- Which customer?
- Which account?
- Which calendar period: from? to?

This enables each accounts manager viewing the document to view report values for a specific customer account during a specific period.

You combine prompts in the same way that you combine query filters.

Combining prompts with query filters

Combining prompts and filters on a single query enables you decide the values for some of the selected objects on the query using filters and allow users to decide the values of other selected objects using prompts. For example, if you combine the following filters and prompts on a HR document:

- [Year] Equal to This Year
- [Job title] Not equal to Senior Executive
- Which employee?

Users viewing the document can choose which employee they view information for, but they can only view data for the current year and they can't view data for senior executives.

To change the order of prompts

1. Click the **Properties** tab in the Query Panel.
2. Select the prompt you want to move up or down in the prompt order in the **Prompt Order** box, then press the Up or Down arrow next to the box.

Using combined queries

chapter 7

Combined queries defined

A combined query is a group of queries that work together to return a single result. All queries in the group must be based on the same universe.

Types of combined query

You can combine queries in three relationships:

- union
- intersection
- minus

In a union combination, Web Intelligence takes the all the data from both queries, eliminates duplicate rows, and builds a combined data set.

In an intersection combination, Web Intelligence returns the data that is common to both queries.

In a minus combination, Web Intelligence returns the data in the first query that does not appear in the second.

Example: Union, intersect and minus queries

In this example you have two queries that return lists of countries as shown in the following table:

Query	Values
Query 1	US; UK; Germany; France
Query 2	US; Spain

Depending on the type of combined query, Web Intelligence returns the following values:

Combination type	Values
UNION	US; UK; Germany; France;Spain

Combination type	Values
INTERSECTION	US;
MINUS	UK; Germany; France

What can you do with combined queries?

Combined queries allow you to answer questions that are otherwise difficult or impossible to frame in a single Web Intelligence query.

Example: Return a data set using a combined query

The Island Resorts Marketing sample universe contains the dimension Year, which returns guests who have already stayed in a resort, and Reservation Year, which returns guests who have reserved to stay in the future. Because of the structure of the database and universe, these objects are incompatible, which means that you cannot include them in the same block in a report.

What if you want to return a single list of years that includes those years where more than n guests stayed in a resort and those years where more than n guests reserved to stay in a resort? You can do this using a combined query, as follows:

Query	Returns
Query 1	Years where more than n guests stayed in a resort
UNION	
Query 2	Years where more than n guests reserved to stay in a resort

The union between these two queries returns the list of years that you want.

How does Web Intelligence generate combined queries?

If your database supports the type of combination in your query, combined queries work at the database level: they alter the query that Web Intelligence submits to the database. They do so by generating SQL (Structured Query Language) queries containing UNION, INTERSECT and MINUS operators.

Note:
SQL is the standard query language of relational databases, although each database has its own dialect.

If your database does not support the type of combination in your query, Web Intelligence performs the query at the report level by generating multiple SQL queries whose data it resolves after retrieval from the database.

To build a combined query

1. Create an initial query in the Query Panel.
2. Click **Add a combined query** on the toolbar.

   Web Intelligence adds a copy of the initial query to the data provider. The second query has the following characteristics:
   - It contains the same report objects as the original query.
   - It does not contain the filters defined on the original query.
   - It is combined with the original query in a UNION relationship.
3. To switch to a query, click **Combined Query n** in the bottom left pane of the Query Panel.

   The individual queries in the combined queries are named Combined Query n.
4. To delete a query, right-click the Combined Query n you want to delete, then select **Remove** on the menu.
5. To change the combination type, double-click on the operator. The operator moves through the sequence UNION, INTERSECTION, MINUS.
6. Build each query within the combined query as you build any normal Web Intelligence query.
7. Click **Run Query**.

Combined query structure

The queries within a combined query must return the same number of objects of the same data type and the objects must be in the same order. You cannot combine queries when the number of objects in the query results and the data types of those objects are not identical. For example, you cannot combine a query than returns Year with a query that returns Year and Revenue, and you cannot combine a query that returns Year with a query that returns Revenue.

You must also pay attention to the semantics of your combined queries. While it is possible to combine a query that returns Year with a query that returns Region if both dimensions are of the same data type, the result - a mixed list of years and regions - is unlikely to be meaningful. Typically, if your first query contains a Year dimension, your second query also contains a dimension that returns a list of years.

To return a list of years and reservation years based on the number of guests

This example describes the workflow for the query described in the example Return a data set using a combined query. You want to build a query that returns a list of years consisting of years where more than n guests stayed in a resort and years where more than n guests reserved to stay in a resort.

1. Select the Island Resorts Marketing universe in the list of universes to open the Query Panel.
2. Drag the Year object to the **Result Objects** pane.
3. Drag the Number of Guests object to the **Query Filters** pane and create a report filter that restricts Number of Guests to greater than n.
4. Click **Combined Query**.

   The **Combined Query** pane appears in the bottom left of the Query panel with the two queries joined by UNION.
5. Click on the second query and remove the Year and Number of Guests objects.
6. Drag the Reservation Year object to the **Result Objects** pane.
7. Drag the Future Guests object to the **Query Filters** pane and create a report filter that restricts the future guests to greater than n.

8. Click Run Query.

The query returns the combined list of years and reservation years.

Related Topics

- *Return a data set using a combined query*

Combined query precedence

The order in which Web Intelligence executes query combinations in a combined query is crucial in determining the final result.

In the simplest form of combined query you combine two or more queries in a relationship as follows:

	Query 1
INTERSECTION	Query 2
	Query 3

In such a case, Web Intelligence first finds the set of data that represents the union/intersection/minus between Combined Query n and Combined Query n + 1, then finds the union/intersection/minus between that data set and the data returned by Combined Query n + 2. Web Intelligence continues in this way through all the queries in the relationship. This gives the following result for the above example:

Query	Data
Query 1	US; UK; France; Germany
Query 2	US; France; Finland
INTERSECTION of 1 and 2	US; France
Query 3	US; Spain
Final INTERSECTION	US

Multiple combined queries

You can combine multiple queries in complex relationships to determine the order of execution, as in the following example:

		Combined Query 1
	MINUS	
INTERSEC TION		Combined Query 2
	Combined Query 3	

Web Intelligence processes query groups from right to left as they appear in the Query Panel, and from top to bottom within each group. (Higher-precedence groups, such as the MINUS group in the above example, appear indented to the right in the Query Panel.) In the above query Web Intelligence first determines the result of the minus combination then finds the intersection of this result with the result of Combined Query 3 as shown in the following table:

Query	Result
Query 1	US; UK; Spain; Germany
Query 2	Germany
Query 1 MINUS Query 2	US; UK; Spain
Query 3	US; Spain; Finland
(Query 1 MINUS Query 2) INTERSECTION Query 3	US; Spain

Note:
If your database directly supports the type of combined query you wish to execute, Web Intelligence generates SQL containing combination operators. In this case the order of precedence depends on the order of precedence defined in the database. See your Web Intelligence administrator for more details.

To set the order of precedence of combined queries in the Java Report Panel

1. Build the first query in the Query Panel.
2. Click **Combined Query**.
3. Repeat these steps until you have built all the component queries.
4. To increase the precedence of a pair of queries, drag and drop a query on to the query with which you want to associate it in the higher-precedence pair.

   Web Intelligence indents the source and target queries in the drag-and-drop operation and combines them by default in a UNION.
5. Continue adding queries to the higher-precedence group by dragging and dropping them on to the space between any two queries already in the group.
6. To create further higher-precedence groups within an existing higher-precedence group, repeat the previous two steps.
7. Double-click the combination operators of all the groups in the query to change them as required.
8. Click **Run Query**.

Filtering data using subqueries

chapter 8

What is a subquery?

A subquery is a more flexible kind of query filter that allows you to restrict values in more sophisticated ways than is possible with a ordinary query filters.

Subqueries are more powerful than ordinary query filters for the following reasons:

- They allow you to compare the values of the object whose values are used to restrict the query with values from other objects.
- They allow you to restrict the values returned by the subquery with a WHERE clause.

What can you do with subqueries?

Subqueries allow you to pose complex questions that are difficult or impossible to formulate with simple query filters. For example: what is the list of customers and their associated revenue where the customer purchased a service that had previously been reserved (by any customer) in Q1 of 2003?

How do subqueries work?

Subqueries work by modifying the SQL that Web Intelligence generates to retrieve the query data. Web Intelligence generates SQL containining a subquery that restricts the data returned by an outer query. For more information on SQL subqueries, see any book on SQL.

Note:
SQL is the query language supported by all relational databases (RDBMS), although each database has its own syntax.

To build a subquery

1. Add the objects that you want to appear in the query to the **Result Objects** pane.
2. Select the object in the Result Objects pane that you want to filter with a subquery and click **Add a subquery** at the top right of the **Query Filters** pane.

The subquery outline appears in the **Query Filters** pane. By default the object you selected appears as the Filter object and Filter By object.

3. To add a WHERE condition to the subquery, drag a report object to the area of the subquery below the Drop an object here boxes.
4. To add a WHERE condition to the subquery, drag a report object to the area of the subquery below the **Drop an object here** boxes.

   You can use an existing subquery or standard query filter as a WHERE condition in a subquery. To do so, drag and drop the existing filter or subquery to the area of the subquery below the Drop an object here boxes. To copy rather than move the existing filter to the WHERE condition, hold down the Control key while dragging and dropping. In this case the existing filter remains in its initial place and becomes part of the WHERE condition of the subquery.
5. Select the operator and values used to filter the object in the WHERE condition.
6. Click **Subquery** to add an additional subquery to the query filter.

   In addition to linking subqueries in AND or OR relationships, you can nest them (create subqueries within subqueries) by dragging an existing subquery to the area beneath the **Drop an object here** boxes. In this case the inner subquery becomes part of the WHERE condition of the outer subquery. To copy rather than move the subquery to the WHERE condition, hold down the Control key while dragging and dropping. In this case the second subquery remains at the same level as the first, and becomes part of the WHERE clause of the first.

   By default the two subqueries are linked in an AND relationship. Click the AND operator to toggle between AND and OR.
7. To nest a subquery (create a subquery within a subquery), drag an existing subquery to the area beneath the **Drop an object here** boxes.

   To copy rather than move the subquery to the WHERE condition, hold down the Control key while dragging and dropping. In this case the second subquery remains at the same level as the first, and becomes part of the WHERE clause of the first

   The inner subquery becomes part of the WHERE condition of the outer subquery.

To find out which customers bought a service that had previously been reserved in Q1 of 2003, and how much revenue have they generated

1. Drag the Customer and Revenue objects to the Result Objects pane of the Query Panel.
2. Select the Service object.
3. Click **Subquery**.

   The subquery outline appears in the Query Filters pane.

   Note:
   The selected object appears in both boxes in the subquery outline. You often use the same object in both boxes, although this is not required. If the objects do not return any common values, the subquery returns no values, and the query therefore returns no values.

4. Drag the Reservation Year object to the area of the subquery outline beneath the Service objects.

   Web Intelligence adds a WHERE condition on the Reservation Year object.

5. Set the Reservation Year condition operator to Equal To.
6. Type ‘FY2003’ in the **Type a constant** box.
7. Drag the Reservation Quarter object to the area of the subquery outline beneath the Service objects.

   Web Intelligence adds the Reservation Quarter object to the WHERE condition.

8. Set the Reservation Quarter condition operator to Equal To.
9. Type ‘Q1’ in the **Type a constant** box.
10. Click **Run Query** to run the query.

Subquery parameters

A subquery or set of subqueries contains the following parameters:

Parameter	Description
Filter Object(s)	The object whose values are used to filter the result objects. You can include more than one Filter Object. If you do, Web Intelligence concatenates the values of the objects you specify.
Filter By Object(s)	The object that determines which Filter Object values the subquery returns. You can include more than one Filter By object. If you do, Web Intelligence concatenates the values of the objects you specify.
Operator	The operator that specifies the relationship between the Filter object and the Filter By object. Because of database restrictions you cannot use certain combinations of operators and Filter By objects together. For example, if you use the Equal To operator with a Filter By object that returns multiple values, the database rejects the SQL because this type of subquery requires the Filter By object to return one value only. In cases where the generated SQL is rejected by the database, you see an error message showing the error description returned by the database

Parameter	Description
WHERE condition (optional)	An additional condition that constrains the list of values of the Filter By object. You can use ordinary report objects, predefined conditions or existing query filters (including subqueries) in the WHERE condition.
Relationship operator	If there is more than one subquery, determines the relationship between the subqueries. AND - the conditions in all of the subqueries must be satisfied. OR - the conditions in any one of the subqueries must be satisfied.

Ranking data using database ranking

chapter 9

What is database ranking?

When you rank data you sort and filter it according to ranking criteria. Web Intelligence allows you to return unranked data from a database, then rank it in Web Intelligence.

A database ranking allows you to specify a ranking at the query and database level so that the data returned to Web Intelligence by the query is already ranked.

Database rankings allow you to answer questions like Return the top 3 customers based on the revenue they generated for each year? at the query level, without the need to return data that falls outside the ranking to Web Intelligence and then filter it using a Web Intelligence ranking.

Database ranking has the following advantages:

- Ranking data can be processing-intensive. By ranking at the database level you allow the server, which is typically far more powerful than the client machine, to perform this processing.
- Pre-ranking data reduces the amount of data retrieved across the network and stored in Web Intelligence.

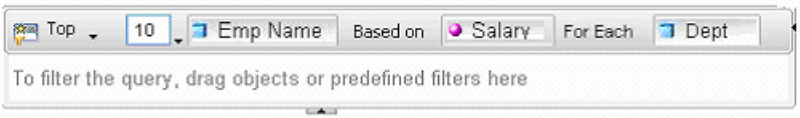
A database ranking works by modifying the SQL that Web Intelligence generates to retrieve the query data. If your database supports ranking, Web Intelligence generates SQL to rank the data. Web Intelligence uses the SQL-99 Rank function in ranking SQL. (SQL is the query language supported by all relational databases (RDBMS), although each database has its own syntax.)

Note:
You can perform a database ranking only if your database supports it. If this is not the case, the **Add a database ranking** button is disabled on the Query Panel toolbar. Databases that support ranking are Oracle, DB2, Terradata and Redbrick.

Related Topics
- *Ranking data*

Database ranking parameters

A database ranking appears as follows in the Query Filters pane of the Query Panel:



The following table describes the parameters from left to right in the ranking:

Parameter	Description
Top/Bottom	Ranking order. • Top - ranks in descending order. • Bottom - ranks in ascending order.
Number of records	The number of records to return in the ranking. For example, the top 10.
Ranking dimension	The dimension used in the ranking. For example, if the dimension is Region and the ranking is Top 10, the ranking returns the top 10 regions.
Based on	The measure by which the ranking dimension is ranked. For example, if the measure is Revenue and the dimension is Region, Web Intelligence ranks regions by the amount of revenue they generate
For Each (optional)	Dimension that specifies additional calculation context for the ranking. For example, if the ranking dimension is Region, the measure is Revenue and the For Each dimension is Country, Web Intelligence ranks regions by revenue within each country.

Parameter	Description
WHERE condition (optional)	Additional restriction on the values returned in the ranking that appears below the other parameters. For example, a ranking of regions with a condition that restricts Country to “USA□? ranks only those regions in the USA.

To create a database ranking

1. Add the objects that you want to appear in your query to the Result Objects pane of the Query Panel.
2. Select the dimension that you want to rank by.
3. Click **Add a database ranking** on the toolbar at the top of the **Query Filters** pane.

   The ranking outline appears in the **Query Filters** pane. The dimension you selected appears as the ranking dimension and the first measure in the query appears as the ranking measure in the **Based on** box.

   Note:
   The **Add a database ranking** button is disabled if your database does not support ranking.

4. Select the ranking direction (Top or Bottom).
5. Type the number of records you want the ranking to return in the box next to Top/Bottom.

   You can specify a prompt instead of a constant by clicking on the arrow next to the number. When you select a prompt the user must enter the ranking number when the query is run.

6. Drag the dimension that provides the calculation context for the measure to the **For Each** box.

   This dimension is optional. To display the **For Each** box, click the arrow to the right of the **Based on** measure.

7. Drag any dimensions that you want to include in the WHERE restriction to the area at the bottom of the ranking.
8. Click **Run Query**.

Related Topics

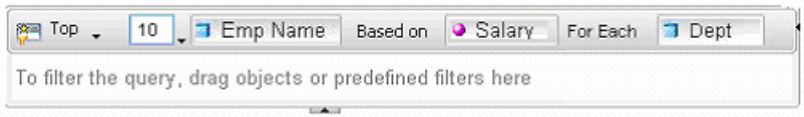
- *What is a subquery?*

To create a report that returns the top 10 employees based on salary, and calculated by department

1. Drag the Department, Employee Name, and Salary objects to the Report Objects pane within the Query Panel.
2. Select the Employee Name object.
3. Click **Add a database ranking** on the toolbar.

   Web Intelligence adds an outline database rank to the Query Filters pane. The ranking dimension is Employee Name and the ranking measure is Salary.
4. Set the ranking direction to Top.
5. Set the ranking number to 10.
6. Click the arrow next to the **Based on** measure if the **For Each** box is not already visible.
7. Set the For Each dimension to Department by dragging and dropping the dimension.

   The ranking now looks like this:



8. Click **Run Query**.

The Java Report Panel reporting interface

chapter 10

By default, the Java Report Panel report interface appears as follows:

- Report tabs - a collection of four tabs at the left of the screen that you use to work with reports.

Tab	Description
Data	Displays the universe objects, formulas and variables that can be included in the report.
Templates	Displays the tables, charts and cells that can be included in the report.
Map	Displays a hierarchical map of the report components (for examples tables, cells, sections, filters).
Properties	Displays the editable properties used to configure the appearance and behavior of the report. The list of properties varies depending on the report component selected.

- Toolbars

Toolbar	Description
Main	You use the main toolbar to switch between query view and report view, to save and print documents, and to activate data tracking and drill mode, and to configure the report interface. The main toolbar is always visible. All the other toolbars can be hidden.
Formatting	You use the formatting toolbar to format text and report objects.
Reporting	You use the report toolbar to add reporting features (for example filters, variables, rankings, calculations).
Page Navigation	You use the page navigation toolbar to navigate through the pages in a report.

- Reports - by default the reports contained in the Web Intelligence document appear to the right of the report tabs and below the toolbars. Each report appears on its own

You can configure the report interface (for example by hiding toolbars or changing the position of the report tabs) by selecting options from the **Configure View** menu on the main toolbar.

Web Intelligence viewing modes

chapter 11

To switch between viewing modes

You can view Web Intelligence reports in different modes depending on how you want to work with data and how you want the data to appear.

1. In Web Intelligence Interactive, select the report tab of the report you want to view.
2. Click the arrow next to the **View** button on the main toolbar above the report.
3. Select the viewing mode.

   Web Intelligence Interactive displays the report in the selected viewing mode.
4. In the Java Report Panel or Web Intelligence Rich Client, use **Switch Page/Quick Display** on the **Reporting** toolbar to alternate between Page mode and Quick Display mode.

Draft mode

Draft mode displays just the tables, reports, and free standing cells in reports.

Use Draft mode when you want to focus on analyzing results, add calculations or formulas, or add breaks or sorts to tables to organize results.

Page mode

Page mode displays the page layout of reports, including page margins, headers, and footers.

Use Page mode when you want to fine-tune the formatting of tables and charts and the layout of report pages.

PDF mode

PDF mode displays the report in PDF format.

Use PDF mode when you want to view the report in PDF format or print the report from within Adobe® Acrobat® Reader®.

Quick Display mode

Quick Display mode is the default display mode in Web Intelligence. It is a pagination mode that is based on the data, rather than the physical size of report pages. Quick Display mode displays just the tables, reports, and free standing cells in reports and displays a maximum number of records vertically and horizontally, depending on the Quick Display settings. Quick Display mode also specifies the minimum page width and height and the amount of padding around the edges of the report.

Because Quick display mode retricts the number of horizontal and vertical rows, a report might not contain all possible data.

Use Quick Display mode when you want to focus on analyzing results, add calculations or formulas, or add breaks or sorts to tables to organize results.

The Quick Display mode properties are configurable either by your administrator in the CMC, or directly in Web Intelligence.

Property	Where config-ured	Notes
Maximum verti-cal records	CMC	
Maximum hori-zontal records	CMC	
Minimum page width	CMC	
Minimum page height	CMC	
Right padding	CMC	

Property	Where configured	Notes
Bottom padding	CMC	
Horizontal records per page	Web Intelligence	• Impacts horizontal tables and crosstabs only • Horizontal tables are never cut vertically • The number of rows in a horizontal table is ignored in vertical records calculation
Vertical records per page	Web Intelligence	• Impacts vertical tables, forms and crosstabs only • The number of rows in a vertical table is ignored in horizontal records calculation

Other notes:

- Table headers and footers do not count as rows.
- Free standing cells and charts do not count as rows.
- Section cells do not count as rows when the section is not empty.
- Sections cells count as vertical rows when the section is empty.
- The Avoid Page Break in Block option has no effect in Quick Display mode

To change Quick Display mode settings in Web Intelligence

You can change the number of horizontal and vertical records per page in Quick Display mode in Web Intelligence.

1. In the Java Report Panel, set the **Page Content** > **Vertical Records per page** and **Page Content** > **Horizontal Records per page** properties.
2. In Web Intelligence Interactive, right-click the report background, select **Format Report** to display the "Format Report" dialog box, and set the **Number of vertical records per page** and **Number of horizontal records per page** in the **General** tab.

To select Enhanced Viewing mode

Your administrator can define minimum page margins, headers and footers that are applied only when you view reports onscreen. This means that the maximum amount of information on report pages is visible when you view reports via your computer screen. To apply the page definition set up by your administrator you need to select Enhanced Viewing mode.

1. Select **Document** > **Properties** (in Web Intelligence Interactive) or right-click a report and select **Document Properties** (in the Java Report Panel or Web Intelligence Rich Client).
2. Select **Enhanced viewing mode**.

Displaying and hiding report data

chapter 12

You can hide and display report data by folding and unfolding the display of different report elements.

You can fold and unfold sections, breaks and tables. Web Intelligence conceals and displays data in different ways depending on the report element.

Report element	Result
Section	When a section is folded, section details are hidden and free cells only are displayed.
Table or break	When a table or break is folded, the rows are concealed and headers and footers only are displayed. (Tables must have headers and footers to be folded and unfolded.) Vertical tables and crosstabs only can be folded and unfolded. **Note:** Folding and unfolding tables and breaks is supported by the Web Intelligence Java Report Panel and Web Intelligence Rich Client only.

To display and hide report data

1. Click **Fold/Unfold** on the report toolbar.

   The Fold/Unfold bar appears to the left of the report.
2. User the icons on the bar, which correspond to and are aligned with individual report elements, to fold and unfold specific report elements.
3. Use the icons at the bottom of the bar to fold and unfold all instances of a type of report element.

Displaying data in tables

chapter 13

Tables in Web Intelligence

When you create a new document and run the query the first time to display the results, Web Intelligence generates a report that includes all of the results in a vertical table. You can modify how the table is organized, remove or add data, change the table type to display the results differently or insert other tables. You can also insert free standing cells to display results in a single cell.

Table types in Web Intelligence

A Web Intelligence report displays results in a block. You can format the block as a specific type of table.

Vertical table

Vertical tables display header cells at the top of the table and the corresponding data in columns. By default, the header cells display the names of the dimensions, details, and measures included in the table. The body cells display the corresponding values.

Lines	Sales revenue	Margin
Accessories	$9,914,546	$3,809,135
City Skirts	$347,775	$132,302
City Trousers	$284,734	$104,346
Dresses	$2,915,620	$1,173,881
Jackets	$677,307	$286,130
Leather	$187,413	$70,599
Outerwear	$1,183,083	$474,302
Overcoats	$436,258	$185,522
Shirt Waist	$4,018,220	$1,616,218
Sweaters	$2,839,035	$1,000,673
Trousers	$903,320	$327,515

Horizontal table

Horizontal tables display header cells at the left of the table and the corresponding data in rows. By default, the header cells display the names of the dimensions, details, and measures included in the table. The body cells display the corresponding values.

Fiscal Period	FY01	FY02	FY03
Sales revenue	$8,095,814	$13,232,246	$15,059,143
Margin	$3,731,971	$5,187,886	$5,667,084

Crosstab

Crosstabs display values for dimensions across the top axis and on the left axis. The body displays the values of a measure that correspond to the cross-section of the dimensions. For example, this crosstab displays values for [Quarter] across the top axis and displays values for [State] on the left axis. The body displays values that [Sales Revenue] for each quarter in each state.

	Q1	Q2	Q3	Q4
California	$1,899,680	$1,760,148	$1,930,517	$1,889,225
Colorado	$525,682	$500,076	$510,777	$523,740
DC	$766,822	$706,447	$692,258	$796,423
Florida	$515,688	$489,998	$387,810	$485,663
Illinois	$846,408	$850,905	$610,765	$714,890
Massachusetts	$312,896	$291,431	$249,529	$429,850
New York	$1,987,115	$2,028,091	$1,672,581	$1,894,435
Texas	$2,875,569	$2,499,277	$2,146,303	$2,596,516

You can include multiple dimensions in crosstabs. For example, this crosstab displays two dimensions. The values for the [Sales Revenue] measure are values each state by quarter for each line.

	Q1	Q1	Q2	Q2	Q3	Q3	Q4	Q4
	City Skirts	City Trousers	City Skirts	City Trousers	City Skirts	City Trousers	City Skirts	City Trousers
California	$7,796	$8,496	$9,075	$1,248	$24,377	$11,924	$33,685	$26,517
Colorado	$726	$2,270	$2,375	$857	$6,421	$2,381	$8,015	$7,468
DC	$2,568	$4,026	$3,564	$1,121	$9,788	$5,338	$8,326	$10,448
Florida	$1,765	$1,737	$2,735		$4,927	$2,511	$7,377	$9,563
Illinois	$588	$2,139	$2,822	$459	$5,552	$5,305	$7,748	$12,987
Massachusetts	$1,194	$532	$2,373		$5,752	$-185	$2,134	$7,565
New York	$10,626	$14,203	$17,241	$1,769	$23,762	$18,689	$28,564	$41,324
Texas	$10,612	$12,604	$22,272	$1,663	$37,119	$20,239	$35,898	$49,539

When you create crosstabs that include a dimension(s) in the body, the body cell values are calculated according to a multi-dimensional data model. The values displayed in the body are calculated according to all of the coordinates on the table axes, whether or not there is a row for the specific coordinate in the SQL result.

	California	Colorado	DC
2001	Colorado Springs	Colorado Springs	Colorado Springs
2001	Los Angeles	Los Angeles	Los Angeles
2001	San Francisco	San Francisco	San Francisco
2001	Washington	Washington	Washington
2002	Colorado Springs	Colorado Springs	Colorado Springs
2002	Los Angeles	Los Angeles	Los Angeles
2002	San Francisco	San Francisco	San Francisco
2002	Washington	Washington	Washington
2003	Colorado Springs	Colorado Springs	Colorado Springs
2003	Los Angeles	Los Angeles	Los Angeles
2003	San Francisco	San Francisco	San Francisco
2003	Washington	Washington	Washington

Forms

Forms are useful in your report if you want to display detailed information per customer, product, or partner. For example, a form is a useful way of displaying individual customer records with information such as the customer account, name, address, and so on.

Forms are also useful for formatting address labels for envelopes.

East Japan

Ishimoto

Customer	Makino
Address	2435 Toyota Ave
Phone Number	3441 3486
Revenue	$257,795.00

Customer	Oneda
Address	94 Toyota Blvd
Phone Number	5183 9463
Revenue	$387,088.00

Structure View and Results View

The Web Intelligence Java Report Panel allows you to make modifications to documents and preview those changes in Structure View, without implementing each change on the Web Intelligence server. This enables you to make multiple formatting changes quickly and preview them. When you return to Results View, Web Intelligence requests the server to apply the changes and returns the modified format in a single operation.

You can create and format tables in either Structure View or Results View. If you have several modifications to make, however, we recommend you make the modifications in Structure View.

Creating and editing tables

To create a table by dragging objects onto a report

1. If the report is empty, select either a single object or a class folder on the **Data** tab, and then drag and drop the object or class onto the report.

2. If the report already contains tables or charts, press the Alt key, then with the Alt key pressed, drag an object onto an empty area of the report.

   A new table header and body cell appears on the report. The table header displays the name of the object.

3. To add another object to the table, drag another object from the **Data** tab and place it to the left or right of the existing column header.
4. When the “Drop here to insert a cell□? ToolTip appears, drop the object onto the left or right of the table header.

   A second column appears before or after the first column. The new column header displays the name of the object.

Web Intelligence displays the values in a vertical table. You can quickly turn the vertical table to a different table format, such as a crosstab by using the Turn To feature.

To create a table by selecting a template

1. Click **View Structure**.

   Working in Structure View allows you to define and preview the new table without requesting the server to apply each of your modifications. You then apply all your modifications and display the results in the new table, by returning to Results View.

2. Click the **Templates** tab.
3. Drag a template from the **Template** tab onto a blank area of the report.

   The template appears on the report.

4. Click the **Data** tab.

   The objects and variables that the document contains appear here. You can add any of these objects or variables to the table.

5. Drag an object or variable onto an empty header or body cell of the table.
6. When the ToolTip “Drop here to replace cell□? appears, drop the object onto the table.

   The empty cell is replaced by the object. If you are working in Results View, the values of the objects display on the table. If you are working in Structure View, the name of the object displays on the table.

7. To add more objects to the template, drag an object from the **Data** tab and drop it onto the template.

Once you have allocated objects to each part of the table template, you can add more objects to increase the size of the table. Each additional object inserts more columns or rows onto the table.

8. To add another object and create an additional table column or row, drag an object from the Data tab and drop it onto a row or column.
   - If you drop the object onto the left of a column, you create a new column before the existing column.
   - If you drop the object onto the right of a column, you create a new column after the existing column.
   - If you drop the object onto the top edge of a row, you create a new row above the existing row.
   - If you drop the object onto the bottom edge of a row, you create a new row below the existing row.
9. If you are working in Structure View, click **View Results** to display the values in the new table.

To duplicate a table

1. Select a table on a report.

   A gray border appears around the table, when the table is selected.
2. Keep your pointer pressed in and press the Ctrl key.

   Web Intelligence creates a duplicate table on top of the original table.
3. With your pointer and the Ctrl key pressed in, drag the duplicate table to an empty area of the report.

   The duplicate table appears on the report.

To apply a different template to a table by using drag and drop

1. Select the report tab that contains the table you want to modify.
2. Click the **Templates** tab.

   If the **Templates** tab is hidden, click the **Show/Hide Manager** button on the Report toolbar. The Templates appear.
3. Drag a template from the Template tab onto a table. You must drop the template directly on the existing report block.

Web Intelligence applies the new template to the table values.

To apply a different template to a table with Turn To

1. To select the table you want to reformat, click the top edge of the table.

   A gray border appears around the table.
2. Right-click the report block.
3. On the shortcut menu, click **Turn To**.

   The "Turn To" dialog box appears.
4. On the **Tables** tab or on one of the **Chart** tabs, select the table or chart template you want to apply to the table.
5. Click **OK**.

If you turned a table to a chart, the unicode font is not retained in the chart if the font for the text on the table was unicode, and if unicode is not defined as your default font for charts. You need to format the chart with the unicode font, if this font is available on your computer. If this is not the case, you need to contact your administrator to configure the Web Intelligence server and your computer appropriately.

To add rows or columns to tables using drag and drop

- Drag the object you want to add to the table from the Data tab, and drop the object where you want to add it:
  - To add the object into a new column to the left of an existing column, drag the object onto the left edge of a column header.
  - To add the object into a new column to the right of an existing column , drag the object onto the right edge of a column header.
  - To add the object into a new row before an existing row, drag the object onto the top edge of a row header.
  - To add the object into a new row after an existing row, drag the object onto the bottom edge of a row header.

  The name of the object appears in the new column or row header, and the values appear in the new body cells.

To add table rows or columns using the Insert row or column toolbar menu

1. Select the table you want to reformat.
2. Select the column or row next to which you want to insert the new column or row.
3. The **Insert column or row** button automatically displays one of the insert options.
4. Click the displayed option or click the arrow next to the **Insert** button, and then select the appropriate option from the drop-down menu.

   Web Intelligence adds a blank column or row to the table.
5. Drag an object from the **Data** tab, and drop the object onto the blank column or row.

   Web Intelligence allocates the selected object to the new column or row. The name of the object displays in the column or row header, and the values for the object display on the body cells.

To remove table rows or columns

- Right-click the table column or row you want to remove and select **Remove Row**, **Remove Column** or **Remove** from the shortcut menu.

To move a row or column

- Drag the selected column or row and drop it before or after another column or row on the table.

  When you drag a row or column, the column or row header displays next to your pointer.

To swap a row or column

- Drag the selected column or row onto the column or row with which you want to make the swap

Web Intelligence swaps the two columns or rows.

To replace a row or column

1. Select the report tab that contains the table you want to modify.
2. Click the **Data** tab.
3. Drag the object you want to add to the table from the **Data** tab, and then drop the object onto the row, column, or body you want to replace.

   The values for the new object display on the table.

To clear cell contents from a table

You can clear cell contents and then use the empty cells to display images, hyperlinks, formulas, or text you type.

You can clear the following types of cell in a table:

- header cells – you can clear each header cell separately
- footer cells – you can clear each footer cell separately
- related body cells – when you clear one body cell, you automatically clear all of the body cells in the same column or row of the table

1. To select the cell you want to clear, click the cell.

   The cell borders are highlighted.
2. Right-click the selected cell.

   The shortcut menu appears.
3. The shortcut menu appears.
4. Click **Clear Cell Contents**.

   Web Intelligence clears the contents from the selected cell(s).

To remove a table

1. To select the table you want to remove, click the top edge of the table.

   A gray border appears around the table.

2. Press the **Delete** key, or right-click the selected table and select **Remove** from the shortcut menu.

Formatting tables and table cells

To select a background color for the table

1. Select the table or table cell for which you want to format a background.
2. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
3. Select the drop-down arrow next to **Appearance** > **Background color**.

   A list of available colors appears.
4. Click the color you want to apply to the selected table or table cell, or click **Custom**, and then create a custom color, using the **Swatches**, **HSB** (Hue, Saturation, Brightness), or **RGB** (Red, Green, Blue) tab, and click **OK**.

   If you know the RGB hexadecimal color reference, you can type the reference into the combo boxes next to the **+** and **-** buttons on the **RGB** tab.

   Web Intelligence applies the background color to the selected table or cell.

To define alternate row and column colors for a table

1. Select the table for which you want to format alternate row colors.

   When the table is selected, a gray border appears around the table.
2. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
3. Open the **Appearance** > **Alternate Row/Column color** property group.
4. Set the frequency for the alternate row color in the combo box next to **Frequency** by clicking the **+** or **-** sign, or by entering a number.
5. Click the arrow next to **Color**.

6. Select a color from the list of colors, or click **Custom**, and then create a custom color, using the **Swatches**, **HSB** (Hue, Saturation, Brightness), or **RGB** (Red, Green, Blue) tab, and click **OK**.

   If you know the RGB hexadecimal color reference, you can type the reference into the combo boxes next to the **+** and **-** buttons on the **RGB** tab.

To insert an image or skin in a table

1. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
2. Click the **...** button next to **Background image** in the **Appearance** property sub-group to display the "Background Image" dialog box.
3. To display a skin, select **Skin** then select the skin from the list.
4. To reference an image using a URL, select **Image from URL** then type the URL.
   - To access an image on the corporate Web Intelligence server, type the image name. Web Intelligence inserts `boimg://` when you click **Apply**.
   - To access an image file directly, click **Image from file**, then click **Browse** to browse to the file.
5. If you chose to reference an image file, use the **Display** and **Position** lists to determine how the image appears.

To format table or cell borders

1. Right-click the table or cell, then select **Format** > **Table** or **Format** > **Cell** from the shortcut menu.

   The **Properties** tab displays the table or cell formatting options depending on which option you selected.
2. Click the **...** button next the the **Text Format** > **Borders** property.
3. Use the buttons in the "Border Editor" dialog box to set the border style.

   You can also set the borders of header cells, body cells and footer cells in the table properties. To do so, click the **...** button next to the **Borders**

property in the **Header cells**, **Body cells** and **Footer cells** property sub-groups.

To format text in table cells

1. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
2. Click the **...** button next to the the **Text format** property in the **Appearance** > **Header cells/Body cells/Footer cells** property sub-group.
3. Format the text in the **Format Text** dialog box.

   You can also format cell text by selecting the cell then setting the **Appearance** > **Text Format** property in the **Properties** tab.

To set cell height and width

You can define the height and width of cells by using drag and drop or specifying the size of cells on the **Properties** tab.

If you want to hide cell contents on reports, you can set the cell width to 0.1 cm so that the cell width can be modified to display the cell contents later.

1. Drag the cell borders until the cell is the height and width you want, or:
2. Click the table.

   The **Properties** tab displays the table formatting options.
3. Set the **Width** and **Height** properties in the **Display** properties group.
4. If you want to set the cell to autofit, select **Autofit Width** and/or **Autofit Height**.

   Some Web Intelligence functions are incompatible with AutoFit cells. If you place any of these functions in an AutoFit cell, Web Intelligence returns the #RECURSIVE error message as the function output.

   You can also set AutoFit cell width and height by double-clicking the cell borders.

   - To set AutoFit cell width, double-click the right border of the cell
   - To set AutoFit cell height, double-click the bottom border of the cell

AutoFit retains the current cell size as the minimum size and enlarges the cell size, if the string or image that the cell contains is larger than the minimum size specified.

Documents that contain tables with the cell size set to AutoFit, take longer to display in the Java Report Panel or InfoView than documents where tables contain cells with a fixed cell width and cell height. We recommend that for large documents, you specify a fixed sized for cell width and cell height for tables.

Effects of autofit and wrap text

The following table lists the effects of the autofit and wrap text features, when used seperately and in combination:

Feature	Effect
Wrap text	Text is wrapped at the end of the cell.
Autofit width	Cell width is adjusted to display all the text.
Autofit height	Cell height is adjusted to display all the text.
Autofit width + autofit height	Cell width and height is adjusted to display all the text
Wrap text + autofit width	Cell width is adjusted to accomodate the longest word. Because the cell height is not adjusted to the number of lines of text, text might be truncated vertically.
Wrap text + autofit height	Cell height is adjusted to accommodate the number of lines of text created by the wrap text. Because the cell width is not adjusted to the longest word, text might be truncated horizontally.
Wrap text + autofit height + autofit width	Cell height and width is adjusted to the text and there is no horizontal or vertical truncation.

To copy formatting using the Format Painter

You can quickly apply the formatting from a report, table or cell to other reports, tables or cells using the Format Painter.

The formatting options applied depend on the objects you choose as the source and target. In general, only properties that affect the visual formatting (for example font style, background color) are applied. Properties that affect the display of data (for example, table properties such as "Avoid duplicate row aggregation" property) are not applied.

1. Select the report, table or cell whose formatting you want to apply.
2. Click the Format Painter to apply the formatting once, or double-click to apply the formatting multiple times.

   The Format Painter is the button furthest to the right on the **Formatting** toolbar.

3. Click the report, table or cell to which you want to apply the formatting.

   Web Intelligence applies the formatting to the report, table or cell you selected. If you single-clicked the Format Painter, it is deactivated.

   If you double-clicked the Format Painter, it remains activated.

4. If you double-clicked, click the Format Painter again or press Esc to cancel the formatting operation. (You can do this before applying the formatting for the first time if you decide to abandon the formatting operation.)

To set the position of a table or chart on the report page

1. Select the border of the table or chart.

   The properties appear in the **Properties** tab.

2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab, then click ... next to the property.
3. Use the "Relative Position" dialog box to set the position.

To layer tables and cells

Layering determines how tables and cells appear when they occupy the same space in a report. An object further forward in the layering order appears over an object further backward in the layering order.

1. Select the table or cell whose layer you want to set.
2. Right-click, click **Order** and click the layering option.

Option	Description
Bring to front	Make the table or cell the first object in the layering order.
Send to back	Make the table or cell the last object in the layering order.
Bring forward	Bring the table or cell one layer forward in the layering order.
Send backward	Send the table or cell one layer backward in the layering order.

To merge table cells

1. Select the cells you want to merge by holding down the Ctrl button and clicking the cells.
2. Select **Yes** next to the **Appearance** > **Text Format** > **Merge Cells** property on the **Properties** tab.

   When you merge cells the merged cell contains the data from the first cell you selected only. Data from all the other cells is lost.

Modifying tables to create crosstabs

To create a crosstab by adding an object to a vertical or horizontal table

1. Drag an object from the **Data** tab onto the top edge of the table or the left side of the table where you want to create the new axis and form the crosstab.
2. When the ToolTip “Drop here to create a crosstab? appears, drop the selected object onto the report.

   Web Intelligence creates a second axis to form a crosstab and inserts the object on the new axis.

To create a crosstab by moving a column or row

1. Select the table column or row you want to move to create the crosstab.
2. Drag the selected column or row onto the top edge of the table or the left side of the table where you want to create the new axis and form the crosstab.
3. Drop the column or row onto the header.

   Web Intelligence creates a second axis to form a crosstab, and displays the data of the column or row you moved on the new axis.

Controlling data display in tables

Showing or hiding empty tables, rows or columns

Sometimes tables or specific rows and columns display no values. For example, if a sales of a specific product are discontinued, table rows or columns that normally show results for that product appear empty. By default, Web Intelligence displays such empty rows, columns, or tables. You can choose to display or hide empty tables, rows or columns.

To show or hide empty tables, rows or columns

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the table formatting options.
2. Select **Display** > **Show when empty** to display empty tables.
3. Select **Display** > **Show rows/columns with empty measure values** to display rows or columns with empty measure values.
4. Select **Display** > **Show rows/columns with empty dimension values** to display rows/columns with empty dimension values.

Aggregating duplicate rows

When rows contain duplicate data, Web Intelligence aggregates measure values by default.

To avoid duplicate row aggregation

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Display** > **Avoid duplicate row aggregation**.

To show or hide headers and footers

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Display** > **Show table headers** to display the headers.
3. Select **Display** > **Show table footers** to display the footers.

To start tables on a new report page

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Start on a new page**.

To display object names in headers on crosstabs

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Click **Display** > **Show object name** to display the object names in additional headers on the crosstab.

To avoid page breaks in tables

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Avoid page breaks in table**.

To repeat table headers or footers on report pages

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Repeat header on every page** to repeat the header on every page.
3. Select **Page Layout** > **Relative Position** > **Repeat footer on every page** to repeat the footer on every page.

Copying tables

To copy a table

You can copy and paste tables within a report or into external applications such as Microsoft Word and Excel. You cannot copy tables from one instance of Web Intelligence to another.

1. Select the table, right-click and select Copy on the menu.
2. To paste the table to another part of the report, right-click where you want the table to appear and click **Paste** on the menu.
3. To paste the table into another application, paste the contents of the clipboard from within the other application.

   You can also copy a table into another application by dragging and dropping the table directly into the open document in the target application.

   The table appears as a picture in the open document if pasted to another application.

To copy a table as text

You can copy the data in a table as plain text into another application. For example, if you copy a table as text into Microsoft Excel, Web Intelligence copies the text in each table cell to a cell in the Excel worksheet. Web Intelligence copies the text to the clipboard as tab-separated text.

1. Select the table, right-click and select **Copy as text** on the menu.
2. Paste the contents of the clipboard into the target application.

   If you choose **Copy as text**, then paste the table into the current Web Intelligence report, the table appears as a normal Web Intelligence table.

Displaying data in free-standing cells

chapter 14

Free-standing cells defined

Free-standing cells are single cells that stand alone in a report. You can place any text or formula in a blank free-standing cell, or you can use pre-defined free standing cells that display specific information.

The free-standing cells are available in the **Templates** tab in the Java Report Panel and Web Intelligence Rich Client, or in the **Table, chart and cell types** tab in the Left Panel in the Web Intelligence HTML viewer.

The available free-standing cells are listed below.

- Formula and Text Cells:
  - Blank Cell - Empty cell in which you can enter any text or formula.
  - Drill Filters - Uses the `DrillFilters` function to display details of the drill filters applied to the report.
  - Last Refresh Date - Uses the `LastExecutionDate` function to display the last date when the document was refreshed.
  - Document Name - Uses the `DocumentName` function to display the document name.
  - Query Summary - Uses the `QuerySummary` function to display details of the queries in the document.
  - Prompt Summary - Uses the `PromptSummary` function to display details of the prompts in the document.
  - Report Filter Summary - Uses the `ReportFilterSummary` function to display the report filters applied to the report.
- Page Number Cells:
  - Page Number - Uses the `Page` function to display the number of pages in the report.
  - Page Number/Total Pages - Uses the `Page` and `NumberOfPages` functions to display the current page number and the total number of pages in the report.
  - Total Number of Pages - Uses the `NumberOfPages` function to display the total number of pages in the report.

For more information on the functions used in free-standing cells, see the *Using Functions, Formulas and Calculations in SAP BusinessObjects Web Intelligence* guide, or see the online help.

To insert a free-standing cell in a report

1. Ensure that the **Templates** tab is displayed.

   You can display the Templates tab by selecting **Configure View** > **Data** on the main menu.

2. Expand the **Report Elements** > **Free-Standing Cells** element in the **Templates** tab to display the free-standing cells.

   The free-standing cells are divided into two groups: **Formula and Text Cells** and **Page Number Cells**.

3. Drag the free-standing cell you want onto the report.
4. Add your own text or formula iif the cell you inserted is a blank cell.
5. Right-click the cell and select **Edit Format** to display the cell format properties on the **Properties** tab.
6. Set the properties on the **Properties** tab to format the cell.
7. To delete the cell, select it and click the Delete button.

To copy a free-standing cell

You can copy and paste free-standing cells within a report or into external applications such as Microsoft Word and Excel. You cannot copy free-standing cells from one instance of Web Intelligence to another.

1. Select the free-standing cell, right-click and select **Copy** on the menu.
2. To paste the free-standing cell to another part of the report, right-click where you want the free-standing cell to appear and click **Paste** on the menu.
3. To paste the free-standing cell into another application, paste the contents of the clipboard from within the application.

   You can also copy a free-standing cell into another application by dragging and dropping the free-standing cell directly into the open document in the target application.

   The free-standing cell appears as a picture in the open document if pasted to another application.

To copy a free-standing cell to another application as text

You can copy the data in a free-standing cell as plain text into another application. For example, if you copy a free-standing cell as text into Microsoft Excel, Web Intelligence copies the text in the free-standing cell to a cell in the Excel worksheet.

1. Select the free-standing cell, right-click and select **Copy as text** on the menu.
2. Paste the contents of the clipboard into the target application.

   If you choose **Copy as text**, then paste the free-standing cell into the current Web Intelligence report, the free-standing cell appears as a normal Web Intelligence free-standing cell.

Organizing data with sections, breaks and sorts

chapter 15

Using sections to group data

Grouping information with sections

Sections allow you to split report information into smaller, more comprehensible parts.

Example: Grouping quarterly revenue results into sections on a report

You are the regional sales manager in Texas. You receive a report showing 2003 annual revenue for stores in your region, broken down by cities and quarters.

City	Quarter	Sales revenue
Austin	Q1	314430
Austin	Q2	273608
Austin	Q3	294798
Austin	Q4	252644
Dallas	Q1	215874
Dallas	Q2	194689
Dallas	Q3	204066
Dallas	Q4	188791
Houston	Q1	572177
Houston	Q2	619924
Houston	Q3	533765
Houston	Q4	520332

To make a comparison of the results for each city per quarter, you set [Quarter] as a section value. The report is broken up into four separate sections by quarter.

Q1

City	Sales revenue
Austin	314430
Dallas	215874
Houston	572177

Q2

City	Sales revenue
Austin	273608
Dallas	194689
Houston	619924

Q3

City	Sales revenue
Austin	294798
Dallas	204066
Houston	533765

Q4

City	Sales revenue
Austin	252644
Dallas	188791
Houston	520332

You can create a single section or include multiple sections with subsections in a report. You can also remove and reposition sections within a report.

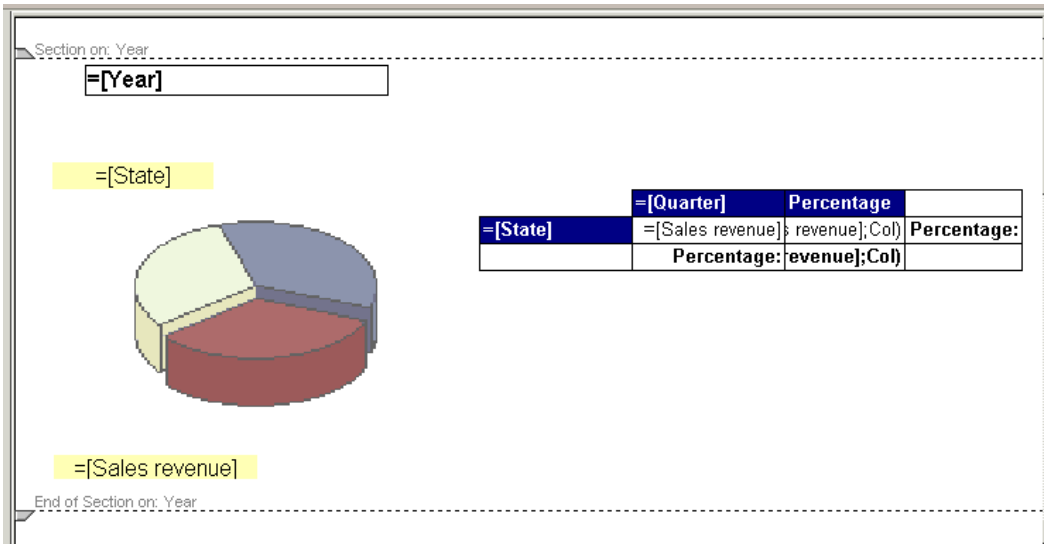
You can create a section from one of two sources:

- on a dimension already displayed on a table or chart
- on a dimension included in the document but not displayed on a table or chart

You cannot create a section with a measure object.

Sections in Structure View

The following illustration shows a report with sections in Structure View. When you view a report in Structure View, each section is clearly indicated by a section divider.It is easier to format sections when you work in Structure View.



Creating and removing sections and subsections

To create a section by moving a cell from a table

1. Verify you are viewing the report in Report View.
2. Select the header cell on the table that displays the name of the dimension, or select a body cell on the table that displays a value for the dimension.

   For example, if you want a section for each state, either select the header cell labelled “State□? or select one of the cells that displays the name of a state.
3. Drag the selected cell above the table and drop it onto the report background.

   A section is created for each value of the selected dimension.

To create a section by adding a dimension from the Data tab

1. Click the **Data** tab.

2. Select a dimension object and, then drag the dimension over to an empty area of the report.
3. Position and drop the dimension where you want the section cell to appear.

   If the report includes tables or charts, then drop the section cell above the tables and charts that you want to be included in the section.

   - If you are in Results View, a cell containing one value for each unique value for the added object appears above the table or crosstab. The data in the table or crosstab is automatically sorted according to the cell value.
   - If you are in Structure View, a cell is added above the table or crosstab.
4. If you are in Structure View, click **View Results** to see the results.

   Web Intelligence applies the section to the report and displays the results.

Creating subsections

You can create a report with multiple sections. You create multiple sections in the same way you create a section:

- by moving a cell from a table and dropping the cell below an existing section cell
- by selecting a dimension object listed on the **Data** tab (in the Java Report Panel or Web Intelligence Rich Client) , and then dragging and dropping the dimension below an existing section cell.

To remove a section cell or section

1. To delete a section, click the beginning or end divider of the section, then press the **Delete** key.
2. To delete a section cell, right-click the cell, then select **Remove** from the menu.

Section properties

You can set the following properties for a section:

- name the section
- specify your criteria for when you consider a section to be empty. (For example, you may consider a section of no interest for your analysis

whenever a specific table or chart within that section is empty. In this case you can choose to specify that the section is to be considered empty.)

- hide or show sections that you consider empty
- include links to sections in the report map so you can jump from section-to-section when navigating the report

To set the section display properties

1. Make sure you are in Report View.
2. Click **View Structure**.

   In Structure View you can see the start and end divider of each section on the report. This makes it easy for you to select a specific section and then choose the properties you want to apply to the selected section.
3. Right-click the section divider.

   The **Properties** tab shows the properties relevant to sections
4. Set the section properties.

If you want to...	then...
Name of the section with a different name from the name of the dimension selected for the section,	type a name for the section in the **General** > **Name** property.
Specify the component(s) of the section that will qualify the entire section as an “empty section,□? if there is no data on the database for that component(s),	Check the components in the drop-down list next to the **Display** > **Hide section when empty** property.
Show the section when there is no data on the database for this section,	check **Show when empty**. (To hide empty sections, uncheck this option.)

5. Click the **View Results** button to view the properties applied to the results on the report.

   Web Intelligence applies the properties to the section and displays the results on the report.

To set the page layout for a section

1. To set the cell position, right-click the section cell then click **Format** on the menu, then set the **Page Layout** > **Relative Position** > **Left edge** and **Top edge** properties on the **Properties** tab.
2. To control the section page breaks, select the section divider, then set the **Page Layout** > **Avoid page break in section** property in the **Properties** tab.
3. To repeat the section cell on each new page, select the section, then select **Page Layout** > **Start on new page** on the **Properties** tab.

Using breaks

Breaks defined

A break is a division within a block in which data is grouped according to a selected dimension, detail, or measure into self contained sections. These sections are represented as smaller tables within the same block of data.

You use breaks to display all the data for each unique value of an object in separate parts.

Using breaks has two main advantages:

- You can more efficiently organize how your data is represented.
- You can display subtotals.

Breaks compared to sections

A section breaks up the data into multiple free-standing cells called section headers. Each section header contains one value for a dimension, with a block of data that corresponds to the dimension value.

A break divides the data up within one block. One column contains the values for a dimension, detail, or measure, which are repeated for each other row of values in the block.

Default sort order in breaks

When you insert a break on an object, the values for the object are automatically sorted in ascending order as follows:

- If the values are numeric, the lowest value appears in the first row of the table, the highest in the last row.
- If the values are alphabetical characters, then the values are sorted in alphabetical order from top to bottom.

You can change this sort order at any time.

You can set multiple breaks and set a sort priority on each break, so that you control how the data is displayed when you insert multiple breaks across several dimensions details, or measures.

To insert a break

1. Click a table cell in the column or row where you want to insert a break.
2. Click **Insert/Remove Break** on the Reporting toolbar.

   Web Intelligence divides the table up into as many mini tables as there are unique values for the selected cell. Web Intelligence inserts a footer at the end of each break.

To prioritize breaks

A table can contain multiple breaks that you can prioritize. For example, you can decide to break on [Year] then on [Quarter], or on [Quarter] then on [Year].

1. Right-click the table that contains multiple breaks and select **Format** > **Table**.

   The **Properties** tab shows the properties relevant to a table.
2. Click the **...** button next to the **Breaks** > **Break priority** property to display the "Breaks" dilaog box
3. Click **Vertical breaks** or **Horizontal breaks** to display the type of break you want to prioritize.

- If the selected table is a vertical table, then all the breaks are applied to columns. These are called Vertical breaks.
- If the selected table is a horizontal table, then all the breaks are applied to rows. These are called Horizontal breaks.
- If the selected table is a crosstab, then breaks can be applied to rows or to columns. You can choose the priority for the Horizontal breaks and for the Vertical breaks.

4. Select the break whose priority you want to change and click the Up/Down buttons to promote/demote the break in the list of breaks.

To define display properties of a break

You can define the following display properties of a break:

Property	Description
Show break header	A header is displayed for each part of the table, crosstab, or form when you insert a break.
Show break footer	A footer is added after the last row for a table or column for a crosstab when you insert a break. When you apply a calculation to the data, the result is shown in the footer.
Remove duplicate values	Removes all duplicate values from the data in a table or crosstab when you insert a break. Each value is only shown once.
Center values across break	Active when **Remove Duplicates** is selected. It merges empty cells and centers the value name over the merged cells.
Apply implicit sort to values	

Property	Description
Start on a new page	Displays each part of the table crosstab, or form created by a break on a new page.
Avoid page breaks in tables	Where possible, keeps each break section on the same page. This option is not taken into account when a block is larger than one page.
Repeat header on every page	Repeats the header at the top of the table on every new page when a table goes over onto a new page.
Repeat footer on every page	Repeats the footer at the bottom of the table on every new page when a table goes over onto a new page.
Repeat break value on a new page	Repeats the current value on each new page.

1. Click a cell in the column/row on which you have defined a break.
2. Open the **Breaks** property group in the **Properties** tab.
3. Set the break properties in the **Breaks** property group.

   Some of the properties are contained in the **Breaks** > **Page layout** property subgroup.

To remove a break

1. Select the column that contains the break.
2. Click **Insert/Remove Break** on the **Reporting** toolbar.

Using sorts to organize data

Sorting the results displayed on reports

You can apply sorts to the values displayed in tables and sections to organize the order in which values are displayed in a report.

The following sort orders are available:

Sort order	Description
Default	This is sometimes referred to as the natural order. Depending on the type of data in the column or row, the results are sorted as follows: • ascending numeric order for numeric data • ascending chronological order for date • Chronological order for months • alphabetical order for alphanumeric data
Ascending	When selected, results are arranged in ascending order: The smallest value at the top of the column moving to the highest value at the bottom. For example: 100, 200, 300 or California, Colorado, Florida.

Sort order	Description
Descending	When selected, results are arranged in descending order: The highest value at the top of the column moving to the smallest value at the bottom. For example: 300, 200, 100 or Florida, Colorado, California.
Custom (available in the Java Report Panel)	You define your own sort order.

To apply an ascending or descending sort

1. Select the section cell or table cells you want to sort.
2. Click the down arrow next to the **Apply/Remove Sort** button on the Report toolbar and then, select **Ascending** or **Descending** from the drop-down list.
3. Repeat the previous step to apply multiple sorts.

To apply a custom sort

1. Select the section cell or table cells you want to sort.
2. Click the down arrow next to the **Apply/Remove Sort** button on the Report toolbar then select **Custom sort** from the drop-down list.
3. Select a value in the list of sorted values and click the **Up** and **Down** buttons to promote/demote it in the sort order.
4. To add an additional temporary value to the list of sorted values, type the value in the **Temporary Values** box, then click **>>** to add it to the sort list.

To prioritize multiple sorts

1. Right-click the table and select **Format** > **Table** to display the **Properties** tab.
2. Click the **...** button next to the **Sorts** > **Sort priority** property to display the "Sorts" dialog box.
3. Click **Vertical sorts** to display the vertical sorts or **Horizontal sorts** to display the horizontal sorts.
4. Select the sort whose priority you want to change and click the **Up/Down** buttons to promote/demote it in the list of sorts.

Displaying data in charts

chapter 16

Creating charts

You can include one or multiple charts on the reports in a Web Intelligence document. You can create a chart when you build or new document or insert charts into an existing document.

If you are building a new document, you need to define the data definition of the document by building a query before you select a chart template.

Once you have defined the query you go to Report View to define the chart(s) on report(s).

To create a chart, you follow three steps:

- select a chart template
- allocate dimensions and measures to the chart axes
- view the results displayed on the chart

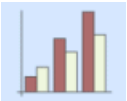
If you want to create a chart that displays the same data as a table on a report, you can copy the table first and then turn the duplicate table into a chart using the "Turn To" dialog box.

Chart types in Web Intelligence

A Web Intelligence report displays results in a block. You can format the block as a specific type of chart.

Bar charts

Bar charts display data in bar form, either vertically or horizontally. Bar charts are useful if you want to compare similar groups of data; for example one time period to another. There are five types of bar charts: grouped, bar and line, stacked, percent, and 3D.



2D bar charts include the optional Z-Axis. Including data on the Z-Axis enables you to show an additional break down of the results displayed on the chart bars.

3D bar charts do not include an axis legend. You can clearly see what information is displayed on the chart bars by looking at the axis labels.

Line charts

Line charts connect specific data values with lines, either horizontally or vertically. Line charts are useful if you want to show trends or changes in data over time. There are five types of line charts: mixed, stacked, percent, 3D, and 3D surface.

Area charts

Area charts are line charts in which the area between the lines and axis are filled in. Area charts are useful if you want to emphasize the size of the total data in a report, as opposed to the changes in the data. You may not want to use an area chart if you have a sharp contrast between specific data points. Use a line chart instead.

You can use more than one measure object on the Y-axis as long as the measures are of the same type and scale; for example, Number of Guests, and Future Guests. There are five types of area charts: absolute, stacked, percent, 3D area, and 3D surface.

Pie charts

Pie charts display data as segments of a whole. Pie charts are useful if you want to show how each part of your report data contributes to the total.

Pie charts have a single axis displayed on the body of the pie. This is the Y-Axis. Each segment of the pie chart displays a value for the measure on the Y-Axis. The pie chart legend indicates the dimension on the X-Axis.

You can only include one measure object in a pie chart. If you have several measures in your report, you should choose another chart type. There are four types of pie charts: pie, 3D pie, ring, 3D ring.

Radar, polar and scatter charts

In radar charts, the X- and Y-axis connect at the chart's center. Radar charts are useful if you want to look at several different factors related to one item. For example, you could use a radar chart to display revenue data for different services within a hotel. On one axis, you could display revenue for the rooms. On another you could display revenue for the restaurant, and so on.

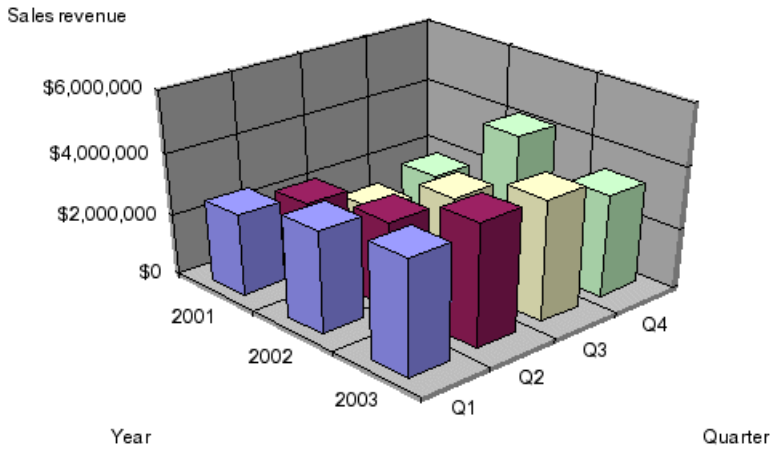
Scatter charts are similar to line graphs, except that the data points are plotted without a line connecting them. Scatter charts are useful if you want to make a comparison between specific data points.

There are four types of radar, polar, and scatter charts: radar line, stacked radar, polar, and scatter.

3D charts

3D charts include three axes: the Y-Axis always displays values for measures (such as sales totals, margins, quantities and so on); the X- and Z-Axis

display values for dimensions (that is, key indicators, such as time, geography, service lines, and so on). In the 3d bar chart displayed below, the chart bars display sales revenue per quarter, per year. The [Sales revenue] measure is on the Y-Axis, the [Quarter] dimension is on the X-Axis, and the [Year] dimension is on the Z-Axis



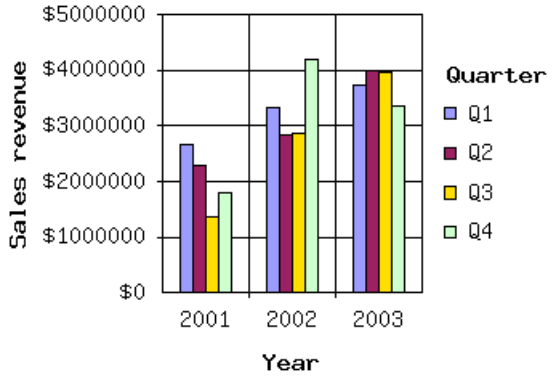
The same data can be displayed in a 2D bar chart.

Related Topics

- *2D charts*

2D charts

The 2D bar chart below includes an optional Z-Axis with the values for quarter. Including data on the Z-Axis enables you to show an additional break down of the results displayed on the chart bars. The [Sales revenue] measure is on the Y-Axis, the [Year] dimension is on the X-Axis, and the [Quarter] dimension is on the Z-Axis. Notice that because the Z-Axis cannot be represented graphically on a 2D chart, the legend provides the information for the Z-Axis values.



The same data can be displayed in a 3D bar chart.

Related Topics

- *3D charts*

Adding, copying and removing charts

To add a chart to a report

It is recommended you work in Structure View when you insert a new chart. This is because Results View is designed to display the data contained in reports. Therefore, you can only view charts in Results View after you have allocated dimensions and measures to the empty chart template.

1. Click **View Structure** on the report panel toolbar.
2. Click the **Templates** tab.
3. Select the chart template drag it onto an empty area of the report.

   The empty template appears on the report.
4. Click the **Data** tab.
5. Drag a dimension or measure object onto the chart axis, where you want the results for that dimension or measure to appear on the chart.
6. Drop the dimension or measure onto the axis when the “Place dimension objects here□? or the “Place measure objects here□? ToolTip appears.

7. To allocate more dimension and measure objects to each chart axis, repeat the previous two steps.
8. To display the results in the chart, click the **View Results** button on the Report toolbar.

   The chart displays the results corresponding to the objects you allocated to the chart axes.

To copy a chart

1. Select the chart, right-click and select **Copy** on the menu.

   Web Intelligence copies the chart to the clipboard.
2. To paste the chart to another part of the report, right-click where you want the chart to appear then click **Paste** on the menu.
3. To paste the chart into another application, paste the contents of the clipboard from within the other application.

   You can also copy a chart into another application by dragging and dropping it directly into the open document in the target application.

   The chart appears as a picture in the open document if pasted to another application.

To remove a chart

- Right-click the chart and click **Remove**, or verify that the **Data** tab is displayed, then drag the chart from the Document pane and drop it onto the **Data** tab.

Changing the chart type

To change the chart type by using drag and drop

1. Click the **Templates** tab.
2. Drag a template onto the chart or table you want to modify. You must drop the template directly on the existing report block. If you drop the template outside the existing report block, you create a separate chart.

3. If you want to move the dimensions or measures to different axes, click the **View Structure** button on the report panel toolbar, then drag the objects you want to move onto the **Data** tab, and then drag and drop the objects you want to display on the chart from the **Data** tab onto each chart axis

To change the chart type by using TurnTo

1. Right-click the table or chart.
2. Click **Turn To**.

   The "Turn To" dialog box appears.
3. Click the tab corresponding to the chart type you want, then click a format.
4. Click **OK**.

   If the new chart type does not have data allocated to both the X-axis and the Y-axis, the chart will not appear when you view the report in Results View or in Drill mode. In this case, click the **View Structure** button on the report panel toolbar, and then click the **Data** tab and drag the appropriate dimensions or measures onto the axes on the new chart template. When you click **View Results**, the chart appears.

   If the font for the text on the table was unicode, and if unicode is not defined as your default font for charts, the unicode font is not retained in the chart. You need to format the chart with the unicode font if available on your computer. If this is not the case, you need to contact your administrator to configure the Web Intelligence server and your computer appropriately.

   Web Intelligence applies the selected template to the block and displays the data in the chart type you chose.

Positioning and sizing charts

To set the position of a table or chart on the report page

1. Select the border of the table or chart.

   The properties appear in the **Properties** tab.

2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab, then click ... next to the property.
3. Use the "Relative Position" dialog box to set the position.

To position a chart in relation to another chart or table

If you have more than one block (table, chart, or form) in your report, you can use relative positioning. Relative positioning allows you to position a selected block (for example, a chart) in relation to other blocks in the report.

If new data on the database modifies the size of the tables or charts, relative positioning ensures that the different tables and charts display correctly without overlapping each other.

Note:
If you position a chart in relation to another block (that is, a chart, table, or form), the position of the related block changes automatically, if you reposition the chart.

1. Right-click the chart and click **Format**.
2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab.
3. Click **...** next to the **Relative Position** property to open the **Relative Position** dialog box.

   If the report does not contain multiple elements, the Relative Position dialog box is not available.
4. Select the distance of the upper left point of the chart in relation to another report element by entering - the number of pixels; the part of the other report element from which you want to measure the pixels (in the first drop-down list); the report element from which you want to measure the pixels (in the second drop-down list).
5. Repeat this for the distance of the lower left point of the chart.

To resize a chart

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.

3. Type the chart width in the **Width** property and the height in the **Height** property.

Formatting charts

To insert and format a chart title

1. Right-click the chart and click **Format**.
2. Click **Yes** next to the**Appearance** > **Title** property.

   The property becomes a property group.
3. Open the **Title** property group and type the title in the **Text** property.
4. Click **...** next to **Text Format** and use the **Format Text** dialog box to format the title.
5. Click **...** next to **Borders** and use the Border Editor dialog box to format the title borders.
6. Select the title background color from the **Background color** list.

To display a chart with a 3D look

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.
3. Select **3D look**.

To add background colors to a chart

1. Right-click the chart and click **Format**.
2. Open the **Appearance** property group on the **Properties** tab.
3. Click the arrow next to **Background color** to display the color palette.
4. Select a color from the color palette or click **More Colors** to display the **Choose Color** dialog box.

To modify chart borders

1. Right-click the chart and click **Format**.
2. Click ... next to **Appearance** > **Borders**.
3. Use the Border Editor dialog box to format the borders.

To select and format chart floors and walls

Floors and walls give depth to charts and help to set off the data displayed on the chart bars or lines. 3D charts have a floor, a left wall, and a right wall. 2D charts just have a floor. You can specify a color for the floor and walls.

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.
3. Select **Show floor** to display the chart floor, **Show left wall** to display the chart left wall and **Show right wall** to display the chart right wall.

   The availability of these options depends on the type of chart.
4. Set the wall and floor color by clicking the **Wall color** and **Floor color** properties in the **Appearance** property group and using the "Color Palette" or the "Choose Color" dialog box to set the color.

To show and format axis legends

1. Right-click the report and select **Format**.
2. Click **Yes** next to the**Appearance** > **Legend** property.

   The property becomes a property group.
3. Open the property group and select the legend position from the **Position** list.
4. Use the **Title** and **Values** subgroups to set the legend title and format the title and legend values.

To avoid page breaks in charts

1. Right-click the chart and click **Format**.

2. Open the**Page Layout** property group on the **Properties** tab.
3. Select **Avoid page breaks in chart**.

To show axis labels on pie charts

1. Right-click the chart and select **Format**.
2. Open the **Appearance** > **Data** > **Values** property group.
3. Select **Show segment labels**.

To format axis label text, borders, and background

1. Right-click the chart and click **Format**.
2. Click **Yes** next to the **Appearance** > **X/Y/Z Axis > Label** property.

   The property becomes a property group and the object name appears on the label.
3. Select **Show object name** to show the object name on the label.
4. Type the text into **Other label** if you want to assign custom text to the label in place of the object name.
5. To format the text, click **...** next to **Text Format** to open the "Text Format" dialog box.
6. Use the "Text Format" dialog box to format the text.

   You can set many of the properties in the "Text Format " dialog box directly from the property list, where they appear beneath **Text Format**.
7. Click **...** next to **Borders** and use the "Border Editor" to format the label borders.

To show, hide or format the axes grid

1. Right-click the chart and select **Format**.
2. Click **Yes** next to **Appearance** > **X/Y/Z** > **Grid** in the **Properties** tab to show the grid.
3. Select **Appearance** > **X/Y/Z** > **Grid** > **Show markers** to show the grid markers.
4. Select**Appearance** > **X/Y/Z** > **Grid** > **Grid color** to select the grid color.

Displaying and formatting chart data

To show a chart when empty

Sometimes charts display no values. For example, if sales of a specific product are discontinued, a chart that normally displays results for that product will appear empty. By default, Web Intelligence displays such empty charts on reports. If wished, you set Web Intelligence to hide charts whenever they are empty.

1. Right-click the chart and click **Format**.
2. Open the **Display** property group in the **Properties** tab.
3. Select **Show when empty**.

To specify a color palette for the chart data

1. Right-click the report and select **Edit**.
2. Open the **Appearance** > **Data** property group in the **Properties** tab.
3. Click **...** next to **Palette** to display the "Choose Palette" dialog box and select one of the predefined palettes in the **Predefined Palettes** list.
4. To edit a pallete, select the pallete, then click **Edit Pallete**.

   The "Edit Palette" dialog box opens
5. Select a color in the palette.

   The "Custom Color" dialog box opens.
6. Create a custom color using the **Custom Color** dialog box, then click **OK**.
7. To set all the colors in the palette to the same color, click **Set All Colors**.

To format axis values numbers and text

1. Select the chart and click **Format**.
2. Open the **Appearance** > **Values** property group in the Properties tab.
3. Click **...** next to the **Number format** property to display the **Number Format** dialog box.
4. Use the "Number Format" dialog box to define the format.

5. Click **...** next to the **Text Format** property to display the "Text Format" dialog box.
6. Use the "Text Format" dialog box to format the text.

   You can set many of the properties in the "Text Format" dialog box directly from the property list, where they appear beneath **Text Format**.

To define the axis value frequency

1. Right-click the chart and click **ormat**.
2. Open the **Appearance** > **X/Y/Z Axis > Values** property group in the **Properties** tab.
3. Select **Automatic frequency** to set the frequency to automatic.
4. Type the frequency in **Frequency** to set the frequency to a specific value.

   Automatic frequency must be unselected before you can type a custom frequency.

   When you set the frequency to n, Web Intelligence displays every n values on the axis.

To show a specific range of axis values

1. Right-click the report and click **Format**.
2. Open the **Appearance** > **X/Y/Z Axis > Scale** property group on the **Properties** tab.
3. Enter the minimum value in **Min. value** and the maximum value in **Max. value**.

   Web Intelligence displays the minimum and/or maximum values you specified on the axis.

   Web Intelligence enables you to auto scale Y-axis by calculating the nearest value for the maximum and minimum range of values set for each chart block in a given report. Auto scale Y- axis is applicable for all kinds of charts, except the pie-chart.

   To enable auto scale Y-axis select **Auto Scale** in the chart **Properties** tab. After enabling the autoscale Y-axis, the minimum and maximum range of values set for a document initially is not displayed.

To show or hide data values

1. Right-click the chart and select **Format**.
2. Open the **Appearance** > **Data** > **Values** group in the **Properties** tab.
3. Select **Show data** to show the data.

To vary the data markers for each result

1. Right-click the chart and select **Format**.
2. Open the**Appearance** > **Data** property group in the **Properties** tab.
3. Select **Vary data markers**.

   You can only vary the data markers for each result on the following chart types: 2D Line charts, 2D Bar and Line charts, and Radar charts.

Linear and logarithmic axes scales

By default, Web Intelligence displays the Y-axis on charts as a linear scale. You can set the axis to a logarithmic scale. Logarithmic scales allow you to examine values that span many orders of magnitude without losing information on the smaller scales.

In a linear scale, the axis markers are evenly spaced. Linear scales are based on addition. Consider, for example, the linear sequence: 1, 3, 5, 7, 9

To get the next number in the sequence, you add 2 to the previous number.

Logarithmic scales are based on multiplication rather than addition. In a logarithmic scale, the steps increase or decrease in size. Logarithmic scales are based on multiplication (or division). Consider, for example, the logarithmic sequence: 2, 4, 8, 16, 32

To get the next number in the sequence, you multiply the previous number by 2. We can say that this sequence represents ``base 2."

Consider the following sequence: 1, 10, 100, 1000, 10000

This sequence represents ``base 10," because you get the next term in the sequence by multiplying the previous term by 10.

To display the Y Axis logarithmically

1. Right-click the chart and select Edit Format.
2. Open the **Appearance** > **Y Axis** > **Scale** property group in the **Properties** tab.
3. Select **Logarithmic**.

   A logarithmic scale uniformly presents percent changes rather than point changes. In other words, the distance from 1 to 2 (100% increase) is the same as the distance from 2 to 4 (another 100% increase).

Formatting numbers and dates

chapter 17

Predefined and custom formats

You can change how values display in specific cells or on chart axes. You do this by applying predefined formats available in Web Intelligence or by creating your own custom formats. You can save your custom formats for reuse on multiple blocks and reports in the same document.

Predefined formats

You can change how values display in specific cells or on chart axes. You do this by applying predefined formats available in Web Intelligence or by creating your own custom formats. You can save your custom formats for reuse on multiple blocks and reports in the same document.

The following predefined formats are available for cells:

Format	Description
Default	The format defined for the object on the universe.
Number	Formats for decimal or integer values.
Currency	Formats for currency values.
Date/Time	Date and time formats.
Boolean	Formats for true and false values.

Related Topics

- *To apply a custom number format to a cell*
- *To define a custom format*

To apply a predefined format to a cell

1. Right-click a cell and click **Format Number** on the shortcut menu.
   The "Format Number" dialog box appears.

2. Click a format in the **Format Type** list.

   The available formats for the format type you selected appear in the **Properties** pane.

3. Click **OK**.

   Web Intelligence applies the new format to the cell.

Custom formats

You can use the Custom format type to define a customized format for any cell. The following table lists the strings you can use to create custom formats:

Character(s)	Display(s)	Example
#	The corresponding digit. If the number has less digits than the number of # characters used to specify the format, no leading zeros are inserted.	'12345' with the format #,##0 gives '12,345' (if your locale defines the grouping separator as a comma) or '12 345' (if your locale defines the grouping separator as a space)
0	The corresponding digit. If the number has less digits than the number of 0 characters used to specify the format, a leading zero(s) is inserted before the number.	'123' with the format #0,000 gives '0,123'
,	The grouping separator as defined by your locale.	'1234567' with the format #,##0 gives '1,234,567' (if you locale defines the grouping separator as a comma) or '1 234 567' (if your locale defines the grouping separator as a non-breaking space)

Character(s)	Display(s)	Example
.	The decimal separator as defined by your locale.	‘12.34’ with the format #.#0 gives ‘12.34’ (if your locale defines the decimal separator as a period) or ‘12,34’ (if your locale defines the decimal separator as a comma)
[%]%	Displays a percentage sign (%) after the result and multiplies the result by 100.	
%	The % sign after the result, but does not multiply the result by 100.	
	A non-breaking space ( )	‘1234567’ with the format # ##0 gives ‘1234 567’
1, 2, 3, a, b, c, $, £, € (and so on)	The alphanumeric character.	‘705.15’ with the format $#.#0 gives ‘$705.15’ or with the format #,#0 € gives ‘705,15 €’
[Red], [Blue], [Green], [Yellow], [Gray], [White], [Dark Red], [Dark Blue], [Dark Green]	The value in the specified color.	‘150’ with the format #,##0[Red] gives ‘150’ #,##0[Blue] gives -’150’
d	The number of the day in the month with no leading zeros. If the date for day is less than two characters, the date displays without a zero before it.	The first day of a month with the format d gives ‘1’

Character(s)	Display(s)	Example
dd	The number of the day with leading zeros. If the date for day is less than two characters, the date displays with a zero before it.	The first day of a month with the format dd gives ‘01’
ddd	The name of the day abbreviated. The first letter is capitalized.	Monday’ with the format ddd gives ‘Mon’
dddd	The name of the day in full. The first letter is capitalized.	‘Monday’ with the format dddd gives ‘Monday’
dddd dd	The day of the week followed by a space and the number of the day.	‘Monday’ with the format dddd dd gives ‘Monday 01’
M	The number of the month with no leading zeros. If the number for month is less than two characters, the number displays without a zero before it.	‘January’ with the format M gives '1'
MM	The number of the month with leading zeros. If the number for month is less than two characters, the number displays with a zero before it.	‘January’ with the format MM gives 01
mmm	The name of the month abbreviated. The first letter is capitalized.	‘January’ with the format mmm gives Jan
mmmm	The name of the month in full. The first letter is capitalized.	‘January’ with the format mmmm gives January

Character(s)	Display(s)	Example
yy	The last two digits for year.	‘2003’ with the format yy gives ‘03’
yyyy	All four digits for year.	‘2003’ with the format yyyy gives ‘2003’
h:mm:ss a	The hour with no leading zeros and the minutes and seconds with leading zeros. The “a□? character displays AM or PM after the time.	‘21:05:03’ with the format h:mm:ss a gives ‘9:05:03 PM’
HH	The hour according to the 24-hour clock.	‘21:00’ with the format HH gives ‘21’
hh	The hour according to the 12-hour clock.	‘21:00’ with the format hh gives ‘09’
HH:mm	The hour and minutes with leading zeros.	‘7.15 am’ with the format HH:mm gives ‘07:15’
HH:mm:ss	The hour, minutes, and seconds with leading zeros.	‘7.15 am’ with the format HH:mm:ss gives ‘07:15:00’
mm:ss	The minutes, and seconds with leading zeros.	‘07:15:03’ with the format mm:ss gives ‘15:03’

To define a custom format

1. Right-click the cell(s) to which you want to apply a custom format.
2. Select Format Number.

   The "Number Format" dialog box appears.
3. In the **Format Type** list, select the format category that corresponds to the data type in the selected cell.
4. Select the **Custom** check box.

Text boxes appear for you to type your custom format(s).

5. Select a format listed in the **Properties** pane, and then edit the selected format by typing additional characters in one or more text boxes.

   For example, if you want to create a custom format for Number values, type the custom format you want in the **Positive**, **Negative**, and **Equal to Zero** boxes. If you want to create a custom format for Boolean values, type the custom format you want in the **True** and **False** boxes.

6. Click **Add**.

   You cannot delete or edit custom formats. To change a custom format, you need to create a new custom format and apply the new format to the selected cell(s). Any custom formats not applied to cells in a document are deleted automatically when you close the Web Intelligence Java Report Panel.

To apply a custom number format to a cell

1. Right-click the cell(s) to which you want to apply the custom format.
2. Select **Format Number**.

   The **Number Format** dialog box appears.

3. Select **Custom**.
4. The list of custom formats already included in the document appears in the **Properties** pane.
5. Select the custom format you want.
6. Click **OK**.

   Web Intelligence applies the custom format to the selected cell(s).

Filtering report data

chapter 18

Report filters defined

You can filter reports to limit the results that are displayed to specific information that interests you. For example, you can limit the displayed results to information for a specific customer or a sales period. The data you filter out remains within the Web Intelligence document; it is simply not displayed in the report tables or charts. This means you can change or remove report filters in order to view the hidden values, without modifying the query definition behind the document.

You can apply different filters to different parts of a report. For example, you can limit the results in the entire report to a specific product line and then limit results in a table or chart further to focus on results for a specific region or customer profile.

To create a report filter, you need to specify three elements:

- a filtered object
- an operator
- a value(s)

You can include multiple filters in a report.

Applying filters to sections

You can apply section filters based on the values in the section header or on values that appear within the section.

Applying a section filter to the section header

If you have a report with a section on [Country], the filter `[Country] = "US"` filters out all sections on countries other than the US.

Applying a section filter to the section data

If you have a report with a section on [Region] and you apply the filter `[Product]="Drinks"` to the section, Web Intelligence retains all sections that contain the product "Drinks".

In this case, the sections remaining in the report contain products other than drinks if these products were sold in these regions. This is because the

section filter retains regions in which drinks were sold, but does not exclude other products from the data in the section.

In other words, Web Intelligence bases the filter on the data in the section, but applies it indirectly to the data in the section header.

Types of report filter

There are three types of report filter in Web Intelligence:

- Standard report filters (available in all forms of Web Intelligence).

  Standard report filters are the most flexible type of report filter. They can use any filter operator and can filter on single values or lists of values.

- Quick filters (available in the Java Report Panel and Web Intelligence Rich Client).

  Quick filters provide an easy way to create filters using the Equal To operator. They can filter on single values or lists of values.

- Simple report filters (available in the Web Intelligence HTML viewer, the Java Report Panel and Web Intelligence Rich Client).

  Simple report filters provide an easy way to create filters using the Equal To operator. They can filter on single values only.

Query filters and report filters compared

You can apply filters at two levels within a document:

- query filters – these filters are defined on the query; they limit the data retrieved from the data source and returned to the Web Intelligence document.
- report filters – these filters limit the values displayed on reports, tables, charts, sections within the document, but they don't modify the data that is retrieved from the data source; they simply hide values at the report level.

Report filter operators

Equal To operator

Use the Equal to operator to obtain data equal to a value.

For example, to return data for the US only, create the filter "County Equal To US".

Not Equal To operator

Use the Not Equal To operator to obtain data not equal to a value.

For example, to return data for all countries except the US create the filter "County Not Equal To US".

Different From operator

Use the Different From operator to retrieve data different from a value.

For example, to retrieve data for all quarters execpt Q4, create the filter [Quarter] Different From "Q4"

Greater Than operator

Use the Greater Than operator to retrieve data greater than a value.

For example, to retrieve data for customers aged over 60, create the filter "[Customer Age] Greater than 60".

Greater Than Or Equal To operator

Use the Greater Than Or Equal To operator to retrieve data greater than or equal to a value.

For example, to retrieve data for revenue starting from $1.5M, create the filter "[Revenue] Greater than or equal to 1500000".

Less Than operator

Use the Less Than operator to retrieve data lower than a value.

For example, to retrieve data for exam grades lower than 40, create the filter "[Exam Grade] Less Than 40".

Less Than Or Equal To operator

Use the Less Than Or Equal To operator to retrieve data less than or equal to a value.

For example, to retrieve data for customers whose age is 30 or less, create the filter "[Age] Less Than Or Equal To 30".

Between operator

Use the Between operator to retrieve data between and including two values.

For example, to retrieve data for weeks starting at week 25 and finishing at 36 (including week 25 and week 36), create the filter "[Week] Between 25 and 36".

Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

Not In List operator

Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

Is Null operator

Use the Is Null operator to retrieve data for which there are no values in the database.

For example, to retrieve customers without children (the children column in the database has no value), create the filter [Children] Is Null.

Is Not Null operator

Use the Is Not Null operator to return data for which there is a value in the database.

For example, to return customers with children, create the filter [Children] Is not Null.

Creating, editing and deleting report filters

To create a report filter using the Quick Filter option

1. Click the report tab of the report you want to filter.
2. If you want to filter a block (that is, a table, chart, or form), then click the top edge of the block to select it. If you want to filter a section, and not just the section cell, click **View Structure** and then select either the start section or end section divider.
3. Click the arrow to the right of the **Add Filter** button on the Report toolbar and select **Add Quick Filter**.

   The **List of Values** dialog box appears. The values for the selected section or block are listed.
4. Select the value(s) you want to display in the section or block.
5. Click **OK**.

   The selected section or block only displays values that correspond to the value you selected.
6. To delete the quick filter, click the arrow to the right of **Add Filter** and select **Remove Filter**.

To create a report filter using the Filter Editor

1. Click the report tab of the report you want to filter.
2. On the Report toolbar, click the **Show/Hide Filter Pane** button to display the Report Filters pane.
3. Select the part of the report you want to filter.

   The **Report Filters** pane displays the name of the selected part of the report. For example, if you select a table, the Report Filter pane displays the name of the selected table.
4. In the **Data** tab, select the object you want to filter.
5. Drag the selected object onto the **Report Filters** pane.

   The Filter Editor appears. The name of the object you selected is displayed below **Filtered Object**.

6. Select the operator.
7. Select **Constant** or **Value(s) from list**.

   When you define filters on measures or variables, you cannot select value(s) from the list of values; you need to type a constant(s).
8. If you selected Constant, type the value(s), you want to retrieve, in the **Constant** box. If you selected **Value(s)**, select the value(s), you want to retrieve, from the displayed List of Values and add them to the **Values Selected** box, by clicking the **>>** button.
9. Click **OK** to confirm the filter definition.

   The selected report, section, or table, chart, or form displays only the values you specified in the custom filter.

To combine multiple filters on a report

1. Create each filter.

   By default Web Intelligence combines all the filters with the AND operator.
2. Double-click the AND operator to toggle between AND or OR.

Related Topics

- *To create a report filter using the Quick Filter option*
- *To create a report filter using the Filter Editor*

To edit a report filter

1. Click the **Show/Hide Filter Pane** button on the Report toolbar to display the **Report Filters** pane.
2. Click the area of the report for which you edit the filters.

   The filters on the selected area display in the **Report Filters** pane.
3. Double-click the filter you want to edit.

   The Filter Editor appears. The name of the filtered object is listed under **Filtered Object**.
4. Edit the filter using the Filter Editor.

To edit a report filter from the report map

1. Select the **Map** tab.
2. Click **Structure** at the top of the tab.
3. Click the report element on which the filter is applied in the report structure.
4. Click **Filters** at the top of the tab.
5. Right-click the filter and select **Edit Filter** to display the filter editor.
6. Edit the filter using the Filter Editor.

To delete a report filter

1. Click the **Show/Hide Filter Pane** button on the Report toolbar to display the **Report Filters** pane.
2. Click the area of the report from which you want to remove the filters.

   The filters on the selected area display in the **Report Filters** pane.
3. Select the filter you want to delete and press **Delete**.
4. You can also delete filter by selecting the filtered object, selecting the arrow to the right of the **Filter** button on the **Reporting** toolbar, and selecting **Remove filter**.

To create simple report filters

The Report Filter toolbar provides a quick method for adding simple report filters to reports.

Simple report filters have the form `<report_object>=<value>`. They can contain the "=" operator only and can filter on a single value only.

For more complex filters, use quick filters (which can contain the "=" or "Inlist" operators) or standard report filters (which can contain any operator).

Note:
You also use the Report Filter toolbar when drilling on reports. In the context of Drill, the Report Filter toolbar is known as the Drill toolbar.

1. Click **Show/hide Report Filter toolbar** on the main menu to display the toolbar.

2. In Web Intelligence HTML, click the icon on the toolbar and select the object on which you want to filter from the menu.

   You can add multiple objects to the toolbar to create multiple filters.

3. In the Java Report Panel or Web Intelligence Rich Client, drag the object on which you want to filter to the toolbar.

   You can add multiple objects to the toolbar to create multiple filters.

4. Select the value on which you want to filter from the drop down list of values.

   Web Intelligence filters the report on the value of the object you selected. For example, if you selected "US" from the list of values of the Country object, Web Intelligence filters the report to exclude all rows where Country does not have the value "US".

5. To remove a filter, select it and click Delete.

To view the filters on a report

1. Click on the area of the report for which you want to see filters. (To view filters defined on the entire report, click outside any table, chart or section.)
2. Click the **Map** tab, then click **Filters**.

   Web Intelligence displays the filters on the area of the report you clicked.

Answering prompts

chapter 19

To enter values to answer a prompt

1. With a report in a Web Intelligence document open, click **Refresh Data** on the right of the main toolbar above the report.

   The "Prompts" dialog box appears.

2. Select a prompt question.

   If the prompts are organized hierarchically in a tree, you need to select the prompt at the lowest level of the hierarchy first. This type of prompt is referred to as a cascading prompt.

   The values you can choose are listed in the pane on the lower left.

   If the list of values is not available, click **Refresh values** to display it. The list of values now appears together with the date on which it was last refreshed.

   If the prompt has been answered previously, the values selected the last time appear in the prompt answer pane on the right. You can either leave those values selected or use **<<** to remove them.

   The options you see when you answer prompts depend on (1) whether this is the first time the results have been refreshed or not and (2) the properties set for the prompts when they were created.

3. Select the values from the list of choices in the pane on the left, for which you want to view results, or type the values into the text box, and click the **>>** to add them to the prompt answer box on the right.

   If you type multiple values, you need to separate each value with a semi-colon (;). For example: Florida;Texas.

4. Click **Run Query**.

   Web Intelligence retrieves the data for the values you specified, and returns the results to the reports.

   Note:
   If the prompt is optional, click **Run Query** without supplying a value. Web Intelligence ignores the prompt.

To enter dates to answer a prompt

1. With a report in a Web Intelligence document open, click **Refresh Data** on the right of the main toolbar above the report.

The "Prompts" dialog box appears.

2. To select a date, click the arrow to the right of the text box, select a date from the popup calendar, and then click **>>** to add the date you selected to the list on the right.

   If the prompt has been answered previously, the values selected the last time appear in the prompt answer pane on the right. You can either leave those values selected or use **<<** to remove them.

3. If the prompt allows you to select multiple dates, and you want to view results for more than one date, repeat the previous step.
4. Click **Run Query**.

   Web Intelligence retrieves the data for the values you specified, and returns the results to the reports.

   Note:
   If the prompt is optional, click **Run Query** without supplying a value. Web Intelligence ignores the prompt.

Filtering data using input controls

chapter 20

Input controls defined

Input controls provide a convenient, easily-accessible method for filtering and analyzing report data. You define input controls using standard windows controls such as text boxes and radio buttons. You associate these controls with report elements such as tables or section headers, and use the controls to filter the data in the report elements. When you select values in the input control, Web Intelligence filters the values in the associated report elements.

You can also define tables and charts as input controls. When you select a value in the table or chart, Web Intelligence filters the values in the associated report elements.

You can use input controls to analyze different scenarios by changing the value of variables. You define a variable with a constant value, then assign an input control, for example a slider, to the variable. You can then change the value of the variable using the slider control; if the variable is part of a formula, you can use the slider control to examine different formula results based on the variable value.

Input controls are report-specific. They are grouped on the **Input Controls** tab.

To add an input control

You must have sufficient document modification rights to add input controls.

1. Select the **Input Controls** tab.
2. Click **New** at the top of the **Input Controls** pane, or right-click an object in a table or chart and select **New input control** to display the input controls wizard.

   If you selected an entire table or chart before clicking **New**, you can select **Include objects from selected block only** to restrict the list of objects in the wizard to the objects in the table or chart you selected. If you did not select a table or chart, or if you used the **New input control** menu to display the input controls wizard, this option is not available.

3. Select the report object to supply values for the input control, then click **Next**.

If you right-clicked an object and selected **New input control** from the menu, the object you right-clicked is already selected.

4. Select the input control type.

   The list of control types is determined by the data type of the report object.

5. Define the input control properties.

   The available properties are determined by the control type and whether you are using Web Intelligence Interactive or the Web Intelligence Java Report Panel/Web Intelligence Rich Client.

Property	Description
Label	The name of the input control
Description	The description of the input control
List of values	The list of values available in the input control. You can use all values of the report object on which the input control is based (the default) or define your own custom list of values.
Use restricted list of values	If you define a custom list of values for the report object, this setting filters the data in the report element you assign to the input control based on this list of values. Even when no values are selected in the input control, Web Intelligence excludes any values not in the restricted list from the report element filtered by the input control. For example, if an input control based on the [Country] dimension is restricted to the values "US" and "France", a table filtered by the input control shows data for US and France only, even when no value is selected in the input control. If you deselect **Use restricted list of values**, all values of [Country] appear in the table when no value is selected in the input control.
Operator	The operator that the input control uses to filter the associated report elements
Default values	The default values that the input control uses to filter the associated report element

Property	Description
Number of lines	The number of lines that the input control displays in the Input Control pane. For example a list of five radio buttons with **Number of lines** set to 3 displays three radio buttons only by default. You access the other two radio buttons by using the scrollbar.
Minimum value	The minimum numerical value you can select in the input control
Maximum value	The maximum numerical value you can select in the input control
Increment	The amount by which the input control increases/decreased a numerical value when you are choosing a value

6. Click **Next** to display the **Assign Report Elements** wizard step.
7. Select the report elements you want the input control to filter.

   Note:
   Each time you save a document, Web Intelligence removes any input controls that have no associated report elements.

8. Click **Finish**.

   The input control appears on the **Input Controls** pane.

To edit an input control

1. Select the **Input Controls** tab.
2. Click **Edit** on the input control to display the **Edit Input Control** dialog box.
3. Edit the input control properties on the **Properties** tab.
4. Edit the report elements associated with the input control on the **Dependencies** tab.

To highlight input control dependencies

1. Select the **Input Controls** tab.
2. Click **Highlight dependencies** on the input control.

The report elements associated with the input control are highlighted.

To organize and remove input controls

1. Select the **Input Controls** tab.
2. Drag and drop input controls to move them up or down on the **Input Controls** pane in Web Intelligence Java Report Panel and Web Intelligence Rich Client. Select an input control, then click **Move the selected input control up/down** at the top of the **Input Controls** pane to move the control up or down in Web Intelligence Interactive.
3. Select an input control, then click **Remove** at the top of the control to remove it from the **Input Controls** pane.

To view the input controls map

1. Select the **Input Controls** tab.
2. Click **Map** at the top of the **Input Controls** tab (Web Intelligence Interactive) or select the **Map** tab, then click **Input controls** at the top of the tab (Web Intelligence Java Report Panel and Rich Client).

Using tables and charts as input controls

You can define tables and charts as input controls. Table- and chart-based input controls appear in the **Input Controls** panel in the same way as regular input controls, but you select values in the table or chart itself to filter the dependent report elements. When you select cells, columns or rows in tables, or clickable data areas in charts, Web Intelligence filters the values in the associated report elements according to the values you selected.

When you click on a table or chart-based control in the **Input Controls** panel, Web Intelligence highlights the table or chart used as an input control.

When a report is in drill mode, table- and chart-based input controls are disabled. They are re-enabled when drill mode is deactivated.

To define a table or chart as an input control

1. Select the table or chart, right-click and select **Define as input control**.

2. Select **All objects** to define all the objects in the table or chart as the filtering objects, or select **Single object** and select the object to define a single object in the table or chart as the filtering object.

   Note:
   You can select dimensions only as filtering objects when you define a table or chart as an input control.

3. Click **Next** and type a name and a description for the input control.
4. Click **Next** and select the report elements to be filtered by the input control.

   Note:
   You cannot select the table or chart that you are defining as an input control from the list of report elements.

5. Click **Finish.**

   The table or chart input control appears in the **Input Controls** pane. When you click on the control, Web intelligence highlights the table or chart defined as the input control.

Related Topics

- *To edit an input control*

To filter data using input controls

1. Display the **Input Controls** pane by selecting the **Input Controls** tab.

   Note:
   The input control displays the message "No dependent report elements" if the report elements filtered by the input control are no longer in the report.

2. Select values in the input control.

   Web Intelligence filters the associated report elements based on the values you select. For example, if you select the "US" value of the [Country] dimension, the filter operator is Equal To, and there is a table associated with the input control, Web Intelligence filters the table on the condition [Country] = "US".

3. To filter using a table or chart defined as an input control, select dimension values in the table (rows, columns or cells) or chart (clickable data areas).

Note:

- Tables or charts defined as input controls can filter using dimension values only.
- The input control shows the message "The table or chart is not in the report" if the table or chart is no longer in the report.
- The input control shows the message "Filtering dimensions not available" if the filtering dimensions are no longer in the table or chart. The input control becomes usable again if you add the dimensions to the table or chart.
- The input control shows the message "Control not usuable while the report is in drill mode" if the report is in drill mode. Drill mode must be turned off to make the input control usable.
- Table- and chart-based input controls are indicated by an icon in the top right-hand corner of the table or chart. Right-clicking the icon displays the following menu:

Command	Description
Edit	Edits the input control
Highlight dependen-cies	Highlights the report elements filtered by the input control
Reset	Removes the filters applied by the input control
Disable/Enable	Disables or enables the input control

4. To remove all filters applied by input controls, click **Reset** at the top of the **Input Controls** pane.

Enhancing reports with calculations, formulas and variables

chapter 21

Calculations, formulas and variables

You can add calculations, formulas and variables (named formulas) to your Web Intelligence reports. For detailed information on the calculation power that calculations, formulas and variables add to your reports, see the *Using Functions, Formulas and Calculations in SAP BusinessObjects Web Intelligence* guide or the online help.

Working with standard calculations

To insert a standard calculation in a table or crosstab

You can insert standard calculations in tables or crosstabs to make quick calculations on table data. For more information on the standard calculations available in Web Intelligence, see the *Using Functions, Formulas and Calculations in SAP BusinessObjects Web Intelligence* guide or in the online help.

You can insert multiple calculations in a table or crosstab. When you apply two calculations to a table or crosstab, a footer is added for each calculation result. You insert multiple calculations in a table or crosstab in the same way that you insert one calculation, but you repeat the procedure for as many calculations as you want to insert.

1. Click **Configure View** > **Toolbars** > **Reporting** (Java Report Panel) or **View** > **Toolbars** > **Report** (Web Intelligence Interactive) to display the **Report** toolbar.
2. Click the table cell that contains the data you want to calculate.
3. Click the arrow at the right of the **Insert calculation-name** button (where calculation-name is the currently-selected calculation) on the **Report** toolbar, then select the calculation you want to insert from the drop-down menu. You can also click the button directly to insert the currently-selected calculation.

   The currently-selected calculation is shown by the mathematical symbol on the button, and changes according to the type of data you select. For example, if the calculation is Sum, the button displays the Σ symbol.

Note:
If you insert a percentage calculation, the results of the percentage are displayed in an additional column or row of the table.

4. To insert other calculations, click the arrow at the right of the button and select the calculation from the drop-down menu.

   A new row is added at the bottom of the table. The aggregated value appears in the new row cell.

To remove a standard calculation

1. Right-click the cell that contains the calculation.
2. Depending on the table type, select **Remove** > **Row** or **Remove** > **Col umn** from the shortcut menu.

Working with formulas

The Formula toolbar

You display the Formula toolbar by clicking the **Show/Hide Formula Toolbar** button on the **Reporting** toolbar (Java Report Panel) or **View** > **Toolbars** > **Formula** (Web Intelligence Interactive). Now, when you select a cell, its formula appears in the Formula toolbar.

The Formula toolbar has the following buttons (the order is different depending on the type of Web Intelligence you are using):

Button	Description
Open Formula Editor	Opens the Formula Editor which allows you to build a formula using a graphical interface
Create variable	Allows you to save a formula as a variable

Button	Description
Clear changes	Clears all changes made to the formula since the last save or validation
Validate formula	Verifies the formula syntax and replaces the current formula

To enter a formula directly into the Formula toolbar without using the Variable Editor, you can type the formula or drag report objects (Java Report Panel only) to the formula toolbar.

To enter a formula in the Formula toolbar by typing the formula

1. Click **Show/Hide Formula Toolbar** (Java Report Panel or Web Intelligence Rich Client) or **View** > **Toolbars** > **Formula** (Web Intelligence Interactive) to display the Formula toolbar.
2. In the Formula toolbar, type the formula.

   For example, to calculate the average revenue generated per item sold, type: `=[Sales Revenue]/[Quantity Sold]`.

   Web Intelligence gives you suggestions for completing the component of the formula you are typing. To select a Web Intelligence suggestion, press the down arrow button to highlight it, then press Return, or select the suggestion with your cursor.
3. To select a Web Intelligence suggestion, press the down arrow button to highlight it, then press Return.

To enter a formula in the Formula toolbar by using drag and drop

- Drag reports objects onto the Formula toolbar.

  Note:
  You cannot drag objects to the Formula toolbar in Web Intelligence Interactive.

  When you release an object, it appears in the Formula toolbar at the cursor position as if you had typed it directly.

To build a formula using the Formula Editor

1. Click the **Open Formula Editor** button on the Formula toolbar to display the Formula Editor.
2. Select the cell on the report where you want to include the formula.
3. In the **Data**, **Functions** and **Operators** panes, double-click the report objects, functions and operators you want to include in the formula, or type the formula directly.

   For example, to create the formula `=Average([Revenue])`, double-click the `Average()` function, then double-click the Revenue object.

   When you double-click a function to include it in a formula, Web Intelligence places the cursor between the function parentheses.

Working with variables

To create a variable from a formula

1. Display the Formula toolbar.
2. Type your formula in the Formula toolbar or select a cell containing a formula.
3. Click **Create variable** on the Formula toolbar

   The "Create Variable" (Java Report Panel or Web Intelligence Rich Client) or "Variable Editor" (Web Intelligence Interactive) dialog box appears.
4. Type the variable name in the **Name** box.
5. Select the variable type by selecting **Dimension**, **Measure** or **Detail**.
6. If you select **Detail**, an "Associated Dimension" box appears. Click **...** next to the box to open the "Objects and Variables" dialog box and select the dimension you want to associate with the detail.
7. Click **OK**.

   The variable appears in the list of report variables in the **Data** tab.

To create a variable using the Variable Editor

1. Click **Show Variable Editor** on the **Reporting** toolbar (Java Report Panel or Web Intelligence Rich Client) or **Variable** > **New** on the **Available Objects** tab of the Left Panel (Web Intelligence Interactive).
2. Type your formula in the **Formula** pane or use the functions and operators on the **Functions** and **Operators** tab to build the formula.
3. Type the variable name in the **Name** box.
4. Select the variable type by selecting **Dimension**, **Measure** or **Detail**.
5. If you select **Detail**, an **Associated Dimension** box appears. Click **...** next to the box to open the **Objects and Variables** dialog box and select the dimension you want to associate with the detail.
6. Click **OK**.

   The variable appears in the list of report variables.

To edit a variable

1. Select the variable in the list of report variables (on the **Data** tab in the Java Report Panel/Web Intelligence Rich Client or the **Available Objects** tab on the Left Panel in Web Intelligence Interactive).
2. Click the right mouse button and click **Edit (Variable)** on the shortcut menu.

   The Variable Editor appears.
3. Edit the variable.
4. Click **OK** to save the new variable definition.

To delete a variable

1. Select the variable in the list of report variables (on the **Data** tab in the Java Report Panel/Web Intelligence Rich Client or the **Available Objects** tab on the Left Panel in Web Intelligence Interactive).
2. Click the right mouse button and click **Delete** on the shortcut menu.

Drilling on report data

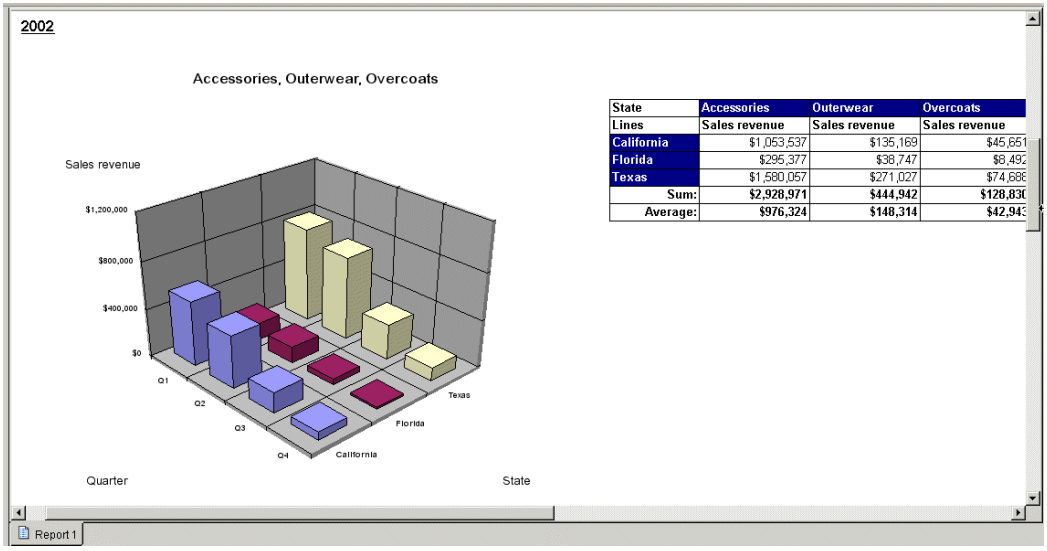
chapter 22

What is drill?

You use drill to analyze the results displayed in reports. Drilling on reports lets you look deeper into your data to discover the details behind a good or bad summary result displayed in tables, charts, or sections.

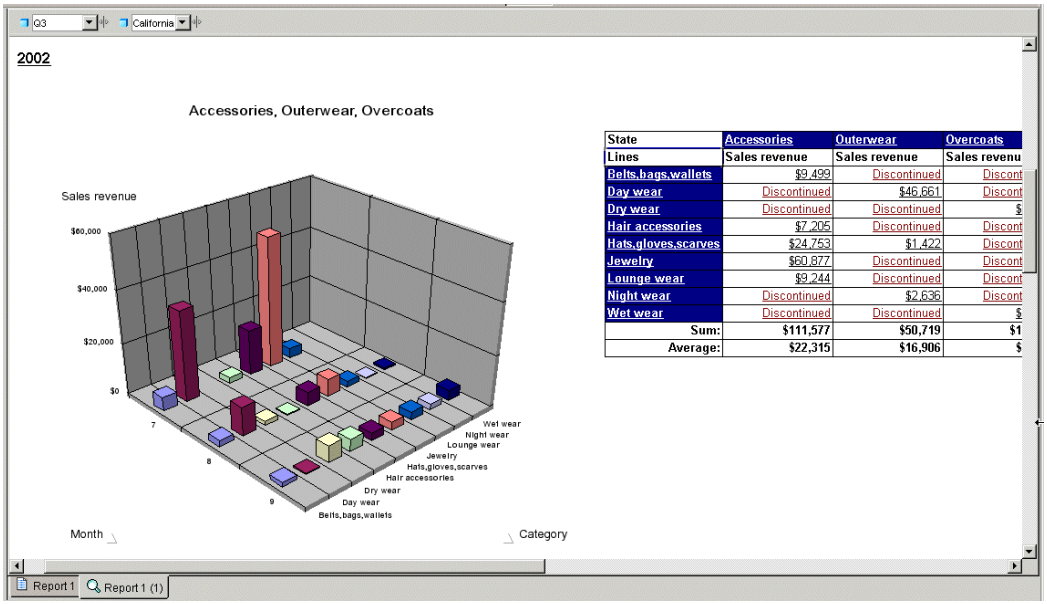
Example: Why did sales of accessories, outwear, and overcoats rise in Q3?

You work for a US national fashion retail chain, and are in charge of sales of accessories, outerwear and overcoat clothing lines in western states. You see that revenue is much higher for Q3 than the other quarters.



State	Accessories	Outerwear	Overcoats
Lines	Sales revenue	Sales revenue	Sales revenue
California	$1,053,537	$135,169	$45,651
Florida	$295,377	$38,747	$8,492
Texas	$1,580,057	$271,027	$74,688
Sum:	$2,928,971	$444,942	$128,830
Average:	$976,324	$148,314	$42,943

To understand why, you drill down to look at the factors behind the result.



State	Accessories	Outerwear	Overcoats
Lines	Sales revenue	Sales revenue	Sales revenu
Belts,bags,wallets	$9,499	Discontinued	Discont
Day wear	Discontinued	$46,661	Discont
Dry wear	Discontinued	Discontinued	$
Hair accessories	$7,205	Discontinued	Discont
Hats,gloves,scarves	$24,753	$1,422	Discont
Jewelry	$60,877	Discontinued	Discont
Lounge wear	$9,244	Discontinued	Discont
Night wear	Discontinued	$2,636	Discont
Wet wear	Discontinued	Discontinued	$
Sum:	$111,577	$50,719	$1
Average:	$22,315	$16,906	$

You see that jewelry sales escalated in July (month #7).

Scope of analysis

The scope of analysis for a query is extra data that you can retrieve from the database to give more details on the results returned by each of the objects in a query. This extra data does not appear in the initial result report, but it remains available in the data cube, so you can pull this data in to the report to allow you to access more detail at any time. This process of refining the data to lower levels of detail is called drilling down on an object.

In the universe, the scope of analysis corresponds to the hierarchical levels below the object selected for a query. For example, a scope of analysis of one level down for the object Year, would include the object Quarter, which appears immediately under Year.

You can set this level when you build a query. It allows objects lower down the hierarchy to be included in the query, without them appearing in the **Results Objects** pane. The hierarchies in a universe allow you to choose your scope of analysis, and correspondingly the level of drill available.

In the Java Report Panel and in Web Intelligence Rich Client, you can also create a custom scope of analysis by selecting specific dimensions for the **Scope of Analysis** pane.

Note:
You cannot set the scope of analysis when working in query drill mode because this drill mode causes Web Intelligence to modify the scope dynamically in response to drill actions.

Levels of scope of analysis

You can set the following levels for scope of analysis:

Level	Description
None	Only the objects that appear in the **Results Objects** pane are included in the query.
• One level down • Two levels down • Three levels down	For each object in the **Result Objects** pane, one, two, or three objects lower down the hierarchy tree are included in the query. The data from these objects is stored in the cube until you add them to the document.
Custom **Note:** This option is available in the Java Report Panel and in Web Intelligence Rich Client only.	All objects added manually to the Scope of Analysis panel are included in the query.

Including a scope of analysis in a document increases the document size significantly. This is because the data necessary for the scope you specify is saved with the document, even though it is not visible in the reports unless you start drill mode and drill down to the data to display the corresponding values.

In order to minimize the size of documents and optimize performance, we recommend that you only include a scope of analysis in documents where you are certain that users will need to drill.

We suggest the following method because it will be easier for you to set the scope of analysis seeing the hierarchy of the classes and objects.

To set the scope of analysis

1. Click **Show/Hide Scope of Analysis Pane** on the Query toolbar to display the **Scope of Analysis** pane.

   All the dimensions in the **Result Objects** pane appear in the **Scope of Analysis** pane. This corresponds to the default scope of analysis - None. (There are no additional levels available for analysis.)

2. Select the analysis level from the **Scope level** list at the top-right corner of the **Scope of Analysis** pane.

   The objects hierarchically below the objects in the **Result Objects** pane appear in the **Scope of Analysis** pane down to the number of levels you selected.

3. To add selected dimensions to the scope of analysis or create a custom scope of analysis, select dimensions in the Query Manager and drag them across to the **Scope of Analysis** pane.

Drill paths and hierarchies

When you analyze data in drill mode, you move along a drill path. These paths are based on the dimension hierarchies set by the designer of the universe. Universe designers organize objects in classes in a hierarchy with the most summary objects at the top and the most detailed at the bottom. So if you want to make a high-level report, you know that your query should include objects at the top of the list. If you want to see more detailed information, you can then switch to Drill mode and drill down on each dimension value displayed in the reports.

For example, if the data from [Quarter] did not sufficiently explain a result, you could drill down to [Month] or [Week], depending on how the universe designer set up the hierarchy. When you drill to a different level, measures, such as a [Revenue] or [Margin], are recalculated accordingly.

Drill paths usually follow the same hierarchy order as the classes on a universe. For example, a class called Time typically includes the [Year] dimension at the top of the class, followed by the [Quarter], [Month], and [Week] dimensions. The hierarchies for drill within the Time hierarchy typically follow the same order, because users want to drill annual results to analyze details for quarter, month, and so on. However, the universe designer can also define custom hierarchies.

Note:
A dimension can belong to several hierarchies. When you drill a result on a dimension that belongs to more than one hierarchy, Web Intelligence prompts you to select the drill path.

To view drill hierarchies

1. Open a document in Edit mode.
2. Verify you are in Query View.
3. Click the **Data** tab.
4. Click the **Hierarchies** radio button.

To switch to drill mode

To start drilling on a report you either switch to Drill mode or, if the report is saved in Drill mode, drill directly.

1. With a document open, verify you are in Report View.
2. Select the report you want to drill.

   The **Drill** button appears in the Web Intelligence toolbar.
3. Click the **Drill** button (you can also select **Analysis** > **Drill** in Web Intelligence Rich Client).

   Note:
   When you open a document that was saved in Drill mode, the document opens in Drill mode if you have the right to drill on documents. If not, it opens in Results view..

   By default, a drill icon appears on the tab of the drillable report. Depending on the drill options you selected on the Web Intelligence Document Preferences page in InfoView, Web Intelligence either makes the selected report drillable or creates a duplicate of the selected report, in drill mode.

Related Topics

- *Start drill session on a duplicate report option*

Retrieving more levels of data to the report

When you are drilling a Web Intelligence report, you may want to drill up or down to a dimension that lies outside the scope of analysis defined for the document. To return the additional data, Web Intelligence must run a new query that includes the additional dimension(s) you specify. This is called extending the scope of analysis.

You can extend the scope of analysis during your drill sessions only if your security profile allows you to do so. Your security profile is controlled by your BusinessObjects Enterprise administrator.

If your Drill options are not set to display the Extend the Scope of Analysis prompt message during drill, you will not be given the option to select filters if you drill beyond the data already available in the document. In this case, Web Intelligence immediately runs a new query and returns data for all the values on the dimensions you are drilling.

To drill out of the scope of analysis

1. Hold your mouse cursor over a dimension value that is at the end of the scope of analysis.

   A ToolTip informs you that a new query is necessary to return the additional data to the document.

2. Drill on the dimension.

   If your Drill options are set for Web Intelligence to prompt you when a drill action requires a new query, the Extend the Scope of Analysis dialog box appears.

   The dialog box lists the dimensions in the hierarchy above and below the drilled value. The dimensions already included in the document are checked. The dialog box also displays the filters that you can select to filter the new query.

3. Select the check boxes next to the dimensions you want to drill.
4. Select the check boxes next to the filters you want to use to filter the query.
5. Click **OK**.

   Web Intelligence runs a new query and returns the additional data to the document and the results for the dimension you drilled to appear on the table.

To choose a drill path when more than one is available

A dimension can belong to multiple hierarchies. When you drill down on such a dimension value, Web Intelligence does not know which drill path to follow. You must define the drill path.

Note:
If the dimension value you choose to drill on is the result of a previous drill, the drill path is already known. Therefore you do not need to select a drill path.

1. Drill on the dimension.

   The "Select Drill Path" dialog box appears. The dialog box lists the dimensions in the hierarchy above and below the drilled value. A check box appears next to each dimensions below the current dimension you are drilling, so that you can select which of these dimensions you want to retrieve from the database, in order to continue your drill action. The dialog box also displays the filters that you can select to filter the new query.
2. Select the path you want to drill.
3. Click **OK**.

To take a drill snapshot

- Click **Snapshot** on the main toolbar.

  Web Intelligence makes a copy of the current state of the drilled report as a seperate report.

Drilling on dimensions in tables and sections

Dimensions typically represent character-type data, such as customer or business names, and dates. Web Intelligence makes calculations based on the dimensions in a report. For example, if you create a report that calculates a region's total sales revenue for a given year, Web Intelligence calculates the [Sales revenue] measure based on the two dimensions: [State] and [Year].

When you drill on a dimension to see the more data behind the displayed result, the sales revenue is calculated according to the values to which you drill. If you drill on [Year] in the above example, Web Intelligence calculates and displays sales revenue by state and quarter, because [Quarter] is the next dimension in the time hierarchy below [Year].

Note:
You cannot drill on detail objects.

Drilling down

You drill down to see the lower-level data that makes up the summary results displayed on reports. This helps explain why high or low results occurred.

Example: Using drill analysis to find out why sales decreased dramatically in 2003

In this example, you receive a report that shows sales revenue results for the accessories line at the eFashion retail store. The following crosstab shows that the Accessories line decreased in 2003.

	2001	2002	2003
Accessories	$2,546,222	$5,468,919	$1,899,405

To analyze more precisely when the decrease occurred, you drill down on the cell value 2003, to view the detailed data for each quarter.

	2001	2002	2003
Accessories	$2,546,222	$5,468,919	$

Drill down to Quarter

When you drill down on the cell value 2003, a filter appears in the Drill toolbar to show that the quarterly values you have drilled to are filtered for the year 2003. The drilled chart clearly shows that the problem arose in Q4 of 2003.

2003

	Q1	Q2	Q3	Q4
Accessories	$357,835	$526,371	$645,055	$370,144

To find out which of the of the categories within the Accessories line was responsible for the drop in revenue, you drill down again on the cell value Accessories.

2003 Accessories

	Q1	Q2	Q3	Q4
Belts,bags,wallets	$195,102	$235,769	$105,772	$223,218
Hair accessories	$83,574	$1,133	$46,847	$15,490
Hats,gloves,scarves	$14,954	$1,553	$12,771	$8,310
Jewelry	$12,118	$10,601	$28,436	$7,406
Lounge wear	$16,266	$59,282	$149,401	$22,105
Samples	$35,821	$218,034	$301,828	$93,616

The drilled crosstab shows which categories were responsible for low revenue in Q4.

Note:
If you try to drill to a dimension that is already displayed in another column or row of the same table, Web Intelligence automatically displays the next available dimension in the drill path.

To drill down on a dimension value in a table or section cell

1. Verify you are in Drill mode
2. On a table or section cell, place your pointer over the dimension value on which you want to drill.

   A ToolTip appears, showing the next dimension in the drill path. If the drilled report includes dimensions from multiple data providers, the ToolTip displays the name of the query and the dimension for the value.
3. Click the value.

   The drilled table or section displays data one dimension level down. The Drill toolbar, at the top of the report, displays the values from which you drilled. These values filter the values displayed on the drilled table.

Drilling up

You drill up on a dimension value to see how the more detailed data aggregates to a higher-level result. For example, you may have drilled down on Year to examine data for each quarter. If you want to see how this data aggregates to yearly results, you can drill up.

When you drill up on a dimension value, you move along the drill path from lower- to higher-level data. For example, you may have drilled down on [Year] to [Quarter]. If you drill up on [Quarter], you return to [Year].

You can only drill up on a dimension value if you have previously drilled down to that dimension, or you have defined the appropriate drill path in the scope of analysis.

To drill up on a dimension value

1. Verify you are in Drill mode.
2. On a table or section cell, right-click the dimension value on which you want to drill up, then on the shortcut menu click **Drill up** , or click the Drill Up icon next to the dimension value you want to drill up.

   If the table is a crosstab without headers that display the names of the dimensions on the table, then the Drill Up icon appears next to each value from which you can drill up.

The report now displays data one dimension level up. The filters that filtered the value you drilled up from, are removed from the Drill toolbar.

Drilling by

When you drill down or up, you move through a hierarchy one dimension at a time. However, you can get another view of the data by slicing it in a different way, and then look at the data in other hierarchies. To do this, you drill by the other dimensions that interest you.

Note:
You can only Drill by to a dimension that is included in the scope of analysis of the document.

Example: Drilling by the Products hierarchy to slice sales revenue results by product

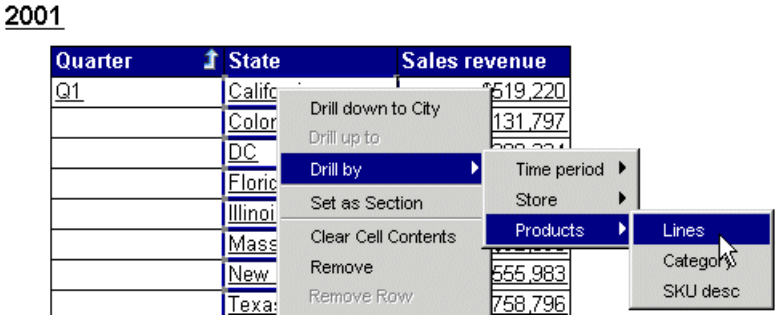
You work as regional manager for California in a retail clothing store, and have been sent the following report that shows quarterly sales revenue by state:

2001

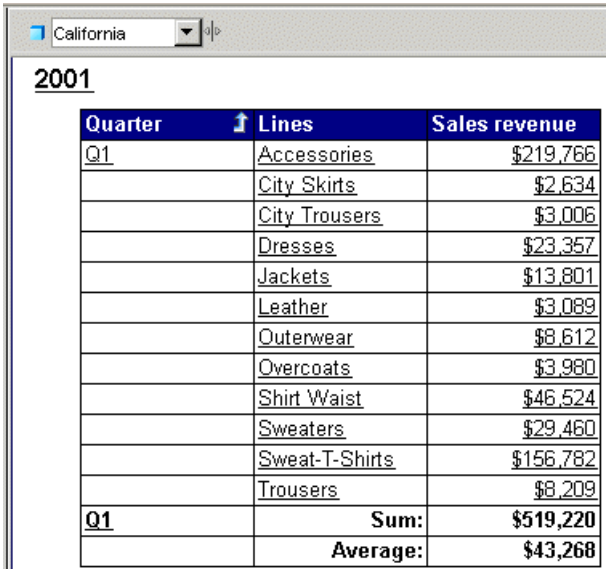
Quarter	State	Sales revenue
Q1	California	$519,220
	Colorado	$131,797
	DC	$208,324
	Florida	$137,530
	Illinois	$256,454
	Massachusetts	$92,595
	New York	$555,983
	Texas	$758,796
Q1	**Sum:**	**$2,660,699**
	Average:	**$332,587**

You are only interested in analyzing the results in the state of California. In addition, you want to analyze the sales revenue broken down by each product line you sell. To drill on California data, you place your pointer on the table cell that says California.

If you drilled down now, however, you would drill to results for each city within California, because [City] is the dimension below [State]. Instead, you select Drill by from the drill menu and then you navigate through the dimensions on the Products hierarchy by selecting the sub-menus until you reach the [Lines] dimension.



The drilled report displays the detailed sales revenue results for each product line sold in California.



Quarter	Lines	Sales revenue
Q1	Accessories	$219,766
	City Skirts	$2,634
	City Trousers	$3,006
	Dresses	$23,357
	Jackets	$13,801
	Leather	$3,089
	Outerwear	$8,612
	Overcoats	$3,980
	Shirt Waist	$46,524
	Sweaters	$29,460
	Sweat-T-Shirts	$156,782
	Trousers	$8,209
Q1	**Sum:**	**$519,220**
	Average:	**$43,268**

To drill by a dimension value

1. Verify you are in Drill mode.
2. On a table or section cell, right-click the dimension value you want to drill by.

   A shortcut menu appears, displaying the available drill paths.
3. Place your pointer on **Drill by**, then on the class to which you want to drill.
4. Click the dimension to which you want to drill.

   The report now displays data for the dimension to which you drilled.

Drilling on measures in tables and sections

When you drill on a measure value, Web Intelligence performs the drill action one level down for each related dimension in the block and displays the new measure calculation for the displayed dimensions.

Example: **Drill on annual sales revenue results to see the breakdown by city and quarter**

For example, you drill down on the year 2003 sales revenue value for California, which is displayed on a crosstab that shows sales revenue by year in by state.

The drilled report displays sales revenue by quarter by city for California – the state on which you drilled.

To drill down on a measure value

1. Verify you are in Drill mode.
2. Place your pointer over the measure value on which you want to drill.

A ToolTip appears, displaying the next dimension(s) in each related drill path

3. Click the measure value.

   Your report now displays data one dimension level down. The table headers display the names of the dimensions you drilled to and the drill up arrow, which indicates you can drill back up to the summary results if wished. The Drill toolbar displays the values that filter the results displayed on the drilled table or section.

To drill up on a measure value

1. Verify you are in Drill mode.
2. Right-click the measure value on which you want to drill up, then click the **Drill up** option on the shortcut menu, or click the **Drill Up** icon next to the measure value you want to analyze.

   The drilled table now displays data one dimension level up.

Synchronizing drill across multiple tables and charts

A Web Intelligence report can contain several tables or charts. The generic term used to refer to tables and charts in this guide is a block. There are two ways to drill on a report with multiple blocks:

- drill simultaneously on each block in the report the contains the drilled dimension
- drill on only the current block of data

You set how Web Intelligence performs drill on reports with the Synchronize drill on report blocks option.

If you set Web Intelligence to synchronize drilling across a report, you drill on each block in the report containing that drilled dimension. The next dimension in the drill path replaces the previous dimension in all blocks of the report.

If you set Web Intelligence not to synchronize drilling on all blocks in a report, the next dimension in the drill path replaces the previous dimension only in the current block of the report.

Related Topics

- *Synchronize drill on report blocks option*

Drilling on charts

Drilling down, up, or by on a chart, provides you with a graphical explanation for why summary results are particularly high or low.

You can drill on:

- dimensions – by drilling on chart axes
- dimensions – by drilling on the chart legend
- measures – by drilling on the data bars or markers in the body of the chart

You cannot Drill by dimensions on chart axes. However, you can Drill by dimensions on chart legends.

Related Topics

- *Drilling on axis legends*

Drilling on dimensions via chart axes

On 2D charts, you can drill on dimensions via the X-Axis. On 3D charts, you can drill on dimensions via the X-Axis and the Z-Axis. Charts can contain one or multiple dimensions on a single axis. When an axis contains multiple dimensions, each possible combination of the dimension values appear on the axis (this is sometimes referred to as a cartesian product).

When you drill on an axis value with multiple dimensions, the drilled results are filtered by both dimensions.

To drill on a chart axis

1. Verify you are in Drill mode.
2. Place your pointer over the dimension value on which you want to drill.
3. If you want to drill down on the dimension value, click the value. If you want to drill up on the dimension value, right-click the value then select **Drill Up**. If you want to drill down on the dimension value, right-click the

value then select **Drill Down**. If you want to drill by the dimension value, right-click the value then select **Drill By**

Note:
Drill by is not available if the axis has multiple dimensions.

Drilling on measures in charts

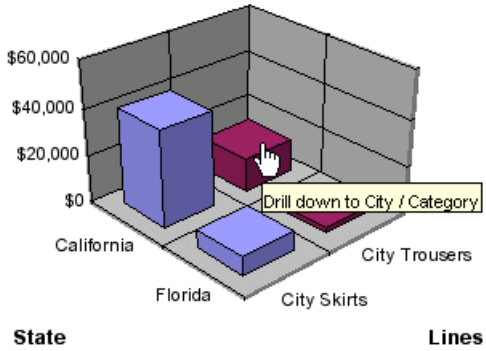
You can drill on the measures displayed on the following types of chart:

- bar charts – by drilling on the bars
- line and radar line charts – by drilling on the data markers
- pie chart – by drilling on the segments

When you drill on measures, Web Intelligence performs the drill action on each dimension displayed on the chart axes. The new measure calculations displayed on the bars or data markers on the drilled chart, correspond to the lower- or higher-level dimensions to which you drilled. The chart axis labels display the names of the drilled dimensions.

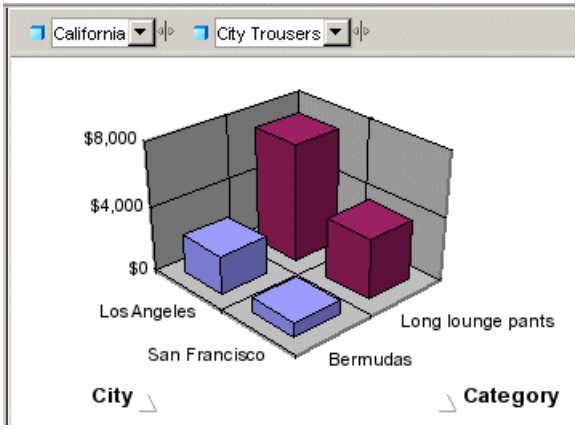
Example: Analyze detailed information for the sales revenue measure on a chart

For example, this 3D bar chart displays values for the [State] dimension on the X-Axis and displays values for the [Lines] dimension on the Z-Axis. This means that the chart bars display values for sales revenue per state per line.



As the example below shows, when you drill down on the bar for “City Trousers□? in “California□? you also drill down from [State] to [City] on the X-Axis and from [Lines] to [Category] on the Y-Axis.

The drilled chart displays sales revenue per city per category for the “City Trousers□? clothing line.



To drill on a measure in a chart

1. Verify you are in Drill mode.
2. Place your pointer on the measure value on which you want to drill.

   On charts, each measure is represented by a bar (on bar charts) or by a data marker (on a line charts and radar line charts).
3. If you want to drill down on the measure value, click the bar or data marker. If you want to drill up on the measure value, right-click the bar or data marker, and then click **Drill up**.

Limitations when drilling measures on charts

When you drill on charts that are not bar charts, Web Intelligence may perform the drill action only on certain dimensions instead of performing the drill action on all of the dimensions on the chart axes. When you drill on measures in the following chart types, Web Intelligence only performs the drill action on the values in the axis legend:

- area charts – 2D, 3D, and stacked
- radar and scatter charts – all types

Note:
You cannot drill on measures in 3D surface charts.

Drilling on axis legends

You can drill on charts via the chart legend whenever the legend lists the dimensions displayed on the chart. When the chart legend lists the measures displayed on the chart, drilling on the legend is not possible.

Drilling on a legend is useful, if you are working with a pie chart, because the axis labels, which display the names of the dimensions represented by each pie segment, are not often displayed.

Note:
You can only Drill by on a chart legend, if there is a single dimension on the axis.

To drill on an axis legend

1. Verify you are in Drill mode.
2. Place your pointer over the value on which you want to drill.
3. To drill down the dimension value, click the color associated with the value. To drill up the dimension value, right-click the color associated with the value, then click **Drill up** ; or click the **Drill Up** icon. To drill by the dimension value, right-click the color associated with the value, then click **Drill by** .

Using filters when you drill

When you drill on a dimension or measure value in a table or chart, Web Intelligence filters the drilled results by the dimension or measure you drilled on. The filter is applied to all of the results displayed on the drilled report.

Filters appear as list boxes in the Drill toolbar. Each list box contains the values associated with that filter. You select the data displayed in a table or chart by choosing the appropriate values from the list boxes.

Note:
You can also use the Drill toolbar outside Drill mode to quickly add simple report filters to reports. In this context the toolbar is known as the Report Filter toolbar.

Example: Filtering drilled reports by different US states

For example, if you drill down on a table cell displaying “California,□? to view results for cities in California, Web Intelligence filters the values in the entire report for California and only displays results for California in the report.

By changing the value of each filter, you can then see data for other values on the drilled dimension. For example, you can select Colorado in the filter on State.

Note:
If the drilled report includes dimensions from multiple data providers, a ToolTip appears when you rest your cursor on the value displayed on the filter. The ToolTip displays the name of the query and the dimension for the value.

Related Topics

- *To create simple report filters*

To change a filter value on the Drill toolbar

1. Verify you are in Drill mode.
2. In the Drill toolbar, click the drop-down arrow relating to the dimension you want to filter.
3. Click the value you want.

To add or remove a drill filter

1. Verify you are in Drill mode.
2. Drag the dimension containing the values around which you want to filter your report and drop it onto the Drill toolbar.

A list box for the new filter appears on the Drill toolbar. You can select a value from the list of values to filter the results displayed on the drilled table, chart, or report.

3. To remove a drill filter, drag the dimension away from the Drill toolbar.

Saving reports with drill filters

When you save a document with reports in drill mode, Web Intelligence maintains any filters that have been generated during drill. When you open a document saved in drill mode, Web Intelligence displays the Drill toolbar on the drilled reports showing the filters generated during the last drill session.

Note:
Documents saved in drill mode take longer to open than documents saved in results mode.

Refreshing data in a drilled report with prompts

Some Web Intelligence reports contain prompts. When you refresh the document, the prompt(s) require(s) you to specify the value(s) you want to retrieve from the database and return to the report(s) in the document. For example, a prompt can require you to specify a year, for which you want to retrieve data. This drilled report shows values for Year 2003 – the year selected for the prompt.

If the drilled report is filtered for Year 2003, and you then refresh the document and select year 2002 to answer the prompt, Web Intelligence retrieves results for 2002 instead of 2003. The drilled report then displays values for 2002.

Drilling with query drill

Query drill defined

You can set Web Intelligence to drill in query drill mode, which behaves differently from the standard drill mode described so far in this chapter. When

you activate query drill, Web Intelligence drills by modifying the underlying query (adding and removing dimensions and query filters) in addition to applying drill filters.

Example: Drilling down from month to week

In this example, Month is the lowest dimension currently available in the query from a time hierarchy, and Week is the dimension immediately below it in the hierarchy.

If you drill down on Month = January, three things happen:

- Web Intelligence adds Week to the query scope of analysis.
- Web Intelligence adds a query filter to restrict Month to January.
- Web Intelligence adds a drill filter to restrict Month to January.

If you drill up from Week to Month, the process is reversed:

- Web Intelligence removes Week from the query scope of analysis.
- Web Intelligence removes the query filter.
- Web Intelligence removes the drill filter.

Note:
Drill filters are not strictly necessary in query drill mode. Web Intelligence applies them for consistency with standard drill mode. For example, the `DrillFilters` function returns the correct value in query drill mode because Web Intelligence applies drill filters to match the query filters.

When do you use query drill?

You use query drill when your report contains aggregate measures calculated at the database level. It is designed in particular to provide a drill mode adapted to databases such as Oracle 9i OLAP, which contain aggregate functions that Web Intelligence either does not support, or cannot calculate accurately at the report level during a drill session.

The kinds of aggregate functions that are candidates for drilling in query drill mode are: percentages, distinct counts, ranks, standard deviations and variances, running aggregates, lead and lag functions. Because query drill modifies the query at each drill operation, it ensures that these aggregates are recalculated by the server each time you drill.

Query drill is also useful for reducing the amount of data that Web Intelligence must store locally during a drill session. Because query drill reduces the scope of analysis when you drill up, Web Intelligence is able to purge unecessary data.

To activate query drill

1. Right-click on the document anywhere outside a table or chart and click **Document Properties** to display the **Document Properties** pane.
2. Open the **Document Options** group within the tab.
3. Check **Use query drill**.

   If your report already has a scope of analysis defined, you see a message telling you to clear the scope of analysis before activating query drill.

Drilling with query drill

Drilling down with query drill

When you drill down, query drill behaves similarly to standard drill at the point where the data moves outside the scope of analysis.

When Web Intelligence filters a drilled dimension in query drill mode it does so by adding a query filter in addition to a drill filter. For example, if you drill on Year=2001, Web Intelligence adds a filter at the query level to restrict the Year dimension to 2001. For this reason, the only value that appears in the drill toolbar for the drilled dimension is the value on which you drilled (in this case 2001). This is different from standard drill mode, in which all values of the dimension are visible in the toolbar. As a result, you cannot change filter values in query drill mode (for example, drill on Year=2001 then switch to Year=2003) as you can in standard drill mode.

Because query drill automatically extends the scope of analysis, you can use it only if your BusinessObjects XI administrator has granted you the the right to drill outside the scope. See your administrator for more details.

Drilling up with query drill

When you drill up, query drill removes dimensions from the query. For example, if you drill up from Month to Quarter, Web Intelligence removes Month from the query. This has two consequences:

- Query drill is incompatible with drill snapshots.

- Web Intelligence does not allow you to drill up beyond any dimension that appears as one of the report objects. For example, if your report displays Year, Quarter and Revenue, you cannot drill up from Quarter to Year because this would remove quarter from the list of report objects.

Related Topics

- *Query drill and drill snapshots*

Query drill and drill snapshots

Do not use drill snapshots when working in query drill mode, because query drill means that snapshots cannot be guaranteed to stay the same.

In query drill mode, snapshots change when you drill up beyond a dimension that you included in a snapshot. Because the drill up removes the dimension from the underlying query, it also removes the dimension from the snapshot.

Query drill and other reports based on the same data provider

If your document contains other reports that contain dimensions on which you drill in query drill mode, these reports are affected because the query drill modifies the dimensions they contain.

You can avoid this (at the cost of retrieving duplicate data into Web Intelligence) by creating a new data provider and rebuilding the other report against it. Now when you drill in query drill mode, the other report remains unaffected.

Example: Drilling on a dimension that appears in another report

If you have two reports based on a query that contains Year, Quarter and Sales Revenue, and you use query drill to drill down to Year = 2001 on the first report, Web Intelligence also filters the data for Year in the second report to include 2001 only.

Merging dimensions from multiple data providers

chapter 23

Merged dimensions defined

You can include multiple data providers in a Web Intelligence document. You often need to synchronize the data returned by these data providers. You do this by incorporating common dimensions into a merged dimension.

Merged dimensions and data synchronization were introduced in Web Intelligence XI R2. They enormously increase the power and flexibility of Web Intelligence by allowing you to synthesise data from different sources in the same report, rather than simply including the data.

For example, if you have one database that contains detailed customer information and another database that contains sales data, you can synchronize the two data sources around the customer.

When to merge dimensions

You merge dimensions when your report draws related data from different data providers. For example, you have a report showing revenue and sales targets. The report contains sections based on the year, and each section shows revenue and sales targets. If revenue and sales target data comes from two different data providers, Web Intelligence does not know that it is related. You tell Web Intelligence that the data is related by merging the two data providers on the common dimension, year.

When you merge dimensions, Web Intelligence creates a new dimension that contains all the values from the original dimensions that make up the merged dimension. You use this dimension in reports as you use any other report object. You can add report objects from all the data providers synchronized through the merged dimension in the same block as the merged dimension.

Choosing which dimensions to merge

The only restriction that Web Intelligence imposes on merged dimensions is that they must be of the same data type: for example, character data. But it does not make sense to merge unrelated dimensions even when their data types are the same. For example, it does not make sense to merge a

dimension containing customer names with a dimension containing sales regions.

Merged dimensions often have the same name in both data sources, but this is not obligatory. It can make sense to merge dimensions with different names if they contain related data.

To merge dimensions correctly you need to be aware of the semantics of the data (what the data refers to) in the different data sources. The dimension data types and names are an approximate guide only to dimensions' suitability for merging.

Merged dimension example

The following example with two data providers illustrates the effect of merging dimensions:

Example: Merging City dimensions

Data Provider 1:

Country	City
US	New York
US	Los Angeles
France	Paris
France	Toulouse

Data Provider 2:

City	Revenue
New York	100000
Los Angeles	75000
Paris	90000

City	Revenue
Toulouse	60000

If you merge the City dimensions and display the Country, merged City dimensions and Revenue measure in a table, Web Intelligence returns the following result:

If the City dimensions are not merged, Web Intelligence displays the following result:

Country	City	Revenue
US	New York	325000
US	Los Angeles	325000
France	Paris	325000
France	Toulouse	325000

Because there is no link between the two data providers through a merged dimension, Web Intelligence is unable to relate the city revenues to countries. As a result Web Intelligence displays the total revenue against each Country/City pair.

If the City dimensions are merged, Web Intelligence displays the following result:

Country	City	Revenue
US	New York	100000
US	Los Angeles	75000
France	Paris	90000
France	Toulouse	60000

Forcing merged calculations with the ForceMerge function

By default, Web Intelligence does not account for merged dimensions in calculations if the merged dimensions do not explicitly appear in the calculation context.

Example: Calculating revenue with ForceMerge

This example has two data providers as follows:

Data Provider 1:

Country	City
US	New York
US	Los Angeles
France	Paris
France	Toulouse

Data Provider 2:

City	Revenue
New York	100000
Los Angeles	75000
Paris	90000
Toulouse	60000

If you merge the [City] dimensions, then create a table with [Country] and [Revenue], Web Intelligence displays the following result:

Country	Revenue
US	325000
US	325000
France	325000
France	325000

Because [City], the merged dimension, does not appear in the table, Web Intelligence does not take the merge into account when calculating revenue. Web Intelligence lists the total revenue in the second data provider against each country.

To display the correct result, replace [Revenue] in the second column with the formula `ForceMerge([Revenue])`:

City	Revenue
US	175000
US	175000
France	150000
France	150000

Web Intelligence now takes the relationship between countries and cities into account when calculating revenue.

Note:
If [Revenue] is a smart measure in the above example, `ForceMerge([Revenue])` returns #MULTIVALUE. This is because the grouping set (Country) does not exist for the [Revenue] measure. `ForceMerge([smart_measure])` always returns #MULTIVALUE, unless by chance no aggregation is required to calculate the measure.

Creating, editing and deleting merged dimensions

To merge dimensions

1. Click **Merge Dimensions** on the toolbar (you can also select**Data** > **Merge Dimensions** in Web Intelligence Rich Client).

   The "Merge Dimensions" dialog box appears.
2. Select the dimensions you want to merge in the boxes at the top of the dialog box.

   When you select a dimension, all dimensions of different data types are disabled because you cannot merge dimensions of different data types.
3. Click **Values** to view the values associated with the dimensions.
4. Click **Merge**.

   The "Create Merged Dimension" dialog box appears. You use this dialog box to specify the properties of the merged dimension.
5. Select the dimension in the **Source Dimension** drop-down list.

   The source dimension provides the default name, description and number formats for the merged dimension.
6. Type the merged dimension name in the **Merged Dimension Name** box and the merged dimension description in the **Description** box.
7. Click **OK**.

   The merged dimension name appears in the "Merged Dimensions" box and the dimensions that are part of the merged dimension appear in the boxes alongside it. Because an original dimension can be part of one merged dimension only, it no longer appears in the box above that lists the original dimensions in the query.
8. Click **OK** to close the "Merged Dimensions" dialog box.

   Web Intelligenceadds the merged dimensions to the list of merged dimensions in the **Data** tab.

To define a merged dimension

You define a merged dimension in the "Create Merged Dimension" dialog box.

1. Type the merged dimension name in the **Merged Dimension Name** box.
2. Type the merged dimension description in the **Description** box
3. To use the name and description of one of the source dimensions in the merged dimension, select the source dimension from the **Source Dimension** list.
4. Click **OK**.

To merge dimensions automatically

You can set Web Intelligence to merge dimensions automatically under the following circumstances:

- The dimensions have the same name
- The dimensions have the same data type
- The dimensions are in the same universe

1. Right-click outside any block or chart and click **Document Properties** on the popup menu.
2. Click **Auto-merge dimensions**.

To control auto merge dimensions

You can set Web Intelligence to not merge dimensions automatically even if the auto-merge dimensions criteria exist.

To disable merging dimensions automatically:

1. Click**Tools** > **Options** > **Data Synchronization**.
2. Uncheck **Auto-Merge dimensions**.

   Note:
   By default, the **Auto-Merge dimensions** option is selected.

3. Click **OK**.

To edit a merged dimension

1. In the **Data** tab, select the dimension in the **Merged Dimensions** folder and click the right mouse button.
2. Select **Edit Merged Dimension** from the menu.

   The "Merged Dimensions" dialog box appears.
3. Edit the merged dimension.

Related Topics

- *To merge dimensions*

To delete a merged dimension

1. Select the dimension in the **Merged Dimensions** folder in the **Data** tab and click the right mouse button.
2. Select **Delete Merged Dimension** from the menu.

Understanding the effects of merged dimensions

Data synchronization through merged dimensions adds enormous power to Web Intelligence. Merged dimensions also have implications for the results that Web Intelligence displays in certain situations. You need to understand these implications to work effectively with merged dimensions and synchronized data.

Synchronizing data providers with different aggregation levels

You can synchronize data providers with different aggregation levels. This can have implications for the way in which Web Intelligence calculates measures.

Example: Synchronizing data providers with different aggregation levels

In this example you have two data providers as follows:

Customer	Year	Revenue
Jones	2004	1500
Jones	2005	2000
Smith	2005	1200

Customer	Number of sales
Jones	12
Smith	10

If you merge the two data providers and the table properties **Avoid duplicate rows aggregation** and **Show rows with empty dimension values** are unchecked, Web Intelligence returns the following:

Customer	Year	Revenue	Number of sales
Jones	2004	1500	12
Jones	2005	1200	12
Smith	2005	1200	10

Web Intelligence cannot determine the number of sales per year for customer Jones because the data provider that stores the number of sales does not break them down by year. Web Intelligence therefore reproduces the total number of sales on each row.

Note:
Although the Number of Sales values are duplicated, if you add a standard calculation to the bottom of the column (for example a Sum or Average calculation), the result is correct.

One way of adressing this issue is to add the dimensions to the second data provider that allow Web Intelligence to calculate to the appropriate level of data. If this is not possible, you must be aware of any situations where Web Intelligence cannot aggregate the data to the necessary level of detail.

Detail objects and merged dimensions

Detail objects are associated with dimensions and provide additional information about the dimension.

Web Intelligence XI R2 requires a one-to-one relationship between dimensions and details (this means that a detail object can have one value only for each value of its associated dimension) and does not take detail objects into account when synchronizing data. The following example illustrates why this is necessary.

Previous versions of Web Intelligence, as well as Desktop Intelligence and BusinessObjects, allow a one-to-many relationship between dimensions and details. If you migrate a report created using any of these products and the detail object contains multiple values, Web Intelligence places the #MULTIVALUE error in the detail cell.

Example: Synchronizing data providers with detail objects

In this example you have two data providers, and [Address] is a detail object related to [Customer]:

Customer	Address	Revenue
John	London	10000
Paul	Liverpool	15000

Customer	Telephone Number
John	1234
Paul	5678

If you create a merged Customer dimension to synchronize the data providers, and Address can have more than one value for each customer, the result is ambiguous because there is no common value around which Web Intelligence can synchronize the data.

For example, Paul might have addresses in Liverpool and London, which means that there is no unique ‘Paul’ row with which Web Intelligence can synchronize Paul's telephone number. Paul has a different telephone number for each address, and Web Intelligence does not know which address to associate with the telephone number:

Customer	Address	Telephone Number
John	London	1234
Paul	#MULTIVALUE	5678

If the relationship between Customer and Address is one-to-one, Web Intelligence can ignore Address in the synchronization. This removes the ambiguity:

Customer	Address	Telephone Number
John	London	1234
Paul	Liverpool	5678

Incompatible objects and merged dimensions

As a general rule, Web Intelligence does not allow you to place dimensions from different data providers in the same table. This is to avoid Cartesian products (the display of all possible combinations of values from unrelated objects) or other ambiguous results, depending on the universe structure.

You can always place measures from different data providers in a table. Web Intelligence calculates the measure depending on what dimensions are available. For example, if you place a measure in a table that contains no dimensions from the same data provider as the measure, Web Intelligence displays its total value in the table.

You can place a merged dimension in a table as long as the table contains other dimensions from a data provider that participates in the merge. You can also place details from different data providers in a table, as long as the details are associated with dimensions that participate in a merged dimension.

In certain situations, it can be valid to place a dimension from another data provider in a table, even when Web Intelligence does not permit this. This occurs when the incompatible dimension has a one-to-one or one-to many relationship with a dimension already in the table. The important point is that there is only one value of the incompatible dimension associated with the dimension in the table (one-to-one). On the other hand, the same value of the incompatible dimension can be associated with multiple values of the dimension in the table (one-to-many).

In the table below, the relationship between Address and Name conforms to these rules: Address has a one-to-one or one-to-many association with Name. There is no one-to-many association in the other direction, between Name and Address (one name with more than one address):

Dimension in table (Name)	Incompatible dimension (Address)
John	London
Paul	London
George	Liverpool

In this case the universe design is incorrect - the incompatible dimension (Address) should be defined as a detail of the dimension in the table (Name).

If you encouter this situation, see your Business Objects administrator and ask for a redesign of the universe.

If it is not practical to change the universe, create a variable at the report level. Define this variable as a detail, associate it with the dimension in the table, and supply the name of the incompatible dimension as the variable definition. The variable simply returns the same values as the incompatible dimension. Because it is defined as a detail of the dimension in the table, Web Intelligence allows you to place it in the same table as the dimension.

Filtering merged dimensions

Merging dimensions has implications for the way in which Web Intelligence applies filters.

Note:
You cannot apply a filter a on merged dimension. You apply filters on the dimensions that make up the merged dimension.

Report filters and merged dimensions

When you apply a report filter to a dimension that is part of a merged dimension, Web Intelligence applies the filter to all data providers that are synchronized through the merged dimension.

Example: Filtering a merged dimension

In this example you have a report with the following data providers, which are merged on the Country dimension

Country	Resort	Revenue
France	French Riviera	835,420
US	Bahamas Beach	971,444
US	Hawaiian Club	1,479,660

Country	Future Guests
France	46
US	56

If you apply the filter Country=□?US□? to the first block, Web Intelligence also filters the second block to give the following result:

Country	Future Guests
US	56

If the Country dimensions are not merged the second block is unaffected by the filter.

Section filters and merged dimensions

When a dimension that is part of a merged dimension is set as a section header, any filter applied to the section also applies to blocks from synchronized data providers within the section.

Related Topics

- *Filtering a merged dimension*

Block filters and merged dimensions

When you apply a block filter to a dimension that is part of a merged dimension, Web Intelligence applies the filter to the block. Web Intelligence does not apply the filter to other data providers synchronized through the merged dimension.

Drilling on merged dimensions

When you merge dimensions, the new merged dimension belongs to the hierarchies of all dimensions involved in the merge.

When you drill upon a merged dimension, the application provides you the query name and context for the object being drilled upon. You need to select the appropriate context applicable for a document.

Extending the values returned by merged dimensions

Merged dimensions were a new concept in Web Intelligence XI R2. Synchronizing data providers already existed in Desktop Intelligence/BusinessObjects but it did not involve the creation of a new merged dimension. BusinessObjects reports use the original dimensions that make up a merged dimension in Web Intelligence.

You can use these original dimensions in a Web Intelligence report. When you place them in the report, Web Intelligence returns by default only those dimension values that have corresponding values in the data providers synchronized through the merge. You need to be aware of this when migrating reports from Desktop Intelligence and BusinessObjects because BusinessObjects/Desktop Intelligence behaves differently.

Example: Web Intelligence and Desktop Intelligence/BusinessObjects behavior when dimensions are merged

You have a report with the following data providers:

Country of origin	Revenue
Germany	470

Country of origin	Revenue
Japan	499

If you include the Country of Origin dimension from Data Provider 1 and the Revenue measure from Data Provider 2 in the same block, Web Intelligence returns the following result:

Country of origin	Revenue
Germany	

The same block in Desktop Intelligence/BusinessObjects returns the following result:

Country of origin	Revenue
Germany	
Japan	499

The block is different in Desktop Intelligence/BusinessObjects because BusinessObjects extends the values of the Country of Origin dimension through the values returned by the Revenue measure.

To extend dimension values

1. Right-click your report outside any blocks or charts and select **Document Properties** on the shortcut menu.

   The **Document Properties** pane appears on the right side of the report.

2. Check the **Extend merged dimension values** option.

Ranking report data

chapter 24

Ranking data

Ranking allows you to isolate the top and bottom records in a set based on a variety of criteria. For example, if you have a block showing countries and associated revenues, ranking allows you to rank the data in the block to show the top 3 countries only, based on the revenue they generate.

Ranking allows you to answer business questions such as:

- Which 3 regions generate the most revenue?
- Which are the bottom 10% of stores in terms of revenue generation?
- What is the group of the best-performing stores that generates a combined revenue of up to $10,000,000?

Web Intelligence allows you to rank data in many ways to answer these kinds of business questions. You can:

- rank the top and/or bottom n records by dimension (for example Country) based on the sum of a related measure (for example Revenue)
- rank the top and/or bottom n% of the total number of records by dimension based on the value of a related measure as a percentage of the total value of the measure
- rank the top and/or bottom n records by dimension based on the cumulative sum of a related measure
- rank the top and/or bottom n records by dimension based on the value of a related measure as a cumulative percentage of the total value of the measure

Rankings and sorts

Web Intelligence sorts data as part of applying a ranking. For example, if you rank the top 3 stores by revenue, Web Intelligence sorts the stores in descending order by revenue generated.

The sorts that Web Intelligence applies in rankings take precendence over sorts that you have previously applied to your data. For example, if you have previously sorted the list of stores in alphabetical order, Web Intelligence overrides this sort when applying the ranking.

Tied rankings

Web Intelligence assigns equal ranking values to tied rankings and pushes back the ranking values of the rows after the tie. This means that a bottom n ranking can return more than n records.

Example: Top and bottom tied rankings

The following table shows a tied ranking. The Top 3 ranking column shows how Web Intelligence ranks these records in a top 3 ranking; the Bottom 3 Ranking column shows how Web Intelligence ranks these records in a bottom 3 ranking.

Dimension	Measure	Top 3 Ranking	Bottom 3 Ranking
A	10	4	1
B	20	3	2
C	30	1	3
D	30	1	3

In each case Web Intelligence includes records up to and including rank 3. This results in the following for a top 3 ranking:

Dimension	Measure
D	30
C	30
B	20

It results in the following for a bottom 3 ranking:

Dimension	Measure
A	10
B	20
C	30
D	30

Ranking parameters

Parameter	Description
Top/bottom	When the calculation mode is Count, the ranking returns the top/bottom n records based on the measure specified in the Based on parameter. For example, the top 3 countries by revenue generated, the bottom 3 year/quarter combinations by revenue generated. When the calculation mode is Percentage, the ranking returns the top/bottom n% of the total number of records based on the measure specified in the Based on parameter. For example, if there are 100 records and you rank the top 10%, the ranking returns the top 10 records. When the calculation mode is Cumulative Sum, the ranking returns the top/bottom records for which the cumulative sum of the measure specified in Based on does not exceed n. When the calculation mode is Cumulative Percentage, the ranking returns the top/bottom records for which the cumulative sum of the measure specified in Based on does not exceed n% of the total of the measure.

Parameter	Description
n/n%	When the calculation mode is Count - the number of records to retrieve based on the measure. When the calculation mode is Percentage - the percentage of records to retrieve based on the measure. When the calculation mode is Cumulative Sum - the cumulative sum that the measure must not pass. When the calculation mode is Cumulative Percentage - the cumulative sum of the measure, represented as a percentage of the total, that the measure must not pass.
Based on	The measure on which the ranking is based.
Ranked By	The ranking dimension. If you specify a ranking dimension, Web Intelligence uses the aggregated values of the Based on measure, calculated for the dimension, to determine the ranking. If you do not specify this dimension, Web Intelligence uses the values of the Based on measure calculated for all dimensions in the block. (In other words, Web Intelligence returns the top/bottom X rows in the block based on the measure.)
Calculation mode	The type of calculation used to create the ranking. See the description of the Top/Bottom and n/n% parameters at the top of this this table for more information.

Example of a ranking

A table contains the following data:

Year	Quarter	Revenue
2006	Q1	100
2006	Q2	200
2006	Q3	300
2006	Q4	500
2007	Q1	400
2007	Q2	700
2007	Q3	300
2007	Q4	600
2008	Q1	200
2008	Q2	200
2008	Q3	400
2008	Q4	500

Total for Q1: 700

Total for Q2: 1100

Total for Q3: 1000

Total Q4: 1600

If you rank the top 2 of each Quarter based on Revenue, Web Intelligence filters out all the rows for Q1 and Q3 because Q4 and Q2 have the highest aggregate revenues.

Ranking and data order

You cannot rank on an object whose values depend on the data order. This is because the ranking changes the data order, which in turn changes the object data, which then requires Web Intelligence to recalculate the ranking. The result is a circular dependency between the ranking and the object that Web Intelligence cannot resolve.

If you create a rank on a measure whose values depend on the data order, for example a measure that that uses the `Previous` function or any of the running aggregate functions such as `RunningSum`, Web Intelligence displays the #RANK error message in all cells in the block.

Ranking workflows

There are two ways of ranking data in Web Intelligence. You can:

- create a ranking by using the Web Intelligence interface
- use the `Rank` function to return a ranking value

When you rank the data in a block by using the Web Intelligence interface, you tell Web Intelligence to sort and filter the data in the block according to the rank. For example, if you rank the top 3 countries in a block by revenue, Web Intelligence sorts the countries in descending order by revenue, then filters the block to remove all countries other than the 3 with the highest revenue.

Note:
When you create a ranking using the interface, Web Intelligence uses the `Rank` function behind the scenes to assign ranking values.

To create a ranking

1. Select the block that you want to rank.
2. Click **Rank**.

   The "Create Rank" dialog box appears
3. Click **Top** and select the number of records if you want to rank the highest records in the block.

4. Click **Bottom** and select the number of records if you want to rank the lowest records in the block .
5. Select the measure on which the ranking is based in the **Based on** list.
6. Click **Ranked By** and select the dimension on which the ranking is based if you want to rank by a particular dimension rather than by all dimensions in the block.
7. Select the rank calculation mode in the **Calculation mode** list.
8. Click **OK**.

Ranking examples

In the following examples, you have a dimension, Region, and a measure, Revenue, which give the following values:

Region	Revenue	% of Total Revenue
South East	1000000	7%
South West	2000000	13%
North East	3000000	20%
North West	4000000	24%
Central	5000000	33%

Example: Rank the top 3 regions by revenue generated

1000000

Parameter	Value
Top/Bottom	Top
n/n%	3

Parameter	Value
For Each	Region (or unspecified because region is the only dimension in the block and therefore the default ranking dimension)
Based on	Revenue
Calculation mode	Count

This ranking gives the following result:

Region	Revenue
Central	5000000
North West	4000000
North East	3000000

To calculate this ranking, Web Intelligence:

- sorts the records in descending order
- displays the top 3 records

Example: Rank the bottom 40% of regions by revenue

To perform this ranking you set the following parameters

Parameter	Value
Top/Bottom	Bottom
n/n%	40%
For Each	Region

Parameter	Value
Based on	Revenue
Calculation mode	Percentage

This ranking gives the following result:

Region	Revenue
South East	1000000
South West	2000000

To calculate this ranking, Web Intelligence:

- sorts the records in ascending order
- works through the records until 40% of the total number of records are displayed

---

Example: Rank the top regions whose cumulative revenue is less than or equal to 10,000,000

To perform this ranking you set the following parameters:

Parameter	Value
Top/Bottom	Top
n/n%	10000000
For Each	Region
Based on	Revenue
Calculation mode	Cumulative sum

This ranking gives the following result:

Region	Revenue
Central	5000000
North West	4000000

To calculate this ranking, Web Intelligence:

- sorts the records in descending order
- works through the records until it reaches the record that causes the the cumulative total of the measure to pass 10,000,000
- includes those records that do not cause the cumulative total to pass 10,000,000

Example: Rank the bottom regions whose cumulative revenue is less than or equal to 30% of the total revenue

To perform this ranking you set the following parameters:

Parameter	Value
Top/Bottom	Bottom
n/n%	30%
For Each	Region
Based on	Revenue
Calculation mode	Cumulative percentage

This ranking gives the following result:

Region	Revenue
South East	1000000

Region	Revenue
South West	2000000

To calculate this ranking, Web Intelligence:

- sorts the records in ascending order
- works through the records until it reaches the record that causes the cumulative total of the measure, expressed as a percentage of the overall total of the measure, to exceed 30%
- displays those records that do not cause the cumulative percentage to pass 30%

Using alerters to highlight results

chapter 25

Alerters defined

Alerters enable you to highlight results that meet or fail specific business targets. You can create a simple alerter to highlight particularly high or low results with a specific color or with a text comment, such as “High Performer".

An alerter can contain up to six conditions. This enables you to highlight information that meets multiple business criteria. For example, you can define an alerter that highlights high revenue for a specific business activity or customer sector.

You can apply alerters to table body cells (by column or row), to section cells, to header cells, and to free-standing cells. However, you cannot apply alerters to entire tables or forms, or to charts.

Business Objects officially supports up to 30 alerters in a Web Intelligence document. You can apply those alerters to a maximum of 20 table columns or rows, free-standing cells, or section cells on the reports.

Business Objects officially supports up to 10 different alerters on a single table column or row, free-standing cell, or section cell.

You can define alerters to activate the following formatting changes to the selected table columns/rows or cells:

- text color, size and style
- cell border colors and style
- cell background display – specific colors, images, or hyperlinks to web pages

You can also define alerters that display a text or formula, an image, or a hyperlink. In this case, the results that meet the condition defined in the alerter will be replaced by the text for formula.

If you define an alerter with multiple conditions, each condition generates the same formatting changes. To generate different formatting changes for different conditions, you must use sub-alerters.

Alerters are dynamic. This means that when you refresh reports with the latest data on the database, the alerters highlight the new results accordingly.

If you apply an alerter to a table row or column with a break, the alerter is only activated when the value that meets the condition in the alerter appears on the first row of that break.

Web Intelligence Interactive displays the formatting effects of alerters created using the Java Report Panel or Web Intelligence Rich Client. You cannot create new alerters in Web Intelligence Interactive.

Sub-alerters

An alerter can be made of multiple sub-alerters, each containing one or multiple conditions. Sub-alerters allow you to apply different conditions and different formatting to a single object.

You must use sub-alerters if you want different conditions to generate different formats. If you define an alerter with multiple conditions, the alerter format is applied to all of the conditions.

For example, in a single alerter defined for [Sales revenue], one sub-alerter can highlight high results in green and a second sub-alerter can highlight low results in red. You can include a maximum of eight sub-alerters in an alerter.

To add, edit, duplicate, prioritize or activate alerters

1. To display the "Alerters" dialog box, click **Alerters** on the Reporting toolbar (you can also select**Reporting** > **Alerters** in Web Intelligence Rich Client.)
2. To add an alerter, click **New** then build the alerter using the Alerter Editor.
3. To edit an alerter, select the alerter from the list, click **Edit** then use the Alerter Editor to edit the alerter.
4. To duplicate an alerter, select the alerter from the list then click **Duplicate**.
5. To remove an alerter, select the alerter from the list than click **Remove**.
6. To activate or deactivate an alerter, select the alerter from the list then check or uncheck the alerter.
7. To prioritize an alerter, select the alerter from the list then use the up or down arrow buttons to change the priority of the alerter in the list.

To build an alerter

1. Type the alerter name in the **Alerter name** box in the Alerter Editor.

2. Type the alerter description in the **Description** box.
3. Define the conditions that trigger the alerter as described in the following four steps.
4. Select the cell or object whose value triggers the alerter in the **Filtered object or cell** box.

   If the cell on which you want to create an alerter contains date or numeric type data (for example, a date or a calculation) you need to select an object or variable instead of **Cell contents**. This is because Web Intelligence considers any value you type into the **Value** text box as a character string.

   - To trigger the alerter using the data in whichever cell is currently selected, click **...**, then select **Cell contents** from the menu.
   - To trigger the alerter using the value of an object or variable, click **...**, select **Select Object or Variable** on the menu, then select the object or variable in the "Objects and Variables" dialog box.
5. Select the operator from the **Operator** list.
6. Enter the value that triggers the alerter in the **Value** box.
   - To enter a value directly, type it in the box.
   - To select a value from the list of values of the object you chose in the **Filtered object or cell box**, click **...** to the right of the **Value** box, click **Select Value** on the menu, then select the value in the "List of Values" dialog box.
   - To select another object or variable as the value, click ... to the right of the **Value** box, click **Select Object or Variable** on the menu, then select the object or variable in the "Objects and Variables" dialog box.
   - To clear the **Value** box, click **...** to the right of the box, the select **Empty** on the menu.
7. To add an additional condition that triggers the alerter, click **+** below the existing conditions, then then choose the filtered cell or object, operator and value as described above.
8. To remove a condition, click **-** next to the condition.
9. To trigger the alerter using a formula instead of conditions as described above, click **Formula**, then type the formula in the box that appears or click **Fx** to build the formula using the Formula Editor.
   - Do not include quote marks before or after the text. For example, if you want the alerter to display OVERDUE, then type: OVERDUE.

- The formula must return True or False. True triggers the alerter; False does not. For example, if the formula is `RowIndex()=3`, the alerter formatting appears on the fourth row of the table.

10. To add an additional condition or set of conditions to the alerter, click **Add Sub-Alerter**, then define the conditions or build a formula as described above.
11. To remove a sub-alerter, click **Remove Sub-Alerter**.
12. To set the format that appears when the alerter is triggered, click **Format** then use the **Alerter Display** dialog box to set the format.

To set the format of an alerter

1. Click **Format** in the Alerter Editor.

   The "Alerter Display" dialog box appears.
2. Type the alerter text or the formula that the alerter uses to generate its output in the **Display** box.

   You can also build a formula by clicking **Fx** and using the Formula Editor.
3. Define the text format (font, font style color and alignment) in the **Text** area.
4. Define the color and image of the alerter background in the **Background** area.
5. Define the alerter border in the **Border** area.
6. Click **OK** to return to the Alerter Editor.

Using formulas to create advanced alerters

You can build advanced alerters using the Web Intelligence formula language rather than using the **Filtered object or cell**, **Operator** and **Operand** choices offered by default.

You can create alerters that display text, formulas, or hyperlinks in the report cells, where results meet the condition(s) defined in the alerter.

This enables you to display messages in cells, such as “UNPAID,□? or to display formulas that change the results (for example, to display a text you specify and the result of the object in the same cell), or to include links to

other web pages that can be consulted easily whenever results meet the business condition(s) set in the alerter.

Example: Highlighting three ranges of quarterly sales revenue results calculated as percentages of the average sales revenue

In this example, you build three alerters to color-code sales revenues, depending on their relationship to the average sales revenue. The table includes results for three years, and this is the average to which you want to compare each sales revenue result calculated per quarter per product line.

Using the Formula option in the Alerter Editor, you build the following alerter, which contains three sub-alerters.

Each sub-alerter has a single condition. Web Intelligence combines the sub-alerters with the Or operator, as follows:

```
[Sales revenue] < ((Average([Sales revenue]) In Block)
 * 0.8)
```

Or

```
=[Sales revenue] < ((Average([Sales revenue]) In Block)
 * 1.2)
```

Or

```
=[Sales revenue] > ((Average([Sales revenue]) In Block)
 * 1.2)
```

The formula you specify for each sub-alerter is calculated as follows:

- The first sub-alerter will be activated on sales revenue results that are < 0.8 (this means, less than 80%) of the average.
- The second sub-alerter will be activated on sales revenue results that are < 1.2 (this means, less than 120%) of the average.
- The third sub-alerter will be activated on sales revenue results that are > 1.2 (this means, greater than 120%) of the average.

You then use the formula pane in the Alerter Display dialog box, to specify the conditional formatting you want displayed on the report cells. Here, you specify an appropriate text string and format you want displayed, when the results in a table cell meet the condition for one of the sub-alerters. You specify the following:

- Report cells containing sales revenue results that are less than 80% of the average revenue display the character string in red.
- Report cells containing sales revenue results that are less then 20% above the average revenue display in blue. Note that this alerter covers values also covered by the first alerter. For example, if the average is 100, then 79 is both > 80% below the average and < 20% above the average. In this case, the first alerter takes precedence.
- Report cells containing sales revenue results that are greater than 20% above the average revenue display in green.

This formatting enables you to see at a glance which product lines are generating above or below the total average sales revenue.

Tracking changes in data

chapter 26

Tracking changes in your data

To make informed and effective business intelligence decisions, you need to understand how the data on which you base those decisions changes over time. Web Intelligence allows you to track and display data changes to help you focus your analysis on key areas and avoid wasting time exploring irrelevant data.

When you track data changes, you select a particular data refresh as a reference point. This data is known as the reference data. When you display the data changes, Web Intelligence places your current data in context by showing how it relates to the reference data.

Here are some examples of the usefulness of data tracking:

- If an outlet no longer appears in a list of the top outlets by sales, Web Intelligence displays the outlet as deleted from the list. You can use this information to investigate why the outlet is no longer a top performer.
- If sales have decreased in a region, data tracking displays the decrease. You can then drill down into the data for the region to understand why revenue is falling.

  In both these cases, data tracking makes the current data more meaningful by placing it in context with old data. Without this context it is much more difficult to identify trends.

Types of data change

Web Intelligence allows you to track the following types of data change:

- added data
- removed data
- modified data
- increased data
- decreased data

You configure the display of these changes through the Web Intelligence interface or the Web Intelligence formula language. The formula language provides advanced users with additional power and flexibility in displaying and formatting changed data.

Data tracking modes

Automatic data tracking mode

In automatic data tracking mode, Web Intelligence always compares the current data with the data before the last refresh. To do this, Web Intelligence sets the current data as the reference data just before each refresh. The reference data is always one refresh behind the current data.

Automatic data tracking is appropriate for scheduled documents when you want to compare the current data with the data before the last refresh.

Manual data tracking mode

In manual data tracking mode, you select the reference data. Web Intelligence continues to use this data as a reference point until you update the reference point.

To activate data tracking

1. Click **Track** on the main toolbar to display the "Activate Data Tracking" dialog box.
2. Select options in the dialog box.

Option	Description
Auto-update the reference data with each data refresh	The current data becomes the reference data after each data refresh. The report always shows the difference between the most recent data and the data before the last refresh.
Use the current data as reference data	The current data becomes the fixed reference data and remains the reference data after further data refreshes. The report always shows the difference between the most recent data and this fixed reference data.

3. Click "Refresh Now" to refresh the data when the dialog box closes.

4. Click **OK**

To change the reference data

1. Click **Data Tracking Options** on the main toolbar, or click the **Auto-update/Fixed Data** hyperlink in the status bar to display the "Data Tracking Options" dialog box.
2. Select the **Reference Data** tab.
3. Select options.

Option	Description
Auto-update the reference data with each data refresh	The current data becomes the reference data after each data refresh. The report always shows the difference between the most recent data and the data before the last refresh.
Use fixed reference data from	The data you select becomes the fixed reference data and remains the reference data after further data refreshes. The report always shows the difference between the most recent data and this fixed reference data.

Displaying changed data

To display or hide changed data

- Click **Hide Changes/Show Changes** (the button tooltip text varies depending on whether changed data is currently visible) to the right of **Track** on the main menu.

Configuring the appearance of changed data

You can configure the appearance (font style, size and color) of changed data in your document. You can seperately configure the appearance of the following changes:

- Inserted, deleted and changed dimension and detail values

- Increased or decreased measure values

Measure values can also adopt the formatting of inserted or deleted dimension values. For example, if a dimension value disappears from a list of values in a block, and the block also shows a measure value for the dimension, both the dimension and measure values appear as deleted data.

Your Business Objects administrator defines the default appearance of changed data in the Central Management Server. When you configure the appearance of changed data in Web Intelligence, you override the CMS defaults.

To configure the appearance of changed data

1. Click **Data Tracking Options** on the main toolbar to display the "Data Tracking Options" dialog box.
2. Select the **Format** tab.
3. Select each type of changed data you wish to display and click "Format" to specify how you want the changes to appear.

How changed data is displayed in blocks

Example: Changed data in a simple block

This example uses a document with a block showing [Country], [Year] and [Revenue]. The original data was as follows:

Country	Year	Revenue
France	2003	1000
France	2004	2000
Japan	2002	1000
Poland	2002	1200

After a refresh, the data is as follows:

Country	Year	Revenue
France	2004	3000
Japan	2003	900
Poland	2002	800
UK	2004	900

When data tracking is activated and data changes displayed, the block appears as follows:

Country	Year	Revenue	Formatting
France	2003	1000	[deleted data formatting on all cells]
France	2004	3000	[increased data formatting on Revenue cell]
Japan	2002	1000	[deleted data formatting on all cells]
Japan	2003	900	[inserted data formatting on all cells]
Poland	2002	800	[decreased data formatting on Revenue cell]
UK	2004	900	[inserted data formatting on all cells]

- The rows showing revenue for France in 2003 and Japan in 2002 represent data that no longers exist after the refresh.
- The revenue for France in 2004 has increased.
- The revenue for Poland in 2002 has decreased.

- The rows showing revenue for Japan in 2003 and the UK in 2004 appeared after the refresh.

How changed data is displayed in reports with merged dimensions

Web Intelligence displays a dimension as changed only if all the dimensions that participate in the merge are changed.

Example: Changed data and merged dimensions

In this example, Country is a merged dimension containing the Country dimensions from two data providers. Before data refresh, the data is as follows:

Country (DP1)	Revenue (DP1)	Country (DP2)	Sales (DP2)
US	10000	US	5000
France	4000		
UK	5000	UK	3000
Germany	1000	Germany	1000

After a data refresh, the data becomes:

Country (DP1)	Revenue (DP1)	Country (DP2)	Sales (DP2)
US	10000	US	4000
France	4000	France	3000
UK	6000	UK	4000
Poland	2000		

When displayed in a block with the merged Country dimension and data changes displayed, the data appears as follows:

Country	Revenue	Sales	Formatting
US	10000	4000	[decreased data formatting on Sales cell]
France	4000	3000	[inserted data formatting on Revenue cell]
UK	6000	4000	[increased data formatting on Revenue and Sales cells]
Germany	1000	1000	[deleted data formatting on all cells]
Poland	2000		[inserted data formatting on Country and Revenue cells]

In the France row, France does not appear as inserted because a France row was not inserted in both data providers. Revenue appears as inserted because it is a new measure value after the data refresh.

In the Poland row, Poland appears as inserted because it is a new dimension value after the data refresh.

How changed data is displayed in sections

Example: Changed data in a report with sections

In this example you have a document with a block showing [Country], [Year] and [Revenue]. The original data was as follows:

Country	Year	Revenue
France	2003	1000
France	2004	2000
Japan	2002	1000
Poland	2002	1200
US	2003	
US	2004	

After a refresh, the data is as follows:

Country	Year	Revenue
France	2004	3000
Japan	2003	900
Poland	2002	800
UK	2004	900

If you create a section on [Country] and display data changes, the report appears as follows:

France [no formatting]

Year	Revenue	Formatting
2003	1000	[deleted data formatting on all cells]

Year	Revenue	Formatting
2004	3000	[increased data formatting on Revenue cell]

Japan [no formatting]

Year	Revenue	Formatting
2002	1000	[deleted data formatting on all cells]
2003	900	[inserted data formatting on all cells]

Poland [no formatting]

Year	Revenue	Formatting
2002	800	[decreased data format-ting on Revenue cell]

UK [inserted data formatting]

Year	Revenue	Formatting
2004	900	[inserted data formatting on all cells]

Web Intelligence displays the data in the section header in either of two ways, depending on the changes in the data in the section:

- If all the rows in the block in the section have changed in the same way, the section header is displayed with the same formatting as the rows.

- If the rows have changed in different ways, or only some rows have changed, the section header retains its default format.

How changed data is displayed in blocks with breaks

When a block contains a break and the **Center value across break** block property is set, Web Intelligence displays the centered value according rules similar to those for section headers.

- If all the rows in the break have changed in the same way, the centered value is displayed with the same formatting as the rows.
- If the rows have changed in different ways, or only some rows have changed, the centered value retains the default formatting.

How changed data is displayed in charts

When the data in a chart has changed, Web Intelligence displays a changed data icon above the chart. When you click the icon, Web Intelligence changes the chart to a table to allow you to see the details of the changes.

Data tracking limitations

If the data provider behind a document is changed, or if the document data is cleared, Web Intelligence no longer displays changed data. If the data provider is changed, the current version of the document is no longer compatible with the reference version. If the data is cleared, the old data no longer exists for comparison.

As a result, the following actions are incompatible with data tracking:

- Drill out of scope
- Query drill
- Deleting a query
- Any modification (including modifications to security rights) that changes the SQL generated by a data provider
- Purging the document

When you perform any of these actions, Web Intelligence clears the data history of the document. It does so because these actions are incompatible

with the display of changed data. For example, if you modify a query, the data in the document changes because of the modification. Any comparison between this data and old data generated from a different query is misleading.

Data tracking and drill

When you use query drill or drill out of scope, Web Intelligence clears the data history because these actions change the data provider. This should not affect you because, when you start to drill, you have already identified the data that requires further analysis. Data tracking has served its purpose and you can now continue with your data analysis.

Data tracking and Refresh on Open

When a document is set to refresh its data on opening (when the Refresh on open document property is selected), data tracking does not display the difference between the data prior to the refresh and the data after the refresh. Web Intelligence treats the data after the refresh as new data because the refresh purges the document.

Using the Web Intelligence formula language to track changed data

When you use the Web Intelligence interface to configure the display of changed data, Web Intelligence builds special behind-the-scenes alerters to display the changes. These special alerters do not appear in the list of standard alerters.

The Web Intelligence formula language allows you to build your own custom alerters for formatting data changes. You can also use the formula language to include special calculations based on data changes. For example, you can include a calculation to show the difference between the previous value and the current value of a measure.

The RefValue function

The Web Intelligence formula language provides access to changed data throught the `RefValue` function. This function gives the value of the reference data for a measure. If there is no reference data, the function returns null.

For example, if the [Revenue] measure currently has the value 1000, and its reference value is 900, the formula `RefValue([Revenue])` returns 900.

The RefValueDate function

The `RefValueDate` function returns the date of the reference data used for data tracking.

Building formulas using the RefValue function

You can use the RefValue function to build formulas that give information about the current data in relation to the reference data.

Example: Finding the difference between the reference value and the current value

The following formula returns the difference between the reference value and the current value of the [Revenue] measure:

```
=If(Not(IsNull([Revenue])) Or Not (IsNull(RefValue([Rev
enue]))); [Revenue]-RefValue([Revenue]))
```

The following table shows data before a data refresh:

Customer	Revenue
Johnson	2000
Smith	3000

Customer	Revenue
Wilson	3500

After refresh, the data changes as follows:

Customer	Revenue
Johnson	3000
Smith	2500

Placed in a third column, the formula returns the following figures:

Customer	Revenue	Difference
Johnson	3000	1000
Smith	2500	-500
Wilson	3500	

Changed data and the calculation context

When data tracking is activated, Web Intelligence displays data as changed only when the calculation context remains the same.

For example, if a measure value changes because you change the calculation context of a block, the new value is not flagged as changed.

Example: Changing the calculation context

In this example you have a block showing [City], [Customer] and [Revenue] as follows:

City	Customer	Revenue
San Francisco	Smith	1000
San Francisco	Jones	2000
Los Angeles	Wilson	3000
Los Angeles	Harris	4000

If you remove [Customer] from the block, Web Intelligence aggregates revenue by city:

City	Customer
San Francisco	3000
Los Angeles	7000

Web Intelligence does not display the revenues as increased because the amount of revenue has not changed. Only the calculation context has changed - revenues are now aggregated by city only, giving higher figures.

If, after a data refresh, Jones' revenue falls to 1000 and Wilson's revenue rises to 4000, the data appears as follows:

City	Customer
San Francisco	2000
Los Angeles	8000

Web Intelligence now displays the data as changed because, independently of the change of calculation context, the total revenue for San Francisco has decreased and the total revenue for Los Angeles has increased.

Sharing Web Intelligence content with other Web applications

chapter 27

Publishing Web Intelligence content as web services

You can make Web Intelligence content available outside Web Intelligence documents by publishing Web Intelligence report blocks (tables, charts or forms) as web services known as BI Services.

Web services provide a standardized mechanism for sharing data between web-based applications. You publish Web Intelligence content to a server where other Web applications can access the web services that supply the content.

Each web service can publish multiple blocks which are made available to web applications through functions that correspond to the blocks. For example, a table published as a web service can be included in a dashboard which can perform filtering and drilling operations on the table through the web service functions.

The structure of a BI service is defined using using WSDL (Web Service Definition Language), the standard format for describing web serivces. Web applications interact with BI services (by passing parameters to them and receiving data in return) using SOAP, a standard protocol for exchanging structured information.

Related Topics

- *BI service structure*

To publish a Web Intelligence report block as a web service

You use the **Publish Content** wizard to publish a Web Intelligence report block as a Web service.

1. Select the table, chart or form you want to publish, right-click and select **Publish Block** to display the **Publish Content** wizard.
2. Click **Next** to move to the first publishing step.

Related Topics

- *To identify duplicate content*

To identify duplicate content

If the report block you are publishing as a web service has already been published, the **Identify Duplicate Content** screen of the **Publish Content** highlights the duplicated blocks. The duplicate block appears in bold beneath the web services that publish it.

- Click **Next** to move to the next step.

Related Topics

- *To define the web service*

To define the web service

Before publishing a block as a Web service, you use the **Define Published Content** screen in the **Publish Content** wizard to name the table, make filters available on the block data, and select the server where the block will be published.

1. Type the name and description under which you want to publish the table in the **Name** and **Description** boxes.
2. Click **Set Filters** and select the objects you want to make available for filtering in the web service.
3. Select the server where you want to publish the content beneath **Host server**.
4. To add, remove or edit servers in the list of host servers, click **Manage servers**, then click **Add**, **Edit** or **Remove** and update the list of servers.
5. Click **Next** to move to the next step.

Related Topics

- *To publish prompts*
- *To save and publish a web service*

Making data available for filtering in a web service

When you publish a report block as a web service, you can make report objects available that web applications can use to filter the data returned by

the web service. For example, if you publish a table containing [Country], [Region] and [Revenue], you can make the [Country] dimension available as a filter. Web applications accessing the web service can then filter on the [Country] dimension.

Filtering objects appear as `FilterCondition` parameters in the `GetReportBlock_<block_name>` function in the web service.

You make objects available for filtering in the **Define published content** screen of the **Publish Content** wizard. The screen lists all the objects in the report and selects the objects in the block you are publishing by default. You can deselect these objects and select any object in the report to make it available as a filter. For example, you can make the [Country] dimension available as a filter when you publish a table containing the [Region] and [Revenue] objects if the [Country] dimension appears in the report. You can also choose not to make the [Region] and [Revenue] objects available as filters.

You do not have to include any report objects as filters except for objects that appear in section headers. These appear selected and you cannot unselect them.

If you publish a block in a section, by default the web service filters on the value of the section object corresponding to the block you selected. For example, if you have a report containing [Country], [Region] and [Revenue] with [Country] as the section header, and you publish the block in the section where [Country]="France", the web service uses "France" as the default value of [Country]. A web application accessing the web service can supply a different value for [Country] and the data returned by the web service changes to correspond with the filter.

If you publish a block in a report containing report filters, the objects on which report filters are defined are selected by default in the screen. You can unselect these objects. If you publish the block without making the objects available as filters, the web service filters data according to the values of the report filters. If you make the objects available, web applications can apply the report filters using different values.

Related Topics

- *GetReportBlock_blockname*

To publish prompts

1. Select or unselect the prompts you want to include or exclude in the list of prompts.
2. Click **Select all** to select all prompts or **Clear all** to clear all prompts.
3. Click **Next** to move to the next step.

Publishing prompts in web services

You use the **Choose Prompts** screen in the **Publish Content** wizard to choose which prompts to publish in the web service when the content you want to publish has related prompts.

If you do not publish a prompt, the web service uses the prompt value supplied when the document was last refreshed and saved. For example, if a user answers "US" to a prompt on [Country], then saves the document, the web service filters data on [Country]="US" the next time it is called with the`refresh=true` parameter.

If a web service publishes prompts, web applications must supply values for the prompts if they call the web service with the `refresh=true` parameter.

To save and publish a web service

You use the **Create Web Service** screen in the **Publish Content** wizard to save and publish the Web service to a host server.

1. To re-publish an existing web service, select the web service, click **Publish**, then click **OK** to exit the wizard.
2. To publish a new web service, select the folder where you want to publish the content and click **Create** to display the **Publish Web Service** dialog box.

   Note:
   Click **Add Folder** to add a new folder.

3. Type the name of the web service in the **Web service name** box and the service description in the **Description** box.

4. Select the authentication method for the web service from the **Authentication** list.
5. Click **OK** to close the dialog box and save and publish the web service.
6. Click **Finish**.

Viewing and managing published Web Intelligence content

You can browse the Web Intelligence content published on different Web servers by using the **Web Service Publisher** pane in Web Intelligence. The **Web Service Publisher** pane also allows you to edit published Web services and import QaaWS (Query as a Web Service) queries, which you can then republish as Web Intelligence content.

To view and manage published content

1. Display the **Web Service Publisher** pane by selecting **Show Published Content** on the main toolbar.
2. Select the server from the **Host server** list.
3. To add, remove or edit servers in the list of host servers, click **Manage servers**, then click **Add**, **Edit** or **Remove** and update the list of servers.
4. Select **Views** and select the way you want the content to be organized from the menu.

Option	Description
View by web services	Published content is organized as web service > block
View by document and web service	Published content is organized as Web Intelligence document > web service > block
View by document and block	Published content is organized as Web Intelligence document > block > web service
Show QaaWS queries	QaaWS (Query as a Web Service) queries appear below the published Web Intelligence content. (QaaWS queries are stored in the same repository folder as BI services.)

5. To edit a published block, select the block and click **Edit** to launch the **Publish Content** wizard.
6. To delete published content, select the published block or the Web service and click **Delete**.
7. To rename a web service, select the web service, click **Rename** and type the new name.
8. To refresh the list of published content, click **Refresh**.
9. To search the list of web services, type the text you want to search for in the search box and select your search options from the menu at the left of the search box.

Option	Description
Match case	Match case when searching
Ignore case	Ignore case when searching
Match from start	Return only those web services or blocks whose name starts with the search text
Match anywhere	Return only those web services or blocks whose name contains the search text

Related Topics

- *Importing and converting QaaWS (Query as a Web Service) queries*
- *To publish a Web Intelligence report block as a web service*

To test published content

You can test published Web Intelligence content and examine the structure of the Web service that publishes it.

1. Display the Web Service Publisher by selecting **Show Published Content** on the main toolbar.
2. Select the Web service you want to test and click **Test web service**.
3. Select the web service function you want to test from the **Operation** drop-down list.
4. Select the parameters and operators for which you want to specify values in the **Input** pane and type their values on the right of the pane benath **Value**.
5. Click Send to call the web service with the values you specified.

   The data returned by the web service appears in the **Server response** pane.
6. Click **Change to tree view**/**Change to table view** to toggle the web service data between a tree view and table format.

Importing and converting QaaWS (Query as a Web Service) queries

You can import QaaWS queries and run them to produce a block that Web Intelligence inserts in a new report. When you import a QaaWS query, Web Intelligence builds a Web Intelligence query based on the structure of the QaaWS query, then runs this query and inserts the resulting block in a new report. Web Intelligence does not modify the original QaaWS query.

Because Web Intelligence does not support the publication of QaaWS queries directly, you can use this workflow to publish QaaWS queries as BI services by publishing the resulting block as a BI service.

Note:
Web Intelligence does not support sorts defined on QaaWS queries. When you run the QaaWS query, any sorts it contains are lost.

To publish a QaaWS query

1. Open the **Web Service Publisher** pane by selecting **Show Published Content** on the main toolbar.
2. Select **View** > **Display QaaWS queries** to display QaaWS queries.
3. Select the QaaWS query you want to import and click **Import QaaWS query**.

   Web Intelligence adds the QaaWS query to the document as a Web Intelligence query. Web Intelligence also adds a report tab with the same name as the QaaWS query. The report tab contains a table corresponding to the query objects.
4. Refresh the added query to display the QaaWS data.
5. Right-click the added table and select **Publish Block** to publish the table as a web service.

Related Topics

- *To publish a Web Intelligence report block as a web service*

BI service structure

External web applications access Web Intelligence content published as web services by calling two functions:

- `GetReportBlock_blockname`
- `Drill_blockname`

In both these function calls, `blockname` is the name of the block as defined in the web service.

Web applications use the SOAP protocol to call the functions and receive the function output which they can then parse.

GetReportBlock_blockname

Function name

```
GetReportBlock_blockname
```

Input parameters

Name	Description	Mandatory?	
login	CMS login	Yes, unless `sessionID` or `serializedSession` is specified.	
password	CMS password	Yes, unless `sessionID` or `serializedSession` is specified .	
reportfilter	One or more report filters. See the table below for more information.	Yes when the report block contains section entries; no otherwise. Blocks with sections therefore have a mix of mandatory and optional `reportfilter` parameters.	
prompt	Prompt values. See below for more information on `LovIndexValue` parameters	Yes when `refresh` = true and the prompt is mandatory; no`false` otherwise.	
resetState	Re-opens the document when the web service is called, resetting drills and filters.	No - default value is `false`.	
refresh	Forces document refresh.	No - default value is `false`.	
getFromLatestDocumentInstance	Retrieves data from the latest document instance.	No - default value is `true`.	

Name	Description	Mandatory?	
getFromUserInstance	Retrieves data from user inbox if the document has been published.	No - default value is `false`.	
turnOutputToVTable	Turns the output to a vertical table. **Note:** If the block is a chart it is always turned to a vertical table even if this parameter is set to `false`.	No - default value is `false`.	
sessionID	Session token to avoid submitting login/password. Increases the session count when submitted.	No.	
serializedSession	Serialized session to avoid submitting login/password. Does not increase the session count when submitted.	No.	

reportfilter parameter

reportfilter paremeters contain two elements:

Name	Description	Values
filtering_value	The value used to filter the data	Any
filtering_operator	The filter operator	EQUAL (default)¦ GREATER ¦ GREATER_OR_EQUAL ¦ LESS ¦ LESS_OR_EQUAL ¦ NOT_EQUAL ¦ INLIST ¦ NOT_INLIST

Example of reportFilter parameter

The filter [Country]="US" is specified as follows:

```
<Country>
  <value>US</value>
  <operator>EQUAL</operator>
</Country>
```

Output parameters

Name	Type	Description
table	TTable	Table cells
headers	THeader	Table headers
footers	TFooter	Table footers
user	string	Login used by the web service call
documentation	string	The web service description supplied by the service designer
documentname	string	The document name
lastrefreshdate	dateTime	The date of the last document refresh
creationdate	dateTime	The date the web service was created
creator	string	User name of the web service creator
isScheduled	boolean	Specifies if document is scheduled
scheduleStartTime	dateTime	The schedule start time if the document is scheduled

Name	Type	Description
scheduleEnd-Time	dateTime	The schedule end time if the document is scheduled
tableType	string	The table type
nbColumns	int	The number of columns in the output table
nbLines	int	The number of rows in the output table

Related Topics

- *Drill_blockname*
- *Sample BI service return data*

Drill_blockname

Function name

```
Drill_blockname
```

Input parameters

The syntax of the `Drill_<block_name>` function is similar to `GetReport Block_<block_name>`, with the following differences:

- there are no `reportfilter` parameters
- there are additional `drillpath` parameters
- there is an additional `drillfilter` parameters

Name	Description	Mandatory?
drillpath	Specifies a drill instruction	Yes
drillfilter	Specifies a filter to apply when drilling	No

drillpath parameter

drillpath parameters are of type DrillPath. They contain three elements:

Name	Description	Values
from	The dimension to drill	Any.
value	The value to drill on	Any
drilloperation	The type of drill operation	UP ¦ DOWN

Note:

- As well as single values (for example "Los Angeles"), `value` can pass definitions such as "All Cities".
- If the drill instruction is invalid, the web service returns the original table data.
- At the end of the drill hierarchy, the web services returns the last available values in the drill hierarchy.
- You can supply more than one `drillpath` parameter providing that the parameters do not refer to different levels in the same drill hierarchy.

drillfilter parameter

drillpath parameters allow you to apply drill filters at the same time as drilling:

Name	Description	Values
dimension	The dimension to filter	Any.
value	The value to filter on	Any
operator	The filter operator	EQUAL ¦ GREATER ¦ GREATER_OR_EQUAL ¦ LESS ¦ LESS_OR_EQUAL ¦ NOT_EQUAL ¦ INLIST ¦ NOT_INLIST

Note:

- As well as single values (for example "Los Angeles"), `value` can pass definitions such as "All Cities"
- If the drill instruction is invalid, the web service returns the original table data
- At the end of the drill hierarchy, the web services returns the last available values in the drill hierarchy

- You can supply more than one `drillpath` parameter providing that the parameters do not refer to different levels in the same drill hierarchy.

Related Topics

- *GetReportBlock_blockname*

BI Services output parameters

The following table lists the output parameters returned by a BI Service:

Name	Type	Description
table	TTable	Table cells
headers	THeader	Table headers
footers	TFooter	Table footers
user	string	Login used by the web service call
documentation	string	The web service description supplied by the service designer
documentname	string	The document name
lastrefreshdate	dateTime	The date of the last document refresh
creationdate	dateTime	The date the web service was created
creator	string	User name of the web service creator
isScheduled	boolean	Specifies if document is scheduled
scheduleStart-Time	dateTime	The schedule start time if the document is scheduled
scheduleEnd-Time	dateTime	The schedule end time if the document is scheduled

Name	Type	Description
tableType	string	The table type
nbColumns	int	The number of columns in the output table
nbLines	int	The number of rows in the output table

Example of table parameter

```
<table>
 <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Bunga
low</cell>
               <cell xsi:type="xsd:double">172980</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Hotel
Room</cell>
               <cell xsi:type="xsd:double">345510</cell>

            </row>
...
</table>
```

Example of headers parameter

```
<headers>
 <row>
              <cell xsi:type="xsd:string">Country</cell>

                <cell xsi:type="xsd:string">Service
Line</cell>
              <cell xsi:type="xsd:string">Service</cell>

              <cell xsi:type="xsd:string">Revenue</cell>
```

```
            </row>
</headers>
```

Example of footers parameter

```
???
```

Related Topics

- *Sample BI service return data*

Sample BI service return data

Web services return data using SOAP. The following is a sample SOAP file returned by a web service:

```
<soap:Envelope
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance...>

   <soap:Body>
      <GetReportBlock_Block1BeachResponse xmlns="multi
docmultiuniversesmultime">
         <table>
            <row>
               <cell xsi:type="xsd:string">Aus
tralia</cell>
               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Bunga
low</cell>
              <cell xsi:type="xsd:double">172980</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">Aus
tralia</cell>
               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Hotel
Room</cell>
              <cell xsi:type="xsd:double">345510</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">Aus
```

```
tralia</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Hotel
Suite</cell>
               <cell xsi:type="xsd:double">464850</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Fast
Food</cell>
                <cell xsi:type="xsd:double">19530</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Poolside
Bar</cell>
                <cell xsi:type="xsd:double">27073</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Restau
rant</cell>
                <cell xsi:type="xsd:double">41160</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
                <cell xsi:type="xsd:string">Activi
ties</cell>
                <cell xsi:type="xsd:double">59820</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
```

```
                <cell xsi:type="xsd:string">Excur
sion</cell>
               <cell xsi:type="xsd:double">113170</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
               <cell xsi:type="xsd:string">Sports</cell>

                <cell xsi:type="xsd:double">69575</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
              <cell xsi:type="xsd:string">Travels</cell>

                <cell xsi:type="xsd:string">Car
Rent</cell>
                <cell xsi:type="xsd:double">49160</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Aus
tralia</cell>
              <cell xsi:type="xsd:string">Travels</cell>

                <cell xsi:type="xsd:string">Travel Reser
vation</cell>
                <cell xsi:type="xsd:double">63300</cell>
            </row>
            <row>
               <cell xsi:type="xsd:string">France</cell>

                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Bunga
low</cell>
               <cell xsi:type="xsd:double">126240</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">France</cell>

                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Hotel
Room</cell>
```

```
              <cell xsi:type="xsd:double">116790</cell>

            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Hotel
Suite</cell>
              <cell xsi:type="xsd:double">320220</cell>

            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
               <cell xsi:type="xsd:string">Fast
Food</cell>
               <cell xsi:type="xsd:double">28440</cell>
            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
               <cell xsi:type="xsd:string">Poolside
Bar</cell>
               <cell xsi:type="xsd:double">46320</cell>
            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
               <cell xsi:type="xsd:string">Restau
rant</cell>
               <cell xsi:type="xsd:double">32640</cell>
            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Recre
ation</cell>
               <cell xsi:type="xsd:string">Activi
ties</cell>
               <cell xsi:type="xsd:double">9000</cell>
            </row>
```

```
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Recre
ation</cell>
               <cell xsi:type="xsd:string">Excur
sion</cell>
              <cell xsi:type="xsd:double">120050</cell>

            </row>
            <row>
              <cell xsi:type="xsd:string">France</cell>

               <cell xsi:type="xsd:string">Recre
ation</cell>
              <cell xsi:type="xsd:string">Sports</cell>

               <cell xsi:type="xsd:double">35720</cell>
            </row>
            <row>
               <cell xsi:type="xsd:string">Nepal</cell>
               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Bunga
low</cell>
              <cell xsi:type="xsd:double">323231</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">Nepal</cell>
               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Hotel
Room</cell>
              <cell xsi:type="xsd:double">330240</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">Nepal</cell>
               <cell xsi:type="xsd:string">Accommoda
tion</cell>
               <cell xsi:type="xsd:string">Hotel
Suite</cell>
              <cell xsi:type="xsd:double">320754</cell>

            </row>
            <row>
               <cell xsi:type="xsd:string">Nepal</cell>
               <cell xsi:type="xsd:string">Food &amp;
```

```
Drinks</cell>
                <cell xsi:type="xsd:string">Fast
Food</cell>
                <cell xsi:type="xsd:double">32960</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Poolside
Bar</cell>
                <cell xsi:type="xsd:double">37915</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Restau
rant</cell>
                <cell xsi:type="xsd:double">32980</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
                <cell xsi:type="xsd:string">Activi
ties</cell>
                <cell xsi:type="xsd:double">78200</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
                <cell xsi:type="xsd:string">Excur
sion</cell>
                <cell xsi:type="xsd:double">96440</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
               <cell xsi:type="xsd:string">Sports</cell>

               <cell xsi:type="xsd:double">102720</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
              <cell xsi:type="xsd:string">Travels</cell>
```

```
                <cell xsi:type="xsd:string">Car
Rent</cell>
                <cell xsi:type="xsd:double">56370</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">Nepal</cell>
              <cell xsi:type="xsd:string">Travels</cell>

                <cell xsi:type="xsd:string">Travel Reser
vation</cell>
                <cell xsi:type="xsd:double">74495</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Bunga
low</cell>
               <cell xsi:type="xsd:double">368870</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Hotel
Room</cell>
               <cell xsi:type="xsd:double">746828</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Accommoda
tion</cell>
                <cell xsi:type="xsd:string">Hotel
Suite</cell>
               <cell xsi:type="xsd:double">842046</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Fast
Food</cell>
                <cell xsi:type="xsd:double">66330</cell>
            </row>
            <row>
```

```
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Poolside
Bar</cell>
                <cell xsi:type="xsd:double">88508</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Food &amp;
Drinks</cell>
                <cell xsi:type="xsd:string">Restau
rant</cell>
               <cell xsi:type="xsd:double">331860</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
                <cell xsi:type="xsd:string">Activi
ties</cell>
               <cell xsi:type="xsd:double">207950</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
                <cell xsi:type="xsd:string">Excur
sion</cell>
               <cell xsi:type="xsd:double">170305</cell>

            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
                <cell xsi:type="xsd:string">Recre
ation</cell>
               <cell xsi:type="xsd:string">Sports</cell>

                <cell xsi:type="xsd:double">74060</cell>
            </row>
            <row>
                <cell xsi:type="xsd:string">US</cell>
              <cell xsi:type="xsd:string">Travels</cell>

                <cell xsi:type="xsd:string">Car
Rent</cell>
                <cell xsi:type="xsd:double">34580</cell>
```

```
            </row>
            <row>
               <cell xsi:type="xsd:string">US</cell>
             <cell xsi:type="xsd:string">Travels</cell>

               <cell xsi:type="xsd:string">Travel Reser
vation</cell>
               <cell xsi:type="xsd:double">43200</cell>
            </row>
         </table>
         <headers>
            <row>
             <cell xsi:type="xsd:string">Country</cell>

               <cell xsi:type="xsd:string">Service
Line</cell>
             <cell xsi:type="xsd:string">Service</cell>

             <cell xsi:type="xsd:string">Revenue</cell>

            </row>
         </headers>
         <footers />
         <user>Administrator</user>
         <documentation></documentation>
         <documentname>_DaaWSDivers1</documentname>
         <lastrefreshdate>2009-02-20T14:19:01.0</lastre
freshdate>
        <creationdate>2009-02-20T14:43:21.109</creation
date>
         <creator>Administrator</creator>
         <isScheduled>false</isScheduled>
         <tableType>Vertical Table</tableType>
         <nbColumns>4</nbColumns>
         <nbLines>42</nbLines>
      </GetReportBlock_Block1BeachResponse>
   </soap:Body></soap:Envelope>
```


BI service WSDL definition


```
<?xml version="1.0" encoding="utf-16"?>
<definitions xmlns:http="http://schemas.xmlsoap.org/ws
dl/http/" xmlns:soap="http://schemas.xmlsoap.org/ws
dl/soap/" xmlns:s="http://www.w3.org/2001/XMLSchema"
xmlns:s0="zozo2" xmlns:tns1="dsws.businessobjects.com"
targetNamespace="zozo2" xmlns="http://schemas.xml
```

```
soap.org/wsdl/" name="BIServices">
   <types>
      <s:schema elementFormDefault="qualified" target
Namespace="zozo2">
         <s:simpleType name="Operator">
            <s:restriction base="s:string">
               <s:enumeration value="EQUAL" />
               <s:enumeration value="GREATER" />
               <s:enumeration value="GREATER_OR_EQUAL"
/>
               <s:enumeration value="LESS" />
               <s:enumeration value="LESS_OR_EQUAL" />
               <s:enumeration value="NOT_EQUAL" />
               <s:enumeration value="INLIST" />
               <s:enumeration value="NOT_INLIST" />
            </s:restriction>
         </s:simpleType>
         <s:complexType name="FilterCondition">
            <s:sequence>
               <s:element name="value" type="s:string"
/>
               <s:element name="operator" type="s0:Oper
ator" />
            </s:sequence>
         </s:complexType>
         <s:complexType name="LovValueIndex">
            <s:sequence>
               <s:element name="valueofPrompt"
type="s:string" />
               <s:element name="index" type="s:string"
/>
            </s:sequence>
         </s:complexType>
         <s:complexType name="DrillFilter">
            <s:sequence>
               <s:element name="dimension"
type="s:string" />
               <s:element name="value" type="s:string"
/>
               <s:element name="operator" type="s0:Oper
ator" />
            </s:sequence>
         </s:complexType>
         <s:element name="GetReportBlock_Block1">
            <s:complexType>
               <s:sequence>
                <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                  <s:element name="password"
```

```
type="s:string" minOccurs="0" nillable="true" />
                  <s:element name="Country"
type="s0:FilterCondition" />
                  <s:element name="Resort" type="s0:Fil
terCondition" minOccurs="0" maxOccurs="unbounded" nill
able="true" />
                  <s:element name="Service_Line"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="Revenue"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="Enter_val
ue_s__for_Country_" type="s0:LovValueIndex" minOccurs="0"
 maxOccurs="unbounded" nillable="true" />
                  <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                  <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
              </s:sequence>
           </s:complexType>
        </s:element>
        <s:element name="GetReportBlock_Block1ff">
           <s:complexType>
              <s:sequence>
               <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                  <s:element name="password"
type="s:string" minOccurs="0" nillable="true" />
                  <s:element name="Country"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="Resort" type="s0:Fil
terCondition" minOccurs="0" maxOccurs="unbounded" nill
able="true" />
                  <s:element name="Service_Line"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="Revenue"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="Enter_val
```

```
ue_s__for_Country_" type="s0:LovValueIndex" minOccurs="0"
 maxOccurs="unbounded" nillable="true" />
                  <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                  <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
               </s:sequence>
            </s:complexType>
         </s:element>
         <s:element name="GetReportBlock_Bloc1">
            <s:complexType>
               <s:sequence>
                <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                  <s:element name="password"
type="s:string" minOccurs="0" nillable="true" />
                  <s:element name="State" type="s0:Fil
terCondition" minOccurs="0" maxOccurs="unbounded" nill
able="true" />
                 <s:element name="City" type="s0:Filter
Condition" minOccurs="0" maxOccurs="unbounded" nill
able="true" />
                  <s:element name="Sales_revenue"
type="s0:FilterCondition" minOccurs="0" maxOccurs="un
bounded" nillable="true" />
                  <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                  <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
               </s:sequence>
            </s:complexType>
         </s:element>
         <s:simpleType name="DrillOperation">
            <s:restriction base="s:string">
               <s:enumeration value="UP" />
```

```
                <s:enumeration value="DOWN" />
            </s:restriction>
        </s:simpleType>
        <s:complexType name="DrillPath">
            <s:sequence>
              <s:element name="from" type="s:string" />

                <s:element name="value" type="s:string"
/>
                <s:element name="drillOperation"
type="s0:DrillOperation" />
            </s:sequence>
        </s:complexType>
        <s:element name="Drill_Block1">
            <s:complexType>
                <s:sequence>
                  <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                    <s:element name="password"
type="s:string" minOccurs="0" nillable="true" />
                    <s:element name="drillPath"
type="s0:DrillPath" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                    <s:element name="filter"
type="s0:DrillFilter" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                    <s:element name="Enter_val
ue_s__for_Country_" type="s0:LovValueIndex" minOccurs="0"
 maxOccurs="unbounded" nillable="true" />
                    <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                    <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                    <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                    <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                    <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
                <s:sequence>
            </s:complexType>
        </s:element>
        <s:element name="Drill_Block1ff">
            <s:complexType>
                <s:sequence>
                  <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                    <s:element name="password"
```

```
type="s:string" minOccurs="0" nillable="true" />
                  <s:element name="drillPath"
type="s0:DrillPath" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                  <s:element name="filter"
type="s0:DrillFilter" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                  <s:element name="Enter_val
ue_s__for_Country_" type="s0:LovValueIndex" minOccurs="0"
 maxOccurs="unbounded" nillable="true" />
                  <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                  <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
               </s:sequence>
            </s:complexType>
         </s:element>
         <s:element name="Drill_Bloc1">
            <s:complexType>
               <s:sequence>
                 <s:element name="login" type="s:string"
 minOccurs="0" nillable="true" />
                  <s:element name="password"
type="s:string" minOccurs="0" nillable="true" />
                  <s:element name="drillPath"
type="s0:DrillPath" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                  <s:element name="filter"
type="s0:DrillFilter" minOccurs="0" maxOccurs="unbounded"
 nillable="true" />
                  <s:element name="resetState"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="refresh"
type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="getFromLatestDocu
mentInstance" type="s:boolean" minOccurs="0" nill
able="true" />
                  <s:element name="getFromUserInstance"
 type="s:boolean" minOccurs="0" nillable="true" />
                  <s:element name="turnOutputToVTable"
type="s:boolean" minOccurs="0" nillable="true" />
               </s:sequence>
```

```
            </s:complexType>
         </s:element>
         <s:complexType name="TRow">
            <s:sequence>
               <s:element name="cell" type="s:anyType"
maxOccurs="unbounded" nillable="true" />
            </s:sequence>
         </s:complexType>
         <s:complexType name="TTable">
            <s:sequence>
               <s:element name="row" maxOccurs="unbound
ed" type="s0:TRow" />
            </s:sequence>
         </s:complexType>
         <s:complexType name="THeader">
            <s:sequence>
               <s:element name="row" maxOccurs="unbound
ed" type="s0:TRow" />
            </s:sequence>
         </s:complexType>
         <s:complexType name="TFooter">
            <s:sequence>
               <s:element name="row" maxOccurs="unbound
ed" type="s0:TRow" />
            </s:sequence>
         </s:complexType>
        <s:element name="GetReportBlock_Block1Response">

            <s:complexType>
               <s:sequence>
                  <s:element name="table"
type="s0:TTable" />
                  <s:element name="headers"
type="s0:THeader" />
                  <s:element name="footers"
type="s0:TFooter" />
                 <s:element name="user" type="s:string"
 />
                  <s:element name="documentation"
type="s:string" />
                  <s:element name="documentname"
type="s:string" />
                  <s:element name="lastrefreshdate"
type="s:dateTime" />
                  <s:element name="creationdate"
type="s:dateTime" />
                  <s:element name="creator"
type="s:string" />
                  <s:element name="isScheduled"
```

```
type="s:boolean" />
                  <s:element name="scheduleStartTime"
type="s:dateTime" />
                  <s:element name="scheduleEndTime"
type="s:dateTime" />
                  <s:element name="tableType"
type="s:string" />
                  <s:element name="nbColumns"
type="s:int" />
                 <s:element name="nbLines" type="s:int"
 />
              </s:sequence>
           </s:complexType>
        </s:element>
        <s:element name="Drill_Block1Response">
           <s:complexType>
              <s:sequence>
                  <s:element name="table"
type="s0:TTable" />
                  <s:element name="headers"
type="s0:THeader" />
                  <s:element name="footers"
type="s0:TFooter" />
                 <s:element name="user" type="s:string"
 />
                  <s:element name="documentation"
type="s:string" />
                  <s:element name="documentname"
type="s:string" />
                  <s:element name="lastrefreshdate"
type="s:dateTime" />
                  <s:element name="creationdate"
type="s:dateTime" />
                  <s:element name="creator"
type="s:string" />
                  <s:element name="isScheduled"
type="s:boolean" />
                  <s:element name="scheduleStartTime"
type="s:dateTime" />
                  <s:element name="scheduleEndTime"
type="s:dateTime" />
                  <s:element name="tableType"
type="s:string" />
                  <s:element name="nbColumns"
type="s:int" />
                 <s:element name="nbLines" type="s:int"
 />
              </s:sequence>
           </s:complexType>
```

```
        </s:element>
        <s:element name="GetReportBlock_Block1ffRe
sponse">
           <s:complexType>
              <s:sequence>
                 <s:element name="table"
type="s0:TTable" />
                 <s:element name="headers"
type="s0:THeader" />
                 <s:element name="footers"
type="s0:TFooter" />
                <s:element name="user" type="s:string"
 />
                 <s:element name="documentation"
type="s:string" />
                 <s:element name="documentname"
type="s:string" />
                 <s:element name="lastrefreshdate"
type="s:dateTime" />
                 <s:element name="creationdate"
type="s:dateTime" />
                 <s:element name="creator"
type="s:string" />
                 <s:element name="isScheduled"
type="s:boolean" />
                 <s:element name="scheduleStartTime"
type="s:dateTime" />
                 <s:element name="scheduleEndTime"
type="s:dateTime" />
                 <s:element name="tableType"
type="s:string" />
                 <s:element name="nbColumns"
type="s:int" />
                <s:element name="nbLines" type="s:int"
 />
              </s:sequence>
           </s:complexType>
        </s:element>
        <s:element name="Drill_Block1ffResponse">
           <s:complexType>
              <s:sequence>
                 <s:element name="table"
type="s0:TTable" />
                 <s:element name="headers"
type="s0:THeader" />
                 <s:element name="footers"
type="s0:TFooter" />
                <s:element name="user" type="s:string"
 />
```

```
                    <s:element name="documentation"
type="s:string" />
                    <s:element name="documentname"
type="s:string" />
                    <s:element name="lastrefreshdate"
type="s:dateTime" />
                    <s:element name="creationdate"
type="s:dateTime" />
                    <s:element name="creator"
type="s:string" />
                    <s:element name="isScheduled"
type="s:boolean" />
                    <s:element name="scheduleStartTime"
type="s:dateTime" />
                    <s:element name="scheduleEndTime"
type="s:dateTime" />
                    <s:element name="tableType"
type="s:string" />
                    <s:element name="nbColumns"
type="s:int" />
                   <s:element name="nbLines" type="s:int"
 />
                 </s:sequence>
              </s:complexType>
           </s:element>
          <s:element name="GetReportBlock_Bloc1Response">

              <s:complexType>
                 <s:sequence>
                    <s:element name="table"
type="s0:TTable" />
                    <s:element name="headers"
type="s0:THeader" />
                    <s:element name="footers"
type="s0:TFooter" />
                   <s:element name="user" type="s:string"
 />
                    <s:element name="documentation"
type="s:string" />
                    <s:element name="documentname"
type="s:string" />
                    <s:element name="lastrefreshdate"
type="s:dateTime" />
                    <s:element name="creationdate"
type="s:dateTime" />
                    <s:element name="creator"
type="s:string" />
                    <s:element name="isScheduled"
type="s:boolean" />
```

```
                    <s:element name="scheduleStartTime"
type="s:dateTime" />
                    <s:element name="scheduleEndTime"
type="s:dateTime" />
                    <s:element name="tableType"
type="s:string" />
                    <s:element name="nbColumns"
type="s:int" />
                   <s:element name="nbLines" type="s:int"
 />
                </s:sequence>
             </s:complexType>
          </s:element>
          <s:element name="Drill_Bloc1Response">
             <s:complexType>
                <s:sequence>
                    <s:element name="table"
type="s0:TTable" />
                    <s:element name="headers"
type="s0:THeader" />
                    <s:element name="footers"
type="s0:TFooter" />
                   <s:element name="user" type="s:string"
 />
                    <s:element name="documentation"
type="s:string" />
                    <s:element name="documentname"
type="s:string" />
                    <s:element name="lastrefreshdate"
type="s:dateTime" />
                    <s:element name="creationdate"
type="s:dateTime" />
                    <s:element name="creator"
type="s:string" />
                    <s:element name="isScheduled"
type="s:boolean" />
                    <s:element name="scheduleStartTime"
type="s:dateTime" />
                    <s:element name="scheduleEndTime"
type="s:dateTime" />
                    <s:element name="tableType"
type="s:string" />
                    <s:element name="nbColumns"
type="s:int" />
                   <s:element name="nbLines" type="s:int"
 />
                </s:sequence>
             </s:complexType>
          </s:element>
```

```
         <s:element name="QaaWSHeader">
            <s:complexType>
               <s:sequence>
                  <s:element name="sessionID"
type="s:string" minOccurs="0" maxOccurs="1" nill
able="true" />
                  <s:element name="serializedSession"
type="s:string" minOccurs="0" maxOccurs="1" nill
able="true" />
               </s:sequence>
            </s:complexType>
         </s:element>
      </s:schema>
   </types>
   <message name="GetReportBlock_Block1SoapIn">
      <part name="parameters" element="s0:GetReport
Block_Block1" />
      <part name="request_header" element="s0:QaaWSHead
er" />
   </message>
   <message name="GetReportBlock_Block1SoapOut">
      <part name="parameters" element="s0:GetReport
Block_Block1Response" />
   </message>
   <message name="Drill_Block1SoapIn">
      <part name="parameters" element="s0:Drill_Block1"
 />
      <part name="request_header" element="s0:QaaWSHead
er" />
   </message>
   <message name="Drill_Block1SoapOut">
     <part name="parameters" element="s0:Drill_Block1Re
sponse" />
   </message>
   <message name="GetReportBlock_Block1ffSoapIn">
      <part name="parameters" element="s0:GetReport
Block_Block1ff" />
      <part name="request_header" element="s0:QaaWSHead
er" />
   </message>
   <message name="GetReportBlock_Block1ffSoapOut">
      <part name="parameters" element="s0:GetReport
Block_Block1ffResponse" />
   </message>
   <message name="Drill_Block1ffSoapIn">
     <part name="parameters" element="s0:Drill_Block1ff"
 />
      <part name="request_header" element="s0:QaaWSHead
er" />
```

```
   </message>
   <message name="Drill_Block1ffSoapOut">
      <part name="parameters" ele
ment="s0:Drill_Block1ffResponse" />
   </message>
   <message name="GetReportBlock_Bloc1SoapIn">
      <part name="parameters" element="s0:GetReport
Block_Bloc1" />
      <part name="request_header" element="s0:QaaWSHead
er" />
   </message>
   <message name="GetReportBlock_Bloc1SoapOut">
      <part name="parameters" element="s0:GetReport
Block_Bloc1Response" />
   </message>
   <message name="Drill_Bloc1SoapIn">
      <part name="parameters" element="s0:Drill_Bloc1"
/>
      <part name="request_header" element="s0:QaaWSHead
er" />
   </message>
   <message name="Drill_Bloc1SoapOut">
      <part name="parameters" element="s0:Drill_Bloc1Re
sponse" />
   </message>
   <portType name="BIServicesSoap">
      <operation name="GetReportBlock_Block1">
         <documentation />
        <input message="s0:GetReportBlock_Block1SoapIn"
 />
         <output message="s0:GetReport
Block_Block1SoapOut" />
      </operation>
      <operation name="Drill_Block1">
         <documentation />
         <input message="s0:Drill_Block1SoapIn" />
         <output message="s0:Drill_Block1SoapOut" />
      </operation>
      <operation name="GetReportBlock_Block1ff">
         <documentation />
         <input message="s0:GetReportBlock_Block1ff
SoapIn" />
         <output message="s0:GetReportBlock_Block1ff
SoapOut" />
      </operation>
      <operation name="Drill_Block1ff">
         <documentation />
         <input message="s0:Drill_Block1ffSoapIn" />
         <output message="s0:Drill_Block1ffSoapOut" />
```

```
      </operation>
      <operation name="GetReportBlock_Bloc1">
         <documentation />
         <input message="s0:GetReportBlock_Bloc1SoapIn"
 />
        <output message="s0:GetReportBlock_Bloc1SoapOut"
 />
      </operation>
      <operation name="Drill_Bloc1">
         <documentation />
         <input message="s0:Drill_Bloc1SoapIn" />
         <output message="s0:Drill_Bloc1SoapOut" />
      </operation>
   </portType>
   <binding name="BIServicesSoap" type="s0:BIServices
Soap">
      <soap:binding transport="http://schemas.xml
soap.org/soap/http" style="document" />
      <operation name="GetReportBlock_Block1">
         <documentation />
         <soap:operation soapAction="zozo2/GetReport
Block_Block1" style="document" />
         <input>
            <soap:header message="s0:GetReport
Block_Block1SoapIn" part="request_header" use="literal">

               <soap:headerfault message="s0:GetReport
Block_Block1SoapIn" part="request_header" use="literal"
 />
            </soap:header>
            <soap:body use="literal" parts="parameters"
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
      <operation name="Drill_Block1">
         <documentation />
        <soap:operation soapAction="zozo2/Drill_Block1"
 style="document" />
         <input>
           <soap:header message="s0:Drill_Block1SoapIn"
 part="request_header" use="literal">
               <soap:headerfault mes
sage="s0:Drill_Block1SoapIn" part="request_header"
use="literal" />
            </soap:header>
            <soap:body use="literal" parts="parameters"
```

```
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
      <operation name="GetReportBlock_Block1ff">
         <documentation />
         <soap:operation soapAction="zozo2/GetReport
Block_Block1ff" style="document" />
         <input>
            <soap:header message="s0:GetReport
Block_Block1ffSoapIn" part="request_header" use="liter
al">
               <soap:headerfault message="s0:GetReport
Block_Block1ffSoapIn" part="request_header" use="literal"
 />
            </soap:header>
            <soap:body use="literal" parts="parameters"
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
      <operation name="Drill_Block1ff">
         <documentation />
         <soap:operation soapAction="zo
zo2/Drill_Block1ff" style="document" />
         <input>
            <soap:header message="s0:Drill_Block1ff
SoapIn" part="request_header" use="literal">
               <soap:headerfault mes
sage="s0:Drill_Block1ffSoapIn" part="request_header"
use="literal" />
            </soap:header>
            <soap:body use="literal" parts="parameters"
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
      <operation name="GetReportBlock_Bloc1">
         <documentation />
         <soap:operation soapAction="zozo2/GetReport
Block_Bloc1" style="document" />
         <input>
            <soap:header message="s0:GetReport
```

```
Block_Bloc1SoapIn" part="request_header" use="literal">
               <soap:headerfault message="s0:GetReport
Block_Bloc1SoapIn" part="request_header" use="literal"
/>
            </soap:header>
            <soap:body use="literal" parts="parameters"
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
      <operation name="Drill_Bloc1">
         <documentation />
         <soap:operation soapAction="zozo2/Drill_Bloc1"
 style="document" />
         <input>
            <soap:header message="s0:Drill_Bloc1SoapIn"
 part="request_header" use="literal">
               <soap:headerfault mes
sage="s0:Drill_Bloc1SoapIn" part="request_header"
use="literal" />
            </soap:header>
            <soap:body use="literal" parts="parameters"
 />
         </input>
         <output>
            <soap:body use="literal" />
         </output>
      </operation>
   </binding>
   <service name="zozo2">
      <documentation />
     <port name="BIServicesSoap" binding="s0:BIServices
Soap">
         <soap:address location="http://noux:8080/dsws
bobje/qaawsservices/queryasaservice?&cuid=AduDhWyVezRPn
nJM_FDS4S0&authType=secEnterprise&locale=en_US&time
out=60" />
      </port>
   </service>
</definitions>
```

Linking to other documents

chapter 28

Linking to other documents

Cells in Web Intelligence documents can be defined as hyperlinks. Web Intelligence hyperlinks are similar to the hyperlinks found on the World Wide Web that allow you to open a different web page from the page you are currently viewing.

When you click a cell that contains a hyperlink, Web Intelligence opens the target document specified in the link. The target document can be a Web Intelligence document, a Crystal Reports document, a site on the world wide web, or any resource accessible through a hyperlink.

Hyperlinks can be either static or dynamic. A static hyperlink always links to the same document in the same way. A dynamic hyperlink can link differently depending on the data in the document containing the hyperlink.

You can create different types of hyperlink:

- A cell where the cell text is the hyperlink text.
- A cell with an associated hyperlink.
- A link to another document in the CMS.

Cell text defined as a hyperlink

When you define the text in a cell as a hyperlink, the cell text itself becomes the hyperlink text. For example, if you define a free-standing cell containing the text `http://www.businessobjects.com` as a hyperlink, clicking on the cell takes you to the Business Objects web page.

This method is best suited for static hyperlinks, where the text in the cell always remains the same and links to the same resource in the same way.

Note:
It is possible to make this type of hyperlink dynamic by using the Web Intelligence formula language to change the cell text based on report data.

To define cell text as a hyperlink

1. Type the hyperlink text in the cell.

2. If you are using Web Intelligence Interactive, right-click the cell and select **Hyperlink** > **Read content as hyperlink** from the menu.

   Note:
   You can also right-click the cell and select **Format** > **Cell** from the menu to display the "Format Cells" dialog box, then select **Read content as** and select **Hyperlink** from the list.

3. If you are using the Java Report Panel, click the cell then set the **Display** > **Read cell content as** cell property to **Hyperlink**.

A hyperlink associated with a cell

When you associate a hyperlink with a cell, you define a hyperlink that Web Intelligence uses to link to the source document when the cell is clicked. The cell text itself is not the hyperlink.

This is the recommended method for creating dynamic hyperlinks, for the following reasons:

- It is specially tailored for working with the parameters in dynamic hyperlinks.
- It shields you from the complexity of hyperlink syntax - you define your hyperlink using a graphical interface and Web Intelligence generates and manages the hyperlink behind the scenes.
- It allows you to define hyperlink text that is different from the cell text.

To add a hyperlink to a cell

1. Right-click the cell and select **Hyperlink** > **New** to display the "Create Hyperlink" dialog box.
2. Select **Link to web page** on the left of the dialog box. (Web Intelligence Interactive only.)
3. Type or paste the hyperlink text into the box.
4. Click **Parse** to extract the hyperlink parameters into the **Customize URL parameters** area (which is not visible until you click **Parse**).

Dynamic hyperlinks contain parameters whose values can change. Parameters appear as `name=value` parts at the end of the hyperlink after the question mark. For example, the URL

```
http://salesandproductreport/default.asp?report
name=products
```

contains one parameter, `reportname`, whose value is “products?.

After you click **Parse**, each parameter appears on a separate line with the parameter name on the left and the parameter value on the right. The static part of the hyperlink (the part without the parameters) appears in the **Main** section.

5. To tell Web Intelligence to supply data from formulas or variables as parameter values, click the arrow next to each parameter value and select an option.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the parameter value.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the parameter value.

Note:
When you modify a parameter, Web Intelligence modifies the full hyperlink syntax in the box at the top of the screen.

6. To add or remove a parameter, modify the hyperlink syntax, then click **Parse**.

Note:
You cannot add or remove parameters directly in the parameter list in the **Customize URL parameters** area. You must modify the URL syntax directly.

7. Click the arrow next to **Cell content** to change the text displayed in the hyperlink cell and choose one of the options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the cell content.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the cell content.

8. Type the tooltip text in the **Tooltip** box or build a dynamic tooltip by using the **Build formula** or **Select variable** options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the tooltip.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the tooltip.

The tooltip appears when you hover your mouse pointer over the cell containing the hyperlink.

9. Click the arrow next to **Target window** to define how the target URL appears.

Option	Description
Current window	The target URL replaces the Web Intelligence document containing the hyperlink in the current window.
New window	The target URL opens in a new browser window.

A link to another document in the CMS

You link to another document in the CMS using the "Create Hyperlink" dialog box (Web Intelligence Interactive only). When you create the link, Web Intelligence builds a formula using the `OpenDocument` function based on the choices you make in the dialog box.

Note:
You can work with the `OpenDocument` function directly by typing the syntax into a cell.

To link to another document in the CMS

1. Right-click the cell where you want to create the link and select **Hyperlink** > **New** from the menu to display the "Create Hyperlink" dialog box.
2. Select **Link to a document** on the left of the dialog box.
3. Click **Browse** and select the target document in the **Choose Document** dialog box, or type the document ID in the **Document ID** box.
4. Click **Refresh on open** if you want Web Intelligence to refresh the data of the target document when the hyperlink is selected.
5. Click **Link to document instance**, then select an option from the drop down-list , to link to an instance of the selected document.

Option	Description
Most recent	The hyperlink opens the most recent instance. **Note:** You cannot specify parameter values in the hyperlink when you choose this option.
Most recent - current user	The hyperlink opens the most recent instance owned by the current user. **Note:** You cannot specify parameter values in the hyperlink when you choose this option.
Most recent - matching prompt values	The hyperlink opens the most recent instance whose prompt values correspond to the values passed by the hyperlink. This option is useful when you want to link to a large document that contains prompts.

6. Click **Report name** and select the name of the report to link to a specific report.

7. Click **Report part**, then click **Select** and right-click the report part (for example a table), to link to a specific part of a report.
8. If you selected **Report part**, select **Display report part only** open the report part only in the target document, or **Position at report part (full document available)** to focus on the report part but display the whole report in the target document.
9. For each prompt in the **Document prompts** section, select one of the following options from the drop-down list:

Option	Description
Build formula	You use the Formula Editor to build a formula to pass a value to the prompt.
Select object	You select an object whose value is passed to the prompt.
Prompt user at runtime	The user specifies a value for the prompt when they click the hyperlink.
Use document default	You configure the hyperlink to not pass a parameter to the target document, and the target document opens with the default value for the prompt. The default value is either the last value specified for the prompt, or the default specified in the document.

10. Choose **Build Formula** or **Select Variable** from the **Cell content** list to specify the content of the hyperlink cell.

Option	Description
Build Formula	You build a formula in the Formula Editor to supply the formula output as the cell content.
Select Variable	You choose a variable from the list in the "Select an Object" dialog box to supply its value as the cell content.

11. Type the tooltip text in the **Tooltip** box or build a dynamic tooltip by using the **Build formula** or **Select object** options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the tooltip.
Select object	You choose the variable from the list in the "Select an Object" dialog box to supply its value as the tooltip.

The tooltip appears when you hover your mouse pointer over the cell containing the hyperlink.

12. Select **New window** or **Current window** from the **Target window** list to determine how the target document opens.

Option	Description
New window	The document opens in a new browser window.
Target window	The document opens in the current browser window and replaces the document containing the hyperlink.

Document instances and values passed to prompts

Hyperlinks supply values to prompts in the target document in two ways: by passing values directly to prompts, or by opening a document instance based on passed values.

In the first case, the hyperlink feeds values directly to the prompts in the target document. In the second case, Web Intelligence opens the document instance whose stored prompt values correspond to the values passed by the hyperlink.

It is more efficient to choose a document instance based on passed parameters if the target document is large.

Certain combinations of instance and parameter settings are incompatible or mutually dependent, as described in the following table:

Instance setting	Impact on parameter setting
Most recent	The hyperlink does not pass parameter values. All parameters are set to **Use document default** and cannot be modified.
Most recent - current user	The hyperlink does not pass parameter values. All parameters are set to **Use document default** and cannot be modified.
Most recent - matching prompt values	You must specify at least one parameter value. Without at least one specified value, the hyperlink returns an error when clicked. The error occurs because the hyperlink is designed to retrieve an instance based on parameter values, but no value is provided for comparison against the instance.

Related Topics

- *Linking to large documents*

Linking to large documents

When the target document contains a large amount of data, it is more efficient to link to an instance than to open and retrieve the document with a passed parameter value. You can schedule and pre-retreive multiple instances with different parameter values. This allows the document to be scheduled and pre-retrieved in advance with different parameter values.

When you click the hyperlink, Web Intelligence opens the appropriate pre-retrieved instance rather than using the passed value to open the document and retrieve the data.

Example: Linking to a large sales report

In this example you link to a large sales report that retrieves sales by region. The report has a parameter that allows the user to select the region. There are four regions - North, South, East, and West.

Your source document has a [Region] dimension. You do the following:

- Configure the hyperlink to pass the value of [Region] as a parameter
- Create four instances of the sales report, one for each value of [Region]
- Schedule these instances for pre-retrieval
- Configure the hyperlink to open the latest instance whose parameter value matches the value passed by the hyperlink

Assuming that the document has a [Region] dimension, the settings are as follows:

Link to document instance setting	Latest value match
Most recent - matching prompt values	[Region]

Working with hyperlinks

To link to another document from a hyperlink

To link to another document from a hyperlink, the hyperlink must first have been created.

1. Hover your mouse pointer over the cell to display the tooltip if a tooltip is defined.

   Note:
   If you used the **Hyperlink** dialog box to define the link and the Formula Bar is displayed, the hyperlink syntax generated by Web Intelligence

appears in the Formula Bar. Do not modify this syntax directly - use the **Hyperlink** dialog box if you need to update it.

2. Click the hyperlink to open the target document.

   Depending on how the hyperlink is configured the target document opens in a new browser window, or it replaces the current document in the current browser window.

To edit a hyperlink

1. Right-click the cell containing the hyperlink and select **Hyperlink** > **Edit** from the menu to display the "Hyperlink" dialog box.
2. Edit the hyperlink using the "Hyperlink" dialog box.

To delete a hyperlink

- Right-click the cell containing the hyperlink and select **Hyperlink** > **Delete** from the menu.

Formatting hyperlink colors

You can define the colors that Web Intelligence uses to display hyperlinks that have already been clicked (visited hyperlinks) and hyperlinks that have not been clicked (unvisited hyperlinks).

To set hyperlink colors

1. Right-click a blank area on the report that contains hyperlinks and select **Format Report** on the menu.
2. Click the **General** tab.
3. In the **Hyperlink color** section, click the arrows next to **Visited** and **Unvisited**, then either select a predefined color or click **More colors** to define a custom color.
4. Click **OK**.

   Web Intelligence applies the color settings you selected to the hyperlinks in the report.

URL reporting using openDocument

URL reporting using openDocument provides URL access to multiple document types by passing a URL string to a BusinessObjects Enterprise server. openDocument provides commands to control how reports are generated and displayed.

You can use openDocument in BusinessObjects Enterprise to create cross-system links to and from the following document types:

- .wid: Web Intelligence documents
- .rep: Desktop Intelligence documents
- .rpt: Crystal reports
- .car: OLAP Intelligence reports

Structuring an openDocument URL

The next sections explain how to use the openDocument function, and how to construct the URL.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platform
Specific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

The URL is constructed using the parameters listed in *openDocument parameter overview*

Joining parameters

Join parameters with the ampersand (&). Do not place spaces around the ampersand. For example: `sType=wid&sDocName=Sales2003`

The ampersand is always required between parameters.

Spaces and special characters in parameter values

Because some browsers cannot interpret spaces, the parameters of the link cannot contain spaces or other special characters that require URL encoding. To avoid the misinterpretation of special characters, you can define a URLEncoded string in the source database to replace the special character with an escape sequence. This will allow the database to ignore the special character and correctly interpret the parameter value. Note that certain RDBMS have functions that allow you to replace one special character with another.

By creating an escape sequence for the plus sign (+), you can instruct the database to interpret the plus sign as a space. In this case, a document title Sales Report for 2003 would be specified in the DocName parameter as: `&sDocName=Sales+Report+for+2003&`

This syntax prevents the database from misinterpreting the spaces in the title.

Trailing spaces in parameter values

Trim trailing spaces at the end of parameter values and prompt names. Do not replace them with a plus sign (+). The viewer may not know whether to interpret the plus sign (+) as part of the prompt name or as a space. For example, if the prompt name displays:

```
Select a City:_
```

(where _ represents a space), enter the following text in the link:

```
lsSSelect+a+City:=Paris
```

where the spaces within the prompt name are replaced with the plus sign, and the trailing space is trimmed off.

For details on prompt parameters of the link, refer to *openDocument parameter overview* .

Capitalization

All of the openDocument parameters are case sensitive.

Link length limit

The encoded URL cannot exceed 2083 total characters.

Parameter values in links to sub-reports

You cannot pass parameter values to a sub-report of a target Crystal report.

Using the IsS parameter with OLAP Intelligence reports

If the target document is an OLAP Intelligence report (.car) you can use the IsS parameter to specify prompts. The parameters are passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

Example: Opening a report to a specific page

If `23CAA3C1-8DBB-4CF3-BA%2CB8%2CD7%2CF0%2C68%2CEF%2C9C%2C6F` is the URL-encoded unique name for the page parameter in the OLAP Intelligence report, you would use the following URL to open the OLAP Intelligence report to page 2:

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&iDocID=440&lsS23CAA3C1-
8DBB-4CF3-BA%2CB8%2CD7%2CF0%2C68%2CEF%2C9C%2C6F=2
```

Example: Opening a cube parameter

If `8401682C-9B1D-4850-8B%2C5E%2CD9%2C1F%2C20%2CF8%2C1%2C62` is the URL-encoded unique name for the cube parameter opening the warehouse cube in the catalogue FoodMart 2000 on MSAS, you would use the following URL to open this cube parameter:

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&lsS8401682C-9B1D-4850-
```

```
8B%2C5E%2CD9%2C1F%2C20%2CF8%2C1%2C62=CATALOG%3DFood
Mart%202000,CUBE%3Dwarehouse&iDocID=616
```

Using the IsM parameter with OLAP Intelligence reports

If the target document is an OLAP Intelligence report (.car) you can use the IsM parameter to specify prompts. The parameters are passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

As was the case for the IsS parameter, IsM parameters are also passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

Example: Opening a report

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&lsMADC216EA-D9A5-42B5-
AE%2C21%2C84%2CA9%2CF9%2C6E%2C31%2C7=[%5BCus
tomers%5D.%5BCountry%5D.%26%5BMexico%5D],[%5BCus
tomers%5D.%5BCountry%5D.%26%5BCanada%5D]&iDocID=544
```

This is a memberset parameter opening up a report with Customers > Country > Mexico and Customers > Country > Canada in the view.

openDocument parameter overview

This section provides a brief overview of openDocument and includes a list of available parameters. Details about the available parameters, their specific uses, and relevant examples are also provided.

Note:
The document containing the openDocument link is called the parent document, and it resides on the parent system. The document to which the link points is called the target document, and it resides on the target system.

Table 28-3: Platform Parameters

Parameter	Description
iDocID	Document identifier.
sDocName	Document name.
sIDType	Crystal object type.
sKind	The file type of target Desktop Intelligence document.
sPath	The name of the folder and subfolder containing the target document.
sType	The file type of target document or report.
token	A valid logon token for the current CMS session.

Table 28-4: Input Parameters

Parameter	Description
lsC	Specifies a contextual prompt if there is an ambiguity during SQL generation (Business Objects and Web Intelligence documents only).

Parameter	Description
lsM[NAME]	Specifies multiple values for a prompt, `[NAME]` is the text of the prompt
lsR[NAME]	Specifies a range of values for a prompt, `[NAME]` is the text of the prompt.
lsS[NAME]	Specifies a value for a single prompt. `[NAME]` is the text of the prompt.
sInstance	Indicates which specific instance of the target report to open.
sPartContext	In Crystal Reports, a report part is associated to a data context.
sRefresh	Indicates whether a refresh should be forced when the target document or report is opened.
sReportMode	For Crystal targets only, indicates whether the link should open the full target report or just the report part specified in `sReportPart`.
sReportName	Indicates which report to open if target document is multi-report.
sReportPart	Indicates which specific part of the target report to open.

Table 28-5: Output Parameters

Parameter	Description
NAII	Forces the display of the prompt selection page.
sOutputFormat	Indicates the format in which the target document is opened.
sViewer	Indicates the selected report viewer (CR & CA only).
sWindow	Indicates whether the target report will open in the current browser window or whether a new window will be launched.

openDocument platform parameters

This section details the openDocument platform parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platform
Specific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

iDocID

Syntax	Description	Mandatory?	Values
`iDocID`	Document identifier.	Yes*	Document identifier (InfoObjectID).

Note:
*One of `sDocName` or `iDocID` is mandatory.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDocID=2010
```

Note:
To obtain the document ID, navigate to the document within the Central Management Console (CMC). The properties page for the document contains the document ID and the CUID. Use this value for the `iDocID` parameter.

sDocName

Syntax	Description	Mandatory?	Values
`sDocName`	Document name without extension If multiple documents have the same name, specify the correct document with `iDocID`.	Yes*	Document name.

Note:
*One of `sDocName` or `iDocID` is mandatory.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+200
```

sIDType

Syntax	Description	Mandatory?	Values
`sIDType`	Central Management Server (CMS) object identifier type.	Yes*	• `CUID` • `GUID` • `RUID` • `ParentID` • `InfoObjectID` (default)

Note:
*Only mandatory if the target is a Crystal report or OLAP Intelligence report (`sType=rpt` or `sType=car`) in an Object Package. Otherwise, use `sPath` and `sDocName`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpecific>?iDocID=2010&sIDType=CUID
```

sKind

Syntax	Description	Mandatory?	Values
`sKind`	The file type of target Desktop Intelligence document.	Yes*	• `FullClient`

Note:
*Only mandatory if the target is a Desktop Intelligence document. Otherwise, use `sType`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpecific>?sKind=FullClient
```

sPath

Syntax	Description	Mandatory?	Values
`sPath`	The name of the folder and subfolder containing the target document.	Yes*	Folder and/or subfolder: `[folder],[subfolder]`

Note:
*Only mandatory if a value is specified for `sDocName` and is not unique.

`sPath` is used only with subfolders of the `Public Folders` folder. If your document is outside of the `Public Folders` folder, for example in the `My Favorites` folder, use the `iDocID` parameter instead of `sPath` and `sDocName`.

Do not add `[Public+Folders]` to the path; start with the name of the first subfolder within `Public Folders`.

```
Public Folders
    folder 1
      folder 1.1
         folder 1.1.1
```

If your document were in folder 1.1.1, you would set `sPath` to: `[folder+1],[folder+1.1],[folder+1.1.1]`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpecific>?sPath=[Sales+Reports]&sDocName=Sales+in+2005
```

sType

Syntax	Description	Mandatory?	Values
`sType`	The file type of target document or report.	Yes	• `wid` • `rpt` • `car`

Note:
This parameter is ignored for agnostic documents.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid
```

token

Syntax	Description	Mandatory?	Values
`token`	A valid logon token for the current CMS session.	No	The logon token for the current CMS session.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=Sales+in+2003&token=<lo
gonToken>
```

openDocument input parameters

This section details the openDocument input parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platform
Specific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

lsC

Syntax	Description	Mandatory?	Values
`lsC`	Specifies a contextual prompt if there is an ambiguity during SQL generation (Business Objects and Web Intelligence documents only). **Note:** Not supported by OLAP Intelligence	No	A prompt value that resolves the ambiguity in the SQL generation.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDo
cID=2010&lsC=Sales
```

lsM[NAME]

Syntax	Description	Mandatory?	Values
`lsM[NAME]`	Specifies multiple values for a prompt. `[NAME]` is the text of the prompt.	No	• Multiple prompt values, separated by a comma. If the target is a Crystal report, each value must be enclosed in square brackets. If the target is a OLAP Intelligence report, use the MDX WITH clause. • `no_value` (only for optional parameters)

Note:

- You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.
- The character `?` is a reserved prompt value for Web Intelligence documents in an openDocument URL. Setting the prompt value to `lsM[NAME]=?` in the URL forces the "Prompts" dialog box to appear for that particular prompt.
- For information on using this parameter with OLAP reports, see *Using the lsM parameter with OLAP Intelligence reports* .

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=rpt&sDocName=SalesReport&lsMSe
lect+Cities=[Paris],[London]
```

lsR[NAME]

Syntax	Description	Mandatory?	Values
`lsR[NAME]`	Specifies a range of values for a prompt. `[NAME]` is the text of the prompt. **Note:** Not supported by OLAP Intelligence	No	• A range of values for the prompt, separated by a double period (..). If the target is a Crystal report, the range must be enclosed in square brackets and/or parentheses (use a square bracket next to a value to include it in the range, and parentheses to exclude it). • `no_value` (only for optional parameters)

Note:
You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=rpt&sDocName=SalesReport&lsRTime+Pe
riod:=[2000..2004)
```

lsS[NAME]

Syntax	Description	Mandatory?	Values
`lsS[NAME]`	Specifies a value for a single prompt. `[NAME]` is the text of the prompt.	No	• A single prompt value. • `no_value` (only for optional parameters)

Note:

- You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.
- The character `?` is a reserved prompt value for Web Intelligence documents in an openDocument URL. Setting the prompt value to `lsS[NAME]=?` in the URL forces the "Prompts" dialog box to appear for that particular prompt.
- For information on using this parameter with OLAP reports, see *Using the lsS parameter with OLAP Intelligence reports*.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDo
cID=2010&lsSSelect+a+City=Paris
```

sInstance

Syntax	Description	Mandatory?	Values
`sInstance`	Indicates which specific instance of the target report to open.	No	• `User` (Link to latest instance owned by current user) • `Last` (Link to latest instance for report) • `Param` (Link to latest instance of report with matching parameter values)

Note:
Use this parameter in combination with `sDocName`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sReportPart=Part1&sInstance=User
```

sPartContext

Syntax	Description	Mandatory?	Values
`sPartContext`	In Crystal Reports, a report part is associated to a data context.	Yes*	Data context of the report part.

Note:
*Only mandatory if a value is specified for `sReportPart`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2005&sReportPart=Part1&sPartContext=0-4-
0
```

Note:
The `sReportPart` and `sPartContext` parameters are supported with the regular DHML viewer (`sViewer=html`). Instead of the first page of the report, the DHTML viewer displays the page and context containing the part with the part highlighted.

sRefresh

Syntax	Description	Mandatory?	Values
`sRefresh`	Indicates whether a refresh should be forced when the target document or report is opened.	No	• `Y` (forces the document's refresh) • `N` (note that the refresh on open feature overrides this value)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDo
cID=2010&sRefresh=Y
```

sReportMode

Syntax	Description	Mandatory?	Values
`sReportMode`	For Crystal targets only, indicates whether the link should open the full target report or just the report part specified in `sReportPart`.	No	• `Full` • `Part`

Note:
Defaults to `Full` if this parameter is not specified. Only applies if a value is specified for `sReportPart`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sReportPart=Part1&sReportMode=Part
```

sReportName

Syntax	Description	Mandatory?	Values
`sReportName`	Indicates which report to open if target document is multi-report.	No	Report name for Web Intelligence documents, sub-report for Crystal Reports, pages for OLAP Intelligence reports.

Note:
Defaults to the first report if this parameter is not specified.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=Sales+in+2003&sReport
Name=First+Report+Tab
```

sReportPart

Syntax	Description	Mandatory?	Values
`sReportPart`	Indicates which specific part of the target report to open.	No	Name of the report part.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sReportPart=Part1
```

Note:
The `sReportPart` and `sPartContext` parameters are supported with the regular DHML viewer (`sViewer=html`). Instead of the first page of the report, the DHTML viewer displays the page and context containing the part with the part highlighted.

openDocument output parameters

This section details the openDocument output parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platform
Specific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

NAII

Syntax	Description	Mandatory?	Values
`NAII`	Forces the display of the prompt selection page. **Note:** Only supported by Web Intelligence documents.	No	• Y (prompt values that are passed with `lsS`, `lsM`, or `lsR` in the URL are applied and not displayed in the "Prompts" dialog box)

Note:

- `NAII=Y` raises the "Prompts" dialog box for any values not specified in the URL. Prompts created with default values are still displayed in the "Prompts" dialog box.
- If all prompt values are specified in the URL, the prompt window does not appear even if `NAII=Y` is specified.

Example:

This example assumes there are two prompts in the Web Intelligence document: `Year` and `Country`. `NAII=Y` forces the "Prompts" dialog box to appear and allows the user to specify a value for the `Country` prompt.

The `Year` prompt is already set to a value of `FY1999` in the URL using the `lsS` parameter and therefore is not prompted for.

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDo
cID=2010&lsSYear=FY1999&NAII=Y&sRefresh=Y
```

sOutputFormat

Syntax	Description	Mandatory?	Values
`sOutputFormat`	Indicates the format in which the target document is opened.	No	• `H` (HTML) • `P` (PDF) • `E` (Excel) • `W` (Word)

Note:
Defaults to HTML if this parameter is not specified.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sOutputFormat=E
```

sViewer

Syntax	Description	Mandatory?	Values
`sViewer`	Indicates the viewer that is used to view the document.	No	• `html` • `part` (Crystal reports only) • `actx` (Crystal reports only) • `java` (Crystal reports only)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sViewer=html
```

Example:

Note:
In order to use parameters in the URL with the ActiveX viewer, `:connect` must be appended to the URL, followed by the parameters.

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sPath=[Sales+Reports]&sDoc
Name=Sales+in+2003&sViewer=actx:connect&IsMCountry=[Thai
land],[Norway]
```

---

sWindow

Syntax	Description	Mandatory?	Values
`sWindow`	Indicates whether the target report will open in the current browser window or whether a new window will be launched.	No	• `Same` (current browser window) • `New` (new browser window is launched)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<plat
formSpecific>?sType=wid&sDocName=SalesReport&iDo
cID=2010&sWindow=New
```

Contextual report linking

The openDocument feature allows you to create contextual links between Crystal reports, OLAP Intelligence reports and Web Intelligence documents. To do this, you construct a URL using the openDocument syntax and then insert the URL into a Crystal report, OLAP Intelligence report or Web Intelligence document.

Contextual report linking allows report designers to specify associations for documents residing in either a Crystal Reports environment (unmanaged) or a BusinessObjects Enterprise environment (managed). Once these associations are created, users follow the resulting navigational paths embedded in the linked documents.

This feature enables you to invoke Business Objects and Web Intelligence documents from Crystal Reports and vice versa. This feature relies on functionality that allows the user to do the following:

- Link Web Intelligence or Business Objects documents within the document domain.
- Link report objects in Crystal Reports.

To insert a link into a Crystal report

You can use openDocument to create hyperlinks in Crystal Reports. To create a link to another report or document, use the Hyperlink Tab of the field Format Editor.

1. Open the source report in Crystal Reports.
2. Right-click the field in which you want to insert the openDocument link and select **Format** from the shortcut menu.
3. In the Format Editor, select the **Hyperlink** tab.
4. Select **A website on the Internet**.
5. In the “Hyperlink information? area, leave the **Website Address** field empty and click the **Format Formula Editor** button.
6. Enter the openDocument link in the following format:

   ```
   "http://[openDocument parameters]"+{Article_lookup.Family_name}
   ```

   Where [openDocument parameters] are described in *openDocument parameter overview* , and the {Article_lookup.Family_name} enables the report to pass context-dependent data.

   Note:
   Test your link in a browser window before inserting it into a report or document.

7. Click **Save and Close** to leave the Formula Workshop.
8. Click **OK** in the Formula Editor to save the link.

To create a link to another report or document from an OLAP Intelligence report

You can use openDocument to create hyperlinks in OLAP Intelligence reports.

1. Open the source report in the OLAP Intelligence designer.
2. On the **Tools** menu, select **Action Manager** .
3. Click **New** to create a new action.
4. Enter an action name.
5. Select the area to which the action (the link) will apply.

6. Enter the openDocument link using the parameters and syntax described in this document.

   Tip:
   Test your link in a browser window before inserting it into a report or document.

7. Click **OK** to save the link.
8. Close the Action Manager dialog box.
9. Create an Analysis Button on the source report.
10. Right-click the Analysis Button.
11. In the drop-down menu, select **Properties** and then **Edit** .
12. Select **Launch an action** .
13. Select the action that corresponds to the openDocument link created in steps 3 through 6.
14. Click **OK** .

Creating links in Web Intelligence documents

You can define objects in a universe that allow Web Intelligence and BusinessObjects users to create reports whose returned values include links to other reports and documents.

When these reports are exported to the repository, users can click returned values displayed as hyperlinks to open another related document stored in the document domain of the repository.You create these links using the openDocument function in the definition of an object in Designer.

More information

For full information on creating links in Web Intelligence reports, see the *Building Reports Using the WebIntelligence Java Report Panel* guide.

You enable report linking in a universe by creating an object (the link object) whose returned values are the same as the values used as input to a prompt in an existing report (the target report).

The openDocument function allows the values for the link object to be returned as hyperlinks. When the user clicks the hyperlink, its value is used as the prompt input for the target report.

You can create documents using the link object as you would with any other object. Users can then click the hyperlinks to access more detailed documents related to the link object.

To create a link object, use the openDocument function in the object's Select statement. The Select statement for a link object follows this order:

```
'<a href="http://<servername>:<port>/OpenDocument/<plat
formSpecific>?sDocName=<document name>&sType=<document
type>&iDocID=<document id>&lsS<prompt message>='+object
 SELECT+'">'+object SELECT+'</a>'
```

The concatenation operator (+) applies for Microsoft Access databases. Use the operator appropriate to your target RDBMS.

For more details on the Select statement, creating link objects, and using link objects in InfoView, refer to the *Designer's Guide*.

Working with documents

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To create a Web Intelligence document from InfoView

1. Click **Document List** on the InfoView toolbar.
2. Click **New** > **Web Intelligence Document**
3. Select the universe on which you want to create the document and click **OK**.

   Note:
   If your InfoView Web Intelligence preferences specify a default universe, this step is omitted and the Web Intelligence query editor opens and displays the objects in the default universe.

4. The Web Intelligence query editor specified in the InfoView Web Intelligence preferences opens and displays the objects in the universe you selected.
5. Build and run the query using the query editor.

To open a Web Intelligence document from InfoView

1. Click **Document List** to show the documents available in InfoView.
2. Navigate to the folder containing your document.
3. Select the document and select **Action** > **View** or **Action Modify** depending on whether you want to view or modify the document.

   The document opens in the view format or document editing tool selected in your InfoView Web Intelligence options.

Related Topics

- *Web Intelligence document creation and viewing options*

To delete a Web Intelligence document from InfoView

1. From the InfoView home page, navigate to the folder that contains the document you want to delete.

2. Select the check box next to the name of the document you want to delete.
3. Click **Delete**.

Saving documents

To save a new Web Intelligence document in InfoView

1. With the document open in the Java Report Panel or Web Intelligence HTML, click **Save** on the main toolbar.

   The **Save Document** dialog box opens.
2. Click **Folders** or **Categories** to display the repository by folders or by categories.
3. In the **Name** box, type the name of the document.
4. Click **Advanced** to display additional document options.
5. In the **Description** box, type a meaningful description of the document (optional).
6. In the **Keywords** box, type keywords that you or other users can use to search for the document in the future (optional).
7. Select **Refresh on open** to refresh the document each time it is opened.
8. Select **Permanent Regional Formatting** to preserve the document regional formatting with the document.
9. Click **OK**.

   The document is saved in InfoView.

To save a Web Intelligence document as an Excel spreadsheet

1. With the document open, click **Document** > **Save to my computer as** > **Excel** (in Web Intelligence HTML) or click the arrow next to **Save**, then select **Save to my computer as**, then click **Excel** (in the Java Report Panel).

Note:
You can save the current report to Excel format in Web Intelligence HTML by selecting **Save report to my computer as** > **Excel** from the menu.

The **File Download** dialog box appears.

2. Type a file name or accept the default name displayed.
3. Select **Save this file to disk**, then click **OK**.
4. Select a file location on your computer, then click **Save**.

Web Intelligence saves a copy of your document in Microsoft Excel format to the location you specified on your computer. Each report within the Web Intelligence document converts to a separate Excel worksheet within the Excel file.

Some Web Intelligence chart formats do not exist in Excel. These charts are automatically converted to the closest corresponding chart format available in Excel.

Web Intelligence starts a new Excel worksheet for each 65K rows of exported data.

To save a Web Intelligence document as a PDF file

1. With the document open, click **Document** > **Save to my computer as** > **PDF** (in Web Intelligence HTML), or click the arrow next to **Save**, then select **Save to my computer as**, then select **PDF** (in the Java Report Panel).

   The **File Download** dialog box appears.
2. Type a file name or accept the default name displayed.
3. Select **Save this file to disk**, then click **OK**.
4. Select a file location on your computer, then click **Save**.

   Web Intelligence saves a copy of your document in Adobe Acrobat PDF format to the location you specified on your computer.

To save a Web Intelligence document as a CSV file

1. With the document open, click **Document** on the toolbar above the displayed reports (in Web Intelligence HTML), or click the arrow next to **Save** (in the Java Report Panel).
2. Select **Save to my computer as** > **CSV** to save the document with the default options or **Save to my computer as** > **CSV (with options)** to choose the options.
3. If you chose **CSV (with options)**, choose the text qualifier, column delimiter and character set in the "Save as CSV - Options" dialog box.
4. Select **Set as default values** in the "Save as CSV - Options" dialog box if you want the options you chose in the previous step to be the default options when you save to CSV.
5. Click **OK** to close the "Save as CSV - Options" dialog box.

   The **File Download** dialog box appears.
6. Select **Save this file to disk**, then click **OK**.
7. Type a file name or accept the default name displayed.
8. Select a file location on your computer, then click **Save**.

   Web Intelligence saves a copy of your document in CSV format to the location you specified on your computer.

Automatic saving and recovery

Saving documents automatically

If Web Intelligence is configured for autosave, and if you have the appropriate security rights, Web Intelligence saves your documents automatically in the `My Favorites/~Web Intelligence` folder as you work. Web Intelligence uses the document name prefixed by the document ID and followed by the autosaved document ID to name autosaved documents. (If the document ID is -1, the document was not saved before being autosaved.)

Note:
Web Intelligence Rich Client does not save documents automatically.

Web Intelligence saves documents at a regular interval, which is defined in the CMC. This interval is reset each time you save a document manually, and each time Web Intelligence saves a document automatically. Web Intelligence also deletes the autosaved document when you save a document manually.

In addition to regular autosaving, Web Intelligence saves documents when your Web Intelligence session times out.

Note:
If you lose a Web Intelligence document before you can save it, check the folder immediately for the autosaved version. The `My Favorites/~Web Intelligence` folder is not a permanent storage location for autosaved documents.

For more information on the settings and security rights that impact automatic saving, see the documentation for the Central Management Console.

Related Topics

- *How Web Intelligence manages autosaved documents*
- *Recovering autosaved documents*

Recovering autosaved documents

If your session times out while you are working on a document, Web Intelligence automatically saves the document in the `My Favorites/~Web Intelligence` folder and displays a dialog box explaining that the session has ended.

If you select **Restore** on the dialog box, Web Intelligence launches a new session and re-opens the autosaved document. The next time you save the document manually, Web Intelligence saves it in its original folder.

If you select **Close**, you are redirected to the InfoView home page. The autosaved document is available in the `My Favorites/~Web Intelligence` folder.

In some cases, Web Intelligence cannot link to the autosaved document after a server timeout or connection loss. In this case Web Intelligence does not offer you the option to restore the autosaved document. You must check the `My Favorites/~Web Intelligence` folder immediately for your

autosaved document. Web Intelligence regularly deletes documents from the folder based on the autosave settings.

Related Topics

- *Saving documents automatically*
- *How Web Intelligence manages autosaved documents*

How Web Intelligence manages autosaved documents

Web Intelligence saves documents automatically in the `My Favorites/~Web Intelligence` folder.

Whenever you save a document manually, Web Intelligence also updates the autosaved document with the changes. As a general rule, Web Intelligence handles autosaving transparently and you do not access autosaved documents directly. You need to access them directly when your Web Intelligence session timed out, and Web Intelligence was unable to reopen your autosaved document.

Note:
If you need to access an autosaved document directly, check the `My Favorites/~Web Intelligence` folder immediately. This folder is not a permanent storage location for autosaved documents.

The `My Favorites/~Web Intelligence` folder has a maximum size limit, which is set in the CMC. When the total size of the documents in the folder exceeds this limit, Web Intelligence deletes as many of the oldest documents in the folder as necessary to make way for the latest document.

Web Intelligence also deletes all documents from the folder at a defined interval, which is set in the CMC.

If you navigate away from your Web Intelligence document in your browser without saving the document, the document is lost and Web Intelligence clears the contents of the `My Favorites/~Web Intelligence` folder.

Related Topics

- *Saving documents automatically*
- *Recovering autosaved documents*

Printing Web Intelligence documents

You print Web Intelligence documents report-by-report. You can print one or multiple reports from a single document.

Web Intelligence prints reports from left to right, and then top to bottom. If a report is wider than the width of the paper size defined in the Report Page Layout, Web Intelligence inserts page breaks for the printout.

The paper size and page orientation for printing can be different from the paper size and page orientation set for the reports when you view them in the Java Report Panel or Web Intelligence Rich Client. This enables users using different printers to specify the appropriate layout when they print.

Web Intelligence prints documents directly in the Java Report Panel and Web Intelligence Rich Client. Web Intelligence HTML exports the document to PDF file that you can then print.

To print a document

1. Click the report tab you want to print.
2. Click the **Print this document** button on the Report toolbar.

   The "Print" dialog box appears.
3. Under the **Print Range** option, you specify whether you want to print the entire selected report or just some of the report pages.

   You can specify the paper size of the report or page(s) for the printout. The paper size you set for printing overrides the paper size defined for the report in the Report Properties Page Layout tab.
4. To change the paper size, click the arrow next to the list box below **Paper Size**,and then select a different paper size from the list.
5. Under the **Orientation** options, select the page orientation that suits the report page layout.
6. Under the **Margins** options, select the margin sizes.
7. Under the **Copies** options, select the number of copies to print.
8. Click **OK**.

Editing document properties

The Web Intelligence document properties are divided into groups in the **Document Properties** pane. To expand a group to see the properties it contains, click the down arrow button next to the group name. When you expand a group, the down arrow button changes to an up arrow button. Click this button to contract the group.

You display the Document Properties pane by right-clicking a report outside all report components and selecting **Document Properties** from the menu.

Group	Property	Description
Document Information	Created by	The document creator.
	Last modified by	The last user to modify the document.
	Creation date	The date the document was created.
	Name	The document name.
	Description	The document description.
	Keywords	The document keywords.
	Locale	The document formatting locale.
	Data tracking	Indicates whether data tracking is activated.
Document Options	Refresh on open	Tells Web Intelligence to refresh the document when it is opened.
	Enhanced Viewing	Optimizes the document appearing for on-screen viewing.

	Use query drill	Tells Web Intelligence to drill in query drill mode.
	Permanent regional formatting	Permanently associates the current document locale with the document.
	Enable Query Stripping	Enables Query Stripping at the document level.
Data Synchronization Options	Auto-merge dimensions	Tells Web Intelligence to synchronize data providers by merging dimensions automatically under certain conditions.
	Extend merged dimension values	Tells Web Intelligence to extend dimension values in reports with synchronized data providers.
Report Order		Sets the report order in a document.

To display document properties

- Right-click a report outside all report components and select **Document Properties** from the menu, or click **...** next to the **General** > **Document Properties** property on the **Data** tab.

To purge data from a document

1. Click **Purge Data** on the main toolbar.

   Web Intelligence purges the data from the document.

2. If the document contains multiple queries and you want to purge the data from a specific query, click the arrow at the right of the **Purge Data** button and select **Purge <Query name>** from the menu.

   Web Intelligence purges the data from the query.

More Information

appendix A

Information Resource	Location
SAP BusinessObjects product information	*http://www.sap.com*
SAP Help Portal	Select *http://help.sap.com* > SAP BusinessObjects. You can access the most up-to-date documentation covering all SAP BusinessObjects products and their deployment at the SAP Help Portal. You can download PDF versions or installable HTML libraries. Certain guides are stored on the SAP Service Marketplace and are not available from the SAP Help Portal. These guides are listed on the Help Portal accompanied by a link to the SAP Service Marketplace. Customers with a maintenance agreement have an authorized user ID to access this site. To obtain an ID, contact your customer support representative.
SAP Service Marketplace	*http://service.sap.com/bosap-support* > Documentation • Installation guides: *https://service.sap.com/bosap-inst guides* • Release notes: *http://service.sap.com/releasenotes* The SAP Service Marketplace stores certain installation guides, upgrade and migration guides, deployment guides, release notes and Supported Platforms documents. Customers with a maintenance agreement have an authorized user ID to access this site. Contact your customer support representative to obtain an ID. If you are redirected to the SAP Service Marketplace from the SAP Help Portal, use the menu in the navigation pane on the left to locate the category containing the documentation you want to access.
Developer resources	*https://boc.sdn.sap.com/* *https://www.sdn.sap.com/irj/sdn/businessobjects-sdklibrary*

Information Resource	Location
SAP BusinessObjects articles on the SAP Community Network	*https://www.sdn.sap.com/irj/boc/businessobjects-articles* These articles were formerly known as technical papers.
Notes	*https://service.sap.com/notes* These notes were formerly known as Knowledge Base articles.
Forums on the SAP Community Network	*https://www.sdn.sap.com/irj/scn/forums*
Training	*http://www.sap.com/services/education* From traditional classroom learning to targeted e-learning seminars, we can offer a training package to suit your learning needs and preferred learning style.
Online customer support	*http://service.sap.com/bosap-support* The SAP Support Portal contains information about Customer Support programs and services. It also has links to a wide range of technical information and downloads. Customers with a maintenance agreement have an authorized user ID to access this site. To obtain an ID, contact your customer support representative.
Consulting	*http://www.sap.com/services/bysubject/businessobjectsconsulting* Consultants can accompany you from the initial analysis stage to the delivery of your deployment project. Expertise is available in topics such as relational and multidimensional databases, connectivity, database design tools, and cus tomized embedding technology.

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ALABAMA TITLE XIX

Provider Enrollment and Re-Enrollment Desk Top Procedure Manual

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Processing Mail

Currently, an Enrollment Specialist is assigned the task of opening, sorting, stamping and counting the mail received in Provider Enrollment. This allows for each staff member to carry out this task and for the Supervisor to change the schedule as necessary.

Provider Enrollment may receive mail through the following sources:

- Individual mail carrier who delivers to the Reception Desk
- Deliver by courier to the front desk/Provider office member delivers the documents
- Mail from the P O Box, which is picked up by and delivered by DXC Mailroom staff
- Mail from specific carriers, such as Federal Express, which is delivered to enrollment by mailroom staff

Mail is delivered to enrollment from these sources at approximately 9 a.m. and again at 2 p.m.

The team leader or selected fill in staff member, processing mail for the current week will do the following:

- Open all packages delivered to the department
- Separate applications, update correspondence, and returned mail items.
- Items, which are not processed by the enrollment department, should be forwarded to the appropriate unit. This may be done by, placing the item in the in-house mail slot of the person or unit, to which the item should have been delivered. If the item is to be forwarded to the Medicaid Agency, the items should be mailed through the state correspondence guidelines, and accompanied by an DXC-memo.
- Sort applications, so that applications from one entity may be bundled together. (This allows the supervisor to allow one person (more if necessary) to process all applications from one provider or provider office. This step helps to ensure consistency in processing the applications.)

All mail for the next business day should be processed and delivered to the enrollment specialists by the end of the day or as directed by the enrollment supervisor.

LOGGING AND STAMPING MAIL

Applications

Applications are logged on the Mail Receipt Log for the current month. On each mail log, the first tab from the left bottom of the workbook is a tab marked 'Apps Received'. This worksheet contains columns to indicate information as follows:

- *Person Item is Assigned to for Completion* – Indicated in this column the name of the Enrollment specialists to handle the document.
- *Date Item is Placed into Production* – Indicated in this column is the date the item was stamped as received, which corresponds with the day the item is assigned for processing.
- *Due Date of the Item to be Processed* – Indicated in this column is the date the item is due to be processed, this date corresponds with the five-day turn around outlined in the contractual guidelines.
- *Provider or Group Name* – Indicated in this column is the full name of the person of facility for whom the application was completed.

- *Physical Address* – Indicated in this column is the physical address as indicated on the enrollment application. Due to the requirement for providers to enroll each site of service,

indication of the physical address helps to ensure staff members can give a delivery status of the correct application, if asked.

- *Application Type* – Indicated in this column is the type of application received for enrollment. Due to there being different type of applications, such as the Additional Location App and Out-of-State Institutional App, indication of this information is helpful in tracking the number of particular types of apps that are being submitted and for what provider types.
- *Additional Location (ALEA) (Yes or No)* – Indicated in this column is a 'Yes' or 'No' to show if an application is an ALEA application. Due to the ALEA forms being a new process, indication of this information helps to show a count of the number of these apps being submitted.
- *Out-of-state Practitioner (OOSP) App (Yes or No)* – Indicated in this column is a 'Yes' or 'No' to show if an application is an OOSP application. Due to the OOSP forms being a new process, indication of this information helps to show a count of the number of these apps being submitted.

Update Correspondence

Update correspondences are stamped page by page, with the date of the next day. This allows for the date on the correspondence to reflect the day in which the correspondence goes into production. The correspondence is also stamped once with the DXC Action stamp. This allows an area for staff members to indicate the action taken, the date of the action and their initials.

Once the update correspondence are sorted and stamped, they are logged on the Mail Receipt Log for the current month. On each mail log, the second tab from the left bottom of the workbook is a tab marked 'Updates Received'. This worksheet contains columns to indicate information as follows:

- *Person Item is Assigned to for Completion* – Indicated in this column the name of the Enrollment specialists to handle the document.
- *Date Item is Placed into Production* – Indicated in this column is the date the item was stamped as received, which corresponds with the day the item is assigned for processing.
- *Due Date of the Item to be Processed* – Indicated in this column is the date the item is due to be processed, this date corresponds with the two-day turn around outlined in the contractual guidelines.
- *Provider or Group Name* – Indicated in this column is the full name of the person of facility for whom the update correspondence was completed.
- *NPI to which the Update Applies* – Indicated in this column is the NPI shown on the update correspondence.
- *Update Type* – Indicated in this column is a brief description of the type of update received, such as EMC Agreement.

The team members are manually assigned updates when indexing. Updates are assigned equally to team members.

Returned Mail

Returned mail pieces sorted into stacks based on the type of mail out returned. Returned mail outs may consist of returned RAs, Patient 1st listings and recipient letters, prior authorization letters, third party recipient and insurance carrier letters, and general mass mail out correspondence.

Once the returned mail pieces are sorted, they are logged on the Mail Receipt Log for the current month, if the item is to be handled by the enrollment department. On each mail log, the third tab from the left bottom of the workbook is a tab marked 'Returned Mail Items'. This worksheet contains columns to indicate information as follows:

- *Person Item is Assigned to for Completion* – Indicated in this column the name of the Enrollment specialists to handle the document.
- *Date Item is Placed into Production* – Indicated in this column is the date the item was stamped as received, which corresponds with the day the item is assigned for processing.
- *Due Date of the Item to be Processed* – Indicated in this column is the date the item is due to be processed, this date corresponds with the two-day turn around outlined in the contractual guidelines.
- *Provider or Group Name* – Indicated in this column is the full name of the person of facility for whom the returned correspondence was to be mailed.
- *NPI to which the Update Applies* – Indicated in this column is the NPI shown on the returned correspondence.
- *Type of Returned Piece* – Indicated in this column is a brief description of the type of correspondence returned, such as PA.

Items, which are not processed by Enrollment, are forwarded to the appropriate departments. All mail to be placed in production the following day is placed on the desk top of the cubical across from the Supervisor.

Scanning and Indexing Mail

Following the stamping and logging of work received in enrollment, all work should be scanned and indexed into individual's workflows to be distributed by the end of the business day. All work should be indexed by provider name, NPI, Document type, Date Received, Due Date, and Status.

Application supporting documentation should be scanned directly behind the application. Open the application on the scanner, select add pages, ensure the "replace pages" option is not selected, scan documentation, and save. Open the application and confirm the pages are appended as expected.

Updates should receive a Document Type "U" for Update.

Distributing Mail

The mail person, or selected fill in staff member, will distribute applications and correspondence as evenly as possible to each present staff member. If able to do so, the Enrollment Supervisor does not provide new mail to the fill in staff member, if the team leader is not present to carry out the mail task. If avoidable, mail is not given to absent staff members.

Items such as third party recipient and insurance carrier letters and Patient 1st recipient letters are bundled and forwarded to Medicaid under an DXC-memo. (See the 'Correspondence Processing' section of the manual for further information regarding the handling of returned mail.)

Assigning Mail to Staff Members

The mail person, or fill in staff member will indicate on the Mail Receipt Log for the current month, the name of the person to whom the item was assigned for processing. This assignment process is based on who the item is distributed to, when carrying out the distribution process above. On each worksheet in the mail log workbook is a 'Person Item is Assigned to for Completion' column, which allows for the name of the person to be indicated.

If a staff member is assigned an item, which is to be processed by another staff member, the REP column of the application should be updated with the email address of the enrollment member that is to work the application. The date of transfer should be indicated in the 'Transfer Date' Column and the person to whom the item was transferred should be indicated in 'Transferred Recipient Column'. These two columns are available on Apps Received, Updates Received and Returned Mail Items Received worksheets of each mail log. By indicating the transference of items on these sheets, this helps to ensure the correct person is contacted regarding the processing of the application, update or returned mail piece, as well as show any patterns of work being shifted to another staff member.

Processing Error Bin

Facsimiles submitted by providers incorrectly are routed to the Error Bin to be manually processed daily before noon. This may include additional documentation in support of an enrollment application.

Enrollment Supervisor or selected fill in staff member will manually review each document and index appropriately routing to workflow to be processed.

Providers who are "repeat offenders" are connected and reeducated on the submission process to prevent future delays in the processing of their application. Completion of this daily task, allows all enrollment and Medicaid Agency Review staff visibility to all received documents for their application review. Error Bin documents should receive a Document Type "D" for supporting documentation.

Receiving and Distributing OPR Memos

OPR memos are Operation memos, which are forwarded to DXC from the Alabama Medicaid Agency, requesting DXC to take action as outlined in the cover memo or as noted on the attachments. Before the Enrollment Supervisor receives the OPR memos the following steps are carried out:

- OPRs are reviewed by the account manager
- OPRs are logged into a database by the receptionist who also copies the correspondence
- The OPRs are then placed in the mail box of the designated manager (i.e., Provider Relations Manager in the receptionist copy room)
- The OPRs are distributed by the designated manager (Provider Relations Manager) to the persons to which the correspondence is written, (i.e., Provider Enrollment Supervisor)

When the Provider Enrollment Supervisor receives the OPRs, the items are logged on the Correspondence Tracking Log Spreadsheet(s). Each Spreadsheet contains a full calendar year of worksheets designated for each month's receipts. The name of each spreadsheet contains the year, in which the spreadsheet was created, (i.e., 2002 Correspondence Tracking). Within each

spreadsheet are worksheets, which contains the name of the month and year in which the items were received, (i.e., April 2002). On each worksheet the following information is logged:

- *OPR Number* – Number assigned by the Medicaid Agency and can be located in the top left box on the OPR cover page.
- *State Stamp Date* – Date of stamp showing the receipt in the various units of the Medicaid office, (i.e., Fiscal Agent Office – 4/1/02).
- *Pick Up Date* – Date of stamp or signature showing who from DXC picked up the item and when.
- *Department Date* – Date on which the Provider Enrollment Supervisor received the OPR.
- *Subject* – Give overview of the correspondence subject, (i.e., Re-certification for Provider A).
- *Who To* – Name of Enrollment staff member to which the correspondence was assigned for completion purposes.
- *Action Date* – Due date, which is assigned on the OPR by Medicaid personnel, DXC Manager or Supervisor
- *Completed* – Date on which the item was completed by assigned person.
- *Answered* – Number of DXC memo, which was written in response to the OPR memo

A sample of the Correspondence Tracking Log can be found at the following link:

- **Provider Team (N): \Provider Rep Contacts and Call Logs \Provider Enrollment \Provider Enrollment Supervisor \Process and Procedures \Samples \2002 Correspondence Tracking Sample**

The production versions of this log can be found at the following link:

- **State (X): \OPR Log \2016 \OPR 2016**

Once the OPR memo information is entered into the appropriate Correspondence Tracking Log, the OPR memos are added to the daily mail for distribution purposes. The staff member to whom the correspondence has been assigned is responsible for completing the action requested or returning the OPR for additional information by the due date indicated on the cover sheet. It is the responsibility of the staff member to obtain a DXC memo number, create the DXC memo to accompany the correspondence. The memo is forwarded to the Provider Relations Manager for sign off purposes. The Provider Relations Manager returns the memo to the supervisor so that the completion date and DXC memo number can be entered into the Correspondence Tracking Log. The supervisor distributes the memos back to staff members, who is then responsible for making copies or arranging for copies to be made as necessary. A sample of the template used to create DXC memos can be found at the following links:

- **Share (I):\ Miscellaneous \Letters \A – Letter Templates**

The memo template applicable, for responding to the OPR is decided by, which staff member of the Fiscal Agent Liaison Office of Medicaid signed off on the OPR. Beneath the heading, which addresses the member of the Fiscal Agent Liaison Office, staff members also indicate the name of the person to whom the response is intended.

Tracking Received and Processed Items

The number of items distributed to each staff member is indicated on each member's Daily Production Log.

A sample of the Daily Production Logs, can be found at the following link:

- **Provider Team (N): Provider Rep Contacts and Call Logs \Provider Enrollment \Provider Enrollment Supervisor \Processes and Procedures \Samples \Daily Production Log Sample**

Although the Enrollment Specialist handling the mail indicates the number of items received on a daily basis, it is the responsibility of the staff member to indicate in the appropriate fields the following items:

- The number of items processed
- Items received which were not distributed by supervisor or team lead
- Telephone calls
- The number of applications reviewed, but not keyed or returned

It is also the responsibility of the staff member to calculate daily numbers before submitting the log sheet to the supervisor or team lead. This log sheet is to be completed daily and the numbers on the sheet should be consistent with the Maintenance and RTP logs completed daily and the entries on the Extended Turn-Around Spreadsheet, which show the action taken on applications and correspondences.

Sending RTP Letters/E-mail to Providers

When applications or correspondence is RTP'd back to a provider, enrollment staff should perform verification that the address for the provider on the RTP letter matches the address written on the envelope. If email notification is used for returned applications, use the contact email indicated on the application.

Before sending to the mailroom to be sent to the provider, the enrollment staff members will perform a review of the returned documents to ensure the information is being sent to the proper address on file for the provider. If the Mail-To address differs from the Pay-To address on file for the provider, mail should be sent back using the Mail-To address.

If a provider has been DENIED enrollment from the agency for a site visit or other reasons noted by the state, returned applications must be QCed by the QA person before being sent back to the provider. This is to ensure the proper documentation is being returned to the provider and that the OIG receives a copy of the denial letter.

The application or update is then given a status of returned (R) in Feith to indicate the enrollment application or update has been returned.

Logging Processed Items

As each item is keyed into the Provider Master File the person who processed the application or correspondence should log the actions taken on the paper Daily Maintenance Log currently used.

As other items are returned for additional information or corrections the person who processed the application or correspondence should log (at a minimum) the name and the reasons for returning on the paper Daily RTP Log currently used.

A library of Daily Maintenance and RTP logs for items processed from 1998 through 2003 can be found in the first cubical of the Provider Enrollment Unit. Each binder is marked by the date range, which can be found in the binder.

Beginning in 2003, an Excel Spreadsheet will be used as Maintenance and RTP logs. A sample of each log can be found at the following links:

- **Share (I):\ Provider Enrollment Supervisor \Processes and Procedures \Samples \Processing Log Sample**

Summarizing Daily Stats

On Monday mornings the supervisor or team lead will summarize the daily numbers of each staff member for a weekly total. Specific weekly totals are placed on the Stats for Dashboard Spreadsheet found on the Leaders (L) Drive. To summarize the totals the daily statistics for each staff member are keyed into the Monthly Stats Spreadsheet.

A sample of the Monthly Stats Spreadsheet can be found at the following link:

- Share (I):\ Provider Enrollment Supervisor \Team \Monthly Team Stats \Stat Sheet Sample

One month of statistics makes up one spreadsheet. Within the spreadsheet are worksheets, which reflect weekly statistics. Information is pulled from each staff members Daily Log Sheet and placed in columns H through N of the worksheet. (Each staff member has a designated column.) When keying Monday's statistics column B should reflect calculations of the totals of columns H through N. Tuesday's statistics total should be reflected in column C. Wednesday's statistics total should be reflected in column D. Thursday's statistics total should be reflected in column E. Friday's statistics total should be reflected in column F. The items are keyed on the row in which the information is presented on the Daily Log Sheet. For example, pull the Application Beginning Inventory number for the person assigned to column H and key that number in column H on row 3, which is titled Application Beginning Inventory.

Once Monday's totals are calculated, the formula for the cells in column C should be added. (So the totals for Monday are not changed, when new information is keyed in column H through N, the numbers in column B should be over keyed. Keying the totals will delete the formula for the cells in the column, but the totals will remain.) This will calculate new totals of what is keyed in column H through N. The process above of pulling information from the Daily Log Sheet and keying the information into the spreadsheet should be duplicated. This process should take place until the totals for each day in the week are calculated.

On a monthly basis, the numbers are reported on the Customer Relations Status Report and on the AL Title XIX Monthly Report.

Audit Procedures (Enrollment QA Person)

The following functions are performed during the weekly internal audit of Provider Enrollment's processed applications:

A query is run to identify additions to the provider file during the previous week. The results of this query are NPI, provider name and the original add date. The query results are saved into a text file and then converted to an Excel Spreadsheet.

- Once the person who processed the application has been identified, applications are randomly selected from the list.
- The applications are retrieved for review.
- The applications are then reviewed for all required documentation such as a copy of the provider's professional license.

- The application is reviewed for thoroughness on behalf of the person who completed the application. This ensures all appropriate information is indicated on the application and all required signatures are present.
- The application information is then compared to the information keyed into the provider file. Accuracy is determined by the number of errors identified in the fields that count towards the 99.8 percent accuracy requirement.
- The application is also reviewed for timeliness to ensure the contractual 10-day turnaround time was met.

Once this review is complete, an e-mail message is sent to the person who processed the document to request specific changes be made, specific errors be corrected, to offer suggestions for processing and also to give praise for a job well done. The person is given a specific time frame to complete any tasking given.

When the time given for completing tasks has passed or when notification is sent to the QA person the task has been completed (whichever is earlier), the file is then reviewed again.

Phone Etiquette

CONTACT INFORMATION:

To avoid staff members receiving a larger call volume than what can be handled along with performing other daily duties, direct extension numbers are not given to providers. The toll free numbers available for departments/staff should be given (provided on the following page). If the caller is in an out-of-state non-bordering (30 miles from Alabama border) location please announce and transfer the call to the particular DXC staff member OR refer them to the 334-215-0111 phone number. By using this phone number the caller can spell the last name of the party, which they are attempting to reach.

CALL TRANSFER:

If there is a need to transfer a call to a staff member's direct extension, please call the receiving party to announce the call being transferred. When announcing the call information such as the caller's name, reason the call is being transferred and the name of the person transferring the call should be given. By announcing call the following situations may be avoided:

- The caller may become upset because they were unable to reach the desired individual, if the person receiving the call is unavailable.
- If the person calling is upset and is transferred to another employee unannounced, the receiving party does not have time to prepare for the call. This could hinder the staff member's ability to effectively handle the provider's issues.

If the receiving party is unavailable, explain this to the caller. To ensure customer service quality, the following steps should be followed:

- Offer to take a message or offer to allow the caller to leave a message on voice mail
- Offer the toll free/general phone line for the department, if staff member to be reached is in a different department than enrollment.
- If the caller's inquiry is in regards to enrollment, offer to assist the caller.

If the caller asks for someone else specific, follow the same procedures as given when attempting to announce and transfer the caller to the originally requested party.

The toll free contact numbers available for provider's to use are listed below:

Provider Assistance Center & Provider Reps:	1-800-688-7989
Provider Enrollment Department:	1-888-223-3630
Electronic Claim Submission Department:	1-800-456-1242

Providers may also access the AVRS system at: 1-800-727-7848

Providers must be in the state of Alabama or within a 30-mile radius of the Alabama stated border to access the toll free numbers.

Correspondence Processing

Changes made to the MMIS panels require the user have update and add capabilities.

Certification and Transmittal Forms (C&Ts)

PROVIDER/SUPPLIER CATEGORIES
Department of Public Health (DPH) must send certification to DXC/Medicaid before specific provider types can be enrolled. Certification forms are also sent to DXC/Medicaid if specific changes are to be made to the existing provider file of the specific provider types. Providers, who are eligible to participate in the Alabama Medicaid Program and are certified through DPH are listed below:

Ambulatory Surgical Center (ASC - 15)
Dialysis (ESRD - 9)
Home Health (HHA or HH - 5)
Hospice (16)
Hospital (1)
Independent Rural Health (IRHC – 12)
Laboratory (LAB – 6)
Nursing Home (NH, SNF, ICF/MR – 2, 3, 10)
Provider Based Rural Health (PBRHC - 12)
Psych Hospital Over 65 (1)
Psych Hospital Under 21 (1)

When DPH has approved certification of the providers, a copy of the Medicare/Medicaid Certification & Transmittal forms (C&T) is sent to Medicaid. Medicaid will forward the C&T's either via hand mail, or under OPR cover letter. The instructions for handling and interpreting/reading each C&T are outlined in this document. However, the change and enrollment processes are given in the Provider Enrollment Operational Procedure Manual.

INTERPRETING/READING PROVIDER/SUPPLIER CATEGORIES
Although only the providers listed above are eligible to participate in the Medicaid program, there are 16 different provider/supplier categories shown on the C&T form. These are listed in block 7. Block L-7 will tell which provider/supplier category to which the C&T applies.

1. Hospital
2. SNF/ICF (Dually certified)
3. SNF/ICF (Distinct Part)
4. SNF
5. HHA (Home Health)
6. LAB
7. X-Ray
8. OPT/SP
9. ESRD
10. ICF
11. IMR
12. RHC (Rural Health Clinic)
13. PTIP
14. CORF (Rehab)
15. ASC
16. Hospice

INTERPRETING/READING ACTION CATEGORIES
Listed below are the types of C&T forms to be forwarded to DXC that require action to be taken, but only if received for a provider eligible to participate or currently participating in the Alabama Medicaid Program. These are listed in block 4. Block L-8 will tell which type of action is required.

TYPE 1Initial Survey
TYPE 3Termination
TYPE 4Change of Ownership (CHOW)
TYPE 9Other

- If a TYPE 1 C&T is received for a provider type that is eligible to participate in the Alabama Medicaid Program, although the provider is not required to enroll in the program, an application and an initial survey letter should be sent to the provider's office. The C&T and a copy of the initial survey letter should be placed in the appropriate enrollment file.
- If a TYPE 3 C&T is received for a provider currently enrolled in the Alabama Medicaid Program, although the provider may not be enrolled in the program the C&T should be reviewed and filed. If the provider is enrolled in the program the appropriate termination letter is sent informing the provider office a termination action was requested and will be

processed. The effective date of termination should be added to the provider file. An end date should be added to the active segment, and end reason decertified segment should be added to the file. The end date of the active action reason code should be the day prior to the termination date given on the C&T. The effective date of the decertified action/reason code should be the termination date given on the C&T.

- If a TYPE 4 C&T is received for a provider currently enrolled in the Alabama Medicaid Program, an application and the appropriate Change of Ownership (CHOW) letter is sent to the provider's office. The C&T and a copy of the CHOW letter should be placed in the 'pending file'.
- If a TYPE 9 C&T is received for a provider currently enrolled in the Alabama Medicaid Program, enrollment staff should refer to Block 16 (State Survey Agency Remarks) for instruction. This block may indicate one or more of the following changes:

Address Change – An address change reflected on a C&T can be processed based on the information in block 3 and block 16 of the C&T. No additional information is required.

Fiscal Year End (FYE) Change – An FYE change reflected on a C&T cannot be processed until DXC receives a copy of the FYE change approval letter, sent to the provider from the Provider Audit Unit of Medicaid. Once both pieces of documentation are received, the file can be updated to reflect the new FYE date shown in block 9 of the C&T. However, the date in block 9 of the C&T must reflect the same date approved by Provider Audit.

Bed Decrease – A bed decrease reflected on a C&T can be processed based on the information is block 16. When a bed decrease has been processed the Bed Decrease letter should be forwarded to the provider's office as notification that the change has been completed. The Bed Decrease template used can be found at the following link:

- Share (I):\ Provider Enrollment \Letters for Nursing Home \Bed Decrease

NOTE: The previous bed count shown should be the number on file before the C&T is processed. A bed decrease C&T is normally applicable to a Nursing Home. Refer to block 7 of the C&T to determine the provider type of the provider.

Bed Increase - A bed increase reflected on a C&T can be processed based on the information is block 16. When a bed increase has been processed the Bed Increase letter should be forwarded to the provider's office as notification that the change has been completed. The Bed Increase template used can be found at the following link:

- Share (I):\ Provider Enrollment \Letters for Nursing Home \Bed Increase

NOTE: The previous bed count shown should be the number on file before the C&T is processed. A bed increase C&T is normally applicable to a Nursing Home. Refer to block 7 of the C&T to determine the provider type of the provider.

Name Change – A name change reflected on a C&T cannot be processed based on the information on the C&T alone. When a name change C&T is received for a provider who is currently enrolled in the Alabama Medicaid program, the staff member processing the C&T must send to the provider the Name Change Form, the Amendment to the Provider Agreement Form, the W-9 tax form and EFT form.

The Name Change Form and the Amendment to the Provider Agreement form can be found at the following link:

- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \Name Change letter
- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \AMENDMENT TO THE PROVIDER AGREEMENT

During the time which lapses between the receipt of the C&T and the receipt of the requested/required completed documentation from the provider's office and/or outside resources, the items currently in possession of DXC should be placed in the 'Pending File.' The letters initiated by enrollment staff and sent to the provider's office must contain the signature of the person processing the C&T. A copy of the letter initiated by enrollment staff should be placed in the pending file, along with any documentation received for the provider, such as the C&T.
Once the documentation sent to the provider's office is returned, the information should be verified and the name change can be processed.

PENDING FILE GUIDELINES

- Only C&Ts, requiring correspondence from the provider so that an action to be taken, should be placed in the pending file drawer.
- When placing the C&T in the pending drawer, a folder should be created for the C&T and any additional information to accompany the C&T, such as CMS/HCFA letters. A copy of the correspondence sent to the provider, such as Amendments, should be placed in the folder as well. By placing these items in the folder, it shows what efforts have been made to process the C&T and when those efforts were made.
- Any correspondence sent to the Agency or the provider while processing the C&T should contain the name and signature of the Provider Enrollment Representative processing the C&T. All copies of the items placed in the pending file should be made after the person processing the correspondence has signed the item.
- The Provider Enrollment Representative who placed the item in the pending file is responsible for following up on the correspondence within the given time frame of any letter/correspondence sent to the provider. Such as applications for a CHOW should be completed and sent to DXC within 30 days of the date on the letter from DXC.
- If an application is received for a provider requiring a C&T and the C&T cannot be located. Contact the state agency (Jayne Potts) to determine if a C&T has been received from the Health Department.
- Enrollment staff will identify applications pending C&T appropriately in their workflows so that periodic QC can be made to identify applications pending C&T so that follow-up can be made for any applications pending over 30 days.

INTERPRETING/READING FILING CATEGORIES

Listed below are the types of C&T forms to be forwarded to DXC that require filing. These C&Ts may be for providers who are and are not eligible to participate or currently participating in the Alabama Medicaid Program.

C&Ts such as the following require filing:
TYPE 2Recertification
TYPE 5Validation
TYPE 6Complaint
TYPE 7Onsite Visit
TYPE 8Termination of ICF Beds

If a C&T is received that does not require action to be taken to the provider file, the information should file it in the actual provider's file, not in the 'Pending File'.

- If the above mentioned items, come over under an OPR memo, the staff member processing the OPR will need to respond to the OPR memo, although the action taken is filing the C&T. (If more than one C&T received is to be filed, the response can be sent under one DXC memo. However, the response must be addressed to one person, and a list of the items to which the response addresses should be listed in the DXC memo. Before the DXC memo will be signed, the items must be filed.)

If the action type is marked as TYPE 9 – Other, the action required is indicated in the Block 16 (State Survey Agency Remarks) of the C&T.

Name Change for Clinics, Facilities, Groups/Payees

NOTE: The name change instructions below are applicable only to those providers who are not listed as requiring a C&T to update files.

Name change correspondence must be submitted in writing. The correspondence should be on leader head and contain the following information:

- Name(s) of the providers of which the change will affect.
- Alabama Medicaid Number(s) of the providers of which the change will affect.
- A description of the change being requested.
- Name and Business title of the person initiating/submitting the change.
- Signature of the person initiating/submitting the change.

A W-9 tax form must be submitted to show proof that the tax name and/or number did not change. If the tax name changes, please refer to the Tax Name Change section for instructions and requirements. If the tax number changed re-enrollment is required.

An Electronic Funds Transfer (EFT) Form must be submitted to show the depository information did not change. A copy of a voided check bank letter should accompany the EFT form, for verification purposes. If the depository information has changed, compare the information on the EFT form to that on the voided check or deposit slip.

To carry out the same function as if the provider's office had created and submitted the written request above DXC may send to the provider the Name Change Form, the Amendment to the Provider Agreement Form, the W-9 tax form and EFT form for completion. The same procedures should be followed regarding the EFT information. The Name Change Form and the Amendment to the Provider Agreement form can be found at the following link:

- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \Name Change letter

- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \AMENDMENT TO THE PROVIDER AGREEMENT

If the required information is submitted the name change can be completed.

Tax Name Change

NOTE: The tax name change instructions below are applicable only to those providers who are not listed as requiring a C&T to update files.

A tax name change requires enrollment staff to send the provider the Tax Name Change Form, the Amendment to the Provider Agreement Form, the W-9 tax form and EFT form for completion. A sample of the Tax Name Change Form can be found at the following links:

The Tax Name Change Form and the Amendment to the Provider Agreement form can be found at the following link:

- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \Tax Name Change letter
- Share: \Provider Enrollment \ Letters for (choose the provider type which corresponds with the type of provider to undergo the name change update) \AMENDMENT TO THE PROVIDER AGREEMENT

If the required information is submitted the tax name change can be completed.

Tax Number Change

If a provider's tax number changes, this may warrant re-enrollment. Refer to the Provider Operations Procedures manual for change of ownership (CHOW) guidelines. A new application may need to be completed and submitted. Upon approval of the application the provider will be enrolled.

An exception to this is if a provider was originally enrolled under his SSN as his/her tax reporting information and the provider obtains a tax number for his/her practice. If the provider obtains a tax name or registers his/her tax information as a practice name, a clinic/facility/group/payee application may be required. Sole proprietorship practices are not required to complete a clinic/facility/group/payee application if the payee name is the individual's name and no other providers are to be enrolled as participants in the practice, with the practice as the payee.

If a clinic/facility/group/payee application is required, the provider must also submit a written request to update the individual file. Updates needed for the individual file may include updating the tax name and payee name to match that of the clinic/facility/group/payee and connecting the individual and clinic/facility/group/payee number on the Group Member Panel. Refer to the Tax Name Change and Name Change for Clinics, Facilities, Group/payee section for instructions and requirements.

Some providers for whom a C&T is required may not have a new enrollment

Addition of Medicare Certification Information

Providers, who enroll in the Alabama Medicaid program and do not submit Medicare certification information upon initial enrollment, may submit Medicare certification information at a later time for update purposes. Medicare certification letters submitted for update purposes or with an application must give (at a minimum) the provider name, Medicare certification date and physical address of practice to which the Medicare certification is associated.

ADDITION OF MEDICARE CERTIFICATION INFORMATION TO THE MEDICARE PANEL

Criteria for entering Medicare information on the Medicare Panel

Verify Medicare certification date and provider NPI using the PECOS website. Key the Medicare ID on the Medicare Panel. Select Medicare/DMERC as applicable. Enter the effective

date. Note: PTANs and UPINs are not to be considered or keyed as the Medicare ID for a provider.

License Updates (Manual)

If a provider submits a copy of his/her current professional license certification, enrollment staff is responsible for ensuring all active provider enrollments associated with this license are updated. If the provider's information is appropriately indicated on the license file, the file should be updated. If the information is not shown on the license file and if the provider has prescriptive authority, the license information should be added using the appropriate license prefix (if applicable).

CHECKING THE LICENSE FILE (License Panel)
To check the License Panel, the license number must be keyed in the License Number field, exactly as was originally added to the file. If the provider's information is populated on the screen, the name should be verified before any updates are made. If the name and license number matches the date in the Expiration Date field may be updated.

CHECKING THE PROVIDER FILE (Contract Panel)
To ensure all provider enrollments associated to the license number are targeted for update purposes, the license number should be keyed in the License No. field on the Provider Search Panel. The license number must be keyed exactly as was originally added to the file. If information is populated at the bottom of the screen, the names listed should be verified. If the name and license number matches the end dates on the Contract Panel can be updated as long as the provider contracts still show active.

If the provider contracts have an end reason of Credit Balance, Deceased, Decertified, Fraud and Abuse, Provider Cancelled or Provider Purge/Deactivate the request must be rejected. If the end reason is Provider Bad Address (temporarily canceled), address update research should be performed. (See the 'Temporarily Terminations Due to Bad Address Information' section for more information about address update research guidelines.)

If the contract end date on the Contract Panel is one year or more prior to the current date, re-enrollment is required. If the end reason on the Contract Panel is Provider Closed (closed per request), the provider may re-enroll

ENTERING LICENSE DATE
The guidelines below should be followed if the provider is either enrolling as a Medicaid participant or if the provider is requesting the license be added for attending or prescriptive purposes only.

Licenses added to the license and/or provider file should be digits with a value greater than zero and may be alphanumeric. Not all providers are to be added to the license file. When the license is added to both the license file and the provider file the license number keyed must be consistent.

- Medical, in-state licenses added to the license/provider file should be keyed as shown on the license. ***EXAMPLE:*** Shown on license, as 12345 should be keyed to the license file as 12345.
- Limited Medical License for in-state providers should be keyed as an alphanumeric license, not containing the hyphen shown on the license. ***EXAMPLE:*** Shown on license as, L-1234 should be keyed as L1234. NOTE: If and when the provider receives a permanent medical license, the limited license should be closed.
- Resident Medical License for in-state providers should be keyed as an alphanumeric license with the prefix of R and in numeric sequence according to the Resident License Book. ***EXAMPLE:*** R1234. NOTE: If and when the provider receives a permanent or limited medical license, the resident license should be closed and the permanent or limited medical license should be used for prescriptions, etc.

- Osteopath Medical License should be keyed as an alphanumeric license with the prefix of DO. ***EXAMPLE:*** DO123. NOTE: The O in the prefix is not a zero, it is the alpha character of O.
- Out-of-state medical licenses added to the license file/provider should be keyed with the state abbreviation preceding the digits added to the file. Digits added to the file, following the state abbreviation, should be digits with a value greater than zero. ***EXAMPLE:*** Shown on license as, TN00000012345 should be keyed to the license file as TN12345.
- Dental, in-state licenses added to the license/provider file should be keyed with the initials of DD preceding the digits added to the file. Digits added to the file, following the initials of DD, should be digits with a value greater than zero***. EXAMPLE:*** Shown on license as, LNO1234 should be keyed to the license file as DD1234. This logic is also applicable to providers licensed through the dental board who are enrolling as Oral Surgeons.
- Out-of-state dental licenses added to the license/provider file should be keyed with the state abbreviation, and the initials of DD preceding the digits added to the file. Digits added to the file, following the state abbreviation, should be digits with a value greater than zero. ***EXAMPLE:*** Shown on license as, TN00000012345 for a dental provider should be keyed to the license file as TNDD12345. This logic is also applicable to providers licensed through the dental board who are enrolling as Oral Surgeons.
- Nurse practitioner, in-state licenses added to the provider file should be keyed as shown on the license. ***EXAMPLE:*** Shown on license as, 1012345 should be keyed to the license file as 1012345. The Mississippi Board of Nursing currently does not issue documentation for prescriptive authority. To verify this, the Mississippi Board of Nursing should be contacted at 601-664-9341. To document the prescriptive authority, write the following information on the submitted license: Date of the verification, Board of Nursing person verifying prescriptive authority, and the enrollment clerk's name. This should then be scanned into Feith as documentation.
- Physician Assistant, in-state licenses added ***to the*** provider file should be keyed with the prefix of PA. EXAMPLE: PA123. License type: Health Board, unless provider presents evidence of prescriptive authority, in which case the type would be Prescriber.
- Social worker, in-state licenses added to the provider file should be keyed with the suffix C. ***EXAMPLE:*** 123C. License type: Healthboard.
- Psychotherapist, in-state licenses added ***to the*** provider file should be keyed with the prefix of PSY. ***EXAMPLE:*** PSY123. License type: Healthboard.
- Physical Therapist, in-state licenses add***ed to th***e provider file should be keyed with the prefix of PTH. ***EXAMPLE:*** PTH123. Occupational Therapist, in-state licenses ***added t***o the provider file should be keyed with the prefix of OT***. EXAMPLE:*** OT123. License type: Health Board
- Speech Therapist, in-state lice***nses added t***o the provider file should be keyed with the prefix of SP. ***EXAMPLE:*** SP123. Audiologist, in-state licenses ***added to th***e provider file should be keyed with the suffix A. ***EXAMPLE: 123A.*** License type: Health Board
- Audiologist, in-state licenses ***added to th***e provider file should be keyed with the suffix A. ***EXAMPLE: 123A.*** License type: Health Board
- Optometrist, in-state licenses added to th***e license/pro***vider file should be keyed as shown on the license. ***EXAMPLE:*** S12TA123. Podiatrist, in-state licenses added to the ***license/prov***ider file should be keyed with the prefix DPM. ***EXAMPLE: DPM***123. Prescriptiv***e authorit***y can be determined by whether the Podiatrist has a DEA certification.

- Chiropractors, in-state licenses added to the provider file should be keyed with the prefix DC. ***EXAMPLE:*** DC123.

Institutions/Facilities/Clinics, etc. should NOT have a license number on file, unless the Medicaid Agency approves such action.

Addition of the Name Information for an Individual Provider

PROVIDER'S LAST NAME:

- The last name should be consistent with the last name indicated on the provider's license.
- The last name should also be reflected on all other files assigned to the provider, with the exception of the providers who participate in the CRS program.
- The providers who participate in the CRS program should have CRS indicated as a prefix to the provider's last name, otherwise the files should be consistent.
- If a provider has more characters in his/her last name than what we allow for on the provider file, you should always key as many characters as possible in the last name field. The last name should not carry over into the first name field.

PROVIDER'S GENERATION:

- A provider's generation (Examples: Jr., Sr., I, II, III) should be keyed after the provider's last name, if character space is permitted (last name didn't take up all spaces).
- After keying the last name, press the space key to generate a space between the last name and the generation.
- Indicate only the alpha characters necessary to identify the generation. Periods and commas are not to be keyed.

PROVIDER'S FIRST NAME:

- A provider's full first name should be keyed in the first name field.
- This name should be consistent with the first name indicated on the provider's license and on other files in the system, even if the provider has an alternate name by which he/she is called.
- If a provider has more characters in his/her first name than what we allow for on the provider file, you should always key as many characters as possible in the first name field. The first name should not carry over into the middle initial field.

PROVIDER'S MIDDLE INITIAL:

- The provider file contains only a one-character field to indicate the provider's middle initial.
- This initial should be included on the file being keyed, if other files contain this initial.
- This initial should be indicated only in the field available for the middle initial. **Do not** press the space key after keying the first name and add either the initial or the middle name.
- After keying the first name, if the first name field characters are not full, press the tab key. By pressing the tab key your cursor will advance to the next appropriate field, which should be the middle initial field.
- If the first name characters are full, your cursor will advance to the next appropriate field (middle initial field), without pressing the tab key. You may then enter the middle initial.

PROVIDER'S DEGREE/TITLE:

- The provider file contains a four-character field to indicate the provider's professional degree or professional title.
- This field should contain the initials, which show if the provider is a DDS, DMD, DO, OD, MD, PHD, PT, etc. Although the provider may not indicate this information on the application, in the space provided, this information can be found on the provider's license.
- Once the middle initial is keyed the cursor should automatically move to the degree/title field. If the middle initial is not keyed you may press the tab key twice, after keying the first name, which will advance the cursor to the degree/title field.

Temporary Terminations Due to Bad Address Information

If return mail is received for a provider it may be due to invalid address information on the provider file. To protect the integrity of the Provider Master file, enrollment staff is required to take action to obtain current address information.

To obtain the needed address update correspondence, enrollment staff is responsible for calling the provider's office and requesting the provider provide current address information. If during the course of the conversation it is discovered that the information on file is invalid, the provider must complete an address update form or submit a written request to update the provider file. Enrollment staff is responsible for forwarding an address update form to the provider, if the provider prefers to complete the address update form. The provider should in turn complete the form and return it to Provider Enrollment. If the provider chooses to submit a written request, it is the staff member's responsibility to follow up on the receipt of the correspondence and to verify that the written correspondence meets the current guidelines. (See the 'Address Updates' section for guidance on written request requirements.)

If the needed address update correspondence is not obtainable, an end reason of Provider Bad Address (temporary cancellation) should be placed on the Contract Panel.

ADDING END REASON OF PROVIDER BAD ADDRESS

At the time of adding the end reason of Provider Bad Address file, all efforts to obtain current address information, should have been exhausted. Once the end reason is added to the file, the processing of claims for the provider is terminated. In order to ensure that claims already received for processing can complete the cycle, the following steps should be taken:

On the contract panel an end date of the current day should be placed on the current contracts. Another contract segment should be added with an end reason of Provider Bad Address with a begin/start date of the following day.

If and when an address update is received and applied to the file, the Bad Address segment start date should be changed to 12/31/2299 and the active segment end date should be changed to reflect the same date as the expiration of the provider's license. (The license expiration date can be found in the license panel.)

Note: If a provider is already closed for any reason, the Bad Address status and dates should NOT be added since the provider is already closed.

WHAT IF THE ADDRESS INFORMATION ON FILE IS CORRECT?

No Mail Receptacle
If returned mail is received, and it found that the address information on file is correct, the mail may have been returned due to a mail receptacle not being available for delivery. Items commonly returned for this reason are prior authorization letters. In this case, the file is not temporarily canceled. The correspondence is then forwarded to either the payee or mailing address on file, which should be an address different from the address shown as the physical location.

Postage Due
If returned mail is received, and it is found that the address information on file is correct, it is possible that the postage fee was not paid in full. In this case, the item should be re-mailed.

File Already Updated
If returned mail is received, and it is found that the address information on file is correct, it is also possible that the file has been updated since the item was mailed. To verify this, staff members should check the last change dates on file and compare the dates to the mail date of the item. In this case, the item should be re-mailed.

Address Updates

Address change correspondence must be submitted in writing. The correspondence should be on leader head and contain the following information:

- Name(s) of the providers of which the change will affect.
- Alabama Medicaid Number(s) of the providers of which the change will affect.
- A description of the change being requested, which should include which of the three addresses on file is to be update. (Mailing, Payee and/or Physical Address)
- Name and Business title of the person initiating/submitting the change.
- Signature of the person initiating/submitting the change.

If the physical address is to be changed a W-9 tax form must be submitted to show proof that the tax name and/or number did not change. If the tax name changes, please refer to the Tax Name Change section for instructions and requirements. If the tax number changed re-enrollment is required.

To carry out the same function as if the provider's office had created and submitted the written request above DXC may send to the provider Address Update Form and W-9 tax form.

When processing a change of address for the payee, the tax id panel must also be updated with the new payee address information.

Specialty Code Changes

Specialty addition or change correspondence must be submitted in writing. The correspondence should be on letterhead and contain the following information:

- Name of the provider, which the change will affect
- NPI and service location of the provider, which the change will affect
- A description of the change being requested, (i.e., please add specialty XXX; please remove specialty XXX.)
- Name and Business title of the person initiating/submitting the change
- Signature of the person initiating/submitting the change

The specialty being added will only be effective for the first of the month received. The specialty must be suitable for the provider's type. Submitting the request is not a guarantee that the change will be made. When adding specialties/contracts such as EPSDT, Plan First, Screening Provider and Mammography specific criteria and qualifications must be met. The effective date to be applied for these specialties are based on the guidelines for the programs. (Refer to the Provider Enrollment Operational Procedure Manual for specifics.)

Sanctioned Providers

Providers may be sanctioned by request of the Alabama Medicaid Agency and/or The Centers for Medicare and Medicaid (CMS). The act of sanctioning means the provider is placed in a suspended status, and is ineligible for enrollment and for payment of services and restricted from performing services for recipients.

An OPR memo may be sent to DXC, which states the name and SSN of a person or the name and tax ID of a business, which has been suspended from the program, along with the effective date of the suspension. Included in the OPR may also be the provider's professional license number, NPIs, instructions to close banking information, and/or instruction to withhold payments.

A sanctioning file is received from the state which is used to updated the Sanction Panel as well as update all associated provider files on a monthly basis. This file is received by the systems team and is used to make all necessary updates.

CLIA Certification Additions and Research

CLIA UPDATE INSTRUCTIONS

CLIA certificates are supplied to providers from the Department of Health & Human Services for the state in which the provider or the laboratory the provider's office uses for specimen testing purposes is located.

Before CLIA information can be added to the provider file for claim processing purposes, the Laboratory name, physical location, director's name, CLIA ID #, effective date and expiration date must be present and legible on the certificate. If the CLIA certificate was sent in for update purposes and not with an application, the NPI should be indicated on the certificate or a cover memo.

CLIA certification numbers are applied to the CL screen for provider numbers that may be used as a performing provider number. To add a CLIA number to the CL screen the provider number must be entered in the Provider Number field. The CLIA number on the certificate, which is 10 alphanumeric characters, is keyed in the CLIA NBR field. Once enrollment staff adds the CLIA number to the file, PF6 is pressed to upload the information to the screen. At this time, the Certification Segment fields at the bottom of the screen should be populated with information.

If the Certification Segment fields at the bottom of the screen are not populated with information, an email is sent to the LAN Team at alabamasystemsops@DXC.com to research and populate the CLIA information. The email should include the group/facility name, NPI, address, CLIA number and effective and end dates.

EFT Changes

Provider Enrollment clerks may receive requested changes to provider EFT account information. When this occurs, enrollment clerks will need the EFT form (if using the paper process) or electronic EFT and a voided check or a letter from the bank. In order to complete the change of provider account information, the enrollment clerk will verify the following items:

- Account information on the voided check or bank letter matches the EFT form
- Verify that the name, NPI number, address, and phone number match the provider file
- Verify that the previous account information provided matches the provider file

If any of the above items cannot be verified on the provider file, the EFT cannot be completed. In this case, the primary contact for the enrollment should be contacted to obtain or verify the requested information.

Required information on the EFT can be found in the section titled "Electronic Funds Transfer Authorization Agreement."

In situations where a provider is removed from EFT "active" status for reasons of a tax levy or state directed, the EFT will be reactivated once the levy has been paid or the state directs. After the tax levy has been paid, the financial department will notify Provider Enrollment that the levy has been satisfied and the EFT can be added. The enrollment staff will then add the previous EFT information into the EFT panel.

Issuing a Provider Web ID to a Group/Payee

In some situations where a provider who is a Group/Payee is enrolled with an effective and end date that is in the past, a provider web id will not be issued. In this situation a web id will need to be manually generated by enrollment staff for the providers to be able to bill for claims.

This is accomplished by accessing the IDs panel, clicking "Add," selecting "Web User ID" as the ID type and "Save." The enrollment will then be issued a web id that will be sent to the provider that they can use to file claims.

DEA Updates

If a provider submits a copy of his/her current DEA certification, enrollment staff is responsible for ensuring all active provider enrollments established for this provider based on the NPI and license number indicated are updated as well as the provider's license file data. If the information submitted is not indicated on the provider file(s) and license file or if the information is incorrect based on the current certificate submitted, the information should be added or updated as applicable by verifying a submitted copy of the provider's DEA certificate. DEA information that is added will receive the first day of the month the request to add the DEA is received by enrollment. The end date of the DEA will be open ended (12/31/2299).

If a provider calls regarding a DEA issue where the DEA is determined to not be on license file, the DEA number may be added to the license file by verifying that the name and license number on the DEA file match the license file and that the DEA is currently active on the DEA file. If this information can be verified, add the DEA number to the license file only.

All Updates are required to be processed within two business days of receipt.

III. ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT (PAPER VERSION)

Electronic Funds Transfer (EFT) Authorization Agreement (Paper)

EFT is required, unless an exemption letter is provided, by the Alabama Medicaid Agency. The EFT paper form is available on the Alabama Medicaid Agency website at: http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx Providers are required to complete the fields marked with an (*) asterisk on the form:

a) ****Provider Name -** Enter the name of the provider to whom payments should be made. This name should be the same as what is shown on the bank account, the provider file and on supporting documentation. Supporting documentation being a voided check OR letter from the bank which will need to be submitted along with this EFT Authorization Agreement.

b) ***Provider Address -** Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the provider for which this ERA Authorization Agreement applies.

c) ***Provider Federal Tax identification Number (TIN) or Employer Identification Number (FEIN) -** Enter the Tax ID associated with the provider for which this EFT Authorization Agreement applies.

d) ***Provider National Identifier (NPI) -** Enter the NPI associated with the provider for which this ERA Authorization Agreement applies.

e) ***Other Identifier -** Enter the Medicaid ID assigned to the provider for which the ERA Authorization Agreement applies.

f) ***Assigning Authority -** Click the Assigning Authority of the Other Identifier previously mentioned. The available selection contains the term Medicaid as this is the only Other Identifier allowed.

g) ***Provider Contact Name -** Enter the name of the person, associated with the provider, who should be contacted with questions regarding this ERA Authorization Agreement.

h) **Title -** Enter the title of the Provider Contact previously mentioned.

i) ***Telephone Number and Telephone Number Extension -** Enter the full phone number as well as a specific phone line extension, if extension is known, for the Provider Contact previously mentioned.

j) ***Email Address -** Enter the full email address for the Provider Contact previously mentioned.

k) **Fax number -** Enter the full fax number for the Provider Contact previously mentioned.

l) ***Provider Agent Name –** Enter the name of the Agent who may be working on behalf of the provider such as a Credentialing Agent/Agency.

m) ***Provider Agent Contact Name** – Enter the name of a contact for the provider's Agent previously mentioned.

n) ***Telephone Number** – Enter the phone number of the provider's Agent previously mentioned. If an Agent contact is listed this should be the phone number of the Agent contact.

o) ***Email Address** – Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email of the Agent contact.

p) ***Financial Institution Name -** Enter the name of the Financial Institution with which the bank account is held.

q) ***Financial Institution Address -** Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the bank with which the bank account is held.

r) **Financial Institution Telephone Number and Telephone Number Extension -** Enter the full phone number as well as a specific phone line extension, if extension is known, for the bank with which the bank account is held.

s) ***Financial Institution Routing Number -** Enter the routing number of the bank account.

t) **Type of Account at Financial Institution -** Select the type of account held with the bank.

u) ***Provider's Account Number with Financial Institution -** Enter the account number of the bank account; Enter <u>ONLY numeric values</u>; no hyphens, spaces or other special characters.

v) ***Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI) -** Select National Provider Identifier (NPI) as this is the method under which the account will be linked.

w) ***Reason for Submission -** Select a reason for which you are submitting the EFT Authorization Agreement.

x) ***Include with Enrollment Submission** – Select the type of supporting documentation which will be submitted with the form as either a voided check OR letter from the bank is required for validation purposes.

y) **Written Signature of Person Submitting the Enrollment** – Upon printing the form, the authorized person MUST also sign this line.

z) ***Printed Name of Person Submitting Enrollment** – Enter the name of the authorized person completing the form.

aa) ***Printed Title of Person Submitting Enrollment** – Enter the title of the authorized person completing the form.

bb) ***Submission Date** – Enter the date, in MM/DD/CCYY format, on which the form is being submitted.

For verification of EFT changes, see section titled "EFT Changes."

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT (ELECTRONIC VERSION)

EFT is required, unless an exemption letter is provided, by the Alabama Medicaid Agency. The EFT electronic form is available on the Provider Enrollment Application Portal at: https://medicaidhcp.alabamaservices.org/provider/Home/ProviderEnrollment/EnrollmentWelcome/tabid/442/Default.aspx?s99=EFTEnrollment&s19=GB1gSsX3XlMn/mZnvATeqpkTjjE=

Providers are required to complete the fields marked with an (*) asterisk on the form:

a) ***Provider Name -** Enter the name of the provider to whom payments should be made. This name should be the same as what is shown on the bank account, the provider file and on supporting documentation. Supporting documentation being a voided check OR letter from the bank which will need to be submitted along with this EFT Authorization Agreement.

b) ***Provider Address -** Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the provider for which this ERA Authorization Agreement applies.

c) ***Provider Federal Tax identification Number (TIN) or Employer Identification Number (FEIN) -** Enter the Tax ID associated with the provider for which this ERA Authorization Agreement applies.

d) ***Provider National Identifier (NPI) -** Enter the NPI associated with the provider for which this ERA Authorization Agreement applies.

e) ***Other Identifier -** Enter the Medicaid ID assigned to the provider for which the ERA Authorization Agreement applies.

f) ***Assigning Authority -** Click the Assigning Authority of the Other Identifier previously mentioned. The available selection contains the term Medicaid as this is the only Other Identifier allowed.

g) ***Provider Contact Name -** Enter the name of the person, associated with the provider, who should be contacted with questions regarding this ERA Authorization Agreement.

h) **Title -** Enter the title of the Provider Contact previously mentioned.

i) ***Telephone Number and Telephone Number Extension -** Enter the full phone number as well as a specific phone line extension, if extension is known, for the Provider Contact previously mentioned.

j) ***Email Address -** Enter the full email address for the Provider Contact previously mentioned.

k) **Fax number -** Enter the full fax number for the Provider Contact previously mentioned.

l) ***Provider Agent Name –** Enter the name of the Agent who may be working on behalf of the provider such as a Credentialing Agent/Agency.

m) ***Provider Agent Contact Name** – Enter the name of a contact for the provider's Agent previously mentioned.

n) ***Telephone Number** – Enter the phone number of the provider's Agent previously mentioned. If an Agent contact is listed this should be the phone number of the Agent contact.

o) ***Email Address** – Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email of the Agent contact.

p) ***Financial Institution Name -** Enter the name of the Financial Institution with which the bank account is held.

q) ***Financial Institution Address -** Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the bank with which the bank account is held.

r) **Financial Institution Telephone Number and Telephone Number Extension -** Enter the full phone number as well as a specific phone line extension, if extension is known, for the bank with which the bank account is held.

s) ***Financial Institution Routing Number** - Enter the routing number of the bank account.

t) **Type of Account at Financial Institution -** Select the type of account held with the bank.

u) ***Provider's Account Number with Financial Institution -** Enter the account number of the bank account; Enter ONLY numeric values; no hyphens, spaces or other special characters.

v) ***Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI) -** Select National Provider Identifier (NPI) as this is the method under which the account will be linked.

w) ***Reason for Submission** - Select a reason for which you are submitting the EFT Authorization Agreement.

For verification of EFT changes, see section titled "EFT Changes." Once the EFT is approved to be enrolled with all required documentation, the EFT is updated on the Web Application Status panel with "Approved." The EFT will then be updated on the provider's file in the MMIS. The documents in Feith workflow should be updated with "F" for finalized.

ELECTRONIC REMITTANCE ADVICE (RA) AGREEMENT

This form is received by Provider Enrollment, but is handled by the Electronic Claims Submission Department. Providers are required to complete the fields marked with an (*) asterisk on the form:

a.) ***Provider Name -** Enter the name of the provider to whom remittance advice applies. This name should be the same as what is shown on the remittance advice and the provider file.

b.) ***Provider Address -** Street, City, State/Province and Zip Code/Postal Code – Enter the full address of the provider for which this ERA Authorization Agreement applies.

c.) **Provider Federal Tax identification Number (TIN) or Employer Identification Number (FEIN) -** Enter the Tax ID associated with the provider for which this ERA Authorization Agreement applies.

d.) ***National Provider Identifier (NPI) -** Enter the NPI associated with the provider for which this ERA Authorization Agreement applies.

e.) ***Other Identifier -** Enter the Medicaid ID assigned to the provider for which the ERA Authorization Agreement applies.

f.) ***Assigning Authority -** Click the Assigning Authority of the Other Identifier previously mentioned. The available selection contains the term Medicaid as this is the only Other Identifier allowed.

g.) **Trading Partner ID -** Enter the Trading Partner ID assigned to the provider for which the ERA Authorization application applies.

h.) ***Provider Contact Name -** Enter the name of the person, associated with the provider, who should be contacted with questions regarding this ERA Authorization Agreement.

i.) **Title -** Enter the title of the Provider Contact previously mentioned.

j.) ***Telephone Number and Telephone Number Extension -** Enter the full phone number as well as a specific phone line extension, if extension is known, for the Provider Contact previously mentioned.

k.) ***Email Address -** Enter the full email address for the Provider Contact previously mentioned.

l.) **Fax number -** Enter the full fax number for the Provider Contact previously mentioned.

m.) ***Provider Agent Name –** Enter the name of the Agent who may be working on behalf of the provider such as a Credentialing Agent/Agency.

n.) ***Provider Agent Contact Name** – Enter the name of a contact for the provider's Agent previously mentioned.

o.) ***Telephone Number** – Enter the phone number of the provider's Agent previously mentioned. If an Agent contact is listed this should be the phone number of the Agent contact.

p.) ***Email Address** – Enter the email address of the provider's Agent previously mentioned. If an Agent contact is listed this should be the email of the Agent contact.

q.) ***Account Number Linkage to Provider Identifier/Provider National Provider Identifier (NPI)** – Enter the NPI of the provider for which the ERA application applies.

r.) ***Method of Retrieval** – Select the method by which the ERA will be retrieved.

s.) **Clearinghouse Name** – Enter the name of the Clearinghouse who may be working on behalf of the provider.

t.) **Clearinghouse Contact Name** – Enter the name of a contact for the Clearinghouse previously mentioned.

u.) **Telephone Number** – Enter the phone number of the Clearinghouse previously mentioned. If a Clearinghouse contact is listed this should be the phone number of the Clearinghouse contact.

v.) **Email Address** – Enter the email address of the Clearinghouse previously mentioned. If a Clearinghouse contact is listed this should be the email address of the Clearinghouse contact.

w.) **Vendor Name** – Enter the name of the Vendor who may be working on behalf of the provider.

x.) **Vendor Contact Name** – Enter the name of a contact for the Vendor previously mentioned.

y.) **Telephone Number** - Enter the phone number of the Vendor previously mentioned. If a Vendor contact is listed this should be the phone number of the Vendor contact.

z.) **Email Address** – Enter the email address of the Vendor previously mentioned. If a Vendor contact is listed this should be the email of the Vendor contact.

aa.) ***Reason for Submission** – Select a reason for which you are submitting the application.

bb.) **Written Signature of Person Submitting the Enrollment** – Upon printing the form, the authorized person MUST also sign this line.

cc.) ***Printed Name of Person Submitting Enrollment** – Enter the name of the authorized person completing the form.

dd.) ***Printed Title of Person Submitting Enrollment** – Enter the title of the authorized person completing the form.

ee.) ***Submission Date** – Enter the date, in MM/DD/CCYY format, on which the form is being submitted.

PLAN FIRST AGREEMENT/ENROLLMENT FORM
Providers should indicate the name of the person or clinic entering the agreement on line.

AGREEMENT FOR PARTICIPATION IN THE PLAN FIRST PROGRAM
Providers should indicate the name of the person or clinic entering the agreement on the first line. Providers should indicate the date on which the provider or clinic is entering into the agreement on the blanks below line 3.

Clinic Enrollment

a.) **Signature** –The signature should be that of the person with authority to sign such documents for the business. Those persons may be the individual provider, business owner, an accountant or person with power of attorney.

b.) **Title** – Providers should indicate the title of the person signing the form.

c.) **Type/Printed name** – Providers should type or print the name of the person signing the forms.

Individual Enrollment

a.) **Signature** –The signature should be that of the individual provider entering the agreement.

b.) **Title** – Providers should indicate the title of the signing the form to enter the agreement.

c.) **Type/Printed name** – Providers should type or print the name of the provider signing the form to enter the agreement.

EPSDT AGREEMENT

a.) **Provider's printed name -** Providers should type or print the name of the provider signing the form to enter the agreement.

b.) **Provider's Signature -** The signature must be an original. Stamp or photo copied, etc. will not be accepted. This signature should be that of the individual provider enrolling in the EPSDT program.

PHYSIOLOGICAL LAB CERTIFICATION

This form should be completed only if the provider's office is certified to provide services such as ultrasound, doppler testing, etc.

MEDICAID/PATIENT 1ST PHYSICIAN ENROLLMENT FORM AND MEDICAID PATIENT 1ST CLINIC ENROLLMENT FORMS

Information required on these forms can be determined by reviewing the Patient 1st section of the Provider Enrollment Operational Procedure Manual.

REFERENCE MATERIALS

This portion of the application provides the enrolling provider with information such as Participation Requirements, to give the provider an idea of what criteria must be met in order to be eligible to enroll as a certain provider type. This section also gives a list of county codes and multiple other documents to assist the provider in completing the application.

DENTAL NOTES

In a meeting with Tina Edwards, Kathy Hall, Kim Davis-Allen and Debbie Smith, the changes below were made to apply to **dental providers only** (DDS, DMD, or MD in the field of Dentistry or Oral Surgery).

- A clinic/facility/group/payee application is not required if the facility is a PC or LLC, which pays to the individuals name AND that individual is the only provider practicing in that facility. This type of enrollment is considered a sole proprietorship, although the provider has obtained a tax ID name and number for tax reporting purposes.
  Example: Dr. John A. Smith, DMD, PC is the tax name, facility name and the tax number is not the provider's social.
- If a provider initially, enrolled in the manner described in example 1 chooses to employ other providers, a clinic/facility/group/payee application is required.
  Example: Dr. John A. Smith, DMD, PC is the tax name, facility name and the tax number is not the provider's social, plus he employs Dr. Joe B. Smith, DDS.
- A clinic/facility/group/payee application is required if there is only one provider practicing in the facility but the payee name is a clinic/facility/group/payee name.
  Example: Dr. John B. Adams, DDS is the only dentist practicing in a facility for which the payee/facility name is Tooth Plus.

CRS Enrollments

a. Upon verification of application information, complete the following actions on the enrollment:

a. Change the name of the individual provider by adding "CRS" to the beginning of the last name (example, CRSSMITH).
b. Change the service location address to: **602 South Lawrence Street, Montgomery, AL 36104-4787** (this service address is standardized for all CRS enrollments)
c. Complete a customary charge worksheet and submit to adjustments

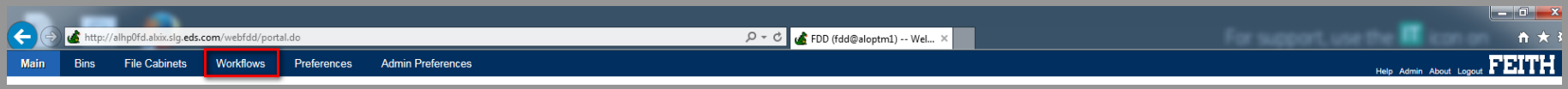
DXC EFT User Workflow Process Overview

Below contains a high-level overview of the DXC User Workflow Process. For specific questions pertaining to approval or business processes, please contact the DXC ALXIX Claims Manager. The below covers all Feith related functionality.
If you are new to WebFDD, please take a moment to review the WebFDD User Guide found on iTRACE | Tech Design | Feith or by using the following link: Feith WebFDD User Guide.

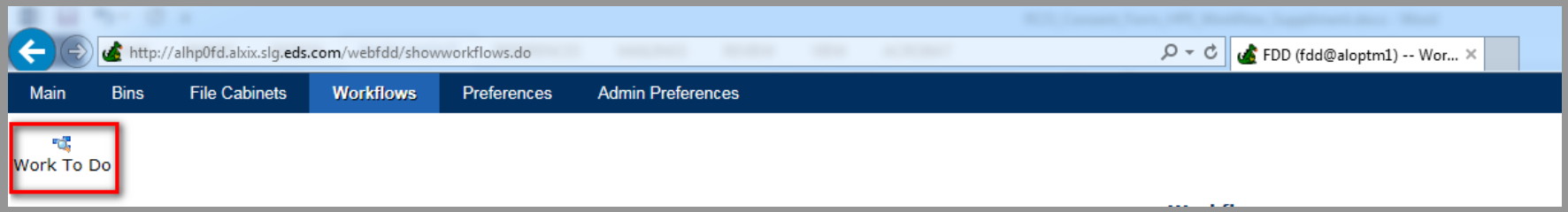
1. To access WebFDD / Feith Workflow, enter the following URL in your web browser address bar: https://alhp4fw.alxix.slg.eds.com/webfdd/

2. Log into WebFDD using the credentials provided to you by the ALXIX LAN team. Note: If you do not know your credentials, or your password has expired, a LAN Service Desk Ticket will resolve your connectivity issues!

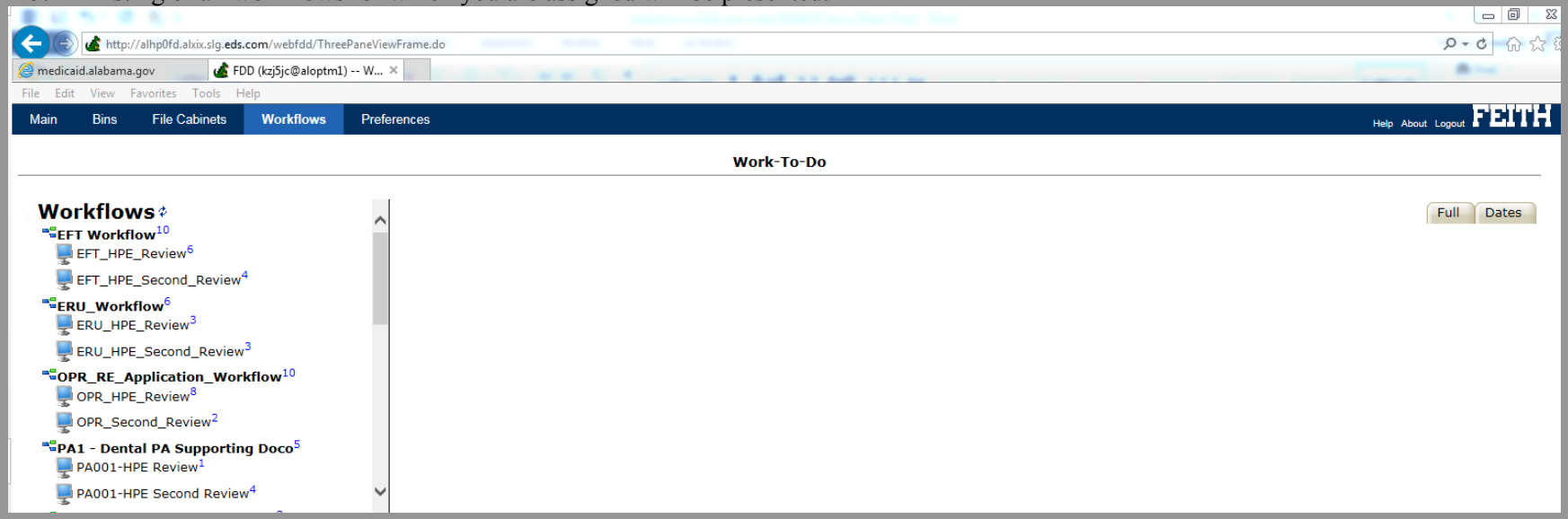
3. Once logged in, select the **Workflows** tab located in the top menu bar:



4. In the upper left-hand corner, you will see an icon labeled **Work To Do**. Press this icon.

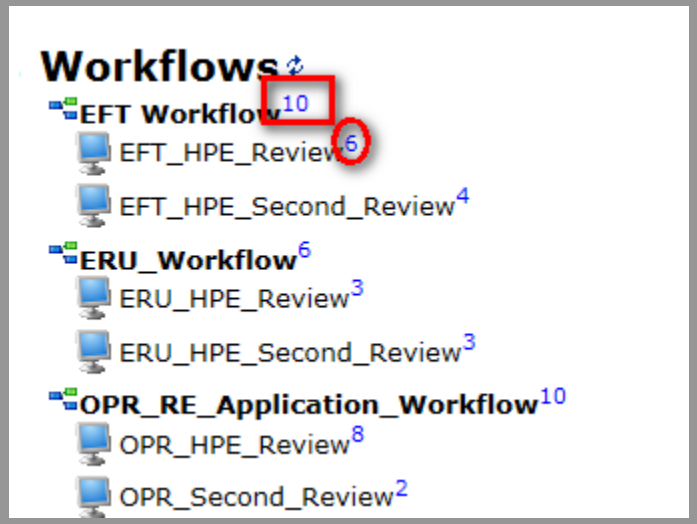


5. A listing of all workflows for which you are assigned will be presented:

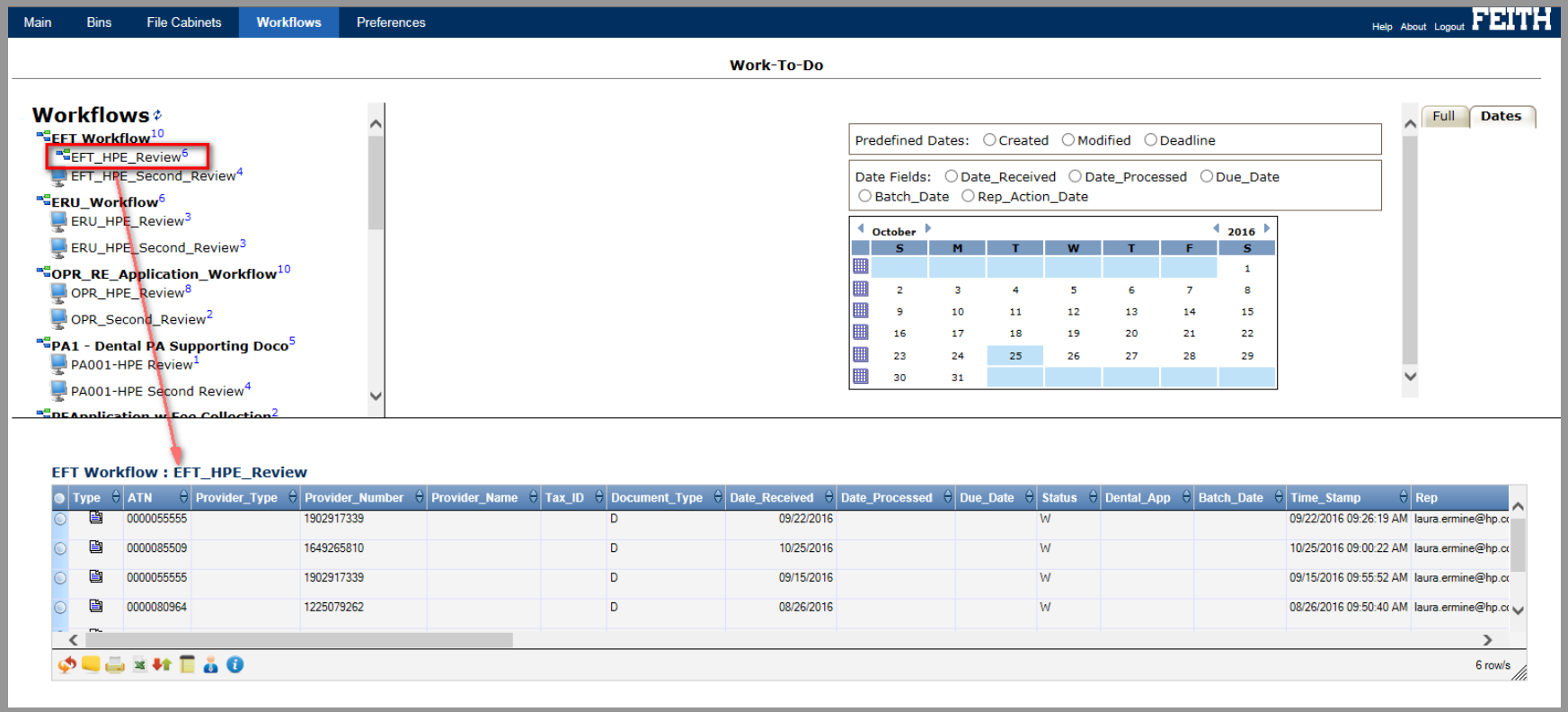


6. The double arrows to the right of the **Workflows** title, allow you to refresh the listings.

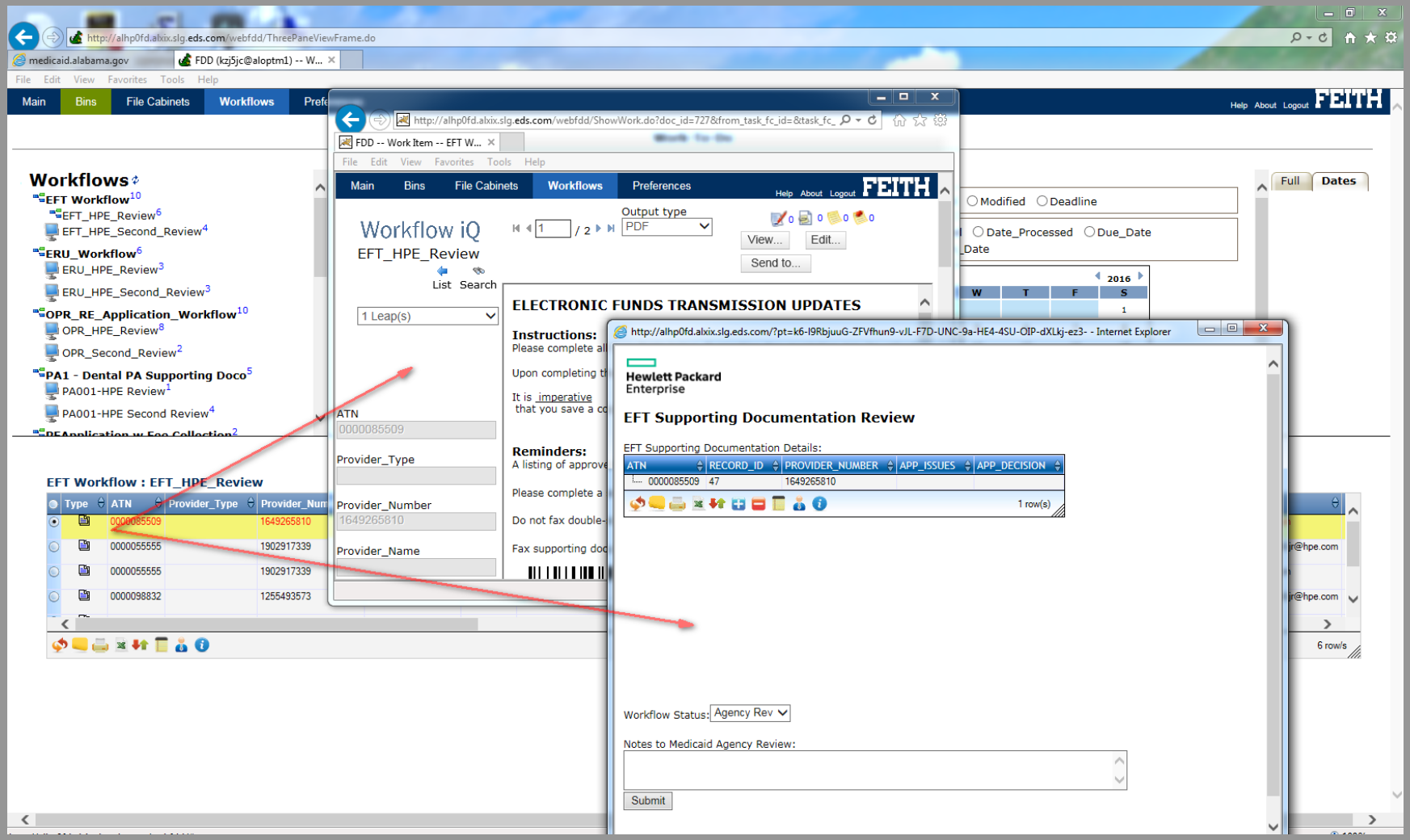
7. The blue numbers to the right of each Workflow Task indicate the total number of documents assigned to you for processing. In the example below, **EFT_DXC_REVIEW** has six documents assigned to the user for processing. The blue ten to the right of **EFT Workflow** indicates for this user there are ten total documents for processing.



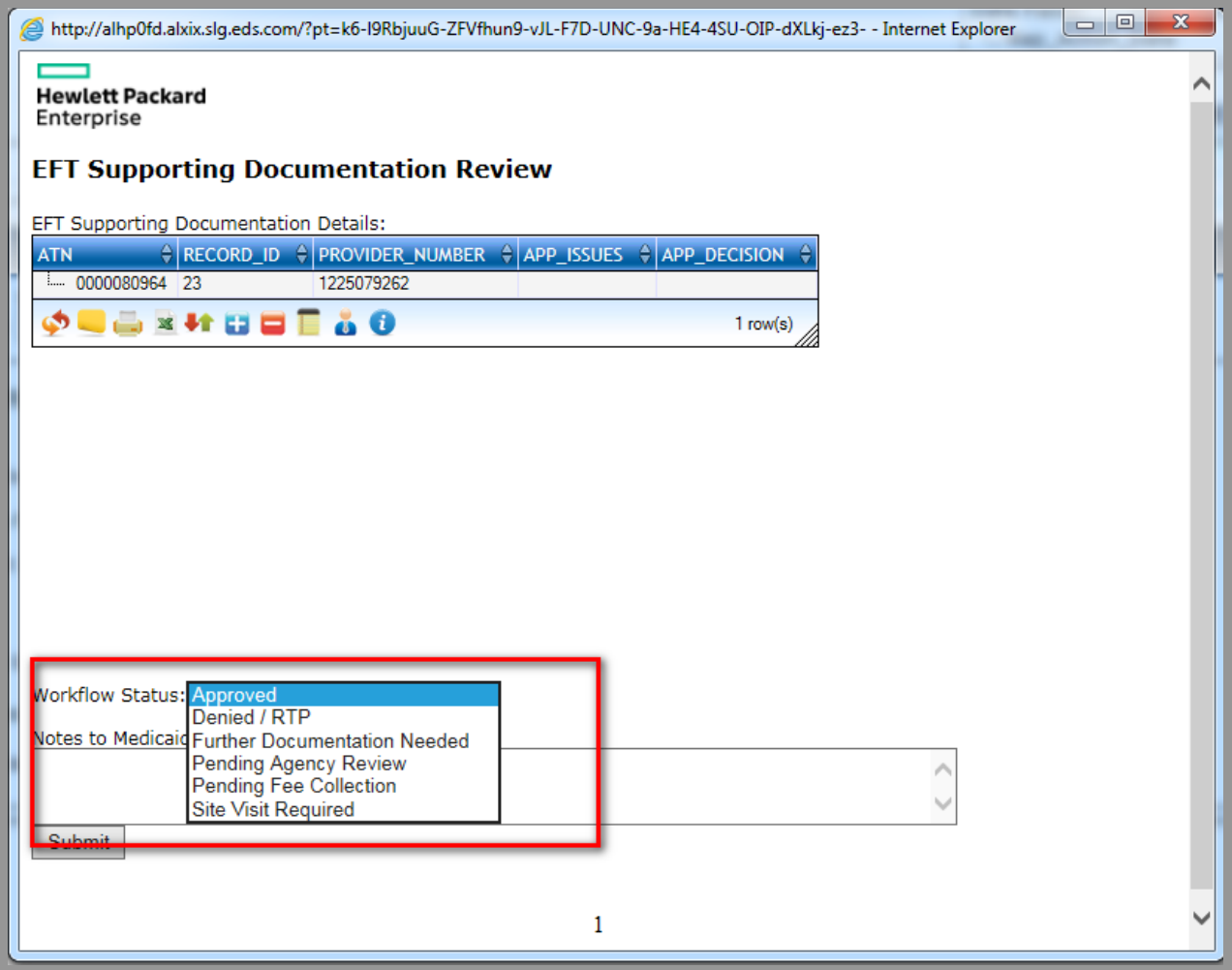
8. The user first selects **EFT_DXC_Review** to retrieve a listing of documents requiring initial review:



9. Clicking on the rows in the search results grid, will open the document and corresponding review form:



10. The user may move the windows around or minimize the form, to allow a review of the documentation submitted by the provider. (Middle window above.)
11. Upon reviewing the documentation, the user will enter the correct status and applicable notes in the **EFT Supporting Documentation Review form.** The Status options are:



Notes:

a. By default all documents received are in a "**Working**" status.

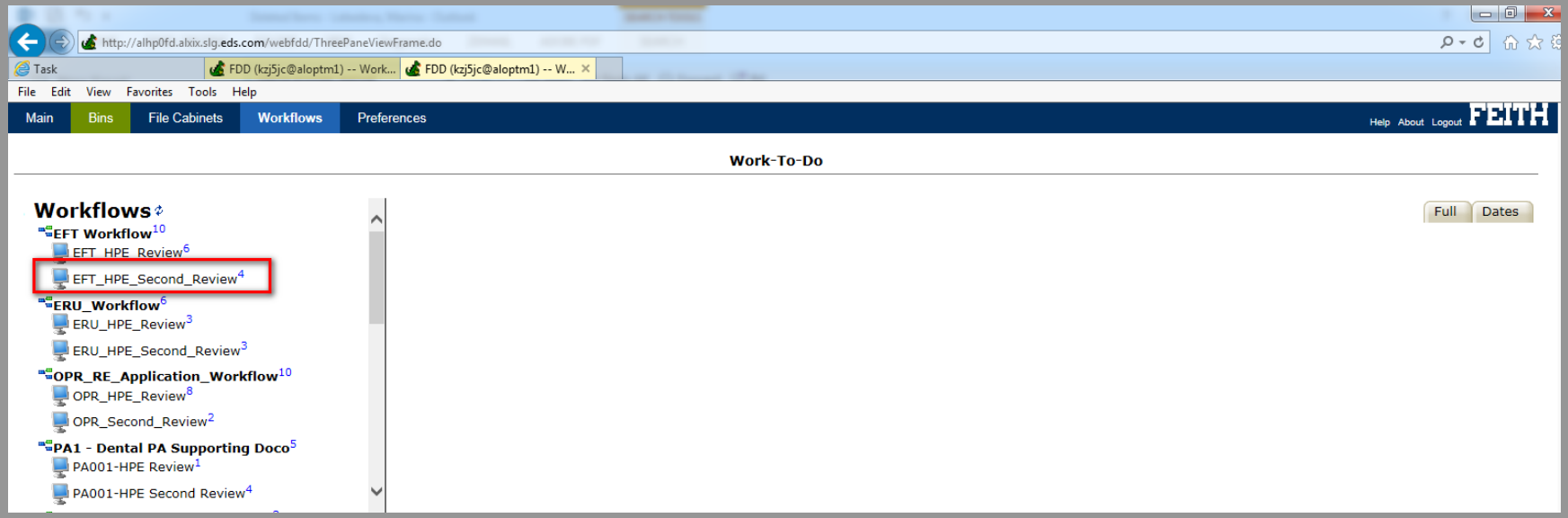
b. By selecting "**Agency Review**," and completing any notes needed, the document will be sent to Medicaid for review.

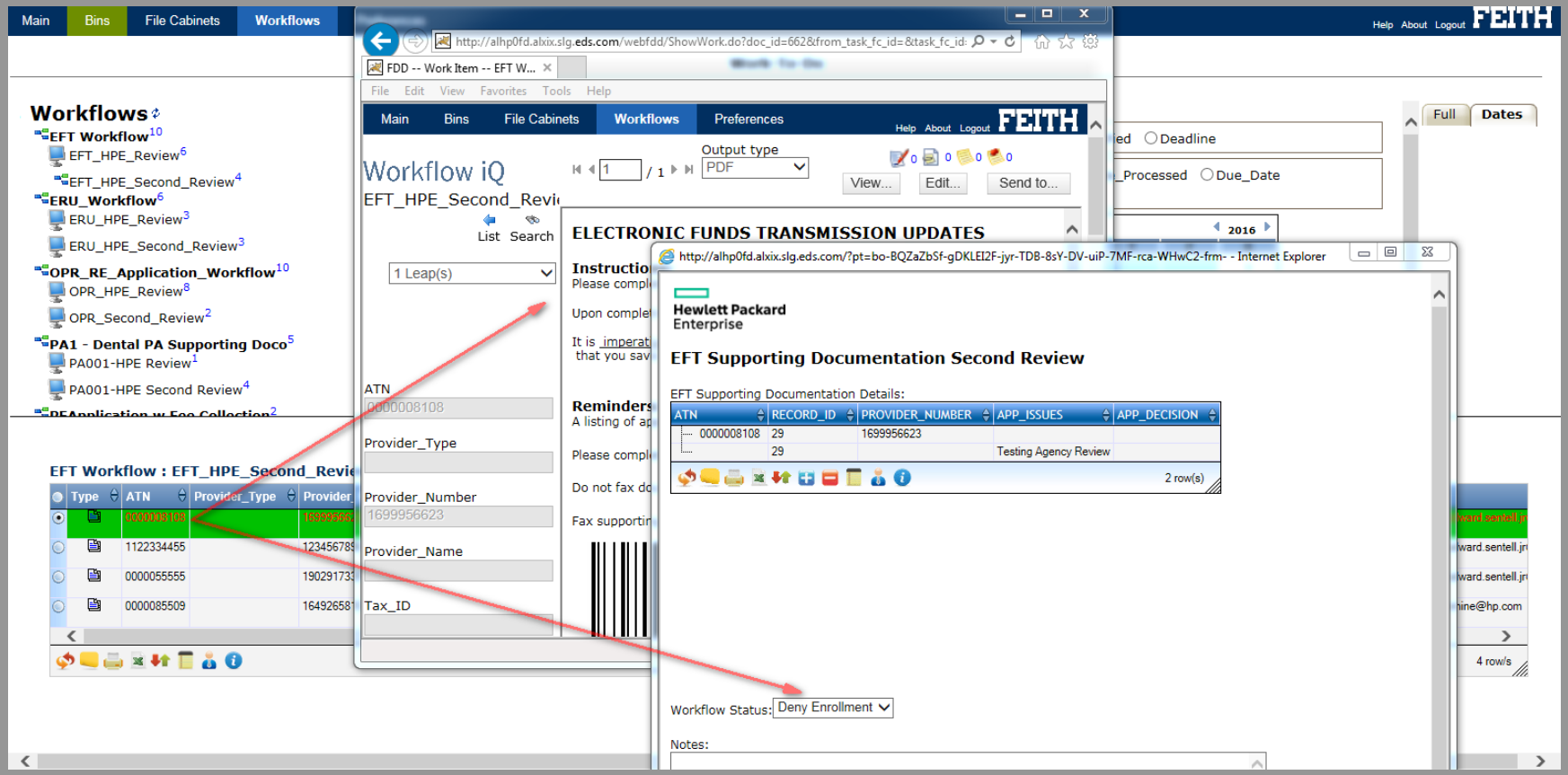
c. All other statuses (**Pending Agency Review, Further Documentation Needed, Approve, Pending Fee Collection, Site Visit Required, and Deny/RTP**) send the document to **DXC Second Review** for follow-up and completion. A document may sit in Second Review while follow up with the provider occurs. Reminder email notifications are sent to the applicable representative if documents have remained in workflow untouched for 3 number of days, per our SLA requirements.

d. This form (and only this form) should be utilized to update the status. Do not update the status in the file cabinet!

12. Once the **Submit** button has been pressed, the document will move in workflow to the next step. Feith will produce the next document for review and continue this pattern until all documents have been processed.

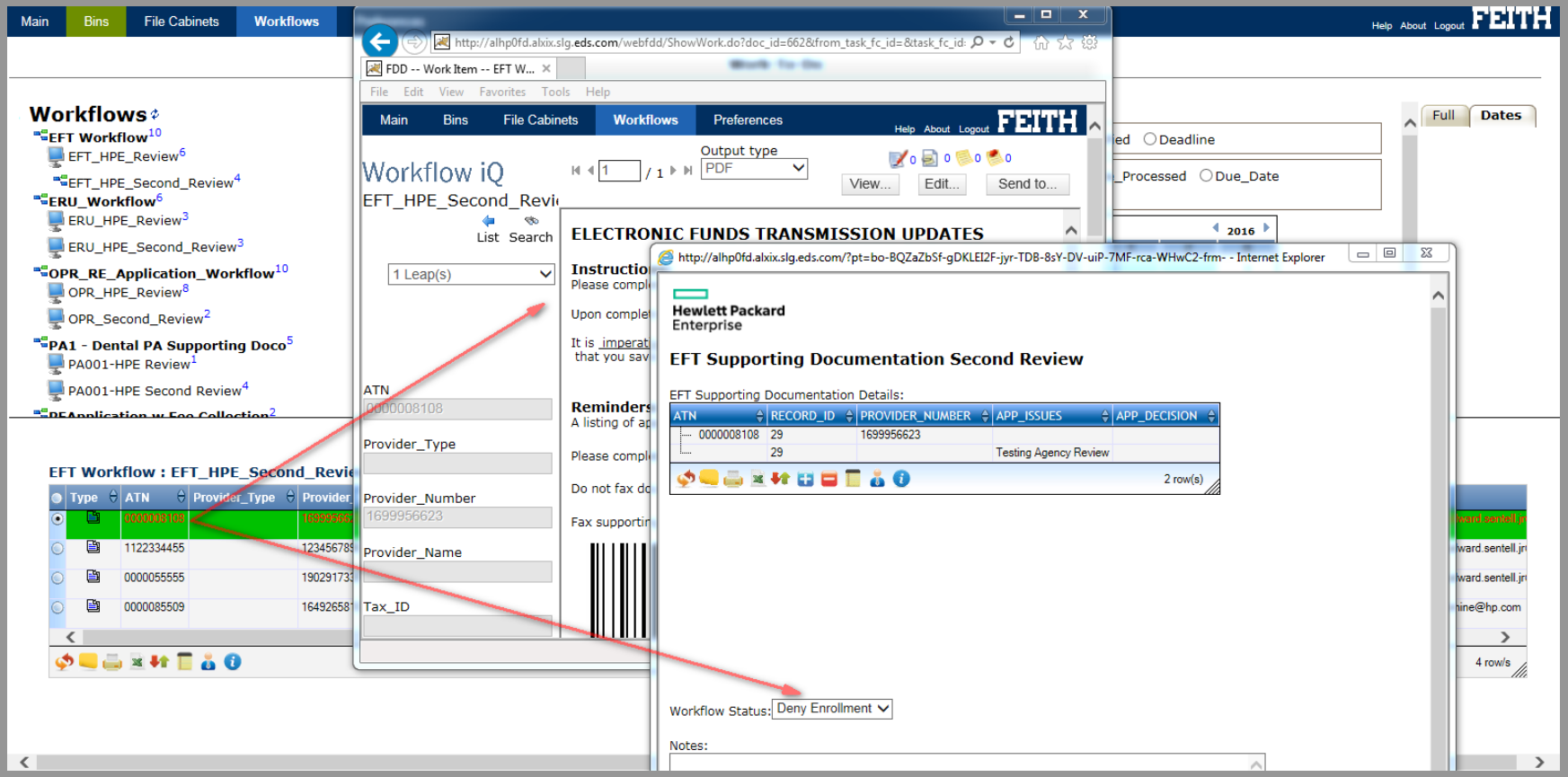
13. Documents sent to Medicaid for review, will be returned to DXC via workflow. At that time an email notification will be sent to the applicable Representative alerting them of the returned document and decision. Medicaid will provide the following decisions upon review: **Approved** or **Denied** The user will then go into **DXC Second Review** and review the documentation:





14. Complete the review process. Using the **Status** dropdown menu, choose the correct status of **Approved** or **Denied.** Enter any notes applicable to this document which should be retained or address any questions which may be relevant down the road.

15. Press **Submit**. The document will move out of your workflow completing the review process.

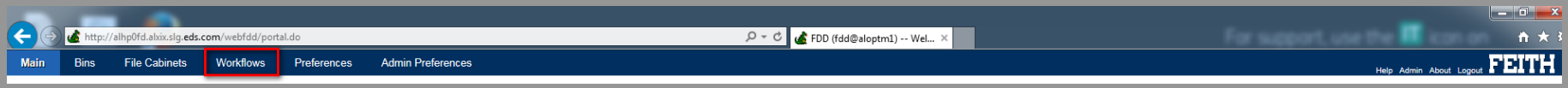


DXC ERU User Workflow Process Overview

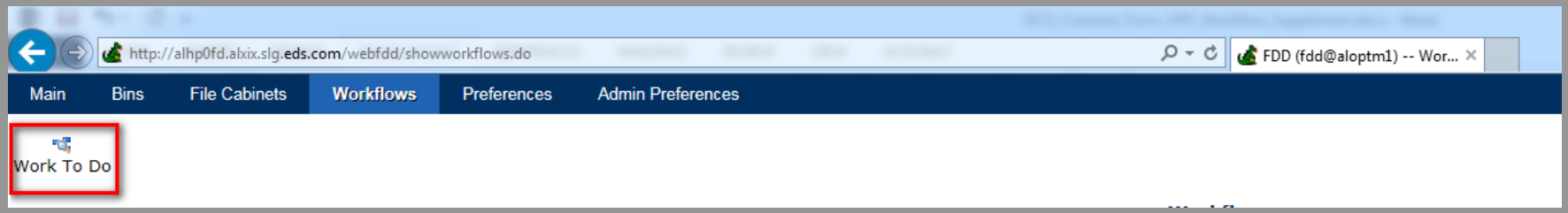
1. To access WebFDD / Feith Workflow, enter the following URL in your web browser address bar: https://alhp4fw.alxix.slg.eds.com/webfdd/

2. Log into WebFDD using the credentials provided to you by the ALXIX LAN team. Note: If you do not know your credentials, or your password has expired, a LAN Service Desk Ticket will resolve your connectivity issues!

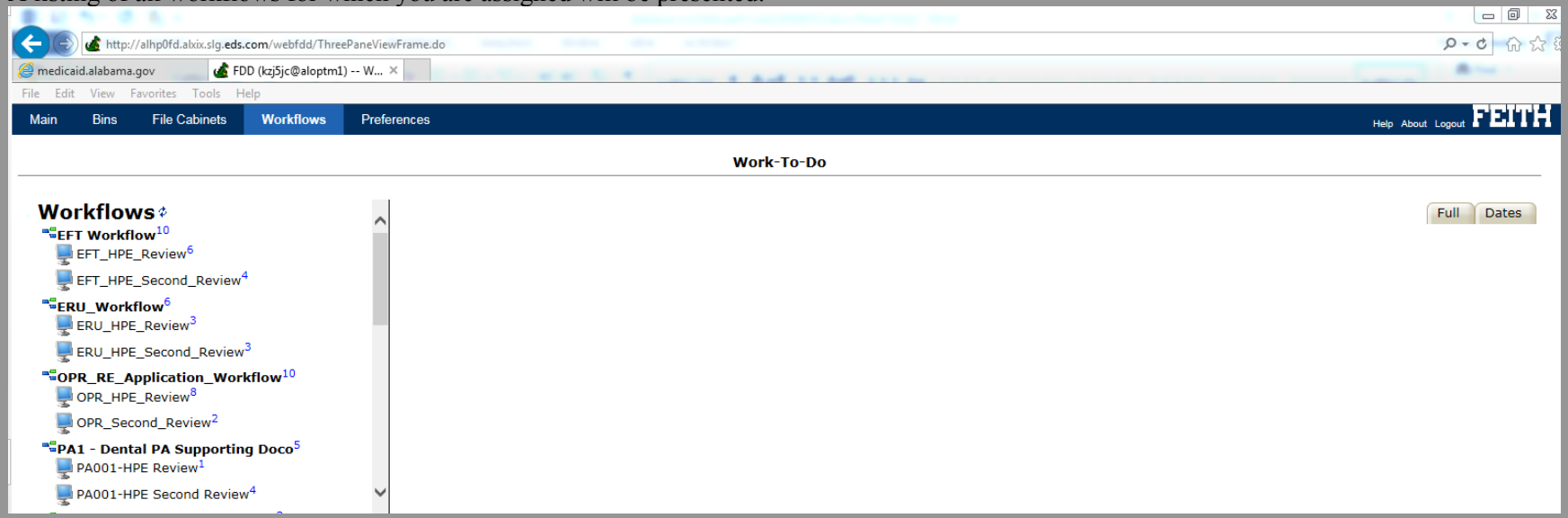
3. Once logged in, select the **Workflows** tab located in the top menu bar:



4. In the upper left-hand corner, you will see an icon labeled **Work To Do**. Press this icon.

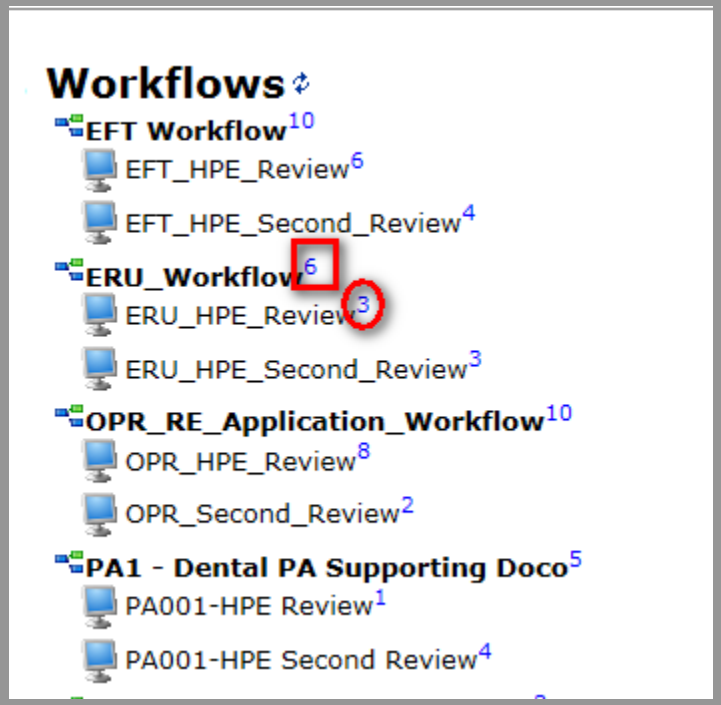


5. A listing of all workflows for which you are assigned will be presented:

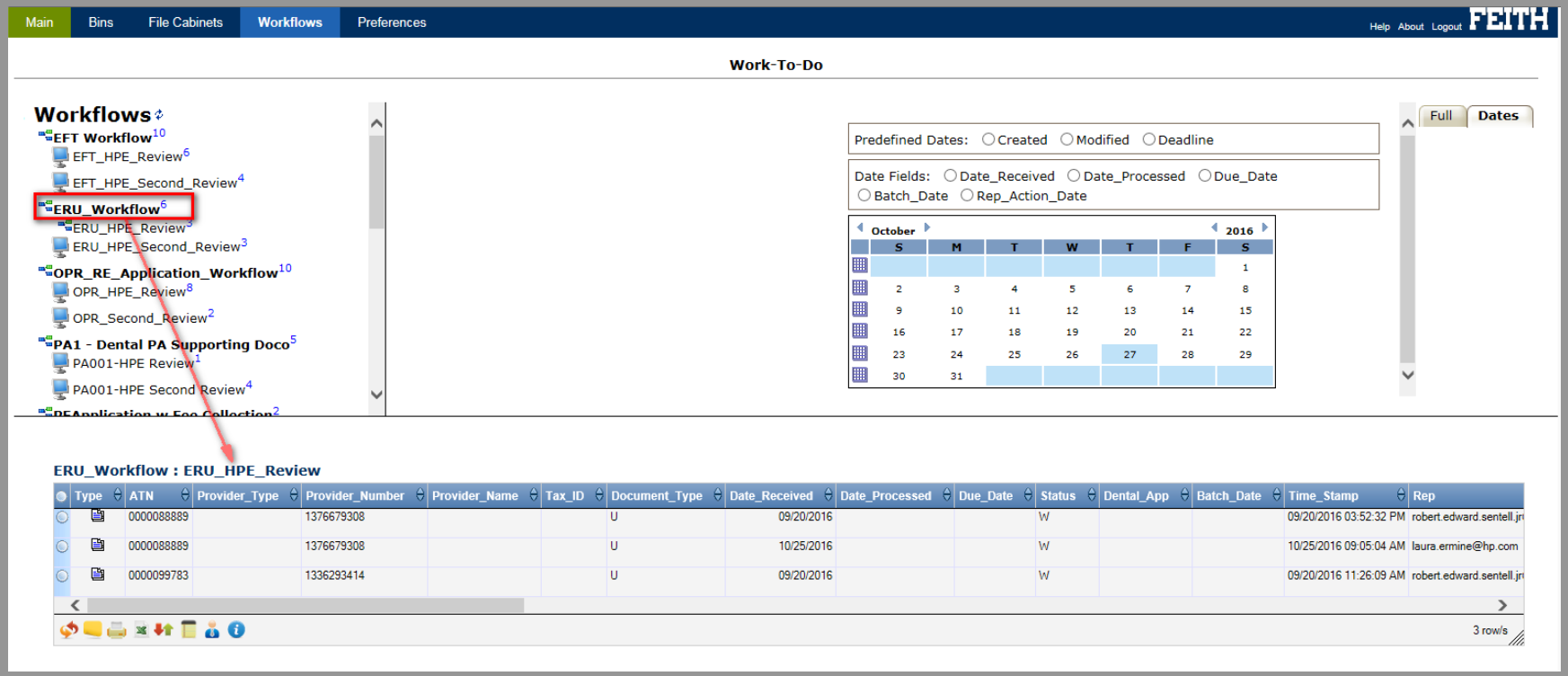


6. The double arrows to the right of the **Workflows** title, allow you to refresh the listings.

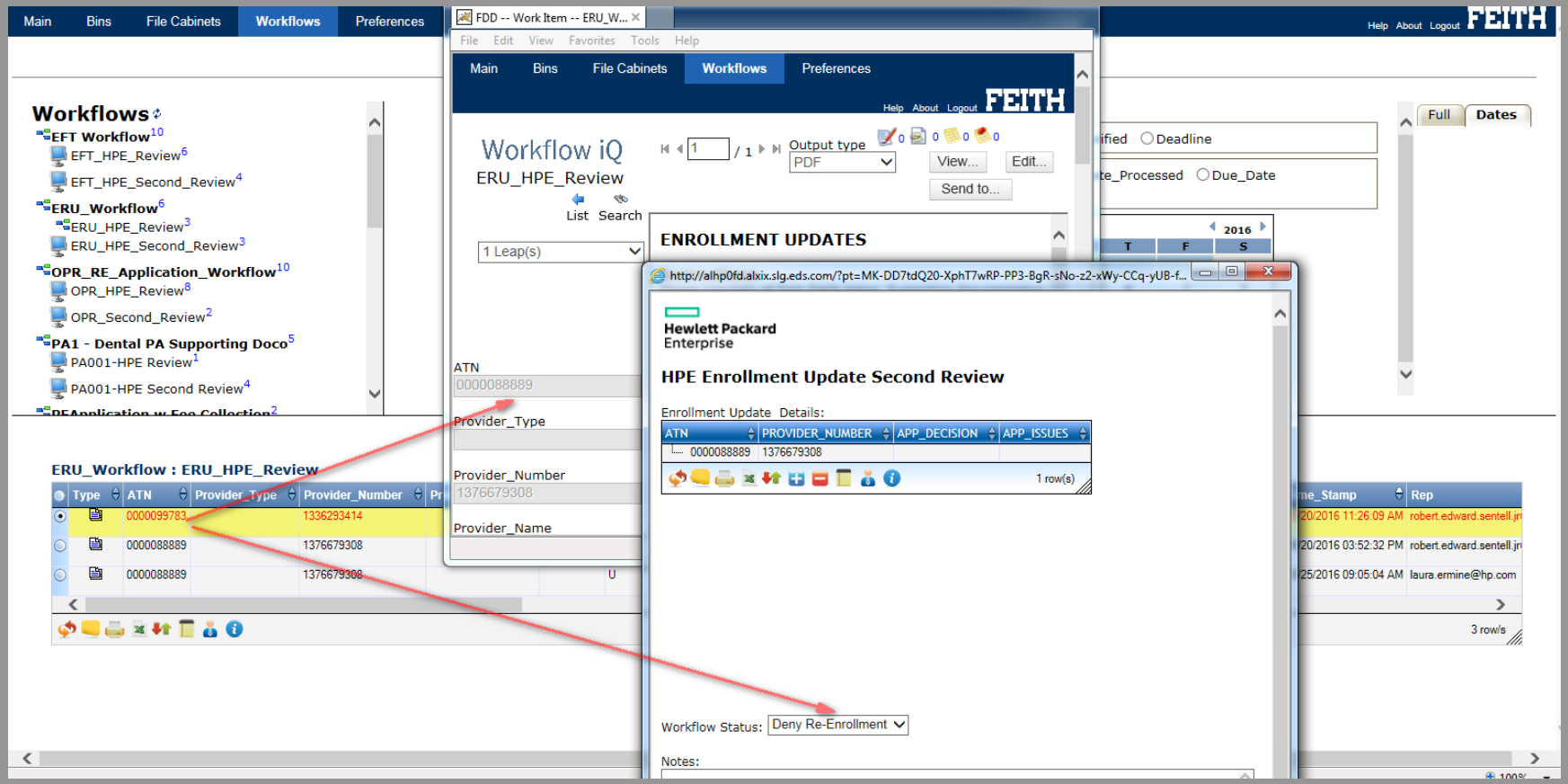
7. The blue numbers to the right of each Workflow Task indicate the total number of documents assigned to you for processing. In the example below, **ERU_DXC_REVIEW** has three documents assigned to the user for processing. The blue six to the right of **ERU Workflow** indicates for this user there are six total documents for processing.



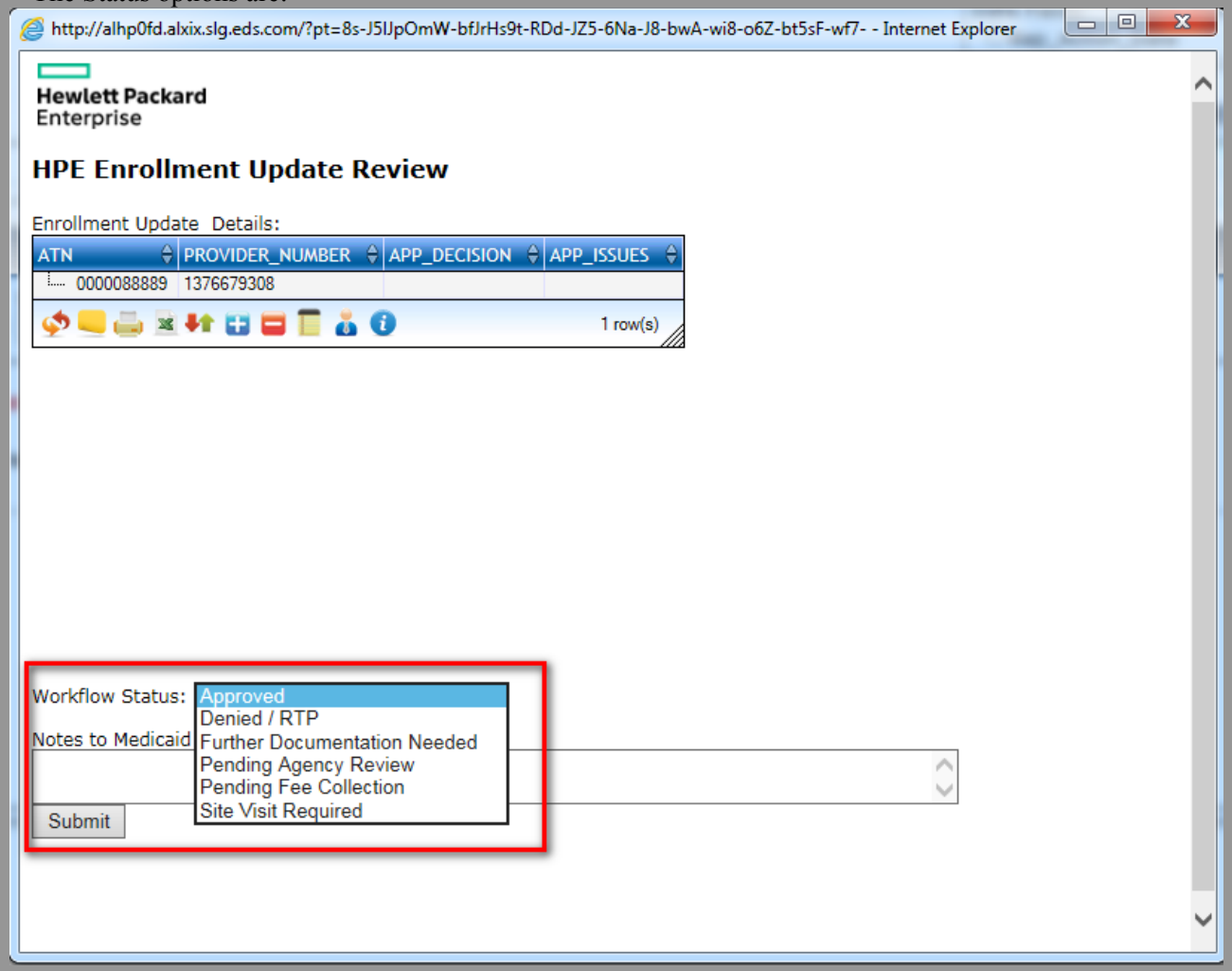
8. The user first selects **ERU_DXC_Review** to retrieve a listing of documents requiring initial review:



9. Clicking on the rows in the search results grid, will open the document and corresponding review form:



10. The user may move the windows around or minimize the form, to allow a review of the documentation submitted by the provider. (Middle window above.)
11. Upon reviewing the documentation, the user will enter the correct status and applicable notes in the **DXC Enrollment Update Second Review form.** The Status options are:



Notes:

a. By default all documents received are in a "**Working**" status.

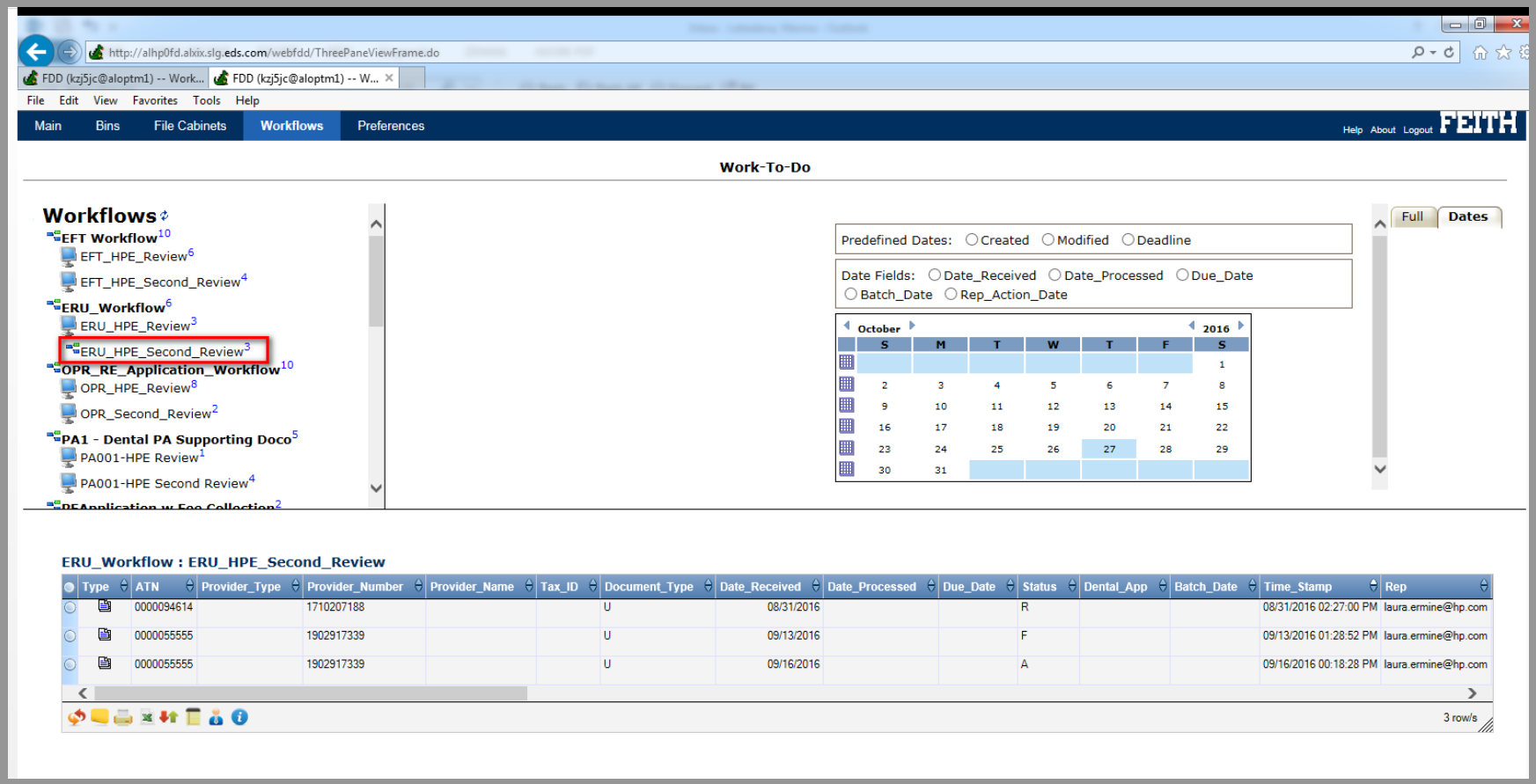
b. By selecting "**Agency Review**," and completing any notes needed, the document will be sent to Medicaid for review.

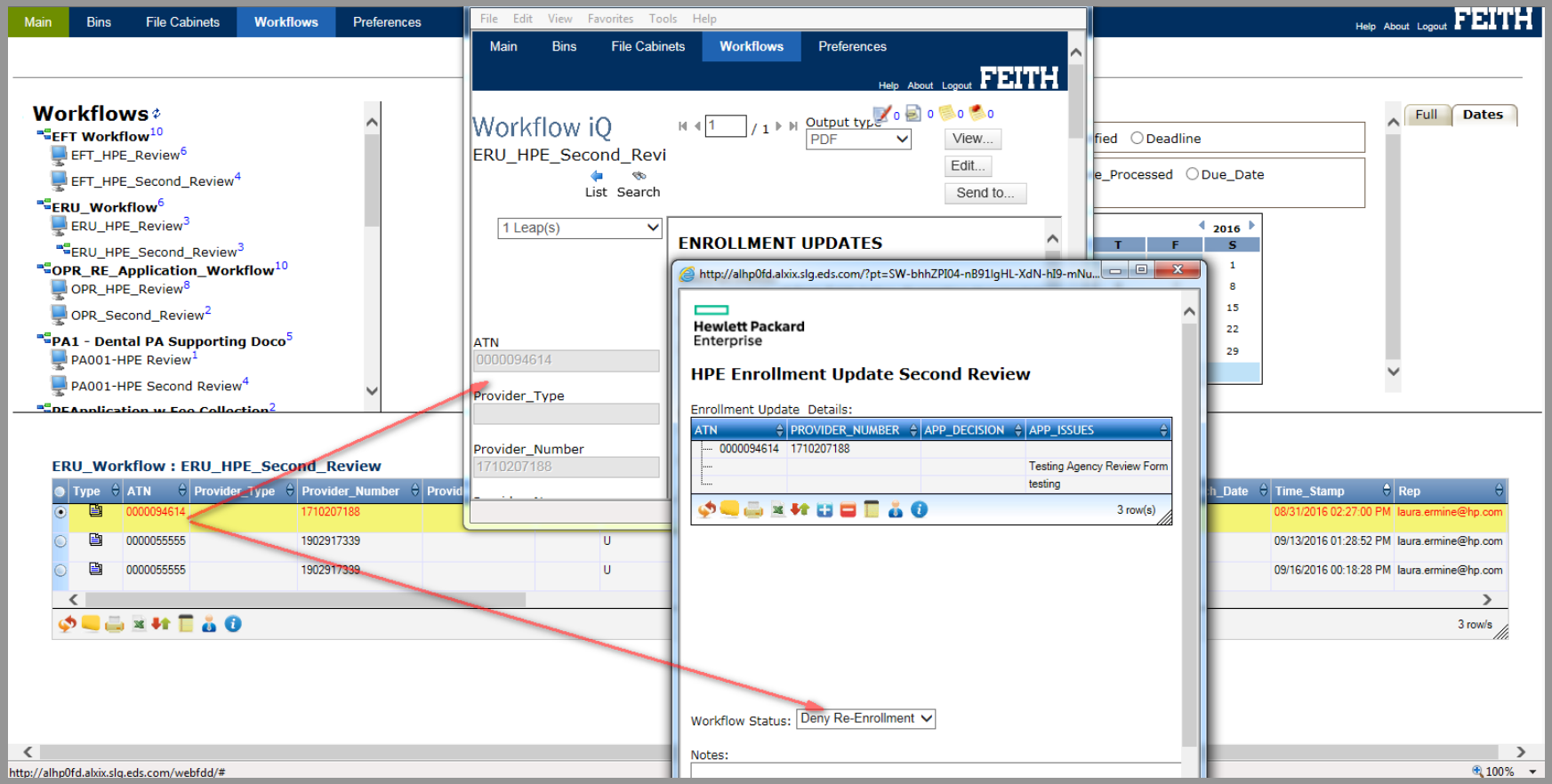
c. All other statuses (**Pending Agency Review, Further Documentation Needed, Approve, Pending Fee Collection, Site Visit Required, and Deny/RTP**) send the document to **DXC Second Review** for follow-up and completion. A document may sit in Second Review while follow up with the provider occurs. Reminder email notifications are sent to the applicable representative if documents have remained in workflow untouched for 3 number of days, per our SLA requirements.

d. This form (and only this form) should be utilized to update the status. Do not update the status in the file cabinet!

12. Once the **Submit** button has been pressed, the document will move in workflow to the next step. Feith will produce the next document for review and continue this pattern until all documents have been processed.

13. Documents sent to Medicaid for review, will be returned to DXC via workflow. At that time an email notification will be sent to the applicable Representative alerting them of the returned document and decision. Medicaid will provide the following decisions upon review: **Approved** or **Denied** The user will then go into **DXC Second Review** and review the documentation:





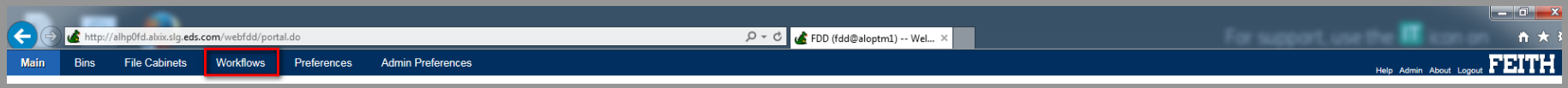
14. Complete the review process. Using the **Status** dropdown menu, choose the correct status of **Approved** or **Denied.** Enter any notes applicable to this document which should be retained or address any questions which may be relevant down the road.
15. Press **Submit**. The document will move out of your workflow completing the review process.

DXC OPR User Workflow Process Overview

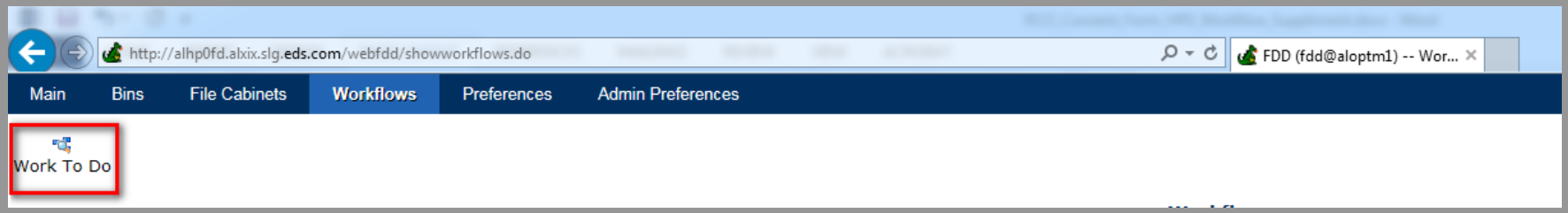
1. To access WebFDD / Feith Workflow, enter the following URL in your web browser address bar: https://alhp4fw.alxix.slg.eds.com/webfdd/

2. Log into WebFDD using the credentials provided to you by the ALXIX LAN team. Note: If you do not know your credentials, or your password has expired, a LAN Service Desk Ticket will resolve your connectivity issues!

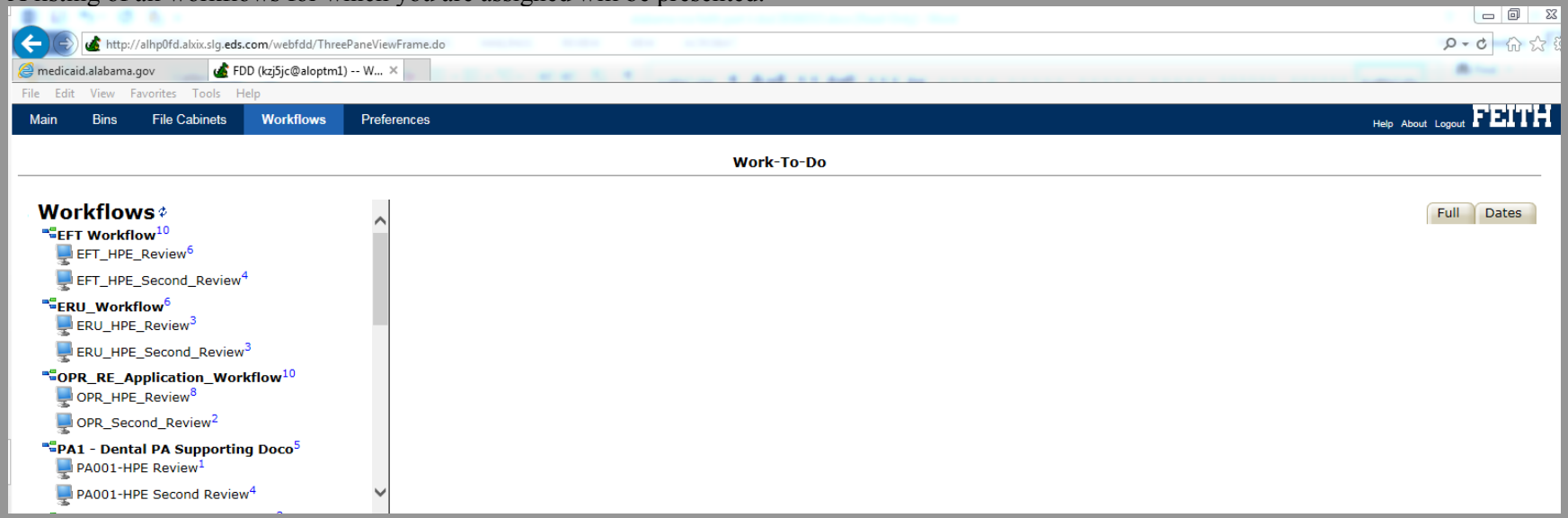
3. Once logged in, select the **Workflows** tab located in the top menu bar:



4. In the upper left-hand corner, you will see an icon labeled **Work To Do**. Press this icon.

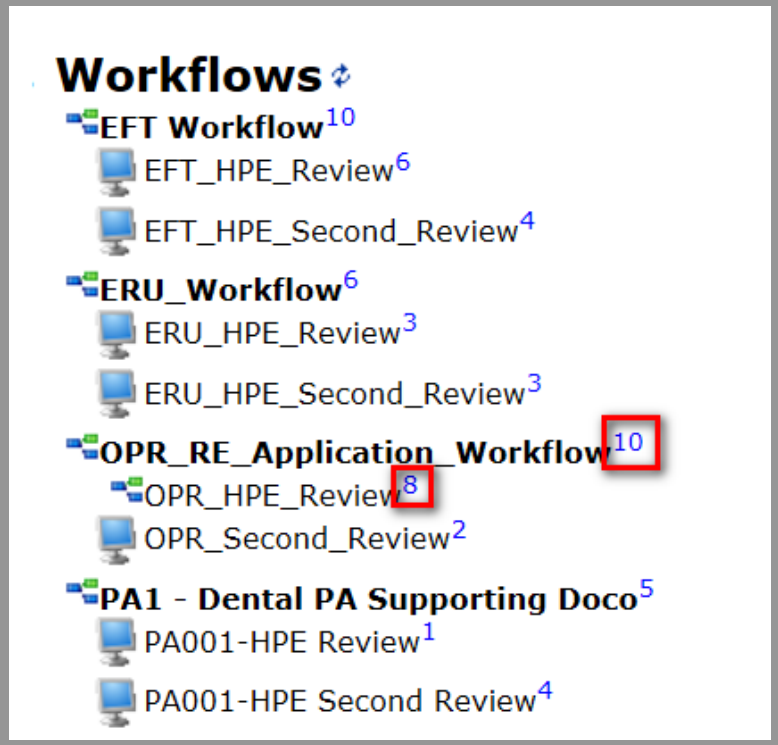


5. A listing of all workflows for which you are assigned will be presented:

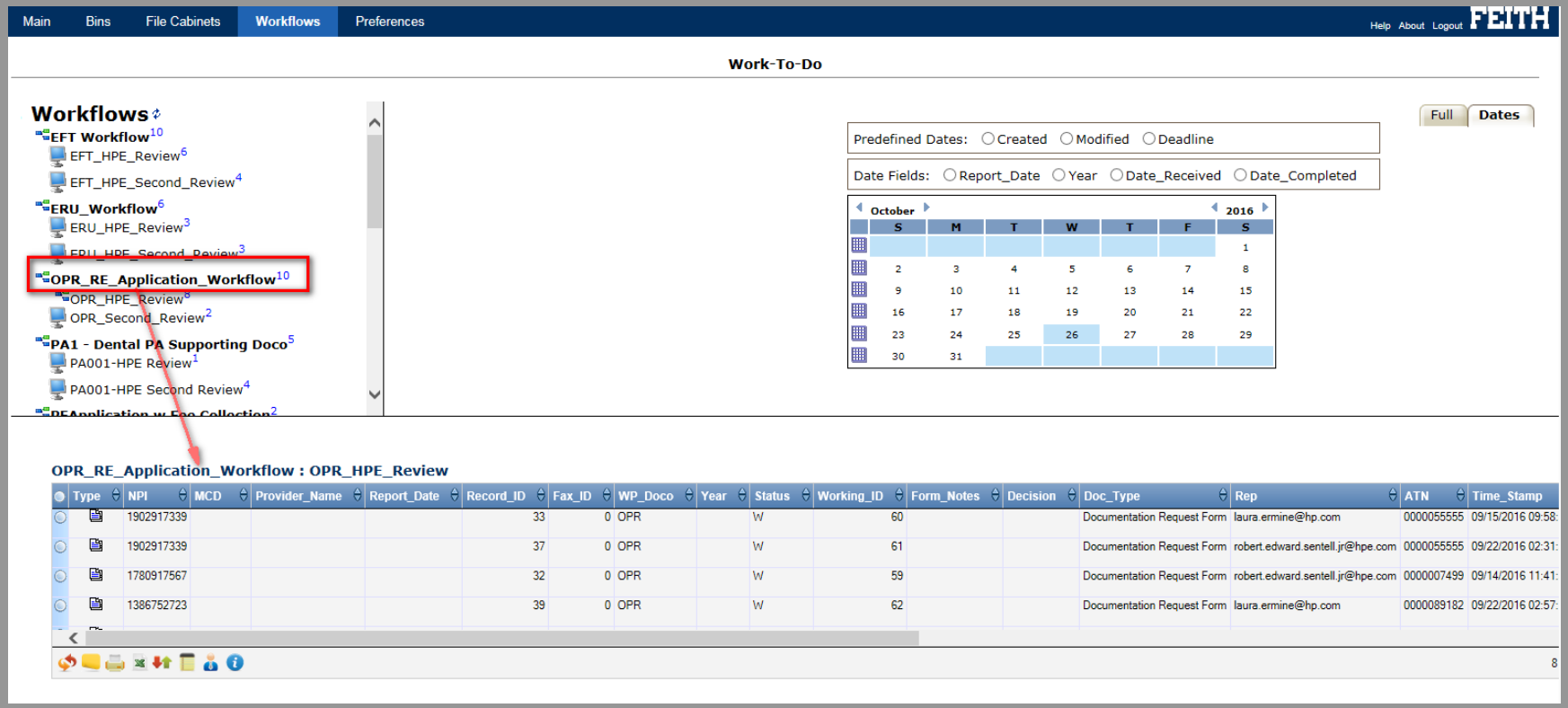


6. The double arrows to the right of the **Workflows** title, allow you to refresh the listings.

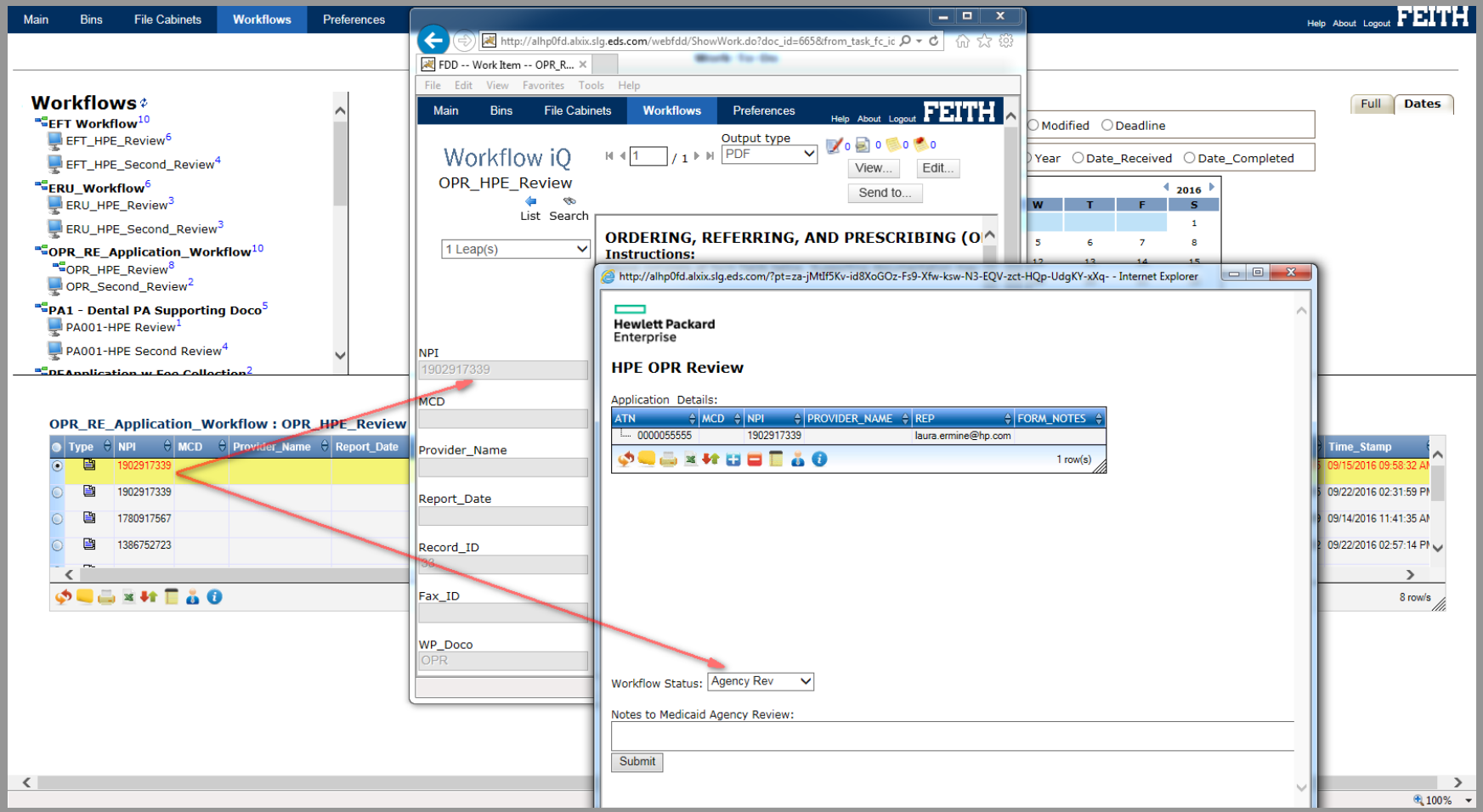
7. The blue numbers to the right of each Workflow Task indicate the total number of documents assigned to you for processing. In the example below, **OPR_DXC_Review** has eight documents assigned to the user for processing. The blue ten to the right of **OPR_RE_Application_Workflow** indicates for this user there are ten total documents for processing.



8. The user first selects **OPR_DXC_Review** to retrieve a listing of documents requiring initial review:

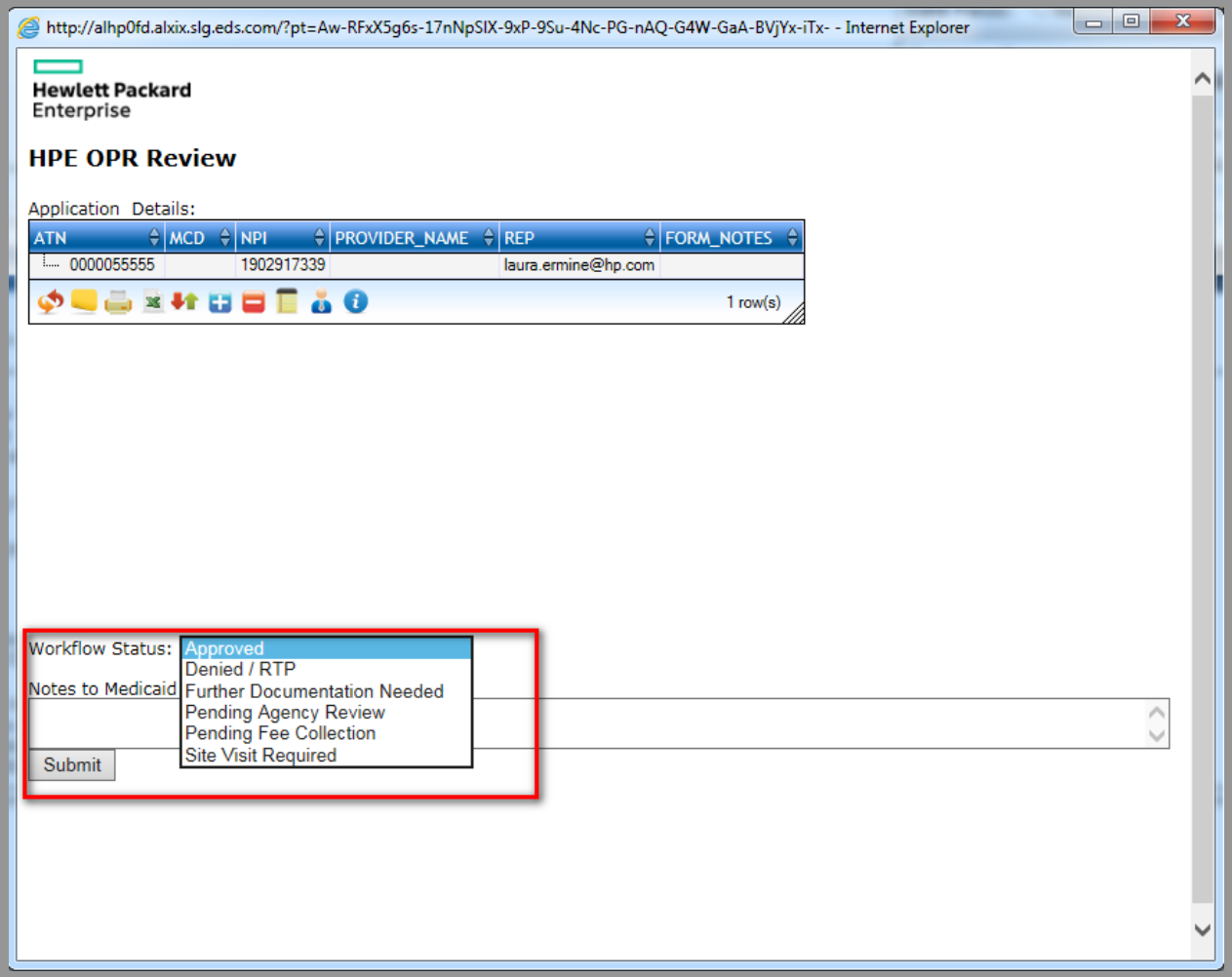


9. Clicking on the rows in the search results grid, will open the document and corresponding review form:



10. The user may move the windows around or minimize the form, to allow a review of the documentation submitted by the provider. (Middle window above.)

11. Upon reviewing the documentation, the user will enter the correct status and applicable notes in the **DXC OPR Review form.** The Status options are:



Notes:

a. By default all documents received are in a "**Working**" status.

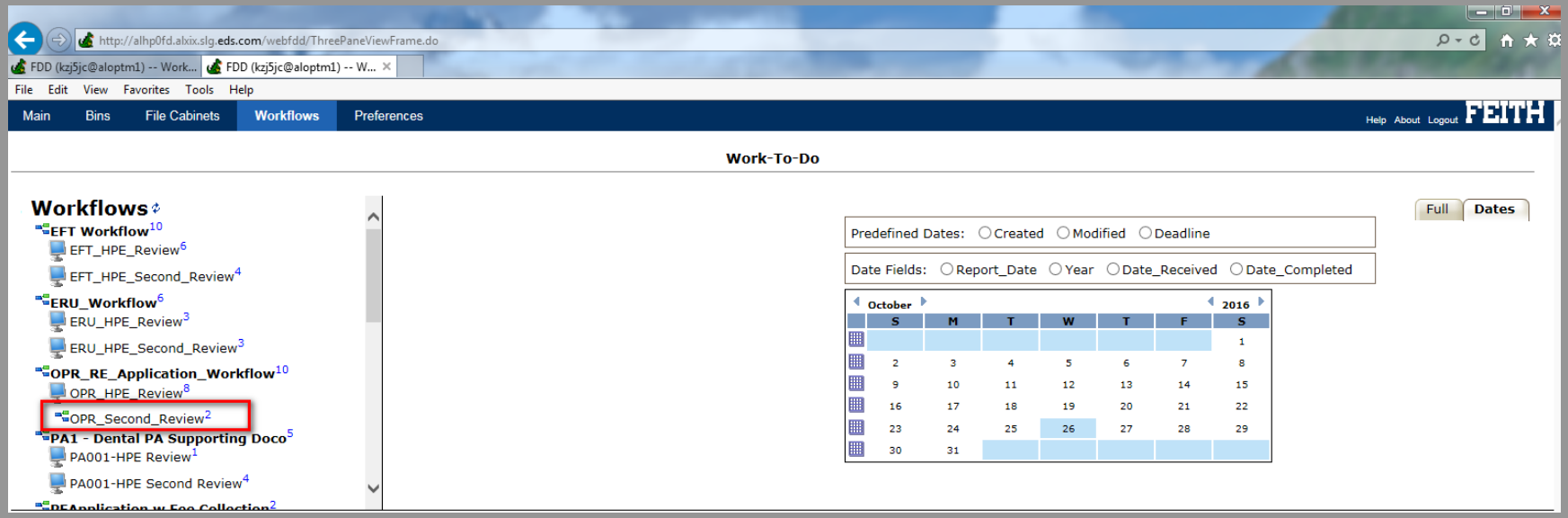
b. By selecting "**Agency Review**," and completing any notes needed, the document will be sent to Medicaid for review.

c. All other statuses (**Pending Agency Review, Further Documentation Needed, Approve, Pending Fee Collection, Site Visit Required, and Deny/RTP**) send the document to **DXC Second Review** for follow-up and completion. A document may sit in Second Review while follow up with the provider occurs. Reminder email notifications are sent to the applicable representative if documents have remained in workflow untouched for 3 number of days, per our SLA requirements.

d. This form (and only this form) should be utilized to update the status. Do not update the status in the file cabinet!

12. Once the **Submit** button has been pressed, the document will move in workflow to the next step. Feith will produce the next document for review and continue this pattern until all documents have been processed.

13. Documents sent to Medicaid for review, will be returned to DXC via workflow. At that time an email notification will be sent to the applicable Representative alerting them of the returned document and decision. Medicaid will provide the following decisions upon review: **Approved** or **Denied** The user will then go into **DXC Second Review** and review the documentation:



14. Complete the review process. Using the **Status** dropdown menu, choose the correct status of **Approved** or **Denied.** Enter any notes applicable to this document which should be retained or address any questions which may be relevant down the road.

15. Press **Submit**. The document will move out of your workflow completing the review process.

Online Enrollment Application Processing

Overview

Online applications are sent via the Provider Web Portal. A link to the enrollment portal can be found on the Alabama Medicaid website at:
http://medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.5_Provider_Enrollment.aspx

Online applications are received by Provider Enrollment electronically through Feith workflow. A facsimile is created of the online application and placed in Feith. Feith is the account's document repository. All documents are stored in this application. The application is then placed into enrollment staff workflows with a document type of "A" for application. For more information on this process, refer to Workflows section below.

The credentialing of a provider will remain the same. All providers will be required to submit required documentation identified in the Provider Operations Procedures Manual.

Processing

Enrollment staff will review the application facsimile along with all additional documentation to determine whether the application can be enrolled based on the requirements found in the Provider Operations Procedures Manual. Once all information is received, enrollment staff will change the status of the application in both the Web Application Status panel (in the MMIS) and Feith Workflow.

All applications received from a provider will have an application tracking number (ATN) assigned. This number should be used for reference to research any application submitted by a provider.

Approved - Applications that are ready to enroll are added to the MMIS by updating the Web Application Status panel to "Approved." The application will then be put into production and a file is created in the MMIS.

Once the application is added to the MMIS, the contracts, group affiliation, enrollment effective date, rate information, and any other additional information should be added to the enrollment.

Recertification – For recertification, the existing provider file should be reopened once the application is approved. Also, the Web Application Status panel should NOT be "Approved" to create a new enrollment. Instead, the Web Application status panel should be "Recertification" and the Enrollment Info panel should be updated by adding a new "Last Enrollment Date." This is the date the provider was recertified.

Corrections Needed

Applications that need corrections that can be made by the provider are given a "Data Corrections Required" status in the Web Application Status panel (MMIS). Staff will also send an email notifying the provider of the specific corrections needed to enroll within five days of receiving the application. The provider may then log in to the web portal, make the required corrections, and resubmit the application. Corrections received are given a status of "Corrections Applied" and will appear in workflow under a document type of "K." The corrections are then reviewed.

The following is a list of corrections that the provider will be able to make to the application (additional corrections to be added as needed):

Individual Within A Group:

- CLIA # & Effective Date
- Collaborating Physician NPI & Name
- DEA # & Effective Date
- Group MCD ID, NPI, Name
- License Information: End Date, Effective Date, License #, State
- Medicare #, Effective Date, Type
- Specialty Code, Indicator, Description
- Taxonomy Code

Group Application:

- CLIA #, Effective Date
- Primary Specialty Indicator
- Specialty Code, Description
- Taxonomy Code

Facility Application

- ACC Effective Date, End Date
- CLIA #, Effective Date
- Decertifying Pharmacy NPI, Name
- Medicaid Surety Bond Information: Effective Date, End Date, Number
- Medicare Surety Bond Information: Effective Date, End Date, Number
- Medicare #, Effective Date, Type
- Primary Specialty Indicator, Specialty, Description
- Taxonomy Code

Sole Proprietor (Individual not in group)

- CLIA # & Effective Date
- Collaborating Physician NPI & Name
- DEA # & Effective Date
- Group MCD ID, NPI, Name
- License Information: End Date, Effective Date, License #, State
- Medicare #, Effective Date, Type
- Specialty Code, Indicator, Description
- Taxonomy Code

Applications that need corrections that cannot be made by the provider are given a "Resubmit Application" status in the Web Application Status panel. Enrollment staff will send an email notifying them why the application has been returned for resubmission. The provider will then

need to access the application and resubmit once all corrections are made and will receive a new application tracking number (ATN). Note that under special circumstances, they provider may be allowed to submit faxed corrections to update an application without resubmitting an application. An example of this is when the Pay-to or Mail-to address information does not match the individual's information. Instances where the provider must resubmit an application are for changes needed in Application Type, Provider Type, or Tax ID.

Exceeds Time Limit - Applications that cannot be processed because the required information is not received by the time limit (10 days) are given a status of "Response Time Passed" in the Web Application Status panel and enrollment staff sends an RTP letter to the provider notifying them that the time limit has expired to submit required documentation (list) and that a new application will need to be submitted to enroll.

Agency Review - Applications that require Agency Review are given a status of "Agency Review Required" in the Web Application Status panel and the application is exempt from the normal processing time limit until received back from the Agency. Applications sent to Agency Review have a status of "A." For Feith workflow instructions, see below.

Web Application Status Panel Procedures (MMIS)

Submission - Provider submits an application on the web portal and an Application Tracking Number (ATN) is assigned to the application. A Facsimile of the application is created and placed into Feith Provider_Enroll file cabinet. Feith will automatically index the application and place into workflow. The applications will be auto assigned equally to enrollment staff taking into consideration those parties who are on leave. The status of the application should be changed in the Web Application Status panel and the provider will be able to see the current status of their application based on this status.

Corrections - If corrections are needed, the enrollment staff will send an email to the provider listing all required corrections. Enrollment staff will also access the Web Application Status panel and update the status of the application to "Data Corrections Required," or "Resubmit Application" depending on the corrections required. Using "Data Corrections Required," the provider will then be able to make limited corrections to the application and resubmit the application back to enrollment under the same ATN. The corrected application will be received and placed in the Provider_Enroll file cabinet with a document type of "K" for corrections applied. Using "Resubmit Application," the provider will access the application and make necessary corrections to the application and resubmit under a new ATN (new signature pages also required under new ATN). For Feith workflow instructions, see below.

Enrollment – Once the application is ready for approval, meaning all documentation needed to complete the enrollment has been received, and/or Agency Review has returned the application indicating it is approved, the application is updated on the Web Application Status panel in the MMIS with "Approved." The application will then be put into production and an enrollment created in the MMIS. For Feith workflow instructions, see below.

Once the application is added to the MMIS, the contracts, group affiliation, enrollment effective dates, and any rate information needed, and any other additional information should be added to the enrollment.

Recertification – For recertification, the existing provider file should be reopened once the application is approved. Also, the Web Application Status panel should NOT be "Approved" to create a new enrollment. Instead, the Web Application Status panel should be "Recertification" and the Enrollment Info panel should be updated by adding a new "Last Enrollment Date." This is the date the provider was recertified.

Each day, the Agency Review workflow will receive QC to ensure that applications placed in Agency Review have the appropriate statuses and document type.

Weekly/Bi-Weekly independent clean-up efforts are conducted by the System Team to ensure workflows are operational. Issues identified such as inappropriate statuses are reported to Provider Enrollment Management for correction/resolution. If reoccurring issues are encountered further training will be conducted with the party to ensure proper workflow processing of applications.

Scheduled Absences for Staff - Enrollment Staff members who are out or on vacation status are removed from Workflow by notifying the provider enrollment supervisor or backup. The individual is then removed from enrollment workflow by accessing the workflow vacation tool. Enrollment staff who are out of the office are removed manually from the Update workflow via notification to Systems Team (Laura Ermine) by approved management.

Failure to properly notify management for workflow exclusion will result in applications being assigned and the potential to miss SLA timeframes. It is imperative you coordinate your leave with management.

Site Visit Requirements (New)

Types of Providers Required to have a Site Visit Completed
The following provider types are required to have a site visit completed during initial enrollment and Re-enrollment:

- Licensed Professional Counselor (LPC) PT 07/SP 170 **(HIGH RISK)**
  - Reenrollment -
- Associate Licensed Counselor (ALC) PT 07/SP 071 **(HIGH RISK)**
  - Reenrollment -
- Licensed Marriage and Family Therapist (LMFT) PT 07/SP 072 **(HIGH RISK)**
  - Reenrollment -
- Licensed Master Social Worker (LMSW) PT 07/SP 073 **(HIGH RISK)**
  - Reenrollment -
- Licensed Independent Clinical Social Worker (LICSW) PT 07/SP 074 **(HIGH RISK)**
  - Reenrollment -
- ABA Therapist PT 17/SP 175
  - Reenrollment -
- Transportation PT 26
  - Reenrollment – visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
- Home Health PT 05 **(HIGH RISK)**
  - Reenrollment – visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
- Hospice PT 06
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
- Private Duty Nursing PT 52
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
- Physical Therapist PT 17
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
    – Individual PT's only require verification of Medicare enrollment in PECOS
- Independent Radiology PT 29
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
- Independent Lab PT 28
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)
  - Out-of-State Non-Bordering Independent Labs can be enrolled by verifying the lab is currently enrolled and active with Medicare (letter), and is currently Clinical Laboratory Improvement (CLIA certified or has accreditation through the College of American Pathologists (CAP) to satisfy site visit requirements.
- DME PT 25 **(HIGH RISK)**
  - Reenrollment - visit is not required if the 5% owners match and a visit was done within the last 5 years in PECOS)

- Out-of-State Non-Bordering DME are enrolled as crossover only. The Medicaid Agency has approved verification of Medicare certification (letter) to satisfy current site visit requirements.
- For new out-of-state Non-Bordering DME applications, verify the Medicare enrollment in PECOS and 5% ownership

Site Visits are also required if a provider is changing locations

** If PECOS indicates 5% owners that are not included in the application, request the disclosures from the needed individuals to satisfy the Site Visit requirement for Reenrollment. If PECOS contains individuals who are no longer 5% owners, the provider must update PECOS before the Medicaid application can be processed.

If a new application is for an out-of-state non-bordering provider requiring a visit and a Medicare visit was not verified, the Medicare verification and 5% owners can be used to satisfy the site visit requirement.

Note: A site visit is not required if Medicare completed a site visit with in the last 5 years.

Until PECOS login information can be given to new enrollment staff, submit email requests for verification to PE/Re-enrollment leader after all documentation is received and the application is ready to be enrolled/reenrolled. The provider enrollment leader will attach a copy of their finding to the application.

If a site visit is not required for reenrollment due to Medicare certification and 5% owners verified along with a site visit within the last 5 years, a .pdf copy of the PECOS file will be made and attached to the application as documentation.

Fingerprinting Checks (New)

Newly Enrolling: DME, HHA, LPC, ALC, LMFT, LMSW, and LICSW providers.

The above listed providers with a risk screening level of high must have a fingerprint based criminal background check (FCBC) completed for any 5% owners. This information is obtained in PECOS and a screenshot of the results are added to the electronic application documentation. If PECOS has not completed a FCBC, the 5% owner information is forwarded to the Agency for the FCBC to be conducted (application placed in Agency Review).

Feith PE Application Workflow Instructions

Periodic training sessions on the workflow process are conducted by the Provider Enrollment management team. Questions pertaining to how the workflow operate are directed to the Systems Team to be addressed. Alternatively, any issues with workflow should be reported immediately to the supervisor for resolution. It is important to provide what steps were performed to achieve the issue, when did the issue first occur, and is the issue limited to one user, etc.

Applications received are reviewed within five business and are given another five business days to enroll if there are no corrections required. If there are corrections needed to process the application, an additional 30 business days are given.

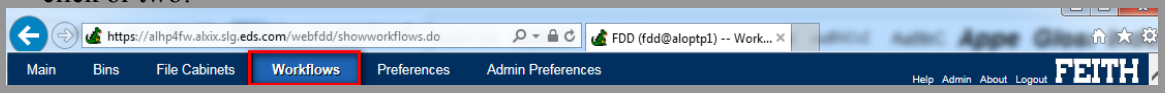
Workflow Overview:

1. Application facsimiles from the Provider Portal are stored nightly into the Feith document repertory, indexed for searchablity, and routed to workflow for processing. This process is also referred to as "applications dropped into workflow."

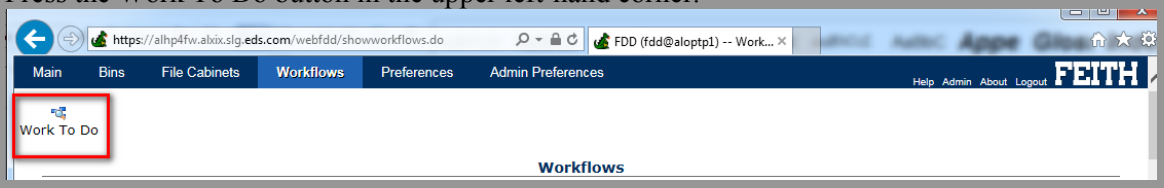
2. Documents are automatically assigned to enrollment staff for processing. For more on this, please refer to the leave section below.

3. The enrollment staff logs into WebFDD using the following URL: https://alhp4fw.alxix.slg.eds.com/webfdd. The URL may be located on iTRACE under Feith as well.

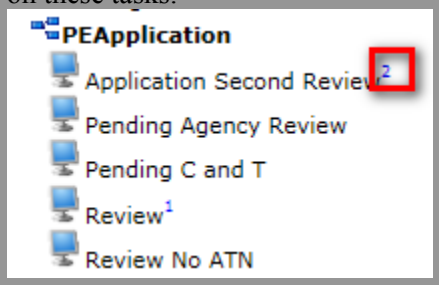
4. Press the Workflow Tab.
   a. If you always go to the Workflow tab first, you may set this to be the main screen upon login within the Preference tab for your user account. This will save you a click or two!



5. Press the Work To Do button in the upper left-hand corner.

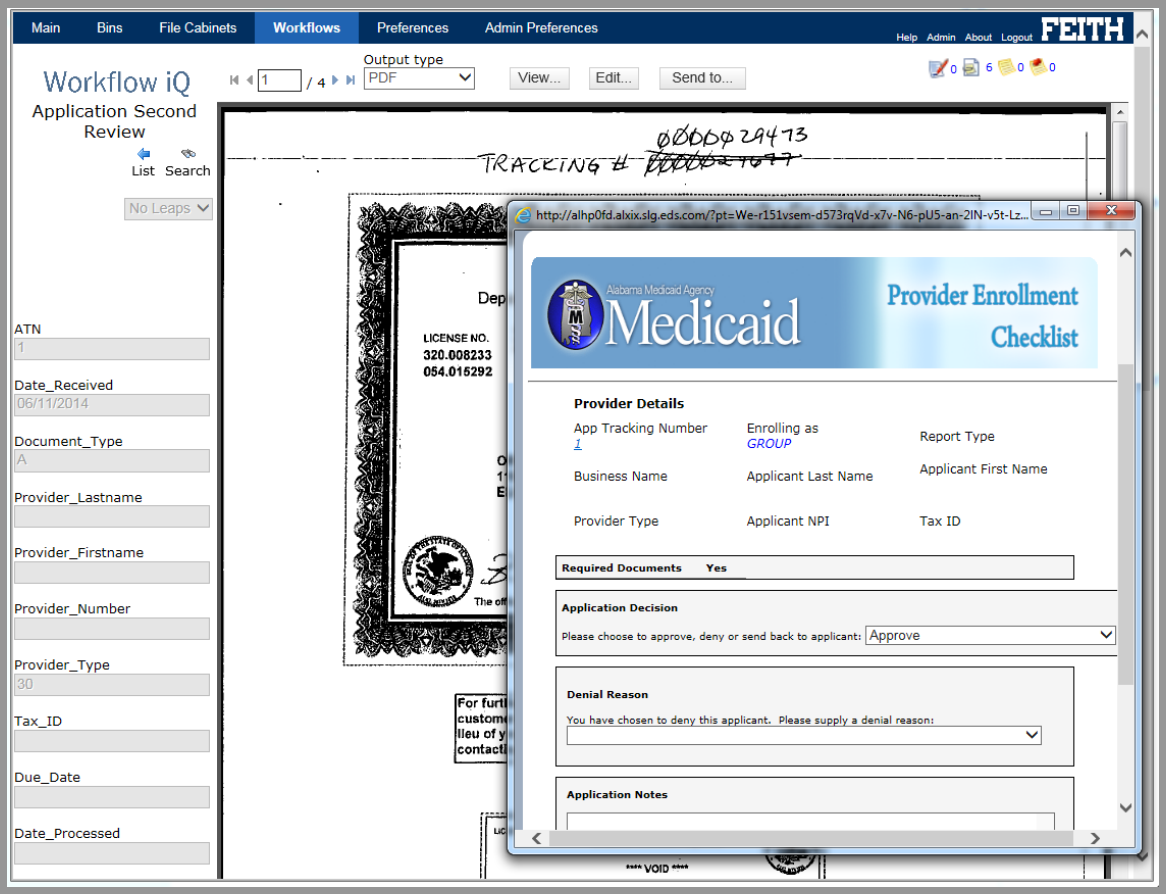


6. A listing of all workflow tasks will be displayed. For each task a blue hyperlink number indicates the number of documents to be processed in each task. A task is a type of review being conducted. Within this workflow there are four main tasks: Review, Second Review, Agency Review, and Finalization of Application. Please see below for more information on these tasks.



7. Click the first item in the search results grid.

8. The document and corresponding workflow form will open. Once completing the task the next document will open automatically for processing. This will occur until the user exits workflow or completes all documents within the task. To ensure you can see all functionality, the web browser should be set at 100% zoom or less. Zoom of 100% or greater will not allow the documents/forms to be visible to the user.



9. In workflow the form should always be completed before table updates within the File Cabinet tab. Failure to do so will result in the document staying within that task and unable to move out of workflow. The rule: If there is a workflow form, it must be completed before any other updates.

Processing Workflow Tasks –

Review Task:

- The status of 'W' will be on the application when it comes into Workflow.
- Items in 'W 'must be in Review Task. (Never Second Review!).
- In Review Task you should conduct initial review and make a determination to 1) send to Medicaid/Agency 2) finalize/deny or 3) ask for additional information from the provider.
- If (and only if) you are waiting on Medicaid or a Provider to complete your review (i.e. requested documentation or sent to Medicaid Review and are waiting on the response) send application to Second Review as a second review will be required to complete the process.

Second Review

- The status of 'P' should be applied to send a document to Second Review.
- Second Review is <u>ONLY</u> for documents that are waiting on something to finalize/deny the enrollment application. (i.e. Document from a Provider/answer from Medicaid)
- When the item is received, a second review (with all the pieces) is conducted and decision is rendered.

Agency Review

- An application may warrant Agency Review in either the Review or Second Review tasks.
- To send to the Agency for review. Change the status to 'A.'
- Once received back from Medicaid, change the status to 'P', complete the Second Review, and finalize the application.

Review Complete

- Applications for which the Review or Second Review are complete will need to be in a final status.
    - Change the status to 'F' for finalized/approved applications.
    - Change the status to 'R for applications which must be RTP/Denied.
- NOTE: Due to our auditing practices, if you accidently finalize an application, you need to reach out to Jeff or Pam so that Systems Team can move the document back into your workflow. Do not try to adjust statuses to move the document. This will not move the document and will cause issues to your application! Please reach out to Jeff/Pam and they will work with Systems to get the application back in your workflow through the normal processes.

If at any time you encounter an error/issue, reach out to the Provider Enrollment management team for assistance. Failure to do so can result in SLAs being missed. If system resolution is needed, management will reach out to the Systems Team for resolution. To ensure fast resolution off your issue, please promptly respond to questions regarding the issue.

Re-Enrollment Application Processing

CMS Federal Requirement 455.414 requires that all providers re-enroll at least every five years. In order to meet these federal requirements, the following procedures for re-enrollment will be accomplished.

Providers who are required to re-enroll will be sent a notification letter instructing them to access the secure provider portal and download the Provider Re-enrollment Facsimile (PRV-A-035-M). Providers will review the Provider Enrollment Facsimile and make any corrections on the document and sign. Any additional documentation required to include the Provider Agreement and Disclosure forms are mailed with the facsimile to Provider Re-Enrollment for processing.

The following actions will occur by the re-enrollment staff to process the re-enrollment applications:

The file clerk will:

- Enter the received date in the "Date Response Received" field on the Enrollment Info Panel.
- Log the application on the Re-enrollment Log with the NPI and Provider name entered on the application and date received.
- Scan the application into the Feith database (see scanning procedures guide for more information). Feith will auto assign the applications to the clerks based on the number of clerks available.
- Forward the original applications to the assigned clerks.

The assigned representative will:

- Run database checks in Accurint (LexisNexis). A PDF copy of the search results should be saved and appended to the scanned copy of the Re-enrollment application.

- Verify the provider's licensure information with the appropriate licensure board if the Accurint database check did not validate the provider's license. The states' licensure boards' information is located on the provider representative drive in the Re-enrollment folder. A PDF copy of the verification should be appended to the scanned provider file.
- Verify the NPI with the NPPES registry if the Accurint database check did not validate the provider's NPI. A PDF copy of the verification should be appended to the scanned provider file.
- If CLIA information is added or changed, verify that the CLIA information entered on the application matches the copy of the CLIA certificate submitted by the provider.
- If DEA information is added or changed, verify that the DEA information entered on the application matches the copy of the DEA certificate submitted by the provider.
- Enter any new specialties indicated on the application. If the provider is adding EPSDT or Plan 1st as a specialty the appropriate agreement must be submitted. Provider must have a CLIA on file if adding the EPSDT specialty.
- Verify that all disclosure questions on the applicable disclosure form were answered. If any question was answered "yes" the application should be forwarded to Program Integrity for review. The Feith workflow should be updated to a status of Agency review. (Status = 'A')
- Verify that contact information was entered. A contact name and phone number is required. The contact can be the same as the provider.
- Verify that the provider submitted a signed and dated provider agreement. The application must be signed by the provider, not a designee. Contact the provider by telephone if the signature is not the provider's signature or if the agreement was not sent. If unable to contact the provider by telephone send the "Corrections Needed" letter to the provider. Enter a note in Feith with the corrections needed. A copy of the corrections letter should be added to the scanned copy of the application in Feith. Sample letter is on Provider Representatives drive in Re-enrollment folder.
- Contact the provider if any of the above information (other than signature) is not submitted or submitted incorrectly. Advise the provider to fax any faxable documentation. A note should be entered into Feith indicating the date the provider was notified of needed corrections and the requested corrections. Review the submitted faxes to determine requested corrections were made. The fax should be maintained with the provider file. A copy of the fax should be given to file clerk to scan and add to the scanned application.
- Contact provider if requested corrections are not received within the required time frame. Verify that a site visit has been performed by Medicare within the last 5 years or by the Provider Representatives for moderate and high risk provider types. If the site visit was performed by the Provider Representatives a copy of the site visit checklist and photographs should be appended to the scanned re-enrollment application. If the site visit was performed by Medicare append a copy of the PECOS screen shot to the scanned re-enrollment application. NOTE: If no visit is documented, review the file but do NOT finalize the re-enrollment.
- Finalize the re-enrollment in the MMIS when the application has been reviewed and all required documentation or corrections, if any, have been received. Finalize the application by accessing the Enrollment Info panel and changing the "Last Enrollment

Date” to the date the application was finalized. Finalize the application in Feith workflow (status = F) and add the date the application was finalized.

Providers Disenrolled due to failure to submit Re-Enrollment

If a provider has been closed due to failure to submit the re-enrollment they will have a 30 day "grace period" to submit the re-enrollment.

If the provider calls within 30 days of the disenrollment date, re-enrollment will reopen the provider contracts with an end date that is 30 days from the DISENROLLMENT date (not 30 days from the date they contacted re-enrollment). The provider will have to submit the re-enrollment documents within the 30 day grace period. If the provider fails to submit the re-enrollment the file will be closed due to the end date on the provider contracts.
If the provider file is closed again, there will not be an additional grace period and the provider will have to submit a new enrollment through the Provider Enrollment Web Portal.

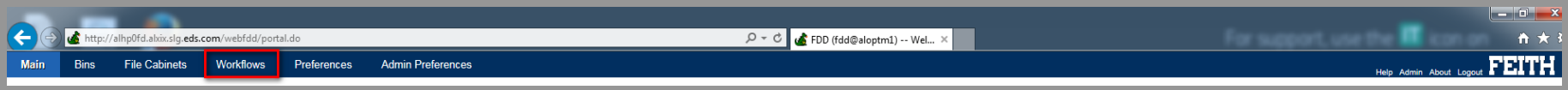
Re-Enrollment Staff members who are out or on vacation status are removed from Workflow (application and update) by notifying the supervisor who in turn, notifies the Systems Team of the absence (Laura Ermine) at least two day prior to the absence. This will be required to remove individuals from re-enrollment "auto-distribute" until the new Feith enhancements are completed.

DXC REA User Workflow Process Overview

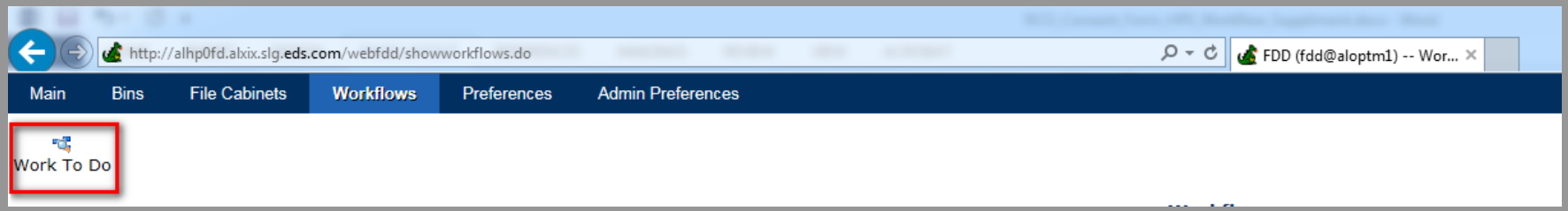
1. To access WebFDD / Feith Workflow, enter the following URL in your web browser address bar: https://alhp4fw.alxix.slg.eds.com/webfdd/

2. Log into WebFDD using the credentials provided to you by the ALXIX LAN team. Note: If you do not know your credentials, or your password has expired, a LAN Service Desk Ticket will resolve your connectivity issues!

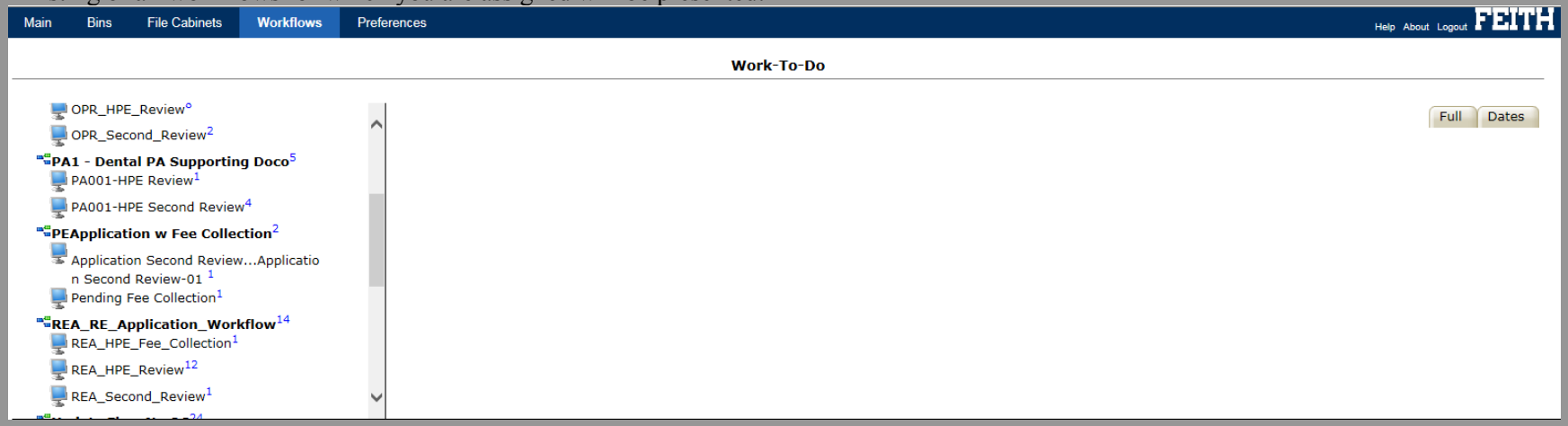
3. Once logged in, select the **Workflows** tab located in the top menu bar:



4. In the upper left-hand corner, you will see an icon labeled **Work To Do**. Press this icon.

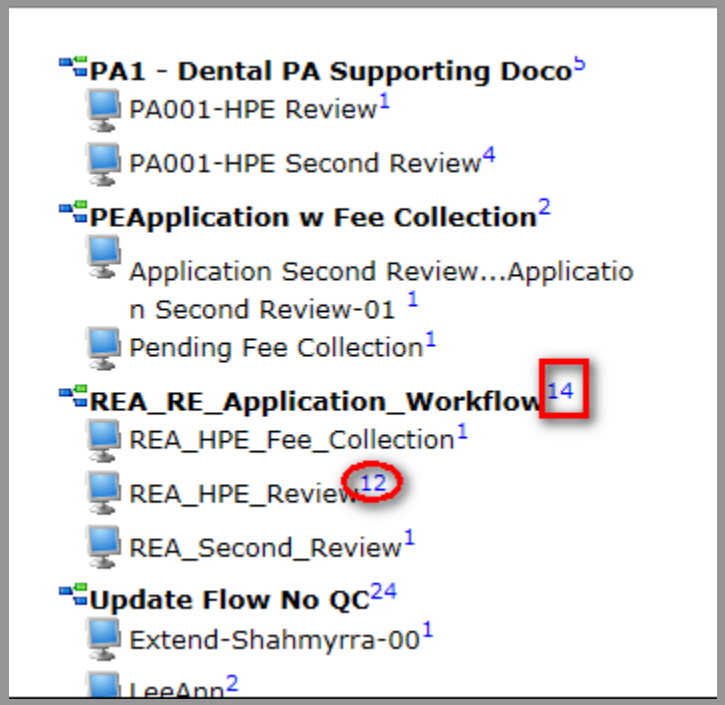


5. A listing of all workflows for which you are assigned will be presented:

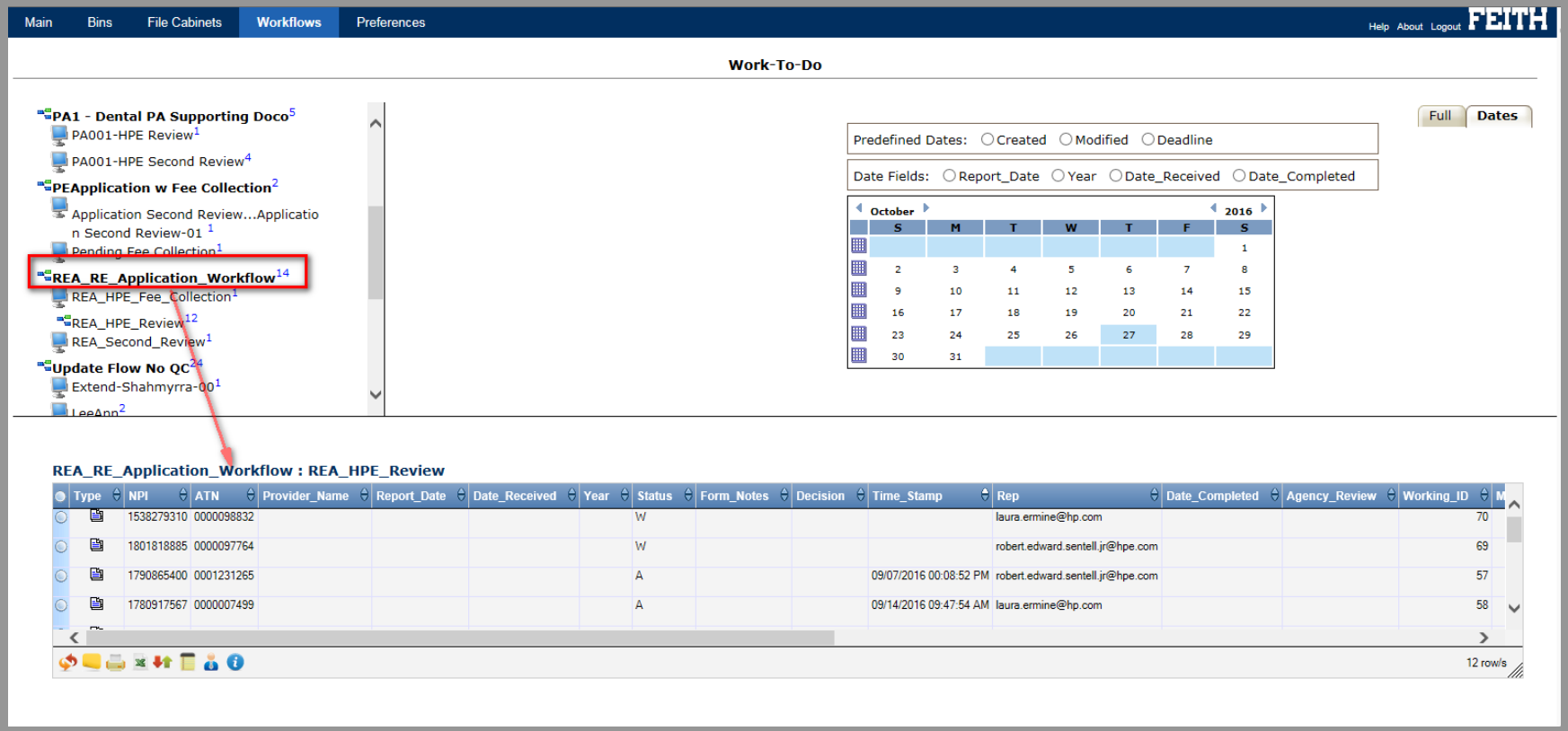


6. The double arrows to the right of the **Workflows** title, allow you to refresh the listings.

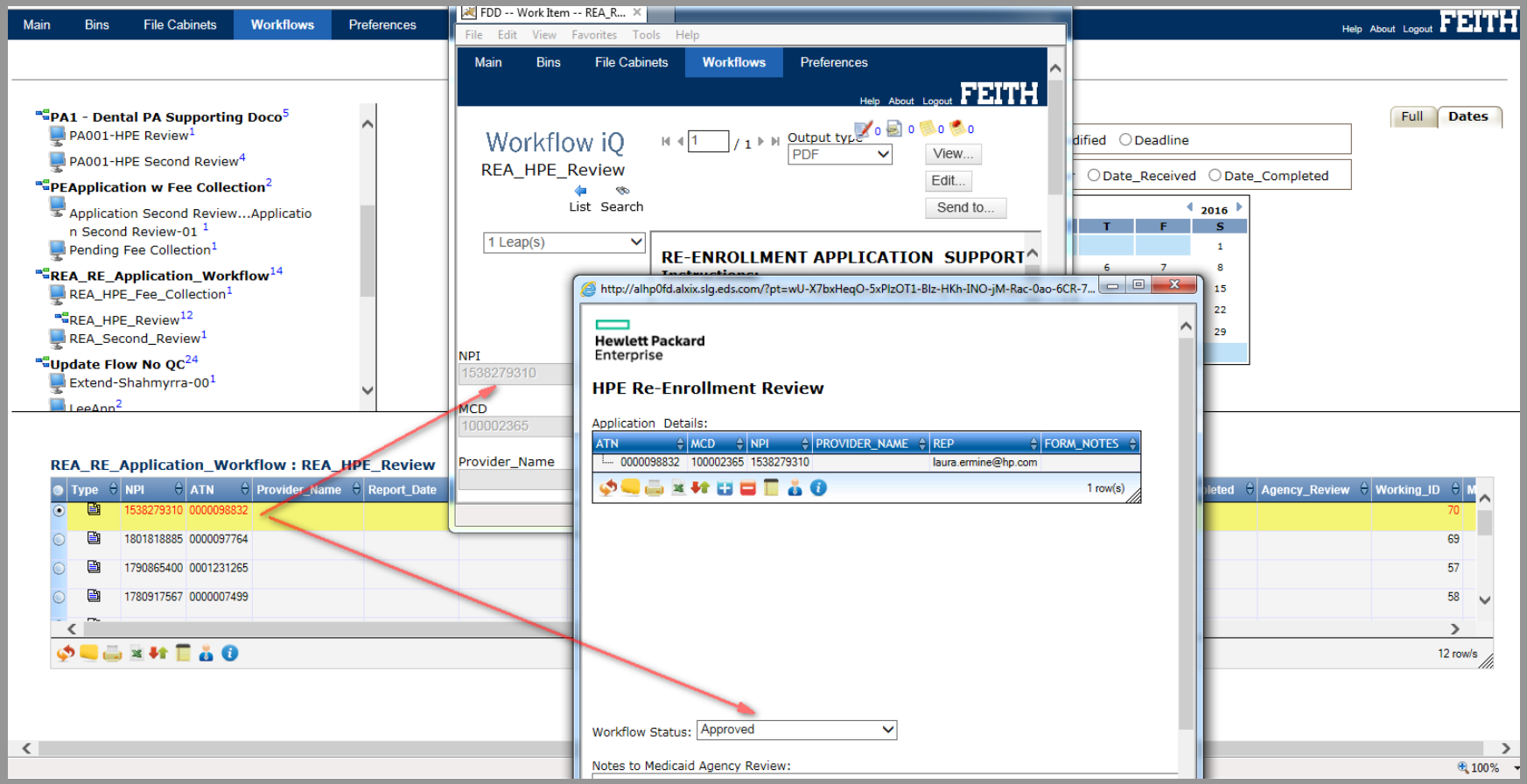
7. The blue numbers to the right of each Workflow Task indicate the total number of documents assigned to you for processing. In the example below, **REA_DXC_Review** has twelve documents assigned to the user for processing. The blue fourteen to the right of **REA_RE_Application_ Workflow** indicates for this user there are fourteen total documents for processing.



8. The user first selects **REA_DXC_Review** to retrieve a listing of documents requiring initial review:

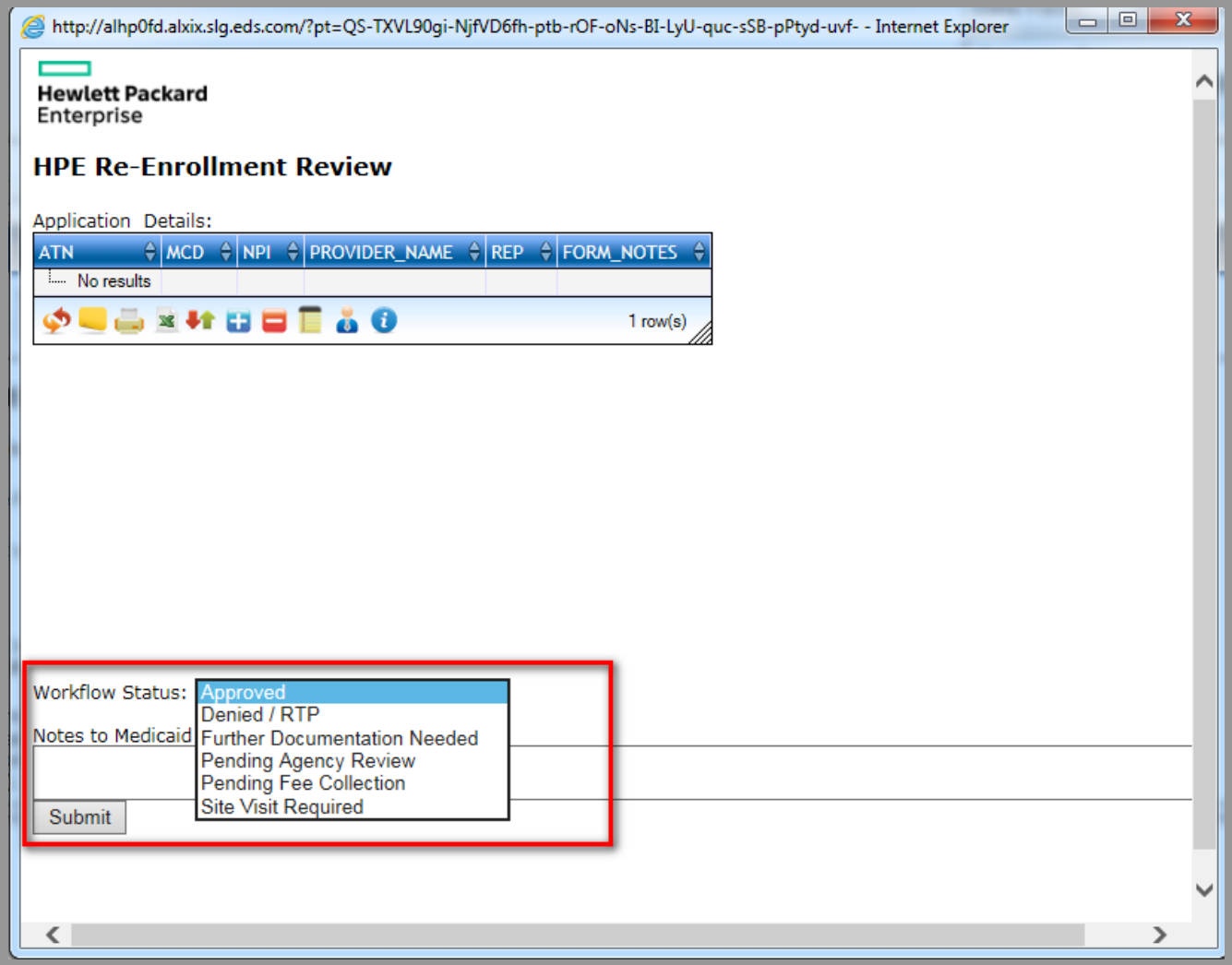


9. Clicking on the rows in the search results grid, will open the document and corresponding review form:



10. The user may move the windows around or minimize the form, to allow a review of the documentation submitted by the provider. (Middle window above.)

11. Upon reviewing the documentation, the user will enter the correct status and applicable notes in the **DXC Re-Enrollment Review form.** The Status options are:



Notes:

e. By default all documents received are in a "**Working**" status.

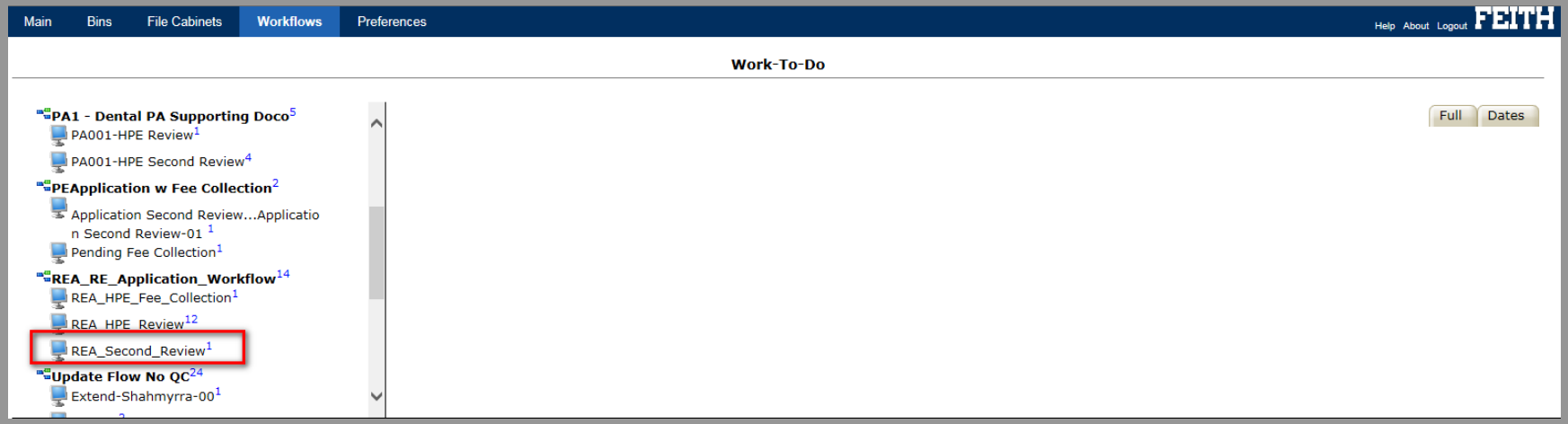
f. By selecting "**Agency Review**," and completing any notes needed, the document will be sent to Medicaid for review.

g. All other statuses (**Pending Agency Review, Further Documentation Needed, Approve, Pending Fee Collection, Site Visit Required, and Deny/RTP**) send the document to **DXC Second Review** for follow-up and completion. A document may sit in Second Review while follow up with the provider occurs. Reminder email notifications are sent to the applicable representative if documents have remained in workflow untouched for 3 number of days, per our SLA requirements.

h. This form (and only this form) should be utilized to update the status. Do not update the status in the file cabinet!

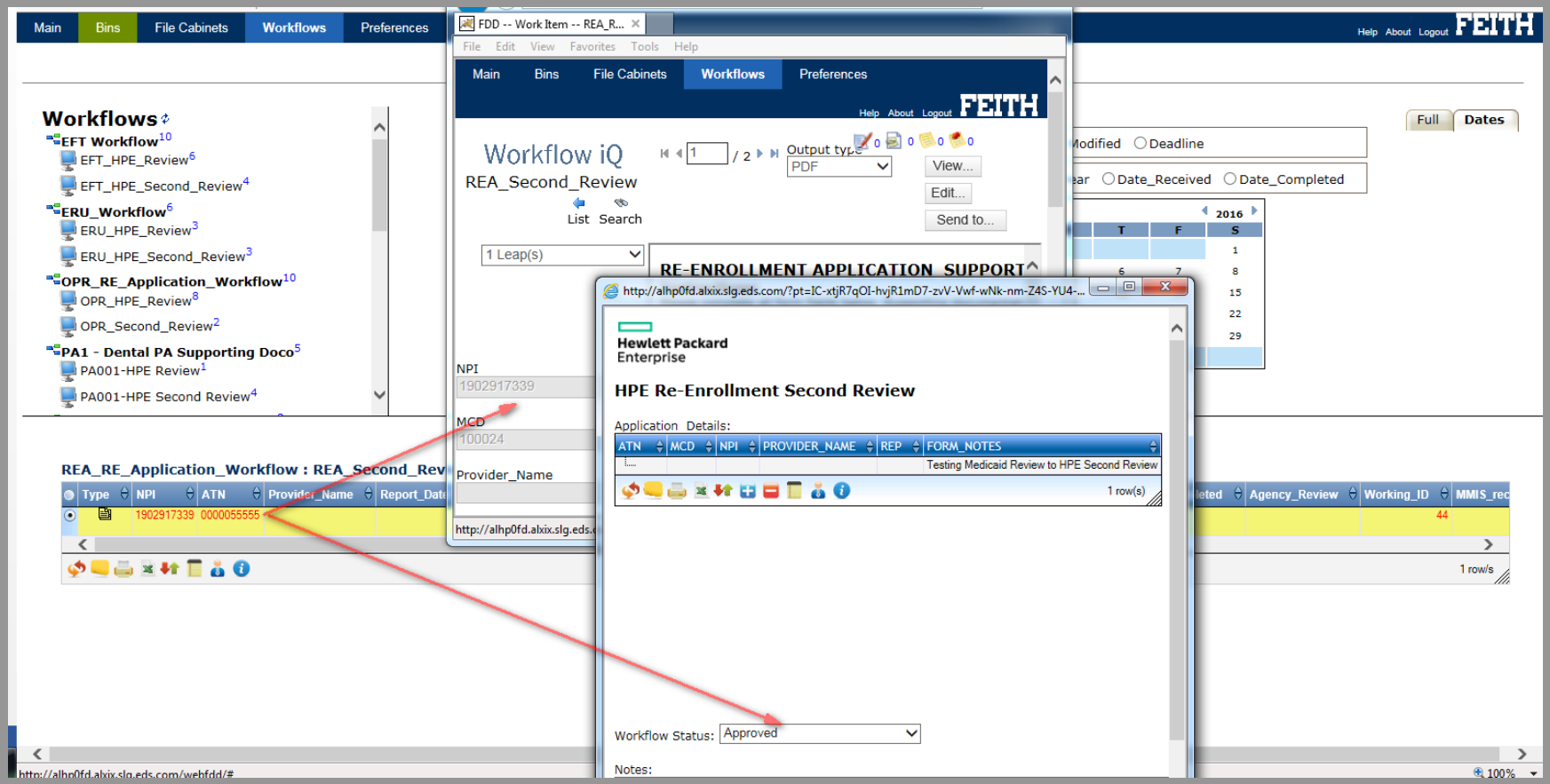
12. Once the **Submit** button has been pressed, the document will move in workflow to the next step. Feith will produce the next document for review and continue this pattern until all documents have been processed.

13. Documents sent to Medicaid for review, will be returned to DXC via workflow. At that time an email notification will be sent to the applicable Representative alerting them of the returned document and decision. Medicaid will provide the following decisions upon review: **Approved** or **Denied** The user will then go into **DXC Second Review** and review the documentation:



14. Complete the review process. Using the **Status** dropdown menu, choose the correct status of **Approved** or **Denied.** Enter any notes applicable to this document which should be retained or address any questions which may be relevant down the road.

15. Press **Submit**. The document will move out of your workflow completing the review process.



Database Checks

DXC staff will access the LexisNexis web portal to perform the following database checks prior to enrollment and re-enrollment:

- List of Excluded Individuals/Entities (LEIE)
- Excluded Parties List System (EPLS)
- Social Security Administration Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Licensure board databases
- Verification of Social Security Number or Employer Identification Number

These database checks will be performed for providers and any owners, agents, or managing employees that are listed on the enrollment application. Provider enrollment staff will review the LexisNexis results for these database checks. If no negative findings are detected, the enrollment process will proceed. If negative findings are detected, the enrollment/re-enrollment application will be routed via Feith Workflow to Agency Review. Program Integrity staff will access the report in Feith Workflow, review the materials, and document their decision in the Feith application which will instruct DXC enrollment staff on how to proceed. DXC enrollment staff will be notified via Feith Workflow that an Agency Review decision has been reached and will either enroll or deny the application based upon Agency Review instructions. A LexisNexis screen-print or report copy will be added to the provider record in the Feith Document Database.

In addition to the above database checks, DXC enrollment staff will also access the Provider Enrollment, Chain and Ownership System (PECOS) for provider types designated as moderate or high risk. This database will indicate whether Medicare has conducted an on-site visit within the past 5 years. If a visit was conducted by Medicare, the enrollment process will continue. If a visit was not conducted by Medicare within the last 5 years, the enrollment application will be staged and a notification will be sent to DXC staff to conduct an unannounced site visit. **Note that all newly enrolling visit providers should receive a site visit as referenced in the Site Visit Requirements section above.**
The above described database checks are all performed manually. On a monthly basis, all providers, owners, agents, and managing employees will be checked against the EPLS and LEIE databases in an automated process.

Processes to Ensure Alignment of State Ownership Data with PECOS

If a provider is required to be enrolled in Medicare prior to enrollment with Medicaid, the 5% owners submitted to Medicaid should match the 5% owners reported to Medicare. The application process cannot proceed until the 5% owners match. Providers should also report to Medicaid any officers, directors, managing employees, agents, etc. Note that the definition of a managing employee encompasses anyone such as a general manager, administrator, director, or others that exercise managerial control or conducts the day to day operation of the provider, facility, or supplier. This would not include board members unless they conduct such business processes. It is expected that the affiliate information (officers, directors, managing employee, etc.) reported to Medicaid match with what was reported to Medicare; however, if it does not, we can accept what the provider submitted and move forward with the application. The main objective is to make sure the 5% owners reported to Medicaid match the PECOS information. It would be optimal for the other affiliates to match as well, but we can move forward with the app as long as the 5% owners match. It is prudent to ask the providers to update with Medicare any affiliate information that may have changed, but that should not stop the enrollment process. When changes occur, providers have a responsibility to update their information with Medicare as well as Medicaid. Disclosure forms are required for all individuals or entities listed in Medicare

as 5% owners as well as other officers, directors, managing employees, etc. If there are not any 5% owners present on the Medicare file, no match is required.

The 5% ownership should be checked at reenrollment as well. If the 5% owners are noted as not matching when reenrollment occurs, the Reenrollment representative should notify the provider of this issue and have them get the information updated with Medicare prior to completing the reenrollment.

Note: Provider enrollment staff should always follow their normal application rules and processes on requesting additional information and returning applications even when it comes to the 5% owner issue.

DENIAL OF ENROLLMENT INSTRUCTIONS

Applications may be denied enrollment by the state for several reasons to include issues with disclosure information present on the application, licensure limitations or other reasons specified by the state. When the state denies enrollment to a provider, the provider must receive a denial of enrollment letter from the enrollment unit. In addition to the denial letter to the provider, a copy of the letter must be sent to:

John Conroy, Office of Inspector General, DHHS/OIG/OI

7175 Security Boulevard Suite 210

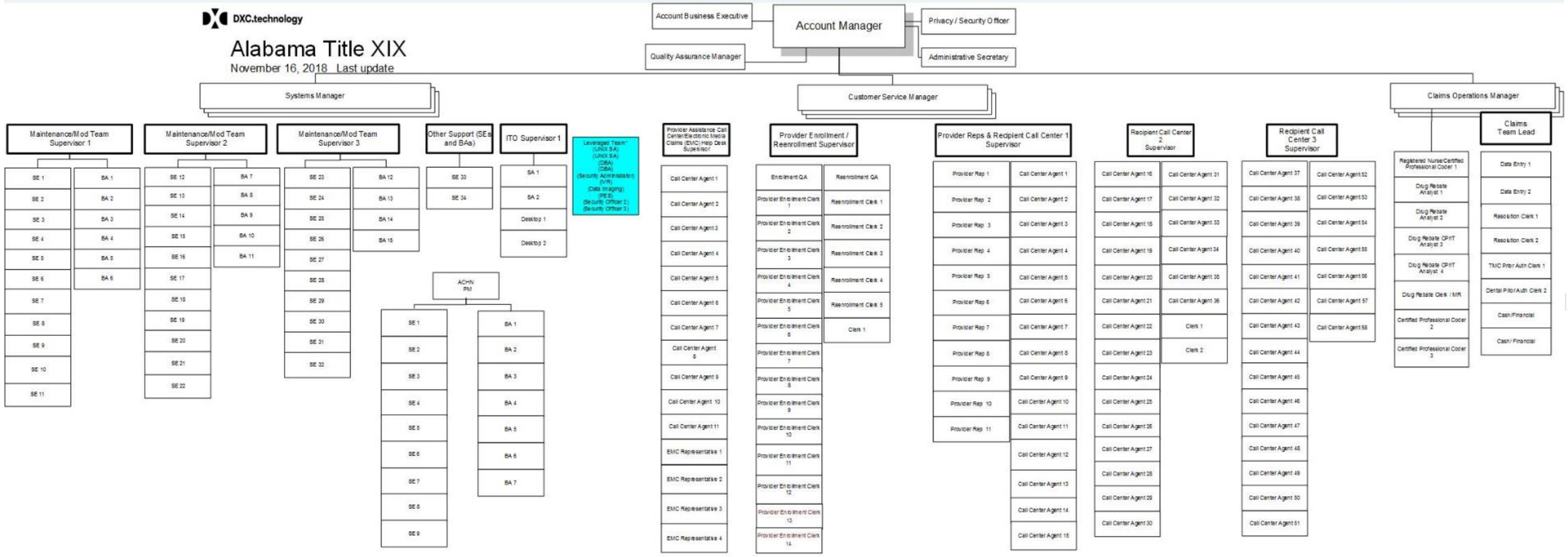
Baltimore, MD 21244-1857

The denial letter should be scanned in with the denied application.

DXC.technology

Alabama Title XIX

November 16, 2018 Last update



The information contained herein is confidential, proprietary, and trade secret of DXC Technology and is provided solely for use in connection with the 2012 Alabama Medicaid Fiscal Agent Contract. The information shall only be accessed or disclosed by those individuals who have a need and requirement to such access.

Checkwrite Schedule 10/6/17 – 9/14/18

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.

October 6, 2017
October 20, 2017
November 3, 2017
November 10, 2017
December 1, 2017
December 15, 2017
January 5, 2018
January 19, 2018
February 2, 2018
February 16, 2018
March 2, 2018
March 16, 2018
April 6, 2018
April 20, 2018
May 4, 2018
May 18, 2018
June 1, 2018
June 15, 2018
July 6, 2018
July 20, 2018
August 3, 2018
August 17, 2018
September 7, 2018
September 14, 2018

Checkwrite Schedule 10/5/18 – 9/13/19

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.

October 5, 2018
October 19, 2018
November 2, 2018
November 21, 2018
December 7, 2018
December 14, 2018
January 4, 2019
January 18, 2019
February 1, 2019
February 15, 2019
March 1, 2019
March 15, 2019
April 5, 2019
April 19, 2019
May 3, 2019
May 17, 2019
June 7, 2019
June 21, 2019
July 5, 2019
July 19, 2019
August 2, 2019
August 16, 2019
September 6, 2019
September 13, 2019

Eligibility Fax Back

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RECIPIENT ELIGIBILITY VERIFICATION REQUEST INFORMATION
DATE: 07/20/2018 REQUESTING PROVIDER NUMBER: [redacted] TIME: 12:17:14

RECIP NAME: [redacted] RECIP ID: [redacted]
ACCT#:x DOB: [redacted] SEX: M CARD#: 02
REQUESTED DOS: 20171001 AUTHORIZATION CODE: 1820100017
Alert: A replacement card has been issued. Current Card number is 02

ELIGIBILITY INFORMATION
Start Date: 10/01/2017 Stop Date: 10/31/2017
Aid Category: 46
Aid Description: Full Medicaid Coverage

NO CO-PAY ALLOWED FOR PREGNANCY RELATED SERVICES
Benefit Plan: TXIX

Medical Care	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Benefit Plan	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Hospital	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 50.00
Hospital In-pat	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 50.00
Hospital Outpat	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Emergency Svc	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Pharmacy	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Physician Off-Visit	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Vision	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Mental Health	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90
Urgent Care	Co-Ins 0	Deduct 0	Copay Min 0.00	Copay Max 3.90

PLEASE NOTE THAT AWARDED STATUS DOES NOT MEAN EVERY MEMBER IN THE HOUSEHOLD HAS AL MED ICAID COVERAGE
Appl for ELDERLY AND DISABLED MEDICAID Status: Awarded on: 01/26/2017

PMP Name: PMP Start DOS: / /
PMP Phone#: PMP 24-HR#: PMP Plan Code:

LTC/Waiver Eligible: Y Waiver Type: IDWV County Code: [redacted]
City: [redacted] ST: AL Zip: [redacted]
Maternity Care Prov Name: Ph#:

ESPDT screening information includes both fee-for-service and encounter claims data

EPSDT Screening Dates:	Medical	Dental	Vision	Hearing
	N/A	N/A	N/A	N/A

LOCK-IN INFORMATION Lock-In: N
There is no Lock-In information for this client

Benefit Limitations are fee for service benefits only.

BENEFIT LIMITATIONS For the Year 2017. Effective 07/20/2018

Counts For	PAID	PEND
Inpatient Hospital Days	0	0
Outpatient Hospital Days	0	0
Physician Office Visits	0	0
Ambulatory Surgery Center	0	0
Home Health Visits	0	0
Dialysis Services	0	0
Eyeglass Exams	0	0
Eyeglass Fitting Exams	0	0
Eyeglass Frames	0	0

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Eyeglass Lenses	0	0
Eyeglass Exams - Child	0	0
Eyeglass Fitting Exams - Child	0	0
Eyeglass Frames - Child	0	0
Eyeglass Lenses - Child	0	0

DENTAL CATEGORY	DATE	PROVIDER
	N/A	

OTHER INSURANCE INFORMATION TPL Indication: Y

Policy#: [redacted] Subscriber Name: [redacted]
TPL Company Code#: Group Policy#: [redacted] Subscriber#: [redacted]
TPL Coverage Ind: 4 Limitation: 1 HIP Ind: Dates:06/01/2012 - 12/31/2299
TPL Company Name:

Policy#: [redacted] Subscriber Name: [redacted]
TPL Company Code#: 09504 Group Policy#: [redacted] Subscriber#: [redacted]
TPL Coverage Ind: 7 Limitation: 7 HIP Ind: Dates:01/01/2004 - 12/31/2299
TPL Company Name: MEDCO PRESCRIPTION

Household Fax Back

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PAYEE HOUSEHOLD INQUIRY INFORMATION

DATE: 06/22/2018 REQUESTING PROVIDER NUMBER: 800000001 TIME: 16:25:43

RECIP ID REQUESTED: DOB REQUESTED: 04/02/2018

NUMBER OF CHILDREN RECORDS FOUND TO MATCH SEARCH CRITERIA: 1

MEMBER: NAME: SEX: U
DOB: 04/02/2018 RACE: Unknown/Not Provided
CERTIFYING PROGRAM: SOBRA

Recipient LTC FAQ
How many home health visits can a recipient receive during a year?
Can I receive more than 104 visits for home health?
Can I receive physical therapy in the home?
Is physical therapy covered in the nursing home?
Where do I get my diabetic supplies?

Answer	IVR Command
A recipient can receive 104 visits per year.	<press 1>
Children can receive more visits through EPSDT. Adults can receive only 104 visits.	<press 2>
Children can receive physical therapy in the home with prior approval. Adults cannot receive physical therapy in the home.	<press 3>
No, however physical therapy is sometimes covered if the recipient has QMB.	<press 4>
You have to go to a Medicaid durable medical equipment provider in your area.	<press 5>

Recipient NET FAQ
Does Medicaid pay for transportation to my doctor's office?
Do I qualify for Transportation Assistance?
How long does it take for my request for transportation assistance to process?
What do I need to do to receive help to pay for transportation to my doctor's appointment?
What information do I need in order to request Transportation Assistance?

Answer
The Medicaid Non- Emergency Transportation Program is set up to help cover the cost of transportation to and from medically necessary appointments if Medicaid recipients have no other way to get to their appointments without evident hardship.
To qualify for transportation assistance you must receive Full Medicaid Benefits or SOBRA Medicaid Benefits.
Thirty to ninety days or more after the date of the appointment.
In order for Medicaid to pay for a ride, you or someone who is helping you will need to call the Medicaid Non-Emergency Transportation Program either before the date of the appointment or no more than one business day after the date of the appointment. You may contact Non-Emergency Transportation by selecting 6 from the Main Menu, during business hours, which are 8 a.m. to 4:30 p.m., Monday through Friday. When you call, the operator will ask for some information to make sure you are covered by Medicaid and also about your need for a ride. This information will be used to decide if Medicaid can pay for your ride.
In order to request assistance with transportation you will need the following information: Date and time of appointment, Doctor's first and last name, city the provider is in, provider's contact phone number, mode of transportation and the reason for the appointment.

IVR Command
<press 1>
<press 2>
<press 3>
<press 4>
<press 5>

Recipient RCC FAQ
How can I change my Patient 1st doctor?
How do I let Medicaid know that my name and/or address have changed?
How do I get another Medicaid card?
How long will it take to get my Medicaid Card?

Answer
Go to www.medicaid.alabama.gov and choose My Medicaid or you may make the change over the telephone between 8 a.m. to 4:30 p.m., Monday through Friday by selecting option 6 on the main menu, and a customer service representative will be able to assist you. You may also fax your request to 334-215- 4140.
If you received your Medicaid through the Social Security Administration, please contact the local Social Security Office that serves the area where you live. The Social Security Office will let Medicaid know your changes. If you received your Medicaid for foster care, adoption assistance or state supplementation through the Department of Human Resources, please contact the local Department of Human Resources in the county where you live. The local county Department of Human Resources will let Medicaid know your changes. If you receive Parent Other Caretaker Relative (formerly MLIF), contact your Medicaid caseworker in the local county health department. If you received your Medicaid through the health department or if you are receiving Parent Other Caretaker Relative (formerly MLIF) or Transitional Medicaid, please contact your Medicaid caseworker in the local county health department where you live. Your caseworker will make the changes. If you received your Medicaid through one of the Medicaid District Offices you can go to www.medicaid.alabama.gov and choose My Medicaid or, press 6 from the call center main menu to be connected to a representative who can assist you in making the changes in your address.
Go to www.medicaid.alabama.gov and choose My Medicaid or you may make the change over the telephone between 8 a.m. to 4:30 p.m., Monday through Friday, selecting option 6 on the main menu, and a customer service representative will be able to assist you.
From the time your request is received it will be 2 to 4 weeks until you receive your Medicaid card.

IVR Command
<press 1>
<press 2>
<press 3>
<press 4>

Recipient Social Security FAQ
What is the difference between Medicare and Medicaid?
How do I contact Medicare?
How do I apply for disability?

Answer
Medicare is a federal health insurance program for the aged and disabled. Most individuals receive Medicare when they turn 65 years old. If you are not age 65 and are disabled, you may receive Medicare if you meet certain conditions. Medicare has two (2) parts: Part A and Part B. Your Medicare card will say which part you have. Your Medicare card is red, white, and blue. Medicaid is a medical assistance program that is funded both by the federal government and the state. [11617] Alabama Medicaid provides medical care to individuals and families who meet certain eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility. Your Alabama Medicaid card is plastic and has blue, green, and white stripes.
Medicare may be contacted by calling 1- 800-633-4227. This is a free call.
To apply for disability contact the local Social Security Office in the area where you live.

IVR Command
<press 1>
<press 2>
<press 3>

Recipient Apply FAQ
How do I apply for Medicaid?
How do I apply for Medicaid if I am pregnant?
What does QMB (Qualified Medicare Beneficiary) Medicaid cover and how do I apply?
What is the Breast and Cervical Cancer Program, what does it cover, and how do I apply?

Answer
Individuals may apply for Medicaid through the following agencies: The Social Security Administration approves the aged, blind, and disabled individuals for the SSI program. In Alabama, individuals who are approved for SSI are also approved for Medicaid. For information about becoming eligible for Medicaid through the Social Security Administration contact the local Social Security Office in the area where you live. The Alabama Department of Human Resources approves foster children, adoption subsidy or adult state supplementation groups. For information about becoming eligible for Medicaid through the Department of Human Resources contact the local Department of Human Resources Office in the county where you live. The Alabama Medicaid Agency approves individuals for Medicaid who are pregnant, children under the age of 19 years or families with low income. For information about becoming eligible for Medicaid through the Alabama Medicaid Agency contact a Medicaid caseworker in your local county health department. The Alabama Medicaid District Offices approve individuals for Medicaid who are elderly and disabled. For information about becoming eligible for Medicaid through the District Offices contact the Medicaid District Office that services the county where you live.
If you are pregnant, you may apply for Medicaid. Contact the Medicaid Eligibility Worker at your local health department.
Under the QMB program Medicaid pays for the following: The Medicare Part B premium, the Medicare deductible, the Medicare coinsurance, which is the 20% that you normally pay after Medicare pays for its part. Medicaid does not pay for any drugs or other medical services under the QMB program. You will receive a Medicaid card for the QMB program. To be approved for QMB Medicaid you must: Have Medicare Part A. Be living in Alabama Be a citizen of the United States or be in this country legally. Have a monthly income below a certain limit. To apply for QMB Medicaid please contact the Medicaid District Office that services the county where you live.
The Breast and Cervical Cancer Program covers women under the age of 65 who have been screened through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. If you would like to make application for this program please contact your local health department, or call 1-877-252-3324 toll-free.

IVR Command
<press 1>
<press 2>
<press 3>
<press 4>

Recipient Eligibility General FAQ
What is the difference between Medicare and Medicaid?
Does Alabama have a general Medicaid Program?
Which Medicaid District Office serves the county where I live?

Answer
Medicare is a federal health insurance program for the aged and disabled. Most individuals receive Medicare when they turn 65 years old. If you are not age 65 and are disabled, you may receive Medicare if you meet certain conditions. Medicare has two (2) parts: Part A and Part B. Your Medicare card will say which part you have. Your Medicare card is red, white, and blue. Medicaid is a medical assistance program that is funded both by the federal government and the state.[11617] Alabama Medicaid provides medical care to individuals and families who meet certain eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility. Your Alabama Medicaid card is plastic and has blue, green, and white stripes.
No. Alabama does not have a general Medicaid program. Individuals must meet certain age, income, resource limits, and disability requirements to get Alabama Medicaid.
• For the counties of Chambers, Clay, Coosa, Lee, Macon, Randolph, Russell, Talladega, and Tallapoosa - use the Auburn-Opelika District Office. • For the counties of Jefferson, Shelby, and St Clair - use the Birmingham District Office. For the counties of Cullman, and Morgan - use the Decatur District Office. • For the counties of Barbour, Coffee, Covington, Crenshaw, Dale, Geneva, Henry, Houston, and Pike - use the Dothan District Office. • For the counties of Colbert, Franklin, Lauderdale, Lawrence, Marion, and Winston - use the Florence District Office. • For the counties of Blount, Calhoun, Cherokee, Cleburne, Dekalb, Etowah, and Marshall - use the Gadsden District Office. • For the counties of Jackson, Limestone, and Madison - use the Huntsville District Office. • For the counties of Baldwin, Clarke, Escambia, Mobile, and Washington - use the Mobile District Office. • For the counties of Autauga, Bullock, Butler, Chilton, Elmore, Lowndes, and Montgomery - use the Montgomery District Office. • For the counties of Choctaw, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, and Wilcox - use the Selma District Office. • For the Counties of Bibb, Fayette, Greene, Hale, Lamar, Pickens, Tuscaloosa, and Walker – use the Tuscaloosa District Office.

IVR Command
<press 1>
<press 2>
<press 3>

Recipient Other FAQ
Will Medicaid pay for my medicine?
How many times can a person stay in a hospital if they have full Medicaid?
Does Medicaid pay for outpatient care?
How many times will Medicaid pay for doctors visits?
Will Medicaid pay for Eye exams?
Does Medicaid pay for dental services?

Answer
Medicaid pays for most drugs ordered by your doctor, many over the counter drugs are also paid for. There are some drugs which must be approved by Medicaid ahead of time. Your doctor or pharmacist can tell you which drugs Medicaid pays for. Persons who are QMB only or who are SLMB eligible do not receive prescription drug coverage.
Medicaid will pay for 16 inpatient hospital days per calendar year for each person. Pregnant women may have more days if necessary. Children under the age of 21 may receive more hospital days in some cases.
Medicaid pays for 3 non-emergency outpatient hospital visits per calendar year. There are no limits on outpatient hospital visits if you go in for lab work, x-ray services, radiation treatment or chemo-therapy only. Medicaid also pays for 3 outpatient surgical procedures per calendar year if the surgeries are done in a place call an ambulatory surgery center.
Medicaid pays for 14 doctor visits per calendar year. These include visits to the doctor's office, emergency room, healthcare clinics and centers. Medicaid also pays for 16 days of doctors care when you are in the hospital. Children can have more doctors visits in some cases.
Medicaid pays for eye exams and eye glasses once every two calendar years for recipients 21 years of age or older. Recipients under age 21 are authorized for the same service each calendar year or more often if documented medical necessity indicates.
Dental services are covered for children under 21 years of age.

IVR Command
<press 1>
<press 2>
<press 3>
<press 4>
<press 5>
<press 6>

IVR FAQ Sources
http://www.medicaid.alabama.gov/content/9.0_Resources/9.5_FAQ_Pages/9.5.2_FAQ_Applying.aspx
IVR Call Flow: https://pwb.alxix.slg.eds.com/alxix/Subsystem/AVRS/default.asp

External Interface S

External Interface	Subsystem	Direction	Media
HMS Case Claim Extract Layout	Third Party Liability	Input	SFTP
A List of Recip Inbound Files	Recipient	Input	SFTP
A List of Recip Outbound Files	Recipient	Output	SFTP
ADPH 1095 Agency Version File Layout	Recipient	Output	SFTP
ADPH 1095 Print Vendor Version	Recipient	Output	SFTP
AMAES Cross Reference File	Recipient	Input	SFTP
AMAES Recip Address Doctor forwarding address updates	Recipient	Output	SFTP
AMAES Recip Portal Email Updates	Recipient	Output	SFTP
AMAES Recip Portal Plastic Card Requests	Recipient	Output	SFTP
AMAES Recip Portal Updates	Recipient	Output	SFTP
AMAES/E&E Recipient Application Files	DSS	Input	SFTP
AMMIS Extract to AMAES File	Recipient	Output	SFTP
AlaHA Month End Claims Extract	Claims	Output	SFTP
Alabama Board of Chiropractors License Roster	Provider	Input	Secure Email
Alabama Board of Dentistry License Roster	Provider	Input	Secure Email
Alabama Board of Medical Examiners License Roster	Provider	Input	Secure Email
Alabama Board of Nursing License Roster	Provider	Input	Secure Email
Alabama Board of Occupational Therapy License Roster	Provider	Input	Secure Email
Alabama Board of Optometry License Roster	Provider	Input	Secure Email
Alabama Board of Physical Therapy License Roster	Provider	Input	Secure Email
Alabama Board of Podiatry License Roster	Provider	Input	Secure Email
Alabama Board of Psychology License Roster	Provider	Input	Secure Email
Alabama Board of Speech Pathology and Audiology License Roster	Provider	Input	Secure Email
B Notice Process File	Provider	Input	Secure Email
BCBS Refund Reason Codes File	Third Party Liability	Input	SFTP
BCBS Refund Request File	Third Party Liability	Input	SFTP
Bank EFT File	Financial	Output	SFTP
Bank Issue file	Financial	Output	SFTP
Bank Recon File	Financial	Input	Secure Email
CMS EDB File	Recipient	Input	SFTP
CMS EDB File for HMS	Recipient	Output	SFTP
CMS Eligibility Extract File	Recipient	Output	SFTP
CMS Eligibility Response File	Recipient	Input	SFTP
CMS ICD-10 Annual Update Diagnosis File	Reference	Input	Web
CMS ICD-10 Annual Update Procedure File	Reference	Input	Web
CMS ICD-10 Diagnosis Order File	Reference	Input	Web
CMS ICD-10 Procedure Order File	Reference	Input	Web
CMS Quarterly Offset Amount File Incoming	Drug Rebate	Input	SFTP

CMS Quarterly Tape Manufacturer Address Records - Incoming	Drug Rebate	Input	SFTP
CMS Quarterly Tape Rate File - Incoming	Drug Rebate	Input	SFTP
CareCore Prior Authorization Extract Input File	Prior Authorization	Input	SFTP
CareCore Prior Authorization Response File	Prior Authorization	Output	SFTP
CareCore Provider Extract	Provider	Output	SFTP
Claims File Extract for Data Niche Data - Outgoing	Drug Rebate	Output	Cartridge
Clinical Laboratory Improvement Act (CLIA) Oscar	Provider	Input	SFTP
Cognosante DSS Extracts	DSS	Output	SFTP
Daily File with Buyin (Part AB) Data	Recipient	Input	SFTP
Daily Managed Care USACSHI Extract File	Managed Care	Output	SFTP
Department of Public Health DSS Business Objects Connection	DSS	Output	Web
Drug Enforcement Agency (DEA) File	Provider	Input	Secure Email
EPSDT Letters Extract	Recipient	Output	SFTP
ERX Drug Formulary file(s)	ePrescribing	Output	SFTP
ERX Drug Response File	ePrescribing	Input	SFTP
ERX Recipient Load and Update file	ePrescribing	Output	SFTP
ERX Recipient Update Response File	ePrescribing	Input	SFTP
Eligibility Audit Trail Extract	Recipient	Output	SFTP
EviCore DSS Claims Extract	DSS	Output	SFTP
Extract of COB Reported MBIs	Recipient	Output	SFTP
FDB Drug Update Files	Reference	Input	SFTP
Financial ATP FIN-PR30-R file	Financial	Output	SFTP
Financial ATP FIN-PR31-R file	Financial	Output	SFTP
Financial ATP FIN-PR32-R file	Financial	Output	SFTP
Financial Electronic Invoice File	Financial	Output	SFTP
HID Claim File	Claims	Output	SFTP
HID Drug Coverage Extract file	Reference	Output	SFTP
HID Drug Extract files	Reference	Output	SFTP
HMS (PCG) Month End Claims Extract	Claims	Output	SFTP
HMS Case Event Upload Layout	Third Party Liability	Output	SFTP
HMS Case Payment Upload Layout	Third Party Liability	Output	SFTP
HMS Case Upload Layout	Third Party Liability	Output	SFTP
HMS Case Value Upload Layout	Third Party Liability	Output	SFTP
HMS Contact and Organization Layout	Third Party Liability	Output	SFTP
HMS Estate Case Recovery Extract File	Third Party Liability	Input	SFTP
HMS Refund Request File	Third Party Liability	Input	SFTP
HealthTech Solutions has DSS Business Objects Connection	DSS	Output	Web
IRS 1095 File for Print Vendor	Recipient	Output	SFTP
LTC Admission Notification File	Long Term Care	Input	Web
M and S Pharmacy Claims Extract	Claims	Output	SFTP
MYERS And STAUFFER Drug Update Files	Reference	Input	SFTP
Managed Care 820 Extract File	Managed Care	Output	SFTP
Med Solutions DSS Claims Extract	DSS	Output	SFTP

MedSolutions Prior Authorization Input File	Prior Authorization	Input	SFTP
MedSolutions Prior Authorization Response File	Prior Authorization	Output	SFTP
MedSolutions Provider extract file	Provider	Output	SFTP
MedSolutions Recipient Extract	Recipient	Output	SFTP
Medicaid Agency DSS Extracts	DSS	Output	SFTP
Medicare Data Extract	Recipient	Output	SFTP
Monthly Eligibility and County Extract	Recipient	Output	SFTP
Monthly MC and-or LTC Wvr File	Managed Care	Output	SFTP
Monthly Managed Care USACSHI Extract File	Managed Care	Output	SFTP
Monthly Medicare Coverage Extract File	Recipient	Output	SFTP
Monthly Recipient Application Extract	Recipient	Output	SFTP
Monthly Recipient Reconciliation File	Recipient	Output	SFTP
Monthly financial transactions file	Financial	Output	SFTP
Nightly Recipient Elig Updates to External Sources	Recipient	Output	SFTP
OIG DSS Claims Extract	DSS	Output	SFTP
OIG Monthly MC File	Managed Care	Output	SFTP
Office of Inspector General Sanctioned Providers file	Provider	Input	Secure Email
Optumas DSS Extracts	DSS	Output	SFTP
Part D Agency File for HMS	Recipient	Output	SFTP
Part D Eligibility File	Recipient	Input	SFTP
Patient 1st Initial Assignment Letter Extract for Mailing Service	Managed Care	Output	SFTP
Patient 1st Provider Directory Extract for Mailing Service	Managed Care	Input	SFTP
Patient 1st Recent Recert Postcard Extract for Mailing Service	Managed Care	Output	SFTP
Plastic ID Card Extract File	Recipient	Output	SFTP
ProDUR criteria files from DXC National Systems	Drug Utilization Review	Input	SFTP
Provider DUR Contractor Interface	Provider	Output	SFTP
Provider Extract File	Provider	Output	SFTP
Provider File Extract for Data Niche Data - Outgoing	Drug Rebate	Output	Cartridge
Provider License semi-monthly extract file	Provider	Output	SFTP
Provider MU Extract File	Provider	Output	SFTP
Provider educational mail out extract file	Provider	Output	SFTP
Qtrly Financial Transpl Exp File	Financial	Output	SFTP
Qualis has BO Deski Installed and DSS Connection	DSS	Output	Web
Quarterly Durable Medical Equipment CCI Update File	Reference	Input	Secure Email
Quarterly Durable Medical Equipment MUE Update Report File	Reference	Input	Secure Email
Quarterly Invoice Extract for CMS - Outgoing	Drug Rebate	Output	Cartridge
Quarterly Outpatient Hospital CCI Update file	Reference	Input	Secure Email

Quarterly Outpatient Hospital MUE Update file	Reference	Input	Secure Email
Quarterly Practitioner CCI Update file	Reference	Input	Secure Email
Quarterly Practitioner MUE Update file	Reference	Input	Secure Email
Recip INH, IWA and IWE SC File	Managed Care	Input	SFTP
Recip SFC, RTF and IMD SC file	Managed Care	Input	SFTP
Recipient ADPHE Count Layout	Recipient	Input	SFTP
Recipient AMAES Rekey File	Recipient	Input	SFTP
Recipient AMAES Update File	Recipient	Input	SFTP
Recipient AR Tax Intercept File	Recipient AR	Output	SFTP
Recipient Cross Reference File	Recipient	Output	SFTP
Recipient Data Sheet Request File	Claims	Input	SFTP
Recipient Duplicate ID SC file	Managed Care	Input	SFTP
Recipient Inbound NCOA Extract	Recipient	Input	SFTP
Recipient Outbound NCOA Extract	Recipient	Output	SFTP
Recipient Risk Level Special Condition File	Managed Care	Input	SFTP
RetroDUR Information Transfer to the retrodur contractor	Drug Utilization Review	Output	SFTP
Semi-Monthly Eligibles for EDB	Recipient	Output	SFTP
State Month End Claims Extract	Claims	Output	SFTP
T-MSIS ADPH Eligibles File	MAR	Input	SFTP
T-MSIS Acknowledgement File	MAR	Input	SFTP
T-MSIS BCBS CLAIMIP File	MAR	Input	SFTP
T-MSIS BCBS CLAIMLT File	MAR	Input	SFTP
T-MSIS BCBS CLAIMOT File	MAR	Input	SFTP
T-MSIS BCBS CLAIMRX File	MAR	Input	SFTP
T-MSIS BCBS Provider File	MAR	Input	SFTP
T-MSIS BCBS TPL File	MAR	Input	SFTP
T-MSIS CLAIMIP File	MAR	Output	SFTP
T-MSIS CLAIMLT File	MAR	Output	SFTP
T-MSIS CLAIMOT File	MAR	Output	SFTP
T-MSIS CLAIMRX File	MAR	Output	SFTP
T-MSIS Eligibles File	MAR	Output	SFTP
T-MSIS Error Report File	MAR	Input	SFTP
T-MSIS Error Summary Report File	MAR	Input	SFTP
T-MSIS Managed Care File	MAR	Output	SFTP
T-MSIS Provider File	MAR	Output	SFTP
T-MSIS TPL File	MAR	Output	SFTP
TPL BCBS of Alabama 277CA Receive File	Third Party Liability	Input	SFTP
TPL BCBS of Alabama 835 Receive File	Third Party Liability	Input	SFTP
TPL BCBS of Alabama 837	Third Party Liability	Output	SFTP
TPL BCBS of Alabama 999	Third Party Liability	Output	SFTP
TPL Daily on request Mass Void Claim File	Third Party Liability	Input	SFTP
TPL Data Match BCBS of Alabama 270 Send File	Third Party Liability	Output	SFTP

TPL Data Match BCBS of Alabama 271 Receive File	Third Party Liability	Input	SFTP
TPL Data Match DEERS Receive File	Third Party Liability	Input	SFTP
TPL Data Match DEERS Send File	Third Party Liability	Output	SFTP
TPL Data Match DHR Carrier Extract	Third Party Liability	Output	SFTP
TPL Data Match DHR Receive File	Third Party Liability	Input/Outpu	SFTP
TPL Data Match DHR Recipient Extract	Third Party Liability	Output	SFTP
TPL Data Match UAIC Receive File	Third Party Liability	Input	SFTP
TPL Data Match UAIC Send File	Third Party Liability	Output	SFTP
TPL HMS Accounts Receivable Send File	Third Party Liability	Output	SFTP
TPL HMS Carrier Extract Send File	Third Party Liability	Output	SFTP
TPL HMS Daily Data Match File	Third Party Liability	Input	SFTP
TPL HMS Monthly Data Match File	Third Party Liability	Input	SFTP
TPL HMS Policy Send File	Third Party Liability	Output	SFTP
TPL HMS Quarterly Data Match File	Third Party Liability	Input	SFTP
TPL HMS Recipient Eligibility Daily Send File	Third Party Liability	Output	SFTP
TPL HMS Recipient Eligibility Monthly Send File	Third Party Liability	Output	SFTP
TPL HMS Tricare Data Match File	Third Party Liability	Input	SFTP
TPL HMS Update Data Match File	Third Party Liability	Input	SFTP
TPL Insurance Policy Extract	Third Party Liability	Output	SFTP
TPL Pharmacy NCPDP Send File	Third Party Liability	Input	SFTP
TPL Prime Therapeutics 999	Third Party Liability	Output	SFTP
TPL Southland Data Match Return File	Third Party Liability	Output	SFTP
TPL Southland Quarterly Data Match File	Third Party Liability	Input	SFTP
TPL USASHI Policy Send File	Third Party Liability	Output	SFTP
TPL Weekly SSA Policy File	Third Party Liability	Input	SFTP
UAB - University of Alabama Birmingham has BO Deski Installed and DSS Connection	DSS	Output	Web
UMM - University of Mass Medical has BO Deski Installed and DSS Connection	DSS	Output	Web
USA - University of South Alabama has BO Deski Installed and DSS Connection	DSS	Output	Web
USACSHI BiWeekly Claim Extract	Claims	Output	SFTP
USACSHI Daily Pharmacy Claims	Claims	Output	SFTP
USASCHI Drug Extract Files	Reference	Output	SFTP
University of South Alabama Claims Extract	Claims	Output	SFTP
Updated Recipient HID Extract File Layout	Recipient	Output	SFTP
Weekly Eligibility and County Extract	Recipient	Output	SFTP

Status Report

Entities	Status	Date Occurred
Health Management Systems (HMS)	Documented	10/28/2016
DXC	Documented	4/14/2010
DXC	Documented	2/19/2010
Alabama Department of Public Health (ADPH)	Documented	9/7/2017
Action in Mailing >> Alabama Department of Public Health (ADPH)	Documented	9/7/2017
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services) >> E&E	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	9/22/2008
Alabama Medicaid Agency (Beneficiary Services) >> E&E >> HID Health Information Design >> University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/28/2016
Alabama Hospital Association (AlaHA)	Documented	7/24/2008
Alabama Chiropractor License Board	Documented	9/22/2008
Alabama Dental License Board	Documented	9/22/2008
Alabama Physician's License Board	Documented	9/22/2008
Alabama Nurse License Board	Documented	9/22/2008
Alabama Occupational Therapists License Board	Documented	9/22/2008
Alabama Optometrists License Board	Documented	9/22/2008
Alabama Physical Therapists License Board	Documented	9/22/2008
Alabama Podiatrists License Board	Documented	9/22/2008
Alabama Psychiatrists License Board	Documented	9/22/2008
Alabama Speech Therapists License Board	Documented	9/22/2008
DXC	Documented	1/28/2014
Blue Cross and Blue Shield of Alabama	Documented	5/24/2018
Blue Cross and Blue Shield of Alabama	Documented	5/24/2018
Regions Bank	Documented	7/30/2008
Regions Bank	Documented	7/30/2008
Regions Bank	Documented	7/30/2008
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
CMS (Or designated Contractor)	Documented	10/28/2016
Center for Medicare and Medicaid Services (CMS)	Documented	10/28/2016
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
CMS (Or designated Contractor)	Documented	6/1/2018

Center for Medicare and Medicaid Services (CMS)	Documented	9/22/2008
Center for Medicare and Medicaid Services (CMS)	Documented	9/22/2008
CareCore	Documented	11/30/2017
CareCore	Documented	11/30/2017
CareCore	Documented	9/7/2017
Data Niche Data	Documented	9/22/2008
CMS (Or designated Contractor)	Documented	1/29/2014
Cognasante	Documented	9/21/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	9/7/2017
University of South Alabama Center for Strategic Health Innovation(USACSHI)	To Be Archived	10/16/2018
Alabama Department of Public Health (ADPH)	Documented	12/16/2013
Drug Enforcement Agency (DEA)	Documented	1/29/2014
Alabama Medicaid Agency	Documented	10/28/2016
SureScripts	Documented	6/8/2011
SureScripts	Documented	10/31/2016
SureScripts	Documented	10/31/2016
SureScripts	Documented	10/31/2016
Alabama Medicaid Agency	Documented	10/28/2016
CareCore	Documented	11/10/2016
Alabama Medicaid Agency	Documented	5/24/2018
First Data Bank (FDB)	Documented	6/15/2008
Alabama Medicaid Agency	Documented	5/24/2018
Alabama Medicaid Agency	Documented	5/24/2018
Alabama Medicaid Agency	Documented	5/24/2018
Alabama Medicaid Agency	Documented	7/30/2008
HID Health Information Design	Documented	7/24/2008
HID Health Information Design	Documented	5/24/2018
HID Health Information Design	Documented	5/24/2018
Health Management Systems (HMS)	Documented	7/24/2008
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Blue Cross and Blue Shield of Alabama	Documented	5/24/2018
Health Tech Solutions (HTS)	Documented	5/31/2018
Action in Mailing	Documented	10/28/2016
Alabama Medicaid Agency >> DXC >> Qualis	Full Production load	9/28/2012
M&S Myers & Stauffer	Documented	8/11/2011
M&S Myers & Stauffer	Documented	5/24/2018
VIVA	Documented	9/1/2015
MedSolutions	Documented	12/16/2013

MedSolutions	Documented	11/30/2017
MedSolutions	Documented	11/30/2017
MedSolutions	Documented	9/7/2017
CareCore >> MedSolutions	Documented	10/28/2016
Alabama Medicaid Agency	Documented	12/16/2013
Office of Inspector General (OIG)	Documented	10/28/2016
Center for Medicare and Medicaid Services (CMS) >> Office of Inspector General (OIG)	Documented	10/28/2016
Alabama Medicaid Agency >> Center for Medicare and Medicaid Services (CMS) >> Optumas	Documented	3/20/2013
University of South Alabama Center for Strategic Health Innovation(USACSHI)	To Be Archived	10/16/2018
Health Management Systems (HMS)	Documented	10/28/2016
Optumas	Documented	10/28/2016
Alabama Medicaid Agency >> Alabama Medicaid Agency (Beneficiary Services) >> HID Health Information Design >> Office of Inspector General (OIG) >> Optumas >> University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/28/2016
Alabama Medicaid Agency >> HID Health Information Design	Documented	7/30/2008
HID Health Information Design >> University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/28/2016
Office of Inspector General (OIG)	Documented	11/10/2016
Office of Inspector General (OIG)	Documented	4/22/2016
Federal Office of Inspector General (OIG)	Documented	9/22/2008
Optumas	Documented	12/16/2013
Health Management Systems (HMS)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Publications Press, Inc (formally Graphics & Mailing)	To Be Archived	9/24/2018
Publications Press, Inc (formally Graphics & Mailing)	To Be Archived	9/24/2018
Publications Press, Inc (formally Graphics & Mailing)	To Be Archived	9/24/2018
DXC Indiana Title XIX	Documented	10/28/2016
DXC National Systems	Documented	9/22/2008
HID Health Information Design	Documented	1/28/2014
Alabama Medicaid Agency >> Center for Medicare and Medicaid Services (CMS) >> Cognasante >> Health Management Systems (HMS) >> Navigant Consulting, Inc >> Optumas	Documented	1/6/2014
Data Niche Data	Documented	9/22/2008
Cognasante	Documented	11/19/2008
Health Tech Solutions (HTS)	Documented	8/16/2016
Publications Press, Inc (formally Graphics & Mailing)	Documented	9/19/2013
Alabama Medicaid Agency	Documented	5/22/2017
Qualis	Documented	12/16/2013
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	12/16/2010
CMS (Or designated Contractor)	Documented	7/17/2009
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018

Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Center for Medicare and Medicaid Services (CMS)	Documented	5/24/2018
Alabama Medicaid Agency	Identified - New	8/1/2018
Alabama Medicaid Agency	Documented	7/14/2016
Alabama Department of Public Health (ADPH)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Medicaid Agency (Beneficiary Services)	Documented	10/28/2016
Alabama Department of Revenue	Documented	10/27/2016
Alabama Medicaid Agency >> Bizware >> CareCore >> HID Health Information Design >> MedSolutions >> Optumas >> University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/28/2016
Alabama Medicaid Agency	Documented	10/31/2016
Alabama Medicaid Agency	To Be Archived	10/16/2018
Anchor Computer Software	Documented	10/28/2016
Anchor Computer Software	Documented	10/28/2016
Alabama Medicaid Agency	To Be Archived	10/16/2018
HID Health Information Design	Documented	9/22/2008
Alabama Medicaid Agency (Beneficiary Services)	Identified - New	2/12/2015
Alabama Medicaid Agency	Documented	7/24/2008
Alabama Department of Public Health (ADPH)	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	4/30/2015
Blue Cross and Blue Shield of Alabama	Documented	5/6/2015
Blue Cross and Blue Shield of Alabama	Documented	5/6/2015
Blue Cross and Blue Shield of Alabama	Documented	5/6/2015
Blue Cross and Blue Shield of Alabama	Documented	4/29/2015
Blue Cross and Blue Shield of Alabama	Documented	5/6/2015
Blue Cross and Blue Shield of Alabama	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	10/31/2016
CMS (Or designated Contractor)	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	5/6/2015
CMS (Or designated Contractor)	Documented	4/30/2015
CMS (Or designated Contractor)	Documented	4/30/2015
CMS (Or designated Contractor)	Documented	4/28/2015
CMS (Or designated Contractor)	Documented	10/31/2016
CMS (Or designated Contractor)	Documented	10/31/2016
Blue Cross and Blue Shield of Alabama >> Health Management Systems (HMS)	Documented	9/9/2011
Blue Cross and Blue Shield of Alabama	Documented	10/31/2016
Blue Cross and Blue Shield of Alabama	Documented	10/31/2016
Blue Cross and Blue Shield of Alabama	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Blue Cross and Blue Shield of Alabama	Documented	10/31/2016

Blue Cross and Blue Shield of Alabama	Documented	10/31/2016
Defense Eligibility Enrollment Reporting System (DEERS)	Documented	10/31/2016
Defense Eligibility Enrollment Reporting System (DEERS)	Documented	10/31/2016
Department of Human Resources (DHR)	Documented	10/31/2016
Department of Human Resources (DHR)	Documented	10/31/2016
Department of Human Resources (DHR)	Documented	10/31/2016
United American Insurance Company (UAIC)	Documented	10/31/2016
United American Insurance Company (UAIC)	Documented	10/31/2016
Health Management Systems (HMS)	Documented	10/31/2016
Health Management Systems (HMS)	Documented	10/31/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/31/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/31/2016
Health Management Systems (HMS)	Documented	10/28/2016
Health Management Systems (HMS)	Documented	10/28/2016
Alabama Medicaid Agency	Documented	11/3/2017
Blue Cross and Blue Shield of Alabama >> Prime Therapeutics	Documented	10/31/2016
Prime Therapeutics	Documented	10/28/2016
Southland Benefit Solutions	Documented	10/28/2016
Southland Benefit Solutions	Documented	10/28/2016
University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/28/2016
Alabama Medicaid Agency	Documented	10/28/2016
University of Alabama Birmingham (UAB)	Documented	12/16/2013
University of Massachusetts Medical (UMM)	Documented	12/16/2013
University of South Alabama (USA)	Documented	12/16/2013
University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	7/24/2008
University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	10/31/2016
University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	5/24/2018
University of South Alabama Center for Strategic Health Innovation(USACSHI)	Documented	7/25/2008
Appriss >> HID Health Information Design	Documented	10/28/2016
Alabama Medicaid Agency >> Optumas	Documented	10/28/2016

Checkwrite Schedule 10/7/16 – 9/15/17

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.

October 7, 2016
October 21, 2016
November 4, 2016
November 11, 2016
December 2, 2016
December 16, 2016
January 6, 2017
January 20, 2017
February 3, 2017
February 17, 2017
March 3, 2017
March 17, 2017
April 7, 2017
April 21, 2017
May 5, 2017
May 19, 2017
June 2, 2017
June 16, 2017
July 7, 2017
July 21, 2017
August 4, 2017
August 18, 2017
September 8, 2017
September 15, 2017

Alabama Medicaid Agency

DXC.technology

Provider Electronic Solutions User Guide

HIPAA Compliant

May 2018

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1 Introducing Provider Electronic Solutions

Thank you for using Hewlett Packard Enterprise *Provider Electronic Solutions*. This software supports the processing of Health Insurance Portability and Accountability Act (HIPAA) ready transactions.

The HIPAA ready forms available for billing and inquiring Alabama Medicaid include the following: 837 Dental, 837 Institutional Inpatient/Outpatient, 837 Institutional Nursing Home, 837 Professional, 278 Prior Authorization, 270 Eligibility Request, 276 Claim Status Request, NCPDP Pharmacy and Pharmacy Reversal, and RX Eligibility. Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Provider Electronic Solutions is available at no charge to Alabama Medicaid providers. This user manual is designed to augment the online help that accompanies the *Provider Electronic Solutions* software. It also provides installation procedures and a contact number for the DXC Technology Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility verification, claim status inquiry, prior authorization request and claims submission.

Chapter 1, Introducing *Provider Electronic Solutions*, is comprised of three sections:

- *What You Need to Know to Use Provider Electronic Solutions*, provides definitions for important electronic claims submission, eligibility verification, prior authorization and claim status concepts.
- *How to Use this Manual*, describes the contents of the user manual.
- *Where to Get Help*, provides a contact list for the EMC Help Desk and other DXC Technology personnel who can assist you with claims-related questions.

1.1 What You Need to Know to Use *Provider Electronic Solutions*

Below are some terms and concepts that will enhance your ability to use *Provider Electronic Solutions*:

Submitting through Batch

Batch submission refers to sending groups of eligibility verification, claim status, prior authorization requests or claims to DXC Technology. A batch may contain one record or many records. These transactions are sent to the DXC Technology system via our public-Internet website. DXC Technology processes the batches of transactions and returns a response to the website. Providers may retrieve their responses through the *Provider Electronic Solutions* application.

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Using a Personal Computer

Provider Electronic Solutions operates in a Microsoft® Windows™ environment. The software is user-friendly and features point-and-click functionality and online help, just like other Windows applications.

To use *Provider Electronic Solutions*, you should have basic knowledge about personal computers (PC) and be able to navigate in Microsoft Windows. Specifically, you should know how to:

- Use a mouse, drop down menus, and navigation buttons.
- Toggle between open windows on your desktop.
- Determine some information about your PC's hard drive and be able to distinguish between a hard drive and a disk (or CD) drive. For instance, you should have a good idea about how much Random Access Memory (RAM) you have, and especially how much disk space (space available on your hard drive) you have. Chapter 2, 'Installing *Provider Electronic Solutions*', describes archiving, file retention, and other subjects that impact your PC's available space.
- Access the Windows Control Panel. Section 2.5, 'Setting up Personal Options', provides a brief description of how to use the Control Panel to research information about your modem.
- Determine a file and path name as necessary. The path name refers to a specific drive (for instance, your hard drive, CD-ROM drive, or 3 ½" diskette drive) and folders within those drives, if applicable.

Your Microsoft Windows user guide should give you information about these topics if you aren't already familiar with them.

Internet Access

Since *Provider Electronic Solutions* submits batch transactions through the public Internet, your PC must have a method of connecting to the Web. An Internet Service Provider (ISP) can provide this connection through a dial-up modem, digital subscriber line (DSL) or a Cable link. Optionally, DXC Technology provides a Remote Access Server (RAS) to gain access to this web site only. Your computer can dial into the RAS using a Modem, RAS is now a toll-free service. An Internet browser will also be required to maintain your security identification number and password. The DXC Technology software is written to work best using the Internet Explorer Browser. This software is available to download from the Alabama Medicaid homepage at **http://www.medicaid.alabama.gov** and from the Help Option on the secure HIPAA web site.

Using a Modem

Your modem may be part of your PC, or attached to your PC. Regardless, it must also be attached to a working phone line. Section 2.5, Setting Up Personal Options, describes how to set up *Provider Electronic Solutions* with your modem information.

Provider Electronic Solutions User Manual versus the Alabama Medicaid Provider Manual

This user manual describes: how to install and set up *Provider Electronic Solutions*, how to navigate in *Provider Electronic Solutions*, how to establish lists to suit your business needs, how to complete the required and optional fields on the electronic forms, how to submit transactions, and how to produce reports. **It does not provide program-specific**

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information. The user manual describes how to complete the electronic claim forms correctly to enable you to submit claims that pay correctly.

Providers should review Part I of the *Alabama Medicaid Provider Manual*, plus the appropriate program chapter in Part II of the manual, for program-specific and claims filing instructions. For instance, the *Provider Electronic Solutions User Manual* will not provide instructions on submitting claims with third party denials, or inform the user which recipient aid categories allow for full Medicaid coverage, or whether a particular procedure code requires prior authorization. Refer to the *Alabama Medicaid Provider Manual* for this information.

NOTE:

If you did not receive a copy of the *Alabama Medicaid Provider Manual,* contact DXC Technology Provider Relations at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid homepage at **http://www.medicaid.alabama.gov/**

1.2 How to Use This Manual

This manual is comprised of the following chapters:

	Chapter Title	***Contents***
1.	Introducing *Provider Electronic Solutions*	Describes what you need to know to use *Provider Electronic Solutions*, how to use the user manual, and who to contact if you have questions.
2.	Installing *Provider Electronic Solutions*	Covers equipment requirements, getting a copy of PES, installation procedures, setting up personal options, installing software updates, and other maintenance options such as archiving and database recovery.
3.	Getting Around	Describes general navigation concepts and provides an overview of the online help feature.
4.	Customizing PES	Provides instructions on how to complete certain lists required for transmission, as well as how to use the lists options.
5.	Verifying Eligibility	Provides instructions for submitting batch eligibility verification requests.
6.	Submitting 837 Dental Claims	Provides instructions on entering claims in the electronic Dental Claim form and submitting the dental claims via a web server or diskette.
7.	Submitting NCPDP Pharmacy Claims	Provides instructions on entering Pharmacy claims in the electronic NCPDP Pharmacy form and submitting the NCPDP Pharmacy claims through web server or diskette.
8.	Submitting 837 Professional Claims	Provides instructions for entering claims in the electronic 837 Professional claim form and submitting the 837 Professional claims via a web server or diskette.
9.	Submitting 837 Institutional Inpatient Claims	Provides instructions for entering claims in the electronic 837 Institutional Inpatient claim form and submitting the 837 Institutional Inpatient claims via a web server or diskette.
10.	Submitting 837 Institutional Outpatient Claims	Provides instructions for entering claims in the electronic 837 Institutional Outpatient claim form and submitting the 837 Institutional Outpatient claims via a web server or diskette.
11.	Submitting 837 Institutional Nursing Home Claims	Provides instructions for entering claims in the electronic 837 Institutional Nursing Home claim form and submitting the 837 Institutional Nursing Home claims via a web server or diskette.
12.	Submitting Claim Reversals	Provides instructions for entering reversals or adjustments in the electronic claim forms and submitting the request via a web server or diskette.

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	Chapter Title	***Contents***
13.	Viewing Response files	Provides instructions on how to receive an electronic response to the claims submitted via web server or diskette.
14.	Generating Reports	Provides instructions on how to generate a summary or detailed report based on the options from the reports screen.
15.	Submitting 278 Prior Authorization request	Provides instructions for entering a request in the electronic 278 Prior Authorization request form and submitting the 278 Prior Authorization request via a web server or diskette.
16.	Submitting 276 Claim Status request	Provides instructions for entering a request in the electronic 276 Claim Status request form and submitting the 276 Claim Status request via a web server or diskette.
17.	Connecting to the Web Server	Provides instructions for connecting to the web server to keep your password updated accordingly. These instructions include connecting through an ISP (Internet Service Provider) or through RAS (Remote Access Server).

Many of the manual chapters feature step-by-step instructions accompanied by illustrations. Throughout the manual, note boxes are used to draw the reader's attention to important concepts.

1.3 Where to get Help

Provider Electronic Solutions features extensive, field-level online help available by pressing <F1>. Certain windows feature a **Help** button which accesses field level help. Field level help means that you can position your cursor in a field you are unfamiliar with, press <F1> or the **Help** button, if applicable, and read the online help to determine the usage of that field. DXC Technology provides a user manual on CD-ROM and online help to ensure access to as much information as possible about *Provider Electronic Solutions*.

If you still have questions, or if you encounter difficulty using *Provider Electronic Solutions* or dialing into the DXC Technology system, contact the Electronic Media Claims (EMC) Help Desk at 1 (800) 456-1242. The Help Desk staff is available from 7:00 a.m. to 8:00 p.m., Monday through Friday, excluding holidays. In addition, pharmacy providers may access the EMC Help Desk from 9:00 a.m. to 5:00 p.m. on Saturdays, including holidays.

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2

2 Installing HIPAA Provider Electronic Solutions

This chapter covers equipment requirements, instructions on obtaining a copy of *Provider Electronic Solutions*, installation procedures, setting up personal options, installing software upgrades, and other maintenance options such as archiving and database recovery.

2.1 Equipment Requirements

Before installing *Provider Electronic Solutions*, you must ensure you have the proper equipment. *Provider Electronic Solutions* is designed to operate on a personal computer with the following equipment requirements:

Minimum	Recommended
• Microsoft Internet Explorer Version 6.0	• Microsoft Internet Explorer Version 6.0
• Pentium III	• Pentium IV
• Windows 2000 (service pack 4 or higher)	• Windows XP
• 256 Megabytes RAM	• 512 Megabytes RAM
• 1024 x 768 Resolution	• 1024 x 768 Resolution
• 56K Baud Rate modem (required only for dial-up transmission)	• 56K+ Baud Rate modem (required only for dial-up transmission)
• CD/ROM drive	• Printer with 8pt MS Sans Serif font (Optional)
• 100 Megabytes free Hard Drive space	
• Dial-Up Networking (If user has no ISP, Internet Service Provider)	

NOTE:

Providers who wish to install *Provider Electronic Solutions* on a Local Area Network (LAN) or configuration other than a stand-alone personal computer should contact the Hewlett Packard Enterprise Electronic Media Claims (EMC) Help Desk at 1 (800) 456-1242 for instructions.

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2.2 Getting a Copy of *Provider Electronic Solutions*

You can receive a copy of the software in several media. Use the table below to determine the best media for you.

Media	***How to Get it***
CD/ROM	Contact the EMC Help Desk at 1 (800) 456-1242. DXC Technology will send you one CD/ROM with accompanying documentation.
Zip™ file	Download from the Alabama Medicaid website at **http://www.medicaid.alabama.gov** Please note that the downloading process may take a long time due to the size of the application file and your connection speed.

When you receive the CD/ROM, store it in a safe place. In the event the program and files are damaged or deleted while on your PC, you must re-install *Provider Electronic Solutions* from the CD/ROM.

NOTE:

Please note that upgrade versions of the software, as described in Section 2.6, Installing Software Upgrades, do not replace a full installation. You must re-install *Provider Electronic Solutions* if the files or programs are damaged or deleted. Contact the EMC Help Desk at 1 (800) 456-1242 for assistance.

2.3 Installation Procedures

You should install your *Provider Electronic Solutions* software only once, unless the software is damaged while on your PC.

Updated versions of the software contain enhancements to the application. These updated releases may be downloaded from the Alabama Medicaid website at http://www.medicaid.alabama.gov/content/7.0_Providers/7.8_PES_Software.aspx. See Section 2.6, Installing Software Updates, for more information.

The installation procedures vary slightly depending on the way you received the software (CD/ROM or Zip file, as described above). This section describes installation procedures from CD, and installation procedures from a Zip file (downloaded from the Web).

2.3.1 Installing from CD

NOTE:

Providers are strongly encouraged to exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications.

This section provides step-by-step instructions for installing *Provider Electronic Solutions* on a PC running at least Windows 2000.

Windows 2000/XP has some special installation instructions. DXC Technology can fax or email a copy of the instructions upon request. Contact the EMC Helpdesk at 1-800-456-1242 for Windows 2000/XP installation instructions.

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Installing from Provider Manual CD

Step 1 Place the *Alabama Medicaid Provider Manual CD* into your CD drive. Double-click on the My Computer icon on your desktop. Double-Click on your CD-ROM drive.

Step 2 Double-Click on the PES folder. Double-Click on PES_setup.exe. Click Next.

Step 3 The setup window should now be displayed. Choose the type of installation to be executed.

Step 4 Choose the default setup type (Typical) unless you have contacted the EMC Help Desk for instructions on workstation setup.

NOTE:

Typical – Installs all the files, **including** the database. This installation is used to install the software to a stand-alone PC, or to initially install the software to a network server. Most installations will be typical installations.

Workstation – Used to add the software to additional PCs that are connected to a network server, where all users share a database. This installation type does not load the database files to the PC; however, it does allow for sharing the database files that were installed to the network.

Step 5 Click 'Next' to continue. The Choose Destination Location window displays.

Step 6 Click 'Next' to choose the default destination folder (recommended) or click Browse to select another destination folder. Then click 'Next' to advance the setup program. The following message displays:

Please note the database destination folder for future WORKSTATION setups.

Step 7 Click 'OK' to access the Setup Complete window. Click 'Finish' to complete setup.

The setup program creates an icon on your desktop for AL DXC Technology *Provider Electronic Solutions*. To access the application, double-click on the icon. The AL DXC Technology *Provider Electronic Solutions* window displays.

Double-click on the AL DXC Technology *Provider Electronic Solutions* icon. For information on the Upgrade icon that also displays in the *Provider Electronic Solutions* window, see Section 2.6, Installing Software Updates.

2.3.2 Installing from a Zip File

NOTE:

Providers are strongly encouraged to exit all other Windows programs before running the setup program. This includes MS Word, e-mail systems, or other applications.

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These instructions assume you are familiar with your Web browser and have used it to access the Internet to download information.

Access the Alabama Medicaid homepage at the following address:

http://www.medicaid.alabama.gov

Step 1 Click on the 'Providers' link

Step 2 Click on the Provider Electronic Solutions Software link. The *Provider Electronic Solutions* Software Specifications page displays.

Step 3 Review the information on the page. Use the scroll bar to move down the page, until you see the Provider Electronic Solutions Full Install.

Step 4 Your browser may ask you if you want to open the application or save it to disk. Choose "Save it to Disk" then click on 'OK' button to choose a directory on your hard drive. Please note this application is too large to fit on a 3.5" diskette. If you choose not to save it to your hard drive, you must have a Zip drive, CD/ROM Write-Once-Read-Many (WORM) recorder, or some other method for saving large files.

Step 5 Wait while the Zip file downloads. The download time varies depending on your Internet connection, your PC's processing speed, and other factors. When the download is complete, access the Zip file through Windows Explorer or File Manager if your download screen closes and continue to step 7, if not continue to step 6.

Step 6 After the download has completed, the download box will ask if you wish to OPEN, OPEN FOLDER, or CLOSE. Choose 'OPEN'. A new box will appear.

Step 7 Double click on "setup.exe" (a blue computer icon may be displayed.) Wait until the Setup Screen Welcome window displays.

Step 8 Click NEXT after reviewing the text in the window.

Step 9 Choose the default setup type (Typical) unless you have contacted the EMC Helpdesk for instructions on workstation setup. Click 'NEXT' to continue. The Choose Destination Location window should now be displayed.

NOTE:

Typical – Installs all the files, including the database. This installation is used to install the software to a stand-alone PC, or to initially install the software to a network server. Most installations will be typical installations.

Workstation – Used to add the software to additional PCs that are connected to a network server, where all users share a database. This installation type does not load the database files to the PC; however, it does allow for sharing the database files that were installed to the network.

Step 10 Click 'Next' to choose the default destination folder (recommended) or click Browse to select another destination folder. Then click 'Next' to advance the setup program. The following message displays:

Please note the database destination folder for future WORKSTATION setups.

Step 11 Click 'OK' to access the Setup Complete window. Click 'Finish' to complete setup.

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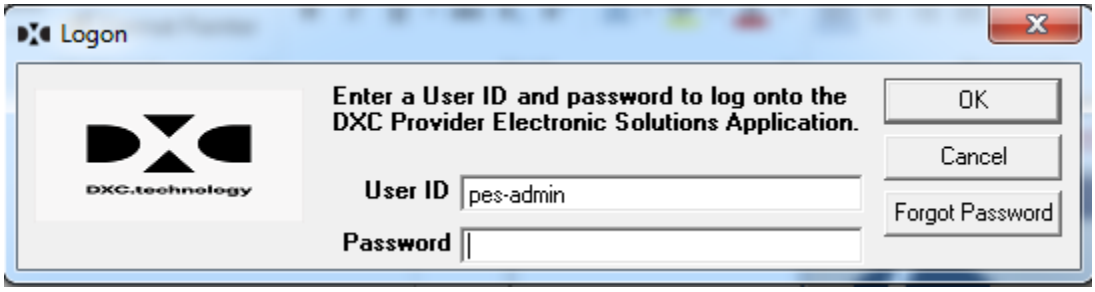
2.4 Accessing the Application

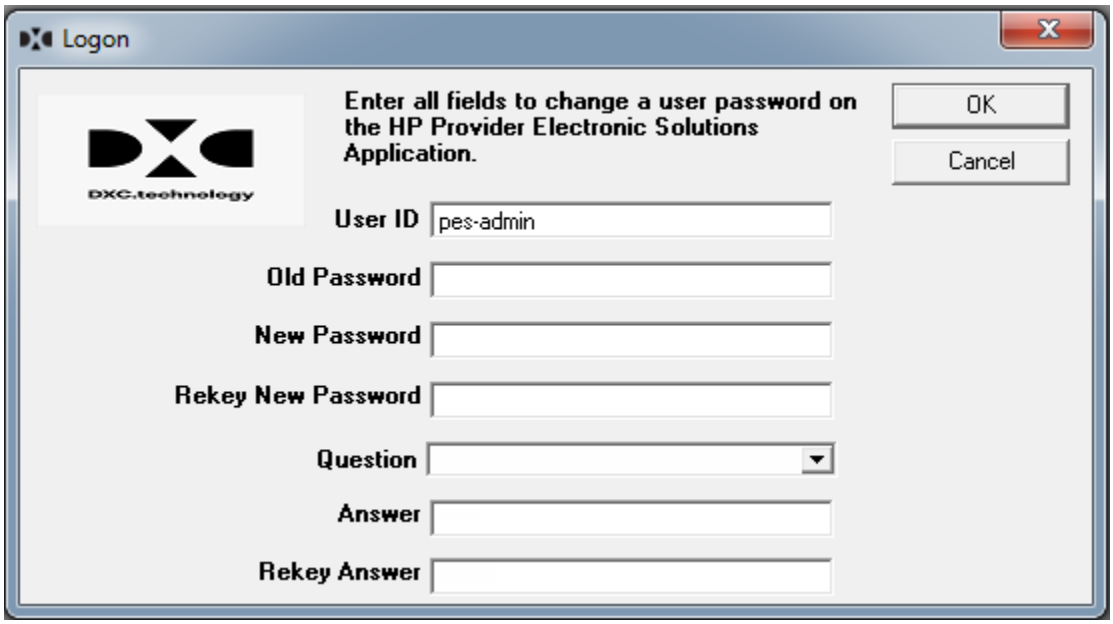
To access the application, perform the following steps:

Step 1 Double click the application folder from the desktop and then select *DXC Technology Provider Electronic Solutions* ***or*** Select the **Start** button on the bottom left-hand corner of your screen, then go to Programs and select AL *DXC Technology Provider Electronic Solutions*.



Step 2 Once the Logon Screen appears enter the default user password which is: **eds-pes** (The default user ID should remain as: pes-admin.) Click OK.

Step 3 The first time you log on, a Password Expired Box will appear, click 'OK'.



Step 4 The Logon Screen will prompt you to change your password. Fill in the information as stated below:

a. Type the old password, **eds-pes** in the Old Password field.

b. Type your new password in the New Password field. Your new password must be a minimum of five alphanumeric characters. **PLEASE STORE YOUR NEW PASSWORD IN A SAFE PLACE IN CASE IT IS FORGOTTEN**.

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c. Retype your new password in the Rekey New Password field.

d. Choose a question as your security question in the event you lose or misplace your new password.

e. Enter and re-enter the answer to your security question in the designated fields. Click 'OK' to continue.

Step 5 The Logon Status Box will appear, indicating that your password was successfully updated. Click 'OK'.

2.5 Setting Up Personal Options

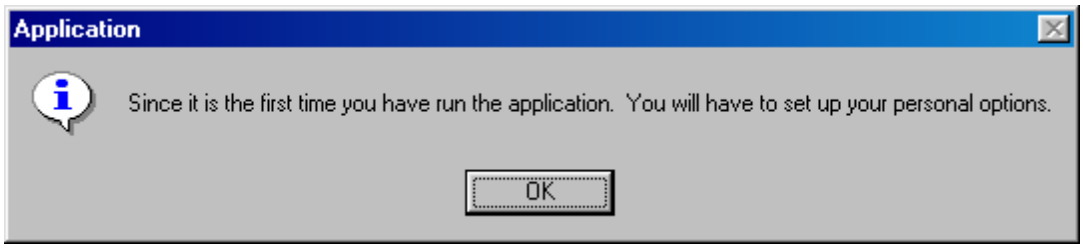
NOTE:

The *Provider Electronic Solutions* software requires that you have a trading partner and web ID in order to submit electronic claims to Alabama Medicaid. To obtain a trading partner ID, please complete the trading partner ID request form, which can be obtained from the AL Links page at https://www.medicaid.alabamaservices.org/ALPortal. If you need assistance, call 1 (800) 456-1242. **You will not be able to use *Provider Electronic Solutions* to submit batch transactions without this information**.

To use *Provider Electronic Solutions*, you must set up your personal options, including the following:

- Modem type and location (unless you use a separate connection device)
- If not connected through an ISP (Internet Service Provider) you must make modifications to install the RAS dial-up connection
- Logon IDs and passwords, as provided to you by the EMC Help Desk

When you access the *Provider Electronic Solutions* for the first time, the following message displays:



Click 'OK' to access the Options window. You can also access this window by selecting Tools>>Options from the menu bar at the top of the *Provider Electronic Solutions* application window.

The Options window contains seven tabs and four main buttons. These are described below:

Tabs

Tab	*Usage*
Batch	Use this tab to set up a trading partner ID, web logon ID, password to log onto the Medicaid website, and the requester's contact information.

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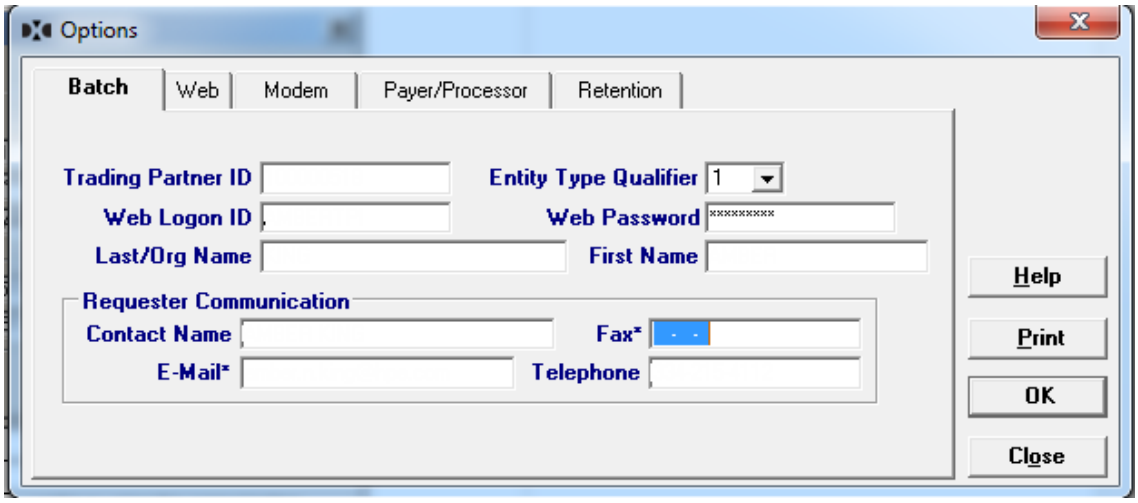
Tab	*Usage*
Web	Use this tab to configure how to connect to the Medicaid website for claim submission.
Modem	Use this tab to set up modem information, such as modem type and communication port.
Payer/Processor	Use this tab to access your system's payer/processor information.
Retention	Use this tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration.

Buttons

Button	*Usage*
Help	Use this button to access the online help for the field currently being accessed.
Print	Use this button to print options selected for all of the tabs.
OK	Use this button to save and close the information added or modified.
Close	Use this button to close the Options window.

2.5.1 Batch Tab

Users access the Batch tab to enter a trading partner ID, web logon ID, password and the requesters contact information. A sample Options window displaying the Batch tab is pictured below:



Field	*Guidelines*
Trading Partner ID	If you have used the software previously, continue using the same trading partner ID. If you need a new trading partner ID, complete the trading Partner request form, which can be obtained from the AL Links page at https://www.medicaid.alabamaservices.org/ALPortal or contact the EMC Helpdesk at 1 (800) 456-1242 for assistance.
Entity Type Qualifier	Choose the best value to indicate if this request comes from a person or non-person. A non-person would refer to a group or facility. A person would indicate an individual billing provider.
Web Logon ID	If you have used the software previously, continue using the same web logon ID. If you need a new web logon ID contact the EMC Helpdesk at 800-456-1242.
Web Password	Enter your password for your web logon ID. Please refer to chapter 17 on updating your password. You must complete that process before continuing.
Last/Org Name	If billing as an individual provider, enter the last name of the physician. If billing as an organization or group, enter the facility's name.

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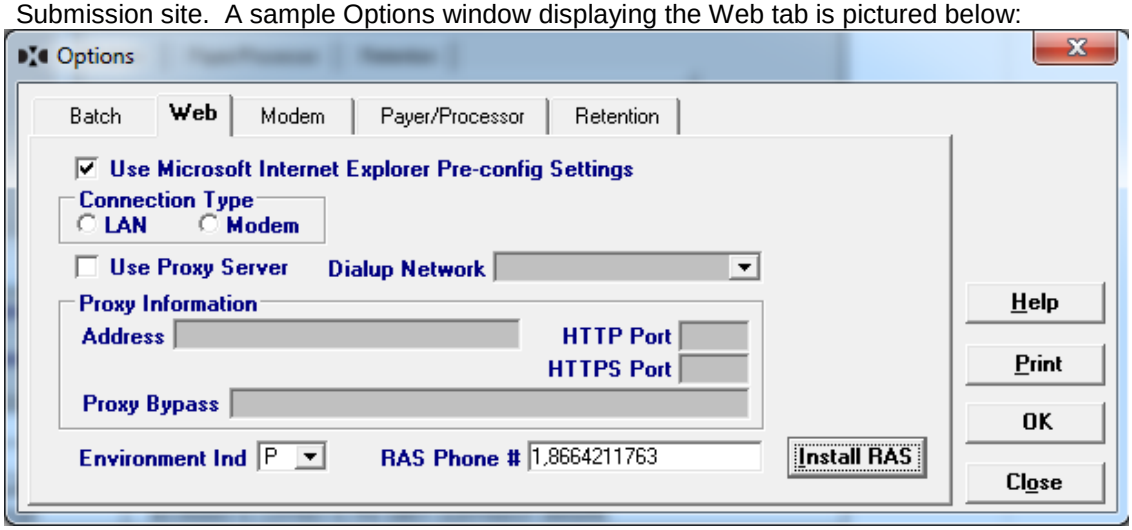
Field	*Guidelines*
First Name	If billing as an individual provider, enter the first name of the physician.
Requester – Contact Name	Enter the name of the software's user for contact purposes.
Requester – Fax	Enter the fax number of the software's user. This field is **optional**.
Requester – E-mail	Enter the e-mail address of the software's user. This field is **optional**.
Requester – Telephone	Enter the telephone number of the software's user.

2.5.2 Web Tab

Users access the Web tab to modify their method of connection to the Medicaid Submission site. A sample Options window displaying the Web tab is pictured below:



Field	*Guidelines*
Use Microsoft IE Pre-config Settings	If checked, the pre-config settings within your Internet Explorer will be accessed to connect to the batch submission website.
Connection Type	If the Internet Explorer Pre-config Settings option is **not** checked, you must choose either LAN or Modem to identify how the PC connects to the Internet.
Use Proxy Server	If the Internet Explorer Pre-config Settings option is **not** checked and your Internet access is filtered through a Proxy Server check this setting.
Dialup Network	If you choose the Modem Connection Type, you must select one of the Dialup Networks from the drop-down box. If you do not have an option listed, follow the instructions for the Install RAS button.
Proxy Information – Address	To obtain the address of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings to obtain the proxy address.
HTTP Port	To obtain the HTTP Port of your proxy server right-click on the Internet Explorer icon and left-click on properties. Click on the Connections tab and enter the LAN Settings. Click on Advanced and review the Port information for HTTP:
HTTPS Port	To obtain the HTTPS Port, follow the instructions above under HTTP Port and enter the Secure port number in this field.
Proxy Bypass	The Proxy Bypass information is found on the same window as the HTTP and HTTPS ports in the Exceptions text area.
Environment Ind	Choose the best value to indicate if the submission is Production or Test. Remember, if you have your indicator as Test your claims will not be paid.
RAS Phone #	If you use a dialup modem, enter 1,8664211763, If your phone service requires additional dialing features you may adjust this number to add those features. Such as dialing a '9' to get an outside line would be entered as: 9,1,8664211763.

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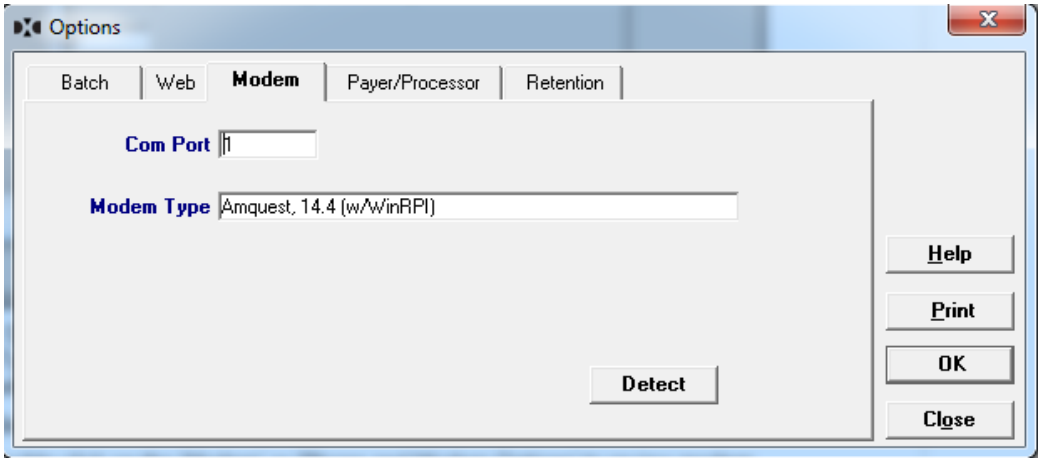
Field	*Guidelines*
Install RAS	If you choose to use a dial-up modem to connect to Medicaid, you must choose a Dialup Network option provided. If you have no option provided, press the Install RAS button and the option AL RAS will be available to you. **NOTE:** Due to a delay in installing RAS, the user may have to click on the 'LAN' option and then back to the 'Modem' option for the RAS Dial-up Network to display.

2.5.3 Modem Tab

Users access the Modem tab to establish connection between the modem and the *Provider Electronic Solutions* application. A sample Options window displaying the Modem tab is pictured below:



Click on the 'Detect' button to determine your modem type. The information displays in the Modem Type field. Perform the following to determine the communications port associated with your modem:

Step 1 Click on the 'Start' button, then choose Settings>>Control Panel.

Step 2 Double-click on the 'Modem' or 'Phone and Modem Options' to review modem information, including the communications port.

Step 3 Enter the communications port information in the Com Port field and continue to the Interactive tab.

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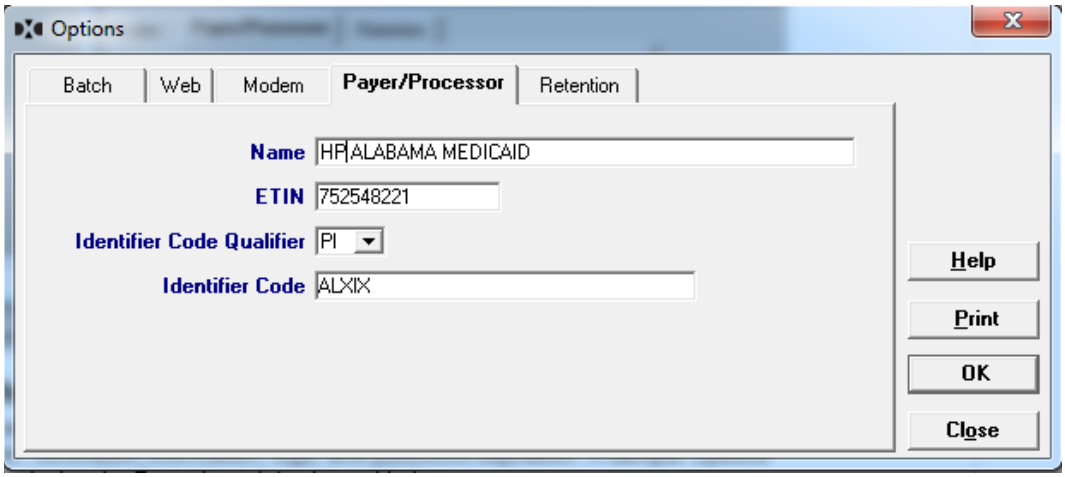
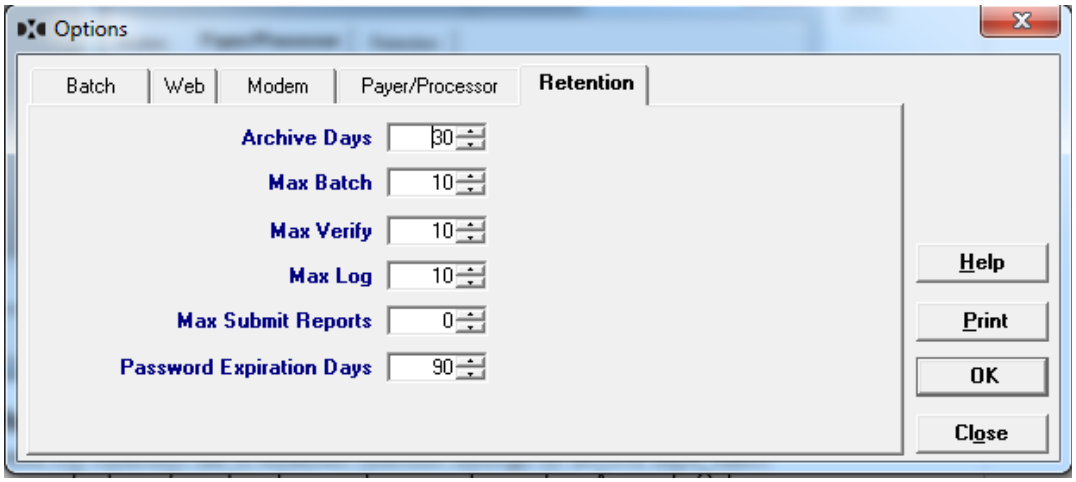
2.5.5 Payer/Processor Tab

This tab contains your system's payer/processor information. The fields on this screen will populate automatically and should not be altered unless directed by DXC Technology. A sample Options window displaying the Payer/Processor tab is pictured below:



2.5.6 Retention Tab

Users access the Retention tab to establish retention settings for archive days, batch information, verification information, logs, and password expiration. A sample Options window displaying the Retention tab is pictured below:



Retention settings indicate the number of days worth of data the software should save. Users may set retention settings as required, or may retain the default settings. Click OK to save the information.

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NOTE:

Increasing the retention settings results in more data saved to your hard drive. *Provider Electronic Solutions* enables you to archive most types of data generated by the system. There may be a better alternative to increasing your retention settings. For more information, refer to Section 2.7, Other Maintenance Options.

2.6 Installing Software Updates

Occasionally, DXC Technology will release updates to *Provider Electronic Solutions*. Upgrading your software is quick and easy with the Get Upgrades option, available from the Tools menu option.

Receiving Notification of Upgrades

DXC Technology notifies providers of software updates in two ways:

- Update notices in the *Provider Insider,* the Alabama Medicaid bulletin
- "Mini-messages" on the Remittance Advice (RA) Banner Page.

You may also elect to use the Get Upgrades option if you unexpectedly experience difficulty in submitting claims, or if you have not used the software for an extended period of time. In this manner, you can be certain you are using the most current version of *Provider Electronic Solutions* even if you have not received an upgrade notification.

Upgrading *Provider Electronic Solutions*

Perform the following tasks to upgrade your *Provider Electronic Solutions* software:

Step 1 Select Tools>>Get Upgrades from the menu bar. Depending on the web connection options you have selected, *Provider Electronic Solutions* connects to the network and returns one of two actions:

If an upgrade is available, the system automatically downloads the upgrade to your PC. Proceed to Step 2.

If no upgrade is available, the system displays the message *No upgrades available to apply*. No further action is necessary.

Step 2 Close *Provider Electronic Solutions*. Access the Provider Electronic Solutions folder on your desktop and click on the Upgrade icon to upgrade the application.

NOTE:

Users must upgrade to version 2.16 before upgrading to the 3.0 version.

Before upgrading to version 3.0 users should submit all "R" status transactions currently in the Provider Electronic Solutions Software.

Once the version 3.0 upgrade has completed, users will not be able to change, copy, resubmit, or restore archived transactions that were entered in the previous versions of the Provider Electronic Solutions Software. The only option will be to delete these transactions.

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All transactions converted from previous versions to version 3.0 will be flagged with a new status based on the status the transaction was in at the time of the upgrade. The following new status codes will be used:

U - All transactions previously in an 'I' status at the time the upgrade is performed will have the status changed to 'U'. U = 4010 Unfinished/Incomplete.

B - All transactions previously in an 'A' status at the time the upgrade is performed will have the status changed to 'B'. B = 4010 Backup record/Archive.

C - All transactions previously in an 'R' status at the time the upgrade is performed will have the status changed to 'C'. C = 4010 Completed not yet Submitted/Ready.

S - All transactions previously in an 'F' status at the time the upgrade is performed will have the status changed to 'S'. S = 4010 Successfully Submitted/Finalized.

NOTE:

Providers are strongly encouraged to exit all other Windows programs before running the upgrade setup program. This includes MS Word, e-mail systems, or other applications.

Be sure to close *Provider Electronic Solutions.* Save any data currently being accessed on *Provider Electronic Solutions*, such as claims, lists, or eligibility verification responses before performing an upgrade on your software.

2.7 Other Maintenance Options

The Tools menu options enable users to archive data, recover the database, download upgrades, and set up options. Procedures for downloading upgrades are described in Section 2.6, Installing Software Upgrades. Set up options are covered in Section 2.5, Setting up Personal Options.

This section describes other maintenance options such as archiving and database recovery.

2.7.1 Archiving

Archiving data is the process used to keep the size of your data small enough for it to be useful, while maintaining historical records of the forms you have entered.

Archiving is designed to make management of forms easier and to keep the space on your hard drive used by the *Provider Electronic Solutions* application to a minimum.

One of the options available under Tools>>Archive>>Create is the setting that controls how many days of forms you wish to keep online on your PC. The standard setting is 30 days; however, you may select whatever setting best suits your needs. This means that when you select Tools>>Archive>>Create Archive from the menu bar, you will keep a copy of any form which was submitted more than 30 days ago. The form is copied to a compressed file and then deleted from your database. Forms submitted in the past 30 days are still accessible through the *Provider Electronic Solutions* database.

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You can store the compressed file on a diskette or leave it on your hard drive. Forms that are ready to be submitted (that have a status of ‘R') are not archived, but remain on your online database until you have submitted or deleted them. Forms that are incomplete (that have a status of ‘I’) and are older than the archived data are removed during the archive process and are not saved on the archived file.

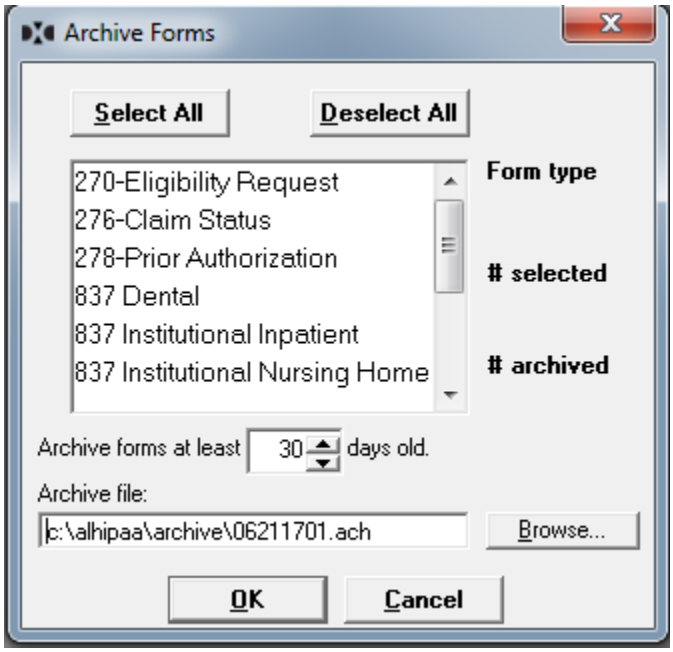
This section describes how to create an archive and how to restore archived files.

Create Archive

NOTE:

If running *Provider Electronic Solutions* on a network, other users must exit the application (must not be viewing, adding, or modifying any forms or lists) before you create an archive. The user creating the archive should have the only open copy of the software while the process runs.

To create an archive select Tools>>Archive>>Create from the menu bar. After verifying that all forms and lists are closed, click OK to proceed. The Archive Forms window displays:



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Using this window, you can:

- Select all the form types to archive by clicking on the 'Select All' button (click on 'Deselect All' to deselect). You may also select specific form types to archive by clicking on the form type.
- Change the default directory and the name of the file to archive by typing the path name in the Archive file field, or by clicking on the Browse button.
- Change the number of days used to archive the forms. (This change applies to the current session only. Select Tools>>Options>>Retention Tab to change the number of retention days for all future sessions.)

Select 'OK' to archive the selected forms. Select 'Cancel' to exit the archive function.

Once you select 'OK', the system archives the forms that match the selection criteria. *Provider Electronic Solutions* displays a confirmation message upon completion. Click 'OK' to exit the Create Archive process.

NOTE:

You can use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Restore Archive

The Restore Archive process enables users to recall forms from an archive file and put them back into the online database. For instance, if you elect to archive to diskette claims more than thirty days old, Restore Archive enables you to return them to the list that displays at the bottom of the *Provider Electronic Solutions* claim form.

Restored claims display with a status of 'A'. You cannot change information on these claim forms; however, you can use the restored forms to:

- Review them to confirm information
- Print them in a report
- Copy them to create a new claim form

NOTE:

5010

PES version 3.0 will not restore archived transactions originally submitted/archived with a previous version (2.16 and earlier).

Any attempt to restore archived transactions in HIPAA 4010 and NCPDP 1.1 format will receive the following error message:

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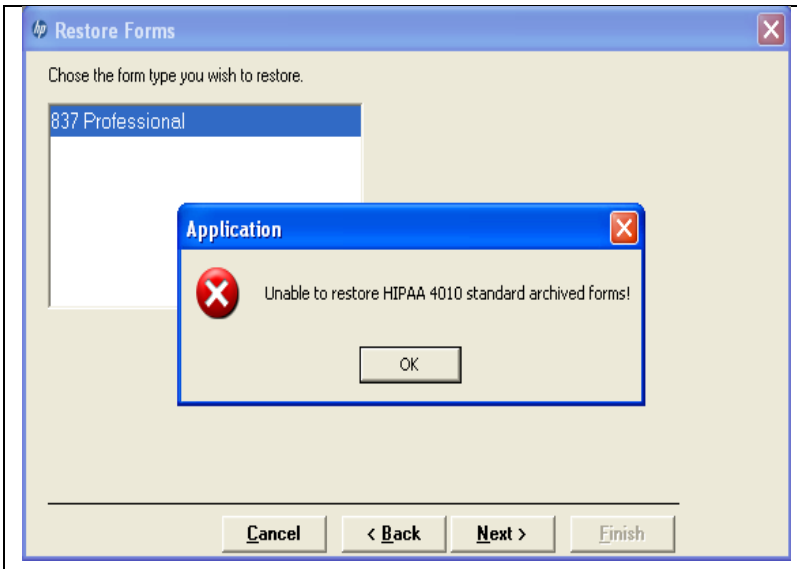
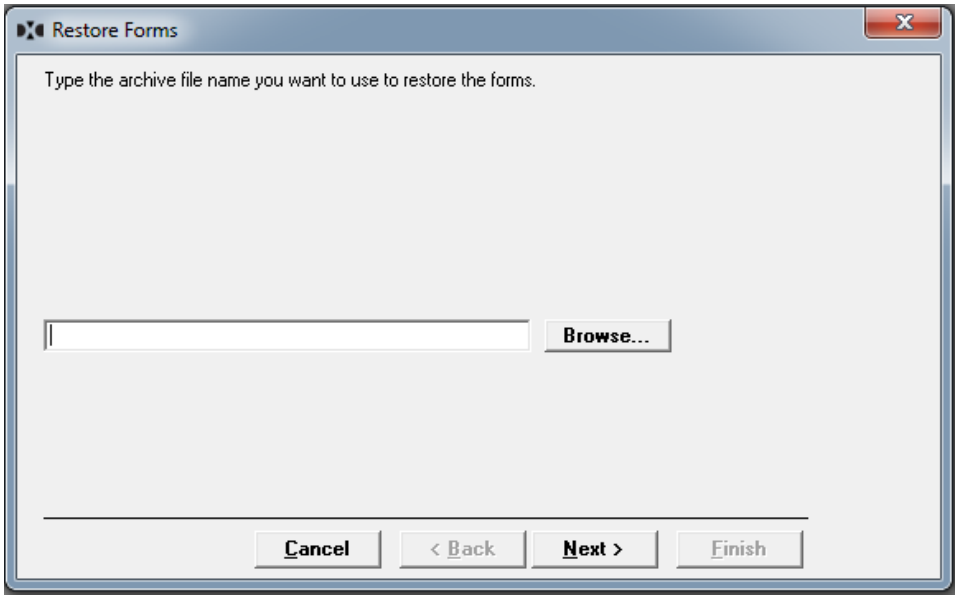


ICD-10

PES version 3.02 will not restore archived transactions originally submitted/archived with a previous version.

Perform the following to restore archived forms:

Step 1 Select Tools>>Archive>>Restore from the menu line. The Restore Forms window displays:



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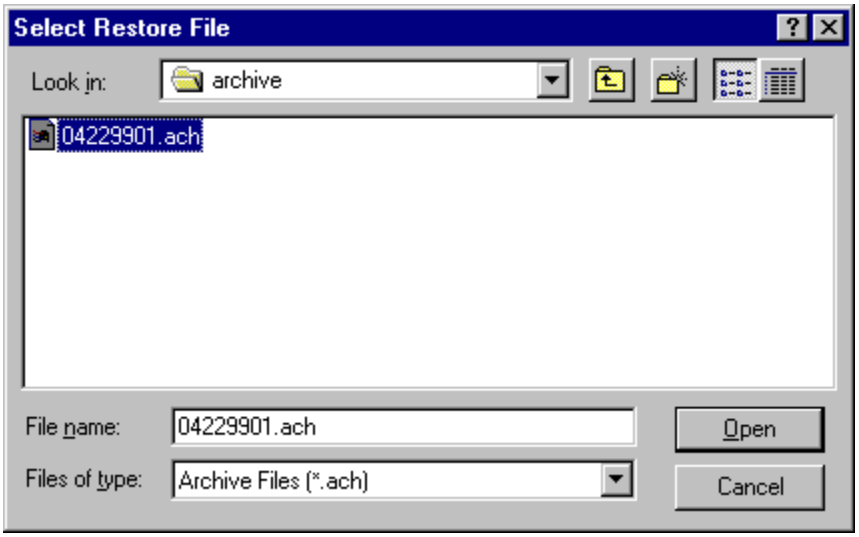
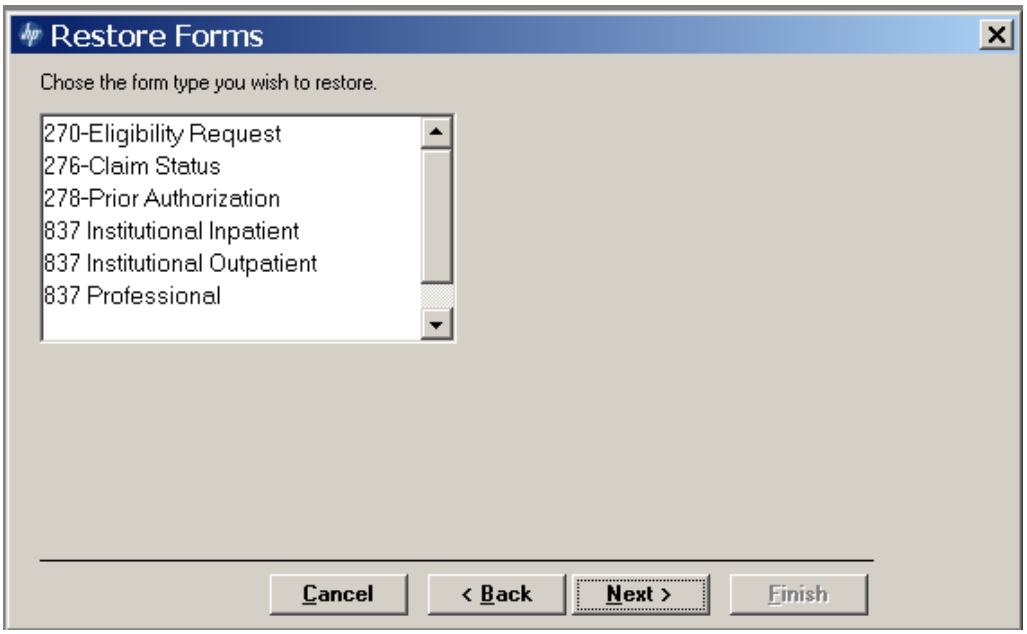
Step 2 Type in the path and file name of the file to restore and click the 'Next' button, or click on the 'Browse' button to search for the path and file name. The following window displays:



Step 3 Select the file and path name and click 'Open' button. Click 'Next' to display the Restore Forms window, pictured below:



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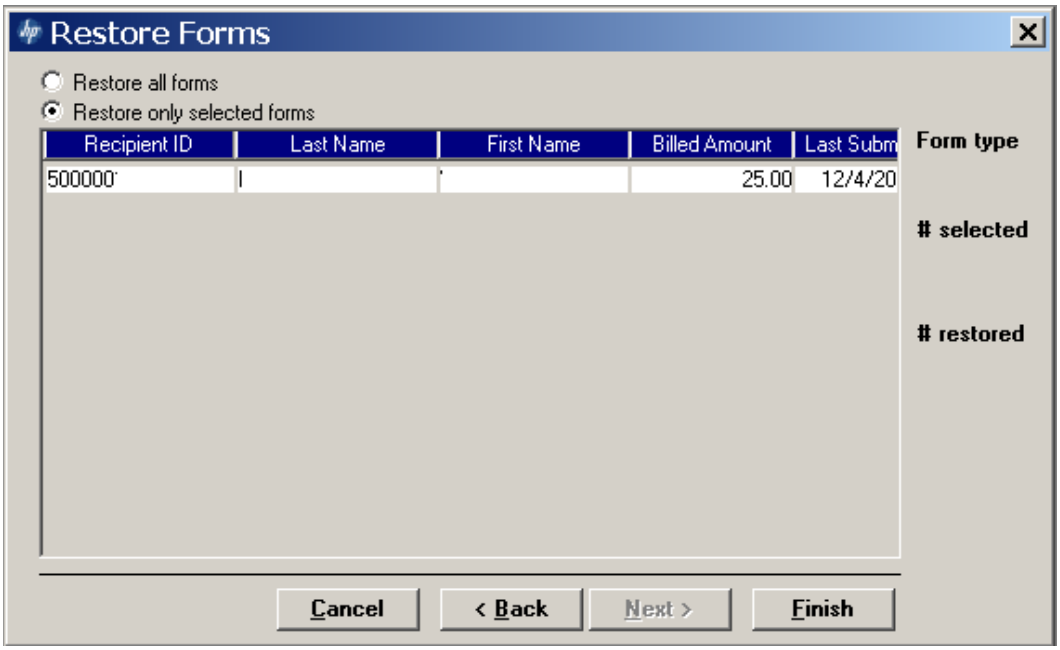
Step 4 Determine which form type(s) you want to restore. To select multiple form types, follow the procedures indicated in the note box under the Create Archive section. Click the 'Next' button to proceed.

Provider Electronic Solutions displays a message if it does not locate any forms matching the selection criteria for the file and path name you selected. When this occurs, you may select 'OK' to select another form type or 'Back' to go back and change the archive path and file name.

When *Provider Electronic Solutions* finds forms that match the selection criteria, the following displays:



Step 5 Select the restore option you want (all at once or only selected forms). To select multiple forms, follow the procedures indicated in the note box under the Create Archive section. The window displays forms by Insured ID (Recipient ID), Last Name, First Name, Billed Amt, and Last Submit Dt. Click the Finish button to proceed.

Provider Electronic Solutions displays a message upon successful restoration of the archived forms. Click 'OK' to exit the Restore Archive process.

2.7.2 Database Recovery

There may be times when there is a problem with your database. The Database Recovery option is designed to help you work with the Help Desk personnel to fix problems with your database.

Compact Database

Compact is used to make the database files smaller and better organized. When you delete a form, empty space is created in the database where that form used to be. Compact will release all the empty space so that it is available for you to use again.

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Repair Database

Repair will attempt to validate all system tables and all indexes. Generally, this feature is helpful when you are having trouble accessing your data. The Help Desk staff will let you know when this is necessary. You may use this feature any time you feel that it would be helpful. Compact is recommended after the Repair.

Unlock Database

Sometimes errors will cause database locks. The database may lock when you are submitting forms, archiving forms, restoring forms, and sometimes when you are adding or editing forms. Use the Unlock feature to unlock the database tables.

2.7.3 Changing Password

There may be times when you feel a need to change your password. The Change Password option is designed to allow you to do so. The password is defaulted to prompt its user to change the password every ninety days. This option may be adjusted, review Section 2.5.7 *Retention Tab* to do so.

Step 1 Go to Tools >> Change Password.

Step 2 Enter your old password in the **Old Password** field.

Step 3 Enter your new password in the **New Password** field.

Step 4 Re-enter your new password in the **Rekey New Password** field.

Step 5 Choose a security question, in the event you lose or misplace your password.

Step 6 Enter and re-enter the answer to your security question in the designated fields.

Step 7 Click OK to save your new Provider Electronic Solutions password.

2.7.4 Security Maintenance

There is an option to add users to access the Provider Electronic Solutions software without having to use the same logon ID. This also establishes certain users to have administrator versus non-administrator rights. This option may be accessed by going to Security >> Security Maintenance. Follow the steps below to add additional users to the *Provider Electronic Solutions* application.

Adding New Users

Step 1 Go to Security >> Security Maintenance to access the screen. You must be logged on as an administrator to complete this process. (The default administrator ID is pes-admin.)

Step 2 Enter a new User ID in the User ID field.

Step 3 Enter the new user's password in the Password field.

Step 4 Choose the new user's authorization level.

- User (Non-administrator) – This option allows the user to access the *Provider Electronic Solutions* software, create and save claims, submit electronic transactions and make the needed adjustments to the personal options menu. (This option only restricts users from adding or removing additional users.)

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- Administrator – This option allows the user to access the *Provider Electronic Solutions* software, create and save claims, submit electronic transactions, adjust their personal options, and create new users.

Step 5 Click on 'Save' once you have completed the above steps. And click on 'Close' to close the Security Maintenance screen.

Step 6 Once the new user logs on, they will be prompted to create a new password. Refer to *Section 2.4 Accessing the Application.*

NOTE:

Store your new user ID and password in a safe location for future use. If your password is lost or misplaced, have your administrator logon as pes-admin to assign your ID a new password.

Removing Users

Step 1 Go to Security >> Security Maintenance to access the screen. (You must be logged on as an administrator to complete this process. The default administrator ID is pes-admin.)

Step 2 Choose the user ID you wish to remove by clicking on it.

Step 3 Once highlighted, the information will auto-write into the fields.

Step 4 Click on 'Delete' to remove the user.

Step 5 Click on 'Close' once you have completed this process for each user you wanted to remove.

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3 Getting Around

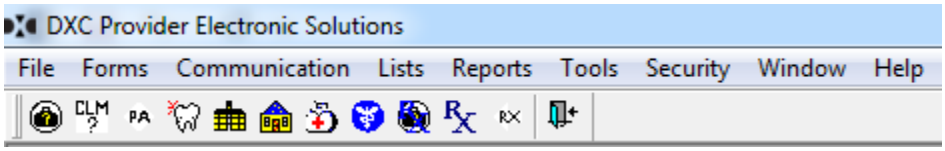
This chapter describes general navigation concepts and provides an overview of the online help feature.

3.1 Navigating in Provider Electronic Solutions

Before you begin using *Provider Electronic Solutions*, review the following section and learn how to navigate through the application with your keyboard and mouse.

Navigating through *Provider Electronic Solutions* is similar to other Windows-compatible applications. The navigation options available are menus, toolbars, and command buttons. Your mouse and keyboard enable you to access these navigation options. Use your mouse to point-and-click as a method for navigating through *Provider Electronic Solutions*.

Below are samples of the menu and icon toolbars that display on the *Provider Electronic Solutions* main window:



This section describes the menu and icon options available with *Provider Electronic Solutions.*

3.1.1 Menus

Provider Electronic Solutions uses menus to navigate throughout the application. The menu options change depending on what window you access. When you open *Provider Electronic Solutions* the main menu displays. You can access items on a menu using the mouse and clicking on their icon. The example below provides two methods for accessing the Eligibility form from the Forms menu option:

- Position your cursor over the Forms menu option and click the left mouse button to display the drop down menu. Scroll down to the Eligibility selection and click once with your left mouse button to display the Eligibility form
- Click on the 'Eligibility' icon

Refer to Section 3.1.2, Icons, for a listing of main menu icons.

The following options are accessible from the main menu:

This menu option…	***Allows you to…***
File	Exit the application.
Forms	Select the online form that you wish to work with.
Communication	Submit batches of forms and process batch responses. Resubmit batches of forms. View Communication Log files.
Lists	Add and edit reference lists, which allow you to collect information to be auto plugged in online forms.

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This menu option…	*Allows you to…*
Reports	Print summary or detail reports with information from forms or reference lists.
Tools	Create and work with archives, perform database maintenance, retrieve upgrades, and change your options. The Options selection allows you to set up communications options and determine retention settings.
Security	Add, delete and restrict users other than the administrator.
Window	Standard options available for most Windows compatible applications.
Help	Obtain help about *Provider Electronic Solutions* functions, screens, menus, and fields. Also view information about this application such as version and copyright.

3.1.2 Icons

The Icons toolbar displays below the menu bar on the main menu. The twelve icons displayed are:

- 270 Eligibility
- 276 Claim Status
- 278 Prior Authorization
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal
- Exit

Users can position the cursor over an icon to display a brief description.

When a form is opened, the toolbar display will change. After opening a specified form from the icon list above, the fifteen icons now displayed are:

- (Add) saves the existing form and calls up a new blank form.
- (Copy) makes a copy of the existing form.
- (Delete) deletes the existing form.
- (Undo) reverses all of the changes done to the existing form since the form was last saved.
- (Save) saves the existing form.
- (Print) can only be accessed from one of the various form screens. Selecting the print button will automatically create a report and allow you to print the report that was automatically created.
- (Cut) deletes the highlighted data and places a copy of the data on the clipboard so that it can be pasted into another field or software program.
- (Copy) copies the highlighted data to the clipboard so that it can be pasted into another field or software program.
- (Paste) inserts data from the clipboard to the selected data fields or another software program.

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- (Filter) allows you to define which forms are displayed at the bottom of the form screen by status, date submitted, name, amount billed, etc.
- (Find) allows you to search for a claim by recipient ID, last name, first name, and billed amount.
- (Sort) allows you to sort the claims that are displayed at the bottom of the form screen by recipient ID, last name, first name, billed amount, status and submit date.
- (Errors) allows you to view errors that have been detected on the current form.
- (Calculator) calls up the calculator.
- (Exit) allows you to exit the application.

3.1.3 Command Keys

Like most Windows applications, *Provider Electronic Solutions* provides the user with command keys. This enables the user to perform actions using either the mouse (point-and-click) or the keyboard. This section describes them.

Command Keys

The table below describes some standard navigation keys available with *Provider Electronic Solutions:*

To do this…	***Press this key…***
Go to the next field	<Tab> or <Enter>
Go to the previous field	<Shift>+<Tab>
Move backward within a field	Left Arrow
Move forward within a field	Right Arrow
Scroll up through a list	Up Arrow
Scroll down through a list	Down Arrow
Open online help for a field when the cursor is on a data entry field	<F1>

The list above includes function keys (usually located at the top of the keyboard and numbered ‘F1’ through ‘F12’), command keys (such as <Alt>, <Shift>, <Tab>, <Ctrl>, and <Enter>), and arrow keys. Depending on your keyboard, the arrow keys may be located on the numeric keypad, or in a separate section from the numeric keypad.

To use arrow keys on the numeric keypad, you will probably press the ‘Num Lock’ key. Press the 'Num Lock' key again to disable the arrow keys on the numeric keypad, making them display numbers instead.

3.2 Online Help

Accompanying the *Provider Electronic Solutions* software is context-sensitive, field-level online help. Context-sensitive and field-level refer to how the help is programmed. You can access help for any field in *Provider Electronic Solutions* simply by positioning your cursor in the field and pressing the <F1> function key usually located at the top of your keyboard.

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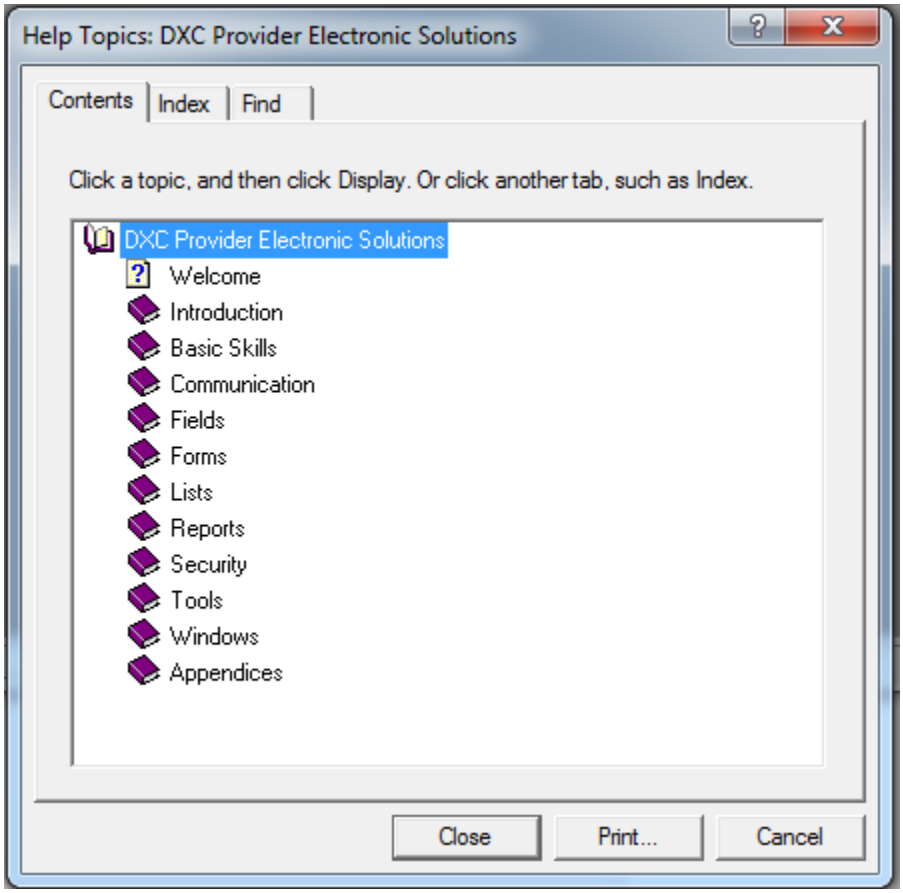
You can also access the online help document and search on specific information by selecting the Help menu option. To access the online help window select Help>>Contents and Index. The following pop-up window displays:



Enter keywords in the Help Topics window and press <Enter> to view information, or double click on topic name to view the information.

You can search by contents, by index (alphabetized), or by using the Find feature. Once you locate a specific topic, you can print the topic, or read it online, and then close the pop-up window.

To return to the list of topics once you've viewed information, click the Help Topics button.

NOTE:

The online help is not a substitute for the *Alabama Medicaid Provider Manual*. It merely provides general help regarding required fields and *Provider Electronic Solutions* functionality. It does not provide program-specific information. If you did not receive a copy of the *Alabama Medicaid Provider Manual,* contact DXC Technology Provider Relations at 1 (800) 688-7989 or download a copy of the manual from the Alabama Medicaid homepage at http://www.medicaid.alabama.gov

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4 Customizing Provider Electronic Solutions

Provider Electronic Solutions contains reference lists of information that you commonly use when you enter and edit forms. For example, you can enter lists of common diagnosis codes, provider numbers, or patient ID's. After saving the list information, the lists are available as a drop down list where you can select data to speed the data entry process and help ensure the accuracy of the form. Building a list can also increase your ability to submit correct claims quickly and efficiently.

To meet the standards set forth by the Health Insurance Portability Accountability Act (HIPAA), Provider and Recipient information is required to be entered into a list. You will no longer be able to enter the provider ID or recipient ID on the form manually.

This chapter describes two ways to build lists and how to use lists when filing claims, eligibility transactions, or claim status.

4.1 Building Lists

There are two ways to build lists with *Provider Electronic Solutions*:

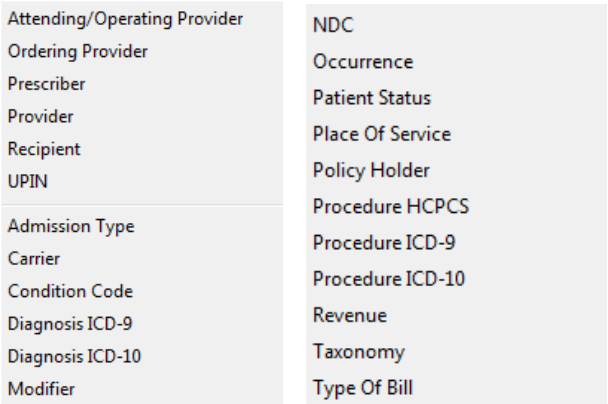
- Accessing list windows through the List menu.
- Double clicking on certain fields while you are completing a claim form or entering an eligibility verification transaction. Double clicking on these fields accesses the corresponding list window.

With *Provider Electronic Solutions*, you have the option of building lists as a separate task, or building (adding) to them as you submit claims.

NOTE:

To access a list window from a claim form, double-click in the field that corresponds to the list window. For example, while keying a claim, double click the Provider ID field to access the list window for providers. Enter information into the corresponding fields. Click the 'Save' button to add it to the list.

You can build the following lists using *Provider Electronic Solutions*:



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Each list type corresponds to a list window. Users may add, edit, or delete list records using list windows.

Below is a description of the buttons that display on each list window. The ‘copy’ button is not a feature on all list windows:

Button	***Usage***
Add	Pressing this button enables you to refresh the list screen so you may add a new record. Please note that if you key over data that already displays on the list window and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the list.
Select	Pressing this button enables you to select the current list record to add to the current transaction.
Help	Pressing this button enables a help screen to appear to answer any questions you may have.
Close	Pressing this button enables you to close the window.
Copy	Pressing this button enables you to build a new list from the current list record.

To Add a New Record to a List

Step 1 Click on the ‘List’ menu from the toolbar. To add a record, select the list by clicking on it.

Step 2 Key information into all required fields.

Step 3 You can enter information in any order, or may enter it in the order presented on the record, pressing the Tab key to move to the next field.

Step 4 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press ‘Save’.

Step 6 Press the ‘Add’ button to add another record.

To Modify a Record from the List

Step 1 Click on the ‘List’ menu from the toolbar. To modify, select the list by clicking on it.

Step 2 Scroll through the list of records that display at the bottom of the list window. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the record. Press ‘Undo All’ if you overwrite a record.

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- Press ‘Delete’ to delete an unwanted record.

To Find a Record in the List

Step 1 Select the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Step 2 Once you have entered the search criteria, click the ‘Find Next’ button with your mouse to search for the next record that matches the search criteria. Continue clicking ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Step 3 Press ‘Cancel’ when you have finished searching.

4.2 Completing the Provider List

The Provider list allows you to collect detailed information about providers that can then be automatically entered into forms. This includes such information as: Provider ID/NPI, last name, first name, address, and SSN/Tax ID.

To Add a New Provider

Step 1 Click on the ‘List’ menu from the toolbar. Select ‘Provider’ from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 3 A sample Provider list window is pictured below:

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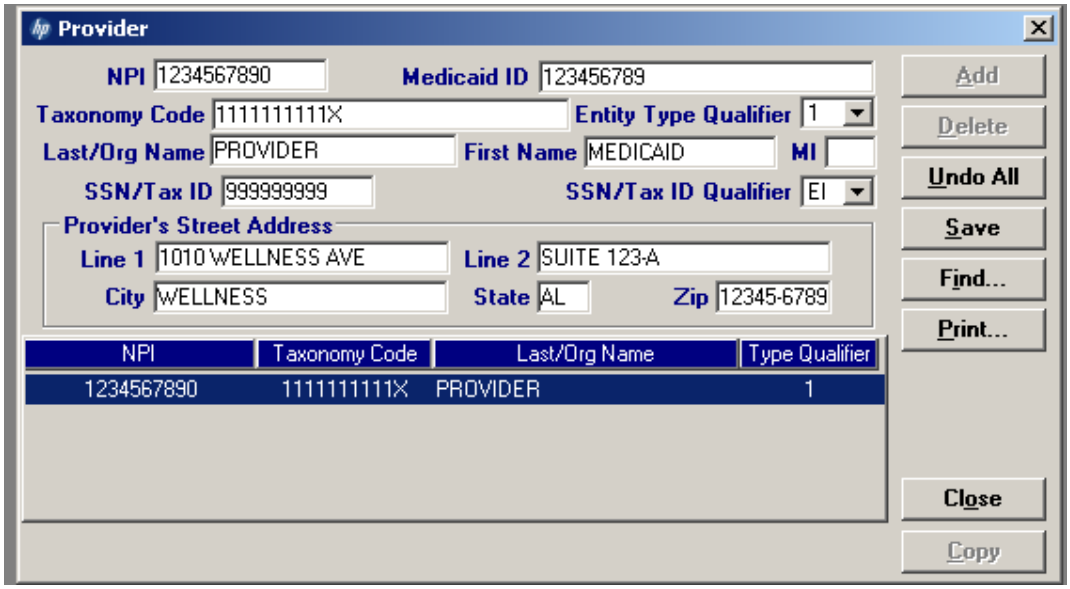

Field	*Guidelines*
Provider NPI	Enter the provider or prescriber's NPI according to the format in the Alabama Medicaid manual. A provider's NPI is 10 characters in length.
Medicaid ID	For provider's with multiple service locations, enter the provider's Alabama Medicaid assigned ID as a secondary identifier. The Medicaid ID can be either 6, 8 or 9 characters in length.
Taxonomy Code	This field lists the code designating the provider type, classification and specialization. This field is optional for all claim types except Dental – it is a required field on Dental claims.
Entity Type Qualifier	Choose a value based on the information entered in the Provider ID/NPI field. 1 – Indicates the number entered in the field belongs to a Person. 2 – Indicates the number entered in the field belongs to a Non-Person.
Last/Org Name	Based on the information entered in the Provider ID/NPI field, enter the name of the facility or the provider's last name.
First Name	If a "1"' was chosen in the Entity Type Qualifier field, enter the provider's first name.
MI	If a "1" was chosen in the Entity Type Qualifier field, enter the provider's middle initial. This field is optional.
SSN/Tax ID	Enter the individual provider's 9-digit social security number or the Tax Identification number of the party being referenced. No hyphens, slashes, dashes or spaces should be used when completing this field. (If the Social Security Number or Tax ID is not known and cannot be obtained, please enter all 9's in this field and choose "SSN Number" from the SSN/Tax ID Qualifier.)
SSN/Tax ID Qualifier	Choose the best value to indicate if: **EI** – SSN/Tax ID entered is the employer's identification number (such as Tax ID) or **SY** - SSN/Tax ID entered is a SSN number.
Provider's Street Address – Line 1	Enter the facility or provider's primary street address. A Post Office Box address cannot be entered.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the facility or provider's City.
State	Enter the facility or provider's State.
Zip+4	Enter the facility or provider's Zip Code plus the 4-digit Zip Code extension.

Step 4 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll

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through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press ‘Save’.

Step 6 Press the ‘Add’ button to add another record.

NOTE:

The Provider List is also used to indicate referring physicians. If you are entering a referring physician, the same information that is entered for a billing provider is required for a referring provider.

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4.3 Completing the Recipient List

The Recipient list allows you to collect detailed information about recipients that can then be automatically entered into forms. This includes such information as: Recipient name, date of birth, address, social security number (SSN), and Recipient ID.

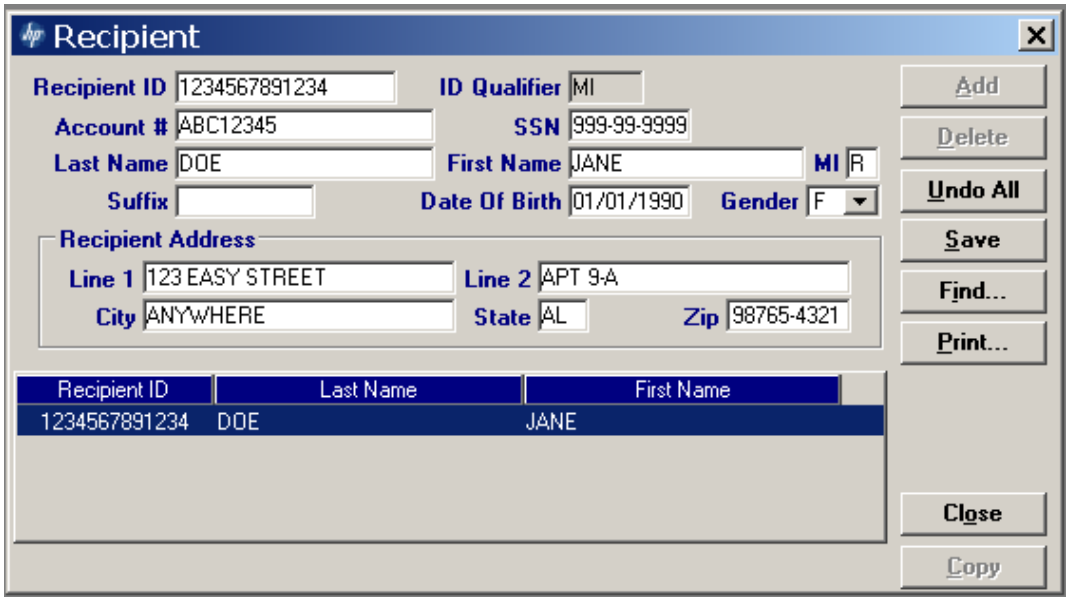
To Add a New Recipient

Step 1 Click on the 'List' menu from the toolbar. Select 'Recipient' from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 3 A sample Recipient list window is pictured below:



Field	*Guidelines*
Recipient ID	Enter the recipient's 13-digit Alabama Medicaid ID.
ID Qualifier	This field auto-defaults to its proper setting.
Account #	Enter the recipient's account number if your facility has assigned one. If no account number has been assigned enter a zero.
SSN	Enter the recipient's 9-digit Social Security Number.
Last Name	Enter the recipient's last name according to their eligibility verification.
First Name	Enter the recipient's first name according to their eligibility verification.
MI	Enter the recipient's middle initial according to their eligibility verification.
Suffix	If applicable, enter the recipient's suffix. Example JR or SR. This field is optional.
Date of Birth	Enter the recipient's date of Birth in MM/DD/CCYY format.
Gender	Choose the best value to indicate the recipient's gender.
Recipient Address – Line 1	Enter the recipient's primary street address.

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Field	*Guidelines*
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the recipient's city.
State	Enter the recipient's state.
Zip	Enter the recipient's Zip. Must be either 5 characters or 9 characters in length.

Step 4 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 5 Correct the mistake and press 'Save'.

Step 6 Press the 'Add' button to add another record.

4.4 Completing the Policy Holder List

The Policy Holder list allows you to collect detailed information about a recipient's third party insurance that can then be automatically entered into forms. This includes such information as: Group #, Carrier Name, policy holder information, etc.

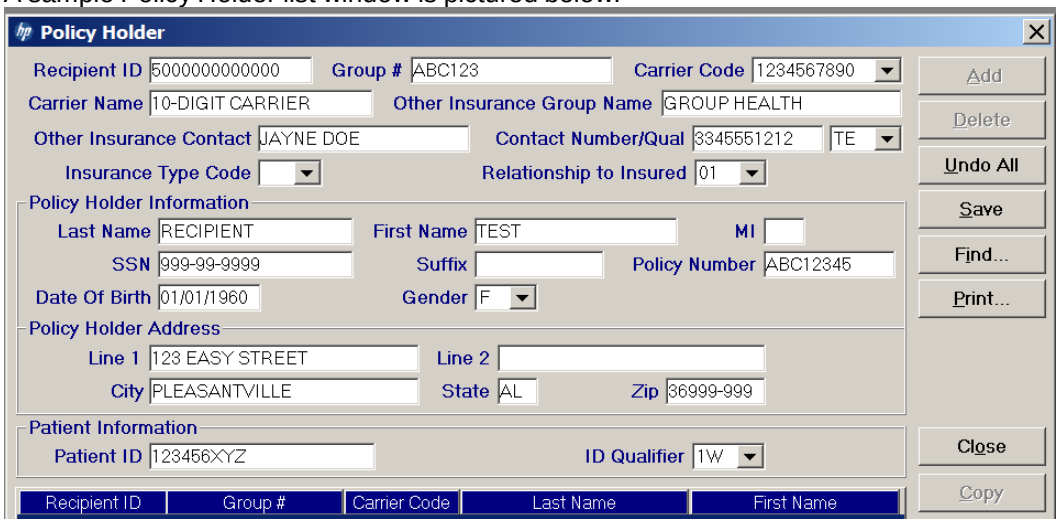
To Add a New Policy Holder

Step 1 Click on the 'List' menu from the toolbar. Select 'Recipient' from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

A sample Policy Holder list window is pictured below:



Field	*Guidelines*
Recipient ID	Enter the recipient's 13-digit Alabama Medicaid ID.

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Field	***Guidelines***
Group #	Enter the recipient's group number, assigned by the other insurance, if applicable.
Carrier Code	Choose a valid carrier code from the drop down box that identifies the recipient's health plan. If you are unable to make a choice based on the list provided, double-click on this field to add a new valid Carrier Code (up to 10 digits). (An expanded list of Carrier Codes can be found on Medicaid's website at http://www.medicaid.alabama.gov/. Select the most current version of the provider manual and navigate to appendix K: Top 200 Third Party Carrier Codes. FQHCs and RHCs can enter a carrier code equal to the NPI for the MCO plans to submit claims with MCO payment as other payers.
Carrier Name	This field auto-writes based on the information chosen in the Carrier Code field.
Other Insurance Group Name	Enter the Other Insurance's group (employer) name. This field is optional.
Other Insurance Contact	Enter the contact name of a valid representative from the other insurance. This field is optional.
Contact Number	Enter the other insurance representative's phone number. This field is optional.
Contact Qual	If applicable, choose the best value to indicate the type of number entered in the Contact Number field. ED Electronic Data Interchange Access Number EM Electronic Mail FX Facsimile TE Telephone
Insurance Type Code	Choose the best value to indicate the type of policy entered. 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-stage Renal Disease Beneficiary in the mandated Coordination Period with an Employers Group Health Plan 14 Medicare Secondary, No-fault Insurance including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability insurance is Primary
Relationship to Insured	Choose the best value to indicate the relationship of the patient to the insured. 01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship
Last Name	Enter the last name of the policy holder.
First Name	Enter the first name of the policy holder.
MI	Enter the Middle Initial of the policy holder. This field is optional.
SSN Number	Enter the social security number of the policy holder. This field is optional.
Suffix	Enter the suffix of the recipient if applicable. Such as JR, SR, etc. This field is optional.
Policy Number	Enter the Policy Number of the policy holder.
Date of Birth	Enter the date of birth of the policy holder.
Gender	Choose the best value to indicate the gender of the policy holder.
Line 1	Enter the address of the policy holder.

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Field	*Guidelines*
Line 2	If applicable, enter the secondary address of the policy holder. Such as “Apt D or Ste 333”.
City	Enter the city of the policy holder.
State	Enter the state of the policy holder in an abbreviated format. EX Alabama = AL
Zip	Enter the zip code of the policy holder.
Patient ID	Enter the patient’s identification number; this may include the number assigned by the other insurance or their social security number. This field is optional.
ID Qualifier	Choose the best value to indicate the type of number entered in the Patient ID field. 1W Member ID Number IG Insurance Policy Number 23 Client Number

Step 3 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 4 Correct the mistake and press ‘Save’.

Step 5 Press the ‘Add’ button to add another record.

4.5 Completing the Provider UPIN List

The Provider UPIN list allows you to collect information about referring providers that can then be automatically entered into the professional claim form. This list contains the following information: the provider’s 6-digit unique identifier number, last name, first name.

To Add a New Provider UPIN

Step 1 Click on the ‘List’ menu from the toolbar. Select ‘Provider UPIN’ from the drop down menu to add a record.

Step 2 Key information into all required fields.

Field descriptions are provided below in the order they display on the form.

A sample Provider UPIN list window is pictured below:

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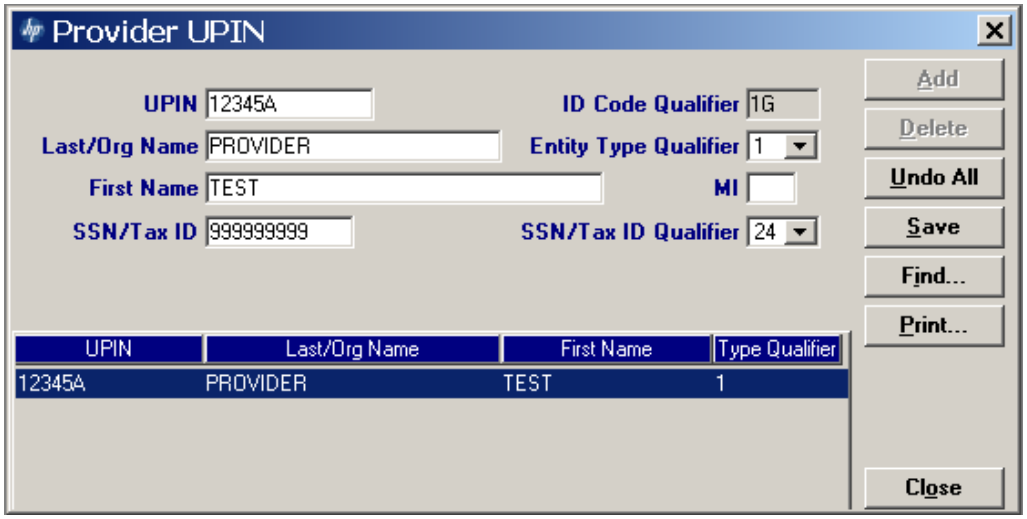

Field	*Guidelines*
UPIN	Enter the provider's 6-character unique provider identifier (ANNNNN or AAANNN characters).
Last/Org Name	Enter the name of the facility or the provider's/prescriber's name that corresponds to the number in the UPIN field.
ID Code Qualifier	Hard coded into the software
Entity Type Qualifier	Choose a value based on the information entered in the UPIN field. 1 – indicates the number entered in the UPIN field belongs to a person. 2 – indicates the number entered in the UPIN fields belongs to a non-person.
SSN/Tax ID	Enter the individual provider's 9-digit social security number or the Tax Identification number of the party being referenced. No hyphens, slashes, dashes or spaces should be used when completing this field. (If the Social Security Number or Tax ID is not known and cannot be obtained, please enter all 9's in this field and choose "SSN Number" from the SSN/Tax ID Qualifier.)
SSN/Tax ID Qualifier	Choose the best value to indicate if: 24 – SSN/Tax ID entered is the employer's identification number (such as Tax ID) or 34 - SSN/Tax ID entered is a SSN number.

Step 3 Press the 'Save' button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 4 Correct the mistake and press 'Save'.

Step 5 Press the 'Add' button to add another record.

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4.6 Using Lists

The lists you maintain can speed up your claims filing process. When you are submitting a claim form and you access a field that corresponds to a list (for instance, the Recipient ID field), the system displays a drop down menu. This drop down list contains the records you have previously added to the list. Scroll through the records and select one. Tab through the field and the system populates the field (and any corresponding fields, such as Recipient Name) with the information from the list record.

Alternatively, you can double-click in any field that corresponds to a list to access the list window. From this window, you may search for a record, modify an existing record, or add a new record.

NOTE:

The system does not verify the accuracy of the data you maintain on lists, other than requiring data to be the correct field length, if applicable. If you key errors in your list file (for instance, if you transpose digits for a recipient ID), you may not know you have made an error until you submit the claim and the claim is rejected. If you use lists, please print and review the lists occasionally to ensure their accuracy.

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5

5 Verifying Eligibility

This chapter provides instructions for submitting eligibility verification requests. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

Version 3.09 of the Provider Electronic Solutions software includes MCO enrollment information on the eligibility response. Please contact the recipient's MCO for further benefit information.

Benefit limitations on eligibility responses are fee-for-service limits only.

EPSDT screening dates are both fee-for-service claim related and encounter claim related dates.

If a "partial" message is returned in a section of eligibility, this means the specific eligibility segment starts or ends within the requested date span and is not effective for the complete date span requested.

Users access the Eligibility Verification window using one of the following methods.

For a 270 request:

- Selecting the Eligibility icon from the toolbar
- Selecting Forms>>270 Eligibility Request

For a NCPDP Pharmacy request: (For Pharmacy's only)

- Selecting the NCPDP Pharmacy Eligibility icon from the toolbar
- Selecting Forms>> NCPDP Pharmacy Eligibility

The electronic form for the 270 Request displays with two tabs: Header 1 and Header 2

The electronic form for NCPDP Pharmacy Request displays with one Header tab.

5.1 Submitting a Request

The Eligibility window contains three main parts:

- Updateable fields used to enter eligibility data.
- Buttons to the right of the window used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several eligibility verification transactions. Users may highlight a row to delete, copy,

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print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Date of Service (DOS), and Status.

Below is a description of the buttons that display on the Eligibility window:

Button	***Usage***
Add	Pressing this button enables you to refresh the window so you may add a new record. Please note that if you key over data that already displays on the record and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record, or press Copy (see below) to build a new record from an existing record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new record from an existing record.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently being displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the window.
Find	Pressing this button enables you to search for a saved record by status, DOS, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the record currently displayed.
Close	Pressing this button enables you to close the window.

To Add a New Record

Access the correct Eligibility form. Key information into all required fields, refer to Section *5.2 Completing the 270 Eligibility Form* **or** Section *5.3 Completing the NCPDP Pharmacy Eligibility Form.*

Step 1 Press the ‘Save’ button to save the record.

The system returns error messages if the record contains errors. Scroll through the error messages and double-click on each error to access the field on the record that contains the error.

Step 2 Correct any mistakes and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete records (status ‘I’) cannot be submitted via batch

To Modify a Record from the List

Scroll through the list of records that display at the bottom of the form. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the record. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct record.
- Press ‘Copy’ to copy a verification request that closely matches the information you need to enter (for example, if you must enter an eligibility verification request for the same recipient on a different date of service) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Eligibility request created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option will be to delete these Eligibility request. All Eligibility request submitted using PES version 3.0 must be created in the 3.0 software as a new request.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

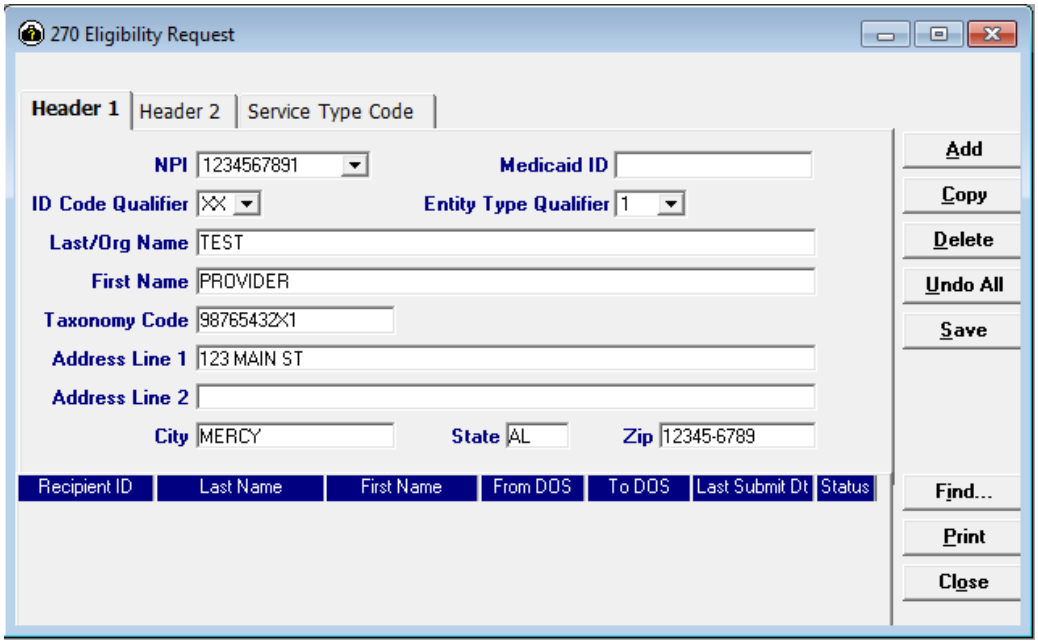
- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

5.2 Completing the 270 Eligibility form

The 270 Eligibility Request form is divided into three Headers. A sample of Header 1 is pictured below:



Please complete the fields below in order to save and send your record:

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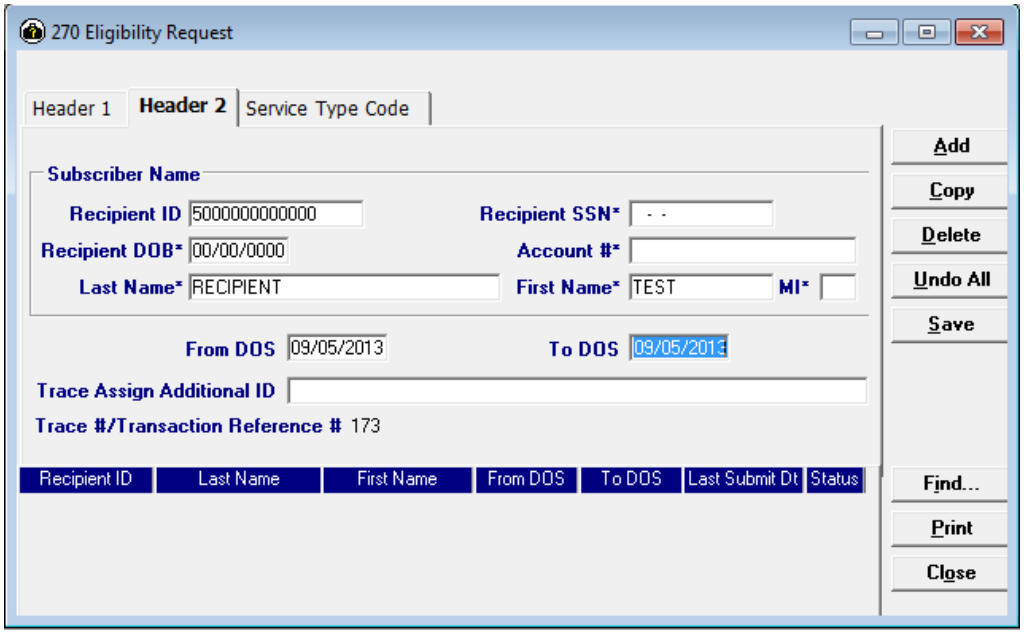
Field	***Guidelines***
NPI	Choose the desired NPI from your Provider list. If you have not added the required NPI to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Medicaid ID	For providers with multiple service locations, enter the Alabama Medicaid ID number as a secondary identifier for the appropriate service location. For providers who do not have an NPI, enter the 9-digit Medicaid ID number. NOTE: If using only the 9-digit Medicaid ID number, the provider information must be manually entered. If using the NPI or NPI with Medicaid ID, the provider information can be populated from the Provider List.
ID Code Qualifier	Select the value that identifies the entity that assigned the ID.
Entity Type Qualifier	Choose a value based on the information entered in the Provider ID/NPI field. 1 – Indicates the number entered in the field belongs to a Person. 2 – Indicates the number entered in the field belongs to a Non-Person.
Last/Org Name	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. If using the 9-digit Medicaid ID, the information must be manually entered. Enter the name of the facility or the provider's last name.
First Name	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. If using the 9-digit Medicaid ID, the information must be manually entered. If a "1" was chosen in the Entity Type Qualifier field, enter the provider's first name.
Taxonomy Code	If using the NPI from the provider list, this field will auto-write based on the information placed in the Provider ID field. This field is optional.
Provider Address – Line 1	If using the NPI from the provider list, the provider address fields will auto-write based on the information placed in the Provider ID field or enter the facility or provider's primary street address.
Line 2	Enter additional street information such as apartment number, or suite. This field is optional.
City	Enter the facility or provider's City.
State	Enter the facility or provider's State.
Zip+4	Enter the facility or provider's Zip Code plus the 4-digit Zip Code extension.

A sample of Header 2 is pictured below:



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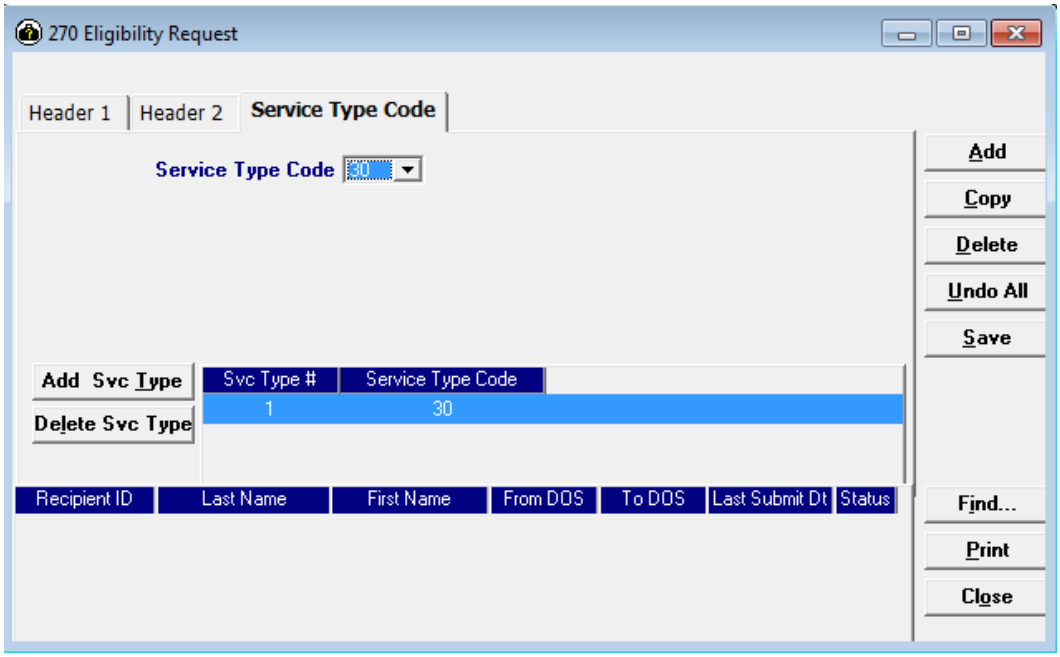
Please complete the fields below in order to save and send your record:

Field	***Guidelines***
Recipient ID	Enter the first 12 digits of the recipient number, the check digit will be returned in the eligibility verification response. Or select a recipient number from the recipient list. This field is optional if inquiring with the recipient's name, date of birth and or SSN.
Recipient SSN	Enter the Social Security Number of the person to which services are rendered. This field is optional if the Recipient ID number is entered.
Recipient DOB	Enter the date the Medicaid recipient was born in MMDDCCYY format. This field is optional if the Recipient ID number is entered.
Account #	Enter the patient account number for your records. This field is optional.
Last Name	Enter the recipient's last name. This field is optional if the Recipient ID number is entered.
First Name	Enter the recipient's first name. This field is optional if the Recipient ID number is entered.
MI	Enter the recipient's middle initial. This field is optional.
From DOS	The current days date will auto write within this field. If you do not wish to use the current date you may enter the start date in MM/DD/CCYY format.
To DOS	The current days date will auto write within this field. If you do not wish to use the current date you may enter the stop date in MM/DD/CCYY format.
Trace Assigning Additional ID	Identifies a further subdivision within the organization.
Trace #/Transaction Reference #	This field allows you to utilize the trace # that is also located on the 271 response to locate which request the response is referring to.

A sample of the Service Type Code tab is pictured below:



Please complete the fields below in order to save and send your record:

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Field	***Guidelines***
Service Type Code	This drop down defaults to Service Type Code 30 – Health Benefit Plan Coverage. This is the same information that has been returned in the past for eligibility requests through Alabama Medicaid. You do not need to do anything on this tab if you wish to have just that information returned as before. If you wish to return a Service Type other than 30 click the dropdown to change the Service Type Code to the Service Type Code you want returned. If you wish to have additional Service Type Code information returned, click the 'Add Svc Type' button to the bottom left of the dropdown field and then change the Service Type Code dropdown to the code you want returned. The software will allow up to 99 Service Type Codes on one eligibility request.

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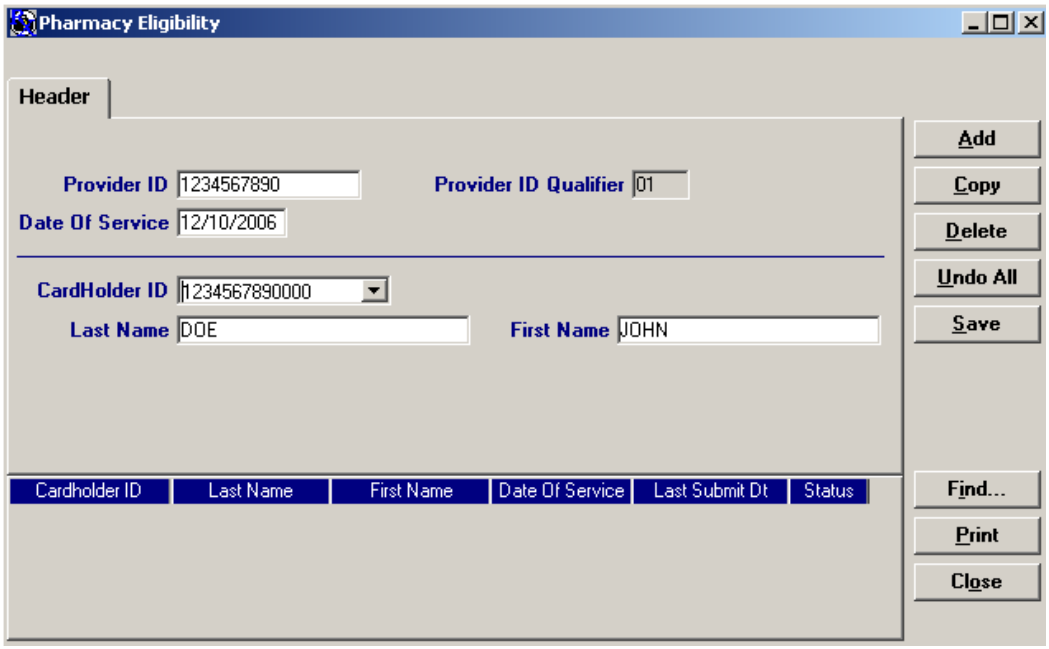
5.3 Completing the NCPDP Pharmacy Eligibility form

A sample of the Header for the request form is pictured below:



Please complete the fields below in order to save and send your record:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Code Qualifier	The value 01 will always be the default selection.
Date of Service	Change the date of service if the eligibility request is in regards to a dispense date other than the current date.
Cardholder ID	Enter the first 12 digits of the recipient number (the check digit will be returned in the eligibility verification response) from the Medicaid identification card.
Last Name	Enter the cardholder's last name. This field is optional if the cardholder ID is entered.
First Name	Enter the cardholder's first name. This field is optional if the cardholder ID is entered.

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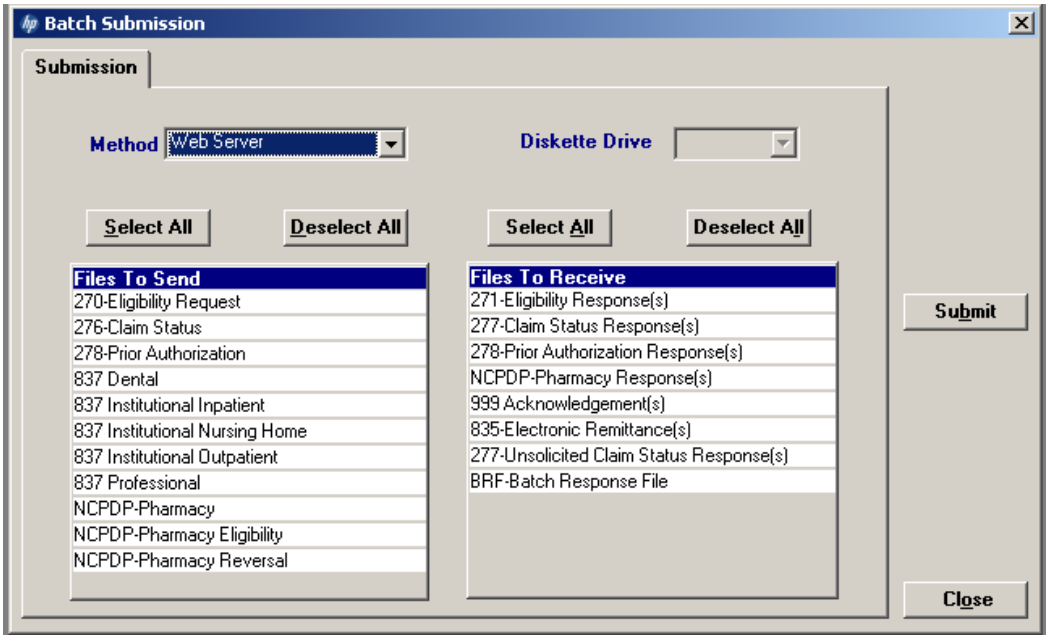
5.4 Submitting a 270 Batch Request

Review the steps for adding an eligibility verification record, modifying a record, and using the list feature as described in Section *5.1, Submitting a Request*. After all records have been entered and saved, submit the batch of 270 eligibility verification records using the procedures provided below.

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the Method drop down list.

Step 3 Determine which files you want to send from the Files to Send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the Files to Receive.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press ‘Submit’, then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

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Step 5 Press the 'Submit' to submit (and receive) the files.
Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

To view Recipient Eligibility information, you must download the Batch Response File (BRF) using the Provider Electronic Solutions software.

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6

6 Submitting 837 Dental Claims

This chapter provides instructions for submitting electronic 837 Dental claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual, *Chapter 13*, for program-specific information.

Users access the Dental electronic claim form using one of the following methods:

- Selecting the Dental icon from the toolbar
- Selecting Forms>>837 Dental

The electronic form displays with three tabs: Header 1, Header 2, and Service. The additional tabs, if applicable are: OI (Other Insurance), OI Adj (Other Insurance Adjustment), and Service Adj (Service Adjustment.

6.1 Entering Claims in the Electronic Dental Form

Each tab on the Dental form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form in an "R" status.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

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To Add a New Claim

Step 1 Access the 837 Dental form and key information into all required fields. (All fields are required unless indicated as optional.)

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the 'Save' button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct the mistake and press 'Save', or press 'Incomplete' to save the record with an incomplete status.

Incomplete claims (status 'I') are not submitted with the batch submission.

Step 4 Press the 'Add' button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. *You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete).* Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients). Modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there

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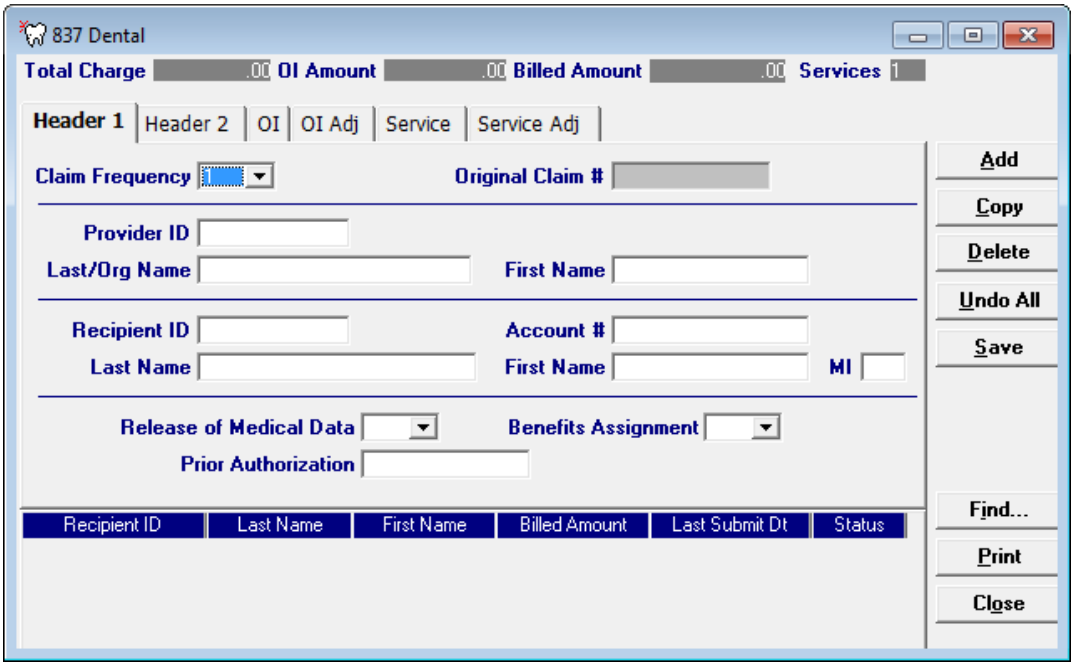
are no records that match the search criteria. Press ‘Cancel’ when you have finished searching.

6.2 Fields on the 837 Dental Claim Form

6.2.1 Header 1 Tab

Below is a sample electronic 837 Dental form displaying the Header 1 tab:



Field	*Guidelines*
Claim Frequency	Choose the best value to indicate type of claim submission. 1 – Indicates this is an original claim (If you have billed this claim previously, but it denied you may still choose a 1 to indicate it is original). 7 – Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill. 8 – Void or reverse a prior claim. You must have the ICN number of the original paid claim in order to complete the claim reversal process.
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the ICN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient’s 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.

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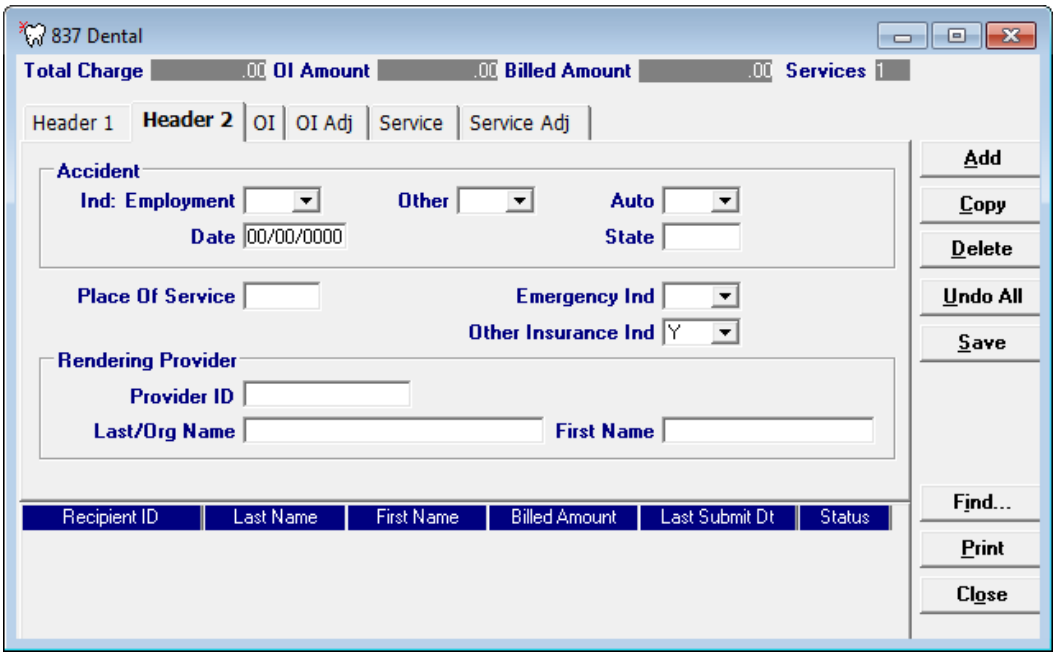
Field	*Guidelines*
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Prior Authorization	If applicable, enter the Prior Authorization number issued by the Medicaid agency. **This field is optional**.

6.2.2 Header 2 Tab

Below is a sample electronic 837 Dental form displaying the Header 2 tab:



Field	*Guidelines*
Ind: Employment	Choose the best value to indicate if services were provided as a result of an on the job injury.
Other	Choose the best value to indicate if services were provided as a result of an injury (other than on the job injury or automobile accident).
Auto	Choose the best value to indicate if services were provided as a result of an automobile accident.
Date	Enter the date of the accident if services are the result of an accidental injury in MM/DD/CCYY format.
State	If applicable, enter the state that the accident occurred in an abbreviated format. For example, **AL** for Alabama.
Place of Service	Choose the best value to indicate where the service took place. • 11 – Dental Office • 21 – Inpatient Hospital • 22 – Outpatient Hospital • 31 – Nursing Facility

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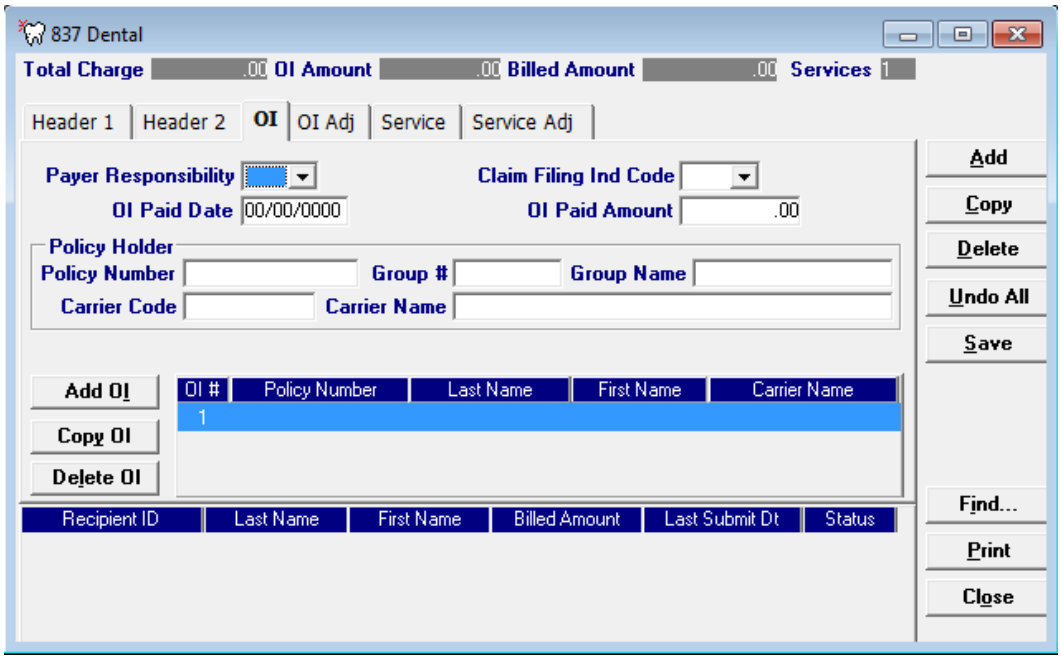
Field	*Guidelines*
Emergency Ind	Choose the best value to indicate if this procedure was due to an emergency.
Other Insurance Ind	Choose the best value to indicate whether or not the recipient has other insurance besides Medicaid. An indication of 'Y' will put the "OI" tab and "OI Adj" tabs on your claim form.
Rendering Provider ID	Choose a provider ID from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions. **Also, if the provider entered here performed all services being billed on this claim, DO NOT enter a rendering provider ID on the Service tab.**
Last/Org Name	This field will auto-write based on the entry in the Rendering Provider ID field.
First Name	This field will auto-write based on the entry in the Rendering Provider ID field.

6.2.3 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Dental form displaying the OI tab.



Field	*Guidelines*
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's insurance coverage status to Medicaid. Do not enter 09 or Medicare-related codes 16 or MB on the OI tab. See Appendix B, section B-3 for specific codes in the dropdown list.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service(s) being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service(s) being billed.

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Field	*Guidelines*
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Group #	This field will auto-write based on the information chosen in the Policy Number field.
Group Name	This field will auto-write based on the information chosen in the Policy Number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy Number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy Number field.

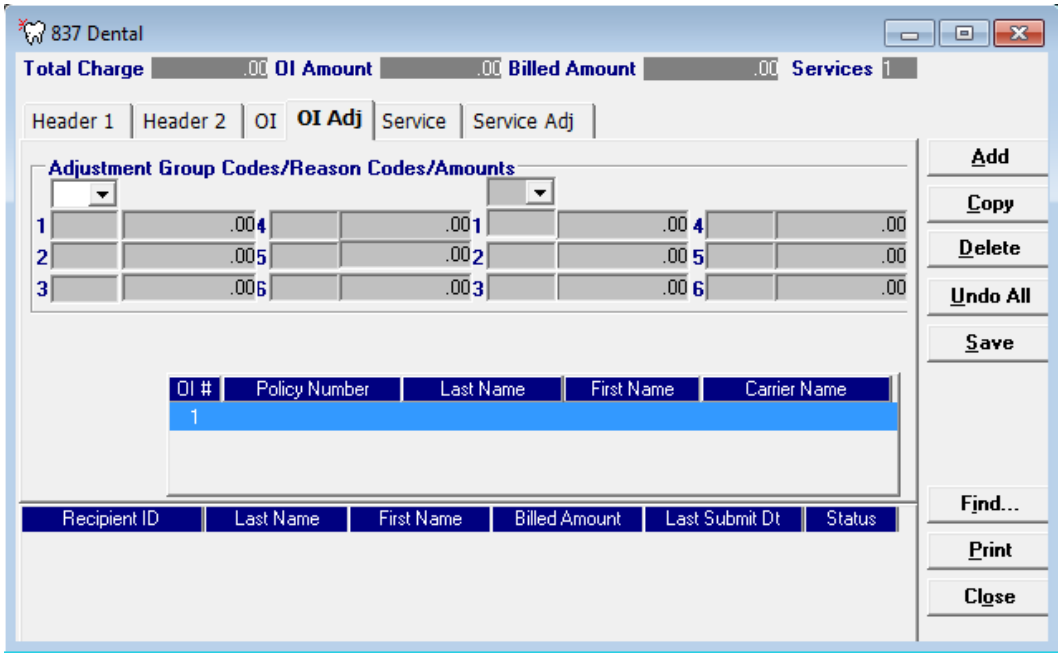
Adding, Deleting, or Copying another insurance.

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

6.2.4 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Dental form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.

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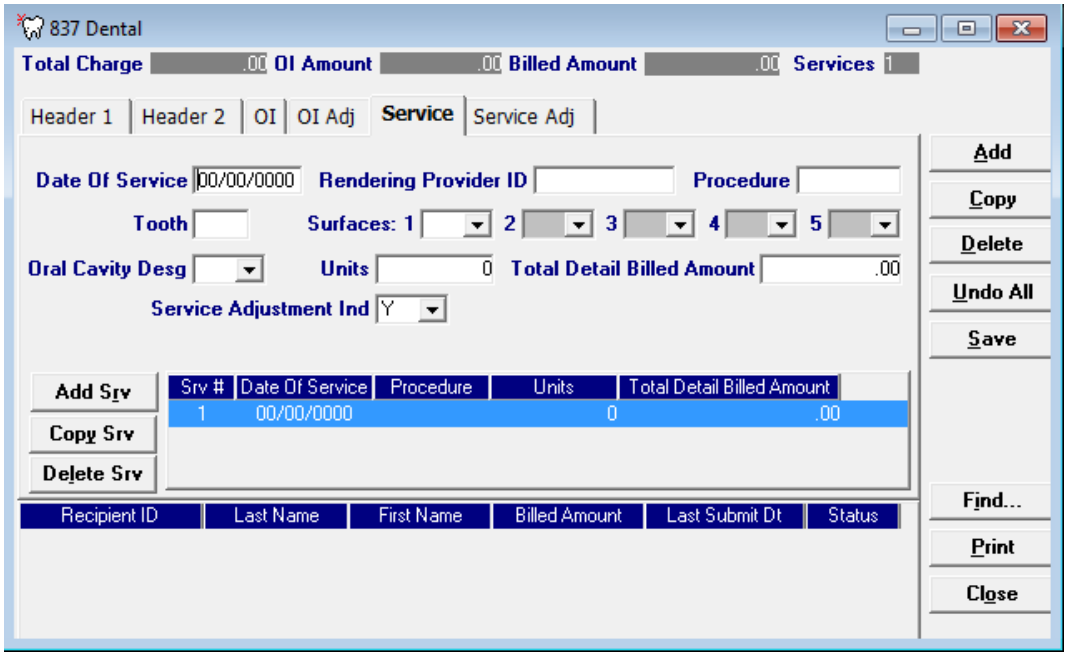
Field	*Guidelines*
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

6.2.5 Service Tab

Below is a sample electronic 837 Dental form displaying the Service tab.



Field	*Guidelines*
Date of Service	Enter the Date of Service for the procedure being billed in MM/DD/CCYY format.
Rendering Provider ID	ENTER A RENDERING PROVIDER ID IN THIS FIELD **ONLY** IF ENTERING AN ID NUMBER THAT IS **DIFFERENT** FROM THE RENDERING PROVIDER ENTERED ON HEADER 2. Otherwise, choose a provider ID from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Procedure	Enter the appropriate ADA procedure code for the procedure being billed. (Such as D0230)
Tooth	If applicable to procedure billed, enter the appropriate tooth number for permanent teeth (01-32) or the appropriate letter for primary teeth (A-T). Medicaid recognizes supernumerary teeth for primary dentition as (AS – TS) and supernumerary teeth for permanent dentition as (51 – 82).

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Field	*Guidelines*
Surfaces	If applicable to procedure billed, choose the appropriate tooth surface of the tooth on which the service is performed (MBD, MOB, MODL). This field is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. B – Buccal D – Distal F – Facial I – Incisal L – Lingual M – Mesial O - Occlusal
Oral Cavity Designation	If applicable, choose the best value to indicate the area of the oral cavity (mouth) where treatment is being performed. 00 – Entire Oral Cavity 01 – Maxillary Area 02 – Mandibular Area 10 – Upper Right Quadrant 20 – Upper Left Quadrant 30 – Lower Left Quadrant 40 – Lower Right Quadrant
Units	Enter the amount of units/quantity being billed for the particular procedure code. If the procedure is performed on different teeth, a separate line of service must be entered.
Total Detail Billed Amount	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
Service Adjustment Ind	Select 'Y' to allow service adjustments to be entered on the service adjustment tab. If you have to enter adjustments for each detail you will need to select Y on this drop down for **EACH** detail line. Then you can go to the Service Adj tab to enter the information.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

6.2.6 Service Adj Tab

Below is a sample electronic 837 Dental form displaying the Service Adj tab.

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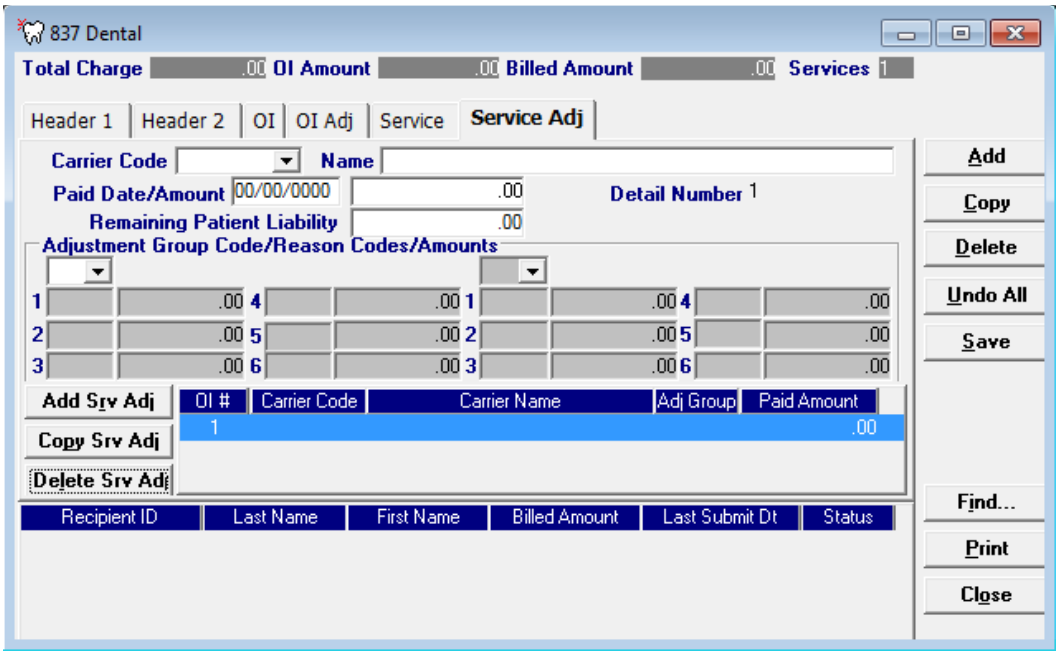

Field	*Guidelines*
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

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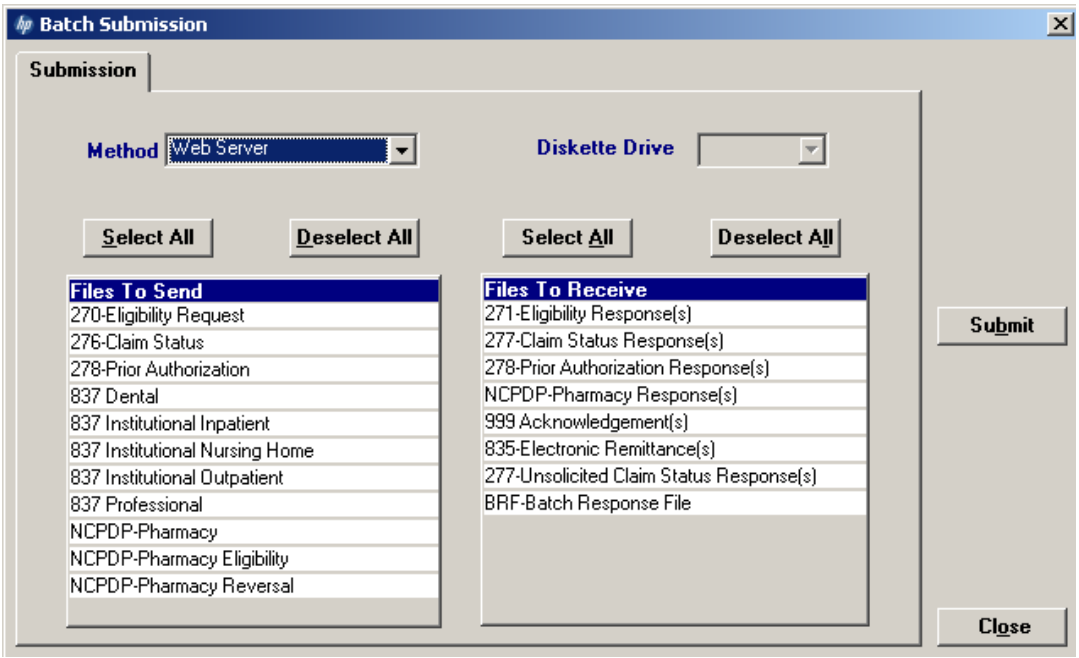
6.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the web server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last* transmission, not the current transmission.

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the BRF using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and perform an online claim search.

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7 Submitting NCPDP Pharmacy Claims

This chapter provides instructions for submitting electronic Pharmacy claims. The interactive submission of pharmacy claims is no longer a feature of this software. Users must perform all interactive transactions using the Interactive Web Portal. For instructions to access the Interactive Web Portal, refer to Chapter 17. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the Pharmacy electronic claim form using one of the following methods:

- Selecting the NCPDP Pharmacy icon from the toolbar
- Selecting Forms>>NCPDP Pharmacy

The electronic form displays with three tabs: Header, Service 1 and Service 2.

7.1 Entering Claims in the Electronic NCPDP Pharmacy Form

Each tab on the Pharmacy form contains four main parts:

- Header line of fields that display the Provider and Recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is helpful if you routinely submit claims for the same procedure code, but different recipients, or when your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To submit pharmacy claims as a batch, refer to section *7.3 Submitting Claims through the Web Server or Diskette*.

DUR Alerts

Please refer to Chapter 27 of the Alabama Medicaid Provider Manual, Pharmacy, for a description of DUR alerts.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

NOTE:

Pharmacy transactions created using 1.1 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using the 1.2 PES (version 3.0). The only option is to delete these Pharmacy transactions. All Pharmacy transactions submitted using PES version 3.0 must be created in the 3.0 software as a new Pharmacy transaction.

To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

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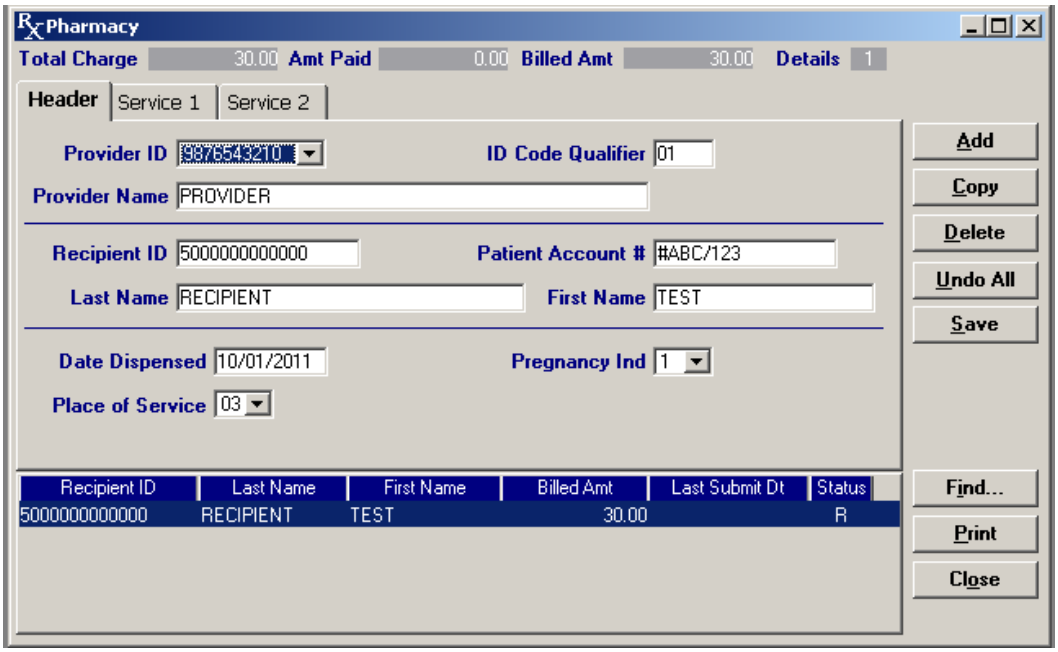
7.2 Fields on the NCPDP Pharmacy Claim Form

7.2.1 Header Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Header tab.



Complete the following fields under the Header tab to submit a pharmacy claim:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Qualifier	The value that identifies the entity that assigned the ID. 01 National Provider Identifier (NPI)
Provider Name	This field will auto-write based on the information placed in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Patient Account #	This field will auto-write based on the information placed in the Recipient ID field.
Last Name	This field will auto-write based on the information placed in the Recipient ID field.
First Name	This field will auto-write based on the information placed in the Recipient ID field.
Date Dispensed	Enter the date the prescription is dispensed to the recipient in MM/DD/CCYY format.
Pregnancy Ind	If applicable, choose the best value to indicate if the recipient is (1) not pregnant or (2) pregnant.
Place of Service	Select the best value from the drop-down-display menu box to indicate where the service was rendered.

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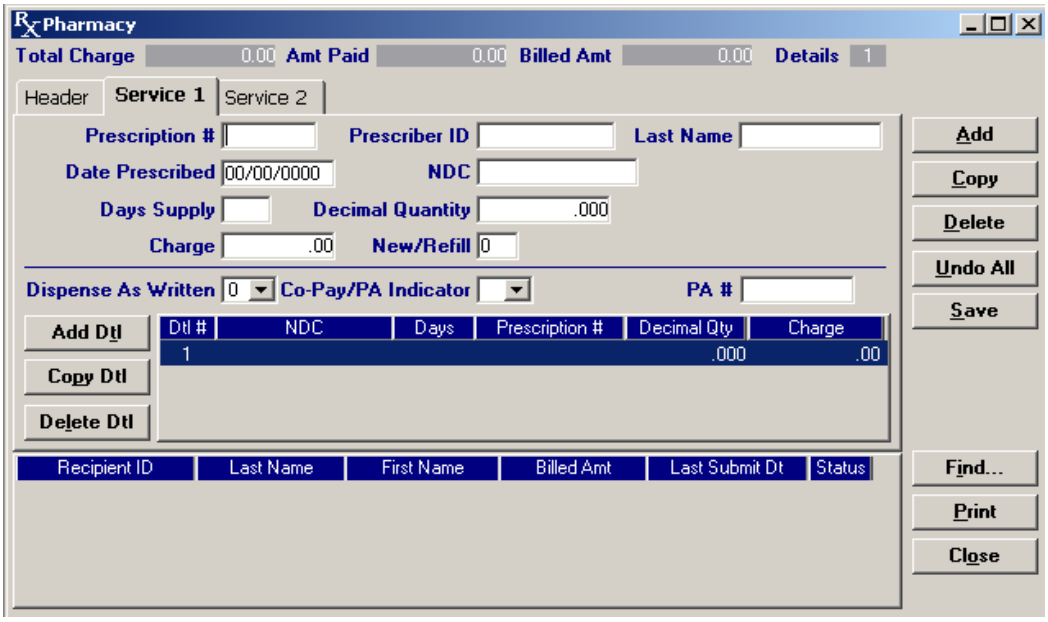
7.2.2 Service 1 Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Service 1 tab.



Complete the following fields under the Service 1 tab to submit a pharmacy claim.

Field	*Guidelines*
Prescription #	Enter the 7 to 12-digit prescription number.
Prescriber ID	Enter the prescriber's professional license number or NPI as it is displayed on the prescription.
Last Name	Enter the prescriber's last name as it is displayed on the prescription. This field will auto write if Provider ID field is populated with information from the prescriber list.
Date Prescribed	Enter the date the prescription was written in MM/DD/CCYY format.
NDC	Enter the 11-digit National Drug Code (NDC).
Days Supply	Enter the day supply according to the prescription. The day supply is limited to a maximum of 999 days.
Decimal Quantity	Enter the quantity or number of units or metric units of medication dispensed. The system displays quantities to the third decimal place. For example, if you enter 45, the system displays 45.000. There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5 ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45 gm tube of ointment should be coded as 00045. If a product is supplied in fractional units, you must key in the decimal as part of the quantity. For example, a 35.5 gm tube of ointment should be entered as 3–5–*decimal*–5 (35.500).
Charge	Enter the amount (dollars and cents) of your customary charge.
New/Refill	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.

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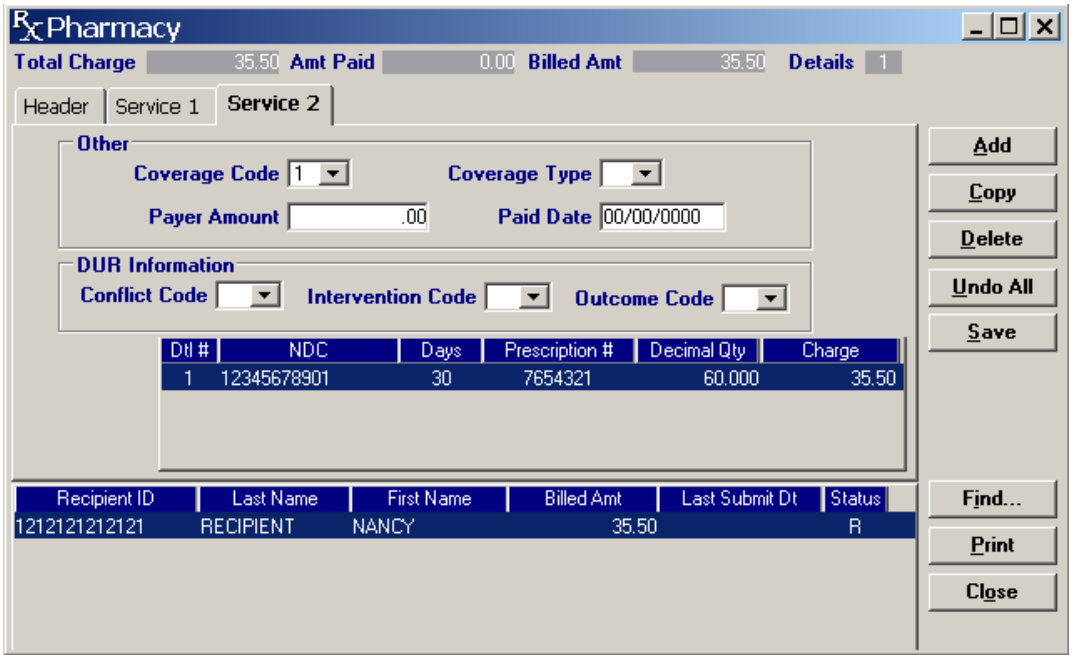
Field	Guidelines
Dispense as Written	Choose the best Dispense as Written (DAW) value from the drop-down-display menu box to indicate the reason if dispensing a brand name product.
Co-Pay/PA Indicator	If applicable, select the appropriate value from the drop down list box. Valid values are: 1 – Prior Authorization or 4 – Co-Pay Exempt. **This field is optional.**
PA #	If applicable, enter the 10-digit numeric Prior Authorization number. This field is optional.

7.2.3 Service 2 Tab

Below is a sample electronic NCPDP Pharmacy form displaying the Service 2 tab.



Complete the following fields under the Service 2 tab to submit a pharmacy claim.

Field	Guidelines
Coverage Code	Choose the best coverage code that indicates the recipient's primary insurance coverage status on the particular prescription being filled. Valid values are 00 – 04.
Coverage Type	If the Coverage Code is a value of 02 - 04, then choose the correct value to categorize the other insurance as primary, secondary or tertiary to Medicaid.
Payer Amount	If applicable, enter any amount paid by an insurance company or other primary payers known at the time of submission. Do not enter Medicaid co-payment or patient payment in this block.
Paid Date	Enter the other insurance's paid date in MM/DD/CCYY format. This field is optional.
Conflict Code	Choose the best value for a soft-edit prescription override. Conflict Codes are always system generated and are as follows: **DD** - Drug - Drug Interaction; **ER** - Overuse; **HD** - High Dose Alert; **LD** - Low Dose Alert; **LR** – Under-use Precaution; **PA** - Patient Age; **PS** - Product Selection; **TD** - Therapeutic Duplication, **ID – Ingredient Duplication**.
Intervention Code	Choose the best value for a soft-edit prescription override. The values are as follows: **OO(Zero + Zero)** - No intervention; **MO(M + Zero)** - Prescriber Consulted; **PO(P + Zero)** - Patient Consulted: **RO(R + Zero)** - Pharmacist Consulted Other Source:

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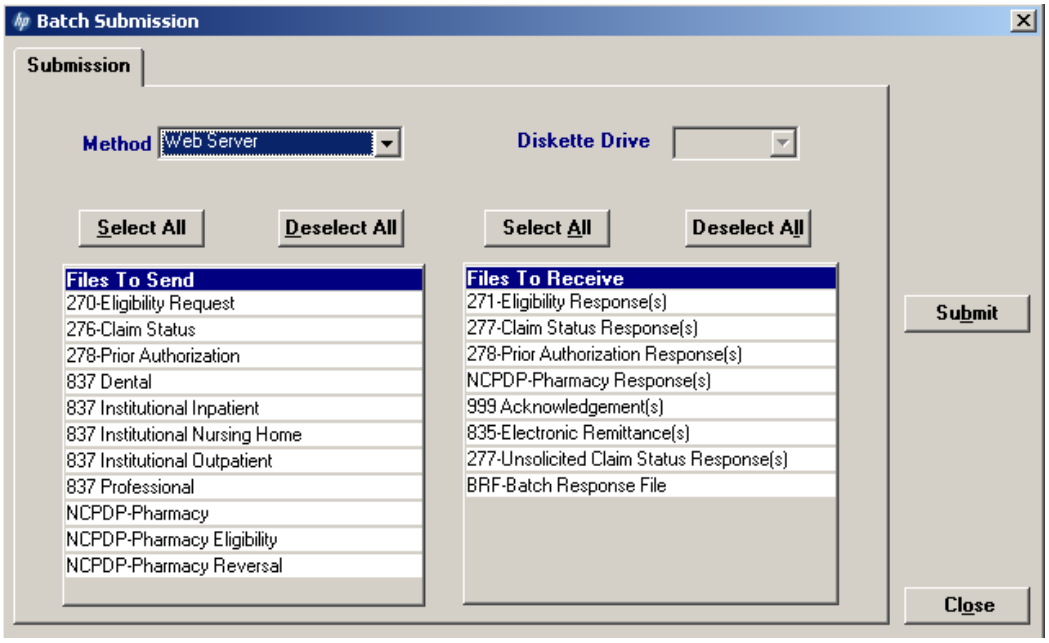
Field	*Guidelines*
Outcome Code	Choose the best value for a soft-edit prescription override. The values are as follows: **1A** - Filled as Is, False Positive; **1B** - Filled Prescription As Is; **1C** - Filled, With Different Dose; **1D** - Filled With Different Directions; **1E** - Filled With Different Drug; **1F** - Filled, With Different Quantity; **1G** - Filled with Prescription Approval; **2A** - Prescription Not Filled; **2B** - Not Filled, Directions Clarified.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, copy, or delete a service. Once you copy a service, you can modify it as necessary.

7.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

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Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the web server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

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8

8 Submitting 837 Professional

This chapter provides instructions for submitting electronic 837 Professional claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

8.1 General Instructions for Entering Electronic Claims

Users access the 837 Professional electronic claim form using one of the following methods:

- Selecting the 837 Professional icon from the toolbar
- Selecting Forms>>837 Professional

The electronic form displays with ten tabs: Header 1, Header 2, Header 3, Service 1 and Service 2. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustments), Crossover, Service Adj (Service Line Adjustments), and NDC.

8.1.1 Entering Claims in the Electronic 837 Professional Forms

Each tab on the 837 Professional form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record that has been submitted previously. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.

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Button	***Usage***
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Professional form. Key information into all required fields.

Field descriptions are provided in section *8.2 837 Professional form* in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.

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- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for example, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

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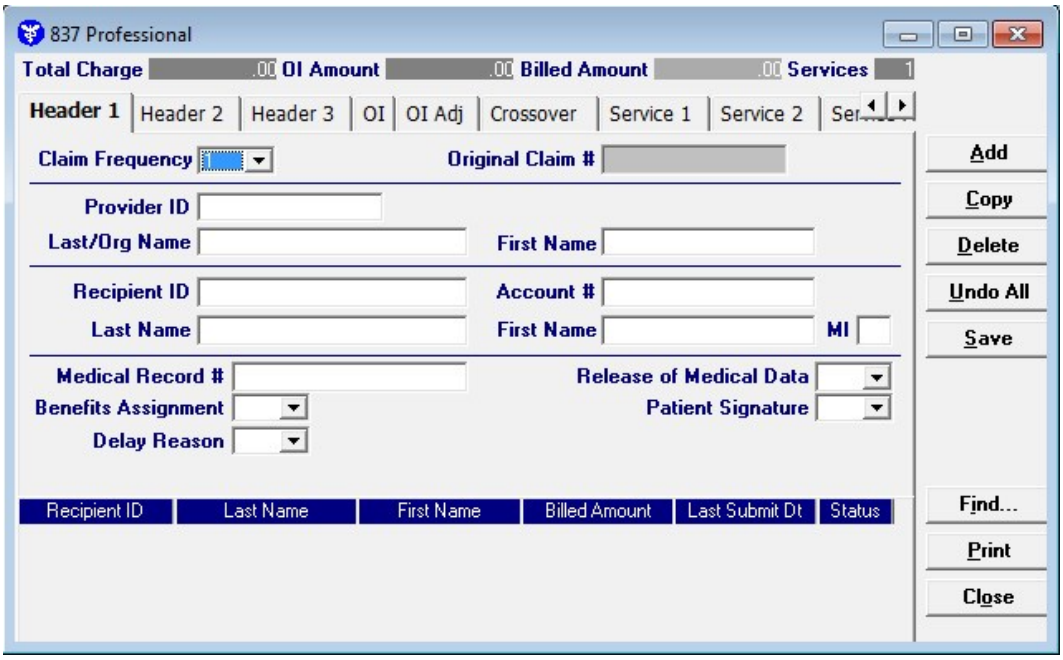
8.2 837 Professional Form *8.2.1*

Header 1 Tab

Below is a sample electronic 837 Professional form displaying the Header 1 tab.



Complete the following fields under the Header 1 tab to submit an 837 Professional claim:

Field	***Guidelines***
Claim Frequency	Choose the best value to indicate type of claim submission. 1 – Indicates this is an original claim (If you have billed this claim previously, but it denied you may still choose a 1 to indicate it is original). 7 – Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill. 8 – Void or reverse a prior claim. You must have the ICN of the original paid clam in order to complete this process.
Original Claim #	If a value other than 1 was entered in the Claim Frequency field, you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose the appropriate group/payee provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.

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First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Info for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Patient Signature	The default value is 'blank.' • **P** – Signature generated by provider because the patient was not physically present for service. • **'Blank'** - Signature generated by an entity other than the patient according to State or Federal law.
Delay Reason	Select the best value from the drop-down-display menu box to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. These delay reasons do <u>not</u> override claims over the year past filing limit. You must process such claims through the required process to receive payment considerations.

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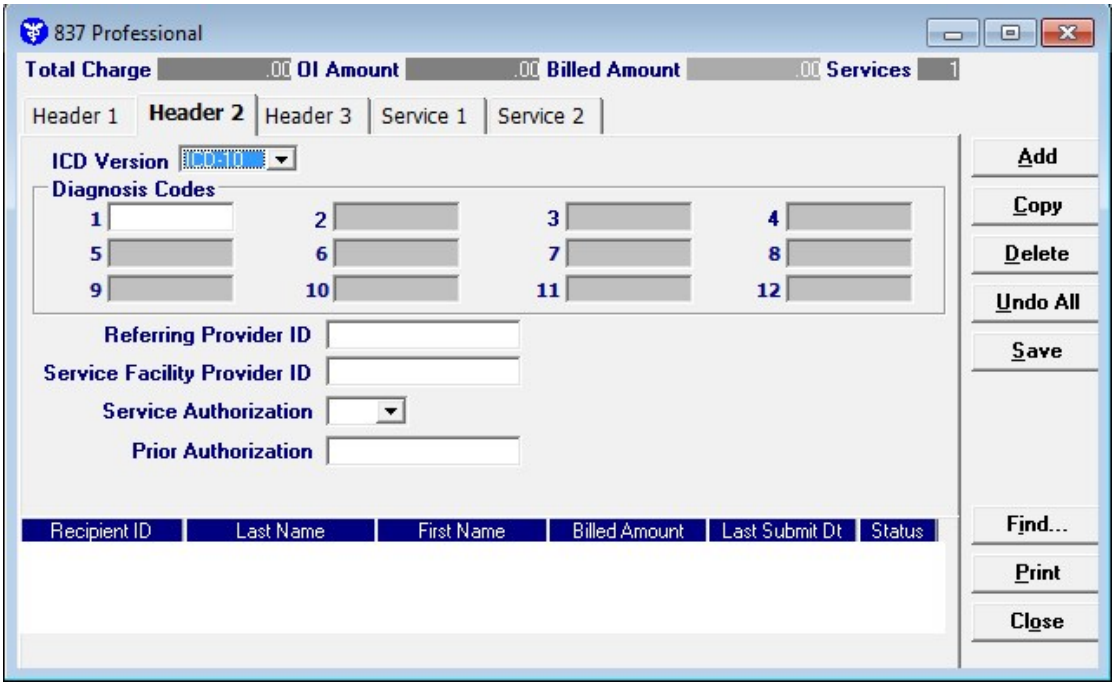
8.2.2 Header 2 Tab

Below is a sample electronic 837 Professional form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an 837 Professional claim:

Field	Guidelines
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Codes	Choose a proper diagnosis code from your diagnosis code list. These fields must be a minimum of 3-digits long and cannot contain decimals. Up to 12 diagnosis codes can be entered.
Referring Provider ID	Choose a provider ID from your provider ID list to indicate which provider referred the recipient to your facility. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Service Facility Provider ID	Select the provider NPI where the service was performed only if the service was provided at a location different than the billing provider location on Header 1 tab.
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. Immediate Urgent Care Services Rendered in a Retroactive Period Emergency Care Client has temporary Medicaid Bypass Provider Contract Check Claim exempt from Program edits Force into MAT Care Program
Prior Authorization	Enter the Prior Authorization number issued by the State Agency. This field is optional.

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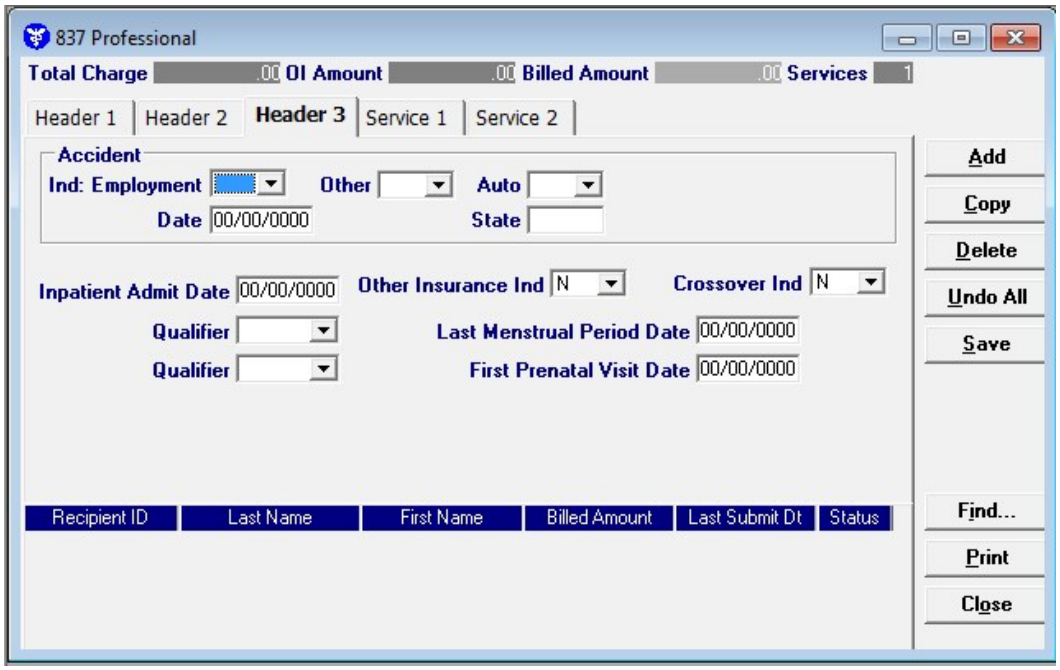
8.2.3 Header 3 Tab

Below is a sample electronic 837 Professional form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an 837 Professional claim:

Field	***Guidelines***
Ind: Employment	Choose the best value to indicate if services were provided as a result of an on the job injury.
Other	Choose the best value to indicate if services were provided as a result of an accident (other than on the job or automobile accident)
Auto	Choose the best value to indicate if services were provided as a result of an automobile accident.
Date	Enter the date of the accident if services were provided as a result of an accidental injury in MM/DD/CCYY format.
State	Enter the state that the accident occurred. The state should be abbreviated.
Inpatient Admit Date	If the recipient is currently admitted into the hospital as an inpatient stay, indicate the admission date in MM/DD/CCYY format.
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.
Qualifier	Choose the best value to indicate last menstrual period
Date	Enter the date of the last menstrual period if services are related in pregnancy in MM/DD/CCYY format.
Qualifier	Choose the best value to indicate first prenatal visit
Date	Enter the date of the first prenatal visit if services are related in pregnancy in MM/DD/CCYY format.

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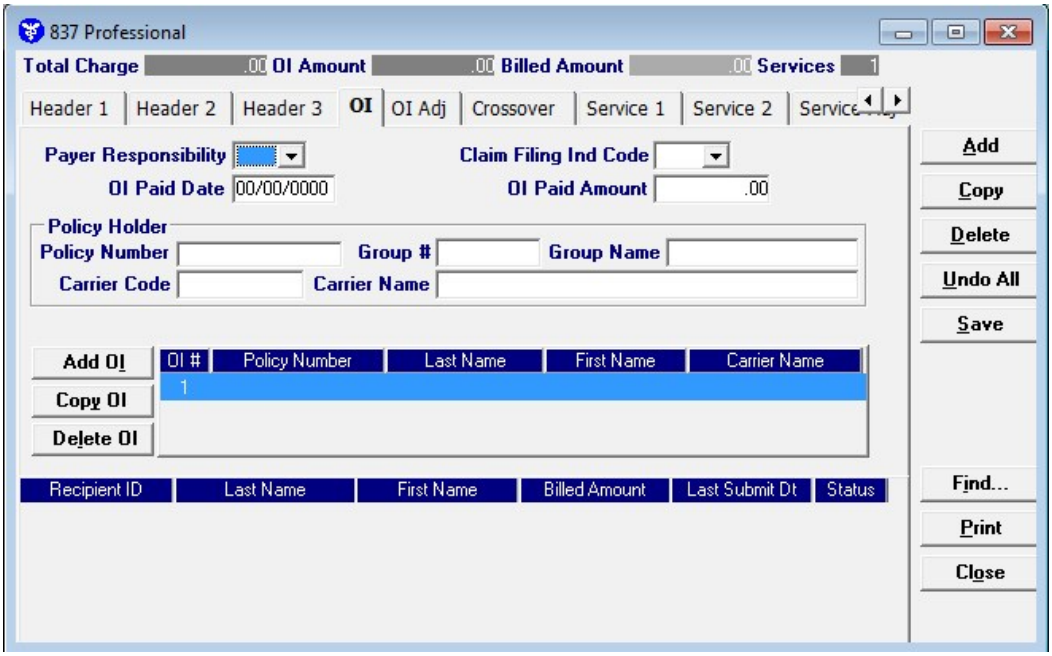
8.2.4 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Professional form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an 837 Professional claim:

Field	***Guidelines***
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the type of insurance the recipient has. (Do NOT select Selfpay or Medicare indicators for the OI tab). Note: For FQHC and Rural Health Clinics, if billing Alabama Medicaid as secondary to an MCO, use a claim filing indicator code of 14.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.

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Field	*Guidelines*
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

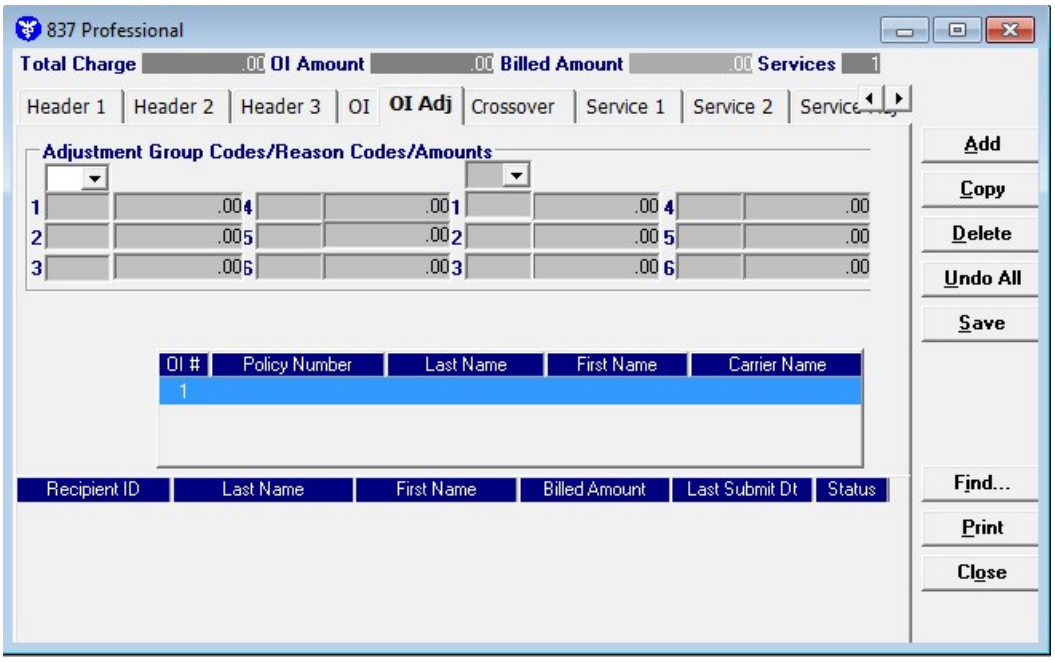
Adding, Deleting, or copying another insurance.

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient.

8.2.5 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Professional form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Complete the following fields under the OI Adj tab to submit an 837 Professional claim:

Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.

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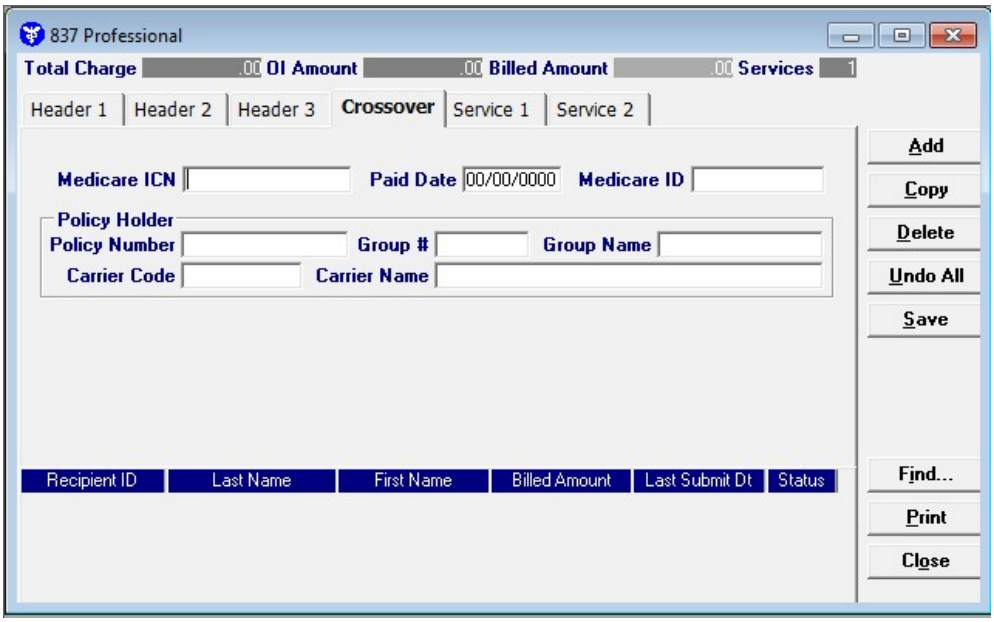
Field	*Guidelines*
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

8.2.6 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Professional form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an 837 Professional claim:

Field	*Guidelines*
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added a Medicare record for the recipient to the Policy Holder list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

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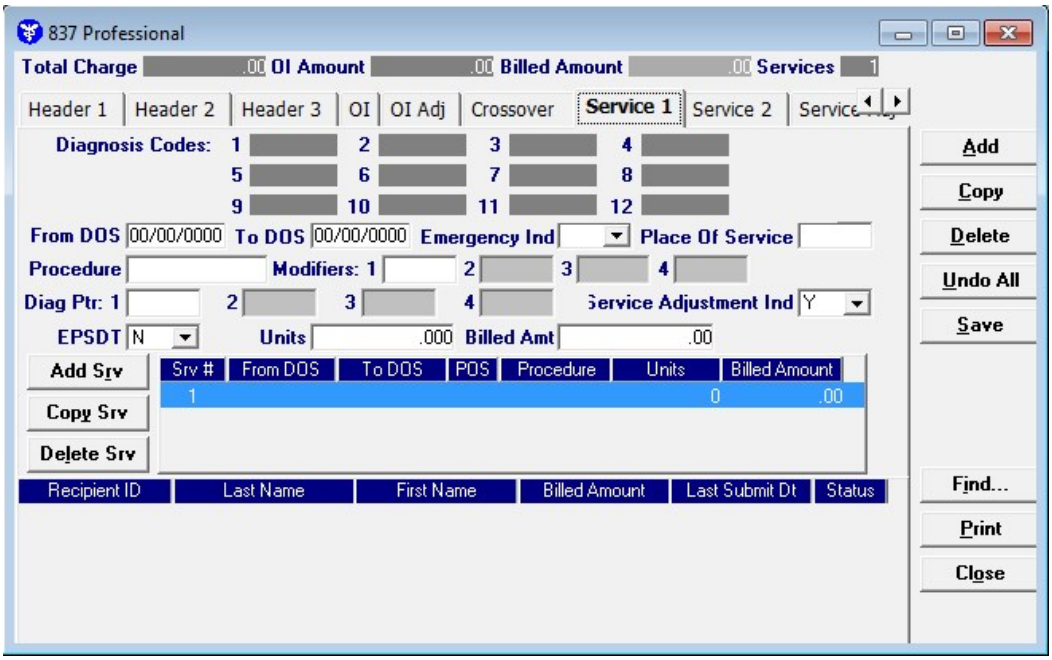
8.2.7 Service 1 Tab

Below is a sample electronic 837 Professional form displaying the Service 1 tab.



Complete the following fields under the Services 1 tab to submit an 837 Professional claim:

Field	***Guidelines***
From DOS	Enter the start date of service for each procedure provided in a MM/DD/CCYY format.
To DOS	Enter the stop date of service for each procedure provided in a MM/DD/CCYY format. If identical services (and charges) are performed on the same day, enter the same date of service in both 'from' and 'to' fields.
Emergency Ind	Choose the best value to indicate if this procedure was due to an emergency.
Place of Service	Choose the best value to indicate where the service/procedure was performed from the Place of Service list.
Procedure	Enter the appropriate five-digit procedure code for each procedure or service billed. Use the current CPT-4 book as a reference.
Modifiers	If applicable, enter the modifier for the procedure.
Diag Ptr	If a diagnosis code was entered, enter a value 1 – 12 to indicate which diagnosis the procedure is a result of.
EPSDT	Choose the best value to indicate if the procedure being billed is due to an EPSDT referral.
Units	Enter the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this block. Fractional units can be indicated – see Chapter 34 of the Provider Manual.
Billed Amount	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private pay patients.

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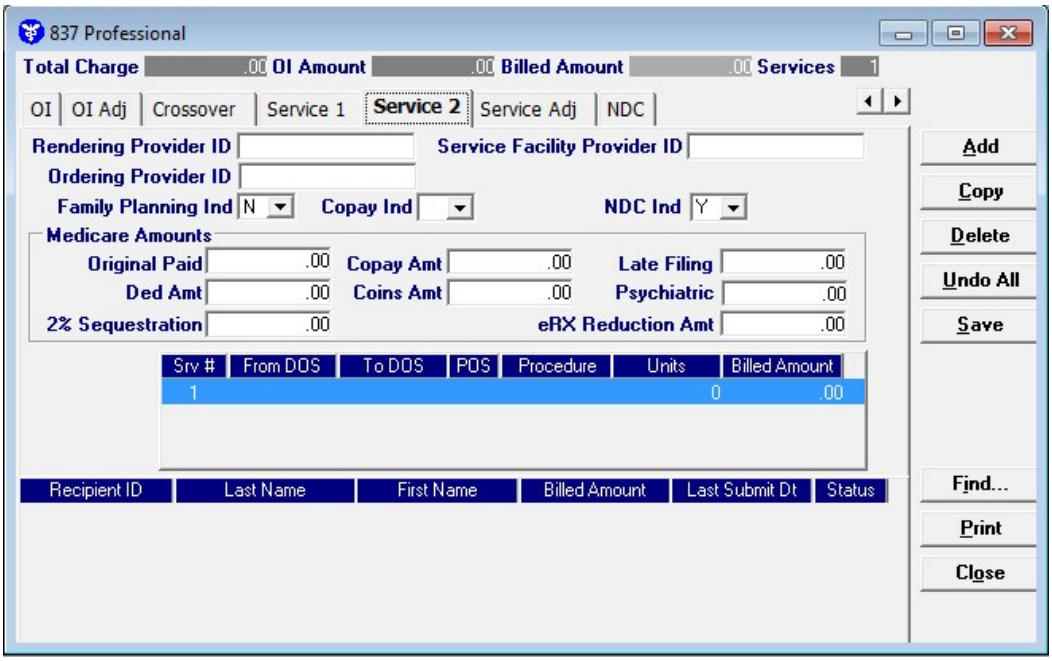
8.2.8 Service 2 Tab

Below is a sample electronic 837 Professional form displaying the Service 2 tab.



Complete the following fields under the Service 2 tab to submit an 837 Professional claim:

Field	***Guidelines***
Rendering Provider ID	Choose a provider ID from your provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.
Ordering Provider ID	Enter the ordering provider if the service or supply was ordered by a provider who is different than the rendering provider for this service line.
Copay Ind	Choose *0 - Co-pay Exempt* if the recipient is pregnant, if the recipient is a Native American with an Active User Letter issued by Indian Health Services, or if the service was due to an emergency.
Family Planning Ind	Choose the best value to indicate if the recipient's services were family planning related.
NDC Ind	Choose the best value to indicate if a National Drug Code (NDC) is being billed on the claim. If 'Y' is selected, the NDC tab will display, complete the information on the NDC Tab.
Medicare Amounts – Original Paid	If applicable, enter the paid amount issued by Medicare for the specific service currently being charge to Medicaid.
Co-pay Amount	If applicable, enter the amount determined by Medicare that the patient must pay for the service currently being submitted to Medicaid. This field is optional.
Late Filing	If applicable, enter the amount determined by Medicare that the patient must pay for late filing fees. This field is optional.
Ded Amt	If applicable, enter the deductible amount issued by Medicare for the specific service currently being charge to Medicaid.

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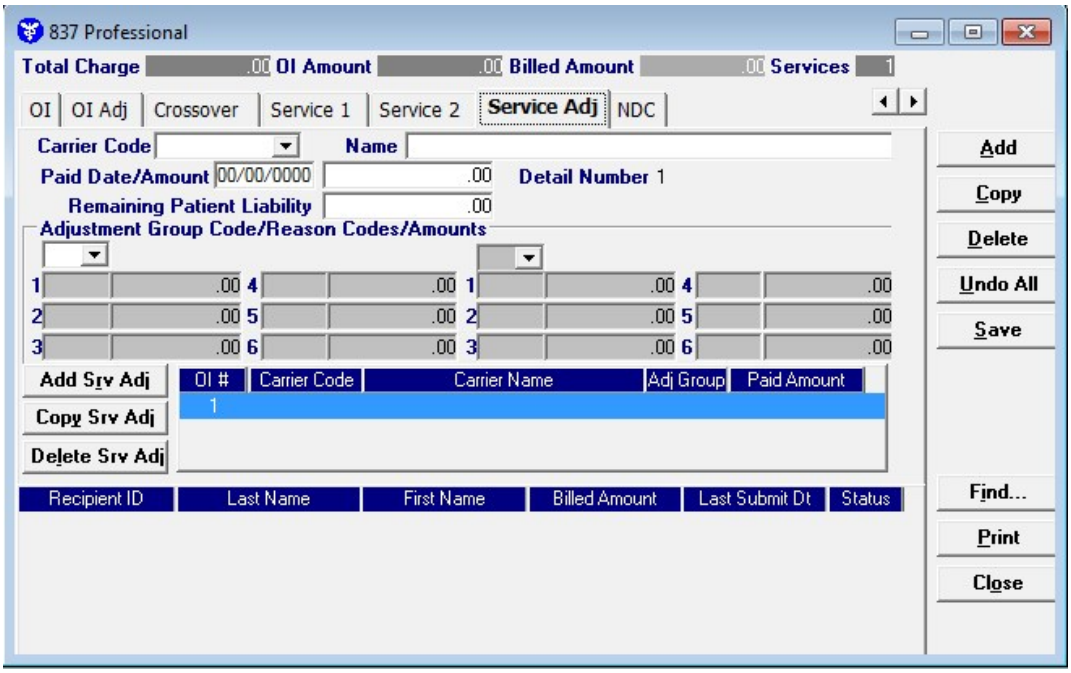
Field	Guidelines
Coins Amt	If applicable, enter the coinsurance amount issued by Medicare for the specific service currently being charge to Medicaid.
Psychiatric	If applicable, enter the amount determined by Medicare that the patient must pay for psychiatric procedures. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
eRX Reduction Amt	If applicable, enter the ERX Reduction Amount.

8.2.9 Service Ad Tab

Below is a sample electronic 837 Professional form displaying the Service Adj tab.



Complete the following fields under the Service Adj tab to submit an 837 Professional claim:

Field	Guidelines
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.

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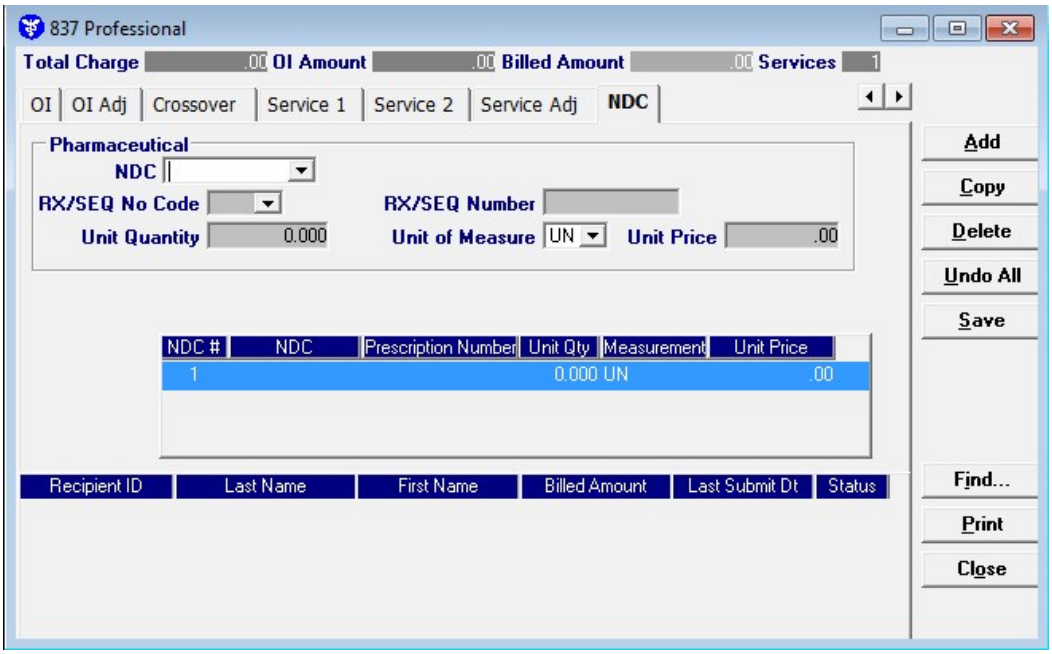
Field	*Guidelines*
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

8.2.10 NDC TAB

Completing the NDC tab is required if the NDC indicator on Service Tab 2 is 'Yes.' Below is a sample 837 Professional form displaying the NDC tab.



Complete the following fields under the NDC tab to submit a National Drug Code (NDC) on an 837 Professional claim:

Field	*Guidelines*
NDC	Enter the appropriate eleven-digit drug code for each drug billed. The NDC number submitted to Medicaid must be the NDC number on the package or container from which the medication was administered. This field is required if the NDC indicator on Service Tab 2 is 'Y.'
RX/SEQ No Code	Select the best value to indicate whether submitting the NDC with a prescription number or a Link Sequence Number. Default value is VY. **This field is optional.**
RX/SEQ Number	If applicable, enter the assigned prescription number or the sequence number when 2 or more drugs are compounded and there is no prescription number. **This field is optional**
Unit Quantity	Enter the number of units for the product billed.
Field	*Guidelines*

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Unit of Measure	Enter the type of units used for the product billed. Use the default value, UN, or select the best value from the drop down display window. Valid values are: F2 – International Unit GR – Gram ME - Milligram ML – Milliliter UN – Unit
Unit Price	Enter the price of the individual unit(s) billed. This field is optional unless more than one NDC is billed on each detail. It is a required field if multiple NDCs are billed on each detail.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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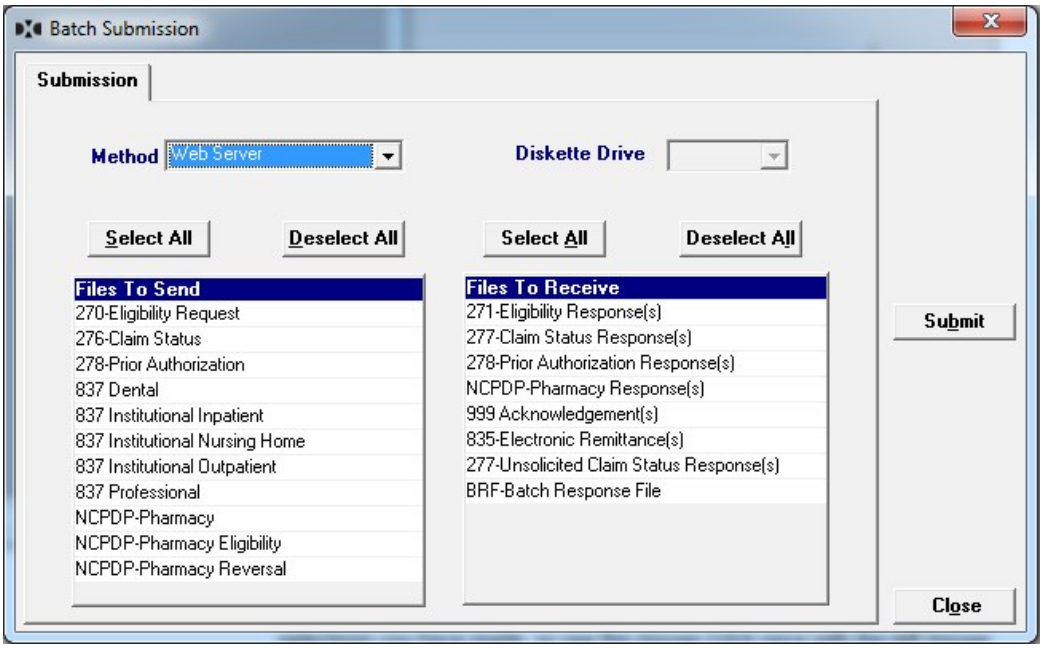
8.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the Method drop down list.

Step 3 Determine which files you want to receive from the Files to Receive list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the ‘Files to Receive’ list.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press ‘Submit’, then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the ‘Submit’ to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

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Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

NOTE:

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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9 Submitting 837 Institutional Inpatient Claims

This chapter provides instructions for submitting electronic 837 inpatient claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Inpatient claim form using one of the following methods:

- Selecting the 837 Institutional Inpatient icon from the toolbar
- Selecting Forms>>837 Institutional Inpatient

The electronic form displays with seven tabs: Header 1, Header 2, Header 3, Header 4, Header 5, Header 6, and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustment, and Crossover.

9.1 Entering Claims in the 837 Institutional Inpatient Form

Each tab on the 837 Institutional Inpatient form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Inpatient form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the 'Save' button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press 'Save', or press Incomplete to save the record with an incomplete status.

Incomplete claims (status 'I') are not submitted with the batch submission.

Step 4 Press the 'Add' button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is 'R' (ready to submit) or 'I' (incomplete). Save the changes. Press 'Undo All' if you inadvertently overwrite a correct claim.
- Press 'Copy' to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press 'Delete' to delete an unwanted record.

NOTE:
Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

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To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

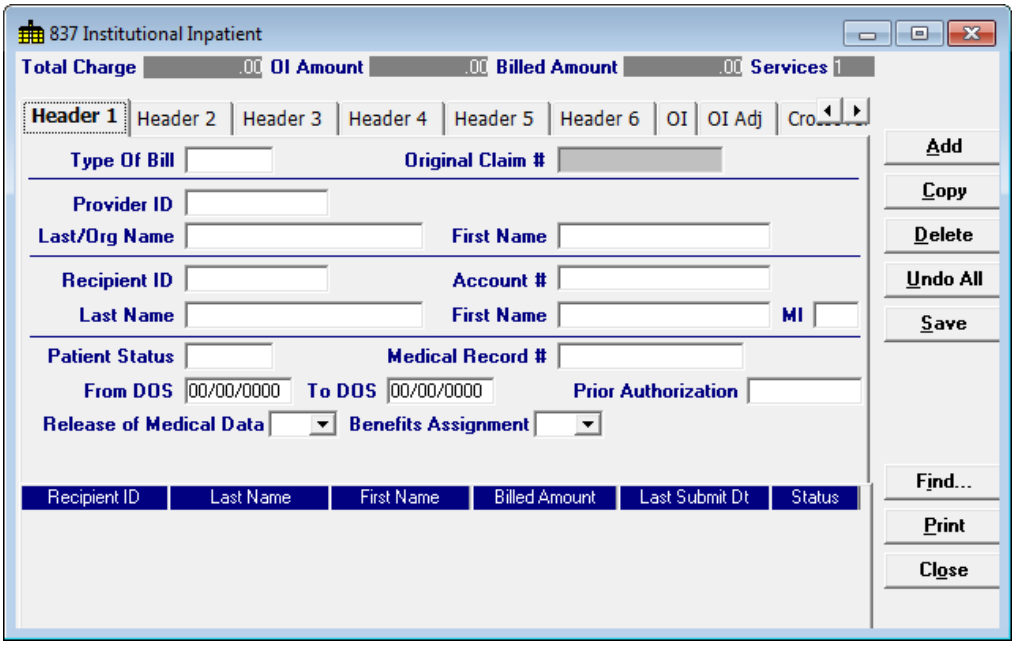
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

9.2 837 Institutional Inpatient Form

9.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Inpatient form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit an Inpatient claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN for the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.

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Field	***Guidelines***
Patient Status	Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period: 01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to NF 04 Discharged to ICF/MR 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an Inpatient to this hospital 20 Expired or did not recover 30 Still patient 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 50 Hospice, home 51 Hospice, medical facility 61 Discharged/Transferred within this institution 71 Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. 72 Discharge/transferred/referred to this institution for outpatient services as specified plan of care. If status code is 30, the total days in the covered and non-covered fields should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Prior Authorization	If applicable, enter the prior authorization number issued by the state. This field is optional.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Information for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.

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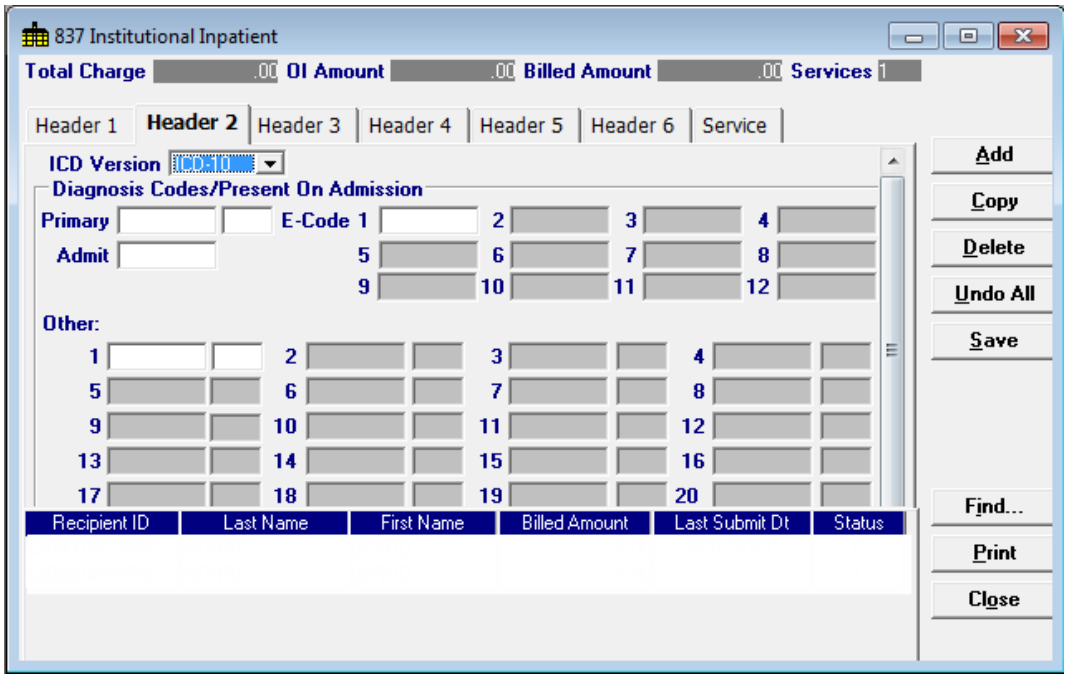
9.2.2 Header 2 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an inpatient claim:

Field	Guidelines
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Admit	Enter a proper admittance diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis – E-Code	Enter the diagnosis code(s) which describe the external cause of injury, poisoning or adverse effect. These fields must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code - Other	If applicable, enter any proper secondary diagnosis code(s). When used, these fields must contain a minimum of 3-digits and cannot contain a decimal.
Present on Admission (POA)	Choose the best value from the drop-down-display window to indicate whether the corresponding diagnosis was present on the patient's inpatient hospital admission. Valid values are: • Y – Yes • N – No • U – Unknown • W – Not Applicable • Blank – Exempt from POA reporting.

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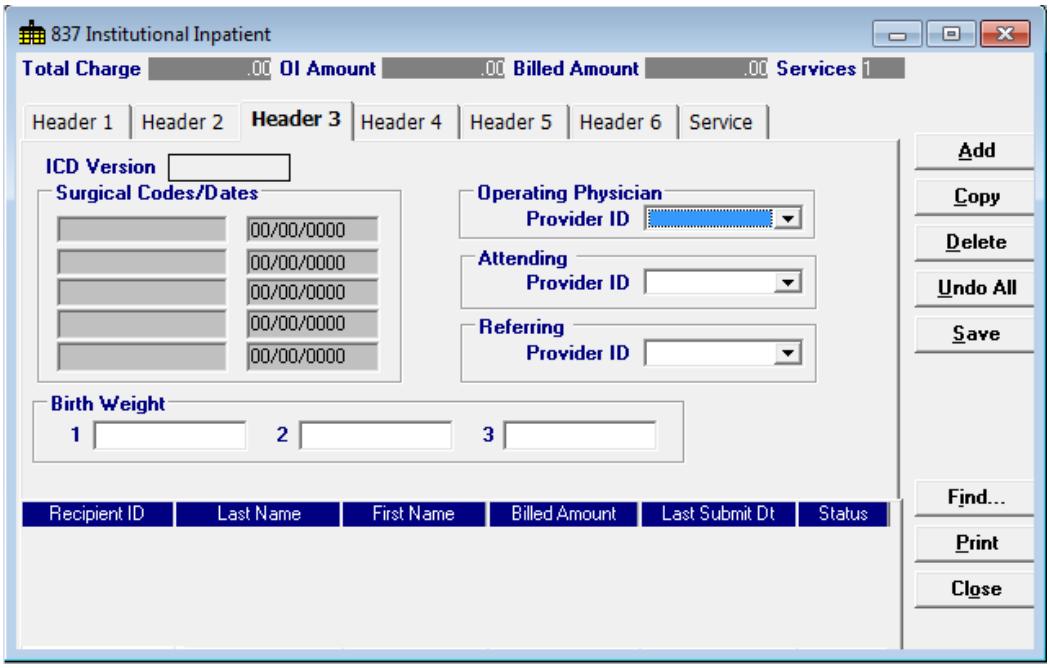
9.2.3 Header 3 Tab

Below is a sample electronic 837 Inpatient form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an inpatient claim:

Field	Guidelines
ICD Version (read only)	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10. Note: This field is read only. Go to Header 2 to change the ICD Version.
Surgical Codes – Principal	If revenue codes billed on this claim include 36X or 72X, enter the principal procedure code.
Surgical Dates	If a surgical code is entered, enter the surgery date in MM/DD/CCYY format.
Operating Physician ID	If a value was entered in the Surgical Code field, then choose a provider number from the corresponding Provider list to indicate which physician performed the operation. If you have not added the required ID to your list, double-click on this field to do so.
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Birth Weight	If applicable, enter a valid birthweight in this field.

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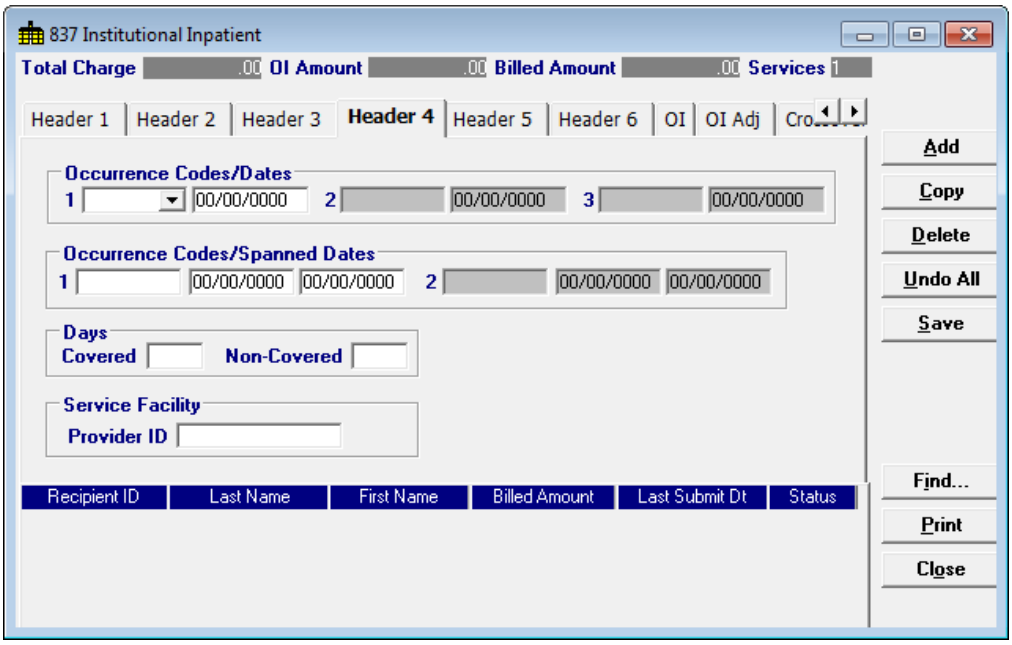
9.2.4 Header 4 Tab

Below is a sample 837 Inpatient form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit an inpatient claim:

Field	Guidelines
Occurrence Codes	Enter the Occurrence Code if applicable. For a full list of these codes see Appendix B Code Lists, Section B.1 Occurrence Codes.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.
Occurrence Code Spanned Dates	Enter the spanned from and to dates in MM/DD/CCYY format.
Days Covered	Enter the total days represented on this claim that are to be covered.
Days Non-Covered	Enter the total days represented on this claim that are not covered. The sum of covered and non-covered days equal the total days billed as reflected in units.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.

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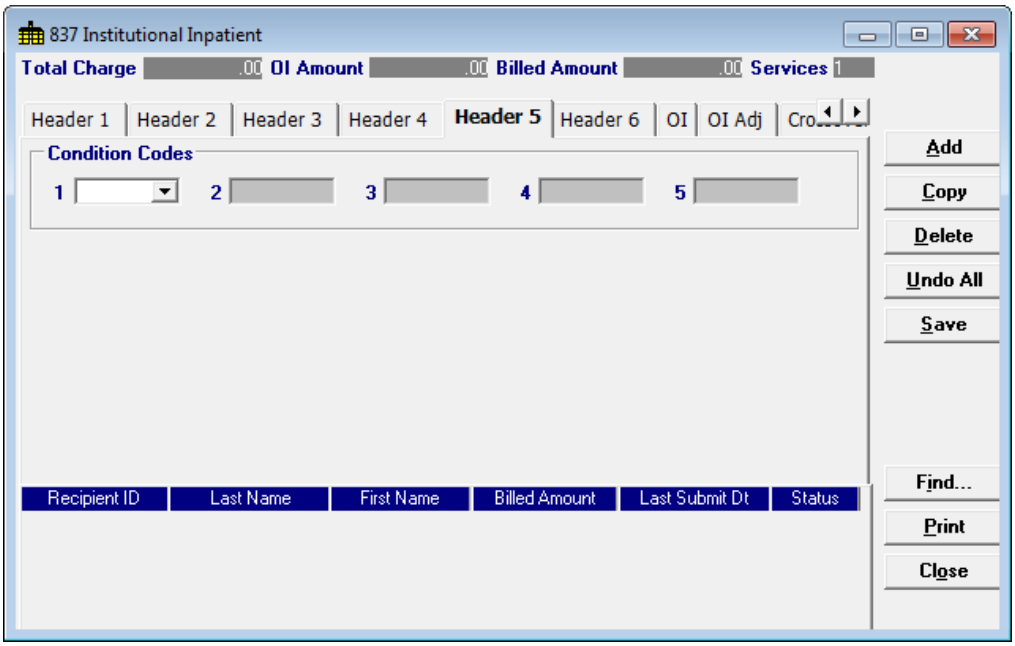
9.2.5 Header 5 Tab

Below is a sample 837 Inpatient form displaying the Header 5 tab.



Complete the following fields under the Header 5 tab to submit an inpatient claim:

Field	***Guidelines***
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. If A1 is entered here, a referring provider number must be indicated. To indicate the referring provider, choose an ID in the Referring Provider ID field on Header 2. For a full list of these codes see Appendix B Code Lists, Section B.2 Condition Codes.

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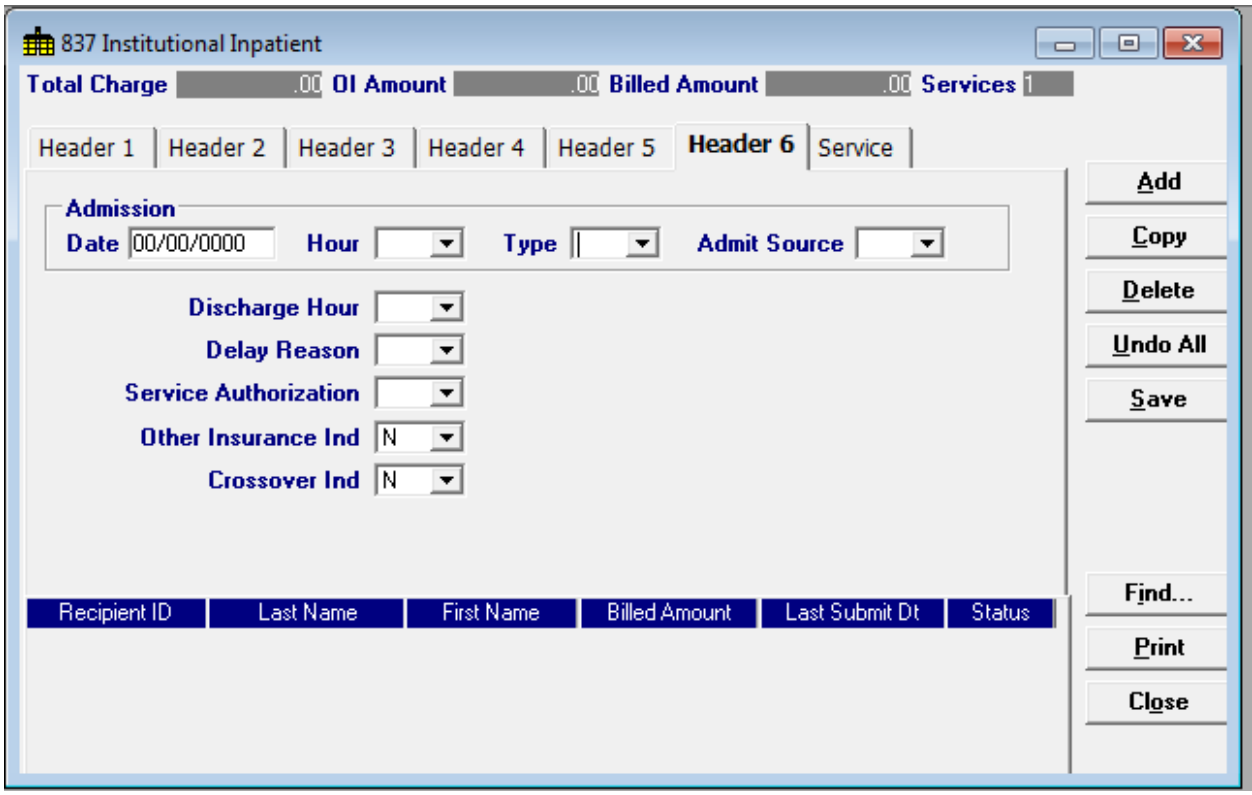
9.2.6 Header 6 Tab

Below is a sample 837 Inpatient form displaying the Header 6 tab.



Complete the following fields under the Header 6 tab to submit an inpatient claim:

Field	***Guidelines***
Admission Date	Enter the date the recipient was admitted into your facility in MM/DD/CCYY format.
Admission Hour	Choose the best value to indicate the hour the recipient was admitted into your facility.
Admission Type	Choose a value from the Admission Type list.
Admit Source	Choose a value from the Admit Source list.
Discharge Hour	Choose the best value to indicate the hour the recipient was discharged from your facility.
Delay Reason	Choose a value to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. Note: This will not override claims that have fallen over a year past timely filing. You will need to proceed to file such claims to the Fair Hearing department.

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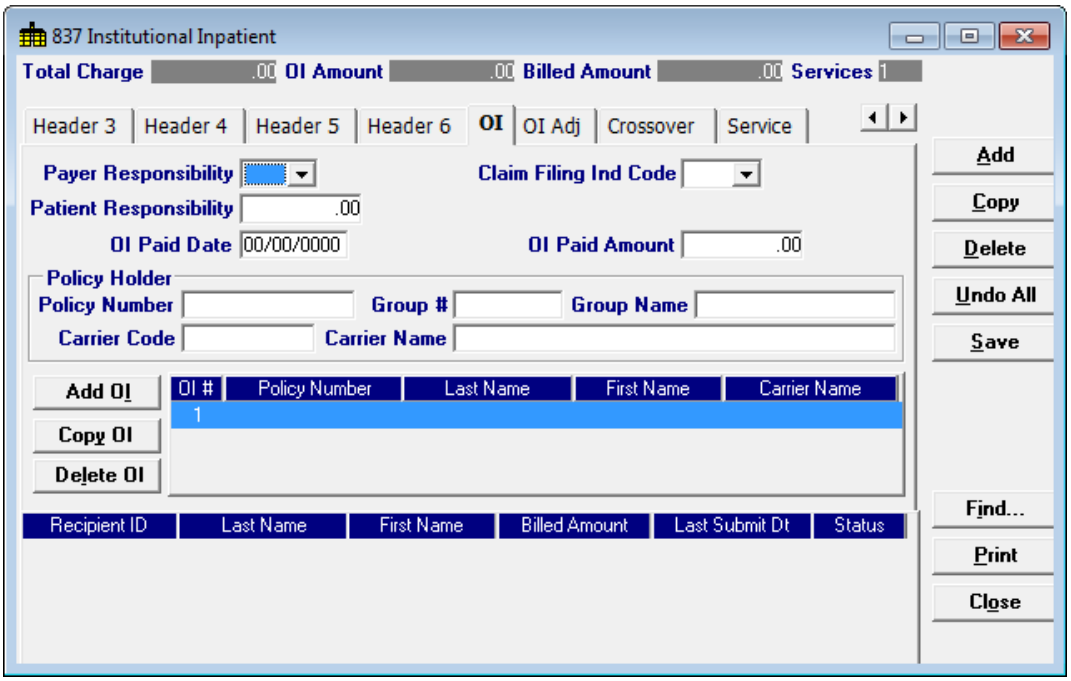
Field	*Guidelines*
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. 1 Immediate Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client has temporary Medicaid 5 Bypass Provider Contract Check 6 Claim exempt from Program edits 7 Force into MAT Care Program
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

9.2.7 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes.' Below is a sample electronic 837 Inpatient form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an inpatient claim:

Field	*Guidelines*
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance.
Patient Responsibility	Enter the amount the recipient will be responsible for paying. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.

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Field	***Guidelines***
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

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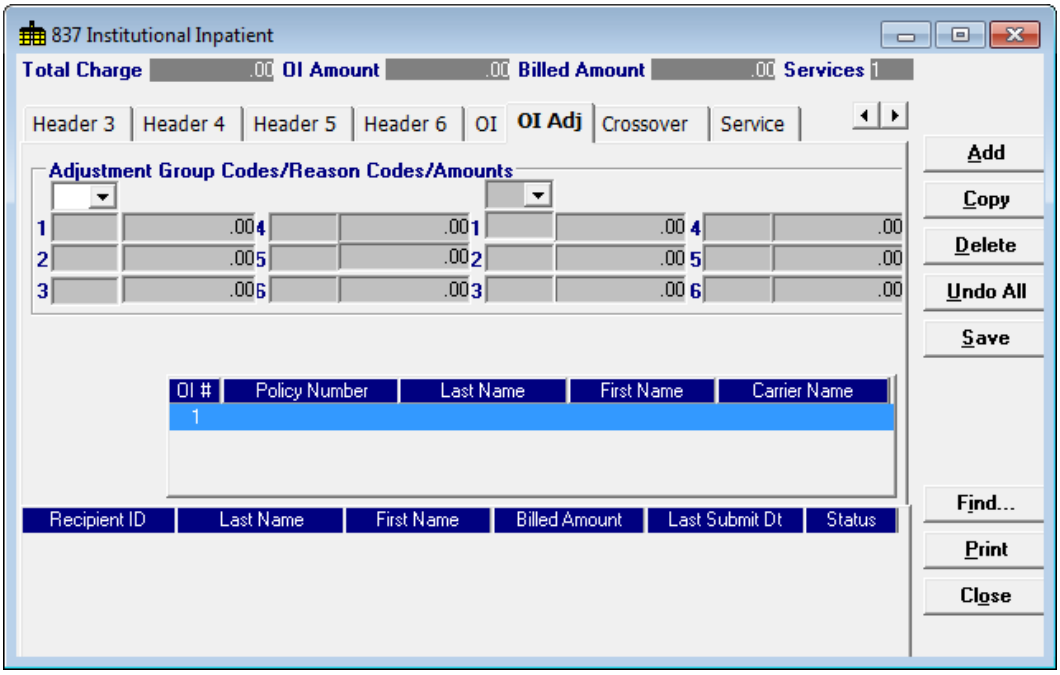
Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

9.2.8 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Institutional Inpatient form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

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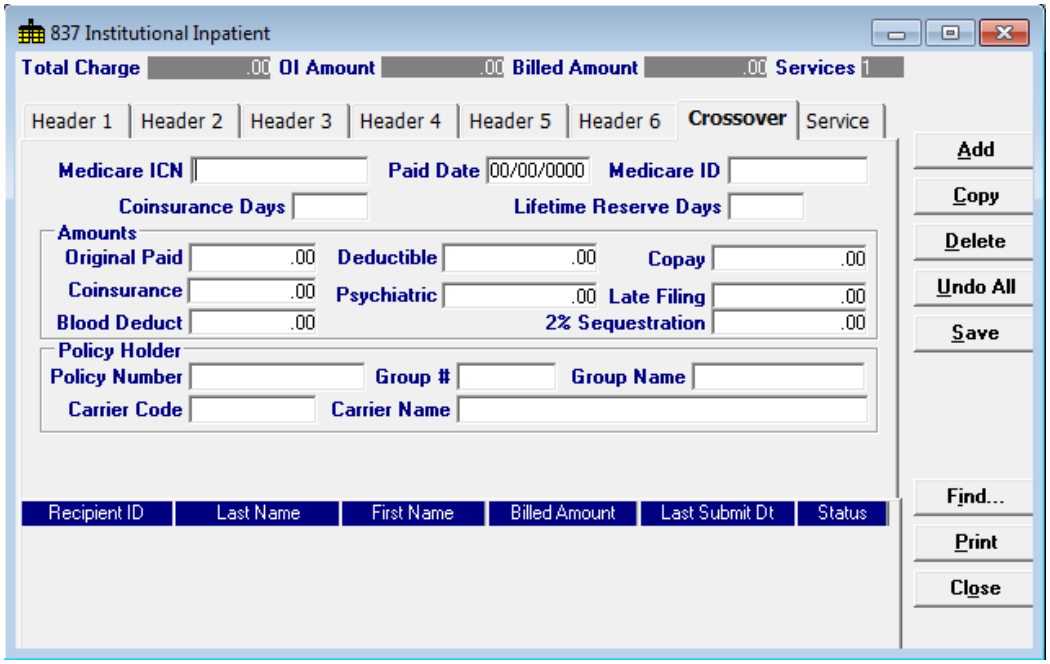
9.2.9 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Inpatient form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an inpatient claim:

Field	Guidelines
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's policy number assigned by Medicare.
Coinsurance Days	Enter the amount of coinsurance days used during the inpatient stay on this claim. This field is optional.
Lifetime Reserve Days	Enter the amount of lifetime reserve days used during the inpatient stay on this claim. Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. This field is optional.
Amounts –Original Paid	Enter the actual amount paid by Medicare for the services being billed to Medicaid.
Deductible	Enter the deductible amount from Medicare. This field is optional.
Co-pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Psychiatric	If applicable, enter the amount Medicare determined the patient must pay for psychiatric services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined a recipient must pay for late filing fees. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined the patient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.

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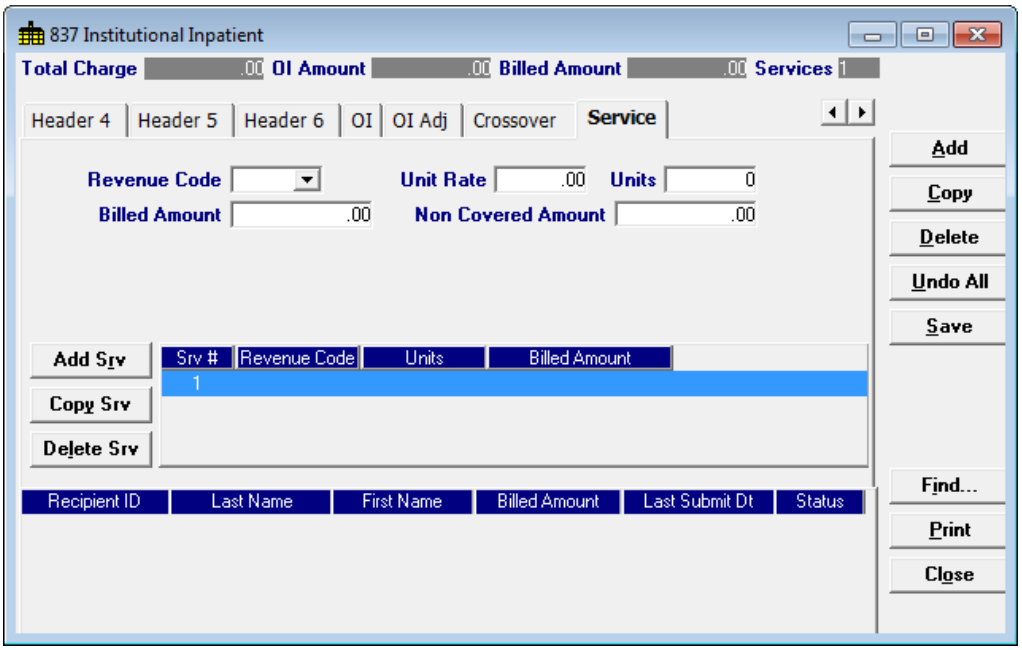
Field	Guidelines
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

9.2.10 Service Tab

Below is a sample 837 Inpatient form displaying the Service 1 tab.



Complete the following fields under the Service 1 tab to submit an inpatient claim:

Field	*Guidelines*
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Unit Rate	If revenue code entered ranges from 100 – 219, enter the accommodation rate for the individual unit billed.
Units	Enter the unit(s) billed for the service.
Billed Amount	Enter the amount billed for the service.
Non Covered Amount	Enter the non covered amount. This field is optional.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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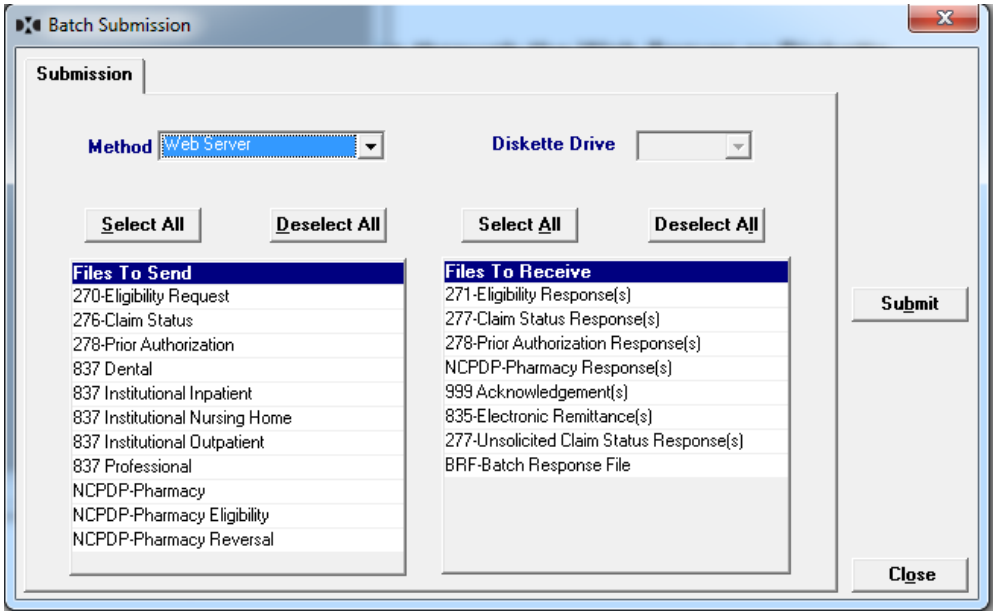
9.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' button to submit and receive the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transmission, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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10

10 Submitting 837 Institutional Outpatient Claims

This chapter provides instructions for submitting electronic 837 outpatient claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

Users access the electronic 837 Institutional Outpatient claim form using one of the following methods:

- Selecting the 837 Institutional Outpatient icon from the toolbar
- Selecting Forms>>837 Institutional Outpatient

The electronic form displays with ten tabs: Header 1, Header 2, Header 3, Header 4 and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (OI Adjustments), Crossover, Service Adj, and NDC.

10.1 Entering Claims in the 837 Institutional Outpatient Form

Each tab on the 837 Institutional Outpatient form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.

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Button	*Usage*
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Outpatient form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press Incomplete to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press Undo All if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

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To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

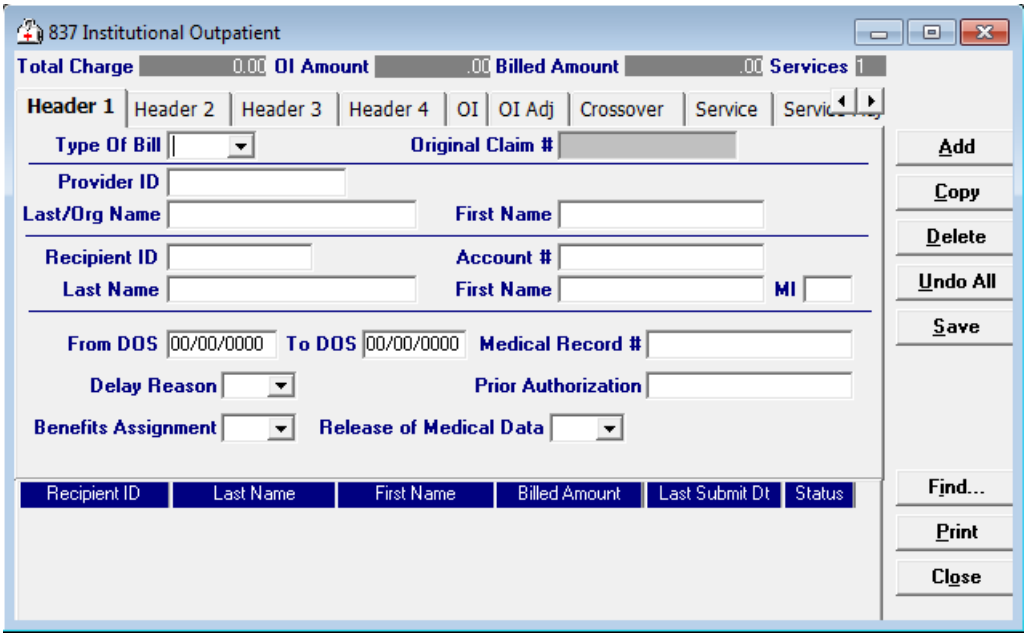
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

10.2 837 Institutional Outpatient Form

10.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Outpatient form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit an outpatient claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital 3 Home Health Agency 7 Clinic (RHC, FQHC) 8 Special Facility **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a ‘7’ (replacement) or an ‘8’ (void), you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient’s 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.

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Field	***Guidelines***
Delay Reason	Choose a value to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional. Note: This will not override claims that have fallen over a year past timely filing. You will need to proceed to file such claims to the Fair Hearing department.
Prior Authorization	If applicable, enter the 10-digit prior authorization number issued by the Medicaid agency. This field is optional.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Information for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim

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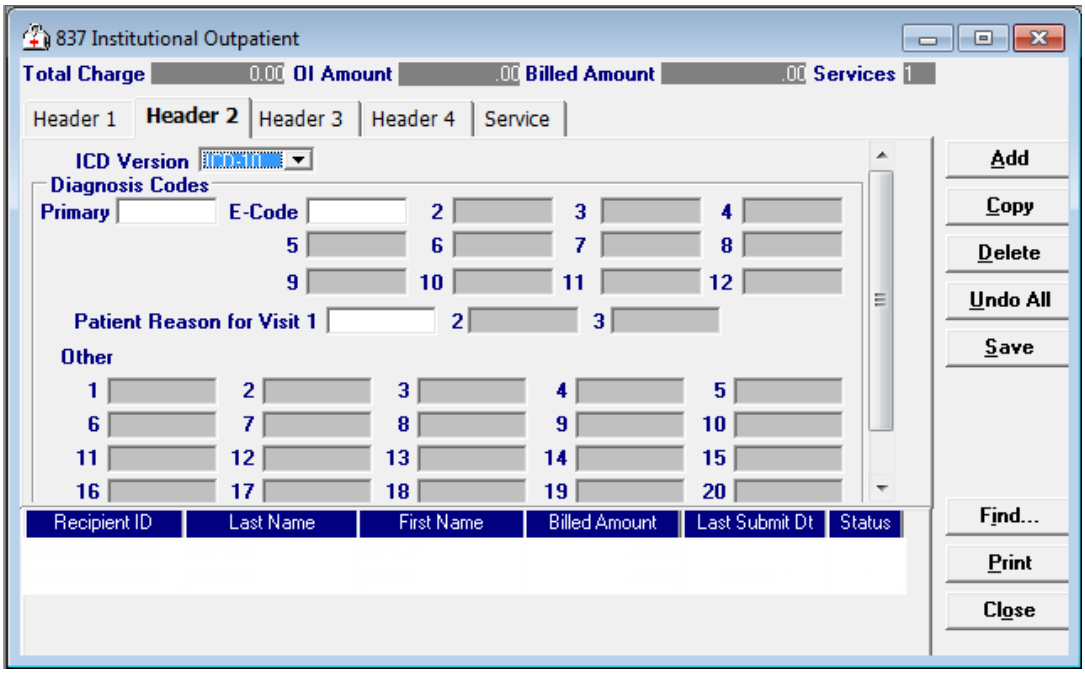
10.2.2 Header 2 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit an outpatient claim:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must contain a minimum of 3-digits and cannot contain decimals.
Diagnosis Code - E-Code	Enter the diagnosis code(s) which describe the external cause of injury, poisoning or adverse effect. These fields must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Patient Reason for Visit	Enter a proper diagnosis code indicating the reason for the outpatient visit. This field must be a minimum of 3-digits long and cannot contain decimals.
Diagnosis Code – Other	If applicable, enter a proper diagnosis code. This field must contain a minimum of 3-digits and cannot contain decimals.

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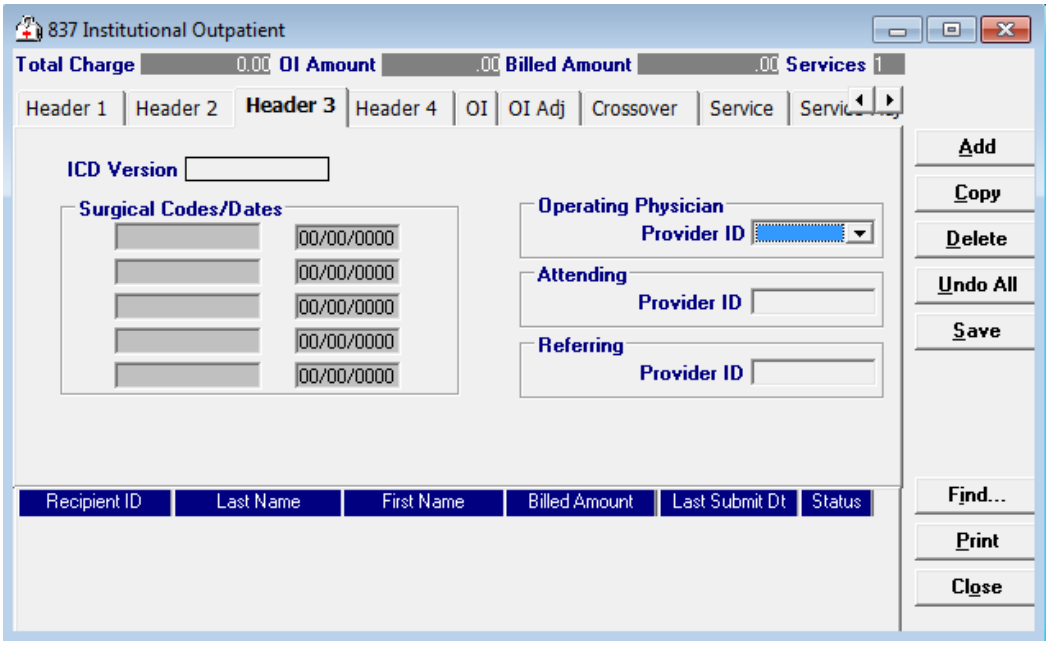
10.2.3 Header 3 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit an outpatient claim:

Field	***Guidelines***
ICD Version (read only)	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10. Note: This field is read only. Go to Header 2 to change the ICD Version.
Surgical Codes	If revenue codes billed on this claim include 36X or 72X, enter the principal ICD-9 procedure code. This field is optional.
Surgical Dates	If a surgical code is entered, enter the surgery date in MM/DD/CCYY format. This field is optional.
Operating Physician Provider ID	If a value was entered in the Surgical Code field, then choose a provider number from the corresponding Provider list to indicate which physician performed the operation. If you have not added the required ID to your list, double-click on this field to do so.
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Referring Provider ID	If applicable, choose a referring provider number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.

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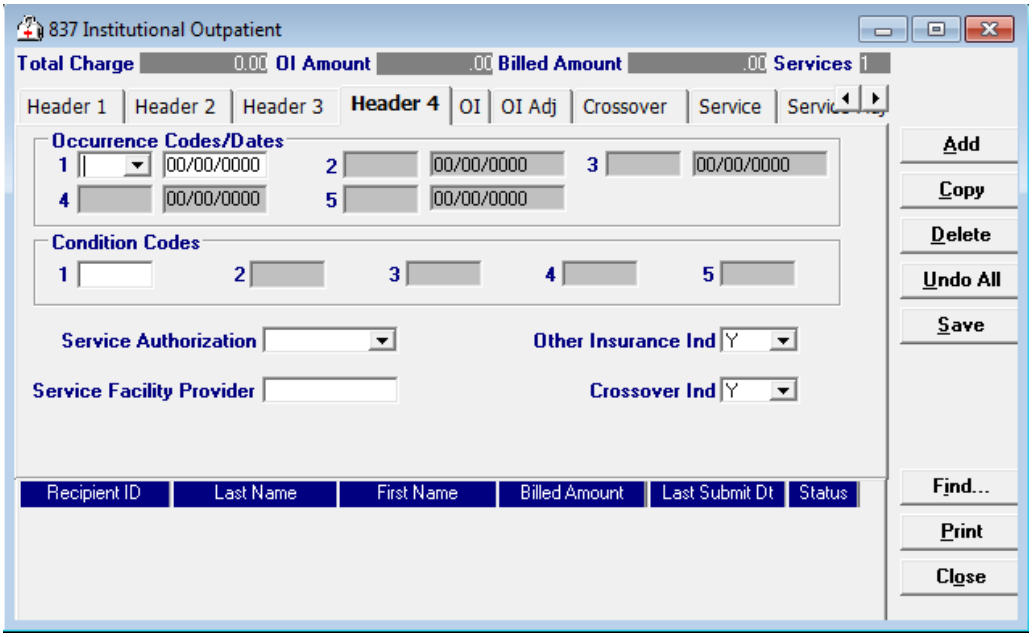
10.2.4 Header 4 Tab

Below is a sample electronic 837 Outpatient form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit an outpatient claim:

Field	***Guidelines***
Occurrence Codes	10.2.4.2 For a full list of these codes see Section B.1 Occurrence Codes in Appendix B Code Lists.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. If A1 is entered here, a referring provider number must be indicated. To indicate the referring provider, choose an ID in the Referring Provider ID field on Header 2. For a full list of these codes see Appendix B, Section B.2 Condition Codes.
Service Authorization	Choose the best value to indicate the type of maternity override or if the service was due to an emergency. This field is optional. 1 Immediate Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client has temporary Medicaid 5 Bypass Provider Contract Check 6 Claim exempt from Program edits 7 Force into MAT Care Program
Other Insurance Ind.	Choose the best value to indicate if the recipient has other insurance. Medicare is <u>not</u> considered other insurance.
Service Facility Provider	Select the provider NPI where the service was performed only if the service was provided at a location different than the billing provider location on Header 1 tab.

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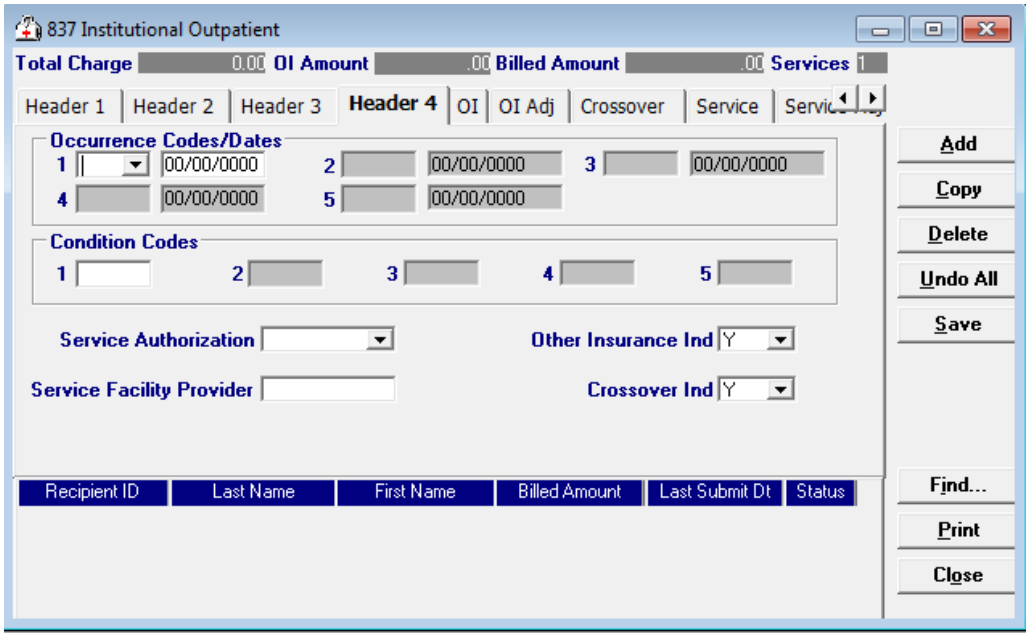
Field	Guidelines
ossover Ind.	hoose the best value to indicate if the claim is a crossover from Medicare.

10.2.5 OI Tab (Other Insurance)

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind.* field was marked as 'Yes'. Below is a sample electronic 837 Outpatient form displaying the OI (Other Insurance) tab.



Complete the following fields under the Other Insurance tab to submit an outpatient claim:

Field	Guidelines
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's other insurance coverage status to Medicaid.
Claim Filing Ind. Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance. Do not use 09 (self-pay), 16 (Medicare HMO), MA (Part A Medicare) or MB (Part B Medicare) on the OI tab.
Patient Responsibility	Enter the amount of the other health plan's patient responsibility, i.e., deductible, coinsurance, co-pay, etc. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.

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Field	*Guidelines*
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

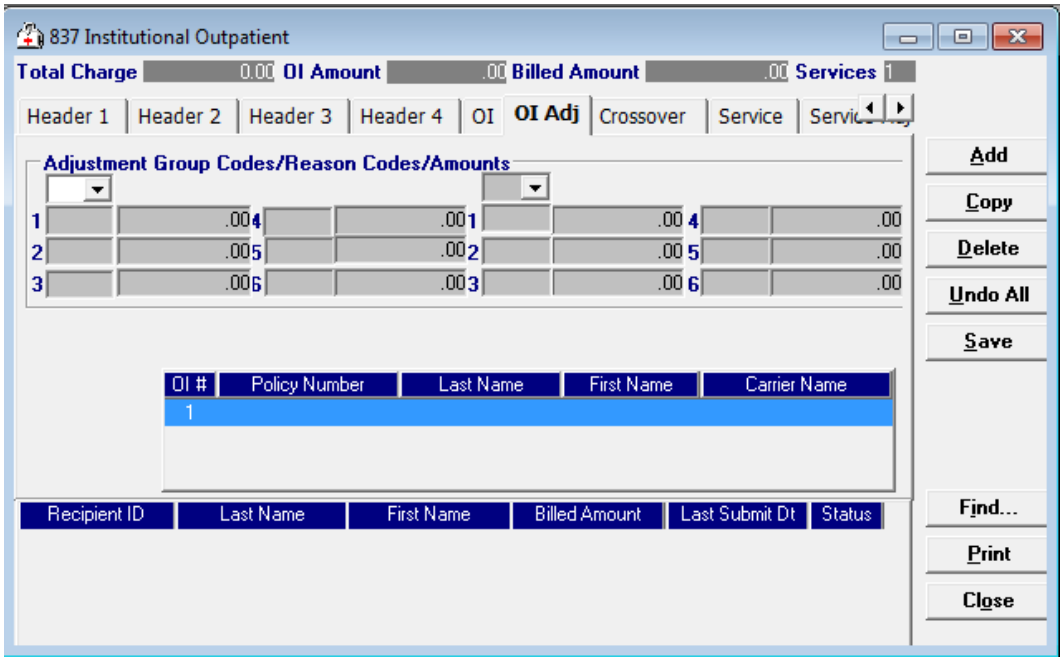
Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient.

10.2.6 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Outpatient form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

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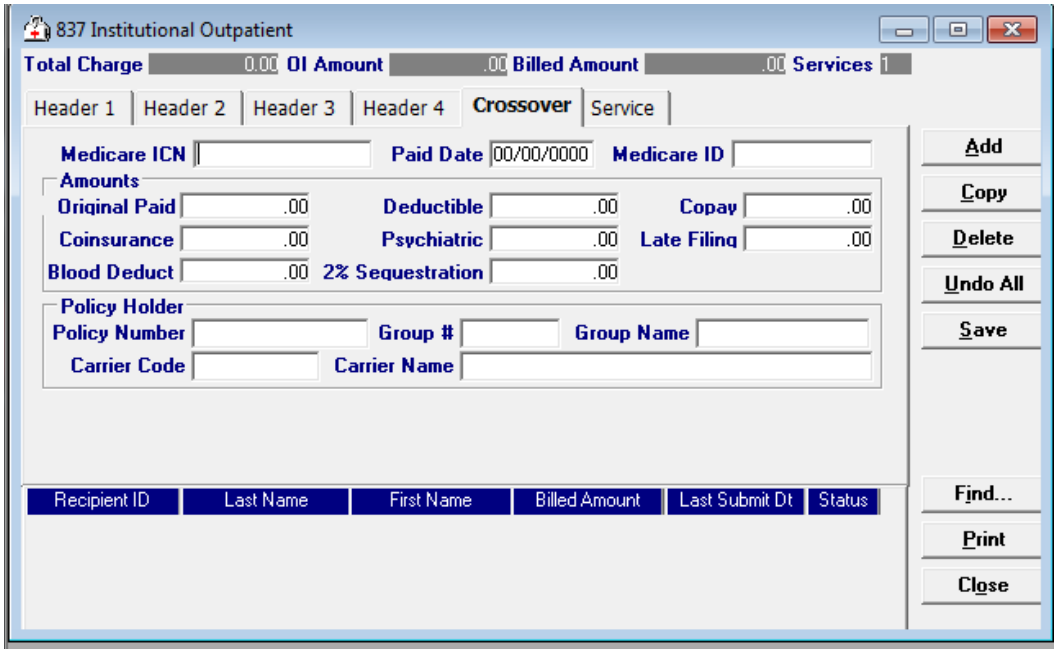
10.2.7 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Outpatient form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit an outpatient claim:

Field	***Guidelines***
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID assigned by Medicare.
Amounts – Original Paid	If applicable, enter the paid amount issued by Medicare for the specific service currently being charged to Medicaid.
Deductible	Enter the deductible amount from Medicare. This field is optional.
Co-pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Policy Number	Choose the appropriate Medicare HIC # from the Policy Holder list. If you have not added a Medicare segment for this recipient to your list, double-click on this field. A screen will appear for you to do so.
Psychiatric	If applicable, enter the amount Medicare determined the patient must pay for psychiatric services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined the patient must pay for late filing fees. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined the patient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
Group #	This field will auto-write based on the information chosen in the Policy number field.

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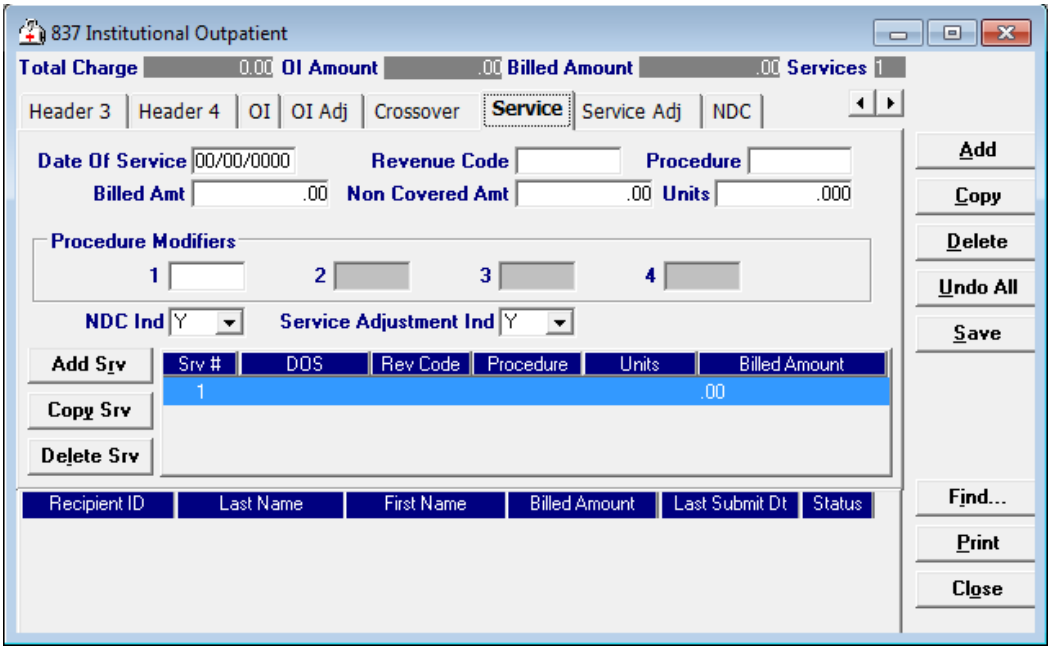
Field	*Guidelines*
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

Service Tab

Below is a sample 837 Outpatient form displaying the Service tab:



Complete the following fields under the Service 1 tab to submit an outpatient claim:

Field	*Guidelines*
Date of Service	Enter the date of service for each procedure provided in a MM/DD/CCYY format.
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Billed Amount	Enter the amount billed for the service.
Non Covered Amount	Enter the non covered amount. This field is optional.
Units	Enter the unit(s) billed for the service.
Procedure	Enter the appropriate five-digit procedure code for each procedure or service billed. Use the current CPT-4 book as a reference.
Procedure Modifiers	If applicable, enter the modifier for the procedure.
NDC Ind	Choose the best value to indicate if a National Drug Code (NDC) is being billed on the claim. If 'Y' is selected, the NDC tab will display, complete the information on the NDC Tab.

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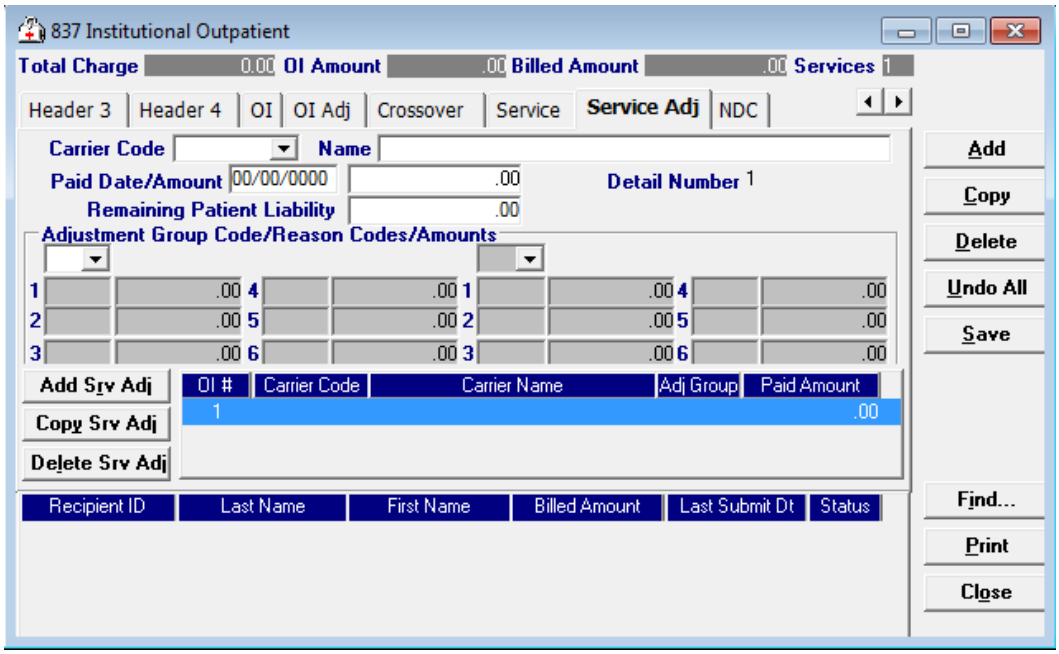
10.2.8 Service Adj Tab

Below is a sample electronic 837 Outpatient form displaying the Service Adj tab.



Field	*Guidelines*
Carrier Code	Select the carrier code from the drop down that you are entering the adjustment for on the selected detail.
Name	This field will populate after you select your carrier code and tab or click out of the carrier code field.
Paid Date/Amount	Enter the paid date from the other insurance for this detail. Directly after the date field, enter the amount paid by the other insurance.
Remaining Patient Liability	Enter the remaining patient liability.
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	To enter information for a second or third insurance carrier for this same detail, click the add service adj button to the right. Then enter the information at the top for this carrier.

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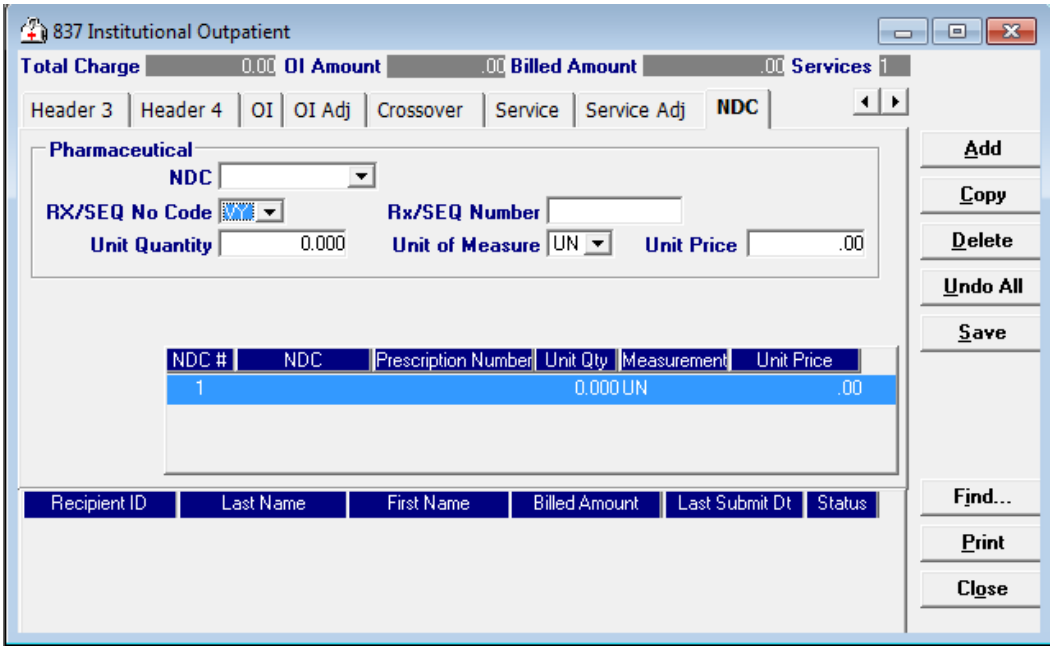
10.2.9 NDC Tab

Completing the NDC tab is required if the NDC indicator on the Service Tab is 'Yes.' Below is a sample 837 Outpatient form displaying the NDC tab:



Complete the following fields under the NDC tab to submit a National Drug Code (NDC) on an outpatient claim:

Field	*Guidelines*
Pharmaceutical - NDC	Enter the appropriate eleven-digit drug code for each drug billed. The NDC number submitted to Medicaid must be the NDC number on the package or container from which the medication was administered. This field is required if the NDC indicator on the Service Tab is 'Y.'
RX/SEQ No Code	Select the best value to indicate whether submitting the NDC with a prescription number or a Link Sequence Number. Default value is VY. **This field is optional.**
RX/SEQ Number	If applicable, enter the assigned prescription number or the sequence number when 2 or more drugs are compounded and there is no prescription number. **This field is optional.**
Unit Quantity	Enter the number of units for the product billed.
Unit of Measure	Enter the type of units used for the product billed. Use the default value, UN, or select the best value from the drop down display window. Valid values are: F2 – International Unit GR – Gram ME – Milligram ML – Milliliter UN – Unit
Drug Unit Price	Enter the price of the individual unit(s) billed. This field is optional unless more than one NDC is billed on each detail. It is a required field if multiple NDCs are billed on each detail.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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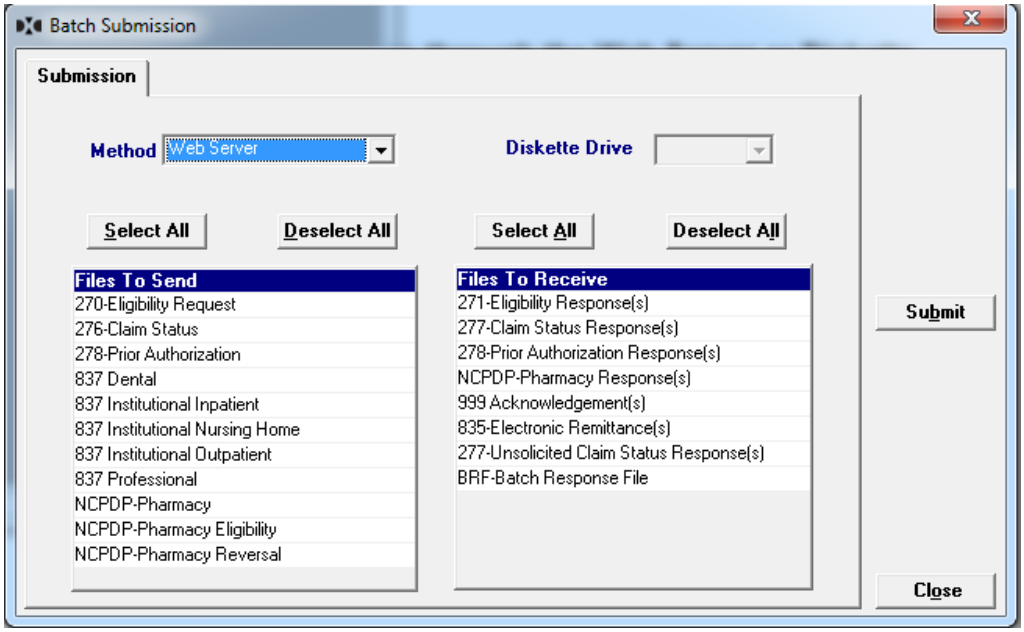
10.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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11

11 Submitting 837 Institutional Nursing Home Claims

This chapter provides instructions for submitting electronic 837 nursing home claims. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information

Users access the electronic 837 Institutional Nursing Home claim form using one of the following methods:

- Selecting the 837 Institutional Nursing Home icon from the toolbar
- Selecting Forms>>837 Institutional Outpatient

The electronic form displays with five tabs: Header 1, Header 2, Header 3, Header 4, and Service. The additional tabs, if applicable, are: OI (Other Insurance), OI Adj (Other Insurance Adjustment), and Crossover.

11.1 Entering Claims in the 837 Institutional Nursing Home Form

Each tab on the 837 Institutional Nursing Home form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code, but different recipients, or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.

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Button	*Usage*
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 837 Institutional Nursing Home form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claims created using 4010 Provider Electronic Solutions (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 Provider Electronic Solutions (version 3.0). The only option is to delete these claims. All claims submitted using Provider Electronic Solutions version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

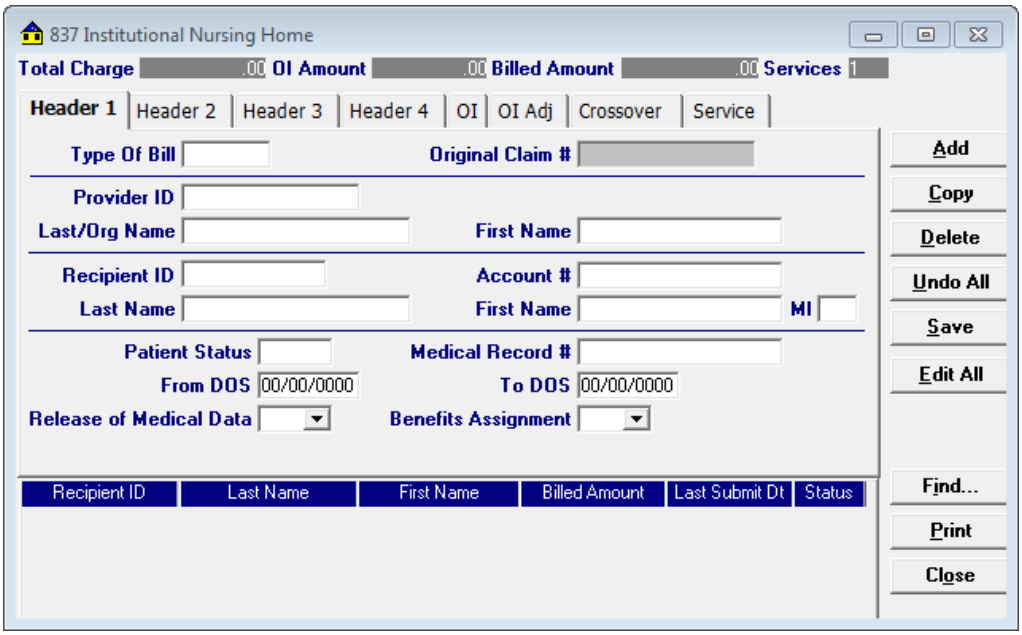
Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

11.2 837 Institutional Nursing Home Form

11.2.1 Header 1 Tab

Below is a sample electronic 837 Institutional Nursing Home form displaying the Header 1 tab.



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Complete the following fields under the Header 1 tab to submit a nursing home claim:

Field	***Guidelines***
Type Of Bill	Enter a Type of Bill according to the values below. **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 3 Inpatient (Medicare Part B only) 8 Reserved for National Assignment **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim 7 Replace a prior paid claim with the current claim. *Replace a prior paid claim. You must have the ICN of the original paid claim to complete this process. Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.* 8 Void or reverse a prior claim. *You must have the ICN of the original paid clam in order to complete this process.* 9 Final Claim for a Home Health PPS Episode
Original Claim #	If the Type of Bill entered ended with a '7' (replacement) or an '8' (void), you must enter the ICN of the claim you are adjusting or voiding. For additional information on completing this process, please refer to Chapter 12.
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.
MI	If a middle initial was entered within the recipient list screen, this field will auto-write. This field is optional.

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Field	***Guidelines***
Patient Status	Enter a proper 2-digit code to indicate the patient's discharge status as of the end date of your billing period: 01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to NF 04 Discharged to ICF/MR 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an Inpatient to this hospital 20 Expired or did not recover 30 Still patient 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 50 Hospice, home 51 Hospice, medical facility 61 Discharged/Transferred within this institution 71 Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care. 72 Discharge/transferred/referred to this institution for outpatient services as specified plan of care. If status code is 30, the total days in the covered and non-covered fields should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
Medical Record #	Enter the medical record number, assigned to the recipient, by the provider, for the service that was performed. This field will accept up to 50 alphanumeric characters. This field is optional.
From DOS	Enter the start date of the service billed in a MM/DD/CCYY format.
To DOS	Enter the stop date of the service billed in a MM/DD/CCYY format.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. • **I** - Informed Consent to Release Medical Info for Conditions or Diagnoses regulated by Federal Statues. • **Y** - Yes, Provider has a signed statement permitting release of medical billing data related to a claim
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.

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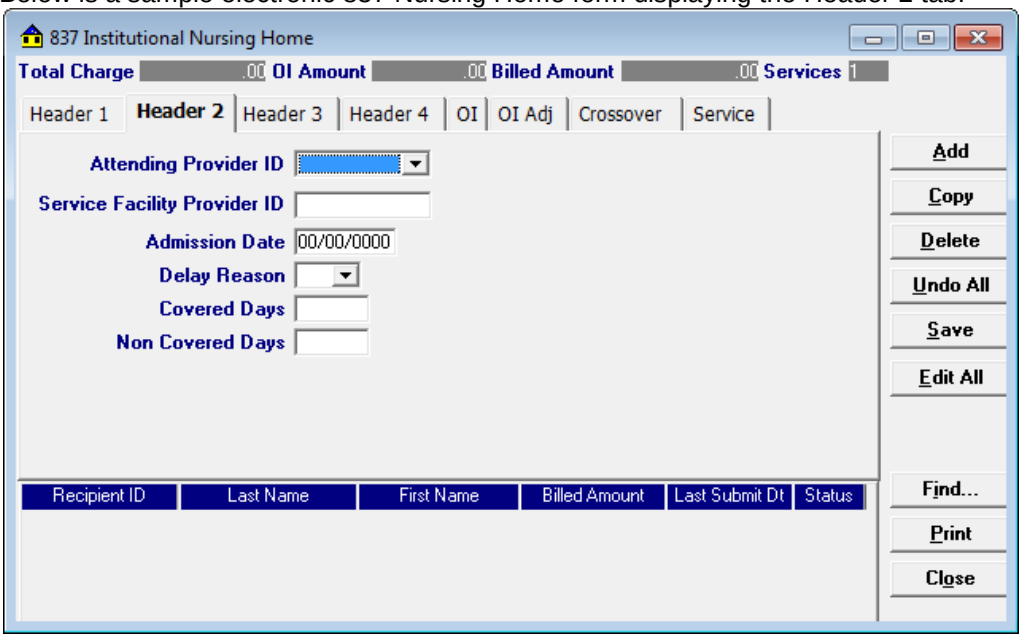
11.2.2 Header 2 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 2 tab.



Complete the following fields under the Header 2 tab to submit a nursing home claim:

Field	***Guidelines***
Attending Provider ID	Choose an attending physicians number from the corresponding Provider list. If you have not added the required ID to your list, double-click on this field to do so.
Service Facility Provider ID	Select the provider NPI where the service was performed if different than the billing provider location on Header 1 tab.
Admission Date	Enter the date the recipient was admitted into your facility in MM/DD/CCYY format.
Delay Reason	Select a value from the drop-down-display menu box to indicate the reason for the delay in filing with Alabama Medicaid. This field is optional.
Covered Days	Enter the total days represented on this claim that are to be covered.
Non Covered Days	Enter the total days represented on this claim that are not covered. The sum of covered and non-covered days equal the total days billed as reflected in units.

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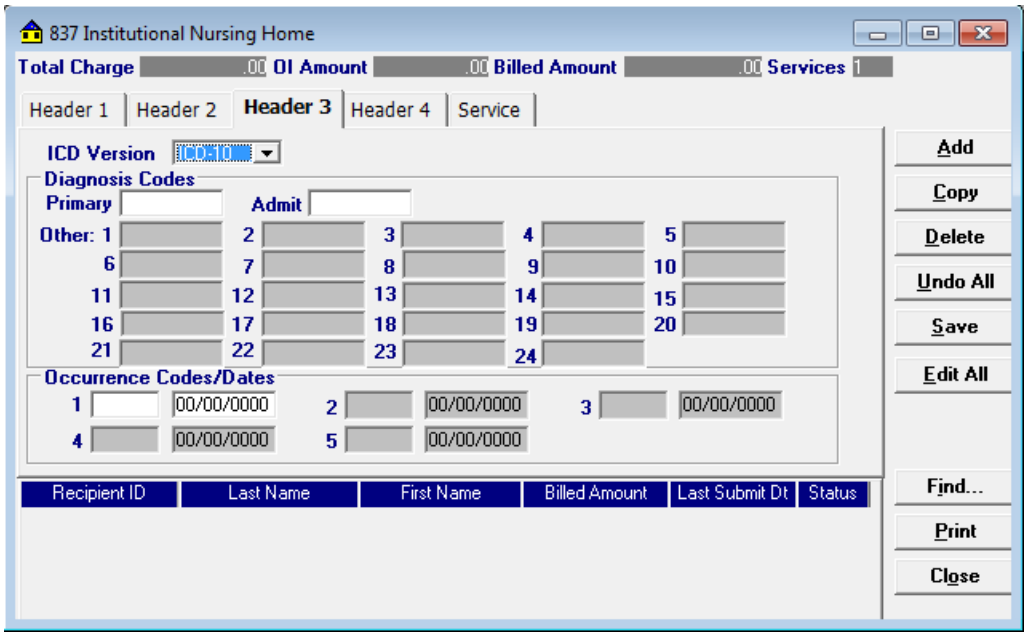
11.2.3 Header 3 Tab

Below is a sample electronic 837 Nursing Home form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit a nursing home claim:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the claim. ICD-9 or ICD-10.
Diagnosis Code – Primary	Enter a proper primary diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Other	If applicable, enter a proper diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Admit	Enter a proper admittance diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Occurrence Codes	See Chapter 5, section 5.4 of the Provider billing Manual for specific Occurrence code requirements. For a full list of these codes see Appendix B, Section B.1 Occurrence Codes in this Provider Electronic Solutions manual.
Occurrence Dates	If a value was entered in the Occurrence Code field, enter the occurrence date in MM/DD/CCYY format.

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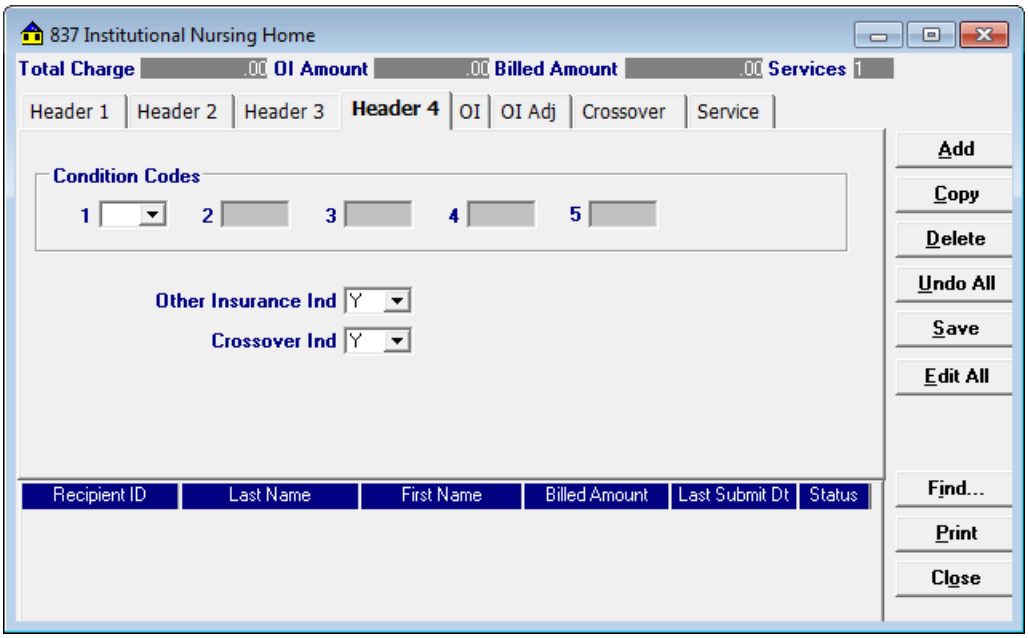
11.2.4 Header 4 Tab

Below is a sample 837 Nursing Home form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit a nursing home claim:

Field	Guidelines
Condition Codes	If applicable, enter a valid 2-digit condition code to indicate Family Planning or an EPSDT referral. For a full list of these codes see Appendix B, Section B.2 Condition Codes.
Other Insurance Ind	Choose the best value to indicate if the recipient has other insurance. Medicare is not considered other insurance.
Crossover Ind	Choose the best value to indicate if the claim is a crossover from Medicare.

11.2.5 OI (Other Insurance) Tab

Completing the Other Insurance (OI) tab is required if an indicator in the *Other Insurance Ind* field was marked as 'Yes'. Below is a sample electronic 837 Nursing Home form displaying the OI (Other Insurance) tab.

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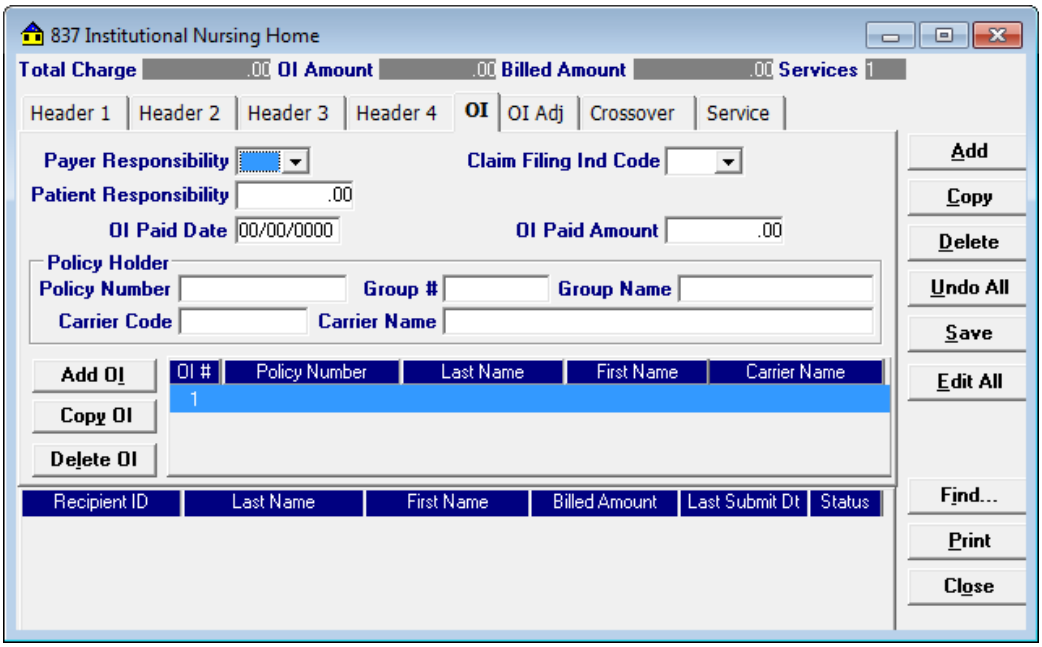

Complete the following fields under the Other Insurance tab to submit a nursing home claim:

Field	***Guidelines***
Payer Responsibility	Select the best value from the drop-down-display menu box to indicate the recipient's primary insurance coverage status to Medicaid.
Claim Filing Ind Code	Select the best value from the drop-down-display menu box to indicate the category of the recipient's other insurance. Do not enter Medicare-related codes 09, 16, MA or MB on the OI tab.
Patient Responsibility	Enter the amount of the other insurance patient responsibility, i.e., deductible, coinsurance, co-pay, etc. This field is optional.
OI Paid Date	Enter the date in MM/DD/CCYY format to indicate when the other insurance paid on the service being billed.
OI Paid Amount	Enter the dollars and cents that the other insurance paid towards the service being billed.
Policy Number	Choose the policy number from the Policy Holder list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

Adding, Deleting, or Copying Another Insurance

Use the buttons to the left of the form to add, delete, or copy another insurance. Once you copy another insurance, you can modify it as necessary. This allows you to list more than one insurance at a time if it is applicable to the recipient. You can have up to three other insurance listings.

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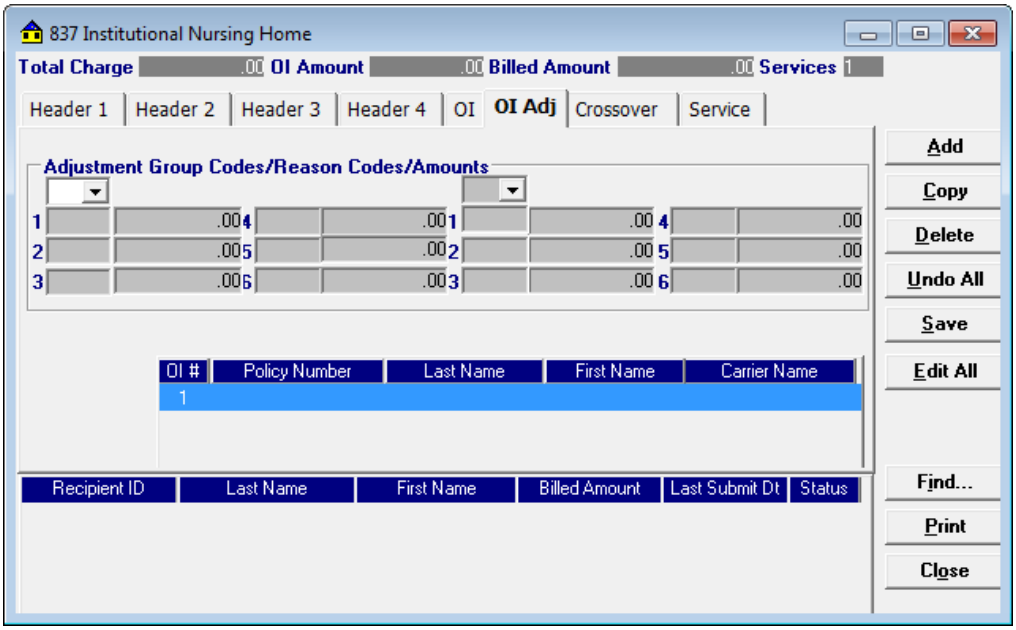
11.2.6 OI Adj Tab (Other Insurance Adjustment)

Below is a sample electronic 837 Nursing Home form displaying the OI Adj tab.

The Adjustment Group Codes/Reason Codes/Amounts table on the form is for inserting adjustment information at the header of the claim for any header level adjustments done by other insurance.



Field	*Guidelines*
Adjustment Group Code	Up to 2 Adjustment Group Codes can be entered per other insurance carrier. See Appendix B, section B.4 for a description of the dropdown options for the Adjustment Group Codes.
Reason Codes	Up to 6 Reason Codes can be entered per Adjustment Group Code. See Appendix B, section B.5 for a description of the dropdown options for the Reason Codes.
Amounts	Enter the amount for each Reason Code entered on the form.
Other Insurance Carrier Listing	After entering the Adjustment Group Codes/ Reason Codes/ Amounts for the first other insurance carrier, click the next other insurance carrier to enter the Adjustment Group Codes/ Reason Codes/ Amounts for that carrier. Continue with next carrier if applicable.

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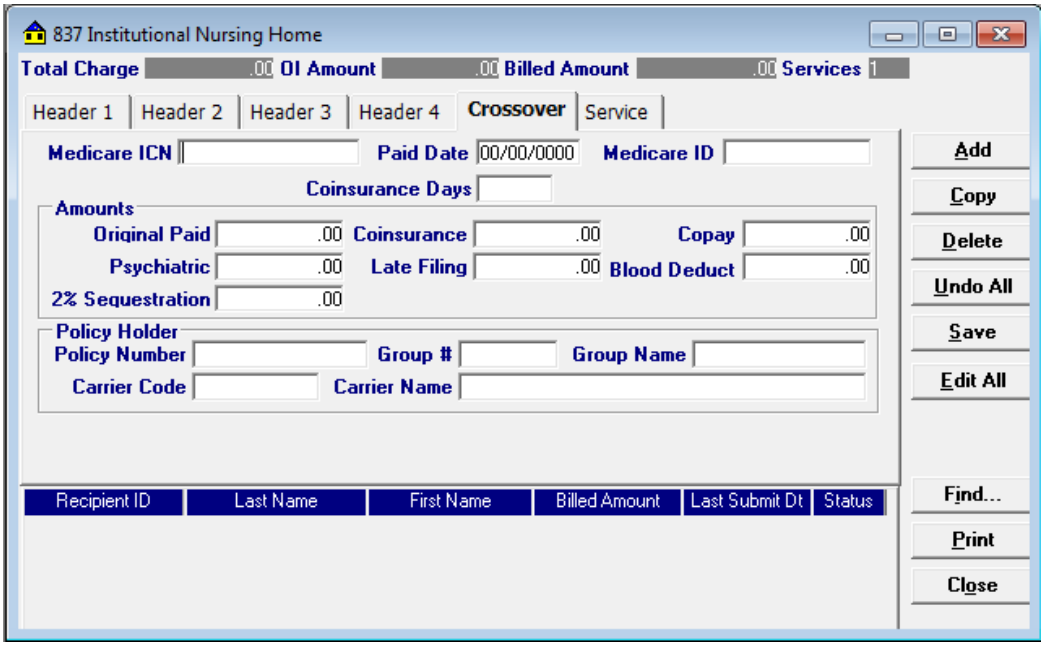
11.2.7 Crossover Tab

Completing the Crossover tab is required if an indicator in the *Crossover Ind* field was marked as 'Yes'. If the claim is Medicare related, this tab allows you to enter the information based on the payment or non-payment made. Below is a sample 837 Nursing Home form displaying the Crossover tab.



Complete the following fields under the Crossover tab to submit a nursing home claim:

Field	*Guidelines*
Medicare ICN	Enter the Claim number assigned by Medicare.
Paid Date	Enter the date Medicare paid the claim in MM/DD/CCYY format.
Medicare ID	Enter the recipient's Medicare ID assigned by Medicare.
Coinsurance Days	Enter the amount of coinsurance days used during the inpatient stay on this claim. This field is optional.
Amounts – Original Paid	Enter the actual payment amount made my Medicare.
Coinsurance	Enter the coinsurance amount from Medicare. This field is optional.
Co-Pay	If applicable, enter the amount Medicare determined the patient must pay toward the services being billed. This field is optional
Psychiatric	If applicable, enter the amount Medicare determined a recipient must pay for psychiatric related services. This field is optional.
Late Filing	If applicable, enter the amount Medicare determined a recipient must pay for late filing. This field is optional.
Blood Deduct	If applicable, enter the amount Medicare determined a recipient must pay for blood procedures performed. This field is optional.
2% Sequestration	If applicable, enter the amount of the 2% sequestration as required by the ACA.
Policy Number	Choose the appropriate Medicare number from the Policy Holder list. If you have not added a Medicare segment for the recipient to your list, double-click on this field. A screen will appear for you to do so.
Group #	This field will auto-write based on the information chosen in the Policy number field.
Group Name	This field will auto-write based on the information chosen in the Policy number field.

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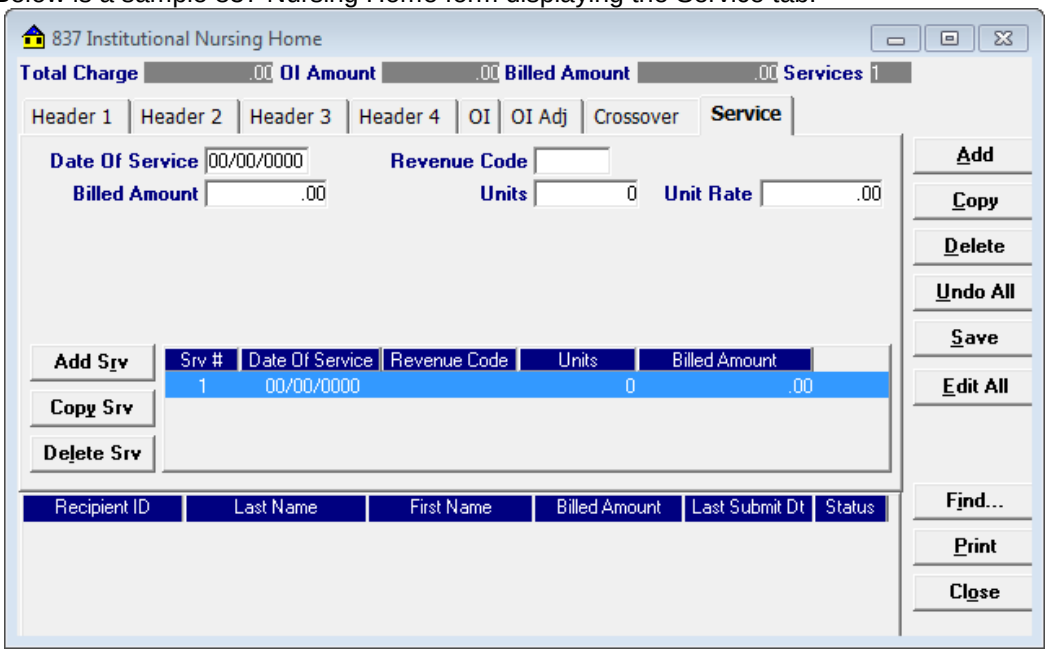
Field	Guidelines
Carrier Code	This field will auto-write based on the information chosen in the Policy number field.
Carrier Name	This field will auto-write based on the information chosen in the Policy number field.

11.2.8 Service Tab

Below is a sample 837 Nursing Home form displaying the Service tab.



Complete the following fields under the Service tab to submit a nursing home claim:

Field	Guidelines
Date of Service	Enter the date of service for each procedure provided in a MM/DD/CCYY format.
Revenue Code	Enter a valid revenue code, or choose one from the revenue code list.
Billed Amount	Enter the amount billed for the service.
Units	Enter the unit(s) billed for the service.
Unit Rate	If revenue code entered ranges from 100 – 219, enter the accommodation rate for the individual unit billed.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

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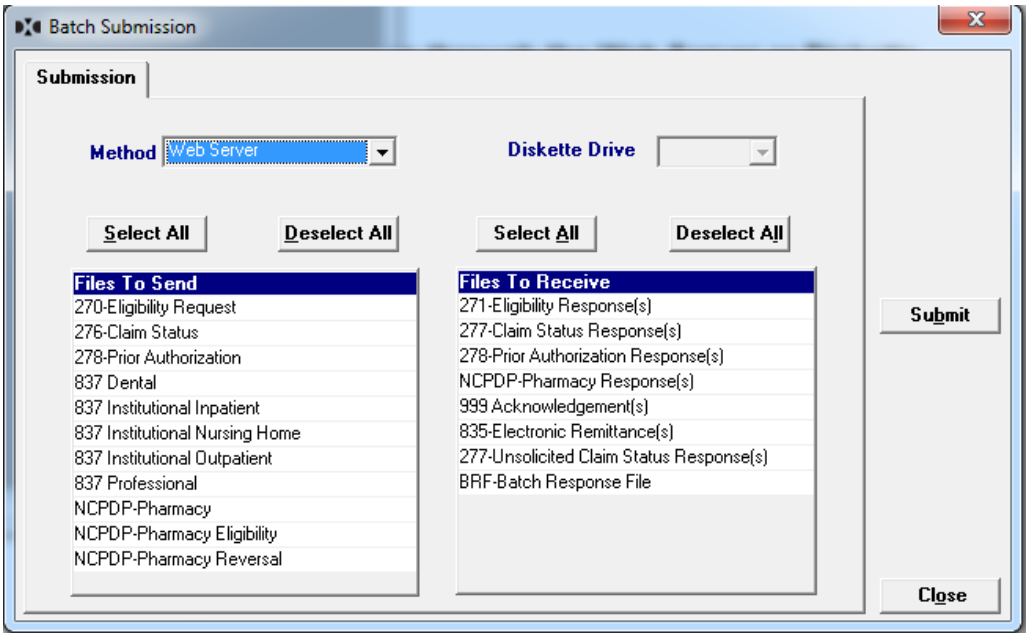
11.3 Submitting Claims through the Web Server or Diskette

Step 1 Select Communication >> Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the Files to Send list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

Step 4 Determine which files you want to receive from the Files to Receive list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view t*he Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.*

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12

12 Submitting Claim Reversals and Adjusting Paid Claims

The new 5010 version of PES is now available in version 3.0. Users need to upgrade to PES version 2.16 before installing PES version 3.0 in order to preserve the PES database list. Once you upgrade to the new version of PES, you will no longer be able to submit, resubmit, copy, modify or restore HIPAA 4010 or NCPDP 1.1 transactions. After completing the upgrade to 3.0, all HIPAA 5010 and NCPDP 1.2 transactions will need to be entered in the software as a new claim.

This chapter provides instructions for submitting electronic pharmacy and non-pharmacy claim reversals. Claim reversals may be submitted by batch, or by diskette.

Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

12.1 General Instructions for Entering Reversals

Users access the NCPDP Pharmacy Claim Reversal window using one of the following methods:

- Selecting the NCPDP Pharmacy Claim Reversal icon from the toolbar
- Selecting Forms>> NCPDP Pharmacy Reversal

Users access the non-pharmacy claim reversal option using one of the following methods:

- Selecting the designated form that the claim was originally filed from the toolbar

  (Example: If the claim paid as an 837 Professional, choose the icon)
- Selecting Forms>> then choosing the designated form that the claim was originally filed on.

  (Example: If the claim paid as an 837 Professional, choose Forms>>837 Professional)

12.1.1 Entering Reversal/Adjustment Requests

The NCPDP Pharmacy Claim Reversal window contains three main parts:

- Updateable fields used to enter claims data.
- Buttons to the right of the form used to save, delete, or modify information entered in the updateable fields.
- List fields at the bottom of the form that enable users to view basic information about several reversal records. Users may highlight a row to delete, copy, print, or modify a claim record. The list fields include Provider ID, Recipient ID, ICN, and Status.

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Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the window so you may add a new record. Please note that if you key over data that already displays on the record and press Save, you will overwrite the previous record. Be sure to press Add before entering a new record, or press Copy (see below) to build a new record from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new record from an existing record. This feature is especially helpful if you are entering multiple batch reversals for batch submission.
Delete	Pressing this button enables you to delete the record currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the record currently displayed.
Save	Pressing this button enables you to save the record you just added or modified. The saved record displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved record by status, last provider ID, recipient ID, and ICN.
Print	Pressing this button enables you to print the record currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Record

Step 1 Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the ‘Tab’ key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct each mistake and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another record.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the record you wish to modify, and perform one of the following:

- Key over incorrect data on the window. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct record.
- Press ‘Copy’ to copy a record that closely matches the information you need to enter and modify the new record accordingly. Save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

To Find a Record from the List

Press the 'Find' button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the 'Find Next' button to search for the next record that matches the search criteria. Continue pressing 'Find Next' until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press 'Cancel' when you have finished searching.

12.2 Claim Adjustments/Reversals for Non-Institutional Claims

Step 1 Open the non-institutional form type that the original claim paid as.

If the claim was originally keyed into PES, you may locate that particular claim in an "F" status and press "Copy" to begin adjusting or reversing the claim.

Step 2 In the Claim Frequency field change the indicator to inform Medicaid if the request is an Adjustment or a Claim Reversal.

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.

8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.

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Step 3 In the Original Claim # field enter the ICN assigned by Medicaid once the claim was accepted and paid. This information can be located on your Batch Response report or *Explanation of Payment*.

Step 4 Fill out the form type according to how it was filed previously. Include the same Recipient ID, and Provider ID that was filed on the original claim.

- If the value '7' was chosen, enter the original claim exactly how it was filed except for the adjustments to be made to the claim. Whatever information is submitted on this claim will replace the claim with the ICN # from Step 3.
- If the value '8' was chosen, enter the original claim exactly how it was filed to complete the claim reversal. Once submitted, this reversal will cross-reference the provider ID and the recipient ID against the ICN # entered. If these fields do not match the information on the original claim, the reversal will be denied.

Step 5 Press 'Save' to save your claim, and follow Section 12.5, Submitting Reversals/Adjustments through Web Server or Diskette.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of payment; however, filing limits apply to claims re-filed as a result of an electronic adjustment or pharmacy reversal.

12.3 Claim Adjustments/Reversals for Institutional Claims

Step 1 Open the Institutional form type that the original claim paid as.

If the claim was originally keyed into PES, you may locate that particular claim in an "F" status and press 'Copy' to begin adjusting the claim.

Step 2 In the Type of Bill field the last digit of the three-digit code will inform Medicaid if the claim is a reversal or an adjustment. End the Type of Bill with a '7' or an '8' to indicate an adjustment or a reversal. See the NOTE below.

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

7 (Replace a prior paid claim.) Please be aware, the payer is to operate on the principle that the original claim will be changed, and that the information present on this adjustment represents a complete replacement of the previously issued bill.

8 (Void or reverse a prior claim.) Please be aware, the payer is to operate on the principle that the original claim will be reversed, and that the information present on this reversal represents a complete void of the paid claim.

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Step 3 In the Original Claim # field enter the ICN assigned by Medicaid once the claim was accepted and paid. This information can be located on your Batch Response report or *Explanation of Payment*.

Step 4 Fill out the form type according to how it was filed previously. Be sure to include the same Recipient ID, and Provider ID that was filed on the original claim.

- If the type of bill ended with a '7', enter the original claim exactly how it was filed except for the adjustments to be made to the claim. Whatever information is submitted on this claim will replace the claim with the ICN # from Step 3.
- If the type of bill ended with an '8', enter the original claim exactly how it was filed to complete the claim reversal. Once submitted, this reversal will cross-reference the provider ID and the recipient ID against the ICN # entered. If these fields do not match the information on the original claim, the reversal will be denied.

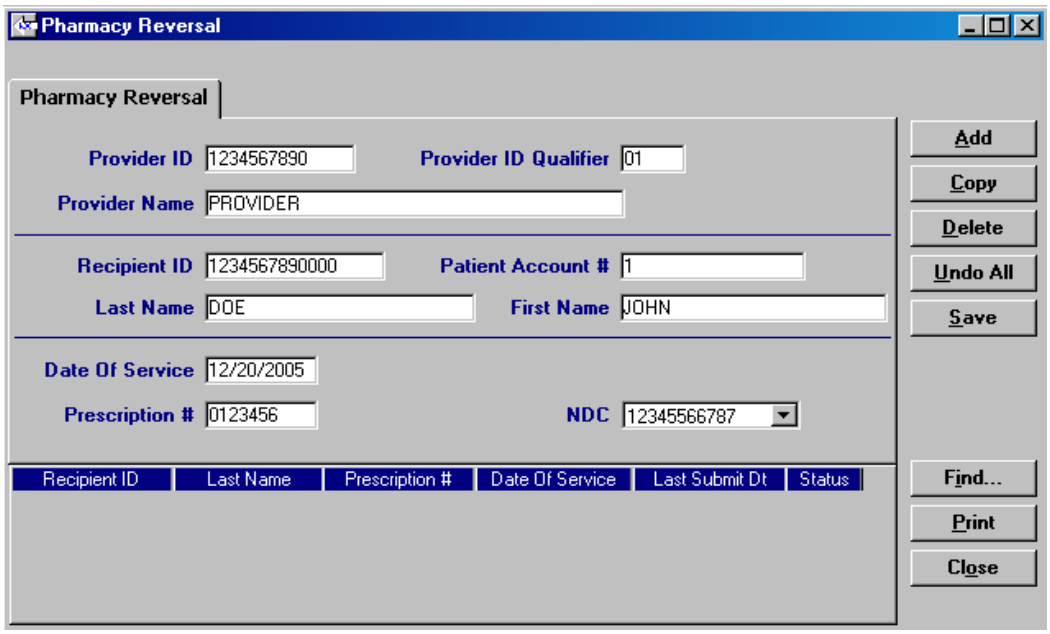
Step 5 Press 'Save' to save your claim, and follow Section 12.5, Submitting Reversals/Adjustments through Web Server or Diskette.

NOTE:

You can adjust paid non-pharmacy claims up to three years from the date of payment; however, filing limits apply to claims re-filed as a result of an electronic adjustment or pharmacy reversal.

12.4 NCPDP Pharmacy Reversal Window

Below is a sample Pharmacy Reversal window:



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Complete the following fields under the NCPDP Pharmacy Reversal tab to submit a pharmacy claim reversal:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Qualifier	Select the value that identifies the entity that assigned the ID.
Provider Name	This field will auto-write based on the information placed in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Patient Account #	This field will auto-write based on the information placed in the Recipient ID field.
Last Name	This field will auto-write based on the information placed in the Recipient ID field.
First Name	This field will auto-write based on the information placed in the Recipient ID field.
Date of Service	Enter the date the prescription was dispensed to the recipient in MM/DD/CCYY format.
Prescription #	Enter the 7 to 12-digit prescription number.
NDC	Enter the 11-digit National Drug Code (NDC).

NOTE:

Claims created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claims. All claims submitted using PES version 3.0 must be created in the 3.0 software as a new claim.

NOTE:

You can submit claim reversals for pharmacy claims up to 18 months after the claim was paid.

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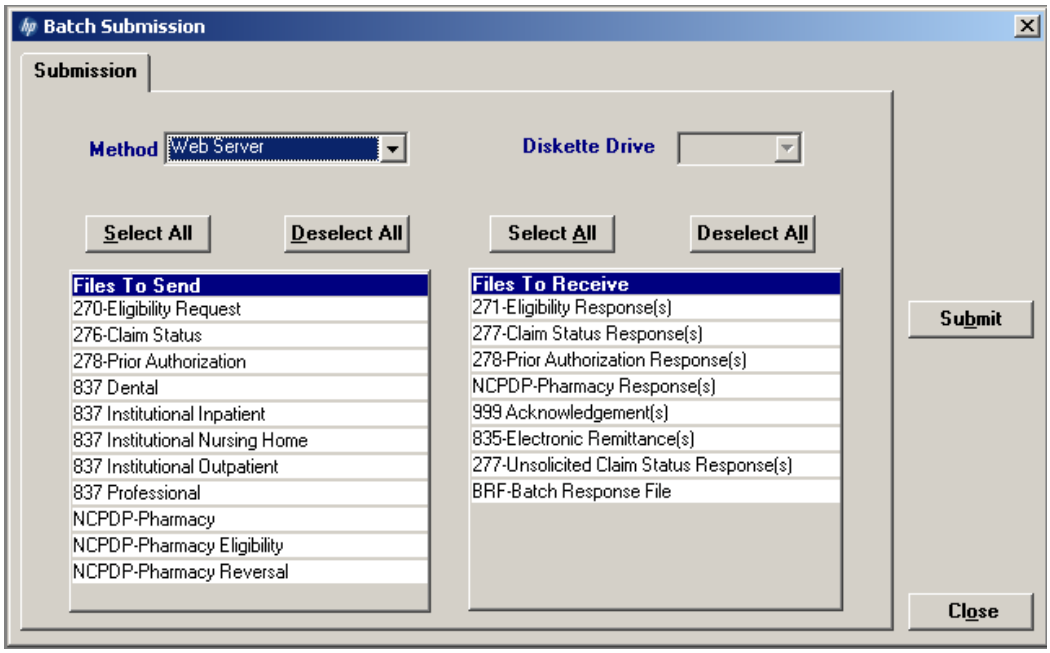
12.5 Submitting Reversals/Adjustments through the Web Server or Diskette

Follow Steps 1-5 to receive the response from the Web Server.

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the Method drop down list.

Step 3 Determine which files you want to send from the Files to Send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for archiving.

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Step 4 Determine which files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

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13

13 Receiving a Response

This chapter describes how to download a response, resubmit a batch, and understand the corresponding submission reports. It also discusses diskette and interactive submission and response.

Chapter 13, Receiving a Response, contains the following sections:

- Sending batch transactions to the Web Server
- Downloading responses from the Web Server
- Viewing batch responses
- Resubmitting batches
- Submitting batches by diskette

13.1 Sending Batch Transactions to the Web Server

Provider Electronic Solutions enables you to submit batch (groups of one or more records) transactions to the DXC Technology Web Server for all claim types, eligibility verification, claim status, prior authorization, and claim reversals. You can send batch transmissions for any combination of record types – for example, you can enter all your daily claims for 837 Professional and 276 Claim Status then submit them all in one batch transmission.

Likewise, you can submit eligibility verification and claim records together in the same batch transmission. *Provider Electronic Solutions* also enables you to upload responses while you are downloading batches to the Web Server.

NOTE:

You may download (receive) and upload (send) batches as often as you like.

Records that are ready for batch submission have a status of ‘R’. The status displays on the list field at the bottom of the claim, eligibility, claim status, or prior authorization form. Once you have added and saved all the records you want to include in your batch (see Chapters 5 -13 for instructions), perform the following steps to submit a batch transmission:

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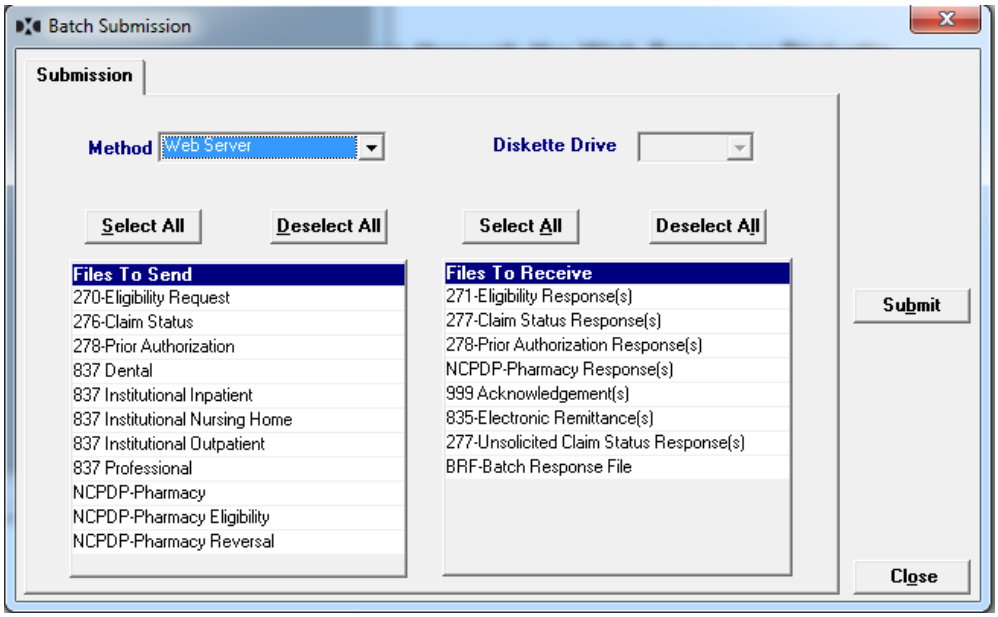
Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the Method drop down list. See Section 13.5, Submitting Batches by Diskette, for instructions on submitting diskettes to DXC Technology.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 4 Determine the files you want to receive from the Files to Receive list.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 5 Follow Steps 1-5 to receive the response from the Web Server.

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NOTE:

When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.*

You must view the Batch Response File (BRF) to determine if your claims were accepted or rejected. To view a BRF to any 837 transaction, you may download the Batch Response File using the Provider Electronic Solutions software or log into the Alabama Interactive Web Portal and select the download option, then select BRF or perform an online claim search.

To download a response, follow the instructions provided in Section 13.1, Sending Batch Transactions to the Web Server. The system displays a 'Submission Successful' message when it successfully connects with the Web Server. This does not mean that your response file has been downloaded.

To determine whether a response has been downloaded, review the file name in the Communication Log or the Verification Log and search for that file name in the Response Log. You can also watch the system as it attempts to download a response. If *Provider Electronic Solutions* locates your response file on the Web Server, it will indicate the number of files downloaded in the lower left hand corner of your screen.

View the response by selecting the Communications>>View Batch Response menu option.

13.2 Viewing Responses

This section describes viewing the batch response, 999s, and communication log screens.

View Batch Response

This option enables the user to view a Batch Response File (BRF). The report shows whether or not claims were accepted or rejected as well as the batch identification number. The accepted and rejected claims will be in the order they were sent and will display the ICN and any applicable rejection codes and descriptions.

The 999-response informs the user if a transaction (270, 276, 278 or 837) was successfully uploaded to the web server and if the transaction was HIPAA compliant. *Provider Electronic Solutions* will not allow a user to send a Non-HIPAA compliant transaction, therefore all 999 responses should be sent back with an AK5 indicating the file was HIPAA compliant and will cycle to Medicaid for processing.

NOTE:

An electronic version of the EOP (835) is available if a request was signed and sent to the EMC Helpdesk. Although Provider Electronic Solutions has the ability to download the file, it does not allow the user to view it. Therefore, if an electronic version of the 835 report is desired, the user must contact an outside vendor for a program that is able to format the file into a report.

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View Communication Log

This option enables the user to view a log of each transaction that occurs between *Provider Electronic Solutions* and the Web Server (batch submission and software upgrades). Each occurrence is assigned a file name. Users scroll down the list of file names located at the top of the Communication Log window and click on a row to access the log associated with the file name.

13.3 Resubmitting Batches

Select Communication>>Resubmission to resubmit entire batches, resubmit records within batches, or to copy batches or records within batches for modification and resubmission. The Batch Resubmission window displays.

Users select from a list of previously submitted batches. The user highlights a particular batch to display all records stored within the batch. The user may perform any of the following:

- Click ‘Select All’ to select all records within a batch for resubmission, then press the ‘Resubmit’ button to resubmit the batch
- Click on one or more records for the batch displayed and press ‘Resubmit’
- Select the ‘Copy’ button to copy the entire batch
- Click on one or more records for the batch displayed and press ‘Copy’

To modify copied records, access the corresponding claim, eligibility, or claim status form and select the copied record from the list that displays at the bottom of the form. Modify and save the record, then submit according to the instructions in Section 13.1, Sending Batch Transactions to the Web Server.

13.4 Submitting Batches by Diskette

To submit batches by diskette, select Diskette from the Method drop down list on the Batch Submission window. Insert a diskette in your PC’s diskette drive. Click on the record type(s) you want to submit. Press the ‘Submit’ button and follow the directions issued from the system.

Mail the disk to the following address:

DXC Technology
Attn: EMC Help Desk
301 Technacenter Drive
Montgomery, AL 36117

DXC Technology receives the diskette and submits the data using a locally installed copy of *Provider Electronic Solutions*. 999 HIPAA Acception/Rejection notice reports are sent to the provider. Providers must perform a 276 Claim Status batch request to retrieve paid and/or denied claims information. Refer to Chapter 16 to complete a Claim Status Request via the *Provider Electronic Solutions* software or Chapter 17 for logon procedures on the Alabama Interactive Web Portal. The Explanation of Payment (EOP) will continue to be mailed to the provider's billing address.

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14

14 Producing Reports

This chapter describes how to select and produce detail, summary, and list reports. It contains the following sections:

- Detail and Summary Reports
- Other Reports

14.1 Detail and Summary Reports

Provider Electronic Solutions enables you to print detail and summary reports for your claims, eligibility verification requests, pharmacy reversals, claim status and prior authorization requests.

Selecting Reports>>Detail Forms enables you to produce a detail report that shows the claim in its entirety.

Selecting Reports>>Summary Forms enables you to produce summary reports such as the basic recipient information, billed amount, the date the claim was last submitted, claim status and the service (claim) lines.

When you select either the detail or summary menu options, you must also select a form. The Detail or Summary Reports window displays accordingly. To customize the report, enter information into at least one of the following fields and press 'Enter':

- Batch Number
- Recipient ID
- Form Status
- Submit Date

The system displays a print preview of the report and populates the Records Selected field with the number of records included on the report. Send the report to your printer as required.

Generating a Detail Form Report

You may select any option available on the Detail Form screen. Choosing this option will allow you to generate a detailed report for any claim type, eligibility request, claim status, or prior authorization request. Follow the step-by-step procedures below to complete this process:

Step 1 Click on Reports >> Detail Forms >> and choose the desired report. The available list includes:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient

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- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal

NOTE:

Creating these detailed reports will not include the responses created upon transmission. The only claim status you will receive on this report is the status of the claim within the Provider Electronic Solutions software. The status indicators include F (Finished/or successfully sent to Medicaid), A (Archived), I (Incomplete Transmission), P (Pending) and R (Ready to send).

These reports are to be used as a form of proof of filing, claim entry and internal usage.

Step 2 Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	Usage
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Recipient ID	To limit the detail report to request for a certain recipient, enter the appropriate 12-digit recipient ID in this field.
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's pull-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

Step 3 Click 'OK' after entering or choosing a value in one of the option screens as listed in Step 2.

Step 4 Click on 'Print' if you wish to print a copy of the report listed on your screen.

Step 5 Click on 'Close' to exit the Detail Report screen.

14.1.1 Generating a Summary Report

You may select any option available on the Summary Form screen. Choosing this option will allow you to generate a basic report for any claim type, eligibility request, claim status, or prior authorization request. Follow the step-by-step procedures below to complete this process:

Step 1 Click on Reports >> Summary Forms >> and choose the desired report. The available list includes:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy

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- NCPDP Pharmacy Reversal

Step 2 Choose one of the search criteria's to generate your report. A listing of each option is defined below:

Search Criteria Option	***Usage***
Batch Number	This number creates a report according to the information entered and submitted on one particular batch transmission. You can locate the Batch Numbers within the Communication>>Resubmission screen.
Recipient ID	To limit the detail report to request for a certain recipient, enter the appropriate 12-digit recipient ID in this field.
Form Status	To create a detailed report according to a certain form status, select the appropriate form status from this field's pull-down list.
Submit Date	To create a detailed report, according to the date of submission, enter the appropriate date in MM/DD/CCYY format.

Step 3 Click OK after entering or choosing a value in one of the option screens as listed in Step 2.

Step 4 Click on 'Print' if you wish to print a copy of the report listed on your screen.

Step 5 Click on 'Close' to exit the Detail Report screen.

14.2 Other Reports

Provider Electronic Solutions enables you to print reports of all you have stored in your list screens. Select the Reports menu option, then choose from the following:

- Attending/Operating Provider
- Ordering Provider
- Prescriber
- Provider
- Recipient
- UPIN
- Admission Type
- Carrier
- Condition Code
- Diagnosis ICD-9
- Diagnosis ICD-10
- Modifier
- NDC
- Occurrence
- Patient Status
- Place Of Service
- Policy Holder
- Procedure/HCPCS
- Procedure ICD-9
- Procedure ICD-10
- Revenue
- Taxonomy
- Type Of Bill

NOTE:

You may print from any of these reports as you so choose. Please be advised that the information displayed within the report is based on your List screens. The Place of Service and Carrier lists have already been populated by DXC Technology. The remainders of your list screen are only populated if the user so chooses to enter and save such information.

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15

15 Submitting 278 Prior Authorization Requests

This chapter provides instructions for submitting electronic requests for the 278 Prior Authorization form, which is available for Medical and Dental requests. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

278 prior authorization requests through Provider Electronic Solutions should only be used to submit fee-for-service requests to Alabama Medicaid. Contact MCOs for their process to submit prior authorizations to them.

Users access the 278 Prior Authorization request form using one of the following methods:

- Selecting the Prior Authorization Request icon from the toolbar called “Prior Auth”
- Selecting Forms>>278 Prior Authorization Request

The electronic form displays with eight tabs: Header 1, Header 2, Header 3, Header 4, Header 5, Header 6, Header 7, and Service 1.

15.1 Entering Requests Using the 278 Prior Authorization Form

Each tab on the 278 Prior Authorization form contains three main parts:

- Updateable fields used to enter PA request data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several PA requests. Users may highlight a row to modify, copy, or print a PA request record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

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Below is a description of the buttons that display on the PA request form:

Button	***Usage***
Add	Pressing this button enables you to refresh the PA request screen so you may add a new record. Please note that if you key over data that already displays on the PA request form and press Save, you will overwrite the previous PA request. Be sure to press Add before entering a new PA request, or press Copy (see below) to build a new PA request from an existing PA request record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new PA request from an existing PA request record. This feature is especially helpful if you routinely submit PA request for the same procedure code for different recipients or for other instances where your PA request may be similar to one another.
Delete	Pressing this button enables you to delete the PA request currently displayed.
Undo All	Pressing this button enables you to undo changes you have made to the PA request currently being displayed.
Save	Pressing this button enables you to save the PA request you just added or modified. The saved PA request displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved PA request by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the PA request currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New PA request

Step 1 Access the 278 Prior Authorization form. Key information into all required fields.

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the PA request contains errors. Scroll through the error messages and double-click on each error to access the field on the PA request that contains the error.

Step 3 Correct each mistake and press ‘Save,’ or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete PA requests (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another PA request.

To Modify a PA request from the List

Scroll through the list of PA request that display at the bottom of the form. Highlight the PA request you wish to modify, and perform one of the following:

- Key over incorrect data on the PA request form. You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct PA request.

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- Press ‘Copy’ to copy a PA request that closely matches the information you need to enter (for instance, if you must enter PA request for identical services, but different recipients) and modify the new record accordingly. Press ‘Save” to save the new record.
- Press ’Delete’ to delete an unwanted record.

NOTE:
Prior Authorization transaction created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these Prior Authorization transactions. All Prior Authorizations submitted using PES version 3.0 must be created in the 3.0 software as a new Prior Authorization transaction.

To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

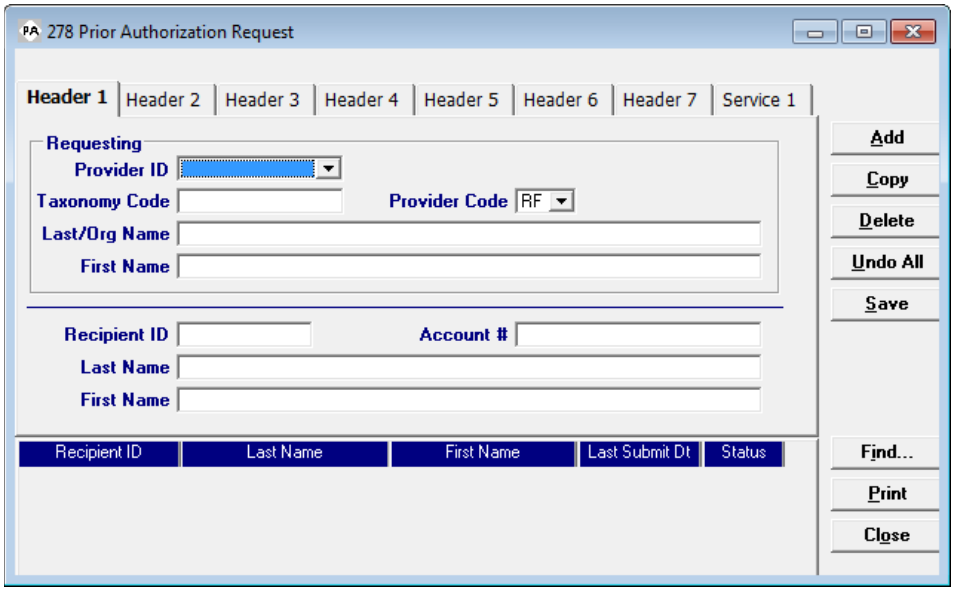
Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

15.2 Fields on the Prior Authorization Form

Header 1 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 1 tab.



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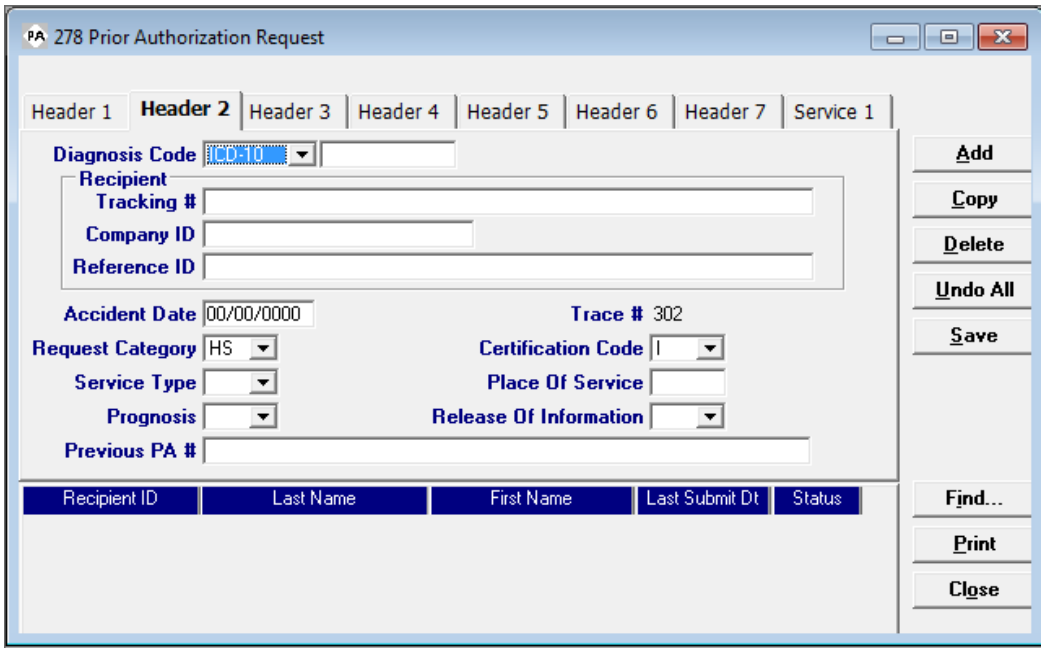
Complete the following fields under the Header 1 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Taxonomy Code	This field will auto-write based on your choice in the Provider ID field. This field is not currently used.
Provider Code	Choose the best value to indicate the type of provider indicated in the Provider ID field. If no value is indicated, the field will auto-plug 'RF'. AD Admitting AS Assistant Surgeon AT Attending OP Operating OR Ordering OT Other Physician PC Primary Care Physician PE Performing RF Referring
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Account #	The account number entered in the recipient list will auto-write based upon which recipient ID was chosen.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen.

Header 2 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 2 tab.



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Complete the following fields under the Header 2 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
ICD Version	The ICD version selected will apply to all diagnosis codes entered on the PA request. ICD-9 or ICD-10.
Diagnosis Code	Choose a proper diagnosis code from your diagnosis code list or enter a valid diagnosis code. This field must be a minimum of 3-digits long and cannot contain decimals.
Tracking #	Enter the recipient's tracking number. The requester assigns a unique trace number to the PA request, or enters the system assigned Trace # located under Header Tab 2 on the 278 request form.
Company ID	Enter the **Requester's** 10-digit Company ID. '1' plus EIN, '3' plus DUNS, or '9' plus nine user-assigned numbers.
Reference ID	Enter the recipient's reference ID to further identify a specific division or group of the company identified in the Company ID field. **This field is optional**.
Accident Date	If applicable, enter the date of the accident in a MM/DD/CCYY format.
Trace #	This field allows you to utilize the trace # that is also located on the 278 response to locate which request the response is referring to.
Request Category	Choose the best value to indicate the review type that resulted in the specific request. AR Admission Review HS Health Services Review IN Individual SC Special Care Review
Certification Code	Choose the best value to indicate the originality or follow-up status of the current Prior Authorization. If any value other than 'I' is chosen, enter the previous PA number into the Previous PA # field. I Initial N Reconsideration R Renewal S Revised
Service Type	Choose the best value to indicate the type of service to be performed. 01 – Medical Care 02 – Surgical 12 – DME – Purchase 18 – DME – Rental 35 – Dental Care 40 – Oral Surgery 42 – Home Health Care 44 – Home Health Visits 54 – LTC Waiver 56 – Medically Related Transportation 69 – Maternity 72 – Inhalation Therapy 74 – Private Duty Nursing 75 – Prosthetic Devices A4 - Psychiatric AD – Occupational Therapy AE – Physical Medicine AF – Speech Therapy AL – Vision – Optometry CQ - Case Management
Place of Service	Choose the best value to indicate where the service/procedure was performed from the Place of Service list.

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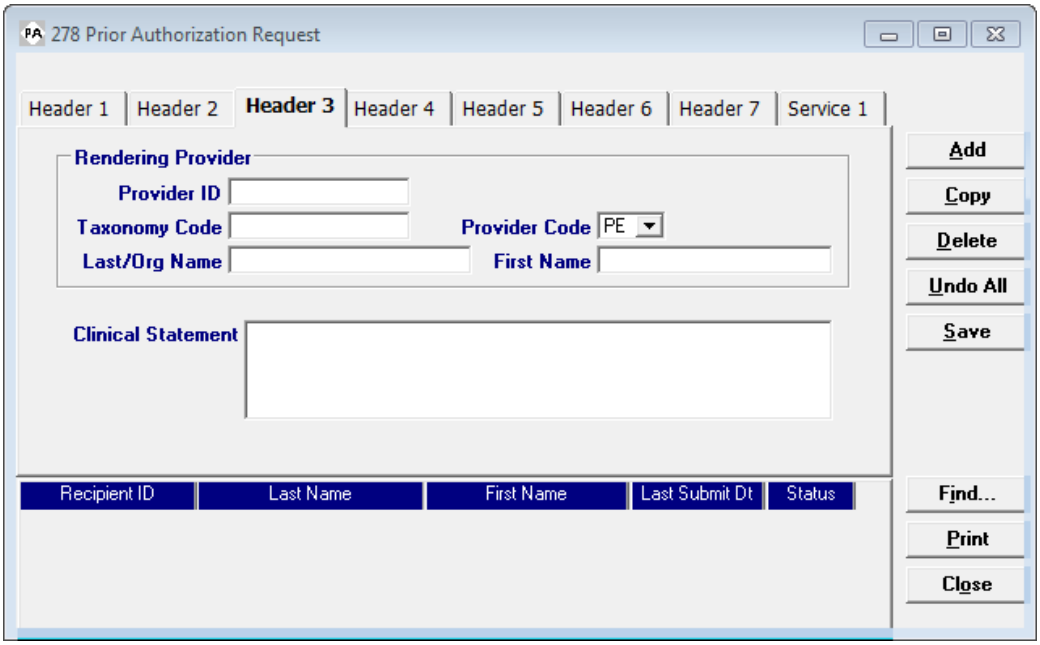
Field	*Guidelines*
Prognosis	Choose the best value to indicate the recipient's current health prognosis. This field is optional. 1 Poor 2 Guarded 3 Fair 4 Good 5 Very Good 6 Excellent 7 Less than 6 Months to Live 8 Terminal
Release of Information	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. M - Provider has limited or restricted ability to release data related to a claim Y - Yes, Provider has signed statement permitting release of medical billing data related to a claim
Previous PA#	If applicable, enter the previous PA number that applies to the services being requested on this PA.

Header 3 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 3 tab.



Complete the following fields under the Header 3 tab to submit a 278 Prior Authorization request:

Field	*Guidelines*
Rendering Provider ID	Choose a provider ID from your provider ID list to indicate which provider will bill the service. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Taxonomy Code	This field will auto-write based on your choice in the Provider ID field.

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Field	***Guidelines***
Provider Code	Choose the best value to indicate the type of provider indicated in the Provider ID field. If no value is indicated, the field will auto-plug 'PE'. AD Admitting AS Assistant Surgeon AT Attending OP Operating OR Ordering OT Other Physician PC Primary Care Physician PE Performing RF Referring
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.
Clinical Statement	If a procedure code requires a modifier for non-transportation PA's, enter the modifier into this field immediately after the associated procedure code. For example, procedure code 19318 may require the modifier 50 to indicate 'Bilateral'. Enter this as '19318-50' so the PA clerk at the State agency may review this accordingly. Please enter a clinical statement, regarding the recipient, when you feel it may help the approval process. Refer to the Provider Manual for required information.

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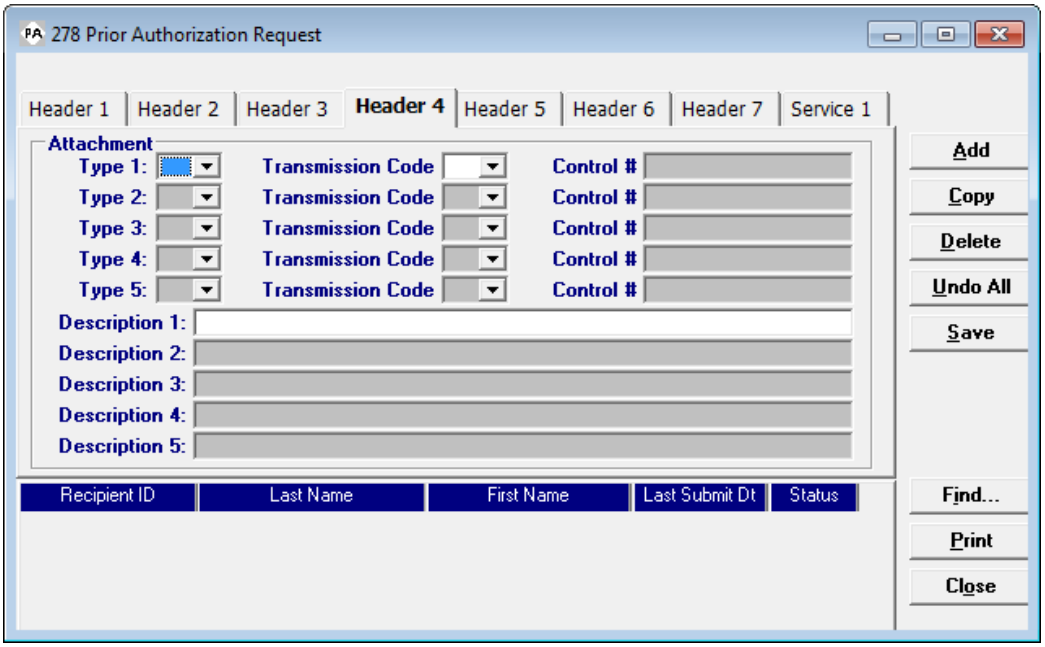
Header 4 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 4 tab.



Complete the following fields under the Header 4 tab to submit a 278 Prior Authorization request with attachments:

Field	***Guidelines***
Attachment Type	If required for PA review, indicate the type of attachment.
Transmission Code	If a value was entered in the Attachment Type field, choose the best value to indicate the method or format, which the reports are to be sent. The only valid values processed by Alabama Medicaid are as indicated: AA Available on Request at Provider Site BM By Mail EL Electronically Only EM E-mail FX By Fax VO Voice
Control #	Enter the attachments control number. This number is based on your internal filing system, and will not be reviewed by Alabama Medicaid. NOTE: Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. Fax them to 334-215-4140, Attn: PA Unit, or mail the attachments to: DXC Technology Attn: PA Unit PO Box 244032 Montgomery, AL 36124
Description	Enter the attachments description. This field is optional.

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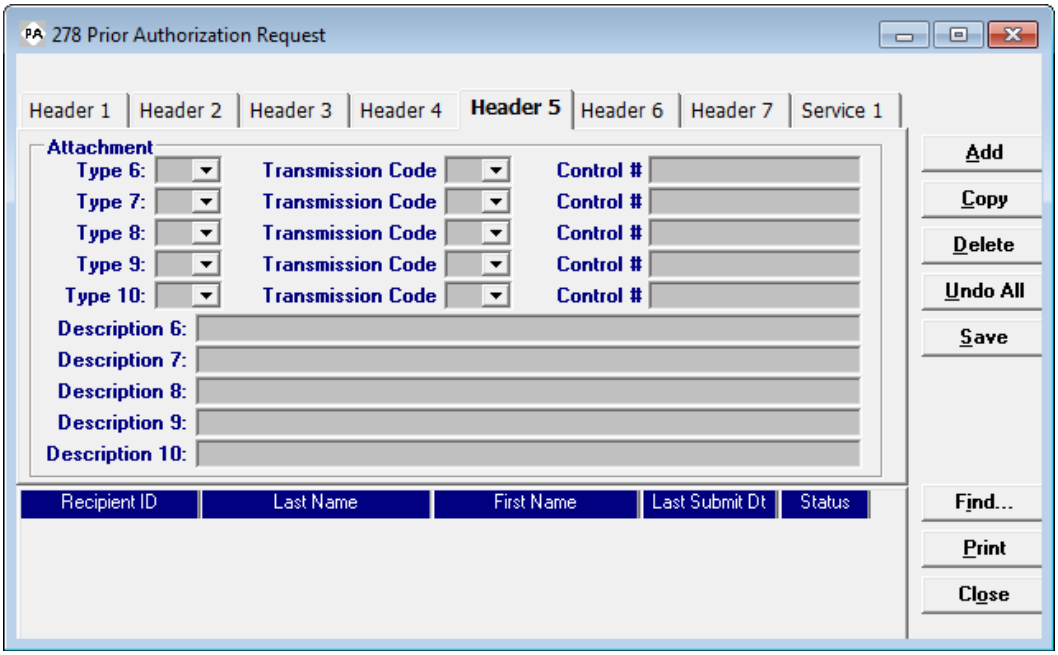
Header 5 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 5 tab.



Complete the following fields under the Header 5 tab to submit a 278 Prior Authorization request with attachments:

Field	***Guidelines***
Attachment Type	If required for PA review, indicate the type of attachment.
Transmission Code	If a value was entered in the Attachment Type field, choose the best value to indicate the method or format, which the reports are to be sent. The only valid values processed by Alabama Medicaid are as indicated: AA Available on Request at Provider Site BM By Mail EL Electronically Only EM E-mail FX By Fax VO Voice
Control #	Enter the attachments control number. This number is based on your internal filing system, and will not be reviewed by Alabama Medicaid. NOTE: Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. Fax them to 334-215-4140, Attn: PA Unit, or mail the attachments to: DXC Technology Attn: PA Unit PO Box 244032 Montgomery, AL 36124
Description	Enter the attachments description. This field is optional.

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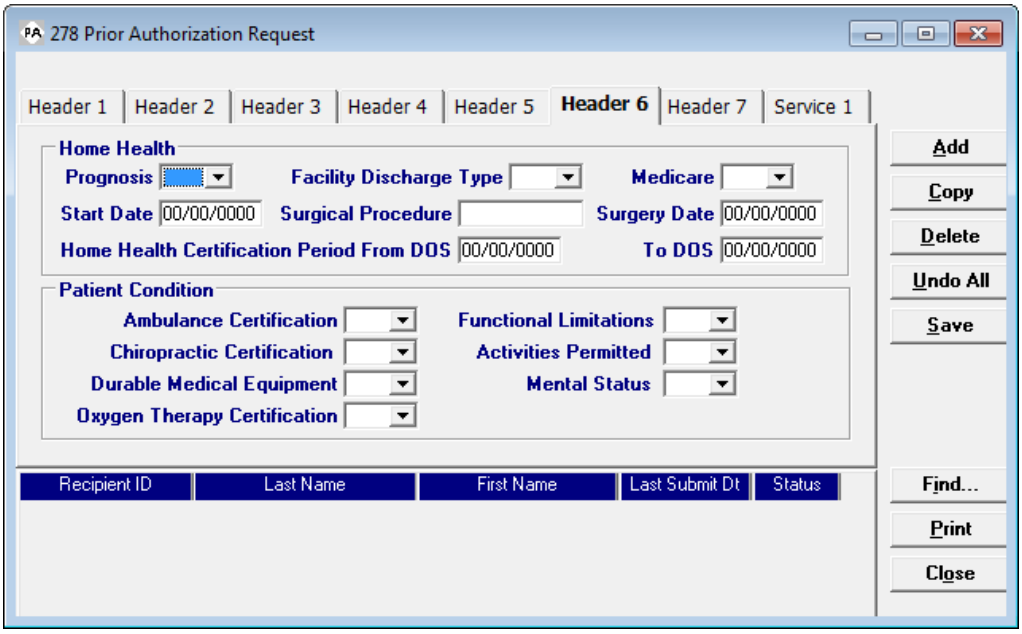
Header 6 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 6 tab.



Complete the following fields under the Header 6 tab to submit a 278 Prior Authorization request:

Field	Guidelines
Home Health Prognosis	Choose the best value to indicate the patient's current home health prognosis. 1 Poor 2 Guarded 3 Fair 4 Good 5 Very Good 6 Excellent 7 Less than 6 Months to Live 8 Terminal
Facility Discharge Type	If a value was indicated in the Home Health Prognosis field, choose the best value to indicate where the recipient was discharged. A Acute Care Facility B Boarding Home C Hospice D Intermediate Care Facility E Long-term or Extended Care Facility F Not Specified G Nursing Home H Sub-acute Care Facility L Other Location M Rehabilitation Facility O Outpatient Facility P Private Home R Residential Treatment Facility S Skilled Nursing Home T Rest Home
Medicare	If a value was indicated in the Home Health Prognosis field, choose the best to value indicate if the patient currently has Medicare
Start Date	The date covered home health services began

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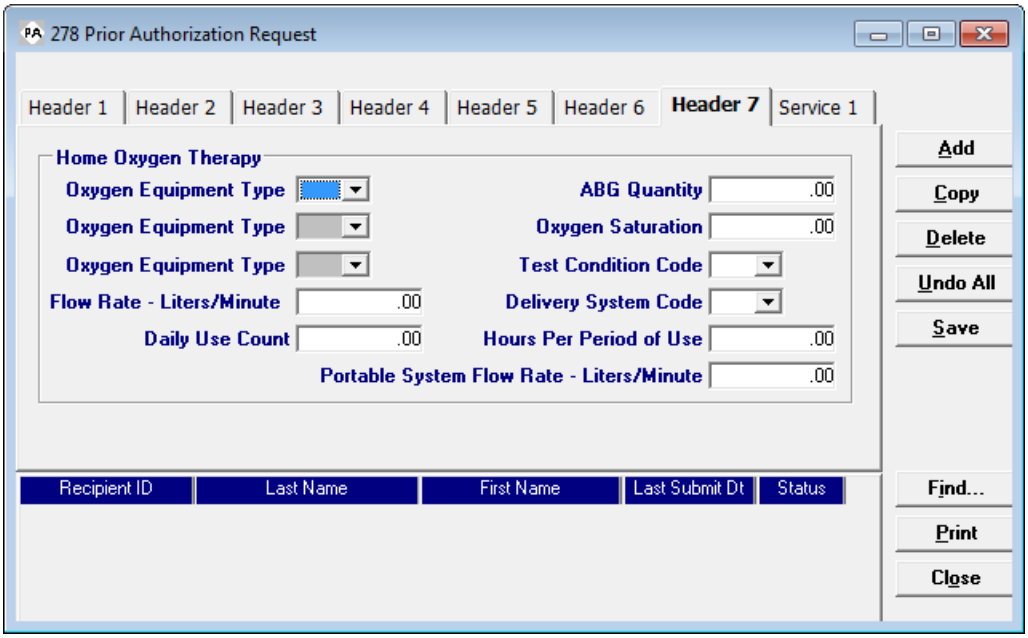
Field	Guidelines
Surgical Procedure	Code value for describing the surgical procedure code. Must be used with Surgery Date.
Surgical Date	The date of the Surgery. Must be used with Surgical Procedure.
Home Health Certification Period from DOS	Starting date of the plan of treatment.
To DOS	Through date of the plan of treatment.
Ambulance Certification	Choose the best value to indicate the correct condition code.
Functional Limitations	Choose the best value to indicate the correct condition code.
Chiropractic Certification	Choose the best value to indicate the correct condition code.
Activities Permitted	Choose the best value to indicate the correct condition code.
Durable Medical Equipment	Choose the best value to indicate the correct condition code.
Mental Status	Choose the best value to indicate the correct condition code.
Oxygen Therapy Certification	Choose the best value to indicate the correct condition code.

Header 7 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Header 7 tab.



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Complete the following fields under the Header 7 tab to submit a 278 Prior Authorization request for Home Oxygen Therapy:

Field	***Guidelines***
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Oxygen Equipment Type	Choose the best value to indicate the specific type of equipment being prescribed for the delivery of oxygen. A Concentrator B Liquid Stationary C Gaseous Stationary D Liquid Portable E Gaseous Portable O Other
Flow Rate – Liters/Minute	Enter the flow rate of the oxygen as will be used. Enter the value as liters per minute. Ex. If 1/4 liters per minute, enter .25.
Daily Use Count	Enter a value to indicate how many days the requested oxygen should last.
ABG Quantity	Enter the Arterial Blood Gas Quantity.
Oxygen Saturation	Enter the Oxygen Saturation Quantity.
Test Condition Code	Select the code indicating the conditions under which a patient was tested. E Exercising N No special conditions for test O On oxygen R At rest on room air S Sleeping W Walking X Other
Delivery System Code	Choose the best value to indicate the delivery of the oxygen into the recipient.
Hours Per Period of Use	Enter a value to indicate number of hours per period of oxygen use
Portable System Flow Rate – Liters/Minute	Enter the flow rate of the oxygen as will be used through a portable system. Enter a value as liters per minute.

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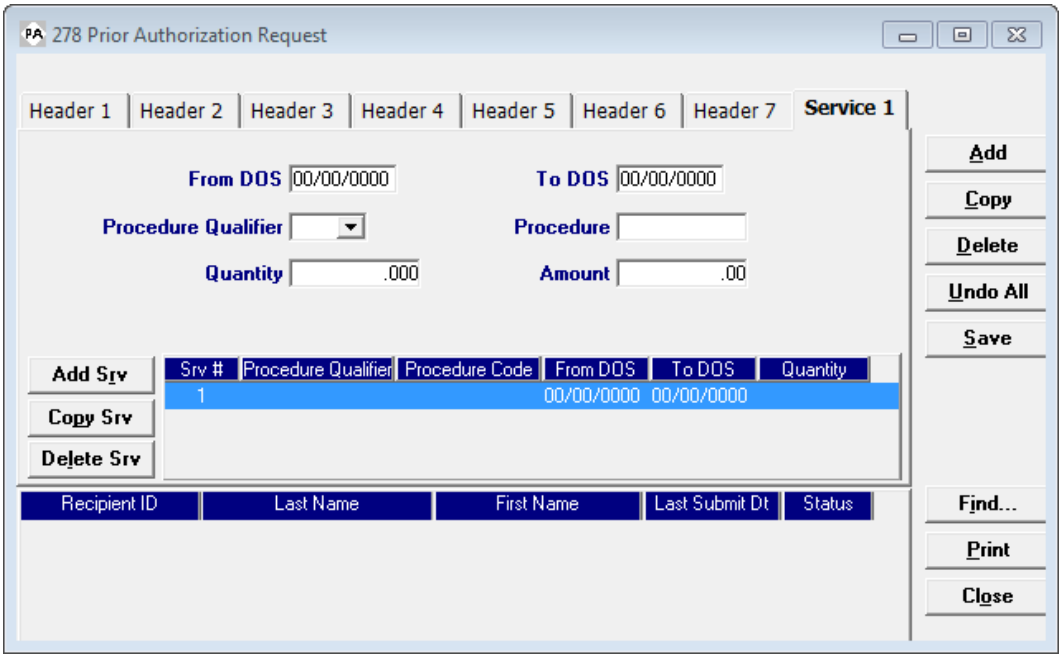
Service 1 Tab

Below is a sample electronic 278 Prior Authorization form displaying the Service 1 tab.



Complete the following fields under the Service 1 tab to submit a 278 Prior Authorization request:

Field	***Guidelines***
From DOS	Enter the start date of service for each procedure requested in a MM/DD/CCYY format.
To DOS	Enter the stop date of service for each procedure requested in a MM/DD/CCYY format. If identical services (and charges) will be performed on the same day, enter the same date of service in both 'from' and 'to' fields.
Procedure Qualifier	Choose the best value to represent the origin of the procedure being billed. NOTE: When the PA is Inpatient or Psychiatric related, enter a valid revenue code into the procedure code field and chose 'HC' as the procedure qualifier. HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes AD American Dental Association Codes JP Universal National Tooth Designation System
Procedure	Choose the procedure being billed from the Procedure/HCPCS list. For Dental Providers: If a procedure code needs to be associated with a tooth number, first key a valid 5-digit procedure code. Press 'Copy Srv' to add a second detail line. On the newly copied detail line, choose JP in the Procedure Qualifier field and enter a valid 2-digit tooth number in the Procedure field. Repeat this for each procedure code which requires a corresponding tooth number. NOTE: Always file the procedure code first, and follow it with the tooth number. For multiple procedure codes, be sure to key in the next procedure code after the tooth numbers have been properly associated with the previous procedure code. For Inpatient/Psychiatric request: Instead of a procedure code, enter a valid revenue code.
Quantity	Enter the quantity being billed.

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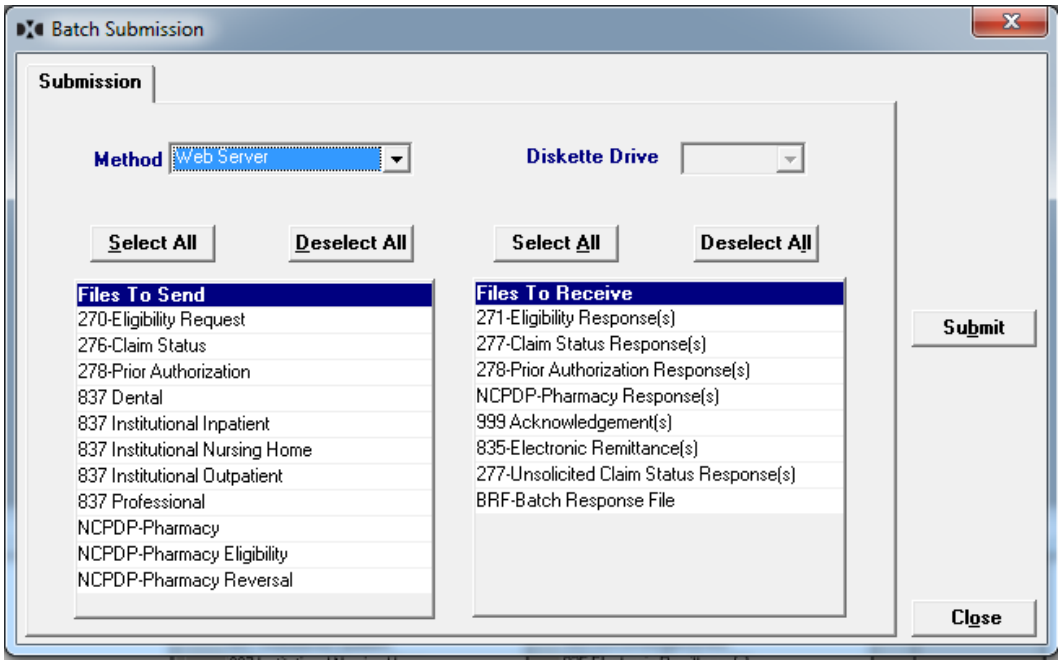
Field	*Guidelines*
Amount	If a quantity was not entered, then enter the amount (dollars and cents) of your customary charge.

Adding, Deleting, or Copying a Service

Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service, you can modify it as necessary.

15.3 Submitting PA Request through Web Server or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the Method drop down list.

Step 3 Determine which files you want to send from the Files to send list.

Choose ‘Select All’ to select all files to send, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine which files you want to receive from the ‘Files to Receive’ list.

Choose ‘Select All’ to select all files to receive, ‘Deselect All’ to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

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If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Communication Log (accessible by selecting Communication>>View Communication Log) provides information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

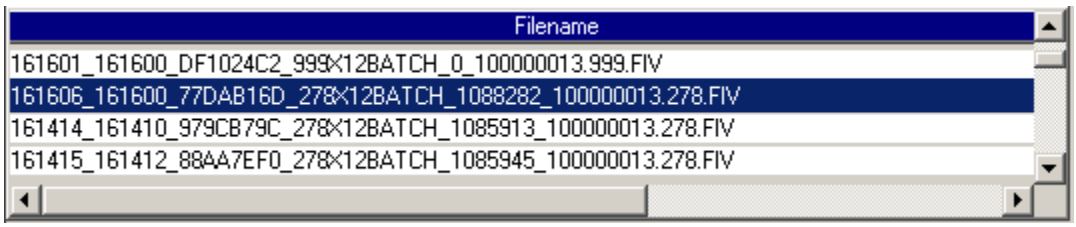
The batch number received is confirmation that your Prior Authorization Request has been received. It does not denote approval or denial of the requested service. After the Medicaid Agency reviews and approves or denies the request, a decision letter will be mailed to the rendering provider.

15.4 Reviewing a 278 Response

A response will be created in less than two hours after your submission. To download the response, please refer to *Section 15.3* and follow steps 4 – 5. Once this step has been completed, you may view the 278 response by going to Communication >> View Batch Response.

15.4.1 Reviewing a 278 Rejected Response

An example of the 278 rejected response is given below:



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Prior Authorization Request Batch Response 1

***** T R A N S A C T I O N I N F O R M A T I O N *****

Transaction Set Creation Date: 10/03/2011 2

Transaction Set Creation Time: 1420 3

***** P R O V I D E R I N F O R M A T I O N *****

Requesting Provider ID: 1234567890 4

***** R E C I P I E N T I N F O R M A T I O N *****

Recipient ID: 500000000000 5

Recipient Account #: #ABC/123 6

Yes/No Condition or Response: N 7

Reject Reason Code: C Please Correct and Resubmit 8

Follow-up Action Code: R Resubmission Allowed 9

***** S E R V I C E P R O V I D E R I N F O R M A T I O N *****

Trace Type Code: 1 10

Trace Number: 214 11

Trace Assigning Entity ID: 9111111111 12

Request Category Code: HS 13

PA Certification Type Code: I 14

Service Type Code: 18 15

Place Of Service: 12 16

Diagnosis Type 1: BK 17

Diagnosis Code 1: 25000 18

Request Status: Recipient Not on File 19

Rendering Provider ID: [illegible] 20

***** S E R V I C E L E V E L I N F O R M A T I O N *****

Service Date: 11/01/2011-11/30/2011 21

Procedure Qualifier: HC 22

Procedure Code: E0250 23

Procedure Amount: No Data 24

Quantity: 1.000 25

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The 278 Response fields are defined below:

Field #	***Field***	***Guidelines***
1	Prior Authorization Request Batch Response	This is the heading of your Prior Authorization response report.
2	Transaction Set Creation Date	This indicates the date in MM/DD/CCYY format of when the PA request was transmitted to Alabama Medicaid.
3	Transaction Set Creation Time:	This indicates the time when the PA request was transmitted to Alabama Medicaid in the military time format.
4	Requesting Provider ID	This reflects the requesting provider ID filed on Header 1 of the PA request form.
5	Recipient ID	This reflects the recipient ID entered on the PA request form on Header 1 tab.
6	Recipient Account Number	This reflects the recipient's account number entered on the PA request form.
7	Yes/No Condition or Response	This field is only available when the recipient's ID contains a rejection. This is represented by a value of 'N'.
8	Reject Reason Code	This field is only available when a request is rejected. HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
9	Follow-up Action Code	This field is only available when a request is rejected. This indicates the user to correct and resubmit the PA request. To do so, please refer to Section 15.1 on modifying a PA request.
10	Trace Type Code	Code identifying which transaction is being referenced.
11	Trace Number	Code that uniquely associates a request to a transaction.
12	Trace Assigning Entity ID	A unique identifier used to further track reference identification.
13	Request Category Code	This reflects the value chosen in the Request Category Code field on Service 1 of the PA request form.
14	PA Certification Type Code	This reflects the value chosen in the PA Certification Type Code field on Service 1 of the PA request form.
15	Service Type Code	This field is only available when a request is rejected. HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
16	Place of Service	This reflects the value chosen in the Place of Service field on Service 1 of the PA request form.
17	Diagnosis Type	Code indicating whether an ICD-9 diagnosis code or ICD-10 diagnosis code is entered on Header 2 of the PA request form. BK = ICD-9 ABK = ICD-10
18	Diagnosis Code	This reflects the diagnosis code entered on Header 2 of the PA request.
19	Request Status	This indicates whether the PA request was "Accepted – Pending Further Review" or "Rejected". If the PA request is rejected, an additional message will follow indicating the rejected reason. Once the Medicaid Agency reviews and approves or denies the request, an electronic response will be received with the "Approved" or "Denied" status. This information will also be mailed to the provider.
20	Rendering Provider ID	This reflects rendering provider ID entered in Header 3 of the PA request form.
21	Service Date	This reflects the date entered in the From DOS and To DOS fields on the Service Tab of the PA request form.
22	Procedure Qualifier	This reflects the value chosen in the Procedure Qualifier field on Service 1 of the PA request form.
23	Procedure Code	This reflects the value entered in the Procedure Code field on Service 1 of the PA request form.
24	Procedure Amount	This reflects the dollar amount entered in the 'Amount' field on the Service 1 tab of the PA request form.

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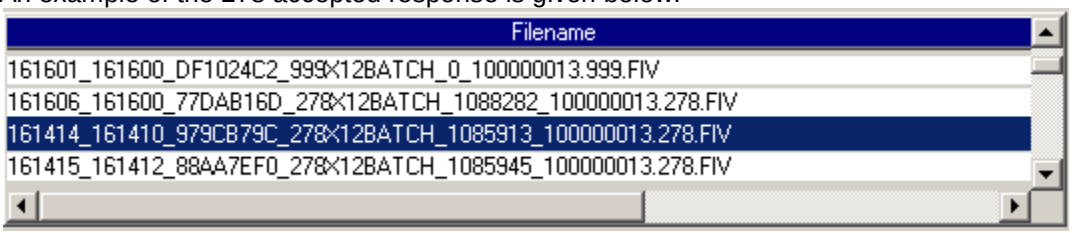
Field #	Field	Guidelines
25	Quantity	This reflects the number of units entered in the 'Quantity' field on the Service 1 tab of the PA request form.

NOTE:

If a PA request is accepted, the request will be forwarded to Alabama Medicaid's PA department for further review. Once the PA clerk approves or denies a Prior Authorization request, a letter of notification will be mailed to the provider's office. An electronic denial or acceptance response will also be available to the provider. This response may be received by performing steps 4 – 5 in Section 15.3 periodically. Please be aware that this approval or denial process can take up to 7-10 business days when all required information is available for review. For a PA status, you may contact provider assistance at 800-688-7989 and provide them with the PA number located on your original 278 response.

15.4.2 Reviewing a 278 Accepted Response

An example of the 278 accepted response is given below:



The 278 Response fields are defined below:

Field #	Field	Guidelines
1	Prior Authorization Request Batch Response	This is the heading of your Prior Authorization response report.
2	Transaction Set Creation Date	This indicates the date in MM/DD/CCYY format of when the PA request was transmitted to Alabama Medicaid.
3	Transaction Set Creation Time	This indicates the time when the PA request was transmitted to Alabama Medicaid in the military time format.
4	Requesting Provider ID	This reflects the requesting provider ID filed on Header 1 of the PA request.
5	Recipient ID	This reflects the recipient ID filed on the PA request.
6	Recipient Account #	This reflects the recipient account number indicated on Header 1 of the PA request.
7	Trace Type Code	Code identifying which transaction is being referenced.
8	Trace Number	Code that uniquely associates a request to a transaction.
9	Entity ID	Code identifying an organizational entity, a physical location, property or an individual.
10	Request Category Code	This code reflects the value chosen in the Request Category Code field on Header 2 of the PA request form.
11	PA Certification Type Code	This code reflects the value chosen in the PA Certification Type Code field on Header 2 of the PA request form.
12	Service Type Code	This code reflects the value entered in the Service Type Code on Header 2 of the PA request form.
13	Place of Service	This code reflects the value entered in the Place of Service field on Header 2 of the PA request form.
14	Certification Action Code	Displays the type of action taken toward the PA request or HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.

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15	PA Number	Prior Authorization Requ ***** T R A N S A C T I O N I N F O R M Transaction Set Creation Date: 10/01/2011 2 Transaction Set Creation Time: 1720 3 ***** P R O V I D E R I N F O R M A T I Requesting Provider ID: [redacted] 4 ***** R E C I P I E N T I N F O R M A T Recipient ID: [redacted] 5 Recipient Account #: TEST FOR DF 9431 6 ***** S E R V I C E P R O V I D E R I Trace Type Code: 1 7 Trace Number: 210 8 Trace Assigning Entity ID: 1111111111 9 Request Category Code: HS 10 PA Certification Type Code: I 11 Service Type Code: 18 12 Place Of Service: 12 13 Certification Action Code: Pending 14 PA Number: [redacted] 15 Reason Code: OV 16 Diagnosis Type 1: BK 17 Diagnosis Code 1: 4350 18 Request Status: ACCEPTED - PENDING FU Rendering Provider ID: [redacted] 20 ***** S E R V I C E L E V E L I N F Service Date: 10/01/2011-12/31/2011 Procedure Qualifier: HC 22 Procedure Code: E1150 23 Procedure Amount: No Data 24 Quantity: 1.000 25

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Field #	***Field***	***Guidelines***
		Once the pending PA is approved or denied, a response will be mailed and provided electronically. Please refer to the NOTE in Section 15.4.1 for further information.
16	Reason Code	HIPAA reason codes are represented here. More detailed reasons are provided in the 'Request Status' message.
17	Diagnosis Type	Code indicating whether an ICD-9 diagnosis code or ICD-10 diagnosis code is entered on Header 2 of the PA request form. BK = ICD-9 ABK = ICD-10
18	Diagnosis Code	This reflects the diagnosis code entered on Header 2 of the PA request.
19	Request Status	This indicates whether the PA request was "Accepted – Pending Further Review" or "Rejected." If the PA request was rejected, an additional message will follow indicating the rejected reason. Once the Medicaid Agency reviews and approves or denies the request, an electronic response will be received with the "Approved" or "Denied" status. This information will also be mailed to the provider.
20	Rendering Provider ID	This reflects rendering provider ID entered in Header 3 of the PA request form.
21	Service Date	This reflects the value entered in the From and To Date of Service fields on Service 1 of the PA request form.
22	Procedure Qualifier	This reflects the value chosen in the Procedure Qualifier field on Service 1 of the PA request form.
23	Procedure Code	This reflects the value entered in the Procedure Code field on Service 1 of the PA request form.
24	Procedure Amount	This reflects the value entered in the Amount field on Service 1 of the PA request form.
25	Quantity	This reflects the value entered in the Quantity field on Service 1 of the PA request form.

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16

16 Submitting 276 Claim Status Request

This chapter provides instructions for submitting electronic requests for 276 Claim Status. Please note this user manual does not discuss program requirements. Refer to the Alabama Medicaid Provider Manual for program-specific information.

NOTE:

276 Claim status requests through the Provider Electronic Solutions will only return claim status on Alabama Medicaid fee-for-service claims.

Users access the 276 Claim Status form using one of the following methods:

-

Selecting the 276 Claim Status icon from the toolbar called ‘Claim Status’
- Selecting Forms>>276 Claim Status Request

The electronic form displays with two tabs: Header 1 and Header 2.

16.1 Entering Requests Using the 276 Claim Status Request Form

Each tab on the 276 Claim Status Request form contains four main parts:

- Header line of fields that contain provider and recipient information.
- Updateable fields used to enter claims data.
- Buttons to the right of the form used to modify and save information entered in the updateable fields.
- List fields at the bottom of the form enable users to view basic information about several claims. Users may highlight a row to modify, copy, or print a claim record. The list fields include Recipient ID, Last Name, First Name, Billed Amount, Last Submit Date, and Status.

Below is a description of the buttons that display on the claim form:

Button	***Usage***
Add	Pressing this button enables you to refresh the claim screen so you may add a new record. Please note that if you key over data that already displays on the claim form and press Save, you will overwrite the previous claim. Be sure to press Add before entering a new claim, or press Copy (see below) to build a new claim from an existing claim record. If you forget to do this and inadvertently key over a saved record, press Undo All (see below) to undo the changes.
Copy	Pressing this button enables you to build a new claim from an existing claim record. This feature is especially helpful if you routinely submit claims for the same procedure code for different recipients or for other instances where your claims may be similar to one another.
Delete	Pressing this button enables you to delete the claim currently displayed.

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Button	***Usage***
Undo All	Pressing this button enables you to undo changes you have made to the claim currently being displayed.
Save	Pressing this button enables you to save the claim you just added or modified. The saved claim displays on the list at the bottom of the form.
Find	Pressing this button enables you to search for a saved claim by status, last submit date, billed amount, first name, last name, or recipient ID.
Print	Pressing this button enables you to print the claim currently displayed.
Close	Pressing this button enables you to close the form.

To Add a New Claim

Step 1 Access the 276 Claim Status Request form. Key information into all required fields. (All fields are required unless indicated as optional.)

Field descriptions are provided below in the order they display on the form. You can enter information in any order, or may enter it in the order presented in the form, pressing the Tab key to move to the next field.

Step 2 Press the ‘Save’ button to save the record.

The system returns error messages if the claim contains errors. Scroll through the error messages and double-click on each error to access the field on the claim that contains the error.

Step 3 Correct the mistake(s) and press ‘Save’, or press ‘Incomplete’ to save the record with an incomplete status.

Incomplete claims (status ‘I’) are not submitted with the batch submission.

Step 4 Press the ‘Add’ button to add another claim.

To Modify a Claim from the List

Scroll through the list of claims that display at the bottom of the form. Highlight the claim you wish to modify, and perform one of the following:

- Key over incorrect data on the claim form. *You cannot do this unless the status is ‘R’ (ready to submit) or ‘I’ (incomplete*). Save the changes. Press ‘Undo All’ if you inadvertently overwrite a correct claim.
- Press ‘Copy’ to copy a claim that closely matches the information you need to enter (for instance, if you must enter claims for identical services, but different recipients) and modify the new record accordingly. Be sure to save the new record.
- Press ‘Delete’ to delete an unwanted record.

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NOTE:

Claim status requests created using 4010 PES (versions other than 3.0) cannot be copied, modified, restored and resubmitted using 5010 PES (version 3.0). The only option is to delete these claim status request. All requests submitted using PES version 3.0 must be created in the 3.0 software as a new request.

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To Find a Record from the List

Press the ‘Find’ button to display the Find pop-up window. Options are:

- Find Where (select a field from the drop down list, if applicable)
- Find What (enter your search criteria here)
- Search (select up or down from the drop down list)

Once you have entered the search criteria, press the ‘Find Next’ button to search for the next record that matches the search criteria. Continue pressing ‘Find Next’ until you find the record you are searching for, or until the system returns a message indicating there are no records that match the search criteria.

Press ‘Cancel’ when you have finished searching.

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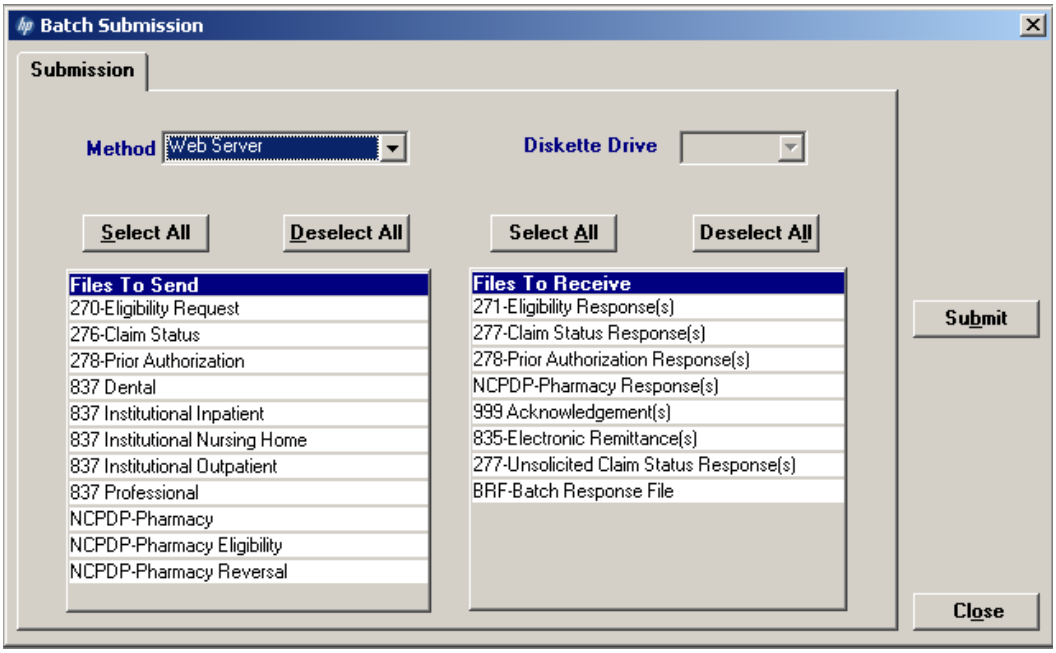
16.2 Submitting Claims through Batch or Diskette

Step 1 Select Communication>>Submission to display the Batch Submission window, pictured below:



Step 2 Determine whether you want to submit by web server or diskette by selecting the correct submission method from the 'Method' drop down list.

Step 3 Determine which files you want to send from the 'Files to Send' list.

Choose 'Select All' to select all files to send, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

Step 4 Determine the files you want to receive from the 'Files to Receive' list.

Choose 'Select All' to select all files to receive, 'Deselect All' to undo any selections you have made, or use the mouse (click once with the left mouse button) to select one form at a time, or multiple form types for submission.

If you elect to submit by diskette, insert a diskette in your PC, press 'Submit', then follow the instructions provided. *Do not select any files to receive because your response will be mailed to you at a later date.*

Step 5 Press the 'Submit' button to submit (and receive) the files.

Provider Electronic Solutions connects to the web server and sends the response. The Verification Log (accessible by selecting Communication>>View Verification) and the Communication Log (accessible by selecting Communication>>View Communication Log) provide information regarding the transaction.

Step 6 Follow Steps 1-5 to receive the response from the Web Server.

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Refer to Chapter 13, Receiving a Response, for information about receiving responses, resubmitting files, and reviewing submission reports.

NOTE:

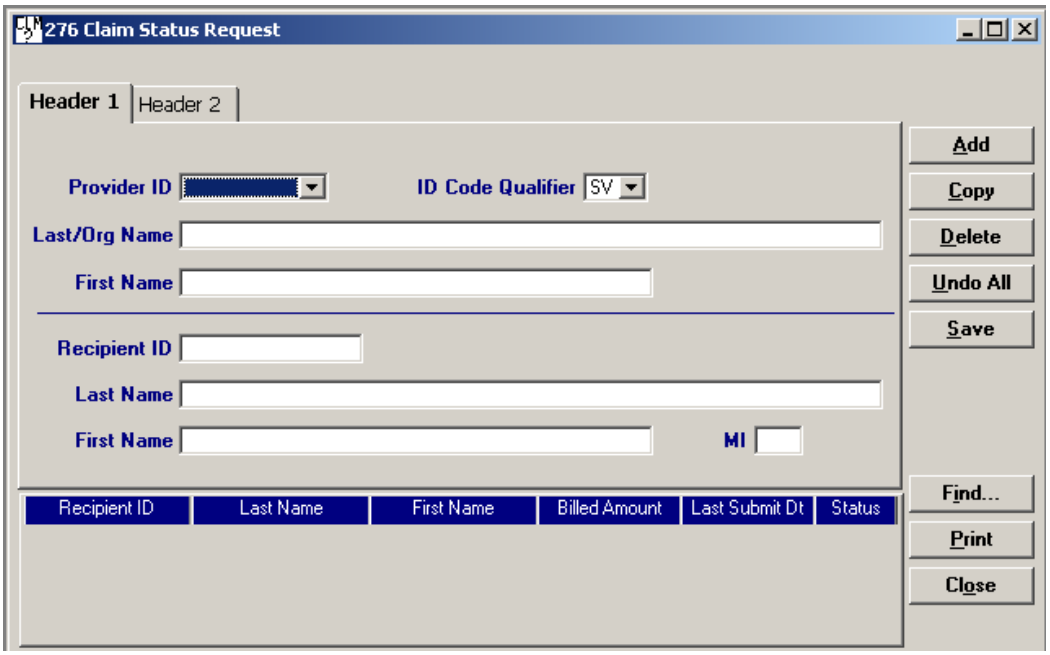
When you submit batch transactions, you must wait a period of time (15 minutes to two hours, depending on the time of day you submit) to download responses to those transactions. Therefore, when you access the Submission window to send files and elect to receive files (steps 4-6 above), remember you are *receiving responses from your last transaction, not the current transmission.* If you have questions regarding the claim status response codes that accompany your response, refer to Appendix A, Rejection Codes, to get a listing of all Claim Status Codes and definitions.

A NOTE on the Claim Status Response: When checking Claim Status, Providers will now see '19000101' displayed in the paid date field if a claim(s) has been adjudicated but has not gone through a check-write cycle. Once the claim(s) process through the check-write cycle, it will display the appropriate check-write date.

16.3 Completing the 276 Claim Status Request Form

16.3.1 Header 1 Tab

Below is a sample electronic 276 Claim Status Request form displaying the Header 1 tab.



Complete the fields described below for the Header 1 tab:

Field	*Guidelines*
Provider ID	Choose a provider ID from your Provider list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Provider ID Code Qualifier	Select the value that identifies the entity that assigned the ID.
Last/Org Name	This field will auto-write based on your choice in the Provider ID field.
First Name	This field will auto-write based on your choice in the Provider ID field.

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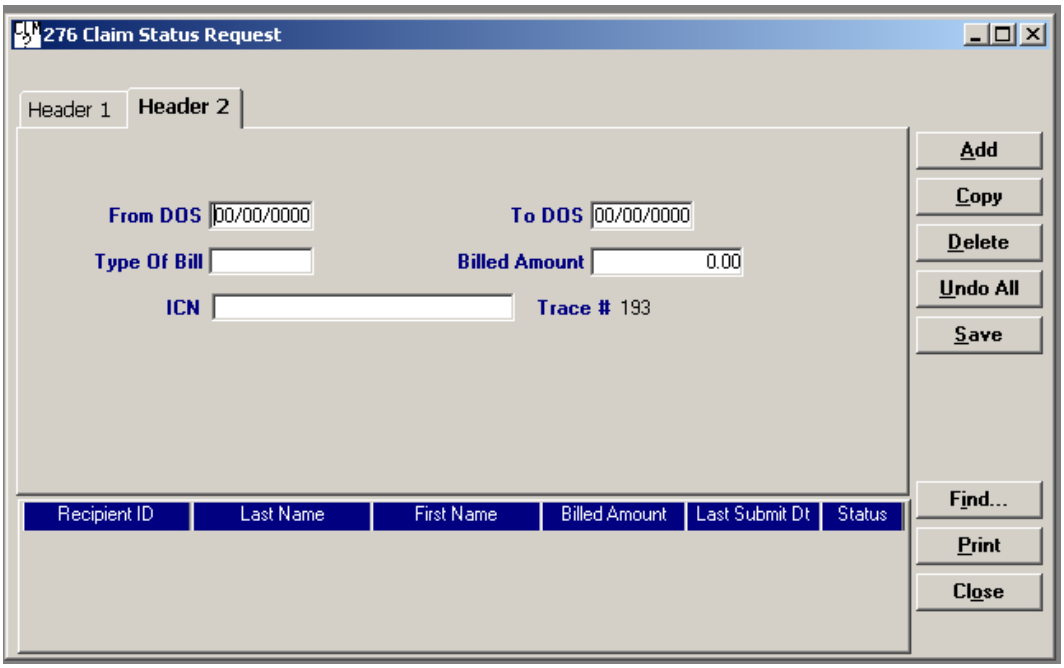
Field	Guidelines
Recipient ID	Choose the Recipient's 13-digit Medicaid number from your recipient list. If you have not added the required ID to your list, double-click on this field. A screen will appear for you to do so, please refer to Chapter 4 for additional instructions.
Last Name	The last name entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.
First Name	The first name entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.
MI	If a middle initial entered in the recipient list will auto-write based upon which recipient ID was chosen. This field is optional.

16.3.2 Header 2 Tab

Below is a sample electronic 276 Claim Status Request form displaying the Header 2 tab.



Complete the fields described below for the Header 2 tab:

Field	Guidelines
From DOS	Enter the start date filed on the claim in MM/DD/CCYY format.
To DOS	Enter the stop date filed on the claim in MM/DD/CCYY format.
Type of Bill	Enter the code specifying the type of facility where the medical service was performed. This only applies to Institutional claim form types. This field is optional.
Billed Amount	Enter the amount you have billed Medicaid on the requested claim. *Do Not* enter the amount Medicaid is scheduled to pay.
ICN	Enter the Internal Control Number, or claims tracking Identification number. This field is optional.
Trace #	This field allows you to utilize the trace # that is also located on the 276 response to locate which request the response is referring to.

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17

17 The Web Server

This chapter provides instructions on what steps to take when connecting to the web Server to update your passwords according to the logon ID's provided to you by the EMC Helpdesk.

Users access the Web Server by the following methods:

- Connecting through an ISP (Internet Service Provider)
- Connecting through the RAS (an option provided by the *Provider Electronic Solutions* software)

17.1 Updating and Maintaining your Web Server Password

Now that you have your Provider Electronic Solutions software, a representative needs to contact one of the following telephone numbers to request a logon ID and password to connect to the Web Server:

- Providers located in Alabama: Contact the EMC Helpdesk at 1-800-456-1242.
- Providers located outside the state of Alabama: Dial (334) 215-0111 and ask for the EMC Helpdesk.

You may connect to the Web Server either through an ISP (Internet Service Provider) or through Remote Access Server (RAS).

17.1.1 Connecting through an ISP (Internet Service Provider)

This section will inform you how to logon to the Web Server through an ISP (Internet Service Provider), such as AOL, NetZero, etc.

Step 1 Open your ISP application and connect to the Internet accordingly.

Step 2 Once properly logged onto the World Wide Web, type in the following URL:

Step 3 https://www.medicaid.alabamaservices.org/ALPortalContinue to **Step 3** in section 17.1.3 Updating your Password for further instructions.

17.1.2 Connecting through RAS

Connecting through RAS (Remote Access Server) is an option created by the *Provider Electronic Solutions* software. This section will inform you how to logon to the Web Server through RAS if you do not have an ISP.

This method requires you to have Internet Explorer version 5.5 and a dial-up modem. If you do not have one or the other, you will need to contact your computer administrator to have it set up for you.

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NOTE:

Before beginning this process, you should have followed the instructions outlined in section 2.5.2 Web Tab. If you have not, please refer to the instructions to set up your connection method through 'modem'. You will need to follow the instructions described in the 'Install RAS' and the 'Dialup Network' fields.

Step 1 Open your AL RAS connection. To do so, click on Start >> Settings >> Control Panel >> 'Network and Dial-Up Connections' and open the 'AL RAS' option.

Step 2 Once opened, a screen should appear as shown below: (If you have completed these steps you may continue to **Step 3** in section 17.1.3 Updating your Password for further instructions.)

NOTE:

Enter your Trading Partner ID in the User Name and password fields. Contact the EMC Helpdesk at 800-456-1242 to give them your Trading partner ID so that dial-up permissions can be granted to you.

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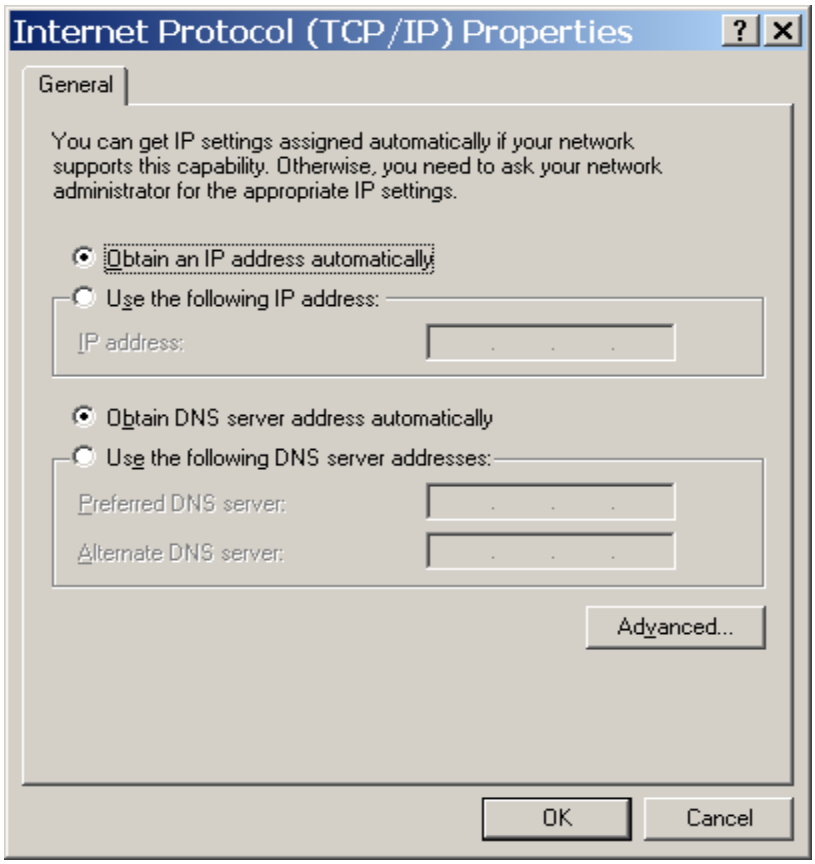
Step 3 Click on ‘Properties’ and click on the ‘Networking’ tab. A sample screen is pictured below:



Step 4 Make sure the Internet Protocol (TCP/IP) option is highlighted and click on ‘Properties’.

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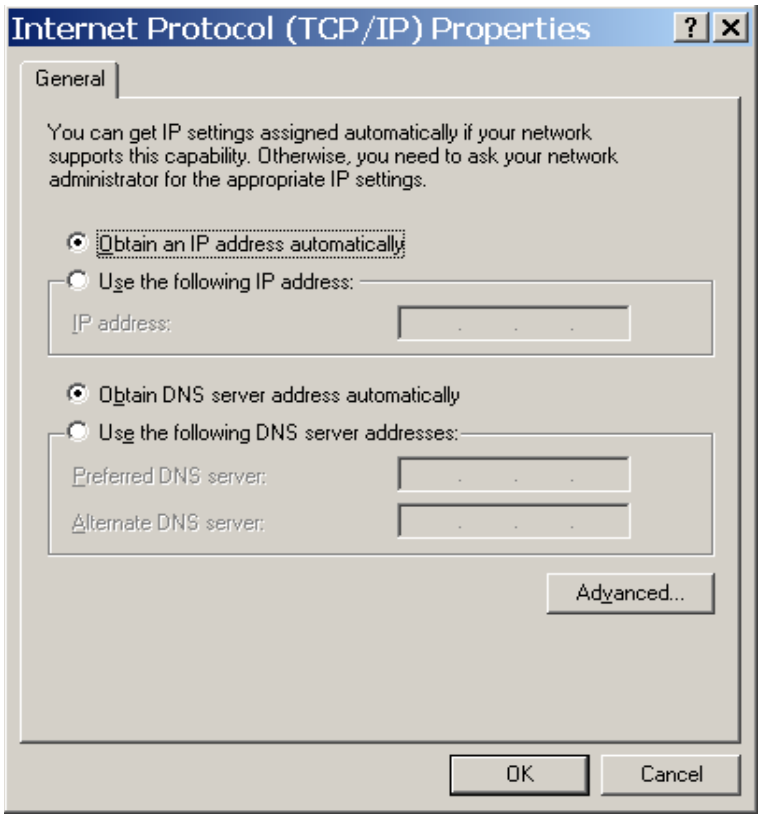
Step 5 Make sure the option for '**Obtain DNS server address automatically**' has been chosen.



Step 6 Click 'OK' to save your changes. Click on 'OK' to exit the Networking tab.

Step 7 Click 'DIAL' to continue to connect through RAS. This will begin the dial-up process according to the number you entered in the web tab. Refer to section 2.5.2 Web Tab.

Step 8 Once connected you may open your Internet Explorer browser.

Step 9 The options for accessing your Internet Explorer browser are described below:

- Go to your Internet Explorer icon located on your desktop.

Click on Start >> Programs >> Internet Explorer. In the browser address bar, enter https://www.medicaid.alabamaservices.org/ALPortal; and then press the **Enter** key on your keyboard."

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NOTE:

If you have a default home page within your IE browser, a message may appear that it was unable to connect. Ignore this message and in https://www.medicaid.alabamaservices.org/ALPortal

Step 10 Continue to **Step 3** in section 17.1.3 Updating your Password for further instructions.

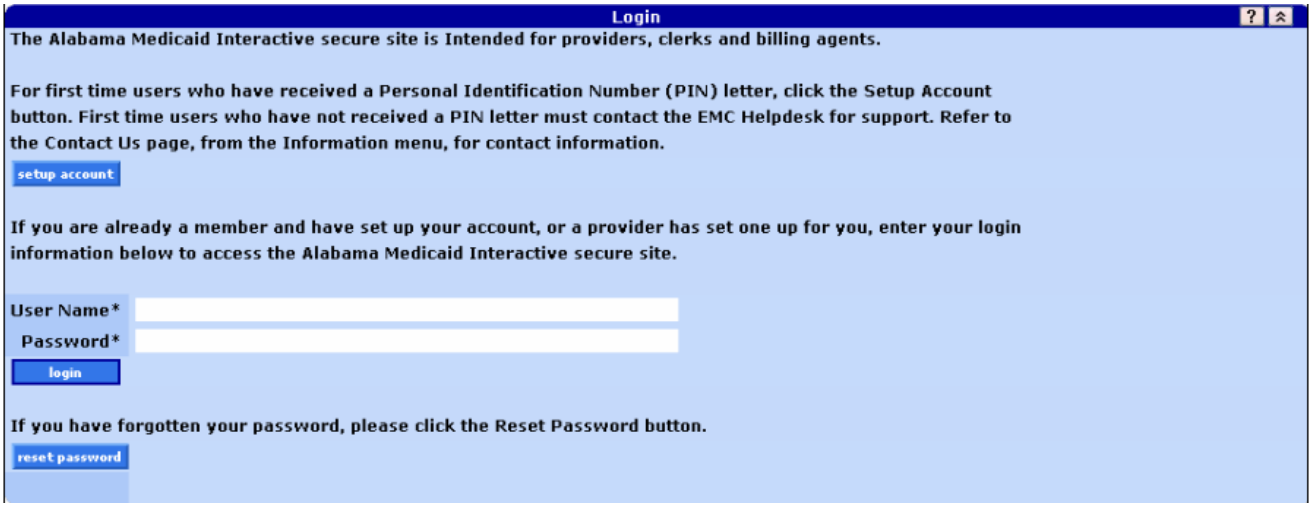
17.1.3 Updating your Password

Your password will need to be updated before a transmission can be attempted through the software. As a security measure, this password will need to be updated every 60 days. Follow the steps below to complete this process according to the method you use to connect to the Internet.

Step 1 Connect to the Web Server using either method as outlined above. Click 'Account' then 'Secure Site' to reach the Logon page.

Step 2 To change your password, follow steps 3 through 9.

Step 3 The main logon screen will look as follows:



Step 4 Type in the Web Logon ID and Web password you have keyed within your Tools >> Options screen. (Refer to section *2.5.1 Batch Tab)*

Step 5 Press the 'Login' button to continue.

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Step 6 A screen should appear as follows:

Step 7 Enter your current and new password in the designated fields. Press the 'change password' button to continue.

Step 8 You will be notified if you have completed this update successfully.

Step 9 Go to Account>>Logoff and proceed to your Tools >> Options screen to enter your updated password. (Refer to section 2.5.1 Batch Tab).

Providers that use the Provider Electronic Software to submit claims to Alabama Medicaid are required to use their new web user ID and password after creating one on the new Interactive Services website. In addition, Provider Electronic Software users are required to request a new Trading Partner ID.

NOTE:

To update the Provider Electronic Software with the new user ID and password, click on Tools >> Options within the Provider Electronic Software. Select the Batch Tab. Enter the new web user ID and password in the corresponding fields displayed.

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A Health Care Claim Status Code

This appendix lists codes that may appear on a Claim Status response. Section A.1, Health Care Claim Status Codes, lists codes that display on the Claim Status response.

A.1 Health Care Claim Status Codes

Below is a list of all Claim Status Codes (CSC) and Descriptions.

CSC	Description
0	Cannot provide further status electronically.
1	For more detailed information, see remittance advice.
2	More detailed information in letter.
3	Claim has been adjudicated and is awaiting payment cycle.
4	This is a subsequent request for information from the original request.
5	This is a final request for information.
6	Balance due from the subscriber.
7	Claim may be reconsidered at a future date.
8	No payment due to contract/plan provisions.
9	No payment will be made for this claim.
10	All originally submitted procedure codes have been combined.
11	Some originally submitted procedure codes have been combined.
12	One or more originally submitted procedure codes have been combined.
13	All originally submitted procedure codes have been modified.
14	Some originally submitted procedure codes have been modified.
15	One or more originally submitted procedure codes have been modified.
16	Claim/encounter has been forwarded to entity.
17	Claim/encounter has been forwarded by third party entity to entity.
18	Entity received claim/encounter, but returned invalid status.
19	Entity acknowledges receipt of claim/encounter.
20	Accepted for processing.
21	Missing or invalid information.
22	... before entering the adjudication system.

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CSC	Description
23	Returned to Entity.
24	Entity not approved as an electronic submitter.
25	Entity not approved.
26	Entity not found.
27	Policy canceled.
28	Claim submitted to wrong payer.
29	Subscriber and policy number/contract number mismatched.
30	Subscriber and subscriber ID mismatched.
31	Subscriber and policyholder name mismatched.
32	Subscriber and policy number/contract number not found.
33	Subscriber and subscriber ID not found.
34	Subscriber and policyholder name not found.
35	Claim/encounter not found.
37	Predetermination is on file, awaiting completion of services.
38	Awaiting next periodic adjudication cycle.
39	Charges for pregnancy deferred until delivery.
40	Waiting for final approval.
41	Special handling required at payer site.
42	Awaiting related charges.
44	Charges pending provider audit.
45	Awaiting benefit determination.
46	Internal review/audit.
47	Internal review/audit - partial payment made.
48	Referral/authorization.
49	Pending provider accreditation review.
50	Claim waiting for internal provider verification.
51	Investigating occupational illness/accident.
52	Investigating existence of other insurance coverage.
53	Claim being researched for Insured ID/Group Policy Number error.
54	Duplicate of a previously processed claim/line.
55	Claim assigned to an approver/analyst.
56	Awaiting eligibility determination.
57	Pending COBRA information requested.
59	Non-electronic request for information.
60	Electronic request for information.

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CSC	Description
61	Eligibility for extended benefits.
64	Re-pricing information.
65	Claim/line has been paid.
66	Payment reflects usual and customary charges.
67	Payment made in full.
68	Partial payment made for this claim.
69	Payment reflects plan provisions.
70	Payment reflects contract provisions.
71	Periodic installment released.
72	Claim contains split payment.
73	Payment made to entity, assignment of benefits not on file.
78	Duplicate of an existing claim/line, awaiting processing.
81	Contract/plan does not cover pre-existing conditions.
83	No coverage for newborns.
84	Service not authorized.
85	Entity not primary.
86	Diagnosis and patient gender mismatch.
87	Denied: Entity not found.
88	Entity not eligible for benefits for submitted dates of service.
89	Entity not eligible for dental benefits for submitted dates of service.
90	Entity not eligible for medical benefits for submitted dates of service.
91	Entity not eligible/not approved for dates of service.
92	Entity does not meet dependent or student qualification.
93	Entity is not selected primary care provider.
94	Entity not referred by selected primary care provider.
95	Requested additional information not received.
96	No agreement with entity.
97	Patient eligibility not found with entity.
98	Charges applied to deductible.
99	Pre-treatment review.
100	Pre-certification penalty taken.
101	Claim was processed as adjustment to previous claim.
102	Newborn's charges processed on mother's claim.
103	Claim combined with other claim(s).
104	Processed according to plan provisions.

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CSC	Description
105	Claim/line is capitated.
106	This amount is not entity's responsibility.
107	Processed according to contract/plan provisions.
108	Coverage has been canceled for this entity.
109	Entity not eligible.
110	Claim requires pricing information.
111	At the policyholder's request these claims cannot be submitted electronically.
112	Policyholder processes their own claims.
113	Cannot process individual insurance policy claims.
114	Should be handled by entity.
115	Cannot process HMO claims.
116	Claim submitted to incorrect payer.
117	Claim requires signature-on-file indicator.
118	TPO rejected claim/line because payer name is missing.
119	TPO rejected claim/line because certification information is missing.
120	TPO rejected claim/line because claim does not contain enough information.
121	Service line number greater than maximum allowable for payer.
122	Missing/invalid data prevents payer from processing claim.
123	Additional information requested from entity.
124	Entity's name, address, phone and ID number.
125	Entity's name.
126	Entity's address.
127	Entity's phone number.
128	Entity's tax ID.
129	Entity's Blue Cross provider ID.
130	Entity's Blue Shield provider ID.
131	Entity's Medicare provider ID.
132	Entity's Medicaid provider ID.
133	Entity's UPIN.
134	Entity's CHAMPUS provider ID.
135	Entity's commercial provider ID.
136	Entity's health industry ID number.
137	Entity's plan network ID.

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CSC	Description
138	Entity's site ID.
139	Entity's health maintenance provider ID (HMO).
140	Entity's preferred provider organization ID (PPO).
141	Entity's administrative services organization ID (ASO).
142	Entity's license/certification number.
143	Entity's state license number.
144	Entity's specialty license number.
145	Entity's specialty code.
146	Entity's anesthesia license number.
147	Entity's qualification degree/designation (e.g. RN,PhD,MD).
148	Entity's social security number.
149	Entity's employer ID.
150	Entity's drug enforcement agency (DEA) number.
152	Pharmacy processor number.
153	Entity's ID number.
154	Relationship of surgeon & assistant surgeon.
155	Entity's relationship to patient.
156	Patient relationship to subscriber.
157	Entity's Gender.
158	Entity's date of birth.
159	Entity's date of death.
160	Entity's marital status.
161	Entity's employment status.
162	Entity's health insurance claim number (HICN).
163	Entity's policy number.
164	Entity's contract/member number.
165	Entity's employer name, address and phone.
166	Entity's employer name.
167	Entity's employer address.
168	Entity's employer phone number.
169	Entity's employer ID.
170	Entity's employee ID.
171	Other insurance coverage information (health, liability, auto, etc.).
172	Other employer name, address and telephone number.

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CSC	Description
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber.
174	Entity's student status.
175	Entity's school name.
176	Entity's school address.
177	Transplant recipient's name, date of birth, gender, relationship to insured.
178	Submitted charges.
179	Outside lab charges.
180	Hospital s semi-private room rate.
181	Hospital s room rate.
182	Allowable/paid from primary coverage.
183	Amount entity has paid.
184	Purchase price for the rented durable medical equipment.
185	Rental price for durable medical equipment.
186	Purchase and rental price of durable medical equipment.
187	Date(s) of service.
188	Statement from-through dates.
189	Hospital admission date.
190	Hospital discharge date.
191	Date of Last Menstrual Period (LMP).
192	Date of first service for current series/symptom/illness.
193	First consultation/evaluation date.
194	Confinement dates.
195	Unable to work dates.
196	Return to work dates.
197	Effective coverage date(s).
198	Medicare effective date.
199	Date of conception and expected date of delivery.
200	Date of equipment return.
201	Date of dental appliance prior placement.
202	Date of dental prior replacement/reason for replacement.
203	Date of dental appliance placed.
204	Date dental canal(s) opened and date service completed.
205	Date(s) dental root canal therapy previously performed.

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CSC	Description
206	Most recent date of curettage, root planing, or periodontal surgery.
207	Dental impression and seating date.
208	Most recent date pacemaker was implanted.
209	Most recent pacemaker battery change date.
210	Date of the last x-ray.
211	Date(s) of dialysis training provided to patient.
212	Date of last routine dialysis.
213	Date of first routine dialysis.
214	Original date of prescription/orders/referral.
215	Date of tooth extraction/evolution.
216	Drug information.
217	Drug name, strength and dosage form.
218	NDC number.
219	Prescription number.
220	Drug product ID number.
221	Drug days supply and dosage.
222	Drug dispensing units and average wholesale price (AWP).
223	Route of drug/myelogram administration.
224	Anatomical location for joint injection.
225	Anatomical location.
226	Joint injection site.
227	Hospital information.
228	Type of bill for UB-04 claim.
229	Hospital admission source.
230	Hospital admission hour.
231	Hospital admission type.
232	Admitting diagnosis.
233	Hospital discharge hour.
234	Patient discharge status.
235	Units of blood furnished.
236	Units of blood replaced.
237	Units of deductible blood.
238	Separate claim for mother/baby charges.
239	Dental information.
240	Tooth surface(s) involved.

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CSC	Description
241	List of all missing teeth (upper and lower).
242	Tooth numbers, surfaces, and/or quadrants involved.
243	Months of dental treatment remaining.
244	Tooth number or letter.
245	Dental quadrant/arch.
246	Total orthodontic service fee, initial appliance fee, monthly fee, length of service.
247	Line information.
248	Accident date, state, description and cause.
249	Place of service.
250	Type of service.
251	Total anesthesia minutes.
252	Authorization/certification number.
253	Procedure/revenue code for service(s) rendered. Please use codes 454 or 455.
254	Primary diagnosis code.
255	Diagnosis code.
256	DRG code(s).
257	ADSM-III-R code for services rendered.
258	Days/units for procedure/revenue code.
259	Frequency of service.
260	Length of medical necessity, including begin date.
261	Obesity measurements.
262	Type of surgery/service for which anesthesia was administered.
263	Length of time for services rendered.
264	Number of liters/minute & total hours/day for respiratory support.
265	Number of lesions excised.
266	Facility point of origin and destination - ambulance.
267	Number of miles patient was transported.
268	Location of durable medical equipment use.
269	Length/size of laceration/tumor.
270	Subluxation location.
271	Number of spine segments.
272	Oxygen contents for oxygen system rental.
273	Weight.

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CSC	Description
274	Height.
275	Claim.
276	UB-04/CMS-1450/CMS-1500 claim form.
277	Paper claim.
278	Signed claim form.
279	Itemized claim.
280	Itemized claim by provider.
281	Related confinement claim.
282	Copy of prescription.
283	Medicare worksheet.
284	Copy of Medicare ID card.
285	Vouchers/Remittance Advices (RAs).
286	Other payer's Explanation of Benefits/payment information.
287	Medical necessity for service.
288	Reason for late hospital charges.
289	Reason for late discharge.
290	Pre-existing information.
291	Reason for termination of pregnancy.
292	Purpose of family conference/therapy.
293	Reason for physical therapy.
294	Supporting documentation.
295	Attending physician report.
296	Nurse's notes.
297	Medical notes/report.
298	Operative report.
299	Emergency room notes/report.
300	Lab/test report/notes/results.
301	MRI report.
302	Refer to codes 300 for lab notes and 311 for pathology notes.
303	Physical therapy notes. Please use code 297:6O (6 'OH' - not zero).
304	Reports for service.
305	X-ray reports/interpretation.
306	Detailed description of service.
307	Narrative with pocket depth chart.
308	Discharge summary.

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CSC	Description
309	Code was duplicate of code 299.
310	Progress notes for the six months prior to statement date.
311	Pathology notes/report.
312	Dental charting.
313	Bridgework information.
314	Dental records for this service.
315	Past period treatment history.
316	Complete medical history.
317	Patient's medical records.
318	X-rays.
319	Pre/post-operative x-rays/photographs.
320	Study models.
321	Radiographs or models.
322	Recent fm x-rays.
323	Study models, x-rays, and/or narrative.
324	Recent x-ray of treatment area and/or narrative.
325	Recent fm x-rays and/or narrative.
326	Copy of transplant acquisition invoice.
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.
328	Speech therapy notes. Please use code 297:6R.
329	Exercise notes.
330	Occupational notes.
331	History and physical.
332	Authorization/certification (include period covered).
333	Patient release of information authorization.
334	Oxygen certification.
335	Durable medical equipment certification.
336	Chiropractic certification.
337	Ambulance certification/documentation.
338	Home health certification. Please use code 332:4Y.
339	Enteral/parenteral certification.
340	Pacemaker certification.
341	Private duty nursing certification.
342	Podiatric certification.

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CSC	Description
343	Documentation that facility is state licensed and Medicare approved as a surgical facility.
344	Documentation that provider of physical therapy is Medicare Part B approved.
345	Treatment plan for service/diagnosis.
346	Proposed treatment plan for next 6 months.
347	Refer to code 345 for treatment plan and code 282 for prescription.
348	Chiropractic treatment plan.
349	Psychiatric treatment plan. Please use codes 345:5I, 5J, 5K, 5L, 5M, 5N, 5O (5 'OH' - not zero), 5P.
350	Speech pathology treatment plan. Please use code 345:6R.
351	Physical/occupational therapy treatment plan. Please use codes 345:6O (6 'OH' - not zero), 6N.
352	Duration of treatment plan.
353	Orthodontics treatment plan.
354	Treatment plan for replacement of remaining missing teeth.
355	Has claim been paid?
356	Was blood furnished?
357	Has or will blood be replaced?
358	Does provider accept assignment of benefits?
359	Is there a release of information signature on file?
360	Is there an assignment of benefits signature on file?
361	Is there other insurance?
362	Is the dental patient covered by medical insurance?
363	Will worker's compensation cover submitted charges?
364	Is accident/illness/condition employment related?
365	Is service the result of an accident?
366	Is injury due to auto accident?
367	Is service performed for a recurring condition or new condition?
368	Is medical doctor (MD) or doctor of osteopath (DO) on staff of this facility?
369	Does patient condition preclude use of ordinary bed?
370	Can patient operate controls of bed?
371	Is patient confined to room?
372	Is patient confined to bed?
373	Is patient an insulin diabetic?

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CSC	Description
374	Is prescribed lenses a result of cataract surgery?
375	Was refraction performed?
376	Was charge for ambulance for a round-trip?
377	Was durable medical equipment purchased new or used?
378	Is pacemaker temporary or permanent?
379	Were services performed supervised by a physician?
380	Were services performed by a CRNA under appropriate medical direction?
381	Is drug generic?
382	Did provider authorize generic or brand name dispensing?
383	Was nerve block used for surgical procedure or pain management?
384	Is prosthesis/crown/inlay placement an initial placement or a replacement?
385	Is appliance upper or lower arch & is appliance fixed or removable?
386	Is service for orthodontic purposes?
387	Date patient last examined by entity.
388	Date post-operative care assumed.
389	Date post-operative care relinquished.
390	Date of most recent medical event necessitating service(s).
391	Date(s) dialysis conducted.
392	Date(s) of blood transfusion(s).
393	Date of previous pacemaker check.
394	Date(s) of most recent hospitalization related to service.
395	Date entity signed certification/recertification.
396	Date home dialysis began.
397	Date of onset/exacerbation of illness/condition.
398	Visual field test results.
399	Report of prior testing related to this service, including dates.
400	Claim is out of balance.
401	Source of payment is not valid.
402	Amount must be greater than zero.
403	Entity referral notes/orders/prescription.
404	Specific findings, complaints, or symptoms necessitating service.
405	Summary of services.
406	Brief medical history as related to service(s).

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CSC	Description
407	Complications/mitigating circumstances.
408	Initial certification.
409	Medication logs/records (including medication therapy).
410	Explain differences between treatment plan and patient's condition.
411	Medical necessity for non-routine service(s).
412	Medical records to substantiate decision of non-coverage.
413	Explain/justify differences between treatment plan and services rendered.
414	Need for more than one physician to treat patient.
415	Justify services outside composite rate.
416	Verification of patient's ability to retain and use information.
417	Prior testing, including result(s) and date(s) as related to service(s).
418	Indicating why medications cannot be taken orally.
419	Individual test(s) comprising the panel and the charges for each test.
420	Name, dosage and medical justification of contrast material used for radiology procedure.
421	Medical review attachment/information for service(s).
422	Homebound status.
423	Prognosis.
424	Statement of non-coverage including itemized bill.
425	Itemize non-covered services.
426	All current diagnoses.
427	Emergency care provided during transport.
428	Reason for transport by ambulance.
429	Loaded miles and charges for transport to nearest facility with appropriate services.
430	Nearest appropriate facility.
431	Provide condition/functional status at time of service.
432	Date benefits exhausted.
433	Copy of patient revocation of hospice benefits.
434	Reasons for more than one transfer per entitlement period.
435	Notice of Admission.
436	Short term goals.
437	Long term goals.
438	Number of patients attending session.
439	Size, depth, amount, and type of drainage wounds.

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CSC	Description
440	Why non-skilled caregiver has not been taught procedure.
441	Entity professional qualification for service(s).
442	Modalities of service.
443	Initial evaluation report.
444	Method used to obtain test sample.
445	Explain why hearing loss not correctable by hearing aid.
446	Documentation from prior claim(s) related to service(s).
447	Plan of teaching.
448	Invalid billing combination. See STC12 for details. This code should only be used to indicate an inconsistency between two or more data elements on the claim. A detailed explanation is required in STC12 when this code is used.
449	Projected date to discontinue service(s).
450	Awaiting spend down determination.
451	Preoperative and post-operative diagnosis.
452	Total visits in total number of hours/day and total number of hours/week.
453	Procedure Code Modifier(s) for Service(s) Rendered.
454	Procedure code for services rendered.
455	Revenue code for services rendered.
456	Covered Day(s).
457	Non-Covered Day(s).
458	Coinsurance Day(s).
459	Lifetime Reserve Day(s).
460	NUBC Condition Code(s).
461	NUBC Occurrence Code(s) and Date(s).
462	NUBC Occurrence Span Code(s) and Date(s).
463	NUBC Value Code(s) and/or Amount(s).
464	Payer Assigned Control Number.
465	Principal Procedure Code for Service(s) Rendered.
466	Entities Original Signature.
467	Entity Signature Date.
468	Patient Signature Source.
469	Purchase Service Charge.
470	Was service purchased from another entity?
471	Were services related to an emergency?

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CSC	Description
472	Ambulance Run Sheet.
473	Missing or invalid lab indicator.
474	Procedure code and patient gender mismatch.
475	Procedure code not valid for patient age.
476	Missing or invalid units of service.
477	Diagnosis code pointer is missing or invalid.
478	Claim submitter's identifier (patient account number) is missing.
479	Other Carrier payer ID is missing or invalid.
480	Other Carrier Claim filing indicator is missing or invalid.
481	Claim/submission format is invalid.
482	Date Error, Century Missing.
483	Maximum coverage amount met or exceeded for benefit period.
484	Business Application Currently Not Available.
485	More information available than can be returned in real time mode. Narrow your current search criteria.
486	Principal Procedure Date.
487	Claim not found, claim should have been submitted to/through 'entity'.
488	Diagnosis code(s) for the services rendered.

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B Code Lists

This Appendix gives the various codes listed from the drop down menus of the Alabama Provider Electronic Solutions Software.

B.1 Occurrence Codes

Occurrence Codes	Description
01	Auto Accident
02	No Fault Insurance Involved-Including Auto Accident/Other
03	Accident/Tort Liability
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual
17	Date Outpatient Occupational Therapy Plan Established
18	Date of Retirement - Patient/Beneficiary
19	Date of Retirement - Spouse
20	Date Guarantee of Payment Began
21	Date UR Notice Received
22	Date Active Care Ended
23	Date of Cancellation of Hospice Election Period
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SNF Bed Became Available
27	Date of Hospice Certification or Precertification
28	Date Comprehensive Outpatient Rehab Plan Established
29	Date Outpatient Physical Therapy Plan Established
30	Date Outpatient Speech Pathology Plan Established
31	Date Beneficiary Notified of Intent to Bill Accommodations
32	Date Beneficiary Notified of Intent to Bill Procedures
33	First Day of Medicare Coordination Period-ESRD Beneficiaries
34	Date of Election of Extended Care Facilities
35	Date Treatment Started for Physical Therapy
36	Date of Inpatient Hosp Discharge-Covered Transplant Patients
37	Date of Inpatient Hospital Discharge-Noncovrd Transplant Pat
38	Date Treatment Started for Home IV Therapy

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39	Date Discharged on a Continuous Course of IV Therapy
40	Scheduled Date of Admission
41	Date of First Test Pre-Admission Testing
42	Date of Discharge
43	Scheduled Date of Canceled Surgery
44	Date Treatment Started Occupational Therapy
45	Date Treatment Started for Speech Therapy
46	Date Treatment Started for Cardiac Rehabilitation
51	Overnight Delivery Room
74	Noncovered Level of Care/Leave of Absence
99	ICU/CCU Stay
A0	Reserved For National Assignment
A1	Birthdate - Insured A
A2	Effective Date - Insured A Policy
A3	Benefits Exhausted
A4	Split Bill Date
B0	Reserved For National Assignment
B1	Birthdate - Insured B
B2	Effective Date - Insured B Policy
B3	Benefits Exhausted
C0	Reserved For National Assignment
C1	Birthdate - Insured C
C2	Effective Date - Insured C Policy
C3	Benefits Exhausted
E0	Reserved For National Assignment
E1	Birthdate - Insured D
E2	Effective Date - Insured D Policy
E3	Benefits Exhausted
F0	Reserved For National Assignment
F1	Birthday - Insured E
F2	Effective Date - Insured E Policy
F3	Benefits Exhausted
G0	Reserved For National Assignment
G1	Birthdate - Insured F
G2	Effective Date - Insured F Policy
G3	Benefits Exhausted
M3	ICF Level of Care
M4	Residential Level of Care

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B.2 Condition Codes

Condition Code	Description
15	Payer Codes
16	Payer Codes
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mothers Name
20	Beneficiary Requested Billing
21	Billing for Denial Notice
22	Patient On Multiple Drug Regimen
23	Home Caregiver Available
24	Home IV Patient Also Receiving-HHA Services
25	Patient is Non-U.S. Resident
26	VA Eligible Patient Receive Svcs in Medicare Cert Facility
27	Patient Referred to a Sole Community Hospital
28	Patient and/or Spouse EGHP is Secondary to Medicare
29	Disabled Beneficiary/Family Mbr LGHP Secondary to Medicare
30	Qualifying Clinical Trails
31	Patient is Student (Full Time - Day)
32	Patient is Student (Cooperative/Work Study Program)
33	Patient is Student (Full Time - Night)
34	Patient is Student (Part Time)
35	Reserved For National Assignment
36	General Care Patient in a Special Unit
37	Ward Accommodation at Patient Request
38	Semi-Private Room not Available
39	Private Room Medically Necessary
40	Same Day Transfer
41	Partial Hospitalization
42	Continuing Care Not Related To Inpatient Admission
43	Continuing Care Not Provided Within Postdischarge Window
44	Inpatient Admission Change to Outpatient
46	Non-Availability Statement on File
47	Reserved For Champus Assignment
48	Psychiatric Residential Treatment Ctr for Children & Adolesc
49	Product Replacement Within Product Lifecycle
50	Product Replacement for Known Recall of a Product
55	SNF Bed not Available
56	Medical Appropriateness

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57	SNF Readmission
58	Terminated Medicare+Choice Organization Enrollee
59	Reserved For National Assignment
60	Day Outlier
61	Cost Outlier
62	Payer Code
66	Provider Does Not Wish Cost Outlier Payment
67	Beneficiary Elects Not To Use Life Time Reserve Days
68	Beneficiary Elects To Use Life Time Reserve Days
69	IME/Payment Only Bill
70	Self-Administered Anemia Management Drug
71	Full Care in Unit
72	Self Care in Unit
73	Self Care Training
74	Home
75	Home - 100 Percent Reimbursement
76	Back-up in Facility Dialysis
77	Provider Accepts or Obligated Due to Contractual Arrangement
78	New Coverage not Implemented by HMO
79	CORF Services Provided Offsite
80	Home Dialysis - Nursing Facility
81	Indian Health Clinic
A0	CHAMPUS External Partnership Program
A1	EPSDT
A2	Physically Handicapped Childrens Program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	Vaccines/Medicare 100% Payment
A7	Induced Abortion-Danger To Life
A8	Induced Abortion-Victim Rape/Incest
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
AB	Abortion Performed Due to Incest
AC	Abortion Performed Due to Serious Fetal Genetic Defect
AD	Abortion Performed Due to Life Endangering Phys Condition
AE	Abortion Performed Due to Physical Health of Mother
AF	Abortion Performed Due to Emotional Health of Mother
AG	Abortion Performed Due to Social or Economic Reasons
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Copayment
AK	Air Ambulance Required

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AL	Specialized Treatment/Bed Unavailable
AM	Non-emergency Medically Necessary Stretcher Transport Reqd
AN	Preadmission Screening not Required
B0	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary is Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
C1	Approved as Billed
C2	Automatic Approval as Billed Based on Focused Review
C3	Partial Approval
C4	Admission/Services Denied
C5	Postpayment Review Applicable
C6	Admission Preauthorization
C7	Extended Authorization
C8	Reserved For National Assignment
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/HIPPS Rate Codes
D3	Second or Subsequent Interim PPS Bill
D4	Change in ICD-9-CM Diagnosis and/or Procedure Codes
D5	Cancel to Correct HICN or Provider Id
D6	Cancel Only to Repay a Duplicate or OIG Overpayment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
DR	Disaster Related
E0	Change in Patient Status
E1	Reserved For National Assignment
G0	Distinct Medical Visit
H0	Delayed Filing, Statement of Intent Submitted
P1	Do Not Resuscitate Indicator
X2	SVC Rendered Due To Managed Care Referral
X3	SVC Rendered Due To Managed Care Referral

B.3 Service Type Code

Service Type Code	Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab

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Service Type Code	Description
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
30	Health Benefit Plan Coverage
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric Inpatient
A8	Psychiatric Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care

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Service Type Code	Description
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

B.4 Adjustment Group Codes

Adjustment Group Code	Description
CO	Contractual Obligations
CR	Correction and Reversals
OA	Other Adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

B.5 Reason Codes

Reason Codes	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-Payment Amount

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C

C.1.1 Application Update Log

C.2 Application Updates

This section details the changes between this user manual version and the previous user manual versions including the Provider Electronic Solutions software version these changes apply to.

Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	n/a	n/a	**NOTE:** Version 3.02 contains ICD-10 changes however only ICD-9 codes should be submitted at this time. Please continue to check the Alabama Medicaid website at www.medicaid.alabama.gov for information about when Alabama Medicaid will be ready to accept ICD-10 codes. The ICD-10 list for entering and saving diagnosis and procedure codes is available and we suggest you enter this data in advance so you are ready for when ICD-10 is implemented.
10/10/2012	Jason Cory	3.02	n/a	n/a	**All Crossover Claims** • Negative amounts in the Crossover Paid Amount field on all crossover claims are now allowed.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	Chapter 2	Section 2.7.1	**Archiving** • Updated Note for versions prior to 3.0 will not be able to have their archived transactions restored. • Added note that 3.02 version of the software will not restore archived transactions originally from previous versions.
10/10/2012	Jason Cory	3.02	Chapter 4	Section 4.1	**Lists Heading** Remove diagnosis list and replace with the following new list: • Diagnosis ICD-9 • Diagnosis ICD-10 Add new ICD Procedure list: • Procedure ICD-9 • Procedure ICD-10 Procedure/HCPCS • Should only be used to hold non-ICD procedure codes.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/10/2012	Jason Cory	3.02	Chapter 4	Section 4.2	**Dental Form/Provider List** Rendering Provider Taxonomy is required on Dental forms. Please ensure that the Taxonomy code is filled in on the Provider list.
10/10/2012	Jason Cory	3.02	Chapter 8	Sections 8.2.2, 8.3.5	**Professional Form** • Added ICD version dropdown list to Header 2. • Updated Service 2 screenshot. • Added Service Facility Provider ID to table description.
10/10/2012	Jason Cory	3.02	Chapter 9	Sections 9 (intro), 9.2.1, 9.2.2, 9.2.3, 9.2.4, 9.2.5, 9.2.6, 9.2.7, 9.2.8, 9.2.9	**Institutional Inpatient Form** • Updated introduction text to include mention of Header 5 and Header 6. • Updated screenshot to capture new Header 6. • Added ICD version dropdown list on Header 2. • Added fields for up to 24 Other Diagnosis Codes on Header 2. • Moved Surgical Code, Operating Physician, Attending, Referring fields to Header 3. • Updated table description to include read only field for ICD version. • Moved Occurrence Codes/Dates, Occurrence Codes/Spanned Dates, Covered Days, Non-Covered Days, Service Facility Provider fields to Header 4.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Updated table description to include spanned occurrence code dates description. • Moved Condition Code fields to Header 5. • Added Header 6 to hold Admission Date, Hour, Type, Discharge Hour Delay Reason, Service Authorization, Other Insurance Indicator, Crossover Indicator fields.
10/10/2012	Jason Cory	3.02	Chapter 10	Sections 10 (intro), 10.1, 10.2.1, 10.2.2, 10.2.3, 10.2.4, 10.2.5, 10.2.6, 10.2.7, 10.2.8	**Institutional Outpatient Form** • Updated introduction text to include mention of Header 4. • Updated screenshots to capture new Header 4. • Added ICD version dropdown list to Header 2. • Added table description for ICD Version “read only” field on Header 3. • Added fields for up to 24 Other Diagnosis Codes on Header 2. • Moved Surgical Code, Operating Physician, Attending, Referring fields to Header 3. • Moved Occurrence Codes/Dates, Condition Codes, Service Authorization, Other Insurance Indicator, Service Facility Provider fields to a new Header 4. • Added table description for Non Covered Amount.
10/10/2012	Jason Cory	3.02	Chapter 11	Sections 11.2.2, 11.2.3	**Institutional Nursing Home Form** • Updated screenshot to include Service Facility Provider ID.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Added table description for Service Facility Provider ID. • Added ICD version dropdown list. • Added fields for up to 24 Other Diagnosis Codes on Header 2.
10/10/2012	Jason Cory	3.02	Chapter 14	Section 14.2	**Other Reports** • Updated Other Reports listing to include UPIN, Diagnosis ICD-9, Diagnosis ICD-10, Procedure ICD-9, and Procedure ICD-10. • Reordered Prescriber and Provider listings to match the order in the software listing. • Removed Other Insurance Reason report listing.
10/10/2012	Jason Cory	3.02	Chapter 15	Sections 15.2, 15.4.1, 15.4.2	**Prior Authorization Form – Header 2** • Updated all screenshots to capture Service tab name change to Service 1. • Added ICD version dropdown list. • Add to table description #17 for Diagnosis Type to include ICD-9 and ICD-10 diagnosis code qualifiers.
10/10/2012	Jason Cory	3.02	Appendix C	n/a	**Created Appendix C – Application Update Log** • Added Appendix C to describe software and documentation changes.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
11/20/2012	Jason Cory	3.02	Appendix B	n/a	**Created Appendix B – Code Lists** • Added Appendix B to hold large lists of codes.
11/20/2012	Jason Cory	3.02	Chapter 4	Section 4.4	• Update Insurance Type Code descriptions in the manual to match software description.
11/20/2012	Jason Cory	3.02	Chapter 15	Sections 15.2.1, 15.2.2	• Updated Provider Code listing in the manual to match what is in the software. • Updated Certification Code listing in the manual to match what is in the software. • Updated Oxygen Equipment Type list in the manual to be listed as multiple lines rather than single line as it was previously.
11/21/2012	Jason Cory	3.02	Chapter 15	Section 15.2.2	• Trimmed down Diagnosis Code description by removing Dental PA requests only information.
11/21/2012	Jason Cory	3.02	Chapter 9	Sections 9 (intro), 9.2.4, 9.2.5	• Updated count of tabs on the form in the introduction. • Update occurrence code and condition code descriptions to reference Appendix B for the code list.
11/21/2012	Jason Cory	3.02	Chapter 10	Sections 10 (intro), 10.2.4	• Updated count of tabs on the form in the introduction.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Update occurrence code and condition code descriptions to reference Appendix B for the code list.
11/21/2012	Jason Cory	3.02	Chapter 11	Sections 11.2.3, 11.2.4	• Update occurrence code and condition code descriptions to reference Appendix B for the code list.
9/25/2013	Jason Cory	3.03	n/a	n/a	Please note that Version 3.03 contains changes for CORE Operating Rules eligibility information. Changes include the ability to request multiple service types on the eligibility request form. In addition, the following Base changes have been made to the manual: • Allow entry of 91 day supply on Pharmacy claims. • Ordering Provider Field added to Professional (837P) claim form for entry at the detail. • Allow for future “To Date of Service” on all Institutional claims, Professional claims, and Dental claims. This is to accommodate the need for future “To Dates of Service” on certain procedures for NCCI updated on 10/1/2013. • Minor other changes listed in below items for version 3.03.
9/25/2013	Jason Cory	3.03	n/a	n/a	• Update date on Cover Page.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
9/25/2013	Jason Cory	3.03	n/a	n/a	• Update Table of Contents.
9/25/2013	Jason Cory	3.03	Chapter 14	Section 14.2	**Other Reports** • Update report listing to show Ordering Provider report.
9/5/2013	Jason Cory	3.03	Appendix B Code Lists	Section B.3 Created	**Section B.3 Service Type Code** • Service Type Code list was added to include the codes and descriptions for each code.
9/5/2013	Jason Cory	3.03	Chapter 5	Sections 5.2	**Eligibility 270 Form** • Updated screenshots for Eligibility form to show the addition of the Service Type Code tab that holds the Service Type Code dropdown list. • Added Service Type Code tab screenshot along with table description for the Service Type Code. • Changed text describing the 270 form as having 2 tabs so that it states there are 3 tabs.
9/25/2013	Jason Cory	3.03	Chapter 4	Section 4.1	**Building Lists** • Screenshot updated to show Ordering Provider list.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
9/25/2013	Jason Cory	3.03	Chapter 7	Section 7.2.2	**Service 1 Tab** • Update table description for Days Supply field showing allowance of 999 days.
9/25/2013	Jason Cory	3.03	Chapter 8	Section 8.3.5	**Service 2 Tab** • Update screenshot to include Ordering Provider field. • Ordering Provider ID added to table description.
1/28/2015	Jason Cory	3.04	n/a	n/a	**NOTE:** Version 3.04 contains updates to allow specific other insurance information to be entered on claims including Remaining Patient Liability, Deductible Amounts, Coinsurance Amounts, and Co-Payment Amounts. Other insurance information can be entered at a header level only on some claims or header and detail level for other claim types for up to three other insurances. In addition, the following Base changes have been made to the manual: • SOBRA and AEF application status for recipient eligibility. • Medicare 2% sequestration. • Allow 0 billed amount on
1/30/2015	Jason Cory	3.04	Table of Contents	n/a	• Updated page numbers • Added B.3 Service Type Code

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Added B.4 Adjustment Group Codes • Added B.5 Reason Codes
1/23/2015	Jason Cory	3.04	n/a	n/a	• Update date on Cover Page.
1/23/2015	Jason Cory	3.04	Chapter 6	Sections 6 (intro), 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.5, 6.2.6	**Dental Form** • Updated tab count and new tab names. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 2 table description, specifically for Other Insurance Indicator field. • Updated OI screenshot. • Updated OI table description, specifically for Payer Responsibility. • Updated Service screenshot. • Updated Service table description to include Service Adjustment Ind field. • Added new section for OI Adj. All subsequent section numbers adjusted. • Added description for the Adjustment Group Codes/Reason Codes/Amounts fields on the form. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/30/2015	Jason Cory	3.04	Chapter 8	Section 8.1,Section 8.2.1, Section 8.2.2, Section 8.2.3,	**Professional Form** • Updated Header 1 screenshot. • Updated Header 2 screenshot.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
				Section 8.2.4, Section 8.2.5, Section 8.2.6, Section 8.2.7, Section 8.2.8, Section 8.2.9, Section 8.2.10	• Updated Header 3 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service 1 tab screenshot. • Updated Service 2 tab screenshot. • Update Service 2 tab table descriptions. • Added section for Service Adj tab. All subsequent section numbers adjusted. • Added description of Service Adj tab. • Added Service Adj tab screenshot. • Added Service Adj table descriptions. • Updated NDC tab screenshot.
1/23/2015	Jason Cory	3.04	Chapter 9	Sections 9 (intro), 9.2.1, 9.2.2, 9.2.3, 9.2.4, 9.2.5, 9.2.6, 9.2.7, 9.2.8, 9.2.9, 9.2.10	**Institutional Inpatient Form** • Updated tab count introduction showing the OI Adj tab as a new optional tab. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated Header 5 screenshot. • Updated Header 6 screenshot. • Updated OI screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Added description of OI Adj tab. • Added OI Adj screenshot. • Added OI Adj table descriptions. • Updated Crossover screenshot. • Updated Crossover tab table descriptions. • Updated Service screenshot. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/28/2015	Jason Cory	3.04	Chapter 10	Section 10 Intro, Section 10.2.1, Section 10.2.2, Section 10.2.3, Section 10.2.4, Section 10.2.5, Section 10.2.6, Section 10.2.7, Section 10.2.8, Section 10.2.9, Section 10.2.10	**Institutional Outpatient Form** • Updated form tab count in the introduction. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service tab screenshot. • Added section for Service Adj tab. All subsequent section numbers adjusted. • Added Service Adj screenshot. • Added description of Service Adj tab. • Added Service Adj table description. • Updated NDC tab screenshot.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
1/23/2015	Jason Cory	3.04	Chapter 11	Sections 11 (intro), Section 11.2.1, Section 11.2.2, Section 11.2.3, Section 11.2.4, Section 11.2.5, Section 11.2.6, Section 11.2.7, Section 11.2.8	**Institutional Nursing Home Form** • Updated tab count introduction showing the OI Adj tab as a new optional tab. • Updated Header 1 screenshot. • Updated Header 2 screenshot. • Updated Header 3 screenshot. • Updated Header 4 screenshot. • Updated OI tab screenshot. • Added section for OI Adj tab. All subsequent section numbers adjusted. • Added description of OI Adj tab. • Added OI Adj tab screenshot. • Added OI Adj table descriptions. • Updated Crossover tab screenshot. • Updated Crossover table descriptions. • Updated Service tab screenshot. • Update paragraph describing OI tab, adding, deleting, or Copying another insurance.
1/23/2015	Jason Cory	3.04	Appendix B Code Lists	Section B.4 Created	**Section B.4 Adjustment Group Codes** • Adjustment Group Codes list was added to include codes and descriptions for each code.
1/23/2015	Jason Cory	3.04	Appendix B Code Lists	Section B.5 Created	**Section B.5 Reason Codes** • Reason Codes list was added to include codes and descriptions for each code.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
11/06/2015	Jason Cory	3.05	n/a	n/a	**NOTE:** Version 3.05 contains updates including the following. • Global update HP Enterprise name change. • Addition of 11 external cause of injury codes for a total of 12 codes possible (e-codes) on inpatient and outpatient claim forms. • Resolution of defect that could cause extra subelements to created on some institutional crossover claims. • All ICD version drop downs defaulted to blank rather than ICD-9. These must now be selected by the user to indicate which diagnosis code version they are billing. • PA fields now allow alpha-numeric data to be entered. • PRCO information is displayed on eligibility requests (271) for recipients assigned to a PRCO. • An application status note was added to eligibility responses (271) stating “Please note that awarded status does not mean every member in the household has AL Medicaid coverage.
11/06/2015	Jason Cory	3.05	n/a	n/a	• Update date on cover page.
11/06/2015	Jason Cory	3.05	Chapter 9	Section 9.2.2, Section 9.2.3	**Institutional Inpatient Form** • Updated Header 2 screenshot to show additional 11 e-codes added for a total of 12 codes and

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					blank ICD version dropdown as the new default selection. • Updated field description to indicate more than just one e-code can be entered. • Updated header 3 screenshot to show blank ICD version indicator.
11/06/2015	Jason Cory	3.05	Chapter 10	Section 10.2.2, Section 10.2.3	**Institutional Outpatient Form** • Updated Header 2 screenshot to show additional 11 e-codes added for a total of 12 codes and blank ICD version dropdown as the new default selection. • Updated field description to indicate more than just one e-code can be entered. • Updated header 3 screenshot to show blank ICD version indicator.
11/06/2015	Jason Cory	3.05	Chapter 11	Section 11.2.3	**Institutional Nursing Home Form** • Updated header 3 screenshot to show blank ICD version indicator. • Updated description table for Occurrence Codes to see chapter 5 of provider billing manual for specific occurrence code requirements.
04/07/2016	Jason Cory	3.06	n/a	n/a	**NOTE:** Version 3.06 contains updates to include RCO enrollment information in the eligibility response file. Also an update to include the HPE logo.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
04/07/2016	Jason Cory	3.06	Chapter 4	Section 4.4	Added note about FQHCs and RHCs able to enter a carrier code equal to the NPI for the RCO plans to submit claims with RCO payment as other payers. Also updated location information related to the Alabama Medicaid website for the provider manual appendix K for top 200 Third Party Carrier Codes.
04/07/2016	Jason Cory	3.06	Chapter 5	Section 5 (intro)	Added note explaining version 3.06 includes updates for RCO enrollment on eligibility response as well as a note that benefit limits returned are fee-for-service limits only and EPSDT screening dates are both fee-for-service claim related and encounter claim related.
04/14/2016	Jason Cory	3.06	Chapter 8	Section 8.2.4	Added note to claim filing indicator for FQHC and Rural Health Clinics about using code 14.
04/08/2016	Jason Cory	3.06	Chapter 15	Section 15 (intro)	Added note to explain 278 prior authorization request should be used for fee-for-service requests for Alabama Medicaid. PAs for RCOs need to be requested through the process setup by the RCO.
04/08/2016	Jason Cory	3.06	Chapter 16	Section 16 (intro)	Added note about 276 claim status only returning Alabama Medicaid fee-for-service claims.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
1/18/2017	Amber King	3.07	Chapter 9	Section 2.3	Updated the screenshot of Header 3 to include new birthweight fields and updated description table on birthweight field.
06/30/2017	Sandra Richardson	3.08	n/a	n/a	**NOTE:** Version 3.08 contains updates including the following. • Global update DXC Technology name change. • All ICD version drop downs defaulted to ICD 10 rather than blank. These must now be selected by the user to indicate which diagnosis code version they are billing.
06/30/2017	Sandra Richardson	3.08	n/a	n/a	• Update date on cover page.
06/30/2017	Sandra Richardson	3.08	Chapter 9	Section 9.2.2, Section 9.2.3	Institutional Inpatient Form • Updated Header 2 screenshot to show ICD 10 version dropdown as the new default selection. • Updated header 3 screenshot to show ICD 10 ICD version indicator.
06/30/2017	Sandra Richardson	3.08	Chapter 10	Section 10.2.2, Section 10.2.3	Institutional Outpatient Form • Updated Header 2 screenshot to show ICD 10 version dropdown as the new default selection.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
					• Updated header 3 screenshot to show ICD 10 version indicator.
06/30/2017	Sandra Richardson	3.08	Chapter 11	Section 11.2.3	Institutional Nursing Home Form • Updated header 3 screenshot to show ICD 10 version indicator.
10/30/2017	Sandra Richardson	3.09	n/a	n/a	**NOTE:** Version 3.09 contains the following changes: • Change references to “RCO” to “MCO” on eligibility response file. • Remove the message from claim status response regarding RCO. • Updated field label on 837 claim forms crossover tab and eligibility batch response to display Medicare ID field label instead of HIC Number.
10/30/2017	Sandra Richardson	3.09	Chapter 4	Section 4.4	• Updated note to carrier code indicator for FQHCs and RHCs able to enter a carrier code equal to the NPI for the MCO plans to submit claims with MCO payment as other payers. Changed “RCO” to “MCO”.
10/30/2017	Sandra Richardson	3.09	Chapter 5	Section 5 (intro)	• Updated note explaining version 3.09 includes MCO enrollment on eligibility response.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/30/2017	Sandra Richardson	3.09	Chapter 8	Section 8.2.4, Section 8.2.6	• Updated note to claim filing indicator for FQHC and Rural Health Clinics. Changed “RCO” to “MCO”. • Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wording to say “Enter the recipient’s Medicare ID”.
10/30/2017	Sandra Richardson	3.09	Chapter 9	Section 9.2.9	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID”
10/30/2017	Sandra Richardson	3.09	Chapter 10	Section 10.2.7	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wording to say “Enter the recipient’s Medicare ID assigned by Medicare”.
10/30/2017	Sandra Richardson	3.09	Chapter 11	Section 11.2.7	• Updated Crossover Header screenshot to show “HIC Number” changed to “Medicare ID” • Updated “HIC Number” label change to “Medicare ID” and change guidelines wordking to say “Enter the recipient’s Medicare ID assigned by Medicare”.

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Date	Author	Software Version	Chapter	Section/Page	Description of changes.
10/30/2017	Sandra Richardson	3.09	Chapter 15	Section 15 (intro)	• Updated note for 278 prior authorization request to indicate contact MCOs for their process to submit prior authorizations to them. Changed "RCO" to "MCO".
02/23//2018	Sandra Richardson	3.10	n/a	n/a	**NOTE:** Version 3.10 contains the following changes: • Updated NCPDP form to include conflict code ingredient duplication. • Updated 837 Professional claim form to include new maternity date fields.
02/23/2018	Sandra Richardson	3.10	Chapter 7	Section 7.2.3	• Updated conflict code guidelines to include ID-Ingredient duplication value.
02/23/2018	Sandra Richardson	3.10	Chapter 8	Section 8.2.3	• Updated Header 3 screenshot to capture last menstrual period and prenatal visit new fields. Also add new fields and guidelines for qualifier, date of last menstrual period, qualifier and date of first prenatal visit.
04/18/2018	Sandra Richardson	3.10	Chapter 15	Section 15.4.1 Section 15.4.2	Redact PHI/PII as well as non-public test data Updated screen layout for: • 15.4.1 Prior Authorization Request response • 15.4.2 Prior Authorization Request response

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Provider Relations Training Plan

Types of site visits

- Moderate and high risk providers include DME (re-enrolls yearly), Private Duty Nursing (re-enrolls every 5 years), Physical Therapy (re-enrolls every 5 years), Ambulance (re-enrolls every 5 years), Independent Laboratory (re-enrolls every 5 years), Independent Radiology (re-enrolls every 5 years), Home Health (re-enrolls yearly), Hospice (re-enrolls every 5 years). Newly added high risk providers are AMHP and newly added moderate risk providers are ABA therapy providers.

- DXC will visit the above listed providers as outlined below:

    - For new enrollments, DXC will visit all moderate and high risk providers prior to completing the enrollment application.

    - For re-enrollments, DXC will visit all DME and home health providers selected for re-enrollment monthly (with the exception of chain DME providers, those letters will be mailed without conducting a site visit). All other moderate risk providers will be visited if they have not had a site visit by Medicare within the last five years.

    - CHOW for moderate and high risk providers

    - Address change for moderate and high risk providers

    - As requested by Medicaid staff

    - DXC will also visit any providers whose risk status has been elevated to moderate or high risk

- Other types of provider visits include:

    - Educational visits for general Medicaid billing questions/training/program integrity reviews
- Workshops (as requested/as new information warrants)

**DXC will work with the Agency to coordinate any provider outreach needed for the ICN's/dental health home project and the Alabama Coordinated Health Network.

Conventions

DXC and Medicaid decided in the past DXC will only attend conventions if allowed to share a booth with Medicaid, have a booth available at no charge, or pay half the booth fee of the Medicaid booth and be allowed to share the booth space. DXC will attend a convention, if requested, to assist a Medicaid speaker, or to speak to a group of providers, as requested by the Agency or association. *DXC may choose to attend a convention at its discretion and pay all booth fees.

Association Meetings/Contact

DXC will continue to send out updates as changes/information requires. Meetings can also be scheduled as needed. Alerts, Insiders and other information are sent out to associations on a regular basis through e-mail communication.

QUICK REFERENCE GUIDE FOR MEDICAID QUALIFICATIONS

1. Are there any children in the home under that age of 19? **(For SOBRA Application Only)**
2. What is your monthly net income before deductions? **(For SOBRA Application Only)**
3. How many adults and how many children currently live in the home? **(For SOBRA Application Only)**
4. Are you currently expecting with child? **(For SOBRA Application Only)**

5. Do you receive Social Security? What day of the month?
   (1st of the month check = auto qualifies for Alabama Medicaid – Social Security Office will send request to activate the Medicaid to the Montgomery District Office)
   (Any other day of the month – will check to see if recipient meet initial qualifications for below district office programs and SOBRA as well.)

6. Do you receive Medicare? And what is Monthly household income? **(For Medicare savings program Only)**

7. Are you single or married? **(For Medicare savings program Only)**

8. Do you have any specific medical diagnoses?
   (Refer to all waiver programs to see if they meet any of the qualifications)
   - Breast & Cervical Cancer
   - HIV/ AIDS Waiver Program
   - SAIL Waiver Program
   - Intellectual Disability Program (ID/ LAH)
   - Technology Assisted Waiver for Adults

9. Do you have a specific medical diagnosis and meet nursing facility level of care criteria? **(SAIL waiver program)**

10. Have you been deemed disabled according to SSA standards and eligible for a nursing home? **(Nursing home program)**

11. Have you been hospitalized for 30 continuous days + 3 days acute care and awaiting placement into a nursing home?
    (Post Hospital Extended Care (PEC) Program)

12. Have you been deemed disabled according to SSA standards and eligible for home health assistance? **(Elderly & Disabled waiver program)**

*** For women who do not qualify for any of the above, if they are between the ages of 19-55, meet the income requirements, and have not had their tubes tied or a hysterectomy then they may ONLY qualify for Plan 1st and not MLIF.

Error Code	Status	Description
201	Active	BILLING PROVIDER ID NUMBER MISSING
202	Inactive	BILLING PROVIDER ID IN INVALID FORMAT
203	Active	RECIPIENT NUMBER MISSING
204	Active	RECIPIENT ID NUMBER - OLD FORMAT
205	Inactive	PRESCRIBING PRACTITIONERS LICENSE NBR MISSING
206	Active	PRESCRIBING PRACTITIONR LICENSE NO. FORMAT INVALID
207	Active	INVALID/MISSING BIRTH WEIGHT
208	Active	PREGNANCY INDICATOR INVALID
209	Active	BIRTH WEIGHT REQUIRED FOR DELIVERY CLAIM
210	Active	BRAND MEDICALLY NECESSARY INDICATOR INVALID
211	Active	REFILL INDICATOR INVALID
212	Active	PRESCRIPTION NUMBER IS MISSING OR INVALID
213	Active	DATE PRESCRIBED IS MISSING
214	Active	DATE PRESCRIBED IS INVALID
215	Active	DATE DISPENSED IS MISSING
216	Active	DATE DISPENSED IS INVALID
217	Active	NDC MISSING
218	Active	NDC INVALID FORMAT
219	Active	QUANTITY DISPENSED IS MISSING
220	Active	QUANTITY DISPENSED IS INVALID
221	Active	DAYS SUPPLY MISSING
222	Active	DAYS SUPPLY INVALID
223	Active	MISSING DIAGNOSIS INDICATOR
224	Active	DIAGNOSIS TREATMENT INDICATOR INVALID
225	Active	REFERRING PROVIDER - INVALID FORMAT
226	Active	REFERRING PROVIDER REQUIRED - ANESTHESIA
227	Active	THIRD PARTY PAYMENT AMOUNT INVALID
228	Inactive	BILLING PROVIDER SIGNATURE MISSING
229	Inactive	SOURCE OF ADMISSION MISSING OR INVALID
230	Inactive	MISSING ATTENDING SURGEON PRESCRIBER NUMBER
231	Inactive	RENDERING PROVIDER NUMBER IS MISSING
233	Active	UNITS OF SERVICE MISSING
234	Active	PROCEDURE CODE MISSING
235	Active	PROCEDURE CODE NOT IN VALID FORMAT
236	Active	NO PROCEDURE FOR REVENUE CODE
238	Inactive	RECIPIENT NAME IS MISSING

239	Active	DETAIL TO DATE OF SERVICE IS MISSING
240	Active	THE DETAIL TO DATE OF SERVICE IS INVALID
241	Inactive	ACCIDENT INDICATOR IS INVALID
242	Active	SECOND HEADER DIAGNOSIS CODE INVALID FORMAT
243	Active	MISSING MEDICARE PAID DATE
244	Active	THIRD HEADER DIAGNOSIS CODE INVALID FORMAT
245	Inactive	MISSING OCCURRENCE CODE
246	Active	FOURTH HEADER DIAGNOSIS CODE INVALID FORMAT
247	Active	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
248	Active	PLACE OF SERVICE IS MISSING
249	Active	PLACE OF SERVICE IS INVALID
250	Active	CLAIM HAS NO DETAILS
251	Active	FIRST MODIFIER INVALID
252	Active	SECOND MODIFIER INVALID
253	Active	THIRD MODIFIER INVALID
255	Active	PATIENT RSN FOR VISIT REQ ON OUTPATIENT HOSP CLAIM
256	Active	ADMIT DIAGNOSIS INVALID ON OUTPATIENT HOSP CLAIM
257	Active	PATIENT RSN FOR VISIT INVALID ON INPATIENT CLAIM
258	Active	PRIMARY DIAGNOSIS CODE MISSING-INSTITUTIONAL CLMS
259	Inactive	DATE BILLED IS MISSING/INVALID
260	Active	UNITS OF SERVICE NOT IN VALID FORMAT
261	Active	TOOTH NUMBER MISSING
262	Active	TOOTH NUMBER INVALID
263	Active	TOOTH SURFACE CODE INVALID
264	Active	DETAIL FROM DATE OF SERVICE MISSING
265	Active	DETAIL FROM DATE OF SERVICE INVALID
266	Active	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES
267	Active	DUPLICATE TOOTH SURFACES SUBMITTED
268	Active	DTL BILLED AMOUNT INVALID
269	Active	DTL BILLED AMOUNT MISSING OR INVALID FORMAT
270	Active	HEADER TOTAL BILLED AMOUNT INVALID
271	Active	HEADER TOTAL BILLED AMOUNT NOT NUMERIC
272	Active	FIRST HEADER DIAGNOSIS CODE INVALID FORMAT

273	Active	TYPE OF BILL MISSING OR INVALID
274	Active	TYPE OF BILL CODE INVALID
275	Active	ADMIT DATE MISSING
276	Active	INVALID DATE OF ADMISSION
277	Active	ADMIT HOUR INVALID
278	Active	ADMIT TYPE MISSING
279	Active	ADMIT TYPE IS INVALID
280	Active	PATIENT STATUS IS MISSING
281	Active	PATIENT STATUS IS INVALID
282	Active	COVERED DAYS MISSING
283	Active	COVERED DAYS INVALID
284	Active	PRIMARY CONDITION CODE INVALID
285	Active	SECOND CONDITON CODE INVALID
286	Active	THIRD CONDITION CODE INVALID
287	Active	FOURTH CONDITION CODE INVALID
288	Active	FIFTH CONDITION CODE INVALID
289	Active	SIXTH CONDITION CODE INVALID
290	Active	SEVENTH CONDITION CODE INVALID
291	Inactive	PRIMARY OCCURRENCE CODE INVALID
292	Inactive	SECOND OCCURRENCE CODE INVALID
293	Inactive	THIRD OCCURRENCE CODE INVALID
294	Inactive	FOURTH OCCURRENCE CODE INVALID
295	Active	DATE FOR FIRST OCCURRENCE CODE MISSING
296	Active	DATE FOR FIRST OCCURRENCE CODE INVALID
297	Active	DATE FOR SECOND OCCURRENCE CODE MISSING
298	Active	DATE FOR SECOND OCCURRENCE CODE INVALID
299	Active	DATE FOR THIRD OCCURRENCE CODE MISSING
300	Active	DATE FOR THIRD OCCURRENCE CODE INVALID
301	Active	DATE FOR FOURTH OCCURRENCE CODE MISSING
302	Active	DATE FOR FOURTH OCCURRENCE CODE INVALID
304	Active	CLAIM HAS TOO MANY DIAGNOSIS SEQUENCES
305	Active	DIAGNOSIS SEQUENCE CONTAINS AN INVALID CHARACTER
306	Active	BOTH ICD-9 AND ICD-10 CODES NOT ALLOWED

307	Active	BOTH ICD-9 AND ICD-10 PROC CODES NOT ALLOWED
308	Active	BOTH ICD-9 AND ICD-10 DIAG CODES NOT ALLOWED
309	Active	ICD PROCEDURE VERSION INVALID FOR COMPLIANCE DATES
310	Active	ICD DIAGNOSIS VERSION INVALID FOR COMPLIANCE DATES
311	Active	PRIMARY DIAGNOSIS PRESENT ON ADMISSION IND INVALID
312	Active	SECOND DIAGNOSIS PRESENT ON ADMISSION IND INVALID
313	Active	THIRD DIAGNOSIS PRESENT ON ADMISSION IND INVALID
314	Active	FOURTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
315	Active	FIFTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
316	Active	SIXTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
317	Active	SEVENTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
318	Active	EIGHTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
319	Active	NINTH DIAGNOSIS PRESENT ON ADMISSION IND INVALID
320	Active	DIAGNOSIS 10-24 PRESENT ON ADMISSION IND INVALID
330	Active	DTP DATE INVALID
331	Active	DATE LAST MENSTRUAL PERIOD MISSING OR INFUTURE
332	Active	DATE FIRST PRENATAL VISIT MISSING OR INFUTURE
339	Active	REVENUE CODE IS MISSING
340	Active	REVENUE CODE IS INVALID
350	Active	NO. OF DETAILS NOT EQUAL TO SUBMITTED DETAIL COUNT
351	Inactive	REFILL NOT ALLOWED FOR NARCOTIC DRUGS
355	Active	FIFTH HEADER DIAGNOSIS CODE INVALID FORMAT
356	Active	SIXTH HEADER DIAGNOSIS CODE INVALID FORMAT
357	Active	SEVENTH HEADER DIAGNOSIS CODE INVALID FORMAT

358	Active	EIGHTH HEADER DIAGNOSIS CODE INVALID FORMAT
359	Active	NINTH HEADER DIAGNOSIS CODE INVALID FORMAT
360	Active	ADMITTING DIAGNOSIS MISSING
361	Active	ADMITTING DIAGNOSIS CODE INVALID
362	Inactive	E' DIAGNOSIS CODE IS INVALID
363	Active	FIRST (PRINCIPAL) ICD PROCEDURE CODE INVALID
364	Active	FIRST (PRINCIPAL) ICD PROCEDURE DATE MISSING
365	Active	FIRST (PRINCIPAL) ICD PROCEDURE DATE INVALID
366	Active	SECOND ICD PROCEDURE CODE INVALID
367	Active	SECOND ICD PROCEDURE DATE MISSING
368	Active	SECOND ICD PROCEDURE DATE INVALID
369	Active	THIRD ICD PROCEDURE CODE INVALID
370	Active	THIRD ICD PROCEDURE DATE MISSING
371	Active	THIRD ICD PROCEDURE DATE INVALID
372	Active	FOURTH ICD PROCEDURE CODE INVALID
373	Active	FOURTH ICD PROCEDURE DATE MISSING
374	Active	FOURTH ICD PROCEDURE DATE INVALID
375	Active	FIFTH ICD PROCEDURE CODE INVALID
376	Active	FIFTH ICD PROCEDURE DATE MISSING
377	Active	FIFTH ICD PROCEDURE DATE INVALID
378	Active	SIXTH ICD PROCEDURE CODE INVALID
379	Active	SIXTH ICD PROCEDURE DATE MISSING
380	Active	SIXTH ICD PROCEDURE DATE INVALID
381	Active	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING
395	Active	HEADER FROM DATE OF SERVICE MISSING
396	Active	HEADER FROM DATE OF SERVICE INVALID
397	Active	HEADER TO DATE OF SERVICE MISSING
398	Active	HEADER TO DATE OF SERVICE INVALID
400	Active	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO
401	Inactive	OBSOLETE - DELETE
405	Inactive	FIFTH OCCURRENCE CODE INVALID
406	Inactive	SIXTH OCCURRENCE CODE INVALID
407	Inactive	SEVENTH OCCURRENCE CODE INVALID
408	Inactive	EIGHTH OCCURRENCE CODE INVALID
409	Inactive	FIRST OCCURRENCE SPAN CODE INVALID
410	Inactive	SECOND OCCURRENCE SPAN CODE INVALID

411	Active	DATE FOR FIFTH OCCURRENCE CODE MISSING
412	Active	DATE FOR FIFTH OCCURRENCE CODE INVALID
413	Active	DATE FOR SIXTH OCCURRENCE CODE MISSING
414	Active	DATE FOR SIXTH OCCURRENCE CODE INVALID
415	Active	DATE FOR SEVENTH OCCURRENCE CODE MISSING
416	Active	DATE FOR SEVENTH OCCURRENCE CODE INVALID
417	Active	DATE FOR EIGHTH OCCURRENCE CODE MISSING
418	Active	DATE FOR EIGHTH OCCURRENCE CODE INVALID
419	Inactive	FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING
420	Inactive	FROM DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID
421	Inactive	TO DTE OF SERV FOR FIRST OCCUR SPAN CODE MISSING
422	Inactive	TO DTE OF SERV FOR FIRST OCCUR SPAN CODE INVALID
423	Inactive	FROM DAT OF SERV FOR 2ND OCCUR SPAN CODE MISSING
424	Inactive	FROM DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID
425	Inactive	TO DTE OF SERV FOR 2ND OCCUR SPAN CODE MISSING
426	Inactive	TO DTE OF SERV FOR 2ND OCCUR SPAN CODE INVALID
427	Inactive	ACCIDENT DATE INVALID
433	Active	MEDICARE DEDUCTIBLE AMOUNT INVALID
434	Active	MEDICARE COINSURANCE AMOUNT INVALID
435	Inactive	MEDICARE BLOOD DEDUCTIBLE AMOUNT INVALID
436	Active	MEDICARE ALLOWED AMOUNT INVALID
437	Inactive	MEDICARE PSYCH ADJUSTMENT AMOUNT INVALID
438	Active	MEDICARE COPAY AMOUNT INVALID
450	Active	INVALID QUADRANT
451	Inactive	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
454	Inactive	INVALID ASSIGNMENT CODE

455	Active	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED
456	Active	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER
457	Active	INVALID PRINCIPAL/OTHER ICD PROCEDURE TYPE
458	Active	HEADER DIAGNOSIS CODE 10 - 24 INVALID FORMAT
460	Inactive	INVALID ATTACHMENT TYPE (HDR)
461	Inactive	VALUE CODE IS INVALID
462	Inactive	VALUE CODE AMOUNT IS MISSING
463	Inactive	VALUE CODE AMOUNT IS INVALID
464	Inactive	OCCURRENCE CODE 9-24 INVALID
465	Active	DATE FOR OCCURRENCE CODE 9-24 MISSING
466	Active	DATE FOR OCCURRENCE CODE 9-24 INVALID
467	Inactive	OCCURRENCE SPAN CODE 3-24 INVALID
468	Inactive	FROM DATE OF SERVICE FOR SPAN CODE 3-24 MISSING
469	Inactive	FROM DATE OF SERVICE FOR SPAN CODE 3-24 INVALID
470	Inactive	TO DATE OF SERVICE FOR SPAN CODE 3-24 MISSING
471	Active	CONDITION CODE 8-24 INVALID
472	Inactive	TO DATE OF SERVICE FOR SPAN CODE 3-24 INVALID
473	Active	ICD PROCEDURE 7-24 INVALID
474	Active	ICD PROCEDURE 7-24 DATE MISSING
475	Active	ICD PROCEDURE 7-24 DATE IS INVALID
477	Inactive	DETAIL FIRST OTHER PHYSICIAN ID IS INVALID
480	Inactive	INVALID ATTACHMENT TYPE
500	Active	DATE PRESCRIBED AFTER BILLING DATE
502	Active	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
503	Active	DATE DISPENSED AFTER BILLING DATE
505	Active	THIRD PARTY PAYMENT AMOUNT MORE THAN CLAIM CHARGE
506	Inactive	ICN DATE PRIOR TO DATE BILLED
507	Active	DETAIL FROM DATE OF SERVICE AFTER TO DATE
508	Active	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS
510	Inactive	1ST OCCURRENCE SPAN FROM DATE IS AFTER THE TO DATE

511	Inactive	2ND OCCURRENCE SPAN FROM DATE IS AFTER THE TO DATE
512	Active	CLAIM PAST FISCAL YEAR FILING LIMIT
513	Active	RECIPIENT NAME AND NUMBER DISAGREE
514	Active	HEADER THRU DATE OF SERVICE AFTER ICN DATE
518	Inactive	COVERED DAYS EXCEED STATEMENT PERIOD
519	Active	ADMIT DATE > HEADER FROM DATE OF SERVICE
526	Active	DETAIL DATES NOT WITHIN HEADER DATES
527	Active	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE
532	Inactive	REVENUE CODE/PROVIDER SPECIALTY MISMATCH
536	Inactive	BILLED DATE IS PRIOR TO DATES OF SERVICE
537	Active	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE
545	Inactive	DELETED - PH now uses 555 for timely filing
554	Inactive	HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE
555	Inactive	CLAIM PAST FILING LIMIT
556	Inactive	PHP FILING LIMIT EXCEEDED
557	Active	MEPD LATE FILING EDIT
559	Inactive	COINSURANCE AMT NOT CORRECT % OF THE TOTAL M'CARE
565	Inactive	HEADER PAID AMOUNT IS GREATER THAN BILLED AMOUNT
568	Active	HEADER DISCHARGE DATE IS LESS THAN ADMIT DATE
569	Inactive	HDR DTE OF ACCIDENT GREATER THAN LAST DTE OF SERV
570	Active	HEADER TOTAL DAYS LESS THAN COVERED DAYS
571	Active	REVENUE CODE REQUIRES ICD PROCEDURE CODE
572	Inactive	DTL ACCOMMODATIONS TOTAL NOT EQ. TO HDR COVRD DAYS
573	Active	COVERED DAYS CONFLICT WITH HEADER DATES
574	Active	SERV DATES ARE NOT IN SAME MONTH-HEADER OR DETAIL
575	Active	SURGERY DATE OUTSIDE VALID RANGE
576	Inactive	CLAIM HAS THIRD-PARTY PAYMENT

577	Active	DETAIL SERVICE DATES ARE NOT IN SAME MONTH
581	Inactive	SPAN THRU DATE LESS THAN SPAN FROM DATE
586	Inactive	INPAT LABOR RM REQUIRE OCCURREN CDE 51 AND DATES
589	Active	SUSPEND ADJUSTMENT FOR PRE-PAYMENT VERIFICATION
590	Inactive	MEPD CLAIM SPANS FISCAL YEAR END
592	Inactive	DATE OVER 1 YR MORE THAN 90 DAYS AFTER MEDICARE PD
594	Inactive	ACCOMMODATION TOTAL UNITS MUST EQUAL DAYS BILLED
595	Active	REGION 91CLAIMS SUSPEND FOR HCA AGENT REVIEW
596	Active	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS
598	Inactive	PCS DAYS BILLED SPAN DIFFERENT MONTHS
599	Inactive	ATTACHMENT CONTROL NUMBER MISSING
602	Active	UNITS NOT EQUAL TO TEETH BILLED
603	Inactive	ATTACHMENT INDICATED BUT NOT YET RECEIVED - HEADER
605	Inactive	FROM DATE IS AFTER TO DATE FOR SPAN OCC. 3-24
606	Active	INVALID OTHER PAYER DATE
607	Inactive	ATTACHMENT INDICATED BUT NOT YET RECEIVED - DETAIL
609	Inactive	PART A CROSSOVER DOS SPANS 20020501
620	Active	TPL DEDUCTIBLE AMOUNT NOT NUMERIC
621	Active	TPL COINSURANCE AMOUNT NOT NUMERIC
622	Active	TPL COPAY AMOUNT NOT NUMERIC
623	Active	TPL PAID AMOUNT NOT NUMERIC
624	Active	TPL DETAIL PAYER DOES NOT HAVE MATCHING HDR PAYER
625	Active	TPL DETAIL PAYER HAS MULTIPLE MATCHING HDR PAYERS
626	Active	TPL DETAIL PAYER ID HAS DUPLICATE
627	Active	TPL HDR COINSURANCE <> SUM OF DTL COINSURANCE
628	Active	TPL HDR DEDUCTIBLE NOT EQUAL SUM OF DTL DEDUCTIBLE
629	Active	TPL HDR COPAY NOT EQUAL SUM OF DTL COPAY
630	Active	TPL HDR PAID AMT NOT EQUAL SUM OF DTL PAID AMT

631	Active	TPL - PATIENT RESPONSIBILITY IS ZERO FOR PAYER
632	Active	TPL HDR PAYER HAS NO DETAIL PAYER INFORMATION
633	Active	TPL HDR PAYER ID IS DUPLICATE OF ANOTHER HDR PAYER
634	Active	TPL PAYER RESPONSIBILITY MISSING OR INVALID
635	Active	TPL PAYER RESPONSIBILITY HIERARCHY IS DUPLICATE
636	Active	TPL TOTAL PAID AMT NOT EQUAL SUM OF HDR PAID AMT
637	Active	CLAIM WITH TPL AMOUNT MISSING TPL PAYER
643	Active	INVALID OTHER COVERAGE CODE
644	Active	OTHER PAYER PAT RESP AMT IS INVALID
645	Active	OTHER PAYER PAT RESP QUALIFIER IS INVALID
646	Active	PT RESPONSIBILITY MUST BE GT ZERO
647	Active	OTHER PAYER AMOUNT MUST BE GT ZERO
652	Inactive	PH-MISSING OR INVALID OTHER PAYER COVERAGE TYPE
666	Active	MO Systematic denial of recycled suspense
675	Active	ADJ - RECIPIENT ID NOT SUBMITTED
676	Active	ADJ - PROVIDER ID NOT SUBMITTED
677	Active	ADJ - ORIGINAL ICN INVALID FORMAT
678	Active	ADJ - ORIGINAL ICN NOT SUBMITTED
679	Active	ADJ - REQUEST RECIPIENT ID NOT FOUND
680	Active	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL
681	Active	ADJ - ORIGINAL ICN NOT FOUND
682	Active	ADJ - ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED
683	Active	ADJ - ORIG CLM ADJUSTMENT ALREADY IN PROGRESS
684	Active	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL
685	Active	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS
686	Active	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE
687	Active	ADJ - INVALID REQUEST - SVC LOC ERROR
688	Active	ADJ - INVALID REQUEST - PHP VOIDS ONLY
689	Active	ADJ - ORIG CLAIM IS IN NCCI NON-ADJUSTABLE STATUS
690	Active	ADJUSTMENT RCO PROVIDER MISSING

691	Active	RCO PROVIDER NOT PRESENT ON ORIGINAL CLAIM
692	Active	ADJUSTMENT RCO PROVIDER DOES NOT MATCH MOTHER
693	Active	FFS ADJUSTING ENCOUNTER OR ENCOUNTER ADJUSTING FFS
800	Active	DETAIL RATE NOT NUMERIC
801	Active	DTL RATE * DTL UNITS NOT EQUAL DTL BILLED AMOUNT
802	Active	MISSING OR INVALID PRESCRIBER ID QUALIFIER
803	Active	SERVICE DATES SPAN ELIGIBILITY CHANGE
804	Active	BILLING PROVIDER CANNOT BE PRESCRIBER
805	Active	INVALID NON-COVERED CHARGE
806	Active	MEDICARE PAID AMOUNT INVALID
807	Active	INVALID TPL ADJUDICATION DATE
808	Active	TPL ADJUDICATION DATE CANNOT BE A FUTURE DATE
809	Active	INVALID LIFETIME RESERVE OR COINSURANCE DAYS
810	Active	INVALID DEDUCTIBLE AMT-SKILLED NURSING FACILITY
811	Active	HEADER FROM DATE OF SERVICE > ICN DATE
812	Active	ADMIT DATE > ICN DATE
813	Active	MEDICARE PAID DATE > ICN DATE
814	Active	DETAIL TO DATE OF SERVICE > ICN DATE
815	Active	SURGICAL ICD REQUIRES OPERATING PHYSICIAN
816	Active	COINSURANCE DAYS NOT NUMERIC
817	Active	INVALID COINSURANCE DAYS
818	Active	LIFETIME RESERVE DAYS NOT NUMERIC
819	Active	LIFETIME RESERVE DAYS > MAX ALLOWED
820	Active	SERVICE PERIOD MAY NOT SPAN FISCAL YEAR
821	Active	INVALID NON-COVERED DAYS
822	Active	REVENUE CODE REQUIRES PROCEDURE CODE
823	Active	RECIPIENT CHECK DIGIT MISSING OR INVALID
824	Active	UNBORN RECIPIENT PENDING ELIGIBILITY VERIFICATION
825	Active	MEDICARE ALLOWED AMT CANNOT BE ZERO
826	Active	TYPE OF BILL INVALID FOR CLAIM TYPE

827	Inactive	NON-COVERED AMOUNT GREATER THAN COVERED AMOUNT
829	Active	DAYS SUPPLY > 3 FOR EMERGENCY PHARMACY CLAIM
830	Active	MEDICARE HDR ALLOW AMT <> SUM OF DTL ALLOW AMT
831	Active	MEDICARE HDR PAID AMOUNT <> SUM OF DTL PAID AMTS
832	Active	OTHER PAYER AMOUNT PAID QUALIFIER INVALID
833	Active	CO-INSURANCE AMOUNT DOES NOT BALANCE
835	Active	MEDICARE DATA NOT FOUND - FORMAT ERROR
836	Active	MEDICARE AMOUNTS INVALID
837	Active	CLAIM DATES OVERLAP PLAN EFFECTIVE DATES
838	Active	MEDICARE COPAY AMOUNT DOES NOT BALANCE
839	Active	HOSPITAL CLAIM SPANS 9/30 AND 10/01
840	Active	ICD-10 CLAIM SPANS ICD-10 START DATE
841	Active	ICD-9 CLAIM SPANS ICD-9 END DATE
842	Active	ES CLAIM REQUIRES DELIVERY
843	Active	EMERG CLAIMS REQUIRE A CERTIFIED EMERGENCY
844	Active	HOSPICE CLAIM ONLY ONE LINE ALLOWED PER CLAIM
845	Inactive	HOSPICE CLM DOS NOT WITHIN 60 DAYS OF HH REVIEW
846	Active	FACILITY PROVIDER NOT SUBMITTED
900	Active	PROVIDER TYPE SPECIALTY GROUP NOT FOUND
901	Active	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE
902	Active	PROCEDURE CODE GROUP NOT FOUND
903	Active	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T
904	Active	GROUP NUMBER NOT FOUND IN MODIFIER GROUP TABLE
905	Active	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL
906	Active	GROUP NUMBER NOT FOUND IN ICD GROUP TABLE
907	Active	GROUP NUMBER NOT FOUND IN DRUG GROUP TABLE

908	Active	GROUP NUMBER NOT FOUND IN VALUE GROUP TABLE
909	Active	GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE
910	Active	BENEFIT PLAN GROUP NOT FOUND
911	Active	INTERNAL ERROR
912	Active	INTERNAL ERROR-DOLLAR DISTRIBUTION
913	Active	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE
914	Active	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE
915	Active	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE
916	Active	GROUP NOT FOUND IN PROVIDER GROUP TABLE
917	Active	GROUP NUMBER NOT FOUND IN PROCEDURE GROUP TABLE
918	Active	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR
919	Active	GROUP NUMBER NOT FOUND IN AID CODE TABLE
920	Active	DRUG THERAPEUTIC CLASS GROUP NOT FOUND
921	Active	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE
922	Active	TABLE ENTRY MISSING T_MCARE_DEDUCTIBLE
923	Active	RULE OVERLAP IDENTIFIED
924	Active	SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND
925	Active	GROUP NUMBER NOT FOUND IN REFERENCE GROUP TABLE.
926	Active	PROCEDURE MODIFIER RESTRICTION ERROR
927	Active	DRG GROUP NOT FOUND
928	Active	BIRTH WEIGHT CDE VALUE GROUP NOT FOUND
1000	Active	BILLING PROVIDER NUMBER NOT ON FILE
1001	Active	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE
1002	Active	PERFORMING PROV NOT ELIGIBLE FOR DOS
1003	Active	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE
1004	Active	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE

1006	Inactive	FACILITY PROV NOT ELIG AT SERV LOC FOR PROG BILLED
1007	Active	PERFORMING PROVIDER NOT ON FILE
1008	Inactive	PERFORMING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER
1010	Active	PERFORMING PROVIDER NOT IN BILLING GROUP
1012	Inactive	NOT USED - RENDERING PROV SPCLTY
1016	Inactive	NON-PARTICIPATING MANUFACTURER
1017	Active	HOSPICE SNF RATE NOT ON FILE
1018	Active	NO/MULTIPLE RATE SEGMNTS FOR LEVEL OF CARE
1019	Active	CLAIM DATES OF SVC SPAN MULTIPLE RATE SEGMNTS
1020	Active	ATTENDING PHYSICIAN ID NOT ON FILE
1021	Active	FIRST OTHER (OPERATING) PROVIDER ID NOT ON FILE
1022	Inactive	SECOND OTHER PHYSICIAN ID NOT ON FILE
1024	Active	BILLING PROVIDER NOT LISTED AS RECIPIENT LOC PROV
1026	Active	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE
1027	Inactive	HEADER REFERRING PHYSICIAN ID NOT ON FILE
1030	Inactive	ANCIL NOT COVERED IN BIRTH CNTR GRP
1032	Active	INVALID CLAIM TYPE FOR BILLING PROVIDER
1036	Inactive	RENDERING PROV TYPE/CLAIM TYPE INVALID - UPDATE CR
1037	Active	FACILITY PROVIDER NUMBER NOT ON FILE
1038	Active	DEA NOT ON FILE FOR PRESCRIBER
1039	Active	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED
1040	Active	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE
1041	Active	PRESCRIBER PRACTICE TYPE NOT VALID FOR DRUG SCHED
1044	Inactive	NOT USED - PCS SUPRSUSP PROV TYP ON DENIED CMS1500
1045	Inactive	NOT USED - SUSPEND SPECIFIC PROV AND RECIPIENT
1048	Inactive	PERFORMING PROVIDER ENROLLMENT STATUS INVALID
1049	Inactive	BILLING PROVIDER ENROLLMENT STATUS INVALID
1050	Inactive	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER

1051	Active	PERFORMING PROVIDER NOT ON FILE (HEADER)
1052	Inactive	DETAIL 2ND OTHER PHYSICIAN ID NUMBER NOT ON FILE
1053	Inactive	DETAIL FIRST OTHER PHYSICIAN ID NUMBER NOT ON FILE
1054	Active	ORDERING PROVIDER NOT ON FILE
1055	Inactive	DETAIL REFERRING PROV NOT ON FILE
1058	Inactive	HEADER MEDICAID ID NOT FOUND FOR CROSSOVER
1065	Active	BILLING PROVIDER NAME AND NUMBER DISAGREE
1070	Active	ATTENDING PROVIDER ID NOT ON FILE - HDR
1071	Active	OPERATING PROVIDER ID NOT ON FILE - HDR
1072	Active	ATTENDING PROVIDER ID NOT ON FILE - DTL
1073	Active	OPERATING PROVIDER ID NOT ON FILE - DTL
1074	Active	PRESCRIBING PROVIDER NOT ON FILE
1079	Active	ORDERING PROV NOT ENROLLED SVC LOCATION
1081	Active	REFERRING PROV NOT ENROLLED SVC LOC HDR-PHYS-DNTL
1082	Active	REFERRING PROV NOT ENROLLED SVC LOC DTL-PHYS-DNTL
1083	Active	REFERRING PROV NOT ENROLLED AT SVC LOC - HDR - UB
1084	Active	ATTENDING PROV - NOT ENROLLED AT SVC LOC - HDR
1085	Active	OPERATING PROV - NOT ENROLLED AT SVC LOC - HDR
1086	Active	REFERRING PROV NOT ENROLLED AT SVC LOC - DTL-UB
1087	Active	ATTENDING PROV - NOT ENROLLED AT SVC LOC - DTL
1088	Active	OPERATING PROV - NOT ENROLLED AT SVC LOC - DTL
1089	Active	PRESCRIBING PROV - NOT ENROLLED AT SVC LOC
1091	Active	REFER PROV STATUS NOT VALID FOR DOS HDR-PHYS-DNTL
1092	Active	REFER PROV STATUS NOT VALID FOR DOS DTL-PHYS-DNTL
1093	Active	REFERRING PROV STATUS NOT VALID FOR DOS - HDR - UB
1094	Active	ATTENDING PROV - STATUS NOT VALID FOR DOS - HDR

1095	Active	OPERATING PROV - STATUS NOT VALID FOR DOS - HDR
1096	Active	REFERRING PROV - STATUS NOT VALID FOR DOS - DTL-UB
1097	Active	ATTENDING PROV - STATUS NOT VALID FOR DOS - DTL
1098	Active	OPERATING PROV - STATUS NOT VALID FOR DOS - DTL
1099	Active	PRESCRIBING PROV - STATUS NOT VALID FOR DOS
1100	Active	ORDERING PROV - STATUS NOT VALID FOR DOS
1200	Active	MATERNITY DISTRICT PROVIDER NOT ON FILE
1201	Active	MATERNITY DISTRICT PROVIDER MISSING OR SPACES
1202	Active	MATERNITY PROVIDER NOT A DISTRICT PROVIDER
1203	Active	MATERNITY DISTRICT PROVIDER NOT ENROLLED
1204	Active	MAT DISTRICT PROV STATUS NOT VALID FOR DOS
1205	Active	MATERNITY DISTRICT PROV NOT AN NPI
1206	Active	MATERNITY DISTRICT PAYER MISSING
1207	Active	MATERNITY DISTRICT PAYER - MORE THAN ONE
1208	Active	MATERNITY CLAIM FREQUENCY NOT 1 OR 8
1209	Active	MATERNITY CLAIM NOT AN ENCOUNTER
1210	Active	MATERNITY ENCOUNTER - INVALID CLAIM TYPE
1211	Active	MATERNITY ENCOUNTER - DUPLICATE CLAIM
1212	Active	MATERNITY ENCOUNTER - VOID CLAIM
1220	Active	SUBMITTER DOES NOT BEGIN WITH TPIDRCO FOR ENCOUNTR
1221	Active	SUBMITTER BEGINS WITH TPIDRCO FOR NON-ENCOUNTER
1225	Active	BILLING PROVIDER TYPE IS RCO
1226	Active	ENCOUNTER INDICATOR IS NOT Y
1227	Active	CLAIM IS FFS BUT SHOULD BE COVERED BY RCO
1228	Active	ENCOUNTER IS PHARMACY OR DENTAL CLAIM
1229	Active	MATERNITY CARE ENCOUNTER SERVICE NOT COVERED
1230	Active	ENCOUNTER PROVIDER MISSING

1231	Active	ENCOUNTER PROVIDER NOT ON FILE
1232	Active	ENCOUNTER PROVIDER NPI NOT SUBMITTED
1233	Active	ENC PROVIDER NOT ENROLLED AT SERVICE LOCATION
1234	Active	ENCOUNTER PROVIDER STATUS NOT VALID FOR DOS
1235	Active	ENCOUNTER PROVIDER MULTIPLE SERVICE LOCATIONS
1236	Active	RCO PROVIDER IS NOT A VALID RCO PROVIDER TYPE
1237	Active	FQHC FFS RCO CLAIM MISSING RCO PAYER
1238	Active	FQHC FFS RCO CLAIM RCO PAID AMT ZERO
1239	Active	FQHC SUBMITTED RCO DOES NOT MATCH RECIPIENT RCO
1240	Active	ENCOUNTER CLAIM RECIPIENT IS NOT IN AN RCO
1241	Active	ENCOUNTER CLAIM DATES OF SERVICE NOT ALL IN RCO
1242	Active	ENCOUNTER RECIPIENT CHANGES RCO DURING DOS
1243	Active	ENCOUNTER CLAIM RCO DOES NOT MATCH RECIPIENT RCO
1250	Active	NO ENCOUNTER PAYER SUBMITTED
1251	Active	MORE THAN ONE ENCOUNTER PAYER SUBMITTED
1252	Active	ENCOUNTER TCN MISSING
1253	Active	ENCOUNTER ADJUDICATION DATE INVALID
1254	Active	ENCOUNTER ADJUDICATION DATE CANNOT BE IN FUTURE
1255	Active	ENCOUNTER MISSING DETAIL PAYER INFORMATION
1256	Active	ENCOUNTER COPAY NOT NUMERIC
1257	Active	ENCOUNTER PAID AMOUNT NOT NUMERIC
1258	Active	ENCOUNTER SUM OF DTL COPAY NOT EQUAL HDR COPAY
1259	Active	ENCOUNTER SUM OF DTL PAID NOT EQUAL HDR PAID
1260	Active	ENCOUNTER COINSURANCE SUBMITTED
1261	Active	ENCOUNTER DEDUCTIBLE SUBMITTED
1262	Active	ENCOUNTER PAID AMOUNT SUBMITTED
1280	Active	RCO DENIED CLAIM
1281	Active	RCO DENIED CLAIM - TPL
1282	Active	RCO DENIED CLAIM - TIMELY FILING
1283	Active	RCO DENIED CLAIM - NOT AN RCO COVERED SERVICE

1284	Active	RCO DENIED CLAIM MISSING AUTHORIZATION OR REFERRAL
1803	Active	GROUP MEMBER CANNOT BE BILLING PROVIDER
1804	Active	PERFORMING PROVIDER CANNOT BE GROUP PROVIDER
1805	Active	BILLING PROVIDER SPECIALTY NOT FOUND FOR DOS
1806	Active	EPSDT REFERRED SVCS RESTRICTED TO RECIPIENTS < 21
1807	Active	CROSSOVER ONLY PROVIDER CANNOT BILL CLAIM TYPE
1808	Active	REFERRING PROV REQUIRED FOR EPDST REFERRAL
1809	Active	REFERRING PROVIDER MUST BE EPSDT SCREENING PROV
1810	Active	PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS
1812	Active	SERVICES NOT COVERED FOR RECIPIENT 22 OR OLDER
1813	Active	PROVIDER SUSPENDED FOR OUTSTANDING CREDIT BALANCE
1814	Active	BILLING PROV ENROLL STATUS NOT VALID FOR DOS
1815	Active	PERF PROV ENROLL STATUS NOT VALID FOR DOS
1816	Active	MATERNITY CARE MUST BE PROVIDED BY DISTRICT PROV
1817	Active	MAT CARE CONTRACT PROV LIMITED TO MAT CARE CLAIMS
1818	Active	BILLING PROVIDER NOT ASSIGNED WAIVER PROVIDER
1819	Active	INVALID POS FOR FQHC PROVIDER
1820	Inactive	PATIENT FIRST CLAIM REQUIRES A REFERRAL
1821	Active	MEDICAL LOCKIN-RECIP LOCKED INTO OTHER PROVIDER
1822	Active	MEDICAL LOCKIN - LOCKIN DATES OVERLAP CLAIM DATES
1823	Active	WAIVER ASSIGNMENT DATES OVERLAP CLAIM DATES
1824	Active	LOC ASSIGNMENT DATES OVERLAP CLAIM DATES
1825	Active	COBA DENIAL - DO NOT CROSSOVER
1826	Active	BILL SVC FOR MAT CARE RECIPIENT AS GLOBAL FEE

1827	Active	NON-MEPD CLAIM FOR MEPD RECIPIENT
1828	Active	BILLING PROV ENROLL STATUS NOT VALID FOR DOS
1829	Active	PERF PROV ENROLL STATUS NOT VALID FOR DOS
1830	Active	PROCEDURE REQUIRES BOTH ORDERING AND REF PROVIDER
1831	Active	PROCEDURE REQUIRES EITHER ORDERING OR REF PROVIDER
1832	Active	PROCEDURE REQUIRES REFERRING PROVIDER
1833	Active	PROCEDURE REQUIRES ORDERING PROVIDER
1834	Active	SUBMITTER ID/EVVM PROCEDURE CONFLICT
1835	Active	PROVIDER UNDER REVIEW - BILLING
1836	Active	PROVIDER UNDER REVIEW - PERFORMING
1900	Active	TAXONOMY IS INVALID: BILLING PROVIDER
1901	Active	TAXONOMY IS INVALID: PERFORMING PROVIDER
1902	Inactive	TAXONOMY IS INVALID: REFERRING PROVIDER
1903	Inactive	TAXONOMY IS INVALID: FACILITY PROVIDER
1905	Inactive	TAXONOMY IS INVALID: OTHER PROVIDER 2
1906	Active	TAXONOMY IS NOT VALID FOR BILLING PROVIDER
1907	Active	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER
1908	Inactive	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER
1909	Inactive	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER
1911	Inactive	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2
1912	Active	TAXONOMY IS MISSING: BILLING PROVIDER
1913	Active	TAXONOMY IS MISSING: PERFORMING PROVIDER
1914	Inactive	TAXONOMY IS MISSING: REFERRING PROVIDER
1915	Inactive	TAXONOMY IS MISSING: FACILITY PROVIDER
1917	Inactive	TAXONOMY IS MISSING: OTHER PROVIDER 2
1918	Inactive	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2
1919	Active	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER

1920	Inactive	TAXONOMY IS INVALID: DTL REFERRING PROVIDER
1921	Active	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER
1922	Inactive	TAXONOMY IS MISSING: DTL REFERRING PROVIDER
1923	Inactive	TAXONOMY IS MISSING: DTL OTHER PROVIDER 2
1924	Inactive	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2
1925	Active	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV
1926	Inactive	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER
1927	Active	NPI REQUIRED: BILLING PROVIDER (HEALTHCARE)
1928	Active	NPI REQUIRED: PERFORMING PROVIDER (HEALTHCARE)
1929	Active	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)
1930	Inactive	NPI REQUIRED: FACILITY PROVIDER (HEALTHCARE)
1931	Active	NPI REQUIRED: RENDERING PROVIDER (HEALTHCARE)
1932	Inactive	NPI REQUIRED: OTHER PROVIDER 2 (HEALTHCARE)
1933	Inactive	NPI REQUIRED: DTL OTHER PROVIDER 2 (HEALTHCARE)
1934	Active	NPI REQUIRED: DTL PERFORMING PROVIDER (HEALTHCARE)
1935	Active	NPI REQUIRED: DTL REFERRING PROVIDER (HEALTHCARE)
1936	Active	INVALID BILLING PROVIDER OVERRIDE SPECIFIED
1937	Active	INVALID PERFORMING PROVIDER OVERRIDE SPECIFIED
1938	Active	INVALID REFERRING PROVIDER OVERRIDE SPECIFIED
1939	Active	INVALID FACILITY PROVIDER OVERRIDE SPECIFIED
1940	Active	INVALID RENDERING PROVIDER OVERRIDE SPECIFIED
1941	Active	INVALID OTHER PROVIDER 2 OVERRIDE SPECIFIED
1942	Active	INVALID DTL OTHER PROVIDER 2 OVERRIDE SPECIFIED

1943	Active	INVALID DTL PERFORMING PROVIDER OVERRIDE SPECIFIED
1944	Active	INVALID DTL REFERRING PROVIDER OVERRIDE SPECIFIED
1945	Active	MULTIPLE SERVICE LOCATIONS FOR BILLING PROVIDER
1946	Active	MULTIPLE SERVICE LOCATIONS FOR PERFORMING PROVIDER
1947	Inactive	MULTIPLE SERVICE LOCATIONS FOR REFERRING PROVIDER
1948	Active	MULTIPLE SERVICE LOCATIONS FOR FACILITY PROVIDER
1949	Active	MULTIPLE SERVICE LOCATIONS FOR RENDERING PROVIDER
1950	Inactive	MULTIPLE SERVICE LOCATIONS FOR OTHER PROVIDER 2
1951	Inactive	MULTIPLE SERVICE LOCS FOR DTL OTHER PROVIDER 2
1952	Active	MULTIPLE SERVICE LOCS FOR DTL PERFORMING PROVIDER
1953	Inactive	MULTIPLE SERVICE LOCS FOR DTL REFERRING PROVIDER
1954	Inactive	ATTENDING PROVIDER - MULTIPLE SVC LOC - DTL
1955	Inactive	OPERATING PROVIDER - MULTIPLE SVC LOC - DTL
1956	Inactive	ATTENDING PROV - MULTIPLE SVC LOC - HDR
1957	Inactive	OPERATING PROV - MULTIPLE SVC LOC - HDR
1958	Inactive	PRESCRIBING PROVIDER MULTIPLE SVC LOC
1959	Inactive	ORDERING PROV - MULTIPLE SERVICE LOCS
1960	Active	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)
1961	Active	NPI REQUIRED: OPERATING PROVIDER (HEALTHCARE)
1962	Active	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)
1963	Active	ATTENDING PROVIDER - NPI REQUIRED - HDR
1964	Active	OPERATING PROVIDER- NPI REQUIRED - HDR
1965	Active	ATTENDING PROVIDER- NPI REQUIRED - DTL
1966	Active	OPERATING PROVIDER- NPI REQUIRED - DTL

1968	Active	NPI REQUIRED: ORDERING PROVIDER (HEALTHCARE)
1969	Active	INVALID DTL ORDERING PROVIDER OVERRIDE SPECIFIED
1970	Active	INVALID ATTENDING PROVIDER OVERRIDE SPECIFIED
1971	Active	INVALID DTL ATTENDING PROVIDER OVERRIDE SPECIFIED
1972	Active	INVALID OTHER PROVIDER 1 OVERRIDE SPECIFIED
1973	Active	INVALID DTL OTHER PROVIDER 1 OVERRIDE SPECIFIED
1974	Active	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER
1975	Active	TAXONOMY IS INVALID: DTL REFERRING PROVIDER
1976	Active	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2
1977	Active	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2
1978	Active	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV
1979	Active	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER
1980	Active	TAXONOMY IS NOT VALID FOR BILLING PROVIDER
1981	Active	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER
1982	Active	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER
1983	Active	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER
1984	Active	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2
1985	Active	TAXONOMY IS INVALID: BILLING PROVIDER
1986	Active	TAXONOMY IS INVALID: PERFORMING PROVIDER
1987	Active	TAXONOMY IS INVALID: REFERRING PROVIDER
1988	Active	TAXONOMY IS INVALID: FACILITY PROVIDER
1989	Active	TAXONOMY IS INVALID: OTHER PROVIDER 2
1995	Active	RENDER/DISPENS/PERFORM PROV ID IN OLD FORMAT - HDR
1996	Active	RENDER/DISPENS/PERFORM PROV ID IN OLD FORMAT - DTL

1999	Active	HEADER BILLING PROVIDER ID IN OLD FORMAT
2001	Active	RECIPIENT ID NUMBER NOT ON FILE
2002	Active	RECIPIENT NOT ELIGIBLE FOR HEADER DATES OF SERVICE
2003	Active	RECIPIENT IS TOTALLY INELIGIBLE FOR DETAIL DOS.
2009	Active	RECIPIENT NOT ELIGIBLE FOR DETAIL DATES OF SERVICE
2011	Inactive	PHARMCY MEDICAL/NON-MEDICAL SUPPL. AND ROUTINE DME
2017	Inactive	RECIPIENT SERVICES COVERED BY HMO PLAN
2037	Inactive	RECIPIENT ID IS INACTIVE
2042	Active	PATIENT LIABILITY SEGMENT OVERLAP
2043	Inactive	RECIPIENT ON REVIEW
2044	Inactive	CLAIM INDICATES RECIPIENT EXPIRED
2045	Active	SERVICE NOT COVERED FOR LTC RESIDENT
2046	Active	RECIPIENT PATIENT STATUS INVALID FOR CLAIM
2047	Active	ADMIT REASON/SOURCE OF ADMISSION MISSING/INVALID
2048	Active	RECIPIENT DISCHARGE RSN MISSING/INVALID(SUSPEND)
2049	Active	RECIPIENT DISCHARGE RSN MISSING/INVALID(DENY)
2050	Active	ADMIT DATE MUST EQUAL HDR FIRST SVC DATE
2051	Active	RECIPIENT ID NUMBER NOT ON FILE
2052	Active	RECIPIENT NOT ELIGIBLE FOR HEADER DATES OF SERVICE
2053	Active	RECIPIENT IS TOTALLY INELIGIBLE FOR DETAIL DOS
2054	Active	UNABLE TO DETERMINE FUND CODE - DETAIL
2055	Active	UNABLE TO DETERMINE AID CAT OR COUNTY
2056	Active	RECIPIENT ELIGIBILITY - CHIP OVERLAP
2057	Active	RECIPIENT PARTIALLY ELIGIBILE - HEADER
2059	Active	RECIPIENT NOT ELIGIBLE FOR DETAIL DATES OF SERVICE
2077	Active	RECIPIENT PARTIALLY ELIGIBILE - DETAIL
2500	Active	RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT)

2501	Active	RECIPIENT COVERED BY MEDICARE A (WITH ATTACHMENT
2502	Active	RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT)
2503	Active	RECIPIENT COVERED BY MEDICARE B (WITH ATTACHMENT)
2504	Active	RECIPIENT COVERD BY PRIVATE INSURANC(NO ATTACHMNT)
2505	Active	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATTACHMNT)
2506	Inactive	INSURANCE DENIAL REQUIRED
2507	Active	RECIPIENT HAS MORE THAN ONE INSURANCE CARRIER
2508	Active	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)
2509	Inactive	RECIPIENT COVERED BY MEDICARE B (PHARMACY)
2510	Inactive	HMO CO-PAY/RECIPIENT HAS TPL
2511	Inactive	HMO CO-PAY/RECIPIENT HAS MEDICARE
2512	Inactive	HMO CO-PAY/NO TPL OR MEDICARE COVERAGE
2514	Inactive	RECIPIENT COVERED BY MEDICARE(A and B), NO MED D)
2550	Active	RECIPIENT HAS MEDICARE HMO COVERAGE
2590	Active	SYSTEM ERROR - COULD NOT ASSIGN TPL INPUT CODE
2591	Active	SYSTEM ERROR - COULD NOT ASSIGN TPL OUTPUT CODE
2603	Active	RECIPIENT/PROVIDER LOCK-IN VIOLATION
2800	Active	STERILIZATION CLAIM REQUIRES PRIOR CONSENT
2801	Active	HYSTERECTOMY CLAIM REQUIRES PRIOR CONSENT
2802	Active	ABORTION DENIED BECAUSE DOC DOES NOT MEET HHS/MEDI
2804	Active	DETAILS COVERED BY MORE THAN ONE PLAN CODE
2805	Active	DOS PRIOR TO DOB
2806	Active	PREGNANCY INDICATOR IS INVALID FOR RECIPIENT SEX
2807	Active	COBA-NO MEDICAID ID FOR MEDICARE ID
2808	Active	COBA - MEDICARE ID NOT ON FILE
2809	Active	OFFICE VISIT REQUIRES GESTATIONAL AGE DIAGNOSIS
2810	Active	DTL HAS MORE THAN ONE GESTATIONAL DIAGNOSIS CODE

2811	Active	MORE THAN ONE GESTATIONAL DIAGNOSIS CODE SUBMITTED
2850	Active	STERILIZATION CLAIM REQUIRES PRIOR CONSENT
2851	Active	HYSTERECTOMY CLAIM REQUIRES PRIOR CONSENT
2852	Active	ABORTION CLAIM REQUIRES PRIOR CONSENT
2999	Inactive	CLAIM BILLED WITH INACTIVE BID
3000	Active	UNITS EXCEED AUTHORIZED UNITS ON PA MASTER FILE
3001	Active	PA NOT FOUND ON DATABASE
3002	Active	NDC REQUIRES PA
3003	Active	PROCEDURE CODE REQUIRES PA
3006	Active	PA DOLLARS EXCEEDED
3018	Inactive	STOP LOSS THRESHOLD REACHED - ENCOUNTER CLAIMS
3019	Active	PA CUTBACK PERFORMED
3021	Inactive	DRG REQUIRES PA
3100	Active	CLAIM AND PA PRESCRIBING PROVIDER DO NOT MATCH
3101	Active	ONLINE PA DENIED BY HID, NDC REQUIRES PA
3102	Inactive	ONLINE PA PROCESS TIMEOUT OR INTERFACE PROBLEM
3103	Active	ONLINE PA PROCESS RESPONSE FROM HID HAD ERRORS
3104	Active	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES
3105	Active	DAW 1 - BRAND WITH GENERIC EQUIV REQUIRES OVERRIDE
3300	Active	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH
3301	Active	BILL EMERGENCY PROCEDURE/REVENUE TOGETHER
3302	Active	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID
3303	Active	MEDICARE PAID AMOUNT EQUAL 100%
3304	Active	NON-COVERED SVC FOR RECIPIENT < SIX MONTHS OLD
3305	Active	NO BASE VALUE FOR ANESTHESIA
3306	Active	HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR AMOUNT
3307	Active	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT
3308	Active	UCC rate not found for provider/procedure/DOS

3309	Active	PROCEDURE CODE - TYPE OF BILL RESTRICTION
3310	Active	SYSTEM ERROR - DISPENSING FEE NOT FOUND
3311	Active	Refill Number exceeds Maximum allowed
3312	Active	DAYS SUPPLY IS GREATER THAN MAXIMUM DAYS SUPPLY
3313	Active	NDC Drug, Product is not preferred
3314	Active	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP
3315	Active	NURSERY DAYS EXCEED LIMIT
3316	Active	NDC IS NOT PAYABLE BY ALABAMA MEDICAID
3317	Active	CLAIM QUANTITY EXCEEDS NDC MAX UNITS
3318	Inactive	LIMITS-NDC AGE RESTRICTION
3319	Inactive	LIMITS-NDC SEX RESTRICTION
3320	Active	SERVICE INCLUDED IN FACILITY FEE
3321	Active	NO PRICE ON FILE - CONTACT MYERS AND STAUFFER
3322	Active	DAW CODE NOT ALLOWED WITH NDC SUBMITTED
3323	Active	PROCEDURE RESTRICTION - MODIFIER REQUIRED
3324	Active	PROCEDURE RESTRICTION - MODIFIER NOT ALLOWED
3325	Active	QUANTITY MUST BE DIVISIBLE BY PACKAGE SIZE
3326	Active	PHARMACY MAINTENANCE SUPPLY REQUIRED FOR DRUG
3327	Active	NDC HAS INVALID THERAPEUTIC CLASS VALUE
3328	Active	RCO HDR PAID CLAIM PROCEDURE ALREADY PRESENT
3351	Active	PRIMARY DIAGNOSIS REQUIRES PRESENT ON ADMISSION IN
3352	Active	SECOND DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3353	Active	THIRD DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3354	Active	FOURTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3355	Active	FIFTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3356	Active	SIXTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND

3357	Active	SEVENTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IN
3358	Active	EIGHTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3359	Active	NINTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION IND
3360	Active	DIAGNOSIS 10-42 REQUIRES PRESENT ON ADMISSION IND
3375	Active	TCM SVCS NOT ALLOWED FOR SAIL / E AND D WAIVERS
3376	Active	FQHC ENCOUNTER EXCLUSION DETAIL
3599	Active	MANUAL PRICING REQUIRED
3800	Active	SERVICE COVERAGE HAS NOT BEEN DETERMINED
3997	Inactive	BPA-RR-DRG - ANY HDR DIAGNOSIS RESTRICTION
3998	Active	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION
3999	Active	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION
4000	Inactive	MORE THAN TWO SURGICAL UNITS ON THE CLAIM
4001	Active	BPA-RP-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION
4002	Active	BPA-RP-NDC - NO COVERAGE
4004	Active	NDC NOT ON FILE
4005	Inactive	ALLOWED AMOUNT HIGH VARIANCE
4006	Inactive	ALLOWED AMOUNT LOW VARIANCE
4009	Inactive	ALLOWED AMOUNT LESS THAN DRUG CHARGE VARIANCE
4010	Inactive	MODIFIER REQUIRES MEDICAL REVIEW
4011	Inactive	INVALID MODIFIER/MODIFIER COMBINATION
4012	Inactive	ABORTION PROCEDURE INDICATED
4013	Active	PROCEDURE CODE IS NOT COVERED FOR DATE OF SERVICE
4014	Active	NO PRICING SEGMENT ON FILE
4015	Inactive	PASARR ASSESSMENT PROCEDURE FOR REVIEW
4016	Active	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION
4017	Inactive	BPA-RP-DRG - BILL PROV PRIMARY PT/PS RESTRICTION
4018	Inactive	BPA-RP-DRG - PERF PROV PRIMARY PT/PS RESTRICTION
4019	Inactive	PROCEDURE CODE REQUIRES ATTACHMENT

4021	Active	BPA-RP-PROC - NO COVERAGE
4023	Active	BPA-RP-NDC - GENDER RESTRICTION
4025	Active	BPA-RP-NDC - AGE RESTRICTION
4026	Inactive	BPA-RP-NDC - MAX UNIT RESTRICTION
4027	Active	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE
4028	Active	BPA-RP-DIAG - GENDER RESTRICTION
4029	Active	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION
4030	Active	BPA-RP-DIAG - AGE RESTRICTION
4031	Active	BPA-PC-DIAG - GENDER RESTRICTION
4032	Active	PROCEDURE CODE NOT ON FILE
4034	Active	BPA-RP-PROC - AGE RESTRICTION
4035	Active	BPA-RP-PROC - GENDER RESTRICTION
4036	Active	BPA-RP-PROC - PLACE OF SERVICE RESTRICTION
4038	Active	PATIENT REASON FOR VISIT DIAGNOSIS NOT ON FILE
4039	Inactive	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS
4040	Active	PRIMARY DIAGNOSIS CODE NOT ON FILE
4041	Active	SECOND DIAGNOSIS CODE NOT ON FILE
4042	Active	THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE
4043	Active	FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE
4044	Active	BPA-RR - NO RULE FOR ASSOC AGE
4045	Active	BPA-RR - NO RULE FOR BENEFIT PLAN
4046	Active	PROCEDURE CODE BILLED PRIOR TO THE EFFECTIVE DATE
4047	Active	FIFTH DIAGNOSIS CODE NOT ON FILE
4048	Active	SIXTH DIAGNOSIS CODE NOT ON FILE
4049	Active	SEVENTH DIAGNOSIS CODE NOT ON FILE
4050	Active	EIGHTH DIAGNOSIS CODE NOT ON FILE
4051	Active	NINTH DIAGNOSIS CODE NOT ON FILE
4052	Active	ADMITTING DIAGNOSIS CODE NOT ON FILE
4053	Active	PRINCIPAL PROCEDURE CODE NOT ON FILE
4054	Active	FIRST OTHER PROCEDURE CODE NOT ON FILE
4055	Active	SECOND OTHER PROCEDURE CODE NOT ON FILE
4056	Active	THIRD OTHER PROCEDURE CODE NOT ON FILE
4057	Active	FOURTH OTHER PROCEDURE CODE NOT ON FILE

4058	Active	FIFTH OTHER PROCEDURE CODE NOT ON FILE
4059	Active	REVENUE CODE NOT ON FILE
4060	Inactive	E-CODE DIAGNOSIS NOT ON FILE
4061	Active	BPA-RR - NO RULE FOR CLAIM TYPE
4062	Active	BPA-RR - NO RULE FOR COND CODE
4063	Inactive	ICD-CM PROCEDURE CODE/AGE RESTRICTION
4064	Active	BPA-RP-ICD - GENDER RESTRICTION
4065	Inactive	ICD-CM PROCEDURE REQUIRES ATTACHMENT
4066	Inactive	ICD-CM PROCEDURE/DIAGNOSIS RESTRICTION
4067	Inactive	NON-COVERED ICD-CM PROCEDURE CODE
4068	Active	BPA-RR - NO RULE CURR BILL PROV CONTRACT
4070	Active	BPA-RR-PROC - MODIFIER RESTRICTION
4071	Active	BPA-RR-PROC - TOOTH NUMBER RESTRICTION
4072	Active	BPA-RR - DIAGNOSIS RESTRICTION
4073	Active	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION
4075	Active	BPA-RP-ICD - FAMILY PLANNING IND RESTRICTION
4076	Active	BPA-RP-NDC - FAMILY PLANNING IND RESTRICTION
4077	Active	NON-COVERED REVENUE CODE
4084	Inactive	DRUG CHG TO ALLOWED CHG EXCEEDS PERCENT
4085	Inactive	NOT USED - INP PSYCH HOSP FOR RECIP AGE 22-64
4088	Inactive	BPA-RR-PROC ¿ ACA PROVIDER INDICATOR
4089	Inactive	MISSING/INVALID HCPCS SURGICAL CDE/SURGERY REV CDE
4093	Active	BPA-RP-DIAG - DIAG ROLE RESTRICTION
4094	Active	BPA-PC-REV - PROV COUNTY RESTRICTION
4095	Inactive	NONSURGICAL SERVICE NOT REIMBURSED TO NON-ASC PROV
4097	Inactive	INVALID MODIFIER
4098	Inactive	RVU NOT ON FILE
4099	Inactive	DRG NOT ON FILE
4100	Inactive	NO BASE AMOUNT ON FILE FOR THE DATES OF SERVICE
4104	Active	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION
4105	Active	NO FLAT FEE ON FILE

4106	Active	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION
4108	Inactive	NO ASC ON FILE
4109	Active	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION
4112	Active	BPA-PC-ICD - FAMILY PLANNING IND RESTRICTION
4113	Inactive	UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY
4114	Inactive	NO GPCI ON FILE
4115	Inactive	NO RBRVS CONVERSION FACTOR
4117	Active	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION
4118	Active	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION
4120	Active	PROCEDURE CODE REQUIRES VALID QUADRANT
4123	Inactive	RBRVS (PRE,POST,INTRA) OPERATIVE PRECENT ZERO
4124	Inactive	RBRVS GLOBAL SURGERY NUMBER IS EQUAL ZERO
4127	Active	CANNOT PRIORITIZE RECIPIENT'S PROGRAMS
4128	Active	ICD PROCEDURE 7-24 NOT ON FILE
4130	Active	PAYER HIERARCHY NOT FOUND
4131	Active	NO BENEFIT PLANS ASSOCIATED TO PAYER
4132	Inactive	DRG GROUPER UNABLE TO ASSIGN DRG FOR PRICING
4133	Inactive	NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS
4134	Inactive	NO PROVIDER OR PEER GROUP RATE FOUND FOR DOS
4135	Inactive	APC GROUPER UNABLE TO GROUP/PRICE
4136	Active	BPA-RP-ICD - BILL PROV PRIMARY PT/PS RESTRICTION
4138	Active	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION
4140	Active	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION
4141	Active	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION
4142	Active	BPA-RP-REV - BILL PROV PRIMARY PT/PS RESTRICTION
4143	Active	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION

4144	Active	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION
4145	Inactive	BPA-PC-DRG - BILL PROV PRIMARY PT/PS RESTRICTION
4146	Inactive	BPA-PC-DRG - PERF PROV PRIMARY PT/PS RESTRICTION
4149	Active	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION
4150	Active	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION
4151	Active	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION
4152	Active	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION
4153	Active	Med Rvw Restriction for Billed NDC
4154	Active	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION
4155	Active	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION
4157	Active	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION
4158	Inactive	BPA-PC-DRG - CURR PROV CONTRACT RESTRICTION
4159	Active	BPA-PC-ICD - CURR PROV CONTRACT RESTRICTION
4160	Active	BPA-PC-NDC - CURR PROV CONTRACT RESTRICTION
4161	Active	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION
4162	Active	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION
4164	Active	INACTIVE DRUG
4165	Inactive	Max Day Restriction for Covered NDC
4166	Active	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN
4167	Active	BPA-RR-REV - NO RULE FOR BENEFIT PLAN
4177	Active	BPA-PC-ICD - BILL PROV PRIMARY PT/PS RESTRICTION
4190	Inactive	BPA-RP-DRG - ANY HDR DIAGNOSIS RESTRICTION
4191	Inactive	BPA-PC-DRG - ANY HDR DIAGNOSIS RESTRICTION
4192	Inactive	BPA-RP-DRG - OTHER DTL DIAG RESTRICTION
4194	Active	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION
4200	Active	CLAIM PRICED AT ZERO

4203	Inactive	DENIAL MODIFIER SUBMITTED ON CLAIM
4207	Active	CLIA NUMBER NOT FOUND FOR PROVIDER
4208	Active	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD
4209	Inactive	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMBINAT
4210	Active	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION
4211	Active	TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID
4212	Active	PROCEDURE CLIA IND/PROVIDER CERT TYPE MISMATCH
4213	Inactive	RE-USED NDC CODES
4215	Active	BPA-RP-PROC - TOOTH NUMBER RESTRICTION
4217	Inactive	NOT USED - WAIVER PROCEDURE
4218	Inactive	NOT USED - WAIVER PROCEDURE
4219	Active	BPA-RR-REV - NO RULE FOR TYPE OF BILL
4222	Active	Med Rvw Restriction for Covered NDC
4223	Active	Med Rvw Restriction for Covered Procedure
4224	Active	BPA-RP-PROC - QUANTITY RESTRICTION
4225	Active	NO ACCOMMODATION REVENUE CODES BILLED.
4226	Active	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISIO
4227	Active	BPA-RP-REV - NO COVERAGE
4229	Active	Med Rvw Restriction for Covered Diagnosis
4230	Inactive	MEDICARE DEDUCT GREATER THAN ANNUAL DEDUCTIBLE LMT
4231	Active	BPA-PC-NDC - MAX UNIT RESTRICTION
4233	Inactive	DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
4235	Inactive	IMPROPER MODIFIER FOR PROCEDURE BILLED
4236	Inactive	INVALID USE OF E DIAGNOSIS CODE
4237	Inactive	INVALID TYPE OF LEAVE FOR LTC CLAIM
4240	Active	PROCEDURE CODE CANNOT BE SPAN DATED.
4241	Inactive	UNABLE TO DETERMINE LEVEL OF CARE FROM REV CODE
4244	Active	BPA-RP-DIAG - NO COVERAGE
4245	Active	FOURTH MODIFIER INVALID FOR DATE OF SERVICE
4246	Active	ADJUSTMENT PAID AMOUNT EXCEEDS THE CASH RECEIPT BA

4250	Active	BPA-RR - PRIMARY PT/PS RESTRICTION BILL/PERF
4251	Active	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE
4252	Active	DIAG CODE 10-24 NOT ON FILE
4254	Active	BPA-RP-REV - AGE RESTRICTION
4255	Inactive	BPA-PC-DRG - ADMIT DIAG RESTRICTION
4256	Active	BPA-RP-PROC - MODIFIER RESTRICTION
4257	Active	BPA-PC-PROC - MODIFIER RESTRICTION
4258	Inactive	BPA-PC-DRG - OCCURRENCE CODE RESTRICTION
4260	Active	NDC REQUIRED FOR PROCEDURE - TOP 20
4261	Active	INVALID UNIT OF MEASURE VALUE
4262	Active	NDC QUANTITY UNITS IS NOT NUMERIC
4263	Active	NDC QUANTITY UNITS IS ZERO
4264	Active	NDC NOT ON THE DRUG FILE
4265	Active	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC
4266	Active	NDC NOT COVERED - PRIMARY NDC NOT ACTIVE ON DOS
4267	Active	NDC NOT COVERED - SECONDARY NDC NOT ACTIVE ON DOS
4268	Active	NDC NOT COVERED - NDC NOT REBATABLE ON DOS
4269	Active	NDC NOT COVERED - SECOND NDC NOT REBATABLE ON DOS
4270	Active	NDC NOT COVERED - NDC RATED LESS THAN EFFECTIVE
4271	Active	DUPLICATE NDC FOR CLAIM DETAIL
4272	Active	NDC NOT COVERED - OBSOLETE OR TERMINATED ON DOS
4273	Active	INVALID NDC QUALIFIER CODE, MUST EQUAL N4
4274	Active	INVALID PRESCRIPTION QUALIFIER CODE
4275	Active	DRUG UNIT PRICE IS NOT NUMERIC
4276	Active	DRUG UNIT PRICE IS ZERO
4277	Active	PROCEDURE REQUIRES NDC
4278	Active	NDC NOT COVERED - NDC NOT EFFECTIVE ON THE DOS
4279	Active	NDC NOT COVERED - NDC INACTIVE ON THE DOS
4280	Active	NDC NOT COVERED - NDC IN REJECT REGARDLESS ON DOS
4281	Active	NDC NOT COVERED - REPACKAGED NDC
4282	Active	NDC REQUIRED FOR NON-CLASSIFED PROCEDURE

4283	Active	MANUAL PRICE NON-CLASSIFIED PROCEDURE
4310	Active	BPA-PC-PROC - ADMIT DIAG RESTRICTION
4311	Active	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION
4312	Active	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION
4313	Active	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION
4314	Active	BPA-RP-DIAG - CLAIM TYPE RESTRICTION
4315	Active	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION
4316	Active	BPA - ANY DTL DIAG RESTRICTION PC-RR
4317	Active	BPA-PC-ICD - ADMIT DIAG RESTRICTION
4318	Active	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION
4319	Active	BPA-PC-ICD - ANY HDR DIAGNOSIS RESTRICTION
4320	Active	BPA-PC-REV - ADMIT DIAG RESTRICTION
4321	Active	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION
4322	Active	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION
4361	Inactive	BPA-RP-NDC - DIAGNOSIS RESTRICTION
4362	Active	BPA-PC-DIAG - TYPE OF BILL RESTRICTION
4363	Inactive	BPA-PC-DRG - TYPE OF BILL RESTRICTION
4364	Active	BPA-PC-ICD - TYPE OF BILL RESTRICTION
4371	Active	BPA-RP-PROC - CLAIM TYPE RESTRICTION
4372	Active	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION
4373	Active	BPA-RP-NDC - CLAIM TYPE RESTRICTION
4374	Active	BPA-RP-REV - CLAIM TYPE RESTRICTION
4376	Active	BPA-RP-ICD - CLAIM TYPE RESTRICTION
4400	Active	BPA-RP-PROC - ADMITTING DIAGNOSIS - GROUP
4401	Active	BPA-PC-PROC - ADMITTING DIAGNOSIS - GROUP
4402	Active	BPA-RR-PROC - ADMITTING DIAGNOSIS - GROUP
4403	Active	BPA-RP-ICD - ADMITTING DIAGNOSIS - GROUP
4404	Active	BPA-PC-ICD - ADMITTING DIAGNOSIS - GROUP
4405	Active	BPA-RR-ICD - ADMITTING DIAGNOSIS - GROUP

4406	Active	BPA-RP-REV - ADMITTING DIAGNOSIS - GROUP
4407	Active	BPA-PC-REV - ADMITTING DIAGNOSIS - GROUP
4408	Active	BPA-RR-REV - ADMITTING DIAGNOSIS - GROUP
4409	Active	BPA-RP-PROC □PRIMARY HDR DIAGNOSIS - GROUP
4410	Active	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS - GROUP
4411	Active	BPA-RR-PROC - PRIMARY HDR DIAGNOSIS - GROUP
4412	Active	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS - GROUP
4413	Active	BPA-PC-ICD - PRIMARY HDR DIAGNOSIS - GROUP
4414	Active	BPA-RR-ICD - PRIMARY HDR DIAGNOSIS - GROUP
4415	Active	BPA-RP-REV - PRIMARY HDR DIAGNOSIS - GROUP
4416	Active	BPA-PC-REV - PRIMARY HDR DIAGNOSIS - GROUP
4417	Active	BPA-RR-REV - PRIMARY HDR DIAGNOSIS - GROUP
4418	Active	BPA-RP-PROC - SECONDARY HDR DIAGNOSIS - GROUP
4419	Active	BPA-PC-PROC - SECONDARY HDR DIAGNOSIS - GROUP
4420	Active	BPA-RR-PROC - SECONDARY HDR DIAGNOSIS - GROUP
4421	Active	BPA-RP-ICD - SECONDARY HDR DIAGNOSIS - GROUP
4422	Active	BPA-PC-ICD - SECONDARY HDR DIAGNOSIS - GROUP
4423	Active	BPA-RR-ICD - SECONDARY HDR DIAGNOSIS - GROUP
4424	Active	BPA-RP-REV - SECONDARY HDR DIAGNOSIS - GROUP
4425	Active	BPA-PC-REV - SECONDARY HDR DIAGNOSIS - GROUP
4426	Active	BPA-RR-REV - SECONDARY HDR DIAGNOSIS - GROUP
4427	Active	BPA-RP-PROC - OTHER HDR DIAGNOSIS - GROUP
4428	Active	BPA-PC-PROC - OTHER HDR DIAGNOSIS - GROUP

4429	Active	BPA-RR-PROC - OTHER HDR DIAGNOSIS - GROUP
4430	Active	BPA-RP-ICD - OTHER HDR DIAGNOSIS - GROUP
4431	Active	BPA-PC-ICD - OTHER HDR DIAGNOSIS - GROUP
4432	Active	BPA-RR-ICD - OTHER HDR DIAGNOSIS - GROUP
4433	Active	BPA-RP-REV - OTHER HDR DIAGNOSIS - GROUP
4434	Active	BPA-PC-REV - OTHER HDR DIAGNOSIS - GROUP
4435	Active	BPA-RR-REV - OTHER HDR DIAGNOSIS - GROUP
4436	Active	BPA-RP-PROC - EMERGENCY DIAGNOSIS - GROUP
4437	Active	BPA-PC-PROC - EMERGENCY DIAGNOSIS - GROUP
4438	Active	BPA-RR-PROC - EMERGENCY DIAGNOSIS - GROUP
4439	Active	BPA-RP-ICD - EMERGENCY DIAGNOSIS - GROUP
4440	Active	BPA-PC-ICD - EMERGENCY DIAGNOSIS - GROUP
4441	Active	BPA-RR-ICD - EMERGENCY DIAGNOSIS - GROUP
4442	Active	BPA-RP-REV - EMERGENCY DIAGNOSIS - GROUP
4443	Active	BPA-PC-REV - EMERGENCY DIAGNOSIS - GROUP
4444	Active	BPA-RR-REV - EMERGENCY DIAGNOSIS - GROUP
4445	Active	BPA-RR-PROC - ANY HDR DIAGNOSIS - GROUP
4446	Active	BPA-RP-ICD - ANY HDR DIAGNOSIS - GROUP
4447	Active	BPA-PC-ICD - ANY HDR DIAGNOSIS - GROUP
4448	Active	BPA-RR-ICD - ANY HDR DIAGNOSIS - GROUP
4449	Active	BPA-RP-REV - ANY HDR DIAGNOSIS - GROUP
4450	Active	BPA-PC-REV - ANY HDR DIAGNOSIS - GROUP
4451	Active	BPA-RR-REV - ANY HDR DIAGNOSIS - GROUP
4452	Inactive	BPA-RP-PROC - ANY DTL DIAGNOSIS - GROUP
4453	Inactive	BPA-PC-PROC - ANY DTL DIAGNOSIS - GROUP
4454	Inactive	BPA-RR-PROC - ANY DTL DIAGNOSIS - GROUP

4455	Inactive	BPA-RP-ICD - ANY DTL DIAGNOSIS - GROUP
4456	Inactive	BPA-PC-ICD - ANY DTL DIAGNOSIS - GROUP
4457	Inactive	BPA-RR-ICD - ANY DTL DIAGNOSIS - GROUP
4458	Inactive	BPA-RP-REV - ANY DTL DIAGNOSIS - GROUP
4459	Inactive	BPA-PC-REV - ANY DTL DIAGNOSIS - GROUP
4460	Inactive	BPA-RR-REV - ANY DTL DIAGNOSIS - GROUP
4461	Inactive	BPA-RP-PROC □PRIMARY DTL DIAGNOSIS - GROUP
4462	Inactive	BPA-PC-PROC - PRIMARY DTL DIAGNOSIS - GROUP
4463	Inactive	BPA-RR-PROC - PRIMARY DTL DIAGNOSIS - GROUP
4464	Inactive	BPA-RP-ICD - PRIMARY DTL DIAGNOSIS - GROUP
4465	Inactive	BPA-PC-ICD - PRIMARY DTL DIAGNOSIS - GROUP
4466	Inactive	BPA-RR-ICD - PRIMARY DTL DIAGNOSIS - GROUP
4467	Inactive	BPA-RP-REV - PRIMARY DTL DIAGNOSIS - GROUP
4468	Inactive	BPA-PC-REV - PRIMARY DTL DIAGNOSIS - GROUP
4469	Inactive	BPA-RR-REV - PRIMARY DTL DIAGNOSIS - GROUP
4470	Inactive	BPA-RP-PROC - SECONDARY DTL DIAGNOSIS - GROUP
4471	Inactive	BPA-PC-PROC - SECONDARY DTL DIAGNOSIS - GROUP
4472	Inactive	BPA-RR-PROC - SECONDARY DTL DIAGNOSIS - GROUP
4473	Inactive	BPA-RP-ICD - SECONDARY DTL DIAGNOSIS - GROUP
4474	Inactive	BPA-PC-ICD - SECONDARY DTL DIAGNOSIS - GROUP
4475	Inactive	BPA-RR-ICD - SECONDARY DTL DIAGNOSIS - GROUP
4476	Inactive	BPA-RP-REV - SECONDARY DTL DIAGNOSIS - GROUP
4477	Inactive	BPA-PC-REV - SECONDARY DTL DIAGNOSIS - GROUP
4478	Inactive	BPA-RR-REV - SECONDARY DTL DIAGNOSIS - GROUP
4479	Active	BPA-RP-PROC - OTHER ANY DIAGNOSIS - GROUP
4480	Active	BPA-PC-PROC - OTHER ANY DIAGNOSIS - GROUP

4481	Active	BPA-RR-PROC - OTHER ANY DIAGNOSIS - GROUP
4482	Active	BPA-RP-ICD - OTHER ANY DIAGNOSIS - GROUP
4483	Active	BPA-PC-ICD - OTHER ANY DIAGNOSIS - GROUP
4484	Active	BPA-RR-ICD - OTHER ANY DIAGNOSIS - GROUP
4485	Active	BPA-RP-REV - OTHER ANY DIAGNOSIS - GROUP
4486	Active	BPA-PC-REV - OTHER ANY DIAGNOSIS - GROUP
4487	Active	BPA-RR-REV - OTHER ANY DIAGNOSIS - GROUP
4500	Active	BPA-RR-NDC - ALGI RESTRICTION
4501	Active	BPA-RR-NDC - NO RULE FOR DISP AS WRITTEN IND
4502	Active	BPA-RP-PROC - EPSDT REFERRAL RESTRICTION
4503	Active	BPA-PC-PROC - EPSDT REFERRAL RESTRICTION
4504	Active	BPA-RP-NDC - ALGI RESTRICTION
4505	Active	BPA-RR-PROC - NO RULE FOR URBAN/RURAL IND
4506	Active	BPA-PC-DIAG - PERF PROV ALL PT/PS RESTRICTION
4508	Active	BPA-PC-PROC - PERF PROV ALL PT/PS RESTRICTION
4509	Active	BPA-PC-REV - PERF PROV ALL PT/PS RESTRICTION
4511	Active	BPA-RP-DIAG - PERF PROV ALL PT/PS RESTRICTION
4514	Active	BPA-RP-PROC - PERF PROV ALL PT/PS RESTRICTION
4515	Active	BPA-RP-REV - PERF PROV ALL PT/PS RESTRICTION
4516	Active	BPA-PC-DIAG - BILL PROV ALL PT/PS RESTRICTION
4517	Active	BPA-PC-NDC - BILL PROV ALL PT/PS RESTRICTION
4518	Active	BPA-PC-ICD - BILL PROV ALL PT/PS RESTRICTION
4519	Active	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION
4520	Active	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION

4521	Active	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION
4522	Active	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION
4523	Active	BPA-RP-ICD - BILL PROV ALL PT/PS RESTRICTION
4524	Active	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION
4525	Active	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION
4526	Active	BPA-PC-PROC - PROV COUNTY RESTRICTION
4527	Inactive	BPA-PC-NDC - PRIMARY HDR DIAGNOSIS RESTRICTION
4529	Active	BPA-RP-REV - PROV COUNTY RESTRICTION
4530	Active	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION
4532	Active	BPA-RR-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4533	Active	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION
4534	Inactive	BPA-RP-DRG - EMERGENCY DIAGNOSIS RESTRICTION
4535	Active	BPA-RP-ICD - EMERGENCY DIAGNOSIS RESTRICTION
4536	Active	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION
4538	Active	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION
4539	Active	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION
4540	Active	BPA-PC-PROC - QUANTITY RESTRICTION
4541	Inactive	BPA-RP-DIAG - REFER PROV RESTRICTION - INACTIVE
4542	Inactive	BPA-RP-DRG - REFER PROV PRIMARY PT/PS RESTRICTION
4545	Inactive	BPA-RP-PROC - REFER PROV RESTRICTION - INACTIVE
4546	Inactive	BPA-RP-REV - REFER PROV RESTRICTION - INACTIVE
4547	Inactive	BPA-PC-DIAG - REFER PROV RESTRICTION - INACTIVE
4548	Inactive	BPA-PC-DRG - REFER PROV PRIMARY PT/PS RESTRICTION
4551	Inactive	BPA-PC-PROC - REFER PROV RESTRICTION - INACTIVE

4552	Inactive	BPA-PC-REV - REFER PROV RESTRICTION - INACTIVE
4553	Inactive	BPA-RR-DIAG - REFER PROV RESTRICTION - INACTIVE
4554	Inactive	BPA-RR-DRG - REFER PROV PRIMARY PT/PS RESTRICTION
4556	Inactive	BPA-RR-NDC - REFER PROV PRIMARY PT/PS RESTRICTION
4557	Inactive	BPA-RR-PROC - REFER PROV RESTRICTION - INACTIVE
4558	Inactive	BPA-RR-REV - REFER PROV RESTRICTION - INACTIVE
4559	Inactive	BPA-RP-DRG - SECONDARY HDR DIAG RESTRICTION
4560	Active	BPA-RP-ICD - SECONDARY HDR DIAG RESTRICTION
4561	Active	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION
4562	Active	BPA-RP-REV - GENDER RESTRICTION
4563	Active	BPA-RR - NO RULE CURR PERF PROV CONTRACT
4564	Active	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION
4565	Active	BPA-RR-ICD - HDR SECONDARY DIAG RESTRICTION
4566	Active	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION
4580	Active	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP
4581	Active	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP
4711	Active	BPA-PC-DIAG - AGE RESTRICTION
4712	Inactive	BPA-PC-DRG - AGE RESTRICTION
4713	Active	BPA-PC-NDC - AGE RESTRICTION
4714	Active	BPA-PC-PROC - AGE RESTRICTION
4715	Active	BPA-PC-REV - AGE RESTRICTION
4716	Active	BPA-PC-ICD - AGE RESTRICTION
4721	Inactive	BPA-RP-DRG - ADMIT DIAG RESTRICTION
4722	Inactive	BPA-RP-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION
4723	Active	BPA-RP-ICD - PRIMARY HDR DIAGNOSIS RESTRICTION
4724	Active	BPA-RP-ICD - ANY HDR DIAGNOSIS RESTRICTION
4726	Active	BPA-RP-ICD - ADMIT DIAG RESTRICTION
4731	Active	BPA-RP-PROC - ANY DTL DIAG RESTRICTION

4732	Active	BPA-RP-REV - ADMIT DIAG RESTRICTION
4733	Active	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION
4734	Inactive	BPA-PC-DRG - PRIMARY HDR DIAGNOSIS RESTRICTION
4736	Active	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION
4741	Active	BPA-RP-PROC - ADMIT DIAG RESTRICTION
4742	Active	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION
4743	Active	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION
4744	Active	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION
4745	Active	BPA-RP-PROC - ANY HDR DIAGNOSIS RESTRICTION
4746	Active	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION
4747	Active	BPA-PC-ICD - HDR SECONDARY DIAG RESTRICTION
4748	Active	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION
4751	Active	BPA-PC-REV - TYPE OF BILL RESTRICTION
4755	Active	BPA-PC-PROC - CURRENT BENEFIT PLAN RESTRICTION
4756	Active	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION
4757	Active	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION
4760	Active	Med Rvw Restriction for Billed ICD
4762	Active	BPA-PC-ICD - PLACE OF SERVICE RESTRICTION
4765	Active	BPA-RP-ICD - NO COVERAGE
4766	Active	BPA-RP-ICD - AGE RESTRICTION
4767	Active	BPA-RP-ICD - PLACE OF SERVICE RESTRICTION
4768	Active	Med Rvw Restriction for Covered ICD
4775	Active	BPA-PC-NDC - BILL PROV PRIMARY PT/PS RESTRICTION
4776	Active	BPA-PC-DIAG - BILL PROV PRIMARY PT/PS RESTRICTION
4801	Active	BPA-PC-PROC - NO CONTRACT
4802	Active	BPA-PC-DIAG - NO CONTRACT
4803	Active	BPA-PC-NDC - NO CONTRACT
4804	Active	BPA-PC-REV - NO CONTRACT
4805	Inactive	BPA-PC-DRG - NO CONTRACT

4806	Active	BPA-PC-ICD - NO CONTRACT
4812	Active	Med Rvw Restriction for Billed Diagnosis
4813	Active	Med Rvw Restriction for Billed Procedure
4814	Active	Med Rvw Restriction for Billed Rev Code
4821	Active	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION
4822	Active	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION
4831	Active	BPA-RR - NO REIMB RULE
4835	Active	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION
4845	Inactive	Med Rvw Restriction for Billed DRG
4871	Active	BPA-PC-PROC - CLAIM TYPE RESTRICTION
4872	Active	BPA-PC-DIAG - CLAIM TYPE RESTRICTION
4873	Active	BPA-PC-NDC - CLAIM TYPE RESTRICTION
4874	Active	BPA-PC-REV - CLAIM TYPE RESTRICTION
4875	Inactive	BPA-PC-DRG - CLAIM TYPE RESTRICTION
4876	Active	BPA-PC-ICD - CLAIM TYPE RESTRICTION
4881	Inactive	BPA-PC-DRG - PLACE OF SERVICE RESTRICTION
4882	Inactive	BPA-RP-DRG - NO COVERAGE
4883	Inactive	Med Rvw Restriction for Covered DRG
4884	Inactive	BPA-RP-DRG - AGE RESTRICTION
4886	Inactive	BPA-RP-DRG - CLAIM TYPE RESTRICTION
4887	Inactive	BPA-RP-DRG - PLACE OF SERVICE RESTRICTION
4900	Active	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION
4901	Active	BPA-RP-DIAG - CONDITION CODE RESTRICTION
4902	Active	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION
4904	Inactive	BPA-RP-DRG - OTHER HDR DIAGNOSIS RESTRICTION
4905	Active	BPA-RP-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4906	Active	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION
4910	Active	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION
4911	Active	BPA-PC-DIAG - CONDITION CODE RESTRICTION
4912	Active	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION
4913	Active	BPA-XX-DIAG - DIAG ROLE RESTRICTION PC-RR
4917	Inactive	BPA-PC-DRG - OTHER HDR DIAGNOSIS RESTRICTION

4920	Inactive	BPA-RP-DRG - BENE PLAN RESTRICTION
4921	Inactive	BPA-RP-DRG - CONDITION CODE RESTRICTION
4922	Inactive	BPA-RP-DRG - OCCURRENCE CODE RESTRICTION
4923	Active	BPA-PC-ICD - OTHER HDR DIAGNOSIS RESTRICTION
4927	Active	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION
4928	Active	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION
4929	Active	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION
4930	Inactive	BPA-PC-DRG - BENEFIT PLAN RESTRICTION
4931	Inactive	BPA-PC-DRG - CONDITION CODE RESTRICTION
4933	Active	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION
4935	Inactive	BPA-RP-DRG - GENDER RESTRICTION
4936	Inactive	BPA-PC-DRG - GENDER RESTRICTION
4937	Active	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION
4938	Active	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION
4939	Active	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION
4940	Active	BPA-RP-ICD - BENE PLAN RESTRICTION
4941	Active	BPA-RP-ICD - CONDITION CODE RESTRICTION
4942	Active	BPA-RP-ICD - OCCURRENCE CODE RESTRICTION
4943	Active	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION
4944	Active	BPA-PC-ICD - GENDER RESTRICTION
4947	Active	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION
4948	Active	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION
4949	Active	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION
4950	Active	BPA-PC-ICD - BENEFIT PLAN RESTRICTION
4951	Active	BPA-PC-ICD - CONDITION CODE RESTRICTION
4952	Active	BPA-PC-ICD - OCCURRENCE CODE RESTRICTION

4953	Inactive	BPA-RR-DRG - OTHER DTL DIAG RESTRICTION
4960	Active	BPA-RP-NDC - BENE PLAN RESTRICTION
4961	Active	BPA-RP-PROC - PROV COUNTY RESTRICTION
4962	Active	BPA-PC-NDC - GENDER RESTRICTION
4963	Active	BPA-PC-PROC - GENDER RESTRICTION
4964	Active	BPA-PC-REV - GENDER RESTRICTION
4965	Active	BPA-PC-NDC - BENEFIT PLAN RESTRICTION
4966	Active	BPA-RR-PROC - OTHER DTL DIAG RESTRICTION
4970	Active	BPA-RP-REV - BENEFIT PLAN RESTRICTION
4971	Active	BPA-RP-REV - CONDITION CODE RESTRICTION
4972	Active	BPA-RP-REV - OCCURRENCE CODE RESTRICTION
4973	Active	BPA-RR-PROC - ANY DTL DIAG RESTRICTION
4975	Active	BPA-PC-REV - BENEFIT PLAN RESTRICTION
4976	Active	BPA-PC-REV - CONDITION CODE RESTRICTION
4977	Active	BPA-PC-REV - OCCURRENCE CODE RESTRICTION
4980	Active	BPA-RP-PROC - BENEFIT PLAN RESTRICTION
4981	Active	BPA-RP-PROC - CONDITION CODE RESTRICTION
4982	Active	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION
4983	Inactive	BPA-RR-DRG - OTHER HDR DIAGNOSIS RESTRICTION
4990	Active	BPA-PC-PROC - BENEFIT PLAN RESTRICTION
4991	Active	BPA-PC-PROC - CONDITION CODE RESTRICTION
4992	Active	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION
4993	Active	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION
4994	Active	BPA-RP-NDC - SPECIFIC THERA CLASS RESTRICTION
4999	Active	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED
5000	Active	MEDICAL EXACT DUPLICATE - AUTO DENY
5001	Active	MEDICAL SUSPECT DUPLICATE - SUSPEND FOR REVIEW
5002	Active	MEDICAL SUSPECT DUPLICATE - AUTO DENY

5003	Active	ENCOUNTER EXACT DUPLICATE
5005	Active	DENTAL DUPLICATE EXACT - DENY
5006	Active	DENTAL POSSIBLE DUPLICATE- SUSPEND FOR REVIEW
5010	Active	OUTPATIENT DUPLICATE EXACT
5011	Active	OUTPATIENT DUPLICATE POSSIBLE - DENY
5012	Active	OUTPATIENT DUPLICATE POSSIBLE - SUSPEND
5013	Active	INSTITUTIONAL DUPLICATION EXACT
5014	Active	INSTITUTIONAL DUPLICATION POSSIBLE
5015	Active	INSTITUTIONAL DUPLICATION POSSIBLE
5016	Active	INSTITUTIONAL/OUTPATIENT DUPLICATE POSSIBLE
5017	Active	INSTITUTIONAL DUPE POSSIBLE - INPT/LTC
5018	Active	INSTITUTIONAL DUPE POSSIBLE - INPT/OUTPT
5019	Active	ENCOUNTER EXACT DUPLICATE
5020	Active	PHARMACY SUSPECT DUPLICATE OF ANOTHER DRUG CLAIM
5021	Active	PHARMACY EXACT DUPLICATE OF ANOTHER DRUG CLAIM
5022	Active	DUPLICATE RX NUMBER FOR SAME DATE OF SERVICE
5200	Active	ADMIN FEE/VACCINE REPLACEMENT CONTRA
5201	Active	VACCINE REPLACEMENT/ADMIN FEE CONTRA
5202	Active	CHEMO ADMIN FEE/OFFICE VISIT CONTRA
5203	Active	OFFICE VISIT/CHEMO ADMIN FEE CONTRA
5204	Active	ADMIN FEE/LAB CODES CONTRA
5205	Active	LAB CODES/ADMIN FEE CONTRA
5206	Active	ADMIN FEE/FACILITY FEE CONTRA
5207	Active	FACILITY FEE/ADMIN FEE CONTRA
5208	Active	ADMIN FEE/OFFICE VISIT CONTRA
5209	Active	OFFICE VISIT/ADMIN FEE CONTRA
5210	Active	EMERG ROOM/CHEMO ADMIN CONTRA
5211	Active	EMERG ROOM/CHEMO ADMIN CONTRA
5212	Inactive	ADMINISTRATION FEE/PRENATAL/FAMILY PLANNING CONTRA
5213	Active	ADMINISTRATION FEE/PRENATAL/FAMILY PLANNING CONTRA
5214	Active	PROFESSIONAL SERVICES ADMINISTRATION FEE CONTRA
5215	Inactive	DME PROCEDURE - LIMIT 400 PER CAL MO
5216	Active	SINGLE COMPONENT/COMBINATION VACCINES CONTRA

5217	Active	SINGLE COMPONENT/COMBINATION VACCINES CONTRA
5218	Active	SUPPLIES/OFFICE VISIT OR LAB CONTRA
5219	Active	OFFICE VISIT OR LAB/SUPPLIES CONTRA
5230	Active	SUBSEQUENT PROCEDURE/ANESTHESIA CONTRA
5231	Active	ANESTHESIA/SUBSEQUENT PROCEDURE CONTRA
5232	Active	CATHETER PLACEMENT/DAILY MANAGEMENT OF EPIDURAL OR
5233	Active	CATHETER PLACEMENT/DAILY MANAGEMENT OF EPIDURAL OR
5234	Active	PRIMARY ANESTHESIA/INJECTION OR CATHETER 50% ALLOW
5235	Active	PRIMARY ANESTHESIA/INECTION OR CATHETER 50% ALLOW
5236	Active	QUALIFYING PROCEDURE CODE LIMIT
5237	Active	ANESTHESIA-MODIFIER COMBINATION INVALID
5238	Active	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES
5239	Active	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES
5240	Active	ALS TRANSPORTATION/SUPPLY CONTRA
5241	Active	ALS TRANSPORTATION/SUPPLY CONTRA
5242	Active	NET EXACT DUPE
5260	Active	HEARING AID/BATTERY CONTRA
5261	Active	BATTERY/HEARING AID CONTRA
5262	Active	AUDIOLOGY COMPREHENSIVE VISIT CONTRA
5270	Active	CRS CLINIC CONTRA
5271	Active	CRS CLINIC CONTRA
5280	Active	SKIN BARRIER CONTRA
5281	Active	SKIN BARRIER CONTRA
5282	Active	OSTOMY POUCH CONTRA
5283	Active	OSTOMY POUCH CONTRA
5284	Active	MISCELLANEOUS DME CODES CONTRA (WALKERS, CRUTCHES,
5285	Active	DME HUMIDIFIER OR CPAP/CPAP CONTRA
5286	Active	DME CPAP OR HUMIDIFIER/CPAP CONTRA
5287	Active	DME CATHETER CONTRA FOR A4221
5288	Active	DME HUMIDIFIER OR BIPAP/BIPAP CONTRA
5289	Active	DME BIPAP OR HUMIDIFIER/BIPAP CONTRA
5291	Active	DME RB INVALID WITHIN WHEELCHAIR WARRANTY

5300	Active	DENTAL PULPAL THERAPY (D3220) SAME DATE OF SERVICE
5301	Active	DENTAL PULPAL THERAPY (D3220) ANY DOS CONTRA
5302	Active	DENTAL PULPAL THERAPY (D3310)SAME DOS CONTRA
5303	Active	DENTAL PULPAL THERAPY (D3310) SAME DOS CONTRA
5304	Active	DENTAL PULPAL THERAPY (D3320) SAME DOS CONTRA
5305	Active	DENTAL PULPAL THERAPY (D3320) SAME DOS CONTRA
5306	Active	DENTAL PULPAL THERAPY (D3330) SAME DOS COTNRA
5307	Active	DENTAL PULPAL THERAPY (D3330) SAME DOS CONTRA
5308	Active	DENTAL PULPAL THERAPY (D3351) SAME DOS CONTRA
5309	Active	DENTAL PULPAL THERAPY (D3351) SAME DOS CONTRA
5310	Active	DENTAL PULPAL THERAPY (D3410) SAME DOS CONTRA
5311	Active	DENTAL PULPAL THERAPY (D3410) SAME DOS CONTRA
5312	Active	DENTAL PULPAL THERAPY (D3430) SAME DOS CONTRA
5313	Active	DENTAL PULPAL THERAPY (D3430) SAME DOS CONTRA
5314	Active	DENTAL PULPAL THERAPY (D3220) DOS CONTRA
5315	Active	DENTAL PULPAL THERAPY (D3220) ANY DOS CONTRA
5316	Active	DENTAL PULPAL THERAPY (D3230) ANY DOS CONTRA
5317	Active	DENTAL PULPAL THERAPY (D3230) ANY DOS CONTRA
5318	Active	DENTAL PULPAL THERAPY (D3240) ANY DOS CONTRA
5319	Active	DENTAL PULPAL THERAPY (D3240) ANY DOS CONTRA
5320	Active	DENTAL PULPAL THERAPY (D3310) ANY DOS CONTRA
5321	Active	DENTAL PULPAL THERAPY (D3310) ANY DOS CONTRA
5322	Active	DENTAL PULPAL THERAPY (D3332) ANY DOS CONTRA

5323	Active	DENTAL - PULP THERAPY COMBINATION NOT ALLOWED
5324	Active	PROPHYLAXIS/FLUORIDE FRAGMENTED BILLING SAME/DIFFE
5325	Active	PROPHYLAXIS/FLUORIDE FRAGMENTED BILLING SAME/DIFF
5326	Active	DENTAL-CORE BUILDUP CONTRA (FLIP SIDE B80)
5327	Active	DENTAL-CORE BUILDUP CONTRA (FLIP SIDE 703)
5328	Active	DENTAL-POST/CORE/RESTORATION/CROWNS CONTRA (FLIP S
5329	Active	DENTAL-POST/CORE/RESTORATION/CROWNS CONTRA (FLIP S
5330	Active	DENTAL- CROWNS CONTRA
5331	Active	DENTAL CROWNS/RESTORATION CONTRA
5332	Active	X-RAYS INCLUDED IN ROOT CANAL THERAPY
5333	Active	ROOT CANAL THERAPY INCLUDES X-RAYS
5334	Active	DEFINITIVE TX/PALLIATIVE(EMERGENCY)TX CONTRA
5335	Active	PALLIATIVE (EMERGENCY) TX/ DEFINITIVE TX CONTRA
5336	Active	DENTAL-CROWNS/RECEMENT OF CROWN SIX-MONTH CONTRA
5338	Active	DENTAL ORAL EVALUATION CONTRA
5339	Inactive	INTENTIONALLY NOT USED
5340	Active	DENTAL ORAL EVALUATION < 3 YRS (D0145) CONTRA
5341	Inactive	INTENTIONALLY NOT USED
5342	Active	DENTAL FLUORIDE VARNISH SAME DOS CONTRA
5350	Active	EXTRACTION/SPACE MAINTAINER CONTRA
5351	Active	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVIC
5352	Active	OTHER PROC/DENTAL EXTRACT CONTRA
5353	Active	DENTAL EXTRACT/OTHER PROC CONTRA
5354	Active	DEFINITIVE TX/SEDATIVE FILLING CONTRA
5355	Active	SEDATIVE FILLING /DEFINITIVE TX CONTRA
5400	Active	HOSPITAL VISITS/EPSDT SCREENING CONTRA
5401	Active	HOSPITAL VISITS/EPSDT SCREENING CONTRA

5402	Active	ANCILLARY SVC/EPSDT SCREENING CONTRA
5403	Active	EPSDT SCREENING/ANCILLARY SVC CONTRA
5404	Active	EPSDT CONTRA
5410	Active	FITTING OF CONTACT LENS CONTRA
5411	Active	FITTING OF CONTACT LENS CONTRA
5412	Active	VISION CARE CONTRA -V2020
5413	Active	VISION CARE CONTRA - V2025
5414	Active	EPSDT VISION SCREEN / EXTERNAL OCULAR PHOTOGRAPHY
5415	Active	EPSDT VISION SCREEN / EXTERNAL OCULAR PHOTOGRAPHY
5416	Active	TONO/VISUAL FIELDS COMPR EXAM CONTRA
5417	Active	TONO/VISUAL FIELDS COMPR EXAM CONTRA
5430	Active	INITIAL/SUBSEQUENT FAMILY PLANNING CONTRA
5431	Active	SUBSEQUENT/INITIAL FAMILY PLANNING CONTRA
5432	Active	PRENATAL VISIT/FAMILY PLANNING CONTRA
5433	Active	PRENATAL VISIT/FAMILY PLANNING CONTRA
5434	Active	HOME VISIT CONTRA (FAMILY PLANNING)
5436	Active	SALPINGECTOMY TUBAL LIGATION CONTRA
5437	Active	SALPINGECTOMY TUBAL LIGATION CONTRA
5438	Active	EPSDT/FAMILY PLANNING CONTRA
5439	Active	FAMILY PLANNING/EPSDT CONTRA
5440	Active	FAMILY PLANNING/STERILIZATION CONTRA
5441	Active	STERILIZATION/FAMILY PLANNING CONTRA
5442	Active	FP-LEVONORGESTREL-CONTRA (J7302-5 YR)
5443	Active	FP-LEVONORGESTREL-CONTRA (Q0090-3 YR)
5451	Active	HOME HEALTH IP/OP SERVICES BILLED ON SAME CLAIM
5455	Active	HOSPICE ONE PER DAY CONTRA
5456	Active	HOSPICE ROUTINE CARE DOD REQUIRED FOR RN/SW ADD-ON
5457	Active	HOSPICE CONTINUOUS CARE VS RN/SW ADD-ON PAYMENT CO
5460	Active	ANCILLARY PROCS/OUTPT SURGERY CONTRA
5461	Active	OUTPT SURGERY/ANCILLARY PROCS CONTRA

5462	Active	SERVICE CODE INCLUDED IN REVENUE CODE 450
5464	Active	LAB PROCS/OUTPT SURGERY CONTRA
5465	Active	OUTPT SURGERY/LAB PROCS CONTRA
5470	Active	CBC/PLATELET COUNT CONTRA
5471	Active	CBC/PLATELET COUNT CONTRA
5472	Active	COMPONENTS/CHEMISTRY PANEL CONTRA
5473	Active	CHEMISTRY PANEL/COMPONENTS CONTRA
5474	Active	DIFF WBC/CBC WITH DIFF WBC CONTRA
5475	Active	CBC WITH DIFF WBC/DIFF WBC CONTRA
5476	Active	COMPONENTS & CBC NOT ALLOWED ON SAME DAY
5477	Active	CBC & COMPONENTS NOT ALLOWED ON SAME DAY
5478	Active	COMPONENTS AND U/A NOT ALLOWED ON SAME DAY
5479	Active	U/A AND COMPONENTS NOT ALLOWED ON SAME DAY
5480	Active	BLOOD COUNT COMPONENTS/ BLOOD COUNT CONTRA
5481	Active	BLOOD COUNT/BLOOD COUNT COMPONENTS CONTRA
5482	Active	COMPONENTS/HEMOGRAM & CBC CONTRA
5483	Active	HEMOGRAM & CBC/COMPONENTS CONTRA
5484	Active	MULTIPLE URINALYSIS COMPONENTS
5486	Active	LAB-PANEL TEST CONTRA
5488	Active	CBC AND COMPONENTS LIMIT
5489	Inactive	CBC AND COMPONENTS LIMIT OUTPATIENT
5490	Active	LAB-CHLAMYDIA/GONORRHEA CONTRA
5500	Active	FETAL DOPPLER/ECHOCARDIOGRAPHY CONTRA
5501	Active	FETAL DOPPLER/ECHOCARDIOGRAPHY CONTRA
5502	Active	FETAL ECHOCARDIOGRAPHY CONTRA
5503	Active	FETAL ECHOCARDIOGRAPHY CONTRA
5504	Active	POSTPARTUM/PRENATAL VISIT CONTRA
5505	Active	POSTPARTUM/PRENATAL VISIT CONTRA
5506	Active	ATTENDANCE AT C-SECTION CONTRA
5507	Active	ATTENDANCE AT C-SECTION CONTRA
5508	Active	C-SECTION/TUBAL LIGATION 50% ALLOW
5509	Active	C-SECTION/TUBAL LIGATION 50% ALLOW
5510	Active	PRENATAL CLINIC POSTPARTUM CONTRA
5511	Active	PRENATAL CLINIC POSTPARTUM CONTRA
5512	Active	PRENATAL/POSTPARTUM VISIT CONTRA
5513	Active	PRENATAL/POSTPARTUM VISIT CONTRA

5514	Active	DELIVERY ONLY / OTHER CONTRA
5515	Active	DELIVERY ONLY / OTHER CONTRA
5516	Active	NURSES MIDWIFE CONTRA
5517	Active	NURSES MIDWIFE CONTRA
5518	Active	DELIVERY/LOCAL ANESTHESIA CONTRA
5519	Active	DELIVERY/LOCAL ANESTHESIA CONTRA
5520	Active	DELIVERY/REGIONAL ANESTHESHIA CONTRA
5521	Active	DELIVERY/REGIONAL ANESTHESIA CONTRA
5522	Active	ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CARE
5523	Active	ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CARE
5524	Active	ROUTINE POST PARTUM CARE PART OF TOTAL OB
5525	Active	ROUTINE POST PARTUM CARE PART OF TOTAL OB
5526	Active	MATERNITY GLOBAL/ANESTHESIA NEGATIVE CONTRA
5527	Active	MATERNITY GLOBAL/DELIVERY NEGATIVE CONTRA
5528	Active	MATERNITY GLOBAL/ULTRASOUND NEGATIVE CONTRA
5529	Active	MATERNITY GLOBAL/URINALYSIS NEGATIVE CONTRA
5530	Active	MATERNITY GLOBAL/BLOOD TEST NEGATIVE CONTRA
5531	Active	MATERNITY GLOBAL/ANTEPARTUM CARE NEGATIVE CONTRA
5600	Active	SUBSEQUENT PROCEDURE/CRITICAL CARE CONTRA
5601	Active	CRITICAL CARE/SUBSEQUENT PROCEDURE CONTRA
5602	Active	MISCELLANEOUS SERVICES EMERGENCY ROOM CONTRA
5603	Active	MISCELLANEOUS SERVICES EMERGENCY ROOM CONTRA
5604	Active	PHYSICIANS-OTOLARYNGOLOGIC EXAM/EAR,NOSE,THROAT,PR
5605	Active	PHYSICIAN-OTOLARYNGOLOGIC EXAM/EAR,NOSE THROAT,PRO
5606	Active	PHYSICIAN/INFUSION THERAPY CONTRA (FLIP SIDE B84)
5607	Active	PHYSICIAN/INFUSION THERAPY CONTRA (FLIP SIDE 732)

5608	Active	PHYSICIAN/APPLICATION AND REMOVAL OF CAST/STRAPPIN
5609	Active	PHYSICIAN/APPLICATION AND REMOVAL OF CAST/STRAPPIN
5610	Active	PROFESSIONAL SERVICES/IMMUNOTHERAPY CONTRA
5611	Active	IMMUNOTHERAPY/PROFESSIONAL SERVICES CONTRA
5612	Active	ALLERGEN IMMUNOTHERAPY CONTRA
5613	Active	ALLERGEN IMMUNOTHERAPY CONTRA
5614	Active	PHYSICIAN VISIT/DIALYSIS PROCEDURE CONTRA
5615	Active	DIALYSIS PROCEDURE/PHYSICIAN VISIT CONTRA
5616	Active	NICU/PICU/Subsequent Procedure Contra
5617	Active	NICU/PICU/Subsequent Procedure Contra
5618	Active	NEWBORN RESUSCITATION/INTUBATION CONTRA
5619	Active	NEWBORN RESUSCITATION/INTUBATION CONTRA
5620	Active	NICU/RESUSCITATION/STANDBY CONTRA
5621	Active	NICU/RESUSCIATATION/STANDBY CONTRA
5622	Active	HOSPITAL VISIT/ELECTROSHOCK THERAPY CONTRA
5623	Active	ELECTROSHOCK THERAPY/HOSPITAL VISIT CONTRA
5624	Active	INITIAL HOSPITAL CARE/EMERGENCY ROOM CONTRA
5625	Active	EMERGENCY ROOM/INITIAL HOSPITAL CARE CONTRA
5626	Active	HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA
5627	Active	HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA
5628	Active	REDUCTION MAMMOPLASTY CONTRA
5629	Active	REDUCTION MAMMOPLASTY CONTRA
5630	Active	INCIDENTAL SURGERY FOR AUDIT 850
5631	Active	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SUR
5632	Active	INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE SUR
5633	Active	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILL
5634	Active	HOSPITAL VISIT/DISCHARGE CONTRA
5635	Active	DISCHARGE/HOSPITAL VISIT CONTRA

5636	Active	HYSTERECTOMY/ADDITIONAL PROC CONTRA
5637	Active	HYSTERECTOMY/ADDITIONAL PROC CONTRA
5638	Active	DELIVERY/HOSPITAL VISIT CONTRA
5639	Active	DELIVERY/HOSPITAL VISIT CONTRA
5640	Active	HOSPITAL ADMISSION/SUBSEQUENT VISIT
5641	Active	HOSPITAL ADMISSION/SUBSEQUENT VISIT CONTRA
5642	Active	ABORTION/LINE-ITEM CONTRA
5643	Active	ABORTION/LINE-ITEM CONTRA
5644	Active	SUBSEQUENT CRITICAL CARE HOSPITAL VISIT CONTRA
5645	Active	SUBSEQUENT CRITICAL CARE HOSPITAL VISIT CONTRA
5646	Active	ROUTINE CARE INCLUDED IN SURGERY FEE
5647	Active	SURGERY FEE INCLUDES ROUTINE CARE
5648	Active	ALLERGY CODES SAME DAY CONTRA
5650	Active	OUTPATIENT OBSERVATION CONTRA
5652	Active	INITIAL NICU CODE CONTRA
5653	Active	SURGERY/CASTING & STRAPPING CONTRA
5654	Active	CASTING & STRAPPING/SURGERY CONTRA
5655	Active	MULTIPLE SURGERY CONTRAS
5656	Active	MULTIPLE SURGERY SAME DAY
5658	Active	PROVIDER SPECIALTY CONTRA
5660	Active	HOSPITAL ADMISSION CODE CONTRA
5661	Active	SUBSEQUENT CRITICAL CARE (99292) NOT VALID W/O INI
5664	Active	INITIAL OFFICE VISIT/ PRIOR VISIT CONTRA
5665	Active	PRIOR VISIT/INITIAL OFFICE VISIT CONTRA
5666	Active	NEW PATIENT/EXISTING PATIENT
5667	Active	EXISTING PATIENT/NEW PATIENT
5710	Active	INDIVIDUAL COUNSELING PSYCHOTHERAPY CONTRA
5711	Active	INDIVIDUAL COUNSELING PSYCHOTHERAPY CONTRA
5712	Active	GROUP COUNSELING OR PSYCHOTHERAPY CONTRA
5713	Active	GROUP COUNSELING OR PSYCHOTHERAPY CONTRA
5714	Active	MEDICATION ADMINISTRATION/MEDICAL MONITORING CONTR
5715	Active	MEDICATION ADMINISTRATION/MEDICAL MONITORING CONTR
5716	Active	INDIVIDUAL COUNSELING SUBSTANCE ABUSE CONTRA

5717	Active	INDIVIDUAL COUNSELING-SUBSTANCE ABUSE CONTRA
5718	Active	MENTAL HEALTH REHAB CONTRA
5719	Active	MENTAL HEALTH REHAB CONTRA
5720	Active	INTAKE EVALUATION/OTHER PSYCHIATRIC CONTRA
5721	Active	OTHER PSYCHIATRIC/INTAKE EVALUATION CONTRA
5722	Active	PHYSICIAN MEDICAL ASSESSMENT AND TREATMENT
5723	Active	PHYSICIAN MEDICAL ASSESSMENT AND TREATMENT
5724	Inactive	IN-HOME/CRISIS INTERVENTION CONTRA
5725	Inactive	CRISIS/IN-HOME INTERVENTION CONTRA
5726	Active	OTHER PSYCH/CHILD & ADOLESCENT DAY TX CONTRA
5727	Active	CHILD & ADOLESCENT DAY TX/OTHER PSYCH CONTRA
5728	Active	ASSESS/INTENSIVE OUTPATIENT SERVICES CONTRA
5729	Active	INTENSIVE OUTPATIENT SERVICES/ASSESS CONTRA
5730	Active	PHARMACOLOGIC MANAGE/PSYCHOTHERAPY CONTRA
5731	Active	PSYCHOTHERAPY/PHARMACOLOGIC MANAGE CONTRA
5732	Active	PSYCHOTHERAPY/HOSPITAL VISITS CONTRA
5733	Active	HOSPITAL VISITS/PSYCHOTHERAPY CONTRA
5734	Active	PSYCHOTHERAPY/OFFICE VISITS CONTRA
5735	Active	PSYCHOTHERAPY/OFFICE VISITS CONTRA
5736	Active	DIAGNOSTIC TESTING CONTRA
5738	Active	REHAB DAY PROGRAM CONTRA
5740	Inactive	INDIVIDUAL AND GROUP THERAPY CONTRA (MHSP)
5750	Active	ULTRASOUND ECHOGRAPHY CONTRA
5751	Active	ULTRASOUND ECHOGRAPHY CONTRA
5752	Active	ABDOMINAL U/S / OB U/S (PROF COMP) CONTRA
5753	Active	OB U/S / ABDOMINAL U/S (PROF COMP) CONTRA
5754	Active	RADIOLOGY CONTRA AUDIT - Medical Only
5755	Active	RADIOLOGY CONTRA AUDIT - Medical and Outpatient
5760	Active	ESWL PRICING
5761	Active	ESWL PRICING OUTPATIENT
5770	Active	IRHC SAME DAY CONTRA

5780	Inactive	TCM VS CASE MANAGEMENT CONTRA
5790	Active	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA
5791	Active	PHYSICAL THERAPY TO ONE AREA CONTRA
5792	Active	PHYSICAL THERAPY APPLIANCES CONTRA
5800	Active	WAIVER:RESPITE OR PERSONAL/RESIDENTIAL CONTRA
5801	Active	WAIVER:RESIDENTIAL/RESPITE OR PERSONAL CONTRA
5802	Active	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT
5803	Active	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT
5804	Active	WAIVERED SERVICES -RESPITE CARE
5805	Active	WAIVER EXACT DUPLICATE
5811	Active	HEARING AND VISION SCREENINGS REQUIRE EP MODIFIER
5812	Active	POST CATARACT CONTRA
5813	Active	POST CATARACT CONTRA
5814	Active	OPERATING MICROSCOPE/INCLUSIVE COMPONENT CONTRA
5815	Active	VISION AND HEARING SCREENING
5816	Active	HIV FAMILY PLANNING CONTRA
5817	Active	NURSERY DAYS INVALID
5818	Active	THERAPY PROC PAYABLE W/THERAPEUTIC TREATMENT ONLY
5819	Active	OP OBSERVATION MUST BE BILLED WITH FACILITY FEE
5820	Active	LTC VENT CANNOT BE BILLED WITHOUT LTC STAY
5821	Active	ADD ON CODE WITHOUT PRIMARY CODE
5822	Active	AVASTIN J9035 NEGATIVE CONTRA
5823	Active	PACE NH DEPENDENT ON PACE NON-NH BILLING
5824	Inactive	FAMILY PLANNING - LARC OUTPT REQUIRES INPT
5825	Active	FAMILY PLANNING OUTPT LARC REQUIRES INPT
5826	Active	FAMILY PLANNING OUTPT LARC REQUIRES INPT J CODES
5830	Active	ROOT CANAL CONTRA - FOR HISTORY PCODE D3310
5831	Active	ROOT CANAL CONTRA - FOR HISTORY PCODE D3320
5832	Active	ROOT CANAL CONTRA - FOR HISTORY PCODE D3330

5900	Active	NCCI-MUE - MAXIMUM QUANTITY EXCEEDED
5910	Active	NCCI-PRACTITIONER - SAME CLAIM
5911	Active	NCCI-PRACTITIONER - DIFFERENT CLAIM, LESSER PROC
5912	Active	NCCI-PRACTITIONER - DIFFERENT CLAIM, GREATER PROC
5920	Active	NCCI-OUTPATIENT - SAME CLAIM
5921	Active	NCCI-OUTPATIENT - DIFFERENT CLAIM, LESSER PROC
5922	Active	NCCI-OUTPATIENT - DIFFERENT CLAIM, GREATER PROC
5930	Active	NCCI DENIED DUPE AUDIT
5940	Active	NCCI-DME - SAME CLAIM
5941	Active	NCCI-DME - DIFFERENT CLAIM, LESSER PROC
5942	Active	NCCI-DME - DIFFERENT CLAIM, GREATER PROC
6001	Active	PROCEDURE CODE EXCEEDS 4 UNITS PER CALENDAR MONTH
6010	Active	ASC VISIT LIMIT (CLAIMS PER YEAR)
6020	Active	BINAURAL HEARING AID REPAIR LIMIT
6021	Active	HEARING AID BATTERY (Z5065) LIMIT
6022	Active	EAR MOLDS LIMITATION
6023	Active	HEARING AID REPAIR LIMIT
6024	Active	HEARING AID STHETHOSCOPE LIMIT
6025	Active	EARMOLDS LIMITATION - BINAURAL
6026	Active	HEARING AID BATTERY LIMIT--BINAURAL
6030	Active	PROCEDURE LIMIT ONCE PER LIFE
6040	Active	DENTAL PERIAPICAL X-RAYS - LIMIT 5 PER CAL YEAR
6041	Active	DENTAL PROCEDURE D9420 LIMITED TO 4 TIMES PER YEAR
6042	Active	DENTAL PROCEDURE D9420 LIMITED TO 30 DAYS
6043	Active	DENTAL PROCEDURE D9420 LIMITED TO 4 TIMES PER YEAR
6044	Active	LIMITATION AUDIT FOR D0140
6045	Active	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFET
6046	Active	DENTAL PROCEDURE SIX-MONTH LIMITATIONS
6047	Active	DENTAL PROPHYLAXIS LIMITATION
6048	Active	DENTAL FLUORIDE LIMITATION
6049	Active	DENTAL TWO PER LIFETIME PER TOOTH
6050	Active	INITIAL AND PERIODIC ORAL EXAM LIMIT
6051	Active	FULL SERIES/PANORAMIC X-RAY LIMIT

6052	Active	SPACE MAINTAINER LIMIT
6053	Active	INITIAL DENTAL EXAM CONTRA
6054	Active	DENTAL ORAL EVALUATION < 3 YRS (D0145) LIMIT
6056	Active	DENTAL FLOURIDE VARN < 3YRS - LIMIT 3 PER CAL YEAR
6057	Active	DENTAL FLOURIDE VARNISH < 3YRS - LIMIT 6 TOTAL
6058	Active	DENTAL FLOURIDE VARNISH > 3 YRS - LMT 1 PER YEAR
6059	Active	DENTAL FLOURIDE VAR FREQ < 3 YRS- LMT 1 PER 90 DAY
6060	Active	DENTAL BITEWING X-RAYS - LIMIT 1 PER 6 CAL MO
6061	Active	DENTAL PROCEDURE LIMIT - 1 PER DATE OF SERVICE
6062	Active	DENTAL CROWNS LIMITED TO 6 PER DAY
6063	Active	DENTAL CORE LIMITED TO 6 PER DAY
6064	Active	DENTAL PULPAL THERAPY LIMITED TO 6 PER DAY
6065	Active	DENTAL ENDONTIC THERAPY LIMITED TO 6 PER DAY
6066	Active	DENTAL RESTORATION LIMIT 1 PER 6 MONTH SAME TOOTH
6067	Active	DENTAL RESTORATION LIMIT 1 PER 12 MO SAME SURFACE
6070	Active	DENTAL PERIAPICAL X-RAY LIMIT
6100	Active	DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH
6101	Active	DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH
6102	Active	DME PROCEDURE LIMITED TO 1 PER 5 CALENDAR YEARS
6103	Active	POUCH - DRAINABLE (A5061) 30 PER MONTH
6104	Active	DME PROCEDURE LIMIT OF 700 PER CALENDAR MONTH
6105	Active	DME CLOSED POUCH TOTAL LIMIT OF 60 PER CAL MONTH
6106	Active	DME PROCEDURE LIMIT 30 PER MONTH
6107	Active	DME PROCEDURE LIMITED TO 40 PER CALENDAR MONTH
6108	Active	DME WC PRESSURE PAD TOTAL LIMIT OF 1 PER CAL YEAR
6109	Active	STERILE/NON-STERILE GLOVE MONTHLY LIMIT

6110	Active	DME TEST STRIPS LIMIT 2 PER CALENDAR MONTH
6111	Active	DME PROCEDURE LIMIT OF THREE PER CALENDAR MONTH
6112	Active	DME PROCEDURE LIMIT OF TWO PER CALENDAR MONTH
6113	Active	DME PROCEDURE LIMITED TO 31 PER CALENDAR MONTH
6114	Active	DME PROCEDURE LIMITED TO 2 PER CALENDAR YEAR
6115	Active	MEDICAL SUPPLIES/APPLIANCES LIMIT
6116	Active	DME PROCEDURE LIMITED TO 1 PER 4 CALENDAR YEARS
6117	Active	DME PROCEDURE LIMITED TO 3 PER CALENDAR MONTH
6118	Active	PROCEDURE CODE LIMIT TO 2 PER CALENDAR MONTH
6119	Inactive	NEBULIZER WITH COMPRESSOR LIMIT
6120	Active	SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES
6121	Active	DME PROCEDURE LIMITED TO 1 PER CALENDAR YEAR
6122	Active	LEG BAG WITH TUBE
6123	Active	DME PROCEDURE LIMITED TO 8 PER CALENDAR YEAR
6124	Active	DME PROCEDURE LIMITED TO 1 PER 3 CALENDAR YEARS
6125	Active	DME PROCEDURE LIMITED TO 2 PER CALENDAR MONTH
6126	Active	DME PROCEDURE LIMITED TO 120 PER CALENDAR MONTH
6127	Active	DME PROCEDURE LIMITED TO 400 PER CALENDAR MONTH
6128	Active	DME PROCEDURE LIMITED TO 1 PER CALENDAR MONTH
6129	Active	DME PROCEDURE LIMITED TO 4 PER CALENDAR MONTH
6130	Active	DME PROCEDURE LIMITED TO 5 PER CALENDAR MONTH
6131	Active	DME PROCEDURE LIMITED TO 10 PER CALENDAR MONTH
6132	Active	DME PROCEDURE LIMITED TO 12 PER CALENDAR MONTH
6133	Active	DME PROCEDURE LIMITED TO 50 PER CALENDAR MONTH

6134	Active	DME PROCEDURE LIMITED TO 90 PER CALENDAR MONTH
6135	Active	DME PROCEDURE LIMITED TO 100 PER CALENDAR MONTH
6136	Active	DME PROCEDURE LIMITED TO 500 PER CALENDAR MONTH
6137	Active	DME PROCEDURE LIMITED TO 1000 PER CALENDAR MONTH
6138	Active	DME PROCEDURE LIMITED TO 1 PER 2 CALENDAR YEARS
6139	Active	DME PROCEDURE LIMITED TO 4 PER CALENDAR YEAR
6140	Active	DME PROCEDURE RENTAL LIMITED TO 1 PER CALENDAR MON
6141	Active	DME PROCEDURE RENTAL LIMITED TO 2 PER CALENDAR MON
6142	Active	DME PROCEDURE RENTAL LIMITED TO 31 PER CALENDAR MO
6143	Active	DME BATTERY CHARGER TOTAL LIMIT OF 1 PER CALENDAR
6144	Active	DME BATTERY TOTAL LIMIT OF 2 PER CALENDAR YEAR
6145	Active	DME NON-INSULIN PROC LIMIT OF 2 PER 3 CAL MO
6146	Active	DME NON-INSULIN PROC LIMIT OF 1 PER 3 CAL MO
6147	Active	DME INSULIN PROC LIMIT OF 4 PER CAL MO
6148	Active	DME INSULIN PROC LIMIT OF 3 PER CAL MO
6149	Active	DME INSULIN PROC LIMIT OF 2 PER CAL MO
6150	Active	VISION AND HEARING SCREENING ONE PER YEAR
6151	Active	INITIAL SCREENING LIMIT
6152	Active	EPSDT SCREENING LIMIT UNDER 1 YEAR
6153	Active	EPSDT SCREENING LIMIT 1 THRU 2 YEARS OF AGE
6154	Active	EPSDT - Intensive Assessment Limit
6155	Active	EPSDT SCREENING LIMIT 3 THRU 20 YEARS
6179	Active	EYE EXAM LIMIT (21 AND >) 11/2012 REINSTATED
6180	Active	OPTOMETRIC LENS LIMIT
6181	Active	EYE OPTOMETRIC LENS LIMIT (21 AND >) 11/2012
6182	Active	EYE OPTOMETRIC FRAME LIMIT (21 AND >) 11/2012
6183	Active	EYE EXAM LIMIT (21 AND OLDER)
6184	Active	EYE FITTING EXAM LIMIT (21 AND >) 11-2012

6185	Active	EYE LENS LIMIT LESS THAN 21
6186	Active	EYE FRAME LIMIT LESS THAN 21
6187	Active	EYE EXAM LIMIT LESS THAN 21
6188	Active	EYE FITTING LIMIT LESS THAN 21
6189	Active	EYE EXAM LIMIT 1 PER 3 YR (21 AND OLDER)
6190	Active	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND OLDER)
6191	Active	EYE REFRACTION LIMIT LESS THAN 21
6192	Active	EYE REFRACTION LIMIT 1 PER 2 YEARS (21 AND >) 2012
6193	Active	EYE EXAM LIMIT 1 PER 3 YR (21 AND >) 03/2013
6194	Active	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND >) 03/2013
6195	Active	EYE FRAME LIMIT 1 PER 3 YR (21 AND >) 03/2013
6196	Active	EYE LENS LIMIT 1 PER 3 YR (21 AND >) 03/2013
6197	Active	EYE FITTING LIMIT 1 PER 3 YR (21 AND >) 03/2013
6200	Active	BIRTH CONTROL PILLS LIMIT - 16 PER YEAR
6201	Active	FAMILY PLANNING PERIODIC FOLLOW-UP LIMIT
6202	Active	HIV COUNSELING YEARLY LIMIT
6203	Active	EXTENDED FAMILY PLANNING VISIT LIMIT
6204	Active	INITIAL FAMILY PLANNING VISIT LIMIT
6205	Active	ANNUAL FAMILY PLANNING VISIT LIMIT
6206	Active	NORPLANT INSERTION LIMITATIONS
6207	Active	NORPLANT PROCEDURE CONTRA
6208	Active	DEPO-PROVERA INJECTION LIMIT (J1055)
6209	Active	Family Planning Home Visit Limitation
6210	Active	LEVONORGESTREL IU LIMIT - 1 PER 5 YRS
6211	Active	DEPO-PROVERA INJECTION LIMIT (J1050-FP)
6212	Active	FP-LEVONORGESTREL-IU LIMIT-1 PER 3 YRS
6213	Active	CARE COORDINATION FOR MALES W/UA MODIFIER'
6214	Active	CARE COORDINATION FOR MALES W/UB, UC, UD MODIFIERS
6230	Active	FQHC MEDICAL ENCOUNTER CONTRA (Z5298)
6231	Active	FQHC DENTAL ENCOUNTER CONTRA (D9430)
6240	Active	HBO-AIR OR GAS LIMIT
6241	Active	HBO-CARBON MONOXIDE POISON & SMOKE INHALATION LIMI
6242	Active	HBO-DECOMPRESSION SICKNESS LIMIT

6243	Active	HBO-GAS GANGRENE LIMIT
6244	Active	HBO-CRUSH INJURY LIMIT
6245	Active	HBO-PYODERMA LIMIT
6246	Active	HBO-HEAL WOUND LIMIT
6247	Active	HBO-OSTEOMYELITIS LIMIT
6248	Active	HBO-RADIATION TISSUE DAMAGE LIMIT
6249	Active	HBO-SKIN GRAFTS AND FLAPS LIMIT
6260	Active	HOME HEALTH VISIT LIMITATION
6270	Active	HOSPICE ONE (1) UNIT PER DAY
6280	Active	CARDIAC REHAB SERVICE LIMIT(OUTPATIENT)
6281	Active	OUTPATIENT VISIT LIMIT
6282	Active	HOSPITAL DAYS-LIMIT EXCEEDED (HARDCODED)
6283	Active	NURSERY DAYS INVALID FOR SINGLE NEWBORN
6284	Active	MEPD FISCAL YEAR DOLLAR LIMIT
6285	Active	HOSPITAL EMERG LIMIT 3 DAYS PER ADMIT
6286	Active	NURSERY DAYS INVALID FOR TWINS
6287	Active	NURSERY DAYS INVALID FOR TRIPLETS
6290	Active	MULTIPLE URINALYSIS LIMIT
6291	Active	SPECIMEN COLLECTION FEE LIMIT ONE PER DAY
6292	Active	LAB DRUG SCREENING LIMIT OF 1 PER DAY
6293	Active	LAB - DRUG SCREENING LIMIT OF 1 EVERY 7 DAYS
6300	Active	PRENATAL EDUCATION LIMIT
6301	Active	MIDWIFE OBSTETRICAL CARE LIMIT
6302	Active	PRENATAL OFFICE VISIT LIMIT
6303	Active	OBSTETRICAL CARE LIMIT
6304	Active	OBSTETRICAL CARE LIMIT FOR SPECIALTY 921
6305	Active	ES - VAGINAL DELIVERY LIMIT
6306	Active	ES - C-SECTION LIMIT
6307	Active	PRENATAL OFFICE VISIT LIMIT PERINATOLOGIST
6308	Active	TOBACCO CESSATION COUNSELING LIMIT 4 PER 12 MONTHS
6309	Active	TOBACCO CESSATION COUNSELING LIMIT 1 PER DAY
6310	Active	PHARMACY MAX QUANTITY EXCEEDED FOR 30-DAY PERIOD L
6311	Active	PHARMACY QTY DISPENSED EXCEEDS MAX QTY BASED ON PA

6312	Active	PHARMACY MAX PRESCRIPTION LIMIT EXCEEDED FOR CALEN
6313	Active	PHARMACY MAX PRESCRIPTION LIMIT EXCEEDED FOR CALEN
6314	Active	PHARMACY MAX PRESCRIPTION LIMIT EXCEEDED FOR CALEN
6315	Active	PHARMACY MAX PRESCRIPTION LIMIT EXCEEDED FOR CALEN
6316	Active	PHARMACY BRAND SCRIPT LIMIT EXCEEDED FOR CAL MONTH
6317	Active	PHARMACY BRAND SCRIPT LIMIT EXCEEDED FOR CAL MONTH
6318	Active	PHARMACY BRAND SCRIPT LIMIT EXCEEDED FOR CAL MONTH
6319	Active	PHARMACY TOTAL SCRIPT LIMIT EXCEEDED FOR CAL MONTH
6320	Active	PHARMACY MAX SCRIPT LIMIT EXCEEDED FOR CAL MONTH
6321	Inactive	MME AUDIT
6322	Inactive	PHARMACY MME NAIVE AGE 0-18y
6323	Inactive	PHARMACY MME NAIVE AGE 19-999
6324	Inactive	PHARMACY MME NAIVE & REFILL EXCEEDS 34 DAYS SUPPLY
6325	Inactive	SHORT ACTING OPIOID W/IN 180 DAYS OF NAIVE PA REQ
6330	Active	RECIPIENT HAS RESERVE MEDICINE THAT EXCEEDS LIMIT
6331	Active	PHARMACY STABLE THERAPY REQUIREMENT NOT MET
6332	Active	PHARMACY STABLE THERAPY REQUIREMENT NOT MET
6340	Active	DRUG SCREEN DAILY MAX FOR PRESENCE OF DRUGS
6341	Active	DRUG SCREEN DAILY MAX FOR G-CODES
6342	Active	DRUG SCREEN YEARLY MAX FOR PRESENCE OF DRUGS
6343	Active	DRUG SCREEN YEARLY MAX FOR G-CODES
6350	Active	DME GESTATIONAL INSULIN LIMIT 4 BOXES PER MONTH
6351	Active	DME GESTATIONAL INSULIN LIMIT 2 BOXES PER MONTH
6400	Active	PAP SMEAR COLLECTION ONE PER DAY
6401	Active	OB ULTRASOUND YEARLY LIMIT
6402	Active	SCREENING MAMMOGRAPHY LIMIT
6403	Active	CARDIAC REHAB SERVICE LIMIT (PHYSICIAN)
6404	Active	CARDIOGRAPHY PROCEDURES LIMIT

6405	Active	STANDBY CARE FREQUENCY LIMIT
6406	Active	NEWBORN LIMIT
6407	Active	NEW PATIENT LIMIT
6408	Active	PHYSICIAN VISIT ONE PER DAY
6409	Active	EXCEEDED PHYSICIAN HOSPITAL
6410	Active	PHYSICIAN BENEFIT LIMIT
6411	Active	INITIAL CRITICAL CARE(99291) LIMITED TO ONE PER DA
6412	Active	ER AND CRITICAL CARE CODES ONE LINE RESTRICTION
6413	Active	EXCEEDED PHYSICIAN HOSPITAL
6416	Active	EMG PROCEDURE LIMIT TO 4 PER CAL YR
6418	Active	OB ULTRASOUND YEARLY LIMIT PERINATOLOGISTS
6510	Active	PSYCHOLOGIST LIMIT-52 A YEAR
6511	Active	PSYCHOLOGIST LIMIT-12 A YEAR
6512	Active	PSYCHOLOGIST LIMIT-26 A YEAR
6513	Active	PSYCHOLOGIST LIMIT-05 A YEAR
6514	Active	MENTAL HEALTH DIAGNOSTIC TESTING LIMIT
6515	Active	INTAKE EVALUATION LIMIT
6516	Active	PHYSICIAN/MEDICAL ASSESSMENT AND TREATMENT LIMIT
6517	Active	DIAGNOSTICS TESTING LIMIT
6518	Active	INDIVIDUAL COUNSELING/PSYCHOTHERAPY LIMIT
6519	Active	FAMILY COUNSELING OR PSYCHOTHERAPY LIMIT
6520	Active	GROUP COUNSELING OR PSYCHOTHERAPY LIMIT
6521	Active	MEDICATION ADMINISTRATIONLIMIT
6522	Active	MEDICATION MONITORING LIMIT
6523	Active	MENTAL ILLNESS DAILY LIVING SKILLS INDIVIDUAL LIMI
6524	Active	MENTAL ILLNESS DAILY LIVING SKILLS GROUP LIMIT
6525	Active	FAMILY SUPPORT EDUCATION INDIVIDUAL LIMIT
6526	Active	FAMILY SUPPORT EDUCATION GROUP LIMIT
6527	Active	ADULT MENTAL ILLNESS INTENSIVE DAY TREATMENT LIMIT
6528	Active	CHILD AND ADOLES MENTAL ILLNESS DAY TREATMENT WITH
6529	Active	CHILD AND ADOLES MENTAL ILLNESS DAY TREATMENT WITH
6530	Active	TREATMENT PLAN REVIEW LIMIT
6531	Active	MENTAL HEALTH CONSULTATION LIMIT

6532	Active	MENTAL HEALTH REHAB 1040 UNIT LIMIT
6533	Active	CHILD AND ADOLESCENT SUBSTANCE ABUSE DAY TREATMENT
6534	Active	IN-HOME INTERVENTION LIMIT
6535	Active	MENTAL HEALTH REHAB 130 UNIT LIMIT
6536	Active	INDIVIDUAL COUNSELING-SUBSTANCE ABUSE LIMIT (Z5452
6537	Active	MENTAL HEALTH REHAB 365-UNIT LIMIT
6538	Active	CRISIS INTERVENTION LIMIT
6539	Active	PRE-HOSPITAL SCREENING LIMIT
6540	Active	MHSP-LIMIT 12 PER YEAR
6541	Active	DIAGNOSTICS ASSESSMENTS LIMIT
6542	Active	REHABILITATIVE DAY PROGRAM LIMIT
6543	Active	PSYCHOLOGY/REHAB - PSYCHOLOGY DX TESTING
6544	Active	PSYCHOLOGY/REHAB - NEUROPSYCHOLOGY DX TESTING
6545	Inactive	PSYCHOLOGY/REHAB - MENTAL HEALTH DX TESTING
6546	Active	PSYCHOLOGY/REHAB - PSYCHOLOGY LIMIT 52 A YEAR
6547	Active	PSYCHOLOGY/REHAB - INDIVIDUAL THERAPY 1 PER WEEK
6548	Active	PSYCHOLOGY/REHAB - GROUP THERAPY 1 PER WEEK
6549	Active	MENTAL HEALTH NON-EMERGENCY TRANSPORATION LIMIT
6550	Active	TREATMENT PLAN REVIEW LIMIT 2 PER QUARTER
6600	Active	RADIOLOGY & CARDIOLOGY LIMIT - PA REQ
6610	Active	DIALYSIS ULTRAFILTRATION LIMIT
6611	Active	RENAL DIALYSIS LIMIT 156
6612	Active	MONTHLY CAPITATION LIMIT
6613	Active	DIALYSIS TRAINING LIMIT
6630	Active	TARGETED CASE MANAGEMENT LIMITED TO ONE PER CALEND
6640	Active	PHYSICAL THERAPY 12-PER YEAR
6641	Active	PHYSICAL THERAPY-10 PER YEAR
6642	Active	PHYSICAL THERAPY-24 PER YEAR
6643	Active	PHYSICAL THERAPY-96 PER YEAR
6644	Active	PHYSICAL THERAPY-16 PER YEAR
6645	Active	PHYSICAL THERAPY-18 PER YEAR
6646	Active	PHYSICAL THERAPY-8 PER YEAR
6647	Active	PHYSICAL THERAPY-36 PER YEAR
6650	Active	RESPITE CARE CONTRACT YEAR LIMIT

6651	Active	HOMEBOUND WAIVER LIMITED TO ONE PER CALENDAR MONT
6652	Active	P/C LIMITED TO ONE PER CALENDAR MONTH-HOMEBOUND
6653	Active	RESPITE CARE SERVICES LIMIT
6654	Active	LAHWV-GOODS/SERVICES LIMITED $1000 PER WAIVER YEAR
6655	Active	LAHWV-TRANSPORTATION LIMITED $1000 PER WAIVER YEAR
6656	Active	WAIVER-ID/LAN JOB COACH
6657	Active	WAIVER-ID/LAH JOB DEVELOPER
6658	Active	WAIVER-ID/LAH SPEECH/HEARING THERAPY LIMIT
6659	Active	WAIVER SERVICE LIMIT $1800 PER WAIVER YEAR
6660	Active	WAIVER SERVICE LIMITED TO $5000 PER WAIVER YEAR
6661	Active	PACE GLOBAL FEE LIMITED TO ONE PER MONTH
6662	Active	WAIVER SERVICE LIMITED TO $1000 PER WAIVER YEAR
6663	Active	WAIVER SERVICE LIMITED TO $2000 PER WAIVER YEAR
6664	Active	WAIVER - TECH/PROF THERA BEHAV LIMIT 1200 UNITS
6665	Active	WAIVER - PROF THERA BEHAVIOR LIMIT 800 UNITS
6666	Active	WAIVER SERVICE LIMITED TO $5000 PER CALENDAR MONTH
6670	Active	PROCEDURE LIMITED TO ONE PER CALENDAR YEAR
6671	Active	PROCEDURE LIMITED TO ONCE PER LIFETIME
6672	Active	PROCEDURE LIMITED TO TWICE PER LIFETIME
6673	Active	PROCEDURE LIMIT TO ONE EVERY TWO YEARS
6674	Active	DUPLICATE ICN
6677	Active	DUPE CLAIM FOR MODIFIERS
6680	Active	ABA INITIAL ASSESSMENT LIMITED 2 PER CAL YEAR
6690	Active	THERAPEUTIC NURSING HOME LEAVE DAYS
6691	Active	REVENUE CODE 184 IS LIMITED TO 14 DAYS PER CALENDA
6700	Active	DME PROCEDURE LIMITED TO 1 PER 8 CAL YRS

6701	Active	DME PROCEDURE LIMIT TO 1 PER DAY
6702	Active	DME PROCEDURE LIMIT TO 1 PER CALENDAR WEEK
6703	Active	DME PROCEDURE LIMIT TO 30 PER 2 CALENDAR MONTHS
6704	Active	DME PROCEDURE LIMIT TO 70 PER 2 CALENDAR MONTHS
6705	Active	DME PROCEDURE LIMIT TO 150 PER CALENDAR MONTH
6706	Active	DME PROCEDURE LIMIT TO 180 PER CALENDAR MONTH
6707	Active	DME PROCEDURE LIMIT TO 210 PER CALENDAR MONTH
6708	Active	DME PROCEDURE LIMIT TO 2 PER 3 CALENDAR MONTHS
6709	Active	DME PROCEDURE LIMIT TO 3 PER CALENDAR YEAR
6710	Active	DME PROCEDURE LIMIT TO 5 PER CALENDAR YEAR
6711	Active	DME PROCEDURE LIMIT TO 6 PER CALENDAR YEAR
6712	Active	DME PROCEDURE LIMIT TO 2 PER 3 CALENDAR YEARS
6713	Active	DME PROCEDURE LIMIT TO 10 PER CALENDAR YEAR
6714	Active	DME PROCEDURE LIMIT TO 12 PER CALENDAR YEAR
6715	Active	DME PROCEDURE LIMIT TO 2 PER 2 CALENDAR YEARS
6716	Active	DME PROCEDURE LIMIT TO 31 PER CALENDAR MONTH 0-20Y
6717	Active	DME PROCEDURE LIMIT TO 150 PER CALENDAR MONTH
6718	Active	DME PROCEDURE LIMIT TO 31 PER CALENDAR MO 21-999Y
6719	Active	DME PROCEDURE LIMITED TO (1) PER 8 CAL YRS
6720	Active	DME PROCEDURE LIMIT TO 1 PER 7 CALENDAR YEARS
6721	Active	DME REPAIRS LIMITED $1000 PER DAY
6722	Active	DME POWER TIRES LIMIT 4 PER CALENDAR YEAR
6723	Active	DME BACK CUSHIONS LIMIT 1 PER 2 CALENDAR YEAR
6724	Active	DME SEAT CUSHIONS LIMIT 1 PER 1 CALENDAR YEAR

6725	Active	DME FOOTREST LIMIT 2 PER CALENDAR YEAR
6726	Active	DME ARMREST LIMIT 2 PER CALENDAR YEAR
6727	Active	DME HEADREST LIMIT 1 PER CALENDAR YEAR
6728	Active	DME SAFETY VEST LIMIT 2 PER CALENDAR YEAR
6729	Active	DME MANUAL TIRES LIMIT 4 PER CALENDAR YEAR
6730	Active	DME MANUAL CASTERS LIMIT 4 PER CALENDAR YEAR
6731	Active	DME POWER CASTERS LIMIT 4 PER CALENDAR YEAR
6732	Active	DME GENERAL CUSHION LIMIT 1 PER CALENDAR YEAR
6733	Active	DME PROCEDURE LIMIT 1 PER 5 CAL YEARS AGE 0-20
6734	Active	DME PROCEDURE LIMIT 1 PER 7 CAL YEARS AGE 21-999
7000	Active	CLAIM FAILED A PRODUR ALERT
7001	Active	INFORMATIONAL PRODUR ALERT
7002	Active	CLAIM DENIED FOR PRODUR REASONS
7003	Active	PRODUR ALERT REQUIRES PA FOR OVERRIDE
7004	Active	NON-OVERRIDEABLE PRODUR ALERT
7024	Inactive	LTC RECIPIENT - NON-COMPOUND DRUG BILLED
7026	Inactive	LTC DRUG ONLY
7040	Inactive	PHARMACY RX SCRIPT LIMIT OF 5 - JAN 01 2014
7050	Inactive	STEP THERAPY REQUIREMENTS NOT MET FOR THIS DRUG
7101	Active	ADMIT DATE LESS THAN FIRST DATE OF SERVICE
7102	Active	TYPE OF BILL INDICATES LATE CHARGES
7103	Active	INTERIM CLAIM LESS THAN MINIMUM STAY
7104	Active	INTERIM CLAIM PATIENT STATUS IS DISCHARGED
7105	Active	NURSERY AND NON-NURSERY REVENUE CODES
7106	Active	PROVIDER DRG BASE RATE IS ZERO
7107	Active	PROVIDER DRG COST TO CHARGE RATIO IS ZERO
7110	Active	DRG AGE THRESHOLD NOT ON FILE OR ZERO

7111	Active	DRG OUTLIER THRESHOLD NOT ON FILE OR ZERO
7112	Active	DRG MARGINAL COST PERCENT NOT ON FILE OR ZERO
7115	Active	DRG INVALID PRINCIPAL DIAGNOSIS
7116	Active	DRG CODE COULD NOT BE DETERMINED
7117	Active	DRG INVALID RECIPIENT AGE
7118	Active	DRG INVALID RECIPIENT GENDER
7119	Active	DRG INVALID DISCHARGE STATUS
7120	Active	DRG INVALID BIRTH WEIGHT
7121	Active	DRG GESTATIONAL AGE AND BIRTH WEIGHT CONFLICT
7122	Active	DRG CODE NOT ON FILE
7123	Active	DRG CODE ON REVIEW
7124	Active	DRG CODE NOT ON RATE FILE
7125	Active	DRG GROUPER INITIALIZATION FAILED
7126	Active	SUPPLEMENTAL PYMT PERCENT NOT ON FILE
7127	Active	PROVIDER MISSING FROM DRG RATE TABLE
7128	Active	DRG - MAJOR DIAGNOSTIC CATEGORY NOT ON FILE
7129	Active	DAY OUTLIER THRESHOLD NOT ON FILE
7130	Active	DAY OUTLIER PER DIEM AMOUNT NOT ON FILE
7200	Inactive	MISCELLANEOUS CLAIMCHECK ERROR
7201	Inactive	PROCEDURE IS A NEWBORN PROCEDURE
7202	Inactive	PROCEDURE IS A PEDIATRIC PROCEDURE
7203	Inactive	PROCEDURE IS A MATERNITY PROCEDURE
7204	Inactive	PROCEDURE IS AN ADULT PROCEDURE
7205	Inactive	PROCEDURE IS NOT INDICATED FOR A MALE
7206	Inactive	PROCEDURE IS NOT INDICATED FOR A FEMALE
7207	Inactive	PROCEDURE IS CLASSIFIED AS A COSMETIC PROCEDURE
7208	Inactive	PROCEDURE IS AN UNLISTED PROCEDURE
7209	Inactive	PROCEDURE IS CLASSIFIED AS EXPERIMENTAL
7210	Inactive	PROCEDURE IS CLASSIFIED AS OBSOLETE
7211	Inactive	PROCEDURE IS INVALID FOR PATIENT'S AGE
7212	Inactive	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (AGE)
7213	Inactive	PROCEDURE IS INVALID FOR PATIENT'S SEX
7214	Inactive	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (SEX)

7215	Inactive	PROCEDURE CODE IS INCIDENTAL
7216	Inactive	NO SEPARATE REIMBURSEMENT FOR VISIT PROCEDURE CODE
7217	Inactive	PROCEDURE CODE HAS BEEN REBUNDLED
7218	Inactive	PROCEDURE ADDED DUE TO REBUNDLING
7219	Inactive	PROCEDURE IS MUTUALLY EXCLUSIVE
7220	Inactive	PROCEDURE IS WITHIN THE NUM OF DAYS PRE-OP RANGE
7221	Inactive	PROCEDURE IS WITHIN THE NUM OF DAYS POST-OP RANGE
7222	Inactive	PROCEDURE DOES NOT REQUIRE AN ASSISTANT SURGEON
7223	Inactive	PROCEDURE MAY NOT REQUIRE AN ASSISTANT SURGEON
7233	Inactive	DENIED DUPLICATE- INCLUDES UNILATERAL OR BILATERAL
7234	Inactive	DENIED DUPLICATE - IS BILATERAL
7235	Inactive	DENIED DUPLICATE - ONLY DONE XX TIMES IN LIFETIME
7236	Inactive	DENIED DUPLICATE - ONLY DONE XX TIMES IN A DAY
7237	Inactive	DENIED DUPLICATE (REBUNDLED)
7238	Inactive	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	Inactive	PROCEDURE IS A POSSIBLE DUPLICATE
7240	Inactive	SMARTSUSPENSE SUSPEND
7241	Inactive	SMARTSUSPENSE DENIAL
7242	Inactive	DX TO PX COMPARISON PROCEDURE DENIED
7243	Inactive	DX TO PX COMPARISON PROCEDURE SUSPENDED
7244	Inactive	MEDICAL VISIT DENIED (CLAIMREVIEW)
7245	Inactive	PX ADDED DUE TO NEW VISIT FREQ CODE REPLACEMENT
7246	Inactive	PX REPLACED DUE TO IOS REPLACEMENT
7247	Inactive	PX ADDED DUE TO IOS REPLACEMENT
7248	Inactive	INTENSITY OF PX HIGHER THAN EXPECTED BASED ON DX
7249	Inactive	PX SHOULD BE REVIEWED AS POSSIBLE MULT COMPONENT
7250	Inactive	PX SHOULD BE REVIEWED AS POSSIBLE DUP COMPONENT
7251	Inactive	PX IS ELIG FOR WORKER'S COMPENSATION/AUTO PAYOR
7252	Inactive	DX1 IS ELIGIBLE FOR THIRD PARTY PAYOR
7253	Inactive	DX2 IS ELIGIBLE FOR THIRD PARTY PAYOR

7254	Inactive	DX3 IS ELIGIBLE FOR THIRD PARTY PAYOR
7255	Inactive	DX4 IS ELIGIBLE FOR THIRD PARTY PAYOR
7256	Inactive	MODIFIER 51 INVALID FOR PRIMARY PROCEDURE
7257	Inactive	MODIFIER 51 MISSING FOR NON-PRIMARY PROCEDURE
7258	Inactive	REVIEW MODIFIER 51
7259	Inactive	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS
7260	Inactive	MORE THAN 40 LINES WERE ELIGIBLE FOR CC PROCESSING
7261	Inactive	INVALID PROCEDURE CODE
7262	Inactive	DOB CANNOT BE GREATER THAN DATE OF SERVICE
7263	Inactive	DOS REQUIRED/INVALID FOR PROCEDURE
7264	Inactive	DOS CANNOT BE A FUTURE DATE
7265	Inactive	BIRTHDATE CANNOT BE A FUTURE DATE
7266	Inactive	AGE CANNOT BE GREATER THAN 124 YEARS
7267	Inactive	ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
7268	Inactive	PROVIDER IS REQUIRED FOR HISTORY PROCEDURES
7269	Inactive	MODIFIER NOT VALID FOR THIS PROCEDURE
7270	Inactive	INVALID MODIFIER/PROCEDURE CODE COMBINATION
7271	Inactive	CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
7272	Inactive	DIAGNOSIS 1 MUST BE A VALID CODE
7273	Inactive	DIAGNOSIS 2 MUST BE A VALID CODE
7274	Inactive	DIAGNOSIS 3 MUST BE A VALID CODE
7275	Inactive	DIAGNOSIS 4 MUST BE A VALID CODE
7276	Inactive	DIAGNOSIS MUST BE A VALID CODE
7277	Inactive	PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
7278	Inactive	INVALID DATE (DATE OF BIRTH)
7279	Inactive	INVALID AMOUNT CHARGED
7280	Inactive	CLAIM LEVEL OR PROCEDURE LINE PROVIDER IS REQUIRED
7281	Inactive	DX TO PX COMPARISON PROCEDURE
7282	Inactive	INTENSITY OF PX HIGHER THAN EXPECTED BASED ON DX
7283	Inactive	PX SHOULD BE REVIEWED AS POSSIBLE MULT COMPONENT
7284	Inactive	PX SHOULD BE REVIEWED AS POSSIBLE DUP COMPONENT

7285	Inactive	PX IS ELIG FOR WORKER'S COMPENSATION/AUTO PAYOR
7286	Inactive	DX IS ELIG FOR WORKER'S COMPENSATION/AUTO PAYOR
7287	Inactive	DX IS ELIG FOR WORKER'S COMPENSATION/AUTO PAYOR
7288	Inactive	SMARTSUSPENSE FLAG
7289	Inactive	SMARTSUSPENSE MONITOR
7290	Inactive	MODIFIER 51 DELETED FOR PRIMARY PROCEDURE
7291	Inactive	MODIFIER 51 ADDED FOR NON-PRIMARY PROCEDURE
7500	Inactive	BILLING PROVIDER ON PREPAYMENT REVIEW
7503	Active	CONFLICT CODE ON RESPONSE CLAIM DOES NOT MATCH
7509	Inactive	RENDERING PROVIDER ON PREPAYMENT REVIEW
8000	Inactive	001-FROM DOS INVALID
8001	Inactive	002-ADMISSION DATE INVALID
8002	Inactive	003-HEADER THROUGH DATE OF SERVICE INVALID
8003	Inactive	004-HEADER NON-COVERED CHARGE IS INVALID
8004	Inactive	005-SURG DATE NOT BETWEEN ADMIT AND TO DATE OF SER
8005	Inactive	006-NON COVERED CHARGES INVALID/EQUAL SUBMITTED CH
8006	Inactive	007-NUMBER DAYS/ BILLING PERIOD DISAGREE
8007	Inactive	008-CLAIMS PAST FILING LIMIT
8008	Inactive	009-HEADER PAID AMOUNT LESS THAN OR EQUAL TO ZERO
8009	Inactive	010-VISIT PROC CODE LIMITED TO REVENUE CODE 450
8010	Inactive	011-BAY HEALTH AGENCY ID CHECK
8011	Inactive	012-NO LVLIII BASE VALUE FOR ANESTHESIA FOR DOS BI
8012	Inactive	013-NEONATAL BILLING CRITERIA
8013	Inactive	014-MODIFIER REQUIREMENTS
8014	Inactive	015-MEDICAL NECESSITY NOT INDICATED
8015	Inactive	017-RECIPIENT NOT ELIGIBLE FOR MEDICAID.
8016	Inactive	018-HOME HEALTH IP/OP SERVICES BILLED ON SAME CLAI
8017	Inactive	019-HIV FAMILY PLANNING CONTRA

8018	Inactive	020-EXTENDED FAMILY PLANNING CONTRA
8019	Inactive	021-OP PHYSICAL THERAPY BILLED WITH OTHER PROCEDUR
8020	Inactive	022-NUMBER OF DAYS BILLED INVALID
8021	Inactive	023-TRANSPLANT RESTRICTION
8022	Inactive	025-CLAIM FOR UNBORN RECIPT PENDING ELIG VERIFICAT
8023	Inactive	026-EPSDT REFERRED SERVICE THERAPY POS RESTRICTION
8024	Inactive	027-MODIFIER RESTRICTED TO X/O CLAIMS
8025	Inactive	028-HEADER PAID AMOUNT EXCEEDS SPECIFIED DOLLAR LI
8026	Inactive	029-TYPE OF BILL INVALID
8027	Inactive	030-UNITS OF SERVICE INVALID
8028	Inactive	031-SUBMITTED RATE INVALID
8029	Inactive	032-DOS NOT WITHIN MODIFIER PRICING CONV(MPC)FILE
8030	Inactive	033-INVALID REVENUE CODE FOR RECIPIENT AGE
8031	Inactive	034-CATARACT REFERRAL SERVICES MODIFIER REQUIREMEN
8032	Inactive	036-RATE TIMES UNITS NOT EQUAL TO DTL SUBMITTED CH
8033	Inactive	037-NURSERY DAYS INVALID
8034	Inactive	038-LEVEL III PRICE EQUAL TO ZERO
8035	Inactive	039-NON-COVERED REVERSE STERILIZATION DIAGNOSIS CO
8036	Inactive	040-QMB/EPSDT PROC LIMITED TO QMB/EPSDT RELATED CL
8037	Inactive	041-MAXIMUM LINES ALLOWED PER CLAIM EXCEEDED
8038	Inactive	042-EPSDT REFERRED CLMS RESTRICTED TO RECIPIENTS <
8039	Inactive	043-CLAIM CHARGE AMOUNT IS INVALID.
8040	Inactive	044-MCARE PAID AMOUNT IS INVALID
8041	Inactive	045-MEDICARE ALLOWED CHARGE MISSING/INVALID
8042	Inactive	046-MCARE TOTAL BILLED IS INVALID
8043	Inactive	047-COINSURANCE AMT NONNUMERIC AND/OR DOES NOT BAL
8044	Inactive	048-EPSDT REF PHYS MISSING OR NOT ON FILE AS SCREE
8045	Inactive	050-EPSDT SCREENING PROC LIMITED TO EPSDT SCREENER
8046	Inactive	051-PATIENT STATUS INVALID

8047	Inactive	052-TOTAL MCARE ALLOWED AMOUNT DOES NOT BALANCE
8048	Inactive	053-NET CHARGE IS MISSING OR INVALID.
8049	Inactive	054-SUM OF DTL NON COV CHG NOT EQL HDR NON COV CHA
8050	Inactive	055-BILL AMT NOT EQUAL SUM OF THE DTL CHARGE AMOUN
8051	Inactive	056-HDR MCARE PAID NOT EQ SUM OF DTL MCARE PAID AM
8052	Inactive	057-TEN UNITS OF Z5294 PRIOR TO Z5295
8053	Inactive	058-MUST BILL SVS FOR MAT WVR/CARE RECOP AS GLOBAL
8054	Inactive	059-CONTRACT PROV MUST BILL SVC FOR MAT WVR/CARE R
8055	Inactive	060-MAT WVR/CARE PROVIDER MAY ONLY BILL MW/MW SERV
8056	Inactive	061-EPSDT - INJECTIBLE TOS RESTRICTION
8057	Inactive	062-FEDERALLY QUALIFIED HEALTH CENTER(FQHC) POS CH
8058	Inactive	063-RECIPIENT COUNTY CODE NOT ON FILE
8059	Inactive	064-INVALID PROCEDURE FOR FQHC CROSSOVER CLAIM
8060	Inactive	065-PROCEDURE/DATE OF SERVICE INVALID
8061	Inactive	066-NATURE OF ADMISSION INVALID
8062	Inactive	067-SVC FOR MATERNITY WVR/CARE RECIPIENT REQUIRES
8063	Inactive	068-HOSPICE COINS/DED AMOUNT INVALID
8064	Inactive	069-DENTAL SEALANT - TOOTH NUMBER AGE LIMIT
8065	Inactive	070-BILL ENC AND FEE FOR SVC PROCEDURES SEPARATELY
8066	Inactive	071-INVALID POS
8067	Inactive	072-PROVIDER NOT ON LEVEL 1 PRICING FILE
8068	Inactive	073-FAMILY PLANNING AGE LIMIT
8069	Inactive	074-EPSDT ONLY PROV BILLED NON-EPSDT REFERRAL CLAI
8070	Inactive	075-PAC 1 PROCEDURE NOT ON LVL 1 PRICING FILE FOR
8071	Inactive	076-MENTAL HEALTH DIAGNOSIS CRITERIA
8072	Inactive	077-VFC PROVIDER MAY ONLY BILL FOR VFC PROCEDURES
8073	Inactive	078-SPAN BILLED CRITICAL CARE
8074	Inactive	079-RENAL DIALYSIS PROCEDURE LIMIT

8075	Inactive	081-COLLECTION FEE/NON-PATIENT EXCLUSION
8076	Inactive	082-SERVICE DATES SPAN RECIPIENT ELIGIBILITY CHANG
8077	Inactive	084-SOBRA ELIGIBLE COVERAGE
8078	Inactive	085-MATERNITY CARE PROVIDER RESTRICTIONS
8079	Inactive	086-TARGETED CASE MANAGEMENT LIMITATIONS
8080	Inactive	087-TCM - MULTIPLE PROCEDURES BILLED
8081	Inactive	088-CLIA NUMBER NOT ON PROVIDER FILE
8082	Inactive	089-MCARE PAID + ALLOWED = ZERO/MCARE PAID AMOUNT=
8083	Inactive	090-GLOBAL PROCEDURE CODE SPAN DATED
8084	Inactive	091-MEDICARE PAID DATE IS INVALID
8085	Inactive	092-TPL ADJUDICATED DATE IS INVALID
8086	Inactive	093-CLAIM PARTIALLY COVERED BY A MANAGED CARE PLAN
8087	Inactive	094-COINSURANCE DAYS ARE GREATER THAN MAX ALWD OR
8088	Inactive	095-LIFETIME RESERVE DAYS ARE > MAX ALWD OR < 0
8089	Inactive	096-LIFETIME RESERVE AND COINS DAYS TO COV DAYS IN
8090	Inactive	097-PROCEDURE AND REVENUE CODE COMBINATION NOT VAL
8091	Inactive	098-NON COV REV SVC/REV CODES/ PROFESSIONAL COMPON
8092	Inactive	099-INVALID DEDUCTIBLE AMOUNT
8093	Inactive	100-DETAIL FROM DATE OF SERVICE IS INVALID
8094	Inactive	101-LAST DETAIL PROCEDURE DATE INVALID
8095	Inactive	102-CLAIMS PAST FILING LIMIT
8096	Inactive	103-THERAPY PROC PAYABLE W/THERAPEUTIC TREATMENT O
8097	Inactive	104-ER AND CRITICAL CARE CODES ONE LINE RESTRICTIO
8098	Inactive	105-SERVICE CODE INCLUDED IN REVENUE CODE 450
8099	Inactive	106-ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER
8100	Inactive	107-PATIENT FIRST CLAIM REQUIRES PMP PROVIDER ON C

8101	Inactive	108-TCM DENTAL REQUIRES VALID REFERRAL
8102	Inactive	109-OP OBSERVATION MUST BE BILLED WITH FACILITY FE
8103	Inactive	110-CROSSOVER SNF INVALID DEDUCTIBLE AMOUNT
8104	Inactive	111-IP/OP NON-COVERED REV CODE FOR EPSDT REFERRED
8105	Inactive	112-RID/PROVIDER NUMBER NOT ON LTC FILE
8106	Inactive	113-ASC INVALID TOS/PROC CODE
8107	Inactive	114-SVC NOT PAYABLE FOR RECIPIENT < 6 MONTHS OLD
8108	Inactive	122-PROCEDURE CODE NOT COVERED-PRIME TEETH
8109	Inactive	123-ORAL CAVITY DESIGNATION
8110	Inactive	124-TOOTH NUMBER IS LIMITED TO ONE PER DETAIL
8111	Inactive	126-INVALID TOOTH SURFACE
8112	Inactive	127-VERIFY TOOTH FOR PULP THERAPY
8113	Inactive	128-TOOTH NUMBER REQUIRED FOR THIS PROCEDURE
8114	Inactive	129-PROC NOT COV FOR PRIMARY,3RD MOLAR,SUPERNUMERA
8115	Inactive	130-INVALID CLAIM TYPE FOR PLAN FIRST PROGRAM
8116	Inactive	131-SERVICE ONLY COVERED UNDER THE PLAN FIRST PROG
8117	Inactive	132-BIRTH CONTROL FROM ONLY PHYSICAN FOR PLAN 1ST
8118	Inactive	133-PLAN 1ST RECIP MUST USE PLAN 1ST NETWORK PROVI
8119	Inactive	134-PLAN 1ST RECIP ONLY ELIGIBLE FOR PLAN 1ST SERV
8120	Inactive	135-ONLY TECH VR RECIP MAY RECEIVE TECH WVR SERVIC
8121	Inactive	136-PLACE OF SERVICE CODE INVALID
8122	Inactive	144-PLACE OF SERVICE CODE INVALID FOR PROVIDER TYP
8123	Inactive	145-MODIFIER NOT ON FILE/ INVALID FOR PROCEDURE
8124	Inactive	146-PROCEDURE CODE/PROVIDER TYPE LIMITATIONS
8125	Inactive	147-INVALID MODIFIER FOR PROCEDURE
8126	Inactive	148-PLACE OF SRVICE CRITERIA
8127	Inactive	149-AGE CRITERIA

8128	Inactive	150-SEX CRITERIA
8129	Inactive	151-INVALID DRUG CODE/DISPENSED DATE/PRICING NDC F
8130	Inactive	152-TOS / PROCEDURE / DRUG CODE INVALID / NOT ON F
8131	Inactive	153-DIAGNOSIS CRITERIA
8132	Inactive	154-PROCEDURE CODE/PROVIDER TYPE LIMITATIONS
8133	Inactive	155-PROCEDURE CODE/PROVIDER TYPE LIMITATIONS
8134	Inactive	156-SUSPECT PROVIDER
8135	Inactive	158-RECIPIENT ELIGIBLE FOR EMERGENCY SERVICES ONLY
8136	Inactive	159-INVALID CLM TYPE FOR EMERGENCY SERVICES RECIPI
8137	Inactive	161-TOS//PROCEDURE CODE NOT ON FILE
8138	Inactive	162-PROCEDURE, SVC, OR COLLECTION FEE LIMITS EXCEE
8139	Inactive	164-HDR/DTL ACCOM DAYS DISAGRE OR NO ACCOM REV BIL
8140	Inactive	173-TPL POLICY NBR AND INSURANCE COMPANY NAME REQU
8141	Inactive	174-DIAGNOSIS REQUIRES ACCIDENT INDICATOR
8142	Inactive	175-SURGICAL PROCEDURE CODE REQUIRED
8143	Inactive	178-PROCEDURE MUST BE BILLED WITH CHEMOTHERAPY
8144	Inactive	179-STERILIZATION CLAIM
8145	Inactive	180-HYSTERECTOMY EDIT
8146	Inactive	181-ABORTION CRITERIA
8147	Inactive	182-VERIFY ATTACHMENT IS ON FILE FOR RECIPIENT
8148	Inactive	183-DOS BEFORE DOB
8149	Inactive	184-SERVICES NOT COVERED FOR RECIPIENT AGE
8150	Inactive	185-PROCEDURE NOT COVERED AT POS FOR PROVIDER
8151	Inactive	189-DIAGNOSIS INVALID FOR PROVIDER SPECIALTY
8152	Inactive	190-PRIMARY DIAGNOSIS CODE IS INVALID
8153	Inactive	191-OTHER DIAGNOSIS CODE IS INVALID
8154	Inactive	192-HDR DIAG OTHER THAN PRIMARY OR SECONDARY INVAL
8155	Inactive	193-HEADER DIAGNOSIS #4 INVALID.

8156	Inactive	194-PRIMARY DIAGNOSIS INAPPROPRIATE FOR RECIPIENT
8157	Inactive	195-OTHER HDR DIAG INAPPROPRIATE FOR RECIPIENT AGE
8158	Inactive	196-PRIMARY DIAGNOSIS INAPPROPRIATE FOR RECIPIENT
8159	Inactive	197-OTHER HDR DIAG INAPPROPRIATE FOR RECIPIENT SEX
8160	Inactive	198-PRIMARY DIAG MUST BE BILLED AT HIGHEST SUBDIVI
8161	Inactive	199-OTHER DIAG MUST BE BILLED AT HIGHEST SUBDIVISI
8162	Inactive	200-PRIMARY DIAGNOSIS IS NOT COVERED
8163	Inactive	201-OTHER DIAGNOSIS IS NOT COVERED
8164	Inactive	205-DETAIL DIAGNOSIS FORMAT.
8165	Inactive	206-DETAIL DIAGNOSIS INAPPROPRIATE FOR RECIPIENT S
8166	Inactive	207-DETAIL DIAGNOSIS INAPPROPRIATE FOR RECIPIENT A
8167	Inactive	218-PERFORMING PROVIDER IDENTIFIED FOR PURGE
8168	Inactive	219-BILLING PROVIDER IDENTIFIED FOR PURGE
8169	Inactive	220-EMC PROVIDER/NO CONTRACT.
8170	Inactive	221-DECEASED PROVIDER
8171	Inactive	222-PROVIDER MOVED - MAIL RETURNED
8172	Inactive	223-PROVIDER SUSPENDED FROM MEDICAID
8173	Inactive	224-PROVIDER INACTIVE OR RETIRED
8174	Inactive	225-PROVIDER NOT ON PROV RATE FILE FOR DATE OF SER
8175	Inactive	226-PROVIDER DOES NOT MATCH CLAIM TYPE
8176	Inactive	227-PROVIDER NOT ELIGIBLE FOR MEDICAID
8177	Inactive	228-SVC DATES NOT WITHIN PROVIDER ENROLLMENT PERIO
8178	Inactive	229-PROVIDER NOT ON FILE
8179	Inactive	230-ATTENDING PHYSICIAN'S LICENSE NUMBER IS MISSI
8180	Inactive	233-INVALID REFERRING PHYSICIAN.
8181	Inactive	235-BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER
8182	Inactive	236-PERFORMING PROVIDER CAN NOT BE A GROUP PROVIDE
8183	Inactive	237-PERFORMING PROVIDER MISSING, INVALID OR CANCEL

8184	Inactive	238-PERF PROV NOT ASSOCIATED WITH THE GROUP ON THE
8185	Inactive	239-QMB PROVIDER/NON-QMB PROVIDER CLAIM
8186	Inactive	248-QMB ONLY RECIPIENT LIMITED TO CROSSOVER CLAIMS
8187	Inactive	250-RECIPIENT NUMBER MISSING, INVALID, OR NOT ON F
8188	Inactive	251-UNUSABLE ELIGIBILITY RECORD
8189	Inactive	253-RECIPIENT IS DECEASED BEFORE THE REQUEST DATE
8190	Inactive	254-CLAIM DENIED RECIPIENT INELIGIBLE
8191	Inactive	255-OVERLAPPING DATES OF SERVICE
8192	Inactive	256-RECIPIENT NUMBER MISSING,INVALID, OR NOT ON FI
8193	Inactive	257-BIRTH DATE IS NOT A VALID DATE
8194	Inactive	258-SUSPECT RECIPIENT(LOCK-IN)
8195	Inactive	259-RECIPIENT NAME AND NUMBER DISAGREE
8196	Inactive	262-CLAIM DENIED RECIPIENT INELIGIBLE
8197	Inactive	263-OVERLAPPING DATES OF SERVICE
8198	Inactive	264-GERIATRIC PSYCH/INPATIENT PSYCH ADMIT AGE LIMI
8199	Inactive	267-CENSUS DATA MISSING FOR MONTH PRIOR TO DOS
8200	Inactive	270-RID NOT ON LTC FILE
8201	Inactive	272-CLM PROV DOES NOT MATCH LTC FILE PROV FOR RECI
8202	Inactive	276-CLAIM DENIED - RECIP INELIGIBLE FOR WVR OR HOS
8203	Inactive	279-CLAIM DENIED. RECIPIENT HAS MEDICARE HMO COVER
8204	Inactive	280-TPL COST AVOIDANCE EDIT
8205	Inactive	281-TPL PAY AND LIST EDIT. **INTERNAL PURPOSES ON
8206	Inactive	282-POTENTIAL MEDICARE / MEDICARE COMPLETE LIABILI
8207	Inactive	283-TYPE OF SERVICE NOT VALID FOR MODIFIER
8208	Inactive	285-FQHC FACILITY RESTRICTED SVCS THRU DOS 12/31/9
8209	Inactive	290-TESTING E2 - 2.3
8210	Inactive	291-TESTING E2 - 2.3
8211	Inactive	292-TOS/PCODE INVALID FOR RADIOLOGY FACILITY
8212	Inactive	293-TESTING E2 - 2

8213	Inactive	294-TESTING E2 - 2.2
8214	Inactive	295-TEST/PROD RECIP OR PROV CANNOT BE MIXED ON A C
8215	Inactive	296-TESTING E SCREENS
8216	Inactive	297-TESTING EDITS
8217	Inactive	298-TEST E1 SCREEN
8218	Inactive	299-TEST E1 SCREEN
8219	Inactive	300-VACCINE PROCEDURE CODE / PROVIDER CHECK
8220	Inactive	301-THIS IS A TEST
8221	Inactive	302-THIS IS A TEST ADD
8222	Inactive	304-OPERATING PHYSICIAN' S LICENSE NUMBER IS MISSI
8223	Inactive	308-PBRHC FISCAL YEAR END CHECK.
8224	Inactive	310-SUBMITTED CHARGE INVALID
8225	Inactive	311-VALIDATE DETAIL NON COVERED CHARGE
8226	Inactive	313-ADMIT DIAGNOSIS MISSING, INVALID, OR NOT ON FI
8227	Inactive	314-SPAN DATES EXCEED ONE CALENDAR MONTH.
8228	Inactive	315-DATES OF SERVICE SPAN THE YEAR 2000
8229	Inactive	316-REQUEST MAY NOT SPAN MORE THAN 90 DAYS
8230	Inactive	317-KATRINA/RITA CLM SPANS PLAN CODES/ELIG PERIODS
8231	Inactive	319-COVERED DAYS GREATER THAN CERTIFIED DAYS
8232	Inactive	320-TOTAL DAYS CERTIFIED MISSING/INVALID
8233	Inactive	322-SURGERY DATES / CODES INVALID
8234	Inactive	323-INVALID CLAIM SUBMISSION REASON CODE
8235	Inactive	355-MANUAL PRICING REQUIRED
8236	Inactive	357-SUBMITTED CHARGE > SIX TIMES THE ALLOWED CHARG
8237	Inactive	358-PHP/EFT REQUIRMENT
8238	Inactive	375-PRODUCT IS NOT PREFERRED
8239	Inactive	382-INVALID CLAIM ADJUSTMENT REQUEST
8240	Inactive	384-PA REQUEST REQUIRES PROGNOSIS CODE
8241	Inactive	385-DUPLICATE PRIOR AUTHORIZATION REQUEST
8242	Inactive	386-INVALID PA DTL- SUBMIT NEW REQUESTS ALONE

8243	Inactive	387-INCOMPLETE PA DTL - NO UNITS OR DOLLARS
8244	Inactive	388-MISSING/INVALID REQUESTING PROVIDER
8245	Inactive	389-PA NUMBER NOT EQUAL TO PA MASTER
8246	Inactive	390-PROVIDER NUMBER NOT EQUAL TO PA MASTER
8247	Inactive	391-OVERLAPPING DOS - PRICING
8248	Inactive	392-NUMBER OF UNITS EXCEEDS PA MASTER
8249	Inactive	393-RID DOES NOT MATCH PA FILE
8250	Inactive	394-PHARMY AUTO PA PROCESSING-COMMUNICATION WITH H
8251	Inactive	397-INVALID PRIOR AUTHORIZATION NUMBER
8252	Inactive	398-ALLOWED CHARGED EXCEEDS PA MASTER FILE
8253	Inactive	399-PA REQUIRED FOR PROCEDURE OR SERVICE
8254	Inactive	400-DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH
8255	Inactive	401-DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH
8256	Inactive	402-HOME GLUCOSE MONITOR LIMIT
8257	Inactive	403-POUCH - DRAINABLE (A5061) 30 PER MONTH
8258	Inactive	404-URINARY CATHETER (A4352)120 PER MONTH
8259	Inactive	405-GAUZE LIMIT - 100 PER MONTH
8260	Inactive	407-CLOSED POUCH LIMIT
8261	Inactive	408-DME PROCEDURE LIMIT 30 PER MONTH
8262	Inactive	409-URINARY POUCH LIMIT FORTY (40) PER MONTH
8263	Inactive	410-BIRTH CONTROL PILLS LIMIT - 16 PER YEAR
8264	Inactive	411-WHEEL CHAIR PRESSURE PAD LIMIT
8265	Inactive	412-FAMILY PLANNING PERIODIC FOLLOW-UP LIMIT
8266	Inactive	413-STERILE/NON-STERILE GLOVE MONTHLY LIMIT
8267	Inactive	414-OB ULTRASOUND YEARLY LIMIT
8268	Inactive	415-SCREENING MAMMOGRAPHY LIMIT
8269	Inactive	416-TEST STRIPS LIMIT 2 PER MONTH
8270	Inactive	417-WAIVER CARE CONTRA
8271	Inactive	420-PHARMACY QTY DISPENSED EXCEEDS MAX QTY BASED O

8272	Inactive	421-PRIMARY ANESTHESIA FOR SAUDIT 421/A05
8273	Inactive	422-NURSING HOME THERAPEUTIC ICF/MR LEAVE DAYS LIM
8274	Inactive	424-MEDICARE DEDUCTIBLE PAID
8275	Inactive	427-HBO-AIR OR GAS LIMIT
8276	Inactive	428-HBO-CARBON MONOXIDE POISON / SMOKE INHALATION
8277	Inactive	429-HBO-DECOMPRESSION SICKNESS LIMIT
8278	Inactive	430-HBO-GAS GANGRENE LIMIT
8279	Inactive	431-HBO-CRUSH INJURY LIMIT
8280	Inactive	432-HBO-PYODERMA LIMIT
8281	Inactive	433-HBO-HEAL WOUND LIMIT
8282	Inactive	434-HBO-OSTEOMYELITIS LIMIT
8283	Inactive	435-HBO-RADIATION TISSUE DAMAGE LIMIT
8284	Inactive	436-HBO-SKIN GRAFTS AND FLAPS LIMIT
8285	Inactive	437-VISION AND HEARING SCREENING ONE PER YEAR
8286	Inactive	438-HEARING AND VISION SCREENINGS REQUIRE EP MODIF
8287	Inactive	441-HOME HEALTH VISIT LIMITATION
8288	Inactive	442-PSYCHOLOGIST LIMIT-52 A YEAR
8289	Inactive	443-PSYCHOLOGIST LIMIT-12 A YEAR
8290	Inactive	444-PSYCHOLOGIST LIMIT-26 A YEAR
8291	Inactive	445-PSYCHOLOGIST LIMIT-05 A YEAR
8292	Inactive	447-CATHETER PLACEMENT/DAILY MANAGEMENT OF EPIDURA
8293	Inactive	448-QUALIFYING PROCEDURE CODE LIMIT
8294	Inactive	449-PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES
8295	Inactive	450-PRIMARY ANESTHESIA/INJECTION OR CATHETER 50% A
8296	Inactive	476-LABORATORY FRAGMENTATION
8297	Inactive	478-COINSURANCE/LIFETIME RESERVEDAYS VERIFICATION
8298	Inactive	483-DME PROCEDURE LIMIT OF THREE PER CALENDAR MONT
8299	Inactive	485-DME PROCEDURE LIMIT OF TWO PER CALENDAR MONTH
8300	Inactive	487-COINSURANCE/LIFETIME RESERVE DAYS OVERLAP JANU
8301	Inactive	489-WAIVER RESPITE CARE CONTRACT YEAR LIMIT
8302	Inactive	490-PHARMACY EXACT DUPLICATE OF ANOTHER DRUG CLAIM

8303	Inactive	491-PHARMACY SUSPECT DUPLICATE OF ANOTHER DRUG CLA
8304	Inactive	492-PHARMACY MAX PRESCRIPTION LIMIT EXCEEDED FOR C
8305	Inactive	493-PHARMACY DRUG PRESCRIPTION/ REFILL NUMBER SUSP
8306	Inactive	501-MEDICAL DUPLICATE - EXACT OF SERVICE IN SYSTEM
8307	Inactive	502-MEDICAL DUPLICATE - EXACT OF SERVICE IN HISTOR
8308	Inactive	503-DUPE CLAIM FOR MODIFIERS
8309	Inactive	504-MEDICAL DUPLICATE - POSSIBLE SERVICE ALREADY P
8310	Inactive	505-MEDICAL DUPLICATE - POSSIBLE SERVICE ALREADY I
8311	Inactive	506-MEDICARE ADJUSTMENT DUPE EXACT
8312	Inactive	507-MEDICARE ADJUSTMENT DUPE POSSIBLE
8313	Inactive	511-INSTITUTIONAL DUPLICATION EXACT
8314	Inactive	512-INSTITUTIONAL DUPLICATION EXACT
8315	Inactive	513-INSTITUTIONAL DUPLICATION POSSIBLE
8316	Inactive	514-INSTITUTIONAL DUPLICATION POSSIBLE
8317	Inactive	515-INSTITUTIONAL NURSING HOME DUPLICATION POSSIBL
8318	Inactive	531-OUTPATIENT DUPLICATE EXACT
8319	Inactive	532-OUTPATIENT DUPLICATE EXACT
8320	Inactive	533-OUTPATIENT DUPLICATE POSSIBLE
8321	Inactive	534-OUTPATIENT DUPLICATE POSSIBLE
8322	Inactive	535-OUTPATIENT DUPLICATE POSSIBLE
8323	Inactive	538-PROVIDER SPECIALTY CONTRA
8324	Inactive	539-TARGETED CASE MANAGEMENT LIMITED TO ONE PER CA
8325	Inactive	542-FETAL DOPPLER/ECHOCARDIOGRAPHY CONTRA
8326	Inactive	543-INSTITUTIONAL/OUTPATIENT DUPLICATE POSSIBLE
8327	Inactive	544-INSTITUTIONAL/OUTPATIENT DUPLICATE POSSIBLE
8328	Inactive	545-INSTITUTIONAL/OUTPATIENT DUPLICATE POSSIBLE
8329	Inactive	546-OUTPATIENT LINE ITEM DUPE EXACT
8330	Inactive	547-OUTPATIENT LINE ITEM DUPE EXACT
8331	Inactive	548-OUTPATIENT LINE ITEM DUPE POSSIBLE
8332	Inactive	549-OUTPATIENT LINE ITEM DUPE POSSIBLE
8333	Inactive	552-FETAL ECHOCARDIOGRAPHY CONTRA
8334	Inactive	559-ASC VISIT LIMIT (CLAIMS PER YEAR)

8335	Inactive	560-OUTPATIENT VISIT LIMIT
8336	Inactive	564-PROCEDURE CODE EXCEEDS 4 UNITS PER CALENDAR MO
8337	Inactive	571-DIALYSIS ULTRAFILTRATION LIMIT
8338	Inactive	574-FITTING OF CONTACT LENS CONTRA
8339	Inactive	576-ALS TRANSPORTATION/SUPPLY CONTRA
8340	Inactive	577-WAIVER SAIL WAIVER EMERGENCY RESPONSE SYSTEM L
8341	Inactive	579-IRHC SAME DAY CONTRA
8342	Inactive	580-VACCINE REPLACEMENT/ADMINISTRATION FEE CONTRA
8343	Inactive	587-RESPITE COMBINATION LIMIT
8344	Inactive	592-VISION AND HEARING SCREENING
8345	Inactive	593-HIV COUNSELING YEARLY LIMIT
8346	Inactive	597-SCREENING/ASSESSMENT BENEFIT LIMIT
8347	Inactive	599-DUPLICATE ICN
8348	Inactive	600-DENTAL PULPAL THERAPY (D3220) SAME DATE OF SER
8349	Inactive	601-DENTAL PULPAL THERAPY (D3310)SAME DOS CONTRA
8350	Inactive	602-DENTAL PULPAL THERAPY (D3320) SAME DOS CONTRA
8351	Inactive	603-DENTAL PULPAL THERAPY (D3330) SAME DOS COTNRA
8352	Inactive	604-DENTAL PULPAL THERAPY (D3351) SAME DOS CONTRA
8353	Inactive	605-DENTAL PULPAL THERAPY (D3410) SAME DOS CONTRA
8354	Inactive	606-DENTAL PULPAL THERAPY (D3430) SAME DOS CONTRA
8355	Inactive	607-DENTAL PULPAL THERAPY (D3220) DOS CONTRA
8356	Inactive	608-DENTAL PULPAL THERAPY (D3230) ANY DOS CONTRA
8357	Inactive	609-DENTAL PULPAL THERAPY (D3240) ANY DOS CONTRA
8358	Inactive	610-DENTAL PULPAL THERAPY (D3310) ANY DOS CONTRA
8359	Inactive	611-EXTRACTION/SPACE MAINTAINER CONTRA
8360	Inactive	613-DENTAL PULPAL THERAPY (D3332) ANY DOS CONTRA

8361	Inactive	614-DENTAL PROCEDURE D9420 LIMITED TO 4 TIMES PER
8362	Inactive	615-DENTAL PROCEDURE D9420 LIMITED TO 30 DAYS
8363	Inactive	616-DENTAL PROCEDURE D9420 LIMITED TO 4 TIMES PER
8364	Inactive	617-LIMITATION AUDIT FOR D0140
8365	Inactive	618-DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER L
8366	Inactive	619-DENTAL PROCEDURE SIX-MONTH LIMITATIONS
8367	Inactive	620-DENTAL PROPHYLAXIS LIMITATION
8368	Inactive	621-PULPAL THERAPY AND RESTORATIONS SAME DOS SAME
8369	Inactive	622-EXTENDED FAMILY PLANNING VISIT LIMIT
8370	Inactive	623-DENTAL FLUORIDE LIMITATION
8371	Inactive	624-FAMILY PLANNING CONTRA
8372	Inactive	625-POST CATARACT CONTRA
8373	Inactive	626-SKIN BARRIER CONTRA
8374	Inactive	627-OSTOMY POUCH CONTRA
8375	Inactive	628-EPSDT CONTRA
8376	Inactive	629-EPSDT/FAMILY PLANNING CONTRA
8377	Inactive	630-WAIVER:SAIL WAIVER LIMITED TO ONE(1) PER CALEN
8378	Inactive	631-PROCEDURE LIMITED TO ONE PER CALENDAR YEAR
8379	Inactive	632-WAIVER MR/LAHW WAIVER SERVICES - RESPITE CARE C
8380	Inactive	633-WAIVER:MR/LAHW RESIDENTIAL HABILITATION/RESPIT
8381	Inactive	634-WAIVER MR AND LAHW-RESPITE CARE LIMIT
8382	Inactive	635-PROPHYLAXIX/FLUORIDE FRAGMENTED BILLING SAME/D
8383	Inactive	637-DENTAL EXTRACTION CONTRA
8384	Inactive	638-FQHC MEDICAL ENCOUNTER CONTRA (Z5298)
8385	Inactive	639-VACCINE/NON STANDARD CONTRA
8386	Inactive	640-MENTAL HEALTH DIAGNOSTIC TESTING LIMIT
8387	Inactive	641-INTAKE EVALUATION LIMIT
8388	Inactive	642-PHYSICIAN/MEDICAL ASSESSMENT AND TREATMENT LIM
8389	Inactive	643-DIAGNOSTICS TESTING LIMIT

8390	Inactive	644-INDIVIDUAL COUNSELING/PSYCHOTHERAPY LIMIT
8391	Inactive	645-FAMILY COUNSELING OR PSYCHOTHERAPY LIMIT
8392	Inactive	646-GROUP COUNSELING OR PSYCHOTHERAPY LIMIT
8393	Inactive	647-MEDICATION ADMINISTRATIONLIMIT
8394	Inactive	648-MEDICATION MONITORING LIMIT
8395	Inactive	649-MENTAL ILLNESS DAILY LIVING SKILLS INDIVIDUAL
8396	Inactive	650-MENTAL ILLNESS DAILY LIVING SKILLS GROUP LIMIT
8397	Inactive	651-FAMILY SUPPORT EDUCATION INDIVIDUAL LIMIT
8398	Inactive	652-FAMILY SUPPORT EDUCATION GROUP LIMIT
8399	Inactive	653-PARTIAL HOSPITALIZATION PROGRAM LIMIT
8400	Inactive	654-ADULT MENTAL ILLNESS INTENSIVE DAY TREATMENT L
8401	Inactive	655-ADULT MENTAL ILLNESS SUPPORTIVE DAY TREATMENT
8402	Inactive	656-CHILD AND ADOLES MENTAL ILLNESS DAY TREATMENT
8403	Inactive	657-CHILD AND ADOLES MENTAL ILLNESS DAY TREATMENT
8404	Inactive	658-TREATMENT PLAN REVIEW LIMIT
8405	Inactive	659-MENTAL HEALTH CONSULTAION LIMIT (Z5243)
8406	Inactive	660-MENTAL HEALTH REHAB 1040 UNIT LIMIT
8407	Inactive	661-CHILD AND ADOLESCENT SUBSTANCE ABUSE DAY TREAT
8408	Inactive	662-IN-HOME INTERVENTION LIMIT
8409	Inactive	663-AUDIOLOGY COMPREHENSIVE VISIT CONTRA
8410	Inactive	664-VISION CARE CONTRA -V2020
8411	Inactive	665-DIAGNOSTIC TESTING CONTRA
8412	Inactive	666-INDIVIDUAL COUNSELING PSYCHOTHERAPY CONTRA
8413	Inactive	667-GROUP COUNSELING OR PSYCHOTHERAPY CONTRA
8414	Inactive	668-MEDICATION ADMINISTRATION/MEDICAL MONITORING C
8415	Inactive	669-REHAB DAY PROGRAM CONTRA
8416	Inactive	670-MENTAL HEALTH REHAB 130 UNIT LIMIT

8417	Inactive	672-INDIVIDUAL COUNSELING-SUBSTANCE ABUSE LIMIT (Z
8418	Inactive	673-MENTAL HEALTH REHAB 365-UNIT LIMIT
8419	Inactive	674-INDIVIDUAL COUNSELING SUBSTANCE ABUSE CONTRA
8420	Inactive	676-CRITICAL CARE/SUBSEQUENT PROCEDURE CONTRA
8421	Inactive	677-MENTAL HEALTH REHAB CONTRA
8422	Inactive	678-INTAKE EVALUATION CONTRA
8423	Inactive	679-PHYSICIAN MEDICAL ASSESSMENT AND TREATMENT
8424	Inactive	680-CRISIS INTERVENTION CONTRA
8425	Inactive	681-DAY TREATMENT CONTRA - ADULT
8426	Inactive	682-DAY TREATMENT CONTRA - CHILD/ADOLESCENT
8427	Inactive	683-CRISIS INTERVENTION LIMIT
8428	Inactive	684-PRE-HOSPITAL SCREENING LIMIT
8429	Inactive	685-INTENSIVE OUTPATIENT SERVICES CONTRA
8430	Inactive	686-CHEMOTHERAPY/OFFICE VISITS CONTRA (FLIP SIDE A
8431	Inactive	687-CRS CLINIC CONTRA
8432	Inactive	688-FQHC DENTAL ENCOUNTER CONTRA (D9430)
8433	Inactive	689-HOSPITAL ADMISSION CODE CONTRA
8434	Inactive	691-POSTPARTUM/PRENATAL VISIT CONTRA
8435	Inactive	692-PRENATAL EDUCATION LIMIT
8436	Inactive	693-TEMPORARY FILLING/DEFINITE FILLING CONTRA (AUD
8437	Inactive	694-MISCELLANEOUS SERVICES EMERGENCY ROOM CONTRA
8438	Inactive	696-PRENATAL VISIT/INITIAL VISIT CONTRA (FAMILY PL
8439	Inactive	697-CARDIAC REHAB SERVICE LIMIT (PHYSICIAN)
8440	Inactive	698-CARDIAC REHAB SERVICE LIMIT(OUTPATIENT)
8441	Inactive	699-CARDIOGRAPHY PROCEDURES LIMIT
8442	Inactive	701-DENTAL TWO PER LIFETIME PER TOOTH
8443	Inactive	702-DENTAL-CROWNS/RECEMENT OF CROWN SIX-MONTH CONT
8444	Inactive	703-DENTAL-CORE BUILDUP CONTRA (FLIP SIDE B80)
8445	Inactive	704-DENTAL-POST/CORE/RESTORATION/CROWNS CONTRA(FLI

8446	Inactive	705-DENTAL- CROWNS CONTRA
8447	Inactive	707-INITIAL SCREENING LIMIT
8448	Inactive	708-MHSP-LIMIT 12 PER YEAR
8449	Inactive	710-DIAGNOSTICS ASSESSMENTS LIMIT
8450	Inactive	711-INDIVIDUAL AND GROUP THERAPY CONTRA (MHSP)
8451	Inactive	712-REHABILITATIVE DAY PROGRAM LIMIT
8452	Inactive	718-PROCEDURE LIMIT ONCE PER LIFE
8453	Inactive	723-RENAL DIALYSIS LIMIT 156
8454	Inactive	725-TEST 8 FOR E SERIES TESTS
8455	Inactive	726-TEST 9 FOR E SERIES
8456	Inactive	727-MONTHLY CAPITATION LIMIT
8457	Inactive	728-DIALYSIS TRAINING LIMIT
8458	Inactive	729-ADMINISTRATION FEE/LABS CODES CONTRA (FLIP SID
8459	Inactive	730-ESWL PRICING
8460	Inactive	731-PHYSICIANS-OTOLARYNGOLOGIC EXAM/EAR,NOSE,THROA
8461	Inactive	732-PHYSICIAN/INFUSION THERAPY CONTRA (FLIP SIDE B
8462	Inactive	733-ADMINISTRATION FEE/FACILITY FEE CONTRA
8463	Inactive	734-OPERATING MICROSCOPE/INCLUSIVE COMPONENT CONTR
8464	Inactive	735-PHYSICIAN/APPLICATION AND REMOVAL OF CAST/STRA
8465	Inactive	738-RADIOLOGY CONTRA AUDIT
8466	Inactive	739-INTRAOCULAR LENS COMBINATION CONTRA
8467	Inactive	741-MHSP CLINIC VISIT
8468	Inactive	742-MULTIPLE URINALYSIS COMPONENTS
8469	Inactive	743-ATTENDANCE AT C-SECTION CONTRA
8470	Inactive	744-EPSDT SCREENING LIMIT UNDER 1 YEAR
8471	Inactive	745-EPSDT SCREENING LIMIT 1 THRU 2 YEARS OF AGE
8472	Inactive	746-HOSPITALIZATION DAY TREATMENT LIMIT
8473	Inactive	749-PLAN FIRST(HIGH RISK)RISK ASSESSMENT
8474	Inactive	750-PREVENTIVE CARE COORDINATION LIMIT
8475	Inactive	751-FAMILY PLANNING/STERILIZATION CONTRA
8476	Inactive	752-PLAN FIRST CARE COORDINATION LIMIT
8477	Inactive	753-MIDWIFE OBSTETRICAL CARE LIMIT
8478	Inactive	754-CBC/PLATELET COUNT CONTRA

8479	Inactive	758-LAB-PANEL TEST CONTRA
8480	Inactive	759-INTUBATION/NEWBORN RESUSCITATION CONTRA
8481	Inactive	760-INITIAL FAMILY PLANNING VISIT LIMIT
8482	Inactive	761-ANNUAL FAMILY PLANNING VISIT LIMIT
8483	Inactive	762-PRENATAL VISIT/SUPPLY VISIT CONTRA
8484	Inactive	763-PRENATAL VISIT/COUNSELING VISIT CONTRA
8485	Inactive	764-PSYCHOLOGIST-PHARMACOLOGIC MANAGEMENT CONTRA
8486	Inactive	766-ROOT CANAL CONTRA
8487	Inactive	767-CASE MANAGEMENT (MENTALY RETARDED)
8488	Inactive	768-DME CODES LIMITED TO THIRTY-ONE UNITS PER MONT
8489	Inactive	769-C-SECTION/TUBAL LIGATION 50% ALLOW
8490	Inactive	770-INITIAL AND PERIODIC ORAL EXAM LIMIT
8491	Inactive	771-UNIT LIMIT EXCEEDED
8492	Inactive	772-DENTAL ORAL EVALUATION CONTRA
8493	Inactive	773-PROFESSIONAL SERVICES IMMUNOTHERAPY CONTRA
8494	Inactive	774-ALLERGEN IMMUNOTHERAPY CONTRA
8495	Inactive	775-PROFESSIONAL SERVICES ADMINISTRATION FEE CONTR
8496	Inactive	776-ALLERGY CODES SAME DAY CONTRA
8497	Inactive	777-PHYSICIAN VISIT/DIALYSIS PROCEDURE CONTRA
8498	Inactive	778-OUTPATIENT OBSERVATION CONTRA
8499	Inactive	779-ADMINISTRATION FEE/PRENATAL/FAMILY PLANNING CO
8500	Inactive	780-PRENATAL CLINIC POSTPARTUM CONTRA
8501	Inactive	781-PRENATAL/POSTPARTUM VISIT CONTRA
8502	Inactive	782-PRENATAL VISIT/FAMILY PLANNING CONTRA
8503	Inactive	784-ULTRASOUND ECHOGRAPHY CONTRA
8504	Inactive	785-PROFESSIONAL (COMPONENT) ULTRASOUND ECHOGRAPHY
8505	Inactive	786-NICU/SUBSEQUENT PROCEDURE CONTRA
8506	Inactive	787-HIV/AIDS WAIVER RESPITE CARE LIMIT
8507	Inactive	788-NORPLANT INSERTION LIMITATIONS
8508	Inactive	789-INITIAL NICU CODE CONTRA
8509	Inactive	790-ADMINISTRATIVE SET LIMT
8510	Inactive	791-NEWBORN RESUSCITATION/INTUBATION CONTRA

8511	Inactive	792-DISPOSABLE AND NONDISPOSABLE NEBULIZER CONTRA
8512	Inactive	793-BINAURAL HEARING AID REPAIR LIMIT
8513	Inactive	794-NICU/RESUSCITATION/STANDBY CONTRA
8514	Inactive	795-NORPLANT PROCEDURE CONTRA
8515	Inactive	796-MISCELLANEOUS DME CODES CONTRA (WALKERS, CRUTC
8516	Inactive	797-WAIVER TA WAIVER MEDICAL SUPPLIES/APPLIANCES L
8517	Inactive	798-TEST 4 E SERIES SCREENS
8518	Inactive	800-STANDBY CARE FREQUENCY LIMIT
8519	Inactive	801-OPTOMETRIC LENS LIMIT
8520	Inactive	802-NEWBORN LIMIT
8521	Inactive	803-HOSPITAL VISITS/EPSDT SCREENING CONTRA
8522	Inactive	804-OPTOMETRIC FRAME LIMIT
8523	Inactive	805-EYE EXAM LIMIT
8524	Inactive	806-BATTERY/HEARING AID CONTRA
8525	Inactive	807-HOME VISIT CONTRA (FAMILY PLANNING)
8526	Inactive	808-HEARING AID BATTERY (Z5065) LIMIT
8527	Inactive	809-EAR MOLDS LIMITATION
8528	Inactive	810-HEARING AID REPAIR LIMIT
8529	Inactive	811-PHYSICIAN VISIT LIMT
8530	Inactive	812-CHEMISTRY PROFILE/PANEL CONTRA
8531	Inactive	813-NEBULIZER WITH COMPRESSOR LIMIT-4 YEARS
8532	Inactive	814-HEARING AID STHETHOSCOPE LIMIT
8533	Inactive	815-ELECTROSHOCK THERAPY VS HOSPITAL VISIT CONTRA
8534	Inactive	816-PROCEDURE CODE LIMIT TO 3 PER CALENDAR MONTH
8535	Inactive	817-PROCEDURE CODE LIMIT TO 2 PER CALENDAR MONTH
8536	Inactive	818-MULTIPLE URINALYSIS LIMIT
8537	Inactive	819-NEBULIZER WITH COMPRESSOR LIMIT
8538	Inactive	820-FITTING EXAM LIMIT
8539	Inactive	821-EPSDT SCREENING LIMIT 3 THRU 20 YEARS
8540	Inactive	822-WAIVER MR AND LAHW SPECIALIZED MEDICAL EQUIPME
8541	Inactive	823-FULL SERIES/PANORAMIC X-RAY LIMIT
8542	Inactive	824-SALPINGECTOMY TUBAL LIGATION CONTRA
8543	Inactive	825-DEPO-PROVERA INJECTION LIMIT (J1055)

8544	Inactive	826-MULTIPLE CHEMISTRY TEST LIMIT
8545	Inactive	827-SPACE MAINTAINER LIMIT
8546	Inactive	828-TPS/PROC LIMITED TO ONCE PER LIFETIME
8547	Inactive	829-EARMOLDS LIMITATION - BINAURAL
8548	Inactive	830-SPECIMEN COLLECTION FEE LIMIT ONE PER DAY
8549	Inactive	831-CBC AND COMPONENTS LIMIT
8550	Inactive	832-HEARING AID BATTERY LIMIT--BINAURAL
8551	Inactive	833-EMERGENCY ROOM/INITIAL HOSPITAL CARE CONTRA
8552	Inactive	835-PROCEDURE LIMITED TO TWICE PER LIFETIME
8553	Inactive	839-HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA
8554	Inactive	840-COMPLETE BLOOD COUNT CONTRA
8555	Inactive	841-PROCEDURE FOR ASSISTANT SURGEON LIMIT TO ONCE
8556	Inactive	842-INITIAL DENTAL EXAM CONTRA
8557	Inactive	843-ASSISTANT SURGERY LIMITED TO ONCE PER LIFETIME
8558	Inactive	844-PROCEDURE FOR ASSISTANT SURGEON LIMIT TO TWICE
8559	Inactive	845-EPSDT VISION SCREEN / EXTERNAL OCULAR PHOTOGRA
8560	Inactive	846-WAIVER:MR/LAHW PREVOCATIONAL SVCS, SUPPORTED E
8561	Inactive	847-PRENATAL OFFICE VISIT LIMIT
8562	Inactive	848-REDUCTION MAMMOPLASTY CONTRA
8563	Inactive	849-DELIVERY ONLY / OTHER CONTRA
8564	Inactive	850-INCIDENTAL SURGERY FOR AUDIT 850
8565	Inactive	851-INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE
8566	Inactive	852-ROOT CANAL THERAPY INCLUDES X-RAYS
8567	Inactive	853-FAMILY PLANNING NORPLANT CONTRA
8568	Inactive	854-PALLIATIVE(EMERGENCY)TREATMENT W/DEFININITIVE
8569	Inactive	855-HOSPITAL VISIT/DISCHARGE CONTRA
8570	Inactive	856-SPACER, BAG LIMIT WITH INHALERS (A4627)
8571	Inactive	857-CBC AND COMPONENTS NOT ALLOWED ON SAME DAY(PRO
8572	Inactive	858-U/A AND COMPONENTS NOT ALLOWED ON SAME DAY
8573	Inactive	859-NEW PATIENT LIMIT

8574	Inactive	860-EPSDT / OFFICE VISIT CONTRA
8575	Inactive	861-NURSES MIDWIFE CONTRA
8576	Inactive	862-LEG BAG WITH TUBE
8577	Inactive	863-EIGHT STOCKING PER YEAR
8578	Inactive	864-HYSTERECTOMY/ADDITIONAL PROC CONTRA
8579	Inactive	865-DELIVERY/HOSPITAL VISIT CONTRA
8580	Inactive	866-CBC AND COMPONENTS NOT ALLOWED ON THE SAME DAY
8581	Inactive	867-HOSPITAL ADMISSION/SUBSEQUENT VISIT
8582	Inactive	868-DELIVERY/LOCAL ANESTHESIA CONTRA
8583	Inactive	869-PERIODIC REVISIT LIMIT
8584	Inactive	870-PSYCHOTHERAPY/HOSPITAL VISITS CONTRA
8585	Inactive	871-PSYCHOTHERAPY/OFFICE VISITS CONTRA
8586	Inactive	872-NORPLANT PHYSICAL WITH COUNSELING
8587	Inactive	873-ABORTION/LINE-ITEM CONTRA
8588	Inactive	874-PROCEDURE LIMIT TO ONE EVERY TWO YEARS
8589	Inactive	875-HOSPITAL DAYS-LIMIT EXCEEDED (HARDCODED)
8590	Inactive	877-PRESSURE PAD WITH PUMP EVERY THREE YEARS
8591	Inactive	878-PHYSICIAN VISIT ONE PER DAY
8592	Inactive	879-OFFICE VISIT/ADMINISTRATION FEE CONTRA
8593	Inactive	880-INCIDENTAL ASSISTANT SURGERY WITH DEFINITIVE S
8594	Inactive	881-PASSIVE TRANSFER TESTS SERIES
8595	Inactive	882-COMPONENTS OF CBC CONTRA
8596	Inactive	883-SUBSEQUENT CRITICAL CARE (99292) NOT VALID W/O
8597	Inactive	884-DELIVERY/REGIONAL ANESTHESHIA CONTRA
8598	Inactive	885-SUBSEQUENT CRITICAL CARE HOSPITAL VISIT CONTRA
8599	Inactive	886-TONO/VISUAL FIELDS COMPR EXAM CONTRA
8600	Inactive	887-CATHETER, CATHETERS TRAYS, AND DRAINAGE BAG LI
8601	Inactive	888-ROUTINE CARE INCLUDED IN SURGERY FEE
8602	Inactive	889-EXCEEDED PHYSICIAN HOSPITAL

8603	Inactive	890-PROC NONCOV WITH OUTPATIENT SURGERY
8604	Inactive	891-PHYSICIAN BENEFIT LIMIT
8605	Inactive	892-INITIAL CRITICAL CARE(99291) LIMITED TO ONE PE
8606	Inactive	893-OBSTETRICAL CARE LIMIT
8607	Inactive	894-ROUTINE CARE INCLUDED IN ASSISTANT SURGERY FEE
8608	Inactive	895-ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CAR
8609	Inactive	896-ROUTINE POST PARTUM CARE PART OF TOTAL OB
8610	Inactive	897-EMERG ROOM/CHOMO ADMIN CONTRA
8611	Inactive	898-MULTIPLE SURGERY SAME DAY
8612	Inactive	900-PRESCRIPTION NUMBER MISSING OR INVALID
8613	Inactive	901-QUANTITY DISPENSED INVALID
8614	Inactive	903-DAYS SUPPLY > AUTHORIZED DAYS OR INVALID
8615	Inactive	904-DATE PRESCRIBED INVALID
8616	Inactive	907-PRESCRIBING PROV ID MISSING, INVALID, OR INACT
8617	Inactive	908-DATE DISPENSED EARLIER THAN THE DATE PRESCRIBE
8618	Inactive	911-REFILL AUTHORIZATION MISSING OR GREATER THAN F
8619	Inactive	913-CLAIM CANNOT BE PAID DUE TO ERROR AT THE DETAI
8620	Inactive	927-OTC PRODUCT NOT COVERED FOR LTC RECIPIENT
8621	Inactive	930-CLAIM DENIED FOR INVALID DAW (DISPENSE AS WRIT
8622	Inactive	931-PHARMACY MISSING/INVALID SERVICE PROVIDER ID Q
8623	Inactive	932-PHARMACY MISSING/INVALID INSURANCE SEGMENT
8624	Inactive	933-PHARMACY MISSING/INVALID CLAIM SEGMENT
8625	Inactive	934-PHARMACY PRODUCT/SERVICE NOT COVERED
8626	Inactive	935-PHARMACY MISSING/INVALID PRODUCT/SERVICE ID QU
8627	Inactive	936-PHARMACY MISSING/INVALID PRESCRIBER SEGMENT
8628	Inactive	937-PHARMACY MISSING/INVALID PRESCRIBER ID QUALIFI

8629	Inactive	938-PHARMACY MISSING/INVALID PRICING SEGMENT
8630	Inactive	939-PHARMACY MISSING/INVALID OTHER PAYER AMOUNT PA
8631	Inactive	940-PHARMACY MISSING/INVALID SEGMENT IDENTIFICATIO
8632	Inactive	941-INVALID COPAY INDICATOR
8633	Inactive	942-PHARMACY ELECTRONIC ADJUSTMENT CONFLICT
8634	Inactive	950-VERIFY DUR CODE VALUES
8635	Inactive	951-PREVIOUSLY DUR ALERTED CLAIM CANNOT BE FOUND
8636	Inactive	952-PREVIOUSLY DUR ALERTED CLAIM CANNOT BE OVERRID
8637	Inactive	997-MORE THAN 10 LEVEL 1 AND 2 ERRORS
8638	Inactive	999-RECYCLE - OVERFLOW CLAIMS TABLE
8639	Inactive	A03-PHARMACY MAX QUANTITY EXCEEDED FOR 30-DAY PERI
8640	Inactive	A04-WAIVER CARE CONTRA
8641	Inactive	A05-ANESTHESIA SUBSEQUENT PROCEDURE AUDIT 421/A05
8642	Inactive	A07-FETAL DOPPLER/ECHOCARDIOGRAPHY CONTRA
8643	Inactive	A08-FETAL ECHOCARDIOGRAPHY CONTRA
8644	Inactive	A09-FITTING OF CONTACT LENS CONTRA
8645	Inactive	A10-ALS TRANSPORTATION/SUPPLY CONTRA
8646	Inactive	A12-VACCINE REPLACEMENT/ADMINISTRATION FEE CONTRA
8647	Inactive	A13-FAMILY PLANNING CONTRA
8648	Inactive	A14-POST CATARACT CONTRA
8649	Inactive	A15-SKIN BARRIER CONTRA
8650	Inactive	A16-OSTOMY POUCH CONTRA
8651	Inactive	A19-WAIVER:MR/LAHW RESIDENTIAL HABILIT./RESPITE CA
8652	Inactive	A21-VACCINE/NON STANDARD CONTRA
8653	Inactive	A24-INDIVIDUAL COUNSELING PSYCHOTHERAPY CONTRA
8654	Inactive	A25-GROUP COUNSELING OR PSYCHOTHERAPY CONTRA
8655	Inactive	A26-MEDICATION ADMINISTRATION/MEDICAL MONITORING C
8656	Inactive	A27-CRITICAL CARE/SUBSEQUENT PROCEDURE CONTRA
8657	Inactive	A28-INTAKE EVALUATION CONTRA

8658	Inactive	A29-PHYSICIAN MEDICAL ASSESSMENT AND TREATMENT
8659	Inactive	A30-CRISIS INTERVENTION CONTRA
8660	Inactive	A31-DAY TREATMENT CONTRA - ADULT
8661	Inactive	A32-DAY TREATMENT CONTRA - CHILD/ADOLESCENT
8662	Inactive	A33-INTENSIVE OUTPATIENT SERVICES CONTRA
8663	Inactive	A34-CHEMOTHERAPY ADMINISTRATION FEES(FLIP SIDE 686
8664	Inactive	A35-CRS CLINIC CONTRA
8665	Inactive	A38-POSTPARTUM/PRENATAL VISIT CONTRA
8666	Inactive	A39-MISCELLANEOUS SERVICES EMERGENCY ROOM CONTRA
8667	Inactive	A40-PRENATAL VISIT/INITAL VISIT CONTRA (FAMILY PLA
8668	Inactive	A43-ADMINISTRATION FEE/FACILITY FEE CONTRA
8669	Inactive	A45-INTRAOCULAR LENS COMBINATION CONTRA
8670	Inactive	A47-ATTENDANCE AT C-SECTION CONTRA
8671	Inactive	A48-CBC/PLATELET COUNT CONTRA
8672	Inactive	A50-INTUBATION/NEWBORN RESUSCITATION CONTRA
8673	Inactive	A52-PRENATAL VISIT/SUPPLY VISIT CONTRA
8674	Inactive	A53-PRENATAL VISIT/COUNSELING VISIT CONTRA
8675	Inactive	A54-PSYCHOLOGIST-PHARMACOLOGIC MANAGEMENT CONTRA
8676	Inactive	A55-C-SECTION/TUBAL LIGATION 50% ALLOW
8677	Inactive	A56-PROFESSIONAL SERVICES IMMUNOTHERAPY CONTRA
8678	Inactive	A57-ALLERGEN IMMUNOTHERAPY CONTRA
8679	Inactive	A60-PHYSICIAN VISIT/DIALYSIS PROCEDURE CONTRA
8680	Inactive	A62-ADMINISTRATION FEE/PRENATAL/FAMILY PLANNING CO
8681	Inactive	A63-PRENATAL CLINIC POSTPARTUM CONTRA
8682	Inactive	A64-PRENATAL/POSTPARTUM VISIT CONTRA
8683	Inactive	A65-PRENATAL VISIT/FAMILY PLANNING CONTRA
8684	Inactive	A66-ULTRASOUND ECHOGRAPHY CONTRA
8685	Inactive	A67-PROFESSIONAL (COMPONENT) ULTRASOUND ECHOGRAPHY

8686	Inactive	A68-NICU/SUBSEQUENT PROCEDURE CONTRA
8687	Inactive	A70-NEWBORN RESUSCITATION/INTUBATION CONTRA
8688	Inactive	A71-DISPOSABLE AND NONDISPOSABLE NEBULIZER CONTRA
8689	Inactive	A72-NICU/RESUSCIATATION/STANDBY CONTRA
8690	Inactive	A75-HOSPITAL VISITS/EPSDT SCREENING CONTRA
8691	Inactive	A76-BATTERY/HEARING AID CONTRA
8692	Inactive	A77-HOME VISIT CONTRA (FAMILY PLANNING)
8693	Inactive	A78-CHEMISTRY PROFILE/PANEL CONTRA
8694	Inactive	A79-ELECTROSHOCK THERAPY VS HOSPITAL VISIT CONTRA
8695	Inactive	A80-SALPINGECTOMY TUBAL LIGATION CONTRA
8696	Inactive	A83-EMERGENCY ROOM/INITIAL HOSPITAL CARE CONTRA
8697	Inactive	A86-HOSPITAL VISIT/PROFESSIONAL COMPONENT CONTRA
8698	Inactive	A87-COMPLETE BLOOD COUNT CONTRA
8699	Inactive	A89-EPSDT VISION SCREEN / EXTERNAL OCULAR PHOTOGRA
8700	Inactive	A90-PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMEN
8701	Inactive	A91-REDUCTION MAMMOPLASTY CONTRA
8702	Inactive	A92-DELIVERY ONLY / OTHER CONTRA
8703	Inactive	A93-INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE
8704	Inactive	A94-INCIDENTAL SURGERY NOT COVERED WITH DEFINITIVE
8705	Inactive	A95-ROOT CANAL THERAPY INCLUDES X-RAYS
8706	Inactive	A96-FAMILY PLANNING NORPLANT CONTRA
8707	Inactive	A97-EMERGENCY ORAL EXAM WITH ANOTHER PROCEDURE COD
8708	Inactive	A98-HOSPITAL VISIT/DISCHARGE CONTRA (FLIP SIDE 855
8709	Inactive	A99-CBC AND COMPONENTS NOT ALLOWED ON SAME DAY
8710	Inactive	B00-U/A AND COMPONENTS NOT ALLOWED ON SAME DAY
8711	Inactive	B02-EPSDT / OFFICE VISIT CONTRA
8712	Inactive	B03-NURSES MIDWIFE CONTRA

8713	Inactive	B04-HYSTERECTOMY/ADDITIONAL PROC CONTRA
8714	Inactive	B05-DELIVERY/HOSPITAL VISIT CONTRA
8715	Inactive	B06-CBC AND COMPONENTS NOT ALLOWED ON SAME DAY
8716	Inactive	B07-HOSPITAL ADMISSION/SUBSEQUENT VISIT CONTRA
8717	Inactive	B08-DELIVERY/LOCAL ANESTHESIA CONTRA
8718	Inactive	B09-PSYCHOTHERAPY/HOSPITAL VISITS CONTRA
8719	Inactive	B10-PSYCHOTHERAPY/OFFICE VISITS CONTRA
8720	Inactive	B11-NORPLANT PHYSICAL WITH COUNSELING
8721	Inactive	B12-ABORTION/LINE-ITEM CONTRA
8722	Inactive	B14-OFFICE VISIT/ADMINISTRATION FEE CONTRA
8723	Inactive	B15-INCIDENTAL ASSISTANT SURGERY WITH DEFINITIVE S
8724	Inactive	B17-COMPONENTS OF CBC CONTRA
8725	Inactive	B18-DELIVERY/REGIONAL ANESTHESIA CONTRA
8726	Inactive	B19-SUBSEQUENT CRITICAL CARE HOSPITAL VISIT CONTRA
8727	Inactive	B20-TONO/VISUAL FIELDS COMPR EXAM CONTRA
8728	Inactive	B21-ROUNTINE CARE INCLUDED IN SURGERY FEE
8729	Inactive	B22-PROC NONCOV WITH OUTPATIENT SURGERY
8730	Inactive	B23-ROUTINE CARE INCLUDED IN ASSISTANT SURGERY FEE
8731	Inactive	B24-ROUTINE PRENATAL CARE INCLUDED IN TOTAL OB CAR
8732	Inactive	B25-ROUTINE POST PARTUM CARE PART OF TOTAL OB
8733	Inactive	B26-EMERG ROOM/CHEMO ADMIN CONTRA
8734	Inactive	B30-DENTAL PULPAL THERAPY (D3220) ANY DOS CONTRA
8735	Inactive	B31-DENTAL PULPAL THERAPY (D3310) SAME DOS CONTRA
8736	Inactive	B32-DENTAL PULPAL THERAPY (D3320) SAME DOS CONTRA
8737	Inactive	B33-DENTAL PULPAL THERAPY (D3330) SAME DOS CONTRA

8738	Inactive	B34-DENTAL PULPAL THERAPY (D3351) SAME DOS CONTRA
8739	Inactive	B35-DENTAL PULPAL THERAPY (D3410) SAME DOS CONTRA
8740	Inactive	B36-DENTAL PUPAL THERAPY (D3430) SAME DOS CONTRA
8741	Inactive	B37-DENTAL PULPAL THERAPY (D3220) ANY DOS CONTRA
8742	Inactive	B38-DENTAL PULPAL THERAPY (D3230) ANY DOS CONTRA
8743	Inactive	B39-DENTAL PULPAL THERAPY (D3240) ANY DOS CONTRA
8744	Inactive	B40-DENTAL PULPAL THERAPY (D3310) ANY DOS CONTRA
8745	Inactive	B43-DENTAL PULPAL THERAPY (D3332) ANY DOS CONTRA
8746	Inactive	B50-PROPHYLAXIS/FLUORIDE FRAGEMENTED BILLING SAME/
8747	Inactive	B56-DENTAL EXTRACTION CONTRA (AUDIT B56/637)
8748	Inactive	B57-TEMPORARY FILLING/DEFINITE FILLING CONTRA (AUD
8749	Inactive	B64-VISION CARE CONTRA - V2025
8750	Inactive	B65-PRIMARY ANESTHESIA/INECTION OR CATHETER 50% AL
8751	Inactive	B66-ROOT CANAL/CROWN CONTRA
8752	Inactive	B67-CATHETER PLACEMENT/DAILY MANAGEMENT OF EPIDURA
8753	Inactive	B74-INDIVIDUAL COUNSELING-SUBSTANCE ABUSE CONTRA
8754	Inactive	B77-MENTAL HEALTH REHAB CONTRA
8755	Inactive	B78-DENTAL CROWNS/RESTORATION CONTRA
8756	Inactive	B79-DENTAL-POST/CORE/RESTORATION/CROWNS CONTRA (FL
8757	Inactive	B80-DENTAL-CORE BUILDUP CONTRA (FLIP SIDE 703)
8758	Inactive	B83-PHYSICIAN-OTOLARYNGOLOGIC EXAM/EAR,NOSE THROAT
8759	Inactive	B84-PHYSICIAN/INFUSION THERAPY CONTRA (FLIP SIDE 7
8760	Inactive	B86-PHYSICIAN/APPLICATION AND REMOVAL OF CAST/STRA
8761	Inactive	B87-ADMINISTRATION FEE/LAB CODES CONTRA (FLIP SIDE

8762	Inactive	C01-OPTOMETRIC LENS LIMIT (21 AND OLDER)
8763	Inactive	C04-OPTOMETRIC FRAME LIMIT (21 AND OLDER)
8764	Inactive	C05-EYE EXAM LIMIT (21 AND OLDER)
8765	Inactive	C06-PAP SMEAR COLLECTION ONE PER DAY
8766	Inactive	C12-NURSING HOME THERAPEUTIC LEAVE DAYS LIMIT
8767	Inactive	C20-FITTING EXAM LIMIT (21 AND OLDER)
8768	Inactive	C21-PHYSICAL THERAPY 12-PER YEAR
8769	Inactive	C22-PHYSICAL THERAPY-10 PER YEAR
8770	Inactive	C23-PHYSICAL THERAPY-24 PER YEAR
8771	Inactive	C24-PHYSICAL THERAPY-96 PER YEAR
8772	Inactive	C25-PHYSICAL THERAPY-16 PER YEAR
8773	Inactive	C26-PHYSICAL THERAPY-18 PER YEAR
8774	Inactive	C27-PHYSICIAL THERAPY-4 PER YEAR
8775	Inactive	C28-PHYSICAL THERAPY-8 PER YEAR
8776	Inactive	C29-PHYSICAL THERAPY-36 PER YEAR
8777	Inactive	C30-PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA
8778	Inactive	C31-PHYSICAL THERAPY TO ONE AREA CONTRA
8779	Inactive	C32-PHYSICAL THERAPY APPLIANCES CONTRA
8780	Inactive	Z01-EPSDT SCREENING TYPE IS INVALID
8781	Inactive	Z03-INVALID EMPLOYMENT INDICATOR
8782	Inactive	Z04-ACCIDENT INDICATOR IS MISSING OR INVALID
8783	Inactive	Z05-VERIFY EMERGENCY INDICATOR.
8784	Inactive	Z09-NET CHARGE IS NOT NUMERIC
8785	Inactive	Z10-EPSDT INDICATOR IS INVALID
8786	Inactive	Z11-DTL DATES OF SERVICE NOT WITHIN HDR DATES OF S
8787	Inactive	Z14-ADMISSION HOUR INVALID
8788	Inactive	Z16-DISCHARGE HOUR IS INVALID
8789	Inactive	Z17-NON-COVERED DAYS ARE INVALID
8790	Inactive	Z18-ONE OR MORE OCCURENCE CODES ARE INVALID
8791	Inactive	Z19-ONE OR MORE OCCURRENCE DATES ARE INVALID
8792	Inactive	Z20-ONE OR MORE OCC DATES NOT BETWEEN HDR DATES OF
8793	Inactive	Z21-ONE OR MORE CONDITION CODES ARE INVALID

8794	Inactive	Z22-OTHER INSURANCE AMOUNT NOT NUMERIC
8795	Inactive	Z23-SURG,OCC,OR CONDITION COUNT IS MISSING OR INVA
8796	Inactive	Z24-TOTAL LIC BEDS ON CENSUS MUST BE <= THAN ON FI
8797	Inactive	Z25-ONE OR MORE COUNTS ON THE CENSUS ARE NOT NUMER
8798	Inactive	Z31-ELIGIBILITY VERIFICATION FUZZY SEARCH MISMATCH
8799	Inactive	Z43-TANDEM REFRESH TEST
8800	Inactive	Z80-ADJUDICATED CLAIM CANNOT BE REVERSED
8801	Inactive	Z81-ACCEPTED CLAIM CANNOT BE REVERSED
8802	Inactive	Z82-RECIPIENT ID/CLAIM RECORD MISMATCH
8803	Inactive	Z83-PROVIDER ID/CLAIM RECORD MISMATCH
8804	Inactive	Z84-CLAIM CAN ONLY BE REVERSED SAME DAY AS SUBMITT
8805	Inactive	Z98-INVALID MMIS DATA FIELDS SENT TO AEVCS
8806	Inactive	Z99-DETAIL COUNT IS MISSING OR INVALID
8948	Inactive	948-SUSPENDED CLAIM DENIED - CONVERSION 2/23/2008.
9000	Inactive	PHARMACY ALLOWED AMOUNT IS LESS THAN BILLED AMOUNT
9999	Active	DUMMY EDIT PLACEHOLDER FOR CONFIGURATOR

Error Code **201**

Erro

Edit #:	201	**Policy #:**	
Message:	BILLING PROVIDER ID NUMBER MISSING		
Groups:			
Criteria:	ALL CLAIM TYPES: THE EDIT SETS IF THE BILLING PROVIDER ID SUBMITTED ON THE CLAIM HEADER IS NULL (NOT SUBMITTED) OR ALL SPAC THIS EDIT POSTS AT THE HEADER. CRITERIA VERIFIED BY CPV 01/31/2007.		
Method of Correction	1. Verify that the provider number was keyed correctly from the claim form. 2. If provider number missing,forward the worksheet and batch to provider enrollment unit.		

Claim Type	Program	ICN Region	Line Status	Disposition Status	EOB Code
All Claim Types	All Programs	All Regions	Active	Deny	0201
All Claim Types	All Programs	10	Active	Suspend	0201
All Claim Types	All Programs	11	Active	Suspend	0201
All Claim Types	All Programs	50	Active	Suspend	0201
All Claim Types	All Programs	51	Active	Suspend	0201
All Claim Types	All Programs	52	Active	Inactive	0201
All Claim Types	All Programs	53	Active	Inactive	0201
All Claim Types	All Programs	54	Active	Inactive	0201
All Claim Types	All Programs	55	Active	Inactive	0201
All Claim Types	All Programs	56	Active	Suspend	0201
All Claim Types	All Programs	57	Active	Suspend	0201
All Claim Types	All Programs	58	Active	Suspend	0201
All Claim Types	All Programs	71	Active	T	0201
All Claim Types	All Programs	72	Active	Deny	0201
All Claim Types	All Programs	79	Active	T	0201
All Claim Types	All Programs	80	Active	Suspend	0201
All Claim Types	All Programs	90	Active	Suspend	0201
All Claim Types	All Programs	91	Active	Suspend	0201

Associated Test Cases

Test Case	Env	Description

Associated Requirements

Requirement

or Disposition

CES OR ALL ZEROES (I.E. '000000000').

Error Code 5200

Edit #:	5200	**Policy #:**	
Message:	ADMIN FEE/VACCINE REPLACEMENT CONTRA		
Groups:			
Criteria:	Audit fails if a current administrative fee procedure code is billed for the sar **NOTE: Recipients age 19 and older are excluded from this audit.** **Took off exclusion of Recipient Plan since auditing is only performe** **(see Resolution Notes)(CO 6434 - CP2009010501)**		
Method of Correction	1. Verify that the codes were keyed correctly. If not, make the necessary c 2. If keyed correctly, deny procedure code setting the audit with EOB code 3. If there is a special batch claim, verify if Agency letter is attached overri This audit is currently on auto-deny with EOB 5200, except for special batc (see Resolution Notes)(CO 6434)		

Claim Type	Program	ICN Region	Line Status	Disposition Status	EOB Code
All Claim Types	All Programs	All Regions	Active	Deny	5200
All Claim Types	All Programs	71	Active	Pay	5200
All Claim Types	All Programs	72	Active	Pay	5200
All Claim Types	All Programs	79	Active	Pay	5200
All Claim Types	All Programs	90	Active	Suspend	5200
All Claim Types	All Programs	91	Active	Suspend	5200

Associated Test Cases

Test Case	Env	Description

Associated Requirements

Requirement

Error Disposition

me date of service by the same performing provider as the corresponding history vaccine replacement procedure code found in the procedure list attached to

d on claim type M (medical).

:orrections.

5200.

ding audit, If yes, force ESC 5200. If no then deny with EOB 5200.

:hes.

this audit panel.

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS IN 4.00 SECOND COMPLIANCE
REPORT PERIOD: 11/01/2018 - 11/30/2018

	AGENCY TRANSACTIONS			CONTRACTOR TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	21,383	20,903	98%	92,124	89,433	97%
11/04/2018 - 11/10/2018	42,342	40,460	96%	234,946	227,709	97%
11/11/2018 - 11/17/2018	36,456	35,253	97%	223,772	216,186	97%
11/18/2018 - 11/24/2018	20,495	19,861	97%	119,192	115,068	97%
11/25/2018 - 11/30/2018	48,354	46,577	96%	215,346	208,515	97%

	HID TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	71,802	70,936	99%
11/04/2018 - 11/10/2018	196,867	194,373	99%
11/11/2018 - 11/17/2018	189,631	187,147	99%
11/18/2018 - 11/24/2018	113,452	111,960	99%
11/25/2018 - 11/30/2018	198,059	195,287	99%

COMPLIANCE THRESHOLD: 90% of transactions within 4.00 seconds or less

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS IN 5.00 SECOND COMPLIANCE
REPORT PERIOD: 11/01/2018 - 11/30/2018

	AGENCY TRANSACTIONS			CONTRACTOR TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	21,383	20,975	98%	92,124	90,233	98%
11/04/2018 - 11/10/2018	42,342	40,783	96%	234,946	230,163	98%
11/11/2018 - 11/17/2018	36,456	35,479	97%	223,772	218,560	98%
11/18/2018 - 11/24/2018	20,495	19,930	97%	119,192	116,372	98%
11/25/2018 - 11/30/2018	48,354	46,879	97%	215,346	210,531	98%

	HID TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	71,802	71,225	99%
11/04/2018 - 11/10/2018	196,867	195,306	99%
11/11/2018 - 11/17/2018	189,631	188,093	99%
11/18/2018 - 11/24/2018	113,452	112,516	99%
11/25/2018 - 11/30/2018	198,059	196,335	99%

COMPLIANCE THRESHOLD: 95% of transactions within 5.00 seconds or less

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS IN 6.00 SECOND COMPLIANCE
REPORT PERIOD: 11/01/2018 - 11/30/2018

	AGENCY TRANSACTIONS			CONTRACTOR TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	21,383	21,033	98%	92,124	90,671	98%
11/04/2018 - 11/10/2018	42,342	40,960	97% **OOC**	234,946	231,601	99%
11/11/2018 - 11/17/2018	36,456	35,628	98%	223,772	219,901	98%
11/18/2018 - 11/24/2018	20,495	20,003	98%	119,192	117,068	98%
11/25/2018 - 11/30/2018	48,354	47,102	97%	215,346	211,677	98%

	HID TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	71,802	71,393	99%
11/04/2018 - 11/10/2018	196,867	195,759	99%
11/11/2018 - 11/17/2018	189,631	188,541	99%
11/18/2018 - 11/24/2018	113,452	112,815	99%
11/25/2018 - 11/30/2018	198,059	196,882	99%

COMPLIANCE THRESHOLD: 97% of transactions within 6.00 seconds or less

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS IN 7.00 SECOND COMPLIANCE
REPORT PERIOD: 11/01/2018 - 11/30/2018

Week	AGENCY TRANSACTIONS Total	Number In Compliance	Percent In Compliance	CONTRACTOR TRANSACTIONS Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	21,383	21,082	99% **OOC**	92,124	90,929	99% **OOC**
11/04/2018 - 11/10/2018	42,342	41,064	97% **OOC**	234,946	232,373	99% **OOC**
11/11/2018 - 11/17/2018	36,456	35,757	98% **OOC**	223,772	220,676	99% **OOC**
11/18/2018 - 11/24/2018	20,495	20,083	98% **OOC**	119,192	117,488	99% **OOC**
11/25/2018 - 11/30/2018	48,354	47,250	98% **OOC**	215,346	212,329	99% **OOC**

Week	HID TRANSACTIONS Total	Number In Compliance	Percent In Compliance
11/01/2018 - 11/03/2018	71,802	71,465	100%
11/04/2018 - 11/10/2018	196,867	195,989	100%
11/11/2018 - 11/17/2018	189,631	188,783	100%
11/18/2018 - 11/24/2018	113,452	112,973	100%
11/25/2018 - 11/30/2018	198,059	197,145	100%

Week	Total Transactions
11/01/2018 - 11/03/2018	185,309
11/04/2018 - 11/10/2018	474,155
11/11/2018 - 11/17/2018	449,859
11/18/2018 - 11/24/2018	253,139
11/25/2018 - 11/30/2018	461,759

COMPLIANCE THRESHOLD: 99% of transactions within 7.00 seconds or less

*** END OF REPORT ***

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS IN 4.00 SECOND COMPLIANCE
REPORT PERIOD: 10/01/2018 - 10/31/2018

	AGENCY TRANSACTIONS			CONTRACTOR TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance	Total	Number In Compliance	Percent In Compliance
10/01/2018 - 10/06/2018	45,991	44,539	97%	229,402	222,184	97%
10/07/2018 - 10/13/2018	41,148	40,026	97%	217,301	209,597	96%
10/14/2018 - 10/20/2018	45,139	44,157	98%	233,804	226,382	97%
10/21/2018 - 10/27/2018	50,609	49,243	97%	231,902	223,310	96%
10/28/2018 - 10/31/2018	30,644	29,862	97%	143,657	139,228	97%

	HID TRANSACTIONS		
Week	Total	Number In Compliance	Percent In Compliance
10/01/2018 - 10/06/2018	221,106	219,354	99%
10/07/2018 - 10/13/2018	189,088	187,151	99%
10/14/2018 - 10/20/2018	187,231	185,308	99%
10/21/2018 - 10/27/2018	193,027	190,067	98%
10/28/2018 - 10/31/2018	117,830	116,593	99%

COMPLIANCE THRESHOLD: 90% of transactions within 4.00 seconds or less

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS RESPONSE VARIANCE
REPORT PERIOD: 11/01/2018 - 11/30/2018

	CONTRACTOR TRANSACTIONS		AGENCY TRANSACTIONS			HID TRANSACTIONS		
Week	Count	Average (seconds)	Count	Average (seconds)	Percent Difference	Count	Average (seconds)	Percent Difference
11/01/2018 - 11/03/2018	92,124	0.8483	21,383	0.6698	-21.0%	71,802	0.4297	-49.3%
11/04/2018 - 11/10/2018	234,946	0.7517	42,342	2.8708	281.9% *OOC*	196,867	0.4605	-38.7%
11/11/2018 - 11/17/2018	223,772	0.9387	36,456	0.8476	-9.7%	189,631	0.4723	-49.7%
11/18/2018 - 11/24/2018	119,192	0.8506	20,495	0.8315	-2.2%	113,452	0.4433	-47.9%
11/25/2018 - 11/30/2018	215,346	0.7871	48,354	0.9718	23.5% *OOC*	198,059	0.4583	-41.8%

Week	Total Transactions
11/01/2018 - 11/03/2018	185,309
11/04/2018 - 11/10/2018	474,155
11/11/2018 - 11/17/2018	449,859
11/18/2018 - 11/24/2018	253,139
11/25/2018 - 11/30/2018	461,759

PERCENT DIFFERENCE THRESHOLD: 20%

*** END OF REPORT ***

ALABAMA MEDICAID AGENCY
MEDICAID MANAGEMENT INFORMATION SYSTEM
TRANSACTIONS RESPONSE VARIANCE
REPORT PERIOD: 10/01/2018 - 10/31/2018

	CONTRACTOR TRANSACTIONS		AGENCY TRANSACTIONS			HID TRANSACTIONS		
Week	Count	Average (seconds)	Count	Average (seconds)	Percent Difference	Count	Average (seconds)	Percent Difference
10/01/2018 - 10/06/2018	229,402	0.7621	45,991	0.9407	23.4% *OOC*	221,106	0.3588	-52.9%
10/07/2018 - 10/13/2018	217,301	0.8827	41,148	0.8015	-9.2%	189,088	0.3909	-55.7%
10/14/2018 - 10/20/2018	233,804	0.7800	45,139	0.6134	-21.4%	187,231	0.3905	-49.9%
10/21/2018 - 10/27/2018	231,902	0.8647	50,609	0.6859	-20.7%	193,027	0.4507	-47.9%
10/28/2018 - 10/31/2018	143,657	0.7629	30,644	0.8279	8.5%	117,830	0.4078	-46.5%

Week	Total Transactions
10/01/2018 - 10/06/2018	496,499
10/07/2018 - 10/13/2018	447,537
10/14/2018 - 10/20/2018	466,174
10/21/2018 - 10/27/2018	475,538
10/28/2018 - 10/31/2018	292,131

PERCENT DIFFERENCE THRESHOLD: 20%

*** END OF REPORT ***

Select purpose of form below:

☐ **Initial Enrollment**
ATN #

☐ **Reenrollment**
NPI #
MCD #

☐ **Update**
NPI #
MCD #

VENDOR DISCLOSURE FORM

Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must complete the following information for each of the following individuals: (Print/Make additional copies as necessary)

Owners	Officers	Shareholders with 5% or more controlling interest
Agents	Directors	Managing Employees

This form must be completed for anyone who holds one of the above listed positions. Completion of this form requires that a valid answer be provided to EVERY question. Incomplete forms will be returned for the missing information.

Submit with bar coded cover sheet to HPES' Provider Enrollment Department at:
P O Box 241685, Montgomery, AL 36124-1685

The completion of this form is required and must be included with the Vendor bid. Please note that the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Attach additional sheets if necessary.

Name:	Title:
Home Address:	Business Address:
Social Security Number:	Employer's Tax ID:
Driver's License Number & Issuer:	Driver's License Expiration Date:
Date of Birth:	Sex: ☐ Male ☐ Female
Previous Home Address (you may put N/A if not applicable):	Previous Business Address (you may put N/A if not applicable):

List the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. This includes relatives (you may put N/A if not applicable).

Name	Address

List the names of **any other disclosing** entity in which person with an ownership or control interest in the disclosing entity also has an ownership or control interest of at least 5% or more (you may put N/A if not applicable).

NOTE: Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under the title V, XVIII, or XX of the Act.

Name	Address	Tax ID	%

Are you related as spouse, parent, child, or sibling to any other owner, officer, agent, managing employee, director or shareholder? ☐ Yes ☐ No If yes, please give names and relationships (Attach additional sheets if necessary):

Name	Relationship

Select purpose of form below:

☐ **Initial Enrollment**
ATN #

☐ **Reenrollment**
NPI #
MCD #

☐ **Update**
NPI #
MCD #

PROVIDER DISCLOSURE FORM (cont.)

List any business transactions with wholly owned suppliers or any subcontractors totaling more than $25,000, during the last 12 months (you may put N/A if not applicable).

FULL LEGAL NAME	ADDRESS	AMOUNT OF BUSINESS TRANSACTION	RELATIONSHIP

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Is your license currently suspended or restricted? ☐ Yes ☐ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐ Yes ☐ No

Convicted means that:

1. A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post-trial motion or appeal pending, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2. A Federal, State or local court has made a finding of guilt against an individual or entity;
3. A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____

_____

_____

_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☐ No

Building Reports with the Web Intelligence Java Report Panel

BusinessObjects XI 3.1 Service Pack 2

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2009-05-29

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About Web Intelligence

chapter 1

How Web Intelligence performs business intelligence over the web

Web Intelligence provides business users with an easy to use interactive and flexible user interface for building and analyzing reports on corporate data over the web, on secured intranets and extranets. The Web Intelligence software is installed by your administrator on a web server on your corporate network.

To use Web Intelligence from your local computer, you log into the business intelligence portal InfoView via your Internet browser. Then, depending on your security profile, you can interact with the reports in corporate documents or edit or build your own documents using a Web Intelligence report panel or query panel.

How Web Intelligence performs business intelligence offline

Web Intelligence can be used offline as Web Intelligence Rich Client, a standalone Microsoft Windows application, equivalent to the Java Report Panel, that you can install on your computer. Web Intelligence Rich Client lets you continue to work with Web Intelligence (WID) documents when you are unable to connect to a CMS, when you want to perform calculations locally rather than on the server, and when you want to work with Web Intelligence documents without installing a CMS or application server.

Web Intelligence Rich Client can also be used when connected to a CMS.

Interacting with Web Intelligence reports

Depending on your security profile and on how Web Intelligence is deployed across your organization, you can view, analyze, or enhance and modify the data displayed on reports.

Viewing and printing Web Intelligence reports

Once logged into the business intelligence portal InfoView, you can access Web Intelligence documents and view reports. Onscreen navigation is made easy with page-to-page navigation buttons and a document map that allows you to jump from section to section or report to report.

The same document can provide the information adapted to each user due to prompts that request each user, who opens the document, to specify the data they want to return to the reports.

When you print, Web Intelligence automatically generates a copy of reports in Portable Document Format (PDF) format for optimum print quality. You can print reports directly from the Web Intelligence Java Report Panel or Web Intelligence Rich Client without exporting to PDF.

Drilling on Web Intelligence reports

Drilling on Web Intelligence reports enables you to analyze the detailed data behind the displayed results. You can turn the report you are viewing into a drillable report or drill on a duplicate of the original report to retain a version of the results before your drill analysis.

Once you have found the information you need, you can save a snapshot of the drilled report to share the results of your analysis with other Web Intelligence users, or save the document in Excel or Portable Document (PDF) format to print or email to other business contacts.

Performing on-report analysis

Viewing Web Intelligence reports in Interactive view format enables you to enhance reports and fine-tune the data reports contain, to highlight the information that most interests you on demand.

On-Report Analysis is designed for:

- users who need to build queries and then want to build reports
- report consumers who need to manipulate the reports created by others

With On-Report Analysis you can:

- view document metadata to understand the data behind reports and see how reports are structured and filtered
- filter and sort results
- add new tables and charts
- add formulas and create variables
- format and change the layout of charts and tables
- slice and dice results by adding other data to charts and tables

Note:
On-report analysis of Web Intelligence reports in Interactive view format is only available if your administrator has deployed Web Intelligence in JSP mode.

Creating and editing Web Intelligence documents

You can create or edit Web Intelligence documents using the Web Intelligence HTML Report Panel, Web Intelligence Query - HTML, Web Intelligence in Interactive mode, the Web Intelligence Java Report Panel and Web Intelligence Rich Client.

Web Intelligence Query - HTML

Designed for users requiring a pure HTML environment to build queries, Web Intelligence Query – HTML offers the ability to define the data content of documents on multiple data sources. You can use Query – HTML to create new documents from scratch or edit the queries in documents created using any of the other Web Intelligence tools.

Used together with On-Report Analysis, Query – HTML provides a complete solution for building queries and designing powerful reports in a pure HTML environment. Once you have run the queries to generate a standard report, you can leverage Web Intelligence On-Report Analysis features to format multiple reports, add formulas, and create variables.

Note:
Web Intelligence Query – HTML and On-Report Analysis in Interactive view format are only available, if your administrator has deployed Web Intelligence in JSP mode.

Web Intelligence Java Report Panel

The Java Report Panel is designed for users who need more flexibility with designing report layout and defining formulas and variables. A graphical Formula Editor enables you to build formulas rapidly using drag-and-drop.

Note:
The Web Intelligence Java Report Panel is available if your administrator has deployed Web Intelligence in ASP mode and if your administrator has deployed Web Intelligence in JSP mode.

Web Intelligence Rich Client

Web Intelligence Rich Client is a locally installed Microsoft Windows application that lets you work with Web Intelligence (WID) documents that are stored locally or in a CMS.

When working without a CMS connection you can work on your local machine with either CMS-secured or unsecured documents.

Web Intelligence Rich Client is based on the Web Intelligence Java Report Panel and provides equivalent document creation, editing, formatting, printing and saving capabilities.

There are a number of reasons for using Web Intelligence Rich Client to work with WID documents:

- You want to work with Web Intelligence documents but you are unable to connect to a CMS (while traveling, for example).
- You want to improve calculation performance: Web Intelligence Rich Client performs calculations locally, rather than on the server, and local calculations can perform better than server calculations.
- You want to work with Web Intelligence documents without installing a CMS or application server.

Web Intelligence HTML Report Panel

Designed for users who need to build basic reports, the HTML Report Panel provides query and report features in a simple wizard-like interface. Each document is based on a single data source and can contain multiple reports, displaying different subsets of information.

In addition, the HTML Report Panel is 508 compliant and can be customized for specialized deployments.

Note:
The Web Intelligence HTML Report Panel is only available if your administrator has deployed Web Intelligence in JSP mode.

Accessing Web Intelligence from InfoView

chapter 2

You access Web Intelligence reports and set global Web Intelligence options from InfoView, the corporate business intelligence portal.

To log in to InfoView

Before you can use InfoView and Web Intelligence you need the following information:

- a URL to the InfoView server
- the InfoView server name and port number
- your login and password
- your authentication, which controls the InfoView resources available to you

Contact your adminstrator for these details if you do not already know them.

Note:
By default the InfoView server name and authentification method are not displayed on the InfoView logon page. You need to supply this information only if your administrator has made these options visible.

You access Web Intelligence by using your web browser to log into InfoView, the corporate business intelligence portal. Once you are in InfoView, you can analyze and enhance Web Intelligence reports.

1. Launch your web browser.
2. Point your browser to the InfoView bookmark or URL.

   The InfoView login page appears.
3. If the **System** box is blank, type the name of the InfoView server followed by a colon (:), and then type the port number.
4. In the **Username** box, type your user name.
5. In the **Password** box, type your password.
6. In the **Authentication** box, select the authentication provided to you by your administrator.
7. Click **Log On**.

   The InfoView home page appears.

To log out of InfoView

When you finish using InfoView or Web Intelligence you need to log out, instead of simply closing your web browser.

Logging out of InfoView ensures that any preferences you modified during your InfoView session are saved. It also lets your administrator track how many users are logged into the system at any given time and thus optimize InfoView and Web Intelligence performance.

- Click **Log Out**.

  The login page appears. You are logged out of InfoView

Web Intelligence InfoView options

Web Intelligence document creation and viewing options

You can set your Web Intelligence options to determine how you create, view and interact with documents using Web Intelligence.

You create documents using a query editor to build the query to retrieve the document data. After the query returns the data to the document, you can view and interact with the data.

Document creation option	Description
Advanced	You create documents using the Java Report Panel, a Java applet than launches in your Web browser. The Java Report Panel is a combined query building, report editing and data analysis environment. If you choose **Advanced** as your document creation option, you also use the Java Report Panel for working with the data returned by the query. The **Select a default view format** option is not taken into account. The Java Report Panel provides the richest feature set of all Web Intelligence query building, report editing and data analysis environments.
Interactive	You build queries using Query - HTML, an HTML-based query editor.
Desktop	You build queries, edit reports and analyze data using Web Intelligence Rich Client, a standalone version of the Java Report Panel that runs outside your web browser.
Web Accessibility	You create reports using the HTML Report Panel, a 508-compliant query and report building environment.

You can use the following view formats to view and interact with existing Web Intelligence documents, or documents that you have just created using a query editor:

View format	Description
Web	Use Web (HTML) format when you want to open reports, answer prompts, navigate reports, and/or perform drill analysis.
Interactive	Use Interactive format when you want to apply filters, sorts, calculations, modify formatting and data displayed on tables and charts, and/or perform drill analysis. Use Interactive format if you are using Query – HTML to define queries, and you want to format reports based on those queries and add formulas and variables. Interactive format + Query HTML provides an approximate equivalent to the Java Report Panel or Web Intelligence Rich Client, in a pure HTML environment. You can also use Interactive format to view and work with reports generated from the HTML Report Panel. Unline Query - HTML, which is a pure query-building environment, the HTML Report Panel also allows you to define reports. After running your query, you can continue to work with the report either by using Interactive format, or by returning to the HTML Report Panel. Interactive view format is only available if your administrator has deployed Web Intelligence in JSP mode.

View format	Description
PDF	Use PDF mode when you want to view static reports.

To select the Web Intelligence query editor

1. Click the **Preferences** button on the InfoView toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. Select the query editor beneath **Select a default creation/editing tool**.
4. Click **OK**.

To select the Web Intelligence view format

You can select different view formats for Web Intelligence documents depending on how you want to interact with the information displayed on the reports. You select your Web Intelligence view options in InfoView. When you modify your view options, the new settings are implemented the next time you open a Web Intelligence document.

1. Click the **Preferences** button on the InfoView toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. In the **Select a view format** section, select the view format.

To select a default universe for new documents

1. Click **Preferences** on the Infoview toolbar.
2. Click**Web Intelligence Preferences** to display the Web Intelligence options.
3. Click **Browse** beneath **Select a default universe** and browse to the universe you want to select as the default.

To set Web Intelligence drill options

Drilling on reports lets you look deeper into data to discover the details behind a good or bad summary result displayed on a table, chart, or section. Before you begin a drill session, you can set your drill options in InfoView to specify how reports will change each time you drill.

1. Click **Preferences** on the Infoview toolbar.
2. Click **Web Intelligence Preferences** to display the Web Intelligence options.
3. Select the drill options under **Drill options** and **Start drill session**.

Hide drill toolbar option

When you drill on a value displayed on a report, the Drill toolbar appears and displays the value on which you drilled. The value displayed on the toolbar filters the results displayed on the drilled report.

For example, if you drill on year 2001, the results displayed on the drilled table are Q1, Q2, Q3, and Q4 for year 2001. This means that the quarterly values you drilled to are filtered by 2001.

Note:
If the drilled report includes dimensions from multiple queries, a ToolTip appears when you rest your cursor on the value displayed on the filter. The ToolTip displays the name of the query and the dimension for the value.

The Drill toolbar allows you to select alternative values on the same level, in order to filter the results differently. For example, if you use the Drill toolbar illustrated above to select “2002,□? the results displayed on the drilled table would be Q1, Q2, Q3, and Q4 for year 2002.

You can opt to hide the Drill toolbar when you start drill mode. The Drill toolbar is only useful if you want to select filters during your drill session.

Prompt when drill requires additional data option

When you drill the results displayed on a Web Intelligence report, you may want to drill to higher- or lower-level information that isn’t included in the

scope of analysis for the document. When this is the case, Web Intelligence needs to run a new query to retrieve the additional data from the data source.

Since queries on large selections of data may take a long time to be completed, you can choose to be prompted with a message every time a new query is necessary. The prompt message asks you whether you want to run the additional query or not. In addition, the prompt lets you apply filters to the extra dimensions you include in the new query. This means you can restrict the size of the query to only the data necessary for your analysis.

You need permission from your administrator to drill out of the scope of analysis during a drill session.

Synchronize drill on report blocks option

When you select the **Sychronize drill on all report blocks** option, the display of all blocks changes to correspond with your drill actions. For example, if you drill down on a block from year to quarter, and your report also contains a chart showing data by year, the chart display also changes to display data by quarter.

If you do not select the option, only the drilled block changes in response to drill actions.

Start drill session option

The **Start drill session** option controls how Web Intelligence behaves when you start drill mode.

Start drill session on existing report option

When you select **Start drill session on existing report**, the current report becomes drillable when you start drill mode. When you end drill mode, the report displays the drilled values.

Start drill session on a duplicate report option

When you select **Start drill on a duplicate report**, Web Intelligence creates a duplicate of the current report when you start drill mode, and you drill on the duplicate. This allows you to compare the results of the original report with the results you discover during your drill analysis.

Web Intelligence locale options

Locales determine how Web Intelligence displays its interface (for example, menu items and button text) and data (for example, date and number formatting).

Web Intelligence has three locales:

Locale	Description
Product Locale	The locale in which the Web Intelligence interface is displayed
Document Locale	The locale of the data currently contained in the document
Preferred Viewing Locale	The user's preferred locale for displaying document data

The InfoView settings determine how the Document Locale and Preferred Viewing Locale interact to display document data.

Related Topics

- *To permanently associate a locale with a document* on page 35

The Product Locale

The product locale is used to display the Web Intelligence interface (for example, menu items and button text).

Note:
The `GetLocale` function returns the Product Locale.

To set the Product Locale

1. Click **Preferences** on the main InfoView toolbar.
2. Click **General** to display the general options.
3. Select the product locale from the **Product locale** list.

The Document Locale

The Document Locale formats the data in a document. For example, the Document Locale determines how Web Intelligence displays dates and numbers.

If the Web Intelligence settings in InfoView give the user's Preferred Viewing Locale priority through the **Use my Preferred Viewing Locale to format the data** setting, Web Intelligence sets the Document Locale to the Preferred Viewing Locale when the user opens a document. When the user saves the document, Web Intelligence saves this Document Locale with the document.

If the Web Intelligence settings do not give the user's Preferred Viewing Locale Priority, Web Intelligence formats the data according to the Document Locale saved with the document.

When a user creates a document, Web Intelligence always assigns the user's Preferred Viewing Locale as the initial Document Locale, whether or not the Web Intelligence settings in InfoView give the Preferred Viewing Locale priority.

A user can permanently associate the current Document Locale with a document by saving the document with the **Permanent Regional Formatting** option selected. Once a document has been saved with the option selected, Web Intelligence ignores the InfoView settings and always formats the document data using the saved Document Locale. This applies to all users, not just the user who selected the **Permanent Regional Formatting** option.

Note:
The `GetContentLocale` function returns the Document Locale.

Related Topics

- *To permanently associate a locale with a document* on page 35

To set the Document Locale

1. Click **Web Intelligence Preferences** to display the Web Intelligence options.
2. Click **Use the document locale to format the data** beneath **When viewing a document**.

The Preferred Viewing locale

The Preferred Viewing Locale is a user's preferred locale for displaying document data. The Document Locale becomes the user's Preferred Viewing Locale when the InfoView settings give the Preferred Viewing Locale priority.

Note:
The `GetPreferredViewingLocale` function returns the Preferred Viewing Locale. The `GetLocalized` function also uses the Preferred Viewing Locale to display translated strings.

To set the Preferred Viewing Locale

1. Click **Preferences** on the main InfoView toolbar.
2. Click **General** to display the general options.
3. Select the preferred viewing locale from the **Preferred viewing locale** list.
4. Click **Web Intelligence Preferences** to display the Web Intelligence options.
5. If you want data to be formatted using the preferred viewing locale, click **Use my Preferred Viewing Locale to format the data** beneath **When viewing a document**.

To permanently associate a locale with a document

1. In Web Intelligence Interactive, select **Document** > **Properties** from the menu to display the" Document Properties" dialog box, then select **Permanent regional formatting**.
2. In the Web Intelligence Java Report Panel or Web Intelligence Rich Client, right-click an empty area of the report, select **Document Properties** to display the **Document Properties** pane, then select **Permament Regional Formatting** in the **Document Options** section of the pane.
3. Save the document.

   The current Document Locale is associated permanently with the document.

Returning data using queries

chapter 3

Creating, editing and saving documents

You create Web Intelligence documents by first selecting a universe in InfoView. Each universe maps to a database containing corporate business information. When you connect to a universe, Web Intelligence automatically launches the document editor selected on the Web Intelligence Document Preferences page in InfoView.

After you have selected a universe, you use the objects in the universe to build a query to return data from the database to your Web Intelligence document.

After creating a document you can save it to the InfoView repository.

Building and working with queries

To build and run a query

1. On the InfoView Home page, click the arrow next to **New**, then select **Web Intelligence Document** on the top toolbar. Alternatively, click **Add Query** in the Query Panel if you are adding a query to a document that already contains at least one query.
2. Click the title of the universe on which you want to create a document.
3. In the **Data** tab, open a class.
4. Select the objects you want to include in the query and drag them to the **Result Objects** pane. To add all the objects in the class, drag the class to the **Result Objects** pane.
5. Repeat the previous step until the query contains all the objects you want to include.
6. Select the objects on which you want to define query filters and drag them to the **Query Filters** pane. To create a quick filter on an object, select the object in the Result Objects pane then click **Add Quick Filter** at the top right of the pane.
7. Set the scope of analysis and other query properties.
8. To remove an object from the **Result Objects** or **Query Filters** panes, click **Remove** at the top right corner of the pane.

9. To remove all objects from the **Result Objects** or **Query Filters** panes, click **Remove All** at the top right corner of the pane.
10. Click **Run Query** to run the query.

How universe objects map to data

Classes and subclasses

Objects are grouped into folders called classes. Each class can also contain one or more subclasses. Subclasses contain objects that are a further subcategory of the objects in the upper level of the class.

The role of classes is to organize the objects into logical groups. When you create queries on the universe, classes help you to find the objects that represent the information that you want to use in a query.

Dimension object

A dimension object represents data that provides the basis for analysis in a report. Dimension objects typically retrieve character-type data, for example; customer names, resort names, or dates.

Dimension objects appear as follows in the Web Intelligence query panel:

Detail object

A detail obect provides descriptive data about a dimension. A detail is always attached to the dimension for which it provides additional information. For example, [Age] is a detail object that is associated with the (Customer] dimension.

Detail objects appear as follows in the Web Intelligence query panel:

Measure object

The measure object retrieves numeric data that is the result of calculations on data in the database. For example, [Revenue] is the calculation of the

number of items sold multiplied by item price. Measure objects are often located in a Measures class.

Measure objects appear as follows in the Web Intelligence query panel:

There are two types of measure:

- classic measures - calculated by Web Intelligence
- smart measures - calculated by the database on which the universe is based

In certain situations, smart measures impact the way in which Web Intelligence displays calculations. For more information on smart measures, see the *Using Functions, Formulas and Calculations in Web Intelligence* guide.

Displaying data from an added query

When a query is not the first query in the document, you need to specify in the New Query box how its data will be displayed.

Option	Description
Insert a table in a new report	Display the data on a new report in the document
Insert a table in the current report	Display the data on the currently selected report in a new table
Include the result objects in the document without generating a table	Include the data in the document without displaying the data on a report. (You can add the objects returned by the query to the report later.)

To interrupt a query

You can interrupt a query before Web Intelligence has returned all the data to the document.

When you interrupt a query, only partial data is returned to the document. The values displayed in the document do not accurately reflect the definition in the query.

Before returning the data to the document, Web Intelligence requests you to choose which version of the data you want retrieved

1. On the "Waiting - Refresh Data" dialog box, click **Cancel**.

   The "Interrupt Data Retrieval" dialog box appears.

2. Select one of the options on the "Interrupt Data Retrieval" dialog box.

Option	Description
Restore the results from the previous data retrieval	Web Intelligence restores the values to the document that were retrieved the last time the query was run. The values displayed will not be the most up to data information available on the database. You can run the query later to return the up to date values from the database
Purge all data from the document	Web Intelligence displays the document empty of values. The structure and formatting of the document is retained. You can run the query later to return the up to date values from the database
Return the partial results	Web Intelligence displays the new values retrieved so far in the appropriate parts of the document. The rest of the document will display the values retrieved the last time the query was run

To remove a query

1. Select a the query you want to remove by right-clicking the appropriate Query tab.
2. Click **Remove**.

To duplicate a query

If you want to build a different query on a universe already included in the document, you can duplicate the existing query on that universe and then modify it, instead of starting from scratch.

1. Select the query you want to duplicate by right-clicking the appropriate Query tab at the bottom of the report panel.
2. Select **Duplicate**

Multiple queries

You can include one or multiple queries in a Web Intelligence document. When you include multiple queries, those queries can be based on a single universe or on multiple universes available in InfoView.

For example, you can include product sales data and customer data in the same document. In this case, your corporate data for product line sales is available on one universe and data on customers is available on another universe. You want to present product line sales results and information on customer age groups in the same report. To do this, you create a single document that includes two queries; one query on each universe. You can then include and format results from both queries on the same report.

Defining multiple queries in a single document is necessary when the data you want to include in a document is available on multiple universes, or when you want to create several differently-focused queries on the same universe. You can define multiple queries when you build a new document or add more queries to an existing document. You can present the information from all of the queries on a single report or on multiple reports in the same document.

Multiple queries, combined queries and synchronized queries compared

Multiple queries can be related in a Web Intelligence document in different ways.

- Basic multiple queries draw unrelated data from different sources.
- "Synchronized queries" relate the data from different queries around a dimension that contains data common to both queries. These dimensions are called merged dimensions.

  You merge dimensions in the Web Intelligence reporting interface after you have created and run your multiple queries.
- "Combined queries" are a special kind of query created in the Web Intelligence query interface. Combined queries generate SQL containing the UNION, INTERSECT and MINUS operators (if the database supports them) or simulate the effect of these operators.

Combined queries allow you to answer complex business questions that are difficult to formulate using standard queries.

You cannot create combined queries in Query - HTML.

Viewing the SQL generated by a query

When you build a query in Web Intelligence, Web Intelligence generates SQL to run against the database to return the query result. S(tructured) Q(uery) L(anguage) is the query language understood by all relational databases.

You can view and edit the SQL generated by Web Intelligence.

Note:
You cannot view the SQL of queries that call database stored procedures.

To view and edit the generated SQL

Note:
You cannot edit the query SQL when the query contains optional prompts. Edit the query to remove the optional prompts before attempting to edit the SQL.

1. Click **SQL** on the query toolbar to display the "SQL Viewer" dialog box.

   When SQL is not editable, values supplied in response to prompts appear directly in the query.

   For example, if "UK" was supplied in response to a prompt on [Country], a line similar to

   ```
   Resort_country.country In ('UK')
   ```

   appears in the query.

   If no value has yet been supplied for the prompt, the Web Intelligence syntax for prompts (described below) appears in the query.

2. Click **Use custom SQL** to make the generated SQL editable.

   When you make the SQL editable, the Web Intelligence syntax for prompts appears in the query.

For example, a line similar to

```
Resort_Country.country  =  @prompt('Enter Country:','A','Re
sort\Country',
Mono,Free,Persistent,,User:0)
```

appears in the query.

3. Click **Validate** after editing the SQL to check that your edits are valid.
4. Click **Copy** (Java Report Panel and Web Intelligence Rich Client only) to copy the SQL to the clipboard.
5. Click **Print** (Query - HTML only) to print the SQL.

Setting the scope of analysis

Scope of analysis

The scope of analysis for a query is extra data that you can retrieve from the database to give more details on the results returned by each of the objects in a query. This extra data does not appear in the initial result report, but it remains available in the data cube, so you can pull this data in to the report to allow you to access more detail at any time. This process of refining the data to lower levels of detail is called drilling down on an object.

In the universe, the scope of analysis corresponds to the hierarchical levels below the object selected for a query. For example, a scope of analysis of one level down for the object Year, would include the object Quarter, which appears immediately under Year.

You can set this level when you build a query. It allows objects lower down the hierarchy to be included in the query, without them appearing in the **Results Objects** pane. The hierarchies in a universe allow you to choose your scope of analysis, and correspondingly the level of drill available.

In the Java Report Panel and in Web Intelligence Rich Client, you can also create a custom scope of analysis by selecting specific dimensions for the **Scope of Analysis** pane.

Note:
You cannot set the scope of analysis when working in query drill mode because this drill mode causes Web Intelligence to modify the scope dynamically in response to drill actions.

Levels of scope of analysis

You can set the following levels for scope of analysis:

Level	Description
None	Only the objects that appear in the **Results Objects** pane are included in the query.
• One level down • Two levels down • Three levels down	For each object in the **Result Objects** pane, one, two, or three objects lower down the hierarchy tree are included in the query. The data from these objects is stored in the cube until you add them to the document.
Custom **Note:** This option is available in the Java Report Panel and in Web Intelligence Rich Client only.	All objects added manually to the Scope of Analysis panel are included in the query.

Including a scope of analysis in a document increases the document size significantly. This is because the data necessary for the scope you specify is saved with the document, even though it is not visible in the reports unless you start drill mode and drill down to the data to display the corresponding values.

In order to minimize the size of documents and optimize performance, we recommend that you only include a scope of analysis in documents where you are certain that users will need to drill.

We suggest the following method because it will be easier for you to set the scope of analysis seeing the hierarchy of the classes and objects.

To set the scope of analysis

1. Click the **Show/Hide Scope of Analysis** Pane button so that it appears pressed in.

   The Scope of Analysis panel appears at the bottom of the Result Objects pane. The default scope of analysis is None. Each dimension in the Result Objects pane appears in the Scope of Analysis pane.
2. Click the down arrow in the **Scope of Analysis** drop-down list box.
3. Select a level for the scope of analysis.

   The level appears in the list box and the dimensions that are hierarchically below each dimension in the Result Objects pane appear in the **Scope of Analysis** pane.
4. If you want to add selected dimensions to the scope of analysis or create a custom scope of analysis, select dimensions in the Query Manager and drag them across to the **Scope of Analysis** panel.

Query contexts

What is an ambiguous query?

An ambiguous query is a query that contains one or more objects that can potentially return two different types of information.

In a universe, certain dimensions may have values that are used for two different purposes in the database. For example, the [Country] dimension in the query below can return two types of information:

- Customers and the country in which they spent their vacation.
- Customers and the country for which they have made their reservation.

The role that Country plays in this query is ambiguous. A country can be either the country where a vacation was sold, or a country where a vacation is reserved. One is existing information (sales), and the other is future information (reservations).

To avoid ambiguities in a query, the universe designer identifies the different ways that objects can be used in the universe, and implements restrictions on how these objects can be combined. These restrictions are called contexts.

What is a context?

A context is a defined group of objects that share a common business purpose. This business purpose is usually the type of information that these related objects represent. For example, a sales context is a grouping of all the objects that can be used to create sales queries. A reservations context is a grouping of all the objects that can be used in reservation queries. Contexts are defined in a universe by the universe designer.

You can combine any object within the same context to create a query. You can also combine objects in different contexts. If you use an object that is common to both contexts, Web Intelligence will try to determine the context that best fits the other objects in the query.

If it cannot determine a context, you are prompted to choose the context that you want to apply to the query.

Choosing a context when you run a query

When you create a query or refresh a report, you may be asked to choose a context before the query can run. Contexts are set up in a universe to avoid ambiguous queries.

To choose a context when you run a query

1. Run the query containing multiple contexts.
   The "Select a Context" dialog box appears.
2. Select the context in the "Select a Context" dialog box.

Web Intelligence query properties

Allow other users to edit all queries property

When selected, other users who have the appropriate editing rights can access Query View and modify the queries in the document. When cleared, only the report creator can modify the queries. This option is selected by default. Unlike the other query properties, which only apply to the selected query, this option applies to all of the queries in the document.

Max retrieval time query property

Maximum time that a query can run before the query is stopped. This can be useful when a query is taking too long due to an excess of data, or network problems. You can set a time limit so a query can stop within a reasonable time.

Max rows retrieved query property

The **Max rows retrieved** query property determines the maximum number of rows of data that are displayed when a query is run. If you only need a certain amount of data, you can set this value to limit the number of rows of data in your document.

Max rows retrieved does not operate at the database level. If you set **Max rows retrieved** to 1000, and your query returns 5000 rows, Web Intelligence initially retrieves all 5000 rows, before discarding 4000 and retaining only the first 1000 rows.

The **Sample result set** query property also applies a restriction on the number of rows in the query, but at the database level. If you set **Max rows retrieved** to 2000 and **Sample result set** to 1000, the query retrieves a maximum of 1000 rows only.

This setting can be overridden by the limits set by your administrator in your security profile. For example, if you set the **Max rows retrieved** setting to

400 rows, but your security profile limits you to 200 rows, only 200 rows of data will be retrieved when you run the query.

Query prompt order

Prompts are listed in the list. You can use the up and down arrows to move a prompt up or down the list to change the order in which they are executed.

Retrieve duplicate rows query property

In a database, the same data may be repeated over many rows. You can choose to have these repeated rows returned in a query, or to have only unique rows returned.

Reset contexts on refresh query property

When selected, you are prompted to choose a context each time a query requiring a context is run. When unselected, Web Intelligence retains the context specified the first time you run the query.

Clear contexts query property

When this property is selected, Web Intelligence clears the contexts listed in the list when you next run the query or refresh the data.

Sample result set query property

The **Sample result set** property determines the maximum number of rows that a query returns. The property applies this restriction at the database level. If the database supports sampling, Web Intelligence adds the restriction to the SQL that Web Intelligence generates to return the data.

If you select the **Fixed** option, Web Intelligence uses fixed sampling. At each data refresh, the query returns the same rows. If you do not set the **Fixed**

option, Web Intelligence uses random sampling. At each data refresh, the query returns a different set of sampled rows.

Sample result set is more efficient than the **Max rows retrieved** property, which discards rows beyond the maximum limit only after retrieving all the rows in the query.

Not all databases support fixed and random sampling. If they are not supported, the properties are disabled (in the Java Report Panel) or invisible (in Query - HTML). Sampling is not available at all in the HTML Report Panel.

Filtering data using query filters

chapter 4

Query filters defined

You limit the data returned to the document by applying filters when you define the query. Using query filters enables you to secure the data that you don't want specific user groups to see and limits the size of the documents that are stored on your network. When you run the query on the document data, the Web Intelligence returns only the values that meet the query filter definitions.

Query filters limit the data Web Intelligence returns to a document. They retrieve a sub-set of the data from the database and return the corresponding values to the document. You define filters to match business questions. For example, you can filter the [Year] dimension to view only sales revenue for Year 2003; or filter the [Annual Income] dimension to view only customers whose annual income is equal to or greater than $1.5M.

Query filters allow you to:

- retrieve only the data you need to answer a specific business question
- hide the data you don't want specific users to see when they access the document
- minimize the quantity of data returned to the document to optimize performance

Example: In Q4 2002, which stores in my sales region gained margins above $130K?

As Regional Marketing Manager for Texas, you are only interested in analyzing margins for Texas, but the sales universe includes data US-wide. In addition, you only want to view information for stores where margins reached over your 4Q 2002 quarterly target figure: $130K. To create a document with only the information you need, you apply a filter on the [State], [Year], and [Quarter] dimensions and a filter on the [Margin] measure:

AND	Year Equal to 2002
	Quarter Equal to Q4
	State Equal to Texas
	Margin Greater than or equal to 130000

To avoid displaying the filtered values Texas, 2002, and Q4 in the table columns Year, Quarter, and State, you exclude the [Year], [Quarter], and [State] objects from the Result Objects pane. When you generate the report, the report values correspond to Texas stores with 4Q 2002 margins greater than or equal to $130K:

Store name	Sales Revenue	Margin
e-Fashion Houston	307,914	133,802
e-Fashion Houston Leighton	316,232	136,055

Query filters and report filters compared

You can apply filters at two levels within a document:

- query filters – these filters are defined on the query; they limit the data retrieved from the data source and returned to the Web Intelligence document.
- report filters – these filters limit the values displayed on reports, tables, charts, sections within the document, but they don't modify the data that is retrieved from the data source; they simply hide values at the report level.

Types of query filter

You can create the following types of query filter:

- predefined filters – created by your administrator
- custom filters – you define on the query
- quick filters - a simplified form of custom filter for simple filters
- prompts – you define these dynamic filters to display a question or a list of values so you or other users can select different filter value(s) at each run query

You can mix different types of filters on a single query.

Predefined query filters

Predefined filters make the specific data you most typically need for reports permanently available in Web Intelligence. They are created by an administrator and saved with the universe. Predefined filters often contain complex expressions that require a detailed knowledge of the database structure. Including predefined filters on the universe means you don't need to create the same custom filters every time you create new Web Intelligence documents based on the same universe.

As a Web Intelligence user, you cannot view the component parts of predefined filters or edit predefined filters.

To select a predefined query filter

- Double-click the predefined filter or drag it to the **Query Filters** pane.

When you run the query, the data corresponding to the query filters you selected is returned to the report.

Quick filters

Quick filters allow you to quickly define the values you want to retrieve for a specific object without launching the Filter Editor. By default, Quick filters use the Equal to operator if you select a single value or the In list operator if you select multiple values.

For example:

- If you select the [Payment Status] dimension and the value "unpaid? you create the filter: [Payment Status] Equal to "unpaid?

- If you select the [Country] dimension and the values US, Japan, Germany, you create the filter: [Country] In list “US;Japan;Germany?

To create or remove a quick filter

1. Select the column you want to filter.
2. Click the arrow to the right of **Add Filter** on the **Reporting** toolbar and click **Add Quick Filter**.

   The **List of Values** dialog box appears. The values for the selected object are listed.
3. Select the values you want to retrieve from the database.

   For example, to filter the query for values in Q1, select the [Quarter] dimension, then select Q1 from the list of values.
4. Click **OK**

   The new filter appears on the **Query Filters** pane.
5. To remove the filter, click the arrow to the right of **Add Filter** and select **Remove Filter**.

Custom query filters

You create custom query filters to limit document data to information corresponding to:

- a specific business question
- the business information needs of a specific group of users

For example, you can create custom filters to retrieve sales results data for specific dates, products, or services, or to view customer information only for customers who are high wage earners or who live in a particular region.

To add and remove custom query filters

1. Select the object you want to filter and drag it to the **Query Filters** pane.

   The query filter appears in outline in the **Query Filters** pane.
2. Click the arrow next to the default operator (In List) and select the query operator from the list of operators.

3. Click the arrow on the right of the query filter and select the type of filter you want to apply: **Constant**, **Value(s) from List**, **Prompt**, **Object from this query**, **Result from another query, Result from another query (Any)**, **Result from another query (All)**.

Option	Description
Constant	You compare the object against a constant value to filter the query result.
Value(s) from list	You compare the object against values from a list of values to filter the query result.
Prompt	You create a filter which requires the user to supply filter values on data refresh.
Object from this query	You compare the object against the values returned by an object from in the same query.
Result from another query	You compare the object against the values returned by an object from another query (the filtering query) to filter the query result.
Result from another query (Any)	You compare the object against any of the values returned by an object from another query (the filtering query) to filter the query result.
Result from another query (All)	You compare the object against all of the values returned by an object from another query (the filtering query) to filter the query result.

4. Type/select the constant, list of values or object you want to include in the filter.
5. To remove the filter, select it and click the Delete key, or click **Remove** at the top right corner of the **Query Filters** pane. To remove all filters, click **Remove All** at the top right corner of the **Query Filters** pane.

Related Topics

- *What is a prompt?* on page 70
- *Filtering a query on values returned from another query* on page 59

Filtering a query on values returned from another query

You can filter a query on values returned from another query. For example, if you want to return results for all the countries in Query 1 that have a corresponding country in Query 2, you can filter the `[Query 1].[Country]` object on the values of the `[Query 2].[Country]` object.

The filtered query must be in a universe based on a relational (RDBMS) data source. The query that supplies the filtering values (filtering query) can be based on a relational, OLAP or local data source.

When you are building a query on a query, the filtering query does not appear in the list of queries that can be used as filtering queries until it has been run or saved.

The filtering query is not refreshed when you refresh the filtered query.

The query filter can filter against all or any of the values returned by the filtering query. The supported combinations of operator and filter mode appear in the table below. If you do not choose an operator from the table, the **Result from another query** menu item is not available.

Operator	Filter mode	Description
Equal To	Any	Keep values in the filtered query that are equal to any value returned by the filtering query.
Not Equal To	All	Keep values in the filtered query that are different from all the values returned by the filtering query.
Greater Than Greater Than or Equal To	Any	Keep values in the filtered query that are greater than/greater than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are greater than/greater than or equal to the minimum value returned by the filtering query.
Greater Than Greater Than or Equal To	All	Keep values in the filtered query that are greater than all of the values in the filtering query. In other words, keep values in the filtered query that are greater than/greater than or equal to the maximum value returned by the filtering query.
Less Than Less Than or Equal To	Any	Keep values in the filtered query that are less than/less than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are less than/less than or equal to the maximum value returned by the filtering query.

Operator	Filter mode	Description
Less Than Less Than or Equal To	All	Keep values in the filtered query that are less than/less than or equal to any of the values in the filtering query. In other words, keep values in the filtered query that are less than/less than or equal to the minimum value returned by the filtering query.
InList	Any	Keep values in the filtered query that are equal to any value in the list of values returned by the filtering query.
Not InList	Any	Keep values in the filtered query that are not equal to any of the values in the list of values returned by the filtering query.

Query filter and prompt operators

Equal To operator

Use the Equal to operator to obtain data equal to a value.

For example, to return data for the US only, create the filter "County Equal To US".

Not Equal To operator

Use the Not Equal To operator to obtain data not equal to a value.

For example, to return data for all countries except the US create the filter "County Not Equal To US".

Different From operator

Use the Different From operator to retrieve data different from a value.

For example, to retrieve data for all quarters execpt Q4, create the filter [Quarter] Different From "Q4"

Greater Than operator

Use the Greater Than operator to retrieve data greater than a value.

For example, to retrieve data for customers aged over 60, create the filter "[Customer Age] Greater than 60".

Greater Than Or Equal To operator

Use the Greater Than Or Equal To operator to retrieve data greater than or equal to a value.

For example, to retrieve data for revenue starting from $1.5M, create the filter "[Revenue] Greater than or equal to 1500000".

Less Than operator

Use the Less Than operator to retrieve data lower than a value.

For example, to retrieve data for exam grades lower than 40, create the filter "[Exam Grade] Less Than 40".

Less Than Or Equal To operator

Use the Less Than Or Equal To operator to retrieve data less than or equal to a value.

For example, to retrieve data for customers whose age is 30 or less, create the filter "[Age] Less Than Or Equal To 30".

Between operator

Use the Between operator to retrieve data between and including two values.

For example, to retrieve data for weeks starting at week 25 and finishing at 36 (including week 25 and week 36), create the filter "[Week] Between 25 and 36".

Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

Not In List operator

Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

Matches Pattern operator

Use the Matches Pattern operator to retrieve data that includes a specific string or part of a string.

For example, to retrieve customers whose date of birth is 1972, create the filter [DOB] Matches Pattern "72".

Different From Pattern operator

Use the Different From Pattern operator to return data that doesn't include a specific string.

For example, to retrieve customers whose date of birth is not 1972, create the filter [DOB] Different From Pattern '72'.

Both operator

Use the Both operator to retrieve data that corresponds to two values.

For example, to retrieve customers who have both a fixed and a mobile telephone, create the filter [Account Type] Both 'Fixed' And 'Mobile'.

Except operator

Use the Except operator to retrieve data that corresponds to one value and excludes another.

For example, to retrieve customers who have a fixed telephone and do not have a mobile telephone, create the filter [Account Type] 'Fixed' Except 'Mobile'.

The Except operator is more restrictive than `Different From` or `Not In List`. For example, a report that returns customers and that includes the filter `[Lines] Different From 'Accessories'` excludes all sales records where the item sold is part of the 'Accessories' line. If the same customer has purchased Accessories and non-Accessories items, the customer still appears in the report, but their spending total includes only non-Accessories sales.

If the filter is `[Lines] Except 'Accessories',` only customers who have bought no accessories are included in the report.

Related Topics

- *Not In List operator* on page 178

- *Different From operator* on page 176

Combining query filters

Combining query filters

Typical business questions require you to retrieve information that matches more than one criteria. For example, if you are analyzing customer services data, you will most likely want to focus on customers for a specific time period and also for a specific region, and probably also for a specific level of customer service contract. You can retrieve data that answers several criteria like this by combining filters in the same query.

Example: Analyze sales revenue this year at stores where the floor size is over 4,000 square feet and sales revenue figures are equal to or less than $1.5M

In this example, you are an operations manager for a retail chain. You want to analyze information about the large retail stores in your chain that are making less than the sales revenue figure your company has set as the target.

To do this you add a predefined filter on the [Year] dimension to specify that you only want to retrieve values for this year. Then you create a second filter on the [Sales Floor Size] dimension to specify that you only want to retrieve data for stores where the floor size is greater than 4,000 square feet. After this, you create a third filter on the [Sales Revenue] measure to specify that you only want to retrieve data for stores where the sales revenue figures are equal to or less than $1.5M. Finally, you combine these three filters with the And operator:

AND	Last Year
	Sales Floor Size Group Greater than or equal to: 4000
	Sales Revenue Less than 1,500,000

When you run the query, only data for stores that satisfy all three criteria will be returned to the report.

To combine query filters

1. Create the filters and add them to the **Query Filters** pane.

   By default, Web Intelligence combines the filters with the AND operator.

2. Double-click the operator (Java Report Panel, Rich Client and Query - HTML) or click the arrow next to the operator checkbox and select the other operator (HTML Report Panel) to toggle between AND and OR.

Nesting query filters

Nesting query filters allows you to create more complex filter conditions than is possible when you combine filters at the same level.

When you nest filters, you set the order in which Web Intelligence evaluates them. For example, Web Intelligence can return the data given by two query filters joined in an OR relationship (where either one filter condition or the other is true) and then further restrict this data by applying another filter to it. In this case, the two filters in an OR relationship are nested, then compared with the other filter in an AND relationship.

The following example illustrates this:

Example: List all sales made in Japan either in Q4 or where the revenue was greater than 1000000

To answer this question you create the following nested query filter:

<table>
<tr><td rowspan="3">AND</td><td>Country Equal To Japan</td><td></td></tr>
<tr><td rowspan="2">OR</td><td>Quarter Equal To Q4</td></tr>
<tr><td>Revenue Greater Than 1000000</td></tr>
</table>

Web Intelligence first returns sales data where the sale was made in Q4 or the revenue was greater than 1000000, then restricts this data further by returning only those sales made in Japan.

To nest query filters

1. Drag and drop a report object onto an existing query filter.

   A query filter outline on the report object appears in a nested AND relationship with the existing query filter.

2. Define the new query filter.

Filtering data using prompts

chapter 5

What is a prompt?

A prompt is a special type of query filter. It is a dynamic filter that displays a question every time you refresh the data in a document. You answer prompts by either typing or selecting the value(s) you want to view before you refresh the data. Web Intelligence retrieves only the values you specified from the database and returns those values to the reports within the document. Prompts allow multiple users viewing a single document to specify a different sub-set of the database information and display it in the same report tables and charts. Prompts also reduce the time it takes for the data to be retrieved from the database.

A prompt contains the following elements:

- a filtered object
- an operator
- a message

For example, to prompt users to select a specific year, you define a prompt on the [Year] dimension:

```
Year Equal To ("Which year?°)
```

In this prompt, the filtered object is [Year], the operator is Equal To, and the prompt message is "Which year?".

You can define prompts on any dimension, measure, or detail object. For example, you can filter the [Year] dimension to return values for a specific year, filter the [Sales Revenue] measure to return values for a range of revenue figures, or filter the [Year/week] detail to return values for a specific week in a year.

You can create multiple prompts, related by the AND or OR operators, in the same query. You can also nest prompts. When the user runs a query, Web Intelligence displays the prompts.

Prompts appear in the SQL generated by a Web Intelligence query as either the value supplied in response to the prompt (when the SQL is read-only), or as Web Intelligence prompt syntax (when the SQL is editable). For example, a prompt on [Country] can appear in the generated SQL as

```
Resort_Country.country  =  @prompt('Enter Country:','A',
'Resort\Country', Mono,Free,Persistent,,User:0)
```

or as

```
Resort_country.country In ('UK')
```

Prompts can be optional. The user is not obliged to specfy a value for an optional prompt. If no value is specified, Web Intelligence ignores the prompt.

Merged prompts

When a document contains multiple data providers, any prompts that include (1) objects with the same data type, (2) operators of the same operator type, and that (3) use the same prompt text are merged.

When all the data providers are refreshed, a single prompt message appears for such prompts.

The List of Values displayed by the merged prompt is the list associated with the object in the prompt that has the most display property constraints.

Cascading prompts

Some objects cause Web Intelligence to display a cascading prompt when they are included in a prompt definition. The universe designer defines the lists of values of these objects hierarchically in relation to other object lists of values in the universe.

Cascading prompts help the user to focus on the object values they want to include in the prompt without the need to search all possible object values.

Example: Choosing a store

In this example the universe designer has defined the [Store Name], [City] and [State] objects in a hierarchy. If you include a prompt `[Store Name] Equal To <value>`, Web Intelligence displays these objects in a hierarchy in the Prompts dialog box. In order to select the store, the user must first select the state in which the store city is found, then the city in which the store is found, then the store itself. When the user selects the state, Web Intelligence restricts the values of City to the cities in the state; when the user selects the city, Web Intelligence restricts the stores to the stores in the city.

Hierarchical lists of values

If your universe contains hierararchical lists of values, these lists appear in tree form. You navigate down through the tree to the items you want.

Whether a list of values appears as a cascading prompt or hierarchically depends on how the list is configured in the universe. See your administrator for more information.

Query filter and prompt operators

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Not Equal To operator

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Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

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Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

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Different From Pattern operator

Use the Different From Pattern operator to return data that doesn't include a specific string.

For example, to retrieve customers whose date of birth is not 1972, create the filter [DOB] Different From Pattern '72'.

Both operator

Use the Both operator to retrieve data that corresponds to two values.

For example, to retrieve customers who have both a fixed and a mobile telephone, create the filter [Account Type] Both 'Fixed' And 'Mobile'.

Except operator

Use the Except operator to retrieve data that corresponds to one value and excludes another.

For example, to retrieve customers who have a fixed telephone and do not have a mobile telephone, create the filter [Account Type] 'Fixed' Except 'Mobile'.

The Except operator is more restrictive than `Different From` or `Not In List`. For example, a report that returns customers and that includes the filter `[Lines] Different From 'Accessories'` excludes all sales records where the item sold is part of the 'Accessories' line. If the same customer has purchased Accessories and non-Accessories items, the customer still appears in the report, but their spending total includes only non-Accessories sales.

If the filter is `[Lines] Except 'Accessories'`, only customers who have bought no accessories are included in the report.

Related Topics

- *Not In List operator* on page 178
- *Different From operator* on page 176

To create a prompt

1. From the **Data** tab, drag the object on which you want to apply a prompt and drop it onto the **Query Filters** pane.

   The query filter appears in outline in the **Query Filters** pane.
2. Click the arrow at the right of the Query Filter and select **Prompt** from the menu.
3. Type the prompt text in the text box.
4. Click the icon next to the text box and use the dialog box that appears to set the prompt properties.
   - If the prompt is for a date and you want users to see the popup calendar in order to select the date(s) then do not select **Prompt with List of Values**
   - If the document contains multiple data providers, and there is already a prompt that includes (1) objects with the same data type, (2) operators of the same operator type, and (3) that uses the same prompt text as the new prompt, Web Intelligence displays a warning to tell you that the two prompts will be merged. This means that whenever all the data providers are refreshed, a single prompt message will appear for the two prompts.
5. Select **Optional prompt** to make the prompt optional.
6. To delete a prompt, right-click it and select **Remove** from the menu.

The prompt appears at each document refresh.

Related Topics

- *Defining how prompts display* on page 76
- *Merged prompts* on page 71

To remove a prompt

- Select the prompt and then click the **Delete** key.

Defining how prompts display

By default, prompts display a box and a list of values. You answer the prompt by either typing the value(s) in the box or by selecting value(s) from the list.

You can modify how prompts display by checking one, some, or all of the following options:

If you want the prompt to display...	(useful when you...)	then...
the list of values associated with the filtered dimension, measure, or detail,	want to view all the values for the object and then select from those values	leave the option selected by default: **Prompt with List of Values**
the value(s) specified the last time the prompt was answered (users can select a different value(s)),	often reselect the same value(s) when you refresh the document, but want the ability to select a different value when necessary, such as the name of the current month	select the option: **Keep last values selected**
the value(s) you specify as the default (users can select a different value(s)),	almost always reselect the same value(s) when you refresh the document, but want the ability to select a different value when necessary, such as the number for the current year	select the option: **Set default value(s)**
a list of values from which users select a value(s),	prevent users from typing a value that might not exist on the database	select the option: **Select only from List**

To make the prompt optional, select **Optional prompt**. The user is not obliged to specify a value for the prompt. In this case, Web Intelligence ignores the prompt.

Note:
If the prompt is for a date and you want users to see the popup calendar in order to select the date(s) then do not select **Prompt with List of Values**

Combining prompts

Combining multiple prompts on a single query enables you to filter the data returned to the document so that each person viewing the reports sees only the information relevant to their business need. For example, you can combine the following three prompts on a Customer Accounts document:

- Which customer?
- Which account?
- Which calendar period: from? to?

This enables each accounts manager viewing the document to view report values for a specific customer account during a specific period.

You combine prompts in the same way that you combine query filters.

Combining prompts with query filters

Combining prompts and filters on a single query enables you decide the values for some of the selected objects on the query using filters and allow users to decide the values of other selected objects using prompts. For example, if you combine the following filters and prompts on a HR document:

- [Year] Equal to This Year
- [Job title] Not equal to Senior Executive
- Which employee?

Users viewing the document can choose which employee they view information for, but they can only view data for the current year and they can't view data for senior executives.

To change the order of prompts

1. Click the **Properties** tab in the Query Panel.
2. Select the prompt you want to move up or down in the prompt order in the **Prompt Order** box, then press the Up or Down arrow next to the box.

Using combined queries

chapter 6

Combined queries defined

A combined query is a group of queries that work together to return a single result. All queries in the group must be based on the same universe.

Types of combined query

You can combine queries in three relationships:

- union
- intersection
- minus

In a union combination, Web Intelligence takes the all the data from both queries, eliminates duplicate rows, and builds a combined data set.

In an intersection combination, Web Intelligence returns the data that is common to both queries.

In a minus combination, Web Intelligence returns the data in the first query that does not appear in the second.

Example: Union, intersect and minus queries

In this example you have two queries that return lists of countries as shown in the following table:

Query	Values
Query 1	US; UK; Germany; France
Query 2	US; Spain

Depending on the type of combined query, Web Intelligence returns the following values:

Combination type	Values
UNION	US; UK; Germany; France;Spain

Combination type	Values
INTERSECTION	US;
MINUS	UK; Germany; France

What can you do with combined queries?

Combined queries allow you to answer questions that are otherwise difficult or impossible to frame in a single Web Intelligence query.

Example: Return a data set using a combined query

The Island Resorts Marketing sample universe contains the dimension Year, which returns guests who have already stayed in a resort, and Reservation Year, which returns guests who have reserved to stay in the future. Because of the structure of the database and universe, these objects are incompatible, which means that you cannot include them in the same block in a report.

What if you want to return a single list of years that includes those years where more than n guests stayed in a resort and those years where more than n guests reserved to stay in a resort? You can do this using a combined query, as follows:

Query	Returns
Query 1	Years where more than n guests stayed in a resort
UNION	
Query 2	Years where more than n guests reserved to stay in a resort

The union between these two queries returns the list of years that you want.

How does Web Intelligence generate combined queries?

If your database supports the type of combination in your query, combined queries work at the database level: they alter the query that Web Intelligence submits to the database. They do so by generating SQL (Structured Query Language) queries containing UNION, INTERSECT and MINUS operators.

Note:
SQL is the standard query language of relational databases, although each database has its own dialect.

If your database does not support the type of combination in your query, Web Intelligence performs the query at the report level by generating multiple SQL queries whose data it resolves after retrieval from the database.

To build a combined query

1. Create an initial query in the Query Panel.
2. Click **Add a combined query** on the toolbar.

   Web Intelligence adds a copy of the initial query to the data provider. The second query has the following characteristics:

   - It contains the same report objects as the original query.
   - It does not contain the filters defined on the original query.
   - It is combined with the original query in a UNION relationship.
3. To switch to a query, click **Combined Query n** in the bottom left pane of the Query Panel.

   The individual queries in the combined queries are named Combined Query n.
4. To delete a query, right-click the Combined Query n you want to delete, then select **Remove** on the menu.
5. To change the combination type, double-click on the operator. The operator moves through the sequence UNION, INTERSECTION, MINUS.
6. Build each query within the combined query as you build any normal Web Intelligence query.
7. Click **Run Query**.

Combined query structure

The queries within a combined query must return the same number of objects of the same data type and the objects must be in the same order. You cannot combine queries when the number of objects in the query results and the data types of those objects are not identical. For example, you cannot combine a query than returns Year with a query that returns Year and Revenue, and you cannot combine a query that returns Year with a query that returns Revenue.

You must also pay attention to the semantics of your combined queries. While it is possible to combine a query that returns Year with a query that returns Region if both dimensions are of the same data type, the result - a mixed list of years and regions - is unlikely to be meaningful. Typically, if your first query contains a Year dimension, your second query also contains a dimension that returns a list of years.

To return a list of years and reservation years based on the number of guests

This example describes the workflow for the query described in the example Return a data set using a combined query. You want to build a query that returns a list of years consisting of years where more than n guests stayed in a resort and years where more than n guests reserved to stay in a resort.

1. Select the Island Resorts Marketing universe in the list of universes to open the Query Panel.
2. Drag the Year object to the **Result Objects** pane.
3. Drag the Number of Guests object to the **Query Filters** pane and create a report filter that restricts Number of Guests to greater than n.
4. Click **Combined Query**.

   The **Combined Query** pane appears in the bottom left of the Query panel with the two queries joined by UNION.
5. Click on the second query and remove the Year and Number of Guests objects.
6. Drag the Reservation Year object to the **Result Objects** pane.
7. Drag the Future Guests object to the **Query Filters** pane and create a report filter that restricts the future guests to greater than n.

8. Click Run Query.

The query returns the combined list of years and reservation years.

Related Topics

- *Return a data set using a combined query* on page 81

Combined query precedence

The order in which Web Intelligence executes query combinations in a combined query is crucial in determining the final result.

In the simplest form of combined query you combine two or more queries in a relationship as follows:

	Query 1
INTERSECTION	Query 2
	Query 3

In such a case, Web Intelligence first finds the set of data that represents the union/intersection/minus between Combined Query n and Combined Query n + 1, then finds the union/intersection/minus between that data set and the data returned by Combined Query n + 2. Web Intelligence continues in this way through all the queries in the relationship. This gives the following result for the above example:

Query	Data
Query 1	US; UK; France; Germany
Query 2	US; France; Finland
INTERSECTION of 1 and 2	US; France
Query 3	US; Spain
Final INTERSECTION	US

Multiple combined queries

You can combine multiple queries in complex relationships to determine the order of execution, as in the following example:

		Combined Query 1
	MINUS	
INTERSEC TION		Combined Query 2
	Combined Query 3	

Web Intelligence processes query groups from right to left as they appear in the Query Panel, and from top to bottom within each group. (Higher-precedence groups, such as the MINUS group in the above example, appear indented to the right in the Query Panel.) In the above query Web Intelligence first determines the result of the minus combination then finds the intersection of this result with the result of Combined Query 3 as shown in the following table:

Query	Result
Query 1	US; UK; Spain; Germany
Query 2	Germany
Query 1 MINUS Query 2	US; UK; Spain
Query 3	US; Spain; Finland
(Query 1 MINUS Query 2) INTERSECTION Query 3	US; Spain

Note:
If your database directly supports the type of combined query you wish to execute, Web Intelligence generates SQL containing combination operators. In this case the order of precedence depends on the order of precedence defined in the database. See your Web Intelligence administrator for more details.

To set the order of precedence of combined queries in the Java Report Panel

1. Build the first query in the Query Panel.
2. Click **Combined Query**.
3. Repeat these steps until you have built all the component queries.
4. To increase the precedence of a pair of queries, drag and drop a query on to the query with which you want to associate it in the higher-precedence pair.

   Web Intelligence indents the source and target queries in the drag-and-drop operation and combines them by default in a UNION.
5. Continue adding queries to the higher-precedence group by dragging and dropping them on to the space between any two queries already in the group.
6. To create further higher-precedence groups within an existing higher-precedence group, repeat the previous two steps.
7. Double-click the combination operators of all the groups in the query to change them as required.
8. Click **Run Query**.

Filtering data using subqueries

chapter 7

What is a subquery?

A subquery is a more flexible kind of query filter that allows you to restrict values in more sophisticated ways than is possible with a ordinary query filters.

Subqueries are more powerful than ordinary query filters for the following reasons:

- They allow you to compare the values of the object whose values are used to restrict the query with values from other objects.
- They allow you to restrict the values returned by the subquery with a WHERE clause.

What can you do with subqueries?

Subqueries allow you to pose complex questions that are difficult or impossible to formulate with simple query filters. For example: what is the list of customers and their associated revenue where the customer purchased a service that had previously been reserved (by any customer) in Q1 of 2003?

How do subqueries work?

Subqueries work by modifying the SQL that Web Intelligence generates to retrieve the query data. Web Intelligence generates SQL containining a subquery that restricts the data returned by an outer query. For more information on SQL subqueries, see any book on SQL.

Note:
SQL is the query language supported by all relational databases (RDBMS), although each database has its own syntax.

To build a subquery

1. Add the objects that you want to appear in the query to the **Result Objects** pane.
2. Select the object in the Result Objects pane that you want to filter with a subquery and click **Add a subquery** at the top right of the **Query Filters** pane.

The subquery outline appears in the **Query Filters** pane. By default the object you selected appears as the Filter object and Filter By object.

3. To add a WHERE condition to the subquery, drag a report object to the area of the subquery below the Drop an object here boxes.
4. To add a WHERE condition to the subquery, drag a report object to the area of the subquery below the **Drop an object here** boxes.

   You can use an existing subquery or standard query filter as a WHERE condition in a subquery. To do so, drag and drop the existing filter or subquery to the area of the subquery below the Drop an object here boxes. To copy rather than move the existing filter to the WHERE condition, hold down the Control key while dragging and dropping. In this case the existing filter remains in its initial place and becomes part of the WHERE condition of the subquery.
5. Select the operator and values used to filter the object in the WHERE condition.
6. Click **Subquery** to add an additional subquery to the query filter.

   In addition to linking subqueries in AND or OR relationships, you can nest them (create subqueries within subqueries) by dragging an existing subquery to the area beneath the **Drop an object here** boxes. In this case the inner subquery becomes part of the WHERE condition of the outer subquery. To copy rather than move the subquery to the WHERE condition, hold down the Control key while dragging and dropping. In this case the second subquery remains at the same level as the first, and becomes part of the WHERE clause of the first.

   By default the two subqueries are linked in an AND relationship. Click the AND operator to toggle between AND and OR.
7. To nest a subquery (create a subquery within a subquery), drag an existing subquery to the area beneath the **Drop an object here** boxes.

   To copy rather than move the subquery to the WHERE condition, hold down the Control key while dragging and dropping. In this case the second subquery remains at the same level as the first, and becomes part of the WHERE clause of the first

   The inner subquery becomes part of the WHERE condition of the outer subquery.

To find out which customers bought a service that had previously been reserved in Q1 of 2003, and how much revenue have they generated

1. Drag the Customer and Revenue objects to the Result Objects pane of the Query Panel.
2. Select the Service object.
3. Click **Subquery**.

   The subquery outline appears in the Query Filters pane.

   Note:
   The selected object appears in both boxes in the subquery outline. You often use the same object in both boxes, although this is not required. If the objects do not return any common values, the subquery returns no values, and the query therefore returns no values.

4. Drag the Reservation Year object to the area of the subquery outline beneath the Service objects.

   Web Intelligence adds a WHERE condition on the Reservation Year object.

5. Set the Reservation Year condition operator to Equal To.
6. Type ‘FY2003’ in the **Type a constant** box.
7. Drag the Reservation Quarter object to the area of the subquery outline beneath the Service objects.

   Web Intelligence adds the Reservation Quarter object to the WHERE condition.

8. Set the Reservation Quarter condition operator to Equal To.
9. Type ‘Q1’ in the **Type a constant** box.
10. Click **Run Query** to run the query.

Subquery parameters

A subquery or set of subqueries contains the following parameters:

Parameter	Description
Filter Object(s)	The object whose values are used to filter the result objects. You can include more than one Filter Object. If you do, Web Intelligence concatenates the values of the objects you specify.
Filter By Object(s)	The object that determines which Filter Object values the subquery returns. You can include more than one Filter By object. If you do, Web Intelligence concatenates the values of the objects you specify.
Operator	The operator that specifies the relationship between the Filter object and the Filter By object. Because of database restrictions you cannot use certain combinations of operators and Filter By objects together. For example, if you use the Equal To operator with a Filter By object that returns multiple values, the database rejects the SQL because this type of subquery requires the Filter By object to return one value only. In cases where the generated SQL is rejected by the database, you see an error message showing the error description returned by the database

Parameter	Description
WHERE condition (optional)	An additional condition that constrains the list of values of the Filter By object. You can use ordinary report objects, predefined conditions or existing query filters (including subqueries) in the WHERE condition.
Relationship operator	If there is more than one subquery, determines the relationship between the subqueries. AND - the conditions in all of the subqueries must be satisfied. OR - the conditions in any one of the subqueries must be satisfied.

Ranking data using database ranking

chapter 8

What is database ranking?

When you rank data you sort and filter it according to ranking criteria. Web Intelligence allows you to return unranked data from a database, then rank it in Web Intelligence.

A database ranking allows you to specify a ranking at the query and database level so that the data returned to Web Intelligence by the query is already ranked.

Database rankings allow you to answer questions like Return the top 3 customers based on the revenue they generated for each year? at the query level, without the need to return data that falls outside the ranking to Web Intelligence and then filter it using a Web Intelligence ranking.

Database ranking has the following advantages:

- Ranking data can be processing-intensive. By ranking at the database level you allow the server, which is typically far more powerful than the client machine, to perform this processing.
- Pre-ranking data reduces the amount of data retrieved across the network and stored in Web Intelligence.

A database ranking works by modifying the SQL that Web Intelligence generates to retrieve the query data. If your database supports ranking, Web Intelligence generates SQL to rank the data. Web Intelligence uses the SQL-99 Rank function in ranking SQL. (SQL is the query language supported by all relational databases (RDBMS), although each database has its own syntax.)

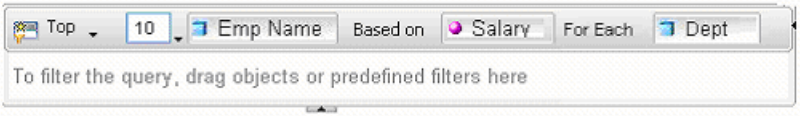
Note:
You can perform a database ranking only if your database supports it. If this is not the case, the **Add a database ranking** button is disabled on the Query Panel toolbar. Databases that support ranking are Oracle, DB2, Terradata and Redbrick.

Related Topics

- *Ranking data* on page 244

Database ranking parameters

A database ranking appears as follows in the Query Filters pane of the Query Panel:



The following table describes the parameters from left to right in the ranking:

Parameter	Description
Top/Bottom	Ranking order. • Top - ranks in descending order. • Bottom - ranks in ascending order.
Number of records	The number of records to return in the ranking. For example, the top 10.
Ranking dimension	The dimension used in the ranking. For example, if the dimension is Region and the ranking is Top 10, the ranking returns the top 10 regions.
Based on	The measure by which the ranking dimension is ranked. For example, if the measure is Revenue and the dimension is Region, Web Intelligence ranks regions by the amount of revenue they generate
For Each (optional)	Dimension that specifies additional calculation context for the ranking. For example, if the ranking dimension is Region, the measure is Revenue and the For Each dimension is Country, Web Intelligence ranks regions by revenue within each country.

Parameter	Description
WHERE condition (optional)	Additional restriction on the values returned in the ranking that appears below the other parameters. For example, a ranking of regions with a condition that restricts Country to “USA□? ranks only those regions in the USA.

To create a database ranking

1. Add the objects that you want to appear in your query to the Result Objects pane of the Query Panel.
2. Select the dimension that you want to rank by.
3. Click **Add a database ranking** on the toolbar at the top of the **Query Filters** pane.

   The ranking outline appears in the **Query Filters** pane. The dimension you selected appears as the ranking dimension and the first measure in the query appears as the ranking measure in the **Based on** box.

   Note:
   The **Add a database ranking** button is disabled if your database does not support ranking.

4. Select the ranking direction (Top or Bottom).
5. Type the number of records you want the ranking to return in the box next to Top/Bottom.

   You can specify a prompt instead of a constant by clicking on the arrow next to the number. When you select a prompt the user must enter the ranking number when the query is run.

6. Drag the dimension that provides the calculation context for the measure to the **For Each** box.

   This dimension is optional. To display the **For Each** box, click the arrow to the right of the **Based on** measure.

7. Drag any dimensions that you want to include in the WHERE restriction to the area at the bottom of the ranking.
8. Click **Run Query**.

Related Topics

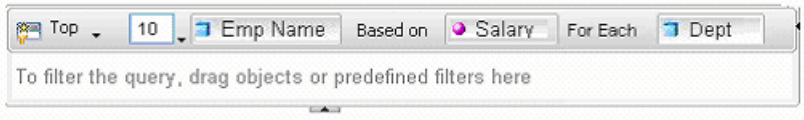
- *What is a subquery?* on page 88

To create a report that returns the top 10 employees based on salary, and calculated by department

1. Drag the Department, Employee Name, and Salary objects to the Report Objects pane within the Query Panel.
2. Select the Employee Name object.
3. Click **Add a database ranking** on the toolbar.

   Web Intelligence adds an outline database rank to the Query Filters pane. The ranking dimension is Employee Name and the ranking measure is Salary.
4. Set the ranking direction to Top.
5. Set the ranking number to 10.
6. Click the arrow next to the **Based on** measure if the **For Each** box is not already visible.
7. Set the For Each dimension to Department by dragging and dropping the dimension.

   The ranking now looks like this:



8. Click **Run Query**.

The Java Report Panel reporting interface

chapter 9

By default, the Java Report Panel report interface appears as follows:

- Report tabs - a collection of four tabs at the left of the screen that you use to work with reports.

Tab	Description
Data	Displays the universe objects, formulas and variables that can be included in the report.
Templates	Displays the tables, charts and cells that can be included in the report.
Map	Displays a hierarchical map of the report components (for examples tables, cells, sections, filters).
Properties	Displays the editable properties used to configure the appearance and behavior of the report. The list of properties varies depending on the report component selected.

- Toolbars

Toolbar	Description
Main	You use the main toolbar to switch between query view and report view, to save and print documents, and to activate data tracking and drill mode, and to configure the report interface. The main toolbar is always visible. All the other toolbars can be hidden.
Formatting	You use the formatting toolbar to format text and report objects.
Reporting	You use the report toolbar to add reporting features (for example filters, variables, rankings, calculations).
Page Navigation	You use the page navigation toolbar to navigate through the pages in a report.

- Reports - by default the reports contained in the Web Intelligence document appear to the right of the report tabs and below the toolbars. Each report appears on its own

You can configure the report interface (for example by hiding toolbars or changing the position of the report tabs) by selecting options from the **Configure View** menu on the main toolbar.

Web Intelligence viewing modes

chapter 10

To switch between viewing modes

You can view Web Intelligence reports in different modes depending on how you want to work with data and how you want the data to appear.

1. In Web Intelligence Interactive, select the report tab of the report you want to view.
2. Click the arrow next to the **View** button on the main toolbar above the report.
3. Select the viewing mode.

   Web Intelligence Interactive displays the report in the selected viewing mode.
4. In the Java Report Panel or Web Intelligence Rich Client, use **Switch Page/Quick Display** on the **Reporting** toolbar to alternate between Page mode and Quick Display mode.

Draft mode

Draft mode displays just the tables, reports, and free standing cells in reports.

Use Draft mode when you want to focus on analyzing results, add calculations or formulas, or add breaks or sorts to tables to organize results.

Page mode

Page mode displays the page layout of reports, including page margins, headers, and footers.

Use Page mode when you want to fine-tune the formatting of tables and charts and the layout of report pages.

PDF mode

PDF mode displays the report in PDF format.

Use PDF mode when you want to view the report in PDF format or print the report from within Adobe® Acrobat® Reader®.

Quick Display mode

Quick Display mode is the default display mode in Web Intelligence. It is a pagination mode that is based on the data, rather than the physical size of report pages. Quick Display mode displays just the tables, reports, and free standing cells in reports and displays a maximum number of records vertically and horizontally, depending on the Quick Display settings. Quick Display mode also specifies the minimum page width and height and the amount of padding around the edges of the report.

Because Quick display mode retricts the number of horizontal and vertical rows, a report might not contain all possible data.

Use Quick Display mode when you want to focus on analyzing results, add calculations or formulas, or add breaks or sorts to tables to organize results.

The Quick Display mode properties are configurable either by your administrator in the CMC, or directly in Web Intelligence.

Property	Where config-ured	Notes
Maximum verti-cal records	CMC	
Maximum hori-zontal records	CMC	
Minimum page width	CMC	
Minimum page height	CMC	
Right padding	CMC	

Property	Where configured	Notes
Bottom padding	CMC	
Vertical records per page	Web Intelligence	• Impacts horizontal tables and crosstabs only • Horizontal tables are never cut vertically • The number of rows in a horizontal table is ignored in vertical records calculation
Horizontal records per page	Web Intelligence	• Impacts vertical tables, forms and crosstabs only • The number of rows in a vertical table is ignored in horizontal records calculation

Other notes:

- Table headers and footers do not count as rows.
- Free standing cells and charts do not count as rows.
- Section cells do not count as rows when the section is not empty.
- Sections cells count as vertical rows when the section is empty.
- The Avoid Page Break in Block option has no effect in Quick Display mode

To change Quick Display mode settings in Web Intelligence

You can change the number of horizontal and vertical records per page in Quick Display mode in Web Intelligence.

1. In the Java Report Panel, set the **Page Content** > **Vertical Records per page** and **Page Content** > **Horizontal Records per page** properties.
2. In Web Intelligence Interactive, right-click the report background, select **Format Report** to display the "Format Report" dialog box, and set the **Number of vertical records per page** and **Number of horizontal records per page** in the **General** tab.
3. As a shortcut, vou can also use the icons on the Page Navigation toolbar (Java Report Panel) or main toolbar (Web Intelligence Interactive) to increase or decrease these settings by increments of 50.

To select Enhanced Viewing mode

Your administrator can define minimum page margins, headers and footers that are applied only when you view reports onscreen. This means that the maximum amount of information on report pages is visible when you view reports via your computer screen. To apply the page definition set up by your administrator you need to select Enhanced Viewing mode.

1. Select **Document** > **Properties** (in Web Intelligence Interactive) or right-click a report and select **Document Properties** (in the Java Report Panel or Web Intelligence Rich Client).
2. Select **Enhanced viewing mode**.

Displaying and hiding report data

chapter 11

You can hide and display report data by folding and unfolding the display of different report elements.

You can fold and unfold sections, breaks and tables. Web Intelligence conceals and displays data in different ways depending on the report element.

Report element	Result
Section	When a section is folded, section details are hidden and free cells only are displayed.
Table or break	When a table or break is folded, the rows are concealed and headers and footers only are displayed. (Tables must have headers and footers to be folded and unfolded.) Vertical tables and crosstabs only can be folded and unfolded. **Note:** Folding and unfolding tables and breaks is supported by the Web Intelligence Java Report Panel and Web Intelligence Rich Client only.

To display and hide report data

1. Click **Fold/Unfold** on the report toolbar.

   The Fold/Unfold bar appears to the left of the report.
2. User the icons on the bar, which correspond to and are aligned with individual report elements, to fold and unfold specific report elements.
3. Use the icons at the bottom of the bar to fold and unfold all instances of a type of report element.

Displaying data in tables

chapter 12

Tables in Web Intelligence

When you create a new document and run the query the first time to display the results, Web Intelligence generates a report that includes all of the results in a vertical table. You can modify how the table is organized, remove or add data, change the table type to display the results differently or insert other tables. You can also insert free standing cells to display results in a single cell.

Table types in Web Intelligence

A Web Intelligence report displays results in a block. You can format the block as a specific type of table.

Vertical table

Vertical tables display header cells at the top of the table and the corresponding data in columns. By default, the header cells display the names of the dimensions, details, and measures included in the table. The body cells display the corresponding values.

Lines	Sales revenue	Margin
Accessories	$9,914,546	$3,809,135
City Skirts	$347,775	$132,302
City Trousers	$284,734	$104,346
Dresses	$2,915,620	$1,173,881
Jackets	$677,307	$286,130
Leather	$187,413	$70,599
Outerwear	$1,183,083	$474,302
Overcoats	$436,258	$185,522
Shirt Waist	$4,018,220	$1,616,218
Sweaters	$2,839,035	$1,000,673
Trousers	$903,320	$327,515

Horizontal table

Horizontal tables display header cells at the left of the table and the corresponding data in rows. By default, the header cells display the names of the dimensions, details, and measures included in the table. The body cells display the corresponding values.

Fiscal Period	FY01	FY02	FY03
Sales revenue	$8,095,814	$13,232,246	$15,059,143
Margin	$3,731,971	$5,187,886	$5,667,084

Crosstab

Crosstabs display values for dimensions across the top axis and on the left axis. The body displays the values of a measure that correspond to the cross-section of the dimensions. For example, this crosstab displays values for [Quarter] across the top axis and displays values for [State] on the left axis. The body displays values that [Sales Revenue] for each quarter in each state.

	Q1	Q2	Q3	Q4
California	$1,899,680	$1,760,148	$1,930,517	$1,889,225
Colorado	$525,682	$500,076	$510,777	$523,740
DC	$766,822	$706,447	$692,258	$796,423
Florida	$515,688	$489,998	$387,810	$485,663
Illinois	$846,408	$850,905	$610,765	$714,890
Massachusetts	$312,896	$291,431	$249,529	$429,850
New York	$1,987,115	$2,028,091	$1,672,581	$1,894,435
Texas	$2,875,569	$2,499,277	$2,146,303	$2,596,516

You can include multiple dimensions in crosstabs. For example, this crosstab displays two dimensions. The values for the [Sales Revenue] measure are values each state by quarter for each line.

	Q1	Q1	Q2	Q2	Q3	Q3	Q4	Q4
	City Skirts	City Trousers	City Skirts	City Trousers	City Skirts	City Trousers	City Skirts	City Trousers
California	$7,796	$8,496	$9,075	$1,248	$24,377	$11,924	$33,685	$26,517
Colorado	$726	$2,270	$2,375	$857	$6,421	$2,381	$8,015	$7,468
DC	$2,568	$4,026	$3,564	$1,121	$9,788	$5,338	$8,326	$10,448
Florida	$1,765	$1,737	$2,735		$4,927	$2,511	$7,377	$9,563
Illinois	$588	$2,139	$2,822	$459	$5,552	$5,305	$7,748	$12,987
Massachusetts	$1,194	$532	$2,373		$5,752	$-185	$2,134	$7,565
New York	$10,626	$14,203	$17,241	$1,769	$23,762	$18,689	$28,564	$41,324
Texas	$10,612	$12,604	$22,272	$1,663	$37,119	$20,239	$35,898	$49,539

When you create crosstabs that include a dimension(s) in the body, the body cell values are calculated according to a multi-dimensional data model. The values displayed in the body are calculated according to all of the coordinates on the table axes, whether or not there is a row for the specific coordinate in the SQL result.

	California	Colorado	DC
2001	Colorado Springs	Colorado Springs	Colorado Springs
2001	Los Angeles	Los Angeles	Los Angeles
2001	San Francisco	San Francisco	San Francisco
2001	Washington	Washington	Washington
2002	Colorado Springs	Colorado Springs	Colorado Springs
2002	Los Angeles	Los Angeles	Los Angeles
2002	San Francisco	San Francisco	San Francisco
2002	Washington	Washington	Washington
2003	Colorado Springs	Colorado Springs	Colorado Springs
2003	Los Angeles	Los Angeles	Los Angeles
2003	San Francisco	San Francisco	San Francisco
2003	Washington	Washington	Washington

Forms

Forms are useful in your report if you want to display detailed information per customer, product, or partner. For example, a form is a useful way of displaying individual customer records with information such as the customer account, name, address, and so on.

Forms are also useful for formatting address labels for envelopes.

East Japan

Ishimoto

Customer	Makino
Address	2435 Toyota Ave
Phone Number	3441 3486
Revenue	$257,795.00

Customer	Oneda
Address	94 Toyota Blvd
Phone Number	5183 9463
Revenue	$387,088.00

Structure View and Results View

The Web Intelligence Java Report Panel allows you to make modifications to documents and preview those changes in Structure View, without implementing each change on the Web Intelligence server. This enables you to make multiple formatting changes quickly and preview them. When you return to Results View, Web Intelligence requests the server to apply the changes and returns the modified format in a single operation.

You can create and format tables in either Structure View or Results View. If you have several modifications to make, however, we recommend you make the modifications in Structure View.

Creating and editing tables

To create a table by dragging objects onto a report

1. If the report is empty, select either a single object or a class folder on the **Data** tab, and then drag and drop the object or class onto the report.

2. If the report already contains tables or charts, press the Alt key, then with the Alt key pressed, drag an object onto an empty area of the report.

   A new table header and body cell appears on the report. The table header displays the name of the object.

3. To add another object to the table, drag another object from the **Data** tab and place it to the left or right of the existing column header.
4. When the “Drop here to insert a cell□? ToolTip appears, drop the object onto the left or right of the table header.

   A second column appears before or after the first column. The new column header displays the name of the object.

Web Intelligence displays the values in a vertical table. You can quickly turn the vertical table to a different table format, such as a crosstab by using the Turn To feature.

To create a table by selecting a template

1. Click **View Structure**.

   Working in Structure View allows you to define and preview the new table without requesting the server to apply each of your modifications. You then apply all your modifications and display the results in the new table, by returning to Results View.

2. Click the **Templates** tab.
3. Drag a template from the **Template** tab onto a blank area of the report.

   The template appears on the report.

4. Click the **Data** tab.

   The objects and variables that the document contains appear here. You can add any of these objects or variables to the table.

5. Drag an object or variable onto an empty header or body cell of the table.
6. When the ToolTip “Drop here to replace cell□? appears, drop the object onto the table.

   The empty cell is replaced by the object. If you are working in Results View, the values of the objects display on the table. If you are working in Structure View, the name of the object displays on the table.

7. To add more objects to the template, drag an object from the **Data** tab and drop it onto the template.

Once you have allocated objects to each part of the table template, you can add more objects to increase the size of the table. Each additional object inserts more columns or rows onto the table.

8. To add another object and create an additional table column or row, drag an object from the Data tab and drop it onto a row or column.
   - If you drop the object onto the left of a column, you create a new column before the existing column.
   - If you drop the object onto the right of a column, you create a new column after the existing column.
   - If you drop the object onto the top edge of a row, you create a new row above the existing row.
   - If you drop the object onto the bottom edge of a row, you create a new row below the existing row.
9. If you are working in Structure View, click **View Results** to display the values in the new table.

To duplicate a table

1. Select a table on a report.

   A gray border appears around the table, when the table is selected.
2. Keep your pointer pressed in and press the Ctrl key.

   Web Intelligence creates a duplicate table on top of the original table.
3. With your pointer and the Ctrl key pressed in, drag the duplicate table to an empty area of the report.

   The duplicate table appears on the report.

To apply a different template to a table by using drag and drop

1. Select the report tab that contains the table you want to modify.
2. Click the **Templates** tab.

   If the **Templates** tab is hidden, click the **Show/Hide Manager** button on the Report toolbar. The Templates appear.
3. Drag a template from the Template tab onto a table. You must drop the template directly on the existing report block.

Web Intelligence applies the new template to the table values.

To apply a different template to a table with Turn To

1. To select the table you want to reformat, click the top edge of the table.

   A gray border appears around the table.
2. Right-click the report block.
3. On the shortcut menu, click **Turn To**.

   The "Turn To" dialog box appears.
4. On the **Tables** tab or on one of the **Chart** tabs, select the table or chart template you want to apply to the table.
5. Click **OK**.

If you turned a table to a chart, the unicode font is not retained in the chart if the font for the text on the table was unicode, and if unicode is not defined as your default font for charts. You need to format the chart with the unicode font, if this font is available on your computer. If this is not the case, you need to contact your administrator to configure the Web Intelligence server and your computer appropriately.

To add rows or columns to tables using drag and drop

- Drag the object you want to add to the table from the Data tab, and drop the object where you want to add it:
  - To add the object into a new column to the left of an existing column, drag the object onto the left edge of a column header.
  - To add the object into a new column to the right of an existing column , drag the object onto the right edge of a column header.
  - To add the object into a new row before an existing row, drag the object onto the top edge of a row header.
  - To add the object into a new row after an existing row, drag the object onto the bottom edge of a row header.

  The name of the object appears in the new column or row header, and the values appear in the new body cells.

To add table rows or columns using the Insert row or column toolbar menu

1. Select the table you want to reformat.
2. Select the column or row next to which you want to insert the new column or row.
3. The **Insert column or row** button automatically displays one of the insert options.
4. Click the displayed option or click the arrow next to the **Insert** button, and then select the appropriate option from the drop-down menu.

   Web Intelligence adds a blank column or row to the table.
5. Drag an object from the **Data** tab, and drop the object onto the blank column or row.

   Web Intelligence allocates the selected object to the new column or row. The name of the object displays in the column or row header, and the values for the object display on the body cells.

To remove table rows or columns

- Right-click the table column or row you want to remove and select **Remove Row**, **Remove Column** or **Remove** from the shortcut menu.

To move a row or column

- Drag the selected column or row and drop it before or after another column or row on the table.

  When you drag a row or column, the column or row header displays next to your pointer.

To swap a row or column

- Drag the selected column or row onto the column or row with which you want to make the swap

Web Intelligence swaps the two columns or rows.

To replace a row or column

1. Select the report tab that contains the table you want to modify.
2. Click the **Data** tab.
3. Drag the object you want to add to the table from the **Data** tab, and then drop the object onto the row, column, or body you want to replace.

   The values for the new object display on the table.

To clear cell contents from a table

You can clear cell contents and then use the empty cells to display images, hyperlinks, formulas, or text you type.

You can clear the following types of cell in a table:

- header cells – you can clear each header cell separately
- footer cells – you can clear each footer cell separately
- related body cells – when you clear one body cell, you automatically clear all of the body cells in the same column or row of the table

1. To select the cell you want to clear, click the cell.

   The cell borders are highlighted.
2. Right-click the selected cell.

   The shortcut menu appears.
3. The shortcut menu appears.
4. Click **Clear Cell Contents**.

   Web Intelligence clears the contents from the selected cell(s).

To remove a table

1. To select the table you want to remove, click the top edge of the table.

   A gray border appears around the table.

2. Press the **Delete** key, or right-click the selected table and select **Remove** from the shortcut menu.

Formatting tables and table cells

To select a background color for the table

1. Select the table or table cell for which you want to format a background.
2. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
3. Select the drop-down arrow next to **Appearance** > **Background color**.

   A list of available colors appears.
4. Click the color you want to apply to the selected table or table cell, or click **Custom**, and then create a custom color, using the **Swatches**, **HSB** (Hue, Saturation, Brightness), or **RGB** (Red, Green, Blue) tab, and click **OK**.

   If you know the RGB hexadecimal color reference, you can type the reference into the combo boxes next to the **+** and **-** buttons on the **RGB** tab.

   Web Intelligence applies the background color to the selected table or cell.

To define alternate row and column colors for a table

1. Select the table for which you want to format alternate row colors.

   When the table is selected, a gray border appears around the table.
2. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
3. Open the **Appearance** > **Alternate Row/Column color** property group.
4. Set the frequency for the alternate row color in the combo box next to **Frequency** by clicking the **+** or **-** sign, or by entering a number.
5. Click the arrow next to **Color**.

6. Select a color from the list of colors, or click **Custom**, and then create a custom color, using the **Swatches**, **HSB** (Hue, Saturation, Brightness), or **RGB** (Red, Green, Blue) tab, and click **OK**.

   If you know the RGB hexadecimal color reference, you can type the reference into the combo boxes next to the **+** and **-** buttons on the **RGB** tab.

To insert an image or skin in a table

1. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
2. Click the **...** button next to **Background image** in the **Appearance** property sub-group to display the "Background Image" dialog box.
3. To display a skin, select **Skin** then select the skin from the list.
4. To reference an image using a URL, select **Image from URL** then type the URL.
   - To access an image on the corporate Web Intelligence server, type the image name. Web Intelligence inserts `boimg://` when you click **Apply**.
   - To access an image file directly, click **Image from file**, then click **Browse** to browse to the file.
5. If you chose to reference an image file, use the **Display** and **Position** lists to determine how the image appears.

To format table or cell borders

1. Right-click the table or cell, then select **Format** > **Table** or **Format** > **Cell** from the shortcut menu.

   The **Properties** tab displays the table or cell formatting options depending on which option you selected.
2. Click the **...** button next the the **Text Format** > **Borders** property.
3. Use the buttons in the "Border Editor" dialog box to set the border style.

   You can also set the borders of header cells, body cells and footer cells in the table properties. To do so, click the **...** button next to the **Borders**

property in the **Header cells**, **Body cells** and **Footer cells** property sub-groups.

To format text in table cells

1. Right-click the table border, then select **Format**, or right-click within the table, then select **Format** > **Table** from the shortcut menu.

   The **Properties** tab displays the table formatting options.
2. Click the **...** button next to the the **Text format** property in the **Appearance** > **Header cells/Body cells/Footer cells** property sub-group.
3. Format the text in the **Format Text** dialog box.

   You can also format cell text by selecting the cell then setting the **Appearance** > **Text Format** property in the **Properties** tab.

To set cell height and width

You can define the height and width of cells by using drag and drop or specifying the size of cells on the **Properties** tab.

If you want to hide cell contents on reports, you can set the cell width to 0.1 cm so that the cell width can be modified to display the cell contents later.

1. Drag the cell borders until the cell is the height and width you want, or:
2. Click the table.

   The **Properties** tab displays the table formatting options.
3. Set the **Width** and **Height** properties in the **Display** properties group.
4. If you want to set the cell to autofit, select **Autofit Width** and/or **Autofit Height**.

   Some Web Intelligence functions are incompatible with AutoFit cells. If you place any of these functions in an AutoFit cell, Web Intelligence returns the #RECURSIVE error message as the function output.

   You can also set AutoFit cell width and height by double-clicking the cell borders.

   - To set AutoFit cell width, double-click the right border of the cell
   - To set AutoFit cell height, double-click the bottom border of the cell

AutoFit retains the current cell size as the minimum size and enlarges the cell size, if the string or image that the cell contains is larger than the minimum size specified.

Documents that contain tables with the cell size set to AutoFit, take longer to display in the Java Report Panel or InfoView than documents where tables contain cells with a fixed cell width and cell height. We recommend that for large documents, you specify a fixed sized for cell width and cell height for tables.

Effects of autofit and wrap text

The following table lists the effects of the autofit and wrap text features, when used seperately and in combination:

Feature	Effect
Wrap text	Text is wrapped at the end of the cell.
Autofit width	Cell width is adjusted to display all the text.
Autofit height	Cell height is adjusted to display all the text.
Autofit width + autofit height	Cell width and height is adjusted to display all the text
Wrap text + autofit width	Cell width is adjusted to accomodate the longest word. Because the cell height is not adjusted to the number of lines of text, text might be truncated vertically.
Wrap text + autofit height	Cell height is adjusted to accommodate the number of lines of text created by the wrap text. Because the cell width is not adjusted to the longest word, text might be truncated horizontally.
Wrap text + autofit height + autofit width	Cell height and width is adjusted to the text and there is no horizontal or vertical truncation.

To copy formatting using the Format Painter

You can quickly apply the formatting from a report, table or cell to other reports, tables or cells using the Format Painter.

The formatting options applied depend on the objects you choose as the source and target. In general, only properties that affect the visual formatting (for example font style, background color) are applied. Properties that affect the display of data (for example, table properties such as "Avoid duplicate row aggregation" property) are not applied.

1. Select the report, table or cell whose formatting you want to apply.
2. Click the Format Painter to apply the formatting once, or double-click to apply the formatting multiple times.

   The Format Painter is the button furthest to the right on the **Formatting** toolbar.

3. Click the report, table or cell to which you want to apply the formatting.

   Web Intelligence applies the formatting to the report, table or cell you selected. If you single-clicked the Format Painter, it is deactivated.

   If you double-clicked the Format Painter, it remains activated.

4. If you double-clicked, click the Format Painter again or press Esc to cancel the formatting operation. (You can do this before applying the formatting for the first time if you decide to abandon the formatting operation.)

To set the position of a table or chart on the report page

1. Select the border of the table or chart.

   The properties appear in the **Properties** tab.

2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab, then click ... next to the property.
3. Use the "Relative Position" dialog box to set the position.

To layer tables and cells

Layering determines how tables and cells appear when they occupy the same space in a report. An object further forward in the layering order appears over an object further backward in the layering order.

1. Select the table or cell whose layer you want to set.
2. Right-click, click **Order** and click the layering option.

Option	Description
Bring to front	Make the table or cell the first object in the layering order.
Send to back	Make the table or cell the last object in the layering order.
Bring forward	Bring the table or cell one layer forward in the layering order.
Send backward	Send the table or cell one layer backward in the layering order.

To merge table cells

1. Select the cells you want to merge by holding down the Ctrl button and clicking the cells.
2. Select **Yes** next to the **Appearance** > **Text Format** > **Merge Cells** property on the **Properties** tab.

   When you merge cells the merged cell contains the data from the first cell you selected only. Data from all the other cells is lost.

Modifying tables to create crosstabs

To create a crosstab by adding an object to a vertical or horizontal table

1. Drag an object from the **Data** tab onto the top edge of the table or the left side of the table where you want to create the new axis and form the crosstab.
2. When the ToolTip “Drop here to create a crosstab? appears, drop the selected object onto the report.

   Web Intelligence creates a second axis to form a crosstab and inserts the object on the new axis.

To create a crosstab by moving a column or row

1. Select the table column or row you want to move to create the crosstab.
2. Drag the selected column or row onto the top edge of the table or the left side of the table where you want to create the new axis and form the crosstab.
3. Drop the column or row onto the header.

   Web Intelligence creates a second axis to form a crosstab, and displays the data of the column or row you moved on the new axis.

Controlling data display in tables

Showing or hiding empty tables, rows or columns

Sometimes tables or specific rows and columns display no values. For example, if a sales of a specific product are discontinued, table rows or columns that normally show results for that product appear empty. By default, Web Intelligence displays such empty rows, columns, or tables. You can choose to display or hide empty tables, rows or columns.

To show or hide empty tables, rows or columns

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the table formatting options.
2. Select **Display** > **Show when empty** to display empty tables.
3. Select **Display** > **Show rows/columns with empty measure values** to display rows or columns with empty measure values.
4. Select **Display** > **Show rows/columns with empty dimension values** to display rows/columns with empty dimension values.

Aggregating duplicate rows

When rows contain duplicate data, Web Intelligence aggregates measure values by default.

To avoid duplicate row aggregation

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Display** > **Avoid duplicate row aggregation**.

To show or hide headers and footers

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Display** > **Show table headers** to display the headers.
3. Select **Display** > **Show table footers** to display the footers.

To start tables on a new report page

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Start on a new page**.

To display object names in headers on crosstabs

1. Select within the table, right-click and select **Format** > **Table** on the menu.
   The **Properties** tab displays the crosstab formatting options.
2. Click **Display** > **Show object name** to display the object names in additional headers on the crosstab.

To avoid page breaks in tables

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Avoid page breaks in table**.

To repeat table headers or footers on report pages

1. Select within the table, right-click and select **Format** > **Table** on the menu.

   The **Properties** tab displays the crosstab formatting options.
2. Select **Page Layout** > **Relative Position** > **Repeat header on every page** to repeat the header on every page.
3. Select **Page Layout** > **Relative Position** > **Repeat footer on every page** to repeat the footer on every page.

Copying tables

To copy a table

You can copy and paste tables within a report or into external applications such as Microsoft Word and Excel. You cannot copy tables from one instance of Web Intelligence to another.

1. Select the table, right-click and select Copy on the menu.
2. To paste the table to another part of the report, right-click where you want the table to appear and click **Paste** on the menu.
3. To paste the table into another application, paste the contents of the clipboard from within the other application.

   You can also copy a table into another application by dragging and dropping the table directly into the open document in the target application.

   The table appears as a picture in the open document if pasted to another application.

To copy a table as text

You can copy the data in a table as plain text into another application. For example, if you copy a table as text into Microsoft Excel, Web Intelligence copies the text in each table cell to a cell in the Excel worksheet. Web Intelligence copies the text to the clipboard as tab-separated text.

1. Select the table, right-click and select **Copy as text** on the menu.
2. Paste the contents of the clipboard into the target application.

   If you choose **Copy as text**, then paste the table into the current Web Intelligence report, the table appears as a normal Web Intelligence table.

Displaying data in free-standing cells

chapter 13

Free-standing cells defined

Free-standing cells are single cells that stand alone in a report. You can place any text or formula in a blank free-standing cell, or you can use pre-defined free standing cells that display specific information.

The free-standing cells are available in the **Templates** tab in the Java Report Panel and Web Intelligence Rich Client, or in the **Table, chart and cell types** tab in the Left Panel in the Web Intelligence HTML viewer.

The available free-standing cells are listed below.

- Formula and Text Cells:
  - Blank Cell - Empty cell in which you can enter any text or formula.
  - Drill Filters - Uses the `DrillFilters` function to display details of the drill filters applied to the report.
  - Last Refresh Date - Uses the `LastExecutionDate` function to display the last date when the document was refreshed.
  - Document Name - Uses the `DocumentName` function to display the document name.
  - Query Summary - Uses the `QuerySummary` function to display details of the queries in the document.
  - Prompt Summary - Uses the `PromptSummary` function to display details of the prompts in the document.
  - Report Filter Summary - Uses the `ReportFilterSummary` function to display the report filters applied to the report.
- Page Number Cells:
  - Page Number - Uses the `Page` function to display the number of pages in the report.
  - Page Number/Total Pages - Uses the `Page` and `NumberOfPages` functions to display the current page number and the total number of pages in the report.
  - Total Number of Pages - Uses the `NumberOfPages` function to display the total number of pages in the report.

For more information on the functions used in free-standing cells, see the *Using Functions, Formulas and Calculations in Web Intelligence* guide, or see the online help.

To insert a free-standing cell in a report

1. Ensure that the **Templates** tab is displayed.

   You can display the Templates tab by selecting **Configure View** > **Data** on the main menu.

2. Expand the **Report Elements** > **Free-Standing Cells** element in the **Templates** tab to display the free-standing cells.

   The free-standing cells are divided into two groups: **Formula and Text Cells** and **Page Number Cells**.

3. Drag the free-standing cell you want onto the report.
4. Add your own text or formula iif the cell you inserted is a blank cell.
5. Right-click the cell and select **Edit Format** to display the cell format properties on the **Properties** tab.
6. Set the properties on the **Properties** tab to format the cell.
7. To delete the cell, select it and click the Delete button.

To copy a free-standing cell

You can copy and paste free-standing cells within a report or into external applications such as Microsoft Word and Excel. You cannot copy free-standing cells from one instance of Web Intelligence to another.

1. Select the free-standing cell, right-click and select **Copy** on the menu.
2. To paste the free-standing cell to another part of the report, right-click where you want the free-standing cell to appear and click **Paste** on the menu.
3. To paste the free-standing cell into another application, paste the contents of the clipboard from within the application.

   You can also copy a free-standing cell into another application by dragging and dropping the free-standing cell directly into the open document in the target application.

   The free-standing cell appears as a picture in the open document if pasted to another application.

To copy a free-standing cell to another application as text

You can copy the data in a free-standing cell as plain text into another application. For example, if you copy a free-standing cell as text into Microsoft Excel, Web Intelligence copies the text in the free-standing cell to a cell in the Excel worksheet.

1. Select the free-standing cell, right-click and select **Copy as text** on the menu.
2. Paste the contents of the clipboard into the target application.

   If you choose **Copy as text**, then paste the free-standing cell into the current Web Intelligence report, the free-standing cell appears as a normal Web Intelligence free-standing cell.

Organizing data with sections, breaks and sorts

chapter 14

Using sections to group data

Grouping information with sections

Sections allow you to split report information into smaller, more comprehensible parts.

Example: Grouping quarterly revenue results into sections on a report

You are the regional sales manager in Texas. You receive a report showing 2003 annual revenue for stores in your region, broken down by cities and quarters.

City	Quarter	Sales revenue
Austin	Q1	314430
Austin	Q2	273608
Austin	Q3	294798
Austin	Q4	252644
Dallas	Q1	215874
Dallas	Q2	194689
Dallas	Q3	204066
Dallas	Q4	188791
Houston	Q1	572177
Houston	Q2	619924
Houston	Q3	533765
Houston	Q4	520332

To make a comparison of the results for each city per quarter, you set [Quarter] as a section value. The report is broken up into four separate sections by quarter.

Q1

City	Sales revenue
Austin	314430
Dallas	215874
Houston	572177

Q2

City	Sales revenue
Austin	273608
Dallas	194689
Houston	619924

Q3

City	Sales revenue
Austin	294798
Dallas	204066
Houston	533765

Q4

City	Sales revenue
Austin	252644
Dallas	188791
Houston	520332

You can create a single section or include multiple sections with subsections in a report. You can also remove and reposition sections within a report.

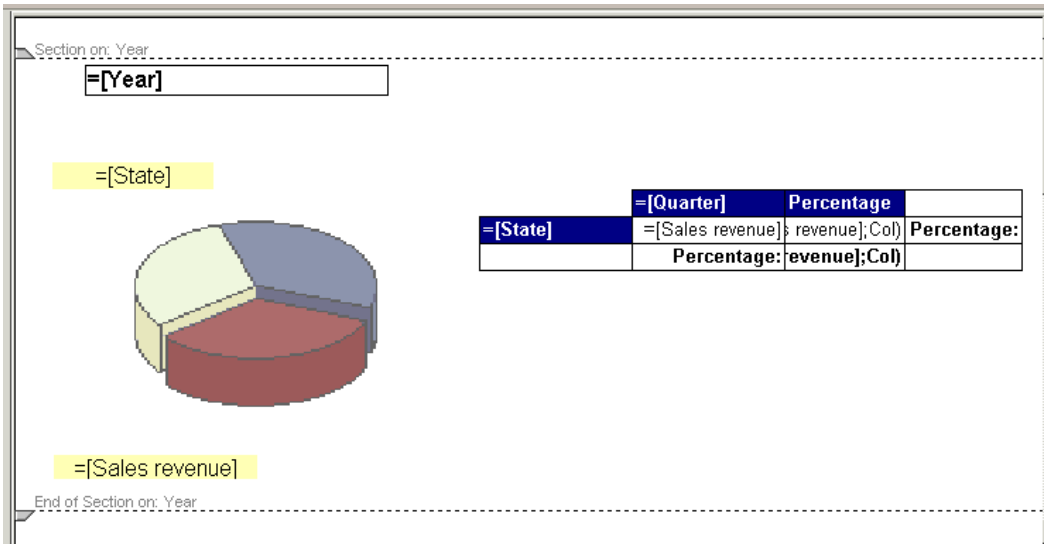
You can create a section from one of two sources:

- on a dimension already displayed on a table or chart
- on a dimension included in the document but not displayed on a table or chart

You cannot create a section with a measure object.

Sections in Structure View

The following illustration shows a report with sections in Structure View. When you view a report in Structure View, each section is clearly indicated by a section divider.It is easier to format sections when you work in Structure View.



Creating and removing sections and subsections

To create a section by moving a cell from a table

1. Verify you are viewing the report in Report View.
2. Select the header cell on the table that displays the name of the dimension, or select a body cell on the table that displays a value for the dimension.

   For example, if you want a section for each state, either select the header cell labelled “State□? or select one of the cells that displays the name of a state.
3. Drag the selected cell above the table and drop it onto the report background.

   A section is created for each value of the selected dimension.

To create a section by adding a dimension from the Data tab

1. Click the **Data** tab.

2. Select a dimension object and, then drag the dimension over to an empty area of the report.
3. Position and drop the dimension where you want the section cell to appear.

   If the report includes tables or charts, then drop the section cell above the tables and charts that you want to be included in the section.

   - If you are in Results View, a cell containing one value for each unique value for the added object appears above the table or crosstab. The data in the table or crosstab is automatically sorted according to the cell value.
   - If you are in Structure View, a cell is added above the table or crosstab.
4. If you are in Structure View, click **View Results** to see the results.

   Web Intelligence applies the section to the report and displays the results.

Creating subsections

You can create a report with multiple sections. You create multiple sections in the same way you create a section:

- by moving a cell from a table and dropping the cell below an existing section cell
- by selecting a dimension object listed on the **Data** tab (in the Java Report Panel or Web Intelligence Rich Client) , and then dragging and dropping the dimension below an existing section cell.

To remove a section cell or section

1. To delete a section, click the beginning or end divider of the section, then press the **Delete** key.
2. To delete a section cell, right-click the cell, then select **Remove** from the menu.

Section properties

You can set the following properties for a section:

- name the section
- specify your criteria for when you consider a section to be empty. (For example, you may consider a section of no interest for your analysis

whenever a specific table or chart within that section is empty. In this case you can choose to specify that the section is to be considered empty.)

- hide or show sections that you consider empty
- include links to sections in the report map so you can jump from section-to-section when navigating the report

To set the section display properties

1. Make sure you are in Report View.
2. Click **View Structure**.

   In Structure View you can see the start and end divider of each section on the report. This makes it easy for you to select a specific section and then choose the properties you want to apply to the selected section.
3. Right-click the section divider.

   The **Properties** tab shows the properties relevant to sections
4. Set the section properties.

If you want to...	then...
Name of the section with a different name from the name of the dimension selected for the section,	type a name for the section in the **General** > **Name** property.
Specify the component(s) of the section that will qualify the entire section as an “empty section,□? if there is no data on the database for that component(s),	Check the components in the drop-down list next to the **Display** > **Hide section when empty** property.
Show the section when there is no data on the database for this section,	check **Show when empty**. (To hide empty sections, uncheck this option.)

5. Click the **View Results** button to view the properties applied to the results on the report.

   Web Intelligence applies the properties to the section and displays the results on the report.

To set the page layout for a section

1. To set the cell position, right-click the section cell then click **Format** on the menu, then set the **Page Layout** > **Relative Position** > **Left edge** and **Top edge** properties on the **Properties** tab.
2. To control the section page breaks, select the section divider, then set the **Page Layout** > **Avoid page break in section** property in the **Properties** tab.
3. To repeat the section cell on each new page, select the section, then select **Page Layout** > **Start on new page** on the **Properties** tab.

Using breaks

Breaks defined

A break is a division within a block in which data is grouped according to a selected dimension, detail, or measure into self contained sections. These sections are represented as smaller tables within the same block of data.

You use breaks to display all the data for each unique value of an object in separate parts.

Using breaks has two main advantages:

- You can more efficiently organize how your data is represented.
- You can display subtotals.

Breaks compared to sections

A section breaks up the data into multiple free-standing cells called section headers. Each section header contains one value for a dimension, with a block of data that corresponds to the dimension value.

A break divides the data up within one block. One column contains the values for a dimension, detail, or measure, which are repeated for each other row of values in the block.

Default sort order in breaks

When you insert a break on an object, the values for the object are automatically sorted in ascending order as follows:

- If the values are numeric, the lowest value appears in the first row of the table, the highest in the last row.
- If the values are alphabetical characters, then the values are sorted in alphabetical order from top to bottom.

You can change this sort order at any time.

You can set multiple breaks and set a sort priority on each break, so that you control how the data is displayed when you insert multiple breaks across several dimensions details, or measures.

To insert a break

1. Click a table cell in the column or row where you want to insert a break.
2. Click **Insert/Remove Break** on the Reporting toolbar.

   Web Intelligence divides the table up into as many mini tables as there are unique values for the selected cell. Web Intelligence inserts a footer at the end of each break.

To prioritize breaks

A table can contain multiple breaks that you can prioritize. For example, you can decide to break on [Year] then on [Quarter], or on [Quarter] then on [Year].

1. Right-click the table that contains multiple breaks and select **Format** > **Table**.

   The **Properties** tab shows the properties relevant to a table.
2. Click the **...** button next to the **Breaks** > **Break priority** property to display the "Breaks" dilaog box
3. Click **Vertical breaks** or **Horizontal breaks** to display the type of break you want to prioritize.

- If the selected table is a vertical table, then all the breaks are applied to columns. These are called Vertical breaks.
- If the selected table is a horizontal table, then all the breaks are applied to rows. These are called Horizontal breaks.
- If the selected table is a crosstab, then breaks can be applied to rows or to columns. You can choose the priority for the Horizontal breaks and for the Vertical breaks.

4. Select the break whose priority you want to change and click the Up/Down buttons to promote/demote the break in the list of breaks.

To define display properties of a break

You can define the following display properties of a break:

Property	Description
Show break header	A header is displayed for each part of the table, crosstab, or form when you insert a break.
Show break footer	A footer is added after the last row for a table or column for a crosstab when you insert a break. When you apply a calculation to the data, the result is shown in the footer.
Remove duplicate values	Removes all duplicate values from the data in a table or crosstab when you insert a break. Each value is only shown once.
Center values across break	Active when **Remove Duplicates** is selected. It merges empty cells and centers the value name over the merged cells.
Apply implicit sort to values	

Property	Description
Start on a new page	Displays each part of the table crosstab, or form created by a break on a new page.
Avoid page breaks in tables	Where possible, keeps each break section on the same page. This option is not taken into account when a block is larger than one page.
Repeat header on every page	Repeats the header at the top of the table on every new page when a table goes over onto a new page.
Repeat footer on every page	Repeats the footer at the bottom of the table on every new page when a table goes over onto a new page.
Repeat break value on a new page	Repeats the current value on each new page.

1. Click a cell in the column/row on which you have defined a break.
2. Open the **Breaks** property group in the **Properties** tab.
3. Set the break properties in the **Breaks** property group.

   Some of the properties are contained in the **Breaks** > **Page layout** property subgroup.

To remove a break

1. Select the column that contains the break.
2. Click **Insert/Remove Break** on the **Reporting** toolbar.

Using sorts to organize data

Sorting the results displayed on reports

You can apply sorts to the values displayed in tables and sections to organize the order in which values are displayed in a report.

The following sort orders are available:

Sort order	Description
Default	This is sometimes referred to as the natural order. Depending on the type of data in the column or row, the results are sorted as follows: • ascending numeric order for numeric data • ascending chronological order for date • Chronological order for months • alphabetical order for alphanumeric data
Ascending	When selected, results are arranged in ascending order: The smallest value at the top of the column moving to the highest value at the bottom. For example: 100, 200, 300 or California, Colorado, Florida.

Sort order	Description
Descending	When selected, results are arranged in descending order: The highest value at the top of the column moving to the smallest value at the bottom. For example: 300, 200, 100 or Florida, Colorado, California.
Custom (available in the Java Report Panel)	You define your own sort order.

To apply an ascending or descending sort

1. Select the section cell or table cells you want to sort.
2. Click the down arrow next to the **Apply/Remove Sort** button on the Report toolbar and then, select **Ascending** or **Descending** from the drop-down list.
3. Repeat the previous step to apply multiple sorts.

To apply a custom sort

1. Select the section cell or table cells you want to sort.
2. Click the down arrow next to the **Apply/Remove Sort** button on the Report toolbar then select **Custom sort** from the drop-down list.
3. Select a value in the list of sorted values and click the **Up** and **Down** buttons to promote/demote it in the sort order.
4. To add an additional temporary value to the list of sorted values, type the value in the **Temporary Values** box, then click **>>** to add it to the sort list.

To prioritize multiple sorts

1. Right-click the table and select **Format** > **Table** to display the **Properties** tab.
2. Click the **...** button next to the **Sorts** > **Sort priority** property to display the "Sorts" dialog box.
3. Click **Vertical sorts** to display the vertical sorts or **Horizontal sorts** to display the horizontal sorts.
4. Select the sort whose priority you want to change and click the **Up/Down** buttons to promote/demote it in the list of sorts.

Displaying data in charts

chapter 15

Creating charts

You can include one or multiple charts on the reports in a Web Intelligence document. You can create a chart when you build or new document or insert charts into an existing document.

If you are building a new document, you need to define the data definition of the document by building a query before you select a chart template.

Once you have defined the query you go to Report View to define the chart(s) on report(s).

To create a chart, you follow three steps:

- select a chart template
- allocate dimensions and measures to the chart axes
- view the results displayed on the chart

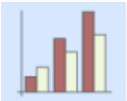
If you want to create a chart that displays the same data as a table on a report, you can copy the table first and then turn the duplicate table into a chart using the "Turn To" dialog box.

Chart types in Web Intelligence

A Web Intelligence report displays results in a block. You can format the block as a specific type of chart.

Bar charts

Bar charts display data in bar form, either vertically or horizontally. Bar charts are useful if you want to compare similar groups of data; for example one time period to another. There are five types of bar charts: grouped, bar and line, stacked, percent, and 3D.



2D bar charts include the optional Z-Axis. Including data on the Z-Axis enables you to show an additional break down of the results displayed on the chart bars.

3D bar charts do not include an axis legend. You can clearly see what information is displayed on the chart bars by looking at the axis labels.

Line charts

Line charts connect specific data values with lines, either horizontally or vertically. Line charts are useful if you want to show trends or changes in data over time. There are five types of line charts: mixed, stacked, percent, 3D, and 3D surface.

Area charts

Area charts are line charts in which the area between the lines and axis are filled in. Area charts are useful if you want to emphasize the size of the total data in a report, as opposed to the changes in the data. You may not want to use an area chart if you have a sharp contrast between specific data points. Use a line chart instead.

You can use more than one measure object on the Y-axis as long as the measures are of the same type and scale; for example, Number of Guests, and Future Guests. There are five types of area charts: absolute, stacked, percent, 3D area, and 3D surface.

Pie charts

Pie charts display data as segments of a whole. Pie charts are useful if you want to show how each part of your report data contributes to the total.

Pie charts have a single axis displayed on the body of the pie. This is the Y-Axis. Each segment of the pie chart displays a value for the measure on the Y-Axis. The pie chart legend indicates the dimension on the X-Axis.

You can only include one measure object in a pie chart. If you have several measures in your report, you should choose another chart type. There are four types of pie charts: pie, 3D pie, ring, 3D ring.

Radar, polar and scatter charts

In radar charts, the X- and Y-axis connect at the chart's center. Radar charts are useful if you want to look at several different factors related to one item. For example, you could use a radar chart to display revenue data for different services within a hotel. On one axis, you could display revenue for the rooms. On another you could display revenue for the restaurant, and so on.

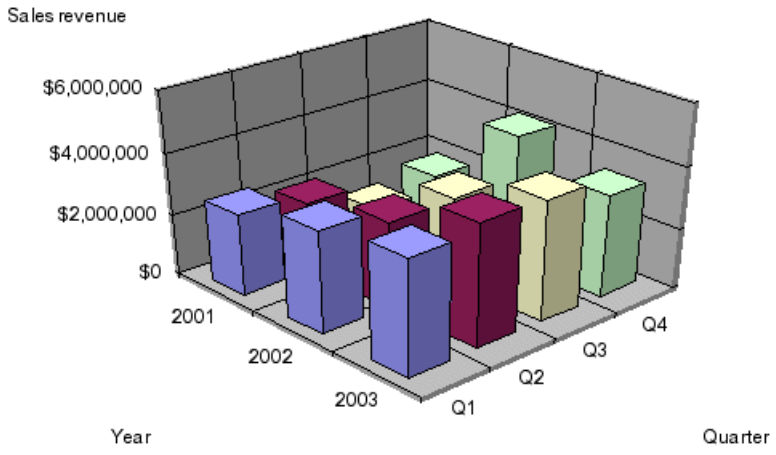
Scatter charts are similar to line graphs, except that the data points are plotted without a line connecting them. Scatter charts are useful if you want to make a comparison between specific data points.

There are four types of radar, polar, and scatter charts: radar line, stacked radar, polar, and scatter.

3D charts

3D charts include three axes: the Y-Axis always displays values for measures (such as sales totals, margins, quantities and so on); the X- and Z-Axis

display values for dimensions (that is, key indicators, such as time, geography, service lines, and so on). In the 3d bar chart displayed below, the chart bars display sales revenue per quarter, per year. The [Sales revenue] measure is on the Y-Axis, the [Quarter] dimension is on the X-Axis, and the [Year] dimension is on the Z-Axis



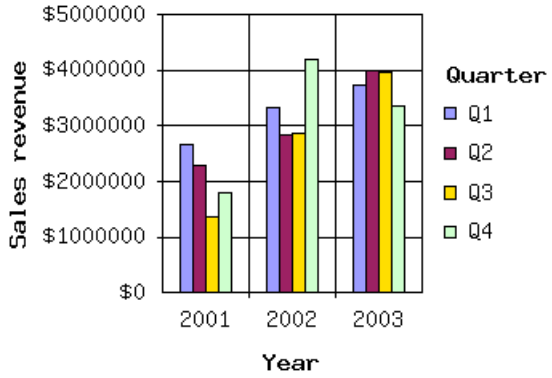
The same data can be displayed in a 2D bar chart.

Related Topics

- *2D charts* on page 153

2D charts

The 2D bar chart below includes an optional Z-Axis with the values for quarter. Including data on the Z-Axis enables you to show an additional break down of the results displayed on the chart bars. The [Sales revenue] measure is on the Y-Axis, the [Year] dimension is on the X-Axis, and the [Quarter] dimension is on the Z-Axis. Notice that because the Z-Axis cannot be represented graphically on a 2D chart, the legend provides the information for the Z-Axis values.



The same data can be displayed in a 3D bar chart.

Related Topics

- *3D charts* on page 152

Adding, copying and removing charts

To add a chart to a report

It is recommended you work in Structure View when you insert a new chart. This is because Results View is designed to display the data contained in reports. Therefore, you can only view charts in Results View after you have allocated dimensions and measures to the empty chart template.

1. Click **View Structure** on the report panel toolbar.
2. Click the **Templates** tab.
3. Select the chart template drag it onto an empty area of the report.

   The empty template appears on the report.
4. Click the **Data** tab.
5. Drag a dimension or measure object onto the chart axis, where you want the results for that dimension or measure to appear on the chart.
6. Drop the dimension or measure onto the axis when the “Place dimension objects here□? or the “Place measure objects here□? ToolTip appears.

7. To allocate more dimension and measure objects to each chart axis, repeat the previous two steps.
8. To display the results in the chart, click the **View Results** button on the Report toolbar.

   The chart displays the results corresponding to the objects you allocated to the chart axes.

To copy a chart

1. Select the chart, right-click and select **Copy** on the menu.

   Web Intelligence copies the chart to the clipboard.
2. To paste the chart to another part of the report, right-click where you want the chart to appear then click **Paste** on the menu.
3. To paste the chart into another application, paste the contents of the clipboard from within the other application.

   You can also copy a chart into another application by dragging and dropping it directly into the open document in the target application.

   The chart appears as a picture in the open document if pasted to another application.

To remove a chart

- Right-click the chart and click **Remove**, or verify that the **Data** tab is displayed, then drag the chart from the Document pane and drop it onto the **Data** tab.

Changing the chart type

To change the chart type by using drag and drop

1. Click the **Templates** tab.
2. Drag a template onto the chart or table you want to modify. You must drop the template directly on the existing report block. If you drop the template outside the existing report block, you create a separate chart.

3. If you want to move the dimensions or measures to different axes, click the **View Structure** button on the report panel toolbar, then drag the objects you want to move onto the **Data** tab, and then drag and drop the objects you want to display on the chart from the **Data** tab onto each chart axis

To change the chart type by using TurnTo

1. Right-click the table or chart.
2. Click **Turn To**.

   The "Turn To" dialog box appears.
3. Click the tab corresponding to the chart type you want, then click a format.
4. Click **OK**.

   If the new chart type does not have data allocated to both the X-axis and the Y-axis, the chart will not appear when you view the report in Results View or in Drill mode. In this case, click the **View Structure** button on the report panel toolbar, and then click the **Data** tab and drag the appropriate dimensions or measures onto the axes on the new chart template. When you click **View Results**, the chart appears.

   If the font for the text on the table was unicode, and if unicode is not defined as your default font for charts, the unicode font is not retained in the chart. You need to format the chart with the unicode font if available on your computer. If this is not the case, you need to contact your administrator to configure the Web Intelligence server and your computer appropriately.

   Web Intelligence applies the selected template to the block and displays the data in the chart type you chose.

Positioning and sizing charts

To set the position of a table or chart on the report page

1. Select the border of the table or chart.

   The properties appear in the **Properties** tab.

2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab, then click ... next to the property.
3. Use the "Relative Position" dialog box to set the position.

To position a chart in relation to another chart or table

If you have more than one block (table, chart, or form) in your report, you can use relative positioning. Relative positioning allows you to position a selected block (for example, a chart) in relation to other blocks in the report.

If new data on the database modifies the size of the tables or charts, relative positioning ensures that the different tables and charts display correctly without overlapping each other.

Note:
If you position a chart in relation to another block (that is, a chart, table, or form), the position of the related block changes automatically, if you reposition the chart.

1. Right-click the chart and click **Format**.
2. Open the **Page layout** > **Relative Position** property group on the **Properties** tab.
3. Click **...** next to the **Relative Position** property to open the **Relative Position** dialog box.

   If the report does not contain multiple elements, the Relative Position dialog box is not available.
4. Select the distance of the upper left point of the chart in relation to another report element by entering - the number of pixels; the part of the other report element from which you want to measure the pixels (in the first drop-down list); the report element from which you want to measure the pixels (in the second drop-down list).
5. Repeat this for the distance of the lower left point of the chart.

To resize a chart

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.

3. Type the chart width in the **Width** property and the height in the **Height** property.

Formatting charts

To insert and format a chart title

1. Right-click the chart and click **Format**.
2. Click **Yes** next to the**Appearance** > **Title** property.

   The property becomes a property group.
3. Open the **Title** property group and type the title in the **Text** property.
4. Click **...** next to **Text Format** and use the **Format Text** dialog box to format the title.
5. Click **...** next to **Borders** and use the Border Editor dialog box to format the title borders.
6. Select the title background color from the **Background color** list.

To display a chart with a 3D look

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.
3. Select **3D look**.

To add background colors to a chart

1. Right-click the chart and click **Format**.
2. Open the **Appearance** property group on the **Properties** tab.
3. Click the arrow next to **Background color** to display the color palette.
4. Select a color from the color palette or click **More Colors** to display the **Choose Color** dialog box.

To modify chart borders

1. Right-click the chart and click **Format**.
2. Click ... next to **Appearance** > **Borders**.
3. Use the Border Editor dialog box to format the borders.

To select and format chart floors and walls

Floors and walls give depth to charts and help to set off the data displayed on the chart bars or lines. 3D charts have a floor, a left wall, and a right wall. 2D charts just have a floor. You can specify a color for the floor and walls.

1. Right-click the chart and click **Format**.
2. Open the **Display** property group on the **Properties** tab.
3. Select **Show floor** to display the chart floor, **Show left wall** to display the chart left wall and **Show right wall** to display the chart right wall.

   The availability of these options depends on the type of chart.
4. Set the wall and floor color by clicking the **Wall color** and **Floor color** properties in the **Appearance** property group and using the "Color Palette" or the "Choose Color" dialog box to set the color.

To show and format axis legends

1. Right-click the report and select **Format**.
2. Click **Yes** next to the**Appearance** > **Legend** property.

   The property becomes a property group.
3. Open the property group and select the legend position from the **Position** list.
4. Use the **Title** and **Values** subgroups to set the legend title and format the title and legend values.

To avoid page breaks in charts

1. Right-click the chart and click **Format**.

2. Open the**Page Layout** property group on the **Properties** tab.
3. Select **Avoid page breaks in chart**.

To show axis labels on pie charts

1. Right-click the chart and select **Format**.
2. Open the **Appearance** > **Data** > **Values** property group.
3. Select **Show segment labels**.

To format axis label text, borders, and background

1. Right-click the chart and click **Format**.
2. Click **Yes** next to the **Appearance** > **X/Y/Z Axis > Label** property.

   The property becomes a property group and the object name appears on the label.
3. Select **Show object name** to show the object name on the label.
4. Type the text into **Other label** if you want to assign custom text to the label in place of the object name.
5. To format the text, click **...** next to **Text Format** to open the "Text Format" dialog box.
6. Use the "Text Format" dialog box to format the text.

   You can set many of the properties in the "Text Format " dialog box directly from the property list, where they appear beneath **Text Format**.
7. Click **...** next to **Borders** and use the "Border Editor" to format the label borders.

To show, hide or format the axes grid

1. Right-click the chart and select **Format**.
2. Click **Yes** next to **Appearance** > **X/Y/Z** > **Grid** in the **Properties** tab to show the grid.
3. Select **Appearance** > **X/Y/Z** > **Grid** > **Show markers** to show the grid markers.
4. Select**Appearance** > **X/Y/Z** > **Grid** > **Grid color** to select the grid color.

Displaying and formatting chart data

To show a chart when empty

Sometimes charts display no values. For example, if sales of a specific product are discontinued, a chart that normally displays results for that product will appear empty. By default, Web Intelligence displays such empty charts on reports. If wished, you set Web Intelligence to hide charts whenever they are empty.

1. Right-click the chart and click **Format**.
2. Open the **Display** property group in the **Properties** tab.
3. Select **Show when empty**.

To specify a color palette for the chart data

1. Right-click the report and select **Edit**.
2. Open the **Appearance** > **Data** property group in the **Properties** tab.
3. Click **...** next to **Palette** to display the "Choose Palette" dialog box and select one of the predefined palettes in the **Predefined Palettes** list.
4. To edit a pallete, select the pallete, then click **Edit Pallete**.

   The "Edit Palette" dialog box opens
5. Select a color in the palette.

   The "Custom Color" dialog box opens.
6. Create a custom color using the **Custom Color** dialog box, then click **OK**.
7. To set all the colors in the palette to the same color, click **Set All Colors**.

To format axis values numbers and text

1. Select the chart and click **Format**.
2. Open the **Appearance** > **Values** property group in the Properties tab.
3. Click **...** next to the **Number format** property to display the **Number Format** dialog box.
4. Use the "Number Format" dialog box to define the format.

5. Click **...** next to the **Text Format** property to display the "Text Format" dialog box.
6. Use the "Text Format" dialog box to format the text.

   You can set many of the properties in the "Text Format" dialog box directly from the property list, where they appear beneath **Text Format**.

To define the axis value frequency

1. Right-click the chart and click **ormat**.
2. Open the **Appearance** > **X/Y/Z Axis > Values** property group in the **Properties** tab.
3. Select **Automatic frequency** to set the frequency to automatic.
4. Type the frequency in **Frequency** to set the frequency to a specific value.

   Automatic frequency must be unselected before you can type a custom frequency.

   When you set the frequency to n, Web Intelligence displays every n values on the axis.

To show a specific range of axis values

1. Right-click the report and click **Format**.
2. Open the **Appearance** > **X/Y/Z Axis > Scale** property group on the **Properties** tab.
3. Enter the minimum value in **Min. value** and the maximum value in **Max. value**.

   Web Intelligence displays the minimum and/or maximum values you specified on the axis.

To show or hide data values

1. Right-click the chart and select **Format**.
2. Open the **Appearance** > **Data** > **Values** group in the **Properties** tab.
3. Select **Show data** to show the data.

To vary the data markers for each result

1. Right-click the chart and select **Format**.
2. Open the**Appearance** > **Data** property group in the **Properties** tab.
3. Select **Vary data markers**.

   You can only vary the data markers for each result on the following chart types: 2D Line charts, 2D Bar and Line charts, and Radar charts.

Linear and logarithmic axes scales

By default, Web Intelligence displays the Y-axis on charts as a linear scale. You can set the axis to a logarithmic scale. Logarithmic scales allow you to examine values that span many orders of magnitude without losing information on the smaller scales.

In a linear scale, the axis markers are evenly spaced. Linear scales are based on addition. Consider, for example, the linear sequence: 1, 3, 5, 7, 9

To get the next number in the sequence, you add 2 to the previous number.

Logarithmic scales are based on multiplication rather than addition. In a logarithmic scale, the steps increase or decrease in size. Logarithmic scales are based on multiplication (or division). Consider, for example, the logarithmic sequence: 2, 4, 8, 16, 32

To get the next number in the sequence, you multiply the previous number by 2. We can say that this sequence represents ``base 2.''

Consider the following sequence: 1, 10, 100, 1000, 10000

This sequence represents ``base 10,'' because you get the next term in the sequence by multiplying the previous term by 10.

To display the Y Axis logarithmically

1. Right-click the chart and select Edit Format.
2. Open the **Appearance** > **Y Axis** > **Scale** property group in the **Properties** tab.
3. Select **Logarithmic**.

A logarithmic scale uniformly presents percent changes rather than point changes. In other words, the distance from 1 to 2 (100% increase) is the same as the distance from 2 to 4 (another 100% increase).

Formatting numbers and dates

chapter 16

Predefined and custom formats

You can change how values display in specific cells or on chart axes. You do this by applying predefined formats available in Web Intelligence or by creating your own custom formats. You can save your custom formats for reuse on multiple blocks and reports in the same document.

Predefined formats

You can change how values display in specific cells or on chart axes. You do this by applying predefined formats available in Web Intelligence or by creating your own custom formats. You can save your custom formats for reuse on multiple blocks and reports in the same document.

The following predefined formats are available for cells:

Format	Description
Default	The format defined for the object on the universe.
Number	Formats for decimal or integer values.
Currency	Formats for currency values.
Date/Time	Date and time formats.
Boolean	Formats for true and false values.

Related Topics

- *To apply a custom number format to a cell* on page 171
- *To define a custom format* on page 170

To apply a predefined format to a cell

1. Right-click a cell and click **Format Number** on the shortcut menu.
   The "Format Number" dialog box appears.

2. Click a format in the **Format Type** list.

   The available formats for the format type you selected appear in the **Properties** pane.

3. Click **OK**.

   Web Intelligence applies the new format to the cell.

Custom formats

You can use the Custom format type to define a customized format for any cell. The following table lists the strings you can use to create custom formats:

Character(s)	Display(s)	Example
#	The corresponding digit. If the number has less digits than the number of # characters used to specify the format, no leading zeros are inserted.	'12345' with the format #,##0 gives '12,345' (if your locale defines the grouping separator as a comma) or '12 345' (if your locale defines the grouping separator as a space)
0	The corresponding digit. If the number has less digits than the number of 0 characters used to specify the format, a leading zero(s) is inserted before the number.	'123' with the format #0,000 gives '0,123'
,	The grouping separator as defined by your locale.	'1234567' with the format #,##0 gives '1,234,567' (if you locale defines the grouping separator as a comma) or '1 234 567' (if your locale defines the grouping separator as a non-breaking space)

Character(s)	Display(s)	Example
.	The decimal separator as defined by your locale.	‘12.34’ with the format #.#0 gives ‘12.34’ (if your locale defines the decimal separator as a period) or ‘12,34’ (if your locale defines the decimal separator as a comma)
[%]%	Displays a percentage sign (%) after the result and multiplies the result by 100.	
%	The % sign after the result, but does not multiply the result by 100.	
	A non-breaking space ( )	‘1234567’ with the format # ##0 gives ‘1234 567’
1, 2, 3, a, b, c, $, £, € (and so on)	The alphanumeric character.	‘705.15’ with the format $#.#0 gives ‘$705.15’ or with the format #,#0 € gives ‘705,15 €’
[Red], [Blue], [Green], [Yellow], [Gray], [White], [Dark Red], [Dark Blue], [Dark Green]	The value in the specified color.	‘150’ with the format #,##0[Red] gives ‘150’ #,##0[Blue] gives -’150’
d	The number of the day in the month with no leading zeros. If the date for day is less than two characters, the date displays without a zero before it.	The first day of a month with the format d gives ‘1’

Character(s)	Display(s)	Example
dd	The number of the day with leading zeros. If the date for day is less than two characters, the date displays with a zero before it.	The first day of a month with the format dd gives ‘01’
ddd	The name of the day abbreviated. The first letter is capitalized.	Monday’ with the format ddd gives ‘Mon’
dddd	The name of the day in full. The first letter is capitalized.	‘Monday’ with the format dddd gives ‘Monday’
dddd dd	The day of the week followed by a space and the number of the day.	‘Monday’ with the format dddd dd gives ‘Monday 01’
M	The number of the month with no leading zeros. If the number for month is less than two characters, the number displays without a zero before it.	‘January’ with the format M gives '1'
MM	The number of the month with leading zeros. If the number for month is less than two characters, the number displays with a zero before it.	‘January’ with the format MM gives 01
mmm	The name of the month abbreviated. The first letter is capitalized.	‘January’ with the format mmm gives Jan
mmmm	The name of the month in full. The first letter is capitalized.	‘January’ with the format mmmm gives January

Character(s)	Display(s)	Example
yy	The last two digits for year.	‘2003’ with the format yy gives ‘03’
yyyy	All four digits for year.	‘2003’ with the format yyyy gives ‘2003’
h:mm:ss a	The hour with no leading zeros and the minutes and seconds with leading zeros. The “a□? character displays AM or PM after the time.	‘21:05:03’ with the format h:mm:ss a gives ‘9:05:03 PM’
HH	The hour according to the 24-hour clock.	‘21:00’ with the format HH gives ‘21’
hh	The hour according to the 12-hour clock.	‘21:00’ with the format hh gives ‘09’
HH:mm	The hour and minutes with leading zeros.	‘7.15 am’ with the format HH:mm gives ‘07:15’
HH:mm:ss	The hour, minutes, and seconds with leading zeros.	‘7.15 am’ with the format HH:mm:ss gives ‘07:15:00’
mm:ss	The minutes, and seconds with leading zeros.	‘07:15:03’ with the format mm:ss gives ‘15:03’

To define a custom format

1. Right-click the cell(s) to which you want to apply a custom format.
2. Select Format Number.

   The "Number Format" dialog box appears.
3. In the **Format Type** list, select the format category that corresponds to the data type in the selected cell.
4. Select the **Custom** check box.

Text boxes appear for you to type your custom format(s).

5. Select a format listed in the **Properties** pane, and then edit the selected format by typing additional characters in one or more text boxes.

   For example, if you want to create a custom format for Number values, type the custom format you want in the **Positive**, **Negative**, and **Equal to Zero** boxes. If you want to create a custom format for Boolean values, type the custom format you want in the **True** and **False** boxes.

6. Click **Add**.

   You cannot delete or edit custom formats. To change a custom format, you need to create a new custom format and apply the new format to the selected cell(s). Any custom formats not applied to cells in a document are deleted automatically when you close the Web Intelligence Java Report Panel.

To apply a custom number format to a cell

1. Right-click the cell(s) to which you want to apply the custom format.
2. Select **Format Number**.

   The **Number Format** dialog box appears.

3. Select **Custom**.
4. The list of custom formats already included in the document appears in the **Properties** pane.
5. Select the custom format you want.
6. Click **OK**.

   Web Intelligence applies the custom format to the selected cell(s).

Filtering report data

chapter 17

Report filters defined

You can filter reports to limit the results that are displayed to specific information that interests you. For example, you can limit the displayed results to information for a specific customer or a sales period. The data you filter out remains within the Web Intelligence document; it is simply not displayed in the report tables or charts. This means you can change or remove report filters in order to view the hidden values, without modifying the query definition behind the document.

You can apply different filters to different parts of a report. For example, you can limit the results in the entire report to a specific product line and then limit results in a table or chart further to focus on results for a specific region or customer profile.

To create a report filter, you need to specify three elements:

- a filtered object
- an operator
- a value(s)

You can include multiple filters in a report.

Applying filters to sections

You can apply section filters based on the values in the section header or on values that appear within the section.

Applying a section filter to the section header

If you have a report with a section on [Country], the filter `[Country] = "US"` filters out all sections on countries other than the US.

Applying a section filter to the section data

If you have a report with a section on [Region] and you apply the filter `[Product]="Drinks"` to the section, Web Intelligence retains all sections that contain the product "Drinks".

In this case, the sections remaining in the report contain products other than drinks if these products were sold in these regions. This is because the

section filter retains regions in which drinks were sold, but does not exclude other products from the data in the section.

In other words, Web Intelligence bases the filter on the data in the section, but applies it indirectly to the data in the section header.

Types of report filter

There are three types of report filter in Web Intelligence:

- Standard report filters (available in all forms of Web Intelligence).

  Standard report filters are the most flexible type of report filter. They can use any filter operator and can filter on single values or lists of values.

- Quick filters (available in the Java Report Panel and Web Intelligence Rich Client).

  Quick filters provide an easy way to create filters using the Equal To operator. They can filter on single values or lists of values.

- Simple report filters (available in the Web Intelligence HTML viewer, the Java Report Panel and Web Intelligence Rich Client).

  Simple report filters provide an easy way to create filters using the Equal To operator. They can filter on single values only.

Query filters and report filters compared

You can apply filters at two levels within a document:

- query filters – these filters are defined on the query; they limit the data retrieved from the data source and returned to the Web Intelligence document.
- report filters – these filters limit the values displayed on reports, tables, charts, sections within the document, but they don't modify the data that is retrieved from the data source; they simply hide values at the report level.

Report filter operators

Equal To operator

Use the Equal to operator to obtain data equal to a value.

For example, to return data for the US only, create the filter "County Equal To US".

Not Equal To operator

Use the Not Equal To operator to obtain data not equal to a value.

For example, to return data for all countries except the US create the filter "County Not Equal To US".

Different From operator

Use the Different From operator to retrieve data different from a value.

For example, to retrieve data for all quarters execpt Q4, create the filter [Quarter] Different From "Q4"

Greater Than operator

Use the Greater Than operator to retrieve data greater than a value.

For example, to retrieve data for customers aged over 60, create the filter "[Customer Age] Greater than 60".

Greater Than Or Equal To operator

Use the Greater Than Or Equal To operator to retrieve data greater than or equal to a value.

For example, to retrieve data for revenue starting from $1.5M, create the filter "[Revenue] Greater than or equal to 1500000".

Less Than operator

Use the Less Than operator to retrieve data lower than a value.

For example, to retrieve data for exam grades lower than 40, create the filter "[Exam Grade] Less Than 40".

Less Than Or Equal To operator

Use the Less Than Or Equal To operator to retrieve data less than or equal to a value.

For example, to retrieve data for customers whose age is 30 or less, create the filter "[Age] Less Than Or Equal To 30".

Between operator

Use the Between operator to retrieve data between and including two values.

For example, to retrieve data for weeks starting at week 25 and finishing at 36 (including week 25 and week 36), create the filter "[Week] Between 25 and 36".

Not Between operator

Use the Not Between operator to retrieve data outside the range of two values.

For example; to retrieve data for all the weeks of the year, except for and not including weeks 25 through 36, create the filter "[Week] Not between 25 and 36".

In List operator

Use the In List operator to retrieve data corresponding to values in a list of values.

For example, to retrieve data for the US, UK and Japan only, create the filter [Country] In List ("US";"UK";"Japan").

Not In List operator

Use the Not In List operator to retrieve data that does not correspond to multiple values.

For example, if you do not want to retrieve data for the US, UK and Japan, create the filter [Country] Not In ("US";"UK";"Japan").

Is Null operator

Use the Is Null operator to retrieve data for which there are no values in the database.

For example, to retrieve customers without children (the children column in the database has no value), create the filter [Children] Is Null.

Is Not Null operator

Use the Is Not Null operator to return data for which there is a value in the database.

For example, to return customers with children, create the filter [Children] Is not Null.

Creating, editing and deleting report filters

To create a report filter using the Quick Filter option

1. Click the report tab of the report you want to filter.
2. If you want to filter a block (that is, a table, chart, or form), then click the top edge of the block to select it. If you want to filter a section, and not just the section cell, click **View Structure** and then select either the start section or end section divider.
3. Click the arrow to the right of the **Add Filter** button on the Report toolbar and select **Add Quick Filter**.

   The **List of Values** dialog box appears. The values for the selected section or block are listed.
4. Select the value(s) you want to display in the section or block.
5. Click **OK**.

   The selected section or block only displays values that correspond to the value you selected.
6. To delete the quick filter, click the arrow to the right of **Add Filter** and select **Remove Filter**.

To create a report filter using the Filter Editor

1. Click the report tab of the report you want to filter.
2. On the Report toolbar, click the **Show/Hide Filter Pane** button to display the Report Filters pane.
3. Select the part of the report you want to filter.

   The **Report Filters** pane displays the name of the selected part of the report. For example, if you select a table, the Report Filter pane displays the name of the selected table.
4. In the **Data** tab, select the object you want to filter.
5. Drag the selected object onto the **Report Filters** pane.

   The Filter Editor appears. The name of the object you selected is displayed below **Filtered Object**.

6. Select the operator.
7. Select **Constant** or **Value(s) from list**.

   When you define filters on measures or variables, you cannot select value(s) from the list of values; you need to type a constant(s).
8. If you selected Constant, type the value(s), you want to retrieve, in the **Constant** box. If you selected **Value(s)**, select the value(s), you want to retrieve, from the displayed List of Values and add them to the **Values Selected** box, by clicking the **>>** button.
9. Click **OK** to confirm the filter definition.

   The selected report, section, or table, chart, or form displays only the values you specified in the custom filter.

To combine multiple filters on a report

1. Create each filter.

   By default Web Intelligence combines all the filters with the AND operator.
2. Double-click the AND operator to toggle between AND or OR.

Related Topics

- *To create a report filter using the Quick Filter option* on page 179
- *To create a report filter using the Filter Editor* on page 179

To edit a report filter

1. Click the **Show/Hide Filter Pane** button on the Report toolbar to display the **Report Filters** pane.
2. Click the area of the report for which you edit the filters.

   The filters on the selected area display in the **Report Filters** pane.
3. Double-click the filter you want to edit.

   The Filter Editor appears. The name of the filtered object is listed under **Filtered Object**.
4. Edit the filter using the Filter Editor.

To edit a report filter from the report map

1. Select the **Map** tab.
2. Click **Structure** at the top of the tab.
3. Click the report element on which the filter is applied in the report structure.
4. Click **Filters** at the top of the tab.
5. Right-click the filter and select **Edit Filter** to display the filter editor.
6. Edit the filter using the Filter Editor.

To delete a report filter

1. Click the **Show/Hide Filter Pane** button on the Report toolbar to display the **Report Filters** pane.
2. Click the area of the report from which you want to remove the filters.

   The filters on the selected area display in the **Report Filters** pane.
3. Select the filter you want to delete and press **Delete**.
4. You can also delete filter by selecting the filtered object, selecting the arrow to the right of the **Filter** button on the **Reporting** toolbar, and selecting **Remove filter**.

To create simple report filters

The Report Filter toolbar provides a quick method for adding simple report filters to reports.

Simple report filters have the form `<report_object>=<value>`. They can contain the "=" operator only and can filter on a single value only.

For more complex filters, use quick filters (which can contain the "=" or "Inlist" operators) or standard report filters (which can contain any operator).

Note:
You also use the Report Filter toolbar when drilling on reports. In the context of Drill, the Report Filter toolbar is known as the Drill toolbar.

1. Click **Show/hide Report Filter toolbar** on the main menu to display the toolbar.

2. In Web Intelligence HTML, click the icon on the toolbar and select the object on which you want to filter from the menu.

   You can add multiple objects to the toolbar to create multiple filters.

3. In the Java Report Panel or Web Intelligence Rich Client, drag the object on which you want to filter to the toolbar.

   You can add multiple objects to the toolbar to create multiple filters.

4. Select the value on which you want to filter from the drop down list of values.

   Web Intelligence filters the report on the value of the object you selected. For example, if you selected "US" from the list of values of the Country object, Web Intelligence filters the report to exclude all rows where Country does not have the value "US".

5. To remove a filter, select it and click Delete.

To view the filters on a report

1. Click on the area of the report for which you want to see filters. (To view filters defined on the entire report, click outside any table, chart or section.)
2. Click the **Map** tab, then click **Filters**.

   Web Intelligence displays the filters on the area of the report you clicked.

Answering prompts

chapter 18

To enter values to answer a prompt

1. With a report in a Web Intelligence document open, click **Refresh Data** on the right of the main toolbar above the report.

   The "Prompts" dialog box appears.

2. Select a prompt question.

   If the prompts are organized hierarchically in a tree, you need to select the prompt at the lowest level of the hierarchy first. This type of prompt is referred to as a cascading prompt.

   The values you can choose are listed in the pane on the lower left.

   If the list of values is not available, click **Refresh values** to display it. The list of values now appears together with the date on which it was last refreshed.

   If the prompt has been answered previously, the values selected the last time appear in the prompt answer pane on the right. You can either leave those values selected or use **<<** to remove them.

   The options you see when you answer prompts depend on (1) whether this is the first time the results have been refreshed or not and (2) the properties set for the prompts when they were created.

3. Select the values from the list of choices in the pane on the left, for which you want to view results, or type the values into the text box, and click the **>>** to add them to the prompt answer box on the right.

   If you type multiple values, you need to separate each value with a semi-colon (;). For example: Florida;Texas.

4. Click **Run Query**.

   Web Intelligence retrieves the data for the values you specified, and returns the results to the reports.

   Note:
   If the prompt is optional, click **Run Query** without supplying a value. Web Intelligence ignores the prompt.

To enter dates to answer a prompt

1. With a report in a Web Intelligence document open, click **Refresh Data** on the right of the main toolbar above the report.

The "Prompts" dialog box appears.

2. To select a date, click the arrow to the right of the text box, select a date from the popup calendar, and then click **>>** to add the date you selected to the list on the right.

   If the prompt has been answered previously, the values selected the last time appear in the prompt answer pane on the right. You can either leave those values selected or use **<<** to remove them.

3. If the prompt allows you to select multiple dates, and you want to view results for more than one date, repeat the previous step.
4. Click **Run Query**.

   Web Intelligence retrieves the data for the values you specified, and returns the results to the reports.

   Note:
   If the prompt is optional, click **Run Query** without supplying a value. Web Intelligence ignores the prompt.

Filtering data using input controls

chapter 19

Input controls defined

Input controls provide a convenient, easily-accessible method for filtering and analyzing report data. You define input controls using standard windows controls such as text boxes and radio buttons. You associate these controls with report elements such as tables or section headers, and use the controls to filter the data in the report elements. When you select values in the input control, Web Intelligence filters the values in the associated report elements.

You can also define tables and charts as input controls. When you select a value in the table or chart, Web Intelligence filters the values in the associated report elements.

You can use input controls to analyze different scenarios by changing the value of variables. You define a variable with a constant value, then assign an input control, for example a slider, to the variable. You can then change the value of the variable using the slider control; if the variable is part of a formula, you can use the slider control to examine different formula results based on the variable value.

Input controls are report-specific. They are grouped on the **Input Controls** tab.

To add an input control

You must have sufficient document modification rights to add input controls.

1. Select the **Input Controls** tab.
2. Click **New** at the top of the **Input Controls** pane, or right-click an object in a table or chart and select **New input control** to display the input controls wizard.

   If you selected an entire table or chart before clicking **New**, you can select **Include objects from selected block only** to restrict the list of objects in the wizard to the objects in the table or chart you selected. If you did not select a table or chart, or if you used the **New input control** menu to display the input controls wizard, this option is not available.

3. Select the report object to supply values for the input control, then click **Next**.

If you right-clicked an object and selected **New input control** from the menu, the object you right-clicked is already selected.

4. Select the input control type.

   The list of control types is determined by the data type of the report object.

5. Define the input control properties.

   The available properties are determined by the control type and whether you are using Web Intelligence Interactive or the Web Intelligence Java Report Panel/Web Intelligence Rich Client.

Property	Description
Label	The name of the input control
Description	The description of the input control
List of values	The list of values available in the input control. You can use all values of the report object on which the input control is based (the default) or define your own custom list of values.
Use restricted list of values	If you define a custom list of values for the report object, this setting filters the data in the report element you assign to the input control based on this list of values. Even when no values are selected in the input control, Web Intelligence excludes any values not in the restricted list from the report element filtered by the input control. For example, if an input control based on the [Country] dimension is restricted to the values "US" and "France", a table filtered by the input control shows data for US and France only, even when no value is selected in the input control. If you deselect **Use restricted list of values**, all values of [Country] appear in the table when no value is selected in the input control.
Operator	The operator that the input control uses to filter the associated report elements
Default values	The default values that the input control uses to filter the associated report element

Property	Description
Number of lines	The number of lines that the input control displays in the Input Control pane. For example a list of five radio buttons with **Number of lines** set to 3 displays three radio buttons only by default. You access the other two radio buttons by using the scrollbar.
Minimum value	The minimum numerical value you can select in the input control
Maximum value	The maximum numerical value you can select in the input control
Increment	The amount by which the input control increases/decreased a numerical value when you are choosing a value

6. Click **Next** to display the **Assign Report Elements** wizard step.
7. Select the report elements you want the input control to filter.

   Note:
   Each time you save a document, Web Intelligence removes any input controls that have no associated report elements.

8. Click **Finish**.

   The input control appears on the **Input Controls** pane.

To edit an input control

1. Select the **Input Controls** tab.
2. Click **Edit** on the input control to display the **Edit Input Control** dialog box.
3. Edit the input control properties on the **Properties** tab.
4. Edit the report elements associated with the input control on the **Dependencies** tab.

To highlight input control dependencies

1. Select the **Input Controls** tab.
2. Click **Highlight dependencies** on the input control.

The report elements associated with the input control are highlighted.

To organize input controls

1. Select the **Input Controls** tab.
2. Drag and drop input controls to move them up or down on the **Input Controls** pane in Web Intelligence Java Report Panel and Web Intelligence Rich Client. Select an input control, then click **Move the selected input control up/down** at the top of the **Input Controls** pane to move the control up or down in Web Intelligence Interactive.
3. Select an input control, then click **Remove** at the top of the control to remove it from the **Input Controls** pane.

To view the input controls map

1. Select the **Input Controls** tab.
2. Click **Map** at the top of the **Input Controls** tab (Web Intelligence Interactive) or select the **Map** tab, then click **Input controls** at the top of the tab (Web Intelligence Java Report Panel and Rich Client).

Using tables and charts as input controls

You can define tables and charts as input controls. Table- and chart-based input controls appear in the **Input Controls** panel in the same way as regular input controls, but you select values in the table or chart itself to filter the dependent report elements. When you select cells, columns or rows in tables, or clickable data areas in charts, Web Intelligence filters the values in the associated report elements according to the values you selected.

When you click on a table or chart-based control in the **Input Controls** panel, Web Intelligence highlights the table or chart used as an input control.

When a report is in drill mode, table- and chart-based input controls are disabled. They are re-enabled when drill mode is deactivated.

To define a table or chart as an input control

1. Select the table or chart, right-click and select **Define as input control**.

2. Select **All objects** to define all the objects in the table or chart as the filtering objects, or select **Single object** and select the object to define a single object in the table or chart as the filtering object.

   Note:
   You can select dimensions only as filtering objects when you define a table or chart as an input control.

3. Click **Next** and type a name and a description for the input control.
4. Click **Next** and select the report elements to be filtered by the input control.

   Note:
   You cannot select the table or chart that you are defining as an input control from the list of report elements.

5. Click **Finish.**

   The table or chart input control appears in the **Input Controls** pane. When you click on the control, Web intelligence highlights the table or chart defined as the input control.

Related Topics

- *To edit an input control* on page 190

To filter data using input controls

1. Display the **Input Controls** pane by selecting the **Input Controls** tab.

   Note:
   The input control displays the message "No dependent report elements" if the report elements filtered by the input control are no longer in the report.

2. Select values in the input control.

   Web Intelligence filters the associated report elements based on the values you select. For example, if you select the "US" value of the [Country] dimension, the filter operator is Equal To, and there is a table associated with the input control, Web Intelligence filters the table on the condition [Country] = "US".

3. To filter using a table or chart defined as an input control, select dimension values in the table (rows, columns or cells) or chart (clickable data areas).

Note:

- Tables or charts defined as input controls can filter using dimension values only.
- The input control shows the message "The table or chart is not in the report" if the table or chart is no longer in the report.
- The input control shows the message "Filtering dimensions not available" if the filtering dimensions are no longer in the table or chart. The input control becomes usable again if you add the dimensions to the table or chart.
- The input control shows the message "Control not usuable while the report is in drill mode" if the report is in drill mode. Drill mode must be turned off to make the input control usable.
- Table- and chart-based input controls are indicated by an icon in the top right-hand corner of the table or chart. Right-clicking the icon displays the following menu:

Command	Description
Edit	Edits the input control
Highlight dependen-cies	Highlights the report elements filtered by the input control
Reset	Removes the filters applied by the input control
Disable/Enable	Disables or enables the input control

4. To remove all filters applied by input controls, click **Reset** at the top of the **Input Controls** pane.

Enhancing reports with calculations, formulas and variables

chapter 20

Calculations, formulas and variables

You can add calculations, formulas and variables (named formulas) to your Web Intelligence reports. For detailed information on the calculation power that calculations, formulas and variables add to your reports, see the *Using Functions, Formulas and Calculations in Web Intelligence* guide or the online help.

Working with standard calculations

To insert a standard calculation in a table or crosstab

You can insert standard calculations in tables or crosstabs to make quick calculations on table data. For more information on the standard calculations available in Web Intelligence, see the *Using Functions, Formulas and Calculations in Web Intelligence* guide or in the online help.

You can insert multiple calculations in a table or crosstab. When you apply two calculations to a table or crosstab, a footer is added for each calculation result. You insert multiple calculations in a table or crosstab in the same way that you insert one calculation, but you repeat the procedure for as many calculations as you want to insert.

1. Click **Configure View** > **Toolbars** > **Reporting** (Java Report Panel) or **View** > **Toolbars** > **Report** (Web Intelligence Interactive) to display the **Report** toolbar.
2. Click the table cell that contains the data you want to calculate.
3. Click the arrow at the right of the **Insert calculation-name** button (where calculation-name is the currently-selected calculation) on the **Report** toolbar, then select the calculation you want to insert from the drop-down menu. You can also click the button directly to insert the currently-selected calculation.

   The currently-selected calculation is shown by the mathematical symbol on the button, and changes according to the type of data you select. For example, if the calculation is Sum, the button displays the Σ symbol.

   Note:
   If you insert a percentage calculation, the results of the percentage are displayed in an additional column or row of the table.

4. To insert other calculations, click the arrow at the right of the button and select the calculation from the drop-down menu.

   A new row is added at the bottom of the table. The aggregated value appears in the new row cell.

To remove a standard calculation

1. Right-click the cell that contains the calculation.
2. Depending on the table type, select **Remove** > **Row** or **Remove** > **Col umn** from the shortcut menu.

Working with formulas

The Formula toolbar

You display the Formula toolbar by clicking the **Show/Hide Formula Toolbar** button on the **Reporting** toolbar (Java Report Panel) or **View** > **Toolbars** > **Formula** (Web Intelligence Interactive). Now, when you select a cell, its formula appears in the Formula toolbar.

The Formula toolbar has the following buttons (the order is different depending on the type of Web Intelligence you are using):

Button	Description
Open Formula Editor	Opens the Formula Editor which allows you to build a formula using a graphical interface
Create variable	Allows you to save a formula as a variable
Clear changes	Clears all changes made to the formula since the last save or validation
Validate formula	Verifies the formula syntax and replaces the current formula

To enter a formula directly into the Formula toolbar without using the Variable Editor, you can type the formula or drag report objects (Java Report Panel only) to the formula toolbar.

To enter a formula in the Formula toolbar by typing the formula

1. Click **Show/Hide Formula Toolbar** (Java Report Panel or Web Intelligence Rich Client) or **View** > **Toolbars** > **Formula** (Web Intelligence Interactive) to display the Formula toolbar.
2. In the Formula toolbar, type the formula.

   For example, to calculate the average revenue generated per item sold, type: `=[Sales Revenue]/[Quantity Sold]`.

   Web Intelligence gives you suggestions for completing the component of the formula you are typing. To select a Web Intelligence suggestion, press the down arrow button to highlight it, then press Return, or select the suggestion with your cursor.
3. To select a Web Intelligence suggestion, press the down arrow button to highlight it, then press Return.

To enter a formula in the Formula toolbar by using drag and drop

- Drag reports objects onto the Formula toolbar.

  Note:
  You cannot drag objects to the Formula toolbar in Web Intelligence Interactive.

  When you release an object, it appears in the Formula toolbar at the cursor position as if you had typed it directly.

To build a formula using the Formula Editor

1. Click the **Open Formula Editor** button on the Formula toolbar to display the Formula Editor.
2. Select the cell on the report where you want to include the formula.
3. In the **Data**, **Functions** and **Operators** panes, double-click the report objects, functions and operators you want to include in the formula, or type the formula directly.

For example, to create the formula `=Average([Revenue])`, double-click the `Average()` function, then double-click the Revenue object.

When you double-click a function to include it in a formula, Web Intelligence places the cursor between the function parentheses.

Working with variables

To create a variable from a formula

1. Display the Formula toolbar.
2. Type your formula in the Formula toolbar or select a cell containing a formula.
3. Click **Create variable** on the Formula toolbar

   The "Create Variable" (Java Report Panel or Web Intelligence Rich Client) or "Variable Editor" (Web Intelligence Interactive) dialog box appears.
4. Type the variable name in the **Name** box.
5. Select the variable type by selecting **Dimension**, **Measure** or **Detail**.
6. If you select **Detail**, an "Associated Dimension" box appears. Click **...** next to the box to open the "Objects and Variables" dialog box and select the dimension you want to associate with the detail.
7. Click **OK**.

   The variable appears in the list of report variables in the **Data** tab.

To create a variable using the Variable Editor

1. Click **Show Variable Editor** on the **Reporting** toolbar (Java Report Panel or Web Intelligence Rich Client) or **Variable** > **New** on the **Available Objects** tab of the Left Panel (Web Intelligence Interactive).
2. Type your formula in the **Formula** pane or use the functions and operators on the **Functions** and **Operators** tab to build the formula.
3. Type the variable name in the **Name** box.
4. Select the variable type by selecting **Dimension**, **Measure** or **Detail**.

5. If you select **Detail**, an **Associated Dimension** box appears. Click **...** next to the box to open the **Objects and Variables** dialog box and select the dimension you want to associate with the detail.
6. Click **OK**.

   The variable appears in the list of report variables.

To edit a variable

1. Select the variable in the list of report variables (on the **Data** tab in the Java Report Panel/Web Intelligence Rich Client or the **Available Objects** tab on the Left Panel in Web Intelligence Interactive).
2. Click the right mouse button and click **Edit (Variable)** on the shortcut menu.

   The Variable Editor appears.
3. Edit the variable.
4. Click **OK** to save the new variable definition.

To delete a variable

1. Select the variable in the list of report variables (on the **Data** tab in the Java Report Panel/Web Intelligence Rich Client or the **Available Objects** tab on the Left Panel in Web Intelligence Interactive).
2. Click the right mouse button and click **Delete** on the shortcut menu.

Drilling on report data

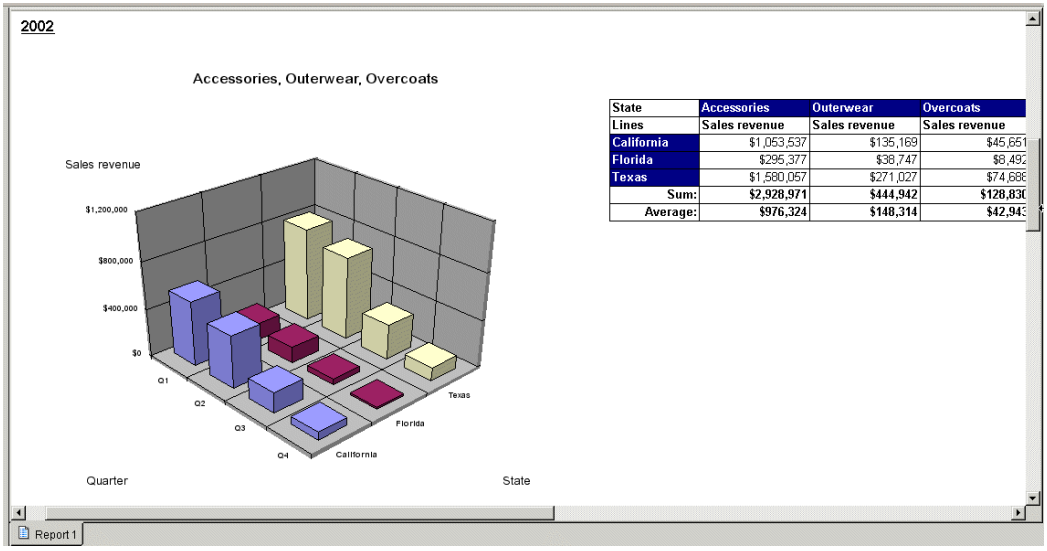
chapter 21

What is drill?

You use drill to analyze the results displayed in reports. Drilling on reports lets you look deeper into your data to discover the details behind a good or bad summary result displayed in tables, charts, or sections.

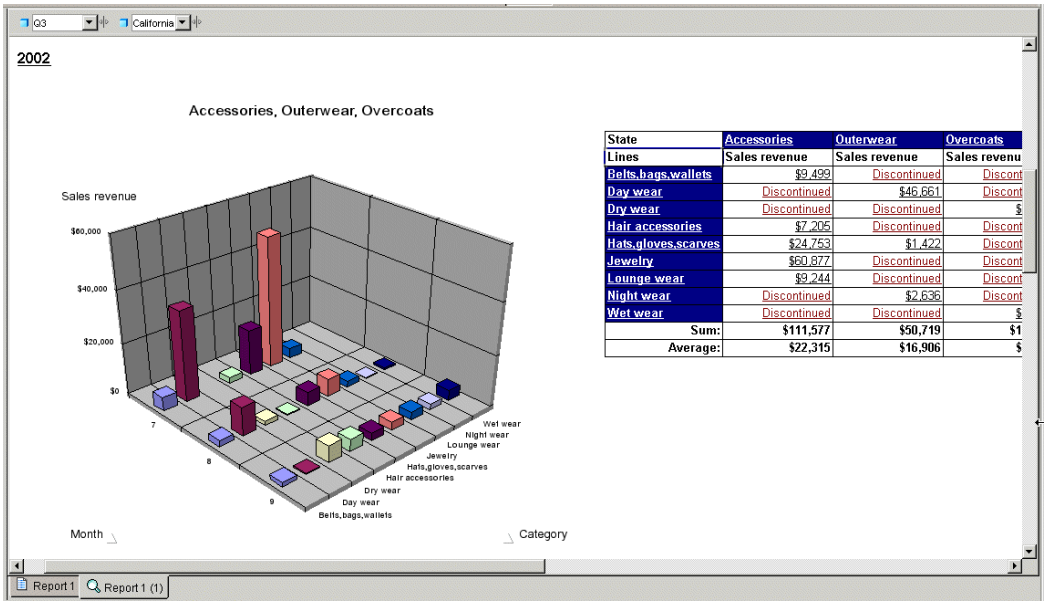
Example: Why did sales of accessories, outwear, and overcoats rise in Q3?

You work for a US national fashion retail chain, and are in charge of sales of accessories, outerwear and overcoat clothing lines in western states. You see that revenue is much higher for Q3 than the other quarters.



State	Accessories	Outerwear	Overcoats
Lines	Sales revenue	Sales revenue	Sales revenue
California	$1,053,537	$135,169	$45,651
Florida	$295,377	$38,747	$8,492
Texas	$1,580,057	$271,027	$74,688
Sum:	$2,928,971	$444,942	$128,830
Average:	$976,324	$148,314	$42,943

To understand why, you drill down to look at the factors behind the result.



State	Accessories	Outerwear	Overcoats
Lines	Sales revenue	Sales revenue	Sales revenu
Belts,bags,wallets	$9,499	Discontinued	Discont
Day wear	Discontinued	$46,661	Discont
Dry wear	Discontinued	Discontinued	$
Hair accessories	$7,205	Discontinued	Discont
Hats,gloves,scarves	$24,753	$1,422	Discont
Jewelry	$60,877	Discontinued	Discont
Lounge wear	$9,244	Discontinued	Discont
Night wear	Discontinued	$2,636	Discont
Wet wear	Discontinued	Discontinued	$
Sum:	$111,577	$50,719	$1
Average:	$22,315	$16,906	$

You see that jewelry sales escalated in July (month #7).

Scope of analysis

The scope of analysis for a query is extra data that you can retrieve from the database to give more details on the results returned by each of the objects in a query. This extra data does not appear in the initial result report, but it remains available in the data cube, so you can pull this data in to the report to allow you to access more detail at any time. This process of refining the data to lower levels of detail is called drilling down on an object.

In the universe, the scope of analysis corresponds to the hierarchical levels below the object selected for a query. For example, a scope of analysis of one level down for the object Year, would include the object Quarter, which appears immediately under Year.

You can set this level when you build a query. It allows objects lower down the hierarchy to be included in the query, without them appearing in the **Results Objects** pane. The hierarchies in a universe allow you to choose your scope of analysis, and correspondingly the level of drill available.

In the Java Report Panel and in Web Intelligence Rich Client, you can also create a custom scope of analysis by selecting specific dimensions for the **Scope of Analysis** pane.

Note:
You cannot set the scope of analysis when working in query drill mode because this drill mode causes Web Intelligence to modify the scope dynamically in response to drill actions.

Levels of scope of analysis

You can set the following levels for scope of analysis:

Level	Description
None	Only the objects that appear in the **Results Objects** pane are included in the query.
• One level down • Two levels down • Three levels down	For each object in the **Result Objects** pane, one, two, or three objects lower down the hierarchy tree are included in the query. The data from these objects is stored in the cube until you add them to the document.
Custom **Note:** This option is available in the Java Report Panel and in Web Intelligence Rich Client only.	All objects added manually to the Scope of Analysis panel are included in the query.

Including a scope of analysis in a document increases the document size significantly. This is because the data necessary for the scope you specify is saved with the document, even though it is not visible in the reports unless you start drill mode and drill down to the data to display the corresponding values.

In order to minimize the size of documents and optimize performance, we recommend that you only include a scope of analysis in documents where you are certain that users will need to drill.

We suggest the following method because it will be easier for you to set the scope of analysis seeing the hierarchy of the classes and objects.

To set the scope of analysis

1. Click **Show/Hide Scope of Analysis Pane** on the Query toolbar to display the **Scope of Analysis** pane.

   All the dimensions in the **Result Objects** pane appear in the **Scope of Analysis** pane. This corresponds to the default scope of analysis - None. (There are no additional levels available for analysis.)

2. Select the analysis level from the **Scope level** list at the top-right corner of the **Scope of Analysis** pane.

   The objects hierarchically below the objects in the **Result Objects** pane appear in the **Scope of Analysis** pane down to the number of levels you selected.

3. To add selected dimensions to the scope of analysis or create a custom scope of analysis, select dimensions in the Query Manager and drag them across to the **Scope of Analysis** pane.

Drill paths and hierarchies

When you analyze data in drill mode, you move along a drill path. These paths are based on the dimension hierarchies set by the designer of the universe. Universe designers organize objects in classes in a hierarchy with the most summary objects at the top and the most detailed at the bottom. So if you want to make a high-level report, you know that your query should include objects at the top of the list. If you want to see more detailed information, you can then switch to Drill mode and drill down on each dimension value displayed in the reports.

For example, if the data from [Quarter] did not sufficiently explain a result, you could drill down to [Month] or [Week], depending on how the universe designer set up the hierarchy. When you drill to a different level, measures, such as a [Revenue] or [Margin], are recalculated accordingly.

Drill paths usually follow the same hierarchy order as the classes on a universe. For example, a class called Time typically includes the [Year] dimension at the top of the class, followed by the [Quarter], [Month], and [Week] dimensions. The hierarchies for drill within the Time hierarchy typically follow the same order, because users want to drill annual results to analyze details for quarter, month, and so on. However, the universe designer can also define custom hierarchies.

Note:
A dimension can belong to several hierarchies. When you drill a result on a dimension that belongs to more than one hierarchy, Web Intelligence prompts you to select the drill path.

To view drill hierarchies

1. Open a document in Edit mode.
2. Verify you are in Query View.
3. Click the **Data** tab.
4. Click the **Hierarchies** radio button.

To switch to drill mode

To start drilling on a report you either switch to Drill mode or, if the report is saved in Drill mode, drill directly.

1. With a document open, verify you are in Report View.
2. Select the report you want to drill.

   The **Drill** button appears in the Web Intelligence toolbar.
3. Click the **Drill** button (you can also select **Analysis** > **Drill** in Web Intelligence Rich Client).

   Note:
   When you open a document that was saved in Drill mode, the document opens in Drill mode if you have the right to drill on documents. If not, it opens in Results view..

   By default, a drill icon appears on the tab of the drillable report. Depending on the drill options you selected on the Web Intelligence Document Preferences page in InfoView, Web Intelligence either makes the selected report drillable or creates a duplicate of the selected report, in drill mode.

Related Topics

- *Start drill session on a duplicate report option* on page 32

Retrieving more levels of data to the report

When you are drilling a Web Intelligence report, you may want to drill up or down to a dimension that lies outside the scope of analysis defined for the document. To return the additional data, Web Intelligence must run a new query that includes the additional dimension(s) you specify. This is called extending the scope of analysis.

You can extend the scope of analysis during your drill sessions only if your security profile allows you to do so. Your security profile is controlled by your BusinessObjects Enterprise administrator.

If your Drill options are not set to display the Extend the Scope of Analysis prompt message during drill, you will not be given the option to select filters if you drill beyond the data already available in the document. In this case, Web Intelligence immediately runs a new query and returns data for all the values on the dimensions you are drilling.

To drill out of the scope of analysis

1. Hold your mouse cursor over a dimension value that is at the end of the scope of analysis.

   A ToolTip informs you that a new query is necessary to return the additional data to the document.

2. Drill on the dimension.

   If your Drill options are set for Web Intelligence to prompt you when a drill action requires a new query, the Extend the Scope of Analysis dialog box appears.

   The dialog box lists the dimensions in the hierarchy above and below the drilled value. The dimensions already included in the document are checked. The dialog box also displays the filters that you can select to filter the new query.

3. Select the check boxes next to the dimensions you want to drill.

4. Select the check boxes next to the filters you want to use to filter the query.
5. Click **OK**.

   Web Intelligence runs a new query and returns the additional data to the document and the results for the dimension you drilled to appear on the table.

To choose a drill path when more than one is available

A dimension can belong to multiple hierarchies. When you drill down on such a dimension value, Web Intelligence does not know which drill path to follow. You must define the drill path.

Note:
If the dimension value you choose to drill on is the result of a previous drill, the drill path is already known. Therefore you do not need to select a drill path.

1. Drill on the dimension.

   The "Select Drill Path" dialog box appears. The dialog box lists the dimensions in the hierarchy above and below the drilled value. A check box appears next to each dimensions below the current dimension you are drilling, so that you can select which of these dimensions you want to retrieve from the database, in order to continue your drill action. The dialog box also displays the filters that you can select to filter the new query.
2. Select the path you want to drill.
3. Click **OK**.

To take a drill snapshot

- Click **Snapshot** on the main toolbar.

  Web Intelligence makes a copy of the current state of the drilled report as a seperate report.

Drilling on dimensions in tables and sections

Dimensions typically represent character-type data, such as customer or business names, and dates. Web Intelligence makes calculations based on the dimensions in a report. For example, if you create a report that calculates a region's total sales revenue for a given year, Web Intelligence calculates the [Sales revenue] measure based on the two dimensions: [State] and [Year].

When you drill on a dimension to see the more data behind the displayed result, the sales revenue is calculated according to the values to which you drill. If you drill on [Year] in the above example, Web Intelligence calculates and displays sales revenue by state and quarter, because [Quarter] is the next dimension in the time hierarchy below [Year].

Note:
You cannot drill on detail objects.

Drilling down

You drill down to see the lower-level data that makes up the summary results displayed on reports. This helps explain why high or low results occurred.

Example: Using drill analysis to find out why sales decreased dramatically in 2003

In this example, you receive a report that shows sales revenue results for the accessories line at the eFashion retail store. The following crosstab shows that the Accessories line decreased in 2003.

	2001	2002	2003
Accessories	$2,546,222	$5,468,919	$1,899,405

To analyze more precisely when the decrease occurred, you drill down on the cell value 2003, to view the detailed data for each quarter.

	2001	2002	2003
Accessories	$2,546,222	$5,468,919	$

Drill down to Quarter

When you drill down on the cell value 2003, a filter appears in the Drill toolbar to show that the quarterly values you have drilled to are filtered for the year 2003. The drilled chart clearly shows that the problem arose in Q4 of 2003.

2003

	Q1	Q2	Q3	Q4
Accessories	$357,835	$526,371	$645,055	$370,144

To find out which of the of the categories within the Accessories line was responsible for the drop in revenue, you drill down again on the cell value Accessories.

2003 Accessories

	Q1	Q2	Q3	Q4
Belts,bags,wallets	$195,102	$235,769	$105,772	$223,218
Hair accessories	$83,574	$1,133	$46,847	$15,490
Hats,gloves,scarves	$14,954	$1,553	$12,771	$8,310
Jewelry	$12,118	$10,601	$28,436	$7,406
Lounge wear	$16,266	$59,282	$149,401	$22,105
Samples	$35,821	$218,034	$301,828	$93,616

The drilled crosstab shows which categories were responsible for low revenue in Q4.

Note:
If you try to drill to a dimension that is already displayed in another column or row of the same table, Web Intelligence automatically displays the next available dimension in the drill path.

To drill down on a dimension value in a table or section cell

1. Verify you are in Drill mode
2. On a table or section cell, place your pointer over the dimension value on which you want to drill.

   A ToolTip appears, showing the next dimension in the drill path. If the drilled report includes dimensions from multiple data providers, the ToolTip displays the name of the query and the dimension for the value.
3. Click the value.

   The drilled table or section displays data one dimension level down. The Drill toolbar, at the top of the report, displays the values from which you drilled. These values filter the values displayed on the drilled table.

Drilling up

You drill up on a dimension value to see how the more detailed data aggregates to a higher-level result. For example, you may have drilled down on Year to examine data for each quarter. If you want to see how this data aggregates to yearly results, you can drill up.

When you drill up on a dimension value, you move along the drill path from lower- to higher-level data. For example, you may have drilled down on [Year] to [Quarter]. If you drill up on [Quarter], you return to [Year].

You can only drill up on a dimension value if you have previously drilled down to that dimension, or you have defined the appropriate drill path in the scope of analysis.

To drill up on a dimension value

1. Verify you are in Drill mode.
2. On a table or section cell, right-click the dimension value on which you want to drill up, then on the shortcut menu click **Drill up** , or click the Drill Up icon next to the dimension value you want to drill up.

   If the table is a crosstab without headers that display the names of the dimensions on the table, then the Drill Up icon appears next to each value from which you can drill up.

The report now displays data one dimension level up. The filters that filtered the value you drilled up from, are removed from the Drill toolbar.

Drilling by

When you drill down or up, you move through a hierarchy one dimension at a time. However, you can get another view of the data by slicing it in a different way, and then look at the data in other hierarchies. To do this, you drill by the other dimensions that interest you.

Note:
You can only Drill by to a dimension that is included in the scope of analysis of the document.

Example: Drilling by the Products hierarchy to slice sales revenue results by product

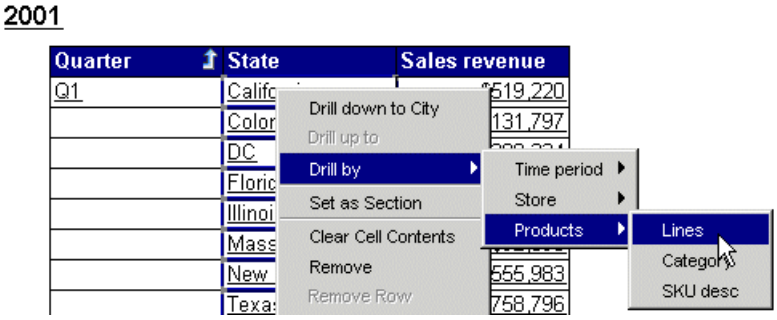
You work as regional manager for California in a retail clothing store, and have been sent the following report that shows quarterly sales revenue by state:

2001

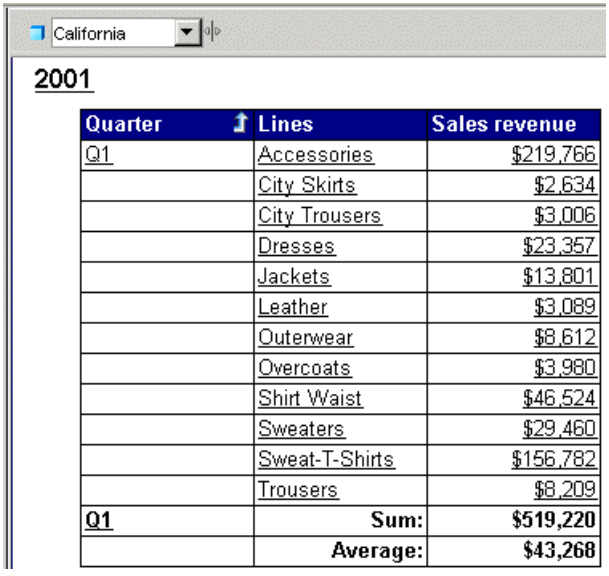
Quarter	State	Sales revenue
Q1	California	$519,220
	Colorado	$131,797
	DC	$208,324
	Florida	$137,530
	Illinois	$256,454
	Massachusetts	$92,595
	New York	$555,983
	Texas	$758,796
Q1	**Sum:**	**$2,660,699**
	Average:	**$332,587**

You are only interested in analyzing the results in the state of California. In addition, you want to analyze the sales revenue broken down by each product line you sell. To drill on California data, you place your pointer on the table cell that says California.

If you drilled down now, however, you would drill to results for each city within California, because [City] is the dimension below [State]. Instead, you select Drill by from the drill menu and then you navigate through the dimensions on the Products hierarchy by selecting the sub-menus until you reach the [Lines] dimension.



The drilled report displays the detailed sales revenue results for each product line sold in California.



Quarter	Lines	Sales revenue
Q1	Accessories	$219,766
	City Skirts	$2,634
	City Trousers	$3,006
	Dresses	$23,357
	Jackets	$13,801
	Leather	$3,089
	Outerwear	$8,612
	Overcoats	$3,980
	Shirt Waist	$46,524
	Sweaters	$29,460
	Sweat-T-Shirts	$156,782
	Trousers	$8,209
Q1	**Sum:**	**$519,220**
	Average:	**$43,268**

To drill by a dimension value

1. Verify you are in Drill mode.
2. On a table or section cell, right-click the dimension value you want to drill by.

   A shortcut menu appears, displaying the available drill paths.
3. Place your pointer on **Drill by**, then on the class to which you want to drill.
4. Click the dimension to which you want to drill.

   The report now displays data for the dimension to which you drilled.

Drilling on measures in tables and sections

When you drill on a measure value, Web Intelligence performs the drill action one level down for each related dimension in the block and displays the new measure calculation for the displayed dimensions.

Example: **Drill on annual sales revenue results to see the breakdown by city and quarter**

For example, you drill down on the year 2003 sales revenue value for California, which is displayed on a crosstab that shows sales revenue by year in by state.

The drilled report displays sales revenue by quarter by city for California – the state on which you drilled.

To drill down on a measure value

1. Verify you are in Drill mode.
2. Place your pointer over the measure value on which you want to drill.

A ToolTip appears, displaying the next dimension(s) in each related drill path

3. Click the measure value.

   Your report now displays data one dimension level down. The table headers display the names of the dimensions you drilled to and the drill up arrow, which indicates you can drill back up to the summary results if wished. The Drill toolbar displays the values that filter the results displayed on the drilled table or section.

To drill up on a measure value

1. Verify you are in Drill mode.
2. Right-click the measure value on which you want to drill up, then click the **Drill up** option on the shortcut menu, or click the **Drill Up** icon next to the measure value you want to analyze.

   The drilled table now displays data one dimension level up.

Synchronizing drill across multiple tables and charts

A Web Intelligence report can contain several tables or charts. The generic term used to refer to tables and charts in this guide is a block. There are two ways to drill on a report with multiple blocks:

- drill simultaneously on each block in the report the contains the drilled dimension
- drill on only the current block of data

You set how Web Intelligence performs drill on reports with the Synchronize drill on report blocks option.

If you set Web Intelligence to synchronize drilling across a report, you drill on each block in the report containing that drilled dimension. The next dimension in the drill path replaces the previous dimension in all blocks of the report.

If you set Web Intelligence not to synchronize drilling on all blocks in a report, the next dimension in the drill path replaces the previous dimension only in the current block of the report.

Related Topics

- *Synchronize drill on report blocks option* on page 32

Drilling on charts

Drilling down, up, or by on a chart, provides you with a graphical explanation for why summary results are particularly high or low.

You can drill on:

- dimensions – by drilling on chart axes
- dimensions – by drilling on the chart legend
- measures – by drilling on the data bars or markers in the body of the chart

You cannot Drill by dimensions on chart axes. However, you can Drill by dimensions on chart legends.

Related Topics

- *Drilling on axis legends* on page 219

Drilling on dimensions via chart axes

On 2D charts, you can drill on dimensions via the X-Axis. On 3D charts, you can drill on dimensions via the X-Axis and the Z-Axis. Charts can contain one or multiple dimensions on a single axis. When an axis contains multiple dimensions, each possible combination of the dimension values appear on the axis (this is sometimes referred to as a cartesian product).

When you drill on an axis value with multiple dimensions, the drilled results are filtered by both dimensions.

To drill on a chart axis

1. Verify you are in Drill mode.
2. Place your pointer over the dimension value on which you want to drill.
3. If you want to drill down on the dimension value, click the value. If you want to drill up on the dimension value, right-click the value then select **Drill Up**. If you want to drill down on the dimension value, right-click the value then select **Drill Down**. If you want to drill by the dimension value, right-click the value then select **Drill By**

Note:
Drill by is not available if the axis has multiple dimensions.

Drilling on measures in charts

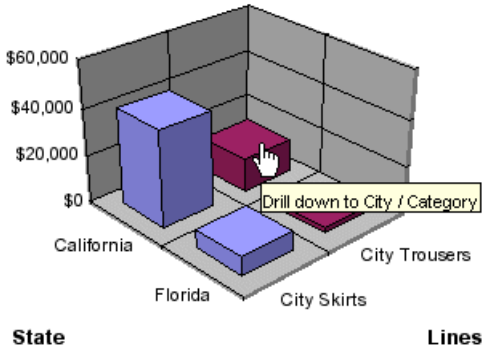
You can drill on the measures displayed on the following types of chart:

- bar charts – by drilling on the bars
- line and radar line charts – by drilling on the data markers
- pie chart – by drilling on the segments

When you drill on measures, Web Intelligence performs the drill action on each dimension displayed on the chart axes. The new measure calculations displayed on the bars or data markers on the drilled chart, correspond to the lower- or higher-level dimensions to which you drilled. The chart axis labels display the names of the drilled dimensions.

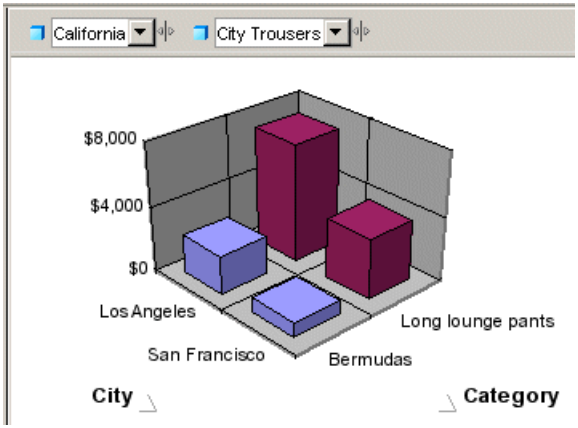
Example: Analyze detailed information for the sales revenue measure on a chart

For example, this 3D bar chart displays values for the [State] dimension on the X-Axis and displays values for the [Lines] dimension on the Z-Axis. This means that the chart bars display values for sales revenue per state per line.



As the example below shows, when you drill down on the bar for “City Trousers□? in “California□? you also drill down from [State] to [City] on the X-Axis and from [Lines] to [Category] on the Y-Axis.

The drilled chart displays sales revenue per city per category for the “City Trousers□? clothing line.



To drill on a measure in a chart

1. Verify you are in Drill mode.
2. Place your pointer on the measure value on which you want to drill.

   On charts, each measure is represented by a bar (on bar charts) or by a data marker (on a line charts and radar line charts).
3. If you want to drill down on the measure value, click the bar or data marker. If you want to drill up on the measure value, right-click the bar or data marker, and then click **Drill up**.

Limitations when drilling measures on charts

When you drill on charts that are not bar charts, Web Intelligence may perform the drill action only on certain dimensions instead of performing the drill action on all of the dimensions on the chart axes. When you drill on measures in the following chart types, Web Intelligence only performs the drill action on the values in the axis legend:

- area charts – 2D, 3D, and stacked
- radar and scatter charts – all types

Note:
You cannot drill on measures in 3D surface charts.

Drilling on axis legends

You can drill on charts via the chart legend whenever the legend lists the dimensions displayed on the chart. When the chart legend lists the measures displayed on the chart, drilling on the legend is not possible.

Drilling on a legend is useful, if you are working with a pie chart, because the axis labels, which display the names of the dimensions represented by each pie segment, are not often displayed.

Note:
You can only Drill by on a chart legend, if there is a single dimension on the axis.

To drill on an axis legend

1. Verify you are in Drill mode.
2. Place your pointer over the value on which you want to drill.
3. To drill down the dimension value, click the color associated with the value. To drill up the dimension value, right-click the color associated with the value, then click **Drill up** ; or click the **Drill Up** icon. To drill by the dimension value, right-click the color associated with the value, then click **Drill by** .

Using filters when you drill

When you drill on a dimension or measure value in a table or chart, Web Intelligence filters the drilled results by the dimension or measure you drilled on. The filter is applied to all of the results displayed on the drilled report.

Filters appear as list boxes in the Drill toolbar. Each list box contains the values associated with that filter. You select the data displayed in a table or chart by choosing the appropriate values from the list boxes.

Note:
You can also use the Drill toolbar outside Drill mode to quickly add simple report filters to reports. In this context the toolbar is known as the Report Filter toolbar.

Example: Filtering drilled reports by different US states

For example, if you drill down on a table cell displaying “California,□? to view results for cities in California, Web Intelligence filters the values in the entire report for California and only displays results for California in the report.

By changing the value of each filter, you can then see data for other values on the drilled dimension. For example, you can select Colorado in the filter on State.

Note:
If the drilled report includes dimensions from multiple data providers, a ToolTip appears when you rest your cursor on the value displayed on the filter. The ToolTip displays the name of the query and the dimension for the value.

Related Topics

- *To create simple report filters* on page 181

To change a filter value on the Drill toolbar

1. Verify you are in Drill mode.
2. In the Drill toolbar, click the drop-down arrow relating to the dimension you want to filter.
3. Click the value you want.

To add or remove a drill filter

1. Verify you are in Drill mode.
2. Drag the dimension containing the values around which you want to filter your report and drop it onto the Drill toolbar.

A list box for the new filter appears on the Drill toolbar. You can select a value from the list of values to filter the results displayed on the drilled table, chart, or report.

3. To remove a drill filter, drag the dimension away from the Drill toolbar.

Saving reports with drill filters

When you save a document with reports in drill mode, Web Intelligence maintains any filters that have been generated during drill. When you open a document saved in drill mode, Web Intelligence displays the Drill toolbar on the drilled reports showing the filters generated during the last drill session.

Note:
Documents saved in drill mode take longer to open than documents saved in results mode.

Refreshing data in a drilled report with prompts

Some Web Intelligence reports contain prompts. When you refresh the document, the prompt(s) require(s) you to specify the value(s) you want to retrieve from the database and return to the report(s) in the document. For example, a prompt can require you to specify a year, for which you want to retrieve data. This drilled report shows values for Year 2003 – the year selected for the prompt.

If the drilled report is filtered for Year 2003, and you then refresh the document and select year 2002 to answer the prompt, Web Intelligence retrieves results for 2002 instead of 2003. The drilled report then displays values for 2002.

Drilling with query drill

Query drill defined

You can set Web Intelligence to drill in query drill mode, which behaves differently from the standard drill mode described so far in this chapter. When

you activate query drill, Web Intelligence drills by modifying the underlying query (adding and removing dimensions and query filters) in addition to applying drill filters.

Example: Drilling down from month to week

In this example, Month is the lowest dimension currently available in the query from a time hierarchy, and Week is the dimension immediately below it in the hierarchy.

If you drill down on Month = January, three things happen:

- Web Intelligence adds Week to the query scope of analysis.
- Web Intelligence adds a query filter to restrict Month to January.
- Web Intelligence adds a drill filter to restrict Month to January.

If you drill up from Week to Month, the process is reversed:

- Web Intelligence removes Week from the query scope of analysis.
- Web Intelligence removes the query filter.
- Web Intelligence removes the drill filter.

Note:
Drill filters are not strictly necessary in query drill mode. Web Intelligence applies them for consistency with standard drill mode. For example, the `DrillFilters` function returns the correct value in query drill mode because Web Intelligence applies drill filters to match the query filters.

When do you use query drill?

You use query drill when your report contains aggregate measures calculated at the database level. It is designed in particular to provide a drill mode adapted to databases such as Oracle 9i OLAP, which contain aggregate functions that Web Intelligence either does not support, or cannot calculate accurately at the report level during a drill session.

The kinds of aggregate functions that are candidates for drilling in query drill mode are: percentages, distinct counts, ranks, standard deviations and variances, running aggregates, lead and lag functions. Because query drill modifies the query at each drill operation, it ensures that these aggregates are recalculated by the server each time you drill.

Query drill is also useful for reducing the amount of data that Web Intelligence must store locally during a drill session. Because query drill reduces the scope of analysis when you drill up, Web Intelligence is able to purge unecessary data.

To activate query drill

1. Right-click on the document anywhere outside a table or chart and click **Document Properties** to display the **Document Properties** pane.
2. Open the **Document Options** group within the tab.
3. Check **Use query drill**.

   If your report already has a scope of analysis defined, you see a message telling you to clear the scope of analysis before activating query drill.

Drilling with query drill

Drilling down with query drill

When you drill down, query drill behaves similarly to standard drill at the point where the data moves outside the scope of analysis.

When Web Intelligence filters a drilled dimension in query drill mode it does so by adding a query filter in addition to a drill filter. For example, if you drill on Year=2001, Web Intelligence adds a filter at the query level to restrict the Year dimension to 2001. For this reason, the only value that appears in the drill toolbar for the drilled dimension is the value on which you drilled (in this case 2001). This is different from standard drill mode, in which all values of the dimension are visible in the toolbar. As a result, you cannot change filter values in query drill mode (for example, drill on Year=2001 then switch to Year=2003) as you can in standard drill mode.

Because query drill automatically extends the scope of analysis, you can use it only if your BusinessObjects XI administrator has granted you the the right to drill outside the scope. See your administrator for more details.

Drilling up with query drill

When you drill up, query drill removes dimensions from the query. For example, if you drill up from Month to Quarter, Web Intelligence removes Month from the query. This has two consequences:

- Query drill is incompatible with drill snapshots.

- Web Intelligence does not allow you to drill up beyond any dimension that appears as one of the report objects. For example, if your report displays Year, Quarter and Revenue, you cannot drill up from Quarter to Year because this would remove quarter from the list of report objects.

Related Topics

- *Query drill and drill snapshots* on page 224

Query drill and drill snapshots

Do not use drill snapshots when working in query drill mode, because query drill means that snapshots cannot be guaranteed to stay the same.

In query drill mode, snapshots change when you drill up beyond a dimension that you included in a snapshot. Because the drill up removes the dimension from the underlying query, it also removes the dimension from the snapshot.

Query drill and other reports based on the same data provider

If your document contains other reports that contain dimensions on which you drill in query drill mode, these reports are affected because the query drill modifies the dimensions they contain.

You can avoid this (at the cost of retrieving duplicate data into Web Intelligence) by creating a new data provider and rebuilding the other report against it. Now when you drill in query drill mode, the other report remains unaffected.

Example: Drilling on a dimension that appears in another report

If you have two reports based on a query that contains Year, Quarter and Sales Revenue, and you use query drill to drill down to Year = 2001 on the first report, Web Intelligence also filters the data for Year in the second report to include 2001 only.

Merging dimensions from multiple data providers

chapter 22

Merged dimensions defined

You can include multiple data providers in a Web Intelligence document. You often need to synchronize the data returned by these data providers. You do this by incorporating common dimensions into a merged dimension.

Merged dimensions and data synchronization were introduced in Web Intelligence XI R2. They enormously increase the power and flexibility of Web Intelligence by allowing you to synthesise data from different sources in the same report, rather than simply including the data.

For example, if you have one database that contains detailed customer information and another database that contains sales data, you can synchronize the two data sources around the customer.

When to merge dimensions

You merge dimensions when your report draws related data from different data providers. For example, you have a report showing revenue and sales targets. The report contains sections based on the year, and each section shows revenue and sales targets. If revenue and sales target data comes from two different data providers, Web Intelligence does not know that it is related. You tell Web Intelligence that the data is related by merging the two data providers on the common dimension, year.

When you merge dimensions, Web Intelligence creates a new dimension that contains all the values from the original dimensions that make up the merged dimension. You use this dimension in reports as you use any other report object. You can add report objects from all the data providers synchronized through the merged dimension in the same block as the merged dimension.

Choosing which dimensions to merge

The only restriction that Web Intelligence imposes on merged dimensions is that they must be of the same data type: for example, character data. But it does not make sense to merge unrelated dimensions even when their data types are the same. For example, it does not make sense to merge a

dimension containing customer names with a dimension containing sales regions.

Merged dimensions often have the same name in both data sources, but this is not obligatory. It can make sense to merge dimensions with different names if they contain related data.

To merge dimensions correctly you need to be aware of the semantics of the data (what the data refers to) in the different data sources. The dimension data types and names are an approximate guide only to dimensions' suitability for merging.

Merged dimension example

The following example with two data providers illustrates the effect of merging dimensions:

Example: Merging City dimensions

Data Provider 1:

Country	City
US	New York
US	Los Angeles
France	Paris
France	Toulouse

Data Provider 2:

City	Revenue
New York	100000
Los Angeles	75000
Paris	90000

City	Revenue
Toulouse	60000

If you merge the City dimensions and display the Country, merged City dimensions and Revenue measure in a table, Web Intelligence returns the following result:

If the City dimensions are not merged, Web Intelligence displays the following result:

Country	City	Revenue
US	New York	325000
US	Los Angeles	325000
France	Paris	325000
France	Toulouse	325000

Because there is no link between the two data providers through a merged dimension, Web Intelligence is unable to relate the city revenues to countries. As a result Web Intelligence displays the total revenue against each Country/City pair.

If the City dimensions are merged, Web Intelligence displays the following result:

Country	City	Revenue
US	New York	100000
US	Los Angeles	75000
France	Paris	90000
France	Toulouse	60000

Forcing merged calculations with the ForceMerge function

By default, Web Intelligence does not account for merged dimensions in calculations if the merged dimensions do not explicitly appear in the calculation context.

Example: Calculating revenue with ForceMerge

This example has two data providers as follows:

Data Provider 1:

Country	City
US	New York
US	Los Angeles
France	Paris
France	Toulouse

Data Provider 2:

City	Revenue
New York	100000
Los Angeles	75000
Paris	90000
Toulouse	60000

If you merge the [City] dimensions, then create a table with [Country] and [Revenue], Web Intelligence displays the following result:

Country	Revenue
US	325000
US	325000
France	325000
France	325000

Because [City], the merged dimension, does not appear in the table, Web Intelligence does not take the merge into account when calculating revenue. Web Intelligence lists the total revenue in the second data provider against each country.

To display the correct result, replace [Revenue] in the second column with the formula `ForceMerge([Revenue])`:

City	Revenue
US	175000
US	175000
France	150000
France	150000

Web Intelligence now takes the relationship between countries and cities into account when calculating revenue.

Note:
If [Revenue] is a smart measure in the above example, `ForceMerge([Revenue])` returns #MULTIVALUE. This is because the grouping set (Country) does not exist for the [Revenue] measure. `ForceMerge([smart_measure])` always returns #MULTIVALUE, unless by chance no aggregation is required to calculate the measure.

Creating, editing and deleting merged dimensions

To merge dimensions

1. Click **Merge Dimensions** on the toolbar (you can also select**Data** > **Merge Dimensions** in Web Intelligence Rich Client).

   The "Merge Dimensions" dialog box appears.
2. Select the dimensions you want to merge in the boxes at the top of the dialog box.

   When you select a dimension, all dimensions of different data types are disabled because you cannot merge dimensions of different data types.
3. Click **Values** to view the values associated with the dimensions.
4. Click **Merge**.

   The "Create Merged Dimension" dialog box appears. You use this dialog box to specify the properties of the merged dimension.
5. Select the dimension in the **Source Dimension** drop-down list.

   The source dimension provides the default name, description and number formats for the merged dimension.
6. Type the merged dimension name in the **Merged Dimension Name** box and the merged dimension description in the **Description** box.
7. Click **OK**.

   The merged dimension name appears in the "Merged Dimensions" box and the dimensions that are part of the merged dimension appear in the boxes alongside it. Because an original dimension can be part of one merged dimension only, it no longer appears in the box above that lists the original dimensions in the query.
8. Click **OK** to close the "Merged Dimensions" dialog box.

   Web Intelligenceadds the merged dimensions to the list of merged dimensions in the **Data** tab.

To define a merged dimension

You define a merged dimension in the "Create Merged Dimension" dialog box.

1. Type the merged dimension name in the **Merged Dimension Name** box.
2. Type the merged dimension description in the **Description** box
3. To use the name and description of one of the source dimensions in the merged dimension, select the source dimension from the **Source Dimension** list.
4. Click **OK**.

To merge dimensions automatically

You can set Web Intelligence to merge dimensions automatically under the following circumstances:

- The dimensions have the same name
- The dimensions have the same data type
- The dimensions are in the same universe

1. Right-click outside any block or chart and click **Document Properties** on the popup menu.
2. Click **Auto-merge dimensions**.

To edit a merged dimension

1. In the **Data** tab, select the dimension in the **Merged Dimensions** folder and click the right mouse button.
2. Select **Edit Merged Dimension** from the menu.

   The "Merged Dimensions" dialog box appears.
3. Edit the merged dimension.

Related Topics

- *To merge dimensions* on page 231

To delete a merged dimension

1. Select the dimension in the **Merged Dimensions** folder in the **Data** tab and click the right mouse button.
2. Select **Delete Merged Dimension** from the menu.

Understanding the effects of merged dimensions

Data synchronization through merged dimensions adds enormous power to Web Intelligence. Merged dimensions also have implications for the results that Web Intelligence displays in certain situations. You need to understand these implications to work effectively with merged dimensions and synchronized data.

Synchronizing data providers with different aggregation levels

You can synchronize data providers with different aggregation levels. This can have implications for the way in which Web Intelligence calculates measures.

Example: Synchronizing data providers with different aggregation levels

In this example you have two data providers as follows:

Customer	Year	Revenue
Jones	2004	1500
Jones	2005	2000
Smith	2005	1200

Customer	Number of sales
Jones	12
Smith	10

If you merge the two data providers and the table properties **Avoid duplicate rows aggregation** and **Show rows with empty dimension values** are unchecked, Web Intelligence returns the following:

Customer	Year	Revenue	Number of sales
Jones	2004	1500	12
Jones	2005	1200	12
Smith	2005	1200	10

Web Intelligence cannot determine the number of sales per year for customer Jones because the data provider that stores the number of sales does not break them down by year. Web Intelligence therefore reproduces the total number of sales on each row.

Note:
Although the Number of Sales values are duplicated, if you add a standard calculation to the bottom of the column (for example a Sum or Average calculation), the result is correct.

One way of adressing this issue is to add the dimensions to the second data provider that allow Web Intelligence to calculate to the appropriate level of data. If this is not possible, you must be aware of any situations where Web Intelligence cannot aggregate the data to the necessary level of detail.

Detail objects and merged dimensions

Detail objects are associated with dimensions and provide additional information about the dimension.

Web Intelligence XI R2 requires a one-to-one relationship between dimensions and details (this means that a detail object can have one value only for each value of its associated dimension) and does not take detail objects into account when synchronizing data. The following example illustrates why this is necessary.

Previous versions of Web Intelligence, as well as Desktop Intelligence and BusinessObjects, allow a one-to-many relationship between dimensions and details. If you migrate a report created using any of these products and the detail object contains multiple values, Web Intelligence places the #MULTIVALUE error in the detail cell.

Example: Synchronizing data providers with detail objects

In this example you have two data providers, and [Address] is a detail object related to [Customer]:

Customer	Address	Revenue
John	London	10000
Paul	Liverpool	15000

Customer	Telephone Number
John	1234
Paul	5678

If you create a merged Customer dimension to synchronize the data providers, and Address can have more than one value for each customer, the result is ambiguous because there is no common value around which Web Intelligence can synchronize the data.

For example, Paul might have addresses in Liverpool and London, which means that there is no unique ‘Paul’ row with which Web Intelligence can synchronize Paul's telephone number. Paul has a different telephone number for each address, and Web Intelligence does not know which address to associate with the telephone number:

Customer	Address	Telephone Number
John	London	1234
Paul	#MULTIVALUE	5678

If the relationship between Customer and Address is one-to-one, Web Intelligence can ignore Address in the synchronization. This removes the ambiguity:

Customer	Address	Telephone Number
John	London	1234
Paul	Liverpool	5678

Incompatible objects and merged dimensions

As a general rule, Web Intelligence does not allow you to place dimensions from different data providers in the same table. This is to avoid Cartesian products (the display of all possible combinations of values from unrelated objects) or other ambiguous results, depending on the universe structure.

You can always place measures from different data providers in a table. Web Intelligence calculates the measure depending on what dimensions are available. For example, if you place a measure in a table that contains no dimensions from the same data provider as the measure, Web Intelligence displays its total value in the table.

You can place a merged dimension in a table as long as the table contains other dimensions from a data provider that participates in the merge. You can also place details from different data providers in a table, as long as the details are associated with dimensions that participate in a merged dimension.

In certain situations, it can be valid to place a dimension from another data provider in a table, even when Web Intelligence does not permit this. This occurs when the incompatible dimension has a one-to-one or one-to many

relationship with a dimension already in the table. The important point is that there is only one value of the incompatible dimension associated with the dimension in the table (one-to-one). On the other hand, the same value of the incompatible dimension can be associated with multiple values of the dimension in the table (one-to-many).

In the table below, the relationship between Address and Name conforms to these rules: Address has a one-to-one or one-to-many association with Name. There is no one-to-many association in the other direction, between Name and Address (one name with more than one address):

Dimension in table (Name)	Incompatible dimension (Address)
John	London
Paul	London
George	Liverpool

In this case the universe design is incorrect - the incompatible dimension (Address) should be defined as a detail of the dimension in the table (Name). If you encouter this situation, see your Business Objects administrator and ask for a redesign of the universe.

If it is not practical to change the universe, create a variable at the report level. Define this variable as a detail, associate it with the dimension in the table, and supply the name of the incompatible dimension as the variable definition. The variable simply returns the same values as the incompatible dimension. Because it is defined as a detail of the dimension in the table, Web Intelligence allows you to place it in the same table as the dimension.

Filtering merged dimensions

Merging dimensions has implications for the way in which Web Intelligence applies filters.

Note:
You cannot apply a filter a on merged dimension. You apply filters on the dimensions that make up the merged dimension.

Report filters and merged dimensions

When you apply a report filter to a dimension that is part of a merged dimension, Web Intelligence applies the filter to all data providers that are synchronized through the merged dimension.

Example: Filtering a merged dimension

In this example you have a report with the following data providers, which are merged on the Country dimension

Country	Resort	Revenue
France	French Riviera	835,420
US	Bahamas Beach	971,444
US	Hawaiian Club	1,479,660

Country	Future Guests
France	46
US	56

If you apply the filter Country=□?US□? to the first block, Web Intelligence also filters the second block to give the following result:

Country	Future Guests
US	56

If the Country dimensions are not merged the second block is unaffected by the filter.

Section filters and merged dimensions

When a dimension that is part of a merged dimension is set as a section header, any filter applied to the section also applies to blocks from synchronized data providers within the section.

Related Topics

- *Filtering a merged dimension* on page 238

Block filters and merged dimensions

When you apply a block filter to a dimension that is part of a merged dimension, Web Intelligence applies the filter to the block. Web Intelligence does not apply the filter to other data providers synchronized through the merged dimension.

Drilling on merged dimensions

When you merge dimensions, the new merged dimension belongs to the hierarchies of all dimensions involved in the merge.

Extending the values returned by merged dimensions

Merged dimensions were a new concept in Web Intelligence XI R2. Synchronizing data providers already existed in Desktop Intelligence/BusinessObjects but it did not involve the creation of a new merged dimension. BusinessObjects reports use the original dimensions that make up a merged dimension in Web Intelligence.

You can use these original dimensions in a Web Intelligence report. When you place them in the report, Web Intelligence returns by default only those dimension values that have corresponding values in the data providers synchronized through the merge. You need to be aware of this when migrating reports from Desktop Intelligence and BusinessObjects because BusinessObjects/Desktop Intelligence behaves differently.

Example: Web Intelligence and Desktop Intelligence/BusinessObjects behavior when dimensions are merged

You have a report with the following data providers:

Country of origin	Revenue
Germany	470

Country of origin	Revenue
Japan	499

If you include the Country of Origin dimension from Data Provider 1 and the Revenue measure from Data Provider 2 in the same block, Web Intelligence returns the following result:

Country of origin	Revenue
Germany	

The same block in Desktop Intelligence/BusinessObjects returns the following result:

Country of origin	Revenue
Germany	
Japan	499

The block is different in Desktop Intelligence/BusinessObjects because BusinessObjects extends the values of the Country of Origin dimension through the values returned by the Revenue measure.

To extend dimension values

1. Right-click your report outside any blocks or charts and select **Document Properties** on the shortcut menu.

   The **Document Properties** pane appears on the right side of the report.

2. Check the **Extend merged dimension values** option.

Ranking report data

chapter 23

Ranking data

Ranking allows you to isolate the top and bottom records in a set based on a variety of criteria. For example, if you have a block showing countries and associated revenues, ranking allows you to rank the data in the block to show the top 3 countries only, based on the revenue they generate.

Ranking allows you to answer business questions such as:

- Which 3 regions generate the most revenue?
- Which are the bottom 10% of stores in terms of revenue generation?
- What is the group of the best-performing stores that generates a combined revenue of up to $10,000,000?

Web Intelligence allows you to rank data in many ways to answer these kinds of business questions. You can:

- rank the top and/or bottom n records by dimension (for example Country) based on the sum of a related measure (for example Revenue)
- rank the top and/or bottom n% of the total number of records by dimension based on the value of a related measure as a percentage of the total value of the measure
- rank the top and/or bottom n records by dimension based on the cumulative sum of a related measure
- rank the top and/or bottom n records by dimension based on the value of a related measure as a cumulative percentage of the total value of the measure

Rankings and sorts

Web Intelligence sorts data as part of applying a ranking. For example, if you rank the top 3 stores by revenue, Web Intelligence sorts the stores in descending order by revenue generated.

The sorts that Web Intelligence applies in rankings take precendence over sorts that you have previously applied to your data. For example, if you have previously sorted the list of stores in alphabetical order, Web Intelligence overrides this sort when applying the ranking.

Tied rankings

Web Intelligence assigns equal ranking values to tied rankings and pushes back the ranking values of the rows after the tie. This means that a bottom n ranking can return more than n records.

Example: Top and bottom tied rankings

The following table shows a tied ranking. The Top 3 ranking column shows how Web Intelligence ranks these records in a top 3 ranking; the Bottom 3 Ranking column shows how Web Intelligence ranks these records in a bottom 3 ranking.

Dimension	Measure	Top 3 Ranking	Bottom 3 Ranking
A	10	4	1
B	20	3	2
C	30	1	3
D	30	1	3

In each case Web Intelligence includes records up to and including rank 3. This results in the following for a top 3 ranking:

Dimension	Measure
D	30
C	30
B	20

It results in the following for a bottom 3 ranking:

Dimension	Measure
A	10
B	20
C	30
D	30

Ranking parameters

Parameter	Description
Top/bottom	When the calculation mode is Count, the ranking returns the top/bottom n records based on the measure specified in the Based on parameter. For example, the top 3 countries by revenue generated, the bottom 3 year/quarter combinations by revenue generated. When the calculation mode is Percentage, the ranking returns the top/bottom n% of the total number of records based on the measure specified in the Based on parameter. For example, if there are 100 records and you rank the top 10%, the ranking returns the top 10 records. When the calculation mode is Cumulative Sum, the ranking returns the top/bottom records for which the cumulative sum of the measure specified in Based on does not exceed n. When the calculation mode is Cumulative Percentage, the ranking returns the top/bottom records for which the cumulative sum of the measure specified in Based on does not exceed n% of the total of the measure.

Parameter	Description
n/n%	When the calculation mode is Count - the number of records to retrieve based on the measure. When the calculation mode is Percentage - the percentage of records to retrieve based on the measure. When the calculation mode is Cumulative Sum - the cumulative sum that the measure must not pass. When the calculation mode is Cumulative Percentage - the cumulative sum of the measure, represented as a percentage of the total, that the measure must not pass.
Based on	The measure on which the ranking is based.
Ranked By	The ranking dimension. If you specify a ranking dimension, Web Intelligence uses the aggregated values of the Based on measure, calculated for the dimension, to determine the ranking. If you do not specify this dimension, Web Intelligence uses the values of the Based on measure calculated for all dimensions in the block. (In other words, Web Intelligence returns the top/bottom X rows in the block based on the measure.)
Calculation mode	The type of calculation used to create the ranking. See the description of the Top/Bottom and n/n% parameters at the top of this this table for more information.

Example of a ranking

A table contains the following data:

Year	Quarter	Revenue
2006	Q1	100
2006	Q2	200
2006	Q3	300
2006	Q4	500
2007	Q1	400
2007	Q2	700
2007	Q3	300
2007	Q4	600
2008	Q1	200
2008	Q2	200
2008	Q3	400
2008	Q4	500

Total for Q1: 700

Total for Q2: 1100

Total for Q3: 1000

Total Q4: 1600

If you rank the top 2 of each Quarter based on Revenue, Web Intelligence filters out all the rows for Q1 and Q3 because Q4 and Q2 have the highest aggregate revenues.

Ranking and data order

You cannot rank on an object whose values depend on the data order. This is because the ranking changes the data order, which in turn changes the object data, which then requires Web Intelligence to recalculate the ranking. The result is a circular dependency between the ranking and the object that Web Intelligence cannot resolve.

If you create a rank on a measure whose values depend on the data order, for example a measure that that uses the `Previous` function or any of the running aggregate functions such as `RunningSum`, Web Intelligence displays the #RANK error message in all cells in the block.

Ranking workflows

There are two ways of ranking data in Web Intelligence. You can:

- create a ranking by using the Web Intelligence interface
- use the `Rank` function to return a ranking value

When you rank the data in a block by using the Web Intelligence interface, you tell Web Intelligence to sort and filter the data in the block according to the rank. For example, if you rank the top 3 countries in a block by revenue, Web Intelligence sorts the countries in descending order by revenue, then filters the block to remove all countries other than the 3 with the highest revenue.

Note:
When you create a ranking using the interface, Web Intelligence uses the `Rank` function behind the scenes to assign ranking values.

To create a ranking

1. Select the block that you want to rank.
2. Click **Rank**.

   The "Create Rank" dialog box appears
3. Click **Top** and select the number of records if you want to rank the highest records in the block.

4. Click **Bottom** and select the number of records if you want to rank the lowest records in the block .
5. Select the measure on which the ranking is based in the **Based on** list.
6. Click **Ranked By** and select the dimension on which the ranking is based if you want to rank by a particular dimension rather than by all dimensions in the block.
7. Select the rank calculation mode in the **Calculation mode** list.
8. Click **OK**.

Ranking examples

In the following examples, you have a dimension, Region, and a measure, Revenue, which give the following values:

Region	Revenue	% of Total Revenue
South East	1000000	7%
South West	2000000	13%
North East	3000000	20%
North West	4000000	24%
Central	5000000	33%

Example: Rank the top 3 regions by revenue generated

1000000

Parameter	Value
Top/Bottom	Top
n/n%	3

Parameter	Value
For Each	Region (or unspecified because region is the only dimension in the block and therefore the default ranking dimension)
Based on	Revenue
Calculation mode	Count

This ranking gives the following result:

Region	Revenue
Central	5000000
North West	4000000
North East	3000000

To calculate this ranking, Web Intelligence:

- sorts the records in descending order
- displays the top 3 records

Example: Rank the bottom 40% of regions by revenue

To perform this ranking you set the following parameters

Parameter	Value
Top/Bottom	Bottom
n/n%	40%
For Each	Region

Parameter	Value
Based on	Revenue
Calculation mode	Percentage

This ranking gives the following result:

Region	Revenue
South East	1000000
South West	2000000

To calculate this ranking, Web Intelligence:

- sorts the records in ascending order
- works through the records until 40% of the total number of records are displayed

---

Example: Rank the top regions whose cumulative revenue is less than or equal to 10,000,000

To perform this ranking you set the following parameters:

Parameter	Value
Top/Bottom	Top
n/n%	10000000
For Each	Region
Based on	Revenue
Calculation mode	Cumulative sum

This ranking gives the following result:

Region	Revenue
Central	5000000
North West	4000000

To calculate this ranking, Web Intelligence:

- sorts the records in descending order
- works through the records until it reaches the record that causes the the cumulative total of the measure to pass 10,000,000
- includes those records that do not cause the cumulative total to pass 10,000,000

Example: Rank the bottom regions whose cumulative revenue is less than or equal to 30% of the total revenue

To perform this ranking you set the following parameters:

Parameter	Value
Top/Bottom	Bottom
n/n%	30%
For Each	Region
Based on	Revenue
Calculation mode	Cumulative percentage

This ranking gives the following result:

Region	Revenue
South East	1000000

Region	Revenue
South West	2000000

To calculate this ranking, Web Intelligence:

- sorts the records in ascending order
- works through the records until it reaches the record that causes the cumulative total of the measure, expressed as a percentage of the overall total of the measure, to exceed 30%
- displays those records that do not cause the cumulative percentage to pass 30%

Using alerters to highlight results

chapter 24

Alerters defined

Alerters enable you to highlight results that meet or fail specific business targets. You can create a simple alerter to highlight particularly high or low results with a specific color or with a text comment, such as “High Performer".

An alerter can contain up to six conditions. This enables you to highlight information that meets multiple business criteria. For example, you can define an alerter that highlights high revenue for a specific business activity or customer sector.

You can apply alerters to table body cells (by column or row), to section cells, to header cells, and to free-standing cells. However, you cannot apply alerters to entire tables or forms, or to charts.

Business Objects officially supports up to 30 alerters in a Web Intelligence document. You can apply those alerters to a maximum of 20 table columns or rows, free-standing cells, or section cells on the reports.

Business Objects officially supports up to 10 different alerters on a single table column or row, free-standing cell, or section cell.

You can define alerters to activate the following formatting changes to the selected table columns/rows or cells:

- text color, size and style
- cell border colors and style
- cell background display – specific colors, images, or hyperlinks to web pages

You can also define alerters that display a text or formula, an image, or a hyperlink. In this case, the results that meet the condition defined in the alerter will be replaced by the text for formula.

If you define an alerter with multiple conditions, each condition generates the same formatting changes. To generate different formatting changes for different conditions, you must use sub-alerters.

Alerters are dynamic. This means that when you refresh reports with the latest data on the database, the alerters highlight the new results accordingly.

If you apply an alerter to a table row or column with a break, the alerter is only activated when the value that meets the condition in the alerter appears on the first row of that break.

Web Intelligence Interactive displays the formatting effects of alerters created using the Java Report Panel or Web Intelligence Rich Client. You cannot create new alerters in Web Intelligence Interactive.

Sub-alerters

An alerter can be made of multiple sub-alerters, each containing one or multiple conditions. Sub-alerters allow you to apply different conditions and different formatting to a single object.

You must use sub-alerters if you want different conditions to generate different formats. If you define an alerter with multiple conditions, the alerter format is applied to all of the conditions.

For example, in a single alerter defined for [Sales revenue], one sub-alerter can highlight high results in green and a second sub-alerter can highlight low results in red. You can include a maximum of eight sub-alerters in an alerter.

To add, edit, duplicate, prioritize or activate alerters

1. To display the "Alerters" dialog box, click **Alerters** on the Reporting toolbar (you can also select**Reporting** > **Alerters** in Web Intelligence Rich Client.)
2. To add an alerter, click **New** then build the alerter using the Alerter Editor.
3. To edit an alerter, select the alerter from the list, click **Edit** then use the Alerter Editor to edit the alerter.
4. To duplicate an alerter, select the alerter from the list then click **Duplicate**.
5. To remove an alerter, select the alerter from the list than click **Remove**.
6. To activate or deactivate an alerter, select the alerter from the list then check or uncheck the alerter.
7. To prioritize an alerter, select the alerter from the list then use the up or down arrow buttons to change the priority of the alerter in the list.

To build an alerter

1. Type the alerter name in the **Alerter name** box in the Alerter Editor.

2. Type the alerter description in the **Description** box.
3. Define the conditions that trigger the alerter as described in the following four steps.
4. Select the cell or object whose value triggers the alerter in the **Filtered object or cell** box.

   If the cell on which you want to create an alerter contains date or numeric type data (for example, a date or a calculation) you need to select an object or variable instead of **Cell contents**. This is because Web Intelligence considers any value you type into the **Value** text box as a character string.

   - To trigger the alerter using the data in whichever cell is currently selected, click **...**, then select **Cell contents** from the menu.
   - To trigger the alerter using the value of an object or variable, click **...**, select **Select Object or Variable** on the menu, then select the object or variable in the "Objects and Variables" dialog box.
5. Select the operator from the **Operator** list.
6. Enter the value that triggers the alerter in the **Value** box.
   - To enter a value directly, type it in the box.
   - To select a value from the list of values of the object you chose in the **Filtered object or cell box**, click **...** to the right of the **Value** box, click **Select Value** on the menu, then select the value in the "List of Values" dialog box.
   - To select another object or variable as the value, click ... to the right of the **Value** box, click **Select Object or Variable** on the menu, then select the object or variable in the "Objects and Variables" dialog box.
   - To clear the **Value** box, click **...** to the right of the box, the select **Empty** on the menu.
7. To add an additional condition that triggers the alerter, click **+** below the existing conditions, then then choose the filtered cell or object, operator and value as described above.
8. To remove a condition, click **-** next to the condition.
9. To trigger the alerter using a formula instead of conditions as described above, click **Formula**, then type the formula in the box that appears or click **Fx** to build the formula using the Formula Editor.
   - Do not include quote marks before or after the text. For example, if you want the alerter to display OVERDUE, then type: OVERDUE.

- The formula must return True or False. True triggers the alerter; False does not. For example, if the formula is `RowIndex()=3`, the alerter formatting appears on the fourth row of the table.

10. To add an additional condition or set of conditions to the alerter, click **Add Sub-Alerter**, then define the conditions or build a formula as described above.
11. To remove a sub-alerter, click **Remove Sub-Alerter**.
12. To set the format that appears when the alerter is triggered, click **Format** then use the **Alerter Display** dialog box to set the format.

To set the format of an alerter

1. Click **Format** in the Alerter Editor.

   The "Alerter Display" dialog box appears.
2. Type the alerter text or the formula that the alerter uses to generate its output in the **Display** box.

   You can also build a formula by clicking **Fx** and using the Formula Editor.
3. Define the text format (font, font style color and alignment) in the **Text** area.
4. Define the color and image of the alerter background in the **Background** area.
5. Define the alerter border in the **Border** area.
6. Click **OK** to return to the Alerter Editor.

Using formulas to create advanced alerters

You can build advanced alerters using the Web Intelligence formula language rather than using the **Filtered object or cell**, **Operator** and **Operand** choices offered by default.

You can create alerters that display text, formulas, or hyperlinks in the report cells, where results meet the condition(s) defined in the alerter.

This enables you to display messages in cells, such as “UNPAID,□? or to display formulas that change the results (for example, to display a text you specify and the result of the object in the same cell), or to include links to

other web pages that can be consulted easily whenever results meet the business condition(s) set in the alerter.

Example: Highlighting three ranges of quarterly sales revenue results calculated as percentages of the average sales revenue

In this example, you build three alerters to color-code sales revenues, depending on their relationship to the average sales revenue. The table includes results for three years, and this is the average to which you want to compare each sales revenue result calculated per quarter per product line.

Using the Formula option in the Alerter Editor, you build the following alerter, which contains three sub-alerters.

Each sub-alerter has a single condition. Web Intelligence combines the sub-alerters with the Or operator, as follows:

```
[Sales revenue] < ((Average([Sales revenue]) In Block) * 0.8)
```

Or

```
=[Sales revenue] < ((Average([Sales revenue]) In Block) * 1.2)
```

Or

```
=[Sales revenue] > ((Average([Sales revenue]) In Block) * 1.2)
```

The formula you specify for each sub-alerter is calculated as follows:

- The first sub-alerter will be activated on sales revenue results that are < 0.8 (this means, less than 80%) of the average.
- The second sub-alerter will be activated on sales revenue results that are < 1.2 (this means, less than 120%) of the average.
- The third sub-alerter will be activated on sales revenue results that are > 1.2 (this means, greater than 120%) of the average.

You then use the formula pane in the Alerter Display dialog box, to specify the conditional formatting you want displayed on the report cells. Here, you specify an appropriate text string and format you want displayed, when the results in a table cell meet the condition for one of the sub-alerters. You specify the following:

- Report cells containing sales revenue results that are less than 80% of the average revenue display the character string in red.

- Report cells containing sales revenue results that are less then 20% above the average revenue display in blue. Note that this alerter covers values also covered by the first alerter. For example, if the average is 100, then 79 is both > 80% below the average and < 20% above the average. In this case, the first alerter takes precedence.
- Report cells containing sales revenue results that are greater than 20% above the average revenue display in green.

This formatting enables you to see at a glance which product lines are generating above or below the total average sales revenue.

Tracking changes in data

chapter 25

Tracking changes in your data

To make informed and effective business intelligence decisions, you need to understand how the data on which you base those decisions changes over time. Web Intelligence allows you to track and display data changes to help you focus your analysis on key areas and avoid wasting time exploring irrelevant data.

When you track data changes, you select a particular data refresh as a reference point. This data is known as the reference data. When you display the data changes, Web Intelligence places your current data in context by showing how it relates to the reference data.

Here are some examples of the usefulness of data tracking:

- If an outlet no longer appears in a list of the top outlets by sales, Web Intelligence displays the outlet as deleted from the list. You can use this information to investigate why the outlet is no longer a top performer.
- If sales have decreased in a region, data tracking displays the decrease. You can then drill down into the data for the region to understand why revenue is falling.

  In both these cases, data tracking makes the current data more meaningful by placing it in context with old data. Without this context it is much more difficult to identify trends.

Types of data change

Web Intelligence allows you to track the following types of data change:

- added data
- removed data
- modified data
- increased data
- decreased data

You configure the display of these changes through the Web Intelligence interface or the Web Intelligence formula language. The formula language provides advanced users with additional power and flexibility in displaying and formatting changed data.

Data tracking modes

Automatic data tracking mode

In automatic data tracking mode, Web Intelligence always compares the current data with the data before the last refresh. To do this, Web Intelligence sets the current data as the reference data just before each refresh. The reference data is always one refresh behind the current data.

Automatic data tracking is appropriate for scheduled documents when you want to compare the current data with the data before the last refresh.

Manual data tracking mode

In manual data tracking mode, you select the reference data. Web Intelligence continues to use this data as a reference point until you update the reference point.

To activate data tracking

1. Click **Track** on the main toolbar to display the "Activate Data Tracking" dialog box.
2. Select options in the dialog box.

Option	Description
Auto-update the reference data with each data refresh	The current data becomes the reference data after each data refresh. The report always shows the difference between the most recent data and the data before the last refresh.
Use the current data as reference data	The current data becomes the fixed reference data and remains the reference data after further data refreshes. The report always shows the difference between the most recent data and this fixed reference data.

3. Click "Refresh Now" to refresh the data when the dialog box closes.

4. Click **OK**

To change the reference data

1. Click **Data Tracking Options** on the main toolbar, or click the **Auto-update/Fixed Data** hyperlink in the status bar to display the "Data Tracking Options" dialog box.
2. Select the **Reference Data** tab.
3. Select options.

Option	Description
Auto-update the reference data with each data refresh	The current data becomes the reference data after each data refresh. The report always shows the difference between the most recent data and the data before the last refresh.
Use fixed reference data from	The data you select becomes the fixed reference data and remains the reference data after further data refreshes. The report always shows the difference between the most recent data and this fixed reference data.

Displaying changed data

To display or hide changed data

- Click **Hide Changes/Show Changes** (the button tooltip text varies depending on whether changed data is currently visible) to the right of **Track** on the main menu.

Configuring the appearance of changed data

You can configure the appearance (font style, size and color) of changed data in your document. You can seperately configure the appearance of the following changes:

- Inserted, deleted and changed dimension and detail values

- Increased or decreased measure values

Measure values can also adopt the formatting of inserted or deleted dimension values. For example, if a dimension value disappears from a list of values in a block, and the block also shows a measure value for the dimension, both the dimension and measure values appear as deleted data.

Your Business Objects administrator defines the default appearance of changed data in the Central Management Server. When you configure the appearance of changed data in Web Intelligence, you override the CMS defaults.

To configure the appearance of changed data

1. Click **Data Tracking Options** on the main toolbar to display the "Data Tracking Options" dialog box.
2. Select the **Format** tab.
3. Select each type of changed data you wish to display and click "Format" to specify how you want the changes to appear.

How changed data is displayed in blocks

Example: Changed data in a simple block

This example uses a document with a block showing [Country], [Year] and [Revenue]. The original data was as follows:

Country	Year	Revenue
France	2003	1000
France	2004	2000
Japan	2002	1000
Poland	2002	1200

After a refresh, the data is as follows:

Country	Year	Revenue
France	2004	3000
Japan	2003	900
Poland	2002	800
UK	2004	900

When data tracking is activated and data changes displayed, the block appears as follows:

Country	Year	Revenue	Formatting
France	2003	1000	[deleted data formatting on all cells]
France	2004	3000	[increased data formatting on Revenue cell]
Japan	2002	1000	[deleted data formatting on all cells]
Japan	2003	900	[inserted data formatting on all cells]
Poland	2002	800	[decreased data formatting on Revenue cell]
UK	2004	900	[inserted data formatting on all cells]

- The rows showing revenue for France in 2003 and Japan in 2002 represent data that no longers exist after the refresh.
- The revenue for France in 2004 has increased.
- The revenue for Poland in 2002 has decreased.

- The rows showing revenue for Japan in 2003 and the UK in 2004 appeared after the refresh.

How changed data is displayed in reports with merged dimensions

Web Intelligence displays a dimension as changed only if all the dimensions that participate in the merge are changed.

Example: Changed data and merged dimensions

In this example, Country is a merged dimension containing the Country dimensions from two data providers. Before data refresh, the data is as follows:

Country (DP1)	Revenue (DP1)	Country (DP2)	Sales (DP2)
US	10000	US	5000
France	4000		
UK	5000	UK	3000
Germany	1000	Germany	1000

After a data refresh, the data becomes:

Country (DP1)	Revenue (DP1)	Country (DP2)	Sales (DP2)
US	10000	US	4000
France	4000	France	3000
UK	6000	UK	4000
Poland	2000		

When displayed in a block with the merged Country dimension and data changes displayed, the data appears as follows:

Country	Revenue	Sales	Formatting
US	10000	4000	[decreased data formatting on Sales cell]
France	4000	3000	[inserted data formatting on Revenue cell]
UK	6000	4000	[increased data formatting on Revenue and Sales cells]
Germany	1000	1000	[deleted data formatting on all cells]
Poland	2000		[inserted data formatting on Country and Revenue cells]

In the France row, France does not appear as inserted because a France row was not inserted in both data providers. Revenue appears as inserted because it is a new measure value after the data refresh.

In the Poland row, Poland appears as inserted because it is a new dimension value after the data refresh.

How changed data is displayed in sections

Example: Changed data in a report with sections

In this example you have a document with a block showing [Country], [Year] and [Revenue]. The original data was as follows:

Country	Year	Revenue
France	2003	1000
France	2004	2000
Japan	2002	1000
Poland	2002	1200
US	2003	
US	2004	

After a refresh, the data is as follows:

Country	Year	Revenue
France	2004	3000
Japan	2003	900
Poland	2002	800
UK	2004	900

If you create a section on [Country] and display data changes, the report appears as follows:

France [no formatting]

Year	Revenue	Formatting
2003	1000	[deleted data formatting on all cells]

Year	Revenue	Formatting
2004	3000	[increased data formatting on Revenue cell]

Japan [no formatting]

Year	Revenue	Formatting
2002	1000	[deleted data formatting on all cells]
2003	900	[inserted data formatting on all cells]

Poland [no formatting]

Year	Revenue	Formatting
2002	800	[decreased data format-ting on Revenue cell]

UK [inserted data formatting]

Year	Revenue	Formatting
2004	900	[inserted data formatting on all cells]

Web Intelligence displays the data in the section header in either of two ways, depending on the changes in the data in the section:

- If all the rows in the block in the section have changed in the same way, the section header is displayed with the same formatting as the rows.

- If the rows have changed in different ways, or only some rows have changed, the section header retains its default format.

How changed data is displayed in blocks with breaks

When a block contains a break and the **Center value across break** block property is set, Web Intelligence displays the centered value according rules similar to those for section headers.

- If all the rows in the break have changed in the same way, the centered value is displayed with the same formatting as the rows.
- If the rows have changed in different ways, or only some rows have changed, the centered value retains the default formatting.

How changed data is displayed in charts

When the data in a chart has changed, Web Intelligence displays a changed data icon above the chart. When you click the icon, Web Intelligence changes the chart to a table to allow you to see the details of the changes.

Data tracking limitations

If the data provider behind a document is changed, or if the document data is cleared, Web Intelligence no longer displays changed data. If the data provider is changed, the current version of the document is no longer compatible with the reference version. If the data is cleared, the old data no longer exists for comparison.

As a result, the following actions are incompatible with data tracking:

- Drill out of scope
- Query drill
- Deleting a query
- Any modification (including modifications to security rights) that changes the SQL generated by a data provider
- Purging the document

When you perform any of these actions, Web Intelligence clears the data history of the document. It does so because these actions are incompatible

with the display of changed data. For example, if you modify a query, the data in the document changes because of the modification. Any comparison between this data and old data generated from a different query is misleading.

Data tracking and drill

When you use query drill or drill out of scope, Web Intelligence clears the data history because these actions change the data provider. This should not affect you because, when you start to drill, you have already identified the data that requires further analysis. Data tracking has served its purpose and you can now continue with your data analysis.

Data tracking and Refresh on Open

When a document is set to refresh its data on opening (when the Refresh on open document property is selected), data tracking does not display the difference between the data prior to the refresh and the data after the refresh. Web Intelligence treats the data after the refresh as new data because the refresh purges the document.

Using the Web Intelligence formula language to track changed data

When you use the Web Intelligence interface to configure the display of changed data, Web Intelligence builds special behind-the-scenes alerters to display the changes. These special alerters do not appear in the list of standard alerters.

The Web Intelligence formula language allows you to build your own custom alerters for formatting data changes. You can also use the formula language to include special calculations based on data changes. For example, you can include a calculation to show the difference between the previous value and the current value of a measure.

The RefValue function

The Web Intelligence formula language provides access to changed data throught the `RefValue` function. This function gives the value of the reference data for a measure. If there is no reference data, the function returns null.

For example, if the [Revenue] measure currently has the value 1000, and its reference value is 900, the formula `RefValue([Revenue])` returns 900.

The RefValueDate function

The `RefValueDate` function returns the date of the reference data used for data tracking.

Building formulas using the RefValue function

You can use the RefValue function to build formulas that give information about the current data in relation to the reference data.

Example: Finding the difference between the reference value and the current value

The following formula returns the difference between the reference value and the current value of the [Revenue] measure:

```
=If(Not(IsNull([Revenue])) Or Not (IsNull(RefValue([Rev
enue]))); [Revenue]-RefValue([Revenue]))
```

The following table shows data before a data refresh:

Customer	Revenue
Johnson	2000
Smith	3000

Customer	Revenue
Wilson	3500

After refresh, the data changes as follows:

Customer	Revenue
Johnson	3000
Smith	2500

Placed in a third column, the formula returns the following figures:

Customer	Revenue	Difference
Johnson	3000	1000
Smith	2500	-500
Wilson	3500	

Changed data and the calculation context

When data tracking is activated, Web Intelligence displays data as changed only when the calculation context remains the same.

For example, if a measure value changes because you change the calculation context of a block, the new value is not flagged as changed.

Example: Changing the calculation context

In this example you have a block showing [City], [Customer] and [Revenue] as follows:

City	Customer	Revenue
San Francisco	Smith	1000
San Francisco	Jones	2000
Los Angeles	Wilson	3000
Los Angeles	Harris	4000

If you remove [Customer] from the block, Web Intelligence aggregates revenue by city:

City	Customer
San Francisco	3000
Los Angeles	7000

Web Intelligence does not display the revenues as increased because the amount of revenue has not changed. Only the calculation context has changed - revenues are now aggregated by city only, giving higher figures.

If, after a data refresh, Jones' revenue falls to 1000 and Wilson's revenue rises to 4000, the data appears as follows:

City	Customer
San Francisco	2000
Los Angeles	8000

Web Intelligence now displays the data as changed because, independently of the change of calculation context, the total revenue for San Francisco has decreased and the total revenue for Los Angeles has increased.

Linking to other documents

chapter 26

Linking to other documents

Cells in Web Intelligence documents can be defined as hyperlinks. Web Intelligence hyperlinks are similar to the hyperlinks found on the World Wide Web that allow you to open a different web page from the page you are currently viewing.

When you click a cell that contains a hyperlink, Web Intelligence opens the target document specified in the link. The target document can be a Web Intelligence document, a Crystal Reports document, a site on the world wide web, or any resource accessible through a hyperlink.

Hyperlinks can be either static or dynamic. A static hyperlink always links to the same document in the same way. A dynamic hyperlink can link differently depending on the data in the document containing the hyperlink.

You can create different types of hyperlink:

- A cell where the cell text is the hyperlink text.
- A cell with an associated hyperlink.
- A link to another document in the CMS.

Cell text defined as a hyperlink

When you define the text in a cell as a hyperlink, the cell text itself becomes the hyperlink text. For example, if you define a free-standing cell containing the text `http://www.businessobjects.com` as a hyperlink, clicking on the cell takes you to the Business Objects web page.

This method is best suited for static hyperlinks, where the text in the cell always remains the same and links to the same resource in the same way.

Note:
It is possible to make this type of hyperlink dynamic by using the Web Intelligence formula language to change the cell text based on report data.

To define cell text as a hyperlink

1. Type the hyperlink text in the cell.

2. If you are using Web Intelligence Interactive, right-click the cell and select **Hyperlink** > **Read content as hyperlink** from the menu.

   Note:
   You can also right-click the cell and select **Format** > **Cell** from the menu to display the "Format Cells" dialog box, then select **Read content as** and select **Hyperlink** from the list.

3. If you are using the Java Report Panel, click the cell then set the **Display** > **Read cell content as** cell property to **Hyperlink**.

A hyperlink associated with a cell

When you associate a hyperlink with a cell, you define a hyperlink that Web Intelligence uses to link to the source document when the cell is clicked. The cell text itself is not the hyperlink.

This is the recommended method for creating dynamic hyperlinks, for the following reasons:

- It is specially tailored for working with the parameters in dynamic hyperlinks.
- It shields you from the complexity of hyperlink syntax - you define your hyperlink using a graphical interface and Web Intelligence generates and manages the hyperlink behind the scenes.
- It allows you to define hyperlink text that is different from the cell text.

To add a hyperlink to a cell

1. Right-click the cell and select **Hyperlink** > **New** to display the "Create Hyperlink" dialog box.
2. Select **Link to web page** on the left of the dialog box. (Web Intelligence Interactive only.)
3. Type or paste the hyperlink text into the box.
4. Click **Parse** to extract the hyperlink parameters into the **Customize URL parameters** area (which is not visible until you click **Parse**).

Dynamic hyperlinks contain parameters whose values can change. Parameters appear as `name=value` parts at the end of the hyperlink after the question mark. For example, the URL

```
http://salesandproductreport/default.asp?reportname=products
```

contains one parameter, `reportname`, whose value is “products?.

After you click **Parse**, each parameter appears on a separate line with the parameter name on the left and the parameter value on the right. The static part of the hyperlink (the part without the parameters) appears in the **Main** section.

5. To tell Web Intelligence to supply data from formulas or variables as parameter values, click the arrow next to each parameter value and select an option.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the parameter value.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the parameter value.

Note:
When you modify a parameter, Web Intelligence modifies the full hyperlink syntax in the box at the top of the screen.

6. To add or remove a parameter, modify the hyperlink syntax, then click **Parse**.

Note:
You cannot add or remove parameters directly in the parameter list in the **Customize URL parameters** area. You must modify the URL syntax directly.

7. Click the arrow next to **Cell content** to change the text displayed in the hyperlink cell and choose one of the options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the cell content.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the cell content.

8. Type the tooltip text in the **Tooltip** box or build a dynamic tooltip by using the **Build formula** or **Select variable** options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the tooltip.
Select object	You choose the object from the list in the "Select Object" dialog box to supply its value as the tooltip.

The tooltip appears when you hover your mouse pointer over the cell containing the hyperlink.

9. Click the arrow next to **Target window** to define how the target URL appears.

Option	Description
Current window	The target URL replaces the Web Intelligence document containing the hyperlink in the current window.
New window	The target URL opens in a new browser window.

A link to another document in the CMS

You link to another document in the CMS using the "Create Hyperlink" dialog box (Web Intelligence Interactive only). When you create the link, Web Intelligence builds a formula using the `OpenDocument` function based on the choices you make in the dialog box.

Note:
You can work with the `OpenDocument` function directly by typing the syntax into a cell.

To link to another document in the CMS

1. Right-click the cell where you want to create the link and select **Hyperlink** > **New** from the menu to display the "Create Hyperlink" dialog box.
2. Select **Link to a document** on the left of the dialog box.
3. Click **Browse** and select the target document in the **Choose Document** dialog box, or type the document ID in the **Document ID** box.
4. Click **Refresh on open** if you want Web Intelligence to refresh the data of the target document when the hyperlink is selected.
5. Click **Link to document instance**, then select an option from the drop down-list , to link to an instance of the selected document.

Option	Description
Most recent	The hyperlink opens the most recent instance. **Note:** You cannot specify parameter values in the hyperlink when you choose this option.
Most recent - current user	The hyperlink opens the most recent instance owned by the current user. **Note:** You cannot specify parameter values in the hyperlink when you choose this option.
Most recent - matching prompt values	The hyperlink opens the most recent instance whose prompt values correspond to the values passed by the hyperlink. This option is useful when you want to link to a large document that contains prompts.

6. Click **Report name** and select the name of the report to link to a specific report.

7. Click **Report part**, then click **Select** and right-click the report part (for example a table), to link to a specific part of a report.
8. If you selected **Report part**, select **Display report part only** open the report part only in the target document, or **Position at report part (full document available)** to focus on the report part but display the whole report in the target document.
9. For each prompt in the **Document prompts** section, select one of the following options from the drop-down list:

Option	Description
Build formula	You use the Formula Editor to build a formula to pass a value to the prompt.
Select object	You select an object whose value is passed to the prompt.
Prompt user at runtime	The user specifies a value for the prompt when they click the hyperlink.
Use document default	You configure the hyperlink to not pass a parameter to the target document, and the target document opens with the default value for the prompt. The default value is either the last value specified for the prompt, or the default specified in the document.

10. Choose **Build Formula** or **Select Variable** from the **Cell content** list to specify the content of the hyperlink cell.

Option	Description
Build Formula	You build a formula in the Formula Editor to supply the formula output as the cell content.
Select Variable	You choose a variable from the list in the "Select an Object" dialog box to supply its value as the cell content.

11. Type the tooltip text in the **Tooltip** box or build a dynamic tooltip by using the **Build formula** or **Select object** options.

Option	Description
Build formula	You build a formula in the Formula Editor to supply the formula output as the tooltip.
Select object	You choose the variable from the list in the "Select an Object" dialog box to supply its value as the tooltip.

The tooltip appears when you hover your mouse pointer over the cell containing the hyperlink.

12. Select **New window** or **Current window** from the **Target window** list to determine how the target document opens.

Option	Description
New window	The document opens in a new browser window.
Target window	The document opens in the current browser window and replaces the document containing the hyperlink.

Document instances and values passed to prompts

Hyperlinks supply values to prompts in the target document in two ways: by passing values directly to prompts, or by opening a document instance based on passed values.

In the first case, the hyperlink feeds values directly to the prompts in the target document. In the second case, Web Intelligence opens the document instance whose stored prompt values correspond to the values passed by the hyperlink.

It is more efficient to choose a document instance based on passed parameters if the target document is large.

Certain combinations of instance and parameter settings are incompatible or mutually dependent, as described in the following table:

Instance setting	Impact on parameter setting
Most recent	The hyperlink does not pass parameter values. All parameters are set to **Use document default** and cannot be modified.
Most recent - current user	The hyperlink does not pass parameter values. All parameters are set to **Use document default** and cannot be modified.
Most recent - matching prompt values	You must specify at least one parameter value. Without at least one specified value, the hyperlink returns an error when clicked. The error occurs because the hyperlink is designed to retrieve an instance based on parameter values, but no value is provided for comparison against the instance.

Related Topics

- *Linking to large documents* on page 289

Linking to large documents

When the target document contains a large amount of data, it is more efficient to link to an instance than to open and retrieve the document with a passed parameter value. You can schedule and pre-retreive multiple instances with different parameter values. This allows the document to be scheduled and pre-retrieved in advance with different parameter values.

When you click the hyperlink, Web Intelligence opens the appropriate pre-retrieved instance rather than using the passed value to open the document and retrieve the data.

Example: Linking to a large sales report

In this example you link to a large sales report that retrieves sales by region. The report has a parameter that allows the user to select the region. There are four regions - North, South, East, and West.

Your source document has a [Region] dimension. You do the following:

- Configure the hyperlink to pass the value of [Region] as a parameter
- Create four instances of the sales report, one for each value of [Region]
- Schedule these instances for pre-retrieval
- Configure the hyperlink to open the latest instance whose parameter value matches the value passed by the hyperlink

Assuming that the document has a [Region] dimension, the settings are as follows:

Link to document instance setting	Latest value match
Most recent - matching prompt values	[Region]

Working with hyperlinks

To link to another document from a hyperlink

To link to another document from a hyperlink, the hyperlink must first have been created.

1. Hover your mouse pointer over the cell to display the tooltip if a tooltip is defined.

   Note:
   If you used the **Hyperlink** dialog box to define the link and the Formula Bar is displayed, the hyperlink syntax generated by Web Intelligence appears in the Formula Bar. Do not modify this syntax directly - use the **Hyperlink** dialog box if you need to update it.

2. Click the hyperlink to open the target document.

Depending on how the hyperlink is configured the target document opens in a new browser window, or it replaces the current document in the current browser window.

To edit a hyperlink

1. Right-click the cell containing the hyperlink and select **Hyperlink** > **Edit** from the menu to display the "Hyperlink" dialog box.
2. Edit the hyperlink using the "Hyperlink" dialog box.

To delete a hyperlink

- Right-click the cell containing the hyperlink and select **Hyperlink** > **Delete** from the menu.

Formatting hyperlink colors

You can define the colors that Web Intelligence uses to display hyperlinks that have already been clicked (visited hyperlinks) and hyperlinks that have not been clicked (unvisited hyperlinks).

To set hyperlink colors

1. Right-click a blank area on the report that contains hyperlinks and select **Format Report** on the menu.
2. Click the **General** tab.
3. In the **Hyperlink color** section, click the arrows next to **Visited** and **Unvisited**, then either select a predefined color or click **More colors** to define a custom color.
4. Click **OK**.

   Web Intelligence applies the color settings you selected to the hyperlinks in the report.

URL Reporting using openDocument

URL reporting using openDocument provides URL access to multiple document types by passing a URL string to a BusinessObjects Enterprise server. openDocument provides commands to control how reports are generated and displayed.

You can use openDocument in BusinessObjects Enterprise to create cross-system links to and from the following document types:

- .wid: Web Intelligence documents
- .rep: Desktop Intelligence documents
- .rpt: Crystal reports
- .car: OLAP Intelligence reports

Structuring an openDocument URL

The next sections explain how to use the openDocument function, and how to construct the URL.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

The URL is constructed using the parameters listed in *openDocument parameter overview* on page 295

Joining parameters

Join parameters with the ampersand (&). Do not place spaces around the ampersand. For example: `sType=wid&sDocName=Sales2003`

The ampersand is always required between parameters.

Spaces and special characters in parameter values

Because some browsers cannot interpret spaces, the parameters of the link cannot contain spaces or other special characters that require URL encoding. To avoid the misinterpretation of special characters, you can define a URLEncoded string in the source database to replace the special character with an escape sequence. This will allow the database to ignore the special character and correctly interpret the parameter value. Note that certain RDBMS have functions that allow you to replace one special character with another.

By creating an escape sequence for the plus sign (+), you can instruct the database to interpret the plus sign as a space. In this case, a document title Sales Report for 2003 would be specified in the DocName parameter as:
`&sDocName=Sales+Report+for+2003&`

This syntax prevents the database from misinterpreting the spaces in the title.

Trailing spaces in parameter values

Trim trailing spaces at the end of parameter values and prompt names. Do not replace them with a plus sign (+). The viewer may not know whether to interpret the plus sign (+) as part of the prompt name or as a space. For example, if the prompt name displays:

```
Select a City:_
```

(where _ represents a space), enter the following text in the link:

```
lsSSelect+a+City:=Paris
```

where the spaces within the prompt name are replaced with the plus sign, and the trailing space is trimmed off.

For details on prompt parameters of the link, refer to *openDocument parameter overview* on page 295 .

Capitalization

All of the openDocument parameters are case sensitive.

Link length limit

The encoded URL cannot exceed 2083 total characters.

Parameter values in links to sub-reports

You cannot pass parameter values to a sub-report of a target Crystal report.

Using the IsS parameter with OLAP Intelligence reports

If the target document is an OLAP Intelligence report (.car) you can use the IsS parameter to specify prompts. The parameters are passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

Example: Opening a report to a specific page

If `23CAA3C1-8DBB-4CF3-BA%2CB8%2CD7%2CF0%2C68%2CEF%2C9C%2C6F` is the URL-encoded unique name for the page parameter in the OLAP Intelligence report, you would use the following URL to open the OLAP Intelligence report to page 2:

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&iDocID=440&lsS23CAA3C1-8DBB-
4CF3-BA%2CB8%2CD7%2CF0%2C68%2CEF%2C9C%2C6F=2
```

Example: Opening a cube parameter

If `8401682C-9B1D-4850-8B%2C5E%2CD9%2C1F%2C20%2CF8%2C1%2C62` is the URL-encoded unique name for the cube parameter opening the warehouse cube in the catalogue FoodMart 2000 on MSAS, you would use the following URL to open this cube parameter:

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&lsS8401682C-9B1D-4850-
8B%2C5E%2CD9%2C1F%2C20%2CF8%2C1%2C62=CATALOG%3DFood
Mart%202000,CUBE%3Dwarehouse&iDocID=616
```

Using the IsM parameter with OLAP Intelligence reports

If the target document is an OLAP Intelligence report (.car) you can use the IsM parameter to specify prompts. The parameters are passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

As was the case for the IsS parameter, IsM parameters are also passed in as a URL-encoded string using the unique name of the parameter set up in the OLAP Intelligence report.

Example: Opening a report

```
http://<servername>:<port>/OpenDocument/<platformSpecif
ic>?sType=car&sIDType=InfoObject&lsMADC216EA-D9A5-42B5-
AE%2C21%2C84%2CA9%2CF9%2C6E%2C31%2C7=[%5BCustomers%5D.%5BCoun
try%5D.%26%5BMexico%5D],[%5BCustomers%5D.%5BCoun
try%5D.%26%5BCanada%5D]&iDocID=544
```

This is a memberset parameter opening up a report with Customers > Country > Mexico and Customers > Country > Canada in the view.

openDocument parameter overview

This section provides a brief overview of openDocument and includes a list of available parameters. Details about the available parameters, their specific uses, and relevant examples are also provided.

Note:
The document containing the openDocument link is called the parent document, and it resides on the parent system. The document to which the link points is called the target document, and it resides on the target system.

Table 26-3: Platform Parameters

Parameter	Description
iDocID on page 299	Document identifier.

Parameter	Description
sDocName on page 300	Document name.
sIDType on page 300	Crystal object type.
sKind on page 301	The file type of target Desktop Intelligence document.
sPath on page 301	The name of the folder and subfolder containing the target document.
sType on page 302	The file type of target document or report.
token on page 302	A valid logon token for the current CMS session.

Table 26-4: Input Parameters

Parameter	Description
lsC on page 303	Specifies a contextual prompt if there is an ambiguity during SQL generation (Business Objects and Web Intelligence documents only).
lsM[NAME] on page 304	Specifies multiple values for a prompt, `[NAME]` is the text of the prompt

Parameter	Description
lsR[NAME] on page 305	Specifies a range of values for a prompt, `[NAME]` is the text of the prompt.
lsS[NAME] on page 306	Specifies a value for a single prompt. `[NAME]` is the text of the prompt.
sInstance on page 307	Indicates which specific instance of the target report to open.
sPartContext on page 307	In Crystal Reports, a report part is associated to a data context.
sRefresh on page 308	Indicates whether a refresh should be forced when the target document or report is opened.
sReportMode on page 309	For Crystal targets only, indicates whether the link should open the full target report or just the report part specified in `sReportPart`.
sReportName on page 309	Indicates which report to open if target document is multi-report.
sReportPart on page 310	Indicates which specific part of the target report to open.

Table 26-5: Output Parameters

Parameter	Description
NAII on page 311	Forces the display of the prompt selection page.
sOutputFormat on page 312	Indicates the format in which the target document is opened.
sViewer on page 312	Indicates the selected report viewer (CR & CA only).
sWindow on page 313	Indicates whether the target report will open in the current browser window or whether a new window will be launched.

openDocument platform parameters

This section details the openDocument platform parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

iDocID

Syntax	Description	Mandatory?	Values
`iDocID`	Document identifier.	Yes*	Document identifier (InfoObjectID).

Note:
*One of `sDocName` or `iDocID` is mandatory.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010
```

Note:
To obtain the document ID, navigate to the document within the Central Management Console (CMC). The properties page for the document contains the document ID and the CUID. Use this value for the `iDocID` parameter.

sDocName

Syntax	Description	Mandatory?	Values
`sDocName`	Document name without extension If multiple documents have the same name, specify the correct document with `iDocID`.	Yes*	Document name.

Note:
*One of `sDocName` or `iDocID` is mandatory.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+200
```

sIDType

Syntax	Description	Mandatory?	Values
`sIDType`	Central Management Server (CMS) object identifier type.	Yes*	• `CUID` • `GUID` • `RUID` • `ParentID` • `InfoObjectID` (default)

Note:
*Only mandatory if the target is a Crystal report or OLAP Intelligence report (`sType=rpt` or `sType=car`) in an Object Package. Otherwise, use `sPath` and `sDocName`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?iDocID=2010&sIDType=CUID
```

sKind

Syntax	Description	Mandatory?	Values
`sKind`	The file type of target Desktop Intelligence document.	Yes*	• `FullClient`

Note:
*Only mandatory if the target is a Desktop Intelligence document. Otherwise, use `sType`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sKind=FullClient
```

sPath

Syntax	Description	Mandatory?	Values
`sPath`	The name of the folder and subfolder containing the target document.	Yes*	Folder and/or subfolder: `[folder],[subfolder]`

Note:
*Only mandatory if a value is specified for `sDocName` and is not unique.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2005
```

sType

Syntax	Description	Mandatory?	Values
`sType`	The file type of target document or report.	Yes	• `wid` • `rpt` • `car`

Note:
This parameter is ignored for agnostic documents.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid
```

token

Syntax	Description	Mandatory?	Values
`token`	A valid logon token for the current CMS session.	No	The logon token for the current CMS session.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=Sales+in+2003&token=<logonToken>
```

openDocument input parameters

This section details the openDocument input parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

lsC

Syntax	Description	Mandatory?	Values
`lsC`	Specifies a contextual prompt if there is an ambiguity during SQL generation (Business Objects and Web Intelligence documents only). **Note:** Not supported by OLAP Intelligence	No	A prompt value that resolves the ambiguity in the SQL generation.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010&lsC=Sales
```

lsM[NAME]

Syntax	Description	Mandatory?	Values
`lsM[NAME]`	Specifies multiple values for a prompt. `[NAME]` is the text of the prompt.	No	• Multiple prompt values, separated by a comma. If the target is a Crystal report, each value must be enclosed in square brackets. If the target is a OLAP Intelligence report, use the MDX WITH clause (refer to *Using the lsS parameter with OLAP Intelligence reports* on page 294 and *Using the lsM parameter with OLAP Intelligence reports* on page 295). • `no_value` (only for optional parameters)

Note:
You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=rpt&sDocName=SalesReport&lsMSe
lect+Cities=[Paris],[London]
```

lsR[NAME]

Syntax	Description	Mandatory?	Values
`lsR[NAME]`	Specifies a range of values for a prompt. `[NAME]` is the text of the prompt. **Note:** Not supported by OLAP Intelligence	No	• A range of values for the prompt, separated by a double period (..). If the target is a Crystal report, the range must be enclosed in square brackets and/or parentheses (use a square bracket next to a value to include it in the range, and parentheses to exclude it). • `no_value` (only for optional parameters)

Note:
You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=rpt&sDocName=SalesReport&lsRTime+Peri
od:=[2000..2004)
```

lsS[NAME]

Syntax	Description	Mandatory?	Values
`lsS[NAME]`	Specifies a value for a single prompt. `[NAME]` is the text of the prompt.	No	• A single prompt value (refer to *Using the lsS parameter with OLAP Intelligence reports* on page 294 and *Using the lsM parameter with OLAP Intelligence reports* on page 295). • `no_value` (only for optional parameters)

Note:
You can remove an optional parameter from the prompt by setting it to `no_value` in the openDocument query string. If you leave an optional parameter out of the openDocument query string, a default parameter value will be applied.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010&lsSSe
lect+a+City=Paris
```

sInstance

Syntax	Description	Mandatory?	Values
`sInstance`	Indicates which specific instance of the target report to open.	No	• `User` (Link to latest instance owned by current user) • `Last` (Link to latest instance for report) • `Param` (Link to latest instance of report with matching parameter values)

Note:
Use this parameter in combination with `sDocName`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sReport
Part=Part1&sInstance=User
```

sPartContext

Syntax	Description	Mandatory?	Values
`sPartContext`	In Crystal Reports, a report part is associated to a data context.	Yes*	Data context of the report part.

Note:
*Only mandatory if a value is specified for `sReportPart`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2005&sReport
Part=Part1&sPartContext=0-4-0
```

Note:
The `sReportPart` and `sPartContext` parameters are supported with the regular DHML viewer (`sViewer=html`). Instead of the first page of the report, the DHTML viewer displays the page and context containing the part with the part highlighted.

sRefresh

Syntax	Description	Mandatory?	Values
`sRefresh`	Indicates whether a refresh should be forced when the target document or report is opened.	No	• `Y` (forces the document's refresh) • `N` (note that the refresh on open feature overrides this value)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010&sRefresh=Y
```

sReportMode

Syntax	Description	Mandatory?	Values
`sReportMode`	For Crystal targets only, indicates whether the link should open the full target report or just the report part specified in `sReportPart`.	No	• `Full` • `Part`

Note:
Defaults to `Full` if this parameter is not specified. Only applies if a value is specified for `sReportPart`.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpecific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sReportPart=Part1&sReportMode=Part
```

sReportName

Syntax	Description	Mandatory?	Values
`sReportName`	Indicates which report to open if target document is multi-report.	No	Report name for Web Intelligence documents, sub-report for Crystal Reports, pages for OLAP Intelligence reports.

Note:
Defaults to the first report if this parameter is not specified.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=Sales+in+2003&sReportName=First+Re
port+Tab
```

sReportPart

Syntax	Description	Mandatory?	Values
`sReportPart`	Indicates which specific part of the target report to open.	No	Name of the report part.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sReport
Part=Part1
```

Note:
The `sReportPart` and `sPartContext` parameters are supported with the regular DHML viewer (`sViewer=html`). Instead of the first page of the report, the DHTML viewer displays the page and context containing the part with the part highlighted.

openDocument output parameters

This section details the openDocument output parameters that are available and gives examples on how to use the commands.

An openDocument URL is generally structured as follows:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?<parameter1>&<parameter2>&...&<parameterN>
```

The exact syntax of the `<platformSpecific>` parameter depends on your implementation:

- For Java implementations, use `openDocument.jsp` in place of the `<platformSpecific>` parameter.
- For .NET implementations, use `opendocument.aspx` in place of the `<platformSpecific>` parameter.

Note:
Variables are denoted with angle brackets. You must substitute the proper value for these variables. For example, you must use the name of your server in place of `<servername>` where it is contained in the code samples below, and you must use your port number in place of `<port>`.

NAII

Syntax	Description	Mandatory?	Values
`NAII`	Forces the display of the prompt selection page. **Note:** Only supported by Web Intelligence documents.	No	• Y (all prompts whose values are passed with `lsS`, `lsM` or `lsR` are pre-selected)

Note:
- If the document prompt values are purged, then `NAII=Y` raises the prompt for any values not specified in the URL.
- If the document prompt values are not purged, then `NAII=Y` raises the prompt for any values not specified in the URL and pre-selects the default values.
- If all prompt values are specified in the URL, the prompt window does not appear even if `NAII=Y` is specified.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010&NAII=YsRe
fresh=Y
```

sOutputFormat

Syntax	Description	Mandatory?	Values
`sOutputFormat`	Indicates the format in which the target document is opened.	No	• `H` (HTML) • `P` (PDF) • `E` (Excel) • `W` (Word)

Note:
Defaults to HTML if this parameter is not specified.

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sOutput
Format=E
```

sViewer

Syntax	Description	Mandatory?	Values
`sViewer`	Indicates the viewer that is used to view the document.	No	• `html` • `part` (Crystal reports only) • `actx` (Crystal reports only) • `java` (Crystal reports only)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sView
er=html
```

Example:

Note:
In order to use parameters in the URL with the ActiveX viewer, `:connect` must be appended to the URL, followed by the parameters.

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sPath=[Sales+Reports]&sDocName=Sales+in+2003&sViewer=ac
tx:connect&IsMCountry=[Thailand],[Norway]
```

---

sWindow

Syntax	Description	Mandatory?	Values
`sWindow`	Indicates whether the target report will open in the current browser window or whether a new window will be launched.	No	• `Same` (current browser window) • `New` (new browser window is launched)

Example:

```
http://<servername>:<port>/OpenDocument/opendoc/<platformSpe
cific>?sType=wid&sDocName=SalesReport&iDocID=2010&sWindow=New
```

Contextual report linking

The openDocument feature allows you to create contextual links between Crystal reports, OLAP Intelligence reports and Web Intelligence documents. To do this, you construct a URL using the openDocument syntax and then

insert the URL into a Crystal report, OLAP Intelligence report or Web Intelligence document.

Contextual report linking allows report designers to specify associations for documents residing in either a Crystal Reports environment (unmanaged) or a BusinessObjects Enterprise environment (managed). Once these associations are created, users follow the resulting navigational paths embedded in the linked documents.

This feature enables you to invoke Business Objects and Web Intelligence documents from Crystal Reports and vice versa. This feature relies on functionality that allows the user to do the following:

- Link Web Intelligence or Business Objects documents within the document domain.
- Link report objects in Crystal Reports.

Click the appropriate link to jump to that section:

- *To insert a link into a Crystal report* on page 314
- *To create a link to another report or document from an OLAP Intelligence report* on page 315
- *Creating links in Web Intelligence documents* on page 316

To insert a link into a Crystal report

You can use openDocument to create hyperlinks in Crystal Reports. To create a link to another report or document, use the Hyperlink Tab of the field Format Editor.

1. Open the source report in Crystal Reports.
2. Right-click the field in which you want to insert the openDocument link and select **Format** from the shortcut menu.
3. In the Format Editor, select the **Hyperlink** tab.
4. Select **A website on the Internet**.
5. In the “Hyperlink information? area, leave the **Website Address** field empty and click the **Format Formula Editor** button.

6. Enter the openDocument link in the following format:

```
"http://[openDocument parameters]"+{Article_lookup.Fami
ly_name}
```

   Where [openDocument parameters] are described in *openDocument parameter overview* on page 295, and the {Article_lookup.Family_name} enables the report to pass context-dependent data.

   Note:
   Test your link in a browser window before inserting it into a report or document.

7. Click **Save and Close** to leave the Formula Workshop.
8. Click **OK** in the Formula Editor to save the link.

To create a link to another report or document from an OLAP Intelligence report

You can use openDocument to create hyperlinks in OLAP Intelligence reports.

1. Open the source report in the OLAP Intelligence designer.
2. On the **Tools** menu, select **Action Manager** .
3. Click **New** to create a new action.
4. Enter an action name.
5. Select the area to which the action (the link) will apply.
6. Enter the openDocument link using the parameters and syntax described in this document.

   Tip:
   Test your link in a browser window before inserting it into a report or document.

7. Click **OK** to save the link.
8. Close the Action Manager dialog box.
9. Create an Analysis Button on the source report.
10. Right-click the Analysis Button.
11. In the drop-down menu, select **Properties** and then **Edit** .
12. Select **Launch an action** .
13. Select the action that corresponds to the openDocument link created in steps 3 through 6.

14. Click **OK** .

Creating links in Web Intelligence documents

You can define objects in a universe that allow Web Intelligence and BusinessObjects users to create reports whose returned values include links to other reports and documents.

When these reports are exported to the repository, users can click returned values displayed as hyperlinks to open another related document stored in the document domain of the repository.You create these links using the openDocument function in the definition of an object in Designer.

More information

For full information on creating links in Web Intelligence reports, see the *Building Reports Using the WebIntelligence Java Report Panel* guide.

You enable report linking in a universe by creating an object (the link object) whose returned values are the same as the values used as input to a prompt in an existing report (the target report).

The openDocument function allows the values for the link object to be returned as hyperlinks. When the user clicks the hyperlink, its value is used as the prompt input for the target report.

You can create documents using the link object as you would with any other object. Users can then click the hyperlinks to access more detailed documents related to the link object.

To create a link object, use the openDocument function in the object's Select statement. The Select statement for a link object follows this order:

```
'<a href="http://<servername>:<port>/OpenDocument/<platformSpe
cific>?sDocName=<document name>&sType=<document type>&iDo
cID=<document id>&lsS<prompt message>='+object SELECT+'">'+ob
ject SELECT+'</a>'
```

The concatenation operator (+) applies for Microsoft Access databases. Use the operator appropriate to your target RDBMS.

For more details on the Select statement, creating link objects, and using link objects in InfoView, refer to the *Designer's Guide*.

Working with documents

chapter 27

To create a Web Intelligence document from InfoView

1. Click **Document List** on the InfoView toolbar.
2. Click **New** > **Web Intelligence Document**
3. Select the universe on which you want to create the document and click **OK**.

   Note:
   If your InfoView Web Intelligence preferences specify a default universe, this step is omitted and the Web Intelligence query editor opens and displays the objects in the default universe.

4. The Web Intelligence query editor specified in the InfoView Web Intelligence preferences opens and displays the objects in the universe you selected.
5. Build and run the query using the query editor.

To open a Web Intelligence document from InfoView

1. Click **Document List** to show the documents available in InfoView.
2. Navigate to the folder containing your document.
3. Select the document and select **Action** > **View** or **Action Modify** depending on whether you want to view or modify the document.

   The document opens in the view format or document editing tool selected in your InfoView Web Intelligence options.

Related Topics

- *Web Intelligence document creation and viewing options* on page 27

To delete a Web Intelligence document from InfoView

1. From the InfoView home page, navigate to the folder that contains the document you want to delete.

2. Select the check box next to the name of the document you want to delete.
3. Click **Delete**.

Saving documents

To save a new Web Intelligence document in InfoView

1. With the document open in the Java Report Panel or Web Intelligence HTML, click **Save** on the main toolbar.

   The **Save Document** dialog box opens.
2. Click **Folders** or **Categories** to display the repository by folders or by categories.
3. In the **Name** box, type the name of the document.
4. Click **Advanced** to display additional document options.
5. In the **Description** box, type a meaningful description of the document (optional).
6. In the **Keywords** box, type keywords that you or other users can use to search for the document in the future (optional).
7. Select **Refresh on open** to refresh the document each time it is opened.
8. Select **Permanent Regional Formatting** to preserve the document regional formatting with the document.
9. Click **OK**.

   The document is saved in InfoView.

To save a Web Intelligence document as an Excel spreadsheet

1. With the document open, click **Document** > **Save to my computer as** > **Excel** (in Web Intelligence HTML) or click the arrow next to **Save**, then select **Save to my computer as**, then click **Excel** (in the Java Report Panel).

Note:
You can save the current report to Excel format in Web Intelligence HTML by selecting **Save report to my computer as** > **Excel** from the menu.

The **File Download** dialog box appears.

2. Type a file name or accept the default name displayed.
3. Select **Save this file to disk**, then click **OK**.
4. Select a file location on your computer, then click **Save**.

   Web Intelligence saves a copy of your document in Microsoft Excel format to the location you specified on your computer. Each report within the Web Intelligence document converts to a separate Excel worksheet within the Excel file.

   Some Web Intelligence chart formats do not exist in Excel. These charts are automatically converted to the closest corresponding chart format available in Excel.

   Web Intelligence starts a new Excel worksheet for each 65K rows of exported data.

To save a Web Intelligence document as a PDF file

1. With the document open, click **Document** > **Save to my computer as** > **PDF** (in Web Intelligence HTML), or click the arrow next to **Save**, then select **Save to my computer as**, then select **PDF** (in the Java Report Panel).

   The **File Download** dialog box appears.
2. Type a file name or accept the default name displayed.
3. Select **Save this file to disk**, then click **OK**.
4. Select a file location on your computer, then click **Save**.

   Web Intelligence saves a copy of your document in Adobe Acrobat PDF format to the location you specified on your computer.

To save a Web Intelligence document as a CSV file

1. With the document open, click **Document** on the toolbar above the displayed reports (in Web Intelligence HTML), or click the arrow next to **Save** (in the Java Report Panel).
2. Select **Save to my computer as** > **CSV** to save the document with the default options or **Save to my computer as** > **CSV (with options)** to choose the options.
3. If you chose **CSV (with options)**, choose the text qualifier, column delimiter and character set in the "Save as CSV - Options" dialog box.
4. Select **Set as default values** in the "Save as CSV - Options" dialog box if you want the options you chose in the previous step to be the default options when you save to CSV.
5. Click **OK** to close the "Save as CSV - Options" dialog box.

   The **File Download** dialog box appears.
6. Select **Save this file to disk**, then click **OK**.
7. Type a file name or accept the default name displayed.
8. Select a file location on your computer, then click **Save**.

   Web Intelligence saves a copy of your document in CSV format to the location you specified on your computer.

Automatic saving and recovery

Saving documents automatically

If Web Intelligence is configured for autosave, and if you have the appropriate security rights, Web Intelligence saves your documents automatically in the `My Favorites/~Web Intelligence` folder as you work. Web Intelligence uses the document name prefixed by the document ID and followed by the autosaved document ID to name autosaved documents. (If the document ID is -1, the document was not saved before being autosaved.)

Note:
Web Intelligence Rich Client does not save documents automatically.

Web Intelligence saves documents at a regular interval, which is defined in the CMC. This interval is reset each time you save a document manually, and each time Web Intelligence saves a document automatically. Web Intelligence also deletes the autosaved document when you save a document manually.

In addition to regular autosaving, Web Intelligence saves documents when your Web Intelligence session times out.

Note:
If you lose a Web Intelligence document before you can save it, check the folder immediately for the autosaved version. The `My Favorites/~Web Intelligence` folder is not a permanent storage location for autosaved documents.

For more information on the settings and security rights that impact automatic saving, see the documentation for the Central Management Console.

Related Topics

- *How Web Intelligence manages autosaved documents* on page 323
- *Recovering autosaved documents* on page 322

Recovering autosaved documents

If your session times out while you are working on a document, Web Intelligence automatically saves the document in the `My Favorites/~Web Intelligence` folder and displays a dialog box explaining that the session has ended.

If you select **Restore** on the dialog box, Web Intelligence launches a new session and re-opens the autosaved document. The next time you save the document manually, Web Intelligence saves it in its original folder.

If you select **Close**, you are redirected to the InfoView home page. The autosaved document is available in the `My Favorites/~Web Intelligence` folder.

In some cases, Web Intelligence cannot link to the autosaved document after a server timeout or connection loss. In this case Web Intelligence does not offer you the option to restore the autosaved document. You must check the `My Favorites/~Web Intelligence` folder immediately for your autosaved

document. Web Intelligence regularly deletes documents from the folder based on the autosave settings.

Related Topics

- *Saving documents automatically* on page 321
- *How Web Intelligence manages autosaved documents* on page 323

How Web Intelligence manages autosaved documents

Web Intelligence saves documents automatically in the `My Favorites/~Web Intelligence` folder.

Whenever you save a document manually, Web Intelligence also updates the autosaved document with the changes. As a general rule, Web Intelligence handles autosaving transparently and you do not access autosaved documents directly. You need to access them directly when your Web Intelligence session timed out, and Web Intelligence was unable to reopen your autosaved document.

Note:
If you need to access an autosaved document directly, check the `My Favorites/~Web Intelligence` folder immediately. This folder is not a permanent storage location for autosaved documents.

The `My Favorites/~Web Intelligence` folder has a maximum size limit, which is set in the CMC. When the total size of the documents in the folder exceeds this limit, Web Intelligence deletes as many of the oldest documents in the folder as necessary to make way for the latest document.

Web Intelligence also deletes all documents from the folder at a defined interval, which is set in the CMC.

If you navigate away from your Web Intelligence document in your browser without saving the document, the document is lost and Web Intelligence clears the contents of the `My Favorites/~Web Intelligence` folder.

Related Topics

- *Saving documents automatically* on page 321
- *Recovering autosaved documents* on page 322

Printing Web Intelligence documents

You print Web Intelligence documents report-by-report. You can print one or multiple reports from a single document.

Web Intelligence prints reports from left to right, and then top to bottom. If a report is wider than the width of the paper size defined in the Report Page Layout, Web Intelligence inserts page breaks for the printout.

The paper size and page orientation for printing can be different from the paper size and page orientation set for the reports when you view them in the Java Report Panel or Web Intelligence Rich Client. This enables users using different printers to specify the appropriate layout when they print.

Web Intelligence prints documents directly in the Java Report Panel and Web Intelligence Rich Client. Web Intelligence HTML exports the document to PDF file that you can then print.

To print a document

1. Click the report tab you want to print.
2. Click the **Print this document** button on the Report toolbar.

   The "Print" dialog box appears.
3. Under the **Print Range** option, you specify whether you want to print the entire selected report or just some of the report pages.

   You can specify the paper size of the report or page(s) for the printout. The paper size you set for printing overrides the paper size defined for the report in the Report Properties Page Layout tab.
4. To change the paper size, click the arrow next to the list box below **Paper Size**,and then select a different paper size from the list.
5. Under the **Orientation** options, select the page orientation that suits the report page layout.
6. Under the **Margins** options, select the margin sizes.
7. Under the **Copies** options, select the number of copies to print.
8. Click **OK**.

Editing document properties

The Web Intelligence document properties are divided into groups in the **Document Properties** pane. To expand a group to see the properties it contains, click the down arrow button next to the group name. When you expand a group, the down arrow button changes to an up arrow button. Click this button to contract the group.

You display the Document Properties pane by right-clicking a report outside all report components and selecting **Document Properties** from the menu.

Group	Property	Description
Document Information	Created by	The document creator.
	Last modified by	The last user to modify the document.
	Creation date	The date the document was created.
	Name	The document name.
	Description	The document description.
	Keywords	The document keywords.
	Locale	The document formatting locale.
	Data tracking	Indicates whether data tracking is activated.
Document Options	Refresh on open	Tells Web Intelligence to refresh the document when it is opened.
	Enhanced Viewing	Optimizes the document appearing for on-screen viewing.

	Use query drill	Tells Web Intelligence to drill in query drill mode.
	Permanent regional formatting	Permanently associates the current document locale with the document.
Data Synchronization Options	Auto-merge dimensions	Tells Web Intelligence to synchronize data providers by merging dimensions automatically under certain conditions.
	Extend merged dimension values	Tells Web Intelligence to extend dimension values in reports with synchronized data providers.
Report Order		Sets the report order in a document.

To display document properties

- Right-click a report outside all report components and select **Document Properties** from the menu, or click **...** next to the **General** > **Document Properties** property on the **Data** tab.

To purge data from a document

1. Click **Purge Data** on the main toolbar.

   Web Intelligence purges the data from the document.

2. If the document contains multiple queries and you want to purge the data from a specific query, click the arrow at the right of the **Purge Data** button and select **Purge <Query name>** from the menu.

   Web Intelligence purges the data from the query.

More Information

appendix A

Information Resource	Location
SAP BusinessObjects product information	*http://www.sap.com*
SAP Help Portal	Select *http://help.sap.com* > SAP BusinessObjects. You can access the most up-to-date documentation covering all SAP BusinessObjects products and their deployment at the SAP Help Portal. You can download PDF versions or installable HTML libraries. Certain guides are stored on the SAP Service Marketplace and are not available from the SAP Help Portal. These guides are listed on the Help Portal accompanied by a link to the SAP Service Marketplace. Customers with a maintenance agreement have an authorized user ID to access this site. To obtain an ID, contact your customer support representative.
SAP Service Marketplace	*http://service.sap.com/bosap-support* > Documentation • Installation guides: *https://service.sap.com/bosap-inst guides* • Release notes: *http://service.sap.com/releasenotes* The SAP Service Marketplace stores certain installation guides, upgrade and migration guides, deployment guides, release notes and Supported Platforms documents. Customers with a maintenance agreement have an authorized user ID to access this site. Contact your customer support representative to obtain an ID. If you are redirected to the SAP Service Marketplace from the SAP Help Portal, use the menu in the navigation pane on the left to locate the category containing the documentation you want to access.
Developer resources	*https://boc.sdn.sap.com/* *https://www.sdn.sap.com/irj/sdn/businessobjects-sdklibrary*

Information Resource	Location
SAP BusinessObjects articles on the SAP Community Network	*https://www.sdn.sap.com/irj/boc/businessobjects-articles* These articles were formerly known as technical papers.
Notes	*https://service.sap.com/notes* These notes were formerly known as Knowledge Base articles.
Forums on the SAP Community Network	*https://www.sdn.sap.com/irj/scn/forums*
Training	*http://www.sap.com/services/education* From traditional classroom learning to targeted e-learning seminars, we can offer a training package to suit your learning needs and preferred learning style.
Online customer support	*http://service.sap.com/bosap-support* The SAP Support Portal contains information about Customer Support programs and services. It also has links to a wide range of technical information and downloads. Customers with a maintenance agreement have an authorized user ID to access this site. To obtain an ID, contact your customer support representative.
Consulting	*http://www.sap.com/services/bysubject/businessobjectsconsulting* Consultants can accompany you from the initial analysis stage to the delivery of your deployment project. Expertise is available in topics such as relational and multidimensional databases, connectivity, database design tools, and cus tomized embedding technology.

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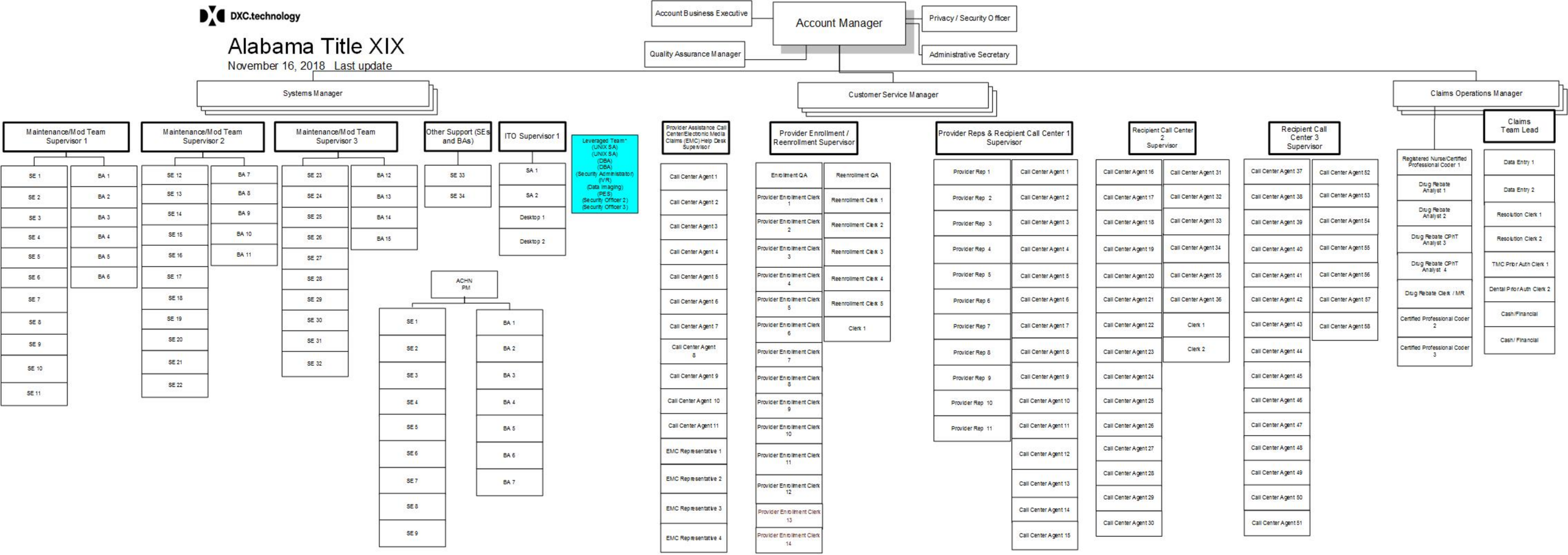

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